WEST HAMPSHIRE
CLINICAL COMMISSIONING GROUP
JOINT STRATEGIC NEEDS ASSESSMENT 2013

This section presents the joint strategic needs assessment for the resident population of West Hampshire CCG (WH CCG). Whenever possible and appropriate, data are presented for the CCG as a whole or for the three groupings of practices that the CCG recognises – West New Forest, WINCAR and Andover and Mid-West Hampshire. Where data are not available by CCG, the local authorities which fall within the CCG boundary are presented. These are Test Valley, Winchester, Eastleigh, New Forest, parts of Basingstoke and Deane and East Hampshire districts.

To place local figures into context, data are compared to other areas. Where available the preferred comparator is England.
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Key findings

- The West Hampshire (WH) population is older than the England population with a smaller proportion of younger people and working age people. This pattern is very marked across the West New Forest practice grouping.

- While overall population growth is forecast to be small over the next five years (8,454 people, 1.59%) a higher proportion of the increase will be in the over 75 age group in all areas of the CCG. The WINCAR and Andover grouping will see the biggest increase.

- This increase, coupled with a reduction in the proportion of 15-44 year olds, has significant implications for employment, health and social care services.

- Despite the ageing population, just over one in five of the CCG population (122,154) is under 20.

- The CCG population is less ethnically diverse than the England population with 93% of people in the 2011 Census identifying themselves as White British.

- Socio-economic deprivation is strongly associated with poor health. Improving education, income and employment are key to reducing the resultant health inequalities and improving the health status of the population.

- Overall the CCG has very low levels of socio-economic deprivation which can make it difficult to identify and tackle the pockets of health and social inequalities that we know exist – almost 75,000 people live in the most deprived quintile nationally; just over one in ten children (10,400) are living in poverty and one in ten people over 60 in the CCG are income deprived.

- Life expectancy is significantly higher across the CCG for men and women than average for both the South East and England.

- The more deprived areas in WH CCG are to be found in Andover town, central and south Eastleigh, Winnall and Highcliffe in Winchester, and Holbury and North Blackfield (Waterside) and New Milton in the New Forest.

- Over a quarter of the population are affected by very poor geographical access to services, reflecting the rural geography of the CCG.

- Being in work is good for health and the proportion of working age people who are economically active in WH is high.
The CCG has a relatively high proportion of people over 65 living alone which increases the risk of loneliness and its associated poor health - increased blood pressure, risk of heart disease and depression.

The previous rise in births may be starting to level off. Revised projections to 2021 indicate a decline in births that fluctuate over time.

Infant mortality rates are lower than the England average as we would expect for an affluent population.

Child mortality rates are not available for the CCG but we know that the UK lags behind Europe in reducing mortality rates for children from asthma, meningitis, pneumonia and diabetic ketoacidosis.

Teenage conception rates in all local authorities in the CCG have been falling since 1998. The rates in Eastleigh and New Forest remain among the highest in the County. Just under 50% of teenage conceptions end in abortion.

WH CCG performs relatively well on a range of health indicators for children and young people but there is still significant room for improvement, given the relative affluence of the population:

- one in eight women are still smoking when she delivers her baby
- only 62% of babies are being breastfed at 6-8 weeks
- too many children are overweight and obese
- there are inequalities in oral health with higher rates of dental decay in Eastleigh and New Forest
- immunisation rates for MMR and dTaPIV booster do not reach the WHO 95% target to ensure herd immunity
- only just over a half of school leavers (compared to the 90% target) receive their school leaver booster – almost the lowest rate amongst Hampshire CCGs

The CCG has a higher than average rate of A&E attendances for children and young people with a below average rate of emergency admissions. This suggests that for many families with children an A&E attendance is the easy access point to unplanned health advice but it is not the most appropriate way to manage their health problem and requires further investigation.

The estimated smoking prevalence amongst adults in all local authorities in the CCG is significantly lower than the England rate of 20%. Differential smoking rates between societal groups make a major contribution to health inequalities. Smoking rates amongst routine and manual workers are much higher than in the general population with three in ten people in this group in New Forest and Test Valley smoking and four in ten in Winchester.
• Obesity rates in adults are similar to England except in Winchester district where they are significantly lower. Too many people in the CCG have an unhealthy weight (about six in ten) and indications are that rates will continue to rise.

• Estimates of the proportion of people in the CCG who are drinking more alcohol than the government recommended level are lower than for England. There is a persistent upward trend in alcohol related admissions.

• Modelled estimates suggest that there is significant under recording/under diagnosis of all long term conditions. There may be as many as 10,760 people with undiagnosed Coronary Heart Disease; 2,669 people with undiagnosed stroke or TIA; 94,767 people with undiagnosed hypertension; 9,134 with undiagnosed diabetes, 32,000 with undiagnosed CKD and just over 4,000 with undiagnosed COPD in WH CCG.

• In contrast to England, cancer incidence rates for 2009-2011 were stable in Hampshire. Overall cancer rates in WH are similar to England but the incidence of lung cancer is significantly lower than the national average and the incidence of prostate cancer significantly higher. Differences in incidence are likely to be partly due to differences in the way that men present with symptoms that could be due to prostate cancer and local clinical practice of PSA testing.

• In 2011/12 there were 11,540 people (2.1%) in WH CCG on GP cancer registers. This rate is higher than England (1.8%) and likely to be due to the CCG age profile - age is a very strong risk factor for cancer. More people are surviving cancer and the number is predicted to continue to increase reflecting improved life expectancy and improved survival from cancer. The needs of cancer survivors are becoming increasingly important.

• Coverage for bowel cancer screening exceeds the national target. Coverage for breast cancer and cervical cancer screening falls short of the national targets, which is surprising and disappointing given the socio-economic profile of the CCG population.

• In WH CCG 9,853 people aged 65 and over are estimated to have depression and in the same age group 3,168 are estimated to have severe depression. Projected figures suggest that this will increase by 20% by 2020.

• Many people with a long term condition have poor mental health and this accounts for 12-18% of the NHS spend on managing these conditions.
• The prevalence of dementia in WH CCG is 0.74% (3,976 people) which is significantly higher than Hampshire (0.65%) and England (0.53%) The older population structure of the CCG is likely to explain the higher prevalence.

• It is estimated that only about half of people with dementia are recorded on GP registers.

• The number of people aged 65 and over with dementia in WH CCG is predicted to increase by 28% from 8,408 in 2012 to 10,761 in 2020.

• The overall rate of hospital admissions as a result of falls and fall injuries in people aged 65 and over is lower than the Hampshire rate, with the highest rate in the Mid-West Hampshire grouping.

• There is variation in the rate of knee arthroscopies in the CCG, with particularly high rates in Test Valley, suggesting that this may be related to demand and supply, rather than need and should be investigated.

• The number of vulnerable adults with physical and learning disabilities requiring support from adult social services continues to increase.

• Estimates suggest that there are 3,650 males and 430 females with autism aged 19 years old and above in WH CCG many of whom are undiagnosed and not known to services.

• WH CCG has the lowest all cause mortality rate in the County, significantly lower than the national rate. The trajectory continues downwards. For the first time in 2011 cancer was the leading cause of death accounting for 30% of deaths compared to 28% from circulatory disease.
Recommendations

- Older people are highest users of health and social care services. While poor health and disability are not inevitable consequences of ageing and the majority of older people remain independent, the prevalence of long term and other health conditions does increase with older age and functional abilities may decline. The CCG needs to ensure that it commissions models of care that cater for the needs of the ageing population.

- It is important to ensure that people are as healthy as possible as they enter older age to enable them to remain independent with a good quality of life for as long as possible, and to minimise the need and demand for social care and NHS services. The CCG needs to include plans for primary and secondary prevention at all stages of the life course in its commissioning plans.

- The CCG should ensure that commissioning plans explicitly tackle the inherent inequalities in the area and apply the principle of proportionate universalism to resource allocation. Particular attention should be given to ensuring and monitoring geographical access to services for all population groups in WH CCG.

- Gender inequalities in accessing timely services should be considered as there is evidence that women are less likely to have access to planned hospital care, particularly for CVD.

- Whilst housing, 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 patients to local initiatives.

- Children and young people under 20 make up a fifth of the CCG population and it is vital that in addition to meeting the needs of older people there is adequate capacity in services for children and their families.

- To improve the low breastfeeding rates, the CCG should ensure that it is involved in local initiatives around breastfeeding and promote multi-agency support to encourage and maintain breastfeeding.

- Tackling childhood obesity remains a high priority and agencies should work together to implement the Hampshire Healthy Weights strategy for children and further enhance work with families.

- Growing up in poverty adversely affects a child’s life chances and future health. The alleviation of childhood poverty should be a key policy driver for
local authorities and other partners, including the CCG, and the Health and Wellbeing Board.

- There is scope to improve immunisation uptake, particularly the teenage booster vaccination. Achieving high coverage will be especially important as the 2nd Meningitis C vaccine is moved to this age. Practices can actively recall those in need of vaccination.

- The CCG should continue to explore the high A&E attendance rate for children and young people to inform the commissioning of urgent care services for children, particularly in the context of UK childhood mortality rates which have not shown the same improvement as in other parts of Europe.

- An increased focus on primary prevention of long term conditions is required. There are common risk factors for cardiovascular disease, including diabetes and dementia, and cancer. Smoking, hypertension, obesity, physical inactivity and alcohol are the major contributors to the overall burden of disease in the UK and addressing these is vital to reducing the prevalence of long term conditions.

- CCGs should support multi-agency work to reduce the impact of alcohol locally, including the training and education of a wide range of frontline practitioners to be confident in the delivery of basic evidence based alcohol screening (identification) and brief advice.

- Whilst smoking cessation services have been relatively successful further work is needed to target communities where smoking rates are particularly high. Routine and manual workers, pregnant women and people with long term conditions should be the focus of attention. There is a need to work with the local authority to promote smoke-free homes especially in families with young children.

- Rising obesity levels will have significant implications for health in the future and requires a systematic multi-agency strategic approach to tackle obesity locally and countywide.

- Action should be taken to identify the significant numbers of people in the CCG who are estimated to be living with undiagnosed cardiovascular disease, including hypertension, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and dementia, with a particular focus on people living in deprived areas so that they can benefit from systematic proactive management of their condition.
To reduce inequalities in health outcomes the CCG should ensure that services are accessible to those groups of people at the highest risk of disease and those who have poorer outcomes from treatment.

The CCG should continue to review services for long term conditions with a view to ensuring that they are commissioning, or working towards commissioning fully integrated evidence -based services.

The CCG should ensure that all chronic disease care pathways include primary prevention and case ascertainment as well as evidence based management and secondary prevention to improve outcomes.

CCGs should evaluate cardiac rehabilitation in Hampshire in line with national guidance and ensure that all cardiac rehabilitation providers are participating in the national audit. Given the predicted increase in the levels of obesity the number of people with diabetes will increase. Practitioners should give as much focus to primary prevention of diabetes, as well as good care and management.

The CCG should ensure that all practices are submitting to the National Diabetes Audit, and should use these data to monitor the proportion of people with diabetes receiving all 9 key care processes and should be aiming to be in the top national quartile for the proportion of people with diabetes achieving HbA1c, blood pressure and cholesterol targets than the national average.

To reduce mortality from cancer the CCG should actively support national and local initiatives to increase awareness and early diagnosis of cancer; review emergency presentations of cancer and explore ways in which they can be reduced as they are associated with a poorer prognosis and work to increase the coverage of cancer screening programmes, particularly breast and cervical cancer screening.

The needs of the increasing number of cancer survivors, including the provision of secondary prevention should be reviewed.

The CCG should prioritise appropriate management of poor mental health, including mental health problems in people with long term conditions and plan for an increase in prevalence.

IAPT should be made available to people with long term conditions and it will be important to ensure that the prescribing of anti depressants reduces as the IAPT service is fully rolled out.
• With high rates of dementia reflecting the older population structure the CCG needs to support early diagnosis and management of dementia and the use of anti dementia drugs according to NICE.

• The CCG should ensure that people with dementia and their carers have access to timely and person centred advice, support and care.

• Musculoskeletal conditions are a major contributor to the burden of disease and promoting bone health using evidence based strategies is increasingly important to reduce the risk of osteoporosis and hip fractures in an ageing population.

• The CCG can achieve better musculoskeletal outcomes, using an integrated care pathway approach, starting with prevention, ensuring appropriate treatment in primary and secondary care and promoting self-management and shared decision making.

• The CCG should continue its work to make an accurate assessment of musculoskeletal needs of the local population and investigate variations in intervention rates to inform the commissioning of services.

• Mortality rates are lower than average in the CCG and continue to fall. There is a need to focus on primary and secondary prevention and good quality care for the main causes of death. The CCG should ensure that men are accessing prevention and treatment services.
1 Demography

In the 2011 Census, the resident population of WH CCG was 538,424 people, consisting of 261,580 men (48.6%) and 276,844 women (51.4%). This makes up 40.8% of the total resident population of Hampshire\(^1\). WH CCG is the largest in the county and covers a geographical area of 224,233 hectares, with an average of 2.4 people per hectare. This is lower than the Hampshire average of 3.6 people per hectare (ONS, 2011). The size of the CCG means that it can be split into three groupings of GP practices that work together (WINCAR & Andover, Midwest Hampshire and West New Forest) to take account of clusters of differing demography and associated behaviours. The Mid-West Hampshire Grouping is the largest grouping with a population of 240,385. WINCAR & Andover is similar in magnitude with a population of 200,540. West New Forest Grouping is the smallest with a population of 97,499.

There are 224,517 households in WH CCG. The population pyramids (figure 1) show that overall WH CCG and the Mid-West Hampshire and WINCAR & Andover groupings have relatively similar population structures to the Hampshire population, with fewer people aged 15-44 years and higher numbers of people aged over 65 years compared to the England population. West New Forest has a very different population structure, with more people over the age of 60 years and significantly fewer younger people compared to the Hampshire and England populations.

Just over one in five (122,154 people) of the total population of WH CCG are aged under 20. For Mid-West Hampshire grouping the proportion of children and young people is about the same as Hampshire (23%), for West New Forest Grouping the proportion is less (19%), and for WINCAR and Andover Grouping the proportion is slightly higher (25%).

\(^1\) ONS resident population, 2011
The population of WH CCG is projected to increase marginally - by 8,545 people (1.59%) by 2018, which is less than the projected increase for Hampshire (1.77%) and England (4.11%) over the same time period (figure 2). The change varies across each area grouping, with Mid-West Hampshire and West New Forest both having a projected decrease of 15-44 year olds (4,276 people or 10.13% and 1,629 people or 12.42% respectively) and WINCAR & Andover a 1.21% (439 people) reduction in the number of 15-29 year olds. All areas in WH CCG are projected to have more people over the age of 75 years old. This increase varies from 268 people (5.02%) in West New Forest, 1,252 people (9.26%) in Mid-West Hampshire to 6,934 people (11.2%) in WINCAR & Andover and compares to 9.94% in Hampshire and 10.56% in England. These population projections highlight the increasing older population in the area.
1.1 Ethnicity and residence in the UK

The 2011 Census showed that 93% of the population in WH CCG identified themselves as White British, which is high compared to the England (79.8%) and Hampshire (91.8%) averages. Non British White people make up a further 3.1% of the population. 0.7% has been resident in the UK for less than 2 years, compared to 0.8% in Hampshire and 1.8% in England.

In WH CCG the largest ethnic groups other than White British as described by detailed Census ethnic group are Indian or British Indian (4,047 people), White: Other Western European (3,209 people), White: Irish (2,721 people), Mixed/multiple ethnic group: White and Asian (2,528 people), Chinese (2,137) and just outside the top five are White: Polish (2,119 people).
What does this mean?

- The WH CCG population is older than the England population with a lower proportion of younger people and working age people. This pattern is very marked in the West New Forest practice grouping of practices.

- While overall population growth is forecast to be small over the next five years (8,454 people, 1.59%) a higher proportion will be in the over 75 age group in all areas of the CCG. The WINCAR and Andover grouping will see the biggest increase with almost 7,000 more people over 75.

- The increasing ratio of retired people to working age people, particularly in West New Forest, means that there are fewer people to provide support for an increasing number of older people. This has significant implications for health and social care services. An ageing population will put pressure on health and social care services, as older people are more likely to have long term conditions with multiple disabilities and people over the age of 65 account for more than 60% of hospital inpatient stays and most health and social care costs.

- There will be changing demands on other services such as housing, transport and leisure.

- Children and young people under 20 make up just over one in five (122,154) of the CCG population and it is vital that there is adequate capacity in services for children and their families as well as services for older people.

- A higher proportion (93%) of people in the CCG identified themselves as White British in the 2011 Census showed compared to England (79.8%). The largest ethnic groups other than White British are Indian or British Indian (4,047 people) and White: Other Western European (3,209 people).
2 Health inequalities

Health inequalities are the avoidable differences in health, well-being and life expectancy between people. It is well established that age, sex, genetic make-up and lifestyle behaviours influence health. Other factors, which are known as the wider determinants also influence current and future 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.

2.1 Life Expectancy

Life expectancy at birth is the average number of years a newborn could expect to live if he or she experienced the age-specific mortality rates in a given year. It is an indicator of current health and mortality conditions. The life expectancy at birth in WH CCG is 81.4 years for males (81.1-81.7) and 85 years for females (84.7-85.2). Figure 3 shows that life expectancy is significantly higher than in Hampshire, England and the South East for both males and females. There is no statistically significant difference in life expectancy between the area groupings in WH.

Figure 3: Life expectancy at birth by geographic area, 2009 to 2011

The Indices of Deprivation 2010 rank local areas across the country in terms of their relative deprivation as measured by a range of different factors. Figure 4 shows the Indices of Deprivation 2010 by LSOA ranked by national decile. The more deprived areas in WH CCG are to be found in Andover town, central and south Eastleigh, Winnall and Highcliffe in Winchester, and Holbury and North Blackfield (Waterside) and New Milton in the New Forest.
WH CCG has lower levels of overall deprivation compared to the England average with a rank for the index of multiple deprivation (IMD) of 200 out of 212 CCGs. However, it is ranked as one of the worst CCGs (26th out of 212) for the geographical barriers sub-domain which measures road distances to key services.

Figure 5: Indices of Deprivation 2010 - England ranks based on summary scores for CCGs

Source: Deprivation data from Department for Communities and Local Government.
The favourable rank of the index of multiple deprivation at CCG level should not lead to the conclusion that deprivation is not an issue for WH as pockets of deprivation do exist affecting large numbers of the population:

- 74,664 people in WH CCG (14% of the population) live in the most deprived quintile nationally for the index of multiple deprivation.

- 148,847 people (28% of the population) live in the most deprived quintile nationally for the geographical barrier sub-domain.

**Figure 6: Proportion of population living in each deprivation quintile in West Hampshire CCG**

![Deprivation Indices 2010 - Proportion of population living in deprivation quintiles](image)

Source: IMD, 2010

### 2.2 Education, income and employment

The conditions in which people are born, grow, live, work and age result in avoidable differences in health and mortality. There is a social gradient to health - the lower a person’s social position, the worse their health. Inequalities exist in education, employment and income. 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\(^3\). Both education and employment influence income and there is a well established link between income and health. For children, growing up in poverty is linked to lower educational attainment, unemployment or low paid employment in later life\(^4\).

2.2.1 Children and young people

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

Figure 7 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 8 shows educational attainment for Hampshire benchmarked against comparator areas.

Figure 7: Percentage of pupils at the end of Key Stage 4 achieving 5+ A*-C grades including English and Maths GCSE at GCSE and equivalents.

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

\(^4\) Griggs J, Walker R. The costs of child poverty for individuals and society. The Joseph Rowntree Foundation. October 2010
Figure 8: Percentage of pupils at the end of Key Stage 4 achieving 5+ A*-C grades including English and Maths GCSE at GCSE and equivalents – Trend Data.

Educational attainment in Winchester and Eastleigh is above the average for Hampshire (58.5%). In New Forest, attainment is in line with the average and in Test Valley it is just below\(^5\).

Figure 9: District level information for pupils achieving five or more GCSEs (or equivalent) at grade A*-C, including English and maths

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

2.2.2 Working age adults

National research shows that people who have never worked or are long-term unemployed have the highest rates of self-reported ‘poor’ health. WH CCG has the lowest rate amongst Hampshire CCGs of people who have never worked or are unemployed: 2.6% compared to 5.6% nationally. Skill levels among Hampshire’s adult population are generally higher than the national average. However, 18.3% of the WH CCG population have no qualifications (figure 10).

Of the 16-74 year old population in WH CCG 72% (279,006) are economically active, compared to 73.2% in Hampshire and 69.9% in England. West New Forest Grouping has a lower proportion (66.8%) of economically active residents reflecting the number of retired people in the area (in the age band 16-74). The percentage of people with no qualifications is highest for the West New Forest Grouping at 21.4%.

WH CCG has a higher proportion than Hampshire but lower than England of one person households, where the householder has a long term disability and households where no adults are in employment where there are no dependent children residing. The highest rates are in West New Forest (10,555, 24.2% and 17,511, 40% respectively). These characteristics are typical for areas with an older population and may indicate groups vulnerable to poorer levels of health because of social isolation, mental ill health and caring responsibilities.

The most common industries for the economically active adult population of WH CCG are wholesale, retail trade and motor vehicles; health and social care; and education.

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6 Census 2011
7 Census 2011
8 ONS 2011
Figure 10: Characteristics of the working age population in West Hampshire

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2.2.3 Older adults

The 2011 Census showed that 13.7% (30,767) of households in WH CCG are made up of people over the age of 65 years living alone. This is higher than for Hampshire (12.6%) and England (12.4%). Looking at the area groupings the proportion in West New Forest is much higher - 18.7% (5310) of households.

Similarly, WH CCG has a higher percentage (11.3%) of one family households where all the members are aged 65 years and over when compared to England (8.1%) and Hampshire (10.3%). The rate in West New Forest is almost double (15.6%) the England rate.

Amongst those over the age of 60 years old, 10.4% (14,318) of WH CCG residents are affected by income deprivation. 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 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.

The 2011 Census showed that 7% (37,385) 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 slightly more than the Hampshire average (6.7%) but less than the England average (8.3%). West New Forest Grouping has a higher rate (8.9%) than Hampshire or England.

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9 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.

In WH 1,546 people (0.4%) over the age of 18 years old were registered as having a learning disability, which is the same as the Hampshire average\textsuperscript{11}. In 2009/10, two thirds of those adults who have learning disabilities who were known to the County Council’s Adult Services were judged to be in settled accommodation, above the national (61%) and regional (63.2%) averages. 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.

Just over one in ten (57,539) of the resident population of WH CCG provide unpaid care which is similar to the England rate. The rate is higher for West New Forest Grouping where 12.3% provide unpaid care.

2.3 Gypsies and Travellers

Significant health inequalities exist between Gypsies and Travellers and the general population in England, even when compared with other socially deprived or excluded groups and with other ethnic minorities. The 2011 Census recorded a total of 2,069 Gypsies and Travellers living in Hampshire. For the local authority districts in WH CCG the largest number are in New Forest (423) followed by Winchester (263), Eastleigh (191) and Test Valley (153). However there is low self-ascription in this ethnic group with many choosing not to identify themselves as Gypsies or Travellers. Local estimates suggest the actual figure in Hampshire is likely to be between 4,690 and 7,630 people.

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

2.4 Housing and homelessness

The relationship between housing and health is complex, however poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. In addition 45% of accidents occur in the home. Whilst social sector housing has improved, less than 50% of private rented homes housing people on benefits are considered decent (2008 data)\textsuperscript{12}.

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

\textsuperscript{11} Data from the 2011-12 Quality and Outcomes Framework (QOF)
\textsuperscript{12} Houses of Parliament Parliamentary Office of Science and Technology. Housing and Health. Postnote. 371, January 2011
resulting from external causes, suicide and accidents are more common than in the general population\textsuperscript{13}.

The rate of statutory homelessness in Hampshire was 0.81 people per 1000 households in 2011-12\textsuperscript{14}. In the last three years (2009/10 to 2011/12) there were 16 people who were homeless in Eastleigh, 46 in New Forest, 23 in Test Valley and 22 in Winchester.

Non statutory homelessness is very difficult to measure but can be estimated from Supported Housing panel data. This shows the highest numbers of applications amongst people with mental ill health and young people. New Forest was amongst the local authority districts in Hampshire with higher applications.

A survey of 142 homeless people in Hampshire found that the main health needs for homeless people are mental ill health, substance misuse, joint aches or problems with bones and muscles, chest pains and breathing problems and dental problems.

Evidence shows that homeless people use proportionately more health services than the general population. Common reasons for visiting secondary care include alcohol misuse, accidents and mental health problems. Hospital admissions in Hampshire show that homeless people are more likely to be men aged between 20-54 and present as emergency admissions.

**What does this mean?**

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

- Overall the CCG has very low levels of deprivation with life expectancy significantly above the national average. This can make it difficult to identify and tackle health and social inequalities and to ensure that those in the greatest need can access appropriate services. There are small geographical pockets of deprivation and over a quarter of the population

\textsuperscript{13}Bethan T. Homelessness kills. 2012 Crisis. \url{http://sasi.group.shef.ac.uk/publications/reports/Crisis_2012.pdf}

\textsuperscript{14}Lower tier local authorities have a statutory duty to provide suitable accommodation for people who are eligible for assistance; homeless through no fault of their own and who fall in to a priority need group. Groups in priority need include: pregnant women; people with dependent children; 16-17 year olds; people aged 18-20 who have been previously looked after; people aged 21 years old and over who are vulnerable as a result of having been looked after; and vulnerable people, such as older people, those with mental ill health and mental and physical disabilities. People who fulfil these criteria are defined as falling into the group of ‘statutory’ homelessness.
are affected by very poor geographical access to services, reflecting the rurality of the CCG.

- The life chances and future health of one in ten children in the CCG who are growing up in poverty will be adversely affected.

- Improving educational attainment is one of the key ways to maximise life chances.

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

- One in ten people over the age of 60 in the CCG are income deprived. Living in poverty prevents an older person from participating fully in society, increasing the risk of social isolation and poor health. Older people living with a disability are at high risk. We know from previous work that in WH CCG there are older people who are asset rich and cash poor living in and around market towns with large numbers in New Forest. These people own their own home, but have a low income and struggle to meet their day to day living costs such as food, clothing, heating and maintaining their home.

- Being in work is good for health and the proportion of working age people who are economically active in WH is high. Conversely being unemployed is bad for health and the current economic climate is likely to adversely affect the health of some sectors of the CCG population with a disproportionate effect on vulnerable groups, such as those with disabilities and young people leaving care.

- People in vulnerable and marginalised groups in the CCG, such as young carers, looked after children and Gypsies and Travellers have poorer health outcomes. These groups are not well identified and their needs are not well understood, making it difficult to address health inequalities.
3 Children and young people

There are approximately 122,124 children and young people aged under 20 years in WH CCG, which is around 22.7% of the total population\textsuperscript{15}.

3.1 Births

Pooled data from 2009-11 show that the general fertility rate in WH CCG is 60.5 live births per 1000 women aged 15-44 years old, which is lower than the rates for Hampshire (64.3)\textsuperscript{16} and England (64.5)\textsuperscript{17}. This varies across the area groupings with the lowest rate for West New Forest (55.9). In the period 2001 to 2011 the general fertility rate for WH CCG increased steadily from 51.7 to 61.5 which reflects the trend observed for Hampshire and for England. Mid-West Hampshire and WINCAR & Andover both have increasing trends, but the trend for West New Forest has been less consistent with a drop in rate for some years including 2011.

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. As data are not available by CCG, data from the four local authorities of Eastleigh, Test Valley, Winchester and the New Forest, that fall within the CCG boundary are presented. The projections suggest that the previous rise in births may be starting to level off. It is hard to predict what future births will look like due to changes in fertility rates and the size and age structure of the female population. Overall, birth projections in the CCG appear to follow the general trend for Hampshire but are constrained by the wide error margin when using local authority based birth projections.

Figure 11: Birth projections for West Hampshire CCG from 2013 to 2021

\textbf{Source: ONS Interim 2011-based Subnational Population Projections}

\textsuperscript{15} 2011 Census
\textsuperscript{16} ONS annual birth extract
\textsuperscript{17} ONS Vital Statistics
3.2 Teenage conceptions

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

At local authority level in the period 2009 to 2011 Eastleigh (31.8 per 1000) and New Forest (26.2 per 1000) had higher rates of under 18 conceptions than Hampshire (25.8 per 1000). Test Valley (24.9 per 1000) and Winchester (16.3 per 1000) have lower rates. All the districts saw a decrease in rates from 2008/10 to 2009/11\(^\text{18}\).

In Hampshire almost one in five conceptions in under 18 year olds are in females aged under 16 (19%). The under 16 conception rates are significantly lower than the England average and are decreasing in Hampshire. In 2009/11 the rate was 5.5 per 1,000 females aged 13-15 compared to 6.0 per 1,000 in 2001/03, this is a reduction of 8.4%. There were 360 under 16 conceptions in 09/11 compared to 422 in 01/03.

In 2009/11, 48.7% of under 18 conceptions in Hampshire ended in abortion which is lower than both the national rate (49.6%) and the South East regional rate (51.2%).

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, although slightly lower than the England average of 13.9% (2012-13), is still not good enough and not comparable to our relative affluence.

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\(^\text{19}\) 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\(^\text{20}\).
The infant mortality rate in WH CCG is 3.3 children under one year old per 1000 births (2.4-4.4) compared to a rate in Hampshire of 3.1 (2.6-3.7). This compares to the England rate of 4.4 per 1,000 live births (95% CIs 4.3-4.5) (Pooled data for 2008-10).

Over the past 30 years child death rates from respiratory and circulatory diseases in England and Wales have been falling, as they have for the whole population, reflecting advances in medical care and preventative measures generally. In 2011 congenital related conditions and cancers were the most common causes of death for children aged under 16 years. However, childhood mortality between the ages of 0 and 14 is among the worst in Europe. Comparator European countries have improved their outcomes over the last 20 years while the UK has fallen behind in the rate of improvements where death rates are 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 deaths are reviewed by the Child Death Overview Panel (CDOP) to identify changing causes as well as looking for possibly modifiable factors for public sector services in the death. The Southampton, Hampshire, Isle of Wight and Portsmouth CDOP reviewed 70 Hampshire death notifications in the 0-18 population in 2011/12. This includes childhood mortality for specific conditions (meningococcal, group A streptococcal infections, septicaemia, asthma, lower respiratory tract infections, diabetes and epilepsy, cancer), suicide, work-related deaths, trauma and negligence, maltreatment and abuse.

3.5 Breastfeeding

Breastfeeding rates and good weaning practice are influenced by deprivation and act as an early contributing factor to the cycle of health and social inequalities\(^{21}\). Only 42.2% of mothers in the most deprived quintile in Hampshire initiate breastfeeding.

In 2012/13 only 62.1% of mothers in WH CCG were breastfeeding at their primary birth visit (9-14 days).

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However, this reduced to 47.9% at 6-8 weeks, which is comparable to the England rate of 47.2% which is amongst the lowest in Europe. At both checks WINCAR & Andover was the area grouping with the highest breastfeeding rate and Mid-West Hampshire grouping was the area with the lowest.

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

3.6 Childhood obesity

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

Pooled data for 2009/10 to 2011/12 show that 7.6% (14,641) of 4-5 year old children in WH CCG are obese, lower than the England percentage of 9.6%. There are 13.7% (13,803) of 10-11 year old children obese in WH CCG in the same period, which is also lower than the national average (19%). There are no significant
differences between the area groupings for the percentages of children obese for either age group. Across all of Hampshire’s CCGs the proportion of children who are obese almost doubles between Reception and Year 6.

**Figure 14: National child measurement programme results in Hampshire 2009/10-2011/12**

<table>
<thead>
<tr>
<th>Population</th>
<th>Year R: Overweight</th>
<th>Year R: Obese</th>
<th>Year 6: Overweight</th>
<th>Year 6: Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>WH CCG</td>
<td>12.7%</td>
<td>7.6%</td>
<td>14.6%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Hampshire</td>
<td>12.9%</td>
<td>8.0%</td>
<td>14.4%</td>
<td>15.4%</td>
</tr>
<tr>
<td>England</td>
<td>13.2%</td>
<td>9.6%</td>
<td>14.6%</td>
<td>19.0%</td>
</tr>
</tbody>
</table>

### 3.7 Oral health

There are inequalities in dental health, with children from areas of deprivation experiencing disproportionately higher levels of oral disease. Persistent dental health inequalities among Hampshire’s five year olds are reflected among twelve year olds as well.

Over a fifth of Hampshire’s five-year-olds experienced dental decay, but in WH CCG this varied from 13.4% in Winchester to 22.7% in Test Valley with rates of 18.7% in Eastleigh and 17.6% in New Forest. The rates of dental decay for all the local authorities in WH CCG are lower when compared to the England average of 30.9%.

The average Hampshire child aged five, had 0.7 decayed, missing (due to extraction) or filled teeth (dmft), compared to a national average of 1.1 teeth per child. For local authorities in WH CCG the rate was lower when compared to England for Winchester (0.4 per child), New Forest (0.5 per child), and Eastleigh (0.5 per child) and the same for Test Valley (0.7%).

A quarter of twelve-year-olds had dental decay in Hampshire, lower than the national prevalence (33.4%). The local authorities in WH CCG all have lower rates with the highest rate being for Eastleigh (31.0%), followed by New Forest (30.7%), Test Valley (24.0%) and Winchester (21.8%).

### 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.

Figures 15 and 16 show that for WH 91.9% of 6 year olds had received the full MMR course (both the MMR1 and MMR2 vaccines), and 94.1% had received the
DTaP/IPV booster. This is below the WHO target of 95% which is required to ensure herd immunity.

**Figure 15: Proportion of children who have received 2 MMRs at 6 years by CCG 2012/12**

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

**Figure 16: Proportion of children who have received dTaP/IPV at 6 years by CCG 2012/13**

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

The School Leaver Booster (SLB) boosts immunity against tetanus, diphtheria and polio. It is available routinely on the NHS for all young people aged between 13 and 18. The Department of Health target for the Td/IPV vaccination (tetanus, diphtheria and polio) is 90%. In WH in 2012/13 the proportion of 18 year olds recorded on the child health information system who had received the SLB was 52.7% - well below the DH recommended level of 90%.
3.9 Hospital activity for children and young people

There were 27,283 per 100,000 first attendances at A&E directly age standardised rates (DSR) for people under the age of 15 years old in WH CCG in the period 2009-12, which is just above the rate for Hampshire (figure 18). Mid-West Hampshire grouping has a lower rate then Hampshire and the other two groupings, which have a very similar rate above that of Hampshire.

Levels of emergency admissions were below the rate for Hampshire (7,572 per 100,000 compared to 8006 per 100,000). WINCAR & Andover grouping has a rate lower than that of Hampshire, whilst the rates for Mid-West Hampshire and West New Forest groupings are not significantly different from Hampshire.
3.9.1 Emergency admissions for asthma, diabetes and epilepsy

Emergency admissions for asthma, diabetes and epilepsy for people under the age of 19 years old may reflect the way in which these long term conditions are managed. Pooled data from 2009-12 in WH CCG show the rate was lower (235 per 100,000) than the Hampshire rate (275 per 100,000).

3.10 Injury and accidents

Unintentional injuries are the leading cause of death in children aged between 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.

In the period 2009/10 to 2011/12 the rate of emergency admissions for unintentional and deliberate injury for people under the age of 18 in WH CCG was 1,132 per 100,000 (4,072 people), which was higher than the Hampshire rate (1,066 per 100,000). There were 1,103 emergency admissions for Mid-West Hampshire grouping, 576 for West New Forest grouping and 1,610 for WINCAR and Andover grouping and no difference in the rates.

3.11 Substance misuse

Admissions for 15-24 year olds due to substance misuse were 798 per 100,000 people (DSR) in WH CCG for the period 2009/10 to 2011/12, lower than the rate for Hampshire (920 per 100,000). Rates vary across the area groupings with Mid-West Hampshire grouping being the highest and WINCAR and Andover being the lowest. Young women have significantly higher rates of admission for substance misuse than young men.

In the same period alcohol specific hospital admissions for people aged under 18 years old in the CCG were 34 per 100,000 the same as the rate for Hampshire, although the New Forest rate is significantly higher. Young women have higher rates of admission than young men.

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.

Just over one in ten 0-15 year olds in WH CCG (10.9%) are living in poverty. This is a lower than the England rate of 21.7% but still represents 10,454 children. Over half of these (5,310) live in Mid-West Hampshire grouping where the rate is 12.1%.

### 3.12.2 Children with disabilities

Children with disabilities and their families are one of the most vulnerable groups in Hampshire. However, defining and measuring the landscape of childhood disability is challenging due to the lack of an agreed definition. Overall, estimates of the number of disabled children in Hampshire ranges from 3,000 to 50,000 depending on the source and definition. Around 7,040 children aged 0-17 years were disability living allowance (DLA) claimants in August 2012. The autumn 2012 Hampshire School Census records 18.2% (11,510) of school pupils in WH CCG as having a special educational need (SEN) which is slightly lower than the Hampshire percentage of 18.9%. Of these, 2.3% (1,441) had a statement to identify their needs, which again is lower than Hampshire (2.6%). A statutory assessment is only necessary if the school or early education setting cannot provide all the help that a child needs. The percentage of boys with SEN is much higher than for girls (23.4% compared to 12.7%).

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 complexity of disability and need. Where we do have some data it clearly reflects this, for example, the increasing NHS activity generated from technology-dependent children.

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

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

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22 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.
What does this mean?

- The health and wellbeing of children and young people in WH is generally very good. However, not all children and young people have the best start in life – one in ten 0-15 year olds are growing up in poverty and this will have an adverse effect on their health in adult life.

- Infant and child mortality rates are sensitive indicators not only of child health, but also of the general health of the population.

- There are unacceptable variations in health outcomes for children and young people in Hampshire and continued action is required across the health economy to tackle this.

- Too many women still smoke during pregnancy.

- Breastfeeding rates amongst the worst in Europe due to an entrenched bottle feeding culture lead to an increased incidence of illness that has a significant cost to the health service. Fewer than half of mothers in WH are breastfeeding at 6-8 weeks which is surprising given the relative affluence of the population.

- Although teenage pregnancy rates are falling they are still too high with rates in Eastleigh and the New Forest above the Hampshire rate and almost 50% of teenage conceptions result in a termination of pregnancy. Teenage pregnancy is associated with health inequalities and teenage mothers and their children are at increased risk from poorer health outcomes. Work must continue to break the intergenerational cycle of exclusion and by reducing the number of under 18 conceptions and ensuring better support for those who became parents.

- The causes of childhood obesity are complex and while childhood obesity rates are much lower than the England rate almost 1 in 8 children in year 6 in WH is obese and we know that childhood obesity has long lasting effects on health increasing the risk of developing long term conditions in adult life.

- Too many children and young people are admitted to hospital because of injuries, accidents and substance misuse.

- Immunisation rates are still too low, particularly the teenage booster vaccination where achieving high coverage is increasingly important as the 2nd Meningitis C vaccine is moved to this age in the vaccination schedule.

- In order to reduce these inequalities in outcomes, health and care services must be accessible – breaking down the barriers that some children, young people and their families face. They must be planned to address the specific
needs of vulnerable groups – looked after children, young carers, children who live in households where there is domestic abuse, young offenders, children with disabilities and children with poor mental health.

- The higher than average rate of A&E attendances for children and young people in WH and the below average rate of emergency admissions suggests that for many children an A&E attendance is not the most appropriate way to manage their health problem and requires further investigation.
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\textsuperscript{23} concluded that tobacco, high body mass index and diet and physical activity made a significant contribution to disability adjusted life years lost in the UK in 2010.

4.1 Smoking and tobacco control

Tobacco use is the single most preventable cause of ill health in the UK and a major contributor to health inequalities. There is clear evidence that through reducing smoking prevalence we will improve healthy life expectancy as well as total life expectancy. The proportion of adults estimated\textsuperscript{24} to be currently smoking is 14.6\% in Eastleigh, 16.8\% in New Forest, 13.6\% in Test Valley and 14\% in Winchester. All are lower than the England rate of 20\%. Smoking prevalence for Hampshire is 17.5\%.

In 2012/13, estimated rates of smoking amongst routine and manual workers were 18.6\% in Eastleigh, 30.4\% in New Forest, 30.6\% in Test Valley and 39.4\% in Winchester, compared to 30\% in Hampshire and 30.3\% in England.

Figure 19 shows people accessing the Hampshire NHS stop smoking service for the districts in WH CCG and the success rate of smokers using the service.

**Figure 19: Penetration of the Hampshire smoker (service user) market by Hampshire NHS stop smoking service**

<table>
<thead>
<tr>
<th>Hampshire</th>
<th>2011 Local Pop. (&gt;15 years)</th>
<th>NHS Stop Smoking Service users</th>
<th>NHS Service users per 100,000 pop. (&gt;15 years)</th>
<th>Successful 4-week quitters per 100,000 pop. (&gt;15 years)</th>
<th>% Success Rate</th>
<th>% Estimated Adult Smoking Prevalence</th>
<th>Estimated Number of Smokers</th>
<th>% of all smokers engaged in NHS stop smoking services per annum (&gt;15 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastleigh</td>
<td>101,633</td>
<td>1,310</td>
<td>1,289</td>
<td>614</td>
<td>48%</td>
<td>14.6</td>
<td>17,786</td>
<td>7.4%</td>
</tr>
<tr>
<td>New Forest</td>
<td>150,951</td>
<td>1,645</td>
<td>1,090</td>
<td>596</td>
<td>55%</td>
<td>16.8</td>
<td>26,266</td>
<td>6.3%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>94,171</td>
<td>852</td>
<td>905</td>
<td>477</td>
<td>53%</td>
<td>13.6</td>
<td>12,242</td>
<td>7.0%</td>
</tr>
<tr>
<td>Winchester</td>
<td>94,116</td>
<td>1,088</td>
<td>1,156</td>
<td>545</td>
<td>47%</td>
<td>14.0</td>
<td>12,517</td>
<td>8.7%</td>
</tr>
</tbody>
</table>


\textsuperscript{24} 2011/12 Integrated Household Survey, ONS
The directly age standardised rate of hospital admissions attributable to smoking in people aged over 35 years old was 1,092 per 100,000 in Eastleigh and 1,134 per 100,000 in New Forest, 954 per 100,000 in Test Valley and 863 per 100,000 in Winchester. These rates are all significantly lower than the England average (1,420 per 100,000, 2010-11).

The directly age standardised rate of deaths wholly or partly attributable to smoking in people aged over 35 years old was 176.5 per 100,000 in Eastleigh, 141.4 per 100,000 in New Forest, 150.5 per 100,000 in Test Valley and 145.9 in Winchester. All are significantly lower than the England rate of 210.6 per 100,000 (2008-10).

4.2 Obesity

Overweight and obesity presents a major challenge to the current and future economy and health of Hampshire. Being overweight or obese significantly increases the risks of developing and dying from cardiovascular disease, Type 2 diabetes, cancer and kidney and liver disease. The risk increases as the “body mass index” increases.

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

Figure 20: Estimated prevalence of adults who are obese by local authority 2006-2008
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 the percentage of population over the age of 16 years old who are identified as drinkers who consume more than the government recommendations are 20.79% for Eastleigh, 26.9% for New Forest, 27.6% for Test Valley and 28.3% for Winchester. This is compared to 26.7% for England.

Figure 21 shows the rate hospital admissions for alcohol attributable conditions. Rates for all of the local authorities in the CCG are significantly lower than the national rate. Since 2002-03 in Hampshire there has been a 9% average year on year growth in the admission rate. For WH CCG the year on year average growth was highest in New Forest (12%) followed by Eastleigh (10%), and Test Valley and Winchester (both 8%).

Figure 21: Alcohol attributable hospital admissions

Figure 22 shows the crude rate of alcohol specific hospital admissions for people under the age of 18 years old in 2008-11. The rate for New Forest is higher than the

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25 The UK Government recommends that women drink less than 15 units per week and men 22 units per week. Care must be taken when interpreting these data; the 95% confidence intervals are very wide, suggesting they are not very reliable.

26 Alcohol-attributable or related conditions include all alcohol-specific conditions (see Section 2.2), plus those where alcohol is causally implicated in some but not all cases of the condition.

27 Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition.
England rate but this does not reach significance. Winchester has a significantly lower rate than the national average.

**Figure 22: Alcohol attributable hospital admissions (under 18)**

![Graph showing alcohol attributable hospital admissions (under 18)](image)

Alcohol attributable mortality in all the local authority areas in WH CCG is similar to the England rate for males and females.

### 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 the rate of acute STIs per 100,000 was 554 for Eastleigh, 411 for New Forest, 482 for Test Valley and 577 for Winchester. In WH CCG around two thirds of acute STI diagnoses were in young people aged 15-24 years and about one in ten were in men who have sex with men.

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 average of 1.5 per 1,000 in 2011.

Eastleigh, Test Valley and Winchester have a higher rate for late diagnosis of HIV, compared to a national average of 52.3%, although the numbers are too small to be significant. Test Valley has a significantly lower rate of uptake when offered an HIV test in a GUM clinic (74.8%) compared to a national average of 80.3%. Late diagnosis of HIV is the largest predictor of HIV mortality and morbidity.
What does this mean?

- Healthy lifestyles have a key role in preventing the development of many long term conditions, particularly cardiovascular disease and cancer. Unhealthy behaviours amongst the CCG population lead to premature deaths and result in significant economic costs for the CCG. Although rates of smoking, and increased drinking are generally better than the national average there is still much room for improvement and a continued drive to reduce rates even further is required.

- Smoking remains the greatest single cause of poor health and preventable disease and mortality and is a major cause of health inequalities. Efforts to address smoking should be particularly targeted at routine and manual workers who are known to have higher smoking rates. COPD is almost entirely preventable by not smoking.

- Alcohol is the second biggest lifestyle risk factor. The rising trends in alcohol related admissions and alcohol attributable mortality amongst the CCG population highlight the need for increased action to tackle increasing and higher risk drinking. Alcohol issues are seen across the whole socio-economic spectrum and are not defined by social deprivation and this is important when planning services.

- Rising rates of obesity are predicted to lead to an increase in the prevalence of cardiovascular disease, Type 2 diabetes, cancer and kidney and liver disease with major implications for health services and an impact on mortality rates. Obesity is the major risk factor for type 2 diabetes.

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

5.1 Cardiovascular disease

Cardiovascular disease (CVD) can be thought of as a family of diseases\textsuperscript{28} with common risk factors, but different outcomes\textsuperscript{29}. Lifestyle risk factors for CVD, such as smoking, physical inactivity, poor diet, obesity and harmful alcohol intake are modifiable. Figure 23 shows the prevalence of the most common forms of CVD for 2011/12. These rates are not adjusted for age, making comparison difficult across areas as those with older populations tend to have higher rates of disease.

Figure 23: Prevalence of the most common forms of CVD in West Hampshire CCG 2011/12

<table>
<thead>
<tr>
<th>CCG</th>
<th>CHD QOF no.</th>
<th>QOF prevalence %</th>
<th>Stroke/TIA QOF no.</th>
<th>QOF prevalence %</th>
<th>Atrial fibrillation QOF no.</th>
<th>QOF prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Hampshire</td>
<td>18673</td>
<td>3.5</td>
<td>11208</td>
<td>2.1</td>
<td>9865</td>
<td>1.9</td>
</tr>
<tr>
<td>Hampshire</td>
<td>44334</td>
<td>3.3</td>
<td>24381</td>
<td>1.8</td>
<td>22411</td>
<td>1.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG</th>
<th>Heart Failure QOF no.</th>
<th>QOF prevalence %</th>
<th>Heart Failure due to LVD QOF no.</th>
<th>QOF prevalence %</th>
<th>Hypertension QOF no.</th>
<th>QOF prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Hampshire</td>
<td>3758</td>
<td>0.7</td>
<td>2147</td>
<td>0.4</td>
<td>76897</td>
<td>14.2</td>
</tr>
<tr>
<td>Hampshire</td>
<td>8339</td>
<td>0.6</td>
<td>4514</td>
<td>0.3</td>
<td>186558</td>
<td>14.0</td>
</tr>
</tbody>
</table>

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

It is estimated that there may be 10,760 people with undiagnosed Coronary Heart Disease, 2,669 people with undiagnosed stroke or TIA and 94,767 people with undiagnosed hypertension in WH CCG. The NHS Health Check programme provides an important opportunity to increase diagnosis and encourage participants to improve their lifestyles.

\textsuperscript{28} There are a broad range of diseases of the circulatory system. The highest prevalence cardiovascular diseases include hypertension, myocardial infarction, stroke and heart failure.

\textsuperscript{29} DH Cardiovascular Disease Team. Cardiovascular disease outcomes strategy. Department of Health, 5/3/2013.
Figure 24: Estimated number of patients missing from QOF disease registers 2011/12

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

In the period 2009/10 to 2011/12 WH CCG had a directly standardised rate of 1187 per 100,000 population for admissions for circulatory disease. This is very similar to the rate for Hampshire (1159 per 100,000). Of the area groupings West New Forest has a much higher rate (1745 per 100,000) than Hampshire and the other groupings (which have rates lower than Hampshire).

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.

The directly standardised CVD mortality rate for WH CCG was 125 per 100,000 compared to 132 per 100,000 people in Hampshire for the pooled period 2009 to 2011. Compared to England (in the period 2008-10) the rate for WH CCG is significantly lower. The area groupings have very similar rates.

The CCG has a directly age standardised rate of preventable CVD mortality for people under 75 years old the same as that for Hampshire of 25 per 100,000. However men in WH CCG have a rate more than three times that of women.
5.2 Diabetes

There are 21,947 people in WH CCG with diabetes. A further 9,134 people in WH may not have been diagnosed. By 2020, it is estimated that there may be 87,000 people in Hampshire with diabetes. There is a very strong link between deprivation, diabetes admissions and complications.

The prevalence of diabetes is lower than the rate for Hampshire and England average and 20% more people are expected to have diabetes than are currently diagnosed.

There is a lower rate of elective admissions for diabetes (41 admissions per 100,000 population compared to 53 per 100,000 in Hampshire). However, the rate for the WH grouping is much higher than average (116 per 100,000).

The rate of all hospital admissions where diabetes is the primary diagnosis, for all ages was 102 admissions per 100,000, lower than the rate for Hampshire (115 per 100,000), although West New Forest grouping has a significantly higher rate than Hampshire (166 per 100,000).
Figure 26: Number of people with diabetes on QOF registers and estimated numbers with diabetes by CCG, 2011/12

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

Figure 27: All admissions for diabetes: Directly standardised rates (per 100,000) and 95% confidence intervals, 2009/10 to 2011/12

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

The diabetic lower limb amputation rate in WH CCG was just lower than the Hampshire rate (10 per 100,000) at 9 amputations per 100,000 (215 amputations).
5.3 Liver disease

Liver disease is one of the few major causes of premature death that is increasing in England, whereas it is decreasing in our European neighbours. Most liver disease is caused by obesity, infection with hepatitis, and harmful drinking, all of which are preventable.

The death rate from preventable liver disease (in under 75s) in the period 2009 to 2011 in WH CCG was 9 per 100,000 compared to the rate for Hampshire of 7 per 100,000 population and the national average of 12 per 100,000. This is 127 deaths in WH CCG over the three year period. At the grouping level there is no significant difference between the rates.

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

5.4 Kidney conditions

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

The prevalence of chronic kidney disease (CKD) in WH CCG is 4.4% (19,045 people over the age of 18). West New Forest has the highest prevalence at 5.4%, which, because the rate is not standardised to control for age, reflects the older population in the area. This compares to a prevalence of 4.2% in Hampshire and 4.3% for England. The NHS Health Check programme provides an opportunity to identify people with CKD before they develop symptoms. It is estimated that there are 32,000 people with CKD in Hampshire yet to be diagnosed.

Unmodifiable risk factors for CKD include older age, sex (prevalence is higher in men), other forms of CVD, family history and South Asian and Black ethnicity (higher risk of needing renal replacement therapy).

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

Acute Kidney Injury (AKI) is characterised by a rapid reduction in kidney function. Causes include: infection, dehydration, shock, and acute illness. Less frequently it is caused by crush injury to the kidney, and obstruction of the urinary tract. It is relatively common affecting about 20% of hospitalised patients, with severe AKI
affecting 1%. AKI is associated with poor outcomes and prolonged hospital stays\textsuperscript{30}. 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\textsuperscript{31} found that only 50% of AKI patients received good care overall though 30% of cases are preventable. Given the rise in population risk factors and mortality for CKD and AKI it is likely that need and demand for services will increase in the next decade. NICE has concluded that earlier detection and treatment of AKI would be cost saving\textsuperscript{32}.

\subsection*{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 7,688 people in WH CCG diagnosed with COPD, a prevalence of 1.4%, which is lower than the England rate of 1.7%. There are thought to be a further 4,043 people with undiagnosed COPD in WH CCG.

Performance by GPs against the QOF indicators for COPD in WH CCG is above the national average, but there is an exception rate of 11%.

There were 2,458 emergency admissions in WH CCG between 2009/10 and 2011/12 where COPD was the primary diagnosis and over half were in people aged under 75 years old.

The rate of emergency admissions for people under the age of 75 years old is lower than for the county as a whole but not significantly (66 per 100,000 compared to 72 per 100,000). The mortality rate for COPD in the CCG is low 17 deaths per 100,000, compared to 26 per 100,000 for England. The rate in men is significantly higher than for women.


\textsuperscript{31} NCEPOD – National Confidential Enquiry into Patient Outcome and Death

\textsuperscript{32} NICE. Costing statement. Acute kidney injury: prevention, detection and management of acute kidney injury up to the point of renal replacement therapy. NICE, 28/8/13.
5.6 Cancer

Cancer incidence 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 WH CCG was 391.9 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). As is the case nationally rates are higher in men (423.6 per 100,000) compared to women (360.3 per 100,000). For the local authority districts in WH CCG there was a 2% increase in the rate of incidence of all cancers in the period 1993-95 and 2008-10 for Test Valley and Winchester, no increase for Eastleigh and a 2% reduction for New Forest.

Figure 28 shows the incidence of different types of cancer in WH CCG. Rates of lung cancer in WH CCG are significantly lower when compared to England and rates for prostate cancer in significantly higher.

**Figure 28: Incidence of cancers in West Hampshire CCG 2008-10. Directly age standardised rates per 100,000 population (South West Cancer Register, ONS, UKCIS)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>England</th>
<th>South East</th>
<th>West Hampshire CCG</th>
<th>Significance when compared to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>266637</td>
<td>129150.9</td>
<td>9362.0</td>
<td>Lower but not significant</td>
</tr>
<tr>
<td>DSR</td>
<td>398</td>
<td>380.2</td>
<td>391.9</td>
<td></td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>397</td>
<td>378.0</td>
<td>383.5</td>
<td></td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>399</td>
<td>382.3</td>
<td>400.4</td>
<td></td>
</tr>
<tr>
<td>Female Breast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>40768</td>
<td>21017.1</td>
<td>1426.0</td>
<td>Lower but not significant</td>
</tr>
<tr>
<td>DSR</td>
<td>126</td>
<td>127.5</td>
<td>125.2</td>
<td></td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>125</td>
<td>125.7</td>
<td>118.3</td>
<td></td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>126</td>
<td>129.4</td>
<td>132.2</td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td></td>
<td></td>
<td></td>
<td>Higher but not significant</td>
</tr>
<tr>
<td>Count</td>
<td>33862</td>
<td>16770.0</td>
<td>1244.0</td>
<td></td>
</tr>
<tr>
<td>DSR</td>
<td>48</td>
<td>46.2</td>
<td>48.2</td>
<td></td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>48</td>
<td>45.4</td>
<td>45.4</td>
<td></td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>48</td>
<td>46.9</td>
<td>51.1</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Count</td>
<td>33770</td>
<td>14039.1</td>
<td>900.0</td>
<td></td>
</tr>
<tr>
<td>DSR</td>
<td>48</td>
<td>38.8</td>
<td>34.6</td>
<td></td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>47</td>
<td>38.2</td>
<td>32.2</td>
<td></td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>48</td>
<td>39.5</td>
<td>37.0</td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td></td>
<td></td>
<td></td>
<td>Significantly higher</td>
</tr>
<tr>
<td>Count</td>
<td>34115</td>
<td>16907.1</td>
<td>1342.0</td>
<td></td>
</tr>
<tr>
<td>DSR</td>
<td>106</td>
<td>104.5</td>
<td>112.9</td>
<td></td>
</tr>
<tr>
<td>Lower 95% CI</td>
<td>105</td>
<td>102.9</td>
<td>106.7</td>
<td></td>
</tr>
<tr>
<td>Upper 95% CI</td>
<td>106</td>
<td>106.1</td>
<td>119.1</td>
<td></td>
</tr>
</tbody>
</table>
Figure 29 shows the cancer screening coverage in WH CCG for each the national programmes. Coverage is lower than the target for breast and cervical cancers and above the target for bowel cancer.

**Figure 29: Cancer screening coverage in West Hampshire CCG**

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Target</th>
<th>No. of eligible on last day of review period (Target Age)</th>
<th>No. of women/screened in previous 30 months (Target Age)</th>
<th>36 month coverage % (Target Age)</th>
<th>2.5-year coverage % (Target Age)</th>
<th>3.5/5.5-year coverage % (Target Age)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Coverage (Target 70%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENGLAND</td>
<td></td>
<td>8421181</td>
<td>5124671</td>
<td>60.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAMPSHIRE</td>
<td></td>
<td>225672</td>
<td>137720</td>
<td>61.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Hampshire CCG</td>
<td></td>
<td>94436</td>
<td>56760</td>
<td>60.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bowel Coverage (Target 60%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENGLAND</td>
<td></td>
<td>7944844</td>
<td>4141939</td>
<td>52.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAMPSHIRE</td>
<td></td>
<td>216852</td>
<td>132601</td>
<td>61.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Hampshire CCG</td>
<td></td>
<td>93199</td>
<td>59045</td>
<td>63.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cervical Coverage (Target 80%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENGLAND</td>
<td></td>
<td>13463227</td>
<td>10146655</td>
<td>75.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAMPSHIRE</td>
<td></td>
<td>324007</td>
<td>254357</td>
<td>78.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Hampshire CCG</td>
<td></td>
<td>128691</td>
<td>102373</td>
<td>79.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

In 2011/12 there were 11,540 people in WH CCG on GP cancer registers. This is 2.1% of the registered population, which is higher than the England and South East prevalence (1.8%). This is likely to be due to the age profile of the CCG as age is a very strong risk factor for cancer. More people are surviving cancer and the number is predicted to continue to increase reflecting improved life expectancy and improved survival from cancer. The needs of cancer survivors are becoming increasingly important.

In the period 2009/10 to 2011/12, the directly age standardised rate of admissions for cancer for people under the age of 75 years was 1,728 per 100,000 population in WH CCG, which was lower than the rate in Hampshire (1,860 per 100,000 population).

The rate of premature mortality (under 75 years old) in the period 2009 to 2011 from all cancers was 90 per 100,000 in WH CCG which is significantly lower than the England rate of 110 per 100,000. Between 2006-08 and 2009-11 there is a non-significant downward trend in the rate of premature mortality for WH CCG reflecting the downward trend observed nationally.

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33 Hampshire Open Exeter system
5.7 Neurological conditions

There is a lack of available, local level data on long term neurological conditions such as multiple sclerosis or motor neurone disease. The only routinely available data are for epilepsy. The prevalence of epilepsy in people aged 18+ in WH CCG is 0.7% (3,163 people), which is the same as nationally and higher than the Hampshire average (0.7%, 7,958 people). The trend in epilepsy prevalence during the three year period from 2009/10 to 2011/12 was stable for Hampshire and England.

5.8 Chronic Pain

Chronic pain is defined as pain or discomfort that troubles a person all of the time or on and off for more than three months. 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.

In WH CCG the directly standardised rate of hospital admission where chronic pain was one of the reasons for admission is 1,992 per 100,000 population, which is lower than the rate for Hampshire (2,125 per 100,000). Rates are higher in females (2,447 per 100,000) than in males (1,538 per 100,000).

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

5.9 Mental health

Positive mental wellbeing reduces population mortality. Poor mental health both contributes to and is a consequence of wider health inequalities. The prevalence of psychotic disorders amongst the lowest quintile of household income is nine times higher than in the highest. The social gradient is also evident for common mental health problems, with a two-fold variation between the highest and lowest quintiles.

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.

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34 CMO report, 2008
Many physical conditions increase the risk of developing 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.

In WH CCG 9,853 people aged 65 and over are estimated to have depression and in the same age group 3,168 are estimate to have severe depression. Projected figures suggest that this could increase by 20% by 2020.

Between 2009 and 2011, 332 people died due to suicide or injury of undetermined intent in Hampshire, an average of over 100 deaths per year. The latest suicide and injury of undetermined intent rate for WH CCG is 8 per 100,000 population (2009-2011 data). The observed rate is not significantly different from those in Hampshire or England, but has increased since 2006/08. Males have a significantly higher suicide rate and the CCG rate was 11.6 per 100,000 males compared to 4.6 per 100,000 female population.

Figure 30 presents the directly standardised admission rates for a number of mental health admissions in WH CCG compared to Hampshire. Gender differences are apparent for each mental illness, females have higher rates of unipolar depressive disorders whilst male delusional disorder rates are higher.

**Figure 30: 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></td>
<td>West Hampshire CCG</td>
</tr>
<tr>
<td>Mental Health Illness - All Admissions - Under 75 years</td>
<td>154</td>
</tr>
<tr>
<td>Mental Health Illness - All Admissions - All ages</td>
<td>157</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders - All admission types</td>
<td>53</td>
</tr>
<tr>
<td>aged 15+</td>
<td>32</td>
</tr>
</tbody>
</table>

5.10 Dementia

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

The prevalence of dementia in WH CCG is 0.74% (3,976 people) which is significantly higher than Hampshire (0.65%) and England (0.53%). The older
population structure of the CCG is likely to explain the higher prevalence. This is borne out by the fact that the prevalence for West New Forest, which has a higher proportion of older people is 1.1%, much higher than the other CCG groupings.

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

The number of people aged 65 and over with dementia in WH CCG is predicted to increase by 28% from 8,408 in 2012 to 10,761 in 2020.

A national report found that older people with dementia who are receiving care in hospital stay significantly longer than those without the condition after being admitted for an emergency and are more likely to be readmitted\(^\text{35}\).

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

People with dementia can live well with their dementia provided they and their carers have good, timely and person centred advice, support and care within a non-stigmatising and understanding community.

5.11 Musculoskeletal conditions

Pain is the most prominent symptom in most people with musculoskeletal problems, causing limitation in function and resulting in long-term work disability with economic consequences for society. This also generates significant activity in the health and social care sector- a fifth of primary care consultations are due to musculoskeletal conditions.

In the period 2009/10 and 2011/12 the rate of hospital admissions for people aged 65 and over as a result of falls and fall injuries was 1,516 per 100,000 people in WH CCG, compared to a rate of 1,623 per 100,000 in Hampshire. Mid-West Hampshire has the highest rate of the area groupings, significantly higher than the other two.

Directly standardised admission rates for hip fracture in the over 65s were similar for the rate for Hampshire (447 per 100,000 compared 455 per 100,000).

The rate of primary hip replacement procedures in the period 2009/10 to 2011/12 was 94 per 100,000 in WH CCG, compared to 98 per 100,000 in Hampshire. WH CCG had a slightly higher rate of revision hip replacement procedures at 16 per 100,000, than Hampshire (15/100,000), but the difference is not significant.

\(^{35}\) Care Quality Commission [CQC] report, March 2013
Knee arthroscopic activity shows that WH CCG has a higher standardised rate of 231 per 100,000, compared to 216 per 100,000 for Hampshire. This is largely due to high activity in population living in the Test Valley (252/100,000).

Admission rates for knee replacements (92/100,000) were similar to those for Hampshire (95/100,000).

There is an overall decline in facet joint activity in WH CCG (77/100,000), less than half the rate for Hampshire of 172 per 100,000 and in line with the lack of clinical effectiveness for this intervention.

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 number of people with long term conditions is increasing. This is partly due to the ageing population associated with a decreasing death rate at all ages and partly due to the steady increase in illnesses caused by unhealthy lifestyles and unequal life opportunities.

- The UK Global Burden of Disease study showed that mental and behavioural disorders (including anxiety, stress, depression, and substance misuse) and musculoskeletal disorders caused the biggest burden of years lived with disability.

- Modelled estimates suggest that a significant number of people in WH CCG are living with cardiovascular disease, including hypertension, atrial fibrillation, diabetes, COPD and dementia who are not diagnosed or not recorded on QOF registers. They are not benefiting from systematic proactive management of their condition. This will affect their quality of life and is likely to result in increased emergency hospital admissions and more associated but avoidable ill health.

- Any redesign of care pathways for long term conditions, including the adoption of an integrated care model, should include primary prevention, action to increase case finding of people with undiagnosed disease and a focus on secondary prevention measures which can reduce morbidity.
• Whilst the evidence base for reducing emergency admissions is scant, there is good evidence to prevent admissions for patients with heart failure and COPD.

• As the population becomes older the CCG should plan how it will commission for increasing numbers of people with multiple long term conditions, particularly diabetes, cancer, dementia and musculoskeletal conditions.

• Cancer incidence is stable and mortality from cancer is lower than the national rate. There are increasing numbers of cancer survivors and we need to understand more about their needs.

• Mental ill health is common with about one in six of the adult population and 10% of children affected at any one time. Half of lifetime mental illness is present by the age of 14. One in ten new mothers suffers from postnatal depression. 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. About one in four primary care consultations is thought to be related to a mental health problem. About 18% of the NHS expenditure on long term conditions is related to poor mental health.

• People with serious mental health problems have higher rates of heart disease, stroke, diabetes, respiratory disease and infections, with much poorer health outcomes. It is important to identify and treat their physical health problems and to facilitate access to relevant preventive services such as smoking cessation, weight management and screening.

• With high rates of dementia reflecting the older population structure, the CCG needs to support early diagnosis and health and social care management of dementia and the use of anti dementia drugs according to NICE guidelines.

• Promoting bone health is important. Early detection of osteoporosis through bone mineral density (BMD) scans, falls and fracture risk assessment, maintenance of mobility, correction of nutritional deficiencies, particularly of calcium, vitamin D and protein, and bone protection drugs and implementing a falls prevention strategy have been shown to significantly reduce the risk of hip fractures.

• 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 (adult social care chapter)

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 WH CCG was for domiciliary care (52%, 320 people) followed by residential care (16%, 722 people) and nursing care (15%, 696 people).

In 2012, 18.6% (20,465) of people aged 65 and over (rising to 35% of men and 50% of women aged 85 and over) were identified as being 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. For WH CCG, 8% (8,262) 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.

Mental and behavioural disorders (including stress, anxiety and depression) and musculoskeletal disorders are the cause of the greatest number of years lived with disability in the UK. Currently we do not have Hampshire estimates of years of life lived with disability.

6.2 Adults with care support needs

In April 2013 Hampshire County Council Adult Services supported 1,036 clients aged 18-64 years old in WH CCG with a substantial or critical learning disability with a package of care. Another 671 people with a substantial or critical physical disability were supported; since 2010 there has been an increase across the County in the number of clients in this group receiving support.

Adults with autism are more likely to be socially disadvantaged, educationally less well qualified, less intellectually able and possibly under-supported by services. Modelled estimates predict that there are 3,650 males and 430 females with autism aged 19 years old and above in WH CCG.

6.3 Carers

In WH CCG 7.6% of the population (40,597 people) provide 1-19 hours of unpaid care a week, which is slightly more than the Hampshire (7%) and England averages (6.5%). West New Forest has the highest number of carers providing this level support in the county (8.6% of the population). In WH CCG, a further 1.1% (5,944 people) provide 20-49 hours a week and 2% (10,988 people) provide 50 or more hours a week.
Almost a quarter (3,320) of care packages for clients over 65 are put in place to support carers who are finding it difficult to cope. In 40.1% of these cases carers are supporting a person with dementia and in 22.4% they are caring for people with reduced mobility.

### 6.3.1 Young carers

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

In WH CCG 0.7% (443) of school pupils are identified as young carers. There are 8,450 people (3.8%) living in a household where there are dependent children and one person with a long term disability. This provides an indication of the number of young people in the CCG who are likely to have caring responsibilities and suggests that many are not known to services.

**What does this mean?**

- Social care needs are projected to rise in both the short and longer term. Those needs are likely to become more complex as the number of people of all ages with multiple morbidities increases and there are increasing numbers of people with severe or complex learning disabilities surviving into adulthood and older age.

- Moving towards integrated health and social care provision can improve patient satisfaction and reduce mortality, though there is no evidence it reduces emergency admissions.

- There can be detrimental social consequences of reduced mobility and dementia on individuals and this in turn can negatively affect health. CCGs must ensure that health services are linked with agencies offering social support, such as volunteer befrienders and support networks for carers.
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.

There are around 5,000 deaths a year in WH CCG, a rate of 440 per 100,000 the lowest is Hampshire (figure 31).

Figure 31: All cause mortality by CCG

At a county level the death rate has been falling, and this is mirrored in the CCG (figure 32).

Figure 32: All cause mortality for West Hampshire CCG directly standardised rolling 3 year average, 2006-08 to 2009-11
In 2011, approximately 30% of all deaths in WH CCG were due to cancer, compared to 28% from circulatory disease and 13% from respiratory disease.

In the period 2009 to 2011 WH CCG had a premature death rate of 201 per 100,000 which is better than the rate for Hampshire and England. The premature death rate is significantly worse for men than for women. In the period 2006 to 2011 the rate of premature mortality has been decreasing in WH CCG as have national and county rates.

Death rates are inversely related to deprivation, with directly standardised rates in the most deprived quintile being 57% higher than in the least deprived quintile (Figure 33).

**Figure 33: All cause mortality by deprivation quintile directly standardised 2009/10-2011/12 pooled**

![Figure 33: All cause mortality by deprivation quintile directly standardised 2009/10-2011/12 pooled](image)

7.1 Preventable deaths

There were 2,320 preventable deaths in WH CCG in the period 2009 to 2011. This equates to a rate of 110 preventable deaths per 100,000 population, lower than the Hampshire average (119 per 100,000) and lower than the national average (146 preventable per 100,000). There are more preventable deaths for men than women.

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36Deaths 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 [here](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/par/E12000004/ati/102/page/6)
The rate of preventable deaths in Hampshire has decreased in the last five years, and this is also true of WH CCG.

**What does this mean?**

- Falling mortality rates are very welcome and although many people live for longer and are fit and well, many people are living longer with illness and disability.

- Cancer is now the leading cause of death in the CCG – this pattern is reproduced in other affluent areas of England. We need to make sure that we are ready to support increasing numbers of people living with and dying from cancer.

- The premature death rate is higher in men than women. It is important that the CCG ensures that men are accessing prevention and present earlier for treatment earlier.

- Although the rate of preventable deaths continues to fall there are still almost 800 preventable deaths on average each year in the CCG.
### 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>Two months old</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>Three months old</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>Four months old</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>52 weeks of age but AFTER 1st birthday</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>Three years and four months or soon after</td>
<td>Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella</td>
<td>DTaP/IPV or dTaP/IPV +MMR</td>
</tr>
<tr>
<td>Girls aged 12 to 13 years</td>
<td>Cervical cancer caused by Human Papillomavirus types 16 and 18.</td>
<td>HPV</td>
</tr>
<tr>
<td>13 to 18 years old</td>
<td>Diphtheria, tetanus, polio</td>
<td>Td/IPV</td>
</tr>
</tbody>
</table>