Hampshire Health and Wellbeing Board

Hampshire Joint Strategic Needs Assessment 2015

Contents

1. Executive Summary

Hampshire is a healthy place to live. We see

- Good life expectancy for both men and women that compares well to our CIPFA neighbours. Life expectancy has increased by 3.2 years for men (to 81.1 years) and 2.3 years for women (to 84.2 years) from 2000/02 to 2011/13
- Fewer people dying from conditions that could be avoided comparing very well to our CIPFA neighbours
- Fewer children living in poverty and less infant mortality comparing well to our CIPFA neighbours
- Good overall educational attainment particularly in the early years
- Less long-term unemployment compared to national and regional rates

Living in Hampshire

The population of Hampshire is changing; our population is getting older and also becoming more diverse. We are living longer with life expectancy increasing but the healthy life expectancy for both men and women is decreasing; the gap means that around 14 years for men and 17 years for women are spent in ill-health or with high levels of need towards the end of their life. There is also significant variation in life expectancy between the least and most deprived areas, and the difference between the areas has increased over the past 10 years.

In the current financial environment, the focus for health and social care services is on those in poor health or greatest need; if the decrease in healthy life expectancy continues more people will be projected to require health and social care over the next 5-10 years. However, there are significant opportunities for the rest of the public and voluntary sector to focus on reducing the risk of people becoming ill or having increasing need; making use of the assets of both the county and districts; focusing on prevention, particularly working with the middle ages (40-64 years) adult population to promote healthy ageing; to keep people active and eating healthily to reduce future risk of disease or to support active management of health conditions to improve outcomes and help people retain independence for longer.

With the increasing older population and the relative reduction in the working age population who will be increasingly need to be involved in caring, the role of the voluntary sector is critical in developing networks and resilience in local communities. Work to strengthen and further develop the voluntary sector in Hampshire now should take account of the future changing population dynamic to ensure that community resilience is built in for the future.

Hampshire is a prosperous area, ranked the tenth least deprived upper tier authority in England (out of 150). However this masks inequalities; within Hampshire there are 3 areas that rank amongst the most deprived 20% of areas in England. The Department for Communities and Local Government is updating the indices of deprivation, for publication in Autumn 2015. Once this

is available it will be important to review any changes to deprivation across Hampshire and in particular to look at the impact of austerity on our community.	
Starting well in Hampshire Overall children who are born and live in Hampshire have good • health • life chances • educational attainment While our Infant and child mortality rates are low compared to national rates, national rates are high compared to our European neighbours There is also variation across Hampshire with some groups of children, particularly our vulnerable children, being disadvantaged with poorer health and low educational attainment. We need to better understand the needs of our more vulnerable children and as part of this work to develop an appropriate evaluation framework to ensure that across the system we commission effective services that improve outcomes for these children. With the transfer to the council of the commissioning responsibility for the Public Health 0-5 there are opportunities to maximise the universal nature of the programme; to get the best possible outcomes on the six high impact interventions that are part of that programme, focussing on prevention and early identification of children and families at risk of future health and social problems. We need to work specifically with • families to ensure that we minimise excess weight gain of children during the primary school years, and to support them achieve and maintain a healthy weight to improve health outcomes • partner organisations to understand the social and emotional health needs of young people and develop interventions that can be targeted more effectively to where they are needed • young people whose future life chances are being damaged by the lack of training, education and employment opportunities, particularly where they have been out of work (or not in work) for more than 12 months	
Staying well in Hampshire Adults in Hampshire in general live longer, have good employment and good opportunities to keep healthy. However there is variation with some people having much poorer health and outcomes. Although people in Hampshire live longer, there has been a fall in healthy life expectancy over the last three years. Staying healthy even if you have a long term condition is important for future wellbeing and independence. Changing the way we live, to eat more healthily and be more active now, will ensure that we remain independent, living at home in the future but it also reduces the risk of developing complications and comorbidities which lead to frailty and disability later in life. Some disabilities can be prevented and the effective use of treatment and	

rehabilitation services directed at helping people who are ill, injured or disabled can reduce dependency and improve quality of life. In order to better understand who we need to support, it is important we have good data and develop robust systems to help identify people with disabilities in order that they can access services appropriately to be able to remain independent Employment is strong in Hampshire, but creates significant disadvantage both financial and emotional, for people who aren't in work. Given the projected reduction in the working age population over the next 5 to 10 years it is important that young people in particular who are out of work are identified and supported to improve their opportunities and future life chances. This is also true of people with learning disabilities. Good mental health is important for good health. Focussed work needs to be done with different groups of people with poorer Mental Health to understand better the lack of access to current services, particularly primary care, and to co-design these services to improve accessibility. People with poorer mental health are also at significant risk of social isolation; developing local communities to improve social networks for this group of people is important in helping to improve their mental and physical health	
Ageing well in Hampshire Older people in Hampshire generally remain fit and healthy for the majority of their remaining years. However, there have been some changes in recent years, whereby the length of time people remain in good health has reduced (albeit very slightly). Understanding the impact of any changes in healthy life expectancy and life expectancy over time is important for the strategic planning of health and care services to ensure that resources are targeted effectively; as part of this it is important to develop prevention initiatives to improve healthy life expectancy and hence independent good quality of living. To support people continuing to be independent and reducing the impact of ill-health, prevention initiatives should focus on • promoting healthy lifestyles across all ages to ensure people have and continue to have good health outcomes and remain independent • prevention of early on-set and vascular dementia • ensuring older people remain warm in winter Focussed work could impact on reducing preventable disabilities, specifically • Improving mobility following a fall to improve outcomes and independence • Reducing blindness caused by preventable conditions such as AMD (smoking related) and diabetic retinopathy (complication of poorly controlled diabetes) Social isolation has a significant impact on health and wellbeing which can lead to poor health outcomes both physical and mental; to improve outcomes it is important therefore that organisations become better at identifying people at risk of loneliness and isolation, so that services and interventions can be developed and effectively targeted. Focussed work to reduce social isolation is needed to • develop tools and measures that support commissioners and service providers to understand the scale of the problem • support the development of interventions that will reduce social	

isolation and loneliness • support local communities and individuals to develop resilience to increase independent living	
Dying well in Hampshire Although the mortality rate has decreased, reflecting that people are generally living longer, the absolute numbers of deaths have increased. This rise is likely to be a reflection of the post war baby boom generation entering the oldest age groups where deaths predominantly occur. The growth in the number of older people and the changes in what people are dying from, means that there would be a benefit in reviewing End of Life Care services, to factor in the changes and consider the structure of the End of Life Care workforce to ensure sustainable services focusing on the wider definition of 'end of life' including CVD and late stages of dementia.	

2. Overview of the people of Hampshire	Click on links below for data
Our population: The population of Hampshire is changing; our population is getting older and we are becoming more diverse • The population of Hampshire is estimated to be 1.34 million people, making it the third most populous county in England after Kent and Essex. • Young people (aged 0-19) make up 23% of the population compared to 24% nationally. • Hampshire has fewer young working aged people (aged 20-39) compared to England as a whole; 23% in Hampshire compared to 27% in England. • Older people (over the age of 75) make up 10% of the population compared to 8% nationally.	Population Pyramid
Diversity: • The ethnic diversity in Hampshire is much lower than England as a whole (8.2% compared to 20.2% respectively) but it is gradually increasing across the county. While the population remains predominantly white British, the proportion of the population that is of ethnic origin has increased from 4.6% in 2001 to 8.2% in 2011 • Asian ethnic groups make up the largest non-white categories in Hampshire. Rushmoor has the largest non-white population at 15.3% (up from 4.4% in 2001); mostly due to a growing Nepalese population	Census data Ethnicity
Where we live: • 23% of Hampshire's population live in the 85% of the county classified as rural, while 77% of the population live in the 15% categorised as urban.	Map of rural urban areas
How our population is growing: • The population of Hampshire is forecast to grow by 6% between 2014 and 2021. The forecasts produced by Hampshire County Council include future housing supply. This includes all large and small sites with planning permission, or allocated in local plans as at April 1st 2014. • The largest proportion of overall population growth is in the number of people aged 75 and over. This is forecast to increase by a quarter (25%) that is approximately 33,000 people by 2021. The low mortality rate in Hampshire means people are living longer. • The number of young people (aged 0-14) is forecast to increase by 10% by 2021 that is approximately 22,104 more children aged 0 to 14 years, compared to 8% nationally. • The proportion of older people to those of working age is increasing, In Hampshire, in 2015 there are approximately 370 people of state pensionable age (SPA) for every 1,000 people of working age (16 to 64 years) compared to a national figure of 305 people of SPA/1,000 people of working age. Over the next 10 years this is expected to rise to 460/1,000 in Hampshire compared to 360/1,000 nationally.	Hampshire County Council Small Area Population Forecasts Population Forecast Age dependency forecasts
How healthy we are: • The Life Expectancy for an area is a recognised measure of its health and wellbeing. Variation in life expectancy within and between areas	

highlights health inequality. • Life expectancy for men in Hampshire has risen from 77.9 years in 2000-02 to 81.1 years in 2011-13 and is significantly better than the male life expectancy for England. • Life expectancy for women in Hampshire has increased from 81.9 years in 2000-02 to 84.2 years in 2011-13 and is significantly better than female life expectancy for England. • The upward trend in life expectancy in Hampshire has levelled off in the past couple of years. • Healthy life expectancy is a measure of the number of years a person born in an area can expect to live in good health. The healthy life expectancy for men is 65.6 years and for women is 66.3 years. Both are in line with our CIPFA neighbours and better than the overall healthy life expectancy for England. However, in Hampshire healthy life expectancy for both men and women is reducing and this could be an indicator of unhealthy lifestyle choices throughout people's lives. Although the trend is based on only three time periods, investigation is needed to understand what is happening. • The stark difference between healthy life expectancy and overall life expectancy indicates increasing years of ill health; around 14 years for men and 17 years for women; therefore although women live longer than men, more life years (43.4% v/s 38.3%) are spent in poorer health • There is also significant variation in life expectancy across Hampshire that indicates an important inequality in health. For men, the gap in life expectancy between the most deprived and least deprived areas has increased over the last decade from 5.7 years to 6.9 years. The gap for women has almost doubled in the last 10 years from 2.8 years to 4.8 years. **Deprivation** • Overall Hampshire is a prosperous area, ranked the tenth least deprived upper tier authority in England (out of 150). • However this masks some inequalities; within Hampshire there are 3 areas that rank amongst the most deprived 20% of areas in England. • The most deprived areas have been identified in Havant, Rushmoor and Gosport. • The Department for Communities and Local Government is updating the indices of deprivation, for publication in the Autumn of 2015. Once this is available it will be important to review any changes to deprivation across Hampshire and in particular to look at the impact of austerity on our community.	Trend for men 1ii Trend for women 1ii Trend for men 1i Trend for women 1i Trend for men 2iii Trend for women 2iii Deprivation Indices
What is this telling us about our population?	Click on links below for data
The population of Hampshire is changing; our population is getting older and also becoming more diverse. We are living longer with life expectancy increasing but the healthy life expectancy for both men and women is decreasing; the gap means that around 14 years for men and 17 years for women are spent in ill-health or high levels of need towards the end of their life. There is also significant variation in life expectancy between the least and most deprived areas, and the difference between the areas has increased over the past 10 years.	

In the current financial environment, the focus for health and social care services is on those in poor health or greatest need; if the decrease in healthy life expectancy continues more people will be projected to require health and social care over the next 5-10 years. However, there are significant opportunities for the rest of the public and voluntary sector to focus on reducing the risk of people becoming ill or having increasing need; making use of the assets of both the county and districts; focusing on prevention, particularly working with the middle ages (40-64 years) adult population to promote healthy ageing; to keep people active and eating healthily to reduce future risk of disease or to support active management of health conditions to improve outcomes and help people retain independence for longer. With the increasing older population and the relative reduction in the working age population who will be increasingly need to be involved in caring, the role of the voluntary sector is critical in developing networks and resilience in local communities. Work to strengthen and further develop the voluntary sector in Hampshire now should take account of the future changing population dynamic to ensure that community resilience is built in for the future.	

3. Starting Well – Children and Young People	Click on links below for data
Our younger population Nearly a quarter of the county's population (23%) is made up of young people (0-19 years), which is slightly less than England as a whole (24%) but in line with our comparators (CIPFA neighbours). The number of young people (aged 0-14) is forecast to increase by 10% by 2021 compared to 8% nationally. So over the next five years we will have approximately 22,104 more children aged 0 to 14 years. However this doesn't materially change the proportion of the population made up of young people. The number of babies being born in Hampshire has increased significantly over the last 10 years (from 54.4/1,000 women aged 15-44 to 59.8/1,000) Across Hampshire there is significant variation the number of babies being born, ranging from 56.6 live births per 1,000 women aged 15-44 in Winchester to 68.5 in Basingstoke and Deane. Where do our young children live? Where do our new-born babies live?	Population Forecast Map Map
Children's Outcomes	
There are a wide number of factors that influence and determine good health, but there is no single definitive measure to tell us if we or our communities are healthy. For children, infant and child mortality and birth weight are good indicators of both the health of our children now and their future health and are often used as measures of comparative health. Hampshire children overall have good health and good life chances, with low levels of Infant and Child Mortality and good educational attainment. **Infant and Child Mortality** Infant mortality is defined as the death of a child in the first year of life. The infant mortality rate (IMR) is the number of babies born alive, who die in the first year of life per 1,000 live births (this allows us to compare different areas). 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 overall health as well as to predict where there will be significant health inequalities. Infant mortality rates show large socio-economic and ethnic differences at national level. Reducing the variation in the IMR is a key national target for tackling inequality and requires initiatives to improve maternal health, child health and the wider determinants of health. The most recent IMR for Hampshire (2011/13) was 3.1 per 1,000 live births. This is significantly lower than the national figure of 4.0 and although not significant was lower than the regional figure (3.3). However while the national trend is still downwards, the Hampshire trend has appeared to plateau. The absolute number of infants that die each year is very small and although not all infant deaths are avoidable, through the reviews of all child deaths (through the Child Death Overview Panel) lessons can be learnt and trends identified to help inform prevention and early intervention initiatives	Infant Mortality 4.01

Deaths in childhood (1-19 years) are very rare; a low rate indicates overall good child health. In England nearly 60% of deaths in childhood occur during the first year of a child's life, and are strongly influenced by pre-term delivery and low birth weight; with risk factors including maternal age, smoking and disadvantaged circumstances. In Hampshire, for the years 2012-2014 just over 50% of childhood deaths occur in the first year of life.

Across England, over the last 25 years, numbers and rates of death among children aged under five years have fallen, but Infant and Child mortality is still higher in England compared to our European neighbours. There is an important difference in death rates between social classes and between genders. After the age of 10 years, more boys die compared to girls, with the difference between genders becoming greater in later childhood and young adulthood.

Evidence[1] has shown that many of the well-established risk factors for death in infancy persist into older ages. These include the association between birth weight and premature mortality, the differential between those children of fathers in manual occupations and those children of fathers in non-manual occupations, and the age, country of birth, lifestyle choices (such as smoking in pregnancy) and marital status of the mother.

The Age Standardised Death Rate (ASDR) for children under 15 years is below both national and regional rates (29.3/100,000 ASDR for Hampshire compared to 30.2/100,000 and 35.9/100,000 for the South East and England respectively for 2011/13 pooled data) further supporting the finding that children in Hampshire have better outcomes compared to the national position.

Understanding the causes of death in children and identifying whether these deaths are potentially avoidable is of value in developing interventions that can improve child outcomes. The causes of childhood mortality differ between age groups, the major causes of death for children (pooled three year data 2012-2014) are:

Age	Major cause of death
under 1 year old	conditions that arise in the perinatal period (62%) and congenital abnormalities (13%)
aged between 1 - 4 years	neoplasms (cancers) (27%) and respiratory conditions (17%)
aged between 5 - 9 years	neoplasms (45%), conditions of the nervous system (including epilepsy and conditions such as muscular dystrophy) (15%) and respiratory conditions (15%)
aged between 10 - 14 years	neoplasms (24%) and conditions of the nervous system (19%)
aged between 15 – 19 years	external causes (49%) (including road traffic accidents and self-harm) and conditions of the nervous system (19%)

[1] http://www.rcpch.ac.uk/improving-child-health/child-mortality/child-mortality#A

Although the numbers are small, in terms of prevention it is the causes of death for babies (less than one year old) and those in the 15-19 year old age groups that have the most potential to be avoidable. Nearly half of the deaths in the 15-19 year old age group being due external causes such as road traffic accidents and deliberate self harm. A focus on

- the health and lifestyle choices of young women to reduce low birth weigh would impact on the deaths in babies and,
- the mental and emotional wellbeing of young people
- road safety in young drivers

would help reduce the numbers of premature deaths

Children's Social and Emotional Development (Mental Health)
Mental and emotional health is fundamental to good health and wellbeing. There are strong links between emotional wellbeing of children and young people and their personal and social development and educational performance and it is an important factor in ensuring that they achieve their full potential. Emotional wellbeing includes confidence and self esteem which contributes to an ability to form good relationships with family and friends. Poor emotional and psychological health or mental health problems may result in educational underachievement, family disruption, anti-social behaviour and offending. Unrecognised and untreated mental health problems create distress not only for children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

Social, emotional and behavioural difficulties are common and affect 30–40% of children and young people at some time. Normal development will include behaviour of concern to adults. Young children may show poor concentration, aggression, lying, stealing, tantrums, toileting or bedtime problems, food fads, specific fears or anxiety; whereas teenagers may have relationship problems, poor anger control and conflict with adults over appearance, school progress or household rules. Mostly these are transient reactions to a particular life event, but for some they may be more prolonged.

Risk factors which increase the likelihood of a child experiencing poorer mental health can arise from:

- Wider environment, e.g. poverty, social housing, homelessness or refugee status
- Family, e.g. parental unemployment (20% of children where neither parent works have mental health problems, compared with 8% where both parents work. Poverty may also contribute); poor parenting; and circumstances which result in a child being looked after by the Local Authority
- Child, e.g. physical disability, chronic health problems, learning difficulties
- School e.g. bullying and several of the above risk factors may result in relative social exclusion at school which may further increase the risk of bullying

Providing the best start in life can maximise children's health, educational, social and emotional development. This can be done by providing good quality universal preventative and early intervention services before the age

of five[2]. Evidence suggests that mental disorder during pregnancy can affect the wellbeing of the women, the foetus and the infant and is likely to be associated with poorer long term outcomes for children. It has been estimated that 10% of new mothers suffer from post-natal depression and this has been associated with cognitive delay and emotional and behavioural difficulties in young children[3]. Identifying poor maternal mental health and poorer health and wellbeing development of children are two of the six high impact areas where health visiting service interventions make a high return on investment. With the transfer of responsibility for the commissioning of the Public Health 0-5 to Local Authorities there are significant opportunities to maximise the impact of the service on improving emotional health and wellbeing for mothers and children. However to assist the identification of poorer emotional health by health visitors, there needs to be appropriate services in place to support those at greater risk. Currently there is very little comparative information to give a good picture of the mental health and wellbeing of older children and young people. Given the benefit and potential return on investment in improving the emotional health and wellbeing of young people, information and indicators need to be developed so early intervention and prevention initiatives can be properly targeted.	
Individual Health Indicators	Click on links below for data
Low birth weight Babies born with a low birth weight have a higher risk of poorer health, dying prematurely and/or developmental issues. Low birth weight can be used as an important predictor of future poor health. Low birth weight is defined as a birth weight of less than 2,500gm (very low birth weight babies are defined as less than 1,500gm). Low birth weight is closely associated with deprivation, and often results from poorer maternal health including dietary intake, multiple births, babies being born prematurely and smoking during pregnancy. Across the population there is variation in levels of low birth weight; a high proportion of low birth weight births in an area could indicate poorer health in mothers, unhealthy lifestyles linked to deprivation and/or issues with the maternity services Hampshire data for low birth weight births (all live births where the baby weighs less that 2.5kg) shows no significant change between 2003 and 2013, (6.3 and 6.6 low birth weight babies born per 1,000 with a recorded weight, respectively). This rate is in line with our CIPFA neighbours and lower than England for those years where data is available (7.5 to 7.0 from 2006 to 2013) again indicating that overall, children in Hampshire enjoy good health and have a positive chance of future good health. However there is variation in low birth weight births between Hampshire districts, from 5.5 low birth weight babies born per 1,000 with a recorded weight in both Fareham and New Forest, to 7.0 per 1,000 in Havant (although this is not statistically significant).	Map

[2] Marmot M. 2009. Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities Post-2010. February 2010.[cited October 2012] www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf
[3] National Collaborating Centre for Mental Health. NICE Guideline C4 Antenatal and postnatal mental health: Full guidelines . 2007. The British Psychological Society& The Royal College of Psychiatrists

While the rates of low birth weight have stayed reasonably constant, the overall birth rate in Hampshire has increased, which means the absolute number of babies born with low birth weight has increased. This is important because there will therefore be an increase in numbers of children with future special needs and this will have implications for all areas of public services; paediatric and neonatal services, Social care services, Specialist education (SEN) and put increased pressure on the continuing care/short breaks budget. **Risk factors for Low Birth Weight** Poor diet and smoking during pregnancy are significant risk factors for a baby having a low birth weight and therefore a risk for poorer child development. Giving women good dietary advice and supporting women to stop smoking before or during pregnancy is therefore important for the future health and development of the unborn child. Births at maternal age extremes, both young teenagers and older women, are also more likely to give birth to lower birth weight babies and need targeted support Across Hampshire between 2010/11 and 2013/14 the proportion of women still smoking at the time of delivery decreased from 12.6% to 11.2% which is consistent with the direction of travel for both regional and national figures. However, in Hampshire the proportion of smokers at time of delivery is higher when compared to the regional figures (South East) and for our regional CIPFA neighbours. There is an opportunity to ensure the Public Health 0-5 services develop robust antenatal support to pregnant women to improve and support healthy lifestyles. **Healthy Weight** Obesity has become one of the major public health challenges for the 21st century. The causes of obesity are complex; with behavioural, genetic, environmental and social components. The health risks associated with being overweight or obese include increasing risk of diabetes, cancer, heart and liver disease, and these risks increase the more weight people put on. Child weight gives a good indicator of future health and development; overweight or obesity in children is a sign of malnourishment and is often linked to deprivation or poverty. This makes obesity a key health inequality issue. In first world nations over the last two to three decades, childhood obesity has been increasing. In response, in 2006 the National Child Measurement programme was introduced across England to measure the height and weight of all 5 and 11 year old children year on year to monitor levels of healthy and unhealthy weight. In 2012/13, the levels of childhood obesity in Hampshire indicated that 7.6% of 4-5 year olds and 15.0% of 10-11 year olds were obese comparing favourably with our CIPFA neighbours and significantly below the England averages of 9.3% and 18.6% respectively. While Hampshire children are generally less overweight or obese compared to other areas there is a doubling of the obesity levels between reception year and year 6 children. This increase in the proportion of children who are obese is replicated nationally. Locally we need to ensure that we minimise excess weight gain	Trend Smoking Status Trend (YR) Trend (Y6)

during the primary school years, working with and supporting families achieve and maintain a healthy weight Information locally confirms there is a link to deprivation and poverty (maps for excess weight in Reception year and Year 6 children compared to the Index of Deprivation affecting children), so that children in more deprived areas have a greater likelihood of being overweight or obese and are therefore at greater risk of certain diseases, with the associated consequences for limited employment opportunities and greater reliance on public sector support. In terms of tackling childhood obesity, higher levels of breastfeeding are linked to lower levels of obesity and better child health. Evidence[4] demonstrates that improving exclusive breastfeeding rates at 6-8 weeks improves longer term health for children and both reduce risks of future disease and hospital admissions and attendances in primary care by protecting babies from common infections. Breast feeding is one of the six high impact areas that have been identified where the health visiting service can have a significant impact on health and wellbeing and improve outcomes for children, families and communities. The increasing Health Visitor workforce and improved focus on breast feeding is starting to have an impact and the transfer of the commissioning responsibility for the Public Health 0-5 presents an opportunity to improve and maximise the levels of breastfeeding.	Map (YR) Map (Y6) Map (IDACI) Breastfeeding By CCG Source NHS England
System Indicators	Click on links below for data
Education Educational qualifications are a key determinant of future employment and income, and educational attainment (or lack of it) is a key risk factor in teenage pregnancy, offending behaviour, truancy, and alcohol and drug misuse. There are also clear links between attainment, absenteeism and both current and future health outcomes for children and young people. Achievement in Early Years is a good predictor of achievement later in childhood. In Early Years learning across Hampshire, boys and girls consistently achieve higher than the England average for attainment across all of the early learning goals. In 2014, the percentage of children achieving a Good Level of Development (GLD) is 67% compared to a national figure of 60%. The Hampshire GLD score rose by 8% compared to the 2013 GLD score. The Hampshire score compares to an average score of 62% for our statistical neighbours. In terms of geographical variation, ten districts have a GLD score greater than the national GLD, with only one district having a score below the national GLD. In 2013 nine districts had a score above the national 'threshold' score and two districts were below. The equalities score (gap), (the percentage difference between the median score for all children and the mean of the bottom 20%) is 25.7% compared to a national score of 33.9% and an average score of 29% for our statistical neighbours. There is still a gender divide with boys doing less well when compared to girls' GLD scores, (59% of boys achieving a GLD compared to 77% of girls). While there remains a differential between boys and girls, boys scores have increased by 8% and girls scores have increased by 10% when compared	Early Years Foundation – Profile Early Years – pupil characteristics Map (Data from 2011/12)

[4] http://www.nice.org.uk/guidance/ph11

to 2013. Ethnic minority group data indicate that white children and Chinese children attained GLD scores in line or above the county average but other minority groups attained below the county average. The lowest scoring groups were Irish Traveller children (11 children in cohort) who attained a GLD of 46% and Gypsy Roma Traveller children (38 children in cohort) who attained a GLD of 24%. The positive impact of the Early Years Foundation support is being evidenced in Key Stage 1 outcomes (outcomes at 7 years old). The increase in health visitor numbers and the transfer of the commissioning responsibility for the Public Health 0-5 gives the Local Authority the opportunity to identify early the children who are not developing as well as they should be through an integrated health and education review at 2- 2 ½ years old. This will facilitate access to early interventions, particularly for those vulnerable minority groups where there is lower early year's attainment. Educational attainment at secondary school level is measured as the percentage of pupils with five or more GCSE (KS4) passes at grades A*–C (including English and Mathematics). For the older children while the 2014 GCSE results aren't strictly comparable to previous years due to changes in marking criteria, 59% Hampshire pupils attained five or more GCSEs A*-C including English and mathematics (excluding retakes) against a national average of 57% (inclusive of retakes, the figure in Hampshire was 61% compared to a national average of 60%). The map highlights variation across Hampshire with lower achievement in GCSE attainment matching lower achievement in early years. Although the data in the map is older than the most recently published figures the findings are still relevant. In terms of improving educational attainment it is clear nationally and locally that some pupils start with a disadvantage due to their family circumstances. The evidence shows that poorer attainment in Key Stages of education (KS2; 11 year olds and KS 4; GCSEs) is strongly associated with deprivation (for example. fewer pupils eligible for free school meals as a proxy for deprivation achieve A*-C grades). In 2014 the DfE developed a new methodology for measuring the gap in attainment between disadvantaged pupils and others over time (disadvantaged children includes those eligible for free school meals (FSM) at any time within the last six years and looked after children who have been in care within the last six months) In 2014 the proportion of disadvantaged children attaining five or more GCSEs (A*-C) including English and Mathematics was 31.3% compared to children who are not disadvantaged at 64.7% that is a gap of 33.4 percentage points. While the gap has fallen compared to the two previous years it is still significant. The gap is also seen across the districts reflecting levels of deprivation with 49% of children in Gosport attaining five or more GCSEs at A*-C (including English and Mathematics) compared to 67% in Hart (overall in Hampshire the score was 59%) In terms of achievement by ethnic minority groups (7% of the school based population), the level of attainment of five or more GCSEs (A*-C) including English and mathematics is above (3%) the Hampshire average across the majority of ethnic groups, with the exception of the black ethnic minority	Key Stage 1 Key stage 2 Key Stage 4 Key Stage 5 Map GCSE Map Early Years (Data from 2011/12)

young people where the attainment level was 47%, Asian Other was 48% and Gypsy, Roma and Traveller young people was 25% compared to a Hampshire average of 59%. However, the results for black ethnic minority groups and travellers are likely to vary significantly due to very small numbers. The Asian Other group are slightly larger and results may vary due to late arrival students in Key Stage 3 and 4[5].

Special Educational Needs (SEN)

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. The Children and Families Act 2014 [Part 3] replaced the statement of SEN and Learning Difficulty Assessment for Post 16 learners, with an outcome focussed Education, Health and Care Plan (EHCP) for children and young people from birth to age 25. This sets out the support requirements for those with SEN if there are needs that are additional to and different from that which is ordinarily available within a mainstream educational setting. The new statutory guidance[6] sets out how this should be achieved with the expectation that there is collaboration between education, health and social care agencies to provide support.

Across Hampshire for 2014/15 children and young people with a statement/EHCP represented 2.85% of the school population, against an England average of 2.8%, and this trend has remained fairly constant. The number of those with a statement/EHCP has risen in line with the increase in population (2.2%).

Educational attainment at 16 years for those with SEN in Hampshire is slightly higher (3.3%) than the England state funded school average. This shows that in 2014 11.3% of those with a statement (EHCPs came in to effect 1.9.14) achieved 5+ A*-C GCSEs including English and Maths against an England average of state funded schools of 8%. However, for those on SEN Support (combining the previous School Action and School Action Plus) the figures are not as positive in Hampshire: 19.1% achieved 5+ A*-C GCSE including English and Maths, against the England average of 23.6%. This represents a 4.5% shortfall.

64.5% of the children and young people with a statement/EHCP in Hampshire are educated within special provision i.e. resourced provision or special schools. This does not represent inclusive practice.

Inclusion is the process of removing barriers to engagement, participation and learning so that everyone benefits fully from educational opportunities. This means influencing inclusive practice across educational settings in Hampshire to ensure those with a statement/EHCP and those on SEN Support have the right support in mainstream education to encourage them to thrive and develop.

Comparing the SEN needs for those with a statement/EHCP between the 2010 and 2014 school census demonstrates the following: there has been a significant rise in autistic spectrum disorder, most notably within mainstream settings with a 69% increase; and in Emotional, Social and Mental Health Difficulties, most notably within non maintained special schools and

[5] Hampshire data sourced from Key to Success export dated 29-Jan-2015, tab I3 EMTAS data book April 2015
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf

resourced provision at 47% and 33% respectively. There has been a significant decline in Profound and Multiple Learning Difficulties with a 21% decline in special schools; and in Specific Learning Difficulties with a 43% and 41% reduction in maintained and special schools respectively.

The developing SEND Reforms Area Ofsted Inspection Framework will focus on the early identification of needs; and then effectiveness in meeting needs and how this has improved outcomes. This in turn feeds in to the joint commissioning of services across education, health and social care. There needs to be an appropriate evaluation framework developed, following the introduction of this new legislation, that will enable Hampshire to monitor outcomes to see how interventions have a positive impact in improving the lives of these vulnerable children and young people by effectively preparing them for adulthood to maximise their opportunities of living an independent life.

Teenage pregnancy

Teenage conception includes all conceptions before the mother's 20th birthday, but the national focus is on conception under 18 years of age as most potential mothers in this age group are in (or should be in) full time education or training. The teenage conception rate is the number of pregnancies that start before the mother's 18th birthday (per 1,000 young women) and includes pregnancies that end either in birth or in termination.

Graph U18Cs

Map
(data from 2008/9-2012/13)

Evidence indicates that high rates of teenage pregnancy are most often associated with low educational attainment and disengagement from school, economic deprivation, and poor mental health. Young people at increased risk of early parenthood and teenage pregnancy include children of teenage mothers, looked after young people, young people misusing alcohol, young people involved in crime, those with low self-esteem and some black and minority ethnic groups. Early onset of sexual activity and poor contraceptive use are other significant risk factors to teenage pregnancy.

The good news is that the under 18 conception rate in Hampshire has been declining from 1998 to 2013 in line with the National figures. However, when we compare areas with higher levels of teenage conceptions to areas with lower levels of educational attainment and deprivation in Hampshire, there is an overlap but this is not uniform.

Key areas for further work are;

- continuing to ensure good access to contraceptive and sexual health services for young people;
- continuing to improve the uptake of Sex and Relationships Education, including delivering targeted programmes in secondary schools in high or increased teenage conception areas;
- maintaining universal training for front line practitioners, with an emphasis on those professional groups that are currently under-represented
- providing support for young parents via targeted interventions to improve outcomes for teen parents and their children and reduce subsequent pregnancies

Employment and Training

There are clear links between educational attainment, absenteeism and both current and future health outcomes for children and young people. Education and skills are part of the key to breaking the intergenerational cycle of inequalities in income and employment opportunity which impact on health. As society has moved from industrial to service economies, those without the necessary education or skill set to adapt are at risk of unemployment and poverty. Lack of further education and training can lead to poor basic skills and limited academic and vocational qualifications.

From 2013, Raising of the Participation Age legislation placed a duty on young people to remain in education, employment or training (EET) until the end of the academic year in which they turned 17. The duty will extend to their 18th birthday from Autumn 2015. Historically, the proportion of young people aged 16-18 (academic year's 12-14 inclusive.) who are not in education, employment or training (NEET) is below both national and regional averages.

For 2014/15, the actual annual NEET figure for Hampshire was 3.6% and the official adjusted NEET figure (which takes into account those young people's whose activity is unknown to the local authority) was 4.3%. This equates to 1,512 young people, similar to the average rate for CIPFA neighbours, and is an improvement on 2013/14. The profile of the NEET cohort is complex and includes young people with a broad range of previous educational achievement and participation. There is significant 'churn' within the cohort each month with only a minority who are NEET for 12-months or more. However, generally young people who are NEET have poorer life outcome and there is evidence[7] that if people are unemployed for more than 12 months they find it increasingly difficult to find permanent employment. Significant cross-agency efforts and investment is being applied to this matter which will likely feature prominently in any future devolution proposal for Wider Hampshire.

Trend NEET

Unintentional injuries

Evidence indicates that there is a range of interrelated factors can lead to a higher risk of injury for children and young people, the risk of an unintentional injury being greatest among households living in the most deprived circumstances. Children and young people from lower socioeconomic groups whose parents have never worked (or who are long-term unemployed) are 13 times more likely to die from such an injury than those whose parents are managers and professionals[8] and 37 times more likely to die in a fire than children living in the least deprived areas[9].

Unintentional injuries are the leading cause of hospitalisation and represent a major cause of premature death for children and young people

Trend - Injuries

A useful indicator for cross-sectorial and partnership working to reduce injuries, including safeguarding, is the rate of hospital admissions caused by unintentional and deliberate injuries. In Hampshire for young people (aged 15-24 years), the rate is still significantly higher than our CIPFA neighbours. In 2013/14 the overall rate for Hampshire was 151.4 admissions per 10,000

[7] http://www.local.gov.uk/c/document_library/get_file?uuid=1629e81a-800a-464f-aa62-807b3e66f217&groupId=10180
[8] https://www.nice.org.uk/guidance/ph30/chapter/2-Public-health-need-and-practice
[9] http://www.chimat.org.uk/earlyyears/injuries

population with significant variation within this; ranging from 176.9/10,000 in Havant to 115.5/10,000 in Winchester. There are caveats to using this indicator; there may be a question regarding the quality of external cause coding and there may be differences in admission thresholds and data recording which need to be taken into account but as a significant cause of morbidity for our young adult population the causes do need to be investigated to help inform prevention initiatives. An accidental injury is an important cause of fractures and dislocations in children and adolescents but there is very little known about the epidemiology of falls in younger people. Falls and fall related injuries are the most common cause of accidental injury to children and are a significant public health problem. The rate of A&E attendances for falls are highest among the under 5 year olds and falls from a height tend to be associated with the most serious childhood injuries. There is evidence that older children are more likely to sustain fractures than younger ones. The map shows clearly geographical variation in the admissions for injuries in the under 5 (NB same caveat as above applies) Road traffic accidents are also another major cause of injury and death both for children and adults. In 2011/13 the rate per 100,000 persons (all ages) for killed and seriously injured casualties on roads in Hampshire was 54.0, significantly higher than the England average of 39.7. The trend in Hampshire has been increasing over recent years and is worse than our CIPFA neighbours. Accidents and unintentional injury are significant causes of morbidity (not just mortality) for our younger population. The causes of these injuries need to be investigated to help inform prevention and early intervention initiatives. as managing minor illness and reducing accidents (Reducing Hospital Attendance/Admissions) is one of the six high impact areas for the health visiting services and there is an opportunity to utilise the health visiting service to effectively target such initiatives **Vulnerable children and young people** Given the right support, children with Special Educational Needs, vulnerable children including those with disabilities, can thrive and develop. Recently published statutory guidance[6] provides comprehensive details of services and support to be provided by all public organisations who work with children who have special educational needs or disabilities. The guidance highlights the need for organisations to work jointly and base the development of their services on local needs. To implement this guidance it is important to understand the local needs, assets and gaps for this population to improve outcomes. Although the guidance is statutory only for SEN and children with disabilities, it would be good practice to apply this approach for services to all vulnerable children. As part of implementation there needs to be an appropriate evaluation framework developed, following the introduction of this new legislation, that will enable Hampshire to monitor outcomes to see how interventions have a positive impact in improving the lives of our vulnerable children and young people by effectively preparing them for adulthood to maximise their opportunities of living an independent life.	Fractures by age chart Map Trend KSI

What is this telling us about starting well in Hampshire?	
Overall children who are born and live in Hampshire have good • health • life chances • educational attainment While our Infant and child mortality rates are low compared to national rates, national rates are high compared to our European neighbours There is also variation across Hampshire with some groups of children, particularly our vulnerable children, being disadvantaged with poorer health and low educational attainment. We need to better understand the needs of our more vulnerable children and as part of this work to develop an appropriate evaluation framework to ensure that across the system we commission effective services that improve outcomes for these children. With the transfer to the council of the commissioning responsibility for the Public Health 0-5 there are opportunities to maximise the universal nature of the programme; to get the best possible outcomes on the six high impact interventions that are part of that programme, focussing on prevention and early identification of children and families at risk of future health and social problems. We need to work specifically with • families to ensure that we minimise excess weight gain of children during the primary school years, and to support them achieve and maintain a healthy weight to improve health outcomes • partner organisations to understand the social and emotional health needs of young people and develop interventions that can be targeted more effectively to where they are needed • young people whose future life chances are being damaged by the lack of training, education and employment opportunities, particularly where they have been out of work (or not in work) for more than 12 months	

4. Staying Well – Adults	Click on links below for data
Our adult population: Hampshire has a slightly lower proportion of working aged adults when compared to England as a whole (56.6% compared to 58.7%) and even fewer young working aged people (aged 20-39) compared nationally (23% to 27% respectively). In Hampshire, there are approximately 370 people of state pensionable age (SPA) for 1,000 people of working age (calculated as 20 to 64 years) this is significantly more than the national figure of 305 people of SPA/1,000 people of working age. Over the next 10 years this is expected to rise to 460/1000 in Hampshire compared to 360/1000 nationally. There is also significant variation (a two fold difference) across the districts with New Forest having a ratio of 530/1,000 compared to Rushmoor with a ratio of 227/1000. The lower proportion of working aged population is significant and has implications for the future. Having an increasing older population relative to the working aged population, particular if there is poorer health, has the potential to put pressure on local communities and the caring system (carers). This changing population dynamic needs to be factored into the planning of both health and social services. The role of the voluntary sector is critical in developing networks and resilience in local communities. Work to strengthen and further develop the voluntary sector in Hampshire now should take account of the future changing population dynamic to ensure that community resilience is built in for the future.	Population Forecast Age dependency forecasts
Outcomes and Individual Health Indicators	Click on links below for data
There are a wide number of factors that influence and determine good health, but there is no single definitive measure to tell us if we or our communities are healthy. Factors or conditions that cause premature mortality or illness can help us understand how healthy our population is. For adults the main causes of premature death are Cancer, Heart disease and respiratory disease. Certain illnesses not only cause mortality but can also cause significant disability if they are not managed effectively can also be indicators of poorer health both now and in the future. For example Diabetes and Mental Health Overall Hampshire is a healthy place to live, but there are a number of causes for concern: The mortality (death) rate in the under 75 year olds is used as a proxy for premature mortality as most deaths in people under the age of 75 years are avoidable. A lower rate of death in this age group is seen as an indicator of better health. Overall Hampshire has lower levels of avoidable mortality in line with CIPFA neighbours and better than the national average. Lower prevalence rates for disease can be an indicator of better overall health in a population. However it is not always clear how much disease is present in a population so the gap between the amount of disease expected	Avoidable Mortality 4.04ii

and what is recorded on practice registers provides an indication of how many undiagnosed people there are. The earlier people are identified the earlier they can be treated, resulting in improved long term outcomes.

Difference between expected and recorded prevalence:
Table 1

CCG	CHD recorded Prevalence	CHD Estimated Prevalence	Diabetes recorded Prevalence	Diabetes Estimated Prevalence	Hyper-tension recorded Prevalence	Hyper-tension Estimated Prevalence
North East Hants and Farnham	2.6% (1 in 38)	3.5% (1 in 29)	5.2% (1 in 19)	6.3% (1 in 16)	12.8% (1 in 8)	22.7% (1 in 5)
North Hampshire	2.6% (1 in 38)	3.6% (1 in 28)	5.7% (1 in 18)	6.2% (1 in 16)	12.3% (1 in 8)	22.9% (1 in 5)
West Hampshire	3.4% (1 in 29)	4.6% (1 in 22)	5.3% (1 in 19)	7.0% (1 in 14)	14.5% (1 in 7)	26.2% (1 in 4)
South Eastern Hampshire	3.8% (1 in 26)	5.3% (1 in 19)	6.2% (1 in 16)	7.5% (1 in 13)	15.4% (1 in 6)	27.2% (1 in 4)
Fareham & Gosport	3.6% (1 in 28)	4.5% (1 in 22)	6.2% (1 in 16)	6.8% (1 in 15)	15.5% (1 in 6)	26.0% (1 in 4)
England	3.3% (1 in 30)	4.7% (1 in 21)	6.2% (1 in 16)	7.3% (1 in 14)	13.7% (1 in 7)	24.7% (1 in 4)

Cardiovascular Disease (CVD) is the second biggest cause of premature death in Hampshire, of which Coronary Heart Disease (CHD) is the main contributor. Across Hampshire the under 75s death rate from Cardiovascular Disease (including Stroke) is lower than the national rate. Although the overall 3 year rolling trend is downward, the rate of decline in Hampshire is slower than regional and national rates, hiding a recent increase in annual deaths from CVD. Comparing recorded and estimated prevalence suggests between 1 and 2% of people with CHD remain undiagnosed and therefore more at risk of poorer health outcomes.

Cardiovascular Mortality 4.04i

Inequalities across Hampshire appear to exist in both mortality (with significant difference in mortality rates between least and most deprived populations), levels of morbidity and access to services, with those most at risk from mortality not necessarily accessing services as well as those least at risk.

Map (Mortality)
Map (Elective)
Map (Non-elective)

The biggest factors that would prevent premature mortality are improving the uptake of healthy lifestyle choices and diagnosing disease early. The NHS Health Check Programme is aimed at identifying early those people with Cardiovascular Disease (CVD), Diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or has certain risk factors, is invited (once every five years) to have a check. With an eligible population of over 418,000 Hampshire's Health Check programme is one of the largest in England. In 2013/14 81,071 people were invited to have a NHS Health Check in Hampshire and of those, 19,905 (24.6%) received a health check. The number of people receiving health checks in Hampshire has significantly increased in 2014/15 (44.5%); however the rate is still low which means the opportunity to reduce the gap between the recorded and estimated prevalence, and identify modifiable risk factors is limited.

Health Check Profiles

Cancer is the main cause of premature death. Rates of deaths from cancer in people under 75 years old have remained relatively flat for males but have decreased for females over the last few years. However this hides inequalities that exist in mortality rates between those living in the most and least deprived areas. There are also differences in the access to services with those who have the highest mortality rates having lower access to services. The NHS five year forward plan highlights the need to increase survival rates through better prevention, better uptake of screening and quicker access to diagnostics and treatment.	Graph Cancer mortality 4.05ii (M) Graph Cancer mortality 4.05ii (F)
While most cancers disproportionately affect the older age groups there are some cancers that affect younger people such as Leukaemia and Melanoma. Nationally, Malignant melanoma of the skin is the second most common cancer in the 15 to 39 year age group, which is a young age distribution for an adult cancer. Melanoma is readily preventable with sensible precautions and if found early, treatment can reduce the potential loss of many years of life. While the numbers are relatively small compared to other cancers, the latest figures show Hampshire to have a significantly higher than national or regional incidence of malignant melanoma. The variation across Hampshire shows generally higher levels in the southern Districts compared to the more northerly ones.	Map Melanoma
Respiratory Diseases: the rates of premature death from respiratory diseases have remained relatively constant in Hampshire over the last decade compared to an improving national position. Map of Emergency admissions for COPD demonstrate a link with areas of high smoking prevalence.	Map COPD Map of Smoking prevalence
Mental Health: The link between mental health problems and social exclusion is intricate and well documented. Mental ill-health can be both the cause and the consequence of social exclusion leading to a vicious cycle of homelessness, unemployment, and worsening physical and mental health. One in four people in the UK will experience a mental health problem in the course of a year[10]. The cost of mental health problems to the economy in England have recently been estimated at £105 billion each year and treatment costs are expected to double in the next 20 years[11]. The key inequalities experienced by people with mental health problems are: • Low levels of employment: in Hampshire in Quarter 2 2014 52.5% of people with mental ill-health were in work compared to 36% nationally. • Social exclusion: This might arise through stigma, discrimination and difficulties in maintaining social and family networks. Risk factors for poorer Mental Health are generally lower in Hampshire compared to national and regional figures, although this varies across the Districts most notably in Gosport and Havant. • Barriers to accessing health services: we have very little definitive data to tell us what barriers might exist to accessing services for people with poorer mental health. However, looking at the proportion	Dashboard

[10] The Mental Health Foundation, http://www.mentalhealth.org.uk/help-information/mental-health-statistics/

[11] Department for Health, 2011, 'No Health without Mental Health: A Cross Government Mental Health Strategy for People of All Ages', http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

of risk factors for mental health that an area has and comparing this with the proportion of people completing GP patient survey who report that they have a long-term mental health problem could be a potential indicator of how accessible services are. People in Gosport and Fareham reported a lower figure for having a long term mental health problem compared to other CCGs but as Gosport has some of the highest level of risk factors for mental health problems within Hampshire, this would benefit from further investigation. • Poorer physical health and increased mortality from some diseases. There is a significant link between mental ill-health and physical ill-health, not only from the perspective that poor mental health and well-being can lead to poor physical health but also for people who have poor mental health having physical health problems that often go undetected. This may result from misdiagnosis of physical ailments; reluctance or inability to access health services; and unhealthier lifestyles, for example poor diet, less exercise and higher levels of smoking. An indictor for this inequality is the rate of premature (under 75 year) mortality in adults with serious mental illness. This is the number of deaths among people aged 18-74 who had contact with specialist mental health services per 100,000 population aged 18 to 74 years. In 2012/13, Hampshire had a rate of 1,410 per 100,000 compared to the national rate of 1,319/100,000. While the Hampshire rate is not statistically higher than England, it is the fifth highest rate in the South East and the trend is marginally increasing compared to the national trend which is fairly flat.	Reporting of poorer mental health Comparison SMI Trend SMI
Mental illness increases the likelihood of suicide. For example, suicide rates are nine times higher amongst those with schizophrenia than in the general population. About three quarters of people who have taken their own lives have not had contact with mental health services in the year before death[12]. Suicide is also a leading cause of premature death and has important social inequalities: • From national figures suicide is five times more common in men (aged 20-64) in social class V than social class I (figures not available at local levels) • Those at risk are often socially excluded and vulnerable to other health inequalities. Key associated factors are: unemployment, confinement in prison, living alone and alcohol and drug misuse • Men are more likely than women to die by suicide at any age. Although it is a crude indicator and care needs to be taken when interpreting these figures, the rate of suicide in a community can be an indicator of the level of mental health problem.	
In Hampshire the absolute numbers of suicides is small (229 for men and 86 for women over the three years 2011/13, that is just over 100 per annum compared to about 12,000 deaths from other caused). While the rate of suicide in Hampshire is still (just) less than the national average, the trend in levels of suicides for men in particular has increased over the past decade with a small peak in 2009/11. The Hampshire Suicide prevention strategy is a multi agency plan to reduce suicide risk in the population of Hampshire	Trend for men Trend for women

[12] Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, (2001)

Work needs to be done with different groups of people with poorer Mental Health to understand better the lack of access to current services, particularly primary care, and to co-design these services to improve accessibility. People with poorer mental health are also at significant risk of social isolation; initiatives that develop social networks for this group of people are important in helping to improve their mental and physical health.

Focus on Diabetes
Diabetes, once present or diagnosed, is a life-long health condition where the person is unable to adequately regulate their metabolism, resulting in high levels of glucose in the blood which the body cannot utilize properly. Type 1 and Type 2 diabetes are the most common types.

Type 1 diabetes usually appears before the age of 40, often in childhood and accounts for around 10% of all people with diabetes. People with Type 1 diabetes require daily insulin injections for life but the cause remains poorly understood.

Type 2 diabetes tends to become apparent in adulthood and accounts for about 90% of all diabetes. The main risk for Type 2 is being overweight and contributory lifestyle factors include an unhealthy diet and lack of exercise. If these lifestyle factors are changed, the onset of Type 2 diabetes can be prevented. Diabetes is also more common in certain ethnic and social groups who are more likely to be overweight or have a genetic predisposition for the condition.

The prevalence of diabetes across Hampshire has increased from 5% in 2009/10, to 5.64% in 2013/14 and national projections estimate that it could reach 7.6% by 2020.[13] Table 1[14] shows the variation in both recorded and estimated diabetes prevalence by CCG. Comparing recorded and estimated prevalence suggests in Hampshire between 0.5 and 1.5% of people who have diabetes remain undiagnosed.

Why is diabetes important?
As a condition Type 2 diabetes is potentially preventable but once a person has diabetes, if the condition isn't well controlled (that is if their blood sugar is not maintained at normal levels), they are more likely to develop complications including heart attack, stroke, and other vascular conditions involving small (microvascular) blood vessels which can lead to eye and kidney problems.

The aim of treatment is therefore to control diabetic symptoms and to reduce the chances of developing blood vessel-related complications. The evidence for this comes from the UK Prospective Diabetes Study (UKPDS).

In terms of findings from this study[15]:

- People living in deprived areas are 2.5 times more likely to have diabetes
- People from Black and Asian minority ethnic (BAME) groups are up to six times more likely to develop diabetes

Prevalence

[13] Public Health England diabetes prevalence model http://www.yhpho.org.uk/resource/view.aspx?RID=154049
[14] Page 21
[15] https://www.dtu.ox.ac.uk/ukpds/

- One in five people with a severe mental illness have diabetes
- The prevalence of diabetes in nursing homes can be as high as 25 per cent, compared to three per cent in the general population
- Complications of diabetes such as heart disease, stroke and kidney damage are three and a half times higher in lower socio-economic groups
- People from deprived or ethnic communities are less likely to have their body mass index or smoking status recorded. They are also less likely to have records for blood sugar levels, retinal screening, blood pressure, and neuropathy or flu vaccination
- Education is important in preventing complications, those who are least well educated are more likely to have retinopathy, heart disease and poor diabetes control

In terms of complications

- The relative risk of developing further complications for people with diabetes in Hampshire is compared at CCG level. There is variation across CCGs on the level of complications but of particular concern are the relative risks for major amputation in the CCG areas in Hampshire, which are all higher than the England rate of 3.22. The relative risk in South-eastern Hampshire CCG is the highest at 5.22, with the rate in North East Hampshire and Farnham CCG being 4.95, West Hampshire is 4.92, Fareham & Gosport CCG is 3.54 and North Hampshire is 3.43.
- Diabetes is the leading cause of blindness before old age and the effects can be mitigated by early intervention. The NHS Diabetic Eye Screening Programme aims to reduce the risk of sight loss among people with diabetes through early detection and treatment. In 2013/14, 85.1% of people (n=52,209) accessed the diabetic retinopathy screening service in Hampshire better that the national average of 82.6% However there is variation across Hampshire in uptake that needs to be addressed.

Fareham and Gosport

South Eastern Hampshire

North East Hampshire and Farnham

North Hampshire

West Hampshire

Tackling Diabetes

The major risk factor for diabetes is being an unhealthy weight (overweight or obese), and the risk increases the more weight that is put on. There is no definitive measure of the number of people who are overweight or obese, national modelled estimates of adult excess weight based on the National Active People survey of self reported height and weight have been developed. These estimates suggest that 65% of adults (aged over 16 years) in Hampshire have excess weight. Across Hampshire the proportion of adults with excess weight ranges from 58.5% in Winchester to 72.9% in Gosport.

The National Diabetes Audit

Tackling unhealthy weight not only relies on how we make choices as individuals but also on interventions that change environmental factors including increasing physical activity and societal norms. Any initiatives need to take this into account to have impact and return on investment.

Diabetes is a key priority for Hampshire's 5 Clinical Commissioning Groups (CCGs), public health, and adult social care.

Ensuring that people with diabetes receive the key tests and access to the right interventions to prevent or delay the complications of diabetes is a vital

component of good diabetes care. Locally patients with Type 2 diabetes usually receive their care in a Primary Care setting. The National Diabetes Audit reports on the percentage of people on the diabetes register who receive all NICE recommended care processes and treatment targets. All Hampshire CCGs participated in the audit; • The quartile rankings show North East Hampshire and Farnham in the top 25% of all CCGs for all the 8 care processes • None of the 5 Hampshire CCGs were in the top 25% of CCGs for patients receiving all treatment targets for glucose control, blood pressure and serum cholesterol • All the CCGs have areas of good performance and underperformance but these varied across the county • Nationally and locally access to structured education needs to be reviewed to ensure all new and existing diabetes have the opportunity for education on their condition. The focus for commissioners and services needs to be on • Systematically address overweight and obesity as an important risk factor for type 2 diabetes • Working with outlying providers to improve performance and outcomes, uptake of screening, and reduce the need for exception reporting • Encouraging and supporting self-management in people with diabetes and their families, particularly in improving healthy living and supporting healthy living choices • Ensure footcare pathways are in accordance with NICE guidance	
System Indicators	Click on links below for data
Employment Being in good employment is beneficial for both physical and mental health; people who are employed have lower rates of limiting long term illness, cardiovascular disease and general health problems. The economic activity rate in Hampshire (that is the proportion of people in the population who could be in employment - so includes those who are employed and unemployed compared to the total population of 16-64 year olds) for the 12 months to December 2014 was 82.0%. This is above the average for Hampshire's nearest (CIPFA) neighbours (80.3%), and well above the England rate (77.4%). The economically inactive rate is therefore 18.0% for the same time frame (that is people who are not looking for a job by reason of retirement, or looking after family). This is below both the England (22.6%) and CIPFA average (19.7%) but was not the lowest of the nearest neighbours (which is Cambridgeshire at 16.8%). The employment rate is also strong at 79.5% and is higher than Hampshire's 15 nearest neighbours and significantly above the England rate (72.5%). Unemployment has been on a consistently downward trend since early 2012. The unemployment rate for the January to December 2014 is 2.9%, this is the lowest of the CIPFA neighbours and well below England (6.2%). Unemployment - Jobseekers Allowance (JSA) Claimants	Labour Market Profile

Most recent data (March 2015) shows the JSA rate is 0.9%, making it one of the lowest among the CIPFA neighbours and well below the England rate (1.9%). Overall, Hampshire has relatively low youth unemployment with a rate of 1.6% for 18 to 24 year olds (March 2015). This is below both the nearest neighbour ((CIPFA) average of 2.1% and the England average (2.9%). While Hampshire's JSA rate is almost half that of its highest nearest neighbour Kent (3.1%), it is still twice the rate of another nearest neighbour Oxfordshire (0.8%) which has the lowest rate. The absolute numbers of young people not in long term employment is low. In April 2015 there were 1,425 young people aged between 18-24 years claiming Jobseekers Allowance which represents just 1.4% of the population. However, there is evidence (ref) that if people are unemployed for more than 12 months they find increasingly difficult to find permanent employment. In April 2015 there were 145 young people claiming JSA for more than 12 months. There is significant variation between Districts ranging from 2.9% (315) young people claiming JSA in Gosport to 0.7% in Winchester and Hart (75 and 45 respectively). **Workplace Health** The Marmot Review[16] recognised the important role of good employment in improving health and reducing health inequalities: "Being without work is rarely good for one's health, but while 'good work' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill". Families without a working member are more likely to suffer persistent low income and poverty. Lower parental income is associated with poor health in children. Improving the health of the working age population is critically important in order to secure higher economic growth, independence and better health with less need for local services. There are considerable economic costs to employers, employees, the state and healthcare system of unemployment and ill-health. A national review of sickness absence calculated that employers pay £9 billion a year in sick pay and associated costs, while the state spends £13 billion a year on health-related benefits[17]. In Hampshire, (in 2010/12) sickness absence represented as a % of working days lost due to sickness absence in the previous working week was 1.6% which was in line with our CIPFA neighbours and national levels. Focusing on the health and wellbeing of the working population, reducing sickness absence by supporting people to remain in good health for longer will have a marked effect on productivity and reduce reliance on public sector services. Simple initiatives to improve physical activity and healthy eating and reduce stress have delivered good returns on investment by reducing sickness and absence[18]. There is an opportunity to develop some proactive communications to private sector employers (large and small) with some basic but compelling messages around the productivity benefits of workplace health and relatively simple and low cost interventions / measures which could have a positive impact on this.	Sickness absences

[16] The Marmot Review Team. Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010. London: Marmot Review Team, 2010.
[17] http://www.instituteofhealthequity.org/projects/increasing-employment-opportunities-and-improving-workplace-health
[18] PricewaterhouseCoopers LLP. Building the case for wellness. London: Department for Work and Pensions, 2008.

Benefits
Health, particularly general wellbeing and mental health, improves broadly in relation to improvements in financial position and employment status. People on low incomes and benefits are less likely to have good health. Total benefits, key out-of-work benefits and ESA/IB provide a fuller picture on the possible impacts to health rather than just the JSA. The Hampshire total benefit rate in August 2014 is 8.0% of working age residents, which is one of the lowest rates among the CIPFA neighbours and also below the England rate (12.3%). The nearest neighbour average is 9.6% while the lowest is 6.8% (Oxfordshire) and the highest is 11.6% (Kent).

The key out-of-work benefit rate for Hampshire is 5.7%, and is one of the lowest among the CIPFA neighbours. The ESA/IB rate is 3.9%, (August 2014). This has remained virtually unchanged compared to the same periods in 2011, 2012 and 2013. Hampshire has one of the lowest ESA/IB rates of its 15 nearest neighbours and is well below the England rate (6.0%).

Benefits relating to ill-health are useful to understand the cause of disability and significant morbidity that affects ability to work across Hampshire. In 2013, the Personal Independence Payment (PIP) was introduced superseding the Disability Living Allowance for working aged people. In terms of ill-health, the conditions that have the greatest impact requiring PIP are Cancer, Mental illness (psychiatric conditions) and Musculoskeletal conditions (which includes Arthritis (osteo and inflammatory) and disorders of the limbs and back).

In Hampshire in January 2015, there were 3986 people claiming PIP, for the following reasons, Malignancy (15%), Psychiatric disorders (29%), Neurological disease (including Stroke, MS, Parkinson's and epilepsy) (11%), Musculoskeletal Disorders/disease (31%), Respiratory disease (5%). This is a slightly different profile compared with regional figures where there are marginally more claimants with malignancies, and psychiatric conditions but fewer with musculoskeletal and respiratory disease.

This information highlights that some of the conditions cause increasing disability are not necessarily those that cause mortality. CCGs and the Council might find it useful to review some of this data as it becomes more established to look at areas of impact of the conditions that cause disability but not necessarily mortality.

Disability
Disability is an important issue. A significant proportion of physical disability could be preventable and the effective use of treatment and rehabilitation services directed at restoring function in people who are already ill, injured or disabled can reduce dependency, improving quality of life. It is important to ensure that the needs of people with disabilities are clearly identified and a personalised response is made with them.

Physically disabled people still face social, environmental and attitudinal barriers, which can restrict their participation in society. Policies that increase independence and enablement are important in supporting good outcomes amongst people with physical disabilities. Independent living is about ensuring rights and entitlements are addressed so that people with

physical disabilities can enjoy the same freedoms to lead lives they wish as those without disabilities. The relationship between physical disability and other health determinants are well established on a national level but we have a paucity of local data to support services at a local level. Information on visual and physical disabilities that we do have tends to focus on older people. In terms of future need, population figures[19] predict, based on current population, that across Hampshire over the next 5 years there will be approximately 2.4% increase in the number of people aged 18-64 years with a moderate physical disability (an increase of 1,515 people) and approximately a 3.3% increase in the number of people with a severe physical disability (an increase of 636 people). In order to understand the scale of the problem, it is important we ensure that there is good data collection on the people with disabilities that are known to services but also that we develop more robust systems to help identify people with disabilities access services appropriately according to need to enable them to maximise their independence. People who have more severe learning disabilities have poorer health outcomes than the general population[20]. Currently there are very few indicators for this population that can inform us whether their health is improving. It is important that health information for people with learning disabilities is recorded so that future need can be better understood. The information on prevalence comes from a range of sources and is not necessarily fully complete. Recorded prevalence is generally the prevalence of people who are on a learning disabilities register in a GP practice or a register held by the Council. These registers usually include those people with moderate or severe learning disabilities (i.e. are known to services). True prevalence will be under reported as it will not include those who generally have milder learning disabilities but who are not always known to services. In general as people with learning disabilities are living longer with increasingly complex health and social care needs. Therefore more support will be needed to help people with learning disabilities remain independent and living in their own homes. A good measure of independence is the number of people with disabilities who are in employment. Having employment for people with disabilities can reduce reliance on local services. Hampshire compares less favourably than its CIPFA neighbours and nationally with the proportion of people with learning disabilities (5.9% compared with 6.7% nationally) and for people in contact with mental health services being in employment (5.7% compared with 8.8% nationally) and the trend is decreasing	GP registered Trend LA reported Trend Trend PwLD employed Comparison MH employed

[19] www.**poppi**.org.uk
[20] Michael J. Healthcare for All: Independent inquiry into access to healthcare for people with learning disabilities 2008

What is this telling us about staying well in Hampshire?	Click on links below for data
Adults in Hampshire in general live longer, have good employment and good opportunities to keep healthy. However there is variation with some people having much poorer health and outcomes. The proportion of working aged population is reducing which has implications for the future. This is not only a concern locally but nationally; as the number of older people increases relative to the number of working age people, the tax income diminishes and it becomes more difficult for the state to continue to provide services, such as pensions and health and social services. This change is also likely to put pressure on local communities and the caring system (carers) and needs to be factored into the planning of both health and social services. Although people in Hampshire live longer and longer in good health, this is beginning to change, with a fall in healthy life expectancy being seen over the last three years. Staying healthy even if you have a long term condition is important for future wellbeing and independence. Changing the way we live, to eat more healthily and be more active now, will ensure that we remain independent, living at home in the future but it also reduces the risk of developing complications and comorbidities which lead to frailty and disability later in life. Some disabilities can be prevented and the effective use of treatment and rehabilitation services directed at helping people who are ill, injured or disabled can reduce dependency and improve quality of life. In order to better understand who we need to support, it is important we have good data and develop robust systems to help identify people with disabilities in order that they can access services appropriately to be able to remain independent Employment is strong in Hampshire, but creates significant disadvantage both financial and emotional, for people who aren't in work. Given the projected reduction in the working age population over the next 5 to 10 years it is important that young people in particular who are out of work are identified and supported to improve their opportunities and future life chances. This is also true of people with disabilities. Good mental health is also important for continuing good health. Focussed work is needed with different groups of people with poorer Mental Health to understand better the lack of access to current services, particularly primary care, and to co-design these services to improve accessibility. People with poorer mental health are also at significant risk of social isolation; initiatives that develop social networks for this group of people are important in helping to improve their mental and physical health	

5. Ageing Well – Older People	Click on links below for data
Our Older Population: Older people aged 65 and over make up 20.3% of the population in Hampshire compared to 17.6% nationally. The largest proportion of overall population growth is expected in the number of people aged 75 and over. This population is forecast to increase by a quarter (25%) over the next 5 years. This equates to there being 33,000 more people over the age of 75 by 2021. The low mortality rate in Hampshire means people are living longer. The key question is whether they are living longer in good health. Where do our older people live?	Population Forecast Analysis Map over 65 Map over 85
Outcomes	Click on links below for data
As with Adults and Children there are a number of indicators that can help us understand overall how healthy our older population is and where there may be specific needs. Life expectancy is a well recognised measure of comparative health within and between populations. Life Expectancy at birth is an estimate of how long a child born today might expect to live if current age and gender specific death rates apply throughout their life. Life expectancy at 65 is the measure of how long a person who is 65 today can be expected to live. Disability-free life expectancy at 65 gives us a measure of how long someone at 65 now can be expected to live in good health, the difference between the two gives an indication of the health of our older population. Nationally disability-free life expectancy for people over 65 years has been looked at as a comparator for a healthy life at 65. In Hampshire, in 2011/13, the life expectancy of a man aged 65 years was 19.5 years, the disability free life expectancy was 12.1 years, therefore the number of years a man over the age of 65 years could be expected to have disability or poor health is 7.3 years, which compared to our CIPFA neighbours is slightly better than average (range 6.0 years to 9.2 years). Similarly, for women in living Hampshire, in 2011/13 the life expectancy at 65 is 21.9 years, with a disability free life expectancy at 65 is 12.4 years and therefore the number of years a woman over 65 years would be expected to have a disability is 9.5 years which compared to our CIPFA neighbours is about average (range 7.4 years to 11.2 years). This suggests that although women in Hampshire are living longer, proportionally they are living longer with disability compared with some of our CIPFA neighbours and compared to men in Hampshire. Understanding the impact of any changes in disability-free expectancy and life expectancy for people over the age of 65 years over time is important for the strategic planning of health and care services to ensure that resources are targeted effectively; but it is also important to develop prevention initiatives to improve healthy life expectancy at any age.	Trend on Male LE at 65 0.1ii Trend on female LE at 65 0.1ii Link to Disability free Life Expectancy figures

Individual Health Indicators	Click on links below for data
Falls and Fractures The risk of an accidental fall increases rapidly with after the age of 65, and there are higher levels evident in people living alone, people with existing medical conditions, and people living in more deprived areas. Most falls occur within the home. Falls and fall related injuries are the most common cause of accidental injury to older people and are a significant public health problem. The risk of fracture depends, in part, on age. Fractures are very common in childhood, and children's fractures are generally less complicated and heal faster than fractures in adults. Bones become more brittle as one's age increases and there is an increased likelihood for fractures from falls that would not occur when you were young. In older age, people become more frail and are more likely to trip and fall. Osteoporosis also makes bones more brittle and more likely to fracture after a fall. In Hampshire: • In 2013/14 the total number of admissions for any fracture was 2,931 of which 18% were for hand and wrist fractures (proportionally higher in the younger age groups), 16% lumbar and pelvis fractures and 65% were hip fractures, the latter two types of fracture occurred more frequently in the over 65 year olds • Of the total number of admissions for hip fracture (1,910 in 2013/14), there were 1,775 admissions for the over 65 year olds and 1,552 admissions people age 75 and over People 65 years and over have the highest risk of falling. About one in three people over 65 years and half of people over 80 years fall at least once a year. A hip fracture is the most immediate consequence of falls among older people. Women are more likely than men to sustain a hip fracture and the incidence rises with age and is associated with the decrease in oestrogen levels. Falling impacts on quality of life, health and healthcare costs[21]. The biggest impact is on mobility. The ability to keep active and remain independent depends greatly on mobility. Mobility can be seriously limited as a consequence of age, by the effects of falls and subsequent physical inactivity. Half of those with hip fracture never regain their former level of mobility and 1 in 5 dies within 3 months[22]. The human cost also includes distress, pain, injury, loss of confidence, loss of independence and mortality. Family members and carers are also affected. Falls are estimated to cost the NHS more than £2.3 billion per year. They account for between 10-25% of ambulance call outs for people aged 65 or over, representing over half of hospital admissions for accidental injuries.	Fractures by age chart

[21] NICE, 2013
[22] Age UK, 2014

Hospitalisation and social care for hip fractures, most of which are caused by falling, is £2 Billion per year. Falls are more common after strokes, where there is visual impairments and sight loss and when people are taking certain medications.

In Hampshire:

- The rate of injuries due to falls in people aged 65 and over is recorded in the Public Health Outcomes Framework. In 2012/13 the Hampshire rate (1,907/100,000) was significantly lower than the England rate (1,962). This was true for older people aged between 65 and 79 years but there was no significant difference for the over 80 year olds
- The rates of hip fractures (resulting from falls) slightly increased between 2012/13 and 2013/14 but there is significant variation across Hampshire for emergency admission rates for hip fractures.

Hip Fracture Trend 4.14i

Map

Over the next 5 years based on population increases in Hampshire[23] it is estimated there will be a 16% increase in the number of hospital admissions for falls for people over the age of 65. Integration of services across health and social care has the potential to streamline the pathway, increase access to evidence-based, cost effective prevention and early intervention services to reduce the potential future burden.

Physical Disabilities – preventable sight loss

Disability is an important issue; a significant proportion of physical disability. Particularly in older age is preventable and the effective use of treatment and rehabilitation services directed at restoring function in people who are already ill or injured can reduce dependency, improving quality of life.

It is important to ensure that the needs of people with disabilities are clearly identified and a personalised response is made with them. Physically disabled people face social, environmental and attitudinal barriers, which can restrict their participation in their community. Policies that increase independence and enablement are important in supporting good outcomes amongst people with physical disabilities. Independent living is about ensuring rights and entitlements are addressed so that people with physical disabilities can enjoy the same freedoms to lead lives they wish as those without disabilities.

The relationship between physical disability and other health determinants are well established on a national level but we have a paucity of local data to support services at a local level. Information on visual and physical disabilities that we do have tends to focus on older people.

Research by the Royal National Institute for Blind People (RNIB)[24] suggests that 50% of cases of blindness and serious sight loss could be prevented if detected and treated in time. Whilst this is mainly due to uncorrected refractive error and untreated cataract, the research implies that the take-up of sight tests is lower than would be expected. This is particularly the case within areas of social deprivation. Low take-up of sight tests can lead to later detection of preventable conditions and increased sight loss due to late

[23] According to www.**poppi**.org.uk

[24] Access Economics (2009), Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population. RNIB

intervention. Risk of sight loss is heavily influenced by health inequalities, including ethnicity, deprivation and age and sight loss can increase the risk of depression, falls and hip fractures, loss of independence and living in poverty. Older people with sight loss are also much more likely to have additional health conditions or disabilities and are more likely to become socially isolated. Sight loss can have a profound effect on overall health and access to services. Many patients with sight loss receive health and social care information in formats that they cannot read, consequently missing essential treatments/services which could prevent further deterioration of their sight. The five leading causes of preventable blindness and partial sight in the UK are: age-related macular degeneration (AMD), diabetic retinopathy[25], glaucoma, cataracts and refractive error. Information on the prevalence of sight loss is based on voluntary registration and is therefore likely to under represent the true impact of the conditions. However data on the number of people who are partially sighted or blind that have lost their sight from one of the three major causes of preventable sight loss, glaucoma, wet AMD and Diabetic Retinopathy, can provide us with a starting point for early intervention and prevention initiatives and help commissioners understand local impact.	
The most recent figures in Hampshire (January 2015) indicate that there are 6,213 people on the register of which 2,792 are blind and 3055 people are partially blind[26].	Trend Sight Loss 4.12iv
In terms of preventable blindness, in 2012/13 there were 395 people in Hampshire with Age-related Macular Degeneration, for which a significant contributory factor is smoking. The rate of AMD in Hampshire is clearly above the national average and therefore the drive to support and extend the reach of stop smoking services is critical not only for disease but also for future disability.	Trend AMD 4.12i
While the count of people with blindness due to Diabetic retinopathy is small (59 in 2012/13) the levels have been increasing. Not only is diabetes a preventable condition but once a person has diabetes, diabetic retinopathy as a complication, the impact of which can be minimised with good screening programmes. Work in partnership with NHS England is needed to assure the Hampshire population has access to consistent screening.	Trend Diabetic Eye disease 4.12iii
Dementia By far the fastest growing issue for people over the age of 65 is the increase in dementia prevalence. Dementia has a significant impact on individuals and their families, presents major challenges for health and social services and remains a misunderstood and stigmatised disease. It is a syndrome, a term for a group of diseases and conditions that are characterised by the decline and eventual loss of awareness such as memory, thinking and reasoning and often by changes in personality and mood.	

[25] Diabetic Retinopathy is when high blood sugar levels cause damage to the retina. If left untreated it can lead to blindness. The projected increase in cases of diabetes makes early diagnosis and treatment of the condition a significant priority
[26] Source from Adults Social Services, Hampshire County Council

Old age is the largest risk factor for dementia and prevalence (that is the number of people who have the condition) doubles every decade after the age of 65. Some 68% of all people with dementia are aged over 80 and most will also have other illness or long term conditions that result in physical impairment. These co-morbidities often go undiagnosed and/or untreated. Alzheimer's disease (AD) is reported to account for the majority of dementias (54%), vascular dementia (16%) and mixed or other dementia's accounting for the remainder[27]. Dementia isn't exclusively a disease of old age. Early onset dementia refers to dementias that occur before the age of 65. In contrast to dementias in older people, dementia's in younger people often present with other features other than memory decline. Early onset dementias are less common than dementias in people over 65 years of age, and younger people are more likely to have rarer forms of dementia. The distribution of dementias in younger people is 31% Alzheimer's disease, 15% vascular dementia, 13% frontotemporal dementia and 12% alcohol-related dementia[28] There is also an increased incidence of the Alzheimer type of early onset dementia in people with down syndrome which can significantly impact on the need for care[29]. Dementia is a leading cause of disability in people aged over 65. Dementia is a progressive disease, and the prognosis after diagnosis is not good. Most people die within five to eight years from diagnosis. Women with dementia outnumber men by two to one. In the UK, people from Black and Minority Ethnic groups (BME) make up just 1.7% of the total population affected by dementia which reflects the younger population amongst BME groups. However, this masks the larger proportion of people from BME groups with early onset dementia, 6.1% compared to 2.2% for the UK and the prevalence in BME groups is expected to increase by 15% over the next 10 years. It is estimated that 63.5% of people with dementia live in the community, of whom two thirds are supported by carers and one third live alone. Approximately 36.5% live in care homes. In Hampshire, in 2012/13 the recorded prevalence of Dementia was 0.66% which is above national and regional recorded prevalence. This equates to 8,840 people. Dementia is a degenerative disease and therefore the needs of an individual for health and social care will change over time with the greatest need towards the end of life. There is growing evidence that certain dementias are preventable, particularly vascular dementia. Our primary focus needs to be on preventing people getting dementia where possible through supporting healthy lifestyles and reducing vascular disease. However, once diagnosed the focus needs to be on supporting people to have the best quality of life that they can and remain independent and active for as long as possible. In the final phase of the condition the focus needs to be on ensuring good end of life care.	Trend for Dementia Comparison for Dementia

[27] Lobo A, Launer LJ, Fratiglioni L, et al. Prevalence of dementia and major subtypes in Europe: a collaborative study of population-based cohorts. Neurologic diseases in the elderly research group. Neurology 2000;54(11 suppl 5):S4–9.
[28] Advances in psychiatric treatment (2009), vol. 15, 380–388 doi: 10.1192/apt.bp.107.004572
[29] Lai, F, and Williams, R. S. (1989) A prospective study of Alzheimer disease in Down syndrome. Archives of Neurology.46,849-853

System Indicators	Click on links below for data
Excess Winter Deaths Older people are particularly at risk of dying during winter months compared to the rest of the population. Excess Winter Deaths is the measure used to describe how many more people die during winter months than at other times of the year. The UK has one of the highest Excess Winter Death (EWD) rates in Europe despite having relatively milder winters because they tend to take fewer precautions (such as wearing warmer protective clothing) in cold weather; compared to those living in countries with cold winters Countries with milder winters also tend to have homes with poorer thermal efficiency (for example, fewer homes have cavity wall insulation and double glazing), which makes it harder to keep homes warm during the winter. It has been shown that low indoor temperature is associated with higher excess winter deaths from cardiovascular disease in England. Nationally, there were 31,280 Excess Winter Deaths in England during 2012/13 which is a 37.2% increase from the previous year. However in 2013/14 there were an estimated 18,200 excess winter deaths which was the lowest number since records began and was linked to a milder winter. The majority of Excess Winter Deaths are in older people; in 2013/14 78% of deaths were in people aged over 75. There are various physiological effects of cold weather, which may lead to death in vulnerable people especially older people. In older people a one degree lowering of living room temperature is associated with a rise of 1.3 mmHg blood pressure; this along with increased blood viscosity increases the risk of strokes and heart attacks. Fuel poverty (i.e. the ability of households to heat their homes) disproportionately affects older households, and rural districts. Understanding the impact of fuel poverty on individual households particularly those who are disadvantaged is important in applying preventative measures to reduce excess winter deaths. In 2012 there were 6.3% of Hampshire households (approximately 34,481 households) living in fuel poverty. (LIHC definition). This is below the national (10.4%) and regional (7.8%) rates. The over 85 year olds are more likely to have an underlying health condition that may make them more vulnerable to a winter death and also by virtue of age are likely to be frail. Respiratory and circulatory diseases each account for around one third of EWDI. The level of circulating Influenza can be a major explanatory factor. A lower resistance to respiratory infections and the increased level of influenza circulating in the population in winter can lead to life-threatening complications in vulnerable groups, such as bronchitis or pneumonia. Excess winter deaths in Hampshire • Trends show that between 2006/07 and 2012/13 the Excess Winter Death Index (EWDI) in Hampshire was in line with our CIPFA neighbours and the national average. • People aged 65 and over account for 94% of excess winter deaths.	Excess Winter Death Trend 4.15i

In Hampshire and in line with the national figures, the highest EWDI is among those over 85 years of age; with over half of excess winter deaths occurring in this age group. **Loneliness and Social Isolation** Why is it important? Loneliness and Social Isolation have different meanings but are often used interchangeably; both can affect all ages but they do disproportionately affect older people. Loneliness is a subjective feeling as it depends on how a person sees it. Most of us feel the need for rewarding social contact and relationships and loneliness is the feeling we get when our need for this type of contact is not met. Loneliness is also reported as a negative feeling associated with loss such as loss of a partner or children relocating. It affects all ages but older people are particularly vulnerable. Social isolation is a lack of contact with society i.e. contact with friends or family or community involvement or access to services. Isolation can lead to loneliness and both can be experienced by anyone of any age and background. The experience of both is generally negative and the resulting impacts are undesirable at the individual, community and societal levels. Population groups vulnerable to social isolation and loneliness include: • Young care-leavers, • Refugees • Those who have a mental health problem. • Carers • People who identify as LGBT • Older adults - in particular women over the age of 85 and older people from ethnic minority groups • Those who live in a residential care home • Those who are from a lower socio-economic status • Those who have developed a chronic condition which limits mobility and reduces social interactions **Social Isolation and Health** A systematic review[30] found that people with stronger social relationships had a 50% increased likelihood of survival than those with weaker social relationships. The influence of social relationships on the risk of death is comparable with risk factors for mortality such as smoking and alcohol consumption and exceeds the influence of physical activity and obesity. Studies[31] have shown that being lonely has a significant and lasting effect on blood pressure, with lonely individuals having higher blood pressure than their less lonely peers. A recent UK cohort study[32] found that social isolation in older people was associated with increased risk of death from any cause. People with a high degree of loneliness are twice as likely to develop Alzheimer's as people	Excess Winter Death 85+ Trend 4.15ii

[30] http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316
[31] http://www.scie.org.uk/publications/briefings/files/briefing39.pdf
[32] http://www.nhs.uk/news/2013/03march/pages/social-isolation-increases-death-risk-in-older-people.aspx

with a low degree of loneliness. These negative impacts on health leads to higher health and social care service use, while lonely and socially isolated older people are more likely to have early admission to residential or nursing care. People with poorer mental health can be significantly impacted by loneliness and social isolation[33]; it can affect self esteem and the way people see themselves or because of stigma. Being lonely also contributes to mental health problems, such as anxiety and depression. Social isolation has been linked to SMI mental health conditions like schizophrenia. Loneliness and social isolation in remote rural areas can be hidden and/or go unnoticed. Hampshire is largely a rural county with 85% of the county defined as rural. Hampshire districts defined as being "significantly" and "predominantly" rural areas are: Basingstoke and Deane, East Hampshire, Eastleigh, Hart, New Forest, Test Valley, and Winchester. People are more likely to live alone than they were in the past. In the 2011 Census there were significant numbers of pensioners living alone across all parts of the county, and that over a quarter of households across Hampshire were single person households (26.7 %). In Hampshire there were 145,623 with people living on their own. About 74.3% of adult social care users and their carers in Hampshire reported 'as having had as much social contact as they liked'. This is similar to national average levels of 74.5%. This cohort only covers a proportion of the older population as not everyone over 65 is in contact with social services. Adult carers were also measured against whether they felt they had enough social contact. However, for carers only 1 in 4 reported that they did which was significantly worse than the national average. Over three quarters of Individual Carers Assessments completed by HCC Adults Services in 2013 were for people over 65 years old. This group are known to have increasing multiple long term health conditions and social care needs, which will increase their risk for social isolation and loneliness, There are specific key 'trigger' or risk factors known to cause loneliness and social isolation in older age. These can be used to help to identify those likely to be at risk or experiencing loneliness in a community. These are: • Lone pensioners, • People over 70, • Older people with sensory impairment, • People over 60 living in deprivation • Older carers • Recently bereaved older people While evidence demonstrates that isolation at any age can cause poor health, the scale of the problem is unknown. Therefore it is important that we become better at identifying people at risk of loneliness and isolation so that effective services can be targeted.	Map over 65 living alone Map over 65 in deprivation The Adult Social Care Outcomes Framework Carers

[33] http://www.mind.org.uk/information-support/tips-for-everyday-living/loneliness/loneliness-and-mental-health/

Evidence on efforts to reduce the social isolation have demonstrated positive outcomes for wellbeing, reduce mortality and morbidity, reduced utilisation of services and good return on investment. An in-depth review of the issues and evidence would be of benefit in the development of cost-effective and targeted initiatives to reduce the impact of isolation and loneliness as well as a strategic approach to the use of the voluntary sector to support this work	
What is this telling us about ageing well in Hampshire?	
Older people in Hampshire generally remain fit and healthy for the majority of their remaining years. However, there have been some changes in recent years, whereby the length of time people remain in good health has reduced. Understanding the impact of any changes in healthy life expectancy and life expectancy over time is important for the strategic planning of health and care services to ensure that resources are targeted effectively; as part of this it is important to develop prevention initiatives to improve healthy life expectancy and hence independent good quality of living. To be support people continuing to be independent and reduce the impact of ill-health, initiatives should focus on • promoting healthy lifestyles across all ages to ensure people have and continue to have good health outcomes and remain independent (making every contact count) • prevention of early on-set and vascular dementia • ensuring older people remain warm in winter Focussed work could impact on reducing preventable disabilities, specifically • Improving mobility following a fall to improve outcomes and independence • Reducing blindness caused by preventable conditions such as AMD (smoking related) and diabetic retinopathy (complication of poorly controlled diabetes) Social isolation has a significant impact on health and wellbeing which can lead to poor health outcomes both physical and mental; to improve outcomes it is important therefore that organisations become better at identifying people at risk of loneliness and isolation, so that services and interventions can be developed and effectively targeted. Focussed work to reducing social isolation is needed to • develop tools and measures that support commissioners and service providers to understand the scale of the problem • support the development of interventions that will reduce social isolation and loneliness • support local communities and individuals to develop resilience to increase independent living A strategic approach on the use of the voluntary sector to support this work would also be of benefit.	
6. Dying Well	Click on links

	below for data
End of Life Care Terminology around the End of Life Care is poorly understood and lacks clarity. However the medical definition is one that is quite widely accepted: *People can be said to be approaching end of life when they appear likely to die within the next 12 months*. Good End of Life Care ensures all residents have a dignified, controlled and peaceful end to their life regardless of age and cause of death. Although End of Life Care is historically referred to in the context of patients with cancer nearly 70% of deaths in Hampshire in 2013 were from causes other than cancer. Amongst other long term conditions, dementia is an important chronic condition for which palliative care is needed because unlike other long term conditions there is a shorter window of opportunity to have meaningful End of Life conversations. This needs to be taken into consideration when commissioning services to support end of life. In order to achieve a good outcome, the needs of the patient, carer and family should be identified and services provided to meet these needs throughout the last phases of life and into bereavement. End of Life Care should include management of pain and other symptoms and provision of psychological, social, spiritual and practical support. While not perfect, the proportion of deaths at Home (or in Hospital) is often used as a proxy indicator for provision of End of Life Care. A higher proportion of deaths at home is considered to be desirable. However the definition of home can be contentious if a patient's home is a care home or hospice. Therefore having a lower proportion of people dying in hospital can be an alternative proxy. The proportion of people dying in Hospital for Hampshire CCGs in 2010/12 varied from 49.0% in Fareham and Gosport to 45.8% in South Eastern Hampshire. Although the mortality rate has decreased, reflecting that people are generally living longer, the absolute numbers of deaths have increased. This rise is likely to be a reflection of the post war baby boom generation entering the oldest age groups where deaths predominantly occur. The growth in the number of older people and the changes in what people are dying from, means that there would be a benefit in reviewing End of Life Care services, to factor in the changes and consider the structure of the End of Life Care workforce to ensure sustainable services focusing on the wider definition of 'end of life' including CVD and late stages of dementia.	

7. Methodology

All the indicators from the Public Health Outcomes Framework were benchmarked against the 15 local authorities CIPFA have identified as being most similar to Hampshire. Indicators have been included in the JSNA where Hampshire was significantly worse than its nearest neighbours. Indicators have also been included where Public Health England Health Profiles highlighted an issue or where an issue is seen as a priority.

Neighbour Authorities

1 Essex
2 West Sussex
3 Kent
4 Warwickshire
5 Gloucestershire
6 Oxfordshire
7 Buckinghamshire
8 Worcestershire
9 Leicestershire
10 Hertfordshire
11 Staffordshire
12 Suffolk
13 Devon
14 Cambridgeshire
15 Northamptonshire