

Hampshire Health and Wellbeing Board

# Hampshire Joint Strategic Needs Assessment 2013

## Executive Summary

2013

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## **1.0 Introduction & Background**

### **1.1 Introduction**

This executive summary of the 2013 Hampshire Joint Strategic Needs Assessment (JSNA) outlines the head lines messages detailed in each of the chapters of this JSNA. It summarises the current and future health and social care needs that could be met by the CCGs, NHS England or local authorities in Hampshire. It outlines the key issues, gaps in knowledge and resultant recommendations for action in nine summary sections which represent the more than forty chapters that comprise the full JSNA, all of which are supported and informed by a significant dataset and evidence base. Each update of the JSNA represents the assessment at that point in time. Thus it will never be a exhaustive assessment of the health and social care needs of the population, but as stated, a strategic overview.

The JSNA is an overview of the health and social care needs of an area. The Health and Social Care Act 2012 put the JSNA into a new strategic context. The Hampshire Health and Wellbeing Board is required to produce a JSNA and to use it to inform a Joint Health and Wellbeing Strategy (JHWS) for Hampshire.

The purpose of the JSNA and JHWS is to set the strategic framework to improve the health and wellbeing and reduce inequalities for all the people of Hampshire. A JSNA and the resultant JHWS are therefore, not an end in themselves, but part of a continuous process of strategic assessment and planning starting with need, moving through to identifying priorities, embedding these in commissioning plans and then assessing outcomes and need, so starting the cycle again (figure 1). The JSNA cannot be an exhaustive statement of everything we know about an area. It is a narrative on the evidence gathered to identify the needs of the population now and in the future.

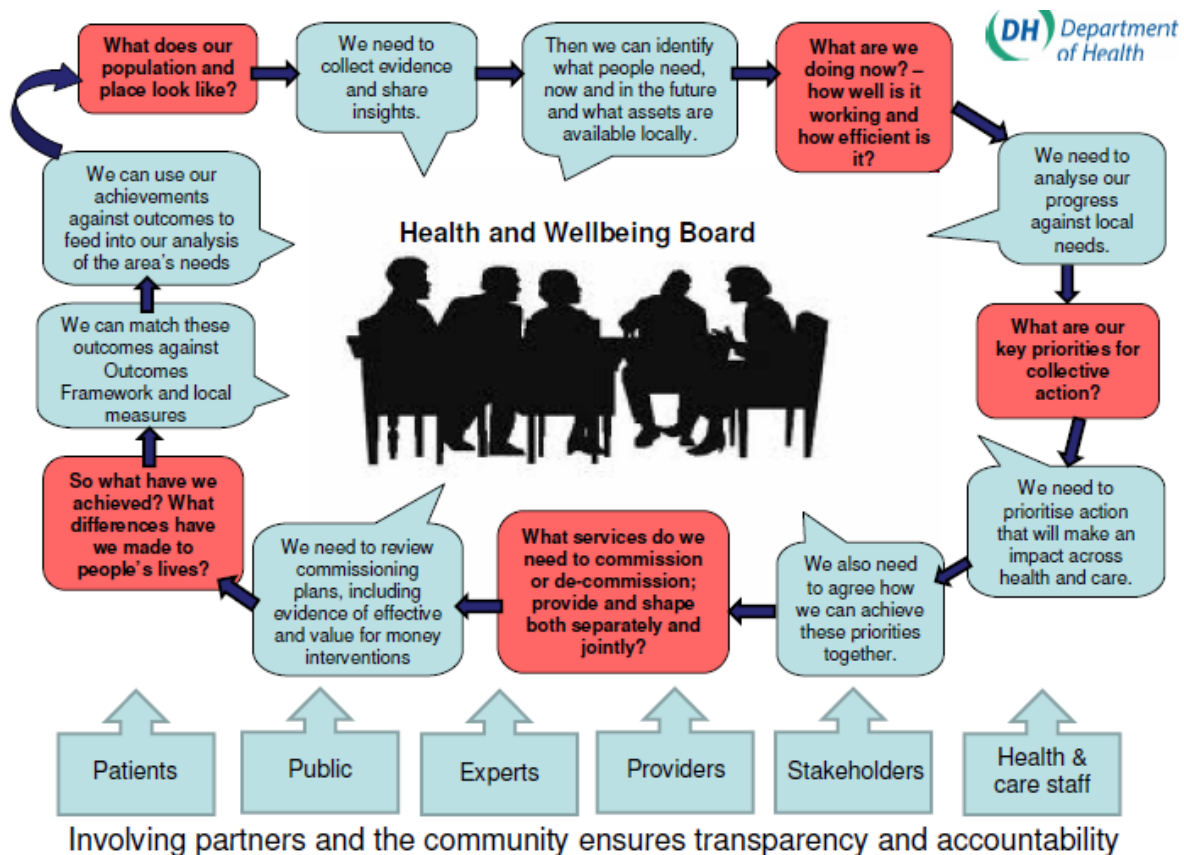
The outputs of the JSNA inform the JHWS regarding what actions local authorities, the local NHS and other partners need to take to meet health and social care needs of the entire population within Hampshire, including addressing the wider determinants that impact on health and wellbeing. To ensure that we are considering the issues that lead to and impact from inequalities, a specific piece of work is being taken forward over the coming months.

The task of the Health and Wellbeing Board is to oversee a sustainable health and social care system in the face of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. If nothing changes, there will be significant unmet need and threats to the quality of care in Hampshire. The ageing population and increased prevalence of chronic diseases require a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, addresses needs rather than wants and is integrated.

To succeed in this task, the Health and Wellbeing Board also needs to oversee improvements in the wider determinants of health. Poor health does not arise by chance and is not simply attributable to genetic make-up, unhealthy lifestyles and a

lack of access to medical care, important as these factors are. Instead, differences in health status reflect the differing social and economic conditions of local communities. The influence of these wider determinants on health requires policy interventions such as the Joint Health and Wellbeing Strategy to be intelligence-led and preventative, focusing on the root causes of ill health (the ‘causes of the causes’), rather than simply treating the consequences of its development. Tackling these conditions determining people’s health outcomes requires action, across the life-course, well beyond the influence of the NHS and health services.

**Figure 1: JSNA and JHWS – explicit link from evidence to service planning**

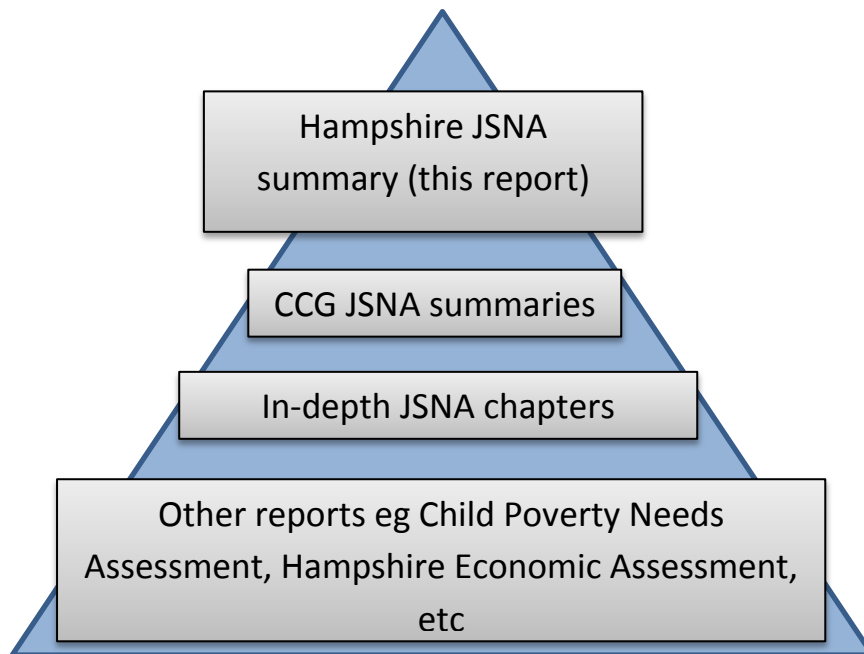


## 1.2 Structure of Hampshire’s JSNA

To accommodate the size and complexity of Hampshire, a pyramidal structure has been adopted to describe the JSNA. Each level of the pyramid provides a different amount of detail (figure 2). This document is the top level, providing a summary of Hampshire’s JSNA. The next level is Clinical Commissioning Group (CCG) JSNA summaries, which give each CCG information about the particular health and social care needs in their area to inform their strategy and commissioning plans. The next level is the in-depth reports where a topic is considered in significant detail to identify needs, equity and suggested unmet need for commissioners. Each of these reports contains detailed recommendations as to how the needs can be met and where further work may be of value. The final level is reports produced by Hampshire County Council and other organisations that provide additional background information on people and place such as the Child Poverty Needs Assessment and the Hampshire Economic Assessment. All of these documents are published on

Hampshire County Council website and are added to continuously as new needs assessments are completed.

**Figure 2: the structure of Hampshire's JSNA**



### 1.3 JSNA headlines

#### **Key issues include:**

- Increasing older population with less informal support and multiple illnesses, needing more social care, health care and appropriate housing with opportunities to improve our healthy life expectancy
- The ageing population is associated with increasing mental frailty. While some of these people will benefit from dementia specific support, the majority can be supported by a step change in our approaches within communities
- Increasing birth-rate
- Continuing large proportion of under 20s with associated issues and an increasing number of vulnerable children and young people, but with a small population of working age adults
- Importance of wider determinants of health: housing, education, employment opportunities, physical environment etc.
- The need to consider the impact of inequalities
- Reducing resources
- Opportunities for services to optimally address need and evidence base
- Acknowledge the changing technology and communication expectations

Though predominantly healthy and wealthy, Hampshire has pockets of significant deprivation. The population is continuing to grow. The age structure has an increasing proportion of older people, with increasing diversity across the county although remaining significantly less diverse than the national average.

Rising numbers of older and vulnerable people living alone raise concerns over their health and the impact on access to care and support. The economic situation and its on-going effects on every aspect of our lives is likely to influence the health of the population for some years to come. Unemployment, education and training are crucial to people's life chances and their on-going health status. Poverty and socio-economic disadvantage are associated with poor health outcomes. There is some evidence that inequalities are increasing in Hampshire, as elsewhere as

demonstrated by an increasing life expectancy gap. The physical environment is an important factor that influences quality of life and health.

The population is living longer, but is not healthier for longer, with our middle aged and elderly population often living with multiples illnesses. The diseases people live with and die from are continually changing, currently we are seeing people becoming more likely to die from cancers and experiencing dementia as they live with successfully treated cardiovascular disease but without having changed their behaviours.

The obesity epidemic, where our population is not of average socio-economic status compared to England, but does have an average prevalence of obesity, is of major significance in terms of: workforce; avoidable illnesses for people of all ages; availability of carers and the spectre of working age people dying before their very elderly parents.

The people of Hampshire have the opportunity to extend the proportion of their life-span that is spent as “healthy years” by improved nutritional intake, becoming physically active, not smoking and reducing alcohol intake.

**Service use:**

The use of some hospital services still bear more resemblance to historical referral routes than choice as well as demonstrating possible links to supply rather than clinical need. There is opportunity to improve the appropriate use of emergency hospital services by enabling people with young families and working age adults to access primary care at times compatible with their needs to maintain their employment status and to meet expectations of around the clock access to information through portable devices. Similarly there is opportunity to further develop the appropriate location for many other services.

Social care services have been evolving to meet increasing need with reducing resources.

**Evidence of what works:**

Each chapter describes the evidence base that informs the recommendations. These are extensive and international where possible. Where the evidence is less robust or in development, the recommendations are specific regarding the needs to evaluate any local actions. A benefit of working across Hampshire and its population of 1.32 million people is that evaluation and possible formal research can be undertaken that show reliable significant differences.



## **2. Hampshire's population**

### **2.1 The population**

- The population of Hampshire is estimated to be 1.32 million people in about 545,000 households, making it the third most populous county in England after Kent and Essex.
- The population is continuing to grow, although slower than the England rate with a significant decrease in the proportion of teenagers and younger working age adults compared to England. The proportion of the population aged 20-39 is projected to decline from 23% in 2011 to 21.7% in 2021.

### **2.2 The age structure**

- The population shows an increasing proportion of older people with 18.5% of the population aged 65 and over compared to 17.2% regionally and 16.3% nationally. 2.6% of the Hampshire population is aged 85 and over, compared to 2.5% regionally and 2.2% nationally. The age structure varies significantly across the districts with an average age of 47 years in New Forest compared to 36 in Rushmoor.
- Children and young people under the age of 20 make up nearly one quarter of the population.
- Rushmoor and Basingstoke and Deane have the highest proportions of their population of working age (aged 18 to 64 years), whilst New Forest has the highest proportion of older people (aged 65 and over). Basingstoke and Deane, Hart and Rushmoor have the largest proportions of their populations consisting of children and young people (aged under 18 years).
- District population projections suggest that the majority of the population growth will be in the 65 and older age groups as people live longer. The 85 and over population group is likely to be where the largest proportionate change will be seen. All districts are projected to see numerical increases in their populations of children and young people (aged 0-19 years).

### **2.3 Births**

- There were 15,238 births registered in Hampshire in 2011. The number of births and the birth rate have been rising year on year from 12,780 in 2002 and appear likely to continue to do so, albeit at a slower rate. This varies year on year and by district.
- Population projections of the numbers of childbearing women (15-44) in Hampshire's local authority areas suggest that in general they will remain fairly stable.
- General fertility rate projections for Hampshire show a slower, but on-going increase for future years. Rushmoor, Gosport and Havant will continue to experience high rates.
- The age at which women have their first child continues to rise with 22.5% of births in Hampshire in 2011 to women aged 35 or older, compared to 20.2% nationally. However the conception rate amongst females aged under 18 of

23.3 per 1,000 women (aged 15-17) in 2011 was lower than the South East and England as a whole (26.1 and 30.7).

## **2.4 Deprivation**

- Hampshire is ranked the tenth least deprived principal authority in England (out of 150), with Hart district the least deprived of all local authorities in England (out of 326).
- Deprivation in Hampshire is most concentrated in a small number of neighbourhoods for example, Leigh Park and Wecock in Havant, Rowner and Town in Gosport. Alongside this are pockets of very localised deprivation across the county, e.g. in Aldershot, Andover, Basingstoke, and Blackfield and Holbury in New Forest.

## **2.5 Diversity and migration**

- The ethnic diversity is gradually increasing across the county although the population remains predominantly white British. Asian ethnic groups make up the largest non-white categories in Hampshire, the South East and across England.
- Rushmoor has the largest non-white population at 15.3% (up from 4.4% in 2001); mostly due to a growing Nepalese population. Across the rest of the county we see a variation from a non-white population of 7.1% in Basingstoke and Deane (up from 3.4% in 2001) to 2.9% (up from 1.5% in 2001) in Havant.
- Most migration into and out of Hampshire is internal, as is the case with other places. 2010 estimates suggest that of the 54,800 people who migrated into Hampshire, only 8.4% were from overseas.
- 23% of Hampshire's population live in the 85% of the county classified as rural, while 77% live in the 15% categorised as urban.

## **Recommendations**

- Consider the entire population of the county, acknowledging the needs of children and young people as well as those of older and vulnerable adults as they are all inter-related. The impact of the relatively small working age population needs consideration and support to age well.
- Ensure that all service contracts include a requirement to record all statutory data, to maximise our ability to analyse and understand our changing population and their needs.
- The differences in population demographics between districts means the level of need for particular services and support will be different, so we must make sure we target our resources appropriately.
- We need our services to take account of and meet the needs of the increasing size and growing diversity of the population.

### **3. Social and environmental context**

#### **3.1 Deprivation**

- Deprivation and socio-economic disadvantage are associated with poor health outcomes. Deprivation in Hampshire is most concentrated in a few relatively well known neighbourhoods, however pockets of localised deprivation exist across the county which may be identified using individual deprivation markers and may be more relatively deprived with affluent areas surrounding them.

#### **3.2 Housing & environment**

- There is less overcrowding in households in Hampshire compared to the South East and nationally, but with variation across the county. Affordable housing is a significant issue in Hampshire, with high house price to earning ratios.
- The number in temporary accommodation per thousand households across Hampshire is below the national average with the exception of Gosport.
- People are more likely to live alone than they were in the past. The 2011 Census found that over a quarter of households across Hampshire were single person households (26.7 %), almost half of which were pensioner households with the highest levels of single person households found in Gosport (29.8 %), New Forest (28.9 %) and Havant (28.6 %), and lowest in Hart (22.4 %), compared to 28.8 % across the South East as a whole and 30.2 % nationally.
- Rising numbers of older and vulnerable people living alone raise concerns over their health and the impact on access to care and support for these groups. Around half of elderly households in Hampshire are reliant on state support.
- The physical environment is an important influence on health.

#### **3.3 Domestic abuse**

- Estimates suggest that 44,000 women and girls aged 16-59 have been a victim of domestic abuse in the past year; but Hampshire Constabulary only received 14,492 reports, suggesting significant under reporting.

#### **3.4 Unemployment**

- The economic situation is an important influence on the health of the population. The number of unemployed benefit claimants (Job seekers Allowance) in Hampshire was around 16,300 (March 2013), down by almost 2,000 from March 2012 and less than the peak in 2010.
- Most claimants are male (approximately two thirds), although female levels and rates rose faster in 2012.

- Youth unemployment remains high. As at March 2013, 6,660 16-24 year olds were claiming JSA (approximately one third all claimants) which is lower than 2009-2010, but significantly higher than 2007.
- Long term unemployment i.e. claiming for over 12 months doubled from March 2011 at one in ten, to one in five in March 2013.
- Unemployment is generally concentrated in Basingstoke Town, Eastleigh Town, Gosport (Rowner & Town), Havant (Leigh Park & Wecock), and Rushmoor (Heron Wood and Mayfield areas).

### **3.5 Skills**

- Skill levels among Hampshire's adult population are generally higher than the national average, but there are fewer highly qualified people in Hampshire than neighbouring counties - over five percentage points lower than Berkshire and approaching ten percentage points below Surrey. Proportionately more highly qualified people live in the centre and north of the county (with the exception of Rushmoor).

### **Recommendations**

- Support economic development and business in Hampshire to maximise opportunities for stable and fulfilling employment for everyone, particularly young people. This includes raising levels of educational attainment and training across the county, with particular focus on those areas where attainment is currently lower. This has lifelong implications for reduced demand on health and social care.
- Look to enable access to affordable housing to avoid homelessness, of at least minimum housing standards and support housing adaptations to enable people to stay in their own home if they are disabled or elderly.
- Continue to make improvements in community safety with a focus on prevention and support for those experiencing domestic abuse.
- Take opportunities to maintain an environment that enables people to be physically active and enhances mental health.
- Undertake a specific assessment and strategic framework to inform and support the Health and Wellbeing Board to consider inequalities Hampshire.

## 4. Children and young people

### 4.1 The population

- 309,462 children and young people aged 0-19 years were recorded as living in Hampshire in 2011, around 23% of the total population.
- Birth projections (2010 to 2033) for Hampshire show an on-going increase in the birth rate following the general trend for England and the South East, possibly plateauing by 2016.
- Although the number of children will increase, the proportion of the population that children and young people comprise is forecast to decline marginally, with those under 18 accounting for almost 21% of the population by 2016 compared to 23% currently.

### 4.2 Maternity

- Nearly all women in Hampshire access maternity services early in their pregnancy which supports good outcomes for woman and baby. However our babies do not get the best start in life with less than half being breast fed by the age of 8 weeks.
- There were 15,238 births in Hampshire in 2011, which represented a steady increase from the 13,320 births of 2000. Over this time Hampshire's birth rate has gone up 13%.
- Hampshire has seen a 35.1% reduction in local teenage conception rates since 1998, compared to a national reduction of 34.1% and a south east region reduction of 31%.
- Among the local authorities in Hampshire in 2011, Rushmoor had the highest birth rate (15.5 births per 1,000 women) and the New Forest had the lowest birth rate (9.1 births per 1,000 women) which reflects the different age structures seen across the county.
- The total fertility rates (TFR) for 2011 give an average number of 1.99 children per woman in Hampshire, higher than the England value of 1.93.
- The General Fertility Rate (GFR) for Hampshire was 62.8 live births per thousand women aged 15–44 in 2011, with 3 districts having rates higher than England - Basingstoke and Deane (69.9), Rushmoor (69.2) and Gosport (65.4).
- About 2/3 of babies born in Hampshire in 2011 were to women aged 25–34, 22% of babies, were each born to younger mothers, aged under 25, and to mothers aged 35 and over.
- The birth rate among mothers aged 30–34 was the highest at 124.3 births per 1,000 women, and was higher than the England rate of 112.2 births per 1,000 women.
- In 2011 although 14.7% of births in Hampshire were to foreign born women, this proportion varied across the county from 25.9% in Rushmoor to Havant at 7.8%.
- Only 2.9% of births in Hampshire were at home. Nationally the homebirth rate was 2.5%. The highest rates of home births were in Test Valley (6.8%) and Winchester (4.8%) with the lowest in Havant (2.1%).

- Although there are no data on the Hampshire prevalence of maternal obesity, the South Central Strategic Health Authority (SHA) population had the second highest overall rate at 5.66% of women with a BMI  $\geq 35$  at any point during pregnancy. This incurs increasing risk for both mother and baby and increased but avoidable costs to maternity services.
- In 2011/12 caesarean sections accounted for 23.2% of all deliveries in Hampshire, of which 9.7% were planned procedures. This is not reflective of the population need or in the best interests of women and their babies.

### *Summary Recommendations*

- Focus on promoting the birth pathway through the 'Normalising Birth Programme' using national resources to promote normal birth and reduce caesarean section rates.
- Further develop the integration of maternity services with pre-conceptual, health visiting and school nursing services, as well as primary care, specialist services and the voluntary sector, to improve outcomes across the life course. This will emphasise the contribution of both antenatal and postnatal care to long term health and wellbeing, as well as the actual birth event. This includes improving perinatal mental health pathways and services.
- Address and highlight the ten key recommendations in response to the findings in the Centre for Maternal and Child Enquiries (CMACE) report "Maternal obesity in the UK: Findings from a national project".
- Clinical commissioning groups should ensure that their contracts for maternity services acknowledge the changing birth-rate and age and risk profile of women while adhering to national standards.
- The focus should be maintained to support vulnerable teenagers to continue the reduction in teenage conception rates.

### **4.3 Child and infant mortality**

- Infant and child mortality rates are sensitive indicators not only of child health, but also of the general health of the population. Infant mortality is a reflection of the delivery of healthcare services to mothers and newborns, as well as the wider social determinants of health.
- The infant mortality rate in Hampshire is 3.1 children under one year old per 1000 births (2.6-3.7.). This compares to the England rate of 4.4 per 1,000 live births (95% CIs 4.3-4.5) (Pooled data for 2008-10).
- Childhood mortality between the ages of 0 and 14 is among the worst in Europe. Comparator European countries have improved their outcomes over the last 20 years while the UK has fallen behind in the rate of improvements with death rates higher for asthma, meningitis, pneumonia and diabetic ketoacidosis.
- Local Safeguarding Children Boards are responsible for reviewing the deaths of all children from birth (excluding still born babies) up to 18 years. Child death review data is collected by the Child Death Overview Panel (CDOP). The Southampton, Hampshire, Isle of Wight and Portsmouth CDOP reviewed 131 death notifications in the 0-18 population in 2011/12 and 70 were Hampshire deaths. This includes childhood mortality for specific conditions (meningococcal,

group A streptococcal infections, septicaemia, asthma, lower respiratory tract infections, diabetes and epilepsy, cancer), suicide, work-related deaths, trauma and negligence, maltreatment and abuse.

- The majority of infant deaths were associated with congenital anomalies with a minority associated with potentially avoidable factors.

#### *Summary recommendations*

- Maximise opportunities for excellent maternity services with clear links to health visiting.
- Ensure the learning from the reviews of child deaths occurs and the effects are audited.

#### **4.4 Education**

- Children in Hampshire have good opportunities to achieve educationally.
- Hampshire has over 136,000 pupils in 498 maintained schools, with a further 33,000 pupils at 34 academies. The number of schools judged good or better by Ofsted increased between inspections in 2011 and 2013. 42% of 16 years olds did not achieve five A\*-C grade GCSEs (or equivalent) including English and maths in 2011/12.
- Only 26% of 16 years olds eligible for free schools meals achieved five A\*-C grade GCSEs (or equivalent) including English and maths in 2011/12.
- Only 9.2% of children in care achieved five A\*-C grade GCSEs (or equivalent) including English and maths in 2011/12.

#### *Summary recommendations*

- Provide opportunities to learn, within and beyond the school day, that raise children and young people's aspirations, encourage excellence and enable them to enjoy and achieve beyond their expectations, particularly supporting those children growing up in poverty and those in care to reduce the achievement gap.
- Promote vocational, leisure and recreational activities that provide opportunities for children and young people to experience success and make positive contribution.

#### **4.5 Inequalities**

- Variations in socioeconomic and family circumstances lead to the variations in outcomes seen in Hampshire's children and young people. There were 29,000 children and young people aged 0-15 living in poverty in Hampshire in 2011, which was 11.8% of all children in this age group. This compares to 21.7% for England. Havant and Gosport had the highest proportion of children living in poverty in 2011 (20% and 18% respectively).
- Obesity prevalence is very variable across Hampshire and mirrors the map of deprivation and childhood poverty.
- Children from areas of deprivation experience disproportionately higher levels of oral disease, with 21.7% of 5 year olds having some dental decay against a national average of 30.9% (2007/08 survey). However 5 year olds in Havant

had dental decay levels of 34.6% - much higher, followed by Rushmoor (30.9%).

- Disabled children and their families constitute one of the most vulnerable groups in Hampshire. Defining and measuring the landscape of childhood disability is challenging due to the lack of an agreed definition across health, education and social care domains, with no single definition being complete. Despite this ambiguity, there is consensus amongst paediatricians, social services managers and educationalists that the population of children accessing services is increasing, as is the complexity of physical disability and complex health need.

#### *Summary recommendations:*

- Address the impact of poverty on the achievement and life chances of children and young people.
- Look to support children and young people's physical, spiritual, social, emotional and mental health, promoting healthy lifestyles and reduce inequalities in outcomes.
- Look to address the needs of disabled children and their families holistically across the breadth of their social, educational and health needs.

## **4.6 Obesity**

- 1 in 5 children in Hampshire entering school are overweight or obese and by the age of 10-11 years this has risen to almost 1 in 3. The majority of affected children will have parents who are also obese.
- Being overweight or obese in childhood has consequences for health and wellbeing in both the short and the long term. The children are likely to experience emotional and psychological effects as the most immediate consequence, while 58% of children who are obese (National Child Measurement Programme classification: above 95th centile) will already have physical health problems affecting their current and future life chances.
- Up to 79% of children who are obese in their early teens are likely to remain obese in adulthood and have a higher risk of morbidity, disability and premature mortality.
- Once established obesity is difficult to reverse and treat so prevention and early intervention are key to reversing the rising levels of obesity.

#### *Summary recommendations*

- Continue to deliver evidence based interventions as informed by NICE, to address childhood obesity through the Children and Young People's Plan, maximising this opportunity to support a future healthy adult population.
- Service specifications for services for children and families (maternity, health visiting, early years and children's centres) should include the role of these services in the prevention of obesity and early intervention with families who are at risk of obesity.



## 4.7 Health protection

- There are three national antenatal screening programmes (infectious diseases in pregnancy, sickle cell and thalassaemia, and fetal anomaly) and three national new-born screening programmes (new-born and infant physical examination, new-born hearing screening, and new-born bloodspot screening). These programmes, which need to adhere to national quality standards, are offered to all women and their babies in Hampshire.
- Uptake of childhood immunisations is relatively good apart from the Teenage Booster which has particularly low uptakes in North East Hampshire and Farnham CCG and West Hampshire CCG at 43.47% and 52.67% respectively.
- 51,638 young people aged 15-24 in Hampshire were tested for Chlamydia in 2011/12 - 34% of the that age group. 2,987 (5.8%) of these tests were positive - a diagnostic rate of about 1,970 per 100,000 population.

### *Summary recommendations*

- All providers of antenatal and new-born screening services must deliver to and report performance and outcome data against, national standards.
- For immunisation to be optimally effective in preventing avoidable but potentially fatal illnesses, the uptake needs to be increased across Hampshire to 95%.
- The Chlamydia testing programme outputs should inform both future commissioning and the input to schools regarding sex and relationship education.

## 4.8 Smoking and substance misuse

- The What do I think? pupil attitude survey 2012, when asked “what do you think of the information and advice you get on drugs?” indicated that in Year 6 - 69.8%, Year 7- 65.8% and Year 9 - 72.3%, of pupils thought that the advice was helpful. Asked the same question for alcohol the results indicated that in Year 6 - 67.4%, Year 7 - 62.3% and Year 9 - 68.1% of pupils thought that the advice was helpful. Asked the question for smoking the results indicated that in Year 6 - 74.3%, Year 7 - 70.3% and Year 9 - 70% of pupils thought that the advice was helpful. This is useful to inform the development of focused approaches to prevention for these age groups.

### *Summary recommendations*

- Develop the current successful approaches for supporting children and young people to manage themselves when risk behaviour opportunities arise.

## 4.9 Accidental injuries in children and young people

- Hampshire compares favourably with England, regional and statistical neighbour averages where comparisons can be made on indicators for unintentional injuries in children.
- The rate of road traffic injuries and hospital admissions for all types of injury in under 16s in Hampshire is comparable with similar areas and lower than the England average.
- More people aged 16-25 years are injured on Hampshire roads compared to the national average (804 and 722 per 100,000 16 to 25 year olds respectively), although rates in Hampshire are similar to comparable counties.
- There were 3,158 hospital admissions due to injuries in children under 18 years in Hampshire in 2010/11.
- There were 320 police reported road traffic casualties in children aged under 16 years in Hampshire in 2011. Almost half of all child road casualties occurred in the 12-15 year age group and 94% of cycle casualties occur in those aged 8-15 years.
- Child road traffic casualties in Hampshire fell by 13% from 2005-2009 to 2011.
- Children from the most deprived families are 13 times more likely to die from unintentional injuries and 37 times more likely to die in a fire than children living in the least deprived areas. Children in the 10% most deprived wards in England are four times more likely to be hit by a car than children in the 10% least deprived wards.

#### *Summary recommendations*

- Professionals should maximise opportunities to protect our children and young people from avoidable, potentially fatal, infections and accidents.
- Develop a cross sector Hampshire Strategy for unintentional injuries in children (promoting 'Making Every Contact Count') and which includes a review of current injury prevention strategies and activities against NICE guidance, including the appointment of an injury co-ordinator for Hampshire and consideration of the relative importance of mode of transport in relation to casualties and casualty rates to target interventions for road traffic injuries.

#### **4.10 Mental health**

- The social gradient in mental health problems is particularly pronounced in childhood with a three-fold variation in prevalence between the highest and lowest socio-economic groups.
- Looked after children are at five to six times increased risk of developing mental health problems. They have a four to five times higher risk of self-harm, and a six to eight times increased risk of conduct disorders.
- Physical and learning disabilities can have an impact on mental health, and children with learning disability have a 6.5 fold risk of mental health problems.
- Poor mental health in childhood is associated with risk behaviours such as smoking and substance abuse, teenage pregnancy, bullying and violent behaviour as well as lower educational achievement, reduced employment opportunities, subsequent criminal behaviour, misuse of drugs and higher suicide rates.

- 10% of children have a mental health problem (around 31,000 in Hampshire), and 50% of lifetime mental illness is present by the age of 14.
- 10% of new mothers suffer from postnatal depression (around 1500 women each year in Hampshire) which also has implications for their children.
- Good parenting has been shown to have the single greatest influence on children's health outcomes including accident rates, teenage pregnancy, substance misuse, truancy, school exclusion and underachievement, child abuse, employability, juvenile crime, as well as mental illness.
- Young offenders have higher rates of mental health problems than their contemporaries. They are 18 times more likely to attempt suicide, and many have earlier undiagnosed and untreated conduct disorders. Interventions to address conduct disorders have been shown to reduce offending behaviour.
- Child and Adolescent Mental Health Services (CAMHS) were recommissioned as a single county wide service as of April 2011. Establishing new arrangements to ensure timely and equal access to high quality services across the county has been on-going. The self-assessed score for the effectiveness of CAMHS in Hampshire has increased from 15 out of 16 in 2009/10 to 16 out of 16 in 2010/11, with an England average of 15.5.

#### *Summary recommendations*

- Develop a mental health strategic framework for the children and young people of Hampshire that includes the following:
  - Ensure that the health visiting contract continues to include the responsibility to identify mothers at risk or in early stages of postnatal depression, and then offer appropriate support and treatment.
  - Enable access to evidence based parenting programmes for those at highest risk.
  - Enable access to effective services to diagnose and treat conduct disorders in childhood, especially amongst first time entrants to the youth justice system.
  - Ensure there is adequate support for young people leaving care, particularly transition to adult services.
  - Ensure that CAMHS meet the breadth of need of our young people and are readily accessible to them and non-stigmatising.

#### **4.11 Autism**

- Nationally the prevalence of autism is around 1%.
- It is estimated that there are 2,802 children and young people aged 0-17 years or 3,823 children and young people aged 0-24 years living with autism in Hampshire.
- There were 738 children recorded with Autistic Spectrum Disorder (ASD) who are educated in a Hampshire maintained school within the county in 2012. 0.4% of children educated in a Hampshire maintained school within the county are recorded as having ASD.
- There were 185 children recorded with ASD in need of social care on Hampshire's social children's services database in January 2012.

- There are no health data available that quantify the number of children in Hampshire with ASD accessing health care services.
- There are likely to be a significant number of yet to be diagnosed children and young people with ASD in Hampshire. The age distribution of children with needs associated with ASD suggests that teenagers with ASD are currently more likely to be in need of children's social care services than younger children.
- The ratio of girls: boys with ASD on the Hampshire education database is 1:7 which is a lower number of girls than the 1:4 national estimated ratio would suggest.
- There is a higher recorded prevalence of children with a diagnosis of ASD living in the north and west of the county, compared to those in the south and east of the county.
- In Hampshire, most children with ASD of primary school age are in mainstream schools. However, once they reach secondary age, a greater proportion of children attend special schools. There are no comparator data.

#### *Summary recommendations*

- Opportunities to develop further collaboration between partnerships supporting children and young people with ASD should be explored.
- Healthcare services should use consistent diagnostic codes for children and young people with ASD to enable their quantification.
- Data sharing across agencies would improve intersectoral working and improve outcomes for children and young people with ASD and a shared database should be considered.
- The different prevalence of children on the education database diagnosed with ASD in the North and West of the County compared to South and East should be investigated.
- A strategic framework within which all services can work which relies on the evidence base will facilitate development of value services and outcome optimisation.

#### **4.12 Child protection**

- There has been an increase in children in care and with protection plans, albeit in line with the national trend.
- 75.2% of care leavers in Hampshire in 2011/12 were in suitable accommodation, a slight increase on the 2010/11 figure of 74.4%.
- The proportion of care leavers in employment, education or training in Hampshire fell to 43% in 2010/11 and now stands at 46.2% in 2011/12 which is below the England average of 57.8%.

#### *Summary recommendations*

- Help children and young people to be safe and feel safe.
- As the numbers requiring services is predicted to continue at an increased level it is vitally important that we address this through preventative and early

intervention services. Therefore Hampshire County Council is working with The Children's Trust and partners to develop comprehensive early help.

## 5. Lifestyle

### 5.1 Physical activity

- Inactivity increases the risk of a wide range of chronic conditions. Increasing physical activity levels across Hampshire would help prevent sickness absence, unnecessary diseases and avoidable deaths and reduce costs to the health and social care as well as to the wider economy.
- The total economic cost of physical inactivity to the NHS alone in Hampshire during 2006-2007 was estimated at £18.14 million.
- National estimates show that 66% of boys and 76% of girls aged between 2 and 15 years old do not meet the recommended levels of 60 minutes or more on all seven days a week – this amounts to approximately 77,000 boys and 84,000 girls not meeting the recommended levels of physical activity in Hampshire.
- 85% of adults in Hampshire do not do enough physical activity to benefit their health, and 44% do no physical activity. The benefits of physical activity are well evidenced and this is the one change everyone can do to improve their healthy life expectancy.
- The population of Hampshire is more active than England or South East averages although the majority of the Hampshire population is inactive. Although we have no robust local data, national estimates suggests that physical activity declines with age and there are significant differences in activity levels between the most and the least well off.

#### *Summary Recommendations*

- Develop a strategic, evidence based approach to support the people of Hampshire be active throughout life.
  - Utilise whole-community approaches, promoting walking and cycling should be a key component of these approaches.
  - Address wider determinants that influence physical activity (e.g. the built environment, access and availability of good quality open and green spaces across the social gradient, planning, transport, housing, environmental and health systems).
  - Focus approaches to target and support the population of Hampshire who are significantly inactive.
  - Support primary and secondary healthcare providers to embed physical activity pathways and brief interventions as standard practice, especially aligned with NHS Health Checks.

### 5.2 Tobacco

- Tobacco use and smoking are the single, greatest cause of poor health and preventable disease. Stopping smoking at any age will improve health and reduce future risks. If people quit before the age of 30 years, many health risks can be avoided completely.

- In 2009, 81,400 deaths were directly related to smoking in England. In Hampshire around 1,850 people die each year from smoking-related causes.
- In 2011-12 Hampshire's estimated percentage smoking prevalence as measured by the Integrated Household Survey (IHS) was 17.5%, although local rates in different parts of Hampshire varied from 14.0% in Winchester, 14.5% in Hart to 24.3% in Rushmoor and 21.7% in Havant against an England average of 20.0%. This variation reflects the well described link between social deprivation and smoking.
- The national prevalence for smoking by 15 year olds was reported as 11% in 2011. A Hampshire 2012/13 schools surveys which included schools in our most deprived areas showed a slightly higher rate than the national figure, with 12.2% of 15 year olds regularly smoking.
- Supporting people to stop smoking prior to and during pregnancy is a significant factor in reducing infant mortality rates and low birth weights.
- The current Hampshire average rate of smoking by mothers at delivery is 11.8% (2012/13). This is lower than the national average of 13.9% for 2011-12 .
- Where parents smoke the research evidence indicates that their children are twice as likely to start smoking between the ages of 13 and 21 years.
- Too few people are accessing Hampshire stop smoking services to make a real difference in the most needy populations.

### *Summary recommendations*

- Develop a comprehensive tobacco control strategy for Hampshire with active involvement of key stakeholders.
- Ensure that the service to deliver the 4-week quitter target is effective and uses all opportunities to support people to not to start and to cease smoking applying national initiatives effectively.
- Work collaboratively with GPs and community pharmacies to address the needs of the "key patient groups" i.e. pregnant mothers, patients on chronic disease register, patients entering or discharging from secondary care and mental health service users.
- Continue to support young people's smoking education and prevention programmes and research areas which support greater understanding and knowledge regarding the uptake of smoking by young people.

### **5.3 Alcohol consumption**

- Alcohol misuse occurs across the whole socioeconomic spectrum. Hart has the overall highest rate. Rushmoor and Gosport are the areas with significantly higher alcohol attributable mortality rates for males and females.
- About 24% of the population drinks more than the safe recommended levels for alcohol each week in Hampshire - about 257,000 people across the county, or one in five people.
- About 6.6% of people who drink alcohol in Hampshire do so at harmful levels (classified as "dependent" on alcohol and their drinking is likely to present health risks). 21.7% of the Hampshire drinking population consume alcohol at

above the recommended levels and are categorised as having an “increasing risk” in terms of health and other associated risks such as offending and anti social behaviours which can impact on families and the wider community.

- There are conflicting data on UK alcohol consumption trends, between what people say they drink and the data on alcoholic drink sales. European research evidence indicates that people under-estimate their personal alcohol consumption by around 60%.
- Levels of abstinence increased nationally from 10% in 1998 to 15% in 2009 (General Household Survey/General Lifestyle Survey). Alcohol abstainers make up a significant minority in many localities though they are often not included in discussions about alcohol. The provision of estimated levels of abstinence at local authority level is of particular importance in understanding the true nature and scale of the alcohol problem.
- Alcohol misuse has many negative societal impacts in terms of the burden it places on other services, such as emergency services, criminal justice services, local authorities, social care and rehabilitation services plus the strains it places on families who also have to live through the consequences of alcohol misuse.

### *Summary Recommendations*

- Target alcohol education and awareness including social marketing initiatives against key groups, populations and setting.
- Continue to train and educate a wide range of frontline practitioners to be confident in the delivery of basic alcohol screening (identification) and evidence based brief advice.
- Develop a locally consistent approach to alcohol awareness and education.
- Identify and support the reduction in alcohol use in older adults.
- Identify, educate and promote an alcohol abstinence in pregnancy.
- Further support improvements in the management of the night-time economy and the wider street and community environment through responsible licencing and license monitoring arrangements, and the implementation of local initiatives which support safer drinking and reduce disorderly and anti-social behaviours.
- Use local intelligence and enforcement powers to reduce under-aged and proxy alcohol sales and street drinking.
- Maximise the opportunity created by the local authority alcohol licensing regulations and public health as statutory consultees to ensure that decisions to licence premises and events takes account of the impact on the health of the population.
- Review alcohol specialist treatment and support services to ensure that they meet the needs of ‘increasing and higher risk’ drinkers.
- The trend of increasing alcohol related hospital admissions needs to be addressed particularly in areas where these are highest and a significant number of people present more than once.



## 5.5 Substance misuse

- National surveys of school pupils have found that the proportion of 10-15 years olds who have ever taken drugs decreased to 27% in 2011 from 48% in 2001. The main drugs used by 10-15 years olds were cannabis and glue, gas aerosols and solvents.
- Figures from the crime survey for England and Wales suggest that while the proportion of the adult population that have ever taken drugs is 36.5%, the proportion reporting taking drugs in the last year fell from 12% in 2001/02 to 8.9% in 2011/12.
- Problem drug use and crime is linked with problem drug users responsible for a large percentage of acquisitive crime. The government states that drug-related crime costs the UK £13.3 billion a year. Drug use in prison is an important public health issue with 51% of prisoners indicating that they are drug dependent and 35% admitting injecting behaviour. One survey reported that 19% of prisoners that had ever used heroin first used it in prison.
- Nationally, mortality rates are higher in people addicted to heroin and people who inject heroin. Those that die are more likely to be white, over 35 years and male, with a history of drug addiction.
- New psychoactive substances (NPSs) are substances of abuse that are not controlled by existing legislation but which may pose a health threat. The development and use of these drugs signals a significant change to the drug market and healthcare service needs.
- There were 13,268 admissions for substance misuse from 2009/10-2011/12 in Hampshire. The highest rates were seen in Rushmoor, Havant and Gosport local authorities, associated with deprivation.
- In 2011/12, 2,134 people received structured treatment services in Hampshire; 80% of people in treatment stated that their main substance was heroin, methadone or other opiates. It is estimated that only 55% (95% CI 38.6%, 95.9%) of opiate/crack drug users are in or know to treatment.
- Data from the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs (PWID) suggest that 45% were infected with Hepatitis C Virus (HCV) in England in 2011. The same survey found that 16% of current and former injectors had evidence of a previous Hepatitis B infection and 1.2% of those surveyed were HIV positive. Levels of transmission of HCV have not changed over the last decade.
- There is good evidence to support prevention and treatment of drug dependence. NICE has published a set of quality standards for drug treatment services.

### *Summary recommendations*

- Focus services for young people and schools in areas where there is a higher risk of people developing drug dependence.
- Undertake further analysis of hospital admissions for drug dependence to determine the reason for recent increases in admissions.
- Explore barriers to and opportunities for increasing the uptake of Hepatitis C testing to increase uptake to at least the national average.

- Consider the feasibility of implementing Naloxone training for carers of people at risk of fatal overdose.
- Ascertain why there is still a significant proportion of people in treatment for >6 years locally with high frequency of representation to services after discharge.
- The implications of the changes in drug use for treatment services should be explored to ensure that local services continue to address needs.
- Review emerging evidence and respond promptly to mitigate the harmful impact of the new psychoactive substances.

## **5.6 Nutrition**

- Within Hampshire, although over 2/3 women start to breast feed their new babies, breastfeeding rates at 6-8 weeks are much lower than expected for the population, at around the national average.
- A balanced, healthy diet is vital throughout life but particularly in the early years, childhood and adolescence when preferences and habits are set for life. There is a low uptake of Healthy Start in Hampshire which aims to improve the health of pregnant women and families on benefits or low incomes by providing vitamins and vouchers for food.
- While research suggests that the risk for many chronic conditions, such as cardiovascular disease and type 2 diabetes is part set in fetal life, many women are becoming pregnancy overweight or obese, significantly increasing health risks for mother and child during and after birth.
- Older people living both at home and in care homes are at increased risk of malnutrition – leading to higher numbers of hospital admissions, longer stays in hospitals and increased risk of mortality.

### *Summary recommendations*

- Continue to focus on improving nutritional intake at all ages, but particularly through rates of breastfeeding.
- Consider novel, alongside evidence based approaches to improve the nutritional status of the most vulnerable people across Hampshire.
- Develop, implement and evaluate a pilot intervention to identify and work with women who are obese in early pregnancy in order to reduce risk of poor birth outcome and unhealthy weights in offspring.
- Improve uptake of Healthy Start.

## **5.7 Dental health**

- The oral health of the population of Hampshire is generally good. However, inequalities remain, with those from the most deprived backgrounds experiencing the highest levels of dental disease – dental (tooth) decay, periodontal (gum) disease and oral cancer.
- More adults are keeping their own teeth into old age, much of it heavily restored. This group will need significant care to maintain this dentition including an increased need for restorative care (large fillings, root canal treatment, periodontal treatment) and more complex prosthodontic care

(dentures, dental crowns and dental bridges). This is a growing problem with an ageing population, particularly those who need residential care.

### *Summary recommendations*

- Continue to ensure that all dental commissioning including developing preventive interventions reflects local needs.
- Monitor access to dental care and service utilisation with a focus on reducing dental health inequalities.
- Focus on prevention, including expansion of supervised tooth brushing initiatives to all “Early Years” settings. Consider involvement of other healthcare professionals to sustain programme in line with “Making Every Contact Count”.

## **5.8 Obesity**

- Overweight and obesity present a major challenge to the economy and health of the Hampshire population. Being overweight or obese significantly increases the risks of developing, living with and prematurely dying from cardiovascular disease, Type 2 diabetes, cancer and kidney and liver disease and the risk increases as the “body mass index” (BMI) increases.
- The estimated costs of managing diseases related to overweight and obesity in Hampshire were £312.2 million in 2010 rising to £333.8 million by 2015 and costs to the wider economy are considerably more (Department of Health).
- About 62% of the adult population in Hampshire is overweight or obese (24% obese and 38% overweight) which is predicted to rise significantly if we do nothing.
- The health risks rise with increased BMI and people with morbid obesity live on average 8–10 years less than people who are a healthy weight.
- There are strong links with obesity and social deprivation which are seen in the Hampshire data for children.
- 1 in 5 children entering school are overweight or obese and by the age of 10-11 years this rises to almost 1 in 3. Children from areas of social deprivation are most affected but 26% of 10-11 year olds in the most affluent areas of Hampshire are overweight or obese. Most overweight or obese children have parents who are also obese.
- Most children who are obese in their early teens will remain obese into adulthood. Once established, obesity is difficult to reverse and treat so prevention and interventions at an early stage for people of any age are key to reversing the rising levels of obesity.
- NICE evidence and guidance inform the multidisciplinary approach.
- There is strong evidence that a 5-10% weight loss can significantly reduce cardiovascular and metabolic risk in obese people.
- The evidence regarding which model of non-surgical weight management interventions is most effective is still emerging. There has been far more research and published results for bariatric surgery.
- The treatment pathway has four tiers and commissioned services at all tiers are accessible via Primary Care.

- Despite high apparent need for weight management services, uptake over the last 2 years across Hampshire has been low. This needs further investigation.

### *Summary Recommendations*

- Develop a strategic approach to reducing obesity for people of all ages in Hampshire.
  - The strategy should identify key times when people are susceptible to weight gain and/or receptive to lifestyle and behavioural change.
  - This should include pregnancy and early years and the working age population.
  - It should rely on NICE guidance.
- Work with employers to develop workplace environments that facilitate and promote healthy lifestyles and support employees who would benefit from weight management programmes.
- Investigate and increase the uptake of commissioned weight management services across Hampshire.

## **6. Illness and disease**

### **6.1 Chronic diseases**

- The number of people with long term conditions such as heart disease, diabetes and lung disease is increasing. This is partly due to the ageing population and the decreasing death rate at all ages, but also partly due to the increase in illnesses caused by unhealthy lifestyles and unequal life opportunities.
- The UK Global Burden of Disease study showed that mental and behavioural disorders (including anxiety, stress, depression, and substance misuse) and musculoskeletal disorders caused the biggest burden of years lived with disability.
- Currently we do not have Hampshire estimates of years of life lived with disability.

#### *Summary recommendations*

- Focus on the prevention of avoidable illness by creating the right circumstances for people to be able to be healthy regardless of age or background (planning, environment, housing, early years).
- Work to maximise the knowledge of everyone working with people across Hampshire (from front line clinician to teacher) of their role to play in prevention, and enable them to take on that role. Investigate the opportunity of a single “every contact counts message”.
- Redress the balance of health and social care services away from the current emphasis on acute and episodic treatment, often for symptom control, towards prevention, self-care and care that is well co-ordinated and integrated.

### **6.2 Cardiovascular disease**

- Improved treatment and a reduction in smoking rates have resulted in a dramatic decline in cardiovascular disease (CVD) mortality rates nationally and in Hampshire.
- For the first time cancer mortality rates have risen above CVD mortality rates nationally and in Hampshire. In 2011 30% of deaths in Hampshire were attributable to cancer and 28% to CVD.
- However, the gap between the expected number of people with CVD based on research, and the prevalence rates recorded by GP practices (about 3% of the population) suggest that there are thousands of Hampshire residents with undiagnosed CVD. The NHS Health Check programme provides an opportunity to diagnose more CVD and encourage participants to improve their lifestyles.
- The worst CVD outcomes are seen for Hampshire’s least affluent residents. There also seem to be inequalities between the sexes. Women seem particularly at risk from strokes and are less likely to have access to planned hospital care.

- Hampshire is part of the first population based cascade testing programme for Familial Hypercholesterolaemia in England (a genetic condition found in at least 1 in 500 people).
- Between 2008/9 and 2011/12 there was a statistically significant increase in CVD hospital admissions across Hampshire from 1,136 per 100,000 people to 1,185 per 100,000. The increase is mainly due to elective admissions which do not seem to be explained on the basis of clinical need.
- The Department of Health's Cardiovascular Disease Outcomes Strategy (2013) recommends evidence based, cost saving interventions that should form the basis of CCG plans for CVD care.
- A Hampshire wide audit of people with Atrial Fibrillation (AF) shows that more people with high risk AF should be anticoagulated.
- The main lifestyle risk factors for CVD (smoking, physical inactivity, poor diet, obesity and harmful alcohol intake) are also the major risk factors for other diseases such as cancer and respiratory disease. These other diseases are not decreasing in the same way as CVD, suggesting the success of evidence based healthcare interventions for CVD rather than behaviour change.

### *Summary recommendations*

- Maximise the uptake of NHS Health Checks and subsequent interventions.
- Implement Making Every Contact Count across the NHS and social care if the Hampshire three pilots are successful.
- GRASP-AF could be a useful tool in Hampshire's GP practices.
- CCGs should consider gender inequalities in accessing timely services as part of their commissioning strategies, particularly in stroke prevention.
- CCGs should evaluate cardiac rehabilitation in Hampshire in line with national guidance and ensure that all cardiac rehabilitation providers are participating in the national audit.
- Increase access to palliative care for CVD patients.

### **6.3 Kidney disease**

- There are two main presentations of kidney disease: Chronic Kidney Disease (CKD) and Acute Kidney Injury (AKI).
- Risk factors for CKD include:
  - Unmodifiable risk factors - older age, sex, family history and South Asian and Black ethnicity;
  - Modifiable risk factors - smoking, physical inactivity, poor diet, high blood pressure and diabetes and deprivation.
- Risk factors for AKI include: being 75 or older, having heart failure, peripheral arterial disease and diabetes and CKD and cardiovascular disease.
- Renal replacement therapy includes the breadth of support and interventions from medical management with drugs, to dialysis and transplant.
- In 2011/12 there were 45,952 people living with CKD identified on GP QOF registers in Hampshire. It is estimated that there are another 32,000 people yet to be diagnosed. The NHS Health Check programme provides an opportunity to identify people with CKD before they develop symptoms.

- The treatment of AKI in hospitals can be sub-optimal. An audit from NCEPOD found that only 50% of AKI patients received good care overall which is being addressed through evidence based NICE advice.
- The nearest kidney unit to Hampshire is at Portsmouth Hospitals NHS Trust. The unit has a relatively lower acceptance rate for renal replacement therapy (RRT) than the national average.
- The cost of treating CKD is disproportionate to the number of people affected. In 2009/10 £1 in every £77 spent in the NHS in England was on CKD. Across Hampshire's five CCGs, the spend on CKD was almost £31 million. Renal replacement therapy accounts for over half the cost of CKD, thus prevention, early diagnosis and early treatment are particularly cost effective for these people.
- The cost of treating AKI appears to be increasing. In England the cost is estimated to be between £434 million and £620 million a year. The costs are often embedded within general critical care costs.

#### *Summary recommendations*

- CCGs should support their GP practices to optimise the diagnosis of CKD as part of their remit to improve the quality of primary care.
- CCGs should ensure their end of life strategies include an adequate focus on non-cancer terminal illnesses including CKD.
- Contracts with acute hospitals should specify the need for early detection and recoding of AKI with adherence to NICE.

## **6.4 Diabetes**

- Diabetes is a condition where the amount of glucose in the blood is too high, resulting in serious vascular complications including heart disease, stroke, blindness, kidney disease and amputations leading to disability and premature death.
- Diabetes is the main preventable cause of blindness in the working age population.
- Good diabetes management has been shown to reduce the risk of complications.
- There is a substantial financial cost associated with diabetes care as well as to the lives of people with diabetes. Complications may begin five to six years before diagnosis and the actual onset of diabetes may be ten years or more before clinical diagnosis.
- The vast majority (approximately 80%) of diabetes is preventable. The cost of treating this primarily preventable condition is very high: 10% of the NHS budget in England and Wales, which is £1.5 million every hour or £25,000 every minute.
- The number of people with diabetes in Hampshire is increasing in line with the national trend. There were 57,092 people in Hampshire with known diabetes during 2011/12 and a further 13,000 people are estimated to have diabetes but have yet to be diagnosed. By 2020, there may be 87,000 people in Hampshire with diabetes.

- About 47% of people with diabetes in Hampshire are still not getting all of the 9 key diabetes care processes at annual review (putting Hampshire into the bottom half of all areas in England). This is putting our people with diabetes at unnecessary risk of complications and leading to avoidable health and social care service expenditure.
- Diabetes is very strongly related to deprivation. The most deprived fifth of people living in Hampshire are more likely to have diabetes and three to five times more likely to develop serious complications and be admitted to hospital because of their diabetes, than the least deprived fifth.
- There are increasing numbers of children with both Type 1 and Type 2 diabetes. Approximately 500 children (under 16) have diabetes in Hampshire, 485 of whom have Type 1 diabetes.
- 70.5% of Hampshire GP practices are now submitting data to the annual National Diabetes Audit which is an improvement, but we should be aiming for 100%.
- The trend in people being admitted to hospital because of a complicating illness resulting from their diabetes (for example heart attack, heart failure or stroke) has increased significantly in Hampshire and nationally over the last 5 years – up from 19,134 admissions in 2008/09 to 26,718 in 2011/12, an increase of 40% in just three years.

### *Summary Recommendations*

- Maximise prevention to reduce the likelihood of developing diabetes. This starts with ensuring the environment in which people live is conducive to a physically active life (adequate and safe green spaces, consideration of planning applications to prevent a proliferation of fast food outlets in our most deprived areas) through supporting children and families, to linking people who develop diabetes to improve their lifestyles, to commissioning high quality integrated diabetes services.
- There needs to be a strong focus on reducing inequalities in diabetes.
- All CCGs should ensure all GP practices are submitting to the National Diabetes Audit and should use these data to monitor the proportion of people with diabetes receiving all 9 key care processes.
- CCGs should review their commissioned diabetes services to ensuring they are commissioning, or working towards commissioning a true integrated service as described by the NHS Diabetes report - Best practice for commissioning diabetes services: An integrated care framework.

## **6.5 Cancer**

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



- The trends in incidence of lung, bowel and breast cancers in Hampshire mirror the England trend but the incidence of prostate cancer in Hampshire is reducing while the England trend is upward.
- In 2011/12 there were 26,741 people were on Hampshire GP cancer registers. This is 2% of the registered population. It is higher than the England and SE prevalence (1.8%) and has increased from 1.6% in 2009/10.
- Cancer is linked to numerous risk factors. It has been estimated that 43% of new cases of cancer are linked to lifestyle and environmental factors, with smoking alone accounting for almost 20% of new cases (23% in men and 16% in women).
- After smoking, dietary factors, being overweight or obese and harmful alcohol use are the biggest risk factors.
- The most recent international comparisons show that England still has worse cancer survival rates than many countries, including Canada, Australia, Sweden and Norway. We appear to be closing the gap in breast cancer, but it has not narrowed for colorectal and ovarian cancer and has widened slightly for lung cancer. The gap for disadvantaged groups is even worse.
- Cancers in children and young people are rare and tend to differ from the types of cancers seen in adults, however are the most common cause of death in children aged between 1 and 15 years. Diagnosing cancer in children and young adults is challenging. Cancer is not a single entity and so there is a wide range of presenting symptoms and signs, many of which mimic common conditions. Early diagnosis reduces long-term side effects and improves survival. Studies have shown that only 1 in a 1000 children who present with persistent headache will have a brain tumour.
- In 20-years a GP will see about 12,000 young people. In about 500 of these consultations, the patient will have a symptom that leads the GP to consider referring for further investigation for cancer. Only one case will turn out to be cancer.
- Treatment for childhood cancers is led from specialist centres.

### *Summary recommendations*

- Increase the focus on preventing cancer by continuing work to reduce the known risk factors for cancer – smoking, obesity, unhealthy diet, alcohol and lack of physical activity.
- Improve screening uptake and coverage across all the cancer screening programmes.
- To reduce mortality rates we need to increase the early diagnosis of cancer by increasing awareness of the early symptoms of cancer in the population and amongst healthcare professionals.
- Ensure that services are accessible to people at the highest risk of cancer and those who have poorer outcomes from treatment to maximise opportunities for cancer survivors.
- Review emergency presentations of cancer in Hampshire and explore ways in which they can be reduced as they are associated with a poorer prognosis.
- Review services for cancer survivors, including the provision of secondary prevention, and ensure that their needs are being met.
- Ensure that cancer waiting time targets continue to be met.

## 6.6 Chronic obstructive lung disease

- Chronic Obstructive Pulmonary Disease (COPD) is strongly related to deprivation. One person dies from COPD every 20 minutes in England. The total annual cost to the NHS of COPD is over £800 million.
- Up to 90% of cases of COPD are caused by smoking and so are preventable.
- There are 18,779 people in Hampshire known to be diagnosed with COPD and we estimate this is only 60% of those who have COPD. Many people with COPD have yet to be diagnosed and so are not receiving the right treatment. Early diagnosis is important to maximise the individual's quality of life and outcomes while minimising their need for health and social care support.
- Incidence and mortality rates are higher in lower socio-economic groups, largely linked to higher smoking rates.
- In Hampshire there is a marked deprivation gradient in emergency admissions and mortality. People in the most deprived fifth of the population are five times more likely to be admitted to hospital as an emergency and three times more likely to die from their COPD than those in the least deprived fifth.
- Due to the socioeconomic profile of Hampshire most hospital admissions are for the most affluent fifth of people, which needs consideration as part of a universal approach if we are to improve overall outcomes.
- Hampshire had 5,956 emergency admissions between 2009/10 and 2011/12 for people with COPD and almost half were in people aged under 75 years.

### *Summary Recommendations*

- Continue to focus on preventing the development of COPD through a comprehensive tobacco control strategy which includes stopping people start smoking as well as smoking cessation services.
- Improve the diagnosis of COPD, including a focus on areas of high prevalence and where there is a low diagnosis rate.
- Ensure that people with COPD who are still smoking are enabled to stop.
- CCGs should review their COPD services with a view to ensuring that they are commissioning an integrated and effective service.
- CCGs should review the arrangements for supporting people with COPD in primary care as part of their role in improving quality of primary care.
- CCGs should ensure that they are commissioning appropriate pulmonary rehabilitation services.

## 6.7 Asthma

- Asthma is the commonest long term condition and affects adults and children.
- It is estimated that 1 in 11 children has asthma.
- The prevalence of asthma in Hampshire is 6.1% - higher than the England prevalence of 5.9%.
- Prevalence is highest in Fareham and Gosport, South Eastern and West Hampshire CCGs.

- Achievement of GP (QOF) indicators for asthma is generally good across Hampshire but there are a high number of people with asthma who are not identified and hence missing out on structured asthma care.
- Hampshire has generally low rates of emergency admissions for asthma when compared to other areas of England, however, there is room for improvement as every admission represents a serious loss of control of a person's asthma. The goal of asthma care is to control symptoms such that people with asthma can lead as normal a life as possible.
- Premature mortality from asthma in adults in England is one and a half times higher than the European average (EU-15).
- The mortality rate from asthma in Hampshire (1.41/100,000) is higher than the England average and there are 28 deaths a year on average in Hampshire.
- It is estimated that 90% of deaths could be prevented.

### *Summary recommendations*

- In order to reduce the high mortality rate from asthma and reduce the rate of emergency admissions we need to ensure that everyone with asthma is receiving high quality evidence-based care in line with the SIGN guidelines:
  - We should review the current care pathway and services for asthma in primary and secondary care to identify any gaps in services and areas where quality improvement and service redesign are needed.
  - Conduct an audit against the NICE quality standards to inform the development and commissioning of asthma services.
  - Investigate the age breakdown of emergency asthma admissions.
  - CCGs with higher admission rates should investigate these further.
  - Ensure everyone with asthma is encouraged to stop smoking.
  - Ensure everyone with asthma receives an annual flu vaccination.
- To ensure that everyone with asthma is receiving high quality, structured care in primary care:
  - We should investigate and reduce the high rate of exception reporting for QOF indicators in primary care.
  - GP practices should consider auditing their asthma management to ensure that it is in line with SIGN guidelines.
- We need to improve our local information about asthma and its management in order to identify those groups of people with asthma who are most at risk of emergency admissions and death from asthma.
- We should seek the views of users and carers to inform our understanding of where services could be improved.

### **6.8 Liver disease**

- Liver disease is a major cause of premature death that is increasing in England, whereas it is decreasing in our European neighbours. Most liver disease is caused by long term harmful alcohol consumption, obesity and infection with hepatitis – all of which are preventable. We do not know how

many people in Hampshire (or England) have liver disease as these data are not collected routinely.

- The death rate from preventable liver disease in Hampshire was 7 per 100,000 population (304 deaths) during the three year period from 2009 to 2011, lower than the national average of 12 per 100,000.
- Gosport was the only part of Hampshire where the death rate was higher than the national average at 14 deaths per 100,000 population (34 deaths).
- The trend in deaths from preventable liver disease in Hampshire was relatively static during the five year period from 2006/08 to 2009/11, unlike the national picture where the trend is increasing. This is probably because there are historically low rates of hepatitis infection in Hampshire, with generally lower than average rates of obesity and harmful drinking.
- However we cannot afford to be complacent, as obesity and harmful drinking rates are increasing in Hampshire.
- Under 18 alcohol admissions to hospital per 100,000 population are lower than the national average.
- Hampshire is in the bottom fifth of areas in England in terms of Hepatitis B vaccination and Hepatitis C testing uptake for injecting drug users and amongst prisoners.
- Hampshire is in the second highest quintile in England for rate of cholecystectomies.
- Hampshire is in the highest spending fifth in England for spend on hepatobiliary disorders, and while outcomes may be good, we may not be getting best value.

### *Summary Recommendations*

- We need to use approaches to obtain better information on the number of people with liver disease in Hampshire.
- We need to continue preventative support to assist people from developing liver disease through decreasing levels of obesity, preventing infection with hepatitis (and ensuring early detection and treatment when someone does become infected), and reducing the number of people who are drinking alcohol at harmful levels.
- Review spend on hepatobiliary disorders to ensure maximum value for money from commissioned services.

### **6.9 Long term neurological conditions**

- There is no definitive list of neurological conditions and consequently it is difficult to understand the issues in terms of size, severity and trajectory. The most common such conditions include: multiple sclerosis, motor neurone disease, epilepsy, Parkinson's disease and acquired brain injury.
- Very little is currently known about the prevalence of LTNCs in Hampshire.
- The Department of Health has proposed developing a neurology dataset. There will also be an increased focus on neurology in 2013 across the country, as it is included in one of the four NHS strategic clinical networks.

### *Summary recommendations*

- There is a need to undertake a LTNC needs assessment to develop a better understanding of LTNCs in Hampshire.

### **6.10 Dementia**

- Dementia describes a set of progressive symptoms which includes memory loss, mood changes and problems with communicating and reasoning.
- Dementia is not just part of growing old. It is caused by diseases of the brain, the most common of which are Alzheimer's and vascular disease. Risk factors include: obesity, diabetes, high blood pressure, inactivity, alcohol consumption, smoking.....risk factors for many other diseases.
- People can live well with their dementia provided they and their carers have good, timely and person centred advice, support and care within a non-stigmatising and understanding community.
- One in six people over 80 and one in 14 people over 65 have a form of dementia. Prevalence is higher in women in the older age groups.
- Of the people with some form of dementia in Hampshire, only 8,695 people are identified on GP dementia registers.
- The number of people with dementia in Hampshire is predicted to increase from 18,323 in 2012 to 24,042 by 2020.

### *Summary recommendations*

- Dementia prevention is the same as prevention for many other chronic diseases. The NHS health check is a means of identifying preventable risk factors.
- Support the development of Hampshire Dementia Alliance with a Hampshire County Council member champion.
- Dementia friendly communities should help change our community culture.
- Clinical Commissioning Groups should support local GPs to diagnose dementia early, commission relevant evidence based support and services and audit adherence to quality/NICE guidance.
- There should be clear requirements in contracts with hospitals for a holistic and integrated approach to a person with dementia in acute hospitals.
- Support carers and their specific needs.
- Further develop the end of life care for this group of people.

### **6.11 Infectious diseases**

- In 2012, over 160 outbreaks or clusters of infectious diseases were managed by Public Health England and over 4,000 infectious diseases notified in Hampshire. Sixty-two percent of notifications were for gastrointestinal infections.
- People continue to get ill with vaccine preventable diseases. In 2012, 6.3% of infectious disease notifications were for measles, mumps or rubella and 12.6% were for pertussis (whooping cough).

- In 2012, there were 78 outbreaks or clusters of infection reported in Hampshire's care homes. Norovirus was the most common cause (78% of notifications) followed by scabies (7%) and seasonal influenza (6%).
- During 2012 there were 68 new cases of TB in Hampshire (equivalent to 5.3 new cases per 100,000 population). This rate was significantly lower than the national and regional incidence. Whilst there is variation by District Authority absolute numbers remain low.
- It is estimated that 2,386 people have Hepatitis C infection in Hampshire. Anonymous surveillance conducted in the South-East region indicates that half of people who inject drugs have evidence of Hepatitis C infection.
- There were 304 C. difficile infections reported in Hampshire in 2012. Reported infections have reduced by two-thirds since 2008. There were 16 MRSA bloodstream infections reported in Hampshire in 2012. The number of infections has reduced by over 80% since 2006.

### *Summary recommendations*

- Maximise communication channels to children, families and school staff to emphasise: keep ill children away from school, wash hands and cover nose/mouth 'catch it, bin it, kill it' and use national campaigns to promote hand hygiene in all healthcare settings and with the general public.
- Ensure robust systems are in place across agencies to respond quickly and effectively to infectious disease incidents and outbreaks.
- Work with CCG commissioners, Public Health England and health care providers to ensure robust systems are commissioned to enable people with infectious TB can easily access and complete treatment.
- Provide oversight to the development of a consistent approach to screening new entrants for TB across the county.
- Work with partners to develop programmes to test for Hepatitis B and C in higher risk populations and ensure pathways are in place to access specialist care.
- Further develop a countywide systematic approach with to the oversight of Healthcare Acquired Infections and infection control services within the community.

## **6.12 Sexual health**

- Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in England and Hampshire followed by HPV (genital warts) and herpes.
- Both the total numbers and rates of STI diagnoses have increased significantly over the last 10 years nationally and locally. The rate of STI diagnoses was higher than the national average in 2011 in Basingstoke & Deane.
- Over two thirds of all diagnoses of STIs in Hampshire (2011) were in people aged 15-24, ranging from 55% in Basingstoke and Deane to 74% in Havant with 12 month STI reinfection rates in both males and females aged 16-19 in Rushmoor, Basingstoke and Deane, Eastleigh, Gosport, Havant and Winchester are higher than the national average.

- In 2011 Hampshire had a Chlamydia diagnostic rate below the recommended level to reduce prevalence with the exception of Havant.
- The prevalence of HIV in Hampshire is low at 0.8 per 1,000 population aged 15-59 in 2009 (0.78 in 2008) compared to a national average of 1.5 in 2011. However, it is increasing in all districts. Rushmoor had a three year rolling average rate of 1.66 in 2008-10 , higher than the national average.
- Nationally, approximately 50% of all adults newly diagnosed with HIV are diagnosed after the point at which treatment should have started (CD4 cell count below 350 cells). In Hampshire 56.6% of new HIV diagnoses (2009 to 2011) were diagnosed late.
- STI rates have been increasing with an unequal impact on young people, men who have sex with men and people from certain minority ethnic groups.
- Left untreated STIs can lead to a range of complications including infertility, ectopic pregnancy, disability, cancer and premature death.
- Unintended pregnancies can have a significant impact on both the physical and mental health of women and their children as well as on their educational outcomes and lifelong social and economic well-being.
- There are clear links between poor sexual health and the use of alcohol and drugs.
- Achieving good sexual health is complex and there are variations in the need for services and interventions for different individuals and groups. It is therefore essential that there is collaboration and integration between a broad range of organisations, including commissioning organisations, and services in order to deliver improved outcomes.

### *Summary Recommendations*

- Action to reduce teenage conceptions should be maintained.
- Continue to improve access to contraception, including Long-Acting Reversible methods of contraception (LARC).
- Work towards a chlamydia diagnostic rate of at least 2,300 per 100,000 young people aged 15-24.
- Focus on embedding chlamydia screening in primary care and core sexual health services and emphasise the need for repeat testing, especially on change of sexual partner.
- Maintain 48 hour access to STI testing and Ccontinue to improve partner notification rates.
- Prevention efforts should be sustained and targeted at groups who are at the most risk.
- Improve awareness, prevention and diagnosis of primary HIV infection.
- Increase the uptake of HIV testing in sexual health clinics & in primary care particularly for high-risk groups.
- Maintain the current high levels of HIV antenatal testing.
- Increase the availability and uptake of community-based HIV Point-of-Care testing with high-risk groups .

## 6.13 Mental health

- Mental health is central to the public's health and "there is no health without mental health".
- In general mental health appears to be better in Hampshire than England as a whole, but there are areas and groups that experience poorer mental health, often associated with deprivation and the wider determinants of health.
- Mental wellbeing leads to
  - Improved quality of life and individual flourishing
  - Increased educational attainment
  - Safer communities with less crime
  - Reduced health inequalities – both physical and mental health
  - Lower health and social care utilisation
  - Improved productivity and employment retention
  - Reduced sickness absence from work
  - Reduced levels of mental illness and distress
- Poor mental health both contributes to and is a consequence of wider health inequalities.
- People with mental illness have significantly higher rates of mortality and morbidity from illnesses such as heart disease, stroke, diabetes, respiratory disease and infections. Those with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely due to physical health problems.
- Many physical conditions increase the chances of poor mental health. It is estimated that 12 to 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health – at least £1 in every £8 spent.
- Mental health problems are common with 1 in 6 of the adult population experiencing mental ill health at any one time (around 22,000 people in Hampshire).
- 10% of children have a mental health problem (around 31,000 in Hampshire), and 50% of lifetime mental illness is present by the age of 14.
- 10% of new mothers suffer from postnatal depression (around 1500 women each year in Hampshire).
- 20% of working-age women and 17% of working-age men are affected by depression or anxiety at any one time.
- Half of all women and a quarter of all men will be affected by depression at some time in their life and 15% experience a disabling depression
- 4% of the population has a personality disorder.
- 1% of the population has a serious mental health problem.
- Hampshire has both a higher prevalence of depression and a higher admission rate for unipolar depressive disorder compared to England.
- Since 2006-08, there has been an increase in the rate of deaths from suicide and injury of undetermined intent in Hampshire.

### *Summary recommendations*

- Support initiatives to improve and maintain mental health in the workplace, including the public sector.



- Continue to support the programme of work being undertaken with specific communities within Hampshire including ex-service personnel to improve access to mental health promotion and mental health care services.
- Improve support for people with mental illness to obtain and retain stable accommodation.
- Improve pathways for the prevention, early diagnosis and treatment of depression in older people.
- Commission better integrated physical and mental health services in primary and secondary care; including psychiatric liaison services in every acute hospital.
- Ensure training for all health service staff in mental health awareness and treatment options across all age groups to increase identification of mental health problems and early intervention.

#### **6.14 Musculoskeletal disorders**

- More than 208,700 people in Hampshire are known to healthcare services as living with musculoskeletal disorders. The total must be greater than this estimate.
- The ageing population in Hampshire means the number of people living with musculoskeletal conditions will increase.
- Pain is the most prominent symptom in most people, causing limitation in function. This generates significant activity in the health and social care sector, including rising volumes of pain prescriptions, biological therapies, surgical procedures, referrals to a range of health professions.
- Residents in Rushmoor (1,933 per 100,000 population), Hart (1,847/100,000) and Gosport (1,844/100,000) had the highest hospital admission rates as a result of falls and fall injuries between 2009/10-2011/12. Winchester residents (1,432/100,000) had the lowest hospital admission rate.
- Hip fracture admission rates were the highest among residents from Gosport (513/100,000) and East Hampshire (501/100,000) and the lowest in Rushmoor (409/100,000). Admission rates for hip fractures in Hampshire appear to be stabilising.
- Havant (112/100,000), Rushmoor (112/100,000), and the New Forest (102/100,000) had some of the highest primary hip replacement rates across Hampshire. Winchester featured as having the lowest numbers of hip replacements, with a rate of 85/100,000 population. There has been a steady rise in primary hip replacement activity over the past four years.
- Knee arthroscopic activity during the past four years suggests a declining trend.
- Admission rates for knee replacements are highest in both Hart and Rushmoor at 110/100,000 and lowest in Winchester (77/100,000). These admission rates are more likely to reflect demand and supply, rather than need. The highest revision rates occurred among residents from Basingstoke and Deane (18/100,000) and Test Valley (17/100,000), and lowest at 11/100,000 in Havant, the New Forest and Winchester.

### *Summary recommendations*

- Support bone health through evidence based, preventative work (nutrition, physical activity etc.).
- Develop evidence based services that address the musculoskeletal needs of local populations.
- Audit the delivery of services for musculoskeletal conditions against national standards.
- Ensure people with a hip fracture have prompt surgery followed by good medical care and rehabilitation.

### **6.15 Chronic pain**

- About one in three people suffer with chronic pain in Hampshire.
- Muscle, bone and joint pain are the main causes of chronic pain, with back pain and osteoarthritis together responsible for over half of all cases.
- It is estimated that one in four people with chronic pain quit their job and have five times more GP visits than people who do not suffer chronic pain, while 2 in every 100 people are admitted to hospital in Hampshire every year due to pain.
- People with severe chronic pain are four times more likely to be anxious or depressed than those without pain and are significantly more likely to have longstanding illnesses.
- The majority of people in chronic pain are medically managed by their GP.
- There is large variation in access to pain management services across England and in Hampshire. There is also a lack of standards in terms of quality of care consequently specialist service provision is patchy both nationally and locally.
- Local service user groups describe inadequate support and the need for increased knowledge and awareness of services and education for healthcare professionals.

### *Summary recommendations*

- Ensure prevention of chronic pain is included in strategies addressing inequalities and the wider determinants of health.
- A pain management network across Wessex would enable a stronger, integrated, more person based, academically rigorous approach to pain management, sharing of good practice (successes and failures), stronger integration of care and ensure more timely implementation of high value interventions.
- Promote the mental and physical benefits of work and encourage employers to adopt simple low cost interventions to support employees with chronic pain.
- Strengthen health literacy and self-care, increasing knowledge and awareness of pain management (for example through expert patient programmes).
- Improve access to help via online programmes and community pharmacists.
- Encourage use of chronic pain pathways to support integrated care and provision of best value service at the appropriate time e.g. pelvic pain

pathway to guide management with regular auditing of service provision and outcomes.

- Raise awareness of patient support groups in general practice and highlight them to people.
- Reduce inequalities in service provision across Hampshire through changed commissioning by CCGs to meet local needs.
- Regular medicines management review (as per other chronic diseases).

## **6.16 Sight loss**

- An estimated 23,500 people in Hampshire over the age of 18 have some degree of sight loss. It is more common in older people and as the population ages, the prevalence of sight loss will increase. An estimated 30,000 people in Hampshire will be affected by sight loss by 2020.
- As access to the eye health system is mainly through primary care, it is essential that GPs, maintain their professional knowledge and are involved in the development of future eye health pathways.
- There is a need for better access to information, particularly at first contact, both about conditions and also about where to go to find other support or services that might help manage those conditions.
- Out of a choice of five priority areas for development, local service users said they primarily wanted to receive their services close to where they live, make sure they receive a prompt service and ensuring the type of information and advice they need is available.

### *Summary recommendations*

- Support a consistent approach to developments in signposting for people with sight loss.

## 7 Adult social care

- Social care needs arise when someone is unable to undertake basic tasks to support themselves in their daily life. This can result from a disability, illness, increased frailty or a change in personal circumstances. As people age their use of social care support generally increases.
- Hampshire, like England, has an ageing population, and social care use is projected to rise over the coming years. Over the next 7 years (2012-2019) it is estimated that the number of people aged 65 and over living in Hampshire will increase by 13.7% (33,561) to reach 279,197, accounting for 26.7% of the adult population. Most significantly the number of those aged 85 and over will increase by 24.5% to 48,974.
- Most social care needs are met by the individual themselves, with support from their family, friends, or the wider community. Currently over 10% of the population provide unpaid care to family, friends and others across Hampshire.
- A significant proportion of this care is provided by older people, often in poor health. The ability of an ageing carer population to meet increasing and more complex social care needs of family and friends has started to impact on the level of support Adult Services provides, with 25% of eligible services for clients over 65 being put in place to support carers finding it difficult to cope.
- The average package of care provided by Adult Services is increasing in size and intensity.
- The number of people with severe or complex learning disabilities who survive into adulthood and older age has and will continue to increase.
- The role of social care in the safeguarding vulnerable adults continues to grow.

### *Summary recommendations*

- Use the opportunities afforded by the requirements to develop integrated solutions overseen by Health and Wellbeing Board to meet the changing needs of our population.
- Work across Adults and Children's services and with Health and Wellbeing Board partners to ensure a clear and consistent pathway for children transitioning into adulthood, which provides support maximising independent living, health, housing, education and employment.
- Ensure that the support needs of carers become integral to all interventions and services.
- Working with partners to ensure safeguarding is everyone's responsibility and to ensure the quality and safety in all the services provided and commissioned.

## 8 Vulnerable people

### 8.1 Loneliness and isolation in older people

- Loneliness is subjective. It is the felt experience of an individual. Isolation describes the absence of social contact i.e. contact with friends or family or community involvement or access to services. Loneliness and isolation are clearly different.
- There are 243,372 people age 65+ in Hampshire; many of whom are fit and lead active, independent lives. However, 48,674 of the 65+ population are estimated to be mildly lonely (20%) and another 19,470 to 24,337 are estimated to be intensely lonely (8-10%).
- There are key 'trigger' or risk factors that can cause loneliness and social isolation in older age. These factors can be used to help to identify those likely to be at risk or experiencing loneliness in a community.
- Hampshire's partnership strategy - Ageing Well in Hampshire Older People's Well-Being (April 2011- March 2014) - identifies 'tackling social isolation and loneliness' as a key objective.
- There are already initiatives running in the county which help to identify those experiencing loneliness and assist them to reengage with their community.

#### *Summary recommendations*

- Prioritise the resourcing and development of the existing community based network of activities and opportunities that help to prevent or alleviate loneliness in older age.
- Embed the benefits of tackling loneliness and isolation within all other health and social care assessments and initiatives.
- Make every contact with an older person a potential opportunity to share appropriate and relevant information to assist with re-engagement with their community and access assistance.
- Develop 'Tackling Loneliness and Isolation Champions/Coordinators across the county and evaluate their effectiveness.
- Establish clear processes for health and social care to access the relevant services and information sources.

### 8.2 Homelessness

- The rate of statutory homelessness in Hampshire was 0.81 people per 1000 households in 2011-12, with the highest levels in Gosport, Havant and East Hampshire.
- Non statutory homelessness is difficult to measure but can be estimated from Supported Housing panel data. Non statutory homelessness data show the highest numbers of applications amongst people with mental ill health, young

people and people living in Fareham and Gosport, Basingstoke and Deane, the New Forest and Winchester.

- Gosport has had the highest number of households accepted as homeless and in priority need in Hampshire since 2009 with a rate of statutory homelessness of 3.32 per 1000 households, higher than the South East and England. Most households eligible for assistance in Gosport during this time had dependent children. The main reasons for the loss of the last settled home included parents or relatives no longer willing or able to accommodate people and a loss of rented or tied accommodation.
- A survey of 142 homeless people in Hampshire found their main health needs to be mental ill health, substance misuse, joint aches or problems with bones and muscles, chest pains and breathing problems and dental problems. Common reasons for visiting secondary care included alcohol, accidents and mental health. Hospital admissions found that homeless people were more likely to be men aged between 20-54 and emergency admissions.
- People who are sleeping, have slept rough and/or are living in hostels and night shelters have significantly higher levels of premature mortality, mental and physical ill health than the general population.

#### *Summary recommendations*

- Strategic and coordinated work on the wider determinants of health including increasing levels of education, training and employment, identifying and working with vulnerable people early.
- Access to flexible primary care (including dental) services, located according to need across the county.
- Improve engagement, early identification and intervention with homeless people.
- Improve the access to diagnosis and management of substance misuse and mental ill health, increase access to support for low level mental health issues and remove barriers to accessing housing and employment opportunities.

### **8.3 Gypsies and travellers**

- Gypsies and Travellers are a significant minority group in Hampshire.
- Significant health inequalities exist between Gypsies and Travellers and the general population in England, even when compared with other socially deprived or excluded groups and with other ethnic minorities.
- It is estimated that Gypsies and Travellers die on average 10-12 years younger than the population.
- The 2011 Census recorded 2,069 Gypsies and Travellers living in Hampshire. However local estimates suggest this is a large underestimate, with the actual population between 4,690 and 7,630 people. Three quarters (75%) of these people are believed to be living in bricks and mortar accommodation, with 25% living on authorised local authority or private sites. The largest number (423) is in the New Forest while the greatest proportion (0.3% of the

population) is in Hart district. Data suggest there are Gypsies and Travellers living in every district in Hampshire.

- There are no robust local data describing behaviours or quantifying the prevalence of illnesses and amongst the Gypsy and Traveller population in Hampshire. Feedback from stakeholders and previous work done in Hampshire suggests that Gypsies and Travellers in the county experience the same issues as described nationally:
  - High rates of smoking and alcohol use with minimal physical activity
  - High levels of domestic abuse to women
  - High prevalence of long term conditions such as heart disease, diabetes, lung disease, and mental health problems
  - Higher levels of dental health problems and fewer dental check-ups
  - Increased risk of preventable childhood infectious diseases such as measles because of lower levels of vaccination.

#### *Summary recommendations*

- Establish a county-wide strategic partnership within the health and Wellbeing Board to oversee and enable the reduction in modifiable inequalities, including those experienced by Gypsies and Travellers which should start with a focus on the key areas identified by the cross-government ministerial working group on tackling inequalities experienced by Gypsies and Travellers (DCLG April 2012).
- Undertake specific needs assessments for other minority groups to inform this strategic approach.

## 9. Death

- The death rate in Hampshire is falling overall in line with the national trend.
- The decreasing death rate means more people are living longer - not living healthier for longer but longer with illness and disability.
- Cancer is now the main cause of death in Hampshire and for the population of each CCG, having taken over from circulatory disease. Approximately 30% of all deaths in Hampshire in 2011 were caused by cancer, compared to 28% from circulatory disease and 13% from respiratory disease. This is similar to England and Wales.
- There were 34,214 deaths in Hampshire during the three year period from 2009 to 2011, a rate of 468 deaths per 100,000 population. This is significantly lower than the England rate of 553 deaths per 100,000 population.
- The death rate has fallen in Hampshire over the three year period from 2009 to 2011, in line with the national trend. However this trend was not seen across all parts of Hampshire –the death rate in women in North Hampshire and men in Fareham and Gosport has remained static. The overall death rate in Fareham and Gosport has also remained static, which is likely to be related to the generally poorer health and bigger health inequalities in that area.
- People living the most deprived parts of Hampshire are still more likely to die before they reach the age of 75.
- Premature mortality is defined as deaths occurring before the age of 75. There were 9,890 premature deaths in Hampshire during the three year period from 2009 to 2011, equating to a death rate of 220 per 100,000 population (significantly lower than the national and south east region averages).
- Premature mortality rates are decreasing nationally and this trend is seen in South Eastern Hampshire and West Hampshire CCGs for both men and women. The premature mortality rate has been static in Fareham and Gosport since 2006. In North East Hampshire and Farnham CCG, the premature mortality rate is dropping overall but has been static for men since 2006. The opposite picture is seen in North Hampshire CCG, where the rate is dropping for men but has remained static for women.
- This picture is reinforced by life expectancy (LE) calculations for Hampshire, which show a LE difference of 13.1 years between the 20% of wards with the highest average LE compared to the 20% of wards with the lowest average LE. The gap is far greater when the range across all wards is considered.
- LE for men in Hampshire was 80.8 years and 84.2 years for women during 2009/11, significantly higher than the national (78.6 and 82.6 years).
- Preventable deaths are those which could be avoided by public health interventions in the broadest sense. Examples include lung cancer, illicit drug use disorders, land transport accidents and certain infectious diseases.
- There were 5,827 preventable deaths in Hampshire during the three year period from 2009 to 2011. This equates to a rate of 119 preventable deaths per 100,000 population, lower than the national average of 146 preventable deaths per 100,000 population. Preventable deaths were significantly more likely to occur in the most deprived fifth of people in Hampshire compared to

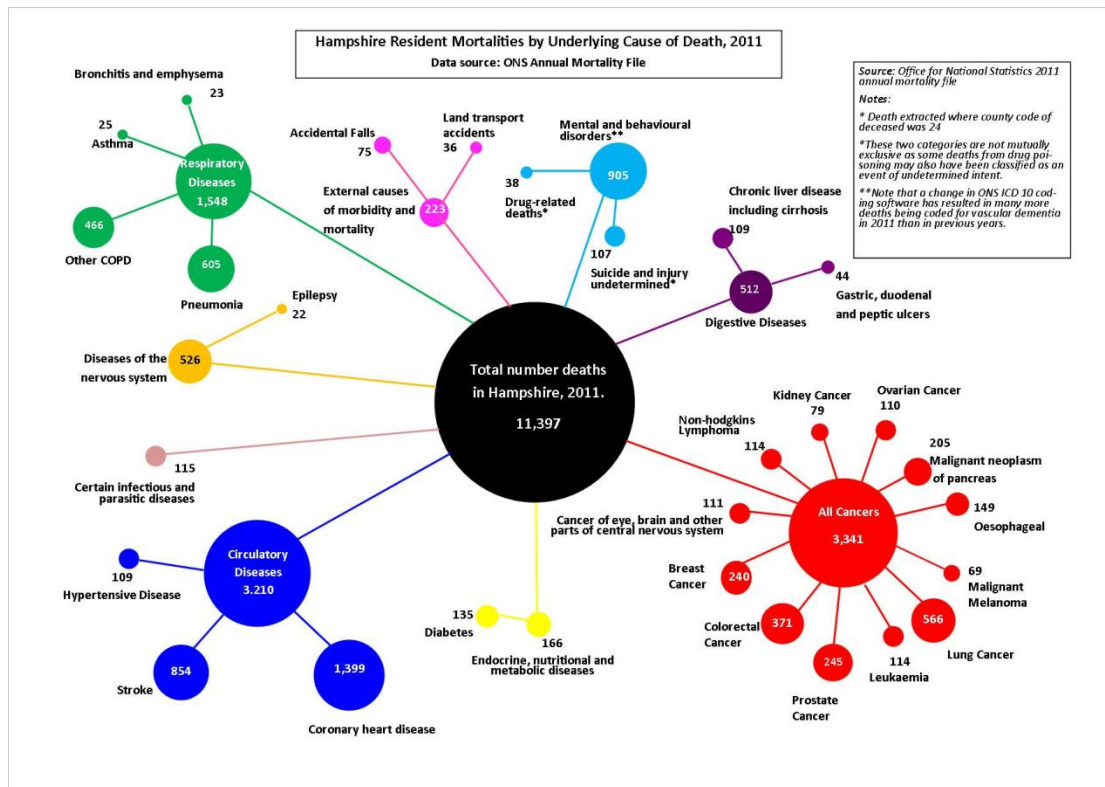


the least deprived fifth, and were more common amongst men than women. The rate of preventable deaths in Hampshire has decreased in the last five years.

### Summary Recommendations

- We need to support increasing numbers of people living with and dying from cancer as it becomes the main cause of death in Hampshire.
- We need to do more to reduce inequalities in avoidable premature deaths between parts of Hampshire. This focus should be on the factors that have the biggest impact on premature death – smoking, alcohol, physical inactivity, obesity – as well as the drivers of these behaviours – poverty, poor educational attainment, unemployment, housing issues.
- As life expectancy increases, we need to do more to reduce the number of years people are living with disability. We need to investigate this for Hampshire and tailor our strategies and interventions accordingly.

**Figure 3: Main causes of death in Hampshire, 2011**



## 10. Use of services

- The number of people attending Emergency Departments (A&E) and being admitted to hospital in an emergency has been increasing over the last decade across England.
- Attendances at urgent care facilities have risen by more than 50% nationally from 2001 to 2011
- There were 299,742 first attendances for Hampshire residents in 2011/12. The rate of attendance was 23,160/100,000 population. Attendances have risen year on year in the last three years and this rise has been statistically significant.
- First attendance rates vary across the county. Pooled attendance rates (2008/09-2011/12) show that Fareham and Gosport, North Hants and South-East Hants CCGs had lower rates than Hampshire overall, whilst North-East and Farnham and West Hants had higher rates of attendance.
- The highest number of attendances in Hampshire is in the 0-4 age band, followed by the 20-25 age band and the 15-19 age band (2012/13)
- Thirty-eight percent of all attendances have the outcome 'discharged – did not require any follow-up treatment', only 24.8% of attendances resulted in admission or transfer to another health care provider
- There is variation by provider in the proportion of attendances admitted from 27.3% at Frimley Park Hospital to 21.5% at Winchester and Eastleigh Trust (note now part of Hampshire Hospitals NHS FT)
- Across Hampshire the highest number of attendances are seen on Monday (15.9%) followed by Sunday (14.8%). The lowest number are seen on Friday (13.7%) and Saturday (13.7%). Fifty-seven percent of attendances occur between the hours of 9am – 5pm, with a peak occurring between 9-11am
- Research evidence suggests that many factors influence the use of emergency departments including: deprivation, convenience, geographical distance, environmental factors and access to primary care
- There were 120,027 emergency admissions for Hampshire residents in 2011/12. The rate of emergency admission was 7938/100,000 population. Admissions rose between 2008/09-2011/12 and the rise is statistically significant.
- There is a large variation in emergency admission rates by CCG and hospital. Pooled emergency admission rates (2008/09-2011/12) show that Fareham and Gosport, North-East Hants and West Hants CCGs had lower rates than Hampshire overall, whilst North Hants and South-East Hants CCGs had higher rates of admissions.
- 18% of emergency admissions are in the 0-19 years aged group, of which 9% are in the 0-4 age group, 39% are in the 20-64 year aged group and 43% are aged over 65 years (April 2009 – November 2012). However we are seeing a change in the age distribution in parts of the county as detailed in detailed work at a locality level.
- 29.5% of all emergency admissions in Hampshire have a 0 day length of stay (LOS). A further 22% have a 1 day length of stay. This varies, with 34% of all admission for residents of North Hants CCG having a 0 LOS compared to 26.2% of North-East Hants and Farnham CCG residents (April 2009 – November 2012).

- Preliminary analysis suggests that the main reason for admission in the 0-19 age group is viral infection unspecified, followed by acute upper respiratory tract infection and acute bronchiolitis (April 2009 – November 2012).
- Preliminary analysis suggests that the main reason for admission in the 65+ age group is urinary tract infection, syncope and collapse and lobar pneumonia unspecified.
- Systematic reviews suggest case management for heart failure, specialist clinics for heart failure patients and self management plans for patients with COPD and asthma, pulmonary rehabilitation for patients with COPD and cardiac rehabilitation for patients with CHD reduce emergency admissions.
- Within the hospital setting individualised discharge planning, asthma education in A&E for children and short stay units reduce admissions.
- Emerging evidence suggests that senior review in A&E, early palliative care and characteristics of primary care may reduce emergency admissions.
- Telemedicine may reduce emergency admissions for heart failure, heart disease, diabetes and hypertension, however it has not been demonstrated to be cost effective at current prices.
- Virtual wards/hospital at home, risk stratification and overall case management for older people and those with COPD, cancer, diabetes and stroke have not been found to reduce emergency admissions.
- Placing GPs in A&E may reduce the number of diagnostic tests ordered and patients admitted, however they may increase attendance rates due to supplier induced demand
- There is little available evidence yet to demonstrate that integrated health and social care reduces emergency admissions.

### *Summary recommendations*

- CCGs, local authorities and NHS England need to take a strategic system wide approach to reducing the demand for using emergency healthcare.
- To address the problems created by changing and increasing demand on urgent and emergency care we need strategic approaches that reduce complexity, reshape primary care and chronic disease management, support patients in their own homes, and change the way that nursing and residential care are incorporated into the system. These need to be built around natural communities and involve a new relationship between the different providers. All of this requires leadership across a system rather than attempting to fix each individual component.
- The evidence base for many initiatives around admission avoidance is weak. CCGs should ensure they implement initiatives for which good evidence exists to scale and build in evaluations, ideally using the entire Hampshire population to optimise the benefits of evaluation.
- CCGs should disinvest where no positive impact can be demonstrated.
- There is much variation in rates of attendance and admission by GP practice in Hampshire. Whilst some of this variation may be due to factors beyond the GPs' control, the quality of and access to primary care should be tackled as part of the system wide approach to improve urgent care.

- Some of the variation in Hampshire may be due to the behaviour of providers, rather than the inherent characteristics of the populations they serve. This should be acknowledged, and acted upon by commissioners and providers.
- The needs of young working age people and their reliance on portable communication devices should be considered.
- Public health should build on the set of evidence briefings already produced to assist commissioners in identifying the most effective and cost effective interventions to reduce emergency attendances and admissions.
- Public health should work with CCGs at the developmental stage when designing pathways and interventions to ensure evidence of effectiveness is embedded into commissioning plans.
- Many of the medical conditions underlying the reason for attendance and admissions, such as COPD, CHD and diabetes are amenable to primary and secondary prevention. CCGs should work as part of the Health and Wellbeing Board to maximise prevention.

## 11. Evidence of what works

Great Britain has been in the forefront of the international development of evidence based healthcare. Professor Archibald Cochrane is recognised internationally as a founder of evidence based medicine; his legacy is kept alive through multiple approaches, specifically the international Cochrane Collaborations. The specialty of public health medicine has been closely associated with this evidence based approach. Locally we have a nationally supported, health technology assessment centre within the University of Southampton. Alongside this, sit ongoing developments in qualitative research techniques and a similarly increasing research base to social care interventions.

Over the last decade we have seen the development of the National Institute of Health and Social Care, NICE, which has the remit to improve outcomes for people using the NHS and other public health and social care services by:

- Producing evidence-based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services;
- Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

These national resources are supported by the work that Public Health England undertakes to inform and support local government in the delivery of its public health and partnership duties. This executive summary identifies NICE developed evidence in support of specific issues, which the individual chapters reference and describe. However, NICE has not and cannot consider everything and where this is the case the relevant sources are described, some of which may be international. However, there are aspects of our health and wellbeing for which an evidence base has yet to be established. This should not deter us from progressing with such interventions, but in these times of reducing resources, stimulate us to apply the questioning approaches established through an evidence based medicine approach to social care and indeed, integrated care, interventions.