The Hampshire Joint Strategic Needs Assessment Refresh
December 2010
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Introduction

The Local Government and Public Involvement Act (2007) currently places a duty on upper tier local authorities and Primary Care Trusts (PCTs) to undertake a Joint Strategic Needs Assessment (JSNA) with the responsibility sitting with the Directors of Public Health, Adult Services and Children’s Services. JSNAs are described as a systematic method for reviewing the health and wellbeing needs of a population to identify ‘the big picture’ of the health and wellbeing needs and inequalities of that population. The JSNA guidance is supported by a core data set which includes key needs and service requirements.

This 2010 Hampshire JSNA revises the 2008 JSNA and has been developed by Hampshire County Council and Hampshire PCT. While providing an update on the identified current and future health and wellbeing needs of the Hampshire population, it is not intended to provide a comprehensive assessment of the needs for every service area.

The current Government has recently signalled its intention through the recent White Paper\(^1\) that JSNAs will continue to be a key planning tool with, general practice consortia, local authorities and Directors of Public Health each having an equal and explicit obligation to prepare it under the oversight of the Health and Wellbeing Board.

We would like to thank everyone who has been involved in the Joint Strategic Needs Assessment, which we hope will continue to help inform priority setting and strategic decision-making across Hampshire.

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Adult Services  HCC  HCC  NHS H/HCC

\(^1\)White Paper: Healthy lives, health people: our strategy for public health in England. HM Government 2010
Executive Summary

1. **Aim of the Joint Strategic Needs Assessment**
   The Joint Strategic Needs Assessment (JSNA) identifies and describes the current and future health and well-being needs of the local population over both the shorter term (3-5 years) and longer term (5-10 years). The purpose of the JSNA is to inform future commissioning decisions and investment priorities. This will ensure that decisions about the allocation of resources are made fairly, efficiently, and effectively.

To complement and expand on the analyses presented here, a number of specific strategic needs assessments and health equity audits have recently been carried out and are available from Hampshire PCT and Hampshire County Council. These include prison health, older people’s health and mental health, Nepali health needs and alcohol and substance misuse issues.

2. **Methodology**
   This 2010 JSNA was produced by a joint Hampshire PCT and Hampshire County Council JSNA Steering Group. The decision was made to undertake an update of the data presented in the 2008 JSNA (a refresh) rather than a more full and substantial review, with a view to completing a full review in time as the changes introduced by the new Government since June 2010 become established. This 2010 update has included engagement with partner organisations, and additional information published by partners since 2008 has been incorporated.

**Demography**

**Population**
The current estimate for the population of Hampshire is 1.29 million people, making it the third largest county in England behind Kent and Essex. In 2008 there were estimated to be 531,000 households in Hampshire.

In 2009 the average age of the Hampshire population was 42 years, slightly older than both the south east region (40 years) and England (39 years). Hampshire has a slightly smaller proportion of its population aged 0-4 years compared to the regional and national figures (5.7% in Hampshire compared to over 6.1% of both the region and national populations). However, the older population groups of Hampshire hold a larger proportion - 18% of the Hampshire population is aged 65 and over (compared to 17.0% and 16.3% respectively for the regional and national proportions), and 2.6% are aged 85 years and over (2.5% and 2.2% regionally and nationally respectively). In 2009 the total support ratio for Hampshire was 58, meaning there were 58 elderly and young people to every 100 people of working age. This compares to 56 elderly and young people to every 100 people of working age across the south east of England as a whole and 54 nationally.

The population of Hampshire is projected to grow by 17.6% from 1,289,400 in 2009 to 1,515,900 in 2033, slightly less than the south east region which is projected to increase by 19.2% over the period, but more than the national growth over the
period (17.1%). Assuming no significant change in mortality, an estimated 27.3% of the population of Hampshire will be aged 65 or older in 2033, higher than the region (24.3%) and nationally (22.6%). The proportion of young people is projected to decline marginally with those aged under 20 accounting for almost 22% of the population by 2033 compared to almost 24% currently. Similar proportions are projected to be seen across the region as a whole and nationally. However as with the south east region and nationally, the absolute number of young people aged 0 to 19 years is projected to increase in Hampshire by 22,300 people.

Age structure of populations varies within Hampshire. New Forest has an older population with an average age of 46 years, whilst Rushmoor’s average age is 10 years younger at 36 years. Rushmoor and Basingstoke have the highest proportions of their population of working age (aged 18 to 64 years), whilst New Forest has the highest proportion of retirement aged people (aged 65 and over). Hart and East Hampshire have the largest proportions of their population consisting of children and young people (aged under 18 years).

Ethnicity
Hampshire has a predominantly white ethnic population. In 2007, 95.6% of the population was estimated to be of a white ethnic group (96.7% of which were categorised as ‘white British’). This represents a higher proportion than either the south east (92.1% of which 94.8% were ‘white British’) or of England as a whole (88.2% of whom 94.8% were ‘white British’). However, this proportion has dropped since the 2001 census when the ‘white’ ethnic group stood at 97.8% of the population of Hampshire. Asian ethnic groups make up the largest non-white categories across Hampshire, the south east and England. Variation across the county is relatively small, from non-white population of 6.7% in Rushmoor (up from 4.4% in 2001); probably due to a growing Nepalese population; to a low of 3.3% (up from 2.1% in 2001) in the New Forest.

Disability
Disability is a multi-dimensional and often dynamic concept which presents measurement challenges. Perceptions of disability among the general population are diverse and there is no clear consensus on what constitutes “disability”. The age structure of those suffering from limiting long term illnesses or disability can be seen from the 2001 census data. The older the respondent, the greater is the likelihood that they reported having a long-term illness or disability. More than 50% of those aged 75 and over reported having such a condition, compared with 5% of the 20-24 age group. Department of Work and Pension data indicate that during the three months to August 2009 over 43,000 people across Hampshire claimed disability living allowance (DLA), 32% of whom were aged at least 60. Two thirds had claimed the benefit for five or more years.

Religion
The 2001 census found that 76.2% of the population of Hampshire stated their religion as Christian, a higher proportion than either the south east region or England. Conversely 15.5% of Hampshire’s residents stated they had no religion compared with 16.5% in the south east region.
**Migration**
Migration is difficult to measure accurately since there are no routinely collected data that measures the movement of people. Migration can be considered in two categories: internal (migration within a country) and international or external (between countries). Figures suggest that most migration into and out of Hampshire is internal. Office for National Statistics 2009 estimates showed that of the 54,300 people who migrated into Hampshire, only 9.8% were from overseas. Similarly, of the 51,100 who left Hampshire, just 11.3% were estimated to have moved overseas.

**Deprivation**
The Index of Multiple Deprivation (IMD) ranks local areas across the country in terms of their relative deprivation as measured by a range of different factors. Data from the 2007 IMD show Hampshire as a prosperous part of England and the south east. Hampshire is ranked as the tenth least deprived principal authority in England and Hart district is the least deprived of all the local authorities in England. Despite this, deprivation is seen at a local level within Hampshire and the districts of Havant and Gosport are ranked in the bottom half of the national rankings. Local small area analysis identifies pockets of localised deprivation across the county, particularly in Rushmoor, Basingstoke and Deane and New Forest.

In 2009 the Department for Communities and Local Government published the Child Wellbeing Index. Hampshire County Council ranked as the fifteenth highest county in England in terms of its child wellbeing. Hart had the highest child wellbeing amongst all local authorities in England. Havant and Gosport were the two local authorities in Hampshire where child wellbeing level fell in the bottom half of local authorities in England, with other localised pockets of poorer child wellbeing across Hampshire.

**Mosaic information**
Experian’s Mosaic Public Sector segments the population into one of fifteen groups based on similar socio-economic behaviour and is useful for painting a picture of an area, especially at a local level.

2009 data suggest that over two fifths of households in Hampshire enjoy a comfortable lifestyle with reasonable incomes, good jobs and home ownership, while around a further fifth benefit from a wealthy and successful way of life living in desirable locations. Compared to the UK average Hampshire has higher proportions of successful professionals and couples with young children in modern housing. There is considerably lower representation of groups associated with socio-economic deprivation. However one in ten households is in the lower income and welfare dependent categories. While there are recognised clusters of these groups in urban areas including Havant and Aldershot, these groups are found in small isolated pockets across the county. Hampshire is perceived as a retirement destination and groups defined as elderly account for about 11% of households in Hampshire. However, there is a distinct inequality in lifestyles, with around half of elderly households reliant on state support.

**Urban/rural**
Hampshire has a lower population density than the national average with 3.5 people per hectare compared to 4.4 people per hectare in the south east region and 4.0
nationally. Gosport, Rushmoor and Havant remain the most densely populated districts within Hampshire.

Sexual identity
The data on sexual identity is from national surveys including the Census. According to the 2001 Census about 0.1% of people aged 16 and over in Hampshire were living in a same sex couple household, slightly lower than the south east and England proportions (both approximately 0.2%). These figures probably underestimate the number of same sex couple households as it is likely that people did not respond to this question in full. More recently the Office for National Statistics reported estimates of the gay and bisexual population of Britain from the Integrated Household Survey, some 250,000 people across Britain. The estimates suggest that 1.5% of the British population reports their sexual identity as gay or bisexual.

Social and environmental context

Poverty
During 2008 in Hampshire 12.2% of children (1 in 8) under the age of 16 were identified as growing up in poverty. This is lower than the south east and England averages, but is a significant proportion of children and has not changed over the last few years. The highest levels seen in Gosport and Havant, the latter where one fifth of the child population are living in poverty.

With regards to income deprivation affecting older people in 2008 in Hampshire, 2.8% of lower super output areas across the county were classified as containing income deprived older people who were amongst the 20% most deprived in England. These small areas were spread across the county, meaning there are small areas of very income-deprived older people living in most of Hampshire’s districts.

Living and built environment
In 2009, 5.8% of all households across Hampshire (31,700 households) registered a housing need (excluding households seeking a transfer within the rented social housing sector). This is lower than the south east (6%) and England (8.2%) averages. Within Hampshire the highest levels were seen in Eastleigh and Gosport and lowest in Basingstoke and Deane. It should be noted that the updating of housing needs registers vary. Some local authorities update each quarter whereas others only review the list every two years or so. Thus numbers may not be comparable.

During 2009 to 2010 the number of households in temporary accommodation per 1000 households across Hampshire was 1.1 per 1000 households, which was below the national average of 2.4 per 1000 households. The exceptions were Gosport and New Forest with 5.2 and 2.2 households per 1000 households respectively (172 households in Gosport and 164 households in New Forest). The numbers of temporary households across all districts were lower than 2008 and

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\(^{2}\) Small geographical areas containing around 1000 to 1500 residents
reflects the work districts have been doing to help those at risk of becoming homeless and in helping those already in temporary accommodation to move out of it.

People are more likely to live alone than they were in the past. The 2001 census found that a quarter of households across Hampshire were single person households, over half of which were pensioner households. Across Hampshire the highest level of single person households were seen in Winchester, New Forest and Gosport (all nearly 28%), and lowest levels were seen in Hart (22%), compared to 30% across the south east and 29% nationally.

**Domestic abuse**
Based on Hampshire’s female population of 870,775 in 2009, it was estimated that 56,000 women and girls aged 16-59 have been a victim of domestic abuse in the past year, 28,736 have been a victim of a sexual assault, and 70,184 have been a victim of stalking. The figure of 56,000 is significantly greater than the 14,492 police reports received in 2009 by Hampshire Constabulary, suggesting that there is a large proportion of people not reporting domestic abuse and consequently not receiving formal help and support.

**Economic**
Hampshire has a relatively high proportion of its working age population in employment at 78.4% (2009) compared to 75% for the south east and 70.6% for the UK. However there was a near doubling of unemployment benefit claimants in Hampshire during 2008 to 2010. The number of unemployed benefit claimants in August 2010 was significantly lower than in 2009, when numbers reached nearly 20,000. However number of claimants remains over 5,000 higher than prior to the economic downturn. About two thirds of claimants are male and a third are aged under 25 years, 12.6% of whom have been claiming this benefit for over six months. The overall trend for male unemployment since 2010 has been downwards. Unemployment is most concentrated in Rushmoor, Gosport and Havant and in the centres of Eastleigh and Basingstoke.

**Skills and qualifications**
Skill levels among Hampshire’s adult population are generally higher than the national average. The draft Hampshire Economic Assessment found that the proportion of highly qualified people in the county is over 5% lower than Berkshire and approaching 10% below Surrey. The most marked difference is in level 4 qualifications (certificate of higher education), which vary from 49.0% in Winchester to 24.7% in Havant, a difference of 24% (2008/09).

**Environment**
Data from the 2001 census showed that 15.6% of all households in Hampshire did not have access to a car or van. This compares to a regional average of 19.4% and national average of 26.8%. The level of crime and fear of crime is a commonly cited influence on quality of life. Crime levels are relatively low in Hampshire and appear to have fallen in recent years. During 2009/10 there were 70,000 notifiable offences recorded by the police across the county. A total of 19,000 offences involved violence towards another person and a further 16,000 were related to criminal damage.
Residents’ views
The 2008 Place Survey found that 85% of Hampshire’s residents were ‘satisfied’ with the area as a place to live, 28% of whom were ‘very satisfied’. Nearly two-thirds (62%) of the residents felt that the level of crime was the most important issue in making their local area a good place to live, followed by health services (49%), clean streets (40%) and education provision (33%). When asked what needs improving in Hampshire, 22% of respondents cited the level of crime; 22% affordable, decent housing; 12% health facilities; 9% access to parks and open spaces; and 4% identified access to nature.

Lifestyle
There is substantial evidence showing that the way we live our lives impacts on our health and wellbeing. Poor diet, lack of physical activity, overweight and obesity, excessive alcohol consumption and cigarette smoking are associated with increased rates of chronic diseases such as type 2 diabetes, cardiovascular diseases, mental ill health and various cancers and earlier death. The people of Hampshire have better health outcomes than national and regional averages across all lifestyle indicators. However, risky behaviours continue to be more common (and similar to the England average) in parts of Gosport and Havant, and to a lesser extent in Rushmoor.

Smoking
The estimated prevalence of smoking in adults across Hampshire has decreased from 20% to 18% since 2008 and is lower than the England average (22%). A decrease was also seen in Gosport and Rushmoor, but these two districts continued to have the highest prevalence of smoking in Hampshire, which were also higher than the south east regional prevalence.

Alcohol
Problematic alcohol consumption is increasing across England as a whole. In Hampshire, the estimated prevalence of binge drinking during 2007 to 2008 was 18%, which was statistically significantly lower than the national average of 20%. Gosport has high levels of all types of problematic alcohol consumption (binge, increasing-risk and higher-risk drinking), which is reflected in the high rate of alcohol-related hospital admissions in this area. Gosport also has the highest level of alcohol-attributable deaths. However admission rates are highest in Rushmoor, while Hart and Fareham (two of the most affluent and healthy districts) have higher than desirable levels of regular consumption across all age groups.

Healthy eating
The estimated levels of healthy eating in adults across Hampshire during 2007/08 were similar to the England average. This is a decrease from 2003/05, where healthy eating levels were generally higher than the national average. Healthy eating in Havant, Gosport and Rushmoor remained lower than the England average.

Physical activity
Using the same measure of physical activity as in the 2008 JSNA, the percentage of adults who were physically activity in Hampshire was estimated as 13%, slightly
higher than the national average. There were no major changes in levels of physical activity amongst adults since 2003/05. Havant remained the district with lowest levels of physical activity, but has seen a slight increase since 2003/05. Using the measure of physical activity monitored in the Hampshire Local Area Agreement, 24% of Hampshire’s residents were physically active.

**Obesity**
The estimated prevalence of obesity in adults in Hampshire during 2006/08 was 23%, which was similar to the national and regional estimates of 24%. Rushmoor, Havant, Basingstoke and Deane, and Eastleigh all had adult obesity prevalence slightly higher than the national and regional averages. No district had an obesity prevalence that had changed significantly over the last two years.

**Drug misuse**
During 2007/8, there were 1,995 adult drug users in Hampshire accessing structured treatment. Hampshire has an estimated Problematic Drug Using (PDU) population of 3,065. During 2007/8, 1,758 PDUs had accessed structured treatment at some point with a further 344 known to services but not accessing structured treatment during that year. The 15-24 year old age group represents 17.2% of the total Hampshire population aged 15-64. In 2007/8, this age group represented 18.0% of the total treatment population when considering all drugs, which was higher than either the regional or national average (15.6% and 12.5% respectively).

**Burden of ill health**

**Circulatory disease**
The crude prevalence of coronary heart disease (3.3%), hypertension (13.7%) and stroke (1.7%) in Hampshire during 2009/10 were similar to the national rates. These county wide figures mask local variations. The rate of admission to hospital for heart attack was highest in Rushmoor, Gosport and Havant, and rate of stroke admissions was highest in New Forest. This shows opportunity to improve prevention.

**Diabetes**
The crude prevalence of diabetes in people aged 17 and over in Hampshire during 2009/10 was 5% which was similar to the national prevalence of 5.4%. Hospital admissions for diabetes were high in Basingstoke and Deane which is not matched by a high prevalence of diabetes. Havant had both high prevalence and high hospital admissions, whereas Rushmoor had relatively low prevalence but relatively high admissions. We know that a significant proportion of diabetes are undiagnosed in the population and this, with differing clinical practice by GPs and hospitals will explain some of these differences.

**Cancer**
The incidence of cancer in Hampshire during 2004/06 was 370.5 new cases of cancer per 100,000 population, which was similar to the national average. The incidence of lung cancer in Hampshire was 34.7 new cases of lung cancer per 100,000, which was lower than the national average (49.5 new cases per 100,000). The exception was Gosport where it was higher than the national average at 55.0 new cases per 100,000 population. The incidence of breast cancer in Hampshire was 130.7 new cases per 100,000 women, which was significantly higher than the
national rate of 122.8 new cases per 100,000 women. This is consistent with international evidence that shows breast cancer to be more common in affluent populations. Cervical cancer incidence in Hampshire was similar to the national average (8 new cases per 100,000 women), as was incidence of colorectal (or bowel) cancer (45 new cases per 100,000 population). Prostate cancer incidence was similar to the national average (99 new cases per 100,000 men), but with variation by district. Five year survival rates from common cancers across Hampshire were generally better than national survival rates, particularly for colorectal and prostate cancer.

Respiratory: chronic obstructive pulmonary disease (COPD)
The crude prevalence of COPD across Hampshire during 2009/10 was 1.3%, which was lower than the national prevalence of 1.6%. Eastleigh had high rates of admission to hospital for COPD which is not matched by high crude prevalence or mortality.

Infectious diseases
The incidence of TB in Hampshire during 2006/08 was lower than the national average, except Rushmoor where the incidence was similar to the national average. The rates of sexually transmitted infections in Hampshire during 2009 were generally lower than the national average. The prevalence of HIV in Hampshire was lower than the national average, whereas the number of people diagnosed late with HIV was similar to the national average. The number of vulnerable adults vaccinated against seasonal flu and pneumococcal infection was higher than the national averages, but a significant proportion of vulnerable adults remained unvaccinated and therefore at risk of infection.

Dental health services
Access to NHS primary care dental services has increased across Hampshire. Since April 2008 new dental practices have opened in Romsey, Gosport, Holbury, Petersfield, Hamble, Waterloo Place, Alton, Bursledon, Basingstoke, Lymington, Bordon, Cowplain/Bedhampton, Chandlers Ford, Winchester and Fareham. New practices are due to open in Hook, Eastleigh, Hedge End and Havant and a number of existing practices have extended their contracts to see more NHS patients. A new pathway for orthodontic care was introduced in September 2008 to support patients who meet the criteria for NHS orthodontic care to receive treatment as quickly as possible. Work is ongoing to develop and implement a pathway for minor oral surgery to enable patients to receive care from their dentist or locally for a range of specialist treatments, rather than in hospital. Improvements to special care dental services include more treatments provided at home for those unable to travel.

Mental health
The crude prevalence of depression across Hampshire during 2009/10 was 9.4%, which was higher than the national prevalence of 8.5%. There may be more people seeing their GP with symptoms and being diagnosed as being depressed, rather than depression being more common in Hampshire. The crude prevalence of mental illness (antisocial personality disorder, borderline personality disorder and psychotic disorder) in Hampshire during 2009/10 was 0.6%, which was lower than the national prevalence of 0.8%. The prevalence of dementia in men in Hampshire was 5.8%, which was similar to the national prevalence. The prevalence of dementia in women...
in Hampshire varied markedly across the county, although the overall prevalence at 8.4% was similar to the national prevalence.

**Avoidable injury and accidents**
The rate of hospital admissions for a broken hip in people over the age of 65 in Hampshire during 2008/09 was similar to national and regional rates. Admission rates in Fareham (370.6 admissions per 100,000) were significantly lower than national and regional rates of 479.2 and 473.0 admissions per 100,000 respectively. The number of road casualties aged over 60 in Hampshire has reduced over the last two years, from a total of 558 in 2007 to 411 in 2009.

**Musculoskeletal**
According to recently published research Havant has the greatest need for knee and hip replacements in Hampshire, followed by Gosport and New Forest. However this is not matched by high hospital admission rates for hip and knee replacements in these districts.

**Self report of long term illness and health**
Self-reported measures of good health were generally higher in Hampshire than the national average. The exceptions are Gosport and Havant, where the percentage of people self-reporting good health was lower than the national average.

**Mortality**

**All cause mortality and main causes of death**
The death rate from all causes across Hampshire is lower than the national and regional rates. People living in Gosport have the highest death rate in Hampshire at 583.3 per 100,000 population, which is similar to the national average of 581.9 per 100,000. Premature mortality (death in people under the age of 75) is highest in Gosport at 308.2 deaths per 100,000, which is similar to the national premature mortality rate of 295.6 deaths per 100,000 population. The proportion of deaths in Hampshire from various causes are consistent with the proportions for England, with 34% of deaths in Hampshire from circulatory disease and 28% from cancer.

**Life expectancy**
Life expectancy (LE) at birth in Hampshire continues be higher than the national and south east region averages. During period 2006/08 LE was 80 years for males and 83.3 years for females across the county. At district level, the highest LE in men was 81.4 years in Fareham. For women the highest LE was 85.4 years in Hart. The lowest LE in Hampshire was seen in Gosport for both men and women (78.7 and 81.4 years respectively). The difference in LE between districts with the highest and lowest LE was 2.7 years for men, which is an improvement from 2004/06 where the gap was 3.5 years. For women this difference was 4 years, which is an increase (a worsening) in the size of the life expectancy gap.

**Healthy life expectancy at age 65**
Healthy life expectancy (HLE) at age 65 is defined as the number of years a person can be expected to live in ‘good’ or ‘fairly good’ health from the age of 65. The most recent data on HLE comes from the 2001 Census. The lowest HLE at age 65 for
men was seen in Rushmoor and Gosport (12.7 and 12.8 years of healthy life at age 65 respectively), compared to 15 years for men over 65 living in Hart, Winchester and the New Forest. For women, the lowest HLE at age 65 was seen in Rushmoor and Gosport (14.8 years), while women in Hart and Winchester had the highest HLE (16.9 and 16.8 years respectively).

Deaths attributable to smoking
Smoking was responsible for 1,721 deaths during the three year period 2006 to 2008 in Hampshire. This equated to a rate of 160.9 deaths per 100,000 population, which was significantly lower than the national rate of 206.8 deaths per 100,000. A reduction in smoking-related deaths has been seen across all 11 districts since 2004/06, however marked variations remain between districts. Gosport, Rushmoor and Havant all had smoking-related death rates similar to the national rate.

Deaths from causes amenable to healthcare
In Hampshire there were 3369 deaths from causes amenable to healthcare during 2006/2008, equating to a rate of 78.8 deaths per 100,000 population. This was significantly lower than the national and south east rates of 101.3 and 87.3 deaths per 100,000 population respectively. The highest rate of deaths from causes amenable to healthcare was seen in Gosport, where there were 260 deaths or 101.5 deaths per 100,000 population. The lowest rate was Fareham, where there were 68.9 deaths per 100,000 during the same time period.

Excess winter deaths
During 2006/08 rate of excess winter deaths in Hampshire was similar to the national rate.

Circulatory (including coronary heart disease (CHD), stroke and heart attack) disease
Circulatory diseases were the main cause of death in Hampshire during 2006/2008 causing 34% of all deaths. The death rate from circulatory disease in Hampshire was lower than the national rate during this time period. Gosport had premature death rates from circulatory disease, CHD, heart attack and stroke that were similar to national death rates. Rushmoor had a premature death rate from CHD that was similar to the national rate. Havant had a premature death rate from stroke that was similar to the national rate.

Cancer
Cancer remained the most second most common cause of death in Hampshire during 2006/2008, causing 28% of all deaths. The death rates from all cancers, lung cancer and colorectal cancer in Hampshire were lower than the respective national death rates, as was the premature death rate (death from cancer in people under the age of 75). For breast, cervical and prostate cancer, the death rates in Hampshire were similar to the respective national rates. For breast cancer, New Forest and Test Valley had relatively high incidence rates but low death rates. Rushmoor had a relatively high death rate from breast cancer but relatively low incidence. This finding is supported by international evidence on breast cancer which shows that more deprived populations have lower incidence of breast cancer but poorer outcomes. For colorectal cancer, both Basingstoke and Deane and Rushmoor have higher mortality rates than would be expected in comparison to
incidence. In contrast mortality from colorectal cancer is lower in Havant than would be expected from incidence. For prostate cancer, the higher incidence seen in some districts was not reflected in higher mortality.

Respiratory disease: chronic obstructive pulmonary disease (COPD)
During 2006/2008 the death rate from COPD in Hampshire was significantly lower than nationally. There was marked variation between districts. Gosport, Rushmoor and Havant all had COPD death rates significantly higher than the regional rate and in Gosport this was statistically significant. In general, the districts with the highest prevalence of smoking were also the districts with the most deaths from COPD.

Suicide
The death rate from suicide in Hampshire was significantly lower than the national rate. There was variation in suicide rate between districts, however the overall number of suicides was very low. No district had a suicide rate significantly higher than the national rate.

Avoidable deaths from accidents
The rate of death from all accidents in Hampshire was lower than the national rate. During 2006/2008 the Hampshire death rate associated with a broken hip (fractured neck of femur) in people over the age of 85 was similar to the national and regional death rates. The crude rate of death from road traffic accidents in Hampshire was similar to the national rate.

Adult social care

Social care needs and provision
The increase in social care needs with age, coupled with the ageing of the population suggest that social care needs in the older population will rise over the next five years. Longer term forecasts, based on ONS population projections, suggest that this trend will continue over the next 20 years. These projections suggest that a minimum of 99,700 people in Hampshire aged over 65 will have at least one social care need in 2010, rising to a minimum of 174,000 in 2030.

Adult Services in Hampshire (working in formal partnerships with health services) supports about 90,000 people every year, approximately 28,000 of whom receive support on a regular basis. This figure includes people receiving equipment or minor adaptations, those with mobility or sensory problems and those receiving professional support as well as clients receiving more substantial ‘packages of care’ either in their own home or in a residential or nursing care home. Variations in the way the numbers are collected each year make year on year comparisons difficult.

The proportion of the population being supported through Adult Services and its partners rises from 0.63% of the 18-64 population to over 20% of people aged 85 and over. Substantial ‘packages of care’ provided through Adult Services increased between 2008/09 and 2009/10 by 4.9%. The most significant increase was in the number of older people receiving services.
Carers
According to the 2001 Census over 113,800 people in Hampshire (more than 1 in 10 people aged over 16) indicated that they provided unpaid care to family members or others who have physical or mental ill health. While about two thirds of these people provided between 1 and 19 hours care, over 1 in 6 were providing unpaid care for more than 50 hours a week. These figures are slightly below national averages.

Learning disability
National estimates suggest that between 2% and 3% of the population as a whole will have a learning disability, with this being moderate or severe in around a quarter of all cases. This suggests that 23,000 people in Hampshire will have a learning disability, with this being moderate or severe in just under 5,000 people.

Safeguarding adults
In 2009/10 the Hampshire Safeguarding Adults Board reported a rise in the total number of reported incidents of alleged abuse from 804 in 2008/09 to 1,437 in 2009/10. This increase evidenced the impact of continued investment, strong partnership working and awareness-raising among the public and workforce. The reported incidents of alleged abuse related to some 1,319 people, with some people subject of more than one reported incident. While the highest number of incidents related to older people, there were a significant number of referrals relating to people with learning disabilities and mental health problems. All incidents reported were followed up and, where required, appropriate action taken, where possible in line with the wishes of the person who was suffering abuse. A small number of cases required formal police intervention.

Children and young people
There are 307,500 children and young people aged 0-19 in Hampshire (2009 ONS mid-year population estimates), 163,000 of whom attend local authority schools. Although Hampshire is generally a good place for children and young people to live, not every child and young person has the opportunity to develop to their full potential leading to significant variations in outcomes.

Since 2008, the following have affected the level of need among Hampshire’s children and young people:

- a more diverse population;
- an increase in teenage conceptions in most districts in Hampshire;
- better recording of breastfeeding at 6-8 weeks, with too few infants being still breastfed at this age;
- a reduction in obesity among four year olds and a small increase in obesity among 10 year olds;
- an increase in the number of young people screened for chlamydia;
- a reduction in the number of actively decaying, filled or removed teeth for an average Hampshire child of five;
- an increase in the percentage of children receiving recommended vaccinations by ages one, two and five;
- a significant increase in the numbers of referrals to children’s social care; the number of children looked after; and the number with a child protection plan.
(although these are national, rather than Hampshire, trends);

- improved Child and Adolescent Mental Health Services, with a new integrated, countywide specialist Tier 2 and 3 service to start in 2011;
- a small increase in the number of school pupils with speech, language and communication needs, or physical disabilities;
- improved levels of attainment for the county’s children and young people in key tests at ages 11 and 16;
- an increase in the numbers of young people not in education, employment or training, as a result of recession;
- a rise in the proportion of school pupils receiving, or eligible for, free school meals.

These findings are the focus in the 2010 annual review of Hampshire’s Children and Young People’s Plan. The Plan is the single, overarching strategy for Hampshire Children’s Trust and sets the direction and priorities for services for children, young people and families until 2012.

**Voice**

There are a variety of ways in which Hampshire resident’s views are captured and used to shape services. Focused action takes place with people using services as well as their carers and families in redesigning services.

The perception of residents’ ability to influence decision making is fairly low:

- 71% disagreed that they could influence decisions about their local area.
- 59% disagreed that they could influence decisions affecting the local NHS services in their area.
- Just under a quarter of people would like to get more involved in the decisions that affect their local area.
- Three out of five people wish to be involved, depending upon the issue.
- A total of 22% reported that they had given their views about their local area during the last year.

Hampshire residents generally have a good perception of local NHS services. Satisfaction with primary care services is consistently high in surveys for GPs, dentists and pharmacists. Joined up working between the NHS and social care services, opportunities to influence decisions and awareness of choice of services were rated much lower.

People using Hampshire County Council (HCC) Adult Services generally have a good perception of the services that they receive. In a 2009 service user survey:

- 87.4% of respondents were satisfied with the service they had received.
- Dissatisfaction had fallen for the third year running down to 4.3%.
- In relation to people using equipment or minor adaptations 94% of people were satisfied with their most recent piece of equipment or minor adaption.
- 71% reported that their equipment had improved their quality of life.
- 80% were very happy with the way they were treated by those discussing their needs.
In the 2010 Pupil Attitude Survey, most respondents reported that they always, or usually, enjoyed school. Pupils aged 12 and 14 thought their local area was a very, or fairly, good place to live.

The majority of Hampshire residents are very satisfied with where they live. Satisfaction levels increase according to age, with 81% of 18-34 year olds, 85% of 35-54 year olds and 89% of people aged 54 plus being satisfied.

Key areas that Hampshire residents see as needing to be improved were activities for teenagers, level of traffic congestion, road and pavement repairs and public transport.

4. **What does this mean for the health and social care needs of the population of Hampshire?**
   Most of the issues affecting the population have marked inequalities across the county. This also applies to the uptake of services and outcomes. NHS Hampshire and Hampshire County Council and GPCS need to align the evidence presented in this JSNA into future commissioning plans and maximise their opportunity for effective use of the available resources.
1. Demography

Summary:
- 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
- There is increasing diversity across the county

1.1 Introduction

Demographic change will continue to have a major influence on social and economic trends. The characteristics of the population – its age composition, ethnic break-down, numbers with disabilities and the inequalities within each of these groups etc. will also influence the health and wellbeing across Hampshire.

Our communities are becoming ever more diverse and mobile. Understanding the drivers of both the current situation and possible future trends are key if plans and programmes for service provision are to be soundly based.

Between the decennial censuses, annual estimates of the population are relied upon. There are two sources of population estimates for Hampshire County. The Office for National Statistics (ONS) calculates mid year estimates (MYE), while Hampshire County Council’s Small Area Population Forecasts (SAPF) provides a current picture of the population across Hampshire as well as population estimates for the coming 7 years. Both sets of figures are derived from the last census data (2001), adding on new births and subtracting deaths and allowing for the ageing population and migration. The SAPF figures also make use of known and planned dwelling information which gives a locally driven set of population estimates for Hampshire. However, the ONS MYE figures enable wider comparison across the country.

This chapter uses the ONS mid year estimates data to allow comparison across England. However, it is of note that the ONS figures compare quite favourably with Hampshire County Councils own figures at the county level, with just 6,800 people or 0.5% separating the two.

To gain a picture of the population across Hampshire in the future, the ONS Sub-National Population Projections (SNPP) are used – again to allow for comparisons beyond Hampshire to be made. The most recent set, 2008 based, currently run to 2033 and report age and gender changes in the population projected at district level.

ONS projections are based solely on past trends so take no account of an area’s ability to accommodate the projected rise in population, nor do they take into account any policy or planning information. As such they should be used primarily to understand likely trends rather than specific population totals.
1.2 **Population**

The current population estimate for Hampshire is 1.29 million people, making it the third largest county in England behind Kent and Essex. There are estimated to be 531,000 households in Hampshire (CLG 2008 Household estimates).

The age structure of the county reflects the demographic history of the population and can also influence its future. Figure 1.1 shows the population pyramid for Hampshire in 2009, with the darker lines showing the national picture. The population pyramid shows the age and gender structure of the population. The large cohorts of the post 2nd World War and 1960s baby booms can be seen in their 40’s and 60’s. The lower mortality seen in females is reflected in the larger proportions of females in the oldest age groups compared to males.

*Figure 1.1: Population Pyramid for Hampshire, 2009*

In Hampshire the average age of the population is 42 years, slightly older than both the South East of England as a whole (40 years) and England (39 years). Hampshire has a slightly smaller proportion of its population aged 0-4 years compared to the region and nationally (5.7% in Hampshire compared to over just over 6% of both the region and national populations), however, the older population groups of Hampshire hold a larger proportion (18% of the Hampshire population is aged 65 and over and 2.6% are aged 85 years and over, compared to 17.0% and 16.3% respectively for the regional and national proportions age 65 and over and 2.5% and 2.2% for those aged 85 years and over.)

Support (or dependency) ratios show the distributions of the population by broad age groups; namely, children (aged 0-15), those of working age (aged 16-64) and those of retirement age (aged 65 and over), in relation to others. The total support
ratio represents the ratio of the non-working age population to the working age population.

In 2009, the total support ratio for Hampshire was 58 – meaning there were 58 elderly and young people to every 100 people of working age. This compares to 56 elderly and young people to every 100 people of working age across the South East of England as a whole and 54 nationally.

Across Hampshire there are variations in age structure. For example, the New Forest has an older population with an average age of 46 years, whilst Rushmoor’s average age is 10 years younger at 36 years. Rushmoor and Basingstoke have the highest proportions of their population of working age (aged 18 to 64 years), whilst New Forest has the highest proportion of retirement aged people (aged 65 and over). Hart and East Hampshire have the largest proportions of their population consisting of children and young people (aged under 18 years).

The population of Hampshire is projected to grow by 17.6% from 1,289,400 in 2009 to 1,515,900 in 2033, slightly less than the South East of England as a whole which is projected to increase by 19.2% over the period, but more than the national growth over the period (17.1%). An estimated 27.3% of the population of Hampshire will be aged 65 or older in 2033, higher than the region (24.3%) and nationally (22.6%). The proportion of young people is projected to decline marginally with those aged under 20 accounting for almost 22% of the population by 2033 compared to almost 24% currently. Similar proportions are projected to be seen across the region as a whole and nationally. However, as with the South East region and nationally, the absolute number of young people aged 0 to 19 years is projected to increase, in Hampshire by 22,300 people. Figure 1.2 below shows the projected age structure of the population of Hampshire, compared to the national picture for 2033.

Figure 1.2: Population Pyramid for Hampshire, 2033

Source: 2008 based Sub National Population Projections
At district level the projections indicate that the majority of the population growth is projected across all districts in the 65 and older age groups over this time period. The 85 and over population group is likely to be where the largest proportionate change will be seen. However, all districts are also projected to see numerical increases in their child and young people populations (aged 0-19 years).

1.3 Births

In 2009 there were 14,641 births registered in Hampshire. This number has risen largely year on year from 12,780 in 2002 (Office for National Statistics Vital Statistics).

The absolute number of births is influenced both by the overall size of the population and by its age structure – a population with a high proportion of young women and men will probably give rise to more births than a population with an older age structure. The Total Period Fertility Rate (TPFR) measures the underlying trends in birth rates. It measures the number of children a woman would be expected to give birth to if she experienced the prevailing age specific birth rates throughout her reproductive life.

The current TPFR for Hampshire is 2.02 children per woman, which has risen from a low of 1.61 in 2001 and is similar to trends at both the regional and national level. Replacement level TPFR is 2.1 as this figure allows for each parent to be replaced and takes account of the small number of children that don’t survive to reproduction age.

Across Hampshire both the number of births and TPFR vary. In Gosport (2.11 births per woman), East Hampshire (2.26), Havant (2.16) and Test Valley (2.11) the TPFR in 2009 was just above replacement level, with the lowest levels seen in Hart (1.92 births per woman) and Winchester (1.91 births per woman). Investigation of the number of births by district suggests that in some parts of Hampshire births have been declining (e.g. Winchester).

The age at which women have their children has been getting older for some time. Many women now have their children in their late 30’s and 40’s. Across Hampshire 23% of births in 2008 were to women aged 35 or older, compared to 24% nationally. At the other end of the age spectrum, in 2008 the conception rate amongst females aged under 18 was 34.0 per 1,000 women (aged 15-17), higher than the South East as a whole (33.0), but lower than England (40.5).

For more information please see the following link: http://www3.hants.gov.uk/planning/factsandfigures/population-statistics/birth-deaths-migration.htm

The Children and Young People and the Lifestyle and Risk Factors chapters also provide more detailed information.
1.4 **Ethnicity**

The Office for National Statistics produces estimates of the number of people by ethnic group at district level across the country.

Hampshire has a predominantly white ethnic population. In 2007, 95.6% of the population was estimated to be of a white ethnic group (96.7% of which were categorised as ‘white British’). This represents a higher proportion than either the South East (92.1% of which 94.8% were ‘white British’) or of England as a whole (88.2% of whom 94.8% were ‘white British’). However, this proportion has dropped since the 2001 census when the ‘white’ ethnic group stood at 97.8% of the population of Hampshire. Asian ethnic groups make up the largest non-white categories across Hampshire, the South East and across England.

Variation across the county is relatively small, from non-white population of 6.7% in Rushmoor (up from 4.4% in 2001); probably due to a growing Nepalese population; to a low of 3.3% (up from 2.1% in 2001) in the New Forest. There is no robust data collected on ethnicity between census’ and as such there is some uncertainty in both the numbers themselves as well as the ethnic groups likely to account for the numbers.

Looking more closely at children and young people, the Spring 2010 School census reported 9.2% of Hampshire school children as being of a non white British ethnic group, 2.3% categorised as Asian and 0.2% categorised as either Roma/Gypsy or as a traveller of Irish Heritage.

For more information on the ethnic make-up of Hampshire’s population please see the link below:

http://www3.hants.gov.uk/planning/factsandfigures/population-statistics/ethnicity.htm

1.5 **Disability**

The Disability Discrimination Act (DDA) states:

"a person has a disability for the purposes of this Act if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities".

Disability is a multi-dimensional, and often dynamic, concept which presents measurement challenges. Perceptions of disability among the general population are diverse and there is no clear consensus on what constitutes “disability”.

Finding data that matches the array of definitions and fully captures disability is an evolving area, both in terms of measuring the numbers of disabled people, as well as capturing information on the transitions into and out of disability at key stages such as childhood into adulthood, as well as the meaningful segregation by type of disability.

The demographic structure of the UK and Hampshire has changed over recent decades with a continued increase in life expectancy at all ages. A key concern is the extent to which our increasing longevity is aligned with more years of good health.
Office for National Statistics (ONS) estimates suggest that across Hampshire disability free life expectancy (i.e. the number of years lived free from disability) in 2001 ranged from a low of 62.6 years in Gosport to 68.8 years in Hart amongst males and 65.1 and 69.7 years amongst females. Both male and female estimates across Hampshire are higher than the national averages (61.7 years for males and 64.2 for females), but Gosport, Rushmoor and Havant are all lower than the regional averages (64.7 years for males and 67.0 for females).

The age structure of those suffering from limiting long term illnesses or disability can be seen from the 2001 census data. The older the respondent the greater likelihood that they reported having a long-term illness or disability. More than 50% of those aged 75 and over reported having such a condition, compared with 5% of the 20-24 age group.

In terms of the numbers claiming benefits, DWP data indicate that during the 3 months to August 2009 over 43,000 people across Hampshire claimed disability living allowance (DLA), 32% of whom were aged at least 60. Two thirds had claimed the benefit for 5 or more years.

The Adult Social Care and Children and Young People chapters provide data on disability by type.

1.6 Religion
The breakdown of the population by religion is collected during the decennial census and is a voluntary question. The 2001 census found that 76.2% of the population of Hampshire stated their religion as Christian, higher proportions than either the South East of England or England as a whole. Conversely 15.5% stated they had no religion across Hampshire compared with 16.5% across the South East of England.

1.7 Migration
Migration can have an impact on population change and even relatively small numbers can impact on the level of need and public services in an area.

Migration is difficult to measure accurately since there are no routinely collected data for measuring the movement of people. Different data sources use different definitions of migration, so estimates of current levels as well as trends are hard to predict and plan for.

Migration can be considered in two categories: internal i.e. migration within a country and international – between countries. Figures suggest that most migration into and out of Hampshire is internal. Office for National Statistics 2009 estimates showed that of the 54,300 people who migrated into Hampshire, only 9.8% were from overseas. Similarly, of the 51,100 who left Hampshire, just 11.3% were estimated to have moved overseas.
This is backed up by a recent Home Movers Survey, by Hampshire County Council. The survey questioned a sample of people who have moved during the 12 month period April 2008 – March 2009. The findings suggested that over half of all moves were amongst people moving within the same district and a further 19% were moves taking place within the county boundary. Just 4% were from people who were moving into Hampshire from abroad.


The National Insurance number (NINO) allocations database can provide an indication of migration numbers into an area from overseas. This shows the annual number of people being allocated NINOs since 2004 in Hampshire was between 4,000 – 8,600, with numbers peaking in 2007 and subsequently declining to 2004 levels. Numbers have been highest in Basingstoke and Deane and Rushmoor.

Recent evidence from the NHS patient register database suggests 7,000 people with a Hampshire address coming from abroad, registered with a GP in 2009, again down from a high in 2007.

Neither NINO or NHS data sources capture outward international migration so the number leaving is unclear. Estimates by ONS suggest that up to 1000 more people enter Hampshire than leave it during the course of a year.

Currently the estimated internal net migration into Hampshire is 3,700 people (Source: ONS).

For more information on migration levels please refer to the link below:

1.8 Deprivation
Tackling deprivation by lifting people out of intergenerational poverty has been a key policy for Government over the past decade. Residents of deprived areas generally experience systemic socio-economic disadvantages such as low levels of economic activity, low incomes, poor health and reduced life expectancy.

The Index of Multiple Deprivation (IMD) ranks local areas across the country in terms of their relative deprivation as measured by a range of different factors. Data from the 2007 IMD suggest Hampshire is a prosperous part of England and the South East. Hampshire is ranked the tenth least deprived principal authority in England and Hart district is the least deprived of all the local authorities in England. Despite this, deprivation is seen at a local level within Hampshire and the districts of Havant and Gosport are ranked in the bottom half of the national rankings. Local small area analysis identifies pockets of localised deprivation across the county, e.g. in Rushmoor, Basingstoke and Deane and New Forest.

Further information about the IMD across Hampshire can be found in:
http://www3.hants.gov.uk/planning/factsandfigures/figures-economics/deprivation_indices.htm
In 2009 the department for Communities and Local Government (CLG) published the Child Wellbeing Index (CWI) which represented the first attempt to create a small area index exclusively for children in England. Hampshire County Council ranked the 15th highest county in England in terms of its child wellbeing. Hart had the highest child wellbeing amongst all local authorities in England. Havant and Gosport were the two local authorities in Hampshire where child wellbeing level fell in the bottom half of local authorities with other localized pockets of deprivation for child wellbeing across Hampshire. Figure 1.3 shows the index across Hampshire.

Figure 1.3: Map of the Child Wellbeing Index across Hampshire

Another data source which classifies the population into distinct types based on a range of social and economic factors is Experian’s Mosaic Public Sector 2009. This geo-demographic database segments the population into one of fifteen groups based on similar socio-economic behaviour, ranging from the very well off to those reliant on benefits and as such is useful for painting a picture of an area, especially at a local level. The classification suggests an increased likelihood for households living within an area of possessing those characteristics, but does not indicate that all households within the area will have those characteristics.

The data in figure 1.4 are based on aggregating postcode modelled data up to the County level.
Hampshire is regarded as a prosperous county and Mosaic suggests this is broadly true. Over two fifths of households enjoy what can be described as a comfortable lifestyle with reasonable incomes, good jobs and home ownership (Groups A, B, E, F and L), while around a further fifth are considered to benefit from a wealthy and successful way of life living in desirable locations (Groups C and D). However, at the other end of the spectrum one in ten households are in the lower income and welfare dependent categories (Groups I, M, N and O). While there are recognised clusters of these groups in urban areas including Havant and Aldershot, these groups are found in small isolated pockets across the county.

In between are a mix of lifestyles ranging from the young and well educated city dwellers, to residents in former council housing who are vulnerable to economic shocks, but not quite in the most deprived groups. Hampshire is also perceived as a retirement destination, particularly on the Hampshire littoral, and groups specifically defined as elderly (L and M) account for an estimated 11% of households in Hampshire. However, there is a distinct inequality in lifestyles, with around half of elderly households reliant on state support.
Figure 1.5: Comparison of Mosaic Group by Hampshire and UK households

Compared to the UK average (figure 1.5 above), Hampshire has higher proportions of successful professionals and couples with young children in modern housing, which suggests the county is considered an attractive location for families and skilled workers. Conversely, there is considerably lower representation of groups associated with socio-economic deprivation.

At the district level it is possible to compare districts to Hampshire county as a whole as well as the UK. Using this categorisation, East Hampshire and Winchester have concentrations of wealthier households, although for the very wealthy the UK (or more likely London) had higher proportions, and the location of the University of Winchester and major public sector employers in Winchester city helps to explain the presence of young, well educated city dwellers, although generally the UK has higher proportions. The three districts of East Hampshire, Test Valley and Winchester, along with the New Forest have concentrations of rural residents reflecting the countryside landscape. The New Forest is a retirement destination, hence the focus of more active and independent elderly residents. The districts of Gosport and Havant have concentrations of lower income groups, which are closer to UK proportions. Basingstoke and Deane and Havant have above average

Source: HCC using Experian 2010
representation in current or former social housing compared to both Hampshire and the UK, reflecting the presence of large council built estates in Basingstoke town and Havant.

Mosaic Public Sector is linked to a number of specific public sector data sources including the Hospitals Episodes Statistics (HES) data. Using this dataset at the national level Experian has shown the groups more likely to suffer from various health conditions compared to the national average. If a Mosaic Group scores 100 then it has precisely the same concentration as the UK as a whole for that variable, whilst scores above 100 suggest behaviour or traits that are greater than the UK average, and vice versa for values below 100. Please note that a segmentation index is only an indicative measure.

This segmentation can be used to indicate possible important health conditions across Hampshire by comparing those groups most evident across Hampshire against the different health conditions and against national comparators.

This type of measure is looking at each Group as a whole compared to the total and the Index scores are based on the national data.

To make the Segmentation Index easier to interpret, we have shaded the cells in each of the tables according to whether they are above or below the UK average. An Index score higher than 150 or lower than 50 would suggest a notable difference to the UK.

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<td>69</td>
<td>55</td>
<td>50</td>
<td>82</td>
<td>74</td>
<td>51</td>
<td>91</td>
<td>51</td>
<td>111</td>
<td>97</td>
<td>126</td>
<td>145</td>
<td>217</td>
<td>108</td>
<td>143</td>
</tr>
<tr>
<td>Fractures</td>
<td>110</td>
<td>109</td>
<td>97</td>
<td>92</td>
<td>81</td>
<td>66</td>
<td>79</td>
<td>68</td>
<td>90</td>
<td>95</td>
<td>105</td>
<td>173</td>
<td>241</td>
<td>87</td>
<td>116</td>
</tr>
<tr>
<td>G40 Endometriosis</td>
<td>70</td>
<td>86</td>
<td>63</td>
<td>81</td>
<td>78</td>
<td>66</td>
<td>95</td>
<td>79</td>
<td>125</td>
<td>87</td>
<td>128</td>
<td>102</td>
<td>102</td>
<td>187</td>
<td>173</td>
</tr>
<tr>
<td>G41, G6, I64 Stroke/transient ischaemic attacks</td>
<td>115</td>
<td>128</td>
<td>80</td>
<td>91</td>
<td>72</td>
<td>41</td>
<td>58</td>
<td>47</td>
<td>76</td>
<td>102</td>
<td>101</td>
<td>244</td>
<td>343</td>
<td>83</td>
<td>81</td>
</tr>
<tr>
<td>I11-15 Hypertension</td>
<td>110</td>
<td>101</td>
<td>63</td>
<td>69</td>
<td>89</td>
<td>46</td>
<td>54</td>
<td>50</td>
<td>118</td>
<td>99</td>
<td>116</td>
<td>175</td>
<td>275</td>
<td>122</td>
<td>119</td>
</tr>
<tr>
<td>I20-26 CHD</td>
<td>106</td>
<td>103</td>
<td>71</td>
<td>91</td>
<td>88</td>
<td>60</td>
<td>52</td>
<td>51</td>
<td>91</td>
<td>106</td>
<td>109</td>
<td>205</td>
<td>272</td>
<td>81</td>
<td>108</td>
</tr>
<tr>
<td>I50 Heart failure</td>
<td>95</td>
<td>120</td>
<td>65</td>
<td>77</td>
<td>73</td>
<td>34</td>
<td>57</td>
<td>42</td>
<td>86</td>
<td>100</td>
<td>105</td>
<td>244</td>
<td>404</td>
<td>88</td>
<td>102</td>
</tr>
<tr>
<td>J40-44 COPD</td>
<td>51</td>
<td>51</td>
<td>31</td>
<td>42</td>
<td>54</td>
<td>25</td>
<td>59</td>
<td>45</td>
<td>97</td>
<td>99</td>
<td>143</td>
<td>176</td>
<td>486</td>
<td>138</td>
<td>157</td>
</tr>
<tr>
<td>J46-49 Asthma</td>
<td>84</td>
<td>74</td>
<td>46</td>
<td>55</td>
<td>82</td>
<td>70</td>
<td>75</td>
<td>84</td>
<td>142</td>
<td>94</td>
<td>127</td>
<td>77</td>
<td>136</td>
<td>154</td>
<td>151</td>
</tr>
</tbody>
</table>

| K70, K73, I83 Chronic liver disease and cirrhosis | 83 | 86| 46| 53| 64| 46| 88| 60| 133| 90| 122| 115| 222| 241| 172|

- **Well above the national average (scores of 150+)**
- **Above the national average (scores of 111-149)**
- **Average (scores of 50-110)**
- **Below the national average (scores of 50-69)**
- **Well below the national average (scores of less than 50)**

33
1.9 **Urban / rural**
The majority of Hampshire’s land is classified as rural (85%), however, only 23% of Hampshire’s population live in rural areas. 77% live in the 15% of Hampshire that is categorised as urban (Source: Hampshire County Council’s 2009 based Small Area Population Forecasts).

Hampshire has a lower population density than the national average with 3.5 people per hectare compared to 4.4 people per hectare for the South East of England and 4.0 nationally.

Gosport, Rushmoor and Havant remain the most densely populated districts within Hampshire.

1.10 **Sexual Identity**
There are little data on sexual identity and most of it is from national surveys. However, one data source that provides information at district and county levels is the national census. From the household matrix it is possible to show the number of people who reported themselves as living as a same sex couple across Hampshire. About 0.1% of people aged 16 and over in 2001 were living in a same sex couple household, slightly lower than the South East and England proportions which were both about 0.2%. These figures are likely to underestimate the number of same sex couple households as it is likely that people did not respond to this question in full.

More recently the Office for National Statistics (ONS) reported estimates of the gay and bisexual population of Britain from the Integrated Household Survey, a survey of some 250,000 people across Britain. The estimates suggest that 1.5% of the British population reports their sexual identity as gay or bisexual with the same proportion for the South East. ONS suggests these figures could underestimate the true numbers owing to high levels of non-response, particularly amongst the young.
2. Social and Environmental Context

Summary:

- Poverty and socio-economic disadvantage is associated with poor health outcomes.
- 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.
- The economic situation and its ongoing effects on every aspect of our lives is likely to be an influential factor to health of the population.
- The physical environment is an important factor that influences and quality of life health.

2.1 Introduction

This chapter draws on a range of data to describe the social and environmental context of life for the people of Hampshire.

Information on the social and environmental context across Hampshire can also be found in the Local Economic Assessment and the Sustainable Community Strategy.

http://www3.hants.gov.uk/business/economic_data/economicassessment.htm

http://www3.hants.gov.uk/73496_sustain_communities_2.pdf

2.2 Poverty

There is no one single definition of poverty. Definitions range from those purely related to income such as *an income of half the national average*, to broader definitions such as this from Peter Townsend who defines poverty as *the absence or inadequacy of those diets, amenities, standards, services and activities which are common or customary in society*.

Poverty in turn is related to health. The poorest in society suffer the most ill health, those slightly above them in society suffering less, those slightly above them less still and so on (M Marmot, Fairer Society, Healthy Lives, 2010).

National Indicator 116 identifies ‘children in poverty’ as those living in families in receipt of out of work benefits or tax credits, and where the families reported income is less than 60% of the national median family income. Across Hampshire, 12.2% (1 in 8) of our children under 16 are growing up in poverty (2008) (see figure 2.1 below). This is lower than the South East and England, but a significant proportion of children and has not changed over the last few years. The proportion varies across Hampshire with the highest levels seen in Gosport and Havant, the latter where one fifth of the child population are living in poverty.

---

3 Townsend P, Poverty in the UK. 1979
Figure 2.1: Percentage of children in ‘poverty’ as at 31/08/2008

<table>
<thead>
<tr>
<th>District</th>
<th>% of Children in &quot;Poverty&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>11.9%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>9.5%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>11.5%</td>
</tr>
<tr>
<td>Fareham</td>
<td>9.4%</td>
</tr>
<tr>
<td>Gosport</td>
<td>18.7%</td>
</tr>
<tr>
<td>Hart</td>
<td>6.5%</td>
</tr>
<tr>
<td>Havant</td>
<td>21.8%</td>
</tr>
<tr>
<td>New Forest</td>
<td>13.6%</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>13.1%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>10.4%</td>
</tr>
<tr>
<td>Winchester</td>
<td>8.3%</td>
</tr>
<tr>
<td>Hampshire</td>
<td>12.2%</td>
</tr>
<tr>
<td>South East</td>
<td>15.2%</td>
</tr>
<tr>
<td>England</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

Source: Department for Work and Pensions

The Children and Young People chapter provides more information on child poverty.

Related to the IMD though not part of it, is a measure of income deprivation affecting older people (IPAOP). It uses the proportion of older people aged 60 and over living in income deprived households (those receiving income support or job seekers allowance or incapacity benefit and their partners (if also aged 60 or over)). The measure is calculated at Lower Super Output Area (LSOA) level.

Across Hampshire, some 2.8% of LSOAs (23) are amongst the 20% most deprived areas in England. Figure 2.2 shows the distribution of income deprived older people across Hampshire.
The JSNA 2008 highlighted the issue facing many older people – that of those who are asset rich but income poor. These older people own their own home, but are often unable to afford to heat and maintain it. Research in 2007 suggested that as many as 30,000 households in Hampshire fell into such a category. With the population across Hampshire set to age further over the coming years, this is likely to become an even greater issue in the future.

http://www3.hants.gov.uk/identifying_and_locating_asset_rich_summary.pdf

2.3 Living and built environment

Living arrangements have a significant impact on health. Poor housing has direct and indirect effects on current and long term health, whilst factors such as living alone give rise to a greater risk of mental health problems and challenges with support when ill. Overcrowding has long been associated with significantly poor health.

Hampshire’s housing stock is generally in good condition, with the number of households in overcrowded accommodation (4%) being below the national average. (Source: Shaping our future together – Hampshire’s Sustainable Community Strategy 2008-18)
Affordable housing is a major issue in the county, with high house price to earning ratios. Although recent economic trends have seen some reduction in house prices, restraint in earnings in many sectors, coupled with restricted access to finance, continue to make it very difficult for many people on lower or average incomes to buy their own house.

The number of households applying to local authorities to register a housing need is an indicator of housing stress, although it is recognised that this significantly under reports actual need. In 2009, 5.8% of all households across Hampshire (31,700 households) registered a housing need (excluding those households seeking a transfer within the rented social housing sector). This is lower than the South East region (6%) and England (8.2%). Across Hampshire, there is variation, with the highest levels seen in Eastleigh and Gosport, and lowest in Basingstoke and Deane (see figure 2.3 below). It should be noted that the updating of housing needs registers vary; some local authorities update each quarter whereas others may only review the list every two years or so. Thus numbers may not be comparable and can change significantly when a review is held. (Source CLG).

**Figure 2.3: Housing need, 2009**

<table>
<thead>
<tr>
<th>District</th>
<th>Number of households on the waiting list (excludes households looking for transfers) as at 1 April 2009</th>
<th>% of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>1800</td>
<td>2.7</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>2300</td>
<td>5.1</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>4700</td>
<td>9.3</td>
</tr>
<tr>
<td>Fareham</td>
<td>1500</td>
<td>3.4</td>
</tr>
<tr>
<td>Gosport</td>
<td>2900</td>
<td>8.7</td>
</tr>
<tr>
<td>Hart</td>
<td>1400</td>
<td>4.0</td>
</tr>
<tr>
<td>Havant</td>
<td>2200</td>
<td>4.4</td>
</tr>
<tr>
<td>New Forest</td>
<td>5200</td>
<td>6.9</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>2500</td>
<td>7.2</td>
</tr>
<tr>
<td>Test Valley</td>
<td>3000</td>
<td>6.4</td>
</tr>
<tr>
<td>Winchester</td>
<td>3200</td>
<td>7.0</td>
</tr>
<tr>
<td>Hampshire</td>
<td>30600</td>
<td>5.8</td>
</tr>
<tr>
<td>South East</td>
<td>205400</td>
<td>6.0</td>
</tr>
<tr>
<td>England</td>
<td>1763100</td>
<td>8.2</td>
</tr>
</tbody>
</table>

Source: Department Communities and Local Government

Under homelessness laws, local councils must ensure that suitable temporary accommodation is available for homeless households who are eligible for assistance, in priority need and unintentionally homeless, until settled (i.e. long-term) accommodation can be found.

Homeless people can suffer high levels of stress from the lack of control over their housing situation, combined with substantial levels of poverty and often poor living
conditions. They often feel very isolated, especially when temporary accommodation is provided at a distance from their local community, family and friends. In addition, many homeless people carry with them the distressing experiences they have suffered which led to their homelessness in the first place, such as domestic violence, relationship breakdown, fleeing persecution from another country, drug and alcohol misuse, and mental health problems (taken from Shelter).

Living in temporary accommodation can have damaging health effects, both physical and mental. Surveys conducted by Shelter have found that:

- people who had been living in temporary accommodation for over a year reported increased health problems and greater use of health services
- almost half of parents with children and 71% of childless people in temporary accommodation said they were depressed.


Numbers in temporary accommodation vary across Hampshire, with highest numbers found in Gosport (172 households) and the New Forest (164 households), see figure 2.4 below. Across all districts, the numbers are much lower than those seen in 2008. This reduction is a result of the work local authorities have been doing to help those at risk to avoid people becoming homeless and also in helping those already in temporary accommodation to move out of it. The number in temporary accommodation per thousand households across Hampshire is below the national average (2.4), with the exception of Gosport (5.2) and the New Forest (2.2), (Source: CLG).

Figure 2.4: Number of households in temporary accommodation, 2009-10

<table>
<thead>
<tr>
<th>District</th>
<th>Total number of households in Temporary Accommodation</th>
<th>No. per 1,000 hhld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>5</td>
<td>0.1</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>84</td>
<td>1.9</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>4</td>
<td>0.1</td>
</tr>
<tr>
<td>Fareham</td>
<td>22</td>
<td>0.5</td>
</tr>
<tr>
<td>Gosport</td>
<td>172</td>
<td>5.2</td>
</tr>
<tr>
<td>Hart</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>Havant</td>
<td>49</td>
<td>1.0</td>
</tr>
<tr>
<td>New Forest</td>
<td>164</td>
<td>2.2</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>8</td>
<td>0.2</td>
</tr>
<tr>
<td>Test Valley</td>
<td>41</td>
<td>0.9</td>
</tr>
<tr>
<td>Winchester</td>
<td>14</td>
<td>0.3</td>
</tr>
<tr>
<td>Hampshire</td>
<td>564</td>
<td>1.1</td>
</tr>
<tr>
<td>South East</td>
<td>3520</td>
<td>1.0</td>
</tr>
<tr>
<td>England</td>
<td>51310</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: Department Communities and Local Government
At the other end of the housing spectrum, the profile of the housing stock across Hampshire suggests 85% of dwellings are either owner occupied or privately rented dwellings (source CLG).

People today are more likely to live alone than they were in the past. The 2001 census found that a quarter of households across Hampshire were single person households, over half of which were pensioner households. Across Hampshire, the highest levels of single person households are found in Winchester, New Forest and Gosport, all at close to 28%, and lowest levels are seen in Hart (22%), compared to 30% across the South East as a whole and 29% nationally (see figure 2.5 below for further details).

Figure 2.5: One person households, 2001

<table>
<thead>
<tr>
<th></th>
<th>All Households</th>
<th>One person: Pensioner</th>
<th>All one person households</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Percentage</td>
<td>Percentage</td>
</tr>
<tr>
<td>Basingstoke and Deane</td>
<td>61722</td>
<td>10.7</td>
<td>25.35</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>43625</td>
<td>13.16</td>
<td>24.80</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>47001</td>
<td>12.74</td>
<td>25.50</td>
</tr>
<tr>
<td>Fareham</td>
<td>43578</td>
<td>13.36</td>
<td>23.60</td>
</tr>
<tr>
<td>Gosport</td>
<td>31337</td>
<td>14.43</td>
<td>27.95</td>
</tr>
<tr>
<td>Hart</td>
<td>32470</td>
<td>10.5</td>
<td>22.39</td>
</tr>
<tr>
<td>Havant</td>
<td>48460</td>
<td>15.09</td>
<td>26.56</td>
</tr>
<tr>
<td>New Forest</td>
<td>71985</td>
<td>17.29</td>
<td>27.69</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>35263</td>
<td>11.91</td>
<td>25.03</td>
</tr>
<tr>
<td>Test Valley</td>
<td>44134</td>
<td>12.8</td>
<td>24.31</td>
</tr>
<tr>
<td>Winchester</td>
<td>43132</td>
<td>15.43</td>
<td>27.98</td>
</tr>
<tr>
<td>Hampshire</td>
<td>502706</td>
<td>13.6</td>
<td>25.70</td>
</tr>
<tr>
<td>South East</td>
<td>3287489</td>
<td>14.39</td>
<td>30.07</td>
</tr>
<tr>
<td>England</td>
<td>20451427</td>
<td>14.37</td>
<td>28.52</td>
</tr>
</tbody>
</table>

Source: 2001 Census

The increase in the numbers of people living alone along with other changes in household formation (high levels of divorce, smaller family sizes, increasing migration etc) impacts on a person’s health, as well as on the availability of informal care and support. A large proportion of care is provided by the family, in particular the spouse, young carers and adult children. However, if more people are living alone or living further away from the family home, such care may be harder to provide, placing greater reliance on formal care services.

It is recognised nationally that certain groups of people may find it more difficult than others to access settled accommodation and that this can have an adverse impact on their overall wellbeing. One such group is people with learning disabilities. In 2009/10, two thirds of adults with learning disabilities who were known to the County Council’s Adult Services were judged to be in settled accommodation, above the national (61%) and regional (63.2%) averages. Some of these were living with their
families and local work has identified concerns amongst these families about future security of tenure as parents age.


2.4 Domestic abuse

There is no one comprehensive source of data on domestic abuse in Hampshire. The Government’s Violence Against Women and Girls ‘ready reckoner tool’ uses findings from the British Crime Survey to estimate the need for local services for domestic violence, sexual violence and stalking in an area. Based on Hampshire’s female population of 870,775 (2009 – Small Area Population Forecasts), we can calculate the following estimations:

- 56,000 women and girls aged 16-59 have been a victim of domestic abuse in the past year;
- 28,736 women and girls aged 16-59 have been a victim of a sexual assault in the past year;
- 70,184 women and girls aged 16-59 have been a victim of stalking in the past year.

The figure of 56,000 is significantly greater than the number of Police reports received (14,492) in the last year by Hampshire Constabulary, suggesting that there is likely to be a significant percentage of people who are not reporting domestic abuse and accessing formal help and support.

The Hampshire Domestic Abuse Forum undertakes an annual Domestic Abuse Snapshot Survey, where agencies record the number of cases during a one week period. In March 2009, the following results were recorded:

- a total of 2,473 cases (victims/survivors) of domestic abuse were recorded during this one week period;
- of the reported cases (victims), 2,184 were female, 257 were male, one victim was transgender and there were 32 cases where the gender was not recorded;
- organisations were aware of 1,894 cases before the snapshot week, which equates to 76.6% of the total number of cases (a 5.8% increase from 2008).

Data on young people affected by domestic abuse are reported in the Children and Young People chapter.

2.5 Economic

In the two years since the last JSNA, the UK economy has been hit by the global economic downturn, resulting in increased unemployment, pay freezes and reduced working hours.

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4 From Hampshire Domestic Abuse Forum: Domestic Abuse Strategic Review Information Pack, April 2010
Whilst a relatively wealthy county, Hampshire has not escaped the impacts of the economic downturn, evidenced by unemployment benefit claimants almost doubling over the past two years from 2008-2010.

Long term unemployment impacts heavily on health. There is a strong association between low socio-economic status and poorer health. Across England and Wales, those who have never worked or are long-term unemployed have the highest rates of self-reported ‘poor’ health; people in routine occupations are more than twice as likely to say their health is ‘poor’ than people in higher managerial and professional occupations; and people from lower socio-economic groups are more likely to have a poor diet and less likely to take regular exercise.

http://www.equalityhumanrights.com/key-projects/triennial-review/

The current number of unemployed benefit claimants in Hampshire is 15,541 (August 2010), a rise of 176 on the July 2010 figure. This figure is significantly lower than the peak in 2009, when numbers reached nearly 20,000. However, it also remains over 5,000 higher than that recorded prior to the economic downturn. The majority of claimants are male (approximately two thirds of all claimants) and a third are aged under 25 years, 12.6% of whom have been claiming the benefit for over six months. However, the overall trend for male unemployment since 2010 has been downwards. Unemployment is generally concentrated in Rushmoor, Gosport and Havant and in the centres of Eastleigh and Basingstoke.

**Figure 2.6: Map of residential unemployment rate across Hampshire**

Source: This map is reproduced from Ordnance Survey material with the permission of Ordnance Survey on behalf of the Controller of Her Majesty’s Stationery Office © Crown copyright. Unauthorised reproduction infringes Crown copyright and may lead to prosecution or civil proceedings. HCC 100019180 2010
Job Seekers Allowance is a narrow measure of worklessness, with the out-of-work measure used by the Government providing a more accurate reflection of exclusion from the labour market. As at August 2010, there were 62,690 people in the main out-of-work benefit group (Job Seekers Allowance, employment support allowance/incapacity benefit, lone parent benefits and other income related benefits). Most of these are on either incapacity benefit, or since October 2008, the replacement employment support allowance.

Hampshire has a relatively high proportion of its working age population in employment at 78.4% (APS 2009) compared to 75% for the South East and 70.6% for the UK. However there are variations across Hampshire.

For more information see Hampshire County Council’s labour market bulletins: http://www3.hants.gov.uk/planning/factsandfigures/figures-economics/hants_l Labour_market.htm

Disabled households tend to have less overall household income than those without a disability. Working disabled people are more likely than the rest of the working population to be on low hourly pay. The fact that disabled people often spend periods of their working-age lives out of work increases their risk of poverty in later life. These worse outcomes are compounded by the extra costs associated with living with disabilities. The proportion of disabled pensioner households with low incomes is not significantly higher than that of non-disabled pensioner households, partly due to their receipt of disability benefits, but the standard threshold of low income makes no allowance for any extra costs of disability.

For more information please see the following report: http://www.equalityhumanrights.com/key-projects/triennial-review/

An example of this is the percentage of people with a learning disability known to the County Council’s Adult Services who are in employment. Although the provisional 2009/10 figure for Hampshire (11.4%) is above national (6.4%) and regional averages (9.7%), over 88% are still unable to find paid work for at least an hour a week.

2.6 Skills and Qualifications

Skill levels among Hampshire’s adult population are generally higher than the national average. However, the draft Hampshire Economic Assessment found that the incidence of highly qualified people in the county is over five percentage points lower than Berkshire and approaching ten percentage points below Surrey.

The proportion of working age adults (19-64 for males and 19-59 for females) qualified to Levels 2, 3 and 4 has increased slowly over the last four years. The percentage qualified to Level 2 (GCSE grade A*-C or equivalent) has risen from 70.5% in 2004/05 to 74.3% in 2008/09. During the same period, the proportion qualified to Level 3 (A-level or equivalent) increased from 51.0% to 52.4; and the percentage qualified to Level 4 or above (includes BTEC National Diplomas, Higher National Certificates, NVQs at Level 4 and degrees) from 30.2% to 33.7%.
Qualification levels vary significantly across the county. The following differences are apparent in the most recent data (2007/08 and 2008/09):

- skills levels in south Hampshire are generally lower than the county average with more highly qualified people living in the centre north of the county the most marked difference being in level 4 qualifications

Incidence of Level 2 qualifications varies from 83.7% in Hart to 69.1% in Rushmoor (2008/09), whilst Level 3 qualifications vary from 63.9% in Winchester to 45.4% in Havant (2007/08). However, the most marked difference is in Level 4 qualifications, which vary from 49.0% in Winchester to 24.7% in Havant, a 24 percentage point difference (2008/09). District data for the percentage of the working age population qualified to Level 4 or above are illustrated in figure 2.7.

**Figure 2.7: Proportion of working age population qualified to Level 4 or higher 2008/09**

![Proportion of working age population qualified to Level 4 or higher: 2008/09](image)

Source: Department for Communities and Local Government

### 2.7 Environment

The environment in which people live has a significant impact on their quality of life.

Data from the 2001 census showed that across Hampshire, 15.6% of all households did not have access to a car or van. This compares to a regional average of 19.4% and national average of 26.8%. With an ageing population, the number and distribution of non-car households is likely to change as more older people choose or have to give up their cars. This in turn, may impact on their access to services but may be influenced by the relatively rural nature of Hampshire as this may influence a person’s choice of transport.

The level of crime and fear of crime is a commonly cited influence on quality of life.
Across Hampshire, crime levels are relatively low and appear to have fallen in recent years. However, during 2009/10 there were 70,000 notifiable offences recorded by the Police across the county. A total of 19,000 involved violence towards another person and a further 16,000 were related to criminal damage, see figure 2.8 below (Source: Home Office).

**Figure 2.8: Notifiable Offences Recorded by the Police, 2009/2010**

<table>
<thead>
<tr>
<th>District</th>
<th>Violence Against the Person</th>
<th>Criminal Damage Including Arson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>2661</td>
<td>2226</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>1453</td>
<td>1370</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>1856</td>
<td>1476</td>
</tr>
<tr>
<td>Fareham</td>
<td>1219</td>
<td>1104</td>
</tr>
<tr>
<td>Gosport</td>
<td>1635</td>
<td>1488</td>
</tr>
<tr>
<td>Hart</td>
<td>629</td>
<td>830</td>
</tr>
<tr>
<td>Havant</td>
<td>2634</td>
<td>2138</td>
</tr>
<tr>
<td>New Forest</td>
<td>2108</td>
<td>2227</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>1519</td>
<td>1376</td>
</tr>
<tr>
<td>Test Valley</td>
<td>1561</td>
<td>1405</td>
</tr>
<tr>
<td>Winchester</td>
<td>1477</td>
<td>1299</td>
</tr>
<tr>
<td>Hampshire</td>
<td>18752</td>
<td>16939</td>
</tr>
<tr>
<td>South East</td>
<td>128942</td>
<td>115639</td>
</tr>
<tr>
<td>England and Wales</td>
<td>810831</td>
<td>749791</td>
</tr>
</tbody>
</table>

Source: Home Office

2.8 **User/Provider views**

The 2008 Place Survey found that 85% of Hampshire’s residents were ‘satisfied’ with the area as a place to live, 28% of whom were ‘very satisfied’. Nearly two-thirds (62%) of the residents felt that the level of crime was the most important issue in making their local area a good place to live (local area is defined as within 15-20 minutes walking distance). This was followed by health services (49%), clean streets (40%) and education provision (33%). Respondents also identified the importance of green space (including access to parks (27%) and access to nature (26%)) as important in making somewhere a good place to live.

When asked what needs improving in Hampshire, 22% of respondents cited the level of crime; 22% affordable, decent housing; 12% health facilities; 9% access to parks and open spaces; and 4% identified access to nature.

For more information see the Patient and Service User Voice and Public Satisfaction chapter.
3. Lifestyle and Risk Factors

Summary:

The people of Hampshire have better health outcomes than national and regional averages across all lifestyle indicators. However, risky behaviours continue to be more common (and similar to the England average) in parts of Gosport and Havant, and to a lesser extent in Rushmoor.

- **Smoking**
  The estimated prevalence of smoking in adults across Hampshire has decreased from 20% to 18% since 2008 and is lower than the England average (22%). A decrease was also seen in Gosport and Rushmoor, but these two districts continued to have the highest prevalence of smoking in Hampshire, which were also higher than the south east regional prevalence.

- **Alcohol**
  Problematic alcohol consumption is increasing across England as a whole. In Hampshire, the estimated prevalence of binge drinking during 2007 - 2008 was 18%, which was statistically significantly lower than the national average of 20%.
  **Binge drinking:** The highest prevalence of binge drinking was seen in Winchester, where the prevalence had also increased the most since 2003/05, followed by Gosport and Basingstoke and Deane.
  **Increasing-risk drinking:** Hampshire levels are similar to England. Hart, Gosport, and Fareham had the highest recorded levels of increasing-risk drinking.
  **Higher-risk drinking:** Hampshire levels are generally lower than the rest of England except in Gosport, which was comparable to the national average.
  Alcohol-related hospital admissions: Hospital admissions related to alcohol were generally lower across Hampshire than England, except Rushmoor where admission rates were higher than the national rate. Admission rates remained high in Gosport and Havant.
  **Summary:** Gosport has high levels of all types of problematic alcohol consumption, which is reflected in the high rate of alcohol-related hospital admissions in this area. Gosport also has the highest level of alcohol-attributable deaths. However, admission rates are highest in Rushmoor, while Hart and Fareham (two of the most affluent and healthy districts) have higher than desirable levels of consumption.

- **Healthy eating**
  The estimated levels of healthy eating in adults across Hampshire during 2007/08 were similar to the England average. This is a decrease from 2003/05, where healthy eating levels were generally higher than the national average. Healthy eating in Havant, Gosport and Rushmoor remained lower than the England average.

- **Physical activity**
  Using the same measure of physical activity as in the 2008 JSNA, the percentage of adults who were physically activity in Hampshire was estimated as 13%, slightly higher than the national average. There were no major changes in levels of physical activity amongst adults since 2003/05. Havant remained the district with
lowest levels of physical activity, but has seen a slight increase since 2003/05. Using the same measure of physical activity as monitored in the Hampshire Local Area Agreement, 24% of Hampshire’s residents were physically active.

- **Obesity**

  The estimated prevalence of obesity in adults in Hampshire during 2006/08 was 23%, which was lower than the national and regional estimates. Rushmoor, Havant, Basingstoke and Deane, and Eastleigh all had adult obesity prevalence slightly higher than the national and regional averages. The prevalence of obesity increased in all districts except for Rushmoor, New Forest and Basingstoke and Deane, where the prevalence dropped slightly. No district had an obesity prevalence that had changed significantly over the last two years.

- **Drug misuse**

  During 2007/8, there were 1,995 adult drug users in Hampshire accessing structured treatment. Hampshire has an estimated Problematic Drug Using (PDU) population of 3,065. During 2007/8, 1,758 PDUs had accessed structured treatment at some point with a further 344 known to services but not accessing structured treatment during that year. Hampshire had a disproportionately low level of crack cocaine use with a prevalence of only 50% of the regional average. The 15-24 year old age group represents 17.2% of the total Hampshire population aged 15-64. In 2007/8, this age group represented 18.0% of the total treatment population when considering all drug, which was higher than either the regional or national average (15.6% and 12.5% respectively).

3.1 **Introduction**

There is substantial evidence showing that the way we live our lives impacts on our health. Poor diet, lack of physical activity, overweight and obesity, excessive alcohol consumption and cigarette smoking are all associated with an increased risk of chronic diseases such as type 2 diabetes, cardiovascular diseases, mental ill health and various cancers. This chapter presents lifestyle data for adults.

3.2 **Smoking**

Smoking is the major modifiable contributor of ill health and early death. More avoidable deaths across the UK are attributed to smoking than to any other single risk factor. Smoking is an important cause of a number of cancers, chronic obstructive lung disease (COPD), coronary heart disease (CHD), stroke and vascular disease. It is well established as a significant factor accounting for the difference in mortality between most and least deprived population groups.

The prevalence of smoking in adults\(^5\) in Hampshire during 2006/08 was estimated as 18% of the population, which was lower than the national and south east region averages (22% and 20% respectively). This was a reduction in estimated smoking prevalence from 20% in 2003-2005. However there was significant variation by district. Both Gosport and Rushmoor continued to have the highest prevalence of

\(^5\) Defined as people over the age of 16
adult smokers at approximately 24%. This was a decrease in smoking prevalence from 27% (Gosport) and 25% (Rushmoor), but was still significantly higher than the south east region average of 20%. It should also be noted that the data presented here mask wide variations within districts.

Figure 3.1 Smoking prevalence in adults

![Smoking prevalence in adults](image)

Smoking cessation
During 2009/10 – 8349 people in Hampshire over the age of 16 successfully gave up smoking. This equated to a quit rate of 802 quitters per 100,000 population, which was worse than the England quit rate of 895 quitters per 100,000 population, but better than the south east regional quit rate of 767 quitters per 100,000 population.

Only a proportion of people attempting to quit smoking are actually successful at any attempt. The percentages of successful quitters by district are shown in figure 3.2. During 2009/10, half of all people in Hampshire who set a quit date were successful in their attempt (16,596 people set a quit date, 8349 were successful). This was similar to the national average (49%) but slightly lower than the south east regional figure (53%). There was significant variation across Hampshire’s districts, with Gosport and Havant having the lowest proportion of successful quitters. Evidence suggests that people living in deprived areas are less likely to access smoking cessation services, and may be less successful in quitting when they do. Hampshire’s cessation service, Quit4Life, has increased service access in the three areas of greatest need (Gosport, Havant, and Rushmoor).
Figure 3.2: percentage of smokers setting a quit date who successfully quit, by district

The London Health Observatory has produced local tobacco control profiles at local authority level (upper and second tier). These profiles bring together a picture of the burden of smoking-related disease, costs and action for local authorities and primary care trusts, showing how well local agencies are tackling the problem compared across regions and local areas.

3.3 Alcohol
Alcohol misuse is a general term used to describe any drinking behaviour, which has the potential to cause harm or threatens to damage the health and wellbeing of the user and those around them. Alcohol misuse therefore includes any level of risk from increasing risk drinking through to alcohol dependence. The Chief Medical Officer requested that the Department of Health and the NHS move to using the terms lower-risk, increasing-risk and higher-risk drinking as outlined below.

Figure 3.3: categories of alcohol use

<table>
<thead>
<tr>
<th>Previous Terminology</th>
<th>New Terminology</th>
<th>Main unit-based definitions</th>
</tr>
</thead>
</table>
| Sensible             | Lower-risk     | For men: not regularly drinking > 3-4 units per day  
 For women: not regularly drinking > 2-3 units per day |
| Hazardous            | Increasing-risk | For men: regularly exceeding > 3-4 units per day > – but not drinking at levels incurring the highest risk  
 For women: regularly exceeding > 2-3 units per day > – but not drinking at levels incurring the highest risk |
| Harmful              | Higher-risk     | For men: regularly drinking > 50 units per week or regularly drinking > 8 units per day  
 For women regularly drinking greater than 35 units per week or regularly drinking > 6 units per day |
| Binge Drinking       |                | Drunking over double the daily recognised sensible levels in any one day (over eight units a day for men and over six units a day for women) |
| Alcohol Dependence   |                | Drinking behaviour characterised by an inner drive to consume alcohol, continued drinking despite harm and commonly withdrawal symptoms on stopping drinking |

Source: NICE public health guidance 24. Alcohol-use disorders: preventing the development of hazardous and harmful drinking

Alcohol affects all of society, from the negative effects of alcohol on the social and behavioural welfare of communities, the economic burden due to loss of employment and reduced capacity to work, through to the burden on the NHS in terms of hospital admissions and treatment in primary care.

**Binge drinking**

Binge drinking is a risky drinking behaviour. The proportion of adults who binge-drink, which means consuming at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women) is shown below (these figures are synthetic estimates, using 2007/08 data). Since 2008 there has been an increase in the prevalence of binge drinking.
nationally from 18% to 20% (and since local estimates are modelled from the national prevalence, the Hampshire prevalence has also increased by 2% from 16% to 18%). The highest levels of binge drinking were estimated in Winchester, Gosport, and Basingstoke and Deane (22%, 21%, and 20.5% respectively). The lowest levels were estimated in Havant, New Forest and Rushmoor, and were significantly below the national average. Since 2008, the estimated prevalence of binge drinking increased most in Winchester and decreased in Rushmoor.

Figure 3.4: estimated prevalence of binge drinking

<table>
<thead>
<tr>
<th>Lifestyle</th>
<th>Alcohol</th>
<th>Binge drinking (synthetic estimate)</th>
<th>Persons &gt; 18 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>South East</td>
<td>England</td>
<td>Prospering Smaller Towns</td>
<td></td>
</tr>
<tr>
<td>0.0</td>
<td>5.0</td>
<td>10.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

**Increasing-risk drinking**

Drinking above recognised sensible levels, but not yet experiencing harm (measured by consumption of between 22 and 50 units per week for males and between 15 and 35 units per week for females) is considered to be increasing-risk drinking (previously called hazardous drinking). No new estimates of this indicator have been released since 2008 (based on 2005 data). The prevalence of increasing-risk drinking across Hampshire was estimated to be 20% of the population, which was comparable to the national average. The highest levels of increasing-risk drinking within Hampshire were in Hart, Gosport and Fareham, whereas the lowest levels were in Havant and New Forest. No district in Hampshire had an estimated level of this type of drinking that was significantly different to the England average.
Higher-risk drinking

Higher-risk drinking is considered as drinking above recognised sensible levels (measured by consumption of over 50 units per week for males and over 35 units per week for females) and experiencing harm, such as an alcohol-related accident, acute alcohol poisoning, hypertension and cirrhosis. No new estimates of this indicator have been released since 2008. The highest level of higher-risk drinking was 5% of the population in Gosport, which was comparable to the national average, followed by Havant then Rushmoor. All other districts were estimated to have higher-risk drinking prevalences that were lower than the national average.
**Alcohol-attributable hospital admissions**

Apart from its impact on emergency services, alcohol use also leads to hospital inpatient care for many conditions including liver disease, cardiac disease, stroke. During 2008/09 18,359 people had an alcohol-related hospital admission in Hampshire. The rate of hospital admissions attributable to alcohol in Hampshire was lower than the national and regional averages, but with marked variation between districts. The districts with the highest admission rates were Rushmoor, Gosport and Havant, with Rushmoor’s admission rate of 1909.8 admissions per 100,000 population significantly higher than the national average of 1582.7 admissions per 100,000 population. This pattern is similar to 2008. However Rushmoor appears to overtake Gosport as the district with the greatest rate of alcohol-related admissions. This indicator is now calculated in a different way from that used in 2008, which may partly explain the increase in national and local admissions.

**Figure 3.7: alcohol-attributable hospital admissions**

![Graph showing hospital stays for alcohol-related harm](image)

**Source:** Health Profiles

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**Alcohol-attributable deaths**

The North West Public Health Observatory\(^7\) is the national data observatory for alcohol related data and it estimated that there were 14,982 deaths across England in 2005 that were attributable to alcohol consumption. This represented 3.1% of all deaths in England during this period. Men were more at risk of harm from their alcohol consumption than women; 4.4% of male deaths were attributed to alcohol compared to 2.0% of female deaths. Alcohol-attributable deaths also varied by age, and although the highest number of deaths were seen in older age groups, young people were disproportionately affected by their alcohol use. For example, among 16-24 year old males, 26.6% of all deaths were estimated to be attributable to alcohol consumption compared to 1.4% among those aged 75 and over. In those

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aged less than 35 years, deaths were most likely to occur from the acute consequences of alcohol consumption, in particular, intentional self-harm and road traffic accidents. Beyond the age of 35, liver cirrhosis, malignant neoplasm of the oesophagus and breast and hypertensive diseases were the most common causes of death attributable to alcohol.

During 2008 there were an estimated 313 alcohol-attributable deaths in Hampshire; 201 of which were men and 112 were women. The following charts show these deaths as rates per 100,000 population. The death rate for both men and women across all local districts in Hampshire was lower than the national average, with the highest rate in Gosport. This is consistent with the pattern of higher risk drinking estimates.

Figure 3.8: male deaths attributable to alcohol

Figure 3.9: female deaths attributable to alcohol
**Projected service use and outcome in 3-5 years and 5-10 years**

During the 1990s, alcohol misuse increased among both men and women and in particular in the 16 to 24 age group. This upward trend was particularly marked among young women. Analysis of recent alcohol use surveys suggests that while the proportion of individuals misusing alcohol remains high, the upward trend in alcohol misuse among men and women in the UK may have peaked. According to the General Household Survey (GHS) 2006, the proportion of men and women in Britain exceeding recommended daily guidelines on at least one day in the previous week remained relatively constant between 1998 and 2004. Between 2004 and 2006, there was a slight reduction among men from 39% to 33%, while the proportion of women remained at 20%. A similar pattern of change was found in the proportions drinking heavily on at least one day in the previous week.

**Current services in relation to need**

The Alcohol Needs Assessment Research Project (ANARP, published in 2004) was the first national alcohol needs assessment in England. Its main focus was to measure the gap between the demand for and provision of specialist alcohol treatment services in England at a national and regional level. It estimated that in the south east region of England, there were over 950,000 people who could have benefited from an intervention aimed at their increasing or higher-risk drinking with a further 183,000 estimated as having alcohol dependence. However only 4.9% of those dependent on alcohol (1 in 20 people) were accessing treatment.

### 3.4 Healthy Eating

Up to a third of deaths from cancer may be related to unhealthy diets. “5 a-day” fruit and vegetable consumption is the second most important cancer prevention intervention after reducing smoking. The evidence shows that consumption of at least five portions of fruit and vegetables a day decreases risk of death from heart disease, stroke, and cancer by up to 20%.

The data reported here are estimates of the numbers of adults who reported consuming five or more portions of fruit and vegetables per day for the period 2006/08. The percentage of people who were estimated to eat healthily in Hampshire was 29% which is similar to the national average. This represents a decrease since 2003/05, when healthy eating in Hampshire was generally higher than the national average. Healthy eating levels have increased across England, but have remained static in Hampshire. The highest levels of healthy eating in Hampshire were seen in Winchester, New Forest and East Hampshire (34%, 33% and 32% respectively). People living in Havant, Gosport and Rushmoor districts were all estimated to have poorer eating habits than the national average (24%, 25% and 26% respectively). These healthy eating data mirror the deprivation levels of the districts.

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9 http://www.nwph.net/alcohol/anarp_data.aspx

10 Department of Health Community Profiles 2008
3.5 Physical activity

People who are physically active have about half the risk of developing coronary heart disease compared to those who have a sedentary lifestyle. Regular physical activity is associated with a reduced risk of diabetes, obesity, osteoporosis and colon cancer and improved mental health. In older adults physical activity is also associated with increased functional capacity.

There are two indicators available describing levels of physical activity in adults. Data in the 2008 JSNA came from Sport England’s Active People Survey (2005/06), which measured sport and ‘active recreation’ but excluded other forms of physical activity such as housework, DIY, activity in one’s job, etc. The survey measured the proportion of adults participating in 20 or more days of moderate intensity sport and active recreation (averaging five or more times per week) in the last four weeks (expressed as a percentage).

Using this definition of physical activity and data from 2007-2009 the estimated level of adult physical activity in Hampshire was nearly 13%. This was slightly but not significantly higher than the England and south east activity levels and similar to data in the 2008 JSNA. None of the eleven districts across Hampshire had physical activity levels significantly lower than the national, regional, or county average. Levels of physical activity remain lowest in Havant (10%). Hart has the highest levels of physically active adults (14%).
The Hampshire Local Area Agreement (LAA) used a different definition of ‘physical activity’ to monitor the number of physically active adults across the county. The LAA indicator originally counted the number of adults undertaking 5 x 30 minutes of sport and active recreation (which does not include everyday physical activities such as walking or cycling to work). This was modified to a proxy of 5 x 30 minutes in 2010. The latest data for this indicator were published in June 2010 and indicated that participation levels (in sport and active recreation) across Hampshire remained relatively static at 24%. District Councils reported that participation at leisure centre venues is down but participation in wider community programmes is increasing.

3.6 Adult Obesity

Obesity is defined as a person having a Body Mass Index (BMI) of 30kg/m² or greater. It is a major risk factor for many serious illnesses including coronary heart disease, diabetes, stroke, osteoarthritis and some types of cancer. Obesity is more common in deprived populations and amongst women in lower socio-economic groups. The National Obesity Observatory website¹¹ contains a wealth of obesity-related data for adults and children.

During 2006/08 the estimated prevalence of obese adults in Hampshire was 23% of the population. This was similar to national and regional estimates of obesity (both 24%). The data show there has been no substantial change to obesity prevalence in Hampshire’s districts in the last two years. Rushmoor, Havant, Basingstoke and Deane and Eastleigh had obesity prevalences slightly higher than the national average.

¹¹ http://www.noo.org.uk/
3.7 Drug misuse

During 2007/8, there were 1,995 adult drug users in Hampshire accessing structured treatment. Hampshire has an estimated Problematic Drug Using (PDU) population of 3,065, the second largest in the south east region commensurate with its relative size. This represents a 2% increase on the previous year’s estimate of need. During 2007/8, 1,758 PDUs had accessed structured treatment at some point with a further 344 known to services but not accessing structured treatment during that year. An estimated 963 or 31% of adults (aged 15 – 64) using opiates or crack cocaine remained treatment naïve – a 3% improvement on the previous year. Eleven percent of clients accessing treatment stated alcohol as either a primary, secondary or third drug.¹²

Hampshire has comparatively low levels of crack cocaine use – the prevalence being 50% of the regional average. However, despite a 20% reduction since 2005/6, there remains a sizeable PDU population (estimated at 1,272) using crack as either their primary or secondary drug of choice. The proportion of females as a percentage of the treatment population in Hampshire increased slightly from 27% to 28% between 2006/7 and 2007/8.¹⁰

The 15-24 year old age group (145,573) represents 17.2% of the total Hampshire population aged 15-64 (844,017). In 2007/8, this age group represented 18.0% of the total treatment population when considering all drugs – this is higher than either the regional or national average (15.6% and 12.5% respectively). However, when looking specifically at Problematic Drug Use, it can be seen that, in common with

¹² Hampshire Drug and Alcohol Action Team (DAAT) Adult drug treatment plan 2009/10
http://www3.hants.gov.uk/education/dat/treatment.htm
regional and national experience, penetration levels are relatively lower than for older age groups.\textsuperscript{10}

**Figure 3.13: estimates of prevalence of drug use**

<table>
<thead>
<tr>
<th></th>
<th><strong>Hampshire</strong></th>
<th><strong>South East</strong></th>
<th><strong>Ranking within South East</strong></th>
<th><strong>Prevalence rate ratio</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007/08</td>
<td>2007/08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence per 100,000 population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PDUs</td>
<td>3.72</td>
<td>5.61</td>
<td>17</td>
<td>66.3%</td>
</tr>
<tr>
<td>Opiate Users</td>
<td>3.19</td>
<td>4.63</td>
<td>16</td>
<td>68.9%</td>
</tr>
<tr>
<td>Crack Cocaine Users</td>
<td>1.54</td>
<td>3.07</td>
<td>19</td>
<td>50.2%</td>
</tr>
<tr>
<td>injecting Drug Users</td>
<td>1.56</td>
<td>2.03</td>
<td>12</td>
<td>76.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Hampshire</strong></th>
<th><strong>South East</strong></th>
<th><strong>Ranking within South East</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2007/08</td>
<td>2007/08</td>
<td></td>
</tr>
<tr>
<td>By Age Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 15 - 24</td>
<td>4.2</td>
<td>5.52</td>
<td>16</td>
</tr>
<tr>
<td>Age 25 - 34</td>
<td>8.4</td>
<td>12.55</td>
<td>16</td>
</tr>
<tr>
<td>Age 35 - 64</td>
<td>2.34</td>
<td>3.52</td>
<td>13</td>
</tr>
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</table>

<table>
<thead>
<tr>
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<th><strong>South East</strong></th>
<th><strong>Ranking within South East</strong></th>
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<tbody>
<tr>
<td></td>
<td>2007/08</td>
<td>2007/08</td>
<td></td>
</tr>
<tr>
<td>Individuals (numbers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PDUs</td>
<td>3,065</td>
<td>30,309</td>
<td>2</td>
</tr>
<tr>
<td>Opiate Users</td>
<td>2,629</td>
<td>25,018</td>
<td>2</td>
</tr>
<tr>
<td>Crack Cocaine Users</td>
<td>1,272</td>
<td>16,585</td>
<td>4</td>
</tr>
<tr>
<td>injecting Drug Users</td>
<td>1,281</td>
<td>10,951</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Hampshire</strong></th>
<th><strong>South East</strong></th>
<th><strong>Ranking within South East</strong></th>
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<tbody>
<tr>
<td></td>
<td>2007/08</td>
<td>2007/08</td>
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</tr>
<tr>
<td>By Age Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 15 - 24</td>
<td>626</td>
<td>5,696</td>
<td>2</td>
</tr>
<tr>
<td>Age 25 - 34</td>
<td>1,191</td>
<td>12,781</td>
<td>3</td>
</tr>
<tr>
<td>Age 35 - 64</td>
<td>1,248</td>
<td>11,831</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Hampshire Drug and Alcohol Action Team (DAAT) Adult drug treatment plan 2009/10

3.8 **Key messages**

This chapter has provided an overview of lifestyles and risk factors in Hampshire. It illustrates the following:

- The people of Hampshire have better health outcomes than national and regional averages across all lifestyle indicators.
- However risky behaviours continue to be more common (and similar to the England average) in parts of Gosport and Havant, and to a lesser extent in Rushmoor.
- There will be wide variations within districts which are masked by district-level data.
4. Burden of Ill Health

Summary:

- **Circulatory disease**
  The crude prevalence of coronary heart disease (3.3%), hypertension (13.7%) and stroke (1.7%) in Hampshire during 2009/10 were similar to the national crude prevalence. These county wide figures will mask variations at a local level. The rate of admission to hospital for heart attack was highest in Rushmoor, Gosport and Havant, and rate of stroke admissions was highest in New Forest. Progress is being made towards treating all people with acute heart problems with primary angioplasty (balloon) rather than thrombolysis (drugs to dissolve the clot); however this is not uniform across Hampshire.

- **Diabetes**
  The crude prevalence of diabetes in people aged 17 and over in Hampshire during 2009/10 was 5% which was similar to the national prevalence of 5.4%. Hospital admissions for diabetes were high in Basingstoke and Deane which is not matched by a high prevalence of diabetes. Havant had both high prevalence and high hospital admissions, whereas Rushmoor had relatively low prevalence but relatively high admissions. We know that a significant proportion of diabetes may be undiagnosed in the population and this, plus differing clinical practice by GPs and hospitals across Hampshire may explain some of these differences.

- **Cancer**
  The incidence of cancer in Hampshire during 2004/06 was similar to the national average. The incidence of lung cancer in Hampshire was lower than the national average except in Gosport where it was higher than the national average. The incidence of breast cancer in Hampshire was higher than the national average, which is consistent with evidence that shows breast cancer is more common in more affluent populations. Cervical cancer incidence in Hampshire was similar to the national average, as was incidence of colorectal (or bowel) cancer. Prostate cancer incidence was similar to the national average, but with variation by district. New Forest had the highest incidence but some of this will be related to increased case finding rather than any actual increase in incidence. Rushmoor had the lowest incidence of prostate cancer. Five year survival rates from common cancers across Hampshire were generally better than national survival rates, particularly for colorectal and prostate cancer.

- **Respiratory: chronic obstructive pulmonary disease (COPD)**
  The crude prevalence of COPD across Hampshire during 2009/10 was 1.3%, which was lower than the national prevalence of 1.6%. Eastleigh had high rates of admission to hospital for COPD which is not matched by high crude prevalence or mortality.

- **Infectious diseases**
  The incidence of TB in Hampshire during 2006/08 was lower than the national average, except Rushmoor where the incidence was similar to the national average. The rates of sexually transmitted infections in Hampshire during 2009
were generally lower than the national average. The prevalence of HIV in Hampshire was lower than the national average, whereas the number of people diagnosed late with HIV was similar to the national average. The number of vulnerable adults vaccinated against seasonal flu and pneumococcal infection was higher than the national averages, but a significant proportion of vulnerable adults remained unvaccinated and therefore at risk of infection.

- **Dental health**
  Access to NHS primary care dental services has been increased across Hampshire. Since April 2008 new dental practices have opened in Romsey, Gosport, Holbury, Petersfield, Hamble, Waterlooville, Alton, Bursledon, Basingstoke, Lymington, Bordon, Cowplain/Bedhampton, Chandlers Ford, Winchester and Fareham. New practices are due to open in Hook, Eastleigh, Hedge End and Havant and a number of existing practices have extended their contracts to see more NHS patients. A new pathway for orthodontic care was introduced in September 2008, which supports patients who meet the criteria for NHS orthodontic care to receive treatment as quickly as possible. Work is ongoing to develop and implement a pathway for minor oral surgery to enable patients to receive care from their dentist or locally for a range of specialist treatments, rather than in hospital. Improvements to special care dental services include more treatments provided at home for those unable to travel.

- **Mental health**
  The crude prevalence of depression across Hampshire during 2009/10 was 9.4%, which was higher than the national prevalence of 8.5%. This may be more people seeing their GP with symptoms and being diagnosed as being depressed, rather than depression being more common in Hampshire. The crude prevalence of mental illness (antisocial personality disorder, borderline personality disorder and psychotic disorder) in Hampshire during 2009/10 was 0.6%, which was lower than the national prevalence of 0.8%. The prevalence of dementia in men in Hampshire was 5.8%, which was similar to the national prevalence. The prevalence of dementia in women in Hampshire varied markedly across the county, although the overall prevalence at 8.4% was similar to the national prevalence.

- **Avoidable injury and accidents**
  The rate of hospital admissions for a broken hip in people over the age of 65 in Hampshire during 2008/09 was similar to national and regional rates. Admission rates in Fareham (370.6 admissions per 100,000) were significantly lower than national and regional rates of 479.2 and 473.0 admissions per 100,000 respectively. The number of road casualties aged over 60 in Hampshire has reduced over the last two years, from a total of 558 in 2007 to 411 in 2009.

- **Musculoskeletal**
  According to recently published research, Havant has the greatest need for knee and hip replacements in Hampshire, followed by Gosport and New Forest. However this is not matched by hospital admission rates for hip and knee

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13 Modelling the need for hip and knee replacement surgery. Part 2. Incorporating census data to provide small-area predictions for need with uncertainty bounds. Andy Judge, Nicky J. Welton, Jat Sandhu, Yoav Ben-Shlomo. Arthritis Care & Research 61 (12): 1667–1673
replacements in these districts.

- **Self report of long term illness and health**
  Self-reported measures of good health were generally higher in Hampshire than the national average. The exceptions are Gosport and Havant, where the percentage of people self-reporting good health was lower than the national average.

### 4.1 Introduction

This chapter contains information on the burden of ill health report by adults in Hampshire. Wherever possible, information for Hampshire and its eleven districts have been benchmarked against England and the south east.

In order to provide health and social care services that meet population need, we need to know what diseases or health problems our local population is experiencing, the number of people affected and where they are. Although we have good mortality data, obtaining robust information about the burden of disability and ill health is less simple.

General Practitioners get paid to record information about disease prevalence in the community. The Quality and Outcomes Framework (QOF) records the prevalence of chronic disease as submitted by general practice disease registers. QOF is the quality measurement process at the heart of the GP contract system. QOF recording is internet-based and compiled by QMAS (Quality Management and Analysis System), a database which is fed automatically from GP practice systems after manual data entry by practice staff.

QOF has four main sections, one of which is ‘clinical’ and comprises information on the treatment of patients in 19 domains representing major diseases or areas of care. Eight of these domains are discussed in this chapter. An important feature of the QOF is the disease registers. It is the responsibility of each GP practice to show that it has systems in place to maintain a high quality register for each domain.

QOF can be used to measure the prevalence of an illness (morbidity) in a population. The system has limitations. It is a GP payment system fed by practice staff, using READ codes which are subject to variation in interpretation. It reflects the results of GP-patient contact rather than population data.

The tables and charts shown are based on crude prevalence which take no account of the demographic features of the population or of ‘multiple registrations’. It does however give a general overview. Figures for districts are derived by assigning to the appropriate district the proportion of each practice population registered as resident in that district.

For comparative purposes, the Association of Public Health Observatories (APHO) developed disease prevalence models to estimate “expected” values for some of the QOF clinical indicators. These models use data from a range of sources to estimate local prevalence rates, taking into account other factors such as age, sex, ethnicity, deprivation, and estimated levels of smoking. At any given time there are

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people who have a disease but are not aware of it because it has not yet been
diagnosed. Disease prevalence models provide estimates of the real prevalence in
the population. These data help us assess the true health needs of communities,
calculate the level of services needed and invest the appropriate level of resources
for prevention, early detection, treatment and care. The models can also be used to
support case-finding by identifying those areas where detection rates are low and
targeting enhanced diagnostic activity on them.

If the reported QOF data is higher than the expected values, then this may be as a
result of:
(1) Higher risk for condition within local population
(2) Poor coding of patients’ conditions
(3) Effective case finding
(4) Ineffective prevention of incidence

Similarly, if the reported QOF data is lower than the expected values, then this may
be as a result of:
(1) Lower risk for condition within local population
(2) Poor coding of patients’ conditions
(3) Ineffective case finding
(4) Effective prevention of incidence

4.2 Circulatory Disease
The term circulatory disease includes all forms of disease of the heart and blood
vessels. It includes coronary heart disease, hypertension and stroke, which are
discussed in this section.

Coronary heart disease (CHD)
Most CHD is preventable, but it remains the biggest cause of premature death in
England. CHD is more prevalent in lower socio-economic groups and in certain
ethnic minorities and certain geographic areas. Men have a higher prevalence of
CHD than women, although the risk for women increases after menopause. The risk
of CHD increases with age. Many factors influence the risk and prognosis of CHD
including cigarette smoking, hypertension, physical inactivity, high serum
cholesterol, diabetes, heavy alcohol consumption, family history and obesity.

Recorded prevalence of CHD
The crude recorded prevalence of CHD in Hampshire during 2009/10 was 3.3%
which was similar to the national prevalence of 3.4%. New Forest (4.3%), Havant
(4.3%), Gosport (3.9%) and Fareham (3.7%) all had a crude CHD prevalence
significantly higher than the national average.
**Figure 4.1: crude recorded prevalence of CHD**

![Chart showing crude recorded prevalence of CHD in Hampshire](chart.png)

**Source:** The Health and Social Care Information Centre. QMAS database.

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**Recorded versus modelled prevalence of CHD**

Figure 4.2 shows a comparison of recorded prevalence (patients already diagnosed with CHD) and modelled prevalence (an estimate of the likely true prevalence of CHD) for each GP practice in Hampshire. The recorded prevalence is generally lower than the estimated prevalence.

**Figure 4.2: comparison of recorded versus modelled prevalence of CHD, showing each GP practice by district**

![Comparison chart showing recorded versus modelled prevalence](comparison_chart.png)

**Hypertension**

Hypertension means high blood pressure. It is a very common condition. Key associations include: salt intake; low birth weight; obesity; physical inactivity and age related hardening of the arteries. Untreated hypertension contributes to a higher risk of stroke, CHD and retinal and renal damage.
Recorded prevalence of hypertension
The crude recorded prevalence of hypertension in Hampshire during 2009/10 was 13.7%, which was similar to the national average of 13.4%. Fareham (16.2%), Havant (16%), New Forest (15.8%) and Gosport (14.3%) all had hypertension prevalences higher than the national average.

Figure 4.3: crude recorded prevalence of hypertension in people of all ages

Recorded versus modelled prevalence of hypertension
Figure 4.4 shows a comparison of recorded prevalence (patients already diagnosed with hypertension) and modelled prevalence (an estimate of the likely true prevalence of hypertension) for each GP practice in Hampshire. The recorded prevalence is generally lower than the estimated prevalence.

Figure 4.4: comparison of recorded versus modelled prevalence of hypertension, showing each GP practice by district
**Stroke**

Stroke is the third biggest killer in the UK and the most common cause of disability. Many strokes are preventable with lifestyle changes and medication. Men are more likely to have a stroke than women, although the risk for women increases after menopause. The risk of stroke increases with age. There is also higher risk of stroke for individuals of South Asian, African and African-Caribbean origin. The risk factors for stroke are broadly similar to those for CHD.

**Recorded prevalence of stroke**

The crude recorded prevalence of stroke across Hampshire during 2009/10 was 1.7%, which was the same as the national average. The New Forest (2.4%), Havant (2%), Test Valley (1.9%) and Winchester (1.9%) all had crude stroke prevalence higher than the national average.

**Figure 4.5: crude prevalence of stroke, all people all ages**

![Chart showing crude prevalence of stroke across Hampshire](chart.png)

*Source: The Health and Social Care Information Centre. QMAS database.*

**Recorded versus modelled prevalence of stroke**

Figure 4.6 shows a comparison of recorded prevalence (patients already diagnosed with stroke) and modelled prevalence (an estimate of the likely true prevalence of stroke) for each GP practice in Hampshire. The recorded prevalence is generally lower than the estimated prevalence.
**Hospital admission and treatment for cardiovascular disease**

This section presents data on hospital admissions and treatment for cardiovascular disease including heart attack and stroke.

**Hospital admissions for heart attack and stroke**

The rate of admission to hospital for a heart attack was 49.8 per 100,000 population and for stroke it was 69.5 per 100,000 population in Hampshire during the period 2007/08-2009/10. As almost all people who have an acute heart attack or stroke and who make contact with health services are admitted to hospital, these indicators can be used as a fairly reliable measure of need. For heart attack, the highest admission rates were seen in Rushmoor, Gosport and Havant, all of which were significantly higher than the Hampshire average. For stroke only New Forest had an admission rate statistically significantly higher than the Hampshire average. In general the districts with the highest prevalence of cardiovascular disease also had the highest admission rates for heart attack, but less so for stroke.
**Figure 4.7:** hospital admissions for heart attack

![Graph showing hospital admissions for heart attack from 2007/08 to 2009/10, with rates per 100,000 population for various areas.](image)

**Sources:** CDS received from Provider Trusts via SUS & ONS Mid Year Population Estimates pro-rated using HCC Population Forecasts.

**Figure 4.8:** hospital admissions for stroke, all ages

![Graph showing hospital admissions for stroke from 2007/08 to 2009/10, with rates per 100,000 population for various areas.](image)

**Sources:** CDS received from Provider Trusts via SUS & ONS Mid Year Population Estimates pro-rated using HCC Population Forecasts.

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**Emergency hospital treatment of acute coronary syndrome**

Acute coronary syndrome (ACS) is part of the spectrum of conditions which includes heart attack, or myocardial infarction. ACS includes both ST elevation myocardial infarction (STEMI) for which emergency treatment with thrombolytic (clot-busting) drugs or primary angioplasty is used and non ST elevation myocardial infarction (nSTEMI), which represent the majority and for whom a different approach is required.\(^{15}\)

The national standard for high quality care for STEMI includes rapid diagnosis and treatment to re-open the blocked coronary artery responsible. Two forms of

treatment are available; primary angioplasty, where the artery is re-opened mechanically using a balloon catheter inserted into the blocked artery and thrombolytic treatment, where the clot is dissolved by a drug given by ambulance or hospital staff. Delay to either treatment is associated with poorer outcomes. Primary angioplasty (also known as pPCI, or primary percutaneous coronary intervention) is the preferred treatment and national standard if it can be provided promptly.

The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. It supplies participating hospitals and ambulance services with a record of their management and compares this with nationally and internationally agreed standards. Data from the most recent MINAP report confirms the move away from thrombolysis to pPCI. According to MINAP about 25% of STEMI patients do not receive treatment. This may be because patients present too late to benefit from treatment, treatment is contraindicated because of severe comorbidities, or angioplasty demonstrates that pPCI will not improve outcome.

Figure 4.9 shows the trend towards pPCI and away from thrombolysis across South Central hospitals in recent years. In 2009/10 South Central hospitals were treating a higher proportion of patients with pPCI than nationally.

Figure 4.9: trend in STEMI treatment in South Central hospitals


The main hospitals used by residents of Hampshire are Southampton General Hospital, Queen Alexandra Hospital (Portsmouth), North Hampshire Hospital

(Basingstoke), Royal Hampshire County Hospital (Winchester), and Frimley Park Hospital (Frimley, Surrey). Figure 4.10 shows the proportion of pPCI to thrombolysis given at each hospital during 2009/10. The Royal Hampshire County Hospital does not provide pPCI. Between them Southampton General Hospital and Queen Alexandra Hospital are estimated to treat half of NHS Hampshire’s STEMI patients.

**Figure 4.10: STEMI treatment in NHS Hampshire’s main hospitals**

![Graph showing STEMI treatment in NHS Hampshire’s main hospitals](image)


**Cardiac revascularisation**

This indicator looks at the rate of hospital admissions for CABG (Coronary Artery Bypass Graft) and PTCA (Percutaneous Transluminal Coronary Angioplasty) in people with cardiovascular disease. It includes people admitted for emergency operations (such as pPCI described above) as well as people whose intervention is planned. The need to aggregate five years of data in order to give sufficient numbers of admissions to make analysis possible means that trends in service provision over this time period may be masked (such as the increasing provision of pPCI in certain hospitals in recent years as described above).

Figures 4.11 and 4.12 show that during 2005/06 to 2009/10, the rate of hospital episodes for CABG was statistically significantly higher in Rushmoor compared to the Hampshire average and statistically significantly lower in Winchester. For PTCA Basingstoke and Deane, New Forest and Rushmoor had relatively higher rates of hospital episodes, while Test Valley and Winchester had relatively lower.
4.3 Diabetes

Diabetes occurs when there is too much sugar in the blood. There are two types of diabetes. Type 1 requires insulin for treatment and usually has an onset in childhood or as a young person with declining incidence thereafter. Type 2 is the most common type of diabetes and can be treated with diet, tablets or insulin depending on its severity. Type 2 is most usually diagnosed in adults aged 40 years and more. If diabetes is not controlled it leads to a range of associated health problems
including: heart disease; kidney failure; blindness and amputation and increased risk of infection.

The incidence of diabetes is increasing nationally as the incidence of obesity increases. Diabetes prevalence is higher in areas of greater deprivation. People living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas. People from some ethnic groups (Asian and Afro-Caribbean) are more likely to develop diabetes and tend to develop it at younger ages.\textsuperscript{17}

\textit{Recorded prevalence of diabetes}

The crude recorded prevalence of diabetes in people aged 17 and over in Hampshire during 2009/10 was 5\% which was similar to the national prevalence of 5.4\%. Havant (6.1\%) and Gosport (5.8\%) had crude diabetes prevalence higher than the national average.

\textbf{Figure 4.13: recorded prevalence of diabetes in people aged 17 and over}

\textit{Recorded versus modelled estimates of diabetes prevalence}

The estimated prevalence of diabetes in people aged 17 and over in Hampshire during 2009 was 6.7\%, slightly lower than the estimated national prevalence of 7.3\% in the same population. The data in figure 4.14 show that 71.5\% of people in Hampshire who are estimated to have diabetes are already recorded as having diabetes on QOF registers. This means that there may be up to a further 20,000 people (29\%) living with diabetes who are not captured on a diabetes register.

\textsuperscript{17} http://yhpho.york.ac.uk/diabetesprofiles/pdf/5QC_Diabetes%20Profile.pdf
Figure 4.14: numbers of people estimated to have diabetes, 2009

<table>
<thead>
<tr>
<th></th>
<th>Modelled estimates of numbers with diabetes</th>
<th>Modelled estimates of prevalence</th>
<th>Lower uncertainty limit</th>
<th>Upper uncertainty limit</th>
<th>QOF 2008/09 numbers with diabetes (aged 17+ years)</th>
<th>Proportion of estimated cases on QOF registers</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>3,034,972</td>
<td>7.3%</td>
<td>5.3%</td>
<td>10.7%</td>
<td>2,213,138</td>
<td>72.9%</td>
</tr>
<tr>
<td>South Central SHA</td>
<td>212,284</td>
<td>6.5%</td>
<td>4.7%</td>
<td>10.2%</td>
<td>151,847</td>
<td>71.5%</td>
</tr>
<tr>
<td>Hampshire</td>
<td>69,075</td>
<td>6.7%</td>
<td>5.0%</td>
<td>9.4%</td>
<td>49,048</td>
<td>71.0%</td>
</tr>
</tbody>
</table>

Source: APHO diabetes prevalence model. Last updated 28/9/2010

**Hospital admission rates for diabetes**

Hospital admissions for diabetes have decreased across all districts in Hampshire since 2008, with the exception of Rushmoor where admissions have remained static. Diabetic admissions in Basingstoke and Deane, despite a significant decrease since 2008, remain significantly higher than the rest of Hampshire, including Rushmoor. This may reflect differences in coding practice between hospital trusts or historical clinical patterns. It is unlikely to be a result of higher need in this area, as the recorded prevalence of diabetes for Basingstoke and Deane is similar to the county and regional averages. Havant has both high prevalence and high admissions. However Rushmoor has relatively low prevalence but relatively high admissions, suggesting there may be a larger population living in Rushmoor with undiagnosed diabetes, a difference in coding practice (diagnosis or admissions) or a difference in what local GPs do and what they expect their hospital colleagues to do.

The main reasons for diabetic hospital admissions are listed in figure 4.16. The greatest proportion of admissions (19%) was ketoacidosis in insulin-dependent diabetics. A breakdown of these admissions by district for the time period 2007/08 to 2009/10 showed Gosport, Havant and Rushmoor had significantly higher admissions for this condition than other districts in Hampshire.

Figure 4.15: hospital admissions for diabetes, all ages
Figure 4.16: reason for diabetic hospital admissions, 2007/08 to 2009/10

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th>% of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin-dependent diabetes mellitus with ketoacidosis</td>
<td>19</td>
</tr>
<tr>
<td>Unspecified diabetes mellitus with ophthalmic complications</td>
<td>16</td>
</tr>
<tr>
<td>Insulin-dependent diabetes mellitus without complications</td>
<td>12</td>
</tr>
<tr>
<td>Non-insulin-dependent diabetes mellitus with peripheral circulatory complications</td>
<td>11</td>
</tr>
<tr>
<td>Non-insulin-dependent diabetes mellitus without complications</td>
<td>11</td>
</tr>
<tr>
<td>Non-insulin-dependent diabetes with ophthalmic complications</td>
<td>5</td>
</tr>
<tr>
<td>Insulin-dependent diabetes mellitus with ophthalmic complications</td>
<td>4</td>
</tr>
<tr>
<td>Non-insulin-dependent diabetes mellitus with ketoacidosis</td>
<td>3</td>
</tr>
<tr>
<td>Insulin-dependent diabetes mellitus with peripheral circulatory complications</td>
<td>2</td>
</tr>
<tr>
<td>Unspecified diabetes mellitus with renal complications</td>
<td>2</td>
</tr>
<tr>
<td>Unspecified diabetes mellitus without complications</td>
<td>2</td>
</tr>
<tr>
<td>Non-insulin-dependent diabetes mellitus with renal complications</td>
<td>2</td>
</tr>
<tr>
<td>Unspecified diabetes mellitus with peripheral circulatory complications</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: CDS received from Provider Trusts via SUS & ONS mid year population estimates pro-rated using HCC population forecasts

Figure 4.17: hospital episodes for ketoacidosis and diabetic coma

Diabetes retinopathy screening
Diabetes affect people’s blood vessels. By the time a person has known to be diabetic for a decade they will have sustained some degree of blood vessel
damage. Commonly the small vessels at the back of the eye, the retina sustain damage and this can result in localised bleeding and sight loss. This is the most common preventable cause of blindness in the working age population. It may not cause symptoms until the disease is at an advanced stage. All people with diabetes are at some risk of getting diabetic retinopathy, but people who have had diabetes for a long time, whose diabetes is poorly controlled, who have high blood pressure or who are on insulin are at higher risk.\textsuperscript{18}

The national screening programme for diabetic retinopathy aims to reduce the risk of sight loss amongst people with diabetes by identifying and treating sight threatening diabetic retinopathy. All people aged 12 and over with diabetes are invited to attend for diabetic retinopathy screening every year.\textsuperscript{19}

During 2009/10 in Hampshire 92\% of people with diabetes (age 17 and over) were screened for diabetic retinopathy. These data have been taken from QOF registers, which record diabetes in people age 17 and above. Children and young people (age 12 to 16) with diabetes are not included in the QOF register but are invited for screening. In June 2010 there were estimated to be around 250 12 to 16 year old diabetics in Hampshire.

\textbf{Figure 4.18: percentage of diabetics age 17 and over screened for diabetic retinopathy, 2009/10}

A proportion of the 8\% of diabetics in Hampshire who were not screened during 2009/10 will have been excluded from screening for a variety of reasons. These reasons include: informed choice not to be invited for screening; no perception of light in either eye; terminally ill; physical or mental disability preventing either screening or treatment; or currently under the care of an ophthalmologist for the

\textsuperscript{18} http://www.retinalscreening.nhs.uk/userFiles/File/diabeticRetinopathyFacts.pdf
\textsuperscript{19} http://www.retinalscreening.nhs.uk/userFiles/File/EyeScreeningForDiabetes.pdf
treatment and follow-up management of diabetic retinopathy.

Figures 4.19 and 4.20 show the proportion of unscreened diabetics in Hampshire during 2009/10, and the reasons for not being screened. The proportion of unscreened diabetics was significantly higher than the national average in Basingstoke and Deane and Rushmoor.

**Figure 4.19: proportion of diabetics aged 17 and over who did not attend diabetic retinopathy screening, 2009/10**

Source: The Health and Social Care Information Centre. QMAS database.

**Figure 4.20: breakdown of reasons for not attending screening**

Source: The Health and Social Care Information Centre. QMAS database.
4.4 Cancer

Some of the most common cancers are included within this section. Breast cancer is a major cause of mortality in women and is more likely as women get older. Lung cancer affects more men than women; however an increasing number of women are becoming affected. Colorectal cancer is the third most common cancer in men and the second most common in women and 90% of cases occur in people over 50 years old.

Cancer incidence is the number of newly diagnosed cases registered during a specific time period. Incidence is presented here as directly standardised rates per 100,000 population. Cancers are registered after diagnosis with the regional cancer registry (for Hampshire, this is the Oxford Cancer Intelligence Unit).

The incidence of some cancers is associated with deprivation. For example, lung cancer (associated with smoking) is more common in both sexes in the most deprived groups, whereas breast and prostate cancer are both more common in the least deprived groups. Conversely there is no association between deprivation and the incidence of colorectal cancer. For colorectal cancer and breast cancer, there are significant associations between increasing deprivation and poorer survival. For lung cancer, 5 year survival is low (less than 10%) in both sexes and across all deprivation groups with no clear trend.

The reasons for the association between deprivation and survival for some cancers could include later stage at presentation, poorer access to or uptake of screening, diagnostic and treatment services, the presence of significant co-morbidities, and/or variations in the quality and effectiveness of treatment services.\(^\text{20}\)

Detailed intelligence on cancer is available from the National Cancer Intelligence Network.\(^\text{21}\)

Cancer incidence in Hampshire

During 2004/06, around 19,000 people in Hampshire were diagnosed with cancer. When expressed as a rate this was 370.5 new cases of cancer per 100,000 population, which was similar to the national incidence rate of 372.4 new cases per 100,000 population. Cancer incidence across the 11 districts varied but was mostly similar to the national rate, apart from Rushmoor where the rate of 312 new cases per 100,000 population was significantly lower than the national rate.

\(^{20}\) http://www.sepho.org.uk/Download/Public/11214/1/South%20Central%20inequalities%20factsheet%20FINAL.pdf

\(^{21}\) http://www.apho.org.uk/addons/_94538/atlas.html
Lung cancer

Lung cancer is the second most common cancer diagnosed in the UK after breast cancer. Around 39,000 people were diagnosed with lung cancer in the UK in 2007. More than 8 in 10 lung cancer cases occur in people aged 60 and over. Smoking causes almost 90% of lung cancer deaths and stopping smoking before middle age avoids most of the risk of smoking-related lung cancer. Living with someone who smokes, increases risk of lung cancer in non-smokers by about a quarter. A small proportion of lung cancer cases are caused by heavy exposure to industrial carcinogens and air pollutants, including diesel exhaust, asbestos, non-ferrous metals, silica, polycyclic aromatic hydrocarbons and nitrogen oxides.\(^\text{22}\)

Lung cancer incidence

Over the three year period from 2004/06, around 1900 people in Hampshire were diagnosed with lung cancer. When expressed as an incidence rate, this was 34.7 new cases of lung cancer per 100,000. This was significantly lower than the national incidence of 49.5 new cases per 100,000. The highest incidence in Hampshire is seen in Gosport, where the incidence of 55.0 per 100,000 population is higher than the national average.

\(^{22}\) Cancer Research UK [http://info.cancerresearchuk.org/cancerstats/types/lung/]
Breast cancer

Breast cancer is now the most common cancer in the UK. In 2007 almost 45,700 women were diagnosed with breast cancer. 8 in 10 women diagnosed with breast cancer are over the age of 50. 

During 2004/06, 3230 women were diagnosed with breast cancer in Hampshire. Expressed as an incidence rate this was 130.7 new cases per 100,000 women. This was significantly higher than the national rate of 122.8 new cases per 100,000 women. In general, we know that more affluent women have a higher incidence of breast cancer than women from more deprived populations. The incidence was highest in Test Valley with 144.9 new cases per 100,000 women, followed by the New Forest with 143.1 new cases per 100,000 women. Both of these are higher than the national and regional averages. The lowest incidence was seen in Rushmoor (117.9 new cases per 100,000 women). All districts except Winchester saw a small rise in breast cancer incidence, but only in Hart was this rise statistically significant.

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23 Cancer Research UK http://info.cancerresearchuk.org/cancerstats/types/breast/
Figure 4.23: incidence of breast cancer, all women

Breast cancer screening uptake
During 2009, 80% of women aged 53-64 eligible for breast cancer screening in Hampshire were screened. This compares favourably to the national and regional screening uptake of 77% and 78% respectively. Gosport, Havant and Rushmoor had slightly lower screening uptakes which were comparable to the national uptake.

Figure 4.24: percentage of women aged 53-64 screened in three years (2009)
Cervical cancer
Cervical cancer is the eleventh most common cancer in women in the UK and the third most common gynaecological cancer after uterus (womb) and ovary. There were around 2,830 new cases of cervical cancer diagnosed in the UK in 2007. More than half of all new cases of cervical cancer are diagnosed in women under 50 years.

Infection with the human papillomavirus (HPV) is one of several risk factors for developing cervical cancer. Infection with other sexually transmitted infections such as HIV/AIDS, herpes simplex virus-2 or chlamydia trachomatis may increase risk of cervical cancer. Smoking increases the risk of squamous cell cervical cancer, as does long term use of the oral contraceptive pill.

Although cervical cancer is not amongst the most common cancers affecting women, it can be successfully treated if detected early. The NHS Cervical Screening Programme was set up in 1988 by the Department of Health. As a result of the screening programme, cervical cancer incidence in the UK has halved over the last 20 years. Cervical screening can prevent around 75% of cancer cases in women who attend regularly. HPV vaccination in schools was introduced into the national immunisation programme in 2008 for girls aged 12-13 as a further measure to prevent cervical cancer.

Cervical cancer incidence
During a three year period (2006/08), 173 women in Hampshire were diagnosed with cervical cancer, which is a rate of 8 new cases of cervical cancer per 100,000 women. This rate is comparable to the national and regional incidence rates. Because the overall numbers are low, it is not possible to display a rate for each local authority area.

Cervical cancer screening: uptake of service
During 2009, 81.6% of eligible women across Hampshire had been screened for cervical cancer in three years. This compares favourably to the national and regional uptakes of 78.9% and 80.1% respectively. There is little variation across Hampshire’s eleven districts with regards to uptake.

Cancer Research UK [http://info.cancerresearchuk.org/cancerstats/types/cervix/]
Figure 4.25: uptake of cervical cancer screening ('smear test') in women aged 25-64

Colorectal (or bowel) cancer
Colorectal cancer is the third most common cancer in the UK. About 38,610 people were diagnosed with bowel cancer in 2007 in the UK. Colorectal cancer incidence rates have remained relatively stable for over a decade. Risk factors for colorectal cancer include a high intake of red and processed meat, being overweight or obese, and drinking more than four units of alcohol per day. Protective factors include a diet rich in fibre.  

Colorectal cancer incidence
During the three year period of 2006/08, around 2500 people in Hampshire were diagnosed with colorectal cancer. When expressed as a rate this was 45 new cases per 100,000 population, which was the same as the national incidence. While there was variation in incidence in Hampshire’s 11 districts, all were similar to the national incidence.

26 Cancer Research UK [http://info.cancerresearchuk.org/cancerstats/types/bowel/]
**Prostate cancer**

Prostate cancer is the most common cancer in men in the UK. A quarter of all new cases of cancer diagnosed in men are prostate cancers, and in 2007 in the UK about 36,100 men were diagnosed with prostate cancer. Over the last 30 years prostate cancer rates in Great Britain have almost tripled, although much of the increase is due to increased detection through widespread use of the prostate specific antigen (PSA) test. More than half of prostate cancer cases are diagnosed in men aged over 70 years. The strongest risk factor for prostate cancer is age, with very low risk in men under the age of 50, but risk increasing with age thereafter. Men with one or more first-degree relatives (father, brother, or son) diagnosed with prostate cancer have an increased risk of prostate cancer, especially if the relative was diagnosed before the age of 60. West African and Afro-Caribbean men have a higher risk of prostate cancer than white men, whereas men born in Asia have a lower risk of prostate cancer than men born in the UK.\(^{27}\)

**Prostate cancer incidence**

During the three year period from 2004/06, around 2400 men in Hampshire were diagnosed with prostate cancer. Expressed as a rate, this was 99 new cases per 100,000 men, which was the same as the national rate. There was great variability in recorded prostate cancer incidence across Hampshire’s 11 districts. New Forest had the highest incidence with 126.6 new cases per 100,000 men. Some of this will be related to increased case finding rather than any actual increase in incidence. Rushmoor had the lowest incidence with 64.7 new cases per 100,000 men.

\(^{27}\) Cancer Research UK [http://info.cancerresearchuk.org/cancerstats/types/prostate/](http://info.cancerresearchuk.org/cancerstats/types/prostate/)
Five year survival rates from prostate, lung, colorectal, cervix and breast cancer

Figure 4.28 shows that five year survival rates from common cancers across Hampshire are generally better than national survival rates, particularly for colorectal and prostate cancer.

**Figure 4.28: percentage of people surviving five years after diagnosis for various cancers (diagnosis 1998-2002)**

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Percentage people surviving after five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Hampshire 82.7</td>
</tr>
<tr>
<td>Colorectal</td>
<td>57.5</td>
</tr>
<tr>
<td>Prostate</td>
<td>82.1</td>
</tr>
<tr>
<td>Lung</td>
<td>7.4</td>
</tr>
<tr>
<td>Cervix (survival data for women diagnosed 2001-03)</td>
<td>Not currently available</td>
</tr>
</tbody>
</table>

Source: [http://www.ncin.org.uk/analysis/eatlas.shtml](http://www.ncin.org.uk/analysis/eatlas.shtml)

4.5 Respiratory

**Chronic obstructive pulmonary disease (COPD)**

Chronic obstructive pulmonary disease is a lung disease characterised by progressive obstruction of lung airflow that interferes with normal breathing and is not fully reversible. Previously COPD was known as chronic bronchitis and emphysema. The major risk factor for COPD is smoking.
Recorded prevalence of COPD
The crude prevalence of COPD across Hampshire during 2009/10 was 1.3%, which was lower than the national prevalence of 1.6%. As with CHD, the prevalences displayed in figure 4.29 are crude, which means they have not been adjusted to take into account the different age structure of each district’s population. As COPD is generally more prevalent in older people, a local authority with a greater proportion of older people will therefore have a higher crude prevalence of COPD. Therefore it is not valid to make comparisons between districts for this indicator.

Figure 4.29: crude prevalence of COPD

Recorded prevalence versus modelled prevalence of COPD
Figure 4.30 shows a comparison of recorded prevalence (patients already diagnosed with COPD) and modelled prevalence (an estimate of the likely true prevalence of COPD in the community) for each GP practice in Hampshire. All districts have a portion of the population with unidentified COPD, particularly so in Eastleigh, Gosport and Havant. This would be expected from knowledge of smoking behaviours.

Figure 4.30: comparison of recorded COPD prevalence (from QOF) and modelled prevalence of COPD, showing each GP practice by local authority area
There is also a relationship between deaths from COPD and deaths attributable to smoking (see Mortality chapter for data on deaths attributable to smoking).

**COPD hospital admissions**

Admission rates for COPD decreased significantly across Hampshire during 2007/08-2009/10 compared to the data reported in the 2008 JSNA (2002/03-2006/07). Eastleigh continues to have the highest admission rates by some considerable margin, and warrants further investigation as this does not fit with the picture of COPD need in terms of prevalence and mortality.

**Figure 4.31: rate of hospital admissions for COPD, all people all ages**

4.6 **Infectious diseases**

*Tuberculosis (TB)*

In England and Wales TB is no longer an infection of the general population, rather it has become an infection affecting specific sectors of the population. During 2006/08 there were 48 new cases of TB in Hampshire, equating to an incidence of 3.8 new cases per 100,000 population. This rate was significantly lower than the national and regional incidence. All districts across Hampshire had a similarly low TB incidence, with the exception of Rushmoor where the incidence of 11.2 per 100,000 was similar to the national incidence. This higher incidence in Rushmoor is a consequence of the large number of Nepali people living there, as there is a high prevalence of TB amongst the general population in Nepal. However, the number of people with TB in each district is small, which means a single extra case of TB in any given year can cause significant variations in the statistics.
Sexually transmitted infections (STIs) and HIV

Latest data indicate that numbers of new cases of sexually transmitted infections (STIs) in the UK rose in 2009. The total number of new cases of STI diagnosed in genitourinary medicine (GUM) clinics and in community-based settings screening for chlamydia, rose by 3% last year, while other STI diagnoses rose by 2% over the same 12-month period. The rise in total numbers of new STI diagnoses between 2008 and 2009 was primarily associated with increased diagnoses of genital chlamydia (7%), gonorrhoea (6%), and genital herpes (5%).

Over the past 10 years there has been a substantial increase in diagnoses of many STIs, although diagnoses of gonorrhoea had been in fall. It is likely that increased transmission through unsafe sexual behaviour, especially among men who have sex with men (MSM), has contributed to the overall rise in STI diagnoses. However, to some extent, the apparent rise in diagnoses of gonorrhoea and genital herpes will have been due to increasing use of more sensitive molecular diagnostic tests. Likewise, improved availability of community-based chlamydia screening for young adults through the National Chlamydia Screening Programme (NCSP) has resulted in more chlamydia diagnoses.

Figure 4.33 shows the rates of selected STI and acute STI diagnoses for Hampshire, compared to national, SHA, and local PCTs. The rates of STI diagnoses in Hampshire are generally lower than national and SHA rates. Note that the rate of chlamydia diagnosis is related to the level of chlamydia screening commissioned by Hampshire PCT, therefore a low rate is not necessarily better.
Prevalence of HIV and percentage of HIV cases diagnosed late

HIV is a viral infection which leads to an impaired immune system resulting in serious illness and a reduction in life span. Through management of the infection with a combination of retroviral medication it is possible to delay the onset of acquired immunodeficiency (AIDs). During 2007, there were 7 people per 10,000 population known to be HIV-positive across Hampshire. This is significantly lower than the national rate of 16 HIV-positive people per 10,000 population. Please note that this indicator gives information the number of people already diagnosed with HIV; it does not provide information on number of new diagnoses of HIV.

Individuals diagnosed with HIV infection with CD4\textsuperscript{29} cell counts less than 200 cells per mm$^3$ are considered late diagnoses. They cannot start anti-HIV therapy as guidelines recommend and therefore may not fully benefit from therapy and have a higher risk of early HIV-related death. Timely diagnosis is therefore essential for the

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\textsuperscript{29} The immune system contains different types of cells that help protect the body from infection. One of these types of specialised cells is called the CD4 or T-cells. HIV attacks these types of cells and uses them to make more copies of HIV. In doing so, HIV weakens the immune system, making it unable to protect the body from illness and infection. People without HIV infection have about 700 to 1000 CD4 cells in a drop of blood the size of a pea. HIV infected people are considered to have “normal” CD4 counts if the number is above 500 CD4 cells in that same size drop of blood. If the number of CD4 cells in that drop of blood drops below 200 CD4 cells, the person is classified as having AIDS.
initiation of effective treatment. In 2008, 57% of HIV-infected individuals who died were diagnosed in the same year with a CD4 count <200 cells/mm³. During 2008, 28.8% of people diagnosed with HIV across Hampshire were classified as being diagnosed late. This is not significantly different to the national rate of late diagnosis (32.1%).

**Access to genitourinary medicine (GUM) clinics**
During 2009/10, 100% of people across Hampshire contacting a GUM service were offered an appointment within 48 hours. The percentage of people actually attending a service within 48 hours of making contact was lower at 85.8%.

**Vaccination of vulnerable and older people**

*Seasonal flu vaccination*
The seasonal flu vaccine is formulated each year to protect against the main strains of influenza which are circulating that year. It is recommended that persons aged under 65 and in specific at risk groups (chronic heart disease, chronic respiratory disease, chronic renal disease, chronic liver disease, diabetes, immunosuppression, stroke, chronic degenerative neurological disease) receive the vaccine as well as those aged over 65 years. While for most people influenza infection is just a nasty experience, for some such as those in the at risk groups, it can lead to more serious illnesses. The most common complications of influenza are bronchitis and secondary bacterial pneumonia. These illnesses may require treatment in hospital and can be life threatening. In Hampshire during 2008, 49.2% of the population eligible for this vaccination were vaccinated, compared to 47.1% nationally.

*Pneumococcal disease vaccination*
The pneumococcal polysaccharide vaccine protects against infection from a bacterium called Streptococcus pneumoniae. Streptococcus pneumoniae can cause diseases such as septicaemia, meningitis and pneumonia. Invasive disease particularly affects the very young, the elderly, those with an absent or non-functioning spleen and other causes of impaired immunity, therefore it is recommended that persons aged over 65 years receive the pneumococcal vaccine to prevent infection. Uptake of this vaccination in Hampshire was 74% during 2004-2008, which is higher than the national uptake of 69%. However this still means that 26% of vulnerable older adults remained unvaccinated and therefore at risk from pneumococcal infection.

4.7 **Dental health**
Access to NHS primary care dental services has increased across all of Hampshire’s districts, with further increases being introduced. Local dental practices are contracted to provide services based on units of dental activity (UDA). Figure 4.34 shows the number of UDAs currently contracted in each district compared with the number that will be contracted when current procurements are completed.

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Figure 4.34: current and planned units of dental activity in Hampshire

<table>
<thead>
<tr>
<th>District</th>
<th>Current UDAs per population</th>
<th>Planned UDAs per population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke</td>
<td>1.49</td>
<td>1.49</td>
</tr>
<tr>
<td>East Hants</td>
<td>1.16</td>
<td>1.16</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>1.54</td>
<td>1.97</td>
</tr>
<tr>
<td>Fareham</td>
<td>1.24</td>
<td>1.42</td>
</tr>
<tr>
<td>Gosport</td>
<td>1.71</td>
<td>1.71</td>
</tr>
<tr>
<td>Hart</td>
<td>1.04</td>
<td>1.28</td>
</tr>
<tr>
<td>Havant</td>
<td>1.51</td>
<td>1.75</td>
</tr>
<tr>
<td>New Forest</td>
<td>1.32</td>
<td>1.50</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>1.58</td>
<td>1.85</td>
</tr>
<tr>
<td>Test Valley</td>
<td>1.11</td>
<td>1.19</td>
</tr>
<tr>
<td>Winchester</td>
<td>1.67</td>
<td>1.67</td>
</tr>
</tbody>
</table>

Source: Primary Care Dental Services Team, NHS Hampshire

Since April 2008 new dental practices have opened in Romsey, Gosport, Holbury, Petersfield, Hamble, Waterlooville, Alton, Bursledon, Basingstoke, Lymington, Bordon, Cowplain/Bedhampton, Chandlers Ford, Winchester, Fareham. New practices are due to open in Hook, Eastleigh, Hedge End and Havant. A number of existing practices have also extended their contracts to enable more NHS patients to be seen.

Figure 4.35 shows a steady increase in the number of Hampshire residents accessing an NHS dentist between 2007-08 and 2009-10. Figure 4.36 shows these data as a percentage increase. This demonstrates there was a 3% increase in number of people accessing an NHS dentist in 2008-09 compared to 2007-08, and a further 7% increase in 2009-10 compared to 2008-09. Figure 4.37 shows the number of people accessing NHS dentists by local authority.
Figure 4.35: number of Hampshire patients treated annually by an NHS dentist between 2007-08 and 2009-10

Number of Patients Accessing an NHS Dentist between 2007-08 until 2009-10

Source: NHS Business Services Authority
Figure 4.36: annual percentage difference in the number of Hampshire residents accessing an NHS dentist, with 2007-08 as baseline year

Source: NHS Business Services Authority

Figure 4.37: number of Hampshire residents accessing an NHS dentist by local authority, 2007-8 to 2009-10

Source: NHS Business Services Authority
Despite improved access to primary care dental services in Hampshire, there is still a perception that it is difficult to access an NHS dentist. NHS Hampshire is working with partners across South Central Strategic Health Authority to identify how patients can be encouraged to make use of the available services and better manage their oral health.

**Orthodontic services**
A review of Hampshire’s orthodontic services was undertaken and as a result a new pathway for orthodontic care was introduced in September 2008. This pathway supports patients who meet the criteria for NHS orthodontic care to receive treatment as quickly as possible. Part of the review identified the need for increased capacity, which has resulted in the introduction of new specialist orthodontic practices in Waterlooville and Winchester. The number of patients able to access NHS orthodontic care in Hampshire has increased and waiting times for treatment have reduced.

**Special care dental services**
Dental services for patients who are unable to access care from a high street dentist for medical or mental health reasons are commissioned from Community Dental Services. Recent improvements to this service include an increase in the number of treatments provided at home to clients unable to travel; an expansion in oral health promotion activities to an increased number of vulnerable client groups; and a survey (currently underway) of nursing and residential home residents to identify oral health need, current access, and desire to receive care.

**Minor oral surgery**
Work is ongoing to develop and implement a pathway for minor oral surgery services which will enable patients to receive care from their dentist when appropriate and be seen in the community for a range of specialist treatments, rather than having to attend hospital.

4.8 **Mental health**
Good mental health has been described as being more than the absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and their communities. Mental wellbeing is about our ability to cope with life’s problems and make the most of its opportunities; it is about feeling good and functioning well, as individuals and collectively.

Mental health and wellbeing can positively affect almost every area of a person’s life: education, employment, family and relationship. It can help people achieve their potential, realise their ambitions, cope with adversity, work productively and contribute to their community and society. Promoting good mental health has many benefits. It can improve health outcomes, life expectancy and educational and economic outcomes and reduce violence and crime. The North East Public Health Observatory (NEPHO) hosts the national Mental Health Observatory which provides

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additional intelligence on mental health to that presented here.\(^{32}\)

**Prevalence of common mental health problems**
Mental health problems generally refer to difficulties we may experience with our mental health that affect us in our everyday lives. Mental health problems can affect the way we feel, the way we think and the way we function. They include conditions such as depression, anxiety, panic, and obsessive compulsive disorder, and also dementia. They can be mild or serious, fleeting or long-lasting. It is estimated that 17.6% of the population aged 18-64 meet the diagnostic criteria for at least one common mental health condition. These conditions were more common amongst women (19.7% of those surveyed) than men (12.5%). See Adult social care chapter for more information.

**Prevalence of depression**
The crude prevalence of depression across Hampshire during 2009/10 was 9.4%, which was statistically significantly higher than the national prevalence of 8.5%. The prevalences displayed in figure 4.38 are crude prevalences, which means they have not been adjusted to take into account the different age structure of each local authority’s population. It is also important to note that the crude recorded prevalence of depression from this data source (general practice QOF data) is representative of the number of people attending their GP with depression, and having the diagnosis recorded in patient notes. In other words, the relatively high crude prevalence of depression in Hampshire compared to England as a whole may be a consequence of more people presenting to their GP with symptoms and being diagnosed as having depression, and not that people in Hampshire are more depressed than people across England as a whole.

**Figure 4.38: crude prevalence of depression**

![Figure 4.38: crude prevalence of depression](http://www.nepho.org.uk/mho/)

\(^{32}\) [http://www.nepho.org.uk/mho/]
**Prevalence of mental illness**

Mental illness refers to more serious mental health problems that often require treatment with specialist services, such as schizophrenia, bipolar disorder, and psychoses. Someone with a serious mental illness may have long periods when they are well and are able to manage their illness. The estimated prevalence of mental illness in the population aged 18-64, taken from a national survey, is shown in figure 4.39 (see Adult social care chapter for more information).

**Figure 4.39: estimated prevalence of mental illness by disorder in people aged 18-64**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>% males</th>
<th>% females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial personality disorder</td>
<td>0.6</td>
<td>0.1</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>0.3</td>
<td>0.5</td>
</tr>
</tbody>
</table>


**Recorded (crude) prevalence of mental illness in Hampshire**

The crude prevalence of all mental illness across Hampshire during 2009/10 was 0.6%, which was significantly lower than the estimated national prevalence of 0.8%. The prevalences displayed in figure 4.40 are crude prevalences, which means they have not been adjusted to take into account the different age structure of each district’s population. Therefore it is not valid to make comparisons between districts for this indicator. This crude recorded prevalence of all mental illness (from general practice QOF data) is very similar to the estimated prevalence of mental illness presented in the table above and in the Adult social care chapter. This suggests that most people with serious mental illnesses in Hampshire are included in general practice disease registers and therefore receiving treatment.

**Figure 4.40: recorded (crude) prevalence of mental illness**

Source: The Health and Social Care Information Centre. QMAS database.
Dementia
The term ‘dementia’ is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. Dementia is a progressive disorder; it is one of the main causes of disability in later life and has a disproportionate impact on capacity for independent living. See Adult social care chapter for more information.

Reported (crude) prevalence of dementia
The crude prevalence of dementia in men aged 65 or over was 5.8% in Hampshire which was similar to the national crude prevalence, and did not vary much between districts. In contrast the crude prevalence of dementia in women in Hampshire varied markedly across the county, although the overall prevalence was 8.4% which was similar to the national prevalence. The prevalences displayed in figure 4.41 are crude prevalences, which means they have not been adjusted to take into account the different age structure of each district’s population. Therefore it is not valid to make comparisons between districts for this indicator.

This crude recorded prevalence of dementia comes from general practice QOF data, therefore represents the number of people diagnosed with dementia and who have this diagnosis recorded in a general practice disease register. The crude QOF prevalence of dementia in Hampshire for both men and women is lower than the combined age-specific estimated prevalence of dementia of 7.9% (men) and 9.7% (women) from POPPI data (the projected numbers of people with dementia based on POPPI projections are included in the Adult social care chapter). This suggests there are people in Hampshire with dementia who have not yet been diagnosed and/or who have not been included in general practice disease registers. This finding is not surprising because dementia can be difficult to diagnose, particularly in the early stages of the disease, because many of the symptoms of dementia can be caused by other conditions.

Figure 4.41: prevalence of dementia in males aged 65+

Source: North East Public Health Observatory

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4.9 Avoidable injury from accidents

Falls
Falls are the most common cause of accidental death or serious injury amongst older people. They affect about one third of all people over 65 and in very elderly people (those over the age of 85) this figure is nearly 40%. They cause injury, restrict activity, destroy confidence, increase isolation and reduce independence. As age advances, the incidence of falls increases, with women more likely to sustain a fracture than men.

Hospital admissions for injuries from falls in people aged 65 and over
There are no benchmarking data available for this indicator. Hospital admissions for falls reflect not only the rate of falls in an area, but also the type of community services available, such as falls prevention teams and intermediate care beds. Therefore changes in the rate of hospital admissions are likely to reflect changes in the provision of health services as well as changes in the numbers of people falling. Since 2008, the admission rates for falls in Hampshire have changed markedly. Rates have increased in the New Forest, but have decreased in East Hampshire, Fareham, Gosport, Hart, Havant, Rushmoor and Winchester.
Hip fractures
The rate of hospital admissions for a broken hip in people over the age of 65 in Hampshire during 2008/09 were similar to national and regional rates. Rushmoor and Test Valley have the highest rates, whereas rates in Fareham are significantly lower than national and regional rates.

Accidents
Accidents are defined as ‘unforeseen events’ according to a standard dictionary definition. However accidents do not occur at random and much can be done to reduce death and injury from accidents by preventing them. The adoption of the term ‘injury’ seems more appropriate but due to widespread usage the term
‘accident’ is sometimes retained.

**Road traffic accidents**

Road traffic accidents are a major cause of injury and premature death. Transport had implications for health inequalities; for example child pedestrian deaths are five times higher in social class V than social class I.

**Road casualties in people over the age of 60**

The number of casualties aged over 60 has reduced over the last two years, from a total of 558 in 2007 to 411 in 2009 (a reduction of 177 casualties). Figure 4.45 shows the number of casualties over the age of 60. 

**Figure 4.45: casualties over 60 years of age by class and district**

![Casualties Over 60 Years of Age by Class and District](image)


4.10 **Musculoskeletal**

Musculoskeletal disorders are a group of inflammatory and degenerative disorders of joints and bones including osteoarthritis, rheumatoid arthritis, gout, and osteoporosis.

**Knee replacement**

Recent research has shown that people’s access to total joint replacement of the hip or knee across England is uneven and not accounted for by age, sex, deprivation, geography and ethnicity. In general, men receive 31% more knee replacements

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34 [http://www.bmj.com/content/341/bmj.c4092.abstract?sid=e581fa6a-e553-4b44-ad60-c2ed0ac58014](http://www.bmj.com/content/341/bmj.c4092.abstract?sid=e581fa6a-e553-4b44-ad60-c2ed0ac58014)
relative to need than women and people living in deprived areas receive around 70% less, relative to need than the most affluent areas for both knee and hip replacements. Figure 4.46 shows the picture for Hampshire. However there is no significant difference in the rate of knee replacements between the most deprived fifth of the population in Hampshire and the most affluent fifth.

Figure 4.46: rate of primary knee replacement in Hampshire, by deprivation quintile

A recent estimate study has produced small-area estimates of need for hip and knee replacement for wards and districts in England. Rates of need were adjusted for the sociodemographic characteristics of an area, which were age, sex, Index of Multiple Deprivation 2004 deprivation quintiles, rurality, and ethnic mix of the area (other important predictor variables such as obesity or individual social class could not be included because they were not available as ward-level population counts).

Geographic variation in the need for hip and knee replacement has been displayed on maps of England (figure 4.47). District rates have been split into five equally sized groups (quintiles) in order to display areas with the highest and lowest rates of need.

The study found that the overall need in those aged 50 years or over in England for knee replacement was 63.5 per 1,000 population. The map shows that the rate of need for knee replacement per 1,000 population is low across Hampshire, with all districts except for Havant, Gosport and the New Forest falling into the quintile with the lowest rate of need. The need for knee replacements in Havant falls in the middle quintile (52.96-61.96 knee replacements needed per 1,000 population), while Gosport and the New Forest fall into the second lowest quintile with regards to need.

35 Modeling the need for hip and knee replacement surgery. Part 2. Incorporating census data to provide small-area predictions for need with uncertainty bounds. Andy Judge, Nicky J. Welton, Jat Sandhu, Yoav Ben-Shlomo. Arthritis Care & Research 61 (12): 1667–1673
(42.99-52.99 knee replacements needed per 1,000 population). Hart featured second in the list of 10 local authorities across England with the lowest need for knee replacements, with a rate of 31.24 knee replacements needed per 1,000 population. These data suggest that we might expect to see Havant, Gosport and the New Forest having higher hospital admission rates for knee replacement than other districts across Hampshire, and Hart with the lowest, if intervention rates were highest in those with greatest need.

Figure 4.47: Rate of need for knee replacement per population of 1,000 (quintiles) across the 354 districts in England.

Hospital admissions for knee replacements
Admission rates for knee replacements across Hampshire have decreased from 564 to 395.7 per 100,000 population over the age of 65. Rates are now highest in Basingstoke and Deane, Hart and Rushmoor districts, and lowest in Winchester, the New Forest and Eastleigh. These admission rates are more likely to reflect demand and supply, rather than need, as they do not reflect rate of need for knee replacement shown in the map above.
Hip replacements

As with knee replacements, while we know there is greater need for hip replacement with increasing deprivation, figure 4.49 shows that across Hampshire there is no significant difference in rate of hip replacements between the most deprived fifth of the population and the most affluent fifth.

Figure 4.49: rate of primary hip replacement in Hampshire, by deprivation quintile

It has been estimated that the overall rate of need in those age $\geq 50$ years in England for hip replacement was 46.8 per 1,000 population. Figure 4.50 shows that
the rate of need for hip replacement per 1,000 population is low across Hampshire and shares the same pattern as need for knee replacement. All districts except for Havant, Gosport and the New Forest fall into the quintile with the lowest rate of need. The need for hip replacements in Havant falls in the middle quintile (39.78-46.57 hip replacements needed per 1,000 population), while Gosport and the New Forest fall into the second lowest quintile with regards to need (32.41-39.78 hip replacements needed per 1,000 population). Hart featured second in the list of 10 local authorities across England with the lowest need for hip replacements, with a rate of 23.06 hip replacements needed per 1,000 population. These data suggest that we might expect Havant and the New Forest to have higher hospital admission rates for hip replacement than other districts across Hampshire, and Hart with the lowest, if intervention rates were highest in those with greatest need.

Figure 4.50: Rate of need for hip replacement per population of 1,000 (quintiles) across the 354 districts in England.

Source: This work is based on data provided through EDINA UK BORDERS, with the support of the Economic and Social Research Council and the Joint Information Systems Committee, and uses boundary material that is copyright of the Crown.
4.11 Self report of long term illness and health

Percentage of households with limiting or long-term illness
Limiting illness rates can serve as an indicator of the overall health of the population. The indicator reported in the 2008 JSNA ‘proportion of residents in households with limiting long-term illness’ is taken from the Census, which was last conducted in 2001. Therefore this indicator has not been included in this update because there are no new data to include.

Percentage of households reporting ‘good’ or ‘very good’ health
This indicator was not included in the 2008 JSNA. Across Hampshire, self-reported measures of good health are generally higher than the national average, and higher than or comparable to the regional average. The exceptions are Gosport and Havant, where the percentage of people self-reporting good health is lower than the national average.
4.12 Key messages

This chapter has provided an overview of the burden of ill health. It illustrates the following:

- The people of Hampshire generally have better health outcomes than national and regional averages across all burden of ill health indicators.
- However the burden of ill health continues to be greater (and similar to the England average) in parts of Gosport and Havant, and to a lesser extent in Rushmoor.
- The relatively greater burden of ill health experienced by people living in these three districts is not always matched by relatively greater access to health care.
- There will be wide variations within districts which are masked by district-level data.
### 5. Mortality

#### Summary:

- **All cause mortality and main causes of death**
  
  The death rate from all causes across Hampshire is lower than the national and regional rates. People living in Gosport have the highest death rate in Hampshire at 583.3 per 100,000 population, which is similar to the national average of 581.9 per 100,000. Premature mortality (death in people under the age of 75) is highest in Gosport at 308.2 deaths per 100,000, which is similar to the national premature mortality rate of 295.6 deaths per 100,000 population. The main causes of death in Hampshire are the same as the rest of England. Thirty four percent of deaths in Hampshire are from circulatory disease and 28% from cancer.

- **Life expectancy**
  
  Life expectancy (LE) at birth in Hampshire continues be higher than the national and south east region averages. During period 2006/08 LE was 80 years for males and 83.3 years for females across the county. At district level, the highest LE in men was 81.4 years in Fareham. For women the highest LE was 85.4 years in Hart. The lowest LE in Hampshire was seen in Gosport for both men and women (78.7 and 81.4 years respectively). The difference in LE between districts with the highest and lowest LE was 2.7 years for men, which is an improvement from 2004/06 where the gap was 3.5 years. For women this difference was 4 years, which is an increase (a worsening) in the size of the life expectancy gap. During 2005/09 there were a number of wards across Hampshire where LE in men and women was lower than the national average.

- **Healthy life expectancy at age 65**
  
  Healthy life expectancy (HLE) at age 65 is defined as the number of years a person can be expected to live in ‘good’ or ‘fairly good’ health from the age of 65. The most recent data on HLE comes from the 2001 Census. The lowest HLE at age 65 for men was seen in Rushmoor and Gosport (12.7 and 12.8 years of healthy life at age 65 respectively), compared to 15 years for men over 65 living in Hart, Winchester and the New Forest. For women, the lowest HLE at age 65 was seen in Rushmoor and Gosport (14.8 years), while women in Hart and Winchester had the highest HLE (16.9 and 16.8 years respectively).

- **Deaths attributable to smoking**
  
  Smoking was responsible for 1,721 deaths during the 3 year period 2006 to 2008 in Hampshire. This equated to a rate of 160.9 deaths per 100,000 population, which was significantly lower than the national rate of 206.8 deaths per 100,000. A reduction in smoking-related deaths has been seen across all 11 districts since 2004/06, however marked variations remain between districts. Gosport, Rushmoor and Havant all had smoking-related death rates similar to the national rate.

- **Deaths from causes amenable to healthcare**
  
  In Hampshire there were 3369 deaths from causes amenable to healthcare during 2006/ 2008, equating to a rate of 78.8 deaths per 100,000 population. This was significantly lower than the national and south east region rates 101.3 and 87.3
deaths per 100,000 population respectively. The highest rate of deaths from causes amenable to healthcare was seen in Gosport, where there were 260 deaths or 101.5 deaths per 100,000 population. The lowest rate was Fareham, where there were 68.9 deaths per 100,000 during the same time period.

- **Excess winter deaths**
  During 2006/08 there were relatively few excess winter deaths in Hampshire with a rate similar to the national rate.

- **Circulatory disease including coronary heart disease (CHD), stroke, and heart attack**
  Circulatory diseases were the main cause of death in Hampshire during 2006/2008 causing 34% of all deaths. The death rate from circulatory disease in Hampshire was lower than the national rate during this time period. Gosport had premature death rates from circulatory disease, CHD, heart attack and stroke that were similar to national death rates. Rushmoor had a premature death rate from CHD that was similar to the national rate, whereas Havant had a premature death rate from stroke that was similar to the national rate.

- **Cancer**
  Cancer was the most second most common cause of death in Hampshire during 2006/2008, causing 28% of all deaths. The death rates from all cancers, lung cancer and colorectal cancer in Hampshire were lower than the respective national death rates, as was the premature death rate (death from cancer in people under the age of 75). For breast, cervical and prostate cancer, the death rates in Hampshire were similar to the respective national rates. At district level, Gosport had a similar premature death rate to the national rate. The death rates from lung cancer in Gosport, Rushmoor, Havant and Basingstoke and Deane were also similar to the national rate, and reflect the level of smoking in these districts. For breast cancer, New Forest and Test Valley had relatively high incidence rates but low death rates. Rushmoor had a relatively high death rate from breast cancer but relatively low incidence. This finding is supported by international evidence on breast cancer which shows that more deprived populations have lower incidence of breast cancer but poorer outcomes. For colorectal cancer, both Basingstoke and Deane and Rushmoor have higher mortality rates than would be expected in comparison to incidence. In contrast mortality from colorectal cancer is lower in Havant than would be expected from incidence. For prostate cancer, the higher incidence seen in some districts was not reflected in higher mortality.

- **Respiratory disease: chronic obstructive pulmonary disease (COPD)**
  During 2006 / 2008 the death rate from COPD in Hampshire was significantly lower than nationally. There was marked variation between districts. Gosport, Rushmoor and Havant all had COPD death rates significantly higher than the regional rate and in Gosport this was statistically significantly higher than the national rate. In general, the districts with the highest prevalence of smoking were also the districts with the highest prevalence of and greatest number of deaths from COPD.
• **Suicide**
  The death rate from suicide in Hampshire was significantly lower than the national rate. There was variation in suicide rate between districts, however the overall number of suicides was very low. No district had a suicide rate significantly higher than the national rate.

• **Avoidable deaths from accidents**
  During 2006/2008 the Hampshire death rate associated with a broken hip (fractured neck of femur) in people over the age of 85 was similar to the national and regional death rates. No district had a hip fracture death rate that was statistically significantly different to the national rate. The rate of death from all accidents in Hampshire was lower than the national rate. The crude rate of death from road traffic accidents in Hampshire was similar to the national rate.

## 5.1 All cause mortality

Mortality from all causes in Hampshire during 2006/08 was 504.3 deaths per 100,000 population. This was significantly lower than the national rate of 581.9 deaths per 100,000 population, reflecting the affluence and good health of many people living in Hampshire. People living in Gosport had the highest death rate in Hampshire at 583.3 per 100,000 population, which was similar to the national rate of 581.9 per 100,000. The lowest all cause death rate was seen in Hart (438.2 deaths per 100,000 population).

**Premature mortality**

Premature mortality is defined as death occurring in people under the age of 75. During 2006/08 the rate of premature death in Hampshire was 238 per 100,000 population, which was lower than the national rate of 296 deaths per 100,000. Premature mortality was highest in Gosport at 308.2 deaths per 100,000, which was similar to the national rate.

**Figure 5.1:** premature mortality

![Bar chart showing premature mortality rates by district in Hampshire and the South East of England for the years 2006-08.](source: National Statistics via NSCDO)

## 5.2 Main causes of death

Across England and Wales in 2009 the main causes of death were circulatory diseases (33% of all deaths), cancers (29% of all deaths) and respiratory diseases.
(14% of all deaths). The main causes of death in Hampshire were also circulatory disease and cancer, together being responsible for 62% of all deaths in Hampshire. Circulatory disease accounted for 34% of all deaths in Hampshire, and cancer 28%. Of cancer deaths in Hampshire, 19% were caused by lung cancer, nearly 11% by colorectal cancer, 8% by breast cancer and 7.5% by prostate cancer. Figure 5.4 shows the breakdown of the 54% of cancers labelled as ‘other’ in the pie chart.

**Figure 5.2: main causes of death in Hampshire, 2006/08 all ages pooled**

![Pie chart showing main causes of death in Hampshire, 2006/08 pooled, all ages.](image)

Source: National Statistics

**Figure 5.3: cause of death by cancer site in Hampshire, 2006/08 all ages pooled**

![Pie chart showing cause of death by cancer site in Hampshire, 2006/08 pooled, all ages.](image)

Source: National Statistics

---

Figure 5.4: proportion of cancer deaths in Hampshire by site of cancer, 2006/08

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>Deaths</th>
<th>% of total cancer deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>1798</td>
<td>19.0%</td>
</tr>
<tr>
<td>Other</td>
<td>1103</td>
<td>11.6%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>1003</td>
<td>10.6%</td>
</tr>
<tr>
<td>Breast</td>
<td>784</td>
<td>8.3%</td>
</tr>
<tr>
<td>Prostate</td>
<td>707</td>
<td>7.5%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>520</td>
<td>5.5%</td>
</tr>
<tr>
<td>Oesophagus</td>
<td>409</td>
<td>4.3%</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>344</td>
<td>3.6%</td>
</tr>
<tr>
<td>Bladder</td>
<td>307</td>
<td>3.2%</td>
</tr>
<tr>
<td>Ovary</td>
<td>307</td>
<td>3.2%</td>
</tr>
<tr>
<td>All leukaemias</td>
<td>295</td>
<td>3.1%</td>
</tr>
<tr>
<td>Brain with central nervous system</td>
<td>268</td>
<td>2.8%</td>
</tr>
<tr>
<td>Stomach</td>
<td>246</td>
<td>2.6%</td>
</tr>
<tr>
<td>Kidney</td>
<td>214</td>
<td>2.3%</td>
</tr>
<tr>
<td>Multiple myeloma</td>
<td>185</td>
<td>2.0%</td>
</tr>
<tr>
<td>Mesothelioma</td>
<td>180</td>
<td>1.9%</td>
</tr>
<tr>
<td>Liver</td>
<td>163</td>
<td>1.7%</td>
</tr>
<tr>
<td>Malignant melanoma</td>
<td>158</td>
<td>1.7%</td>
</tr>
<tr>
<td>Uterus</td>
<td>80</td>
<td>0.8%</td>
</tr>
<tr>
<td>Oral</td>
<td>74</td>
<td>0.8%</td>
</tr>
<tr>
<td>Bone and connective tissue</td>
<td>65</td>
<td>0.7%</td>
</tr>
<tr>
<td>Cervix</td>
<td>59</td>
<td>0.6%</td>
</tr>
<tr>
<td>Larynx</td>
<td>36</td>
<td>0.4%</td>
</tr>
<tr>
<td>Non-melanoma skin cancer</td>
<td>34</td>
<td>0.4%</td>
</tr>
<tr>
<td>Small intestine</td>
<td>29</td>
<td>0.3%</td>
</tr>
<tr>
<td>Gallbladder</td>
<td>23</td>
<td>0.2%</td>
</tr>
<tr>
<td>Thyroid</td>
<td>21</td>
<td>0.2%</td>
</tr>
<tr>
<td>Vulva</td>
<td>21</td>
<td>0.2%</td>
</tr>
<tr>
<td>Hodgkin's lymphoma</td>
<td>17</td>
<td>0.2%</td>
</tr>
<tr>
<td>Salivary glands</td>
<td>12</td>
<td>0.1%</td>
</tr>
<tr>
<td>Eye</td>
<td>8</td>
<td>0.1%</td>
</tr>
<tr>
<td>Penis</td>
<td>7</td>
<td>0.1%</td>
</tr>
<tr>
<td>Nasopharyngael</td>
<td>5</td>
<td>0.1%</td>
</tr>
<tr>
<td></td>
<td>9482</td>
<td></td>
</tr>
</tbody>
</table>

Source: ONS Annual Mortality File

5.3 Life expectancy (LE)

Life expectancy (LE) at birth is a statistical calculation of the average number of years that could be lived by a group of people born in the same year, if mortality at each age remains constant in the future. It is seen as a measure of overall quality of life in an area.

LE at birth in Hampshire continues be higher than the national and south east region averages and continues to increase. During 2006/08 LE in Hampshire was 80 years for males, and 83.3 years for females. Within Hampshire, the highest LE in men was 81.4 years in Fareham. For women the highest LE was 85.4 years in Hart. The lowest LE in Hampshire was seen in Gosport for both men and women (78.7 and
81.4 years respectively). In 2006/08 the gap between the districts with the highest and lowest LE was 2.7 years for men, which is an improvement from 2004/06 where the gap was 3.5 years. For women this difference was 4 years, which is an increase (a worsening) in the size of the life expectancy gap.

Figure 5.5: male life expectancy

Figure 5.6: female life expectancy

Figure 5.7: trends in life expectancy for men
**Figure 5.8: trends in life expectancy for women**

**LE in electoral wards**

LE can be calculated at the geographical level of electoral wards. However the results for small populations, such as electoral wards, can be heavily influenced by local factors such as the presence of nursing homes and other care establishments in the ward. Where a significant proportion of the electoral ward population lives in nursing homes or other care establishments, this may artificially lower the LE of that ward. This means that the data presented below must be considered with this caveat in mind and may partially explain any unexpected findings.

The charts show that there are numerous electoral wards spread across the county where LE is significantly lower than the England average.

**Figure 5.9: male LE at ward level compared to England average**
Figure 5.10: female LE at ward level compared to England average

<table>
<thead>
<tr>
<th>Ward</th>
<th>LE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hangers and Forest</td>
<td>72.0</td>
</tr>
<tr>
<td>Forton</td>
<td>72.2</td>
</tr>
<tr>
<td>Town</td>
<td>73.9</td>
</tr>
<tr>
<td>Bridgemary South</td>
<td>75.0</td>
</tr>
<tr>
<td>Bridgemary North</td>
<td>75.1</td>
</tr>
<tr>
<td>Battins</td>
<td>75.2</td>
</tr>
<tr>
<td>Liss</td>
<td>75.2</td>
</tr>
<tr>
<td>Eastleigh South</td>
<td>75.4</td>
</tr>
<tr>
<td>St John and All Saints</td>
<td>75.6</td>
</tr>
<tr>
<td>St Mary's</td>
<td>75.7</td>
</tr>
<tr>
<td>Heron Wood</td>
<td>75.7</td>
</tr>
<tr>
<td>Romsey Extra</td>
<td>75.8</td>
</tr>
<tr>
<td>Alton Eastbrooke</td>
<td>76.0</td>
</tr>
<tr>
<td>Norden</td>
<td>76.0</td>
</tr>
<tr>
<td>St. Mark's</td>
<td>76.2</td>
</tr>
</tbody>
</table>

Source: ONS Annual Mortality File. Comparator data is for 2007-09, source: ONS
Figure 5.12: wards where female LE is significantly lower than England average

<table>
<thead>
<tr>
<th>Ward</th>
<th>LE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alton Eastbrooke</td>
<td>75.8</td>
</tr>
<tr>
<td>Heron Wood</td>
<td>77.1</td>
</tr>
<tr>
<td>Liss</td>
<td>77.6</td>
</tr>
<tr>
<td>Norden</td>
<td>78.3</td>
</tr>
<tr>
<td>Anglesey</td>
<td>78.6</td>
</tr>
<tr>
<td>Whitchurch</td>
<td>78.7</td>
</tr>
<tr>
<td>Forton</td>
<td>79.1</td>
</tr>
<tr>
<td>Alverstoke</td>
<td>79.1</td>
</tr>
<tr>
<td>Bridgemary South</td>
<td>79.2</td>
</tr>
<tr>
<td>Horndean Hazleton and Blendworth</td>
<td>79.3</td>
</tr>
<tr>
<td>Hedge End Wildern</td>
<td>79.4</td>
</tr>
<tr>
<td>St John and All Saints</td>
<td>79.7</td>
</tr>
<tr>
<td>Battins</td>
<td>79.7</td>
</tr>
<tr>
<td>Alton Wooteys</td>
<td>79.8</td>
</tr>
<tr>
<td>Warren Park</td>
<td>79.9</td>
</tr>
<tr>
<td>Littleton and Harestock</td>
<td>80.0</td>
</tr>
<tr>
<td>Fernhill</td>
<td>80.1</td>
</tr>
<tr>
<td>St. Mark's</td>
<td>80.1</td>
</tr>
<tr>
<td>Park Gate</td>
<td>80.4</td>
</tr>
<tr>
<td>Binsted and Bentley</td>
<td>80.4</td>
</tr>
<tr>
<td>Eastleigh South</td>
<td>80.4</td>
</tr>
<tr>
<td>Rowhill</td>
<td>80.5</td>
</tr>
<tr>
<td>Titchfield</td>
<td>80.7</td>
</tr>
</tbody>
</table>

Source: ONS Annual Mortality File. Comparator data is for 2007-09, source: ONS

LE by deprivation quintile
During 2006/08 in Hampshire, men considered be most affluent (in IMD deprivation quintile 1) had a LE of 81.5 years compared to 76.6 years for men in deprivation quintile 5, a gap of 4.9 years. For women the gap in LE between the most and least deprived was 3 years (LE of 84.1 years in quintile 1 compared to 81.1 years).

5.4 Health life expectancy at age 65
Healthy life expectancy (HLE) at age 65 is defined as the number of years a person can be expected to live in ‘good’ or ‘fairly good’ health from the age of 65. The most recent data on HLE come from the 2001 Census. The lowest HLE at age 65 for men was seen in Rushmoor and Gosport (12.7 and 12.8 years of healthy life at age 65 respectively). This compared to an HLE of 15 years for men over 65 living in Hart, Winchester and the New Forest. For women, the lowest HLE at age 65 was seen in Rushmoor and Gosport (14.8 years), while women in Hart and Winchester had the highest HLE (16.9 and 16.8 years respectively).
5.5 Deaths attributable to smoking
Smoking was responsible for 1,721 deaths during 2006/08 in Hampshire. This equated to a rate of 160.9 deaths per 100,000 population, which was significantly lower than the national rate of 206.8 deaths per 100,000. A reduction in smoking-related deaths has been seen across all 11 districts since 2004/06, however marked variation remains between the districts. Gosport, Rushmoor and Havant all had smoking-related death rates similar to the national rate.

Figure 5.13: deaths attributable to smoking, people aged 35+

Source: Health Profiles

5.6 Deaths from causes amenable to healthcare
This indicator has been developed to reduce preventable deaths and was not available for the 2008 JSNA. Causes of death are included if there is evidence that they are amenable to healthcare interventions, including prevention, and that in the age groups specified, death rates should be low, given timely, appropriate, and high quality care. Examples include:

- Perinatal deaths, ages 0-6 days
- Whooping cough, measles, ages 0-14 years
- Asthma, ages 0-44 years
- Diabetes mellitus, ages 0-49 years
- Coronary heart disease, ages 0-74 years;
- Maternal deaths, all ages
- Misadventures to patients during surgical and medical care, all ages

In Hampshire there were 3369 deaths from causes amenable to healthcare during 2006 to 2008, equating to a rate of 78.8 deaths per 100,000 population. This was significantly lower than the national and south east region rates. The highest rate of deaths from causes amenable to healthcare was seen in Gosport, where there were 260 deaths or 101.5 deaths per 100,000 population. The lowest rate was Fareham, where there were 68.9 deaths per 100,000 during the same time period.
5.7 Excess winter deaths

The number of extra deaths in winter varies depending on a variety of factors including temperature – both indoor and outside and the prevalence of disease in the population. England has a higher excess winter mortality rate than should be expected for the severity of its winters compared to much of northern Europe. Increases in deaths from respiratory and circulatory diseases are responsible for most of the excess winter mortality. Influenza is often implicated in winter deaths as it can cause complications such as bronchitis and pneumonia, especially in the elderly, although relatively few deaths are attributed to influenza itself. During 2006/08 the numbers of excess winter deaths in Hampshire were relatively few, which means there is a greater degree of uncertainty when comparing across districts. In general, the rate of excess winter deaths in Hampshire was similar to the national rate.

Figure 5.15: excess winter deaths
5.8 **Circulatory disease**

Circulatory diseases affect the circulatory system as listed in chapter I00 to I99 in the tenth International Classification of Disease. This includes rheumatic, hypertensive, ischaemic, cerebrovascular and pulmonary-related heart diseases.

In Hampshire during the three year period 2006 to 2008 about 12,000 people died from circulatory disease. This equates to a mortality rate of 159.9 deaths per 100,000 population, which was lower than the national and south east region rates. All districts in Hampshire had either similar or fewer deaths than nationally, except Gosport where the rate of 189.0 deaths per 100,000 population was higher than the regional rate and was similar to the national rate of 183.6 deaths per 100,000 population.

**Premature deaths from circulatory disease**

Dying before the age of 75 is defined as premature death. The premature death rate in all Hampshire’s districts has decreased in recent years, particularly in Basingstoke and Deane, New Forest and Rushmoor.

Around 2500 people in Hampshire died prematurely from circulatory disease during 2006/08. This equates to a premature death rate of 56.7 deaths per 100,000 population, significantly lower than the national and regional rates. The highest premature death rate was seen in Gosport, which at 78.1 deaths per 100,000 population was similar to the national rate of 74.8 deaths per 100,000 population.

**Figure 5.16: trend in premature death from circulatory disease**

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37 International Classification of Disease 10 [http://apps.who.int/classifications/apps/icd/icd10online/](http://apps.who.int/classifications/apps/icd/icd10online/)
Coronary heart disease (CHD)

CHD is a major subset of circulatory disease. About 1300 people under the age of 75 died from CHD in Hampshire during 2006/08. This equates to a premature death rate of 30.1 deaths per 100,000 population, which was significantly lower than the national or regional death rates. Rates of premature death from CHD in Gosport and Rushmoor remained higher than other districts in Hampshire, and were similar to the national premature mortality rate. Basingstoke and Deane, Fareham, New Forest and Rushmoor have all seen a significant decrease in premature deaths from CHD in recent years.

Figure 5.18: trend in premature mortality from coronary heart disease
Myocardial infarction (MI), or heart attack

MI are an extreme symptom of circulatory disease. Total numbers of MIs as well as death from MI have been falling steadily both nationally and in Hampshire for the last 15 years.

Figure 5.20: trend in mortality from MI, all persons all ages

There were 484 deaths from acute MI in Hampshire during the three year period 2006 to 2008 (160, 179, and 145 deaths in each year respectively). This equated to a rate of 11.0 per 100,000 population, which was significantly lower than the national and regional rates. Premature death rates from MI were highest in Gosport and Havant and were similar to the national average, with all other districts having much lower rates.
Stroke

Stroke is another subset of circulatory disease. Like MI, over the 15 year period from 1993 to 2008 the number of deaths from stroke has been falling in England and in Hampshire.

Figure 5.22: trend in deaths from stroke

There were 464 deaths from stroke across Hampshire during the three year period 2006 to 2008 (159, 155, and 150 deaths in each year respectively), which equated to a rate of 10.4 per 100,000 population. This rate was significantly lower than the national and regional rates. The premature death rate from stroke was highest in Gosport, where the rate of 15.8 per 100,000 population was similar to the national rate. The premature death rates from stroke across the other Hampshire districts were lower than the national or regional rates. Fareham had the lowest rate at 8.1 deaths per 100,000 population.
5.9 Cancer
During 2006/08 around 9500 people in Hampshire died from cancer. This equated to a rate of 157.5 deaths per 100,000 population, significantly lower than the national rate.

Premature death from cancer
The number of premature deaths from cancer since 1993 has been decreasing both nationally and in Hampshire. During 2006/08 in Hampshire around 4500 people under the age of 75 died from cancer, equating to a death rate of 101.7 deaths per 100,000 population. This was significantly lower than the national death rate of 114 deaths per 100,000 population. Gosport had the highest premature death rate from cancer at 123.4 deaths per 100,000 population, which was similar to the national rate.

Figure 5.24: trend in premature deaths from cancer
Lung cancer deaths
During the three year period 2006 to 2008 about 1800 people died from lung cancer in Hampshire. This equated to a rate of 30.6 deaths per 100,000 population, which was significantly lower than the national rate of 38.6 deaths per 100,000. The highest death rates were seen in the four districts with the highest smoking prevalence, namely Gosport, Rushmoor, Havant and Basingstoke and Deane. The rate of death from lung cancer in these four districts was similar to the national rate.
**Breast cancer deaths in women**

During 2006/08, around 800 women died from breast cancer in Hampshire. During this time period breast cancer incidence increased slightly across Hampshire, while the death rate decreased slightly from 28 deaths per 100,000 women to 26 deaths per 100,000 women. This death rate was similar to the national and regional rates. Rushmoor has a relatively low breast cancer incidence (see Burden of ill health in adults chapter), but a relatively high mortality rate. This finding is supported by international evidence on breast cancer which shows that more deprived populations have lower incidence of breast cancer but poorer outcomes while the reverse picture is seen in wealthy populations.

**Figure 5.27: breast cancer deaths in women**

![Breast cancer deaths in women chart](image-url)

**Cervical cancer deaths**

During the three year period 2006 to 2008, 59 women in Hampshire died from cervical cancer which equated to a rate of 2.1 deaths per 100,000 women. As with cervical cancer incidence (see Burden of ill health chapter), this rate was similar to national and regional death rates, and cannot be displayed by district because the numbers are too small.

**Colorectal (bowel) cancer deaths**

During 2006/08 in Hampshire 1031 people died from colorectal cancer. This equated to a death rate of 16.2 deaths per 100,000 population, which was lower than the national rate of 17.7 deaths per 100,000. No district in Hampshire has a colorectal death rate significantly higher than the national rate. However Winchester (13.3 deaths per 100,000) and Havant (14.3 deaths per 100,000) have death rates statistically significantly lower than the national rate. Both Basingstoke and Deane and Rushmoor have higher mortality rates than would be expected in comparison to incidence. In contrast mortality from colorectal cancer is lower in Havant than would be expected from incidence.
Prostate cancer deaths

Deaths from prostate cancer have fallen across England in recent years and a similar decrease has been seen in Hampshire. During 2006/08, 707 men died from prostate cancer in Hampshire. This equated to a death rate of 24.2 deaths per 100,000 men, which was similar to the national rate of 24.5 deaths per 100,000 men. Although death rates varied between the 11 districts, prostate cancer death rates in all districts were not significantly different to the national rate of death. Despite the high incidence of prostate cancer in the New Forest and Test Valley (see Burden of ill health chapter), this was not reflected in high mortality rates in these districts. Conversely, prostate cancer incidence was low in Basingstoke and Deane, East Hampshire and Rushmoor, which was not reflected in correspondingly low mortality rates. As discussed in the Burden of ill health chapter, some of the higher incidence in a district may be related to increased case finding rather than any actual increase in incidence.

Figure 5.29: prostate cancer deaths
5.10 **Respiratory: chronic obstructive pulmonary disease (COPD)**

Chronic obstructive pulmonary disease is a lung disease characterised by progressive obstruction of lung airflow that interferes with normal breathing and is not fully reversible. Previously COPD was known as chronic bronchitis and emphysema. The major risk factor for COPD is smoking.

During 2006/08 in Hampshire there were 1441 deaths from COPD. This equated to a death rate from COPD of 20.6 deaths per 100,000 population, which was significantly lower than the national rate of 26.6 deaths per 100,000 population. However there were marked variability in death rates between districts. Gosport, Rushmoor and Havant all had COPD death rates significantly higher than the regional rate, and in Gosport (32.6 deaths per 100,000 population) this was statistically significantly higher than the national rate. Conversely the lowest death rate in Hampshire was in the New Forest, where the rate was significantly lower than the national and regional rates. In general, the districts with the highest prevalence of smoking were also those with the highest prevalence and greatest number of deaths from COPD.

**Figure 5.30: COPD deaths**

5.11 **Suicide**

Figure 5.31 shows death from suicide and undetermined injury per 100,000 population in Hampshire during 2006/08. The death rate from suicide in Hampshire was 6.5 deaths per 100,000 population, which was statistically significantly lower than the national rate. There was variation in suicide rate between districts, however the overall number of suicides was very low. No district had a suicide rate significantly higher than the national rate.
5.12 Avoidable deaths from accidents

**Death from broken hip in people aged 85 and over**

During 2006/08 165 people in Hampshire died associated with breaking their hip, giving a death rate similar to the national and regional death rates. The number of people dying in each district as a result of breaking their hip was small, which means a single extra death in any given year can cause significant variations in the statistics. No district had a hip fracture death rate that was statistically significantly different to the national rate.

**Figure 5.32: Mortality from fracture of femur in people aged 85 and over**
**Numbers of people killed or seriously injured on roads**

Road traffic accidents are a major cause of injury and premature death and varies by socio-economic status with child pedestrian deaths five times higher in social class V than social class I. In 2009 there were 3103 accidents on Hampshire roads, including motorway and trunk roads, but excluding the cities of Southampton, Portsmouth and the Isle of Wight. These resulted in 4033 casualties, of which 650 road users were killed or seriously injured and 54 children under the age of 16 were killed or seriously injured. Figure 5.33 shows that although the total number of people killed or injured on roads in Hampshire fell from 2005 to 2009, the numbers of people killed or seriously injured remained relatively static. The downward trend in total numbers was a consequence of a fall in numbers of people slightly injured. This contrasts with data in the 2008 JSNA, which showed that for the period 1999-2005, the number of people killed or seriously injured on Hampshire’s roads fell from 1055 to 613.

**Figure 5.33: road casualty statistics for Hampshire, 2005-2009**

<table>
<thead>
<tr>
<th>Year</th>
<th>Killed</th>
<th>Seriously injured</th>
<th>Killed or seriously injured (KSI)</th>
<th>Slightly injured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>68</td>
<td>545</td>
<td>613</td>
<td>4358</td>
<td>4971</td>
</tr>
<tr>
<td>2006</td>
<td>59</td>
<td>559</td>
<td>618</td>
<td>4177</td>
<td>4795</td>
</tr>
<tr>
<td>2007</td>
<td>80</td>
<td>632</td>
<td>712</td>
<td>4112</td>
<td>4824</td>
</tr>
<tr>
<td>2008</td>
<td>46</td>
<td>541</td>
<td>587</td>
<td>3576</td>
<td>4163</td>
</tr>
<tr>
<td>2009</td>
<td>36</td>
<td>614</td>
<td>650</td>
<td>3383</td>
<td>4033</td>
</tr>
</tbody>
</table>


Figure 5.34 shows the crude rate per 100,000 people killed or seriously injured on Hampshire’s roads during 2006/08. The Hampshire crude death rate was similar to the England and south east regional rates. However the crude rate in Winchester of 87.5 deaths per 100,000 population was higher than the national rate. In contrast, significantly lower rates of deaths compared to the national rate were seen in Fareham, Havant and Rushmoor. There are some caveats with this indicator. Firstly, not all road casualties are reported to police. Secondly, areas with low resident populations but with high traffic flows may have artefactually high rates because the at-risk resident population is not an accurate measure of exposure to transport.

Figure 5.34: people killed or seriously injured on roads in Hampshire crude rate per 100,000 population

Trauma > People killed or seriously injured on roads > Persons > All ages

2006-08

Source of data: Health Profiles
6. Children and Young People

Summary:

There are 307,500 children and young people aged 0-19 in Hampshire (2009 ONS mid-year population estimates), 163,000 of which attend local authority schools.

Although Hampshire is a good place for children and young people to live, not every child and young person has the best possible start in life or the support needed to develop to their full potential. As a result, significant variations in outcomes occur for some children and young people.

Since the 2008 JSNA, the following changes have impacted on the level of need among Hampshire’s children and young people:

- an increase in the diversity of the children and young people population;
- an increase in teenage conceptions in most districts in Hampshire and a rise in the percentage of terminations;
- improved recording of breastfeeding prevalence at 6-8 weeks, which illustrates that too few infants are still breastfeed at this age;
- a reduction in obesity among four year olds and a small increase in obesity among 10 year olds;
- an increase in the number of young people screened for Chlamydia;
- improved dental health, with a reduction in the number of actively decaying, filled or removed teeth for an average Hampshire child of five, but higher rates in areas of deprivation;
- an increase in the percentage of children receiving recommended vaccinations by ages one, two and five;
- a significant increase in the numbers of referrals to children’s social care; the number of children looked after; and the number with a child protection plan (although these are national, rather than Hampshire, trends);
- improved Child and Adolescent Mental Health Services, with a new integrated, countywide Specialist Tier 2 and 3 service to start in 2011;
- a small increase in the number of school pupils with speech, language and communication needs, or physical disabilities;
- improved levels of attainment for the county’s children and young people in key tests at ages 11 and 16;
- an increase in the numbers of young people not in education, employment or training, as a result of recession;
- a rise in the proportion of school pupils receiving, or eligible for, free school meals.

This needs assessment reinforces the areas identified for renewed focus in the 2010 annual review of Hampshire’s Children and Young People’s Plan. The Plan is the single, overarching strategy for Hampshire Children’s Trust and sets the direction and priorities for services for children, young people and families until 2012.
6.1 Introduction
This chapter focuses on Hampshire’s children and young people, providing an overview of indicators of need at a county and district level.

Hampshire context
There are approximately 307,500 children and young people aged 0-19 years, around 22% of the total population (2009 Office for National Statistics mid-year population estimates). Hampshire has over 163,000 pupils in 535 maintained schools, including Education Centres (School Pupil Census, January 2010).

Barriers faced by some children and young people
Although Hampshire is a good place for children and young people to live, inequalities can mean that not every child and young person has the best possible start in life or the support needed to develop to their full potential. As a result, significant variations in outcomes are seen for a proportion of Hampshire’s children and young people. Examples include:

- 42% of 16 year olds did not achieve five A*-C grade GCSEs (or equivalent) including English and maths in 2009/10;
- only 30.5% of 16 year olds eligible for free school meals achieved five A*-C grade GCSEs (or equivalent), including English and maths in 2009/10;
- 91% of children in care did not achieve five A*-C grade GCSEs (or equivalent) including English and maths in 2009/10;
- more 10-14 year olds are pedestrian casualties on Hampshire roads than any other age group, with 55 young casualties in 2009;
- 18% of Year 6 pupils, 22% of Year 7 pupils and 15% of Year 9 pupils reported that they had experienced bullying in school (Hampshire Pupil Attitude Survey, 2010).

6.2 Level of need in the population
This section provides the data and context on the level of need in the children and young people population.

Proportion of children in poverty
Tackling child poverty is vital in reducing inequalities and deprivation, improving the life chances of children and young people in low income families. The current economic climate is pushing more families into poverty, evidenced by increases in unemployment, applications for Jobseekers Allowance and the take up of free school meals. Children who grow up in poverty are likely to lack many of the positive experiences and opportunities that others take for granted. Groups at risk of experiencing poverty include:

- lone parent families;
- large families (four or more children);
- children with parents who are disabled or have mental health problems;
- children with disabilities;
- teenage parents;
- children growing up in social housing; and
- Black and minority ethnic children (including Gypsy and Traveller children).
The national measure used for calculating child poverty is the proportion of children who live in families in receipt of out of work benefits. There is a two year delay in the availability of data, which currently prevents a direct assessment of the impact of recession. However, it is thought that those in part time and low paid work will be most affected and new vulnerable groups may emerge. Figure 6.1 shows the proportion of children who live in families in receipt of out of work benefits at a district level.

Figure 6.1: District level information for the proportion of children and young people (age 0-19) living in families in receipt of out of work benefits (2008/09)

Source: HM Revenue and Customs, August 2008

Figure 6.2 shows the proportion of children in families in receipt of out of work benefits at Lower Super Output Area, highlighting areas of poverty within each district.
The causes of poverty are very broad, reflected in the national Child Poverty Unit’s hierarchy of factors that can reduce poverty (figure 6.3, below).
The statistics illustrated in figures 6.1 and 6.2 show that the proportions of children in poverty are highest in Havant and Gosport. The data show that the main poverty factors in Hampshire are: household structure; employment; and gaps in achievement. An analysis of a wide range of low income measures indicates that the New Forest has the greatest proportion of children in poverty. Hampshire County Council is developing a local Child Poverty Strategy to be published in 2011. This will outline actions to tackle a range of poverty factors, based on current need.

Other measures of deprivation are described in the Social and Environmental Context chapter.

**Teenage conceptions**
Teenage mothers are at risk of poorer outcomes, therefore the national target is to reduce the under 18 conception rate by 50% by 2010. This is measured by the percentage change in the rate of conceptions per 1,000 girls aged 15-17 years compared with the 1998 baseline rate.

The rate of under 18 conceptions in Hampshire increased from a rate of 31.7 per 1,000 girls in 2007 to 34.0 per 1,000 girls aged 15-17 years in 2008. Figure 6.4 illustrates the trend in conception rates and the percentage leading to abortion in Hampshire since 1998. Whilst conceptions have steadily declined overall and the proportion leading to abortion has increased slightly. However, the rate leading to termination is not dissimilar from other shire county populations.
Figure 6.4: Under 18 conception rate and percentage leading to an abortion between 1998 and 2008

Source: ONS, Health Statistics Quarterly

The 2006-08 under-18 rolling three year rate shows a mixed picture for Hampshire. Figure 6.5 provides district level information, including a comparison to the 2005-07 rolling three year rate. The change between the two sets of average conception rates varies significantly, from a 13.3% increase in East Hampshire to a 24.3% reduction in Havant. This analysis helps focus prevention work across the county.

Figure 6.5: District level information for conception rates

<table>
<thead>
<tr>
<th>District</th>
<th>2006-08 rate</th>
<th>2005-07 rate</th>
<th>% change in rate 1998-00 to 2006-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>36.4</td>
<td>35.3</td>
<td>+0.4%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>25.9</td>
<td>24.3</td>
<td>+13.3%</td>
</tr>
<tr>
<td>Hart</td>
<td>19.8</td>
<td>17.7</td>
<td>-5.6%</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>41.8</td>
<td>39.0</td>
<td>+5.4%</td>
</tr>
<tr>
<td>Fareham</td>
<td>29.9</td>
<td>28.2</td>
<td>0%</td>
</tr>
<tr>
<td>Gosport</td>
<td>56.7</td>
<td>52.3</td>
<td>+12.2%</td>
</tr>
<tr>
<td>Havant</td>
<td>42.3</td>
<td>41.7</td>
<td>-24.3%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>31.3</td>
<td>28.4</td>
<td>+12.2%</td>
</tr>
<tr>
<td>New Forest</td>
<td>30.1</td>
<td>30.5</td>
<td>-7.3%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>31.5</td>
<td>32.5</td>
<td>+6.0%</td>
</tr>
<tr>
<td>Winchester</td>
<td>21.2</td>
<td>22.5</td>
<td>+1.9%</td>
</tr>
<tr>
<td>Hampshire</td>
<td>32.7</td>
<td>31.6</td>
<td>-1.9%</td>
</tr>
</tbody>
</table>

Source: ONS, Health Statistics Quarterly
Nationally, there has been an increase in the percentage of conceptions in girls aged 15-17 years leading to abortion during 2006-08, which is mirrored in Hampshire (see figure 6.4). Figure 6.6 shows the variations at district level, from 48% in Gosport to 64% in Fareham. The South Central Strategic Health Authority average for 2008 was 50.2%.

**Figure 6.6: District level information for abortion rates**

<table>
<thead>
<tr>
<th>District</th>
<th>2005-07 % leading to abortion</th>
<th>2006-08 % leading to abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>56.8%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Hart</td>
<td>61.8%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>47.1%</td>
<td>51.0%</td>
</tr>
<tr>
<td>Fareham</td>
<td>62.5%</td>
<td>64.0%</td>
</tr>
<tr>
<td>Gosport</td>
<td>47.6%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Havant</td>
<td>46.0%</td>
<td>49.0%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>54.4%</td>
<td>54.0%</td>
</tr>
<tr>
<td>New Forest</td>
<td>49.3%</td>
<td>53.0%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>53.0%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Winchester</td>
<td>61.3%</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>52.2%</strong></td>
<td><strong>53.0%</strong></td>
</tr>
</tbody>
</table>

Source: ONS, Health Statistics Quarterly

**Maternity**

There is national expectation that all women should be able to access maternity services for a full health and social care assessment of needs, risks and choices by 12 completed weeks of their pregnancy. The assessment aims to provide them with personalised maternity care and improve the outcomes of the pregnancy. The percentage of pregnant women in Hampshire accessing maternity services within 12 weeks increased from 80.7% in June 2008 to 95.5% in June 2010.

Smoking while pregnant has significant detrimental health effects on both mother and baby. Figure 6.7 illustrates quarterly data for the percentage of women who were smokers at the time of delivery, showing an increase at the end of 2008, followed by a steady decrease to 12.8% in June 2010.
The benefits of breastfeeding are well documented and include increased levels of immunity against infection and disease in infancy and throughout life; better growth and development; and reduced adult obesity. Figure 6.8 shows the trend in breastfeeding initiation and continuation over the last two years. This demonstrates that the percentage of mothers initiating breastfeeding has remained relatively constant. However, the prevalence of breastfeeding at six to eight weeks has increased from 18.6% to 44.3% during the same period.

Child obesity and physical activity

In a 2009 survey of school pupils in Years 6 (age 10), 8 (age 12) and 10 (age 14), 21% of Hampshire pupils reported eating five or more portions of fruit and vegetables every day (Tellus4 survey). However, this is a decline from 27% in 2008 (Tellus3 survey).
Child obesity
Progress in tackling childhood obesity has been good, with an increase in the proportion of children weighed and measured as part of the national measurement programme; and achievement of targets for the percentage of children in Reception Year (age four) and Year 6 (age 10). A national rise in obesity had been expected in 2009/10, however Hampshire figures show a small decrease in obesity among children in Reception Year from 8.6% in 2008/09 to 8.4% in 2009/10 although there was a slight increase in obesity among children in Year 6 from 15.5% in 2008/09 to 16.0% in 2009/10. Figure 6.9 provides the data by district.

Figure 6.9: District level information for obesity (2008/09)

<table>
<thead>
<tr>
<th>District</th>
<th>Reception</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>6.3%</td>
<td>17.0%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>7.7%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Hart</td>
<td>7.5%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>11.7%</td>
<td>18.8%</td>
</tr>
<tr>
<td>Fareham</td>
<td>8.7%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Gosport</td>
<td>11.0%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Havant</td>
<td>9.3%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>9.2%</td>
<td>14.6%</td>
</tr>
<tr>
<td>New Forest</td>
<td>8.0%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>7.7%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Winchester</td>
<td>6.3%</td>
<td>12.4%</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>8.64%</strong></td>
<td><strong>15.47%</strong></td>
</tr>
</tbody>
</table>

Source: NHS Information Centre

Hart has the lowest obesity levels for both Reception Year and Year 6 pupils, while Gosport has the highest for both Reception and Year 6.

A case study demonstrating how Hampshire County Council’s Catering Service, Hampshire Primary Care Trust and Eastleigh Borough Council are working in partnership to promote healthy eating using school meal recipes, is provided in the ‘evidence of what works’ section.

Physical activity
Partners across Hampshire are committed to keeping children active, in line with the national aim to increase the percentage of five to 16 year olds participating in at least two hours a week of high quality physical education and sport at school during curriculum time. The annual School Sport Survey demonstrates that the percentage of five to 16 year olds in the county participating in physical education and sport increased from 81% in 2008/09 to 88% in 2009/10.
**Health and wellbeing**

**Sexual health**
Poor sexual health is a source of health inequality and has been linked to deprivation and social exclusion, with higher rates of disease being experienced by young people from Black and ethnic minority groups and those living in poverty.

Chlamydia is the most common sexually transmitted infection in the UK, which affects both men and women. The National Chlamydia Screening Programme offers testing to men and women under the age of 25. The focus is on increasing the number of young people who are screened and reducing numbers with a positive diagnosis. In 2009/10, 29,240 15-24 year olds in Hampshire were screened, representing 19.0% of the local 15-24 year old population. 5.6% of those screened were positive. Figure 6.10 shows the improvement from 2008/09.

**Figure 6.10: comparison data for Chlamydia screening in Hampshire**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>2008/09</th>
<th>2009/10</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 15-24 screened</td>
<td>23,013</td>
<td>29,240</td>
<td>+6,227</td>
</tr>
<tr>
<td>Percentage of 15-24 population screened</td>
<td>15.4%</td>
<td>19.0%</td>
<td>+3.6%</td>
</tr>
<tr>
<td>Percentage of those screened who were positive</td>
<td>7.1%</td>
<td>5.6%</td>
<td>-1.5%</td>
</tr>
</tbody>
</table>

Source: National Chlamydia Screening Programme

**Substance misuse**
In a 2009 survey of school pupils in Years 6 (age 10), 8 (age 12) and 10 (age 14), 10.2% of Hampshire’s pupils reported either frequent misuse of drugs or alcohol, or both, an increase of 0.7% from 2008/09 (7.5%). However, the survey results showed the number of young people who reported taking drugs one or more times in the last four weeks had reduced to 7% in 2009/10 from 17% in 2008/09, while the number who had reported being drunk one or more times in the last four weeks had increased to 16% in 2009/10 from 14% in 2008/09. Figure 6.11 provides the 2009/10 results by district and illustrates the variation in reported levels of substance misuse across the county.
Over half of the pupils taking part in the survey felt that the information and advice they received in school about alcohol (56%), smoking (59%) and drugs (58%) was helpful (Tellus4 survey). However, these levels were all below the national averages. In a second survey, 11.8% of pupils in Year 8 and 34.7% of those in Year 10 reported that they had smoked a cigarette (Hampshire Wellbeing Survey). The majority of those taking part said that they had smoked only ‘once or twice’.

Figure 6.12 illustrates the numbers of young people aged under 18 being admitted to hospital due to alcohol specific conditions in the three year period 2006/07 to 2008/09 (as an approximate rate per 100,000 population). This shows significant variations between districts, with the New Forest, Eastleigh and Rushmoor having a higher rate of admissions than the Hampshire average (50 per 100,000). In contrast, Hart and East Hampshire have a lower than average rate.

Figure 6.12: hospital admissions due to alcohol specific conditions, rate per 100,000 under 18 year olds 2006/07-2008/09

Source: NWPFO from Hospital Episode Statistics
**Care leavers wellbeing**

Young people leaving care are at particular risk of social exclusion. Suitable accommodation for care leavers is vital support for a successful transition to adulthood. In 2009/10, 83.5% of care leavers in Hampshire were in suitable accommodation, a decrease of 6.7% since 2008/09. Figure 6.13 provides the 2009/10 data at district level, showing the variance between Gosport at 46.7% and East Hampshire, Rushmoor and Eastleigh at 100.0%. However, the number of care leavers in each district may be small, which means one care leaver moving in or out of suitable accommodation can cause significant variations in the statistics.

**Figure 6.13: District level information for care leavers in suitable accommodation**

<table>
<thead>
<tr>
<th>District</th>
<th>2009/10*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>81.3%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hart</td>
<td>N/A</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>100.0%</td>
</tr>
<tr>
<td>Fareham</td>
<td>N/A</td>
</tr>
<tr>
<td>Gosport</td>
<td>46.7%</td>
</tr>
<tr>
<td>Havant</td>
<td>95.5%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>100.0%</td>
</tr>
<tr>
<td>New Forest</td>
<td>88.2%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>83.3%</td>
</tr>
<tr>
<td>Winchester</td>
<td>80.0%</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>83.5%</strong></td>
</tr>
</tbody>
</table>

*N/A applies to those districts where the cohort is nil or less than five

Source: SWIFT MI reports, August 2010

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39 The definition of a former care leaver is a young person aged 19 who was looked after under any legal status (other than V3 or V4) on 1 April in their 17th year (National Indicators for Local Authorities and Local Authority Partnerships: Updated National Indicator Definitions, 2009).

40 The definition for suitable accommodation is accommodation that provides safe, secure and affordable provision for young people. It would generally include short term accommodation designed to move young people on to stable long-term accommodation, but would exclude emergency accommodation used in crisis (National Indicators for Local Authorities and Local Authority Partnerships: Updated National Indicator Definitions, 2009).
Injuries to children and young people
In 2008/09, Hampshire hospitals recorded a rate of 117.3 children and young people aged 0-17 admitted to hospital with unintentional\(^{41}\) or deliberate\(^{42}\) injuries per 10,000 population. This is an increase from 2007/08, when the rate was 109.8 admissions per 10,000. Figure 6.14 provides the data by district, showing the rate change in admissions between 2007/08 and 2008/09. Admissions in Rushmoor reduced by 16 per 10,000, while Gosport has seen an increase of 36 admissions per 10,000.

Figure 6.14: District level information for hospital admissions caused by unintentional and deliberate injuries

<table>
<thead>
<tr>
<th>District</th>
<th>2007/08 (per 10k)</th>
<th>2008/09 (per 10k)</th>
<th>Rate change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>110.2</td>
<td>112.6</td>
<td>+2.4</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>99.2</td>
<td>100.5</td>
<td>+1.3</td>
</tr>
<tr>
<td>Hart</td>
<td>73.9</td>
<td>99.0</td>
<td>+25.1</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>116.8</td>
<td>100.8</td>
<td>-16.0</td>
</tr>
<tr>
<td>Fareham</td>
<td>102.1</td>
<td>115.4</td>
<td>+13.3</td>
</tr>
<tr>
<td>Gosport</td>
<td>107.8</td>
<td>143.8</td>
<td>+36.0</td>
</tr>
<tr>
<td>Havant</td>
<td>144.8</td>
<td>138.4</td>
<td>-6.4</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>115.7</td>
<td>107.4</td>
<td>-8.3</td>
</tr>
<tr>
<td>New Forest</td>
<td>117.3</td>
<td>131.3</td>
<td>+14.0</td>
</tr>
<tr>
<td>Test Valley</td>
<td>102.3</td>
<td>124.8</td>
<td>+22.5</td>
</tr>
<tr>
<td>Winchester</td>
<td>109.7</td>
<td>116.6</td>
<td>+6.9</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>109.8</strong></td>
<td><strong>117.3</strong></td>
<td><strong>+7.5</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics

Infant mortality
Infant mortality is one of the key factors for determining health inequalities. Nationally, rates have fallen since the 1970s, but this rate of decrease has slowed since 2006. The 2001-05 data shows that the infant mortality rate in Hampshire was 3.5 per 1,000 live births, below the national average of 5.1 per 1,000 live births. Across districts, rates were below the national average, except for in Gosport, which

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\(^{41}\) The definition of an unintentional injury is an accidental external cause of harm, for example traffic accidents; falls; trips; accidental contact with tools/machinery etc; drowning; exposure; burns and scalds etc (National Indicators for Local Authorities and Local Authority Partnerships: Updated National Indicator Definitions, 2009)

\(^{42}\) The definition of a deliberate injury refers to the codes for assault, which are X85-Y09, covering different types of assaults – bodily force, sexual assault by bodily force, sharp/blunt objects etc (National Indicators for Local Authorities and Local Authority Partnerships: Updated National Indicator Definitions, 2009)
had a rate of 5.6 per 1,000 live births.

Dental health
Oral hygiene is important from an early age as it helps a child to grow up with healthy teeth and gums and reduces the risks of tooth decay and dental erosion. In 2008/09, the average Hampshire child aged five had 0.7 teeth which were actively decaying, filled or had been removed, compared to a national average of 1.1 teeth per child and the South East average of 0.9 teeth per child. This shows improvement from 2005/06, when an average of 1.1 teeth were actively decaying, filled or had been removed, compared to a national average of 1.5 teeth.

Immunisations
The percentage of children receiving recommended vaccinations by ages one, two and five has increased in Hampshire over the last two years, as shown in figure 6.15.

Figure 6.15: vaccination coverage

<table>
<thead>
<tr>
<th>Age one</th>
<th>Age two</th>
<th>Age five</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/IPV/Hib</td>
<td>PCV</td>
<td>Hib/MenC</td>
</tr>
<tr>
<td>April-June 2008</td>
<td>95.3%</td>
<td>87.6%</td>
</tr>
<tr>
<td>April-June 2010</td>
<td>96.5%</td>
<td>90.3%</td>
</tr>
</tbody>
</table>

(DTaP/IPV/Hib): Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b
(PCV): Pneumococcal infection
(Hib/MenC): Haemophilus influenza type b, meningitis C
(MMR): Measles, mumps and rubella
(DTaP/IPV): Diphtheria, Tetanus, Polio, Pertussis

Source: Practitioner and Patient Services Agency, October 2010

However, coverage for most of these vaccinations remains below the levels advised by the World Health Organisation (95.0%), particularly the MMR vaccine. Figure 6.16 illustrates the variations in MRR vaccination coverage across districts, showing that the differences are greatest at age five. Rushmoor has lower coverage than the Hampshire average at both ages two and five, whilst Test Valley and Winchester are below average at age five only.
Figure 6.16: proportion of children receiving measles, mumps and rubella vaccinations by district

Source: Practitioner and Patient Services Agency, October 2010

Safeguarding and children looked after

In the last two years, a number of factors have combined to increase demand for social care services, in particular the economic downturn and high profile safeguarding cases such as Baby P. During this period, the number of children looked after (CLA) and children with child protection plans in Hampshire has increased. Figure 6.17 shows the annual number of CLA since 2005/06, clearly showing a significant increase of 7% in 2008/09, with a continuing upward trend in 2009/10.

Figure 6.17: annual CLA figures for Hampshire

Source: SWIFT MI reports, October 2010
Figure 6.18 illustrates the trend in the number of children with a child protection plan over the last five years (some of the most vulnerable children in the county). In 2008/09, figures rose significantly by 36% to over 600 children and young people.

Figure 6.18: annual child protection plan figures for Hampshire

![Number of child protection plans in Hampshire over the last five years](image)

Source: Children in Need Census, 2009/10

The majority of child protection plans in the county are as a result of neglect (62.1% in 2009/10). Figure 6.19 illustrates the category of abuse which resulted in child protection plans in Hampshire in 2009/10. This demonstrates that the proportion of plans due to neglect or physical abuse is higher than the national average.

Figure 6.19: child protection plans by category, 2009/10

![Child protection plans by category](image)

Source: Children in Need Census, 2009/10
The number of referrals has increased sharply over the last two years, rising by 23% in 2008/09 and remaining at this level in 2009/10. Figure 6.20 shows the pattern of referrals over the last five years.

**Figure 6.20: annual referral figures for Hampshire**

![Graph showing number of referrals in Hampshire over the last five years](image)

**Source:** Children in Need Census, 2009/10

**Domestic abuse**

Data on the prevalence of domestic abuse in the county is not yet sufficiently robust, with significant differences between estimates from the annual British Crime Survey (the Violence Against Women and Girls ‘ready reckoner’) and the number of Police reports received by Hampshire Constabulary. The Hampshire Domestic Abuse Forum undertakes an annual Domestic Abuse Snapshot Survey, where agencies record the number of cases during a one week period. During the 2009 survey, 68% of the 2,473 cases reported were identified as being parents or carers of children/young people under 18. Furthermore, 428 cases involved parents or carers who were under 18 themselves. A total of 3,506 children and young people were recorded as being involved in cases during this one week period, which is an increase of 189% from 2008 (when the total number was 1,213). Respondents were aware of 196 cases (8% of total) where the victim of abuse was pregnant.

Further information on the level of domestic abuse is provided in the Social and Environmental Context chapter.

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43 Hampshire Domestic Abuse Forum: Domestic Abuse Strategic Review Information Pack, April 2010
**Young offenders**
In Hampshire, the level of first-time offending fell by 16% between 2007/08 and 2008/09, from 1,600 per 100,000 young people aged 10-17, to 1,340 per 100,000.

In the last two years, the number of young people receiving a custodial sentence has fallen from 109 to 88 in 2009 in Hampshire, a 19.3% reduction. Over the same period, the number of children looked after receiving a custodial sentence has fallen by 57% (from 14 to six). The significant decrease in the use of custodial sentences has been largely due to innovative ‘custody panels’, which review each case and lessons learnt when a young person goes into custody. A case study is provided in the ‘evidence of what works’ section.

**Child and Adolescent Mental Health Services**
Progress has been made in developing consistent Child and Adolescent Mental Health Services (CAMHS), particularly transition to Adult Mental Health Services. In the last two years, the self-assessed score for the effectiveness of CAMHS in Hampshire has increased from 12 out of 16 to 15 out of 16 in 2009/10.

Although Hampshire has some good services, arrangements for CAMHS have been complex and, in some places, inconsistent (with 10 specialist teams and services across five NHS organisations). In order to address this, the CAMHS Commissioning Partnership has tendering for an integrated, countywide Specialist Tier 2 and 3 CAMHS. The new service is due to start in Spring 2011.

**Children with learning difficulties and/or disabilities**
Children and young people with learning difficulties and/or disabilities are at risk of not being able to achieve their full potential. The national Aiming High for Disabled Children programme aims to better support disabled children, young people and their families/carers. Hampshire services are focused around the Aiming High core offer, which is a set of five standards (information; transparency; assessment; participation; and feedback) that families can expect to receive from services.

Information on the satisfaction of parents who access services for disabled children in Hampshire is provided in the ‘feedback’ section.

Figures from the January 2010 School Pupil Census show that 2.6% of pupils in Hampshire had a statement of Special Educational Needs (SEN). The term SEN refers to children and young people who have learning difficulties and/or disabilities that makes learning, or access to education, more difficult than children of the same age. An SEN statement is a legal document that sets out a child’s needs and the extra help they should receive. Figure 6.21 illustrates the type of SEN for pupils with statements or at School Action Plus in Hampshire, illustrating that the most common type is moderate learning difficulties (26.8%) and the second most common is behavioural, emotional and social difficulties (22.7%).
Overall, the numbers of pupils with SEN statements or at School Action Plus, as a proportion of the total number of pupils, has remained steady over the last five years at approximately 7.5%. The only noticeable changes are in the percentage with behaviour, emotional and social difficulties (which has decreased slightly); the proportion with speech, language and communication needs (which has increased slightly); and the number of physical disabilities (which has also increased slightly).

**Educational attainment and progression**

Educational attainment is one of the most important determinants of future health outcomes. Hampshire County Council is responsible for the education of all children and young people aged 0-19 years; and has a statutory responsibility to plan, fund and deliver education and training opportunities for young people and learners up to the age of 25 with learning difficulties and/or disabilities.

Schools are required to report attendance and absence rates on a termly basis, with targets to reduce the percentage of persistent absence in secondary schools (defined as pupils missing 20% or more of the school year). The trends in Hampshire are positive. In 2009/10, the percentage of persistent absence was 4.7%, a 0.5% improvement from 2008/09.

Overall in 2009/10 (the exams taken in summer 2010), the county’s children and young people achieved higher standards than in previous years and were better than the national average. In 2009/10, 58.4% of pupils achieved five or more
GCSEs (or equivalent) at grade A*-C including English and maths, a 3.0% improvement on 2008/09 (55.4%). Figure 6.22 provides the results for 2009/10 at district level.

Figure 6.22: District level information for pupils achieving five or more GCSEs (or equivalent) at grade A*-C, including English and maths

<table>
<thead>
<tr>
<th>District</th>
<th>2008/09</th>
<th>2009/10</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>49.9%</td>
<td>52.8%</td>
<td>+2.9</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>58.0%</td>
<td>62.5%</td>
<td>+4.5</td>
</tr>
<tr>
<td>Hart</td>
<td>66.2%</td>
<td>73.8%</td>
<td>+7.6</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>44.2%</td>
<td>45.4%</td>
<td>+1.2</td>
</tr>
<tr>
<td>Fareham</td>
<td>54.0%</td>
<td>55.1%</td>
<td>+1.1</td>
</tr>
<tr>
<td>Gosport</td>
<td>46.2%</td>
<td>44.7%</td>
<td>-1.5</td>
</tr>
<tr>
<td>Havant</td>
<td>46.8%</td>
<td>49.7%</td>
<td>+2.9</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>62.0%</td>
<td>64.2%</td>
<td>+2.2</td>
</tr>
<tr>
<td>New Forest</td>
<td>53.5%</td>
<td>57.6%</td>
<td>+4.1</td>
</tr>
<tr>
<td>Test Valley</td>
<td>54.9%</td>
<td>56.5%</td>
<td>+1.6</td>
</tr>
<tr>
<td>Winchester</td>
<td>71.4%</td>
<td>71.2%</td>
<td>-0.2</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>55.4%</strong></td>
<td><strong>58.4%</strong></td>
<td><strong>+3.0</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>49.8%</strong></td>
<td><strong>53.0%</strong></td>
<td><strong>+3.2</strong></td>
</tr>
</tbody>
</table>

Source: KEYPAS, September 2010

Improvement was evidenced across the county between 2008/09 and 2009/10. Hart, in terms of attainment and improvement, was the best performing district during 2009/10, while Rushmoor has been the worst performing district for both years.

Children looked after – attainment

Although most of Hampshire’s children and young people achieve good academic outcomes, there are gaps in attainment amongst vulnerable groups, particularly CLA.

Steady improvement has been evidenced in GCSE attainment for CLA, including achieving five or more GCSEs (or equivalent) at grade A*-C including English and maths. There has been a 2.7% improvement between 2007/08 and 2008/09 in the percentage achieving five or more GCSEs (or equivalent) including English and maths from 4.9% to 7.6% respectively. Figure 6.23 provides the district breakdown for the 2008/09 results.
Figure 6.23: District level information for CLA achieving five or more GCSEs (or equivalent) at grade A*-C, including English and maths

<table>
<thead>
<tr>
<th>District</th>
<th>2008/09*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>0.0%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>N/A</td>
</tr>
<tr>
<td>Hart</td>
<td>N/A</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>N/A</td>
</tr>
<tr>
<td>Fareham</td>
<td>20.0%</td>
</tr>
<tr>
<td>Gosport</td>
<td>16.7%</td>
</tr>
<tr>
<td>Havant</td>
<td>20.0%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>N/A</td>
</tr>
<tr>
<td>New Forest</td>
<td>8.3%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>N/A</td>
</tr>
<tr>
<td>Winchester</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>7.6%</strong></td>
</tr>
</tbody>
</table>

*N/A applies to those districts where the cohort of CLA is nil or less than five.

Source: KEYPAS, September 2010

2009/10 results are not yet available at district level, however provisional results for the county indicate that the proportion of children in care achieving five or more GCSEs including English and maths has increased to 9.0%.

**Special Educational Needs – attainment**

The gap between the percentage of pupils with SEN and their peers achieving five GCSEs (or equivalent) at grade A*-C, including English and maths, has worsened over the last two years. Provisional results for 2009/10 show that the achievement gap in Hampshire was 52.4%, a small increase of 1.2% from 2008/09. Figure 6.24 illustrates the difference in the gap at district level.
The majority of districts have seen an increase in the gap between SEN pupils and their peers. However, Hart, Test Valley and Havant have all reduced the gap from 2008/09.

**Attainment of pupils eligible for free school meals**
Children and young people eligible for free school meals live in families in receipt of income support; Jobseekers Allowance; and/or tax credits. One measure for identifying whether children in receipt of free school meals are reaching their potential is the attainment gap between these pupils and their peers achieving five A*-C grades (or equivalent) including English and maths. The gap in Hampshire increased to 33.3% in 2009/10 (provisional results), from 31.9% in 2008/09. At a district level, the attainment gap varies, with Gosport at 18.5% and Winchester at 39.5% (see figure 6.25, below). Figure 6.25 also illustrates the percentage change in performance between 2008/09 and 2009/10 (provisional results). It is clear that the most significant changes have been in Basingstoke, which has seen a 9.8% increase; and Hart, which has reduced the gap by 7.9%.
### Figure 6.25: District level information for the achievement of pupils eligible for free school meals and their peers achieving five GCSEs (or equivalent) at grade A*-C, including English and maths

<table>
<thead>
<tr>
<th>District</th>
<th>2008/09</th>
<th>2009/10 (prov.)</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>25.5%</td>
<td>35.3%</td>
<td>+9.8</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>36.8%</td>
<td>34.6%</td>
<td>-2.2</td>
</tr>
<tr>
<td>Hart</td>
<td>40.8%</td>
<td>32.9%</td>
<td>-7.9</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>16.6%</td>
<td>20.9%</td>
<td>+4.3</td>
</tr>
<tr>
<td>Fareham</td>
<td>38.8%</td>
<td>36.5%</td>
<td>-2.3</td>
</tr>
<tr>
<td>Gosport</td>
<td>23.6%</td>
<td>18.5%</td>
<td>-5.1</td>
</tr>
<tr>
<td>Havant</td>
<td>24.1%</td>
<td>26.1%</td>
<td>+2.0</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>32.7%</td>
<td>39.0%</td>
<td>+6.3</td>
</tr>
<tr>
<td>New Forest</td>
<td>34.7%</td>
<td>31.1%</td>
<td>-3.6</td>
</tr>
<tr>
<td>Test Valley</td>
<td>34.1%</td>
<td>29.0%</td>
<td>-5.1</td>
</tr>
<tr>
<td>Winchester</td>
<td>41.7%</td>
<td>39.5%</td>
<td>-2.2</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>31.9%</strong></td>
<td><strong>33.3%</strong></td>
<td>+1.4</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>27.8%</strong></td>
<td><em>Not available</em></td>
<td><em>Not available</em></td>
</tr>
</tbody>
</table>

Source: KEYPAS, September 2010

**Black and Minority Ethnic pupils**

Black and Minority Ethnic (BME) children and young people, particularly those for whom English is a second language, are at risk of facing barriers to participation, or experiencing prejudice and discrimination because of their ethnic background.

Communities across Hampshire are becoming more diverse and mobile. Figure 6.26 provides a comparison of pupil numbers by ethnicity in 2006 and 2010. This demonstrates that the most significant change has been in the ‘any other Asian background’ category, which has risen by 113.6%, reflecting the increasing Nepalese population.
Figure 6.26: comparison of pupil ethnicity in Hampshire in 2006 and 2010 (School Pupil Census, January 2006 and 2010)

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>2006</th>
<th>2010</th>
<th>% change 2006-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>144,007</td>
<td>135,888</td>
<td>-5.6%</td>
</tr>
<tr>
<td>Irish</td>
<td>284</td>
<td>265</td>
<td>-6.7%</td>
</tr>
<tr>
<td>Gypsy/Roma or Traveller of Irish Heritage</td>
<td>241</td>
<td>230</td>
<td>-4.6%</td>
</tr>
<tr>
<td>Any other White background</td>
<td>2,513</td>
<td>3,290</td>
<td>30.9%</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>557</td>
<td>675</td>
<td>21.2%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>245</td>
<td>351</td>
<td>43.3%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>744</td>
<td>980</td>
<td>31.7%</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>971</td>
<td>1,348</td>
<td>38.8%</td>
</tr>
<tr>
<td>Indian</td>
<td>658</td>
<td>918</td>
<td>39.5%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>171</td>
<td>221</td>
<td>29.2%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>276</td>
<td>362</td>
<td>31.2%</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>806</td>
<td>1,722</td>
<td>113.6%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>160</td>
<td>188</td>
<td>17.5%</td>
</tr>
<tr>
<td>African</td>
<td>356</td>
<td>563</td>
<td>58.1%</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>124</td>
<td>174</td>
<td>40.3%</td>
</tr>
<tr>
<td>Chinese</td>
<td>384</td>
<td>420</td>
<td>9.4%</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>415</td>
<td>470</td>
<td>13.3%</td>
</tr>
<tr>
<td>Unclassified</td>
<td>3,128</td>
<td>1,610</td>
<td>-48.5%</td>
</tr>
</tbody>
</table>

Source: School Pupil Census, January 2010

The attainment of 16 ethnic groups is monitored at age 16, measured by the percentage achieving five or more GCSEs (or equivalent) at grade A*-C, including English and maths. However, 2008/09 results were not published for Black Caribbean; White/Black Caribbean; any other Black background; Pakistani; Irish; and Bangladeshi, as the cohort size for the group was less than 30. Figure 6.27 illustrates results for the 10 ethnic groups where the percentage of pupils achieving five GCSEs (or equivalent) at grade A*-C including English and maths was published in 2008/09. The Gypsy/Roma and Traveller of Irish Heritage group; Black African and White/Black African; other Asian background group; and any other ethnic group all performed below the county average (55.4%).
Hampshire Ethnic Minority and Traveller Achievement Service works to raise attainment for BME and Traveller pupils and has recently won a national award for encouraging students to become interpreters to support fellow pupils who are learning English. A case study is provided in the ‘evidence of what works’ section.

**Post-16 education, employment and training**

Partnership working across providers ensures that a variety of learning opportunities are available for young people when leaving school; so that a high proportion stay in education beyond the age of 16. Developments in 14-19 education reflect the strength of partnership working across Hampshire, driven through the 14-19 consortia (education providers; voluntary sector; and Education Business Partnerships).

The long term goal is to increase the participation of young people at age 17 in education or work based learning, in order to better their prospects. Hampshire has seen an improvement in the percentage of young people participating, with a 1.0% rise between 2008/09 (78.0%) and 2007/08 (77.0%).

**16-18 year olds not in employment, education or training**

As a result of recession, the number of young people not in education, employment or training (NEET) increased in Hampshire, rising from 5.2% in 2007/08 to 6.3% in 2008/09. Over the last year, the proportion of 16-18 year olds that were NEET has started to fall, reaching 5.7% in 2009/10, as shown in figure 6.28.
A case study describing how Hampshire Connexions helps Year 11 pupils at risk of losing interest in education over the summer holidays, is provided in the ‘evidence of what works’ section.

Care leavers in employment, education and training
The proportion of care leavers in employment, education or training in Hampshire fell to 47.7% in 2009/10 from 64.1% in 2008/09. Figure 6.29 provides district level data for 2009/10, showing the variation between districts, from 31.3% in Basingstoke and Deane to 60.0% in Winchester. However, the number of care leavers in each district may be small, which means one care leaver moving in or out of employment, education or training can cause significant differences in the statistics.
Figure 6.29: District level information for care leavers in employment, education or training

<table>
<thead>
<tr>
<th>District</th>
<th>2009/10*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>31.3%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>40.0%</td>
</tr>
<tr>
<td>Hart</td>
<td>N/A</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>50.0%</td>
</tr>
<tr>
<td>Fareham</td>
<td>N/A</td>
</tr>
<tr>
<td>Gosport</td>
<td>46.7%</td>
</tr>
<tr>
<td>Havant</td>
<td>54.5%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>60.0%</td>
</tr>
<tr>
<td>New Forest</td>
<td>47.1%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>50.0%</td>
</tr>
<tr>
<td>Winchester</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td><strong>47.7%</strong></td>
</tr>
</tbody>
</table>

*N/A applies to those districts where the cohort is nil or less than five

Source: SWIFT MI reports, August 2010

Children of Armed Forces personnel

Hampshire has a greater range of Armed Forces than any other county in the UK.\(^{44}\) The Army has major units in Aldershot (Rushmoor), Bordon (East Hampshire), Middle Wallop (Test Valley), Minley (Hart) and Winchester; and the only dedicated Army port in the country at Marchwood (New Forest). The headquarters of the UK Land Forces has recently been established in Andover (Test Valley). The Royal Navy has its headquarters and major port based in Portsmouth and RAF Odiham (Hart) is the home of the RAF fleet of Chinook helicopters.

Approximately 22,000 serving personnel are stationed in Hampshire (including Portsmouth).\(^{45}\) However, only 5,189 (less than 2% of) school pupils in the county were identified as having a parent serving in the Armed Forces in 2010 (School Pupil Census, January 2010). Nationally, it is estimated that there is an average of 0.76 children for each serving person\(^{46}\), which could suggest that the Hampshire school pupil census figures under-represent the true numbers. The approximate ratio of 0.76 children per service person applied to the number of personnel in the county would bring the total estimated number of children to 16,700 (although this includes Portsmouth).

44 ‘County Council Services in Support of the Armed Forces in Hampshire’, Hampshire County Council Cabinet report 26 July 2010
45 ‘County Council Services in Support of the Armed Forces in Hampshire’, Hampshire County Council Cabinet report 26 July 2010
The January 2010 school pupil census figures show that the distribution of service children reflects the location of key bases, as would be expected. However, the percentage change in the number of pupils identified as having at least one parent serving in the Armed Forces between 2008 (when this question was first included in the census) and 2010 is more unexpected. As shown in figure 6.30, the greatest increase has been in the New Forest (numbers rose by 64%, from 123 in 2008 to 202 in 2010); and the largest decrease in Basingstoke and Deane (a fall of 24%, from 25 in 2008 to 19 in 2010).

Figure 6.30: number of service children (from the School Pupil Census, January 2008, 2009 and 2010)

<table>
<thead>
<tr>
<th>District</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>% change 2008-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gosport</td>
<td>1,123</td>
<td>1,120</td>
<td>1,084</td>
<td>-3.5%</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>952</td>
<td>1,039</td>
<td>975</td>
<td>2.4%</td>
</tr>
<tr>
<td>Fareham</td>
<td>913</td>
<td>933</td>
<td>913</td>
<td>0.0%</td>
</tr>
<tr>
<td>Test Valley</td>
<td>527</td>
<td>499</td>
<td>502</td>
<td>-4.7%</td>
</tr>
<tr>
<td>Hart</td>
<td>451</td>
<td>528</td>
<td>496</td>
<td>10.0%</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>335</td>
<td>371</td>
<td>411</td>
<td>22.7%</td>
</tr>
<tr>
<td>Winchester</td>
<td>269</td>
<td>263</td>
<td>258</td>
<td>-4.1%</td>
</tr>
<tr>
<td>Havant</td>
<td>206</td>
<td>264</td>
<td>252</td>
<td>22.3%</td>
</tr>
<tr>
<td>New Forest</td>
<td>123</td>
<td>167</td>
<td>202</td>
<td>64.2%</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>71</td>
<td>95</td>
<td>77</td>
<td>8.5%</td>
</tr>
<tr>
<td>Basingstoke and Deane</td>
<td>25</td>
<td>27</td>
<td>19</td>
<td>-24.0%</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td>4995</td>
<td>5306</td>
<td>5189</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Source: School Pupil Census, January 2010

The true number of service children in the county is unknown, for the following reasons:

- the school pupil census only includes children aged 4-16, so the number aged 0-4 or 16-18 is unidentified;
- parents can choose not to identify their child as being from a service family in the school pupil census;
- a proportion of service children do not attend local authority maintained schools – it is estimated that 7.5% of service children nationally attend boarding schools\(^{47}\), as the cost of places is subsidised by the Ministry of Defence.

In addition, there is no method of calculating the number of children whose parents were serving personnel, but left the military at some point during their childhood. Therefore, the impact on these children and young people is unknown.

\(^{47}\) Boarding Schools Association estimate, 2005
One of the first comprehensive national reports on service children, from the Royal Navy and Royal Marines Children's Fund\textsuperscript{48}, described the possible problems that can be experienced by these children, including:

- extrovert or introvert behaviour;
- finding it difficult when their serving parent has to go away for long periods of time (an increasing occurrence for those based in Hampshire over recent years);
- greater likelihood of their parents divorcing;
- bullying at school;
- difficulty making friends due to frequent moves;
- disruptions to schooling.

A 2009 survey of Army families in Hampshire, carried out by Ipsos Mori on behalf of the County Council, found that 48% of those responding had experienced problems or concerns with the difference in the standard of education their child receives when changing schools; and 39% had difficulties or concerns about finding a place for their child at a school of their choice. However, the response rate for the survey was low, with just 18% of the 4,254 questionnaires completed.

During 2010, Hampshire County Council became the second local authority in the country to become a 'Welfare Pathway Pilot', a Government initiative aimed at improving access to help, advice and benefits for members of the Armed Forces, veterans and their families. The initiative, which runs until October 2011, includes improving available information on County Council services; increasing partnership working to fill any gaps in provision; and supporting those leaving the Armed Forces.

### 6.3 Projected service use outcome in 3-5 years and 5-10 years

#### Universal services

The proportion of the population that is made up of young people in Hampshire is forecast to decline marginally, with those under 18 accounting for almost 21% of the population by 2016, compared to 22% currently. Despite this, actual numbers of young people will not decrease; Basingstoke, East Hampshire, Rushmoor, Test Valley and Winchester are forecast to see increases in the number of children and young people over this period.

The number of pupils in Hampshire schools in January 2010 was 323,558 (School Pupil Census, January 2010), a fall of 5.5% from 2003. Figure 6.31 illustrates the trend in pupil numbers since 2002/03, with forecasts to 2014/15. The number of primary school pupils is expected to increase over the next three to five years, whilst the number of secondary school pupils is forecast to fall. Consequently, total pupil numbers are predicted to remain steady over the next few years.

\textsuperscript{48} ‘The Overlooked Casualties of Conflict’, Royal Navy and Royal Marines Children’s Fund report, 2009
The County Council’s School Places Plan\(^49\) ensures that an appropriate balance between supply and demand is secured, in line with population projections and plans for housing development.

**Increased demand on safeguarding services**

In the last two years, a number of factors have combined to increase demand for social care services. Analysis of trends between 2007/08 and 2009/10 suggests that the rise began at the start of the economic downturn and was given further impetus with the reporting of the Baby P case (which happened at the same time as the rollout of Hampshire County Council’s contact centre ‘Hantsdirect’). By the time the Lord Laming Report was published, the numbers had peaked. The following changes were evidenced in Hampshire between the third quarter of 2007/08 and the same period in 2009/10:

- the rate of initial contacts per 10,000 children and young people increased by 22%;
- the referral rate increased by 28%;
- the number of initial assessments per 10,000 children and young people fell by 2.3%;
- the number of Initial Child Protection Conferences per 10,000 children and young people remained static;
- the number of children subject to a child protection plan per 10,00 increased by 41.9% (in actual terms, this was 194 additional children and young people);
- the number of children becoming looked after increased by 7.7%;
- the number of children looked after at the end of each quarter increased by 9.0%.

The complex and multiple causes of this rise in demand for services means that it was virtually impossible to predict, however it seems likely that numbers will

\(^{49}\) [http://www3.hants.gov.uk/education/schools/school-places.htm](http://www3.hants.gov.uk/education/schools/school-places.htm)
continue at an increased level for the next three to five years.

**Impact of recession**
The recession has clearly increased demand for some services for children and young people, although the full extent is not yet known. There is currently a two year delay in publication of data for the proportion of children in poverty (as measured by those living in families in receipt of out of work benefits), which prevents a full assessment of the impact of the recession on children.

However, there is evidence that the number of pupils receiving free meals rose 19.7% between 2006 and 2010, whilst the number eligible increased by 15.0%, as illustrated in figure 6.32.

**Figure 6.32: free school meal trends**

Source: School Pupil Census, January 2010

The economic downturn has had a significant impact on employment prospects for Hampshire’s young people, with an increase in the number of 16-18 year olds NEET and a fall in the percentage of care leavers in education, employment or training.

Finally, it seems likely that the recession has contributed to the increase in demand for safeguarding services, as described above.

### 6.4 Current services in relation to need

**Hampshire Children’s Trust and Local Children’s Partnerships**
The statutory requirement for local authorities to have in place a Children’s Trust and to produce a Children and Young People’s Plan (CYPP) has recently been removed. However, Hampshire County Council and partners remain committed to the current model for partnership working. Hampshire Children’s Trust is responsible for promoting co-operation in order to improve outcomes for all Hampshire’s children and young people, with a focus on addressing inequalities.
In the last year, 18 Local Children’s Partnerships (LCPs) have been established as the ‘delivery arm’ of Hampshire Children’s Trust at a local level. They are responsible for implementing the priorities of Hampshire’s CYPP through the development and implementation of local delivery plans.

**Schools and colleges**
Hampshire’s schools and colleges provide a good start for children and young people, with an increasing number judged good or better by Ofsted. 98% of schools in the county provide extended services (July 2010), offering a range of provision and activities, often beyond the school day, to help meet the needs of children, their families and the wider community, including:
- high quality 8am-6pm childcare provided on the school site, or through other local providers;
- a varied menu of activities, including study support;
- family support, including information sessions and family learning activities;
- wider activities helping to re-engage pupils in school and learning;
- swift and easy access to a wide range of targeted and specialist services.

**Sure Start Children’s Centres**
There are 81 children’s centres in the county, enough to reach all 73,800 of Hampshire’s under fives (Office for National Statistics 2009 mid-year population estimate). Children’s centres aim to give every child the best possible start in life. They provide each access to a range of different services for families with children under five, including:
- information and advice on family support services;
- drop-in sessions for parents, carers and childminders;
- access to early education and childcare for children under five;
- access to child and family health services;
- links with Jobcentre plus, further education and training opportunities.
Two ‘mobile’ centres ensure that services are fully accessible in the rural areas of East Hampshire and the New Forest; and also target some of the most vulnerable children and families.

**Universal health services**
Universal health services are provided in a variety of settings, including hospitals, GP practices, children’s centres and schools. Services cover midwifery, health visiting, community nursing, GPs, primary care and CAMHS.

**Family support**
Families in Hampshire are able to access a wide range of support across a variety of settings. Existing support for families is currently being mapped and aligned with LCPs. As a result, Locality Teams will be responsible for co-ordinating targeted, evidence based intervention activities and acting as the main point of contact to ensure families can access specialist services. Delivery partners and services, including early years settings; children’s centres; Home School Link Workers; Parent Support Advisers; Behaviour Support Teams; and Integrated Youth Support Services will be more closely aligned with LCPs, which are at the centre of
Hampshire’s Prevention and Early Intervention Strategy.

**Safeguarding services**
All agencies that work with children share a commitment to safeguard and promote their welfare. Hampshire Safeguarding Children Board co-ordinates the work of all partners with responsibility for safeguarding and promoting the welfare of children.

Hampshire County Council is committed to improving outcomes for children and young people at risk or in care, in line with the national frameworks provided by Working Together to Safeguard Children and Care Matters. The County Council and Children’s Trust share responsibility for ensuring the best outcomes for these children and young people. Safeguarding services and services for children in care are provided through a co-ordinated approach, based on need and multi-agency arrangements.

**Prevention and early intervention**
An integrated Children’s Trust Prevention and Early Intervention Strategy has been developed during the last year. The vision is to offer the right help at the right time, so it has more benefit and lasting impact. The Strategy identifies a series of key aims for 2010-12, based on the following principles:

- prevention is preferable;
- interventions should be timely, with a focus on appropriate outcomes;
- services should identify risks to children and young people as quickly and as early as possible and ensure that these are addressed;
- inequalities for children and their families should be reduced;
- services should be flexible and tailored to individual need.

6.5 **Feedback**
Hampshire’s Participation Strategy outlines ambitious aims and objectives, reflecting commitment to the engagement of children and young people. Examples of successful activities include:

- placing an emphasis on pupil voice in schools and an ethos of rights, respect and responsibilities, providing systematic opportunities for children and young people to participate in decisions, so that they learn to make an active contribution to their school, community and wider society;
- representatives from 11 districts on the Hampshire County Youth Council, influencing key decisions and ensuring that the voices of young people are heard in service development;
- the participation of children and young people in the development of LCP delivery plans;
- recruitment of five Care Ambassadors, assigned to local teams, to promote more local engagement of children and young people in care.

Additional information on the participation of children and young people, and their views on services provided in the county, is available in the ‘Patient and Service User Voice and Public Satisfaction’ chapter.

Partners in Hampshire routinely engage with parents and carers to ensure that services are accessible, inclusive and responsive to local needs. Examples include:
- elected parent representatives sitting on the governing body of every school;
- parents and carers as key partners in the development, delivery and governance of children’s centres;
- ensuring that through the Parent Partnership Service, parents and carers play an informed part in planning provision to meet their child’s SEN;
- building partnerships between the local authority and school; and
- encouraging parents and carers to be involved in the development of local policy and practice.

**User feedback: services for disabled children**

A national survey collects parental views on services for disabled children and young people, measuring the quality of health; education; and care and family services against the five elements of the Aiming High for Disabled Children core offer, which include:

- information – whether parents are receiving all the information they need in a way that they can easily access;
- transparency – whether parents are being told about how decisions are reached regarding services for their child;
- assessment – how assessments are carried out and whether parents have to repeat the same information to many different professionals;
- participation – whether parents are being listened to and involved when decisions are made about their child;
- feedback – whether families are asked for feedback on how they find the services they receive and if this feedback is acted upon.

In 2009/10, parental satisfaction results for Hampshire overall were below the national level at 57%. Areas where parents thought they received an ‘acceptable level’ of service, which compared better against the national average are provided in figure 6.33.

**Figure 6.33: Parental experiences of services for disabled children in Hampshire, 2009/10**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Hampshire</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transparency in health</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Participation in health</td>
<td>68%</td>
<td>61%</td>
</tr>
<tr>
<td>Feedback in health</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Transparency in education</td>
<td>94%</td>
<td>92%</td>
</tr>
<tr>
<td>Feedback in education</td>
<td>22%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: Department for Education

Although this survey has ceased for 2010/11, the collection of parental views will form part of a green paper on SEN and children with disabilities.
Evidence of what works

**Obesity and physical activity case study: Cook and Eat**

In 2009/10, 105 of the county’s schools took part in Cook and Eat, which was developed in partnership between NHS Hampshire, the County Council’s Catering Service and Eastleigh Borough Council. The programme has been targeted at areas of the county with the highest rates of obesity. Schools in these areas that are not currently participating receive information on the programme, often followed up by a visit from a public health worker. All equipment and paperwork is provided for schools to make the delivery of the programme as simple as possible. The aim of the programme is that parents and children learn:

- practical cooking skills;
- healthy eating tips;
- food hygiene and safety;
- how to budget and reduce food bills; and
- how to create menus for the family.

**Youth offending case study: Reducing use of custody for young offenders**

The pilot initiative in North Hampshire reduced the rate of custodial sentences by 42% in one year (2008/09) and is now being used in other authorities.

Children’s Services, the Youth Offending Team, Action for Children and the Howard League for Penal Reform, formed an expert panel to review all custodial sentences of 12 months or less, to see if action could have been taken to avoid custody. The aim was to reduce the use of short custodial sentences where a stringent community penalty would have been just as successful, but cause less disruption to the child/young person’s home life, education and emotional wellbeing.

As a result of the pilot, staff have developed an enthusiasm for critical appraisal and a real team ethos and determination to improve professional practice. Inter-agency communication and an understanding of each other’s roles has also been gained.

Custody panels now operate in all areas of Hampshire.

**Educational attainment and progression case study: Community Language Tasters and Young Interpreters**

In June 2010, Hampshire’s Ethnic Minority and Traveller Achievement Service won a joint award for these two innovative projects in community languages.

Community Language Tasters is a project that helps raise awareness of, and celebrates, the 124 different languages spoken across Hampshire. Bilingual tutors visit primary schools to deliver a series of taster language sessions, with the aim of inspiring young pupils to welcome other countries during the London 2012 Olympic Games.

The Young Interpreter scheme trains pupils to become interpreters to support fellow students who are learning English as an Additional Language. The benefits to both sets of children are that new learners feel supported and young interpreters take on a key role in the school community, enabling them to develop both their
communication and interpersonal skills.

**Education, employment and training case study: Connexions summer ‘on track’ project**

Hampshire’s ‘on track’ project is designed to help Year 11 pupils likely to lose interest in education during the summer holidays between school and college. It has an emphasis on children in care, minority ethnic groups and those without a guaranteed place for education in the following September.

In summer 2009, 14-19 consortia allocated funding for the scheme. A total of 82 young people took part, achieving a range of Level 1 qualifications, including first aid; volunteering; food hygiene; residential and adventure short course award (British Army); Royal Yachting Association competent crew certificate and Level 1 power boating.

In one consortium, eight out of 10 participants are now pursuing courses in college, one received ongoing support and another secured a part time job.

Further examples of ‘what works’ are available in the 2010 Annual Review of Hampshire’s Children and Young People’s Plan.

### 6.7 Key messages

This chapter has provided an overview of need among Hampshire’s children and young people at a county and district level. In the two years since the last JSNA, the level of need has changed, mostly as a result of:

- the increasing diversity of the population;
- greater demand for safeguarding services;
- the economic downturn.

These factors and their impact on need reinforce the areas identified for renewed focus in the 2010 annual review of Hampshire’s Children and Young People’s Plan. The Plan is the single, overarching strategy for Hampshire Children’s Trust and sets the direction and priorities for services for children, young people and families until 2012. The six CYPP priorities are shown below:

| 1. Reducing the incidence and impact of poverty on the achievement and life chances of children and young people. |
| 2. Securing children and young people’s physical, spiritual, social, emotional and mental health, promoting healthy lifestyles and reducing inequalities. |
| 3. Providing opportunities to learn that raise children and young people’s aspirations, encourage excellence and enable them to enjoy and achieve beyond their expectations. |
| 4. Ensuring that children and young people are safe and feel safe, enabling |

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them to build resilience and personal confidence.

5. Providing vocational, leisure and recreational activities that provide opportunities for children and young people to experience success and make a positive contribution.

6. Removing barriers to access, participation and achievement, and not tolerating discrimination and abuse.
7. Adult Social Care

Summary:

- Social care needs arise when someone is unable to undertake basic tasks to support themselves in their daily life. Needs can arise as a result of a disability or illness, from a safeguarding concern, with the greatest number of people developing a need as they age. Hampshire has an aging population, with social care needs projected to rise in both the short and longer term.

- Most social care needs are met by the individual themselves and with support from their family, friends, or the wider community. Adult Services provides support and advice to help people identify ways in which they can meet their social care needs and a range of services to support those who are most vulnerable. Only those whose needs are assessed as ‘critical’ or ‘substantial’ are eligible for ‘packages of care’, with individuals contributing towards these on a means tested basis.

- Following a wide ranging engagement exercise through Hampshire County Council’s Commission of Inquiry into Personalisation and the future of adult social care, social care services are being transformed, with increased emphasis on early intervention and prevention and a stronger focus on crisis care that is designed to help people recover their independence where possible. Users are getting more involved in identifying the best way of achieving their social care outcomes through ‘self directed support’.

7.1 Introduction
Social care needs arise when someone is unable to undertake basic tasks to support themselves in their daily life. Needs are unique to each individual and can range from the ability to wash and dress, to the ability to make decisions and to be aware of risks. Some social care needs are long term, for example where someone is born with a physical or learning disability or suffers an illness or accident that leaves them permanently disabled. Others are shorter term, where someone needs support when recovering from a period in hospital or overcoming a mental health problem.

There is clear evidence that the level of social care needs increase as people age. With an aging population in Hampshire, the level of need is projected to rise over both the short and longer term. The numbers requiring social care support at a younger age are only projected to rise slightly over time, although the impact of these on social care service provision can still be significant as care needs may be required for life and there is evidence of small projected increases in the number of people with severe and complex learning disabilities who survive into adulthood and older age. There is also a growing role for social care in safeguarding vulnerable adults.

Self help and support from family and friends meet most social care needs, with formal services only becoming involved to support those who are most vulnerable and least able to meet their own needs or where there is evidence of abuse.
Following a major engagement exercise through Hampshire County Council’s Commission of Inquiry into Personalisation and the future of adult social care, social care services in Hampshire are being transformed, with greater emphasis on early intervention and prevention, crisis care and a new system of self directed support which allows people to shape the services they receive to meet their assessed needs.

7.2 Level of Need in the population

Defining social care needs
Social care needs arise when someone is unable to undertake basic tasks to support themselves in their daily life. Social care needs are currently assessed against the following 11 aspects of day to day living to identify the degree to which an individual may be unable to look after themselves.

- Practical aspects of daily living – such as shopping, cleaning, cooking, doing the laundry, managing money, paying bills, changing light bulbs.
- Meeting personal needs – such as washing, dressing, having a bath or help to use the toilet.
- Time spent with other people – such as making and keeping friends – looking at all people an individual has contact with, not just their family.
- Getting around outside the home – such as using local shops and facilities, being able to go to a place of worship, going to the cinema, clubs or community centre, helping neighbours and being involved in local organisations.
- Work and learning – such as having a job, learning new things and undertaking voluntary work.
- Staying safe, both in the home and when out – such as personal safety when using the cooker, going down stairs or going on a bus.
- Personal awareness of risks to self and other – such as being aware of the impact your behaviour has on other people, doing things that could harm others or put yourself at risk.
- Meals and nutrition – such as needing help to prepare food or help to eat and drink.
- Home environment – such as being able to get in and out of your home and being able to use all rooms.
- Making important decisions about life – such as where to live and who you want to support you.
- Time spent with support – understanding how much support is required, whether provided by family or through a paid carer.

When looking at social care needs, the Government recognises five key groups, which reflect the main reasons why people have a social care need. These groups are not discrete and people who fall within different groups may have the same type of need, although it can be seen from the above list that some types of need are likely to be more prevalent in some groups than others. These groups are:

- learning disabilities – this covers people who are born with a disability that affects their cognitive functions.
- mental health – which covers people who have a mental illness.
• physical disability – this covers a wide range of people with some form of physical limitation which could affect the use of their arms and legs, or their hearing, sight or speech.
• substance misuse – people who are impaired through abuse of alcohol or drugs; and
• vulnerable people – for example those who have been abused.

The aging population
The greatest risk factor in terms of numbers of people with social care needs is age, with clear research evidence that many social care needs increase with age. For example, one study\textsuperscript{51} found that 0.4\% of people aged 18-24 have a physical disability that means they require help from someone else for their personal care needs (getting in and out of bed, getting in and out of a chair, dressing, washing, feeding, and use of the toilet). This figure rises to 1.7\% of the population for the 55-64 age group. Figures for the percentage with a moderate need, where individuals are only able to perform the above tasks with some difficulty, rise more rapidly from 0.6\% in 18-24 year olds to 8.8\% of those aged between 55-64.

Figure 7.1: Percentage of people aged 18-64 predicted to have a moderate or serious personal care disability, by age group, 2010

\textbf{Percentage of people aged 18-64 to have a moderate or serious physical disability, by age group, 2010}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure71.png}
\caption{Percentage of people aged 18-64 predicted to have a moderate or serious personal care disability, by age group, 2010}
\end{figure}

Source: Prevalence needs reported in PANSI (Projecting Adult Needs and Service Information System) based on prevalence data on adults with physical disabilities requiring personal care by age and sex in the Health Survey for England, 2001.

These needs increase more steeply in older people. Research in 2001 found that 18\% of men and 21\% of women aged 65-70 were unable to manage at least one

\textsuperscript{51} Prevalence needs reported in PANSI (Projecting Adult Needs and Service Information System) (Crown copyright 2010) based on prevalence data on adults with physical disabilities requiring personal care by age and sex in the Health Survey for England, 2001.
self-care activity on their own\textsuperscript{52}. Activities included the ability to bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails or take medicines. These figures rose to over half (51\%) of men and nearly three quarters of women (74\%) aged 85 and over.

**Figure 7.2: Percentage of people 65+ predicted to be unable to manage one self-care activity on their own, 2010 (by age and gender)**

\begin{figure}
\centering
\includegraphics[width=\textwidth]{Figure7.2.png}
\caption{Percentage of people 65+ predicted to be unable to manage one self-care activity on their own, 2010 (by age group)}
\end{figure}

An even higher percentage of elderly people (rising to 68\% of men and 82\% of women aged 85 and over) were found to be unable to manage at least one domestic task on their own\textsuperscript{53}. Tasks included household shopping, washing and drying dishes, cleaning windows inside, jobs involving climbing, using a vacuum cleaner to clean floors, washing clothing by hand, opening screw tops, dealing with personal affairs, doing practical activities. A significant proportion of people aged 65 and over (rising to 35\% of men and 50\% of women aged 85 and over) were found to be unable to manage at least one mobility activity on their own\textsuperscript{54}. ‘Mobility activities’ included going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed. These needs will overlap as many people have more than one social care need as they age.

\textsuperscript{52} Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010) based on figures taken from Living in Britain Survey (2001), table 35.

\textsuperscript{53} Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010) based on figures taken from Living in Britain Survey (2001), table 37.

\textsuperscript{54} Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010) based on figures taken from Living in Britain Survey (2001), table 29.
While there is a general recognition that the aging process results in a gradual loss of functionality, which can lead to a social care need, the age at which this happens and precise cause for it happening will be unique to each individual. The following have been identified as potentially significant causes, with evidence that the prevalence of these increases with age:

- Dementia
- Falls (percentage predicted to have a fall, whether or not it results in injury)
- Visual impairment (percentage predicted to have a moderate or severe visual impairment, which will include some conditions which are treatable)
- Hearing impairment (percentage predicted to have a moderate or severe hearing impairment – people with moderate deafness will have difficulty following speech without a hearing aid)
Hampshire has an ageing population. The Hampshire Small Area Population Forecasts\(^59\) estimate that in 2010 over 18\% of Hampshire’s population (some 235,700 people) are over 65, with 2.9\% (some 37,300 people) aged 85 and over. Over the next six years the older population is projected to rise, with a fifth of the population of Hampshire (20.5\% - some 274,500 people) projected to be aged 65 or over by the year 2016 and the number over 85 anticipated to rise to some 46,100 (3.4\% of the population). The increase in social care needs with age, coupled with the increasing age of the population strongly suggest that social care needs in the older population will rise over the next five years. Longer term forecasts, based on ONS population projections, suggest that this trend will continue and strengthen over the next 20 years. These projections\(^53\) suggest that a minimum of 99,700 people aged over 65 will have at least one social care need in 2010, rising to a minimum of 174,000 in 2030.

These projections should be used with caution, particularly when looking long term. The percentages of those who may have a social care need are national averages and take no account of local circumstances. For example, healthy life expectancy at

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\(^{55}\) Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010) based on data from Personal Social Services Research Unit (PSSRU), London School of Economics and the Institute of Psychiatry, King’s College London, for the Alzheimer’s Society (2007) Dementia UK: A report into the prevalence and cost of dementia.

\(^{56}\) Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010) based on figures taken from Health Survey for England (2005), volume 2, table 2.1: Prevalence and number of falls in last 12 months, by age and sex.

\(^{57}\) Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010). Figures are taken from Charles, N. (2006) The number of people in the UK with a visual impairment: the use of research evidence and official statistics to estimate and describe the size of the visually impaired population RNIB.


\(^{60}\) Office for National Statistics

age 65 is above the national average in all parts of Hampshire with figures for the New Forest, Hart and Winchester districts being some of the highest in England. This may influence the actual level of need in the local area, the age at which particular social care needs arise and the severity of those needs.

These projections also assume that there is no significant change in the factors that lead to social care needs rising with age. While these factors and their interaction are complex, there is no doubt that certain illnesses play a significant role, in particular dementia (see chapter on ‘Burden of Ill Health in Adults’ for further information about dementia). The prevalence of dementia increases with age and almost inevitably gives rise to social care needs. Changes in the treatment available or a major breakthrough in prevention of this condition would have a significant impact in reducing levels of social care need. With other conditions, such as stroke or heart disease, a proportion of those afflicted may be left with an on-going social care need. Again, improvements in treatment and rehabilitation may have an impact on the actual number of people who have social care needs and the severity of those needs.

Figure 7.5: People aged 65+ predicted to have dementia, Hampshire Districts. 2010-2030

Source: Prevalence needs reported in POPPI (Projecting Older People Population Information System) (Crown copyright 2010) based on data from Dementia UK

It is also not clear how the life experiences of different generations will affect their future social care needs. Those who were 85 or over in 2001 (the date the research was conducted) would have been born before 1916, whereas those due to turn 85 in 2016 would have been born in the early 1930’s, and those reaching 85 in 2030 would have been born at the end of the Second World War.
Needs in younger adults
While smaller numbers of adults under the age of 65 are projected to have a social care need, many of these needs will be for life. People who are born with or early in life acquire a disability (whether affecting their ability to learn and understand the world around them, their movement, sight, hearing or communication) or long term illness (particularly one affecting their mental health, including their ability to socialise and their perception of reality) are particularly disadvantaged. Their social care needs can extend beyond those relating to self care and carrying out basic domestic tasks, with barriers to education, finding work and living independently. In some cases these people will require support to help prevent them harming themselves or others and to prevent them being exploited.

One particular group recognised as having long term social care needs are people who have a learning disability, which is usually identified at birth or in childhood. Research\(^61\) estimates that between 2% and 3% of the population as a whole will have a learning disability, with this being moderate or severe in around a quarter of all cases. These projections suggest that over 23,000 people in Hampshire in 2010 will have a learning disability, with this being moderate or severe in just under 5,000 people. The actual numbers in Hampshire are likely to be less than projected as the national research reflected an increased prevalence of learning disabilities in South Asian communities and the size of the South Asian community in Hampshire is below the national average (see Demography chapter).

Research undertaken as part of the Adult Psychiatric Morbidity Survey 2007\(^62\) highlighted the needs of adults who had characteristics on the Autism Spectrum Disorder, a lifelong developmental disability that affects the way a person communicates and relates to people around them. The survey suggested that 1% of the adult population (1.8% of men and 0.2% of women), met the recommended threshold of a score of 10 or more on the Autism Diagnostic Observation Schedule. It found that adults who met this criteria for ASD are socially disadvantaged, less well educationally qualified, less able intellectually and possibly under-supported by services, presenting a case for better support to this group to help them achieve better outcomes. A proportion of people with autism spectrum disorders will also already be included in estimates of people with a learning disability.

Certain mental health problems are also linked to social care needs (the chapter on ‘Burden of Ill Health in Adults’ also provides information on the prevalence of mental

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A survey found that 17.6% of the people it covered met the diagnostic criteria for at least one common mental health condition. These conditions were defined as ones that cause marked emotional distress and interfere with daily function (hence creating potential social care needs) but do not affect insight or cognition. They comprise different types of depression and anxiety, including obsessive compulsive disorder. These conditions were more common amongst women (19.7% of those surveyed) than men (12.5%). If this rate is reflected in the Hampshire population it would suggest that over 126,000 people would suffer from one of these common mental health conditions in 2010.

The same survey also looked at rates of more severe mental health disorders, including
  - anti-social personality disorders, which are characterised by disregard for and violation of the rights of others, leading to a pattern of aggressive and irresponsible behaviour;
  - borderline personality disorders, which are characterised by personal and emotional instability, leading to severe difficulties in sustaining relationships, with self harm and suicidal behaviour being common; and
  - psychoses, disorders that produce disturbances in thinking and perception severe enough to distort perception of reality.

While these disorders are far less common, with prevalence rates of between 0.3% and 0.4% in the population as a whole, individuals suffering from these conditions can have much higher levels of need for both medical and social care interventions to keep both them and the community in which they live safe.

Unlike physical disabilities, which do rise with age, there are only minor variations in prevalence rates of both learning disabilities and mental health problems with age. Demographic changes in the 18 – 64 population over the next 20 years are also limited, such that the number of people projected as having social care needs as a result of such conditions only increases marginally over time. There is evidence of small increases in the survival rates of young people with severe and complex learning disabilities and reduced mortality among older adults with learning disabilities, which may increase the complexity of social care needs.

As with all projections these figures need to be used with caution as they are based on national prevalence rates and do not take account of local circumstances. Over time, there has been a shift in national policy from use of institutionalised care for people with learning disabilities and mental health problems to more care being available within the community. This has involved the closure of large institutions, with their former residents moved to more suitable accommodation, often in the same vicinity. This can lead to higher prevalence of such conditions in pockets close to former institutions than would otherwise be expected. Specialist services that are based in a particular locality may also attract the people they support to live in that area.

These projections are also based on the circumstances that prevailed at the time they were made. Recent research by the Academic Centre for Defence Mental Health and Institute of Psychiatry at King’s College London concluded that the absolute number of military personnel requiring support or treatment is increasing. The authors indicated this rise is not because of an increase in the rate of mental disorders, but as more of the UK armed forces are deployed, the number of people needing help will inevitably increase and that services should anticipate a steady increase in the number of serving and ex-service personnel needing support. Any impact from of the recent economic situation has also yet to be identified.

**Safeguarding**

Safeguarding Adults is a responsibility placed on health and social care through the ‘No Secrets’ guidance (Department of Health 2000) which is issued under Section 7 of the Local Authority and Social Services Act 1970. Through this guidance, statutory health and social care organisations are encouraged to work together to put in place services which act to prevent abuse of vulnerable adults, provide assessment and investigation of abuse and ensure people are given an opportunity to access justice.

A vulnerable adult, as defined in the ‘No Secrets’ guidance is:

- A person aged 18 or over
- Who is or may be in need of community care services by reason of mental or other disability, age or illness and
- Who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation

Safeguarding risks can arise through neglect or abuse, which can be financial, psychological, physical or sexual. Any form of neglect or abuse will have a detrimental impact on the health and wellbeing of the person facing that abuse. In some cases this detrimental impact will extend to their families. Extreme cases of abuse can lead to death or suicide.

Any vulnerable person can be at risk of neglect or abuse. Research undertaken in 2007 suggested that 2.6% of people aged 66 and over who live in private households had experienced some form of elder abuse with 6% of those experiencing more than one type of abuse. The research suggests that the likelihood of mistreatment was higher in women, increased as a person’s health declined and was more likely in people who felt lonely. Higher levels of abuse were found in those living in social rented accommodation. Women aged 85 and over were more likely to be neglected, while men aged 85 and over and those living alone were most likely to suffer financial abuse. The research suggested that this was likely to be an underestimate of the overall prevalence rate as it excluded


abuse taking place in more institutional settings and did not take account of the experience of people who were unable to express concerns, in particular elderly people with dementia.

7.4 Projected service use and outcome in 3-5 years and 5-10 years
Social care needs are primarily met within the community. People will find ways to meet most low level needs themselves and even those with greater needs will draw on the help of family and friends, make use of local support networks or gain help from specialist charities and ‘not for profit’ organisations in addition to seeking support from Adult Social Care. Specialist (albeit at times very simple) equipment, aids and adaptations can help people remain independent and in control of their own life for longer. As described more fully in the next section, there are an increasing range of services offered to help people maintain their personal independence and not become reliant on long term social care services. This section focuses on the services provided directly by Hampshire County Council Adult Services to support people with social care needs.

Fair Access to Care Services
There is little firm evidence about the triggers that move someone with a social care need to seek an assessment. While in some cases an illness or accident, particularly involving hospitalisation, may bring a person into contact with social care, in other cases changes in personal circumstances, in particular the loss of a close friend or relative who has been providing support, will trigger the need for more formal care. In 2009/10, referrals were received from the following sources, although not all resulted in an assessment.

Figure 7.6: Sources for referrals 2009/10

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Number of referrals in 2009/10</th>
<th>Percentage of all 2009/10 referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health, including hospitals, GPs and community health services</td>
<td>23,111</td>
<td>37%</td>
</tr>
<tr>
<td>Self referrals and from friends, families and neighbours</td>
<td>20,385</td>
<td>33%</td>
</tr>
<tr>
<td>Local authorities, including LA housing and Adult Social Care</td>
<td>5,426</td>
<td>9%</td>
</tr>
<tr>
<td>Legal services, Police, Courts etc</td>
<td>5,631</td>
<td>9%</td>
</tr>
<tr>
<td>Others</td>
<td>7,552</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: Information from 2009/10 RAP return

Where it appears to Hampshire County Council that someone may be in need of community care services, that person is entitled to an assessment of their social care needs by Adult Social Care and will receive advice and information on options for meeting that need. Local authorities set the level of need at which they will provide services and, at present in Hampshire only those assessed as having ‘critical’ or ‘substantial’ needs are eligible for support. Clients who receive services and who have the financial means to do so will pay a means tested contribution towards the care they receive.
The following types of need will be assessed as 'critical' and therefore eligible for support:

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

The following types of need will be assessed as 'substantial' and therefore currently eligible for support:

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Over the course of any one year, Adult social care in Hampshire, working in formal partnerships with health services, will support about 90,000 people, with about 28,000 people receiving support on a regular basis. This figure includes people receiving equipment or minor adaptations, those with mobility or sensory problems and those receiving professional support as well as clients receiving more substantial 'packages of care' either in their own home or in a residential or nursing care home. Variations in the way the numbers are collected each year make year on year comparisons difficult. The apparent drop in numbers seen on the RAP (Referrals Assessment and Packages of Care) return between 2008/09 and 2009/10 is due to the way that people receiving equipment have been counted, and does not reflect a real reduction in numbers receiving support and services.

A review of the base data from which the RAP return is drawn suggests that more substantial 'packages of care' provided through Adult Services increased between 2008/09 and 2009/10 by about 4.9%. The most significant increase was in the number of older people receiving services.

In terms of services provided, the greatest increase was in packages of care to support clients to continue living in their own home, which rose for all client groups.
While use of short term residential care (used to provide respite breaks and for periods of reablement) rose, the numbers being supported in long term residential and nursing care remained constant overall. The following table shows the number of packages of care provided in 2008/09 and 2009/10, which forms part of the RAP return. Individual clients can have more than one package of care. It excludes figures on equipment, adaptations and personal support which form part of the overall figures.

Figure 7.7: Packages of Care Provided 2008/09 and 2009/10

<table>
<thead>
<tr>
<th>Source</th>
<th>Older People</th>
<th>Physical Disability</th>
<th>Learning Disability</th>
<th>Mental Health</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08/09</td>
<td>09/10</td>
<td>08/09</td>
<td>09/10</td>
<td>08/09</td>
<td>09/10</td>
</tr>
<tr>
<td>Home care</td>
<td>8,862</td>
<td>9,418</td>
<td>967</td>
<td>1,023</td>
<td>791</td>
</tr>
<tr>
<td>Day care</td>
<td>2,022</td>
<td>1,954</td>
<td>315</td>
<td>291</td>
<td>881</td>
</tr>
<tr>
<td>Direct Payment</td>
<td>962</td>
<td>944</td>
<td>537</td>
<td>691</td>
<td>246</td>
</tr>
<tr>
<td>Short Term Residential</td>
<td>575</td>
<td>610</td>
<td>81</td>
<td>60</td>
<td>148</td>
</tr>
<tr>
<td>Nursing</td>
<td>2,659</td>
<td>2,711</td>
<td>94</td>
<td>75</td>
<td>37</td>
</tr>
<tr>
<td>Residential</td>
<td>3,167</td>
<td>3,104</td>
<td>126</td>
<td>121</td>
<td>805</td>
</tr>
<tr>
<td>Other</td>
<td>122</td>
<td>170</td>
<td>83</td>
<td>76</td>
<td>80</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18,369</td>
<td>18,911</td>
<td>2,203</td>
<td>2,337</td>
<td>2,988</td>
</tr>
</tbody>
</table>

Source: Extract based on 2008/09 and 2009/10 RAP returns

Hampshire performs well against its ‘nearest neighbour’ comparator group in terms of the number of people it supports to live independently in the community. This measure is directly age standardised to allow comparison between authorities and includes people supported through grant funding to voluntary and community organisations as well as the services captured through the RAP return.

Figure 7.8: People supported to live independently through Social Services, all adults (2009-10)

Source: National Indicator Data Sets
The number of people receiving ‘direct payments’ also increased between 2008/09 and 2009/10. As part of the transformation of Adult Services, people are being given more control about the type of support they receive to meet their assessed social care outcomes, through a system of ‘self directed support’. This allows clients to have more say in designing and procuring their own services, with funding provided up to a limit linked to the assessed need, having taken account of other support that the person receives. This system was introduced in response to the national ‘Putting People First’ concordat and was strongly supported in the findings of the Commission of Inquiry into Personalisation (see section 7.5 below). It is being rolled out across Hampshire during 2010/11.

An initial analysis of those in receipt of social care services as a proportion of the resident population has been carried out to provide a comparison to the predicted prevalence of need looked at earlier in this chapter. This reflects the expected trend in terms of the age of clients, with the proportion of the population being supported through Adult Services and its partners rising from 0.63% of the 18-64 population to over 20% of people aged 85 and over. This work also suggests that a higher proportion of the elderly female population receives support than the elderly male population.

**Carers**

‘Carers’ – family and friends who provide support to someone with a social care need – play a vital role in providing care and support. At the time of the 2001 census, over 113,800 people in Hampshire, over 1 in 10 people aged over 16, indicated that they provided unpaid care to family members or others who have physical or mental ill health. While about two thirds of these people provided between 1 and 19 hours care, over 1 in 6 were providing unpaid care for more than 50 hours a week. These figures are slightly below national averages.

**Figure 7.9 : Percentage of people providing unpaid care, 2001 by District**

![Percentage of people providing unpaid care, 2001 by District](chart.png)

Source: Data taken from 2001 Census, available from Hampshire Facts and Figures web page

Recognising the importance of this source of care, which will meet many low level needs in their entirety and often provide a substantial proportion of social care support even in people with high level needs, people providing care are entitled to an assessment of their needs and advice information and, where appropriate, services to support their role. In 2009/10 a formal carers assessment was carried out, with advice, information and support provided, for carers of 25.9% of clients,
just under the national average (26.4%).

**Self Funders**
Some people prefer not to involve formal Council services in their social care needs and will both source and fund services themselves. As social care services are not free at the point of delivery, other people who have an assessment may still choose to arrange and pay for their own support, particularly if they are aware that they would pay for care arranged for them.

Research undertaken by the Institute of Public Care, Oxford Brookes University indicates that there are between 13,409 and 24,073 older people in Hampshire who pay the full cost of their domiciliary care themselves. Of these self funders, between 3,000 and 4,500 may have critical or substantial personal care needs.\(^{66}\)

The second stage of this research included a survey sent to 11,000 Hampshire residents and interviews with 31 residents. Key findings include:

- The very old, women, people who live alone, and less mobile older people requiring a degree of care, communities of wealthy older people living in large seaside housing, and older people living on social estates with limited budgets are the people most likely to be paying for care themselves;
- Most self-funders of personal care (defined as help with intimate care, bathing and washing) and help taking medicines and help moving around the home are likely to use a care agency. Self funders are more likely to pay an individual for most other types of care, while lower level help and support (such as cleaners and transport) is frequently arranged on a more ad hoc and informal basis;
- Many self-funders appear to have had contact with Hampshire County Council and many of those interviewed for this research had been assessed and were either paying a contribution to County Council organised care, or paying in full for care arranged or recommended by the County Council. However, the survey findings indicate that there are significant proportions of people who pay for care who have not contacted the council;
- It is clear that there are also considerable numbers of people paying for lower level help and support who may not be in contact with HCC. The voluntary sector appears to play an important role in meeting the needs of this group, thereby potentially contributing to reducing demand for more intensive service later on;
- Help with shopping, cleaning and gardening are all areas where there is a need among the older population.
- People who pay for their own care are a significant element in the home care market, the main source of personal care at home is unpaid, informal care. Supporting carers is therefore an important activity to enable older people to live independently at home.\(^{67}\)

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\(^{66}\) Institute of Public Care, Oxford Brookes University (2010) *People who fund their own personal care at home in Hampshire and their likely eligibility for future state-funded care*

\(^{67}\) Institute of Public Care, Oxford Brookes University (2010) *People who fund their own personal care at home in Hampshire Stage 2 report*
**Safeguarding**

In its 2009/10 Annual Report, the Hampshire Safeguarding Adults Board reported a rise in the total number of reported incidents of alleged abuse from 804 in 2008/09 to 1,437 in 2009/10. This increase evidenced the impact of continued investment, strong partnership working and awareness raising among the public and workforce.

The reported incidents of alleged abuse related to some 1,319 people, with some people subject of more than one reported incident. While the highest number of incidents related to older people, there were a significant number of referrals relating to people with learning disabilities and mental health problems.

**Figure 7.10: Reported incidents of alleged abuse by client group 2009/10**

<table>
<thead>
<tr>
<th>Client Group</th>
<th>Total number of People aged 18 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disability</td>
<td>267</td>
</tr>
<tr>
<td>Mental Health</td>
<td>122</td>
</tr>
<tr>
<td>Older Persons</td>
<td>723</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>89</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>12</td>
</tr>
<tr>
<td>Other / unknown</td>
<td>106</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,319</strong></td>
</tr>
</tbody>
</table>

Source: Hampshire Safeguarding Board Annual Report 2009/10

Cases of physical abuse were be most frequently reported in 2009/10, with over a quarter of all cases reported including an element of this. Neglect and financial / material abuse also featured strongly, with reports of both being above 20% of the total.

All incidents reported were followed up and, where required, appropriate action taken, where possible in line with the wishes of the person who was suffering abuse. A small number of cases required formal Police intervention.

**7.5 Current services in relation to need**

Based on recommendations arising from the Commission on Personalisation and in light of current financial constraints, a three strand approach is being adopted to social care, focusing on prevention & early intervention, crisis care, and long term care.

**Prevention and early intervention**

To manage future demand, greater emphasis is being put on prevention and early intervention to help people remain in control of their own lives for as long as possible. Current prevention and early intervention work is focused primarily on older people, as this is where the greatest pressure for future services is projected to arise and includes the following services.
Advice and Information: A new website ‘Care Choices’ has been developed to help provide a joined up source of information for people who are looking at their future care needs as they age. This supplements hard copy publications giving information about the type of services that are available in the community and to help people identify services that can meet their longer term care, including residential and nursing homes.

Older Persons Wellbeing: The Older Persons Wellbeing strategy highlighted issues identified by people aged 65 and over as important to them to help them maintain their independence. This work highlighted the need for good, accessible information and a range of transport options to help people access basic services. A number of positive initiatives have been launched through this work, including:

- the ‘trigger tool’ – a system that allows a more joined up approach between agencies by providing information so that the staff or volunteers from one organisation who have contact with an elderly person can help them make contact with another service or agency that they benefit from, if they can see that the older person has a need that falls outside their remit;
- Older Persons Area Link (OPAL) – a network of specially trained and trusted volunteers, co-ordinated by Age Concern, who can help older people become more engaged and involved in activities in their local area recognising the risks that social isolation can bring;
- Better Balance for Life – a series of nine exercises designed to improve flexibility and balance for older people, which is being rolled out to a wide range of agencies that work with older people to help reduce the risk of falls. Evidence has identified the importance of physical exercise in falls prevention in older people.

Supporting People: Supporting People is a national programme, which offers a range of support services to help vulnerable people live independently by supporting them to establish or remain in their own home. The services focus on providing practical support rather than personal care. Within Hampshire, this programme supports over 15,000 people each year. In addition to helping older people remain in their own home, the programme also provides:

- Socially Excluded Services, including services for homeless people, homeless families, ex-offenders, teenage parents, young people at risk and short term mental health services.
- Disability Services, including services for people with physical disabilities, learning disabilities and long term mental health services
- Domestic Abuse Services, including hostels and refuges to support women escaping domestic abuse and generic domestic abuse services who help any victim of domestic abuse.

Community Innovations Teams: These teams provide support and advice to people identified as becoming vulnerable and less able to manage to maintain their independence. Health, social care and voluntary sector workers come together to help individuals recover or maintain their independence, identifying social opportunities, equipment or medical interventions as appropriate to help them continue to be independent.
Equipment and adaptation: People with both health and social care needs can be helped to continue to remain independent for longer with the support of suitable equipment and, where required, adaptations to their home. The Integrated Community Equipment Services provides over 81,500 pieces of equipment a year and carried out over 9,000 minor adaptations to homes in 2009/10 in support of health and social care service clients. More major adaptations to homes, funded through Disability Facilities Grants, are administered by District Councils. Over £4 million was allocated to Districts in Hampshire in 2009/10 to support grant funded works.

Telecare: Telecare is a wide range of alarms and sensors that can enable people to live safely and independently in their own home. It can help improve confidence and minimise risks and can also provide peace of mind to carers and families. The most well known is the pendant alarm but there are many others, including falls detectors, bed sensors and smoke detectors. Since August 2008, Adult Services has supported 2,300 installations of telecare to support older people remain independent. The use of telecare to support people with learning disabilities live more independently is starting to be explored.

Crisis Care
These services aim to help people build confidence and recover basic skills following some form of crisis, such as a fall or period in hospital, so that they can continue to live independently and enjoy life. Services include:

Time to Think Re-ablement Beds allow more vulnerable, particularly older people, a chance to recover in a supported setting after a stay in hospital so that they are better placed to make a decision about their long term care needs. Use of these beds has allowed people who would have gone into long term residential care following a period in hospital to regain their independence and return home.

A separate ‘Welcome Home’ service is available to help those eligible for social care support with more practical aspects of life following a period in hospital, so that they can return home rather than either stay in hospital or move to long term residential care.

Community Response Teams: The Community Response Services provides short term assessment and reablement for those meeting social care eligibility criteria to help people regain confidence and build up skills following hospital admission.

Long Term Support
In recent years emphasis has been given to helping people remain in their own home, supported by appropriate packages of care. Where the care needs are too great for this, care in a residential or nursing home may be required. A number of day services are also available.

The move to Self Directed Support will give people who are eligible for social care support more direct say in the type of ‘services’ that will best achieve their agreed outcomes. While some service users are content to continue with the current range

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68 Data from Hampshire County Council Adult Services Wellbeing and Partnerships Team
of services others have used the flexibility this presents – for example choosing community activities rather than a buildings based day service. This will see a more user driven range of opportunities develop as the system is rolled out.

Adult Services is working with partners to increase the supply of Extra Care Housing. This provides an alternative to residential care, allowing people to retain their own front door within a housing scheme that has enhanced levels of social care support, including night time cover.

7.5 Feedback

User Voice
Hampshire County Council hosted a Commission of Inquiry into Personalisation and the future of adult social care in 2008. The expert Commission carried out a major engagement exercise with service users, their carers, workers in social care and the general public to develop a user centred model for social care. Information about the work of the Commission and copies of its recommendations and final report can be found at


The Older People’s Wellbeing Strategy was developed to address the issues that older people identified as most important to help them remain independent. This highlighted the need for good information and the challenges of accessing services, either in person or electronically, as people age.

Hampshire County Council works with a range of service user and carer groups including Completing the Circle, the Personalisation Expert Panel and Older People’s Forums around the county. Adult Services has developed Service User & Care Involvement standards. Service users and carers are routinely involved in project boards, recruitment and procurement panels.

The Hampshire Link has been established and work is underway to plan the transition to Health Watch.

Provider Voice
Hampshire County Council works with individual providers and their trade organisations, such as Hampshire Care Association Hampshire Domiciliary Care Providers Limited, Community Action Hampshire and ROCC (an independent charitable organisation that provides support to purchasers, commissioners and providers of housing, care and support. Providers workshops are run throughout the year to facilitate communication with the sector.

Hampshire County Council supports the development of its social care providers workforce through its PaCT (Partnership in Care Training) programme, which provides access to subsidised training.
7.6 **Evidence of what works**
As part of the role out of SDS, outcomes achieved for people are being measured at assessment and as part of regular reviews to inform understanding of the impact that is being achieved from social care services.

7.7 **Key messages**
This chapter has provided an overview of adult social care in Hampshire. It illustrates the following:

- Research indicates that social care needs increase with age. With an aging population, it is projected that social care needs in Hampshire will increase in both the short and longer term.

- There is also evidence of small projected increases in the number of people with severe and complex learning disabilities who survive into adulthood and older age.

- All projections need to be used with caution. It is not clear how the life experiences of different generations will impact on their needs as they age. Medical advances and changes in approaches to care can also impact on future needs.

- There is evidence of increased pressure on social care services within Hampshire, although the relationship between social care needs in the community and provision of services is complex and influenced by a range of social, economic and health factors.

- The approach to social care services is changing, with greater emphasis on prevention, early intervention and re-ablement. A personalised approach allows users and their carers to shape the way social care is provided to meet their assessed needs.

- There is also a growing role for social care in safeguarding vulnerable adults.
8. Patient and Service User Voice and Public Satisfaction

Summary:

There are a variety of ways in which Hampshire residents’ views are captured and used to shape services. Focused action takes place with people using services as well as their carers and families in redesigning services.

The 2008/09 Place Survey and 2009 ICM research found that the perception of residents’ ability to influence decision making is fairly low:
- 71% disagreed that they could influence decisions about their local area (figure 8.11).
- 59% disagreed that they could influence decisions affecting the local NHS services in their area (figure 8.5)
- Just under a quarter of people would like to get more involved in the decisions that affect their local area
- Three out of five people wish to be involved, depending upon the issue.
- A total of 22% reported that they had given their views about their local area during the last year

The 2009 ICM Research shows that Hampshire residents generally have a good perception of local NHS services (figure 8.1). Satisfaction with primary care services is consistently high in surveys for GP’s, dentists and pharmacists (figure 8.4). Joined up working between the NHS and social care services, opportunities to influence decisions and awareness of choice of services were rated much lower.

People using Hampshire County Council (HCC) Adult Services generally have a good perception of the services they receive. In a 2009 service user survey:
- 87.4% of respondents were satisfied with the service they had received. This was divided between (44.7%) being very satisfied and (42.7%) quite satisfied
- Dissatisfaction had fallen for the third year running down to 4.3%
- In relation to people using equipment or minor adaptations 94% of people were satisfied with their most recent piece of equipment or minor adaption (figure 8.6)
- 71% reported that their equipment had improved their quality of life
- 80% were very happy with the way they were treated by those discussing their needs

In the 2010 Pupil Attitude Survey the majority of pupils who took part reported that they always, or usually, enjoyed school (figure 8.12). Pupils aged 12 and 14 thought their local area was a very, or fairly, good place to live.

In the 2008/09 Place Survey the majority of Hampshire residents are very satisfied with where they live with 85% of people being satisfied with their local area. Satisfaction levels increase according to age, with:
- 81% of 18-34 year olds being satisfied
- 85% of 35- 54 year olds and
- 89% of people aged 54+ being satisfied
Key areas that Hampshire residents see as needing to be improved (figure 8.10) were:

- activities for teenagers
- level of traffic congestion
- road and pavement repairs and
- public transport

8.1 Introduction
This section describes what is known about residents’ satisfaction. It illustrates what they think of current services and their perception of Hampshire as a place to live. It includes some basic facts and figures which help to show the trends. The views expressed are subjective and give some insight into the perceptions of the population.

There are a wide range of opportunities for involvement and gaining feedback on health and social care services.

Public bodies have statutory duties to consult and involve local people in the development and delivery of local services. There are number of legislative changes that will influence public involvement and engagement in the future.

In order to gain detailed insight to the issues that really matter to local people a variety of methods are used. These include targeting specific groups to ensure all communities have an opportunity to shape future services. Communication tools used vary from roadshows, social media, video diaries to user involvement groups.

This section includes data from a variety of sources including:

- The Place Survey 2008/09 and the Patient Survey July 2009 – June 2010 to highlight the levels of satisfaction
- Feedback from specific events, complaints and comments to provide a picture of health, wellbeing and care from the viewpoint of Hampshire residents
- Results from the December 2009 bi-annual local residents surveys carried out by ICM research and commissioned by South Central Strategic Health Authority

8.2 User involvement groups
There are a number of user involvement groups that are run by local people to give citizens a voice. They have been set up either to campaign for a specific service or to bring service users and patients together on a variety of issues.

Local Involvement Networks
The statutory body that functions as an independently minded critical friend to health and social care services is a Local Involvement Network (LINks). They work closely with both Hampshire County Council (HCC) and NHS Hampshire. LINks are likely to become HealthWatch in the future. Hampshire LINk has over 2,000 members who have been involved in a range of issues including:

- Gosport War Memorial Hospital Phlebotomy Service redesign
• Transfer of services from Royal Hospital Haslar to Gosport War Memorial Hospital ensuring patients affected by the move had their views heard
• Winchester city and rural GP cluster patient ‘sign up to LINK’ initiative
• Primary percutaneous coronary intervention public feedback survey
• Consultation on Adult Services Contribution Policy

**Adult Social Care Service Users**
Hampshire County Council Adult Services works with a variety of service user and carer groups. These are identified within the Adult Social Care chapter. Groups work with the department to share their views and opinions. They have been actively involved in:
- information and publicity material
- polices and procedures and
- staff training

**Young People**
There is a variety of groups that young people can participate in order to share their views. These are listed in the Children and Young Peoples Chapter and give people up to the age of 21 the opportunity to influence local issues. They include Hampshire County Youth Council (HCYC), District Youth Council’s and the UK Youth Parliament.

### 8.3 Health Services
NHS Hampshire’s five year strategy *Healthy Horizons* sets out its strategic goals. It includes a commitment to “putting patients at the centre of everything we do”. NHS Hampshire uses a range of local, regional and national surveys to identify the perceptions and experiences of patients.

During 2009/10 NHS Hampshire provided opportunities to listen to and involve over 22,000 local people and 2.3 million opportunities for people to access health information. Over 1,500 people have joined ‘Signed Up to NHS Hampshire’ where they can keep up to date on their local NHS. They also receive targeted information on health matters of interest to them.

**Patient perspectives of local health services**
NHS Hampshire is committed to gathering and using patient and public views on the issues that really matter to them. These views are fundamental to informing:
- The development of new and existing services and pathways of care
- Continuously monitoring the quality of services commissioned or provided for local people
- Supporting local people to improve their health, make healthy choices and access appropriate services

Detailed insight has been used in a number of ways which has helped shape services. These include:
- Insight into the behaviours and issues affecting access to urgent care. This highlighted that 25% of Emergency Department (ED) attendances could have been treated elsewhere but people were often confused about
their options. During 2009/10 a ‘Choose Well’ campaign was developed to help local residents know when they should attend the ED and what alternatives are available.

- Hampshire Deaf Association Deaf World Event provided feedback from the deaf community on access issues and patient experiences. This prompted NHS Hampshire to develop a web based British Sign Language interpretation service in GP practices across the county.
- Patients with diabetes using video and written diaries to focus on the impact of the condition; information and advice; and support networks. The experiences of the patients involved were used to develop a survey which was sent to all Diabetes UK members in Hampshire. The results of the survey have been used to shape the commissioning of community and acute services.

**Public satisfaction with local NHS Services**

ICM research was commissioned by South Central Strategic Health Authority to carry out a survey of public attitudes in the NHS South central area twice a year. The survey investigates public attitudes about how the health services are provided locally and includes over 1,100 Hampshire residents. Results for the period November 2009 to February 2010 show that Hampshire residents generally have a good perception of local NHS services. GP’s, dentists and pharmacists were rated highly. Joined up working between the NHS and social services, opportunities to influence decisions, and awareness of choice of services were rated much lower. This is reflected in the following survey results for Hampshire:

**Perceptions of service locally**

The majority of people (78%) tended to agree that their local NHS provided them with a good service, while 10% neither agreed or disagreed. 11% tended to disagree and 2% had no opinion.

**Figure 8.1: Perception of services locally**

<table>
<thead>
<tr>
<th>Perception of services locally</th>
<th>To what extent, if at all, do you agree or disagree with the following statement: My local NHS is providing me with a good service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>Tend to agree</td>
</tr>
<tr>
<td>27%</td>
<td>51%</td>
</tr>
</tbody>
</table>

**Source:** ICM research

**Improving health and wellbeing**

The majority (74%) of people felt that their local NHS helped improve their health and wellbeing, 14% neither agree nor disagree, 4% had no opinion and 8% disagreed.
Figure 8.2: Local NHS helps improve the health and wellbeing of me and my family

<table>
<thead>
<tr>
<th>Local NHS helps improve the health and wellbeing of me and my family</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent, if at all, do you agree or disagree with the following statement:</td>
</tr>
<tr>
<td>My local NHS helps improve the health and wellbeing of me and my family?</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>21%</td>
</tr>
</tbody>
</table>

Source: ICM research

Satisfaction with an NHS hospital
When asked how satisfied they were with the last visit they had to an NHS hospital 70% were satisfied.

Figure 8.3: Satisfaction with NHS hospitals

<table>
<thead>
<tr>
<th>Satisfaction with NHS hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking about the last time that you visited an NHS hospital, overall, how satisfied or dissatisfied were you with this last visit as a patient?</td>
</tr>
<tr>
<td>Very satisfied</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>41%</td>
</tr>
</tbody>
</table>

Source: ICM research

Satisfaction with primary care services
Satisfaction with primary care services is improving and is consistently high in surveys for GP’s and pharmacists. 92% were satisfied with the care at GP surgery or health centre, 3% were dissatisfied and 5% were neither satisfied nor dissatisfied. The survey showed the following results:

- 89% of people were satisfied with their last visit to their local doctor/GP. An improvement on the last year which was 85%
- 85% were satisfied with the last visit to their dentist. An improvement from the previous year which was 76%
- 89% were satisfied with their last visit to an NHS pharmacy or chemist. An improvement from the previous year which was 88%
Figure 8.4: Satisfaction with primary care services

<table>
<thead>
<tr>
<th>Satisfaction with primary care services</th>
<th>Very satisfied</th>
<th>Quite satisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Quite satisfied</th>
<th>Very dissatisfied</th>
<th>Never visited</th>
<th>Don’t know / no opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local doctor or GP</td>
<td>57%</td>
<td>31%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>NHS dentist</td>
<td>55%</td>
<td>29%</td>
<td>3%</td>
<td>0%</td>
<td>1%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Pharmacist or Chemist</td>
<td>24%</td>
<td>19%</td>
<td>5%</td>
<td>3%</td>
<td>9%</td>
<td>25%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: ICM research

The survey highlighted perceptions were less favourable in relation to their opinion of the local NHS, joined up services and how much people felt they could influence their local NHS.

- In relation to their opinion of the local NHS 47% said they would speak highly of the local NHS and 12% would be critical, 38% would be neutral and 2% had no opinion.
- When asked about local NHS and social services working together to provide “joined up” service only 24% agreed, 17% neither agreed nor disagreed and 13% disagreed. The remaining 46% didn’t know.
- In relation to what extent, if at all, do you agree or disagree with the following statement – I can influence decisions affecting the local NHS services in my area. Only 11% agreed, 17% neither agreed nor disagreed and 59% disagreed, the remaining 14% didn’t know.

Figure 8.5: Local decision making – NHS

<table>
<thead>
<tr>
<th>Local decision-making - NHS</th>
<th>Strongly agree</th>
<th>Tend to agree</th>
<th>Neither agree not disagree</th>
<th>Tend to disagree</th>
<th>Strongly disagree</th>
<th>Don’t know / No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent, if at all, do you agree or disagree with the following statement: I can influence decisions affecting the local NHS service in my area?</td>
<td>1%</td>
<td>10%</td>
<td>17%</td>
<td>29%</td>
<td>31%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Source: ICM research

Complaints and comments

NHS Hampshire has a statutory duty in relation to handling and recording complaints and comments. The 2010 Annual Report reported that:

- a total of 237 complaints were received during the year 1 April 2009 to 31 March 2010
- A total of 955 comments, concerns, compliments and requests for information were received
- Of these 14 were comments, 143 were concerns, 19 were compliments
Complainants have the right to directly refer to the Parliamentary Health Service Ombudsman (PHSO). They can request for the case to be reviewed if they remain dissatisfied after the completion of local resolution. For this reason it cannot be stated with certainty how many complaints relating to services commissioned by NHS Hampshire have been sent to the PHSO during April 2009 to March 2010. However, notification was received of six such complaints. They were regarding

- 2 related to dental care
- 3 for GP’s
- 1 was about Continuing NHS funded healthcare.

Of the six complaints, two were returned for further work at local resolution stage; none were taken forward for investigation.

8.4 Adult Social Care

Engaging with service users is an ongoing and two way process. Consultation and user involvement is seen as integral to transforming services for all age groups as users have told Hampshire County Council Adult Services ‘Nothing about us without us’. The approach to involvement varies according the nature of the services and the needs of recipients of care and support.

User perspectives in adult social care


The Commission gathered ideas, comments and personal experiences in relation to the personalisation of adult social care. The Commission published a report ‘Getting Personal: A fair deal for better care and support’ which presented the following findings:

- **Putting people first** – the majority of people welcomed personalisation and supported the concept. A comparatively small number were opposed
- **Cultural change** – a number of respondents highlighted lack of power and choice for individuals in the current system and the need for change in both local authority services and the independent sector
- **That ‘little bit of help’ and self funder** – more help and information needed to take difficult decisions about care options and ways to pay for care
- **Support for carers** - to prevent crisis, gain easy access to advice, information and training.
- **Funding social care in the long term** – approximately 70 respondents discussed funding care and a considerable proportion expressed anger at the unfairness of the current system.

Service user and carer satisfaction of social care

Periodically Adult Services carry out a variety of service user surveys. Results show that people using Adult Services generally have a good perception of the services they receive.
In the 2009 Adult Services User Survey, 1997 service users were selected at random and 687 people returned surveys. The finding showed that

- **87.4%** respondents were satisfied with the service that they received. This was divided between (44.7%) being very satisfied and (42.7%) quite satisfied
- **Dissatisfaction had fallen for the 3rd year running down to 4.3%**
- **When asked if they were treated with respect and dignity the replies were, always 73.1%, and 22.9% usually, giving a total positive response of 96%**

The Department of Health undertakes an annual User Experience Survey Programme which targets areas of particular interest within Adult Social Services. Opinions are sought over a range of service areas, including community equipment, carers and home care.

**Community Equipment**

In 2009/10 and 2007/08 the community equipment and minor adaptations in England survey took place. The 2009/10 survey involved 675 Hampshire service users and results show:

- **The majority of service users were very or extremely satisfied with the equipment that they received (figure 8.2)**
- **71% reported that the adaption or equipment that they received improved their quality of life**
- **80% were very happy with the way they were treated by those discussing their needs**
- **Satisfaction levels remain high when compared with the 2007/08 survey**

**Figure 8.6: Satisfaction with community equipment and minor adaptions**

<table>
<thead>
<tr>
<th>Overall, how satisfied are you with the most recent piece of equipment/minor adaptation to your home that you received from [Social Services]?</th>
<th>2010 Number</th>
<th>2008 Number</th>
<th>2010 %</th>
<th>2008 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am extremely satisfied</td>
<td>295</td>
<td>395</td>
<td>43.70</td>
<td>44.28</td>
</tr>
<tr>
<td>I am very satisfied</td>
<td>249</td>
<td>329</td>
<td>36.89</td>
<td>36.88</td>
</tr>
<tr>
<td>I am quite satisfied</td>
<td>97</td>
<td>129</td>
<td>14.37</td>
<td>14.46</td>
</tr>
<tr>
<td>I am neither satisfied nor dissatisfied</td>
<td>19</td>
<td>22</td>
<td>2.81</td>
<td>2.47</td>
</tr>
<tr>
<td>I am quite dissatisfied</td>
<td>5</td>
<td>11</td>
<td>0.74</td>
<td>1.23</td>
</tr>
<tr>
<td>I am very dissatisfied</td>
<td>9</td>
<td>1</td>
<td>1.33</td>
<td>0.11</td>
</tr>
<tr>
<td>I am extremely dissatisfied</td>
<td>1</td>
<td>5</td>
<td>0.15</td>
<td>0.56</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>675</strong></td>
<td><strong>892</strong></td>
<td><strong>100.00</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Source: Department of Health

**Older People – Home care**

The Department of Health has run consecutive surveys on home care in 2002/03, 2005/06 and 2008/09. People in receipt of care in their own home were asked what they thought of the service they received. The 2008/09 survey was sent out to 2,000 Hampshire people in receipt of home care and 1011 responded. The findings show:

- **82% of people were satisfied, 5% were neither satisfied nor dissatisfied and 2% were quite dissatisfied. Consistently people using home care**
commissioned by Adult Services have been satisfied as the table below illustrates

**Figure 8.7: Older people home care user survey**

<table>
<thead>
<tr>
<th>Overall, how satisfied are you with the help from Adult Services that you receive in your own home?</th>
<th>2009 %</th>
<th>2006 %</th>
<th>2003 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am extremely satisfied</td>
<td>18</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>I am very satisfied</td>
<td>40</td>
<td>36</td>
<td>38</td>
</tr>
<tr>
<td>I am quite satisfied</td>
<td>34</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>I am neither satisfied nor dissatisfied</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>I am quite dissatisfied</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>I am very dissatisfied</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>I am extremely dissatisfied</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Department of Health

**Carers**

In November 2009 the Department of Heath carried out a survey to gain insight from carers. It looked at carers’ experiences of services and how they were supported to fulfil their caring responsibilities. Of the 498 Hampshire carers who responded, the majority were satisfied. This can be seen in the responses to the question below.

**Figure 8.8: Carers’ satisfaction**

<table>
<thead>
<tr>
<th>Overall how satisfied are you with the support or services you and the person you care for have received from Social Services in the last 12 months?</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>We haven’t received any support or services from Social Services in the last 12 months</td>
<td>21</td>
<td>4.3</td>
</tr>
<tr>
<td>I am extremely satisfied</td>
<td>81</td>
<td>16.5</td>
</tr>
<tr>
<td>I am very satisfied</td>
<td>183</td>
<td>37.2</td>
</tr>
<tr>
<td>I am fairly satisfied</td>
<td>149</td>
<td>30.3</td>
</tr>
<tr>
<td>I am neither satisfied nor dissatisfied</td>
<td>38</td>
<td>7.7</td>
</tr>
<tr>
<td>I am fairly dissatisfied</td>
<td>11</td>
<td>2.2</td>
</tr>
<tr>
<td>I am very dissatisfied</td>
<td>4</td>
<td>0.8</td>
</tr>
<tr>
<td>I am extremely dissatisfied</td>
<td>5</td>
<td>1.0</td>
</tr>
<tr>
<td>Total respondents</td>
<td>492</td>
<td>100.0</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Source: Department of Health

**Complaints and comments**

Adult Services service user complaints and compliments are recorded annually in the Complaints and Customer Care Team Annual Report. The introduction of a new criteria for the acceptance of statutory complaints resulted in a reduction of complaints being recorded. Of all the referrals received during April 2009 to March 2010, 237 were complaints and 318 were compliments. The number of compliments received raised by 57% in comparison to the same period in the previous year.
Figure 8.9: Respond data base

<table>
<thead>
<tr>
<th>Respond data base</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Complaints</td>
<td>424</td>
<td>263</td>
<td>264</td>
<td>237</td>
</tr>
<tr>
<td>Number of Compliments</td>
<td>185</td>
<td>164</td>
<td>182</td>
<td>318</td>
</tr>
<tr>
<td>Total</td>
<td>655</td>
<td>472</td>
<td>517</td>
<td>555</td>
</tr>
</tbody>
</table>

Source: Adult Services, Hampshire County Council

8.5 Local Area and neighbourhood

All district, borough and city councils in Hampshire have a variety of ways by which they ascertain the views and opinions of their residents. These can vary from tenant surveys, public events, focus groups, consultations and networks.

One of the ways that all councils gather views from residents is through their Citizen Panels and View Point Surveys. Through postal questionnaires and events they have consulted people on issues include:

- community safety,
- home insulation,
- transport and tourism,
- being active and wellbeing.

Results of surveys are published on council websites.

Residents’ perspective of local area

The 2008/09 Place Survey was conducted by each District Council in Hampshire. The results were aggregated and weighted so that an overview of opinions across the county could be given. Surveys were sent out to 29,088 households in Hampshire and 16,028 were returned which is a response rate of 55%. The survey identified that across Hampshire:

- 85% were satisfied with their local area as a place to live
- Satisfaction levels increase according to age with 81% 18-34, 85% of 35-54 and 89% of 54+ being satisfied
- There was a variation between districts, with 92% of Winchester residents being satisfied with their local care, compared to only 71% of residents in both Gosport and Rushmoor
- 93% felt safe when outside in their local area during the day. This dropped to 55% at night. There is a clear gender divide with 34% of women and 19% of men feeling unsafe after dark
- 26.9% agreed that older people in their local area get the help they need to live at home for as long as they want. The majority 59% didn’t know and 14% disagreed

The Place Survey identified what Hampshire residents thought made an area a good place to live. 62% of residents identified levels of crime as being the most important, followed by 49% of residents who thought health services were important.
When asked what most needed improving. The top priority was activities for teenagers 47%, which was followed closely by traffic congestion at 42%. The findings are illustrated in figure 8.10.

Figure 8.10: Residents’ perspective of local area

![Figure 8.10: Residents’ perspective of local area](image)

Source: Place Survey

**Influencing decisions**

The Place Survey also asked people about how involved they felt they were with local decision making in their local area. The local area was defined as being within 15-20 minutes walking distance from your home. The perception of residents’ ability to influence decisions making was fairly low: survey results showed

- When asked if they agreed or disagreed that they can influence decisions affecting their local area, 28% agreed and 71% disagreed.
- When asked if people wanted to be more involved in the decisions that affect their local area 24% said yes, 9% no and 67% said it depended upon the issues.

Figure 8.11: Local decision-making in the local area

<table>
<thead>
<tr>
<th>Local decision- making in local area</th>
<th>Do you agree or disagree that you can influence decisions affecting your local area?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitely agree</strong></td>
<td><strong>Tend to agree</strong></td>
</tr>
<tr>
<td>Definitely agree</td>
<td>Tend to disagree</td>
</tr>
<tr>
<td>3%</td>
<td>25%</td>
</tr>
<tr>
<td>49%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: Place Survey
Children and Young People

Partners across the county are committed to the following vision for the participation of children and young people:

In Hampshire, all children and young people have the opportunity to participate in decisions which affect their lives. They will have access to the services they need, when they need them and shape how these services are planned and delivered.

Key activities for securing the regular participation of children and young people include:

- annual surveys of primary and secondary school pupils, seeking their views on their school, local area and wellbeing
- district and county youth councils
- representation in the UK Youth Parliament
- consultation on specific strategies
- Care Ambassadors, young people who have been, or are, in care who support other children in care to have a voice
- Hampshire’s Rights, Respect and Responsibilities programme, which places an emphasis on pupil voice. This includes providing systematic opportunities for children and young people to participate in decisions. This helps them learn to make an active contribution to their school, community and wider society

Children and Young People’s Perspectives

Children and young people in Hampshire are routinely engaged in consultation on new strategies or changes to services. Examples include influencing Plans and Strategies, community consultations and Aiming High for Disabled Children. Detailed insight has been used in a number of ways to help shape services. These include:

- The Stanmore Community Plan which was influenced through a consultation with young people of secondary school age through Kings’ School, Winchester.
- A consultation as part of Aiming High for Disabled Children was held at a bowling centre in Eastleigh. Young people, their families and carers were asked their opinion about the formation of ‘Youth Action’ a young people’s group. The results influenced how the group was developed and run.

Pupils’ Attitudes

The Pupil Attitude Survey is an annual survey, carried out in the summer term, seeking the views of pupils in Years 2 (age 6), 6 (age 10), 7 (age 11) and 9 (age 13) about their school.

The majority of pupils participating in 2010 reported that they always, or usually, enjoyed school.
Figure 8.12: Pupils’ attitudes

<table>
<thead>
<tr>
<th>School year</th>
<th>Year 2</th>
<th>Year 6</th>
<th>Year 7</th>
<th>Year 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approx age</td>
<td>6</td>
<td>10</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Total no. of pupils</td>
<td>10,042</td>
<td>8,747</td>
<td>7,194</td>
<td>6,674</td>
</tr>
<tr>
<td>I always enjoy being at school</td>
<td>60.6%</td>
<td>17.3%</td>
<td>8.7%</td>
<td>4.7%</td>
</tr>
<tr>
<td>I usually enjoy being at school</td>
<td>36.6%</td>
<td>72.8%</td>
<td>71.3%</td>
<td>68.8%</td>
</tr>
<tr>
<td>I rarely enjoy being at school</td>
<td>Not an option</td>
<td>8.6%</td>
<td>16.6%</td>
<td>22.3%</td>
</tr>
<tr>
<td>I never enjoy being at school</td>
<td>2.8%</td>
<td>1.3%</td>
<td>3.4%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Source: The Pupil Attitudes Survey

The annual pupil wellbeing survey seeks the opinions of Year 8 (age 12) and Year 10 (age 14) pupils on a variety of health and wellbeing issues. In 2009, 72% of those taking part thought that their local area was a very, or fairly, good place to live. A total of 22% reported that they had given their views about their local area during the last year.

Care Ambassadors

During 2010, Hampshire County Council recruited five young people who are/have been in care as ‘Care Ambassadors’. The part-time role was specifically developed to improve participation of children in care and strengthen corporate parenting (the collective responsibility of the County Council to provide the best possible care and protection for children in care). The Care Ambassadors are linked to locally based children in care teams and have a key role in:

- widening participation and ensuring that there are a range of communication methods for children in care, including social networking
- acting as young advisors, guiding the County Council on issues for children and young people in care
- organising events and holding consultations, encouraging children and young people to participate in all aspects of their care

8.7 Health and Wellbeing

In 2009 over 1,000 people in Hampshire took part in a consultation to find out their thoughts on health and wellbeing. The feedback was used to develop Hampshire’s first health and wellbeing partnership strategy. The majority thought that people should take greater responsibility for their health and wellbeing. Feedback indicated the following areas as needing the most attention:

- Healthy Living – enabling people to take informed choices about their lifestyles through support and guidance
- Healthy Communities – supporting and engaging at a neighbourhood level to address social, economic and environmental issues
- Preventative Services – refocusing of community based services to
8.9 **Key messages**
The following key messages are aligned with the findings from surveys and consultation exercises carried out throughout Hampshire:

- More people would like to be involved and engaged in order to influence decision making. There is evidence that more people would prefer would be to get involved when decisions impact on their lives or neighbourhood. A more targeted approach to citizen involvement will enable more people to take an interest.
- The Government has expressed a wish to reshape LINks into HealthWatch. NHS Hampshire and Hampshire County Council will need to work with Hampshire LINk to plan the transition.
- Gathering the views of local people will help gain insight into how to influence behaviour change. Evidence shows that to address the issues highlighted in the lifestyles chapter requires people to make healthy choices. There is an opportunity to target at risk groups. Methods such as social marketing can be used to influence how people make decisions about their health and wellbeing.
- Issues of concern to Hampshire residents include joined up working between health and social care, activities for young people, public transport, roads and pavements and congestion.
- Hampshire residents have expressed a continuing need for information and advice to support them to make informed choices about their care, treatment and support.
### 9. Glossary and Acronyms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>In-patient admission stay of patient into hospital. Used when calculating number of patient stays.</td>
</tr>
<tr>
<td>Birth rate</td>
<td>Number of births per 1000 population.</td>
</tr>
<tr>
<td>BME</td>
<td>Black and minority ethnic.</td>
</tr>
<tr>
<td>Community strategy</td>
<td>The Local Government Act 2000 introduces a duty for local authorities to develop a community strategy, promoting the social, economic and environmental wellbeing of their areas, achieving sustainable communities.</td>
</tr>
<tr>
<td>HCC</td>
<td>Hampshire County Council</td>
</tr>
<tr>
<td>HPCT</td>
<td>Hampshire Primary Care Trust</td>
</tr>
<tr>
<td>Incidence</td>
<td>It is the number of new cases of a disease occurring in a population over a given time period.</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>Number of deaths at ages under one year per 1,000 live births.</td>
</tr>
<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
<td>Is the means by which PCTs and local authorities will describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs.</td>
</tr>
<tr>
<td>Life expectancy at birth for an area in each time period</td>
<td>An estimate of the average number of years a newborn baby would survive if he or she experienced the particular area’s age-specific mortality rates for that time period throughout his or her life.</td>
</tr>
<tr>
<td>Local Area Agreement (LAA)</td>
<td>Is a 3-year agreement made to achieve shared central and local priorities in a local area.</td>
</tr>
<tr>
<td>Mortality rate</td>
<td>Number of deaths per 1000 population.</td>
</tr>
<tr>
<td>PNA</td>
<td>Pharmaceutical Needs Assessment</td>
</tr>
<tr>
<td>Population pyramid</td>
<td>Is a graphical illustration showing the distribution of age-sex groups in a population, normally in the shape of a pyramid.</td>
</tr>
<tr>
<td>Practice Based Commissioning (PBC)</td>
<td>Is about engaging GP practices and other primary care professionals in the commissioning of services. Through</td>
</tr>
</tbody>
</table>
PBC, frontline clinicians are being provided with the resources and support to become more involved in commissioning decisions.

**Prevalence**

It is the number of old and new cases (total cases) of a disease occurring in a population over a given time period and indicates how widespread the disease is.

**Quality and Outcomes Framework (QOF)**

QOF was introduced in 2004 as part of a new contract for General Practitioners (GPs). As part of the framework, GPs maintain registers of 10 chronic conditions predominantly managed within primary care. GPs are awarded points based on the treatment and follow-up provided during the year for patients on the disease registers.

**Standardised rates**

Standardised rates allow the comparison of death rates in different areas, as they take into account the differing age-structures of the populations. There are two methods of standardisation: Standardised Mortality Ratios (SMRs) (also called indirect standardisation) and Age Standardised Rates (ASRs) (also called direct standardisation).