

**FAREHAM AND GOSPORT**  
**CLINICAL COMMISSIONING GROUP**  
**JOINT STRATEGIC NEEDS ASSESSMENT 2013**

This section presents the joint strategic needs assessment for the resident population of Fareham and Gosport CCG. Where possible and appropriate, data are presented for the CCG. Where data are not available by CCG data from the two local authority districts of Fareham and Gosport that fall within the CCG boundary are presented.

To place local figures into context data are compared to other areas. Where available the preferred comparator is England. Where this is not available comparison with Hampshire as a whole has been made.

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## Key findings

- Whilst the absolute increase in the population over the next 5 years is small, a higher proportion of the population will be in the older age cohorts.
- There are significant inequalities within the CCG. A male child born today in Gosport can expect to live 3.3 years less than a male child born in Fareham. Inequalities across both of the two local authorities are greater, however those within Fareham are less severe than within Gosport.
- Gosport is one of the most deprived areas in Hampshire and the lower super output areas (LSOAs) of Gosport Town Centre, Leesland and Grange are within the top 20% most deprived wards in England. Deprivation is directly linked to ill-health, and it is important to improve education, employment and income to improve the health status of the population.
- The CCG has a relatively high proportion of people over the age of 65 years living in one person households. In Gosport 12.7% of people aged over 60 years are living in income deprived households.
- Teenage pregnancy rates in Gosport are the highest in the county and the rate of reduction has been less than other districts.
- Indicators for the population of Gosport are relatively poor on a range of child focussed health indicators: infant mortality, child mortality, breastfeeding rates and childhood obesity levels. There are 4,758 children aged 0-15 living in income deprived households in Fareham and Gosport CCG.
- Of particular concern is the low educational attainment of children in Gosport, with which it will be difficult to break inter-generational cycles of low-skilled employment, low income and poorer health.
- Synthetic alcohol drinking estimates show that 26.9% of the population of Gosport and 27.3% of the population of Fareham who are identified as drinkers are consuming more than the government recommendations. Alcohol attributable mortality in males is also high in Gosport.
- Over one-third of people classed as routine and manual workers smoke in Gosport and the estimated proportion of adults that are obese in Gosport is the highest in the county and higher than the estimate for England.
- It is estimated that 3,165 people have undiagnosed Coronary Heart Disease, 1,194 undiagnosed stroke/TIA and 32,315 have undiagnosed hypertension and 2,021 people have undiagnosed diabetes in Fareham and Gosport CCG.

- Fareham and Gosport CCG has the highest rate of preventable Cardio Vascular Disease mortality in the county. There are potentially large numbers of people with undiagnosed cardiovascular disease.
- Gosport has the highest rate of cancers (all types) in the county. Rates for lung cancer are particularly high. Whilst overall rates of cancer in Fareham are similar to the south-east of England, rates of breast cancer are higher.
- Gosport has high rates of hospital admissions as a result of falls and hip fractures in people aged 65 and over.
- At a county level, all cause mortality has been falling, however in Fareham and Gosport, the rate has not decreased for men, resulting in a static mortality rate overall. Mortality rates are higher in Gosport than Hampshire and the south-east of England, but comparatively lower in Fareham.

## Recommendations

- Older people are higher users of health and social care services. The prevalence of chronic and other health conditions increases with older age and functional abilities may decline. Health services need to ensure models of care cater for the changing needs of the ageing population.
- It is important to maintain the health of people whatever their age and as they age to minimise the need and demand for social care and NHS services and maintain quality of life. The CCG needs to include plans for primary and secondary prevention in its commissioning plans.
- The CCG will need to ensure commissioning plans explicitly tackle the inherent inequalities in the area and use the principle of proportionate universalism in allocating funds.
- Whilst housing, employment and education are outside the responsibilities of the CCG, they are crucial to good health. The CCG should work with partners and through the Hampshire Health and Wellbeing Board to highlight the link between deprivation and health and link patients to local initiatives.
- The infant mortality rate (IMR) for Gosport is the highest in Hampshire. Whilst numbers are small, commissioners should ensure there is joined up action to reduce infant deaths, including good quality pre-natal care, good support for families in the early years and using evidence from the Child Death Overview process to support evidence based interventions.
- Breastfeeding rates are particularly low in Gosport, and whilst this is partially due to cultural norms in the area there is scope for ensuring consistent multi-agency support to encourage and maintain breastfeeding. The CCG should ensure it is involved in local initiatives around breastfeeding.
- In order to tackle childhood obesity, agencies should continue to work together to implement the Hampshire Healthy Weights strategy for children with a particular focus on Gosport and further enhance work with families.
- Poverty affects children's life chances and future health. The alleviation of childhood poverty and minimisation of its long term effects should be a key policy drive for local authorities and other partners locally and through the Health and Wellbeing Board.
- There is scope to improve uptake of the teenage booster vaccination, achieving high coverage will be especially important as the 2<sup>nd</sup> Meningitis C

vaccine is moved to this age. Practices can actively recall those in need of vaccination.

- CCGs should ensure opportunities for reducing alcohol intake are taken through quality health promoting conversations with health professionals and support multi-agency work to reduce the impact of alcohol locally.
- Whilst smoking cessation services have been relatively successful in Gosport concerted effort is needed to target communities where smoking is the norm. There is also a need to work with the local authority to promote smoke-free homes especially in families with young children.
- Obesity levels will have significant implications for health in the future and requires a systematic multi-agency strategic approach to tackle obesity locally and countywide.
- Whilst the absolute number of people diagnosed with HIV in Gosport and Fareham CCG is low, there is a higher proportion of late diagnoses than nationally. Clinicians should encourage those at increased risk of HIV to test, and consider HIV as part of the differential diagnosis even when the person appears to be at lower risk of infection.
- Concerted action is required to tackle lifestyle factors that increase the risk of CVD morbidity and mortality and maximise treatment opportunities.
- There is good evidence that secondary prevention of CVD can reduce morbidity. CCGs should encourage case finding in people at higher risk of disease and fully implement the NHS Health Checks programme with a particular focus on practices serving more deprived populations.
- There is scope for increasing case finding in 'at risk' patients and improving care processes for patients with diabetes. This will contribute to reducing avoidable complications and unnecessary hospital use.
- Given the levels of obesity, especially in Gosport, the number of people with diabetes will increase. Practitioners should give as much focus to primary prevention of diabetes, as well as good care and management.
- Chronic disease pathways should be linked to case ascertainment and primary prevention. COPD is potentially preventable as 90% of cases are attributable to smoking and potentially 3,408 people are undiagnosed in Fareham and Gosport CCG.

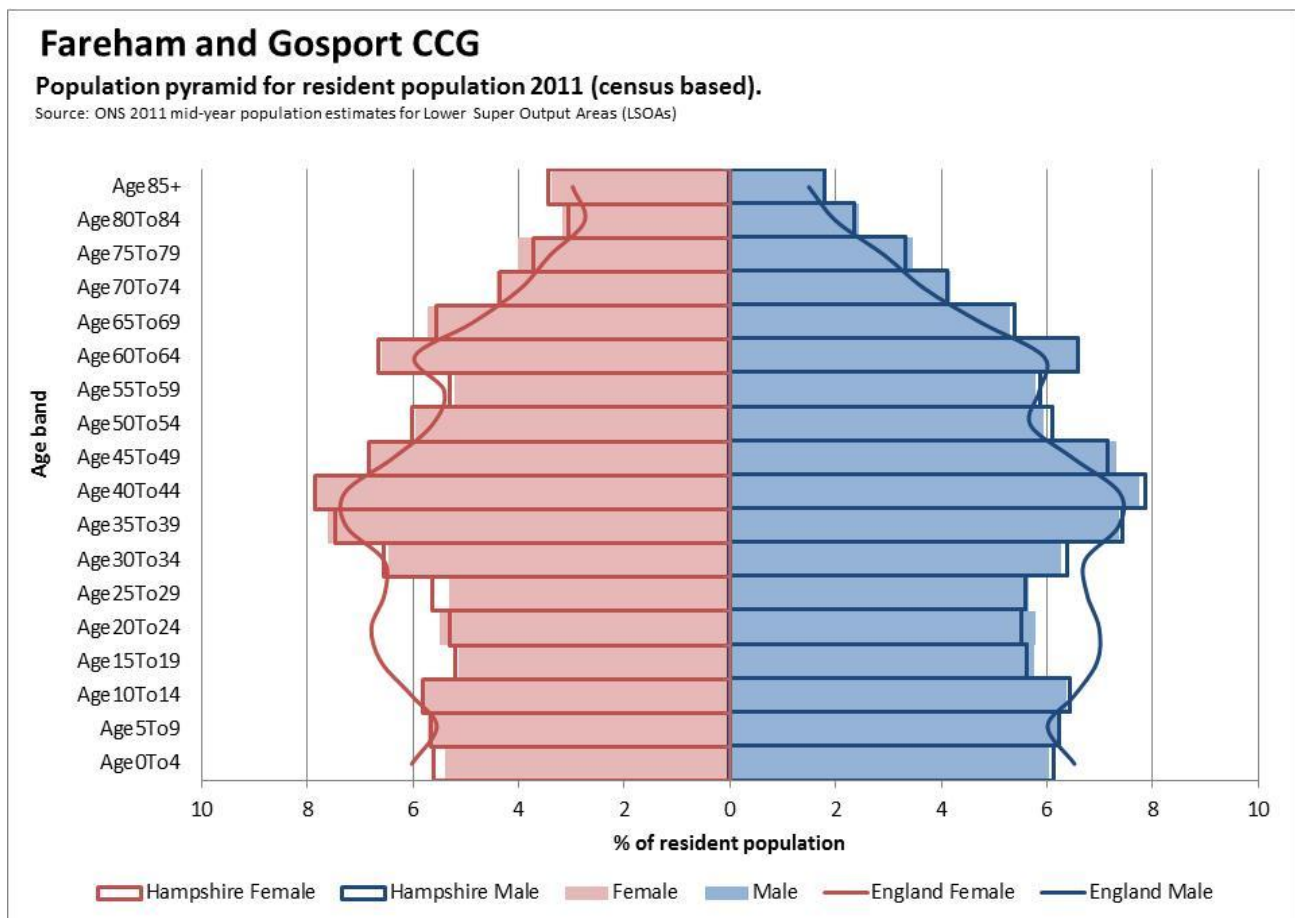
- Whilst the evidence base for reducing emergency admissions is scant, there is good evidence to prevent admissions for patients with heart failure and COPD. Gosport has the highest rate of emergency admissions for COPD in the county.
- Promoting bone health and using evidenced based strategies can reduce the risk of hip fractures.
- The CCG can achieve better musculoskeletal care and outcomes, using an integrated care pathway approach, starting with prevention, ensuring appropriate treatment in primary and secondary care and promoting self-management and shared decision making.
- There can be detrimental social consequences of reduced mobility and dementia on individuals and this in turn can negatively affect health. CCGs must ensure that health services are linked with agencies offering social support, such as volunteer befrienders and support networks for carers.
- Reductions in mortality have stalled in Gosport. There is a need to focus on primary and secondary prevention and good quality care for the main causes of death. However focus should also be on tackling the wider determinants of health including risky health behaviours, poverty, unemployment and education.

## 1 Demography

In the 2011 census the resident population of Fareham and Gosport CCG was 197,867 people, consisting of 97,207 men (49%) and 100,660 women (51%). This makes up 15% of the total population of Hampshire.<sup>1</sup> The geographical area of Fareham and Gosport CCG is relatively small (10,550 hectares) and is the most densely populated in Hampshire with 18.7 people per hectare compared to 3.6 people per hectare in Hampshire. There are 83,289 households in the Fareham and Gosport CCG.

The population pyramid (Figure 1) shows that the CCG has a relatively similar age structure to the England and Hampshire populations. There are fewer 15-29 year olds and slightly more 40-54 year olds and over 60 year olds compared to England. When looking at the two Districts, Gosport has a higher proportion of people aged 0-39 years than Hampshire and England, whereas Fareham has a higher proportion of people aged 50+ than Hampshire and England.

**Figure 1: Fareham and Gosport CCG population pyramid for resident population, 2011**



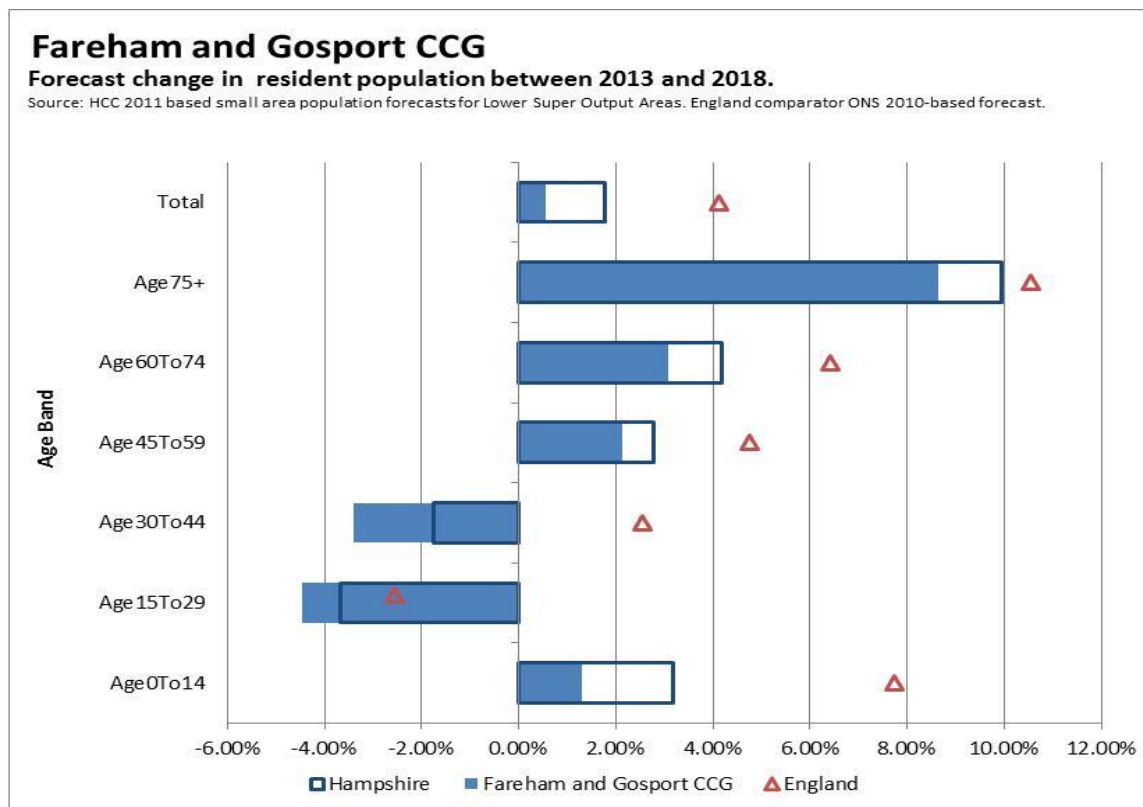
<sup>1</sup> ONS resident population, 2011



Overall 23.2% of the total population of Fareham and Gosport CCG is aged 0-19 compared to 23.5% for Hampshire and 24% for England.

The population of Fareham and Gosport CCG is projected to increase by 1,056 (0.56%) by 2018, lower than the projected increase for both Hampshire (1.77%) and England (4.11%) over the same time period. Figure 2 shows that there is a projected increase in all population groups aside from 15-44 year olds, which is estimated to shrink by 2,790 people (7.87%), a larger decrease than the Hampshire equivalent of 5.4%. The biggest increase in population will be seen in people aged 75 years and over, with an increase of 1,650 people (8.63%), however this is less than in Hampshire (9.94%) and England (10.56%).

**Figure 2: Forecast change in the resident Fareham and Gosport CCG population, 2013 to 2018**



**Table 1: Forecasted change in the resident population of Gosport District and Fareham District**

	Gosport			Fareham		
	2013	2018	% change	2013	2018	% change
<b>0-4 yrs</b>	14694	14814	0.82%	18191	18508	1.74%
<b>15-29 yrs</b>	15169	14403	-5.05%	17910	17180	-4.08%
<b>30-44 yrs</b>	15899	15398	-3.15%	21272	20557	-3.36%
<b>45-59 yrs</b>	14908	15192	1.91%	23739	24221	2.03%
<b>60-74 yrs</b>	11670	12049	3.25%	18928	19445	2.73%
<b>75+ yrs</b>	7586	8119	7.03%	11376	12426	9.23%
<b>Total</b>	79926	79975	0.06%	111416	112337	0.83%

## 1.1 Ethnicity

The 2011 Census showed that 94.4% of the population in Fareham and Gosport CCG identified themselves as White British, which is high compared to England (79.8%) and Hampshire (91.8%). Non British White people make up a further 2.6% of the population. 0.4% have been resident in the UK for less than 2 years, compared to 0.8% in Hampshire and 1.8% in England.

In Fareham and Gosport CCG the largest ethnic groups other than White British as described by detailed Census ethnic group are Indian or British Indian (1,091 people), Mixed/multiple ethnic group: White and Asian (1,083 people), White: Irish (788 people), White: Other Western European (732 people), Asian/Asian British: Chinese (681).

### What does this mean?

- Whilst the absolute increase in the population over the next 5 years is small, a higher proportion of the population will be in the older age cohorts. Older people are higher users of health and social care services. The prevalence of chronic and other health conditions increases with older age and functional abilities may decline. Health services need to ensure models of care cater for the needs of older people.
- It will become increasingly important to maintain the health of older people to minimise the increasing need and demand for social care and NHS services and maintain quality of life in the older years. The CCG needs to include plans for primary and secondary prevention in its commissioning plans.

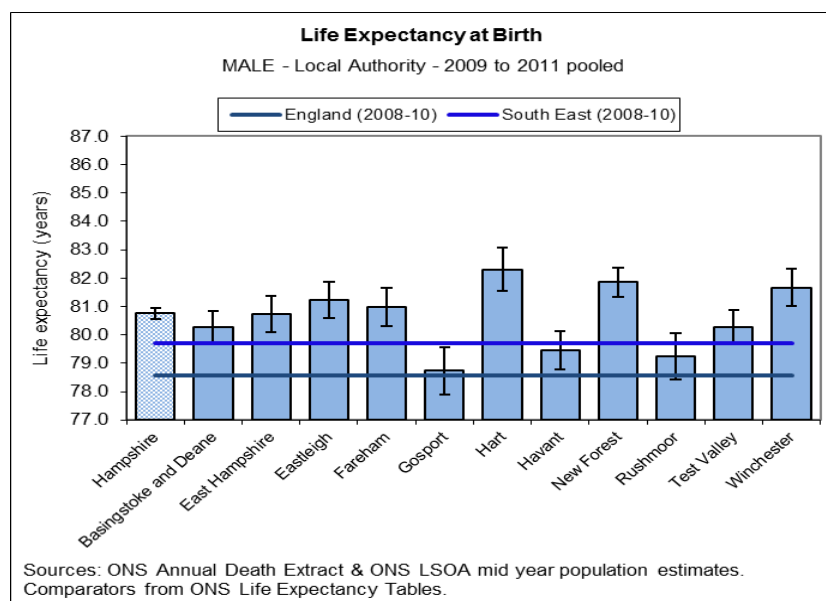
## 2 Health inequalities

Health inequalities are the avoidable differences in health, well-being and life expectancy between people. It is well known that age, sex, genetic make-up and lifestyle behaviours influence health. Other factors, which are known as the wider determinants also influence health. These include income, education, employment, housing and neighbourhood circumstances. The wider determinants of health can affect a person's health directly as well as their ability to manage their own health. They also help explain the difference in health and life expectancy between the poorest and richest in society.

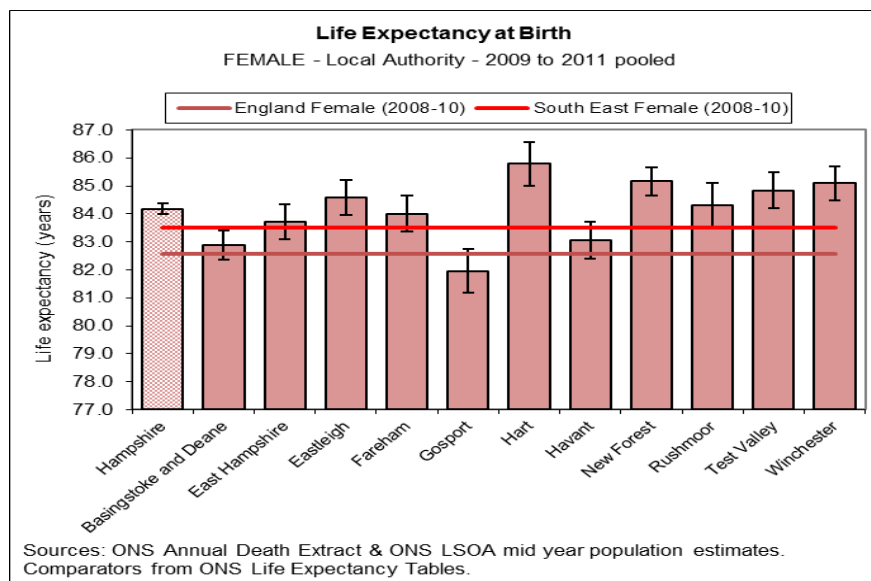
Life expectancy at birth is the average number of years a newborn could expect to live if he or she experienced the age-specific mortality rates in a given year. It is an indicator of current health and mortality conditions. The life expectancy at birth in Fareham and Gosport CCG was 80.1 years for males and 83.2 years for females. This is relatively low compared to the rest of Hampshire, with levels for females lower than the South East.

In Fareham, life expectancy in 2009-11 was 81 years for males and 84 years for females and in Gosport it was 78.7 years for males and 82 years for females. Life expectancy for males and females in Gosport is significantly lower than the Hampshire average. For Fareham life expectancy is similar to the Hampshire average for both males and females (Figure 3 & 4).

**Figure 3: Male life expectancy at birth – local authority 2009-2011 pooled**

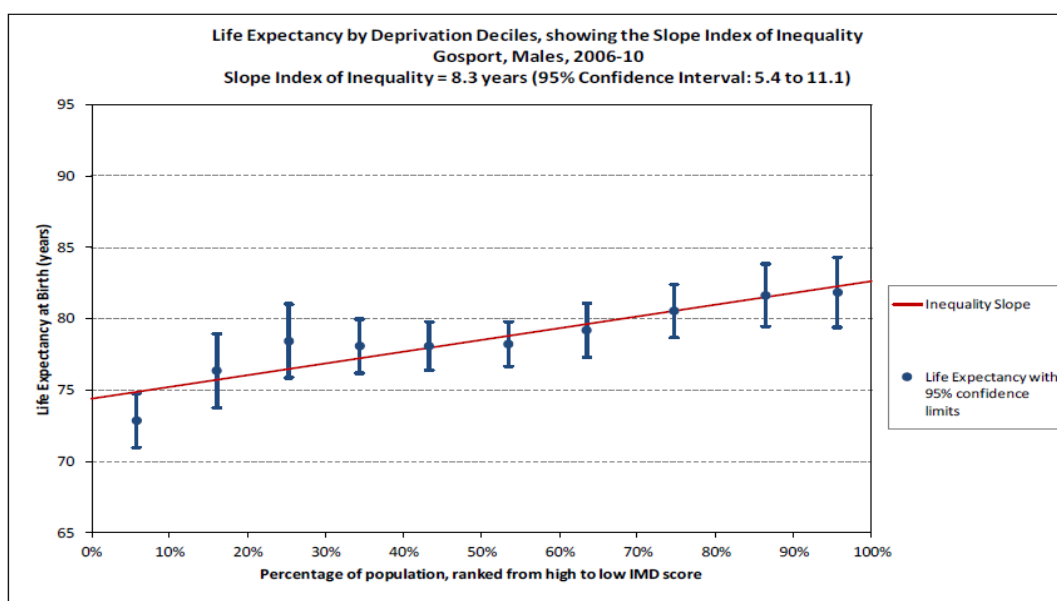


**Figure 4: Female life expectancy at birth – local authority 2009-2011 pooled**



The slope index of inequality shows the social gradient in life expectancy. The population in an area is grouped into ten deciles according to socio-economic status and the life expectancy of each decile calculated from mortality data. The resulting statistic shows the difference in life expectancy between the most and least deprived decile. Life expectancy is 8.3 years lower for men (Figure 5) and 3.0 years lower for women in the most deprived areas of Gosport compared to the least deprived. In Fareham life expectancy was 5.3 years lower for men and 2.8 years lower for women living in the most deprived areas, compared to the least deprived.<sup>2</sup>

**Figure 5: Life expectancy by deprivation decile showing the Slope Index of Inequality for Gosport (males)**



<sup>2</sup> Public Health England. Slope Index of Inequality. <http://www.apho.org.uk/resource/view.aspx?RID=110518>

## 2.1 Overall deprivation

The Index of Multiple Deprivation (IMD) ranks local areas across the country in terms of their relative deprivation as measured by a range of different factors. Fareham and Gosport both have lower levels of overall deprivation compared to England. However, Gosport is one of the most deprived areas in Hampshire and the lower super output areas (LSOAs) of Gosport Town Centre, Leesland and Grange are within the 20% most deprived wards in England.

In Gosport 22.6% (7,994) of households are deprived in two or more of the IMD domains, compared to 16.6% (7,714) in Fareham and 17.9% in Hampshire. In Gosport, the children and young people, education and skills, crime, living environment and outdoors domains are all ranked in the top 100 most deprived areas when compared with other areas in England (IMD 2010). This is also the case for the outdoors subdomain in Fareham (Figure 6).

**Figure 6: Indices of Deprivation 2010 - England ranks based on summary scores for Fareham and Gosport District Local Authority areas<sup>3</sup>**

	IMD	INCOME	EMPLOYMENT	HEALTH DEPRIVATION AND DISABILITY	EDUCATION SKILLS AND TRAINING	BARRIERS TO HOUSING AND SERVICES	CRIME	LIVING ENVIRONMENT	Indoors Sub-domain	Outdoors Sub-domain	Geographical Barriers Sub-domain	Wider Barriers Sub-domain	Children/Young People Sub-domain	Skills Sub-domain	IDACI	IDAOP1
Fareham District	311	303	293	319	256	257	257	218	289	81	129	281	252	259	298	317
Gosport District	155	166	187	169	71	255	87	93	124	52	286	108	21	121	130	228

80% of the population of Gosport (63,711 people) live in the most deprived quintile nationally for wider barriers, which includes household overcrowding<sup>4</sup> and homelessness.<sup>5</sup>

<sup>3</sup> Further information on the Indices of Deprivation 2010 domains can be found at <https://www.gov.uk/government/publications/english-indices-of-deprivation-2010>

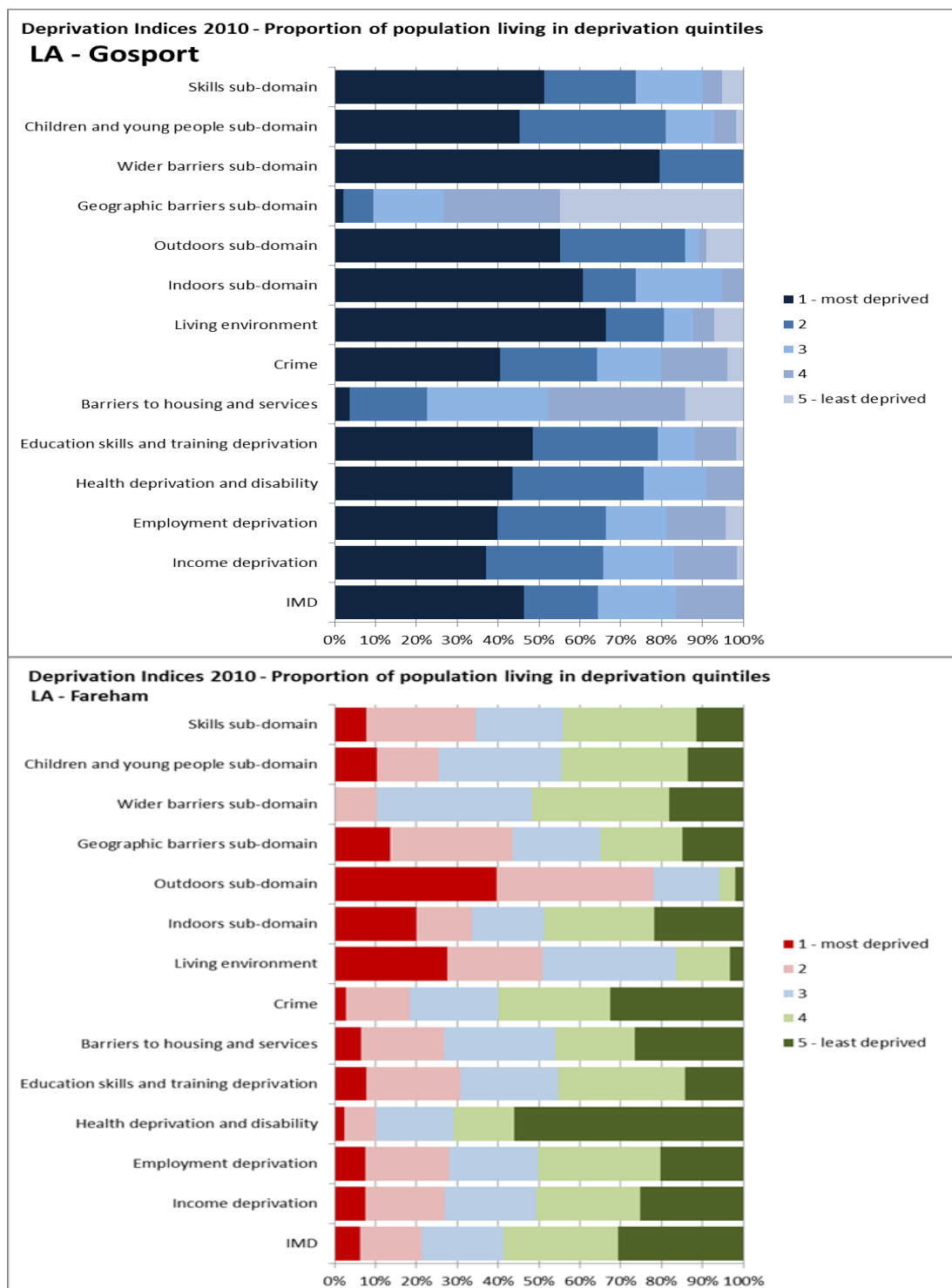
<sup>4</sup> Household overcrowding: the proportion of households within an LSOA which are judged to have insufficient space to meet the household's needs

<sup>5</sup> Homelessness: the rate of acceptances for housing assistance under the homelessness provisions of the 1996 Housing Act (at local authority district level), difficulty of access to owner-occupation (local authority district level), proportion of households aged under 35 whose income means they are unable to afford to enter owner occupation.

Over 50% of the population also live in the most deprived quintile for the indoor, outdoor, living environment and skills sub domains. These domains cover indicators such as the quality of housing, access to central heating, air quality, road traffic accidents and the proportion of adults aged 25-54 with no or low qualifications.

43% (34,769 people) of the population live in the most deprived quintile for health deprivation and disability (figure 7).

**Figure 7: Proportion of population living in deprived quintiles in Gosport and Fareham, IMD 2010**



Fareham has much lower proportions of people living in the most deprived quintile for each domain. 40% (43,977) of the population in this area live in the most deprived quintile for the outdoors subdomain, and 28% (30,512) for the living environment. 2% (2,553 people) of the population live in the most deprived quintile for health deprivation and disability (Figure 7).

## **2.2 Education, income and employment**

The conditions in which people are born, grow, live, work and age result in avoidable differences in health and mortality. There is a social gradient to health - the lower a person's social position, the worse their health. Inequalities exist in education, employment and income. Gaps in educational attainment between children living in the most and least deprived areas of England can be seen from school entry to GCSE grades. There is also a direct correlation between levels of educational attainment in youth and levels of ill-health in older age.

Whilst unemployment contributes to poor health, being in good employment is protective of health.<sup>6</sup> Both education and employment influence income and there is a well established link between income and health. For children, growing up in poverty is linked to lower educational attainment, unemployment or low paid employment in later life.<sup>7</sup>

### **2.2.1 Children and young people**

The proportion of pupils attaining five A\* to C GCSEs is used to measure educational attainment in 16 year olds. Deprivation is generally associated with worse GCSE results.

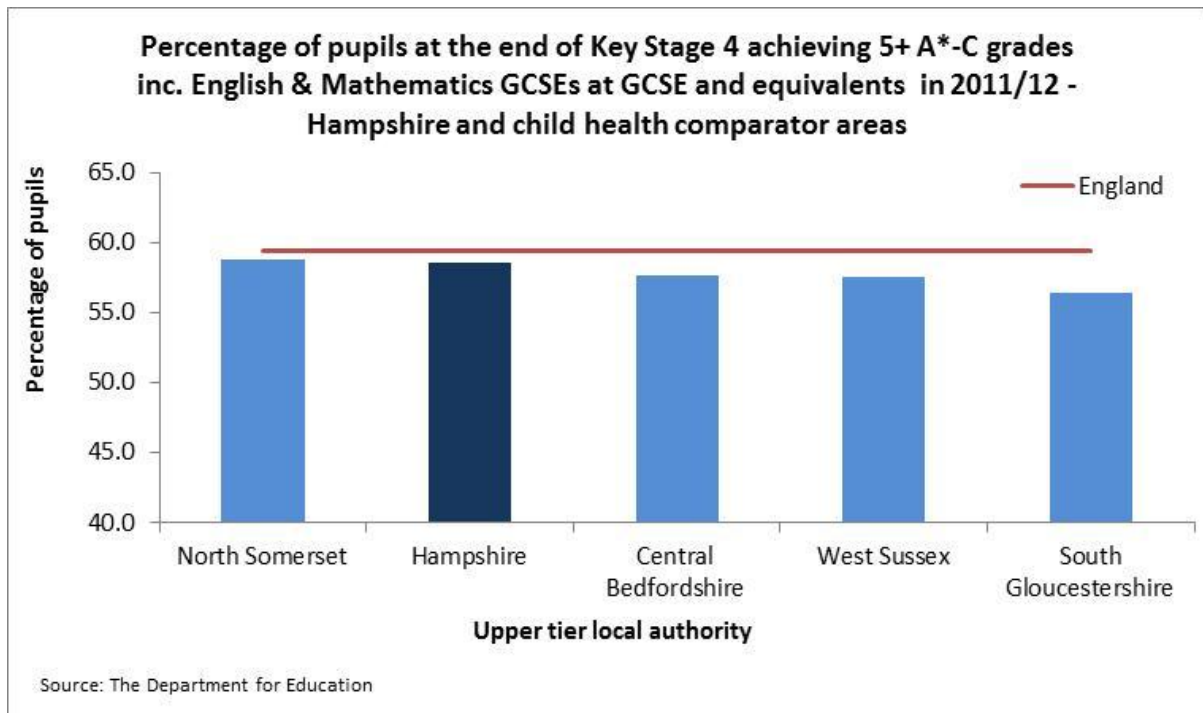
Figure 8 shows the percentage of Hampshire pupils (58.5%) at the end of key stage 4 achieving five or more A\*-C grades including English and Maths at GCSE, compared to the pupils for Hampshire's closest statistical neighbours. All have a similar rate.

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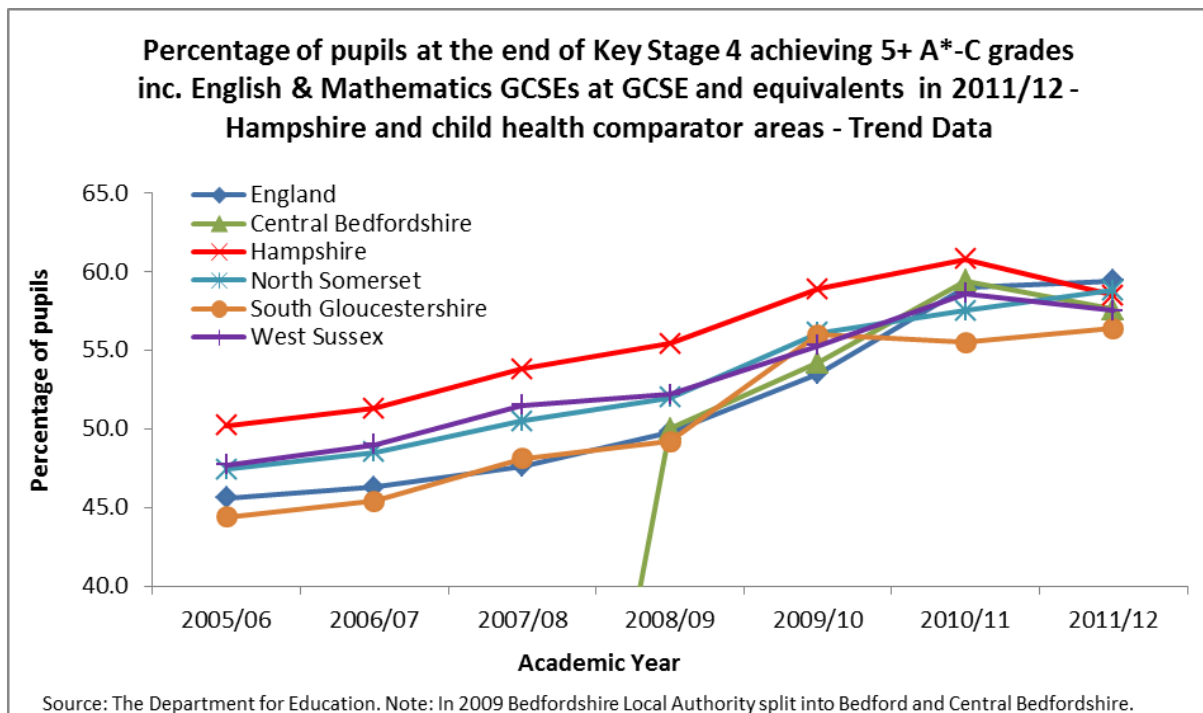
<sup>6</sup> Marmot M. Fair Society, Healthy Lives. London: The Marmot Review

<sup>7</sup> Griggs J, Walker R. The costs of child poverty for individuals and society. The Joseph Rowntree Foundation. October 2010

**Figure 8: Percentage of pupils at the end of Key Stage 4 achieving 5+ A\*-C grades including English at Maths GCSE at GCSE and equivalents.**



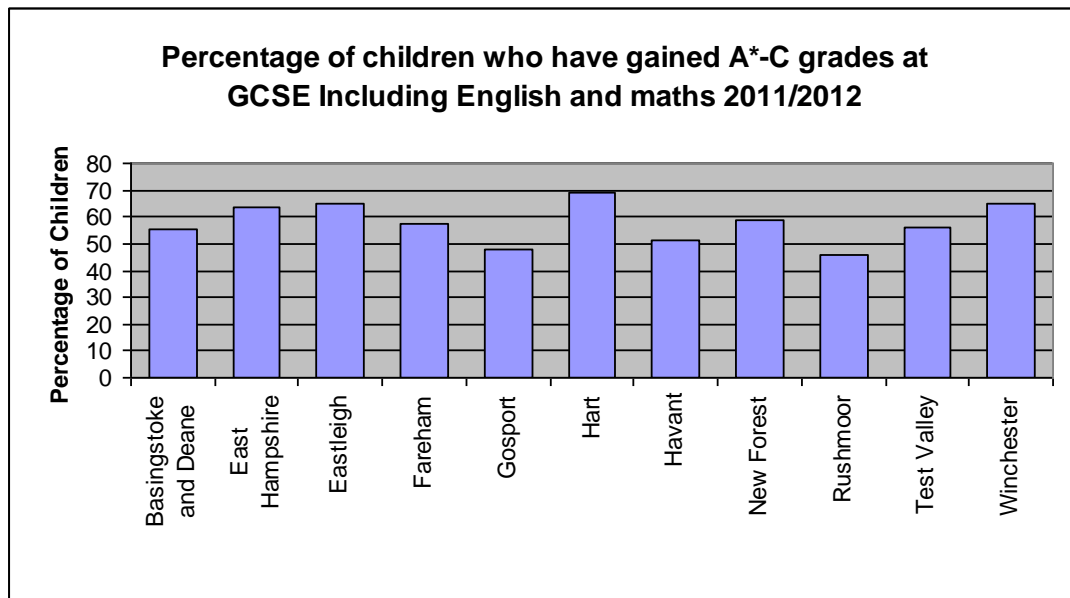
**Figure 9: Percentage of pupils at the end of Key Stage 4 achieving 5+ A\*-C grades including English at Maths GCSE at GCSE and equivalents – Trend Data.**





The proportion of young people in Gosport attaining 5 GCSEs including English and maths is one of the lowest in the county, and lower than the England average of 59.4%.<sup>8</sup>

**Figure 10: District level information for pupils achieving five or more GCSEs (or equivalent) at grade A\*-C, including English and maths**



Source: Department for Education

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

### 2.2.2 Working age adults

72% (42,981) of the 16-74 year old population in Gosport and 72.7% (59,063) in Fareham are economically active compared to 73.2% in Hampshire and 69.9% in England. Skill levels among Hampshire's adult population are generally higher than the national levels. However, 21.6% of the Gosport population have no qualifications and the district has the lowest levels of people aged between 16-64 years old with qualifications of A level or above.

Table 2 shows that Gosport has higher levels of adults with no qualifications and youth unemployment than both Hampshire and England. It also has higher levels of

<sup>8</sup>[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/219343/sfr02\\_202013\\_at.xls](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/219343/sfr02_202013_at.xls)

unemployment for all ages, lone parents not in employment and people who have never worked compared to Hampshire. The most common industries for the economically active adult population to work in both Fareham and Gosport are wholesale, retail trade and motor vehicles, public administration and defence, manufacturing and education.

**Table 2: Characteristics of the working age population in Fareham and Gosport**

	Fareham %	Gosport %	Hampshire %	England %
Residents aged over 16 years old with no qualifications	17.6 (16,181 people)	21.6 (14,347 people)	18.5	22.5
Unemployed (16-74 years olds)	2.6 (2,117 people)	4.2 (2520 people)	3	4.4
Unemployed 16-24 year olds	0.8 (628 people)	1.3 (803 people)	0.8	1.2
Never worked	0.2 (195 people)	0.5 (323 people)	0.3	0.7
Lone parent households not in employment	26.4 (621 people)	37.4 (1109 people)	32.4	40.5

### 2.2.3 Older adults

The 2011 Census identified that 12.9% (10,766) of households in the CCG area were defined as one person households with the occupant being over the age of 65 years old. This is higher than Hampshire (12.6%) and England (12.4%). Amongst those over the age of 60 years old, 9% (2664 people) in Fareham and 12.7% (2363 people) in Gosport are living in households which are income deprived.<sup>9</sup> This compares to 10.7% in Hampshire overall and 18.3% in England.

### 2.2.4 Disability

Households where one of the members has a disability tend to have less overall income compared to households where there is no one living with a disability. People with disabilities who are in work are more likely than the rest of the working population to be on low hourly pay. Many disabled people spend periods of their working-age lives out of work and this increases their risk of poverty in later life. These worse outcomes are compounded by the extra costs associated with living with disabilities.<sup>10</sup>

<sup>9</sup> This can be defined as the proportion of adults aged 60 or over living in Income Support or income based Jobseeker's Allowance or Pension Credit (Guarantee) families.

<sup>10</sup> See (<http://www.equalityhumanrights.com/key-projects/triennial-review/>)

The 2011 Census showed that 7.1% (14,015) of the CCG population aged 16-64 years old had their day-to-day activities limited a lot by their long term health condition or disability. This is more than in Hampshire (6.7%) but less than England (8.3%).

In Fareham and Gosport 0.3% of people (n=485) over the age of 18 years old were registered as having a learning disability. This is similar to the Hampshire level of 0.4%.<sup>11</sup> In 2009/10, two thirds of adults with learning disabilities who were known to the County Council's Adult Services were judged to be in settled accommodation, which is more than national (61%) and regional (63.2%) levels. Some of these were living with their families. Over 88% of people with learning disabilities were unable to find paid work for at least an hour a week.

### **2.3 Housing and homelessness**

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

Homeless people die on average 30 years younger than the general population. Alcohol and drugs are a major cause of death in homeless people, and deaths resulting from external causes, suicide and accidents are more common than in the general population.<sup>13</sup>

In Fareham 80% of homes are either owned outright or mortgaged, compared to 65.3% in Gosport. In Fareham 10% of home are privately rented compared to 16.3% of homes in Gosport.

The rate of statutory homelessness in Hampshire was 0.81 people per 1000 households in 2011-12, with the highest levels in the areas of Gosport, Havant and East Hampshire.<sup>14</sup> Gosport has had the highest number of households accepted as homeless and in priority need in Hampshire each year from 2009-12 to 2011/12 with

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<sup>11</sup> Data from the 2011-12 Quality and Outcomes Framework (QOF)

<sup>12</sup> Houses of Parliament Parliamentary Office of Science and Technology. Housing and Health. Postnote. 371, January 2011

<sup>13</sup> Bethan T. Homelessness kills. 2012 Crisis.

[http://sasi.group.shef.ac.uk/publications/reports/Crisis\\_2012.pdf](http://sasi.group.shef.ac.uk/publications/reports/Crisis_2012.pdf)

<sup>14</sup> Lower tier local authorities have a statutory duty to provide suitable accommodation for people who are eligible for assistance; homeless through no fault of their own and who fall in to a priority need group. Groups in priority need include: pregnant women; people with dependent children; 16-17 year olds; people aged 18-20 who have been previously looked after; people aged 21 years old and over who are vulnerable as a result of having been looked after; and vulnerable people, such as older people, those with mental ill health and mental and physical disabilities.

an average of 111 per year. Fareham had an average of 21 per year for the same period.

## **2.4 Gypsies and Travellers**

Significant health inequalities exist between Gypsies and Travellers and the general population in England, even when compared with other socially deprived or excluded groups and with other ethnic minorities. The 2011 Census recorded a total of 2,069 Gypsies and Travellers living in Hampshire. This included 85 people (0.08%) in Fareham and 32 people (0.04%) in Gosport. Local estimates suggest the actual figure in Hampshire is likely to be much higher than the census data; between 4,690 and 7,630 people.

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

### **What does this mean?**

- There are significant inequalities within the CCG. A male child born today in Gosport can expect to live 3.3 years less than a male child born in Fareham. Inequalities within Gosport are even higher. The CCG will need to ensure commissioning plans explicitly tackle the inherent inequalities in the area and use the principle of proportionate universalism.
- Gosport is one of the most deprived areas in Hampshire and the lower super output areas (LSOAs) of Gosport Town Centre, Leesland and Grange are within the 20% most deprived wards in England.
- Whilst housing, employment and education are outside the responsibilities of the CCG, they are crucial to good health. The CCG should work with partners to highlight the link between deprivation and health and link patients to local initiatives.
- Of particular concern is the low educational attainment of children in Gosport, with which it will be difficult to break inter-generational cycles of low-skilled employment, low income and poorer health.
- The CCG has a higher proportion of people over the age of 65 years living in one person households. In Gosport 12.7% of people aged over 60 years are living in income deprived households. These people are potentially vulnerable to isolation and poorer health outcomes as compared to Hampshire.

### 3 Children and young people

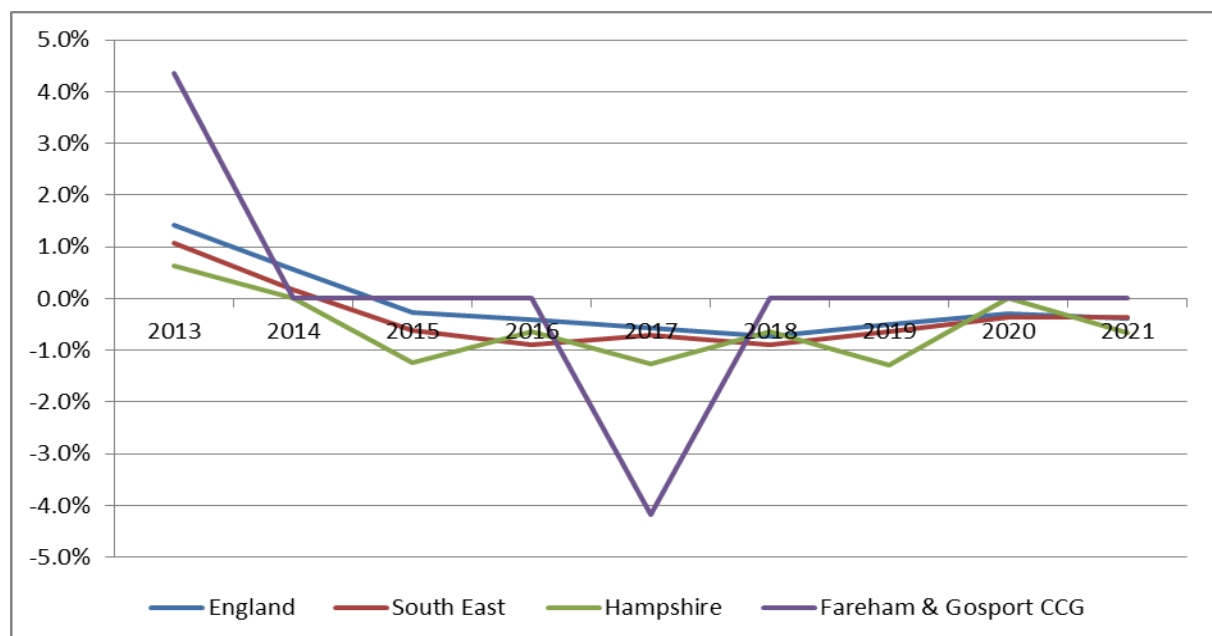
There are 45,866 children and young people aged under 20 in Fareham and Gosport, making up 23.2% of the population.<sup>15</sup>

#### 3.1 Births

Pooled data from 2009-11 show that the general fertility rate in Fareham and Gosport CCG is 64.8 (62.6-66.9) live births per 1000 women aged 15-44 years old, which is very similar to the Hampshire rate (64.3)<sup>16</sup> and the England rate (64.5).<sup>17</sup>

Predicted future numbers of births based on the ONS Interim 2011-based birth projections (2013 to 2021) are available for Hampshire and its local authorities but not by CCG. Consequently, data from the two local authorities of Fareham and Gosport that fall within the CCG boundary are presented. The projections suggest that the on-going rise in births in the CCG may be starting to level off. It is hard to predict what future births will look like due to changes in fertility rates and the size and age structure of the female population. Overall, birth projections in the CCG appear to follow the general trend for Hampshire but are constrained by the wide error margin when using local authority based birth projections due to the small populations under consideration.

**Figure 11: Birth projections for Fareham and Gosport CCG from 2013 to 2021**



Source: ONS Interim 2011-based Subnational Population Projections

<sup>15</sup> 2011 Census.

<sup>16</sup> ONS annual birth extract

<sup>17</sup> ONS Vital Statistics

### 3.2 Teenage conceptions

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

Despite the decrease, Gosport had the highest rate in the county at 40.6 per 1,000 girls in 2009-11, which was a 13.8% decrease from 2008-10. Gosport also has the highest under 16 conception rate of 9.5 per 1,000. Rates in Fareham were 22 per 1000 girls (2009-11), 11.6% less than in 2008-10 (ONS, Conception Statistics England and Wales 2011). Rates are reducing at a slower rate in Gosport than in other areas of the county.

In 2009/11, 40.7% of under 18 conceptions in Gosport ended in abortion which is lower than the Hampshire (48.7%) and national (49.6%) rates.

### 3.3 Smoking in pregnancy

Smoking in pregnancy is important as it increases the risk of having a low birth weight baby and of infant death. The rate of smoking at the time of delivery in Hampshire is 11.8%, which is lower than the England rate of 13.2% (2012-13).

### 3.4 Infant and child mortality<sup>18</sup>

Infant and child mortality rates are sensitive indicators not only of child health, but also of the general health of the population. Infant mortality is a reflection of the delivery of healthcare services to mothers and newborns, as well as the wider social determinants of health. Infant mortality rates are comparatively higher for low income families<sup>19</sup> and there is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation's health as well as a predictor of health inequalities. Evidence in the *Marmot Review: Fair Society, Healthy Lives* noted that factors including births outside marriage, maternal age under the age of 20 and deprivation, were independently associated with an increased risk of infant mortality.<sup>20</sup>

The infant mortality rate for Gosport was 4.0 per 1,000 live births (95% CIs 2.2-6.9), the highest rate in Hampshire, equating to 13 deaths a year. The infant mortality rate for Fareham was 3.7 per 1,000 live births (95% CIs 1.9-6.4), equating to 12

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<sup>18</sup> Infant mortality is deaths of infants aged under 1 year per 1000 births. Under-5 mortality rate, is a the probability of death derived from a life table and expressed as rate per 1,000 live births( WHO)

<sup>19</sup> <http://www.childrehealthwatch.org/upload/resource/Duncan2000.pdf>

<sup>20</sup> [http://www.ons.gov.uk/ons/dcp171778\\_300596.pdf](http://www.ons.gov.uk/ons/dcp171778_300596.pdf)

deaths a year. This compares to the England rate of 4.4 per 1,000 live births (95% CIs 4.3-4.5) (Pooled data for 2008-10).

Over the past 30 years child death rates from respiratory and circulatory diseases in England and Wales have been falling, as they have for the whole population, reflecting advances in medical care and preventative measures generally. In 2011 congenital related conditions and cancers were the most common form of death for children aged under 16 years. However, childhood mortality between the ages of 0 and 14 remains among the worst in Europe. Comparator European countries have improved their outcomes over the last 20 years while the UK has fallen behind in the rate of improvements where death rates are higher for asthma, meningitis, pneumonia and diabetic ketoacidosis.

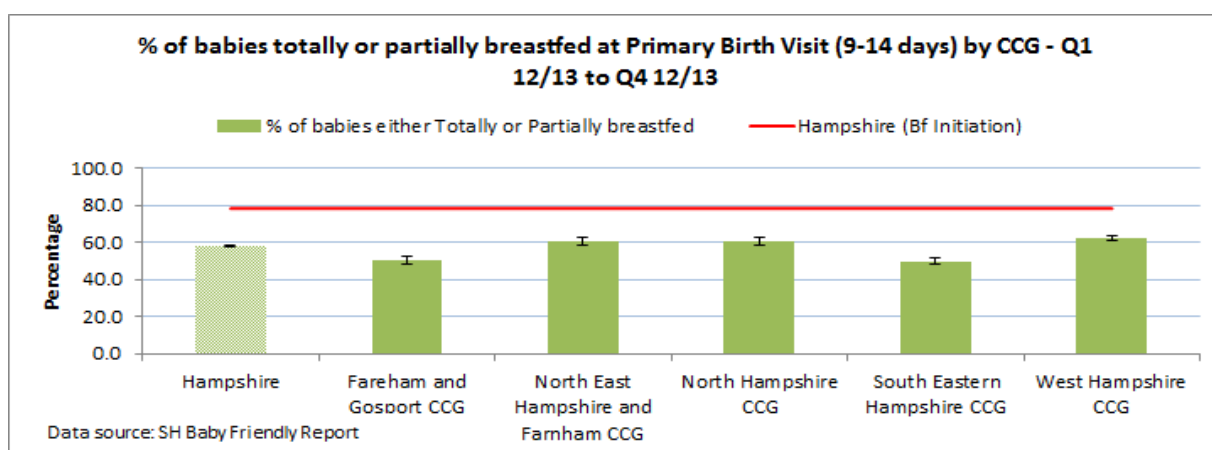
Local Safeguarding Children Boards are responsible for reviewing the deaths of all children from birth (excluding still born babies) up to 18 years. Child death review data are collected by the Child Death Overview Panel (CDOP). The Southampton, Hampshire, Isle of Wight and Portsmouth CDOP reviewed 70 Hampshire death notifications in the 0-18 population in 2011/12.

### 3.5 Breastfeeding

Breastfeeding rates and good weaning practice are influenced by deprivation and act as an early contributing factor to the cycle of health and social inequalities.<sup>21</sup> Only 42.2% of mothers in the most deprived quintile in Hampshire initiate breastfeeding.

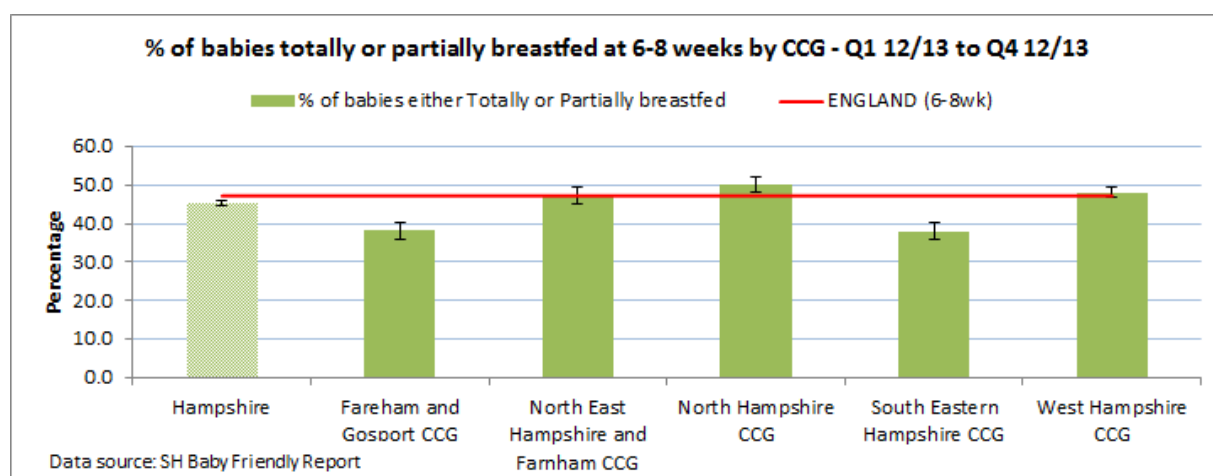
Fareham and Gosport CCG, along with South Eastern Hampshire CCG has the lowest breastfeeding rates in the county. This is due to lower rates in Gosport, where 29.8% of mothers were breastfeeding at 6-8 weeks, compared to 42.9% of mothers in Fareham (Figure 12 & 13).

**Figure 12: Percent of babies totally or partially breastfed at Primary Birth Visit 2012/13**



<sup>21</sup> Chief Medical Officer (2008) The Chief Medical Officer's report 2007. Under their skins: tackling the health of the teenage nation. London: Department of Health.

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



### 3.6 Childhood obesity

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

Pooled data for 4-5 year olds show that for the CCG as a whole 8.6% were obese (Table 3). This masks considerable local variation, the proportion of children that were found to be obese in Gosport was 9.4% compared with 8.1% in Fareham. Similarly for 10-11 year olds the proportion that was obese was 19.4% for Gosport and 14.7% for Fareham. Gosport has the highest rates in the county and for the older cohort, higher rates than the England average. Across all of Hampshire’s CCGs the proportion of children who are obese almost doubles between Reception and Year 6.

**Table 3: National child measurement programme results in Hampshire 2009/10-2011/12**

Population	Year R: Overweight	Year R: Obese	Year 6: Overweight	Year 6: Obese
F&G CCG	13.7%	8.6%	13.6%	16.6%
Hampshire	12.9%	8.0%	14.4%	15.4%
England	13.2%	9.6%	14.6%	19.0%

### 3.7 Oral health

Overall, Hampshire’s five and twelve year old children have good dental health when compared to national figures, but there are variations in oral health at district level. There are inequalities in dental health, with children from areas of deprivation



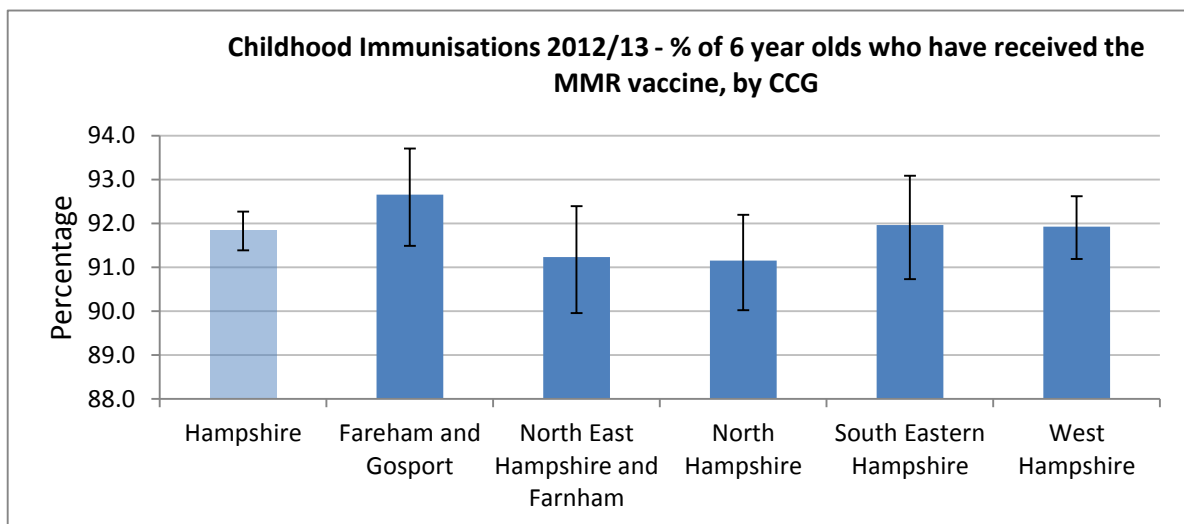
experiencing disproportionately higher levels of oral disease. Persistent dental health inequalities among Hampshire's five year olds are reflected among twelve year olds as well.

In the most recent 2008/09 survey of twelve year olds, 25.2% of Hampshire children had experience of dental decay (33.4% for England) with an average of just under two teeth affected (2.21% nationally). Over twice as many twelve year old children from Gosport (32.6%), had dental decay in 2008/09, compared to just 13.5% of children from Hart. Among five year olds in 2007/08, 21.7% had experience of dental decay, against the national average of 30.9%.

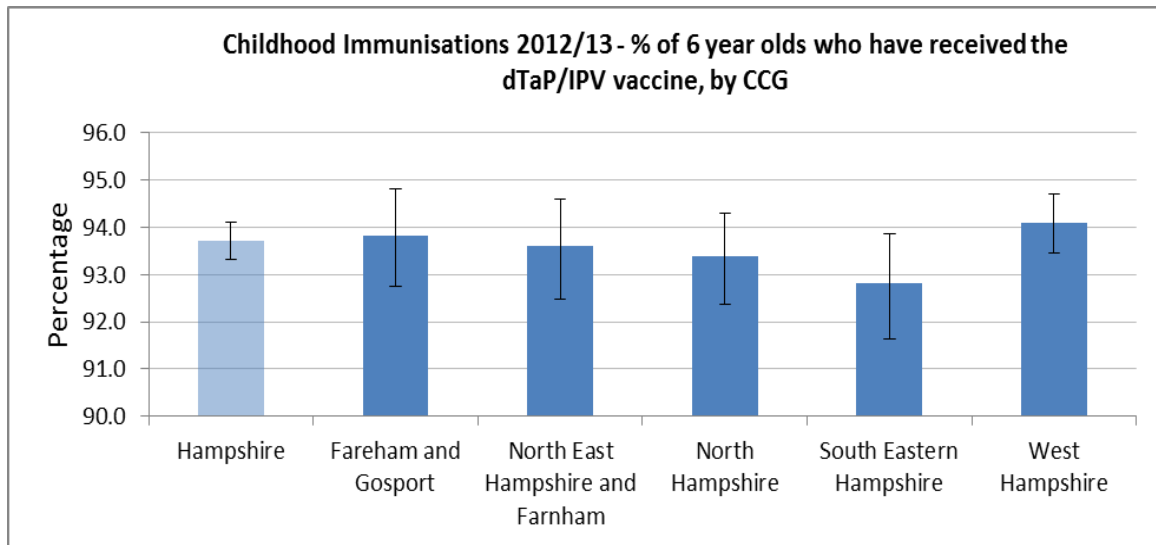
### 3.8 Immunisation

Childhood immunisations are essential to protect individuals and the community against potentially serious infectious diseases. The uptake rate at 6 years of age is used to assess the impact on health of the individual and community. The uptake rate for Fareham and Gosport for MMR 2 at 6 years of age is 92.7% (Figure 14), whilst the uptake for dTaP/IPV (diphtheria, tetanus, pertussis and polio) is 93.8% (Figure 15). This is below the WHO target of 95% which is required to ensure herd immunity; it is higher than the uptake for Hampshire as a whole.

**Figure 14: Proportion of children who have received 2 MMRs at 6 years by CCG 2012/13**

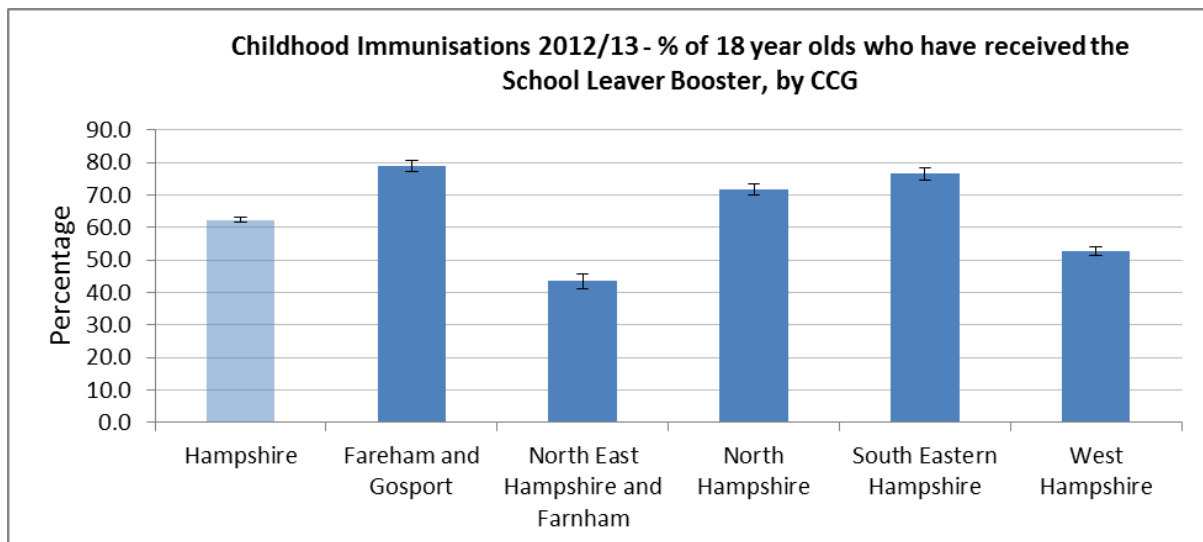


**Figure 15: Proportion of children who have received dTaP/IPV at 6 years by CCG 2012/13**



The Teenage Booster vaccine Td/IPV (tetanus, diphtheria and polio) scheduled for all 13-18 year olds is provided by general practices. The figure 16 shows that the uptake rate recorded on the child health information system for Fareham & Gosport CCG was 78.95% which falls below the DH recommended level of 90%.

**Figure 16: Proportion of children who have the school leaver booster by 18 years by CCG 2012/13**



### 3.9 Emergency admissions for asthma, diabetes and epilepsy

Emergency admissions for asthma, diabetes and epilepsy for people under the age of 19 years old may reflect the way in which these long term conditions are managed. Pooled data from 2009-12 in Fareham and Gosport CCG show that the rate was lower (218 per 100,000) than in Hampshire (275 per 100,000) and when

compared to other CCGs. Rates increased in males from 2008-11 and have been steadily decreasing from 2009-12 for females.

### **3.10 Injury and accidents**

Unintentional injuries are the leading cause of death in children aged between one and four years and 15 to 19 years in England and Wales and are the second leading cause of death in children aged 10 to 14 years. Children from the most deprived families are 13 times more likely to die from unintentional injuries and 37 times more likely to die in a fire than children living in the least deprived areas.

The rate of emergency admissions for unintentional and deliberate injuries in people under the age of 18 from 2009-12 in Fareham and Gosport CCG was 1,038 per 100,000, which was similar to the Hampshire rate (1066 per 100,000). In Gosport in 2011, there were 226 per 100,000 (DSR) cycling casualties in 0-15 year olds, which is more than twice as many as the next highest rate area (Havant).

### **3.11 Vulnerable children and young people**

#### **3.11.1 Children in poverty**

Tackling child poverty is vital in reducing inequalities and deprivation, improving the life chances of children and young people in low income families. The Income Deprivation Affecting Children Index represents the proportion of all children aged 0-15 living in income deprived households<sup>22</sup> and can help to measure the levels of children living in poverty in an area.

Almost one in five (2,988, 19.8%) 0-15 year olds in Gosport and 1,780 (9.1%,) 0-15 year olds in Fareham live in income deprived households. Although the proportion living in income deprived households in Gosport is lower than in England (21.7%), it is the second highest in the county and higher than Hampshire as a whole (12.1%).

#### **3.11.2 Children with disabilities**

Children with disabilities are one of the most vulnerable groups in Hampshire. However, defining and measuring the landscape of childhood disability is challenging due to the lack of an agreed definition across health, education and social care domains, with no single source being accurate or complete. Overall, estimates of the numbers of disabled children in Hampshire ranges anywhere from 3,000 to 50,000 depending on the source and the way in which disability is defined. Around 7,040 children aged 0-17 years were disability living allowance (DLA) claimants in August

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<sup>22</sup> This is defined as either families receiving Income Support, income-based Jobseeker's Allowance, Pension Credit (Guarantee) or those not in receipt of these benefits but in receipt of Child Tax Credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs.

2012. The autumn 2012 Hampshire School Census records 16.8% (4,235) of school pupils in Fareham and Gosport CCG as having a special educational need (SEN) and of these, 2.5% (638) had a statement to identify their needs. A statutory assessment is only necessary if the school or early education setting cannot provide all the help that a child needs.

Despite the ambiguity and lack of robust data on childhood disability, there is a consensus amongst paediatricians, social services managers and educationalists that the population of children using services is increasing and so is the complexity of disability and complex health need. Where we do have some data it clearly reflects this, for example, paediatric intensive care activity in Hampshire has risen by 28%, rising from 305 admissions in 2007 to 391 in 2011, along with increasing NHS activity generated from technology-dependent children.

Several factors are responsible for the increase in the numbers of disabled children and young people, including Hampshire's rising birth trend (14.4% rise, from 13,320 in 2000 to 15,238 in 2011), better survival rates, improvements in care, increasing births at maternal age extremes, multiple pregnancies, assisted reproductive technology, preterm births, low birth weight, prematurity, genetic abnormalities, congenital abnormality, sensory deficits, learning difficulties, respiratory illnesses, cerebral palsy and Down's syndrome.

Nationally, the Children and Young People's Health Outcomes Forum in their proposals to Government recommends that the Department of Health, Department for Education and Public Health England (PHE) improve data about children with disability and complex needs by 2015.

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

### **What does this mean?**

- The infant mortality rate (IMR) for Gosport is the highest in Hampshire. Whilst numbers are small, commissioners should ensure there is joined up action to reduce infant deaths, including good quality pre-natal care, good support for families in the early years and using evidence from the Child Death Overview Panel to support evidence based interventions.
- Teenage pregnancy rates in Gosport are the highest in the county, and the rate of reduction has been less than other districts. Whilst the factors that increase the risk of teenage pregnancy are complex, health professionals have a vital role in preventing teenage pregnancy and supporting teenage mothers.

- Breastfeeding rates are particularly low in Gosport, and whilst this is partially due to cultural norms in the area there is also scope for ensuring consistent multi-agency support to encourage and maintain breastfeeding. The CCG should ensure it is involved in local initiatives around breastfeeding.
- The causes of childhood obesity are complex but can have long lasting implications for the health of the individual. The CCG should play a full part in implementing the Hampshire Healthy Weights strategy for children with a particular focus on Gosport and further enhance work with families.
- There are 4,758 children aged 0-15 living in income deprived households in Fareham and Gosport CCG. Poverty can affect children's life chances and future health. The alleviation of childhood poverty should be a key policy drive for local authorities and other partners locally.
- There is scope to improve uptake of the teenage booster vaccination, achieving high coverage will be especially important as the 2<sup>nd</sup> Meningitis C vaccine is moved to this age in the vaccination schedule. Get all practices to search on their database to ascertain who has not been vaccinated and actively call.

## 4 Health related behaviour

Lifestyle factors such as smoking, excessive alcohol intake, a poor diet and sedentary lifestyle increase the risk of disease. A recent Lancet study concluded that tobacco, high body mass index and diet and physical activity made a significant contribution to disability adjusted life years lost in the UK in 2010.<sup>23</sup>

### 4.1 Smoking and tobacco control

Tobacco use is the single most preventable cause of ill health in the UK and a major contributor to health inequalities. There is clear evidence that through reducing smoking prevalence we will improve healthy life expectancy as well as total life expectancy.

The proportion of adults estimated<sup>24</sup> to be currently smoking is 17.8% in Fareham and 20.4% in Gosport, which is higher than the estimate for Hampshire at 17.5%. In 2012/13, rates of smoking amongst routine and manual workers were 27.6% in Fareham and 31.6% in Gosport, compared to 30% in Hampshire and 30.3% in England.

The directly age standardised rate of deaths wholly or partly attributable to smoking in people aged over 35 years old was 212.2 per 100,000 in Gosport and 152.5 per 100,000 in Fareham. Rates in Gosport are higher than the England rate of 210.6 per 100,000 (2008-10).

In 2011-12, 11.1% of all smokers aged over 15 years old in Fareham and 14.1% in Gosport were accessing NHS stop smoking services. There was a 4 week quitter success rate of 44% in Fareham and 46% in Gosport. Whilst the penetration rates are some of the highest in the county, the success rates are amongst the lowest.

### 4.2 Obesity

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

It is estimated that 62% of the adult population in Hampshire is overweight (38%) or obese (24%). Future projections do not indicate any flattening out of the current

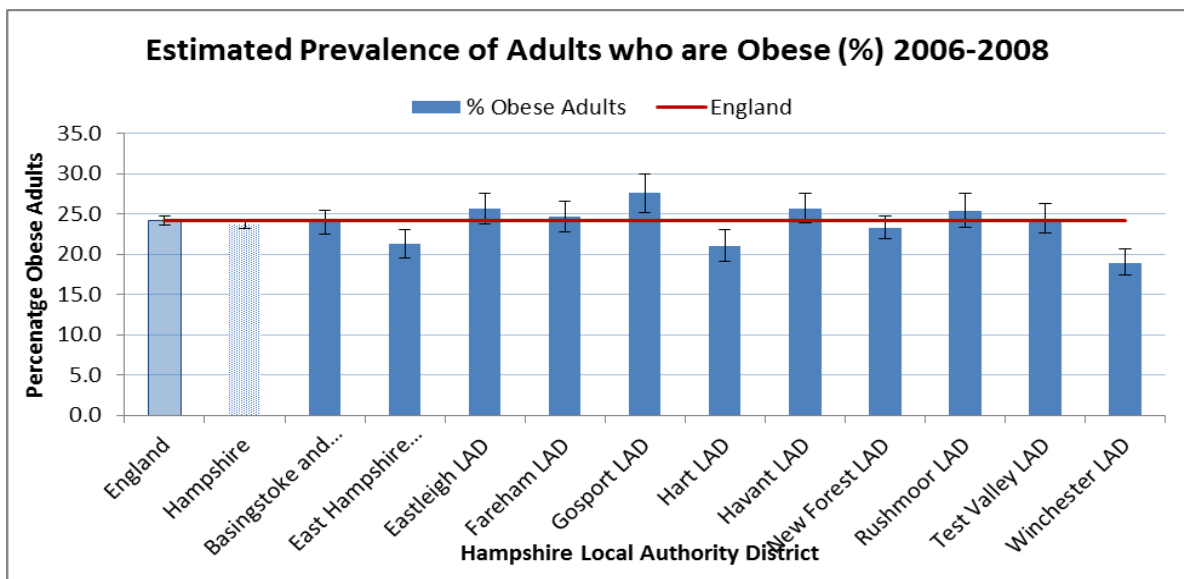
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<sup>23</sup> Murray CJL, Richards MA, Newton JN et al. UK health performance: findings of the Global Burden of Disease Study 2010. *The Lancet* - 23 March 2013 ( Vol. 381, Issue 9871, Pages 997-1020 )  
DOI: 10.1016/S0140-6736(13)60355-4

<sup>24</sup> 2011/12 Integrated Household Survey, ONS

rising trend but instead predict a significant rise in obesity and severe obesity. The prevalence of obesity and of being overweight changes with age. For adults it is lowest in the 16-24 year old age group and gets generally higher in the older age groups for both men and women. Gosport has the highest modelled prevalence of obesity in the County, and the prevalence is significantly higher than the national average. Fareham has a similar modelled prevalence to Hampshire and England (figure 17).

**Figure 17: Estimated prevalence of adults who are obese by local authority 2006-2008**



### 4.3 Alcohol

Regularly drinking more than the government-recommended safe limit increases the risk of developing chronic diseases including liver disease, diabetes, cardiovascular disease and cancers of the breast and gastrointestinal tract.

Synthetic estimates show that 26.9% of the Gosport population and 27.3% of the Fareham population over the age of 16 years old who are identified as drinkers consume more than the government recommendations.<sup>25</sup>

The rate of admission for alcohol-attributable conditions was 1442.6 per 100,000 in Gosport in 2010/11. This is lower than the national rate of 1895.2 per 100,000 and higher than the Hampshire rate of 1357.4 per 100,000. The rate in Fareham is 1164.4 per 100,000, which is lower than the Hampshire and England rates.<sup>26</sup>

<sup>25</sup> The UK Government recommends that women drink less than 15 units per week and men 22 units per week. Care must be taken when interpreting these data as they are derived from a statistical model.

<sup>26</sup> See <http://www.lape.org.uk/>

The directly age standardised rate of alcohol specific hospital admissions for people under the age of 18 years old in 2009-12 in Gosport was 43 per 100,000, which is higher than Hampshire (34 per 100,000). Rates in Fareham were 26 per 100,000, which is lower than Hampshire.

There is an upward trend in the rate of alcohol related admissions. In Hampshire since 2002/03 there has been 9% average year on year growth in the rate of admissions. This is comparable to the England average year on year growth which is also 9%. For the local authorities in Fareham and Gosport CCG the year on year average growth for Fareham was 7% and Gosport was 4%.

In 2009-11, the directly age standardised rate of alcohol attributable mortality was 10 per 100,000 for females of all ages and 21 per 100,000 for males of all ages in Gosport. These are both the highest in the county. Rates in men (9 per 100,000) in Fareham were higher than in Hampshire (8 per 100,000) and rates for women (3 per 100,000) were lower than in Hampshire (5 per 100,000).

#### **4.4 Sexual health**

Left untreated, sexually transmitted infections (STIs) can lead to a range of complications including ectopic pregnancy, infertility, disability, cancer and premature death. STIs are the main cause of infertility (particularly in women) and can also facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility.

In 2011, Gosport ranked 150th and Fareham 193rd out of 326 local authorities (where one is the highest) in England for rates of STIs. The rate of acute STIs in Gosport was 642.1 per 100,000 and in Fareham this was 578 per 100,000 (all ages). 69% of acute STI diagnoses were in young people aged 15-24 years. Around 8% were in men who have sex with men.

The chlamydia diagnosis rate was 2385.4 per 100,000 young people in Gosport, which is the second highest rate in the county behind Havant. This compares to 1,975 per 100,000 in Hampshire and 2,125 per 100,000 in England. Nationally it is recommended that we should achieve a diagnosis rate for chlamydia of 2,400 per 100,000.

The prevalence of HIV in Hampshire is low at 0.8 per 1,000 population aged 15-59 in 2009 (0.78 in 2008) compared to the national rate of 1.5 per 1,000 in 2011.

Of those diagnosed with HIV 66.7% in Fareham and 55.6% in Gosport were classified as having a late diagnosis, compared to a national level of 52.3%. Late diagnosis of HIV is the largest predictor of HIV mortality and morbidity.



**For information about physical activity please see the Hampshire JSNA.**

### **What does this mean?**

- Synthetic drinking estimates show that 26.95 of the population of Gosport and 27.3% of the population of Fareham who are identified as drinkers are consuming more than the government recommendations. Alcohol attributable mortality in males is also high in Gosport. CCGs should ensure opportunities for reducing alcohol intake are taken through quality health promoting conversations with health professionals and support multi-agency work to reduce the impact of alcohol locally.
- Over one-third of people classed as routine and manual workers smoke in Gosport. Whilst smoking cessation services have been relatively successful in Gosport concerted effort is needed to target communities where smoking is the norm. There is also a need to work with both local authorities to promote smoke-free homes especially in families with young children.
- The proportion of adults that are obese in Gosport is the highest in the county and higher than the estimate for England. Rates are not much lower in Fareham. This will have significant implications for health in the future and requires a systematic multi-agency strategic approach to tackle obesity locally and countywide.
- There is a lack of data on levels of physical activity at a local level. However physical activity should be encouraged with everyone, but especially those at risk of or with chronic illness. General practices should consider using motivational interviewing techniques such as 'Let's Get Moving'.
- Whilst the absolute number of people diagnosed with HIV in Gosport and Fareham CCG is low, there is a higher proportion of late diagnosis than nationally. Clinicians should encourage those at increased risk of HIV to test, and consider HIV as part of the differential diagnosis even when the person appears to be at lower risk of infection.

## 5 Long term conditions

Fareham and Gosport CCG has a higher recorded prevalence of a number of conditions including cardiovascular disease, cancer, asthma, depression and dementia as compared to the England average, however it is not possible to determine whether the data are significantly higher than England.

### 5.1 Cardiovascular disease

Cardiovascular disease (CVD) can be thought of as a family of diseases<sup>27</sup> which have common risk factors, but different outcomes.<sup>28</sup> Lifestyle risk factors for cardiovascular disease (CVD), such as smoking, physical inactivity, poor diet, obesity and harmful alcohol intake are modifiable. Table 4 shows the prevalence of the most common forms of CVD. These rates are not adjusted for age, making comparison difficult across areas as those with older populations tend to have higher rates of disease. Hypertension is the most common form of CVD in Fareham and Gosport CCG and the county as a whole.

**Table 4: Prevalence of the most common forms of CVD in Fareham & Gosport CCG**

CCG	CHD		Stroke/TIA		Atrial fibrillation	
	QOF no.	QOF prevalence %	QOF no.	QOF prevalence %	QOF no.	QOF prevalence %
Fareham & Gosport	7517	3.8	3781	1.9	3575	1.7
Hampshire	44334	3.3	24381	1.8	22411	1.8

CCG	Heart Failure		Heart Failure due to LVD		Hypertension	
	QOF no.	QOF prevalence %	QOF no.	QOF prevalence %	QOF no.	QOF prevalence %
Fareham & Gosport	1385	0.7	797	0.4	30919	15.5
Hampshire	8339	0.6	4514	0.3	186558	14.0

CCG level expected prevalence rates are available for CHD, stroke/TIA and hypertension (table 5).

<sup>27</sup> There are a broad range of diseases of the circulatory system. The highest prevalence cardiovascular diseases include hypertension, myocardial infarction, stroke and heart failure.

<sup>28</sup> DH Cardiovascular Disease Team. Cardiovascular disease outcomes strategy. Department of Health, 5/3/2013.

**Table 5: Estimated number of patients missing from QOF disease registers**

CCG	Coronary Heart Disease			Stroke/TIA			Hypertension		
	QOF prevalence %	Expected prevalence %	Undiagnosed no.	QOF prevalence %	Expected prevalence %	Undiagnosed no.	QOF prevalence %	Expected prevalence %	Undiagnosed no.
Fareham & Gosport	3.8	5.4	3165	1.9	2.5	1194	15.5	31.7	32315
NE Hants and Farnham	2.6	4.4	3916	1.4	2.0	1346	12.4	28.2	34370
North Hampshire	2.7	4.5	3805	1.4	2.0	1251	12.0	28.3	35030
SE Hampshire	3.9	6.4	5168	1.9	2.9	2141	15.2	33	37086
West Hampshire	3.5	5.5	10670	2.1	2.6	2669	14.2	31.7	94767
Hampshire	3.3	5.4	28213	1.8	2.5	9482	14.0	30.8	223870

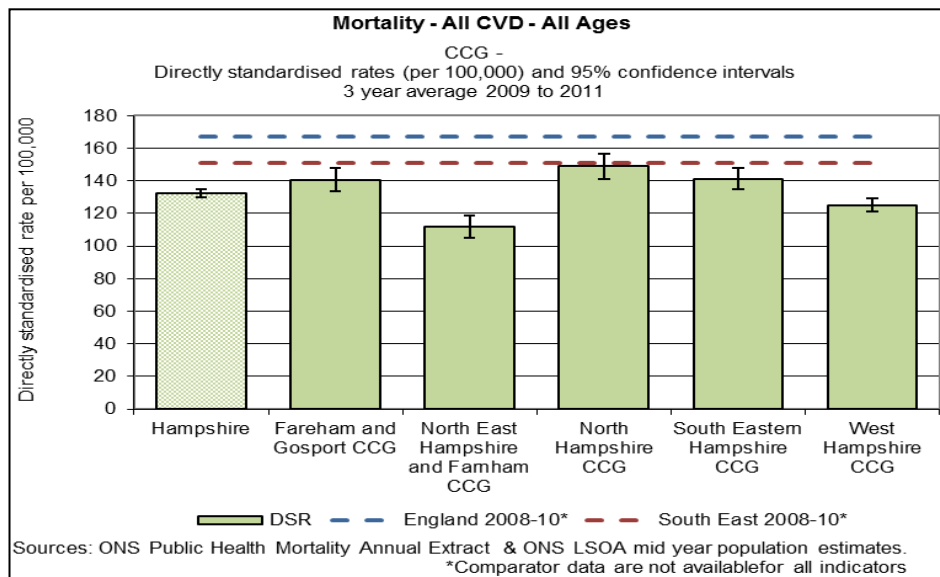
It is estimated that there are 3,165 people with undiagnosed Coronary Heart Disease, 1,194 people with undiagnosed stroke or transient ischaemic attack (TIA) and 32,315 people with undiagnosed hypertension in Fareham and Gosport CCG. The NHS Health Check programme provides an important opportunity to increase diagnosis and encourage participants to improve their lifestyles.

Between 2008/9 and 2011/12 CVD admissions have reduced from 1,111 per 100,000 people (1,070-1152) to 1,006 per 100,000 people (967-1045) in Fareham and Gosport CCG. This is against an increase in CVD admissions in the county, which can be attributed to increases in elective work.

Geographical inequalities are present at every stage of the care pathway for CVD from risk of developing the disease to choice of place of death. Outcomes tend to be worse the more deprived an area is. There may also be inequalities between the sexes with women being less likely to have access to planned hospital care. Of the cardiovascular diseases women are particularly prone to stroke.

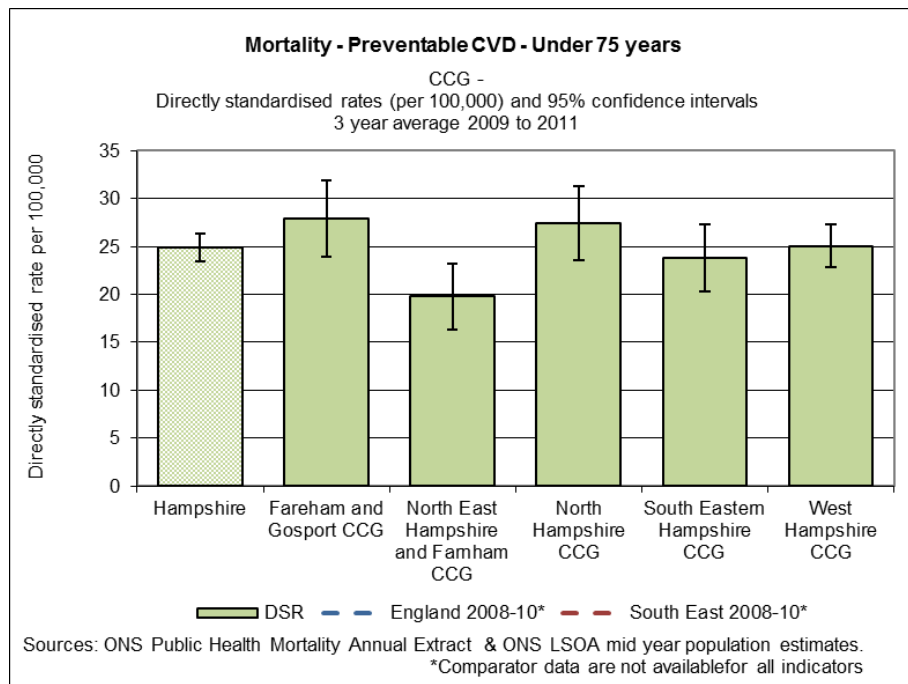
The CVD mortality rate for Fareham and Gosport CCG is 141 per 100,000 compared to 132 per 100,000 people in Hampshire, though this is not statistically significant (Figure 18).

**Figure18: Directly standardised rate of mortality caused by cardiovascular disease 2009-2011**



The CCG has the highest rate of preventable CVD mortality in the county for people under 75 years old, at 28 per 100,000 compared to 25 per 100,000 in Hampshire though this is not statistically significant (Figure 19).

**Figure 19: Directly standardised rate of preventable mortality caused by cardiovascular disease 2009-2011**



## 5.2 Diabetes

There are 58,719 people in Hampshire and 9,120 in Fareham and Gosport CCG diagnosed with diabetes (Table 6). A further 2,021 people in Fareham and Gosport CCG may not have been diagnosed.

**Table 6: Number of people with diabetes on QOF registers and estimated numbers with diabetes by CCG 2011-12**

Area	Number (QOF 2011/12)	Prevalence (QOF 2011/12)	Estimated Number	Estimated Prevalence	Lower uncertainty limit	Upper uncertainty limit	Estimated number of people unrecorded or undiagnosed
NHS Fareham and Gosport CCG	9120	5.7%	11,141	6.8%	5.0%	10.4%	2,021

The proportion of people achieving good blood glucose control is 69.1% compared to 69.9% nationally and 69.6% achieved good blood pressure control compared to 70.7% nationally.

The rate of elective admissions for Fareham and Gosport CCG is lower than Hampshire as a whole as are all admissions for diabetes (Table 7). However the diabetic lower limb amputation rate (16 amputations per 100,000, 132 amputations) was higher than the Hampshire rate (11 amputations per 100,000 population).

**Table 7: All admissions for diabetes: Directly standardised rates (per 100,000) and 95% confidence intervals, 209/10 to 2011/12**

	Persons		95% CI		Comparison to Hampshire
	Number	DSR	LL	UL	
Hampshire	4935	114.53	111.21	117.85	
Fareham and Gosport CCG	526	81.45	74.15	88.75	Significantly lower
North East Hampshire and Farnham CCG	533	82.62	75.46	89.77	Significantly lower
North Hampshire CCG	1545	222.95	211.66	234.25	Significantly higher
South Eastern Hampshire CCG	666	99.29	91.30	107.28	Significantly lower
West Hampshire CCG	1766	101.53	96.54	106.53	Significantly lower

### 5.3 Liver disease

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

The death rate from preventable liver disease in Hampshire was 7 per 100,000 population from 2009 to 2011, lower than the national rate of 12 per 100,000. This equates to 304 deaths per year. Gosport was the only part of Hampshire where the death rate was higher than the national rate at 14 deaths per 100,000 population (34 deaths), however this is not statistically significant. Hampshire is in the bottom fifth of areas in England in terms of Hepatitis B vaccination and Hepatitis C test uptake for injecting drug users and amongst prisoners.

### 5.4 Kidney conditions

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

The prevalence of chronic kidney disease (CKD) in Fareham and Gosport is 4.0% (6,425 people over the age of 18). This compares to a prevalence of 4.2% in Hampshire and 4.3% for England. The NHS Health Check programme provides an opportunity to identify people with CKD before they develop symptoms. It is estimated that there are 32,000 people with CKD in Hampshire yet to be diagnosed.

Unmodifiable risk factors for CKD include older age, sex (prevalence is higher in men), other forms of CVD, family history.

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

Acute Kidney Injury (AKI) is characterised by a rapid reduction in kidney function. Causes include: infection, dehydration, shock, and acute illness. Less frequently it is caused by crush injury to the kidney, and obstruction of the urinary tract. It is relatively common affecting about 20% of hospitalised patients, with severe AKI affecting 1%. AKI is associated with poor outcomes and prolonged hospital stays.<sup>29</sup> Even uncomplicated AKI has a mortality rate of up to 10% while over half patients with AKI as part of multi-organ failure die.

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<sup>29</sup> London Acute Kidney Injury Network. Why is acute kidney injury important? London Acute Kidney Injury Network, 2012. <http://londonaki.net/research/index.html>

Risk factors for AKI include being 75 or older, CVD including heart failure, peripheral arterial disease and diabetes as well as CKD. Nationally the treatment of AKI in hospital may not be optimal. The National Confidential Enquiry into Patient Outcome and Death found that only 50% of AKI patients received good care overall although 30% of cases are preventable. Given the rise in population risk factors and mortality for CKD and AKI, it is likely that need and demand for services will increase in the next decade. NICE has concluded that earlier detection and treatment of AKI would be cost saving.<sup>30</sup>

## **5.5 Chronic Obstructive Pulmonary Disease (COPD)**

There is one death every 20 minutes from COPD in England. The total annual cost to the NHS of COPD is over £800 million. Up to 90% of cases of COPD are caused by smoking and so are preventable. Most people with COPD have not been diagnosed and so are not receiving the right treatment and support to manage their condition. COPD is strongly related to deprivation. Incidence and mortality rates are higher in lower socio-economic groups, largely linked to higher smoking rates.

There are 2,910 people in Fareham and Gosport CCG diagnosed with COPD, a prevalence of 1.5%. This is the second highest rate in the county but below the national rate of 1.7%. There are thought to be a further 3,408 people with undiagnosed COPD in Fareham and Gosport CCG.

The Fareham and Gosport CCG QOF indicators for COPD are the same or above the national average and the exception rate is 11.7%, similar to the exception rate for England at 11.8%.<sup>31</sup>

There were 953 emergency admissions for COPD in Fareham and Gosport CCG between 2009/10 and 2011/12 and over half were in people aged under 75 years old. The rate of emergency admissions for people under the age of 75 years in Gosport is the highest in the county (108 per 100,000).

Fareham and Gosport has the highest mortality rate in Hampshire from COPD at 26 deaths per 100,000, in line with England.

## **5.6 Cancer**

Cancer incidence is rising in England. In contrast the trend in cancer incidence for Hampshire has been stable since 2001/03. The directly age standardised incidence rate for all types of cancers in Fareham and Gosport CCG was 388.5 per 100,000 population in 2008-10, which is higher than the South East (380.2 per 100,000) but

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<sup>30</sup> NICE. Costing statement. Acute kidney injury: prevention, detection and management of acute kidney injury up to the point of renal replacement therapy. NICE, 28/8/13.

<sup>31</sup> 2011/12 data. See <http://www.apho.org.uk/PracProf/Profile.aspx>

lower than England (398.1 per 100,000). Rates are higher in men (393.3 per 100,000) compared to women (383.7 per 100,000). Table 8 shows the incidence of different types of cancer in Fareham and Gosport. Rates of all cancers in Gosport and breast cancer in both areas are above the England rates.

**Table 8: Incidence of cancers in Fareham and Gosport, 2008-10. Directly age standardised rates per 100,000 population (South West Cancer Register, ONS, UKCIS)**

Type of cancer	Fareham	Gosport	South East	England
All	381.6	400.3	380.2	398.1
Lung	31.2	48.8	38.8	47.7
Breast	139.8	130.6	127.5	125.7
Colorectal	47.4	41.8	46.2	47.9
Prostate	84.4	74.1	104.5	105.8

Table 9 shows the cancer screening coverage for Fareham and Gosport CCG for each of the national programmes. Fareham has lower coverage than the national target for breast and cervical screening but performs well compared to England and Hampshire.

**Table 9: Cancer screening coverage in Fareham and Gosport <sup>32</sup>**

<b>Breast Coverage (Target 70%)</b>	No. of eligible women on last day of review period (47-73) - Mar 12	No. of women screened in previous 30 months (47-73) - Mar 12	36 month coverage % (47-73) - Mar 12
England	8,421,181	5,124,671	60.9
HAMPSHIRE	225,672	137,720	61.0
Fareham and Gosport CCG	34,524	21,222	61.5
<b>Bowel Coverage (Target 60%)</b>	No. of eligible people on last day of review period (60-74) - Mar 12	No. of people screened in previous 30 months (60-74) - Mar 12	2.5-year coverage % (60-74) - Mar 12
England	7,944,844	4,141,939	52.1
HAMPSHIRE	216,852	132,601	61.1
Fareham and Gosport CCG	33,187	20,475	61.7

<sup>32</sup> Hampshire Open Exeter system



<b>Cervical Coverage (Target 80%)</b>	No. of eligible women on last day of review period (25-64) - Mar 12	No. of women screened in previous 42/66 months (25-64) - Mar 12	3.5/5.5-year coverage % (25-64) - Mar 12
<b>England</b>	<b>13,463,227</b>	<b>10,146,655</b>	<b>75.4</b>
<b>HAMPSHIRE</b>	<b>324,007</b>	<b>254,357</b>	<b>78.5</b>
<b>Fareham and Gosport CCG</b>	<b>48,233</b>	<b>37,814</b>	<b>78.4</b>

Cancer is linked to numerous risk factors. It has been estimated that 43% of new cases of cancer are linked to lifestyle and environmental factors and smoking accounts for almost 20% of new cases (23% in men and 16% in women). In 2011/12 there were 4,225 people on Fareham and Gosport CCG GP cancer registers. This is 2.1% of the registered population, which is higher than the England and SE prevalence (1.8%) and has increased from 1.7% in 2009/10. More people are surviving cancer and their needs are becoming increasingly important.

From 2009-12, the directly age standardised rate of admissions for cancer as the primary diagnosis for people of under the age of 75 years old all ages was 1932 per 100,000 population in Gosport, which was higher than the rate in Hampshire (1860 per 100,000 population) and Fareham (1855 per 100,000 population). The rate of premature mortality (under 75 years old) from all cancers was 98 per 100,000 in Fareham and 112 per 100,000 in Gosport compared to the Hampshire rate of 97 per 100,000 and the England rate of 110/100,000. Between 2006-08 and 2009-11 the trend in premature mortality for the CCG is stable compared to a downward trend nationally.

## **5.7 Neurological conditions**

There is a lack of available, local level data on long term neurological conditions such as multiple sclerosis or motor neurone disease. The only routinely available data are for epilepsy. The prevalence of epilepsy in people aged 18+ in Fareham and Gosport CCG is 0.8% (1255 people), which is the same nationally and higher than the Hampshire prevalence (0.7%, 7,958 people). The trend in epilepsy prevalence during the three year period from 2009/10 to 2011/12 was stable for Hampshire and England.

## **5.8 Chronic Pain**

Chronic pain is defined as pain or discomfort that troubles a person all of the time or on and off for more than three months. There are no data on chronic pain prevalence available at the Hampshire level. Application of the findings of the Health Survey for England 2011 to the county showed that about one in three men and women suffer with chronic pain. Muscle, bone and joint pain are the main causes of chronic pain,

with back pain and osteoarthritis together responsible for over half of all cases. Nationally, people with severe chronic pain are five times more likely to visit their GP, four times more likely to be anxious or depressed than those without pain and are significantly more likely to have longstanding illnesses.

The directly standardised hospital admission rate for chronic pain for Fareham and Gosport CCG is 1777 per 100,000 population, which is lower than Hampshire and the lowest rate in the county. Rates are higher in females (2253 per 100,000) than in males (1335 per 100,000).

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

## **5.9 Mental health**

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

Poor mental health both contributes to and is a consequence of wider health inequalities. It is associated with increased health-risk behaviour and increased morbidity and mortality from physical ill health.

Poor mental health both contributes to and is a consequence of wider health inequalities. It is associated with increased health-risk behaviour and increased morbidity and mortality from physical ill health. The prevalence of psychotic disorders amongst the lowest quintile of household income is nine times higher than in the highest. The social gradient is also evident for common mental health problems, with a two-fold variation between the highest and lowest quintiles.

People with mental illness have significantly higher rates of mortality and morbidity from illnesses such as heart disease, stroke, diabetes, respiratory disease and infections. Those with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely due to physical health problems.

Many physical conditions also increase the chances of poor mental health. It is estimated that 12 to 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health – at least £1 in every £8 spent.

About one in six of the adult population experiences mental ill health at any one time and 10% of children have a mental health problem. Half of lifetime mental illness is present by the age of 14.

One on ten new mothers suffers from postnatal depression, and around a fifth of working-age adults are affected by depression or anxiety at any one time. Half of all women and a quarter of all men will be affected by depression at some time in their life and 15% experience a disabling depression.

Serious mental health problems such as schizophrenia, psychoses & bipolar disease such as affect about 1% of the population.

Depression is the most common mental health disorder in later life but it is not a natural or normal part of ageing. Those with physical health problems have higher rates of depression, and up to 50% of older people in residential care have clinically severe depression, yet only between 10% and 15% receive any active treatment.

Between 2009 and 2011, 11 per 100,000 population (26 people) in Gosport and 7 per 100,000 people (23 people) died from suicide and injury of undetermined intent. This compares to 8.1 per 100,000 population (332 people) in Hampshire (2009-2011 data) and 7.9 per 100,000 population in England (2008-2010).

One of the risk factors for suicide is intentional self harm and in 2009/11 the Fareham and Gosport CCG rate for intentional self harm was 263 per 100,000 people, which is higher than the Hampshire rate of 226 per 100,000. There is a significant correlation between deprivation and self harm admissions.

Table 10 shows that Fareham and Gosport CCG has admission rates for mental health illness which are significantly worse than Hampshire rate. Gender differences are apparent for each mental illness, females have higher rates of unipolar depressive disorders and men have higher rates of unipolar delusional disorder rates.

**Table 10: Mental health Admissions- Directly standardised rates (per 100,000) and 95% confidence intervals, 2009/10 to 2011/12 pooled**

Admissions	Directly Age Standardised Rates per 100,000 population		
	Fareham and Gosport CCG	Hampshire	Comparison to Hampshire
Mental Health Illness - All Admissions - Under 75 years	257	173	Significantly worse
Mental Health Illness - All Admissions - All ages	261	177	Significantly worse
Schizophrenia, schizotypal and delusional disorders - All admission types - Aged 15+	54	46	Not significantly different
Unipolar depressive disorders - All admission types - Aged 15+	77	46	Significantly worse

## 5.10 Dementia

Dementia describes a set of symptoms which include memory loss, mood changes and problems with communicating and reasoning. It is not an inevitable part of ageing. One in 6 people over 80 years and one in 14 people over 65 years old have a form of dementia. Alzheimer's disease is the most common form, accounting for 62% of all dementia cases. Prevalence is higher in women and in older age groups. Vascular dementia has the same risk factors as other forms of CVD and is potentially preventable.

There are estimated to be over 18,000 people with dementia in Hampshire, but only 8,695 people on GP dementia registers which suggests that many people are not being identified. The POPPI tool estimates that there are 1,049 people in Gosport and 1,747 people in Farnham over the age of 65 with dementia.

The number of people with dementia in Hampshire is predicted to increase by over 30% from 18,323 in 2012 to 24,042 in 2020. This equates to an increase of 573 people (33%) in Gosport and 331 people (32%) in Fareham 2020.

A national report found that older people with dementia who are receiving care in hospital stay significantly longer than those without the condition after being admitted for an emergency and are more likely to be readmitted.<sup>33</sup>

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

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

## 5.11 Musculoskeletal

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

Between 2009 and 2012, the rate of hospital admissions as a result of falls and fall injuries in the 65 years and over population was 1,633 per 100,000 people in Fareham and Gosport CCG, compared to a rate of 1,623 per 100,000 in Hampshire.

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<sup>33</sup> Care Quality Commission [CQC] report, March 2013

Residents from Gosport (1,844/100,000) had higher rates compared to Fareham residents (1,586/100,000). Rates are significantly higher for females than males.

The hip fracture emergency admission rate in people over the age of 65 years old was 471 per 100,000. The rate was highest in Gosport (513 per 100,000), compared to the rest of Hampshire (455 per 100,000).

The rate of primary hip replacement procedures between 2009 and 2012 was 99 per 100,000 in Fareham and 95 per 100,000 in Gosport, compared to 98 per 100,000 in Hampshire. Fareham had the lowest rate of revision hip replacement procedures at 10 per 100,000, compared to the Hampshire hip revision rate of 15 per 100,000.

Gosport has the lowest age standardised rate of knee arthroscopies at 172 per 100,000, compared to 183 per 100,000 in Fareham and 216 per 100,000 in Hampshire overall. The CCG rate was 178 per 100,000.

Admission rates for knee replacements were 97 per 100,000 in Gosport and 89 per 100,000 in Fareham, compared to the Hampshire rate of 95 per 100,000. The overall rate in the CCG was 92 per 100,000.

There is an overall decline in facet joint activity in Fareham and Gosport CCG (78/100,000) in line with the lack of long term clinical effectiveness for this intervention, compared to the Hampshire rate of 172 per 100,000.

## **5.12 Sight loss**

An estimated 23,500 people in Hampshire over the age of 18 have some degree of sight loss. It is more common in older people and as the population of Hampshire ages, the prevalence of sight loss will increase. This projects an estimated 30,000 people in Hampshire being affected by sight loss by 2020.

As access to the eye health system is mainly through primary care, it is essential that GPs maintain their knowledge of eye health/conditions and are involved in the development of future eye health pathways.

## **5.13 Emergency attendances and admissions to hospital**

Emergency attendances and admissions are costly to the health system. Prolonged stays in hospital have been associated with loss of functional independence in older people and an increase in the risk of acquiring health care associated infections.<sup>34</sup> It is acknowledged that some attendances and admissions may be avoidable through

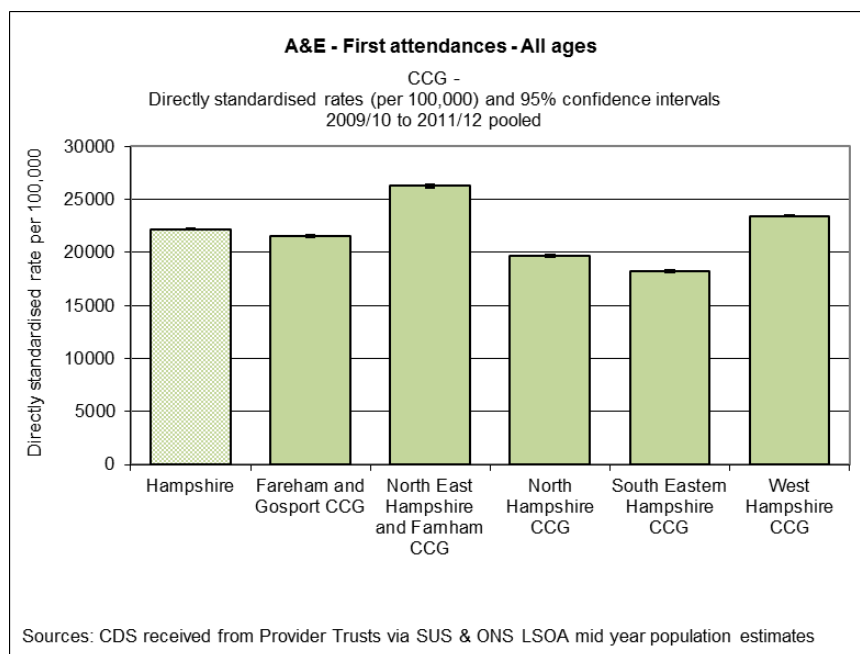
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<sup>34</sup> Glasby 2003 in Poteliakoff E, Thompson J. Emergency bed use: What the numbers tell us. 2011, The Kings Fund <http://www.kingsfund.org.uk/sites/files/kf/data-briefing-emergency-bed-use-what-the-numbers-tell-us-emmi-poteliakhoff-james-thompson-kings-fund-december-2011.pdf>

better primary and secondary prevention and the management of patients in alternative settings.

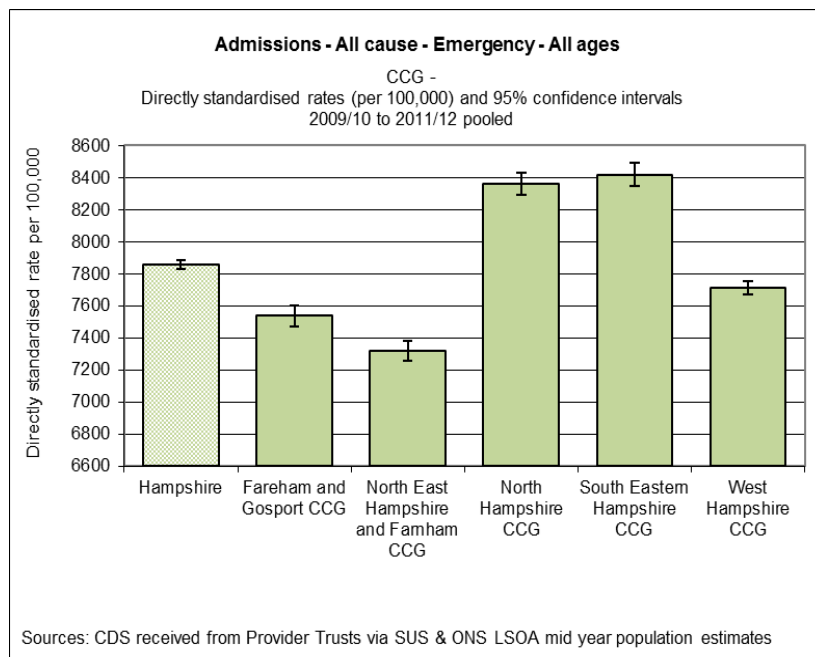
There were 299,742 first attendances for Hampshire residents in 2011/12. Attendances have risen year on year in the last three years and this rise has been statistically significant. First attendance rates vary by CCG. Pooled attendance rates (2008/09-2011/12) show that Fareham and Gosport, North Hants and South-East Hants CCGs had lower rates than Hampshire overall, whilst North-East and Farnham and West Hants had higher rates of attendance (Figure 20). The highest number of attendances in Hampshire is in the 0-4 age band, followed by the 20-25 age band and the 15-19 age band (2012/13).

**Figure 20: First attendances at A&E by CCG directly standardised 2009/10-2011/12 pooled**



There were 120,027 emergency admissions for Hampshire residents in 2011/12. Admissions rose between 2008/09-2011/12 and the rate rise is statistically significant. There is a large variation in admission rates by CCG. Pooled emergency admission rates (2008/09-2011/12) show that Fareham and Gosport, North-East Hants and West Hants CCGs had lower rates than Hampshire overall, whilst North Hants and South-East Hants CCGs had higher rates of admissions (Figure 21).

**Figure 21: Emergency admissions by CCG directly standardised 2009/10-2011/12 pooled**



### What does this mean?

- Fareham and Gosport has the highest rate of preventable CVD mortality in the county. Concerted action is required to tackle lifestyle factors that increase the risk of CVD morbidity and mortality and maximise treatment opportunities.
- There are potentially large numbers of people with undiagnosed cardiovascular disease. There is good evidence that secondary prevention can reduce morbidity. CCGs should encourage case finding in people at higher risk of disease and fully implement the NHS Health Checks programme with a particular focus on practices serving more deprived populations.
- There is scope for increasing case finding in at risk patients and improving care processes for patients with diabetes. Whilst performance is in line with England, given the population in some parts of the CCG, we would expect it to be higher.
- Given the levels of obesity, especially in Gosport the number of people with diabetes will increase. Practitioners should give as much focus to primary prevention of diabetes, as well as good care and management.
- Chronic disease pathways should be linked to primary prevention. COPD is potentially preventable as 90% of cases are attributable to smoking and potentially 3,408 people are undiagnosed in Fareham and Gosport CCG.

- Whilst the evidence base for reducing emergency admissions is scant, there is good evidence to prevent admissions for patients with heart failure and COPD. Gosport has the highest rate of emergency admissions for COPD in the county.
- Gosport has the highest rate of cancers (all) in the county. Rates for lung cancer are particularly high. Whilst overall rates of cancer in Fareham are similar to the south-east, rates of breast cancer are higher.
- Gosport has high rates of hospital admissions as a result of falls and hip fractures in people aged 65 and over. Promoting bone health by early detection of osteoporosis through bone mineral density (BMD) scans, falls and fracture risk assessment, falls prevention strategies, maintenance of mobility, correction of nutritional deficiencies, particularly of calcium, vitamin D and protein, and bone protection drugs, have been shown to significantly reduce the risk of hip fractures.
- The CCG can achieve better musculoskeletal care and outcomes, using an integrated care pathway approach, starting with prevention: encouraging healthy behaviours (prevention); effective referral mechanisms; appropriate treatment; in orthopaedic, rheumatology and pain management services, across primary, community, acute and social care; engaging patient organisations; self-management and shared decision making. The CCG should also ensure the use of evidence based practice.



## **6 People and society**

### **6.1 Older people with care support needs**

In April 2013 there were 9,929 people aged 65 years and over with substantial or critical social care needs supported by Hampshire County Council Adult Services. In line with the rest of the county, the majority of this demand in Fareham and Gosport CCG was for domiciliary care (49.6%, 786 people) followed by residential care (20.7%, 328 people) and nursing care (15.4%, 244 people).

In 2012, 18.7% (7,011) of people aged over 65 years old in Fareham and Gosport CCG were identified as unable to manage at least one mobility activity on their own. This includes being unable to go outdoors, walk down the road, climb stairs, get around the house, to the toilet or in and out of bed. In Fareham and Gosport CCG 7.4% (2,786) of people over the age of 65 years old were estimated to have dementia (POPPI) and this was the most common reason for increasing long term packages of social care.

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

### **6.2 Adults with care support needs**

In April 2013 Hampshire County Council Adult Services supported 358 clients aged 18-64 years old in Fareham and Gosport CCG with a substantial or critical learning disability with a package of care. Another 217 people with a substantial or critical physical disability were supported.

Adults with autism are more likely to be socially disadvantaged, educationally less well qualified, less intellectually able and possibly under-supported by services. Modelled estimates predict that there are 1340 males and 160 females with autism aged 19 years old and above in Fareham and Gosport CCG.

### **6.3 Carers**

10.3% (20,249 people) in Fareham and Gosport CCG provide unpaid care to family members or others because of long term physical or mental ill health or disability, or problems related to old age. This is similar to Hampshire and England (10.1% and 10.2% respectively). 7% (13,766 people) provide 1-19 hours of unpaid care a week, 1.1% (2,203 people) provide 20-49 hours a week and 2.2% (4280 people) provide 50 or more hours a week.

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

### **6.3.1 Young carers**

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

In Gosport, 0.7% (77 people) of school pupils and 0.4% (63 people) in Fareham are identified as being young carers. These figures capture 11% of the total number of carers aged 0-24 in Hampshire. Moreover, 4.3% (3,579 people) of the Fareham and Gosport CCG population live in a household where there are dependent children and one person with a long term disability. This may also provide an indication of the number of young people with caring responsibilities in the area.

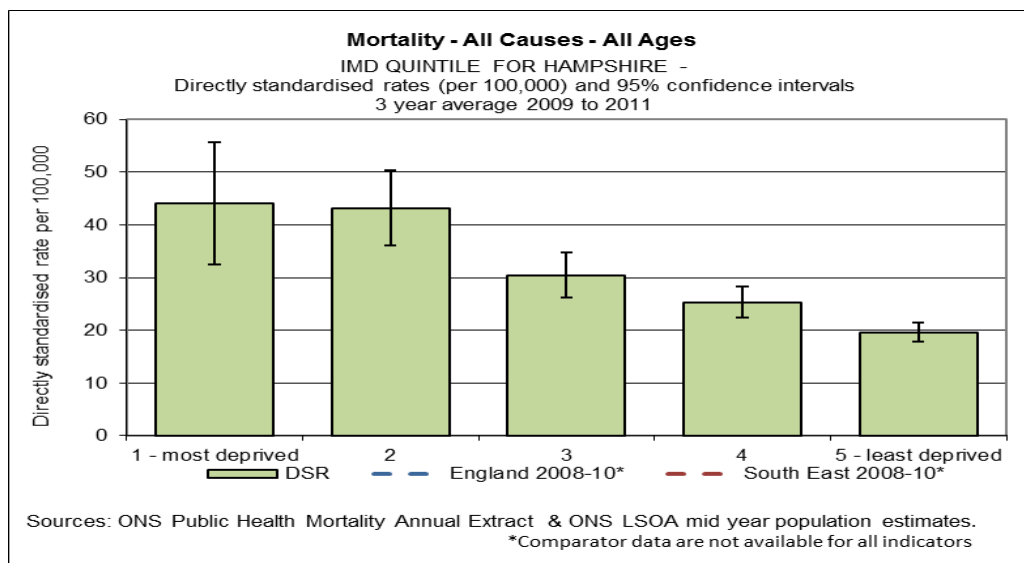
#### **What does this mean?**

- Moving towards integrated health and social care provision can improve patient satisfaction and reduce mortality, though there is no evidence it reduces emergency admissions. As more people become older and in need of social care joint working will be vital.
- There can be detrimental social consequences of reduced mobility and dementia on individuals and this in turn can negatively affect health. CCGs must ensure that health service are linked with agencies offering social support, such as volunteer befrienders and support networks for carers.

## 7 Death

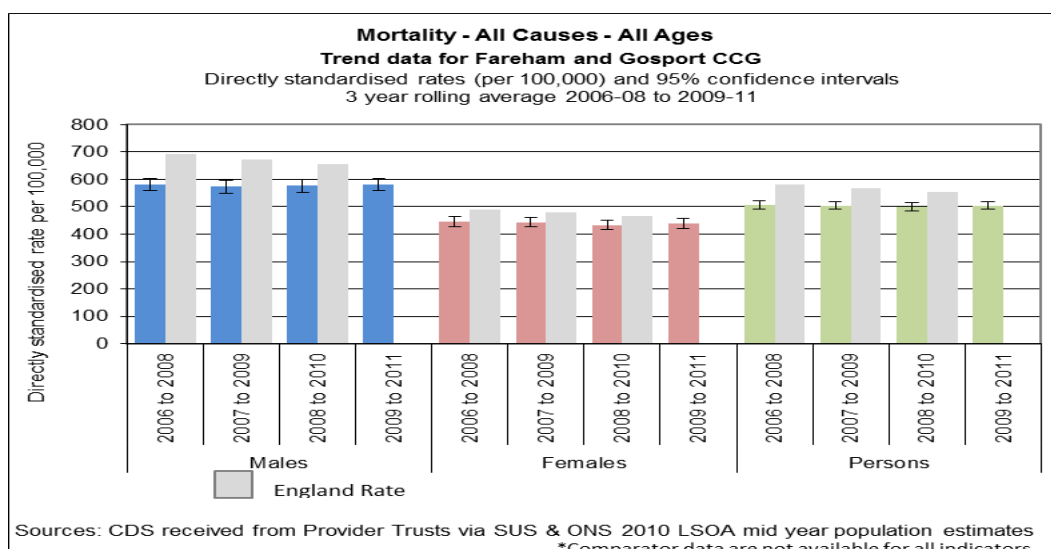
There were 34,214 deaths in Hampshire from 2009 to 2011; a directly age standardised rate of 468 deaths per 100,000 population, which is significantly lower than the England rate of 553 deaths per 100,000 population. Death rates are inversely related to deprivation, with directly standardised rates in the most deprived quintile being 57% higher than in the least deprived quintile (Figure 22).

**Figure 22: All cause mortality by deprivation quintile directly standardised 2009/10-2011/12 pooled**

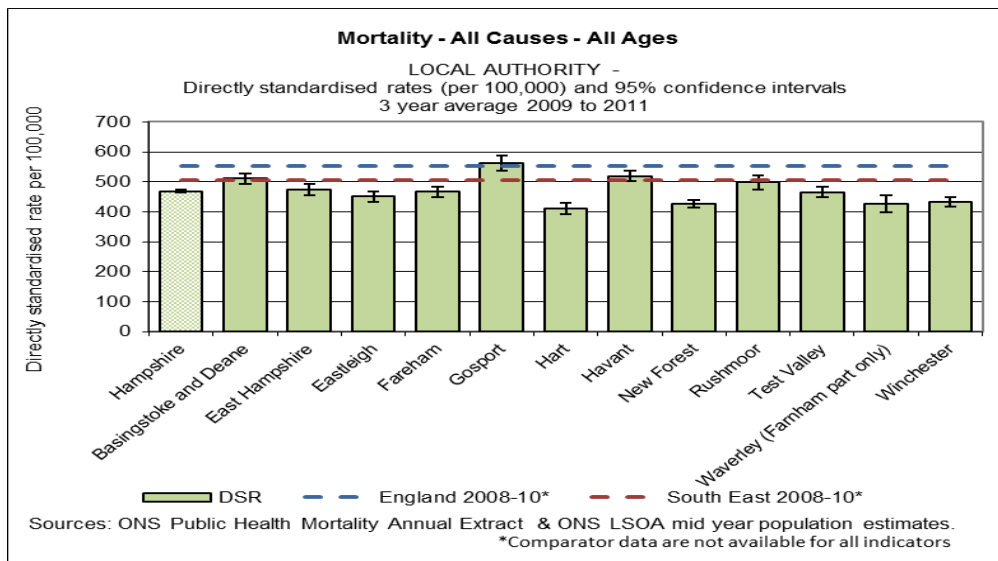


At a county level, all cause mortality has been falling, however in Fareham and Gosport, the rate has not decreased for men, resulting in a static mortality rate overall (Figure 23). Gosport local authority area has the highest all-cause mortality rates in the county (Figure 24).

**Figure 23: All cause mortality for Fareham & Gosport CCG directly standardised rolling 3 year average 2006-08 to 2009-11**



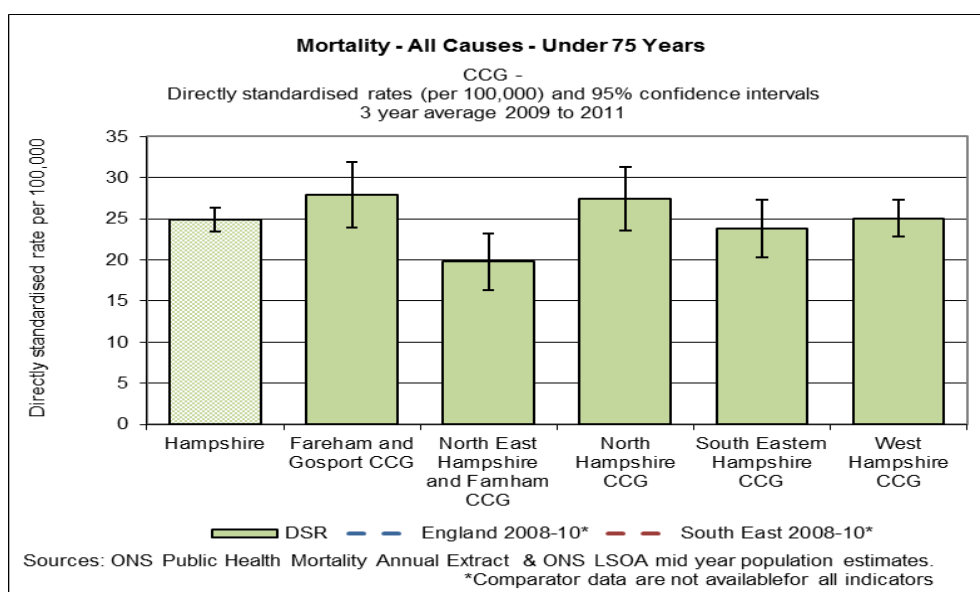
**Figure 24: All cause mortality by local authority area directly standardised 2009-2011**



In 2011, approximately 30% of all deaths in Hampshire were caused by cancer, compared to 28% from circulatory disease and 13% from respiratory disease. Fareham and Gosport CCG had a marginally lower proportion of deaths from coronary heart disease and a marginally higher proportion of deaths from COPD than Hampshire.

Fareham and Gosport CCG had the highest premature death rate in Hampshire at 245 per 100,000 respectively (Figure 25), which is lower than the England and similar to the South East rate. This rate has remained static since 2006, whilst national and county rates have been decreasing.

**Figure 25: All cause mortality under 75 years by CCG directly standardised 2009-2011**



## 7.1 Preventable deaths

There were 993 preventable deaths in Fareham and Gosport CCG from 2009 to 2011. This equates to a rate of 134 preventable deaths per 100,000 population, higher than Hampshire (119 per 100,000) and lower than nationally (146 preventable deaths per 100,000).<sup>35</sup>

The rate of preventable deaths in Hampshire has decreased in the last five years, however in Fareham and Gosport there has been a slight increase, mostly driven by increasing rates in men.

### What does this mean?

- Reductions in mortality have stalled in Gosport. There is a need to focus on primary and secondary prevention and good quality care for the main causes of death. However focus should also be on tackling the wider determinants of health including risky health behaviours, poverty, unemployment and education.
- Whilst the higher death rates observed in men are likely to stem from multiple factors, the CCG should ensure that men are accessing prevention and treatment services appropriately.
- Cancer is now the leading cause of death in Hampshire. As incidence of some cancers increases and survival improves, health services will need to be designed to deal with increasing demand for the detection and treatment of cancer and palliative care.

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<sup>35</sup> Deaths that are considered to be potentially avoidable by public health interventions in the broadest sense. The definition includes amenable mortality and preventable deaths have been defined by the Public Health Outcomes Framework, further information is available <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/par/E12000004/ati/102/page/6>