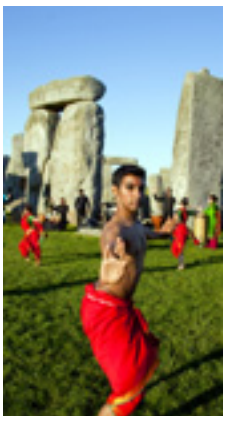
Wiltshire's Joint Strategic Assessment for Health and Wellbeing

a single version of the truth







NHS Wiltshire

Wiltshire Council
Where everybody matters

Wiltshire Assembly
Public Service Board

Foreword

We are delighted to present the Joint Strategic Assessment (JSA) for Health and Wellbeing 2012/13 for Wiltshire.

The assessment has been led by Maggie Rae, Corporate Director of Public Health and Public Protection in partnership with a number of agencies who are listed in full in the acknowledgements.

This JSA is a needs assessment for health and wellbeing, which supports the overall approach to using evidence and intelligence, known in Wiltshire as the Joint Strategic Assessment programme for Wiltshire. This programme was commissioned by the shadow Health and Wellbeing Board which looks at the evidence of needs for all Wiltshire partnerships.

The JSA for Health and Wellbeing 2012/13 represents a further milestone in our journey to develop a full understanding of the health and social care needs of our local population in Wiltshire in these challenging times, when we are facing a tough financial position and other challenges such as an ageing population. Despite these challenges we remain committed to ensuring that everyone in Wiltshire has the opportunity to enjoy healthy lives and good services.

Building on the four previous versions, published in 2008, 2009, 2010/11 and 2011/12, this document provides a picture of the needs of our population now and into the future, through a process centred around transforming data into knowledge and knowledge into wisdom. With this wisdom, we can ensure we use our commissioning power to meet the needs of the population.

The production of an annual JSNA was made a statutory requirement in the establishment of the Local Government and Public Involvement in Health Act, 2007. The production of an annual JSNA remains a statutory requirement, and this JSA for health and wellbeing fulfils the requirements of statutory JSNA.

Councillor Keith Humphries, Cabinet member for Public Health and Protection Services, Wiltshire Council

Councillor Jane Scott, Leader, Wiltshire Council

Dr Steve Rowlands, Chair, Wiltshire Clinical Commissioning Group

Tony Barron, Chair, NHS Wiltshire

Patrick Geenty, Chief Constable, Wiltshire Constabulary

Introduction

The Joint Strategic Assessment for Health and Wellbeing 2012/13 provides a summary of the current and future health and wellbeing needs of people in Wiltshire. It has been developed with a clear ambition to further improve the scope and quality of our data, centred on transforming data into knowledge and knowledge into wisdom to provide a comprehensive picture of local needs.

The JSA for Health and Wellbeing has emerged as the assessment tool on which all commissioning decisions for the county are based and, as such, it covers a breadth of topics focusing from health and social needs to wider factors affecting the wellbeing of our community. Such topics include climate change and the economy, recognising the dynamic nature of health and well-being and the factors that influence it. The role of the JSA for Health and Wellbeing includes providing knowledge of such influences in order to enable timely commissioning decisions to build resilient communities for Wiltshire. The JSA for Health and Wellbeing provides an opportunity to look ahead three to five years so that:

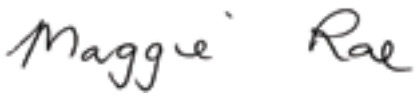
- inequalities within our population are reduced
- services are shaped by local communities
- social inclusion is increased
- the above outcomes are maximised at minimum cost

This year's work has been made possible through further consolidating and expanding a strong partnership of collaborative working between local partners.

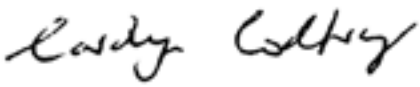
This assessment comes at a time when the NHS is being reorganised. Wiltshire Primary Care Trust (PCT) will be disbanded at the end of March 2013 and public health responsibilities will transfer from PCTs to local authorities, whilst Wiltshire Clinical Commissioning Group (CCG) will take on new commissioning powers.

As part of this reorganisation, local authorities are required to establish Health and Wellbeing Boards. Wiltshire has a shadow Board that will be formally constituted in April 2013. The Board will have responsibility for the Joint Health and Wellbeing Strategy. This assessment and the Joint Strategic Assessment for Wiltshire 2012 13 which it informs will be key documents in guiding the Board's work and developing the Strategy.

We would like to thank everyone that has been involved in the development of this, our fifth health and wellbeing needs assessment. We are confident that this will enable us to proceed to set priorities for providing services and strategic commissioning to improve the health and wellbeing of all people in Wiltshire.



Maggie Rae Corporate Director of Public Health and Public Protection NHS Wiltshire and Wiltshire Council



Carolyn Godfrey Corporate Director Wiltshire Council

Sue Redmond Corporate Director Wiltshire Council

How to read this document

The 2012/13 suite of documents mark a step-change in the quality and quantity of information, data and intelligence provided under the auspices of the JSA for Health and Wellbeing (JSA HW).

The 2012/13 version concentrates on the key facts and key messages along with a focus on 'topic reports', which are areas identified as benefiting from new research or collation of existing disparate knowledge. In order to continue to provide the breadth and depth of information required, the Wiltshire Intelligence Network website (www.intelligencenetwork.org.uk) has been utilised to host a wealth of supporting assessments, briefings and resources totalling over 1,000 pages. Please use the links in this document and the briefing notes to maximise the usefulness of this product.

The new approach allows for greater flexibility, inclusiveness and scalability. It also allows for stakeholders to help shape the agenda and enables all intelligence, data and resources that are captured, to be used.

This summary document is a reference resource and is not designed to be read cover to cover in one go. It relies on extensive signposting to guide readers to their areas of interest and links related topics together to enable information to be presented once but discovered from a variety of start points.

An even more concise information sheet (executive briefing) has been produced which provides a two page guide on the JSA HW which is available here: tinyurl.com/hwjsa211

As well as the topic reports and briefings on all the major areas of health and wellbeing the JSA HW documents detail the indicators from a number of outcomes frameworks relevant to the subject.

The JSA HW also contains a mine of resources to inform the reader about the reference materials that underpin the analyses and perform a vital role in helping transform raw data into intelligence. These include information on geographical boundaries, Mosaic, deprivation, primary research (surveys), statistical techniques and the Wiltshire Intelligence network.

This document is an annual report and will next be published in 2013/14. However, the supporting briefings will be updated throughout intervening period to keep them up to date and maximise their usefulness. New topic reports for 2013/14 will also be chosen to reflect stakeholder priorities and evidence gaps.

The JSA HW would not be possible without the large number of contributors from many services and subject areas. It is their expertise that enriches the product. Therefore, if you have something to contribute please get in touch using the contact details at the end of the report.

Contents

Key facts

The 2011 mid-year population estimate for Wiltshire is 474,300 and this is expected to increase to 505,416 in 2021. In 2009 Wiltshire's ethnic minority groups made up 4.7% of the population.

Life expectancy in Wiltshire for 2008 to 2010 was 79.6 years for males and 83.7 years for females.

Between 2006 and 2010 life expectancy was 6.6 years lower for men and 3.8 years lower for women in the most deprived areas of Wiltshire than in the least deprived areas. The gaps for males and females have widened since between 2001 and 2005.

Females in Wiltshire can expect to live on average 12.0 years disability free from the age of 65, to 77.0 years, whereas males can expect to live on average 11.7 years disability free post 65, to 76.7 years.

The infant mortality rate in 2008 to 2010 in Wiltshire was 4.1 per 1,000 live births.

In 2009, Wiltshire had 12,240 children living in poverty, which represents 12.0% of children.

In 2010/11, 8% of Reception pupils and 16.4% in Year 6 in Wiltshire were found to be obese.

In Wiltshire, in 2010/11 there were 1,140 admissions due to an injury in children and young people under the age of 18. This equates to 112 per 10,000 young people.

The average number of decayed, filled or missing teeth per 5 year old child in Wiltshire in this was 0.95 compared with 1.11 nationally.

In March 2012, in Wiltshire there were 2,100 children identified as children in need, of these 169 were subject to a child protection plan and 416 were in care.

The annual rate of premature mortality in Wiltshire from cardiovascular disease in 2008 to 2010 was 52 per 100,000 population. This rate has halved since 1998 and 2000, when it was 99 per 100,000. In 2010 cancers accounted for 581 deaths (around 45% of the total) in the under 75s and 1,192 all age deaths (over 25% of the total). There were 18,790 people aged 17 or over living with diabetes in 2010/11, representing 5% of the population.

In Wiltshire, approximately 60,000 adults are estimated to have a common mental disorder. Estimates suggest that the number of people aged 65 or over with severe depression will increase from 2,500 in 2012 to 4,000 in 2030.

In Wiltshire 69,000 people suffer from migraines; 2,300 to 3,650 from epilepsy; 650 to 750 from multiple sclerosis and 850 from cerebral palsy.

Wiltshire Council and the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) provided community based services to 6,538 in 2011/12 and to a further 1,275 in residential care and 896 in nursing care.

In Wiltshire there are over 29,000 people aged between 18 and 64 and almost 38,000 older people aged 65 and over who have a moderate or serious physical disability.

Around an estimated 51,000 in Wiltshire have some form of hearing impairment.

Estimates would currently suggest that there are approximately 8,496 people with a learning disability living in Wiltshire.

There has been a 34% increase in admissions to hospital as a result of a fall in people aged over 65 between 2003/04 and 2010/11 in Wiltshire. In 2010/11 there were 3,054 admissions as a result of a fall per 100,000 people aged over 65.

There are a growing number of people living with the Human immunodeficiency virus (HIV) in Wiltshire. 153 people accessed treatment and care in 2010 and there are 178% more HIV diagnosed individuals in Wiltshire in 2010 than there were in 2003.

Although the prevalence of smoking is declining, 18.5% of adults in Wiltshire are smokers. There were 724 individuals from Wiltshire registered in structured drug treatment between April 2010 and March 2011.

Between July 2011 and June 2012, 2,229 domestic abuse incidents were reported to Wiltshire Police.

In Wiltshire 25.3% of adults do 3 or more 30-minute sessions of moderate intensity activity per week.

Around 1 in 12 people (8%) said their health had got worse for reasons connected to the economic downturn.

There was a 21% reduction in alcohol related violent crimes for December 2010 to November 2011 compared to the same time period in the previous year.

In 2011/12, 355 people were accepted as homeless, which is a significant increase from 240 in 2010/11.

The number of people killed or seriously injured in road traffic collisions in Wiltshire fell from a baseline of 389 in 1994-98 to 254 in 2011.

Within Wiltshire in 2011/12 just over 1,500 noise complaints' were received and 20 noise abatement notices were served.

Demographics

Summary

Understanding the size and structure of Wiltshire's population is fundamental if the council and its partners are to have the ability to prioritise and deliver services efficiently.

Population data is available from the Office for National Statistics (ONS). The ONS has released population counts from the 2011 Census and produced the mid-year estimates for 2011, which are the most up to date and accurate estimates of Wiltshire's true population. The ONS also produces population projections and has recently published interim projections based on the 2011 Census up to 2021.

Additionally, Wiltshire Council uses a population modelling tool which enables generation of local population projections based on ONS and other administrative datasets. There are numerous benefits to using this population model, which include being able to produce population projections by individual ages and sex for bespoke geographies within Wiltshire such as community areas. This model was used to produce trend based Wiltshire and Community Area population estimates and projections for 2001 to 2026.

In general, it is advisable to use ONS data when needing to compare Wiltshire with other areas or for official statistics. However, when greater accuracy or more detail at a sub Wiltshire level is required, Council produced data is preferable.

Key conclusions and recommendations

The Census estimated Wiltshire's total population at 471,000 people, some 7,600 persons higher than previously thought by the ONS. The 2011 mid-year estimate for Wiltshire is 474,300 which is around 15,000 people more than the 2010 estimate. Clearly, either increasing numbers of people or more accurate information about them has service planning implications.

Due to an increasing older population there is more and growing pressure on the economically active part of the population to maintain the welfare of the economically dependent. This is, to a large extent, a national issue in terms of education, health service, and pension provision. Informal care and support will also be needed even more in the future, especially in an already older population like Wiltshire's.

Wiltshire is a largely white-British and rural area. People in minority groups are often not present in sufficient numbers to form coherent groups. This can result in an unknown demand for services and hence unmet need[1]. This makes it difficult to provide services to a population which is diverse in nature and dispersed in location.

There are uncertainties over the projections of the number of women of child bearing age which will effect fertility rate calculations. Also, the numbers eligible for screening programmes will change in the future and producing accurate statistics reflecting the changes to state pension age for women will be a technical challenge.

Demographics

The introduction to demographics briefing note can be downloaded here tinyurl.com/hwjsa100

2011 population

Wiltshire

The 2011 Census has taken place and Wiltshire had a very successful census programme, involving much stakeholder and community engagement, resulting in an excellent 96% overall response rate. The Census estimated Wiltshire's total population at 471,000 people, some 7,600 persons higher than previously thought by the ONS.

Mid-year estimates have now been released for 2011 and Wiltshire's estimated population is 474,300. This is the most up to date and accurate estimate of Wiltshire's true population Ref. Table 1.

The population age structure for Wiltshire is broadly similar to the population of the South West region. A dependency ratio is a simple ratio of those of non working age to those of working age. As the ratio increases there may be an increased burden on the economically active part of the population. Currently, Wiltshire has a dependency ratio similar to that of the South West but higher than England.

At 4.7% of the population, Wiltshire has a lower proportion of ethnic minorities than the South West region as a whole (5.9%) and a considerably lower proportion than national figures (England, 12.5%)[2] However, the increase in the proportion of the population from ethnic minority groups in Wiltshire between 2001 and 2009 has been larger than that in England.

The full demographics: ethnicity briefing note can be downloaded here tinyurl.com/hwjsa103

[1] Needs Analysis for Equalities in Wiltshire. Informing an Equalities Framework for Wiltshire and developing options for the future of equalities implementation in the county. (2009) REGENworks

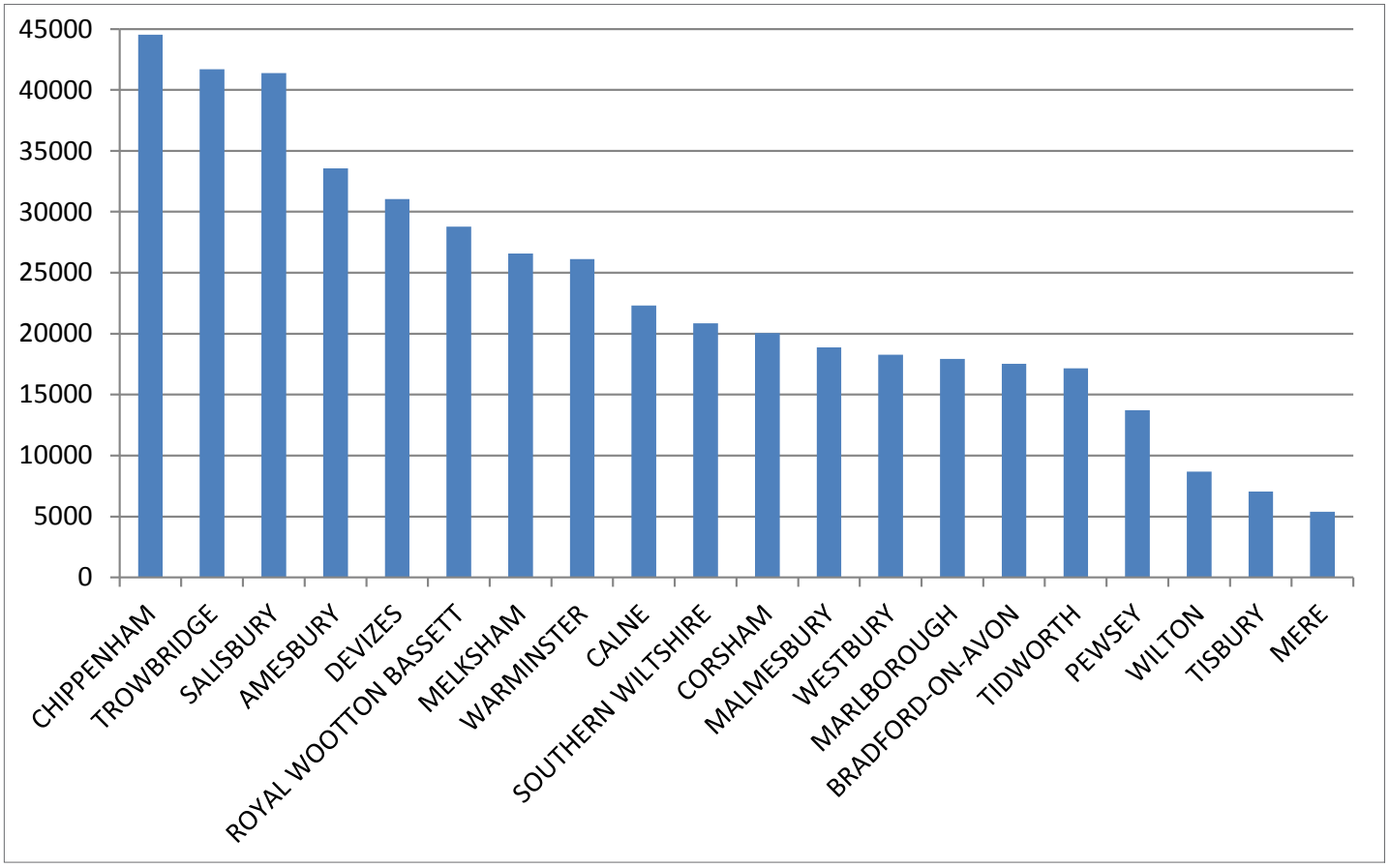
[2] Population estimates by ethnic group mid-2009, ONS experimental statistics

Table 1: Population by broad age group, 2011

	Wiltshire		South West		England	
	Number	% of total population	Number	% of total population	Number	% of total population
0-15	91,100	19.2%	929,900	17.5%	10,030,100	18.9%
16-64	296,800	62.6%	3,326,400	62.8%	34,347,400	64.7%
65 plus	86,400	18.2%	1,044,500	19.7%	8,729,700	16.4%
Total	**474,300**	**100.0%**	**5,300,800**	**100.0%**	**53,107,200**	**100.0%**

Source: ONS 2011 mid-year estimates: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039

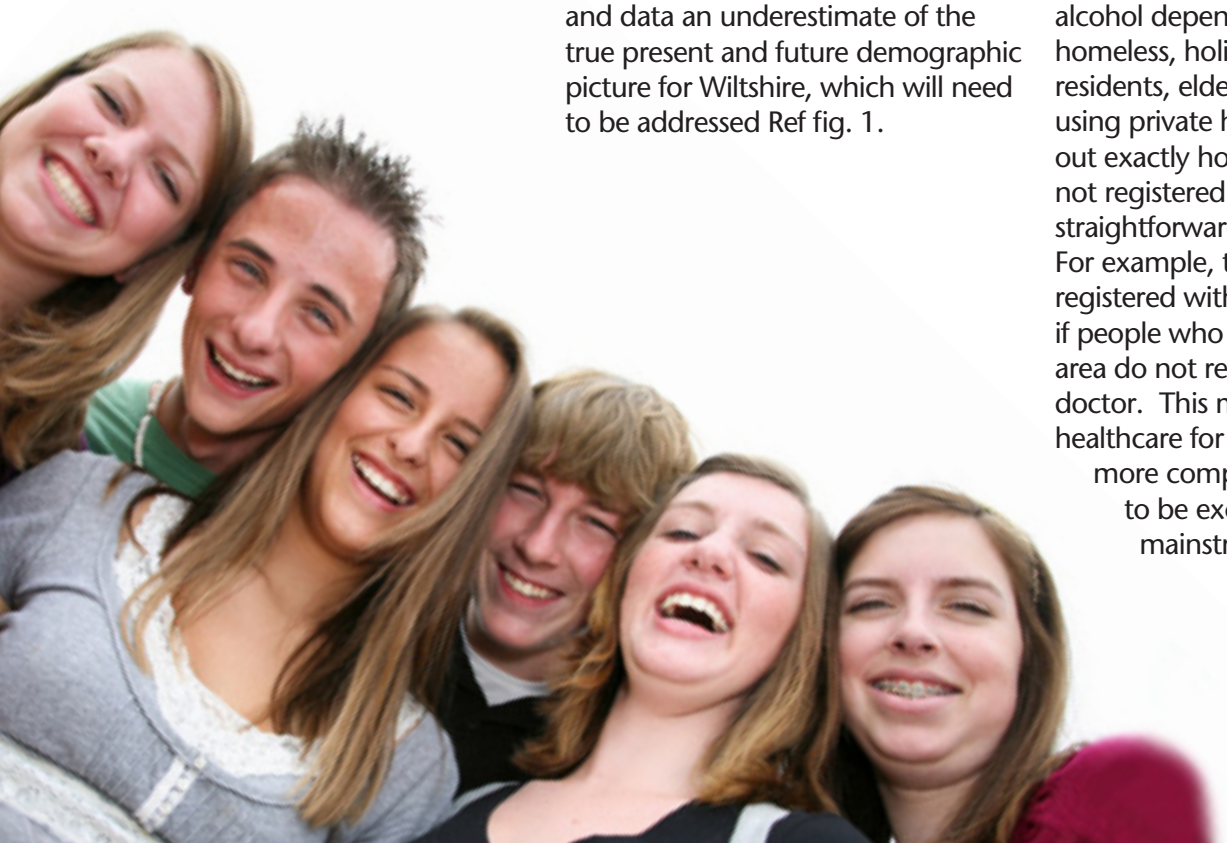
Figure 1: Wiltshire community area total populations, mid-year 2011



Source: Wiltshire Council popgroup – trend based projections, 2011

Sub Wiltshire

Wiltshire has a robust methodology for producing population estimates and projections at Community Area geographies. This was used to publish 'Wiltshire Population 2011 – Wiltshire and Community Area Population Estimates and Projections 2001 to 2026: Trend based' in July 2011. However, the higher than expected 2011 Census and 2011 mid-year estimates of Wiltshire's total population renders the current Wiltshire Population 2011 document and data an underestimate of the true present and future demographic picture for Wiltshire, which will need to be addressed Ref fig. 1.



Registered population

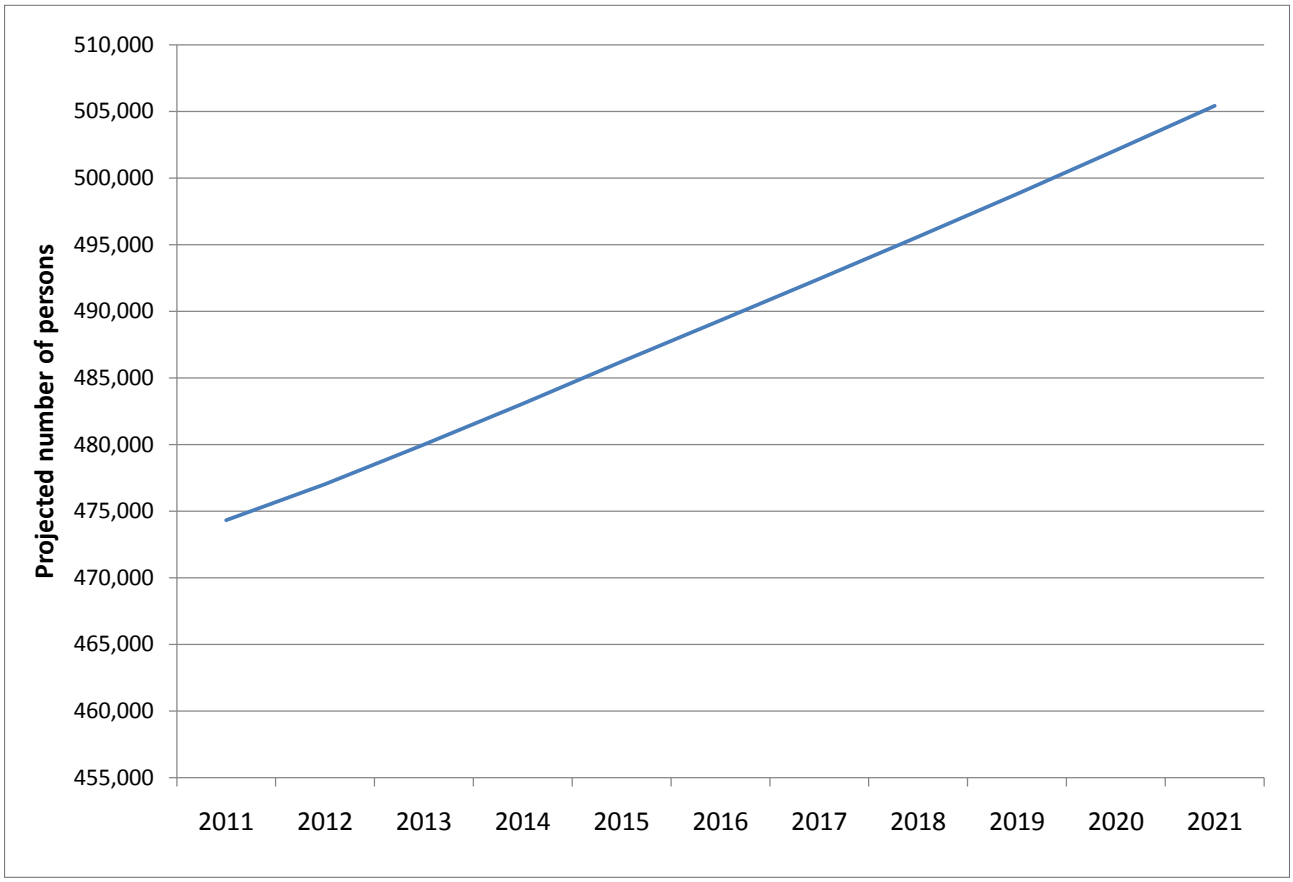
The majority of people are registered with General Practices. There were a total of 467,715 people registered with Wiltshire GPs on 31st March 2012. However, some people are not registered for a variety of reasons, for example drug and alcohol dependent people, the homeless, holiday makers, temporary residents, elderly people or people using private healthcare. Finding out exactly how many people are not registered with a doctor is not straightforward for many reasons. For example, the number of people registered with a GP can be inflated if people who move away from the area do not register with another doctor. This makes providing healthcare for people in these groups more complex as they are likely to be excluded from the mainstream health services.

Future population projections

The ONS have produced interim population projections based on the 2011 Census. Wiltshire's population is projected to grow from 474,300 in 2011 to 505,416 in 2021. This represents a 6.6% increase which is slightly below the growth projected in the South West (8.3%) and England (8.6%) over the same period.

The projected population figures show a steep increase in older people with the percentage of the population in Wiltshire aged 65 or over reaching 22.6% by 2021. This represents a 32% increase in the number of people over 65 in Wiltshire over this 10-year period. The number of Wiltshire's residents aged over 85 years is projected to increase from around 12,000 in 2011 to over 17,000 by 2021.

Figure 2: Projected population of Wiltshire, 2011 to 2021



Source: ONS 2011 based interim population projections: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/index.html

The dependency ratio is projected to increase by 12.8% between 2011 and 2021 in Wiltshire compared to a 7.4% rise in England. As the ratio increases, there is an increased pressure on the economically active part of the population to maintain the welfare of the economically dependent. This is, to a large extent, a national issue in terms of education, health service, and pension provision. However, care and support is often provided by carers such as spouses, partners, family members, friends and neighbours. Informal care and support is, therefore, especially important in Wiltshire.

The full age and ageing population briefing note can be downloaded here tinyurl.com/hwjsa101

Calculations of a fertility rate usually involve the number of women of child-bearing age, conventionally 15 to 44 years. Projections based on the 2011 Census estimate that there are 84,950 women aged between 15 and 44 in Wiltshire in 2011 and by 2021 this number will decrease by 9.7% to 76,740.

It appears the number of women eligible for the breast screening programme will increase by 16.3% in the ten years between 2011 and 2021; this is much more than the populations for cervical or abdominal aortic aneurysm (AAA) screening.

The full demographics: gender briefing note is available here: tinyurl.com/hwjsa102

Demographics - resources

- 2011 Census: www.ons.gov.uk/ons/guide-method/census/2011/index.html
- 2011 Census information for Wiltshire: www.intelligencenetwork.org.uk/population-and-census/
- 2011 mid-year population estimates: tinyurl.com/wjsahw104
- 2011 Census based interim population projections (up to 2021): tinyurl.com/hwjsa191
- 'Experimental' ethnic population statistics for Wiltshire (up to 2009): tinyurl.com/wjsahw103
- Trend-based estimates of population in Wiltshire and Community Areas for 2001 and 2009 and projections up to 2026:
  Report: tinyurl.com/wjsahw100
  Data: tinyurl.com/wjsahw101
- Equality in Wiltshire: A Statistical Profile tinyurl.com/wjsahw102

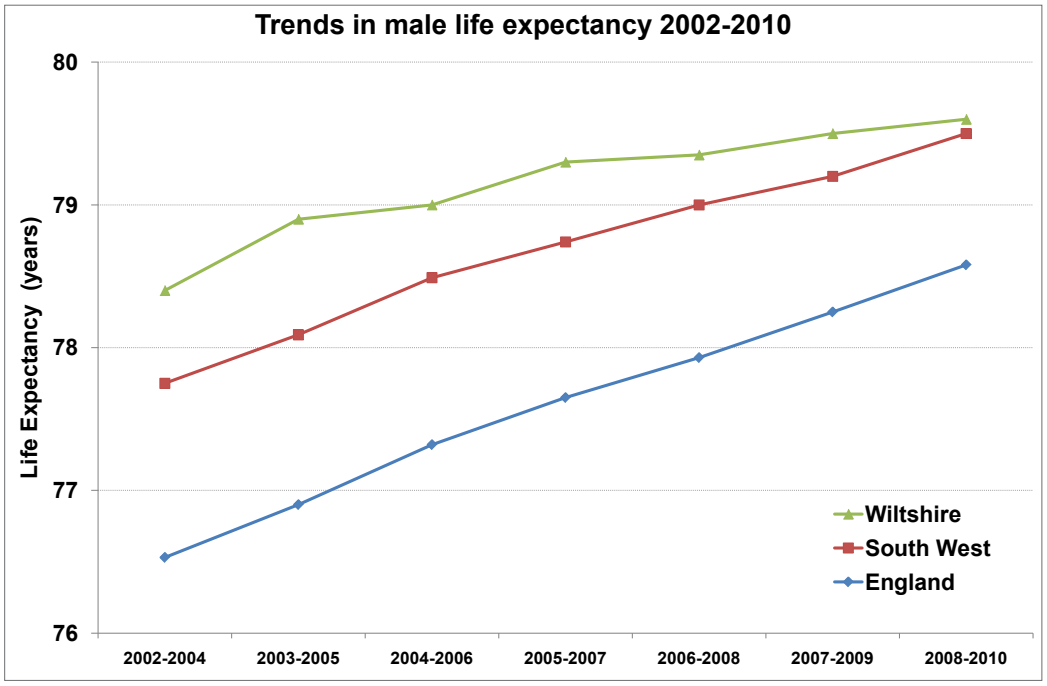
Demographics - Outcome Frameworks summary

The following indicators from the Public Health Outcomes Framework; the NHS Outcomes Framework and the Adult Social Care Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Indicator
Public Health	2.24 / 4.14	Falls and fall injuries / Hip fractures in over 65s
Public Health	4.1	Infant mortality
Public Health	4.3	Mortality from causes considered preventable
Public Health	4.13	Health-related quality of life for older people
Public Health	4.16	Dementia and its impacts
NHS	2	Health-related quality of life for people with long-term conditions
NHS	2.6	Enhancing quality of life for people with dementia
Adult Social Care	1.A	Social care-related quality of life
Adult Social Care	2.A	Permanent admissions to residential and nursing care homes, per 100,000 population
Adult Social Care	2.B	Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

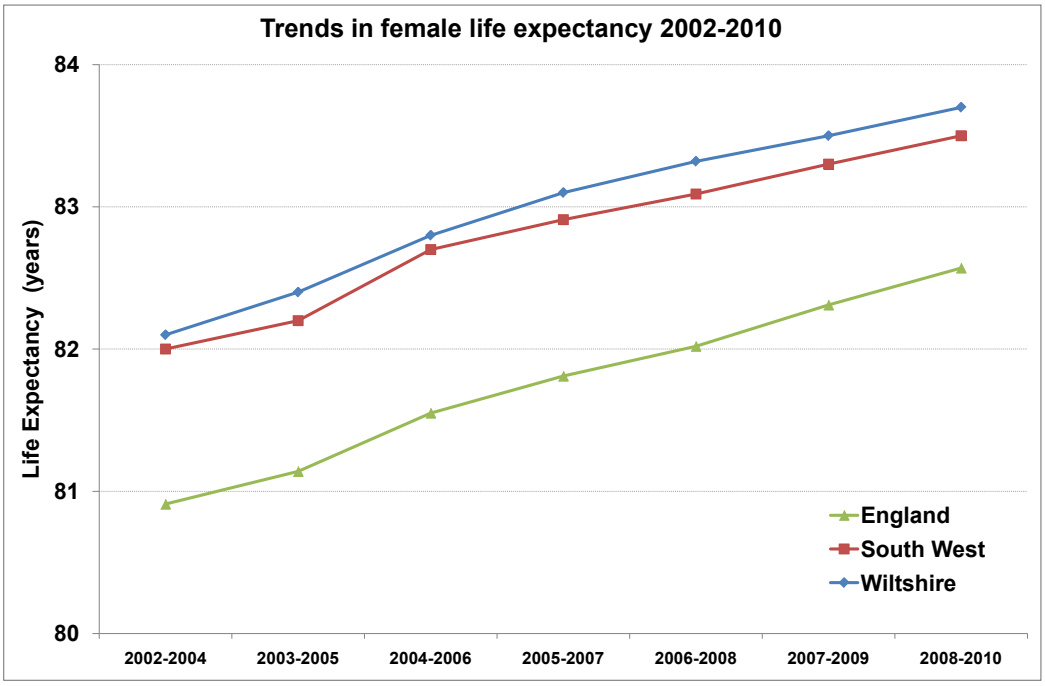
Life expectancy and mortality

Figure 3: Trends in male life expectancy at birth 2002 to 2010



Source: ONS, October 2011

Figure 4: Trends in female life expectancy at birth, 2002 to 2010

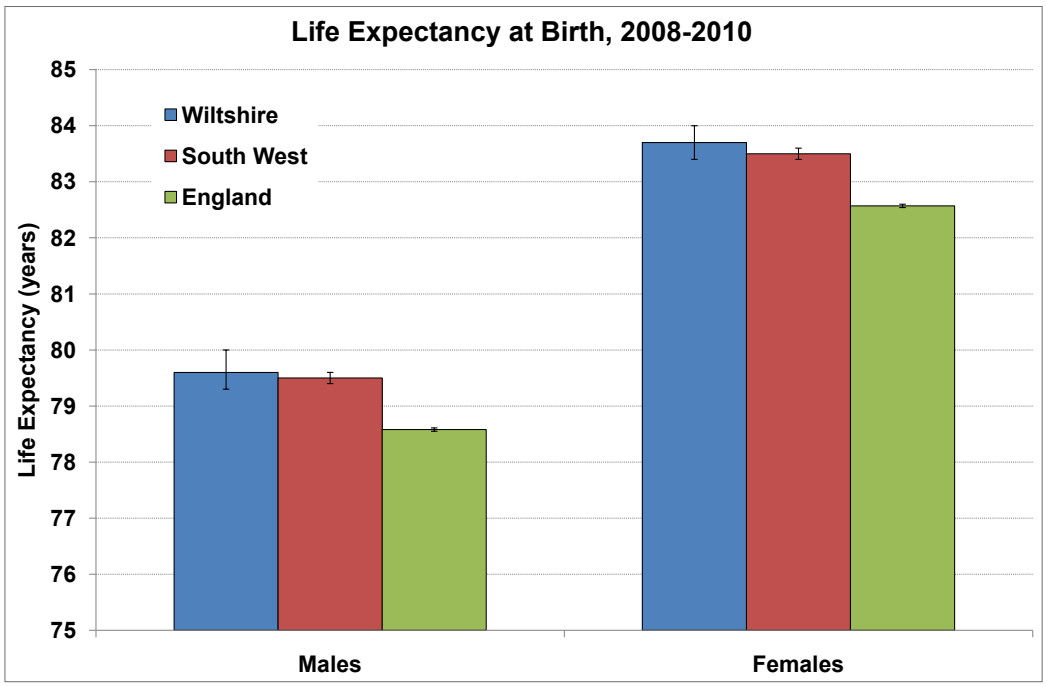


Source: ONS, October 2011

This section summarises the key measures that are frequently used to give an overview of the health of a population, including life expectancy and all-cause mortality. Wiltshire compares reasonably well on all these measures with the rest of England and the South West.

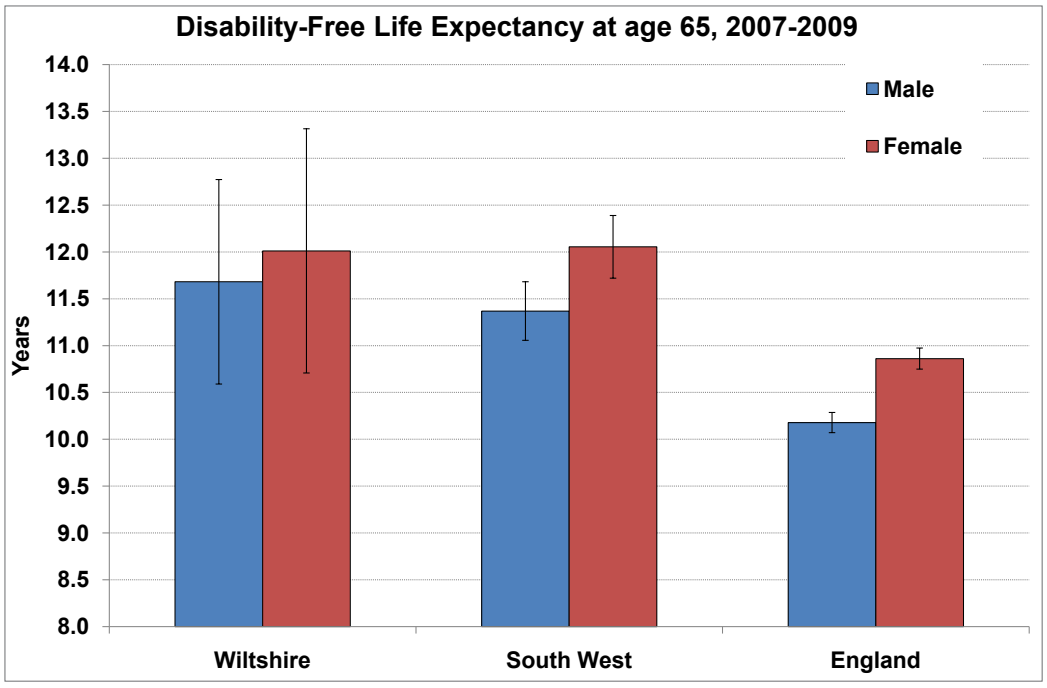
Life expectancy at birth is often used as a measure of the health of a population. It is calculated as the average number of years a new born baby might be expected to live based on current trends. Life expectancy in England has increased over the last century and this general trend is continuing as health services and the wider determinants of health generally improve. This pattern is also reflected in Wiltshire (see Figure 3 and Figure 4).

Figure 5: Life expectancy at birth 2008 to 2010



Source: ONS, October 2011

Figure 6: Average number of disability free years after the age of 65



Source: ONS, www.statistics.gov.uk/StatBase/Product.asp?vlnk=12964

The population in the South West has a higher life expectancy than England as a whole and people in Wiltshire also live longer than the general population in the South West. Life expectancy in Wiltshire for 2008 to 2010 is 79.6 years for males and 83.7 years for females. See Figure 5.

Disability free life expectancy

Disability free life expectancy is a measure of how many years on average a person can expect to live free from disability or limiting illness. These years can be from birth or from a given age such as 65.

Figure 6 shows the predicted number of years a person can expect to live disability free after reaching the age of 65.

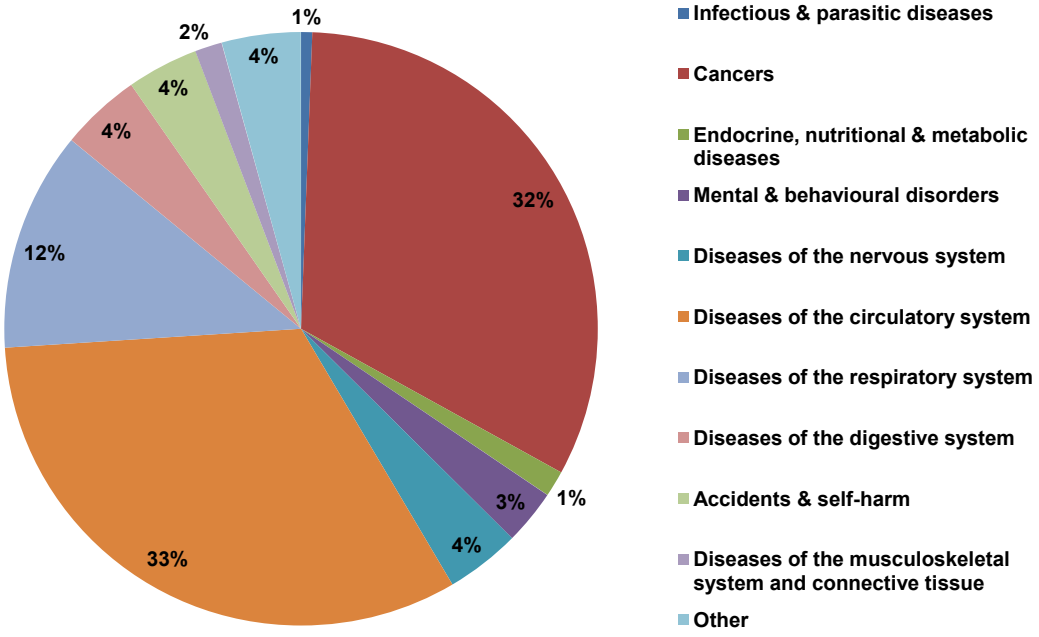
It is clear that Wiltshire is performing well, and Wiltshire residents can look forward to more disability free years than the average South West or England resident.

- Females in Wiltshire can expect to live on average 12.0 years disability free from the age of 65, to 77.0 years,
- Males can expect to live on average 11.7 years disability free post 65, to 76.7 years.

Mortality

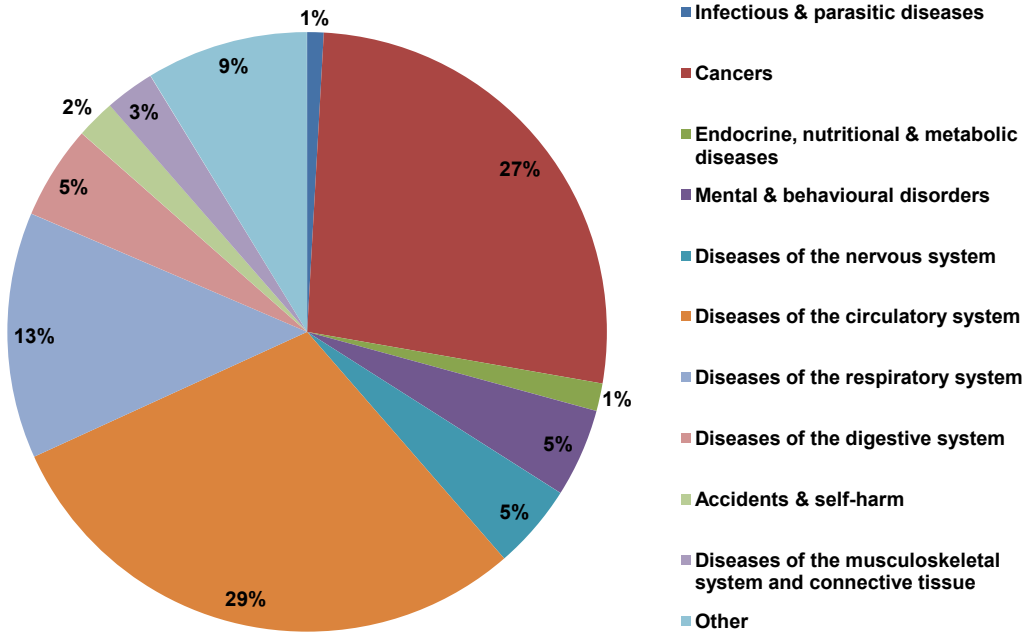
All age all-cause mortality (AAACM) rates are also used as a proxy measure for life expectancy. When all age all-cause mortality rates improve, life expectancy can be expected to improve.

Figure 7:
Causes of death in males in Wiltshire, 2010



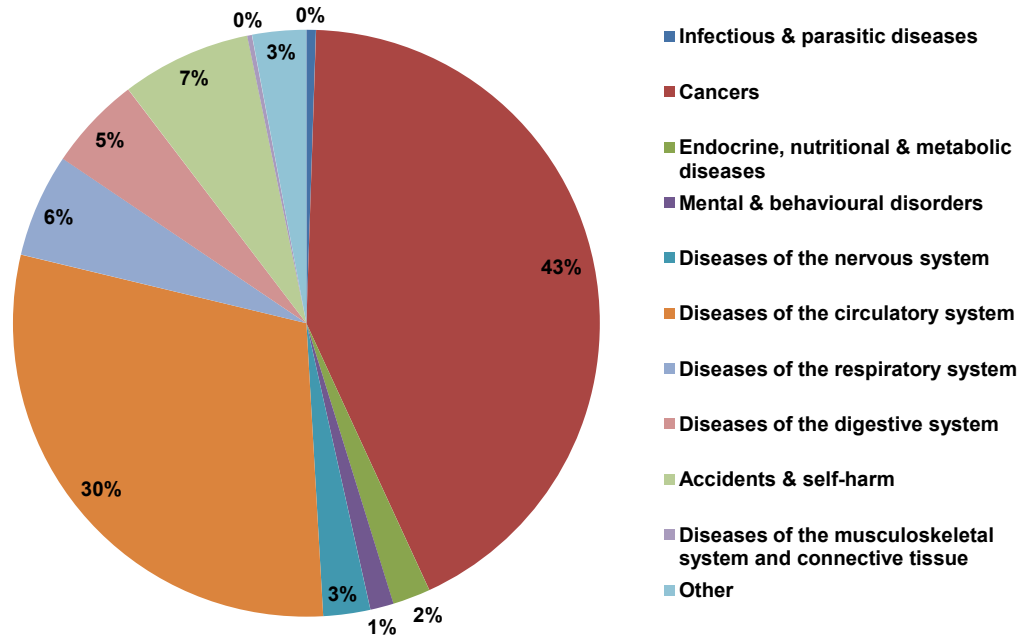
Source: ONS Vital Statistics (table 3), 2010

Causes of death in females in Wiltshire, 2010



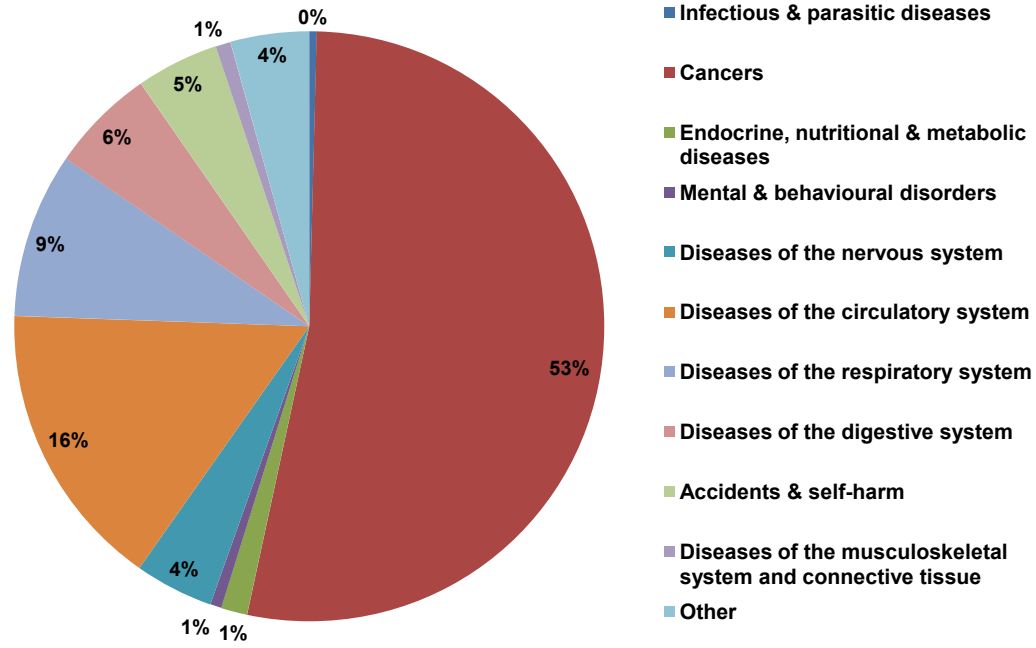
Source: ONS Vital Statistics (table 3), 2010

Figure 8:
Causes of death in males under 75s in Wiltshire, 2010



Source: ONS Vital Statistics (table 3), 2010

Causes of death in females under 75s in Wiltshire, 2010



Source: ONS Vital Statistics (table 3), 2010

Of particular interest are causes of death amongst the under 75s, because deaths in this age group are defined as premature.

In 2010, there were 1,272 deaths under the age of 75, representing 30.9% of all deaths in the county. The two major causes of premature death nationally, and in Wiltshire, are circulatory disease (including coronary heart disease and stroke) and cancers. Figure 8 illustrates this. Overall, mortality from all causes in the under 75 age group has been declining in Wiltshire, the South West and England (see Figure 9 and Figure 10).

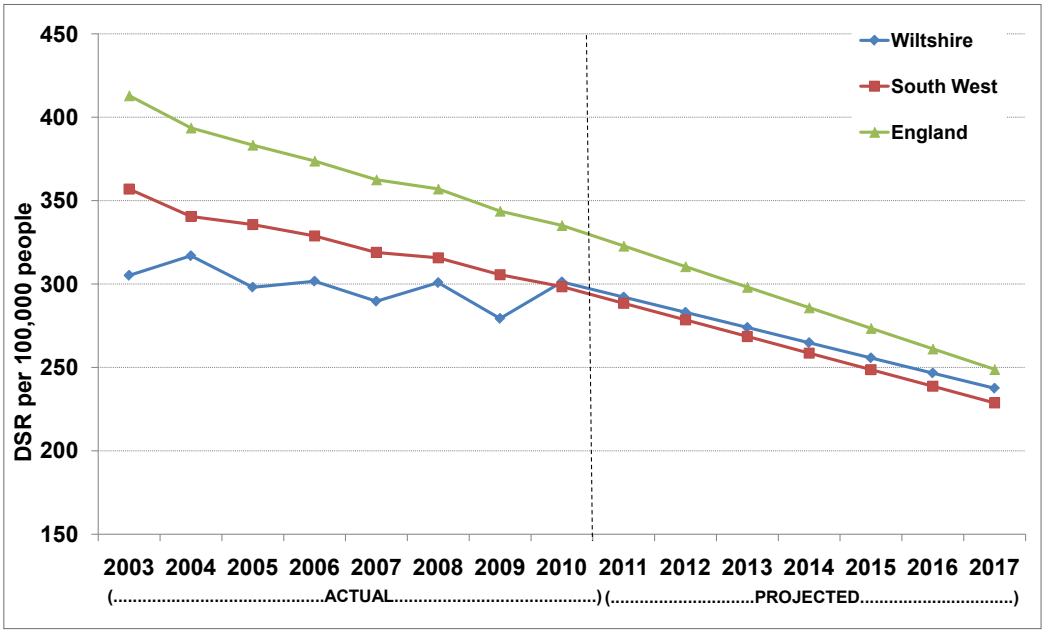
At a local level, the inclusion of the life expectancy indicator within the Wiltshire Council Business Plan Corporate Scorecard ensures that issues of health, deprivation, and life expectancy, are high on the agenda of all partners in Wiltshire.

The data in this section reveals the different causes of premature mortality recorded in Wiltshire, and highlights important areas to target to prevent deaths in people under 75. In particular, cancers and diseases of the circulatory system are shown to contribute significantly to premature mortality.

Life expectancy and mortality - resources

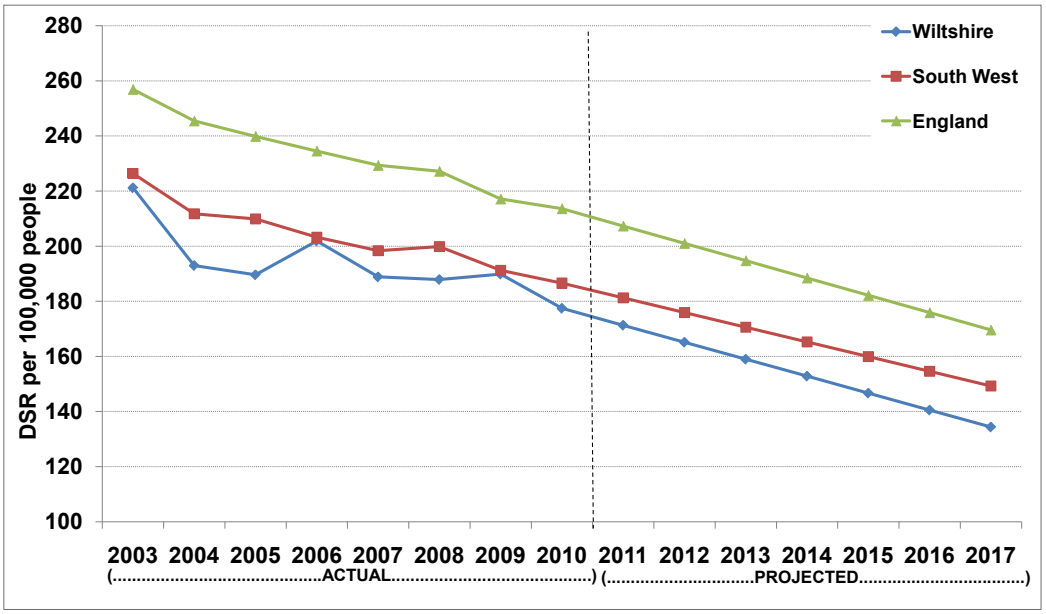
- ONS topic guide to life expectancy www.statistics.gov.uk/hub/population/deaths/life-expectancies
- ONS topic guide to mortality rates: www.statistics.gov.uk/hub/population/deaths/mortality-rates
- WMPHO excess winter deaths interactive mapping tool: www.wmpho.org.uk/excesswinterdeathsinEnglandatlas/

Figure 9: All-cause mortality rate in males under 75, 2003 to 2017



Source: The NHS Information Centre for health and social care. © Crown Copyright; 2010
www.nchod.nhs.uk

Figure 10: All-cause mortality rate in females under 75, 2003 to2017



Source: The NHS Information Centre for health and social care. © Crown Copyright; 2010
www.nchod.nhs.uk

Life expectancy and mortality - Outcome Frameworks summary

The following indicators from the Public Health Outcomes Framework and the NHS Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Outcome / Indicator
Public Health	O1	Healthy life expectancy
Public Health	O2	Differences in life expectancy and healthy life expectancy between communities
Public Health	1.10	Killed and seriously injured casualties on England's roads
Public Health	4.1	Infant mortality
NHS	1.6	Reducing deaths in babies and young children
Public Health	4.13	Mortality from causes considered preventable
NHS	1a	Potential Years of Life Lost from causes considered amenable to healthcare
Public Health / NHS	4.4 / 1.1	Mortality from cardiovascular diseases
Public Health / NHS	4.5 / 1.4	Mortality from cancer
Public Health / NHS	4.6 / 1.3	Mortality from liver disease
Public Health / NHS	4.7 / 1.2	Mortality from respiratory diseases
Public Health	4.8	Mortality from communicable diseases
Public Health	4.10	Suicide
Public Health	4.15	Excess winter deaths
NHS	1b	Life expectancy at 75 (i) males (ii) females
NHS	1.5	Reducing premature death in people with serious mental illness
NHS	1.7	Reducing premature death in people with learning disabilities

Health inequalities

Introduction

Health inequalities are variations in health between population groups resulting from a variety of societal and economic processes that are unequally distributed within or between populations. They are avoidable and unfair.

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked with the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health in terms of health care and unhealthy behaviours. It should become the main focus.

Local services cannot be complacent and there is a need to maintain focus on major health issues, for example reducing premature mortality and deaths from cancer and cardiovascular disease. Inequalities do exist in Wiltshire and, especially with an ageing population structure; health needs are subject to change over future years.

Lifestyle, behaviour, access and uptake of health services also influence health inequalities, and in many cases are linked with the social determinants of health.

Health is a multi-dimensional concept, and therefore there are many ways in which both health, and hence health inequality, can be measured. Using the correct measurement is important to ensure inequalities are identified and monitored.

Key conclusions and recommendations

- Between 2006 and 2010 life expectancy was 6.6 years lower for men and 3.8 years lower for women in the most deprived areas of Wiltshire than in the least deprived areas. The gaps for males and females have widened since between 2001 and 2005.
- Lifestyle factors vary by socio economic gradient, with those in more deprived areas being more likely to have 'unhealthy' lifestyles such as smoking.
- Action to reduce health inequalities needs to address social determinants of health such as poverty, education, employment and housing.
- People living in rural areas and older people can have difficulty in accessing healthcare services.

'The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities.'[3]

[3] World Health Organisation (WHO). Social determinants of health. http://www.who.int/social_determinants/en/

Background

The social determinants of health are mostly responsible for health inequalities. Behaviour and lifestyle, and access and uptake of health services also influence health inequalities. The lifestyle factors which influence health inequalities are sometimes referred to as the 'proximate' causes of health inequalities, because they are the immediate precursors of disease, as opposed to the 'distal', 'upstream' or 'wider determinants', such as poverty, housing or education. Variation in access and uptake of health services is influenced by availability, quality, costs and information.

There are many different measures of health inequalities, with the 'slope index of inequality' currently being one of the most common ways to show the gap in life expectancy within an area. In rural areas it should be remembered that area measures of deprivation may mask pockets of deprivation.

The full briefing note on measuring health inequalities is available here: tinyurl.com/hwjsa104

Life expectancy

Between 2006 and 2010 life expectancy was 6.6 years lower for men and 3.8 years lower for women in the most deprived areas of Wiltshire than in the least deprived areas. The gaps for males and females have widened since between 2001 and 2005. This gap is statistically significantly lower for men and women than the median for England.

In England and in Wiltshire inequalities between the sexes are narrowing in terms of disability-free life expectancy after age 65. In Wiltshire, disability-free life expectancy increased by 27.4% in males over the age of 65, and 22.8% in females between the periods 2000 to 2002 and 2007 to 2009.

Variations in life expectancy linked to deprivation are associated with variations in morbidity and mortality from different conditions or diseases. The pattern of causes of deaths contributing to the life expectancy gap is broadly similar for both males and females, with cancers, circulatory and respiratory diseases accounting for over 65% in each.

The full briefing note on inequalities in outcomes is available here: tinyurl.com/hwjsa113

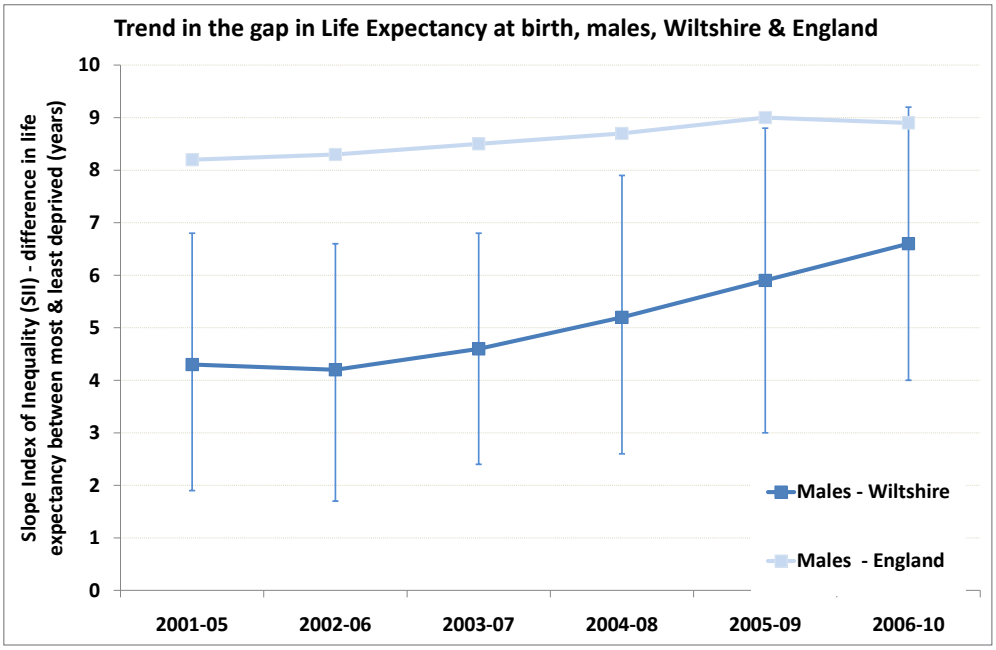
Infant mortality

The infant mortality rate between 2008 and 2010 in 2008 to 2010 in Wiltshire was 4.1 per 1,000 live births and has increased in each period since an historical low point of 3.2 per 1,000 in 2005 to 2007. Numbers in Wiltshire are too small for a local analysis but national evidence shows that infant mortality rates are higher in more deprived areas.

Access and uptake

Access to healthcare services are one piece in the overall picture of health inequalities. Variation in access and uptake of health services is influenced by availability, quality, costs and information.

Figure 11: Trend in slope index of inequality (males)



Source: Health Inequality Indicators for Local Authorities and Primary Care Organisations: http://www.apho.org.uk/resource/item.aspx?RID=110505

Figure 12: Trend in slope index of inequality (females)

Source: Health Inequality Indicators for Local Authorities and Primary Care Organisations: http://www.apho.org.uk/resource/item.aspx?RID=110505

The NHS must ensure that access to all services are equitable for different groups. As Wiltshire has a relatively older and more rural population, these aspects need to be considered in local access and uptake of health services.

The full briefing note on inequalities in access and uptake is available here: tinyurl.com/hwjsa105

Lifestyle and behaviour

Lifestyle factors vary by socio economic gradient, with those in more deprived areas being more likely to have 'unhealthy' lifestyles such as smoking. In Wiltshire there is evidence of inequalities in lifestyles and behaviours similar to those seen nationally.

Nationally:

- Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK.
- Young people, black minority communities and men who have sex with men (MSM) are disproportionately affected by sexually transmitted infections (STIs).
- Children in the 10% most deprived wards are three times more likely to be hit by a car than children in the 10% least deprived wards.

In Wiltshire:

- Alcohol related admissions in the most deprived quintile are 61% higher than in the least deprived quintile.
- Estimates are that obesity was over 8% higher in the most deprived population quintile compared to the least deprived in 2009.
- In 2011/12 the prevalence of breastfeeding at 6 to 8 weeks in the most deprived population quintile was significantly lower than the Wiltshire average and significantly lower than the rate observed in any other deprivation quintile.

The full briefing note on inequalities in lifestyles and behaviours is available here: tinyurl.com/hwjsa112

Minority groups

Within society, there are some groups at higher risk of poorer health outcomes relating to specific health and social care needs and wider determinants of health. Within Wiltshire such groups include black, Asian and ethnic minority communities, prisoners, homeless people, the military and gypsies and travellers.

The full briefing note on minority groups is available here: tinyurl.com/hwjsa114

Reducing health inequalities

Many major conditions are strongly correlated to deprivation as are the lifestyles that contribute to them. Actions to reduce health inequalities need to address social determinants of health and be across the life course. This requires local service providers to work in partnership.

It is clear that people in Wiltshire still die prematurely as a result of deprivation, highlighting the need to concentrate efforts in targeting interventions to reach those most in need. Among the interventions that are evidenced to reduce the life expectancy gap are: smoking cessation; statin therapy, use of anti hypertensives; and early detection of cancer. There is evidence that actions targeting causes of early death, particularly those related to health inequalities, can contribute to improving life expectancy. Figure 13 illustrates this.

Assessment of need should include assessment of access to and uptake of health services, which may be especially important in Wiltshire given the rural older population where inequalities may be masked.

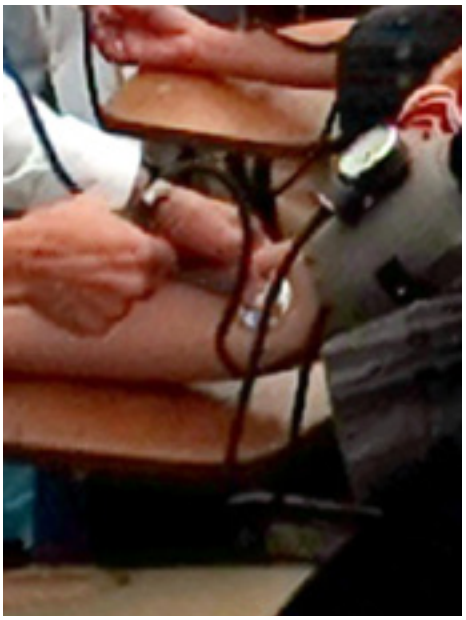
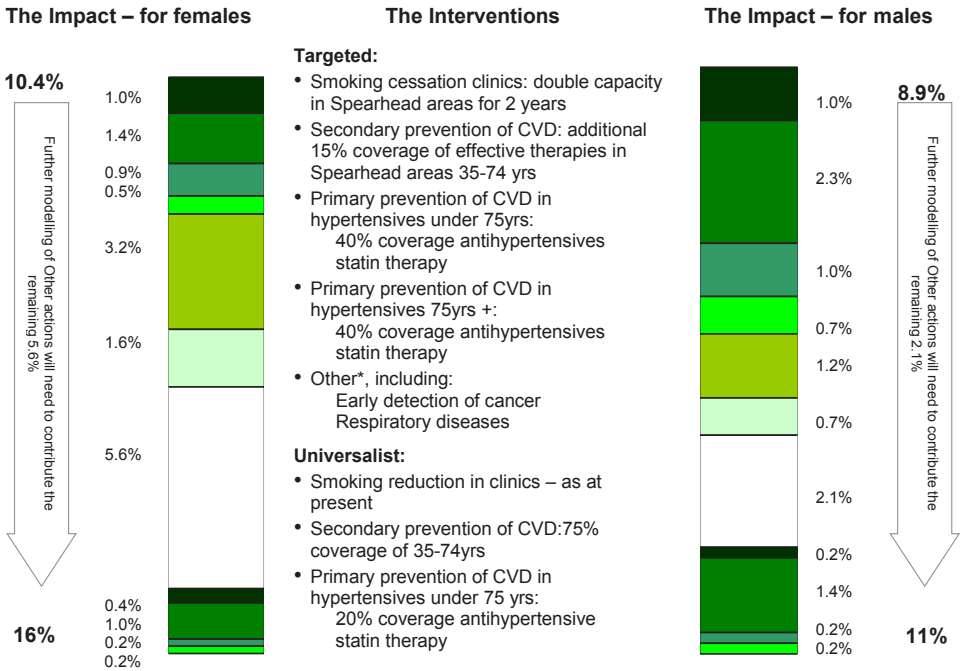


Figure 13: Interventions to reduce the inequalities gap



Source: Tackling Health Inequalities: 2004-06 data and policy update for the National Target, Department of Health, Health Inequalities Unit, Dec 2007

Targeted Public Health programmes in Wiltshire to reduce health Inequalities

Health trainer programme:

- Working with probation, Her Majesty's Prison (HMP) Erlestoke, family member of military personnel and Wiltshire Addiction Support Programme.
- Health Trainers help people to develop healthier behaviour and lifestyles in their own local communities. They offer practical support to change their behaviour to achieve their own choices and goals.
- Targeting people in probation, prison and addiction support programmes are more likely to be at risk of a number of physical and mental health problems.

Early years healthy eating programme:

- Focused in areas with higher than average levels of obesity.

Cardiovascular disease outreach:

- Activity in pharmacies – delivered in partnership with Local Pharmaceutical Committee.
- Ad hoc sessions at markets and other venues - implemented via locality lead GPs and Public Health Lifestyles Team.
- Targeting areas where the population is at greater risk of cardiovascular disease which is one of the main causes of mortality.

Citizens Advice in Primary Care:

- Citizens Advice available in three GP practices with high levels of deprivation.
- The project's aim is to provide advice on housing, debt, benefits and employment to those that require it but may otherwise not access this advice, and thereby improve the wider determinants of people's health.

College based sexual health drop-in sessions:

- To address some of the issues of young people having access to appropriate clinics.

Affordable Warmth Partnership:

- Targeted information about the assistance available to improve energy efficiency and to help with fuel bills.
- Addresses some of the wider determinants of health, and has potential to directly impact on health by people having warm enough houses.

Breastfeeding peer support programme:

- Women with experience of breastfeeding are trained to support new mothers with breastfeeding in areas with low breastfeeding rates.
- Breastfeeding is known to be good for both mother and baby, and can affect health throughout the life course.

Universal Public Health programmes in Wiltshire which contribute to reducing health inequalities

Health improvement campaigns:

- Active Health (physical activity on referral) programme.
- Adult and children weight management programmes.
- Healthy schools programme.
- Change 4 Life programme.
- Implementation of Wiltshire Alcohol strategy.
- Pharmacy health promotion campaigns.
- Generic health promotion campaigns.

NHS Health Checks offered by GPs for all those aged 40-74 years, not already on a CVD register.

Stop Smoking Service.

Generic health promotion campaigns.

Behaviour Change workshops to support front line workers (in statutory and voluntary organisations) who deal with 'lifestyle issues'. The training aims to explore client centred approaches which can 'help people help themselves' with regard to lifestyle issues.

Health inequalities - resources

For more detailed information on: measuring inequalities; inequalities in outcomes; inequalities in behaviour and lifestyles; inequalities in access and uptake; and minority groups see the relevant individual briefings: tinyurl.com/hwjsa203.

- Fair Society, Healthy Lives. The Marmot Review: www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report
- The Wiltshire Health Inequalities Strategy and Implementation Plan 2007-2010 described the scale and nature of local inequalities problems and planned interventions to narrow the gap in life expectancy. www.wiltshirepct.nhs.uk/Publications/Strategies/HealthInequalitiesStrategy_2007_2010.pdf
- Slope Index of Inequality for life expectancy by deprivation deciles, 2006-10: www.apho.org.uk/RESOURCE/VIEW.ASPX?RID=110504
- The Indices of Deprivation 2010 (ID 2010) www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/
- Deprivation in Wiltshire: Indices of Deprivation 2010 tinyurl.com/hwjsa192

Health inequalities - Outcome Frameworks summary

The Public Health Outcomes Framework for England, 2013-2016[4] outlines the overarching vision for public health as 'to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest'. Each indicator domain has an objective that includes health inequalities:

Domain	Objective
1. Improving the wider determinants of health	Improvements against wider factors that affect health and wellbeing and health inequalities
2. Health improvement	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
3. Health protection	The population's health is protected from major incidents and other threats, while reducing health inequalities
4. Healthcare public health and preventing premature mortality	Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

[4] Department of Health tinyurl.com/hwjsa300

Children and young people

Introduction

Good child health is important not only for children and families now but for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression, arise in childhood. Child health, development and wellbeing also has broader effects on educational achievement, violence, crime and unemployment. Life chances and outcomes for children and young people can be achieved by multi-agency working across prevention and early intervention; raising aspirations and narrowing gaps in inequality and promoting healthy lifestyles. This can be achieved by focussing on enabling and empowering individuals, families and communities.

Key conclusions and recommendations

Complex and vulnerable families

To enable referrals to be progressed appropriately and complex families to be supported in the best way the Children's Social Care 'front door' must be right and key agencies need to work together to support both parents and children in the family. The Gateway Panel work needs to work effectively and there also needs to be proper oversight of the support that families are receiving. From this an assessment is required to judge whether this is resulting in improved outcomes (the 'tracking' required for the Troubled Families payment by results scheme). The effectiveness of a family focused assessment, rather than one that is mainly child focused, should be assessed.

Child mortality

Mortality rates in both infants and under 15s have risen in Wiltshire in recent years, whilst national and regional rates for these indicators over the same periods have been decreasing.

Health inequalities

The important message for all in the system, is that we must promote exposure to positives, protect exposure from negatives, and prevent harm of all kinds at every stage of the pathway. It follows that if those who design, commission, deliver and evaluate services against the evidence of a continuum of need are committed to dealing with health inequalities, it takes concerted joint action, preferably before the person is sick, rather than waiting until they are so. Commissioning and delivering to narrow the gaps, whilst not allowing those already well served to see their wellbeing suffer is undoubtedly a challenge. That should not stop the endeavour.[5]

Child poverty

Out of Wiltshire's 281 lower super output areas, 49 have over 20% and 13 have over 30% of children living in poverty. If not addressed these will form a 'hard core' of child poverty in Wiltshire.

Immunisations

In Wiltshire a key challenge is to maintain current levels of vaccination uptake, as well as identifying groups or settings where coverage is low at a local level, and designing appropriate interventions to improve equity in service delivery. Targeted work to improve MMR uptake in some localities and overall uptake of the adolescent booster vaccination for diphtheria, tetanus and polio is being undertaken early in 2012.

[5] Inequalities in health outcomes and how they might be addressed, Children and Young People's Health Outcomes Forum, June 2012.

Childhood obesity; healthy eating and physical activity

Levels of obesity in Wiltshire remain stable and are generally below the South West and England rates. However, over 1 in 5 Reception Year children and nearly 1 in 3 Year 6 children are overweight or obese and the challenge is to reduce these figures. Trowbridge, Calne and Warminster Community Areas and Children's Centres were highlighted as having higher percentages of children with weights higher than the healthy standard. Strong associations between obesity and socio economic status, age and gender are apparent in Wiltshire. There is also a gender gap in physical activity levels and these levels also decrease as children get older and more sedentary in behaviour. Less than one quarter eat the recommended 5 portions a day of fruit or vegetables.

Smoking

There is a national and local focus on reducing the rate of smoking during pregnancy to 11% or less by the end of 2015. Initiatives are in place to prevent tobacco from being sold to under age children, tackle risk taking behaviour and influence policy to make areas used frequently by children either smoke free or viewed as socially unacceptable to smoke in.

Substance misuse

The majority of young people in Wiltshire do not misuse substances. There are concerted efforts locally to increase awareness about the harms associated with substance use, including so called 'legal highs'. The aim is to embed substance misuse within all safeguarding processes and to ensure that substance misuse services are acceptable and assessable to all children and young people. There are plans to undertake further work to engage young people with the development of preventive and specialist services. Alongside this coordinated approach is the aim to improve relevant data collection and information sharing across partner agencies and conduct specific surveys to address gaps in intelligence, including equality monitoring data.

Safeguarding children in need

Government guidance is currently being revised following the 2011 Munro review of child protection which made recommendations for reforming the child protection system, improving safeguarding arrangements and early intervention. Locally, the 2012 Ofsted inspection of Safeguarding and Looked After Children that found the quality of services for safeguarding were inadequate and services for looked after children were adequate with some good aspects. An improvement plan has been developed in response to this.

Complex and vulnerable families

This topic report forms a larger section on complex families and safeguarding children in need and is available here: tinyurl.com/hwjsa126

Why this area is important

Children in families who experience multiple social, economic and health issues can have poor outcomes, partly due to their parents having problems being effective parents. Families who have multiple and complex needs are defined by central government as those with a combination of issues, including:

- Persistent offending behaviour
- Persistent anti-social behaviour
- Prejudiced behaviour
- Mental health issues
- Drugs and alcohol issues
- Domestic violence
- Safeguarding issues
- Vulnerability
- Poverty
- Debt
- Worklessness.

Some families manage their issues and their children do well but others do not. These families almost always have other long standing problems which may lead to their children repeating the cycle of disadvantage. The families are often chaotic and have children who are excluded from school, encounter child protection problems and sometimes are young offenders. A number of these families will be known to social services and typically will cycle through episodes of short term and long term support and sometimes be subject to statutory interventions when the children become subject to child protection plans or are taken into care. However, some of these families will often fall below existing service thresholds and many of them will also have a history of non engagement with services and be considered to be 'hard to change'. Previous government research has highlighted that 2% of families suffer significant multiple problems that in turn make them more likely to place demands on local services, such as health, social care and criminal justice.

In December 2011 the Government announced additional funding for local authorities to work with partners to radically transform the lives of the country's most troubled families. The newly formed Troubled Families Unit within the Department for Communities and Local Government (DCLG) has stated that this is an opportunity to fight the problems of inter-generational poverty, disadvantage and disconnection from the mainstream of society which have affected parts of our communities. Troubled families within this programme are defined as those families who:

- are involved in crime or anti-social behaviour,
- have a child who has been excluded or is persistently absent from school,
- are in receipt of out of work benefits,
- cause high costs to the public purse.

The programme targets the support needs of families experiencing multiple problems through the use of a dedicated key worker approach by:

- joining up local services,
- dealing with each family's problems as a whole rather than individually,
- appointing a single key worker to access key issues and work intensively to help them change and function more effectively as a unit and within a community and improving the life opportunities for the children.

Supporting complex families will help improve opportunities for children, increase the contribution that the family makes to the community, and save the public money that is spent when problems escalate further.

What are the needs of the local population?

In March 2012, the Complex Families Unit estimated that we have approximately 500 troubled families in Wiltshire. Actual numbers of families are not currently known and to some extent will never be accurate. The Troubled Families' programme outlines how families can be identified locally by combining data crime and antisocial behaviour, education absence and the workless. The programme also acknowledges that these families will also have many other problems, those who meet the three criteria outlined in the government's definition, will be many of the families who are already known to services.

Given that Wiltshire has relatively low deprivation, crime and unemployment numbers, and relatively low numbers of children in need supported by children's social care, it would be expected that the proportion of complex families would be below the national average.

Current service provision

In Wiltshire, the Complex Families Project is our response to the Government's Troubled Families Initiative and we have signed up to working with 140 families during the first year of this three year project. We are also required to work closely with the provider selected for the South West by the Department for Work and Pensions to support workless households with children back into paid employment.

Some families will be already engaged with intervention services, for example Social Care, Education Welfare, Youth Offending/Police, Job Centre Plus. The aim is to get a better joined up, coordinated response to the whole family situation.

During the last few months, we have been building on the work that had already been undertaken during 2011 as a result of the Family and Parenting Support Commissioning Strategy. Specifically, we have:

- Completed the commissioning of two new services:
  - Action for Children is providing a new service called Wiltshire Families First. This is for families who do not meet the threshold for children's social care but with needs that cannot be met by support offered by Children's Centres and Parenting Support Advisors alone. The family situation will be complex and might be due to problematic substance misuse of parents, mental health needs of parents, domestic violence, offending or anti-social behaviour.
  - The other new service is an enhanced Family Group Conferencing Service provided by Daybreak. This will enable more families to find their own solutions to difficulties they are experiencing. Referrals for Family Group conferences will only come from Children's Social Care.
- Completed the re-design of the Council's in house family support service within Children's Social Care. This service undertakes a wide range of work including court assessments. The two existing geographical teams are being re-shaped into two County-wide teams: one for Contact and Assessment and one for Intensive Family Support. This will allow a greater focus on intervention for families needing help.
- Revised the Gateway Panel process. The Gateway Panel was started in September 2011 to support Lead Professionals working with children and young people following the completion of the Common Assessment Framework but where limited progress was being made in resolving difficulties. The revised Gateway Panel process now focuses on access to family and parenting support services, providing the 'gateway' to Wiltshire Families First, the Family Group Conferencing Service, the Children's Social Care Family Support Service and the specialist Family Assessment and Support Service provided by Oxford Health who run local Child and Adolescent Mental Health Services.

Next steps

The focus of the Wiltshire Complex Families Project will be on the following activities:

- Getting the Children's Social Care 'front door' right to enable referrals to be progressed appropriately and complex families to be supported in the best way.
- Ensuring the Gateway Panel works effectively, that there is sufficient oversight of the support that families are receiving and whether this is resulting in improved outcomes.
- Assessing the effectiveness of using a Family Common Assessment Framework form rather than one that is mainly child focused.

Demographics

Wiltshire has 114,900 children and young people aged 0-19 according to the 2011 mid-year estimates. This is 24.2% of the total Wiltshire population.

Table 2: Children by 5-year age band, 2011

	Wiltshire		South West		England	
	Number	% of total population	Number	% of total population	Number	% of total population
0-4	28,600	6.0%	297,300	5.6%	3,328,700	6.3%
5-9	27,300	5.8%	274,100	5.2%	2,990,100	5.6%
10-14	29,300	6.2%	295,500	5.6%	3,067,400	5.8%
15-19	29,700	6.3%	326,200	6.2%	3,324,300	6.3%
0-19 total	**114,900**	**24.2%**	**1,193,100**	**22.5%**	**12,710,500**	**23.9%**

Source: ONS 2011 mid-year estimates: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039

It is forecast that the population of children and young people (age 0-19) in Wiltshire will increase between 2011 and 2021 by 4.2% but will account for only 23.7% of the total population in 2021[6]. In Wiltshire increases in fertility along with increases in the number of women of reproductive ages has resulted in a steady increase in the number of births between 2002 and 2010. There were 4,692 births in 2002 and 5,468 in 2010. The number of births is expecting to keep rising over the next few years.

The full briefing note for this section is available here: tinyurl.com/hwjsa127

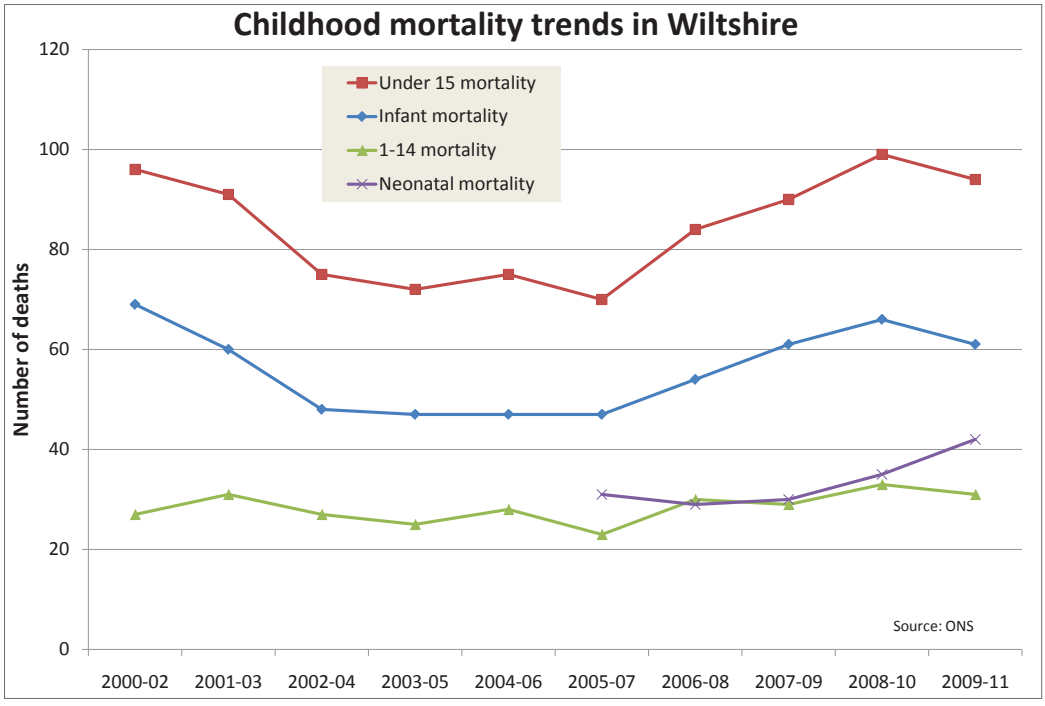
Child mortality

Mortality rates[7] in under 15s have risen in Wiltshire in recent years from 37.8 per 100,000 in 2006 to 2008 to 43.6 per 100,000 in 2008 to 2010[8]. This places Wiltshire below the national rate of 45.5 per 100,000 but above the South West rate of 38.0 per 100,000. However, the difference is not significant in either case. National and regional rates have been decreasing between 2006 to 2008 and 2008 to 2010.

Mortality rates[9] in infants under the age of 1 have also risen in Wiltshire in recent years. The infant mortality rate in 2008 to 2010 was 4.1 per 1,000 live births and has increased in each period since an historical low point of 3.2 per 1,000 in 2005 to 2007. This places Wiltshire below the national rate of 4.6 per 1,000 but above the South West rate of 3.7 per 100,000. Again, this is not significantly different in either case. National and regional rates have been decreasing between 2005 to 2007 and 2008 to 2010.

[6] 2011 interim subnational population projections, Subnational Population Projections Unit, ONS: Crown Copyright.
[7] The NHS Information Centre for health and social care. © Crown Copyright.
[8] Directly standardised for age using the European Standard population.
[9] The NHS Information Centre for health and social care. © Crown Copyright.

Figure 14: Childhood mortality trends in Wiltshire



Source: ONS, Vital Statistics. 2000 to 2010 includes provisional data for 2011

The full briefing note for this section is available here: tinyurl.com/hwjsa128

Health inequalities

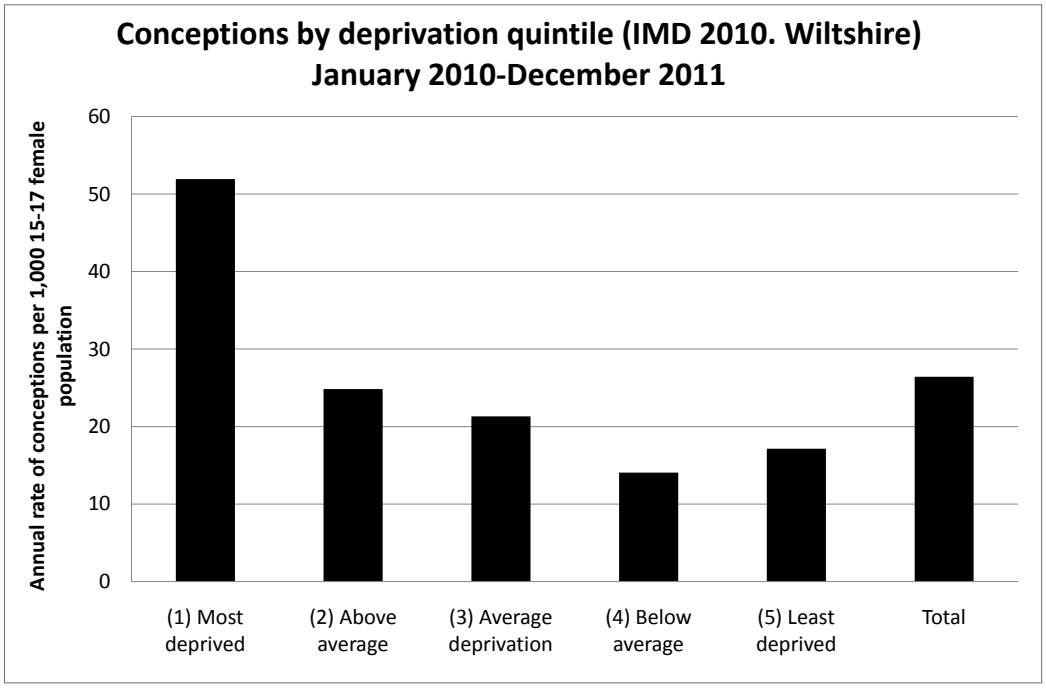
Considerable variations exist in both health service outcomes for children, and therefore, their whole-of-life-course outcomes. Variations become inequitable if individuals or groups in a population or community are denied fair access to either determinants of health or lifestyles or services which could improve their life chances and outcomes. Poor and deprived children and young people generally have worse health related outcomes than rich or affluent counterparts.

In 2009 Wiltshire had 12,240 children living in poverty, which represents 12.0% of children, according to Her Majesty's Revenue and Customs data. This compares well with other local authority areas in the South West of England, but masks the fact that of the 281 lower super output areas, 49 have over 20% and 13 have over 30% of children living in poverty.

Whilst many young parents will have positive parenting experiences, evidence[10] clearly shows that having children at a young age can have a negative impact on young women's health and wellbeing and severely limit their education and career prospects. Analysis of teenage conceptions data show that 37.3% of conceptions occurred to those in the most deprived quintile.

The full briefing note for this section is available here: tinyurl.com/hwjsa129

Figure 15: Conceptions by deprivation quintile



Source: teenage conceptions agreed dataset for Wiltshire, Sept 2012.

[10] Teenage Pregnancy: Accelerating the Strategy to 2010, Department for Education and Skills, September 2006

Antenatal, newborn and childhood screening

The underlying concept of screening is that early detection of risk factors or early disease is beneficial for the clinical or public health outcome. The UK National Screening Committee (UK NSC) currently recommends the offer of sickle cell and thalassaemia; infectious diseases in pregnancy; Down's syndrome and fetal anomaly ultrasound screening; newborn and infant physical examination; newborn bloodspot and newborn hearing. These are complemented by additional programmes in childhood around growth; hearing and vision.

The full briefing note for this section is available here: tinyurl.com/hwjsa130

Immunisations

In the first year of life children are vaccinated against Diptheria, Whooping Cough, Polio, Tetanus, Haemophilus influenza b and pneumococcal infection. In the 2nd year of life children begin their course of vaccination against measles, mumps and rubella. There are also targeted vaccination programmes for Tuberculosis and Hepatitis B, and vaccination for girls against the Human Papilloma Virus (HPV).

Immunisation coverage in Wiltshire is high compared to both the South West region and England as a whole. However, Wiltshire still has to improve to reach World Health Organisation targets (WHO) of 95% across all immunisation indicators.

The full briefing note for this section is available here: tinyurl.com/hwjsa131

Obesity

During 2010/11, 4,613 pupils in Reception and 4,404 pupils in Year 6 in Wiltshire were weighed and measured as part of the National Child Measurement Programme (NCMP). In that period 8.0% of Wiltshire Reception pupils measured were found to be obese; this compares to 9.4% for England. This is the second lowest level of obesity in the South West. In Year 6 16.4% of Wiltshire children were found to be obese; in England the figure was 19%. This ranks Wiltshire 7th out of 14 PCTs in the South West. Strong associations between obesity and socio economic status, age and gender are apparent in Wiltshire.

The full briefing note for this section is available here: tinyurl.com/hwjsa132

Healthy eating and physical activity

An appropriate diet and physical activity are vital for good health. They are both key to halting the rise in childhood obesity that is being seen nationally. The proportion of school pupils eating five or more portions of fruit and vegetables a day in Wiltshire is 24%, compared with 19% in England[11]. Wiltshire has 37,000 physically active school-aged children spending at least 3 hours per week on high quality physical education (PE) and school sport[12]. This equates to 63.4% of pupils in Wiltshire which is significantly higher than the percentage for England (55.1%). The 2011 Health Related Behaviour Survey[13] showed that 92% of primary school pupils have a bicycle but only 7% cycled to school on the morning of the survey. 48% of primary school pupils walked to school, 42% came by car.

Surveys show that there is a link between good health and other outcomes such as educational aspirations and attainment.

[11]Tellus survey (2009), DCSF
[12]Wiltshire Child Health Profile 2012, Child and Maternal Health Observatory, March 2012. Department of Health. tinyurl.com/hwjsa301
[13]Wiltshire Health Related Behaviour Survey 2011, Healthy Schools Wiltshire. Wiltshire Council. 2012. tinyurl.com/hwjsa302

The full briefing note for this section is available here: tinyurl.com/hwjsa115

Table 3: Physical activity and GSCE expectations

GCSE expectation	Average days taking hard exercise
I don't expect to take any GCSEs	2.3
I don't know what GSCEs I'm going to take, if any	2.4
I expect to take a few GCSEs (1 to 4)	3.0
I expect to take several GCSEs (5+)	3.0
I expect to take several GCSEs at grades A to C	3.5

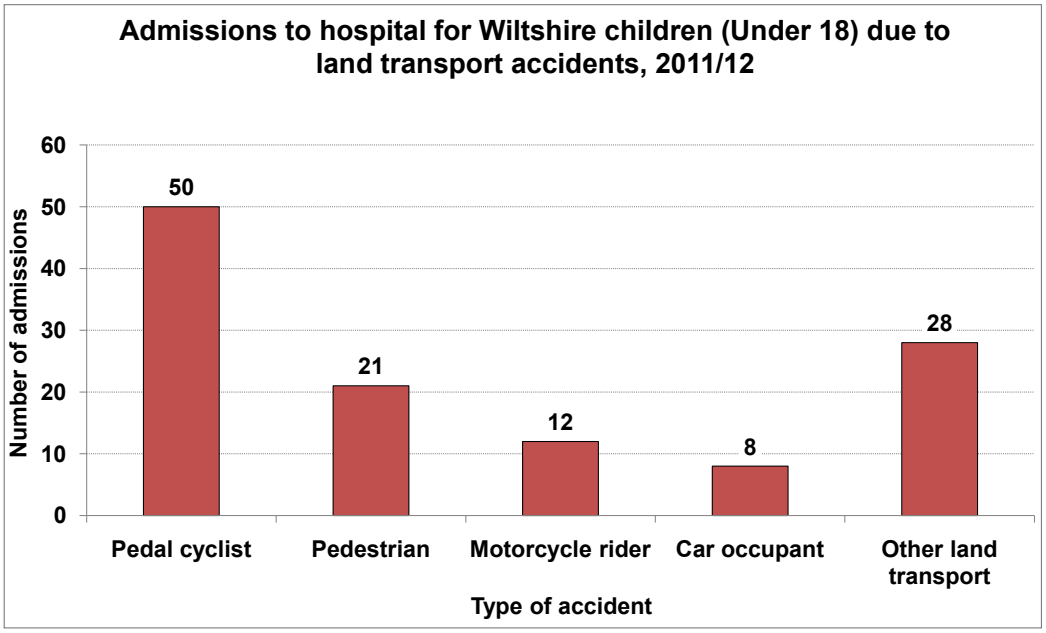
Source: Wiltshire Health Related Behaviour Survey, 2011

Accidents and injuries

Unintentional injury accounts for more hospital admissions than any other cause in children[14]. In Wiltshire in 2010/11 there were 1,140 admissions due to an injury in children under 18. This equates to 112 per 10,000 young people. Mortality due to accidents and injuries in children and young people is rare but there were still 42 deaths in under 20s due to injury in Wiltshire between 2006 and 2010. Transport accidents accounted for about 50% of these deaths. The number of children aged 0 to 15 who were killed or seriously injured in road collisions in Wiltshire reduced from 1994-98 to 2010 by 48% which was very close to the 50% (or 16 casualties) target.

The full briefing note for this section is available here: tinyurl.com/hwjsa116

Figure 16: Hospital admissions under 18s involved in land transport accidents



Source: Hospital Patient System, NHS Wiltshire, August 2012

Emotional wellbeing and mental health

It is estimated that in England an average of 1 in 10 children aged between 5 and 16 years has a mental health problem at any given time. Self-harming behaviour in young people is not uncommon and 10% to 13% of 15 and 16 year olds have self harmed.

Table 4 provides an estimate of the approximate numbers of children and young people with a mental health disorder at any given time (based on national prevalence rates).

The full briefing note for this section is available here: tinyurl.com/hwjsa117

Table 4: children and young people (aged 5-16) with a mental health disorder

Type of disorder	Boys		Girls		Total
	Prevalence	Number	Prevalence	Number	Number
Conduct disorders	7.5%	2607	3.9%	1317	3924
Emotional disorders (depression and anxiety)	3.1%	1078	4.3%	1452	2529
Being hyperactive (ADHD)	2.6%	904	0.4%	135	1039
Less common disorders (ASD, eating disorders, tics)	1.9%	660	0.8%	270	931

Source: ONS population estimates and projections (2011) supplied by Dr Foster Intelligence

Note: numbers may not sum correctly because of rounding. Note: some children have more than one disorder.

[14] Audit Commission (2007) Better safe than sorry: preventing unintentional injury to children.

Disabilities

The government green paper, 'Support and Aspiration: a new approach to special educational needs and disability' 2011[15], and subsequent draft legislation[16] signals a radically different approach in supporting children and young people with special educational needs and disability. The focus is on early intervention and prevention and the intention is to create a single assessment process and a single plan covering education, health and social care for children and young people aged 0-25 years with special educational needs and disabilities. Wiltshire is one of 20 pathfinders developing approaches to delivering the aspirations raised in the green paper. The 0-25 year Special Educational Needs and Disability (SEND) Service is being developed along with a single assessment process, an approach to deliver personal budgets and a new 'local offer' that will describe what support is available for children and young people with SEN and disabilities and who provides it.

The full briefing note for this section is available here: tinyurl.com/hwjsa118

Sexual health

The teenage conception rate in Wiltshire is continuing its decline since a peak in 2007. The number of conceptions in Q1 2011 was the lowest since Q2 2003. However, whilst the county wide rate is below the nation and regional rates, within Wiltshire there are small areas which have persistently high teenage conception rates.

In 2011/12, there were 11,108 Chlamydia tests which represents 21.3% of the target population aged 15 to 24 being screened in Wiltshire, compared to 25.9% in the South West and 28.2% in England[17]. In terms of positive test results, 8% of tests in Wiltshire were returned positive in 2011/12, which was slightly higher than the South West of 7.9% and that of England at 7.3%.

The full briefing note for this section is available here: tinyurl.com/hwjsa119

Smoking

The prevalence of smoking in children and young people is difficult to measure accurately. The Wiltshire Health Related Behaviour Survey 2011 found that 10% of Year 10 pupils had smoked in the week previous to the survey. Comparisons with England suggest that smoking prevalence in children and young people in Wiltshire is slightly lower.

Data for 2011/12[18] estimates that 14.2% of pregnant women in Wiltshire are smoking in pregnancy, higher than in the South West (13.2%) or England as a whole (13.2%). However, this is still above the Government target reducing rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

The full briefing note for this section is available here: tinyurl.com/hwjsa120

Substance misuse

The majority of young people in Wiltshire do not misuse substances. Of those who do use, the main substances of choice remain as cannabis and alcohol. Hospital admissions data shows that a small number of young people are admitted for overdoses of alcohol and/or drugs, often combined with mental health issues, and that there could also be an issue in relation to over the counter drugs. In 2011/12 there were 67 admissions to hospital of young people aged under 18 that were directly attributable to alcohol and a further 164 for drug misuse related reasons. Three quarters of young people in treatment also have some level of mental ill health problems. Young people who are excluded from school are more likely to try tobacco, alcohol and cannabis than other young people.

The full briefing note for this section is available here: tinyurl.com/hwjsa121

[15] Support and Aspiration: a new approach to special education needs and disability (March 2011) http://www.education.gov.uk/childrenandyoungpeople/send/b0075291/green-paper

[16] Draft legislation on Reform of provision for children and young people with Special Educational Needs. Presented to Parliament by the Secretary of State for Education by Command of Her Majesty (September 2012) tinyurl.com/hwjsa303

[17] Chlamydia Testing Data 2011/12, Primary Care Trust (PCT) and Strategic Health Authority (SHA) specific tables, 1st April 2011 to 31st March 2012. National Chlamydia Screening Programme (NCSP), Health Protection Agency, Centre for Infections. http://www.chlamydiascreening.nhs.uk/ps/data/data_tables.html

[18] Statistics on Women's Smoking Status at Time of Delivery: England Quarter 4, 2011/12. Copyright © 2012. The Health and Social Care Information Centre, Lifestyle Statistics. 24 May 2012

Dental health

The dental health of children in Wiltshire is generally good. A 2007/08 survey found the average number of decayed, filled or missing teeth per 5-year old child in Wiltshire was 0.95 compared with 1.11 nationally which is significantly lower. The results for 12 year olds show Wiltshire to be similar to the South West and England, for this age group. However, there are inequalities in dental health within Wiltshire with higher levels of tooth decay in relatively deprived areas.

The full briefing note for this section is available here: tinyurl.com/hwjsa122

Youth offending

Youth offending in Wiltshire is relatively low and the number of first time entrants to the Youth Justice System fell by over 50% from 2009/10 to 2010/11. The Wiltshire Youth Offending Team (WYOT) works with 10 to 17 year olds who have offended to ensure their risks are managed and support is offered to help them understand and manage their behaviour.

The full briefing note for this section is available here: tinyurl.com/hwjsa123

Safeguarding children in need

The numbers of children in need and subject to protection plans or in care in Wiltshire are generally rising and are higher in 2011/12 than in 2009/10. However, numbers per 10,000 children are generally lower than the national or statistical neighbour averages, apart from the numbers in care which are similar to the statistical neighbour average. In August 2012, there were 1,283 active Common Assessment Framework (CAFs) in Wiltshire. If risk of harm is identified then the child and family would be referred to social services. In March 2012 in Wiltshire there were 2,100 children identified as children in need, of these 169 were subject to a child protection plan and 416 were in care.

This section is part of a larger report on complex families and safeguarding children in need and is available here: tinyurl.com/hwjsa126

Wider determinants of health

Educational achievement in Wiltshire is generally in line or better than similar areas. There have been improvements in attainment of children in early years settings, primary schools and secondary schools. However, the gap between the attainment of children in vulnerable groups and their peers is too large and whilst showing some improvement should be narrowed further. There were 822 young people not in employment, education or training (NEET) in Wiltshire, in March 2012; this is 5.9% of those aged 16 to 18. The winter 2011 Tomorrow's Voice survey[19] found that 13% of 11-18 year olds felt very unsafe when out in their local area after dark and a further 23% felt fairly unsafe.

The full briefing note for this section is available here: tinyurl.com/hwjsa125

[19] Tomorrow's Voice report, Winter 2011, Wiltshire Council. tinyurl.com/hwjsa304

Children and young people - resources

Wiltshire's Children and Young People's Plan 2012-15[20]

The Plan's purpose is to describe how it is intended to improve the wellbeing of children and young people in Wiltshire. With a particular emphasis on vulnerable young people, it is designed to specifically help ensure that all children and young people (i) Are healthy, (ii) Stay safe, (iii) Enjoy and achieve, (iv) Make a positive contribution and (v) Achieve economic wellbeing.

Wiltshire's Children and Young People's Needs Assessment 2011[21]

This assessment contains a broad overview of the characteristics of children and young people in the county and a summary of the key indicators relevant to the five Every Child Matters outcomes of; (i) Be Healthy, (ii) Stay Safe, (iii) Enjoy and Achieve, (iv) Make a Positive Contribution and (v) Achieve Economic Well-being. tinyurl.com/hwjsa193

2011 Health Related Behaviour Survey[22]

The Health Related Behaviour Survey takes place every year across the country; the most recent Wiltshire surveys have taken place in 2011. These surveys produce the most detailed and reliable profile of young people's life at home, at school/college, and with their friends. http://www.wiltshirehealthyschools.org/partnership-projects/wiltshire-health-related-behaviour-survey/

National Child and maternal health Observatory (Chimat)

ChiMat provides information and intelligence to improve decision-making for high quality, cost effective services. It supports policy makers, commissioners, managers, regulators, and other health stakeholders working on children's, young people's and maternal health. http://www.chimat.org.uk/

Healthy Child Programme: pregnancy and the first five years of life[23]

The Programme focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

Healthy Child Programme: from 5-19 years old[24]

The Programme sets out the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. It outlines suggested roles and responsibilities for commissioners, health, education, local authority and partners to encourage the development of high-quality services.

Change4life

The programme helps children and adults to adopt a healthier lifestyle by encouraging people to eat well, move more and live longer. The programme now extends to other areas such as alcohol. http://www.nhs.uk/change4life

Chimat Knowledge hub – safeguarding

The Safeguarding hub aims to keep up to date with current policy and good practice by signposting to information resources, initiatives and organisations. http://www.chimat.org.uk/default.aspx?QN=SAFEGUARDING

[20] Children and Young People's Plan 2012-15, Wiltshire Children & Young People's Trust, March 2012. tinyurl.com/hwjsa305

[21] Children and young people in Wiltshire: Needs Assessment, Wiltshire Children's Stakeholder Partnership, July 2011. tinyurl.com/hwjsa306

[22] Wiltshire Health Related Behaviour Survey 2011, Healthy Schools Wiltshire. Wiltshire Council. 2012 tinyurl.com/hwjsa307

[23] Healthy Child Programme: Pregnancy and the first five years of life, Department of Health. Crown copyright 2009, first published October 2009. tinyurl.com/hwjsa308

[24] Healthy Child Programme: From 5-19 years old, Department of Health. Crown copyright 2009, first published October 2009. tinyurl.com/hwjsa309

Children and young people - Outcome Frameworks summary

The Children and Young People's Health Outcomes Forum has proposed a range of indicators to measure health outcomes in children and young people[25] . These are still under consideration and require development before publication as a formal Outcomes Framework. The following indicators from the Public Health Outcomes Framework and the NHS Outcomes Framework have been selected as the ones most relevant to this section.

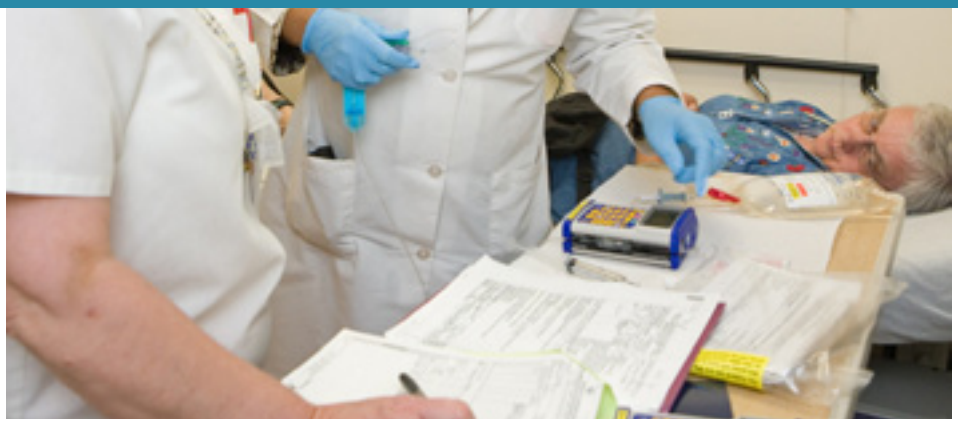
Framework	Reference	Indicator
Public Health	1.1	Children in poverty
Public Health	1.2	School readiness
Public Health	1.3	Pupil absence
Public Health	1.4	First-time entrants to the youth justice system
Public Health	1.5	16-18 year olds not in education, employment or training
Public Health	2.1	Low birth weight of term babies
Public Health	2.2	Breastfeeding
Public Health	2.3	Smoking status at time of delivery
Public Health	2.4	Under 18 conceptions
Public Health	2.5	Child development at 2-2.5 years
Public Health	2.6	Excess weight in 4-5 and 10-11 year olds
Public Health	2.7	Hospital admissions caused by unintentional and deliberate injuries in under 18s
Public Health	2.8	Emotional wellbeing of looked after children
Public Health	2.9	Smoking prevalence – 15 year olds
Public Health	2.21	Access to non-cancer screening programmes: (i) HIV (ii) syphilis, hepatitis B and susceptibility to rubella (iii) antenatal sickle cell and thalassaemia (iv) newborn blood spot (v) newborn hearing (vi) newborn physical examination (vii) diabetic retinopathy
Public Health	3.2	Chlamydia diagnoses (15-24 year olds)
Public Health	4.1	Infant mortality
Public Health	4.2	Tooth decay in children aged five years
Public Health	4.10	Suicide
NHS	1.6	(i) infant mortality and (ii) neonatal mortality and stillbirths
NHS	3.2	Preventing lower respiratory tract infections (LRTI) in children from becoming serious
NHS	4.8	Improving children and young people's experience of healthcare
NHS	5.5	Admission of full-term babies to neonatal care

[25] Tomorrow's Voice report, Winter 2011, Wiltshire Council. tinyurl.com/hwjsa304

Burden of ill-health: general health

Introduction

Despite the variety of diseases and reasons for ill-health the majority of the burden of ill health can be categorises into a small number of main disease groups: cancer; cardiovascular disease (CVD); diabetes; respiratory disease and communicable disease.



Key conclusions and recommendations

Projecting the future burden of disease

Mortality; admissions and procedure models generally show a rapidly increasing burden of disease in the period 2011/12 to 2026/27. The increasingly ageing population will present many challenges to those managing the health economy within Wiltshire. The demand for and nature of services is likely to change and there will be major pressures in the health economy for commissioners at a time when budgets are not increasing. Enhancing the projections produced for this topic report will enable evidence based consideration of how to address future demand.

Cancer

Mortality rates from cancer are falling but the numbers affected are increasing. This will increase service demand with perhaps more complex elderly patients. There is work to be done to reduce the health inequalities associated with premature mortality for some of the main cancer sites. Addressing risky lifestyle behaviour, in order to change smoking habits and improve poor diets will be vital, combined with active screening and symptoms awareness programmes to help mortality rates fall further. Wiltshire also has relatively high rates of people first being diagnosed with cancer as part of an emergency admission to hospital. Further work is required to understand why these admissions are occurring, and why percentages are differences across GP practices.

Cardiovascular disease

Reduce the health inequalities associated with premature cardiovascular disease mortality. There is an increasing relative gap in cardiovascular disease mortality rates between the most deprived quintile and the Wiltshire average. These health inequalities can be reduced through public health action. High and increasing levels of obesity are a concern but are a modifiable risk factor for cardiovascular disease.

Diabetes

The prevalence of diabetes is projected to rise and this will place a substantial burden upon the health service due to the need for active management of the condition, and increased hospital admissions. Reducing morbidity and mortality in the face of rising prevalence is a key challenge. Effective management, monitoring through the National Institute for Health and Clinical Excellence's (NICE) 9 key care processes, and patient education is vital to prevent disease progression and to reduce complications. Equitable access for patient in terms of educational programmes and lifestyle interventions must be ensured.

Respiratory disease

There needs to be effective management and treatment, following national guidance, to reduce hospital admissions and associated morbidity and mortality. Further work is needed to explain the variation in Chronic Obstructive Pulmonary Disorder (COPD) prevalence between GP practices, and whether this is linked to a lack of effective diagnosis at GP level. This is especially important in light of the fact there are up to 5,000 people living with undiagnosed COPD in Wiltshire, based on modelled estimates.

Communicable disease

Maintaining the high standards that have brought healthcare associated infection rates down drastically in recent years, especially in the context of the increasing amount of community service provision. Maintaining effective surveillance and having health services able to react quickly to disease outbreaks and emerging threats. Identifying and managing high risk groups in an appropriate fashion.

Projecting the future burden of disease

The full topic report for this section is available here: tinyurl.com/hwjsa149

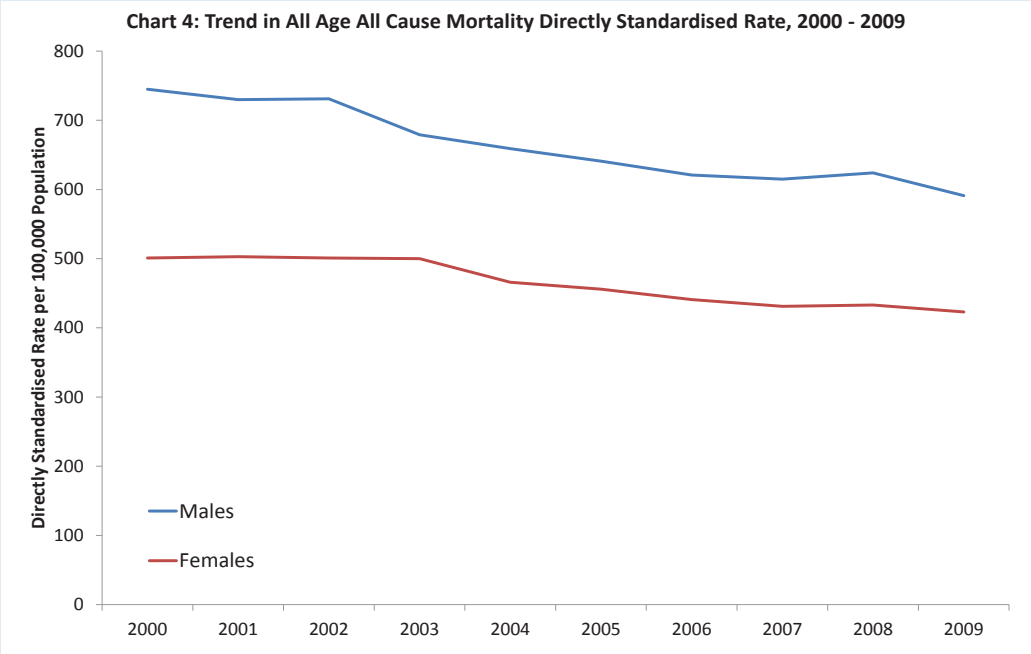
Introduction

The population of Wiltshire is increasing. The 2011 Census population count was nearly 9% higher than the 2001 estimate of 433,500. In addition the 2011 Census showed an increase in the proportion of the population over 65 from 16.5% to 18.1% over the same period. Wiltshire Council estimate also indicates that nearly a quarter of the population will be over 65 by 2026.

All age all cause mortality rates are of the main indicators used to judge the success of health services in improving health outcomes of the local population. The rate has been falling for both males and females in Wiltshire over the past decade.

However, over the same period the actual number of deaths has remained about the same, around 4,000 per year in Wiltshire.

Figure 17: Trend in all-age, all-cause mortality rates in Wiltshire



Source: DFI PHM

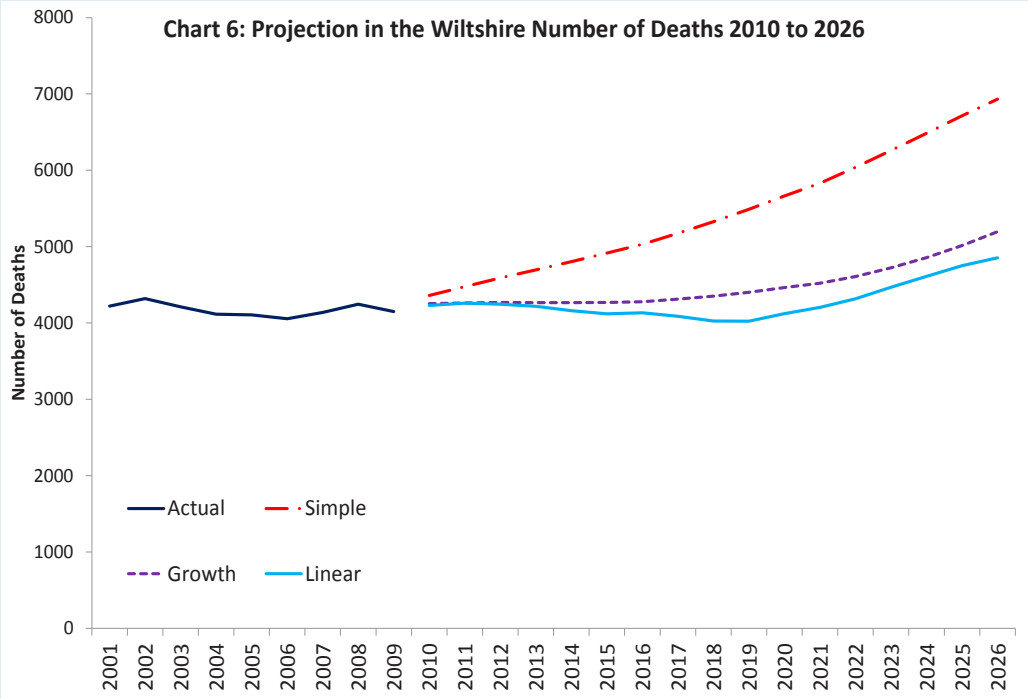
The likely impact of this population change, combined with changes in disease incidence and mortality, on the demand for NHS Services cannot be entirely predicted but looking at projections can provide insights. This topic report starts the process of getting a better understanding of how the changing demographics of the population will impact on the demand for NHS services. The report looks at mortality both generically and also for some specific conditions. Additionally it looks at the projection for service use – considering both procedures and also emergency admissions. Three projection models are used:

1. Simple Model – This uses the age specific rates for the last 3 years of available data and applies these rates to the population projection data.
2. Growth Model – This model adjusts the age specific rates to take account of the trend in the last 9 years data and applies these adjusted rates to the population projection data.
3. Linear Model – This fits a straight line to the last 9 years of actual activity and population and then uses the population projection to estimate activity levels in future years.

Modelling results

Figure 18 shows projection of the number of deaths in Wiltshire up to 2026 based on the 3 models used.

Figure 18: Projected number of deaths in Wiltshire



Source: DFI, PHM and Wiltshire Projection Model

All 3 models show a substantial increase in the number of deaths from the current level of around 4,000 to nearly 5,000. This rise is in the older age bands where people tend to need more treatment and may also have to live with a long term condition which will place a greater burden on social care services as well as the providers of primary and secondary healthcare.

The mortality models for different causes show a slightly different picture. The circulatory disease picture is inconsistent with one model projecting an increase and the other projecting a decrease. This suggests the burden of circulatory disease is probably going to remain constant or reduce slightly. The burden of respiratory disease is likely to increase with all three models showing an increase. Finally for cancer mortality the models arrive at a similar picture showing substantial increase in mortality associated with cancer. Cancer incidence is projected to rise from current levels of 2,500 cases per annum to around 3,500 in. This represents an increase in incidence of around 40% which is likely to increase pressure on services.

The results show an increase in each of the modelled hospital procedures over the next 15 years. For example hip replacement activity has been modelled to continue to increase from around 1,000 now to between 1,300 and 2,100 in 2026-27.

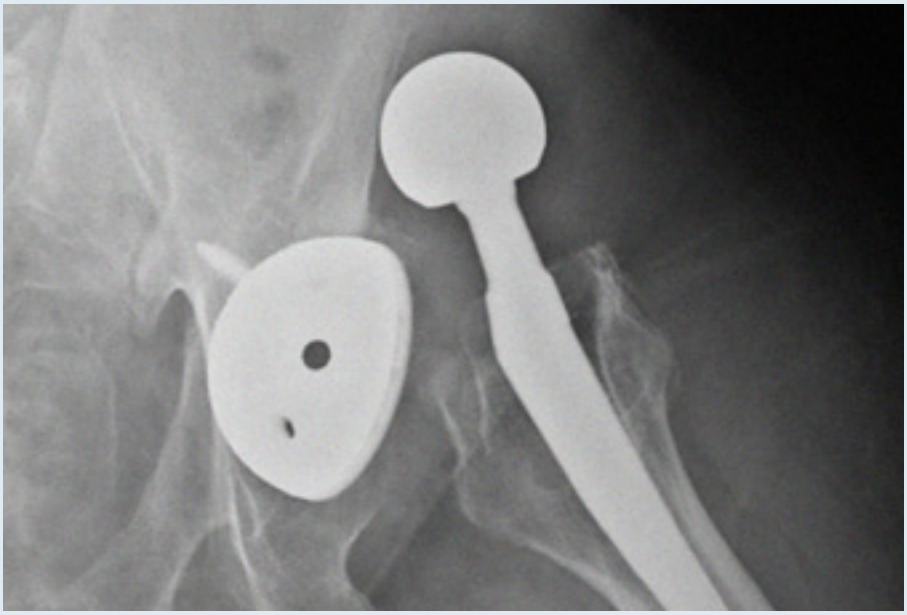
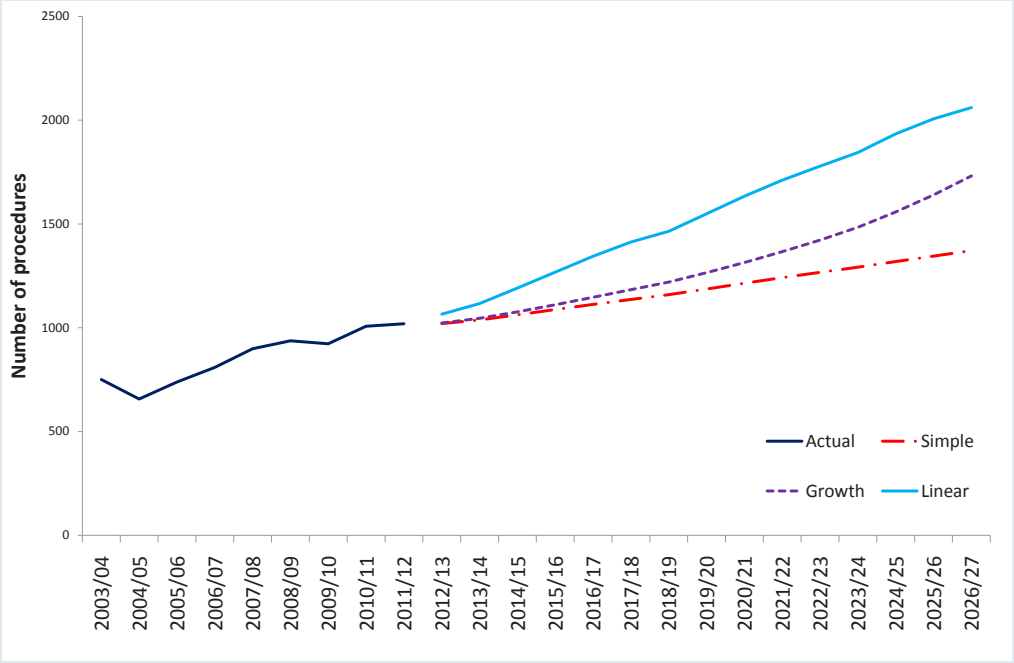


Figure 19: Projected number of elective hip replacements in Wiltshire



Source: DFI, PHM and Wiltshire Projection Model

All 3 models show substantial increases in the number of hip replacements between now and 2026/27. This is likely to mean additional expenditure on these procedures of around £2m and in the case of the linear model perhaps up to £6m, based on the average cost of a hip replacement procedure in 2011/12 for Wiltshire registered patients assuming national tariff (£6k per procedure).

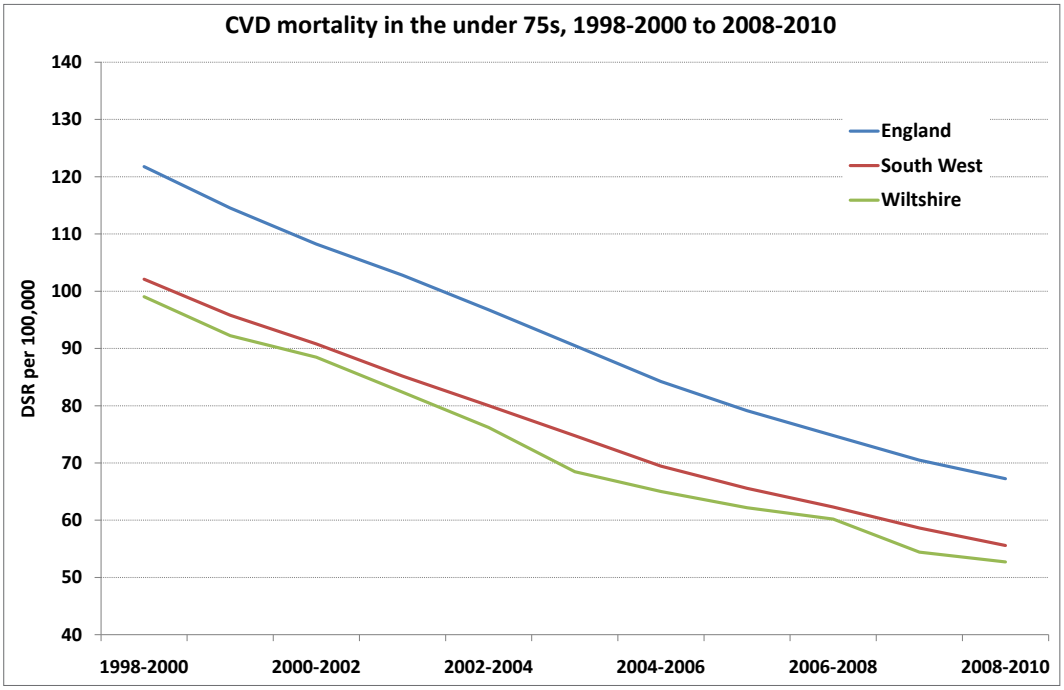
Recommendations

In terms of service use, demand is generally increasing and the increased cost in the projections in this report shows an increase of potentially up to £20m. A figure calculated by summing the highest forecast cost projections in this report for hip and knee replacements, coronary artery bypass graft (CABG) and Percutaneous transluminal coronary angioplasty (PCTA) procedures and emergency respiratory admissions. This is likely to cause major pressures in the health economy for commissioners at a time when budgets are not increasing. A focus is needed on patient pathways which reduce the demand on acute services and are likely to help manage the budget. In particular, continued joint working with Social Care on respiratory disease might help with the management of an increasing burden of disease while managing to reduce emergency admissions to hospital.

Cardiovascular disease

The annual rate of premature mortality from cardiovascular disease (CVD) in Wiltshire has approximately halved between 1998 and 2000, when it was 99 per 100,000, and 2008 to 2010, when it was 52 per 100,000 population and Wiltshire has a lower rate than England or the South West.

Figure 20: trends in CVD mortality in under 75s

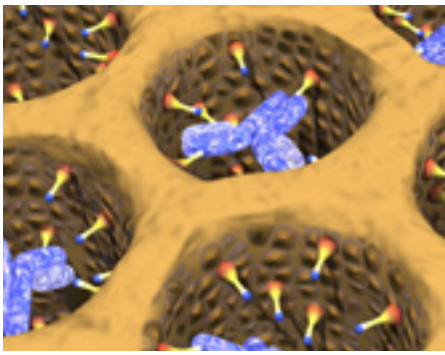


Source: NCHOD: (I00-I99) 0- Directly standardised premature CVD mortality rates per 100,000

However, around 260 people under the age of 75 still die from CVD each year, and there is work to be done to reduce the health inequalities associated with premature CVD mortality. Addressing risky lifestyle behaviour, to affect smoking, obesity and exercise especially, will be vital as Public Health programmes continue to reduce mortality and morbidity from CVD.

The full briefing note for this section is available here:
tinyurl.com/hwjsa151

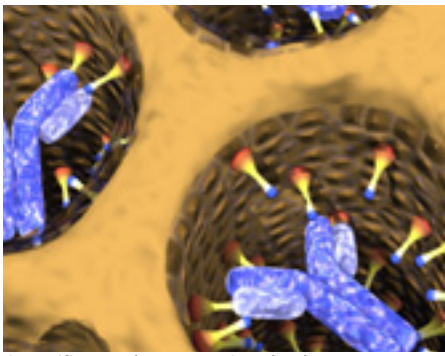
Cancer



The annual rate of premature mortality from cancer in Wiltshire has, unlike other principle causes of mortality, remained stable in the last decade, though the number of deaths has risen by 10%. In Wiltshire in 2010 cancers accounted for 581 deaths in the under 75s which is around 45% of the total. Cancers also accounted for 1,192 of all age deaths which equates to over 25% of all deaths. These percentages have increased over the last 15 years reflecting the aging population and advances in treating other diseases which accounted for mortality such as circulatory conditions. Wiltshire's mortality rate from cancer is now only marginally lower than England and higher than the South West.

When compared with England, Wiltshire has statistically significantly lower incidence rates for lung cancer in both males and females. However, Wiltshire has a significantly higher incidence rate of prostate cancer and skin cancer (not malignant melanoma) in both males and females.

The full briefing note for this section is available here:
tinyurl.com/hwjsa150



Respiratory disease

Respiratory conditions cause substantial morbidity, premature mortality and disability. Between 2008 and 2010 13.2% of deaths in Wiltshire were due to respiratory conditions and respiratory disease was mentioned on 33% of death certificates. Hospital admissions for respiratory conditions are increasing in Wiltshire, and are projected to increase in the future. Modelled estimates suggest 2.6% of people in Wiltshire have COPD, and this means as many as 5,000 people may be living with the condition undiagnosed. Smoking is the main risk factor for respiratory disease.

The full briefing note for this section is available here: tinyurl.com/hwjsa157

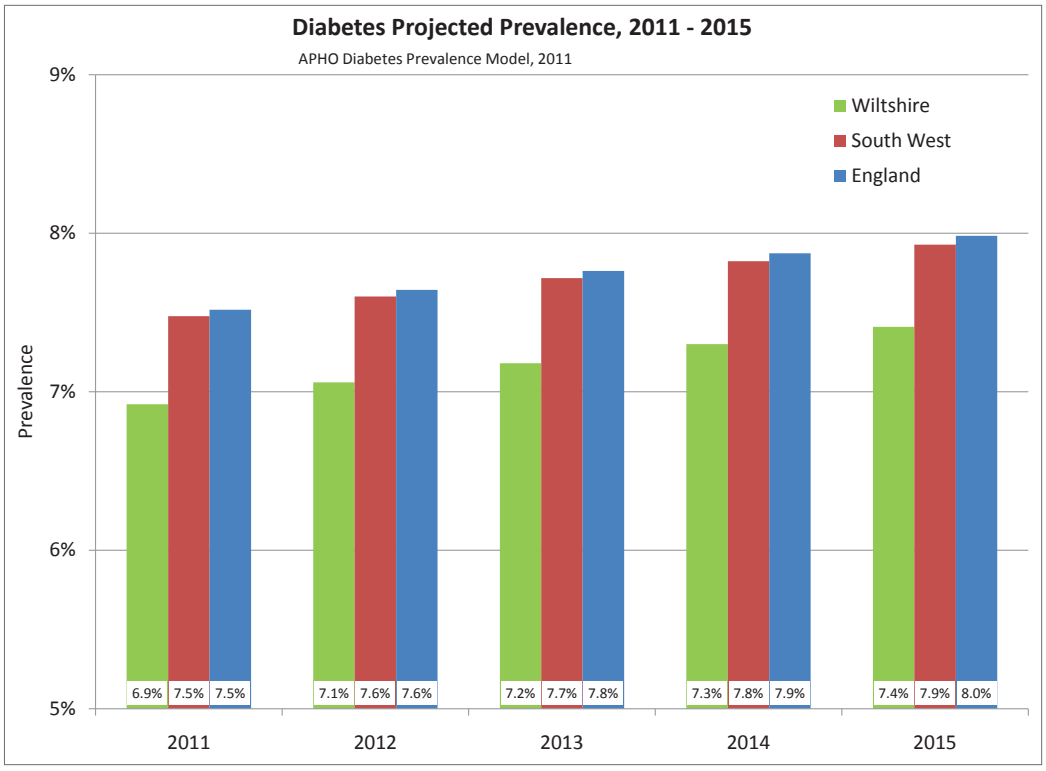
Diabetes

The Public Health importance of diabetes is becoming increasingly recognised. Its prevalence both nationally and in Wiltshire is rising, and spending on diabetes care currently accounts for around 10% of the national NHS budget. Early diagnosis and subsequent careful management are vital to reduce morbidity and mortality from diabetes and its associated conditions. 9 NICE key care processes have been identified for comprehensive diabetes service provision, and Wiltshire's performance across these is generally good. However, only 50.1% of diabetes patients received all 9 processes over 2010/11, lower than the England average of 54.3%. This suggests a more integrated approach to care at GP level could benefit Wiltshire patients.

In 2010/11 there were 18,790 people aged 17 or over living with Diabetes (type 1 or 2) in Wiltshire, representing 5% of the GP registered population[26]. The true prevalence (including those living with undiagnosed diabetes) in Wiltshire is estimated to be 6.9%, which is higher than the 5% of people who are on GP registers for diabetes. The prevalence of diabetes is projected to rise[27] to 7.4% by 2015. This would mean there are 7020 adults with undiagnosed Diabetes in Wiltshire.

The full briefing note for this section is available here: tinyurl.com/hwjsa156

Figure 21: Estimated projected total diabetes prevalence



Source: APHO diabetes prevalence model, 2011

In 2010 43 people in Wiltshire died of diabetes. Diabetes mortality rates have fallen in Wiltshire, mirroring the trend observed in the South West and England.

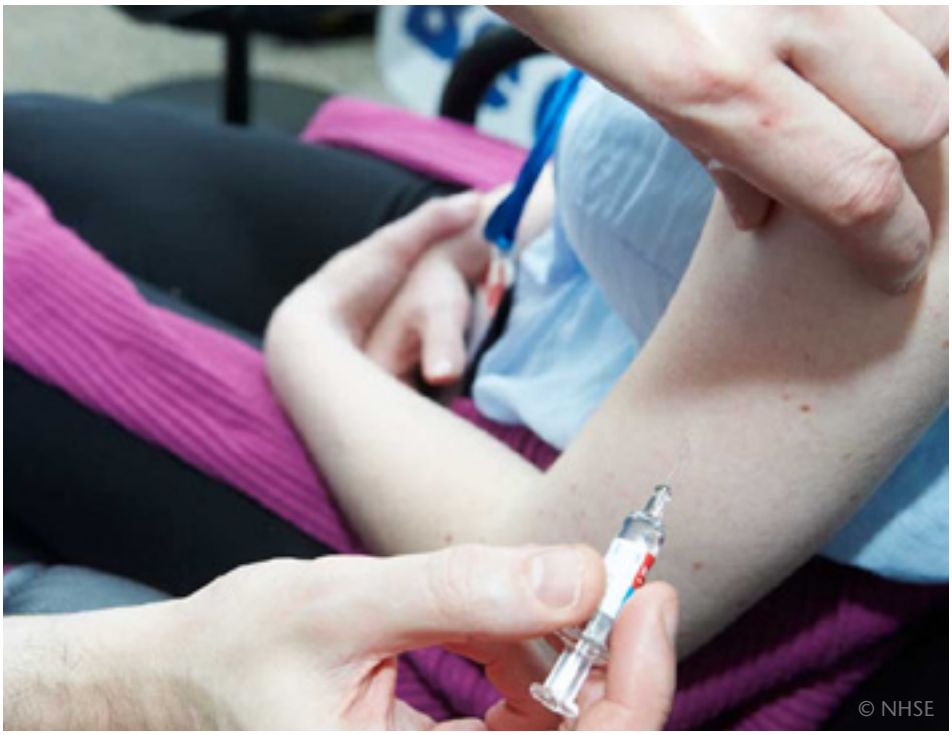
[26] QOF, 2010/11
*Please note unadjusted prevalence does not take into account differences in age structure or gender (which may influence expected prevalence) of the populations compared.
[27] CAPHO Diabetes Prevalence Model, 2011

Communicable disease

In 2011/12 there were 1,294 admissions of patients with a primary diagnosis of an infectious disease. This was a 6.2% decrease from 2010/11. If the trend of the last 5 years persists, infectious disease admissions are projected to fall by another 7% by 2016/17.

Maintaining effective surveillance, prevention and control of infectious disease is vital for the health of the local population. Healthcare associated infections including meticillin-resistant Staphylococcus aureus (MRSA), seasonal flu, and outbreaks of other infectious diseases can all potentially cause severe illness and death, and of interest to the public. In Wiltshire rates of healthcare associated infections have declined to a low rate through the implementation of good practice throughout health services. Other infectious diseases have also been successfully managed in the county, with very low numbers of cases recorded.

The full briefing note for this section is available here: tinyurl.com/hwjsa158



General health - resources

- National Cancer Intelligence Network data briefings. www.ncin.org.uk/publications/data_briefings/default.aspx
- National Cancer Intelligence Network GP and PCT Profiles. www.ncin.org.uk/cancer_information_tools/profiles/gp_profiles.aspx
- Cancer Research UK: http://publications.cancerresearchuk.org/
- The local Cancer Networks: Central South Coast (www.csccn.nhs.uk/index.html), Avon, Somerset & Wiltshire (www.aswcs.nhs.uk)
- Cardiovascular disease profiles: http://www.sepho.org.uk/CVDprofiles.aspx
- Avon, Gloucester, Wiltshire and Somerset Cardiac and Stroke Network. http://www.agwscs.nhs.uk/network/index.html
- Diabetes Community Health Profile for Wiltshire. http://yhpho.york.ac.uk/diabetesprofiles/PDF2012/5QK_Diabetes%20Profile.pdf
- State of the Nation 2012 – Diabetes UK report on the current diabetes landscape in the UK. tinyurl.com/hwjsa194
- Chronic Obstructive Pulmonary Disorders (COPD) and Asthma outcomes strategy. The document outlines COPD and asthma as national priority outcome areas, and lists 6 objectives to improve quality and outcomes. tinyurl.com/hwjsa195
- Respiratory health and lung function formed the key focus of the 2010 Health Survey for England: tinyurl.com/hwjsa196
- Infectious Diseases. An A to Z and further information on Infectious Diseases see the Health Protection Agency website. http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/
- The Green Book provides national policy and guidance on vaccines and vaccination procedures for all the vaccine preventable infectious diseases. It contains resources on all routine immunisation programmes. tinyurl.com/hwjsa197

General health - Outcome Frameworks summary

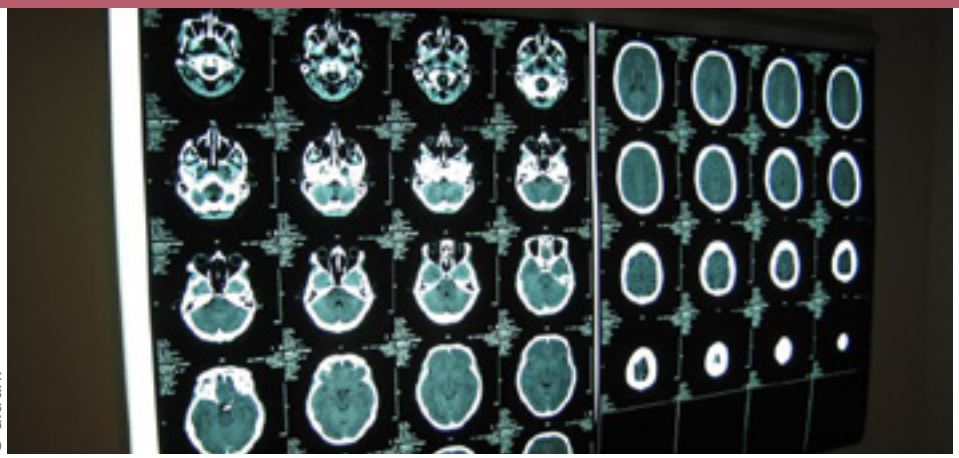
The following indicators from the Public Health Outcomes Framework; the NHS Outcomes Framework and the Adult Social Care Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Indicator
Adult Social Care	2.A	Permanent admissions to residential and nursing care homes, per 100,000 population
Public Health	2.3	Smoking status at time of delivery
Public Health	2.6	Excess weight in 4-5 and 10-11 year olds
Public Health	2.9	Smoking prevalence – 15 year olds
Public Health	2.11	Diet
Public Health	2.12	Excess weight in adults
Public Health	2.13	Proportion of physically active and inactive adults
Public Health	2.14	Smoking prevalence – adults (over 18s)
Public Health	2.17	Recorded diabetes
Public Health	2.19	Cancer diagnosed at stage 1 and 2
Public Health	2.20	Cancer screening coverage
Public Health	2.21	Access to non-cancer screening programmes
Public Health	2.22	Take up of the NHS Health Check programme
Public Health	3.1	Air pollution
Public Health	3.2	Chlamydia diagnoses
Public Health	3.3	Population vaccination coverage
Public Health	3.4	People presenting with HIV at a late stage of infection
Public Health	3.5	Treatment completion for tuberculosis (TB)
Public Health	3.7	Comprehensive, agreed inter-agency plans for responding to public health incidents
Public Health / NHS	4.4 / 1.1	Mortality from cardiovascular diseases
Public Health / NHS	4.5 / 1.4 (vii)	Mortality from cancer
Public Health / NHS	4.7 / 1.2	Mortality from respiratory diseases
Public Health	4.8	Mortality from communicable diseases
Public Health	4.15	Excess winter deaths
NHS	1.4	One-and five-year survival from colorectal / breast / lung cancers
NHS	2	Health-related quality of life for people with long-term conditions
NHS	3.2	Emergency admissions for children with lower respiratory tract infections (LRTIs)
NHS	3.4	Improving recovery from stroke
NHS	5.2	Incidence of healthcare associated infection (HCAI) (i) MRSA (ii) C. difficile

Burden of ill-health: mental health and neurological disorders

Introduction

In the UK, it is estimated that one in four people will experience mental health problems (not including dementia) in their lifetime and that more than one in six people in England have a neurological condition. One in fourteen people aged over 65 has a form of dementia and one in six people over 80 has a form of dementia.



© ultrahi

Key conclusions and recommendations

Mental health and dementia - developing public mental health interventions

Identify the asset base and sources of resilience in disadvantaged communities which can be developed in order to improve good mental health and social inclusion. There is a need to expand the provision of health checks and targeted health promotion services for people with mental health problems at community level. Evidence-based community engagement programmes targeted at deprived areas and communities need to be enhanced and extended. There needs to be increased provision of targeted prevention programmes such as parent training/education programmes and school based social skills training.

Mental health and dementia - Preparing services for future challenges

Increased rates of suicide and self-harm have resulted in a new strategy and action plan, but will need to be continually monitored. An ageing population means there will be more people with dementia and this is currently under-diagnosed in Wiltshire. This is likely to impact on a wide range of services, not just those for people with dementia. It will also result in financial pressures and capacity issues for health and social care. There is the potential for an increase in risk factors for poor mental health and well-being such as unemployment and decreased physical activity, may lead to a further increase in the burden of mental illness.

Neurological disorders

There needs to be wider engagement with people with neurological conditions, especially those living in more deprived areas, as hospital admissions are higher in these areas. There needs to be improved diagnosis, referral, knowledge and awareness amongst health and social care professionals alongside increased self management by increasing knowledge and education. Fast response services and support need to be provided when required to reduce crisis and emergency admissions in conjunction with community support for client, families and carers and consider the need for and capacity of neuro-rehabilitation.

Autism spectrum conditions

Outcomes for people autism, which have been highlighted as significantly poorer compared to the general population, need to be improved. These difficulties are exacerbated as there are inequalities with access to service provision. Some of these individuals will require a lifetime of support while others will require initial low level support to prevent costly and intensive interventions later on in life. An accessible, person centred and preventative assessment process, supported by a workforce who is knowledgeable about autism, will therefore be critical to enable people with autism to succeed, contribute and be included as equal citizens.

Vulnerable adults

The NHS reforms and demographic changes like the ageing population, more healthcare provided at home and personal budgets bring new challenges to safeguarding, for example plurality of providers, increasing complexity of partnerships and organisational memory loss. National data showing a high percentage of safeguarding alerts for people living in care homes and the serious case review at Winterbourne View in South Gloucestershire highlight the importance of prevention. Assurance needs to be shown that the provider is fully aware of a patient's needs and are able to safely meet those needs.

Mental health and dementia

The full topic report for this section is available here: tinyurl.com/hwjsa133

Background

In 2004, 22.8% of the total burden of disease in the UK was attributable to mental disorder including self-inflicted injury. Depression alone accounts for 7% of the disease burden, more than any other health condition[28].

It is estimated that mental health problems cost £48.6 billion nationally in health and social care and lost employment, which will increase to £88.5 billion by 2026. Approximately half of the total cost of mental health problems is attributed to the cost of loss of earning and approximately half of the increase is due to the increasing prevalence of dementia[29].

Risk factors and at-risk groups for mental health problems

Risk factors increase the likelihood of experiencing poor mental health and well-being, and are often complex and inter related. Important risk factors for mental health issues are:

- Deprivation,
- Unemployment,
- Homelessness and poor housing,
- Loneliness,
- Alcohol and drug dependency

Whilst anyone can develop mental health problems or experience poor mental wellbeing, some groups are at higher risk due to their background or circumstances. They may benefit from specific or targeted interventions to improve mental health. They include people on low incomes, black and minority ethnic groups, people with learning disabilities, people with a chronic physical illness, older adults, carers and offenders. Other groups may not be at increased risk but may need to be considered due to specific health needs such as maternal mental health and mental health of veterans.

Risk factors for dementia

Risk factors for dementia can be considered genetic or environmental. Age is the largest risk factor for dementia. For vascular dementia risk factors include cardiovascular risk factors such as smoking, hypertension, diabetes, increased cholesterol and lack of physical activity.

The risk of developing Alzheimer's disease is significantly higher for those with Down's syndrome than the general population. High educational attainment or higher premorbid IQ has been shown across different cultures to exert a protective effect against the development of dementia.

Prevalence of mental health problems in Wiltshire

Common mental health disorders

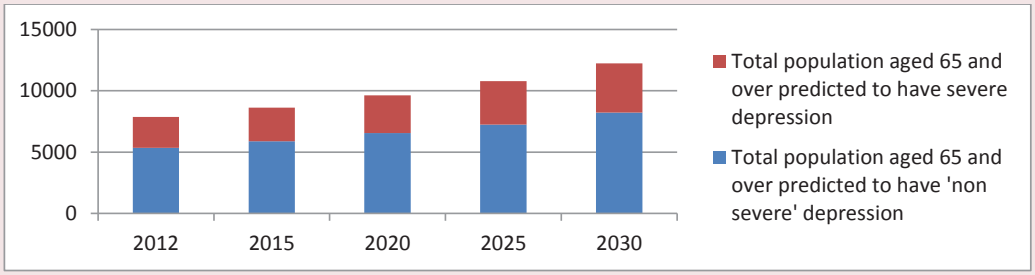
Nationally 16.2% of the adult population (19.7% of women and 12.5% of men) have a common mental health problem such as anxiety or depression disorders[30]. This means in Wiltshire approximately 60,000 adults are estimated to have a common mental disorder (CMD). People with a CMD are much more likely to use health services than those without a CMD.

Table 5: Estimated number of adults in Wiltshire with a CMD[31]

	Men	Women	Adults (16+)
Mixed anxiety and depression disorder	13.025	20,781	33,806, (8.8%)
Generalised Anxiety Disorder	6,288	10,146	16,434, (4.3%)
Depressive episode	3,454	5,392	8,846, (2.3%)
All phobias	1,406	3,639	5,045, (1.3%)
Obsessive Compulsive Disorder	1,707	2,468	4,175, (1.1%)
Panic disorder	2,001	2,076	4,077, (1.1%)
Any CMD*	23,043	37,084	60,127

Estimates suggest that the number of people aged 65 or over with severe depression will increase from 2,500 in 2012 to 4,000 in 2030[32].

Figure 22: Projected number of over 65s suffering from depression, Wiltshire



In the Adult Psychiatric Morbidity Study in 2007 people living in households with the lowest levels of income were more likely to have a CMD than those living in the highest income households[33].

Serious mental illness; psychosis and affective psychosis

Psychoses can be serious and debilitating conditions, associated with high rates of suicide. The Quality Outcome Framework 2010/11 mental health register which includes people with schizophrenia, bipolar affective disorder and other psychoses included 3,090 people in Wilshire (0.7% of registered population).

Suicidal thoughts, suicide attempts and self-harm

Suicide rates in the South West rose by 24% between 2007 and 2009. In England overall there was a rise of 10% over the same period. Between 2006 and 2009, there were 205 deaths in Wiltshire that were given a verdict of suicide or injury undetermined. Numbers of admissions for self-harm in the South West rose 73% between 2002 and 2009. These figures are likely to underestimate the true incidence of self-harm, as they only include admissions to hospital[34]. Although females represent the greater proportion of self-harm admissions, males who self-harm are at greater risk of suicide. Wiltshire has a statistically significantly higher directly standardised rate for emergency hospital admissions for self-harm compared to England.

Psychiatric co-morbidities

Psychiatric comorbidity is defined as meeting the diagnostic criteria for two or more psychiatric disorders. This is associated with increased severity of symptoms, longer duration, greater functional disability and increased use of health services. In Wiltshire it is estimated there are around 26,000 people with two or more psychiatric disorders (7.1% of population). People living in households in the bottom two income quintiles had higher rates of comorbidity than those in higher income households[35].

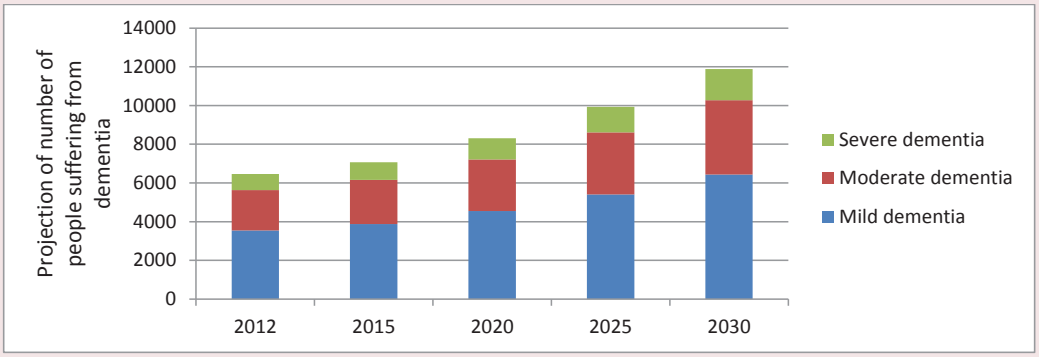
Dementia

Dementia is most common in older people, but can also affect young people too. One in fourteen people over 65 has a form of dementia and one in six people over 80 has a form of dementia[36]. The prevalence of dementia in Wiltshire is predicted to rise with our ageing population. Current estimates suggest there are around 6,000 people with dementia in Wiltshire. This is predicted to nearly double by 2030 to 11,878 (Figure 23). There will also be an increase in people with severe dementia from approximately 800 in 2012 to 1,600 in 2030.

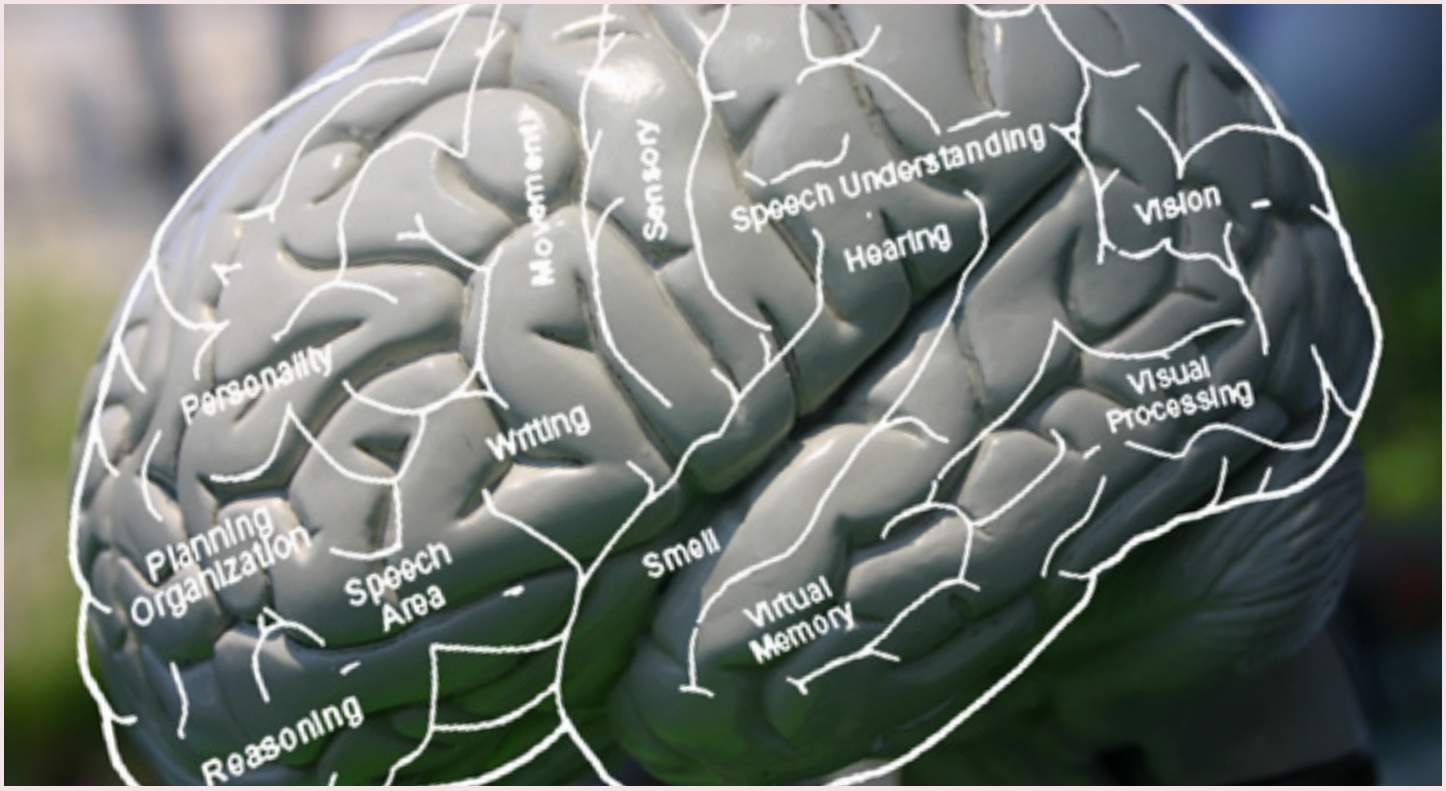
There is strong evidence to show the benefit of early diagnosis of dementia to individuals and families, as well as the wider economy[37].

[28] The Royal College of Psychiatrists (2010) No Mental Health Without Public Mental Health.
[29] McCrone P, Dhanasiri S, Patel A, Knapp M and Lawton-Smith S. Paying the Price. The cost of mental health care in England to 2026.
[30] Adult psychiatric morbidity in England, 2007. Results of a household survey. tinyurl.com/hwjsa311
[31] Adult psychiatric morbidity in England, 2007. Results of a household survey. tinyurl.com/hwjsa311
[32] The Royal College of Psychiatrists (2010) No Mental Health Without Public Mental Health.
[33] Adult psychiatric morbidity in England, 2007. Results of a household survey. tinyurl.com/hwjsa311
[34] South West Public Health Observatory. Suicide and Self-harm in the South West. 2011
[35] Adult psychiatric morbidity in England, 2007. Results of a household survey. tinyurl.com/hwjsa311
[36] Dementia UK The Full Report, 2007.
[37] Dementia UK The Full Report, 2007.

Figure 23: Projection of cases and severity of dementia.



Data source: POPPI, 2012 and Dementia UK The Full Report, 2007.



Current service provision

The wide range of services available in Wiltshire include:

- Crisis resolution.
- Mental Health Recover Teams.
- Early intervention in psychosis.
- Adult acute inpatient care.
- Psychiatric intensive care unit.
- Social care teams.
- Community Services; vocational services, advocacy, specialist housing, Wiltshire Wildlife Trust green gym.
- Psychological therapies.
- In-patient services.
- Day services for older people.
- Community Dementia services.
- Secure services.
- Residential and nursing care.
- Social care support including direct payments, personalised care and support, telecare, help to live at home (HTL@H) etc.

Challenges for consideration

Developing public mental health interventions

- Identify the asset base and sources of resilience in disadvantaged communities which can be developed in order to improve good mental health and social inclusion.
- Expand the provision of health checks and targeted health promotion services for people with mental health problems at community level.
- Enhance and extend evidence-based community engagement programmes targeted at deprived areas and communities.
- Increase provision of targeted prevention programmes such as parent training/education programmes and school-based social skills training.

Improving the current service

- NHS commissioned mental health services are currently being reviewed and a detailed report will be published.
- Overcoming negative attitudes to mental health issues and ensuring it is given equal importance to physical health issues.

Preparing services for future challenges

- NHS commissioned mental health services are currently being reviewed and a detailed report will be published.
- Increased rates of suicide and self-harm have resulted in a new strategy and action, but will need to be continually monitored.
- An ageing population means there will be more people with dementia. This is likely to impact on a wide range of services, not just those for people with dementia. It will also result in financial pressures and capacity issues for health and social care.
- Dementia is under diagnosed in Wiltshire.
- Prison population have a large burden of mental illness including personality disorders.
- Potential for an increase in risk factors for poor mental health and well-being such as unemployment and decreased physical activity, may lead to a further increase in the burden of mental illness.

Research to fill gaps in knowledge

- Limited information on mental health in different groups or areas of Wiltshire.
- Limited information of mental health of those in probation or veterans.

Neurological disorders

It is estimated that more than one in six people in England have a neurological condition. Some are life threatening and many can severely affect a person's quality of life and cause lifelong disability. Neurological conditions account for 20% of acute hospital admissions and are the third most common reason for seeing a GP.

In Wiltshire 69,000 people suffer from migraines; 2,300 to 3,650 from epilepsy; 650 to 750 from multiple sclerosis (MS) and 850 from cerebral palsy (CP). 70% of emergency neurological condition admissions are attributable to epilepsy, migraine and Parkinson's disease. There are more admissions for common neurological conditions amongst the most deprived quintile of Wiltshire's population.

The full briefing note for this section is available here: tinyurl.com/hwjsa134

Autism spectrum conditions

Autism spectrum condition is an umbrella term to describe a range of conditions which are commonly divided into three main subgroups: Aspergers syndrome; high functioning autism and autism. It is reported that 1% of the population have autism[38] and therefore in Wiltshire, an estimated that 4,589[39] individuals are affected by the condition; 1,010 children and young people and 3,579 adults over 18 years old. The outcomes of people with autism are significantly poorer than the general population[40].

Some of these individuals will require a lifetime of support, while others will require initial low level support to prevent costly and intensive interventions later on in life. An accessible, person centred and preventative assessment process should be supported by a workforce that is knowledgeable about autism. This is critical in enabling people with autism to succeed, contribute and be included as equals.

The full briefing note for this section is available here: tinyurl.com/hwjsa135

Vulnerable adults

Safeguarding is the responsibility of whole communities and depends on the everyday vigilance of everyone who plays a part in the lives of children or adults in vulnerable situations to ensure that people are kept as safe from harm as possible. Multiple agencies are involved in adult safeguarding. The agencies' primary aim is to prevent abuse where possible, but if the preventative strategy fails, ensure that robust, proportionate procedures are in place for dealing with incidents of abuse.

There were a total of 855 alerts about safeguarding issues in Wiltshire during 2011/12. Of these, 60% of alerts related to older people aged 65 and over; 51.9% were for people with physical impairment, 24.7% for people with learning difficulties and 9.4% for people with mental health problems. All alerts are triaged using an agreed threshold document to ensure appropriate action is taken. During 2011/12 348 investigations were initiated.

The full briefing note for this section is available here: tinyurl.com/hwjsa136

[38] tinyurl.com/hwjsa312
[39] http://www.intelligencenetwork.org.uk/
[40] Howlin P., Goode S., Hutton J. and Rutter, M.(2004) 'Adult outcomes for children with autism', Journal of Child Psychology and Psychiatry, vol 45, no 2, pp 212–229.

Mental health and neurological disorders - resources

- No Health without Mental Health (2011) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf
- Living well with dementia: a National Dementia Strategy (2009) tinyurl.com/hwjsa198
- North East Public Health Observatory. Community Mental Health Profile 2012. http://www.nepho.org.uk/cmhp/index.php?pdf=E06000054
- Adult psychiatric morbidity in England, 2007. Results of a household survey. tinyurl.com/hwjsa199
- A recent report from the Neurological Alliance highlights key recommendations to improve services for people with neurological conditions. http://www.neural.org.uk/store/assets/files/275/original/Intelligent-Outcomes-Neurological-Alliance-MHP-Health-Mandate-report.pdf
- National Service Framework for Long Term Neurological Conditions, 2005. tinyurl.com/hwjsa201
- To view the Wiltshire autism consultation document and for further information about the Wiltshire Autism Partnership, please visit http://www.wiltshire.gov.uk/healthandsocialcare/disabilities.htm
- NAS Adult Autism strategy website: http://www.autism.org.uk/autismstrategy
- Wiltshire Council, Safeguarding Adults public information: http://www.wiltshire.gov.uk/healthandsocialcare/adultcare/safeguardingadults/safeguardingadultspublicinformation.htm#lsab
- Abuse of Vulnerable Adults in England 2010/11: Experimental Statistics. 2012. tinyurl.com/hwjsa200

Mental health and neurological disorders - Outcome Frameworks summary

The following indicators from the Public Health Outcomes Framework; the NHS Outcomes Framework and the Adult Social Care Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Indicator
Public Health	1.6	People with mental illness and/or disability in settled accommodation
Public Health	1.7	People in prison who have a mental illness or significant mental illness
Public Health	1.8	Employment for those with a long-term health condition, including those with a learning difficulty/ disability or mental illness
Public Health	1.11	Domestic abuse
Public Health	1.18	Social connectedness
Public Health	2.10	Hospital admissions as a result of self-harm
Public Health	4.9	Excess under 75 mortality in adults with serious mental illness
Public Health	4.10	Suicide
Public Health	4.16	Dementia and its impacts
NHS	1.5	Reducing premature death in people with serious mental illness
NHS	2.5	Enhancing quality of life for people with mental illness
NHS	2.6	Enhancing quality of life for people with dementia
NHS	4.7	Improving experience of healthcare for people with mental illness
Adult Social Care	1.F	Proportion of adults in contact with secondary mental health services in paid employment
Adult Social Care	1.H	Proportion of adults in contact with secondary mental health services who live independently, with or without support
Adult Social Care	4.A	The proportion of people who use services who feel safe
Adult Social Care	4.B	The proportion of people who use services who say that those services have made them feel safe.

Burden of ill-health: disability and conditions effecting older people

Introduction

In 2011, Wiltshire had 82,100 people aged 65 or over. The projected population figures predict a 32% increase in the number of people over 65 in Wiltshire between 2011 and 2021 and a 42% rise in the number of over 85s in the same period. In Wiltshire in 2011/12, 42,205 over 65s were admitted to hospital which was 40% of all elective admissions and 45% of all emergency admissions. Wiltshire Council and the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) provided community based services to 6,538 in 2011/12 and to a further 1,275 in residential care and 896 in nursing care.

Increasing numbers of healthy and active older people is not only a fact to be celebrated as a social achievement but also presents a significant resource for Wiltshire. Whilst some older people have significant care needs, in general, older and retired people also have a wealth of knowledge and experience, time and energy, as well as their own financial resources to contribute to modern societies as citizens, volunteers, workers, family members and consumers.

This potential should be valued and harnessed to improve the quality of life and dignity of older people. Innovative ways need to be identified to encourage healthy and active ageing and intergenerational solidarity, therefore making a genuine impact on creating modern 'societies of all ages' Greater emphasis on intergenerational activities should be encouraged in both health and social terms.

Key conclusions and recommendations

Reducing admissions to care homes

Improve the understanding of the factors that influence older people's decisions to enter care homes. Complete a review of existing strategies and develop one action plan that brings together all actions focused on reducing care home admissions. Improve current services, for example, implementation of Help to Live at Home; expansion of Step up to Active Recovery and Return (STARR) scheme and improving new information and advice services and Community Care Assessments.

Physical disability

Although there is an increasing national profile of physical disability, the profile of this area locally compared to other service areas remains low. This is significant because those instances which constitute a 'physical disability' can be located in many areas of the health and social care business. This consideration aside, there are national and local issues which need to be factored in when planning services for the future, alongside financial pressures to deliver good quality, cost effective services.

Sensory impairment

Gathering information about the local population who have visual and hearing impairments can be complex. Local Authorities are obliged to maintain registers, but there is no obligation on individuals to register. A key issue for deaf, deafened and hard of hearing people is access to information in an appropriate format and the provision of appropriate equipment is central to promoting independence.

Provision of consistent, accessible and inclusive eye care pathways and a framework for prevention and early intervention is required. Similar there is a need for prevention and early diagnosis which can significantly reduce the impacts of hearing loss, including social isolation and mental ill health.

Learning disabilities

Content of contracts and their monitoring will need careful management and scrutiny as part of role to safeguard adults from harm. Continued use of the Framework Agreement[41] for purchasing all supported living related services for adults with a learning disability. The Welfare Reform Act (2012) and the introduction of Personal Independence Payments and Universal Credit may prevent people with learning disabilities from living independently in the future due to high rents/lower benefits. Information systems and procedures need to improve so that it is possible to collect information about people living with older family carers, those with secondary disabilities and people who have expressed an interest in living independently.

Falls and bone health

The five priority areas for action identified in the Wiltshire Falls and Bone Health Strategy 2012-14[42] are: update the falls and osteoporosis care pathways for use across Wiltshire; make sure an individual person's risk of falling is assessed and people have access to evidence-based treatments; make sure an individual person's risk of osteoporosis is assessed and suitable treatment started; maintain improvement of hospitals in the management of hip fractures; raise awareness of osteoporosis and falls with older people, their carers, staff who work with them and other health care providers, including the promotion of healthy lifestyles.

Carers

Within Wiltshire there is a large number of 'hidden carers' and identifying these is a high priority. To help with this 'carer awareness' among health care professionals, employers, and other organisations including schools needs increasing further. In addition, promotion needs developing which helps carers to identify themselves as such. Additional resource is needed to improve take up of services from among Black, Asian and Minority Ethnics (BAME) groups; young people between the ages of 16 and 25 years; carers from military services, and carers of people with substance misuse problems.

End of life care

The provision of high quality care to the patient and their family and carers to ensure that everyone's wishes around end of life care are identified and respected, and dignity is preserved, both during the patient's life and after death.

Reducing admissions to care homes

The full topic report for this section is available here: tinyurl.com/hwjsa137

Background

Wiltshire Council places on average 330 older peoples into residential or nursing homes each year. At 31 March 2012 the Council were supporting 896 people over 65 in nursing homes and a further 1,275 in care homes without nursing. Including those people funding their own care in care homes there are a total of 4,600 living in care homes in Wiltshire. This is 1.3% of the population. This has risen from 4,360 in 2007.

Care homes account for 64% of the older persons services budget, which is an increase of 57% in 2010. The target for spend is 40%. This places the county as the third highest in the number of placements made. Conversely, the Council spends 28% of its budget on supporting people at home and is the second worst performing authority in this area[43].

There are two reasons why this causes concern. The first, being that the majority of older people wish to remain in their own homes. The second, being that the average costs of placements funded by Wiltshire Council is £500 for residential and £600 for nursing with average lengths of stay being 643 days for residential and 413 for nursing care. Those funding their own care pay more, admit themselves to care homes earlier and live longer, average length of stay is 4 years so their position is considerably worse. 25% of those who self fund their placements become the financial responsibility of the local authority. Gross costs for average length of stay are £46,000 for residential and £35,000 for nursing. This compares with the average costs for care at home which are £7,700 per annum[44].

[41] Supported Living Framework, http://www.wiltshire.gov.uk/healthandsocialcare/disabilities.htm
[42] Wiltshire Falls and Bone Health Strategy, 2012-2014 Wiltshire Council & NHS Wiltshire. tinyurl.com/hwjsa313
[43] National Adult Social Care Intelligence Network 2012/2011 report
[44] Wiltshire Council departmental dashboard 1.4.11 to 24.3.12

Care home market

The care home market in Wiltshire continues to thrive. However, there has been a move away from the provision of care homes providing personal care towards those providing nursing care.

Wiltshire Council's purchasing reflects this shift away from residential care towards nursing care.

Table 6: Number of residential placements purchased between 2007 and 2012

Area	2007	2012	Change
East	455	275	-180
North	597	605	+8
South	451	433	-18
West	455	236	-219
Total	1958	1621	-337

Table 7: Number of nursing placements purchased between 2007 and 2012

	2007	2012	Change
East	215	282	+67
North	202	488	+286
South	481	585	+104
West	485	531	+46
Total	1383	1878	+495

These are projected to rise to 697 (residential) and 489 (nursing) in 2020 and 887 and 600 in 2030.

Reducing admissions

A study completed by Oxfordshire[45] found that 3 out of 5 people moving into a care home lived alone. A number had pre-disposing conditions namely:

- urinary incontinence (45%);
- dementia (40%);
- bowel incontinence (34%);
- depression (25%);
- visual impairment (21%);
- stroke (19%);
- diabetes (17%).

There is further evidence from Oxfordshire and some London Boroughs that specific, targeted interventions can reduce the number of admissions. These include provision of support to carers, assistance with continence management, improved advice about nutrition and hydration, better support in a crisis, reducing the number of falls, recognising and treating older people with depression and greater support to those caring for someone with dementia.

These findings match those identified from work completed in 2009 in partnership with the Care Services Efficiency Delivery programme sponsored by the Department of Health. A number of workshops were held involving older people, carers and other stakeholders.

The workshops identified key themes for investment. These are:

- Falls
- Continence
- Nutrition and hydration
- Mental well being
- Joint Working and improved information
- Carers

An action plan was developed that will be reviewed in the light of work undertaken subsequent to the completion of the care pathway.

[45] Support to the Early Intervention and Prevention Services for Older People and Vulnerable Adults Programme: Report on Study of Care Pathways, Oxfordshire County Council/ Institute of Public Care, March 2010

Future work

The intention is to develop a joint commissioning strategy and implementation plan focused on reducing admissions to care homes. This will draw on and link with existing strategies around falls, carers, mental health and information and advice.

Specifically, more work is required to develop understanding of the reasons for people entering care homes in Wiltshire, both those supported by the Council and those who are self funding. Once completed, existing investment in those areas that are identified as being trigger points for admission will be reviewed and implementation proposals will be developed to address these areas. The impact of these interventions on the number of people admitted to residential care will be monitored and evaluated. This is being undertaken within the governance of the Council's Transformation Steering Group. A project team will be established and regular progress reports will be made. This will ensure links and dependencies can be identified and guarantee deliverability.

Challenges for consideration

Improving our understanding of the factors that influence older people's decision to enter a care home:

- Complete desktop reviews of 50 admissions to care homes to identify factors and interview 25 recently admitted residents to care homes. Convene focus groups of carers to better understand current pressures and factors that might influence their future decisions.

Complete review of existing strategies:

- Develop one action plan that brings together all actions focused on reducing care home admissions. Identify resources and governance arrangements and agree timescales.

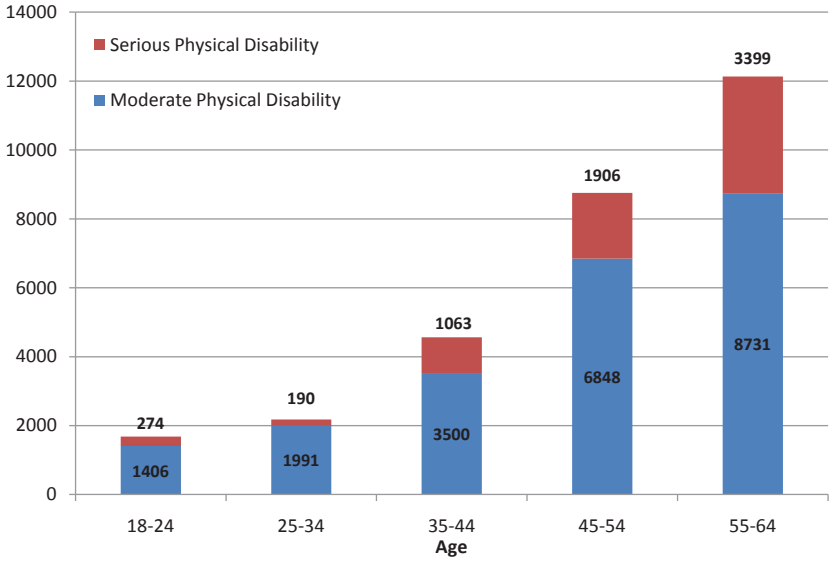
Improving current services:

- Implementation of Help to Live at Home will enable more people to live at home.
- Expansion of STARR scheme to include non bed based services, to ensure customers have time to make decisions when not in a crisis.
- Implementation of falls strategy will reduce the number of falls.
- Improving new information and advice services to ensure people have information they require when they require it.
- Re-align investment in community services where necessary.
- De-commission and re-commission services where necessary.
- Improving Community Care Assessments.
- Improving information, advice and support to people not eligible for financial support from the Council.
- Analyse the demand for night nursing services.

Physical disability

Defining the specific number of individuals with some form physical disability is problematic due to the range and type of conditions that may be considered a 'physical disability'. In Wiltshire there are over 29,000 people aged between 18 and 64 and almost 38,000 older people aged 65 and over who have a moderate or serious physical disability. This is a total of almost 67,000 for the county[46].

Figure 24: Estimated numbers of people with a serious or moderate physical disability in Wiltshire and their age range



Source: www.pansi.org and www.poppi.org

In June 2012, Wiltshire Council provided services to 4,160 people physically disabled people which included 971 aged 18-64 and 3,189 aged 65 and over. The Council was also either in contact, or had occasional contact with a further 19,905 physically disabled people which included 4,280 younger adults and 15,625 older people. These figures exclude those with sensory impairments.

The full briefing note for this section is available here: tinyurl.com/hwjsa139

[46] Projecting Adult Needs and Service Information System and Projecting Older People Population Information System (www.pansi.org and www.poppi.org)

Visual impairment

There is a growing incidence in key underlying causes of sight loss including obesity and diabetes. This means that without appropriate, preventative action, the numbers of people with sight problems in the UK are likely to increase dramatically over the next 25 years[47]. There is expected to be a 115% increase in blind and partially sighted people in the UK from 2012 to 2050. The 60 to 74 age group and over 75 years are the age groups most at risk of sight loss and one in five people aged over 75 have some sight impairment. For one in eight this impairment is significant. For people aged over 90 years, 36.9% have a significant sight impairment[48]. This will place an ever increasing pressure on health and social care budgets in the foreseeable future.

The full briefing note for this section is available here: tinyurl.com/hwjsa141

Hearing impairment

There are more than 10 million people in the UK with some form of hearing loss. The term 'Deaf, deafened and hard of hearing' does not describe a simple homogeneous group. Table 8 shows the estimated number in Wiltshire.

The challenges faced by people with hearing loss are numerous. Barriers to effective communication result in inequality in a number of areas such as education system, the workplace, housing, health and leisure are all areas where blind and partially sighted people struggle to access services and play an active role.

The full briefing note for this section is available here: tinyurl.com/hwjsa140

Deafblindness

Dual sensory loss in this document to refers to people who combined sight and hearing losses cause difficulties with communication, access to information, and mobility. It may also be called deafblindness and both terms are used. The number of people living with a dual sensory impairment in Wiltshire is estimated to increase from 2,893 in 2012 to 3,114 (+8%) in 2015 and 4,806 (+66%) in 2030.

The full briefing note for this section is available here: tinyurl.com/hwjsa142

Learning disabilities

People with learning disabilities are one of the most vulnerable groups in society. They are known to experience inequalities in health and have shorter life expectancy than other people. They also have poorer physical and mental health. Estimates would currently suggest that there could be approximately 8,496 people with a learning disability living in Wiltshire. Community teams for people with learning disabilities currently provide health or social care support to around 1,600 individuals with a learning disability. The majority of people known to specialist services will have a severe learning disability. It is predicted that by 2030 the number of adults with learning disabilities, needing support aged over 18, will increase by 800 to 900.

The full briefing note for this section is available here: tinyurl.com/hwjsa143

Rheumatologic and orthopaedic conditions

Musculoskeletal conditions are the most common reason for repeat consultations with a GP, making up to 30% of primary care consultations. The ageing population will further increase the demand for treatment of age related disorders such as osteoarthritis. Lifestyle factors, such as obesity, can contribute to some musculoskeletal conditions.

In Wiltshire during 2011/2012 there were 11,504 hospital admissions for musculoskeletal conditions, resulting in 24,725 bed days. There were 1,856 hospital admissions for osteoarthritis of the hip and knee, resulting in 8,015 bed days. There has been a small increase in admissions (2.5%) but a large decrease in the bed days (-17.6%) since 2009/10.

The full briefing note for this section is available here: tinyurl.com/hwjsa144

[47] Minassian, D and Reidy, A (2009) Future sight loss in the UK. An epidemiological and economic model. London, RNIB

[48] JR Evans et al (2002) Prevalence of Visual Impairment in people aged 75 and older in Britain: results from the MRC trial of assessment and management of older people in the community. British Journal of Ophthalmology 86: pp 795-80

Table 8: Hearing impairment nationally and in Wiltshire

Circumstances	England	% of Population	Numbers in Wiltshire
Some form of hearing impairment	8.4 million	14.00%	51,058
Use a hearing aid	2 million	3.60%	13,129
Need access to telephone not using voice	420,000	0.76%	2,771
A profound hearing loss	250,000	0.50%	1,823
Use British Sign Language	62,000	0.10%	365

Figures from the 1995 Registers of Deaf and Hard of Hearing People

Falls and bone health

Nationally each year 1 in 3 people aged over 65 and almost half of people aged over 85 have one or more falls every year. There has been a 34% increase in admissions to hospital as a result of a fall in people aged over 65 between 2003/04 and 2010/11 in Wiltshire. In 2010/11 there were 3,054 admissions as a result of a fall per 100,000 people aged over 65. That means one in 33 people aged 65 or over were admitted to hospital as a result of a fall. Falls are more common, and more likely to have serious consequences, in older people. Therefore, as Wiltshire has an ageing population, falls is a focus area for Public Health. The Joint Wiltshire Falls and Bone Health Strategy has been updated in 2012[49].

The full briefing note for this section is available here: tinyurl.com/hwjsa145

Carers

In July 2012, there were in excess of 6,400 Wiltshire carers identified and registered. There were 1,347 carer referrals in 2012/13 of which 782 were previously unknown carers. There are currently (summer 2012) around 100 new referrals a month which represents a 50% increase from 12 months ago. 1,443 carers aged 65 or over receive social care services in Wiltshire. In 2011, Carers UK estimated that the value of unpaid care given by Wiltshire carers is £727.6 million per year[50]. The real figure is likely to be higher than this, as many people do not see the support they provide to their family or friends as unpaid care and so would not have identified themselves.

The full briefing note for this section is available here: tinyurl.com/hwjsa146

End of Life care

Given a choice most people state that they would choose to die in their own home, a care home or a hospice. Many people are unable to die where they choose. The majority die in hospital, often going against their preference and that of their family and carers.

Around 4,000 Wiltshire residents die each year. The majority of deaths occur in adults over the age of 65, following a period of chronic illness. Table 9 shows where people died in Wiltshire and in England overall.

[49] Wiltshire Falls and Bone Health Strategy, 2012-2014 Wiltshire Council & NHS Wiltshire. tinyurl.com/hwjsa313

[50] 'Valuing Carers 2011 – Calculating the value of Carers Support' (written by Dr Lisa Buckner and Professor Sue Yeandle – University of Leeds and Carers UK with support from Centre for International Research on Care, Labour and Equalities)

Table 9: Place of death, 2008 to 2010

	Hospital	Home	Hospice	Care home
Wiltshire	49.9%	22.8%	3.1%	21.6%
England	54.5%	20.3%	5.2%	17.8%

Source: End of life LA profiles, 2012

The figures in Table 9 contrasts starkly with peoples' expressed preference: national figures indicate that 64% of people would prefer to die at home, 21% in a hospice and only 4% in hospital.

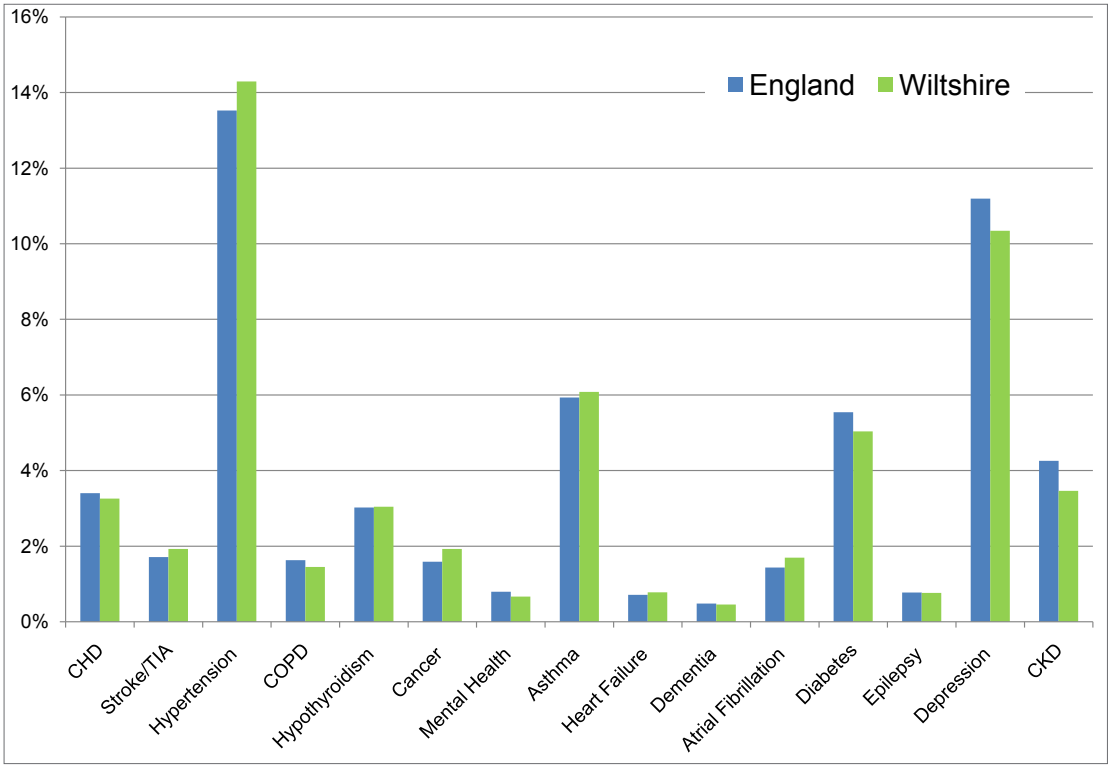
The full briefing note for this section is available here: tinyurl.com/hwjsa148

Long term conditions

Figure 25 shows the prevalence of some major long-term conditions in Wiltshire and England. The term encompasses a wide range of health problems including non communicable and communicable diseases, mental disorders and on-going physical impairments.

The full briefing note for this section is available here: tinyurl.com/hwjsa147

Figure 25: Prevalence of selected long-term conditions in Wiltshire and England (2010/11)[51]*



* Conditions shown are the long-term conditions routinely collected for Quality Outcomes Framework disease registers.

Disability and conditions effecting older people - resources

- The Institute of Public Care websites www.pansi.org.uk and www.poppi.org.uk also provide future projection of prevalence based on independent research and the population estimates.
- Wiltshire's Physical Impairment Strategy, 2009 – 2014, Wiltshire Council http://www.wiltshire.gov.uk/healthandsocialcare/disabilities.htm#Disabilties-local-strategies-Anchor
- Improving the Life Chances of Disabled People (DH 2005) tinyurl.com/hwjsa202
- Wiltshire Council Hearing and Vision Team: http://www.wiltshire.gov.uk/healthandsocialcare/healthandmedicaladvice/hearingandvision.htm
- To find out more about the UK Vision Strategy please visit the UK Vision Strategy website.
- For more information, including reasons for visual impairment, symptoms, causes and treatment click on this link to the action for blind people website.
- For more information, including reasons for hearing impairment, symptoms, causes and treatment see the action on hearing loss website: http://www.actiononhearingloss.org.uk/supporting-you/factsheets-and-leaflets/ears-and-ear-problems.aspx
- Wiltshire's Learning Disability strategy (Commissioning Intentions): http://www.wiltshire.gov.uk/healthandsocialcare/disabilities.htm#Disabilties-local-strategies
- National Hip Fracture Database: http://www.nhfd.co.uk/
- 'Carers' page of the Council's website: http://www.wiltshire.gov.uk/healthandsocialcare/carers.htm
- National End of Life Care Intelligence Network (NEoLCIN): www.endoflifecare-intelligence.org.uk.
- End of Life Care Profiles: http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/default.aspx.

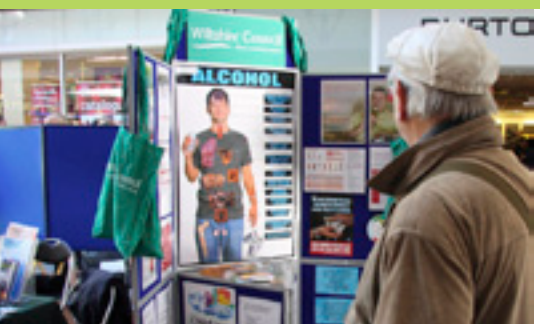
[51] QOF 2010/11. Conditions shown are the long-term conditions routinely collected for QOF disease registers.

Disability and conditions effecting older people - Outcome Frameworks summary

The following indicators from the Public Health Outcomes Framework; the NHS Outcomes Framework and the Adult Social Care Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Indicator
Adult Social Care	1.A	Social care-related quality of life
Adult Social Care	1.C	Direct payments
Adult Social Care	1.D	Carer-reported quality of life
Adult Social Care	1.E	Proportion of adults with learning disabilities in paid employment
Adult Social Care	1.G	Proportion of adults with learning disabilities who live in their own home or with their family
Adult Social Care	2.A	Permanent admissions to residential and nursing care homes, per 100,000 population
Adult Social Care	2.C	Delayed transfers of care from hospital, and those which are attributable to adult social care
Adult Social Care	3.B	Overall satisfaction of carers with social services
Adult Social Care	3.D	Proportion of people who use services and carers who find it easy to find information about services
NHS	1.B	Life expectancy at 75
NHS	2 / 2.4	Health-related quality of life for (2) people with long-term conditions / (2.4) carers
NHS	2.2	Employment of people with long-term conditions
NHS	3.1	Patient Reported Outcomes Measures (PROMs) for elective hip / knee replacement.
NHS	3.3	Improving recovery from injuries and trauma
NHS	3.4	Improving recovery from stroke
NHS	3.5	Improving recovery from fragility fractures
NHS / Adult Social Care	3.6 /2.B	Helping older people to recover their independence after illness or injury
NHS	4.6	Improving the experience of care for people at the end of their lives
Public Health	1.6	People with mental illness and/or disability in settled accommodation
Public Health	1.8	Employment for those with a long term health condition (including learning disability/mental illness)
Public Health	2.12	Excess weight in adults
Public Health	2.13	Proportion of physically active and inactive adults
Public Health	2.17	Recorded diabetes
Public Health	2.24	Falls and fall injuries in the over 65s
Public Health	4.12	Preventable sight loss
Public Health	4.13	Health-related quality of life for older people
Public Health	4.14	Hip fractures in over 65s

Health promotion and preventative services



Introduction

Health promotion and improvement addresses inequalities in health, the wider social influences in health and lifestyles. Its purpose is to encourage people to adopt actions that reduce the risk of developing disease. Behaviours such as poor diet, excessive alcohol consumption, lack of exercise and obesity are important risk factors for major diseases such as cancer, diabetes, coronary heart disease, stroke and respiratory disease.

Public health takes a population approach to health improvement, but can also focus on the individual and on distinct sub populations such as deprived or minority groups. It also considers quality of life through the prevention and treatment of diseases, for example health screening and immunisation. It includes both physical and mental health.

Key conclusions and recommendations

Men's health

Lifestyle choices such as smoking and drinking remain a factor in poor health outcomes for males. Although the excellent work of smoking cessation services is more successful with men than women. Encouraging men to access these services will help to begin to address underlying inequalities. Local variation needs to be tackled at a local level. Prioritisation of population needs should endeavour to take account of the underlying reasons for variation. Leaders in the local community should try and set the example for others to follow.

Maternity and newborn

To maintain continuity of care and appropriate staffing levels alongside a rising birth rate and continue to promote normal birth against increasing acuity in pregnancy such as maternal obesity and women with pre-existing medical conditions. To continue to effectively encourage and support women to make healthy lifestyle choices that are known to positively impact on the health outcomes of both the mother and baby such as stop smoking, breastfeeding, physical activity, healthy eating.

Sexual health

There are issues around access to sexual health services. The range and availability of screening for sexually transmitted infections (STIs) available is geographically limited. Contraceptive and Sexual Health (CaSH) clinics see a disproportionate amount of women seeking Long Acting Reversible Contraception (LARC) methods for reasons other than contraception whom should be referred to appropriate Gynaecology services.

Drug misuse

The Wiltshire drug treatment system has continued to improve its performance throughout 2011/12. Concerted efforts will be made to build on this in order to reach Wiltshire's targets and to provide a treatment system that increased and meaningful engagement resulting in planned successful discharges and completions. An annual drugs needs assessment informs development of services. A particular priority in Wiltshire is on supporting recovery of those in treatment, and coming out of treatment, by focusing on issues such as housing and employment in order to support individuals from relapsing.

Physical activity and healthy eating

Levels of participation in physical activity do not reflect the Chief Medical Officers recommendation that adults take 30 minutes of moderate intensity physical activity on at least five days of the week. Less than one quarter eat the recommended 5 portions a day of fruit or vegetables. There is a need to tackle perceived barriers around eating healthier and doing more physical activity such as the price of food and lack of time to exercise. Modes of transport that place more emphasis on active travel need to be encouraged.

Dental health

An increasing number of adults are retaining their own teeth. The population in Wiltshire is getting older and it must be ensured that appropriate care is available to deal with the more complex restorative problems of old age. Smoking is a critical risk factor for periodontal disease and mouth cancer. Smoking reduction strategies should emphasise this point and the link between smoking and oral disease should be made clear to dental patients.

Screening

The need for appropriate interventions to increase uptake of bowel cancer screening in deprived areas in Wiltshire, as a clear correlation between deprivation and uptake has been observed. The data show significant variation in cervical screening coverage rates by GP practice, age, geographical area and demographics and a need for targeted work to increase uptake, particularly for younger women.

Men's health

The full topic report for this section is available here: tinyurl.com/hwjsa167

Background

A recent report by the European Commission[52] highlighted the wide variation of health outcomes and health status within Europe for men compared to women and also within the countries of Europe. It also suggests a better understanding of the health of men is essential for two main reasons:

- As the demography of the population changes, the male population needs to be and remain as fit and able as possible.
- The fundamental principle of equality, as many men see their lives blighted by serious health problems which have a huge impact on their families and wider society.

The European Union Report concludes that the health of the male population is multifaceted and is not constrained by male specific conditions. It highlights the issues which arise as a result of premature mortality which should be gender neutral such as cancers, communicable diseases and accidents.

Life expectancy

Table 10: Life expectancy of males and at birth

	Male	Female	Gap
Europe	76.1	82.2	6.1
England	78.6	82.6	4.0
South West	79.5	83.5	4.0
Wiltshire	79.6	83.7	4.1

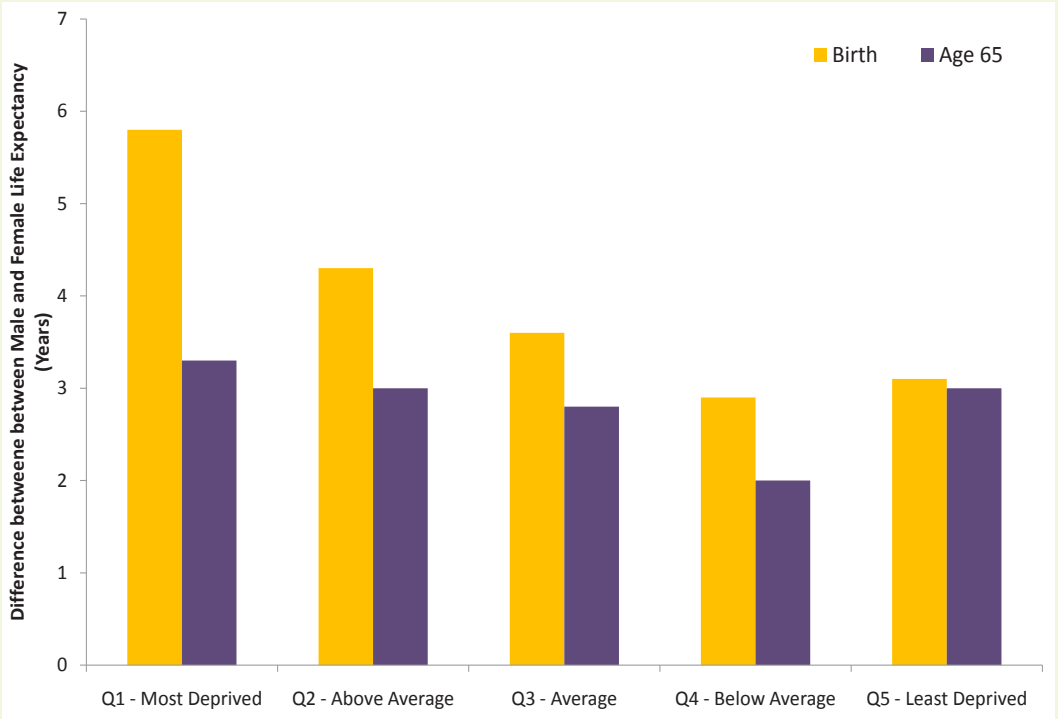
Sources: European Commission and NHS Information Centre

At the age of 75 the gap in life expectancy between the genders has more than halved to less than 2 years. This reflects the differences in male infant mortality, male suicide and also from deaths as a result of accidents. The relative gap is also worth consideration, at birth the difference is around 5% of male life expectancy, at 75 the relative difference has increased to around 15%.

Deprivation and the gender gap in life expectancy

Figure 26 shows the gap between female and male life expectancy at birth and at age 65 by local quintile of Index of Multiple Deprivation (IMD) 2010. At birth the gap in life expectancy is 6 years in the most deprived quintile which reduced by a third to 4 years in the above average quintile and then almost halves to around 3 years for the remaining 3 quintiles of deprivation. This shows that overall life expectancy at birth for both genders is impacted by levels of deprivation and for males the impact is greater. At age 65, life expectancy is not impacted by deprivation and therefore the reason for the gap in life expectancy is explained by other factors. This is emphasised by the gap between males and females in the least deprived quintile being around the same at birth and at age 65. This suggests that males in this quintile are not as affected by deaths in the younger age groups.

Figure 26: Gender gap in life expectancy by deprivation quintile



Source: DFI PHM

Why do men have worse outcomes than women?

This relates in part to biology, and also down to the role played by men in the workforce. There is also anecdotal evidence that generally women are more concerned about their health seeking assistance earlier than men for an equivalent condition and are more aware of lifestyle factors which affect health. In recent years more women have entered employment and are taking risks with lifestyle choices. This might have led to a reduction in the gap between male and female life expectancy. The gap remains broadly similar despite substantial advances in life expectancy in the last 10 years.

Men seem to perceive their health as better than the females in Wiltshire though outcome in terms of life expectancy is worse in males. In addition despite having a slightly higher rate of limiting long term illness they appear to think they are in generally good health. Data from the Wiltshire wide 'What Matters to You?' Survey'[53] illustrates the perception that males generally believe they lead healthy lifestyles and are in generally good condition. Though the actual measured health outcomes suggest a different story might be the case.

Lifestyle choices

In terms of lifestyle data the Wiltshire wide 'What Matters to You?' Survey[54] provides some information about lifestyle and behaviours in men. For physical activity 40% of men think their lifestyle is already healthy compared to 36% of women.

Men also seem happier with their weight with 49% being content compared to 43% of women. This is reinforced by the perception of weight loss needed with only 7% of men thinking they needed to lose a lot of weight compared to 13% of women. In terms of smoking the prevalence for both males and females is similar. Other evidence suggests smoking uptake in young women is higher than young men. It is also working class men who are not giving up despite the health messages. Alcohol consumption is also more prevalent in men than women with around 28% of women claiming not to drink at all with around half that (15%) for men.

Ways to improve men's health

A comprehensive plan for men's health would aid a more detailed understanding of the issues affecting men's health in Wiltshire. Health promotion activity targeted at the male population should be developed in conjunction with male population and in particular the hard to reach groups. There is a need to target messages on health promotion, to help improve health literacy and symptom recognition among men.

Services need to respond flexibly to the needs to men, this may involve longer opening times to allow them to work and still attend the GP surgery or smoking cessation session. It should also look at the idea of being a one stop shop where all issues can be addressed. It might also involve moving services to the workplace so men can easily access the services or more generally the services need to be where men go and this should include the hard to reach groups such as the unemployed, homeless, current and ex-prisoners and the disabled. If men understand the need to seek medical help through improved health literacy and are able to access services through flexible delivery.

Challenges for consideration

Ensuring the collection of data allows for the effective measurement of gender differences.

Cancer is one of the biggest killers in the UK and it is increasing, developing a specific cancer plan with specific recommendations for men. Raising awareness of symptoms in men will help with early detection. Research on why men have generally lower survival would also help with the development of strategies to improve outcomes for men with cancer.

The impact of increased alcohol consumption on health outcomes is beginning to be understood and the consequences for the male population are potentially great. Developing strategies to change drinking habits will help lessen the impact in the long term. While a strategy on pricing for alcohol will have to come from central government there is an opportunity to use local licensing laws to help in the process.

Table 11 – 'What Matters to You?' Survey results

Question	Male	Female
Poor health stops me being physically active	19.5%	18.6%
Already live a healthy lifestyle	40.8%	36.1%
Physical Health is Very Good, Good or Fairly Good	94.1%	93.7%

Source: 'What Matters to You?' survey, Wiltshire Council, 2011

[52] 'The State of Men's Health in Europe, Report, European Union 2011, ISBN 978-92-79-20167-7

[53] 'What Matters to You?' survey (Dec 2011): What you told us (health and lifestyles snapshot report). Public Health Wiltshire, September 2012. tinyurl.com/hwjsa314

[54] 'What Matters to You?' survey (Dec 2011): What you told us (health and lifestyles snapshot report). Public Health Wiltshire, September 2012. tinyurl.com/hwjsa314

Maternity and newborn

In Wiltshire increases in fertility along with increases in the number of women of reproductive ages has resulted in a steady increase in the number of births between 2002 and 2010. There were 4,692 births in 2002 and 5,468 in 2010. The number of births is expected to continue to increase over the next few years.

In 2010 in Wiltshire 5.9% of live or still births were of babies with a birth weight below 2,500g. This is lower than the South West value (6.4%) and statistically significantly below the England value of 7.3%. Wiltshire has a lower rate of caesarean sections at 20.8% compared to that of England at 24.8% or the South West at 24.0%. The ambition is to sustain this low rate locally.

Breastfeeding initiation rates in Wiltshire are consistently higher than the national and regional averages, and have remained above 80% since 2008/09. Data for quarter 1 2012/13 shows that Wiltshire's breastfeeding rate at 6 to 8 weeks has increased to 49.0% which is similar to the South West regional average of 48.7% and higher than the England value of 47%.

The full briefing note for this section is available here: tinyurl.com/hwjsa168

Sexual health

There were 2,270 acute sexually transmitted infections in Wiltshire in 2010[55] which is 494 per 100,000 people. This crude rate was statistically significantly lower than both the England rate of 775 per 100,000 and the South West rate of 637 per 100,000. 2011 figures for Gonorrhoea show that the number of cases in Wiltshire has increased to 53, which is almost double the 2009 figure of 29.

There are a growing number of people living with HIV in Wiltshire. 153 people accessed treatment and care in 2010 and there are 178% more HIV-diagnosed individuals in Wiltshire in 2010 than there were in 2003.

The full briefing note for this section is available here: tinyurl.com/hwjsa169

Smoking

Although the prevalence of smoking is declining, 18.5% of adults in Wiltshire are smokers compared to 19.8% for the South West region and 20.7% for England. There are still around 650 deaths from smoking related causes each year in Wiltshire and smoking is still the biggest cause of premature death (e.g. from lung cancer). Data for 2011/12[56] estimates that 14.2% of pregnant women in Wiltshire are smoking in pregnancy, higher than in the South West rate of 13.2% or England as a whole at 13.2%. Smoking levels are significantly higher among routine and manual workers compared to the rest of the population and stood at 29.3% for Wiltshire in 2010.

Smoking cessation and other tobacco control measures are vital in improving the health of the population. Over 2011/12 5,412 people were supported by the NHS Wiltshire Stop Smoking Service to set a quit date. Local survey data[57] for Wiltshire shows support for banning smoking in additional places which are not covered by the 2007 ban covering enclosed public places and workplaces.

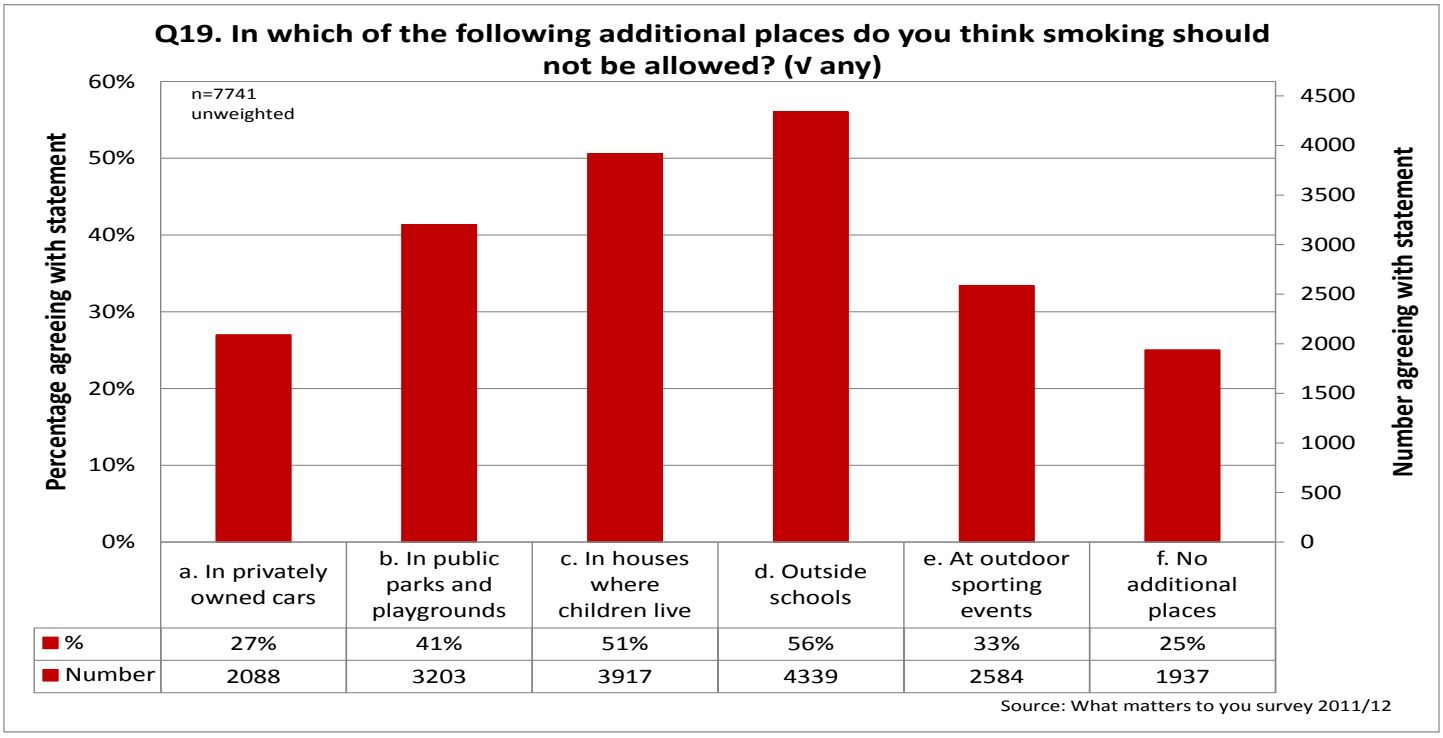
The full briefing note for this section is available here: tinyurl.com/hwjsa170

[55] Health Profile, 2012: Wiltshire, Department of Health, July 2012. www.healthprofiles.info

[56] Statistics on Women's Smoking Status at Time of Delivery: England Quarter 4, 2011/12. Copyright © 2012. The Health and Social Care Information Centre, Lifestyle Statistics. 24 May 2012

[57] 'What Matters to You?' survey (Dec 2011): What you told us (health and lifestyles snapshot report). Public Health Wiltshire, September 2012. tinyurl.com/hwjsa314

Figure 27: Where people think smoking should not be allowed



Alcohol

Alcohol misuse has been directly linked a range of health issues both acute and chronic. Alcohol related hospital admissions having been rising in Wiltshire, although they remain at lower levels than those in either the South West or England.

Likewise, alcohol specific mortality is increasing in Wiltshire, although rates are again lower than regional and national averages. Wiltshire's Alcohol Strategy ensures a county wide, coordinated approach to tackling all aspects of alcohol related harm, and has contributed to improved performance in adult treatment services.

The full briefing note for this section is available here: tinyurl.com/hwjsa171

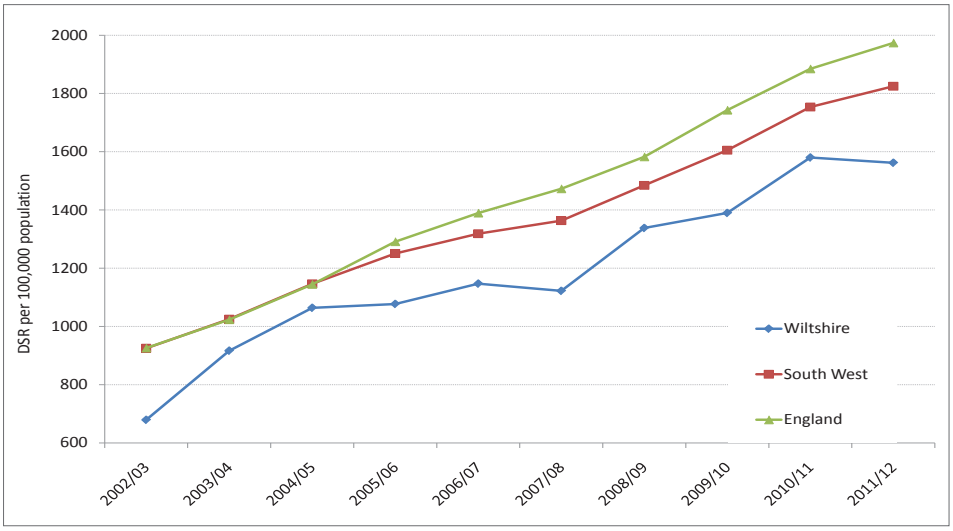
Drug misuse

There were 724 individuals from Wiltshire registered in structured drug treatment (Tier 3 or 4) by the National Drug Treatment Monitoring System (NDTMS) between April 2010 and March 2011[58]. The number of people dependent on illicit drugs is estimated to be significantly higher than the number receiving treatment and registered on NDTMS. 9,318 people aged 18 to 64 are predicted to have a drug problem in Wiltshire in 2011.

The full briefing note for this section is available here: tinyurl.com/hwjsa172

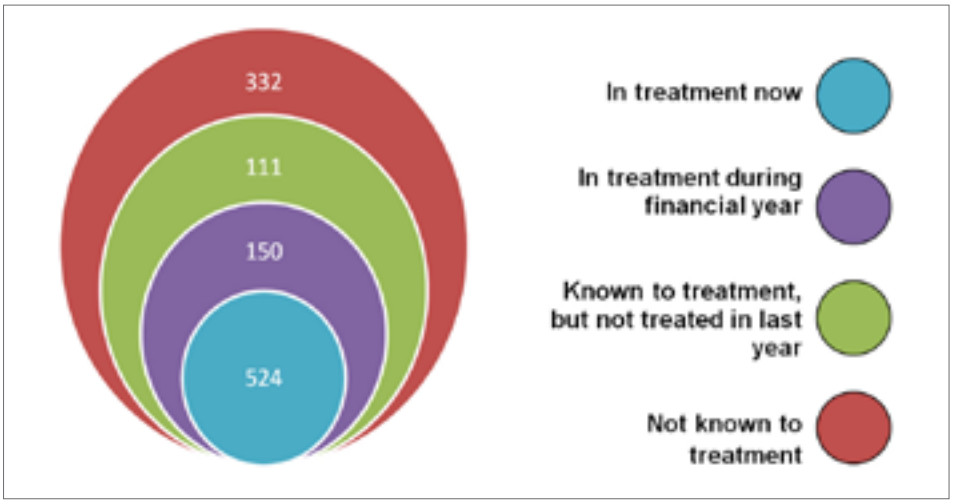
[58] Adult Partnership Quarterly Performance Report, 2011/12

Figure 28: Alcohol related admissions, 2002/03 to 2011/12



Source: NWPHO

Figure 29: Estimated 'problem' drug users in Wiltshire, 2010/11



Source: NDTMS

Domestic abuse

2,229 domestic abuse incidents were reported to Wiltshire Police from July 2011 to June 2012. This represents an increase of a further 429 incidents (23%) on the same period in the previous year. At present it is estimated that only 20% of incidents will be reported to police. The minimum cost of domestic abuse in Wiltshire[59] is estimated to be £19.6 million per year (based on 2010 projections). Wiltshire was a pilot force for the Domestic Violence Protection Notices/Orders and 78 were issued between July 2011 and June 2012.

The full briefing note for this section is available here: tinyurl.com/hwjsa173

Obesity

Obesity is a major contributor to premature mortality, morbidity and disability, and obesity in Wiltshire is now higher at 25.2% than in the South West or England.

Obesity in adults is expected to continue to rise. Local obesity reduction initiatives include Counterweight, physical activity on referral, health trainer and NHS Health Checks. These provide local mechanisms of tackling the obesity crisis.

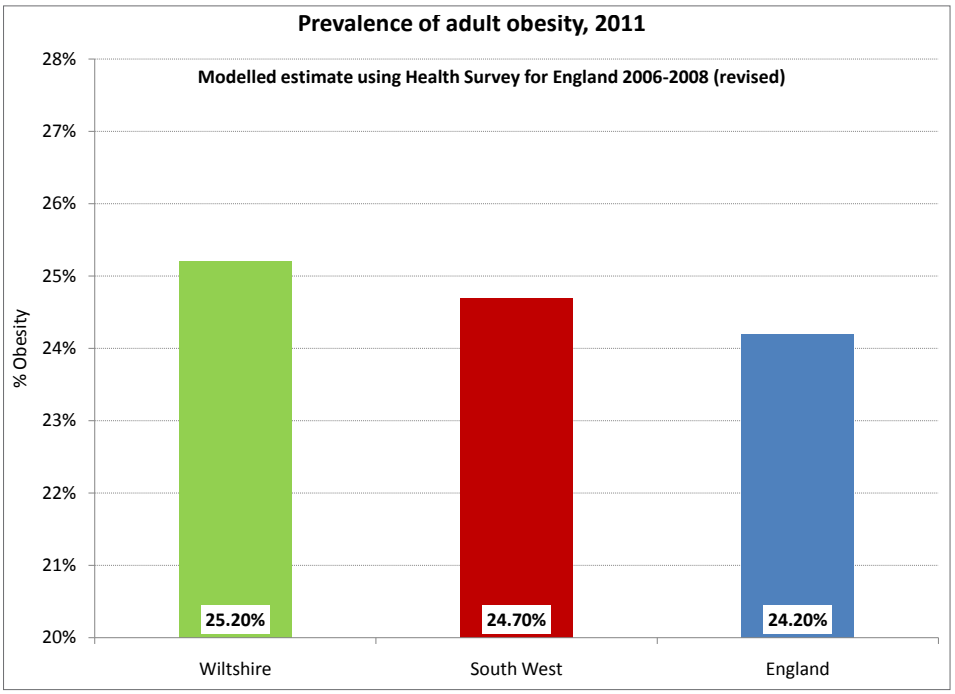
The full briefing note for this section is available here: tinyurl.com/hwjsa159

Physical activity and healthy eating

Overall, participation in physical activity is higher in Wiltshire than in the South West or England. 25.3% of Wiltshire's adults do three or more 30-minute sessions of moderate intensity activity per week. However, it is clear that levels of participation do not reflect the Chief Medical Officers recommendations, with nearly half (43.0%) of the Wiltshire population failing to do 30 minutes of moderate intensity activity during any of the previous four weeks. The NHS 5 A Day program aims to change the way people think about fruit and vegetable consumption and highlights the benefits of eating more fruit and vegetables. Wiltshire has a higher proportion of people who meet the 'five or more a day' ideal, at 30.9%, compared with

[59] Minimum costs of domestic abuse in Wiltshire are based on the original costs produced in the report 'The Cost of Domestic Violence', Walby et al 2004

Figure 30: Prevalence of adult obesity



29.6% for the South West and 28.7% for England as a whole.

The full briefing note for this section is available here: tinyurl.com/hwjsa160

Dental health

There are inequalities in dental health within Wiltshire with higher levels of tooth decay in relatively deprived areas. Access to NHS dentistry in Wiltshire is good. Most residents do not have to travel more than 5 miles to obtain NHS dental care. According to recent figures, 50.4% of the Wiltshire population had accessed NHS dental services in the previous 24 months. Although these proportions are increasing faster than regional or national averages, the percentage of Wiltshire residents accessing NHS dental services is still below the regional and national average.

The full briefing note for this section is available here: tinyurl.com/hwjsa161

Screening

In 2010/11 Wiltshire's breast cancer screening uptake was higher than that of the South West and England. Likewise in 2010/11 80.4% of eligible women were screened for cervical cancer in Wiltshire with county achieving its 80% target. Bowel cancer screening was rolled out in Wiltshire in 2009, and 2011 uptake exceeded the target of 60%. However, survey work at a local level has revealed a lower uptake of the service in the more deprived areas of Wiltshire.

The full briefing note for this section is available here: tinyurl.com/hwjsa162

Vaccination

Uptake of the pneumococcal vaccine in over 65s in Wiltshire is slightly under the levels in the South West and England and the uptake of seasonal flu vaccine is very similar to the South West and England. Vaccination uptake of frontline health care workers has been low nationally at 34.7% between September 2010 and February 2011. It was 32.6% amongst all healthcare workers in Wiltshire[60].

The full briefing note for this section is available here: tinyurl.com/hwjsa163

[60] Seasonal influenza vaccine uptake amongst frontline healthcare workers (HCWs) in England. Winter season 2010/11. tinyurl.com/hwjsa315

Pharmaceutical Needs Assessment

The Pharmaceutical Needs Assessment[61] is a key tool for identifying what is needed at local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. Taking into account local demography and the provision of pharmaceutical services in Wiltshire, it is evident that there is adequate provision of such facilities. Services are accessible in a range of locations and in a variety of set ups.

The full briefing note for this section is available here: tinyurl.com/hwjsa164

Health Trainers

In Wiltshire, the Health Trainers are working with prisoners, military dependants and civilians, offenders and those with drug and alcohol addictions. The Wiltshire Health Trainers are working with adults who have some of the worst health outcomes and the highest incidence of health inequalities.

The full briefing note for this section is available here: tinyurl.com/hwjsa165

Health promotion and preventative services - resources

- NHS Maternity statistics http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/maternity
- CHiMat (Child and maternal health observatory): http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=10&geoTypeId=1
- Sexual Health Balanced Scorecard http://www.apho.org.uk/sexualhealthbalancedscorecard
- Health Protection Agency Sexual Health Profiles: http://www.hpa.org.uk/sexualhealthprofiles
- NICE local government public health briefings:
- Tobacco[62] http://publications.nice.org.uk/tobacco-phb1
- Physical activity: http://publications.nice.org.uk/physical-activity-phb3
- Local Alcohol Profile for Wiltshire - Alcohol related indicators measuring the impact of alcohol on the local community, and comparing Wiltshire.
- Adult Drug Treatment Needs Assessment 2012/2013: http://tinyurl.com/Wjsahw105
- Wiltshire Council domestic abuse information webpages: http://www.wiltshire.gov.uk/communityandliving/communitysafety2/saferwiltshiredomesticabuse.htm
- The National Obesity Observatory: http://www.noo.org.uk/
- Active People Survey. http://www.sportengland.org/research/active_people_survey.aspx
- Statistics on Obesity, Physical Activity and Diet: England, 2012: http://tinyurl.com/Wjsahw106
- The Information Centre for health and social care provides information and data on dentistry, dentists and dental payments: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry
- NHS Cancer Screening Programmes:
  Bowel: http://www.cancerscreening.nhs.uk/bowel/index.html
  Cervical: http://www.cancerscreening.nhs.uk/cervical/
  Breast: http://www.cancerscreening.nhs.uk/breastscreen/
- The Flu Information Programme 2012/13. http://immunisation.dh.gov.uk/flu-vac-prog-201213/

[61] Wiltshire's Pharmaceutical Needs Assessment, Wiltshire Pharmaceutical Services Steering Group. Public Health, NHS Wiltshire, January 2011. http://tinyurl.com/hwjsa316

[62] Local government public health briefings: tobacco, National Institute for Health and Clinical Excellence, 15 July 2012. http://guidance.nice.org.uk/phb3/

Health promotion and preventative services - Outcome Frameworks summary

The following indicators from the Public Health Outcomes Framework; the NHS Outcomes Framework and the Adult Social Care Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Indicator
Public Health	1.11	Domestic abuse
Public Health	1.15	Statutory homelessness
Public Health	1.16	Utilisation of green space for exercise/health reasons
Public Health	2.1	Low birth weight of term babies
Public Health	2.2	Breastfeeding initiation and 6-8 week prevalence
Public Health	2.3	Smoking status at time of delivery
Public Health	2.11	Diet
Public Health	2.12	Excess weight in adults
Public Health	2.13	Proportion of physically active and inactive adults
Public Health	2.14	Smoking prevalence – adults (over 18s)
Public Health	2.15	Successful completion of drug treatment
Public Health	2.16	People entering prison with substance dependence issues not known to community treatment
Public Health	2.17	Recorded diabetes
Public Health	2.18	Alcohol-related admissions to hospital
Public Health	2.19	Cancer diagnosed at stage 1 and 2
Public Health	2.20	% eligible women screened for (i) breast cancer in previous 3 years (ii) cervical cancer in previous 5 years
Public Health	2.21	Antenatal and newborn screening
Public Health	2.22	Take up of the NHS Health Check programme
Public Health	3.2	Chlamydia diagnoses (15-24 year olds)
Public Health	3.4	People presenting with HIV at a late stage of infection
Public Health	3.13	Population vaccine coverage
Public Health	3.7	Comprehensive, agreed inter-agency plans for responding to public health incidents
Public Health	4.1	Infant mortality
Public Health	4.2	Tooth decay in children aged 5 years
Public Health / NHS	4.4 / 1.1	Mortality from cardiovascular diseases
Public Health	4.5	Mortality from cancer
Public Health	4.6	Mortality from liver disease
Public Health	4.7	Mortality from respiratory diseases
Public Health	4.8	Mortality from communicable diseases
NHS	1.4	Survival from colorectal cancer /breast cancer Under 75 mortality rate from cancer
NHS	1.6	Infant mortality and neonatal mortality and stillbirths
NHS	4.5	Women's experience of maternity services
NHS	5.5	Admission of full-term babies to neonatal care

Wider determinants of health

Introduction

The wider determinants of health are also known as the social determinants and have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. These factors and their interaction are represented in figure 31.

Figure 31: The determinants of health and wellbeing in our neighbourhoods

Source: Barton & Grant 2006

Key conclusions and recommendations

Health and wellbeing benefits of access to nature

The benefits of outdoor activity and contact with nature should be promoted and local people encouraged to maximise the opportunities for outdoor activity. Opportunities for individuals to benefit from contact with nature should be provided and targeted at those most in need or suffering from existing conditions, as this could act as a treatment or therapy.

Economy

It will be challenging to respond to a further period of no or low economic growth and continuing changes to benefits and tax credits that will impact severely on many population groups, including disabled people, people with mental health problems, and large families on low incomes. The effects will be noticeable on levels of personal debt; mental ill-health; child poverty; fuel poverty and homelessness.

Housing

The quality of existing stock needs to be improved and made best use of across Wiltshire. All opportunities to meet existing and future housing need should be utilised. People need help to achieve independence and make choices and local communities across Wiltshire are in need of support.

Transport

Table 12: Wiltshire's health related strategic objectives for transport

Ref	Strategic Objective
SO2	Provide, support and/or promote a choice of sustainable transport alternatives.
SO3	Reduce the impact of traffic on people's quality of life and Wiltshire's built and natural environment.
SO8	Improve safety for road users and reduce the casualties on Wiltshire's roads.
SO11	Reduce the level of air pollutant and climate change emissions from transport.
SO14	Promote travel modes that are beneficial to health.
SO15	Reduce barriers to transport and improve access for people with disabilities and mobility impairment.
SO17	Improve sustainable access to Wiltshire's countryside and provide a more useable public rights of way network.

Source: Local Transport Plan 3: 2011-2026

Air quality

Detailed actions need developing and implementing for individual Air Quality Management Areas. New developments need to be located where there is a viable range of transport choices. The self-containment of settlements should be boosted to reduce commuter flows and to take the opportunities from managed development and growth to help address the areas where particular air quality problems occur.

Climate change

Car use needs to be reduced and active transport such as walking and cycling promoted. Public rights of way, parks and other green spaces need maintaining and enhancing. Energy efficiency needs improving and buildings need to be designed sustainably. Local food production growing fruit and vegetables at home should be encouraged.

Arts and culture

Work needs to be done to diversify the experiences available within the cultural offer, especially in rural settings. There are fewer men than women engaging in cultural activities and work needs to be done to increase engagement with young adults, especially those aged between 20 and 29. There are also fewer people with limiting disabilities and people from non-white backgrounds participating in the cultural offer. It is important to ensure the benefits of participation are available to all and that the cultural offer reflects the diversity of the county.

Health and wellbeing benefits of access to nature

The full topic report for this section is available here: tinyurl.com/hwjsa174

Introduction

Regular contact with nature has many positive effects on physical and mental health and wellbeing. Directly, contact with nature can help to prevent of health problems, but also to treat illness and provide therapy and care. This applies in particular to people suffering from, or at risk of, cardiovascular disease, long term mental health conditions or severe mental illness, children with Attention Deficit Hyperactivity Disorder (ADHD) and other emotional and behavioural difficulties, and those recovering from surgery. Activities in natural green space can also create opportunities for families and communities to spend time together, provide nutritious foods, be a catalyst for behaviour and lifestyle change, and positive childhood experience, behaviour and emotional development.

River Avon Plantation Start Walk Field Ryan Tabor 260311 CD1

Securing the benefits of access to nature

The key to securing these benefits is in providing accessible natural green space close to where people live, known as 'green infrastructure'. High quality green infrastructure can reduce health and social care costs, increase economic output and strengthen communities, as well as increasing people's commitment to protect the natural environment. Areas of higher deprivation tend to have less access to natural green space. In a 2011 survey by Wiltshire Council, 45% of respondents identified access to nature as among the most important in making somewhere a good place to live.

The Wiltshire and Swindon Local Nature Partnership gained official status in July 2012 and is building close relations with the Wiltshire and Swindon Health and Wellbeing Boards.

Wiltshire's emerging Core Strategy recognises the importance of green infrastructure to health and wellbeing (para 1.3) and specifies that new development 'shall make provision for the retention and enhancement of Wiltshire's Green Infrastructure network, and shall ensure that suitable links to the network are provided and maintained' (Core Policy 52)[63]. Wiltshire Council has committed to producing a Green Infrastructure Strategy but this is not yet in place. Such a strategy should aim to enhance the quality of existing green infrastructure and plan to

[63] Wiltshire Core Strategy Pre-Submission Document February 2012, Wiltshire Council

incorporate green infrastructure in relation to new developments. The Council's Rights of Way Improvement Plan 2008 – 2012 (to be replaced with a new plan in 2013) plays an important role in ensuring high quality green infrastructure but is not sufficient in itself. The Wiltshire Local Transport Plan 2011-2026 also refers to improvements in cycling, walking, sustainable transport and active travel which can make an important contribution to green infrastructure.

What are the needs of the population?

Access to nature can potentially benefit everyone as part of a healthy lifestyle, as it generally encourages physical activity and maintains or improves wellbeing. High quality and wildlife rich green space close to where people live can provide a motivation for outdoor physical activities, especially for those who are not attracted to indoor activities such as gyms or exercise classes. There is a wealth of evidence on the positive effects on children's development and future health and wellbeing in particular[64]. However, some people do not feel at ease in natural environments and access/ participation should be on a voluntary basis.

Groups of people with, or at risk of, particular conditions can benefit most from access to nature as a form of prevention or treatment of health problems. These include those:

- needing to increase physical activity, particularly those who are overweight or obese;
- at risk of cardiovascular disease, e.g. with high blood pressure, high cholesterol or diabetes;
- children with Attention Deficit Hyperactivity Disorder (ADHD);
- children with emotional and behavioural difficulties (other than ADHD), and social communication difficulties;
- suffering from chronic stress, persistent low mood, depression, anxiety or long-term mental health conditions;
- with severe mental illness leading to aggression and antisocial behaviour;
- recovering from healthcare procedures, such as surgery.

It is estimated that physical inactivity costs the NHS in Wiltshire more than £6 million per year[65]. Cardiovascular disease is the second biggest cause of premature mortality for the population in Wiltshire. It is estimated that more than one thousand children aged 5 to 16 years old have ADHD in Wiltshire and more than 2,500 have emotional disorders such as depression and anxiety. In adults, it is estimated that approximately 60,000 individuals have a common mental health problem such as anxiety or depression in addition to around 6,000 people with dementia.

Levels of access to quality green space in Wiltshire are not well known, as the Green Infrastructure Strategy is not yet in place. People in rural areas do not necessarily have greater access to green space than in urban areas, as the network of public rights of way, access land and other green infrastructure does not extend to all rural areas.

Areas of higher deprivation tend to have less access to natural green space. In England the most deprived communities are ten times less likely to live in the greenest areas; a UK study found that income related inequality in health is affected by exposure to green space[66]. It demonstrated that those with close access to green space lived longer than those with no green space, even when adjusted for social class, employment and other factors and the impact was significantly greater amongst the least affluent individuals in society.

[64] Natural Childhood, Stephen Moss, National Trust 2012
[65] Be Active, Be Healthy, Department of Health 2009, from Wiltshire's Joint Strategic Needs Assessment for Health and Wellbeing 2011-2012
[66] Mitchell R, Popham F, (2008). Effect of exposure to natural environment on health inequalities: an observational population study. The Lancet 372 (9650): pp 1655-1660.

Current service provision

Public bodies in Wiltshire and the UK government have made commitments to increasing the health and wellbeing benefits of access to nature and encouraging closer collaboration between the health, environment and planning sectors. The new Wiltshire and Swindon Local Nature Partnership provides an ideal framework to take this collaboration forward. Wiltshire Council has committed to producing a Green Infrastructure Strategy to help deliver the Core Strategy but this is not yet in place.

Current service provision ranges from independent use of green infrastructure by many local people, organised walking and running groups, to structured programmes of activity for individuals with mental health and wellbeing problems, referred by health professionals. There is clear scope for expanding such projects to reach more of those in need.

While Wiltshire is predominantly rural, with almost 94% of the land classified as green space[67], this says very little about the quality and level of access. Factors involved in good access include proximity, free entry, disabled access, perceptions of personal safety and transport links. The more accessible and attractive the green space, the more likely it is to be used by a wide range of people[68].

Challenges for consideration

Promote the benefits of outdoor activity and contact with nature, and encourage maximum take up by local people of opportunities for outdoor activity.

Provide opportunities for individuals to benefit from contact with nature, targeting those most in need and/or suffering from existing conditions where this could act as a treatment or therapy.

Provide support and training for GPs and other health professionals in providing advice about physical activity in green spaces as an alternative or adjunct to medication or other treatment, and referring patients to suitable projects where available.

Invest staff time and other resources in the preparation and delivery of the Wiltshire Green Infrastructure Strategy to provide more and higher quality green space close to where people live.

[67] State of the Environment Wiltshire and Swindon 2012, Wiltshire Wildlife Trust, May 2012

[68] Economic Benefits of Accessible Green Spaces for Physical and Mental Health: Scoping Study CJC Consulting with Prof. Ken Willis and Dr Liesl Osman, October 2005

Economy

Wiltshire claimant count levels are consistently below those found in the South West and England. The claimant count amongst the young is a concern with 30.3% of all claimants falling into the 18 to 24 age group, this is higher than that experienced regionally and across England. In 2011/12, 12,246 residents of Wiltshire received help from the Citizens Advice Bureau (CAB) service about debt and/or benefits to maximise their incomes.

Around 1 in 12 people (8%) said their health had got worse for reasons connected to the economic downturn. People in deprived areas and young or disabled people seem to have been disproportionately affected. 76% of GPs believed the economic downturn has had a negative impact on their patient's health in the last four years.

The full briefing note for this section is available here: tinyurl.com/hwjsa175

Community safety

Violent crime accounts for 20% of all crime in Wiltshire and is therefore a key priority. There has been a reduction in volume year on year which exceeds the reduction in all crime. Overall, there has been a reduction of 22% in violent crime between 2010/11 and 2011/12. There was also a 21% reduction in alcohol related violent crimes for December 2010 to November 2011 compared to the same time period in the previous year.

2,229 domestic abuse incidents were reported to Wiltshire Police from July 2011 to June 2012. This represents an increase of a further 429 incidents (23%) on the same period in the previous year. In Wiltshire, the number of recorded alcohol related sexual offences has reduced overall from 9% in 2010 to 6% in 2011. There were 1,538 fewer reports of anti social behaviour (ASB) to Wiltshire Police between January and December 2011 in comparison to the year before. Criminal damage has also seen a reduction of 9% in the same time period.

The full briefing note for this section is available here: tinyurl.com/hwjsa176

Housing

Wiltshire is the second largest housing authority in the South West. There were 17,108 households on the housing register in April 2012[69]. During 2011/12, Wiltshire delivered 626 new affordable homes compared to the target of 450. The number of households living in temporary accommodation at the end of March 2012 was 121[70] which is a reduction from 145 in March 2011. 355 people were accepted as homeless in 2011/12, which is a significant increase from 240 in 2010/11 and is one of the highest in the South West.

The full briefing note for this section is available here: tinyurl.com/hwjsa177

Transport

Car usage in Wiltshire is expected to rise by between 17% and 28% from 2011 to 2025. Over 40% of households in Wiltshire already possess two cars or more. The number of cycling trips in Wiltshire has remained fairly stable since 2001[71]. Just 3% of journeys to work are currently made by bicycle in the county, although 40% of people live within cycling distance of their place of work. Per capita CO2 emissions from road transport in Wiltshire have fallen since 2005; however, they still remain above the average for the South West and England.

The number of people killed or seriously injured (KSI) in road traffic collisions in Wiltshire fell from a baseline of 389 per year between 1994 and 1998 to 254 in 2011 and the overall rate of reduction is comparable to the national trend. This translates to a statistically significantly higher rate of KSI in Wiltshire in 2008-2010 at 54.1 per 100,000 population compared to the England rate of 44.3 per 100,000.

The full briefing note for this section is available here: tinyurl.com/hwjsa178

Table 13: Costs of the road traffic collision casualties in Wiltshire 2010[72]

Severity of injury	Number of casualties	Cost per casualty	Total cost
Fatal	21	£1,585,510	£33,295,710
Serious	164	£178,160	£29,218,240
Slight	857	£13,740	£11,775,180
Total	**1,042**		**£74,289,130**

Notes:
The base costs per casualty are as quoted in 'Road Casualties in Great Britain' 2010
Casualties on Highway Agency, M4 and Trunk roads are excluded

[69] Dept of Community Services, Wiltshire Council, April 2012.
[70] Source: CLG live table 784, 2012 data
[71] Wiltshire Local Transport Plan 2011-2026: SEA Scoping Report, 2011. http://www.wiltshire.gov.uk/ltp3-sea-scoping-report.pdf
[72] Road Casualties in Wiltshire and Swindon, The thirteenth joint report ~ 2011, (Based on 2010 data) tinyurl.com/hwjsa317

Environment

Air quality in Wiltshire is predominantly good with the majority of the County having clean unpolluted air. Seven Air Quality Management Areas have been declared in urban areas due to levels of nitrogen dioxide above the recommended limits. In Wiltshire there is a legacy of contamination emanating from past industrial and commercial use of land, e.g. gasworks, particularly in the major conurbations. There are approximately 3,000 residential properties within 50m of a point location which may be subject to contamination. This equates to approximately 1.5% of residential property in Wiltshire. Within Wiltshire in 2011/12 just over 1,500 noise complaints' were received and 20 noise abatement notices were served.

The full briefing note for this section is available here: tinyurl.com/hwjsa179

Arts and culture

Culture and the arts support the wellbeing of both individuals and the whole community. Participation in cultural activities in Wiltshire is above the national average with almost 50% of adults regularly engaging with arts activities or using their local library and more than half of all adults visiting a museum at least once a year. Attendance at heritage attractions is increasing in Wiltshire, largely due to an increase in visits to historic monuments and archaeological sites, historic houses and gardens. This increase is following the national trend.

Wider determinants of health - resources

- State of the Environment Wiltshire and Swindon 2012, Wiltshire Wildlife Trust, May 2012. http://tinyurl.com/hwjsa106
- Wiltshire Council Core Strategy 2006-2026 Submission Document: http://tinyurl.com/hwjsa107
- Air Quality Strategy for Wiltshire, 2011 – 2015, Wiltshire Council, http://tinyurl.com/hwjsa108
- Wiltshire Local Transport Plan 2011-2026 Local Transport Strategy. http://www.wiltshire.gov.uk/ltp3-strategy.pdf
- The Department for Environment, Food and Rural Affairs (Defra) noise maps (Numbers 50 - 52, 67 - 69, and 85 – 87): http://archive.defra.gov.uk/environment/quality/noise/environment/actionplan/locations.htm).
- Department for Transport 'Transport Statistics' webpage: http://www.dft.gov.uk/statistics/
- NOMIS – official labour market statistics: http://www.nomisweb.co.uk/
- Home Office crime statistics: http://homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/
- Crime in England and Wales (Office for National Statistics): http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales
- Local crime statistics website: street-level crime and outcomes maps and data. http://www.police.uk/
- Department of Communities and Local Government live tables: housing: http://www.communities.gov.uk/housing/housingresearch/housingstatistics/livetables/
- Intelligence Network:
- Culture, Leisure and Tourism: http://www.intelligencenetwork.org.uk/culture/
- Economy: http://www.intelligencenetwork.org.uk/economy/
- Crime and Community Safety: http://www.intelligencenetwork.org.uk/crime-community-safety/
- Planning and Housing http://www.intelligencenetwork.org.uk/planning-housing/
- Environment: http://www.intelligencenetwork.org.uk/environment/

Table 14: Engagement in the arts and visits to museums, galleries and libraries

	Wiltshire	South West	England
Percentage of people (aged over 16) who engaged in the arts three times in the last year	48.1%	47.5%	43.8%
Percentage of people (aged over 16) who visited a museum or art gallery in the last year	53.3%	51.4%	51.5%
Percentage of people (aged over 16) who used a public library in the last year	45.5%	44.0%	45.0%

Data from Active People Survey 4 (October 2009 – October 2010)

The full briefing note for this section is available here: tinyurl.com/hwjsa180

Wider determinants of health - Outcome Frameworks summary

The following indicators from the Public Health Outcomes Framework; the NHS Outcomes Framework and the Adult Social Care Outcomes Framework have been selected as the ones most relevant to this section.

Framework	Reference	Indicator
Public Health	1.1	Children in poverty
Public Health	1.4	First-time entrants to the youth justice system
Public Health	1.5	16-18 year olds not in education, employment or training
Public Health	1.6	People with mental illness and/or disability in settled accommodation
Public Health	1.8	Employment for those with a long-term health condition
Public Health	1.10	Killed and seriously injured casualties on the roads
Public Health	1.11	Domestic abuse
Public Health	1.12	Violent crime (including sexual violence)
Public Health	1.13	Re-offending
Public Health	1.14	The percentage of the population affected by noise
Public Health	1.15	Statutory homelessness
Public Health	1.16	Utilisation of green space for exercise/health reasons
Public Health	1.17	Fuel poverty
Public Health	1.18	Social connectedness
Public Health	1.19	Older people's perception of community safety
Public Health	2.7	Hospital admissions caused by unintentional and deliberate injuries in under 18s
Public Health	2.13	Proportion of physically active and inactive adults
Public Health	2.15	Successful completion of drug treatment
Public Health	3.1	Air pollution
Public Health	3.7	Comprehensive, agreed inter-agency plans for responding to public health incidents
Public Health / NHS	4.4 / 1.1	Mortality from cardiovascular diseases
Public Health / NHS	4.7 / 1.2	Mortality from respiratory diseases
Public Health	4.8	Mortality from communicable diseases
Public Health	4.15	Excess winter deaths
Adult Social Care	1.E	Proportion of adults with learning disabilities in paid employment
Adult Social Care	1.F	Proportion of adults in contact with secondary mental health services in paid employment
Adult Social Care	1.G	Proportion of adults with learning disabilities who live in their own home or with their family.
Adult Social Care	1.H	Proportion of adults in contact with secondary mental health services who live independently

Resources

Geographical boundaries

The full resources section for geographical boundaries is available here: tinyurl.com/hwjsa181

Figure 32: Wiltshire's 20 Community Areas

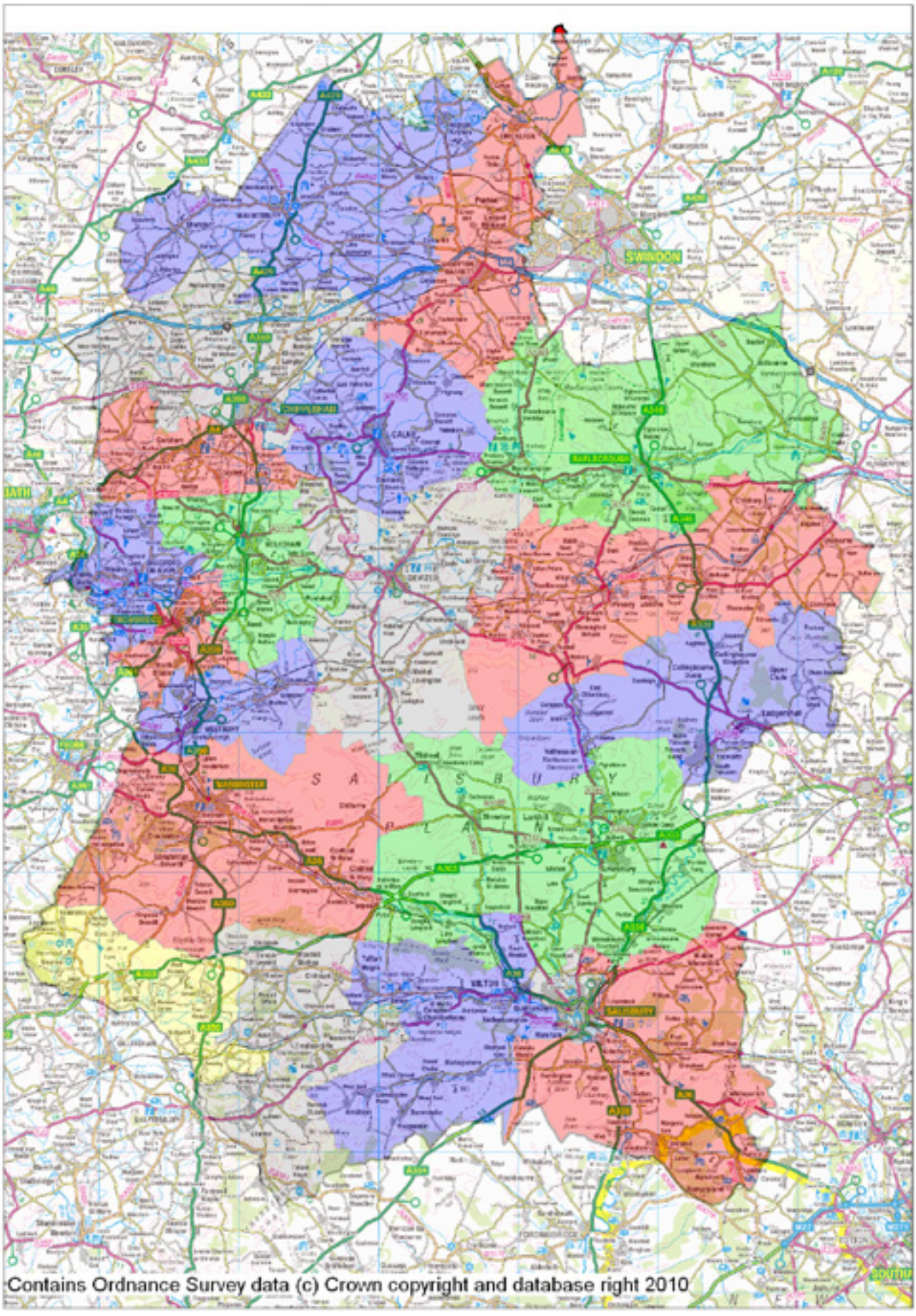
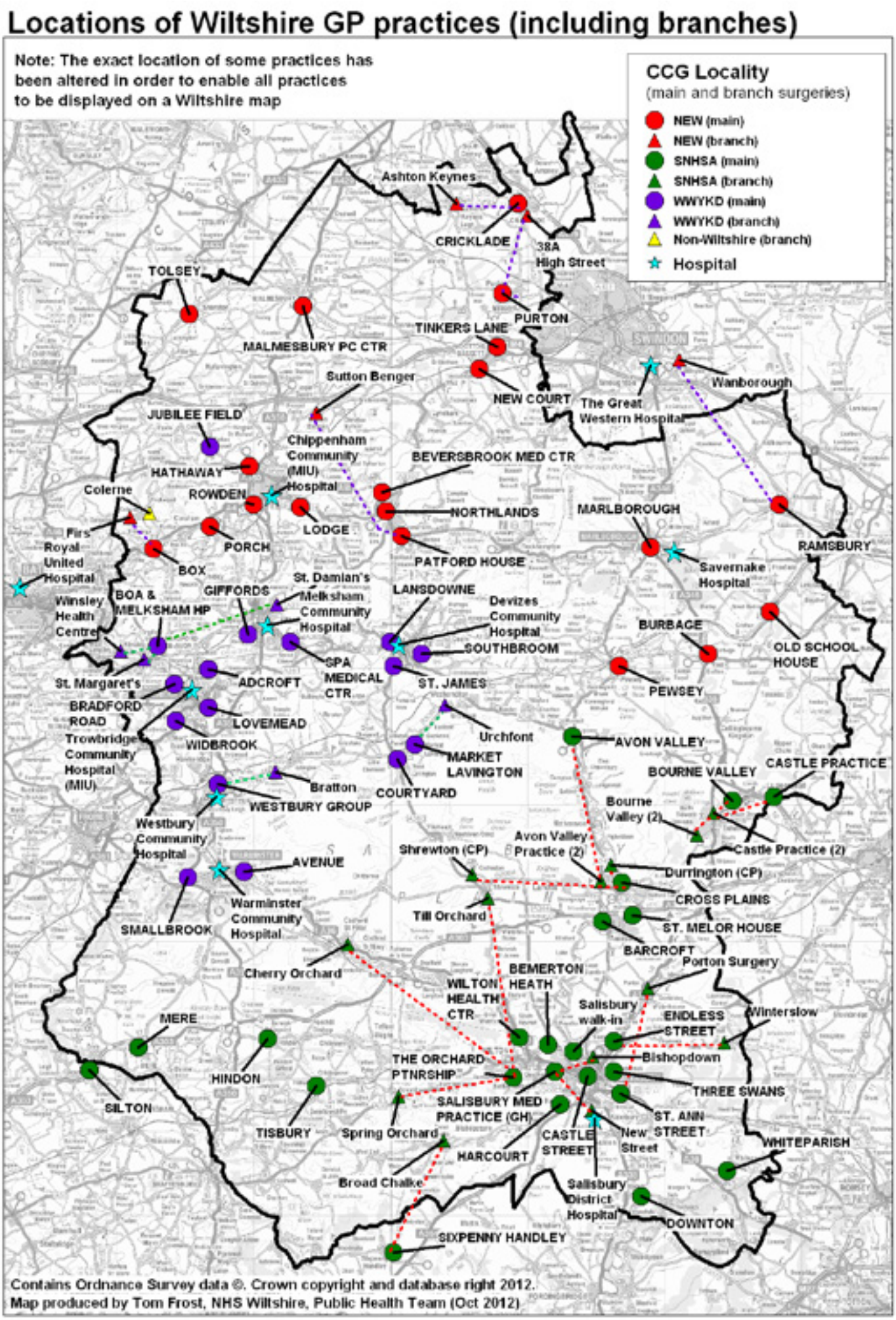


Figure 33: Wiltshire's hospitals and GP practices



Deprivation

The full resources section for deprivation is available here: tinyurl.com/hwjsa182

The Indices of Deprivation 2010 (ID 2010) were released on 24 March 2011 and update the indices previously presented in 2000, 2004 and 2007.

The ID 2010 comprises:

- The Index of Multiple Deprivation (IMD 2010)
- 7 Domains indices of deprivation (including health and disability)
- 2 income sub-domains (children / older people)

Wiltshire is ranked as the 245th most deprived area out of 326 in England according to the average of ranks summation method.

Overall Wiltshire is relatively more deprived (compared to the rest of England) than it was in 2007. This is shown by the average IMD ranking falling from 23,814 to 22,229.

Salisbury St Martin (central) has replaced Trowbridge John of Gaunt (Studley Green) as the most deprived lower super output area (LSOA) in Wiltshire.

In 2010 there are 5 Wiltshire LSOAs in the most deprived 20% nationally (compared to only 3 in 2007):

- Salisbury St Martin (Central)
- Trowbridge Adcroft (Seymour)
- Trowbridge John of Gaunt (Studley Green)
- Salisbury Bemerton (west)
- Salisbury Bemerton (south)

The least deprived LSOA in Wiltshire is Royal Wootton Bassett South (south east). In 2007 it was Salisbury Bishopdown (north). Salisbury St Martin (central) remains the most deprived Wiltshire LSOA in the health and disability deprivation domain.

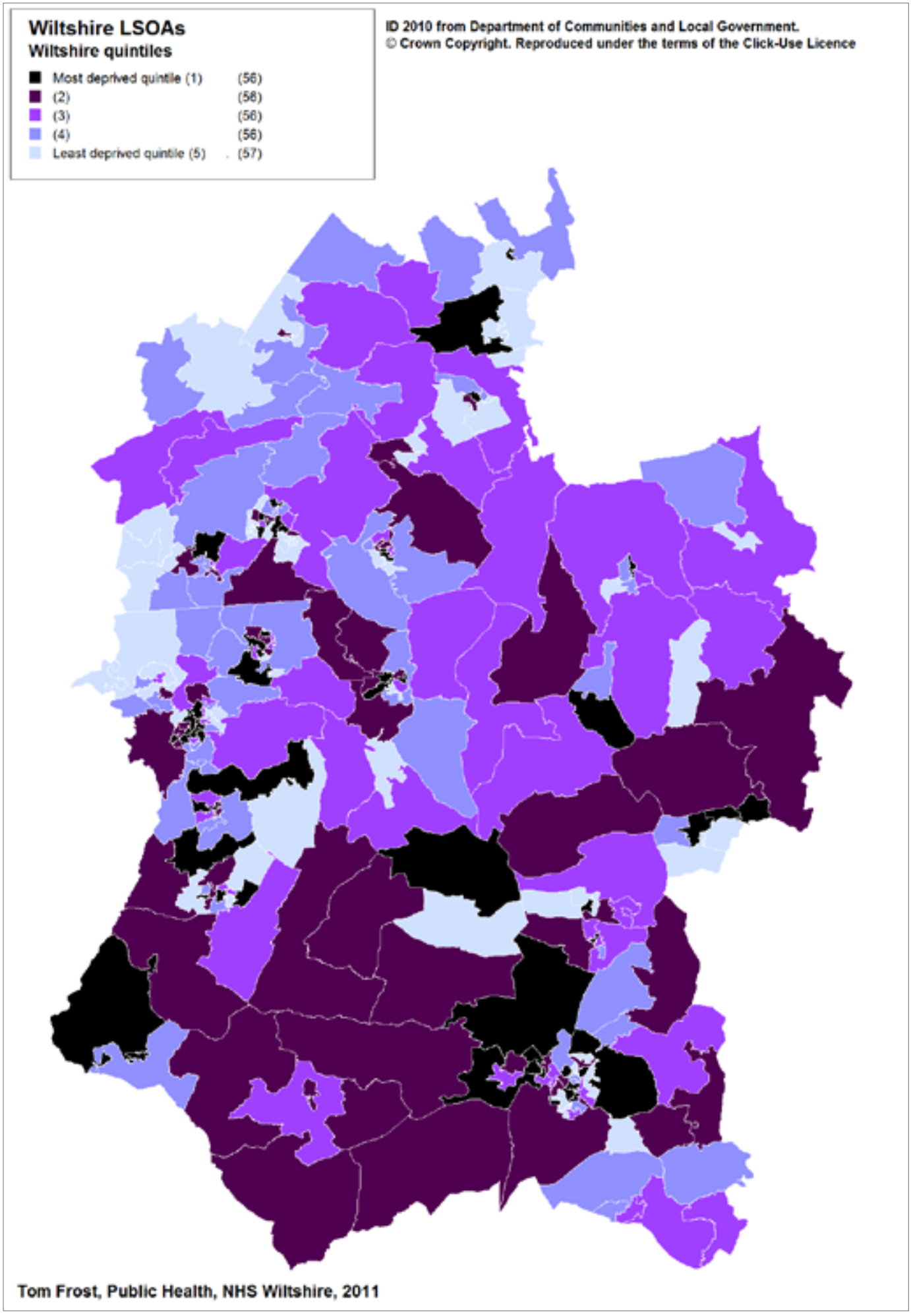
Figure 34 shows Wiltshire's LSOAs split into fifths (quintiles) based on their overall deprivation ranking.

Further information

Further information on the Indices of deprivation can be found on the Department for Communities and Local Government website: http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/ including a summary report for England: http://www.communities.gov.uk/documents/statistics/pdf/1871208.pdf

Wiltshire data and a report can be downloaded from the Wiltshire Intelligence network: http://www.intelligencenetwork.org.uk/community/?opentab=1

Figure 34: Wiltshire IMD quintile 2010



Source: DCLG, ID 2010

Mosaic

The full resources section for Mosaic is available here: tinyurl.com/hwjsa183

Introduction

Mosaic Public Sector is a geo-demographic segmentation system similar to those widely used in the commercial world, which help organisations to understand the needs, motivations and requirements of customers. Mosaic classifies and describes populations in more rounded terms than pure demographic data, and at fine levels of geography, down to household level within Wiltshire. It includes data on criminal justice, education, the environment, health, etc. Mosaic helps organisations to understand current and future service demand, allowing organisations to:

- anticipate and plan future resource requirements,
- understand needs of customers and local areas optimising resource allocation,
- target resources to facilitate entitlement and enrolment,
- develop personalised communications to change behaviour and improve service adoption.

Figure 35: Wiltshire households by Mosaic Group

Group description		Households
D	Successful professionals living in suburban or semi-rural homes	34,954
B	Residents of small and mid-sized towns with strong local roots	29,689
F	Couples with young children in comfortable modern housing	23,612
A	Residents of isolated rural communities	18,187
E	Middle income families living in moderate suburban semis	17,896
J	Owner occupiers in older-style housing in ex-industrial estates	15,645
H	Couples and young singles in small modern starter homes	14,185
K	Residents with sufficient incomes in right-to-buy social housing	13,226
M	Elderly people reliant on state support	10,287
L	Active, elderly people living in pleasant retirement locations	8,565
G	Young, well-educated city dwellers	4,433
C	Wealthy people living in the most sought after neighbourhoods	4,126
I	Lower income workers in urban terraces in often diverse areas	2,945
O	Families in low-rise social housing with high levels of benefit need	2,858
N	Young people renting flats in high density social housing	2,040

Source: Mosaic data 2012; Wiltshire Council

Wiltshire Council, Wiltshire Police and NHS Wiltshire purchased a joint license for Experian's Mosaic Public Sector.

How Mosaic works

Although every household has its own unique characteristics, there are features that bind groups of households together. Mosaic Public Sector conducts a complex analysis of 440 data items to identify natural groupings that exist within the population. These groupings form the basis of Mosaic's 69 types, which are arranged in 15 groups. Every household within Wiltshire is assigned to one of these types. With so many data items included in the modelling process, it is unlikely that every household will match all of its type's average values. What it does mean, though, is that the majority of the type's population is more likely to reflect the characteristics of its assigned type than those of any other type.

Primary research

The full resources section for primary research is available here: tinyurl.com/hwjsa186

Public services in Wiltshire regularly consult with the public and stakeholders on a range of issues and uses research to provide an evidence base to inform decision making.

Wiltshire Voices

- People's Voice - a standing panel of approximately 4,000 Wiltshire residents aged 18 plus which looks into satisfaction with the services as well as residents' perceptions on a wide range of aspects of living within Wiltshire.
- Carers' Voice – a standing panel to seek people's views on the issues and services that affect them in their role as Carers.
- Tomorrow's Voice - a series of regular questionnaires surveying young people in Wiltshire via secondary schools and colleges.

What Matters to you? survey

A survey was carried out in December 2011 inviting Wiltshire residents to comment on a range of topics that affect life where they live. This included lifestyles and health. A total of 7,741 people responded to the survey and the results show extremely high levels of satisfaction with the local area as a place to live and increased levels satisfaction with public services. The report 'What you told us – health and lifestyles snapshot' presents a selection of the key results: http://tinyurl.com/hwjsa109

Health related behaviour survey

The Health Related Behaviour Survey takes every few years in Wiltshire, the most recent survey being in 2011. For Wiltshire's young people these surveys produce the most detailed and reliable profile of their life at home, at school/college, and with their friends. This information is used, alongside other data, to identify local health priorities and inform planning of local service delivery. http://www.wiltshirehealthyschools.org/partnership-projects/wiltshire-health-related-behaviour-survey/

Vulnerable families survey

In October 2010, NHS Wiltshire conducted a Vulnerable Families Survey by asking Health Visitors to complete a survey form on every family in their caseload. They were asked to report on 34 different factors and data was collected on almost 20,000 families. http://tinyurl.com/hwjsa110

Wiltshire local pharmaceutical services public survey

To inform the NHS Wiltshire's pharmaceutical needs assessment (PNA)[73] a local pharmaceutical services public survey was carried out in 2010. 2,484 surveys were return providing an insight into people's use and need for pharmaceutical services.

http://tinyurl.com/hwjsa111

National Patient Survey

The National GP Patient Survey is carried out annually, with patients asked a range of questions that assess their experiences of using GP services in Wiltshire.

[73] Wiltshire's Pharmaceutical Needs Assessment, Wiltshire Pharmaceutical Services Steering Group. Public Health, NHS Wiltshire, January 2011. http://tinyurl.com/hwjsa316

Finance

The full resources section for finance is available here: tinyurl.com/hwjsa187

Programme budgeting - introduction

In order to function optimally commissioners use intelligence and information to better understand current patterns of provision, and to identify opportunities for improving services. Programme Budgeting is a well established technique for assessing investment in health programmes rather than services.

No causal relationship between spend and outcome can be inferred from the data presented here. The limitations of both the Programme Budget data and outcome data need to be considered. The outcome information available varies between programmes. In addition the coverage of outcome measures varies across programmes; for some outcome measures may encompass the whole programme, for others they may only cover part of a programme. The analysis is intended to raise questions which can be investigated further using the quantitative and qualitative outcome data available locally.

The Department of Health has commissioned the Association of Public Health Observatories (APHO) to develop a tool which helps commissioners to link health outcomes and expenditure. The development of this tool and a Spend and Outcome Factsheet for every PCT in England has been led by Yorkshire and Humber Public Health Observatory[74].

Programme budgeting – 2010/11 analysis

Overall NHS Wiltshire spent £1,707 per head on healthcare in 2010/11. The average for PCTs with similar socio-economic backgrounds (the ONS 'cluster' group) was £1,724.

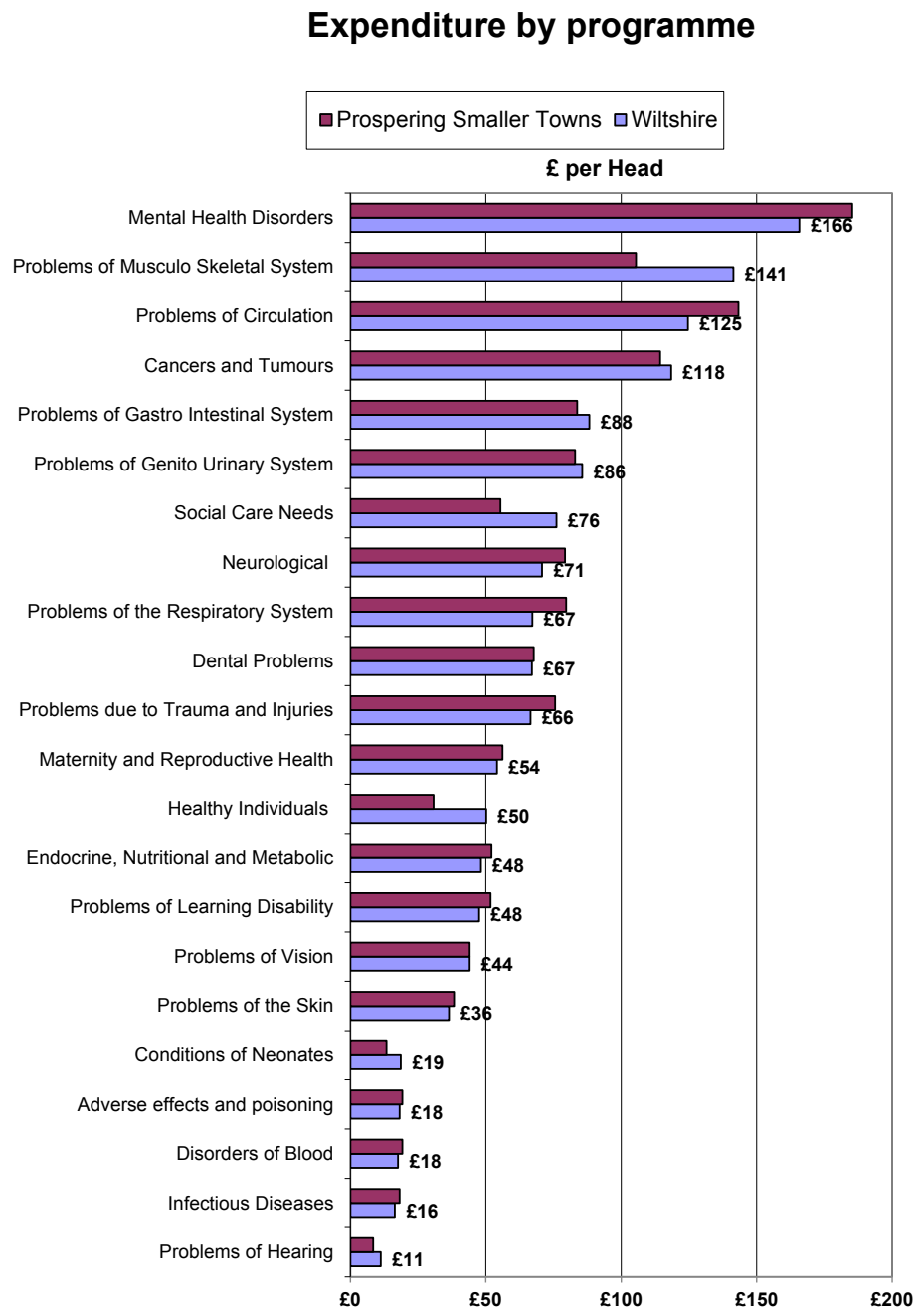
Nationally the out of the 23 Programme Budgeting programmes of care, the four with the highest expenditure were mental health, problems of circulation, cancers and tumours and problems of the musculo skeletal system. NHS Wiltshire's spend is below the cluster average on mental health and circulatory programmes, and is very similar to the cluster average on cancer and tumours. However, NHS Wiltshire spend on musculo skeletal problems was much higher than the cluster average.

Compared with national figures, Wiltshire had a lower spend on mental health, a similar spend on circulation and cancer and tumour programmes, but a higher spend on musculo skeletal problems.

Compared with the cluster average, NHS Wiltshire spent 63% more on healthy individuals, 40% more on conditions of neonates, 37% more on social care needs, 34% more on problems of the musculo skeletal system and 33% more on problems of hearing.

However, it spent 16% less on problems of the respiratory system, 13% less on problems of circulation and 12% less on problems due to trauma and injuries than average for its cluster.

[74] tinyurl.com/hwjsa318



Source: Department of Health Programme Budgeting data

NHS Wiltshire spent 50.3% of all spending on secondary care. This was a larger percentage than the cluster at 48.4%, the South West at 50.0% or England at 49.2%. However, in monetary terms Wiltshire spent less per head (£858), than the South West (£868) and England (£862) averages but more than the cluster average (£833).

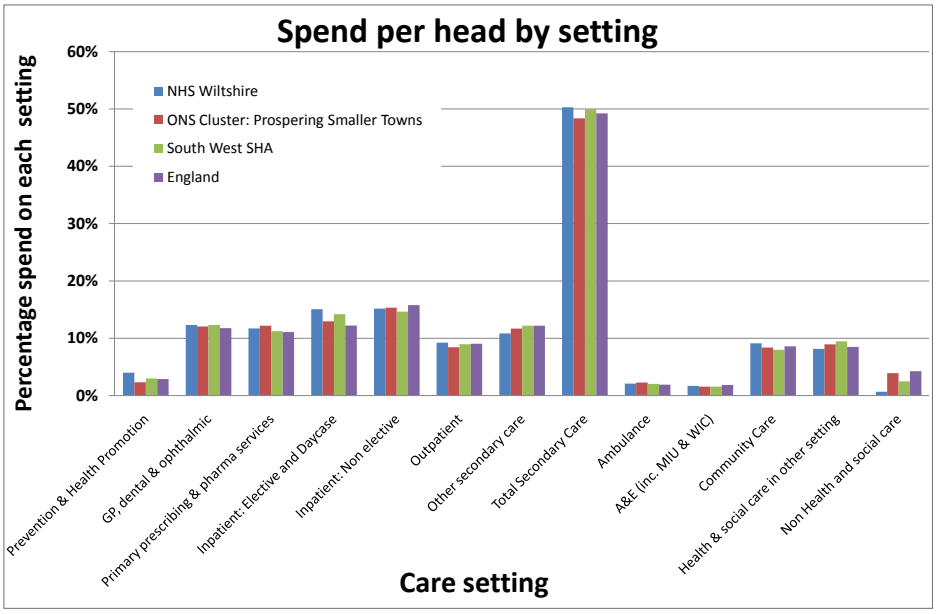
NHS Wiltshire spent only 4% of all spending on prevention and health promotion. This equates to £68 per head. However, this was a larger percentage and amount than the cluster (2.3%, £40), the South West (3.0%, £52) or England (2.9%, £51) averages.

NHS Wiltshire spent less on non health and social care settings (0.7%, £11 per head) than the cluster (3.9%, £67), the South West (2.5%, £43) and England (4.3%, £74) averages.

NHS Wiltshire spent more on elective and day-case inpatient care (15.1%, £257 per head) than the cluster (12.9%, £223), the South West (14.2%, £246) and England (12.2%, £214) averages.

Figure 36 shows the expenditure per head in Wiltshire compared to a group of statistical similar places (the ONS 'cluster').

Figure 36: Expenditure by programme



Source: Department of Health Programme Budgeting data

Figure 37 shows the spending per head by NHS Wiltshire and comparators for 2010/11. This is the first year this analysis has been provided.

Figure 37: Expenditure per head by care setting

Intelligence network

The full resources section for the Intelligence Network is available here: tinyurl.com/hwjsa188

The Wiltshire Intelligence Network is hosted by Wiltshire Council and consists of a number of key organisations who collect and analyse local level data. These include NHS Wiltshire, The South West Observatory, Wiltshire Police, Wiltshire Fire and Rescue Service and Wiltshire Wildlife Trust. The Wiltshire Intelligence Network was developed in response to a growing demand for local information. This information has been used for the development of local strategies, funding applications and assisted with local decision making.

The Wiltshire Intelligence Network aims to improve access to information about Wiltshire by providing a single location where local data and reports on a wealth of topics can be accessed. These topics include:

- Consultations - Results from a number of key, regular public consultations.
- Local Area Profiles - Local profiles for the Wiltshire County Community Areas.
- Population and Census - Population and 2011 Census data and reports for Wiltshire and profiles from the 2001 Census.
- Health and Wellbeing - JSA for Health and Wellbeing in Wiltshire; child needs assessments and information on adults and older people requiring care.
- Education and Skills - School and college achievement information.
- Economy - Strategic Economic Assessments and key data and reports.
- Crime and Community Safety - Data and reports relating to crime and community safety in Wiltshire.
- Community - Information on community lifestyles, deprivation, rural services and the military presence in Wiltshire.
- Planning and Housing - The local planning and housing evidence base.
- Transport and Communications - Information from the Local Transport Plan; broadband provision in Wiltshire and mobile phone coverage.
- Environment, Climate Change, Waste and Recycling - Local and regional information relating to environmental issues.
- Culture, Leisure and Tourism - Information on culture, leisure and tourism in Wiltshire and the South West region.
- Maps - a number of geographic and thematic maps, available to download.

Outcomes Frameworks

The full resources section for outcomes frameworks is available here: tinyurl.com/hwjsa189

The full resources section for outcomes frameworks can be downloaded here: tinyurl.com/hwjsa189

The Public Health Outcomes Framework (PHOF) for England, 2013-2016[75] was published in January 2012 by the Department of Health. It outlines the overarching vision for public health as 'to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest. See figure 38 for an overview of the Framework and figure 39 for an 'at a glance' view of the indicators.

NICE has published a briefing[76] which links NICE guidance relevant to over 40 of the PHOF indicators and shows how it can help local authorities tackle their public health priorities. http://publications.nice.org.uk/phb5

The NHS Outcomes Framework[77] set out how the improvement of healthcare outcomes for all will be the primary purpose of the NHS. See figure 41 for an 'at a glance' view of the Framework and indicators.

Data from the NHS Outcomes Framework indicators and for some Public Health Outcome Framework indicators is available via the Information Centre Indicator Portal: https://indicators.ic.nhs.uk/webview/

The Adult Social Care Outcomes Framework[78] (ASCOF) is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care. See figure 40 for an 'at a glance' view of the Framework and indicators. ASCOF data is available from the NHS Information Centre http://tinyurl.com/ascof111222

The Children and Young People's Health Outcomes Forum has published a report on how health-related care for children and young people can be improved. It includes recommendation about a number of new outcomes measures and the strengthening of existing indicators. http://healthandcare.dh.gov.uk/forum-recommendations/

The NHS Commissioning Board, supported by NICE and working with professional and patient groups, is developing a Commissioning Outcomes Framework (COF) that measures the health outcomes and quality of care (including patient reported outcome measures and patient experience) achieved by clinical commissioning groups. http://www.nice.org.uk/aboutnice/cof/cof.jsp

The Quality and Outcomes Framework (QOF) was introduced in 2004 as part of the General Medical Services Contract, the QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. http://www.nice.org.uk/aboutnice/qof/qof.jsp.

QOF data is available from the NHS Information Centre: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework

[75] Healthy Lives, Healthy People: Improving outcomes and supporting transparency, Department of Health, January 2012. http://tinyurl.com/hwjsa319

[76] NICE guidance and public health outcomes, National Institute of Health and Clinical Excellence (NICE), October 2012. http://publications.nice.org.uk/phb5

[77] NHS Outcomes Framework 2012/13, Department of Health, 2011.

[78] Transparency in outcomes: a framework for quality in adult social care: The 2012/13 Adult Social Care Outcomes Framework, Department of Health, March 2012.

Public Health Outcomes Framework

The Public Health Outcomes Framework focuses on the two high-level outcomes:

- increased healthy life expectancy,
- reduced differences in life expectancy and healthy life expectancy between communities.

To understand how well health is being improved and protected these outcomes are complemented by 66 indicators, many with multiple parts. These indicators are grouped into four domains:

- improving the wider determinants of health,
- health improvement,
- health protection,
- healthcare public health and preventing premature mortality.

Figure 38: Public Health Outcomes Framework overview

Public Health Outcomes Framework

OUTCOMES

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest

Outcome 1: **Increased healthy life expectancy**
Taking account of the health quality as well as the length of life

(Note: This measure uses a self-reported health assessment, applied to life expectancy.)

Outcome 2: **Reduced differences in life expectancy and healthy life expectancy between communities**
Through greater improvements in more disadvantaged communities

(Note: These two measures would work as a package covering both morbidity and mortality, addressing within-area differences and between area differences)

DOMAINS

DOMAIN 1:	DOMAIN 2:	DOMAIN 3:	DOMAIN 4:
Improving the wider determinants of health	Health improvement	Health protection	Healthcare public health and preventing premature mortality
Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities	Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities
Indicators Indicators Indicators } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*

Figure 39: Overview of outcomes and indicators for The Public Health Outcomes Framework for England, 2013-2016

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

1 Enhancing quality of life for people with care and support needs

Overarching measure

1A. Social care-related quality of life

Outcome measures

People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.

1B. The proportion of people who use services who have control over their daily life
1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments

Carers can balance their caring roles and maintain their desired quality of life.

1D. Carer-reported quality of life *

People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

1E. Proportion of adults with learning disabilities in paid employment ***
1F. Proportion of adults in contact with secondary mental health services in paid employment ***
Placeholder: Proportion of working age adults in contact with social services in paid employment (to replace 1E/1F)
1G. Proportion of adults with learning disabilities who live in their own home or with their family **
1H. Proportion of adults in contact with secondary mental health services living independently, with or without support **

2 Delaying and reducing the need for care and support

Overarching measures

2A. Permanent admissions to residential and nursing care homes, per 1,000 population
Placeholder: Effectiveness of prevention/preventative services

Outcome measures

Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.

Placeholder: Effectiveness of prevention/preventative services

Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services.

2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services*
Placeholder: Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

2C. Delayed transfers of care from hospital, and those which are attributable to adult social care*
Placeholder: Effectiveness of reablement: regaining independence

3 Ensuring that people have a positive experience of care and support

Overarching measure

People who use social care and their carers are satisfied with their experience of care and support services.

3A. Overall satisfaction of people who use services with their care and support
3B. Overall satisfaction of carers with social services

Outcome measures

Carers feel that they are respected as equal partners throughout the care process.

3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for

People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

3D. The proportion of people who use services and carers who find it easy to find information about services

People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Overarching measure

4A. The proportion of people who use services who feel safe**

Outcome measures

Everyone enjoys physical safety and feels secure.
People are free from physical and emotional abuse, harassment, neglect and self-harm.
People are protected as far as possible from avoidable harm, disease and injuries.
People are supported to plan ahead and have the freedom to manage risks the way that they wish.

4B. The proportion of people who use services who say that those services have made them feel safe and secure
Placeholder: Effectiveness of safeguarding services

Figure 40: Adult Social Care Outcomes Framework

*Included in/consistent with NHS OF
**Included in/consistent with Public Health OF

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare *(TheNHS CommissioningBoardwouldbe expectedtofocusonimproving mortalityin allthecomponentsofamenablemortalityaswellasthe overallrate)*
1b Life expectancy at 75

Improvementareas

Reducing premature mortalityfrom themajorcauses ofdeath
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival
i One- and ii five-year survival from colorectal cancer
iii One- and iv five-year survival from breast cancer
v One- and vi five-year survival from lung cancer

Reducing premature deathinpeople with seriousmentalillness
1.5 *Under75 mortalityrate inpeoplewith seriousmentalillness**

Reducing deaths inbabies andyoungchildren
1.6.i Infant mortality*
1.6.ii Perinatal mortality (including stillbirths)

2 Enhancing quality of life for people with long term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions (EQ-5D)**

Improvementareas

Ensuringpeople feelsupportedtomanage theircondition
2.1 Proportion of people feeling supported to manage their condition***

Improving functionalabilityinpeople withlong-term conditions
2.2 Employment of people with long-term conditions

Reducingtime spentinhospitalbypeople withlong-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancingquality oflife forcarers
2.4 Health-related quality of life for carers (EQ-5D)**

Enhancingquality oflifeforpeople withmentalillness
2.5 Employment of people with mental illness

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 28 days of discharge from hospital***

Improvementareas

Improvingoutcomesfromplannedprocedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventinglowerrespiratorytractinfections (LRTIs)inchildren from becomingserious
3.2 Emergency admissions for children with LRTIs

Improvingrecoveryfrominjuriesandtrauma
3.3 *An indicatorneedstobedeveloped.*

Improvingrecoveryfromstroke
3.4 *An indicatorneedstobedeveloped.*

Improvingrecoveryfromfragilityfractures
3.5 The proportion of patients recovering to their previous levels of mobility/ walking ability at i 30 days and ii 120 days***

Helping olderpeopletorecovertheirindependenceafterillnessorinjury
3.6 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
4b Patient experience of hospital care

Improvementareas

Improvingpeople'sexperienceofoutpatientcare
4.1 Patient experience of outpatient services

Improvinghospitals'responsivenesstopersonalneeds
4.2 Responsiveness to inpatients' personal needs

Improvingpeople'sexperienceofaccidentand emergencyservices
4.3 Patient experience of A&E services

Improvingaccesstoprimary careservices
4.4 Access to i GP services and ii dental services

Improvingwomen andtheirfamilies'experienceofmaternity services
4.5 Women's experience of maternity services

Improving theexperienceofcareforpeopleattheendoftheirlives
4.6 *An indicatorneedstobedevelopedbasedonthesurveyofbereavedcarers*

Improvingexperienceofhealthcare forpeoplewith mentalillness
4.7 Patient experience of community mental health services

Improvingchildrenandyoung people'sexperienceofhealthcare
4.8 *An indicatorneedstobedeveloped.*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

Improvementareas

Reducingthe incidenceofavoidableharm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare-associated infection (HCAI)
i MRSA
ii *C difficile*
5.3 Incidence of newly acquired category 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improvingthesafetyofmaternity services
5.5 Admission of full-term babies to neonatal care

Delivering safecaretochildreninacutesettings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining howtheNHS will be accountablefor outcomes
Five domains
articulatingtheresponsibilities of theNHS
Ten overarching indicators
coveringthebroadaims of each domain
Thirty-one improvement areas
lookinginmore detail at key areas withineach domain
Fifty-one indicators in total
measuring overarchingandimprovement areaoutcomes

The NHS Outcomes Framework 2011/12 at a glance

**Shared responsibilitywithPublicHealthEngland*

***EQ 5D™ isatrademarkofthe EuroQol Group.Furtherdetailscanbefoundat: www.euroqol.org*

****IndicatoralsoincludedintheAdultSocialCare OutcomesFramework*

Indicatorsinitalicsareplaceholders,pendingdevelopmentoridentificationofa suitableindicator

Statistical guide

The full resources section for the statistical guide is available here: tinyurl.com/hwjsa210

Confidence intervals

A point estimate is a single value that serves as the best estimate of the true value of a measured characteristic in a population (in figure 42 the peak of each bar). Confidence intervals are used to measure the imprecision in estimates that we make. They are displayed graphically as error bars. Their size depends on the size of the population of interest, the degree of variability in the health indicator and the required level of confidence, normally 95%.

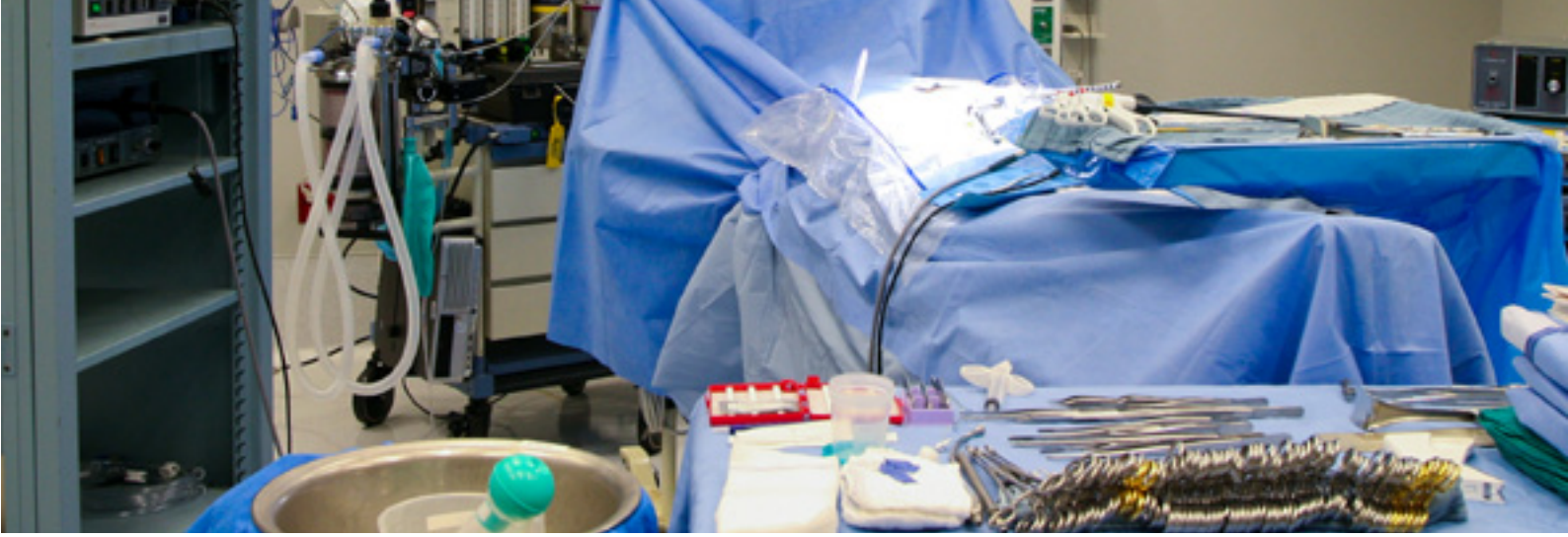
Figure 42 shows an example of where confidence intervals do not overlap (Wiltshire and England) and the difference is statistically significant. Where confidence intervals do overlap a statistical test is required to determine significance. However, if the point estimate of one falls within the confidence interval of the other, then the difference is not significant (Wiltshire and the South West in Figure 42).

Figure 42: Mortality data with confidence intervals

Source: The NHS Information Centre for health and social care.

Sample size

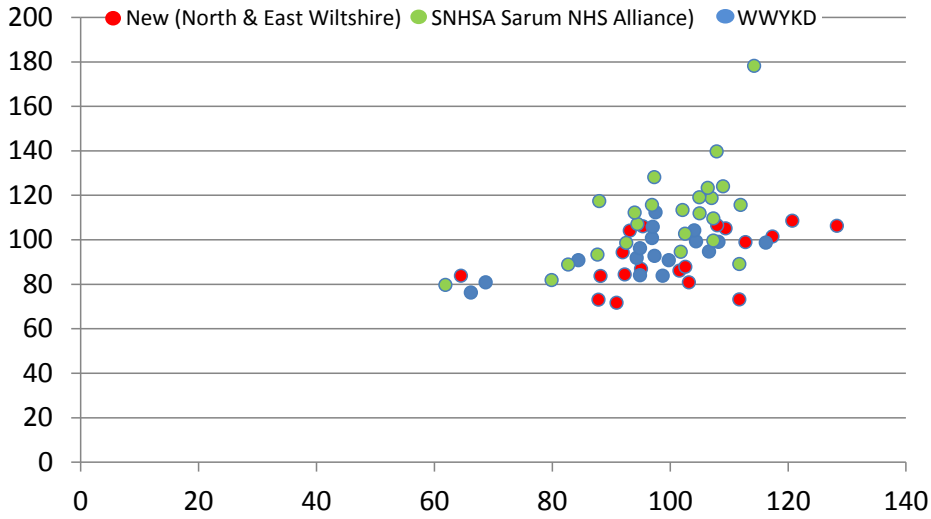
A smaller population means that it is more likely that random variation within that population may account for an estimate. In Figure 42, Wiltshire's confidence intervals are much wider than for the South West or England. This reflects Wiltshire's much smaller population size.



Association and causation

Scatter plots show the level of correlation between the two indicators of interest. For example, when comparing elective and emergency admissions the pattern is as shown in Figure 43.

Figure 43: Scatter plot showing correlation



The scatter plot reveals that at GP practice level there is evidence of a positive relationship between elective and emergency admissions. This is shown by the positive diagonal clustering of GP practices on the scatter plot. As elective admissions increase across GP practices an increase in emergency admissions is observed.

The scatter plots do not imply that one of the indicators is directly causing or influencing the other. It may be that other variables are not accounted for in the analysis and it is these that explain the association. Scatter plots are intended to provide a tool to reveal such correlations only, and provide the basis for further investigation or analysis.

Further information

The Association of Public Health Observatories (APHO) produced a number of technical briefings which are practical, 'how to' guides, designed to support health practitioners and analysts, and to promote the use of public health intelligence in decision making. http://www.apho.org.uk/default.aspx?RID=39306

They include:

- Commonly Used Public Health Statistics and their Confidence Intervals: http://www.apho.org.uk/resource/item.aspx?RID=48457
- Statistical process control methods in public health intelligence: http://www.apho.org.uk/resource/item.aspx?RID=39445

Glossary and abbreviations

The glossary and abbreviations section can be downloaded as a separate document here: tinyurl.com/hwjsa190

A&E	Accident and Emergency
AAA	Abdominal aortic aneurysm
AAACM	All age all cause mortality
Action for Children	Children's charity running Wiltshire's family and parenting support service
ADHD	Attention deficit-hyperactivity disorder
Alcohol attributable/related admissions or deaths	Cases (admissions or deaths) where the underlying cause was a condition thought to be directly or indirectly attributable to excessive alcohol consumption. This takes into account the fact that for many conditions excessive alcohol consumption is known to be a contributory factor to some, but not all, cases.
Alcohol specific admissions or deaths	These cases (admissions or deaths) are a subset of all alcohol attributable / related cases, and cover cases relating to conditions such as acute alcohol poisoning or alcoholic liver disease or alcoholic cardiomyopathy, where excessive alcohol consumption is a contributory factor in all cases.
APHO	Association of Public Health Observatories
ASB	Anti-social behaviour
ASD	Autistic spectrum disorder
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BAME	Black, Asian and minority ethnic
CAB	Citizens Advice Bureau
CABG	Coronary artery bypass graft
CAF	Common Assessment Framework
CaSH clinics	Contraceptive and sexual health clinics
CCG	Clinical Commissioning Group
CHIMAT	Child and Maternal Health Observatory
CMD	Common mental disorder
Commissioning	A continuous cycle of activities that contribute to the securing of services, including the specification of services to be delivered, contract negotiations, target setting, monitoring and managing performance.
Community Area	20 local administrative areas of Wiltshire based on research into local communities and normally centred around a local town.
Community Area Board	18 formally constituted arms of Wiltshire Council with delegated authority to act as a local executive of the Council. The Boards will consist of elected Council members and representatives from health, police, fire and other organizations. All Boards apart from South West Wiltshire are co-terminous with Area Partnerships.
Community Area Partnership	20 key local bodies to act as the co ordinated voice of the community with representation from town and parish councils, local business, the voluntary sector, local people and community leaders. The partnerships carry out consultations, debate local issues and prioritise community needs in Community Area Plans.
COPD	Chronic obstructive pulmonary disease
CP	Cerebral Palsy
CVD	Cardiovascular disease
DCLG	Department for Communities and Local Government
Defra	Department for Environment, Food and Rural Affairs
Elective admission	A planned admission to hospital
Emergency admission	An unplanned admission to hospital
Gateway Panel	A panel that meets regularly to decide which families and young people, referred to them, require access to intensive family and parenting support services in Wiltshire
GP	General Practitioner
GWH	Great Western Hospital in Swindon
HCAI	Health Care Acquired Infections
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
HPV	Human Papilloma Virus

HTL@H	Help to live at home
ICD10	10th version of the International statistical classification of diseases and related health problems
ID	Indices of deprivation
IMD	Index of Multiple Deprivation. This combines a range of indicators into a single deprivation score, including social and economic measures and a measure for 'Health Deprivation and Disability'. These measures may be used individually, or can be combined to rank areas relative to each other so that comparisons can be made.
Incidence	The rate at which new cases of a disease occur.
IQ	Intelligence Quotient
JSA	Joint Strategic Assessment
JSA HW	Joint Strategic Assessment for Health and Wellbeing
JSNA	Joint Strategic Needs Assessment
KSI	Killed or seriously injured
LA	Local authority
LARC	Long acting reversible contraceptive
LD	Learning disabilities
LRTI	Lower respiratory tract infection
LSCB	Local Safeguarding Children Board
LSOA , SOA	Lower level super output area - a new geographic hierarchy designed to improve the reporting of small area statistics
MLSC	Maternity Liaison Strategy Committee
MMR	Measles, mumps and rubella vaccine
Morbidity	A diseased state, disability, or poor health
Mortality	The condition of being mortal, or susceptible to death
Mosaic	Social demographic segmentation tool based on lifestyle data. Mosaic aims to segment the population into a number of distinct groups where the members share similar characteristics.
MRSA	Methicillin resistant staphylococcus aureus
MS	Multiple sclerosis
NCMP	National Child Measurement Programme
NDTMS	National Drug Treatment Monitoring System
NEET	Young people not in education, employment and training
NHS	National Health Service
NHS Wiltshire	Alternative name for Wiltshire PCT
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
Obese	Body mass index of over 30 (adults)
ONS	Office for National Statistics
Overweight	Body mass index 25-30 (adults)
PANSI	Projecting Adult Needs and Service Information System
PCT	Primary Care Trust
PCTA	Percutaneous transluminal coronary angioplasty
Personal Independence Payments	A new benefit payment replacing Disability Living allowance in April 2013 for eligible working age people aged 16 to 64
PNA	Pharmaceutical needs assessment
PopGroup	Model used to produce population estimates and projections for Wiltshire
POPPI	Projecting Older People Population Information
Prevalence	The proportion of a population who have a disease.
PROMs	Patient reported outcome measures
QOF	Quality and Outcomes Framework
RUH	Royal United Hospital in Bath
SEN	Special educational needs
SEND	Special Educational Needs and Disability service
SFT	Salisbury Hospital Foundation Trust
STARR	Step up to Active Recovery and Return
STI	Sexually transmitted infection
SWPHO	South West Public Health Observatory

TB	Tuberculosis
Tomorrow's Voice	Annual secondary school survey in Wiltshire
Triage	Process of determining the medical priority of individuals based on severity of their condition.
Troubled Families	Families are characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour
UK NSC	United Kingdom National Screening Committee
Universal Credit	Universal Credit is a new single payment for people who are looking for work or on a low income
Vital Statistics	Office for National Statistics publication of statistics relating to births and deaths.
Ward	Electoral and administrative boundary. These were in existence alongside the four district councils for Wiltshire and have been superseded by electoral divisions for Wiltshire Council.
Welfare Reform Act 2012	Legislation to introduce a number of wide-ranging changes to the benefits and tax credits system
WHO	World Health Organisation
Wiltshire Council	Unitary council formed 1st April 2009.
Wiltshire Families First	Support service run by Action for Children
WYOT	Wiltshire Youth Offending Team

Acknowledgements

Report prepared by:

Public Health Team	NHS Wiltshire
Tom Frost	Public Health Scientist, Public Health Wiltshire
Rebecca Maclean	Speciality Registrar in Public Health, Public Health Wiltshire
Simon Hodsdon	Public Health Intelligence Officer, Public Health Wiltshire
Aimee Stimpson	Associate Director, Evidence and Intelligence, Public Health Wiltshire
Zoe Clifford	Speciality Registrar in Public Health, Public Health Wiltshire
John Dennis	Public Health Intelligence Officer, Public Health Wiltshire

With grateful thanks to the following for their contributions to this JSA:

Doug Anderson	Demographer, Knowledge Management, Wiltshire Council
Julie Baptista	Commissioning Officer for People with Physical Impairment, Wiltshire Council
Nick Bolton	PDE adviser: drugs, Wiltshire Council
Layla Bridger	Project Manager, Programme Office, Wiltshire Council
Rhian Burgess	Commissioning and Contracts lead (adult care – mental health, Wiltshire Council
Sarah Cardy	Chief Executive Officer, Wiltshire Citizens Advice
Maria Cattelona	Commissioning Officer – Disabilities, Dept. of Community Services, Wiltshire Council

Laura Colley	Researcher, Knowledge Management, Wiltshire Council
Emma Cooper	Community Partnership Manager, Wiltshire Council
Lynda Cox	Head of Performance Management and Co-ordination, Department for Children & Education, Wiltshire Council
James Cuthbert	Interim Head of Performance, Dept. of Community Services, Wiltshire Council
Julia Davey	Commissioning Officer, DCS Disabilities Team, Wiltshire Council
James Fortune	Lead Commissioner (11-19), Children's Service, Wiltshire Council
Nicola Gregson	Head of Commissioning: Care, Support and Accommodation, Wiltshire Council
Jenny Hawley	Environmental Intelligence Officer, Wiltshire Wildlife Trust
Victoria Hamilton	Commissioning & Service Improvement, WWYKD CCG locality
Sarah Hartley	Performance and research officer, Housing, Wiltshire Council
Jeremy Hooper	Veritas Analysis
Sally Hunter	Senior Researcher, Knowledge Management, Wiltshire Council
Simon Jeffery	Commissioning and Contracts Lead (Disabilities), Wiltshire Council
Emma Joy	Prevention Project Worker, Wiltshire Services for Young People, Wiltshire Public Health
Blair Keltie	Integrated Youth Safeguarding and Offending Services Manager, Wiltshire Council
Rachel Kent	Environmental Health Officer, Wiltshire Council
Paul Lipinski	Business Information Analyst, Wiltshire Council
Tim Mason	Wiltshire Community Safety Partnership Manager
Chris McMullin	Principal Performance Analyst, Wiltshire Police
Hayley Mortimer	Domestic Abuse Reduction Co-ordinator, Wiltshire Council
Rob Murphy	Principal Transport Planner, Wiltshire Council
Annie Paddock	Commissioning and Contracts lead (adult care – mental health), Wiltshire Council
Diana Pointon	Senior Researcher, Knowledge Management, Wiltshire Council
Lorraine Prior	Contracts manager, Commissioning, NHS Wiltshire
Phil Powell	Head of Commissioning - Learning Disabilities, Wiltshire Council
Debbie Skellern	Economic Growth Manager, Wiltshire Council
Nicole Smith	Head of Strategic Housing, Wiltshire Council
Susan Tanner	Head of Commissioning and Joint Planning, Children's Service, Wiltshire Council
Elizabeth Tempest	Epidemiology & Surveillance Analyst, Health Protection Agency South West
Gary Tomsett	Environmental Control and Protection, Wiltshire Council
Peter Tyas	Team manager arts and archives, Wiltshire Council
Karen Walters	Senior Commissioning & Contracts Officer (Carers), Wiltshire Council
Mike Wells	Child Health information analyst, Great Western Hospital Trust, Swindon
Ian White	Commissioning Officer, Dept. of Community Services, Wiltshire Council

Individuals who contributed to individual topic reports and section briefings are also acknowledged in those documents.

Grateful thanks must also go to the many people who supplied data or reviewed text for individual sections.

For further information please contact: **research@wiltshire.gov.uk** or visit **www.intelligencenetwork.org.uk**

Wansdyke, Wiltshire by Nick Sarebi