4. Burden of Ill Health

Summary:

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

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

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

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

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

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

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

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

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

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

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

### 4.1 Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hypertension
Hypertension means high blood pressure. It is a very common condition. Key associations include: salt intake; low birth weight; obesity; physical inactivity and age related hardening of the arteries. Untreated hypertension contributes to a higher risk of stroke, CHD and retinal and renal damage.
**Recorded prevalence of hypertension**

The crude recorded prevalence of hypertension in Hampshire during 2009/10 was 13.7%, which was similar to the national average of 13.4%. Fareham (16.2%), Havant (16%), New Forest (15.8%) and Gosport (14.3%) all had hypertension prevalences higher than the national average.

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

![Graph showing prevalence of hypertension in Hampshire districts](image)

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

**Recorded versus modelled prevalence of hypertension**

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

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

![Graph comparing recorded and modelled prevalence of hypertension](image)
**Stroke**

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

**Recorded prevalence of stroke**

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

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

![Graph showing crude prevalence of stroke across Hampshire](image)

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

**Recorded versus modelled prevalence of stroke**

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

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

Hospital admissions for heart attack and stroke

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

![Chart showing hospital admissions for heart attack from 2007/08 to 2009/10 for various districts in Hampshire, Basingstoke and Deane, East Hampshire, Eastleigh, Fareham, Gosport, Hart, Havant, New Forest, Rushmoor, Test Valley and Winchester.](image)

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

![Chart showing hospital admissions for stroke from 2007/08 to 2009/10 for various districts in Hampshire, Basingstoke and Deane, East Hampshire, Eastleigh, Fareham, Gosport, Hart, Havant, New Forest, Rushmoor, Test Valley and Winchester.](image)

**Emergency hospital treatment of acute coronary syndrome**

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

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

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

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

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

Figure 4.9: trend in STEMI treatment in South Central hospitals

Changes in treatment for STEMI from 2007/8 to Q1 2010/11
(England benchmark for 2009/10)


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

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

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

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

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

Figure 4.12: hospital episodes for PTCA

4.3 Diabetes

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

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

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

**Figure 4.13: recorded prevalence of diabetes in people aged 17 and over**

![Graph showing recorded prevalence of diabetes in Hampshire during 2009/10](image)

**Prevalence (%)**

- Hampshire CC
- Basingstoke and Deane CD
- East Hampshire CD
- Eastleigh CD
- Fareham CD
- Gosport CD
- Havant CD
- Hart CD
- Hampshire CC
- New Forest CD
- Rushmoor CD
- Test Valley CD
- Winchester CD

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

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

\(^{17}\) [http://yhpho.york.ac.uk/diabetesprofiles/pdf/5QC_Diabetes%20Profile.pdf](http://yhpho.york.ac.uk/diabetesprofiles/pdf/5QC_Diabetes%20Profile.pdf)
Hospital admission rates for diabetes

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

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

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

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

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

Figure 4.17: hospital episodes for ketoacidosis and diabetic coma

**Diabetes retinopathy screening**

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

The national screening programme for diabetic retinopathy aims to reduce the risk of sight loss amongst people with diabetes by identifying and treating sight threatening diabetic retinopathy. All people aged 12 and over with diabetes are invited to attend for diabetic retinopathy screening every year.\footnote{http://www.retinalscreening.nhs.uk/userFiles/File/EyeScreeningForDiabetes.pdf}

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

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

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4.18.png}
\caption{Percentage of diabetics age 17 and over screened for diabetic retinopathy, 2009/10}
\end{figure}

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

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

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

![Figure 4.19](image1)

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

![Figure 4.20](image2)

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

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

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

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

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

Detailed intelligence on cancer is available from the National Cancer Intelligence Network.²¹

**Cancer incidence in Hampshire**

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

²⁰ [http://www.sepho.org.uk/Download/Public/11214/1/South%20Central%20inequalities%20factsheet%20FINAL.pdf]
²¹ [http://www.apho.org.uk/addons/_94538/atlas.html]
Lung cancer
Lung cancer is the second most common cancer diagnosed in the UK after breast cancer. Around 39,000 people were diagnosed with lung cancer in the UK in 2007. More than 8 in 10 lung cancer cases occur in people aged 60 and over. Smoking causes almost 90% of lung cancer deaths and stopping smoking before middle age avoids most of the risk of smoking-related lung cancer. Living with someone who smokes, increases risk of lung cancer in non-smokers by about a quarter. A small proportion of lung cancer cases are caused by heavy exposure to industrial carcinogens and air pollutants, including diesel exhaust, asbestos, non-ferrous metals, silica, polycyclic aromatic hydrocarbons and nitrogen oxides.

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

Breast cancer

Breast cancer is now the most common cancer in the UK. In 2007 almost 45,700 women were diagnosed with breast cancer. 8 in 10 women diagnosed with breast cancer are over the age of 50.\(^\text{23}\)

During 2004/06, 3230 women were diagnosed with breast cancer in Hampshire. Expressed as an incidence rate this was 130.7 new cases per 100,000 women. This was significantly higher than the national rate of 122.8 new cases per 100,000 women. In general, we know that more affluent women have a higher incidence of breast cancer than women from more deprived populations.\(^\text{24}\) The incidence was highest in Test Valley with 144.9 new cases per 100,000 women, followed by the New Forest with 143.1 new cases per 100,000 women. Both of these are higher than the national and regional averages. The lowest incidence was seen in Rushmoor (117.9 new cases per 100,000 women). All districts except Winchester saw a small rise in breast cancer incidence, but only in Hart was this rise statistically significant.


**Breast cancer screening uptake**

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

**Figure 4.24: percentage of women aged 53-64 screened in three years (2009)**
**Cervical cancer**

Cervical cancer is the eleventh most common cancer in women in the UK and the third most common gynaecological cancer after uterus (womb) and ovary. There were around 2,830 new cases of cervical cancer diagnosed in the UK in 2007. More than half of all new cases of cervical cancer are diagnosed in women under 50 years.\(^{25}\)

Infection with the human papillomavirus (HPV) is one of several risk factors for developing cervical cancer. Infection with other sexually transmitted infections such as HIV/AIDS, herpes simplex virus-2 or chlamydia trachomatis may increase risk of cervical cancer. Smoking increases the risk of squamous cell cervical cancer, as does long term use of the oral contraceptive pill.\(^{25}\)

Although cervical cancer is not amongst the most common cancers affecting women, it can be successfully treated if detected early. The NHS Cervical Screening Programme was set up in 1988 by the Department of Health. As a result of the screening programme, cervical cancer incidence in the UK has halved over the last 20 years. Cervical screening can prevent around 75% of cancer cases in women who attend regularly. HPV vaccination in schools was introduced into the national immunisation programme in 2008 for girls aged 12-13 as a further measure to prevent cervical cancer.\(^{25}\)

**Cervical cancer incidence**

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

**Cervical cancer screening: uptake of service**

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

**Colorectal (or bowel) cancer**

Colorectal cancer is the third most common cancer in the UK. About 38,610 people were diagnosed with bowel cancer in 2007 in the UK. Colorectal cancer incidence rates have remained relatively stable for over a decade. Risk factors for colorectal cancer include a high intake of red and processed meat, being overweight or obese, and drinking more than four units of alcohol per day. Protective factors include a diet rich in fibre.\(^26\)

**Colorectal cancer incidence**

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

\(^{26}\) Cancer Research UK \[http://info.cancerresearchuk.org/cancerstats/types/bowel/\]
Figure 4.26: incidence of colorectal cancer, all people all ages

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

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

Figure 4.27: incidence of prostate cancer in men, all ages

![Graph showing incidence of prostate cancer in Hampshire across different areas]

Source: National Statistics via NCHOD

**Five year survival rates from prostate, lung, colorectal, cervix and breast cancer**

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

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

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

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

4.5 **Respiratory**

**Chronic obstructive pulmonary disease (COPD)**

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

Figure 4.29: crude prevalence of COPD

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

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

**COPD hospital admissions**

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

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

![Rate of hospital admissions for COPD](image)

4.6 **Infectious diseases**

**Tuberculosis (TB)**

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

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

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

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

source: Health Profiles

Figure 4.33: Rates of selected STI & acute STI diagnoses made in England, by PCT of residence in 2009

<table>
<thead>
<tr>
<th></th>
<th>Rates per 100,000 population: 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlamydia (by age group)</td>
</tr>
<tr>
<td></td>
<td>15-24</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td></td>
</tr>
<tr>
<td>2180.6</td>
<td>94.4</td>
</tr>
<tr>
<td><strong>South Central SHA</strong></td>
<td></td>
</tr>
<tr>
<td>1613.1</td>
<td>71.4</td>
</tr>
<tr>
<td><strong>Berkshire East</strong></td>
<td></td>
</tr>
<tr>
<td>775.7</td>
<td>23.1</td>
</tr>
<tr>
<td><strong>Berkshire West</strong></td>
<td>1415.5</td>
</tr>
<tr>
<td><strong>Buckinghamshire</strong></td>
<td>1295.4</td>
</tr>
<tr>
<td><strong>Hampshire</strong></td>
<td>1809.1</td>
</tr>
<tr>
<td><strong>Isle of Wight</strong></td>
<td>1777.0</td>
</tr>
<tr>
<td><strong>Milton Keynes</strong></td>
<td>2296.7</td>
</tr>
<tr>
<td><strong>Oxfordshire</strong></td>
<td>1370.5</td>
</tr>
<tr>
<td><strong>Portsmouth City Teaching</strong></td>
<td>2236.2</td>
</tr>
<tr>
<td><strong>Southampton City</strong></td>
<td>1885.9</td>
</tr>
</tbody>
</table>


Prevalence of HIV and percentage of HIV cases diagnosed late

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

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

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

**Access to genitourinary medicine (GUM) clinics**

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

**Vaccination of vulnerable and older people**

**Seasonal flu vaccination**

The seasonal flu vaccine is formulated each year to protect against the main strains of influenza which are circulating that year. It is recommended that persons aged under 65 and in specific at risk groups (chronic heart disease, chronic respiratory disease, chronic renal disease, chronic liver disease, diabetes, immunosuppression, stroke, chronic degenerative neurological disease) receive the vaccine as well as those aged over 65 years. While for most people influenza infection is just a nasty experience, for some such as those in the at risk groups, it can lead to more serious illnesses. The most common complications of influenza are bronchitis and secondary bacterial pneumonia. These illnesses may require treatment in hospital and can be life threatening. In Hampshire during 2008, 49.2% of the population eligible for this vaccination were vaccinated, compared to 47.1% nationally.30

**Pneumococcal disease vaccination**

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

4.7 **Dental health**

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

30 [http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HealthProfiles/]
Figure 4.34: current and planned units of dental activity in Hampshire

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

Source: Primary Care Dental Services Team, NHS Hampshire

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

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

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

- **2007-08**: 370,000
- **2008-09**: 410,000
- **2009-10**: 430,000

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

Source: NHS Business Services Authority

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

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

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

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

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

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

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

additional intelligence on mental health to that presented here.32

**Prevalence of common mental health problems**

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

**Prevalence of depression**

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

**Figure 4.38: crude prevalence of depression**

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**Prevalence of mental illness**

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

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

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


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

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

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

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

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

**Reported (crude) prevalence of dementia**

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

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

**Figure 4.41: prevalence of dementia in males aged 65+**

![Prevalence of dementia in males aged 65+](image-url)
4.9 Avoidable injury from accidents

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

Hospital admissions for injuries from falls in people aged 65 and over
There are no benchmarking data available for this indicator. Hospital admissions for falls reflect not only the rate of falls in an area, but also the type of community services available, such as falls prevention teams and intermediate care beds. Therefore changes in the rate of hospital admissions are likely to reflect changes in the provision of health services as well as changes in the numbers of people falling. Since 2008, the admission rates for falls in Hampshire have changed markedly. Rates have increased in the New Forest, but have decreased in East Hampshire, Fareham, Gosport, Hart, Havant, Rushmoor and Winchester.
Figure 4.43: hospital admissions for falls in people aged 65 and over

![Graph showing hospital admissions for falls in people aged 65 and over from 2007/08 to 2009/10.]

**Hip fractures**
The rate of hospital admissions for a broken hip in people over the age of 65 in Hampshire during 2008/09 were similar to national and regional rates. Rushmoor and Test Valley have the highest rates, whereas rates in Fareham are significantly lower than national and regional rates.

Figure 4.44: emergency hospital admissions for fractured neck of femur, all people aged 65 and over

![Graph showing emergency hospital admissions for fractured neck of femur, all people aged 65 and over from 2008/09.]

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

*Road traffic accidents*

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

*Road casualties in people over the age of 60*

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

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


4.10 **Musculoskeletal**

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

*Knee replacement*

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

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

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

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

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

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

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

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

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

Source: This work is based on data provided through EDINA UK BORDERS, with the support of the Economic and Social Research Council and the Joint Information Systems Committee, and uses boundary material that is copyright of the Crown.
**Figure 4.48:** hospital episodes for total knee replacements, all people aged 65 and over

![Graph showing hospital episodes for total knee replacements, all people aged 65 and over from 2007/08 to 2009/10.](image)

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

**Hip replacements**

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

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

![Graph showing rate of primary hip replacement in Hampshire, by deprivation quintile.](image)

Sources: CDS received from Provider Trusts via Secondary Uses Service (SUS) and standardised using Hampshire County Council 2008 based Small Area Population Forecasts for 2008 multiplied by 3.

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

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

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

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

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

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