Shropshire Joint Strategic Needs Assessment Priorities

Emma Sandbach

Shropshire Joint Strategic Needs Assessment Priorities

Table of Contents

Introduction

The Joint Strategic Needs Assessment (JSNA) has been a mandatory requirement for PCT's and Local Authorities since 2007. It seeks to identify health needs in the local population and inform the commissioning of services based on these needs. The Health and Social Care Bill 2011 has given a renewed focus on the JSNA by giving it a central role in bringing partners together in deciding priorities. These priorities will form the structure of the Health and Well Being Strategy, which will be key to commissioning health and social care services in the local area.

Shropshire has previously published two JSNA's with the most recent being in 2009-10. The JSNA process is currently being refreshed to take into account the changes in policy and include a wider remit. It is realised that the process will change over time and that not all information will be immediately available, but will be added to and enhanced as new data becomes available. This JSNA summary document outlines priority areas identified from analysis of data and information available on http://shropshire.gov.uk/jsna.nsf

Why are some issues chosen as priorities and not others

There are many different areas of health and wellbeing need in Shropshire; however there are certain health issues that have been identified in the JSNA as being a priority. Reasons that particular issues in Shropshire have been identified as priority areas are listed below, however it should be noted that there issues that are not identified as priorities are still important areas of health and wellbeing need and work programmes will still address these, e.g. sexual health. Information on these areas is included on the web site at http://shropshire.gov.uk/jsna.nsf

Reasons that some of the health and wellbeing areas have been prioritised over others is that they impact on a larger portion of the population, are linked to other health conditions that impact on large sections of the population and that there is a cause for concern on these issues due to them being worse than other areas of the country or they are showing a trend in the wrong direction. This report focuses on areas that have been prioritised in terms of their health and wellbeing need in Shropshire.

Engagement and public involvement

Part of the development of this year's JSNA has included engagement with stakeholders and the public. For the first time events and discussion groups took place with a wide audience of participants from the statutory and voluntary sectors and from patient and customer representative groups. These events took place in different locations in the county in order to incorporate a more local view of health priorities and needs. Findings from the events have been included in the JSNA and have been used to help identify local priorities.

The Marmot Review and the Shropshire JSNA

The Marmot Review was published in 2010 and it considers an evidence based strategy to tackle the wider determinants of health by highlighting the fact that many people in England are not living as long as the most affluent in society. Therefore, it is not sufficient to focus most resources on the most deprived 10% of the population as the gradient of inequality extends from the most affluent in society downwards. The Marmot report stresses the importance of addressing health inequalities by creating the conditions for people to take control of their own lives. To achieve this, action across the social determinants of health is needed which places emphasis on local government due to their involvement in service provision and commissioning that addresses wider health determinants.

The Marmot Review acknowledges that inequalities start before birth and continue throughout the lifecycle. Therefore, six policy objectives were identified, with the first having the highest priority:

- giving every child the best start in life
- enabling all children, young people and adults to maximize their capabilities and have control over their lives
- creating fair employment and good work for all
- ensuring a healthy standard of living for all
- creating and developing sustainable places and communities
- strengthening the role and impact of ill-health prevention

The Shropshire JSNA shows the links to the six Marmot policy objectives. This enables issues relating to key stages in the life course to be addressed in a clear way and related to different determinants of health so that they are not tackled in isolation. This approach is also timely as the function of Public Health will be moving to the Local Authority. The Marmot Review stresses that the Local Authority is pivotal in reducing health inequalities due to their position as local leaders in improving the population's health and reducing health inequalities.

Shropshire – the people and the place

Shropshire is a large county in the West Midlands, with a population of around 293,400 of mainly white British ethnicity and a high proportion of people aged over 50 years old. Like many rural areas, Shropshire is expecting an increase in the future population of people aged 65 years and over.

Overall the county is fairly affluent – however there are areas of deprivation and factors of rural sparsity which create issues with access to services. Shropshire also has low earnings rate, although it benefits from a low unemployment rate. The majority of employment is in the public sector.

Shropshire's geography is an important consideration - it covers a large area of 1235 square miles, of which only approximately 6% comprises suburban and rural development and continuous urban land. The geography of Shropshire is diverse. The southern and western parts of the county are

generally more remote and self-contained and have been identified as a rural regeneration zone.

The landscape provides the backdrop for the market towns as key focal points for communities, businesses, leisure and tourism. Shropshire is entirely inland and its borders also have importance for the people living at the edges of the county – as people may have historic, family or work connections with the bordering areas of Mid Wales, Cheshire, Staffordshire, Telford and Wrekin and onto the West Midlands, Worcestershire and Herefordshire. Shropshire's rural geography and many borders with neighbouring authorities have been highlighted in stakeholder consultation as a potential problem for accessing services and patient treatment.

The health of Shropshire's population

Overall the health of the population in Shropshire is good and both male and female life expectancy is significantly higher than the national figures. Similarly, rates of all age all-cause mortality for males and females are significantly lower than the national figures. Life expectancy has increased in the total population in the last decade and all age all-cause mortality has decreased. However, inequalities in health persist in Shropshire and the increases in life expectancy and reductions in all age all-cause mortality have not had equal impact across all sections of the population.

In the most deprived fifth of areas in Shropshire there has been no significant increase in life expectancy in either males or females, although there has been a significant increase in life expectancy in the most affluent fifth of the population. There are also significantly lower rates of life expectancy in the most deprived fifth of areas compared to the most affluent fifth for both males and females, and this gap appears to be increasing.

Four key issues affecting the health of the population in Shropshire

The following four overarching areas have been highlighted due to their impact on health in Shropshire or the impact on health and wellbeing they will have in the future.

Ageing population

This is one of the key challenges in health and wellbeing for Shropshire. The ageing population has implications for service provision due to the associated rise in long term conditions. Following healthy lifestyle choices are key to healthy ageing as poor lifestyles are more likely to impact on older age groups, e.g. increased risk of obesity and diabetes due to poor diet throughout a person's life. The following issues were identified in Shropshire as being a priority for the ageing population.

Health Inequalities

The World Health Organisation defines health inequalities as 'differences in health status or in the distribution of health determinants between different population groups'. Health inequalities can be attributed to biological variations, e.g. less disability prevalence in younger populations compared to older populations; other health inequalities are attributable to the environment and conditions outside the control of the individual. Many of the health inequalities as a result of environmental conditions are avoidable and can lead to inequity in health. For example in Shropshire health inequalities have been identified in life expectancy and mortality rates between the most and least deprived populations in the county.

Lifestyle risk factors to health

Lifestyle risk factors to health are lifestyle behaviours that adversely affect health, e.g. smoking, lack of physical activity, etc. These behaviours are important as many of them lead to developing long term conditions and communicable diseases, such as smoking can cause lung cancer. Therefore, disease can be prevented by tackling poor lifestyle behaviours. Lifestyle risk factors are of a concern to the health of the population in Shropshire as they are impacted on by health inequalities, e.g. more smokers in more deprived areas and fewer people are physically active in older age groups. Engagement work with GP's in Shropshire identified lifestyle risk factors as being a major concern affecting the health of the population.

Long term conditions and non-communicable disease

Long term conditions are defined as health problems that require on-going management over a period of years or decades. This can include non-communicable diseases such as cardio-vascular disease (CVD), some communicable disease such as HIV, some mental health disorders such as depression and some on-going impairment such as blindness. Long term conditions are conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.

Many long term conditions and non-communicable disease are the result of lifestyle risk factors and changing demographics. Increases in the ageing population, increases in obesity and other lifestyle risk factors and possible increases in health inequalities will all lead to an increase in long term condition prevalence. This can lead to pressure on current service provision. Long term conditions therefore are a significant area of concern in Shropshire due to the ageing population, health inequalities in the population and considerable proportions of the population with life style risk factors. There is also a higher recorded prevalence of long term conditions in Shropshire compared to the national. Engagement work with GP's in Shropshire highlighted prevalence in long-term conditions as a significant problem.

Starting well

Ensuring that children have the best start in life is vital for reducing health inequalities. Much of a person's future health and wellbeing is determined by early year's development. The most important and effective health interventions are those which address inequalities and health behaviours in a child's early years.

Included in this section of the report are priorities for Shropshire that support the giving every child the best start in life. However, some of the priorities that support giving every child the best start in life are included in the section on strengthening the role and impact of ill-health prevention, e.g. breastfeeding, early years nutrition, etc.

Smoking in pregnancy

Smoking in pregnancy increases the likelihood of miscarriage and still birth and increases the risk of premature birth and low birth weight. Smoking in pregnancy can also have long term effects on the health of children, such as increased risk of infections, developing asthma and becoming a smoker when older.

Despite smoking prevalence in Shropshire being significantly lower than the national average, prevalence of smoking in pregnancy (16%) is high compared to the national average (13.5%). Significantly more Shropshire women aged under 25 years smoke during pregnancy compared older age groups. There are also significantly more women smoking in pregnancy in the most deprived fifth of areas in Shropshire compared to the county average. This results in health inequalities being passed onto the next generation, as children with parents that smoke in the home are more likely to be exposed to harm from second-hand smoke, and more likely to become smokers themselves when they grow up.

In Shropshire a wide range of NHS stop-smoking services are available, commissioned on a 'payment by results' model. The tariff payment offered to providers of smoking in pregnancy services in enhanced to recognise the importance of prioritising this group of smokers. As a result specialised support should be available to all smokers who are pregnant or planning a family. This includes the development of services within local Children's Centres.

Smoking services in Shropshire collect patient feedback and overall levels of satisfaction are very high. Comments that are received by patients are used to make changes to the services. The services are NICE compliant and an action plan has been developed in collaboration with Midwifery Services to implement NICE guidance.

NICE guidance (PH26)[i] recommends that all pregnant women who smoke, those planning a pregnancy and those with a child under 12 months should be referred to an NHS stop smoking service:

- Professionals working with pregnant women should identify those who smoke, including through the use of a CO monitor
- Pregnant women who smoke should be referred to NHS stop smoking services
- Stop smoking service staff should make direct telephone contact with all pregnant women that have been referred
- Assistance should be offered to help partners who smoke
- Evidence based behavioural support strategies should be used
- Where not contradicted, pharmacological treatment such as nicotine replacement therapy should be offered
- Services should meet the needs of disadvantaged smokers
- All professionals providing on-going support should be trained to National Centre for Smoking Cessation Training standards and all professionals coming into contact with pregnant women should be trained in brief opportunistic advice

Mumps, Measles and Rubella (MMR) vaccinations in 5 year olds

Mumps, measles and rubella are infectious diseases that can have serious complications such as meningitis, swelling of the brain, deafness and complications in pregnancy. In England MMR vaccination rates fell after a 1998 study linked the MMR vaccine with autism, however this work has since been discredited. Since then national MMR vaccination rates have increased in the population, however overall they are still somewhat short of achieving the national target.

Overall coverage rates for primary immunisations in Shropshire are relatively high. However, in Shropshire the percentage coverage (90% in 2010-11) for five year olds for MMR is not meeting the national target (94%). There has been an increase in uptake in the first three quarters of 2011-12, although this is still not on target. In comparison to the national figures MMR at 5 years old is significantly above average, however there is some variation between GP practices.

Immunisation clinics are provided by GP practices and invites are sent to parents when their children are 12 months, 24 months and 5 years old to attend a clinic. Currently in Shropshire there is no domiciliary service to follow up children that miss their appointments. However, when immunisation staff receives training they are notified of the shortfall in MMR vaccinations and to try and encourage their uptake.

NICE has produced guidance (PH21) on increasing uptake in immunisations in people under 19 years old in areas where uptake is low. The guidance includes recommendations such as:

- Multifaceted, coordinated immunisation programmes should be adopted to increase timely immunisations amongst low uptake groups.
- Accurate and structured systems and methods for recording immunisations to inform on the vaccination status of people aged under 19 years.
- Training of staff involved in immunisations and that training is updated on a regular basis.
- Nurseries, schools and colleges and health professionals should work with parents to encourage these schools to become vaccination locations and to promote uptake of immunisations.
- Improve access to and information about immunisations to those groups with low uptake.

Child and adolescent mental health

Mental health problems in childhood and adolescence can have tragic consequences, including suicide, substance misuse, inability to live independently, involvement in the criminal justice system, failure to complete school, lack of vocational success and other health problems. Children from the poorest fifth of areas in England are three times more likely to suffer from mental health problems than those from the most affluent fifth[ii]. Also Looked After Children (LAC) and children with learning disabilities are more likely to suffer mental health problems than other children. National Statistics estimate that nationally around 68% of LAC in residential care have a mental health problem.

Some of the more common mental health problems affecting children and young people are depression, anxiety, behaviour disorders and attention deficit and hyperactivity disorder (ADHD). Increasing children and young people's self-esteem is important as those with poor self-esteem are more likely to develop mental health problems. In Shropshire it is estimated that there are around 4,000 children and young people with a diagnosed mental health problem. The conditions with the highest prevalence rate in Shropshire are conduct disorders, followed by emotional disorders and then hyperkinetic disorders.

Most mental illnesses begin before adulthood and often continue throughout life. Half of all lifetime cases of diagnosable mental illness begin by age 14 and three-quarters by mid-20s, therefore early intervention and prevention are important. In terms of the burden of disease, mental illness is the single largest cause in the UK and its extent has a huge impact on society overall[ii].

Mental health has a considerable impact on other areas of the public health agenda, as lifestyle risk factors such as smoking and hazardous alcohol consumption are significantly greater in people with mental health problems than the general population. Also those with long term conditions are significantly more at risk from mental health problems than people that don't suffer from long term conditions. In Shropshire with our ageing population this could be a significant issue as many people in this age group have a long term condition.

In Shropshire there are services for child and adolescent mental health. Targeted Mental Health in Schools (TaMHS) is a whole school and targeted approach to raise awareness in staff, pupils and parents about the importance of supporting our emotional and mental health. Reducing the stigma of mental health so children, young people and parents are not afraid to ask for support is key to early intervention. Training is provided to whole school staff to increase confidence, knowledge and skills to recognise early signs, symptoms and behaviours associated with emotional needs. Key staff within schools are also trained to enable them to deliver targeted intervention programmes offering additional support to vulnerable children in groups or on a one to one basis. Supporting these needs whilst developing and promoting the four key psychological factors, will build the young person's resilience to enable them to deal with issues now and in the future, reducing this risk of

developing negative coping strategies such as alcohol abuse or self-harming. Referring and consulting appropriately with specialist services and developing staff's own emotional resilience to supporting the emotional needs of children are also important aspects of TaMHS.

In Shropshire there is also the Child and Adolescent Mental Health Service (CAMHS) which is a specialist mental health service for children and young people. Many children and young people are referred to CAMHS for conditions such as anxiety disorders, depression, family relationships and ADHD. Recently a review of the CAMHS service was undertaken and some gaps were identified. These were poor access to the service and that many referrals were not accepted, confusion around referral pathways and poor communication from specialist CAMHS service, e.g. slow response times and no acknowledgement of referrals. The recommendations from this review are now being implemented.

NICE has issued three guidance documents relating to children and young people's emotional well-being. Public Health guidance (PH28): promoting the quality of life of looked after children and young people includes recommendations on promoting stable and a full range of placements, encouraging educational achievement, supporting transition to independent living, meeting particular needs of LAC (e.g. BME, disabilities) and putting the LAC at the heart of decision making.

NICE has also published guidance on social and emotional well-being in primary and secondary education settings (PH12 and PH20). Recommendations for primary settings include providing secure environments that prevent bullying and promote support for children and families, programmes to develop children's social and emotional well-being, planning activities to develop children's social and emotional skills and to train staff to identify signs of social and emotional problems in children.

The guidance on secondary education recommends that establishments should have access to specialist skills required, that practitioners have knowledge and skills to develop young people's social and emotional well-being, that a safe environment is provided which encourages self-worth and reduces the threat of bullying and promotes positive behaviour and that social and emotional skills education is tailored to the young person's needs.

Educational outcomes for vulnerable children and young people

There is a relationship between educational attainment and health, as the longer people spend in the education system the more likely they are to be healthy and make healthier lifestyle choices. Therefore, educational attainment can be seen as an indicator of a person's future health and well-being. Educational attainment is not distributed amongst the population equally, with children and young people who are looked after (LAC), those living in more deprived areas and those who are homeless achieving less well and less likely to remain in the education system as long as others.

Overall in Shropshire there is a higher level of educational attainment at both early years and GCSE compared with the national figures and similar local authorities. The proportion of children eligible for free school meals (FSM) has increased in Shropshire since 2005-06 at both early years and GCSE. Compared to the national and other similar local authorities both pupils not entitled to FSM and their peers who take up an entitlement to FSM have higher levels of attainment, and outcomes have been improving for both groups over the last four years. However, there is a significant gap in the pupil attainment, with those receiving free school meals having lower attainment levels than those who do not.

The same pattern has been identified in children with Special Educational Needs (SEN). The number and proportion of SEN children at GCSE level has increased since 2005-06 and there has also been an increase in SEN children achieving 5 GCSE grades A* to C (including English and Mathematics). However, there is still a gap between SEN children achieving 5 GCSE grades A* to C and children without SEN, with the latter significantly more likely to achieve 5 GCSE's A* to C. The gap between SEN children and children without SEN achieving 5 GCSE's A* to C has increased since 2005-06, as the proportion of children without SEN achieving that level of attainment is improving at a faster rate than for SEN children.

Locally there are many initiatives to narrow gaps in attainment. Schools track the progress of target pupils in detail and plan for interventions, both in day to day classroom teaching and through a range of small group and one-to-one support. Since April 2011 schools have received the pupil premium which is targeted at offering support to pupils receiving FSM, looked after children and those from service families.

There is some evidence to support interventions to improve educational outcomes for vulnerable children and young people[iii]. Some of the following have been identified as ways to improve outcomes:

- Effective feedback to learners
- Involving pupils in planning, monitoring and reviewing their learning
- Peer tutoring and peer learning
- Early intervention
- One to one tutoring

Living well

Living a healthy life can increase life expectancy and improve quality of life. Making the right lifestyle choices reduces the likelihood of premature death and suffering certain long term conditions. Lifestyle risk factors, such as smoking and poor diet are often precursors for ill-health and they also have a relationship with deprivation in Shropshire and in England overall. People living in the most deprived areas are significantly more likely to smoke, be obese, be physically inactive and have poor nutrition compared to those from more affluent areas. They are therefore more likely to suffer from non-communicable diseases, such as CVD and cancer as a consequence.

This section of the report identifies the lifestyle risk factors in Shropshire that are drivers for some of the health inequalities seen between different groups in the population. It also highlights the long term conditions and communicable diseases of most concern in Shropshire that can result from poor lifestyle choices.

Healthy eating and nutrition

The amount and type of food that you eat can have a major effect on your health. Eating a healthy diet reduces the risk of being obese, diabetic and suffering diseases such as heart attack, stroke, osteoporosis and cancer. Overall a healthy diet increases life expectancy. The Department of Health recommends that to improve diet five or more portions of fruit and vegetables should be eaten each day.

Healthy eating and nutrition is important for people at all ages, but especially for pregnant women, infants and children as it is at a young age that many eating habits are formed. Encouraging breastfeeding of babies and healthy eating from an early age is important, as this can prevent future obesity.

In Shropshire around three quarters of women breastfeed at delivery of their baby (75.9%, 2011/12), which is similar to the national average, and 45.1% (Q4 2010-11) breastfeed at 6-8 weeks after delivery, which is also similar to the national figure. Women in the most deprived areas and younger mothers are less likely to breastfeed their babies than those in older age groups and more affluent areas. As Shropshire is relatively affluent and teenage births are low, the figures for breastfeeding might be expected to be higher than the national average.

The latest lifestyle information for children in Shropshire states that 39% ate 3-4 portions of fruit and vegetables per day, which is higher than the national proportion (35%). 21% of children locally stated they consumed 5 or more portions; the figure nationally was 19%. For adults in Shropshire it is estimated that 28.3% consume the recommended five or more portions of fruit and vegetables per day, which is also similar to the national figure (26.3%). Previous local lifestyle surveys have shown a relationship between five a day consumption and deprivation, with more fruit and vegetables consumed in the least deprived areas.

Local services in Shropshire (Maternity at SaTH, Health Visitors and Children's Centres) are working through the accreditation stages of UNICEF Baby Friendly Initiative in order to achieve full Baby Friendly status, although locally there is concern that the funding may not continue. The Healthy Start programme (a UK-wide government scheme to improve the health of low-income pregnant women and families with young children) has also been introduced locally; this is a statutory requirement and is supported by NICE (PH11)[iv]. The scheme encourages participants to eat a more nutritious diet and to lead healthier lifestyles by providing vouchers to buy healthier foods, milk and infant formula as well as free vitamin supplements. By working with community pharmacies Healthy Start vitamins are more accessible to those receiving vouchers. On-going work is taking place with agencies to engage families of young children to increase the local uptake of the scheme.

Shropshire Healthy Eating Award (SHEA) aims to encourage restaurants, cafes and other food establishments to offer customers healthy menu options. SHEA has four levels ranging from bronze to platinum and is awarded to premises that:

- Provide and promote healthy food choices
- Possess good standards of food hygiene
- Staff are trained in respect of food hygiene
- Are breastfeeding friendly (platinum level only)

There are currently 220 local award holders.

A mapping exercise of local initiatives that either directly or indirectly reduces obesity levels in Shropshire is currently underway. The findings will help identify policy and environmental level initiatives as well as those aimed at individuals, communities and whole populations. The results will also inform the development and implementation of a local obesity strategy.

NICE has published guidance on healthy eating and nutrition, some of which are covered in (PH11) Maternal and Child Nutrition. The guidance recommends vitamin supplements for all pregnant or breastfeeding women and young children, however families on low incomes may be at greater risk of conditions associated with vitamin deficiency e.g. Ricketts, spina bifida. Other recommendations are:

- To encourage breastfeeding and that appropriate training is given to support this
- Encourage and support parents of infants aged 6 months to introduce a variety of nutritious foods to their diet

Relevant guidance on obesity and preventing non-communicable disease are included in other sections of this document along with current dietary recommendations.

Physical activity

Being physically active is one of the best ways to prevent disease and there is a relationship between the amount of physical activity people do and all-cause mortality. Active lifestyles are important in reducing and preventing diseases such as cardiovascular disease, obesity, diabetes, some cancers, musculoskeletal conditions, depression and other mental health conditions. The Chief Medical Officer (CMO) has made recommendations on physical activity for people at the different stages of life; early years, children and young people, adults and older people[v]. These recommendations include children and young people engaging in moderate to vigorous activity for at least 60 minutes on 7 days per week, adults engaging in at least 150 minutes of moderate activity per week and to minimise sedentary behaviour across all age groups.

The latest Sport England Active People Survey (2008-09) highlights that 16.1% of people aged over 16 years in Shropshire were moderately physically active for at least 30 minutes on three days per week. This is similar to the national figure of 16.6% of people; however the Active People indicator does not match the CMO's requirement.

Lifestyle surveys and the Active People diagnostic tool for local authorities highlight that physical activity in Shropshire decreases with age. People living in the most deprived areas of Shropshire are less likely to be physically active than those from more affluent areas, but not significantly so. There is no significant difference between genders taking part in physical activity, but more males than females report being active. This is also found in local lifestyle surveys of pupils aged 11-15 years old, with more boys being active than girls.

The Shropshire Active4Health programme provides a website with a search facility for local exercise classes and programmes that are appropriate 'first steps' into activity for inactive adults. Existing exercise providers are able to register as Active4Health providers and have their activity classes detailed on the website. The site also provides links to other local and national websites providing information on physical activity. Active4Health is included as part of Shropshire's adult weight management services, Help2Slim.

GP Consultation focus groups identified access to physical activity and exercise referral schemes as being a current problem for their overweight and obese patients. 'Let's get moving' is a physical activity care pathway devised by the Department of Health for use in primary care. It includes a standardised screening tool for assessing the physical activity level of patients, and evidence-based behavioural change techniques to support them in increasing their physical activity levels. It is being introduced into GP practices in Shropshire as part of the rollout of the NHS Health Check programme.

Specific NICE guidance has been issued on physical activity and recommendations are also included in NICE guidance on the prevention of non-communicable diseases such as type 2 diabetes

The specific guidance includes promoting physical activity for children and young people (PH17)[vi], physical activity and the environment (PH8)[vii] and promoting physical activity at work (PH13)[viii]. There is also overarching guidance (PH2)[ix] on four commonly used methods to increase physical activity:

- Brief interventions
- Exercise referral
- Pedometers
- Walking and cycling schemes

NICE guidance (PH16)[x] provides specific recommendations to promote community exercise, including 'walking for health' scheme for the mental well-being of older people.

Alcohol

It is estimated that up to 22,000 premature deaths per year in the UK are caused by alcohol misuse[xi]. Alcohol contributes to a wide range of medical conditions, including acute alcohol poisoning, cirrhosis of the liver, pancreatitis, stroke, cardiovascular diseases and cancer. It also contributes to health issues such as obesity and accidental injury and much social harm, e.g. crime and disorder.

Alcohol-related harm, from mental ill-health and alcohol-related physical complications, is estimated to cost the NHS around £2.7 billion per year; this is equivalent to about £6 million per 100,000 population aged 10 years and above. Despite the growing burden of alcohol misuse on the health service, it is estimated that only 2% of NHS expenditure on alcohol-related harm is currently spent on specialist alcohol services.

In Shropshire it is estimated that just over three quarters (75.4%) of the adult population are 'low risk' drinkers, similar to the national proportion of 72.1%. Local estimates for 'increasing risk' drinking state that 19.5% of the population in Shropshire fall into this category, similar to the national figure of 20.8%. In terms of 'higher risk' drinking it is estimated that in Shropshire 5.1% (around 6,000 people) of the population fell into this category, similar to the national figure of 7.1%. Finally, 'binge drinking' accounted for 18.4% of the adult population; again this is similar to the national figure of 18%.

Lifestyle surveys in Shropshire have shown that there is no difference between deprivation quintiles in the proportions of people who exceed the weekly drinking limits. However, males are more likely to exceed than females and younger age groups are more likely to exceed the limits than older age groups. Similar proportions of people in all deprivation groups reported binge drinking, although males were significantly more likely than females to report binge drinking and younger age groups were also more likely to binge drink than older age groups.

In Shropshire all admissions to hospital, both alcohol specific and alcohol attributable, for males and females are significantly lower than the national figures. This is also the case for alcohol related recorded crimes and alcohol related violent crimes. However, alcohol specific and alcohol attributable mortality figures for Shropshire are similar to the national average.

Alcohol services in Shropshire saw 396 referrals to services in 2010-11, with most of the referrals coming from self, family or friends and health and mental health services. In terms of numbers of people entering treatment, those aged 35-49 years account for higher numbers than any other groups. If the estimates of there being around 6,000 high risk drinkers in Shropshire are accurate, then the number entering treatment accounts for around 7% of this population.

Current service provision for alcohol includes a single point of referral, an increase in alcohol screening, identification and brief advice, brief and extended brief interventions as well as longer term counselling and support

options. Schemes specifically targeting individuals where the court has identified alcohol as a key factor in criminal activity are also in place. There is dedicated support offered in GP practices across the county linked to the NHS Health Check scheme and specialist nursing and medical support available. Support is also available for carers and concerned others. If screening programmes are utilised to their maximum effect there is concern that capacity in alcohol services may not adequately address local need.

In engagement work with GP's alcohol was highlighted as a significant problem currently affecting health in Shropshire. This was of particular concern to GP's in the North and South of the county. These GP's felt that improved services were needed in Shropshire.

As part of the Community Alcohol Partnerships implemented in Ludlow and Oswestry engagement surveys were carried out with residents to measure perceptions of underage drinking and with young people to measure actual alcohol use. The youth surveys did show high levels of alcohol use from young people aged 16 and above, as well as a preference for higher strength drinks and drinking a high number of drinks on a regular basis away from parental supervision.

There is a number of NICE guidance documents published on preventing harmful drinking and on the effectiveness of alcohol treatment services. NICE guidance PH24[xii] on preventing harmful drinking and PH7[xiii] on school based interventions on alcohol include the following recommendations:

- Alcohol education should form part of the school curriculum
- Children and young people thought to be drinking harmful amounts should be offered one-to-one advice and referral to services where appropriate
- Screening adults for alcohol misuse problems should be undertaken in certain situations
- Brief interventions should be offered
- Motivational support and referral to specialist services should be offered to people considered harmful drinkers
- Mapping of alcohol-related harm should inform licensing policy

Obesity

Obesity in England has increased from around 7% of the adult population in 1980 to the current figure of just under a quarter of adults (24.2%). In children in England obesity currently affects just under 10% of those aged 4-5 years old and just under 19% of those aged 10-11 years old. Obese children are more likely to suffer bullying as a result of their weight and are more at risk of type 2 diabetes and other diseases in the future than children who are a healthy weight. Adult obesity is linked to a wide range of medical conditions including diabetes, heart disease, stroke, breathing problems, liver disease, arthritis, depression and cancer.

Although obesity prevalence in both adults and children in Shropshire is similar to the national figures, this still amounts to a very large number of affected people. As a consequence, obesity in Shropshire accounts for a large and growing burden of disease. Obesity is not spread equally throughout the population and inequalities exist, for example people in older age groups and those living in the most deprived areas of Shropshire are more likely to be obese than the average. As there is an ageing population in Shropshire, obesity is likely to increase in line with this. With Shropshire being a relatively affluent county with fewer areas of disadvantage the fact that there are similar levels of obesity to the national average is a matter of concern.

An integrated pathway for the management of adult obesity has been developed in Shropshire. It aims to provide referrals into treatment programmes at the earliest possible stage and provides interventions at four levels. Tier 1 services aim to prevent obesity in patients with a BMI<30 and include physical activity, information and advice and a directory of NICE approved commercial providers for referral. In Shropshire a tier 2 service is under development (Help 2 Slim) and is currently operating in over two thirds of Shropshire GP surgeries. It is a nurse led service for patients with BMI>30 (BMI>27 with co-morbidities) to enable them to achieve a clinically beneficial 5-10% weight loss. Currently there is no tier 3 (specialist obesity service) or tier 4 (obesity surgery) provision in Shropshire.

The NCMP is a national programme that measures the height and weight of children in reception year and year 6. The programme provides routine feedback to children's parents and school nurses about their weight. The nurses can then take calls from parents to advise them on appropriate action. Recently there has been a pilot weight management programme for children in Shropshire. This was a family based intervention which targeted overweight and obese children in one of the most deprived areas of Shropshire.

Obesity has been highlighted during local GP engagement work as being a significant problem affecting the health of the population at present and in the future. Access to appropriate services for treatment of obesity was also highlighted as a problem.

NICE has issued various guidance documents that include recommendations for reducing obesity and obesity related disease. Summaries for these documents have been included in this report under the appropriate headings, e.g. preventing type 2 diabetes and cardiovascular disease. There is also specific guidance on weight management before, during and after pregnancy (PH27)[xiv].

In 2006 NICE produced its main guidance on prevention, identification, assessment and management of overweight and obesity in children and adults (CG43). The recommendations include:

- How staff in health setting should assess whether someone is overweight and obese
- What staff in health settings should do to help people lose weight
- Care for people whose weight puts them at risk
- How people can make sure their children are a healthy weight
- How public sector organisations should make it easier for people to improve their diet and become more active

The evidence also highlights that multi component interventions e.g. that include both physical activity and diet together, those that offer individual support and those that include behaviour change are the most effective in managing obesity.

In terms of specific evidence for the treatment of obesity in adults the following interventions have been recommended by NICE[xv]:

Diet

- For sustainable weight loss, use a diet with 600 calories/day deficit (600 kcal less than the person needs to stay the same weight)
- Low-calorie diets (1000-1600 kcal/day) may also be considered, but are less likely to be nutritionally complete
- Very-low calorie diets (less than 1000 kcal/day) may be used for a maximum of 12 weeks continuously, or intermittently with a low-calorie diet (e.g. for 2-4 days per week), if the person is obese and has reached a plateau in weight loss

Physical activity

- Physical activity is effective in producing a modest total weight loss and is important for maintaining weight loss

Behavioural / CBT interventions

- Behavioural / CBT therapies are effective in weight loss, specifically if they are combined with other treatment options

Medication

- Medication may be considered for patients who have not reached their target weight loss or have reached a plateau on dietary, activity and behavioural changes alone

Bariatric surgery

- Bariatric surgery is a clinically effective intervention for treating severe obesity

In terms of managing obesity in children and young people, multicomponent interventions with the whole family are recommended, focused on healthy eating, physical activity and reducing the time spent sitting (e.g. watching television or playing computer games).

Recommendations are also made for action at a population level, to address the wider social determinants of obesity. This includes:

- Working with the community to identify barriers to physical activity
- Ensuring that design of buildings and open spaces encourages people to be more active
- Promoting active travel
- Encouraging local shops and caterers to promote healthy food choices
- Providing regular opportunities in schools and early years settings for enjoyable active play and structured physical activity sessions
- Ensuring school policies and the whole school environment encourage physical activity and a healthy diet, implement healthy schools policies and create links with sports clubs and partnerships

NICE is also currently developing guidance on lifestyle weight management services for overweight and obese adults, children and young people.

Diabetes

There are around 2.5 million people in England (5.5% of the population) classed as diabetic. This figure is most likely to be an under count, as it is estimated there are another 750,000 people with undiagnosed diabetes in England. There are several risk factors for diabetes which include genetic risks, ethnicity, age and being overweight or obese.

Type 2 is the most common form of diabetes, accounting for around 90% of cases. It is strongly associated with obesity, which is a significant health problem in Shropshire as around a quarter of Shropshire adults are classed as obese. Therefore, a significant number of Shropshire people are at risk of diabetes because of this. Also increasing age leads to increasing risk of obesity and since Shropshire has an ageing population this could impact on the prevalence of diabetes locally.

People that have a close family member who has diabetes are significantly more likely to get diabetes themselves. People from South Asian, African, Caribbean and Middle Eastern backgrounds are more likely to be at risk of diabetes than the general population. In Shropshire the Black and Minority Ethnic (BME) population is significantly lower than the national average, so this will not impact on diabetes prevalence as much as other risk factors locally.

In Shropshire recorded diabetes prevalence is similar (5.4%) to the England figure. However the modelled prevalence for 2011 was 7.9% for people aged 16 years and over, which would suggest that there is an under diagnosis. The NHS Health Check should help identify some of these patients. There is variation between diabetes prevalence between GP practices in Shropshire.

NICE recommends (CG15) that all diabetic patients receive the 9 key care processes, which include measurements such as blood pressure, foot screening and eye screening. The NHS Atlas of Variation reveals that Shropshire is in the lowest or second lowest fifth of the country for the percentage of type 1 and 2 diabetics receiving the 9 key care processes. There is considerable variation between GP practices.

However, Shropshire performs well for the percentage of diabetics receiving diabetic retinopathy screening (above the national target). Also, the rate of visual impairment certificates where the main cause is diabetes is low in Shropshire. The percentage length of hospital stay for diabetics compared to non-diabetics is low, but the percentage of major lower limb amputations caused by diabetes is high.

NICE has issued public health guidance about preventing diabetes in the population (PH35)[xvi]. It includes several recommendations including:

- Taking action at a national level to address the risk factors underlying the rise in type 2 diabetes (and related non-communicable diseases), such as poor diet and lack of physical activity.

- Undertaking local needs assessment and creating strategies locally to promote healthy eating and physical activity in at risk groups and enable behaviour change through creation of supportive environments.
- Training for professionals to raise awareness of the condition and how to prevent it.
- Targeting interventions to communities and individuals at high risk.

Further NICE guidance is in preparation on risk identification and interventions for individuals at high risk of type 2 diabetes[xvii].

Cardio-vascular Disease

Cardio-vascular disease (CVD) is the most common cause of death in Shropshire accounting for around 35% of all deaths annually. Much premature death (under 75 years) from CVD is caused by lifestyle risk factors, e.g. smoking and poor diet, and therefore is preventable.

Locally premature mortality from CVD has decreased significantly in the last two decades, and in Shropshire rates are significantly lower than the national figures. However, males are significantly more likely to die prematurely from CVD than females. Males living in the most deprived fifth of areas in Shropshire are significantly more likely to die prematurely than males in the least deprived fifth, whereas there is no difference in premature death between females living in the most and least deprived areas of Shropshire.

The NHS Atlas of variation reports that Shropshire has a low number of reported high blood pressure as a percentage of estimated prevalence. This may indicate that a considerable number of cases of high blood are going undetected.

The NHS Health Check programme has been developed to prevent heart disease, diabetes, stroke and kidney disease. People aged 40-74 years that are not already diagnosed with one of these conditions are invited once every five years to have a check to assess their risk of developing one of these diseases. They will be given advice to help them reduce or manage their risk of disease.

The checks include BMI measurement, smoking status, alcohol screening, physical activity levels, family history of heart disease, blood pressure measurement, cholesterol measurement and a diabetes test as appropriate. The NHS Health Check has been available in Shropshire since May 2011 and by the end of 2011/12 around 7,800 patients had been invited for a Health Check of whom 2,500 had received a Health Check.

The Making Every Contact Count (MECC) initiative also provides advice and support on how to address lifestyle risk factors and stay healthy. MECC encourages frontline staff to build healthy lifestyle advice into their contacts with the public, and signpost to lifestyle risk management services (LRMS). MECC covers the areas of smoking, alcohol, physical activity, healthy eating and obesity in the first instance. However, organisations can broaden it out to include other lifestyle areas, e.g. sexual health or breastfeeding. Many of the areas addressed by the MECC initiative would help in the prevention of CVD.

Evidence around preventing cardiovascular disease on a population level has been issued by NICE (PH25)[xviii]. Recommendations in order to prevent cardiovascular disease include:

- Reduce levels of salt intake - including clear guidance about appropriate levels of salt, ensuring food production and catering continues to reduce salt levels and food is labelled appropriately.

- Reduce levels of saturated and trans-fats – including ensuring food producers use less of these in manufacturing and that the contents of products are labelled to include levels of fats.
- Restricting the marketing and promotions for food high in salt, sugar and fat aimed at children and young people.
- Clearly label all products to highlight their contents.
- Encouraging people to be more physically active by supporting and promoting physically active travel.
- Public sector catering should contribute to a healthy balanced diet.
- Planning policy should be used to restrict take-aways and other food retailers in certain areas, e.g. near schools.

Cancer

Cancer is the second most common cause of death in Shropshire, accounting for around 27% of deaths annually. It is estimated that more than a third of all cancers could be prevented by reducing lifestyle risk factors such as smoking and poor diet.

In Shropshire there is a similar premature cancer mortality rate compared to the national figures and overall premature mortality has declined in the last two decades. However, since 2005-07 cancer trends increased slightly (not significant), although they decreased again in 2008-10. Premature mortality from cancer is higher in males than it is in females and there are significantly more premature deaths in the most deprived fifth of the county than the national average.

Although much cancer is preventable, some is not. Therefore, early diagnosis, referral and effective treatment is key to preventing mortality from cancer. Cancer screening services are one way of early diagnosis of cancer. There are cancer screening programmes for breast, cervical and bowel cancer.

Currently the NHS breast screening programme is available to women aged 50-70 years, which is gradually being extended to include women aged 47-73 years by 2016. In Shropshire breast screening uptake is 81.7% (2011), which is higher than the national figure of 73.4% and also higher than the national target of 70%; however there is variation between GP practices for screening uptake rates. Similar proportions of women were screened for breast cancer in 2008 and 2011. There is a relationship between deprivation and screening, with women living in more deprived areas less likely to attend screening than those from more affluent areas. There is also a relationship between being a member of a black and minority ethnic (BME) group and lower uptake of screening across all three cancer screening programmes.

The cervical screening programme is open to women aged 25-64 years old. In Shropshire cervical screening uptake is 80.7% (April 2011) which is higher than the national figure (73.7%, 2010-11) and slightly higher than the national target (80%). Cervical screening uptake in Shropshire has decreased in the last year compared to previous years. Like breast screening there is variation in uptake between GP practices and there is also a relationship with deprivation similar to that seen in breast screening.

The NHS bowel screening programme is open to men and women aged 60-69 years. The uptake of bowel screening in Shropshire is 61.3% (2010-11) which is higher than the regional average (55.2%, 2010-11) and the national target (60%). Again there is variation between GP practices and also a relationship with deprivation similar to that seen in the other screening programmes.

Waiting times to treatment are important as they can increase the likelihood of positive outcomes for those with cancer. Nationally cancer waiting times are measured on the percentage of patients with an urgent cancer referral seen

within 2 weeks and percentage of patients who started treatment within 31 days and 62 days. In Shropshire cancer waiting times at year end were all meeting the national standards.

A further key challenge and opportunity for public health in Shropshire during the next 5-10 years will be to effectively address the health and wellbeing needs of growing numbers of Cancer Survivors (people living with and beyond cancer). Nationally it is estimated that there are currently 2 million cancer survivors predicted to rise to 4 million by 2030. Given Shropshire's ageing population there is a need to maximise the health and wellbeing of cancer survivors and reduce the health and social costs by focussing increasingly on health promotion, the prevention of late effects and effective symptom management. Public Health is contributing to new initiatives to meet the health improvement needs of survivors with the "Get Active, Feel Good": Exercise and Cancer Survivorship Project.

The major preventable risk factor for cancer is smoking, which causes the majority of cases of lung cancer and also causes cancer at many other sites including lips, tongue, mouth, gullet, stomach, liver, pancreas, bowel, kidney and bladder. Obesity and poor diet also increases cancer risks significantly, particularly cancers of the breast, bowel and womb. Excess alcohol consumption is another important risk factor, associated with cancers of the mouth, gullet, breast and bowel. Rates of skin cancer are strongly related to sun exposure without adequate skin protection, and are on the increase.

Road Traffic Collisions

Over 1 million people die each year due to road traffic collisions worldwide and a further 20 to 50 million suffer non-fatal injuries[xix]. Accidents are the leading cause of death for people under 25 years old and road traffic collisions (RTC) account for the majority of these deaths. Many people that are non-fatally injured in RTC endure disability and limiting conditions as a result of the injury.

In Shropshire there is a higher than national mortality rate from RTC, with males aged 15-24 years most likely to be involved in an RTC. RTC's account for 89% of deaths from accidents in all people aged 0-24 years. Reasons young males are more likely to be involved in RTC than other age groups are because:

- They are more likely to take risks than females and those in other age groups
- They are more inexperienced than drivers than older drivers that have been driving for longer

In Shropshire the majority of the roads are rural A or B roads. These are often less busy than roads in urban areas, but are more likely to be twisty, hilly and reduce the distance a driver can see ahead. Traffic is often travelling at higher speed than in urban areas, which also increases the likelihood of more severe RTC's.

Research provided by Road Safety Analysis report, "Young Drivers' Road Risk and Rurality", stated that young drivers are 37% more likely to be involved in an injury collision than their urban counterparts. Also that rural drivers have 31% higher mileage than their urban counterparts which probably accounts for a significant part of the increased risk to young rural drivers; though average annual mileage travelled appears to have little effect on adult collision risk.

The following evidence has been produced on preventing RTC's[xx]:

- Adapting the environment: this can include traffic calming measures, cycle lanes and pedestrian crossing areas
- Road safety education and skills training: injuries from RTCs can be reduced through education and promotional interventions that encourage the use of safety equipment
- Addressing drink driving: Bar server training programmes can improve server behaviours and reduce customer intoxication levels. There is some evidence that they can also reduce night time RTCs
- Multi-component interventions: Comprehensive programmes that combine strategies such as education and traffic calming measures can reduce the incidence of child pedestrian injury
- Enforcement of legislation: Speed enforcement detection devices can be effective in reducing RTCs and associated injuries

Ageing well

Ageing is inevitable but suffering ill health in later life is not. It is never too late to adopt a healthier lifestyle and take steps to prevent ill health. It is just as important for people in older age to have a balanced diet, remain physically active, not smoke and maintain a positive attitude. By doing this older people are more likely to avoid health problems and may be able to manage existing problems more effectively. Shropshire has a larger proportion of older people than the national average and this section of the population is expected to increase significantly, therefore ageing well is vitally important for the future population of Shropshire.

This section of the report identifies areas of priority in Shropshire for people in older age groups. It highlights health issues which are preventable such as falls and seasonal flu, dementia which is partially preventable by lifestyle choices and also end of life care.

Dementia

Dementia is a progressive disease which includes symptoms such as memory loss, mood changes and problems communicating and reasoning. Most people affected by dementia area age 65 years and over and the likelihood of having dementia increases with age. This is important locally due to the fact Shropshire has a higher proportion of older people than the national average and the population aged 65 years and over is expected to continue increasing.

Risk factors associated with dementia have been identified[xxi]:

- Age – the disease is more common in older people
- Gender – women are more likely to be affected than men
- Genetics – particularly in early on-set dementia
- Medical history – more common in people affected by some other diseases, e.g. multiple sclerosis, Huntington's disease, Downs Syndrome and HIV.
- Lifestyle – diet, smoking, etc especially for vascular dementia

In Shropshire it is thought that just over 7% of people aged 65 years and over have dementia, the figures are higher for women (8.5%) than men (5.5%). This figure is expected to increase to 7.5% for all people aged 65 and over by 2021. The expected increase in Shropshire is likely to be at a faster pace than for the expected increase in England overall. Prevalence estimates for dementia are thought to be more than double the recorded rate in Shropshire.

There are different types of dementia; of which some are preventable (e.g. vascular dementia) and some are not (e.g. Alzheimer's). Vascular dementia is preventable by choosing healthy lifestyle behaviours such as, healthy diet, maintaining health weight, regular exercise, moderate alcohol intake, not smoking and controlling blood pressure and diabetes[xxii].

Currently there are some lifestyle risk management services available, e.g. stop smoking services and some weight management services. These should help prevent some types of dementia. In Shropshire there is also a memory clinic for patients with dementia, GP's can assess patients and refer them to the clinic. Patients can then be monitored at the clinic unless they are in need of an in-patient admission. A care at home team has also recently been established to enable patients with dementia manage their condition in their own homes. There are also voluntary sector providers, the Alzheimer's Society and the Red Cross, who provide support to carers of people with dementia.

Engagement undertaken with GP practices in all localities of Shropshire has identified dementia as a significant problem affecting health currently and in the future. GP's in the south of the county particularly identified Community Mental Health Teams (CMHT) for the elderly being an area of good practice locally, however they also mentioned that dementia care services needed improving.

NICE have published guidance on care for people with dementia (CG42)[xxiii]. They recommend that a person centred approach should be used when caring for people with dementia. The care should involve a combination of medication and cognitive stimulation (depending on the type of dementia). They also recommend that carers of people with dementia should have access to psychological interventions in order to help them cope with the demands of their role.

Falls

One in three over 65s and one in two over 80s fall each year. Injuries sustained from falls are one of the most common causes of death in people aged 75 years old and over. There is a high possibility for people who have fallen to have repeated falls after an initial fall. Aside from increased risk of death as a result of falling, there is also an increased risk of disability, loss of self-confidence and reduced quality of life. There are many risk factors for falls in older people including medication, reduced strength and balance, dementia, acute and chronic medical conditions, alcohol misuse, poor vision, inappropriate footwear and environmental factors. Osteoporosis can potentially increase the risk of a fall and result in serious injuries such as fractured neck of femur.

In Shropshire admissions to hospital from falls increase with age and there are significantly more admissions from females over the age of 75 years old. This is important due to the fact there are large numbers of people aged 75 year and over in Shropshire and the population in this age groups is expected to continue increasing.

In Shropshire there is a Falls Prevention Services which operates both in the community and in community hospitals. The services are compliant with NICE and other clinical standards guidance[xxiv]. The service assesses patients who have fallen, are at risk or fearful of falling and incorporates bone health assessment. Places on evidence based exercise programmes or one to one home based exercises are offered and provision is made for people with dementia. Information and training is provided about falls prevention in hospital and the community and 'falls champions' have been identified across different community services.

Engagement work identified falls as being a particular current concern to GP's in the Shrewsbury area as there was also concern about the capacity of services to deal with increasing demands. Falls has consequences for utilisation of both primary and secondary care services. In the South of the county services around frail and vulnerable populations, which may include those that have suffered a fall, were seen as being an area of good practice.

An audit of the falls prevention service patient feedback forms has been undertaken. The results indicated that patients were happy with the service.

NICE (CG21)[xxv] gives guidance for specific strength and balance exercise training for falls prevention in older people. It recommends that:

- Older people should be identified by health professionals as to whether they have fallen in the past year and how it happened. If they have reported a fall they should be observed for balance and gait deficits and considered for an intervention
- If an older person attends for medical attention for a fall they should be given a falls risk assessment which will identify falls history
- Older people who have fallen or who are at risk of falling should be given a falls prevention intervention. This should include strength and

balance training, home hazard assessment, vision assessment and a medication review

- Verbal and written information should be given to people at risk of falling and their carers about what they can do to prevent further falls
- Healthcare professionals working with people at risk of falling should have basic competence in falls assessment and prevention

Seasonal Flu

Influenza (flu) is a short illness that is caused by a virus; it is highly infectious and can affect people of all ages. However, there are some groups that are more at risk from flu than others, as it can lead to pneumonia and in some cases death. Every year during the flu season there is a national campaign aimed at people aged over 65 years old, people with an existing long term condition, pregnant women and people with a weakened immune system which routinely invites them for a flu vaccination, as they are particularly at risk from flu.

In Shropshire during the 2011-12 flu season the percentage uptake of flu vaccination in people aged 65 and over was 72.8% which is lower than the national target of 75% and the national average (74%). The percentage uptake for people with long term conditions was 52% which is similar to the national figure (51.6%), but lower than the aspirational figure of 60%. The proportion of pregnant women vaccinated in Shropshire was 40.8%; this is much higher than the national figure of 27.4%.

There is variation in the vaccination rates between GP practices in Shropshire with some achieving over 80% and others achieving less than 65% uptake in people aged 65 years or over. The variation between GP practices in Shropshire for the percentage of at risk patients being vaccinated is even greater than that for people aged 65 years and over, with some practices achieving over 65% of patients vaccinated and others achieving under 45%. There is no relationship between deprivation and flu vaccination uptake.

There are 3 main ways of preventing flu[xxii]:

- Hygiene – hand washing and cleaning
- Flu vaccinations
- Antiviral medicine

End of Life

End of life care is support for people who are approaching death. It helps them to live as well as possible until they die, and to die with dignity. It also includes support for their family and carers. The aim is to make the patient as comfortable as possible by relieving pain and other distressing symptoms while providing psychological, social and spiritual support for patients and carers.

There are a number of national drivers to improve the quality of end of life care, following on from the Department of Health strategy in 2008[xxvi]. This presented a high level pathway and described the building blocks for each of these, including the GSF (Gold Standards Framework). The main recognized target for end of life care is measuring the proportion of people who die in hospital, with the supposition that it is usually desirable to die elsewhere. The reduction of numbers dying in hospital is used as a proxy measure for quality services to support people at the end of life.

The National Audit Office highlights the fact that between 56% and 74% of people request to die at home. However, around 35% of people actually die at home or in a nursing home. In Shropshire in 2010 just under 20% of people died at home, 11.5% in a nursing home and a further 10.6% in a residential home. Locally around 45% of people died in an acute hospital. In Shropshire people that died from cancer were more likely to die at home or in the hospice compared to all causes of death. This is in part because the pattern of cancer progression is easier to predict. Previous work undertaken locally has highlighted that significantly more people in the least deprived fifth of Shropshire die at home compared to those in the most deprived fifth.

The health economy wide Unscheduled Care strategy led to a high level End of Life Care group to be formed. This is chaired by the Medical Director from the Severn Hospice and has membership from the Clinical Commissioning Group (CCG), Shropshire Council, acute trust, community health trust and the Independent sector. The strategic objectives are:

- Services across the health economy are coordinated and configured to give patients the best possible care at the end of life, including to die wherever possible in the place of their choosing
- All 'hands-on' health and social care staff to have the skills to give the best possible care to patients (and support for their relatives) at the end of life

This group is taking forward work in the following areas:

- Out of hours care
- Last 6 weeks of life – separate key worker role, pathways and communications workstreams
- Education and training

This builds on work currently taking place, such as ongoing training delivered across the health economy for PPC (Preferred Priorities for Care) which will

help people to make their preferred place of death known, and the roll out of the local iteration of the Liverpool Care Pathway version 12, which is to support people identified as being in their last days or week of life.

Currently in Shropshire there are a number of services operating that provide end of life care. These include hospice day services and in-patient care, Hospice at Home service, specialist palliative care nurses both in the community and in hospital, and district nursing services.

NICE has published quality standards for end of life care[xxvii]. The NICE quality standards define clinical best practice within this topic area. They provide specific, concise quality statements, measures and audience descriptors to provide the public, health and social care professionals, commissioners and service providers with definitions of high-quality care.

Vulnerable communities

A community or group within a population may be vulnerable if their age, health status, economic status, minority status or other factor means that they are disadvantaged in society. This may mean that they are more open to exploitation and are more likely to be marginalised than the general population. Overall, Shropshire has relatively low levels of deprivation, however inequalities still exist and disadvantage can often be more pronounced when compared to relative affluence. As there are fewer areas of deprivation in the county those that are disadvantaged can be more vulnerable.

This section of the report focuses on issues that are linked to groups of people in the population that are likely to be disadvantaged in Shropshire. However, it should be noted that many health issues in this report could also be included in vulnerable communities and that this section highlights more of the wider determinants of health that could impact on some of these health conditions. Included in this part of the report are local priorities on youth unemployment, workplace earnings and homelessness.

Youth Unemployment

In the UK there are currently around 1 ½ million young people not in education, employment or training. Nationally, youth unemployment is becoming a significant issue, with the number of 16-24 year olds claiming JSA rising by 14.3% over the last year. Employment is a future determinant of health, as unemployment is linked to poor health and increased mortalityxxviii. This is a major concern as the current economic situation mean there is less work for people of all ages, including young people.

In Shropshire, there was an 11.7% increase in Job Seekers Allowance (JSA) claimants aged 16-24 years old, with 31% of all JSA claimants now aged 24 or less (February 2012). There are reports that an average of 80 young people are now applying for every available job. Unsurprisingly, there are significantly more JSA claimants in the most deprived areas of Shropshire compared to the least deprived.

Locally there are a number of services and initiatives that are in place to address the needs of local young people that are unemployed. These include Connexions, Citizens Advice, Jobcentre Plus, Adult and Community Learning and Next Steps. There are also areas of joint work with different agencies that are undertaken including work with children's services to address needs within families with multiple problems and work with social landlords.

Evidence on how to prevent youth unemployment has been published by the ACEVO Commission on Youth Unemployment[xxix]. Their report highlights a number of ways in which it can be prevented, including:

- Increasing the range, quality and co-ordination of progression routes from education to work. This could be targeted at those most at risk of becoming NEET

- Increase young people's 'soft employment' skills such as self-discipline, communication, concentration and motivation
- Increase young people's understanding of the labour market, e.g. what jobs are available and how to get them and utilising employer engagement in education
- Increase access to high quality work experience, as this especially benefits the most disadvantaged young people
- Improve partnerships that are required to support young people with complex needs to succeed in education, e.g. young carers, young people with limiting long-term conditions
- Young people in work should act as mentors for those who are not

Low Workplace Earnings

Income is one of the major factors in determining deprivation. There are significantly more health inequalities in areas of deprivation compared to more affluent areas; therefore low workplace earnings have a relationship with poor health. People with higher incomes are more able to enjoy a healthier lifestyle as they can purchase goods and services to prevent the onset of ill health. They are also less likely to be stressed due to financial problems.

Overall in England workplace earnings have increased slightly in the last four years, with male earnings significantly higher than females. For people whose workplace is in Shropshire, earnings have risen by 6.1% since 2008. There was a slight decline in earnings between 2010 and 2011 (-0.8%). The gap in earnings between women and men working in Shropshire was larger than the gender gap nationally and regionally. Also in comparison to the West Midlands and England averages, the earnings of people working full-time in Shropshire were considerably lower. For part time workers in Shropshire earnings were actually slightly higher than that of the West Midlands and England; this is because people working part-time in Shropshire work more hours on average than the national or regional averages.

Average full time wages for Shropshire residents are higher than those for people whose work place is in Shropshire and resident earnings have risen more rapidly than workplace earnings. This suggests that many of Shropshire's residents work outside the county, particularly those in better paid employment. However, Shropshire female resident earnings are lower than female earnings where the workplace is in Shropshire. Overall full time Shropshire resident earnings are higher than the West Midlands average, but lower than the national average. This means that those with no option but to work within Shropshire are subject to lower wages than Shropshire residents overall who are more mobile and able to work outside the county.

There is currently an economic growth strategy being developed with Shropshire Council and Shropshire Business Board. This aims to attract more businesses to the county and create more jobs.

Homelessness

Homelessness is the most acute form of housing need. A person can be legally classed as homeless if they are living on the street, sleeping on a friend's sofa, staying in a hostel and suffering from overcrowding or other bad conditions. To prevent homelessness, it is important to recognise that there is a wide range of groups vulnerable to homelessness, with young people as a key concern.

In Shropshire there was an increase of 95 acceptances for homelessness in 2010/11 compared to 2009/10. Acceptances for females appear higher than acceptances for males, with 43.9% of acceptances being female lone parents. Also 15.4% of lone person applications came from females, compared to 14.5% from males. Around 18% of acceptances were from couples with dependent children. Acceptances for homelessness appear to be greater for people in younger age groups being higher than those in older groups, e.g. over a third of acceptances were for people aged 16-24 years old.

There is some published evidence to support preventing homelessness[xxx]. The following highlights some cost effective ways of preventing homelessness:

- Housing advice - including working with private landlords and identifying high risk groups
- Facilitating access to private tenancies – including rent deposit schemes
- Family mediation services – including reconciling relationships, especially between young people and their families
- Preventing homelessness through domestic violence victim support – including sanctuary schemes
- Prison based homelessness prevention – including close collaboration between prison and external housing services and peer involvement schemes
- Tenancy sustainment services – including help with benefits, budgeting, debt management, etc.

Summary

The report highlights issues in health and wider determinants that are currently a priority in Shropshire. Some of these issues will continue to be issues for the foreseeable future and may worsen if effective measures are not put in place to stop their increase. Other issues included are shorter term in nature and may need less of an intervention to improve their outcomes. Similarly some of the priorities are of higher priority in terms of the size of the population they impact on, whereas others may be more of a priority due to the fact that they impact on sections of the population rapidly. Other priority issues are outside of the control of health and social care, but without resolution they will impact on the health of the population.

The information presented in this JSNA priorities document has driven the development of the Health and Wellbeing Strategy (HWB Strategy). The HWB Strategy identifies five overarching strategic priorities; these are aligned on the key issues presented in this document. Below each overarching priority there are a number of priorities for action, such as reversing the rising trend in obesity, which are based on the information on different health issues in Shropshire highlighted in this document. The information in both the JSNA and HWB Strategy in Shropshire will support the Health and Wellbeing Board in understanding the needs of the local community.

References

[i] http://publications.nice.org.uk/quitting-smoking-in-pregnancy-and-following-childbirth-ph26

[ii] No Health Without Public Mental Health: the case for action, Parliamentary Briefing, Royal College of Psychiatrists, 2010
http://www.rcpsych.ac.uk/PDF/Final%20PS4%20briefing_for%20website%20A4.pdf

[iii] Pupil Premium Toolkit, Education Endowment Foundation and the Sutton Trust
http://educationendowmentfoundation.org.uk/uploads/pdf/Pupil_Premium_Toolkit_%2820.12.11%29.pdf

[iv] http://publications.nice.org.uk/maternal-and-child-nutrition-ph11

[v] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209

[vi] http://publications.nice.org.uk/promoting-physical-activity-active-play-and-sport-for-pre-school-and-school-age-children-and-young-ph17

[vii] http://publications.nice.org.uk/physical-activity-and-the-environment-ph8

[viii] http://publications.nice.org.uk/promoting-physical-activity-in-the-workplace-ph13

[ix] http://publications.nice.org.uk/four-commonly-used-methods-to-increase-physical-activity-ph2

[x] http://guidance.nice.org.uk/PH16

[xi] Alcohol Harm Reduction Strategy for England. PM Strategy Unit; 2004

[xii] http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-drinking-ph24

[xiii] http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7

[xiv] www.nice.org.uk/guidance

[xv] http://publications.nice.org.uk/obesity-cg43

[xvi] http://publications.nice.org.uk/preventing-type-2-diabetes-population-and-community-level-interventions-ph35

[xvii] Http://guidance.nice.org.uk/PHG/Wave19/62

[xviii] http://publications.nice.org.uk/prevention-of-cardiovascular-disease-ph25

[xix] Global Status Report on Road Safety, WHO,
http://whqlibdoc.who.int/publications/2009/9789241563840_eng.pdf

[xx] Road Traffic Accidents: A review of evidence for prevention from the UK focal point for violence and injury prevention, S. Wood, M.A. Bellis, S. Watkins, 2010,
http://www.cph.org.uk/showPublication.aspx?pubid=665

[xxi] www.alzheimers.org.uk

[xxii] www.nhs.uk

[xxiii] http://publications.nice.org.uk/dementia-cg42

[xxiv] AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older People, 2010 http://www.medcats.com/FALLS/frameset.htm

[xxv] http://publications.nice.org.uk/falls-cg21

[xxvi] Department of Health End of Life Care Strategy, 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

[xxvii] http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/home.jsp

[xxviii] http://www.nice.org.uk/niceMedia/documents/worklessness_health.pdf

[xxix] http://www.bristol.ac.uk/cmpo/publications/other/youthunemployment.pdf

[xxx] Evaluating Homelessness Prevention, Communities and Local Government, 2007 http://www.communities.gov.uk/documents/housing/pdf/573347.pdf