Shropshire Council

NHS
Shropshire County
Primary Care Trust

Committee and Date	Item
Joint Member Board for Health and Wellbeing in Shropshire 23 November 2009 10.00 a.m.	**4**

DRAFT JOINT STRATEGIC NEEDS ASSESSMENT

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Introduction

A full joint strategic needs assessment (JSNA) was completed in 2008, providing an evidence base for the PCT Strategic Plan, Local Area Agreement, Comprehensive Area Assessment and Community Strategy.

This has been updated for 2009 with information from key partners, including statistical data, service use information and more qualitative intelligence such as community, service user and patient feedback.

The report enclosed provides the key points in relation to the people of Shropshire and their health and wellbeing.

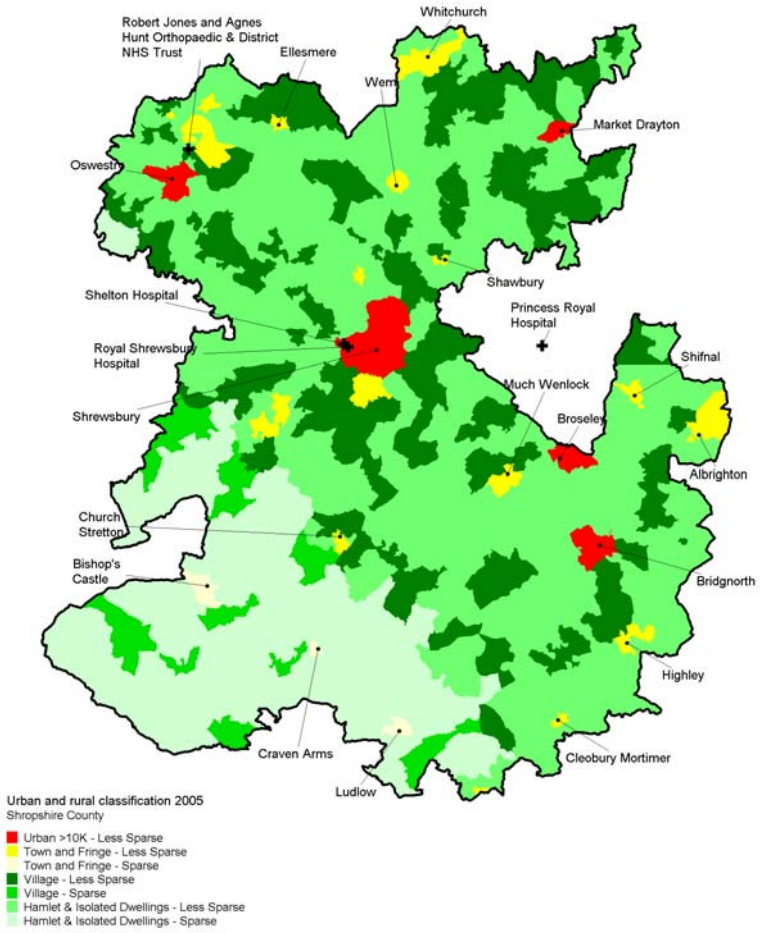
This provides the most current picture in relation to health needs, building on the existing base of evidence for partnership working.

Please see enclosed report.

SECTION 3 – THE SHROPSHIRE CONTEXT

The people of Shropshire

A full joint strategic needs assessment (JSNA) was completed in 2008, providing an evidence base for the PCT Strategic Plan, Local Area Agreement and Community Strategy. This has been updated for 2009 with information from key partners, including statistical data, service use information and more qualitative intelligence such as community, service user and patient feedback.

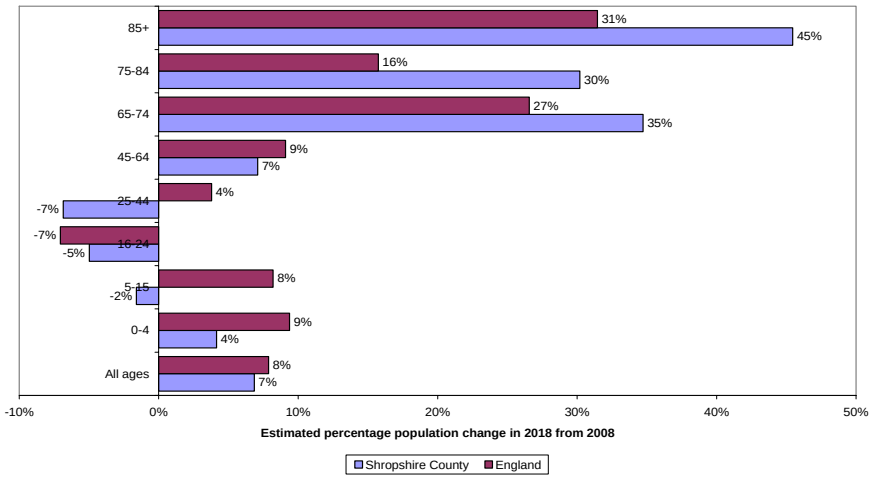


Source: Urban and rural classification 2005, National Statistics and Census Output Area Boundaries, National Statistics, Digital Mapping Solutions from Dotted Eyes

The population of Shropshire according to the most recent data (2006) was recorded as 289,300. The GP registered population as at 2007 – 2008 was 294,420. Shropshire is a large inland county, and although headline statistics suggest it is generally affluent, there are inequalities across the county, which

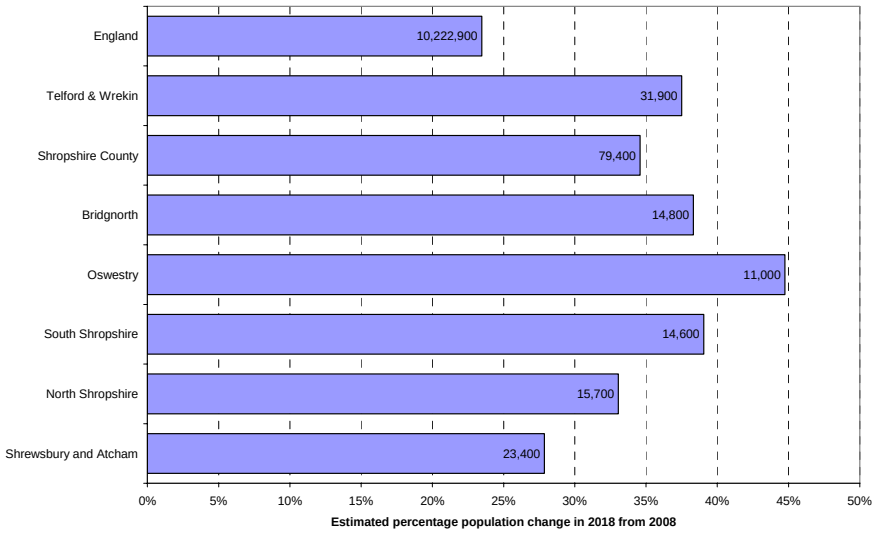
impact on health and care needs, as well as a higher than average ageing population coupled with a reduction in younger people.

Figure 1: Population projections by age, Shropshire & England, 2008-2018



Source: 2006 based sub-national population projections, National Statistics website: www.statistics.gov.uk

Figure 2: Population projections by area compared to England for people aged 65 and over: 2008 to 2018



Source: 2006 based sub-national population projections, National Statistics website: www.statistics.gov.uk

There are areas of deprivation, which are further complicated by the rurality of the county and the consequent sparsity of the population. There are only four market towns in the whole county with a population of over 10,000. Emerging

evidence shows that health outcomes are correlated to areas of greater deprivation in the county.

Health profile

- Life expectancy is high in Shropshire, having improved significantly over the past 15 years, with a significant decrease in all causes of mortality
- Life expectancy for men in the most deprived areas is 4 years less than for men in the most well off areas.
- Smoking prevalence and obesity levels are higher in people living in the most deprived fifth of areas of Shropshire
- The rate of hospital admission in Shropshire for alcohol-related harm is amongst the lowest in the region, however it is increasing fast

New: Updates for JSNA 2009!

Figure 1 and 4 show trends in male and female life expectancy in Shropshire. Trends in male life expectancy have increased significantly since 2001, with a further increase shown in the most recent (2007) data below. Trends in female life expectancy are continuing to follow the general improvement since 1993 (all sourced from Death Extracts, Revised mid year population estimates, National Statistics).

Figure 1 Trends in Life Expectancy in males

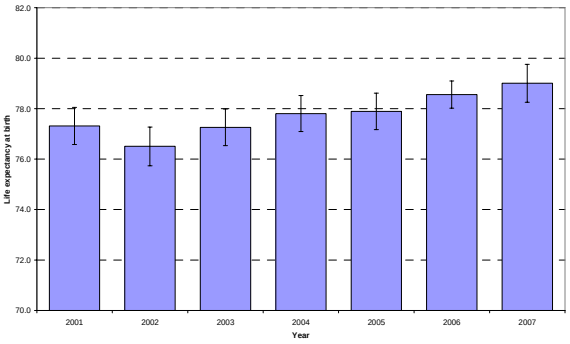
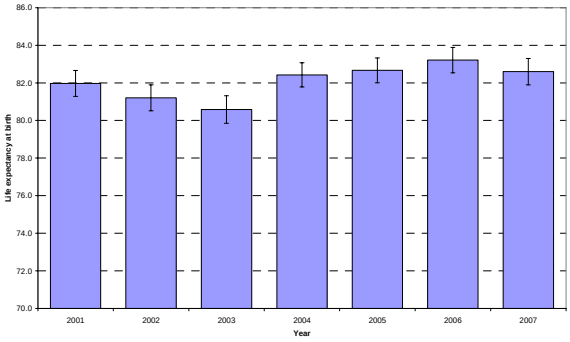


Figure 2 Trends in Life Expectancy in females



Overall in Shropshire rates of all-age-all-cause- mortality are significantly lower than the figure for England and Wales for both males and females and are steadily decreasing, as shown in Figures 5 and 6. The bars in the dark blue are trajectories that have to be achieved for vital signs and the national indicator set.

Figure 5 Trends in all-age all-cause mortality in males

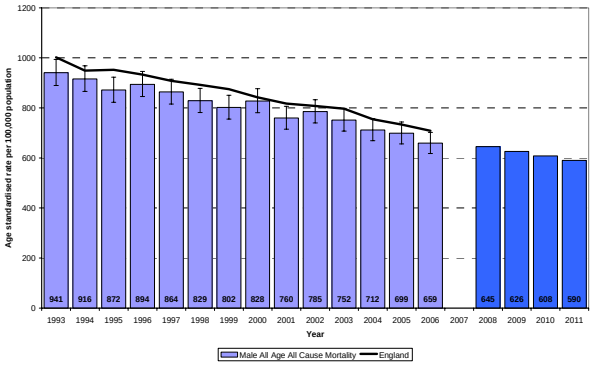
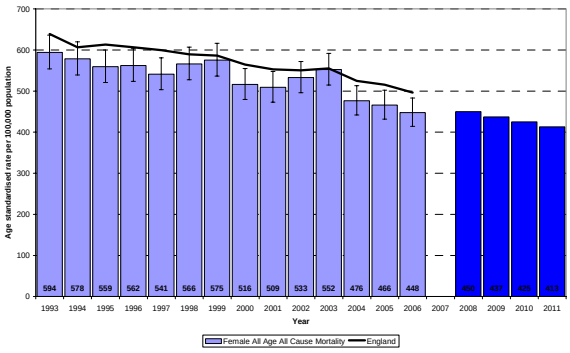
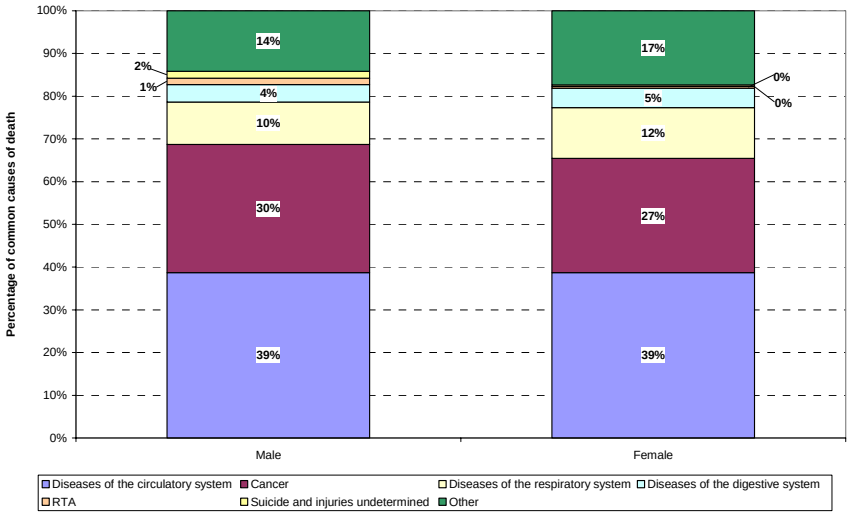


Figure 6 Trends in all-age all-cause mortality in females



The most common causes for both males and females were circulatory disease and cancer. It is important to understand common causes as this enables interventions to be targeted and in turn should decrease mortality rates further.

Figure 7 Common causes of death in males and females (2006)

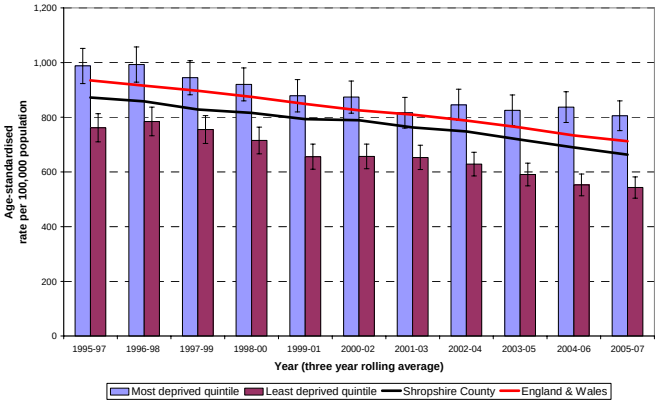


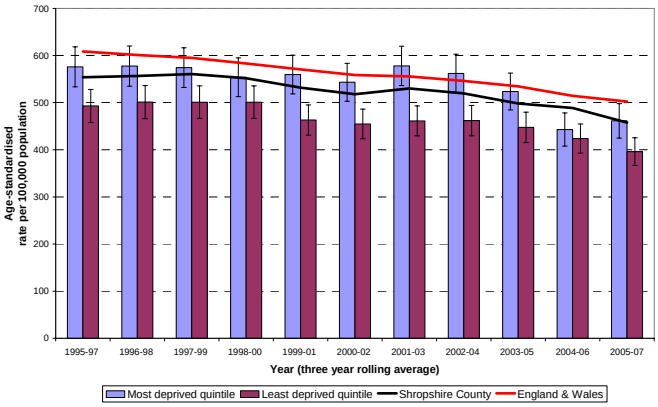
Source: Death extracts, National Statistics, 2006.

Poverty, relative deprivation and social exclusion have a major impact on health and inequalities are found in Shropshire as elsewhere in the country:

Figures 8 and 9 show that whilst mortality rates have improved across all areas in Shropshire, the trend is not as strong for males living in the most deprived areas. Additional data (see full JSNA Updated 2009) also shows that the gap between the most and least deprived appears to have been growing.

Figure 3 All-age all-cause mortality rates: men





NEW! Figure 9 All-age all-cause mortality rates:women

Males living in the most deprived fifth of areas have a significantly lower life expectancy than those living in the least deprived fifth. Since 2001-2003 the gap in life expectancy between the most and least deprived fifth of areas has been increasing (Figure 11).

On the contrary, there has been a significant increase in female life expectancy in the most deprived areas since 2003-2005 and no change in least deprived areas therefore the gap has been decreasing significantly.(Figure 12).

Figure 10 Absolute gap between most deprived and least deprived quintiles for life expectancy in males

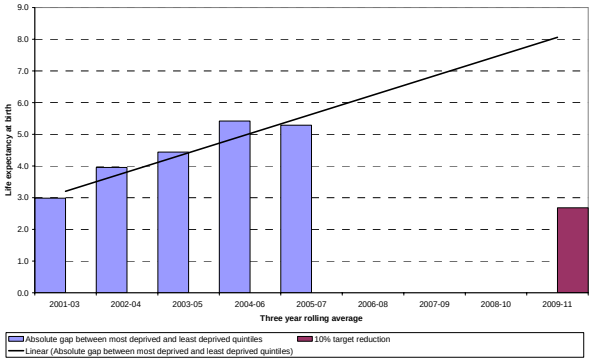
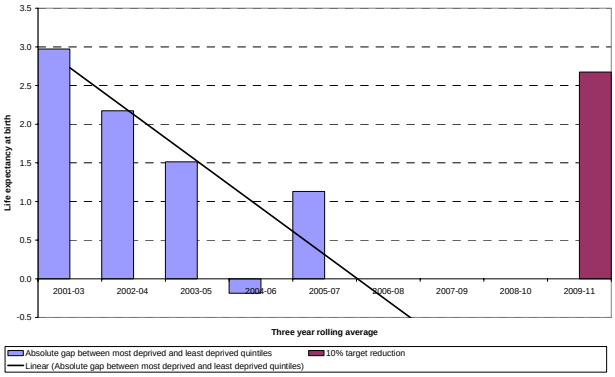


Figure 11 Absolute gap between most deprived and least deprived quintiles for life expectancy in females



Source (Figure 12 and 13): Death extracts, National Statistics, Vital Statistics Table 3, ONS mid-year population estimates, National Statistics, Crown Copyright, Indices of Deprivation 2007, Office of the Deputy Prime Minister, Crown Copyright and Exeter System (GP Patient Registration System), Shropshire County Primary Care Trust.

New data for the JSNA Update 2009 has confirmed significant differences have been found between people living the in the most and least deprived areas related to premature mortality from circulatory diseases and cancer:

Figure 12: Premature mortality from circulatory diseases by deprivation, 2003-2007

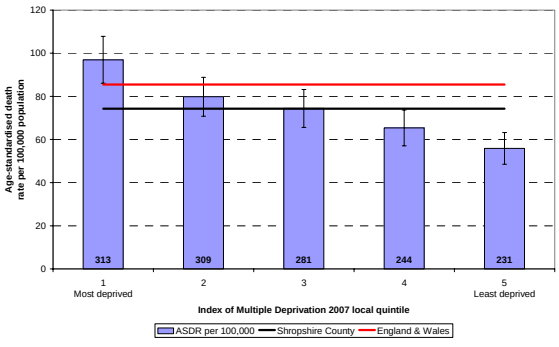
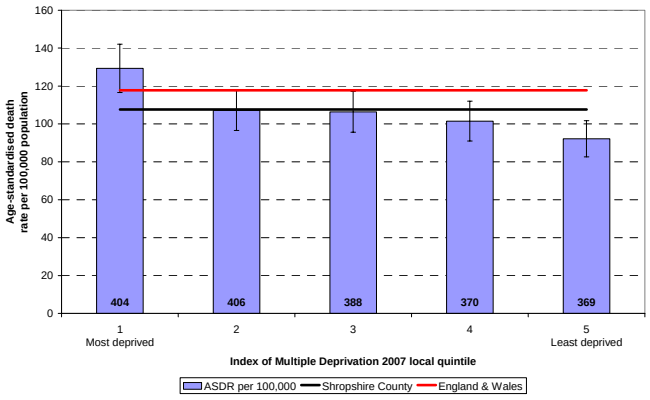


Figure 13 Premature cancer deaths by deprivation, 2003-2007

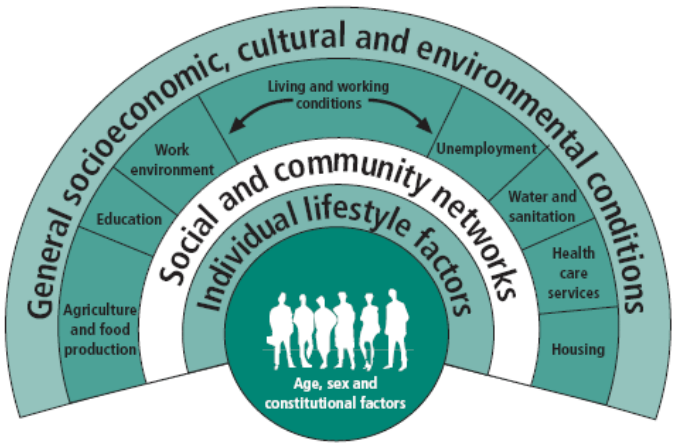


Source: Death extracts, National Statistics

The highlights given above show the challenges that are faced as a result of health inequalities, which are addressed in the PCT Strategic Plan and in other partnership documents including the Local Area Agreement.

The following diagram identifies wider determinants of health and their impact on the population. (From Social Determinants of Health: The Solid Facts, 2nd Ed., World Health Organisation Europe, 2003.). In order to reduce inequalities in health action must be taken in partnership with other agencies including Shropshire Council, Children's Trust, Police, Probation, Fire Service, Voluntary and Community Sector and others:

Fig. 1. Social determinants of health



Source: Dahlgren G, Whitehead M. Tackling inequalities in health: what can we learn from what has been tried? Background paper for *"The King's Fund International Seminar on Tackling Health Inequalities"*. Ditchely Park, Oxford: King's Fund; Reproduced with permission of the authors.

WHO 05.111

This year the Primary Care Trust has actively contributed to the Shropshire Comprehensive Area Assessment, which builds on the Local Area Agreement as well as last year's Strategic Plan for World Class Commissioning. The process confirmed the broad shared understanding of need across Shropshire and has further improved the way that partners agree priorities for this population.

For the PCT in playing its part as the local leader for health within this partnership context, the evidence drives the prioritisation for the Strategic Plan and underpins the key outcome areas and measures selected.

Further detail is available in the full JSNA document. There are more detailed assessments in specific areas including maternity, children and young people, planned care, older people and end of life care, offenders health, eye care and hearing care, sexual health, long term conditions and disabilities, as well as looking at links across sectors such as housing and innovations in technology.

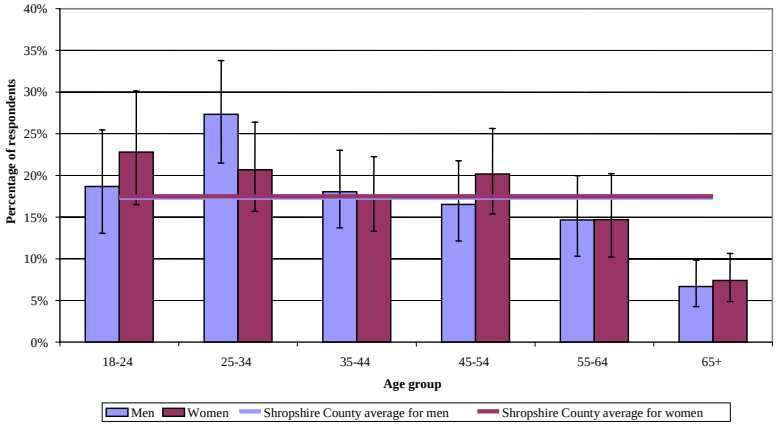
JSNA KEY OUTCOME AREAS 2009 UPDATE

The JSNA has also been updated in 2009 to track other key outcome areas:

Smoking

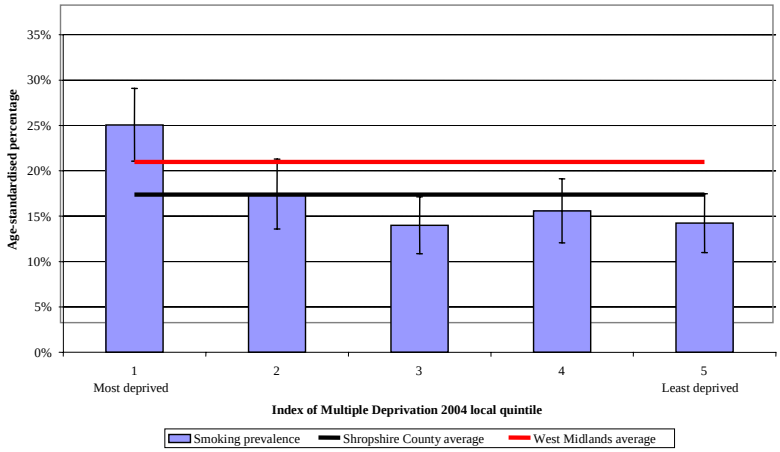
The JSNA has a range of information relating to smoking, with updates for 2009 on key areas – the prevalence of smoking (how many people smoke), numbers of people quitting, correlation to areas of deprivation. Although smoking rates are lower than for the West Midlands, it is the largest cause of preventable illness and premature death in the county. In addition, it is significantly more common in the fifth most deprived areas compared to the lowest three quintiles.

Figure 1: Smoking prevalence in Shropshire County by age and gender, 2005



Source: West Midlands Adult Health and Lifestyle Survey 2005

Figure 2: Smoking prevalence in Shropshire County by deprivation, 2005



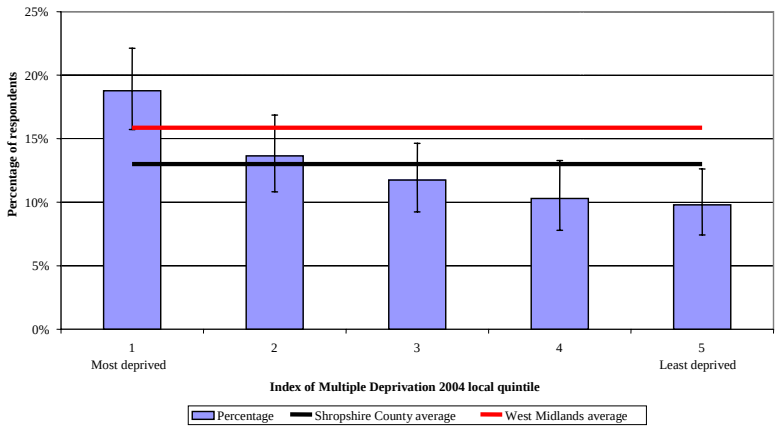
Source: West Midlands Adult Health and Lifestyle Survey 2005

Also, new data for 2008 – 2009 confirms that quit rates in Shropshire remain lower than the regional and national average figures – this was chosen as one of the key measures for World Class Commissioning, to drive forward improvement in this area.

Obesity and Childhood Obesity

Adult obesity rates in Shropshire increase with increasing deprivation. People living in the most deprived fifth of areas in Shropshire have significantly higher rates of obesity than those living within the 3 least deprived quintiles.

Figure 3: Prevalence of obesity in Shropshire County by deprivation, 2005



Source: West Midlands Adult Health and Lifestyle Survey 2005

Childhood obesity is a particularly important outcome because children who are overweight are more likely to develop diabetes and be obese as adults. Obesity can also lead to social and psychological issues eg. low self esteem.

Refer to the Full JSNA for more information about Maternity, Children and Young People's Health, including updates from the Shropshire Children's Trust.

New data is available this year from the 2007-08 National Child Measurement Programme in Shropshire. This has reported that 11.2% of reception and 17.5% of year 6 pupils were obese. The figure for reception year children is significantly higher than the national proportion although similar for year 6 children. There were significantly more year 6 children living in the fifth most deprived areas classed as obese compared to the least deprived fifth.

Figure 4: Obesity in children in Reception and Year 6 (2007-08)

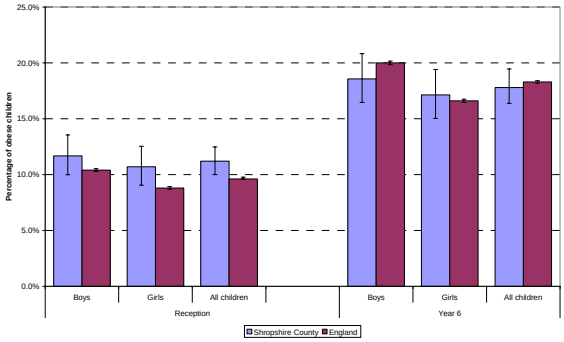
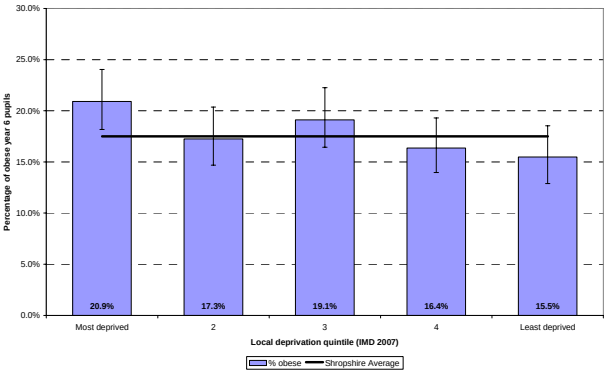


Figure 5: Year 6 children classed as obese by deprivation 2007-08



Alcohol Misuse

The 2005 West Midlands Lifestyle survey identified that around 18% of people aged 18 years and over in Shropshire exceeded the weekly sensible limits for alcohol. The West Midlands figure of 20% was statistically significant. **Error! Reference source not found.** shows the estimates for hazardous and harmful drinking in Shropshire County compared to the West Midlands and England.

Table 1 Synthetic estimates for hazardous and harmful drinking

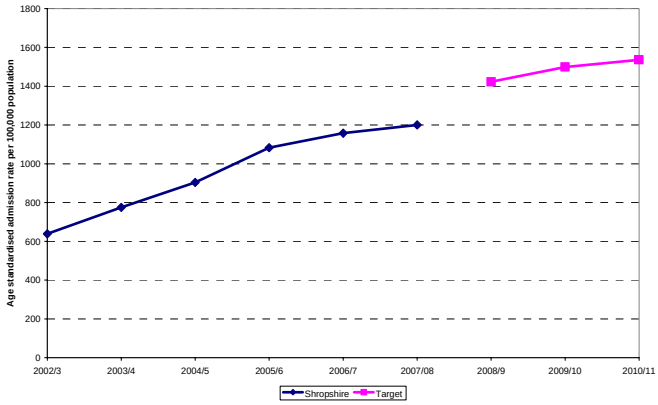
	Hazardous Drinking		
	Proportion	95% Confidence Interval	
		Lower Limit	Upper Limit
Shropshire County	19.41%	17.82%	21.00%
West Midlands	18.29%	16.80%	19.79%
England	20.10%	18.42%	21.77%
	Harmful Drinking		
	Proportion	95% Confidence Interval	
		Lower Limit	Upper Limit
Shropshire County	4.28%	3.83%	4.72%
West Midlands	4.92%	4.40%	5.43%
England	5.03%	4.50%	5.57%

Source: North West Public Health Observatory, Local Alcohol Profiles, 2006

Drunkenness in the evenings is noted as one of the top issues in the most recent Crime and Disorder Reduction Strategy for Shropshire. The town centres of Oswestry and Shrewsbury, followed by Bridgnorth, Oswestry and Market Drayton areas are noted as particular hot spots.

In addition to the social problems, alcohol related health issues also account for both chronic and acute health problems. The measure of 'alcohol related admissions to hospital' has been chosen as a World Class Commissioning measure, Tier 3 Vital Sign and a Local Area Agreement target. New data is available this year showing an increase in admission rates in Shropshire – the aim is to slow the rate of increase in future years:

Figure 6: Alcohol related hospital admissions per 100,000 population in Shropshire



Source: www.hesonline.org.uk and Mid-year Population estimates, National Statistics

Long term conditions

The number of people suffering from a long-term illness or disability has increased dramatically over the last decade both nationally and In Shropshire, in 1991, 32,300 (12%) Shropshire residents reported having a long-term limiting illness; the 2001 census reports 50,800 (18%). This represents a 54.3% change which is higher than the rate for England which was 46%.

An approximation is also noted in the JSNA for people with disabilities at 14%. (Further data on physical, sensory and learning disabilities in the full version).

Numbers are expected to rise due to an ageing population – which is higher than average in Shropshire - and certain lifestyle choices that people make. Long term conditions are those conditions that currently cannot be cured, such as Coronary Heart Disease; Chronic Obstructive Pulmonary Disease; Diabetes; Stroke and long term neurological conditions such as Dementia.

Lifestyle factors are often contributory factors and some conditions are avoidable – however it is important to note that not all conditions are preventable in all people therefore effective management is essential.
New figures in are included in the updated JSNA for 2009 – showing the higher prevalence of many conditions in Shropshire compared to England:

Table 2: Prevalence of Long Term Conditions: Shropshire and national rates

	Shropshire prevalence		National Prevalence	
	Proportion	Number	Proportion	Number
Coronary heart disease	3.84%	11,312	3.50%	1,892,432
Heart failure	0.92%	2,720	0.75%	406,668
Stroke and transient ischaemic attack	2.19%	6,457	1.63%	881,689
Hypertension	14.43%	42,490	12.79%	6,908,055
Diabetes mellitus	4.03%	11,876	3.87%	2,088,335
Chronic obstructive pulmonary disease	1.56%	4,593	1.48%	799,772
Epilepsy	0.68%	1,992	0.60%	324,130
Hypothyroid	2.61%	7,672	2.71%	1,461,912
Cancer	1.40%	4,136	1.08%	585,797
Palliative care	0.14%	406	0.12%	62,562
Mental health	0.65%	1,912	0.73%	394,395
Asthma	6.37%	18,741	5.75%	3,105,212
Dementia	0.52%	1,541	0.41%	220,246

Chronic kidney disease	3.67%	10,819	2.94%	1,589,353
Atrial fibrillation	1.75%	5,145	1.30%	701,157
Obesity	7.38%	21,714	7.65%	4,129,304
Learning disabilities	0.30%	884	0.27%	144,909
Total practice population		***294,420***		

Source: Quality and Outcomes Framework, 2007-08

The 2001 Census asked about **carers** for the first time. In Shropshire 11% (30,000 people) said they provided unpaid care for a family member or friend, with 2% providing over 50 hours per week.

Further information on carers, older people and planned care more generally is available in the full JSNA.

Dementia

Research commissioned by the Alzheimer's Society in 2007 forecast an increase in dementia prevalence of 38% over the next 15 years and 154% over the next 45 years.

The report also produced local estimates for PCT's. This is new data included in the updated JSNA – the Table below shows the dementia prevalence estimates for Shropshire County PCT currently, in 2017 and in 2021.

Table 3: PCT dementia prevalence estimates and projections

	Shropshire County (current)		
	Total	**% 65+ with dementia**	**% total with dementia**
Males	1374	5.47	0.96
Females	2643	8.47	1.81
Persons	4017	7.15	1.17
	Shropshire County (2017)		
	Total	**% 65+ with dementia**	**% total with dementia**
Males	2138	5.92	1.37
Females	3431	8.24	2.18
Persons	5569	7.17	1.78
	Shropshire County (2021)		
	Total	**% 65+ with dementia**	**% total with dementia**
Males	2437	6.27	1.57
Females	3881	8.64	2.47
Persons	6317	7.54	2.02

Source: PCT Dementia Estimates, Dementia UK, 2007, www.alzheimers.org.uk

Further projections have been made using POPPI and PANSI tools (detailed tables can be found in the Updated JSNA 2009). Overall, there is expected to be a slightly bigger increase nationally compared to Shropshire for early onset dementia by 2025. However there is projected to be a significantly higher

percentage increase in people aged over 65 years with dementia in Shropshire in 2025 compared to England.

In Shropshire QOF data recorded 0.52% of patients with dementia (on GP registers), less than half the estimated prevalence.

Shropshire County PCT has chosen this measure as a World Class Commissioning outcome – the GP is often the first point of contact for a patient and the start of the care pathway. It is a key part of the work to improve mental health and help people to stay healthy. It also impacts on the work to bring care closer to home and enable people to have further choice for example being more independent at home.

Mental Health

> "There is no health without mental health… Mental Health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens"
>
> WHO European Declaration on Mental Health, 2005

It has been estimated that one in four people will suffer a mental health problem at some point in their lives. Around 1 in every 3 people who see their GP will have a significant mental component to their illness.

There is little available information on prevalence however it is possible to use national prevalence figures as a basis for a local calculation.

Table 4: National prevalence of mental health and estimates for Shropshire

	National Prevalence	Estimated number in Shropshire
General population with some degree of mental disorder	26% to 32%	47,755 to 58,775
General population who will attend GP practice for mental health problems	23% to 26%	42,245 to 47,755
People who attend a GP practice for a mental health problem who will be treated only in primary care	10% to 18%	18,367 to 33,061
People who attend GP practice for mental health problems who are referred to secondary care	1% to 2%	1,837 to 3,673
People who attend GP practice for a mental health problem who will receive an in-patient admission	0.1% to 0.6%	184 to 1,102

Further details are available on specific conditions – refer to full JSNA 2009.

The PCT has recognised the need for effective care and management of mental health as part of wider wellbeing and health improvement. The promotion of mental health and wellbeing remains a Strategic Plan Priority.

Further work has been commissioned from **Dr Foster** for the updated JSNA – amongst the analysis is an indication of the correlation between outcomes, as well as areas of deprivation, and issues around access to services. For example, in one emerging finding the average length of stay in hospital is frequently higher than normal for alcohol related mental health condtions.

End of Life Care

End of Life Care is recognised as essential to help those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

Advances in practice to meet needs at end of life:

- Roll out of the Gold Standards Framework in Primary Care and work to promote the framework for use in nursing Care Homes
- Liverpool Care of the Dying Pathway
- Rapid access to equipment and drugs ~ just In Case palliative drug boxes
- Bringing together specialist nursing teams and provision of hands on care.

Key measures of end of life care include the delivery of high quality care across all settings, reduction of people with cancer and other long term conditions dying in hospital and an increase in people supported to die at home – which is the measure chosen to track the outcome for World Class Commissioning as it links to care closer to home and the promotion of choice and control.

The position recorded in last year's JSNA for Shropshire compared well to national averages and Shropshire has set itself a trajectory to continue improving this percentage so that more people are able to choose the end of life care they need.

Table 5: Percentage of deaths that occur at home: Shropshire, National and Regional (source: JSNA, 2008).

	Shropshire performance	National average	Peer Group (WM)
Percentage of all deaths that occur at home	20.8%	18.9%	19.1%

Urgent and Emergency Care

- The national clinical and organisational audit for stroke identified many areas in need of development, particularly improving the number of patients treated on a stroke unit and access to scans and thrombolysis within 24 hours of diagnosis to improve care and future prognosis

- There have been significant challenges around the delivery of urgent care services and the 98% four hour A&E target. A clear action plan has been developed and implementation of these systems and changes are essential to the health economy

Working in Partnership to improve outcomes for people in Shropshire

The JSNA contains more qualitative input this year, for example from patient and public involvement at the PCT and service user views gathered by the Council. Also, the update contains a summary of health issues gathered during the local involvement process for **Parish Plans** in Shropshire.

Shropshire Parish Plans – Health Needs (Information sourced 2009)

- People often express high levels of satisfaction with their health and care services and support for developments such as improved access, outreach, care at home.
- People often respond positively about their local GP practice. However a number of improvements are also suggested including better opening hours for GPs, out of hours and Saturdays. People would also welcome greater screening facilties and clinics locally eg. healthy living and local prescription pick ups/ delivery services.
- Access to NHS Dentists is commonly raised as an issue. Many people travelling to a private dentist but expressed desire to have more local dentist.
- Transport raised frequently – with difficulties in accessing hospital and other health professionals or facilities. Parking also an issue at local facilities.
- Varied comments made about emergency /urgent care – including Shropdoc and Ambulances. General support but concerns include waiting times, finding local addresses, distances ambulances have to travel and capacity of air ambulance.
- People often noted that care is often provided by family members unpaid and they need support. People expressed willingness to take part if good neighbour schemes, car sharing and other local support
- People often prioritised older people as needing the most care, and those who have mobility problems or health issues affecting their day to day life(23% of people in one parish reporting poor daily health).
- Support for increased support at home, as well as other care provision such as sheltered housing, day care, residential care. People use a range of social care – meals on wheels, home care and equipment – some issues raised about waiting lists for social care
- Desire for better mental health provision, especially for people at risk
- Support for health promotion more generally – as well as health education, outreach services, links with parish halls etc

The Community and Voluntary Sector have also been involved as they often have detailed knowledge of community needs, are frequently aware of gaps in service provision; and can facilitate exchanges with local communities and groups. The VCS Assembly network for Shropshire, which comprises 288 local organisations, were asked to contribute any data that they felt might be relevant and a representative also met with the analyst involved to consider what types of data it might be useful for Assembly members to collect for future updates. **Further detail relating to Voluntary and Community Sector and Public Involvement is contained in the full JSNA document.**