1. INTRODUCTION

1.1 The following executive summary comprises:

* An overview of the original findings from the partnership JSNA dataset and report from 2008

* Further analysis and narrative following the updated structure and content being published on a rolling basis covering the period 2010-2015, in particular two new in-depth sections on tackling inequalities and health improvement, and older people and long term conditions.

2. POPULATION AND DEMOGRAPHIC CHANGE

2.1 In Bournemouth, and especially Poole, the high and growing number of elderly and very elderly people present a major health need. Bournemouth’s large student population brings specific needs relating to (for example) sexual health services.

2.2 Socio-economically, Bournemouth, and particularly Poole have more very affluent people than the England average. However, there are wide disparities between the most and the least well-off, which in Poole is causing a growing health inequality gap.

2.3 Migration, especially from Eastern Europe has been significant in recent years, bringing challenges for services in ensuring equal access to people from different cultures.

2.4 The birth rate is relatively stable over the longer term, but has recently begun to rise steeply. The death rate continues to fall, contributing to the increasingly elderly population profile.

2.5 Population projections in the medium to long term show a continued trend towards an older population, especially the numbers of over 85s. As ill-health increases with age, this is the main challenge for local health and social care services.

3. SOCIAL AND ENVIRONMENTAL CONTEXT

3.1 Deprivation: In addition to the marked variation between socio-economic groups, the conurbation of Bournemouth and Poole comprises very distinct residential zones, which are occupied by people from similar backgrounds and income level. This presents problems to universal services, which have tended to be provided evenly. In order to achieve equal health and social care outcomes, some targeting of provision may be necessary in a manner which appears unequal.

3.2 Employment and economic profile. As with the rest of England, Bournemouth and Poole is experiencing a sharp economic decline after many years of growth. Unemployment is rising, but still is below the national average. Wage and salary levels are lower that in SE England, while house prices are relatively high, because of the attraction of the area to retirees. This high ration of house prices to earnings presents an obstacle to young people trying to enter the property market. Bournemouth has a relatively high proportion of small flats and homes in multiple
occupation; living conditions which sometimes are accompanied by a greater propensity for ill health.

3.3 Transport and environment: The conurbation has developed over the last century on a zonal pattern, which has led to a high proportion of local needs requiring significant journeys on a decentralised pattern not easily served by public transport. This creates health problems, particularly inactivity, and the adverse environmental impact of high levels of motor traffic.

3.4 Crime and disorder: Generally low levels of crime and disorder obtain across the two boroughs. However, the centre of Bournemouth features a ‘night-time economy’ which brings alcohol-related crime, disorder and health problems. Bournemouth was an outlier for violent crime in 2007/8. Some estates of social housing in both boroughs have higher than average reports from residents of concern for these issues.

3.5 Education: The attainment of pupils in Bournemouth, in maths and English lags behind that of similar authorities elsewhere.

4. LIFESTYLES AND BEHAVIOURS

4.1 Smoking rates are low by national comparison, and continue to fall, but not at rates which will achieve the national targets.

4.2 Alcohol consumption is rising, as is the proportion consumed at home. Most adults consume more than Government recommended levels. There are high levels of liver disease in men living in Bournemouth, probably linked to high alcohol consumption.

4.3 Obesity and overweight affects over 60,000 adults in Bournemouth and Poole, and a third of school children aged 10. Levels in 5 year olds have recently stabilised at just under a quarter.

4.4 Drug misuse. Visible problem drug use clusters in central areas, especially Bournemouth, but the trade is sustained by a much wider clientele. Nevertheless, across the population as a whole, adverse health impact is less than that of alcohol and tobacco consumption.

4.5 Sexual health. Sexually transmitted disease is most common in areas with high levels of young residents, especially around the academic institutions and outer housing estates.

4.6 Under-18 conceptions. These predominate in areas of mainly social housing.

4.7 Physical activity. The conurbation is well served by clubs, beaches and parkland for the minority who seek out physical activity. However the most common opportunity for physical activity- walking to satisfy life’s daily needs (food, work, companionship) is less well served for the reasons described above under ‘transport and environment’.

4.8 Mental health and well-being. Rates in Bournemouth are very high compared with national average, and higher than those in Poole. This may be associated with a high proportion of social isolation and mobility in Bournemouth.
5. **POPULATION GROUPS**

5.1 Children’s needs summary. Overall children in Bournemouth and Poole have a good start to life. However, it is an area of contrasts and there are still significant inequalities in the health of children and young people. The Indices of Multiple Deprivation 2007 show that there are some super output areas among the worst 10 per cent for child poverty in England and Wales: 9 in Bournemouth and 2 in Poole. A further 17 super output areas in Bournemouth fall within the worst 20 per cent nationally and in Poole 8 fall within the worst 25 per cent nationally.

5.2 Older person’s needs summary. Many of the large number of older residents enjoy good health, because of high accumulated wealth and the support this can buy. However, hospitalisation rates are high. For a minority of the elderly, who have fewer assets and lower income, chronic illness rates are high, as are levels of emergency hospital admissions.

5.3 Long-term conditions. Diabetes, coronary heart disease, atrial fibrillation and cancer are prevalent in both Bournemouth and Poole with more cases recorded on GP registers than expected. Hypertension, chronic obstructive pulmonary disease, dementia and heart failure are all under recognised and recorded, as is adult obesity.

5.4 Carers. Because of the high proportion of elderly people, there are many carers, who have needs of their own, as well as in their role as carer.

5.5 Vulnerable adults. There are clear gaps between estimates of the number of vulnerable adults living in the Bournemouth and Poole population and the number currently supported by adult social care services. However, the prevalence of adults with learning disability, as measured by the GP practices, rose sharply in 2008/9 to double that expected, compared with national rates.

6. **POPULATION HEALTH OUTCOMES**

6.1 Life expectancy / healthy life expectancy. The all-age all-cause mortality gap between the most and the least well-off parts of Poole is very wide, and growing wider. In Bournemouth it is less wide, and narrowing slightly. The healthy life expectancy gaps are wider still, because people from deprived areas experience the onset of chronic illness earlier.

6.2 The major causes of death are circulatory disease, but the rate for Bournemouth is lower than the national average and cancer (close to the national average). For Poole, both values are better than national average.

6.3 The burden of ill-health and disease associated with the ageing of the population is likely to increase in the future, because of natural population ageing. More than one in four people in Poole are likely to be over 65 years old by 2030. Conversely, slow population growth and relatively fewer young people, means fewer people whose health burden is less. In addition, more people are surviving into later life with chronic disease – as mortality rates from heart attack and stroke decline, and people survive illnesses that previously would have killed them.

6.4 Infectious disease has seen a resurgence recently, with new influenza strains, high levels of norovirus, and a small increase in TB notifications.
6.5 Tackling inequalities in health is the main challenge for health and local authorities, requiring concerted action to address the underlying causes, starting in areas of greatest need, such as the six Public Health Action Areas.

7. **LOCAL VOICE: WHAT PEOPLE WANT FROM SERVICES**

7.1 Local people in Bournemouth and Poole say they want their services to reflect the following:

* Patient- carer- and family-focussed
* Encouragement for self-care, patient empowerment and the promotion of health and well-being
* Where services are provided by a combination of agencies, users want seamless care, clear patient pathways and timely access
* They want service providers to treat them with kindness, dignity and respect
* They want to avoid complications of poor care, and unplanned admissions
* They desire a comprehensive range of local community health and hospital services
* They want services to be provided in a safe and clean environment
* They expect to be involved in their care, so that they can give informed consent.

8. **EMERGING THEMES AND PRIORITIES**

8.1 Priorities emerging from JSNA.

* Support for older people to remain physically and mentally able, and to live in the best of health for as long as possible
* Mental health issues, and particularly the mental health of older people
* Continuing inequalities in health outcomes that persist across the conurbation, especially in Poole

8.2 Trends in future needs. The growing level of chronic illness in the population is more than a function of demographic change. It is caused on the one hand by the ability of health and social services to help people cope with the impact of ill-health outstripping their ability to cure disease. On the other hand it reflects the depleting vigour of the population, particularly declining levels of physical activity.

8.3 Meeting the gaps. The Wanless Report (2004) envisaged a population ‘fully engaged with its health’ as the only affordable way to cope with the rising levels of morbidity. His prescription remains to be implemented, across the board. However, some sections of the local population have really taken his message to heart, and are enjoying a healthy active older age as a result. In order for this to apply more widely, something beyond exhortation is needed. The Marmot review (2010) will stress the
importance of action to reduce not just health inequalities, but the inequality in the accumulated reserves (mental, physical and social) which individuals build in childhood, and draw on in later life.

9. FUTURE WORK PROGRAMMES

9.1 The Local Area Agreements for Bournemouth and Poole, taken as a whole, will if fully implemented have a major impact on health inequalities. The next, third phase of the LAA should build on this start, informed by this JSNA, to accelerate progress.

9.2 Implementing the Transforming Community Services Strategy will be crucial to meeting the unmet needs around provision of community alternatives to secondary care, particularly for older people and long term conditions, and for people with dementia.

9.3 Shifting investment and resources in health and social care towards earlier intervention within defined pathways of care should improve the impact of prevention and reduce reliance over the longer term on more acute and end of life care. Ultimately, this JSNA has highlighted the importance of commissioning health and social care services to meet population need rather than demand.
SECTION 1
IMPROVING HEALTH AND TACKLING INEQUALITIES

10. INTRODUCTION

10.1 The population of Bournemouth and Poole is healthier than many parts of England when assessed on measures like life expectancy, all age all cause mortality rate, and mortality rates due to major killers like cancer and circulatory disease.

10.2 But this relatively healthy picture masks very different health outcomes between smaller areas within the conurbation. All age all cause mortality (AAACM) rates in the fifth of areas ranked as most deprived are similar to those in some of the most deprived PCTs in England, such as Tower Hamlets (see AAACM analysis).

10.3 This chapter summarises needs assessment information relating to inequalities in major health outcomes at the population level for Bournemouth and Poole. Information on other types of inequality, such as inequalities in take up of health or social care services, are described in other individual chapters in the JSNA relating to those particular care groups or pathways.

10.4 Many of the physical risk factors that are associated with an increased risk of developing chronic disease and the major killers like circulatory disease and cancer are related to lifestyles. In particular, smoking, alcohol consumption, poor diet and lower physical activity levels all contribute to an increased risk of developing a range of chronic diseases.

10.5 As the prevalence of these unhealthy behaviours tends to be higher in areas that have higher multiple deprivation scores, this is part of the explanation as to why there are higher rates of chronic disease, higher mortality rates and lower life expectancy observed in the most deprived parts of Bournemouth and Poole.

11. MAJOR CHALLENGES

- Life expectancy gap across wards – data from 1999-2003 found an 11 year difference in life expectancy between wards in Bournemouth and Poole

- Slope index of inequality – a new indicator measuring life expectancy in the least and most deprived deciles shows a six year gap for females and nearly nine years for males within the PCT’s least and most deprived areas

- All Age All Cause Mortality rate in most and least deprived wards shows the gap in death rates is narrowing in Bournemouth but growing in Poole

- Lifestyle risk factor prevalence continues to be higher in the most deprived areas compared with the least deprived, especially smoking prevalence

12. NATIONAL AND REGIONAL BENCHMARKING DATA

12.1 National and regional benchmarking data shows evidence of a gap in mortality between least and most deprived wards for each local authority area when assessed by ward (Figures i. and ii.). Similarly, the national metric Slope Index of Inequality shows a gap in life expectancy in males and females when comparing least and most deprived Lower Super Output Areas (Figures iii and iv).
Figure i. AAACM gap at ward level, Bournemouth Local Authority Area

Figure ii. AAACM gap at ward level, Poole Local Authority Area

Source: SWPHO / ONS
13. PROGRESS IN MEETING KNOWN GAPS AND CHALLENGES

13.1 The gap in AAACM rates has been narrowing in Bournemouth but is growing in Poole. However, mortality rates in the most deprived areas of Bournemouth are still higher than the most deprived areas of Poole.

13.2 Analysis suggests that many deaths due to cancer and circulatory disease are due to preventable lifestyle and health behaviours – tackling these risk factors in the most deprived areas as a priority is the only way that further progress can be sustained in reducing national targets such as AAACM rates, under 75 cancer mortality rates and under 75 circulatory disease death rates.
13.3 This chapter of the JSNA summarises:

- information on the prevalence of risk factors related to health behaviours such as smoking, obesity, alcohol consumption, poor diet and lack of physical activity;
- data on the prevalence and pattern of the most important risk factors for lifestyle related diseases by locality and population segmentation (e.g. MOSAIC group);
- population health measures demonstrating inequalities by small area;
- qualitative information on inequalities and health improvement priorities;
- analyses of progress in narrowing the gaps in health inequality;
- major gaps and challenges in meeting unmet needs;
- modelling on the projected impact on service use in 3-5 years time;
- major pathways, evidence and cost effectiveness for health improvement services; and
- summary and recommendations for commissioners

14. DEMOGRAPHY AND EPIDEMIOLOGY – WHO IS AT RISK AND WHAT ARE THE RISK FACTORS?

14.1 Inequalities in health outcome can be demonstrated in many different ways. The most important national measures used to assess progress in improving health at the population level include:

- all age all cause mortality (deaths from all causes at all ages);
- under-75 cancer and circulatory disease death rates (measures of premature death due to major killers); and
- life expectancy at birth (usually calculated on a small area basis e.g. wards).

14.2 Each of the above measures when assessed on a small area basis locally shows evidence of unequal outcomes between the population that lives in areas classified as most deprived, compared with areas that are least deprived.

14.3 The Index of Multiple Deprivation 2007 (see Figure x, page 11) is a composite score that is used to rank and classify small geographical areas called Lower Super Output Areas (LSOAs). These are smaller areas than wards (typically four or five LSOAs comprise each ward). When measures of health outcome such as AAACM are examined on a small area basis, the death rates tend to be higher in areas that have a higher deprivation score compared with areas with a lower deprivation score.

14.4 There are also patterns of mortality within the conurbation that show the differing impact of lifestyle related illnesses by age. For example, life expectancy at birth is calculated using age-specific death rates for each area. In areas where there are more deaths occurring at relatively younger ages, this lowers life expectancy compared with areas where there are more deaths occurring later in life.
14.5 Figure v shows life expectancy at birth by ward for the period 1999-2003 for Bournemouth and Poole. Those wards with lower life expectancies are experiencing more premature deaths compared with the mortality experience of the rest of the PCT.

![Figure v.](image)

14.6 Analysis of deaths from all causes occurring before the age of 65 years shows wide variation in the rates by ward. In addition, many of these early deaths are related to unhealthy lifestyles, including drug and alcohol misuse, mental health, poor diet and lack of physical activity – 40 per cent of all deaths were due to cancers and 20 per cent due to circulatory disease, risk factors for which are modifiable in many cases.
15. RISK FACTORS

15.1 Improving the health of populations living in the most deprived areas of the PCT is a strategic priority given the observed differences in health outcome between deprived and least deprived areas. Because many of the deaths are due to diseases caused in part by lifestyle risk factors, commissioning of services to support people to change behaviours will preferentially be targeted at more deprived areas, where mortality rates are highest.

15.2 The most important modifiable risk factors are smoking, poor diet and lack of physical activity (including the development of obesity), alcohol and drug misuse.

15.3 Accurate data on the prevalence of these risk factors is hard to come by. However, there are two sources that can be used to estimate the prevalence of these lifestyle risk factors:

- Synthetic estimates of smoking, diet and physical activity at small area level, based on Health Survey for England data
- MOSAIC Public Sector postcode data (a population segmentation from Experian) on the likelihood of different demographic groups locally being heavy smokers, having poor diet, low physical activity levels and being obese.

15.4 The national synthetic estimates of lifestyle behaviours at ward level have wide confidence intervals indicating that the estimates are imprecise.

15.5 Local MOSAIC data has been analysed to produce maps showing the likelihood of demographic types living within each postcode having various lifestyle risk factors. These include maps for likelihood of being a heavy smoker, eating less than one portion of fruit or vegetables per day, being obese (body mass index >30 Kg/m²), taking no exercise or being at higher risk of teenage conceptions. In all of these maps there is a close association between postcodes highlighted by Mosaic as being more likely than the national average to have these risk factors, and the public health action areas.
Figure vi. Heavy Smokers

Figure vii. Obesity
Figure viii. Likelihood of eating less than one portion of fruit and vegetables per day (Health Survey for England)

Figure ix. Likelihood of taking no exercise in past month (HSE)
16. MOSAIC GROUPS MOST LIKELY TO DISPLAY LIFESTYLE RISK FACTORS

16.1 Most likely to be a heavy smoker: Mosaic groups F, G, H and D.
Typical area likely to be found:
- Boscombe and Springbourne Public Health Action Area (e.g. Types D25, F35 >6 times as prevalence compared with PCT population)
- Kinson PHAA (e.g. types H45, 46 and 47 3-7 times more prevalent than PCT population)

16.2 Most likely to have a BMI >30: Mosaic Groups H, I, G and C
Typical area likely to be found:
- Newtown and Alderney PHAA (Mosaic Type C16 nearly three times as prevalent compared with PCT, Group I, >2 times as prevalent)
- Kinson PHAA

16.3 Most likely to have taken no exercise in past 12 months: Mosaic groups I, G, F and H
Typically found:
- Poole Town PHAA (Mosaic types I49, F39),
- Kinson (Mosaic groups H)

17. KNOWN HEALTH STATUS OF THE POPULATION: QUANTITATIVE ANALYSIS

17.1 Measurement of the Slope Index of Inequality in life expectancy for Bournemouth and Poole between most and least deprived areas shows that it is wider than many similar PCTs for males and females, and above the national median. The interpretation is stark – males and females in Bournemouth and Poole born in the ten per cent of areas ranked as most deprived can expect to live nine and six years less than males and females born in the ten per cent of areas that are least deprived.

17.2 This difference translates into very different all age all cause mortality rates in the least and most deprived areas:
- Bournemouth UA – the gap in all age all cause mortality rates between least and most deprived areas has fallen from 240 deaths per 100,000 to around 214 deaths per 100,000 since 2000
- Poole UA – the gap in AAACM rates between the least and most deprived areas has nearly doubled, from 113 deaths per 100,000 to 200 deaths per 100,000 in the same time.

17.3 Between 2000 and 2007 the AAACM rate in the least deprived areas of Poole have fallen considerably while those in the most deprived have remained the same. In Bournemouth, there has been a roughly similar fall in AAACM rates in the least and most deprived areas, maintaining the gap. Death rates in the most deprived areas of Bournemouth remain higher than those of the most deprived areas of Poole.

18. KNOWN HEALTH STATUS OF THE POPULATION: QUALITATIVE INSIGHTS FROM STAKEHOLDERS

18.1 Extensive qualitative research was commissioned in 2009 to understand more about the barriers experienced by particular groups locally in accessing health improvement services, specifically smoking cessation and healthy eating / physical activity in the
context of tackling obesity. Given that many of the chronic illnesses that are contributing to higher death rates in the most deprived areas are lifestyle related, the research wanted to explore motivation and barriers to giving up smoking and eating more healthily / taking more physical activity.

18.2 The research comprised a mixture of focus groups and depth interviews with carefully targeted populations, recruited from the public health action areas. As well as area deprivation score, the researchers were asked to identify people from other demographic segments, including:

- Teenage parents
- Older people with long term conditions
- Low income families

18.3 The research highlighted that some key groups locally did not view giving up smoking as realistic, particularly older people living alone. Targeting smoking cessation efforts to this group may be unrealistic.

18.4 There were many perceived barriers around access to services, and making access quicker and easier is one way that access to health improvement services could be improved in deprived areas. In other words, providing a uniform service may not provide incentives for different communities and populations.

18.5 Similarly, in exploring barriers to changing lifestyles to reduce obesity, participants very strongly identified the need for appropriate opportunities to increase physical activity in settings they felt comfortable with, along side practical help with cooking skills. Community-based exercise classes specifically for people with obesity were also suggested on a pay as you go basis, ideally with crèche facilities.

18.6 Overall the research suggests that the level of intrinsic motivation to quit smoking or change lifestyles in relation to obesity is much lower in some key groups living in the public health action areas, compared with other parts of the population that have embraced changing lifestyles more readily. Due to competing pressures, motivation to quit smoking or lose weight is seen as less important than other issues.

18.7 The PCT is developing an independent health advisory group where different representatives from diverse communities can assist with understanding qualitative information about inequalities in access and health outcome locally. Examples of recent forums have included focus group work understanding stigma around HIV in BME communities, meeting with Muslim community representatives to discuss access and inequalities issues, and a discussion forum with BME representatives around obesity and diet.

18.8 Results of a recent forum to discuss health inequalities identified several local issues facing different communities, including:

- Primary care access issues among the gypsy and traveller community
- Mistrust of childhood immunisations by BME communities

18.9 There are issues around poor delivery of some health services to specific groups including the elderly, people with language difficulties, and misunderstanding among BME communities about how to access services.
19. IDENTIFYING UNMET NEED: KEY GAPS

19.1 Investing in preventative services to improve lifestyles and health behaviours in the most deprived areas is a priority if the observed gap in life expectancy and AAACM rates is to be closed.

19.2 In particular, tackling risk factors associated with cardiovascular disease, cancer and premature deaths (e.g. alcohol and illicit drug use) would contribute most to reducing this gap in health outcomes.

19.3 However, there remain significant gaps between population needs and the current level at which health improvement services are provided.

For example:

- There are an estimated 40,000 people at any one time who may be smoking and what to quit (based on national estimates of 70 per cent of the total population of smokers). Local smoking cessation services currently see between 2,500 and 3,000 people per year – less than 10 per cent of the need.

- There are an estimated 60,000 adults in the PCT who are obese – current services that offer access to advice and support on improving diet and increasing physical activity reach a fraction of this number.

19.4 Given the association between some cancers and cardiovascular disease with lack of physical activity and overweight / poor diet, failing to close this gap between population need for health improvement and current provision risks:

- Worsening inequalities in AAACM (as rates are driven by cancer and cardiovascular disease)

- Poorer population health outcomes overall as the recent fall in deaths due to cardiovascular disease and early cancers may be reversed due to obesity-related disease.

19.5 Consultation with local service users and stakeholders as part of a local pan-Dorset NHS conference in 2009 showed tackling obesity was recognised as among the top five health concerns locally.
20. **AREA OR LOCALITY BASED INFORMATION**

20.1 Bournemouth and Poole has 21 Lower Super Output Areas ranked in the fifth of areas nationally that are most deprived (17 in Bournemouth and 4 in Poole). Together, these small areas are home to around 20,000 people, or about 7 per cent of the population. This deprivation map (Figure shows Bournemouth and Poole with all of the LSOAs shaded to represent the degree of deprivation, based on national quintiles. Because of the comparatively worse health experienced by residents living in the most deprived areas compared with the rest of the conurbation, six public health action areas have been identified, shown on the map by dashed blue boundaries. These closely correlate to areas with the highest IMD scores.

*Figure x. Deprivation Score (IMD 07) and local Public Health Action Areas*

20.2 The demographic tables for the public health action areas provide rough estimates of the numbers of people living in each of these areas by age and sex. In total these areas are home to around 80,000 people, or 27 per cent of the PCT population resident within the local authority boundaries.

20.3 For more information on the profile of each of these small areas based on segmentation by Experian’s MOSAIC Public Sector see the profiles at `\dhscfps01\data\Public Health Folder\JSNA Bournemouth and Poole\adults\improving health and tackling inequalities\core datasets\Mosaic profiles PHAAs`. Each shows the extent to which particular demographic types are over or underrepresented in these areas compared with the PCT as a whole.

20.4 The PCT is continuing to undertake small area needs assessment in each of the public health action areas to better understand needs on a locality basis. The
detailed information on a range of health indicators relating to these areas can be accessed at \dhscfps01\data\Public Health Folder\Joint Strategic Needs Assessment\Locality JSNA\Chapter 1.

21. ANALYSIS OF INEQUALITIES

21.1 This chapter is mainly about tackling the observed inequalities in health outcome seen between least and most deprived areas within the PCT.

21.2 However, there are other inequalities apart from health outcome that contribute to the overall pattern of health inequality observed locally. These can be described in the following ways:

- Inequalities in wider determinants of health e.g. in area deprivation score, employment or educational achievement across the conurbation;
- Inequalities in access or take up of preventive, health or social care services across the conurbation;
- Inequalities in risk of disease or poorer outcome arising from ill health experienced by particular groups locally.

21.3 The first point is illustrated by the variation in area IMD 2007 score across the conurbation, and is often used as a variable against which to analysis observed patterns in use or outcome from health or social care services.

21.4 The second type of inequality is important locally in that there are variations locally in uptake of preventive health services such as cancer screening by general practice weighted deprivation score. Breast, bowel and cervical screening uptake rates have all been found to vary locally depending on the deprivation score of practices from which patients are invited. These associations are significant on statistical testing. Analysis of outcome from cervical screening shows that not only do deprived areas have poorer uptake, but they also are more likely to have more abnormal smears – a proxy for unprotected sexual intercourse.

Figure xi. Variation in uptake of Bowel Screening by practice deprivation score

![Figure xi. Variation in uptake of Bowel Screening by practice deprivation score](image-url)
Variation in cervical screening uptake in women 25-49 years by practice IMD score

The third inequality can be illustrated locally by the unequal burden of HIV experienced by heterosexual people who have acquired their infection from overseas, particularly from countries in sub-Saharan Africa. Bournemouth and Poole has for many years had a large population of men who have sex with men, and the proportion of infections newly diagnosed was predominantly from this population. This pattern has changed in recent years, and more than half of newly diagnosed infections are now in heterosexuals who acquired them outside of the UK. Local audit of patients presenting for treatment for HIV has shown that a greater proportion of patients who acquire their infection heterosexually, and originate from overseas are diagnosed late compared with patients who acquire their infection in the UK.

MEETING THE GAPS – ANALYSIS OF PROGRESS

Previous sections have shown how there is a widening gap in AAACM rates between deprived and least deprived areas of Poole, and a slight narrowing of the gap in Bournemouth. Further analysis has been done to understand:

- Diseases and risk factors most likely to underlie the observed pattern of inequality
- Drivers of performance to explain this pattern

The London Health Observatory inequalities tool has been used locally to gauge the life expectancy years gained if the most deprived quintile of small areas (based on IMD score) had the same mortality rates as the average for the other four quintiles for each local authority. The results for Poole highlight the importance of cardiovascular and respiratory disease for males and females, and are strongly associated with smoking.
Table ii

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22.3 Results for Bournemouth are to some extent similar, and highlight the importance of the difference in coronary heart disease rates and respiratory disease including lung cancer between most and least deprived quintiles.

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22.4 The observed difference between AAACM rates and life expectancy between least and most deprived areas, based on this analysis, shows that it is in part related to different mortality rates due to chronic diseases with a strong association with smoking, physical activity and diet – and to a lesser extent alcohol and substance misuse. The population health gains experienced by more affluent communities have not been enjoyed by those living in the most deprived areas. This is borne out by analysis of smoking prevalence by practice which shows higher rates of smoking in our more deprived areas.

22.5 The PCT is monitored nationally in terms of its progress in reducing deaths from cardiovascular disease and cancer among the under 75s as a broad proxy for early deaths, some of which are preventable. Recent analysis of progress in reducing under-75 cancer death rates has shown:

- Wide variation in mortality rates by ward across the PCT
- A large proportion of early deaths in cancer are from cancers with an association with lifestyle risk factors such as smoking, diet, alcohol and exercise.

22.6 Although under-75 cancer death rates locally are lower than the national rate, progress has been slow on this measure in recent years. This analysis would suggest that one of the reasons for slower progress has been that lung cancer death rates in the more deprived areas of the PCT are not changing as quickly as other areas of England.
22.7 A recent analysis of inequalities in lung cancer in the South West found there had been little change in the age standardised incidence rate and subsequent mortality rate for lung cancer among males in Bournemouth between 1995-1997 and 2004-2006.¹ There has been a much larger fall in the national age standardised incidence rates for lung cancer among males in the same period. Incidence rates are now similar between Bournemouth and the average for England.

22.8 The message for health improvement is that resources and services need to be more closely targeted to deprived communities if this gap in health outcomes is to be closed.

23. PROJECTED SERVICE USE AND OUTCOMES IN THE MEDIUM TERM

23.1 Improving lifestyle risk factors such as smoking and obesity will be crucial to sustaining the observed reductions in AAACM rates, under 75 cancer death rates and under 75 CVD rates within the conurbation. Because the population in the least deprived areas is enjoying much better health in general than many areas of England, the only way of continuing to make progress is to improve mortality rates in the most deprived areas.

23.2 However, local modelling has also highlighted the importance of prevention and modification of lifestyle risk factors in being able to sustain health and social care services in the medium term. For example, introducing cardiovascular risk checks in the most deprived fifth of areas and identifying unmet needs in terms of smoking cessation, physical activity and dietary change is predicted to have a large impact on future need for expensive secondary care procedures such as emergency treatment of heart attacks and strokes. Pathway modelling for stable angina and stroke shows:

- improving the management of hypertension in primary care of patients already known to GPs could prevent 72 strokes per annum
- improving statin prescribing for people identified at greater than 20 per cent CVD risk in ten years would prevent 34 strokes per annum and 99 heart attacks or coronary revascularisations
- improving cardiovascular risk factors from people identified as high risk in the most deprived areas via NHS Health Check has the potential to prevent 40 strokes in a five year period
- without tackling primary prevention of stroke, emergency admissions are predicted to rise by up to 200 admissions over the next three to five years in line with past trajectory.

23.3 Modelling undertaken to support the development of an adult obesity strategy locally shows that obesity will become a major driver of future need for knee and to a lesser extent hip replacements. In the decade between 2015 and 2025, the modelling predicts increases in obesity could more than double the number of knee replacement operations, and increase the required number of hip replacements by about 40 per cent. The charts show this graphically compared with a model based on age alone. The estimated cost to the local NHS of obesity is projected to rise from £46.4 million in 2007 to £57.7 million by 2015 if prevalence is not reduced.

¹ SWCIS/SWPHO. Lung Cancer inequalities in the South West Region. March 2009.
24. MAJOR PATHWAYS: EVIDENCE AND COST-EFFECTIVENESS SUMMARY

24.1 The 2009 Transforming Community Services for Bournemouth and Poole plan outlined several health improvement pathways that will be important in the context of reducing the gap in health outcomes locally. These include:

- Smoking cessation services
- Obesity including services to improve physical activity levels and diet
- NHS Health Check (cardiovascular risk assessment for 40-74 year olds)

24.2 The supporting strategy for health improvement and reducing inequalities that was developed as part of the TCS strategy has mapped needs and the current level of met needs from local services within these pathways clearly.

24.3 Modelling of the costs and benefits associated with implementing NHS Health Check in deprived areas as a priority shows that implementing a systematic cardiovascular primary prevention programme locally would be highly cost effective at about £3,500 per QALY gained. Early pathway modelling suggests starting Health Check in the most deprived areas of the PCT would identify up to 350 people with hypertension and 280 people with raised cholesterol per year who would benefit from statin treatment. Treating these people and lowering their cholesterol and blood pressure would prevent about 40 strokes and 15 heart attacks or CHD-related deaths in a five year period.

24.4 National guidance on health improvement specifically addressing the issue of reducing inequalities in health includes:

- NICE Public Health guidance on identifying and reducing people most at risk of dying prematurely
• Achieving behaviour change and guidance on community engagement for health improvement.

24.5 More specific health improvement guidance can be found within the sections of the JSNA dealing with these lifestyle and behaviour risks individually.

25. SUMMARY AND RECOMMENDATIONS

25.1 There are several gaps and challenges arising from this needs assessment in relation to improving health and tackling health inequalities. In particular:

• benchmarking data on life expectancy and AAACM rates clearly shows different mortality rates in the least and most deprived areas of the conurbation, with mortality rates similar to Tower Hamlets in the most deprived areas of Bournemouth;

• A widening gap in AAACM rates between least and most deprived areas of Poole;

• Small area analysis suggests much of this disparity can be explained by lifestyle related diseases (some cancers such as those of digestive tract and lung cancer, circulatory disease, and early deaths due to drug and alcohol misuse).

25.2 Major areas of unmet need in relation to the current provision of health improvement services include:

• Developing community-based approaches to supporting people to take more physical activity and improve diet (to tackle obesity);

• Improving access to and take up of smoking cessation services among the most deprived parts of the conurbation;

• Developing systematic primary prevention services in relation to people identified at high risk of cardiovascular disease, starting in the most deprived areas (e.g. implementing NHS Health Check).
1. INTRODUCTION

1.1 Older people are special, having survived life’s vicissitudes through world war, food and other resource shortage, widespread infectious disease, smoking and motoring epidemics. They matter hugely to maintaining healthy families and communities by passing on their survival skills to the next generations.

1.2 They also matter because, as their personal reserves are depleted by the passage of time, their later life can be eased considerably by appropriately designed and fairly delivered local services.

1.3 Thanks to continued improvements in education, housing, diet, and health and social services, older people are living longer than ever before, while the birth and immigration rates stay low, so the age group which uses most social and health care services is also growing more rapidly than most other sections\(^2\) of the population. (See data set Population growth 2010-2026 Poole/Bournemouth).

1.4 Bournemouth and Poole is second only to Dorset in NHS South West for the proportion of older (70+) people admitted for hospital elective care\(^1\) (42%). This rate is rising faster than any other PCT in the region; up from 36% in three years. For non-elective admissions, the rate for older people (75+) is 54%, also second highest to Dorset. However, in this case, the rate has been steady for the last 4 years.

1.5 Two factors are strongly linked with the ability of older people to stay healthy: close family support, and disposable income. These factors, and their links with patterns of disease, are explored in the following section.

2. DEMOGRAPHY AND EPIDEMIOLOGY (WHO IS AT RISK, WHAT ARE THE RISK FACTORS)

2.1 Irrespective of the quality of local services, the family is the first and most commonly used source of health and social support. However, advancing years erodes this vital resource. There are over 9,000 old people living alone in Bournemouth now, a figure projected to rise to over 10,500 in the next 205 years. By that time, there will be a similar number of elderly living alone in Poole, up from 7,700 today. The current number of people aged 65 and over unable to manage at least one self-care activity on their own is over 22,000, and predicted to rise to over 27,000 by 2025.

2.2 The income of older people across Bournemouth and Poole varies markedly, clustering in the Public Health Action Areas (figure xiv):

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\(^2\) Except 20-25 year olds in Bournemouth
2.3 This clustering of low income older people is mirrored in the pattern of disease affecting the elderly. Figure xv shows the rates of dementia identified across the two boroughs, comparing the prevalence recorded by local GPs with the rate expected by applying national rates to weighted populations.
2.4 Stroke is a condition which increases markedly with age, and often precipitates lasting dependency. The pattern of prevalence is far from uniform, with a much greater prevalence in more deprived communities.
2.5 Risk factors for older people include those which increase the likelihood of falls. Whereas falling is a natural learning event for children, and an occasional embarrassment for adults, it can bring serious consequences in later life, when bones are brittle and recovery slow. Hip fracture is a common and serious consequence of a fall in older people, often leading to long-term dependency and sometimes early death. Figure xvii below shows that hip fractures are rising rapidly in Bournemouth and Poole and have overtaken the regional and national rates in recent years.
Physical activity is as important in old age as it is for any adults, yet rates fall precipitately after retirement age. Despite the fact that most jobs are now sedentary, people still take the ‘putting your feet up’ adage literally, with potentially lethal consequences. Keeping active in later life is strongly associated with maintaining physical (Hagenfelt 2004) and mental health (Arent 2000). Although physical activity is associated by many with gyms, leisure centres and sport, the exercise derived from all these is dwarfed by that gained from everyday walking, housework and gardening. The location and climate of Bournemouth and Poole are ideal for regular exercise, but 90% of older residents do not do enough to stay fit. Figure xviii (below) shows the typical pattern for Mosaic (the population segmentation tool from Experian) Type 16 (recently retired women on modest income). Almost 80% take no measurable exercise, with fewer than 10% exercising more than three times weekly. Paradoxically, the most commonly quoted reason for taking exercise by this group is for health benefit, while poor health is also the commonest reason for abstaining.
3. KNOWN HEALTH STATUS OF THE POPULATION: QUANTITATIVE ANALYSIS

3.1 Overall people live longer in Bournemouth and Poole than many other areas of England. Life expectancy for males in 2005-2007 was 78.4 years, and 82.7 for females. Both measures place the PCT above the national median benchmark but below the median for SHA peer PCTs. This overall measure of life expectancy masks variation across the PCT. For more information about the variation in life expectancy see Section 1, on health inequalities.

**figure xix:** Healthy life expectancy by ward 1999-2003 (Source SWPHO)
3.2 Figure xix above shows another measure of health status available at ward level, which is the estimate of the number of years of life lived in good health, or healthy life expectancy. This shows a variation across the PCT of more than 14 years. Wards with the lowest healthy life expectancy are Boscombe East, Kinson and Central in Bournemouth, and Hamworthy, Alderney and Newtown and Poole Town. These wards are also within the public health action areas of the PCT.

3.3 Table iii on page 31 shows the reported prevalence of selected long term conditions in each of the seven practice based commissioning localities in Bournemouth and Poole expressed as a ratio of expected prevalence. Prevalence from each practice within the locality has been aggregated for each condition. A number close to or equal to 100 indicates no difference between what is recorded on GP registers and the expected prevalence based on national models.
### Table iii. Selected long term conditions – reported vs expected prevalence where 100 = no difference from expected number for practice based commissioning localities in Bournemouth and Poole.

<table>
<thead>
<tr>
<th>Bournemouth Localities</th>
<th>Heart failure</th>
<th>Depression</th>
<th>CHD</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Atrial Fibrillation</th>
<th>Obesity</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>60</td>
<td>124</td>
<td>64</td>
<td>70</td>
<td>44</td>
<td>103</td>
<td>31</td>
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<td>North</td>
<td>51</td>
<td>122</td>
<td>78</td>
<td>94</td>
<td>51</td>
<td>102</td>
<td>51</td>
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<tr>
<td>West</td>
<td>56</td>
<td>126</td>
<td>76</td>
<td>85</td>
<td>48</td>
<td>105</td>
<td>38</td>
<td>198</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poole Localities</th>
<th>Heart failure</th>
<th>Depression</th>
<th>CHD</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Atrial Fibrillation</th>
<th>Obesity</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkstone</td>
<td>55</td>
<td>128</td>
<td>85</td>
<td>86</td>
<td>51</td>
<td>106</td>
<td>43</td>
<td>161</td>
</tr>
<tr>
<td>Poole Bay</td>
<td>53</td>
<td>73</td>
<td>81</td>
<td>69</td>
<td>50</td>
<td>122</td>
<td>26</td>
<td>222</td>
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<tr>
<td>Poole Central</td>
<td>71</td>
<td>112</td>
<td>88</td>
<td>95</td>
<td>50</td>
<td>120</td>
<td>38</td>
<td>228</td>
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<td>Poole North</td>
<td>55</td>
<td>80</td>
<td>104</td>
<td>80</td>
<td>57</td>
<td>111</td>
<td>41</td>
<td>203</td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework / NHS comparators 2008/9

2010-2015 Bournemouth and Poole Joint Strategic Needs Assessment 2.0
3.4 There is no adjustment made to take account of the different age and sex structures of each practice based locality, so the observed differences could be due to different population structures. For some conditions, there are also likely to be differences in the proportion recorded on GP registers which explains the variation across the conurbation. This is particularly true of silent conditions like hypertension which are often present with no symptoms.

3.5 Heart failure, CHD, diabetes, hypertension and obesity all show fewer cases than expected based on national prevalence models. At least some of this will be explained by under-recognition. For some conditions like CHD and diabetes, the figures may truly represent fewer cases in the population compared with what would be expected nationally – i.e. there is less population need. For obesity, heart failure and hypertension the low prevalence is more likely to be explained by under-detection.

3.6 Depression, cancer and atrial fibrillation (abnormal beating of the heart) are over represented compared with national prevalence models. There are several possible explanations, including a greater burden of disease in the population from these conditions, or an older age structure within practices (especially for age-related conditions such as cancer). In the case of cancer, local incidence rates after adjusting for age differences show Bournemouth and Poole to have one of the highest rates in England — well within the top 20 per cent of local authority areas. Depression prevalence appears to be higher in Bournemouth localities than Poole, and may represent a true difference in the burden of mental ill health between the local authority areas.

4. KNOWN HEALTH STATUS OF THE POPULATION: QUALITATIVE INSIGHTS FROM STAKEHOLDERS

4.1 The PCT consulted with a range of stakeholders including older people as part of developing its Transforming Community Services strategy for improving management of long term conditions.

4.2 Comments received from older people about the PCTs commissioning intentions included broad support for providing more services closer to home that are currently provided in hospital. There was strong support for only going to hospital when problems were identified, not for routine follow ups or blood tests. There was support for more provision of community rehabilitation services like cardiac rehabilitation in group settings rather than one to one.

4.3 There was strong support for more investment in preventative work such as exercise classes for elderly people, to improve their ability to remain independent. Other comments related to ensuring adequate skills in the community to cope with issues, and prevent people from having to access hospital.

4.4 Comments from partners including local authority workers included support for the creation of new models of community care, including virtual wards and more integrated health and social care teams. There was support for earlier intervention for people with conditions like dementia, and support for locality based working.

4.5 Bournemouth and Poole councils together supported 585 clients in residential care in 2008/9 (source NASCIS), a similar number to 2007/8. However, the number supported in more intensive nursing homes fell by 20% to 85 persons.
5. IDENTIFYING UNMET NEED: KEY GAPS

5.1 The NHS Bournemouth and Poole hospitalisation rate for older people is second highest in the region, and efforts to reshape services to provide more care closer to home require adequately skilled and resourced community teams. Qualitative and quantitative information shows that there is a large unmet need in terms of being able to access community alternatives to hospital admission, particularly for people with long term conditions.

5.2 The analysis of practice prevalence compared with expected prevalence shows that there is a large unmet need in the community arising from under-diagnosed conditions, particularly dementia as well as heart failure, hypertension, and obesity. There are likely to be many more people living in the community with these conditions compared with those currently known to registers. Given that many of these conditions can be prevented by undertaking more physical activity at earlier ages, there is also an unmet need for support to increase physical activity levels.

5.3 The most important way of meeting this need would be to increase the amount of walking taken by older people. Advice from GPs and other health professionals is necessary, but not sufficient, especially as this group overall also takes less activity than recommended. Doctors and nurses are local leaders, and behaviour which they themselves model is more likely to be emulated.

5.4 Local authorities, as shapers of the places where people live, are key partners in any strategy to encourage daily walking, for all ages not just the elderly. An invaluable and growing resource of evidence-based interventions is being amassed by Bristol City Council, (Davis 2009) iii. Re-allocation of road space and traffic speed reduction will make local walking more pleasant, and feel safer which will naturally increase participation rates. Schemes in London and Stockholm have increased walking rates by 30 per cent, (and reduced congestion) financed through levies on non-active private transport. The combination of carrot (more facilities and space for walking and cycling) with stick (congestion levy) distinguishes success from failure in schemes designed permanently to increase physical activity measurable at a population level. (Maibach 2009) iv

5.5 Through the Local Transport Plan, a mechanism exists for shifting investment from non-active to active travel modes. This should be vigorously pursued, because higher levels of walking will not only benefit older people, but all ages, and protect against many chronic, highly prevalent diseases. It will also contribute to reducing carbon emissions. These measures are likely to be popular, because in the recent Place Survey of local residents, the quality of pavements, reduction of traffic congestion scored highly as both important to the quality of life, and in need of improvement. (Bournemouth Borough 2009) v For older people, top concerns were crime, and (lack of) clean streets. If more car users were persuaded to walk instead, this would deter crime through increased social cohesion (Bursick & Grasmic 1993) vi

5.6 Planning regulations can be used to promote local walking. Mixed neighbourhoods with a high proportion of commercial establishments are associated with higher walking rates among older people. (Nagel et al 2008) vii The development and implementation of core strategies by local authorities with partners can do much to influence levels of physical activity.
6. AREA OR LOCALITY BASED INFORMATION

6.1 The health and social care teams working within the conurbation have developed agreement on seven localities across Bournemouth (three localities) and Poole (four localities). Each differs in terms of their population composition. This is shown quite clearly by the life expectancy at birth chart for each of these localities, below.

figure xix

NHS Bournemouth and Poole
Proportion of residents in Bournemouth and Poole living in neighbourhoods belonging to each of the five national quintiles for life expectancy at birth (persons 1999 to 2003)

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Bournemouth and Poole</th>
<th>Bournemouth East</th>
<th>Bournemouth North</th>
<th>Bournemouth West</th>
<th>Pannorne</th>
<th>Poole Bay</th>
<th>Poole Central</th>
<th>Poole North</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile 1</td>
<td>12.6%</td>
<td>17.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>27.7%</td>
<td>0.0%</td>
<td>56.1%</td>
</tr>
<tr>
<td>Quintile 2</td>
<td>37.4%</td>
<td>18.4%</td>
<td>26.6%</td>
<td>0.5%</td>
<td>73.7%</td>
<td>72.5%</td>
<td>56.9%</td>
<td>43.3%</td>
</tr>
<tr>
<td>Quintile 3</td>
<td>23.0%</td>
<td>17.4%</td>
<td>43.5%</td>
<td>59.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>17.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quintile 4</td>
<td>21.1%</td>
<td>15.5%</td>
<td>27.9%</td>
<td>43.5%</td>
<td>26.3%</td>
<td>0.0%</td>
<td>26.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quintile 5</td>
<td>5.6%</td>
<td>32.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

National Quintiles for Life Expectancy at Birth: Quintile 5 = 55.4 - 65.7 yrs; Quintile 4 = 46.7 - 55.3 yrs; Quintile 3 = 39.3 - 46.7 yrs; Quintile 2 = 29.7 - 39.3 yrs; Quintile 1 = 18.1 - 29.7 yrs.
Data source - Office of National Statistics
6.5 The 2009 Place Survey found that 90 per cent of older people living in Poole express themselves satisfied with their home and neighbourhood (Borough of Poole 2009). The value for Bournemouth was 86.2 per cent, and that for England 83.9 per cent. (Bournemouth Borough 2009)

6.6 In the same survey, 39 per cent of Poole and 34.5 per cent of Bournemouth respondents felt that older people are supported to live independently at home (compared with England average 30 per cent; Bournemouth Borough 2009)

7. ANALYSIS OF INEQUALITIES

7.1 The greatest health inequality is that which prevents people reaching old age in the first place. The risk of mortality from all causes in 2005-2007 varied between 450 and 700 deaths per 100,000 persons between the least and the most deprived fifths of the population of Bournemouth and Poole, equivalent to a difference in life expectancy of 11 years. For those who do survive to retirement age and beyond, there is a marked difference in experience of disability, depending on social class. Figure xxi (below) is taken from the forthcoming Strategic Review of health inequality by Professor Sir Michael Marmot. It shows that while life expectancy (pink shading) increases with social advantage, the slope for disabling illness (blue shading) is even

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3 Directly standardised rate
more severe, with the median age at which disability affects those in the lowest social
groups occurring in the early 50s – 15 years earlier than for those at the other end of
the spectrum.

Among older people, there are inequalities in health status. These are most closely linked
with household resource, and deprivation (Grundy 2001)\textsuperscript{x}. The pattern of chronic obstructive
pulmonary disease (COPD, a condition which affects people in later life, after years of
smoking, and/or industrial exposure to air-borne pollutants) shows how practices which
serve the public health action areas with high rates of elderly people, have much higher
rates (see figure xxii below).

\textbf{figure xxi}

Among older people, there are inequalities in health status. These are most closely linked
with household resource, and deprivation (Grundy 2001)\textsuperscript{x}. The pattern of chronic obstructive
pulmonary disease (COPD, a condition which affects people in later life, after years of
smoking, and/or industrial exposure to air-borne pollutants) shows how practices which
serve the public health action areas with high rates of elderly people, have much higher
rates (see figure xxii below).
7.2 Use of health services by older people varies across the conurbation. There is a very clear association between higher rates of emergency admissions and area deprivation score, as shown in Figure xxiii below. There could a number of explanations – the prevalence of long term conditions is higher in areas with higher deprivation scores, and so the observed increase in emergency admissions is directly related to differences in prevalence; or there are differences in the way that community services are organised and provided, with fewer alternatives to hospital admission available to people living in more deprived areas.
7.3 Long-term follow-up of old people in a similar population shows that the most important ways to promote a healthy old age are:

- Postponing retirement
- Promoting healthy lifestyles
- Social, interaction, especially between generations and family support (Dolye et al 2009).

8. MEETING THE GAPS – ANALYSIS OF PROGRESS

8.1 Of Doyle’s three key interventions to improve health in old age, (postponing retirement, promoting healthy lifestyles, and social interaction/family support), the first is not a strategic aim of either local authority or the PCT. Healthy lifestyles are promoted, often in partnership, and particularly at older people. Social interaction is mainly supported by the local authorities.

8.2 The PCT has worked in partnership to promote healthy lifestyles. There has been a particular link for several years to leisure services. Increasingly, the PCT is working with transport and spatial planners in recognising their roles in enabling and encouraging everyday physical activity. The current Local Transport Plan (LTP 2) makes reference (SE Dorset 2008), particularly to the need to promote everyday walking. However, there needs to be far greater emphasis on reducing numbers of car journeys, especially short journeys. There has been a significant rise in public transport journeys and the next Local Transport Plan (LTP3) needs to actively promote further public transport, the infrastructure for creating pleasant and safe
walking and cycling journeys, and this in itself should encourage more people to leave their cars at home.

8.3 The next local transport plan (LTP 3) should correct this oversight, focusing especially on areas of greatest health need.

8.4 Social interaction is closely linked with the local transport situation. For example, fast, busy roads inhibit interaction between neighbours while low public transport fares promote them. The LAA objective to reduce traffic congestion could inadvertently increase social isolation. On the other hand, if area-wide 20mph zones were introduced across residential areas, this would benefit social interaction, and cut road casualties, by as much as 40%. (Grundy C 2009)

8.5 Progress in closing the observed gap in all-age all cause mortality rates between least and most deprived areas locally is covered in more detail in section 1 (inequalities). In summary, progress has been better in Bournemouth UA where the gap has narrowed compared with Poole UA where the gap has widened. It should be noted that AAACM rates in the most deprived areas of Bournemouth remain higher than Poole’s most deprived areas.

9. PROJECTED SERVICE USE AND OUTCOMES IN THE MEDIUM TERM

9.1 The greatest potential impact on use of health services in the medium term arising from this analysis of older people and long term conditions is a continuing increase in emergency admissions and secondary care activity, especially if community alternatives are not developed in line with recommendations in Transforming Community Services plans.

9.2 The proportion of people aged 65 and over is set to increase by 1-2 per cent in the next five years. Given that 36 per cent of all admissions to secondary care are among the over 65s and that 58 per cent of the total cost is attributable to this age cohort, any increase in the demographic is likely to increase future activity and costs of secondary care.

9.3 From the analysis of prevalence of long term conditions locally, it is clear that use of health services in connection with diagnoses of cancer will continue to rise unless there are reductions in the incidence rates of cancer locally. Prevalence as recorded by practices has risen from 1.2 per cent overall to 1.6 per cent in two years – within five years prevalence could be 2.0 per cent if current trends continue.

9.4 Social care use is also anticipated to rise significantly, particularly for services jointly commissioned with local authorities such as dementia services. The first JSNA in 2008 highlighted the projected rise in known dementia cases in the next 10 to 15 years, and also identified a growing number of older people likely to develop mental health issues, exacerbated by increasing numbers living alone. This rise is not just anticipated to arise from demographic change, but increased recognition and recording of existing early cases.

9.5 Unless new models of early intervention and community support are developed for older people with dementia then it is likely that future costs of traditional style support (e.g. nursing home or community mental health inpatient care) will be unaffordable. Analysis of a high level pathway for dementia care for Transforming Community Services plans shows that there are currently more than 5,000 people with dementia, 3,000 of who require community management of moderate to high level symptoms.
In the next five to 10 years these numbers are predicted to grow by around 20 per cent.

9.6 Finally, failure to redirect resources to focus on health improvement in mid-life and beyond in the most deprived populations of the PCT risks the development of a widening gap in all-age all cause mortality rates (see Section 1, inequalities for more information). Progress in reducing rates in Bournemouth in the most deprived areas has been good, but less so in Poole over the past five years. However, it should be noted that Bournemouth AAACM rates in the most deprived areas remain higher than the most deprived areas of Poole.

10. MAJOR PATHWAYS: EVIDENCE AND COST-EFFECTIVENESS SUMMARY (OPTIONAL)

10.1 The Transforming Community Services strategy of the PCT sets out a number of priority pathways that will require detailed work up and implementation if the care and management of long term conditions is to be transformed. The general trend of all of these pathways is to provide care closer to home, and via more integrated community teams.

10.2 Over time, the aim is for these pathways to reduce reliance on secondary care by focusing on earlier intervention and support outside hospital.

10.3 In addition, the PCT has undertaken three major pathways analyses to support redesigning services and current investment for stroke, stable angina and acute care closer to home (locality based integrated health and social care teams).

11. SUMMARY AND RECOMMENDATIONS

11.1 There are several gaps and challenges from this Joint Strategic Needs Assessment in relation to older people and long term conditions.

11.2 There is a large unmet need at the population level to increase physical activity undertaken by older people, particularly given the links between lack of physical activity and the development of many chronic diseases. There are increasing opportunities via Local Transport Plans to use a range of measures designed to promote more walking.

11.3 There is also a large unmet need in terms of the current shape of health and social care services to support people with long term conditions in community settings. Although numbers of people being actively case managed by community matrons have increased markedly in the past two years (WCC indicator 10.8 – from 269 cases per 100,000 in 2006 to 519 per 100,000 in 2007) this appears to have had no impact on reducing admissions to hospital over the same period.

11.4 There is an urgent need to identify community alternatives to hospital admission, and to implement pathways that provider earlier intervention in settings closer to home if the current trend of increasing activity and spend in the acute sector is to be reversed.

11.5 Finally, there is a major challenge around reversing the observed inequalities in mortality present across the conurbation, including the gap in mortality rates from all causes in the least and most deprived fifth of areas, the life expectancy gap across wards of 11 years, and the reduced healthy life expectancy experienced by residents living in these deprived areas.
Accessed 15 Jan 2010


Bournemouth Borough Council 2009 Place Survey. Ibid.