JOINT STRATEGIC NEEDS ASSESSMENT 2008

Adding life to years and years to life
JOINT STRATEGIC NEEDS ASSESSMENT 2008
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contents</td>
<td>2</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Key Points from the Joint Strategic Needs Assessment Summary</td>
<td>5</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>6</td>
</tr>
<tr>
<td>Joint Strategic Needs Assessment (JSNA)</td>
<td>23</td>
</tr>
<tr>
<td>Shropshire- setting the scene</td>
<td>30</td>
</tr>
<tr>
<td>The Health of the Population in Shropshire</td>
<td>41</td>
</tr>
<tr>
<td>Maternity, birth, children and young people</td>
<td>58</td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>79</td>
</tr>
<tr>
<td>Long Term Conditions</td>
<td>106</td>
</tr>
<tr>
<td>Mental Health and Substance Misuse</td>
<td>116</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>132</td>
</tr>
<tr>
<td>Community Safety and Vulnerable Groups</td>
<td>134</td>
</tr>
<tr>
<td>Additional Information</td>
<td>142</td>
</tr>
<tr>
<td>Individualised Budgets</td>
<td>155</td>
</tr>
<tr>
<td>Bibliography</td>
<td>156</td>
</tr>
</tbody>
</table>
Introduction

Joint Strategic Needs Assessment (JSNA) is a key element of the commissioning framework for health and well-being issued by the Department of Health in March 2007. The duty of Directors of Public Health, Directors of Adult Social Care and Directors of Children’s Services to produce a JSNA is enshrined in the Local Government and Public Involvement in Health Act, which received royal assent in October 2007.

The Department of Health defines JSNA as ‘the means by which Primary Care Trusts (PCTs) and local authorities will describe the future health, care and well-being needs of local populations’.

Shropshire’s JSNA has been developed by Shropshire County PCT and Shropshire County Council.

Information in the JSNA builds on existing and current data sources and strategies held by the PCT and across the Council’s community services and children services Directorates. The JSNA uses the LAA Evidence Base developed by the Shropshire Partnership as its foundation.

The Joint Member Board, which consists of members of the PCT and Council, approved the JSNA on 3rd June 2008, and declared it as the bedrock of commissioning decisions in relation to health and social care.

This document can be considered as an aggregate whole or can be disaggregated into three distinct documents.

1) A single page key points summary
2) A 17 page executive summary
3) A full 137 page assessment.

Joint Strategic Needs Assessment will be a living document accessible from both the PCT and County Council websites and will have hyperlinks which connect ongoing needs assessments which will add to the richness of data available on the health and well-being of the residents of Shropshire.

Information from qualitative surveys will be added to the JSNA so that communities’ experience of existing services and thoughts on future design can be integrated into commissioning decisions. Currently, this evidence is done on a service by service basis and incorporating it into the JSNA through links to parish plans and surveys will enable a more centralised resource.
Key Points from the Joint Strategic Needs Assessment Summary

- Shropshire County has a significantly higher proportion of the population aged 65 years and over than national figures. The population of people aged 65 years and over is set to continue increasing in the future. This increase will potentially put pressure on existing services.

- Although Shropshire is a relatively affluent area, inequalities still exist between different groups in the county. For example, people living in the most deprived areas of Shropshire are significantly more likely to die prematurely from all causes including the most common causes of death such as cancer and circulatory disease.

- Overall mortality is low for young people, although the 15-24 years age group and in particular males, are significantly more likely to die as a result of a road traffic accident than people of the same age group nationally.

- Young people are also more at risk from some sexually transmitted infections that other age groups in the population. Diagnosis of Chlamydia at the RHS GUM clinic in people aged under 20 years old has increased by 71% since 1999.

- Alcohol consumption is a concern for young people in Shropshire with around 26% of young people ages 11-15 years old stating that they were regular drinkers, which is significantly higher than the national proportion. When looking at drinking in people aged 15, the prevalence of regular drinkers had increased to 45.1%.

- Some young people are more likely to experience these inequalities more than others. Young people who are not in employment, education or training and those that are looked after children are more likely to experience health inequalities than other young people.

- It has been identified that people from more deprived areas are significantly more likely to die prematurely, particularly men. This inequality is due to a large extent to the health behaviours of people from the different deprivation groups. People living in the most deprived areas of Shropshire are significantly more likely to have long term conditions, smoke, are more likely to be physically inactive, are less likely to eat five portions of fruit and vegetables a day and are more likely to be obese than those in the most affluent fifth.

- Shropshire is a large rural County with a sparse population, 0.9 people per hectare. This geography could present challenges for traditional methods of service delivery.
Executive Summary

This executive summary is a shortened version of the JSNA and highlights the important elements of the larger document. This executive summary commences with information relative to demographic and inequality data, then goes on to look at pertinent data across life cycle of Shropshire residents, vulnerable groups and then onto appropriate information regarding supporting resources.

Demography
Shropshire borders Wales to the West and the southern and western parts of the county are generally more remote and self contained than the rest and the rest and have been identified as a rural regeneration zone. The county’s economy is largely reliant on agriculture, tourism, food industries, healthcare and other public services. Currently, Shropshire is a two tier local government area with local government structure broadly aligned to the centres of major populations – Shrewsbury and Atcham District Council, North Shropshire Council (containing Market Drayton and Whitchurch), Bridgnorth District Council, South Shropshire District Council (containing Ludlow) and Oswestry Borough Council. Shropshire becomes a unitary Council in April 2009. The new council will have 3 planning areas (North, Centre and South) and is coterminous with the Primary Care Trust.

Shropshire is a diverse, large, predominantly rural, inland County, situated in the West Midlands. With a population of just 289,300 and at only 0.9 persons per hectare, the county is one of the most sparsely populated in England. Shropshire has a very low population density. Approximately 36% of the population live in rural areas. South Shropshire has the lowest population density.

Shrewsbury is home to around a quarter of the population and is a key employment, shopping and cultural centre for Shropshire, and a popular destination for tourists and visitors. The county’s economy is based mainly on agriculture, tourism, food industries, healthcare and other public services. The profile of Shropshire County, its history, geography and population distribution makes delivering services effectively and efficiently more difficult.

Population
The latest mid-year population estimates produced by the Office for National Statistics (ONS) estimate that 289,300 people lived in Shropshire on the 30th June 2006. Males represent 49.4% of Shropshire’s population and females represent 50.6%. In 2006, Shropshire already has a greater percentage of people aged over 65 years than is the case nationally. The 65 years and over population in Shropshire is projected to continue to increase quite steeply to 2029. This has implications for the delivery of services to the older population, particularly meeting the needs of the increasing elderly and frail population.

Around 3,400 (1.2%) people living in Shropshire County are from a black and minority ethnic (BME) group. The proportion is considerably lower than the national average of 8.7%, and 11% in the West Midlands. The proportion of children from BME groups is higher than for adults at 3%. The profile of Shropshire is changing with migrants from Europe moving into the area and there are now some identifiable pockets of emerging
communities’ (e.g. Polish residents), and their needs will require consideration when planning services. Emergency admission rates to hospital in populations from a BME group are 1.4 times higher than the ‘white’ population and significantly higher than the County average.

Generally the age profile of people belonging to BME groups is younger than the white population and, unlike national trends; the local ethnic population is not concentrated within deprived areas but distributed evenly throughout the County.

Population Projections
The population of Shropshire has grown by 7.7% (20,600 people) from 1991 to 2006, compared to a national figure of 6.0%. Since 1991 population growth in Shropshire has been due to migration into the area. Shropshire, like most parts of the country, has an ageing population. Shropshire has a relatively high concentration of people in the older age groups. In 2006, about 47.4% of the County’s residents were aged 45 or over, compared to only 40.5% nationally.

Deprivation
The index of multiple deprivation is an important overall measure of deprivation, poverty and social exclusion. It can help identify areas of most need, and prioritise service and resource allocation. The index is mapped by Super Output Areas which provide a finer definition of geography than electoral wards. Overall, Shropshire County is a relatively affluent area and using the average population-weighted SOA score is ranked as being the 111th most deprived County of 145 counties and unitary authorities (Index of Multiple Deprivation 2004). It is worth pointing out that deprivation is measured on established urban domains and may not identify deprivation caused by rurality and isolation. Accordingly, levels of deprivation in Shropshire may not be accurately reflected in national indices of deprivation.

The Health of the Population
Age-standardised rates per 100,000 populations for all age all cause mortality (AAACM) are used as a proxy to measure progress for targets on increasing overall life expectancy and reducing inequalities in life expectancy in the NHS Operating Framework: Vital Signs and the National Indicator Set. Another measure of assessing the overall health of the population is life expectancy at birth. This can be defined as the average number of years a new-born baby would survive if they experienced the age-specific mortality rates for a particular area and time period throughout their life.

Both life expectancy and all-age all-cause mortality allow comparisons in populations with different age structures. Life expectancy is more sensitive to deaths at an early age than all-age all-cause mortality. Because of the differences between the measures, different priorities may be identified depending on which measure is used. Therefore, reducing certain causes of death can have a much greater impact on life expectancy than on AAACM and vice versa than other causes of death. It should be noted that because of the difference between AAACM and life expectancy they should not be used interchangeably.
Life expectancy for males and females in Shropshire is significantly higher than the national figure and all-age all-cause mortality for males and females is significantly lower. Although Shropshire’s figures compare favourably to the national picture, inequalities still exist in the local population. Forecasts of AAACM are set to continue decreasing and to exceed the targets for both males and females. Forecasts for life expectancy are expected to continue increasing in both males and females.

Health Inequalities
Health inequalities are differences in opportunities to attain the highest level of health. These differences are measured by rates of illness and life expectancy. The most important element of these differences lies in the fact that they are avoidable.

Health is determined by a number of factors and investments in different areas will return dividends in terms of health improvement. ‘Health inequality” is influenced by a number of factors including demography (age, gender and ethnicity), socio-economic and environmental factors (income, employment, educational attainment, housing and crime) and lifestyle factors.

Life expectancy is more affected by deaths at early ages than AAACM. Rates of AAACM in males in the most deprived fifth of areas in Shropshire are significantly higher than in the least deprived fifth, although rates in both the most and least deprived quintiles had decreased over time. The absolute gap in male AAACM between the most and least deprived fifth of areas in Shropshire is increasing, as rates are decreasing more rapidly in the least deprived quintile than in the most deprived quintile.

Male life expectancy in the least deprived quintile has significantly increased since 2001-03. During the same time period male life expectancy in the most deprived fifth has decreased, although this decrease is not significant it has led to an increase in the absolute gap in life expectancy between the most and least deprived fifth of areas in Shropshire.

Circulatory disease accounts for the highest proportion of deaths in males, although the trends demonstrate that there has been a reduction in the proportion of deaths attributable to circulatory disease and that this trend is forecasted to continue in the future. The relative contribution of deaths from cancers to AAACM appears to be increasing. However, the cause specific death rates from cancers are decreasing slightly; the relative contribution of cancers to AAACM is increasing due to the fact that there is an overall decline in AAACM rates over this period. The relative contribution of deaths due to accidents to AAACM has increased slightly since 2002 and, in the absence of new interventions, is predicted to continue increasing to 2010.

The relationship between deprivation and ill-health is well documented and people living in deprived communities often have poorer access to healthy, affordable food, safe leisure and recreation facilities and convenient public transport. As a consequence there is a higher prevalence of certain illnesses and disease in areas of higher deprivation, such as all circulatory diseases, coronary heart disease, stroke and lung cancer (DPH Report 2005/06 pp 19 – 21).
Reducing the rates of premature mortality will be a major component of trying to narrow health inequalities in terms of life expectancy (LE). Early death has a profound effect on LE, even more so than on AAACM. Significant differences between the most and least deprived quintiles have been identified for premature mortality from circulatory diseases (coronary heart disease, stroke and other circulatory-related disease) and premature cancer.

Factors such as housing, education and employment have an impact on health outcomes. These factors need to be addressed in partnership with all agencies to tackle inequalities in health. The following diagram identifies wider determinants of health and their impact on the population, e.g. your education, work, housing, etc impact on social networks. The way people socialise and who they socialise with will to a large extend determine their lifestyle behaviours, which in turn impacts upon their overall health. In order to reduce inequalities in health at a population level action must be taken on the layer of the diagram that includes education, unemployment, work, etc. Therefore it is not the duty of one agency, but requires all agencies involved in the delivery of services relating to wider determinants to be involved in tackling inequalities in health.

Fig. 1. Social determinants of health

Source: Dalhgren 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", Ditchley Park, Oxford; King's Fund; Reproduced with permission of the authors.
Maternity, Birth, Children and Young People
Pregnancy and the first years of life are one of the most important stages in the life cycle and as predictors for future life changes. This is when the foundations of future health and wellbeing are laid down. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. This is particularly true for children who are born into disadvantaged circumstances.

The 0 to 15 year aged population in Shropshire is projected to continue to decline until 2016 and stabilising through to 2029. However recent figures show an increase in birth rates. Changes in the size of the 0 to 15 year age group has implications for the future health of the local economy and labour force, as well as the delivery of public services aimed at supporting young people. 17% (50,300) of the population of Shropshire County are women of childbearing age. There is a projected decline in the number of women of reproductive age in the next 2 decades in Shropshire.

General fertility trends (GFR) in Shropshire are significantly lower than national rates. GFR’s are defined as live births per 1000 women aged 15-44. There has been a significant increase in general fertility rate in Shropshire and England & Wales since 2000-02.

Inequalities and Birth
There is a significantly higher fertility rate in women living in the most deprived quintiles in Shropshire than the national figure. All other quintiles have significantly lower rates. In Shropshire sole registered births account for less than 1% of all the births. Teenagers were 6 times more likely to be single parents and single parent families were more likely to be economically deprived.

Babies that weigh less than 2,500 grams at birth are classed as low birth weight. Women living in deprived areas are more likely to give birth to low birth weight babies. Smoking, alcohol misuse, substance misuse, poor nutrition and inadequate prenatal care are all associated with higher risk of low birth weight. Birth weight is important as low birth weight babies have a higher risk of complications, such as infections, breathing problems and gastrointestinal problems. In Shropshire the proportion of low birth weight babies is significantly lower than the national and regional figures.

Pregnancy
Overall, Shropshire has a significantly lower rate of under 18 conceptions than the national figure. However, data for 2001-2003 identifies wards in Central Oswestry, Market Drayton and North Shrewsbury where levels of teenage pregnancy are significantly higher than the England average. The 1998 Shropshire baseline was 34 pregnancies per 1,000 compared to a national baseline of 45. A nationally set target is to reduce this by 50% by 2010.

There is a significantly higher rate of smoking in women living in the most deprived areas of Shropshire compared to the Shropshire County average. Similarly, smoking rates during pregnancy are highest in younger mothers, 40% of those that smoke during pregnancy are aged under 20 years old.
Women aged 35-39 years old have significantly higher breastfeeding initiation rates than those aged 29 years and younger. Women aged under 24 years old are significantly less likely to initiate breastfeeding than the Shropshire County average.

Maternity Services
Over 90% of patients in Shropshire PCT and Telford and Wrekin PCTs use hospital services provided by Shrewsbury and Telford Hospitals NHS Trust. Hospital services are provided by Shrewsbury and Telford Hospitals NHS Trust in an integrated way to provide continuity of care for the women of Shropshire. The Trust also covers residents in Powys and Mid Wales.

There is a consultant led unit at the Royal Shrewsbury Hospital for mothers and babies who are considered to have clinical risk that may need an intervention of a consultant obstetrician, there are low-risk maternity units in Bridgnorth, Oswestry, Ludlow, Telford and Shrewsbury. In addition, the person's home may also be a preferred choice if there is low risk of clinical complications or problems for mothers and babies. An average of 25% of births in both Shropshire and Telford in 2006/07 was midwife led. Nationally, the average length of a hospital stay for a normal delivery without complications is 1.4 days. In Shropshire this is significantly higher at 2.5 days.

Accidents & Emergencies
Accidents are the most common cause of death in people aged 0-24 years old in Shropshire. There has been a significant increase in mortality from accidents since 1993-95 in Shropshire. In the years 2002-2006, 29% of deaths in this age group were caused by accidents. Children and young people in Shropshire are significantly more likely to die from accidents that the national figure and males are more likely to die from accidents than Shropshire females. 89% of deaths from accidents in the 0-24 years old are attributable to road traffic accidents.

Unlike mortality rates from accidents, in-patient admissions to hospital have significantly decreased since 1999-2001 financial year. However, not all sections of the population are affected evenly, as admission rates to hospital from accidents are significantly higher in the most deprived areas of the population and males have significantly higher admission rates than females.

There were significantly higher attendance rates at A&E for people aged 0-24 years old in Shropshire than any other age group. Males accounted for a significantly higher rate of attendances than females in all age groups, excluding the over 65 years group.

Immunisation
Immunisation is one of the most important weapons for protecting individuals and the community from serious diseases. In Shropshire vaccination coverage is higher than the national figure. Locally, the vaccination with the lowest coverage figure is MMR (measles, mumps and rubella). However, since 2004-05 there has been an increase in coverage in MMR vaccinations at two years in Shropshire. Current coverage figures for MMR in Shropshire are higher than the national figures.
Childhood Obesity
The National Child Measurement Programme (NCMP) was established in 2005. Every year, as part of the NCMP, children in Reception and Year 6 are weighed and measured during the school year to inform local planning and delivery of services for children; as well as to gather population-level surveillance data to allow analysis of trends in growth patterns and obesity. Children who are overweight are more likely to develop diabetes later life and are more likely to be obese as adults. Obesity can also lead to children being affected by bullying about their weight, low self-esteem and difficulty in being active. The 2006 NCMP in Shropshire reported that 10.1% of reception and 16.8% of year 6 pupils were obese. These figures are similar to national proportions.

Vulnerable Young People
The proportion of Shropshire’s school leavers who move on to further education, employment or training is high compared to the national average. A high percentage (86%) of young people leaving the looked after system are in education, training or employment at the age of 19.

Young people from the most vulnerable communities must have the same opportunities on leaving school as their peers elsewhere. These vulnerable communities include geographic areas of need, looked after children and teenage mothers. It should be noted that 87% of children in Shropshire live in households that are not income deprived.

At the time of the 2001 Census there were 5,509 lone parent households with dependant children in Shropshire nearly 5% of all households. Nationally and regionally there are a significantly higher proportion of lone parent households with dependant children than the figure for Shropshire.

22% of young people surveyed in Shropshire said they had been bullied, compared with the national figure of 24%.

Nationally the percentage of young people who became homeless because parents, relatives or friends are no longer able or willing to accommodate them has increased from 27% in 1997 to 38% in 2004. In March 2006 there were 205 young people in priority need for housing in Shropshire.

Current performance on re-offending rates and offending rates for looked after children are not as good as the national average. The 2001 re-offending rate for Shropshire is 54.6% which is higher than national average of 48%.

Staying Healthy
In the 2001 Census, the general health question asked people to assess their own health over the last 12 months prior to Census Day (29 April 2001), as “good”, “fairly good”, or “not good”. The results from this question show that almost 70% of Shropshire residents felt that their health was “good” with only 8.5% of Shropshire residents reporting their general health as “not good”. This is significantly lower than the national and regional figures reporting their health as “not good”.

- 12 -
Alcohol
Drunkenness in the evenings by both adults and young people are two of the County's top problems as identified by the Safer, Stronger Communities block. Areas that were identified as having the greatest problems were in the town centres of Oswestry and Shrewsbury. Street drinking was also highlighted as a concern in the Bridgnorth, Oswestry and Market Drayton areas.

Alcohol and young people
The number of young people in Shropshire aged between 11 to 15 years who drink at least once a week is significantly higher than the national average. Significantly more boys in Shropshire County drink every week, compared to girls. Most young people in the survey reported that they never buy alcohol but obtain it from friends and relatives.

The proportion of women exceeding safe drinking levels is greatest in the 15 - 24 age groups, the proportion being similar to that for young men. The proportion of young men exceeding sensible levels in this age group is similar to men in all age groups up to 55-64 years.

Adult alcohol consumption
In Shropshire men reported heavier levels of binge drinking than women – 33% compared with 17.4% respectively. Drinking patterns change with age – levels of binge drinking are particularly high in young adults. A higher proportion of people from the most deprived quintile binge drink compared with the Shropshire County average.

Smoking
Smoking is the leading cause of preventable illness and premature death, and the biggest single cause of the difference in death rates between the rich and poor.

Smoking and young people
82% of smokers take up the habit during teenage years. Regular smoking in children is defined as smoking one or more cigarettes a week. 7% of 11 to 15 year olds in Shropshire are regular smokers. This has dropped from 8% in 2004 and is similar to the rate for England (9% in 2006, 10% in 2002).

The rates of smoking for people aged 11-15 years old are significantly higher in the most deprived quintile compared to the least deprived. The proportion of children living with a smoker increases steadily with deprivation. In particular, children living within the most deprived fifth of areas in Shropshire are significantly more likely to live with a smoker than children living within the two least deprived quintiles.

In the most deprived areas, targets to increase number of young people quitting smoking are under performing. Females aged 16-24 years have the highest rate of smoking and males aged 16-24 years the second highest rate of smoking of all age groups.
Adult smoking prevalence
Adult smoking prevalence in Shropshire County is significantly lower than the average for the West Midlands (17% compared with 21%). Smoking rates are not significantly different between males and females within each age group. Rates in women are highest within the 18-24 age groups, whereas for men it is the 25-34 age groups.

Rates of smoking in adults are significantly higher for people who live within the most deprived fifth of areas in Shropshire compared to those who live within the least deprived quintiles.

Physical Activity
The benefits of physical activity go far beyond preventing and reducing overweight and obesity. Increased physical activity can lead to reducing the risk of heart disease, diabetes and cancer and can also improve self-confidence.

Physical activity and young people
The Chief Medical Officer recommends that young people do moderate physical activity for at least 60 minutes every day. In Shropshire, 55% of boys and 41% of girls aged 11 to 15 achieve these levels. Even though rates have much increased since 2004 (when 48% of boys and 24% of girls) rates are still significantly lower than the England average (70% boys and 59% girls).

The number of young people joining sports clubs in 2004 increased from 5,941 to 7,452. 100% schools in Shropshire participate in the Healthy Schools programme.

Physical activity and adults
Only 22.1% of people in Shropshire take part in the minimum recommended level of sport and active recreation (3 x 30 minutes moderate level activity per week) (Sport England Active People Survey 2005 – 2006). Women, disabled people and those living in rural Shropshire are even less likely to take part.

Physical inactivity increases with age both for men and women. Physical inactivity rates are significantly lower in Shrewsbury and Atcham than the West Midlands average. Rates between all Shropshire Councils are however not significantly different. Adults who live within the most deprived fifth of areas in Shropshire have significantly higher rates of inactivity than the average for Shropshire. On the other hand, people who live within the three least deprived quintiles have significantly lower rates of inactivity than the average for the West Midlands.

Healthy Eating
A poor diet can be associated with conditions such as heart disease, diabetes, obesity and several kinds of cancer. National trends show that some of the greatest nutritional inequalities are found in fruit and vegetable consumption.
Healthy eating and young people
Overall, in Shropshire 5% of 11 to 15 year old girls consume no portions a day, which significantly less than boys (10%). The average rate for 11 to 15 year olds in Shropshire is 7.4% which is similar to the average of fruit and vegetables for England (9.3%). In Shropshire, 20% of girls and 19% of boys aged 11 to 15 consume the recommended 5 portions or more of fruit and vegetable a day. Significantly more pupils in Shropshire consume 5 portions of fruit and vegetables compared to national figures.

Healthy eating and adults
The proportion of adults in Shropshire consuming the recommended five portions or more of fruit and vegetable generally increases with age. Higher proportions of women tend to achieve this than males. Rates for people living the most deprived fifth of areas in Shropshire have lower rates than that for all other quintiles and the Shropshire average but are similar to the West Midland average. In Shropshire, 29% of men and 40% of women report consuming five portions or more a day.

Obesity
Obesity is defined in adults as a body mass index (BMI) above 30. This measure is calculated by dividing a person's weight (kg) by height (m2). BMI of 20-25 is considered to be the healthy range. Obesity rates 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.

Screening
Breast cancer
Early detection and treatment are the most promising approach to reducing breast cancer mortality. Rates of breast cancer incidence and mortality are similar to the West Midlands rate in Shropshire County. Incidence of breast cancer has increased since 1980-82 and mortality has decreased over the same period which highlights the improvements detection and treatment.

With improved diagnosis, treatment and care regimes, breast cancer survival rates have increased from 62% (cases diagnosed between 1980 to 1984) to 83% (2005) in Shropshire County. Breast screening coverage rates in Shropshire County PCT have remained steady since 1993 and are significantly higher than the national target of 70%.

Cervical cancer
Incidence and mortality rates from cervical for Shropshire County are similar to the West Midlands Region. Over the last two decades incidence and mortality trends have decreased both locally and regionally.

With improved diagnosis, treatment and care regimes, cervical cancer survival rates across the West Midlands appear to have increased from 62% (cases diagnosed between 1981-1985) to 70% (cases diagnosed 1996-2000). Five-year survival rates for cases diagnosed between
1996-2000 are similar to the West Midlands average. Cervical cancer screening coverage in Shropshire is significantly higher than the national figure. Women aged 25-29 years old have significantly lower coverage rates than other age groups.

**Falls**
Falls are significantly higher in people aged 75 years and over than all other age groups. Females in Shropshire are also significantly more likely to be admitted to hospital from falls than males.

**Sexual Health**
A national rise in the incidence of Chlamydia is reflected locally, with infection rates highest in young people aged between 15-24 years old.

**Planned Care**

**Older People**
It is estimated that approximately 8,700 (13%) of people aged over 60 within Shropshire live in families on low incomes, compared with 15% for England.

Different levels of service are provided to older people in Shropshire, ranging from residential/nursing care for people with complex needs, through to preventive services, which help people stay independently in their own home, thereby avoiding or delaying the need for social care services. Since 2002/03, Shropshire Council have managed the balance of these services and continued to reduce admissions into residential/nursing care, and at the same time, increase numbers of older people helped to stay independently in their own home.

Home care services are practical services that assist the client to function as independently as possible in their own home. A survey of Service Users aged 65+ that were in receipt of home care in 2005/06 was conducted. Of those surveyed 61% were either “very or extremely” satisfied with the service they received. Preventive services in Shropshire cover a wide range of low level services which help people to remain independent in their own home, without the need for social care.

**Learning Disability**
The number of adults with learning disabilities (ALD) using social services increased by 15% between 2001 and 2004 in Shropshire. Overall there was a total increase of 11% of people (18 years and over) generally using social services. In the same period, the number of people with learning disabilities aged over 65 rose by 31%.

Between 1997 and 2004, there was an increase of 35% in adults with learning disabilities living in residential and nursing homes and an increase of 172% in adults with learning disabilities receiving domiciliary care. Between 2001 and 2004, the number of disabled children looked after in long term placements rose by 14%
Of the 900 plus service users known to the County Council in November 2006; 631 were supported to live in either their own home or their family home. There are currently over 142 people with a learning disability whose main carer is over the age of 65.

As at 2007 the ALD service had 29 individuals with complex needs in transition from Children and Young People’s services. There were 29 service users with pre-senile dementia. There were 57 service users aged 65 or over with a further 20 aged between 60 and 65.

Physical Disability
The number of people suffering from a long-term illness or disability has increased dramatically over the last decade both locally and nationally. The largest increase was seen in the South of Shropshire, reflecting the large increase in older people also seen in that Area. Of the 287,900 people who live in Shropshire approximately 14% have a disability. There are approximately 9,000 wheelchair users in the County of which approximately 3,300 are between 18 and 64 years old.

Approximately 225 people under the age of 65 are admitted to hospital following a stroke. Approximately 40 of this group are likely to have a long-term disability. It is predicted that there will be approximately 500 people with MS in Shropshire at any one time, with numbers in other diagnostic groups being similar.

There are approximately 2,000 adults in Shropshire who are blind and 3,000 people who are severely partially sighted. Generally, 90% of all blind or partially sighted people are over the age of 60. At any one time we would expect there to be approximately 2,270 adults with hearing loss in Shropshire.

Mental Health and Substance Misuse

Mental Health
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. Unemployed people are twice as likely to have depression as people in employment. In Shropshire, levels of unemployment are low compared to most inner cities.

Groups at risk of mental health problems
Children living in deprived households are three times more likely to have mental health problems than children living in more affluent households. People with physical illness have twice the rate of mental health problems compared to the general population. There is a high rate of mental health problems in the prison population in Shropshire. Nationally, personality disorders are more common than neurotic disorders for young offenders.

Around 40 people in Shropshire are admitted to hospital annually for depression. The current rate for depressive disorders locally is lower than the national rate. People who have been abused or been victims of domestic violence have higher rates of mental health problems. There were
1,356 incidences reported in 2003/04. The reporting of domestic violence in the County appears to be low, based on national data. Almost half of people using night shelters or sleeping rough may have a serious mental disorder; up to half may be alcohol dependent. In a survey conducted in March 2004 the total number of people in Shropshire (including children and other dependents) who considered themselves homeless were 269.

Some black and minority ethnic communities are diagnosed as having higher rates of mental health problems than the general population.

Between 2000/01 and 2004/05 there were on average 1,250 acute admissions to hospitals in Shropshire where there was a primary diagnosis of mental and behavioural disorders (regardless of speciality or hospital). Similar to other health trends there is a strong correlation between levels of admissions and deprivation. Levels of admissions are particularly higher in women aged between 25-34 and those aged 75 and over. People from a “Black” ethnic group are also more likely to be admitted to hospital than other groups. Annually, on average there are 500 acute admissions that are thought to be due to deliberate self-harm in Shropshire. Over 90% of these self-harm admissions are drug-related poisoning.

**Suicide**

In Shropshire there are on average 26 male and 5 female deaths from suicide per year. Rates in men are significantly higher than women, with men in making up 84% of all suicides (compared with 74% nationally). During 2000-2004, in Shropshire County rates for men were higher than the national level. Suicide rates do not affect everyone in the population equally; males aged under 65 years old are most likely to be affected by suicide. Therefore, suicide is one of the causes of death that has a large impact on life expectancy.

Mortality rates from suicides in young men aged 15-24 is significantly higher in Shropshire than for England and Wales. Rates of admission for episodes of self harm in men and women aged 15-24 in Shropshire are highest in this age group. The rates of admission as a result of self harm for young women are double those for young men.

Self harm and suicidal thoughts are common in offenders in Shrewsbury Prison and Stoke Heath Young Offenders Institute. The suicide rate has risen in both prisons recently, with the expected number of cases rising year on year.

**Alcohol**

Between April 2002 and March 2004, 13.7% of recorded crimes were alcohol related. The highest concentrations of these crimes are in Oswestry and Shrewsbury town centres. Assaults constituted the largest group of alcohol related crimes at 41%. 31% of all crimes with alcohol markers related to criminal damage to property and vehicles. 16% alcohol marker crimes were domestic violence incidents.

The Shropshire Community Substance Misuse Team received 830 referrals from adults for alcohol misuse between 1 April 2002 and 31 March 2004. Two thirds of these referrals were from men (66%), with a third from women (34%). The majority of the people seeking help were in the 25 to 44 age group.
Drug Misuse
In Shropshire there is an estimated prevalence of 1,025 Problem Drug Users (PDUs), which accounts for around 1% of Shropshire’s population aged between 15-64 years old. In Shropshire there were 763 people in drug treatment services at the end of 2006-07, these accounts for 74% of the estimated number of PDUs in Shropshire.

In terms of in-patient admissions with a primary diagnosis of mental and behavioural disorders due to psychoactive substance use, males accounted for 68% of all admissions in 2006-07 and females 38%. Males aged 25-34 years old were the most likely group to be admitted to hospital, with significantly more people in this group being admitted than in any other group. Overall the most deprived fifth of areas in Shropshire accounted for 44% of all admissions, significantly more than all the other deprivation groups. Of the 154 admissions for mental and behavioural disorders due to psychoactive substance use 81% (125) were for use of alcohol. The remaining 29 were for other drugs.

The Shropshire Drug Intervention Programme (DIP) team includes qualified nurses, social workers and counsellors who are employed as criminal justice workers. They assess, care manage and provide harm reduction advice to people problems with drugs who are involved with the criminal justice system. Over half (54%) of clients undertaking initial assessment stated that they had overdosed, with 37% stated that they had done so deliberately. Age groups most likely to have overdosed were the 35 years and over age group (67%) (although numbers for this age group were very small) and 18-24 years age group (52%). The group with the highest proportions of those who had deliberately overdosed were from the 18-24 years old age group. The age group that was most likely to have committed an offence was the 18-24 years age group. Offences that were most likely to be committed were shoplifting and drug dealing/trafficking/selling with 27% and 15% of clients admitting to these crimes respectively.

Long Term Conditions
There are 15.4 million people with a long term condition in England. Numbers are expected to rise due to an ageing population and certain lifestyle choices that people make. Health and social care services need to be prepared and responsive to meet the challenges that this may pose.

Long term conditions are those conditions that currently cannot be cured, but can be managed by medication and other therapies. This includes conditions such as:

- Coronary Heart Disease
- COPD
- Diabetes
- Dementia
- Stroke
Over the last decade there has been a dramatic increase in the number of people living in Shropshire who suffer from a long-term illness or disability, rising from 12% in 1991 to 18% in 2001. This represents a 54.3% change compared to 46.1% change rate for England as a whole, although the proportion overall of people living with a limiting long-term condition is slightly below the average for England.

**Informal and unpaid care**
The 2001 Census defined provision of care as looking after others (e.g. family, friends, and neighbours) because of long-term physical or mental ill-health or disability or problems relating to old age. In Shropshire County, over 30,000 people (11% of the population) were providing such care, with 2% providing over 50 hours per week. The percentage of people providing unpaid care was highest in the South of Shropshire (11.1%), possibly reflecting the high proportion of older people in the area. This was also higher than the national and regional level.

**End of Life Care**
There are a wide range of providers of end of life care including generalists, specialists, unpaid carers both voluntary sector and family.

**Vulnerable groups**

**Domestic Violence**
It is estimated that over 12,000 women per year will have experienced some form of physical and/or psychological violence or abuse in Shropshire. 739 offences were reported in Shropshire during 2006-07. Between January and December 2007, 228 victims of domestic violence were referred to the Independent Domestic Violence. Recent analysis has shown that alcohol is a factor in approximately 50% of all domestic violence offences in Shropshire

3 Independent Domestic Violence Advisors, employed by Stonham, are able to support Shropshire domestic violence victims in Shropshire, whose cases are proceeding through the criminal justice system, or whose cases are the subject of Multi Agency Risk Assessment Conferences. There are 2 refuges and one Safe House in Shropshire, providing 24 units of accommodation for women and their children fleeing domestic violence.

**Anti-social Behaviour**
80% of anti social behaviour incidents in Shropshire involves:

- Rowdy behaviour- which accounts for 60% of all anti social behaviour events recorded by police in Shropshire. It is usually associated with the town centre ‘night time economy’ ‘and the impact of alcohol misuse’ either in the vicinity of public house / nightclubs and / or on routes away from town centres.
- Vehicle related nuisance is the next largest category accounting for 12% of total police recorded anti social behaviour.
• Nuisance neighbours - ranging from minor arguments / disputes, boundary disputes, noise (including noisy parties) and general intolerance as well as some instances that will result in a criminal offence of harassment.

Fire Safety
Despite the perception that Shropshire is a prosperous and safe County, data provided by the government indicates that there are 37,000 homes which are 'well above' average risk from fire and a further 8,054 which are ‘above’ average risk within Shropshire. This is substantially above the national average and demonstrates the vulnerability of our County and its communities to the dangers of fire.

Through a study of fires, fire deaths and injuries, it is clear that certain individuals and communities are at greater risk form fire than others. These vulnerable groups include:

• The elderly.
• Children and young people.
• People living alone.
• Those living in socially deprived areas and those who are long term unemployed.
• Disabled people and those suffering long term illness.
• Those suffering mental illness.
• Black and ethnic minorities (including the new communities from east Europe).
• Gypsies and travellers.
• Individuals who use (non prescription) drugs and those who are heavy drinkers.

Supporting Resources

Assistive Technology
"Assistive Technology (AT) is any product or service designed to enable independence for disabled and older people."

There are many organisations, including charities, voluntary and commercial enterprises, who are currently engaged in promoting the use of Assistive Technology across Shropshire.

Several areas have been identified as demonstrating the greatest potential for the use of AT:

• Dementia Care
• Supporting Carers
• Ageing Independently
Enabling independence for adults with physical disability
Long Term Health Conditions

Workforce
The proportion of the population of working age in Shropshire and is slightly lower than national and regional averages. The South Area has the lowest proportion, reflecting the older age structure of the population. The general workforce availability will impact on continued ability to meet the staffing and human resource requirements within health and social care. Integrated workforce strategies have been developed across statutory, private and voluntary sector organisations to attract a skilled and motivated workforce for both adults and children.

Individual budgets
Shropshire is keen to optimize the opportunities that individualised budgets and self-directed support may bring in developing local, responsive and bespoke services for the residents which would benefit from their use.
Joint Strategic Needs Assessment (JSNA)

Background

A JSNA is the means by which Local Authorities and Primary Care Trusts assess current and future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs.

It is also required to advise the development of the Local Area Agreement and should align with the three yearly planning cycle.

Minimal information required for JSNA

<table>
<thead>
<tr>
<th>Demography</th>
<th>Population, births, ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social and environmental</td>
<td>Rural/urban and other characteristics, deprivation, benefits</td>
</tr>
<tr>
<td>Current known health status</td>
<td>Illness and lifestyle, teenage conceptions, limiting long-standing illness</td>
</tr>
<tr>
<td>Current met needs</td>
<td>Social Care service users</td>
</tr>
<tr>
<td></td>
<td>Primary Care information relating to disease prevalence and HES</td>
</tr>
<tr>
<td>Service user</td>
<td>Social care (user surveys), primary and community care (GPAQ, PALS, complaints), hospital (self-reported health outcomes, satisfaction surveys)</td>
</tr>
<tr>
<td>Public demands</td>
<td>Local Authority (Annual Residents Surveys, Health Scrutiny Reports), NHS (petitions)</td>
</tr>
</tbody>
</table>

What or who needs to be identified?

Given populations – People the local authority or the primary care trust are bound to know because those individuals and/or their carers require assistance either because of the nature of their condition or through their frailty.

Target populations – Those populations an organisation should know now because they are at high risk and poorer outcomes could be prevented if timely interventions were to take place in the immediate future.

Vulnerable populations – populations where intervention now may be beneficial either in terms of future prevention or in terms of significantly improving the quality of an individuals life but where identification of need may be hindered by environmental, cultural or social factors.
The JSNA in context
Content

The JSNA contains a range of information to inform a number of local authority and PCT strategies and plans.

Each of these plans will identify key areas for action relevant to the area of service delivery they cover.

The result is a large number of identified priorities.

These link together in a hierarchy of plans and activities which are diagrammatically represented overleaf.

Making these links will ensure joined up commissioning across health and social care and will have a positive impact on locally provided services.

The large number of identified needs are cross referenced to provide a shorter list of shared priorities, which in turn were used to negotiate the Local Area Agreement.

The JSNA information will also ensure that areas not prioritised within the Local Area Agreement are nevertheless monitored, addressed as necessary and continue to be considered in longer term planning.

The following pages show:-

- The inter-relationship between associated priorities and plans
- Priorities identified within Health, Children’s services and Adult social care
- How specific issues from the JSNA are used to develop LAA priorities and those of World Class Commissioning
This model shows the inter-relationship of associated plans and priorities

**Supporting Plans**

- General health and well-being - Public Health Strategy
  - All activity – all partners
- Themed strategies
  - eg:- Children’s Trust
  - DAAT
  - Supporting People etc.
- Joint Commissioning Strategies
  - PCT Vision
- Directorate Service Plan
  - Joint Commissioning Strategies
- Local Area Agreement
  - LSP delivery plans

**Priorities**

- Local Community Priorities
- Vulnerable People - priorities
- Local Health priorities
- Adult social care priorities
- Local Strategic Partnership priorities
Shropshire borders Wales to the West and the southern and western parts of the county are generally more remote and self contained than the rest and the rest and have been identified as a rural regeneration zone. The county’s economy is largely reliant on agriculture, tourism, food industries, healthcare and other public services. Currently, Shropshire is a two tier local government area with local government structure broadly aligned to the centres of major populations – Shrewsbury and Atcham District Council, North Shropshire Council (containing Market Drayton and Whitchurch), Bridgnorth District Council, South Shropshire District Council (containing Ludlow) and Oswestry Borough Council. Shropshire becomes a unitary Council in April 2009. The new council will have 3 planning areas (North, Centre and South) and is coterminous with the Primary Care Trust.

The following priorities are based upon the information within this Joint Strategic Needs Assessment and describe the strategic direction of service delivery to meet the future health, care and well-being needs of local populations.

<table>
<thead>
<tr>
<th>Children’s Trust identified needs</th>
<th>Local Health identified needs</th>
<th>Adult Social Care identified needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the harmful effects of <strong>alcohol</strong></td>
<td>Tackling inequalities</td>
<td>Providing opportunities for improved physical health, particularly older people</td>
</tr>
<tr>
<td>Increase the number of schools gaining National Healthy Schools programme status</td>
<td>Reducing the numbers of people who smoke</td>
<td>Promote and provide preventative services</td>
</tr>
<tr>
<td>Increase the number of young people in the most deprived areas quitting smoking</td>
<td>Tackling obesity (particularly in children)</td>
<td>Reducing the fear of crime and substance misuse</td>
</tr>
<tr>
<td>Developing Children’s Centres across the county</td>
<td>Improving sexual health</td>
<td>Increase access to services for carers</td>
</tr>
<tr>
<td>Developing <strong>Children’s Centres</strong> across the county</td>
<td>Improving mental health and well-being</td>
<td>Develop a range of services to provide high quality care and choice</td>
</tr>
<tr>
<td>Reducing bullying</td>
<td>Reducing alcohol-related harm and encouraging sensible drinking</td>
<td>Improving the quality of life and independence of vulnerable adults through:-</td>
</tr>
<tr>
<td>Reduce the rate of conceptions among under 18 year olds in Shropshire</td>
<td>Life Expectancy for men</td>
<td>- Individualised budgets</td>
</tr>
<tr>
<td>Increase the number of schools (including Independents) with a School Travel Plan</td>
<td>End of Life Care</td>
<td>- Increasing benefits claimants</td>
</tr>
<tr>
<td>Improving the response to and for children and families suffering domestic violence</td>
<td>Age specific issues:-</td>
<td>- Developing a range of cultural services delivered to people in their own homes, residential or care settings</td>
</tr>
<tr>
<td>Increasing involvement in decision making</td>
<td>- Breastfeeding</td>
<td>Improving access to domestic violence services</td>
</tr>
<tr>
<td>Reducing offending amongst young people</td>
<td>- Positive Parenting</td>
<td>Support for people with complex learning disabilities</td>
</tr>
<tr>
<td>Reducing the number not in education, employment or training</td>
<td>- Access to mental health, substance misuse and sexual health services for all young people and young adults</td>
<td></td>
</tr>
<tr>
<td>Local Area Agreement Priorities for adults</td>
<td>Overarching /shared aims</td>
<td>Specific issues identified</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| 1. Reducing the risks of loss of independence and preventing older people needing to enter care services | Reducing the risks of loss of independence and preventing older people needing to enter care services | Prevention/low level services  
Falls prevention |
| 2. Ensuring that older vulnerable people have access to appropriate accommodation, tenancy and personal support to enable independence | Ensuring that older people are able to secure and sustain their independence in a home appropriate to their circumstances | Ensuring appropriate accommodation is available for vulnerable adults inc adaptations to property  
Extra Care housing |
| 3. Improving wellbeing, social inclusion and choice enabling independence of vulnerable people including those with Learning Disabilities, Physical Disabilities and Mental Health needs. | Improving wellbeing, social inclusion and choice and enabling independence of older people | Financial security- benefits take-up; direct payments  
Healthy lifestyles and Health improvement – exercise, obesity  
Access to services |
| | Support for maintaining day to day activities and social integration for adults with Mental Health problems | Young people  
Eating disorders |
| | Community based facilities and work and life opportunities for adults with Learning Disabilities | Accommodation options inc Adult Placement, Supported Living and floating support  
Respite - Children with disabilities |
| | Enabling people with physical disabilities to live independently | Accommodation inc adaptations to property  
Access to health and other services  
Respite including children with disabilities |
| 4. Support to adults who misuse substances (drugs and alcohol) to reduce dependency and harm | Support to adults who misuse substances (drugs and alcohol) to reduce dependency | Drug misuse- Retention in treatment and successful completion  
Reduction of alcohol misuse among vulnerable groups especially young people |
| 5. Supporting healthy lifestyle choices of Shropshire People | Improving the quality of life and supporting improved health of Shropshire People | Young people – sexual health  
Housing – lone parents  
Support for carers |
Using the JSNA to rectify World Class Commissioning Outcomes

<table>
<thead>
<tr>
<th>Mandatory priority</th>
<th>Shropshire performance</th>
<th>National average</th>
<th>Peer Group (WM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy (male)</td>
<td>77.6</td>
<td>77.3</td>
<td>76.8</td>
</tr>
<tr>
<td>CHC controlled blood pressure</td>
<td>87.4%</td>
<td>87.6%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Smoking quitters</td>
<td>721.8</td>
<td>843.8</td>
<td>903.4</td>
</tr>
<tr>
<td>Update of influenza vaccinations by over 65’s</td>
<td>72.3%</td>
<td>73.5%</td>
<td>72.9%</td>
</tr>
<tr>
<td>Childhood obesity in reception age children</td>
<td>10.1%</td>
<td>9.9%</td>
<td></td>
</tr>
<tr>
<td>Rate of hospital admissions per 100,000 for alcohol related harm</td>
<td>847.5</td>
<td>1,488</td>
<td>1547.3</td>
</tr>
<tr>
<td>Percentage of all deaths that occur at home</td>
<td>20.8%</td>
<td>18.9%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Percentage of stroke admission given a brain scan within 24 hours</td>
<td>33%</td>
<td>43.9%</td>
<td>37.6%</td>
</tr>
</tbody>
</table>
Shropshire- Setting the Scene

Shropshire is a diverse, large, predominantly rural, inland county, situated in the West Midlands. With a population of just 289,300 and at only 0.9 persons per hectare, the county is one of the most sparsely populated. Shropshire sits on the far western edge of the West Midlands region and borders Wales and the North West region.

Shropshire County Council will become Shropshire Council when the two tier authority becomes unitary. The challenges identified in relation to inter alia, housing, environmental health and licensing will be easier to address the challenges affecting Shropshire’s population once it becomes one Council.

The county has several small market towns - only four of these have a population of over 10,000 (Census 2001). Shrewsbury is the county town and has the status of a sub-regional focus in the Regional Spatial Strategy and is developing a Growth Point Strategy. The town is home to around a quarter of the population and is a key employment, shopping and cultural centre for Shropshire and mid-Wales, and a popular destination for tourists and visitors.

Shropshire’s historic market towns also provide jobs and a range of local shops and services for their resident communities and large rural hinterlands. The county’s economy is based mainly on agriculture, tourism, food industries, healthcare and other public services.

Shropshire has strong links with the neighbouring unitary council, Telford & Wrekin. The eastern part of Shropshire also has strong connections with the West Midlands conurbation. Parts of north Shropshire have strong links with the Potteries and with towns in south Cheshire, and are also influenced by Merseyside and Manchester. Oswestry, the second largest town in Shropshire, has strong links with adjacent areas within Wales. The southern and western parts of the county are generally more remote and self contained and have been identified as a rural regeneration zone.

Shropshire has a rich and varied natural and historic environment. About one third of the county is upland, mostly to the south and west, the highest point being Brown Clee at 540 metres. Almost 81,000 hectares of the South Shropshire hills are designated as an Area of Outstanding Natural Beauty and contain a variety of landscapes varying from arable farming to remote moorland and extensive woodlands (this includes 491 hectares in Telford and Wrekin). Approximately 2% of Shropshire is covered by Sites of Special Scientific Interest (SSSI's) and woodland covers 7.7% of the land area.
Central Area
The Central Area (see fig 1) has a population of 95,900 (2006) and covers an area of 60,163 hectares, giving a population density of 1.59 people per hectare. Since 1991 the population has increased by 4.2%, lower than the county and national averages. The Central Area has a similar proportion of children, a higher proportion of people of working age and a lower proportion of people of retirement age and over than the county as a whole. In 2001 96.6% of the population were classified as white.
In 2005 there were 49,800 employee jobs located in the Central Area; 84.8% of these were in the service sector, 8.7% in manufacturing, 5.3% in construction and 1.2% in agriculture. The economic activity rate for residents of working age in the Central Area in 2006 was 82.7%, which is higher than the county and national averages. The main town in the district is Shrewsbury with a population of 67,126 (2001). Shrewsbury is a strongly performing retail and service centre serving not only the County but parts of Telford and Wrekin and Mid-Wales. It is also increasingly attracting higher value office based employment.

North Area
The North Area has a population of 99,200 (2006) and covers an area of 93,524 hectares, giving a population density of 1.06 people per hectare. Since 1991 the population has increased by 13.1%, higher than the county and national averages. The North Area has a similar proportion of children, a higher proportion of people of working age and a lower proportion of people of retirement age and over than the county as a whole. In 2001 98.9% of the population were classified as white.

In 2005 there were 38,300 employee jobs located in the North Area; 72.6% of these were in the service sector, 17.2% in manufacturing, 6.8% in construction and 3.4% in agriculture. The economic activity rate for residents of working age in the North Area in 2006 was 80.0%, which is lower than the county but higher than the national averages.

The largest towns in the district are Market Drayton with a population of 10,407 (2001) and Oswestry with a population of 16,660 (2001). Oswestry acts as a commercial and administrative centre, serving a much wider area extending into Wales.

South Area
South Area has a population of 94,100 (2006) and covers an area of 166,043 hectares, giving a population density of 0.57 people per hectare. Since 1991 the population has increased by 5.9%, lower than the county but similar to the national averages. The South Area has a lower proportion of children, a lower proportion of people of working age and a higher proportion of people of retirement age and over than the county as a whole. In 2001 99.1% of the population were classified as white.

Population estimates
The latest mid-year population estimates produced by the Office for National Statistics (ONS) estimate that 289,300 people lived in Shropshire on the 30th June 2006. Males represent 49.4% of Shropshire’s population and females represent 50.6%. The population of Shropshire is evenly distributed across the three areas with 34% of residents living in the North Area and 33% in the Central Area and 33% in the South Area.

Around 3,400 (1.2%) people living in Shropshire County are from a black and minority ethnic (BME) group. The proportion is considerably lower than the national average of 8.7%, and 11% in the West Midlands; but shows an increase from the 1991 Census (0.7)
Population change
The population of Shropshire has grown by 7.7% (20,600 people) from 1991 to 2006, compared to a national figure of 6.0% and a regional figure of just 2.6%. The male population has grown by 8.4% (11,000) and the female population has grown by 7.0% (9,500 people) between 1991 and 2006.

In the more recent period, 2001 to 2006, the growth in the county (2.1%) has been slightly lower than the national but higher than regional averages.

The North Area’s population has experienced the highest level of growth since 1991 (13.1%), compared with the other Shropshire areas. The Central Area has experienced the lowest population growth (4.2%) followed by the South Area (5.9%). In the more recent period, 2001 to 2006, only the North area experienced population growth higher than the national and regional averages. The Central Area experienced no net population growth during this period.

Since 1991 population growth in Shropshire has been due to migration into the area. Natural change in the county results in a loss of population (more deaths then births). Consequently, without migration the county’s population would have decreased. However it should be noted that the number of births is beginning to rise. Migration into Shropshire would include the movement of armed forces personnel and their families. Migration into the area has come mainly from neighbouring areas such as Wales, Cheshire, Wolverhampton, Herefordshire and Staffordshire. The profile of Shropshire is changing with migrants from Europe moving into the area and there are now some identifiable pockets of emerging communities.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>87,800</td>
<td>94,500</td>
<td>99,200</td>
<td>11,500 13.1%</td>
<td>4,700 5%</td>
</tr>
<tr>
<td>Central</td>
<td>92,100</td>
<td>95,900</td>
<td>95,900</td>
<td>3,800 4.2%</td>
<td>0 0%</td>
</tr>
<tr>
<td>South</td>
<td>88,900</td>
<td>92,900</td>
<td>94,100</td>
<td>5,200 5.9%</td>
<td>1,300 1.4%</td>
</tr>
<tr>
<td>Shropshire</td>
<td>268,700</td>
<td>283,300</td>
<td>289,300</td>
<td>20,600 7.7%</td>
<td>6,000 2.1%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>5,229,700</td>
<td>5,280,700</td>
<td>5,366,700</td>
<td>137,000 2.6%</td>
<td>86,000 1.6%</td>
</tr>
<tr>
<td>England</td>
<td>47,875,000</td>
<td>49,449,700</td>
<td>50,762,900</td>
<td>2,887,900 6%</td>
<td>1,313,200 2.7%</td>
</tr>
</tbody>
</table>

Population Age Groups

Shropshire has a relatively high concentration of people in the older age groups. In 2006 about 47.4% of the county’s residents were aged 45 or over, compared to only 40.5% nationally.

Shropshire, like most parts of the country, has an ageing population. This is caused by greater longevity, long-term decline in the number of births and the ageing of the post-war ‘baby boom’ generation. Since 1991 the number of people in Shropshire aged 45 to retirement age (males 64 years, females 59 years) has increased by 26.1%, compared to an increase of 22.2% nationally. The number of people of retirement age and over in Shropshire has risen by 22.9% since 1991. This is significantly higher than the national figure of 7.2%.

In contrast, the number of people aged 16-29 has fallen by 18.1%; compared to a fall of 8.5% nationally, this age group accounts for 13.1% of the county’s population compared to 18.3% for England. This reduction is partly influenced by long-term falling birth rates and partly due to young people choosing to spread their wings at this age, to attend university, travel or to find work. History suggests though that many return to Shropshire later in their lives. The number of people in Shropshire aged 30-44 has risen by only 4.0% compared to an 10.7% rise nationally, this age group accounts for 19.9% of the population compared to 22.1% nationwide.

Since 1991 the number of people in Shropshire aged 45 to retirement age (males 64 years, females 59 years) has increased by 26.1%, compared to an increase of 22.2% nationally.
Population Sparsity and Distribution

The population of the North (99,200), Central (95,900) and South Areas (94,100) are similar but the density varies. The Central Area has the greatest population density, but it is less than half the national average, and the South Area has the lowest.

Shrewsbury is the largest settlement in Shropshire with a population of 67,126 in 2001, representing 24% of the total population at that time. The other main market towns are much smaller: Oswestry with 16,660, Bridgnorth with 11,891, Market Drayton with 10,407, Ludlow with 9,250 and Whitchurch with 8,067. The population of these market towns represents 20% of the total for Shropshire. The 2001 Census shows that only 6% of the county’s land area is urban but is occupied by 64% of the county’s population. The remaining 102,850 people (36%) live in rural areas.

Shropshire has a very low population density. Approximately 36% of the population live in rural areas. This sizeable proportion of the population are distributed widely and sparsely across a large geographical area with many small settlements. Any clusters of population outside the main market towns are few and also very small.

This population distribution together with a low population density, makes delivering services effectively and efficiently more difficult. Funding allocations from central government for services in the county are in part determined by the size of the population, and do not currently take into consideration service delivery difficulties associated with population distribution in Shropshire.

**Index of Multiple Deprivation 2004 in Shropshire County**

The index of multiple deprivation is an important overall measure of deprivation, poverty and social exclusion. It can help identify areas of most need, service priorities and resources. The index is mapped by Super Output Areas which provide a finer definition of geography than electoral wards.

**Electoral wards which contains SOAs failing within the most deprived quintile in Shropshire County**

<table>
<thead>
<tr>
<th>Bridgnorth</th>
<th>North Shropshire</th>
<th>Oswestry</th>
<th>Shrewsbury and Atcham</th>
<th>South Shropshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broseley</td>
<td>Ellesmere and Welshampton</td>
<td>Cambrian</td>
<td>Bagley</td>
<td>Ludlow Henley</td>
</tr>
<tr>
<td>Highley</td>
<td>Hodnet</td>
<td>Carreg Liwyd</td>
<td>Battlefield and Heathgates</td>
<td>Ludlow St Peter’s</td>
</tr>
<tr>
<td>Shifnal Ldsall</td>
<td>Market Drayton East</td>
<td>Castle</td>
<td>Column</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Market Drayton North</td>
<td>Llanyblodwel and Pant</td>
<td>Meole Brace</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Market Drayton South</td>
<td>St Martin’s</td>
<td>Sutton and Reabrook</td>
<td></td>
</tr>
<tr>
<td>Whitchurch North</td>
<td>Gatacre</td>
<td>Underdale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitchurch South</td>
<td>Gobowen</td>
<td>Harlescott</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whitchurch West</td>
<td>Sundorne</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Castlefields and Quarry</td>
<td>Monkmoor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Indices of deprivation ODPM Crown Copyright 2004*
Index of Multiple Deprivation 2004 – Income Deprivation Affecting Older People Index (idaopi)

It is estimated that approximately 8,700 (13%) of people aged over 60 within Shropshire live in families on low incomes, compared with 15% for England. Levels within the county range from 4% to 33%, with 30 of Shropshire’s 192 SOA’s having significantly higher levels of income deprivation affecting older people than nationally.

SOA’s with the highest number of children classed as income deprived are located within the electoral wards of Monkmoor and Bagley (Shrewsbury) and Shifnal Idsall (South area).

Issues: Older People living in Shropshire on low income and resulting poverty, vulnerability, social exclusion.

Income deprivation is considered to be one of the most important aspects of deprivation. This domain measures the percentage of people over 60 who are in receipt of means tested benefits. Shropshire has a larger than average number of older people and this is expected to increase in future years placing greater demands on local services. This index should be used locally to identify areas of most need and to identify service priorities and resources (including funding bids) and help tackle inequalities within Shropshire.
People from Black and Minority Ethnic Communities

Around 3,400 (1.2%) people living in Shropshire County are from a black and minority ethnic (BME) group. The proportion is considerably lower than the national average of 8.7%, and 11% in the West Midlands; but shows an increase from the 1991 Census (0.7%). The numbers of people from a BME group are dotted around the County, which poses a challenge for service provision. The largest numbers of people are from Chinese communities, with a large proportion living within the Lawley ward of Shrewsbury & Atcham. The next two largest groups are from the Indian and the Mixed White and Black Caribbean populations.

The proportion of children from BME groups is higher than for adults at 3%

The profile of Shropshire is changing with migrants from Europe moving into the area and there are now some identifiable pockets of emerging communities, e.g. Polish residents, and their needs will require consideration when planning services.

Generally the age profile of people belonging to BME groups is younger than the white population and, unlike national trends, the local ethnic population is not concentrated within deprived areas but distributed evenly throughout the County.

In Britain generally only 5% of people from BME are aged over 65 Compared with 17% in White groups. Since 1991 the number of people of retirement age in Shropshire has risen by 17% compared to the national rate of 5%. Now 22% of population are of retirement age.

Emergency admission rates to hospital in populations from a BME group are 1.4 times higher than the ‘white’ population and significantly higher than the County average.
Provider Landscape

**Acute**
- Shrewsbury and Telford Hospitals
- Robert Jones and Agnes Hunt
- Out of County (incl 3 PCTs, 30 of which 6 over £1m)

**Mental Health and Learning Disability (NHS)**
- South Staffordshire and Shropshire Foundation Trust
- Telford & Wrekin PCT (CAMHS etc)
- Out of County (4)

**Community Services**
- SCPCT Provider Arm
- Hospices (3)
- Telford & Wrekin PCT (loan stores, children's services etc)

**Primary Care**
- GP practices (44)
- General Dental Practitioners (45)
- Optometrists (54 incl 8 mobile)
- Community Pharmacists (45)

**Independent Sector/Social/Council**
- Care Homes (46)
- Voluntary etc for Learning disability mostly via SCC (33)
- Voluntary etc for Adult M Health (16)
Key factors to be considered

- Shropshire is a diverse, large, predominately rural inland county with a wide range of land use, economic activities, employment and social conditions.

- It covers 1235 square miles of which only approximately 6% comprises suburban and rural development and continuous urban land.

- With an estimated 289,000 residents, Shropshire has the smallest population of any of the remaining 2 tier shire counties in England, and with a population density of 0.9 persons per hectare, or about 234 persons per square mile, it is also one of the most sparsely populated counties in England.

- The 2001 Census shows that whilst 6% of the county’s land area is urban it is occupied by 64% of the county’s population. The remaining 102,850 people (36%) live in rural Shropshire in villages, hamlets and in the countryside.

- Shrewsbury and Atcham borough has the largest population with a population in 2001 of 67,126. The main market towns were smaller. Oswestry with 16,660, Bridgnorth with 11,891, Market Drayton with 10,407, Ludlow with 9,250 and Whitchurch with 8,067.

- Shropshire’s population has been increasing at a faster rate (7%) than England (5.3%) as a whole since 1991. Much of that has been due to migration.

- Shropshire has a relatively high concentration of people in the older age groups. In 2005 about 47% of the county’s residents are aged 45 or over, compared to only 40% nationally. 26% are over the age of 60 compared to 21% in England.

- In contrast the number of people aged 16-29 has fallen by 18%, compared to a fall of 12% nationally. This age group accounts for 14% of the county’s population compared to 19% for England.

- 1.2% of the population identified themselves as being from black, mixed or other minority ethnic groups, significantly lower than the national figure of 9% and the West Midlands regional figure of 11%.

- Overall Shropshire County is a relatively affluent area. In England there are 32,482 ‘super output areas’ (SOA) of these only 3 SOAs in Shropshire fall within the most deprived fifth of SOAs in England.

- The profile of Shropshire County, its history, geography and population distribution makes delivering services effectively and efficiently more difficult.
The Health of the Population in Shropshire

Overall Shropshire is a relatively affluent area. Life expectancy for males and females in Shropshire is significantly higher that the national figure and all-age all-cause mortality for males and females is significantly lower. Although Shropshire’s figures compare favourably to the national picture inequalities still exist in the local population.

This chapter of the needs assessment will look at measures of overall health in the population and the impact of inequalities on the measures of overall health. The chapter will include:

- All-age all-cause mortality
- Life expectancy
- Health inequalities

These measures are particularly important as they are indicators in several performance frameworks:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Performance Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-age all cause mortality (AAACM) rate</td>
<td>Directly age standardised mortality rate per 100,000 population, from all causes at all ages.</td>
<td>Tier 2: VSB01</td>
</tr>
<tr>
<td>All-age all cause mortality (AAACM) rate</td>
<td>Directly age standardised mortality rate per 100,000 population, from all causes at all ages.</td>
<td>NI 120</td>
</tr>
<tr>
<td>All-age all cause mortality (AAACM) rate</td>
<td>Directly age standardised mortality rate per 100,000 population, from all causes at all ages.</td>
<td>LAA</td>
</tr>
<tr>
<td>Health Inequalities</td>
<td>Average IMD (deprivation index) score</td>
<td>WCC Outcome Measures</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>Life expectancy at time of birth, Years</td>
<td>WCC Outcome Measures</td>
</tr>
</tbody>
</table>

Local deprivation quintiles have been calculated for Shropshire County to assist in identifying the inequalities within the county, their relationship to poor health outcome, and the equity of service provision. These quintiles are therefore useful for local planning but are obviously not the same as the national deprivation quintiles, which are more likely to be used when benchmarking Shropshire prevalence rates against others regionally or nationally. Since Shropshire is relatively affluent, there will only be a small number of local super output areas (LSOAs) falling within the national most deprived quintile and some of the lowest quintile in Shropshire will fall in middle quintiles elsewhere.

In terms of numbers (based on 2005 figures):

Local Quintile: Number of LSOAs: 38 Population: 53,268
National Quintile: Number of LSOAs: 4 Population: 5,751

It is worth pointing out that deprivation is measured on established urban domains and may not identify deprivation caused by rurality and isolation. Accordingly, levels of deprivation in Shropshire may not be accurately reflected in national indices of deprivation.
All-age all-cause mortality

Age-standardised rates per 100,000 populations for all age all cause morality (AAACM) are being used as a proxy to measure progress for targets on increasing overall life expectancy and reducing inequalities in life expectancy in the NHS Operating Framework: Vital Signs and the National Indicator Set for Local Authorities. They are calculated by summing the age-specific products of the local death rate and a reference population and dividing by the total reference population (commonly the European Standard Population4). This figure is then multiplied up to make it a rate per 100,000 persons. The resulting rate is that which could be expected to occur if the local population had the same age-distribution as the reference population. As a result populations with different age-structures can be compared between areas and through time.

The reference population values act as weights that determine the relative influence of the local death rate in different age-groups on the DSR. A younger death does not necessarily have any more impact on the DSR value than an older death. However, since the European Standard Population was introduced in 1976, the UK population has aged due to increases in life expectancy and a falling birth rate. Consequently, the impact of deaths occurring at older ages on the DSR has gradually fallen and deaths at younger ages have relatively slightly more influence on the DSR than they did in 1976ii.

Overall in Shropshire AAACM rates are significantly lower than the figure for England and Wales for both males and females. Figure 1 shows trends in all-age all-cause mortality in males in Shropshire. There has been a significant decrease in rates since 1993. The bars in the dark blue are trajectories that have to be achieved for vital signs and the national indicator set. The 2006 rate is not significantly different from the projected 2008 figure.

Figure 1 Trends in all-age all-cause mortality in males

Source: Death extracts, National Statistics, Revised mid-year population estimates, National Statistics website: www.statistics.gov.uk
Figure 2 shows the trends in all-age all-cause mortality in females for Shropshire. Like the trends for males there has been a significant decrease in mortality rates since 1993. The rate in 2006 is not significantly different to the first year of the trajectory (2008).

![Figure 2 Trends in all-age all-cause mortality in females](image)


**Life Expectancy**

Life expectancy at birth in an area can be defined as the average number of years a new-born baby would survive if they experienced the age-specific mortality rates for a particular area and time period throughout their life. It is calculated by entering age-specific mortality rates into a life table to calculate the probability of dying at each age interval. These probabilities are then applied to a hypothetical population cohort of newborn babies. The two factors affecting life expectancy are the ages at which deaths occur and the volume of deaths occurring. A child death reduces an area’s life expectancy at birth much more than the death of an elderly person.

This statistic is widely used as a measure of a population’s general health status and most people believe they understand what it means. It can be used to compare populations with different age-structures, both between areas and through time. Life expectancy in Shropshire is significantly higher than the national figure for both males and females.
Figure 3 shows trends in male life expectancy in Shropshire County. Trends in life expectancy have increased significantly since 1993 and in 2006 male life expectancy had increased by 3.9 years since 1993.

Source: Death extracts, National Statistics, Revised mid-year population estimates, National Statistics website: www.statistics.gov.uk
Figure 4 shows trends in life expectancy in females. Like the trends for males there has been a significant increase in life expectancy in females since 1993. In 2006 average life expectancy had increased by 3.4 years since 1993.

**Figure 4 Trends in Life Expectancy in females**

Source: Death extracts, National Statistics, Revised mid-year population estimates, National Statistics website: www.statistics.gov.uk

**All-Age All-Cause Mortality V's Life Expectancy**

Both life expectancy and all-age all-cause mortality allow comparisons in populations with different age structures. Life expectancy is more sensitive to deaths at an early age than all-age all-cause mortality. Because of the differences between the measures different priorities may be identified depending on which measure is used. Therefore, reducing certain causes of death can have a much greater impact on life expectancy than on AAACM and vice versa than other causes of death. It should be noted that because of the difference between AAACM and life expectancy they should not be used interchangeably.

**Causes of Death**

Figure 5 shows common causes of death for males and females. The most common causes for both males and females were circulatory disease and cancer. It is important to understand common causes of death as this enables interventions to be targeted and in turn should decrease AAACM rates further.
Figure 5 Common causes of death in males and females (2006)

![Percentage of common causes of death](image)


Figure 6 shows trends in common causes of death for males in Shropshire County. Circulatory disease accounts for the highest proportion of deaths in males, although the trends demonstrate that there has been a reduction in the proportion of deaths attributable to circulatory disease and that this trend is forecasted to continue in the future. The relative contribution of deaths from cancers to AAACM appears to be increasing. However, the cause specific death rates from cancers are decreasing slightly; the relative contribution of cancers to AAACM is increasing due to the fact that there is an overall decline in AAACM rates over this period. The relative contribution of deaths due to accidents to AAACM has increased slightly since 2002 and, in the absence of new interventions, is predicted to continue increasing to 2010.
Figure 6 Trends in common causes of death for males


Figure 7 shows trends in the relative contribution of common causes of death to AAACM in females of all ages. Circulatory disease accounts for the highest proportion of deaths in females, although the trends demonstrate that there has been a reduction in the proportion of deaths attributable to circulatory disease and that this trend is likely to continue in the future. The relative contribution of deaths from cancers to AAACM appears to be increasing. However, the cause specific death rates from cancers are decreasing; the relative contribution of cancers to AAACM is increasing due to the fact that there is an overall decline in AAACM rates over this period. By 2010 cancer will account for the highest proportion of all deaths for females. The relative contribution of deaths due to accidents in females to the AAACM is low and not predicted to increase as much as in males.
Figure 7 Trends in common causes of death for females


Inequalities in Health

Life is short where its quality is poor. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives. Poverty, relative deprivation and social exclusion have a major impact on health and premature death, and the chances of living in poverty are loaded heavily against some social groups. Although overall Shropshire is an affluent area, inequalities still exist. People living in the most deprived fifth of areas in Shropshire are significantly more likely to experience higher rates of AAACM and lower life expectancy than those living in the most affluent areas.
Inequalities in all-age all-cause mortality rates

Figure 1 and Figure 2 shows that AAACM rates in males are decreasing, however the rate at which they are decreasing has not been the same for all sections of the population.

**Figure 14 Female life expectancy**

Source: 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

Figure 15 shows the absolute gap between the most and least deprived areas of Shropshire for female life expectancy and also includes a trend line. The absolute gap for females has decreased since 2001-2003 and in 2004-2006 females living in the most deprived quintile had higher life expectancy than females in the least deprived areas, although this was not significantly higher.

**Figure 15 Absolute gap between most deprived and least deprived quintiles for life expectancy in females**
Figure 8 shows the difference in decrease between males living in the most deprived quintile and males living in the least deprived quintile. Although there has been a significant decrease in AAACM rates for males from the most deprived quintile, the trend in this decrease hasn’t been as severe as it has for males living in the most affluent fifth of quintiles in Shropshire.

It also appears that since 2001-03 the gap in the decrease between males in the most deprived and least deprived quintile has been increasing (Figure 9). This means that inequalities between the deprivation groups in the case of all-age all-cause mortality have been increasing.

Source: 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
Figure 8 All-age all-cause mortality rates in men

![All-age all-cause mortality rates in men](image)

Figure 9 Absolute gap between most deprived and least deprived quintiles for men

![Absolute gap between most deprived and least deprived quintiles for men](image)

Source: 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

Figure 10 shows trends in AAACM rates for females. Rates have decreased significantly for both females living in the most and least deprived areas of Shropshire. However there has been a steeper decrease in the trends for females living in the most deprived areas. The current three year rolling average shows that there are similar AAACM rates in females living in the most and least deprived areas of Shropshire. The gap between deprivation areas has been significantly reduced since 1996-97(Figure 11).
Figure 10 All-age all-cause mortality rates in women

Figure 11 Absolute gap between most deprived and least deprived quintiles for women

Source:  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
Figure 12 shows trends in life expectancy for males in the most and least deprived fifths of Shropshire. The trends highlight that people 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 deprived and least deprived fifth of areas has been increasing (Figure 13). Although not significant the trend in male life expectancy in the most deprived quintile is deceasing, whilst the trend in male life expectancy in the least deprived quintile has increased significantly since 2001-2003.

Figure 13 shows the absolute gap between the most and least deprived areas of Shropshire for male life expectancy and also includes a trend line. Based on the three year rolling averages since 2001-2003 this trend is predicted to continue increasing.

Figure 12 Male life expectancy

Figure 13 Absolute gap between most deprived and least deprived quintiles for life expectancy in males

Source: 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
Figure 14 shows trends in life expectancy for females in the most deprived and least deprived quintiles in Shropshire. In 2001-2003 females living in the most deprived areas of Shropshire had significantly lower life expectancy than people living in the least deprived fifth of areas. However, since 2003-2005 there has been no significant difference in the most deprived and least deprived quintiles in Shropshire. There has been a significant increase in female life expectancy in the most deprived quintile since 2001-03; life expectancy in the least deprived quintiles over the same period has not changed.

**Figure 14 Female life expectancy**

![Graph showing life expectancy trends](image)

Source: 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

Figure 15 shows the absolute gap between the most and least deprived areas of Shropshire for female life expectancy and also includes a trend line. The absolute gap for females has decreased since 2001-2003 and in 2004-2006 females living in the most deprived quintile had higher life expectancy than females in the least deprived areas, although this was not significantly higher.
Reducing the rates of premature mortality will be a major component of trying to narrow health inequalities in terms of life expectancy. Early death has a profound effect on LE, even more so than on AAACM. Significant differences between the most and least deprived quintiles have been identified for premature mortality from circulatory diseases (coronary heart disease, stroke and other circulatory-related disease) and premature cancer.
Figure 16: Premature mortality from circulatory diseases by deprivation, 2002-2006

Source: Death extracts, National Statistics

Figure 17 Premature cancer deaths by deprivation, 2002-2006

Source: Death extracts, National Statistics
Addressing Inequalities

In Shropshire, people living in the most deprived areas of the county are significantly more likely to suffer poor health outcomes compared to those in the least deprived areas. Many of the causes of death that lead to reduced rates in life expectancy and increased rates of AAACM are linked to increased risks in lifestyle factors, such as smoking and obesity. Therefore, many inequalities in health can be explained by higher prevalence of lifestyle risks in more deprived communities.

The following diagram identifies wider determinants of health and their impact on the population, e.g. your education, work, housing, etc impact on social networks. The way people socialise and who they socialise with will to a large extend determine their lifestyle behaviours, which in turn impacts on their overall health. In order to reduce inequalities in health at a population level action must be taken on the layer of the diagram that includes education, unemployment, work, etc. Therefore it is not the duty of one agency, but requires all agencies involved in the delivery of services relating to wider determinants to be involved in tackling inequalities in 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”, Ditchley Park, Oxford; King’s Fund; Reproduced with permission of the authors.
Summary

- Overall AAACM rate in Shropshire are decreasing and life expectancy is increasing for both males and females.
- The proportion of deaths attributable to circulatory disease is forecast to decrease in both males and females and in females cancer is forecast to be the most common cause of death by 2010.
- Forecasts of AAACM are set to continue decreasing and to exceed the targets for both males and females.
- Although differences in life expectancy between women in the upper and lower quintiles is narrowing; differences between life expectancy for men remains steadfastly apart.
- Forecasts for life expectancy are expected to continue increasing for both males and females.
- Life expectancy is more affected by deaths at early ages than AAACM.
- Rates of AAACM in males in the most deprived fifth of areas in Shropshire are significantly higher than in the least deprived fifth, although rates in both the most and least deprived quintiles had decreased over time.
- The absolute gap in male AAACM between the most and least deprived fifth of areas in Shropshire is increasing, as rates are decreasing more rapidly in the least deprived quintile than in the most deprived quintile.
- There is no significant difference in the rates between the most and least deprived quintiles in females for AAACM.
- Rates in the most deprived quintile for females AAACM are decreasing more rapidly than in the least deprived, where rates have decreased but not significantly since 1998-2000.
- Male life expectancy in the least deprived quintile has significantly increased since 2001-03.
- During the same time period male life expectancy in the most deprived fifth has decreased, although this decrease is not significant it has led to an increase in the absolute gap in life expectancy between the most and least deprived fifth of areas.
- Female life expectancy increased significantly in the most deprived quintile and stayed similar in the least deprived quintile.
- There is no significant difference between the most and least deprived quintiles for female life expectancy.
- Factors such as housing, education and employment have an impact on health outcomes. These factors need to be addressed in partnership with all agencies to tackle inequalities in health.
Maternity, birth, children and young people

Introduction and demography

Shropshire is faced with reducing numbers of children and young people.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total pupil Pop.</th>
<th>% fall on 2002</th>
<th>Actual/Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>40,244</td>
<td>Not applicable</td>
<td>Actual</td>
</tr>
<tr>
<td>2003</td>
<td>40,157</td>
<td>-0.2%</td>
<td>Actual</td>
</tr>
<tr>
<td>2004</td>
<td>40,035</td>
<td>-0.5%</td>
<td>Actual</td>
</tr>
<tr>
<td>2005</td>
<td>39,374</td>
<td>-2.2%</td>
<td>Actual</td>
</tr>
<tr>
<td>2006</td>
<td>39,111</td>
<td>-2.8%</td>
<td>Actual</td>
</tr>
<tr>
<td>2007</td>
<td>38,087</td>
<td>Not applicable</td>
<td>Projected</td>
</tr>
<tr>
<td>2008</td>
<td>37,393</td>
<td>Not applicable</td>
<td>Projected</td>
</tr>
<tr>
<td>2009</td>
<td>36,742</td>
<td>Not applicable</td>
<td>Projected</td>
</tr>
</tbody>
</table>


Population projections – 2004 to 2029

The 0 to 15 year aged population in Shropshire is projected to continue to decline until 2016 and stabilising through to 2029. However recent figures show an increase in birth rates.

This means that the 0 to 15 year old population in Shropshire represented;

- 19.4% in 1991,
- 19.1% in 2001
- 18.2% in 2006 and is projected to reach;
- 15.8% in 2016 and
- 15.0% in 2029.

Changes in the size of the 0 to 15 year age group has implications for the future health of the local economy and labour force, as well as the delivery of public services aimed at supporting young people.
Life opportunities for children and young people:-

**Employment, education or training**
The proportion of Shropshire’s school leavers who move on to further education, employment or training is high compared to the national average.

A high percentage (86%) of young people leaving the looked after system are in education, training or employment at the age of 19.

In June 2007, some areas performance against targets for numbers of young people not in education, employment or training remain below target:-

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Drayton</td>
<td>7.6%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Oswestry</td>
<td>6.1%</td>
<td>4.8%</td>
</tr>
<tr>
<td>26.8%L. A. C</td>
<td>26.8%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Young people from the most vulnerable communities should have the same opportunities on leaving school. These vulnerable communities reflect geographic areas of need, looked after children and teenage mothers.

Issues: Children within the County living in low income families and resulting poverty, vulnerability, social exclusion and impact on there future life opportunities.

Income deprivation is considered to be one of the most important aspects of deprivation. This domain measures the percentage of children under 16 who are living in families in receipt of means tested benefits or in receipt of working families or disabled person’s tax credits. Should be used locally to identify areas of most need and to identify service priorities and resources (including funding bids) and help tackle inequalities within Shropshire.
Support for parents and carers:–
87% of children in Shropshire live in households that are not income deprived.

‘Parents and the home environment will always have the most important impact on a child’s development. Where parents are actively engaged in activities with their children, they demonstrate better intellectual, social and behavioural development.’ (Choice for parents, the best start for children: a ten year strategy for childcare, December 2004, pg 7).

‘By 2010 all families will have access to a Sure Start Children’s Centre offering a range of children’s activities, information for parents about childcare options, access to other children and families’ services, and and support to other childcare providers. ’ (Choice for parents, the best start for children: a ten year strategy for childcare, December 2004, pg 31).

Lone parent households
At the time of the 2001 Census there were 5,509 lone parent households with dependant children in Shropshire, nearly 5% of all households. The chart below shows that nationally and regionally there is a significantly higher proportion of lone parent households with dependant children than in the Shropshire areas. Central Shropshire has the highest proportion of lone parent households with dependant children, followed by the North and then the South of the County. The more urban area of Central Shropshire has a younger age structure than the North and South Areas and as a consequence has younger households.
Pregnancy and the first years of life are one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. This is particularly true for children who are born into disadvantaged circumstances.

17% (50,300) of the population of Shropshire County are women of childbearing age. Although there is a projected decline in the number of women of reproductive age in the next 2 decades general fertility trends (GFR) in Shropshire are significantly lower than national rates. GFR’s are defined as live births per 1000 women aged 15-44. Figure 18 shows three year rolling trends for live births rates in Shropshire. There has been a significant increase in general fertility rate in Shropshire and England & Wales since 2000-02.

Across Shropshire birth rates amongst BME groups are relatively evenly distributed.

**Figure 18 Trends in general fertility rates in Shropshire County (live births)**

![Graph showing trends in general fertility rates in Shropshire County (live births)](image)

Source: Birth extracts and Vital Statistics Table 1, National Statistics, Crown Copyright
There is a significantly higher fertility rate in women living in the most deprived quintiles in Shropshire than the national figure (Figure 19). All other areas have significantly lower rates. Nationally, about 20% of mothers belong to the two most deprived quintiles compared to 21% in Shropshire County. In Shropshire sole registered births account for less than 1% of all the births. Teenagers were 6 times more likely to be single parents and single parent families were more likely to be economically deprived.

**Figure 19 General fertility rates in Shropshire County (live births) by deprivation**

![Figure 19 General fertility rates in Shropshire County (live births) by deprivation](image)

Source: Birth extracts and Vital Statistics Table 1, National Statistics, Crown Copyright

Figure 20 shows projected birth trends in Shropshire County up to 2020. There are three projected trends based on various different time periods. The green line is a trend based on the total number of births (live and still) from the last 20 years of trends. The pink line is based on 10 years worth of trends in total births. Finally the red line is based on trends in total births from the last six years; this has been produced as there has been an increase in the number of births and as increase in the fertility rates since 2001.

The trends based on the last 20 and 10 years show a future reduction in the number of births, however the trends based on the last six years show a projected increase in births.
Figure 20 Projected birth trends in Shropshire County (2007-2020)

Source: Birth extracts and Vital Statistics Table 1, National Statistics, Crown Copyright

Infant mortality
Infant mortality rates in Shropshire are similar to national figures. The trends in infant mortality have significantly decreased since 1986-88. Infant mortality rates in Shropshire are similar across all deprivation groups.

Figure 21 Infant mortality rates per 1,000 live births in Shropshire County
Pregnancy

Figure 22 shows smoking status at delivery by deprivation. There is a significantly higher rate of smoking in women living in the most deprived areas of Shropshire compared to the Shropshire County average. Similarly, smoking rates during pregnancy are highest in younger mothers, 40% of those that smoke during pregnancy are aged under 20 years old.

Figure 22 Smoking at delivery by deprivation 2006/07

![Bar chart showing smoking rates by deprivation quintile.](image)

Source: Maternity Services, Shrewsbury and Telford NHS Hospital Trust

Figure 23 shows breastfeeding rates by age group of mothers in Shropshire. Women aged 35-39 years old have significantly higher breastfeeding initiation rates than those aged 29 years and younger. Women aged under 24 years old are significantly less likely to initiate breastfeeding than the Shropshire County average (72%). In Shropshire breastfeeding prevalence at six to eight weeks was 44% in quarter four of 2006/07.

- 65 -
Recent research has shown the link between Body Mass Index (BMI) and poorer outcomes in pregnancy. Data from SATH records 24.4% of all mothers had a BMI of over 30 at their initial assessment.

**Low Birth Weight**

Babies that weigh less than 2,500 grams at birth are classed as low birth weight. Women living in deprived areas are more likely to give birth to low birth weight babies. Smoking, alcohol misuse, substance misuse, poor nutrition and inadequate prenatal care are all associated with higher risk of low birth weight. Birth weight is important as low birth weight babies have a higher risk of complications, such as infections, breathing problems and gastrointestinal problems.

In Shropshire the proportion of low birth weight babies is significantly lower than the national and regional figures (Table 1). Oswestry has the highest proportion of low birth weight babies out of all the areas in Shropshire and North Shropshire the lowest. The West Midlands regional figure is significantly higher than the national figure. Although the proportion of low birth weight babies in from deprived areas in Shropshire is slightly higher than those in less deprived areas there is no significant difference.
### Table 1 Low birth weight rates in Shropshire County (2004-2006)

<table>
<thead>
<tr>
<th></th>
<th>Proportion of LBW babies</th>
<th>95% Confidence interval</th>
<th>Statistical difference to national</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower limit</td>
<td>Upper limit</td>
</tr>
<tr>
<td>Bridgnorth</td>
<td>6.1%</td>
<td>4.9%</td>
<td>7.5%</td>
</tr>
<tr>
<td>North Shropshire</td>
<td>4.9%</td>
<td>3.9%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Oswestry</td>
<td>6.3%</td>
<td>5.0%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Shrewsbury and Atcham</td>
<td>5.3%</td>
<td>4.5%</td>
<td>6.1%</td>
</tr>
<tr>
<td>South Shropshire</td>
<td>5.2%</td>
<td>4.0%</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Shropshire County</strong></td>
<td><strong>5.5%</strong></td>
<td><strong>5.0%</strong></td>
<td><strong>6.0%</strong></td>
</tr>
<tr>
<td>West Midlands</td>
<td>9.0%</td>
<td>8.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td><strong>England &amp; Wales</strong></td>
<td><strong>8.1%</strong></td>
<td><strong>8.0%</strong></td>
<td><strong>8.1%</strong></td>
</tr>
</tbody>
</table>

### What matters to young people?

- **Young people and alcohol**
  
  In the Health of Young People Survey 2007 (HYPS), 26% of 11 to 15 year olds stated that they consume alcohol at least once a week compared to (the national average (17% in 2005)).

  TellUs2 shows significantly higher numbers of young people consuming alcohol than the national average – 56% of Shropshire children in Years 8 and 10 had ever had a whole alcoholic drink compared to 48% nationally. Similarly, 33% of Year 8 and 10 pupils said they had never had an alcoholic drink (29% of 11-15 young people from HYPS 2007) compared to 48% nationally.
• **Bullying**
  The 2005 Shropshire Crime and Disorder Audit showed that 22% of young people surveyed said they had been bullied, compared with the national figure of 24%.

  However HYPS 2007 showed 38% of Shropshire 11-15 young people reporting having been bullied (currently provisional, 33% confirmed in 2006). This is significantly higher than nationally (24% in 2005). TellUs 2007 shows 34% of Shropshire Yr 8 and 10s reported being bullied compared to 30% nationally.

  Consultation for the Children and Young Peoples plan 'doing more to stop bullying' was the top 'make a positive contribution' priority according to the views of children and young people.

• **Homelessness amongst young people**

  Nationally the percentage of young people who became homeless because parents, relatives or friends are no longer able or willing to accommodate them has increased from 27% in 1997 to 38% in 2004.

  45% of young people who are homeless have experienced violence in the family home on more that one occasion. “Sustainable Communities: settled homes; changing lives” (ODPM, 2005).

  In March 2006 there were 205 young people in priority need in Shropshire.

• **Offending amongst young people**

  Current performance on re-offending rates and offending rates for looked after children are not as good as the national average. The 2001 re-offending rate for Shropshire is 54.6% which is higher than national average of 48%.

  All 19 year olds leaving care were living in suitable accommodation as at end of March 2005.

• **Some key statistics**

  - Mortality rates from suicides in young men aged 15-24 is significantly higher than for England and Wales.

  - Rates of admission for episodes of self harm in men and women aged 15-24 in Shropshire are highest in this age group. The rates of admission for young women are double those for young men.

  - Child and Adolescent Mental Health Services (CAMHS) support is available 24 hours a day, every day and there is a comprehensive team for children and young people with mental health issues and learning disabilities. Nationally 45% of services achieve this.
- The Youth Service reached 38% of those in its target age range. The government target is 25%.

- 96% of secondary schools, 93% of primary and both special schools have drug, alcohol and tobacco life-skills education programmes in line with national quality standards.

- The number of young people joining sports clubs in 2004 increased from 5,941 to 7,452.

- 100% schools in Shropshire participate in the Healthy Schools programme.

- At end 06/07 % of Looked After Children for more than 2½ yrs living in same placement for 2+ years was 51.9% vs. 65.9% nationally. At end 06/07 there were 16% of Shropshire LAC with 3+ placements during the year vs. 12% nationally.

- In the most deprived areas, targets to increase number of young people quitting smoking are under performing. The aim is to increase the numbers stopping smoking by 30% by 2009. At Q1 2007 the actual result was 267 against a target of 214.

- Females aged 16-24 years have the highest rate of smoking and males aged 16-24 years the second highest rate of smoking of all age groups.

- The proportion of women exceeding safe drinking levels is greatest in the 15 - 24 age group, the proportion being similar to that for young men. The proportion of young men exceeding sensible levels in this age group is similar to men in all age groups up to 55-64 years.

- Shropshire is a low crime area, with a rate of 67.8 crimes per 1000 population. The number of recorded crimes is falling in parts of Shropshire.

- 22% of sampled children and young people aged 11-17 years reported being bullied in the last twelve months (Safer Shropshire Partnership) compared with 25% in the national Child Line secondary school survey of 11 to 15 year olds (2003).

25% of Shropshire schools have reached the national standard in Personal, Social and Health Education (PSHE) and 10% are working towards this standard. 75% of secondary schools and special schools are involved in the development of Confidential Help and Advice for Teens (CHAT).
59% of secondary and 100% of special schools have relationship and sex education programmes that meet national Healthy School standards. The rate of chlamydia infection, the most common sexually transmitted infection (STI) is highest in young people aged 16-24 both locally and nationally.

Female chlamydia infection by age and point of diagnosis for Shropshire County PCT, 2003
The 1998 Shropshire baseline was 34 pregnancies per 1,000 compared to a national baseline of 45. A nationally set target is to reduce this by 50% by 2010. Further targeted work is required but very good progress has been achieved in recent years with a 23.6% reduction achieved last year (compared to 12% reduction nationally).

Data for 2001-2003 identifies areas in Central Oswestry, Market Drayton and North Shrewsbury as areas where levels of teenage pregnancy are significantly higher than the England average. Whilst these wards are relatively deprived areas, there are other wards of similar deprivation which have lower rates of teenage pregnancy. The highest rates of smoking in pregnancy are in young women aged under 25.
Accidents

Accidents are the most common cause of death in people aged 0-24 years old in Shropshire. In the years 2002-2006 29% of deaths in this age group were caused by accidents. Children and young people in Shropshire are significantly more likely to die from accidents that the national figure and males are more likely to die from accidents than females. Figure 24 shows trends in mortality rates from accidents in people aged 15 to 24 years old. There has been a significant increase in mortality from accidents since 1993-95 in Shropshire. 89% of deaths from accidents in the 0-24 years old are attributable to road traffic accidents.

Figure 24 Mortality rates from accidents in young persons aged 15 to 24

Unlike mortality rates from accidents, in-patient admissions to hospital have significantly decreased since 1999-2001 financial year. However, not all sections of the population are affected evenly, as admission rates to hospital from accidents are significantly higher in the most deprived areas of the population (Figure 25) and males have significantly higher admission rates than females.

The highest admission rates to hospital for people in the 0-24 years age group are for falls. Road traffic accidents (RTA’s) are the second highest admission rate.
Figure 25 Hospital in-patient admission rates from accidents for people aged 0-24 by deprivation, 2003/04 to 2007/08

![Bar chart showing hospital in-patient admission rates from accidents by deprivation and age group, 2003/04 to 2007/08.](image)

Source: Hospital In-patient Contract Minimum Data Set, Shropshire County and Telford & Wrek PCT's Informatics Service, 2003-04 to 2007-08

Figure 26 shows A&E attendances for accidents in Shropshire. Whilst the diagnosis coding for attendances is variable, all admissions are coded as either RTA, assault, deliberate self harm, sports injury, fireworks injury, other accidents, bought in dead and other than above. However, coding has only been made fully available in the most recent financial year (2007/08). Figure 26 shows A&E attendance rates which were due to accidents (those coded RTAs, sports injuries, firework injuries and other accidents) by age group and gender.

There were significantly higher attendance rates at A&E for people aged 0-24 years old in Shropshire than any other age group. Males accounted for a significantly higher rate of attendances than females in all age groups, excluding the over 65 years group.
Figure 26 Age standardised A&E attendances for accidents 2007/08

![Age standardised A&E attendances for accidents 2007/08](image)

Source: Hospital A&E Contract Minimum Data Set, Shropshire County and Telford & Wrekin PCT’s Informatics Service

Figure 27 shows a summary of the accidents data from A&E, hospital admissions and deaths. This is only for the year 2007/08, as this was the only year with complete coding available for A&E attendances, however as death extracts have not been published yet, the deaths number has been taken from the number of admissions where the discharge coding has indicated that the patient has died.

Figure 27 2007/08 Accidents in Shropshire PCT responsible population

- A&E Attendances
  - All ages = 11,489
  - 0-24 = 5,349

- Hospital Admissions
  - All ages = 2,368
  - 0 – 24 = 604

- Deaths
  - All ages = 51*
  - 0 – 24 = 1**

Deaths are taken from admissions and may not be reliable
* in 2006 the death extracts showed 61 deaths.
** in 2006 the death extracts showed 7 deaths
Immunisations and vaccinations

Immunisation is one of the most important weapons for protecting individuals and the community from serious diseases. The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection. This means that individuals who cannot be vaccinated will still benefit from the routine vaccination programme. This concept is called population (or 'herd') immunity. When vaccine coverage is high enough to induce high levels of population immunity, infections may even be eliminated from the country, e.g. diphtheria. But if high vaccination coverage were not maintained, it would be possible for the disease to return.

The overall aim of the routine childhood immunisation programme is to protect all children against the following preventable childhood infections:

- Diphtheria
- Tetanus
- Pertussis (whooping cough)
- Haemophilus influenzae type b (Hib)
- Polio
- Meningococcal serogroup C (MenC)
- Measles
- Mumps
- Rubella
- Pneumococcal.

In Shropshire vaccination coverage is higher than the national figure. The vaccination with the lowest coverage figure is MMR (measles, mumps and rubella). In 1998 the public lost confidence in the MMR as a vaccine fearing serious side effects and influenced by the publication and promulgation in the media of research which has since been discredited. This led to a fall in uptake of the vaccine to the point where there was serious concern that widespread outbreaks of measles could occur with consequent deaths or serious ongoing health problems. Public confidence in the vaccine is beginning to return and the aim is to work towards 95% of children receiving two MMR immunisations before entering school. Children entering school not having had MMR vaccine remain vulnerable to infection particularly if a case of measles occurs in their school.

---

1Immunisation against infectious disease, Department of Health, 2006, www.dh.gov.uk
Figure 28 shows trends in MMR coverage at two years and two vaccinations at five years. Since 2004-05 there has been an increase in coverage in vaccinations at two years in Shropshire. Current coverage figures for MMR in Shropshire are higher than the national figures.

**Figure 28 Trends in MMR coverage**


**Childhood Obesity**

The National Child Measurement Programme (NCMP) is one element of the Government’s work programme on childhood obesity, and is operated jointly by the Department of Health (DH) and the Department for Children, Schools and Families (DCSF). The NCMP was established in 2005. Every year, as part of the NCMP, children in Reception and Year 6 are weighed and measured during the school year to inform local planning and delivery of services for children; and gather population-level surveillance data to allow analysis of trends in growth patterns and obesity.

Children who are overweight are more likely to develop diabetes later life and are more likely to be obese as adults. Obesity can also lead to children being affected by bullying about their weight, low self-esteem and difficulty in being active.
Figure 6 Obesity in children in Reception and Year 6 (2006)


The 2006 NCMP in Shropshire reported that 10.1% of reception and 16.8% of year 6 pupils were obese. These figures are similar to the national proportions.

Maternity Services

- 17% (50,300) of the population of Shropshire County are women of childbearing age.
- There is a projected decline in the number of women of reproductive age in the next 2 decades in Shropshire.
- There was an increase in the number of births within Shropshire since 2002. These were greatest in Oswestry, Shrewsbury & Atcham.
- Population growth is highest in North Shropshire.
- In Shropshire sole registered births account for less than 1% of all the births. Teenagers were 6 times more likely to be single parents and single parent families were more likely to be economically deprived.
• Nationally, about 20% of mothers belong to the two most deprived quintiles compared to 21% in Shropshire County.

• Smoking rates during pregnancy are highest in younger mothers (up to 40%) and in the most deprived communities.

• Recent research has shown the link between Body Mass Index (BMI) and poorer outcomes in pregnancy. Data from SATH records 24.4% of all mothers had a BMI of over 30 at their initial assessment. In Birmingham and Black Country 19.3% of the women had a BMI over 30.

• Across Shropshire birth rates amongst BME groups are relatively evenly distributed.

• Significantly poorer outcomes are seen in areas of high deprivation, BME groups and younger and older maternal age. In Shropshire, mothers from the 2 most deprived groups accounted for 20% of all the births between 2002 and 2006, but they accounted for 25% of all stillbirths and 29% of perinatal deaths.

• The average length of a hospital stay for a normal delivery without complications is 1.4 days. In Shropshire this is significantly higher at 2.5 days.

• 8.8% of those tested and 0.4% of all women had a positive result for Downs syndrome.

• At SATH following NICE Guidelines, each woman undertakes Edinburgh Postnatal Depression score. Over the 2006/07 period, 142 (2.8%) women had personal or strong family history of mental illness detected at booking.

• Targeting women with risk indicators for poor outcomes will need to include:
   Strengthening the smoking cessation services in pregnancy.
   Developing services for mother with obesity.
   Development and strengthening of care pathways for women with other indicators of vulnerability such as unsupported teenage pregnancy, domestic violence, homelessness etc Increase the number of women who are cared for by a named midwife pilot.
   Reduce the length of stay for hospital admission for a normal birth by one day/
   Achieve access to ante-natal care for all mothers within 12 weeks.
   Improve clinical pathways for mothers with mental health needs to reflect best practice.
Staying Healthy

Life expectancy in Shropshire is generally high. On average men and women in Shropshire County live 9 months longer than the national average, however, there are differences for those living in the most deprived areas and Infant mortality trends in Shropshire are similar to England and Wales.

The health deprivation and disability domain identifies areas with relatively higher levels of people who die prematurely or whose quality of life is impaired by poor health or disability and is composed from four indicators: years of potential life lost (1997-2001), comparative illness and disability ratio (2001), measures of emergency admissions to hospital (1999/00 to 2001/02), adults under 60 suffering from mood or anxiety disorders, based on prescribing, hospital admissions, suicides and health benefits data (1997-2002).

General health

In the 2001 Census, the general health question asked people to assess own health over the last 12 months prior to Census Day (29 April 2001) as “good”, “fairly good”, or “not good”. The results from this question show that almost 70% of Shropshire residents felt their health was good with only 8.5% of Shropshire residents reporting their general health as “not good”. This is significantly lower than the national and regional figures. Similar to limiting long-term illness, the lowest proportion of residents reporting their health as “not good” was seen in Central Shropshire and the highest proportion in the North of Shropshire.
Lifestyle risk factors:

**Alcohol**
The 2005 West Midlands Regional Lifestyle Survey asked whether respondents drank alcohol - This allows us to estimate levels of alcohol consumption within Shropshire County using nationally defined definitions.

Findings from the survey show:-

- Men reporting heavier levels of binge drinking than women – 33% compared with 17.
- 4% of men and 1% of women are heavy drinkers, i.e. drinking more than 50 and 35 units of alcohol per week.
- Drinking patterns change with age – levels of binge drinking are particularly high in young adults.
- A higher proportion of people from the most deprived quintile binge drink compared with the Shropshire County average.

Significantly more children in Shropshire County (25%) are regular drinkers compared to the national average (17%).

**Smoking**
Smoking is the leading cause of preventable illness and premature death, and the biggest single cause of the difference in death rates between the rich and poor.

82% of smokers take up the habit during teenage years. Regular smoking in children is defined as smoking one or more cigarettes a week. 7% of 11 to 15 year olds in Shropshire are regular smokers. This has dropped from 8% in 2004 and is similar to the rate for England (9% in 2006, 10% in 2002). 1% of 11 year olds are regular smokers, compared to 17% of 15 year olds. Females are significantly more likely to smoke regularly or occasionally than males. The large majority of Shropshire 11 to 15 year olds has never tried smoking.

The rates of smoking are similar for the 3 least deprived quintiles but the rates for the most deprived quintile are significantly higher rates – these are around double.
**Figure 29: Smoking status in children aged 11-15 in Shropshire County by gender, 2007**

Source: Shropshire and Telford Health of Young People Survey 2007

**Table 2: Smoking prevalence by age in Shropshire County, 2007**

<table>
<thead>
<tr>
<th>Shropshire County</th>
<th>Number of regular smokers</th>
<th>Age</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>11-15 year olds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1%</td>
<td>1%</td>
<td>9%</td>
<td>9%</td>
<td>17%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td></td>
<td>173</td>
<td>625</td>
<td>388</td>
<td>709</td>
<td>324</td>
<td>2219</td>
<td></td>
</tr>
<tr>
<td><strong>England (2006)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td></td>
<td>1%</td>
<td>1%</td>
<td>5%</td>
<td>13%</td>
<td>20%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td><strong>Base</strong></td>
<td></td>
<td>1266</td>
<td>1701</td>
<td>1650</td>
<td>1626</td>
<td>1909</td>
<td>8152</td>
<td></td>
</tr>
</tbody>
</table>

Source: Shropshire and Telford Health of Young People Survey 2007
Figure 30: Percentage of children aged 11-15 in Shropshire who smoke regularly by District, 2007

Source: Shropshire and Telford Health of Young People Survey 2007

Figure 31: Percentage of children aged 11-15 in Shropshire County who smoke regularly by deprivation, 2007

Source: Shropshire and Telford Health of Young People Survey 2007
The uptake of smoking is a complex process. A factor strongly associated with decisions to start smoking is the influence of family members and peers. The proportion of children living with a smoker increases steadily with deprivation. In particular, children living within the most deprived fifth of areas in Shropshire are significantly more likely to live with a smoker than children living within the two least deprived quintiles.

Figure 32: Percentage of children aged 11-15 in Shropshire County who live with a smoker by deprivation, 2007

Adult smoking prevalence in Shropshire County is significantly lower than the average for the West Midlands (17% compared with 21%). Nevertheless, smoking remains the largest cause of preventable illness and premature death in the County, accounting for an estimated 625 deaths per year. Smoking rates are not significantly different between males and females within each age group. Rates in women are highest within the 18-24 age group, whereas for men it is the 25-34 age group.

Rates of smoking in adults are significantly higher for people who live within the most deprived fifth of areas in Shropshire compared to those who live within the 3 least deprived quintiles.
Figure 33: Smoking prevalence in Shropshire County by age and gender, 2005

Source: West Midlands Adult Health and Lifestyle Survey 2005

Figure 34: Smoking prevalence in Shropshire County by deprivation, 2005

Source: West Midlands Adult Health and Lifestyle Survey 2005
Physical activity
The benefits of physical activity go far beyond preventing and reducing overweight and obesity. Increased physical activity can lead to reducing the risk of heart disease, diabetes and cancer and can also improve self-confidence. The Chief Medical Officer recommends that young people do moderate physical activity for at least 60 minutes every day.

In Shropshire, 55% of boys and 41% of girls aged 11 to 15 achieve these levels. Even though rates have much increased since 2004 (48% of boys and 24% of girls) rates are still significantly lower than the England average (70% boys and 59% girls).

No significant inequalities exist by District or deprivation levels.

Table 3: Proportion of children aged 11-15 who take physical activity for over 60 minutes every day in Shropshire

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
<th>95% confidence interval</th>
<th>Lower limit</th>
<th>Upper limit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shropshire County</td>
<td>608</td>
<td>55%</td>
<td></td>
<td>52%</td>
<td>58%</td>
</tr>
<tr>
<td>England</td>
<td>2253</td>
<td>70%</td>
<td></td>
<td>69%</td>
<td>72%</td>
</tr>
<tr>
<td>Girls</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shropshire County</td>
<td>458</td>
<td>41%</td>
<td></td>
<td>39%</td>
<td>44%</td>
</tr>
<tr>
<td>England</td>
<td>1794</td>
<td>59%</td>
<td></td>
<td>57%</td>
<td>61%</td>
</tr>
<tr>
<td>All children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shropshire County</td>
<td>1066</td>
<td>48%</td>
<td></td>
<td>46%</td>
<td>50%</td>
</tr>
<tr>
<td>England</td>
<td>4047</td>
<td>65%</td>
<td></td>
<td>64%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Source: Shropshire and Telford Health of Young People Survey 2007

Only 22.1% of people in Shropshire take part in the minimum recommended level of sport and active recreation (3 x 30 minutes moderate level activity per week) (Sport England Active People Survey 2005 – 2006). Women, disabled people and those living in rural Shropshire are even less likely to take part.

Physical inactivity increases with age both for men and women. Physical inactivity rates are significantly lower in Shrewsbury and Atcham than the West Midlands average. Rates between all Shropshire Counties is however not significantly different.

Adults who live within the most deprived fifth of areas in Shropshire have significantly higher rates of inactivity than the average for Shropshire. On the other hand, people who live within the three least deprived quintiles have significantly lower rates of inactivity than the average for the West Midlands.
A poor diet can be associated with conditions such as heart disease, diabetes, obesity and several kinds of cancer. National trends show that some of the greatest nutritional inequalities are found in fruit and vegetable consumption.

Overall, in Shropshire 5% of 11 to 15 year old girls consume no portions a day, which significantly less than boys (10%). The average rate for 11 to 15 year olds in Shropshire is 7% which is similar to the average for England (6%). There was no significant inequality when it comes to consumption of fruit and vegetables by District.

In Shropshire, 20% of girls and 19% of boys aged 11 to 15 consume the recommended 5 portions or more of fruit and vegetable a day. This compares to 22% of girls and 19% of boys of the same age in England.

The recommended levels of physical activity in adults are 30 minutes or more of moderate-intensity physical activity on five or more days of the week. Within each age group, there are no significant differences between the rates of men and women undertaking the recommended levels of physical activity or more. The highest rates for men and women are found within the 18-24 age group. Rates between deprivation groups do not significantly differ.
Eating habits

Figure 36: Fruit and vegetable consumption in children aged 11-15 in Shropshire County, 2007

The proportion of adults in Shropshire consuming the recommended five portions or more of fruit and vegetable generally increases with age. Higher proportions of women tend to achieve this than males.

Rates for people living the most deprived fifth of areas in Shropshire have lower rates than that for all other quintiles and the Shropshire average but are similar to the West Midland average. All other Counties have significantly higher rates of consuming five or more portions than the West Midlands average. In Shropshire, 29% of men and 40% of women report consuming five portions or more a day.

Source: Shropshire and Telford Health of Young People Survey 2007
Figure 37: 5-A-Day: proportion of adults eating at least five portions of fruit and vegetables a day in Shropshire County by age and gender, 2005

Source: West Midlands Adult Health and Lifestyle Survey 2005

Figure 38: 5-A-Day: proportion of adults eating at least five portions of fruit and vegetables a day in Shropshire County by deprivation, 2005

Source: West Midlands Adult Health and Lifestyle Survey 2005
Smoking quitters
Table 4 shows smoking quit rates per 100,000 population aged 16 and over for people in Shropshire, West Midlands and England. Quit rates in Shropshire are lower than the regional and national average figures.

<table>
<thead>
<tr>
<th></th>
<th>Rate per 100,000 population aged 16 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shropshire</td>
<td>721.8</td>
</tr>
<tr>
<td>West Midlands</td>
<td>903.4</td>
</tr>
<tr>
<td>England</td>
<td>843.8</td>
</tr>
</tbody>
</table>

Source: Vital Signs, 2006/07

Deaths attributable to smoking
In 2008 the Association of Public Health Observatories and Department of Health published local health profiles. The profiles included information about several health issues in the local area, such as smoking. The death rate attributable to smoking in Shropshire was 197.1 per 100,000 population in 2004-06. Which was significantly lower than the England rate of 225.4 per 100,000 population.

Obesity
Local information on obesity has been obtained from the 2005 West Midlands Regional Adult Lifestyle Survey and also from analysis of 2004/05 general practice data.

Levels of obesity detected from GP information systems are higher than those found from self reporting in the lifestyle survey.
Comparison of obesity levels from General Practice Clinical Information Systems and adult lifestyle surveys

<table>
<thead>
<tr>
<th></th>
<th>Year (method of data collection)</th>
<th>Sample size</th>
<th>Obese (BMI &gt; 30)</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Lower limit</td>
</tr>
<tr>
<td>Shropshire County</td>
<td>2004/05 (GP CIS)</td>
<td>77,904</td>
<td>13,967</td>
<td>17.0%</td>
</tr>
<tr>
<td></td>
<td>2005 (survey)</td>
<td>1,408</td>
<td>196</td>
<td>13.9%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>2005 (survey)</td>
<td>23,960</td>
<td>3,854</td>
<td>16.1%</td>
</tr>
<tr>
<td>England</td>
<td>2004 (survey)</td>
<td>2,444</td>
<td>576</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

|                |                                  | Number      | Percentage        | Lower limit            | Upper limit            |
| Women          |                                  | 94,940      | 19,009            | 20.1%                  | 19.8%                  | 20.3%                  |
| Shropshire County | 2004/05 (GP CIS)                   | 1,346       | 152               | 12.0%                  | 10.3%                  | 13.9%                  |
|                | 2005 (survey)                      | 23,844      | 3,728             | 15.6%                  | 15.2%                  | 16.1%                  |
| West Midlands  | 2005 (survey)                      | 3,353       | 747               | 23.8%                  | 22.3%                  | 25.4%                  |
| England        | 2004 (survey)                      |             |                   |                       |                       |                       |


Obesity is defined in adults as a body mass index (BMI) above 30. This measure is calculated by dividing a person's weight (kg) by height (m2). 20-25 is considered to be the healthy range. Obesity rates 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 39: Prevalence of obesity in Shropshire County by deprivation, 2005

Source: West Midlands Adult Health and Lifestyle Survey 2005
Sexual Health

- A national rise in the incidence of Chlamydia is reflected locally, with infection rates highest in young people aged between 15-24.
- HIV infection - the prevalence rate for Shropshire County was 19 per 100,000 population and significantly lower than the national average (77 per 100,000).
- In 2003, the Shropshire County under 18s conception rate was 31 per 1,000 girls aged 15-17. Overall levels within Shropshire County and its five districts are lower than regional and national level.

Current Shropshire County figures show that 100% of patients are offered an appointment at a GUM service within 48 hours. Figure 40 shows the numbers of attendances at Shrewsbury GUM clinic has increased since 1999. In people aged under 20 years old Chlamydia infections have increased by 54% in males and 78% in females since 1999.

Figure 40 STI infections at Shrewsbury GUM

Source: KC60, Shrewsbury GUM Clinic, Shrewsbury and Telford Hospitals Trust, 1999-2007

Terminations of pregnancy

Overall, rates of termination of pregnancy in Shropshire females aged 15 to 44 increased between 2003 and 2005 (apart from a small dip in 2005) but have significantly dropped in 2007. The proportion of NHS-funded terminations that were early (undertaken at 9 weeks of gestation or less) has been increasing since 2003. Rates in 2007 were similar to those for England and Wales.
Rates of late terminations (occurring at 13 weeks or more of gestation) have decreased since 2004, but have steadied in 2007 and were significantly higher than the England and Wales average.

**Figure 41 Proportion of NHS-funded TOPs that are early (9 weeks or less gestation)**

![Proportion of NHS-funded TOPs that are early (9 weeks or less gestation)](image)

Source: Office for National Statistics Abortion Statistics, Crown Copyright

**Long Acting Reversible Contraception**

The number of visits for Long Acting Reversible Contraceptives (LARC's) in clinics in Shrewsbury and Oswestry has been increasing since 2005. Whitchurch, Ludlow and Bridgnorth saw low numbers of visits for LARC's and the numbers have dropped since 2005.

Trends in prescribing of LARC's by age group suggest that women aged 18 years or over were more likely to visit clinics for LARC's than those aged under 18 years.

**Screening**

**Breast Cancer**

Early detection and treatment are the most promising approach to reducing breast cancer mortality. Rates of breast cancer incidence and mortality are similar to the West Midlands rate in Shropshire County. Incidence of breast cancer has increased since 1980-82 and mortality has decreased over the same period.
Figure 42 Breast cancer incidence and mortality trends (all ages)

Breast Cancer Survival

With improved diagnosis, treatment and care regimes, breast cancer survival rates have increased from 62% (cases diagnosed between 1980 to 1984) to 83% in Shropshire County and 75% in Telford & Wrekin. Five-year survival rates for both Primary Care Trusts (PCTs) are similar to the West Midlands average (Table 5). Survival rates at five years by deprivation are shown in Table 5.

Table 5 Breast cancer survival rates at five years (for cases diagnosed 1996-2000)

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower limit</td>
</tr>
<tr>
<td>Shropshire County</td>
<td>83</td>
<td>79</td>
</tr>
<tr>
<td>Telford &amp; Wrekin</td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td>West Midlands</td>
<td>80</td>
<td>79</td>
</tr>
</tbody>
</table>

Source: Cancer Information Service, West Midlands Cancer Intelligence Unit
Breast screening coverage by PCT
Screening rates in Shropshire County PCT have remained steady since 1993 and are significantly higher than the national target of 70% (Figure 43).

Figure 43 Coverage rates for Shropshire County and Telford & Wrekin

Cervical Cancer Screening
Incidence and mortality rates from cervical cancer (measured as age-standardised incidence rates, ASIRs) for Shropshire County and Telford & Wrekin are similar to the West Midlands Region. Over the last two decades incidence and mortality trends have decreased both locally and regionally.
Survival rates at five years

With improved diagnosis, treatment and care regimes, cervical cancer survival rates appear to have increased from 62% (cases diagnosed between 1981-1985) to 70% in West Midlands (cases diagnosed 1996-2000). Five-year survival rates for cases diagnosed between 1996-2000 are similar to the West Midlands average (Table 9).

Table 6 Five-year survival rates from cervical cancer, 1996-2000

<table>
<thead>
<tr>
<th></th>
<th>Survival rate</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower limit</td>
</tr>
<tr>
<td>Shropshire County</td>
<td>68%</td>
<td>56%</td>
</tr>
<tr>
<td>Telford &amp; Wrekin</td>
<td>71%</td>
<td>56%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>70%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Source: Cancer Information Service, West Midlands Cancer Intelligence Unit
Figure 45 shows the coverage rates compared with England by age group. Women at the lower end of the spectrum, i.e. those aged 25-29 have particularly low coverage rates.

**Figure 45 Coverage rates by age group (as at 31st March 2007)**

![](image)

Note: These figures are all women screened in the last five years as at the 31st March 2007

Source: Shropshire & Telford Cervical Screening Office, Shropshire County Primary Care Trust

**Key local information:**

Levels of teenage pregnancy conception rates within Shropshire County and its five districts are lower than regional and national levels.

Bridgnorth, North Shropshire and Oswestry have premature death rates for circulatory diseases, which are similar to the national average. The overall County rate and those for Shrewsbury and Atcham and South Shropshire are significantly lower than the average for England and Wales.

Overall rates of death from cancer are below that of the national average and trends continue to decrease.

There are approximately 56 accidental deaths a year in Shropshire. The largest causes being road traffic accidents (46%) and falls (23%). Accidental death rates in the County are similar to the national rates.
There are approximately 30 suicides annually in Shropshire and rates in the County are similar to the national rates, but rising.

Estimates have shown that 37% of CHD deaths can be attributed to physical inactivity. This compares to 19% of CHD deaths attributable to smoking and 13% attributable to high blood pressure.

Falls are significantly higher in people aged 75 years and over than all other age groups, females are also significantly more likely to be admitted to hospital from falls than males.

Emergency admissions from falls by age and gender, 2000/01 to 2004/05
Planned Care

Population projections – 2004 to 2029

More information on demography relating to older people can be found in the section on demography and in the Shropshire 2007 LAA evidence base.

The chart adjacent illustrates that the 65 years and over population in Shropshire is projected to continue to increase quite steeply to 2029.

The 65 years and over population in Shropshire has increased as follows:

- 17.2% in 1991,
- 18.1% in 2001
- 19.4% in 2006 and is projected to reach;
- 24.6% in 2016 and
- 30.0% in 2029.

The post war baby boomers are now reaching retirement age. Improvements in medical care and quality of life now mean this generation of people have a much better life expectancy than in the past. In 2006, Shropshire already has a greater percentage of people aged over 65 years than is the case nationally. The County is also an attractive place to retire. All these factors have implications for the delivery of services to the older population, particularly meeting the needs of the increasing elderly population.

**Planned Care**

The diagram shows the different levels of services provided to older people, ranging from residential/nursing care for people with complex needs, through to lower levels of preventive services, which help people stay independently in their own home, thereby avoiding or delaying the need for social care services. The inner circle/bulls eye (marked 1) shows the most intensive level of social care provision (residential/nursing care) for those with the most complex needs, the further from the centre, the less complex the needs are.

The table shows that, over the years, since 2002/03, Shropshire County Council have managed the balance of these services and continued to reduce admissions into residential/nursing care, and at the same time, increase numbers of older people helped to stay independently in their own home, in line with Central Government policy. Increasing numbers receiving help to live at home (marked 3) can prevent or postpone a person needing more intensive packages of care (marked 2), and this in turn, can reduce numbers admitted into residential/nursing care. This is in the context of an increasing older population (a greater rate than the national average increase).

<table>
<thead>
<tr>
<th>Numbers of older people accessing a range of services</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Admissions to residential/nursing home - during the year</td>
<td>564</td>
<td>557</td>
<td>530</td>
<td>460</td>
<td>427</td>
</tr>
<tr>
<td>2 Intensive Home Care - sample week</td>
<td>490</td>
<td>473</td>
<td>475</td>
<td>493</td>
<td>534</td>
</tr>
<tr>
<td>3 Helped at Home - specific definition - as at 31 March.</td>
<td>4347</td>
<td>4251</td>
<td>4397</td>
<td>4531</td>
<td>4659</td>
</tr>
<tr>
<td>4 Helped at Home Intermediate care - during the year</td>
<td>1032</td>
<td>1595</td>
<td>1809</td>
<td>2366</td>
<td>2642</td>
</tr>
<tr>
<td>5 Helped at Home Prevention Contract - during the year</td>
<td>390</td>
<td>950</td>
<td>1214</td>
<td>1342</td>
<td>1555</td>
</tr>
<tr>
<td>6 Older People with Long Term Illness (as a % of all older people)</td>
<td>25180 (48.2%)</td>
<td>25478 (48%)</td>
<td>25180 (48.2%)</td>
<td>26,460 (48%)</td>
<td>26,730 (48%)</td>
</tr>
<tr>
<td>7 Older People 65+</td>
<td>52,240</td>
<td>53,079</td>
<td>54,110</td>
<td>55,122</td>
<td>55,700 (estimate)</td>
</tr>
</tbody>
</table>
Home Care

This map shows the distribution of older people (aged 65+) receiving home care.

Home care services are practical services that assist the client to function as independently as possible in their own home.

Overall, there is a fairly even distribution across the County, and as expected, there are concentrations of service users around the most populated areas.

We conducted a survey of Service Users aged 65+ who were in receipt of home care in 2005/06. Of those surveyed 61% were either “very or extremely” satisfied with the service they received. This is very good performance compared to other Councils.
The map gives the location of Care Homes within Shropshire (for all client groups).

427 people aged 65+ were admitted on a permanent basis in the year to residential or nursing care.

22 adults aged 18-64 were admitted on a permanent basis in the year to residential or nursing care.
Preventive Services

Preventive services in Shropshire cover a wide range of low level services which help people to remain independent in their own home, without the need for social care. These services include council events to raise peoples’ awareness of healthy lifestyles, including exercise classes for older people and senior safety events. Other services included in the range of prevention services are the helped at home scheme provided by Age Concern, and also the Care Development Team and Care Information Providers commissioned from the Community Council of Shropshire. Some of the preventive services available to older people are shown in the map opposite.

Following a major investment by Shropshire County Council in the Help at Home Services provided by Age Concern, Shropshire was successful in its bid to become a Pathfinder Authority with the Local Government Association for preventive services to older people. This has enabled a variety of services to be brought together in the context of an overall Preventive Services Strategy for Older People.

The Preventive Strategy is crucial in co-ordinating the various preventive services for older people across the county, enabling older people to live independently for as long as possible.
Introduction and Demography

A 2004 report by the Association of Directors of Social Services (ADSS) Learning Disability Task Force estimated that, between 2001 and 2021, there would be an increase of 11% in the total number of people with learning disabilities in England. Equally significantly, the number of older people (aged over 60) with learning disabilities was projected to rise by 36%.

The number of adults with a learning disability in Shropshire is growing:-

- The number of adults with learning disabilities using social services increased by 15% between 2001 and 2004 (compared to an overall increase of 11% in people over 18 using social services);
- In the same period, the number of people with learning disabilities aged over 65 rose by 31%;
- Between 1997 and 2004, there was an increase of 35% in adults with learning disabilities living in residential and nursing homes and an increase of 172% in adults with learning disabilities living in residential and nursing care;
- Between 2001 and 2004, the number of disabled children looked after in long term placements rose by 14%

Learning disability is one of the most common forms of disability in the UK. It is also the least understood. A learning disability is a lifelong condition. It is acquired before, during or soon after birth and affects an individual’s ability to learn. The causes of many learning disabilities are not known, but the most common example is Down’s Syndrome

Source: www.mencap.org.uk/html/about_learning_disability/learning_disability_causes.htm

Social services are provided in accordance with the criteria of fair access to care, subject to a baseline assessment of whether or not an individual is classed as having a learning disability. The defining criterion for this is that an individual must have an assessed IQ of 70 or lower plus a critical or substantial need.
The situation in Shropshire reflects the national trend and translates into numbers of individuals as follows in the table below:-

<table>
<thead>
<tr>
<th></th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals in service</td>
<td>829</td>
<td>860</td>
<td>892</td>
</tr>
<tr>
<td>Individuals in transition</td>
<td>29</td>
<td>31</td>
<td>32</td>
</tr>
<tr>
<td>Older people in service</td>
<td>57</td>
<td>64</td>
<td>70</td>
</tr>
<tr>
<td>Older carers</td>
<td>142</td>
<td>164</td>
<td>186</td>
</tr>
</tbody>
</table>

In the past three years 101 people have entered the service, an increase of some 12%. The number of people over 65 in the service is projected to rise by 35% in the coming five years.

Of the 900 plus service users known to the County Council in November 2006; 631 were supported to live in either their own home or their family home.

There are currently over 142 people with a learning disability whose main carer is over the age of 65.

In November 2006 the ALD service currently has 29 individuals with complex needs in transition from Children and Young People’s services.

There were 29 service users with pre-senile dementia. There were 57 service users aged 65 or over with a further 20 aged between 60 and 65.

Over 425 people currently use day opportunities funded by Shropshire County Council.
Long Term Conditions

Introduction

The number of people suffering from a long-term illness or disability has increased dramatically over the last decade both locally and in Shropshire. In 1991, 32,300 (12%) residents reported having a long-term limiting illness; the 2001 census reports 50,800 (18%). The largest increase was seen in the South of Shropshire, reflecting the large increase in older people also seen in that Area.

At the local level, there are only slight variations within the County, with the lowest proportion seen in Central Shropshire (17.5%), and the highest proportion is seen in North of the Shropshire (18.4%). Again this is largely due to the numbers of older people. At the small area level there are more inequalities within the County. In these areas of high long-term illnesses there will be additional health and social needs.

At the small area level, the Lower Layer Super Output Area (LLSOA) located in Gobowen ward had the highest proportion of residents providing unpaid (34.3%). LLSOAs in Ludlow Henley ward (26.9%), Market Drayton North (26.2%), Church Stretton North ward (26.1%) and Ludlow St. Laurence’s ward (26.0%) follow on in terms of highest ranking (each LLSOA, with the exception of 2, cover 2 wards).
Long Term Conditions

There are 15.4 million people with a long term condition in England. Numbers are expected to rise due to an ageing population and certain lifestyle choices that people make. Health and social care services need to be prepared and responsive to meet the challenges that this may pose. www.library.nhs.uk

Long term conditions are those conditions that currently cannot be cured, but can be managed by medication and other therapies. This includes conditions such as:

- Coronary Heart Disease
- COPD
- Diabetes
- Dementia
- Stroke

All sections of the population are at risk from lifestyle factors that can result in avoidable illness and disease. Initiatives to deal with the rising burden of preventable disease need to be tailored to various target groups, men, young people and older members of the population. However, not all conditions are preventable in all people. Conditions like high blood pressure, high cholesterol, obesity and diabetes increase the risk of developing heart disease and need to be treated well to reduce the risk of heart attacks and strokes. Having a stroke can have a serious and long-term effect on health, well-being and independence of people affected. Diabetes can have a number of serious complications including heart attacks, sight loss, limb loss and renal failure.

Effective management is required to reduce the risk of further disease and complications.

Over the last decade there has been a dramatic increase in the number of people living in Shropshire who suffer from a long-term illness or disability, rising from 12% in 1991 to 18% in 2001 (JSNA p36). This represents a 54.3% change compared to 46.1% (JSNA p38, LAA Evidence Base, p180) change rate for England as a whole, although overall the proportion of people living with a limiting long-term condition is slightly below the average for England.
Prevalence of LTC in Shropshire compared to national

<table>
<thead>
<tr>
<th>Disease Area</th>
<th>QoF prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCT</td>
</tr>
<tr>
<td>CHD</td>
<td>3.91%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1.00%</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>2.17%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>14.10%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3.89%</td>
</tr>
<tr>
<td>COPD</td>
<td>1.54%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0.68%</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>2.40%</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.15%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.68%</td>
</tr>
<tr>
<td>Asthma</td>
<td>6.36%</td>
</tr>
<tr>
<td>Dementia</td>
<td>0.53%</td>
</tr>
<tr>
<td>Depression 2</td>
<td>9.54%</td>
</tr>
<tr>
<td>CKD</td>
<td>2.62%</td>
</tr>
<tr>
<td>AF</td>
<td>1.78%</td>
</tr>
<tr>
<td>Obesity</td>
<td>7.14%</td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework, 2006-07

Comparing County rates with national rates, the areas which are most prevalent above national expectations in Shropshire relate to Depression, Hypertension, Asthma, Stroke/TIA and CHD.
Introduction and demography - Informal / unpaid Social care

People with long-term limiting illnesses may require some form of long term care provided by an informal carer (often a relative) or formal state or private health services. The 2001 Census, for the first time, asked a question about whether people provided unpaid care for a family member or friend and if they did the number of hours per week. The 2001 Census defined provision of care as looking after others (e.g. family, friends, and neighbours) because of long-term physical or mental ill-health or disability or problems relating to old age.

In Shropshire County, over 30,000 people (11% of the population) were providing such care, with 2% providing over 50 hours per week. The percentage of people providing unpaid care was highest in the South of Shropshire (11.1%), possibly reflecting the high proportion of older people in the area. This was also higher than the national and regional level.

At the small area level, the LLSOA located in Lawley ward had the highest proportion of residents providing unpaid (14.9%). LLSOAs in Column ward (14.8%), Church Stretton North ward (14.7%) and Llanyblodwell and Pant ward (14.4%) follow on in terms of the highest ranking.
The North of Shropshire had the highest percentage of people providing fifty or more hours a week in unpaid care. Interestingly, the North of Shropshire has the same percentage of carers in this group as England and Wales (2.1%).

It is planned to include a question on unpaid care in the 2011 census, to enable comparison with 2001. It will be possible to examine the relationship between the growth in the older population and the levels of unpaid care.

Unpaid carers often require support from local authorities and health care providers to look after the person they are caring for and to enable them to maintain some quality of life. This is particularly necessary where the unpaid carer is of a vulnerable population group i.e. still a child, an elderly person, an individual also having a limiting long-term illness, from a minority ethnic group etc.

![Provision of unpaid care, 2001](image)

Note: Provision of care is defined as looking after; giving help or support to family members; friends; neighbours or others because of long-term physical or mental ill-health or disability or problems relating to old age.

Key statistics

There are currently circa 11 million disabled adults in the UK, equivalent to 21% of the population. Over the last 30 years there has been an increase in the number of people reporting impairment.

Of the 287,900 people who live in Shropshire approximately 14% have a disability. 2.5% of the staff employed by the County Council has a recognised disability.

There are approximately 9,000 wheelchair users in the County of which approximately 3,300 are between 18 and 64 years old.

Approximately 225 people under the age of 65 are admitted to hospital following a stroke. Approximately 40 of this group are likely to have a long-term disability.

It is predicted that here will be approximately 500 people with MS in Shropshire at any one time, with numbers in other diagnostic groups being similar.

There are approximately 2,000 adults in Shropshire who are blind and 3,000 people who are severely partially sighted.

Generally, 90% of all blind or partially sighted people are over the age of 60.

At any one time we would expect there to be approximately 2,270 adults with such a hearing loss in Shropshire. This number would be greater if we were to include the likelihood that 14% of the population have some form of hearing disability, which for Shropshire would indicate approximately 39,620 people. It is estimated that there are around 470 people in Shropshire who are deaf-blind or who have dual sensory impairment.

- The number of Adults with Physical Disabilities who were helped to live at home through social care services in 2006-07 was 1072
- 30% of blue badges issued in 2007 were issued to people under the age of 65 – this equates to 1,700
- In 206-07, 84 people aged under 65 eligible for social care received a direct payment
- The number of carers of adults with a physical disability who received a break from their caring duties rose to 651 in 2006-07
- At March 31st 2007; 887 people were waiting for adaptations to their property
- 94% of equipment provided by Shropshire County Council to help people remain at home, was delivered in 7 days during 2006-07
### Percentage of people with self-reported limiting long-term illness, 2001

<table>
<thead>
<tr>
<th>Region</th>
<th>People with a limiting long-term illness in 1991</th>
<th>Change 1991 to 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Proportion</td>
</tr>
<tr>
<td>North</td>
<td>10,983</td>
<td>18.4%</td>
</tr>
<tr>
<td>Central</td>
<td>11,302</td>
<td>17.5%</td>
</tr>
<tr>
<td>South</td>
<td>10,627</td>
<td>17.9%</td>
</tr>
<tr>
<td>Shropshire</td>
<td>32,912</td>
<td>17.9%</td>
</tr>
<tr>
<td>England</td>
<td>6,028,203</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

People with a long-term limiting illness have reduced economic power due to reduced employment opportunities. In Shropshire, 21,300 residents reported an illness preventing them from working. The proportion of those of working age with a long-term limiting illness in Shropshire is 13%, this compare with 14% nationally.

Note: Limiting long-term illness covers any long-term illness; health problem or disability, which limits daily activities or work.


### Percentage of people of working age with self-reported limiting long-term illness, 2001

<table>
<thead>
<tr>
<th>Region</th>
<th>People with a limiting long-term illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>North</td>
<td>7,488</td>
</tr>
<tr>
<td>Central</td>
<td>7,183</td>
</tr>
<tr>
<td>South</td>
<td>6,621</td>
</tr>
<tr>
<td>Shropshire</td>
<td>21,296</td>
</tr>
<tr>
<td>England</td>
<td>4,014,605</td>
</tr>
</tbody>
</table>

Note: Limiting long-term illness covers any long-term illness; health problem or disability, which limits daily activities or work. Working age population is 16-54 inclusive for men and 16-59 inclusive for women.

Shropshire

Adult Social Care

June 06 – Department of Health - Older People Home Care Users survey – SCC

Do care workers do the things you want done? 68% said ‘always’
Do care workers come at times to suit you? 84% said ‘always’ or ‘usually’ (a slight fall from 90.9% in 02/03)
Are you kept informed? 79% said ‘always’ or ‘usually’
Were you told about direct payments by your Social Worker? Just 35% said yes, and this was flagged as needing attention.

2004 - Department of Health - User Survey of Physically Disabled and Sensory Impaired Adults – SCC

65% of respondents to the survey said their views were ‘always’ or ‘usually’ taken into account (38% ‘always’)
86.4% said they they can contact social services easily.
Were you told about Direct Payments by your social worker? 51% said yes. This is comparatively high. Most people said they received a good level of support in using direct payments.
Do care workers come at times which suit you? 88% agreed.

Community Services Scrutiny Panel Male Carer Task & Finish Group: Albert Road Day Services Centre 24/9/07

There is a lack of male carers – both for appropriate provision of personal care, and for the different interests they have which they may share with service users e.g. swimming.

Shropshire County PCT

The most recent Healthcare Commission PCT Patients’ Survey for Shropshire County indicates the following:

- Receptionists were rated 75% for courtesy, higher than the national average but not in the top 20% of PCTs.
- GPs and other health professionals both scored 97% for treating patients with respect and dignity, which was on the threshold for the top 20% nationally.
- GPs and other health professionals scored relatively well for listening to patients and explaining clearly the reasons for treatments.
There was room for improvement in:
- GPs giving patients the time to discuss their problem
- GPs and Dentists involving patients in decisions about their treatment.
- Referrals: information flows between GPs and the person referred to were often incomplete, and patients often did not receive copies of related correspondence.

Views on Joined-up Working

‘Scoping Service User Views’, a 2004 study of service-user views of Adult Social Care by York University noted that: “All stakeholders and constituencies are agreed that joint working is an essential part of any future vision; the challenge is to refine this approach in order to meet the requirements of the socially inclusive model. This implies a ‘whole systems’ approach, rather than specific, ad hoc partnerships - a mode of working that is not yet well developed. The evidence suggests that users are currently confused about what services are available and who the providers are, and are anxious to see better joined-up working”.

Joseph Rowntree Foundation A study of the views of current and potential service-users on low-level care.

This looks at priorities for Older People and Middle Aged People looking forward. ‘Low-level care’ is important because it can be seen as prevention, given the inter-relatedness of social, mental and physical well-being.

Older People

Current older people’s priorities for help are grouped into the following (not in any order of importance):
- House and Garden
- Staying in and Going Out
- Managing Personal Affairs
- Staying Informed
- Shopping
- Transport
- Socialising
- Leisure and Recreation
Priorities of those Currently Middle-Aged (Levinson 1995)

- Services that promote or maintain independence rather than elements of care
- Services such as social life and leisure to enable clients to remain intellectually active, for instance using a computer and getting out and about
- Income
- Service choices that could be adapted to the client’s time of life and level of need

Learning Disabilities – British Institute of Learning Disabilities

The Mansell Report emphasises the need for investment in specialized skills development rather than increased numbers of employees. It also proposes a focus on person-centred, preventative skills for challenging behaviour, rather than ‘reactive management’ through physical intervention.

In this it is supported by B.I.L.D., which comments

"The report recognises the need to develop the level of expertise within teams and services that are supporting people, which are often limited by the level of skills, training and overall experience that they have.

The report recognises the importance of teams and service providers working together to share experience and expertise and therefore maximising opportunities for positive outcomes for the service user. BILD has, over the years, recognised the need to support professionals at all level and develop skills within the workforce through offering a range of publications, learning opportunities and conferences aimed at professionals, families and carers. It is acknowledged that more must be done at a national level to develop workforce skills in the support of people who require more intensive support; this report comes at a time when specialist Learning Disability Award Framework (LDAF) units have ceased to exist in favour of the shorter induction Learning Disability Qualification (LDQ).

Large teams of staff who have limited skills are much less effective than smaller, focussed teams who can deliver good quality outcomes for people based on a level of expertise and understanding. In keeping with this the development of specialist teams to support services is seen as invaluable, (paragraphs 62 and 63 of the report.) BILD welcomes the recommendations related to workforce development and will strengthen our links with national bodies, including the Sector Skills Council, to promote the development of specialist training at all levels."
Our NHS, Our Future

Findings from the recent nationwide engagement exercise for Our NHS, Our Future, the review being conducted by Lord Darzi, and due to report in June 2008, indicate the following:

- Patients/public saw staff as a real asset to the NHS, and praised them for doing a good job in often difficult circumstances.
- Communication, particularly between staff and patients and between different services, was raised as an issue. Patients wanted to be treated as individuals, have staff answer their questions and explain procedures. Many mentioned that communication could be better between services so that they felt more joined up.
- There was patchy knowledge and understanding of services available at primary care level.
- Participants felt that much perceived underperformance in terms of quality stemmed from understaffing and lack of sufficient resources.
- Getting a prompt appointment (possibly same-day) appointment with a GP was seen as an issue by a substantial minority of patients.

Principal themes that emerge from a study of existing information are:

- A desire from patients and users of services to have a say in decisions about their treatment.
- Issues of communication within and between health and social care services.
- Limited patient and service user understanding of services and treatments available.
- The importance placed on preventative 'low level' care.
Mental Health and Substance Misuse

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 routinely available information on the local prevalence of mental health disorders. However, national prevalence rates in conjunction with the local adult population can be used to estimate the number of people thought to be suffering from various disorders.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>National Prevalence</th>
<th>Estimated number in Shropshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population attending primary care with depression in one year</td>
<td>12%</td>
<td>22,041</td>
</tr>
<tr>
<td>Percentage of population attending primary care with severe depression in one year</td>
<td>3%</td>
<td>5,510</td>
</tr>
<tr>
<td>Lifetime risk of having a depressive episode</td>
<td>5%</td>
<td>9,184</td>
</tr>
<tr>
<td>Lifetime risk of having a bi-polar disorder</td>
<td>1.3%</td>
<td>2,388</td>
</tr>
<tr>
<td>Risk of suicide or death from undetermined causes for people who have affective disorders</td>
<td>15%</td>
<td>1,378</td>
</tr>
<tr>
<td>Anxiety and phobias</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People attending GP surgery</td>
<td>9%</td>
<td>16,530</td>
</tr>
<tr>
<td>Anxiety and depression</td>
<td>13%</td>
<td>23,877</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active one-year prevalence of schizophrenia</td>
<td>1%</td>
<td>1,837</td>
</tr>
<tr>
<td>One-year contact with psychiatric services</td>
<td>0.3%</td>
<td>551</td>
</tr>
<tr>
<td>Annual incidence</td>
<td>0.01% to 0.05%</td>
<td>18 to 92</td>
</tr>
<tr>
<td>Risk of suicide or death from undetermined causes for people with schizophrenia</td>
<td>10% to 15%</td>
<td>184 to 276</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder (OCD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence</td>
<td>1% to 5%</td>
<td>1,837 to 9,184</td>
</tr>
<tr>
<td>Lifetime prevalence</td>
<td>2.5%</td>
<td>4,592</td>
</tr>
<tr>
<td>Eating disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anorexia nervosa prevalence in women aged between 15 and 30</td>
<td>0.5 to 2%</td>
<td>105 to 420</td>
</tr>
<tr>
<td>Bulimia nervosa in women</td>
<td>1% to 3%</td>
<td>907 to 2,721</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime prevalence</td>
<td>13%</td>
<td>23,877</td>
</tr>
<tr>
<td>Six-month prevalence</td>
<td>4.5% to 6.1%</td>
<td>8,265 to 11,204</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence</td>
<td>10%</td>
<td>18,367</td>
</tr>
<tr>
<td>Prevalence for prison population</td>
<td>10% to 14%</td>
<td>32 to 45</td>
</tr>
</tbody>
</table>
“There is no health without mental health. Mental health is central to the human, social and economic capital of nations and should be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment. 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.”
Source: WHO European Declaration on Mental Health, 2005

Risk Factors

➢ Unemployed people are twice as likely to have depression as people in employment. In Shropshire, levels of unemployment are low compared to most inner cities. However, mental health problems can still occur even with full employment, particularly within a low wage economy. The income domain from the Index of Multiple Deprivation (IMD) 2004 identified that there were approximately 26,600 people living on low income within Shropshire (9%).

➢ Children living in deprived households are three times more likely to have mental health problems than children living in more affluent households. It is estimated that there are approximately 7,000 children under 16 living in child poverty in Shropshire (13%).

➢ People with physical illness have twice the rate of mental health problems compared to the general population.

➢ There is a high rate of mental health problems in the prison population. Personality disorders are very common, as are neurotic disorders for young offenders. Self harm and suicidal thoughts are common in Shrewsbury Prison and less so at Stoke Heath. The suicide rate has risen in both prisons, with the expected number of cases rising per year. Drug and alcohol problems are common among prisoners.

➢ Half of all women and a quarter of men will be affected by depression at some stage during their lives. The majority of mild forms of depression are usually treated in primary care settings. Around 40 people in Shropshire are admitted to hospital annually.

The current rate for depressive disorders locally is lower than the national rate.

➢ People who have been abused or been victims of domestic violence have higher rates of mental health problems. There were 1,356 incidences reported in 2003/04. The reporting of domestic violence in the County appears to be low based on national data.

➢ Almost half of people using night shelters or sleeping rough may have a serious mental disorder, up to half may be alcohol dependent. In a survey conducted in March 2004 the total number of people in Shropshire (including children and other dependents) who considered themselves homeless were 269.

➢ Some black and minority ethnic communities are diagnosed as having higher rates of mental health problems than the general population.
Hospital Admissions

Between 2000/01 and 2004/05 there were on average 1,250 acute admissions in Shropshire County where there was a primary diagnosis of mental and behavioural disorders (regardless of speciality or hospital).

Similar to other health trends there is a strong correlation between levels of admissions and deprivation.

Levels of admissions are particularly higher in women aged between 25-34 and those aged 75 and over.

People from a “Black” ethnic group are also more likely to be admitted to hospital than other groups.

Mental health admissions by ethnicity, 2000/01 to 2004/05

[Graph showing mental health admissions by ethnicity]
Annually, on average there are 500 admissions that are thought to be due to deliberate self-harm in Shropshire.

Over 90% of these self-harm admissions are drug-related poisoning.

In Shropshire there are on average 26 male and five female deaths from suicide per year. Rates in men are significantly higher than women, with men in making up 84% of all suicides (compared with 74% nationally). During 2000-2004, in Shropshire County rates for men were higher than the national level.

This map identifies the current locations of the Community Mental Health Teams, the Recovery Team, Shelton Hospital, Crisis Houses and Supported Housing Initiatives.

The number of adults with mental health problems who were helped to live at Home by social care services in Shropshire during 2006/07 is 1282.

15 of these receive a direct payment.
Suicide

Shropshire has similar suicide and injury undetermined rates to national figures. Error! Reference source not found. shows suicide trends in Shropshire. In 2004-06 there were similar suicide rates compared to the figures in 1988-1990. Rates have decreased slightly since their peak in 2001-03, but not changed significantly.

Figure 46 Trends in suicide and injuries undetermined

Suicide rates do not affect everyone in the population equally; males aged under 65 years old are most likely to be affected by suicide. Therefore, suicide is one of the causes of death that has a large impact on life expectancy.

Figure 47 shows suicide rates by deprivation quintile in Shropshire. Although there was no significant difference in rates, there was a higher number (22) of suicides recorded in the most deprived fifth of areas in Shropshire in 2004-06. The confidence intervals on these figures are wide due to the small number of deaths.

Figure 47 Suicides and injuries undetermined by deprivation, 2004-2006
Dementia

Shropshire has an ageing population and dementia is most likely to affect people aged 65 years and over. The table below shows dementia prevalence estimates and projections for Shropshire. Currently it is estimated that just over 7% of people aged 65 years and over have dementia. However, this figure is expected to increase to over 7.5% of people aged 65 years and over. There is a higher prevalence of females with dementia, which is probably due to the fact that female life expectancy is longer than male life expectancy.

Figure 48 PCT dementia prevalence estimates and projections
<table>
<thead>
<tr>
<th></th>
<th>Shropshire County (current)</th>
<th></th>
<th>Shropshire County (2017)</th>
<th></th>
<th>Shropshire County (2021)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>% 65+ with dementia</td>
<td>% total with dementia</td>
<td>Males</td>
<td>% 65+ with dementia</td>
</tr>
<tr>
<td>Males</td>
<td>1374</td>
<td>5.47</td>
<td>0.96</td>
<td>2138</td>
<td>5.92</td>
</tr>
<tr>
<td>Females</td>
<td>2643</td>
<td>8.47</td>
<td>1.81</td>
<td>3431</td>
<td>8.24</td>
</tr>
<tr>
<td>Persons</td>
<td>4017</td>
<td>7.15</td>
<td>1.17</td>
<td>5569</td>
<td>7.17</td>
</tr>
</tbody>
</table>


**Alcohol Misuse**

In Shropshire substance misuse services include multi agency support to people with either drugs or alcohol related issues. More information on demography can be found in the Shropshire 2007 LAA evidence base and the Crime, Disorder and Substance Misuse Strategy.

**Alcohol Abuse in Shropshire**
Drunkenness in the evenings by both adults and young people are two of the County’s top three problems. Areas that were identified as having the greatest problems were in the town centres of Oswestry and Shrewsbury. Street drinking was also highlighted as a concern in the Bridgnorth, Oswestry and Market Drayton areas.

The 2001 West Midland Regional Lifestyle survey found that 23% of men and 13% of women in Shropshire drink more than the sensible levels per week. In relation to age, with the exception of the over 65s, the proportions of men exceeding sensible drinking levels tend to be similar throughout all the age groups; in women this number reduces with age.

Alcohol and Young People

The number of young people in Shropshire aged between 11 to 15 years who drink at least once a week is significantly higher than the national average. The proportion of 12 and 15 year olds who drink at least once a week is significantly higher than the national average. Significantly more boys in Shropshire County drink every week, compared to girls. Most young people in the survey reported never buying alcohol but obtaining it from friends and relatives.

Alcohol and Crime

Between April 2002 and March 2004, 13.7% of recorded crimes were alcohol related (This may be subject to under reporting). Alcohol related crime was spread throughout the county. However, the highest concentrations of these crimes are in Oswestry and Shrewsbury town centres.

Assaults constituted the largest group of alcohol related crimes at 41%. These crimes ranged from common assault to grievous bodily harm (GBH) and wounding. 31% of all crimes with alcohol markers related to criminal damage to property and vehicles. 16% alcohol marker crimes were domestic violence incidents. 31% of the total number of offenders screened by the Arrest Referral workers for drug misuse had also consumed alcohol in the last thirty days.

Treatment

The Shropshire Community Substance Misuse Team received 830 referrals from adults for alcohol misuse between 1 April 2002 and 31 March 2004. Two thirds of these referrals were from men (66%), with a third from women (34%). The majority of the people seeking help were in the 25 to 44 age group. Compared to the rest of the county, the majority of people seeking help for alcohol misuse were from the Shrewsbury and Atcham area.

Admission to hospital
Alcohol related hospital admissions have been increasing in Shropshire since 2002-03. Alcohol has been identified as a local priority by Shropshire County Council and Shropshire County PCT and alcohol related hospital admissions has been chosen as a LAA, Tier three Vital Sign and a World Class Commissioning Outcome Measure.

The chart below shows alcohol related hospital admission trends in Shropshire and the West Midlands and the Shropshire targets. The targets show an increase in admission rates and the aim is to slow the rate of increase. Shropshire has lower admission rates than the West Midlands region.

Figure 49 Alcohol related hospital admissions per 100,000 population in Shropshire

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

Problem Drug Misuse

The problem drug using (PDU) population is based on estimates from the University of Glasgow’s Centre for Drug Misuse Research (2004/05). In Shropshire there is an estimated prevalence of 1,025 PDUs, which accounts for around 1% of Shropshire’s population aged between 15-64 years old (based on 2005 mid-year populations estimated, National Statistics). In Shropshire there were 763 people in drug treatment services at the end of 2006-07, these accounts for 74% of the estimated number of PDUs in Shropshire; in 2005-06 the number was 724 accounting for around 71% of estimated PDUs in Shropshire, which is an overall increase of 3% on the previous year.
### Comparison between PDU estimates, people in treatment and PDUs in treatment in Shropshire and England

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>% of estimate</th>
<th>95% Confidence interval</th>
<th>Lower limit</th>
<th>Upper limit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shropshire</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number in treatment</td>
<td>763</td>
<td>74%</td>
<td>71.7%</td>
<td>77.1%</td>
<td></td>
</tr>
<tr>
<td>Number of PDU’s in treatment</td>
<td>503</td>
<td>49%</td>
<td>46.0%</td>
<td>52.2%</td>
<td></td>
</tr>
<tr>
<td>PDU estimate</td>
<td>1025</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number in treatment</td>
<td>192248</td>
<td>59%</td>
<td>58.5%</td>
<td>58.9%</td>
<td></td>
</tr>
<tr>
<td>Number of PDU’s in treatment</td>
<td>112314</td>
<td>34%</td>
<td>34.1%</td>
<td>34.5%</td>
<td></td>
</tr>
<tr>
<td>PDU estimate</td>
<td>327466</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Estimates of prevalence of opiate use and/or crack cocaine use (2004/05): The centre for Drug Misuse Research: University of Glasgow. Adult Partnership Quarterly Report, Quarter 3 2006/07 NDTMS.

### Hospital Episode Statistics

In this section HES data has been used to analyse in-patient admissions with a primary diagnosis of mental and behavioural disorders due to psychoactive substance use. This covers a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances (which may or may not have been medically prescribed).

**Key messages:**

Overall males accounted for 68% of all admissions in 2006-07 and females 38%.

Significantly more males than females aged over 25 years old were admitted to hospital for mental and behavioural disorders due to psychoactive substance use.

In the 0-24 years old age groups similar numbers of males and females were admitted to hospital.

Males aged 25-34 years old were the most likely group to be admitted to hospital, with significantly more people in this group being admitted than in any other group.
Overall the most deprived fifth of areas in Shropshire accounted for 44% of all admissions, significantly more than all the other deprivation groups.

18% of admissions were matched on the drug treatment services records and the in-patient records.

154 admissions for mental and behavioural disorders due to psychoactive substance use 81% (125) were for use of alcohol. The remaining 29 were for other drugs.

In-patient admissions by local deprivation quintile (2002/03-2006/07)

In-patient admissions by age and gender (2002/03-2006/07)

Treatment Bulls Eye
As part of the needs assessment guidance issued by the National Treatment Agency for Substance Misuse each partnership is required to produce a ‘treatment bull’s eye’. The bull’s eye is a graphical representation of the problem drug user estimate showing the number of the estimated total in, or known to, treatment and the number not known to treatment.

Shropshire DAAT therefore estimates that 742 of the estimated 1,025 problem drug users are known to treatment services, and that 503 were in treatment on 31st March 2007. Therefore there are 239 problem drug users known to the treatment system but who are no longer in treatment. Of these, given a successful completion rate of 46% in Shropshire, 122 of those previously known to treatment probably continue to use drugs in a problematic way. It is also likely that some of those successfully discharged from treatment will have returned to problematic drug use. Whilst it is difficult to estimate this number, a survey over a 12 month period of readmissions to the in-patient detoxification unit found that 33% of patients who had previously been successfully discharged had been readmitted. As this is the only local data we have available we could estimate that 39 of the 117 successfully discharged are likely to have returned to problem drug use.

Community Perceptions of drug taking, drug dealing and crime
The details below have been taken from the West Mercia Crime Survey 2006
Key Messages:

- More respondents in the most deprived fifth of areas in Shropshire stated that they thought drunken disorder was a problem in the local area and to have reported this problem
- More people living in the most deprived quintile stated that they thought illegal drugs were a problem in their neighbourhood than in all other areas
- More respondents in the most deprived fifth of areas stated that they had seen evidence of drug taking and that they knew someone who they think deals illegal drugs.
- More people living in the most deprived fifth of areas thought that illegal drug use had become a more serious problem in their neighbourhood than in all other areas.
- More people living in the fifth most deprived areas believed that drug dealing was a problem and had reported it to the police.
- Overall the local media was the most common explanation given by respondents for why they thought illegal drug use was a problem.

The Drug Intervention Programme

The Shropshire Drug Intervention Programme (DIP) team includes qualified nurses, social workers and counsellors who are employed as criminal justice workers. They assess, care manage and provide harm reduction advice to people problems with drugs who are involved with the criminal justice system.

If an offender is identified as having a drug problem and agrees to meeting with a drugs worker then they are referred to the DIP and an initial contact completed by the worker and arrangements for assessment made.

West Midland non-intensive DIP areas total number of contacts and assessments
## Non-intensive DIP (West Midlands) performance 2006-07

<table>
<thead>
<tr>
<th></th>
<th>Total Contacts</th>
<th>Total Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herefordshire</td>
<td>78</td>
<td>51</td>
</tr>
<tr>
<td>Shropshire</td>
<td>188</td>
<td>80</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>936</td>
<td>549</td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>237</td>
<td>150</td>
</tr>
<tr>
<td>Telford &amp; Wrekin</td>
<td>103</td>
<td>83</td>
</tr>
<tr>
<td>Warwickshire</td>
<td>278</td>
<td>245</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>437</td>
<td>264</td>
</tr>
<tr>
<td>West Midlands</td>
<td>2257</td>
<td>1422</td>
</tr>
<tr>
<td>National</td>
<td>23041</td>
<td>12165</td>
</tr>
</tbody>
</table>

Source GOWM 2007

### Drugs and Lifestyles

As part of the initial assessment clients referred for the Drug Intervention Programme are asked a number of questions about how their substance misuse affects their lifestyles.

Findings from this part of the assessment in 2006-07 include:

- Over half (54%) of clients undertaking initial assessment stated that they had overdosed, 37% stated that they had done so deliberately.
- Age groups most likely to have overdosed were the 35 years and over age group (67%) (although numbers for this age group were very small) and 18-24 years age group (52%).
- The group with the highest proportions of those who had deliberately overdosed were from the 18-24 years old age group.
- Most clients stated that they spent over £100 in the last four weeks on drugs, with people in the 25-34 years age group spending the most.
- When asked where they got money for drugs the most likely response was from benefits or from benefits and crime.
- 43% of clients stated that they had committed an offence in the last four weeks, 23% had committed between 1-5 offences.
- The age group that was most likely to have committed an offence was the 18-24 years age group.
• Offences that were most likely to be committed were shoplifting and drug dealing/trafficking/selling with 27% and 15% of clients respectively admitting to these crimes.

• When asked about their offending in more depth 41% of clients stated that it was in order to raise money to buy drugs and 41% stated that it was committed under the influence of substances.

Number of initial contacts by outcomes from the initial contact sheet

<table>
<thead>
<tr>
<th>Number of initial contacts</th>
<th>Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up offered</td>
<td>52</td>
</tr>
<tr>
<td>Liaise with keyworker</td>
<td>51</td>
</tr>
<tr>
<td>Not yet ready to engage</td>
<td>22</td>
</tr>
<tr>
<td>Receiving sufficient treatment or support already</td>
<td>16</td>
</tr>
<tr>
<td>YP Drug Team</td>
<td>9</td>
</tr>
<tr>
<td>Other - give details</td>
<td>8</td>
</tr>
<tr>
<td>Refused to be seen</td>
<td>5</td>
</tr>
<tr>
<td>Referred to DTTO</td>
<td>3</td>
</tr>
<tr>
<td>Referred to CSMT</td>
<td>3</td>
</tr>
<tr>
<td>Released before being seen</td>
<td>2</td>
</tr>
<tr>
<td>No drugs used</td>
<td>2</td>
</tr>
<tr>
<td>Assessment not offered</td>
<td>2</td>
</tr>
<tr>
<td>Referred to CARAT</td>
<td>1</td>
</tr>
<tr>
<td>Not satisfied suitable treatment available</td>
<td>1</td>
</tr>
<tr>
<td>Given information</td>
<td>1</td>
</tr>
<tr>
<td>Concerned about impact on criminal case</td>
<td>1</td>
</tr>
<tr>
<td>blank</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>180</strong></td>
</tr>
</tbody>
</table>
89% of initial contacts belonged to white ethnic groups. 11% of initial contacts did not have a stated ethnicity.

88% of initial contacts were males compared with 12% females

91% of initial contacts were aged 18 years or over

80 initial assessments became part of the DIP team caseload in 2006-07.

The most common response is that they are being offered a follow up by the DIP team. The most likely reasons for people not becoming a DIP contact was that they were already in treatment services and did not want to change or that they were not ready to engage.
End of Life Care

End of Life services currently available
There are a wide range of providers of care; generalists, specialists, unpaid carers both voluntary sector and family.

Hospice: Currently there are a total of 21 beds provided by Severn Hospice.

Outreach/hospice at home services: This is an integrated service that includes Marie Curie nurses- it provides palliative care at home for patients with malignant and non-malignant conditions- mainly at night but also receives referrals for care during the day.

Acute hospitals - bed usage for end of life care: There are no designated palliative care beds. However there are currently three Clinical Nurse Specialists in Palliative Care working within SaTH. 2 at RSH and 1 at PRH.

Community hospitals / beds: There are four community hospitals within the Shropshire County area in Bishops Castle, Bridgnorth, Ludlow and Whitchurch. The Sheldon Ward at Robert Jones and Agnes Hunt in Oswestry also has 16 community beds. There are no designated palliative care beds. However, the community hospital specification requires terminally ill patients to be cared for within this setting and to use the Care of the Dying pathway for these patients.

Community specialist palliative care teams: There are currently eight Macmillan nurses and four Hospice Outreach nurses (11.2 WTEs) providing specialist care across both PCTs.

Voluntary Care:- There are several voluntary agencies throughout the county providing non-nursing services to support patients and carers at home.

- Red Cross: Home from Hospital provides short term help with shopping, prescription collection, getting to the GP surgery, telephone support or check and chat visits. This service is available in the Shrewsbury & Atcham and Oswestry areas.

- Age Concern: Offers benefits advice; home from hospital scheme for over 60s in the South Shropshire area; help at home subsidised by Shropshire County Council which can include help with shopping, housework, gardening etc. Neighbourhood visiting run as help at home provides a companionship service for an hour a week.

- Shropshire County Carers: This service is based in Shrewsbury and provides support for carers including help with form filling, helpline 9-5 on weekdays, outreach workers in some surgeries providing individual and group support, manual handling, relaxation and stress relief training and outings for carers.
- Crossroads: Available to full time family carers across both PCT areas. This service provides a three hour period once a week with the same staff being deployed each week. Staff are paid, trained support workers. Visits usually take place between Monday and Friday. Personal care can be carried out including toileting and provision of meals as well as being a companionship service. Referrals to the service are usually made through social workers.

Social care end of life facilities: includes home support, day care and equipment provision; services to carers and nursing and residential care. (see previous sections).

Care homes/beds for both personal care and nursing care:
There are a total of 30 care homes with nursing in Shropshire which equates to 1190 beds.

Psychological support and bereavement counselling for carers and families (including children) is provided by a number of agencies:

<table>
<thead>
<tr>
<th>Hamar Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>SaTH</td>
</tr>
<tr>
<td>Severn Hospice</td>
</tr>
<tr>
<td>CRUSE</td>
</tr>
<tr>
<td>Macmillan/Hospice Outreach</td>
</tr>
<tr>
<td>Community DN teams</td>
</tr>
<tr>
<td>GP practices</td>
</tr>
</tbody>
</table>
Community Safety and Vulnerable Groups

DOMESTIC VIOLENCE
Domestic Violence is best understood as a pattern of behaviour, characterised by the exercise of control and misuse of power over an intimate partner (or household member). It encompasses a broad range of behaviours, which can often overlap and rapidly shift in intensity. It takes many forms including physical, sexual, economic and emotional abuse as well as isolation and destruction of pets and property. Abusers may also involve children in the abuse, directly or indirectly. Children will always be affected by violence in the home, even where they do not suffer direct violence themselves. Domestic violence is Britain’s biggest ‘hidden’ crime. Only a small proportion of incidents (less than 20%) are reported to the police.

The Home Office defines Domestic Violence as: Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults aged 18 or over who are or have been intimate partners or family members, regardless of gender or sexuality. (2004)

Prevalence

Nationally:-
Domestic violence accounts for just under a fifth (17%) of all recorded violent crime;
Domestic violence means that nearly half of all female murder victims are killed by a current or former partner;
89% of victims who suffer sustained domestic violence are female.
29 per cent of those who had experienced domestic abuse in the previous year stated that children had been aware of what was going on during the last incidence of violence.

In Shropshire:-
Based on a study by Stanko et al (1998), it is estimated that over 12,000 women per year will have experienced some form of physical and/or psychological violence or abuse in Shropshire.
A total of 111 Multi Agency Risk Assessment Conference cases were reviewed during the twelve months to October 2007.
739 offences were reported in Shropshire during 2006-07
Between January and December 2007, 228 victims of domestic violence were referred to the Independent Domestic Violence Advisors
Key local information

Recent analysis has shown that alcohol is a factor in approximately 50% of all domestic violence offences in Shropshire.

It is estimated that domestic violence accounts for just under a fifth (17%) of all recorded violent crime in Shropshire.

3 Independent Domestic Violence Advisors, employed by Stonham, are able to support Shropshire domestic violence victims in Shropshire, whose cases are proceeding through the criminal justice system, or whose cases are the subject of Multi Agency Risk Assessment Conferences.

There are 2 refuges and one Safe House in Shropshire, providing 24 units of accommodation for women and their children fleeing domestic violence.

Children’s services systems are being developed to identify domestic violence concerns on the Integrated Children’s System and PCT child protection system.

Shropshire’s Local Public Service Agreement (LPSA) 6 seeks to improve criminal justice services relating to domestic violence by improving the criminal justice response to incidents of domestic violence.

Risk factors

- Domestic violence is acknowledged to be Britain’s biggest hidden crime, and one that overwhelmingly affects women and their children. For women aged 19 – 44, it is the leading cause of morbidity, greater than cancer and road traffic accidents. Nearly half of all female murder victims are killed by a current or former partner.

- Domestic violence can also affect male victims, and the lesbian, gay, bisexual and transgender community.

- Domestic violence affects people from all ethnic groups and social backgrounds.

- Domestic violence is a primary indicator of child protection needs.

- Pregnancy is a high-risk period during which violence may begin or escalate (Mezey et al, 2000).

- The incidence of violence against pregnant women is higher and produces more morbidity than many other conditions for which they are routinely screened (Bewley et al, 2000).

Domestic violence has the highest rate of repeat victimisation of any crime, and victims are likely to suffer many repeated incidents before reporting. On average, women experience 35 incidents of physical abuse before informing anyone (Metropolitan Police Research).

THE PICTURE IN SHROPSHIRE

Table 1: Multi Agency Risk Assessment Conferences cases reviewed during the twelve months to October 2007

<table>
<thead>
<tr>
<th>Baseline 2005/06</th>
<th>2006/7 Target</th>
<th>2006/7 Actual</th>
<th>2007/8 Target (quarter 3)</th>
<th>2007/8 Actual (quarter 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>556</td>
<td>570</td>
<td>739</td>
<td>447</td>
<td>666</td>
</tr>
</tbody>
</table>

Table 2: Increase in reported offences in Shropshire since the introduction of the LPSA

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Children under 5 years</th>
<th>Children 5yrs to 18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shrewsbury</td>
<td>60</td>
<td>3</td>
<td>57</td>
<td>44</td>
<td>52</td>
</tr>
<tr>
<td>North Shropshire and Oswestry</td>
<td>33</td>
<td>2</td>
<td>31</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Bridgnorth and South Shropshire</td>
<td>18</td>
<td>0</td>
<td>18</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Shropshire</td>
<td>111</td>
<td>5</td>
<td>106</td>
<td>79</td>
<td>102</td>
</tr>
</tbody>
</table>
Table 3: Independent Domestic Violence Advisor referral data January to December 2007

<table>
<thead>
<tr>
<th>No. of referrals</th>
<th>228</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of referral</td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>226</td>
</tr>
<tr>
<td>Health</td>
<td>1</td>
</tr>
<tr>
<td>Refuge</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of referrals successfully contacted by service</th>
<th>224</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of referrals engaging with service</td>
<td>98</td>
</tr>
<tr>
<td>No. of high risk referrals</td>
<td>209</td>
</tr>
<tr>
<td>No. of very high risk referrals</td>
<td>19</td>
</tr>
<tr>
<td>No. of IDVA clients where court process taking place</td>
<td>43</td>
</tr>
<tr>
<td>No. of IDVA clients supported through court process</td>
<td>35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breakdown of ethnicity referrals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>1</td>
</tr>
<tr>
<td>White British</td>
<td>215</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Not provided</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other support offered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>53</td>
</tr>
<tr>
<td>Benefits</td>
<td>29</td>
</tr>
<tr>
<td>Education</td>
<td>32</td>
</tr>
<tr>
<td>Refuge</td>
<td>19</td>
</tr>
<tr>
<td>Health</td>
<td>38</td>
</tr>
<tr>
<td>Target hardening (security)</td>
<td>24</td>
</tr>
<tr>
<td>Immigration</td>
<td>1</td>
</tr>
<tr>
<td>Support Group</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

| No. of male survivors | 6 |

- 137 -
Anti social behaviour

This is defined in the Crime and Disorder Act 1988 as ‘acting in an anti-social manner as a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the complainant’.

It is defined in accordance with the National Incident Category List in the National Standards for Incident Recording Instructions for Police Forces in England and Wales. The list includes, amongst others, rowdy behaviour, noisy neighbours, animal nuisance, street drinking, vehicle related nuisance, and environmental nuisance.

80% of anti social behaviour incidents in Shropshire involves :-

- Rowdy behaviour- which accounts for 60% of all anti social behaviour events recorded by police in Shropshire. It is usually associated with the town centre ‘night time economy’ and the impact of alcohol misuse either in the vicinity of public house / nightclubs and / or on routes away from town centres.

- Vehicle related nuisance is the next largest category accounting for 12% of total police recorded anti social behaviour.

- Nuisance neighbours - ranging from minor arguments / disputes, boundary disputes, noise (including noisy parties) and general intolerance as well as some instances that will result in a criminal offence of harassment.
The top five police reported Anti-social behaviour incidents in Shropshire between January and October 2007 are as follows:

- Rowdy Behaviour 61.40%
- Vehicle related nuisance 11.48%
- Nuisance Neighbours 8.88%
- Malicious Communication 6.03%
- Harassment 2.23%

Shropshire’s LAA has two outcomes and six indicators which relate to anti-social behaviour, including the Respect mandatory indicator.

Shropshire’s LAA has two outcomes and six indicators which relate to anti-social behaviour, including the Respect mandatory indicator.

<table>
<thead>
<tr>
<th>LAA</th>
<th>Indicator</th>
<th>Target 07/08</th>
<th>Actual 07/08</th>
<th>On target?</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAA 12</td>
<td>To improve the quality of life of the people of Shropshire by reducing the fear of crime and reassuring the public.</td>
<td>(i) The proportion of adults who feel safe in their home area after dark. (Bigger is better)</td>
<td>62%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>(ii) A percentage reduction in people’s perception of Anti-Social Behaviour. (Smaller is better)</td>
<td>57%</td>
<td>49%</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>(iii) Reducing the level of criminal damage. (Smaller is better)</td>
<td>2136 (6 month target)</td>
<td>2095 (6 month actual)</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>(iv) Percentage of people who feel that parents in their local area are made to take responsibility for the behaviour of their children. (User Satisfaction Survey – identifying the percentage who feel that the negative of this is a problem) (Smaller is better)</td>
<td>20%</td>
<td>26%</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>(v) Percentage of people who feel that people in their area treat them with respect and consideration. (User Satisfaction Survey – identifying the percentage who feel that the negative of this is a problem) (Smaller is better)</td>
<td>41%</td>
<td>37%</td>
<td>✓</td>
</tr>
</tbody>
</table>
Fire Safety

The Fire and Rescue Service National Framework Document 2005-06\(^1\) and the Fire and Rescue Services Act 2004\(^2\) establishes the Government’s intent that ‘Prevention’ will be at the heart of Fire and Rescue Services (FRS) activities. Shropshire Fire & Rescue Service has a very robust Fire Safety strategy which is aimed at reducing fires, fire injuries and fire deaths throughout the County. The Framework Document considerably broadens the role of the Fire Service and introduces a statutory duty for FRS to engage in reducing deaths caused through road traffic collisions and water related accidents. We are also now heavily engaged in national resilience activity such as flood preparations, minimising the impact of terrorist incidents and other major disaster recovery work.

Shropshire Fire & Rescue Services targeted key outcomes are for:

- **A Safe Shropshire**
- **A Prosperous Shropshire**
- **An Attractive Shropshire**
- **A Cohesive Shropshire**

Despite the perception that Shropshire is a prosperous and safe County, data provided by the government indicates that there are 37,000 homes which are ‘well above’ average risk from fire and a further 8,054 which are ‘above’ average risk within Shropshire. This is substantially above the national average and demonstrates the vulnerability of our County and its communities to the dangers of fire.

---


Vulnerable Groups
Through a study of fires, fire deaths and injuries, it is clear that certain individuals and communities are at greater risk from fire than others.

These vulnerable groups include;

- The elderly. It is a sad fact that the elderly are 5 times more likely to die as a result of a fire than others.
- Children and young people.
- People living alone.
- Those living in socially deprived areas and those who are long term unemployed.
- Disabled people and those suffering long term illness.
- Those suffering mental illness.
- Black and ethnic minorities (including the new communities from east Europe).
- Gypsies and travellers.
- Individuals who use (non prescription) drugs and those who are heavy drinkers.

The Shropshire Fire & Rescue Service have ‘People at Risk Team’ focuses specifically on those communities by providing support, education, and smoke alarms to secure their safety.

The department for Communities and Local Government established PSA 3 for reductions in fire deaths and arson;

- To reduce the number of accidental fire-related deaths in the home by 20% by 31st March 2010
- To achieve a 10% reduction in deliberate fires by 31 March 2010.

All UK Local Fire Authorities are measured against a suite of fire related best value performance indicators which include;

- BVPI 142 The number of primary3 fires per 10,000 population and accidental fires in dwellings per 10,000 dwellings;
- BVPI 143 The number of deaths and injuries, arising from accidental fires in dwellings per 100,000 population.
- BVPI 146 Number of calls to malicious false alarms
- BVPI 149 False alarms caused by automatic fire detection per 1,000 non-domestic properties
- BVPI 206 Number of deliberate fires including; primary fires, cars and secondary fires per 10,000 population;
- BVPI 207 The number of fires in non-domestic premises per 1,000 non-domestic premises.
- BVPI 208 The % of people in accidental dwelling fires who escape unharmed without Fire & Rescue Service assistance.
- BVPI 209 The % of fires attended in dwellings where: A smoke alarm had activated; a smoke alarm was fitted but did not activate or, no smoke alarm was fitted.
Additional Information

What is Assistive Technology?

King’s Fund Consultation
"Assistive Technology (AT) is any product or service designed to enable independence for disabled and older people."

World Health Organisation
"An umbrella term for any device or system that allows individuals to perform tasks they would otherwise be unable to do or increases the ease and safety with which tasks can be performed."

Audit Commission Report ‘Assistive Technology’
“AT can be defined as: any item, piece of equipment, product or system that is used to increase, maintain or improve the functional capabilities and independence of people with cognitive, physical or communication difficulties. This broad definition incorporates an incredibly large number of devices, ranging from ‘low-tech’ mobility devices such as a walking stick to ‘high-tech’ speech synthesizers or stair-climbing wheelchairs"
What is Telecare?

Telecare is a type of assistive technology, but often considered in its own right. An official definition of Telecare is “the continuous, automatic, and remote monitoring of real live emergencies and lifestyle changes over time in order to manage the risks associated with independent living.”

In simple terms, telecare includes sensors or monitors (e.g. fall or gas detectors) attached to a community alarm service that trigger a warning at a control centre that can be responded to within defined time-scales.

Telecare has been accurately referred to as the second generation in community alarm services.
What is Telehealth?

Telehealth enables remote interaction between clinicians and patients, through the use of information and communication technologies such as interactive video, digital imaging and electronic data transmission. This includes telemedicine application for diseases such as CHF, COPD, Diabetes and IHD and can provide remote monitoring for blood pressure, blood glucose, cardiac arrhythmia, asthma, and provide home personal medical assistants units, integrated health monitors and medication reminder systems.
Shropshire and AT - current position

There are many organisations, including charities, voluntary and commercial enterprises, who are currently engaged in promoting the use of Assistive Technology across Shropshire. The range of scenarios for use of AT is wide, from very specialist applications to meet complex needs to simple devices to help people with day-to-day tasks in their homes.

Heaths Houses and Telecare: A housing scheme with an existing community alarm service was upgraded to enable telecare sensors to be used by residents. A stock of approximately 250 pieces of telecare equipment was purchased, some of which were installed and the remainder to be stored and issued according to need. The range of equipment proposed was not specific to individual assessed needs but considered an appropriate package for residents in a sheltered housing scheme. This approach to deploying Telecare equipment was in-line with the Telecare model adopted by the majority of other Local Authorities.

Alertacall – Telecare Safety Confirmation System: Alertacall is an alternative to the pendant style community alarm. It is a big-button telephone with an additional button that the service user to presses to confirm their safety on a daily basis. It enables the person to provide reassurance to their family and carers of their well-being without intrusion to their privacy, but allows for carers and family to be alerted promptly should a problem arise.

Just Checking: The Just Checking system provides objective information on the daily activities of people who live in their own homes. The system involves the installation of small wireless movement sensors in the main rooms of the person’s home. Data from the sensors is gathered by a controlling modem and sent via a GSM router and then it can be viewed as a log of daily activity over the internet. It is being used by practitioners from social work, occupational therapy and community mental health nurse teams as an as an assessment tool for use in service user’s homes on a 4 – 6 week basis.

Meeting assessed social care needs: a wide range of Assistive Technology Devices have been provided to over 60 service users. In an ongoing project to provide information and advice to both practitioners and the public, the deployment of Assistive Technology as part of a care package, continues toward mainstreaming status.

Potential usage of AT in the UK

Assistive Technology is a potential solution that could be utilised to meet a wide range of needs. In the UK it is estimated that 4 million people currently use AT, but this does not reflect the number who could benefit from AT but are not currently able to do so.

There is little evidence on the proportion of disabled people who use, or may benefit from, assistive technology while for publicly funded care; eligibility criteria can limit access to services for those with relatively low need. As a result, current service patterns are not reliable guides to
the extent of need. However, a good indicator of potential recipients of AT can be identified by numbers of people with needs that AT can support. (Data courtesy of FAST)

**In the UK potential recipients of Assistive Technology:**
- 11,000,000 disabled adults
- 700,000 disabled children
- 6,000,000 informal carers
- 1,200,000 people over 65 who use social care

**Electronic AT: telecare, environmental controls and smart homes**
- 5,000 current environmental control users
- 1,400,000 current social alarm service users
- 160,000 older people who are targeted to receive telecare services

**Telemedicine and home nursing**
- 2,000,000 people with diabetes
- 5,200,000 people with asthma
- 148,790 people with COPD

**AT for housing and the built environment**
- 20,462 extra care housing units
- 378,622 sheltered housing units

**AT for daily living (community equipment/ household activities)**
- 1,000,000 community equipment users
- 1,700,000 informal carers using community equipment services

**AT for cognitive support**
- 750,000 people with dementia of whom 18,000 are under 64
- 13.8% of those 85-94 years of age will have dementia
- 40.2% of those over 90 years of age will have dementia
- 230,000 - 350,000 people with severe learning disabilities
- 580,000 - 1,750,000 with milder learning disabilities
Potential Usage of AT in Shropshire

"AT can support the aspirations of many older or disabled people by providing them with greater choice. As the average age of the population increases and the pressure on formal and informal carers intensifies, the use of AT will become increasingly prominent. Indeed, AT is the key to delivering many public policy initiatives across Government. Future advances in technology will increase this potential and should lead to more AT products being readily available in the high street."

Source: Audit Commission Report ‘Assistive Technology

As a result of Shropshire County Councils preliminary evaluation of the use of assistive technology, and supported by emerging evidence nationally, the following areas have been identified as demonstrating the greatest potential for the use of AT.

- Dementia Care
- Supporting Carers
- Ageing Independently
- Enabling independence for adults with physical disability
- Long Term Health Conditions

Based on Projections from the Office of National Statistics, the projected number of people in Shropshire who fall within these broad categories and could benefit from the use of AT:

<table>
<thead>
<tr>
<th>Shropshire Projections</th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population &gt; 65</td>
<td>58800</td>
<td>62600</td>
<td>73200</td>
<td>81000</td>
<td>88900</td>
</tr>
<tr>
<td>Dementia &gt; 85 years (1/5)</td>
<td>1520</td>
<td>1620</td>
<td>1880</td>
<td>2220</td>
<td>2740</td>
</tr>
<tr>
<td>Dementia &gt; 65 years (1/20)</td>
<td>2940</td>
<td>3130</td>
<td>3660</td>
<td>4050</td>
<td>4445</td>
</tr>
<tr>
<td>LTC (1/3)</td>
<td>96667</td>
<td>97526.4</td>
<td>99837.3</td>
<td>102213</td>
<td>104457</td>
</tr>
<tr>
<td>Supporting Carers (1/6)</td>
<td>48919</td>
<td>49354</td>
<td>50523</td>
<td>51726</td>
<td>52862</td>
</tr>
<tr>
<td>Physical Disability (1/7)</td>
<td>41010</td>
<td>41374</td>
<td>42355</td>
<td>43363</td>
<td>44315</td>
</tr>
</tbody>
</table>
**Why use AT?**

**Dementia Care:** For those people who live alone or with a carer, AT can help cope with the difficulties associated with the early stages of dementia, specifically around problems that arise due to memory loss.

- Mitigate the risks associated with memory loss and provide practical help to deal with memory loss.
- Reduce carer anxiety and time spent supervising the service user.
- Reduce tension between the carer and service user.
- Improve service user and carer’s confidence in the person’s ability to continue to live independently at home.
- Delay or prevent entry to residential or nursing care.

**Carers:** AT can support carers to provide care to a person whom they share a home, or live independently from, by helping carers monitor a person’s well-being, and feel reassured that if help is required they will be alerted.

- Improve the relationship between the service user and the carer, thereby contributing to both parties well-being.
- Improve the service user and carer’s confidence in the person’s ability to continue to live independently at home.
- Decrease likelihood of carer breakdown.
- Delay or prevent entry into residential or nursing care.
- Provide practical tools to manage risks.

**Long Term Health Conditions:** AT can support people with long-term health conditions by enabling regular monitoring of patients in their own homes, which identify earlier than currently possible when patients’ conditions deteriorate, thus averting an acute exacerbation of their condition. In addition, strong evidence is emerging from many pilot schemes which demonstrate significant cost savings.

- Reduce feelings of anxiety for users and carers.
- Self manage and increase treatment/medication compliance.
- Enhance opportunities to provide preventative health care services.
- Reduce mortality.
- Reduce hospital admissions and length of stay.
- Enable earlier hospital discharge.
- Increase clinical effectiveness at reduced overall financial spend.
- Improve users and carers quality of life.
To help people age independently: 80% of older people want to live in their own homes; they want to be independent and to be as healthy as possible; and most of all they want to be in control of their lives. AT can support these aspirations by allowing people to continue to live as independently as possible. Older people can benefit from a wide range of AT from simple devices that provide practical assistance with daily tasks, to services that provide a sense of psychological well-being through reassurance that should an accident or emergency occur, help will come to them.

- Provide practical tools to enhance independent living.
- Increase opportunities to self-manage.
- Enhance opportunities to provide preventative health care services.
- Improve the person's confidence in their ability to continue to live independently at home.
- Delay or prevent entry into residential or nursing care.
- Mitigate against the risk of accidents.

Physical Disability: AT has been in use for people with physical disability for many years through the provision of specialist services, which have provided ‘traditional’ AT such as orthotics, prosthetics, wheelchair services, ‘standard’ community equipment and audiology services. While, newer forms of AT, particularly for educational and leisure pursuits, are providing vital opportunities to enhance quality of life for people with physical disabilities.

- Provide practical tools to enhance independent living.
- Increase opportunities to self-manage.
- Provide tools to improve quality of life through improving access to education, employment and leisure.
- Improve the service user and carer’s confidence in the person’s ability to continue to live independently at home.
- Mitigate against the risks of living independently.
Key Messages – Current Knowledge in Shropshire

Initial learning would suggest the following:

- The use of telecare sensors in addition to community alarm functionality is a viable option for some people to help them remain independent in their own homes, but is only one of a range of options that could be considered.

- In some situations, the intervention of a call centre operator was deemed to be intrusive as relatives and friends wanted the alarm to contact them directly should a problem occur.

- Cost/benefits have been difficult to evidence in the use of Telecare, in keeping with the national experience. However, based on Shropshire’s experience where AT has been used, there have been small savings based on a reduction in care needs due to the use of AT, or an enhancement of a person’s well-being which has enabled them to continue living in their own home.

- Where AT was deployed as a result of a community care assessment, equipment proved to be useful in the following areas: helping people with memory loss, supporting informal carers to monitor the needs of the person, mitigating the risk of falls, enabling independence for people with physical disability.

- AT is currently used to meet complex health needs through a variety of specialist funding streams and the NHS.

- Where AT is used to meet social care needs, it is often in a preventative mode, and therefore eligibility for funding is limited.

- AT, complementing and augmenting other services such as property adaptations, personal care, rehabilitation etc has a role to play as part of a holistic solution to individual needs.
Workforce planning

Introduction
The information in the following pages contributes to an overview of the local workforce by type, number and setting, and issues relating to recruiting or retaining staff in social care across all sectors. Further information on general labour force and economy issues is available in the Shropshire 2007 LAA evidence base.

Working age population distribution
The chart below shows the working age population as a proportion of the total population in 2006. The proportion of the population of working age in Shropshire and the three areas is slightly lower than national and regional averages. The South Area has the lowest proportion, reflecting the older age structure of the population.

![Working age population as a percentage of total population 2006](chart)

The general workforce availability will impact on continued ability to meet the staffing and human resource requirements within health and social care.

The chart below shows employment trends for social care within the County Council.
Most care staff (excluding nurses, social workers and therapists) work within the care sector (54%). 55% of these are aged over 40, however the largest number by age band are 25 -39 years of age. The gender profile is predominantly female with only 13% of the workforce male.

Information from the UKHCA (2004) shows a national gender profile in which males made up 8.7% of the care workforce (5.4% reported in 2000). This figure rises to 10.5% (2004) when looking at the proportion of male Registered Managers.
Gender Profile

Female 87%
Male 13%

Deployment of care staff in Shropshire

- Within care sector: 54%
- Within health sector: 32%
- Outside care/health: 14%
In 2006 most care staff in the independent sector were white British.

Most of their clients were older people (38%), followed by older people with mental health issues -EMI (15%) and learning disabilities (13%).

Pay and conditions of employment were not the main reason for leaving. In 2006, 51% of the workforce had achieved a minimum of NVQ Level 2 in care.
Main reason for staff leaving

- Pay/Conditions of employment: 15%
- Nature of Work: 16%
- Competition from other employers: 36%
- Retirement: 4%
- Personal Reasons: 13%
- Dismissal: 8%
- Others: 8%

Ethnic Origin of Staff

- Ind Shrop
- Ind Telford

Source - Care Workforce Development Partnership Training Needs Analysis 2006

Carers NVQ 2 and 3

Expected to Achieve an Award: NVQ 3 Children & Young People: 64, NVQ 2 in Care: 583
Registered for an Award: NVQ 3 Children & Young People: 59, NVQ 2 in Care: 417
Holding an Award: NVQ 3 Children & Young People: 16, NVQ 2 in Care: 1041
Individualised budgets

Direct payments were introduced under the Community Care (Direct Payments) Act 1996 and extended to people over 65 in 2000. Individual budgets bring together a number of income streams beyond social care, including the disabled facilities grant and Supporting People programme. They are being piloted in 13 local authorities with results expected in April 2008.

The organization - In Control helps councils introduce systems enabling people to plan their own support using personal budgets. Evidence from the In Control pilots is that individualised services, based on what people want, cost the same - if not less - than traditional services.

Individual budgets and the interface with health (CSIP 2008) identifies barriers to a more integrated approach to personal budgets that incorporates health as well as social care. Based on a think tank discussion, it looks at the challenges faced by individual budget pilot sites in relation to healthcare. The paper highlights an underdeveloped healthcare market, little diversity in supply, limited knowledge of service costs and risk-averse services as barriers, but points out that similar issues faced local authorities in introducing personal budgets for social care.

There has been a recent case for the parents of a young woman with a serious heart condition and learning disabilities, and who qualifies for full NHS funding. The case has settled after a successful preliminary “permission” stage of judicial review proceedings (and therefore not created a binding precedent, in terms of what must happen in other cases) with the outcome that the NHS Trust agreed to pay the parents to continue to care for the woman at home. If the woman had been social services’ responsibility, in terms of her profile of needs and her legal status, she might (if she had mental capacity) have been able to consent to Direct Payments. The judge accepted the family’s argument that there was no legal bar to the PCT making such payments and no reason to justify different treatment of those who are the responsibility of social services, and the health services. (The case Gunter v SW Staffs PCT (2005) suggests that PCTs, using their powers under the 1977 Act, can arrange for the provision of services by an Independent User Trust.)

Individuals purchasing their own care from health and social care agencies or of consortium approaches of individuals pooling their commissioning resources will be major strategic drivers in the development of future health and social care services.
Bibliography

- Shropshire County Council Corporate plan
- Older Peoples Overarching Strategy
- Joint Commissioning Strategy 2007 – 2010
- A Strategy for Healthy Communities and Healthy Ageing – Shropshire Partnership 2007
- Choosing Health in Shropshire County, Annual Report of the Director of Public Health, 2005-06, Shropshire County PCT.
- A vision for health improvement and healthcare in Shropshire 2008 – 2018
- Safer Shropshire Partnership Crime, Disorder and Substance Misuse Strategy 2005-08
- Adult Substance Misuse Needs Assessment and Treatment Plan, 2006-07, Shropshire Drug and Alcohol Action Team.
- Shropshire Supporting People 6 year Strategy
- Integrated Transport Plan
- Safer Shropshire Partnership Implementing the Respect Programme in Shropshire
- Domestic Violence Strategy
- Workforce Strategy for Adult Health and Social Care in Shropshire (Nov 2007)
• Information for All Age All Cause Mortality Local Area Agreement, June 2008.

• Maternity Services Health Care Needs Assessment, Shropshire County and Telford & Wrekin PCT, 2008.

• Accidents profile of children and young people living in Shropshire County (draft), 2008.

• The Child Health Promotion Programme, Pregnancy and the First Five Years of Life, Department of Health and Department for Children Schools and Families, March 2008.

• Healthy Communities and Healthy Ageing

• Falls Strategy Action Plan & Strategic Framework

• Working with Carers - a Joint Strategy 2007-2010

• DAAT Adult needs assessment

• Alcohol Strategy

• Maternity services in Shropshire county and Telford and Wrekin PCTs - a health care needs assessment

• End of Life baseline review January 2008

• Children’s Trust Plan

• Shropshire Community Strategy

• Community Services Directorate Service Plan
i www.library.nhs.uk
ii Life expectancy and all-age all-cause mortality rates: Issues for identifying local health inequalities priorities, Yorkshire and Humber Public Health Observatory, July 2007

iv The Child Health Promotion Programme, Pregnancy and the First Five Years of Life, Department of Health and Department for Children Schools and Families, March 2008.