



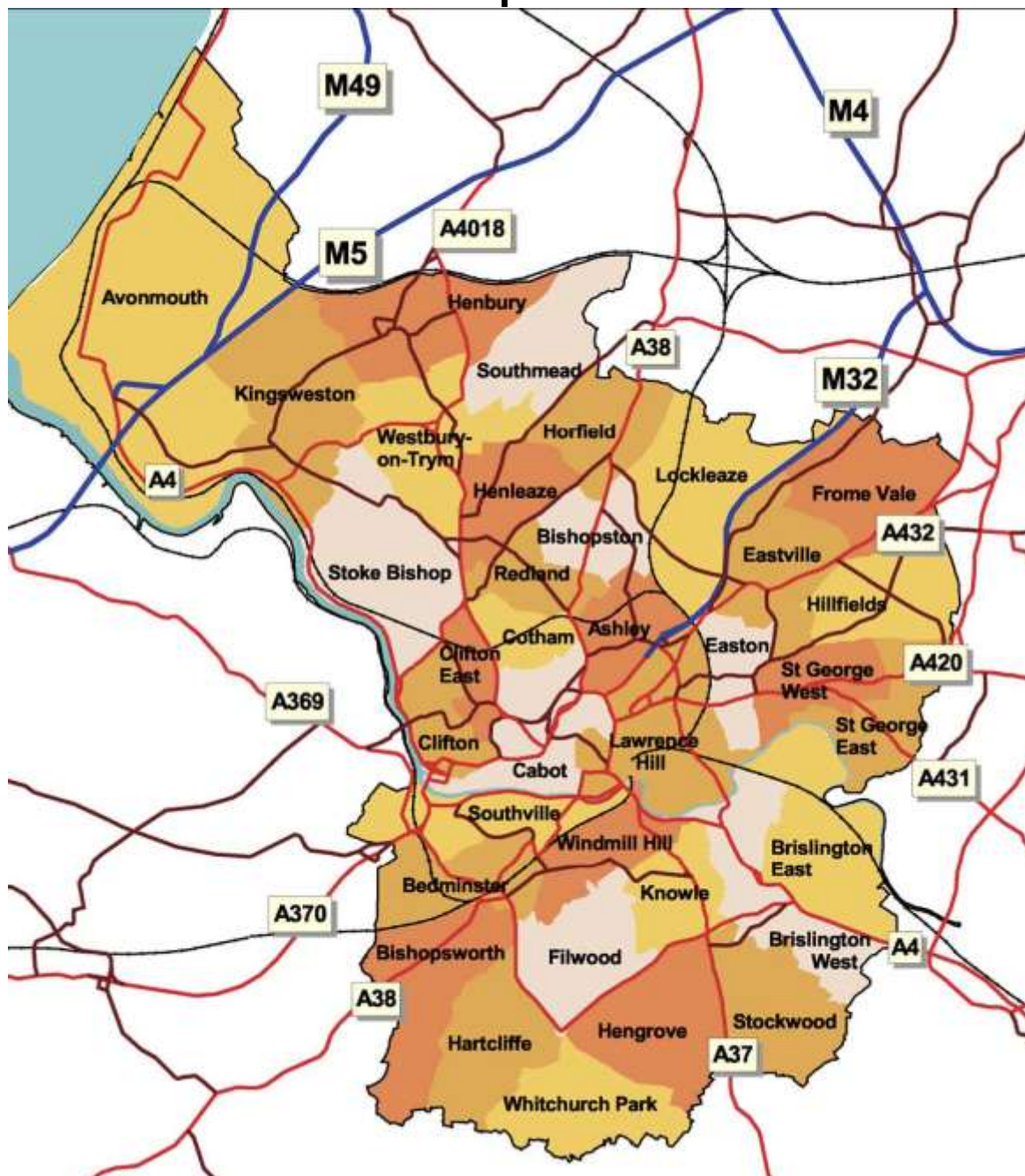
Bristol **NHS**
Primary Care Trust

Joint Strategic Needs Assessment of health and wellbeing in Bristol

Baseline report
October 2008

Sarah McMahon
JSNA Project Manager

Ward map of Bristol



A number of **comparator groups** are referred to in this assessment:

South West – towns and cities in the region (see Annex 12)

Core Cities – Bristol is a member of Core Cities, a working group of eight major cities in England that also include Birmingham, Liverpool, Leeds, Manchester, Newcastle, Nottingham and Sheffield.

Statistical Neighbours – these are local authorities with similar characteristics and this group is used to compare indicators for children and young people. They include Bristol, Southampton, Portsmouth, Brighton and Hove, Reading, Derby, Peterborough and Sheffield.

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Glossary and abbreviations

1+ADL	Unable to carry out one or more of the main self care activities of daily living (being able to wash, dress, feed, toilet, walk etc)
A&E	Accident and Emergency
AAACM	All age all cause mortality
ACC	Adult Community Care, Bristol City Council (re-named Health and Adult Social Care from September 2008)
APHO	Association of Public Health Observatories
ASD	Autistic spectrum disorder
Atopy	Inherited tendency to allergy
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BCC	Bristol City Council
BCG	Bacillus Calmette-Guerin vaccine (to prevent tuberculosis)
BME	Black and minority ethnic groups
BMI	Body mass index
BOFP	Bristol Older People's Forum
BPCT	Bristol Primary Care Trust
BRI	Bristol Royal Infirmary
CAMHS	Child and Adolescent Mental Health Services
CGE model	Computer generated equilibrium model
CHD	Coronary heart disease
Children of the 90s (ALSPAC)	Avon Longitudinal Study of Pregnancy and Childhood
CLG	Communities and Local Government
CMT	Bristol City Council's Corporate Management Team
Commissioning	A continuous cycle of activities that contribute to the securing of services, including the specification of services to be delivered, contract negotiations, target setting, monitoring and managing performance.
Confidence limits (cl)	A 95% confidence interval is a range within which the true population would fall for 95 per cent of the times the sample survey was repeated. It depends on the amount of variation in the underlying population and the sample size, and is a standard way of expressing the statistical accuracy of a survey-based estimate.
COPD	Chronic obstructive pulmonary disease
Core cities	Birmingham, Bristol, Liverpool, Leeds, Manchester, Newcastle, Nottingham and Sheffield
CPR	Child Protection Register
CSCI	Commission for Social Care Inspection
CSIP	Care Services Improvement Partnership
CVD	Cardio vascular disease
CYP, CYPS	Children and Young People's Services, Bristol City Council
DH	Department of Health
DLA	Disability Living Allowance
DMF	Decayed, missing and filled (teeth)
DPH	Director of Public Health
Dual Diagnosis	People with substance misuse and psychiatric problems.
DWP	Department of Work and Pensions
EBD	Emergency bed days
EIS	Early Intervention Service

Equalities impact assessment (EIA)	An assessment that should be carried out on any policy, plan as a matter of course, to assess if the policy/plan is likely to discriminate against any equalities group.
GP	General practitioner
GUM	Genito-urinary medicine
GVA	Gross value added
H&W-B	Health and Wellbeing Delivery Group (Bristol Partnership)
HEA	Health equity audit
HESA	Higher Education Statistics Agency
HIV	Human immunodeficiency virus
HNA	Health needs assessment
HPA	Health Protection Agency
IDU	Injecting drug user
IHD	Ischaemic heart disease
IMD	Index of Multiple Deprivation
Incidence	The rate at which new cases of a disease occur
IVF	In vitro fertilisation
JLTP	Joint Local Transport Plan
JSNA	Joint Strategic Needs Assessment
LA	Local authority
LAA	Local Area Agreement
LD	Learning difficulties
LGB	Lesbian, gay and bisexual
LINK	Local Information Network
LLTI	Limiting long-term illness
LSOA , SOA	Lower level super output area - a new geographic hierarchy designed to improve the reporting of small area statistics
MMR	Measles, mumps and rubella (vaccine)
MRSA	Methicillin-resistant Staphylococcus aureus
MYE	Mid year (population) estimates
N&HS	Neighbourhood and Housing Services (BCC)
NEET	Not in education, employment and training
Neighbourhood Partnership areas	A new citywide network of neighbourhoods (each area consisting of two or three wards) to give residents a greater say in how they shape and change their area.
Net migration	Inward migration minus outward migration
NI	National indicators
NICE	National Institute for Health and Clinical Excellence
NR, NRA	Neighbourhood renewal area - a national initiative through which areas with significant deprivation develop plans to tackle these problems.
Obese	Body mass index of over 30
ODPM now CLG	Office of the Deputy Prime Minister now called Communities and Local Government
ONS	Office for National Statistics
OSC	Overview and Scrutiny Commission
Overweight	Body mass index 25-30
PALS	Patient Advisory and Liaison Service
PBC	Practice-based commissioning

PCT	Primary Care Trust
PEC	Professional Executive Committee (Primary Care Trust)
POPPI	Projecting Older People Population Information
PPI	Patient and Public Involvement Forum
Prevalence	The proportion of a population who have a disease
Problematic drug use	Use of illegal drugs which cause health or social harm to the individual.
PRU	Pupil referral unit
PSA	Public sector agreement
PSHE	Personal, social and health education
Psychosocial	The interrelation of social factors and individual thought and behaviour
PWLD	People with learning difficulties
QOF	Quality Outcomes Framework (indicator)
QOL	Quality of life (indicator)
Quality of Life Survey	Local postal survey of over 4,500 residents annually (see Annex 13)
Quintile	Deprivation quintiles divide areas in fifths according to some measure of deprivation and can be used to analyse variations in health between deprived and affluent sections of the population regardless of where they live.
RSL	Registered social landlord
RTA	Road traffic accident
SAP	Standard assessment profile
SEN	Special educational needs
SEPHO	South East Public Health Observatory
SMT	Senior Management Team (Primary Care Trust)
SP	Supporting People - funding stream to provide accommodation and floating support for housing-related services for older people and people with drug and alcohol problems.
SRE	Sex and relationships education
Statistical neighbours	Southampton, Portsmouth, Brighton and Hove, Reading, Derby, Peterborough and Sheffield.
STI	Sexually transmitted infection
SWE	South West of England
SWPHO	South West Public Health Observatory
Target (stretch target)	Reward target set in the LAA
TB	Tuberculosis
UA	Unitary authority
UBHT	United Bristol Healthcare Trust
UHB	University Hospitals Bristol (formerly UBHT)
UoB	University of Bristol
UV	Ultraviolet
UWE	University of the West of England
WHO	World Health Organisation
VCS	Voluntary and community sector
Ward	Electoral boundary; there are 35 wards in the city. Ward averages referred to in maps are a total for all wards divided by 35.
YOT	Youth Offending Team

Executive Summary

Top 12 key findings from the Joint Strategic Needs Assessment

1. Bristol's population is projected to increase by over 100,000 between 2008 and 2028. Generally Bristol is a prosperous city and **life expectancy** is improving, but there is a nine year difference in life expectancy between the most affluent and most deprived Bristol wards.
2. As life expectancy improves, the number of children and adults with **disabilities and limiting long-term illness and mental health problems** is rising and these conditions are more common in deprived areas.
3. Levels of **obesity** are increasing in children and adults. Measures to reduce the use of the car, increase cycling and walking and design of sustainable communities all help tackle obesity.
4. There is a link between **deprivation, poor educational attainment, low skills, poor emotional health and community safety issues** and healthy lifestyle risk factors such as poor diet, obesity, smoking, substance misuse and teenage pregnancy.
5. Main causes of death and ill health in local residents include cancer, cardiovascular disease (CVD) and respiratory disease. The number of people with **CVD, diabetes and some cancers** is projected to increase as obesity rates rise and the population ages. As treatments and survival rates improve, there will also be more people living with long term conditions.
6. The number of people with **dementia** will increase by about 33% in the next 20 years due to our ageing population and the location of those affected will be higher in certain neighbourhoods.
7. There are close links between **poor housing** and poor health outcomes. Almost a quarter of Bristol's private sector homes are 'non-decent'. Housing requirements are changing due to an ageing population, with more people with disabilities and limiting long-term illness and demand for smaller household units. Many new housing developments that are planned are in deprived and congested areas of the city.
8. Determinants of health such as poor **built environment, urban congestion and traffic pollution** all impact on physical and mental wellbeing. These issues tend to be worse in deprived areas.
9. **Admissions to hospital** are high in the older and younger age groups (e.g. through falls, accidents, urgent management of their condition/disability). Improved primary prevention, appropriate community and home care services, improved access to information on health management and lifestyle issues and suitable housing all help reduce hospital admissions.
10. Almost 40,000 people across the city are providing **unpaid care** for another person, and many carers are ageing themselves and may not be in good health. Yet it is estimated we do not know a quarter of our carers and do not have a complete register of young carers.
11. Bristol is a multicultural city yet not all residents have equal access to health and social care for equal need. Some **minority groups** experience a higher prevalence of specific illnesses but are less likely to access some services, services may also not be appropriate and they may delay seeking help.
12. There are a number of **information gaps**, particularly around carers and people with learning difficulties, physical impairments and mental health, but also in relation to ethnicity recording which restricts our knowledge and understanding of the issues.

Summary of Chapter 1- Introduction and background

1. The Joint Strategic Needs Assessment (JSNA) is carried out jointly by Bristol City Council (BCC) and Bristol Primary Care Trust (BPCT). It is driven by evolving national policies and changing local needs.
2. It brings together in one place, detailed information on local health needs, building on what we already know but also looking forward into the future to identify some new and emerging challenges.
3. The intention is to allow BCC, BPCT and their partners to strategically position resources and services to meet changing population needs and, if necessary, redesign services to address these future challenges.
4. The report is structured to include a description of the process followed and methods used (Chapter 2) and the local Bristol context (Chapter 3). Chapters 4-8 describe and analyse local health and wellbeing needs from different perspectives. Overall findings and gaps in knowledge are identified in the final chapter (9) “where do we need to be in 2011 and beyond?” Additional information is included in Annexes 1-16. Annex 10 matches wards to local service boundaries and is of particular interest to those planning and delivering services.
5. The ‘local voice’ is integral to this report (using results and findings from local surveys and consultations) and is interspersed throughout the relevant chapters (see the blue pages).

Summary of Chapter 2 - Process, scope, methods and outcomes

6. The JSNA process adopted is participatory and iterative (we learn together as we go along). Governance arrangements are clear (the Steering Group reports to three Joint Commissioning Boards and the management structures within both organisations).
7. Both organisations have given a commitment to ensure that the JSNA becomes embedded as an on-going process. It is incremental but will also need to be refreshed and updated to keep it ‘live’ and relevant.

Summary of Chapter 3 – Bristol context

8. Bristol is a relatively prosperous city and is one of the fastest growing core cities. Bristol’s population is increasing and that trend is projected to continue over the next 20 years. Between 2008 and 2028, Bristol’s population is projected to increase by over 100,000 residents. Over a similar period 29,500 new homes are planned to be built in the city (the Proposed Changes to the Regional Spatial Strategy is suggesting 36,500 additional homes). Planners and developers need to ensure homes are fit for purpose for single occupancy and an ageing population.
9. Meeting the health needs of the growing and increasingly diverse population in already congested inner city areas (e.g. Cabot and Lawrence Hill) will be a major challenge for service providers as this growth is occurring in areas where there is already pressure on services and significant health inequalities.
10. The city currently compares favourably with other core cities (see page 40) for most health and wellbeing indicators, but will need to re-examine its priorities to maintain progress and prevent deterioration.
11. These issues will be addressed with the Corporate Plan priorities (see page 17) by adopting the Bristol Development Framework and tackling inequalities.

Summary of Chapter 4 – Determinants of health and wellbeing

12. In Bristol, like other core cities, there are many close links between deprivation, poor housing and healthy outcomes. Almost a quarter of Bristol's private sector homes are 'non-decent'. At the same time housing requirements are changing due to an ageing population, smaller household units and net immigration. A high proportion of older people have falls in their homes. Many homes are not designed or adapted for elderly or disabled occupiers.
13. There are also close links between the environment (traffic congestion, pollution, lack of space, community safety) and physical and mental wellbeing. Poor urban planning that promotes car use, congestion and fear of crime can limit opportunities for physical exercise, recreation and community interaction.
14. Another emerging theme is the link between poor educational attainment and skills and unhealthy lifestyles (substance misuse, smoking, teenage pregnancy, diet), common mental health problems and low self esteem. Please see next chapter where some of these issues are explained in more detail.
15. People at each end of the age spectrum – the very young and very old – have the highest requirements for primary and secondary care.
16. Some of these issues will be addressed with the Corporate Plan priorities by adopting the Bristol Development Framework, reducing traffic congestion, raising attainment at all key stages and at 19, tackling inequalities, tackling fear of crime, improving parks and open spaces and increasing opportunities for active travel. But healthy housing is a key issue that arguably needs a higher profile amongst corporate and partner priorities.

Summary of Chapter 5 – Healthy lifestyles

17. Not surprisingly lifestyle risk factors such as smoking, alcohol and drug misuse, obesity/poor diet and lack of physical activity all contribute to poorer health outcomes (cancer, heart disease, stroke, diabetes and other long term conditions) especially in groups experiencing deprivation, where ability to make healthier choices is often limited by poor socio-economic conditions (poor knowledge of cooking skills and nutrition, lack of access to shops selling healthy food, lack of access to safe open spaces for activity etc.)
18. There are links between lower educational attainment, deprivation, substance misuse and risk taking behaviour (see section on teenage pregnancy).
19. Levels of obesity are increasing – particularly in children, thus storing up significant health problems for the future – especially if linked to other lifestyle risk factors already discussed. If current trends in obesity continue, health and social care services will struggle to meet demands in the future (with more people living with long term conditions and increasing hospital admissions for obesity related illnesses).
20. Strategies that tackle obesity have striking similarities to those tackling climate change. Many climate change goals also help prevent obesity - such as measures to reduce traffic congestion, increase cycling and walking, design of sustainable communities and reducing carbon footprints. Improving health is an essential element in the design of sustainable communities.
21. Some of these issues will be addressed with the Corporate Plan priorities, Local Area Agreement (LAA) targets and World Class Commissioning outcomes (pages 15-18), to tackle inequalities, improve physical activity, reduce obesity, reduce teenage pregnancies, reduce the harm caused by alcohol and drugs misuse, reduce smoking and exposure to second hand smoke. There are opportunities to make strategic links between reducing obesity and interventions to tackle climate change.

Summary of Chapter 6 – The burden of ill health – morbidity and mortality

22. Main causes of death and ill health in local residents include cancer, cardiovascular disease (CVD) and respiratory disease. The number of people with CVD, diabetes and some cancers is projected to increase as obesity rates rise.
23. Bristol's birth rate is increasing. The number of very low birth weight babies is also increasing and many who survive can develop high levels of disability and complex needs. The extent of this problem is not known and further work is needed.
24. Another common theme is that the worst health outcomes are noted in areas of deprivation. Overall outcomes for the most deprived areas are improving but the inequalities gap is not closing (the difference in health outcomes between the most deprived and most affluent wards).
25. These main causes of ill health are being addressed with the World Class Commissioning outcomes and priorities of the Bristol Primary Care Trust to reduce cancer mortality rates, reduce cardiovascular disease mortality, reduce infant mortality and low birth weight and tackling health inequalities.

Summary of Chapter 7 – Health and wellbeing

26. The number of children and adults with physical impairments, learning difficulties and mental health problems is growing, mainly due to people living longer and advances in medical treatments. Disabilities are set to rise by about 57% in the next 20 years and dementia will increase by about 33%, thus challenging the care services to provide appropriate levels of support. An integrated approach to delivering joint health and social services is already bringing benefits by reducing hospital admissions and potential long-term costs.
27. The distribution of care needs across the city will change as demographic profiles change e.g. as children with disabilities now will grow up to be users of adult services. The pattern of dementia sufferers will change as the population ages, yet we do not know the location of all residents aged 85 years or more. Services are currently responding to the needs of older clients in wards with a higher proportion of elderly residents rather than wards with a young and growing (but needy) population. Thus the geographical focus of services and service pressures will change as ward demographics change.
28. Hospital admissions are high (e.g. through falls, accidents, urgent management of conditions and disabilities) in the older and younger age groups. Medical advances in treatment and use of assisted technology allow more healthcare services and support to be available at home. This will change the nature of how we are delivering healthcare and with improved primary prevention, home care services, improved access to information on health management and lifestyle issues, there is potential for hospital admissions to reduce.
29. Bristol has almost 40,000 people across the city providing unpaid care and many of them are ageing themselves, may not be in good health and many have multiple roles. Yet it is estimated we do not know a quarter of our carers. Further work is needed to improve the record of our carers, their location and needs including a complete register of young carers.
30. Most older people (aged 65 and over) prefer to receive the health and social care they require at home. There is potential to shift more care out of hospital and into the community. Improved outcomes would result from supplying more hours of home care to a larger number of people. However we should be aware that some elderly people living alone would prefer to receive their care in a more 'sheltered' home environment (e.g. sheltered housing) thus reducing their social isolation.

31. Some of these issues will be addressed with the LAA targets to ensure people of all ages and vulnerable people can live independent lives, increase social care clients receiving Self Directed Support, reduce the number of emergency bed days, increase carers' needs assessments, advice and information. In addition, Corporate Plan priorities include improving efficiency through commissioning, actively promoting service user and carer independence, safety and wellbeing, developing a network of reablement services, extending very sheltered housing, developing self directed care, increasing early intervention and prevention services, widening opportunities for older people and developing Linkage hubs (see page 98).
32. Given the growing levels of dementia within our ageing population, further work is needed to reassess the geographical focus and identify this vulnerable group. There is also potential to do more work on the health and wellbeing issues facing young carers.

Summary of Chapter 8 - Health and wellbeing of special groups

33. Bristol is a multicultural city yet not all residents have equal access to health and social care for equal need. Some BME groups experience a higher prevalence of specific illnesses but are less likely to access some services, services may not be appropriate and they may delay seeking help. As mentioned elsewhere in this report, difficulties in data recording (e.g. ethnicity, disability) mean that data analysis does not always reveal these inequalities. Improvements in data recording should facilitate health equity audits across a range of services and help to pin point some of these issues more accurately, thus supporting actions to improve access to services and strengthening existing interventions.
34. While other groups may engage with the health and social care services they often have unmet needs that may not be fully understood or articulated e.g. see the sections on students (mental health), lesbian, gay and transgender people (sexual health and gender identity), travellers (safety/stress), the homeless (drugs, alcohol-related problems, mental health) etc. While some in depth studies are underway (e.g. prison health needs assessment) or recently completed, local knowledge of other groups is incomplete and thus further work is needed (e.g. health needs of new migrants from Eastern Europe).
35. Whilst tackling inequalities is addressed in the Corporate Plan, LAA and World Class Commissioning outcomes, given the above analysis further work is needed to improve the health and wellbeing of special and minority groups and unmet needs.

Summary of Chapter 9 - Where do we need to be in 2011 and beyond?

36. The JSNA helps identify current and projected trends in health and wellbeing and how the city will change in the next three, ten and twenty years. There are a number of information gaps, particularly around disability and location of vulnerable people, but also in relation to ethnicity recording. This is limiting our ability to analyse data in a more meaningful way restricting our knowledge/understanding of the issues. However, anecdotal and 'local voice' information also seems to confirm local perceptions of unmet need. Further work is needed.
37. Many of the trends identified in this assessment are also national trends and not unique to Bristol. But the city can make a real difference to health and wellbeing by making healthy choices the easiest choices, commissioning to reduce inequalities, commissioning for self care and support for carers and health promoting workforces.
38. Knowledge from this assessment will be used to support decisions on local priorities and for the commissioning of health and social care and generally support how we deliver services in Bristol. It has identified some areas where 'resources shift' is crucial for preparing for the future.

1. Introduction and background

National and local policy drivers

In 2006, the Department of Health White Paper *Our health, our care, our say*¹ set out a new direction for improving the health and wellbeing of the population in order to achieve:

- better prevention and early intervention for improved health, independence and wellbeing
- more choice and a stronger voice for individuals and communities
- tackling of inequalities and improved access to services
- more support for people with long term needs.

Our health, our care, our say identified the need for directors of public health, adult social services and children's services to undertake regular strategic needs assessments of the health and wellbeing status of their populations, enabling local services to plan, through Local Area Agreements (LAAs), both short and medium term objectives. Later that year the local government White Paper, *Strong and Prosperous Communities*, outlined a vision of responsive services and empowered communities, including a community call for action across local public services².

The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities to prepare Local Area Agreements in consultation with others, including district councils in two-tier areas. The Act also places a duty on upper-tier local authorities and primary care trusts (PCTs) to produce a **Joint Strategic Needs Assessment (JSNA)**. This duty, also described in the draft statutory guidance *Creating Strong, Safe and Prosperous Communities*, commenced on 1st April 2008.

New national indicators

The new performance framework³ for local authorities, working alone, or in partnership, contains 198 national priorities for local delivery, many of which are relevant to improving health and wellbeing. These indicators have been influenced by existing Public Service Agreements (PSAs – see page 16). Although performance will be measured against all 198 indicators, each Local Area Agreement has up to 35 national priority targets that are subject to performance monitoring, with local partners free to agree additional targets to support improved local delivery and outcomes. Relevant national indicators, including those selected for the refresh of the LAA, are covered in this JSNA.

Commissioning for health and wellbeing

The Department of Health *Commissioning Framework for Health and Wellbeing*⁴ builds on these recent reforms. It identifies eight steps to effective commissioning, which include understanding the needs of populations and individuals. It is anticipated that the JSNA will identify the health and wellbeing needs of a local population, and lead to more effective service provision by informing the Sustainable Community Strategy, LAA, and other relevant commissioning strategies, thus driving improvements in the health and wellbeing of the local area and reducing health inequalities. The underlying intention is that the JSNA will identify areas where the local authority and PCT can work more closely together to commission and deliver services differently.

¹ Department of Health (2006) *Our health, our care, our say: A new direction for community services*

² Communities and Local Government (2006) *Strong and Prosperous Communities – The local government White Paper*

³ Communities and Local Government (2007) *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators*.

⁴ Department of Health (2007) *Commissioning Framework for Health and Wellbeing*.

The Department of Health has issued a *World Class Commissioning Competency Framework* (December 2007) to drive the long-term commissioning strategies of PCTs and their collaborative work with community partners. The JSNA is integral to 'world class commissioning' and partnership working including public engagement.

Complementing this work is the national review of existing NHS priorities undertaken by Lord Darzi *Our NHS – our future*.⁵ The vision he sets out is to provide fair, personalised, effective and safe services so that patients and the public have confidence in the care they receive. The findings will further support the JSNA.

The national policy agenda requires local authorities to:

- give strong emphasis to promoting independence, health and wellbeing, through effective commissioning towards the provision of earlier support to older and disabled people
- deliver and support self-directed and personalised care to give users and carers greater choice, 'voice' and control about the support they receive, especially via direct payments and individualised budgets
- commission effective services jointly with health and social care.

Public Service Agreements (PSA) targets

Relevant to the JSNA are the following delivery agreements that set out a vision and delivery strategy for health and wellbeing. They each include headline indicators that are to be monitored to show improvement, and the majority of these are considered in this JSNA (see following box).

Public Service Agreement targets relevant to the JSNA

PSA Delivery Agreement 12: improve health and wellbeing of children and young people

Indicators

- Prevalence of breastfeeding at six to eight weeks
- Percentage of pupils who have school lunches
- Levels of childhood obesity
- Emotional health and wellbeing and child and adolescent mental health services (CAMHS)
- Parents' experience of services for disabled children and the 'core offer' (statement of what parents should expect to receive)

What is a Joint Strategic Needs Assessment?

Bristol's JSNA is a process that will identify the current and future health and wellbeing needs of the local population and targets set by Local Area Agreements, and lead to agreed commissioning priorities that will improve outcomes and reduce health inequalities. It will also identify areas where 'resources shift' is crucial in preparing for the future.

Key components of the assessment are:

- ✓ prevalence and trends of ill health, impairment and other factors which impact on wellbeing
- ✓ seeking and listening to the views of interested parties, including those who provide services
- ✓ gaining an understanding of the population's expectations and wishes
- ✓ information to support decisions on local priorities for developing and transforming services.

⁵ Department of Health (2007) Professor Lord Darzi, NHS Next Stage Review Interim Report.

Public Service Agreement targets relevant to the JSNA (continued)

PSA Delivery Agreement 14: increase the number of children and young people on the path to success

Indicators

- Reduce the percentage of 16-18 year olds not in education, employment or training (NEET)
- More participation in positive activities
- Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances
- Reduce the under-18 conception rate

PSA Delivery Agreement 17: tackle poverty and promote greater independence and wellbeing in later life

Indicators

- The employment rate of those aged 50-69 and difference between this and the overall employment rate
- The percentage of pensioners on low income
- Healthy life expectancy at age 65
- The proportion of people over 65 who are satisfied with their home and their neighbourhood
- The extent to which people over 65 receive the support they need to live independently at home

PSA Delivery Agreement 18: improve health and wellbeing for all

Indicators

- Difference in all age all cause mortality between England and the 20% of areas with the worst health and deprivation
- Smoking prevalence
- Proportion of people promoted to live independently
- Access to psychological therapies

PSA Delivery Agreement 19: ensure better care for all

Indicators

- The self-reported experience of patients/users
- NHS-reported referral-to-treatment times for admitted patients
- NHS-reported referral-to-treatment times for non-admitted
- The percentage of women who have seen a midwife, or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy
- Long-term conditions
- General practitioner services
- Healthcare associated infection rates – *Methicillin-resistant Staphylococcus aureus* (MRSA)
- Healthcare Associated Infection rates - *Clostridium difficile*

Bristol's Local Area Agreement (LAA)

Bristol's Local Area Agreement 2008 – 2011 is an agreement between central and local government. The LAA sets out local priorities and targets based on a review of current need (including the JSNA) and how these can be met by delivering local solutions. This review has fed into this assessment. The LAA also contributes to national priorities set by the government.

At the heart of Bristol's LAA is a set of targets negotiated between the Bristol Partnership and the Government Office for the South West. Most of the targets cover three years from April 2008-March 2011. There are 77 indicators of which 30 are new designated targets included in the National

Indicator set. There are also 16 statutory education and early years targets. The indicators are structured around the four themes or 'blocks', taken from Bristol's Sustainable Community Strategy and Corporate Plan (see below).

The Bristol Partnership's Health and Wellbeing Delivery Group (and its constituent members e.g. Police, PCT etc) has set challenging local targets (see following box). Health and wellbeing indicators within the LAA are included in this JSNA at the start of chapters 3-7 and evidence of current and future need is explored.

Relevant health and wellbeing LAA targets include:

- reduce the mortality rate from circulatory diseases
- increase rates of breastfeeding
- improve physical activity
- tackle childhood obesity
- reduce teenage conceptions
- ensure people of all ages and vulnerable people can live independent lives
- increase social care clients receiving Self Directed Support
- reduce the number of emergency bed days
- increase carers' needs assessments, advice and information.

See Bristol's Local Area Agreement at <http://www.bristolpartnership.org/vision/strategy/laa08>

Bristol's Corporate Plan

The City's Corporate Plan, July 2008, contains over 60 priorities and nearly half of these are related to health and wellbeing, evidenced in this JSNA. The Corporate Plan has four 'Our City' themes and health and wellbeing priorities from those themes are listed below.

1. Our city: ambitious together

- Tackling inequality
- Reducing traffic congestion
- Improving road safety
- Reducing carbon dioxide (CO₂) emissions
- Adopting the Bristol Development Framework

2. Our city: making a difference

- Improving efficiency through commissioning
- Raising attainment at all key stages and at 19 years
- Reducing the number of children in care
- Reducing teenage conceptions
- Actively promoting service user and carer independence, safety and wellbeing
- Developing a network of reablement services
- Extending very sheltered housing
- Developing self directed care
- Increasing early intervention and prevention services
- Widening opportunities for older people and developing Linkage hubs
- Reducing fear of crime
- Expanding older people's access to physical activities

3. Our city: safer and healthier

- Tackling domestic abuse/violence
- Reducing the harm caused by alcohol and drugs misuse
- Increasing the physical activity levels of all Bristol residents

- Increasing the opportunities for active travel
- Promoting healthy eating and reducing obesity
- Reducing smoking and exposure to second-hand smoke
- Promoting positive and mental health and wellbeing

4. Our city: better neighbourhoods

- Establishing neighbourhood partnerships
- Tackling fear of crime in neighbourhoods
- Improving parks and open spaces

See complete report at <http://www.bristol.gov.uk/ccm/content/Council-Democracy/Democracy-Elections/corporate-plan.en>

World Class Commissioning

Guidance on World Class Commissioning includes a number of outcome measures for Primary Care Trusts. Bristol's PCT has chosen ten outcomes that have been agreed by partners and are reflected in strategic planning priorities, where the local PCT can bring added value. These are listed below.

1. Life expectancy
2. Tackling health inequalities
3. Under 18 conception rate
4. Smoking quitters
5. Cancer mortality rate
6. Cardiovascular disease
7. Percentage of all deaths that occur at home
8. Percentage of obese Reception and Year 6 primary school-age children
9. Stroke prevention through recognition and effective management of transient ischaemic attack
10. Alcohol misuse.

Building on our strengths

Improving health and wellbeing in the city has been a long-standing priority and partnership work is well developed. When information about needs is collected it is easy to focus on the problems. We need to remember that some of these needs are well known and that valuable work is underway to address them. We therefore recognise achievements and strengths that we can bring to the table, as we are not operating in a vacuum.

The following areas of good practice in Bristol have been identified in formal and informal national assessments and local reviews of health and wellbeing.

The **Health Scrutiny Commission** for Bristol City Council (BCC) has a number of co-opted members from the voluntary and community sector, representing community groups.

The **Healthy Communities Peer Review** (July 2007) commented on a number of areas of good practice:

- clear and recognised leadership on improving health
- enthusiasm for the agenda
- availability of resources
- genuine dialogue with communities for identification of health needs
- health scrutiny commission includes co-opted members
- wealth of relevant data available to inform this agenda
- joint director of public health appointment. The Director of Public Health is a director in both the PCT and Council.

The Children and Young People's Services Annual Performance Assessment / Self-assessment (2008) identified the following ten achievements:

1. strategic leadership of school improvement and the local authority's relationship with secondary schools
2. improved primary and secondary attendance
3. marked reduction in exclusion in primary and secondary schools
4. performance on adoption improved to national levels
5. teenage pregnancy rates reduced
6. the proportion of young people in specialist treatment for substance misuse has increased
7. the percentage not in education, employment and training has reduced
8. reduction in the number of 10-17 year olds first time offending
9. improvement in performance in delivering a comprehensive Child and Adolescent Mental Health Service (CAMHS)
10. outcomes for children in care are improving.

Whilst good work is in progress, it is always possible to improve and seize opportunities to position some services more strategically for the future. With this mind, at the end of each chapter which analyses need, we have identified key pointers that indicate areas that require more attention for the future. However, we balance this with evidence of actions that are already underway to address these needs and gaps in our knowledge.

Summary of Chapter 1

The Joint Strategic Needs Assessment (JSNA) is carried out jointly by Bristol City Council (BCC) and Bristol Primary Care Trust (BPCT). It is driven by evolving national policies and changing local needs.

It brings together in one place, detailed information on local health needs, building on what we already know, but also looking forward into the future to identify some new and emerging challenges.

The intention is to allow BCC, BPCT and their partners to strategically position resources and services to meet changing population needs and, if necessary, redesign services to address these future challenges.

The report is structured to include a description of the process followed and methods used (Chapter 2) and the local Bristol context (Chapter 3). Chapters 4-8 describe and analyse local health and wellbeing needs from different perspectives. Overall findings and gaps in knowledge are identified in the final chapter (9) "where do we need to be in 2011 and beyond?" Additional information is included in Annexes 1-16. Annex 10 matches wards to local service boundaries and thus is of particular interest to those planning and delivering services.

The 'local voice' is integral to this report (using results and findings from local surveys and consultations) and is interspersed throughout the relevant chapters (see the blue pages in the report).

2. Process, scope, methods and outcomes of the JSNA

The JSNA is intended to be both 'joint' and 'strategic' i.e. indicate where services may need to be commissioned or delivered differently in anticipation of changing future needs.

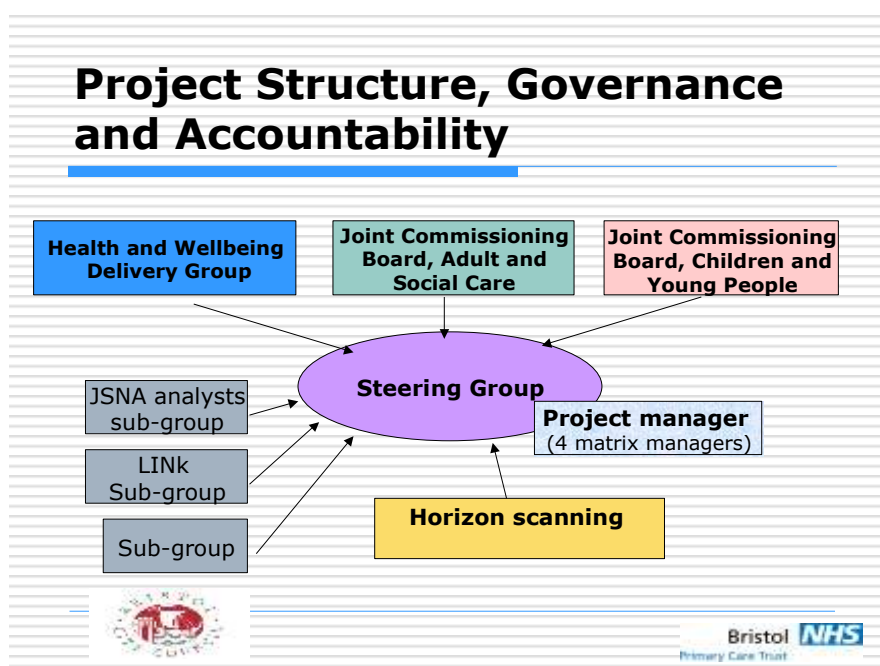
It is therefore important to develop a process to enable all partners to understand changing needs and priorities and thus feel able to contribute to the strategic direction of travel identified through the JSNA process. Partners are defined as the joint leads, Bristol City Council (BCC) and Bristol Primary Care Trust (BPCT also known as NHS Bristol) and their respective partners in the commissioning and delivery of services for the people of Bristol.

Process and governance

The process adopted was as follows.

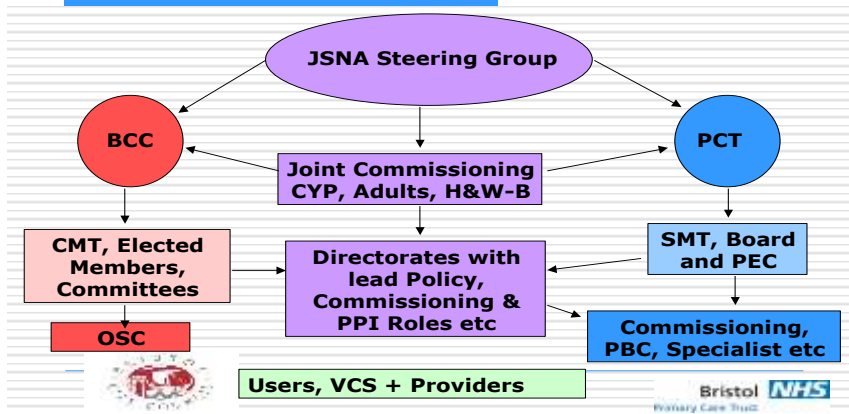
A leadership group was established: (led by Public Health and the joint commissioning functions of the Council and Primary Care Trust (i.e. Children and Young People (CYP) and Adult Community Care (ACC)), a 'joint' Project Manager was appointed and data sources were identified.

A wider steering group was established, chaired by the 'joint' Director of Public Health (DPH) bringing together the leadership group with commissioners, data analysts and other stakeholders. The steering group had an overview of the process and the final report. Several subgroups carried out specific pieces of work e.g. data analysis.



The steering group is accountable to the three joint commissioning boards/groups, all of which have responsibilities towards delivering the Local Area Agreement (LAA). The three boards also have either 'lay' or voluntary and community sector representation.

Ownership -> Embedding



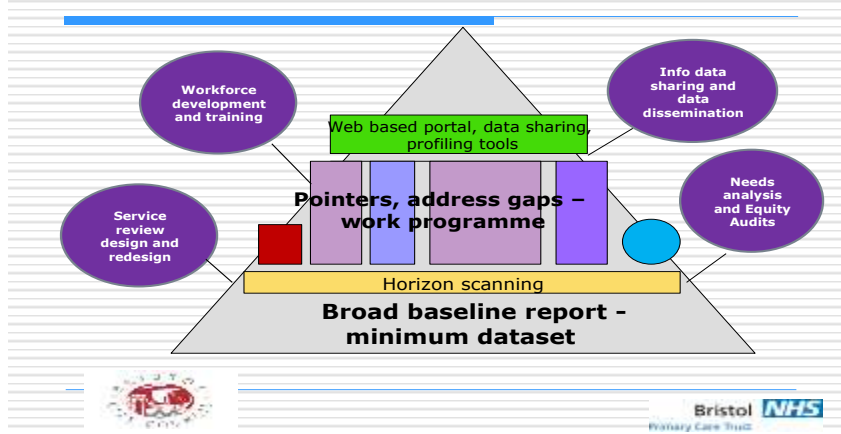
The JSNA Steering Group was also responsible for taking forward, the findings of this JSNA within their own organisations and with partners – see above diagram, which illustrates Council structures on the left and the PCT on the right. The Overview and Scrutiny Commission (OSC) also has a key role as do Practice Based Commissioners (PBC) within the PCT (these are groups of local GPs).

Methodology: overall approach

An incremental approach to the JSNA has been adopted. The intention, during this first year, is to produce a baseline needs-focused report with some (albeit limited) horizon scanning and gap identification. The expected outcome is a baseline JSNA report with a proposed strategic direction of travel in order to meet challenges of the future (by autumn 2008). Work on the report started in late 2007 using national guidance⁶ and preliminary data sets have been used to inform strategic documents in both BCC and BPCT, including the LAA.

This baseline report will be followed by specific pieces of work (filling any knowledge gaps) and more detailed horizon scanning linked to financial and service-related information, leading to more specific strategic recommendations (by Autumn 2009). This is represented by the figure below.

Expected JSNA Outputs



⁶ Department of Health (2007) Guidance on Joint Strategic Needs Assessment (Draft Guidance June 2007)

Scope

A JSNA is potentially a very large undertaking, covering all client groups and a range of time horizons. It is important to recognise at the outset that it cannot be expected to provide for ALL information needs for everyone all of the time. However, it provides a coherent overview of need, in the first instance, making the best use of existing information. It will be added to incrementally in subsequent years and this current report provides:

Analysis of the various current and projected needs of the local population

- All population/client groups (to a certain level of detail) e.g. children, adults, groups with special needs (males, females, disabled people, Black and minority ethnic (BME) groups, Travellers, prisoners etc).
- A citywide perspective whilst at the same time reflecting local variations e.g. geographic, socio-economic.
- An in-depth analysis of specific topics, conditions, groups and service needs, using clear criteria to prioritise this work within available resources (see below).
- Evidence from the recommended minimum dataset, including relevant national indicators.⁷

Setting of the needs analysis within the wider strategic context

- Takes account of existing national policy, guidelines, work streams etc.
- Reflects current national and local targets (e.g. the LAA, but also considers new ones).
- Builds on current local priorities and existing local 'givens' (i.e. Bristol Prospectus, Children and Young People's Plan etc).
- Where appropriate, considers evidence of good practice from elsewhere.

Strategic information to meet the needs of both organisations (BCC and PCT)

- Defines the current baseline and confirms what we think we already know, and identifies areas for more in-depth study.
- Identifies some projected future changing needs (e.g. demographic changes, emerging/new technologies, alternative delivery mechanisms etc).
- Provides comparative analysis (e.g. with other core cities) and analysis according to local needs/different commissioning groups, topic or thematic areas (e.g. Bristol overview, localities, wards, practice-based commissioning clusters etc).

Gap analysis to inform service re-design

- Considers current and projected needs alongside existing provision for health (health conditions, health and wellbeing) and social care, and alongside locally expressed 'wants' in relation to needs (the 'local voice') i.e. a gap analysis.
- Considers evidence of good practice in the context of the resultant 'gap' analysis, leading to identification and signalling of the potential for service change.

Criteria to prioritise in-depth work

Where specific and more detailed investigation is required the following criteria have been used to prioritise the available 'research' capacity.

- Areas where there is potential to influence commissioning/service redesign and a clear need to improve outcomes.
- Pinch points/service pressures/ performance problem areas within the system which are likely to increase (e.g. dementia).

⁷ Department of Health (2007) Guidance on Joint Strategic Needs Assessment

- Areas where little (quality) evidence or information exists on which to base strategic decisions.
- Where there is potential to deliver more efficiently and effectively, or make better use of resources through commissioning and delivering differently to improve service quality.

Deliverables and timescales

- The JSNA will inform planning timescales (short, medium, long-term horizons) and in the future will be timed to coincide with strategic dates in planning cycles.
- A baseline JSNA report and summary with signals for future directions of travel (autumn 2008), followed by a 'refresh' (filling some gaps) autumn 2009.
- A work programme of specific in-depth analyses phased over the next three years e.g. health needs assessments, audits/equity audits, evaluations, service reviews.
- Dedicated web-based portal to facilitate the communication of the JSNA and its outputs (e.g. data sets, toolkits and methods, key publications, web links etc).
- Preliminary datasets will be available by November 2008.

Sources of information for the JSNA

Local information for this report has been gathered from a variety of data sources within Bristol City Council, Bristol Primary Care Trust, South West Public Health Observatory and Health Protection Agency. National data sets (e.g. from the Office for National Statistics [ONS]) have also been used.

Community engagement

Concerns on health and wellbeing issues have emerged following consultation with patient forums, user groups and from resident surveys. These are referred to throughout this assessment as

LOCAL VOICE (on the blue pages) and include:

- Quality of Life residents' survey (see Annex 13)
- Bristol Patients' Forum
- Patient and public involvement forums
- Age Concern
- Bristol Older People's Forum
- Citizens' Panel
- Young People's Quality of Life Survey
- Every Child Matters Survey
- Young people's 'Have Your Say' conference
- Patient Advice Liaison Services
- Complaints received by services.

A host for the **LINK** (Local Information Network) has been established for Bristol (May 2008). The LINK will also represent the 'local voice' and contribute to the JSNA sub-group.

Links to other documents

There is some overlap of the JSNA with other needs assessment reports mentioned below.

Catching in the Rye 2007/08 – provides a full assessment of needs, views and services for children and young people, based on the five outcomes for Every Child Matters. In this report there is a good overlap with the outcomes 'Being Healthy' and 'Staying Safe', see www.bristolchildren.org.uk

Public Health Annual Report – recent public health reports in Bristol have been on selected health topics, rather than a general assessment of needs, although a minimum data set is available. This JSNA will help support future public health reports. See www.bristolpct.nhs.uk

Indicators of Quality of Life 2006 – this annual report provides broad contextual information about the city, based on a selection of quality of life indicators and sustainability themes. Many of the same indicators and ward maps are referred to in this report, but developed with more up-to-date trend and projected information. See Annex 13 and also www.bristol.gov.uk/qualityoflife

The JSNA also builds on evidence gathered in existing commissioning strategies and plans in 2008 and there is overlap with demographic profiling and assessments of need. Supply of services, and market and activity analysis is less well developed in this report.

Comparators

The health and wellbeing of Bristol residents is compared to other areas in order to assess where Bristol sits in the ranking. Different comparators have been used at different times:

- England and Wales
- the Strategic Health Authority area [SHA] which covers the whole of the South West
- Core Cities group
- electoral ward boundaries across the city
- neighbourhood renewal areas
- others used by partners e.g. Regional Centres, Statistical Neighbours, ONS Cluster for Cities and Services etc

These comparisons are not without their difficulties. For example, the SHA area is predominantly rural with some large towns and cities. In contrast, Bristol is an urban area with inner city deprivation thus it can be expected to have some different health outcomes to those of its more rural neighbours. A more useful comparison therefore would be to a city with similar challenges.

Bristol is a member of the Core Cities group – a working group of eight major cities in England that includes: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield. These cities share some of the same challenges as Bristol, so, where feasible, we have used Core Cities as a comparator.

Health and wellbeing indicators are also compared across the city by using wards or neighbourhood renewal (NR) areas. Bristol has 35 wards with an average ward population of approximately 11,500. NR areas have been identified as deprived communities and are compared with non-deprived areas, (see pages 42-43 on 'deprivation').

Data quality and interpretation issues

Data quality is inevitably a concern, especially when bringing together data sets from two large and complex organisations. We have tried to control for this by cross-checking and validating information from different sources. However, some of the data used is not of high quality – but it is used to throw some light on complex issues in the absence of more detailed information.

For example, the Young People's Quality of Life Survey 2007 provides valuable insights into young people's lifestyles across the city, but due to the voluntary participation of schools, some groups and areas may be under-represented in this survey. However, we have used this data in the absence of more reliable studies, thus findings should be interpreted with caution.

Similarly, we have used projections to indicate likely future needs. These are based on our understanding of what is happening now and, given current trends, are used to quantify what challenges the city may face in the future. However, as with all projections, they are based on assumptions which may or may not remain valid. For example, the rate of immigration may be slower than expected as people may choose to move to other areas. Thus projections should be

treated as an indication rather than a hard fact. More work will be done on these prior to the next JSNA 'refresh'.

Constraints

There have been a number of constraints on the delivery of the JSNA.

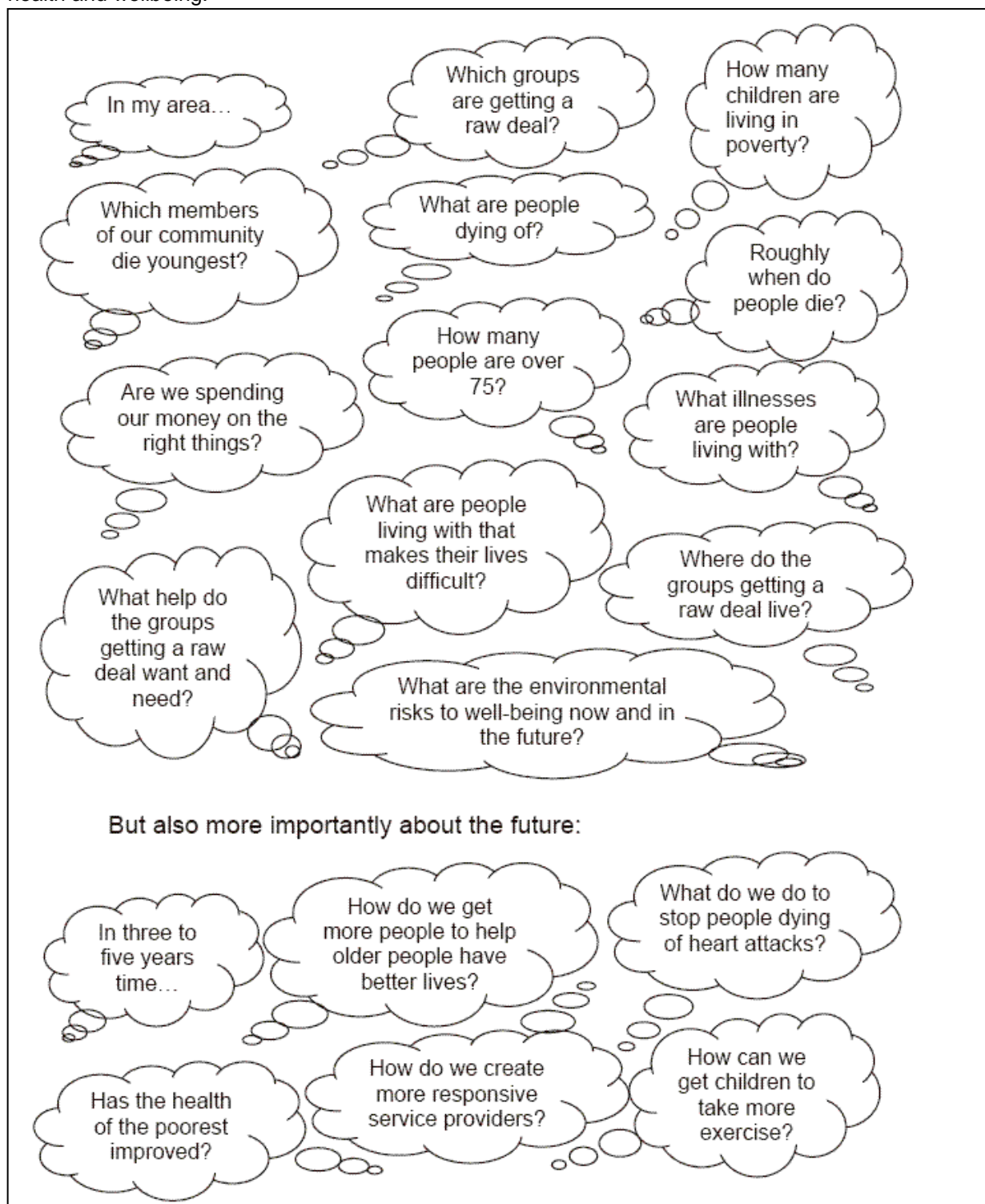
- While BCC and the PCT share coterminous boundaries, both organisations use smaller area groupings/boundaries to organise their work. These local organisational boundaries are often different and have presented some difficulties for local profiling. In many instances, wards have been used as the common geography, (see Appendix 10 which matches wards to local service boundaries).
- The challenge has been to deliver a balanced baseline report which is sufficiently detailed to inform decision-making, yet is still readable and not unwieldy. A second phase will be required to develop a more strategic overview, linked to financial information which assesses implications on service redesign and workplace development.

Key questions and challenges for the JSNA

Each JSNA is unique and will reflect local circumstances, but there are common questions that many health and social care providers have had difficulty answering in the past. Please see examples in the following figure provided by the Department of Health. In addition to national questions, consultation with senior managers (commissioning and service managers) in both the PCT and BCC have led to a list of key local questions and challenges for the JSNA to address. Some of these local questions, which this report will attempt to consider, are listed below.

1. How do we reduce the ten-year gap in life expectancy across the city?
2. How can we best target resources to the neighbourhoods with greatest need?
3. Are we 'closing the gap' between the most deprived quintile and the rest of the city?
4. Where do we have disproportionate access to services?
5. How many migrants/new arrivals are there in the city and what are their health needs?
6. How will the city's economy, job prospects and development change in the long and short term?
7. The needs assessment will be most useful if broken down to neighbourhoods and localities relevant to each healthcare organisation.
8. The assessment must improve strategic use of information on long-term conditions and social care, across departmental boundaries.
9. How do we address the city's mental health burden? What is the evidence of need, existing provision and demand for alternative therapies?
10. Do adequate facilities exist to support transitions from child to adult services?
11. What is the true picture of children and young people with impairments and mental health problems across the city?
12. What are the health needs of our BME elders? Do they have access to healthcare?
13. How many over 85-year olds will be living in the city in future and what are their health needs?
14. Will dementia levels increase, and if so, how rapidly?
15. What will be the level of demand for care home provision in the next five years?
16. There is concern that increased housing development will lead to increased overcrowding and unhealthy living conditions in some areas.
17. Will respiratory conditions and heat stress increase with our warming climate?
18. What are people's expectations for current and future healthcare – how do we manage expectations?

JSNA key national questions: Source: Department of Health 2007, Commissioning framework for health and wellbeing.



Expected outcomes

The JSNA has focused on outcome indicators, using an outcome based accountability approach.⁸ The minimum data set and indicators are linked to relevant national outcomes on health and wellbeing (see box opposite) and local issues. There are also expected and specific outcomes for Bristol that will lead on from the intelligence included in the JSNA. It is expected that the JSNA:

- will enhance joint understanding of the challenges across the city between BCC and BPCT and will be used to inform strategies, policies and resource allocations
- will facilitate joint commissioning and service redesign - which are both strategic and effective because they are based on good analysis of relevant and timely information
- will ensure services are shaped by local communities as the 'Local Voice' is integral to this report
- will ensure inequalities are stabilised and then reduced across the city and for certain groups
- will improve health and wellbeing for children and adults
- will ensure service quality and accessibility improves in key areas.

Relevant national outcomes

Every Child Matters

The introduction of the Children Act 2004 and the publication of *Every Child Matters: Change for Children* heralded a new era in the delivery of children's services. The Government's aim for every child, whatever their background or circumstances, is based on five outcomes:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing.

Our Health, Our Care, Our Say

This White Paper¹ identified seven outcomes for people's lives that social care will support:

- improved health and emotional wellbeing
- improved quality of life
- making a positive contribution
- exercising choice and control
- freedom from discrimination
- attaining economic wellbeing
- experiencing personal dignity.

Summary of Chapter 2

The JSNA process adopted is participatory and iterative (we learn together as we go along). Governance arrangements are clear (the steering group reports to three joint commissioning boards and the management structures within both organisations).

Both organisations have given a commitment to ensure that the JSNA becomes embedded as an on-going process. It is incremental but will also need to be refreshed and updated to keep it 'live' and relevant.

⁸ IDeA (2006) Improving Service Delivery – introducing outcome-based accountability.

3. Bristol - context

Relevant national indicators:

- *NI 13 Migrants' English language skills and knowledge*
- *NI 75 Achievement at GCSEs*
- *NI 117 Number of 16-18s not in education, employment or training*
- *NI 151 Overall employment rate*
- *NI 152 Working-age people on out-of-work benefits*
- *NI 154 Net additional homes provided*
- *NI 155 Number of affordable homes*

Socio-economic context

The health of the city, and particularly health inequality is related to the levels of employment and deprivation. Employment, in particular, can have a protective effect on mental health by boosting confidence and self-esteem.

Overall, Bristol is a prosperous city with a growing economy. The unemployment rate of five per cent⁹ is lower than the England and the core cities averages. Most jobs are in the central area of the city and Annex 1 shows the current number of jobs by employment sector.

The economic projections for the South West and Bristol are favourable, with a projected rise of 2.1% in employment during 2006 - 2014. There are likely to be more jobs in construction, private services, education, health and social care. (See Annex 4 for more detail).

As prosperity and population increase over the next 20 years, an extra 42,500 - 54,200 jobs are likely to be created.

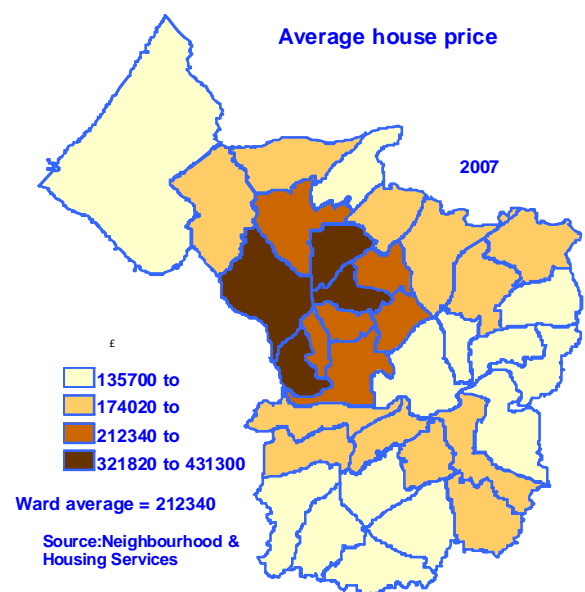
Homes in Bristol

Bristol has approximately 147,613 homes of which 61% are privately owned, 15% privately rented and 24% are social rented (28,046 rented from the local authority).

There is increasing affluence amongst older people and over 36,000 residents aged 65 years or more are owner-occupiers; 77% of homes are owner-occupied by residents 55-64 years, dropping to 62% by residents aged over 85. In 2008, 2,020 people aged 65 years and over live in care homes (local authority and private) and this proportion will show a small increase to 2,190 by the year 2050.

House prices are higher than the national average and there is considerable variation in the average house price across the city, as shown in the map opposite.

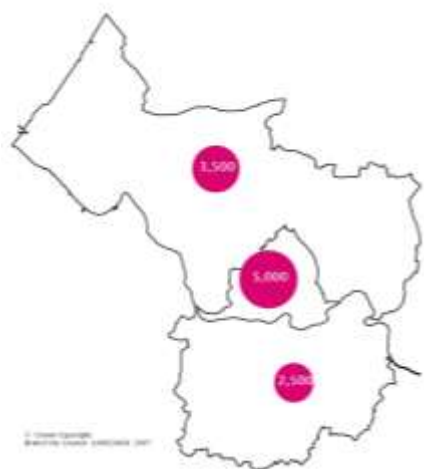
The city's population is set to rise in the next 20 years (2008-2028) by 107,200 and in total 29,500 new homes are planned to be built in the city (the *Proposed*



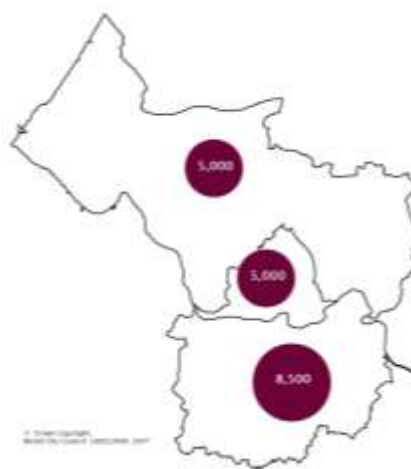
⁹ International Labour Organisation measure July 2006-June 2007

Changes to the Regional Spatial Strategy is suggesting a further 7,000 additional homes, making a total of 36,500 new homes).¹⁰ The maps below show the potential distribution of these new homes.

Homes with planning permission



Proposed additional homes



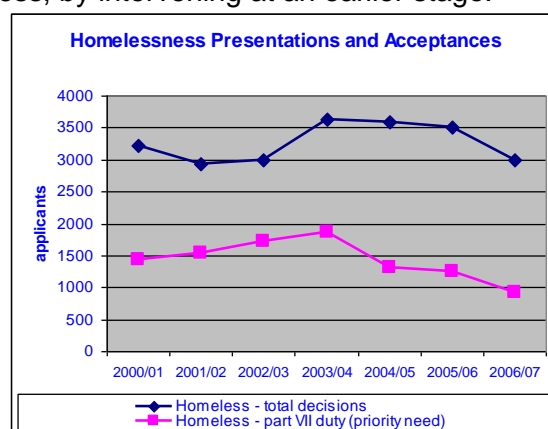
Source: Crown copyright, Bristol City Council 100023406 2007

A large proportion of new homes are likely to be in Lawrence Hill and Cabot, followed by Filwood, Hengrove and Lockleaze. Lawrence Hill and Cabot already have populations above the ward average (see ward population, page 32). Only eight per cent of our housing growth is driven by the rising population of elderly people, unlike the rest of the South West, where it is 53% and North Somerset where it is 88%.¹¹

There has been an increasing trend over the last 50 years for smaller household size, including one-person households. This change is creating a demand for more space and increased consumption of resources. See also 'Healthy housing', on page 49.

Homelessness and overcrowding

The rate of statutory homelessness in Bristol per 1,000 households is 7.1 (2005-2006) and is higher than England (4.4) but average for core cities (APHO and DH 2008)¹². Between 2000-2001 and 2006-2007 the rise in the number of homeless households presenting to the council has steadied. The proportion in priority need, to whom the Council owes a duty to home, has fallen by 51% since 2003-2004. Since this date the council has changed internal and externally-commissioned services to prevent homelessness, by intervening at an earlier stage.



Source: Neighbourhood and Housing Services (BCC)

¹⁰ Bristol City Council (2008) Bristol Development Framework - Preferred Options.

¹¹ Lifetime Homes, Lifetime Neighbourhood (2008) Presentation by Luke O'Shea, CLG

¹² Core city comparisons provided by Association of Public Health Observatories and Department of Health.

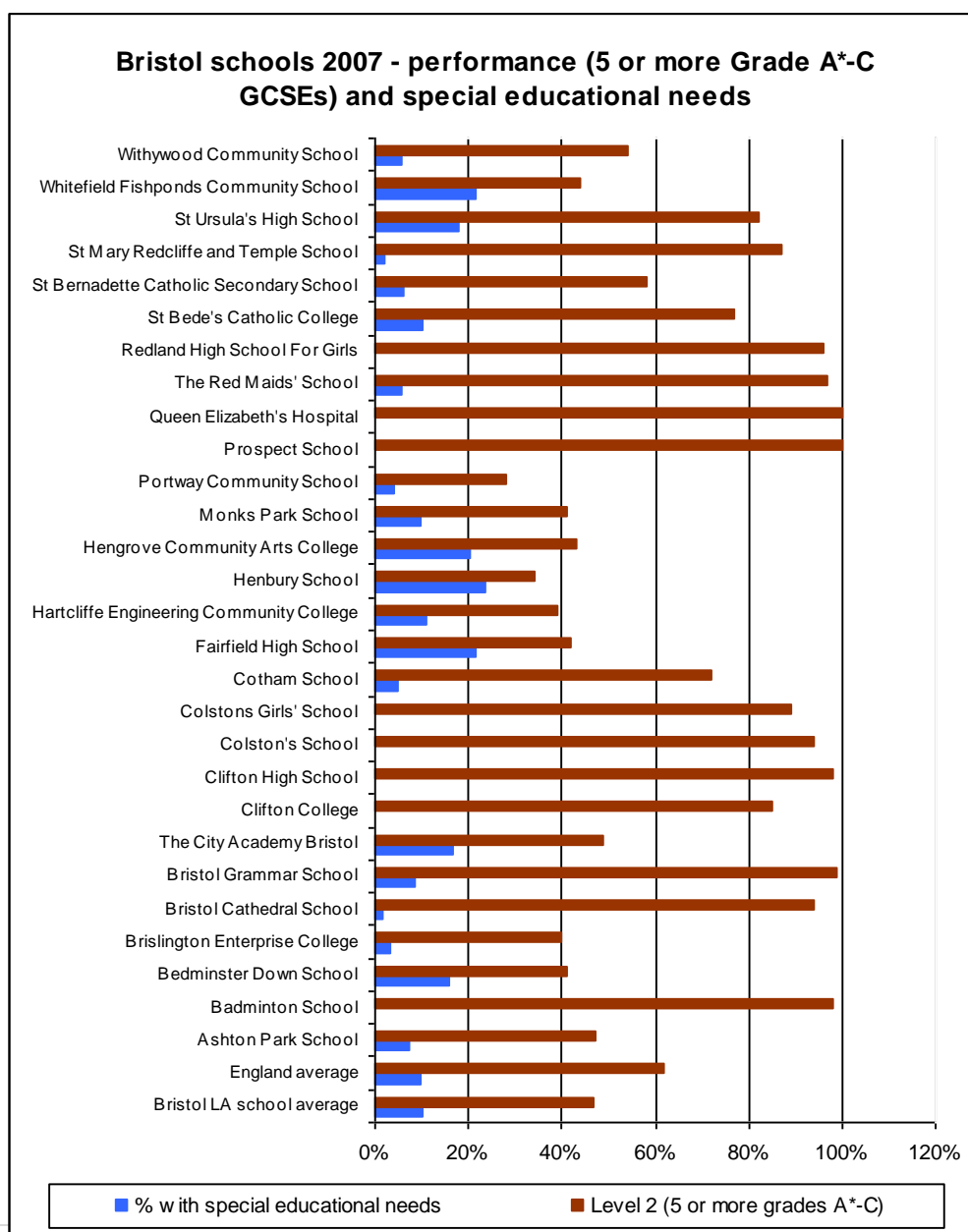
The majority of homeless households are found homes in long-term temporary accommodation, consisting of self-contained units. This type of preferred temporary accommodation is slowly increasing in Bristol.

In the 2001 Census 3,400 households were living at two rooms or more below the 'occupancy rate' i.e were overcrowded, and it was estimated these households contained at least 2,600 children. Since 2001, the numbers of overcrowded households with children may have increased as a result of population/migration trends (page 38) and be at greater risk of homelessness.

Skills and education

Education has a significant bearing on employment and social exclusion, and those with no or low level qualifications and the unemployed are at higher risk of common mental health problems.

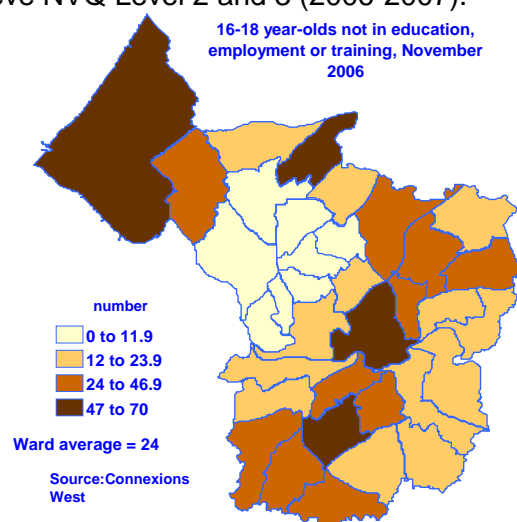
Bristol has 17 local authority secondary schools and does not compare well with core cities for GCSE achievement (ranking bottom of the eight core cities and of all English authorities). Weak literacy skills and poor attendance remain barriers to learning for many pupils. Over recent years, Bristol secondary schools have shown improvement and in 2007, 47% of young people achieved five or more A*-C GCSEs (compared to 55% in England). Raising standards of attainment is a key priority for the city. See educational attainment (below) Source: [www.dcsf.gov.uk/performance/](http://www.dcsf.gov.uk/performance/tables/)



In 2008, Bristol local authority (LA) nursery schools have 38% of children from 'non-White British' groups. In LA primary schools and secondary schools this proportion is 28% and 25% respectively. A total of 14% of pupils have English as an additional language (Source: Equalities Impact Assessment 2008, CYPS).

Bristol also has 12 private schools that perform well with over 80% of pupils achieving five or more A*-C GCSEs. The majority of these schools have no pupils with special educational needs (SEN). In contrast, 3,391 pupils have SEN (7.4%) at local authority schools. If all Bristol schools are considered, Bristol achieves better than the England average, but many Bristol private schools have pupils not resident in the city. Also many children living in Bristol go to schools outside Bristol.

Seventy six per cent of 16-18 year olds are in education, employment or training (the same as the England average, 2007) and only seven per cent are not in education, employment and training (NEET) (better than Bristol's statistical neighbours, see page 2). Many of these young people live in Bristol's most deprived wards. See map below based on 834 young people. By age 19 years, 63% of young people achieve NVQ Level 2 and 3 (2006-2007).



Bristol has two universities and attracts many students to the city. The number of students at the two main universities in Bristol - University of Bristol (UoB) and University of the West of England (UWE) – has risen since 2001. Higher Education Statistics Agency (HESA) data shows that between 2001-2006, the total number of students at UoB increased by 2,435 (11%). Of the 23,630 students in 2005-2006, 84% of students were UK residents, 5% overseas EU residents and 11% overseas non-EU residents. At UWE there has been an even greater increase in student numbers with an additional 4,395 students between 2001-2006. Of the 28,825 students in 2005-2006, 92% of students were UK residents, 3% overseas EU residents and 5% overseas non-EU residents.

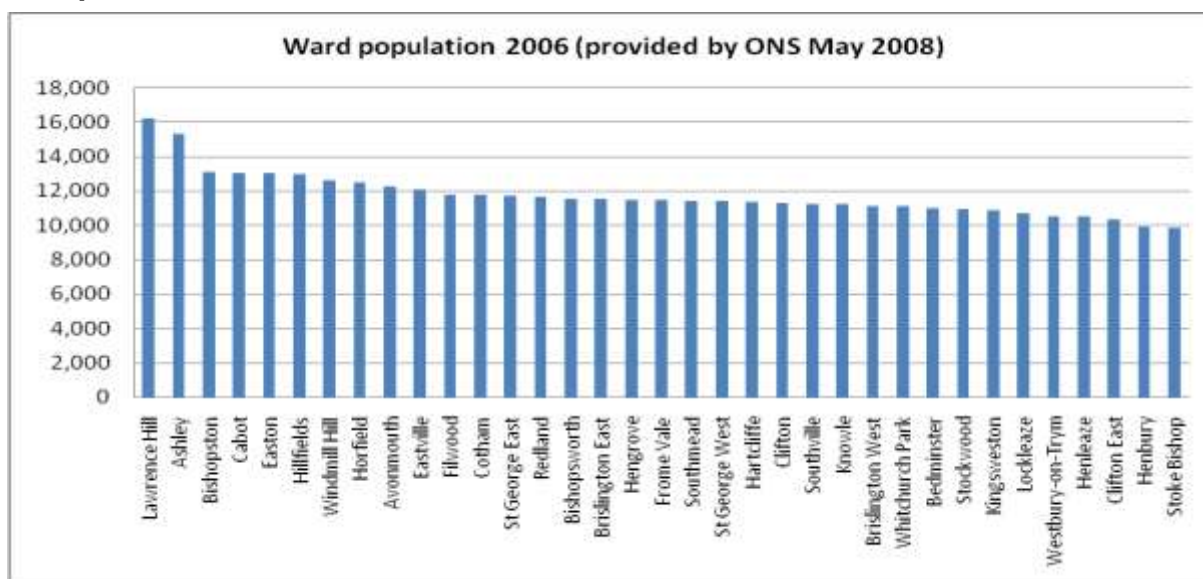
It is estimated that approximately half of Bristol's 52,500 students live in the city. See Annex 2 for the distribution of students across the city.

Changing population and culture

The most recent population update for Bristol is the Office for National Statistics (ONS) Mid Year Estimates (MYE) 2007 that records Bristol's population at **416,400**: 49.9% (207,900) are males and 50.1% (208,500) are females.

We know that not all population groups are fully included e.g. some of those living in multi-occupied dwellings and recent migrants, and may not appear in official statistics (see page 38).

Ward profile

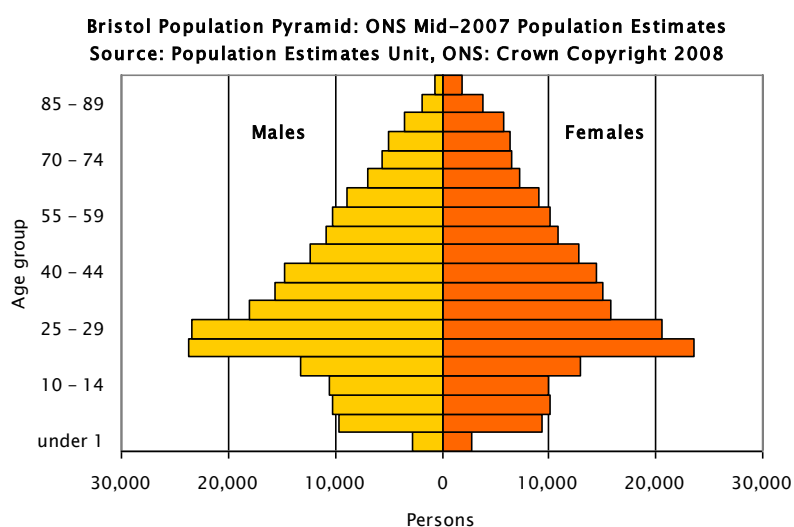


Bristol has 35 wards and the following graph shows the ward populations in 2006 (most recent ward figures provided by ONS Experimental Statistics, Crown copyright). The central wards of Lawrence Hill and Ashley have populations of well over 15,000 persons.

Another source of population data is the GP registered population for 2007 and 428,000 residents are registered with a GP practice in Bristol. The ward maps based on this population are shown in Annex 8. This register is known to over-count the population, as people are not removed from the register when they move out of the area, but only when they register with a new doctor.

Age and gender profile

Bristol has a relatively young population profile. Bristol has an estimated 91,200 young adults aged 20-29 years, making up 22% of the total population. This proportion is higher than the England average of 13%. There are 55,100 people aged 65 and over, making up 13% of the total population. This proportion is lower than the England average of 16%.



The city also has 91,500 children and young people aged 0-19 years, 22% of the total population compared to the England average of 24%. Based on the ward population (ONS 2006), the wards with the largest numbers of children are in the inner city - Lawrence Hill and Ashley, and the more

peripheral local authority housing areas - Filwood, Southmead and Hillfields. Wards with the highest numbers of older people (aged 65 or over for males and 60 or over for females) are Bishopsworth, Hengrove, Stockwood, Frome Vale and Westbury-on-Trym. The largest concentration of people aged 85 and over is in Westbury-on-Trym (in 2006, 624 were 85 years or more). The number of males and females is roughly equal for most age groups until retirement age, when Bristol has 31,400 females compared to 23,700 males aged 65 years or more (ONS Mid-2007 population estimates).

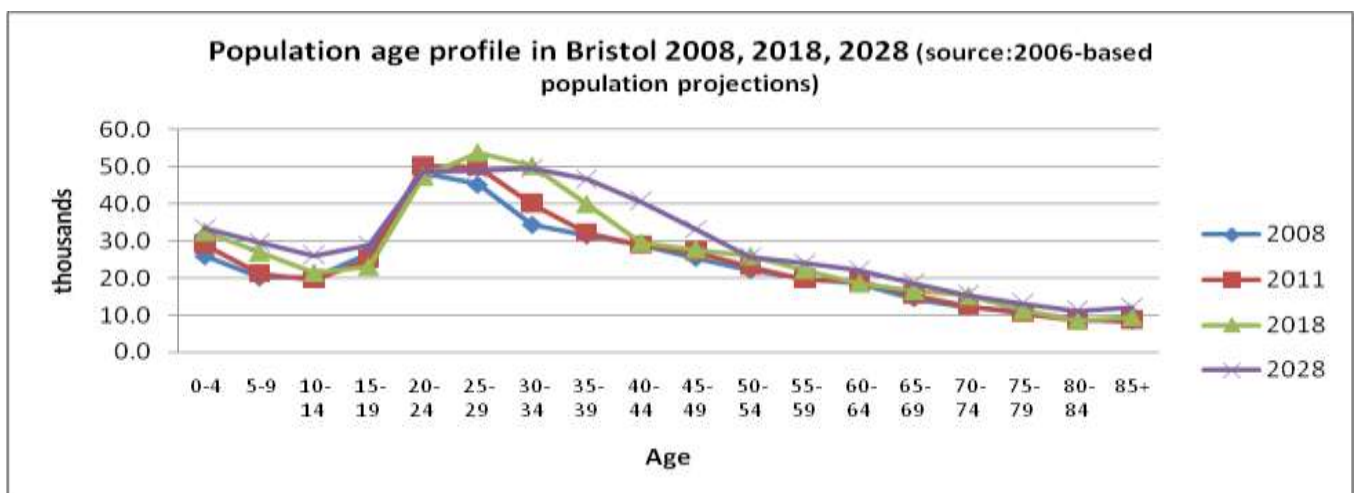
Population change

Between 2001 and 2007 there has been a 6.8% increase in population, particularly in the inner city areas of Bristol (Cabot, Lawrence Hill, Ashley) as well as in Horfield and Eastville, where the ward populations have increased by over 1,000 people (see map on next page).

Between 2001 and 2006 Bristol saw a 5.3% population increase - well above the national average of 2.5%. Along with Manchester and Nottingham it is one of the fastest growing core cities.

Population projections (ONS 2006-based sub national population projections) predict our population will rise by 32.2% between 2006 and 2031, with an extra 132,300 persons (107,200 persons between 2008 and 2028), to reach a population of 542,000 by 2031. These projections are trend-based, ie they are based on the assumption that trends from the past five years (in births, deaths and migration) will continue into the future. These projections are not based on policy objectives in terms of housing, regeneration or other policy plans. **There is a high level of uncertainty over the projections, particularly the migration estimates, and they may therefore not provide an accurate picture of future population change.**

The 'bulge' created by our large population of 20-24 year olds will move up the age groups and by 2018 the bulge will be due to people in their 30s, as shown in the graph below. (See Annex 5 for population pyramids for Bristol, compared to the rest of the region for 2008, 2011, 2018 and 2028. See Annex 6 for population projection figures by five year age bands.



Source: ONS 2006 Sub-national population projections

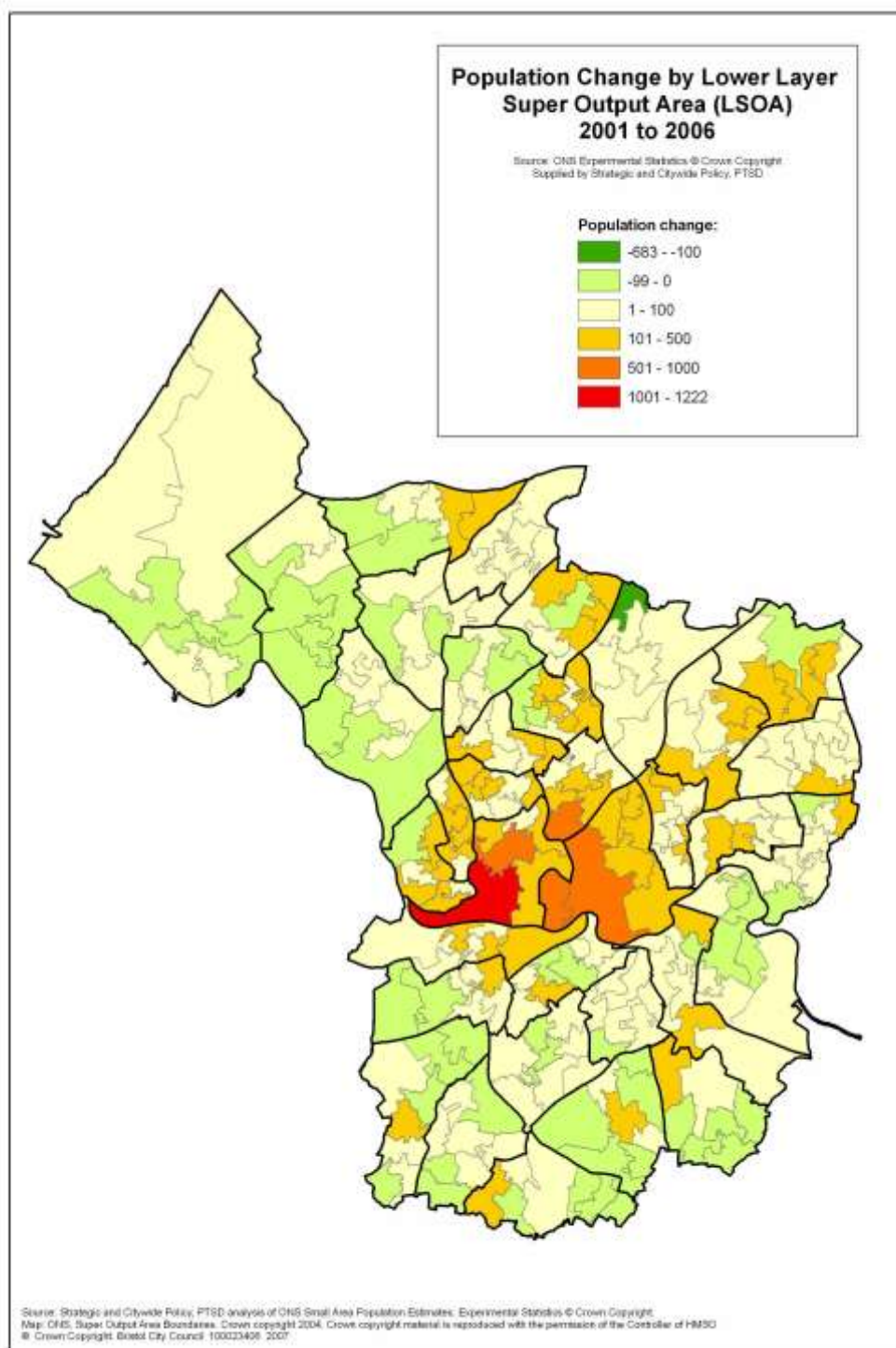
Bristol's young profile is partly due to students attending further educational establishments in the city. It is estimated that there are 25,000 students living in Bristol. The young profile is also due to many migrants and new arrivals in the city of working age (see page 38).

Children and young people

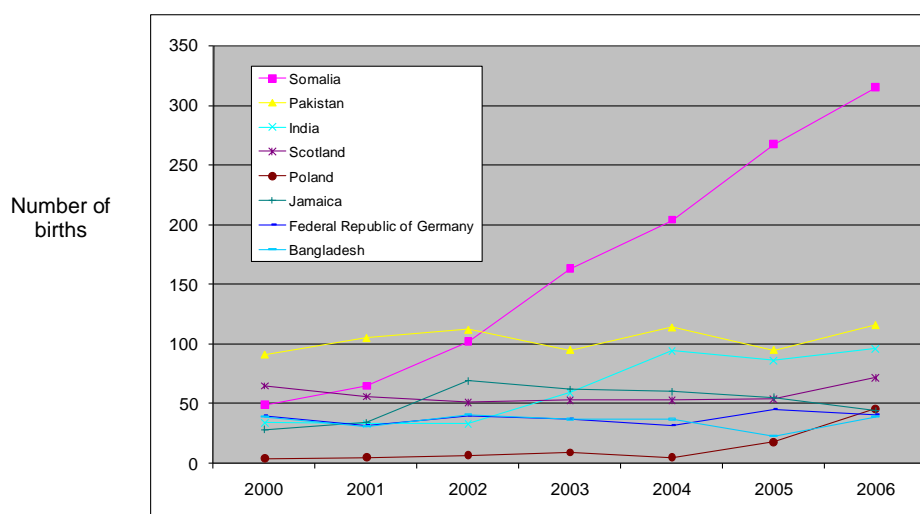
Bristol's birth rate is rising. Live births are increasing and deaths are decreasing, resulting in an increase in the population due to natural change (ie live births minus deaths). Since 2001, Bristol

has an additional 6,700 residents due to natural change alone. Levels of natural change are in fact higher than at any time since 1991, mainly due to a recent increase in numbers of births.

In 2000, Bristol had 4,650 births, rising to 5,707 in 2006. The birth rate is highest amongst new arrivals to the city, particularly to mothers from Somalia, see graph on page 35. Currently there is a higher birth rate in Lawrence Hill, Ashley and Easton where many of the new arrivals to the city come to live, join relatives, or settle in cheaper housing.



Bristol birth trends – births to mothers of non-English or Welsh origin



Source: Bristol Primary Care Trust

Based on ONS 2006-based population projections, over the next three years we will expect to see a rise in the number of children under ten years old with an estimated extra 4,200 children, and a further 9,100 between 2011 and 2018.

Population projections for 10-19 year olds show a possible population decrease over the next ten years, before the numbers of young people reach close to 2008 levels again by 2021. There will be 2,200 fewer 10-19 year olds in 2011 and 2018, (see Annex 6).

Age	2008	2011	2018	2028
0-9	46,000	50,200	59,300	63,100
10-19	46,800	44,600	44,500	55,200

Older people (50 years and over)

The population aged 65 and over is 13% (55,100 people in 2007). The population projections for older people (2008-2028) show a steady increase overall. One of the significant rises will be in the 85 and over age group, with an increase of 1,200 persons by 2018, and a further 2,600 persons between 2018 and 2028 (see Annex 6 and 7).

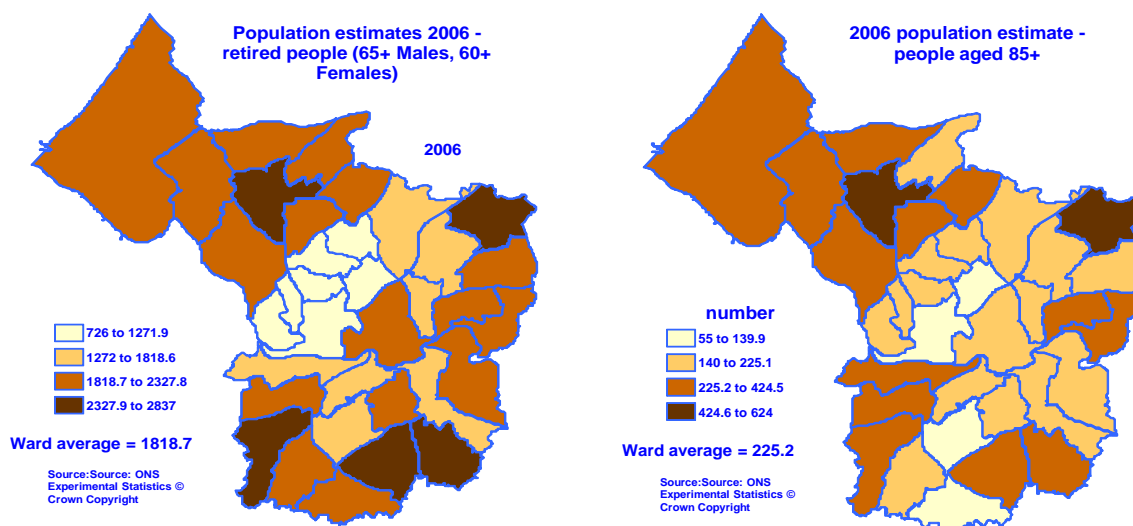
Age	2008	2011	2018	2028
50-64	60,500	61,900	66,700	71,900
65-84	46,700	46,900	51,300	58,700
85+	8,300	8,700	9,500	12,100

The best estimate of the ward distribution of our current population of retirement age (65 years and over for males and 60 years and over for females) is shown in the next ward map (ONS 2006 population estimates). The second map shows our most elderly population aged 85 and over (ONS 2006 population provisional ward estimates).

The size of the over 75 years population is forecast to rise by about 34% over the next 25 years. This is smaller than the predicted rise for this age group nationally (at 65%).

Living alone

Approximately 35% of older residents aged 65 and over live alone, over 19,000 Bristol residents in 2007. Around 45%¹³ of residents aged 75 and over live alone - approximately 13,000 residents. It is not known how many residents aged 85 or more live alone, but it likely to be in excess of 2,000. Many older residents choose to move out of Bristol in retirement for a better quality of life elsewhere. These residents tend to be owner-occupiers in good health, and the remaining older population is likely to have higher health and social care needs.



Ethnic population

The ethnic profile of the city is based on *ONS Population Estimates by Ethnic Group*. The estimates are available from 2001 to 2006 and are useful to understand changes in the ethnic profile of the population since the 2001 census.

The total population in 2001 was 390,000 of which 31,900 (8.2%) was made up of BME groups. This BME population in Bristol is estimated to have increased by 14,200 up to 2006, giving a total BME population of 46,100 (11.2%) in 2006.

South Asians (Indian, Pakistani and Bangladeshi) make up one of the largest BME groups with an estimated 17,300 people in 2006, followed by the Black African and Caribbean community with 11,700 people.

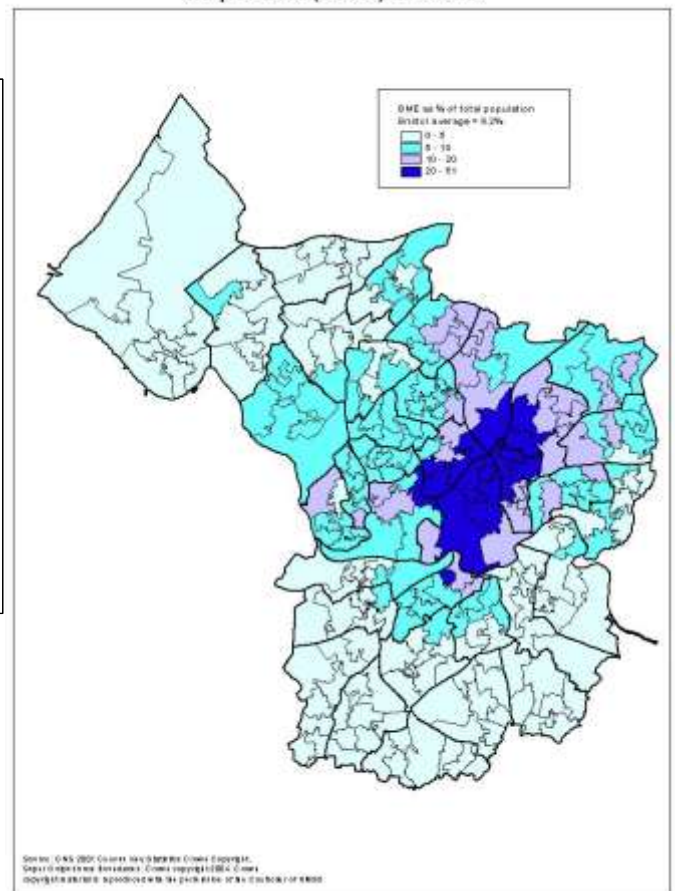
The graphs (overleaf) indicate that only five per cent (2,300) of all BME residents are of pensionable age. The BME population tends to have a younger age profile with 29% of the Mixed White/Black Caribbean group and 23% of the Mixed White/Black African group aged under 16 years.

The BME groups with the largest increases have been the Indian (+3,700), Chinese (+2,900) and Black African (+2,900) ethnic groups. In addition to these BME groups, the 'White Other' group has also substantially increased in Bristol. Between 2001 and 2006, this group is estimated to have increased by 6,900 to a 2006 total of 17,400 people.

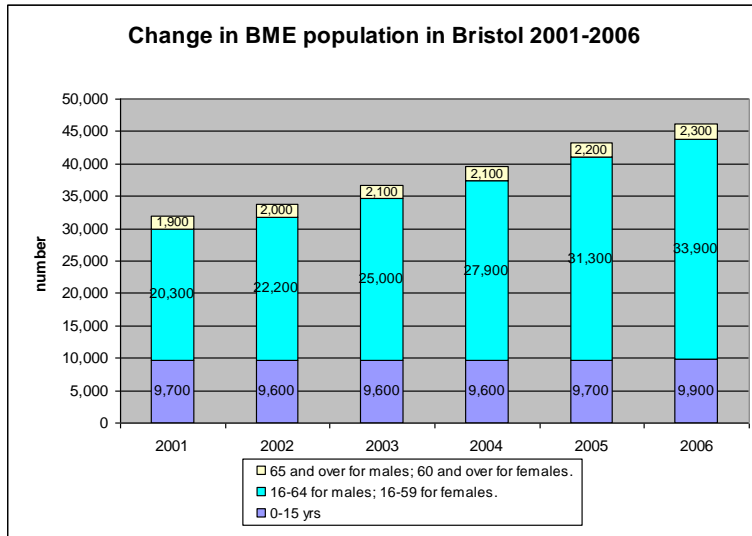
¹³ Second Blooming at www.swpho.org.uk

The map indicates the neighbourhoods with the highest concentrations of BME residents (based on the census 2001).¹⁴

Black and Minority Ethnic Residents by Super Output Area (LSOA) in Bristol



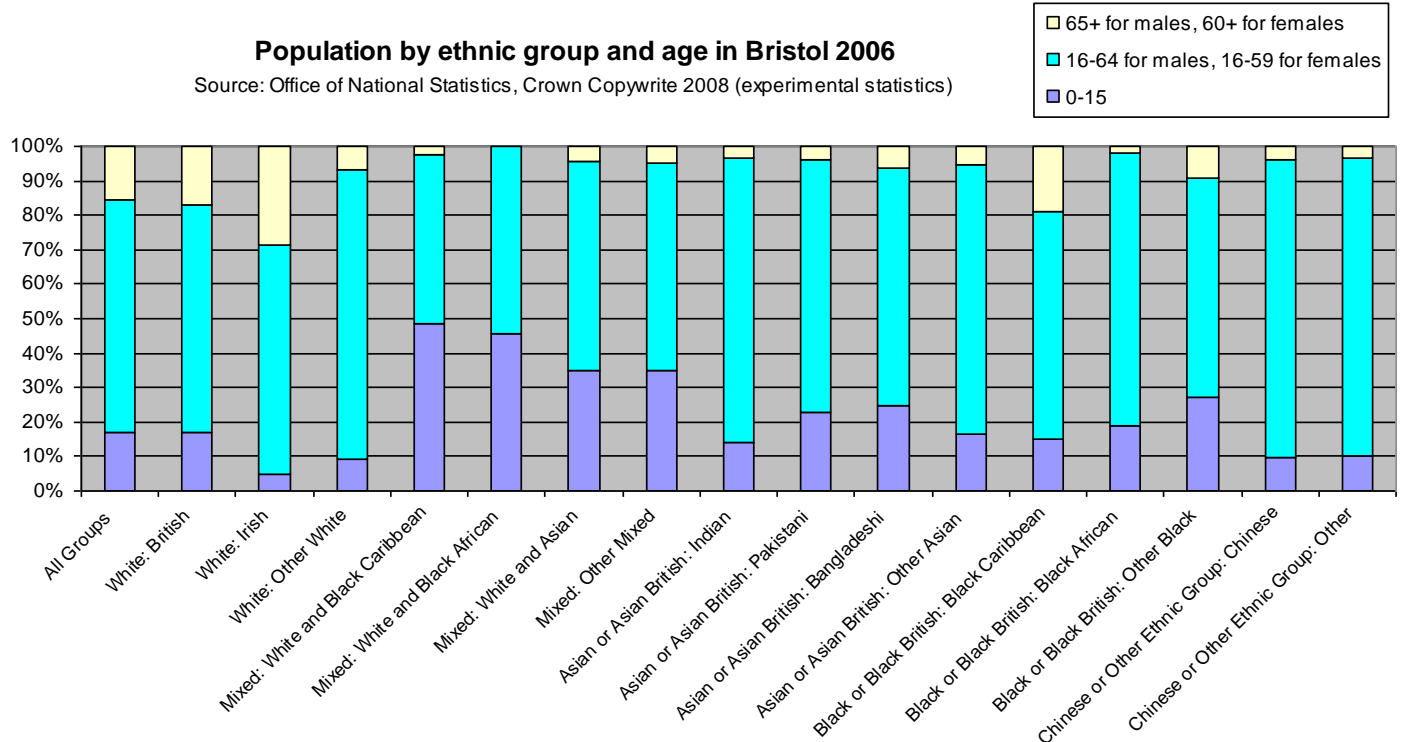
Change in BME population in Bristol 2001-2006



Source: Office for National Statistics, Crown Copyright 2008 (Experimental Statistics)

Population by ethnic group and age in Bristol 2006

Source: Office of National Statistics, Crown Copyright 2008 (experimental statistics)

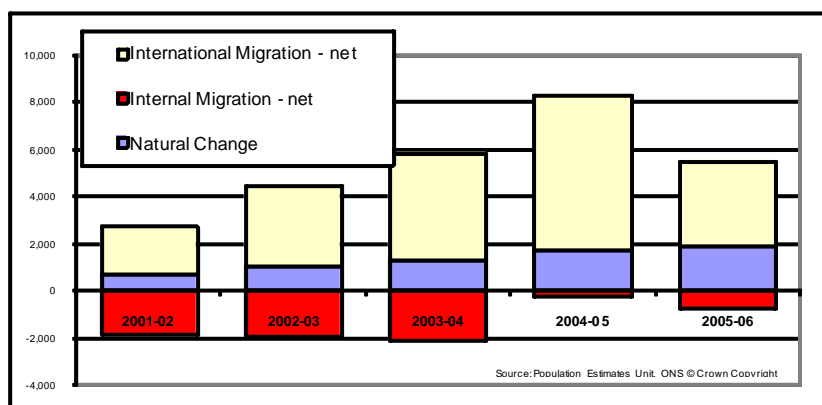


¹⁴ ONS: Crown Copyright 2008 (Experimental statistics). Provided by Strategic and Citywide Policy Team, Planning, Transport and Sustainable Development, BCC.

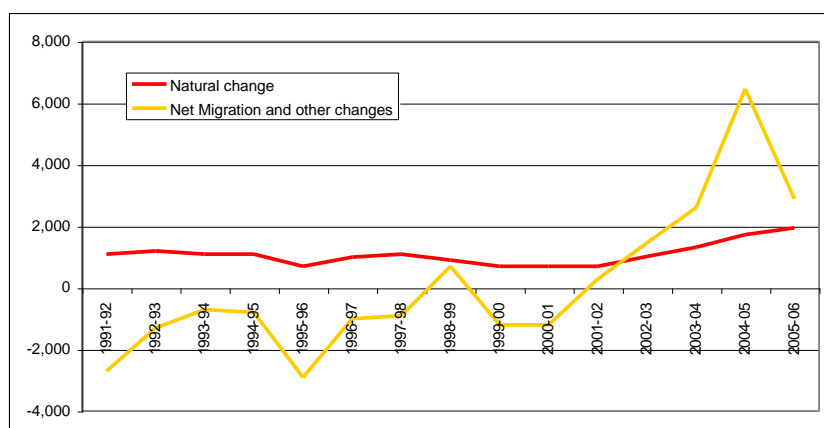
New arrivals - migrant population

Natural change, international migration and internal migration are components of population change (graph below). The high proportion of international migration since 2001 accounts for the relatively large increase in the population. As well as natural change (mentioned earlier) Bristol has seen high levels of both outward and inward migration.

Bristol population 1991-2006 – graphs showing components of change



Source (both graphs): Population Estimates Unit, ONS: Crown Copyright 2007



As shown above, the greatest increase has occurred in net international migration, particularly in 2004-2005 when the A8 Accession countries joined the European Union. Between 2001 and 2006, the population of Bristol increased by 20,300 due to net international migration, including Somali and Polish nationals coming to work in Bristol.

In contrast, net internal migration (internal migration includes migration within England and Wales, plus cross-border migration flows to and from Scotland and Northern Ireland) has seen more people leaving Bristol to go to other areas, than moving into Bristol. Between 2001 and 2006, Bristol lost 6,800 people.

Compared to the rest of the sub-region, more than twice as many people moved into Bristol as moved into the other three local authorities added together. Compared to other core cities, Bristol lost less people due to internal migration than Birmingham, Liverpool, Manchester and Nottingham. In Birmingham and Liverpool, net internal migration losses have far outweighed net international migration gains resulting in an overall loss of people in terms of net migration change.

There are a number of alternative sources of information that have the potential to improve estimates of both internal and international migrants. These include administrative sources such as

National Insurance registrations. In Bristol between 2002- 2003 and 2006-2007, a total of 23,240 National Insurance numbers were issued to non-UK nationals. By far the largest proportion of these – 20% – were issued to Polish nationals (4,700). India was next with 1,660 (7%) and Somalia with 1,460 (6%).

Records are available from the Council's private sector housing team, who are required to inspect private sector properties before immigration status can be granted to new migrants. The number of immigration inspections has doubled in the last five years from 103 in 2003-2004 to over 204 in 2007-2008.

Recent information from Polish community representatives indicates that many Poles are now starting to return to Poland due to improving economic prospects there.

Numbers of people migrating can vary considerably over short periods of time and be difficult to estimate. The figures reported may therefore indicate a snapshot in time but not be able to accurately predict future trends in migration. Further improvements to population and migration statistics are desirable, given the current high levels of population change. There are three specific areas of improvement that data users are seeking:

- estimates of a broader range of population statistics and indicators (eg short term migrants)
- more accurate counts of the numbers of migrants entering and leaving the UK
- more accurate counts of local populations.

Changing culture

Bristol's culture has changed over the last 50 years and some key cultural drivers for the next 50 years could be:¹⁵

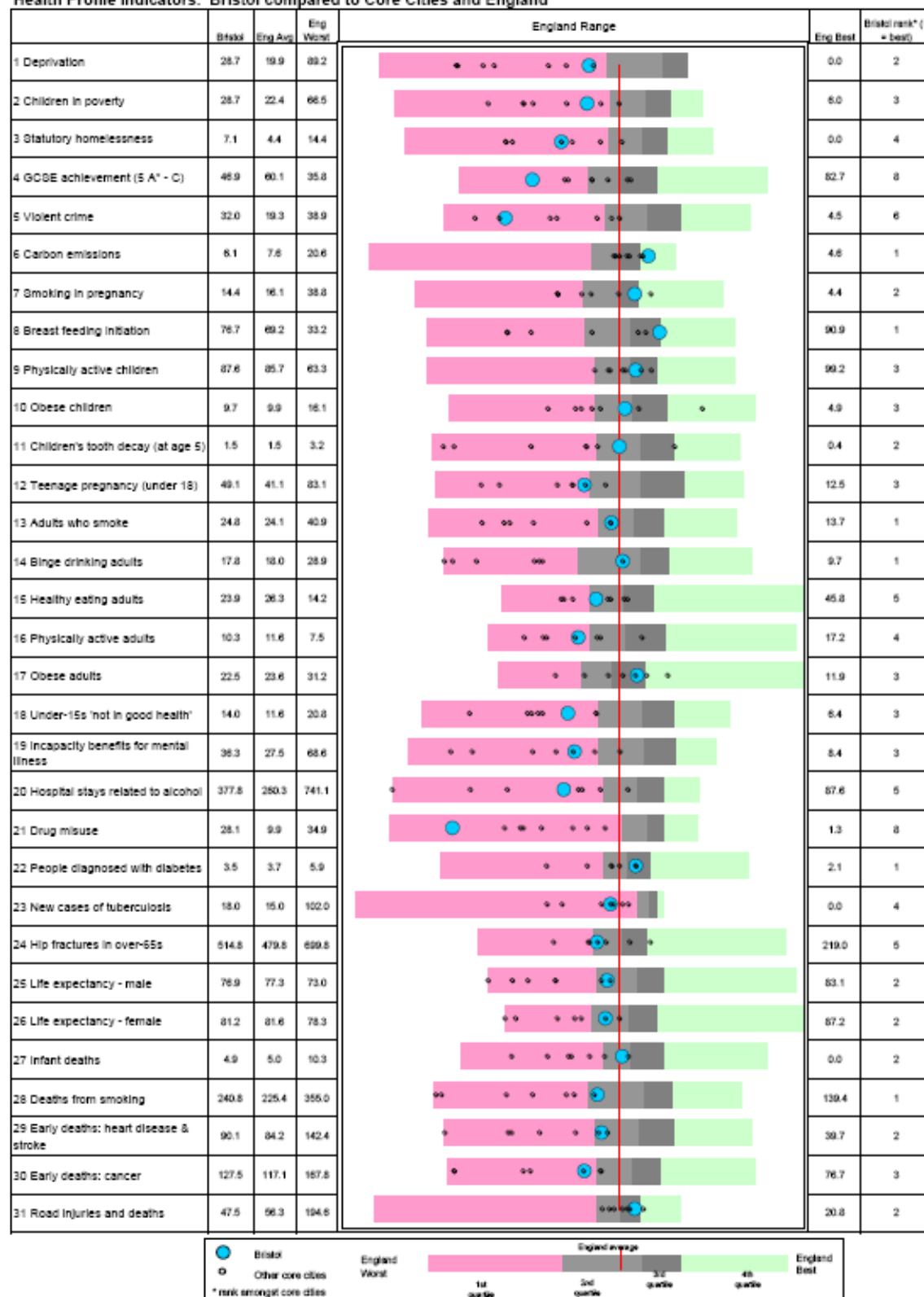
- migration into Bristol by more ethnically diverse communities seeking improved job prospects
- migration out of Bristol of retired people seeking a rural quality of life
- increasing inequality with the rich set to get richer over the next ten years
- changes in regulation – shift from the regulation of production to regulating consumption and behaviour e.g.
 - road user charging
 - charges for domestic waste disposal
- growing global dimension and increased influence and importance of developing countries in particular as bigger consumers
- an increasing demand for high energy domestic appliances and nano-technology
- convenience driven consumers – greater demand for convenience foods and reliance on car travel to shopping centres and retail parks
- 'I want it now' consumers:
 - growth in 24 hour and internet shopping
 - mobile phones and internet facilitate last minute planning
 - fewer people saving and more people comfortable with short term debt.
- rise in personal mobility with increasing car ownership and the freedom this brings
- higher expectations on what the state should provide for health and wellbeing :
 - resources for non-urgent surgery e.g. breast enlargement, gastric banding
 - higher quality environment.

¹⁵ 'Looking to the future – drivers for change' Professor James Irwin's presentation given at the 10th Annual Conference of the AQM Resource Centre and Environment Protection UK SW Division, Bristol 21.02.08

How does Bristol compare with other core cities?

Bristol is a member of Core Cities, a working group of eight major cities in England that includes Birmingham, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield. The following chart shows how we compare as a snapshot for 2007.

Health Profile Indicators. Bristol compared to Core Cities and England



Source: AFHO and Department of Health. © Crown Copyright 2008.

The city is better than average of core cities for adults who smoke, residents who are obese, residents with diabetes, binge drinking adults, breast feeding initiation and the city has low carbon emissions. However, Bristol's indicators are amongst the worst for GCSE achievement, drugs misuse and violent crime. Some of the indicators are measured using the *Health Survey for England* and are modelled estimates based on small sample sizes, so the results should be interpreted with caution. These indicators will be explored in more depth in subsequent chapters. Please note – this is a snapshot of 'now' and not a projection of the future.

In view of the changing population dynamics the city will need to question its focus on health and wellbeing issues to maintain progress and prevent deterioration.

Key pointers for the Bristol context

Population

- The city's population is set to rise in the next 20 years (2008-2028) by 107,200.
- In ten years there will be an extra 1,200 persons aged 85 and over, and a further 2,600 persons between 2018-2028.
- There is no comprehensive count of migrant numbers in Bristol, or age of inward and outward migrants nationally, or locally.
- The birth rate is rising most rapidly in areas of the city experiencing deprivation, and amongst the city's new international migrants. In ten years there will be an extra 13,000 children aged under ten years.
- Eight per cent of our housing growth is driven by the rising population of elderly people, unlike the rest of the South West, where it is 53% and North Somerset, where it is 88%.

Summary of Chapter 3

Bristol is a relatively prosperous city and is one of the fastest growing core cities. Bristol's population is increasing and that trend is projected to continue over the next 20 years.

In total 29,500 new homes are planned to be built in the city in the next 20 years (the Proposed Changes to the Regional Spatial Strategy is suggesting 36,500 additional homes). Planners and developers need to ensure homes are fit for purpose for more single occupancy and an ageing population, including those living with limiting long term conditions and disability.

Meeting the health needs of the growing and increasingly diverse population in already congested inner city areas (e.g. Cabot and Lawrence Hill) will be a major challenge for service providers as this growth is occurring in areas where there is already pressure on services and significant health inequalities.

Age can be a determinant of health, with people at each end of the age spectrum – the very young and very old – having the highest requirements for primary and secondary care.

Some of these issues will be addressed with the Corporate Plan priorities (see page 17) by adopting the Bristol Development Framework and tackling inequalities'.

The city currently compares favourably with other core cities for most health and wellbeing indicators, but will need to re-examine its priorities to maintain progress and prevent deterioration.

4. Determinants of health and wellbeing

Relevant national indicators:

- NI 116 Proportion of children in poverty
- NI 158 Percentage of decent council homes
- NI 167 Congestion – average journey time
- NI 175 Access to services by bus, walking and cycling
- NI 182 Satisfaction with regulatory services
- NI 184 Food establishments broadly compliant with food hygiene law
- NI 186 Per capita carbon dioxide emissions in the local authority area
- NI 187 Fuel poverty - people receiving income-based benefits living in homes with low energy efficient rating
- NI 188 Adapting to climate change
- NI 195 Street and environmental cleanliness.

Determinants of health and wellbeing:



Source: Grant and Barton, University of the West of England 2006

The above diagram illustrates the determinants of health and wellbeing that are discussed in this section.

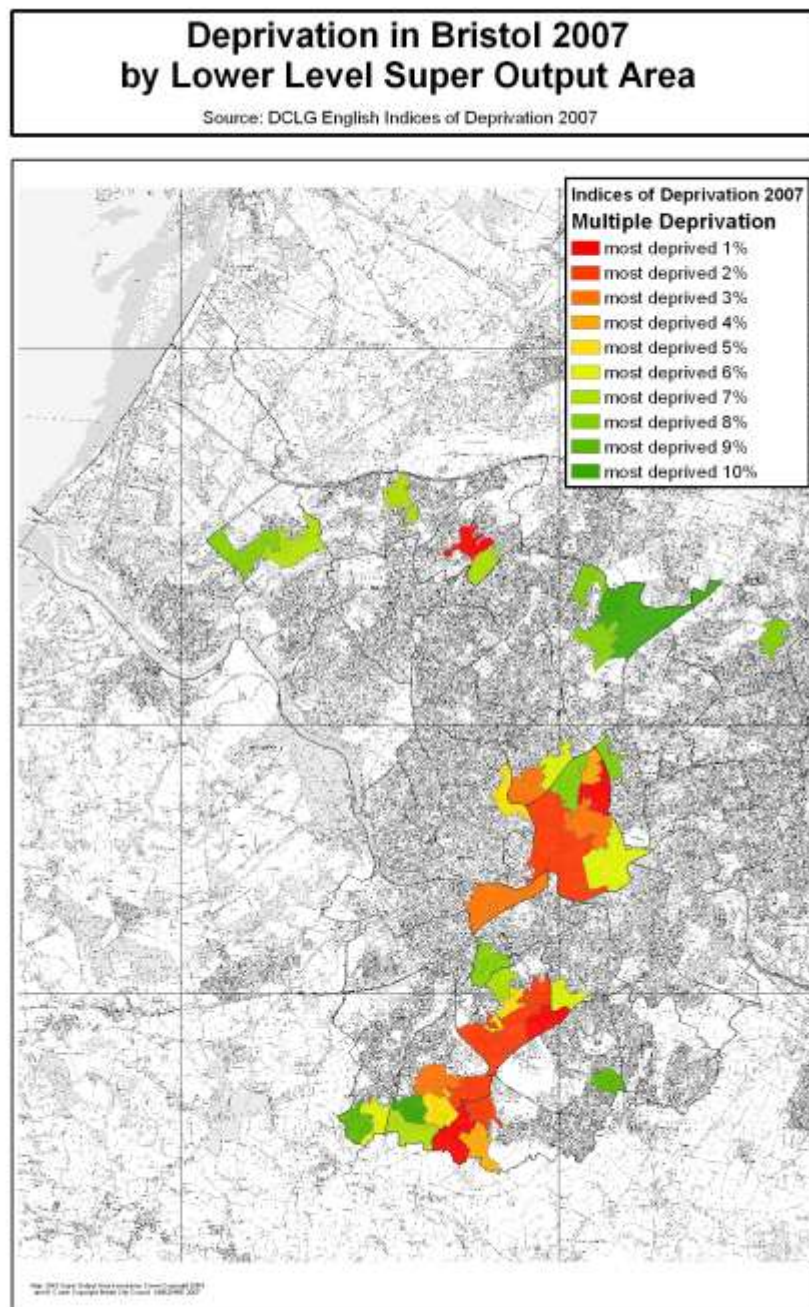
Deprivation

Bristol has some of the most deprived areas in the country, as well as some of the most affluent. Bristol can be studied using 252 small geographical areas known as lower level super output areas (LSOAs). Thirty-nine of the LSOAs are in the most deprived ten per cent nationally, in other words **65,000** Bristol residents (15%) live in the most deprived ten per cent of LSOAs and **20,116** children aged 0-15 years (29%) live in income-deprived households, (see following map).

Bristol has established, through the local Neighbourhood Renewal Strategy, eight priority (most deprived) neighbourhoods that have benefitted from Neighbourhood Renewal funding (2001-2008). Health and other wellbeing inequalities exist between these priority areas and the rest of the city. These areas are:

- Lawrence Weston
- Southmead
- Lockleaze
- St Pauls
- Lawrence Hill and Easton
- Barton Hill Community at Heart area
- Filwood
- Hartcliffe and Withywood Partnership area

Not surprisingly, these deprived neighbourhoods also experience poorer health outcomes than their more affluent neighbours. This is explained more in Chapters 5 to 7.



Environment

Transport and mobility

How we travel can affect access to health services, road traffic accidents, how much exercise we take and traffic pollution.

The city is becoming increasingly congested with a reduction in travel time and a 30% increase in traffic growth in the last ten years. These issues are being tackled in the West of England *Joint Local Transport Plan*¹⁶ submitted to central government.

An efficient transport network is critical for the maintenance of Bristol's economic success. Congestion is estimated as costing £350m per year in the West of England,¹⁷ while traffic speeds are the second slowest outside London. The diagrams below depict the current level of congestion in the Bristol region. The width of the red traffic flow lines increase with congestion. The second diagram shows the level that would be expected in 2016 if the West of England transport vision is not realised.

Traffic congestion 2006



Traffic congestion 2016



Source: Bristol City Council

At present, Bristol is deeply reliant on the car – 60% of journeys to work are by car. Measures to reduce traffic congestion that improve walking, cycling and design of sustainable communities, could also prevent obesity and improve health.

Built environment

There is growing recognition that the leading causes of illness and premature death (including heart disease, respiratory diseases, injuries and mental health problems) may be exacerbated by elements of the built environment which contribute to sedentary lifestyles and harmful environments.¹⁸

Space

Adequate provision of space has been linked to health outcomes. An association has been found between poor mental health and lack of space within the home and social space for interaction outside.¹⁸ Multi-occupation dwellings and high rise flats are housing risk factors strongly associated with poor mental health.¹⁸

Children are at particular risk of poor health as a result of limited space and restricted access to play areas may be linked to behavioural problems.¹⁹

¹⁶ Joint Local Transport Plan for the West of England 2006-2011

¹⁷ West of England Partnership, 2007 – Our Future Transport

¹⁸ Health Impacts of the Built Environment, Institute of Public Health Ireland, 2006

¹⁹ Designing healthy and inclusive public outdoor spaces for young people. Mahdjoubi and Page (2005/6) UoB

Urban areas that lack public gathering spaces can encourage sedentary living habits, social isolation and limit physical activity. The availability of parks and civic spaces increases the potential for social interaction and community activities. Residents are likely to take more physical activity in residential environments that have access to good quality green space. See page 87 for local research using Bristol's quality of life survey.

It has been argued that planning policies have resulted in fragmentation by emphasising the needs of the individual over those of the community, making it difficult for people to develop and sustain social support networks. Neighbourhood designs most likely to promote social networks are those that are mixed use and pedestrian orientated, enabling residents to perform daily activities without the use of the car.¹⁸ Studies have shown that as traffic volumes increase, people's sense of neighbourliness decreases.

Air quality - indoor

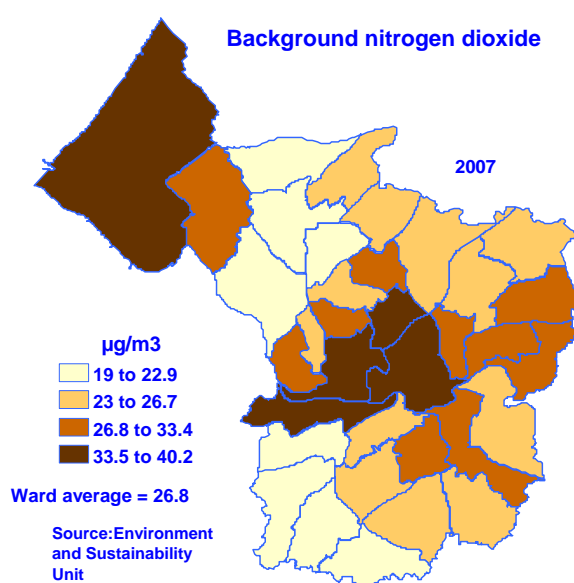
We can spend 80% to 90% of our time indoors. The design of homes and the air we breathe can impact directly and indirectly on our health. Five main harmful substances have been identified indoors by the World Health Organisation (WHO). These are radon, environmental tobacco smoke, cooking and heating pollutants, volatile organic compounds and asbestos, all of which have been linked to respiratory diseases including asthma, lung cancer and mesothelioma. In Bristol homes, radon levels are low compared to the rest of the South West.²⁰

Poor ventilation, damp and mouldy homes and house dust mites are also associated with respiratory ill health, allergies and skin problems. New research has found a further association with fatigue, headache, chronic anxiety and depression.¹⁸

Children are more at risk from poor air quality, as they breathe 50% more air per pound of body weight than adults.¹⁸ The elderly and those with pre-existing respiratory diseases are also more susceptible. See later section on healthy housing (page 49).

Air quality - outdoor

The main source of air pollution in the city is traffic pollution. The city has declared an air quality management area that includes the main arterial traffic routes into the city. The extent of this area is based on pollution levels in excess of the WHO recommended standard set to protect health. Pollution levels in Bristol are generally comparable with core cities.



The key traffic pollutant in the city is nitrogen dioxide (NO₂), see ward map. There is also concern about fine particles (PM₁₀ and PM_{2.5}) and ozone. In general, people in properties close (less than 10 metres) to a busy road may be exposed to concentrations of NO₂ that are higher than the recommended level. There is also difficulty in meeting the less stringent *Joint Local Transport Plan* objectives for nitrogen dioxide.

Despite predictions that urban concentrations of nitrogen dioxide would fall, this reduction has not materialised. This is believed to be mainly due to the increased number of light duty diesel vehicles and to the fitting of catalytically regenerative particle traps to larger vehicles. Concentrations of all these pollutants are still predicted to fall in the future, although not as fast as initially expected.

²⁰ Health Protection Agency – JSNA briefing tool January 2008.

Fine particulate matter can have both acute and chronic effects on health. Ultra-fine or nano-particulate matter smaller than ten microns in diameter (PM₁₀ and PM_{2.5}) can exacerbate respiratory illness. It can also be responsible for cardiovascular and carcinogenic effects, shortening life expectancy. The odds 'of having a' heart attack increases with the increase in ambient PM_{2.5}. This may be due to the large surface area of ultra-fine particles, which are retained longer in the lung, causing inflammation and circulatory problems.²¹ There are still many gaps in our knowledge of the effects on health of particle surface area and particle numbers compared to particle mass. Current health based standards for PM₁₀ and PM_{2.5} relate only to particle mass. But the consensus based on available epidemiological studies is that every 10µg/m³ increase in concentration during an air pollution episode is associated with a one per cent increase in deaths.

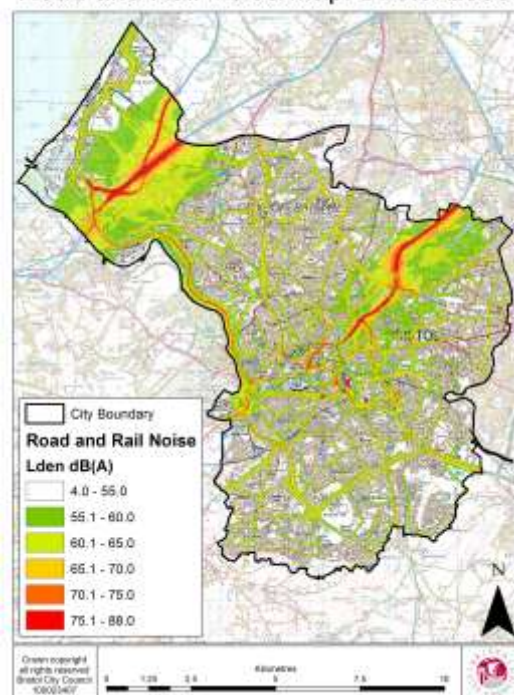
Ozone concentrations can rise during hot sunny spells to levels resulting in acute respiratory health problems for vulnerable people. Ozone can be the result of complex photochemical reactions in the atmosphere and also the long-range movement of air masses from Europe.

Noise

There is increasing evidence that environmental noise has adverse effects on health. The WHO has released preliminary research that shows the association between environmental noise and stress and heart disease. It has been estimated that environmental noise can be implicated in up to three per cent of deaths from ischaemic heart disease. Other effects include sleep disturbance, annoyance, cognitive functioning and mental health. In 2008, the WHO will produce guidelines on noise exposure levels.

Traffic speed and the proximity of heavy traffic have the greatest influence on environmental noise, and in Bristol this form of pollution is growing. Detailed noise mapping is currently being carried out by the city council (see next map) but little reference is currently made to this information in planning and development decisions.²² New developments with the potential to affect noise may be required to submit a noise assessment through the planning process in future.

Road and Rail Noise Map: Bristol 2005



Source: Environment and Sustainability Unit, Bristol City Council

²¹ Environmental Protection UK South West (2008) Presentation by Professor Bob Maynard, Health Protection Agency

²² Environment and Sustainability Unit, BCC

The RANCH study looked at the effect of road traffic and aircraft noise exposure on children's cognition and health in European countries including the UK.²³ In the study, controlling for other social deprivation and health factors, an association was found between aircraft noise and poor reading, comprehension, stress and hyperactivity. Annoyance also increased with aircraft noise. The opposite was found with road traffic noise, where a positive association was found with recall memory.

Water pollution from surface water courses

The Bristol public has access to surface water courses due to the city's numerous rivers and streams, lakes and the Floating Harbour. Low flows, low oxygen content, intermittent sewage and chemical contamination and dumped rubbish can all cause a risk to public health. Prolonged exposure to contaminated water may cause gastrointestinal illness (vomiting and diarrhoea) and Weil's disease (although this is rare). Surface water quality is steadily improving in the city, but can worsen temporarily after heavy rain.

The Bristol Living Rivers Project is a joint initiative between Bristol City Council and the Environment Agency to protect water quality, which is routinely monitored and results and health advice are made available. Illegal misconnections that discharge polluted water into watercourses, are also identified and corrected through Operation Streamclean.

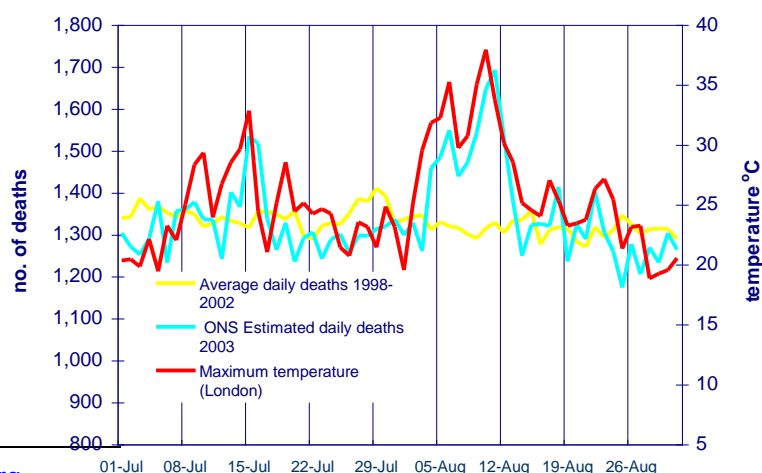
Climate change

Climate change is a public health issue. The city is warming and in 2007 we saw the hottest April and the wettest June since records began. In 2008, we experienced the fourth warmest January, one of the sunniest Februarys in the last 100 years and the hottest May since the 1970s. The latest climate change models predict an increase in annual temperature of between 2.5°C and 3°C by the end of the century. This 'warming' is already affecting the health of the population through increasing heatwaves, pollution, flooding and food-borne/water-borne disease.²⁴

Climate change is due to the increase in greenhouse gases such as carbon dioxide (CO₂) and methane. CO₂ emissions (mainly from buildings and transport) are measured nationally and per capita emissions in Bristol (6.1) are lower than the England average (7.6).

Heatwaves pose the greatest threat to health. Hot summers, like that experienced in Bristol in 2003, could be a regular event by 2040. During the hot summers of 2003 and 2006 a peak was seen in deaths of older people, particularly in their own homes and in residential homes. Heat stress is also exacerbated in overweight and obese adults. Premature deaths and increased hospital admissions during heatwaves have led to heatwave plans for local areas.

August 2003 heatwave mortality (Health Protection Agency 2008)



²³ www.ranchproject.org

²⁴ DOH and Health Protection Agency (2007), Health Effects of Climate Change in the UK

Hot weather is associated with raised ozone levels, secondary particulates and exacerbation of respiratory and circulatory diseases, particularly in the elderly. In 2003, a third of the deaths associated with the hot weather were attributable to poor air quality and two thirds were related to heat stress.

It is estimated that annual ozone concentrations between 2003 and 2020 will result in a 15% increase in attributable deaths and hospital admissions for respiratory illnesses.

Sea level rise will occur with climate change and Bristol has a number of areas at sea level, particularly Avonmouth. But a rise in sea level is unlikely to occur this century.

Bristol is more likely to suffer flooding from flash floods and storms. Wet and windy, stormy weather is also increasing. Increased pollen levels can be triggered by summer storms leading to respiratory illness. Older people and children will suffer more falls, injuries and drowning during storms. People are likely to suffer anxiety and depression following flooding events.

Surprisingly, 70% of hospital admissions due to pollution-related respiratory problems are from low risk patients. This weather-related threat is being addressed by the Met Office and their *Healthy Outlook COPD Forecast Alert Service* in use in Cornwall and the Midlands. Up to a 70% reduction in hospital admissions has been seen for low-risk patients, as well as associated NHS savings (see 'Areas of good practice' page 115).²⁵

Warmer summers are likely to increase food-borne disease. In Bristol, in recent years there has been an increase in campylobacter food poisoning. Water-borne disease is also likely to rise with increased water temperature and increased rainfall over short periods leading to contamination from flooding. Exposure to contaminated water is likely to increase with the growth in water-based leisure activities.

The South West area is more at risk from melanoma skin cancer due to increased ultraviolet exposure in coastal areas. But warmer weather will provide a health benefit and encourage more exercise, if measures are taken to protect the skin against prolonged exposure.

Excess winter deaths and fuel poverty

Excess winter mortality is calculated as winter deaths minus the average of non-winter deaths. For every degree Celsius colder, around 8,000 extra deaths occur nationally.

Climate change will bring benefit from a potential reduction in hospital admissions and early deaths related to cold winters. In 2005-2006 there were 26,000 excess deaths (brought forward) by the cold winter nationally. Of these, 183 deaths occurred in Bristol. Cold-related mortality fell by more than 33% between 1971 and 2003.

People aged over 65 account for 93% of excess winter deaths which are due to respiratory illnesses and thrombosis.

Fuel poverty affects a higher proportion of older people. A household in fuel poverty is defined as one which needs to spend more than ten per cent of its income on heating its home. Cold weather, poor energy efficiency and high energy costs all contribute to fuel poverty. Soaring energy costs will lead to more people living with fuel poverty.

Grants for energy efficiency improvements can help tackle fuel poverty and excess winter deaths and these have been targeted to energy poor areas (see Annex 3). The Standard Assessment

²⁵ AQM Resource Centre & Environmental Protection UK South West, 10th Annual Conference 'Environment and Health – Prevention Before Cure', February 2008.

Profile level (SAP) is a national measure of energy efficiency in homes, where 100 indicates excellent energy efficiency. In Bristol the private sector housing stock has a SAP of 59, compared to 62 for Council stock.

Healthy housing

The Acheson report²⁶ into inequalities and health showed that older people and children are more likely to be affected by poor housing conditions than other sectors of the population.

Bristol has an ageing housing stock - 40% of housing is pre-1919 - requiring more repair and adaptation for our changing population.

Homes for older people

National consultation with older people was carried out in 2007-2008 to support the recent strategy *Lifetime Homes, Lifetime Neighbourhood: a National Strategy for an Ageing Society*. Below is a summary of views.

What older people want

- Housing should be well designed with growing older in mind; it should meet the needs of all age groups. We should build adaptable 'homes for life'.
- Space is important: we often need room to accommodate visiting family or a carer, and need good storage space.
- Housing design should be user-friendly, low maintenance and safe – a downstairs WC and bathroom with shower and bath are especially important. Our homes should also be affordable to heat.
- Access to green, private space, and a safe neighbourhood is important, as is housing that is accessible to good local transport, facilities and amenities.
- Access to independent information and advice about our housing options is needed.
- Support is necessary for people to stay living in their own homes. A reliable repairs and adaptations services is needed for that bit of help around the home.
- But above all, people want to be listened to, to be involved in the design of everything that will affect us, from planning and lifetime homes standards, to the creation of safer environments, to testing new equipment and IT devices.

Bristol's Private Sector House Condition Survey

This survey of Bristol's private sector housing stock was carried out in the winter 2007-2008. The majority of Bristol's housing stock is private sector (85%). A random sample of 1609 homes was selected (weighted with a larger sample from the central area of the city).²⁷ The survey picked up health and safety issues in relation to occupiers.

Recent results indicate that 29,500 properties have failed the Decent Homes Standard (based on the surveyor's judgement of building condition, services and facilities, thermal comfort and hazards

²⁶ Acheson, D (1998) Independent inquiry into inequalities in health.

²⁷ Bristol City Council, Private Sector House Condition Survey 2007-2008.

to vulnerable groups). This is equivalent to 23% of 'non-decent' homes in the private sector and compares with only five per cent failing the Fitness Standard for housing in 2001.²⁸

In contrast, 14% of public sector housing failed the Decent Homes Standard in 2007-2008 (approximately 4,000 homes).

Results indicate the top five hazards were:

1. falls associated with stairs and steps
2. excess cold
3. falls on the level
4. entry by intruders
5. falls between levels, electrical and food safety.

The majority of non-decent housing can be found in the city's Victorian terraced properties.

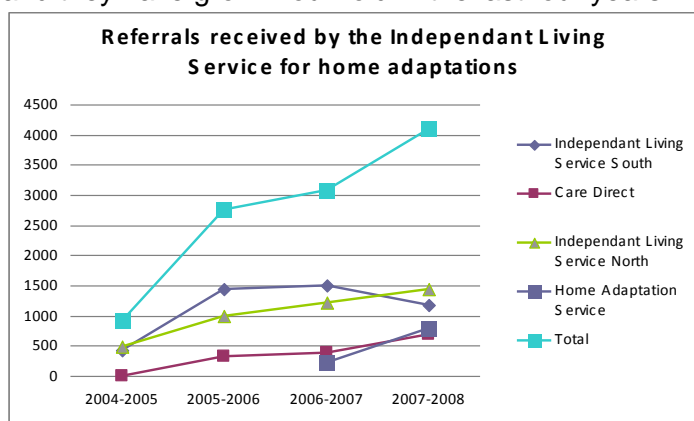
A social survey was carried out as part of the Private Sector House Condition Survey and over 5,000 of the residents who occupied non-decent housing were vulnerable (provisional figures). Vulnerability is defined as:

- in receipt of means tested benefit
- having a long-term illness or disability.

Fifteen percent of homes surveyed were occupied by people with learning difficulties, physical or sensory impairment, mental health issues or long-term illness. Three percent were occupied by unpaid carers, 14% by BME residents and 13% of occupants were over 60 years. In 2.8% of properties disabled adaption requirements had not been met (equivalent to 4,000 private sector homes). There were 4.2% of non-decent properties occupied by children under 16 years. In total the number of vulnerable people living in non-decent housing was 24%.

Home adaptation

The demand for home adaptations can be monitored by referrals received by the Independent Living Service and they have grown four-fold in the last four years.



Source: Neighbourhood and Housing Services

Given the high level of homes occupied by people claiming Disability Living Allowance (page 124), the demand for home adaptations is likely to remain high, with a high level of unmet need. Adapting homes for current occupiers, making use of the Disabled Facilities Grant, can help plug the gap in suitable housing provision for our ageing population.

The Housing Health and Safety Rating System allows the local authority to take action against landlords and home owners to deal with health hazards from falls, excess cold and security.

²⁸ The Housing Health and Safety Rating System superseded the Fitness Standard in 2006.

Supporting People programme

Vulnerable people have the opportunity to improve their quality of life with supported housing and supported living services, provided by the Supported People (SP) programme. The programme provides strategically planned housing-related support services that complement existing care services, in a stable environment which enables greater independence. Very sheltered housing (VSH) is an example and the Council is committed to a VSH programme of about 600 units by 2008-2009.

In 2005, 6,000 older people households were helped by SP funding, of which about 85% were social sheltered tenants: a further 3,000 pensioners were connected to dispersed alarms (alarm system connected to a call centre). These statistics are likely to represent unmet need as we know there are over 13,000 lone pensioners aged 75 and over in the city; 8,000 of these have a limiting long-term illness and 10,500 people aged 65 and over are claiming Attendance Allowance.

Only a small minority of older people households (estimated to be about 1,200-1,500) receive detailed information and advice about their housing independence options annually. In addition, only limited information is shared between Council departments on the support needs of vulnerable tenants, tenants with learning difficulties and older carers.

Areas of good practice

Health referrals to the Warm Front Scheme

Those qualifying for the national Warm Front Scheme receive grants for heating and insulating their homes, so reducing fuel poverty. West Sussex PCT have coordinated the promotion of this scheme with the annual flu jab campaign, and referred patients in most need from a fuel poverty/health perspective. The success of this joined up work was shown in 2006-2007 by 30% of all national referrals coming from West Sussex alone.

Safe at Home initiative by Age Concern Milton Keynes aims to reduce fire, crime and fear of crime amongst vulnerable adults, and to maintain people safely in their own homes for as long as they wish. The scheme has been designed for the first person visiting a vulnerable adult at home to carry out a brief single assessment. Any action required is then referred to the relevant agency. Professionals likely to visit homes of vulnerable people have appropriate training on how to reduce fear of fire and crime and poor housing conditions.

Lifetime homes

Registered social landlords (RSLs) nationally are already installing 'bathrooms for life' to suit any potential occupier – abled or disabled - with flexible appliances. This approach is being piloted by Monmouthshire County Council with flexible appliances preferred for Disabled Facilities Grants.

LOCAL VOICE

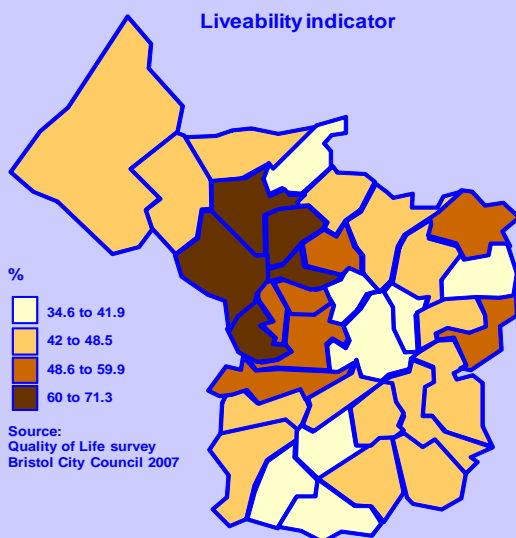
Transport

According to a survey of Bristol's Citizen Panel in October 2007, the worst thing about Bristol was the level of traffic congestion. This was also an issue that was considered to have got worse.

Liveability

The liveability indicator was developed by the Bristol Partnership (Environment Delivery Group) and has been used to measure resident satisfaction with the cleanliness (pollution) and attractiveness (built and green space) of the environment. The indicator is measured using the Council *Quality of Life Survey* (see Annex 13). An average 49% of residents were satisfied with the liveability of their neighbourhood in 2007, and 37% were satisfied who lived in neighbourhood renewal areas. Although the indicator value has improved in recent years, there is a widening gap in satisfaction between the most deprived wards and the rest of the city.

In 2007, residents said street litter, dog fouling and traffic congestion were some of the worst things about living in Bristol. Residents living in the west/northwest areas of the city reported the highest levels of liveability (see map below).

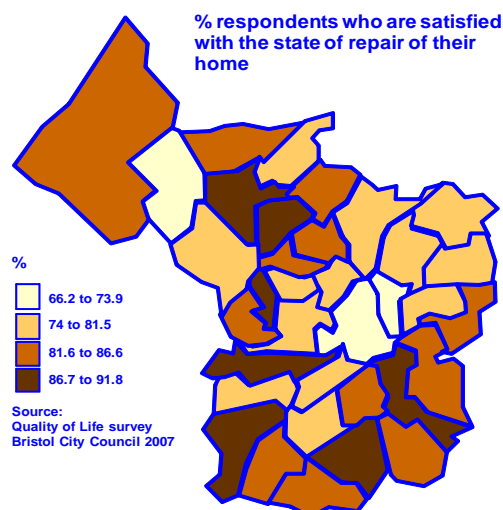


Healthy homes

In the Bristol Older People's Forum survey (BOPF) questions were asked about their homes and:

- 8% said their homes were in a poor state of repair, and more than half said their homes were in a good state of repair.
- 8% also said their homes were unsuitable for their needs, and a further 38% said the suitability of their homes was okay.

In the Council quality of life survey 2007, residents were asked 'how satisfied are you with the state of repair of your home?' The majority of residents (82%) said they were happy, but over a quarter of residents in Lawrence Hill, Easton and Kingsweston were not satisfied.



In February 2007, the Council carried out a survey of homeowners as part of the consultation for their private housing policy. The items causing most concern to homeowners were:

- damp and mouldy conditions – 21% of homes
- no double glazing – 20% of homes
- lack of modern bathroom facilities – 17% of homes
- lack of modern kitchen facilities – 17% of homes
- lack of energy efficiency measures – 14% of homes
- concern on safety of electrical wiring – 14% of homes.

Food Safety

The public is at risk from food poisoning and a number of food-borne infectious diseases due to poor food hygiene practices. Nationally food hygiene failure by businesses causes over half a million cases of disease and 300 deaths every year. Total costs to the economy are around £900m each year²⁹.

Bristol City Council has a programme of risk-based inspection of its 4,500 food premises in the city. Bristol Port receives 210,000 tonnes of imported food and imports are checked under food safety legislation.

Every food business is required to implement a documented food safety management system to help reduce the incidence of food poisoning. Approximately 700 Bristol food premises are non-compliant. Many food businesses in the city are owned by people from Black and minority ethnic communities and a higher proportion of these businesses are subject to enforcement action (see 'recent current initiatives' page 64).

Infectious disease

Bristol City Council receives approximately 1,200 infectious disease notifications and many are related to contaminated food or water. Spread of infectious disease can be a problem at schools and can be reduced by good hygiene practices.

²⁹ South West Regulators' Forum, Oct 2007 (Rogers Review)

Workplace safety

Work-related ill health accounts for half a million cases each year in the UK. Resulting sickness absence costs employers from £360m to £610m.²²

In Bristol, the economic cost of work related accidents and ill health is estimated at £83m per annum. There are an estimated 266,000 working days lost; 204,000 due to work-related ill-health and 62,000 due to work related injury. The most frequent types of reported accidents are slips/trips/falls and manual handling injuries. The Council inspects 12,000 premises under Health and Safety legislation to ensure workplace safety and protect the health of employees.

Of increasing concern is the high number of migrant workers coming to Bristol (page 38) who work in high risk jobs (repetitive tasks, long hours and shift work). These workers may be vulnerable due to their lack of knowledge of the English language and workplace rights.

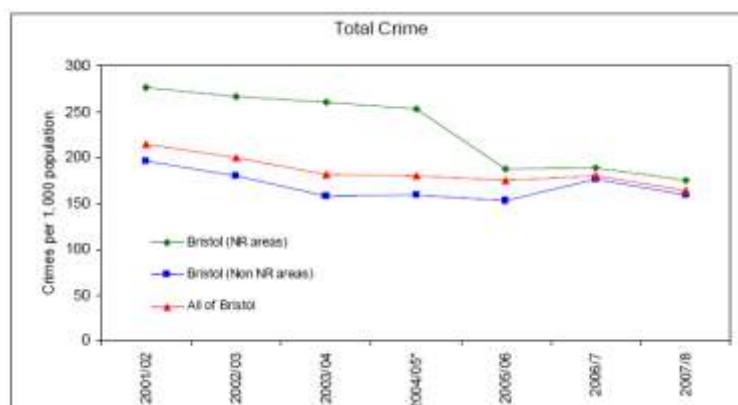
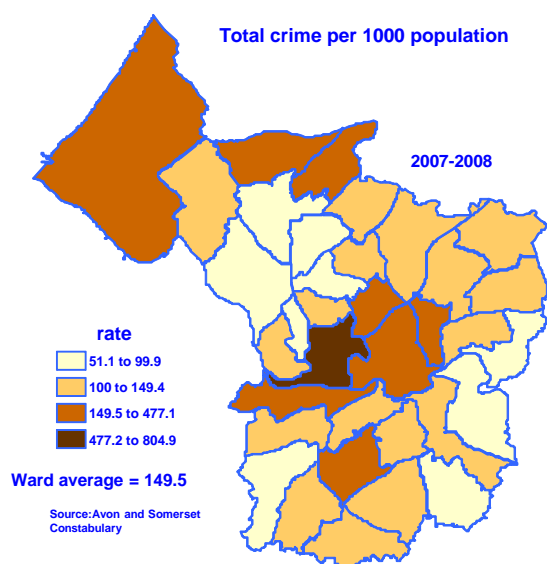
Community safety

Crime and fear of crime

There has been a steady drop in total recorded crime in Bristol, recorded by Avon and Somerset Constabulary since 2004 (see next graph).

In 2007- 2008 Bristol had a reported crime rate of 164 crimes per 1,000 population. This is higher than the England and Wales average. When violent crime in Bristol is compared to that in other core cities, Bristol ranks sixth worst (out of eight).

Source: Bristol Partnership, SON crime data



The map above shows most crime occurs in the central area and often relates to alcohol/binge drinking in and outside licensed premises.

The city also has the second highest number of drug users in treatment in the country. Approximately three per cent (8,000) of Bristol's population aged 15-64 years are problem drug users, which is higher than the England average of one per cent (page 73).

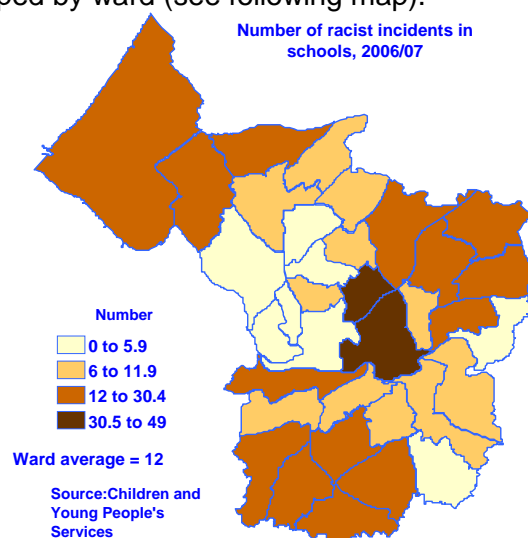
Discrimination, harassment and bullying

Persistent discrimination, harassment and bullying, regardless of age, can have long-lasting effects of depression, low self-esteem, self harm or attempted suicide.

A MORI poll found that 35% of pupils in mainstream schools fear being bullied, while 23% report having been bullied. In Bristol, 22% of young people at secondary schools said they had been bullied (see Annex 13 and 'local voice', page 59, for residents' perceptions in Bristol and young people's views on bullying).

Racial discrimination in schools

A recording system for racist incidents exists in schools and includes information about the victim, perpetrator, incident and follow-up action. Monitoring takes place on a daily basis and racial incidents can be grouped by ward (see following map).



There were 441 incidents recorded in schools in 2006-2007. In 2007-2008 this increased by nine per cent to 480 incidents. The highest proportion of incidents was recorded in primary schools, the largest group of victims were Black or Black British (38%), dual heritage (24%) and Asian (15%) pupils. More incidents occurred in Ashley and Lawrence Hill where there is a high proportion of pupils from BME groups.

Domestic abuse and children at risk

Of all violent crime, domestic violence is the least likely to be reported. Research shows that less than ten percent is reported to the police. In fact, up to 80% of all reporting goes firstly to health services. Incidents reported to the police in Bristol have shown an overall increase over the past five years and this is a positive indication that more people have confidence in the police reporting system and follow-up action.

The frequency of domestic violence and abuse in Bristol is estimated to be 26,195 incidents per annum, which equates to 70 a day (*Bristol Domestic Violence and Abuse Strategy 2008-2011*). In 2006-2007, 7,009 incidents were reported to the police and 1,383 children were living in the families involved. In 2007-2008 there was an 11% increase in the number of notifications to the police of domestic abuse incidents involving households with children.

Most domestic violence incidents are reported in areas where the population is most dense and in smaller homes where neighbours are more likely to hear and report violence. Research shows there is no evidence to associate more domestic violence with poverty and deprivation.

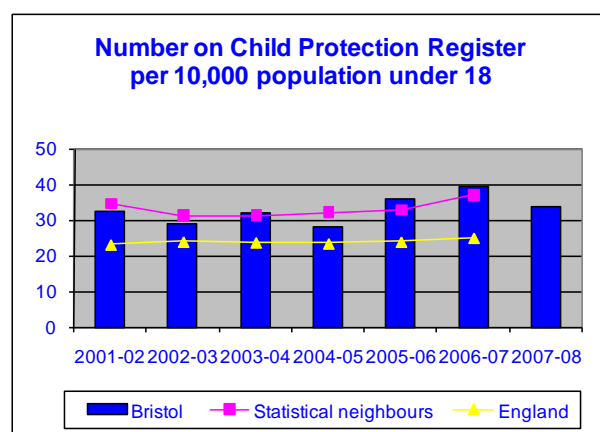
Children are present in approximately 30% of domestic violence incidents and are at an increased risk of behavioural problems, emotional trauma, and mental health difficulties in later life.

Child Protection Register

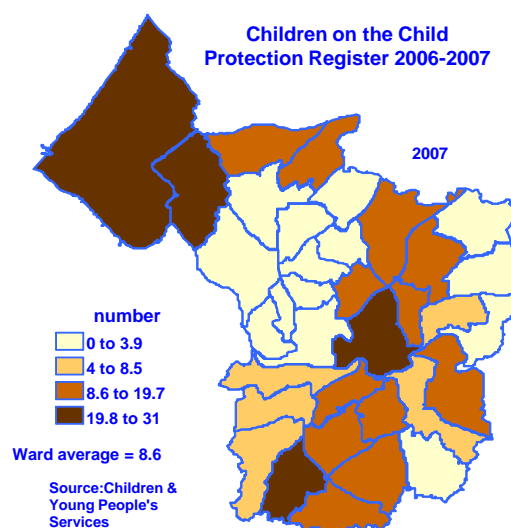
The Child Protection Register (CPR) indicates children at risk of abuse in the family. There were 314 children on the CPR at 31 March 2007.

From 2001-2002 to 2006-2007 there was an increase in rate from 33 per 10,000 children on the register to 40. However, the length of time the children are on the register is decreasing. Bristol's rate of children on the CPR dropped in 2007-2008 and is similar to its statistical neighbours (see page 2), but higher than the England average (see following graph). The ratio of BME to white children on the CPR is similar to the proportion of BME children in the local population. This indicates BME children are able to access services and can be identified for referral.

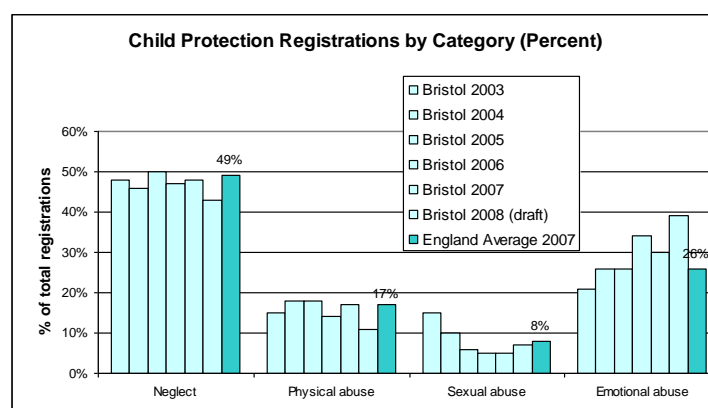
The distribution of these children is constantly changing, and in 2006-2007, the majority lived in Avonmouth, Kingsweston, Hartcliffe and Lawrence Hill. There is a relationship between wards with a high number of incidents of domestic violence and children on the CPR (see map below).



Source: Children and Young People's Services



The most frequent reason for registration is neglect. In the period 2006-2007 a lower proportion of registrations were due to physical abuse and sexual abuse (see following graph).

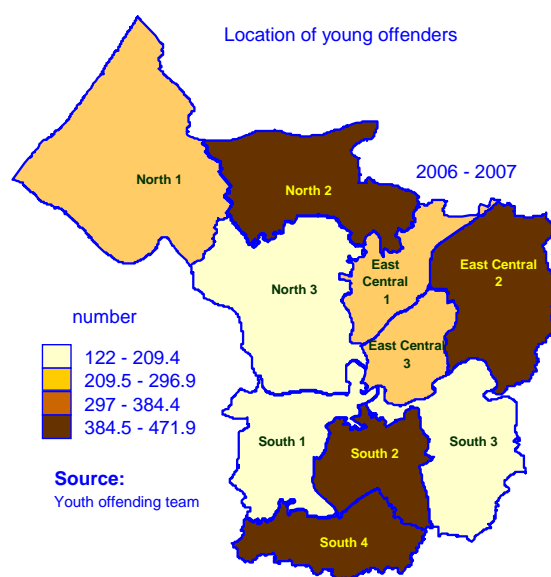


Source: Children and Young People's Services

Young offenders

Bristol's Youth Offending Team (YOT) keep records of all offenders and offences committed by young people between the ages of 10 – 17 years. In 2006-2007 there were 3,209 offences and 1,317 offenders, with many offenders committing more than one offence. The majority of offences were committed by 15-17 year-old males (996 offenders).

The following map shows the home location of offenders. Areas where there are large housing estates like Southmead, Lockleaze, Knowle West, Hartcliffe and Whitchurch have more young offenders; these areas also have a high population of children between the ages 10 – 17 years. The most frequently committed crimes are motoring, theft, violence against the person and criminal damage.



The status of young people can be a risk factor for their likelihood of offending (ie. not in education, training, employment or excluded from school). Youth surveys have also indicated young people most likely to get into trouble with the police are those who:

- are disaffected with school
- have friends and acquaintances who exhibit anti-social behaviour
- hang around in public places and have parents or carers who have little knowledge of their whereabouts.

Fear of Crime

In the annual quality of life surveys (Annex 13) residents were asked:

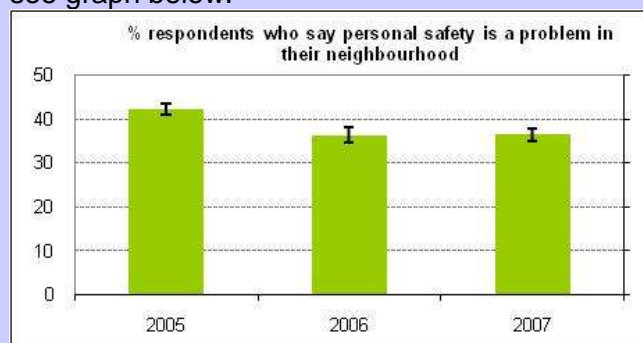
"How safe do you feel at night and during the day?"

"Do you feel crime has got worse over the last three years?"

"Is your personal safety a problem in your neighbourhood?"

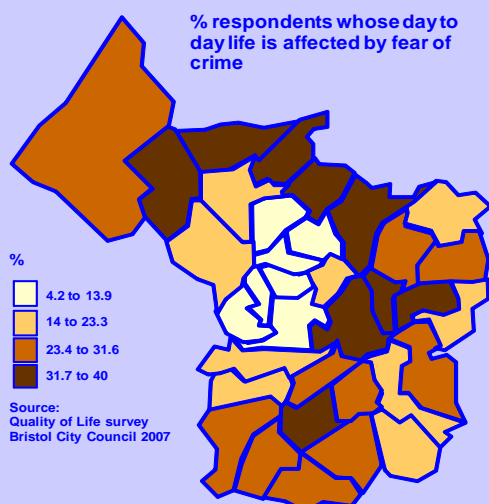
"Does fear of crime affect your day-to-day life?"

The proportion who feel safe at night and during the day has not changed over recent years and residents who feel crime has got worse has also stayed the same. But the proportion of residents who feel their personal safety is a problem, has lowered (improved), see graph below.



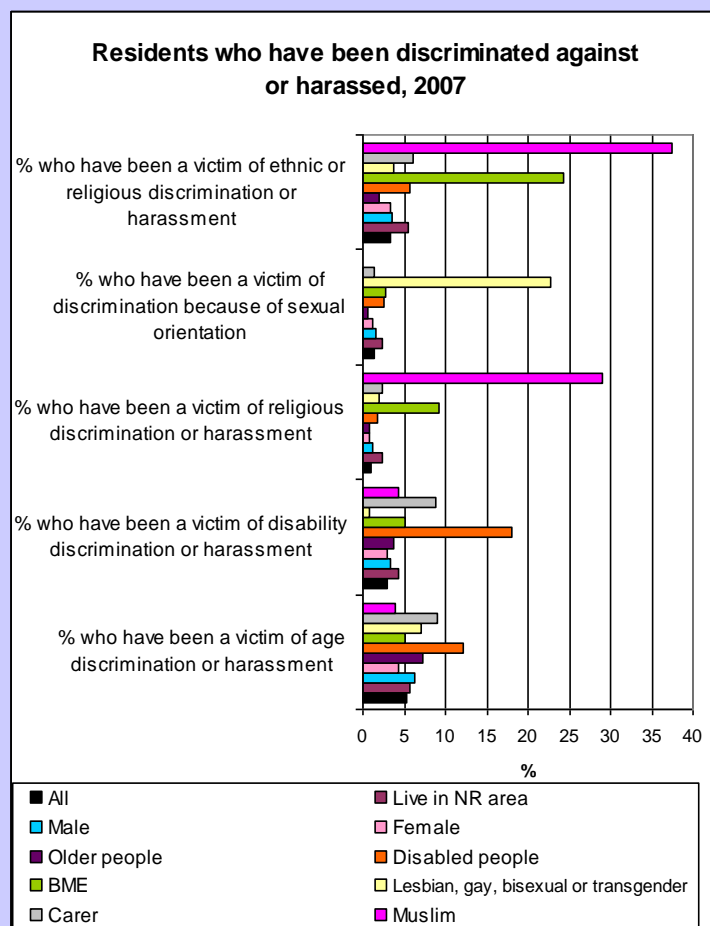
Source: Quality of Life Survey

Results from the 2007 survey also indicated 23% of residents feel fear of crime affects their day-to-day life (25% in 2006). This indicator is higher for residents living in neighbourhood renewal areas (37%), disabled people (39%), BME people (32%) and older people (26%). The following map shows the large variation in 'fear of crime' across Bristol.



Discrimination and harassment

Residents were asked in the *Quality of Life Survey 2007* if they had been discriminated against or harassed in the last 12 months, due to their age, disability, religion, sexual orientation, ethnicity or race.



Source: Quality of life survey results, 2007

Results shown in the graph above indicate people of Muslim faith, BME groups, disabled people and carers suffer more discrimination and harassment. Age discrimination generally, however, is the most common cause of harassment and discrimination for most residents in the survey (over 8,000 residents responded to this survey).

Older people and fear of crime

Researchers at Bristol University have been assessing a measure that reflects quality of life of older people.³⁰ They have identified

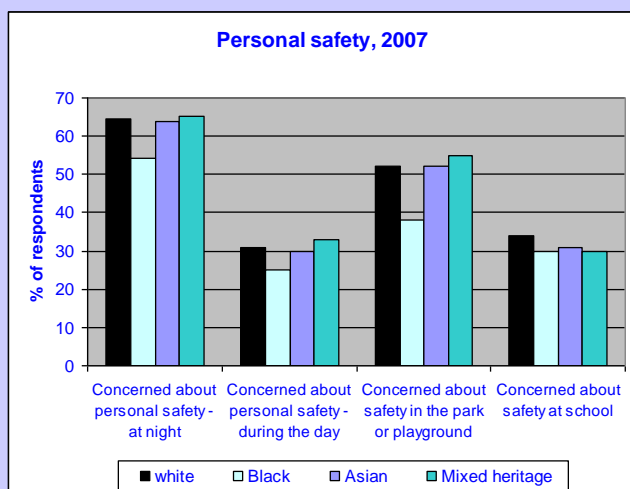
³⁰ Dept of Social Medicine, University of Bristol, Terry Flynn (2008) ICECAP Instrument valuation survey.

through qualitative research five attributes of a quality of life score: attachment, security, role, enjoyment and control. Using the results from Bristol residents' quality of life survey, they have found an association between a low quality of life score for older people and fear of crime affecting day-to-day life.

Young people and personal safety

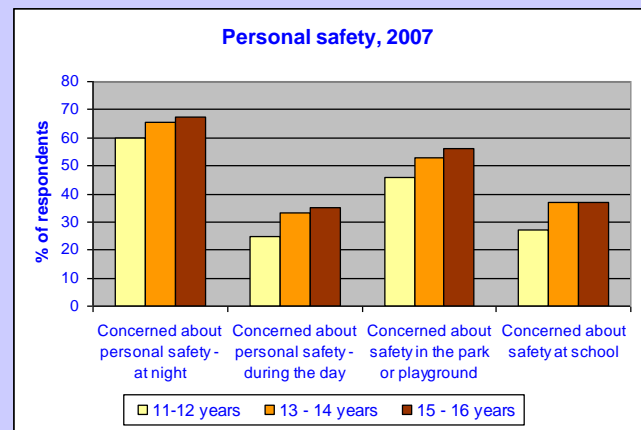
Fear for personal safety was explored in the *Young People's Quality of Life Survey 2007* (Annex 13). Questions covered safety outside during the day, at night, in parks/playgrounds and at school. Of all young people, 64% were concerned about personal safety at night (same proportion was recorded in 2006), and 31% were concerned about the same during the day. Over half were concerned about personal safety in parks and playgrounds and a third were concerned with safety at school.

When the survey was analysed by gender, girls were more concerned about their personal safety when outside. Black young people were least concerned about personal safety compared to mixed heritage children.



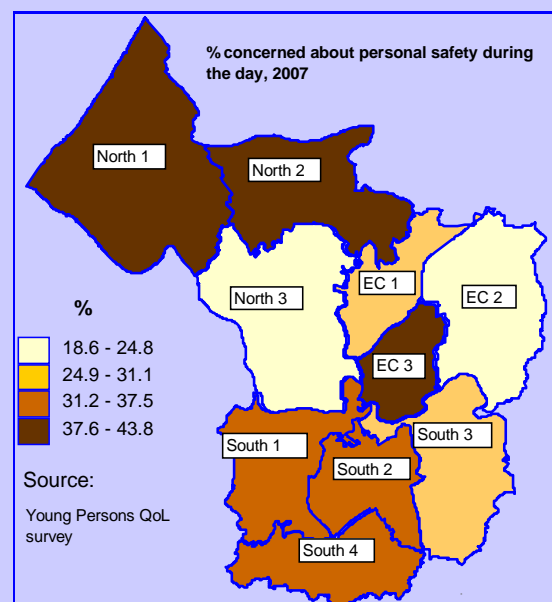
Source: Young People's Quality of Life Survey

Age can also affect perception of personal safety and older teenagers were more concerned about safety generally (see following graph).



Source: Young People's Quality of Life Survey

The following locality map is based on those pupils who gave their postcodes. Young people in west/central area and east Bristol have the least personal safety concerns.

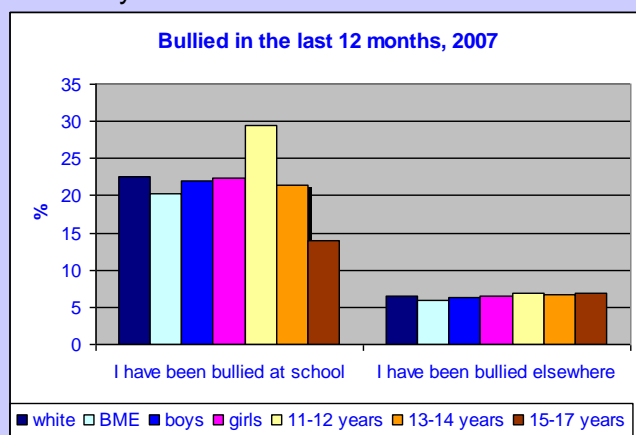


When analysed by neighbourhood renewal (NR) and non-NR areas, significantly more young people were concerned about their safety in NR areas, particularly at night.

Bullying

In the *Young People's Quality of Life Survey 2007* concern about bullying was measured, as well as the number of victims and perpetrators of bullying. The question was asked 'Have you been bullied in the last 12 months?' At school, 22% said they had been bullied and only seven per cent said they had been bullied elsewhere. In 2006, 15% said they had been bullied at school and 12% bullied elsewhere. Gender and ethnic

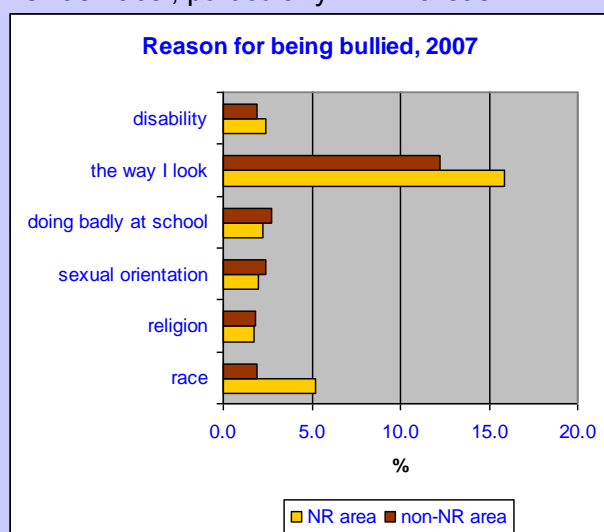
background had less influence than age and 29% of younger pupils aged 11-12 years said they were bullied at school, compared to 14% of 15-16 year olds.



Source: Young People's Quality of Life Survey

When analysed spatially by neighbourhood renewal (NR) and non-NR areas, more young people were bullied in school in NR areas (23%) compared to elsewhere (19%).

The following graph shows 'the way I look', as the main reason for being bullied at school as well as 'race', particularly in NR areas.



Source: Young People's Quality of Life Survey

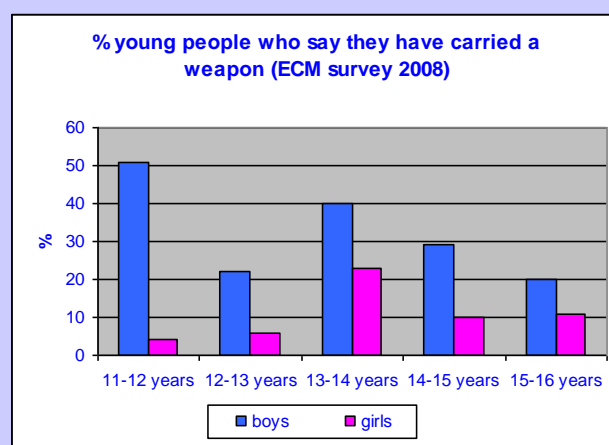
An additional question was asked 'Have you bullied another person in the last 12 months?' Twelve per cent said they had (9% in 2006). 16% of boys, 9% of girls and 15% of BME pupils admitted to bullying. There was a small difference between those who admitted to bullying in NR areas (15%) compared to non-NR parts of the city (11%).

This indicator is likely to underestimate the proportion of children who say they bully others, as different pupils have different definitions of bullying. Also many would be too ashamed to admit to bullying.

In the *Every Child Matters Survey 2008* (Annex 14) 25% of secondary school pupils and 29% of primary school pupils said they had been bullied in the last 12 months. Nearly a quarter of secondary and 28% of primary pupils said they felt afraid to go to school (sometimes and often) because of bullying. Ten percent admitted they had bullied others.

Over a fifth of pupils who had been bullied said 'the way I look' was the reason.

In the *Every Child Matters Survey 2008*, overall 20% of secondary pupils (mainly boys) said they had carried a weapon for self protection. The breakdown by gender and age is shown below.



Source: Every Child Matters Survey

In the same survey 58% said they used internet chat rooms and 18% of these pupils said they had received a chat message that had scared or upset them.

Neighbourhood Partnership area summary

Determinants of health and wellbeing vary across the city's neighbourhood partnership areas.

Significantly better than average

Significantly worse than average

Neighbourhood Partnership	Deprivation areas 2007 (most and least deprived 10% LSOAs nationally)	Unemployed claimants (highest and lowest 10% LSOAs nationally)	Poor air quality 2006	Liveability 2006	Energy poor housing (targeted for energy efficiency grants 2000-08)	% residents who feel fear of crime affects day to day life 2006
1. Avonmouth and Kingsweston	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth
	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston
2. Henbury and Southmead	Henbury	Henbury	Henbury	Henbury	Henbury	Henbury
	Southmead	Southmead	Southmead	Southmead	Southmead	Southmead
3. Stoke Bishop, Westbury-on-Trym and Henleaze	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym
	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop
	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze
4. Cabot, Clifton, Clifton East	Cabot	Cabot	Cabot	Cabot	Cabot	Cabot
	Clifton	Clifton	Clifton	Clifton	Clifton	Clifton
	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East
5. Cotham, Redland and Bishopston	Cotham	Cotham	Cotham	Cotham	Cotham	Cotham
	Redland	Redland	Redland	Redland	Redland	Redland
	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston
6. Horfield and Lockleaze	Horfield	Horfield	Horfield	Horfield	Horfield	Horfield
	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze
7. Eastville, Frome Vale and Hillfields	Eastville	Eastville	Eastville	Eastville	Eastville	Eastville
	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale
	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields
8. Ashley, Lawrence Hill and Easton	Ashley	Ashley	Ashley	Ashley	Ashley	Ashley
	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill
	Easton	Easton	Easton	Easton	Easton	Easton
9. St George East and St George West	St George East	St George East	St George East	St George East	St George East	St George East
	St George West	St George West	St George West	St George West	St George West	St George West
10. Southville and Bedminster	Southville	Southville	Southville	Southville	Southville	Southville
	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster
11. Bishopsworth, Hartcliffe and Whitchurch Park	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth
	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe
	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park
12. Filwood, Knowle and Windmill Hill	Filwood	Filwood	Filwood	Filwood	Filwood	Filwood
	Knowle	Knowle	Knowle	Knowle	Knowle	Knowle
	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill
13. Brislington East and Brislington West	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East
	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West
14. Stockwood and Hengrove	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood
	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove

Key pointers for determinants of health and wellbeing

Deprivation

Health inequalities can be directly related to levels of deprivation. A substantial proportion of Bristol people (16%) live in the most deprived ten per cent of neighbourhoods nationally and suffer poor health, low skills levels and low expectations.

- Twenty-nine per cent of children aged 0-15 years live in income-deprived households.
- The birth rate is rising most rapidly in areas of the city experiencing deprivation, and amongst the city's new international migrants.
- A higher proportion of people with disabilities and limiting long-term illness live in deprived parts of the city.
- Lawrence Hill has the largest ward population with some of Bristol's most deprived communities and the lowest life expectancy. In the past five years this ward has experienced one of the biggest increases in population in the city.

Related current initiatives

- The independent Legacy Commission will oversee a three-year programme of work to tackle inequalities in services, for the benefit of all communities.
- Job opportunities are being increased for workless people in disadvantaged neighbourhoods. The new Cabot Circus shopping development will help reduce the number of people claiming incapacity benefits in Ashley, Lawrence Hill and Filwood wards (target 300 claimants).

Gaps in our knowledge

- There is no comprehensive count of inward migrant numbers in Bristol.

Education

Education has a significant bearing on healthy lifestyles, and those with no or low level qualifications and the unemployed are at higher risk of obesity, common mental health problems, general wellbeing and teenage pregnancies amongst young women.

Related current initiatives

In the next three years the local authority is:

- raising attainment in all key stages and in relation to under-performing groups
- improving attendance at schools and reducing exclusion
- rebuilding schools and developing learning environments
- providing 24 new children's centres
- improving sex and relationships education and learning from good practice elsewhere.

Environment

Measures to reduce traffic congestion that improve walking, cycling and design of sustainable communities, could also prevent obesity and improve health.

- In recent years traffic emission reduction measures have failed to impact on current outdoor pollution levels.
- Children and older people are at greater risk from poor indoor and outdoor air quality.

Climate change will mean between 2008-2020 the risk of a heatwave, like the hot summer experienced in 2003, will increase and be a regular event by 2040.

- Thunderstorms and flooding will also become regular.

- Air pollution from ozone concentrations between 2003 – 2020 will result in a 15% increase in attributable deaths and hospital admissions for respiratory illnesses. Admissions could also increase, triggered by high pollen levels during thunderstorms.
- Older people are the population at greatest risk from heat stress, respiratory illness and injuries.
- But excess winter deaths due to cold weather will decrease.

Related current initiatives

- A health impact assessment has been undertaken of the *Bristol Development Framework Preferred Options* paper. This has reinforced the role of neighbourhood design to promote pedestrian orientated mixed use developments, enabling residents to perform daily activities without the use of the car and promote health and wellbeing.
- Improving parks and open spaces in deprived parts of the city is a priority and Local Area Agreement stretch target.
- Issues relating to climate change, reducing greenhouse gases and improving liveability are being tackled through the Green Capital initiative. Its agenda for the city includes:
 - creating a high quality, clean attractive built and natural environment
 - tackling the causes of climate change
 - supporting the creation of balanced and sustainable communities within Bristol
 - coordinating opportunities through the region's projected growth and local regeneration priorities.
- Reducing traffic congestion and air pollution is being addressed through the measures in the Joint Local Transport Plan with options to increase bus transport and cycling.

Gaps in our knowledge

- There has been limited research on the impact of the built environment on physical activity.
- There are no pedestrian counts so we cannot monitor walking improvement.
- There is insufficient knowledge on the impact of thunderstorms and flooding on wellbeing.
- There are still many gaps in our knowledge of the effects of particulate pollution on health. Current health-based standards for PM₁₀ and PM_{2.5} relate only to particle mass. Increasing nano-technology could increase the risk of nano-particulate material and risk of respiratory/circulatory problems.

Healthy housing

Poor housing conditions can lead to poor health and present health and safety hazards. Given the high level of homes occupied by people claiming Disability Living Allowance and the ageing population, the demand for housing independence and home adaptations is likely to remain high. Only a small minority of older people households receive detailed information and advice about their housing independence options annually.

Three quarters of all homes are privately owned or rented and this proportion has increased since 2001. The recent *Private Sector House Condition Survey 2007* estimated that:

- 23% of private sector homes (29,500) are non-decent
- most non-decent housing is in Cabot ward
- the number of vulnerable people living in non-decent homes is 24%
- falls in homes and poor energy efficiency are the most common hazards
- 4,000 private sector homes require adaptations for older people.

Soaring energy costs will lead to more people living with fuel poverty.

Related current initiatives

- 'Signposting' is a private sector housing project to flag up hazards found during routine inspections, and alert the correct agency e.g. fire hazard, housing adaptation, security upgrade, energy efficiency. A new pilot is due to start to tackle 'falls prevention' in north Bristol, targeting older and disabled people.
- Energy efficiency is being improved in homes by subsidising loft and cavity wall insulation in areas with fuel poverty.
- Subsidised loans are being offered to homeowners to enable them to improve the condition of their properties to meet the Decent Homes Standard, available from Wessex Home Improvement Loans in partnership with the Council.
- Landlords are to be offered more support and advice for managing housing for vulnerable people.
- Home adaptations, making use of the Disabled Facilities Grant are helping to plug the gap in suitable housing provision for our ageing population.
- A Council tenancy audit is being rolled out based on pilots in Bedminster and Barton Hill, to profile tenants and their support needs.
- A property database is being developed by the Council to identify public sector adapted properties for re-use by disabled tenants.
- A *Supporting People Strategy Update* is currently being produced and will go out for consultation in August 2008. Supporting People is also implementing a commissioning plan for older people.

Gaps in our knowledge

- Only limited information is shared between the Council teams on the support needs of vulnerable tenants, tenants with learning difficulties and older carers.
- The tenure of people claiming Disability Living Allowance is not recorded. Tenure is also not recorded for hospital admissions attributed to falls. If this information was available, it would enable forward planning of any home adaptations required to the Council, or private sector housing stock, reducing hospital stays.

Food and workplace safety

Poor food hygiene practices in food businesses can lead to risks from food-borne infectious disease. Many food businesses in the city are owned by people from BME communities and a higher proportion of these are subject to enforcement action.

Of increasing concern is the high number of migrant workers coming to Bristol who work in high risk jobs (repetitive tasks, long hours and shift work). These workers may be vulnerable due to their lack of knowledge of the English language and workplace rights.

Related current initiatives

- Safer Food Better Business Project is improving food hygiene in premises owned by the BME community. It provides training and coaching in a variety of ethnic languages.
- A new intervention approach is being introduced to promote food safety practices in relevant premises, and compliance with food hygiene law across the city.
- Preventing the spread of infectious disease in schools through improved reporting, control and management.

Community safety

High crime levels increase fear of crime that can lead to depression, isolation and vulnerability and poor general wellbeing. The Bristol crime rate is higher than the England and Wales average and when compared to other core cities for violent crime, Bristol ranks sixth worst (out of eight).

- Most crime occurs in the central area and often relates to alcohol/binge drinking in and outside licensed premises.

- There has been an 11% increase in the number of domestic abuse incidents involving households with children, who are at an increased risk of behavioural problems, emotional trauma, and mental health difficulties in later life.
- The proportion of children on the Child Protection Register is increasing. Neglect and emotional abuse are the main reasons for registration.
- Approximately a third of residents living in neighbourhood renewal areas, children and young people, disabled people and BME people feel fear of crime affects their day-to-day life (city average is 23%).
- Local survey results show people of Muslim faith, BME groups, disabled people and carers suffer more discrimination and harassment. Age discrimination generally however, is the most common cause of harassment and discrimination for most residents.
- More children are bullied in school than elsewhere and a quarter are afraid to go to school because of bullying. One in five young people aged 11-16 years said they carried a weapon (mainly boys) for self-protection.

Related current initiatives

- The Council is reducing the number of children in care and improving outcomes for vulnerable children by strengthening prevention and early intervention arrangements increasing the number of children adopted.
- There is a consistent multi-agency response to domestic abuse referrals involving children, through area based services.
- Anti-bullying campaigns have been further developed and are re-focusing how we support the improvement of behaviour in schools.
- There is new guidance for schools on dealing with racist, disablist and homophobic harassment.
- Bobby Van Scheme involves working with Avon and Somerset Constabulary to reduce crime and fear of crime and is targeted at victims of burglary who are aged over 60 years. The scheme covers security improvements and fitting smoke alarms where appropriate.

Summary of Chapter 4

In Bristol, like other core cities, there are many close links between deprivation, poor housing and healthy outcomes. Almost a quarter of Bristol's private sector homes are 'non-decent'. At the same time housing requirements are changing due to an ageing population, smaller household units and net immigration. A high proportion of older people have falls in their homes. Many homes are not designed or adapted for elderly or disabled occupiers.

There are also close links between the environment (traffic congestion, pollution, lack of space, community safety) and physical and mental wellbeing. Poor urban planning that promotes car use, congestion and fear of crime can limit opportunities for physical exercise, recreation and community interaction.

Another emerging theme is the link between poor educational attainment and skills and unhealthy lifestyles (substance misuse, smoking, teenage pregnancy, diet), common mental health problems and low self esteem. Please see next chapter where some of these issues are explained in more detail.

People at each end of the age spectrum – the very young and very old – have the highest requirements for primary and secondary care.

Some of these issues will be addressed with the Corporate Plan priorities by adopting the Bristol Development Framework, reducing traffic congestion, raising attainment at all key stages and at 19, tackling inequalities, tackling fear of crime, improving parks and open spaces and increasing opportunities for active travel. But healthy housing is a key issue that arguably needs a higher profile amongst corporate and partner priorities.

5. Healthy lifestyles

Relevant national indicators:

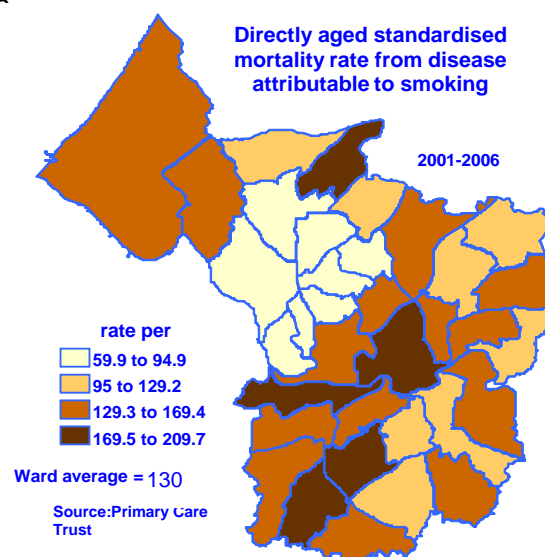
- NI 6 Participation in regular volunteering
- NI 9 Use of public libraries
- NI 11 Engagement in the arts
- NI 32 Domestic violence
- NI 39 Alcohol-harm related hospital admission rate
- NI 53 Prevalence of breastfeeding at 6-8 weeks from birth
- NI 55 Obesity among primary school age children in Reception
- NI 56 Obesity among primary school age children in Year 6
- NI 110 Young people's participation in positive activity
- NI 112 Under 18 conception rate
- NI 123 16+ current smoking rate prevalence

Smoking

Smoking is the single biggest cause of the difference in death rates between the rich and the poor. Early deaths attributable to smoking are significantly higher in Bristol compared to the rest of the South West (see Annex 12A).

In Bristol, the number of adults who smoke is falling. Recent estimates modelled from the Health Survey for England 2003-2005, indicate that 25% of Bristol people smoke, which is similar to the England average of 24%. Bristol ranks joint lowest (best) out of the eight core cities.³¹ The previous survey (2000-2002) showed 34% smoked in Bristol compared to an England average of 26%. While smoking prevalence is falling, these data should be interpreted with some caution as sample sizes are generally small. (See also 'local voice' page 69). Smoking rates are higher in manual occupational groups than non-manual.

The following map shows mortality from disease attributable to smoking. Rates per 100,000 population are highest in Filwood and Southville. For this indicator Bristol is also lowest compared to the other eight core cities.

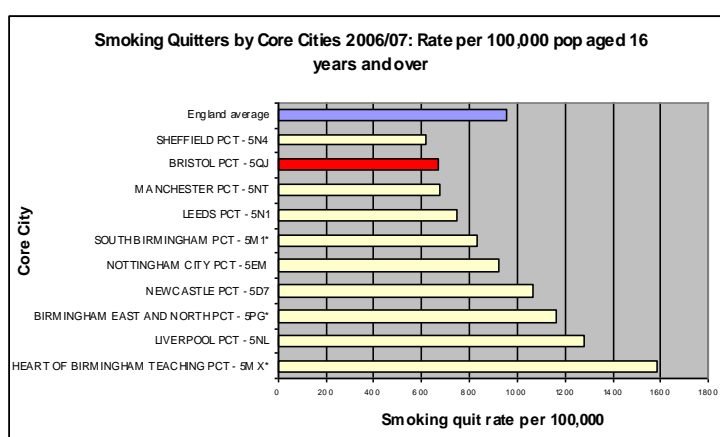


³¹ Association of Public Health Observatories and Department of Health 2008

Stop smoking trends

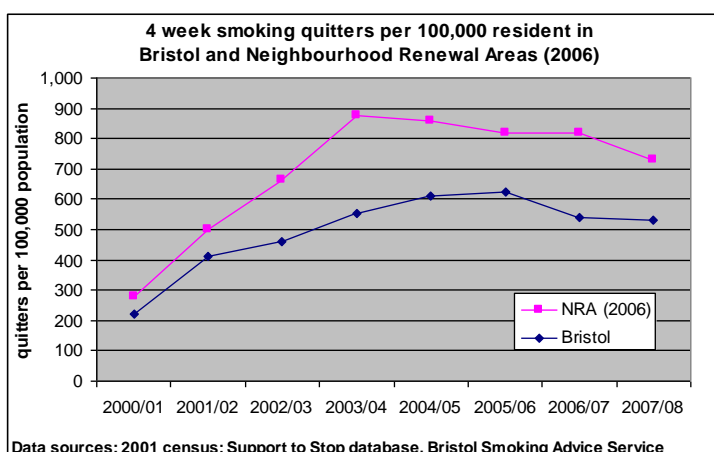
Stop smoking services are a key NHS intervention to reduce smoking in all groups, with a particular focus on routine and manual groups where smoking prevalence is generally higher. The effectiveness of the services is currently monitored through measuring four week smoking quitters (see graphs below).³² Nationally, a smoking quitter is defined as someone who sets a quit date and stops smoking for four weeks. The quit rate in Bristol is low compared to most core cities and the England average. There are also four week quitters who are not part of the NHS stop smoking services, who will not be counted in these statistics.

These stop smoking services are part of a programme of action needed to meet national targets of reducing smoking rates to 21%, or less, by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.



Source: Bristol Primary Care Trust (both graphs)

The following graph shows the service has reached more smoking quitters in the most deprived quintile, where there are more smokers (20% of the population) compared to the rest of the city. The trends indicate the effectiveness of interventions from 2003 and also the staggered introduction of cessation services, but the number of quitters is now levelling. There is some evidence to suggest that the smoking legislation (smoking ban in public places) is encouraging more to give up.

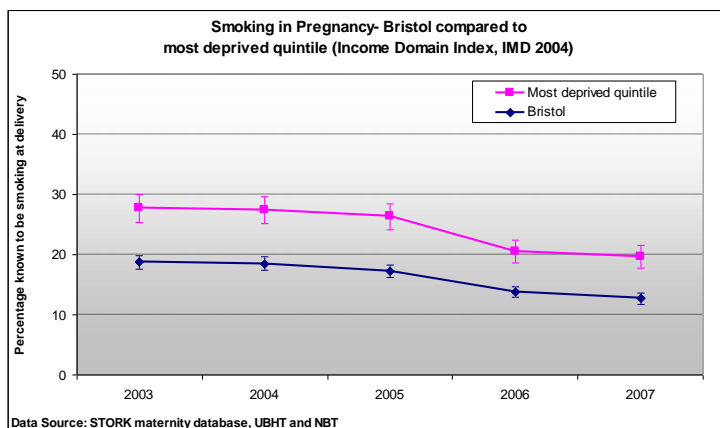
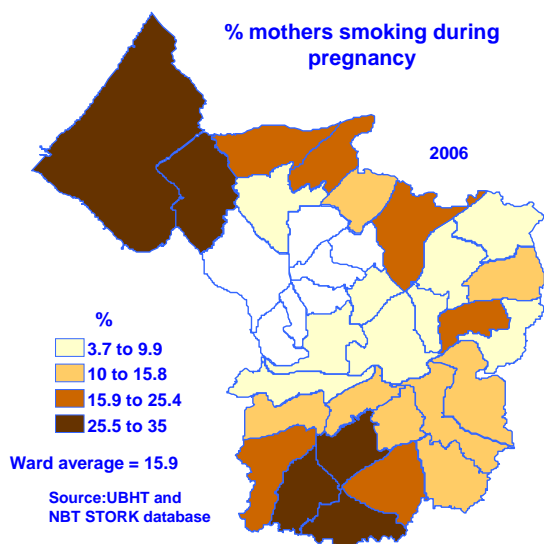


Smoking during pregnancy

Smoking during pregnancy can contribute to low birth weight. In Bristol 14% of women smoke during pregnancy, below the England average (16%) and is one of the lowest rates for core cities.

³² Four week smoking quitters per 100,000 population is a DH measure of the smoking cessation service, rather than an outcome. In reality a proportion of smoking quitters resume smoking.

The map below identifies wards with a high proportion of mothers smoking at the time of delivery in 2006. The rate of smoking in 2006 dropped to 14% (recorded from the Local Delivery Plan returns), which is better than the benchmark average (20%) despite high levels of deprivation and higher overall rates of smoking in the population. This rate fell further in 2007 to 12.6%. Fewer BME women smoke during pregnancy.³³



The graph above compares smoking in pregnancy in the most deprived quintile and the rest of the city. The gap appears to be narrowing.

Smoking – children and young people

There is a lot of evidence to suggest that children in households where there are smokers suffer worse health. The findings from local school surveys in 2007 and 2008 indicate a third of households occupied by children have 'others smoking' (see page 69).

In a national study of 11-15 years olds carried out in 2006 by the National Centre for Social Research and the National Foundation for Educational Research, nine per cent said they smoked regularly. The proportion of young people who had never smoked was 61%.

Smoking prevalence amongst young people increases as household income decreases.³⁴ Young people are more likely to be smokers if they have parents, older siblings and/or friends who smoke. Smoking is also associated with other types of risk behaviour, such as illegal drugs and drinking alcohol, and with anti-social behaviour.³⁵

The WHO Study³⁵ and the 2006 national study³⁴ found far more adolescent girls than boys smoke, whilst BME pupils are least likely to smoke regularly. This can result in gender-related health problems such as cardiovascular diseases and reproductive health.

³³ Bristol and South Gloucestershire PCTs (2004) Trends in need and demand for neonatal services

³⁴ Department of Health (2002) Health Survey for England

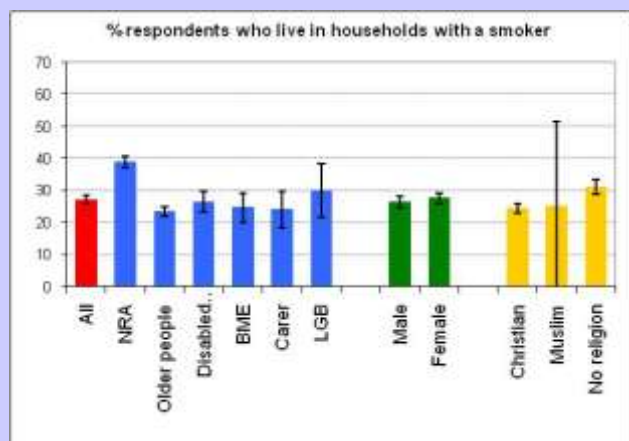
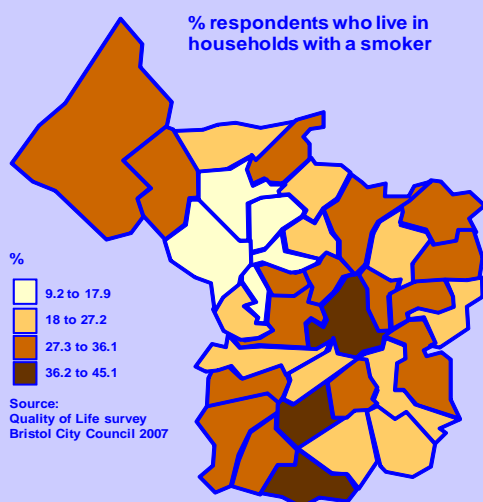
³⁵ WHO Study (2001-2002) Health Behaviour in School Age Children

Adults who say they smoke

The annual quality of life surveys (Annex 13) indicated a possible drop in smoking rates between 2006 and 2007. The survey asked residents if they smoked and if there were others smoking in the household. Approximately 16% said they smoked (18% in 2006) and this increased to 27% for people living in neighbourhood renewal areas (30% in 2006).

Approximately 27% said they lived in households with a smoker (30% in 2006) and 14% of these households had someone regularly smoking within the home (16% in 2006). When analysed by equalities groups, 39% of residents in neighbourhood renewal areas lived in households with a smoker (46% in 2006).

The vertical lines on the bar chart show confidence limits.

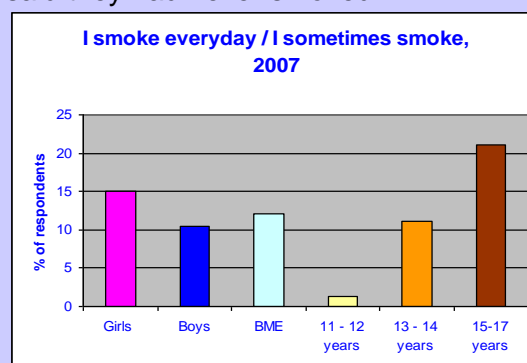


Source: Quality of Life Survey 2007

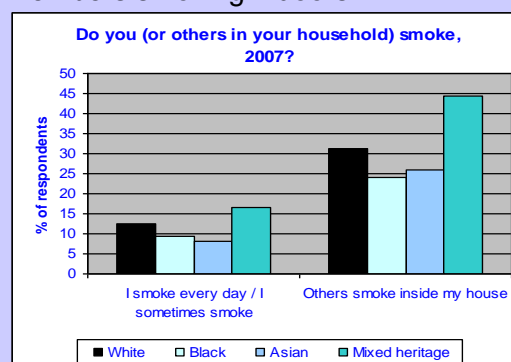
Smoking - young people's views

In the *Every Child Matters Survey 2008* (Annex 14), nine percent of secondary school pupils said they smoked (regularly or occasionally). More girls smoked (11%) compared to boys. Over a third of primary and secondary pupils said others smoked indoors in their homes.

In Bristol's *Young People's Quality of Life Survey 2007*, overall, 13% of 11 -16 year olds said they smoked (regularly or sometimes). More 15-16 year olds smoked (21%) and more girls smoked (15%). The majority (81%) said they had never smoked.



When analysed by ethnicity (below) a smaller proportion of Asian pupils said they smoked, compared to mixed heritage pupils (17%). An estimated 31% of all survey respondents and 44% of mixed heritage pupils were at risk of passive smoking from other family members smoking indoors.



The same smoking rates were found in neighbourhood renewal areas (NR) and non-NR areas, but more children were exposed to second-hand smoke in the more deprived parts of the city.

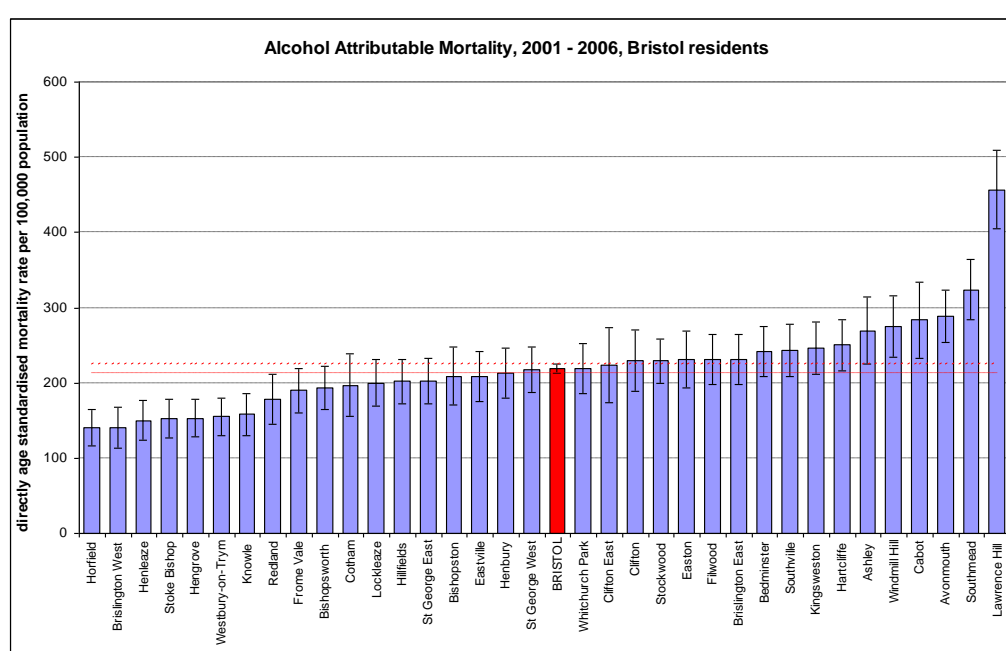
Indicator	NR area	Non-NR area
% who smoke	11.7%	11.7%
% who have others smoking in the house	48.1%	26.2%

Alcohol consumption

Alcohol consumption is rising in the UK and in the last 20 years the relative cost of alcohol has halved. Compared to other core cities Bristol has slightly better outcomes for alcohol health profile indicators.

The number of binge-drinking adults in Bristol is less than the England average and second (lowest) out of the eight core cities. However, alcohol-related mortality is significantly higher in Bristol compared to the rest of the South West (see Annex 12C). Between 2001-2006, 324 residents died with an alcohol-specific disease and the most common causes of death were alcoholic liver disease (51%) and fibrosis and cirrhosis of the liver (29%).

Across the city, alcohol attributed mortality is significantly higher than average in Lawrence Hill, Southmead and Avonmouth. The majority of deaths are in the 40-65 years age group.



Source: Bristol Primary Care Trust

Figures for alcohol-related and specific hospital admissions are higher than most core cities. Residents living in Lawrence Hill and Cabot are over-represented. The high number of admissions from Cabot may be related to a number of hostels in the vicinity. Over the last three years there were over 8,000 admissions to hospital for alcohol-specific conditions and this trend is rising. Almost one half of admissions (48%) were admitted on more than one occasion over the three year period.³⁶

Alcohol-related violent crimes, sexual crimes and domestic disturbances are also increasing in Bristol, and such crime levels are worse than in other core cities. Alcohol consumption can also contribute to mental illness, (both as symptoms and a cause).

Funding of treatment for alcohol misuse

The level of funding for treatment for alcohol misuse is disproportionately low in relation to the estimated level of people dependent on alcohol.

³⁶ Bristol Primary Care Trust (Feb 2008) Alcohol Health Needs Assessment for Bristol.

Alcohol consumption by young people

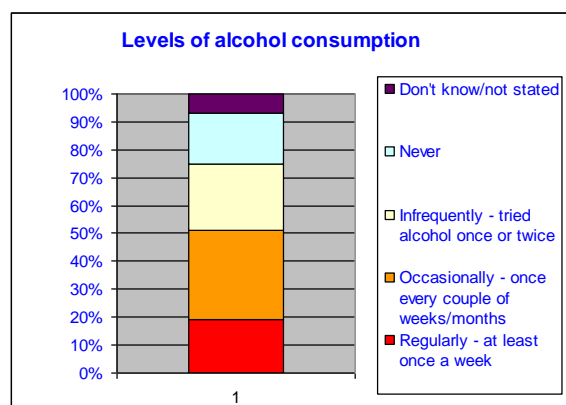
British teenagers are some of the heaviest drinkers in Europe and while the trend for alcohol consumption in the UK has risen in recent years, in Europe it has fallen in most wine producing countries. The WHO Study (2001-2002) *Health Behaviour in School Age Children* identified England and Wales as having the highest numbers of 13 and 15 year olds (30% and 56% respectively) who drink alcohol weekly, in Europe.

New research from Ipsos Mori Pupil's Alcohol Drinking Survey and the Office of the Children's Commissioner (2006), found that three-quarters of underage young people (11-16 year olds) have tried alcohol at least once, compared to 43% in 2002 and 67% in 2004. This research indicated those most likely to have tried alcohol were:

- white
- 15-16 year olds from rural communities, where there were fewer teenage activities
- living with two working parents
- in non-deprived regions.

Those least likely to have tried alcohol were:

- children under 11 years
- BME children
- living in a household with no parent working.



Source: Ipsos Mori Pupils' Alcohol Drinking Survey

The Ipsos Mori *Pupil's Alcohol Drinking Survey 2006*, found girls start drinking later than boys, but drinking increases significantly between 13-14 years when they overtake boys. A third of all 15-16 year old girls in the UK are regular drinkers.

The recent *Youth Alcohol Action Plan* (Home Office and DH 2008) notes the proportion of 11–15 year olds who drink regularly fell from 28% in 2001 to 21% in 2006. While that is good news, at the same time, the average weekly consumption among young people who drink increased very sharply. The number of units consumed by young people in that age group doubled between 1990 and 2000 and has remained at the same level since.

Many young people continue to be successful in illegally purchasing alcohol. Most alcohol consumed by young people is obtained from their own home, with or without the consent of their parents.

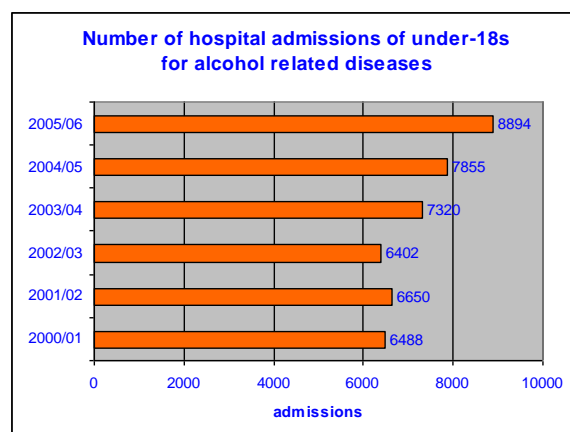
There is a social acceptance of drinking alcohol and children as young as five years can have a social drink at home, but parents need to be encouraged to teach responsible drinking.

Alcohol misuse causes many problems:

- accidents
- unwanted and unprotected sexual activity
- poor school performance and attendance
- crime and antisocial behaviour
- harm to health as a result of binge and chronic drinking, including liver cirrhosis in later years.

Binge drinkers are likely to be under 25 years of age. Hospital admissions of children and young people with acute alcohol poisoning have risen dramatically.³⁷

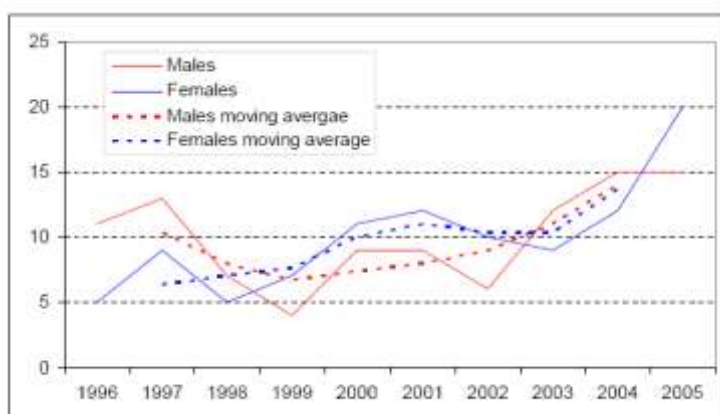
The graph below illustrates the increasing number of under-18s who are receiving treatment for alcohol-related diseases in the UK.



Source: Hospital Episode Statistics, published by the Secretary of State in response to a parliamentary question, 2007.

In Bristol, hospital admissions for alcohol specific conditions for males aged under 18 (per 100,000) is higher than most core cities (6th worst out of 8). The following graph shows the rising trend in admissions for young people in the city for alcohol-related disorders.

Number of admissions to hospital for mental and behavioural disorders due to use of alcohol in people under 18 years, Bristol 1996-2005



Source: Alcohol Health Needs Assessment, Bristol Primary Care Trust, 2008

See also following section on 'Young people and substance misuse'.

³⁷ Alcohol Harm Reduction Strategy for England www.strategy.gov.uk.

Drug misuse

In Bristol drug misuse is much higher than the England average, and ranks worst out of the eight core cities. There are between 3,280 and 5,540 injecting drug users in the city. Approximately 70% of the injecting drug users are men. There are an estimated 8,000 drug users in total, with 4,535 in treatment.³⁸

Injecting drug use carries the risk of transmitting infections such as human immunodeficiency virus (HIV), hepatitis B and hepatitis C. Drug-related deaths can be due to overdose poisonings, acute injuries and chronic problems. Oral health and the diet of drug users can be poor. Heroin and stimulant misuse leads to low saliva production, which increases the risk of tooth decay. People who misuse drugs also report a high intake of sugar-containing foods and drinks.

In 2006, there were 31 drug-related deaths in Bristol. This number is lower than expected, and Bristol's injecting drug users have a lower risk of death than other injecting drug user populations. This may be because of the high rates of opiate substitution treatment in Bristol, and represents a public health success for the city.

Waiting times for drug users to access treatment are reducing. Most clients (89%) stay on drug treatments for 12 weeks or more increasing the effectiveness of their treatment.

Hospital admissions related to bacterial infections from injecting drugs has risen between 1998-2004. There is a predominance of admissions through Accident and Emergency departments suggesting poor contact with health services and reluctance to seek treatment until the point of crisis.

There are many psychosocial issues for drug users. A drug user may lose their home, family, friends, finance, employment, self respect and the basic necessities of life. This can be compounded by judgemental attitudes. Psychosocial interventions enable recovery alongside a medical response.

Young people and substance misuse

Substance misuse is defined as illicit drug use including alcohol.

Drug use is at its most prevalent during adolescence and early adulthood and the average age of first drug use is getting younger. A quarter of young people are likely to try an illegal drug by the age of 16 (but this proportion is now falling). Any health-related problems may not be evident until young people are in their 20s.

In the national study of 11-15 years olds carried out in 2006 by the National Centre for Social Research and the National Foundation for Educational Research, 35% of pupils said they had been offered drugs, a decrease from 42% in 2001. The prevalence of drug use had also declined since 2001. In 2006, 17% said they had taken drugs in the year previous compared to 20% in 2001. Of these young people, ten per cent were most likely to have taken cannabis in the year previous (a decrease from 13% in 2001).

Young people who misuse drugs are often:

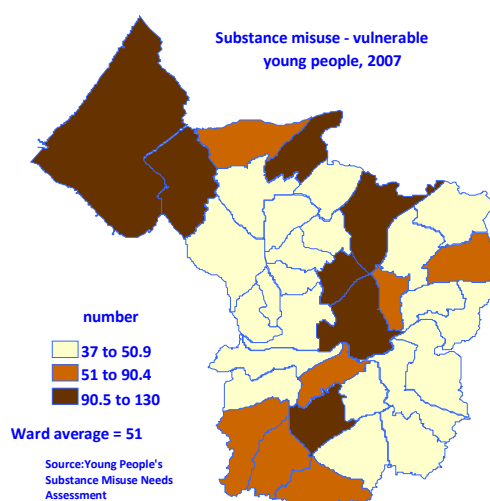
- excluded, disaffected or vulnerable young people
- living with a drug user
- bored
- trying to forget or hide problems
- living in areas of deprivation.

³⁸ Director of Public Health, PCT (2007) The Health of Bristol 2007

A young people's substance misuse needs assessment was carried out in Bristol in 2005 and December 2007. This assessment identified vulnerable young people at greater risk of substance abuse due to truanting, school exclusion, in social care, youth offending and young homelessness. In Bristol there are 46,500 young people aged between 10-19 years (ONS mid-2007 population estimate) and the following key statistics relate to those who are vulnerable.

- Young people requiring a response to tier 1 services (mainstream/education) = 1,777 (representing those vulnerable).
- Young people requiring early intervention services (tier 2 – youth-orientated advice and information) = 920 -1,150.
- Young people requiring tier 3 services (specialist structured treatment) = 307
- Young people requiring tier 4 services (residential detox/rehabilitation) = c.10.

The following ward map of those most vulnerable was created by the needs assessment model. Filwood and Lawrence Hill have the highest number of vulnerable young people (130 and 128 respectively).



The *Young People's Substance Misuse Needs Assessment 2007* gathered information from substance misuse services using a questionnaire. This information was used to give a profile of service users and types of substances most frequently used. The following table indicates those services/projects most regularly used by young people. There were 731 referrals between October 2006 and September 2007 and 15% were from BME groups.

Service for substance misuse	Number and ethnicity of young people in contact	
	White	BME
Tier 2 - Targeted support with Early Intervention Service (EIS); screening and brief interventions	402	64
Tier 3 – Treatment, care plans and interventions		
• Drugs and young people's project (for children in care and/or where there is a social worker involved)	55	10
• Bristol YOT	120	30
• Young people's drug treatment service	86	10

Source: Young People's Substance Misuse Needs Assessment 2007

The same questionnaire indicated cannabis and alcohol were the substances most commonly used by young people in contact with services listed here, followed by cocaine and ecstasy. The level of alcohol use needs to be further reviewed as not all services were offering primary alcohol interventions and therefore may underestimate the need.

The use of extra strong 'skunk' cannabis has risen five fold in the last six years.³⁹ Bristol University's Centre for Research on Drugs and Health has warned of mental health risks.

All secondary schools (including special schools) have access to an EIS drugs worker; 41% have developed school drug policies; 56% of primary schools have developed local schemes following drug education input. There has been a year-on-year increase in the number of young people accessing treatment.

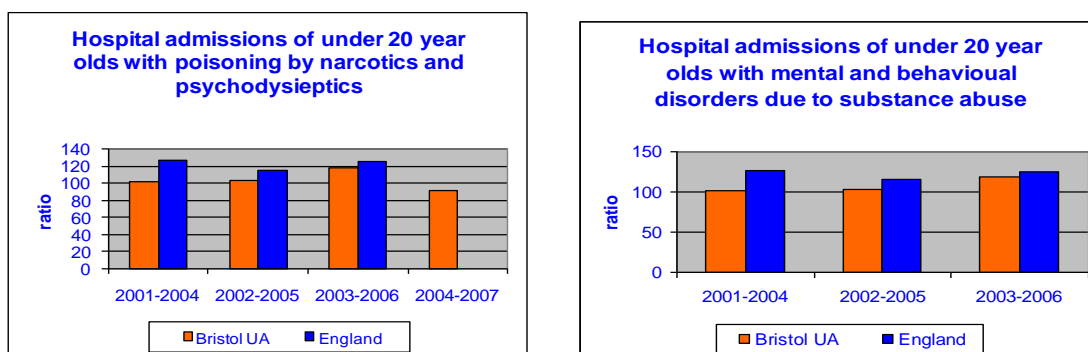
There are specialist workers who deal with hidden harm (from parental or carer substance misuse) in EIS and in the Drugs and Young People's Project.

Safer Bristol Drugs Strategy Team has commissioned Bristol PCT to deliver its EIS to young people in all secondary schools and over the coming year will be seeking to offer services to persistent truants, excludees and those not in education, employment or training (NEET). Young offenders are assessed for substance misuse when they enter the Youth Offending Team and are referred to a YOT drugs worker.

How does Bristol compare

In 2005, a national indicator was developed for the 'proportion of young people (who are drug users) in substance misuse treatment (aged less than 18 years)'. Bristol recorded five per cent in 2006 and seven percent in 2007 for this indicator, lower than the regional figure of ten per cent. This indicates average performance for Bristol and this proportion needs to increase to reflect success in getting more young people into treatment.

Another indicator considers substance misuse-related hospital admissions for young people under the age of 20 years. As the following graphs illustrate, the admissions ratios for Bristol are lower than the England average. Admission ratios are calculated as the actual number of hospital admissions divided by the expected number of admissions. A low admission ratio indicates drug misuse in the area is not leading to a high number of admissions to hospital and probably indicates there is good access to treatment/services that address problems short of hospital admission.



Source: Annual Performance Assessment dataset, Children and Young People's Services (both graphs) (A 'psychodysieptic' is a substance that can cause hallucinations e.g. LSD).

Sexual behaviour

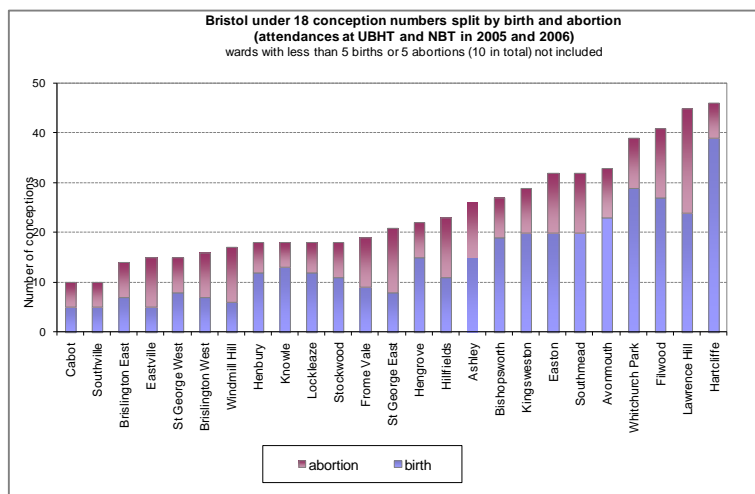
Teenage pregnancy

Teenage pregnancy is often a cause and a consequence of social exclusion. The following map indicates where the number of teenage pregnancies is high, mainly in areas of deprivation, social

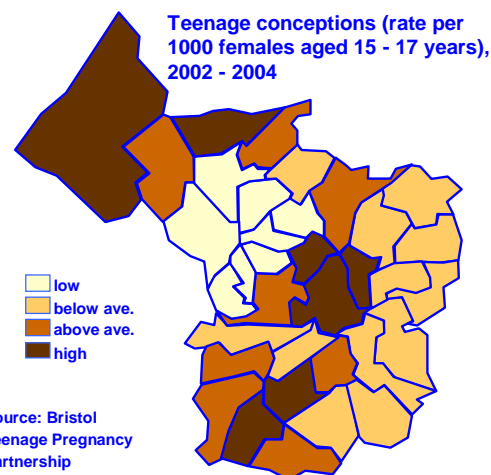
³⁹ Institute of Psychiatry at Kings College London (2008) 'Skunk' cannabis link to psychosis study.

housing and in areas of low educational achievement. As mentioned earlier, alcohol misuse can also lead to unplanned and unprotected sexual activity.

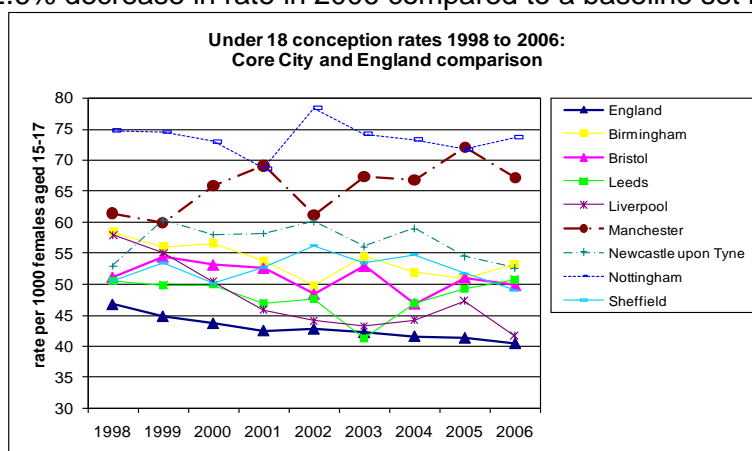
The under-18 conception rate in Bristol in 2004-2006 was 49.1 per 1,000 females. This is higher than the England average of 41.1 (provisional figures APHO and DH 2008). Hartcliffe and Lawrence Hill have the highest number of teenage pregnancies (see below), but a higher proportion of young women in Hartcliffe do not want abortions, indicating that interventions need to be different in different wards. A fifth of conceptions to under-18 mothers are second or subsequent pregnancies.



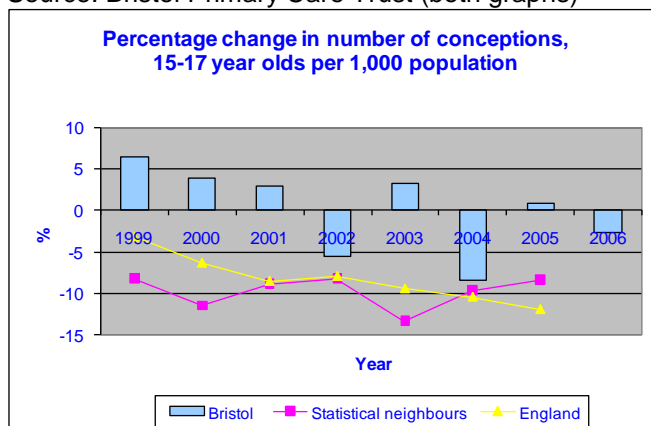
Source: Bristol Primary Care Trust



Compared to its statistical neighbours and core cities, Bristol has a similar teenage pregnancy rate. Bristol saw a 2.6% decrease in rate in 2006 compared to a baseline set in 1998 (see lower graph).



Source: Bristol Primary Care Trust (both graphs)

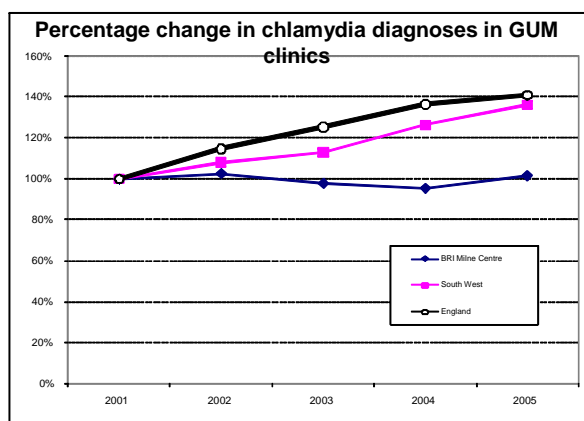


The Bristol Teenage Pregnancy Partnership Board oversees implementation of the teenage pregnancy strategy. There is strong evidence on what needs to be in place to lower the rate of teenage pregnancy and this includes:

- provision of discrete, credible and highly visible young people-friendly sexual health and contraception advice services
- strong delivery of personal, social, and health education (PHSE) and sex and relationships education (SRE) in schools and community settings
- targeted work with 'at risk' young people and in particular looked after children
- extensive workforce training on sex and relationships issues with mainstream partner agencies.

Chlamydia infection

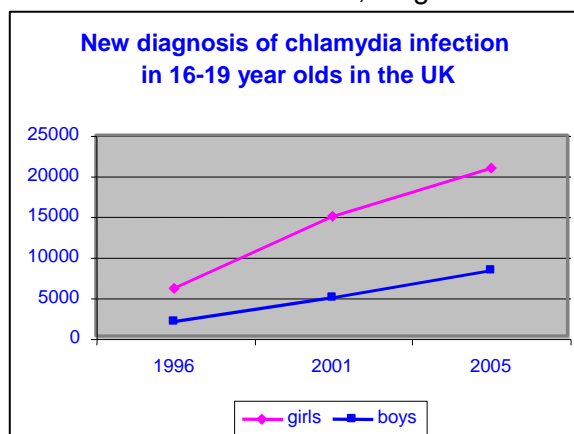
Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in England. As with all sexually transmitted infections the number of cases diagnosed is always an underestimate of the true level of infection, since many infections are not symptomatic and are therefore not diagnosed. Compared to the South West region and England, diagnoses of chlamydia have remained fairly level since 2001. In the South West and nationally levels of chlamydia diagnoses have increased by around 40%. The highest rates were seen in the 20-29 age group for both males and females.



Source: Bristol Primary Care Trust

In the UK generally, the number of young women with chlamydia has tripled since 1996, and although the number of young men with the disease is smaller, the figures for 16-19 year old males have quadrupled. The 16-24 year group now accounts for 65% of all cases of chlamydia.

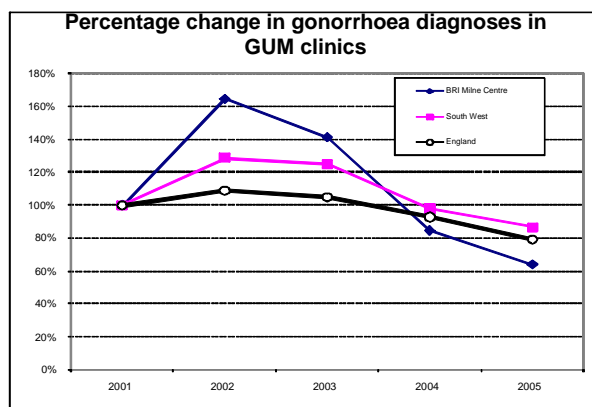
Some of this rise is due to better detection, diagnosis and reporting.



Source: Health Protection Agency, 2008

Gonorrhoea

Diagnoses of gonorrhoea have been falling since 2002, with Bristol experiencing a dramatic decrease in 2005, having less than a third of the cases it had in 2002. The highest rate of gonorrhoea was seen in the 20-29 age group, in both males and females.



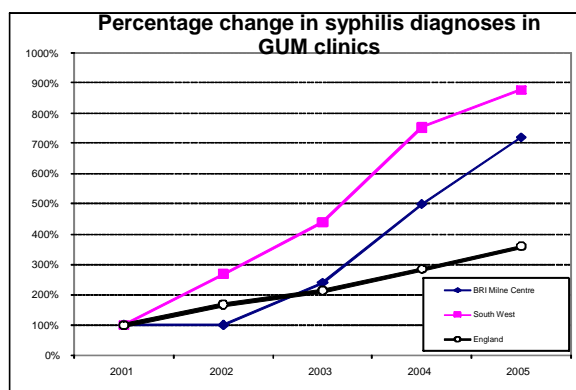
Source: Bristol Primary Care Trust

Herpes

Rates of herpes infection have remained steady for the past five years in England and have shown a fall in Bristol.

Syphilis

In England, syphilis is relatively uncommon, but diagnoses in genito-urinary medicine (GUM) clinics have increased substantially since 2001, both locally and nationally. This increase has been driven largely by a number of localised outbreaks across the UK. The first of these took place in Bristol and was associated with heterosexual intercourse, commercial sex work and the use of crack cocaine. The highest incidence rates were seen in males aged 30-39 and females aged 20-29. It should be noted that syphilis is still rare in Bristol, with less than 30 cases per year in the city.



Source: Bristol Primary Care Trust

LOCAL VOICE

Bristol's Big Drink Debate

This Bristol Partnership survey of Bristol citizens and businesses took place between February and May 2008. People were asked in a questionnaire to give their thoughts on how the harm from excess drinking can be reduced in the city. There were nearly 1,000 responses; 54% were from women, 46% from men, 5.5% from BME groups and the majority were in the age range 25-54 years. Some findings are below.

- The majority agreed there should be better publicity, health warnings, advice and information on the hazards of alcohol abuse.
- Most businesses agreed (93%) that selling alcohol to underage young people should be heavily penalised.
- Over 86% agreed supermarkets, off-licenses, pubs and clubs should display more information about drink strength, alcohol units, and non-alcoholic drinks should be promoted.
- Respondents (84%) agreed schools should do more to teach a healthy approach to alcohol consumption.
- Respondents were less supportive of anything prohibitory when it came to adults and alcohol consumption.

In addition, free text responses indicated some strong views in two areas.

1. The current design of the city centre and dockside appears to be for a youth-based alcohol industry. This is excluding families and different cultures, and limiting the use of the city centre as a 'living centre'.
2. The sale of alcohol at discounted prices in off-licenses and supermarkets is fueling the problem. These businesses have no responsibility for the behaviour of people consuming the alcohol, or where it is consumed (unlike pubs and clubs).

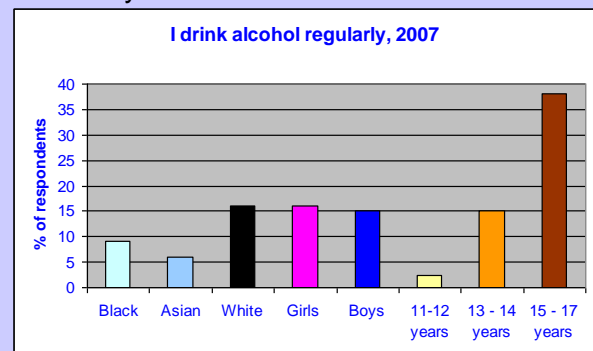
Alcohol – young people's views

In the Every Child Matters survey 2008 (see Annex 14), 34% of secondary school pupils and 15% of primary school pupils said they

had consumed an alcoholic drink (more than just a sip) in the previous seven days. A third said their parents always knew about this. Boys started drinking earlier (13-14 years), but by age 15-16 years, more girls were drinking alcohol compared to boys.

Over a third said they purchased alcohol in an off-licence and a quarter purchased alcohol in a supermarket. Most (77%) said they drank alcohol at home (or in a friend or relative's home), whilst 44% said they had drunk alcohol in a public space.

The Young People's Quality of Life Survey 2007 recorded 16% of young people drinking alcohol regularly. In the 11-12 year old age group, 3% said they were regular drinkers compared with 15% 13-14 year olds and 38% of 15-16 year olds.



Source: Young People's Quality of Life Survey

Drinking alcohol rates were similar by gender and were lowest for BME young people.

Spatial distribution shows there were more young people mainly in the west of the city, who said they were regular drinkers.



Drugs – young people’s views

In the Every Child Matters Survey 2008 (see Annex 14), 18% said they had been offered cannabis, 11% offered poppers and 6% offered cocaine. A few (6%) said they had used cannabis in the last month.

In the Young People’s Quality of Life Survey 2007, the question was asked ‘Have you taken drugs in the last 12 months (do not include those taken for medical reasons)’? Three per cent said they regularly took drugs and a further eight percent said they had taken drugs once or twice. There was a clear age profile with five per cent of 15-16 year olds experimenting with illegal drugs regularly in the last year, compared to one per cent of 11-12 year olds.

Spatial analysis indicates more young people who took drugs lived in the north and central areas, where access to drugs may be greater. An analysis of use of alcohol and drugs by NR/non-NR area indicated these habits were not associated with deprivation.

Indicator	NR area	Non-NR area
% who regularly take drugs	1.3%	2.5%
% who regularly drink alcohol	12.3%	15%

Source: Young People’s Quality of Life Survey

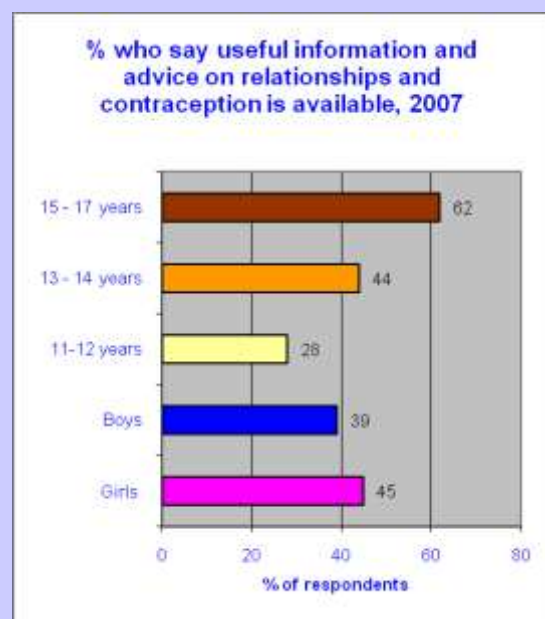
Sexual health – young people’s views

In the Young People’s Quality of Life Survey 2007, when questioned about the availability of advice on contraception and relationships, 42% said it was available. Although previous surveys are not strictly comparable (as different schools participate each year), this indicator has dropped slightly since last year when 47% said it was available (32% in 2004-2005).

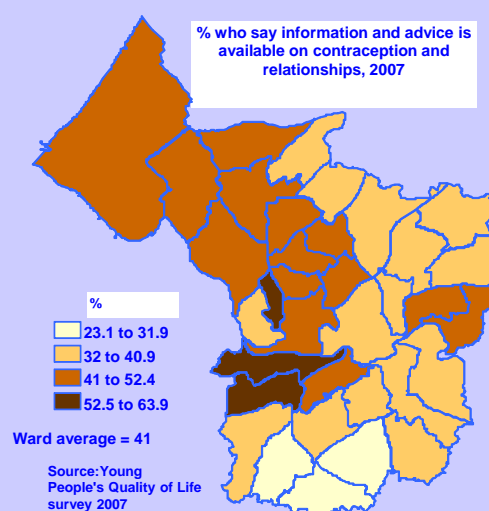
More older teenagers (62%), had ‘information and advice’ compared with the 11-12 year olds. More girls thought they had better access to information and advice. Further free text comments made by young people included their desire for better access to advice on contraception.

The map below shows that fewer young people living in the far south of the city said they had access to information and advice. More pupils in non-NR areas (44%) said they had good access to information compared to young people in NR areas.

The question was also asked where young people would like to get such information and advice on contraception and relationships. More boys would prefer to get this from school classes and the internet and more girls prefer magazines.



Source: Young People’s Quality of Life Survey



Nutrition

The Department of Health healthy balanced diet is considered as, (per day):

- five or more portions of **fruit and vegetables**
- 18 grams of **dietary fibre**
- no more than six grams of **salt**
- total intake of **fat** at 35% of food energy intake
- **saturated fat** no more than 11% of food energy intake
- added or non-milk **sugars** no more than 11% of food energy intake.

An unbalanced diet can lead to a number of health problems, including type II diabetes, circulatory diseases and obesity.

In Bristol, 24% of adults eat a healthy diet (England average is 26%), average for the core cities. This is a modelled estimate based on the Health Survey for England 2003-2005 (APHO and DH 2008).

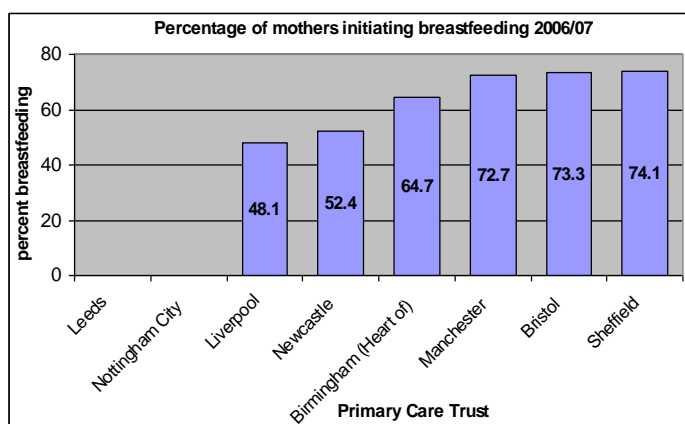
Breastfeeding

Breastfeeding provides the most suitable nourishment for the baby, protecting against disease by providing antibodies. Department of Health guidance encourages exclusive breastfeeding for at least the first six months of a babies life. The benefits of breastfeeding could last a lifetime – with lower blood pressure in later years.

Children of the 90s research at Bristol University indicated that breastfeeding may even protect against obesity by influencing later appetite regulation, and is associated with lower blood pressure for breastfed children studied at seven years of age. Researchers also found that the fastest growing infants were bottle-fed babies who graduated to solid food too early (before three to four months).⁴⁰

In the national *Infant Feeding Survey 2005*, breastfeeding rates were 78% at initiation and 50% at six weeks of age. This rapidly decreased to 25% at six months.

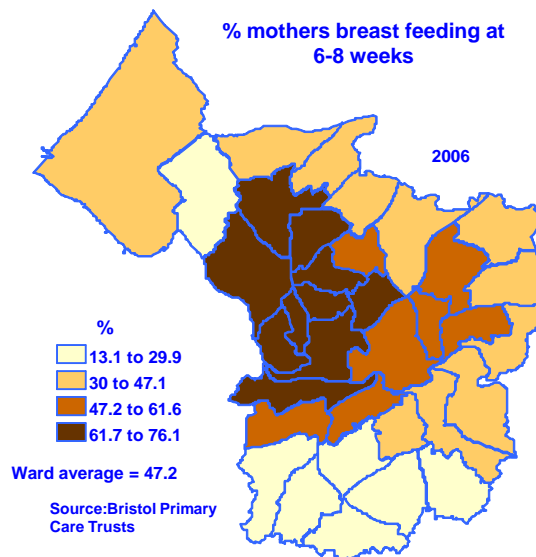
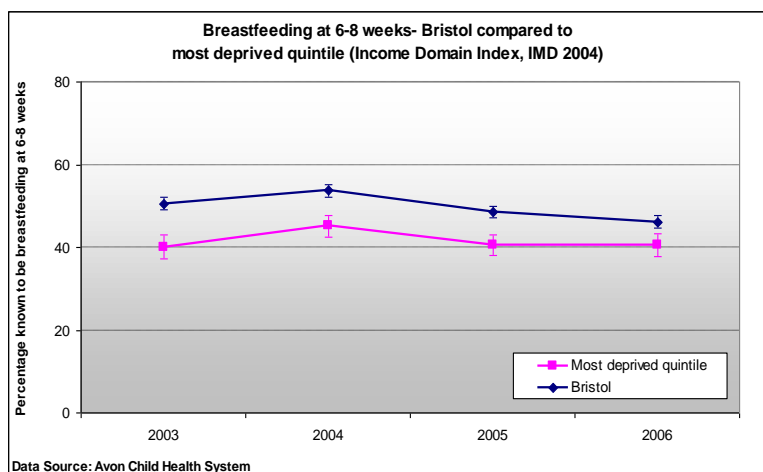
Breastfeeding initiation rates in Bristol are 74% (2007-2008). Rates compare well with other core cities (below), and England at 69% in 2006-2007. At six-eight weeks rates drop to 47% (January - June 2007).



⁴⁰ Ken Ong et al (March 2006) 'Dietary energy intake at 4 months predicts postnatal weight gain and childhood body mass index', *Pediatrics* March 2006

New mothers are being supported by a number of breastfeeding initiatives which are being developed through children's centres and outlined in the breastfeeding strategy. Older mothers (35 years and over) and those in managerial and professional households are most likely to have breastfed their babies for longer (*Health Survey for England 2002*). Women least likely to breastfeed are teenage mothers and white women living in deprived circumstances.

When breastfeeding trends at six-eight weeks in the most deprived communities are compared with the rest of the city (2006-2007), the gap appears to be narrowing, but this is due to a drop in the overall rate in Bristol, which is not desirable. The rate of breastfeeding needs to increase in the most deprived quintile.



Figures from Child Health Surveillance show breastfeeding rates at six-eight weeks for children born in 2006, by ward (map above). There are more breastfed babies in the west/north west areas of the city, showing a strong relationship with general good health recorded in children and more affluent families. Recent figures indicate there is still a big difference between wards, from 13% breastfeeding in Whitchurch Park to 77% in Redland.

Children and young people with a healthy diet

Over 20 local schools participated in *Food for Life*, a pilot project which promoted healthy eating and healthy school meals and resulted in a significant increase in consumption of unprocessed food. Recent media interest in healthier meals at school may also be improving fruit and vegetable consumption. Bedminster Down School has been selected to be one of six schools in the region to take part in the Soil Association *Food for Life* flagship programme.

All of Bristol's schools are engaged with the Healthy Schools programme and 83% have Healthy Schools status in 2008. The programme promotes personal, social, health education (PSHE) including sex and relationship education (SRE), drug education, emotional health and wellbeing, healthy eating and physical activity.

The Bristol Healthy Schools programme has been awarded 'outstanding' by the Beacon Scheme on leadership, engagement, actions, partnerships and equalities and diversity. Youngsters across the city are eating more healthily and some schools are even growing their own vegetables.

Obesity

The rise in the number of people overweight or obese is a national concern, with obese children at risk of becoming obese adults, and at risk from type 2 diabetes, angina, heart disease, some

cancers and poor mental health in adulthood. High levels of cholesterol and blood pressure occur more often in overweight children and adults.

The population who are obese or overweight is rising nationally as we become a more sedentary society, but our bodies are still suited to the 'hunter-gatherer' lifestyle. Modern lower levels of physical activity greatly reduce our energy needs from food, compared to our ancestors. At the same time our energy intake from food is increasing due to a greater proportion of calories from fats and sugar and increased portion sizes. The combination of reduced energy use through exercise and increased energy gain from food, results in weight gain.

Nationally, 67% of men and 56% of women are either overweight or obese. Obesity prevalence is higher in urban than in rural areas. Nearly a quarter (23%) of all Bristol adults are obese, a lower percentage than most core cities and the England average of 24% (APHO and DH 2008). Bristol also compares well with the rest of the South West, with the percentage obese significantly lower (see Annex 12D).

A recent report by the Foresight Project⁴¹ looked forty years ahead. By 2050, modelling indicated that 60% of men, 50% of women and 25% of children under 16 could be obese. The financial impact to society attributable to obesity, at current prices, is estimated to cost £2.5 billion nationally,⁴² £13.4 billion in workplace absence,⁴³ and by 2050 there will be a seven-fold increase in NHS costs.

There is national recognition that more research is needed to:

- understand the impact of the built environment on diet/activity behaviour;
- provide better evidence for vulnerable adults, children, low income and ethnic communities.

Health experts have said primary care trusts can only tackle five percent of the obesity problem, compared to 30% by local authorities.⁴⁴

Older people

Based on POPPI⁴⁵ projections for Bristol, the number of obese people over 65 years (with a Body Mass Index over 30) will increase by 13% by 2025. POPPI estimates there are currently 13,254 older people who are obese increasing to 14,932 by 2025. Thus there is no room for complacency.

Children and young people

The national rise in obesity amongst children and young people is a cause of concern. Obese children aged of 10-13 years have an 80% chance of becoming obese adults, with a reduced life expectancy. The International Journal of Pediatric Obesity 2006 studied children aged 5-18 years. It noted that in the UK, 36% of girls were overweight (10% clinically obese) and 26% of boys were overweight (8% clinically obese). These figures were higher than the Western European average. Obesity among children aged 2-10 years has risen from 9.9% in 1995 to 16.7% in 2005. Among 11-15 year olds, obesity has risen from 14.4% in 1995 to 20.5% in 2005 (Health Survey for England).

There are two main reasons for this trend:

- children are exposed to a high energy-dense diet (fatty foods and soft drinks)
- children are more sedentary.

Another reason is that more parents are overweight than before and 'program' the child to be overweight irrespective of lifestyle.⁴⁶ There is a strong correlation between parental and child obesity.

⁴¹ Government Office for Science (2007), Tackling Obesities: Future Choices.

⁴² Department of Health (2004) 'At Least 5 a Week'

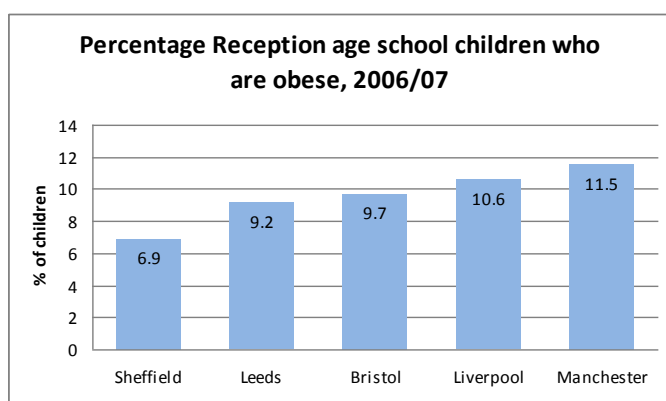
⁴³ Confederation of British Industry (2007) Obesity summit

⁴⁴ Dr William Bird (2008) Natural England Health Expert

⁴⁵ Projecting Older People Population Information System

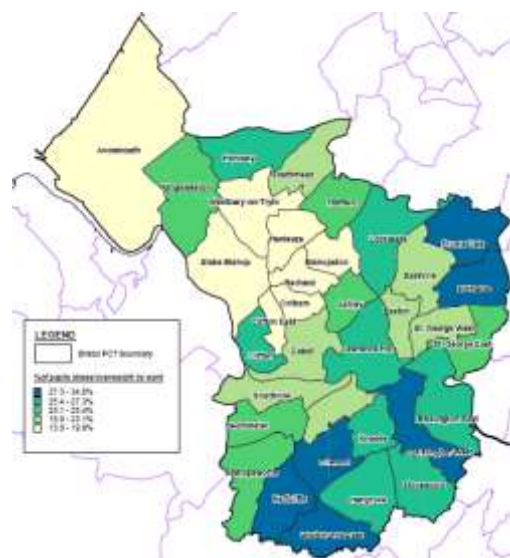
Children who are obese are at increased risk of emotional problems that last well into adulthood. A study at the University of Medicine and Dentistry of New Jersey found that obese girls aged 13-14 years are four times more likely to experience low self-esteem than non-obese girls. The study also reported that obese boys and girls with low self-esteem had higher rates of loneliness, sadness and nervousness. These children were more likely to smoke and drink alcohol compared with obese children with normal self-esteem.

The levels of obesity among Bristol children are rising but are in line with the findings for core cities and England as a whole, see graph below based on five of the eight core cities (APHO and DH 2008). In 2006-2007, at Reception age, 9.7% of children were obese (9.9% in England) and in Year 6, 15.2% were obese (17.5% in England). In 2007-2008 the National Child Measurement Programme indicated 19.5% of Year 6 children were obese (provisional figure).



Source: Bristol Primary Care Trust

Percentage of four-five year olds obese or overweight



The map above is based on data collected by Bristol PCT during 2002-2005. The Body Mass Index was recorded for Reception year children born between 1998 and 2001. Being overweight or obese is more common in deprived areas, and in the south and east of the city.

Physical activity

Physical activity not only contributes to wellbeing but is essential for good health. People who are physically active reduce their risk of:

- heart disease by 50%
- stroke by up to 40%
- developing type 2 diabetes
- developing colon and breast cancer
- developing high blood pressure
- premature death by 20-30%.⁴⁷

In addition, physical exercise helps control weight, helps build and maintain healthy bones, muscles and joints, and promotes psychological wellbeing.

A ten per cent increase in adult activity would benefit England by at least £500m a year (saving about 6,000 lives).⁴⁸

⁴⁶ Professor Tim Cole, Institute of Child Health, University College London

⁴⁷ Sport of England Briefing 2005

A minimum of five times 30 minutes moderate physical activity is required per week for population health. It is estimated only 30% of adults achieve this.⁴⁷ Only ten percent of Bristol adults were estimated to be physically active in 2005-2006 compared to 12% nationally (APHO and DH 2008). The Quality of Life Survey 2007 results indicate that more Bristol residents (35%) take exercise than the national estimate, (see 'local voice' page 87).

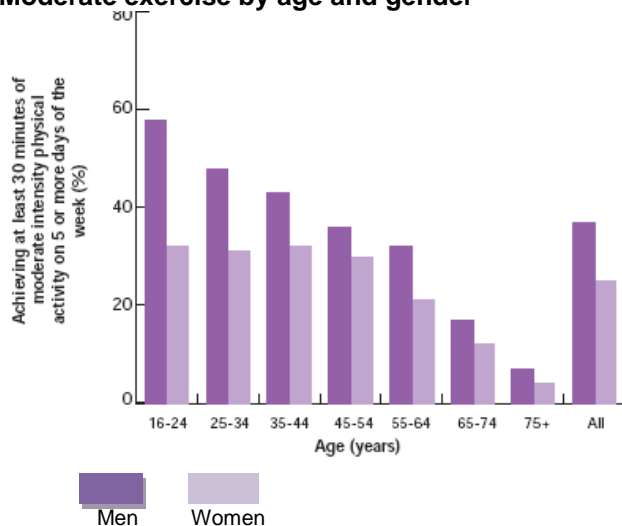
Walking is the most accessible way to increase physical exercise and this can be encouraged through general lifestyle, community interaction and the physical layout of the built environment. Walking one hour more per week (difference between a typical driver and non-driver) would counteract a weight gain of two stone over a decade, and a longer term slide into obesity.

Older people

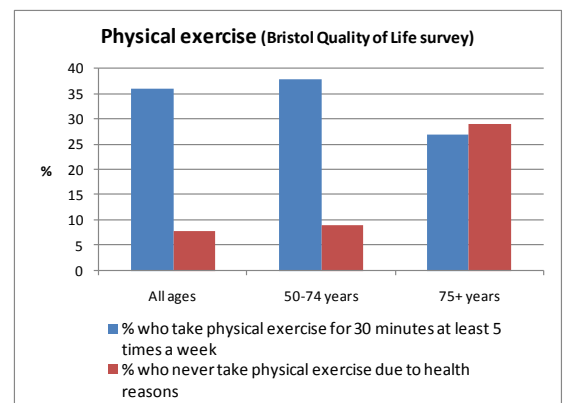
Physical exercise has a wide range of health benefits for older people, including maintaining independence, preventing falls, benefits to the cardiovascular system, improved sleep quality, psychosocial benefits such as improved social integration and mental health.

Evidence from the *Health Survey for England 1998* indicated physical activity declined with age (below). Recent and local evidence from the *Quality of Life Survey 2007*, indicates physical activity drops from age 75 years. Limitation due to overall health is seen as the main reason.

Moderate exercise by age and gender



Source: Health Survey for England 1998



Source: Quality of Life Survey 2007

Children and young people

It is recommended that children have one hour of physical exercise a day. Bristol compares well for 'percentage of 5-16 year olds who spend at least two hours/week on high quality PE and school sport' at 88%, and is better than the core cities and England average (86%). The Health Survey for England 2002 found that physical activity varied with age and gender and physical activity among girls declined from about age 11 years.

Children of the 90s researchers in Bristol have found that even small increases to your daily exercise routine, such as walking your child to school each day, could cause significant reduction in childhood obesity.⁴⁹ The greatest impact on children's freedom to play and take exercise has been the rise of the car – there are now four cars for every child in the UK.

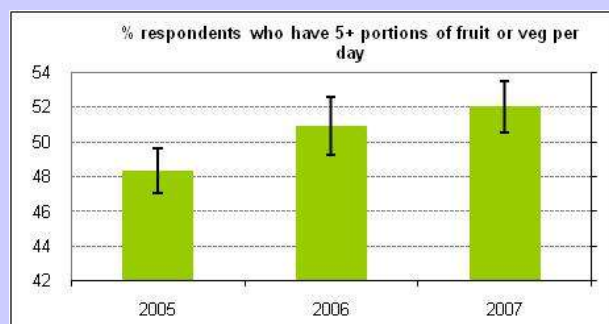
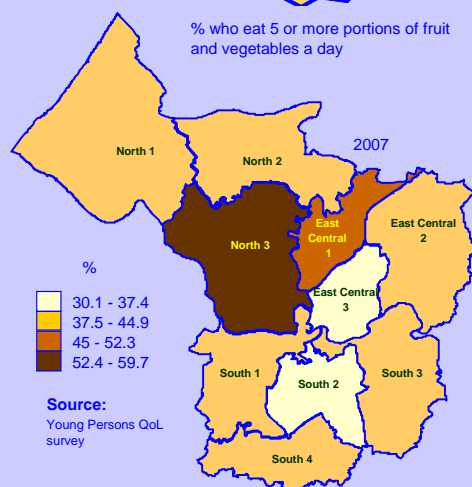
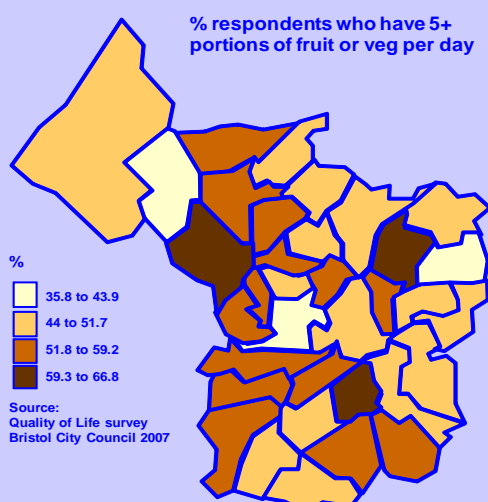
⁴⁸ Presentation by Melvyn Hillsdon, UoB (April 2008), 'How much does the environment shape physical activity in Bristol'

⁴⁹ Ness A R et al (2003) PLoS Medicine, Objectively measured physical activity and fat mass in a large cohort of children'.

LOCAL VOICE

Healthy eating

In the Council's quality of life survey and young people's quality of life survey, 52% and 45% respectively, said they ate five or more portions of fruit and vegetables daily in 2007. This indicator shows an improving trend that is statistically significant for adults (lower graph).



Source: Quality of Life Survey

When analysed by age and gender, more young people aged 11-12 years, more older people aged 50 years plus, more girls and more women consume a higher proportion of fruit and vegetables.

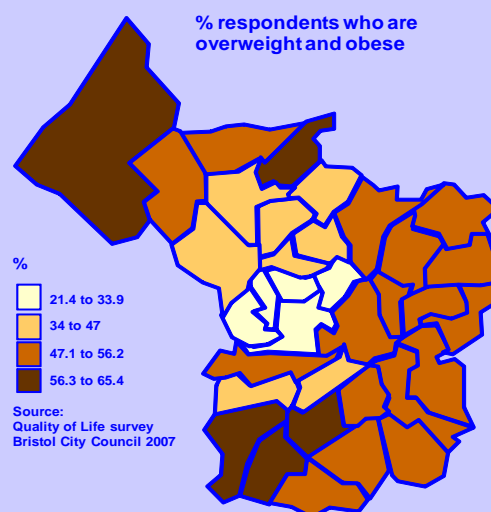
The pattern by ward and locality is similar for both age groups, indicating people from more affluent wards have a healthier diet. Analysis by NR/non-NR area also reflected the link between a less healthy diet and deprivation, with 37% of children eating five or more portions in NR areas and 48% elsewhere in the city.

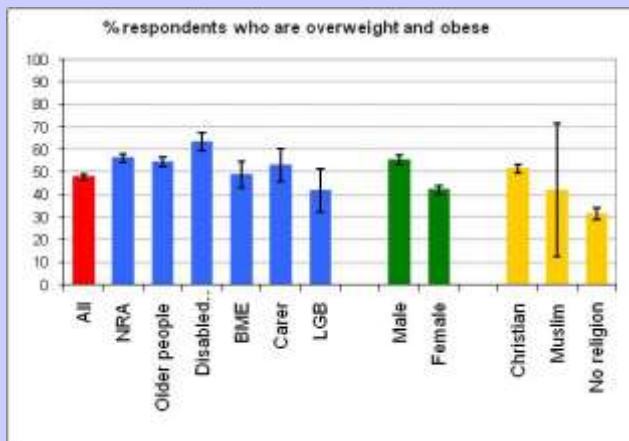
In the *Every Child Matters Survey 2008* (see Annex 14), 18% of secondary school pupils said they ate five or more portions of fruit and vegetables daily. This compares with 31% of primary school pupils in the same survey.

In the same survey in secondary schools, 17% of pupils said they ate nothing before lessons in the morning, compared with 7% of primary school pupils.

Obese or overweight adults

Body mass index (BMI) is measured annually using the quality of life residents survey (based on residents' own measurements of their weight and height). The following map and graph show percentage overweight and obese from the 2007 survey: 48% of residents were overweight and obese in both 2006 and 2007; 16% were obese (BMI ≥ 30) in 2007 compared to 14% in 2006.





Source: Quality of Life Survey 2007

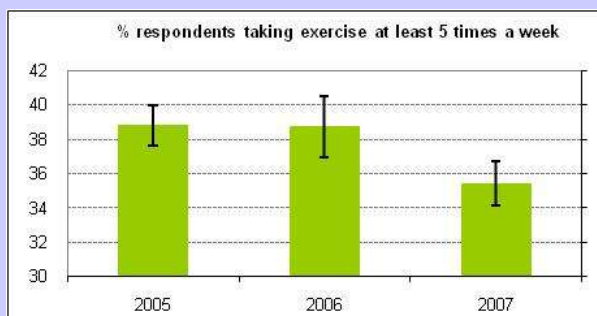
Equalities analysis (above) indicated over half of survey respondents living in NR areas, disabled people, older people and men were overweight. Significantly more people from these groups were also obese, with highest levels recorded for disabled people (30%) and people living in NR areas (23%). But the proportion of men and women who were obese was the same (16%).

Weight and young people's views

In the Every Child Matters survey (2008) more girls said they would like to lose weight and this increased with age. Most 15-16 year old girls (78%) wanted to lose weight, compared to 40% of boys.

Moderate exercise taken by adults

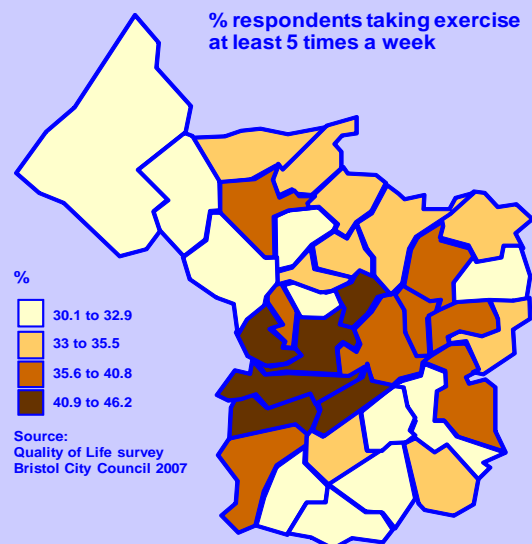
The amount of moderate exercise taken by residents is measured using the annual quality of life surveys. Significantly fewer residents took moderate exercise at least five times a week in 2007 (35%) compared to the previous years (38%).



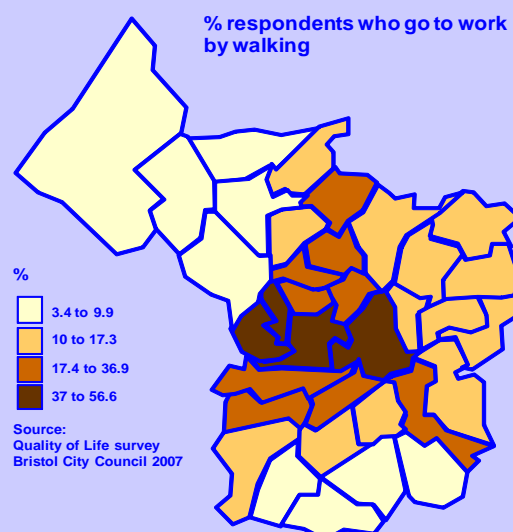
Source: Quality of Life Survey

More residents took regular exercise in central areas with the highest levels recorded in

Clifton (46%). Equalities analysis indicated exercise levels were the same for deprived and non-deprived areas, but were higher for carers (43%) and lesbian, gay and bisexual people (48%). Levels were lowest for disabled people (22%).



Walking or cycling to work can provide valuable exercise and more adults walked to work in these same central wards (map below).



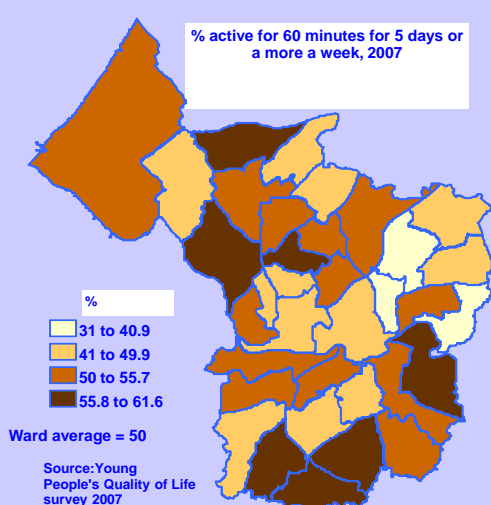
Bristol University researchers using quality of life data have found, not surprisingly, an association between the amount of exercise taken and the proximity to good quality green space and feeling safe in neighbourhoods.

Exercise and older people

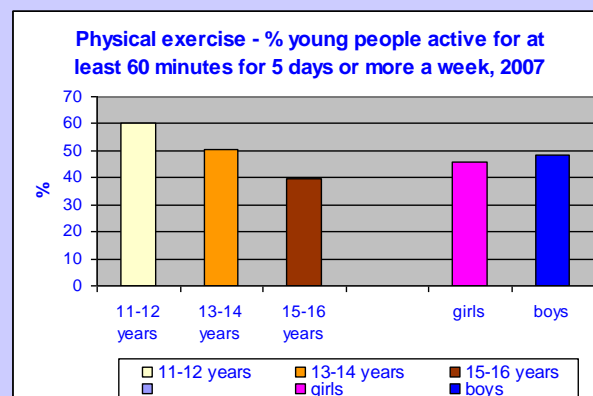
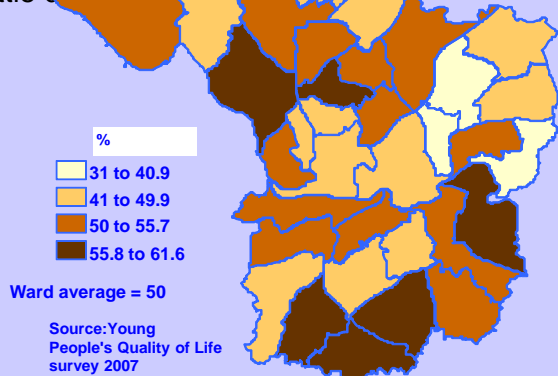
Researchers at Bristol University have been assessing a measure that reflects quality of life of older people (see page 90). Using the results from Bristol quality of life survey, they have found a low quality of life score is associated with low levels of physical activity (ie, people who do not take exercise once a week).

Exercise taken by young people

Secondary school children were asked how often they were physically active for a 60 minute period for at least five days a week (Young People's Quality of Life Survey 2007).



Physical activity was explained as running, brisk walking, biking, skate boarding, swimming, football etc. Just over half (52%) said they were physically active for this period. Boys were more active than girls and the amount of physical exercise dropped with age (following a general trend). The map indicates that in the Eastville and George East areas were exercising least. The area showed little



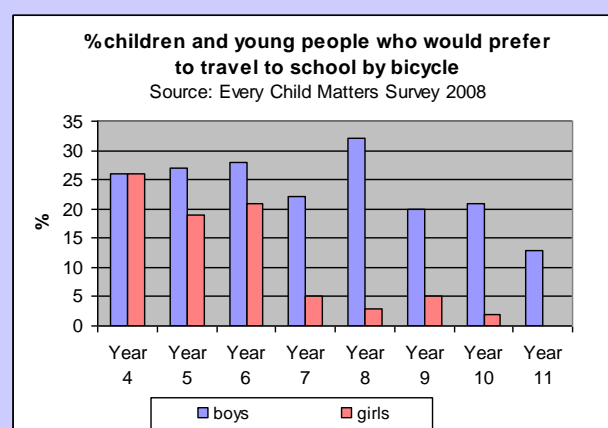
Source: Young People's Quality of Life Survey

Researchers at Bristol University⁵⁰ have found that children from deprived areas take more exercise at home in unstructured play. Children who are driven home from school are less likely to take exercise after school.

Travel to school

In the *Every Child Matters* survey 2008, children and young people were asked about their main mode of transport to school.

- At primary school only 51% of children walk to school, three per cent cycle and a third go by car.
- At secondary school approximately two thirds walk to/from school, 14% travel to/from school by car and eight per cent cycle.
- Primary and secondary school children were asked how they would like to travel if they had a choice; overall 25% of primary school children and 13% of secondary school pupils said they would like to cycle (see graph below).



⁵⁰ Presentation by Melvyn Hillsdon, UoB (April 2008), 'How much does the environment shape physical activity in Bristol'

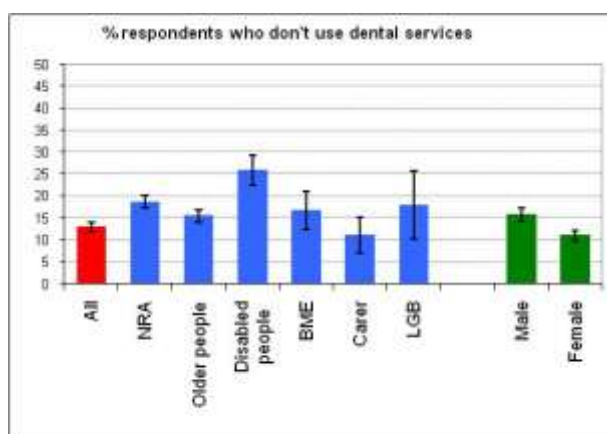
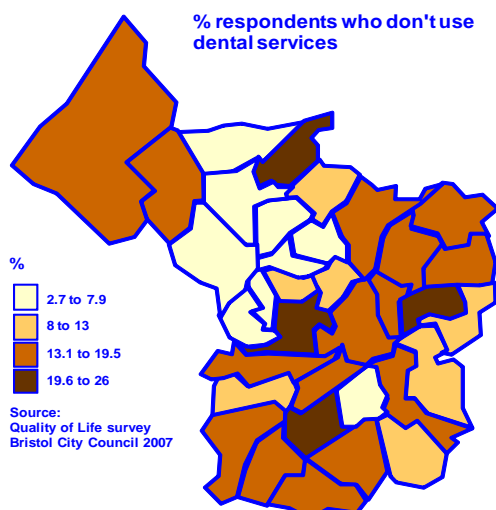
Oral health

People registered with a dentist

There are 56 dental practices with NHS contracts, of which 11 are contracts for special services (orthodontic, oral surgery or sedation). NHS dental care is currently under-served in many of the deprived areas of the city (Hartcliffe, Southville, Bishopworth, Henbury, Southmead, city centre, Lawrence Hill and Easton).

In a Citizens' Panel survey in 2005, ten per cent of panel members said they were not registered with a dentist (see 'local voice' page 91).

In the quality of life surveys, residents were asked if they used private, NHS or no dentist. The graph below shows 13% of respondents did not use a dentist (in both 2006 and 2007), and this figure is significantly higher for people who live in the neighbourhood renewal areas (NRA) (19%), disabled people (26%) and men (16%). The graph suggests that lesbian, gay and bisexual people use dental services less. However, numbers of respondents were small and we are less confident about these figures (Annex 13).

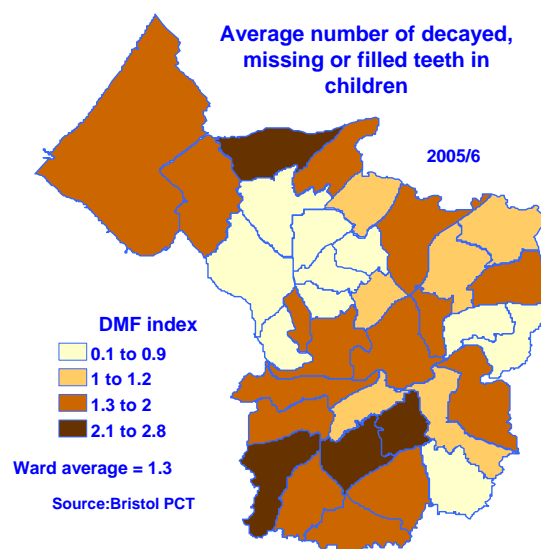


Source: Quality of Life Survey 2007

Children and young people

In Bristol, the proportion of children with tooth decay is similar to the average for England, and it ranks second best of the eight core cities. But oral health outcomes in Bristol are worse than in surrounding areas in the South West.

Bristol PCT conducted a dental decay survey of Bristol's Year 1 children (age five to six years) in 2005-2006. Dental decay is measured by the average number of teeth per child that are decayed (D) or have been extracted/missing (M) or filled (F) - the DMF index. Results showed that half of five to six year olds had decayed teeth, with children living in deprived areas suffering more decay (see map opposite).



Access to NHS dentistry in the Bristol area is low, with only

68% of children registered, and there are fewer dentists in the areas where most tooth decay occurs. Recent investment and service developments are planned to address this gap.

Positive and creative behaviour

Increasing positive and creative activities can improve mental health and wellbeing and can be an alternative to less healthy lifestyles. For example, creative leisure activities can provide a positive diversion in neighbourhoods with high substance misuse, teenage pregnancies and low educational achievement.

Participation in leisure, culture, voluntary and community activity can encourage social interaction and often involve more physical activity.

Social networks, inclusion and sense of belonging

Poor social networks may be associated with a number of health outcomes, including obesity, cardiovascular disease, mental health problems and increased rates of mortality. Social interaction and shared values arising from social networks is associated with better levels of health, social inclusion, psychological wellbeing, educational attainment, employment chances and neighbourhoods with a lower crime rate.

Elderly people who are isolated can be vulnerable if they suffer ill health and lack support from family, friends, neighbours and caring professionals. Isolation can also increase the risk of anxiety and depression.

People who feel they can influence decisions in their local area have a greater sense of wellbeing and feeling of 'belonging' to their neighbourhood. Improving the proportion of people who feel influential is a stretch target in Bristol's Local Area Agreement.

Positive behaviour and quality of life for older people

Researchers at Bristol University have been assessing a measure that reflects quality of life of older people.⁵¹ They have identified through qualitative research five attributes of a quality of life score: attachment, security, role, enjoyment and control. Using the results from Bristol residents' quality of life survey, they have found low quality of life scores are associated with:

- living alone
- never talking to extended family
- being housebound
- having no faith
- doing few creative activities
- attending few culture and leisure events
- not doing voluntary work
- not taking moderate exercise at least once a week.

⁵¹ University of Bristol, Terry Flynn, Department of Social Medicine (2008) ICECAP Instrument Valuation Survey,

Dental Services – Citizens’ Panel Survey, 2005

Panel members were asked about dental treatment. Main findings included:

- 81% were satisfied with their current dentist
- 53% were registered with an NHS dentist
- 36% were registered privately and 42% of this group would prefer to change to an NHS dentist
- 10% were not registered at all. The majority of these people wanted to register with an NHS dentist
- 87% felt they should not have to travel further than five miles to the dentist, and half felt being able to walk to the dentist was important
- the car was the most important mode of transport to the dentist and 67% thought finding a parking space at the dentist was important.

Dentistry Watch Survey Report – Bristol Patients Forum, 2007

This sample survey provided a snapshot of dental services in 2007. It asked how people accessed NHS dental care in Bristol, patients’ and the public’s feelings about treatment, and dentists’ opinions about the services they delivered. Findings were as follows.

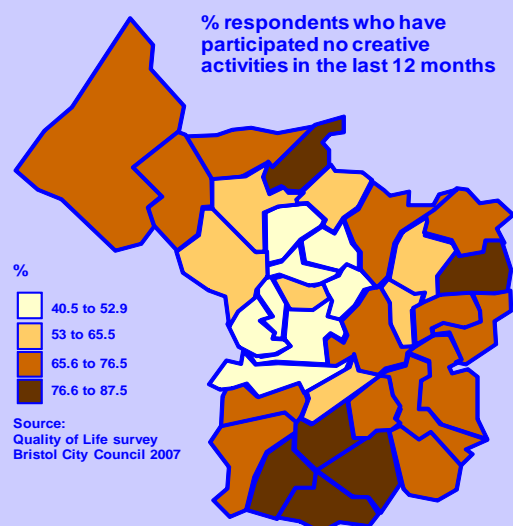
- All NHS patients were happy with the treatment provided by the dentist, and thought charges provided value for money.
- 63% of private dental patients said they went private because they couldn’t get an NHS dentist.
- 59% of dentists surveyed were taking NHS patients.
- 76% of dentists believed the new dental contracts had not made it easier for NHS patients to get an appointment.
- 90% of dentists believed that NHS patients got a worse quality of service than private patients.
- Half of dentists believed the new dental contracts made the quality of care NHS patients receive worse.

Positive and creative behaviour

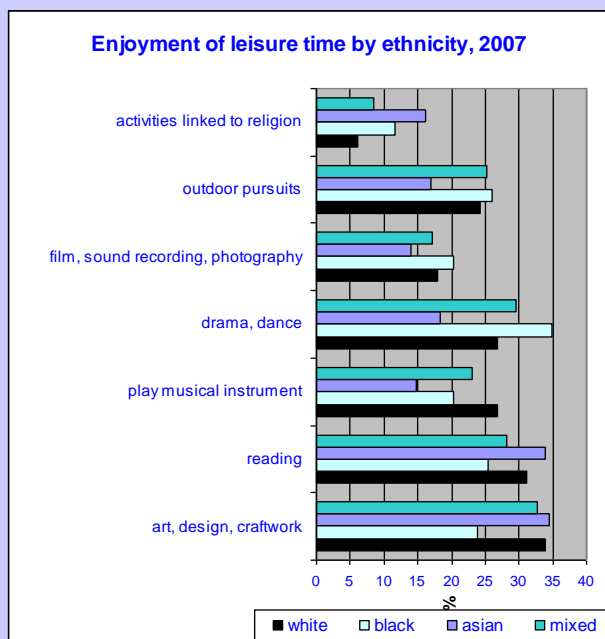
In the Quality of Life Survey 2007 (Annex 13) the question was asked ‘Have you participated in any creative activities in the last 12 months?’ Creative activities were defined as:

- art/design/crafts
- drama/dance
- creative writing
- play musical instrument/sing
- video/sound recording/photography
- other (describe).

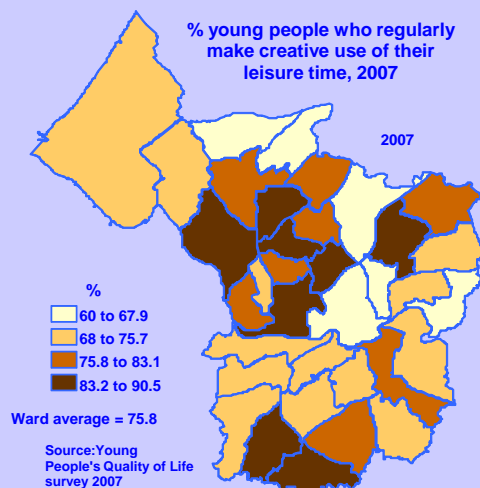
Over a third of respondents (34%) overall said they had participated in creative activities, but 76% of residents living in NR areas and 81% of disabled people did not participate. The following map identifies wards in the south of the city, and wards with deprived areas, with fewer residents participating in creative activities.



A similar question was explored in the *Young People’s Quality of Life Survey 2007*. Three quarters (76%) said they participated in creative activities for at least two hours a week. For some creative activities there were clear differences by ethnicity (see next graph). More Black young people had a preference for physical activities like drama, dance, filming and sport, whilst Asian young people spent more time on reading, art and activities linked to their religion. Spatial analysis indicated fewer young people participated in creative activities in neighbourhood renewal areas, particularly in Southmead, Lockleaze, Lawrence Hill, Easton, Henbury and St George East.



Source: Young People's Quality of Life Survey



Leisure and cultural activity for older people

The Bristol Older People's Forum⁵² (BOPF) and the Council's quality of life survey (QOL) asked older people about how often they participated in leisure and cultural activities.

- 30% said they did not make use of the city's leisure, recreation and cultural facilities (BOPF).
- 39% of older people said they participated in three or more leisure or cultural events in the last 12 months, compared to 49% in the city overall (QOL).

⁵² Bristol Older People's Forum (BOPF) Quality of Life Survey 2006, based on a sample of 561 older people in Bristol.

Social contacts and isolation

The Bristol Older People's Forum asked older people about their social contacts:

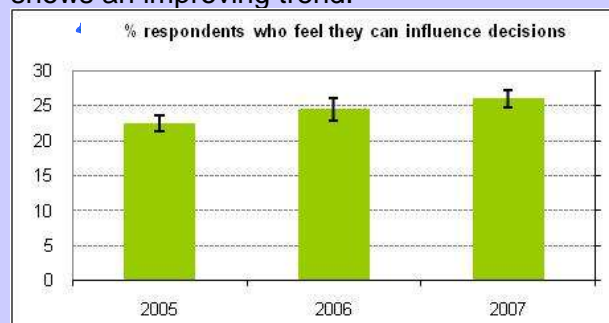
- 8% said their social contact with family and friends was poor
- 70% described their social contacts as good.

Social contact was also explored in the Council's Quality of Life Survey 2007:

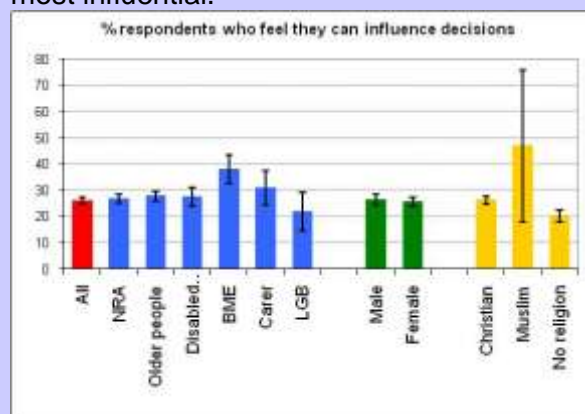
- 89% of older people (aged 50 and over) said they talked to (or texted /emailed) family friends, acquaintances and caring professionals at least once a week
- 6% of older people said they never had contact
- 7% of residents living in neighbourhood renewal areas said they never had contact
- 11% of disabled people said they never had contact.

Feeling influential

'Do you feel you can influence decisions in your local neighbourhood?' has been asked in the quality of life survey for several years. The proportion of residents feeling influential shows an improving trend.



The following graph shows results from 2007 when more residents from BME groups felt most influential.



Source: Quality of Life Survey (both graphs)

Neighbourhood Partnership area summary

The variation in healthy lifestyle behaviour indicators across wards in Bristol is shown in the table below.

Significantly better than average

Significantly worse than average

Neighbourhood Partnership	Smoking attributed mortality 2001-2006	Alcohol attributed mortality 2001-2006	% residents overweight and obese 2006	Teenage conceptions 2002-2004	Substance misuse – vulnerable young people 2007	% residents who take moderate exercise at least once a week
1. Avonmouth and Kingsweston	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth
	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston
2. Henbury and Southmead	Henbury	Henbury	Henbury	Henbury	Henbury	Henbury
	Southmead	Southmead	Southmead	Southmead	Southmead	Southmead
3. Stoke Bishop, Westbury-on-Trym and Henleaze	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym
	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop
	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze
4. Cabot, Clifton, Clifton East	Cabot	Cabot	Cabot	Cabot	Cabot	Cabot
	Clifton	Clifton	Clifton	Clifton	Clifton	Clifton
	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East
5. Cotham, Redland and Bishopston	Cotham	Cotham	Cotham	Cotham	Cotham	Cotham
	Redland	Redland	Redland	Redland	Redland	Redland
	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston
6. Horfield and Lockleaze	Horfield	Horfield	Horfield	Horfield	Horfield	Horfield
	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze
7. Eastville, Frome Vale and Hillfields	Eastville	Eastville	Eastville	Eastville	Eastville	Eastville
	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale
	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields
8. Ashley, Lawrence Hill and Easton	Ashley	Ashley	Ashley	Ashley	Ashley	Ashley
	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill
	Easton	Easton	Easton	Easton	Easton	Easton
9. St George East and St George West	St George East	St George East	St George East	St George East	St George East	St George East
	St George West	St George West	St George West	St George West	St George West	St George West
10. Southville and Bedminster	Southville	Southville	Southville	Southville	Southville	Southville
	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster
11. Bishopsworth, Hartcliffe and Whitchurch Park	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth
	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe
	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park
12. Filwood, Knowle and Windmill Hill	Filwood	Filwood	Filwood	Filwood	Filwood	Filwood
	Knowle	Knowle	Knowle	Knowle	Knowle	Knowle
	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill
13. Brislington East and Brislington West	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East
	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West
14. Stockwood and Hengrove	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood
	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove

Key pointers for healthy lifestyles

Smoking

Smoking is the single biggest cause of the difference in death rates between the rich and the poor. The proportion of adults who smoke in Bristol is falling. Surveys have also indicated the gap is narrowing for 'smoking in pregnancy' between the deprived communities and the rest of the city. But many children and young people are exposed to second-hand smoke at home and can suffer poor health; 31% said they lived in households with 'others smoking' (48% in deprived areas). More girls smoke than boys, and this proportion is increasing.

Related current initiatives

- The Council is restricting and controlling tobacco advertising, promotion and sponsorship.
- Stop smoking services are available and are delivered through the NHS.
- 'Support to Stop' advice is being given to young people in deprived parts of Bristol.
- Through the Smoke Free Homes Strategy, all frontline healthcare, environmental health and Avon Fire and Rescue staff will receive training and during their routine visits they will promote the benefits of not smoking indoors. Fact sheets have also been provided for private landlords and housing associations.
- ASSIST smoking prevention project has 18 schools signed up to a training package. It is targeting young smokers aged 12-13 years and high smoking levels in Bristol's Special Schools.

Sexual behaviour

Higher levels of teenage pregnancy in Bristol are found mainly in areas of deprivation and in areas of low educational achievement. Alcohol misuse can also lead to unplanned and unprotected sexual activity. Fewer young people in 2007, particularly boys, say information and advice on contraception and relationships is available (compared to 2006).

Chlamydia diagnoses of this sexually transmitted infection are increasing.

Related current initiatives

- In consultation with young people, Bristol is establishing an identity for Young People's Sexual Health Services (4YP), which will raise the profile and ensure services perform at the accepted standard. Sexual health drop-ins have been established in 14 secondary schools run by the Brook Clinic.
- The chlamydia screening programme is being rolled out across Bristol and the South West. The programme is increasing detection and will continue to do so for the next year, aiming for a 50% coverage of 15-24 year olds.

Gaps in our knowledge

- Future health needs of older people (aged 55 years plus) who are sexually promiscuous, are not known for this age group. 'Safe sex' messages have not been targeted at older people.

Substance misuse

The number of adults who misuse drugs is well above the England and core cities average. The city has the second highest number of drug users in treatment in the country.

- The number of people accessing treatment for substance misuse is increasing and waiting times to access treatment are reducing. Most clients (89%) stay on drug treatments for 12 weeks or more, increasing the effectiveness of their treatment.
- Many admissions related to drug misuse come through A&E departments. This can reflect poor 'user' contact with health services and a reluctance to seek treatment, and early

intervention services would be helpful.

Alcohol related and specific hospital admissions and alcohol-related domestic violence are increasing in Bristol and levels are worse than in most core cities. The gap between alcohol-specific admissions in the deprived communities and in the rest of the city is not closing.

- Alcohol consumption for young people remains high with over a third of 15-17 year olds admitting to regular drinking, and can be associated with risk-taking behaviour. Not all substance misuse services are offering primary alcohol interventions and therefore there may be an underestimate of the need.
- Hospital admissions for alcohol-specific conditions for males aged under 18 (per 100,000) are higher than most core cities - sixth (worst) out of eight.

The current design of the city centre and dockside appears to be for a youth-based alcohol industry. This is limiting its use as a 'living city centre' used by all cultures and ages.

Related current initiatives

- The Early Intervention Service is reducing substance misuse and increasing treatment rates for young people aged 18 years and under. This is mainly delivered in state secondary schools, pupil referral units and special schools.
- A family intervention group has been set up by the Young People's Drug Treatment Service to provide support that parents say they need.
- Harm reduction services for adults currently being prioritised include: expansion of the needle and syringe exchange, enhanced awareness and education for injectors and staff, specialist nursing via open access and mobile facilities and proactive outreach to drug users.
- Drug services users are involved in the commissioning process and have developed a service-user form.
- Two specialist domestic violence units have recently been established that will help tackle alcohol-related incidents.
- The update of the young people's substance misuse needs analysis will focus on alcohol use and hidden harm (substance misuse by a parent or carer).
- A multi-partnership group (Council, police and PCT etc) is being established to address the make-up of the city centre and dockside and promote its use as a 'living city centre'.
- A Supporting People commissioning plan for drugs and alcohol services of £1.7 million has been agreed.

Gaps in our knowledge

- No information is available in Bristol on attendances at Accident and Emergency departments or for ambulance calls for illnesses and injuries related to alcohol, so there is no ethnicity breakdown available.
- There is no recording by GPs of alcohol-related conditions.
- Alcohol misuse by newly arrived migrants, Gypsies and Travellers is not known due to poor ethnicity recording.
- Future health needs of older people (aged 55 years plus) who are current alcohol and drug misusers, are not known.

Nutrition and obesity

The health benefits of breastfeeding can last a lifetime and can help protect against obesity. A gap exists between breastfeeding (at six-eight weeks) in the deprived communities and in the rest of the city. There is still a lack of basic cooking skills and knowledge of healthy eating amongst young adults in deprived areas.

The prevalence of obesity is increasing.

- Prevalence is higher in Year 6 (10-11 years) than in Reception (four to five years) and is

increasing. There is a strong correlation between parental and child obesity.

- Obesity is likely to increase by 13% in the population aged over 65 years by 2025. This older population is set to increase leading to an even higher number of obese residents in the city.
- There are more residents in Southmead, Lockleaze, Bishopsworth and Filwood who are overweight or obese.

Related current initiatives

- Bristol will be implementing the UNICEF Breastfeeding Baby Friendly Initiative (BFI) in hospitals (already accredited) and in the community by October 2009. By implementing BFI in the community, Bristol will become one of the first 'BFI cities'.
- Nutrition in schools is improving through Bristol Healthy Schools and Transforming School Meals Agenda.
- In 2008, a childhood obesity clinic is due to start in Knowle West and a clinic has already started in Horfield.
- Six 'MEND' (obesity and treatment) programmes have been developed for young people across Bristol.
- Bristol's Food and Health Strategy (BCC and PCT) is improving diet and health:
 - by prioritising projects in deprived communities with high health needs e.g. Cooking from Scratch for teenagers and young parents in Knowle West is improving knowledge of cooking skills, nutrition and food hygiene.
 - through the Council healthy food policy
 - by improving diets for older people through nutrition training for social care personnel and through healthy eating advice in lunch clubs.
- National Food Champion Award – the Council Public Health Services have won this Food Standards Award for the promotion of community diet and nutrition.

Gaps in our knowledge

- There is national recognition that more research is needed into the determinants of obesity to provide better evidence of risk factors for vulnerable adults, children, low income and ethnic communities.

Physical exercise

An increase in adult and child physical activity would bring health benefits. There is an association between the amount of exercise taken and the proximity of access to good quality green space and feeling safe in the locality. The greatest impact on children's freedom to play and take physical exercise has been increased use of the car.

- Walking one hour more per week (difference between a typical driver and non-driver) would counteract a weight gain increase of two stone over a decade, and a longer term slide into obesity.
- There are low levels of physical activity in the population aged 75 years and over.
- Few children and young people cycle to school (less than 10%). When asked how they would like to travel to school if they had a choice (*Every Child Matters Survey 2008*), 13% of secondary pupils and 25% of primary pupils said they would like to travel by bicycle.

Related current initiatives

- The Healthy Schools Programme is increasing opportunities for healthy lifestyles with school travel plans promoting cycling.
- Active Bristol is an ambitious programme 2008-2013, to reverse the decline of physical activity for people in Bristol. The programme will use a social marketing strategy to influence target groups. It has two strands – Active Travel and implementing the physical activity strategy. Examples of Active Travel projects include:
 - group led walks for older people
 - Bike It to Bristol schools – a Council and Sustrans project to encourage more children to cycle

- new Council health and transport specialist
- reducing speeds driven in residential streets.
- Everyone Active – this Council initiative is to encourage everyone to take part in activities to improve their fitness and wellbeing. It is the new brand for the Council's five leisure centres and three swimming pools.
- GP Physical Activity Referral Scheme enables GPs to refer patients to Council sports and fitness centres to improve health and wellbeing.
- Bristol has been chosen as England's first Cycling City – a premier showcase city for promoting cycling as a safe, healthy and practical alternative to the private car. The successful bid has secured £11.4 million (for Bristol and South Gloucestershire) to transform the cycling infrastructure.
- Recreational facilities for children and young people in deprived parts of the city, are being improved through the Play Lottery Programme, Play Bus and Play Van, play programme for disabled and BME children, Pen Park facility and South Bristol Sports Centre.

Oral health

NHS dental care is currently under-served in many of the deprived areas of the city. Access for children to NHS dentistry in the Bristol area is low with only 68% of children registered. There are fewer dentists in the areas where most tooth decay occurs.

Related current initiatives

- A dental student outreach facility in the South Bristol Community Hospital is due to open in September 2009. It will have 20 dental chairs and is estimated to provide 20,000 outpatients appointments per year.
- A new practice will open in Hartcliffe in 2008, with potentially another new practice opening in Southmead.

Positive behaviour and social networks

Increasing positive and creative activity can improve mental health and wellbeing . Only 28% of all residents in the south of the city participate in creative activities and only 21% of disabled people participate.

Good social networks can be associated with good health outcomes, psychological wellbeing and happier neighbourhoods. Older people and disabled people can suffer from isolation and community support.

- In the *Bristol Older People's Forum Survey 2006*, eight per cent said their lack of social contact with family and friends was poor.
- In the *Quality of Life Survey 2007*, 11% of disabled people said they never talk to, text or email family, friends and caring professionals.

Related current initiatives

- Developing a young people's website 'Go Places Do Things' which will provide information about things to do in all areas of the city. The Council will improve access to facilities and activities by working with transport providers.
 - The Council now has an *Older People's Quality of Life Strategy* in place, see <http://www.bristol.gov.uk/ccm/content/Health-Social-Care/Services-for-the-elderly/older-people-in-bristol-strategy.en> It is aimed at those who are 50-plus and has been developed with older people from the Bristol Older People's Forum - identifying the things that older people themselves really want to see changed. The plan has Five Big Ideas.
1. Celebrating Age annual event is helping to promote services and activities for older people in the city and promote a positive image.

2. LINKAGE project will develop a network of activity to support older people and address the gap in services. LINKAGE hopes to achieve improved access to services, supporting older people to make a positive contribution to other older people's lives, providing activities good for people's mental health and physical wellbeing and providing practical help. The project is being piloted in two neighbourhoods – Bedminster/Southville and Easton/Lawrence Hill.
3. Volunteering - motivation, support and training for older people to make a contribution to the community through volunteering.
4. The first contact check list - provides a broad range of simple questions that professionals can ask an older person e.g. about benefits, home maintenance, fire safety, home security, falls etc, and help refer them on for further help, support or services.
5. Assistive technology - provision of a basic 'assistive technology' pack - (a community alarm, fire alarm, bogus caller alarm, very low temperature alert, falls monitor and access to a call out service if required), for frail older people who live in their own homes.

Gaps in our knowledge

- The location of people aged 85 and over is not known.

Summary of Chapter 5

Not surprisingly, lifestyle risk factors such as smoking, alcohol and drug misuse, obesity/poor diet and lack of physical activity all contribute to poorer health outcomes (cancer, heart disease, stroke, diabetes and other long-term conditions). This is especially so in groups experiencing deprivation, where ability to make healthier choices is often limited by poor socio-economic conditions (poor knowledge of cooking skills and nutrition, lack of access to shops selling healthy food, lack of access to safe open spaces for activity etc.)

There are links between lower educational attainment, deprivation, substance misuse and risk - taking behaviour (see section on teenage pregnancy).

Levels of obesity are increasing – particularly in children, thus storing up significant health problems for the future – especially if linked to other lifestyle risk factors already discussed. If current trends in obesity continue, health and social care services will struggle to meet demands in the future (with more people living with long term conditions and increasing hospital admissions for obesity-related illnesses).

Tackling obesity has striking similarities to tackling climate change. Many climate change goals also prevent obesity - such as measures to reduce traffic congestion, increase cycling and walking, design of sustainable communities and reducing carbon footprints. Improving health is an essential element in the design of sustainable communities.

Some of these issues will be addressed with the Corporate Plan priorities, Local Area Agreement (LAA) targets and World Class Commissioning outcomes (pages 18), to *tackle inequalities, improve physical activity, reduce obesity, reduce teenage pregnancies, reduce the harm caused by alcohol and drugs misuse, reduce smoking and exposure to second hand smoke*. There are opportunities to make strategic links between reducing obesity and interventions to tackle climate change.

6. The burden of ill health – morbidity and mortality

Relevant national indicators:

- *NI 120 All age all cause mortality rate*
- *NI 121 Mortality rate from all circulatory diseases for ages under 75*
- *NI 122 Mortality rate for all cancers at ages under 75*
- *NI 137 Healthy life expectancy*

Health deprivation and life expectancy

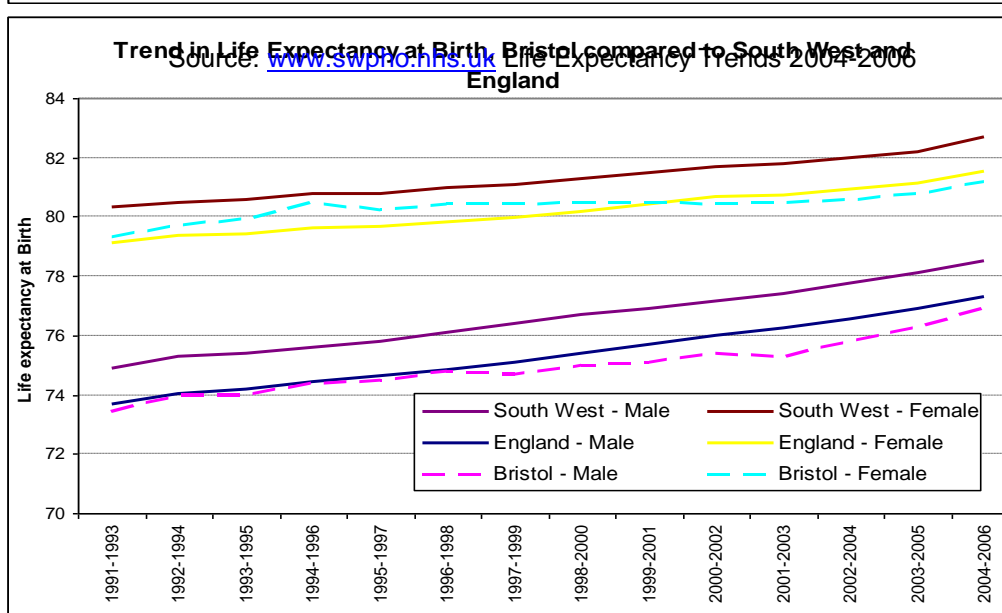
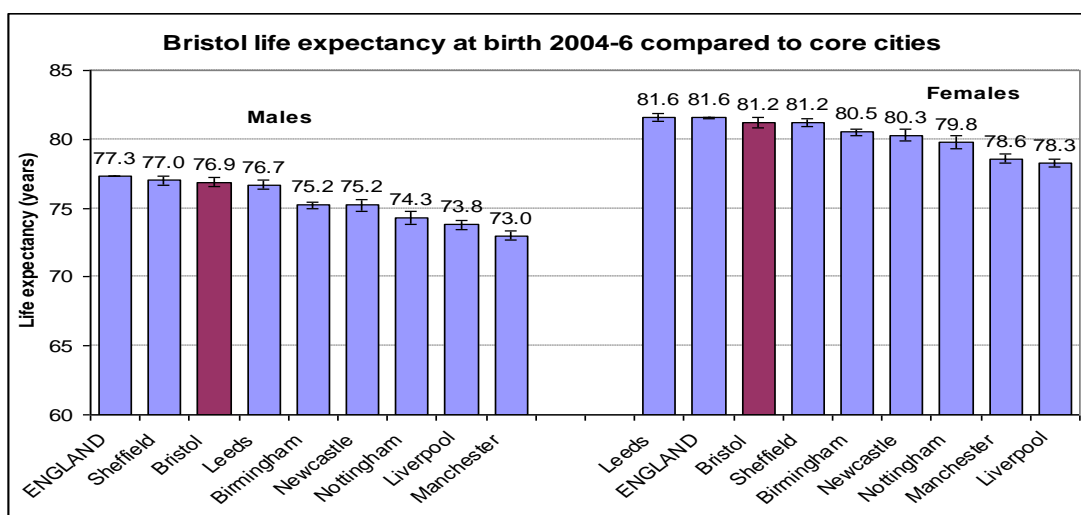
When looking at health and disability in relation to deprivation, the Department of Communities and Local Government English Indices of Deprivation 2007 have drawn together a number of indicators within the domain for 'health deprivation and disability'. These include:

- years of potential life lost (ONS 2001-2005)
- comparative illness and disability ratio (Department of Work and Pensions (DWP) 2005)
- measures of acute morbidity, derived from Hospital Episodes Statistics (DH 2004-2005)
- measure of adults under 60 years suffering from moods and anxiety disorders based on prescribing (Prescribing Pricing Authority 2005), Hospital Episodes Statistics (DH 2004-2005) and Incapacity Benefit data (DWP 2005).

These indicators are combined as a single indicator for Health Deprivation and Disability 2007 and results can be mapped across the city (see following map, page 98). The map shows that the most economically-deprived residents occupy the neighbourhoods with high levels of health deprivation and disability.

Life expectancy at birth is an estimate of the average number of years a new born baby would survive if he or she experienced the particular area's age-specific mortality rates throughout his or her life.

Life expectancy for Bristol residents is increasing and compares well against other core cities (next graph). For the period 2004-2006, life expectancy was 76.9 years for males and 81.2 years for females in Bristol. Life expectancy is slightly lower than the national average; 0.4 years below for Bristol males and 0.3 years below for Bristol females.



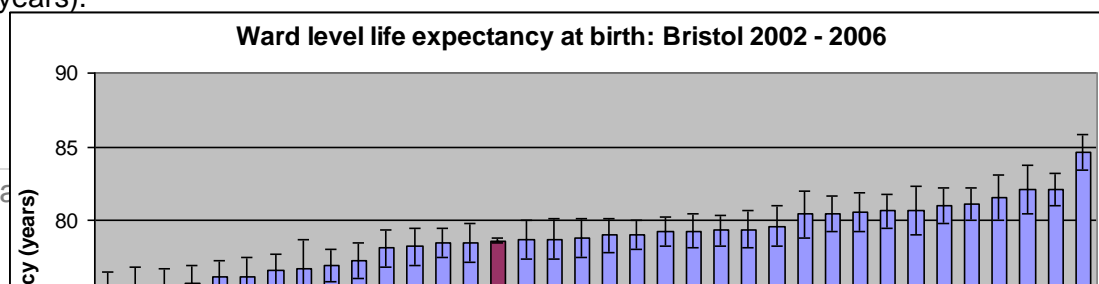
Source: www.swpho.nhs.uk Life Expectancy Trends 2004-06.

Over the last three years (from 2001-3 to 2004-6) Bristol has seen an improvement in male life expectancy that is greater than that for England, South West and the core cities. However, the improvement rate for female life expectancy in Bristol is less good when compared with other core cities i.e. is higher only than Liverpool's.

Life expectancy is improving nationally (above) but trends in healthy life expectancy have not kept pace with improvements in total life expectancy. See Disability and LLTI, page 124.

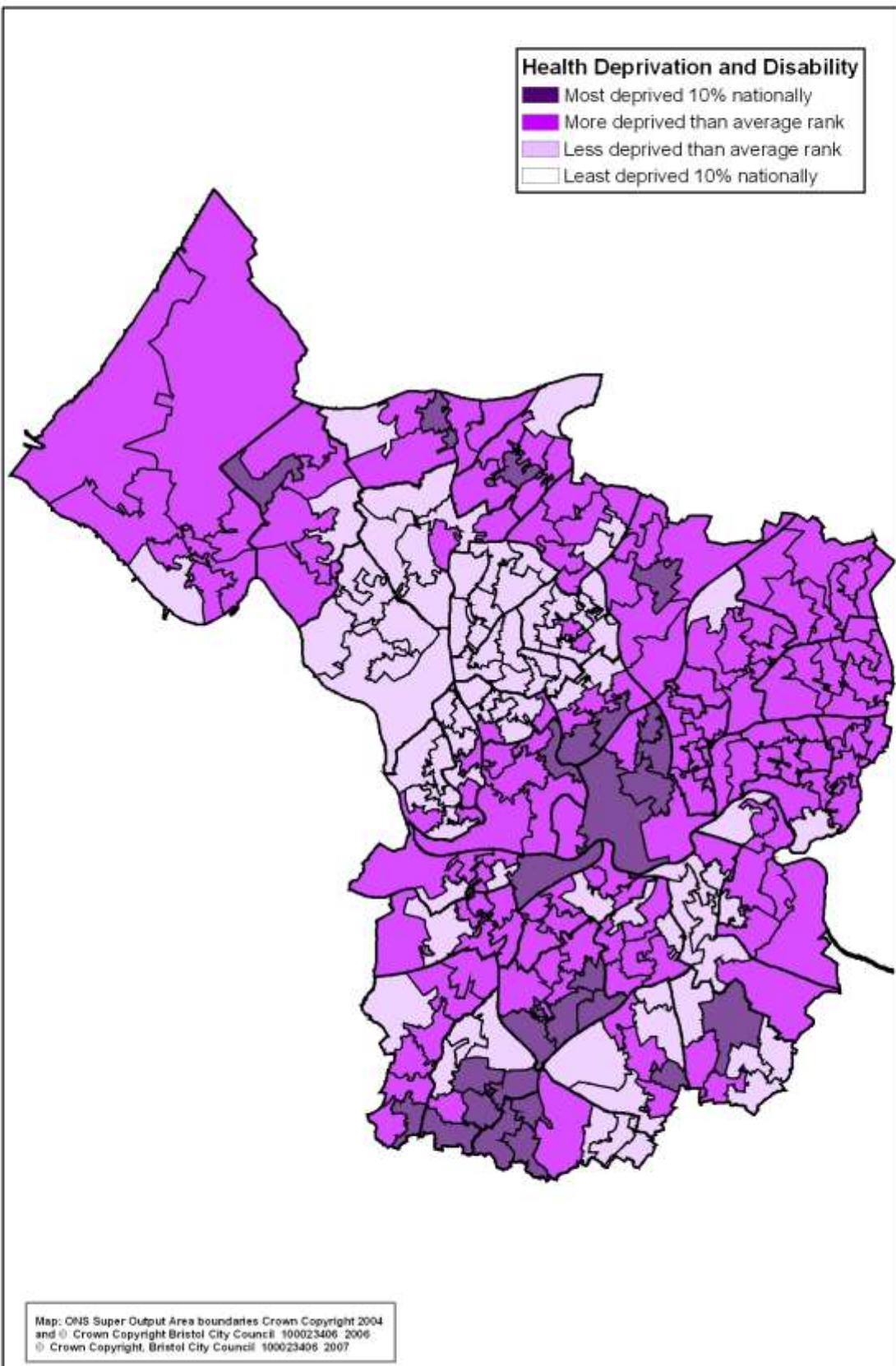
Life expectancy at ward level has been measured since 1998-2002. From this date until 2001-2005 a ten year gap has remained for life expectancy at birth between the most affluent and most deprived Bristol wards. Figures for 2004-2006 indicate this gap has now narrowed to nine years (below). Southmead has the lowest life expectancy (75.3) and Henleaze has the highest (84.6). From 2001-2005 the overall life expectancy for Bristol has increased from 78.3 to **78.6** years.

Confidence intervals suggest significant increases from 1998-2002 to 2002-6 for 5 wards: Ashley (3.5 years), Brislington East (2.4 years), Clifton East (3.6 years), Cotham (3.4 years) and Lawrence Hill (2.6 years).

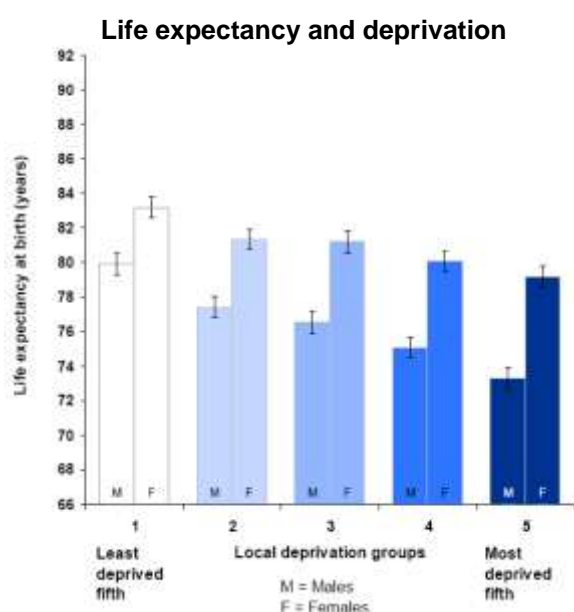
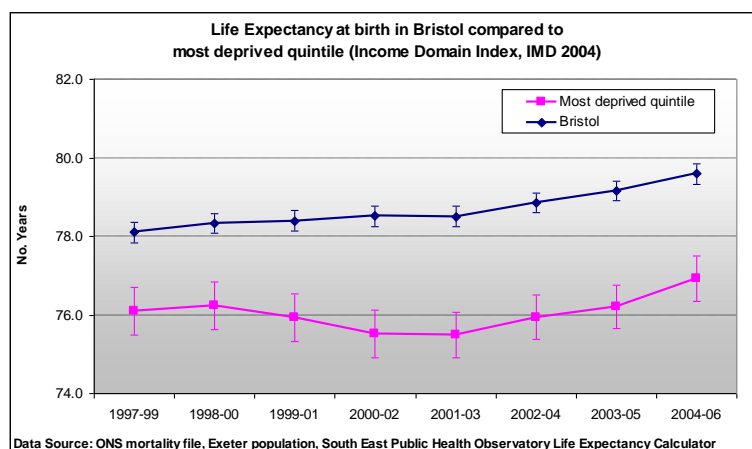


Deprivation in Bristol 2007

Source: DCLG English Indices of Deprivation 2007 analysed by Strategic and Citywide Policy, PTSD



When the most deprived quintile (20% of the population) is compared to the rest of the city, the gap is not widening. But inequalities in life expectancy for men are more marked in deprived groups (lower graph based on 2002-2006 figures). See also Annex 16, which shows excess mortality for males in the most deprived quintile.



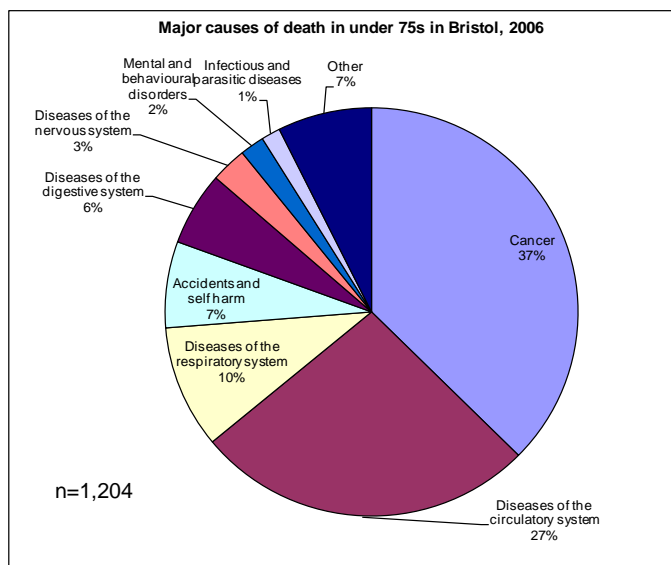
Source: Health Profile for Bristol 2008, www.healthprofiles.info

The government has set a target to reduce health inequalities by ten per cent by 2010 as measured by infant mortality and life expectancy. For the life expectancy component of the target, the government aims to reduce by at least ten per cent the gap between the 20% worst areas for health deprivation indicators and the population as a whole. A recent review found that 'life expectancy at birth' is not a well understood concept, so 'all age all cause mortality' (AAACM) rates which are a very close proxy for life expectancy, will be used to monitor changes. If AAACM rates improve, life expectancy will improve.

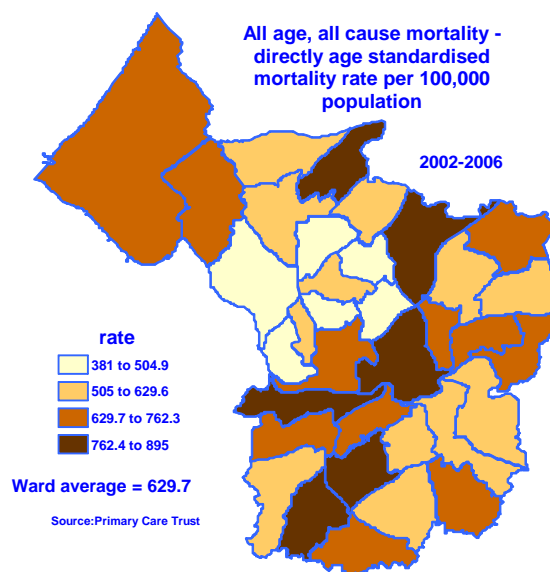
All cause death rates

In 2006, 1,204 people died before the age of 75 (over a third of all deaths in 2006). Major causes of death are cancer and circulatory diseases (heart disease and stroke). These account for almost two thirds of deaths of under 75s (see pie chart overleaf).

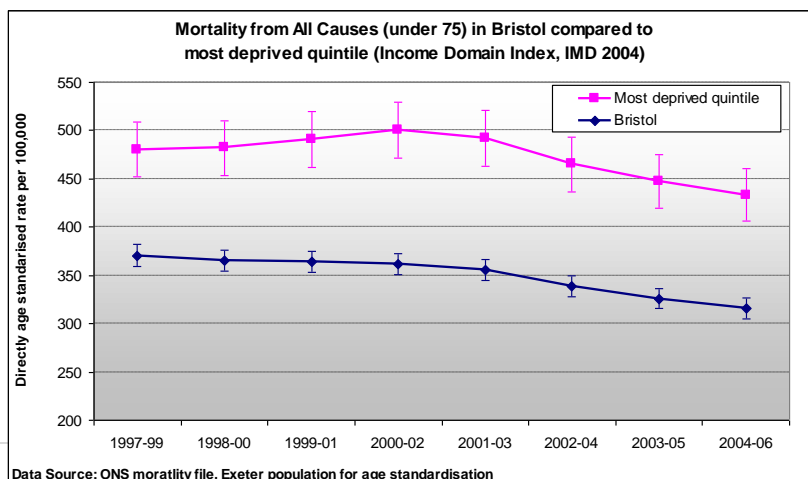
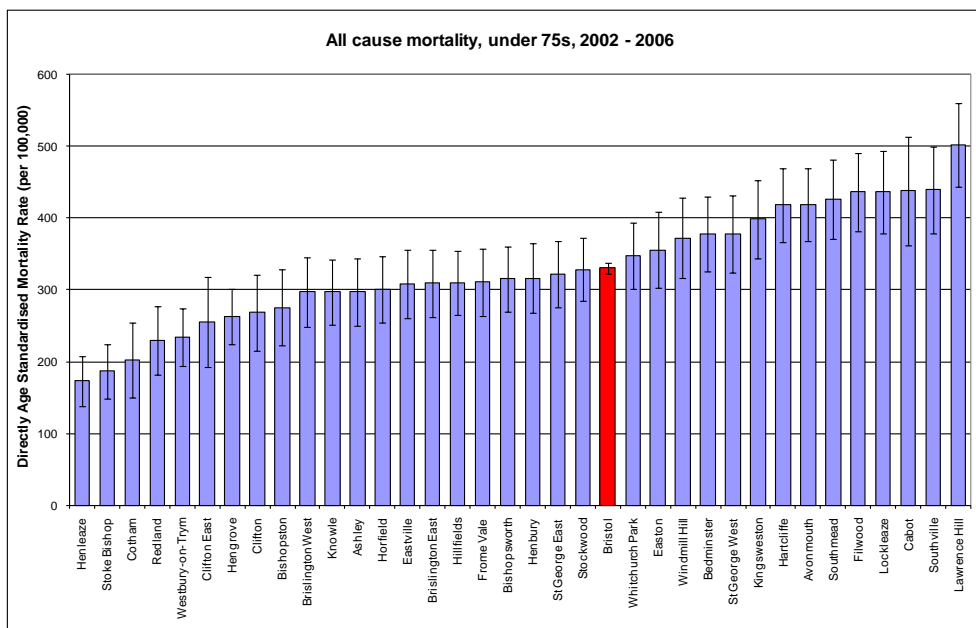
The indicator 'All age, all cause mortality' is shown in the map overleaf, for the five year period 2002-2006. More deaths occur in the more deprived wards, but the highest number is in Southville.



Source: Bristol Primary Care Trust

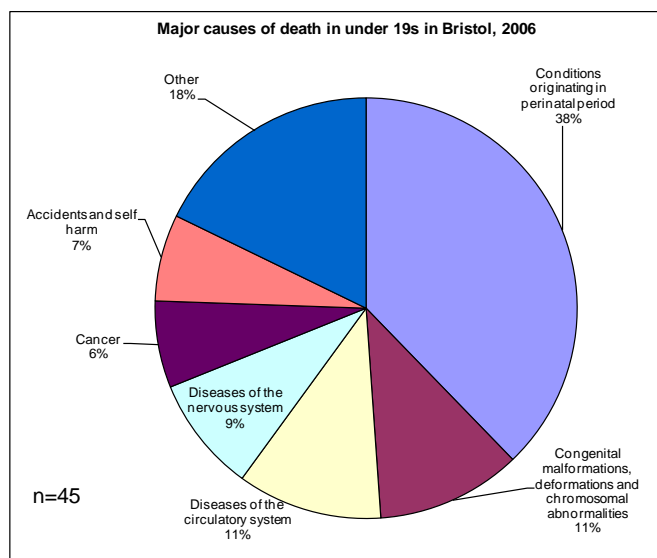


The following graphs show how Bristol wards and the most deprived quintiles compare for premature death (all cause mortality aged under 75 years). The gap does not appear to be closing between these areas. This indicator shows Lawrence Hill ward is significantly worse than the rest of the city. Of Bristol's deprived wards, Ashley is the exception, and has low mortality rates due to the more heterogeneous nature of the ward with some pockets of affluence.



Infant and child mortality

Fortunately deaths in children and teenagers are rare. In 2006, 45 deaths occurred in those under the age of 19 in Bristol. The major causes of death in childhood are from conditions originating in the perinatal period (from 24 weeks gestation up to six completed days of life). These include complications of pregnancy, labour and delivery, low birth weight, slow foetal growth, infections and congenital problems.



Source: Bristol Primary Care Trust

Deaths of infants aged less than one year was 5.0 per 1,000 live births in Bristol in 2006-2007, close to the England average of 5.1. Bristol also ranks top (best) out of the eight core cities. There has been a steady fall in infant mortality in Bristol over the last five years, including perinatal mortality (number of stillbirths and deaths of infants at ages under seven days). Despite the fall in infant mortality there are still health inequalities, and babies from families from low-income groups are more likely to die before their first birthday. Urgent action is required to firstly stabilise the gap and then secondly, to narrow the gap.

Other factors that can contribute to infant mortality include:

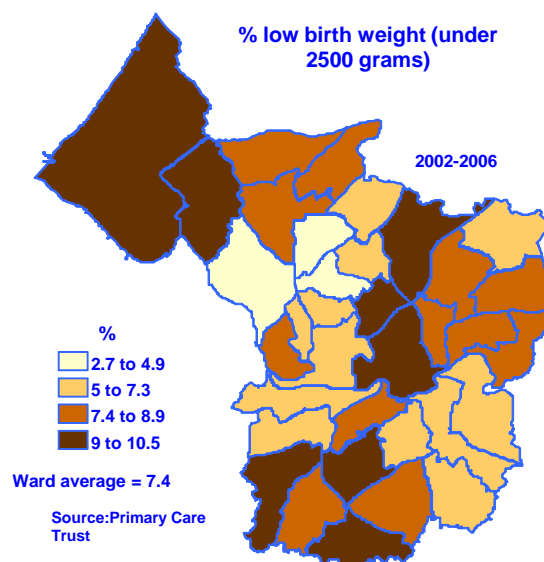
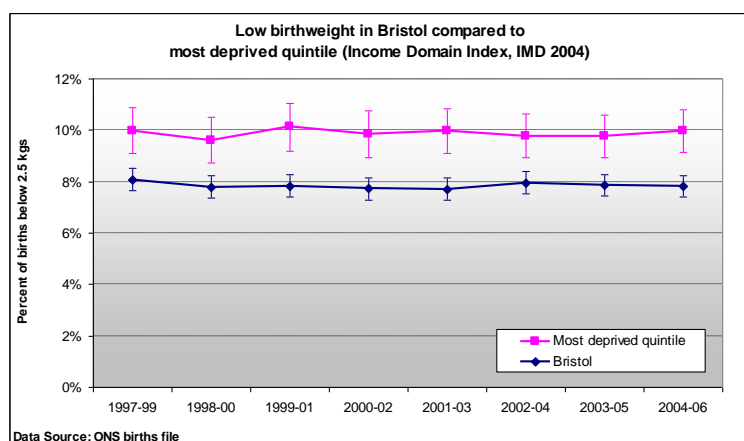
- low birth weight
- poor take-up of antenatal care, late booking for antenatal care
- sharing a bed with the baby
- baby sleeping on its front
- smoking in the house
- overcrowded housing conditions.

Low birth weight

Low birth weight can be caused by premature birth and/or growth restriction in utero. This can lead to poor health in infancy, increased risk of ill health and disability in later life and premature death.

Low birth weight (less than 2,500 grammes) is associated with:

- ethnicity – low birth weight is commoner amongst BME groups
- drug dependency
- smoking during pregnancy
- teenage pregnancies
- women who book late for antenatal care
- multiple births.



Women belonging to BME groups, particularly those born outside the UK, teenage mothers, and women with more disadvantaged backgrounds are likely to book late for antenatal care.⁵³

The map above identifies the more deprived wards of Whitchurch Park, Filwood and Ashley as having the lowest birth weights. Between 2002-2006, Bristol's low birth weight rate was 7.8%, close to the England average of 7.9%.

Low birth weight trends (graph above) show that the gap between the most deprived quintile and the rest of the city has not closed.

Very low birth weight babies

The proportion of very low birth weight babies (less than 1500 grammes) born each year is 1.5% in Bristol⁵⁴ (same as national picture), equivalent to approximately 90 babies.

The number of very low birth weight babies is increasing due to a number of factors. Bristol's birth rate is rising and neonatal expertise available in Bristol means that women with a risk of premature delivery may be cared for in the city rather than in a local maternity unit. The current threshold for considering a baby to be viable is 23 weeks and this is unlikely to fall further. But modern developments in obstetric practice and foetal medicine are improving survival of babies born at 24 and 25 weeks gestation, needing neonatal care. In addition, advances in In Vitro Fertilisation (IVF) and fertility treatment mean there are more multiple births.

Many of these very low birth weight babies, and babies born in multiple births, carry higher risks of developing abnormalities, disabilities and complex needs.

The EPICure National Study (2005) traced 1,125 babies born in England in 1995 at under 26 weeks gestation. Of these, only 314 survived (28%) and nearly half developed a disability or learning difficulty (see also page 129 'children with complex needs').

Cancer

Cancer is one of the biggest killers in Britain. One in three people will be diagnosed with cancer in their lifetime and one person in four will die from cancer. The total number of new cases is increasing by 1.4% per annum in Britain. Around 130,000 people die from cancer every year and

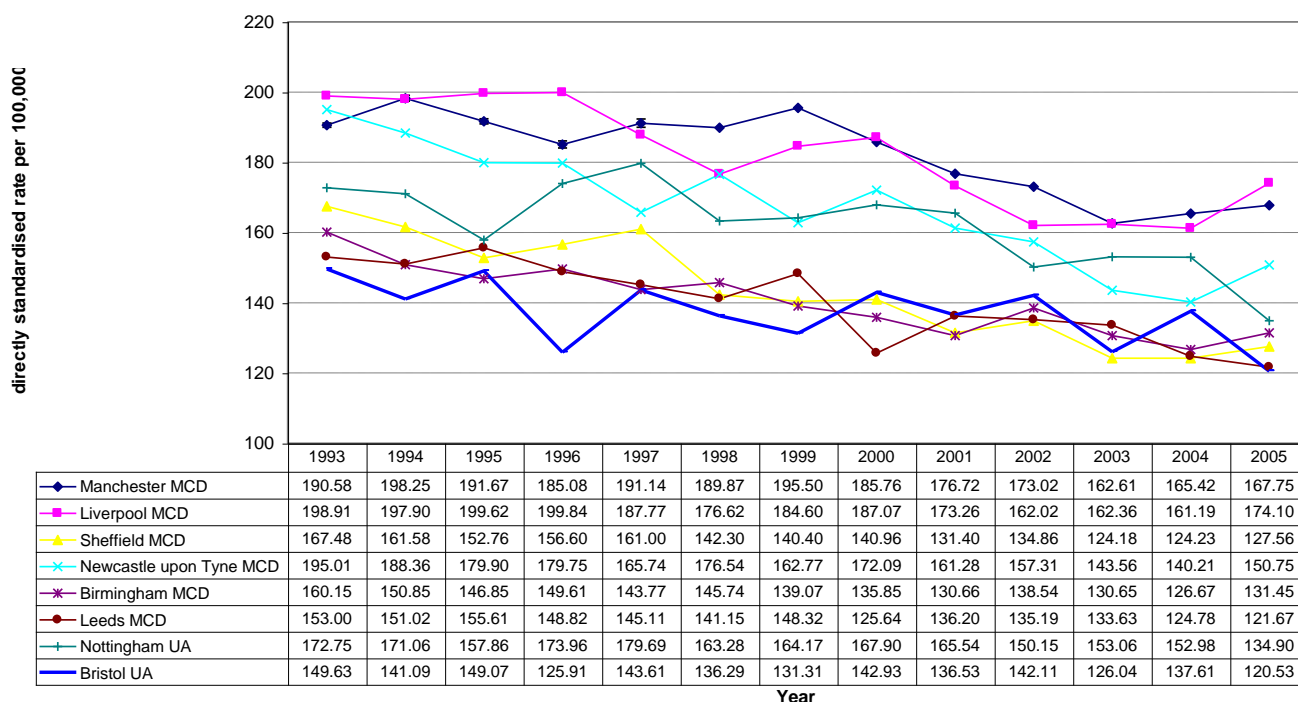
⁵³ Late bookings for antenatal care, 2008 www.avon.nhs.uk/phnet

⁵⁴ Bristol and South Gloucestershire PCTs (2004) Trends in Need and Demand for Neonatal Services

65,000 of them are aged under 75. A recent study⁵⁵ compares the UK with five other countries with similar economic status and concludes that for most cancers we are comparable. For lung cancer we are worse, due to smoking. For breast cancer and bowel cancer we are worse, but death rates for both these cancers in the UK are coming down. The target is a 20% reduction by the year 2010 from the baseline rate in 1995-97.

In Bristol, mortality due to cancer in the under 75s has fallen since 1993 from around 150 deaths per 100,000 to around 120 deaths per 100,000. Bristol's rate is similar to the national rate and is lower than the rate in most other core cities (see graph below).

Trends in Mortality from Cancers- under 75s Bristol compared to core cities 1993-2005



Source: Bristol Primary Care Trust

Main influences on cancer death rates in under-75s

Screening – the impact of screening programmes (and early detection) is estimated at a three per cent reduction in deaths. For prostate cancer there is no current evidence that screening would have any impact.

Early diagnosis – can lead to earlier treatment, improved care pathways and improved outcomes/survival.

Treatment – new advances in cancer treatment could achieve a ten per cent or greater reduction in deaths.

Smoking – tobacco smoke is a powerful, multi-organ carcinogen. One third of all deaths from cancer are linked to tobacco smoke. Successful tobacco control will have the greatest impact on cancer deaths.

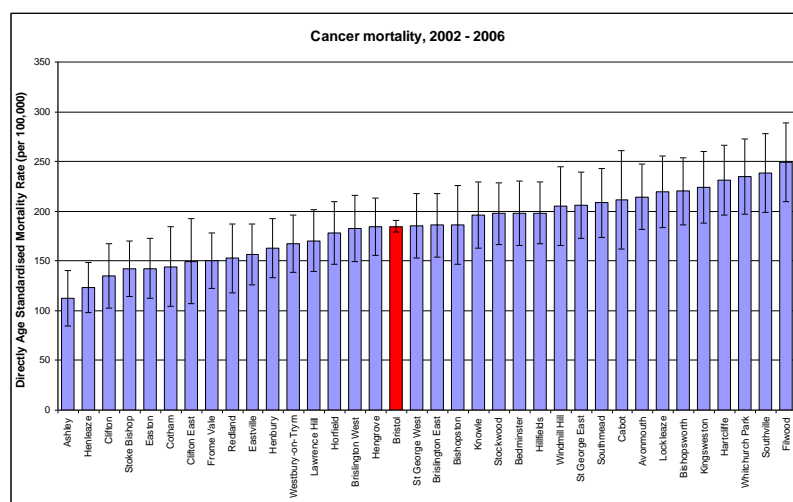
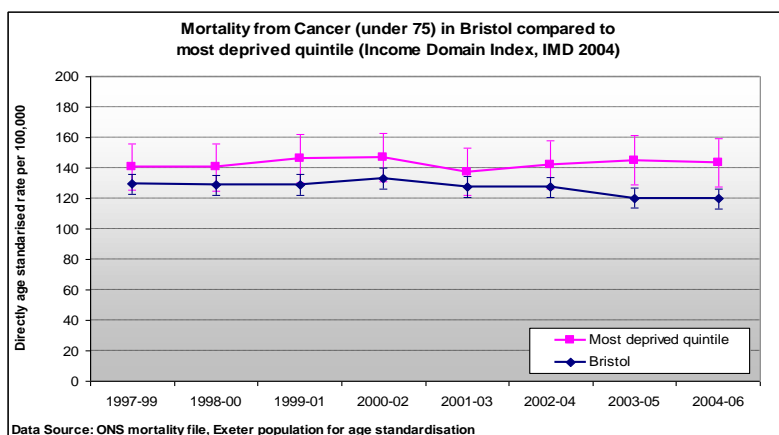
Food, physical activity, alcohol and sun – current evidence suggests improved nutrition and increased physical activity (together) contribute to a reduction in cancer deaths. Negative impacts of alcohol and sun are important, but make a smaller contribution.

⁵⁵ Doll R, Boreham J. (2005) 'Recent trends in cancer mortality in the UK'. Br J Cancer Vol 7. pages 1329-35.

Occupational exposure to cancer-causing agents – occupational exposures are a small influence but must be minimised. Second-hand tobacco smoke at work has been the biggest occupational risk. The smoking ban in the workplace, since July 2007, may have changed this situation.

Inequalities in cancer

In 2005, there were 915 Bristol deaths from cancer of which 421 were below the age of 75 years. But cancer incidence and mortality rates are higher in areas of social deprivation. When the most deprived quintile is compared to the rest of the Bristol, the downward trend is not apparent in the most deprived communities and the gap is widening (see following graphs).



Source: Bristol Primary Care Trust (both graphs)

Types of cancer mortality by gender

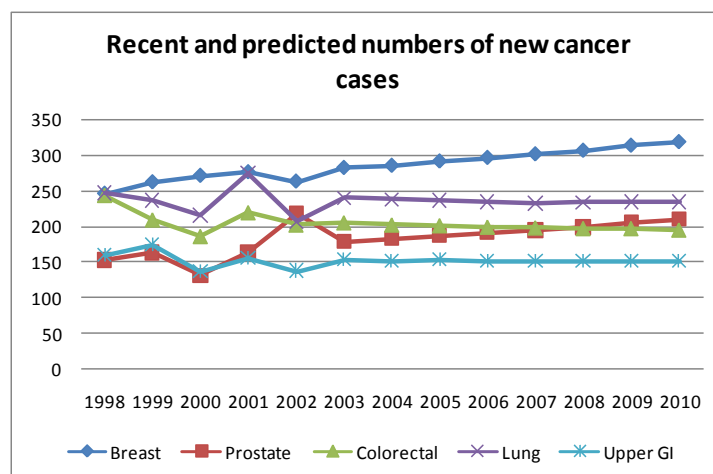
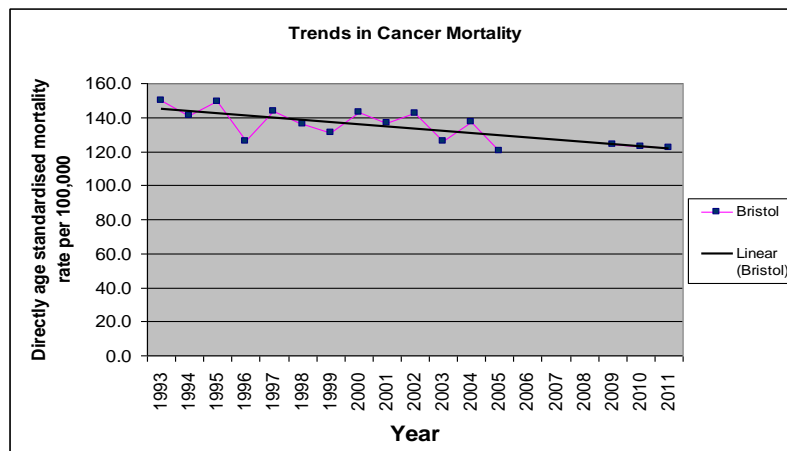
In males, lung cancer is most common, followed by prostate, colorectal, oesophagus, stomach and pancreas. Lung cancer has dropped since the 1970s, whilst cancers to the prostate and oesophagus are rising.

In females, breast and lung cancers are most common, followed by cancers in the ovary, pancreas, stomach and cervix. Mortality from breast cancer has dropped since the early 1990s, but deaths from lung cancer have risen since the 1960s to a level similar to breast cancer (ONS statistics).

Trends in cancer mortality by age

Age specific cancer mortality is decreasing as diagnosis and treatment for cancer improves, and mortality is predicted to continue dropping (as shown in the graph overleaf). However, the total

number of incidents is increasing as the population ages, and cancer is becoming similar to a chronic illness. The lower graph shows the main causes of cancer and cases are predicted from 2004. Breast and prostate cancer are expected to show the steepest increase.



Source: Bristol Primary Care Trust (both graphs)

Palliative care

Palliative care is the active care of patients with advanced, progressive and incurable disease. In the UK the provision of palliative care at home is an increasingly preferred choice of patients and their carers.⁵⁶ Palliative care home support is becoming increasingly important as it provides choice and dignity for end of life care.

In Bristol during 2004-2005 1,281 patients were referred to this service. There was a higher proportion of patients with bowel and lung cancers than other cancer types.

Areas of good practice

The Palliative Care Home Support Service covers Bristol, North Somerset and South Gloucestershire and was initiated with Lottery funding in 2001. The service addresses inequalities and improves access to home support services for sufferers in deprived areas and areas with a high BME population. Historically these areas have had limited access to hospice and social care services. The service provides care for those with less than six weeks to live and offers day and evening and overnight care. A health equity audit of 100 patients was conducted in 2005 in Bristol. It found the Palliative Care Home Support Service was reaching disadvantaged groups (62% of patients) and BME groups.

⁵⁶ Higginson IJ, Romer AL. J Palliat Med. (2000) Place of care in advanced cancer: a qualitative systematic literature review of patient preferences.

Diseases of the circulatory system

Cardiovascular disease (CVD) is the biggest cause of preventable death in England. Some 300,000 people have a heart attack each year and hundreds of thousands of people are living with angina or heart failure in England. Thousands die or experience severe disability due to strokes. These diseases are also a major clinical cause of health inequality. England has higher rates of the disease relative to comparable countries and it is one of the public's top priorities for health.

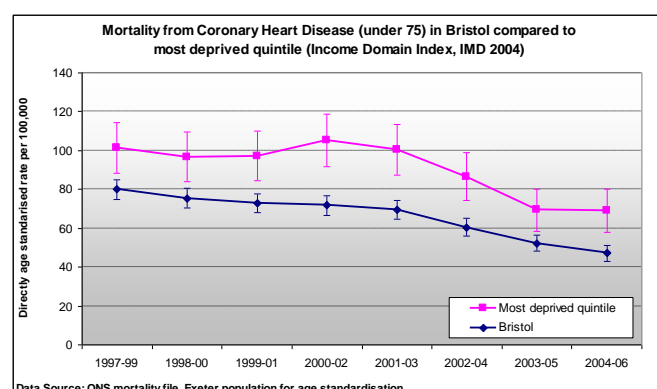
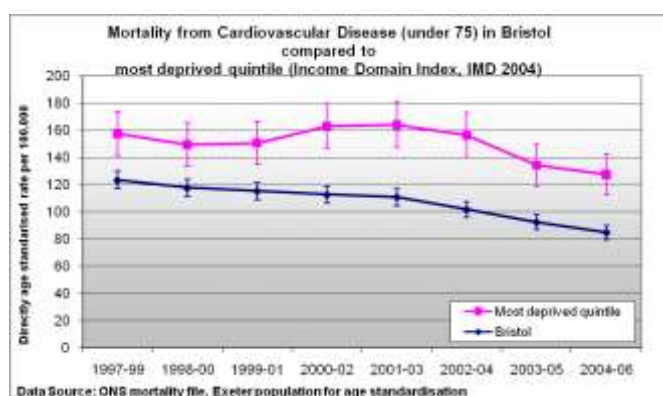
In Bristol, 27% of all deaths are due to diseases of the circulatory system. The death rate from heart disease and stroke is close to the England average, and ranks third lowest out of core cities. In the city, there are 12,600 people who are known to have coronary heart disease and over 7,000 people with strokes or transient ischaemic attacks. In 2005, 1,198 people died of cardiovascular disease, of which 305 were below the age of 75 years. One in eight of these deaths (150) is attributable to smoking.⁵⁷

The mortality rate for coronary heart disease (CHD) has fallen dramatically since 1993 from around 110 deaths per 100,000 to around 50 deaths per 100,000. The fall in Bristol has mirrored the national pattern, which can be attributed to the reduction in levels of smoking and improved diet. But the numbers of people living with the disease has increased.

The major risk factors for coronary heart disease are smoking, physical inactivity and obesity. Raised cholesterol and raised blood pressure are important related and modifiable risk factors. Heart-related conditions are also the most common cause of hospital admissions (see page 148).

Inequalities in circulatory diseases

Coronary heart disease and cardiovascular disease premature mortality show a marked gradient with deprivation. When the most deprived quintile is compared to the rest of the city, the trend is still downward but the gap is not closing (see below).



There are also gender inequalities and Annex 16 shows excess mortality for males in the most deprived quintile for coronary heart disease (CHD).

Bristol has a significant population of people of South Asian origin and higher rates of CHD are found amongst this population. Rates of mortality from ischaemic heart disease amongst South Asian men and women can be 1.5 times that of the general population.⁵⁸ However, the uptake of cardiac rehabilitation services is particularly low amongst this group. The 'Living with Heart Disease' action research project in Bristol examined the equity of access to primary care services between South Asian and White CHD patients.

⁵⁷ Bristol PCT Staying Healthy – Prospectus 2008-2011

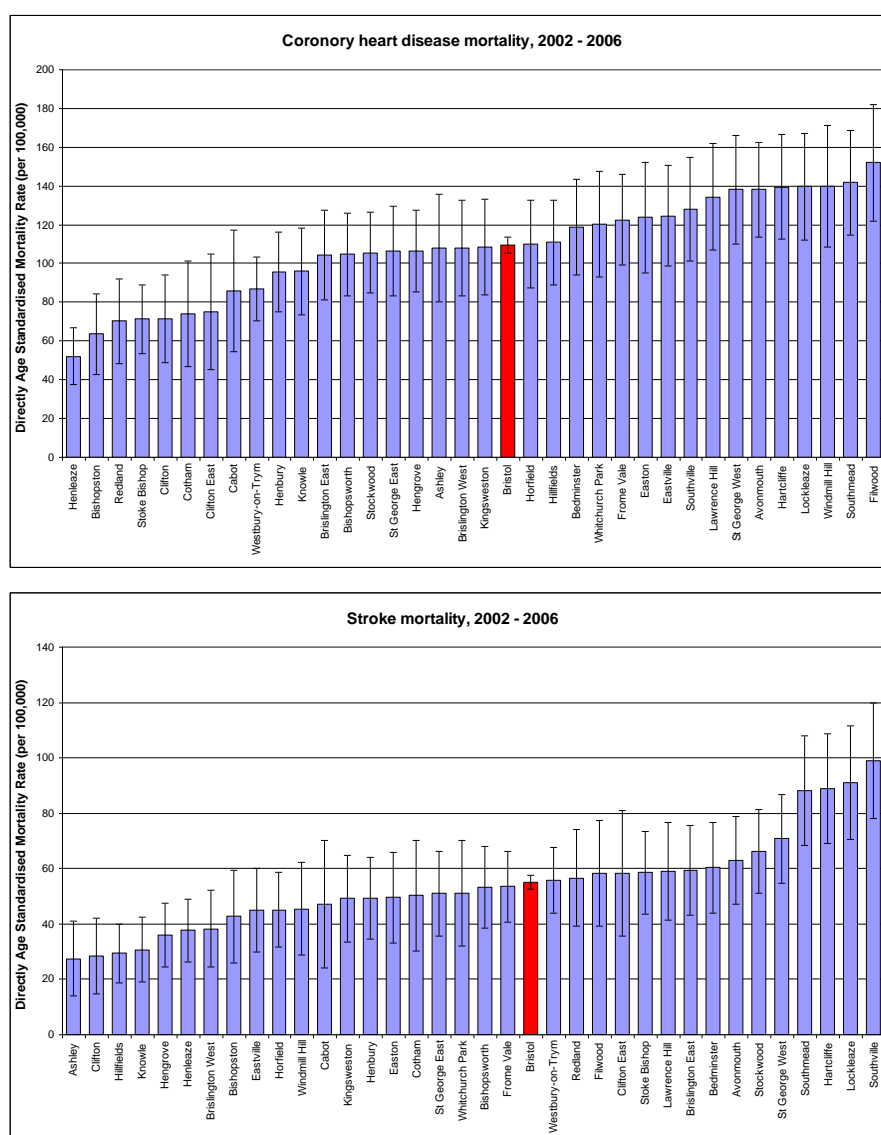
⁵⁸ Wild & McKeigue 'Cross sectional analysis of mortality by country of birth in England and Wales 1970-1992. BMJ 1997;314:705

GPs are developing profiles of their registered patients and this can provide a rich source of information. There is scope to develop a CHD register to include ethnicity.

An equity profile of coronary heart disease in Bristol⁵⁹ showed no clear evidence of inequity of uptake of healthcare services for CHD across socio-economic groups, and there is a need to focus on CHD prevention and to tackle the determinants of heart health.

There is concern that the downward trend in circulatory disease mortality may not continue. This is due to the rising level of obesity and diabetes in the population and increasing population of residents of South Asian and Black African or Black Caribbean origin (see 'diabetes' page 111).

Ward analysis (below) indicates Filwood is significantly worse than the rest of the city for CHD. Southville, Lockleaze, Hartcliffe and Southmead have significantly higher mortality from strokes.



Source: Bristol Primary Care Trust (both graphs)

Stroke

Statistics drawn from POPPI (Projecting Older People Population Information System) indicate seven per cent of people 65 years and over have long-standing health conditions caused by heart attacks and 2.6% caused by strokes. For Bristol this means we have 4,254 older people with these

⁵⁹ Primary Care Trust, March 2007

conditions and this figure will rise to 5,556 by 2015. Many affected patients will experience a degree of disability and will have support needs.

Diabetes

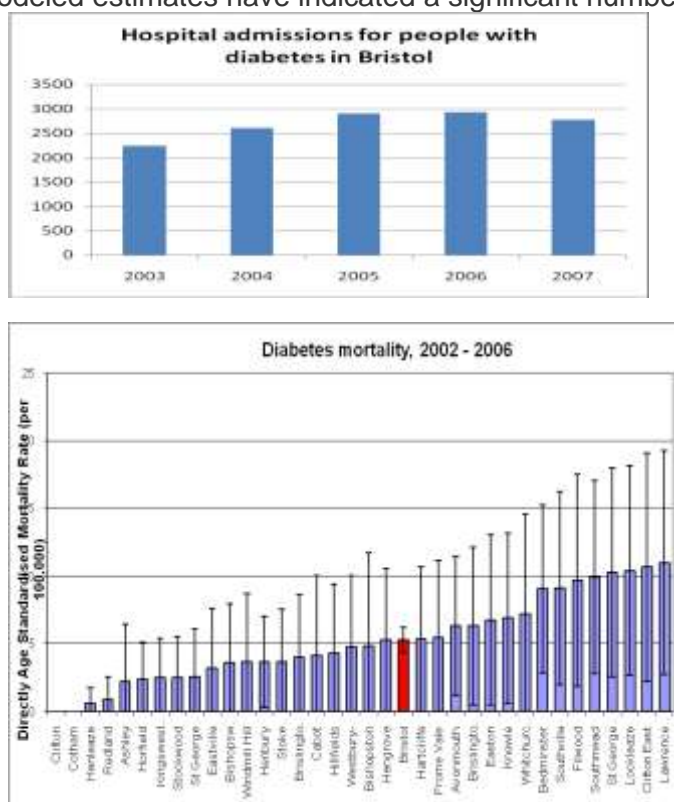
In Bristol the population with diabetes is close to the England average and is joint lowest out of the eight core cities.

Prevalence is related to the proportion of older people and BME people in the population and levels of obesity. A person with a BMI over 35 is up to 80 times more likely to develop diabetes over ten years than someone with a BMI of less than 22.

In the city, 15,000 people have been diagnosed with diabetes, but there may be up to 7,000 people who remain undiagnosed and who may benefit from early treatment.⁵⁷

South Asian men and women were found to have the highest rates of diabetes (up to six times higher than the general population) and Bristol has 17,300 residents with South Asian origins (2006). Prevalence of type 2 diabetes in the Bangladeshi and Pakistani communities was found to be over five times higher than the general population. There is also evidence that people of South Asian origin have worse diabetic control than the general population.⁶⁰ Prevalence of diabetes is also higher in Black African or Black Caribbean groups (up to three times higher than the general population).

Diabetes is increasing in Bristol, related to rising levels of obesity, ageing and the increase in the proportion of BME residents. It is likely that the ranking of Bristol as the lowest of core cities is an underestimate and modeled estimates have indicated a significant number of undiagnosed cases.⁶¹



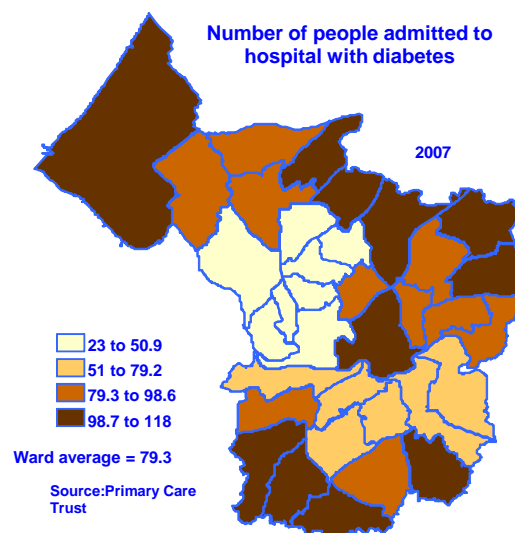
Source: Bristol Primary care Trust (both graphs)

⁶⁰ Chowdhury and Lasker 'Complications and cardiovascular risk factors in South Asians and Europeans with early-onset diabetes' QJMed (2002) 95:241-246.

⁶¹ PSB Diabetes population prevalence model, phase 2, Yorkshire and Humberside PCT

The highest mortality from diabetes (previous graph) occurred in Lawrence Hill and Clifton East for the period 2002-2006, but these are not significant differences. There was significantly lower mortality from diabetes in Clifton, Cotham and Henleaze.

The map (opposite) indicates the location of residents who have been admitted to hospital and is similar to the map of those who are overweight or obese (page 86).



Diabetes - children and young people

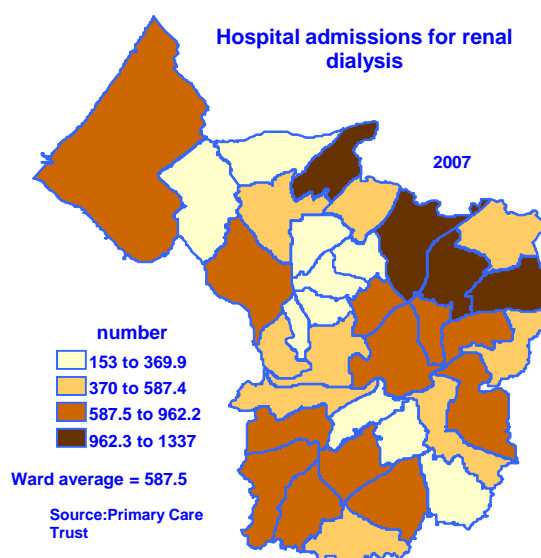
Type 1 diabetes is one of the most common chronic childhood illnesses currently affecting 18-20 per 100,000 children a year in the UK. This type of diabetes has also been increasing in the UK (from 13.5 per 100,000 children in 1988). The greatest increase is in children under five years. In Bristol approximately 25% of children seen with diabetes are under ten years of age. Although it is still rare in the UK, currently three per cent of children seen in diabetes clinics in Bristol have type 2 diabetes.

Kidney disease and renal dialysis

A common cause of chronic kidney disease is diabetes and hypertension. Risk increases exponentially with age and is higher if you are of South Asian or African-Caribbean origin. Being overweight with a lack of physical exercise can predispose to this condition.

Renal dialysis is a high cost service and the number of Bristol residents admitted to hospital in Bristol for renal dialysis day treatment is rising. In 2003, there were 144 patients, increasing to 200 in 2007, requiring a total of over 20,000 visits for renal dialysis a year. A fifth of day admissions are of BME people.

The location of patients who require day treatment with renal dialysis (map opposite) may well reflect proximity to a hospital/treatment centre.



Areas of good practice

Self care – Birmingham Ownhealth – this is a partnership between Birmingham East and North PCT, Pfizer Health Solutions and NHS Direct to deliver proactive telephone-based healthcare support to individuals with long-term conditions. The service aims to support people with cardiovascular disease, heart failure and diabetes to take a more active and informed role in managing their own health. There are consistently high levels of satisfaction with the service, improvement in patient self-efficacy, health behaviours and in some clinical indicators such as cholesterol.

Review of stroke care services in South Bristol - Patient and Public Involvement Forum (PPI), 2005

This PPI survey looked at stroke care across acute and primary care trust boundaries. The survey found United Bristol Healthcare Trust and South and West Bristol PCT provide high quality clinical care, nursing and rehabilitation for patients admitted with stroke, with knowledgeable and dedicated staff. The Immediate Care Centre and Rehabilitation Centre at Knowle were 'ahead of the game' in the way health and social care staff worked together.

But they also found that people who stayed in specialised units appeared more satisfied with all aspects of their care than those who stayed on other types of ward. Also patients still experienced some problems accessing all the services they needed after discharge, because of lack of communication and coordination between the two services.

In view of the predicted rise in the incidence of strokes, the PPI Forum proposed:

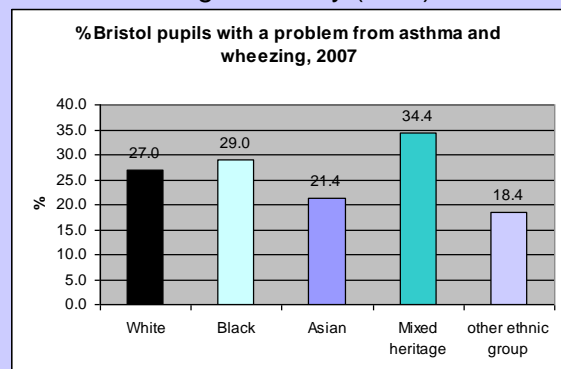
- a discrete and dedicated stroke unit in the Bristol Royal Infirmary
- an additional discrete unit and rehabilitation beds in the new South Bristol Community hospital
- ensure that by 2008 no stroke patients are placed on ordinary wards
- ensure that young stroke victims are not further distressed by being placed in wards with the very elderly
- staff caring for stroke victims to have specialist training
- early preparation for discharge after stroke to help recovery and ease the work of carers

- consider extending the working practices from the centres to other areas to aid the delivery of person-centred care.

Self-reported asthma and wheezing by young people

Self-reported asthma was measured through the Young Person's Quality of Life Survey 2007 where the question was asked 'Do you have asthma or a problem from wheezing?' Over a quarter (27%) of all survey respondents said they sometimes suffered from asthma or wheezing and this is similar in proportion to that found in previous surveys. Spatial distribution of sufferers suggests there are many factors that can exacerbate chronic wheezing and asthma, such as areas of high traffic pollution, poor housing and poverty. The higher proportion of young people with asthma living in neighbourhood renewal areas (34%) indicates the impact of deprivation.

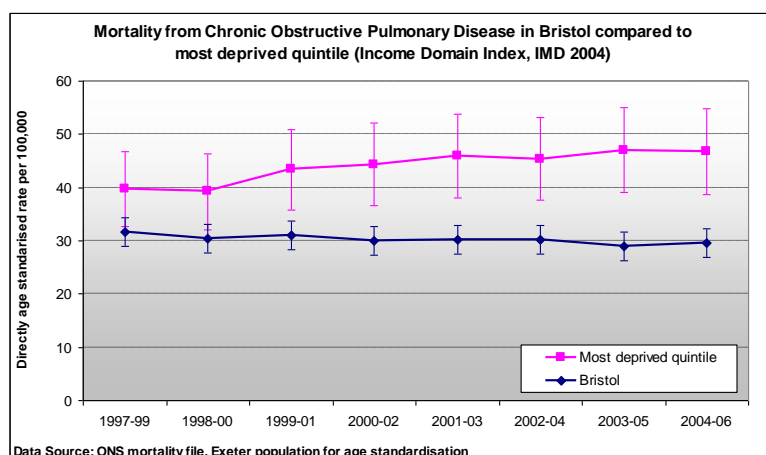
Age of sufferer did not appear to be significant unlike ethnicity; the lowest proportion of asthma sufferers was recorded in Asian young people (21%) and the highest in those of mixed heritage ethnicity (34%) see below.



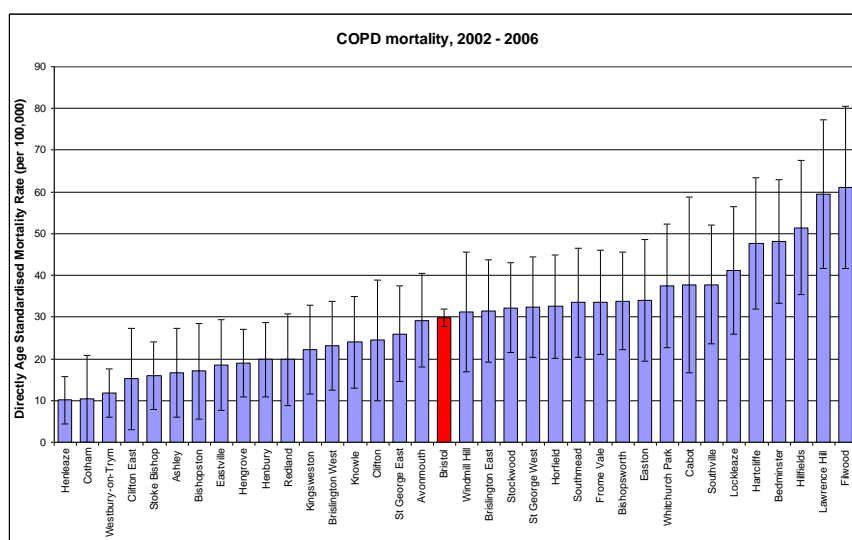
Source: Young People's Quality of Life Survey

Respiratory health and chronic obstructive pulmonary disease (COPD)

Trends in mortality for COPD show little change since 1997, but when the most deprived quintile is compared to the rest of the city the gap appears to be widening.



The ward graph indicates there is significantly more mortality from COPD in Filwood, Lawrence Hill and Hillfields. This pattern appears to correlate with wards with high mortality attributable to smoking (page 66).



Source: Bristol Primary Care Trust

POPPI estimates that there are 1,181 sufferers of bronchitis/emphysema aged 65 and over. This estimate will rise to 1,254 by 2015 and 1,365 by 2025. These estimates do not take into account increased respiratory illness from climate change (see page 47) due to air pollution and pollen. Men are twice as likely as women to suffer from these conditions.

Annex 16 shows mortality from COPD in the most deprived quintile compared to the rest of the city and women appear to suffer excess mortality.



Areas of good practice

Healthy Outlook COPD Forecast Alert Service

www.metoffice.gov.uk/health/copd_forecasting.html

The Met Office service 'Healthy Outlook' can drastically reduce hospital admissions, while providing an improved quality of care for people with COPD.

People with COPD are reminded to take appropriate action to keep themselves well, by alerts in advance of impending high risk weather periods.

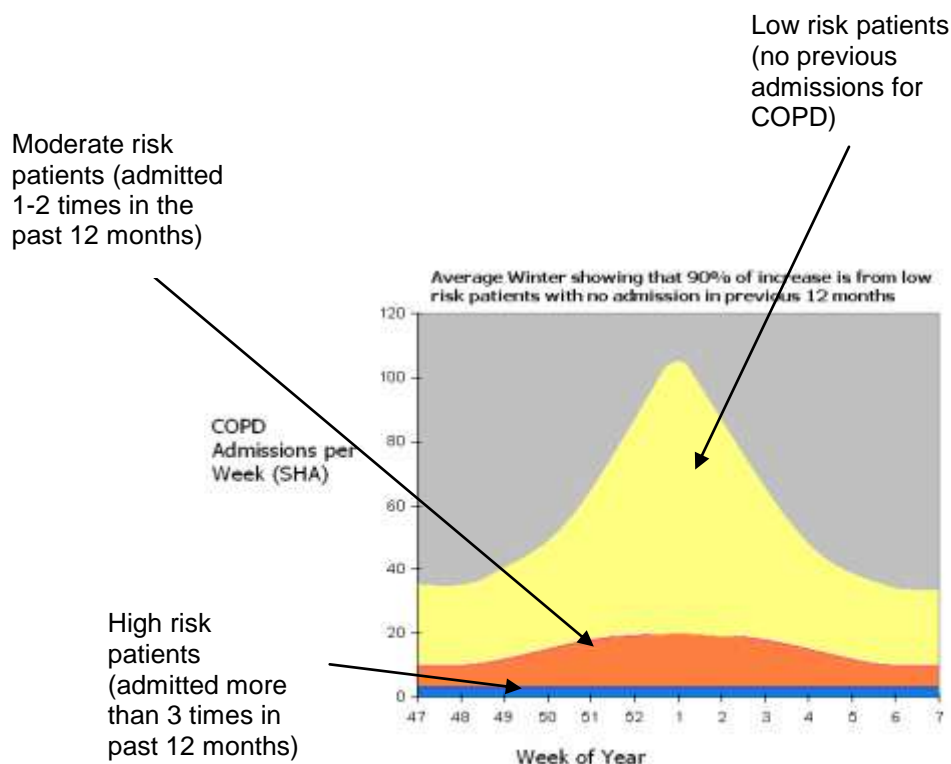
When trialled in Cornwall, nine practices used the Healthy Outlook COPD Forecast Alert to deliver anticipatory care. These practices had an average COPD admission rate 54% lower than practices that did not use the system. As a result, Cornwall Primary Care Trust could save up to £300,000 a year through reduced admissions.

The service includes:

- winter COPD forecast, by e-mail twice per week between October and the end of March
- summer COPD forecast issued once per week by e-mail
- automated telephone calls to patients, from October to the end of March, when forecast risk is elevated
- one Patient Pack per COPD patient
- one Clinicians' Guide per 500 patients
- training courses for patients receiving the service.

Hospital admissions for COPD

'Low risk' patients make up 70% of admissions during winter and 90% of week-on-week variation.

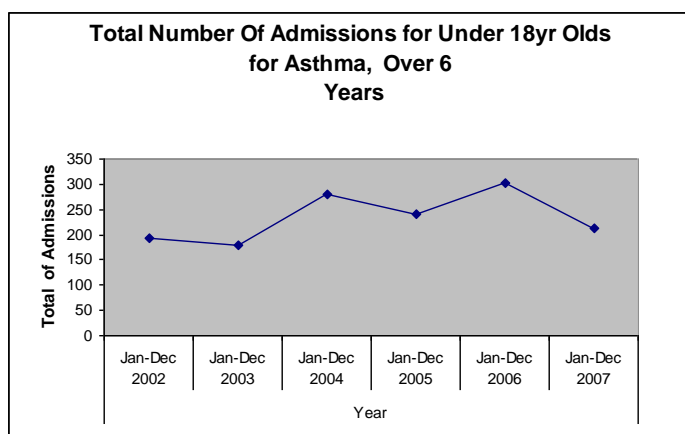


Source: South West Public Health Observatory

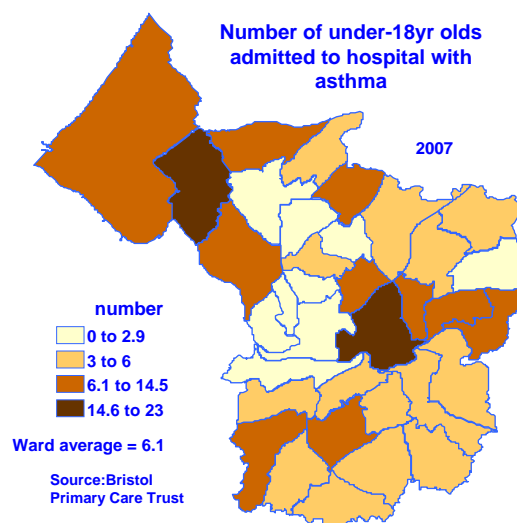
Respiratory health of children

Improved hygiene in westernised regions of the world may be responsible for the increased prevalence of diseases of the immune system, such as asthma and atopy, by creating too sterile an environment. New research from the *Children of the 90s* study, reinforces views that frequent use of chemical household products is associated with wheezing in pre-school children.

Hospital admissions for asthma are shown in the following map and graph. Lawrence Hill and Kingsweston are the localities with the highest number. Clearly affluent wards in Bristol have lower admissions, but so do some deprived wards such as Hartcliffe, Hillfields and Southmead. There has been a drop in admissions in 2007, with 214 admissions for asthma compared to 303 in 2006 (a fall of 29%).



Source: Bristol Primary Care Trust

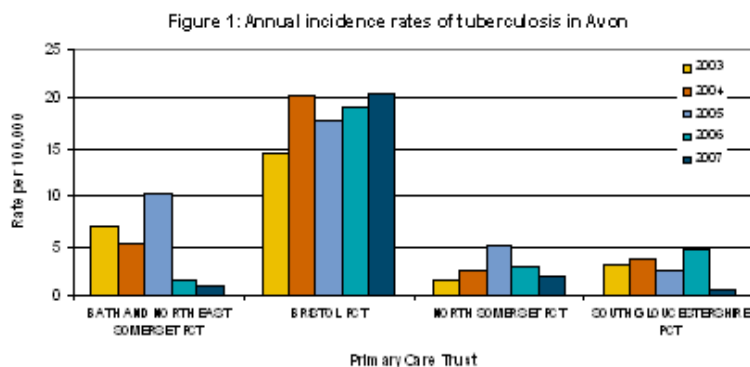


Infectious disease

Tuberculosis (TB)

TB remains a major cause of long-term illness. Although nationally the number of notifications has dropped from a level of 117,000 in 1913, when surveillance began, to a low of 5,086, notifications have now been on the increase since 1987. TB in England increased by 35 % over the last ten years and is still rising.

The rate of TB cases in 2006 in Bristol, at 19.2 per 100,000, was higher than the national average, (14.8 per 100,000). Three quarters (76.5%) of the reported tuberculosis cases in Avon over the last five years were in Bristol (see graph below). In 2007, there were 84 cases of TB reported in Bristol, based on notifications to the Avon Health Protection Team.



Source: Enhanced National Tuberculosis Surveillance: South West Region Reports 2005-2006, January to June 2007- Health Protection Agency South West

The majority of notifications are from residents born outside the UK. Of the recent 84 cases, 18% were from Black Africans and 18% from people of South Asian origin.

The risk of TB is greater for infants living in areas of Bristol where there is high incidence of TB, or if they have a parent/grandparent from a country with a high incidence. At present, not all these infants receive at-birth vaccinations, and routine BCG vaccinations are no longer recommended at 10-14 years. See current initiatives for tackling TB page 121.

Vaccination

Trends in most vaccination rates have remained steady in Bristol and are similar to the England average, but lower than that in the South West. Measles, mumps and rubella (MMR) vaccination rates are lower than other vaccinations, mirroring trends in England as a whole. The trend in Bristol is improving, but slowly.

Vaccination rates vary across the city. Variations may be due to a more mobile population in the inner city. Processes have been mapped in an inner-city practice to identify factors that are affecting uptake. Vaccination is offered on an opportunistic basis in addition to, and outside of, formal clinics.

Percentage of children vaccinated before their second birthday

Source: NHS Immunisation Statistics

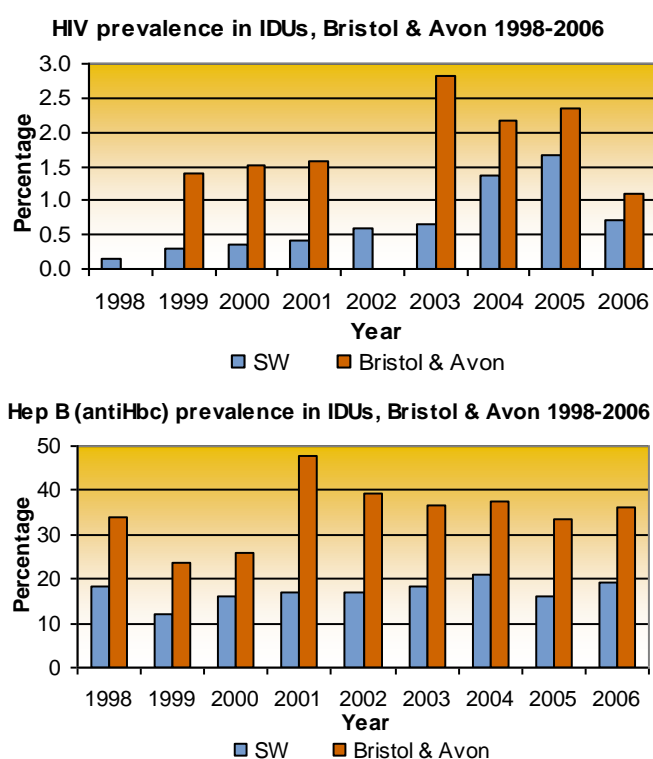
	Year	Bristol	South West	England
Diphtheria	03/04	93.1%	96.0%	93.7%
	04/05	93.2%	94.8%	93.5%
	05/06	93.1%	95.6%	94.0%
	06/07	93.4%	95.8%	93.4%
Tetanus	03/04	93.1%	96.1%	93.7%
	04/05	93.2%	94.8%	93.5%
	05/06	93.1%	95.5%	93.9%
	06/07	93.4%	95.8%	93.4%
Polio	03/04	92.9%	96.0%	93.7%
	04/05	93.1%	94.7%	93.4%
	05/06	93.0%	95.5%	93.9%
	06/07	93.4%	95.8%	93.4%
Pertussis	03/04	92.5%	95.5%	93.3%
	04/05	92.7%	94.3%	93.1%
	05/06	92.8%	95.3%	93.7%
	06/07	93.4%	95.8%	93.4%
Hib	03/04	92.4%	95.6%	93.4%
	04/05	92.7%	94.5%	93.3%
	05/06	92.7%	95.6%	93.7%
	06/07	93.4%	95.8%	93.4%
MMR	03/04	79.7%	81.1%	79.9%
	04/05	77.3%	80.5%	80.9%
	05/06	82.5%	86.2%	84.1%
	06/07	84.3%	87.0%	85.3%
MenC	03/04	92.2%	94.8%	92.7%
	04/05	92.2%	93.8%	92.8%
	05/06	92.8%	95.4%	93.3%
	06/07	93.0%	95.3%	93.3%

HIV and hepatitis

Human immunodeficiency virus (HIV) prevalence is increasing nationally with up to a third of HIV infections remaining undiagnosed. This increase is due to an increase in homosexual and heterosexual HIV transmission, especially in the BME population, and through transmission by injecting drug users. Almost half of the HIV diagnoses in 2006 were in Black Africans. There has also been a geographical shift of HIV-infected people out of London and a higher proportional increase elsewhere.

HIV and hepatitis C have a higher prevalence in Bristol compared to the rest of the South West region. Reported hepatitis C infection is also rising. Injecting drug use remains the single most important risk factor for acquiring the disease.

The graphs below show trends in Bristol and Avon compared to the South West. They are based on the percentage of injecting drug users (IDUs) tested found to have HIV or hepatitis B.



Source: Health Protection Agency January 2008.

Neighbourhood Partnership area summary - main causes of death 2002-2006

The inequality in main causes of death across Bristol wards (2002-2006) is shown in the table.

Significantly better than average
Significantly worse than average

Neighbourhood Partnership	All cause death rate	COPD	Cancer	Coronary heart disease	Stroke
1. Avonmouth and Kingsweston	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth
	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston
2. Henbury and Southmead	Henbury	Henbury	Henbury	Henbury	Henbury
	Southmead	Southmead	Southmead	Southmead	Southmead
3. Stoke Bishop, Westbury-on-Trym and Henleaze	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym
	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop
	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze
4. Cabot, Clifton, Clifton East	Cabot	Cabot	Cabot	Cabot	Cabot
	Clifton	Clifton	Clifton	Clifton	Clifton
	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East
5. Cotham, Redland and Bishopston	Cotham	Cotham	Cotham	Cotham	Cotham
	Redland	Redland	Redland	Redland	Redland
	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston
6. Horfield and Lockleaze	Horfield	Horfield	Horfield	Horfield	Horfield
	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze
7. Eastville, Frome Vale and Hillfields	Eastville	Eastville	Eastville	Eastville	Eastville
	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale
	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields
8. Ashley, Lawrence Hill and Easton	Ashley	Ashley	Ashley	Ashley	Ashley
	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill
	Easton	Easton	Easton	Easton	Easton
9. St George East and St George West	St George East	St George East	St George East	St George East	St George East
	St George West	St George West	St George West	St George West	St George West
10. Southville and Bedminster	Southville	Southville	Southville	Southville	Southville
	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster
11. Bishopsworth, Hartcliffe and Whitchurch Park	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth
	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe
	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park
12. Filwood, Knowle and Windmill Hill	Filwood	Filwood	Filwood	Filwood	Filwood
	Knowle	Knowle	Knowle	Knowle	Knowle
	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill
13. Brislington East and Brislington West	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East
	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West
14. Stockwood and Hengrove	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood
	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove

Key pointers for morbidity and mortality

Inequalities in mortality rates

The gap in mortality between the deprived communities and the rest of the city, is not closing for infant mortality, cancer, coronary heart disease and COPD.

- The main causes of mortality are consistently higher in several wards – Lawrence Hill, Filwood, Southville, Lockleaze, Hartcliffe, Southmead and Avonmouth.
- High mortality rates attributable to smoking and COPD occur in many of the same wards.
- There appears to be an association between the wards with high mortality rates and wards with least healthy lifestyles (e.g. smoking).
- Life expectancy is lower for men and a number of healthy lifestyle outcomes are worse (low consumption of fruit and vegetables, being overweight, respiratory health).

Related current initiatives

- By 2010, South Bristol Community Hospital will be built and improve access to hospital facilities in the south of the city. This will include new walk-in facilities.
- New health centres are to be introduced in areas of high health need. In 2009, the new Eastville Community Healthcare Centre will be built and by 2011 a new health centre will be functional in Easton.
- By 2018, the Bristol Royal Infirmary (BRI), Southmead and Frenchay hospital will be rebuilt and improved.
- Opening times of GP surgeries will change to give improved access between 8.00am – 8.00pm.

Neonatal care

The birth rate is increasing, particularly for BME mothers who are known to have a higher proportion of low birth weight babies, and also book late for antenatal care.

- Modern developments in obstetric practice and foetal medicine are expected to reduce stillbirths and increase the number of babies surviving and needing neonatal care.
- Advances in In Vitro Fertilisation (IVF) and fertility treatment mean there are more multiple births with very small babies.
- Many very low birth weight babies who survive can develop high levels of disability and complex needs.

Related current initiatives

- The PCT is moving towards a policy of single embryo transfer for IVF treatment, but will increase treatment for more fertility cycles.
- Enhanced community midwifery service will increase access to services. The service can be contacted directly and be used by those groups who tend to make less use of, or delay, antenatal care.
- Culturally sensitive antenatal classes will be developed, to improve access and address the rising number of births to mothers from BME groups.

Gaps in our knowledge

- It is difficult to determine the number of very low birth weight babies in Bristol who go on to develop disabilities and complex needs.

Cancer, CVD, CHD, diabetes and stroke

Cancer deaths are falling, but the number of cases is increasing due to our ageing population.

Rates of cancer diagnosis are increasing (due to better detection) but prevalence is higher in socially deprived areas.

There is concern that the downward trend in circulatory disease mortality may not continue. This is due to the rising levels of obesity and diabetes in the population and the increasing population of residents of South Asian and Black African or Black Caribbean origin.

- Higher rates of CHD are found amongst South Asians (1.5 times that of the general population) and Bristol has a significant population of people of South Asian origin.
- GP patient profile data is a rich source of information and there is scope to develop a CHD register, including ethnicity.

Diabetes is set to rise in the population due to rising levels of obesity, ageing and an increase in the proportion of South Asian residents in Bristol.

Patients identified the need to improve access to specialised care for stroke sufferers on the ward and in the community.

Related current initiatives

- In 2008, breast surgery will be centralised at St Michael's and adult ENT at Southmead Hospital.
- In 2009 there will be a new regional Cardiac Thoracic Centre at the BRI.
- The PCT is working with practices to identify the number of people at risk of CVD, CHD and diabetes, with registers that reflect the population risk factors. It is anticipated that numbers on registers will increase by five per cent per year for the next three years.
- Patients on GP registers with CVD, diabetes or hypertension and a BMI over 30, will receive specialist dietetic, advice and management..
- All stroke sufferers to be offered community rehabilitation at discharge

Gaps in our knowledge

- It is likely that the ranking of Bristol as lowest of core cities for residents with diabetes is an underestimate and modeled estimates have indicated a significant number of undiagnosed cases in the city.

TB, HIV and hepatitis C

TB is a growing problem and early diagnosis, treatment and de-stigmatising is essential. HIV and hepatitis C have a higher prevalence in Bristol compared to the rest of the South West region. This increase is due to an increase in homosexual and heterosexual HIV transmission, especially in the BME population, and transmission by injecting drug users.

Related current initiatives

In response to the growing TB problem, priorities include:

- provision of a specialist nurse service which will allow for increased community-based care particularly for directly observed therapy (DOTs)
- negative pressure ventilation facility (to treat resistant cases of the disease)
- neonatal screening service with a targeted BCG vaccination policy
- identifying needs and targeting population groups most at risk.

Summary of Chapter 6

Main causes of death and ill health in local residents include cancer, cardio vascular disease (CVD) and respiratory disease. The number of people with CVD, diabetes and some cancers is projected to increase as obesity rates rise.

Bristol's birth rate is increasing. The number of very low birth weight babies is also increasing and many who survive can develop high levels of disability and complex needs. The extent of need is not known and further work is needed.

Another common theme is that the worst health outcomes are noted in areas of deprivation and the inequalities gap is not closing. Although overall, outcomes for the most deprived areas are improving.

These main causes of ill health are being addressed with the World Class Commissioning outcomes and priorities of the Bristol Primary Care Trust to reduce cancer mortality rates, reduce coronary heart disease mortality, reduce infant mortality and low birth weight and tackling health inequalities.

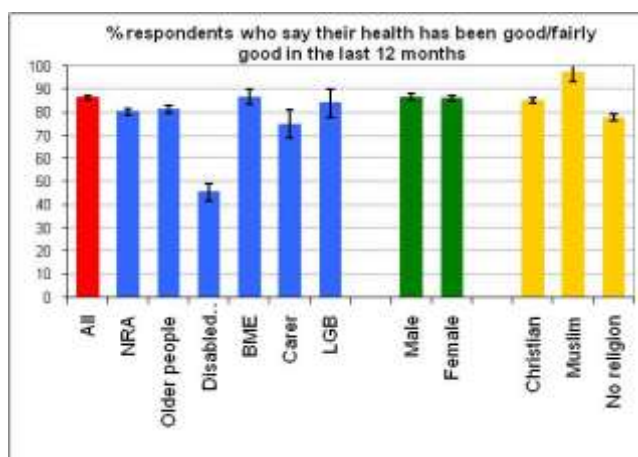
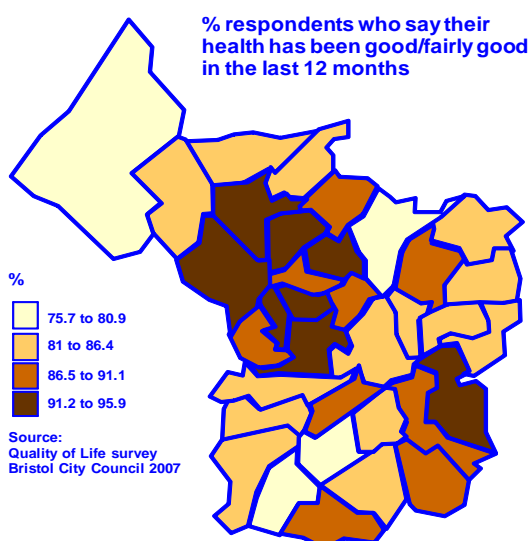
7. Health and wellbeing

Relevant national indicators:

- NI 48 Children killed or seriously injured in road traffic accidents
- NI 50 Emotional health of children
- NI 51 Effectiveness of CAMHS services
- NI 70 Hospital admissions caused by unintentional and deliberate injuries to children and young people
- NI 119 Self-reported measure of people's overall health and wellbeing
- NI 125 Achieving independence through rehabilitation/immediate care
- NI 127 Self-reported experience of social care users
- NI 128 User-reported measure of respect and dignity in their treatment
- NI 129 End of life care – enabling people to die at home
- NI 130 Social care clients receiving self-directed support
- NI 131 Delayed transfers of care
- NI 134 Emergency bed days
- NI 135 Carers receiving needs assessment, review or a specific service or advice
- NI 136 People supported to live independently
- NI 138 Satisfaction of over 65s with home and neighbourhood
- NI 139 Extent to which older people receive the support they need to live independently at home
- NI 146/NI 147 Adults with learning difficulties in settled accommodation/employment
- NI 149/NI 150 Adults in contact with secondary mental health services in settled accommodation/employment

Feeling in 'good health'

'How has your health been in the last 12 months?' has been asked in quality of life resident's surveys for the past four years (Annex 13). The percentage of respondents with good/fairly good health was 89% in 2006 and fell to 86% in 2007. There was a wide variation across the city (see map below). The gap was wider when 'good health' was analysed by equalities groups (graph below) with significantly more disabled people, carers, residents living in neighbourhood renewal areas (NRA) and older people reporting poor health.

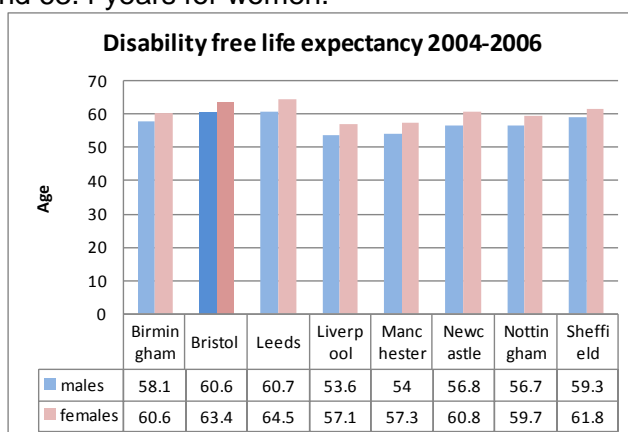


Source: Quality of Life survey 2007

Disability and limiting long-term illness (LLTI)

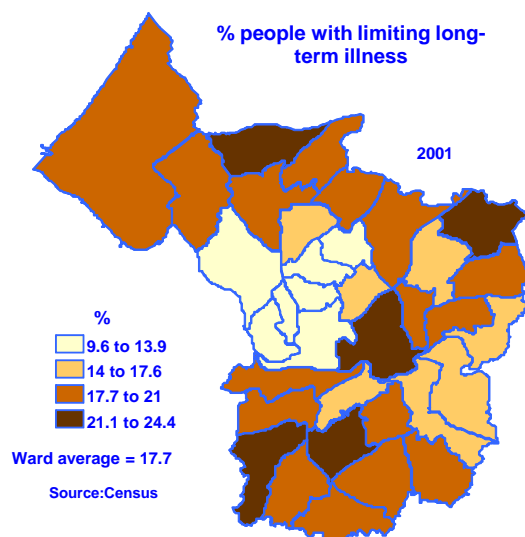
In Bristol, health deprivation and disability often coincides with multiple deprivation. In recent years trends in healthy life expectancy have not kept pace with improvements in total life expectancy due to disability-causing diseases (dementia, coronary heart disease, stroke and arthritis). Even the most optimistic scenarios forecast that the number of disabled people will rise 57% over the next 20 years nationally. Disability is a predictor of future health and social care service demand.

Compared with other core cities, Bristol is doing well, with 60.6 years of disability-free life expectancy for men and 63.4 years for women.



Source: www.swpho.nhs.uk Disability free life expectancy Trends 2004-06.

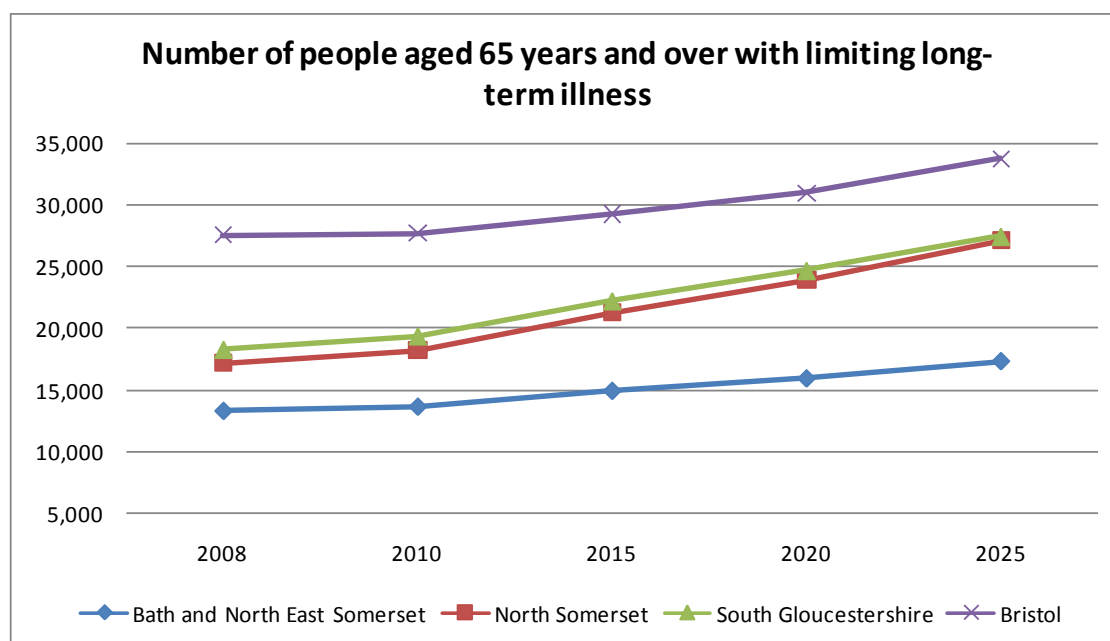
The map below is taken from the 2001 census. It shows there are more people with limiting long term illness in deprived wards, and wards with an older age profile. See page 36 for ward location of older residents.



Limiting long-term illness trends for older people (65 years and over)

Rates of limiting long-term illness increase with age. Over 50% of people aged 65 and over in Bristol have a limiting long-term illness. This is currently 27,590 people and is, predicted to rise to 29,260 in 2015 and 33,740 in 2025 – overall a 22% rise (POPPI estimates). The following graph shows this steady rise contrasted with a slightly steeper rise in surrounding local authorities.⁶²

⁶² BCC Residential Futures Project, Nov 2007



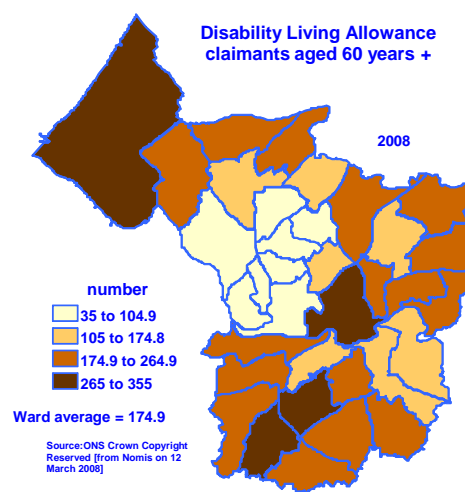
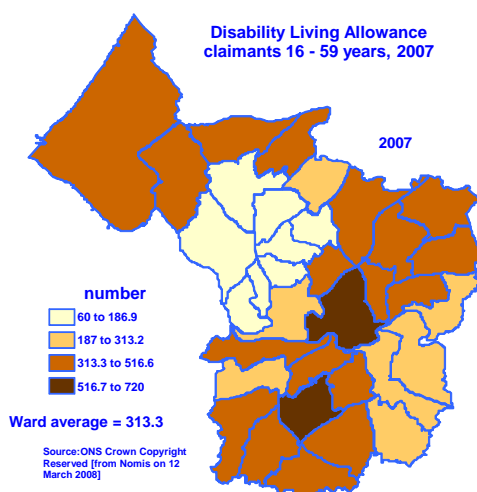
Source: Projection Older People Population Information System 2008

Limiting long-term illness is often grouped with disability. People with disability and long-term conditions make up 52% of GP appointments, 65% of outpatients and 72% of all inpatient bed days. They are also high users of social care and community services.

There is no national definition for 'people with disabilities' and, as a result, record keeping by different agencies cannot be aggregated to give a complete local picture. The phrase 'people with disabilities' may include or exclude people with physical impairments, learning difficulties and mental illness. These three groups are dealt with separately in this report.

Physical impairments

The actual number of adults with physical impairments in the city is difficult to assess and some adults do not access services so are 'hidden'. People claiming Disability Living Allowance (DLA) is one source and 2007 figures are shown in the following maps for adults 60+ years and 16-59 years. Since 2002 there has been an increase in the number of Bristol residents claiming DLA from 15,390 (2002) to 19,515 (2007) (www.neighbourhood.statistics.gov.uk). Lawrence Hill and Filwood have the highest numbers of people claiming DLA. Tenure of these residents is not recorded, making it difficult for the Council to plan for home adaptations. Benefits, grants and other assistance is available for disabled people aged under 16 years and over 60 years.



Sensory impairment

Visual impairment

Currently there are an estimated 5,600 people with a visual impairment (registered blind or partially sighted) aged 65 years and over (POPPI estimate). As our population grows, this figure will change little over the next ten years due to technological advances in treatment.

Deafness

Approximately one in 1,000 people is deaf. Based on our current population this equates to 4,105 people in Bristol.

Deafblind

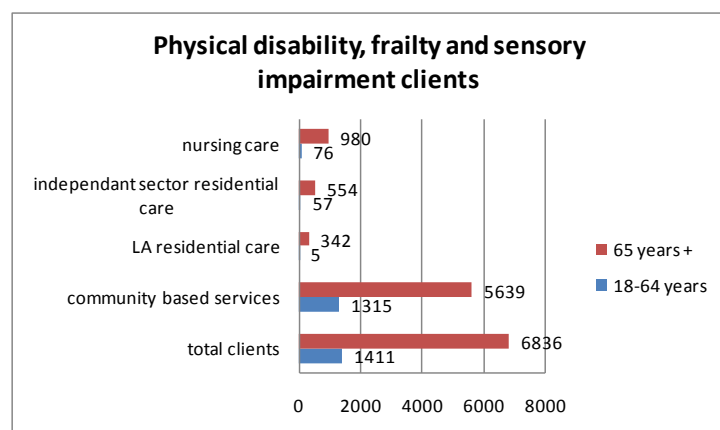
Rising life expectancy and increasing numbers of older people in the population mean a growing number of older people are affected by dual sensory impairment. People are referred to as deafblind if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. Many people who are deafblind are not officially recorded by local authorities due to its definition. The national figure of 250,000 people as deafblind is thought to be a serious underestimate.

Dual sensory loss is recognised by deafblind specialists as an underlying cause of falls, as well as creating the potential for isolation. Enabling people to reduce this environmental challenge through minor changes to lighting and furniture, together with interventions to reduce isolation, can make a substantial impact on maintaining independence. Early identification of dual sensory impairment and comparatively inexpensive interventions could provide long-term cost savings, such as reducing some acute hospital admissions.

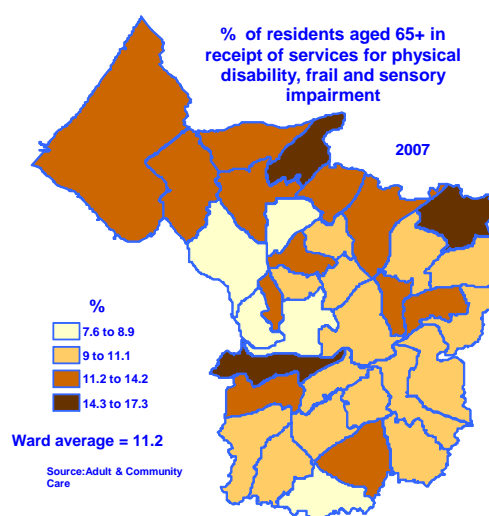
Social care for adults with disability, frailty and sensory impairment

Adult Community Care (ACC) statistics 2006-2007 for their client groups aged 65 years and over are shown in the next map and graph.

The proportion of residents in receipt of services is highest in Southville, Frome Vale and Southmead. Filwood, Hartcliffe, Lawrence Hill and Avonmouth have the highest numbers of DLA claimants aged 60 years and over and this pattern is not reflected by the proportion of social care clients. This is only a partial picture and ACC is one of several service providers for people with physical impairments.



Source: Adult Community Care



Arthritis and rheumatism

The two most common forms are osteoarthritis and rheumatoid arthritis. Osteoarthritis is uncommon in people aged less than 40 years. Risk factors include being overweight and having had an injury. Osteoarthritis can lead to hip or knee replacements.

The prevalence of arthritis and rheumatism is higher in women than men. In 2003-2005 in Bristol, the rate per 1,000 was 25 for men and 44 for women. These rates increase six fold with age and for people aged 65 and over, rates per 1,000 are 110 for men and 194 for women (POPPI).

Neurological conditions

There are ten million people living in the UK with a neurological condition. Over one million are disabled by their condition and 350,000 require help with most of their daily activities. Nineteen per cent of hospital admissions in the UK are for a neurological problem requiring treatment (Neuro numbers, Neurological Alliance 2003).

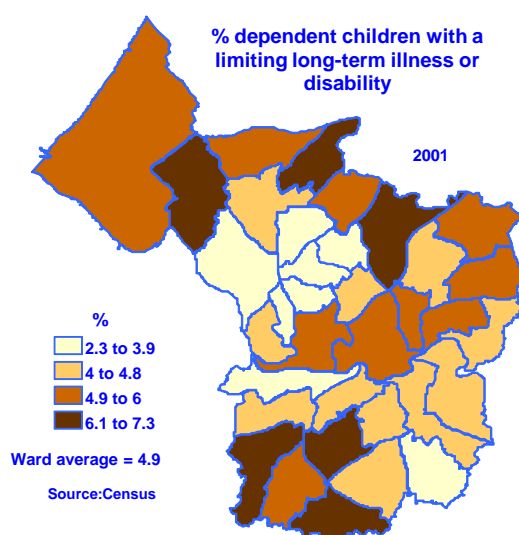
Neurological conditions can affect all ages, but there is an increased prevalence among older people. This prevalence is set to increase sharply in the next 20 years due to improved life expectancy, improved general healthcare and improved diagnostic techniques.

Conditions include motor neurone disease (MND), multiple sclerosis (MS), Parkinson's disease, people with brain injuries and stroke and advanced dementia (see page 136).

Children and young people with physical impairments

Nationally, the number of disabled children and young people is growing and has increased by 62% since 1975. There is also an increase in the number of children with complex needs (see page 105).

Based on 2001 census figures, there are approximately 4,050 dependent children in Bristol with a limiting long-term illness, or disability. The map shows that the wards with the highest numbers of children with impairments are similar to the wards with the greatest deprivation (page 43).

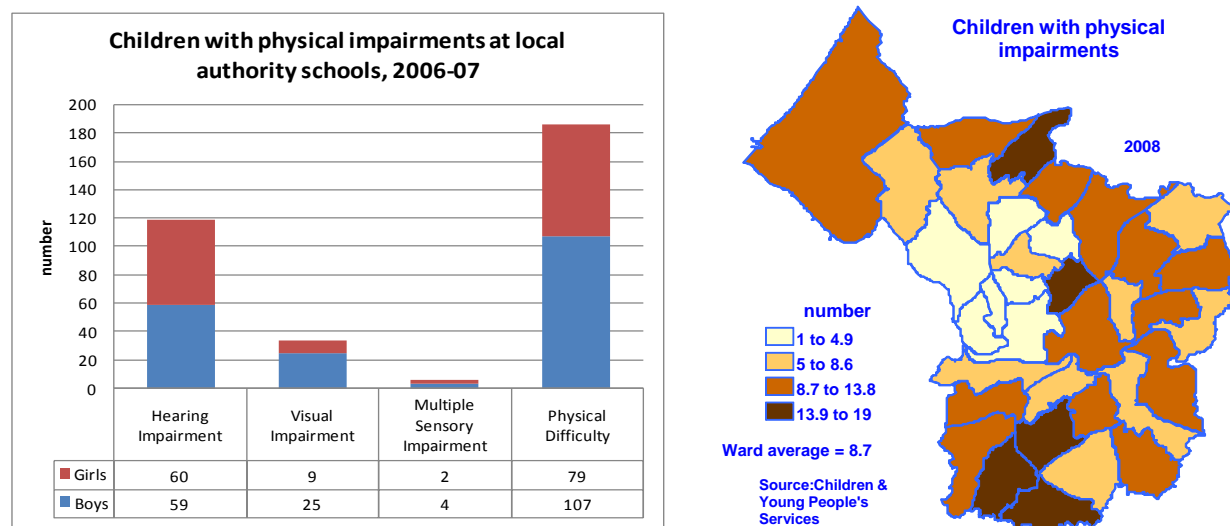


The majority of disabled children are those with low severity high prevalence conditions, such as delayed language development, mild to moderate learning difficulties and development coordination

disorder. A smaller but significant group of children and young people have serious conditions such as spina bifida, cerebral palsy, autism and severe learning difficulties.

A more recent indication of numbers of children with physical impairments can be obtained from the Pupil Census April 2008. This census records pupils with special educational needs and these include physical difficulties, visual and hearing impairment and multiple sensory impairment. There are 345 children with a physical impairment as their 'primary need' at local authority schools; 57% are boys.

The following graph and map show the distribution of these children.

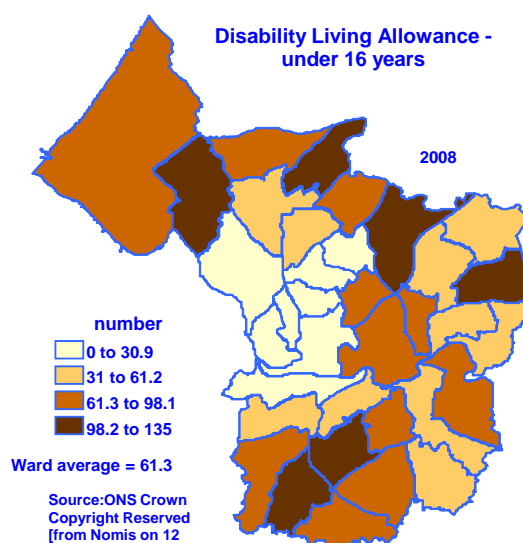


Source: Children and Young People's Services

In addition to these children there will also be those with a physical impairment as a 'secondary need', disabled children of pre-school age and children not requiring council services.

The following map indicates Disability Living Allowance (DLA) claimants aged 0-15 years in March 2008. In total there are 2,146 claimants, with the highest number (135 children) in Filwood.

When Bristol is compared to the South West region and the rest of England and Wales, it shows the city has a slightly higher proportion of claimants at 11.4%, compared to 11.1% and 10.3% respectively (ONS data 2008).



Equipment needs for disabled children and children with complex needs

The local authority and the PCT should ensure that disabled children are able to use/access any equipment they need, and that the equipment is tailored to the individual needs of the child and their future development.

There is a lack of information about the numbers of disabled children who need equipment. There are between 310-330 children known to paediatric services in north Bristol with equipment needs. Figures are also available from UHB referrals for children with neuro-developmental disorders. South Bristol has some wards with the highest numbers of disabled children, but figures on equipment needs are not known.

There are estimated to be five or six new cases a year of babies with cerebral palsy in North Bristol. General trends are towards a higher proportion of children with complex needs, attributed to the increasing survival of very premature babies and longer life expectancy of disabled children. National studies (EPICure Studies 2005)⁶³ indicate 22% of babies born before 26 weeks of gestation who survive develop severe disability (cerebral palsy, blindness or profound deafness) and a further 24% develop moderate learning difficulties.

Approximately 90 babies are born each year in Bristol with very low birth weight (less than 1,500 grammes) but the proportion of these children who go on to develop disabilities and complex needs is not known.

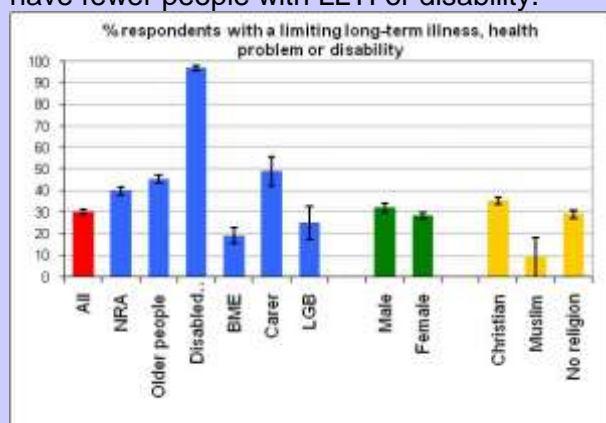
⁶³ Marlow N, Wolke D, Bracewell M, Samara M. (2005) Neurologic and developmental disability at 6 years of age following extremely preterm birth. *New England Journal of Medicine* 352: 9-19
Wood N, Gibson A, Marlow N, Costeloe K, Hennessy E, Wilkinson AR. (2005) The EPICure Study: Perinatal antecedents and correlates of disability in extremely preterm children. *Archives of Disease in Childhood* 90: F134-F140

LOCAL VOICE

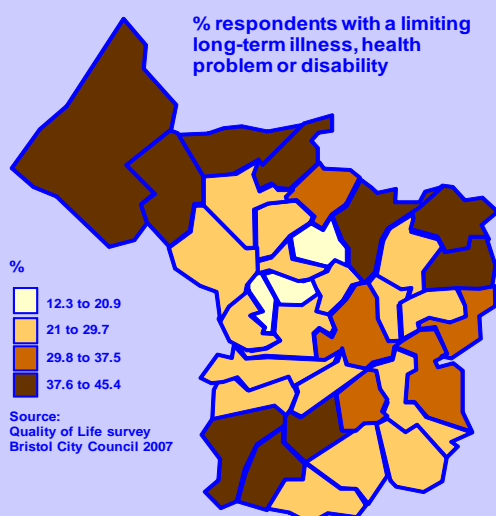
Self reported disability and limiting long-term illness (LLTI)

In 2007, 30% of the respondents to the quality of life resident survey (Annex 13) said they had a limiting long-term illness or disability. There were significantly more respondents who were over 50 years (45%), carers (49%), neighbourhood renewal area residents (40%) and men (32%) who said they were disabled, or had a LLTI. This indicator has increased significantly since 2006, when an average 23% said they had a limiting long term illness (37% for respondents over 50 years). This may reflect increased levels of LLTI in the general population.

The following graph and map are based on 2007 results and show more affluent areas have fewer people with LLTI or disability.






Source: Quality of Life Survey 2007

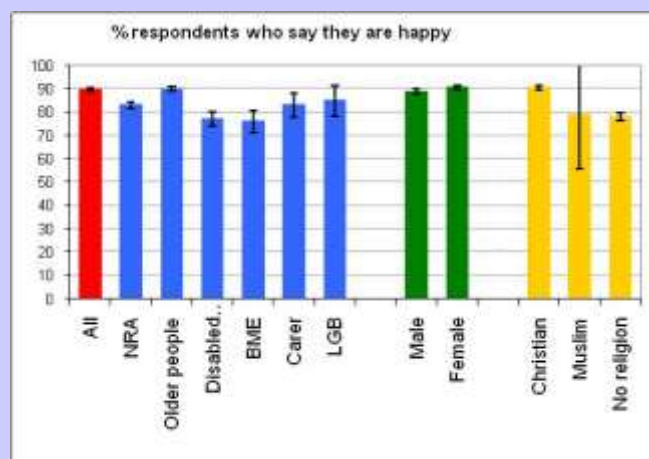


'Inclusion for Action 2007'

This conference was for disabled and non-disabled young people from Bristol schools aged 11-16 years. Its aim was to make an inclusion wish list (below) and provide a better understanding of disability and disability equality.

Teachers/youth workers should have disability equality training	
All schools and youth or play settings need to be friendly and welcoming	
Bristol needs to have good public transport with escorts or buddy systems	
All schools and youth and play settings need to get rid of all bullying	
Pupils should have information about how everyone is different and learn about disability equality	
There needs to be an increase in the range of accessible sports activities and inclusive physical education available	
Schools and youth and play settings need to have more equipment (e.g. furniture and accessible games) which is easier to obtain	
All buildings young people use must avoid having stairs and where there are stairs, have lifts, ramps etc	

All settings should provide interpreters when needed and ensure all teachers can sign	
All settings should use signs, symbols, pictures, photos in schools and settings to make information accessible	
All settings should create more opportunities for disabled and non-disabled young people to interact during unstructured/free times	



Source: Quality of Life Survey 2007

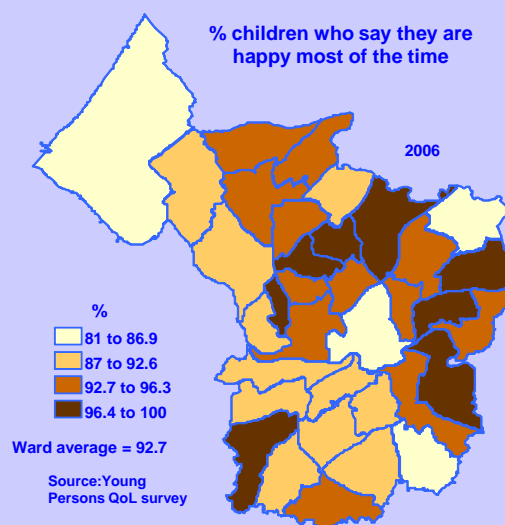
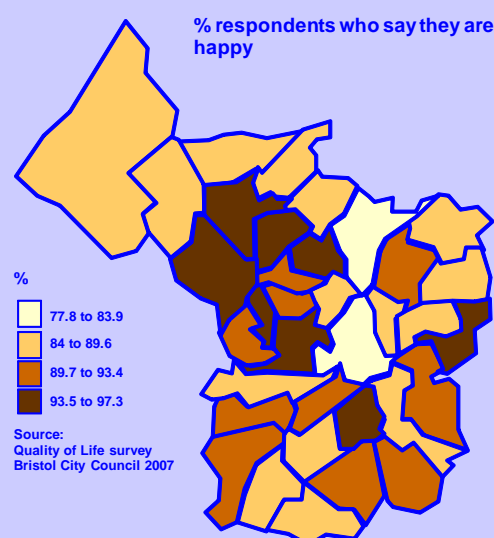
Mental and emotional wellbeing

The Bristol Older People's Forum asked 561 older people about their mental health and wellbeing in their Quality of Life Survey 2006. Only seven per cent said they had poor mental health and wellbeing, and this issue was less of a problem than their physical health.

Happiness and depression

In the Council's Quality of Life Survey and Young Person's Quality of Life Survey 2007, the question was asked 'How happy are you most of the time?' Results indicate 90% of adults, 91% of boys and 93% girls said they were very happy, or fairly happy, most of the time. Significantly fewer disabled people (77%), BME groups (76%) and people who describe themselves as having 'no religion' (78%) said they felt they were happy most of the time.

The following maps and graph show how adults and young people rate their happiness across the city. Lockleaze and Lawrence Hill have the most 'unhappy' people. In the young people's survey, Avonmouth and Lawrence Hill have most 'unhappiness' (19% and 18% respectively).



Mental health of adults

Nationally, one in four adults will experience an episode of mental distress in their lifetime. One in twelve of those will suffer severe and enduring mental illness, diagnosed and treated. Many cases of mild to moderate mental illness may not be diagnosed or treated.

Mental illness happens as a result of the interplay between environmental adversity and genetic susceptibility. Adversity during childhood (e.g. bullying, abuse) may predispose people to mental health problems in later life. Adversity throughout life may cumulatively influence a person's risk.

Risk factors particularly relevant to tackling mental distress include poverty and unemployment, poor education, social isolation and discrimination. Migrants and refugees can be a particularly vulnerable group due to forced relocation, trauma and bereavement. Some studies show the value of improvements in the built environment to a community's sense of wellbeing and quality of life, although the evidence base in this area needs further development.⁶⁴ See page 44.

Depression, self harm and suicide are two to three times more common amongst people on low incomes, than people in middle, or high, income groups. In addition, the highest levels of suicide in Bristol are found in areas where markers of social fragmentation are high, such as high population mobility, single person households and concentrations of rented accommodation.⁶⁵

Women can be vulnerable to mental illness due to the effects of pregnancy and childbirth. Ten per cent of new mothers are likely to develop depressive illness, although many of these women may have suffered depressive illness during pregnancy, or even before. Eating disorders primarily affect young women.

Many people with mental health problems also have other problems that affect their health, particularly relating to alcohol and drugs (dual diagnosis). People with a diagnosis of severe and enduring mental illness, such as schizophrenia and bi-polar disorder, are at increased risk of a range of physical illnesses and conditions such as coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity.⁶⁶ The World Health Organisation estimates that mental health problems are the commonest cause of premature death and life years lost with a disability.⁶⁷

Mental illness affects people's ability to find and hold down employment. Only 21% of people with long-term mental illness are in employment. This is the lowest of any disabled group.⁶⁸ An estimated 80 million work days are lost each year through anxiety, depression and stress. It is estimated that failure to address mental health problems in the workplace costs businesses and the public sector £9 billion each year.⁶⁹

Ethnicity is an important issue for mental health. There is considerable variation in the number of people in hospital from different ethnic groups. Thus the recording of information by ethnicity is important. However, the South West has a particularly poor level of recording of ethnicity in mental health.⁷⁰

⁶⁴ Halpern D (1995) Mental health and the built environment. London: Taylor and Francis.

⁶⁵ Evans J, Middleton N, Gunnell D. (2004) Social fragmentation, severe mental illness and suicide. Soc Psych Psych Epi; 39:165-170.

⁶⁶ DH (2006) Choosing Health: Supporting the physical health needs of people with severe mental illness.

⁶⁷ SEPHO DoH CSIP. Promoting well being for people at risk of mental health problems.

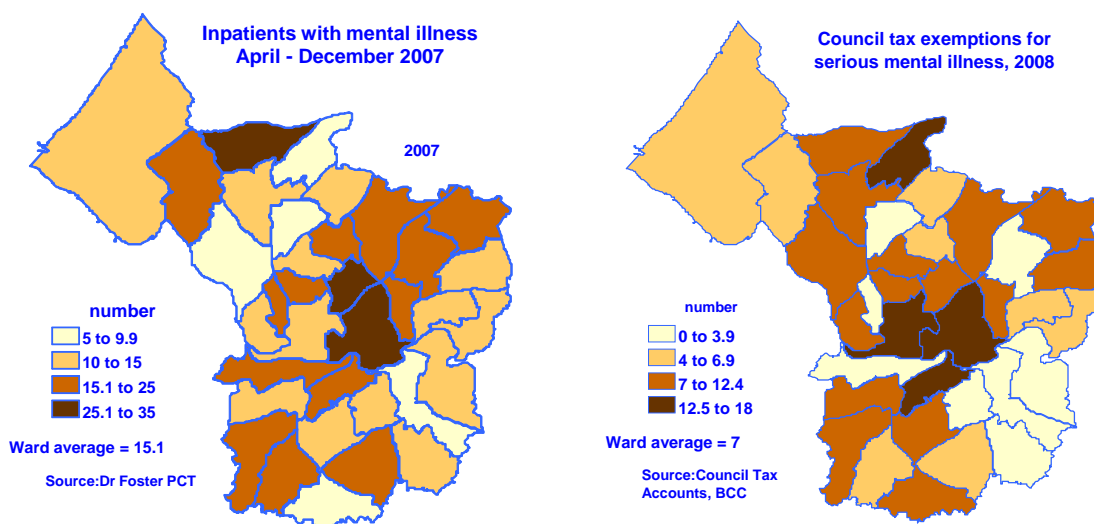
⁶⁸ Office of the Deputy Prime Minister 2004

⁶⁹ DH (1999) National Service Framework for Mental Health,

⁷⁰ Mental Health: South West Regional Summary, 2007 www.swpho.nhs.uk

In Bristol, the population who suffer from mental health problems is above the England average, and ranks fifth out of the core cities. Based on national proportions (see first paragraph), Bristol is likely to have approximately 6,900 adults who have severe and enduring mental illness.

It is very difficult to find accurate data and estimate the actual number of people with mental health problems as there is a stigma attached to it. This has led to a reluctance by the patient and GP to record mental health diagnoses due to implications of being on a mental health database (employment, insurance etc). The Dr Foster tool (used by the PCT) uses GP practice activity levels and can show trends, comparisons and ward detail for specific health and wellbeing issues. The map below shows mental health inpatients based on GP activity records for 2007.



An additional indication of the ward location of those with serious mental health problems is from those who declare they have 'serious mental illness' on their council tax return. The map above shows the pattern across Bristol.

The rate of adults with mental health issues in contact with Avon and Wiltshire Mental Health Partnership NHS Trust in Bristol has been cited by the PCT as (currently) at 248.6 per 100,000 population. With a current population of 416,400, this would give a figure of 1,035 adults. Compared to the estimated 6,900 people with severe and enduring mental illness, there is clearly unmet need in the city.

Depression

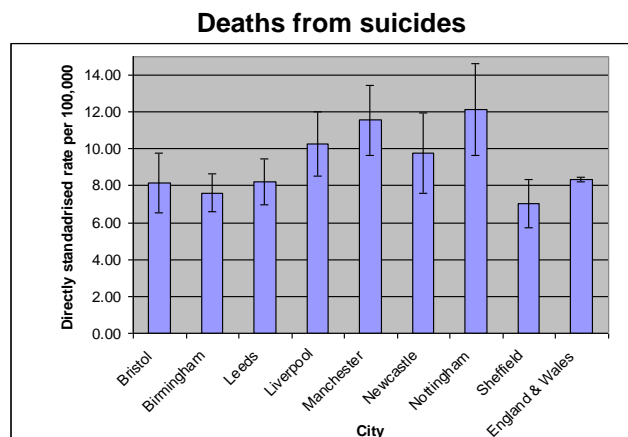
Between 10% - 15% of older people (65 years and over) are likely to have depression. In Bristol, this equates to between 5,400 (low estimate) and 8,160 (high estimate). Four per cent are estimated to have severe depression.

Obese people have been found to have higher rates of depression. David A. Katz MD and colleagues at the University of Wisconsin-Madison, assessed quality of life in 2,931 patients with chronic health conditions including obesity. They found that clinical depression was highest in very obese participants (BMI over 35).

Suicide - adults

In the South West, 1,390 residents died due to suicide or undetermined cause of injury in the period 2003-2005. Males accounted for about three quarters of these deaths (see Annex 16 for excess male mortality). In Bristol, the average mortality rate (8.14 per 100,000 population) from suicide and undetermined death for the period 2004-2006 is just below the national rate. Compared to the other core cities, Bristol has the third lowest rate, and the rate is declining (see following graph).

Young men between 20-39 years have the highest rates of suicide in the city. Incidence is also high in the most deprived and socially fragmented areas (Knowle West, Easton, Lawrence Hill and Ashley). These areas have a high migrant population. Currently suicide data does not include ethnicity.



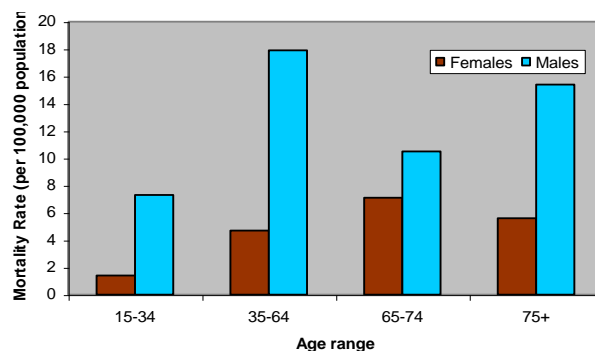
Source: Compendium of Clinical and Health Indicators, 2008

Thirty five per cent (29) of all suicides and undetermined injury between 2004-2006, were of individuals in contact with mental health services.

Suicide and older people

The graph below shows age and sex specific mortality rates for suicide and undetermined death in the Bristol 2004-2006 (per 100,000 population). It illustrates that a high proportion of older men die by suicide. Men and women are both at risk if they are single, recently separated, divorced or widowed, but women are more likely to have stronger social supports and seek psychiatric or medical intervention.

Mortality rate for suicide and undetermined death in the Bristol 2004-2006



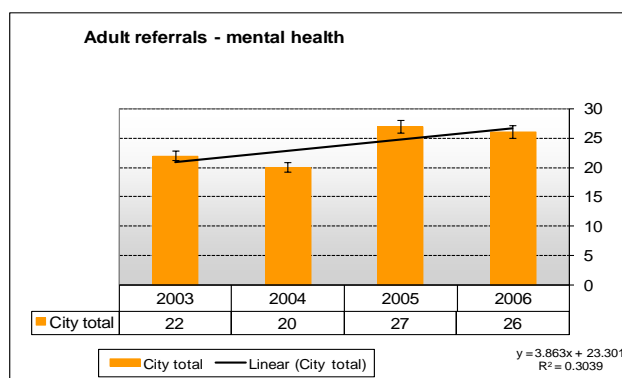
Source: Compendium of Clinical and Health Indicators, 2008

Social care for people with mental health problems

The following graph shows the percentage of adults referred to social care services for mental health reasons in Bristol. This proportion, expressed as a ward average, has increased in recent years.

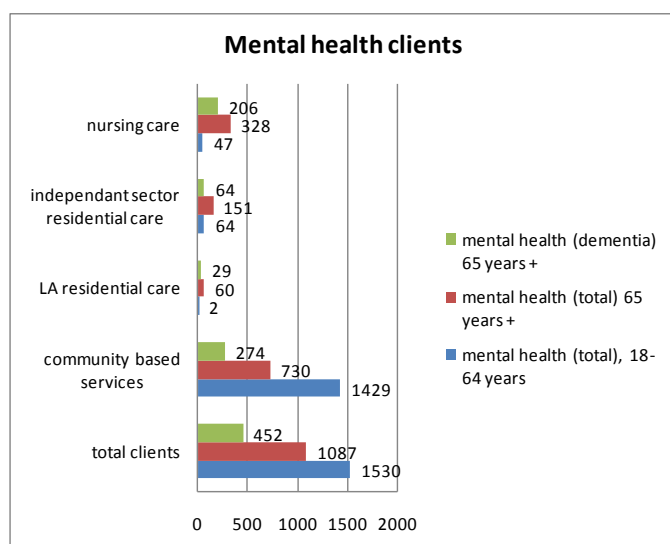
Areas of good practice

Crisis houses – these non-traditional, voluntary sector residential settings provide an alternative to an inpatient ward for people at risk of admission, or in crisis. They can offer short-stay facilities and have patient contracts for good behaviour. A women-only crisis house is proposed for Bristol, and funding is being explored.

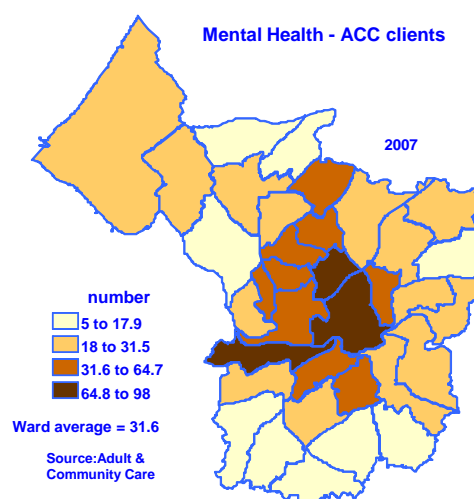


Source: Adult Community Care

Adult Community Care (ACC) statistics (2006-2007) for their client age groups 18-64 years and 65 years and over are shown in the map and graph below. More clients are shown in Lawrence Hill, Ashley and Southville, but the highest proportion of residents who are clients (all ages) occurs in Southville. ACC clients only reflect a partial picture and other sources shown here (page 133) indicate a high prevalence of mental illness in wards such as Southmead and Henbury.



Source: Adult Community Care



Mental health services

In the past, treatment was largely restricted to anti-depressants and other medications, with only limited access to psychological and talking therapies. Commissioning needs to consider a flexible range of services between GP-based support and secondary care.

Service improvement is being addressed through Bristol's *Mental Health Services – Vision for the Future*.⁷¹ This identifies the following issues:

- services need to be more responsive to people's needs
- the choices people ask for are not always available
- more should be done to address the mental health needs of BME groups
- access to psychological therapies needs to be improved
- recognising and addressing carers' needs.

The vision includes underlying principles that inform all aspects of service provision – choice, service-user involvement, self-help, listening and consultation and equality. At present there are

⁷¹ Local Implementation Team, PCT (Feb 2008), A Vision for the Future, Bristol mental health

significant gaps in self-help services, as well as the need to compile information on starter grants and sources of funding for self-help groups.

In Bristol, there is widespread concern that BME communities are disproportionately represented among users of mental health inpatient services. Research into their needs is lacking.

There are many things that can be done to promote mental wellbeing, for example:

- promoting physical activity
- taking steps to reduce suicide among the most vulnerable groups
- providing support and funding to voluntary groups to provide health promotion services
- improving access to services particularly for communities with a higher prevalence of mental illness.

Dementia

The term dementia is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of the skills needed to carry out daily activities. The symptoms are caused by structural and chemical changes to the brain and there are four common forms:

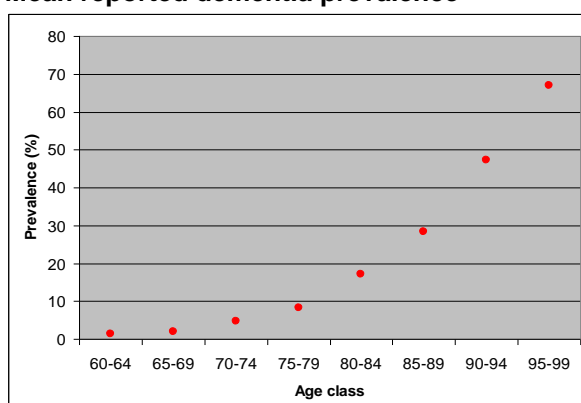
- Alzheimer's disease
- vascular dementia
- frontal temporal dementia
- dementia with Lewy bodies.

Dementia increases exponentially with age. In the UK one in five people over 85 has dementia and one in 14 over 65 has a form of dementia.

Fifteen per cent of people with a diagnosis of dementia are cared for in residential homes, 11% in nursing homes, 11% in hospital and just under 50% at home with an informal carer. Of concern are the estimated 13% who live alone at home. These figures deal with diagnosed dementia and a lot of people with mild dementia may not be diagnosed. Bristol City Council and independent providers currently have 382 beds for people with dementia, which has been recognised as insufficient.

The following graph is based on mean prevalence recorded in international studies.⁷² It is a progressive condition with symptoms which become more severe over time, and this needs to be anticipated in care plans.⁷³

Mean reported dementia prevalence



Source: Age Concern – prevalence study⁶⁸

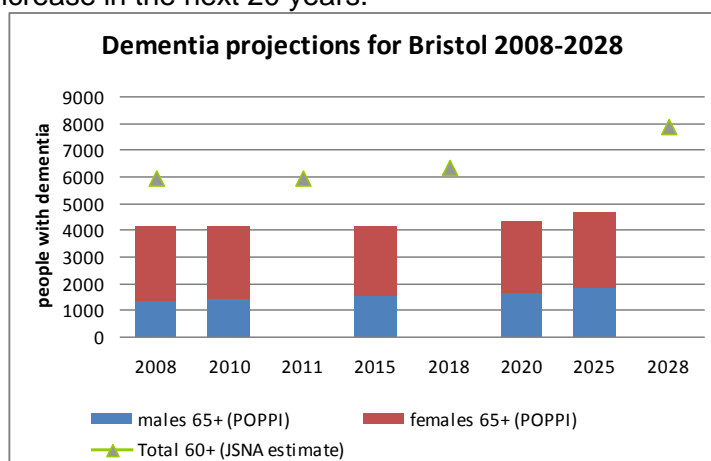
⁷² Age Concern Regional Support Services SW Lottery Supported Capacity Building Project

⁷³ Alzheimer's Society (2007) Dementia UK Full Report

The prevalence of early onset dementia is higher in men than women for those aged 50-65, while late onset dementia is marginally more prevalent in women than men. Around 6% of all people with early onset dementia are among BME groups, compared to only 2% BME for the UK population.

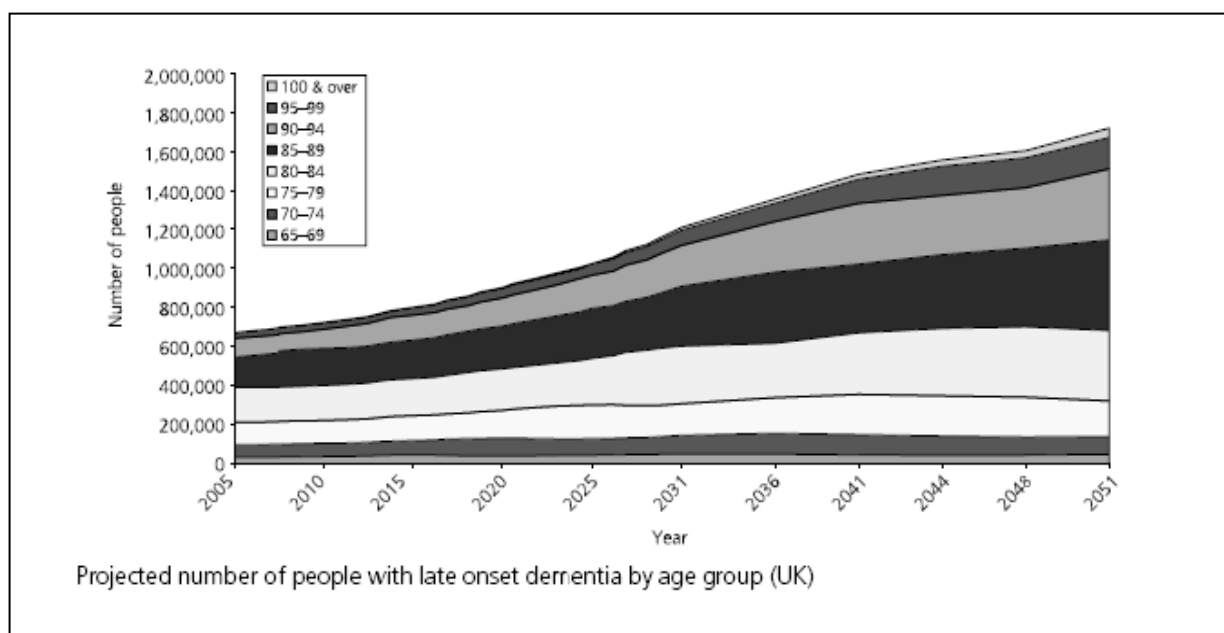
The number of people with dementia is forecast to increase nationally by 38% in 15 years and 154% in 45 years. The lower graph shows the UK projection,⁷³ indicating that early onset dementia will remain steady compared to late onset.

This JSNA has estimated a figure for Bristol 2008 of 5,921 people with dementia aged 60 and over (using the most recent ONS 2006 projected age profile for the city, see Annex 6), and the mean prevalence rates recorded in the previous graph ranging from 1.4% at 60-64 years to 28% at 85-89 years). This method can be used to provide estimates for 2011, 2018 and 2028 (see graph below), showing a 33% increase in the next 20 years.



These estimates are higher than those from Projecting Older People Population Information System (POPPI), which is based on the age group 65 and over. POPPI predicts we have 4,105 people with dementia in 2008 and will have 4,646 by 2025 (graph above shows both estimates).

Overall, ten per cent of deaths in men over 65 years and 15% of deaths in women of the same age, are attributable to dementia. Due to both the higher mortality in men and higher age-specific prevalence in women, there will be more women with dementia.



Source: Alzheimer's Society (2007) Dementia UK Full Report

People with Downs syndrome now have improved life expectancy (60 years). With this comes the greater risk of dementia (see page 143 - People with learning difficulties).

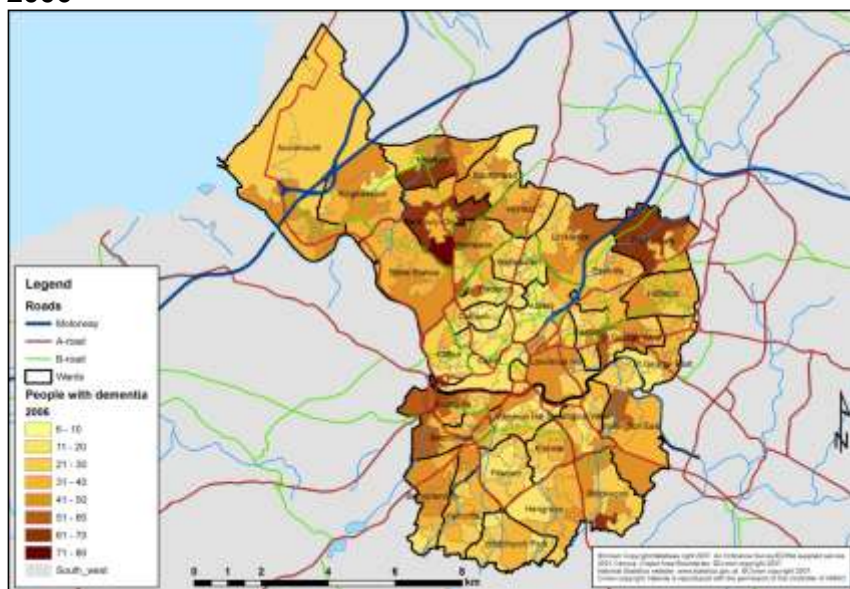
Spatial distribution of people with dementia

Recent local research commissioned by Age Concern⁷² has modelled the spatial distribution of residents with dementia for the next 50 years. The model is based on national prevalence data for each age group over 60 years and ONS population projections, but assumes the population is not mobile and the mortality rate is constant (see following maps).

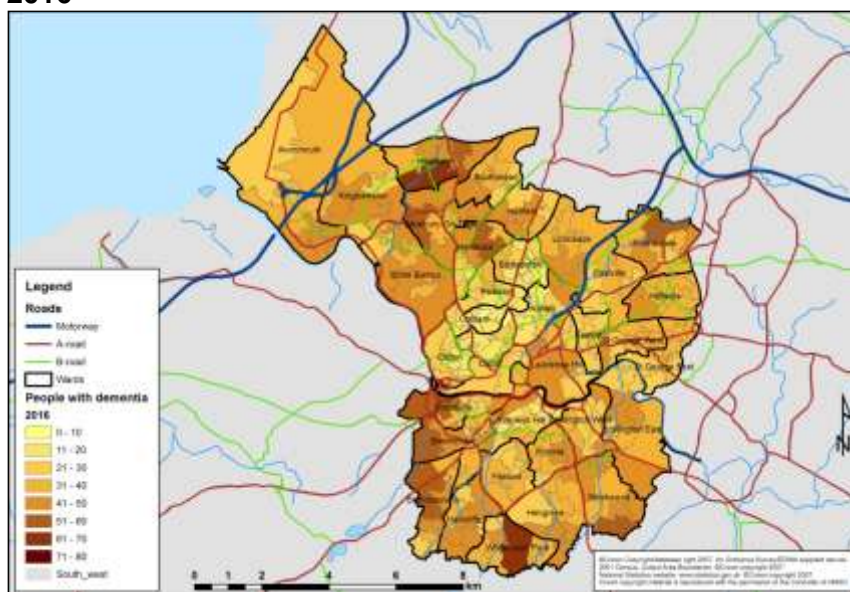
Even with this limitation it can be seen how the pattern changes over the next three years, with an increasing number of residents with dementia in south Bristol, particularly in Bishopsworth and Whitchurch Park. See Annex 9 for maps of dementia projections up to 2051 (five year intervals).

The following graph, also drawn from the same research, shows the distribution of dementia change by ward (ten year intervals). Some wards such as Henbury and Stoke Bishop show little change, whilst others with a currently younger age profile show most change (Ashley and Cotham).

2006

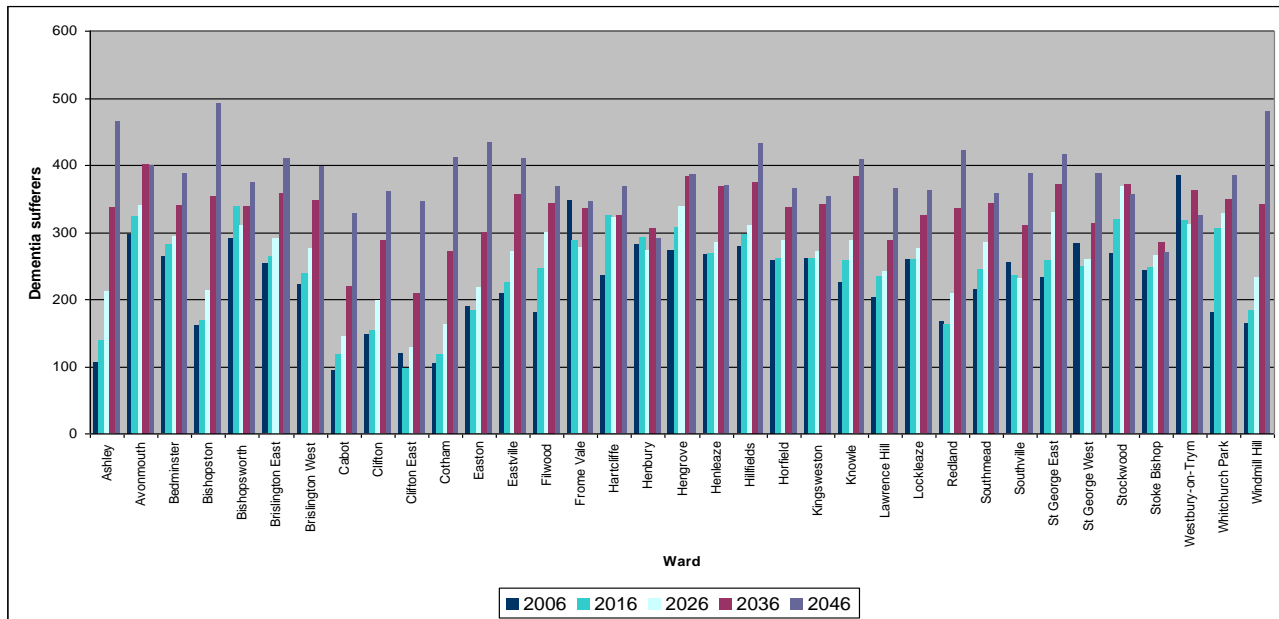


2016



Source: Age Concern – prevalence study⁷²

Projected dementia sufferers by ward



Source: Age Concern – prevalence study⁷²

Mental health of children and young people

Nationally, ten per cent of children suffer from mental illness. In 2005, more boys suffered mental health disorders (12.6%) compared to girls (10.3%) in the 11-16 years age band, as reported by the British Medical Association (BMA) in June 2006. The BMA found a higher prevalence of mental health problems among children from deprived backgrounds, broken homes, children in care, refugee and asylum seekers and young offenders.

The degree of emotional health will vary from child to child, as children have different levels of resilience. Risk factors limiting resilience are:⁷⁴

- parental death, illness or mental illness
- repeated early separation of parents
- overly harsh or inadequate parenting, abuse or neglect
- parental criminality
- parental job loss or unemployment.

Protective factors are:

- IQ
- general health
- secure attachment to at least one adult
- sociability
- consistent parenting
- good housing.

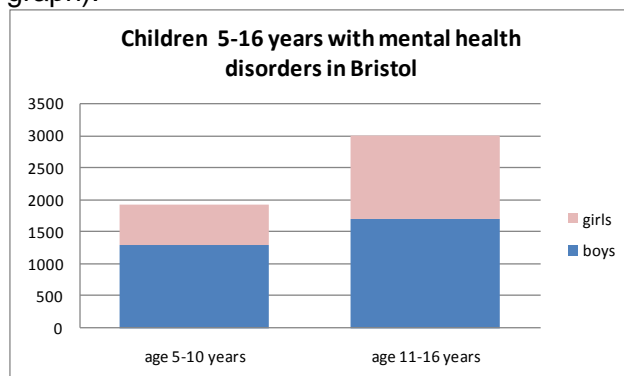
Children who have recently arrived from countries with civil unrest and who experience bullying and racism in the community, are more likely to suffer from more mental disorders. To address this, a project in Bristol is looking at the mental health of Somali children and results indicate they are exposed to the following risk factors:

- trauma in fleeing a war-torn country
- insecure immigration status

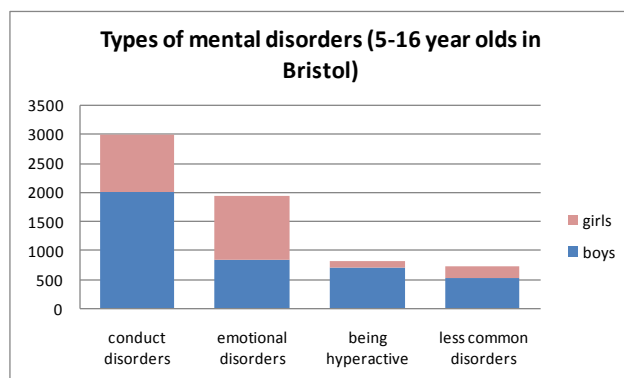
⁷⁴ Paper to Stakeholder Group (May 2008), Bristol's Emotional Health and Wellbeing Strategy for Children and Young People 2009-2014

- language barriers
- discrimination
- cultural barriers
- housing problems
- family stress
- financial problems
- differing expectations between communities and generations.

Estimates for Bristol are available from the Child and Adolescent Mental Health Services (CAMHS) mapping website,⁷⁵ extrapolated from national figures. Based on ONS 2005 population estimates for the 5-10 and 11-16 year age bands this proportion is equivalent to over 3,000 boys and over 1,930 girls (see next graph).



Types of mental disorders are shown in the following graph (any child may have more than one disorder).



Source: www.camhsmapping.org.uk (both graphs)

Figures for prevalence by ethnicity and spatial distribution across the city are not known. It is also not known if BME children are accessing CAMHS services, as ethnicity is not always recorded.

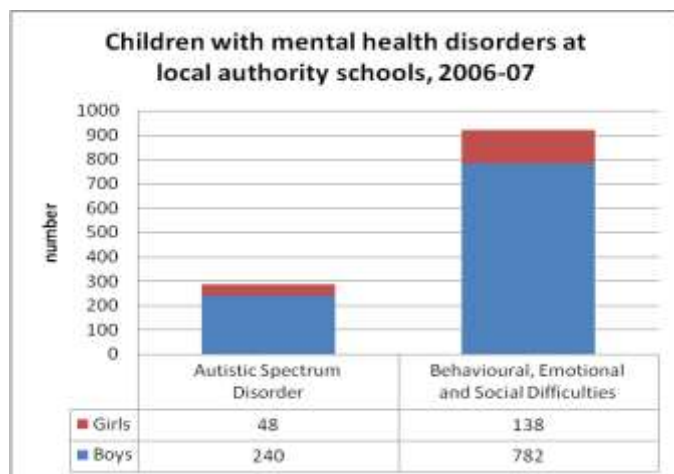
A recent indication of numbers of children with mental health disorders can be obtained from the Pupil Census April 2008. This census records pupils with special education needs and this includes: autistic spectrum disorder (ASD) and children with behavioural, emotional and social difficulties. There are 1,208 children in this category at Bristol's local authority maintained schools and they are mainly boys. See following graph and map for gender and ward breakdown.

National research has reported prevalence of ASD to be between 0.6 – 1% per 10,000 children (5-16 years).⁷⁶ Prevalence is increasing but the reason for this is not known. If applied to Bristol, this would equate to 610 cases. There are 288 pupils with ASD attending our local authority schools in 2008.

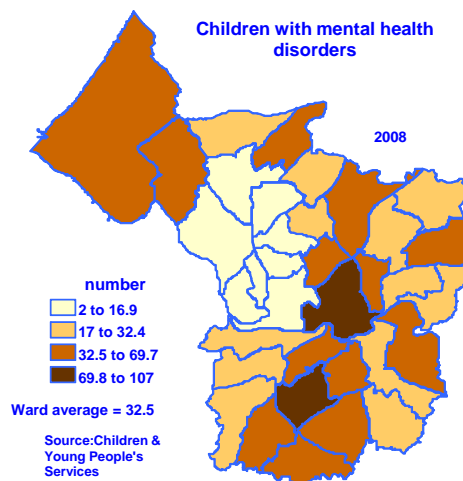
⁷⁵ www.camhsmapping.org.uk

⁷⁶ The Lancet (2006); 368:210-215 Special Needs and Autism Project

In 2004, the CAMHS mapping report, based on psychiatric morbidity in children and young people, estimated that need would be highest in Whitchurch Park, Filwood, Lawrence Hill, Ashley, Lockleaze, and Hartcliffe. The following map indicates that Filwood and Lawrence Hill still have more children with mental disorders in 2008.



Source: Children and Young People's Services

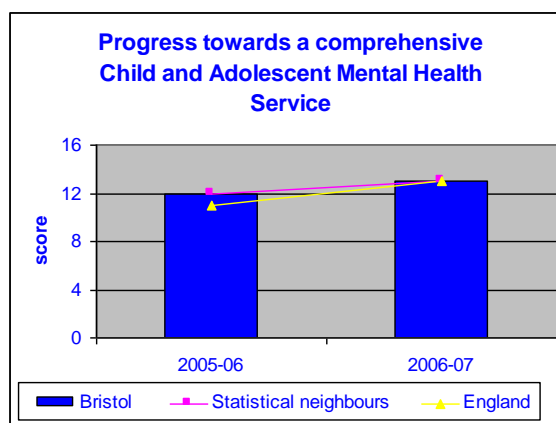


Disabled children are more vulnerable to emotional ill health. They are also more vulnerable to abuse, which increases the likelihood of emotional ill health. We know that there are more disabled children living in deprived areas, particularly Filwood.

About two-thirds of children living in residential care have been assessed as having a mental disorder and about 40% of those children living with foster carers or their birth parents. In Bristol in 2008, there are 643 children in care, so the above proportion would equate to approximately 257 children across all settings who might experience some type of mental disorder.

Nationally, our services from CAMHS compare well. The graph below shows how Bristol scores (out of a maximum 16 points) on progress towards a comprehensive CAMHS. But professionals agree that CAMHS alone cannot meet the needs of the estimated ten per cent of children with mental health problems. A comprehensive CAMHS requires a shared ownership of improving emotional health and wellbeing across children's services from prevention, early intervention and referral, when appropriate. A new approach to management of referrals called the 'choice and partnership approach' is significantly reducing waiting lists for first appointments. There has been investment in learning disability psychiatry and community child health therapy provision this year. However, there remain workforce issues regarding different provision across the city. Of particular concern are those professions with an ageing workforce, such as health visiting.⁷⁷

Source: Annual Performance Assessment CYPS



⁷⁷ Commissioning Manager, CYPS

Suicides and self harm – children and young people

Paracetamol overdose and cutting are the two most common forms of self harm reported in children and young people. Girls are much more likely to self harm than boys. Children aged five to ten are more likely to self harm if they have experienced stressful life events, and all are more likely to do so if they have been around other people who self harm. It is often linked with being bullied. In 5-15 year olds, self harm has been found to be twice as prevalent among children from the lowest socio-economic income group and those living in rented accommodation. Risk factors for suicide in young people are parental separation and divorce, mental illness in parents, poor parent/child relationships and a history of abuse.

A recent University of Minnesota study revealed that children who were teased about being overweight were more likely to have poor body image, low self-esteem and symptoms of depression. The study found that 26% of teens who were teased at school and home reported they had considered suicide and nine percent had attempted it. Suicide is the third leading cause of death among adolescents.⁷⁸

A history of self harm is a risk factor for suicide. Around 40% of suicides have a history of self harm, and at least one per cent of people who self harm take their own lives within a year.

Overall, approximately seven per cent of adolescents will harm themselves at some point and 20% will think seriously about it.⁷⁹ Approximately three per cent of adolescents will attempt suicide,⁸⁰ and 40% of those who survive will repeat it.⁸¹ The highest incidence of self harm is in young women aged 15-19 years; 7.6 per 100,000 15-19 year olds will commit suicide.

Applying these statistics to Bristol's population of 26,100 15-19 year olds (both sexes mid-2007 population estimate), approximately 800 are likely to attempt suicide, and one or two are likely to die as a result.

People with learning difficulties (PWLD)

Learning difficulty (LD) includes the presence of a significantly reduced ability to understand new and complex information and to learn new skills, with a reduced ability to cope independently. LD starts before adulthood, with a lasting effect on development.

Epidemiological studies have reported a significant association between poverty and the prevalence of LD. People living in poverty are exposed to environmental and psychosocial hazards, as well as the financial and social impact of exclusion and unemployment. There is also a higher prevalence among young people of South Asian communities. Research by Emerson and Hatten suggests that there may be up to three times as many PWLD as in the general population.^{82,83}

Learning difficulty is associated with greater health needs and an increased risk of particular health conditions. Studies suggest that the health needs of people with learning difficulties are poorly understood and historically have been poorly met.⁸⁴ The health issues of this group relate firstly to a

⁷⁸ Archives of Pediatrics and Adolescent Medicine, "Associations of Weight-Based Teasing and Emotional Well-being Among Adolescents," August 2003)

⁷⁹ Andrews and Lewinsjohn, Royal College of Psychiatrists (2003) quoted in CAMHS: An Operational Handbook

⁸⁰ Hawton, K & James, A (2005) Suicide and deliberate self harm in young people. BMJ 330;891-894

⁸¹ Wright, B and Richardson, G (2003) Deliberate Self Harm in CAMHS: An Operational Handbook

⁸² www.lancaster.ac.uk/fass/ihr/research/leaning/download/futureneed.pdf

⁸³ Briefing on learning disabilities (January 2008), NHS Confederation

⁸⁴ Bristol and District People First (2003) Nothing about us without us. DH 2001 Valuing People - a new strategy for learning disability for the 21st century. White Paper. London: The Stationery Office.

reduced intellectual and social functioning and also to poor access and sub-optimal uptake of healthcare services. Incidence of some cancers and of coronary heart disease are higher in people with learning difficulties, as well as being overweight, not eating a balanced diet and a lack of physical activity.

Women with learning difficulties are less likely to have cervical smears or carry out breast self examination, or understand the reasons for doing so, than women from the general population. Oral health and uptake of dental services are both poorer in this population. PWLD can encounter problems accessing sexual health services because of a common misconception that PWLD are not sexually active and a lack of specialist services. Vision and hearing impairments are much more common in PWLD and yet they are less likely to be assessed for these impairments and receive aids for vision and hearing.

About 30% of PWLD suffer from epilepsy (due to related brain injuries). PWLD should have the same access to treatment for their epilepsy as anybody else.

Prevalence of PWLD in Bristol (all ages)

The number of people with learning difficulties is increasing, partly due to people living longer as a result of medical and technological advances. People with a learning difficulty make up approximately two percent of the total population. It is estimated that approximately 8,400 of Bristol's population have learning difficulties and 2,100 people (a quarter of this group) have moderate to severe learning difficulties. Due to its history as an institutional care provider, Bristol may have a higher than expected number of residents with LD.

The actual numbers of PWLD are not certain. Adult Community Care (ACC) and GPs are aware of some PWLD, but not all. The PCT is aware of approximately 2,860 PWLD and ACC aware of 1,790, but there is likely to be overlap with double counting between these two organisations. The Learning Difficulties Service has estimated that they are aware of only 30% of PWLD. This means there are likely to be 5,500 PWLD not 'in the system' with potential unmet need. This is partly due to the stigma attached to having a learning difficulty and a reluctance to be labelled.

The table below gives figures for the current and projected PWLD population in Bristol. It is based on the most recent population projection statistics (ONS 2006) and the prevalence referred to here.

PWLD	2008	2011	2018	2028
Population projection	422,000	440,700	480,300	529,200
All LD – all ages (2%)	8,440	8,814	9,606	10,584
Moderate to severe LD – all ages (0.5%)	2,110	2,204	2,402	2,646

The PCT local enhanced service is encouraging GPs to register PWLD; 36 GP practices have volunteered and 1,000 PWLD are on the register.

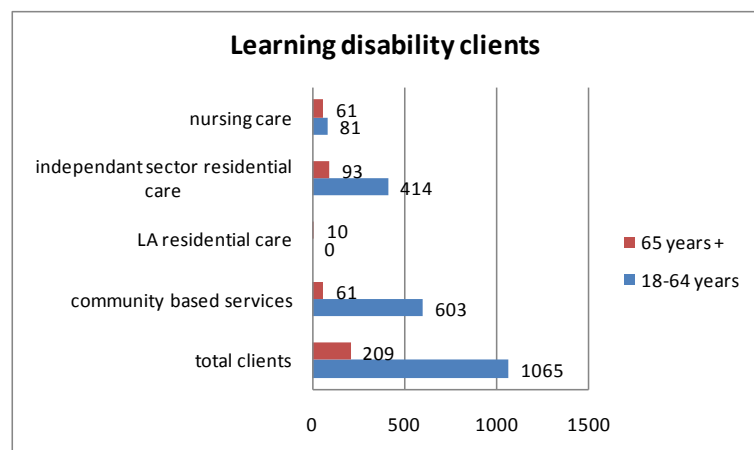
Older people with learning difficulties

This group of people is likely to increase in number as life expectancy increases and they are more likely to rely on social care services and supported accommodation. One key area will be support for people with dementia secondary to Downs syndrome. In 1900, the average life expectancy of someone with Downs Syndrome was nine years, and it is now 50-60 years.

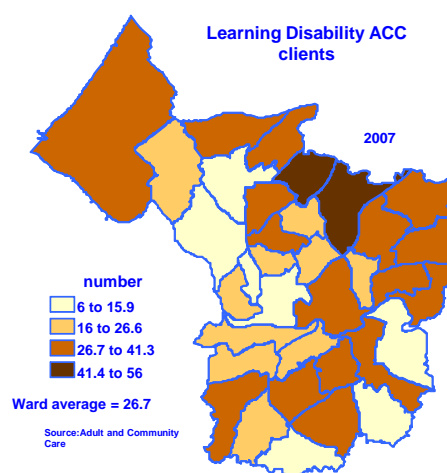
Social care for PWLD

ACC clients (all adults) are shown in the following graph and map, with a higher number and proportion of clients in the north of the city, particularly Lockleaze and Horfield. These figures do not reflect a high number of young people in the south of the city and in neighbourhood renewal areas

(such as Filwood, Hartcliffe and Whitchurch Park), who are identified in the following section on young people with learning difficulty.



Source: Adult Community Care



Areas of good practice

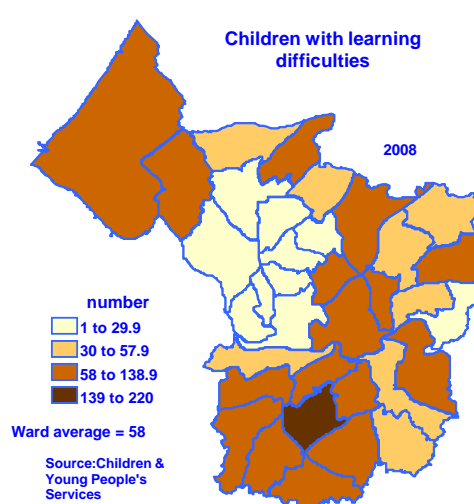
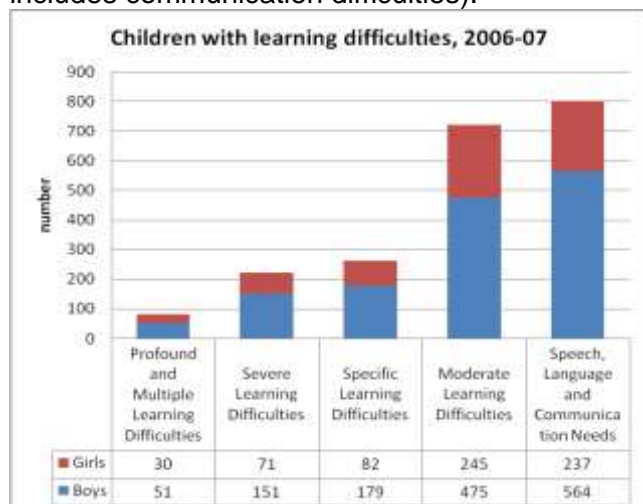
Sheffield Learning Difficulty Register – Sheffield has two part-time register managers who are able to provide a comprehensive picture of children and adults with learning difficulties in the city. This has provided a good evidence base for their commissioning strategy.

Children and young people with learning difficulties

There is better evidence for the numbers of children with a learning difficulty, compared to adults. CAMHS mapping service estimates that Bristol has 1,200 children (5-19 years) with learning difficulties. Forty percent of these children will have mental health problems.

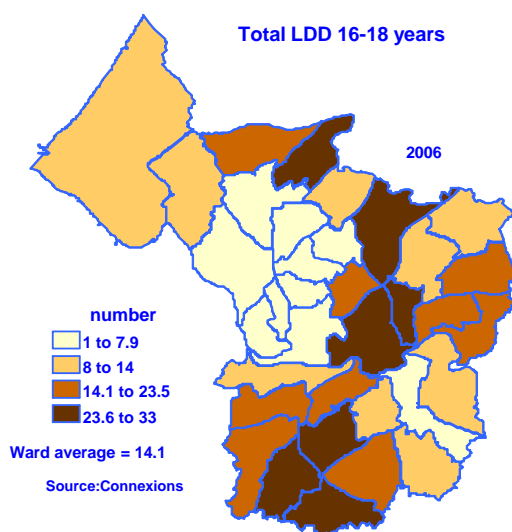
There is likely to be a rise in the numbers of children with severe and complex learning difficulties due to increased survival of very premature babies.

A more recent indication of children with learning difficulties can be obtained from the Pupil Census April 2008. This census records pupils with special educational needs and this includes moderate, severe, specific, profound and multiple learning difficulties. At local schools, 2,085 children are noted as having learning difficulties, and 68% are boys (see following graph and map which also includes communication difficulties).



Source: Children and Young People's Services

A quarter (24%) of pupils with special educational needs (SEN) are from BME groups (similar to the proportion of BME children at local authority schools – 22.5%). But 42% of children with profound and multiple learning difficulties are from BME groups (34 pupils). The majority of Bristol's private schools have no SEN pupils.



Of these pupils, some will continue to experience learning difficulties in their adult life. The map opposite shows the location of young people aged 16-18 years (recorded by Connexions), with learning difficulties and disabilities (LDD), a total of 494 young people in November 2006.

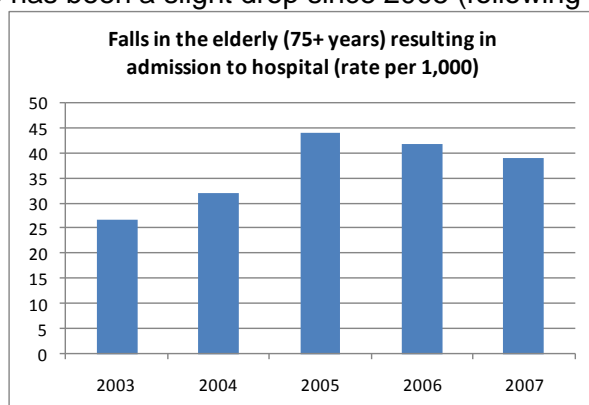
There would be a clear benefit to Bristol in having a citywide register, along with enhanced sharing of data on learning difficulties between children and adult health and social care agencies.

Accidental injuries - adults

Falls in older people

Nationally, one older person dies every five hours as the result of a fall. Older people's falls alone cost the NHS £0.7 billion each year; 1.25 million falls result in hospital admissions each year. Falls account for 71% of accidents for those aged 65 years and over and 54% of injuries. In the South West, 43% of people aged 85 and over have had a fall in the last 12 months.⁸⁵

The number of older people in Bristol who suffer falls and enter hospital has increased since 2003, although there has been a slight drop since 2005 (following graph).

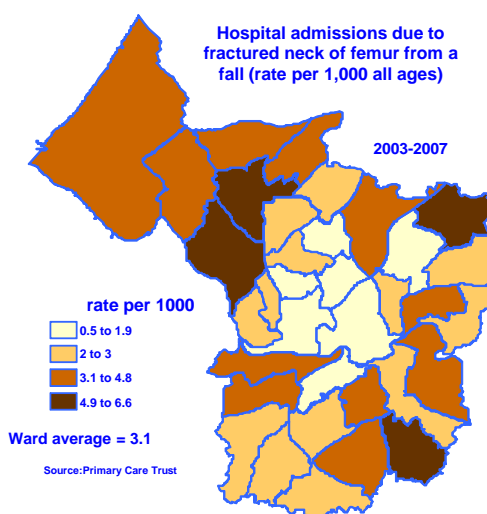
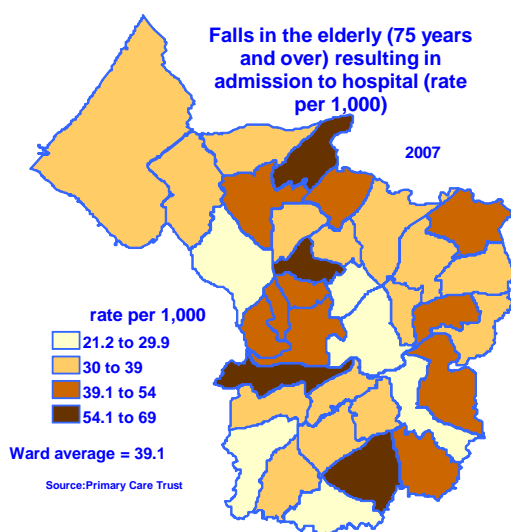


Source: Bristol Primary Care Trust

Hospital admissions due to fractured neck of femur as a result of a fall can be mapped for the period 2003-2007(all ages), see overleaf. The highest rate of falls occurs in wards with a more elderly age profile: Westbury-on-Trym, Frome Vale, Stoke Bishop and Stockwood.

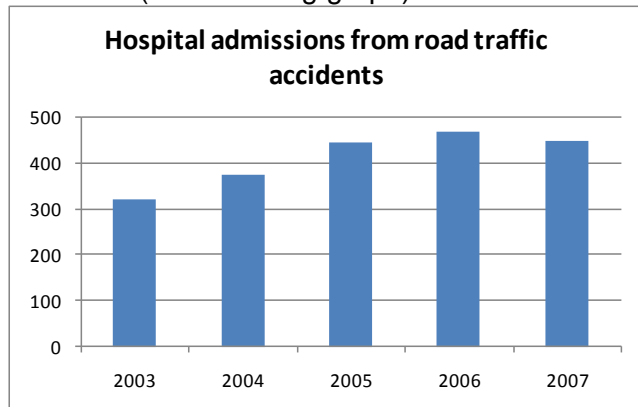
⁸⁵ Second Blooming, www.swpho.org.uk

The number of older people with hip fractures aged over-65 years in Bristol is above the England average, but ranks average for core cities.

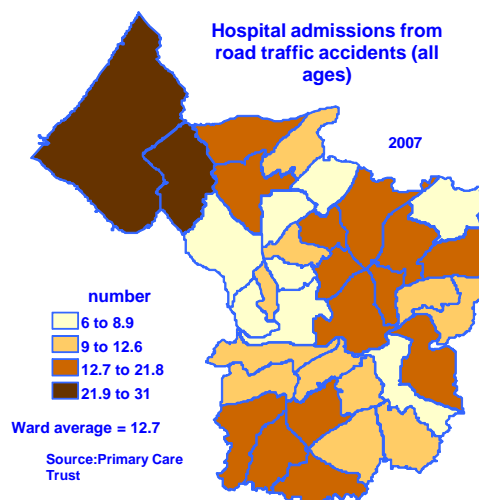


Road traffic accidents (RTAs)

In Bristol, the rate of road injuries and deaths is close to the England average, and ranks second best out of the eight core cities. However, the trend over the last five years shows an overall increase in hospital admissions for road traffic accidents (see following graph).



Source: Bristol Primary Care Trust

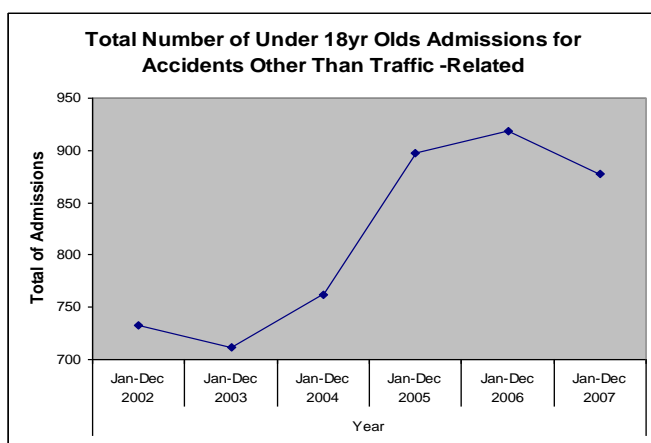


In 2007, Kingsweston residents had the highest number of hospital admissions due to road traffic accidents (31). More RTAs occur in heavily trafficked areas e.g. motorways and A roads.

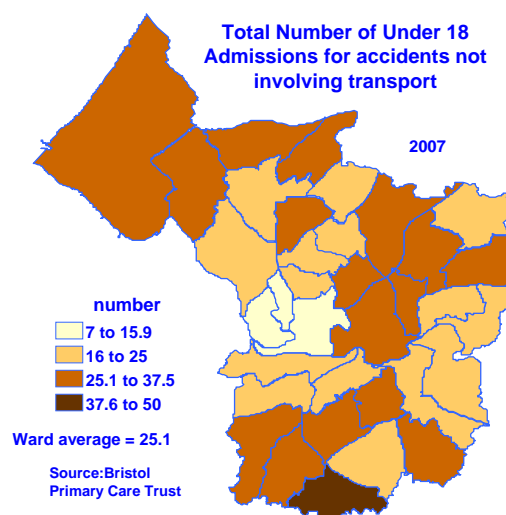
There are also gender differences and Annex 16 shows excess mortality for males living in the most deprived quintile of Bristol for road traffic accidents.

Accidental injuries - children and young people

Unintentional injuries lead to more admissions to hospital for children than any other reason. Boys are more accident prone - nationally minor accident rates in 2001-2002 per 1,000 persons were 210 for boys and 159 for girls. Rates are similar for both sexes when children are young, but increase for males, so that by the mid-teens their rates are much higher (*Health Survey for England 2002*). Accidental injury recorded as hospital admissions by the PCT is shown in the following graph and map (it does not include road traffic accidents). Accidents steadily increased until 2006, but 2007 has seen a five per cent drop with a total of 877 admissions for accidents (919 in 2006). Whitchurch Park has the highest numbers of accidents at 50.



Source: Bristol Primary Care Trust



Children of the 90s researchers also found that those children in single-parent families and stepfamilies were disproportionately likely to experience accidents and receive medical treatment for physical illnesses. In addition, these children were more likely to be hospitalised, or to receive attention from a hospital doctor for an injury or illness.

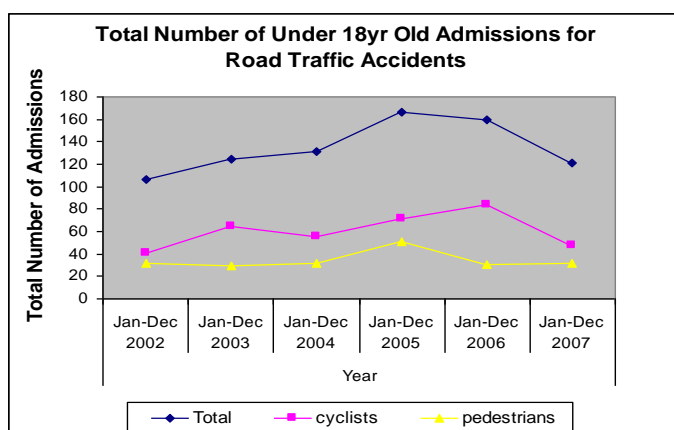
Recent joint research in 2007 by *Children of the 90s* and the University of East Anglia found that children under five years living in some neighbourhoods in Bristol are three times more likely to have an accident in the home than those living in the 'safer' areas of the city. They identified seven accident hotspots: Sea Mills, Eastville, St Anne's (Brislington), Monks Park, Fishponds, Trym (part of Southmead) and Mayfield Park. Researchers said that poverty, housing type and neighbourhood quality may play some part in the explanation, but do not explain it all. Further research is continuing and can be found at www.alspac.bristol.ac.uk

RTAs of children and young people

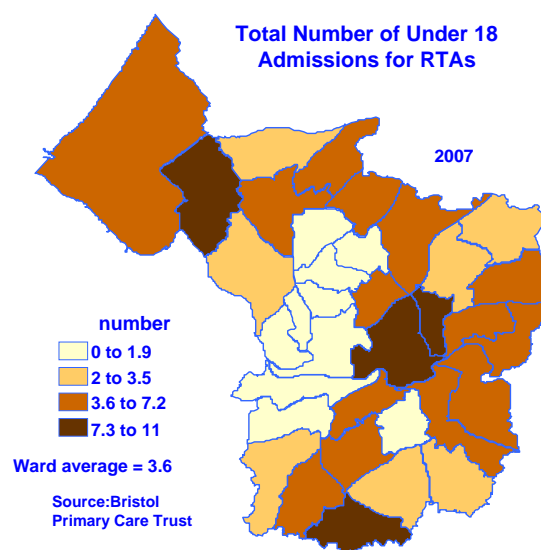
Statistics for admissions to hospitals capture young drivers as well as pedestrians. The following graph shows there was an increase in RTA hospital admissions until 2005, but 2007 has seen a fall to 121 admissions. Accidents involving child cyclists almost halved in 2007, with 48 admissions (84 in 2006). Child pedestrian accidents remained fairly steady (32 admissions in 2007). Changes in children's walking, cycling and car use rates will influence exposure to risk of injury on the road.

Eighteen children were killed or seriously injured in Bristol in 2007 (25 in 2005) indicating a reduction. However, the number of children killed or seriously injured on the roads in neighbourhood renewal areas is higher than in other areas.

Whitchurch Park records the highest number of admissions. The map also reflects the wards with high child populations and deprived communities.



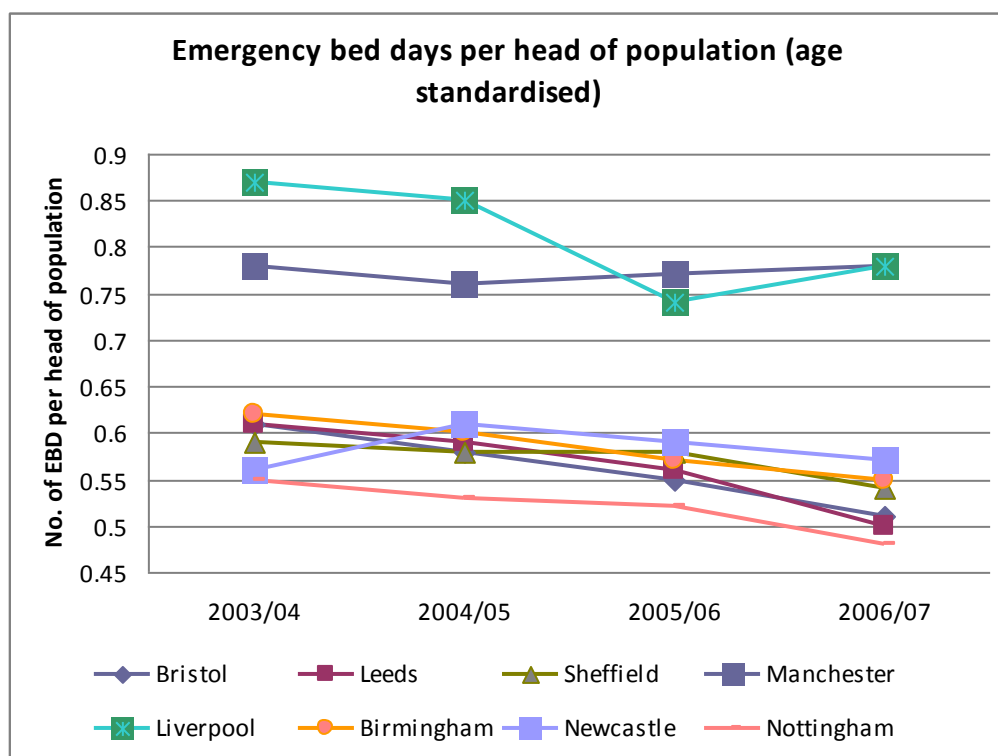
Source: Bristol Primary Care Trust



Hospital admissions

Emergency bed days (EBD)

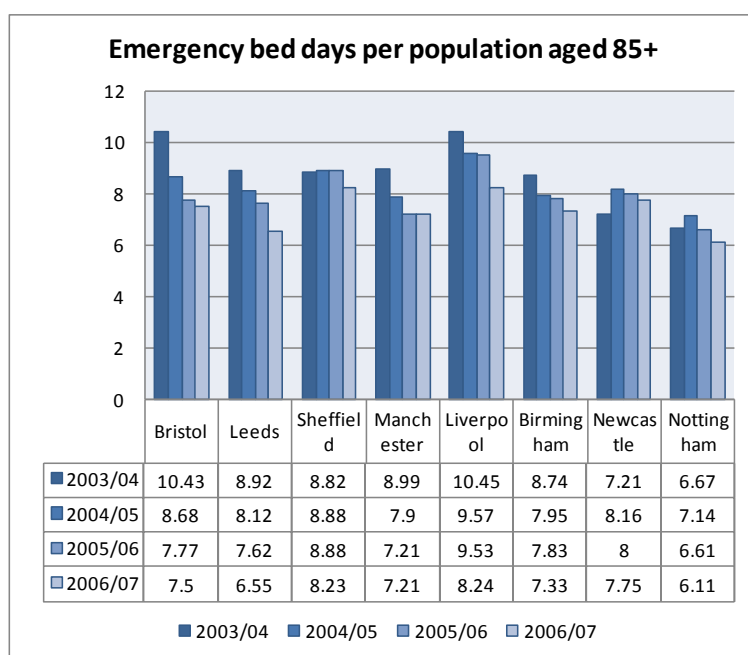
Emergency bed days per head of population is defined as the number of days a patient spends in hospital following an emergency admission. It is a national indicator and Bristol compares well with other cities with 0.51 EBD per head of population, (third out of eight core cities, see graph below). In 2006-2007 there were a total of 261,697 EBDs and two thirds of these were for people aged 65 and over.



Source: Department of Health

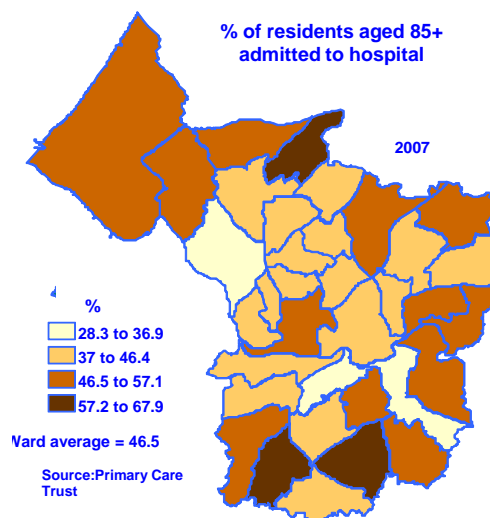
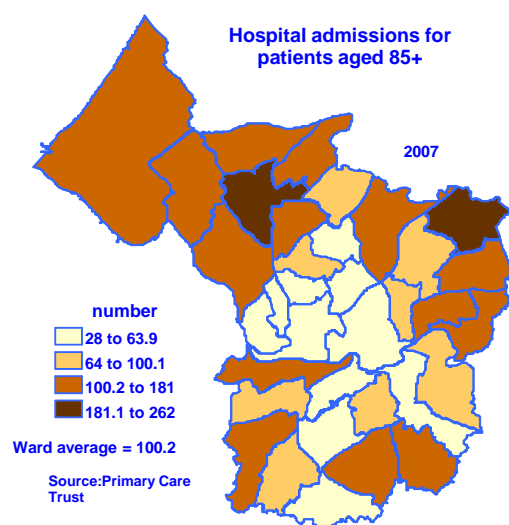
Hospital admissions and EBDs for older people

A high number of people aged 85 and over are included in hospital admission figures. Nearly a quarter of EBDs were accounted for by people aged 85 and over in Bristol. In 2006-2007, there were 3,508 admissions from people aged 85; EBD for people aged 85 and over was 7.5. This figure has reduced from 10.43 EBDs in 2003-2004. This reduction may be due to avoiding emergency admissions and also partly due to transferring care to community settings after management of the cause for the emergency admission. Bristol is fifth out of eight core cities for duration of EBDs in people aged 85 and over (see graph below).



Source: Department of Health

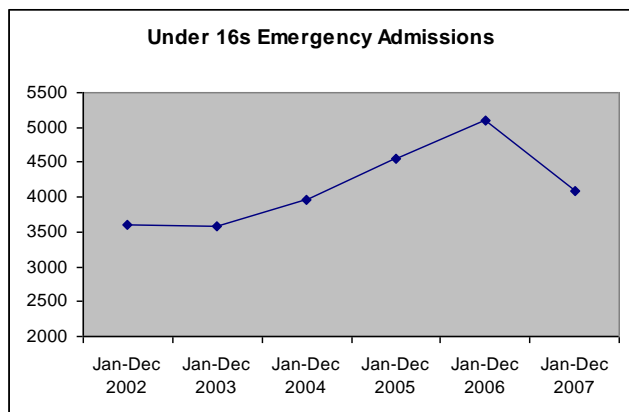
The following maps show the location of Bristol's most elderly residents who were admitted to hospital in 2007. The first map shows actual number of admissions and reflects the population distribution of people aged 85 plus, with more elderly people living in Westbury-on-Trym and Frome Vale. The second map shows the percentage of people aged 85 years plus admitted to hospital and indicates that the level of need is also high in the wards of Southmead, Hartcliffe and Hengrove.



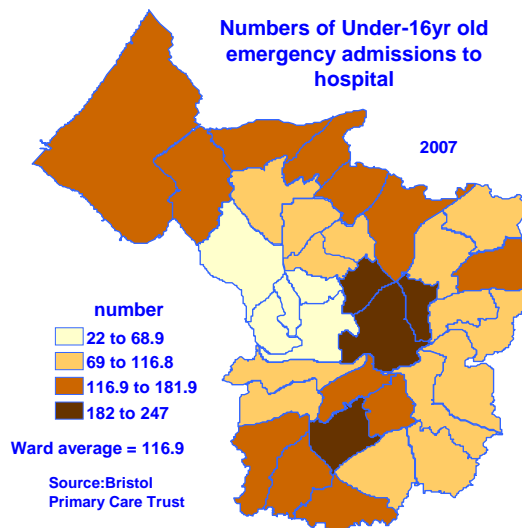
Hospital admissions for children and young people

Emergency hospital admissions steadily increased between 2002 and 2006. In 2007, there was been a ten per cent fall with 4,092 admissions compared to 5,091 in 2006.

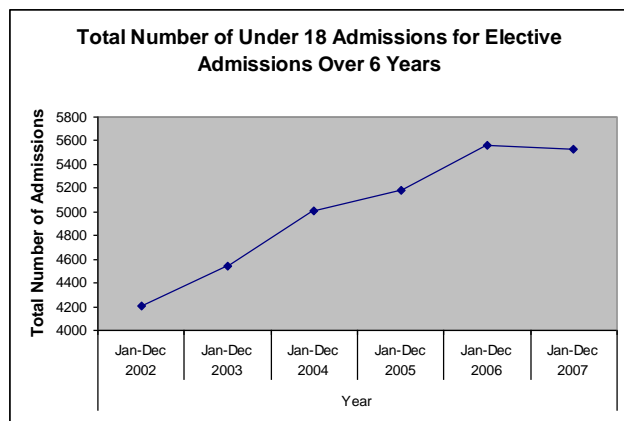
The following ward map shows that the highest number of emergency admissions was in Lawrence Hill with 247 admissions (this ward had 319 admissions in 2006). The more deprived neighbourhood renewal areas of Bristol also had higher admissions.



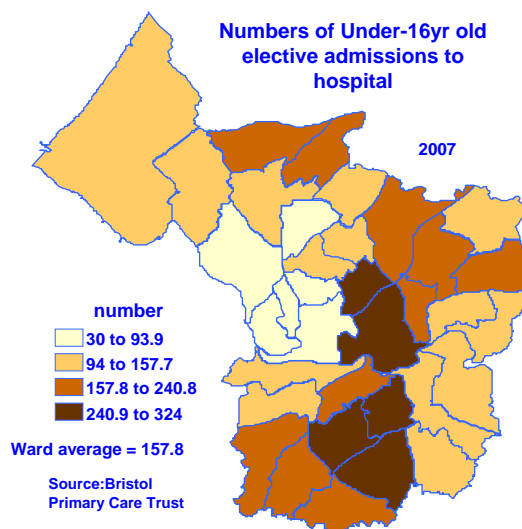
Source: Bristol Primary Care Trust



The following map shows elective (planned) hospital admissions; Lawrence Hill and Filwood had the highest numbers (over 290). Again there has been a steady increase since 2002 (see next graph) until 2007, when admissions steadied at 5,524 (5,564 admissions in 2006).



Source: Bristol Primary Care Trust

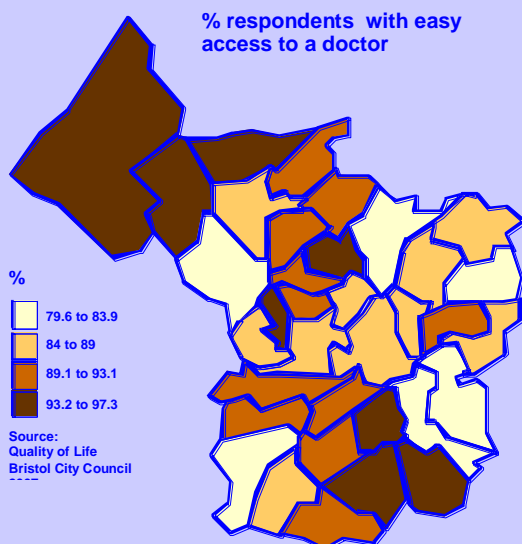


LOCAL VOICE LOCAL VOICE

Access to GP and hospital

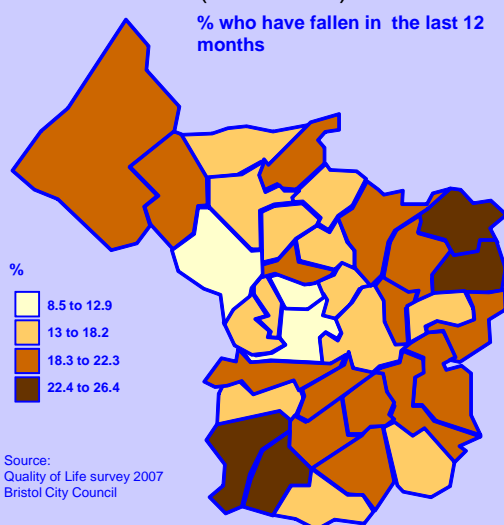
The quality of life residents' survey explored how easy it is to get to the doctor or hospital in neighbourhoods. Results from 2007 indicate 89% of residents have good access to a doctor and 62% have good access to a hospital, dropping to 28% in south Bristol.

The ward map indicates only 80% of residents living in Hillfields and Brislington East have good access to a doctor. Significantly fewer disabled people say they have good access to a doctor (78%) and to hospital (48%), when compared to the rest of the city.



Falls

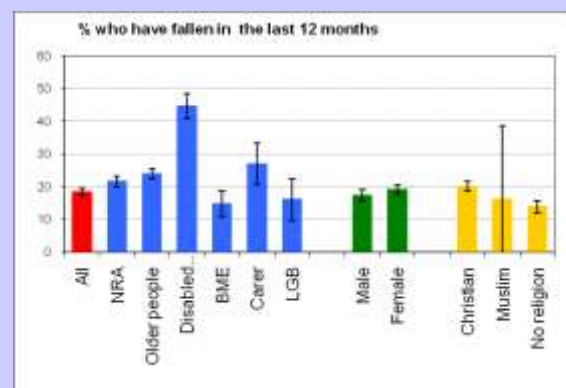
Residents were also asked in the same survey if they had accidentally fallen in the last 12 months (see below).



Some residents living in wards with high fall rates also have poor access to a doctor e.g. Frome Vale, Hillfields, Bishopsworth and Hartcliffe. Results from the survey indicated:

- 18% of all residents said they had fallen in the last 12 months
- significantly more older people aged 50 plus years had fallen (24%)
- significantly more disabled people had fallen (45%)
- 27% of carers said they had fallen.

See graph below.



Source: Quality of Life Survey 2007

The question was also asked 'Has your daily life suffered as a result of the fall in the last 12 months?' Twenty eight per cent said it had, with significantly more disabled people suffering (43%).

Accidents – young people's views

In the Every Child Matters survey 2008 young people were asked if they had had an accident in the last 12 months (that required medical attention). Boys were slightly more accident prone and a third of all children at primary and secondary schools said 'yes'. This pattern changed at age 15-16 years, when no girls and only ten per cent of boys had had an accident.

Social care needs of older people

Over the next 20 years, the Wanless Social Care Review⁸⁶ predicts that the number of older people with impairment and dependency will increase. The review suggests there is potential to shift more care out of hospital and into the community and that improved outcomes would result from supplying more hours of home care to a larger number of people.

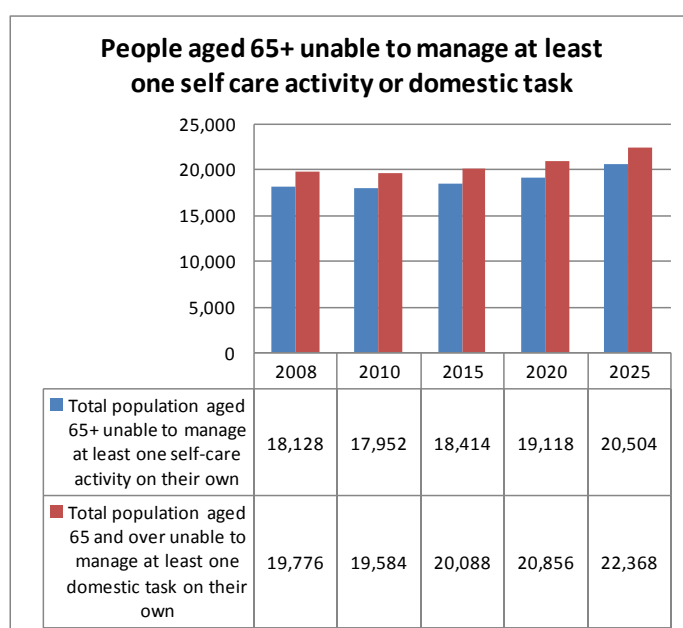
Physical impairments, frailty and mental health can lead to daily problems managing domestic tasks. Older people are considered to have high levels of need, according to the standard assessment, if they are unable to carry out one or more of the main self-care activities of daily living (1+ADL) (being able to wash, dress, feed, toilet, walk and so on). Over the 20 years to 2025, the Wanless Review projects a rise of 44% in the number of older people who do not require care, an increase of 53% in those with some need and a 55 % increase in those with a high level of need. According to expert analysis commissioned for the review, these increases reflect a future where population health improves due to moderate reductions in obesity and other 'lifestyle' conditions, as well as to the introduction of effective new treatments or technologies.

The main driver for this higher demand for care is disability in later life arising as a consequence of:

- cardiovascular and cerebrovascular disease
- stroke
- sensory problems (vision and hearing)
- arthritis
- incontinence
- dementia and depression.

An expansion of morbidity will occur if the extra years gained from increased longevity are mostly spent in disability or poor health.

In Bristol, POPPI estimates that there are 19,776 people aged 65 and over, who are unable to manage at least one domestic task on their own, and 18,128 who cannot manage at least one self-care activity (1+ADL). This equates to 33% of the population aged 65 and over. The population requiring help to manage their self-care will have increased by 300 by 2015 and by 2,500 by 2025, see graph below.



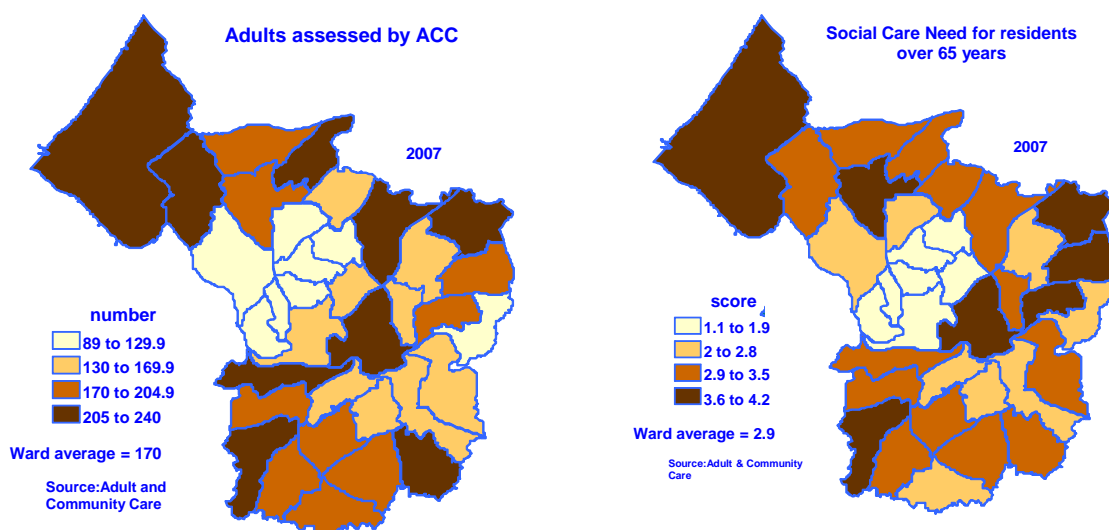
Source: POPPI estimates

⁸⁶ Wanless Social Care Review, PSSRU (2006) Securing the Future for Older People

This 13% increase in the population needing help with self-care is based on research⁸⁷ that pre-dates the Wanless Review. If the Wanless estimate is used, the number of people with care needs will more than double.

There is evidence that a range of preventative measures can reduce dependency, disability and ill health, and that such schemes should be targeted at those whose condition is likely to deteriorate or who have a high predicted risk of costly future needs.

Timeliness of assessment and of delivery of care packages is a current national indicator. Total assessments carried out by ACC in 2007 are shown on the map below (5,950 assessments).



ACC have also looked at a fair shares assessment of social care need for the population aged 65 and over (map above right). The assessment is based on the age profile of the ward population, weighted for those aged 85 and over, living alone, living in rented accommodation, have a limiting long term illness or disability and those who are income support claimants with pensioner premium. These health and wellbeing determinants are combined as an overall weighted score for each ward. In the map the higher scores reflect more need. Some lower levels of satisfaction with social care (see page 160) occur in wards with high needs for older people, such as Avonmouth, Westbury-on-Trym and Frome Vale.

Access to social care by equalities groups

In Bristol, equalities analysis of social care clients was carried out for the period 2006-2007 as an initial assessment. There is a higher take-up of social care services by women across most areas. This may be due to more men being supported by carers or partners, or a reluctance to seek help, and may represent unmet need.

In a national report on access to social care by BME elders,⁸⁸ 30% of the BME group surveyed thought social care needs were poorly met due to language barriers, lack of information and understanding and cultural differences. Take-up of social day care was generally high for Black African-Caribbean groups, but there was a generally low take-up of all services by Chinese and Vietnamese people.

Based on the 2007 population (provided by ONS in 2008), Bristol has five per cent of BME people in

⁸⁷ Bridgwood, A. (1998) People Aged 65 and Over: 22% of 65-74 year olds and 44% of men and women aged 75 and over are unable to manage on their own at least one of the self-care activity.

⁸⁸ Health and Social Care Research Findings (2005) Black and Minority Ethnic Elders in the UK

the retired sector (2,300 persons). The following percentages of BME people aged 65 and over (of total clients aged 65 and over) are receiving social care services in Bristol:

- 4.3% helped to live at home
- 3.1% home care provided by the local authority
- 3.6% home care provided by independent providers
- 2.9% residential placements provided by the local authority
- 2.9% residential placements provided by independent providers
- 6% receiving equipment via the Independent Living Service
- 3.7% received assessments
- 4.5% receiving a carer service
- 5.1% receiving a service from the Mental Health Team
- 9.8% attending day care centres
- 4% receiving a service from a locality team.

These figures indicate there is a reasonable take-up of the majority of services (except for residential placements) by BME people, and this may be related to how they meet eligibility criteria for services and the strength of the BME voluntary sector and outreach teams.

When area-based service use by BME adults is considered, there are big variations across the city. Less than one per cent of ACC clients are from BME groups in the North 1 area (Avonmouth, Kingsweston, Southmead, Henbury, Stoke Bishop, Westbury-on-Trym and Henleaze) and South 1 area (Clifton, Clifton East, Cotham, Cabot, Southville, Bedminster, Bishopsworth, Hartcliffe and Whitchurch Park). These areas have fewer BME clients than the population profile suggests, as North 1 and South 1 areas have BME populations of over 4% (census 2001).

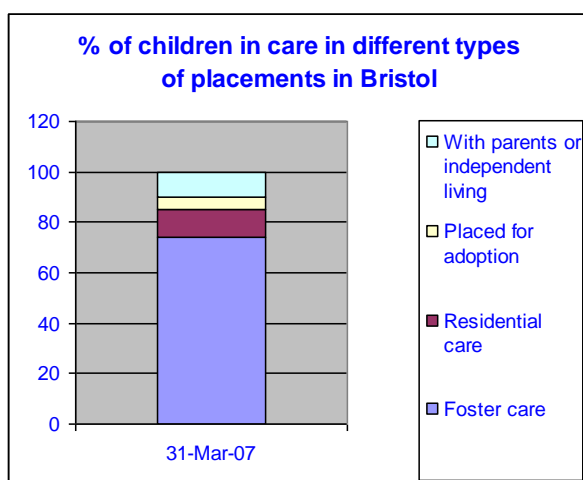
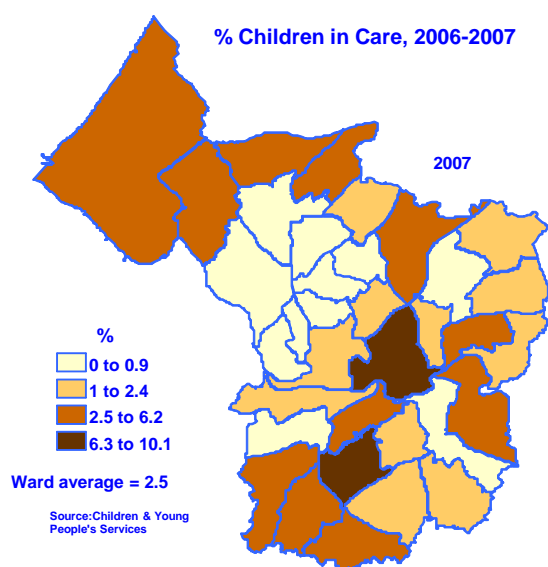
Social care needs of children and young people

In 2006-2007, 5,729 children were referred to social care services. Of these children, 643 were taken into the care of the local authority as 'children in care' (or 'looked after children'). Recent figures for 2007-2008 indicate an increase and 678 children were taken into care. The following map shows the distribution by ward. The highest proportions of children in care come from Lawrence Hill and Filwood.

Children in care represent the extreme end of the spectrum of vulnerability in that their care needs cannot be addressed in the home environment. Reasons why children are being looked after can include:

- parental illness, imprisonment or death
- family breakdown
- abuse or neglect by parents
- abandonment
- special needs of the child
- criminal behaviour of the child.

Placement of children in care can be with parents, relatives, foster carers, adoption or residential care (see following graph).

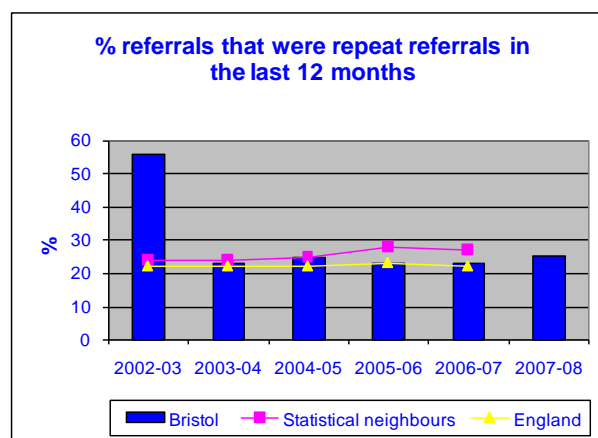
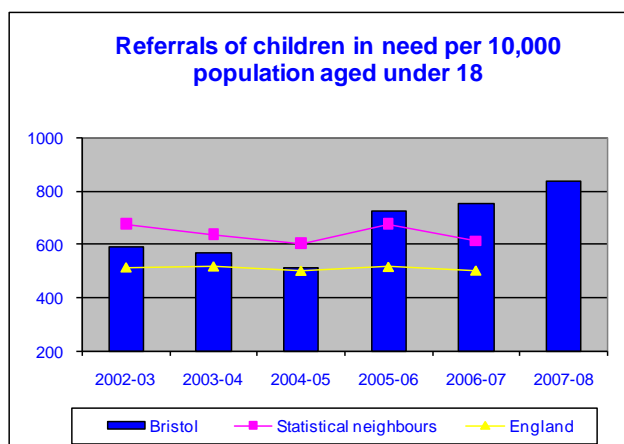


Source: Children and Young People's Services

The rate of referrals in Bristol is higher than the city's statistical neighbours and the England average (see graph below).

Repeat referrals could suggest that initial needs were not properly assessed or appropriate services were not in place. A quarter of Bristol's referrals are repeat referrals – similar to the England average.

A stable foster placement is preferable to frequent changes of foster carers. Most children in care in Bristol have been with their foster placements for at least two years (72%), a proportion which is better than the national figure (at 65%).



Source: Children and Young People's Services (both graphs)

Disabled children in care

Parents' and carers' needs are routinely assessed by the Disabled Children's Social Work Team, alongside assessment of the needs of disabled children.

Clear protocols exist for transfer to adult services. Transitional reviews are a particular focus for officers reviewing children in care. The Care and After Team is developing understanding of the particular needs of disabled care leavers.

Short breaks for disabled children

The provision for Bristol children is as follows.

- The Bush Residential Resource Centre (BRR) provides short breaks for disabled young people from the ages of 5 to 18 years with a high level of need such as those on the autistic spectrum. The centre has up to 44 residential placements for young people.
- New Belbrook service is based in Lawrence Weston and offers a similar service to the Bush RRC in the north of the city and can provide 30 children with overnight stays.
- The Family Link Service has approximately 65 carers with 100 children in placements for short breaks. The service provides for a range of disabled young people including deaf and Asian young people between the ages of 5 and 18 years.
- Bristol Autism Project (BAP) runs parent groups and activities for young people from the ages of 5 to 13 years, parents and siblings, during the school holidays. There are up to 80 children receiving a service via BAP.
- There are several other provisions commissioned from the voluntary sector. These offer a range of specialist short-break provisions ranging from after-school, youth, play and community-based activities to support disabled young people and their families.

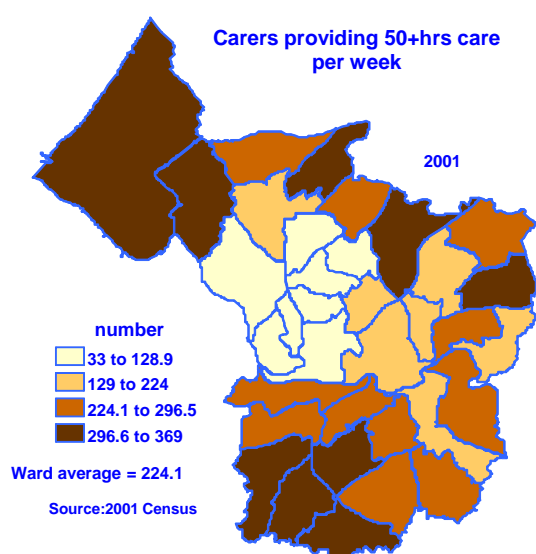
Carers

A carer is someone, who, without payment, provides help and support for a child, relative, friend or neighbour, who could not manage without their support. This could be due to age, physical or mental illness, addiction or disability. The carer may be an adult, a child or a young person. Unpaid carers are the main providers of care in the community, on whom the health and social care system relies. In Bristol alone, in 2007, carers provided care valued at £530.8 million.⁸⁹

In the *Census 2001*,⁹⁰ 35,344 people in Bristol aged 16 years or more said they provided unpaid care. In 2001, the total population of the city was estimated at 380,615 and carers represented 9.3% of the population. Based on our current population of 416,400 this equates to approximately 38,700 people providing between one and 50 or more hours unpaid care per week.

Many people, including those with intensive caring roles, do not think of themselves as 'carers', so these figures are likely to be an underestimate. Caring is often a transitional status, with many people entering and exiting caring roles each year. This means the total number of people who experience caring during stages of their lives is larger than the 'snapshot' figures recorded in the census.⁹¹

The 2001 census indicated the greatest number of carers were of working age – in Bristol 20% of people between 45 and 64 described themselves as carers. However, people aged 85-89 spend the longest time caring – over half of carers in this age group provide 50 plus hours of care per week. The map below shows the location of carers (all ages) in 2001 providing 50 plus hours of care a week. Of a total of 7,842 carers, the highest number was located in Filwood, Bishopsworth and Hartcliffe.



In the census, 11.3% of women and 8.6% of men said they were carers. However, this pattern reversed in later life (70 years and over), where there was a higher proportion and greater time commitment to care-giving amongst men. In Bristol in 2001, there were more female carers aged 65-74 years, but more male carers aged 75 plus.

Caring is most prevalent amongst groups of the population who may experience most strain from doing so; people over 85 and people over 45 in multiple roles.

⁸⁹ University of Leeds and Carers UK (2007) 'Valuing Carers – calculating the value of unpaid care'

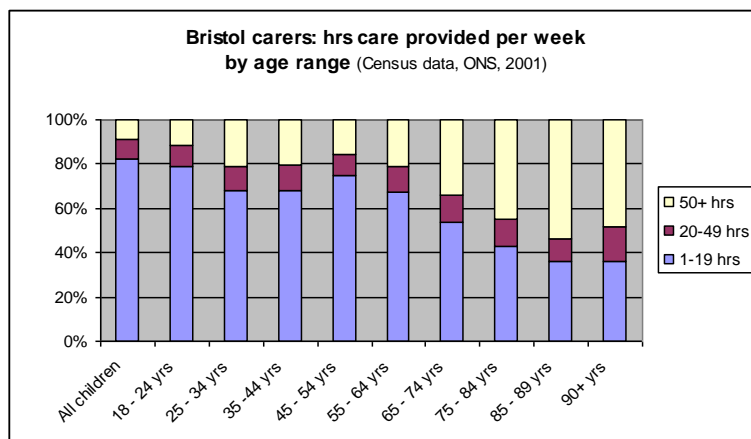
⁹⁰ 2001 Census Summary Statistics for Bristol <http://www.bristol.gov.uk/statistics>

⁹¹ Department of Work and Pensions (2008) Select Committee report 'Valuing and Supporting Carers'

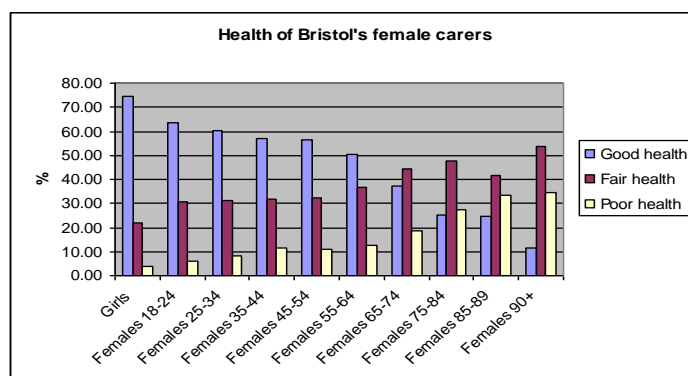
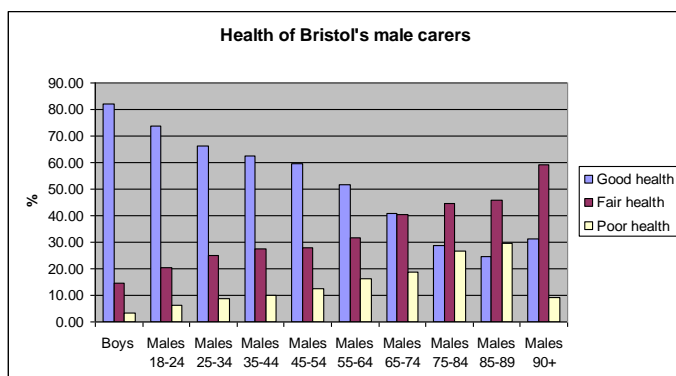
All parts of the UK will see significant increases in the demand for care in the first half of the 21st century, due increasing numbers of people living with limiting long term illness, disability and dementia. The trend for assisting more sick and disabled people to live at home will also increase the demand for care by family carers.⁹¹

Older people who are carers

An increasing proportion of residents over 65 years provide a high level of care (see graph).



Source: Census 2001(all graphs)



In 2001, 22% of Bristol carers were aged 65 and over and 34% of these carers provided 50 hours or more care a week. A greater proportion of carers reported poor health with increasing age of carer, particularly female carers.

POPPI estimates the current number of carers aged 65 and over in the city at 6,535 people, rising to 6,860 by 2015. POPPI also estimates Bristol has currently 366 carers aged 85 years and over (333 carers in 2001) and that nearly a quarter of carers aged 65 and over are in poor health in 2008 (over 1,400 carers).

Fifty hours or more care per week

POPPI estimates that Bristol has over 2,500 carers aged 65 and over providing 50 hours or more care per week, rising to over 2,600 by 2015.

Based on Adult Community Care performance figures 2007-2008 (for carers aged 65 and over), Bristol has:

- 135 carers assessed or reviewed separately
- 1,525 carers assessed or reviewed jointly with client
- 44 carers declining an assessment

- 794 carers receiving services, as an outcome of assessment or review
- 373 carers receiving information or advice, as an outcome of assessment or review.

A total of 1,734 carers aged 65 and over have, therefore, received assessments or reviews. This is equivalent to 75% of those who provide 50 hours or more care per week.

The carer self assessment has provided an alternative pathway for carers who might not otherwise have approached ACC.

Working carers

Working age carers comprise the largest group in Bristol. In this group, carers are most likely to be women and a significant proportion do not have good health themselves:

- 27,352, or 78% of all Bristol carers are aged 18-64 years
- 60% of carers of working age are women
- 42% do not have good health
- 18.6% of this group provides 50 plus hours' of care per week.

In general, men and women with the heaviest caring responsibilities are two to three times more likely, than workers without caring responsibilities, to report poor health in the last year.

Carers often have to give up work and suffer 'opportunity penalties'. One of the reasons carers struggle to return to work is because of the lack of affordable, reliable and flexible care services.⁹¹ The national carers' strategy (2008)⁹² highlights the need to support carers to remain in or return to work using measures such as an awareness-raising campaign for employers and carers about flexible working, and ensuring skills training is provided in a flexible manner.

Assessing the quality of life of carers

Researchers at Birmingham and Bristol universities have been assessing a measure that reflects quality of life for unpaid carers. They have identified through qualitative research six attributes of caring: getting on, organisational assistance, social support, activities, control and fulfilment. The final measure, that can be used in carer assessments focuses on the process of providing care, rather than the health outcomes from caring.⁹³ This measure could potentially be used in Bristol.

Young carers (under 18 years)

It is estimated that one in every 100 school children is a young carer providing 14 hours of care per week for a relative who has a disability, physical or mental illness or substance misuse problem (Include Project, Children's Society 2008).

Young people should not be expected to carry inappropriate levels of caring and the person being cared for is likely to have unmet care needs. Tasks a young carer may be undertaking at home include:

- washing, cooking and cleaning on behalf of the whole family
- personal care and giving medication
- emotional support
- intimate care
- childcare for younger siblings
- other e.g. accompanying a parent to hospital as a translator.

⁹² DH (2008) 'Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own'

⁹³ H Al-Janabi et al, Social Science and Medicine 67(2008) 'What do people value when they provide unpaid care for an older person?'

Inappropriate levels of care can have an adverse impact on the development, health and life chances of a young person. Young carers may be late or absent from school, because of their responsibilities. They may appear to be tired or disengaged, isolated from peers and under-achieving. Many report bullying. In addition, they have the added burden of worry and concern for the person they care for. They may feel they cannot afford to be ill themselves due to their caring responsibilities.

In the census 2001, Bristol identified 827 young people (under 18 years) providing between 1-50 hrs of care for another person. Bristol has 55,300 children and young people aged 5 -17 years (population 2006 ONS MYE) and it is likely there are 500 -1,000 young carers in the city. There is no complete register of young carers and many are 'hidden'. Some may not recognise themselves as a young carer. Others may keep their caring role a secret, for fear of inappropriate intervention or because of the stigma surrounding some health conditions, addictions and disabilities.⁹⁴

In the *Young People's Quality of Life Survey 2007* (see Local Voice –page 162) a high proportion of young carers were from BME groups and lived in deprived parts of the city. Many children have inappropriate translation roles for family members who are ill or disabled and are unable to speak English.

Refugee children are particularly vulnerable and having suffered significant upheaval and trauma, are also faced with having to care for a family member in a strange culture and unfamiliar surroundings. This responsibility, which often includes translation, can restrict and impede their development and integration into the community and can harm their mental and physical health and wellbeing.

Areas of good practice

Gloucestershire - young carers' booklet 'Minds, myths and me'

This booklet, designed and written by young people, is available for young carers in Gloucestershire who live with someone with a mental illness. See www.glosyoungcarers.org.uk

Fareham and Gosport young carers have compiled suggestions for GPs on how youngsters can be supported in their role. These include:

- making appointments more flexible
- having information about young carers and about potential sources of support visible and accessible for staff and for patients and carers
- raising awareness of young carers and ensure that health professionals liaise with each other
- ensuring GPs are available for young carers to talk to about their situation without them having to wait until they have a health problem
- considering adding a caring role to detail on medical records.

Care shortfall

Carers

Nationally carers say that many are at breaking point because of inadequate services (Carers' Voices, Carers UK, 2008).

In Bristol it is estimated (previous section) that we have approximately 38,700 carers (all ages, providing between one and 50 plus hours of care).

Young carers are not the most appropriate providers of health and social care, and there are likely to be unmet needs if a young person is the main carer.

⁹⁴ The Children's Society, Include Project (2008), Supporting pupils who are young carers,

Older people not eligible for social care

A recent national Commission for Social Care Inspection (CSCI) report on social care in England, has raised serious concerns about the number of people excluded from social care help through the application of existing eligibility criteria. People who are not eligible and choose not to take up privately purchased services have the greatest level of shortfall in their care.⁹⁵

The national report identified the poor quality of life outcomes for people ineligible for council social care. These include:

- low expectations for modest quality of life desires
- struggle to cope and find their way in a system with little or no help
- risk of being fast tracked into residential care before other options are explored
- prior to entering a residential home, few have received social care assessments
- feeling isolated and alone with little access to advice and information
- continuing to spend savings past the threshold at which they should be referred for public funding.

The CSCI report goes on to say that approximately one percent of the total population of people who have disabilities or impairments and high support needs, receive no services and have no informal care. This would equate to approximately 270 people aged 65 plus in Bristol if the current estimate of people with limiting long-term illness is used. For people requiring less intensive support the shortfall is 15% - approximately 4,000 people aged 65 plus.

As with the rest of the country, Bristol will experience care shortfalls. But to a lesser extent than the surrounding authorities, which have larger proportions of the population aged 65 plus years.

Older people with dementia

It is recognised there is unmet need for people with dementia in the city (see page 136). Bristol has an estimated 4,000+ people over 65 with dementia and an estimated 13% of these people will be living alone at home without help (at least 500 people). In addition, a lot of people with mild dementia may not be diagnosed. ACC and independent providers have only 382 beds for people in the city with dementia.

People with mental illness and learning difficulties

The rate of adults with mental health issues in contact with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) in Bristol, at 248.6 per 100,000 population, represents and under-provision of care. With an estimated 6,900 people with severe and enduring mental illness in the city, only 15% are receiving care (see page 136) and there is clearly unmet need.

The Learning Difficulties Service is only aware of 30% of PWLD. This means there are likely to be 5,500 PWLD not 'in the system' with potential unmet need (page 143).

Children and young people

Groups of people particularly disadvantaged by eligibility criteria include young people in transition between children and adult services, as eligibility thresholds are higher for adults.

⁹⁵ State of Social Care in England 2006/07 Part 2: Eligibility and self funding: the impact on people, Commission for Social care Inspection, 2007

Quality of life of adult carers

In the Quality of Life Residents' Survey 2006, of 4,412 people who responded, 196 said they were carers for someone with a long-term illness or disability. Their views were analysed for each question asked and results are found on www.bristol.gov.uk/qualityoflife. Some interesting findings are given below.

Profile:

- 71% were female and 29% were male
- 66% were over 50 years old
- 38% had a limiting long-term illness or disability
- 5% were from BME groups
- 48% had no educational or technical qualifications (23% citywide).

Satisfaction with services:

- 50% were satisfied with social services (39% citywide)
- 85% were satisfied with health services (79% citywide)
- 20% would like more advice and information on benefits (12% citywide)

Lifestyle:

- significantly more (58%) take moderate exercise (39% citywide)
- 17% were not in good health (11% citywide)
- 54% have a good quality of sleep at night (70% citywide)
- 23% had had a fall in the last 12 months (compared to 17% citywide) and 29% said their quality of life had suffered as a result of the fall (16% citywide).

Location

- The greatest proportion of carers lived in Lockleaze (11%) followed by Kingsweston, Southmead, Knowle, Bishopsworth, Hartcliffe and Whitchurch Park
- significantly more (53%) felt their personal safety was a problem in their neighbourhood (36% citywide).

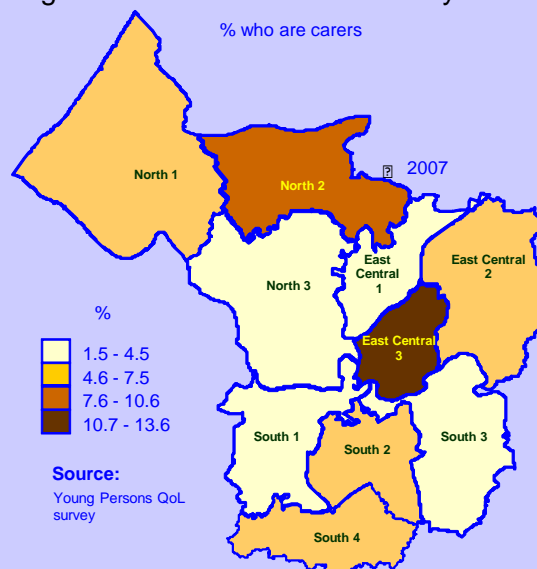
The same survey asked carers if they were well supported by social care services and other care organisations. Less than half (44%) said 'yes'.

In 2007, 340 carers participated in this survey but a full analysis is not yet available. Early findings and comparisons with 2006 indicate:

- There were more carers who have a limiting long-term illness or disability (49%)
- More carers were in poor health (25%)
- More carers said they were supported by social care services and other care organisations (51%).

Views of young carers

The *Young People's Quality of Life Survey 2007* asked over 3,600 Bristol children if they cared for a relative with an illness or disability. 161 said they did (4%). This proportion will include those who provide short periods of care, for a few hours a week. The map below shows the distribution of these young carers. Equalities analysis indicated more were found amongst BME communities in the city.



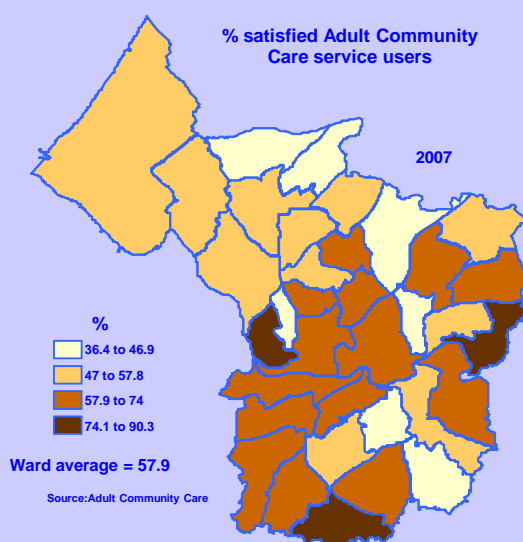
At the Young Carers (national) Festival 2006, young carers gave their tips for schools that included the following.

1. Recognise our responsibility can affect our education and school work.
2. Find out about us, what we need and how we are not like other students. Sometimes we are too embarrassed to tell you ourselves.
3. Don't automatically punish us when we are late. Sometimes we can't help being late if we are helping at home.
4. Provide more support and flexibility such as lunchtime drop-ins, homework clubs and more time to do coursework.

5. Include more information about young carers and disability issues in PHSE lessons.
6. Let us phone parents if we need to find out if they are OK.
7. Ensure teachers are offered training on young carers and disability issues.

Self-reported experience of social care users, 2007

Service user satisfaction is now a national indicator for 2008. Bristol undertook a similar survey prior to the national indicator and 58% of social care users were satisfied (see below). The highest levels of satisfaction were found in St George East, Clifton and Whitchurch Park.



Commission for Social Care Inspection (CSCI) bands have been used for a similar statutory survey in 2005-2006 and Bristol was in the middle band (average for local authorities).

Family Doctor Survey 2007

The Bristol Older People's Forum carried out this survey in April 2007 and responses were received from 693 older people. Key findings were as follows:

- The opinion of older people in Bristol about the services provided by their family doctors generally was a very favourable and positive one.
- Older people were less positive about accessibility to their doctor's premises

for people with mobility problems. Seven per cent say they were poor.

- More than one in ten older people had difficulty getting to see their doctor when they needed to and the appointments system could be restricting and unfair.
- Eight per cent said transfer to and from treatment centres was poor.

In the Bristol *Older People's Forum's Quality of Life survey 2006*, ten per cent of older people described the quality of health and social care and support they received as poor.

GP Services for older people in Care Homes, Very Sheltered Housing and Sheltered Housing Schemes - Bristol Patients Forum (BPF) 2007

Overall the residents were satisfied with their GP and pharmacy services, but some issues were raised and the BPF recommended the following.

- Practices to be encouraged to set up volunteer support groups, particularly for the provision of transport to the surgery for residents.
- Communication for those with learning disabilities was made difficult when doctors did not speak good English.
- Improve publicity of GP services so residents know when they can contact the surgery.
- Increase awareness of the Patient Advice and Liaison Service (PALS) and complaints procedure.

Neighbourhood Partnership area summary

Variation in indicators of general health and wellbeing across the city are shown below.

Significantly better than average							
Significantly worse than average							
Neighbourhood Partnership	% residents who feel their health has been good in the last 12 months 2006	Disability Living Allowance claimants (all ages, March 2008)	ACC clients with mental health needs, 2007	Children with Special Educational Needs, 2008	Social Care Need for residents over 65 years, 2007	% residents who say they are fairly or very happy, 2007	Children in Social Care, 2006
1. Avonmouth and Kingsweston	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth	Avonmouth
	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston	Kingsweston
2. Henbury and Southmead	Henbury	Henbury	Henbury	Henbury	Henbury	Henbury	Henbury
	Southmead	Southmead	Southmead	Southmead	Southmead	Southmead	Southmead
3. Stoke Bishop, Westbury-on-Trym and Henleaze	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym	Westbury-on-Trym
	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop	Stoke Bishop
	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze	Henleaze
4. Cabot, Clifton, Clifton East	Cabot	Cabot	Cabot	Cabot	Cabot	Cabot	Cabot
	Clifton	Clifton	Clifton	Clifton	Clifton	Clifton	Clifton
	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East	Clifton East
5. Cotham, Redland and Bishopston	Cotham	Cotham	Cotham	Cotham	Cotham	Cotham	Cotham
	Redland	Redland	Redland	Redland	Redland	Redland	Redland
	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston	Bishopston
6. Horfield and Lockleaze	Horfield	Horfield	Horfield	Horfield	Horfield	Horfield	Horfield
	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze	Lockleaze
7. Eastville, Frome Vale and Hillfields	Eastville	Eastville	Eastville	Eastville	Eastville	Eastville	Eastville
	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale	Frome Vale
	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields	Hillfields
8. Ashley, Lawrence Hill and Easton	Ashley	Ashley	Ashley	Ashley	Ashley	Ashley	Ashley
	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill	Lawrence Hill
	Easton	Easton	Easton	Easton	Easton	Easton	Easton
9. St George East and St George West	St George East	St George East	St George East	St George East	St George East	St George East	St George East
	St George West	St George West	St George West	St George West	St George West	St George West	St George West
10. Southville and Bedminster	Southville	Southville	Southville	Southville	Southville	Southville	Southville
	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster	Bedminster
11. Bishopsworth, Hartcliffe and Whitchurch Pk	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth	Bishopsworth
	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe	Hartcliffe
	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park	Whitchurch Park
12. Filwood, Knowle and Windmill Hill	Filwood	Filwood	Filwood	Filwood	Filwood	Filwood	Filwood
	Knowle	Knowle	Knowle	Knowle	Knowle	Knowle	Knowle
	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill	Windmill Hill
13. Brislington East and Brislington West	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East	Brislington East
	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West	Brislington West
14. Stockwood & Hengrove	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood	Stockwood
	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove	Hengrove

Key pointers for health and wellbeing

Children and young people with learning difficulties, physical impairments, emotional health problems and complex needs

Nationally and locally the number of disabled children and young people is growing. South Bristol has the wards with the highest numbers of disabled children.

The number of babies with very low birth weight (less than 1500 grammes) is increasing in the city. A high proportion of these children go on to develop disabilities and have complex needs.

There is a higher prevalence of mental health problems among children from deprived backgrounds. Two thirds of children in residential care have a mental health problem.

Joined-up work between agencies can improve transition services provided for young people as they progress into adulthood, to ensure better provision for young people with mental health problems and learning difficulties.

Relevant current initiatives

- Access to specialist services is being improved for children with disabilities and complex health needs. In 2008 there has been a ten per cent increase in therapy provision.
- Access is being improved to CAMHS:
 - o a new approach to management of referrals called the 'Choice and Partnership' approach is significantly reducing waiting lists for first appointments
 - o this year there has been investment in learning disability psychiatry
 - o there is increased access to specialist CAMHS for 16-17 year olds.
- Primary care data-sharing project will release GP patient profile data on mental health needs and physical impairments for children and young people. This will enable better sharing with the Council and PCT, better analysis of needs and help compile a register.
- Bristol has established 24 children's centres across the city, to address area-based needs for pre-school children in their reach areas.
- A citywide transition project is addressing the shortfall in the process of transitions between child and adult services.

Gaps in our knowledge

- There is no national definition for 'children with disabilities' and, as a result, record keeping by different agencies cannot be aggregated to give a complete local picture. Definitions for children and young people with disabilities can include, or exclude, people with physical impairments, learning difficulties and mental illness.
- Figures on equipment needs for disabled children are not known in some parts of the city.
- Prevalence of autistic spectrum disorder (ASD) is increasing but the reason for this is not known.

Carers

It is estimated one in every 100 school children is a young carer. There are likely to be unmet needs if the main carer is a young person. GPs and school staff are best placed to identify young carers.

- Working age carers comprise the largest group in Bristol. In this group, carers are most likely to be women and a significant proportion does not have good health themselves. Unpaid caring is most prevalent in groups who may experience most strain from doing so; people over 85 and people over 45 in multiple roles.
- In local surveys, 25% of carers said they were in poor health, 49% had a long-term illness or disability and 51% said they were well supported by social care services.

Relevant current initiatives

- The Council is improving the outcomes for young carers and their families by developing effective early intervention.
- A young carers' lead person is to be identified in each school.
- A specialist youth club for young carers was established in July 2007, to provide a social outlet.
- The Self Assessment/Self Help project has helped identify carers and their needs.
- Expert Carers Programme is a new initiative about advocacy and self care. It promotes advice from carer to carer.
- A Joint Carers Strategy 2008-2011 has been developed with an integrated action plan that has been expanded jointly with Children and Young People's Services and Bristol PCT. Its aim is to ensure that carers are recognised and valued, informed and involved and feel supported and healthy.
- The Black Carers Project is supporting carers of all ages in BME communities (especially those who are isolated and commonly referred to as 'hidden' carers). The project is increasing awareness as well as recognition of needs of Black carers by networking with statutory and voluntary agencies providing health and social care.
- The Primary Care Data Reporting Tool will provide better access to patient data held by GPs e.g. carers' registers.

Gaps in our knowledge

- There is no complete register of young carers and many are 'hidden' and it is suspected there is a high proportion of BME young carers.
- At least 25% of carers over 65 who provide 50+ hours per week are not known to ACC.

Adults and older people with physical impairments, mental health problems and learning difficulties

As life expectancy improves, there is a growing number of disabled people and people with long-term conditions. Currently in Bristol, 50% of people over 65 years have a physical impairment or limiting long-term illness. These people make most use of primary, secondary and social care services. Identification of people with dual sensory impairment and comparatively inexpensive interventions at an early stage, could provide long-term cost savings through such things as reduced acute hospital admissions.

The number of people with mental health problems in the city is growing. At present there are significant gaps in self-help services for people with mental health problems. There is also a need to compile information on starter grants and sources of funding for self-help groups.

- There is concern that BME communities are disproportionately represented among users of mental health inpatient services.
- Dual diagnosis is a term to describe those who have both a mental illness and a substance abuse diagnosis. These people should have integrated care, but there are few primary care teams in mental health and this impacts on the capacity of secondary care mental health services.
- Bristol has an estimated 5,900 people over 60 years with dementia. Dementia is increasing with our ageing population and in Bristol will increase by 33% in the next 20 years (lower than national estimates). Of concern are the estimated 13% of people with dementia who will be living alone at home.
- Only 15% of adults with severe and enduring mental health problems are in contact with AWP, representing an under-provision of care.

The number of people with learning difficulties is increasing, partly due to people living longer as a result of medical and technological advances. There is also a higher prevalence among young people of South Asian communities - up to three times as high as in the general population. A high number of people in neighbourhood renewal areas have learning difficulties.

Relevant current initiatives

Putting People First is modernising and transforming ACC services and includes the following.

- Individual budgets for care needs based on self-directed care.
- Investment in prevention and early intervention – improve the determinants of health and increase independence.
- 'Widening the front door' and improving access to information/not shutting our self-funders.
- Seamless work with Bristol PCT.
- Efficiency savings so transformation can occur within existing resources.
- *Residential Futures Project* - over the next five years, the Council will:
 - open three newly refurbished care homes for people with dementia.
 - introduce a range of short-break services, to benefit older people and their carers, in four of the council's care homes which it is envisaged will eventually become Resource Centres offering short stay services.
 - a separate staff team will provide an improved range of respite services including planned and bookable short breaks. The team will also take people who are currently not eligible for intermediate care services, but who also cannot return home or who need further assistance. These people will be offered a 6-8 week assessment while staff work with them and their carers, working in a re-enabling way to maximise their potential for independent living.
- The Very Sheltered Housing partnership programme will see the development of 600 very sheltered housing flats by 2012.
- The *Assistive Technology Project* will mainstream the use of electronic aids to independence from April 2009.
- The *Home Care Futures Project* has led to a new Short Term Assessment and Reablement Service (STAR). STAR delivers an initial assessment and a reablement service over a period of six weeks. The model of care ensures that more people can have their needs met at home, reducing admission to residential care.
- Bristol's *Older People's Quality of Life Strategy*, see page 97.
- Bristol's *Mental Health Services – Vision for the Future* includes underlying principles – choice, service user involvement, self-help, listening and consultation and equality. The vision outlines how the needs of BME groups are being addressed with improved consultation, partnership with BME carers, increasing the representation of BME staff, better provision of information for BME communities and translation services.
- Improvements will be made to the quality of data held by GPs by incentives, that will allow improved patient profiling and longer consultation periods for patients, e.g those with language difficulties, dementia etc.

Gaps in our knowledge

- It is difficult to assess actual numbers of disabled people in the city and some adults do not access health or care services, so are 'hidden/not recorded'.
- As with children and young people, there is no national definition for 'people with disabilities' and as a result, record keeping by different agencies cannot be aggregated to give a complete local picture.
- Many people who are deafblind are not officially recorded by local authorities.
- The Learning Difficulties Service is only aware of 30% of PWLD. This means there are likely to be 5,500 PWLD with potential unmet need not 'in the system'.
- Ethnicity of mental illness cases is poorly recorded and research into the needs of BME communities is lacking.
- Exact numbers of people suffering from dementia are not known as many people with mild dementia may not be diagnosed.

Shortfalls in care

Many people who require long-term care would prefer it if this could be provided in their own homes. An important gap in the local market has been identified for short-term residential care (assessment,

respite and step down facilities). Those people who are not eligible and choose not to take up privately purchased services have the greatest level of care shortfall. More men report disabilities and long-term limiting illness, but there is a lower take-up of social care services by men across most areas. This may be due to more men being supported by carers or partners, or a reluctance to seek help and it may represent unmet need.

Satisfaction with social care is lowest in some of the areas with highest need, e.g. Avonmouth, Easton, and Filwood.

Relevant current initiatives

- Putting People First will improve access to information for self-funders.
- See Residential Futures and Home Care Futures Projects – previous section, page 167.

Gaps in our knowledge

- We do not know the care needs of people who are not eligible for social care, or if they are receiving information and advice.

Hospital admissions

Two thirds of emergency bed days in hospital are due to admissions from people aged over 65.

- Falls in older people (over 75 years) resulting in hospital admissions are increasing. In Bristol, nearly a third of people aged 85+ have had a fall in the last 12 months.
- Hospital admissions for children and young people are beginning to fall.

The Dr Foster tool can identify which patients are the most frequent users of primary and secondary care services.

Relevant current initiatives

- Joint Community Health and Social Teams – this is a Kings Fund project running as a pilot at two GP surgeries. It co-locates, with integrated working, social care locality workers and community health workers. The project involves joint case working, enabling the early identification of those at health and social care risk in the community, avoiding hospital admission and reducing emergency bed days.
- The Promoting Independence Team (ACC) is also identifying people at risk of hospital admission and this team will be incorporated into the project.
- The Dr Fosters tool will help flag up patients at risk and has potential for predictive modelling. The project has potential to be rolled out to all GPs.
- Enhanced services in the community such as community matrons and health workers, are reducing the numbers of people admitted to hospital.
- Short Term Assessment and Reablement (STAR) is helping those with a recent health crisis or recent hospital stay, to cope at home.

Access to healthcare

Broad concerns residents would like addressed have related to:

- improving access to information on healthcare and benefits available (including translation/interpretation services)
- improving access to and publicity of GP services, so residents know when they can contact the surgery, particularly if they are disabled, elderly and live in deprived areas
- improving training of health professionals on disability and equalities issues
- improving access to and knowledge of specialist care - there is a general trend that people are more prepared to travel to and pay for specialist services.

Relevant current initiatives

- Patient surveys are currently underway on extended access to GP services. It is likely that opening times of GP surgeries will improve with access 8.00am–8.00pm.
- New GP practice is to be opened for the East Cabot/West Lawrence Hill area with extended

opening hours.

- New Walk-in GP Centre to cover general practice and urgent care, to be located in an extended Eastville Health Centre.
- By 2010, South Bristol Community Hospital will be built and improve hospital facilities in the south of the city and a new walk-in centre will be established as part of this new community hospital.

Summary of Chapter 7

The number of children and adults with physical impairments, learning difficulties and mental health problems is growing, mainly due to people living longer and advances in medical treatments. Disabilities are set to rise by about 57% in the next 20 years and dementia will increase by about 33%, thus challenging the care services to provide appropriate levels of support. An integrated approach to delivering joint health and social services is already bringing benefits by reducing hospital admissions and potential long-term costs.

The distribution of care needs across the city will change as demographic profiles change e.g. as children with disabilities now will grow up to be users of adult services. The pattern of dementia sufferers will change as the population ages, yet we do not know the location of all residents aged 85 years or more. Services are currently responding to the needs of older clients in wards with a higher proportion of elderly residents rather than wards with a young and growing (but needy) population. Thus the geographical focus of services and service pressures will change as ward demographics change.

Hospital admissions are high (e.g. through falls, accidents, urgent management of conditions and disabilities) in the older and younger age groups. Medical advances in treatment and use of assisted technology allow more healthcare services and support to be available at home. This will change the nature of how we are delivering healthcare and with improved primary prevention, home-care services, improved access to information on health management and lifestyle issues, there is potential for hospital admissions to drop.

Bristol has almost 40,000 people across the city providing unpaid care and many of them are ageing themselves, may not be in good health and many have multiple roles. Yet it is estimated we do not know a quarter of our carers. Further work is needed to improve the record of our carers, their location and needs, including a complete register of young carers.

Most older people (aged 65 and over) prefer to receive the health and social care they require at home. There is potential to shift more care out of hospital and into the community. Improved outcomes would result from supplying more hours of home care to a larger number of people. However, we should be aware that some elderly people living alone would prefer to receive their care in a more 'sheltered' home environment (e.g. sheltered housing) thus reducing their social isolation.

Some of these issues will be addressed with the LAA targets to ensure people of all ages and vulnerable people can live independent lives, increase social care clients receiving Self Directed Support, reduce the number of emergency bed days, increase carers' needs assessments, advice and information. In addition, BCC Corporate Plan priorities include improving efficiency through commissioning, actively promoting service user and carer independence, safety and wellbeing, developing a network of reablement services, extending very sheltered housing, developing self directed care, increasing early intervention and prevention services, widening opportunities for older people and developing Linkage hubs.

Given the growing levels of dementia within our ageing population, further work is needed to reassess the geographical focus and identify this vulnerable group. There is also potential to do more work on the health and wellbeing issues facing young carers.

8. Health and wellbeing of special groups

Whilst this report is concerned with the health and wellbeing of the population as a whole, it is clear there is a wide variation in health needs and some groups have special needs. These are discussed briefly here.

Black and minority ethnic (BME) communities

Many of the major chronic diseases are more common in some BME groups than in the overall population. These include coronary heart disease, stroke, diabetes, hypertension and tuberculosis (TB).

In Bristol, there is widespread concern that BME communities are disproportionately represented among users of mental health inpatient services.

Higher rates of HIV/AIDS/STI are observed amongst Black Africans. In 2007, half of the HIV diagnoses were in Black Africans (see page 118). Similar findings are observed in the UK in general.

Sickle cell disease is most common amongst African and African Caribbean people. Between 8-25% of people of African and African Caribbean origins are carriers of sickle cell disease. Between 3-17% of people with Mediterranean and Asian origins are carriers of the inherited blood disorder, thalassaemia. A sickle cell and thalassaemia project runs in Easton in Bristol, where a large proportion of the population is from BME communities.

Rates of TB are higher in Asian than Caucasian people. Rates in African Caribbean people have also been shown to be statistically significantly higher than in Caucasians, but significantly lower than in Asians⁹⁶. In 2007, the majority of TB notifications in Bristol were from people born outside the UK. Of the 84 recent cases, 18% were from Black Africans and 18% from people of South Asian origin (see page 116).

A higher proportion of people from BME groups have early onset dementia (6%), compared to only 2.2% of BME people with dementia for the UK population as a whole.

African-Caribbean elders have the highest incidence of high blood pressure compared to other BME groups. African-Caribbean and South Asian elders also have a high incidence of diabetes.

South Asian (Indian, Pakistani and Bangladeshi)

Bristol has a significant population of people of South Asian origin.

Many South Asian women book late for antenatal care, which is a risk factor for low birth weight.⁹⁷

Higher rates of CHD are found amongst South Asians e.g. rates of mortality from ischaemic heart disease in both men and women are 1.5 times that of the general population.⁹⁸ The uptake of

⁹⁶ Bakhshi et al (1997) *Ethnic Health*. 1997 Aug ;2 (3):147-53

⁹⁷ National Perinatal Epidemiology Unit, Oxford University (2003), Rowe R, Garcia J. Access to care for low income childbearing women.

cardiac rehabilitation services is particularly low amongst this group. The 'Living with Heart Disease' action research project in Bristol examined the equity of access to primary care services between South Asian and White CHD patients.

South Asian men and women were found to have the highest rates of diabetes in the Health Survey for England.⁹⁹ Prevalence of type 2 diabetes in the Bangladeshi and Pakistani communities was found to be over five times higher than the general population.

There is also a higher prevalence of people with learning disabilities among young people of South Asian communities and this may be up to three times as high as the general population.^{100,101}

Regional studies,¹⁰² have reported high rates of oral cancer incidence in South Asian populations (particularly the Bangladeshi population) in which the habit of areca nut or betel quid chewing is still prevalent.¹⁰³ Over 90% of oral cancer patients use tobacco for either smoking or chewing.

The *Health Survey for England 1999* observed that the lowest uptake of dental services was found among Bangladeshi children.

Black African and Somali

HIV diagnoses are higher among Black Africans and an estimated four per cent of the Black African population in the UK is living with diagnosed HIV infection. A high proportion of Black Africans with HIV become infected prior to living in the UK.

Life expectancy for Somali people is low (men 47 years, women 50 years) due to the political situation, war and adversity in Somalia, and 'elderly' is more of a relative term. There is also a different understanding of the word 'disability' and it has no direct translation. Language is often a barrier to accessing services and little service provision exists for the elderly and disabled. Poor housing and living conditions are additional problems together with social exclusion. This community needs extra outreach support to help overcome the language barrier and receive advice and information on accessing services.

Somali women are noted as a group with high levels of need due to the rising birth rate in this group and tendency to have low birth weight babies. Somali women are also at risk of vitamin D deficiency due to their traditional dress and lack of exposure to the sun.

Black Caribbean

Nationally very low birth weight and high levels of need for antenatal care are commonest for infants born to mothers of Black Caribbean and Black African origin.¹⁰⁴

People of Caribbean origins were found to have the highest rates of diabetes in the Health Survey for England. In addition, groups with Caribbean origins have been shown to have rates of hypertension that are 50% higher than the general population. Men and women born in the Caribbean have also been shown to have a greater risk of dying from a stroke (76% and 110% higher respectively) than that for those born in Britain.¹⁰⁵

⁹⁸ Wild & McKeigue 'Cross sectional analysis of mortality by country of birth in England and Wales 1970-1992. *BMJ* 1997;314:705

⁹⁹ Forouhi et al (2005) Diabetes prevalence in England, 2001 – estimates from an epidemiological model. *Diabetic medicine* Vol 23(2).

¹⁰⁰ www.lancaster.ac.uk/fass/ihr/research/leaning/download/futureneed.pdf

¹⁰¹ Briefing on learning disabilities January 2008, NHS Confederation

¹⁰² ONS, Social focus in brief: Ethnicity (2002)

¹⁰³ CRC Cancer Stats: Oral Cancer. Cancer Research Campaign, July 2000

¹⁰⁴ Health Statistics Quarterly 23, 2004

¹⁰⁵ Stewart et al (1999) Ethnic differences in incidence of stroke. *BMJ* 1999; 318:967-971

Respiratory symptoms have been shown to be commoner amongst Black Caribbean boys and girls than in other BME groups in the UK.¹⁰⁶

Eastern European

In the last three years there has been international migration from the Accession States and many Polish young people have migrated to Bristol in search of improved job prospects. It is estimated by Polish community representatives¹⁰⁷ that there are between 10,000 and 20,000 Polish new arrivals.

Many young Polish new arrivals are living in poor quality and overcrowded conditions, as access to housing benefit does not apply in the first year of residence, and they can suffer abuse from landlords.¹⁰⁷ It is estimated that between 15 and 20 Polish people are currently homeless.

Recent Polish migrants tend to be generally healthy and the birth rate for Polish young women has increased in the last two years in Bristol. Most are accessing antenatal services, although there is a shortage of Polish speaking health professionals and translation services.

There is evidence from Polish community representatives that a high proportion of female Poles suffer domestic abuse and there is a reluctance to come forward and report this crime. In Poland there is a greater tolerance of domestic violence and victim support training is being considered by the Polish community locally. Domestic abuse is often linked with alcohol misuse.

Mental health is a concern for any migrant population and in 2007 there were ten deaths of young Poles in Bristol (including four suicides).

Many Polish elders moved to Bristol at the time of the Second World War, and are now in their 80s and 90s. It is estimated that approximately 300 elders reside in Bristol. Many are widows with a poor grasp of English, and regress to the Polish language. Many have lost their independence and require welfare state services and care/nursing places. Polish elders can have a strong reluctance to ask officials for help.¹⁰⁸ The Council's Neighbourhood and Housing Services (N&HS) are looking into improved methods of disseminating information on housing options, disabled facility grants and translation services.

Chinese and Vietnamese

The populations of these groups are rising in Bristol and from 2001-2005 the Chinese population increased by 2,500. National research¹⁰⁹ indicates that Chinese and Vietnamese people tend to have better health than other BME groups although a higher proportion have osteoporosis and memory problems.

These groups use GP services less, partly due to their better health and a reliance on traditional Chinese medicines, but also due to a lack of access and information about healthcare services. Social care services are also used less often than by other BME groups.

Recent migrants, asylum seekers and refugees

Asylum seekers and refugees are a particularly vulnerable population with significant, unique health needs. The greatest threat to their health is from diseases - communicable, degenerative and psychological - associated with poverty and overcrowding, and from the trauma they may have suffered.¹¹⁰ These may be traumas or conditions they have experienced in their country of origin, such as violence, poverty, civil unrest/political instability and poor access to healthcare services. On

¹⁰⁶ Pancino et al (2007) Ethnic variation in childhood asthma and wheezing illnesses. International Journal of Epidemiology (May 24, 2007)

¹⁰⁷ Julia Verne and Polish Catholic Church community, Stokes Croft

¹⁰⁸ Meeting between George Peszynski and S.Smart N&HS.

¹⁰⁹ Health and Social Care Research Findings (2005) Black and Minority Ethnic Elders in the UK

¹¹⁰ BMA London (2002) Asylum seekers: Meeting their healthcare needs.

arrival in the UK, further problems are encountered from homelessness, overcrowding, high mobility and isolation. Generally, the physical health problems experienced by asylum seekers are similar to those of the indigenous populations, and care must be taken not to stigmatise this group as purveyors of communicable diseases. This group is particularly vulnerable to poor mental health as a result of forced migration and relocation and, in addition, some children and adults have witnessed or experienced torture and bereavement.

The Haven is the Bristol PCT health service for newly arrived asylum seekers. All new arrivals are provided with a primary care health check, which includes childhood immunisations and screening for TB. However, individuals arriving as part of 'family reunions' are not seen by the Haven.

An issue of growing concern is the plight of asylum seekers who have been denied leave to remain in the UK, but who are unable and unwilling to return home because of security reasons. These individuals have no means to support themselves and face restrictions in entitlement to free secondary care and difficulties accessing primary care. Destitution has been identified as an issue of major concern by refugee support agencies.

The National Asylum Support Service (NASS) currently provides bed spaces for 421 asylum seekers in the Bristol area. There are a further 105 asylum seekers on the register, but currently living with friends. The number of destitute asylum seekers who have exhausted all their appeal rights, but are unable to return home, is unknown. A comprehensive evaluation and review of services for asylum seekers is currently underway.

Children in care

Children in care represent the extreme end of the spectrum of vulnerability in that their needs are such that they cannot be addressed in the home environment. Reasons why children are being looked after can include:

- parental illness, imprisonment or death
- family breakdown
- abuse or neglect by parents
- abandonment
- special needs of the child
- criminal behaviour of the child.

Children may also be placed in care if they are unaccompanied asylum seekers.

It is estimated that 40% of children in care have significant emotional ill health, much of which is shown in conduct disorder. Many of these children have experienced abuse, neglect, and removal from their family. In Bristol, the number of children in care in 2008 is 643. If 40% of these have significant emotional ill health, this would be 257 children and young people.

As a subset of this group, 66% of young people in residential care were assessed as having a mental disorder.¹¹¹ In March 2007, 70 young people were placed in residential settings and 46 of these would be likely to have a mental disorder. This is not a static population: 856 individual children were in care for some period of time during the 12 months up to March 2007. Only 72% had been in care continuously for longer than 12 months.

Children in care have regular health checks (dental checks, health assessments). Figures for 2006-2007 demonstrate that 85% of children in care have had a dental check in the previous 12 months.

All of those young people (12 years and over) who have a healthcare assessment also receive an education pack and support from trained social workers and/or foster carers on sex and relationships and substance misuse.

¹¹¹ Bristol CYPS, Catching in the Rye 2007-8, April 2008

Carers

Carers are a particularly needy group due to their caring responsibilities and the impact of these on their physical health.

Surveys in this report have indicated many carers live in the more deprived parts of the city and can suffer poor health, disability and lack of sleep. Twenty per cent said they would like more advice and information on benefits available to carers.

Young carers may be late or absent from school because of their responsibilities. They may appear to be tired or disengaged, isolated from peers and under-achieving. Many report bullying. In addition, they have the added burden of worry and concern for the person they care for.

Students

GP practices address student health needs by providing two specialist health centres in the city (Clifton and Malago).

Students often arrive in Bristol with no support networks and with financial and study pressures. Trends over the last five years have shown an increase in eating disorders, mental health issues, drugs and alcohol-related issues and sexual health concerns. Student health centres offer a Level 2 enhanced service for sexual health, that enables testing and treatment.

Students with mental health problems have been recognised as presenting unmet need. Access to appropriate secondary services e.g. to specialists, cognitive and behavioural therapists, is difficult and often mental health teams have little capacity for this extra workload. Both the University of West of England and Bristol University have established counselling services.

Lesbian, gay and bisexual (LGB) and transgender people

The sexual health of gay men has dominated research into the health needs of the lesbian gay and bisexual (LGB) community. This bias has had an impact on health service delivery to this group. While gay men are the group at greatest risk of HIV infection in the UK and are at a higher risk of other sexually transmitted infections (STIs), the LGB community has other important health needs. Lesbian and bisexual people are particularly under-represented in healthcare research, with the knock-on effect that healthcare services are less likely to be tailored to their needs.

Mental health problems are a significant cause of ill health among LGB people. Anxiety, self harm, suicide and attempted suicide have all been linked with the combined effects of the experience of discrimination, prejudice and internalised negative feelings.¹¹² A report on the mental health and social wellbeing of LGB people in England and Wales by MIND revealed higher levels of reported psychological distress amongst LGB people than heterosexual people. Higher levels of substance abuse and eating disorders have also been attributed to societal discrimination.¹¹³

An NHS survey found that while health staff are willing to address LGB needs, there is a lack of knowledge and awareness about how to do this.

Sexual health promotion in the LGB community has traditionally taken the form of targeted material to highlight the increased risk of STIs in some groups. LGB people can also be at an increased risk of alcohol misuse, liver and lung cancers, due to lifestyle. The relative success of targeted sexual

¹¹² NHS Scotland & Stonewall Scotland (2003) Towards a Healthier LGBT Scotland

¹¹³ King M, McKeown E (2003) Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales MIND www.mind.org.uk

health campaigns would recommend this targeted approach in raising awareness of general health issues in the LGB community.

People who are transgender are commonly, and incorrectly, assumed to belong to the LGB community. While some transgender individuals are LGB, the term transgender is an inclusive umbrella term used to describe the diversity of gender identity and gender expression and does not refer to sexuality. Transgender people are individuals who do not conform to the common ideas of gender roles and this includes transsexuals. The term transsexual refers to people whose gender identity does not match their sex at birth and includes pre-operative, post-operative and non-operative individuals. What transgender people and LGB people have in common is the experience of discrimination in society, in the form of transphobia and homophobia respectively, as well as problems of access because of a lack of appropriate mainstream or specialist services.

Mental health problems and addiction are more common in transgender people than the general population.¹¹⁴ This is thought to be a consequence of the combined effect of discrimination and internalised negative feelings. Self harm, depression and suicidal thoughts are significantly higher among transgender people.

Possibly the most important problems transgender people face, stem from the lack of understanding of gender identity, transsexualism and transgender health issues amongst healthcare professionals.

Gypsies, Travellers and show people

A study in Sheffield found that Gypsy Travellers have significantly poorer health status and more self reported symptoms of ill health than other resident English speaking ethnic minorities and economically disadvantaged white UK residents.¹¹⁵

In Bristol there is one transit site in Lawrence Weston and a new permanent site in south Bristol. Many roadside encampments spring up throughout the year. The Travellers' Health Project provides an outreach health visiting service covering Bristol and neighbouring authorities.

In a recent local study¹¹⁶ of a selection of Travellers and Gypsies, housing problems were identified as having the biggest impact on wellbeing, with the associated worry about future security and safety, stress and depression.

Gypsy and Traveller children experience many disruptions to their education, which impact on achievement and employment opportunities later on. The close link between education and health means that this disruption of education is undermining their health in later life.

Prisoners

The prison in Horfield can house up to 606 adult male inmates. The prison has a mixture of remand and post-sentencing prisoners, so lengths of stay are variable. Approximately 80% have problems with drug use and related mental health and general health issues. An average of 35-50 prisoners a week declare substance and/or alcohol misuse, with a problematic drug using population of around 200 prisoners.

With many prisoners on remand, the prison has a high turnover, with a large proportion held there for only a few months. This brings with it the challenge of continuity of treatment and care pathways on discharge. Treatment programmes exist for those with drug misuse problems but not for alcohol

¹¹⁴ Stonewall and NHS Scotland (2003) Towards a Healthier LGBT Scotland.

¹¹⁵ University of Sheffield (2004) The Health Status of Gypsies and Travellers in England.

¹¹⁶ Bristol Mind, (February 2008) Assertive Outreach Research Project, Bristol Mind

misuse. Many inmates will have accommodation problems on release, and some will form part of Bristol's homeless population, further exacerbating drug problems.

The nearest women's prison is Eastwood Park in South Gloucestershire housing up to 346 prisoners from all over the UK. The same problematic drug use and difficulties with accommodation on release apply to these women. Many female prisoners will have funded their drug use by commercial sex work.

Commercial sex workers

Bristol has a commercial sex industry and 2004 figures¹¹⁷ indicated there were 250 women and 12 men working on the streets. However, local workers estimate that the numbers are far higher - about 500 female sex workers working on and off the streets and about 150 male workers.¹¹⁸ There is evidence to suggest that the national pattern of male sex workers using the internet to seek clients extends to Bristol. This makes activity difficult to quantify.

The health of commercial sex workers is very poor. Problematic drug use and sexually transmitted infections contribute to poor general health and increased use of hospital admissions. Many of this client group are also homeless.¹¹⁹ Many of the women fund drug use (their own and their partner's) through sex work. This group is made more vulnerable by pregnancy and childbirth and the outcomes for children of commercial sex workers are poor.

Homeless people

Homeless people are a vulnerable group with complex health problems. Homelessness takes a number of forms, of which rough sleeping is only a small part. The term also refers to those living in temporary inadequate housing, which can have a negative impact on health, educational achievement and employment. Data is only routinely collected on homeless households who have applied to local authorities for help (see page 29). In 2006-2007 there were approximately 3,000 homeless households applying to Bristol City Council for assistance.

Problems related to drug dependency, alcohol misuse, poor oral health, mental illness and tuberculosis are some of the health problems associated with homelessness. It is estimated that 70-80% of single homeless people in the UK have a drug dependency problem. The incidence of tuberculosis is 200 times higher in homeless people than in the general population.

Access to services is a key issue, as people who are homeless are 40 times less likely to be registered with a GP than the general population. This makes continuity of treatment difficult.

Summary of Chapter 8

Bristol is a multicultural city yet not all residents have equal access to health and social care for equal need. Some BME groups experience a higher prevalence of specific illnesses but are less likely to access some services, services may not be appropriate and they may delay seeking help. As mentioned elsewhere in this report, difficulties in data recording (e.g. ethnicity, disability) mean that data analysis does not always reveal these inequalities. Improvements in data recording should facilitate health equity audits across a range of services and help to pinpoint some of these issues more accurately, thus supporting actions to improve access to services and strengthening existing interventions.

¹¹⁷ Imperial College (2004), Bristol Drug Market Mapping Project, links with sex work. Centre for Research on Drugs and Health Behaviour

¹¹⁸ Personal communication from Bristol Drugs Project and Terrence Higgins Trust.

¹¹⁹ Jeal N, Salisbury CA, Journal of Public Health 2004 June 26(2); 147-51. Health Needs Assessment of Street Prostitutes

While other groups may engage with the health and social care services, they often have unmet needs that may not be fully understood or articulated e.g. see the sections on students (mental health), lesbian, gay and transgender people (sexual health and gender identity), travellers (safety/stress), the homeless (drugs, alcohol-related problems, mental health) etc. While some in-depth studies are underway (e.g. prison health needs assessment) or recently completed, local knowledge of other groups is incomplete and thus further work is needed (e.g. health needs of new migrants from Eastern Europe).

Whilst tackling inequalities is addressed in the BCC Corporate Plan, LAA and World Class Commissioning outcomes, given the above analysis, further work is needed to improve the health and wellbeing of special and minority groups and address unmet needs.

9. Where do we need to be in 2011 and beyond?

Key findings from the JSNA

The following cross cutting themes are based on pointers emerging from this assessment and the text in *italics* indicates where there is scope for change.

Inequalities in mortality rates and healthy lifestyles

- The gap in mortality between deprived communities and the rest of the city is widening for:
 - infant mortality
 - cancer
 - coronary heart disease
 - COPD.
- Mortality for above causes is consistently higher in several wards – Lawrence Hill, Filwood, Southville, Lockleaze, Hartcliffe, Whitchurch Park, Southmead and Avonmouth.
- Cancer and CVD mortality is falling, but the prevalence of patients living with cancer or cardiovascular disease is increasing.
- There is concern that the downward trend in circulatory disease mortality may not continue, due to the rising level of obesity and diabetes in the population.
- Local survey results (Annex 13) indicate the proportion of adults who smoke is significantly higher in deprived areas compared to the rest of the city. Smoking can be mapped to areas with poor health outcomes.
- Local survey results (Annex 13) indicate there is a higher proportion of residents obese or overweight in neighbourhood renewal (NR) areas compared to the rest of the city.
- Increased participation in physical activity in these areas could reduce the risk of heart disease, stroke, developing type 2 diabetes and premature death. In addition, physical exercise helps to:
 - control weight and obesity
 - build and maintain healthy bones, muscles and joints
 - promote psychological wellbeing.
- The gap in levels of alcohol-specific admissions to hospital between the deprived communities and with the rest of the city is not closing.
- Determinants of health and healthy lifestyles score poorly in many of the wards which have high mortality rates, particularly Lawrence Hill, Filwood and Southmead.

For cardiovascular disease, there needs to be a stronger focus on primary prevention, better diagnosis and improved systematic management of weight and diabetes.

Tackling the determinants of health and enabling people in deprived wards to adopt healthy lifestyles would have a major impact on the overall improvement in health and wellbeing in the city.

Tackling obesity has striking similarities to tackling climate change. Many climate change goals would also prevent obesity - such as measures to reduce traffic congestion, increase cycling and walking, or design of sustainable communities. Improving health is an essential element in the design of sustainable communities. Bristol has the opportunity to tackle obesity and increase physical activity through the Bristol Development Framework for the next 20 years and the current Active Bristol initiative.

There is scope for GP practices and practice-based commissioning to make more use of localised evidence of health and wellbeing in their areas. This could enhance the 'fair shares' approach to practice based commissioning and provide resources and services more sensitive to the local population's need.

The Council, PCT and other agencies carry out much health promotion activity. There is scope to better coordinate this area of work across these organisations.

The Council and PCT should lead by example and promote healthy lifestyles amongst their workforce. As the largest employers in the city, of an ageing workforce, there is potential to influence thousands of people in Bristol by promoting a culture of health and wellbeing in the workplace.

Improving children's health and wellbeing

- Almost a third of children in Bristol live in deprived households.
- There are strong links between poor educational attainment and unhealthy lifestyles, common mental health problems and low self-esteem.
- Higher rates of teenage conceptions are mainly in areas of deprivation and in areas of low educational attainment.
- Child obesity is increasing. There is a strong correlation between parental and child obesity.
- The greatest restriction on children's freedom to play, walk to school, and take physical exercise is car congestion. There are more road traffic accidents involving children in deprived areas.
- A third of Bristol children are exposed to second-hand tobacco smoke at home.
- Children report bullying in school more than elsewhere in their neighbourhoods and a quarter are afraid to go to school because of bullying. One in five young people between the ages of 11-16 years reported carrying a weapon for self-protection.
- The number of domestic abuse incidents in households with children has recently increased.
- Alcohol consumption in young people remains high, with over a third of 15-17 year olds admitting to regular drinking. Not all substance misuse services are offering primary alcohol interventions and therefore there may be an underestimate of need.

Tackling child poverty and health inequalities requires improved access to health and support services in deprived areas in order to improve outcomes for these most vulnerable children and young people.

Healthy lifestyles need to be promoted at an early age through interventions targeted by age, gender and neighbourhoods.

Joined-up work between agencies can improve the transition process for young people as they progress into adulthood, to ensure better provision for young people with mental health problems and learning difficulties.

Births and neonatal care

- The birth rate is increasing and within the next ten years (2008-2018) ONS figures estimate there will be an extra 13,000 0-9 year olds in the city.
- The birth rate is higher in more deprived neighbourhoods and is high amongst BME mothers, who are known to have a higher proportion of low birth weight babies and also tend to book late for antenatal care.
- Modern developments in obstetric practice and foetal medicine are reducing stillbirths and increasing the number of babies surviving and needing neonatal care. Advances in infertility treatment are also increasing the number of multiple births of very small babies.
- Many very low birth weight babies of below 26 weeks gestation who survive, develop high levels of disability and complex needs. There is a lack of local information about the numbers of babies born with complex needs, but numbers are predicted to rise as the birth rate rises.

Better information would enable the improved provision of services and equipment. Infertility treatment policy could also be reviewed to support more single births and reduce the risk of multiple births and premature babies, which both carry a higher risk of complications.

Improving older people's health and wellbeing

- Over the next 20 years (2008-2028) the population of people aged 65 and older will increase from 55,000 to 70,800, including an extra 3,800 residents aged 85 years and over.
- As life expectancy improves, there is a growing number of people with disabilities and long-term conditions. Approximately half of people over 65 years have a disability or limiting long-term illness and are high users of primary and secondary care and social care services, as they need support to effectively manage their conditions.
- Obesity is set to increase by 13% in the population aged over 65 years by 2025 and, if nothing changes, 31% of older people will be obese (based on the current level of obesity recorded in the quality of life survey). Diabetes is set to rise in the older population due to rising levels of obesity. Improved levels of physical exercise could greatly reduce obesity.
- We do not know the location of the most vulnerable population, particularly those who live alone. In the local surveys (Annex 13) six per cent of older people and 11% of disabled people said they had no social contact with family, friends, neighbours or caring professionals. We need a means to identify vulnerable people living in isolation.
- Many older people who are deafblind are not officially recorded by local authorities.

Early identification of our most vulnerable and elderly population including those who have dual sensory impairment, could bring benefits from comparatively inexpensive interventions and long-term cost savings, reducing some acute hospital admissions.

Most older people (aged 65 and over) prefer to receive the health and social care they require at home. There is evidence that the greater emphasis on respite care, day care and social work would improve outcomes. There is potential to shift more care out of hospital and into the community. Improved outcomes would result from supplying more hours of home care to a larger number of people. However, we should be aware that some elderly people living alone would prefer to receive their care in a more 'sheltered' home environment (e.g. sheltered housing) thus reducing their social isolation.

Housing for older people

- The recent House Condition Survey 2007 reported over 5,000 vulnerable adults living in 'non-decent homes'. Falls in homes is the most common hazard. It is estimated that 4,000 private sector homes require adaptations for frail and disabled older people. Given the high level of homes that are owner-occupied by people claiming Disability Living Allowance, the demand for home adaptations is likely to remain high, with a high level of unmet need.
- The population aged 85 and over is set to rise steadily, but this elderly group are likely to have disabilities. At least one in five will have dementia and require greater assistance to live in their own homes.
- Older people are the population at greatest risk from heat stress and respiratory illness, which are likely to occur with the warming climate and this could also be addressed through the design of new homes.

Improving the independence of older people by enabling them to live in their own homes could be addressed with home adaptations and new build. The Regional Spatial Strategy is suggesting 36,500 additional homes could be built in the city in the next 20 years and planners and developers need to ensure homes are fit for purpose for single occupancy and an ageing population. 'Lifetime homes' can be suited to any potential occupier with more flexible use of rooms and appliances.

Shortfalls in care and unmet need

- Dementia is increasing with our ageing population. Of concern are the estimated 13% of people with dementia who will be living alone at home. In addition, a lot of people with mild dementia may not be diagnosed. Bristol has an estimated 5,900 people over 60 with dementia but has only 382 beds for people with dementia in residential and nursing homes (all sectors).
- The increasing demand for informal carers (due more people living with limiting long term conditions and disabilities) and reductions in lengths of stay at hospital, will result in increased need for healthcare services delivered at home and unmet need.
- Those people who are not eligible and choose not to take up privately purchased care services have the greatest level of shortfall in their care.
- There is evidence that some BME residents are not accessing social care services. When area-based social service use by BME adults is considered, there are big variations across the city. In some areas the number of ACC clients who are from BME communities is disproportionately low.
- There is low take-up of social care services by men across most areas. This may be due to more men being supported by carers, or partners, or a reluctance to seek help. The figures may represent unmet need.

- Most ACC clients receiving a disability service are in Lockleaze, Lawrence Hill and Southmead. Filwood has the second highest number of Disability Living Allowance claimants and this need is not reflected by the proportion of social care clients.
- In general, satisfaction with social care is lowest in some of the areas with highest need, such as Avonmouth, Easton, and Filwood.

GPs are now being asked to keep registers of people with dementia and there is an opportunity to build on identification of service users by developing a care pathway that starts at primary care. However, all registers of dementia must use standard definitions in order to facilitate comparisons.

Carers

- Informal caring is most prevalent amongst groups who may experience most strain from doing so; elderly people and middle-aged women in multiple roles. In 2001, 22% of Bristol carers were over 65 years and a greater proportion reported fair or poor health with increasing age of carer, particularly female carers.
- In local surveys (Annex 13), 25% of carers said they were in poor health, 49% had a long-term illness or disability and 51% said they were well supported by social care services.
- There is no complete register of young carers and many are 'hidden' and it is suspected there are a high proportion of BME young carers. It is estimated one in every 100 school children is a young carer. Inappropriate levels of caring by a young person often means the person being cared for has unmet care needs.

Unpaid carers are the main providers of the care in the community on which the social care system relies. The city needs to invest in the health of its carers, starting with an improved record of their location and needs.

Health and wellbeing of BME groups

- Higher rates of CHD are found amongst South Asians (1.5 times that of the general population) and diabetes can be up to six times higher. Bristol has a significant population of people of South Asian origins.
- In Bristol, there is widespread concern that BME communities are disproportionately represented among users of mental health inpatient services.
- Some infectious diseases are more prevalent amongst BME groups. TB has a higher prevalence amongst Asians and incidence is increasing. HIV and hepatitis C diagnoses and treatment are increasing in Bristol. Almost half the HIV diagnoses in 2006 were in Black Africans and Bristol has a growing population.

Early diagnosis of TB, treatment and de-stigmatising of both TB and HIV is essential.

Improved patient profiling (of ethnicity, religion and language) in GP practices will provide us with a better understanding of the needs of the BME patient population and help us to provide more appropriate services.

Social care providers should also have an understanding of the different health needs of BME groups (mentioned above). It should be recognised that there are barriers to accessing services such as language and cultural differences, and additional measures may have to be used to encourage take-up.

Reducing hospital admissions

- A high proportion of hospital admissions are from residents aged 85 plus (a quarter of emergency bed days). Many of the admissions relate to falls. There are a high number of admissions from Bristol's most elderly populations living in Westbury-on-Trym and Frome Vale, but the proportion of elderly people admitted is highest in Southmead, Hengrove and Hartcliffe.
- There is a predominance of drug misuse and alcohol-related admissions through A&E departments. Alcohol related admissions are increasing.
- It is estimated that annual ozone concentrations between 2003 and 2020 will result in a 15% increase in attributable deaths and hospital admissions for respiratory illnesses. Admissions will also be triggered by high pollen levels during thunderstorms.

Most falls occur in homes and improving design and adaptations in homes could avoid this problem. Better knowledge of the location, tenure, care needs and assessment of the home environment of Bristol's most elderly population is an important step towards reducing admissions.

The high number of drug and alcohol misuse admissions suggests poor contact with health services and a reluctance to seek treatment until the point of crisis. A method of promoting early intervention could be beneficial.

The Met Office Forecast Alert Services, used elsewhere in the South West, are able to cut COPD admission rates by 50% and this service could be used in Bristol.

Commissioning for self care

This new approach to commissioning has three stages.

1. *Individuals take responsibility – e.g. self treatment and choose healthy lifestyles.*
2. *People with chronic illnesses have improved access to information on their health management and lifestyle issues that will improve their health, and are supported to take more responsibility.*
3. *Regular health interventions with GP and patient working together on personalized care. This can involve a shift of resources and the patient often taking more control in their health care, for example:*
 - *co-payment for some treatments*
 - *use of tele-health (internet or phone) for greater access to health testing and advice from external agencies to provide health alerts e.g. Met Office, local air quality teams.*

Opportunities exist for the Council and the PCT to ensure they commission appropriate support services for self care, especially stages 1 and 2 (above) which need to be integrated into a seamless care pathway.

Mental health, happiness and positive/creative behaviour

- The number of people with mental health problems in the city is growing. The distribution of mental health needs across the city is unclear and ACC clients indicate there is a higher prevalence in Lawrence Hill, Ashley and Southville.
- At present there are significant gaps in self-help services for people with mental health problems. There is also a need to compile information on starter grants and sources of funding for self-help groups.

- More is known about children and young people with mental health problems and it is estimated that ten per cent of all children have needs. Two thirds of children living in residential care have a mental health disorder.
- More joined-up work between agencies could improve transition services provided for young people as they progress into adulthood, to ensure better provision.
- Happiness in the city is lowest for people with disabilities. It is also related to where you live. Lawrence Hill has more unhappy adults, young people and children, than elsewhere in Bristol.
- Less than 28% of residents participate in creative activities in the south of the city and only 21% of disabled people participate. Many wards where residents are less happy are also wards with a low participation in positive and creative activities.

Increasing positive and creative activities available to disabled people and people living in neighbourhood renewal areas could improve mental health and wellbeing in the city.

People with learning difficulties

- Learning difficulty is associated with greater health needs, which are poorly understood for this group.
- The Learning Difficulties Service is only aware of 30% of PWLD. Current evidence shows there are more ACC clients with learning difficulties located in the north of the city, whilst high numbers of children with learning difficulties have been identified in the south of the city by CYPS and Connexions.

There is a clear benefit to Bristol in having a citywide register, with enhanced sharing of statistics for children and young people with learning difficulties between adult health and social care services.

Where are the knowledge gaps?

The gaps and limitations identified in this assessment will help set a future work programme for the JSNA. Some issues raised here cannot be addressed in the short term but can be flagged as areas for future local or national development. The main gaps are as follows.

Population

Throughout this report, projections for health and social care are based on ONS 2006-based population projections. These projections are trend based. This means that assumptions about future levels of births, deaths and migration are based on observed levels over the previous five years ie the projections show what the population will be if recent trends continue.

These projections will differ from local policy-based projections. Policy-based population projections by five year age band from 2006-2026 are currently being calculated for wards in Bristol, taking into account future housing, regeneration or other policy assumptions.

Existing gaps

- Currently there is no comprehensive count of migrant numbers nationally or locally, although ONS are undertaking work to improve the estimation of migration both internally within the

- UK and internationally.
- Other than the 2001 census, it is not possible to say how many people aged 85 and over live alone.

Ethnicity

The recording of ethnicity has been increasingly common since the mid-nineties with a commitment by the Department of Health to mainstream ethnicity recording in all routine health data. However, the fact that NHS organisations have multiple data collection systems makes both collection and analysis difficult. There is now good ethnicity data in some parts of the hospital system and collection of ethnicity data is being developed across primary care. Ethnicity recording in social care is better and has enabled initial ethnicity-related inequality assessments.

Existing gaps

- There is poor recording ethnicity for children and adult mental health cases generally in the South West. There is local concern that BME people are disproportionately represented amongst service users.
- Currently suicide data does not include ethnicity.
- Improvements have been made with GP patient profiling, particularly for new patients. But there are still some gaps in information on ethnicity and language for existing patients.
- Population estimates by ethnic group are very limited. The latest estimates by ONS are currently at 2006 and only available at local authority level. The only comprehensive data for smaller geographies is derived from the 2001 census. These data obviously do not reflect the changes that have occurred in the population of Bristol in the last two years.
- It is not known if some ethnicity-related health issues may be actually deprivation-related. Further geographical analysis can help disentangle these effects.

The current inadequacies are not sufficient reason to overlook measurement of the health gap between minority ethnic groups and the general population. We can have confidence in a consensus from qualitative research, other national data and anecdotal evidence that an ethnic dimension to health inequality exists. The strategic and increased use of health equity audits and health impact assessments can provide evidence of unmet need amongst minority groups.

Adult mental health, learning difficulties and dementia

The number of people with mental health problems in the city is growing, and is one of the highest spend areas of the Primary Care Trust. The number of people with learning difficulties is also increasing. The prevalence of dementia is due to increase almost three fold in the next 45 years nationally, yet these issues continue to be under-appreciated, misunderstood and poorly defined. Public funding for research lags behind that of other serious medical conditions. The prevalence of dementia has a disproportional impact on the capacity for independent living and dementia contributes to 11.2% of all years lived with disability for people aged over 60 years, compared to stroke (9.5%), musculoskeletal disorders (8.9%), cardiovascular disease (5.0%) and all forms of cancer (2.4%).¹²⁰

Existing gaps

- The actual numbers and location of people with mental health problems and learning difficulties is not known, as many are not receiving services and thresholds for some services are high. There is also a stigma attached to having a mental illness or learning difficulty and a reluctance to be labelled.

¹²⁰ World Health Report Global Burden of Disease (2003)

- There is an incomplete picture of where older people with dementia live in the city due to under-recording and people not requesting health care services. Since 2006-2007, GPs have had incentives to record the number of people with dementia, which should improve the citywide picture.
- There is also a lack of knowledge about the number and age of carers for people with dementia in the community.

Children with physical impairments, learning difficulties and emotional health needs

Existing gaps

- No complete record of children with these health needs is kept in Bristol and available information is fragmented, kept by different agencies and often duplicated. It is recognised that in the absence of a national definition of 'people with disability', that is fully acceptable to all stakeholders, there are limitations to compiling a complete register.
- Figures for prevalence of emotional health and wellbeing of children and young people by ethnicity and spatial distribution are not known, and it is also not known if BME children are accessing CAMHS services.
- GPs have information on children with physical impairments and mental health needs, but they own this data and may decide not to share with the PCT or Council. Also they need analytical support to enable the provision of reliable data and a register.
- There is a lack of Bristol-wide information about the numbers of disabled children who have equipment needs. Between 310 and 330 children with equipment needs are known to paediatric services in north Bristol. Figures are also known from UHB referrals for children with neuro-developmental disorders. South Bristol has some wards with the highest numbers of disabled children (based on Disability Living Allowance claimants) but figures on equipment needs are not known.

Evidence for GP practice-based commissioning (PBC)

PBC is related to historical spend on secondary care for a GP practice. There is concern amongst health professionals that resources available to practices do not reflect the actual level of health need of the practice population or 'fair share'. For example, in more deprived communities, a lack of information about services available and unhealthy lifestyles has meant people present late to their GP, leading to increased healthcare costs.

Alcohol consumption

Existing gaps

- No information is available on alcohol-related attendances at Accident and Emergency departments in Bristol or for ambulance calls. Nor is there ethnicity coding.
- There is no recording by GPs of alcohol-related conditions.
- Alcohol misuse by newly arrived migrants, Gypsies and Travellers is not known due to poor ethnicity recording.

Obesity

There is national recognition that more research is needed into the determinants of obesity.

Existing gaps

- We need to provide better evidence for vulnerable adults, children, low income and ethnic communities.
- The impact of the built environment on diet/activity behaviour is not well understood. We need a better understanding of the benefits of more physical exercise in reducing obesity.
- Currently the city has limited evidence on the amount of walking people undertake: there are no pedestrian counts so we cannot monitor any increase in walking.

Carers

Existing gaps

- In common with most local authorities, there is no up-to-date record of carers (location and health needs) apart from the census 2001.
- There is evidence that at least a quarter of unpaid carers are not receiving a carers assessment and not having needs met once assessed.¹²¹
- There is a lack of knowledge of the location of elderly carers aged 85 years and over.
- There is no up-to date picture of the location and health needs of young carers in the city.

People not eligible for social care

Existing gap

- Those people who are not eligible and choose not to take up privately purchased care services have the greatest level of shortfall in their care. Further research needs to be done to estimate the number of residents in Bristol with a care shortfall.

People aged 55 and over

Existing gaps

- Future health needs of older people who misuse alcohol and drugs are not known.
- Future health needs of older people who are sexually promiscuous are not known as 'safe sex' messages have not been targeted at older people.

Tenure

Existing gaps

- The tenure of people claiming Disability Living Allowance is not recorded. If this information was available, it would enable forward planning of any home adaptations required to the Council, or private sector housing stock.
- Tenure is not recorded for hospital admissions attributed to falls. Knowledge of tenure would alert the private sector Home Adaptations Team to any home adaptations required, that could reduce hospital stay duration for patients.

Improved understanding of existing intelligence

Public perception

The 'local voice' has been captured in this report through a number of surveys, forums and active dialogues with local people. This is a rich source of statistical and anecdotal information and

¹²¹ National Audit Office (2007) Improving Services and Support for People with Dementia

engagement with communities should be an ongoing process and empower local people to voice their needs and wants for services. The LINK (Local Involvement Network), established in Bristol in May 2008, will provide a mechanism for this and a stronger local voice to feed into the JSNA.

The limitations of surveys of public opinion need to be understood. Survey results should be analysed in a way that takes into account the profile of respondents. Weighted sampling methods which take into account these differences in populations may help in reducing errors. However surveys often fail to accurately represent the whole population because those who respond to surveys differ from people who choose not to respond. The quality of life surveys boost sampling in neighbourhoods known to respond less well, to try to ensure the responses reflect a more accurate profile of the city's residents. There are few surveys with samples large enough to show significant changes/trends and an understanding of confidence limits (ie. how confident we can be that the results have not occurred by chance) is required for the interpretation of results.

Improved sharing of intelligence

This JSNA has identified scope for improved sharing of intelligence between Children and Young People's Services, Adult Community Care, N&HS (Supporting People), PCT and GPs, particularly information on vulnerable people with learning difficulties, disabled people, those with mental health issues and children with complex needs. Analysts from different health and social care organisations need a means to regularly work together, to share data, compile registers of health need and to avoid duplication. A web-based portal or data hub would be useful for sharing such information on health needs in Bristol.

GPs are collecting more detailed records on their patients, including ethnicity and mental illness. But GP records are not accessible to local authority professionals. Improved sharing of records could improve the coordination of care. Also, the Dr Foster tool, based on GP practice activity data is available to the PCT and can help flag individuals who make most demand on services. This tool could be used by social care services to identify individuals with care needs and reduce hospital admissions.

Although we have a lot of facts and figures available, this information is of variable quality. Key issues with the quality of the information include:

- problems with the accuracy of data recording
- problems with the timeliness of the data (it may become out of date quite quickly)
- problems with the completeness of the information
- problems with the relevance for some data to illustrate a problem.

Furthermore, the figures may illustrate the extent of a problem but we also need qualitative research to help understand why a problem is occurring and how interventions may be able to help.

Next steps for the JSNA

The JSNA is not a 'one off' and is a process that needs to be updated and maintained. Below is an outline of how the PCT and BCC can ensure the JSNA continues and is kept up-to-date, well evidenced, focused and accessible to various audiences.

Communicate JSNA findings to various audiences, in different formats

Make use of:

- summary reports, briefings and newsletters
- guidance on 'how to use' the JSNA with case studies
- web-based information: reports, databases/spreadsheets
- profiles for equalities groups and neighbourhoods
- presentations, posters and leaflets.

Work programme to address the gaps and overlap

A work programme will be developed to address the evidence gaps. This will involve exploring new information sources, further research, working with data providers, commissioning managers and their teams to consider areas of poor intelligence and how this can be addressed. The JSNA also overlaps with other reports (Catching in the Rye, Indicators of Quality of Life report, Public Health reports) and there is scope to combine and reduce reporting and improve efficiency.

Provide a website for the JSNA and data sharing HUB

Initially the Bristol Partnership website will be used, where the JSNA can be accessed, and related data and supporting documents posted. Research will be initiated into the opportunities for a data sharing HUB or multi-agency database available online for improved sharing and interrogation of health and wellbeing and social care statistics.

Maintain information exchange through sub-groups

Analysts sub-group – analysts from different health and social care organisations need to continue to meet and regularly work together, to enable improved data sharing, compilation of registers of health need and to avoid duplication.

LINKs (Local Information Network) sub group – a JSNA representative should continue as a LINKs Core Group member to ensure community input and engagement. Explore, through LINKs, public healthcare issues and new areas for consultation.

Horizon scanning sub-group – there is some awareness of future needs for the city, but generally limited work has been done by organisations delivering health and wellbeing services. There is also a lack of guidance and tools available in this field. In some areas - future health and social care need, future transport and housing - work is underway (Residential Futures Project, environmental modelling) and expertise could be shared across all areas to strengthen the value of the JSNA. An initial assessment of projected health and wellbeing need and contextual issues is summarised in the horizon scanning table in the next section (overleaf).

Refresh and further development of the JSNA

- The JSNA will need to be **updated** by August 2009 to fit with BCC and PCT planning cycles.
- Develop the JSNA with more research into the **local market and workforce** and consider whether the workforce is 'fit for purpose' for any re-design of services.
- **Resource utilisation** - the JSNA will need to consider the use of health and social care resources in terms of service costs and staff resources, and potential for resource 'shift' and inform difficult discussions concerning 'decommissioning' of some interventions/services.
- **Further analysis** of the JSNA database - there is scope to analyse the relationships between health and wellbeing indicators. Providing profiles for different localities will help explore these relationships and improve buy-in from locality commissioners and managers.
- Further research into the health and wellbeing benefits of a more **holistic (cross-agency) approach to providing services for vulnerable families**.

Horizon scanning

	2011	2018	2028
POPULATION	50,200 children 0-9 years ↑ 44,600 children 10-19 years ↓ 61,900 people 50-64 years ↑ 46,900 people 65-84 years ⇄ 8,700 people 85+ years ↑ 6,519 carers (POPPI estimate)	59,300 children 0-9 years ↑ 44,500 children 10-19 years ↓ 66,700 people 50-64 years ↑ 51,300 people 65-84 years ↑ 9,500 people 85+ years ↑ 6,860 carers (POPPI estimate)	63,100 children 0-9 years ↑ 55,200 children 10-19 years ↑ 71,900 people 50-64 years ↑ 58,700 people 65-84 years ↑ 12,100 people 85+ years ↑ 7,350 carers (POPPI estimate)
Political	More patient choice; More capacity for new providers;	PCT improvement in contracting and commissioning; More older people cared for in the community with adapted homes; More 'out of hospital' care; More older people funding their own care;	
Economic	House price rises and potential credit crunch; 2.1% rise in employment 36,000 residents 65+ are owner occupiers; Reduced funding in the Comprehensive Spending Review; Payment by results; More patients prepared to travel for certain treatments; Foundation Trust status will increase commissioning with providers; Improve recruitment and retention of ageing workforce in PCT and BCC; New South Bristol Community Hospital; More Walk-in Centres Potential threat to government funding of health and social care.	Expansion in housing development More single person household units; 38,104 residents 65+ are owner occupiers; Major investment required to 40% of the private sector housing stock built pre-1919. New community hospitals in Southmead and Frenchay. Redevelopment of the BRI; Centralised paediatrics at Bristol Royal Hospital for Children	29,500 new homes in Bristol; 42,028 residents 65+ are owner occupiers; 54,000 extra jobs;
Social	Population rises with more international migrants, more dispersed in the city; More older people migrate out of the city; PBC related to health and wellbeing need; Personal budgets for social care needs; 100 very low birth weight babies; 5,966 people with dementia 60+; 8,538 people with arthritis 65+; 3,801 people with conditions related to CHD 65+; 1,466 people with conditions related to stroke 65+; 27,150 people with limiting long-term illness or disability 65+	More ethnically diverse population; more BME elders; Greater demand for care in the community due to more dementia, more limiting long-term illness and disability; Greater demand for home adaptations for older and disabled people; More obesity; Improved life expectancy; 125 very low birth weight babies; 6,365 people with dementia 60+; 8,937 people with arthritis 65+; 4,011 people with conditions related to CHD 65+; 1,547 people with conditions related to stroke 65+; 28,650 people with limiting long-term illness or disability 65+	Greater demand for care in the community due to more dementia, more limiting long-term illness and disability; 13% rise in obesity; Pandemic flu? Improved life expectancy; 135 very low birth weight babies; 7,860 people with dementia 60+; 9,899 people with arthritis 65+; 4,424 people with conditions related to CHD 65+; 1,706 people with conditions related to stroke 65+; 31,600 people with limiting long-term illness or disability 65+

Techno-logical	High cost of new technologies for neurological (brain and spinal) surgery.; Quicker introduction of new drugs (National Institute of Health and Clinical Excellence licensing quicker); Increasing demand for specialised and costly new drugs; Improved diagnostics will mean patients are nearer the prescribing line; Improved recording of prevalence, equalities issues and improved patient records;	More home-based working supported with IT; More nano-technology; Better management in the community of certain diseases (e.g. diabetes); Improved treatments will mean patients get better quicker; Genetic advances leading to early preventative treatments; Better IT and patient records, and access to this information; Higher profile of food science research to address ill health;	More use of nano-technology in treatments; Genetic advances leading to early preventative treatments
Environ-mental	Traffic congestion; More travel planning; Reducing carbon footprints; Greater Bristol Bus Network improves with ten showcase bus routes;	Improved road network with South Bristol Ring Road and second Avonmouth crossing; More healthy/eco homes with good ventilation and energy efficiency; Air quality deteriorates with warmer weather exacerbating respiratory illness;	New bus rapid transit; Warmer weather will mean better conditions for taking exercise, growing fruit and vegetables and eating a healthier diet; Fewer excess winter deaths; Air quality improves due to cleaner vehicles; Higher risk of skin cancer and heat stress;
Legal	PCT will need to ensure that its commissioning policies for all interventions are robust, legal and logical and can withstand scrutiny at all levels including courts of law.	Better management of patient expectations;	

Summary of Chapter 9

The JSNA helps identify current and projected trends in health and wellbeing and how the city will change in the next three, ten and twenty years. There are a number of information gaps, particularly around disability and location of vulnerable people, but also in relation to ethnicity recording. This is limiting our ability to analyse data in a more meaningful way restricting our knowledge/understanding of the issues. However, anecdotal and 'local voice' information also seems to confirm local perceptions of unmet need. Further work is needed.

Many of the trends identified in this assessment are also national trends and not unique to Bristol. But the city can make a real difference to health and wellbeing by making healthy choices the easiest choices, commissioning to reduce inequalities, commissioning for self care and support for carers and health promoting workforces.

Knowledge from this assessment will be used to support decisions on local priorities and for the commissioning of health and social care and generally support how we deliver services in Bristol. It has identified some areas where 'resources shift' is crucial for preparing for the future.