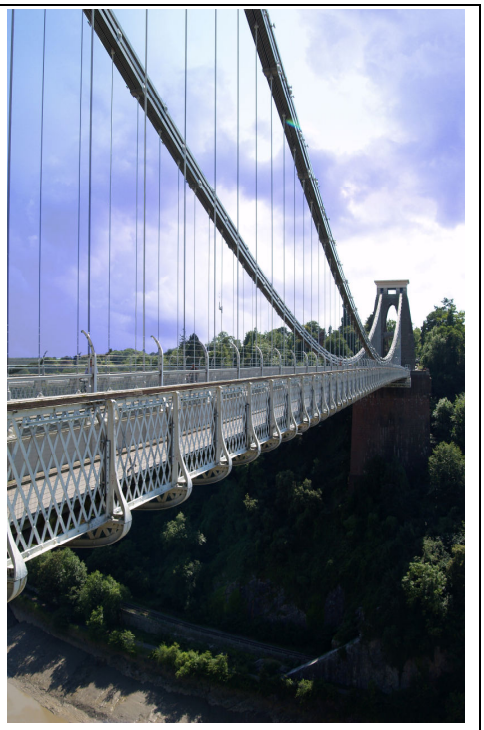
Joint Strategic Needs Assessment 2010

...keeping you informed



Understanding Health & Wellbeing in Bristol

The Joint Strategic Needs Assessment (JSNA) is an ongoing process that identifies current and future health and wellbeing needs of the local Bristol population. This informs decisions not just about how we design, commission and deliver services (both now and in the future), but also about how the urban environment is planned and managed. Our aim is to improve and protect health and wellbeing across the city while reducing health inequalities.

Bristol's JSNA baseline report for Bristol was published in October 2008, with an update released in 2009. These reports described some of the key health and wellbeing issues for the local population, and looked into the future to predict how these might change, and what the implications of these changes might be in terms of service planning. The JSNA provides an analysis to support strategic decision-making.

All reports are available online at www.bristol.gov.uk/JSNA and are supported by a regularly updated core dataset (http://profiles.bristol.gov.uk).

An Update for 2010

There have been many national policy and economic changes in the past 12 months. These will influence what we need to do locally in order to continue to improve health and wellbeing and reduce inequalities in our local population – both now and in the future. In view of this rapidly changing national (political and economic) policy context, this year's JSNA has taken a different approach from previous years and focuses on:

The need to better support decision-makers during this period of austerity and change.

A "joint" (multi-agency and multi-sectoral) approach is suggested in order to strengthen and sustain efforts to improve health and wellbeing across the city. A conceptual model and some tools are introduced to help us rise to the challenge. All this is underpinned by latest evidence of health and wellbeing need, policy and best practice to ensure an evidence-based approach to commissioning decisions locally.

Research and evidence referenced within this report can be requested at **JSNA@bristol.gov.uk**.

Contents

Final Version (v7.9)

Executive Summary

This 2010 JSNA update remains focussed on the priority areas that need to be considered when commissioning services across the city, in order to improve health and wellbeing and reduce inequalities – both now and into the future. These priority areas have been revised and are supported by updated data sets (see electronic links embedded in this document).

Since the previous update report (2009) we have experienced a continued recession, change of government, new White Papers / policy papers for Local Government, the NHS and Public Health, and all alongside a Comprehensive Spending Review.

In view of this rapidly changing national (political and economic) policy context, this year's JSNA has taken a different approach from previous years and focuses on: **The need to better support decision-makers during this period of austerity and change, and so to affect changes through commissioning.**

The first part of this document reminds us of key strategic "pointers" for Bristol, indicating local priority areas and comparing key Bristol indicators with other similar Core Cities[1].

A Bristol Commissioning Model for Health and Wellbeing has been developed to inform discussions about how to reposition resources and improve service quality and efficiency at a time of economic restraint. Difficult decisions will need to be made and the new model can be used to support decision-making, to ensure that real benefits for local residents are achieved now. However, at the same time, the new model highlights the need to ensure that today's decisions leave the city ready for future challenges. Suggestions as to how this model may be used in practice are included alongside some worked examples (i.e. it gives examples of the economic case for change for some lifestyle risk factors and long term conditions). This model, if used wisely and widely, has the potential to help guide us through this period of austerity and change, leaving Bristol well prepared for the future.

The recent Marmot Review[2] (2010) also reminds us of the economic and social benefits of addressing inequalities. A local review of inequalities has been undertaken and the key findings for Bristol are included in this JSNA. Not surprisingly, there are strong links between deprivation and poorer health and wellbeing outcomes. Although some progress has been made in Bristol towards tackling inequalities, further work is needed. The importance of sustaining work to secure a "positive start in life" for the children of Bristol is highlighted.

The later sections of this JSNA Update remind us of the importance of mitigating the consequences of the recession especially for potentially vulnerable people (e.g. mitigating adverse impacts on mental health) and supporting the recovery whilst preparing for the future. Resilience remains important (to ensure robust responses to e.g. pandemic flu or other emergencies) alongside the need to commission sustainable services and mitigate some of the adverse effects of climate change.

Finally, there is a continuing need to fill current knowledge gaps and to use this knowledge to make sustainable improvements for health, wellbeing and quality of life (especially for disadvantaged groups) across the city. There is both an opportunity and a need to move care closer to home and to personalise care to better meet individual needs. There are also opportunities to improve service quality and efficiency.

We therefore need to consider how best to ensure that people receive the support they need in order to be able to take more responsibility for their own health and improve their resilience to poor health (thus reducing reliance on health and social care systems).

[1] Core Cities is a grouping of the 8 major cities in the UK, outside of London. These are Bristol, Birmingham, Liverpool, Leeds, Manchester, Newcastle, Nottingham and Sheffield.

[2] *Fair Society, Healthy Lives: The Marmot Review* (www.ucl.ac.uk/marmotreview)

What are local priority areas for improvement and how does Bristol compare?

The strategic priority areas that need to be tackled across Bristol are identified though the updated data sets (that sit behind this summary report) and priorities include:

Population changes and changing needs

- Bristol's population continues to rise faster than the national rate of increase. The most recent official projection[3] is a rise by 2033 of almost 40% to 586,000 [although underlying trends included here such as recent migration (2004-2008) may not continue].

- According to the latest Annual School Census, 28% of reception year children in Bristol are from a BME group; thus our local population profile is also changing.

- The inequalities gap across Bristol remains – in 2010 the gap between the wards with the highest and lowest life expectancy stands at 8.6 years. There is a close correlation between deprivation and reduced life expectancy.

- Life expectancy is improving and overall population size is increasing in Bristol. More people are living longer, but often with long term health conditions or with special support needs. It is expected that these increases will put pressure on services such as health, social care, housing and education.

Children now, adults of the future

- Levels of obesity in Bristol children have not changed significantly in the past two years with 10.5% of reception year children and 18.4% of year 6 children being obese. Obesity rates tend to rise with increasing age, thus we are at risk of an 'obesity' epidemic.

- Up to 7.5% of children in Bristol have a disabling condition or chronic illness that could potentially impact on their daily lives. These children and their carers may need support from multiple services and partners to enable them to achieve a good quality of life.

- Many deprived and disadvantaged families are reluctant or unable to access any services. It is the children within these families who have the worst start in life, missing out on vital early emotional, social, cognitive and communication development. Research shows early childhood interventions are key to achieving equity and we need to proactively engage early and intensively over time with the most deprived families to avoid associated high health and social care costs to society in the future.

- Evidence suggests[4] that over 75% of psychiatric disorders develop below the age of 25, with disorders in childhood leading to ongoing problems in adulthood. Mental illness is consistently associated with deprivation, low income, unemployment, poor education,

[3] 2008-Based Subnational Population Projections for Bristol, ONS Migration and SNPP Unit, ONS, 2010

[4] Position Statement PS4/2010 *No health without public mental health,* Royal College of Psychiatrists London 2010

poorer physical health and increased health-risk behaviour. Implementation of prevention strategies would make an important impact on health and social outcomes for individuals and society.

Ageing and caring

- The number of older people is increasing. For example, the number of people aged over 65 living with dementia is forecast to rise from 4200 in 2010 to 4740 in 2020, a 13% increase – and potentially could rise to 6000 by 2030, a 43% increase[5].

- The number of people with cardio-vascular disease, diabetes and some cancers is projected to increase as obesity rates rise and as the population ages, despite new treatments and improved survival rates – emphasising the importance of prevention.

- Preventable admissions to hospitals are high and rising (e.g. due to unintentional injuries such as falls, urgent management of pre-existing condition etc). For example, falls-related admissions (people over 65) increased over 12% in 2009/10 and are predicted to rise by 85% over the next 15 years – often involving preventable injuries.

- There are an estimated 40,000 people across the city providing unpaid care for another person (adult or child) with health and wellbeing related needs. With many carers ageing and experiencing their own long-term conditions, this will have an impact upon their availability to continue 'caring' and upon services that support them.

Health and wellbeing

- There are clear links between healthy lifestyle risk factors (such as poor diet, alcohol or substance misuse, smoking, risky sexual behaviours etc) and deprivation/poverty, poor educational attainment, poor emotional health and community safety concerns

- There are also close links between poor housing and poor health. Housing requirements are changing (partly due to people living longer with long term conditions and disabilities, but also more people are living at home and are alone).

- Bristol is a multi-cultural city and some minority groups experience a higher prevalence of specific illnesses but are less likely to access services, and services may not always meet their specific needs

[5] Projecting Older People Population Information System: www.poppi.org.uk

Feeling happy, well and safe

- Nationally, since the recession began, 7% of workers have started taking antidepressants for stress and mental health problems directly caused by the pressures of recession on their workplace. In Bristol there have been increases in the rates of prescriptions for antidepressant drugs, the largest increase roughly coinciding with the same time period that saw an increase in people coming on to the Job Seekers Allowance claimant roll.

- According to the Safer Bristol Partnership's Crime and Disorder Strategic Assessment, there was a decline of almost 17% in Serious Acquisitive Crimes in Bristol during 2009/10. However, in spite of this encouraging trend, Bristol still compares relatively poorly for most acquisitive crime types against other Core Cities – ranking 6th out of 8 for serious acquisitive crimes, with a rate of 27 crimes per 1000 population (9% higher than the Core City average).

- The Safer Bristol Partnership's Drug Treatment Needs Assessment demonstrates that major changes need to be made to the current treatment system to increase the likelihood of clients achieving successful exit from treatment and move on from drug use.

Looking to the future and how we live

- A poor built environment, urban congestion and travel pollution all impact adversely on mental health and well being – confirming the need to build a healthy and sustainable city for the future.

- Global oil production will most likely reach a peak before 2030, which will have a profound effect on our utilisation and dependence on energy sources. Our way of life is putting liveable climate, biodiversity, clean water, food and natural resources under threat, promoting adverse health impacts, which will be greatest for those who are already the least well off.

- It is essential that individuals and organisations reduce their 'ecological footprint'. The NHS, for example, must achieve a carbon footprint by 2015 that is 10% less than the 2007 benchmark. Services need to be prepared for coping with the likely extreme weather events, hotter drier summers, and wetter winters that climate change will bring about. Strategic planning for health and wellbeing will need to include changing our management of energy use in buildings, of travel and transport, of food production, of procurement, and of models of care.

How do we compare with other similar cities?

Throughout this publication, there are a number of references made to the Core Cities. This is a working group of the 8 major cities in the UK, outside of London. These are Bristol, Birmingham, Liverpool, Leeds, Manchester, Newcastle, Nottingham and Sheffield.

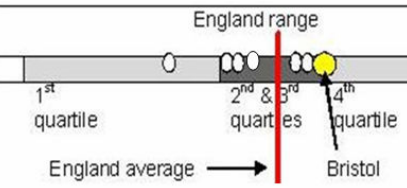
Whilst it is useful to make comparisons, many of the cities are not comparable in terms of size and demographic profile. In the future, the JSNA will make further use of other areas to benchmark Bristol against, such as a statistical neighbours group (e.g. including Reading, Sheffield and Southampton, which are more comparable to Bristol). In this JSNA however, we use the usual Core Cities for comparison – *please see The Bristol Health Profile 2010 summary chart overleaf, which compares Bristol's performance on a range of indicators.*

In the horizontal blocks on the chart, Bristol is shown as the largest circle. The other core cities are shown as smaller circles, so Bristol's performance can easily be compared. The England average is shown as a solid vertical line through the chart. Thus any circles to the left of the line indicate room for improvement (i.e. if the large shaded circle is on the left of the line, Bristol is performing worse than the England average), whilst circles to the right of the line show a performance better than the England average (i.e. if the large shaded circle is on the right of the line, Bristol is performing better than the England average).

This diagram may help explain this further:

Taking indicator 7, smoking in pregnancy, as an example:

Bristol	Eng Av.	Eng Worst	England range	Eng best	Bristol rank
12.0	14.6	33.5		3.8	1



Mothers·smoking·in·pregnancy·where·status·is·known·2009/2009:¶
%·in·Bristol·=·12%¶
Average·%·across·all·England·=·14.6%¶
Worst·%·figure·in·England·(not·just·core·cities)·=·33.5%¶
Best·%·figure·in·England·(not·just·core·cities)·=·3.8%¶
Out·of·all·the·core·cities·(shown·as·circles),·Bristol·(shown·as·the·yellow·circle)·ranks·as·best·at·number·1¶

Overall, Bristol generally does better than other Core Cities especially in areas such as carbon emission, reducing smoking in pregnancy and increasing breastfeeding initiation rates.

However, Bristol does less well for example in: violent crime, adult binge drinking and hip fracture in over 65s. These are all areas where there is significant room for improvement. Interestingly, these are also areas where prevention has the potential to contribute to reductions in pressures on services, thus contributing to potential longer term cost savings.

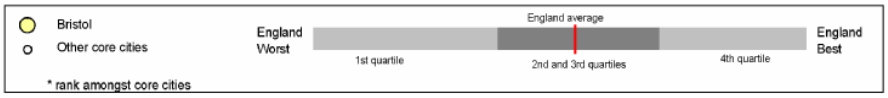
Bristol Health Profile 2010

Bristol compared to Core Cities and England

The health profile below is based upon the Association of Public Health Observatories 2010 Health Profiles and shows how the health of Bristol compares with the rest of England and the other Core Cities. Bristol is represented by the yellow circle. The average for England is shown by the red line. The range of results for England's local authorities is shown as a grey bar. The core cities are represented by small black circles.

Indicator	Bristol	Eng Avg	Eng Worst	England Range	Eng Best	Bristol rank* (1 = best)
1. Deprivation	28.7	19.9	89.2		0.0	2
2. Children in poverty	28.7	22.4	66.5		6.0	3
3. Statutory homelessness	n/a	2.5	9.8		0.0	1
4. GCSE achieved (5A*-C inc. Eng & Maths)	40.4	50.9	32.1		76.1	7
5. Violent crime	26.4	16.4	36.6		4.8	6
6. Carbon emissions	5.3	6.8	14.4		4.1	1
7. Smoking in pregnancy	12.0	14.6	33.5		3.8	1
8. Breast feeding initiation	77.8	72.5	39.7		92.7	1
9. Physically active children	46.0	49.6	24.6		79.1	5
10. Obese children	10.4	9.6	14.7		4.7	5
11. Children's tooth decay (at age 5)	1.5	1.1	2.5		0.2	3
12. Teenage pregnancy (under 18)	51.2	40.9	74.8		14.9	4
13. Adults who smoke	25.6	22.2	35.2		10.2	4
14. Binge drinking adults	30.1	20.1	33.2		4.6	6
15. Healthy eating adults	27.6	28.7	18.3		48.1	1
16. Physically active adults	12.2	11.2	5.4		16.6	2
17. Obese adults	22.6	24.2	32.8		13.2	2
18. Incidence of malignant melanoma	13.6	12.6	27.3		3.7	5
19. Incapacity benefits for mental illness	37.4	27.6	58.5		9.0	4
20. Hospital stays for alcohol related harm	2266	1583	2856		784	5
21. People diagnosed with diabetes	3.7	4.3	6.7		2.7	3
22. New cases of tuberculosis	19.5	15.4	109.9		0.6	4
23. Hip fracture in over-65	548.1	479.2	643.5		273.6	6
24. Excess winter deaths	14.7	15.6	26.3		2.3	3
25. Life expectancy - male	76.9	77.9	73.6		84.3	3
26. Life expectancy - female	81.7	82.0	78.8		88.9	2
27. Infant deaths	5.0	4.8	8.7		1.1	2
28. Deaths from smoking	229.2	206.8	360.3		118.7	2
29. Early deaths: heart disease & stroke	85.3	74.8	125.0		40.1	3
30. Early deaths: cancer	124.8	114.0	164.3		70.5	4
31. Road injuries and deaths	39.1	51.3	167.0		14.6	2

Source: APHO and Department of Health. From 'Health Profiles 2010 © Crown Copyright 2010.'



Core Cities are: Bristol, Liverpool, Sheffield, Newcastle, Leeds, Manchester, Birmingham and Nottingham.

Indicator Notes**

(1) % of people in this area living in 20% most deprived areas of England 2007 **(2)** % of children living in families receiving means-tested benefits 2007 **(3)** Crude rate per 1,000 households 2008/09 **(4)** % at Key Stage 4 2008/09 **(5)** Recorded violence against the person crimes crude rate per 1,000 population 2008/09 **(6)** Total end user CO2 emissions per capita (tonnes CO2 per resident) 2007 **(7)** % of mothers smoking in pregnancy where status is known 2008/09 **(8)** % of mothers initiating breastfeeding where status is known 2008/09 **(9)** % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 **(10)** % of school children in reception year 2008/09 **(11)** Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 **(12)** Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) **(13)** % adults, modelled estimate using Health Survey for England 2006-2008 **(14)** % adults, modelled estimate using Health Survey for England 2007-2008 **(15)** % adults, modelled estimate using Health Survey for England 2006-2008 **(16)** % aged 16+ 2008/09 **(17)** % adults, modelled estimate using Health Survey for England 2006-2008 **(18)** Directly age standardised rate per 100,000 population under 75 2004-2006 **(19)** Crude rate per 1,000 working age population 2008 **(20)** Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) **(21)** % of people on GP registers with a recorded diagnosis of diabetes 2008/09 **(22)** Crude rate per 100,000 population 2006-2008 **(23)** Directly age-standardised rate per 100,000 population for emergency admission 2008/09 **(24)** Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 **(25)** At birth, 2006-2008 **(26)** At birth, 2006-2008 **(27)** Rate per 1,000 live births 2006-2008 **(28)** Per 100,000 population age 35+, directly age standardised rate 2006-2008 **(29)** Directly age standardised rate per 100,000 population under 75, 2006-2008 **(30)** Directly age standardised rate per 100,000 population under 75, 2006-2008 **(31)** Rate per 100,000 population 2006-2008

** More detailed definitions and the original APHO Health Profiles are available at http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

Changing World, Changing Lives

There have been many national changes since the last JSNA update. We have experienced the "banking" crisis, a recession and a change of government. The political and economic context in which we now operate has changed significantly.

The evolving political landscape (following the election of the new coalition government) has meant a new policy arena. The proposed changes to Local Authorities[6] and the services they provide (e.g. Children and Young People's Services [CYPS]; Adult Health and Social Care, Housing etc) are described in various policy and legislative documents including the Localism Bill (December 2010). When these proposed changes to Local Authorities are coupled with the Health White Paper[7] (July 2010) and the Public Health White Paper [8] (November 2010), it becomes clear that we will all need to work in very different ways in the future.

There is also a significant financial challenge for the rest of the public sector, as discussions about "balancing the books" (reducing the national debt through reducing public sector spending and improving efficiency and effectiveness) takes on increasing importance both nationally and locally. While the Health Services have been given some "protection" from the most severe public sector efficiency savings, the same is not true in other parts of the public sector, e.g. local authority services, education, policing, criminal justice system, etc.

Even in the Health Sector, there are significant challenges to be tackled over the next 5-10 years as the relative protection is based on current levels of expenditure rather than on projected future needs. The Spending Review 2010[9] sets out the funding settlement for the NHS over the period 2011/12-2014/15. It states that funding to the NHS will increase by £10.6bn (10.2%) to £111.4bn per annum over this period. The increase in NHS funding, while welcome, comes with a commitment for the NHS to pay £1bn a year for social care, together with a number of other commitments set out in the Spending Review 2010 and in the Operating Framework for the NHS in England 2011/12. It will also need to pay for the population's increasing requirements for health and social care.

Locally our population is changing, creating different individual health needs across our diverse population. We have an ageing and growing population living longer and often with significant health needs; this coupled with medical innovations and new (sometimes expensive) treatments, associated with high expectations from the population, means that health and social care needs and demands are steadily increasing, as are costs.

In line with the Government's commitment to protect health spending overall, NHS Bristol's revenue funding will increase by 7% in cash terms up to the end of March 2015 (excluding the funding of £5.6m allocated specifically for transfer to Social Care). This represents 1.0% in real terms based on pay and prices inflation of 2.5%. At the same time, the administration budget will be reduced and reinvested to support the delivery of services commissioned by NHS Bristol.

After comparing the likely health spending requirements of the growing and ageing population with the funding available, current plans indicate that NHS Bristol will need to generate efficiency savings of about £19 million by April 2012. In addition, local health care

[6] See for example, *Local Democratic Legitimacy for Health*, Department of Health, 2010 and also the proposed "Localism Bill" (introduced 13/12/2010)
[7] *Liberating the NH,* Department of Health, 2010
[8] *Health Lives, Healthy people: Our strategy for Public health in England.* Department of Health, 2010
[9] *HM Treasury: Spending Review*; October 2010

providers will also need to generate recurrent efficiency savings of about 4%. At the time of publishing this report, the current uncertainty regarding health sector reforms means that it is hard to make accurate projections of efficiency savings needed for future years (2012 – 2014/15) and work is ongoing, however similar levels of recurrent efficiency savings are anticipated across the local health economy i.e. by the Primary Care Trust which currently "buys" (commissions) health services and by the providers of health services.

Similarly, following the national Comprehensive Spending Review in Oct 2010, and Funding Settlement announcement in Dec 2010, Bristol City Council's expectation is that it will need to make efficiency savings of around £70m over the next four years, starting with £28m in the year beginning April 2011. Next year alone this represents a reduction of approx 7% on the Council's total net spending, with ongoing efficiency savings needed of about 27% (in real terms) over the 4 year period to 2014/15 (or 23% in cash terms) to balance the expected reductions in national government grant funding, which will require a fundamental re-think of the way the council carries out it's business.

The City Council and NHS Bristol are using the opportunity of declining funds across the whole public sector to become more efficient. In particular, the Council is supporting the devolvement of power and resources to communities, where people know best how to use them, whilst the Council and NHS together are reviewing, prioritising and streamlining services. This may result in different services being commissioned in the future.

Nationally, and locally, there is an expectation that people, families, communities and neighbourhoods will need to be more engaged in activities in their own communities, to support a shrinking public sector. This is coupled with a new national agenda which has been designed to give people more choices and control over their lives and the services that support them e.g. as part of the personalisation agenda (including moves towards personal budgets for service users).

The challenge in Bristol for the next 3-5 years is in determining how best to:

- Remain focussed on the priority areas and health and wellbeing outcomes that need to be improved across the city (both now and into the future)
- Deliver quality services more efficiently and effectively; making better use of resources and better managing increasing demands
- At the same time, ensure that people are supported to make healthier choices; and ensure that healthier choices are easier choices (at home, in their communities or schools, in the work place etc)
- Ensure that local people have a "voice", are actively engaged locally in their own communities, in shaping services and in decisions that affect them/their care
- Continue to ensure, through decisions taken now, that Bristol is a city fit for the future, while remembering that it can take a long time before policy changes (made now) have their full impact on health and wellbeing outcomes (in the future) – which is why it is important to take a longer term and "whole life course approach" to improving health, wellbeing and public health generally[10]

How this might be taken forward is explored further in the next sections of this document.

[10] Department of Health; 30th November 2010 "*Our Health and Wellbeing Today*" page 20

What Does this Mean for Bristol?

National projections for the next few years suggest there will be increasing health and social care needs within the population (due in part to an ageing population living longer but with long term conditions), alongside increasing pressures on services. National policy papers have recommended a strengthened focus on preventing problems from arising, alongside ensuring good access to quality early interventions and services when needed.

The Joint Strategic Needs Assessment (JSNA) has confirmed similar demographic changes and challenges locally in Bristol. Thus there is a need to increase resilience to poor health, so that the increasing pressures on health and social care services can be better managed in the future (reduced) as the population becomes healthier. Current evidence suggests that we should focus on a number of areas[11] to improve health outcomes, including the below (and linked to The Bristol Commissioning Model for Health & Wellbeing chart overleaf):

- **Prevention:** tackling and reducing lifestyle risk factors (such as obesity, alcohol misuse, smoking etc) and also protecting health and wellbeing (e.g. through improving access to screening programmes, immunisation, appropriate information/advice etc). Please see the green section of the chart labelled "Prevention, Risk Assessment, Targeted Early Intervention".
- **Services**: ensuring rapid (timely), easy access to quality services, and/or interventions proportionate to need. Some of these services and interventions may be delivered closer to home or in the community and may be personalised (e.g. personal budgets). Please see the yellow, amber and red sections of the chart overleaf.
- **Addressing the wider social influences on health and wellbeing and tackling health inequalities**

In cities like Bristol, there are clear inequalities, with those experiencing deprivation having worse outcomes than their more advantaged neighbours. Thus a priority is to reduce inequalities generally, but in health and wellbeing specifically. Improvement across all three areas (identified above) is needed to reduce inequalities and improve health and wellbeing.

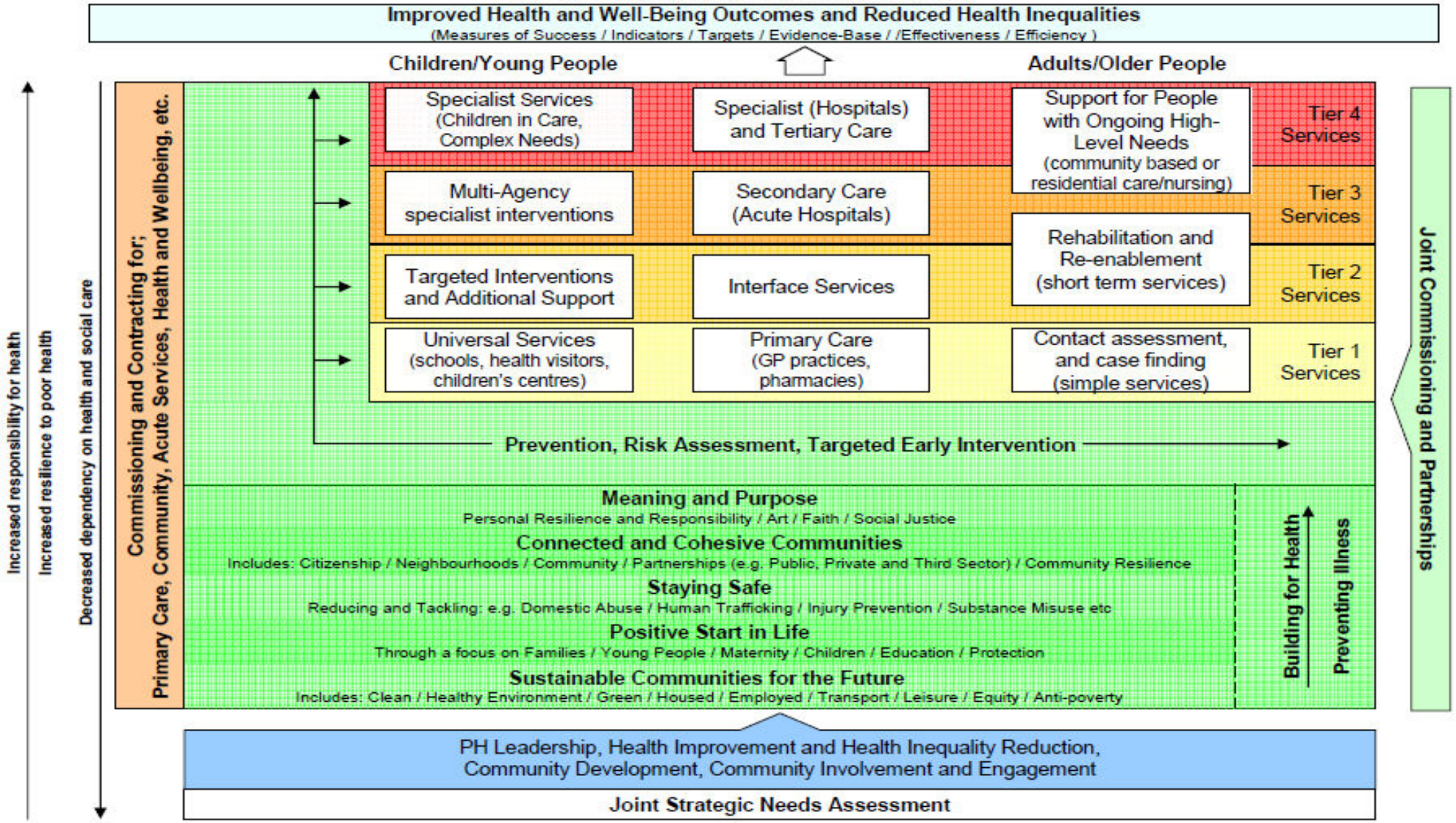
The recent Marmot Review[12] reconfirms that any action on inequalities or lifestyles will require action across all of the social determinants of health - and that focussing *only* on the disadvantaged groups will not reduce inequalities sufficiently. Thus actions to improve health and wellbeing generally must be universal, but with a scale of intensity proportionate to the level of disadvantage. This is often called proportionate universalism, and this thinking is at the core of our efforts to improve health and wellbeing locally.

Bearing this in mind, a conceptual Bristol Commissioning Model for Health and Wellbeing in Bristol is helpful (see next page). This model is based on current policy, best practice and a well-developed evidence base. It has been adapted from a model developed originally to underpin improvements in mental health and wellbeing[13] but also incorporates the findings from the Marmot Report in order to ensure its relevance for wider use here in Bristol.

[11] Department of Health; 30th November 2010 "*Our Health and Wellbeing Today*" page 21
[12] Marmot, M et al 2010 Fair Society, Healthy Lives: The Marmot Review, Strategic Review of Health Inequalities in England post-2010. Technical report, The Marmot Review. (www.marmot-review.org.uk/)
[13] New Horizons: A Shared Vision for Public Health, The Department of Health: Mental Health Division, December 2009

The Bristol Commissioning Model for Health and Well-Being

(Commissioning Model adapted by Bristol Public Health from i) "New Horizons: A Shared Vision for Public Health. The Department of Health: Mental Health Division, December 2009" and ii) "Fair Society, Healthy Lives" The Marmot Review, 2010)



The top part of the Model (coloured yellow, amber and red) describes current health and social care services. For example, when ill or needing advice or support, most people would either contact their GP, their Health Visitor (for child or family advice) or their Local Authority which provides support for those with extra needs (these are called first level or first tier services and are coloured yellow). If more complex services were required, then the individual or family would be referred up through the system into the more specialised services (coloured amber and red).

However, we know in Bristol that we have both an increasing younger population and an ageing population (people living longer with long-term conditions), bringing extra pressures on services - both now and into the future. The evidence suggests that a stronger focus on prevention and on tackling the wider influences on health (often called "determinants") will help prevent some problems arising or will delay their onset, thus supporting people to live longer but with a greater quality of life (healthier, well and independent).

Opportunities for prevention (and tackling the wider determinants of health) are coloured green in the Model. From the Model, it can be seen that even when someone is admitted to hospital (the amber and red layers) it is not too late to support them improve their general health and well being and thus reduce their risk of even more serious disease or re-admission to hospital e.g. to remind/help them to stop smoking or to offer advise on diet or alcohol consumption (see the green area wrapped around the amber and red).

In order to achieve longer-term efficiencies and better quality and innovative services, the Bristol Commissioning Model for Health and Wellbeing confirms that any improvements or changes (and investments) need to be considered throughout the whole life experience.

In practice, this means looking at the services and care pathways people will need to access at moments in time (as their needs will change over time). However, it also involves taking into account the many other factors that influence health and wellbeing and the related choices that people will make (coloured green). This Model tries to explain this "connectivity" by using the evidence-base to map the key elements that needs to be considered when commissioning for health and wellbeing – both now and into the future.

This is important as the full impact (and outcomes) of commissioning decisions taken now may not be seen or measured for several years. If we do not get investments and decisions right now, we will store up problems for the future and there is a risk that services will not meet changing demands and the whole system will be unaffordable. However, by using a structured and evidence-based approach (which is suggested in this Model) to move resources around the system (and commissioning and delivering differently) future outcomes can be improved with potential efficiencies also achieved.

In doing this, people are enabled and supported to improve their resilience to poor health (in the face of a shrinking public sector). By implication, Commissioners will need to focus on prevention and inequalities reduction while commissioning efficient and quality services/interventions.

Gaps or inefficiencies in the green and yellow segments of the Model will result in greater pressures on services, with costs then accruing at the higher (and costlier) end of the system (coloured amber and red). This is very pertinent to both the City Council and NHS locally and supports the need to improve efficiency and service quality in times of post-recession austerity.

The green sections of the Model recognise the importance of helping people to be healthier and stronger (both mentally and physically) and take more responsibility for their own health through securing a healthy, safe and sustainable environment.

Sustainable Communities for the Future: Clean, Green, Environment, Housed, Employed, Anti Poverty, Equity and Inequality Reductions

Having a home, living in a neighbourhood which is well cared for, with clean air and having access to green spaces are essential building blocks for health.

Wealth and health are closely linked, so income maximisation, debt and anti-poverty programmes are very important for health. Over and above absolute poverty, the evidence-base shows that more equal societies have better health overall, and fewer social costs. Thus tackling inequalities is crucial for health and wellbeing.

The Model also confirms the need to invest in children to ensure a healthier population in the future (who are well informed and able to practice "health protecting" behaviours).

Positive Start in Life: A focus on maternity, children, families and young people

Maternal health through pregnancy and positive child-parent relationships during the first few years of life lay crucial foundations for future health and wellbeing.

Parental affection, parental involvement with school and positive community role models will all help to build resilience and wellbeing. Positive and negative experiences in early years, childhood and adolescence can impact on adulthood in terms of physical and mental health, risk of suicide, anti-social behaviour and crime.

Early experiences will also influence the lifestyle choices that children make in later life e.g. as young adults (diet/eating habits, smoking, alcohol or substance misuse, sexual risk taking behaviour, unplanned teenage pregnancy etc).

However, this can be undermined if people do not feel safe. A perceived lack of security can undermine both physical and mental health and wellbeing.

Staying Safe: Reducing Domestic Abuse, Tackling Human Trafficking, Injury Prevention, Substance Misuse, Bullying, Discrimination, Safeguarding

Violence and abuse, trauma, discrimination, fear of crime and bullying all undermine health and wellbeing resulting in high, and long term costs for health social care and society as a whole.

These costs are often hidden but may relate to physical problems (injuries resulting from abuse of violence which require treatment) and Mental Health problems (e.g. a consequence of abuse or related to substance misuse) – or both.

If people don't feel safe or lack access to safe communal space, they may not take sufficient exercise to maintain their health or may lack social contacts (necessary for mental wellbeing)

However, evidence suggests that people are most likely to feel safe, secure and well if they live in cohesive and connected communities.

Connected Communities: Citizenship, Neighbourhoods, Communities

Communities with higher levels of connectedness and coherence have lower rates of crime and better health. Positive relationships and connections with friends, family and supportive neighbours are good for our health.

Transport, the built environment, and community spaces can support community connectedness, as can culture, leisure, sport and other activities. Community connectedness is particularly important for the health and wellbeing of older people.

In order to be strong, resilient individuals (and potentially take more responsibility for their own health and wellbeing) people need to have a strong sense of meaning and purpose.

Meaning and Purpose: What gets you out of bed in the morning? What are your passions and interests?

It may be faith, art, sport, politics, caring for others – or even just day to day survival. It's about what makes you – you.

An inner sense of meaning and purpose can help individuals through great trials and traumas, both emotional and physical. This quality also appears to reduce risk of ill health.

This new Model confirms, like earlier national reports[14], that health and wellbeing is "*everybody's business"* and that multi-disciplinary and multi-sectoral approaches are needed to make sustainable improvements in health and wellbeing while reducing inequalities.

Given the increasing needs of an ageing population and the rising pressures on services at a time of austerity, there is a pressing need and an opportunity to improve health and wellbeing and to change patterns of care and health seeking behaviours. This is arguably the biggest health and wellbeing challenge that we face in the next few years in Bristol.

The approach suggested in this Model recognises that some health-related problems and/or social care support needs can be averted by targeted early interventions, but that if health does come under stress, then timely (rapid) access to quality interventions and services is needed. This Model can therefore be used to strengthen and support commissioning locally, to help prioritise interventions and services that will improve health and wellbeing (in the short, medium and longer term) and to reduce inequalities in Bristol.

This new Model, with its focus on commissioning for Health and Wellbeing for the future (and not just ill-health or support needs now), could therefore be used to underpin everything we do here in Bristol.

[14] Wanless D. *Securing good health for the whole population*. London: HM Treasury, 2004. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4074426 (last accessed on 5 October 2010)

Rising to the Challenge: Using the Model for Commissioning in Practice

We need to commission effective and high quality services and interventions that are "fit for the future" and improve health and wellbeing. The diagram below illustrates the interface between commissioners (purchasers of services for local people), providers of services for local people, local people/their communities and improved health and wellbeing.

Commissioning for Health and Wellbeing in Practice

This diagram draws on earlier research and has been adapted in light of recent policy changes[15] and illustrates that the key to achieving the necessary outcomes lies in effective joint working, partnership working and local engagement.

[15] Peckham S, Taylor P and Turton P, 19. "An unhealthy focus on Illness", Health Matters, 1998, Issue 33 p8-10.

Key Points: Using the new Model in Partnership and Practice

- *Commissioning "fit for the future"* doesn't just start with primary care or universal services and end with highly specialist medical care or social care support packages – although commissioning "fit for now" often does just that. It means focussing on outcomes and long-term benefits not just services for short-term outcomes.

- *Connectedness:* Physical health, wellbeing and resilience to poor health are inextricably linked with mental health and wellbeing and vice versa. However, during commissioning processes and through service delivery, mental and physical health are often commissioned and managed separately - as are supporting health, social care and wellbeing interventions. The new Model reminds us of the importance of the whole person/whole life/whole system approach to effective commissioning for health and wellbeing – not just addressing the disease or the individual social care need. The responsibility for delivering this will rest on effective joint working and partnership working e.g. between the Council, NHS organisations, GPs, local business, carers, third sector agencies and other partners.

- *Impact of System Re-design*: When commissioning new/different care pathways "fit for the future", the Model reminds us that it is important to consider the impact of any service-related changes on the whole system – not just on the individual service. What, for example, will be the impact on communities, on carers or on related services (see also the diagram "Commissioning for Health and Wellbeing in Practice")? We need to be mindful of the intended benefits but also of any potential unintended consequences of change (some of which may also prove beneficial), and plan for these.

- *Quality, Improvement, Efficiency and Prevention*: In an increasingly financially constrained climate, the commissioning of services (to meet current and future health and wellbeing needs of local people) needs to move from a focus on volume and price to one on quality and outcomes whilst ensuring cost-effectiveness. At the same time, services also need to shift from treating illness towards preventing it occurring in the first place. There is growing evidence that a well-structured programme of prevention and intervention services (e.g. falls prevention, cancer prevention through screening and smoking cessation) can improve quality of life for individuals and lead to reduced reliance on high cost services, delivering long term value for money[16]. The Bristol Commissioning Model for Health and Wellbeing can be used to help inform difficult decisions about local priorities – such as where to invest or disinvest. Some worked examples (including costs and benefits) are included in the "Can We Afford *not* to Change?" section.

- *Enabling Commissioning*: In 2010 Bristol City Council created a new "Enabling Commissioning Framework", to develop a common language and understanding across the Council for what strategic commissioning is, why it is effective, and how it should be undertaken. Enabling Strategic Commissioning is an evolving process that will be: centred on people, collaborative, well-evidenced, sustainable and challenging. This is mutually supportive with The Bristol Commissioning Model for Health & Wellbeing, as it provides a best-practice framework for implementing the commissioning outcomes indicated through using the Model. More details on the Enabling Commissioning Framework are at: ***www.bristol.gov.uk/commissioning/***

[16] Joseph Rowntree Foundation 2000 Low intensity support services: a systematic literature review, York

Eight Key Steps (Top Tips) for effective Commissioning for Health and Wellbeing

So how can we effectively commission in a joined up way across these different sectors? The way of thinking illustrated in the new Commissioning Model is aligned with some existing Commissioning Frameworks for Health and Wellbeing[17] to achieve key aims such as:

Commissioning for Health and Wellbeing : Aims

- A shift towards services that are personal, sensitive to individual need and that maintain independence and dignity – "No decision affecting me without me."
- A strategic reorientation towards promoting health and wellbeing, investing now to reduce future ill health cost
- A stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities

Eight key steps to effective commissioning for health and wellbeing

1. Putting people at the centre of commissioning – giving people greater choice and control over services and treatments, and access to good information and advice – a "health partnership" and joint decision making
2. Understanding the needs of populations and individuals – undertaking Joint Strategic Needs Assessments and balancing the needs of the whole population and groups with specific needs with the requirements of individuals
3. Sharing and using information more effectively – sharing information while taking proper account of confidentiality and sharing data to create high level "intelligence"
4. Assuring high-quality providers for all services – developing relationships with providers and engaging them in needs assessments
5. Recognising the interdependence between work, health and wellbeing – improving employee health and wellbeing and helping people into employment
6. Developing incentives for commissioning for health and wellbeing – for example, encouraging NHS and GP Commissioners to be more flexible in using NHS funds and vice versa in local Authorities – consider the development and use of "pooled budgets"
7. 'Making it happen': local accountability – be clear how local commissioners will be held to account
8. 'Making it happen': capability and leadership – building commissioning leadership and capability

[17] Department of Health 2007 Commissioning framework for health and wellbeing London: Department of Health. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604 (accessed 5 October 2010)

The main themes running through all the evidence about commissioning for health and wellbeing (and preparing for the future) can be summed up in a recent Kings Fund report[18] which stated:

"The key areas of focus for commissioners should be reducing spending on low-value interventions, and redesigning pathways (especially for people with long-term conditions) to avoid unnecessary hospital admissions. Integrating care across health and social care boundaries is an important element of pathway redesign."

The new Commissioning Model can be used to support such an approach.

Using the Model when Commissioning Services

Tier 1: Universal Services: e.g. Primary Care, Health Visitors and Schools, early assessments etc

Physical and mental health is directly linked. Good mental health and wellbeing reduces the risk of cardio vascular diseases, cancers, stroke and a range of other diseases. When unwell (physically or mentally), people need timely (rapid access) to core services or advice in order to be assessed, diagnosed and treated (to prevent a deterioration and/or promote recovery). Approximately 80% of health and social care needs will be addressed through Tier 1 services (meaning that about 20% may need referral elsewhere). They can advise or "sign post" people to other means of support and self help or refer them into other services, including prevention services (e.g. stop smoking).

Tier 2: Interface Services, Community Services, targeted interventions, additional support
e.g. services delivered by allied health professionals, social care specialists, other community-based specialists or hospital specialists working in the community, district/community nurses, interventions with young people and families, community care etc.

Early assessment or diagnosis and intervention close to home and using community-based services, will support people and their carers within their own communities and families, so can help people keep their independence, autonomy and connections, all of which are health building. Early intervention also has the potential to improve outcomes.

Tier 3 Hospital Care and Specialist Health and Social Care Provision

When hospital care or specialist provision is needed, the principles of autonomy, connectedness, meaning and purpose will all help promote wellness and recovery. There may also be opportunities to introduce prevention (to reduce risks of deterioration or re-admission). Addressing issues of equity, access, fair distribution of services and freedom from discrimination will help address inequality of experience and of outcome.

Tier 4: Highly specialist health and social care services

As for Tier 3 services, when hospital care or highly specialist provision is needed, the principles in the Model (of autonomy, connectedness, meaning and purpose) will all help promote wellness and recovery. There may also be opportunities to introduce prevention (to reduce risks of deterioration or re-admission). Addressing issues of equity, access, fair distribution of services and freedom from discrimination will help address inequality of experience and of outcome.

[18] John Appleby et al 2010 Improving NHS productivity. More with the same not more of the same Kings Fund London

Can We Afford *not* to Change?

Question: If we tackle only **some** unhealthy behaviour (smoking and harmful alcohol use) and reduce this behaviour by just **10%** now - what do we estimate we could save on our NHS bill?

Answer: There is a potential to save **£4.1 – £5.8 million in one year**

Some of these financial benefits may be seen very quickly e.g. A&E alcohol-related admissions; other benefits may take longer to be realised e.g. health cost reductions of stopping smoking.

Putting a price on health and wellbeing is always difficult. Predicting the changing cost of delivering services (both now and is the future) is also very challenging. A wide range of factors need to be considered, costs may change because of factors like: new national policies, changes in the population (changing population profiles), the arrival of new therapies or drugs that may reduce the need for hospital care and improve health outcomes or people changing their health-related behaviours e.g. more people "binge drinking", poor diet and rising levels of obesity (and related conditions) or changing smoking habits (stopping or starting smoking).

Precise costing now and predicting costs in the future are both difficult, as so many factors need to be considered. However it is possible to use some approximate figures, to give insights into the health, social and economic benefits of change. We have illustrated this through two small case studies and some key Bristol "facts". In calculations, all estimated costs are stated in approximately today's monetary value and also best estimates of current activity/trends are used[19].

CASE 1 – ALCOHOL

In the financial year 2009/10 there were 3,278 admissions in Bristol hospitals that were due wholly to problems to do with alcohol consumption (e.g. cirrhosis of the liver). Each spell cost us on average £1,375 – a total bill for the year of about £4.5 million.

If we implement programmes designed to tackle the high level of drinking (which causes these problems) and as a result, and are able to prevent only 1 in 10 of these spells, this could still save us an estimated £0.5 million per annum at current costs.

Add to that the cost of hospital spells that are only partially due to excess alcohol consumption (e.g. a trip or a fall when drunk causing injury or injury due to alcohol-related domestic violence, as well as various chronic conditions such as hypertension and cardiac arrhythmia). In 2009/10 there were 6,966 spells in Bristol hospitals due to such causes. Each spell cost us on average £ 1,749 – a total bill of over £ 12.2 million. Programmes to reduce the level of drinking and which prevent 1 in 10 of these spells could save an estimated £1.2 million of these costs.

But what if we do nothing?

Total NHS costs in Bristol attributable to alcohol admissions in 2009/10 = £16.7 million. However, projected costs in just 10 years' time based on an analysis of recent trends and population changes are in the region of £22 - £33 million

And what about the total cost of health care of alcohol harm in Bristol, not just hospital stays? It is estimated that this is £31 – £51 million in 2010, and, if we do nothing, it could rise to £43 – £97 million by 2020.

[19] Spell costs are based on estimated local unit costs with PBR rules and NWPHO spells. More detail about the methodology used to develop this information is available on request

CASE 2 - SMOKING

Bristol GP practice information estimates that there were 73,700 smokers in Bristol in 2009/10. National studies have estimated the total cost to the NHS during 2009/10 to be £327-£562 per smoker. This makes a total cost for all smokers in Bristol in 2009 to be about £24 - £41 million.

If we implement programmes to reduce the numbers of smokers by 10% in one year we could save an estimated £ 2.4 – £4.1 million locally in Bristol.

But what if we do nothing?

Total NHS costs due to smoking in 2009/10 = £24 – £41million
Projected costs in just 10 years' time based on trend analysis, even after taking into account falling rates of smoking nationally = £23 – £39 million

So – doing nothing and relying on a natural decline in smoking behaviour means that costs in 10 years' time might be £1 – £2million less, but doing something now to reduce numbers of smokers by 10% could save £2.4 – £4.1 million per year in the future.

How much does it cost to help someone stop smoking?

The average cost to support someone to stop smoking (remembering that not everyone who tries to stop will succeed) is currently £259[20] per quitter. This seems to be a small price to pay when compared with the smoking related costs described above.

Key Facts: Did you know…?

Question: If we take action now, to improve health and wellbeing (and reduce reliance on services) … and … if we also change the way we commission and deliver services (better quality services closer to home), how much can we save from the health and wellbeing bills to invest differently (e.g. how much can we expect through savings to the NHS locally and also savings in health, social care and children's services run by the City Council)?

Answer: This is hard to estimate, given the many factors described elsewhere in this JSNA. However, it is clear that if we do nothing, pressures on services and associated costs will continue to rise at an unsustainable rate – an untenable position, especially in the current economic climate.

Some key facts for Bristol (over the page) will give some clues as to what may happen and what is possible.

[20] NHS South West smoking cessation figures, 09-10. Dept Health definition of a quitter is: 'A client is counted as having successfully quit smoking at the 4-week follow-up if he/she has not smoked at all since two weeks after the quit date.'

Key facts:

Children and disabling conditions: *Did you know…?*

- In 2009/10 it was estimated that about 4600 young people in Bristol aged 0-18 years were defined as having a significant physical or mental difficulty that could potentially impact on their daily lives?
- Adding figures for those suffering with a severe chronic illness brings that total to over 7000?
- Nearly twice as many boys as girls were defined as having a potentially disabling condition?
- The single most important disabling conditions (when not including chronic illness) were mental impairments, including general and specific learning difficulties?

These figures need to be closely monitored. The changing patterns of survival and outcomes for very sick and premature babies may impact on planning services for the future.

Unhealthy lifestyles: *Did you know…?*

- In Bristol, nearly 23% of adults are obese?[21]
- If current national trends continue then by 2020 44% of men and 38% of women aged 40-65 will be obese? This will cause increases in the levels of diabetes, heart disease, stroke, liver cancer and premature death.
- In Bristol, around 33% - one third - of Year 6 children (10 -11 year olds) are either overweight or obese?
- In Bristol Reception classes, a bigger proportion of Bristol children are either overweight or obese than nationally?
- In Bristol, the cost (in 2010 £) of diseases & conditions relating to being overweight or obese is predicted to rise by over £10 million between 2010–2015, to £154 million?

An aging population: *Did you know…?*

- Between 2010 and 2030 it is predicted that the population of people living in Bristol aged 65 and over may have increased by 34%?
- It's estimated that in 2010 Bristol has 4200 people aged 65 and over with dementia, which is 7.6% of the 65+ population? This could rise to 6000 by 2030.
- Total costs relating to dementia, including costs relating to health, social care, informal care and personal funding, are difficult to calculate but national studies[22] estimate that in Bristol in 2010 these costs are around £120-£140 million?
- These costs are projected to rise by 2020 to between £135-£159 million, the biggest elements of which are care homes and informal care costs?
- During 09/10, 2289 people over 65 were admitted (in an emergency) to hospital after a fall, an increase of 12.6% on 08/09[23]? I.e. more than 6 fallers per day - often with preventable injuries. And predictions estimate an 85% increase over the next 15 years

[21] Bristol Health Profile 2010 - Public Health Observatory: www.apho.org.uk/default.aspx?RID=49802
[22] Dementia UK 2007; Eurodem 2008; Expert Delphi 2008 – all figures escalated to 2010 costs
[23] Hospital Episode Statistics, NHS Bristol, 2010

Key Facts: Housing

Did you know…?

At any one time over 8,000 vulnerable households are supported by Supporting People services? In 09/10:

- Over 5,500 households completed a planned programme of support that enabled them to stay in their homes
- Over 3,000 households were supported to move on from temporary accommodation with support to independent housing.

23% of private sector homes failed the Decent Homes Standard (2007), compared to less than 10% housing association homes and about 7% of homes owned by the council (both 2010)?

72% of disabled people first heard about the Home Adaptations Service (HAS) from their GP or other health professionals? Overall satisfaction with HAS was 97% in 2009/10.

Key Facts: Physical inactivity

Did you know…?

- Lack of everyday physical activity is a key cause of heart disease, diabetes, high blood pressure, mental ill health, osteoporosis, musculoskeletal disorders, stroke, obesity and some cancers?
- Physical activity has, to some extent, been "designed out" of everyday life? Dominance of motorised transport and parked vehicles has created many urban spaces where walking, cycling, playing and outdoor social interaction are no longer perceived as safe, attractive or normal.
- Regular physical activity cuts the risks of coronary heart disease (CHD), adult diabetes, and obesity all by 50% and high blood pressure by 30%?

Key Facts: Mental Health and Wellbeing

Did you know…?

Mental health and wellbeing is fundamental to good physical health. Mental health is linked with physical health in the following ways:

- Depression is linked with a 50% increased mortality, comparable to the effects of smoking?
- Poor mental health is linked to a higher risk of coronary heart disease, stroke and other conditions?
- Improving the mental - physical care interface, for example through increased and better use of liaison psychiatry, could save costs to the NHS by supporting recovery and reducing in-patient stays?

Health Inequalities Update

Addressing inequalities in health is a high priority for Bristol as illustrated by the 2008 Baseline JSNA findings.

Fair Society, Healthy Lives (The Marmot review - a strategic review of health inequalities in England published in February 2010) provides a set of six priority objectives to address health inequalities at all levels. These are

- **Give every child the best start in life**
- **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
- **Create fair employment and good work for all**
- **Ensure a healthy standard of living for all**
- **Create and develop healthy and sustainable places and communities**
- **Strengthen the role and impact of ill health prevention**

The review also introduces two concepts; proportionate universalism and action across the life course that, amongst others, should be considered in work to address health inequalities. Proportionate universalism implies that in order to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

More detailed information on health inequalities in Bristol in the context of the Marmot review, bringing together available data in the key policy areas will be published as a supplement. The following provides an overview.

Give every child the best start in life

The Marmot review puts the highest priority on the early years, highlighting effects that early years have on lifelong aspects of health and wellbeing such as heart disease, obesity, mental health, educational achievement and economic status.

Data available for mothers smoking at the time of delivery, breastfeeding initiation, breastfeeding continuation and low birth weight show that the gap between the most deprived fifth of the population and the Bristol average or least deprived fifth has remained relatively unchanged over the monitored period. There has however been an overall reduction in those smoking at the time of delivery both in the most deprived fifth of the population and Bristol as a whole.

Data from children's centres being developed across the city are currently fairly limited but provisional figures suggest those Bristol families in the most deprived 30% nationally are well represented in children's centre registrations.

Early years attainment (as monitored by achievement on the Early Years Foundation Stage profile, including communication, language and literacy and personal social and emotional development) is improving in Bristol year on year and the gap between the lowest achieving 20% and the Bristol average is decreasing steadily.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

Education is linked with a range of outcomes including better employment, income and physical and mental health.

Assessments at Key stage 1 to 4 of children and young people in Bristol show wide variation in achievement in all subjects between those eligible for free school meals (a proxy for deprivation) and those who are not eligible. Where limited trended data is available for GCSE, (Key stage 4 level) no reduction in the achievement gap is apparent.

Overall however, achievement at Key stages 2 and 4 is improving. Key stage 2 data show Bristol had reached similar levels to that of the other core cities and other places with similar characteristics in 2009-2010. Key stage 4 results (GCSE or equivalent) for Bristol still remained below that of other places with similar characteristics in 2009/10 data. Between school achievement at Key stage 4 is also marked.

Bristol is achieving well compared to other places with similar characteristics and England overall in reducing the gap between those eligible for free school meals and those who were not eligible at aged 15, and their achievement of a level 2 or 3 qualification at aged 19. The percentage of young people Not in Education, Employment or Training (NEET) in March 2010 was also lower than it had been over the previous two years.

Create fair employment and good work for all and ensure a healthy standard of living for all

Good employment helps protect health; unemployment contributes to poorer health.
There is comparatively little data available around these two policy areas, particularly in relation to health in the workplace.

Overall Bristol has the lowest unemployment rate (as defined by the International Labour Organisation, ILO) of the core cities and a rate lower than the Great Britain average. Bristol also compares favourably to other core cities with regard to rates of worklessness (the proportion of the working age population claiming out of work benefits). Rates of claimants of Job Seekers Allowance in Bristol are roughly in line with national rates but higher than the South West average, rates of claimants climbed steadily between mid July 2008 and March-May 2009, after which they remained steady.

Create and develop healthy and sustainable places and communities

The health and wellbeing of individuals is influenced by the communities and environments in which they live.

Availability of green space, use of active modes of transport, proportions of people exercising at least 5 times a week, and walking time to a park or open space appear similar across the deprivation gradient. What does differ with deprivation is concern over climate change, numbers of road traffic collisions, use of green space and perceptions of availability and consumption of fresh fruit and vegetables.

Air quality and traffic pollution, and noise from traffic are reported fairly evenly.
Social isolation as determined by the percentage of people who never or rarely see or talk to extended family or friends is highest in the least deprived fifth of the population.

Strengthen the role and impact of ill health prevention

There continues to be a gap between the most deprived fifth of the population and Bristol as a whole in all-cause mortality and premature all-cause mortality, with the gap changing little over time. Life expectancy at birth continues to rise but the difference in years between the Bristol average and the most deprived fifth stands at 1.8 years, with a much wider differential between the most and least deprived wards (8.6 years).

All-age cancer mortality and premature cancer mortality data show a persistent gap between the Bristol average and the most deprived fifth of the population. Similar measures for cardiovascular diseases (all-age and premature mortality) suggest mortality rates across the Bristol population are slowly decreasing, with some lessening of the inequalities gap. Emergency admissions for stroke show marked differences between deprivation fifths, with those in the most deprived fifth of the population having approximately twice the rate of admission compared to those in the least deprived.

Smoking, hospital admissions attributable to alcohol and childhood obesity also follow steep inequality gradients with rates rising across the deprivation fifths of population. The rise in alcohol admission rates over the past few years in all deprivation fifths is of particular concern.

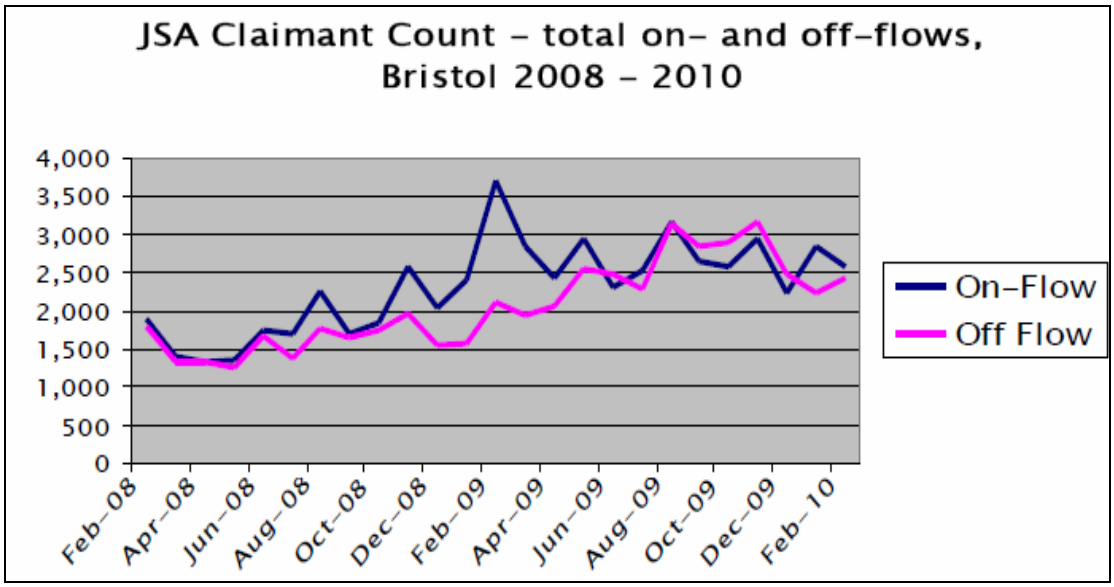
For the full report see www.marmot-review.org.uk/.

Health Impact of the Recession

The UK economy entered recession in the second quarter of 2008, which inevitably led to increased unemployment. When the recession began, predictions were made of potential adverse effects on public health as a result of job losses, such as a rise in mental health or addiction problems; the adoption of less healthy lifestyles (e.g. increased consumption of cheaper food with less nutritional value); smoking or "over-eating" (e.g. as a response to stress) as well as well as poor disease management (e.g. due to over-burdened health services or delays in patients seeking care due to worries about additional costs)[24].

Some small-scale surveys conducted in other European countries have shown an increase in suicide rates and mental health problems alongside cuts in health services[25]. In the UK, there have been reports of increased use of public services such as benefits and welfare advice, crime and domestic violence-related services and council-provided leisure facilities. The Audit Commission also published a report last year warning of potential increases in alcohol and drug addiction and in mental health problems[26].

Locally in Bristol, unemployment has risen since early 2008, with a peak in the number of people starting to claim Job Seekers Allowance (JSA) in March 2009 (Source: Bristol's Recession Story, data from NOMIS):



The steady rise in Job Seekers Allowance claimants has been attenuated by a steady rise in the number of people ceasing to claim Job Seekers Allowance (called off-flow in the graph above).

[24] Maslen C. The Impact of the Recession on Health – an Evidence-Base Rapid Review. Bristol Public Health, 2010.
[25] Richards T 2009 Governments must act now to prevent slide into poverty and ill health after recession BMJ 339:b4087
[26] Audit Commission 2009 When it comes to the crunch: How councils are responding to the recession

As noted above, unemployment has a damaging effect on psychological health (which is independent of pre-existing health) and much research has found a strong correlation between involuntary job loss and clinical and sub-clinical depression, anxiety, substance abuse and antisocial behaviour[27].

In Bristol, one way of monitoring this impact is through monitoring prescribing rates of anti-depressants. There have been changes in prescribing rates between quarter 1 (April to June) and 3 (October to December) of each of the financial years from 2007/08 to date.

Prescribing rates of anti-depressant and similar or related drugs

		Change in prescribing rate
Q1 to Q3,	**2007/08**	5.7% increase
Q1 to Q3,	**2008/09**	7.3% increase
Q1 to Q3,	**2009/10**	4.9% increase

The data from Q1 to Q3 2008/09 shows the largest increase in prescribing compared to the same period in 2007/08 and 2009/10. This roughly coincides with the period when the number of people coming on to the Job Seekers Allowance claimant roll was seeing an increase.

However the peak in Job Seekers Allowance claimants was around March 2009 and there is likely to be some delay between becoming unemployed and feeling depressed or anxious.

Further analysis[28] of the data indicated a correlation between the increase in residents claiming out of work benefits and the increase in prescribing rates of anti-depressants. This correlation suggests that around 13% of the increase in anti-depressant prescribing rates may be due to the increase in claimants of out of work benefits.

As we come through the recession, there is a continuing risk of a recession "double dip" (with associated implications for mental health and wellbeing). In Bristol, approximately 48,700 people are employed in the public sector (21.1% of Bristol's total employment), thus any impact from proposed public sector efficiency savings also needs to be factored in. There is some good news however; Bristol has been assessed as the most resilient of any large urban area due the presence of high growth businesses and a well-qualified workforce.

For a full, updated Local Economic Assessment in Bristol see the Business support and advice section on the Bristol City Council website:
http://www.bristol.gov.uk/ccm/navigation/business/business-support-and-advice/economic-information-and-analysis/

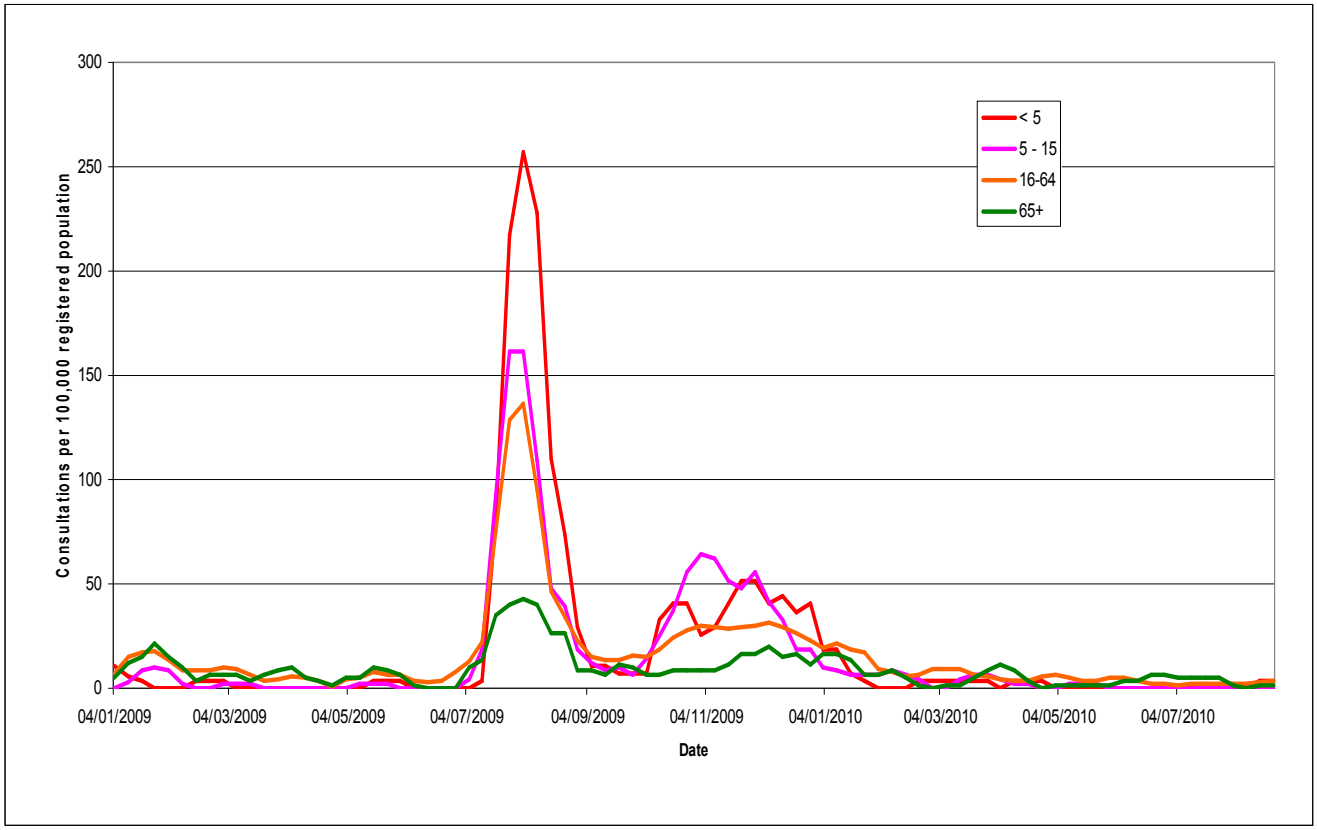
[27] Catalano R 2009 Health, medical care and economic crisis NEJM 360(8): 749-751
[28] Health and the Recession: Unemployment and Mental Health, NHS Bristol, April 2010

Local Resilience and Emergency Planning

When commissioning services (developing or changing services locally to improve health and wellbeing and reduce inequalities), it is important to remember that services must be prepared and resilient in "normal" times and also at times of any future crises. Hence appropriate JSNA information will be made available to support emergency preparedness, contingency planning and commissioning functions.

Pandemic Flu example

It is now more than one year since the peak of the first wave of Pandemic (swine) flu in Bristol (see graph below). During the July 2009 peak (week ending 26th July 2009), the rate of primary care (GP-led) consultations for flu-like illness[29] in Avon was 245 per 100,000 population. Just over one year later (week ending 22nd August 2010) the rate had returned to the more "normal" levels for the time of year of about 3 cases per 100,000 – a huge difference.



In Bristol (and in line with national trends), those with the highest infection rates were in the younger age groups (especially children under 15 years old), with the elderly relatively less affected. This pandemic, although relatively mild, created a significant pressure on key services (health, social care, education etc). Services actually coped very well – a tribute to the detailed planning and preparedness locally in anticipation of such an event. However, there are key lessons to learn from this experience, especially as the next event that comes along may be less mild and create even greater pressure on hard-pressed services.

[29] This includes all patients with a Flu-like illness and not just those with Swine Flu, as it is clinically not possible to differentiate between different types of Flu without Laboratory testing.

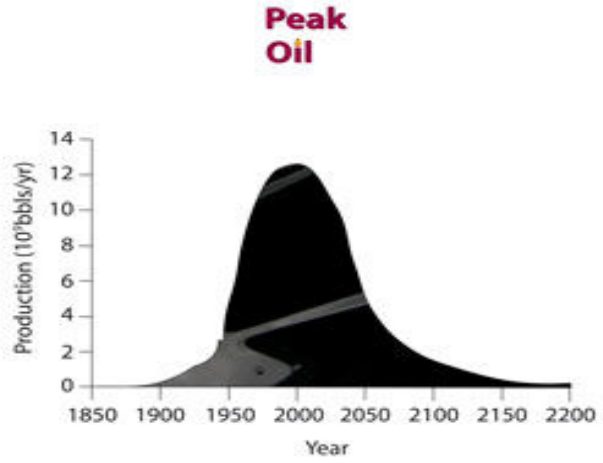
Climate Change and Sustainability

Human populations are facing a unique set of challenges, with profound implications for health and healthcare.

One hundred and fifty years' of cheap oil has enabled construction, transport, food production, medical advances, and population growth on an unprecedented scale. Unfortunately, as well as giving us a quality of life that our ancestors could only have dreamed of, this has also caused loss of biodiversity, acceleration in climate change because of greenhouse gas emissions, and major depletion in non-renewable resources.

Energy

According to the UK Energy Research Group[30] global oil production will most likely reach a peak before 2030. Once we are past the peak then each barrel of oil gets more and more difficult to extract. There may be lots more oil somewhere, but if the energy needed to extract it is nearly as much as the energy you will get from it, then the economics, and the gap between supply and demand is very different from what we have been used to up to now.



A report produced in autumn 2009 'Building a positive future for Bristol after Peak Oil'[31] contains recommendations that are of essential importance for the future health and prosperity of Bristol citizens. The report highlights the need for:

- leadership on preparing for peak oil
- engaged communities
- planning and transport decisions based around local accessibility to essential goods and services
- actions and policies to support a sustainable food system focused on robust local supply chains
- creation of jobs and skills that are relevant in a fossil-fuel depleted future.

[30] Sorrell S, Speirs J, Bentley R, Brandt A, Miller R. Global Oil Depletion. An assessment of the evidence for a near-term peak in global oil production. UK Energy Research Centre. August 2009. ISBN 1-903144-0-35 http://www.ukerc.ac.uk/support/Global%20Oil%20Depletion Accessed 6 October 2010

[31] Osborn S. Building a Positive Future for Bristol after Peak Oil. Bristol Partnership. October 2009 http://www.bristol.gov.uk/ccm/content/Environment-Planning/sustainability/file-storage-items/peak-oil-report.en Accessed 26 May 2010

An editorial in the British Medical Journal in September 2010[32] highlights the fact that 'health care will change, whether we like it or not, and carbon reduction, fuel depletion and financial stringencies have to be looked at together'. It emphasises the need for 'simpler more robust systems that are capable of local maintenance, and the importance of fairness regarding access to food, water, transport, and essential health care.' Responding to this article, a senior economic adviser to the Department of Health[33] states 'We need now to be discussing and preparing for the bumpy ride…however uncomfortable (and "negative") such a debate might be. In the short to medium term, the biggest single impact of peak oil on health care is likely to be significant economic dislocation, with direct impacts on NHS funding and coverage, and generalised economic insecurity across the entire population.' This is a major issue that affects strategic planning for health.

Environment

Human health depends on what are termed 'ecosystem services' - a liveable climate, clean water, food, natural resources etc. At present, our way of life is putting these services under threat, so we need to change our 'ecological footprint'. This is important for reducing health inequalities too, because climate change and environmental impacts of climate change, will most affect those who are already the least well off[3435]. The NHS Carbon Reduction Strategy[36] guides the way for a 10% cut in carbon footprint 10% 2015 (from 2007 benchmark). NHS organisations and all other service providers also need to ensure that services are well prepared for extreme weather events, hotter drier summers, and wetter winters, which Met Office projections show are likely[37]. These mitigation and adaptation requirements need to be incorporated into strategic planning within the health sector and across civic society. We can change our management of energy use in buildings, of travel and transport, of food production, of procurement, and of models of care. Many of these aspirations are contained within the Bristol 20:20 Plan (Bristol's Sustainable City Strategy)[38], and many of the changes that reduce our ecological footprint also make life better, communities more engaged, and improve health outcomes for people.

[39]

[32] Raffle A E. Oil, health and healthcare. BMJ 2010;341:c4596

[33] Hensher M. Oil, health and healthcare. BMJ 2010;341:c4596 response

[34] CAG Consultants. (2009). Differential Social impacts of Climate Change in the UK: SNIFFER (Scotland and Northern Ireland Forum for Environmental Research) http://www.cagconsultants.co.uk/resources.html

[35] Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R *et al*. Managing the health effects of climate change: Lancet and University College London Institute for Global Health Commission. *Lancet* 2009;**373**:1693-733.

[36] Pencheon, D. Saving Carbon, Improving Health. NHS carbon reduction strategy for England. 2009. Cambridge, NHS Sustainable Development Unit http://www.sdu.nhs.uk/

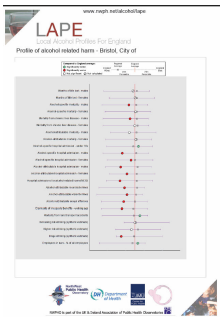
[37] Met Office Climate Change Projections UKCP09 June 2009 http://www.metoffice.gov.uk/climatechange/science/projections

[38] Bristol 20:20 Plan (Bristol's Sustainable City Strategy) – see http://www.bristolpartnership.org/vision-for-bristol

[39] Bristol 'Playing Out' project June 2010: Photo by Kamina Walton. www.playingout.net

Progress and Data Updates

The JSNA core data set was updated with the latest available information during autumn 2010. The core data set is accessed via a web-based flexible tool called Instant Atlas, which allows you to choose what information to display across a ward map of Bristol. This is particularly useful when comparing different areas of the city. The tool also allows you to view historical trends in the data. If you would like to do further work with the data, e.g. for drafting a commissioning strategy, Instant Atlas provides the ability to download the data behind the map into a table.
The core data set is available via Bristol Data Profiles website, a partnership website that brings together a wide range of statistical reports and atlases, relating to Bristol at many different geographic levels. Along with the JSNA core data set, data from Bristol Quality of Life survey and other information is also available. Bristol Data Profiles website is http://profiles.bristol.gov.uk/.
Scroll down this page to:
- section 5 to find the JSNA
- section 4 to find the Quality of Life survey
- section 14 to find Mosaic Public Sector Profiles



North West Public Health Observatory published the 2010 Local Alcohol Profiles in September 2010. This is a profile of alcohol related harm for local authority areas. Bristol does not compare favourably with England, with over half the indicators being significantly worse than England for Bristol. When compared with Core Cities, Bristol stands out as being one of the worst Core Cities for alcohol related crime. For more information on the alcohol profiles please see www.nwph.net/alcohol/lape/.

The Association of Public Health Observatories (APHO) published the 2010 Health Profiles in June 2010. In Bristol we re-analyse the APHO data to compare Bristol against other Core Cities, this analysis can be seen on page 7. The original APHO Health Profile is available on the APHO website, the re-analysed profile is on the Bristol Partnership website. Web links are as follows www.bristolpartnership.org/intelligence for re-analysed profiles and www.apho.org.uk for original APHO profiles.

The Bristol Director of Public Health (DPH) Annual Report was released in October 2010 along with the data annex that contains a wealth of health data about Bristol. Both the annual report and the data annex are available from www.bristol.nhs.uk/about-us/publications/public-health-report.aspx

Every Child Matters (ECM)

The Every Child Matters survey represents the views of over 5000 young people in Bristol and has been undertaken for the last 3 years. Questions cover areas of the ECM agenda including healthy eating, physical activity, emotional health and wellbeing, bullying relationships, sexual health, drugs, school absence and young people's aspirations

Reports are available at: http://www.bristol.nhs.uk/your-health/healthy-schools.aspx

Bristol Children and Young People Needs Assessment

Bristol Children and Young People's Service are currently producing a needs assessment to provide the strategic context for improving outcomes for children, young people and families in Bristol. It will provide a solid foundation for the development of:

- Bristol's Children and Young People's Plan 2011-2014
- Bristol Safeguarding Children Board Plan (which will then become the safeguarding element of the CYP Plan)
- Bristol's Child Poverty Strategy.

It may also be used to inform and enrich other needs assessments within the Children and Young People's Trust and Bristol Partnership.

The document will form the appendix to the CYP Plan, and will be based around the five *Every Child Matters* themes, plus sections on *demography* and on *child poverty*. A Draft Plan was released in Dec 2010 for consultation (ongoing until March 2011), and updates will be made available on a blog site, which will allow stakeholders to respond to information as it becomes available. The address for the site is: http://bristolchildren.wordpress.com

Crime and Disorder Strategic Assessment

Safer Bristol Partnership published their Crime and Disorder Strategic Assessment in December 2010. The strategic priorities in the assessment are:

- Reducing Re-offending
- Making Bristol the Safest Core City by accelerating acquisitive crime reductions
- Addressing Anti-social Behaviour across the City
- Improving the levels of Public Protection
- Trinity Neighbourhood
- Cross-cutting Issues – Organised Crime Groups and Drugs

The document also contains a range of crime statistics for Bristol. To see the full document please see the Safer Bristol website:
http://www.bristol.gov.uk/ccm/navigation/community-and-living/crime-prevention/

Bristol Drug Treatment Needs Assessment 2010

To inform the Bristol 2011/12 Drug Treatment Plan, the Safer Bristol Partnership conducted a joint community and prison adult drug treatment Needs Assessment, carried out between November 2010 and January 2011. A range of partners have been consulted from local services in health, housing and employment, criminal justice and prison and a variety of relevant national and local data sources have been gathered and analysed.

The key findings include:

- National Treatment Agency national prevalence estimates suggest that there are 5285 Problem Drug Users (PDUs) in Bristol. These are users of heroin and/or crack cocaine. Of these, 4304 are estimated to be opiate users and 3630 crack cocaine users. Bristol ranks as the second highest rate of PDUs among the English Core Cities of Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham and Sheffield.

- 68% (3572/5285) of the estimated problem drug users in Bristol have had contact with structured treatment services in the 2 year period 2008-10. Tier Two services in the Bristol treatment system, including needle exchange, engage large numbers of drug users but not all of these clients enter structured drug treatment.

- 95% of clients in treatment in Bristol are heroin and/or crack cocaine users compared to a national proportion of 84%. This raises questions about the ease of access to treatment for other drug users in the city. The current treatment system does not appear to provide adequate service provision to engage non-PDUs and achieve successful outcomes for this client group.

- The young people's data shows a 9% reduction in the total number of young people in treatment between 2008-09 and 2009-10 from 292 to 267 respectively. Data about main substance was recorded for 272 young people during 2009-10. The most prevalent pattern was poly drug use involving cannabis and alcohol. 45% of young people in treatment were recorded in this category. There has been an increase in positive outcomes for young people in treatment in terms of planned discharges, which have risen this year to 79% from 52% last year.

The Needs Assessment demonstrates that major changes need to be made to the current treatment system to increase the likelihood of clients achieving successful exit from treatment and move on from drug use. The full report includes gender, age and ethnicity information for this client group, service waiting times, mental health, unemployment and housing, needle and syringe provision and blood born virus screening.

The full report is available on the Safer Bristol website: www.saferbristol.org.uk.

Preventable Hospital Admissions

During 2010, new sources of data on unintentional injury were developed. These included mapping A&E patient attendances to highlight where accessing urgent care services may be more difficult; a Walk in Centre survey on the main causes of minor injuries, leading to new awareness campaigns [see: Walk in centre]; and new projections on the increasing numbers of injurious falls in the elderly population to inform future falls prevention - which estimate falls-related admissions (over 65) may increase around 85% over the next 15 years [more detail: rob.benington@bristol.nhs.uk].

In addition, NHS Bristol and Cycling City partners worked together to improve the safety and enjoyability of cycling by evaluating the causes and circumstances of "*non-collision* cycling injuries" (the largest cause of all hospital admissions for cyclists). This was the most detailed study into this issue so far conducted in Great Britain and informed a winter campaign to raise awareness of the key hazard identified - slipping on ice. [Full details at: Non collision incidents].

Learning Difficulties and Health needs

In Bristol, a Sexual Heath Needs Assessment was undertaken in 2010 to investigate increasing local evidence that Sex and Relationships Education (SRE) and access to sexual health services may not be meeting the needs of children, young people and adults with learning difficulties. Through engaging with local people with learning difficulties, the people that support them, sexual health services and learning difficulty organisations, it was identified that there are multiple gaps in current services and the provision of SRE needs improving. For a copy of the full report please see: http://www.bristol.nhs.uk/about-us/publications.aspx and scroll down to "Sexual Health" – there is also an Easy English version.

On a national level, the Learning Disabilities (Difficulties) Observatory was established in 2010 to provide better information and statistics on the health and wellbeing of people with learning disabilities. Further information is at www.improvinghealthandlives.org.uk/.
Relevant reports on the health needs of people with learning difficulties include:
- Health Inequalities & People with Learning Disabilities in the UK in 2010:
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf
- Health Inequalities & People with Learning Disabilities 2010 - actions for commissioners:
www.improvinghealthandlives.org.uk/uploads/doc/vid_8360_IHAL2010-01%20Health%20Inequalities4%20(3).pdf

Homelessness

A homeless health needs audit, in conjunction with Homeless Link, has been undertaken. Surveys were conducted with clients from a range of homelessness agencies in Bristol between December 2009 and March 2010 covering access and usage of health services; physical and mental health; drug and alcohol use and access of screening and vaccinations.
This information is intended to provide a broad baseline of local need among this population, suggest patterns in usage of services, and suggest where potential gaps exist.

The full report can be found at: http://www.homeless.org.uk/health-needs-audit but key findings include:

- 89% of clients are registered with a GP (the majority permanently). 40% are registered with a dentist.
- 84% of clients smoke (but 31% of smokers want to give up)
- 56% of clients say they eat at least 2 meals per day on average, BUT
    - Only 6% eat 5 or more pieces of fruit or vegetables per day.
    - 40% do not eat any fruit or vegetables
- The most common physical health problems were related to:
    - sleep problems (57%)
    - joint pain/problems with bones and muscles (46%)
    - dental problems (41%)
    - chest pain/breathing problems (37%)
- 67% of clients say they use one or more type of drug
- 78% of clients drink alcohol. The amount consumed varies, but 34% of those who say they drink indicate that they usually drink more than 10 units of alcohol each time they drink
- 76% of clients reported one or more problems relating to mental health and 57% said they had a long term mental health need or condition
- Approximately a third of clients on average received vaccinations or accessed screening.

Housing – making the links to Health

Among its outcomes the Housing Strategy seeks to provide an environment for healthier living and to address social and health inequalities. The 2009 Government green paper[40] noted: "We need services that will keep people independent and well for longer... one way of doing this is through better joined up working between health, housing and social care services…"

The City Council has sought to address this by setting up a multi-agency strategic partnership to deliver the Housing Strategy called Homes4Bristol. It brings together representatives including the council, the PCT, private and social landlords, developers and lenders to ensure a joint approach to tackling housing issues.

Mind the Gap

The first of the Housing Strategy's three themes, 'mind the gap', proposes actions to help bridge the deprivation gap in access to housing. The gap results in greater costs and less value for money both for individual households and the city as a whole. For some households this will result in overcrowding or homelessness that have serious implications for health, wellbeing and educational attainment.

Focus on the private sector

In this sector 23.8% of vulnerable households live in a non-decent home.

The most common 'danger to health' hazards found in private homes were: excess cold; danger of falls; damp and mould growth; and entry by intruders. Since 2003 by investing in partnership working and providing a range of grants, loans and enforcement activity including 'named' Government funding [41], 1,944 properties were made decent and 1,841 serious hazards were dealt with. Action to alleviate hazards has been through area based targeted action in some of the most deprived areas of the city (declared Home Action Zones); e.g. tackling the 'excess cold' hazard through funding the Bristol Energy Efficiency Scheme (BEES[42]) and the 'entry by intruders' hazard through funding the Police Safer Homes vans. Relevant Housing Strategy action: 'increase the number of properties with increased insulation measure installed …by the council or its partners' (impacts on health, household expenditure and the environment)

Challenges from 2011 - The 2010 Comprehensive Spending Review removed Private Sector Renewal funding from the council. This will result in most of the proactive work undertaken in recent years stopping from April 2011 e.g. energy efficiency and most housing repair work. The service will continue to target action through two priorities:

- *Introduction of the Bristol Housing Management and Quality Standard* - targeted at deprived neighbourhoods across all housing tenures. Aiming not only at improving housing standards, but also the management of rented accommodation and the broader local environment.

- *Targeted enforcement powers* - target action at the worst landlords who are housing many of the most vulnerable households in the city. Landlords will be encouraged to improve their accommodation (and bring it back into use if empty) to meet an 'Accreditation' standard which ensures homes are decent and have no serious hazards. Where encouragement fails, the service will use the full range of legal powers to improve housing conditions.

[40] 'Shaping the future of care together'
[41] Private sector renewal fund
[42] BEES: since 1998, targeted on an area basis to install insulation in privately owned or rented properties for vulnerable households

Health impact assessment of the Housing Strategy

The link between good housing and healthy communities is recognised in the Housing Strategy in another theme, 'healthy home, healthy you, healthy city'.

We know that in some parts of the city there are substantial variations in the quality, tenure and type of housing. These variations are linked to health as well as education, income and social cohesion. Inadequate housing is closely linked to:

- Lower general health and subjective perceptions of wellbeing
- Greater health inequality
- Higher health and safety risks - especially overcrowding[43]
- Lower household income
- Limited community cohesion

In addition, national and local research indicates areas that have poor quality housing and local infrastructure tend to have greater than average health problems such as respiratory and heart problems and admissions to hospital due to falls.

The Housing Strategy has it's own action plan - all the actions should improve health outcomes.

Home Adaptations Service

Housing Strategy action: 'improve delivery of aids and adaptations to vulnerable people'. This service is available to all disabled people regardless of housing tenure. In 2009/10 there were 822 major adaptations and 1,271 minor adaptations[44] carried out. This service aims to prioritise effectively and for example discharge from hospital cases are fast tracked. Demand is increasing year on year and a Service Review to improve the major adaptations part of the service is due to be completed in January 2011.

Sustainable environments

Creating sustainable environments will help to promote healthier communities and further the progress of Bristol's Green Capital programme. Investment and good levels of maintenance and repair will help sustain healthy homes, people and communities.
In addition support for vulnerable households through programmes such as **Supporting People** is crucial, helping some to maintain independence and for others to achieve independence (see 'did you know' page 22).

In conclusion the illustrations above demonstrate how the efforts of housing agencies contribute to better health outcomes.

[43] Overcrowding is an acknowledged contributor to lower educational achievement and higher health risks to vulnerable groups. By the end of 2010, the council will have completed an overcrowding pathfinder action plan to help reduce it.
[44] Minor adaptations = up to £1,000, major adaptations = over £1,000

Locality Commissioning Organisation Profiles

NHS Bristol Public Health are developing health and wellbeing profiles for the forthcoming locality commissioning organisations. The profiles will bring together public health intelligence, NHS and social care activity analysis and information on wider determinants of health such as deprivation, lifestyle and economic indicators from variety of sources, for example from Bristol Quality of Life survey and the Office for National Statistics.
Further information is available at www.bristol.nhs.uk

Neighbourhood Partnerships Statistical Profiles

Bristol City Council released updated neighbourhood statistical and mosaic profiles in May 2010. In 2008, Bristol introduced Neighbourhood Partnership Areas as a new form of Neighbourhood Governance across the city.

Each Neighbourhood Partnership is made up of two or three electoral wards, and there are fourteen Neighbourhood Partnerships in total across the authority. Neighbourhood Partnership Statistical Profiles have been compiled for each of these areas, incorporating a range of statistics held by Bristol City Council.These are a collection of the most up to date data from a variety of sources available at geographic levels lower than Neighbourhood Partnership Area. This includes ward and LSOA (Lower Super Output Area) level data.

The Mosaic Public Sector profiles classify all citizens in the United Kingdom by allocating them to one of 61 Types and 11 Groups. The Groups and Types in these profiles paint a rich picture of UK citizens in terms of their socio-economic and socio-cultural behaviour. Bristol City Council has produced a mosaic profile for each neighbourhood partnership area in Bristol.

For further information and to see the neighbourhood partnership statistical profiles and the mosaic profiles please go to http://www.bristol.gov.uk/ccm/content/Council-Democracy/Statistics-Census-Information/neighbourhood-partnership-profiles/neighbourhood-partnerships-statistical-profiles-.en

Health and Wellbeing Factsheets

Improving health and tackling inequality are amongst Bristol City Council's main priorities.
A series of factsheets have been created that provide information about some of the key health issues facing our city and what is being done to address them.

Various Bristol City Council and NHS Bristol teams, projects and initiatives supplied information contained in these factsheets. They can be accessed at the following web-link:
www.bristol.gov.uk/healthfactsheets

Putting People First in Bristol (PPFB)

Putting People First is a government initiative to transform social care with four key elements:

- Providing more **choice and control** to people using social care services
- Focusing on **prevention and early intervention** approaches
- Improving universal access to **information and advice**
- Building s**ocial capital**

PPFB is a 3-year programme to deliver these changes, from 2008 to March 2011, when it will have delivered on key milestones. The council has engaged with stakeholders to inform the transformation and redesign of social care through the PPFB programme (and key elements of this work will continue through the HSC Transformation Programme, to build on PPFB and bring lasting transformational change across care delivery and commissioning). For more information on PPFB, see the Putting People First pages on the Bristol City Council website:
http://www.bristol.gov.uk/ccm/content/Health-Social-Care/ppfb/putting-people-first-in-bristol.en

Bristol Somali Community Calculator

Censuses are carried out every 10 years, however, people move and populations change more frequently. Sometimes it is hard to get reliable population figures in the intervals between censuses. This is especially true for some of the more "mobile" sub-groups of the population. Yet, reliable figures are needed in order to plan services.

A wide range of estimates of the size of Somali population in Bristol is regularly quoted, with some estimates of up to 30,000 Somalis living in Bristol. It is known that there has been a significant increase in the number of Somalis in Bristol; however, it has been difficult in the past to produce any reliable estimates.

When refugees or asylum seekers flee, they often initially settle in one area / part of the country but may then move to another one, perhaps to reunite with extended family members or friends. So they may initially appear in the registers / lists of an area and may not be de-registered by the services when they move – thus artificially inflating numbers.

Bristol City Council's consultation, research and intelligence team have developed a methodological tool for estimating the size of the Somali community within Bristol called the Bristol Somali Community Calculator. The estimates are based upon a number of variables including information from the 2010 School Census and ONS Birth Statistics, combined with information from a local survey undertaken in 2007/8.

A large number of different scenarios were run using the Bristol Somali Community Calculator and the results were that there are an estimated 6,600 – 10,000 Somalis living in Bristol. This is the first time Bristol has had a clearer based estimate of the size of the Somali population.

Further information will be included in the new version of BCC's "The Population of Bristol" document to be released later this year.

Bristol City Council Quality of Life Survey

In May 2010 the results of the 2009 Quality of Life Survey were released. Based on the trends of over 50 indicators measured by this residents' perception survey, quality of life has generally improved in Bristol in 2009 compared to previous years.

General health in Bristol is improving or staying good and we compare favourably with similar cities based on the indicator results in this report. Fewer residents say they smoke and more people eat a healthier diet. Levels of obesity and limiting long-term illness remain stable, as do levels on happiness and wellbeing, and Bristol is similar to the national average. Of concern is the drop in exercise levels and participation in active sport.

Wealth inequality is measured using the indicators 'satisfaction with jobs' and 'skills and qualifications'. The latter has remained relatively stable for the last five years, but satisfaction with jobs is declining, which may reflect the current economic situation.

For more information and the full report please go to www.bristol.gov.uk/qualityoflife.

Knowledge Gaps and How We Are Tackling them

Do we know what we don't know?

- We need to know more about the health needs of vulnerable groups such as newly arrived children (including asylum seeking families and travellers) and children of offenders. The JSNA could help commissioners understand their needs better

- Children may experience avoidable (preventable) hospital admissions, thus better intelligence on trends (and bench marking) could help identify opportunities for improvement.

- An additional priority for Bristol is tackling child poverty and its effects through improved joint targeting. The JSNA could play a role by analysing and highlighting the specific health issues associated with child poverty.

- At present the Council data collection systems do not record numbers and existing expenditure for people with Autistic Spectrum Conditions (ASC). It is being proposed that these systems are adjusted to explicitly cover ASC, so that data from the PCT and Local Authority can feed in to the JSNA to establish the local picture and assist with strategic planning and commissioning.

- Data on the ethnic origins of patients has historically been a gap in health data. Many major diseases, for example coronary heart disease, diabetes, and tuberculosis, are believed to be more common in one or more ethnic groups than in the overall population. Research also indicates inequalities in health outcomes and access to health interventions between ethnic groups. A comprehensive means of monitoring ethnicity and language information is currently being rolled out to practices across NHS Bristol, which will, in the future, help us to build the evidence needed to address these issues.

- The Personalisation agenda within Social Care services is having a profound effect on how services are delivered to people. The effects of this will mean that processes for incorporating the views of local people into the JSNA will need to evolve, as people begin to have more control over their own Social Care "personal budgets", and access universal services more. We will need to incorporate the views of all service users, including those who fund their own care.

- In a changing policy landscape, the JSNA will need to be refreshed in line with changing priorities. The forthcoming transfer of health commissioning responsibilities from PCTs to GP Consortia is a prime example of such changes on the horizon.

- The more questions we ask, the more gaps are uncovered. Helping to fill those gaps is essential in order to ensure that planners and commissioners of services have access to the information and strategic intelligence that they need to make informed choices

Conclusions and Next Steps

This Joint Strategic Needs Assessment (JSNA) is an evolving document, intended to provide the underpinning data and analysis to support decision-makers and inform commissioning decisions throughout health services, adult social care and services for children & young people across Bristol, especially given the financial climate and need to achieve efficiencies and promote quality services. It provides a new Commissioning Model, with a focus on commissioning for health and wellbeing for the future, which is designed to be used to underpin commissioning work across NHS Bristol and Bristol City Council.

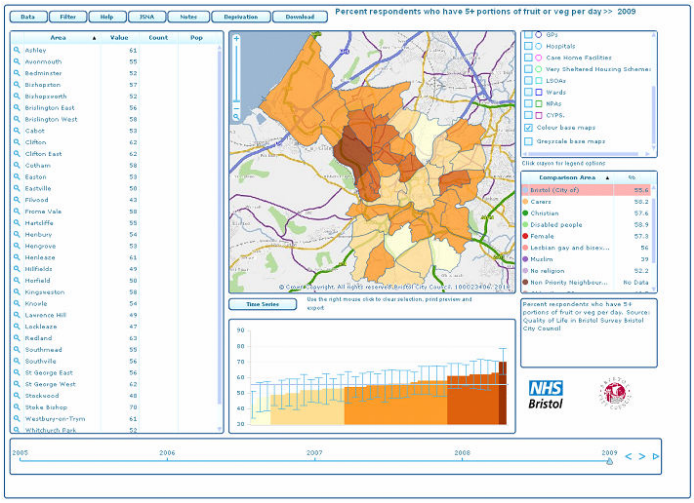
In order to effectively progress the JSNA forward, there are 6 key areas to work on:

- **Re-alignment**

Re-align the JSNA in view of the changing policy landscape (e.g. introduction of GP Commissioning Consortia) to ensure it continues to be fit for purpose.

- **Building Evidence**

Continuously add to the evidence base, through identifying information gaps and looking ahead in terms of changing needs and financial pressures.



The core dataset is available on Instant Atlas through the JSNA section on the Bristol Data Profiles website: http://profiles.bristol.gov.uk/

Data is provided by Ward, and Time Series data now tracks changes over time.

If you would like to do further work with the data, e.g. for drafting a commissioning strategy, Instant Atlas provides the ability to download the data behind the map into a table.

- **Existing Services**

Provide information to support service re-design to improve quality and efficiency of services, address inequalities and provide more personalised services closer to home.

- **Communication**

Ensure that all those who need strategic planning information can access the JSNA to inform their decisions, and that it is available in different formats to be widely accessible.

- **Managing our Knowledge**

Continuously improve the way we collectively store, analyse and share data and intelligence, and review how this is used to inform commissioning decisions.

- **High Performance**

Ensure that the JSNA is locally and widely recognised as an example of best practice, and is a key document in strategic decision-making across the local community

Glossary of Terms

Term / Abbreviation/ Name	Definition
BME	Black and minority ethnic groups - Mixed, Asian or Asian British, Black or Black British, Chinese or other ethnic group (ONS definition).
Commissioning	A continuous cycle of activities that contribute to the securing of services, including assessing the need in the population, specification of services to be delivered, contract negotiations, target setting, monitoring and managing performance, identifying where change is needed and initiating change.
Comprehensive Spending Review	A governmental process carried out by the HM Treasury to set firm and fixed three-year departmental expenditure limits and, through public service agreements, define the key improvements that the public can expect from mass resources.
Core Cities	Bristol is a member of Core Cities, a working group of eight major cities in England, outside of London. These are Birmingham, Liverpool, Leeds, Manchester, Newcastle, Nottingham and Sheffield.
Demographic	The characteristics of a human population, e.g. age, gender, race.
IDEA	Improvement and Development Agency – an organisation which supports improvement and innovation in local government
Health inequalities	Gaps in the quality of health and health care across racial, ethnic, sexual orientation and socioeconomic groups
JSNA	Joint Strategic Needs Assessment – an ongoing process of understanding the health and wellbeing need in Bristol, to provide key findings to inform the commissioning of health and care services.
Proportionate universalism	It implies that in order to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
Regional Centres	A comparator group of 19 local authorities which have similar socio-demographic characteristics as defined by the Office for National Statistics (ONS). The 19 regional centres are Bristol, Salford, Liverpool, Sheffield, Newcastle, Leeds, Plymouth, Bournemouth, Southend, Brighton & Hove, Portsmouth, Southampton, Exeter, Eastbourne, Hastings, Lancaster, Lincoln, Norwich and Worthing.
Serious Acquisitive Crime	Offence where the offender derives material gain from the crime.
Social determinants of health	The economic and social conditions under which people live which determine their health, e.g. income, education, employment.
Statistical neighbour (NHS)	A comparator group of 8 local authorities which have very similar socio-demographic characteristics as Bristol as defined by the Office for National Statistics (ONS). The members of that group are as follows: Plymouth, Norwich, Bristol, Salford, Newcastle, Southampton, Sheffield and Leeds. The Statistical Neighbours group is a subset of the ONS Regional Centres comparator group.
Obese	Body mass index (BMI), a measurement which compares weight and height, defines people as obese when it is greater than 30 kg/m^2. Body mass index is defined as the individual's body weight (kg) divided by the square of his or her height (m)

Alternative formats

If you need this information in a different format, please contact Nick Smith, JSNA Project Manager at **JSNA@bristol.gov.uk, o**r phone on (0117) 9037304 – if not available, please leave a message.

Acknowledgements

And finally… we would like to thank everyone who has been involved in compiling the 2010 JSNA Update Report. There are too many to mention individually, but many thanks to all the staff and other stakeholders who have contributed, especially from NHS Bristol, Bristol City Council, LINk and the Care Forum.