Joint Strategic Needs Assessment 2012

Strategic Summary

Understanding Health and Wellbeing in Bristol

The Joint Strategic Needs Assessment (JSNA) is an ongoing process to identify the current and future health and wellbeing needs of the local Bristol population. It informs decisions about how we design, commission and deliver services (both now and in the future), to improve and protect health and wellbeing across the city while reducing health inequalities.

The JSNA 2012 (formerly JSNA 2011-12) is an updated re-structure of the previous JSNA Baseline. The detailed evidence base is contained in the separate Data Appendices, including individual summaries. These are referenced throughout this Strategic Summary, which provides an overview of the changing health and wellbeing picture in Bristol.

The JSNA raises questions such as:

- Are demographic changes reflected in commissioning plans?
- Are services appropriately targeted and tailored to reflect need?
- Are there significant areas of un-met need?
- What are the pressures on services in the future?

The development of Bristol's Joint Health and Wellbeing Strategy will be informed by the JSNA. The JSNA provides the objective assessment of local needs, and the Joint Health and Wellbeing Strategy is where decisions, opinions and priorities will become involved. It is an opportunity for Bristol, through the Health and Wellbeing Board, to agree what the priorities for Bristol are.

The Bristol JSNA website is **www.bristol.gov.uk/JSNA**, including 2012 Data Appendices. The JSNA Atlas (an on-line profile of ward-level data) is at http://profiles.bristol.gov.uk (profile 5). For queries or different formats, please contact JSNA@bristol.gov.uk.

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Census update: (v8 Dec 2012)

Bristol JSNA 2012

Bristol is a rapidly growing city[1]. It is a diverse city[2] with a relatively young population[3] and a strong local economy[4]. On a range of health indicators[5] Bristol ranks as one of the healthiest of the Core Cities[6] (and of other comparable cities), even though Bristol may not compare so well to the England or Southwest averages. The population growth means that the health needs in Bristol are growing and changing. In order to meet these, especially given current financial constraints, requires everybody's combined efforts. Health is "everybody's business" not just that of the health and social care sectors alone.

For Bristol overall, health and wellbeing has gradually improved for many indicators. However, the main story is in the differences within Bristol. The overall citywide picture can hide the differences in experiences for different areas and population groups within the city. There are areas of Bristol that are very affluent, and areas that rank amongst the most deprived in the country[7]. Child poverty[8] in Bristol is significantly higher than the average rate for England, and there are stark health inequalities between different areas.

As a proxy for inequalities and deprivation issues more generally (including income), where you live in Bristol can be seen as one of the biggest factors affecting your health and wellbeing[9]. This is explored below through the 3 Locality areas (of the Bristol Clinical Commissioning Group[10]), which broadly reflect different aspects of this picture (although there are also strong differences within these localities, particularly in the North of the city).

Many of the big health issues for the city mirror national challenges. For example, cancer is still the biggest killer of people under 75 (38%), followed by cardio-vascular diseases (23%)[11]. Obesity is a major contributing factor to poor health outcomes[12], as is smoking[13] and the rise in alcohol consumption[14]. Mental ill health[15] has a major impact on wellbeing. Appropriate support for older people with dementia is a growing issue[16], as is support for people with Long Term Conditions[17] and the need to better integrate social care and health services. And the current financial challenges highlight issues such as better directing people (in non-emergencies) to access primary care (eg GPs) rather than more costly secondary care services (eg hospitals)[18]. However, some of the challenges are specific to Bristol, such as the needs of Bristol's rapidly growing child population.

Since the last JSNA there have been notable changes in Bristol, including major health service changes such as the building of the new South Bristol Community Hospital and the redeveloped Cossham Hospital in process, but also through urgent care provision continuing to develop more community based support out of acute hospital settings.

Population Change

[This section only amended Dec 2012 to reflect the Census 2011 release]

Population growth and change is probably the most significant issue for Bristol's Health and Care Services. Bristol's population is currently estimated at 428,100[19], and in the last decade Bristol is estimated to have grown much faster (9.7%) than the England & Wales average (7.1%), and 3rd fastest of the Core Cities[20]. Growth has been focussed in the central areas of Bristol[21], reflecting that the citywide picture can obscure differences within it. For example, since 2001 Bristol overall had a 9.7% growth, but the central wards of Cabot (62%) and Lawrence Hill (44%) saw much greater increases, with these two wards accounting for almost a third of the population increase across the city[22]. However, new government projections estimate that Bristol's population will now increase broadly in line with the England average[23] (8.1% over 2010-2020).

Bristol has a young population profile, with an average (median) age of 33 compared to 39 for England & Wales[24]. Overall the majority of the population increase were young working adults (20-34 year olds)[25], largely due to international immigration. However the single largest rise (% relative to 2001) has been in the number of under 5's[26], with projections showing the number of young children in Bristol will continue through the high birth rate (see Children and Young People section). Also, household projections indicate a substantial increase in the number of one-person households over the next 20 years[27].

The new estimate of Bristol's Black and Minority Ethnic (BME) population is 16% or 68,600 people[28], double the 2001 figure. For children the proportion is much higher, with 26% of Bristol school pupils coming from BME groups (over 28% of Reception Year children)[29]. Also, 6% (26,100 people) of the local population now are non-British white[30] (including recent immigrants from Eastern Europe) which is a very significant increase, and over a quarter of children born in Bristol are to mothers who were born outside the UK[31]. The BME population continues to be highly concentrated in Inner City wards, but East Bristol is becoming increasingly diverse also. This raises issues such as access to appropriate services, particularly primary care, and highlights the need to effectively engage with the wider community through the voluntary and community sector, carers and self-help groups as well as reviewing what services may need to change or be targeted elsewhere.

Carers are a key part of the overall health and social care support network in Bristol. There are over 40,100 people providing unpaid care locally (including young carers) which represents nearly 1 in 10 of the population (9.4%), a similar proportion as in 2001[32].

Economic Outlook

Bristol is a relatively affluent city that has weathered the effects of the recession comparatively well, but it has not been immune. Various reports including the recent Cities Outlook 2012 and 'The Future of Business 2011'[33], suggest that Bristol is well placed to take advantage of Britain's new economic landscape. Bristol has well-established creative and knowledge-based industries that many identify as key to future economic growth, plus high productivity, a diverse and mixed economy and excellent universities.

Meaningful employment is important not only to the economy, but also to personal health and wellbeing. Compared to Core Cities, Bristol has a low unemployment rate, but by mid-2010 Bristol's unemployment rate had risen and was level with the national average[34]. Moreover, Bristol has concentrated areas of persistent worklessness[35] in some of the most deprived areas. Therefore any interventions to improve health and wellbeing must also access people not in education or work and those experiencing deprivation (to tackle inequalities in health). There are also opportunities to engage with employers to improve health in the workplace.

Furthermore, Bristol's economic success over the past 10-15 years has brought with it urban challenges such as congestion and high house prices; relative to earnings, Bristol is the only Core City where housing is less affordable than the national average[36]. Compounded by a difficult financial climate, key workers and younger people are finding it harder to find work and somewhere to live. Over half of children in poverty live in working families with low income[37]. There is also evidence that mental health issues have increased following the recession.

There is a wide disparity in income between different areas of Bristol, with some wards having an average household income over double that of others[38]. Further, as a consequence of 2012 Welfare Reform, it is estimated that £125million could be lost from the Bristol economy by 2016[39], which will be concentrated in areas already more deprived.

Children and Young People

Arguably, the biggest challenge facing Bristol (both now and for the future) is in addressing the needs of our rapidly growing young and ethnically diverse population. There are more children under 16 living in Bristol than people aged over 65, and compared to projections for the country as a whole, Bristol's projected growth profile is markedly younger[40]. Over 10 years to 2020 Bristol's highest growth rate is for children (under 16), an increase of over 17% (over 12,000 more children)[41]. The significant increase in the under 5 population (over 17%, compared to 6.7% in all ages for 2006-2010) is already having a significant impact on school places[42] and some health and social care services, eg maternity, social workers, health visitors and GPs. This will continue to be a challenge for the foreseeable future.

There are sound economic arguments and also real opportunities for continuing to focus on improvements to child health and wellbeing through addressing their specific needs. It is important to ensure that children have the best possible start in life, not least because "children now are adults of the future".

As noted above, many ethnic groups in Bristol have a younger age profile, with considerably higher proportions of BME children and young people than adults, especially those with dual heritage[43]. Inner City and East schools have a significant proportion of pupils with English as an Additional Language; in Lawrence Hill, this figure exceeds 50%[44]. This could have impacts on educational attainment and future life chances.

In addition to the impact on universal services, such as schools and universal health provision, there is an increasing need for targeted specialist services, such as special schools and community children's nursing services, for children with complex learning difficulties and disabilities. For example, our special schools are providing for children with increasingly complex health and care needs (eg in the past 15 years the South West has seen a 30-fold increase in the prevalence of children living out of hospital on ventilators).

Over a quarter of children grow up in poverty in the city. Child poverty is a central determinant of life chances, and impacts on health and wellbeing in multiple ways. Data available on mothers smoking at the time of delivery, breastfeeding initiation and continuation, and low birth weight show the gap between the Bristol average and the most deprived quintile has remained relatively unchanged over recent years[45]. Infant mortality is 20% higher for poorer children than richer children[46].

Health indicators are poor for Bristol's children in need and children in care population, and there has been a significant increase of both these groups of children over the past year[47]. The costs to families and public services of meeting these needs is increasing, and requires an integrated response from health, social care and education.

We know that experiences in early years in particular have life long effects on many outcomes, such as heart disease, obesity, mental health, educational achievement and economic status[48]. Obese children tend to become obese adults, affecting rates of diabetes and heart disease.

Adults and Older People

Supporting an active and healthy ageing is also clearly important. In recent years there has been a reduction in the number of older people (over 65) in Bristol[49], but future projections show an increase of over 9% (over 5,000) by 2020 [50], albeit lower than the national projection (23%) for older people. Moreover, people are living longer, and within the small increase projected in the number of people over 75 is a relatively large increase in people over 90, which will have a disproportional impact in terms of need.

As well as living longer, more people are living with long-term conditions such as dementia and/or other chronic health problems or disabilities[51]. These factors, plus the increasing numbers of older people (mainly over 75) now living alone, will put increased pressure on health and social care services. Older people (over 65) make up close to two-thirds of adult social care clients[52]. As the role of the public sector as a provider of care changes, the role of carers and community support organisations will be increasingly important but they need to be supported by integrated, efficient, accessible and effective services.

In Bristol as a whole, more than 1 in 5 of older people (over 60) live in income-deprived households[53]. The pattern across the city mirrors patterns of deprivation in general. Impacts of this may include older people in these areas being unable to adequately heat their home (fuel poverty) and unable to afford appropriate food (malnutrition, also connected to ability to access adequate food)[54]. Plus, people in more deprived areas not only have lower estimates of life expectancy, but they are also more likely to spend more of their later years with a disability or long-term condition[55].

There are also health inequalities experienced by specific groups of disabled people, such as people with learning difficulties, mental health issues or sensory impairments[56], as well as for carers[57]. Underlying these are wider issues to be addressed, such as the impact of access issues for disabled and older people (eg links between visual impairment and factors such as increased falls, or community understanding of dementia). The increase in social care support delivered via community-based services (whether purchased directly by individuals or via the local authority on their behalf) needs to address issues such as the choice of appropriate community or mainstream services and availability of facilities such as adult changing spaces in the community to ensure that people can get “out and about”.

Health Inequalities

Despite the general city-wide improvement in health and wellbeing outcomes, there are clear and persistent health and wellbeing inequalities across the city, including a persistent inequality in life expectancy between the most and least deprived areas (with a gap of about 9 years between the wards with the highest and lowest life expectancy estimates)[58]. Inequalities in health and wellbeing outcomes between the most affluent and most disadvantaged areas are longstanding, deep seated and have proved difficult to change. Bristol has distinct geographical concentrations in deprivation and affluence (which in some areas sit side by side, especially in North Bristol).

In addition to the long-term life expectancy estimate, health inequalities are also shown through more immediate indicators, such as more deprived wards having higher levels of obesity, higher rates of emergency hospital admissions for conditions such as childhood asthma, and higher rates of people dying prematurely due to cancer, cardiovascular disease and other conditions[59]. Plus a number of lifestyle outcomes (see next section) show persistent links to deprivation, such as almost 1 in 5 mothers in the most deprived areas smoking in pregnancy (compared to 1 in 50 in the least deprived), which impacts on the ability to give these children a healthy start in life[60].

Reported incidents of domestic violence are also higher in more deprived areas[61] (although this may be a reflection of reporting patterns rather than incidents, due to the overall under-reporting on this issue). Up to 90% of all domestic violence cases will have children in the household, which impacts negatively on efforts to give children a positive start in life.

However, Bristol also has a range of community assets that can be drawn on to help tackle such problems, and there are many opportunities for local involvement and engagement in tackling deprivation-related problems[62]. An example is the potential use of Social Prescribing[63] to formally support GPs; linking patients with non-clinical needs to support from the community and voluntary sector to improve their mental health and wellbeing.

Inner City and East Bristol

There are concentrated and persistent areas of deprivation in the Inner City, with a changing profile in East Bristol[64].

In the Inner City almost half the children live in families receiving means tested benefits. The overall Bristol population growth has largely concentrated in the Inner City, with a young and increasingly diverse ethnic population. 3 of the 4 Inner City wards have the highest proportions of BME residents in Bristol, and for children these proportions are much higher, with 80% of pupils in Lawrence Hill being BME, and 60% in Easton and Ashley[65]. Most of the Inner City has very high rates of child poverty, and high levels of overcrowding[66]

Inner City wards, particularly Lawrence Hill, have low health and wellbeing outcomes on most indicators, and premature mortality rates are consistently higher in the Inner City than elsewhere in Bristol[67]. Estimates of smoking, alcohol consumption and numbers of adults in drug treatment are higher in the Inner City than Bristol overall. However, there are also some positive indicators that may protect health. For example, the Inner City wards on average have higher rates of mothers initiating breastfeeding and lower rates of mothers smoking during pregnancy than in Bristol as a whole (even though deprived areas usually have poorer outcomes on these indicators).

Across East Bristol the age profiles vary over wards. Population estimates indicate a 40% increase in the under 1 population since 2001, with a decline in the over 75 population[68]. Most areas in East Bristol are more deprived than the national average, and over the last few years most have increased in relative deprivation, especially concentrated in the Greater Fishponds area[69]. However, this is not one of the most deprived areas in Bristol.

South Bristol

There are concentrated and persistent areas of deprivation in South Bristol[70]. Almost half the areas are more deprived than the national average and the health of South Bristol is generally worse than the Bristol average. For Filwood ward (Knowle West), there are poor health outcomes on most indicators. South Bristol has areas of persistent worklessness, high numbers of children with Special Educational Needs and high numbers of disabled people[71]. Premature mortality due to cancer is also highest in the South.

Population growth is much lower than the Bristol average, and in some small pockets of outlying areas of South Bristol the population actually fell slightly between 2001 and 2010. The South of Bristol has a much lower proportion of BME residents than the Bristol average

North and West Bristol

Overall, this is a relatively affluent area with generally positive health outcomes[72], and high levels of educational attainment. Taken as a locality as a whole, Bristol North and West has much lower levels of deprivation, child poverty, obesity, smoking, etc.

However, there are significant levels of deprivation across the North of the area, which has a population profile more similar to South Bristol. Consequently there are significant health inequalities, as overall indicator rates can mask localised differences.

Population growth in North and West Bristol is lower than the Bristol average, and this area has the highest life expectancy estimates, and a relatively low proportion of BME residents.

Lifestyles and Health Improvement

While good progress is being made across the city, and health and wellbeing are gradually improving across a number of indicators, there is a continuing need to tackle health risk factors related to lifestyles. These cover issues such as alcohol and drug misuse, smoking (including in pregnancy), obesity, healthy eating and physical activity, sexual health and teenage pregnancy. In general, less healthy lifestyles follow a similar geographical profile as areas of deprivation.

Bristol overall has very positive indicators around pregnancy, with low smoking in pregnancy rates and high levels of breastfeeding[73] (which protects infant health and wellbeing), plus recently falling teenage pregnancy rates[74]. However, differences within the city persist, with some of the more deprived areas continuing to show variable outcomes. On average young mothers (under 25 years) seem less likely to breastfeed (although this may be a reflection of the higher proportion of young mothers living in more deprived areas), whilst BME mothers appear to be more likely to start breastfeeding.

Increasing physical activity and healthy eating are key to encouraging a healthy weight. Physical activity rates in Bristol (and nationally) are consistently low, especially in adults[75], although there are positive signs of an increase in “active travel” in Bristol[76] (eg cycling and walking), increasing physical activity as part of everyday lifestyles.

Substance misuse patterns within the city appear to be changing, with high levels of alcohol use across most groups, cannabis the most likely drug to be used daily, frequent use of ecstasy and cocaine, and other emerging drugs[77]. Many people use more than one substance. Relative to other drugs Bristol has low (and recently falling) levels of heroin and crack use, but these users have a disproportionate impact on crime and welfare dependency. Drug-related hospital admissions appear to have stopped rising, but show a strong connection with deprivation.

The increase in alcohol misuse is a key concern in Bristol (as it is nationally), evidenced by the consistent increase in alcohol-related hospital admissions[78]. This is also shown in high hospital admission figures for younger people[79] (under 25), where the prevailing issues are misusing alcohol and cannabis.

There is a clear positive trend in the reduction of the average number of households with smokers in Bristol over the last 5 years, and Bristol has the second lowest rate of the Core Cities[80]. However, there are still persistent areas where around 1 in 3 people smoke.

Healthy City

In Bristol, as elsewhere, key determinants of health in each area include: the quality of housing, the local physical environment and access to open spaces, transport infrastructure, feeling safe and freedom from fear of crime[81] as well as the prevailing attitudes to lifestyle issues in different communities. Poor housing can have direct links to poor health outcomes, and housing is relatively less affordable in Bristol than other cities[82]. More people now rely on private rented homes, yet over 28% of these in Bristol fail the Decent Homes Standard[83].

Whilst Bristol has lower than average incidents of road traffic collisions overall, there are higher than average numbers of pedestrians injured[84]. Deprived communities may be disproportionately affected by road traffic collisions of all levels of severity. Also, the main source of pollution in cities is road traffic[85], though Bristol's carbon emissions are reducing, and per capita are the lowest of the Core Cities[86]. Active Travel is an example of a healthy lifestyle change that also contributes to a reduction in pollution ("healthy city, healthy people").

Overall though, a healthier city will not come just from individual actions, but needs an integrated approach to planning the built environment to create a supportive environment and infrastructure for a Healthy City. This needs to focus on areas with poor health outcomes and inequalities (eg Inner City or South Bristol) and to take account of the health impact of living in the city in the future, eg: improving access to green spaces and to shops selling healthy food, as well as incorporating sustainability issues for a healthier future.

Service Landscape, Service Utilisation and Needs

Currently about £1.2 billion is spent on health and care annually within the Bristol economy. However, in line with the national picture, both the City Council and the NHS are required to make efficiency savings and will need to continue changing patterns of care, while introducing more choice.

A review is underway in Bristol (as nationally) about how to provide services that centre on personal choice and control and that meet people's needs while retaining individual dignity. Older people are now choosing more 'extra care' housing or opting to stay in their own homes. Adults are now more in control of the services they use through personalised budgets and many people who use day services want to take part in activities that support them in the community. Prevention, early intervention and integration of social care and NHS services will remain vital elements in future social care provision.

These changes are coupled with a rapidly changing national landscape for service delivery, with new or different providers and an impact on the role for carers, as more complex conditions are managed at home. The key national policy drivers are choice, quality, prevention and cost/value for money.

Bristol will face a number of challenges in meeting the needs of a growing and changing population within available resources. Projections of future service utilisation and future needs are always difficult, and some estimates are open to debate. However, when taking into account both upper and lower estimates, if current population changes and service utilisation trends continue, services will come under increasing pressure. For example:

- There are projected increases in the numbers living with long-term conditions (e.g. diabetes[87]), disabilities and/or safeguarding issues, with varying degrees of need for ongoing services (both for children and adults)[88], alongside support for their carers.

- There is a small but notable increase in emergency hospital admissions for conditions that may be managed in primary care[89]. At the same time, close to half of patients surveyed said that they didn't know how to contact out of hours GP services[90], and migrant communities report a lack of understanding of the primary care system[91]; if addressed these issues could reduce some pressures on emergency departments.

- Bristol has ongoing un-met needs, as evidenced by persistent inequalities in health outcomes across the city and the ongoing identification of needs in specific sub-groups of the population[92]. Service utilisation projections may be an under-estimate as they are based on existing patterns of care and do not always take into account un-met needs (eg increased capacity is being planned in the new mental health services).

- There are variations in spend across Bristol that may or may not be related to need or service access. For example, in NHS programme budgeting comparisons, Bristol appears to have a relatively high spend on mental health but worse outcomes alongside notable differences in service utilisation across the city[93]. This may reflect differing needs or an opportunity to change services and address service access issues (NB: work is already underway to commission new mental health services)

There are also some encouraging trends. Elective hospital admissions appear to have decreased (possibly related to demand management initiatives or changing needs?) as do premature mortality rates in all areas, especially re heart disease and stroke[94]. Health care services are valued, with above average levels of satisfaction with primary care services[95].

However, there is a need to continue restructuring patterns of care, alongside an opportunity to reposition services to meet changing demand and address un-met needs. This is especially relevant where health and wellbeing outcomes need to be improved and inequalities reduced. Some of this work is already underway (e.g. the development of the new community hospital in South Bristol and the introduction of more personalised care).

Challenges for Commissioners and Planners in the next 3-5 years

The main challenges for Bristol are in defining how best to:

- Maintain a focus on prevention (and healthier lifestyle choices) across the whole life course, including healthy active ageing. For example, making healthier choices much easier choices (at home, in local communities or schools, in the work place, in a sustainable city fit for the future), through strategic planning, partnership working and local engagement (as health is "everybody's business").

- Manage demands on services to meet the needs of a growing and changing population

- Target and re-position resources to deliver quality services more efficiently and effectively to meet increasing demands, whilst changing patterns of care

- Identify efficient and effective ways of utilising resources and improving patient experiences e.g. through integration of services and/or closer partnership working

- Further reduce inequalities in health and wellbeing outcomes whilst implementing change, as there are significant inequalities in outcomes across the city, including some that are hidden. Service changes can be used to reduce inequalities but can also inadvertently exacerbate them.

References to full JSNA 2012 Data Appendices

(Available at **www.bristol.gov.uk/jsna2012**)

[1] See Population 1.1 / ONS population estimates unit 2011
[2] See Population 1.4 / ONS population estimates by ethnic group
[3] See Population 1.3 / ONS population estimates unit 2011
[4] See Healthy Communities 2.2 (inc 2.2.2 Future changes)
[5] See Health and Wellbeing 4.0 (Bristol Health Profile) / Dept of Health 2011 www.healthprofiles.info
[6] See Introductory Appendix (Benchmarking, p8)
[7] See Healthy Communities 2.1.1 / Index of Multiple Deprivation 2010
[8] See Healthy Communities 2.2.5 / Bristol Child Poverty Needs Assessment
[9] See Health and Wellbeing 4.1 (plus other indicators throughout)
[10] See Introductory Appendix
[11] See Health and Wellbeing 4.2.2 and 4.6.8 / Bristol Director of Public Health report
[12] See Lifestyles & Health Improvement 3.2
[13] See Lifestyles & Health Improvement 3.5
[14] See Lifestyles & Health Improvement 3.3
[15] See Health and Wellbeing 4.5.1
[16] See Health and Wellbeing 4.5.2
[17] See Health and Wellbeing 4.6
[18] See Service Utilisation 5.2.4 and 5.2.6
[19] ONS 2011 Mid-Year Estimate, released Sept 2012 (based on Census 2011)
[20] Population 1.1 – Updated via BCC "2011 Census First Release" (Source: ONS © Crown Copyright 2012)
[21] See Population 1.5 / ONS experimental statistics
[22] Population 1.12 – Updated via BCC "2011 Census: Population and household estimates for small areas"
[23] See Population 1.7 / Population of Bristol report (April 2012) and ONS 2010-based subnational population projections
[24] Updated via BCC "Key Statistics about Bristol from 2011 Census" (Source: ONS © Crown Copyright 2012)
[25] See Population 1.3 / ONS population estimates unit 2011
[26] Source: ONS © Crown Copyright 2012
[27] See Population 1.9 / Increase of 71,000 one-person households by 2028
[28] Updated via BCC "Key Statistics about Bristol from 2011 Census" (Source: ONS © Crown Copyright 2012)
[29] See Population 1.4 / 2011 School census
[30] Updated via BCC "Key Statistics about Bristol from 2011 Census" (Source: ONS © Crown Copyright 2012)
[31] See Population 1.6 and 1.11.4 / Exact figure 27%, for 2010 births
[32] Population 1.10 – Updated via BCC "Key Statistics about Bristol from 2011 Census" (Source: ONS 2012)
[33] See Healthy Communities 2.2.2 Future changes / HSBC "Future of Business" report
[34] See Healthy Communities 2.2.3 / Local Economic Assessment
[35] See Healthy Communities 2.2.4
[36] See Healthy Communities 2.5.8
[37] Average for Core Cities (51%) and England (61%); Bristol Child Poverty Strategy / See Healthy Communities
[38] See Healthy Communities 2.2.1
[39] See Healthy Communities 2.2.2 / WRAMAS estimate
[40] See Population 1.3, 1.6 & 1.7 / ONS 2010-based subnational population projections
[41] See Population 1.7 / Population of Bristol report (April 2012) and ONS 2010-based subnational population projections
[42] See Population 1.3 / Bristol's School Organisation Strategy 2011-15
[43] See Population 1.4
[44] See Population 1.4
[45] See 3.5.3 (smoking); 3.1.7 (Breastfeeding) & 4.3.1 (Birth weight)
[46] See Health and Wellbeing 4.3
[47] 2011-12 / See Service Utilisation 5.1.1 & 5.1.2
[48] Marmot review 2010 - "Give every child the best start in life"
[49] See Population 1.3
[50] See Population 1.7
[51] See Health and Wellbeing 4.1
[52] See Service Utilisation 5.1.3
[53] See Healthy Communities 2.2.1
[54] See Lifestyles & Health Improvement 3.1.8 and Healthy Communities 2.3.4
[55] See Health and Wellbeing 4.1
[56] See Health and Wellbeing 4.4 and 4.5
[57] See Population 1.10
[58] See Health and Wellbeing 4.1

[59] See Lifestyles & Health Improvement 3.2 and Health and Wellbeing 4.2 & 4.6
[60] See Lifestyles & Health Improvement 3.5.3
[61] See Healthy Communities 2.6.4 and 2.6.5 / See Safer Bristol "*Violence and Abuse Strategy 2011 – 2014"*
[62] See Healthy Communities 2.1
[63] A formal way of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services in order to improve their mental health and wellbeing
[64] See Health and Wellbeing 4.0 / Bristol Public Health Inner City and East Locality Profiles 2011
[65] See Population 1.4 / 2011 School census
[66] See Healthy Communities 2.2.5 and 2.5.4
[67] See Health and Wellbeing 4.0 and 4.2
[68] See Bristol Public Health East Locality Profile 2011
[69] See Healthy Communities 2.1.1
[70] See Health and Wellbeing 4.0 / Bristol Public Health South Locality Profile 2011
[71] See Healthy Communities 2.2.4 & 2.4.2 and Health and Wellbeing 4.4.1
[72] See Health and Wellbeing 4.0 / Bristol Public Health North & West Locality Profile 2011
[73] See Lifestyles & Health Improvement 3.5 and 3.1.7
[74] See Health and Wellbeing 4.7.1
[75] See Lifestyles & Health Improvement 3.1
[76] See Lifestyles & Health Improvement 3.1
[77] Safer Bristol Substance Misuse Needs Assessment 2012 / See Lifestyles & Health Improvement 3.4
[78] See Lifestyles & Health Improvement 3.3
[79] See Lifestyles & Health Improvement 3.4
[80] See Lifestyles & Health Improvement 3.5
[81] See Healthy Communities 2.6.2
[82] See Healthy Communities 2.5.8
[83] See Healthy Communities 2.5.2 / Private Sector House Condition Survey 2011
[84] See Healthy Communities 2.3.3
[85] See Healthy Communities 2.3.2
[86] See Healthy Communities 2.3.1
[87] See Health and Wellbeing 4.6 and Service Utilisation 5.2
[88] See Service Utilisation 5.1.1-5.1.3 and 5.1.10
[89] Further analysis is needed / See Service Utilisation 5.2.10
[90] See Service Utilisation 5.2.1
[91] See Population 1.11
[92] Eg see Health and Wellbeing 4.1 / Population 1.11
[93] See section 5.2.17 and also section 5.1.3 which shows that Inner City and East has the highest percentage of Adult and social care users accessing mental health services
[94] See Health and Wellbeing 4.2 and 4.6.2
[95] See Service Utilisation 5.2.1 and 5.2.3

Alternative formats

If you need this information in a different format, please contact Nick Smith, JSNA Project Manager at **JSNA@bristol.gov.uk,** or phone on (0117) 90-37304.

Acknowledgements

And finally… we would like to thank everyone who has been involved in producing the Bristol JSNA 2012 Baseline. There are too many to mention individually, but many thanks to all the staff and other stakeholders who have contributed, especially from Bristol City Council, NHS Bristol and the Bristol Clinical Commissioning Group, LINk, the Care Forum and Voscur.