# Joint Strategic Needs Assessment (JSNA) 2016-2017

## Data profile of Health and Wellbeing in Bristol

www.bristol.gov.uk/jsna

NHS
Bristol Clinical Commissioning Group

BRISTOL

BRISTOL CITY COUNCIL

# Table of Contents

## Table of Contents

# Foreword from the co-chairs of the Bristol Health and Wellbeing Board

A joint foreword from the co-chairs of the Bristol Health and Wellbeing Board:

**Dr Martin Jones**
– Chair of NHS Bristol Clinical Commissioning Group

**Marvin Rees**
– Mayor of Bristol

**The data in the 2016-17 JSNA gives a mixed picture of the health and wellbeing of people in Bristol. In many ways it shows a city doing well; the number of people smoking continues to decline and teen pregnancies have reduced by half in the past decade. But it also reinforces what we already know about the divisions and inequalities within the city.**

The gap in life expectancy between the most and least deprived areas of Bristol has continued to rise whilst our city's high earners bring home over six times more than Bristol's lowest paid. Obesity, alcohol misuse and poor mental health remain major public health challenges with the most deprived being disproportionally affected.

Health inequalities are one of the factors that led the Resolution Foundation to suggest Bristol is one of the worst cities in England in which to be born poor. This is not only a city shame, but an economic and political liability.

We cannot build a strong economy or a stable political culture on an unwell population with low levels of health resilience. We need to take charge of the wider determinants of population health such as poverty, education and crime. This means we must get the city working together because no single organisation or individual can control these factors working alone. Population health is not just an issue for the NHS and we are all involved in shaping it. We must meet the crisis of the moment, whilst also building the foundations of our future by focusing on prevention and early intervention.

We need Bristol to be a city where mental health is given the same value as physical health, all young people get a good start in life and health inequalities are eliminated. We are working towards this in a very difficult climate of shrinking budgets and increasing demands, but organisations are responding by working more closely together than ever. However, it remains a challenge for the whole city and everyone needs to play a role if we are to make a real difference.

The JSNA gives us an idea of where our biggest challenges lie and we must not lose sight of the people behind this data. They need to be at the heart of the decisions we make about how to keep the population healthy. The JSNA has helped to shape the council's new draft **Corporate Strategy** which outlines our plans to tackle the challenges we face, and has fed into the **Sustainability and Transformation Plan** which sets out a cohesive future for local people's healthcare.

The Bristol Health and Wellbeing Board brings together Bristol City Council and NHS Bristol Clinical Commissioning Group with other partners to promote more joined-up decision-making between organisations. As co-chairs of the board, we will be working with the Health and Wellbeing Board to set the direction of travel for the city's population health and clearly lay out the part we must all play in delivering that direction. We will be making some big asks of our key city shapers from business, the public and voluntary sectors as we firmly believe that this will help us build a healthier future.

# JSNA 2016-17 Executive Summary

## Introduction

The Joint Strategic Needs Assessment (JSNA) is an ongoing process to identify the current and future health and wellbeing needs[1] of the local Bristol population. Bristol City Council (BCC) and NHS Bristol Clinical Commissioning Group (CCG) have equal and joint duties to prepare the JSNA through Bristol's Health and Wellbeing Board. The JSNA should inform 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 provides the underlying data to inform Bristol's Health and Wellbeing Strategy.

The JSNA Data Profile 2016-17 provides an updated and expanded overview of the changing health and wellbeing needs in Bristol, and highlights the current challenges[2]. It also includes a more explicit focus on data by gender, with many indicators broken down for males and females separately. The Bristol JSNA is now being complemented by a suite of needs assessments (JSNA chapters) which will include data broken down by wider equalities groups where possible. These chapters look not only at the quantitative data from the JSNA Data Profile, but also include information on current services, the evidence base and service user views. This will enable the JSNA to more effectively drive planning and commissioning across the city.

## JSNA 2016-17 Executive Summary

Bristol has the highest healthy life expectancy of all the Core Cities but for several health outcomes, the city performs poorly relative to the England average. Crucially, even on indicators where Bristol performs well overall, significant inequalities within the city remain.

The population of Bristol is now almost 450,000 people and has grown at a faster rate than nationally, especially in the inner city. The population is relatively young with a high but falling birth rate, but there has been an increase in older people in the North and West inner locality. The city is increasingly diverse especially amongst children, and Somalia and Poland are the most common countries of origin for non-UK born mothers.

Whilst life expectancy has shown a gradual improvement over the last 25 years, for men, it remains significantly below the England average. The gap in life expectancy between the most and least deprived areas of Bristol has increased in recent years for both men and women, although it is similar to the other Core Cities. Even for healthy life expectancy, the gap within the city is significant and compares unfavourably with other local authorities nationally.

[1] Within this report, the term "significantly" is used to refer to a change or difference being "statistically significant"
[2] Note - A draft JSNA 2016 Data Profile was published in Oct 2016. The draft JSNA was developed to inform the CCG operational plan underlying the new Sustainability and Transformation Plan (STP), and to inform the Council's draft Corporate Strategy and the Voluntary and Community Sector Grants process during Autumn 2016. The draft JSNA was then updated with new data (where relevant) and a summary added, for formal release as the JSNA 2016-17 Data Profile

Premature mortality rates have been gradually falling mostly due to reducing cardiovascular disease, with a smaller contribution due to fewer early cancer deaths. Premature mortality remains significantly higher than nationally, however, and rates for women vary four fold within Bristol. Cancer is the leading cause of early death, followed by cardiovascular disease. When years lost through early death and years lived in poor health are both taken into account, national data sources suggests that cardiovascular disease, diabetes and cancer are the most important contributors. However musculoskeletal conditions and mental illness are the major contributors to years lived in poor health.

We know that many of these health issues are preventable with a significant proportion resulting from unhealthy lifestyles, with poor diet, obesity, tobacco, alcohol and low physical activity being the biggest lifestyle issues for Bristol. Over the last decade though, preventable deaths have been reducing; smoking has been steadily declining and at 18% the Bristol rate is now similar to the England average. This city figure however masks the large differences seen within different areas of Bristol such as the five-fold difference in the number of households with a smoker. Almost six out of ten adults in Bristol are overweight or obese but only half of adults eat the recommended 5 fruit and vegetables a day. Although excess weight is lower than the England average and the lowest of Core Cities, it is contributing to the rising rate of diabetes as well as being a risk factor for cardiovascular disease, some cancers and musculoskeletal conditions, and so remains a significant public health issue. Rates of children leaving primary school with excess weight have now reached 35.4% (2015/16). Bristol meanwhile has a high density of fast food outlets and local data suggests poor dietary habits amongst children which further deteriorate through the teenage years, as well as poor dental health. Physical activity rates for Bristol as a whole are good with high rates of active travel concentrated amongst more affluent groups. Harm from alcohol misuse however does not appear to be improving, with high rates of hospital admissions due to alcohol and alcohol-related deaths for men remaining significantly higher than the national average. Bristol has the largest estimated rate of opiate and/or crack users of the Core Cities and drug related deaths have been rising. Rates of sexually transmitted infections are high, and TB rates in Bristol are almost double the England rate.

Although lifestyle issues are important, it is crucial to address the underlying or wider determinants of poor health, as well as mental health and wellbeing which are closely linked to lifestyle choices and to physical health outcomes. Bristol adults and young people have lower life satisfaction than the England average and local data suggests that mental wellbeing is worse for certain groups - those living in deprived areas, disabled people and lesbian, gay and bisexual people. Over 35,000 adults in Bristol have a diagnosis of depression, and an estimated 7,100 children aged 5-18 have a common mental disorder. Bristol's suicide rate is high relative to England and self-harm rates are high for adults and young people, especially for females.

We know giving children the best start in life is vital, and yet over 23% of children live in poverty in the city. Bristol's overall deprivation score has deteriorated in the last five years, although the city remains less deprived than most of the Core Cities. Average earnings in Bristol are above

the Core City average but the gap between high and low earners is increasing. Unemployment rates are similar to the national average and sickness absence rates appear to have reduced.

Bristol's housing market remains buoyant; house prices in Bristol are now higher than the England average and housing is becoming increasingly unaffordable for many. Homelessness is an issue and the number of rough sleepers has increased considerably over the last five years. The rate of fuel poverty is high in Bristol and excess winter deaths last year rose sharply, reflecting the national picture. Air pollution is a concern in some parts of the City, predominantly in areas of high traffic congestion.

Children's education results have improved with GCSE scores now similar to national figures, but significant variation remains across different parts of the city with only 30% of disadvantaged pupils achieving 5+ GCSEs (including English and Maths). A-level results are lower than nationally and the rate of young people going onto higher education is particularly low in the south of the city. The rate of young people not in education or training is reducing but remains higher than the national figure.

In the last year, reports of antisocial behaviour and youth offending have continued to fall but there has been an increase in recorded crime, mostly from violence without injury and within the city centre. Fear of crime whilst clearly reducing in Bristol remains a greater problem for those from deprived areas, BME people, disabled people and those of Muslim faith. Recorded rates of sexual offences and domestic abuse incidents have increased and the number of cases of female genital mutilation now recorded by healthcare providers appears high.

## Summary data points from each section

### Life expectancy

• Life Expectancy in Bristol has increased by 4.3 years for men and 3.1 years for women in the past 20 years.

• Despite rising life expectancy, Bristol is significantly worse than the England average for men.

• Inequalities in life expectancy have not improved. The gap between the most deprived and least deprived areas is now 9.6 years for men and 7.0 years for women.

• Men in Bristol live for around 63 years in good health; women live for around 64 years in good health. On average men have 15 further years in poor health and women have 19 further years in poor health.

• The number of years people are living in ill health within Bristol range from 11 years to 31 years for females and from 10 years to 24 years for males.

• Dietary risks, tobacco and obesity are the biggest contributors to early death and disability. Alcohol & drug misuse and lack of physical activity are also key lifestyle risk factors.

• Premature mortality rates in some areas of Bristol are over 3 times as high as other areas.

### Population

• The population has grown 10.8% since 2005 (8% nationally).

• Growth has been mainly concentrated in the inner city, especially young adults. The child population has risen across Bristol.

• Bristol's population is young, (median age of 33.1 compared to 39.9 nationally). There is a larger proportion of adults under 40.

• The city is increasingly diverse. Around 16% of the population are from BME backgrounds but amongst children it is 28%.

• The birth rate remains high but has fallen for the last 3 years, though natural change (births minus deaths) was still 44% of the population increase from 2014 to 2015.

• The population is projected to increase 10.4% to 488,500 by 2024.The child population is projected to rise 16.2% by 2024 (13,400 more children).

• The proportion of older people is lower than nationally but is now rising, mainly in the North & West (inner). Projected to be 7,700 additional people 65 & over by 2024, a 13.1% rise.

### Children & Young People's Health

• The percentage of full term births in Bristol with a low birth weight has risen slightly and is now broadly similar to national.

• Infant mortality rates in Bristol are no longer rising and are similar to national rates.

• Breastfeeding rates are higher than national but within Bristol are lowest for women from White ethnic groups living in deprived wards.

• Maternal smoking rates at delivery, are falling and are similar to national rates, but varies across the city.

• 3250 children in Bristol have a "limiting long-term illness or disability", proportionately more than nationally.

• Child hospital admissions for asthma are rising, especially in the Inner City. 2 of 3 admissions are for boys.

• The proportion of Bristol children who are obese or overweight is similar to the national average; at school entry 22.9% have excess weight, but this has now reached 35.4% for those leaving primary school.

• Rates of dental decay for Bristol appear similar to national rates but there are large inequalities across Bristol, and fewer children attend dental check-ups. Rates for tooth extractions in hospital are high.

• Immunisation coverage for child immunisations is above national average for under 1s, but are below the 95% target for under 2s as nationally. There are significant variations in coverage across the city.

• More 15 year olds smoke in Bristol than nationally, and girls at that age are more likely to smoke than boys.

• An estimated 6% of 15 year olds regularly drink alcohol, similar to the England average, and 18% have tried cannabis, significantly higher than nationally (11%).

• Almost10% of children and young people experience emotional health problems nationally, and self-harm hospital admission rates (10-24 years) in Bristol exceed the England average.

• Young people in Bristol report lower life satisfaction than nationally.

• Bristol has above average coverage for chlamydia screening (27% of 15 to 24 year olds, 2015)

• The rate of teenage conceptions in Bristol has shown a steep decline since 2007 and is now lower than the England average.

• There has been an improvement in health assessments for looked after children, but immunisation rates and dental checks are low.

## Wider Determinants

There are many factors which affect our ability be healthy, known as the "wider determinants of health". These include lifestyle, social & community influences, work and general economic, cultural and environmental conditions. These are a major contributor to health inequalities;

• Deprivation - 16% of Bristol's population live in the "10% most deprived areas in England" in 2015, compared to 14% in 2010. The greatest levels of deprivation are in Hartcliffe & Withywood, Filwood and Lawrence Hill.

• Child Poverty - Bristol has 18,900 children (under 16) in low-income families (23.2%), higher than England average (20.1%) and higher than previous year, with significant inequalities within Bristol.

• Education - Bristol's education results improved, but only 30% of "Disadvantaged pupils" attained 5+ GSCEs including English & Maths, compared to 67% of other pupils.

• Around 8,800 children in Bristol schools have some level of Special Educational Needs, 15% of Bristol pupils (2016, all age)

• There are around 700 children are in care in Bristol at any given time

• The rate of 16-18 year olds "not in education, employment or training (NEET)" is significantly worse in Bristol than nationally.

• The rate of young people going on to Higher Education in "Bristol South" has persistently been one of the lowest in the country

• First-time entrants to the Youth Justice System are significantly higher than nationally, but the rate in Bristol is now falling.

• Employment & Economy - The unemployment rate in Bristol (5.2% in 2015) has fallen and is now similar to the national average. • Bristol has high average earnings, but the highest paid 10% earn 6.4 times as much every week as the bottom 10%.

• Sickness absence rates are lower in Bristol than nationally and in other Core Cities.

• Housing – the rise in house prices, and shortage of affordable housing has led to the highest yet "affordability ratio". There has been a rise in private renting.

• Homelessness - The average number of rough sleepers in Bristol rose to 33 per week in 2015/16 from only 5 per week in 2010/11.

• Fuel Poverty - over 26,100 households are "fuel poor". This is 13.6% of Bristol households, higher than national average and comparable authorities.

• Air pollution – a modelled estimate suggests that around 300 deaths a year in Bristol can be attributed to air pollution (exposure to both nitrogen dioxide and fine particulate matter), 8.5% of all deaths.

• Promoting Healthy Urban Environments - more people in Bristol commute to work by bicycle or on foot than elsewhere. 82% of people are satisfied with parks and green spaces in Bristol, but only 66% in deprived areas. Road traffic injuries are significantly lower than nationally.

• Crime numbers are now rising, especially violent crime & public order offences. Rates of violent crime are the highest of core cities.

•Anti-social behaviour is falling, and residents noting fear of crime "affects their daily life" has halved over the last 5 years.

• Numbers of reported sexual offences rose by 28% in Bristol last year (21% nationally). 84% of victims were female (2015/16).

• Domestic Abuse - the rate of recorded domestic abuse incidents in Bristol has shown a significant rise over the last 2 years

• Adult Social care – there has been a rise in adults (18-64) receiving community support services

**Healthy Lifestyles**

• 62% of people in Bristol are physically active. More people in Bristol commute to work by bicycle or on foot than in any other local authority.

•Almost 6 out of 10 adults in Bristol (57.8%) are overweight or obese, though this is significantly lower than nationally (64.8%) and the lowest of core cities. • Men are significantly more likely to be overweight than women, but women have higher levels of obesity.

• Obesity is a key factor in the causes of premature death in Bristol from coronary heart disease and some cancers, and is a main cause of Type 2 diabetes.

• Quality of Life survey (2015) indicates significantly more residents in deprived areas are obese or overweight.

• Around half of respondents to Bristol's Quality of Life survey stated they eat 5 portions of fruit & vegetables a day (46% of men and 55% of women).

• 64% of the food retail sector in Bristol are Takeaway & Convenience Foods (36% are "fresh food shops")

• Bristol's estimated level of smoking in adults has declined from 23.5% in 2010, when it was significantly worse than the England average, to 18.1% in 2015 which is similar to the England average of 16.9%.

• Smoking-related deaths in Bristol are significantly higher than the England average rate.

• Alcohol-related hospital admissions in Bristol are significantly higher than the England average for both men and women.

• Alcohol-related deaths in men are significantly higher than national rates (28.5 per 100,000; national 16.1) and are rising.

• Bristol has the largest estimated rate of opiate and/or crack users of the English core cities.

• Bristol has a high treatment success rate for opiate-users compared to Core Cities, but for those leaving non-opiate or alcohol services, Bristol has significantly worse treatment success rates than nationally (2015)

### Health Protection and Sexual Health

Health Protection seeks to reduce the harm caused by communicable and non-communicable diseases, and minimise health impacts from environmental hazards. Sexual health covers relationships, pregnancy prevention, and sexually transmitted infections including HIV.

• The rate of new STI diagnoses in Bristol (excluding chlamydia in under 25s) for 2015 (1024 per 100,000 population) is considerably higher than the national average (660 per 100,000).

• Bristol has above average coverage for chlamydia screening (27% of 15 to 24 year olds were screened in 2015). However chlamydia detection rates are significantly below the 'target'.

• The diagnosed prevalence rate of HIV has risen in recent years and is now similar to the national average. Bristol is considered to be over the threshold for expanded testing for HIV / 43% of new HIV diagnoses are considered to be "late" – but is falling and similar to national

• The TB rate for Bristol is almost twice as high as the rate for England, and is 2nd highest of 16 comparable cities (2013-15)

• The risk of complications from flu is greater in children under six months of age, older people, pregnant women and those with underlying conditions such as diabetes and liver disease.

• Flu vaccinations for people 65 and over have now fallen to 72.4%, below the 75% target.

• Infection prevention and control is fundamental to stop the spread of infectious and communicable disease.

• Overuse and incorrect use of antibiotics are major drivers of antibiotic resistance; rates of "broad-spectrum antibiotics" use are consistently higher (worse) in Bristol but are now falling.

### Long Term Conditions

• Early deaths due to cardiovascular disease (CVD) remain significantly higher than national average. • The rate of early deaths from CVD in men is significantly higher than for men nationally, and is more than twice the rate for women. • There is significant variation in rates of CVD early deaths across the city.

• The rate of early deaths due to cancer is falling, but more slowly than nationally and remains significantly higher than England. This has been the case for men, and now for women also.
• Overall, more men than women die early every year due to cancer, in Bristol & nationally.

• Screening coverage for breast, cervical & bowel cancer in Bristol are all significantly lower than the England average.

• Recorded rates of diabetes continue to rise in Bristol as in England overall. Estimates suggest that almost 10% of those over 16 years in Bristol have raised blood sugar levels indicating an increased risk of diabetes. This is almost 35,000 people.

• In Bristol, rates of early deaths from respiratory disease are significantly higher than the England average. These rates are significantly higher for both men and women.

• Admission rates to hospital for COPD (chronic lung disease) and for asthma are both significantly lower in Bristol than the England average.

• Early deaths from liver disease in Bristol overall are broadly similar to the England average, but are significantly higher for men. Rates are over twice as high in men than women in Bristol.

• Most liver disease is due to alcohol, obesity and viral hepatitis. Rates of alcohol specific hospital admissions are significantly higher than England for both men and women, and hospital admission rates for liver disease are higher for men.

• Musculoskeletal conditions are the main cause of years lived with disability (YLD) in England, accounting for 24% of all YLD. • Modelled data on musculoskeletal conditions estimates that 16,000 people in Bristol have hip osteoarthritis and 26,500 have knee osteoarthritis.

• Preventable mortality rates in Bristol remain higher than England, though significantly lower than in most core cities. There are around 675 “preventable deaths” per year in Bristol.

• Rates for preventable mortality are significantly higher in men than women.

**Mental Health**

• Mental health conditions are one of the biggest contributors of years lived with disability.

• 35,200 Bristol patients (8.8%) have a diagnosis of depression, above the England average (8.3%), this is highest in Bristol North & West (outer) at 10.7%. • 5,200 patients (1.3%) had a new diagnosis of depression in 2015-16, above England average.

• In Bristol during 2015-16 there were 1,345 emergency admissions for self-harm; 869 females and 476 males. • There is a correlation between higher rates of self-harm and people living in more deprived areas.

• Bristol’s suicide rate is significantly higher than England average. The majority of suicides are men. However, the suicide rate for women in Bristol is now significantly higher than nationally and appears to be rising. • The incidence of suicide and undetermined death is highest amongst people in the most deprived areas.

• Excess mortality rate in adults with serious mental illness is higher in Bristol than nationally.

• 6.8% of Bristol residents reported low life satisfaction, significantly more than nationally.

• Local data shows 13% have “below average mental wellbeing”, but significantly more in deprived areas (20%).

• There are an estimated 7,100 children aged 5-18 with a common mental disorder.

• Self-harm hospital admission rates (10-24 years) exceed the England average; young people in Bristol report lower life satisfaction than nationally.

• Up to one in five women and one in ten men may be affected by mental health problems in the perinatal period.

**Older People's Health and Social care**

• There are an estimated 4,100 people over 65 living with dementia in Bristol, and around 69% have a GP diagnosis. • The number of people with dementia (65+) is projected to rise by 14% by 2024, and by 66% by 2039 (due to the high projected rise in people 85+)

• Dementia risk can be reduced by leading a healthy lifestyle - not smoking, eating well, and being active.

• Bristol's hospital admission rates following a fall (in people 65+) are significantly higher than the England average, but are now showing signs of reducing. • Rates of hip fractures (in people 65+) are showing signs of reducing and are no longer higher than the England average.

• There were 289 excess winter deaths in Bristol (2014/15), a significant rise in the last year, as seen nationally. The ratio of excess winter deaths for women rose sharply (2 out of 3 excess winter deaths were women).

• More people in Bristol are able to die at home than nationally.

• 4,240 adults received a community-based social care support service (Community Support Service) at end 2015-16 with a rise in adults under 65 years old. • There has been a rise in the number of older people in council funded care homes or extra care housing, but a reduction in those receiving home care services (at end 2015-16)

• There are estimated to be between 6,300 and 11,400 socially isolated older people in Bristol.

**Public Feedback**

• Access to services, including difficulties accessing information about services and/or booking and attending appointments, was a key theme in the negative feedback gathered by Healthwatch Bristol. In contrast, services that were easy to access and focused on shaping treatment and support around the service user were positively regarded.

**Further data – useful overarching profiles**

- Health Profiles: summary information on health (and factors affecting health) for every local authority in England - https://fingertips.phe.org.uk/profile/health-profiles
- Public Health Outcomes Framework (PHOF): indicators on how well public health is being improved and protected - http://www.phoutcomes.info/

## Map of new Bristol City Council wards 2016 and sub-locality areas for NHS Bristol Clinical Commissioning Group

# Section 2
# Life Expectancy

## Summary points

- Life Expectancy in Bristol has increased by 4.3 years for men and 3.1 years for women in the past 20 years.
- Despite the rise in life expectancy Bristol is significantly worse than the England average for men.
- Inequalities in life expectancy have not improved. The gap between the most and least deprived areas is 9.6 years for men and 7.0 years for women.
- Men in Bristol live for around 63 years in good health; women live for around 64 years in good health. On average men have 15 further years in poor health and women have 19 further years in poor health.
- The number of years people are living in ill health within Bristol range from 11 years to 31 years for females and from 10 years to 24 years for males.
- Dietary risks, tobacco and obesity are the biggest contributors to early death and disability. Also, alcohol & drug misuse and lack of physical activity are key lifestyle risk factors.
- Premature mortality rates in some areas of Bristol are over 3 times as high as other areas
- **Further data** – detailed analysis on life expectancy and premature mortality is in the 2016 Bristol Director of Public Health report "Living Well for Longer – The Case for Prevention"[3]

## 2.1 Life Expectancy for Bristol[4]

Life Expectancy at Birth (LEB) is the average number of years a person would expect to live based on current mortality rates.

People in Bristol are living longer. Compared to 20 years ago, men in Bristol now live 4.3 years longer, and women live 3.1 years longer. Life expectancy in Bristol (2012-14) is 78.3 years for men and 82.8 years for women.

**Gender:** Life expectancy for men in Bristol (78.3 years) is significantly worse than the England average of 79.4 years. For women life expectancy in Bristol (82.8 years) is broadly similar to the England average (83.1 years).

Due to the limited amount of personal details recorded on a death certificate it is not possible to calculate life expectancy estimates for other equalities dimensions such as ethnicity.

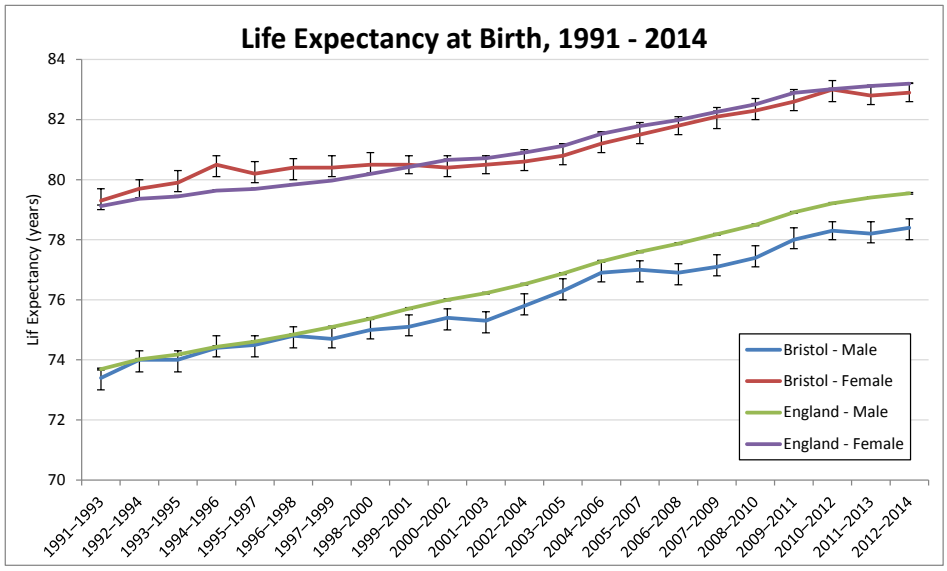


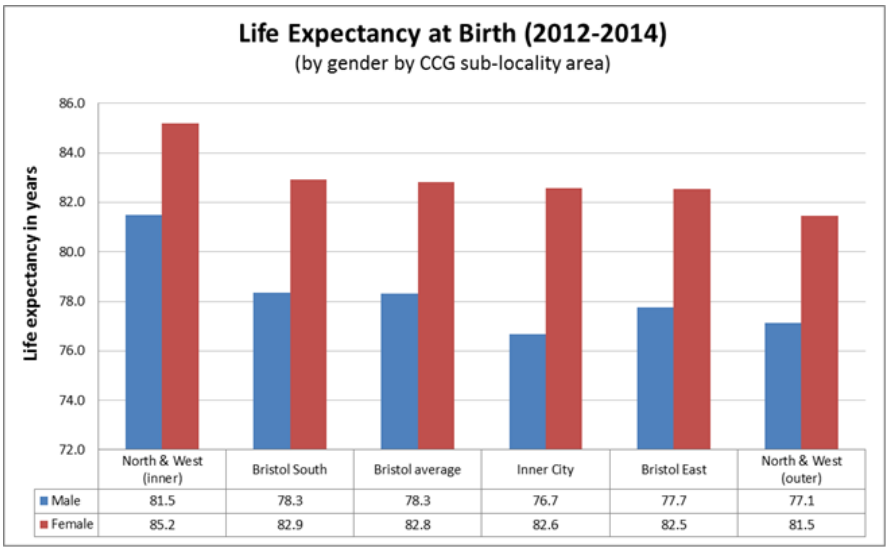

*Fig 2.1.1: Life expectancy trends*
*Source: Office for National Statistics, November 2015*

[3] 2016 Bristol DPH report "Living Well for Longer – The Case for Prevention": www.bristol.gov.uk/policies-plans-strategies/director-of-public-health-annual-report
[4] Note – The overall Life Expectancy for Bristol figures are the same as in JSNA 2015, as Public Health England delayed the release of new 2013-15 data until Feb 2017. However, the remaining sections are all based on updated data, unless noted.

## 2.2 Life Expectancy within Bristol

At a sub locality level (fig 2.2.1) life expectancy in Bristol varies significantly. Bristol North West (inner) has the highest life expectancy in Bristol for both men (81.5 years) and women (85.2 years) both being significantly better than Bristol as a whole. The neighbouring sub-locality of Bristol North West (Outer) has the worst female life expectancy (81.5 years) in Bristol. Bristol's worst male life expectancy is in Inner City (76.7 years). Male life expectancy in Inner City is unexpectedly low compared to female life expectancy in that area. Further investigation is needed to identify the reason for the low male life expectancy in Inner City.

There are large differences in life expectancy between the wards of Bristol. For men Cotham has the highest life expectancy (83.6 years) and for women Clifton has the highest life expectancy (90.1 years). Central (74.8 years) has the lowest life expectancy in Bristol for men and Southville (77.2 years) is lowest for women[5]. Due to the unusual age structure in the ward of Hotwells and Harbourside it is not possible to calculate an accurate estimate of life expectancy in this ward.




| | North & West (inner) | Bristol South | Bristol average | Inner City | Bristol East | North & West (outer) |
|---|---|---|---|---|---|---|
| Male | 81.5 | 78.3 | 78.3 | 76.7 | 77.7 | 77.1 |
| Female | 85.2 | 82.9 | 82.8 | 82.6 | 82.5 | 81.5 |

*Fig 2.2.1: Life expectancy by sub locality, 2012-2014*
*Source: Bristol Public Health Knowledge Service using ONS data (Aug 2016)*

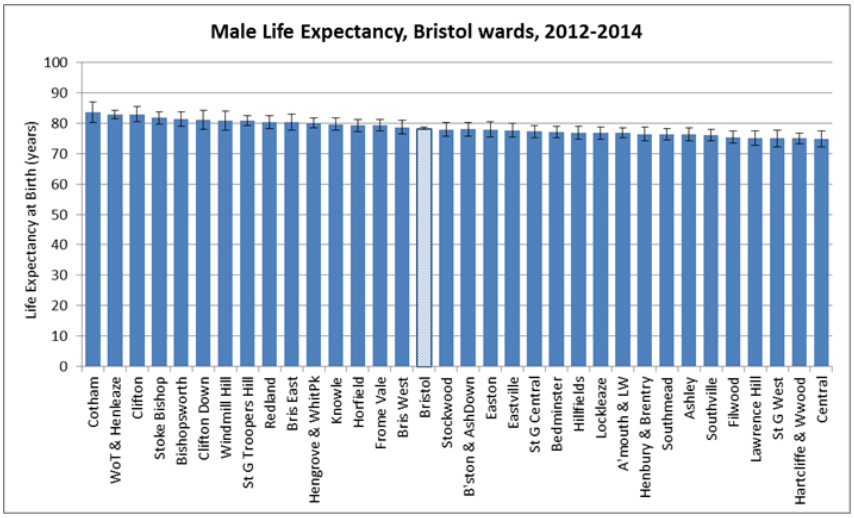



*Fig 2.2.2: Male life expectancy by ward, 2012 – 2014*
*Source: Bristol Public Health Knowledge Service using ONS data*

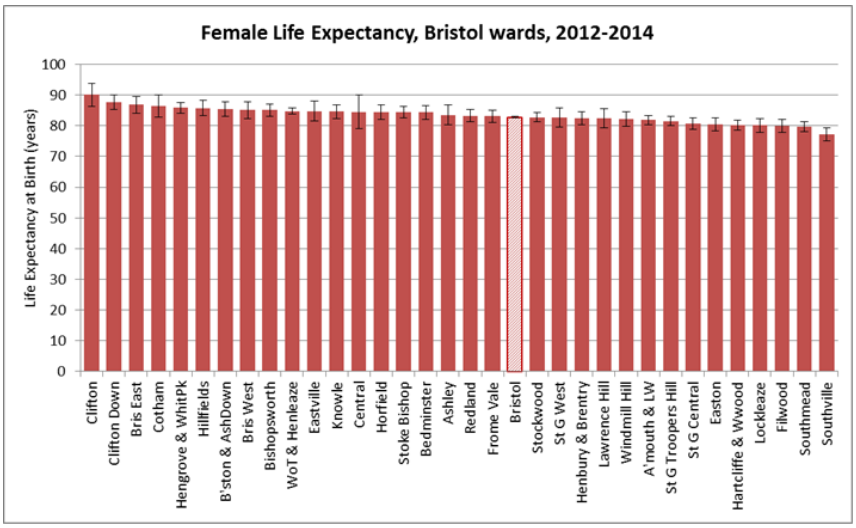



*Fig 2.2.3: Female life expectancy by ward, 2012 – 2014*
*Source: Bristol Public Health Knowledge Service using ONS data*

[5] Note - changes in methodology (new ward boundaries and 3 year averages) mean that this data (new wards, 3 yrs) cannot be compared with JSNA 2015 (old wards, 5 yrs)

## 2.3 Life Expectancy Gap

The standard national measure of inequality in life expectancy is the Slope Index of Inequality (SII) statistic. This measures the estimated difference (using a line of best fit) in life expectancy (in years) between the most deprived 10% of the population and the least deprived 10% within Bristol. This measure allows us to compare Bristol's inequalities to other local authorities and to monitor changes over time in a statistically robust manner[6].

**The gap in life expectancy between the *most* deprived and *least* deprived groups is currently 9.6 years for men** (fig 2.3.1) **and 7.0 years for women** (fig 2.3.2). This gap has not shown any clear signs of reducing in the last 10 years.

The main cause of the gap in life expectancy in Bristol for both men and women is cancer[7].

Compared to other English Core Cities, Bristol's slope index of inequality for men (fig 2.3.3) is mid-ranking, but for women is one of the lowest gaps (fig 2.3.4), although these differences are not statistically significant.

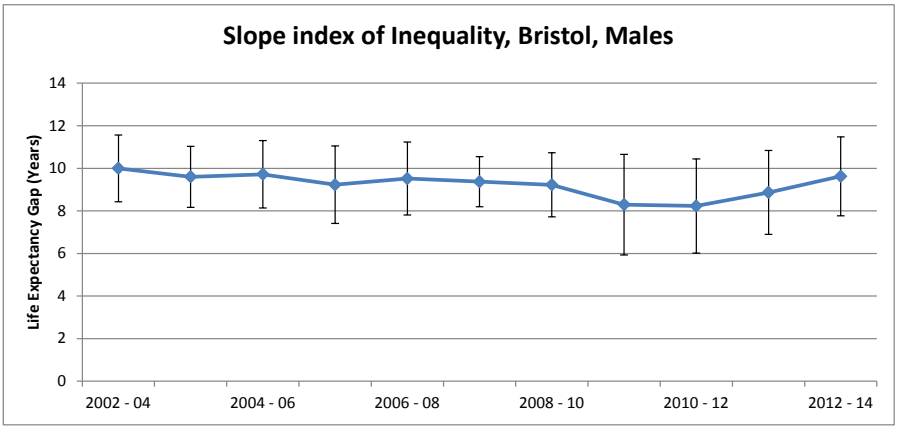



*Fig 2.3.1: Male slope index of inequality*
*Source: Public Health Outcomes Framework, August 2016*


*Fig 2.3.2: Female slope index of inequality*
*Source: Public Health Outcomes Framework, August 2016*

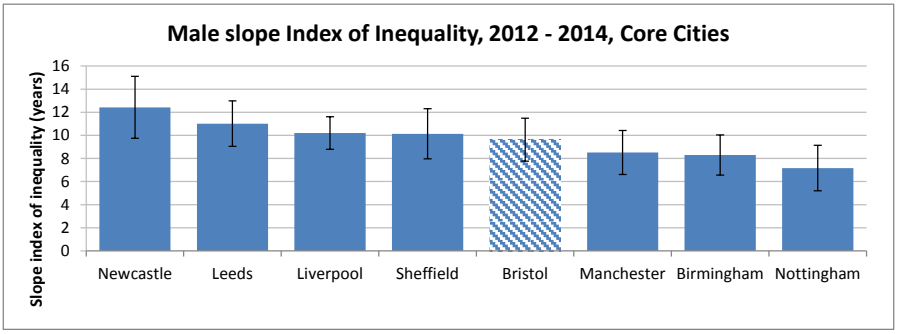



*Fig 2.3.3 Male slope index of inequality by Core Cities*
*Source: Public Health Outcomes Framework, August 2016*


*Fig 2.3.4: Female slope index of inequality by Core Cities*
*Source: Public Health Outcomes Framework, August 2016*

[6] NB Due to these reasons, the Slope Index of Inequality is used as the primary measure of the gap in life expectancy, not the difference between the individual wards with the lowest and highest figures.

[7] http://fingertips.phe.org.uk/profile/segment/area-search-results/E06000023?place_name=Bristol&search_type=parent-area

## 2.4 Healthy Life Expectancy

This is the average number of years a person would expect to live *in good health* based on current mortality rates and self-reported good health.

In Bristol, Healthy Life Expectancy estimates (2012-14, ONS) are 63.3 years for men and 64.2 years for women (fig 2.4.1), which are broadly similar to the national average. Bristol has the highest healthy life expectancy of the Core Cities for both genders.

**Gender:** Men in Bristol live an average of 15.0 years in poor health, whilst women have 18.6 years of poor health; these figures are similar to England as a whole.

The Healthy Life Expectancy measure is relatively new, so limited trend data is available. The data that is available (fig 2.4.2 and fig 2.4.3) shows that there has been no statistically significant change in healthy life expectancy in Bristol.

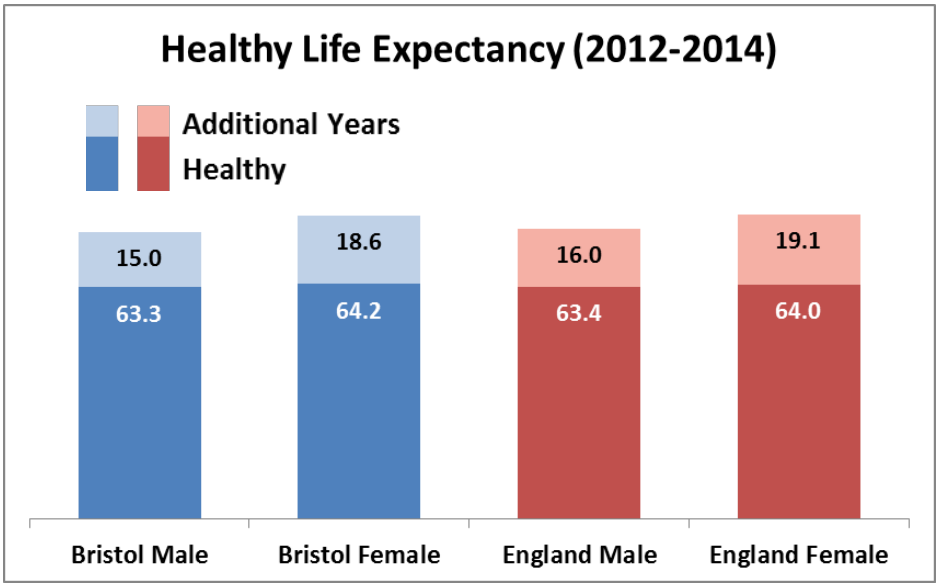



*Fig 2.4.1: Healthy Life Expectancy and overall Life Expectancy*
*Source: ONS via Bristol Public Health Knowledge Service, Nov 2016*

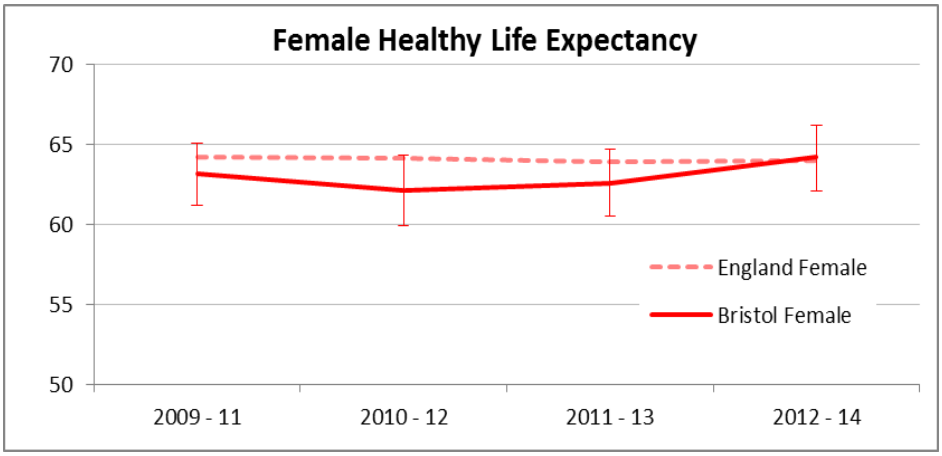



*Fig 2.4.2: Healthy Life Expectancy trends- Female*
*Source: ONS via Public Health Outcomes Framework (Aug 2016)*

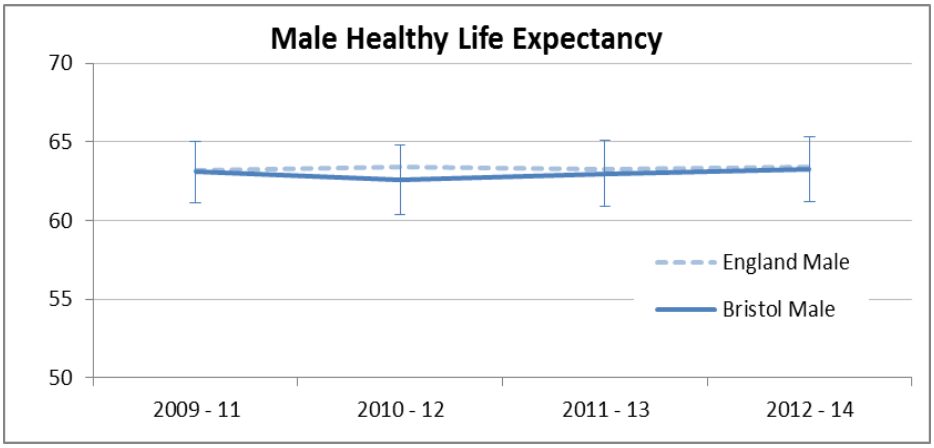



*Fig 2.4.3: Healthy Life Expectancy trends- Male*
*Source: ONS via Public Health Outcomes Framework (Aug 2016)*

## 2.5 Healthy Life Expectancy Gap[8]

Small area data[9] from Office for National Statistics is available for Healthy Life Expectancy within Bristol, and this highlights the gap within the city. It is not ward-level data, but for smaller areas.

Within Bristol there are five areas where male healthy life expectancy is in the lowest 5% in England (Knowle West, Barton Hill, Withywood, Upper Easton and Hartcliffe) and for females there are three areas that fall within the lowest 5% (Withywood, Hartcliffe and Barton Hill).

**The gap in healthy life expectancy between the most deprived 10% and the least deprived 10% within Bristol** (ie the Healthy Life Expectancy slope index of inequality) **for males is 16.3 years and for females it is 16.7 years.**

The number of years people are living in ill health has a vast range[10] from 11 years to 31 years for females and from 10 years to 24 years for males between areas.

Bristol's healthy life expectancy gap does not compare well with other local authorities - out of 149 local authorities in England for males Bristol is 27th worst and for females it is 23rd worst.

Healthy Life Expectancy, Females, 2009-2013

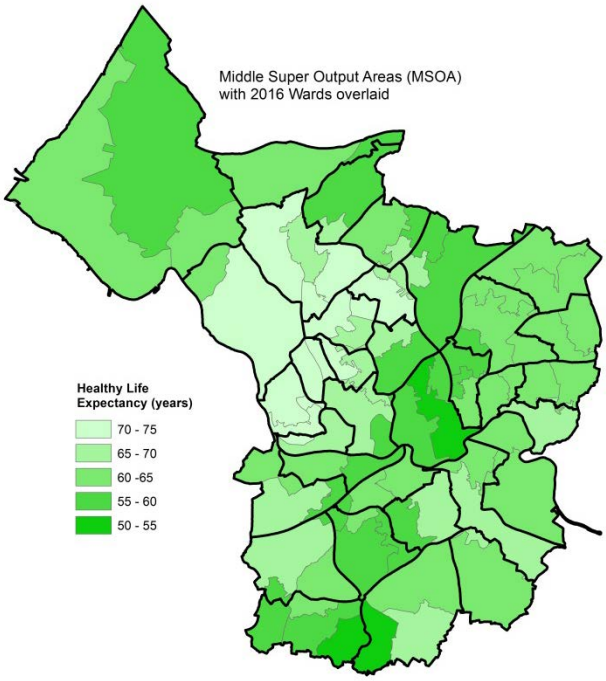



*Fig 2.5.1: Healthy Life Expectancy by MSOA, Females, 2009-2013*

Healthy Life Expectancy, Males, 2009-2013

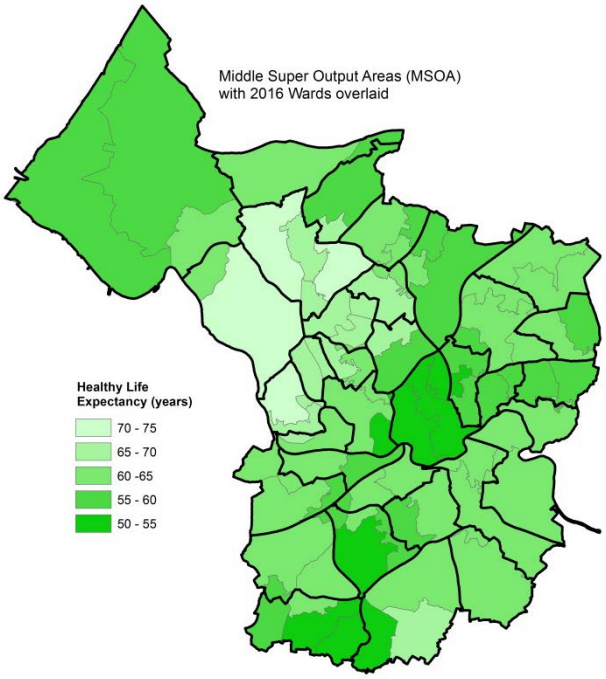



*Fig 2.5.2: Healthy Life Expectancy by MSOA, Males, 2009-13*

[8] As in JSNA 2015 / is not updated annually
[9] 2009-2013 for Medium Super Output Areas (MSOA). Source: ONS, Nov 2015. Analysed by Bristol Public Health Knowledge Service
[10] NB this is range for MSOA areas

## 2.6 Global Burden of Disease

Global Burden of Disease (GBD) statistics are produced by a multinational academic team and use multiple sources of information to estimate the burden of disease associated with a variety of major diseases and risk factors. GBD combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health.

Disability Adjusted Life Years (DALYs) are calculated as the sum of years lived with disability (YLD) and years of life lost (YLL). YLDs are years lived in less than ideal health. This includes conditions that may last for only a few days, as well as conditions that can last a lifetime. YLLs are years of life lost due to premature mortality, i.e. deaths before *average* life expectancy.

In the UK overall the number of years lost to premature mortality (8.1 million years) is similar to the number of years lived with disability (8.6 million years) (GBD 2013)

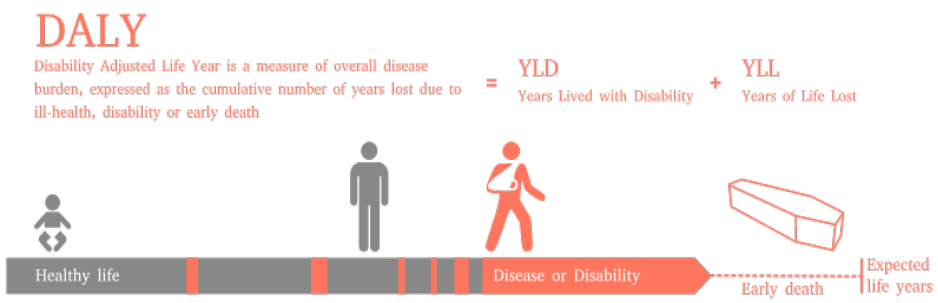



*Fig 2.5.1: Method of calculating Disability Adjusted Life Years*

Below are two graphs – fig 2.6.2 shows the risk factors split by related cause of death and disability and the second showing causes of death and disability split by the associated risk factors. These are calculated by applying the UK results of the Global Burden of Disease project to Bristol's population. Dietary risks[11], tobacco smoke and high body-mass index are the three highest risk factors that lead to early death and disability. In addition, alcohol & drug misuse and lack of physical activity are key lifestyle risk factors.

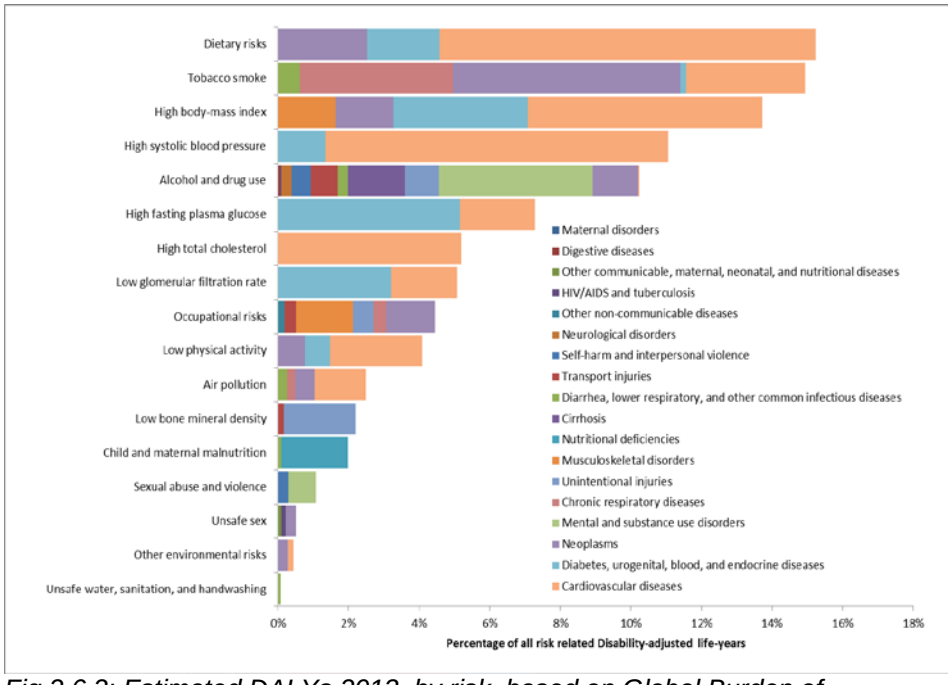



*Fig 2.6.2: Estimated DALYs,2013, by risk, based on Global Burden of Disease, Institute of Health Metrics and Evaluation / Public Health England Source: Bristol Public Health Knowledge Service*

[11] Dietary risks include, for example, diets low in fruit, vegetables and fibre and diets high in sodium, processed meat and trans-fatty acids.

Figure 2.6.3 shows that cardiovascular disease (CVD) is the largest cause of DALYs in Bristol. Although mortality rates from CVD have reduced considerably, many people are living with this long term condition.

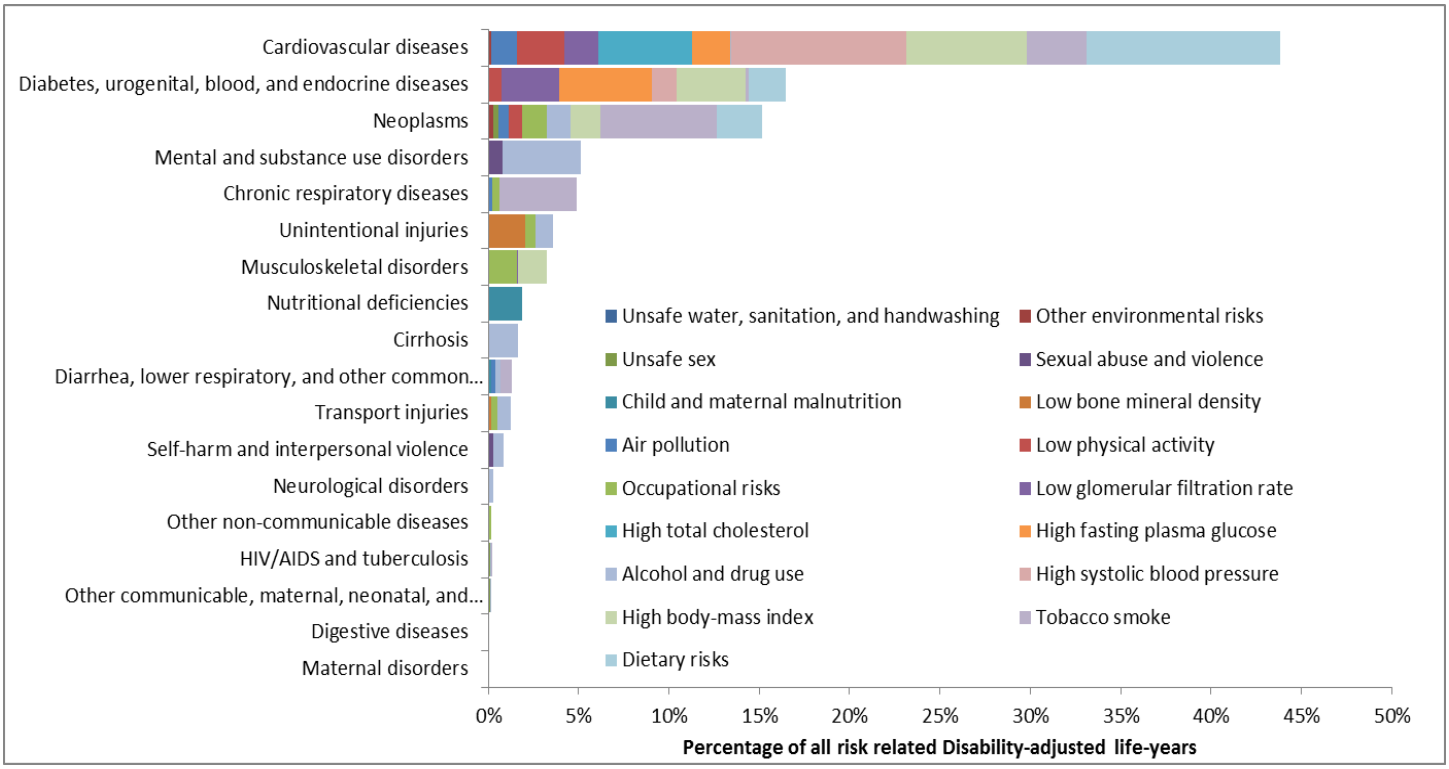



*Fig 2.6.3: Estimated DALYs,2013, by risk, based on Global Burden of Disease, Institute of Health Metrics and Evaluation / Public Health England Source: Bristol Public Health Knowledge Service*

## 2.7 Premature Mortality

Rates of premature (under 75 years) mortality are falling in Bristol and for both men and women the mortality rates in 2014 were significantly lower than levels five years earlier (fig 2.7.1). However, Bristol's premature mortality rates, for both men and women are significantly worse than the England rates.

Most of the reduction in Bristol is due to fewer early deaths from cardiovascular diseases and a smaller contribution from fewer cancer deaths.

At a sub-locality level North & West (outer) females and Inner City males have significantly higher premature mortality rates than Bristol as a whole. North & West (inner) has significantly lower rates for both male and females (fig 2.7.2).

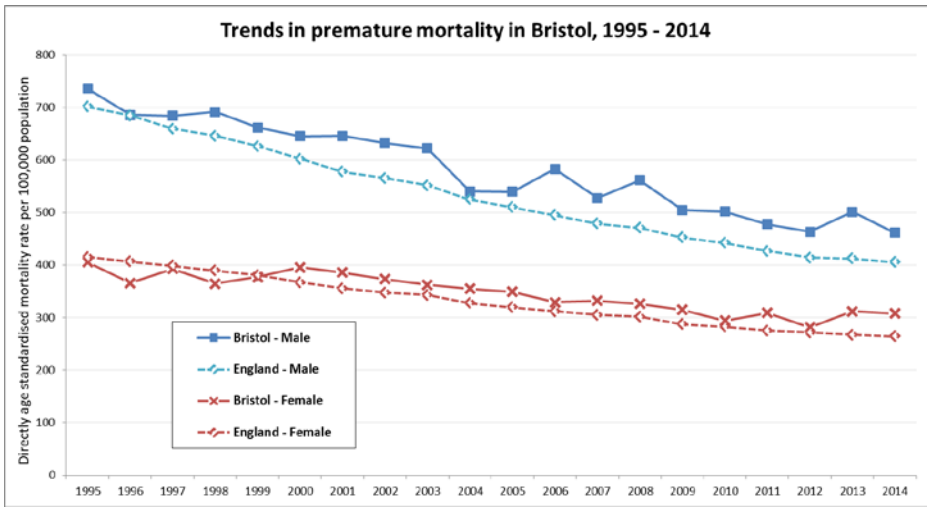
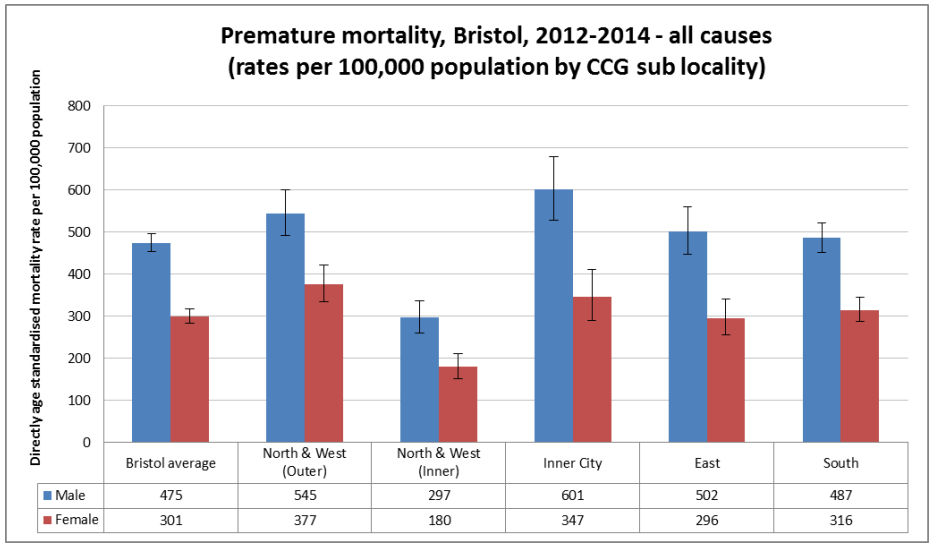



*Fig 2.7.1: Premature mortality trends 1995 – 2014*
*Source: National Clinical Health Outcomes Database, HSCIC*




| | Bristol average | North & West (Outer) | North & West (Inner) | Inner City | East | South |
|---|---|---|---|---|---|---|
| Male | 475 | 545 | 297 | 601 | 502 | 487 |
| Female | 301 | 377 | 180 | 347 | 296 | 316 |

*Fig 2.7.2: Premature mortality with Bristol by sub locality; 2012-2014*
*Source: Bristol Public Health Knowledge Service using ONS data (Aug 2016)*

At a ward level there are large differences in premature mortality between wards in Bristol.

Westbury on Trym & Henleaze ward has the lowest male premature mortality rate and for females, Clifton has the lowest rate. St George West has the highest male premature mortality rate and Southville has the highest female rate.

For men Westbury on Trym & Henleaze's premature mortality rate is less than a third of the St George West's death rate and for women Clifton's mortality rate is almost a quarter of Southville's rate.

In Bristol the top 4 causes of premature mortality are cancer, cardiovascular disease, respiratory disease and liver disease.

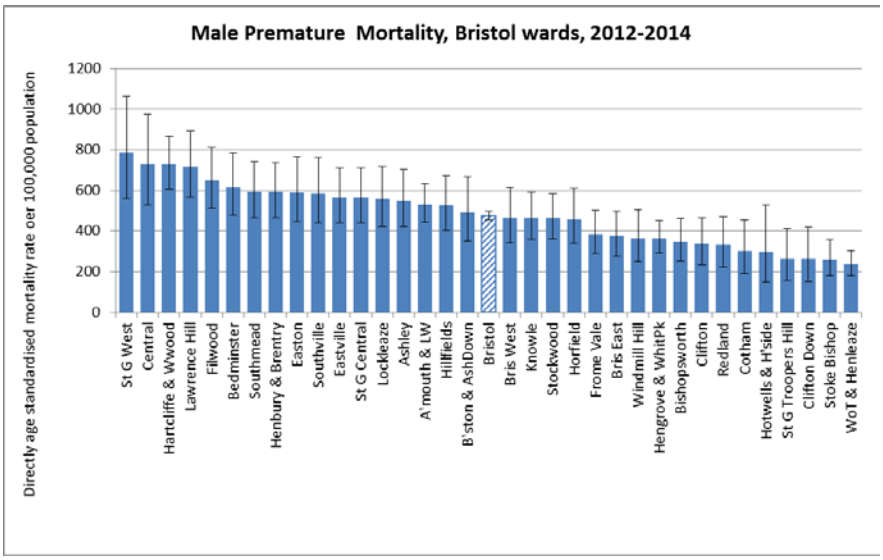



*Fig 2.7.3: Male premature mortality, Bristol wards, 2012-2014*
*Source: Bristol Public Health Knowledge Service using ONS data (Aug 2016)*

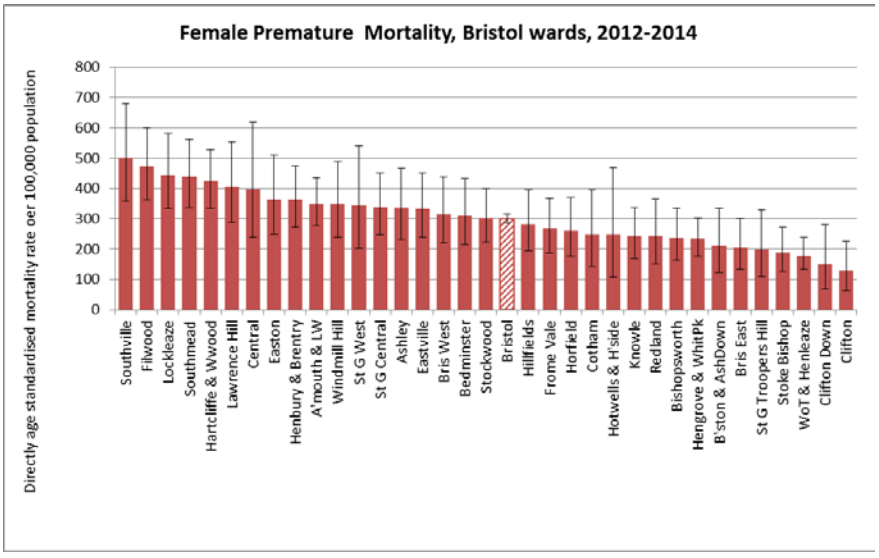



*Fig 2.7.4: Female premature mortality, Bristol wards, 2012-2014*
*Source: Bristol Public Health Knowledge Service using ONS data (Aug 2016)*

### Further data

- Longer Lives atlas: Highlights premature mortality across every local authority in England http://healthierlives.phe.org.uk/topic/mortality

# Section 3
# Population[12]

## Summary points

- The population has grown 10.8% since 2005 (8% nationally).
- Growth has been mainly concentrated in the inner city, especially young adults. The child population has risen across Bristol.
- Bristol's population is young, (median age of 33.1 compared to 39.9 nationally). There is a larger proportion of adults under 40.
- The city is increasingly diverse. Around 16% of the population are from BME backgrounds but amongst children it is 28%.
- The birth rate remains high but has fallen for the last 3 years.
- The population is projected to increase 10.4% to 488,500 by 2024.The child population is projected to rise 16.2% by 2024 (13,400 more children).
- The proportion of older people is lower than nationally but is now rising, mainly in the North & West (inner). Projected to be 7,700 additional people 65 & over by 2024, a 13.1% rise.

## 3.1 Bristol population overview

The population of Bristol is estimated to be **449,300 people**[13], the 8th largest city in England. Bristol has a relatively young age profile; the median age of people living in Bristol in 2015 was 33.1 years old, compared to 39.9 years in England and Wales.

Bristol has 83,800 children under 16 (18.6% of population), with a lower % of children under 10 than nationally (despite the rise in the child population). The working age (16-64 yrs. old) population is 306,300 (68%), which is a higher % than nationally (63%), especially young adults up to 40 years. The older people population (65 & over) is 59,300 (13.2%), lower than nationally (17.9%); in fact, Bristol has a lower proportion of older adults from 45 years upwards than nationally (fig 3.1.1)

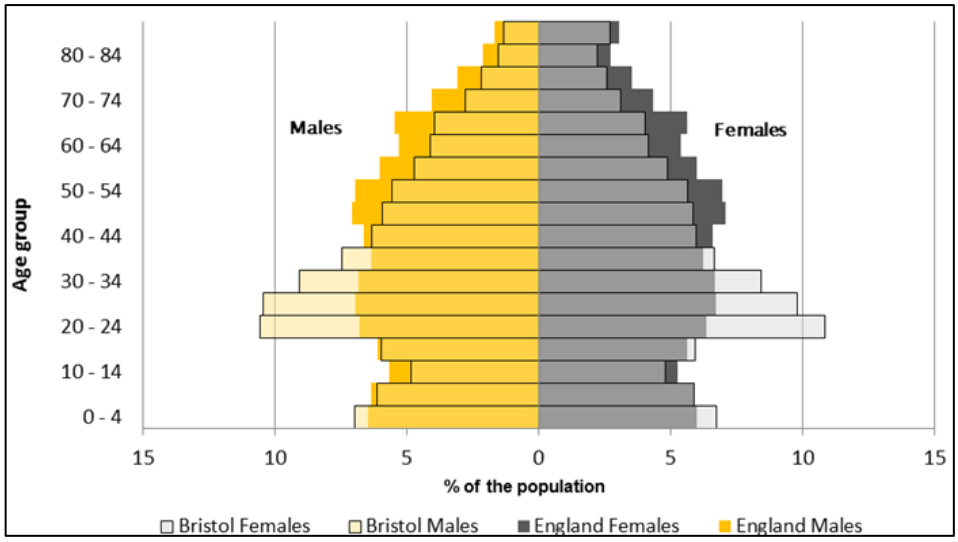



*Fig 3.1.1 Mid-2015 Population pyramid for Bristol vs England*
*Source: ONS 2015 Mid-Year Population Estimates. Crown Copyright 2016*

| Age Band | Males | | Females | | Persons | |
|---|---|---|---|---|---|---|
| | number | % | number | % | number | % |
| 0-15 | 42,600 | 19.0 | 41,200 | 18.3 | 83,800 | 18.6 |
| 16-24 | 35,000 | 15.6 | 35,500 | 15.8 | 70,500 | 15.7 |
| 25-49 | 88,200 | 39.2 | 82,400 | 36.7 | 170,500 | 38.0 |
| 50-64 | 32,400 | 14.4 | 32,900 | 14.7 | 65,300 | 14.5 |
| 65 and over | 26,600 | 11.8 | 32,700 | 14.6 | 59,300 | 13.2 |
| **All ages** | **224,800** | **100.0** | **224,600** | **100.0** | **449,300** | **100.0** |

*Table 3.1.2 Mid-2015 Population estimates by age and sex for Bristol*
*Source: ONS 2015 Mid-Year Population Estimates. Crown Copyright 2016*

[12] See "Population of Bristol 2016" report www.bristol.gov.uk/population

[13] ONS 2015 Mid-Year Population Estimate, released 2016

***Registered patient v resident population***

It should be noted that NHS Bristol CCG primarily works with the registered GP patient population. At the end of March 2015 there were 493,800 patients registered to GPs in Bristol, substantially higher[14] than the estimate of people living in Bristol (449,300 in June 2015). Mainly this difference is working age adults (16-64), with the numbers of under 16's and over 65's being similar in both. For comparison, GP records indicate 476,600 patients with a Bristol address (including 11,200 with a GP outside of Bristol).

## Population within Bristol

Ward-level population[15] is shown for the new 2016 wards (fig 3.1.3). Total population size ranges from 5,200 in Hotwells & Harbourside to 21,100 in Avonmouth & Lawrence Weston. Note – Bristol wards are no longer approx. equal in size, with 5 larger wards and 3 smaller wards, as shown.

Age profiles for the 3 CCG Localities are shown in fig 3.1.4. In particular, there are less older people 65 & over living in Inner City & Bristol East.

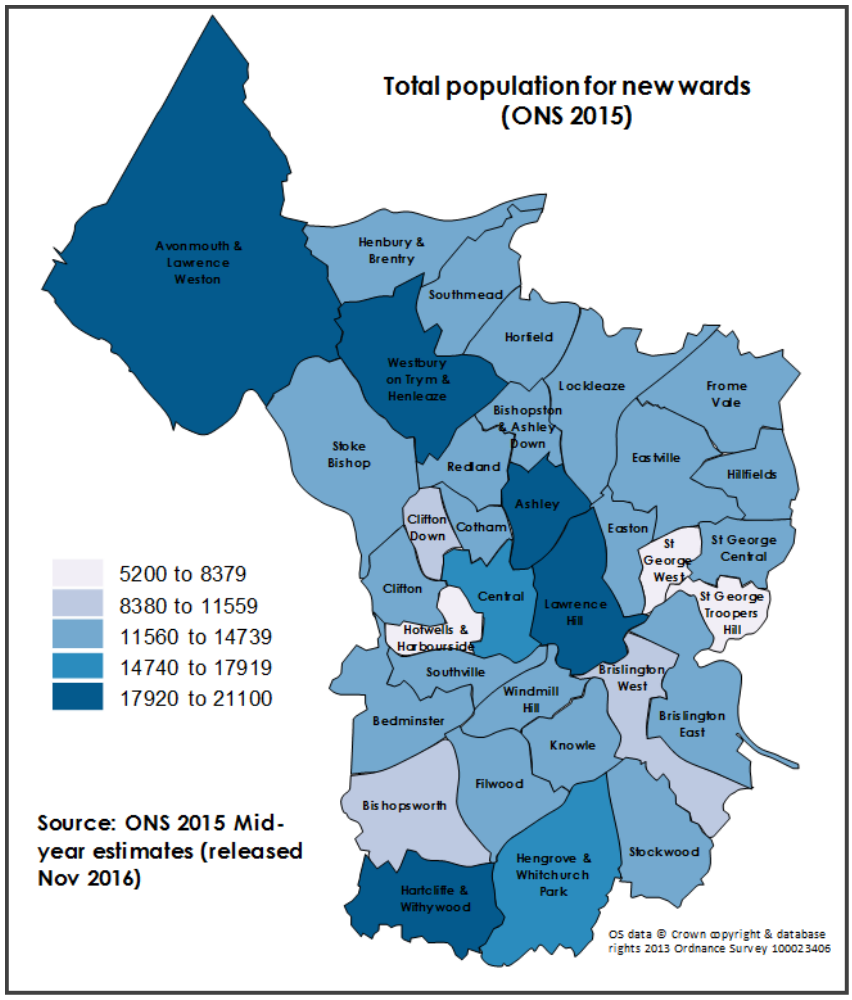



*Fig 3.1.3: Bristol resident population 2015 (by new wards, 2016)*
*Source: BCC Performance, Information & Intelligence based on ONS 2015 Small Area Population Estimates; Crown Copyright 2016*

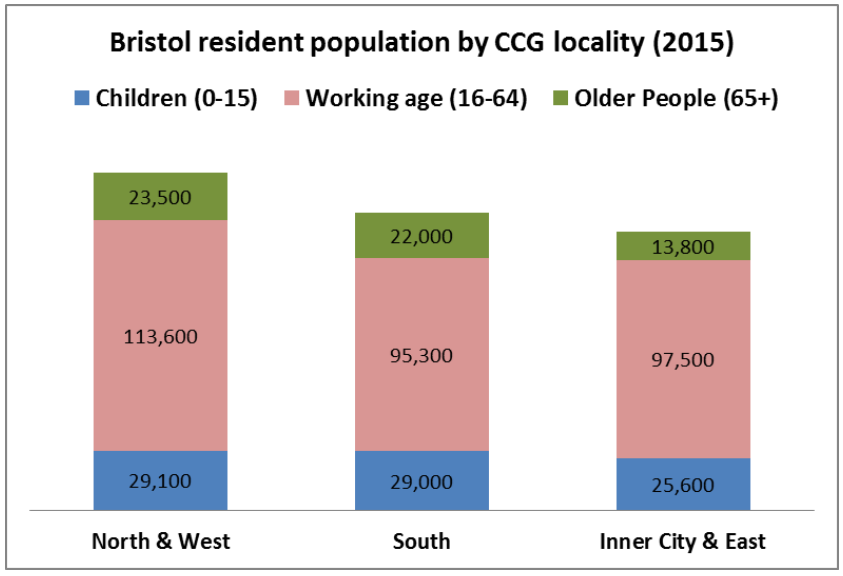



*Fig 3.1.4: Population age profiles by 3 CCG localities, 2015 (Nov 2016)*
*Source: Performance, Information and Intelligence, Bristol City Council, using data from ONS licensed under the Open Government Licence v.1.0.*

[14] This is often referred to as "list inflation". Some patients may be registered in more than one area, have more than one NHS number, remain on GP lists after having died or left the country; also GPs have no real incentive to remove people from lists. www.adls.ac.uk/department-of-health/gp-patient-register-dataset/?detail

[15] ONS Mid-year estimate 2015 released Nov 2016

## 3.2 Population changes

There has been over a decade of considerable population growth in Bristol. Since 2005 the population is estimated to have increased by 43,900 people (fig 3.2.1). This increase of 10.8% compares to an England and Wales rise of 8% over the same period.

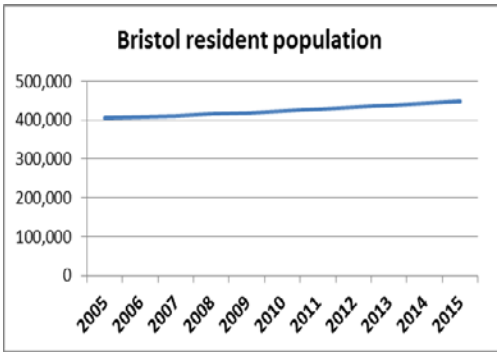
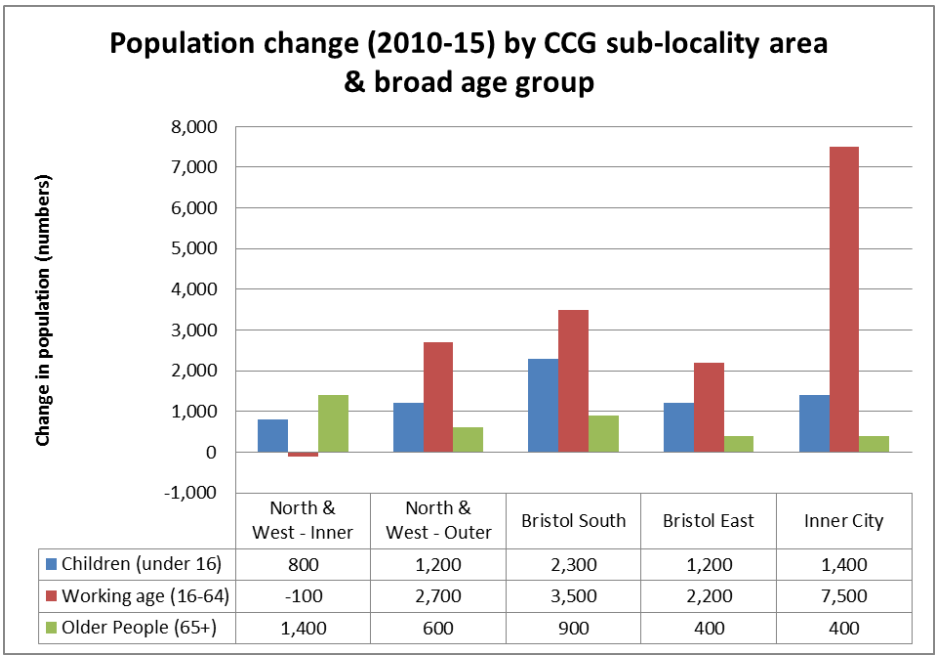



*Fig 3.2.1 Source: ONS Annual Mid-Year Population Estimates 2005-15*

Over the last 5 years (2010-15), half of the 26,300 rise in Bristol population was in the Inner City & East. By broad age group, the majority of increase was due to the 15,800 rise in working age people, with almost half in the Inner City (fig 3.2.2), though this number fell in North & West inner.

Numbers of children rose 7,000, with rises across the city, highest in South Bristol. However, while numbers of older people rose 3,600, this was mainly in North & West 'inner' area.

Future growth is also likely to be mainly in Central Bristol. More than half (53%) of planned new homes 2015/16 - 2019/20 is likely to be in the Inner City area, the majority of which are flats.

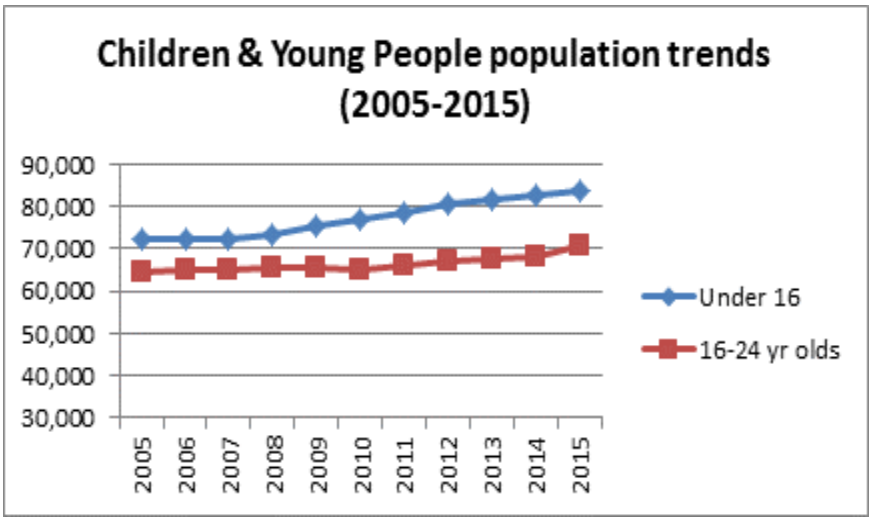



| | North & West - Inner | North & West - Outer | Bristol South | Bristol East | Inner City |
|---|---|---|---|---|---|
| Children (under 16) | 800 | 1,200 | 2,300 | 1,200 | 1,400 |
| Working age (16-64) | -100 | 2,700 | 3,500 | 2,200 | 7,500 |
| Older People (65+) | 1,400 | 600 | 900 | 400 | 400 |

*Fig 3.2.2: Population change 2010-15. Source: Performance, Information and Intelligence, Bristol City Council. Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0.*

### Child population changes

Bristol has 83,800 children under 16 and 70,500 young people 16-24 with increases of around 900 children and 2,100 young people in the last year (fig 3.2.3).




*3.2.3: Source: ONS 2005-2015 Mid-Year Population Estimates. Crown Copyright 2016*

In the last decade (2005-15), the number of children (aged 0-15) living in Bristol is estimated to have increased by 11,700 (16.2%). This increase has been largely amongst the under 8 year olds and in particular among the 2-5 year olds (an increase of 36%). The growth in the number of under 5s in the last

decade (+7,100) is the fourth highest nationally[16]. In recent years though, the fastest rising age band is those aged 5-9 (fig 3.2.4), as would be expected.

Bristol's child population (under 16) is rising in all areas, with highest rise in South Bristol (fig 3.2.5) (though proportionately more in Inner City & East). For young people (16-24 years) though, numbers have risen mainly in the Inner City, but also in N&W inner (mainly students).

Within localities rates of change vary considerably between wards[17], with implications for how services can manage demand and where services should most appropriately be located.

### Older people population changes

Bristol has 59,300 older people 65 & over, an increase of 500 older people in the last year. Within that number are 9,100 people 85 & over.

Over the last decade, after a period of the older population (65 & over) falling in Bristol, it is now rising year on year (fig 3.2.6). This rise has been mainly in the North & West locality (fig 3.2.2) (and mainly in the 'inner' area), which is very different to the population change for other ages.

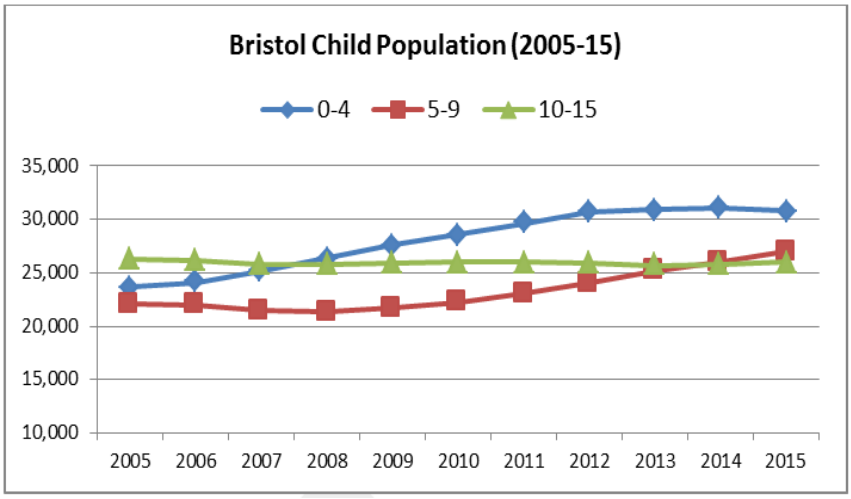



*Fig 3.2.4, Source: ONS 2005-2015 Mid-Year Population Estimates. CC 2016*

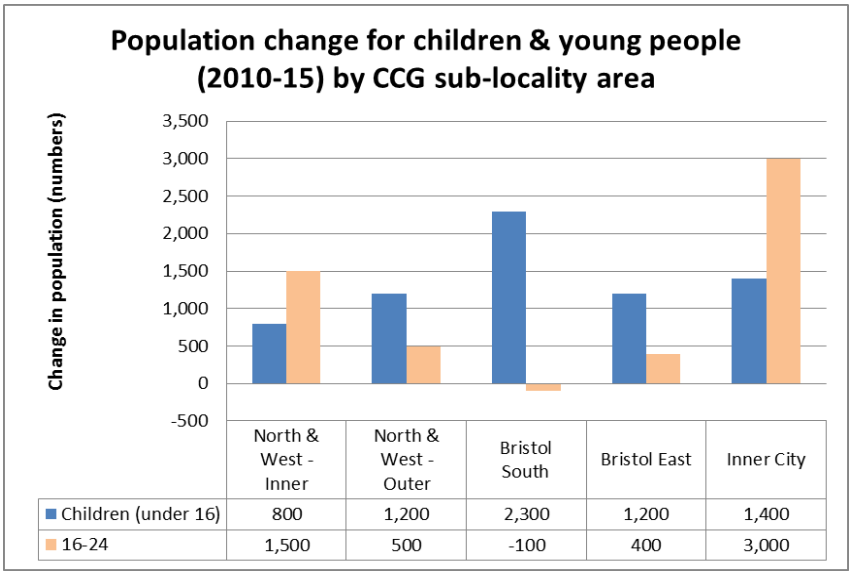



*Fig 3.2.5: Population change 2010-15. Source: Performance, Information & Intelligence, BCC. Adapted from ONS data (Open Government Licence v.1*

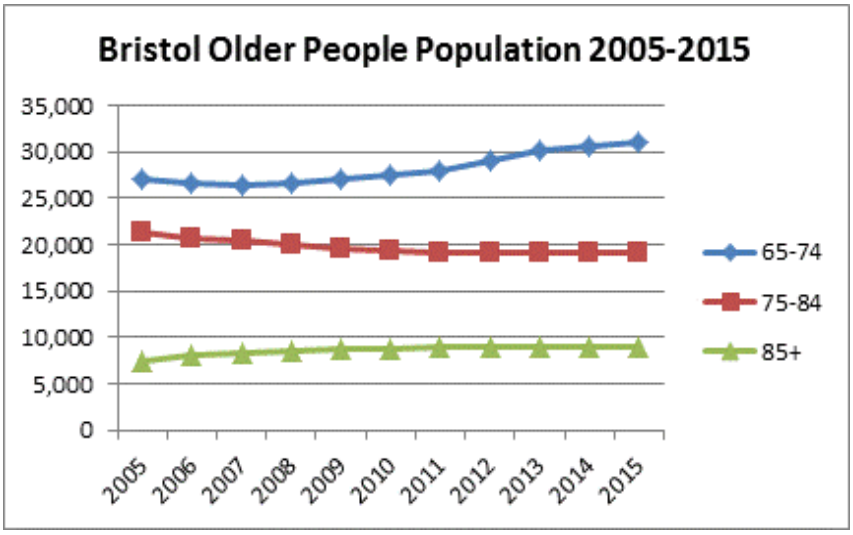



*Fig 3.2.6, Source: ONS 2005-15 Mid-Year Population Estimates. CC 2016*

[16] Population of Bristol 2016 report: www.bristol.gov.uk/population
[17] Further data available via on-line JSNA Atlas: http://ias.bristol.gov.uk/ or on request.

## 3.3 Population diversity

16% of Bristol's population are from black and minority ethnic groups (BME), but Inner City & East has a much larger proportion of BME population (31%), with North & West (12%) and South (7%). Using an alternative definition, 22% of Bristol's population are non-'White British'[18], and by locality this is 38% in Inner City & East, 19% North & West and 12% in South.

Bristol residents born outside the UK increased from 8% to 15% in the last decade[19], which affects changing health needs of the local community, and communicating best routes to access appropriate health services. Across Bristol the rate of residents born outside the UK is 8% South, 14% North & West and 23% Inner City & East (over 30% in the Inner City alone).

### Child diversity

The child population is increasingly ethnically diverse. The 2011 national census showed that 28% of Bristol children (under 16) belong to a Black or Minority Ethnic (BME) group, compared to the Bristol average of 16% BME. Using the alternative definition of diversity, 32% of children belong to the non-'White British' population, compared to the Bristol population average of 22%. Ethnic diversity varies considerably across the city; 53% of children under 16 in the Inner City & East are BME, compared with 21% in North & West and 13% in South (fig 3.3.1). By ward, the figure ranges from 4% BME in Bishopsworth to 60% in Lawrence Hill.

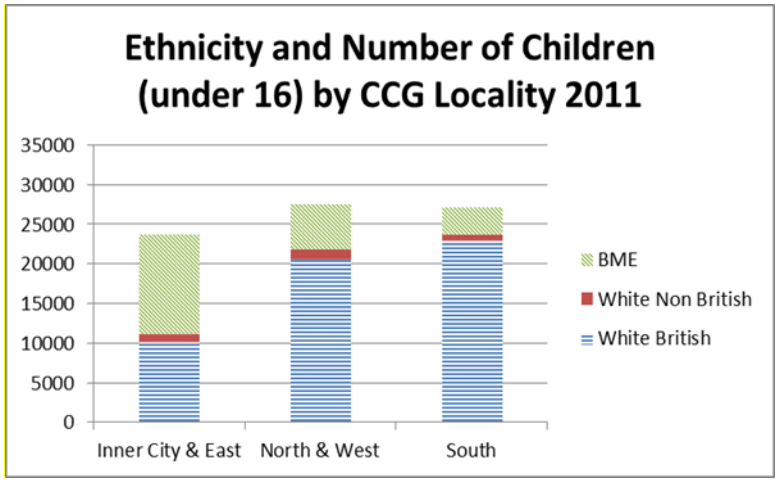



*Fig.3.3.1, source: ONS 2011 Census*

According to the 2015 School Census, there were 11,900 BME school age children (5-15 yrs) in Bristol council-maintained schools (27.7% of the student population).

Also, there are 8,000 pupils with English as an Additional Language (EAL), 18.7% of students 5-15 yrs, higher than 18% in 2014. The map (fig 3.3.2) highlights that there are much higher % EAL pupils in Inner City & East Bristol (highest wards being Central, 53%, and Lawrence Hill, 64%, of all pupils having English as an Additional Language).

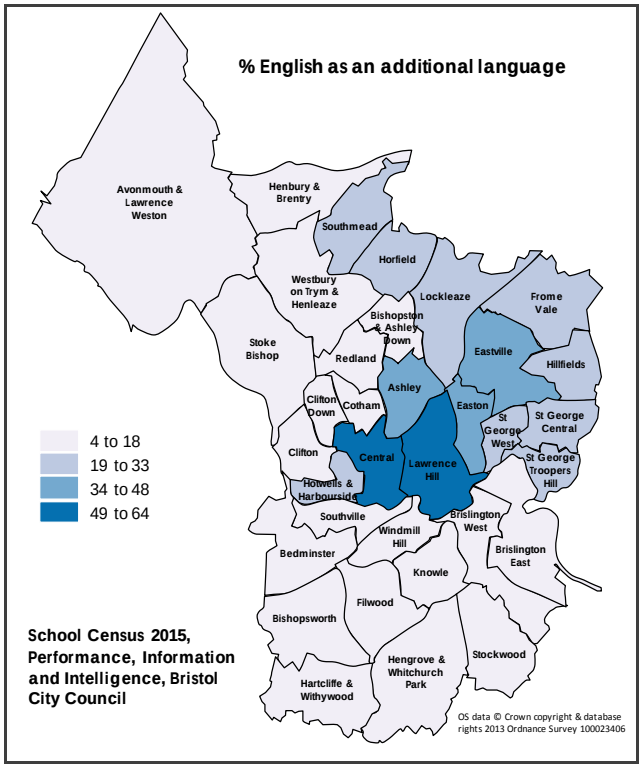



*Fig 3.3.2, source: BCC 2015 School Census (applied to 2016 wards)*

[18] BME population is all groups with the exception of all White groups. Non-'White British' is all groups except White British. Source: ONS 2011 Census
[19] Source: ONS Census 2011 and 2001

## 3.4 Births

The number of births in Bristol fell for the third year in a row but is still above average for the last decade (fig 3.4.1). In 2014/15 there were 6,380 births in Bristol. Births in Bristol had risen by 48% between 2001/02 - 2011/12[20], with the birth rate rising fastest in Inner City & East. Although births are no longer rising, in the 12 months to mid-June 2015 there were 3,000 more births than deaths, meaning that natural change (births minus deaths) accounted for 44% of the population increase in the city.

The recent fall in births is not happening across all of Bristol though. Numbers of births are remaining constant in South Bristol on average, but falling in the other localities[21] (fig 3.4.2).

By ward, annual numbers of new births in 2014/15 varied from 50 (Hotwells and Harbourside) through to 373 (Lawrence Hill). Although Inner City wards have the highest numbers of births, the rate (births per 1,000 population) is falling fastest in the Inner City.

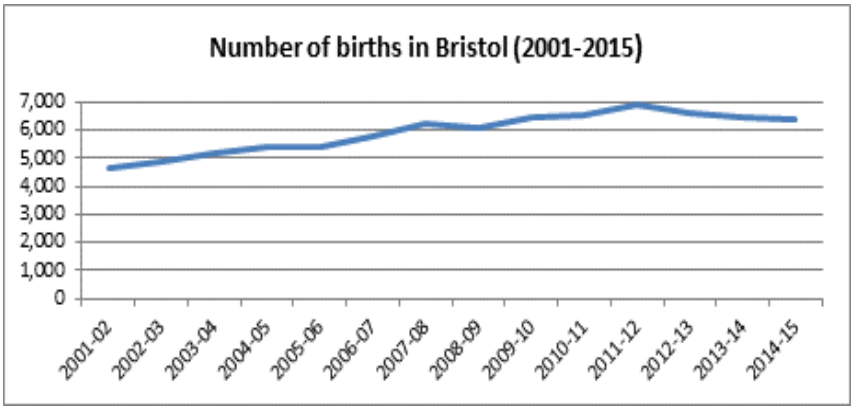



*Fig 3.4.1 Source: Population Estimates Unit, ONS: Crown Copyright 2016*

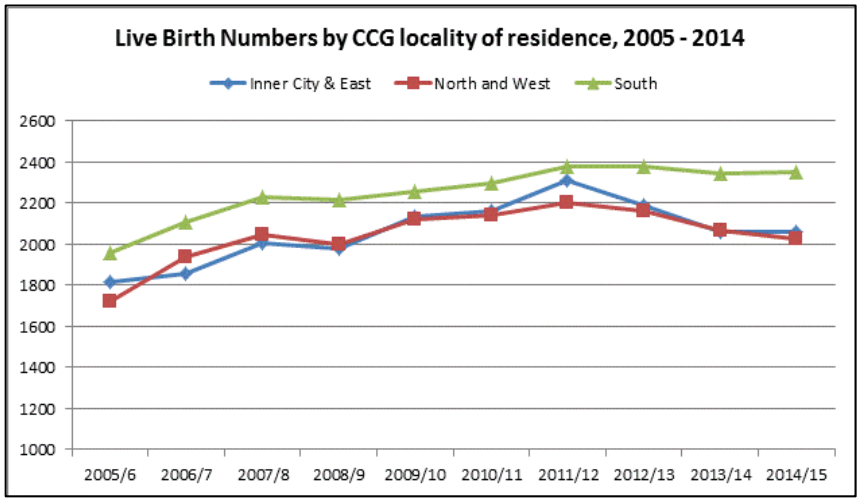



*Fig 3.4.2 Source: Public Health Birth File, PHKS, Bristol City Council, 2016*

Most births are to UK-born mothers (4,620 in 2014). 28.3% (1,820) of births in Bristol are to non-UK born mothers, and this figure has fallen slightly since 2012. Somalia and increasingly Poland are the most common countries of the mother's origin for Bristol births to non-UK born mothers (fig 3.4.3)

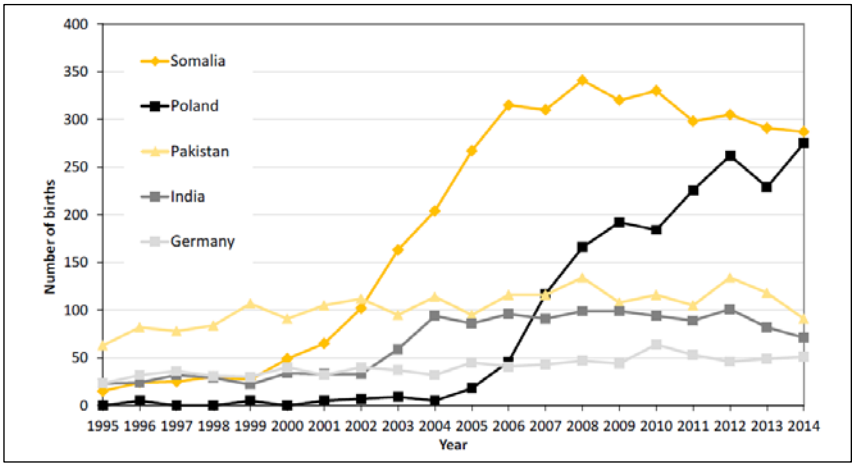



*Fig 3.4.3 Live births in Bristol to non-UK born mothers for the 5 most common countries of birth of mother (1995-2014) Source: ONS Birth Data, 2015*

[20] Mid-Year Population Estimates. Population Estimates Unit, ONS: Crown Copyright 2016
[21] Public Health Birth File, Bristol Public Health Knowledge Service, 2016

## 3.5 Population projections

The population of Bristol is projected to increase 10.4% to 488,500 by 2024 – (figs 3.5.1 & 3.5.2) and potentially rise to 545,600 by 2039[22].

The main drivers of population growth are expected to be due to natural change (i.e. more births than deaths) rather than migration.

### Child projections

By 2024, there are projected to be 13,400 more children (16.2% rise), but the young person population (16-24 yrs) remains broadly stable

Most of the rise in the child population for 2014-24 is projected to be in the 10-14 years age band (29% rise - figs 3.5.3 & 3.5.4), impacting on secondary school age services, but numbers of young children continue rising.

### Older People projections

There are projected to be 7,700 more people 65 & over by 2024, a 13% rise (and potentially a 44% rise by 2039).

For people 85 and over, there are projected to be 1,100 more by 2024, a 12% rise (but potentially an 84% rise by 2039).

| Age | 2014 | 2019 | 2024 | Bristol change to 2024 | | National change |
|---|---|---|---|---|---|---|
| 0-15 | 82,800 | 90,400 | 96,200 | 13,400 | **16%** | **8%** |
| 16-24 | 68,400 | 68,600 | 68,900 | 600 | **1%** | **-5%** |
| 25-49 | 167,900 | 178,700 | 186,400 | 18,500 | **11%** | **1%** |
| 50-64 | 64,600 | 68,600 | 70,500 | 5,900 | **9%** | **12%** |
| 65-74 | 30,600 | 32,800 | 33,200 | 2,600 | **8%** | **9%** |
| 75+ | 28,200 | 29,100 | 33,300 | 5,100 | **18%** | **33%** |
| All ages | 442,500 | 468,100 | 488,500 | 46,000 | **10%** | **7%** |

*Table 3.5.1 Source: ONS 2014-based Sub-national Population Projections*

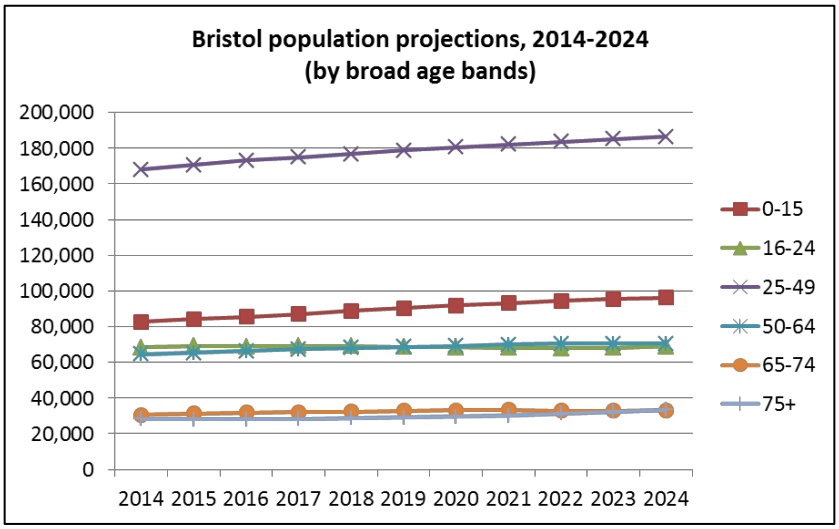



*Fig 3.5.2 Source: ONS 2014-based Sub-national Population Projections*

| Age group | 2014 | 2019 | 2024 | % change 2014-24 | % National change |
|---|---|---|---|---|---|
| 0-4 | 31,000 | 32,100 | 34,100 | **10%** | **1%** |
| 5-9 | 26,000 | 28,600 | 29,300 | **12%** | **5%** |
| 10-14 | 21,400 | 25,200 | 27,500 | **29%** | **18%** |
| 15-19 | 26,300 | 25,600 | 29,200 | **11%** | **4%** |

*Table 3.5.3 Source: ONS 2014-based Sub-national Population Projections*

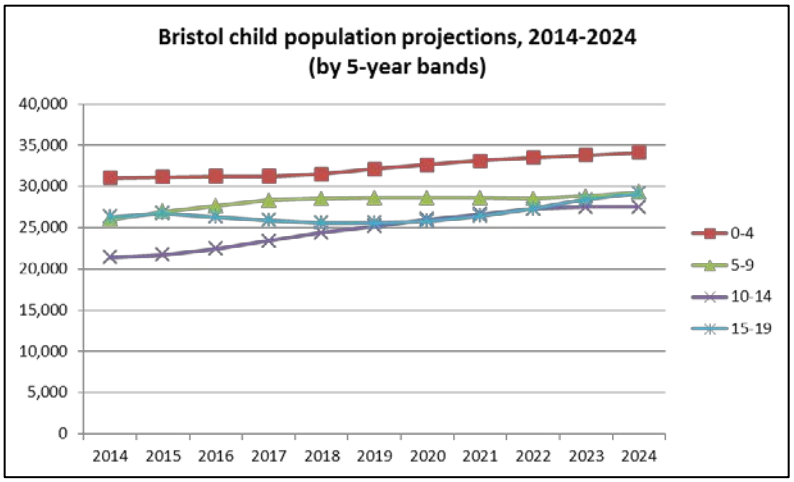



*Fig 3.5.4 Source: ONS 2014-based Sub-national Population Projections*

[22] ONS 2014-based Sub-national Population Projections, published May 2016. ***Note*** – *These are trend-based projections, so assumptions for future levels of births, deaths and migration are based on levels from 2009 to 2014. They show what the population will be if trends continue, and do not attempt to predict the impact of future policies, economic circumstances, local development, or other factors. Trends may not continue long term.*

# Specific population groups

## 3.6 Carers[23]

According to the 2011 Census, there are over 40,100 carers in Bristol (all ages), which is just under 1 in 10 of the population (9.4%). Over the last decade (since 2001 Census) the number of unpaid carers recorded has increased by 5,000, but the proportion stayed the same (9.3% in 2001) as Bristol's population has risen considerably. The majority of adult carers (25,700) are caring under 20 hours a week but just over 9,000 are providing unpaid care for 50 hours or more each week.

Of the 40,100 unpaid carers identified in the 2011 Census, 860 were children under 16 and 2,700 were young people aged 16-24.There are also 8,300 carers who are over 65 years of age (15% of all people over 65 in Bristol), and 40% of people in this age category (3,350 people) provide care for over 50 hours a week, which is disproportionately high.

For further information, see the Bristol Carers Strategy refresh 2015–2020: www.bristol.gov.uk/policies-plans-and-strategies/carer-strategy

### Young Carers

According to the 2011 Census, there were 860 children under 16 and 2,700 young people aged 16-24 who were carers. However, it is estimated that there are more young carers in Bristol than this as young carers are a largely hidden group, and may not be recognised within the family where they have caring responsibilities, or even identify themselves in that role.

Using national prevalence estimates[24] based on research with young people, it is estimated that there may be as many as 7,600 young carers in Bristol.

This study showed that the majority of these young carers would have been caring for between 3-5 years (3,390) and 2,770 have been caring for 2 years or less. 82% of them (6,320) are providing emotional support and supervision and 18% (1390) are carrying out personal care. Young carers are known to have particular health needs[25] (mainly mental health/social isolation/educational attainment impacts e.g. Young carers are one and half times more likely to have a special educational need or a long-standing illness or disability). At present we do not collect specific indicators locally on Young Carers and their needs.

[23] This section uses Census 2011 data and is mainly unchanged from JSNA 2015

[24] Source: Bristol Carers Support Centre, using Becker and Dearden formula (Loughborough University) applied to ONS mid-2014 population estimates for Bristol

[25] Source: Children's Society Report 'Hidden From View', via Bristol Carers Strategy 2015–2020; www.bristol.gov.uk/policies-plans-and-strategies/carer-strategy

## 3.7 People with Long-term health problems or Disability

According to the 2011 Census, there are 71,700 people in Bristol with a "limiting long-term illness or disability". As a proportion this is 16.7% which is lower than the 17.9% national average.

This is a lower proportion than in 2001 (was 17.8% with a 'long-term limiting illness'), but this is due to the overall population increase. The actual number of people whose day-to-day activities are limited has increased from 67,700 people to 71,700 people in 2011.

Of these, 34,550 (8%) have day-to-day activities that are limited *a lot* and 37,150 (9%) have day-to-day activities limited *a little*.

**Gender:** There are more women than men with a "limiting long-term illness or disability" living in Bristol – 15.6% of men and 17.8% of women. This is due to women generally living longer than men.

Within Bristol, the Census 2011 data shown by the new Bristol wards 2016 highlights that a higher % of people with a long-term health problem or disability live in the most deprived South Bristol wards (Filwood and Hartcliffe & Withywood, both over 20%), but also in Lawrence Hill and most of the "outer" North & West wards.

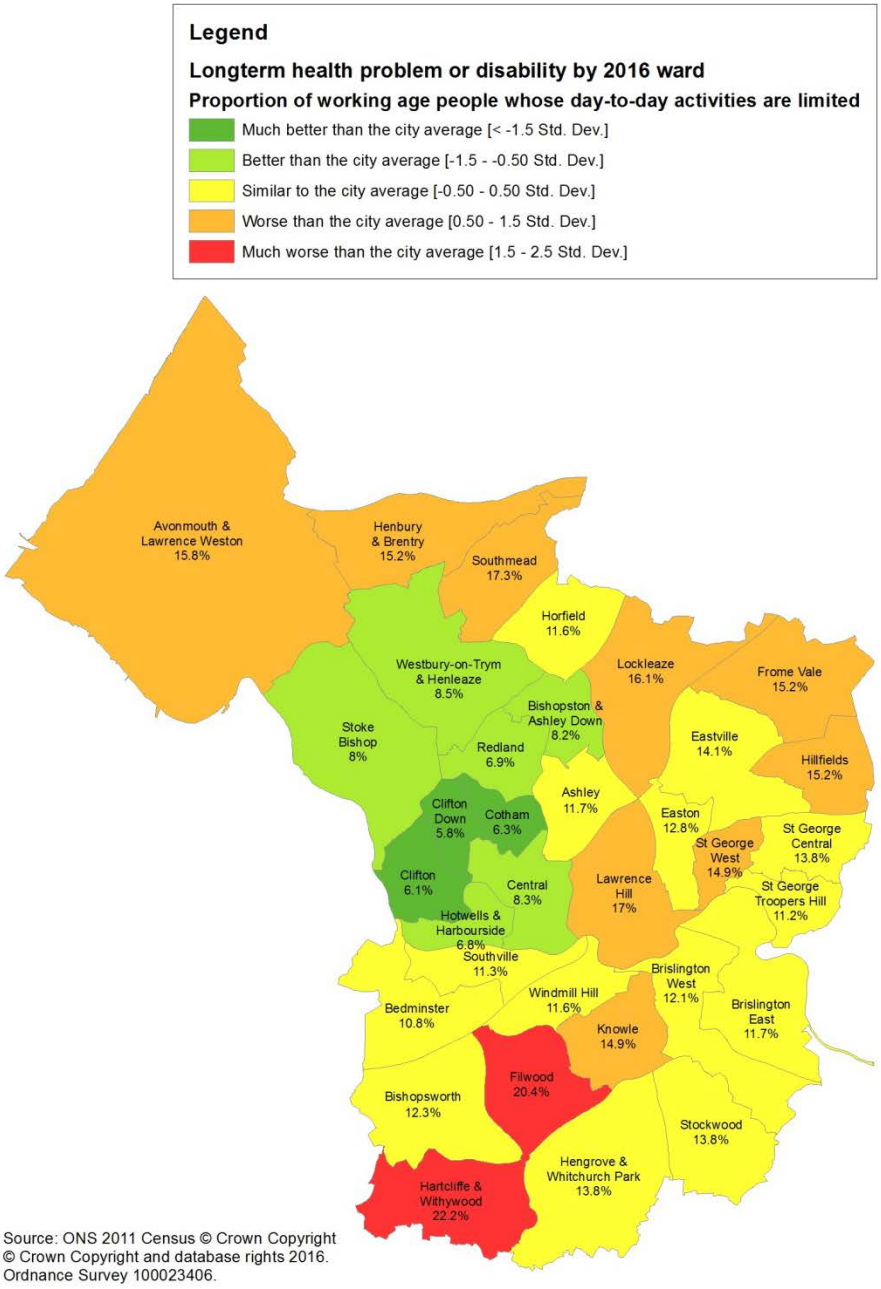



*Figure 3.7.1: Long-term health problem or disability by Bristol ward*
*Source: 2011 Census ONS Crown Copyright Reserved [updated to Bristol wards 2016, BCC Performance, Information & Intelligence]*

## 3.8 People with Learning Disabilities and Autism

### 3.8.1 Learning Disabilities

According to overall population estimates[26], there are around 8,600 adults in Bristol with some level of Learning Disability in 2016. Of these, around 1,800 adults are estimated to have a moderate or severe learning disability, and hence likely to be in receipt of services.

Data from GP patient registers[27] indicates there are around 2,200 people (all ages) recorded as having Learning Disabilities (LD) in Bristol. This will focus on those with moderate to severe LD who are most likely to require support. This represents 0.45% of the patient population, which is similar to the England average (0.44%).

BCC Adult Social Care data (April 2016) shows 640 clients receiving a community support service have Learning Disabilities (aged 18-64).

In addition, there are over 1820 pupils[28] recorded with a Learning Disability in Bristol schools in 2016, of which 160 are "Severe" and 100 are "Profound & Multiple Learning Disabilities".

### 3.8.2 People with Learning Difficulties: health inequalities

People with learning disabilities have poorer health than the general population, much of which is avoidable. As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers[29].

National research[30] shows increased rates of health conditions for people with learning disabilities, including epilepsy, mental health and heart disease, and inequalities in life expectancy - men with learning disabilities die an average 13 years sooner than the wider population whilst women die 20 years sooner.

**Further information**

- **Learning Disability Profiles** – a range of data about people with learning disabilities at Local Authority level http://fingertips.phe.org.uk/profile/learning-disabilities
- Bristol City Council services: www.bristol.gov.uk/social-care-health/help-for-people-with-learning-difficulties
- Comments from people with Learning Disabilities – see Healthwatch report at http://bit.ly/1NpxRLd

### 3.8.3 Autistic Spectrum Conditions

In terms of overall population prevalence[31], there are estimated to be 3,570 adults in Bristol with some level of autistic spectrum condition in 2016 (18+, including 560 people over 65)

**Gender:** The adult estimate is 3,210 males and 360 females.

Note – Many people with Autistic Spectrum Conditions do not require formal interventions from services. More detailed information on children with Autistic Spectrum Conditions is available through Special Educational Needs data. There are over 750 pupils[32] recorded with Autism in Bristol schools in 2016.

**Further information**

- See www.bristol.gov.uk/social-care-health/autism
- JSNA Chapter on "Children & young people with Social and Communication Interaction Needs" (inc Autism)

[26] Institute of Public Care, POPPI and PANSI tools, www.poppi.org.uk ; national 2004 prevalence estimate applied to the Bristol population; accessed Oct 2016
[27] NHS Quality Outcomes Framework, QOF, 2014/15 [NB This changed from recording adults to all ages in 2014/15]
[28] Source: Bristol school census 2016 – see section 5.6 Special Educational Needs
[29] Statement from Public Health England Learning Disability Profiles
[30] "Confidential Inquiry into premature deaths of people with learning disabilities"; University of Bristol, 2013; www.bristol.ac.uk/cipold
[31] Institute of Public Care, POPPI and PANSI tools, www.pansi.org.uk ; prevalence estimate of 1% of adult population applied to the Bristol population; accessed Oct 2016
[32] Source: Bristol school census 2016 – see section **5.6 Special Educational Needs**

## 3.9 Gypsy, Roma & Travellers

Gypsy, Roma & Travellers (GRT) have historically had the poorest outcomes of any ethnic group in England[33]. The obstacles and constrains facing GRT families are multiple and complex.

Local evidence suggests that there are around 500 Gypsy and Traveller families living in Bristol[34] although there are fluctuations in number due to seasonal travel.

An estimate of overall numbers of GRT children in the Bristol area is around 600-1000 children, although these may not all be in Bristol at one time. This community has increased substantially in size in recent years, with a very significant rise in numbers of Roma children. There is strong evidence that this community have higher levels of unmet health needs, and experience poor access to health services.

Bristol has a relatively large New Traveller population. These, as well as Bargees (boat dwellers) are often underrepresented in GRT data and provision but share similar health/educational outcomes.

### 3.9.1 Health outcomes

Gypsy, Roma & Travellers have poorer life outcomes than any other group, across a wide range of social indicators[35]. The average life expectantly of a GRT person is 50 years.

A robust study compared the health needs of 293 Gypsies and Travellers in 5 areas in England (including Bristol), to the needs of 293 non-travelling adults. Key findings from this study are included below (SWPHO, 2011:3 - 4)[36]

**Child Health for Gypsy, Roma & Travellers**

- Higher infant mortality rates (up to five times higher)
- Lower birth weight
- Lower levels of breastfeeding
- Lower immunisation rates
- Higher rates of accidents

**Adult Health for Gypsy, Roma & Travellers**

- Reduced life expectancy
- More likely to have a long-term illness, health problem or disability which limits daily activities or work (11% higher)
- Higher prevalence of anxiety (28% vs 4%) & depression
- Higher maternal death rates
- Higher prevalence of miscarriage (16% vs 8%)
- Higher prevalence of arthritis (22% vs 10%), rheumatism (6% vs 1%); heart disease including angina (8% compared to 4%)

Further research[37] shows that

- Domestic abuse is a notable issue for GRTs. Estimated that 60%-80% of women from travelling communities experience domestic abuse during their lives
- Suicide rates are 7 x higher than the general population

### 3.9.2 Educational outcomes[38]

- 50% of GRT pupils eligible for free school meals (2015)
- 4 times more likely to have Special Educational Needs (2004)
- 2 times more likely to be excluded from primary school.
- Earlier average age of leaving school.

[33] Ofsted; Dec 2014 and SWPHO, 2011:3
[34] Bristol GTAA, 2013
[35] Bhattacharyya et al. 2003; DfE, 2010 and Rowe and Goodman, 2014
[36] South West Public Health Observatory (SWPHO) report (October 2011) / Excluding New Age travellers; undertaken by Parry et al.
[37] www.twelvescompany.co.uk/cornwall/information-about-specialist-support/gypsies-travellers
[38] References via GRT Cultural Awareness: Health and Engagement; Bristol 2016

## 3.10 Lesbian, Gay, Bisexual and Transgender people (LGBT)

Current estimates of the LGB population vary, with the National Sexual Attitudes and Lifestyle Survey (2013) recording 2.8% of males and 2.7% of females, but the Department of Trade and Industry[39] estimated between 5-7%. Based on the 2015 resident population, this would give up to 31,500 Lesbian, Gay and Bisexual people living in Bristol.

The Gender Identity Research and Education Society (GIRES) now estimates the number of Trans people in the UK at 1% of the population defined as being on a "gender variant spectrum"[40]. This would give a population of over 4,500 Trans people in Bristol.

### 3.10.1 Bristol LGBT Health & Wellbeing needs

A new survey commissioned by Bristol Healthwatch regarding LGBT Health Needs was published in 2016[41]. The results from this survey are as follows:

- 61% of participants had sought help for anxiety or depression
- 32% had hurt or injured themselves (known as self-harm)
- 20% were feeling unhappy and depressed in recent weeks.
- 59% had thought about suicide or tried to kill themselves.
- Most people would seek help from friends (54%) or a partner (52%) when they are unwell.
- 35% stated they had a physical health condition expected to last 12 months or more.
- 34% stated they had a mental health condition expected to last 12 months or more.
- 68% said they had felt discriminated against because of their gender identity and / or their sexual orientation.
- 55% of participants had experienced discrimination on the streets, 48% whilst at work, 44% in bars and clubs and 37% whilst at school.
- 67% were "out" in their local area and 25% weren't "out"
- Participants were most likely to be "out" in social spaces, at work and when volunteering.
- We found that participants feared discrimination and prejudice, or a lack of understanding from health care professionals, directly relating to their gender identity and / or their sexual orientation.
- Awareness of LGBT+ issues, as well as making assumptions and stereotyping LGBT+ people, among some health care professionals was a concern for many participants.
- Assumptions that LGBT+ people are cisgender and / or heterosexual. "What about your [opposite sex] husband / wife?" is a common question, particularly for lesbians and gay men in same-sex relationships.
- Some LGBT+ people do not "come out" when accessing a range of services, because they fear being treated negatively or experiencing poor service as a result. For example, they may have experiences of receiving homophobia, biphobia and / or transphobia from professionals or fear that this might take place.
- A lack of understanding and awareness from health professionals of issues for trans patients relating to gender identity was a concern for many of the trans participants.
- LGBT+ people fear holding their (same-sex) partner's hand in public for fear of attack, especially when on the streets.

[39] Source: Final Regulatory Impact Assessment: Civil Partnership Act 2004
[40] Source: Gender Identity Research Education Society – GIRES (2009)
[41] Source: 'Evidence for Change', Bristol Lesbian, Gay, Bisexual and Trans Health and Wellbeing Research Report September 2016 by The Diversity Trust & Bristol Healthwatch http://healthwatchbristol.co.uk/wp-content/uploads/2016/06/Diversity-Trust-Report-2016.pdf

## 3.11 Migrant Health Needs

### 3.11.1 Migrants by Country of Birth

In 2011, 15% people living in Bristol were born outside the UK, this is an increase since 2001 when the proportion of people born outside the UK was 8%. Of the 15% born outside the UK, 19,686 (4.6%) were born in other EU countries (including 10,520 in Accession countries) and 40,540 (9.5%) were born in countries outside of the EU.

There are more than 187 countries represented in Bristol. Poland was the most popular country of birth with 6,415 Polish-born residents, followed by 4,947 people who were born in Somalia – the latter is the 4th highest number of Somali-born of all local authorities in England.

Lawrence Hill ward[42] has the highest proportion of people not born in the UK, at 39%, and Central ward has the second highest proportion, with 33% of all residents born outside the UK. Many of these are students.

### 3.11.2 Migrants by age and sex

Recent migrants include more or less equal numbers of men and women. More recent migrants have a younger age profile than people who migrated in previous decades. Of the most recent migrants (arrived 2001-11) 70% are aged under 35 years.

### 3.11.3 Migrants and where they live in Bristol

The majority of new migrants to Bristol live in the inner city areas of Bristol which are characterised by a high proportion of BME residents, a high proportion of rented accommodation, a high proportion of non-family households and higher than average levels of unemployment (fig 3.11.4)

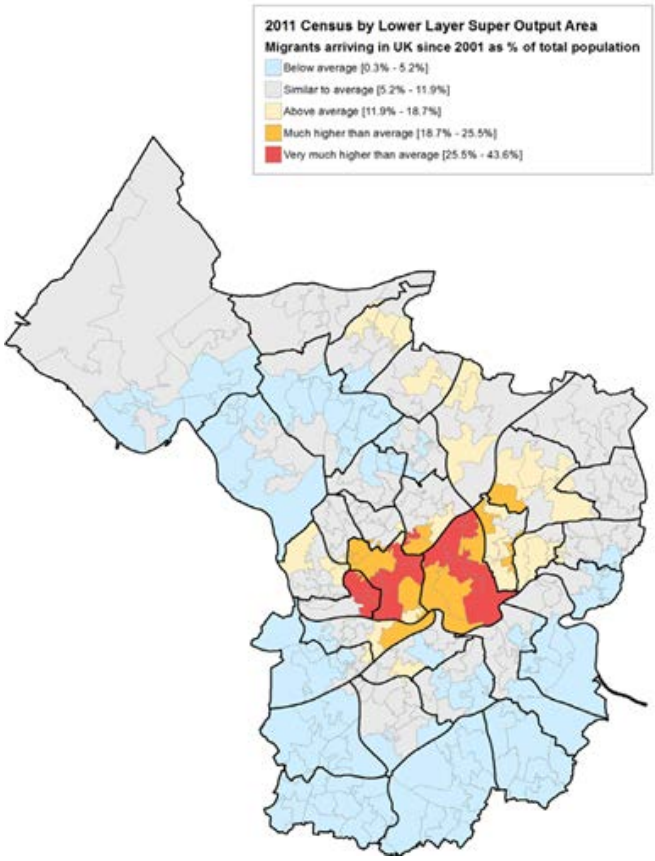



*Fig 3.11.4 Migrants arriving in UK since 2001 as % of total population*
*Source: 2011 Census ONS © Crown Copyright 2013 [from Nomis]*

Analysis of changes in age structure between 2002 and 2012 show that population growth in Central Bristol was focused in the early 20's age group, mainly thought to be students. Data on housing development indicates that there has been a large increase in student accommodation in the city centre.

### 3.11.4 Language

For the first time in 2011, the Census asked a question about main language spoken and proficiency in English. This found that there are at least 91 main languages spoken in Bristol.

English is the main language spoken in Bristol followed by Polish and Somali. Overall 9% of people do not speak English as their main language.

[42] Census 2011 for new 2016 wards

## 3.12 Gender[43]

The Bristol population is 224,600 females and 224,800 males (or 50% women and 50% men). However, there are more women than men aged 65 and over and more men than women in the 25-49 year age group (further details in "3.1 Bristol population overview").

Healthy Life Expectancy is broadly similar for women (64.2 years) and men (63.3 years) in Bristol. Also the gap in healthy life expectancy (*between the most deprived 10% and the least deprived 10% in Bristol*) is similar for females (16.7 years gap) and males (16.3 years gap).

### 3.12.1 Key headlines for women

- Women in Bristol live an average of 18.8 years in poor health, longer than the average for men (15.1 years); these figures are similar to England as a whole (2012-14)
- Early deaths due to cancer for women have risen in Bristol are now significantly higher than England (2013-15).
- Bristol rates for early deaths due to respiratory disease for women are significantly higher than England (2013-15).
- Alcohol-related hospital admissions are now significantly higher than the England average for women (2014/15).
- A rise in the proportion of people who feel that "sexual harassment is an issue in Bristol" (22%); in the last year, 84% of victims of Sexual offences were female (2015).
- The proportion of unemployed women (claiming Job Seekers Allowance) in Bristol increased to an all-time high in Oct 2014 of 36.4%.
- Nationally more than 1 in 4 women experience domestic abuse in their lifetimes; last year 3 out of 4 victims of "domestic abuse" in Bristol were female.
- Bristol has one of the highest numbers of recorded cases of female genital mutilation (FGM) in England. (2015/16).
- Women (63%) are significantly less likely to be physically active than men (68%), but are significantly more likely to eat healthily ("5-a-day") (women 55%, men 46%). (2015).
- Women have higher levels of obesity than men.
- In Bristol during 2015-16 there were 1,345 emergency admissions for self-harm; 869 (65%) by females and 476 (35%) by males.
- The suicide rate for women in Bristol (7.7 per 100,000) is significantly higher than the national female average, and highest of core cities. It appears to be rising. (2013-15).
- Nationally 60-70% of carers of people with dementia are women. They report that this affects them economically, physically and emotionally. (2015).
- The majority of falls-related hospital admissions for older people 65 & over in Bristol are females (68%). (2014-15).
- Nationally, girls at 15 are significantly more likely to be a smoker than males (very different to the adult picture) and more likely to have had an alcoholic drink than boys. (2016)
- Girls report worse mental wellbeing than boys. 42% girls and 27% boys had a low or medium low wellbeing score (Bristol Pupil Voice, 2015)
- The ratio of "excess winter deaths" for women in Bristol rose significantly from 5.9 in 2013/14 to 38.2 in 2014/15. This was in line with a sharp rise nationally, and means there were 38.2% more women dying in the winter months in 2014/15 compared with the non-winter months.

[43] All points are drawn from throughout the JSNA 2016 Data Profile. Sources can be found in the relevant section

### 3.12.2 Key headlines for men

- Life expectancy for men is significantly worse in Bristol than the England average (and men on average live 4.5 years less than women) (2012-14)
- A higher proportion of boys than girls in Bristol are overweight or obese (23.5% boys 4-5 years old; 21.9% girls / 35.7% boys 10-11 years; 33.6% girls). (2012-15)
- Alcohol-related deaths in men are significantly higher than national average, and rising. (2012-14)
- Men (50%) are significantly more likely to be overweight than women (41%). (2015)
- Men are significantly less likely to abstain from drinking (for at least 2 days in a row) than women (32% men abstain, 47% women). (2015)
- The rate of early deaths due to cardiovascular disease (CVD) is significantly higher for men in Bristol than it is for men nationally, and is more than twice that for women (2013-15).
- Bristol rates for early deaths for men due to cancer are significantly higher than the England male average, and significantly higher than for women (2013-15).
- Bristol rates for early deaths due to respiratory disease for men are significantly higher than England (2013-15).
- Bristol rates of early death from liver disease are significantly above the England average for men, and are over twice as high in men than women (2013-15).
- Preventable mortality rates are significantly higher in men than women, and are higher than nationally.
- Men in their mid-life years have the highest rates of suicide in Bristol. The national picture reflects this, although the rate is significantly higher in Bristol. (2010-14).

## 3.13 Other groups

There are population profiles for many Equalities groups using Census 2011 data on the Council's Equalities data and research webpage, including different ethnicities and faith communities: [www.bristol.gov.uk/people-communities/equalities-data-and-research](www.bristol.gov.uk/people-communities/equalities-data-and-research)

Specific vulnerable groups to identify more detailed information on in future include the above, plus disabled people, including sensory impairment, and to develop sections on offenders, veterans, sex workers and others.

# Section 4
# Children & Young People's Health

## Summary points[44]

### Population

- Bristol's child population is rising in all areas, but is rising fastest in Inner City & East locality, and the child population is increasingly ethnically diverse.
- Births have fallen but natural change (births minus deaths) was still 44% of the population increase in the city in 2014/15.
- 0-15 population is projected to rise by 16.2% by 2024.

### Baby and maternal health

- The percentage of full term births in Bristol with a low birth weight has risen slightly and is now broadly similar to national.
- Infant mortality rates in Bristol are no longer rising and are similar to national rates.
- Breastfeeding rates are higher than national but within Bristol are lowest for women from White ethnic groups living in deprived wards.
- Maternal smoking rates at delivery are falling and are similar to national rates, but varies across the city.

### Children and Young People's Health

- 3250 children in Bristol have a "limiting long-term illness or disability", proportionately more than nationally.
- Child hospital admissions for asthma are rising, especially in the Inner City. 2 of 3 admissions are for boys.
- The proportion of Bristol children who are overweight or obese at school entry is 22.9%, but now 35.4% for those leaving primary school (both similar to national average).
- Rates of dental decay for Bristol are similar to national but there are large inequalities across Bristol, and fewer children attend dental check-ups than nationally. Rates for tooth extractions in hospital are higher than nationally.
- Immunisation coverage for child immunisations is above national average for under 1s, but are below the 95% target for under 2s as nationally. There are significant variations in coverage across the city.
- More 15 year olds smoke in Bristol than nationally, and girls at that age are more likely to smoke than boys.
- An estimated 6% of 15 year olds regularly drink alcohol, similar to the England average, and 18% have tried cannabis, significantly higher than nationally (11%).
- Almost 10% of children and young people experience emotional health problems, and self-harm hospital admission rates (10-24 yrs) exceed England average[45].
- Young people report lower life satisfaction than nationally.
- Bristol has above average coverage for chlamydia screening (27% of 15 to 24 year olds screened in 2015).
- The rate of teenage conceptions in Bristol has shown a steep decline since 2007 and is now lower than the England average.

### Social care and wider determinants

- A higher % of children living in low income families in Bristol (23.2%) than nationally (20.1%), and now rising.
- Education results improved, but inequalities across the city remain.
- Improvement in health assessments for "looked after children", but immunisations and dental checks are low.
- First-time entrants to the Youth Justice System in Bristol are significantly higher than nationally, but now falling.

[44] These cover all relevant Children & Young People areas throughout the JSNA sections.

[45] See **9.6 Emotional Health and Wellbeing of Children & Young People**

## 4.1 Low birth weight

Babies born weighing less than 2500g are more likely to need additional health, education and social care support during childhood. Reasons for low birth weight may include (i) conditions during pregnancy, e.g. poor health in the mother, smoking, drinking or drugs during pregnancy, or crowding (e.g. twins or triplets) (ii) having a developmental or congenital problem.

In 2014, 2.6% of term births (i.e. those born after 37 weeks of pregnancy) were of low birth weight. This is rising (fig 4.1.1), but is broadly similar to the average for England (2.9%)[46] and Bristol still has one of the lowest rates of Core Cities.

Babies born prematurely, i.e. before 37 weeks of pregnancy, are much more likely to be of low birth weight. In 2014, 5.4% of all Bristol live births had a 'low birth weight'; significantly lower than the England average (7.0%)[47].

As numbers of low birth weight babies are relatively small we use 5-year averages to allow comparison at ward level. Across Bristol this average fell from 7.5% (2001-05) to 5.6% (2010-14). However, there remains inequality at ward level, from under 3.5% low birth weight babies in Hotwells & Harbourside and Clifton to 7.3% in Easton, Hartcliffe & Withywood and Filwood[48] (fig 4.1.2).

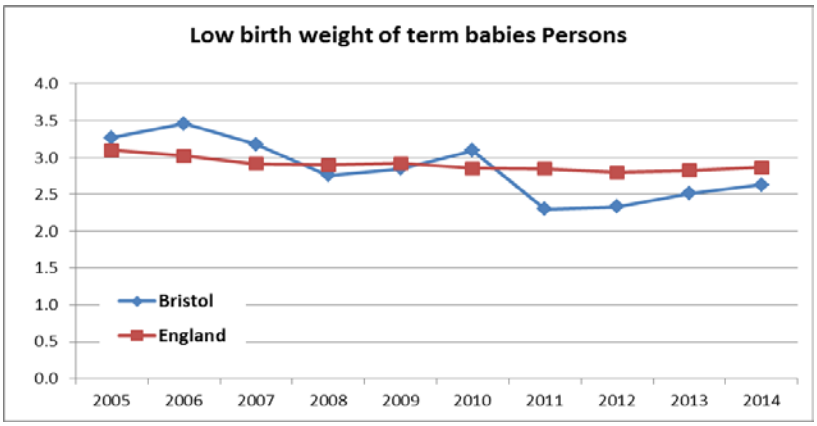



*Fig. 4.1.1, % of all live births at term with low birth weight*
*Source: ONS, via Public Health Outcomes Framework, Aug 2016*

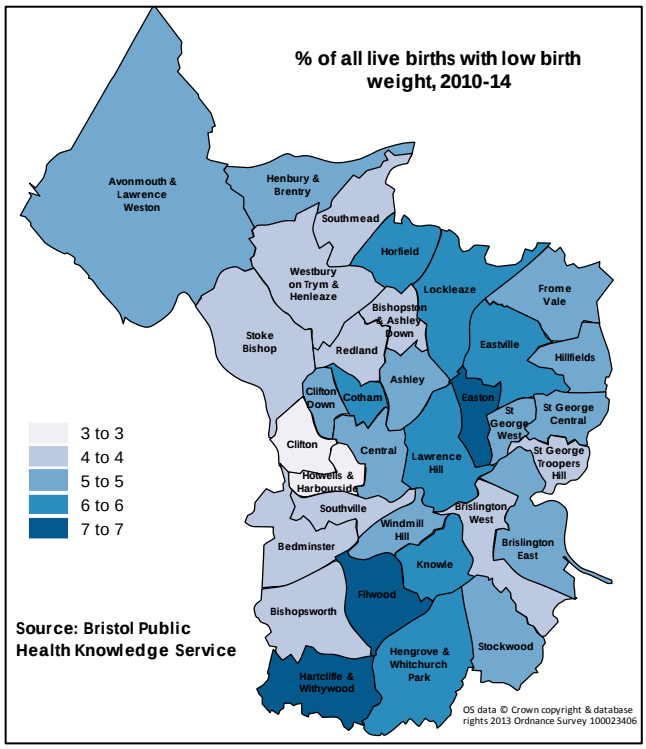



*Fig. 4.1.2, % of all live births with low birth weight (5 yr average of all births before and after term, excluding stillbirths and those with unrecorded weight).*
*Source: Bristol Public Health Knowledge Service 2016*

A project[49] to explore trends in childhood disability in Bristol linked individual data on birth weight and children with special educational needs over a 10 year period. This showed that low birth weight was strongly associated with the child having special needs when they reached school age, with a graduated effect: the lower the birth weight, the greater the risk.

[46] 2014 is still latest, as in JSNA 2015
[47] ONS, Birth Characteristics 2014 (via Bristol Public Health Knowledge Services)
[48] Source: Bristol Public Health Knowledge Service, 2016
[49] Disability trends modelling project, Bristol City Council, report April 2014

## 4.2 Infant mortality

The infant mortality rate is the number of deaths in the first year of life per 1000 live born children. Infant mortality in England is at an all-time low and is falling for all groups, yet significant inequalities remain with higher rates in children born into poverty, to teenage mothers or mothers who have not accessed antenatal care or have lifestyle choices (e.g. smoking, alcohol or drug misuse) that increase vulnerability of their infants.

The rate of infant mortality[50] in Bristol is 3.4 deaths per 1,000 live births (2013-15).The rate had risen in recent years, and is now similar to the England average (3.9 deaths per 1000 births) - fig 4.2.1. However, Bristol is still one of the lowest of Core Cities.

The most likely reason for the recent rise is random variation due to small numbers of cases (as the rise is not statistically significant), but we will need to monitor this trend carefully so that action can be taken if modifiable reasons are identified. Locality level trends are available, but numbers are very small and therefore changes difficult to meaningfully interpret.

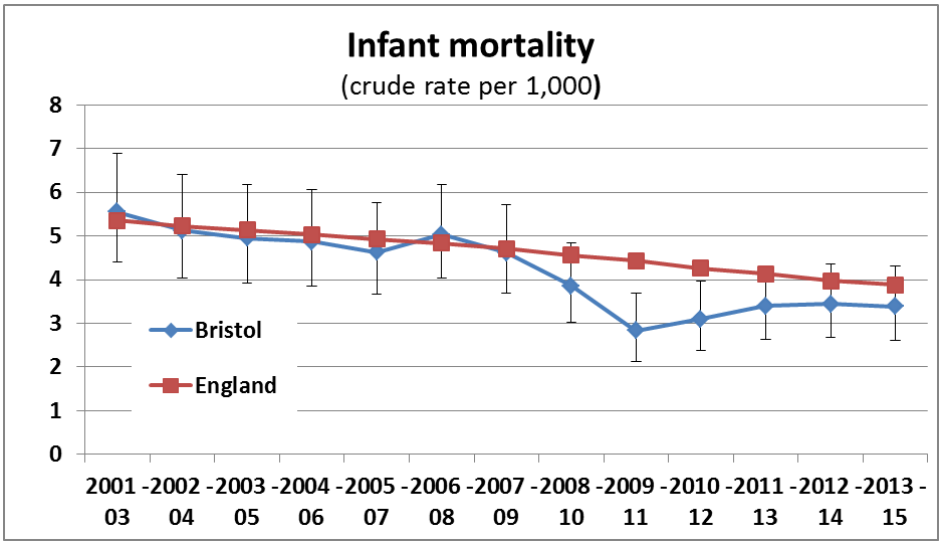



*Fig 4.2.1: Rate of Infant mortality (age under 1 year) per 1000 live births for Bristol v England, 2001-13 to 2013-15*
*Source: ONS via Public Health Outcomes framework, Nov 2016*

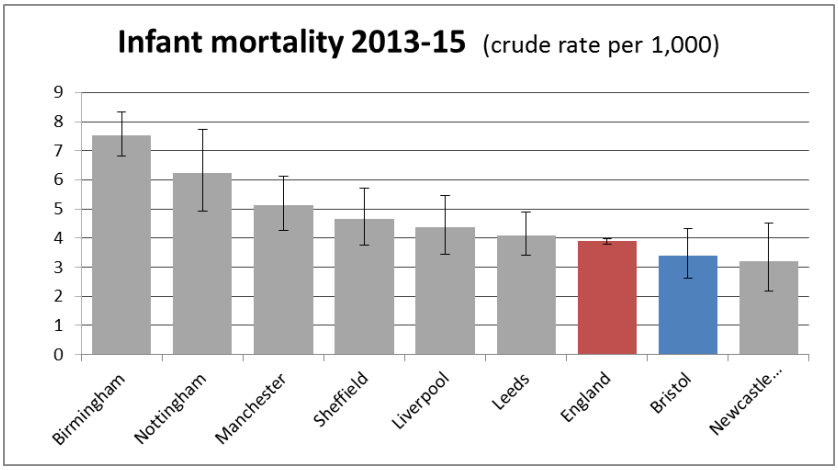



*Fig 4.2.2: Rate of Infant mortality (age under 1 year) per 1000 live births for English Core Cities, 2013-15*
*Source: ONS via Public Health Outcomes framework, Nov 2016*

[50] Source: ONS birth & deaths data, via Public Health Outcomes Framework (Nov 2016)

## 4.3 Breastfeeding

### 4.3.1 Breastfeeding (initiation)

Breast milk is the best form of nutrition for a new-born baby. Breast fed babies have lower risks of diarrhoea and common infections, are less likely to grow up to be overweight or develop eczema. Breastfeeding is good for mothers too; with lower rates of breast and ovarian cancer and breastfeeding helps mothers lose weight after pregnancy.

Nationally about 74% of mothers use breast milk as the first food for their baby[51]. In Bristol this rate has been much higher than average for several years (see fig 4.3.1). In 2014/15 the Bristol rate was 82.2%, highest of Core Cities. However, we know that breastfeeding initiation rates vary by ethnic group and are lowest for women from white ethnic groups living in deprived wards in the city.

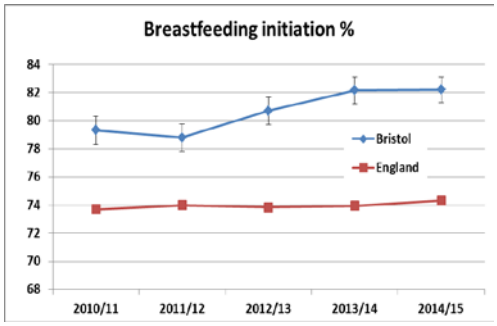



*Fig. 4.3.., Breastfeeding initiation rates in Bristol, as compared to England. Source: via Public Health Outcomes Framework (Aug 2016)*

### 4.3.2 Breastfeeding (continuation)

WHO recommends all mothers should feed their babies only breast milk for the first six months of life, and continue as long as they wish up to 2 years and beyond. All mothers have contact with health services when their baby is 6-8 weeks of age, and so breastfeeding continuation is measured then (not at 6 months). Continuation rates are lower than initiation rates as mothers may encounter barriers to successful breastfeeding. Bristol has significantly better breastfeeding continuation rates at 6-8 weeks (58.4% in 2014/15) than England (43.8%) and is highest of the English Core Cities and higher than almost all comparable cities[52]. Within this, Bristol has better rates of *exclusive* breastfeeding at 6-8 weeks (40%) than nationally (30%)[53].

However, there is variation in breastfeeding continuation rates across Bristol. Rates are generally higher in North and West (inner) locality (up to 84% in Clifton), and much lower in South Bristol (down to 30% in Hengrove & Whitchurch Park and 24% in Hartcliffe & Withywood) – fig 4.3.2. Generally, there is a higher rate of breastfeeding in BME communities.

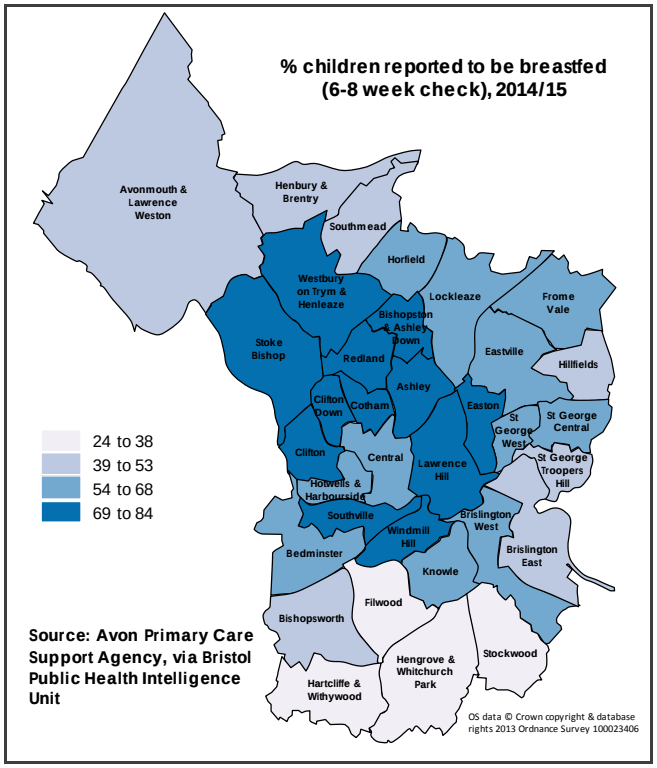



*Fig 4.3.2, 2014/15 Breastfeeding rates at 6-8 week; Source: Avon Primary Care Support Agency, via Bristol Public Health Knowledge Service 2016*

[51] 2014-15 is still latest, as in JSNA 2015. Source: NHS England 2014/15, via Public Health Outcomes Framework (Aug 2016)

[52] Source: NHS England 2014/15, via Public Health Outcomes Framework (Aug 2016)

[53] 2014/15; www.england.nhs.uk/statistics/statistical-work-areas/maternity-and-breastfeeding/

## 4.4 Smoking during pregnancy

All smoking is harmful. Smoking during pregnancy can be harmful for the baby, potentially leading to reduced blood supply to the developing baby and poor growth, and it can also increase the risk of miscarriage and premature birth. Pregnant women who smoke are encouraged and supported to give up. Women are asked to self-report their smoking status at the time of delivery of their baby.

For several years the rate of smoking at the time of delivery in Bristol mothers had been lower than the national average, down to 10.3% in 2010/11. This rose 2012-2014, but has been falling since and is in line with the national average. Figures for 2015-16 show **10.1% (over 630) pregnant mothers in Bristol self-reported as smokers**[54] (fig 4.4.1). This is broadly similar to the England average (10.6%), but is one of the lowest rates for Core Cities, and for other comparable cities.

Further analysis of local data up to 2012 (by Bristol Public Health Knowledge Service, 2014) showed that the rates of smoking in pregnancy were highest in areas of greatest deprivation.

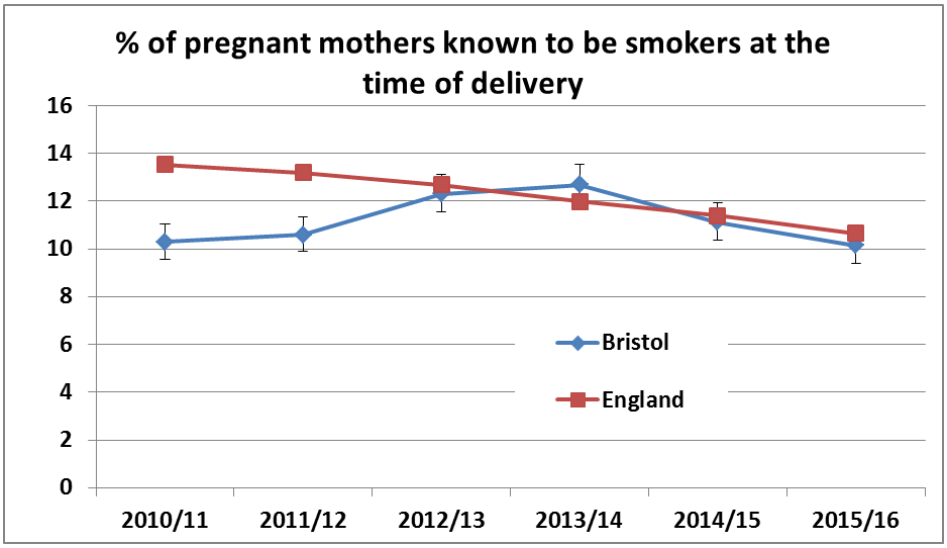



*Fig. 4.4.1, source: Health and Social Care Information Centre 2016; via Bristol Public Health Knowledge Service 2016 and PHOF Nov 2016*

Updated local data is not yet available[55], but during the period 2008-12 (fig 4.4.2) the average rate of smoking in Bristol was 11.2%, however, there was significant ward level variation with rates ranging from 0.9% in Clifton East, to 27.9% in Whitchurch Park (NB using the old 2015 ward boundaries). The highest concentration of pregnant mothers who smoke is consistently in the outer wards of North & West (average 17.4%) and South Bristol (14.8%). Average rates were lower in Inner City (7.1%) and lowest in North and West (inner) (1.5%).

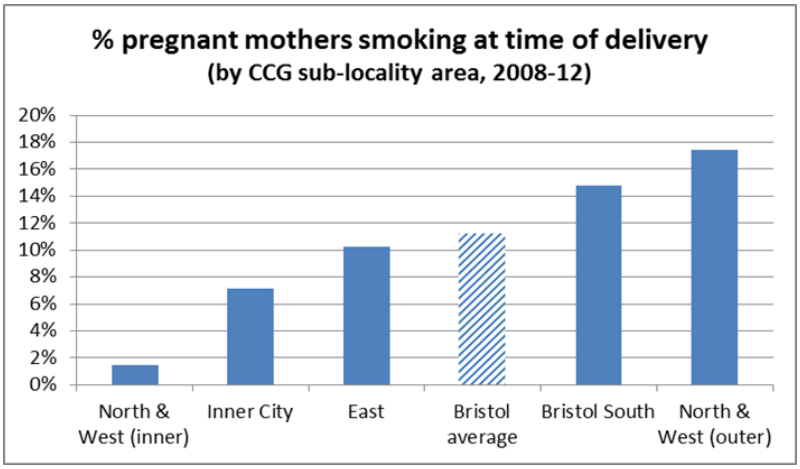



*Fig. 4.4.2, source: Local NHS maternity providers; via Bristol Public Health* Knowledge Service*, 2014*

[54] Smoking Status at Time of Delivery, 2015-16; Health and Social Care Information Centre 2016 (also via PHOF Nov 2016)

[55] Bristol Public Health are working with NHS Bristol CCG and NHS provider trusts to reinstate local data, backdated to 2013, so this analysis will be available in future

## 4.5 Disabled children

According to the Census 2011, 3,250 children in Bristol have a "limiting long-term illness or disability"[56]. This is 4.1% of the local child population, higher than the national average 3.8% (*note – this is in contrast to the all-age population, where Bristol is below national % – see section 3.7*). Of these, 1,300 children (1.7% of Bristol children) have their daily activities *limited a lot* and 2,000 children (2.5%) *limited a little*. Across Bristol (fig. 4.5.1), the Census data highlights the variation from 2.7% in North & West (inner) to 4.6% in South and 4.8% in North & West (outer).

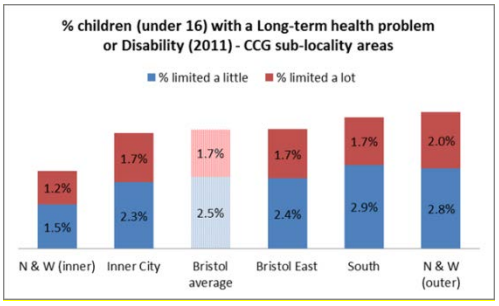



*Fig 4.5.1: % Children with long-term health problem or disability by CCG sub-localities. Source: ONS Census 2011*

New 2016 local Bristol City Council data for Disabled children[57] indicates there are over 830 disabled children (under 18) in Bristol and around 1,000 disabled children and young people up to age 25. However, this is based on those who meet the criteria for services from Social Care, plus children in Bristol schools with physical and sensory impairments (not learning disabilities or autism), and so will be lower than the Census 2011 estimate for those with a "limiting long-term illness or disability".

**Gender:** 500 disabled boys (under 18) and 330 disabled girls.

Across the city, the rate of disabled children (per 1,000 child population) varies from around 2.5 living in Cotham and Clifton, to 16 in Henbury & Brentry (fig 4.5.2). When shown as numbers (by gender), there are more in the larger wards (see fig 4.5.3).

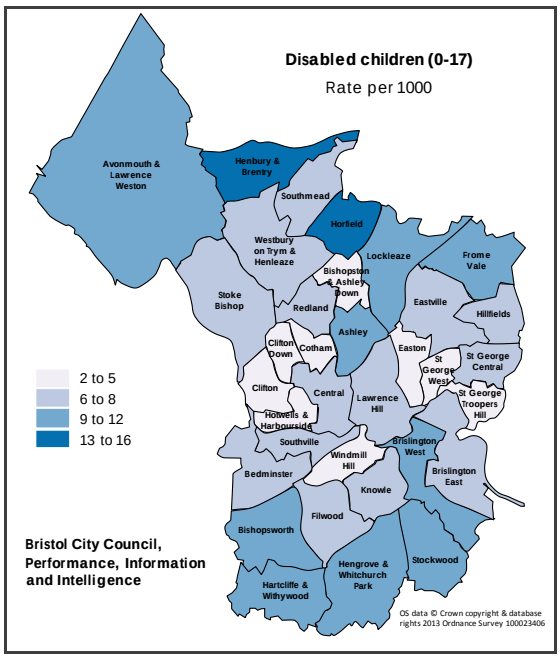



*Fig 4.5.2: Disabled children (0-17), rate per 1,000. Children with physical and sensory impairment (2016 School Census) plus children working with the BCC Disabled Children's Team. Source: Bristol Council Performance, Information & Intelligence, 2016*

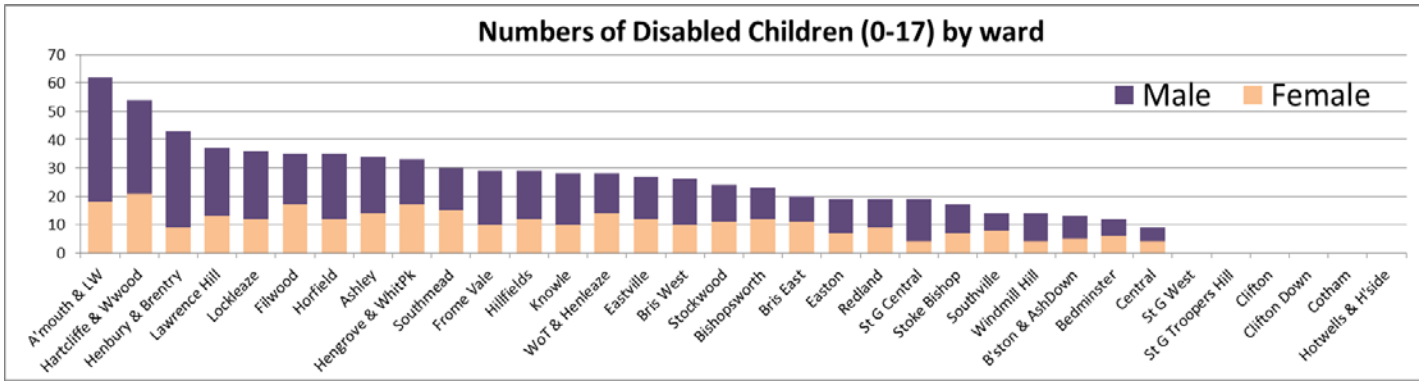



*Fig 4.5.3 Source: BCC Performance, Information and Intelligence, 2016. **Please note** – Figures have been supressed for Clifton, Clifton Down, Cotham, Hotwells & Harbourside, St George Troopers Hill and St George West due to insufficient numbers to publish*

[56] Children under 16, Source: ONS Census 2011 – as in JSNA 2015

[57] Children 0-17; Based on SEND categories of physical and sensory impairment from BCC School Census, plus children working with BCC Disabled Children's Team, 2016

## 4.6 Chronic Childhood Illnesses

### 4.6.1 Asthma

Asthma is the most common chronic disease of childhood. The causes are not completely understood, but the strongest risk factors for developing asthma[58] are a combination of genetic predisposition with environmental exposure to inhaled particles that may provoke allergic reactions or irritate the airways, such as: indoor allergens (eg house dust mites, pollution and pets); outdoor allergens (eg pollens and moulds); tobacco smoke; and air pollution.

In 2015-16, there were over 230 child (0-18) emergency admissions to hospital due to asthma[59] (a rate of 240 per 100,000 children). This figure has been rising in recent years[60].

Within Bristol, the rate is higher in the Inner City area (448 per 100,000) in 2015/16 than the city average, whilst in North & West (inner) it is only 73 per 100,000.

By ward, 5-year average rates for hospital admissions[61] were highest in Lawrence Hill and Central (336 per 100,000) and Southmead (300), plus Easton, Southville and Bedminster all had rates over 280 per 100,000 (fig 4.6.1).

**Gender:** Around 2 out of 3 of childhood asthma admissions (2011/12-2015/16) were boys. Male rates were highest in Lawrence Hill, Bedminster and Central (around 450 per 100,000 males), whereas female rates were highest in Southmead (330).

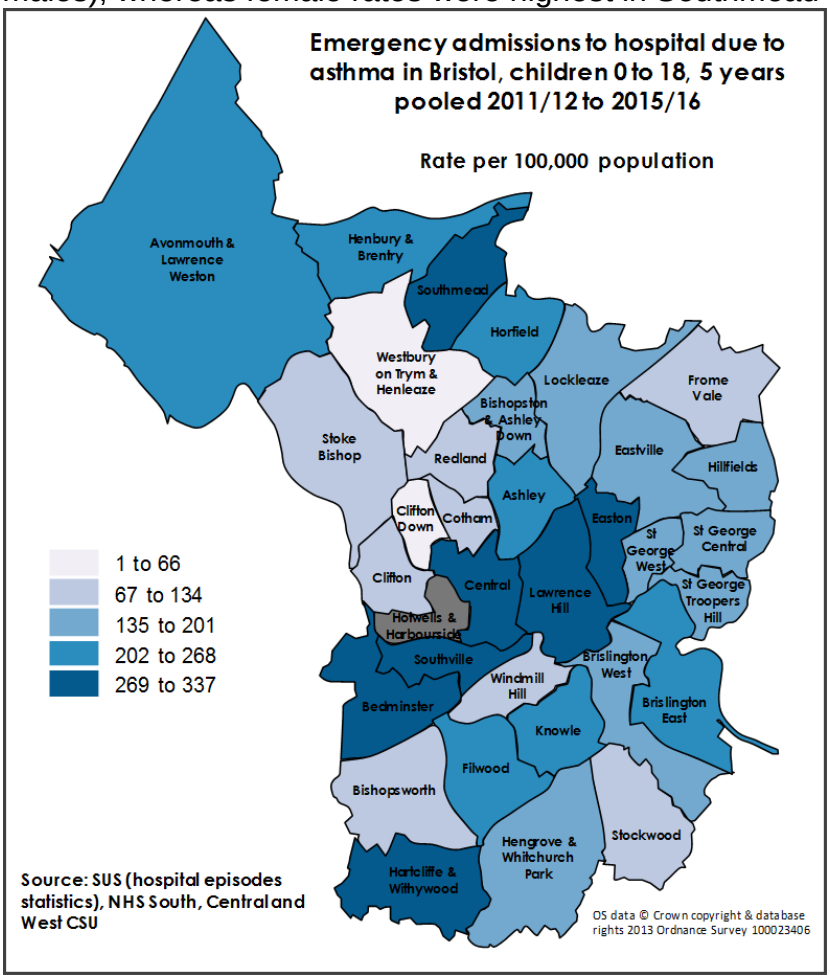



*Fig 4.6.1 Child hospital admissions for asthma, pooled rate by ward; crude rate per 100,000; Source: Bristol Public Health Knowledge Service, 2016 [Note - Hotwells and Harbourside is suppressed due to very small population]*

### Asthma and second hand smoke

Asthma attacks can be triggered by second hand smoke. The principle source of exposure to second hand smoke for children is in the home[62].

According to the Bristol Quality of Life survey 2015-16, 18% live in a household with a smoker, with rates highest in Hartcliffe & Withywood (34%). For households where someone smokes regularly inside the home - rates in Hartcliffe & Withywood and Lawrence Hill are 3 times the Bristol average. Smoking inside the home increases potential exposure to second hand smoke.

[58] World Health Organisation, Fact sheet on Asthma (No.307), Nov 2013
[59] Admissions directly due to asthma, 0-18 yrs Source: Hospital episode stats via Bristol Public Health Knowledge Service, 2016
[60] Note – the higher figure reported in JSNA 2015 was *all* admissions of children with asthma, not just those directly *due to* asthma
[61] Local ward data is a pooled rate for the 5 years 2011/12 – 2015/16. Bristol average is 199 per 100,000 for this time period.
[62] Action on Smoking and Health (ASH), Research report - Asthma & Smoking, 2015

### 4.6.2 Epilepsy[63]

Epilepsy is the most common serious neurological disorder in children affecting around 1 in 220 children. It is characterised by a tendency to have seizures. There is no clear difference in rates of epilepsy between males and females and different ethnicities, but is more common amongst more deprived populations.

The presentation, management and prognosis are highly variable. Seizures can be potentially life threatening. Epilepsy can occur in isolation or be associated with other conditions, such as learning difficulties or cerebral palsy and can follow as a result of brain injury. Epilepsy is associated with decreased academic achievement, unemployment, lower incomes, and also with increased risk of mental health problems. Treatment is important for improving social and health outcomes.

Based on national estimates and local GP data, there are around 1000 children with a diagnosis[64] of epilepsy in the Bristol, North Somerset and South Glos area and around 100 new cases per year [65]. Within Bristol there are almost 500 children with a diagnosis of epilepsy recorded. In 2013/14, 76 Bristol children were admitted as an emergency to hospital. This admission rate of 74.2 per 100,000 is now similar to the national average (77.1 per 100,000)[66] but has been rising (fig 4.6.2).

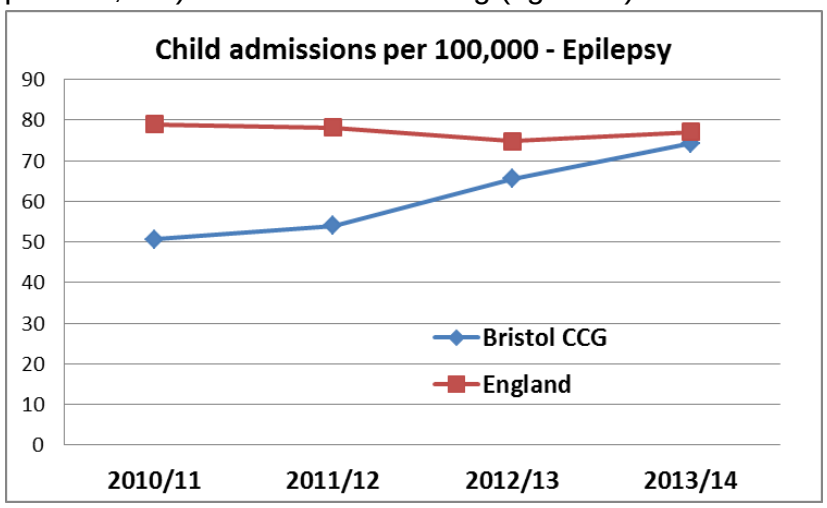



*Fig 4.6.2 Rates of child hospital admissions due to epilepsy*

### 4.6.3 Diabetes

The incidence of child (0-18) emergency admissions due to diabetes[67] in 2013/14 was 43.9 per 100,000 population in Bristol, similar to the national average (56.6 per 100,000) – fig 4.6.3.

However, the number of bed days resulting from the admission is significantly less in Bristol than nationally. Bristol compares well with N. Somerset, Somerset and S. Glos with a similar number of admissions but significantly less bed days.

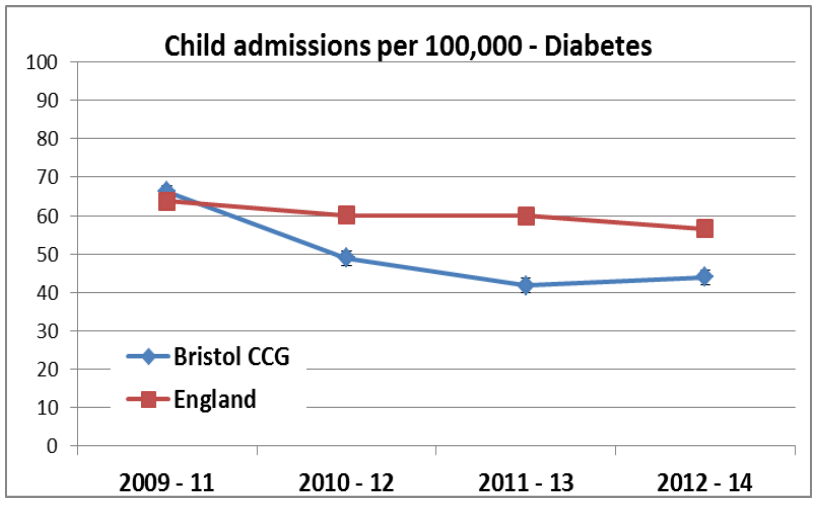



*Fig 4.6.3 Rates of child hospital admissions due to diabetes*

[63] Section taken from the draft Childhood Epilepsy JSNA Chapter covering Bristol, N Som and S Glos, via Bristol Public Health.
[64] Source: local primary care (EMIS) data, via Bristol Public Health, Aug 2015
[65] Epilepsy prevalence, incidence and other statistics . Joint Epilepsy Council of the UK and Ireland. September 2011.
[66] Source: ChiMat Disease Management Information Tool (DMIT), 2015
[67] Source: ChiMat Disease Management Information Tool (DMIT), 2015

## 4.7 Healthy Weight

The National Child Measurement Programme (NCMP) measures the height and weight of children in Reception year (4-5 year olds) and in Year 6 (10-11year olds) to assess the proportion that are overweight or very overweight (obese). This data is used at a national level to inform public health planning and at a local level to inform planning and delivery of services for children.

Being obese as a child is a strong predictor for adult obesity, and this is linked to diabetes, heart disease, stroke and cancer. Tackling obesity is complex as the causes are societal, cultural, environmental and economic as well as individual choices.

### 4.7.1 Excess weight in 4-5 year olds

The proportion of children with excess weight in England has been largely constant, around 22-23%, since NCMP began in 2006/07. The Bristol rate had been around 25%, higher than England, for 2007 to 2010, but since 2010/11 has been broadly similar to average (fig 4.7.1a). Bristol is 22.9% in 2015/16, similar to England, 22.1%. 2014/15 data showed more boys (23.5%) had excess weight than girls[68] (21.9%), and Bristol was mid-ranking for Core Cities.

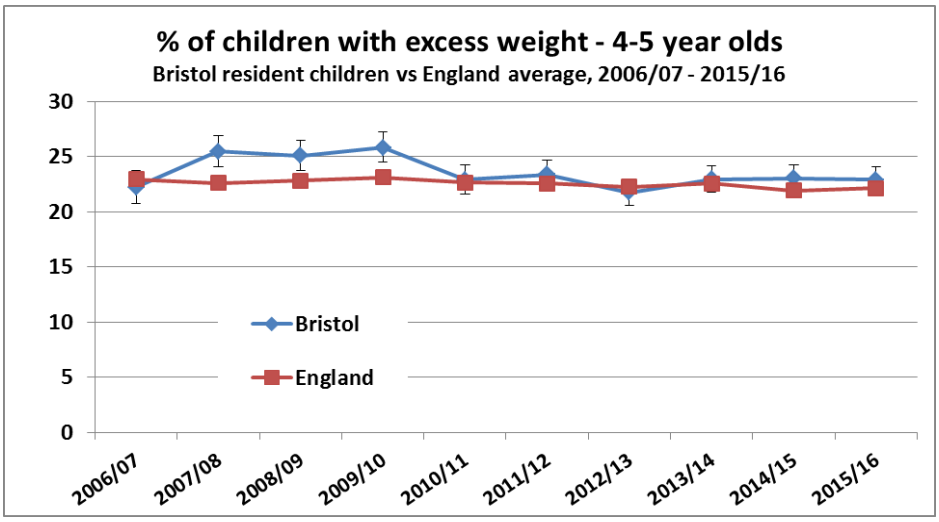



*Fig 4.7.1a Source: National Childhood Measurement Programme (NCMP) via Bristol Public Health Knowledge Service, Nov 2016*

Within Bristol, the proportion of 4-5 yr olds who are overweight or obese is much lower in North & West (inner) (17%) and highest in North & West (outer) [69] (26%) - fig 4.7.1b. Due to the relatively small numbers, the data are presented as 3 year averages. By ward, the range is from 11% in Clifton Down to 30% in Filwood and 31% in Hartcliffe & Withywood (2012-15)[70]. In some wards by the time they start school, almost 1 in 3 children have a weight likely to cause health problems later in life. This illustrates the importance of activity to promote healthy eating and physical activity during early childhood.

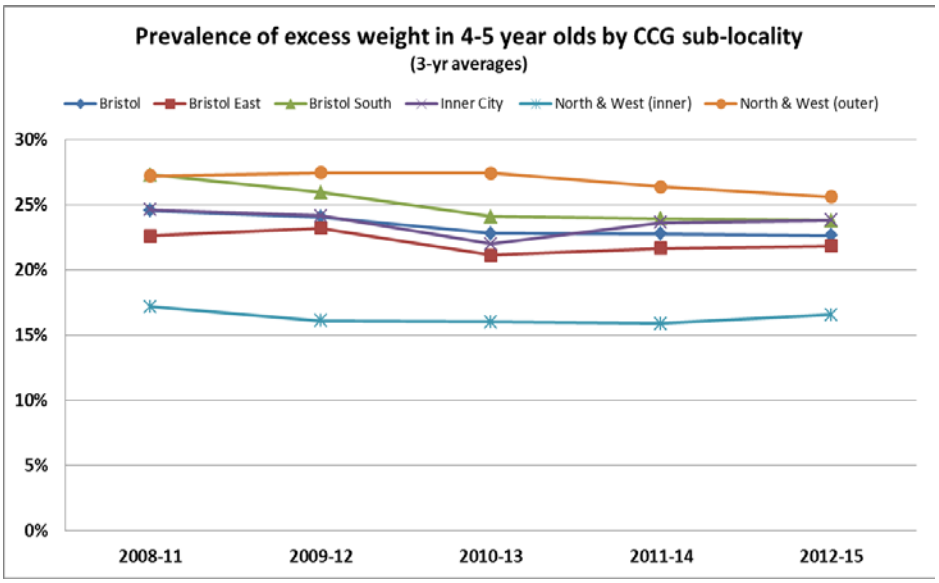



*Fig 4.7.1b Excess weight in 4-5 yr olds by Bristol area, 2012-15*
*Source: NCMP via Bristol Public Health Knowledge Service, Aug 2016*

[68] 2012-15, Source: Bristol Public Health Knowledge Service, Aug 2016

[69] 2012-15, Source: Bristol Public Health Knowledge Service, Aug 2016
[70] Note – ward map is not shown but is available in the JSNA Atlas tool

### 4.7.2 Excess weight in 10-11 year olds

The proportion of 10-11year old children overweight or obese in England has been largely constant, around 32-33% since the NCMP programme began in 2006/07. However, in Bristol the rate has been rising in recent years and in 2015/16 the proportion of 10-11year olds who were obese or overweight was 35.4%. This is broadly similar to the national average of 34.2% (fig 4.7.2a). Data to 2015 showed more 10-11 year old boys (35.7%) have excess weight than girls (33.6%)[71], and Bristol was mid-ranking for Core Cities.

Within Bristol, the proportion of 10-11yr olds overweight or obese has risen sharply in Bristol East in recent years. It is significantly lower in North & West (inner), whilst all other areas have more than 1 in 3 children overweight or obese by the time they leave primary school[72].

By ward, the range is from 17% in Redland to 42% in Lawrence Hill and 44% in Hartcliffe & Withywood (2012-15) (fig 4.7.2b).

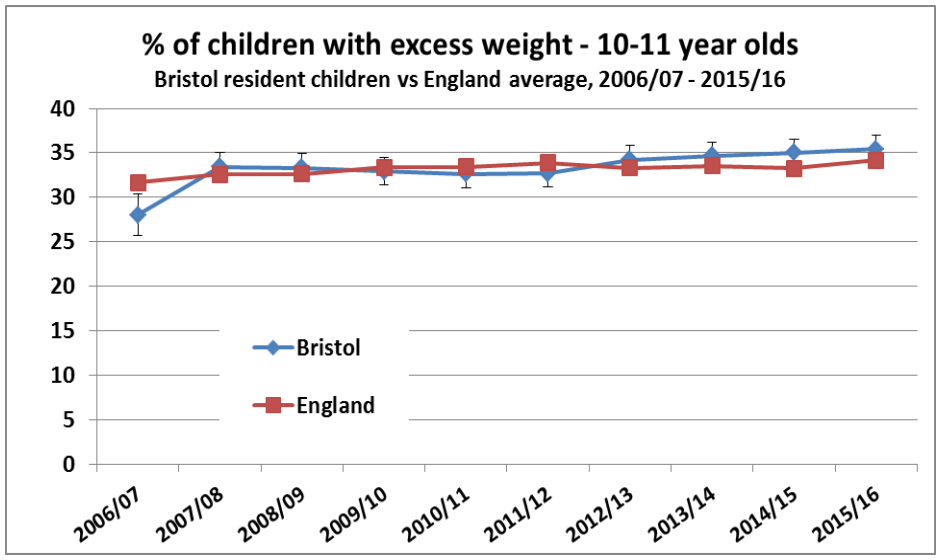



*Fig 4.7.2a: Source: National Childhood Measurement Programme (NCMP) via Bristol Public Health Knowledge Service, Nov 2016*

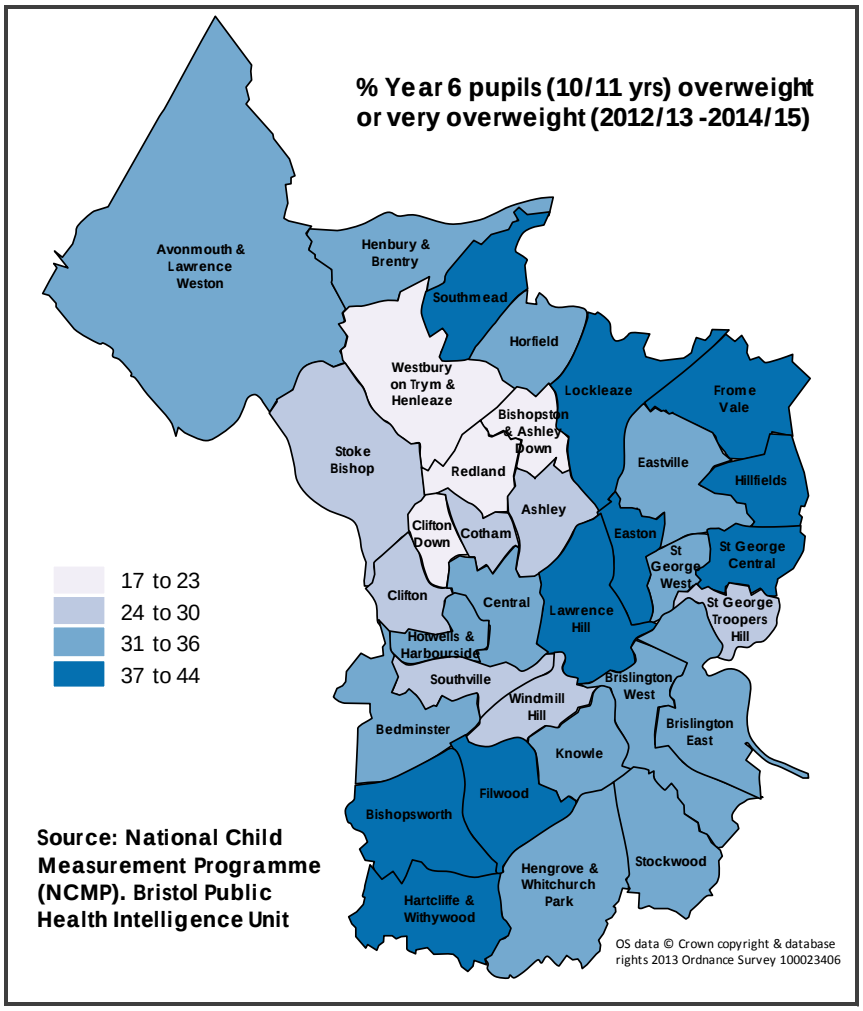



*Fig 4.7.2b: Excess weight in 10-11 yr olds by Bristol wards, 2012-15*
*Source: NCMP via Bristol Public Health Intelligence Unit 2016*

[71] 2012-15, Source: Bristol Public Health Knowledge Service, Aug 2016
[72] 2012-15, Source: Bristol Public Health Knowledge Service, Aug 2016

## 4.8 Dental health

Oral diseases can have a considerable impact on a child's general health and wellbeing. Poor oral health is associated with being underweight and a failure to thrive, and affects a child's ability to sleep, speak, play and socialise with other children. Children with poor oral health may have increased school absenteeism, and decreased school performance.

National Dental Surveys are conducted in England of 3, 5, and 12 year olds, and involve looking at the numbers of decayed, missing or filled teeth across a sample of mainstream schools.

The most recent survey was in 5 year olds (2014-15), and reported that 71.05% of reception children were free from dental decay, statistically similar to nationally (75.2%)[73]. The rate of decayed, missing or filled teeth per child (1.1) is similar to the rate for England (0.8). However, this survey only assessed 277 out of 5574 reception children in Bristol.

The proportion of 3 year olds (2013/4) with decay (15.3%) is higher than the England average (11.7%)[74]. However, the Bristol sample was small and the consequent broad confidence intervals highlight the lack of precision in this estimate and may explain some of the variation compared to other areas. Nonetheless, the survey results highlight the importance of improving oral health in this vulnerable age group.

The average number of decayed, missing or filled teeth in 12 year olds (2008/9) was higher (1.1) than nationally (0.74) [75].

More children have not attended NHS dental services in the previous 24 months in Bristol (33.4% of 0-17 year olds) than the England average (32.5%) (2014).

### Tooth extractions

In 2014/15, over 800 Bristol children and young people (0-19 years) were admitted to hospital for extraction of one or more decayed primary or permanent teeth[76]. As a rate this is 0.8% of the resident population, higher than the England average (0.5%), and has risen in recent years.

For young children under 5, the rate is 0.6% of children of that age admitted to hospital for tooth extraction, double the England average (0.3%) for that age group (2014/15).

Bristol Public Health are currently working with Public Health England on more in-depth analysis of children within Bristol admitted to hospital for dental extraction due to tooth decay.

[73] Source: Public Health Outcomes Framework, August 2016.
[74] Via Profile for Oral health in Bristol. June 2015. Public Health England.
[75] Via Profile for Oral health in Bristol. June 2015. Public Health England.
[76] Dental Public Health Intelligence Programme, 2014/15

## 4.9 Childhood Immunisations[77]

For most immunisations, achieving an uptake of at least 95% of all children it is important because this is the level where 'herd immunity' can be achieved, i.e. when enough children have been vaccinated that the amount of disease circulating in the community is very low. This means that the few children unable to receive their vaccination (e.g. because they have an immune system that doesn't work, or children who are having treatment for other diseases which prevents them from getting their vaccinations) can still be protected from catching the disease because there is less of it about.

Note – this section uses data on established immunisations. Other immunisations recently added to the schedule will be reported in a future JSNA and include:

- Meningitis type B – by 1 yr old
- Rotavirus – by 1 yr old
- Men B booster – by 2 years old
- DTaP/IPV booster – by 5 years
- Tetanus, Diptheria and Polio – by 14 years old
- Meningococcal groups A, C, W and Y – by 14 years old

Plus

- Childhood Flu immunisations - in JSNA **7.6 Flu Immunisations**

### 4.9.1 Immunisations due by 1 year old

**a) DTaP/IPV/Hib** is a single vaccination that protects children against five serious diseases; Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio and Haemophilus influenzae type B (a cause of meningitis and pneumonia as well as other types of infection). By the age of one year a child is recommended to have been given 3 doses of the vaccine; all three doses are required to protect the child. The 95.8% uptake in Bristol (2014/15) is significantly better than England as a whole (94.2%), see fig 4.9.1, and is one of the highest of the English Core Cities.

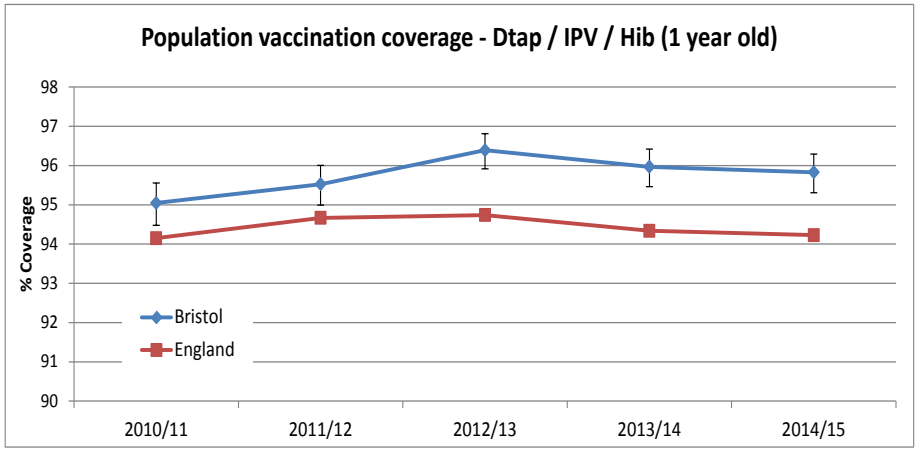



*Fig. 4.9.1: Source: Cover of Vaccination Evaluated Rapidly 2014/15 data via Public Health Outcomes Framework, Aug 2016*

**b) MenB** - Meningococcal disease occurs due to infection by a bacteria that causes both meningitis (infection of the membrane that covers the brain inside the skull), and septicaemia (infection of the blood stream). This vaccine is against type B (MenB). [*Note – this replaces the MenC immunisation being phased out*]

**c) PCV** is a vaccine to protect against streptococcus pneumoniae infection which can cause pneumonia, meningitis (infection of the covering of the brain inside the skull) and septicaemia (infection of the blood). By the age of one year, a child is recommended to have been given two doses of the vaccine. The 95.1% uptake of this vaccine in Bristol (2014/15) is significantly higher than the England average (93.9%) but has been falling slightly in recent years.

[77] All data source is "Cover of Vaccination Evaluated Rapidly (COVER)" via PHOF 2016, compared to the national average.

### 4.9.2 Immunisations due by 2 years old

**a) DTaP/IPV/Hib** - By the age of two years old, a child should have been given 3 doses of the vaccine (NB same doses as above, due to be given by 1 years old). The 2014/15 uptake of this vaccine in Bristol by 2 years of age (97.0%) is significantly better than England (95.7%).

**b) PCV booster** – In addition to the 2 doses of the vaccine above, a booster dose is due at 12-13 months. The 2014/15 uptake of this booster in Bristol is 91.5%, now significantly lower than the England average of 92.2%.

**c) Hib / MenC booster** - A booster vaccination offered about 12 months of age. The 2014/15 uptake in Bristol was 91.4%, now significantly lower than the England average of 92.1%.

**d) MMR one dose** - MMR is a single vaccine that protects against Measles, Mumps and Rubella (German measles). One dose should be received by 2 years age (usually at 12 months). Nationally, MMR uptake was low during the 1990s, partly due to the reported link between MMR, bowel disease and autism. This link has now been discredited, and uptake has risen. A catch-up campaign and high levels of measles cases in England and Wales during 2012/13 encouraged many parents to vaccinate their child.

As recently as 2008/9 in Bristol, the uptake of one dose of MMR by age 2 years was as low as 79.9%, but this is now 91.4% (2014/15). However, this figure is significantly lower than the England average (92.3%) - see fig 4.9.2, although is mid-ranking for Core Cities.

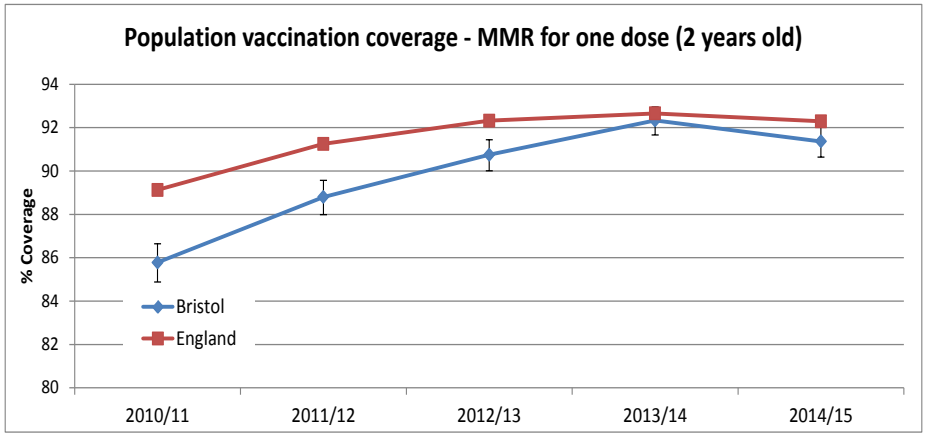



*Fig. 4.9.2 Source: Cover of Vaccination Evaluated Rapidly 2014/15 data via Public Health Outcomes Framework, Aug 2016*

### 4.9.3 Immunisations due by 5 years old

**a) MMR first vaccination** – Two MMR doses should have been received by the age of 5 years (one at about 12 months and one at about 3 & ½ years of age). In Bristol, uptake of the 1st MMR dose by age 5 rose to 95.2% in 2014/15, significantly higher than the England average (94.4%).

**b) MMR second vaccination** - In 2008/9 the uptake of both doses of MMR by age 5 in Bristol was as low as 71.8%, but this has risen year on year to 88.6% in 2014/15 - see fig 4.9.3. The Bristol rate is now similar to the England average (88.6%) for the first time, although still below the 95% target. Bristol is no longer lowest of the Core Cities (is now mid-ranking).

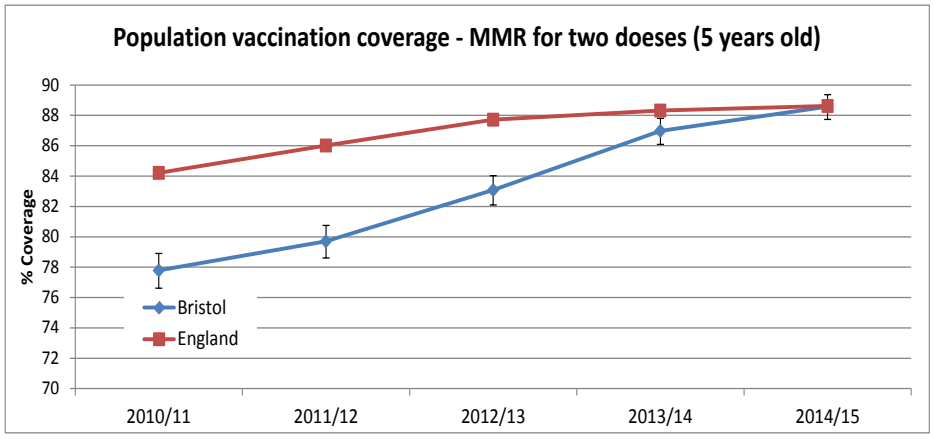



*Fig. 4.9.3 Source: Cover of Vaccination Evaluated Rapidly 2014/15 data via Public Health Outcomes Framework, Aug 2016*

**c) Hib / Men C booster** - A booster vaccination routinely offered about 12 months of age (as above). Uptake of this vaccine by 5 years old has been increasing from about 84% in 2008/09. The uptake in Bristol in 2014/15 was 93.7%, significantly higher than the England average of 92.4%.

### 4.9.4 Local vaccination coverage data

Recent local data[78] for 2015/16 (fig 4.9.4) highlights the pattern of differences across the city

- all immunisations have lowest uptake rates in Inner City & East
- most immunisations have highest uptake rates in South Bristol
- North & West and South Bristol meet or almost meet 90% coverage for all Immunisations
- Inner City & East is below 90% coverage for several immunisations

These data indicate that continued targeted work to promote childhood immunisations in Inner City and East locality is required.

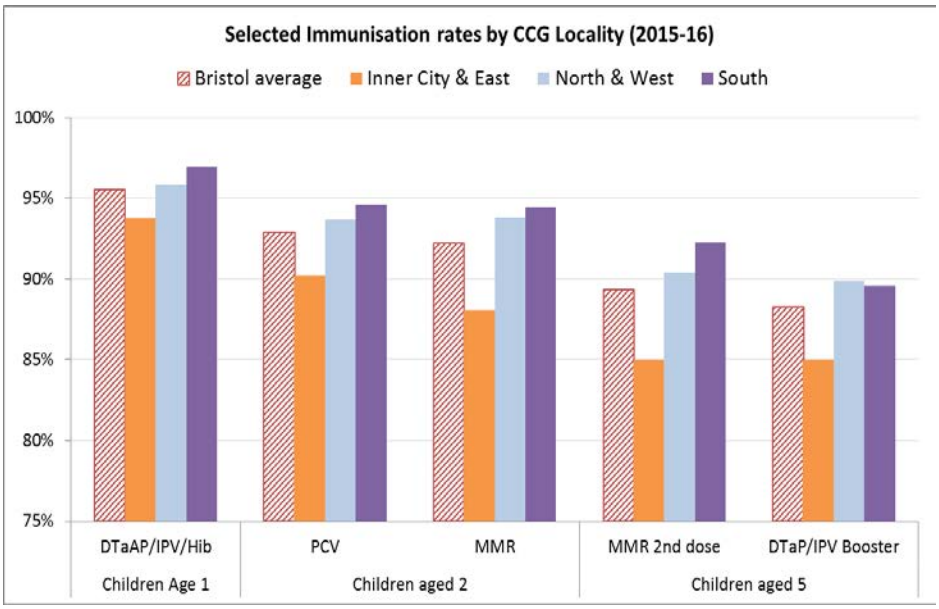



*Fig. 4.9.4 Source: Health and Social Care Information Centre Supplied by Bristol Public Health Knowledge Service, Aug 2016*

### 4.9.5 Immunisations due by 14 years old

**a) HPV** - Human Papilloma Virus (HPV) vaccine protects against the common types of this virus which can cause cervical cancer. The vaccine is routinely offered to girls in Year 8 at school (aged 12-13 years). Until this academic year, three doses of the vaccine, given over a period of 6 months, needed to be received to enable protection from infection.

In Bristol we had consistently achieved about 70% uptake of all 3 doses; this rose to 84.5% (2014/15) but is still significantly below England average (89.4%). The immunisation scheduled has changed from three doses to two doses in 2015-16, which may enable better coverage of a complete course of the vaccine.

[78] Source: Health and Social Care Information Centre, via Bristol Public Health Knowledge Service, Aug 2016

## 4.10 Injuries

### 4.10.1 Injuries in children (0-14)

Emergency hospital admission rates from unintentional or deliberate injuries to children aged 0-14 in Bristol are consistently similar to national rates[79] – see fig 4.10.1a. The Bristol rate is 108 per 10,000 children aged 0-14 (2014/15), similar to the England of 110 per 10,000.

Using local data[80], there are considerable differences in injury rates between wards, with the highest rates observed in Hartcliffe & Withywood, Bedminster and Avonmouth & Lawrence Weston (all over 140 per 10,000) - fig 4.10.1b.

The leading cause of injury-related emergency admissions in children 0-14 is falls (35% of all injuries, the only category above 10%).

**Gender:** Bristol admission rates for injuries (0-14 yrs) are 124 per 10,000 in boys, and 98 per 10,000 in girls (2014-16 pooled data).

### Young children (under 5)

For children aged 0-4 years the rate for Bristol (141 per 10,000) is similar to the rate for England (137 per 10,000) and mid-ranking for Core Cities.
The leading causes of injury-related admissions in young children 0-4 are falls (32%) and accidental poisoning (12%).

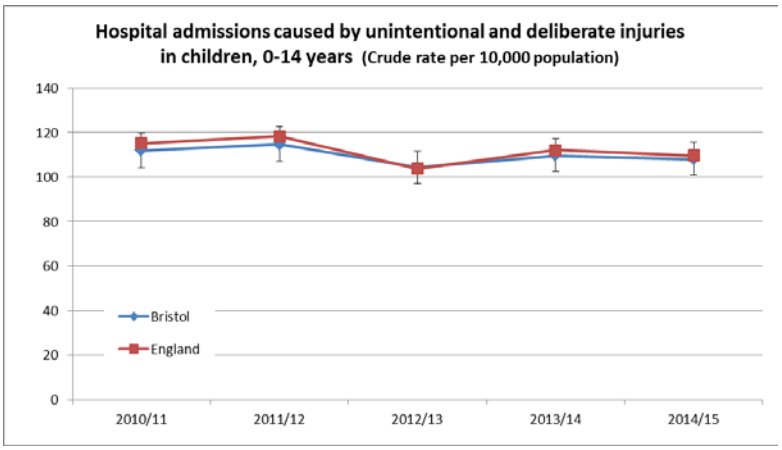



*Fig. 4.10.1a Source Hospital Episode Statistics via PHOF Aug 2016*

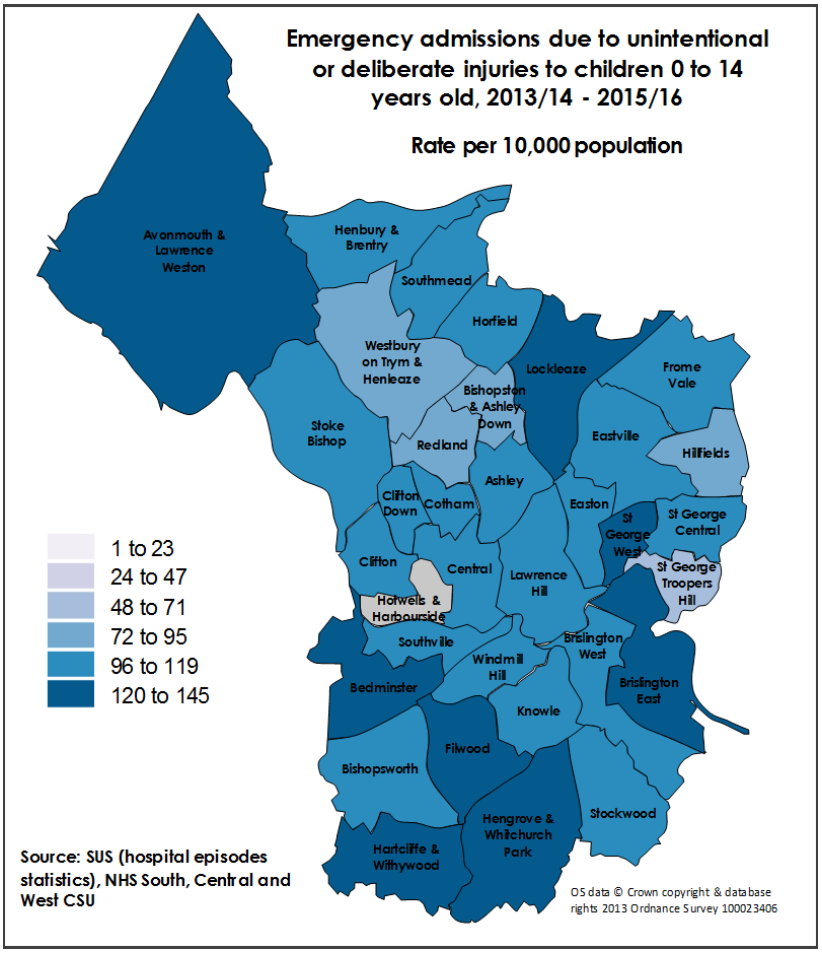



*Fig. 4.10.1b Source: Bristol Public Health Knowledge Service (2013/14 - 2015/16)*

[79] Crude rates of emergency admissions per 10,000 population, via PHOF tool, Aug 2016
[80] 2014-16 (3 yr pooled data), Source: Bristol Public Health Knowledge Service, Aug 2016

### 4.10.2 Injuries in young people

Rates of emergency hospital admissions in 2014/15 caused by unintentional or deliberate injuries in young people aged 15-24 years old in Bristol is 147 per 10,000 population. This rate has been rising and is now significantly higher than the national average rate of 132 (per 10,000) – see fig 4.10.2a.

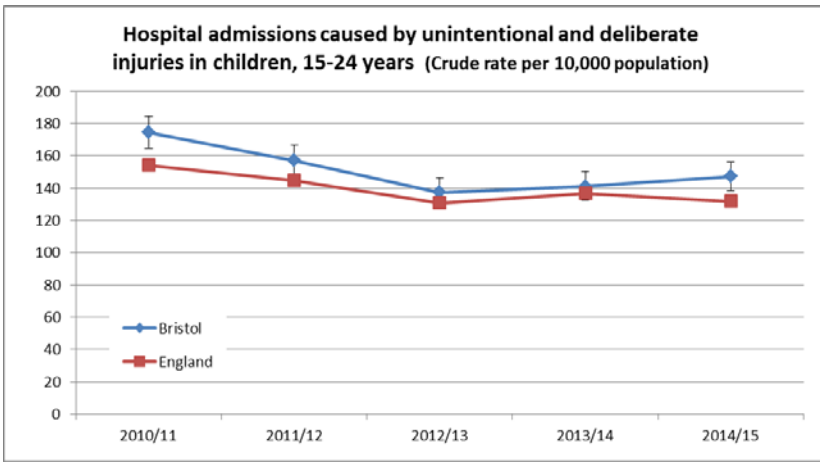



*Fig. 4.10.2a Source Hospital Episode Statistics via PHOF Aug 2016*

Using local data[81], there is considerable variation by ward, with rates highest in Easton, St George Troopers Hill and Henbury & Brentry (all over 250 per 10,000) - fig 4.10.2b.

There are over 1000 emergency admissions for unintentional or deliberate injuries in Bristol in 15-24 year olds per year. The leading cause in this age group is intentional self-poisoning or self-harm[82], which were the causes of around 450 of these (43%) during 2015/16. Other major causes are falls (13%), transport accidents & collisions (9%) and assaults (8%)

**Gender:** Bristol injury admission rates for 15-24 yr. olds are 141 per 10,000 in boys, and 146 per 10,000 in girls (2014-16 pooled data)

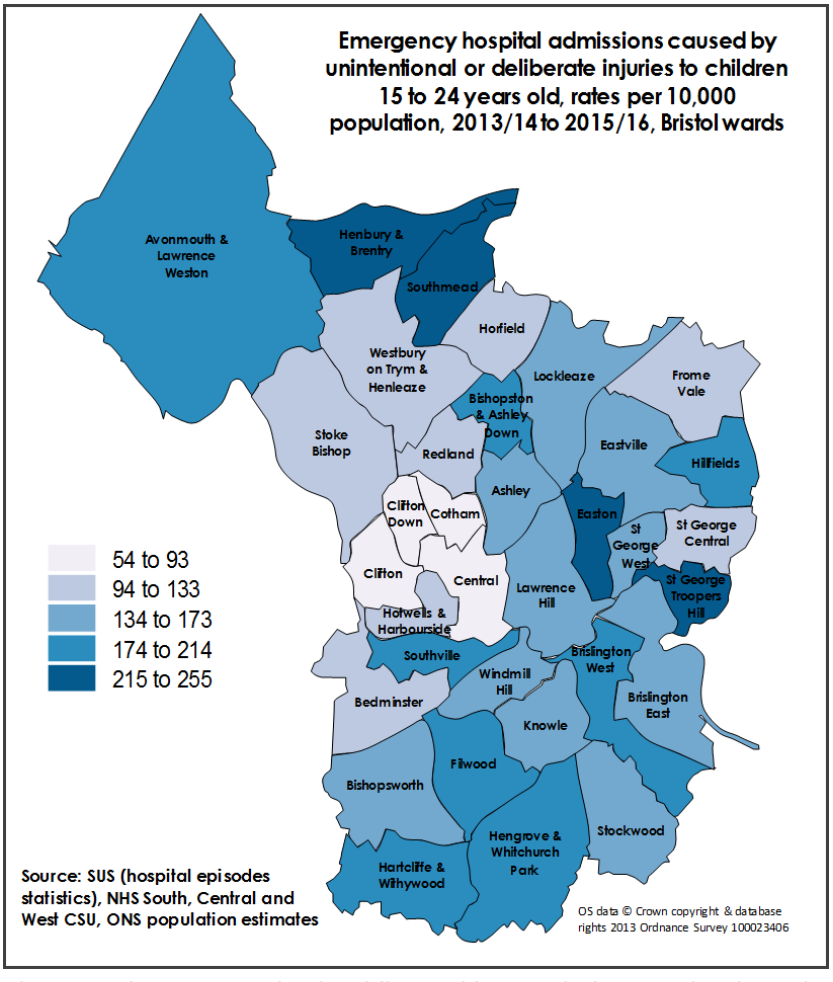



Fig. 4.10.2b Source: Bristol Public Health Knowledge Service (2013/14 - 2015/16)

[81] 2014-16 (3 yr pooled data), Source: Bristol Public Health Knowledge Service, Aug 2016
[82] 2014-16 (3 yr pooled data), Source: Bristol Public Health Knowledge Service, Aug 2016. For more details about deliberate self-harm, see Emotional Health and Wellbeing of Young People (in JSNA section 9. Mental Health)

## 4.11 Teenage pregnancy

Becoming a parent whilst a teenager has been associated with poorer health for mother and baby, poorer educational attainment and employment chances. Young parents need additional support to help them to safeguard their health and wellbeing as well as that of their child.

The rate of teenage conceptions in Bristol (under 18 years of age) have shown a steep decline since 2007 and are now, for the first time in many years, lower than the England average (22.1 per 1,000 vs 22.8 per 1,000). Fig 4.11.1 shows the dramatic decline in rates in Bristol and nationally. The numbers of teenage conceptions in Bristol fell from 360 in 2007 to 146 in 2014.

Although the numbers of women conceiving in their teens has fallen markedly in Bristol, the data reported by specialist teenage conceptions staff working in the city, it seems likely that those still conceiving have complex needs and require a high level of support.

The proportion of the population affected by teenage conception may be relatively small. In 2014 it was 1 in 45 women in the appropriate age group in Bristol, but the risk varies widely across the city. In those wards where it is most frequent, around 1 in 15 women aged between 15 and 17 years of age conceived during an average year (2012 – 2014), while the risk was at least 6 times less in the wards with the lowest incidence. Higher rates of teenage conception tend to be found where deprivation is higher, and teenage conception can be both a cause and symptom of disadvantage, helping to embed and perpetuate poorer outcomes where it is most common.

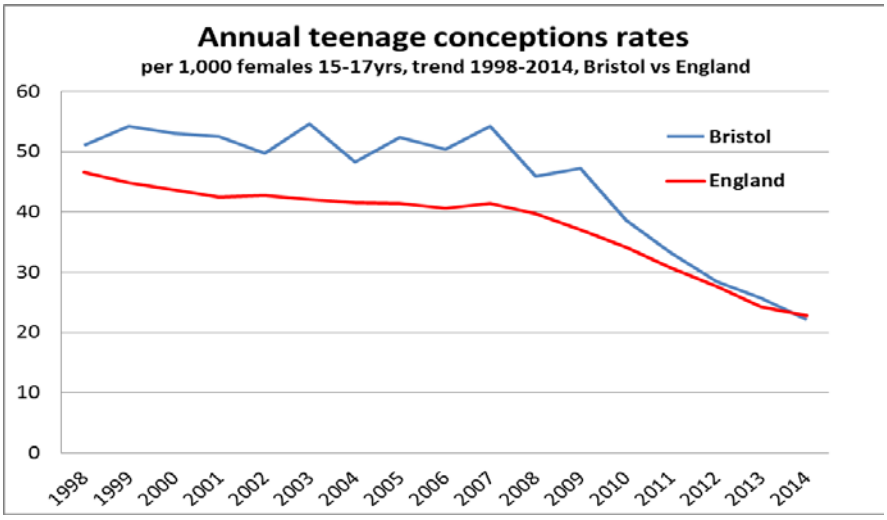



*Fig. 4.11.1 Source: Office of National Statistics, via Bristol Public Health Knowledge Service Aug 2016*

Fig 4.11.2 illustrates the variation in teenage conception rates across the city, and while the entire city has seen considerable decline in their rates, this variation remains apparent. The Inner City has seen the greatest fall in rates, while Bristol South now has the highest rates.

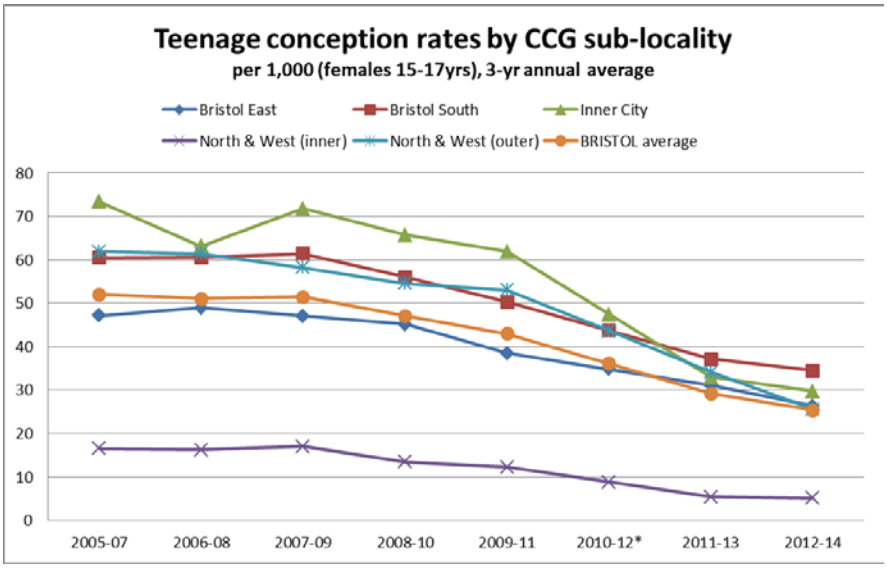



*Fig. 4.11.2 Source: Bristol Public Health Knowledge Service Aug 2016*
**Imputed values for missing data*

## 4.12 Lifestyle behaviours of Young People

### 4.12.1 Diet

Bristol's local "Pupil Voice" survey (2015)[83] in Bristol schools shows that the number of pupils who eat at least 5 portions of fruit and veg a day declines as they get older. For boys, the number halves between school years 4 and 10 from 29% to 17%, for girls the swing is from 31% to 23%.

The Pupil Voice survey estimates that 75% of secondary school pupils eat a home cooked meal made of raw/fresh/whole ingredients. 57% of primary pupils reported the same.

Around a third of pupils never or rarely eat fish and just under 10% rarely eat or never eat vegetables or fresh fruit.

Around half of secondary pupils ate vegetables most days, but more (56%) ate fresh fruit.

Unhealthy diets can be much more prevalent in certain groups within the population. Less than 5% of young people in contact with the young offending team in 2015 reported regularly eating 5 or more portions of fruit and veg per day.

### 4.12.2 Physical activity

The What About YOUth (WAY) survey[84] 2014-15, estimates that every day 17% of Bristol's 15 year olds take part in at least an hour of physical activity. This is significantly higher than the national average of 13.9%.

The Pupil Voice survey estimates that around 90% take part in exercise / physical activity or sport at least once a week. In all year groups, boys took part more often than girls.

### 4.12.3 Smoking

The What About YOUth (WAY) survey[85] 2014-15, estimates that "current smokers" at age 15 in Bristol is 11.3%, significantly higher than England (8.2%).

WAY survey data on "regular smokers"[86] at age 15 shows that Bristol is 7.8%, significantly higher than England average of 5.5%.

**Gender:** Nationally, females at age 15 are significantly *more* likely to be a smoker than males, which is very different to the adult picture[87]. WAY data is not available by gender for Bristol. However, the local "Pupil Voice" survey also indicates that more girls than boys are smoking in year 10.
Additional local Bristol Pupil Voice survey (2015) data indicates that 25% of boys and 28% of girls report having tried a cigarette, while 18% of all year 10 respondents report that they have tried an e-cigarette. Of those that smoke, most smoke 1-5 cigarettes per week.

Smoking prevalence can be much higher in certain groups within the population, even at a relatively young age. An analysis[88] of local 2015 data from young offenders in contact with services in Bristol indicated that 65% of those aged 15 or less were current smokers. Again, girls in this cohort were more likely to smoke.

[83] Part of Bristol Healthy Schools. www.bristolhealthyschools.org.uk/

[84] What About YOUth (WAY) survey 2014-15. http://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132846/pat/6/par/E12000009/ati/102/are/E06000023

[85] What About YOUth (WAY) survey 2014-15. Smoking Prevalence also via www.tobaccoprofiles.info

[86] usually smoke at least 1 cigarette per week

[87] See 6.4 Smoking in Healthy Lifestyles

[88] Analysis carried out by Bristol Public Health Knowledge Service, 2015

### 4.12.4 Alcohol

The What About YOUth (WAY) survey[89] 2014-15, estimates that 66.7% of 15 year olds in Bristol have had an alcoholic drink at some time, which is significantly higher than nationally (62.4%).

The survey also estimates that 6.1% of 15 year olds in Bristol are regular drinkers (at least once a week), similar to England (6.2%). Also 16.6% report "being drunk" in the previous 4 weeks, similar to England (14.6%).

The local Pupil Voice 2015 survey reports 37% of pupils in year 10 (14-15 yr. olds) had drunk alcohol in the previous 4 weeks, over double the % of year 8 pupils.

**Gender:** WAY data is not available by gender for Bristol. Nationally, 15 yr. old females are significantly more likely to have had an alcoholic drink than males, and to report being drunk in the previous 4 weeks, although males are more likely to drink regularly.

### 4.12.5 Drug misuse

The What About YOUth survey 2014-15 estimates that 17.7% of 15 year olds in Bristol have tried cannabis, significantly higher than the national average (10.7%) – see fig 4.12.5.

The WAY survey estimates that 8.9% of 15 year olds in Bristol had used cannabis in the previous month, significantly higher than nationally (4.6%), and 2nd highest of all local authorities.

Also, 2.5% of 15 year olds in Bristol report using other drugs (not cannabis) in the last month, again significantly higher than the national average (0.9%). This may include new psychoactive substances, as well as drugs like cocaine and ecstasy.

The local Pupil Voice survey reports 9% of year 10 boys and 6% of your 10 girls used cannabis in the previous month, plus 6% of year 8 boys and 4% of girls. In this younger age group nitrous oxide (laughing gas) was the most likely substance to have been tried, whereas in the older group cannabis was more common.

**Gender:** Nationally, 15 year old females and males are equally likely to have ever tried cannabis and to have used it in the previous month. However, girls are more likely to have taken drugs other than cannabis in the previous month, although the proportions that use these substances are very small.

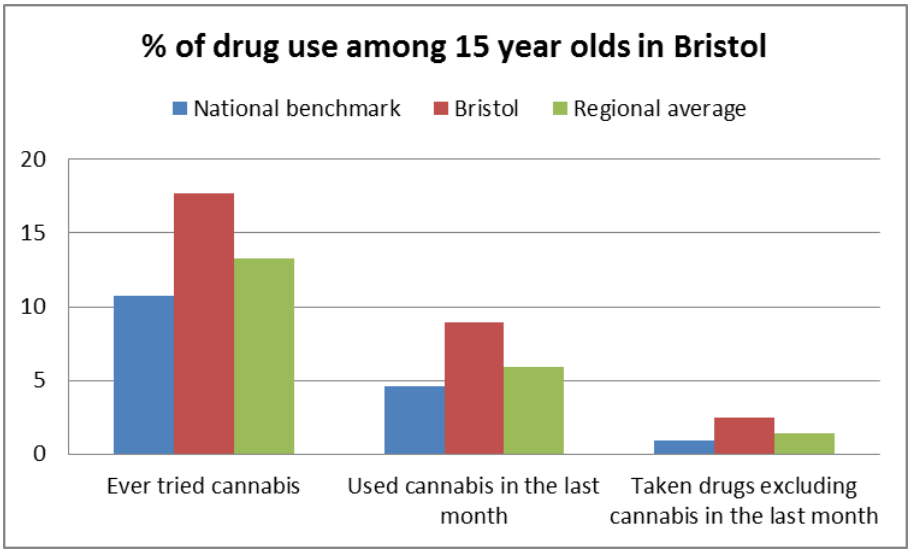



*Fig 4.12.5; Drug use in 15 yr olds; Source: What About YOUth (2014/15)*

### Further data

- Health behaviours in young people – What About YOUth? Survey: https://fingertips.phe.org.uk/profile/what-about-youth

[89] What About YOUth (WAY) survey 2014-15. Smoking, drinking and drugs http://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132874/pat/6/par/E12000009/ati/102/are/E06000023

# Section 5
# Wider Determinants

## Summary points

There are many factors which affect our ability be healthy, known as the "wider determinants of health", including lifestyle, social & community influences, work and environment. These are a major contributor to health inequalities.

### Deprivation

- 16% of Bristol's population live in the "10% most deprived areas in England" in 2015 (14% in 2010).
- The greatest levels of deprivation are in Hartcliffe & Withywood, Filwood and Lawrence Hill.

### Child Poverty

- Bristol has 18,900 children (under 16) in low-income families (23.2%), higher than England average (20.1%) and higher than previous year, with significant inequalities within Bristol.

### Education and Young People

- Bristol's education results improved, but only 30% of "Disadvantaged pupils" attained 5+ GSCEs inc English & Maths, compared to 67% of other pupils.
- Around 8,800 children in Bristol schools have some level of Special Educational Needs, 15% of Bristol pupils (2016, all age).
- Around 700 children are "in care" in Bristol at any given time.
- The rate of 16-18 year olds "not in education, employment or training (NEET)" is significantly worse in Bristol than nationally.
- The rate of young people going to Higher Education in "Bristol South" has persistently been one of the lowest in the country.
- First-time entrants to the Youth Justice System are significantly higher than nationally, but the rate in Bristol is now falling.

### Employment & Economy

- The unemployment rate in Bristol (5.2% in 2015) has fallen and is now similar to the national average.
- Bristol has high average earnings, but the highest paid 10% earn 6.4 times as much every week as the bottom 10%.
- Sickness absence rates are lower than national and core cities.

### Housing

- Rise in house prices, and shortage of affordable housing; now highest yet "affordability ratio". Private renting cost is rising.
- The average number of rough sleepers in Bristol rose to 33 per week in 2015/16 from only 5 per week in 2010/11.

### Fuel Poverty

- Over 26,100 households are "fuel poor"; 13.6% of Bristol households, more than national average and comparable areas

### Air pollution

- A modelled estimate is around 300 deaths a year in Bristol can be attributed to air pollution, which is 8.5% of all deaths.

### Promoting Healthy Urban Environments

- More people in Bristol commute to work by bicycle or on foot than elsewhere. 82% of people are satisfied with parks and green spaces in Bristol, but only 66% in deprived areas.
- The rate of road traffic injuries is significantly below national.

### Crime

- Crime numbers are now rising, esp violent crime & public order offences. Rates of violent crime are highest of core cities.
- Anti-social behaviour is falling, and residents noting fear of crime "affects their daily life" has halved over the last 5 years
- Numbers of reported sexual offences rose by 28% in Bristol last year (21% nationally). 84% of victims were female (2015/16).

### Domestic Abuse

- The rate of recorded domestic abuse incidents in Bristol has shown a significant rise over the last 2 years.

## 5.1 Deprivation[90]

The Indices of Deprivation 2015 provide a set of relative measures of deprivation across England, based on 7 different domains:

- Income Deprivation.
- Employment Deprivation.
- Education, Skills and Training.
- Health Deprivation & Disability.
- Crime.
- Barriers to Housing & Services.
- Living Environment Deprivation.

The Index of Multiple Deprivation (IMD) 2015 reinforces previously identified patterns of deprivation across the city. The greatest levels of deprivation in Bristol are in Hartcliffe & Withywood and Filwood in South Bristol, and in Lawrence Hill in the Inner City, but there are also pockets across the outer part of North Bristol (esp in Lawrence Weston, Southmead and Lockleaze) – see fig 5.1.1.

In 2015, a greater proportion of Bristol's population live in the most deprived areas in England, than in 2010 – 16% of Bristol's total population live in the 10% most deprived areas compared to 14% in 2010 – an increase of two percentage points. 22% of Bristol's children live in the 10% most deprived areas, and 14% of Bristol's older people.

Bristol has 42 "areas" in the most deprived 10% in England. Of these 42 areas, 26 are in the most deprived 5% and 6 areas[91] are in the most deprived 1% in England. In 2010, only 1 area was in the most deprived 1%.

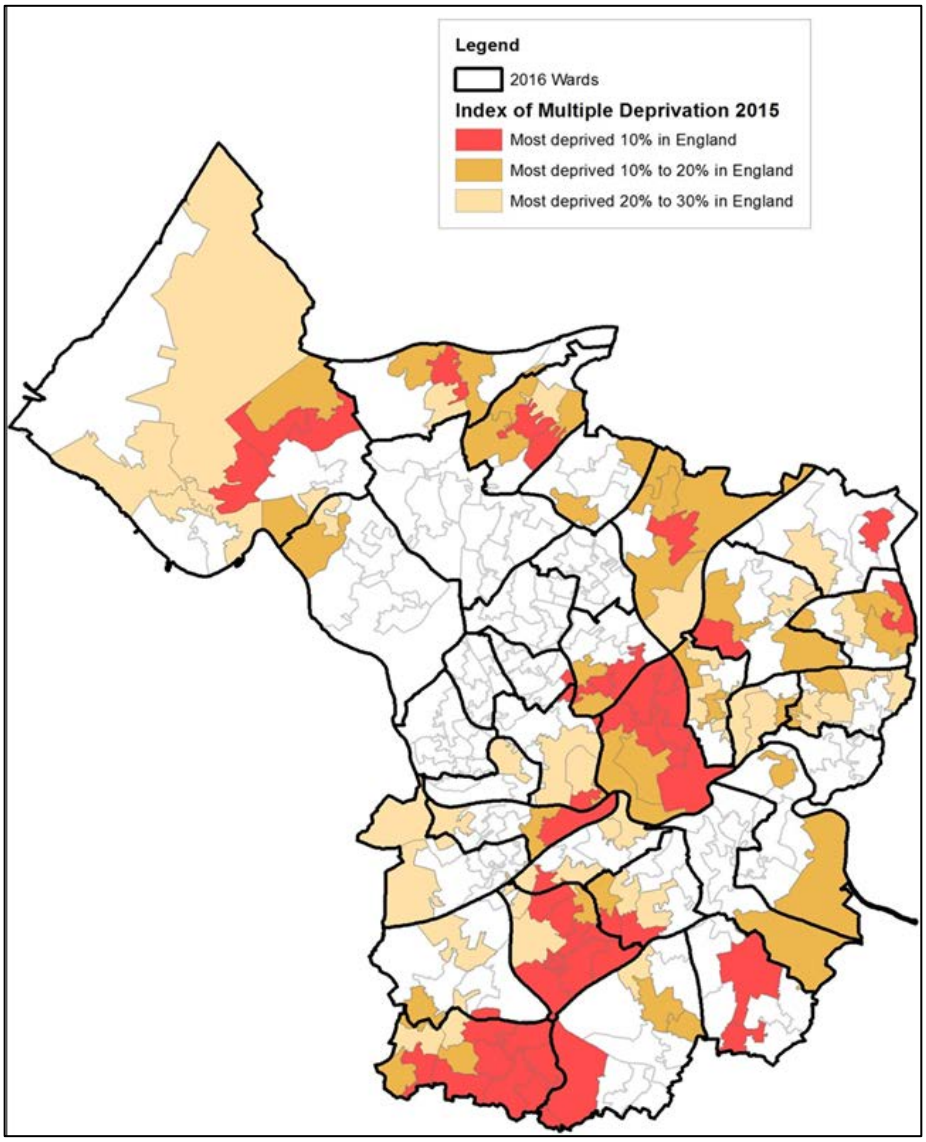



*Fig 5.1.1: Multiple Deprivation 2015 - Bristol LSOA[92] areas ranked in the most deprived 10-30% in England (with new 2016 ward boundaries overlaid)*
*Source: English Indices of Deprivation 2015, DCLG © Crown Copyright*

The overall IMD 2015 score[93] for Bristol is 27.2, higher than the England average score of 21.8 (though lower than all but 1 of the English Core Cities). However, since 2010 Bristol's relative rank in terms of Multiple Deprivation has increased (got worse) more than the other Core Cities, but from a less deprived starting point

[90] See Deprivation in Bristol 2015 Report, www.bristol.gov.uk/deprivation

[91] 4 of these are in Hartcliffe & Withywood, 1 in Filwood and 1 in Lawrence Hill

[92] Lower Super Output Areas; areas of about 1,500 population for national comparison

[93] Source: DCLG via PHE Health Profile. **Note** - This is 1 of 6 summary measures to help understand deprivation patterns across local authority (LA) areas. The pattern and scale of deprivation will vary, for example, some LAs have pockets of concentrated deprivation whilst some LAs have more widespread deprivation.

## 5.2 Income deprivation[94]

Almost 72,000 people in Bristol (17% of the population) suffer from income deprivation. The proportion varies across the city.

There are 37 Lower Super Output Areas (LSOAs)[95] in Bristol in the most income deprived 10% nationally; of these 17 are in Bristol South, 12 are in Inner City, 5 in Bristol North and West (outer) and 3 in Bristol East. In all these areas more than 30% of residents are income deprived.

By the new wards, the highest levels of income deprivation are in Lawrence Hill, Filwood and Hartcliffe & Withywood (fig 5.2.1).

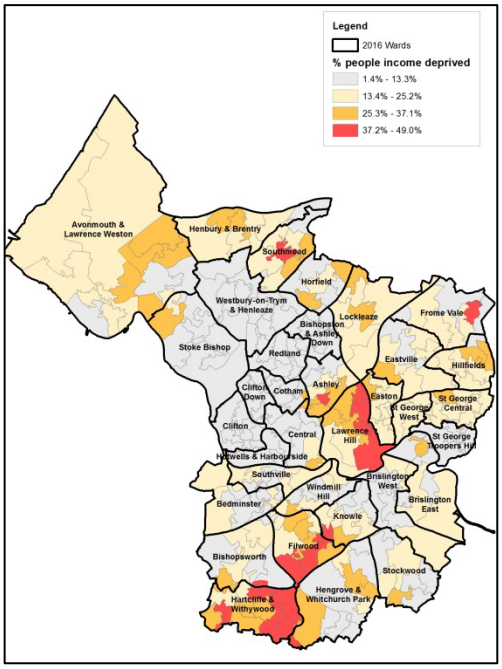



*Fig 5.2.1. Income deprivation (all age)*

### Income deprivation affecting children (IDAC)

In Bristol as a whole over 19,700 children (24% of all children) live in income deprived households. The proportion varies greatly across the city. In 12 LSOAs more than half of the children live in income deprived households – 9 of these areas are in South Bristol, and 3 in the Inner City. One area ('Fulford Road North' in Hartcliffe & Withywood) is in the most deprived 100 areas in England for income deprivation affecting children.

By the new wards, the highest levels of income deprivation affecting children are in Lawrence Hill, Filwood and Hartcliffe & Withywood – see fig 5.2.2.

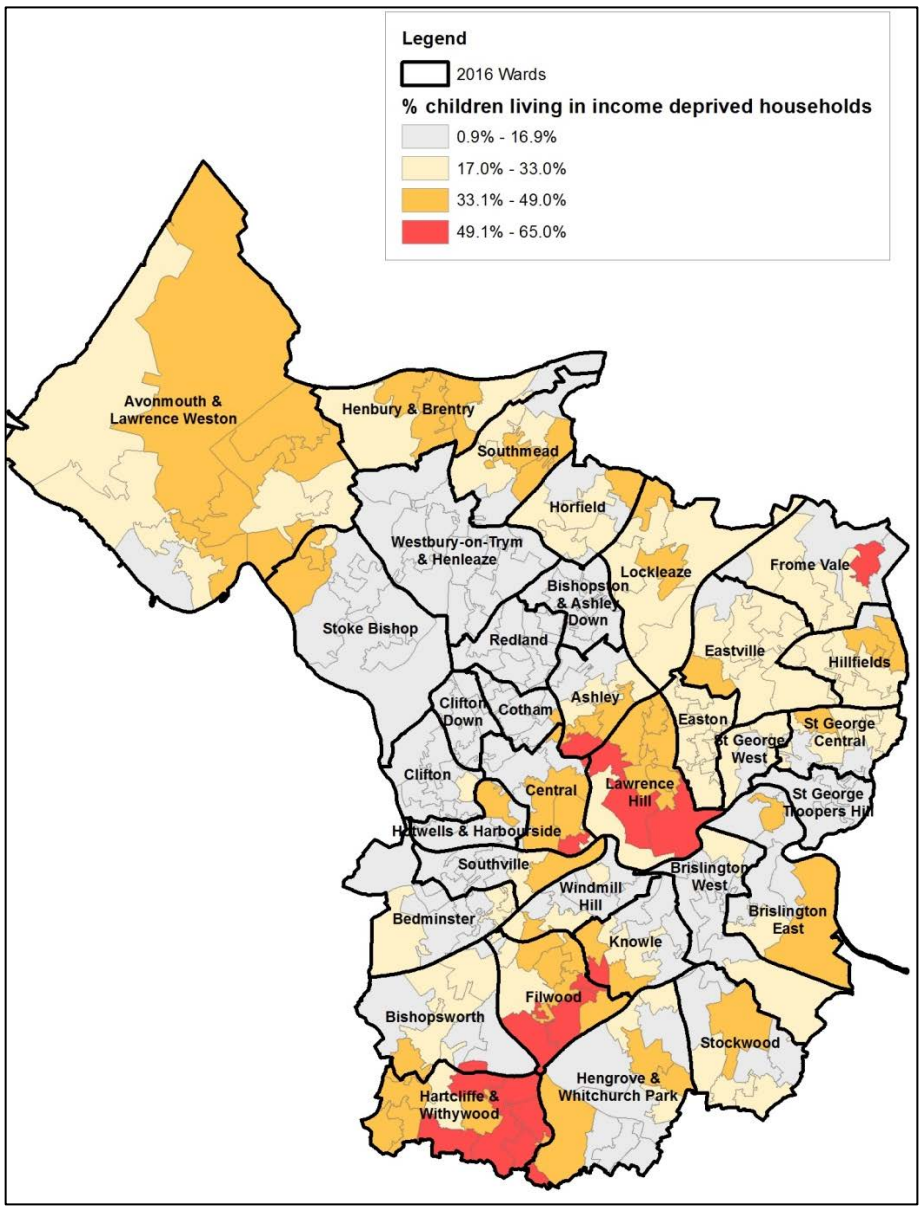



*Fig 5.2.2. Income deprivation affecting children, shown by LSOA area (2015)*

[94] See Deprivation in Bristol 2015 www.bristol.gov.uk/deprivation

[95] LSOA are statistical areas of about 1,500 population, used for national comparisons

## Income deprivation affecting older people (IDAOP)

In Bristol as a whole over 15,000 (20% of all older people) live in income deprived households. The proportion varies greatly across the city. There are 9 LSOAs where more than half of the older people living there are income deprived - 8 of these areas are in the Inner City, and 1 in South Bristol. One area ('St Pauls Grosvenor Road' in Ashley) falls in the most deprived 100 areas in England for income deprivation affecting older people.

By the new wards, the highest levels of income deprivation affecting older people are in Lawrence Hill, Filwood and Ashley – fig 5.2.3.

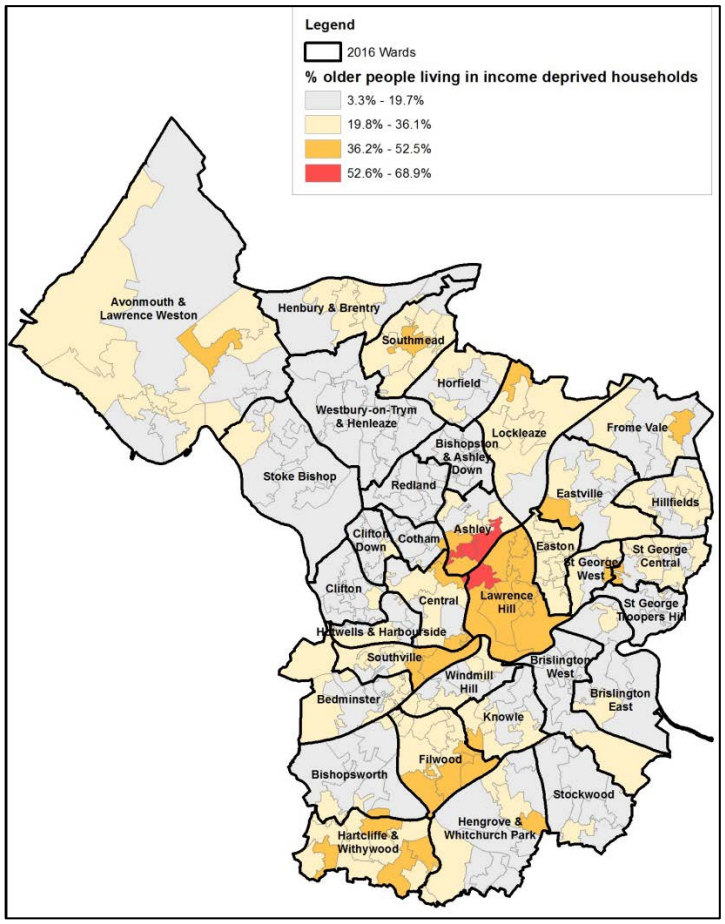



*Fig 5.2.3. Income deprivation affecting older people, by LSOA area, 2015*

## People struggling financially

The question 'How well would you say you yourself are managing financially these days?' was asked in the 2015-16 Quality of Life survey. 12% said they found it quite or very difficult to get by, which has been falling in the last 2 years (from 15% in 2013-14).

However, a significantly higher percentage of people living in deprived areas (18%) were struggling, and 22% of disabled people, as well as 26% of people of Muslim faith.

By ward, the range was from 4% of people in Redland to 22% in Hartcliffe & Withywood (fig 5.2.4).

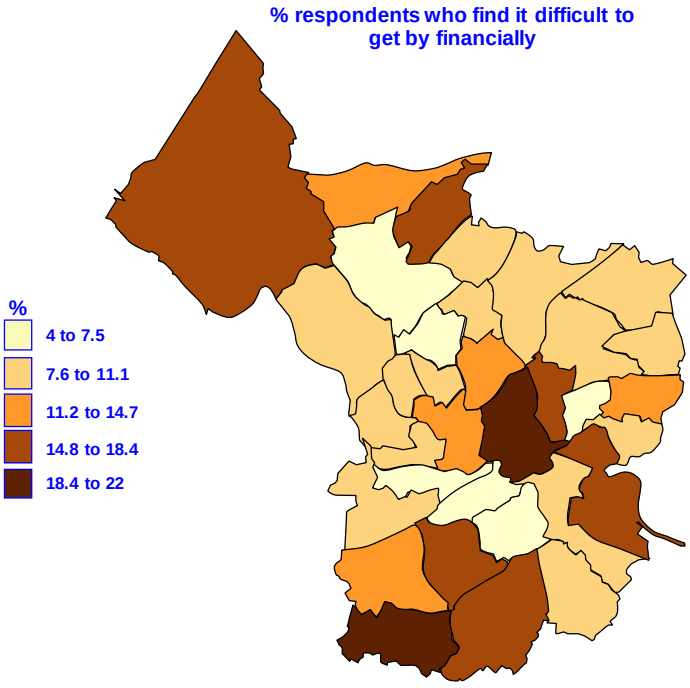



*Fig 5.2.4 People who say they are struggling financially*
*Source: Bristol Quality of Life survey 2015-16*

## 5.3 Child Poverty

Living in relative poverty means that families tend to make less healthy lifestyle choices than more affluent families. Data on families in receipt of benefits[96] is a good indicator of the proportion of families living in relative poverty.

New data for 2014 (released Sept 2016) shows that the number and % of children living in low-income families[97] is higher than in the previous year (fig 5.3.1).

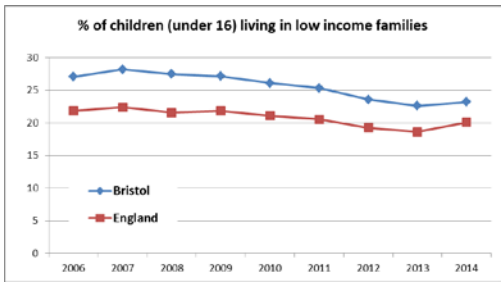



*Fig 5.3.1: Children living in low-income families; Source: DWP, Sept 2016*

As of 2014 there are 18,900 children under 16 in low-income families in Bristol; this is 23.2% of children, higher than the England average (20.1%). If measured for all children (under 20), the rate in Bristol is 23% (nationally 19.9%).

Bristol still has the 2nd lowest rates of children in low-income families of Core Cities (for both measures).

The greatest levels of child poverty are in Hartcliffe & Withywood and Filwood in South Bristol, and increasingly concentrated in Lawrence Hill and the Inner City (Redcliffe North area in Central rose to 66% of children in low income families) (fig 5.3.2).

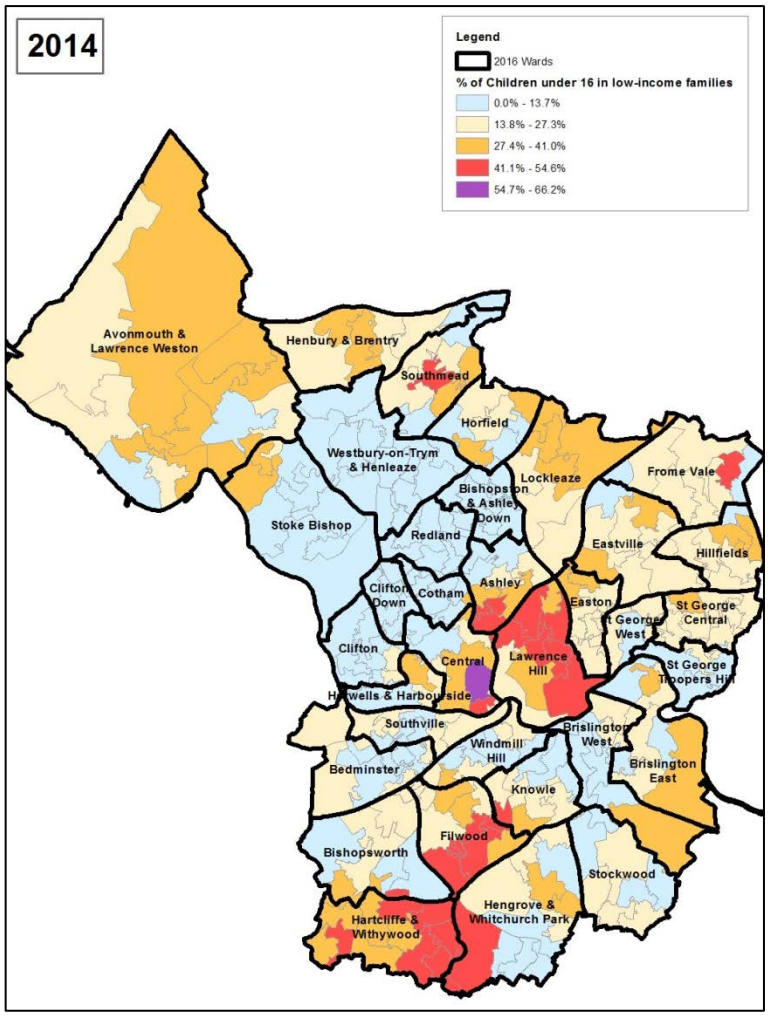



*Fig 5.3.2: % of children in low income families, by LSOA; Source: DWP 2016*

When averaged to the 5 Bristol CCG sub-locality areas, the biggest rise in the last year was Bristol East (now 22%) and Inner City (highest at 35%). The rate in North & West inner (lowest at 4%) is stable, and the inequalities gap between these areas is no longer reducing.

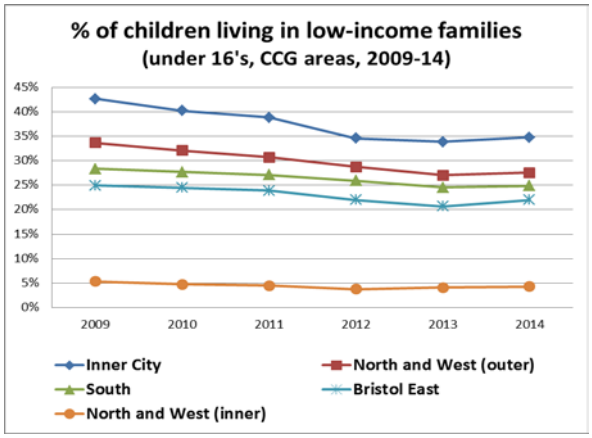



*Fig 5.3.3: Children living in low-income families by CCG locality; Source DWP via Bristol City Council Performance, Information & Intelligence, Sept 2016*

[96] Note these rates are based on actual benefits data released nationally 2 years in arrears. The data therefore has a delay in reflecting changes to benefits policy & uptake.

[97] Snapshot of the % of children living in families (using Child Benefit data) in receipt of out-of-work benefits (Income Support or income-based Job Seekers Allowance) **or** of child tax credits with an income less than 60% of the national median income. Source: Dept of Work & Pensions), Personal Tax Credits, 2014 data released Sept 2016

## 5.4 Education

### 5.4.1 Early Years

The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children's development (4-5yr olds) at the end of the academic year in which the child turns 5, and measures development against the early learning goals. This was a new indicator in 2013.

In 2015, 64% of children under 5 were assessed as having a good level of development at Foundation Stage, against an England average of 66%. Across Bristol in 2015, this ranged from 54% in Frome Vale to 83% in Redland.

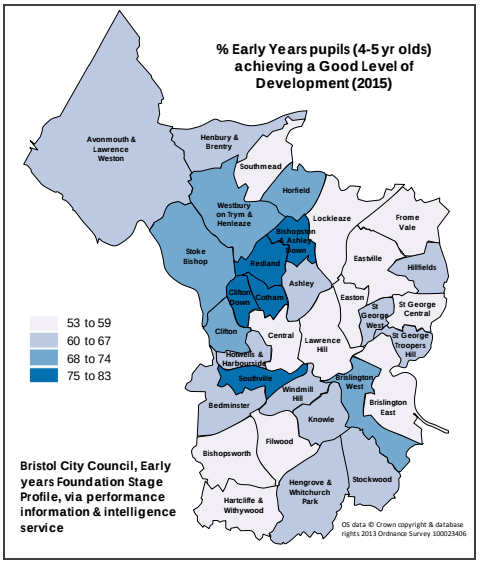



*Fig 5.4.1: Source: Bristol City Council*

### 5.4.2 SATs

SATs are a formal assessment for pupils leaving Primary school (aged 10/11 years). The main measure is now the % achieving a level 4 or above in Reading, Writing and Maths combined.

Level 4 is the level of attainment typical for an 11 year old. Of Key Stage 2 pupils in Bristol, assessed in Year 6, 78% achieved level 4 or above in Reading, Writing and Maths combined (2015). This is higher than last year, but is lower than the national rate (80%) and Core Cities (79%). Across Bristol attainment at Level 4 ranged from 60% in Central to 96% in Bishopston and Ashley Down.

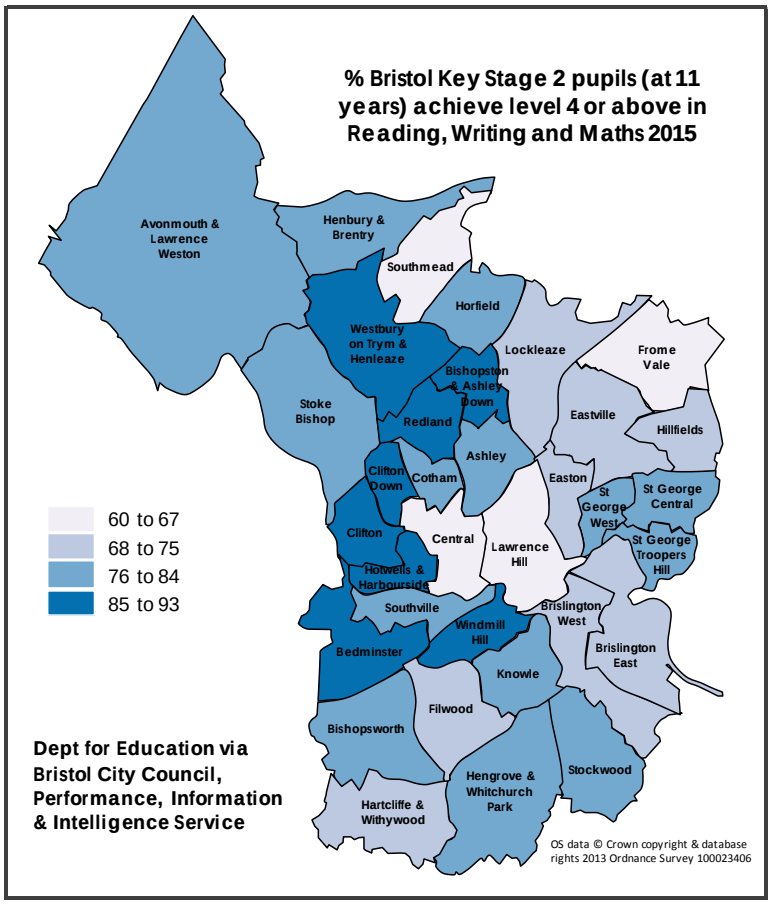



*Fig 5.4.2: Dept of Education, via Bristol City Council, 2015 results*

### 5.4.3 GCSE results[98]

In 2015, 54% of Bristol pupils attained 5 or more GCSEs at grade C or above (including English and Maths), a point rise of 18% since 2008. This is now similar to the national average (54%) but higher than the average for English Core Cities (52%).

However, within Bristol there remains significant variation, with over 91% children achieving this level of attainment in Redland, but only 35% in Filwood.

Furthermore, only 30% of "disadvantaged pupils"[99] attained 5+ GSCEs including English and Maths, compared to 67% of all other pupils in Bristol

**Gender:** 50% of boys attained 5+ GSCEs including English and Maths, and 58% of girls.

An alternative measure is for pupils achieving at least 5 GCSEs at grades A*-C in *any* subject (not necessarily including English and Maths). Attainment figures for this indicator are 63% for Bristol pupils, and 65% England average (2015).

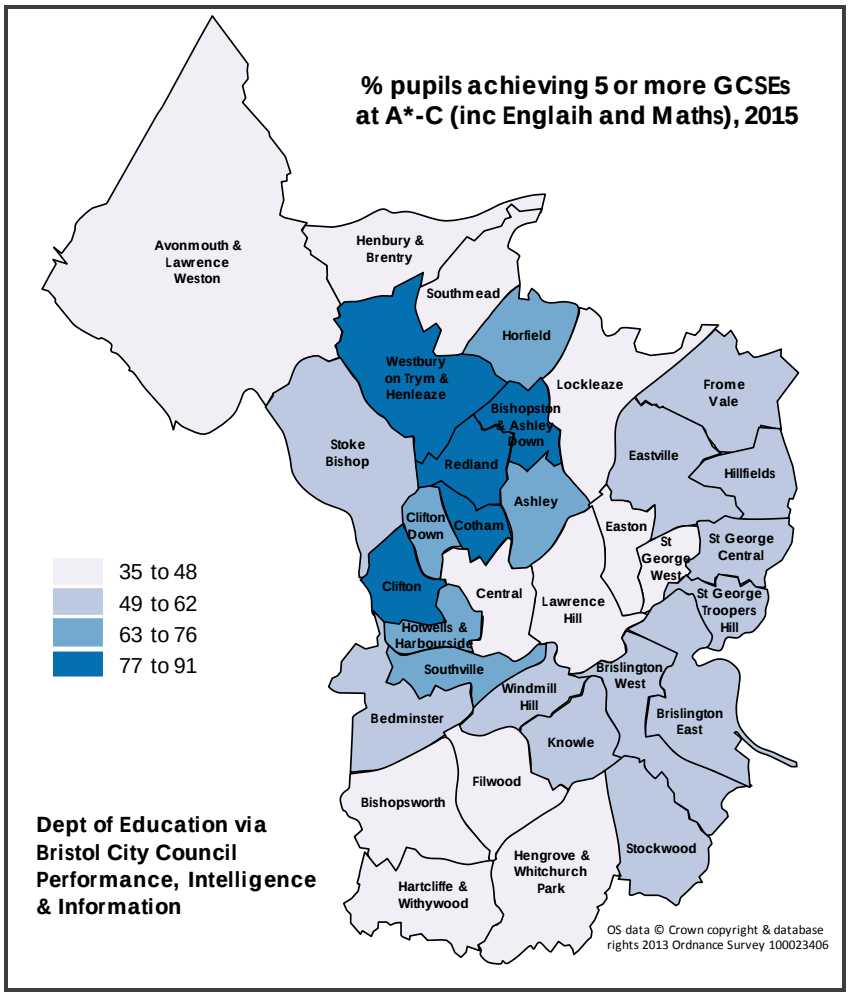



*Fig 5.4.3: Pupils attaining 5+ GSCEs including English and Maths by ward, 2015; Source: Dept. of Education, via Bristol City Council*

### 5.4.4 A level results[100]

In 2015, 74% of Bristol A level pupils attained 3+ A Levels (at grades A*-E). This is similar to previous years and lower than the national average (79%).

### 5.4.5 Higher Education

Recent reports on trends in higher education participation[101] have highlighted that rates for young people going on to higher education are particularly low in South Bristol. The rate of young people going on to Higher Education in the parliamentary constituency area of "Bristol South" (c15-17%) has persistently been one of the lowest rates in the country (1999-2013).

[98] Further details in Bristol Education Performance Report.
[99] Pupils who have ever been In Care or adopted, or been eligible for Free School Meals at any point in the last 6 years
[100] Further details in Bristol Education Performance Report.
[101] Vital Signs for the West of England, 2016 / Trends in young participation in higher education; Higher Education Funding Council for England (2013) www.hefce.ac.uk/

## 5.5 Pupil Absence

Children who do not attend school are more likely to fail to achieve their educational potential. We know that children who fail to achieve at school are more likely to have adverse health and wellbeing outcomes later in adulthood.

In 2014/15 the amount of school-time missed by pupils in Bristol schools[102] was 5.1%, which is significantly higher than the national average (4.6%). The trend chart (fig 5.5.1) shows Bristol is broadly reducing in line with national rates.

Locally[103], the wards with the highest absence rates were Filwood (9.1%), Hotwells & Harbourside (8.5%) and Lawrence Hill (8.3%). The lowest rates of absenteeism were in Westbury-on-Trym & Henleaze (4.5%), Redland (5.0%) and Southville (5.4%).

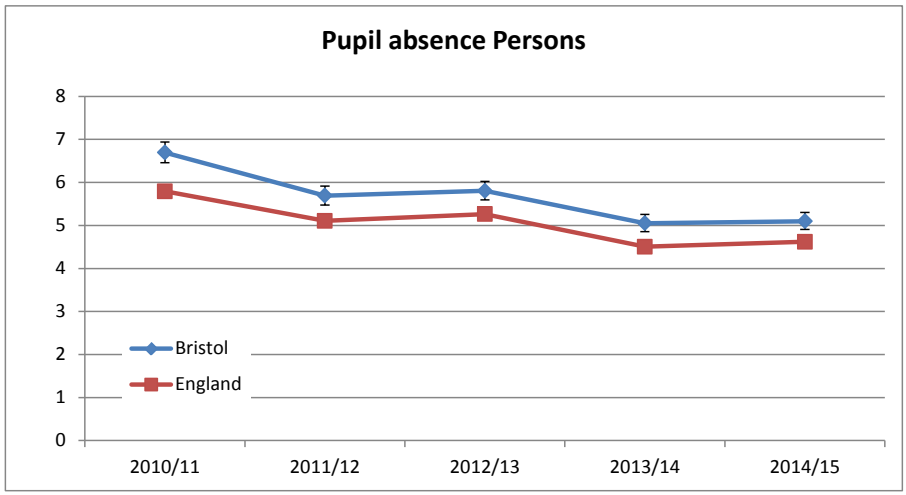



*Fig 5.5.1 Source via PHOF (Aug 2016)*

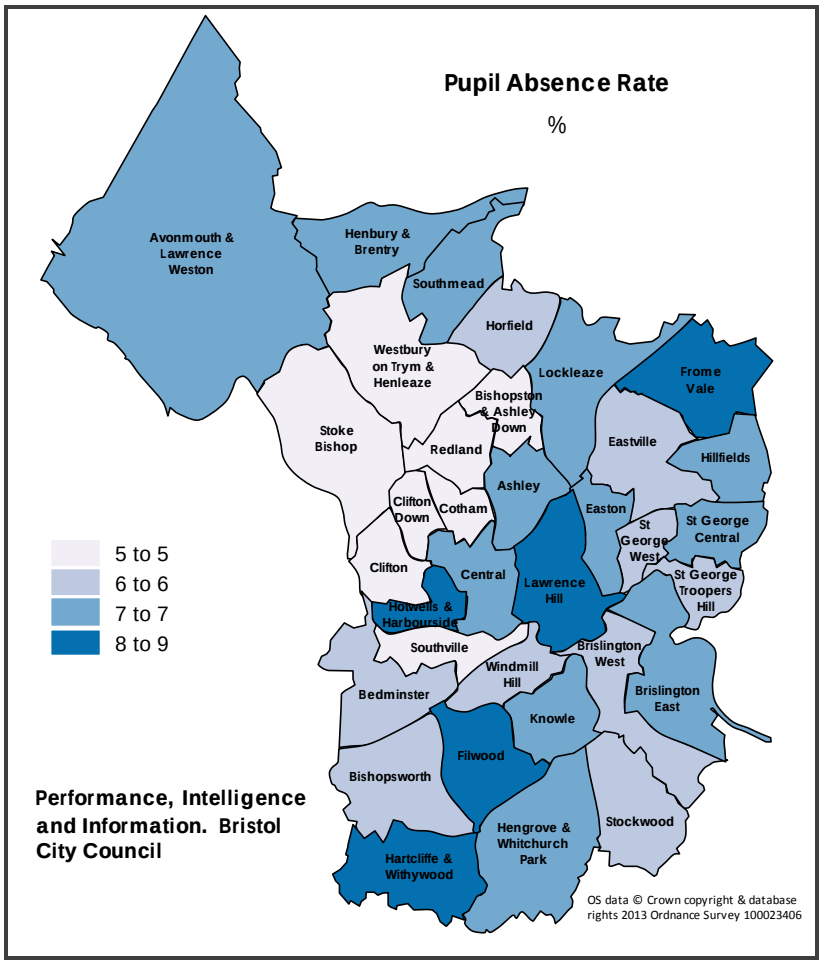



*Fig 5.5.2 Pupil absence rate by ward*

[102] % of half days missed by pupils due to overall absence
Source: Department for Education via Public Health Outcomes Framework, Aug 2016

[103] Ward absence rates are taken from a different source than the national rates. Local results include pupils who live outside of the Bristol area but go to school inside

## 5.6 Special Educational Needs (SEN)

Overall, in 2016 there are approx. 8,800 children in Bristol schools with some level of Special Educational Needs (SEN)[104], 15.2% of all Bristol pupils (all ages) [105]. [This is all SEN incidents, including where the school provides additional support "in-house", and includes 275 out-of-area pupils in Bristol schools] .

Across Bristol numbers of children with SEN are higher in more deprived areas. By ward, numbers of pupils with SEN are highest in Hartcliffe & Withywood (760) and Filwood (600), followed by Lawrence Hill and Avonmouth & Lawrence Weston. In contrast, there are less than 50 SEN children in Clifton Down. Fig 5.6.1 shows pupils with SEN as a % of all Bristol pupils in that ward.

**Note** – SEN categories changed in 2015 to SEND[106] and also added pupils on a lower "School Support" level of need into the data-sets. This level did not feature in SEN previously, so the primary need categories (fig 5.6.2) cannot be compared to past analysis. Also, SEND data provides a new proxy for estimating Disability, see "**4.5 Disabled children**" section.

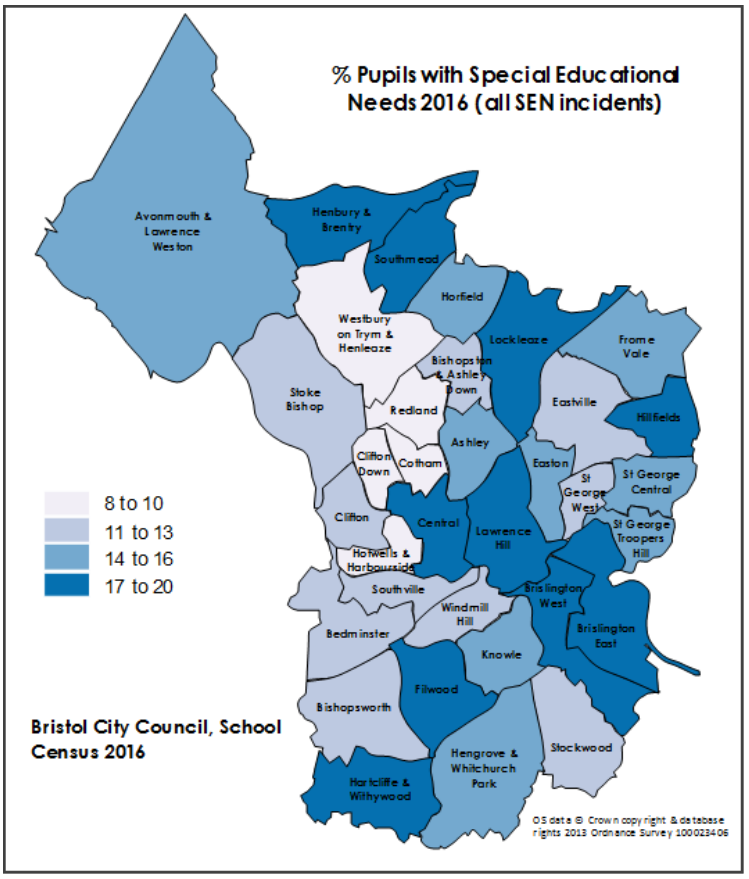



*Fig.5.6.1: SEN 2016; Source: BCC, Performance, Information & Intelligence*

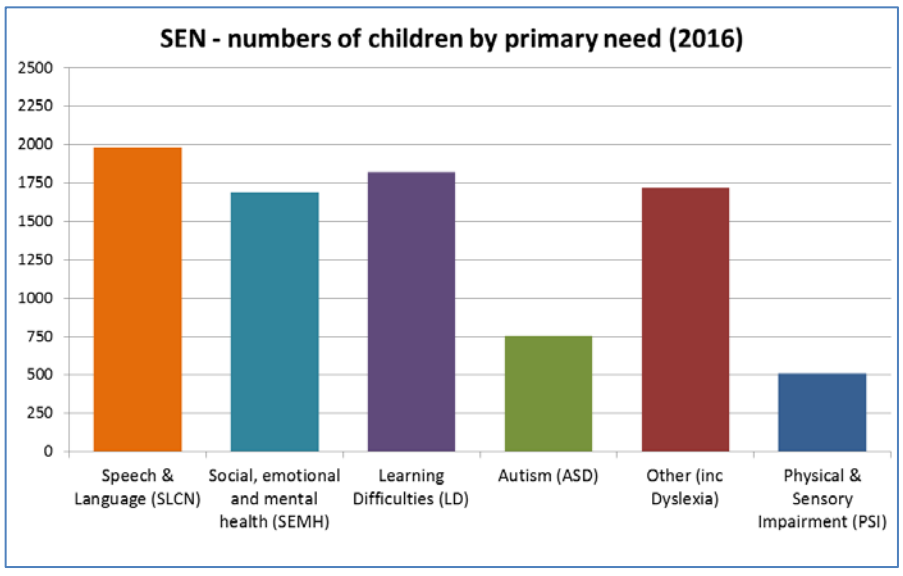



*Fig.5.6.2: SEN Primary Need Breakdown 2016. Source: Bristol City Council, Performance, Information & Intelligence*

Further data

- JSNA Chapter on "Children and young people with Social and Communication Interaction Needs" (due Jan 2017)

[104] Source: January School Census 2016; Bristol City Council
[105] Note - in JSNA 2015 the higher SEN % used was for 5-15 year olds, not all ages, and SEN recording changed after 2015
[106] Special Educational Needs & Disability

## 5.7 Children in Need (Social Care)

There were 1,800 “Children in need” (allocated to a Social worker) at end March 2016[107]. Data cleansing work in 2015 and a new approach to “early help” reduced recent figures (fig 5.7a)

By ward there is a large difference across Bristol, from approx 4 per 1000 children in Cotham and Clifton Down to 61 per 1000 in Central (fig 5.7b).

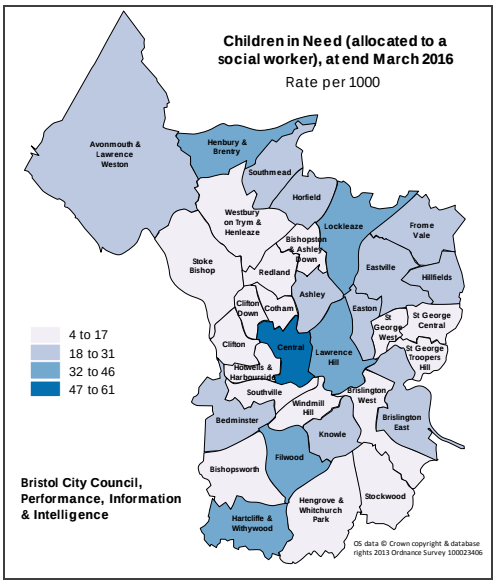



*Fig 5.7b: Children allocated to Bristol's Child Social Services by ward (excluding those "in care" or on Child Protection register), March 31st 2016, as rate per 1,000 child population*

### 5.7.1 Children in care

There are currently just under 700 children in care in Bristol at any given time (fig 5.7a shows snapshot measure taken at the end of March each year), which is similar to previous years.

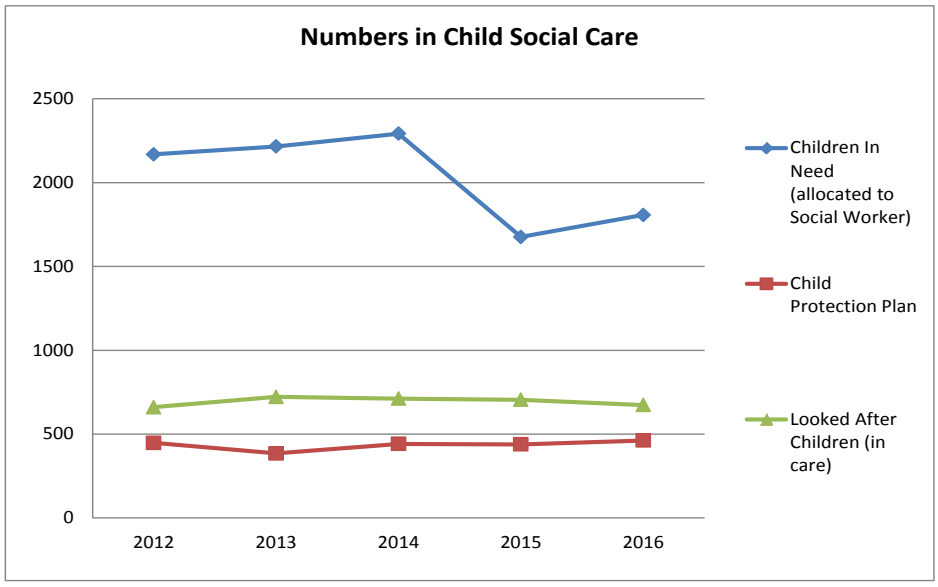



*Fig 5.7a: Children known to Bristol Social Services (numbers allocated to Child Social Services / “in care" / on Child Protection register) on March 31st. Supplied by: Bristol City Council, Performance, Information & Intelligence*

However, it should be noted Children in care is not a static population. For example, there were approx 990 individual children in care for some period of time during the 12 months up to March 2015. The number of long-term looked after children (in care continuously for a year or more) is not rising. However more children came into care for shorter periods.

Health assessment figures for Bristol children in long term care are mixed:

- 92% have completed Health Assessments in 2015, a slight increase from 91% in 2014. This compares to a national rate in 2015 of 90%;
- 82% have completed Dental Checks in 2015, a decrease from 92% in 2014. This compares to a national rate in 2015 of 86%;
- 83.5% have all immunisations recorded as up-to-date (2016), which is an improvement locally but remains lower than the national rate of 87.8% in 2015.

42% of children in care in Bristol are categorised under cause for concern, as measured by the Strengths and Difficulties Questionnaire, which assesses emotional health and wellbeing. This compares to 37% nationally. 12% are categorised as having borderline cause for concern, compared to 13% nationally.

### 5.7.2 Child Protection Plans

There are currently approx. 460 children with a Child Protection Plan (at end March 2016), similar to previous years (fig 5.7a).

[107] Source: Bristol City Council, Performance Information & Intelligence, 2016

## 5.8 Not in Education, Employment or Training (NEET)

Young people who are not in Education, employment or training are more likely to adopt unhealthy lifestyles, and less likely to achieve good health outcomes in adulthood.

There are **5.8% of 16-18 year olds** in Bristol[108] (2015) who are recorded as being "not in education, employment or training". This rate is falling and is broadly similar to other Core Cities, but is still significantly worse than the national average of 4.2% (fig 5.8.1)

However, locally[109], figures range from less than 2% in many wards in the inner North & West area, to 9% of young people in Filwood, Southmead and Stockwood (see fig 5.8.2), which highlights the inequalities in opportunity for young people in some of the most deprived areas of Bristol.

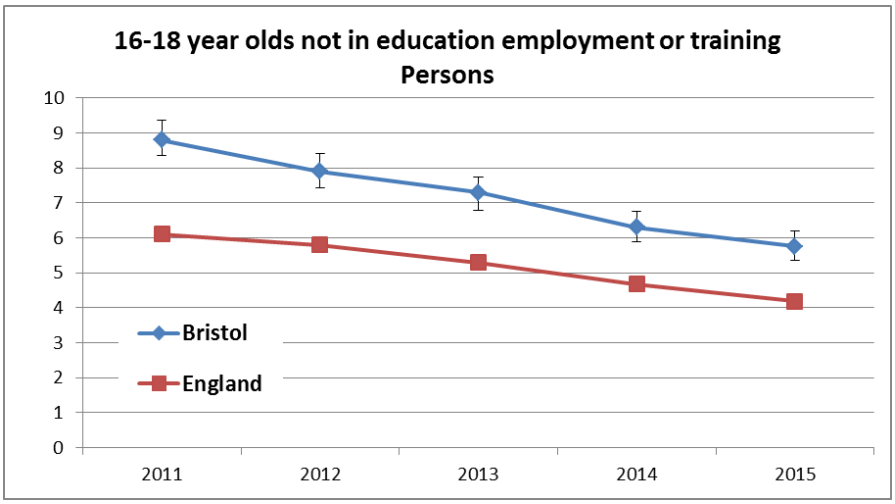



*Fig 5.8.1 Source: Dept for Education (via Public Health Outcomes Framework, Aug 2016)*

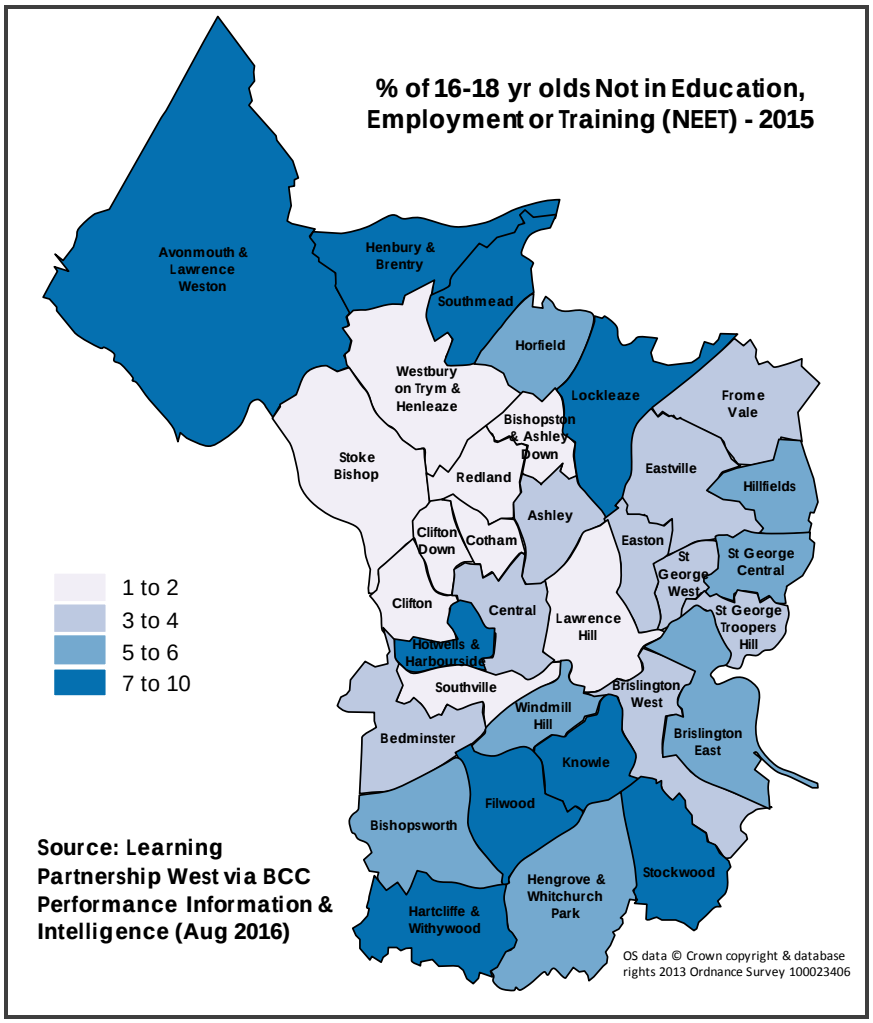



*Fig 5.8.2 % NEET by Bristol wards (data for Nov 2015 – Jan 2016) Source: Learning Partnership West via Bristol City Council, Performance Information & Intelligence (Aug 2016)*

[108] Source: Dept for Education, 2016 (also via Public Health Outcomes Framework data tool, Aug 2016)
[109] Source: Learning Partnership West (Nov 2015-Jan 2016) via Bristol City Council, Performance Information & Intelligence

## 5.9 Young Offenders

Young people in the criminal justice system are more likely to make unhealthy life style choices and are less likely to succeed in education and are more likely to have adverse health outcomes in adulthood. The Youth Offending Team is a multiagency team who work with young offenders.

The rate of first-time entrants to the Youth Justice System[110] in Bristol is 595 per 100,000 (for 2015-16), significantly higher than the national average (357 per 100,000) but is falling - fig 5.9.1. As individuals, there were just over 200 young people who entered the Youth Justice System for the first time in 2015-16, down from 300 in 2012-13.

At the end of 2015, Bristol had one of the highest rates of Core Cities and other comparator authorities. However, the Bristol rate is now falling, and has had its biggest reduction, year on year, since 2009-10. The Bristol rate is also falling faster than most other cities and faster than national average. The current rate is the lowest rate recorded in Bristol.

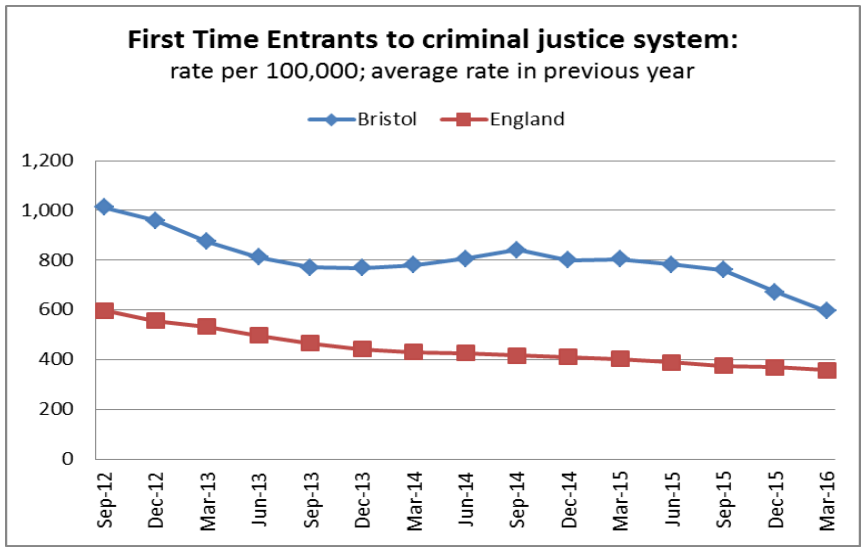



*Fig.5.9.1: Rate of young people aged 10-17 receiving their first reprimand, warning or conviction. Source: Police National Computer via BCC YOT team*

Local data shows 440 individual youth offenders[111] in Bristol in 2015-16, a rate of 12.6 per 1,000 (NB not all are first time entrants). By ward, this ranges from 0 in some inner North & West wards to 45 per 1,000 in Hotwells & Harbourside (fig 5.9.2).

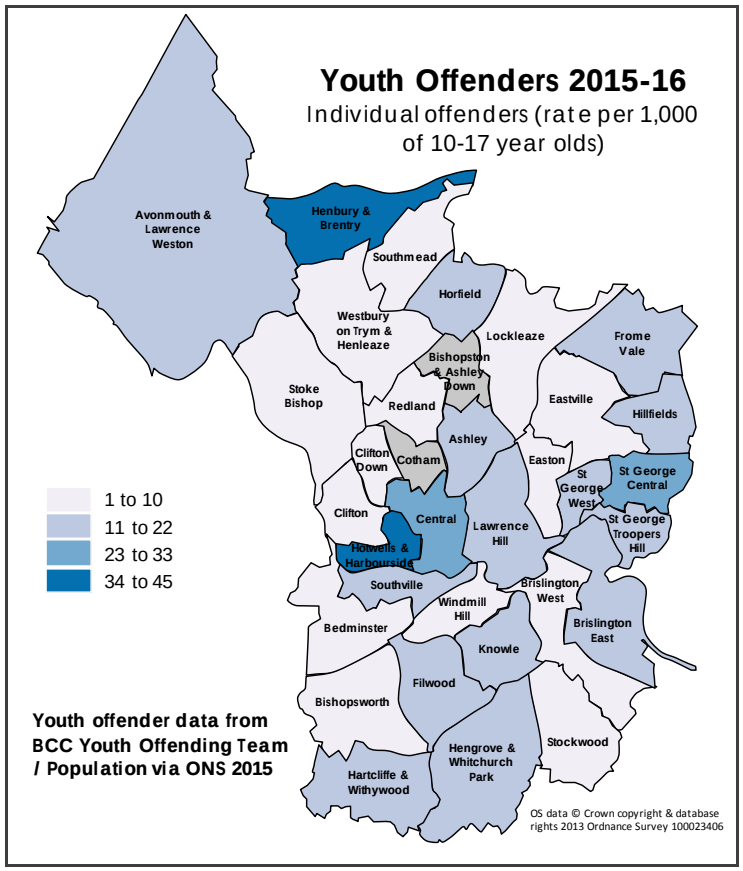



*Fig.5.9.2: Rate of individual Youth Offenders 2015-16 (Youth Offending team)*

[110] 10-17 year olds receiving their first reprimand, warning or conviction. Source: Police National Computer database via Bristol City Council Youth Offending Team, 2016

[111] Source: Police National Computer database via BCC Youth Offending Team, 2016

## 5.10 Employment

In 2015, the percentage of working age economically active people in Bristol (80.4%) was broadly similar to the average for England (78.0%).

In 2015 the unemployment rate[112] for Bristol fell sharply to 5.2%, and was similar to the average for England (5.3%). It has now fallen back similar to pre-recession levels (fig 5.10.1).

Employment has increased since the recession (due to a rise in female employment) but remains below pre-recession levels (due to falling male employment). The rate (and numbers) of unemployed people claiming unemployment benefit (the claimant count rate) fell more or less continually in 2013, 2014 and 2015 and is now at levels comparable to those in pre-recession 2007.

In 2015, there were 12,100 economically inactive people who wanted a job, while 13,100 people were classed as unemployed. This meant that a total of 25,200 people were involuntarily workless. These represented 10.4% of the economically active population – lower than across England (12.1%).


*Fig 5.10.1 Unemployment rate (% people 16-64) England & Bristol, 2004-15*

### Economic participation and unemployment: key facts[113]

- Economic activity rate 2015: 80.4% (England 78.0%)
- Employment rate 2015: 76.2% (England 73.8%)
- Unemployment rate 2015: 5.2% (England 5.3%)
- Worklessness rate 2015: 10.1% (England 8.9%)
- 12.7% of working age claiming benefits 2015 (England 11.7%)

### Economic performance: key facts

- £13.28 billion in economic output in 2014 (1% of England total); rise of 6.5% since 2013 compared to 4.6% for England.
- Gross Value Added (GVA) per head: £30,007 in 2014 (England £25,367); rise of 5.3% since 2013 (3.7% England)
- Workplace-based jobs in Bristol increased significantly by 7.5% from 232,200 to 249,700 between 2012 and 2014
- GVA per hour worked[114] for Bristol in 2014 was £29.4 (England £31.5); rise of 6% since 2013 (1.7% for England)

### Earnings and Earnings Gap[115]

In 2015, Bristol had the highest median (& mean) Total Gross Weekly earnings of the English Core Cities

In Bristol, the 2015 median earnings of the highest earning 10% in work was £875, compared to £137 for the lowest paid 10%[116].

[112] NB the % of economically active working age people who were out of work and looking for work

[113] For regular updates, see BCC Economic Quarterly Briefings at www.bristol.gov.uk/business-support-advice/economic-information-and-analysis

[114] Data are nominal and are not adjusted for inflation.

[115] See BCC Economic Briefing "Earnings Gap for Bristol Residents: Nov 2016"

[116] Annual Survey of Hours and Earnings, 2015

So, the highest paid 10% earned 6.4 times as much every week as the bottom 10%.

Between 2002 and 2015, this gap in Bristol's weekly earnings grew at an average rate of £16.80 each year, similar to the growth in the gap for England (£16 per year).

Furthermore, taking 2015 data as a starting point and assuming the "top 10%" earnings grow at 3% per year, even if the "bottom 10%" grew 3 times as quickly (9%), the gap between the two would take close to 20 years to start closing.

### Job Seekers Allowance (JSA) claimants by gender

Prior to 2012 there had been at least twice as many men as women claiming JSA[117]. Post-recession, in 2009-14 the situation changed and now the proportion of Bristol women claiming JSA has increased to an all-time high[118] (36.4%, Oct 2014) – fig 5.10.2.

The number of women claiming JSA decreased at a rate of about 1,020 per year in the 23 months to Dec 2014, but this was under half the rate of decrease (2,340 per year) for male JSA claimants over the same period.

As of July 2016, there were 3,295 men and 1,785 women claiming JSA in Bristol, 20% *below* and 21% *above* the pre-recession levels of July 2008, respectively.

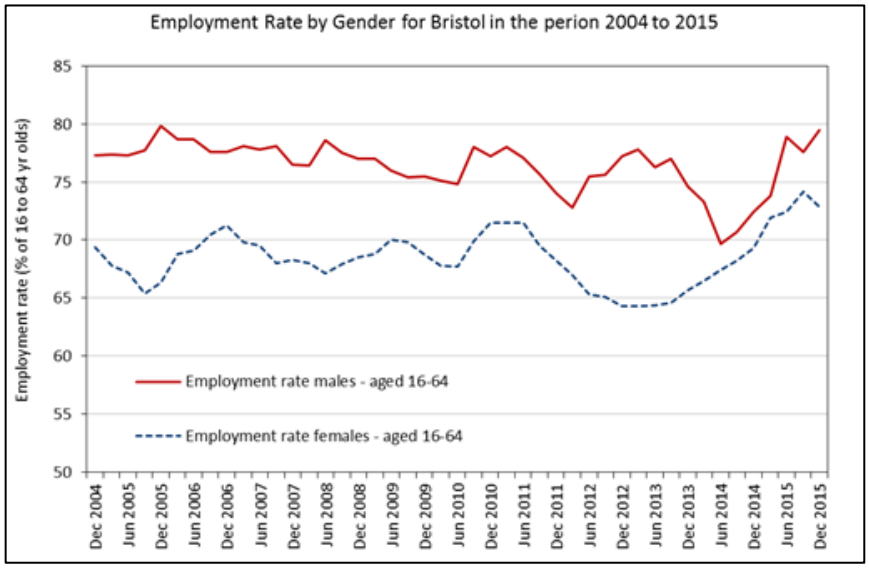



*Fig 5.10.2 Unemployment rate by gender for Bristol in the period 2004 to 2015*

### Youth Unemployment

In July 2016 the number (955) of young claimants (18-24 years old) resident in Bristol was 63% below the level (2,585) of July 2013 and about 42% below the pre-recession level (1,645) of July 2008. About 39% (215) of the young people claiming JSA[119] are classed as long-term claimants. This compares poorly with the pre-recession monthly average[120] of 15.6% and although it had fallen, from 41.6% in 2012 to 21% in 2014, since Oct 2015 it has been rising at 1.8 percentage points per month.

### Unemployment amongst 50 to 64 Year Olds

The number (1,150) of older[121] claimants resident in Bristol was 61% below the level (1,665) of July 2013 but remains at over four times the pre-recession level (250) of July 2008. The proportion (22%) of claimants aged 50 to 64 year is at an historic[122] high and 52% of claimants in this age group are long term claimants. The numbers of claimants in both of these groups have only changed slightly over the last nine months. Further, having been on a decreasing trend throughout 2013, 2014 and 2015, the total numbers of older claimants increased for eight of the last nine months, suggesting that the trend may have reversed.

[117] Data since 1983, the earliest date in the JSA data series. In Bristol, more than 3 times and 2.5 times for 48% and 77% of the data series respectively
[118] the same is true nationally (UK) but with the high at 36.5%
[119] Applies to JSA only (data since 1983) and excludes c6% claiming Universal Credit
[120] For the years 2005 to 2008 inclusive
[121] aged 50 and over
[122] Since June 1983 the earliest date in the JSA claimant count data series.

## 5.10.1 Employment and health

### Sickness Absence

Bristol's sickness absence rates fell in the latest period[123] and are now significantly lower than national average (fig 5.10.3) and the lowest of the Core Cities, with 0.9% of working days lost due to sickness.

Local research[124], carried out in 2013, highlighted the following:

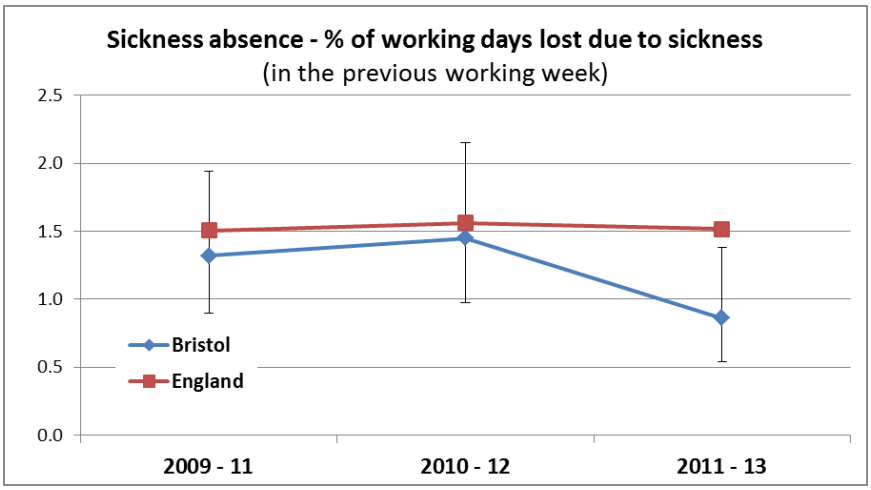
- 10 million working hours were lost to sickness or injury in 2010 at a cost to the Bristol economy of £240 million.
- Sickness absence rates were higher amongst public sector and older workers (50+)
- By sector, rates were highest in manufacturing, construction and agriculture.

### Causes of sickness absence

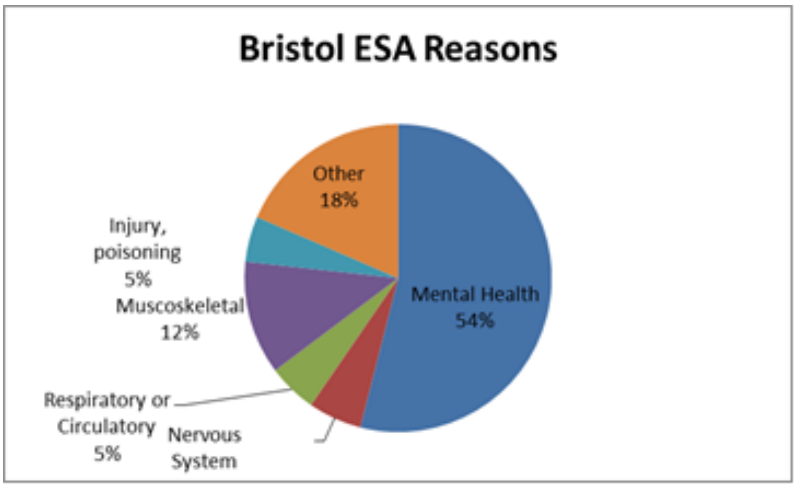
National 2014 data showed that, after minor illnesses, the most common reasons for sickness absence was back, neck and muscle pain, followed by stress, anxiety and depression.

### ESA claimants by health reason

In Bristol, the largest cause of Employment and Support Allowance claims[125] is poor mental health (54%), followed by musculoskeletal conditions (12%)[126] – fig 5.10.4.




*5.10.3: Labour Force Survey via Public Health Outcomes Framework 2016*




*5.10.4: Employment and Support Allowance claims by health reason; Source: ONS statistics, NOMIS, October 2016*

### Sickness absence resulting from work-related stress

Local research[127] into stress and absence identified that:

- 1 in 4 days lost to sickness absence in Bristol were work-related, that is, the ill health symptoms/condition were considered to be a result of work or made worse by work.
- Stress, depression or anxiety accounted for 36% of work-related ill health.
- The average spell of sickness absence for stress, depression or anxiety in was 7.6 days compared to an average of 4.7 days for all sickness absence.
- Workload was the most frequent cause of job stress.
- Higher-level professionals, front-line supervisors, those working for a large organisation or dealing face to face with the public reported above average rates of stress-related sickness absence attributable to work.

[123] 2011-13; Source: Labour Force Survey / ONS via PHOF (Aug 2016)
[124] Profiling Sickness Absence Within the City of Bristol, A. Weyman, A. Buckingham, University of Bath, Feb 2013 (2010 data)
[125] Source: ONS statistics, NOMIS, Oct 2016
[126] See JSNA sections**: 8.8 Musculoskeletal and 9. Mental Health**
[127] Profiling Work-Related Stress Sickness Absence Within the City of Bristol , A. Buckingham and A. Weyman, University of Bath, October 2013 (using 2010 data)

## 5.11 Housing

House prices in Bristol are rapidly rising, faster than nationally and faster than average incomes.

There is a serious shortage of affordable housing in the city and rising homelessness.

Also a significant increase in private renting (and rental costs)

### 5.11.1 Housing Stock[128]

55% of houses in Bristol are owner-occupied, 24% privately rented, 15% owned by the city council and 6% by housing associations. The private rented sector increased significantly since 2001, from 12% to 24%, and has overtaken the social sector.

### 5.11.2 Housing Need

The 2015 Strategic Housing Market Assessment (SHMA)[129] highlighted a shortage of affordable housing in Bristol, with a need for 18,800 affordable homes 2016-36 (an average of 940 new affordable homes per year over the 20 year period).

For 2015-20, Bristol needs to develop at least 4,570 dwellings, and has a 5 year "deliverable supply" of 7,230 dwellings already available for this period[130].

### 5.11.3 House Prices & Affordability

House prices in Bristol are rising. The average house price in Bristol (Apr 2016) was £242,600, which is now higher than the England average of £224,700[131] (see fig 5.11a).

In the last year (April 2015-2016), average house prices in Bristol increased by 12.7%, against a 9.1% rise in England, and in the last 10 years, average house prices in Bristol increased by £83,300 (a 52% rise, against a 31% rise in England)[132].

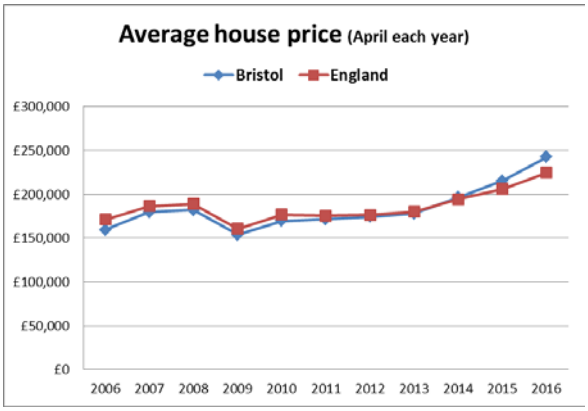



*Fig 5.11a Average house prices; Source UK House Price Index, Land Registry, April 2006 to April 2016*

The "affordability ratio" measures the relationship between the price of the cheapest homes and the lowest level earnings. In 1997 this ratio was 3.19 in Bristol, rising to a peak of 7.91 in 2007 before reducing. However, this ratio is again rising, and in 2015 set a new peak of 8.18 (i.e. the cost of the cheapest home in Bristol was over 8 times the annual earnings of lower income households)[133]. The England average in 2015 was 7 times.

A similar ratio (7.80) applies when average (median) earnings are compared to median house prices for Bristol (7.63 nationally)

### 5.11.4 Private Rented Sector

The private rented sector is growing, in size and cost. Figures[134] for Oct 2013 to Sept 2014 gave an average rent for Bristol of £828 a month. In Jan 2016, this had risen to £904 a month.

For the foreseeable future, private renting will remain the default option for younger households. There is an increasing 'affordability gap' as house prices continue to rise. In an already challenging market, the shortage of housing supply means that high or even higher prices to rent or buy are likely to continue.

[128] ONS Census 2011
[129] via www.bristol.gov.uk/housing/housing-strategy-and-supporting-strategies
[130] 5 Year Housing Land Supply 2015-20 www.bristol.gov.uk/documents/20182/34184/Five+Year+Housing+land+supply+report/544796c7-9d02-4243-a139-c14e72689680
[131] UK House Price Index, Land Registry, April 2016 https://data.gov.uk/dataset/uk-house-price-index
[132] UK House Price Index, Land Registry, April 2006 to April 2016
[133] Source DCLG, 2016 www.gov.uk/government/statistical-data-sets/live-tables-on-housing-market-and-house-prices
[134] Source: Valuation Office Agency

## 5.12 Homelessness

Homelessness is associated with severe poverty and adverse health, education and social outcomes. "Statutorily homeless" are unintentionally homeless and considered to be *in priority need* (eg families), and so are some of the most vulnerable and needy members of the community.

Plus, those assessed as being eligible as statutorily homeless, but not "in priority need" (eg single homeless people), or those in temporary accommodation, can have greater public health needs than the population as a whole.

- Over 150 people were eligible as homeless but "not in priority need" in Bristol in 2015/16, triple the 2013/14 number. As a rate this rose significantly to 0.8 per 1,000 households[135]; and is no longer below the national average. Bristol is mid-ranking for Core Cities and comparable cities.
- Over 470 people in temporary homeless accommodation in Bristol in March 2016, 1.5 times the 2014 number. As a rate this has risen in recent years (2.5 per 1,000 households)[136]; but is still significantly below the national average 3.1 per 1,000 (fig 5.12.1). Bristol is 3rd highest of Core Cities.

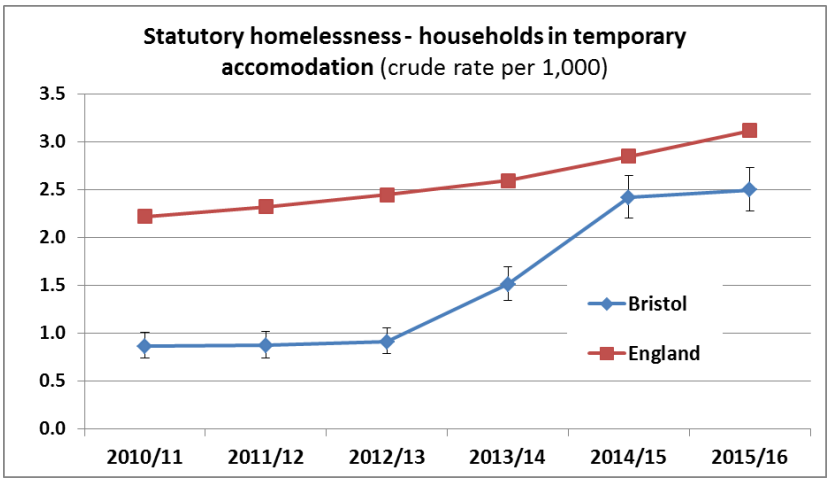



*Fig.5.12.1: Source: via Public Health Outcomes Framework, Nov 2016*

### Rough Sleepers[137]

The rough sleeping service highlights the following trends[138]

• The average number of rough sleepers in Bristol rose from 5 per week in 2010/11 to 33 per week in 2015/16 – fig 5.12.2

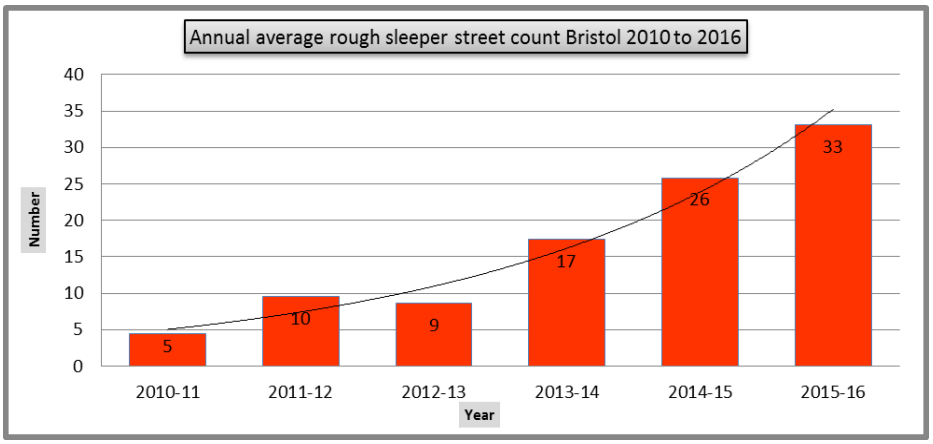



*Fig.5.12.2: Average rough sleepers; Source: Monthly hotspot count, Rough Sleeper Outreach team, 2016*

• Rough sleeper individuals are predominantly male aged 26-50, but a rise in younger rough sleepers (18-35 years) in 2015.

• Country of origin, where known, was almost 80% from UK, and 16% Central & Eastern European

• The main (known) reason for rough sleeping is eviction, followed by relationship breakdown.

• 80% of rough sleepers were in the city centre

**Gender:** 83% of rough sleepers are men

[135] Crude rate; Source: Dept for Communities & Local Government, via PHOF Nov 2016
[136] Crude rate; Source: Dept for Communities & Local Government, via PHOF Nov 2016
[137] For support: www.bristol.gov.uk/housing/tell-us-about-someone-sleeping-rough
[138] 2015-16 Homelessness Trends in Bristol report, inc information about people seen rough sleeping through weekly hotspot counts by Outreach teams in Bristol

## 5.13 Fuel Poverty

The drivers of fuel poverty are low income, poor energy efficiency and high energy prices. Living in a home at a low temperature has been linked to a range of negative health outcomes[139]. Also, it has been estimated that at least 1 in 10 of excess winter deaths[140] are caused by fuel poverty[141].

Since 2012, the measure of Fuel Poverty has been the Low Income High Cost indicator, where a household is fuel poor if:

- they have required fuel costs above national median level;
- were they to spend that amount, their remaining income would be below the official poverty line.

In Bristol, it is estimated that over 26,100 households are "fuel poor" (using Low Income High Cost)[142]. This is 13.6% of households, significantly higher than the national average (10.6%) and rising – fig 5.13.1.

All of the English "Core Cities" are higher than England, and Bristol is mid-ranking. However, compared to statistically similar cities[143], Bristol has the highest % of fuel poor households – fig 5.13.2.

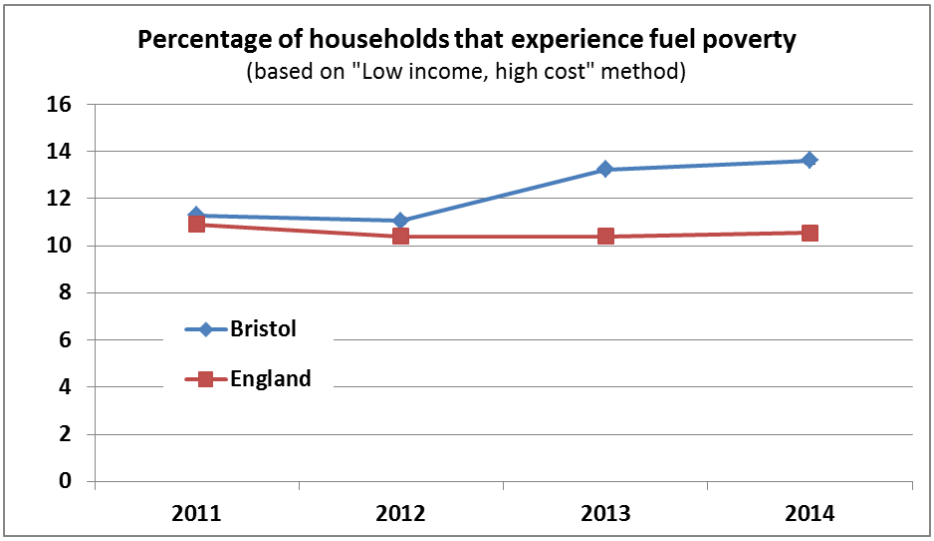



*Fig 5.13.1 % of households in Fuel Poverty (based on low income, high cost) Source Department of Energy and Climate Change, via PHOF (Nov 2016)*

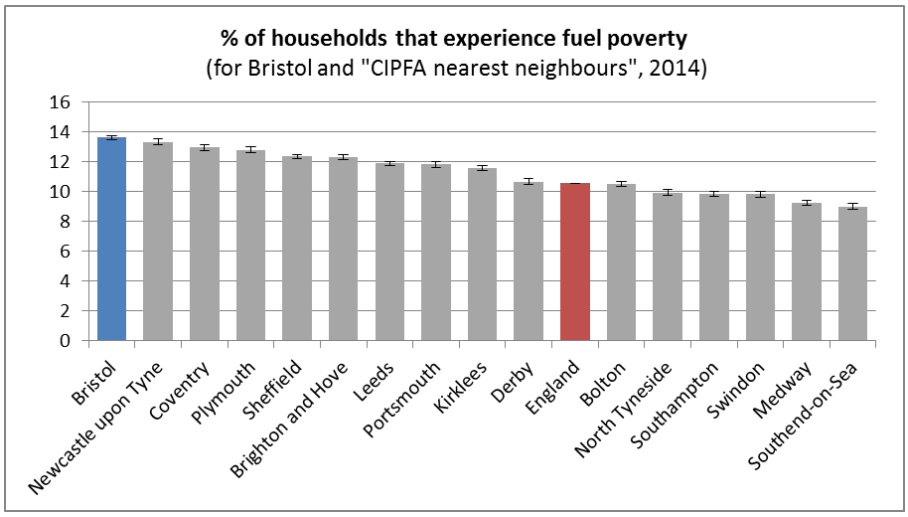



*Fig 5.13.2 % of households in Fuel Poverty (for CIPFA nearest neighbours) Source Department of Energy and Climate Change, via PHOF (Nov 2016)*

[139] Marmot Review via Public Health England
[140] See JSNA **10.3 Excess Winter Deaths**
[141] Response to Fuel Poverty Review report 2012 via Public Health England (in PHOF)
[142] 2014 data released via Fuel Poverty Statistics report, June 2016 www.gov.uk/government/statistics/annual-fuel-poverty-statistics-report-2016
[143] "CIPFA nearest neighbours" for Bristol

## 5.14 Internet connectivity

Data from the Office for National Statistics (ONS) shows that 94.9% of Bristol adults (338,000 adults) have "Used the internet in the last 3 months"[144] (this data is for the first quarter, Q1, of 2016).

For comparison, this is a rise of 30,000 adults in Bristol in the last 3 years (from 85% in 2013), and Bristol's 94.9% of connected citizens is significantly higher than the UK average of 87.9%. Fig 5.14.1 shows that the percentage of people who have "ever used" the internet (measured for Q1 of each year) has been rising faster in Bristol than nationally.

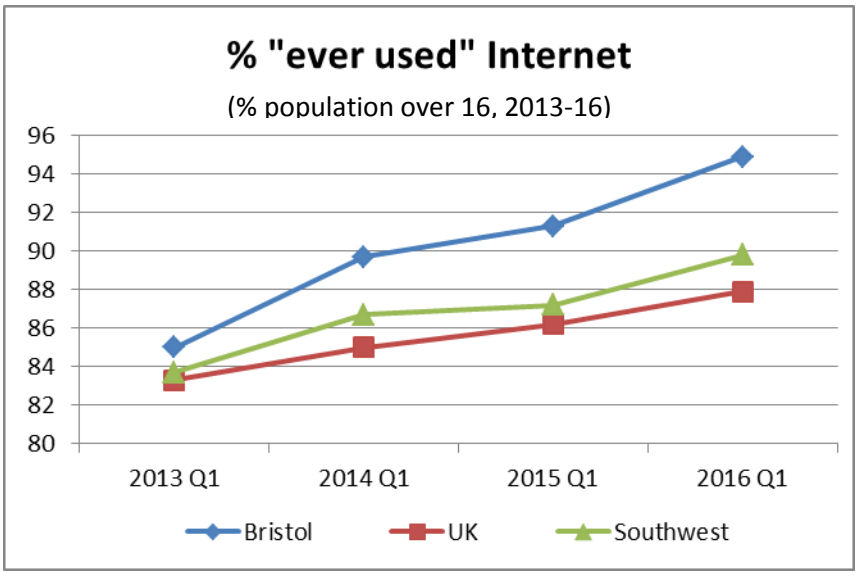



*Fig 5.14.1 Source: ONS Internet Access Quarterly Update, May 2016*

However, the ONS report that accompanies this does highlight that, nationally, "While we have seen a notable increase in internet usage across all groups in recent years, many older and disabled people are still not online, with two-thirds of women over 75 having never used the internet."

In 2016 there are 18,000 adults in Bristol who have not used the internet at all in the last 3 months (or longer), although this figure is reducing rapidly (in 2015 it was 31,000, and in 2013 was 54,000 people).

[144] Adults over 16; ONS 2016 www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2016

## 5.15 Social Isolation[145]

Social isolation[146] can have physically and emotionally damaging effects resulting in:
•depression •poor nutrition
•decreased immunity •anxiety
•fatigue •social stigma.

Using Public Health England estimates, there could be 20,000 people aged 18-64 experiencing social isolation in Bristol as well as between 6,300 and 11,400 people aged 65 & over[147].

Whilst older people are most at risk of social isolation, it is often caused by specific life events that can happen at different times in people's lives (eg leaving school, becoming a parent, divorce, retirement, or bereavement).

For full discussion, see www.bristol.gov.uk/socialisolation which also covers health impacts[148].

### Social isolation of older people

Socially isolated older adults have:
•longer stays in hospital
•a greater number of GP visits and
•more dependence on homecare services

Social isolation amongst older people is being addressed by Bristol Ageing Better and work is underway with partners and the National Lottery to develop local solutions.

### Social isolation of social care service users

In England, the majority of social care service users do not have as much social contact as they would like. In most local authorities, the proportion of people who say they have as much social contact as they would like is below 50%[149].

In Bristol, 43.6% of service users said they "have as much social contact as they would like" in 2015/16, similar to the national average (45.4%), fig 5.15.1, and mid-ranking for Core Cities.

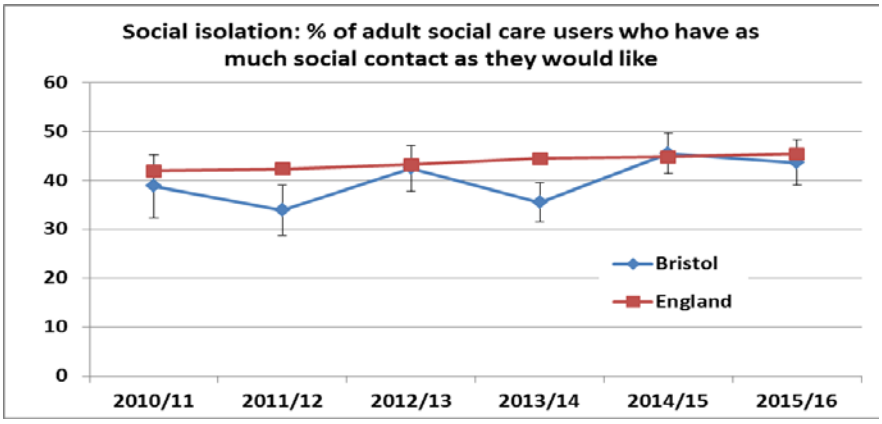



*Fig 5.15.1 Source: Adult Social Care Survey via PHOF (Nov 2016)*

### Social isolation of carers

The Personal Social Services Survey provides information about the indicator relating to the social isolation of carers. Data for 2014/15 indicates that only 33.3% of carers in Bristol say they "have as much social contact as they would like", which has fallen significantly since 2012/13 and is now significantly lower than the English average (38.5%) – fig 5.15.2.

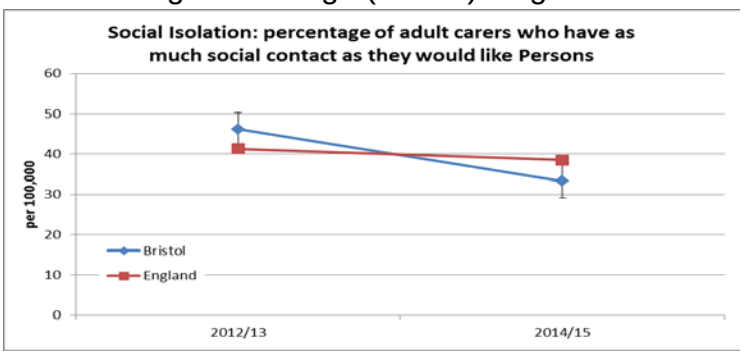



*Fig 5.15.2 Source Social Services Survey via PHOF (Aug 2016)*

[145] Extract from www.bristol.gov.uk/policies-plans-strategies/social-isolation
[146] Including "loneliness"; is where people have: 'few social contacts and few social roles, as well as an absence of mutually rewarding relationships with other people.'
[147] Social Isolation in Bristol (2013), Initial Findings Report, www.bristol.gov.uk/socialisolation
[148] Research on health impacts are also at: www.campaigntoendloneliness.org/threat-to-health/
[149] Source: Adult Social Care Survey - a random sample of social care users run each year by local authorities following Department of Health guidance

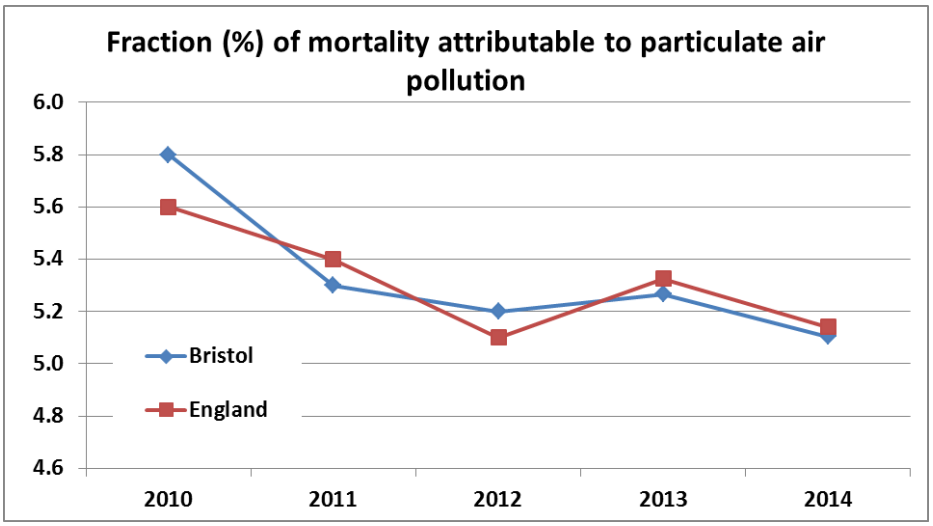
## 5.16 Air pollution

### Health Impact

Air pollution generated from human sources such as the combustion of fuels for heat, electricity and transport is having an adverse effect on the health of Bristol's communities. In 2014, 5.1% of "all-cause adult mortality" in Bristol was considered attributable to "anthropogenic particulate air pollution"[150], which is similar to the national proportion (fig 5.16.1) and is mid-ranking for Core Cities.

In addition, a recent local report[151] estimates that around 300 deaths each year in Bristol can be attributed to exposure to both nitrogen dioxide ($NO_2$) and fine particulate matter. This represents about 8.5% of deaths in Bristol being attributable to air pollution. [NB this is higher as the local report considers $NO_2$ as well].

The proportions of deaths attributable to air pollution vary across the city in relation to pollutant concentrations, from around 7% in some wards to around 10% in others. Concentrations are highest in the centre of the city and therefore so are deaths attributable to air pollution.




*5.16.1: Mortality attributable to particulate air pollution.*
*Source: Background annual average PM2.5 concentrations, using a national air dispersion model, and calibrated using concentrations taken from sites in Defra's Automatic Urban and Rural Network. Via PHOF, Nov 2016*

Long-term exposure to air pollution contributes to the development of cardiovascular disease, lung cancer and respiratory disease[152]. Those at particular risk include children aged 14 and under, older people aged 65 and over, pregnant women and not unexpectedly people with pre-existing respiratory or heart conditions[153]. Lower socio-economic communities suffer the greatest consequences of air pollution[154].

### Air Quality Management Area

Road transport is a major source of particulate matter and nitrogen oxides accounting for 31% of nitrogen dioxides, 18% of PM10, 19.5% of PM2.5 emissions in the UK[155].

Through monitoring of the city's air quality, a geographical area has been identified where health standards (known as objectives) are not achieved and an Air Quality Management Area (AQMA) has been established in line with DEFRA (Department for Environment and Rural Affairs) recommendations.

[150] Via Public Health Outcomes Framework (PHOF), Nov 2016
[151] Air Quality Consultants (2016). Health Impacts of Air Pollution in Bristol (draft report). Bristol: Air Quality Consultants.
[152] World Health Organization (2016). Ambient (outdoor) air quality and health factsheet. http://www.who.int/mediacentre/factsheets/fs313/en/ (accessed 23.11.16)
[153] National Institute for Health and Care Excellence (2015). Air pollution – outdoor air quality and health. Final scope. London: NICE
[154] Marmot, M (2010). Fair Society Healthy Lives. Marmot Review.
[155] Department for Environment, Food and Rural Affairs (2015). Emissions of air pollutants in the UK 1970 to 2014.

Fig 5.16.2 indicates the boundary of the Air Quality Management Area (AQMA) for Bristol, inside which air quality is at risk of exceeding government objectives.

The AQMA is based around busy road junctions and arterial roads where nitrogen dioxide from the exhausts of slow moving vehicles does not get readily dispersed because of the surrounding buildings.

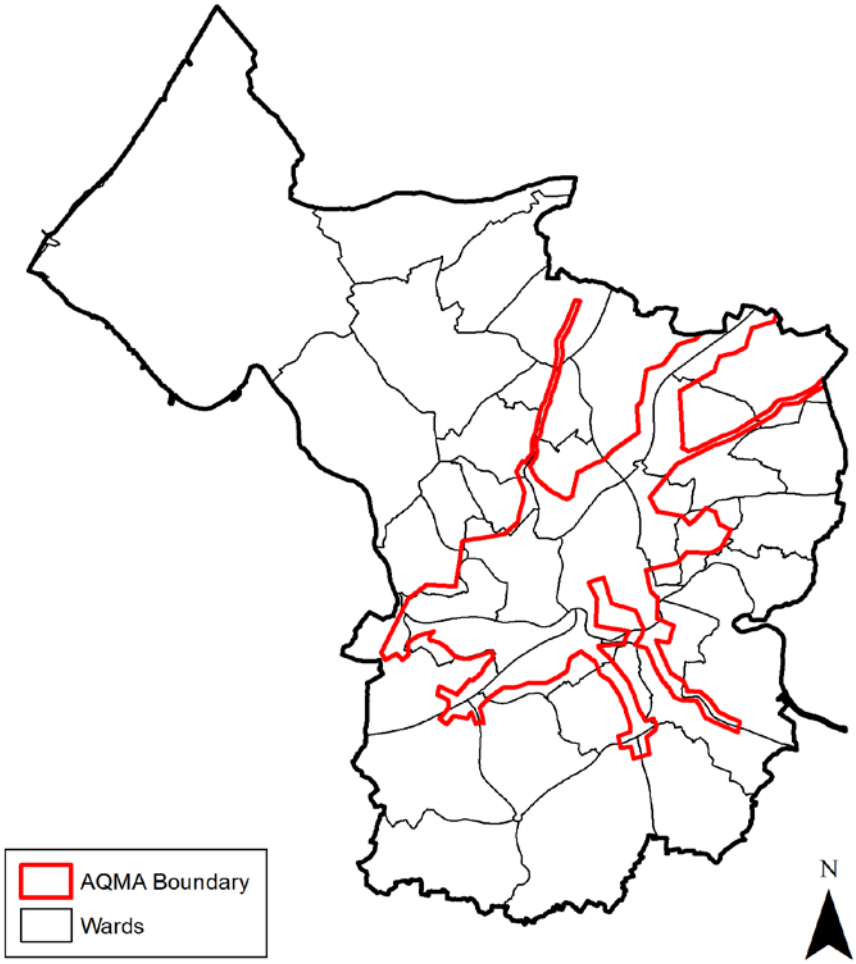



*Fig 5.16.2 Map of Bristol's Air Quality Management Area (AQMA)*

However, monitoring has also shown that whilst concentrations vary there seems to be a decline in nitrogen dioxide ($NO_2$) in the last five years. Fig 5.16.3 indicates the trend from a set of 22 diffusion tubes that measure nitrogen dioxide ($NO_2$) levels across the city (to report air quality in the Joint Local Transport Plan), and this does seem to show a decline in the last five years.

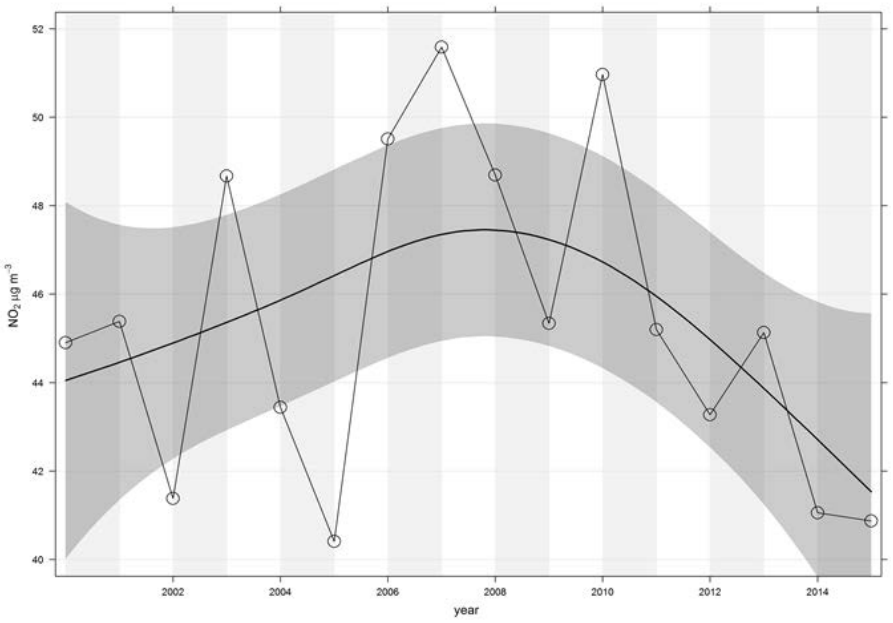



*Fig 5.16.3 Trend of $NO_2$ at all roadside diffusion tube sites in Bristol*

## 5.17 Promoting Healthy Urban Environments

Promoting a healthy urban environment enables economic prosperity and a population with better physical health, more positive mental health and self-esteem, increasing wellbeing.

There are many Bristol initiatives supporting the creation of healthy urban environments: eg the Joint Spatial Plan, The Bristol Transport Study, Bristol Green Capital Partnership, The Good Food Plan and Sustainable Food City status.

The physical environment is a major determinant of health, wellbeing and premature mortality. Research[156] shows causality between the environments people experience in their daily lives and public health challenges. Day-to-day urban environments may also exacerbate health inequalities.

An increasing number of people in Bristol (36%) use outdoor space for exercise/health reasons, more than nationally (18%)[157].

Locally[158], 82% of people are satisfied with their neighbourhood as a place to live, but only 66% in deprived areas. Similarly, 82% of people are satisfied with the quality of parks and green spaces in Bristol, but only 66% in deprived areas – fig 5.17.1. Over half (55%) of people visit parks and open spaces weekly, but only 41% in deprived areas.

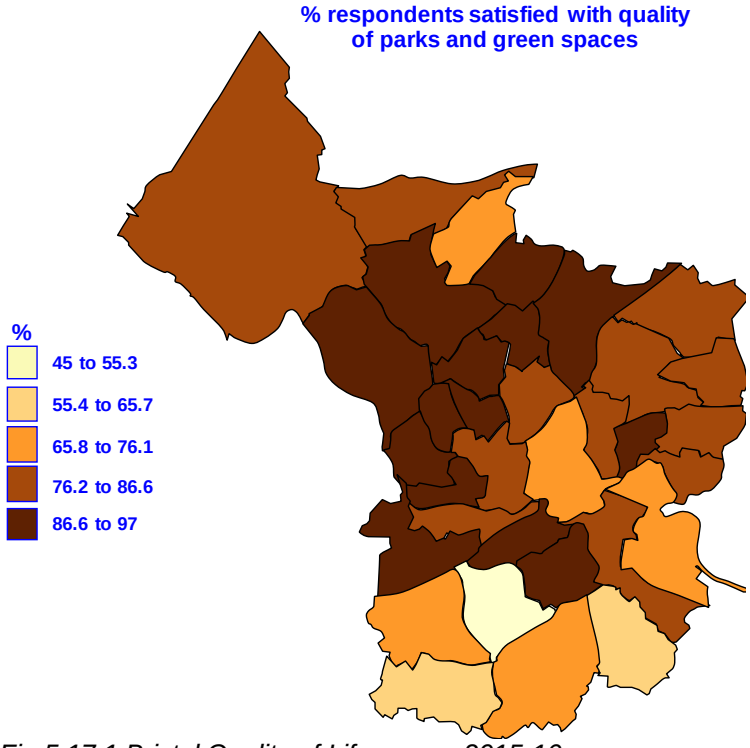



*Fig 5.17.1 Bristol Quality of Life survey 2015-16*

### Active Travel[159]

More people in Bristol commute to work by bicycle or on foot than in any other Local Authority. Cycle use almost doubled (rose 94%) and walking rose 40% 2001-11. The majority of people under 40 in Bristol in employment choose not to commute by car. A typical person who cycles to work in Bristol is likely to be "a white male, aged 25 to 39, with a degree, who works full time in a professional occupation and cycles 2K-5K to work". Promotion needs to continue on supporting active travel for groups with poorer health outcomes.

### Road traffic injuries

Bristol's rate of road traffic injury[160] (28 per 100,000) is significantly lower than the national average (39 per 100,000), and the 2nd lowest rate of Core Cities. In 2014, 116 people were killed or seriously injured on Bristol's roads. However, the rate of serious injury & fatalities tends to be lower on urban roads, (affecting comparison with the national figure), and the data under-reports injuries by pedestrians and cyclists. Longer term the 'Safer System approach to road safety in Bristol 2015-24'[161] sets out the evidence based approach for adapting the urban environment to protect vulnerable road users and communities.

[156] References available / Further links between transport and health at "Essential Evidence": www.travelwest.info/evidence
[157] Natural England: Monitor of Engagement with the Natural Environment survey, 2014-15
[158] Bristol Quality of Life survey 2015-16

[159] Census 2011, Topic reports: www.bristol.gov.uk/census
[160] Police data, Dept of Transport 2012-14 via PHOF (Nov 2015)
[161] www.bristol.gov.uk/streets-travel/road-safety-plans

## 5.18 Crime

There was a 10% rise in the total number of recorded crime in Bristol in 2015/16 compared to 2014/15, to 45,900 crimes. This total remains lower than 2011/12 and previous years (fig 5.18.1). The 10% rise in recorded crime in Bristol is similar to the 8% rise in England and Wales last year.

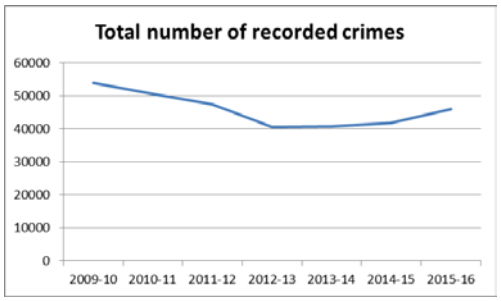



*Fig 5.18.1 Number of all recorded crimes in Bristol; Source: Police data*

The main areas that rose are "violence without injury" (rose 67% to 7,730) & "public order" offences (+62% to 4,020) [162]. But domestic burglaries fell (-8% to 2,030).

For comparison, "violence against the person" offences, (with and without injury, as a crude rate) indicate there were 26.6 violent offences (per 1,000 population) in Bristol in 2015/16, above the national average of 17.2 (fig 5.18.2). This is the highest rate of all the English core cities, and 3rd highest of 16 comparable local authorities.

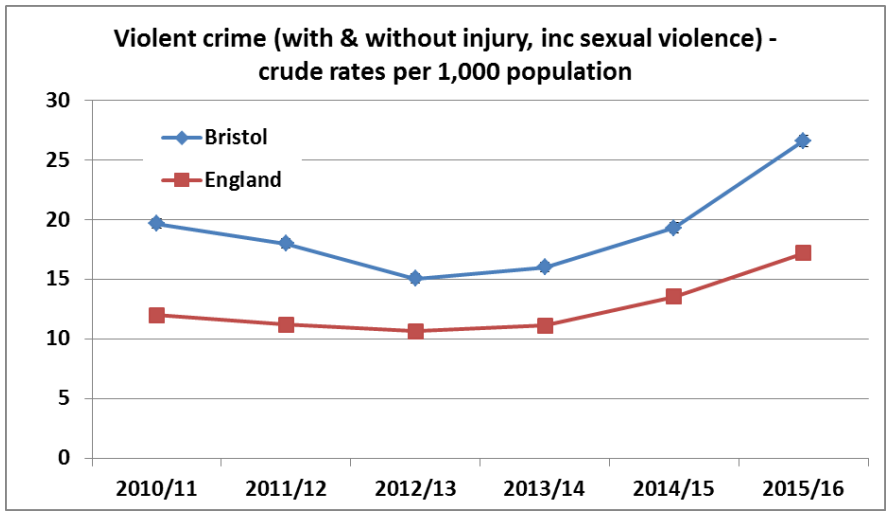



*Fig 5.18.2 Recorded violent crime; Source: Home Office via PHOF, Nov 2016*

**Gender:** Police data for "violence against the person" (2015/16): 47% of victims were female and 43% male (10% unknown).

The 2015/16 crime rate (all crimes) is 103 per 1,000 population. Within Bristol rates are by far highest in Central ward (511 crimes per 1,000), and then Hotwells & Harbourside (260) and Southville (156 crimes per 1,000). St George Troopers Hill and Clifton Down are lowest (under 50 crimes per 1,000) - fig 5.18.3.

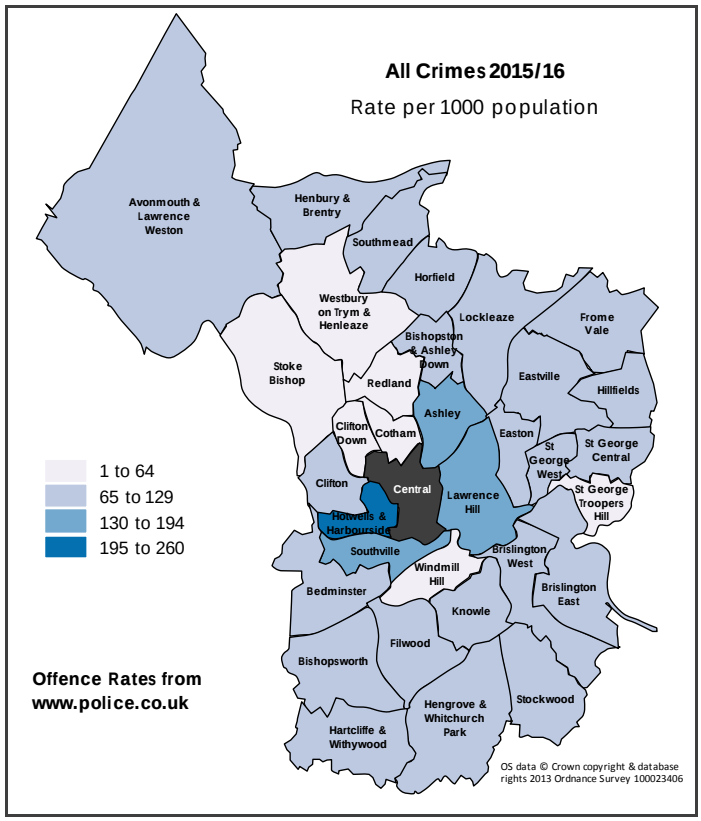



*Fig 5.18.3 Rates of all recorded crimes 2015/16; Source: Police data*
*Note – rate for Central is 511 per 1,000 (not marked on legend due to scale)*

[162] Significant rises were noted nationally. Improvements in crime recording is likely to have resulted in a rise in the number of offences recorded. Crime Survey for England and Wales analysis indicates recording improvements are more likely to affect less serious violence offences.

In 2015, 13% of residents said fear of crime affected their day-to-day life, a consistent improvement from 2009 when 26% of residents said they were affected. However, significantly higher rates of concern were from BME people (20%), those in deprived areas (24%), disabled people (25%) and those of Muslim faith (33%). By ward, the highest rates of concern were people in Filwood (27%) and Hartcliffe & Withywood (33%) – see fig 5.18.4.

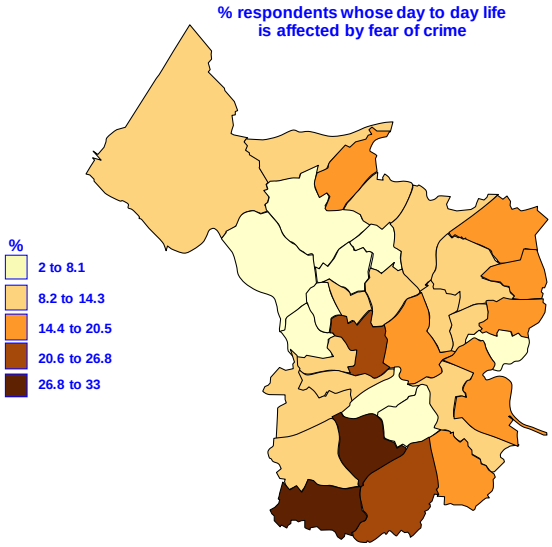



*Fig 5.18.4 Fear of crime affecting daily life; Source: Quality of Life 2015-16*

## Anti-Social behaviour

In 2015/16 there were around 15,900 Anti-Social behaviour (ASB) incidents reported to police in Bristol. Around 74% were 'ASB-Nuisance' (11,800); 17% were 'ASB-Personal' (2,700); and 9% were 'ASB-Environmental' (1,400). The number of Anti-Social behaviour incidents reported to police has reduced by 22%, driven by a fall in ASB-Nuisance incidents – fig 5.18.5.

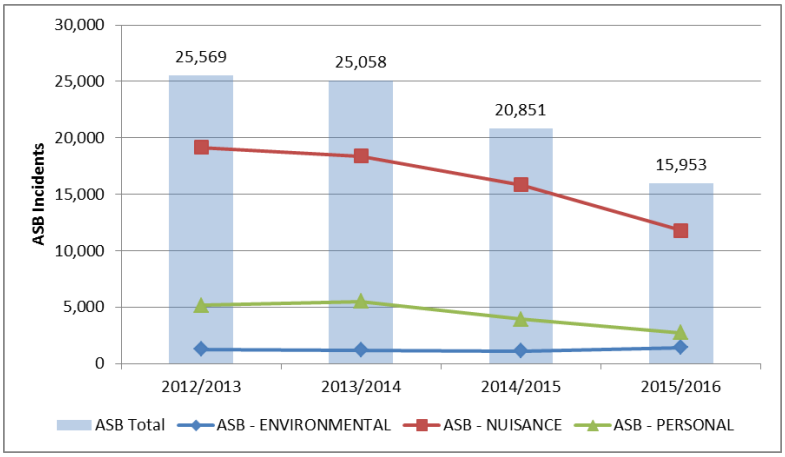



*Fig 5.18.5 ASB incidents in Bristol by financial year; Source: Police data*

In 2015, 24% of residents thought anti-social behaviour was a problem in their local neighbourhood, which is a significant improvement on 33% in 2010. In deprived areas of the city though, 41% of residents note a problem from anti-social behaviour in 2015 (fig 5.18.6 for differences)

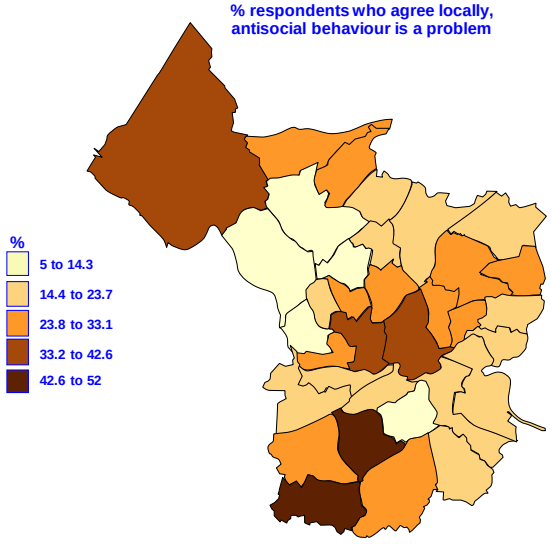



*Fig 5.18.6 ASB as a problem in neighbourhood; Source: Quality of Life 2015-16*

## 5.19 Sexual violence and harassment[163]

Nationally, the Crime in England and Wales survey[164] 2015-16, indicates a rising trend in Police recorded data for "Sexual offences" over the last few years. [Note - this is thought to reflect an improvement in the recording of sexual offences by the police and an increased willingness of victims to come forward to report crimes, including historical crimes[165]].

In Bristol, the rate rose by 28% last year alone, compared to a 21% rise nationally. Fig 5.19.1 shows the rise in the rate of reported sexual offences.

Locally, organisations such as "Somerset and Avon Rape and Sexual Abuse Support (SARSAS)" have also reported increased numbers of victims seeking support, with SARSAS noting an 84% rise in 2015/16[166].

**Gender:** Police data for "Sexual offences" in 2015/16 shows that 84% of victims were female and 13% male (with 3% unknown).

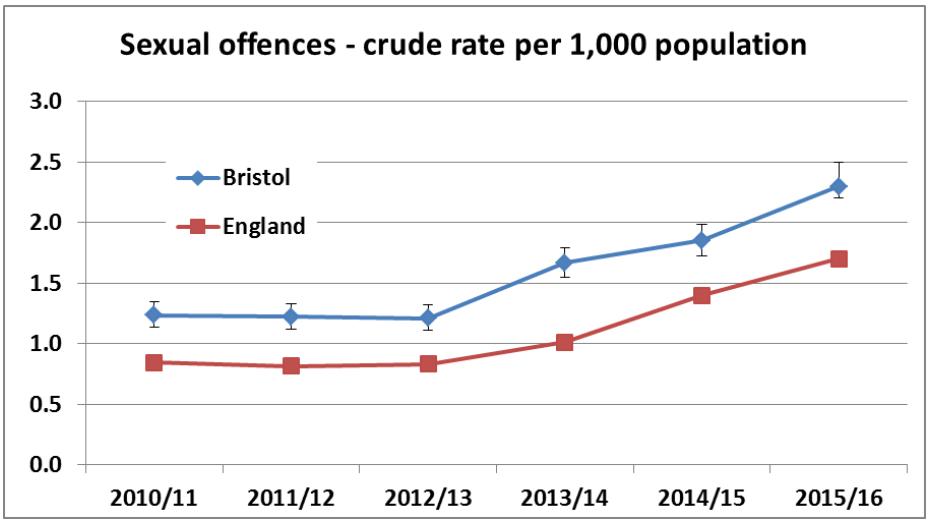



*Fig 5.19.1 Rate of sexual offences; Source: Home Office via PHOF, Nov 2016*

Self-reported data from the Bristol Quality of Life survey 2015-16 indicates 22.2% of people feel that "sexual harassment is an issue in Bristol". This figure has been rising over the last couple of years (from 18.6% in 2013-14), and is significantly higher in deprived areas (31.4%). By ward, the highest rates are in Easton, Lawrence Hill (both 35%) and Filwood (36%) – see fig 5.19.2.

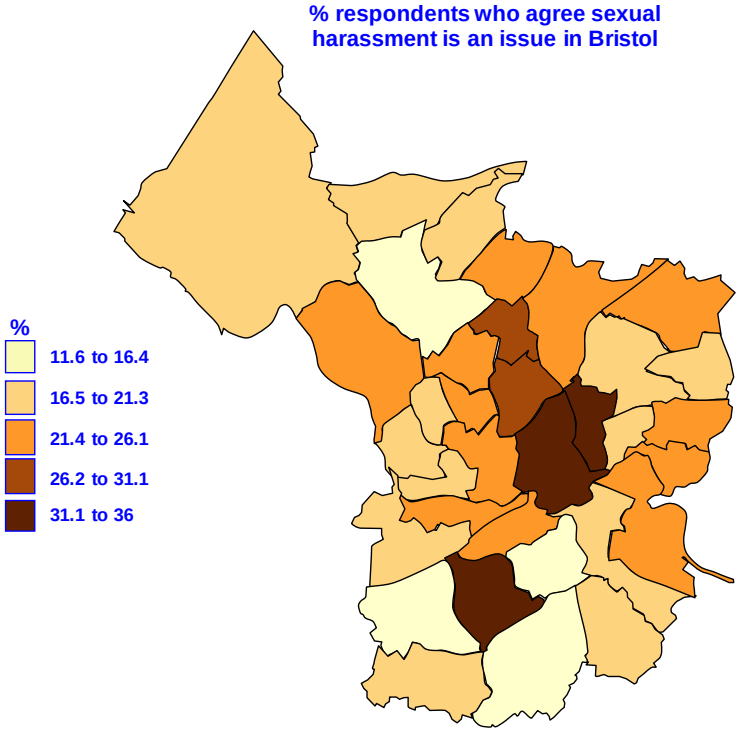



*Fig 5.19.2 Source: Bristol Quality of Life survey 2015-16*

[163] In 2016 the incoming Mayor pledged to make Bristol "a safe city for women and girls and to have a zero-tolerance approach to gender-based violence, abuse, harassment and exploitation" (Our Bristol Plan, 2016)

[164] http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmar2016

[165] Police analysis indicates that, due to newly-reported historical crimes & other issues, recorded crime data currently is not a reliable indication of trends in sexual offences.

[166] SARSAS Annual Report 2015/16; based on referral log data for Oct 2015 to Sept 2016 (compared to 2014-15)

## 5.20 Domestic Abuse[167]

Nationally, 27% of women and 13% of men experience domestic abuse in their lifetimes[168], with negative impacts on mental and physical health and further impact on families including children.

The rate of domestic abuse incidents in Bristol recorded by the Police was 17.3 incidents per 1000 population (2014-15). This was a significant rise in the last 2 years (fig 5.20.1), although remains significantly lower than the England average (20.4). There are many factors that can lead to increased reporting of domestic abuse including raised awareness so more victims seek help.

**Gender:** Police data for victims of "domestic abuse" offences in 2015/16 is that 74% of victims were female and 20% were male (with 6% unknown).

Local data on the rate of domestic abuse incidents[169] by ward (2015/16) highlights a significant variation in reported rates across the city, from 3 per 1000 in Clifton Down to 42 per 1000 population in Hartcliffe & Withywood (fig 5.20.2). [Note - this rate is for incidents[170] not "crimes" as used in JSNA 2015]

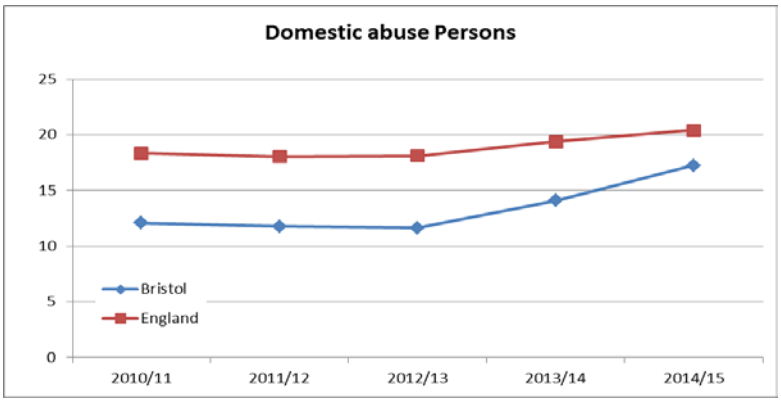



*Fig 5.20.1: Rate of domestic abuse incidents recorded by the Police per 1000 population over 16 years of age (via PHOF, Aug 2016)*

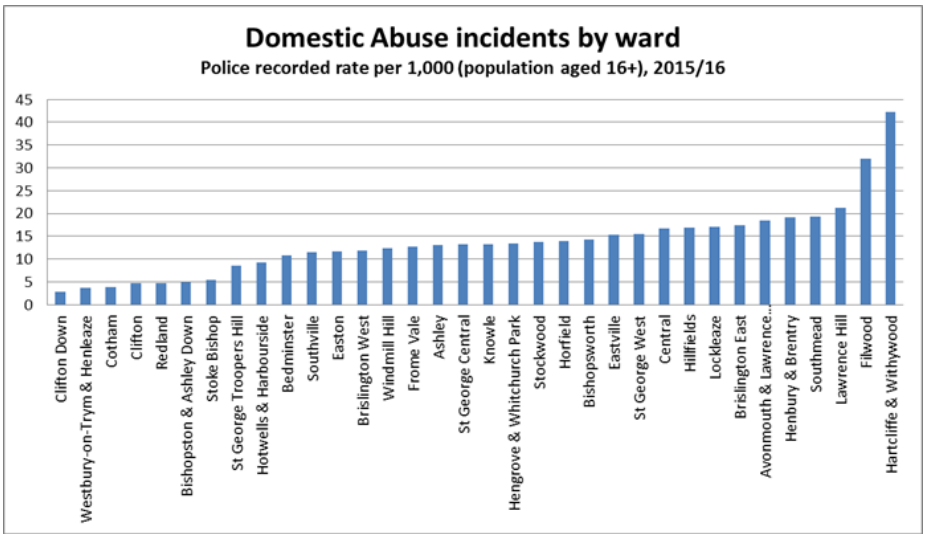



*Fig 5.20.2 Rate of domestic abuse incidents 2015-16; Source Police data*

The 2015-16 Quality of Life survey looks at perceptions, and found that only 8% of people agreed domestic violence was a private matter, a significant reduction on 14% in 2010. There is variation between Bristol wards, from 2% in St George West to 16% in Southmead (fig 5.20.3).

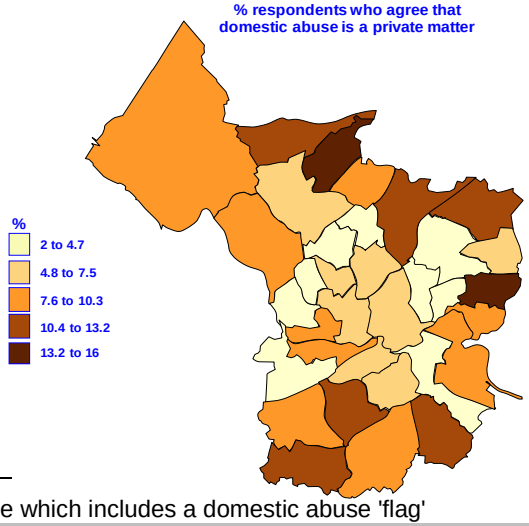



*Fig 5.20.3 Source: Quality of Life survey 2015-16*

[167] This is a BCC priority area and will be addressed in more detail in a JSNA Chapter 2016-17 – release via www.bristol.gov.uk/jsna

[168] % of 16-59 years, CSEW 2016, via ONS www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/chapter4intimatepersonalviolenceandpartnerabuse

[169] Recorded by the Police, per 1000 population over the age of 16. **Note** – This domestic abuse data is unlikely to reflect the true extent of offending and should be used with caution. It is from the Police live data system so may change. Rates are per incident not per person, so could include multiple offences against 1 victim.

[170] Incidents are any recorded crime which includes a domestic abuse 'flag'

## 5.21 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM has been illegal in the UK since 1985, with the law strengthened in 2003 to prevent girls travelling from the UK and undergoing FGM abroad.

The Female Genital Mutilation (FGM) Enhanced Dataset[171] is a repository for individual level data collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices[172].

Nationally, during the year April 2015 to March 2016 there were 5,700 newly recorded cases of FGM with data submitted. Of the recorded cases there were a total of 8,660 healthcare attendances from these patients / clients.

Nationally, 90% of women and girls where the country of birth was identified were born in an Eastern, Northern or Western African country, and 6% were born in Asia. Somalia in Eastern Africa accounts for more than one third of all newly recorded women and girls with a known country of birth (37%).

More than half of all cases nationally relate to women and girls from Greater London boroughs.

However, during 2015-16 there were 385 newly-recorded[173] FGM cases in Bristol. This is the second highest number of cases in all individual Local Authorities in England (behind only Birmingham) – see fig 5.21.1.

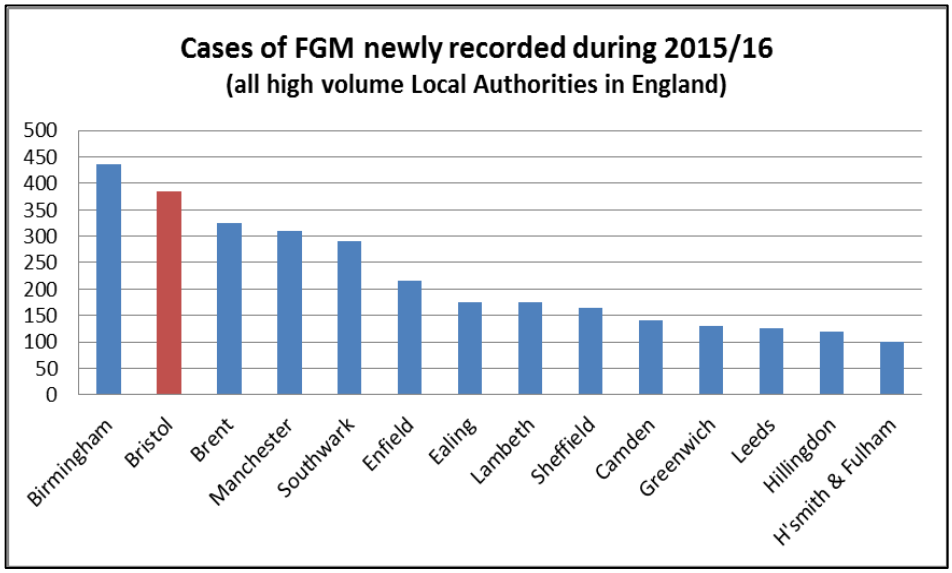



*Fig 5.21.1 Numbers of newly-reported cases of FGM;*
*Source: HSCIC; FG M Enhanced Dataset: 2015-16, experimental statistics*

The fact that Bristol ranks highly in these figures reflects the partnership work that has been ongoing between Bristol health professionals and communities to raise awareness so that people are open to talking about FGM and seeking help and support.

The figures partly reflect a higher prevalence of FGM in Bristol, as Bristol has one of the largest numbers of people from FGM affected communities outside London, but also reflect that Bristol professionals are asking the questions so that FGM is recorded and safeguarding advice and support can be provided to victims.

[171] http://digital.nhs.uk/catalogue/PUB21206/fgm-apr-2015-mar-2016-exp-rep.pdf

[172] Caution is advised when interpreting these findings because data completeness is often low and varies by submitter

[173] Note – The FGM procedures could have taken place at any time (not necessarily in the last year) but there is now a mandatory requirement to report FGM in accordance with the Serious Crime Act 2015.

## 5.22 Community Assets[174]

### 5.22.1 Neighbourhoods

82% of residents said they are satisfied with their neighbourhood (2015), a steady and significant improvement since 2010 (79%).

Satisfaction was significantly lower in deprived areas of the city (66%), and for disabled people (72%). Most satisfied were in Redland and Westbury on Trym & Henleaze (98%) but almost all areas were over 70% satisfaction with the notable exception of Filwood at 54% - fig 5.22.1.

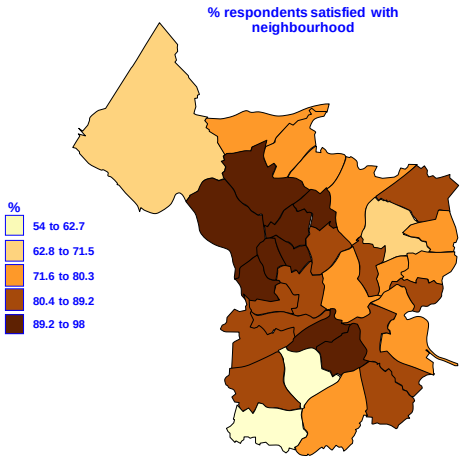



*Figure 5.22.1 Source: Bristol Quality of Life survey 2015-16*

### 5.22.2 Volunteering

About half of all residents (52%) volunteer or "help out" at least 3 times a year. This level is lower in deprived areas with 45% of people volunteering regularly. By ward, the range is from 1 in 3 people in Hartcliffe & Withywood to 2 in 3 in Westbury-on-Trym & Henleaze and Redland. Overall, the most common category was "helping out neighbours" – fig 5.22.2.

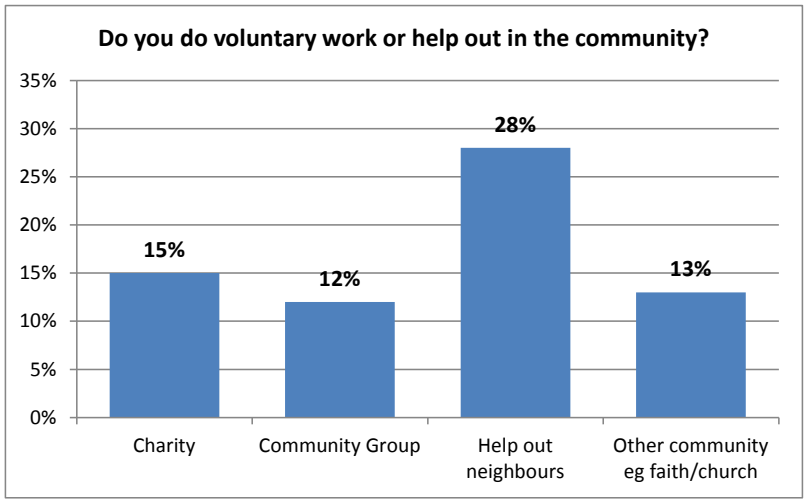



*Figure 5.22.2 Source: Bristol Quality of Life survey 2015-16*

### 5.22.3 Influence Local Decisions

A quarter of residents (25% in 2015) feel they can influence decisions about their local area, a gradual increase over the 5-years (22% in 2010). However, in several more outlying wards results were lower (Hengrove & Whitchurch Park, Stockwood, Filwood, Hillfields and St George Central all under 15%), whereas 40% of residents in Westbury-on-Trym & Henleaze feel they have influence in their local area – fig 5.22.3.

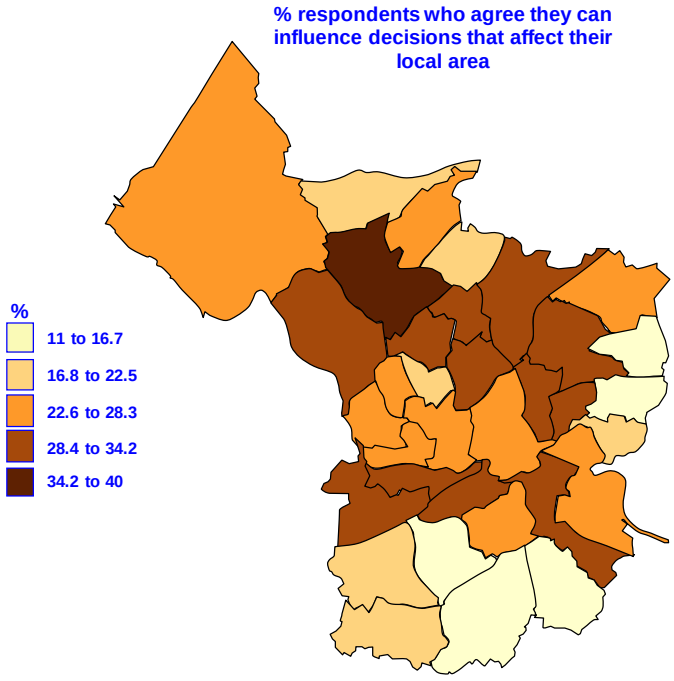



*Fig 5.22.3 Source: Bristol Quality of Life survey 2015-16*

[174] Source: Bristol Quality of Life 2015-16 www.bristol.gov.uk/qualityoflife

# Section 6
# Healthy Lifestyles

## Summary points[175]

### Physical activity

- 62% of people in Bristol are physically active
- More people in Bristol commute to work by bicycle or on foot than in any other Local Authority

### Healthy Weight

- Obesity is a key factor in the causes of premature death in Bristol from coronary heart disease and some cancers, and is a main cause of Type 2 Diabetes.
- Almost 6 out of 10 adults in Bristol (57.8%) are overweight or obese, though this is significantly lower than national (64.8%) and lowest of core cities
- Men are significantly more likely to be overweight than women, but women have higher levels of obesity.
- Significantly more residents in deprived areas are obese or overweight.

### Healthy Eating

- Around half of respondents to Bristol's Quality of Life survey stated they eat "5 portions of fruit & veg a day".
- Men eat significantly less fruit and vegetables than women; 46% of men ate '5 a day' and 55% of women.
- 64% of the food retail sector in Bristol are Takeaway & Convenience Foods (36% are "fresh food shops").

### Smoking

- Bristol's estimated level of smoking in adults has declined from 23.5% in 2010, when it was significantly worse than the England average, to 18.1% in 2015 which is similar to the England average of 16.9%.
- Smoking-related deaths in Bristol are significantly higher than the England average rate.

### Alcohol

- Alcohol-related hospital admissions in Bristol are significantly higher than the England average for both men and women.
- Alcohol-related deaths in men are significantly higher than national (28.5 per 100,000; national 16.1) and rising.

### Substance misuse

- Bristol has the largest estimated rate of opiate and/or crack users of the English core cities (2011/12).
- Bristol has a high treatment success rate for opiate-users compared to Core Cities, but for those leaving non-opiate or alcohol services, Bristol has significantly worse treatment success rates than nationally (2015)

[175] This section looks at adults. Issues for Children and Young People are noted in Section 4.

## 6.1 Physical activity

National survey data for physically active adults[176] indicates that 62% of Bristol adults are considered "active", which is now significantly higher than the national average (57%) (fig 6.1.1), and one of the highest rates of Core Cities and other comparable cities.

Locally, Bristol's Quality of Life survey asks the same question[177], and found that almost 2 in 3 people are physically active[178] (taking at least 150 mins a week of moderate or 75 mins a week of vigorous exercise). N.B. Although the Quality of Life survey result differs slightly from the national survey, it allows comparison of physical activity within Bristol.

Across Bristol the rate is lowest in parts of South Bristol (48% in Hartcliffe & Withywood), and up to 80% in Hotwells & Harbourside (fig 6.1.2). Only 56% of people living in deprived areas are physically active.

25% of Bristol adults are considered inactive. This is the lowest amongst the core cities and lower than the national average (30%) (fig 6.1.2)

**Gender:** Women (63%) are significantly less likely to be physically active than men (68%).

48% of people (Quality of Life, 2015-16) stated they participate in sport at least once a week. In more deprived areas though, this rate is only 32%.

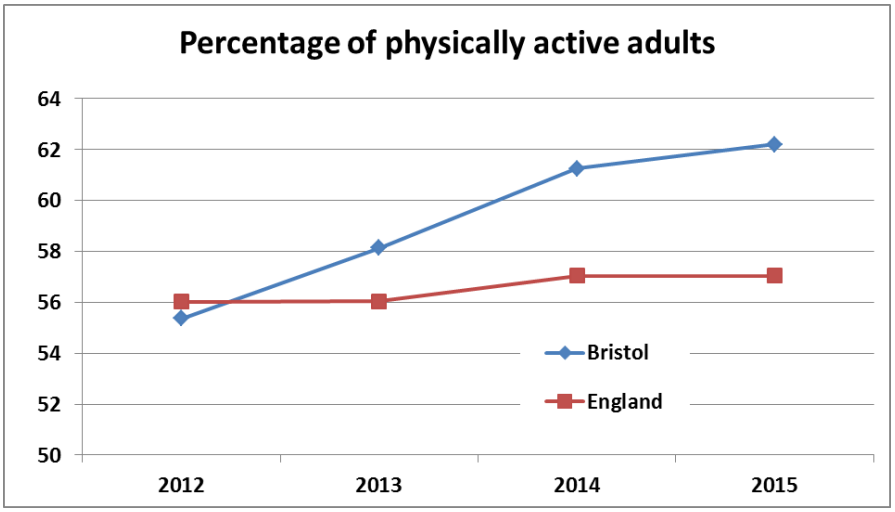



*Fig 6.1.1: Physically active adults and physically inactive adults – Bristol (Active People Survey, 2015)*

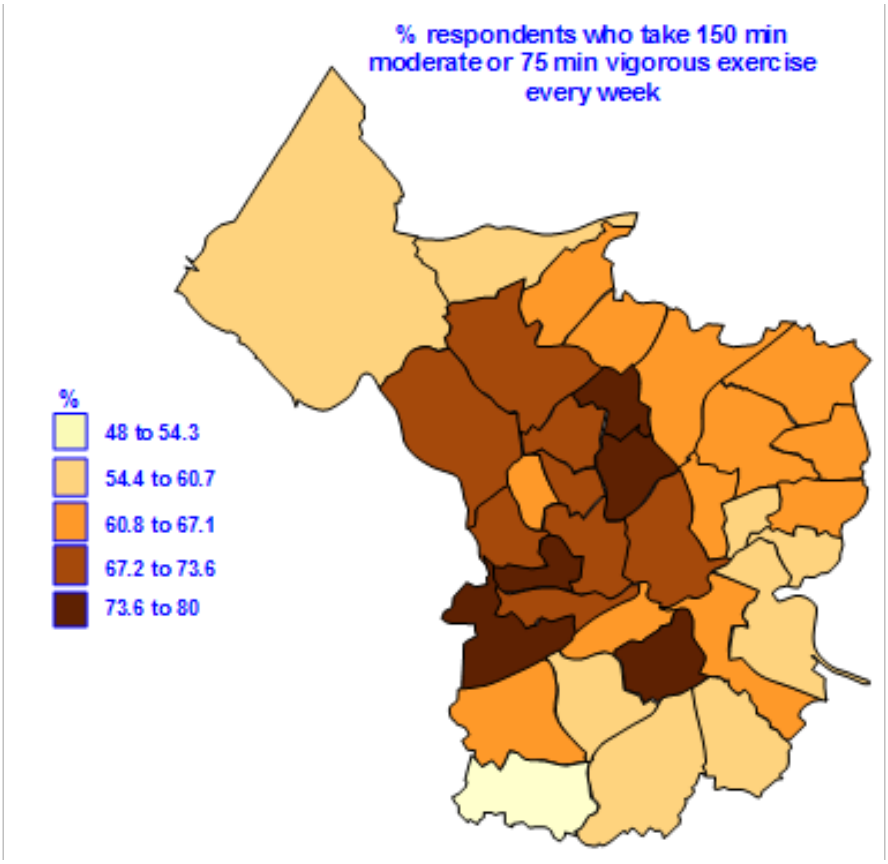



*Fig 6.1.2: Physically active people. Source: Quality of Life survey 2015-16*

[176] % adults achieving at least 150 mins physical activity per week (Active People Survey, Sport England, 2015) via Public Health Outcomes Framework (Aug 2016)
[177] Prior to 2015 the QoL question focussed on "daily exercise" which gave a much lower result (35%) than "physical activity" (65%)
[178] Bristol Quality of Life survey 2015-16 www.bristol.gov.uk/qualityoflife

## 6.2 Healthy Weight

Over half the Bristol population are overweight or obese (57.8%, Active People survey, 2013-15)[179]. However, this is significantly better than the national average (64.8%) and is the lowest of core cities.

Local survey data[180] provides a much lower estimate, but the national Active People survey is considered more accurate[181]. However, Quality of Life can be used to highlight local differences:

- Variation across Bristol wards (fig 6.2.1) from around 1 in 5 residents in Hotwells & Harbourside to 2 in 3 residents in parts of South Bristol (66% in Hengrove & Whitchurch Park and Hartcliffe & Withywood)
- Significantly more disabled people (65%) and older people (56%) are overweight or obese than the city average (45%).
- Further Quality of Life data indicates that 15% of residents in Bristol are "obese"
- **Gender:** Men are significantly more likely to be overweight than women, but women have higher levels of obesity.

Poverty and deprivation appear to be associated with a higher risk of excess weight in Bristol, but the relationship is complex and seems to affect women more than men in Bristol.

One of the services in place to help address this is the "Weight Management on Referral" scheme, which has received over 11,000 referrals in the last 5 years. Nearly 2/3 of those referred go on to start a course of weight-loss sessions. Around 50 – 60% of those starting a course will complete it, and of those around the same proportion will achieve or exceed the target weight loss of 5% of their start weight.

Only 23% of people (Active Peoples survey) use the outdoor spaces for exercise/ health reasons.

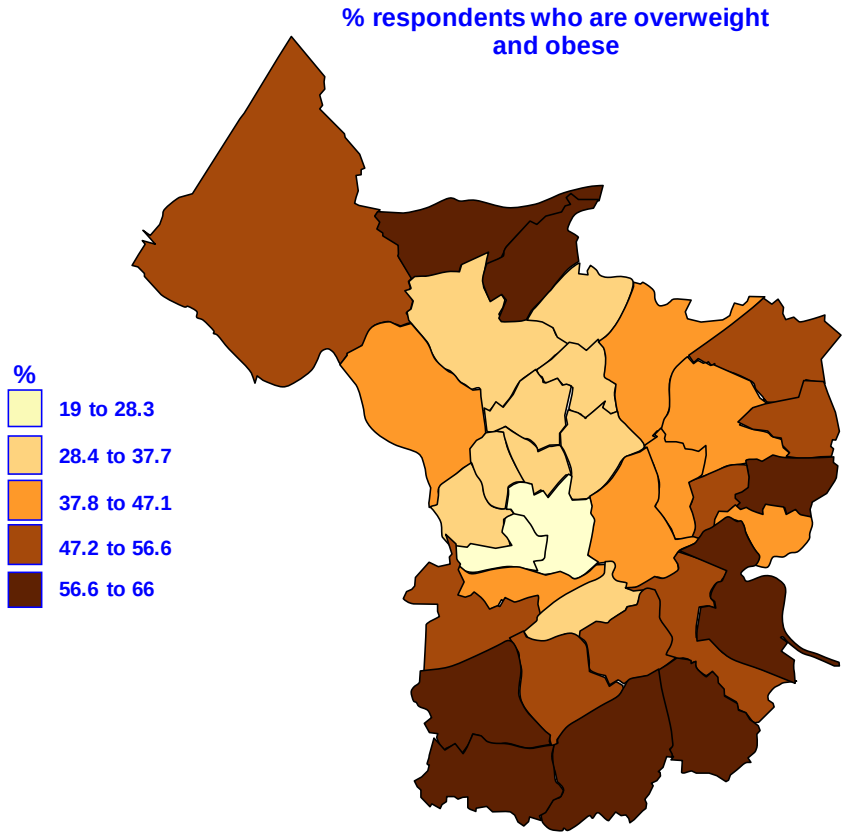



*Fig 6.2.1: % Overweight & obese, Quality of Life survey 2015-16*

[179] Active People survey via PHOF, Nov 2016
[180] Bristol Quality of Life survey 2015-16 www.bristol.gov.uk/qualityoflife
[181] Adults tend to underestimate their weight & overestimate their height when providing self-reported measurements and the amount this occurs can differ between population groups. The Active People survey has been adjusted for this to estimate the likely *actual* height and weight of individuals, and so produce more accurate BMI estimates.

## 6.3 Healthy eating

Achieving a healthy diet involves consuming a wide range of foods and limiting intake of foods high in fat, sugar and salt. High intakes of high-sugar foods and drinks are likely to have an impact on levels of obesity and type 2 diabetes.

Within Bristol, about half of adults (53%) meet the recommended "5 or more portions of fruit and vegetables a day", similar to the national average (52%)[182].

However, local survey data[183] indicates people having 5-a-day of fruit & veg ranges from 34% in Filwood to 62% in Westbury-on-Trym & Henleaze (fig 6.3.1).

**Gender:** Women (55%) are significantly more likely to eat 5-a-day than men (46%)[184].

Local data[185] in Bristol indicates there are close to 1,200 registered retail premises for food (excluding cafes and mobiles). Of these, 64% are largely Takeaway & Convenience Foods and 36% "fresh food shops", with variation across the city. There appears to be an association between obesity rates and areas with the highest densities of fast food outlets. A new JSNA Chapter on "Food" is planned in 2016-17, to look at these issues in more detail.

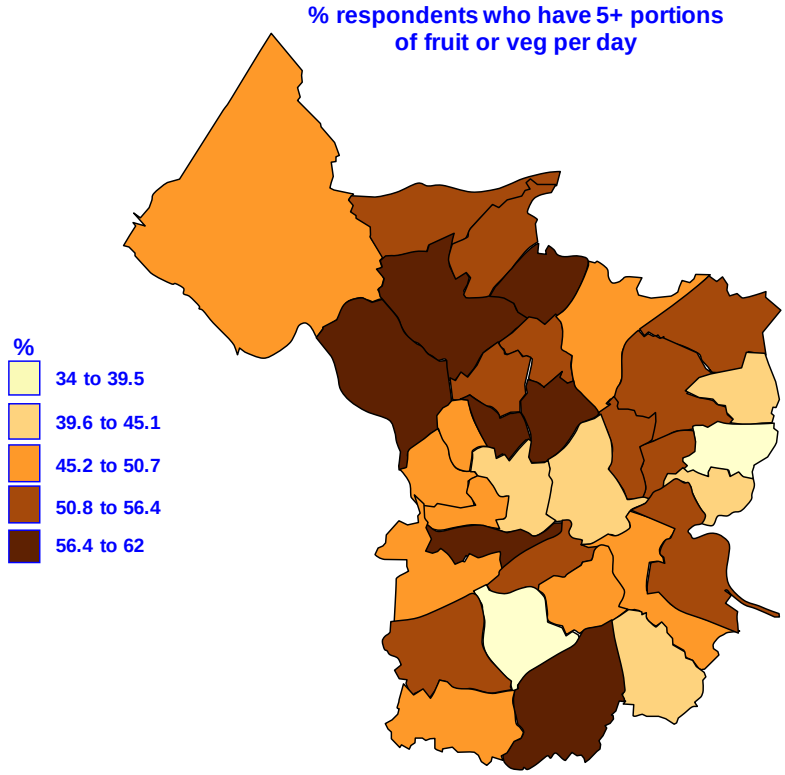
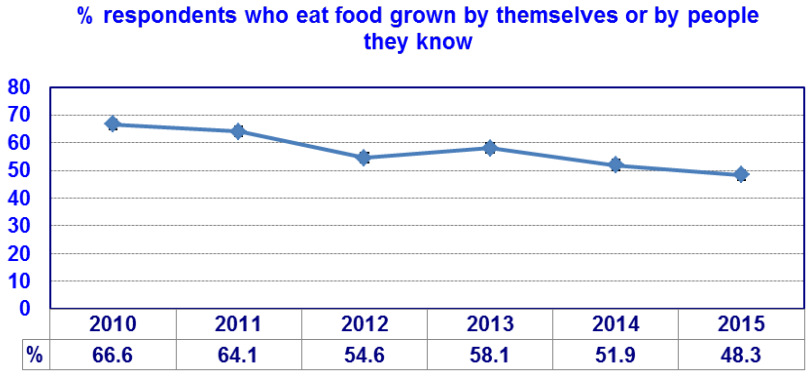



*Fig 6.3.1: % eat 5-a-day, Quality of Life survey 2015-16*

### Locally grown food

On average 48% of Bristol residents (occasionally) eat food produced by them or by people they know[186]. However, this figure has been falling over recent years (67% in 2010):




| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| % | 66.6 | 64.1 | 54.6 | 58.1 | 51.9 | 48.3 |

*Fig 6.3.2: % eat food grown by themselves or people they know, QoL 2015-16*

**Gender:** Women (52%) are significantly more likely to eat food produced by themselves or people they know than men (45%).

[182] Active People Survey 2015, via PHOF
[183] Bristol Quality of Life survey 2015-16 www.bristol.gov.uk/qualityoflife
[184] Bristol Quality of Life survey 2015-16
[185] BCC Environmental Health, 2016
[186] Bristol Quality of Life survey 2015-16

## 6.4 Smoking[187][188]

The number of smokers in Bristol is falling. New 2015 data[189] is that 18.1% of Bristol adults smoke, now similar to the 16.9% national average (fig 6.4.1), and one of the lowest of the Core Cities.

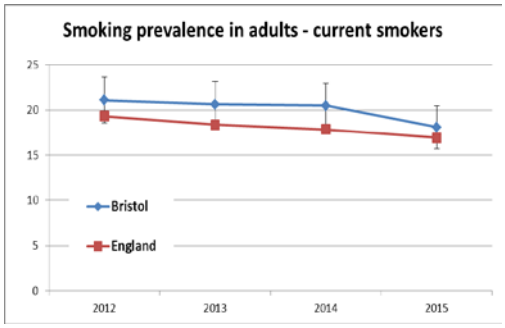



*Fig 6.4.1: Smoking prevalence in adults*

**Gender:** Nationally, women (14.9%) are significantly less likely to smoke than men (19.1%). However, the national data is not available by gender for Bristol.

Local Quality of Life Survey[190] data shows the number of *households with a smoker* is at a new low of 18%, following a six year fall. Variation across the city is 7% of households in Westbury-on-Trym & Henleaze to 34% in Hartcliffe & Withywood (fig 6.4.2). People living in deprived areas (29%) are significantly more likely to live in a household with a smoker.

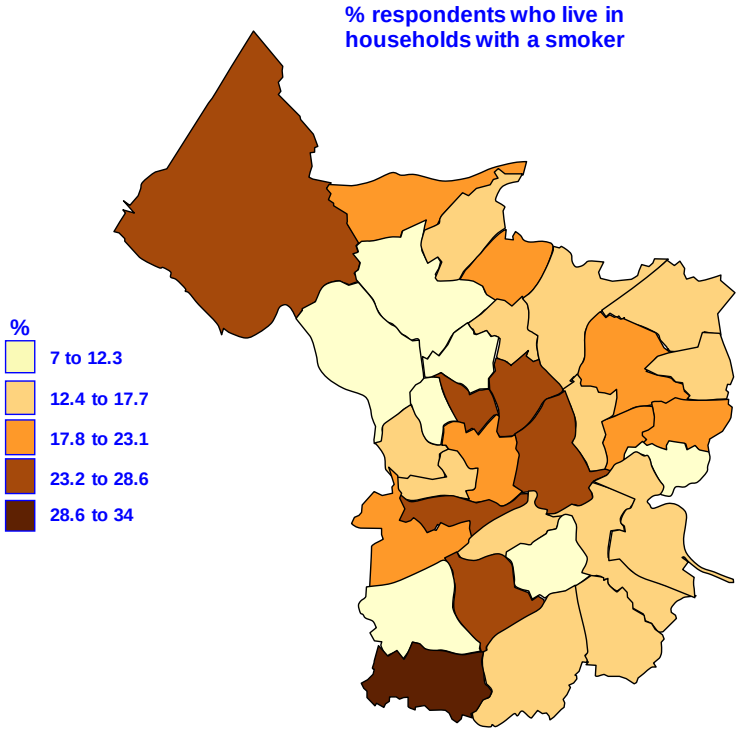



*Fig 6.4.2: % Households with a smoker, Quality of Life survey 2015-16*

### Hospital admissions

There were almost 3,700 smoking-related hospital stays[191] in Bristol in 2014/15, a rate of 1,957 per 100,000 population. This is significantly worse than the national average (1,671 per 100,000) and has risen significantly in the last year (fig 6.4.3).

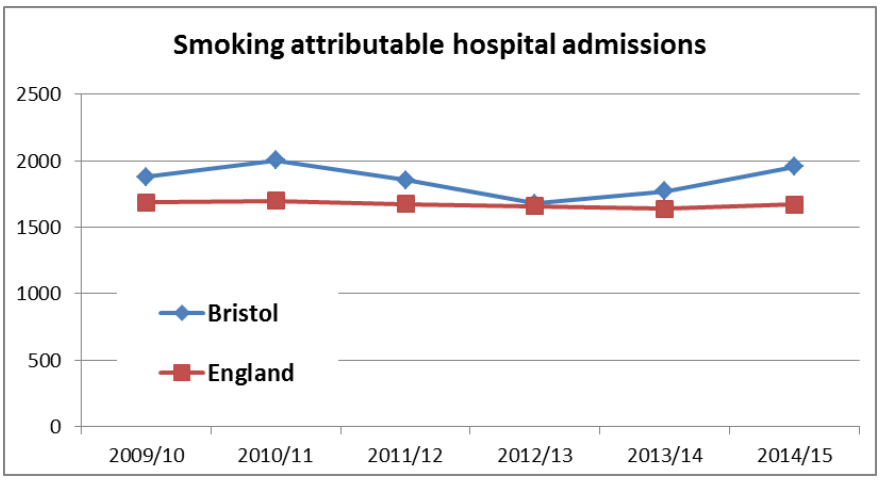



*Fig 6.4.3: Smoking attributable admissions (rate per 100,000, aged 35+)*

[187] The national indicator for Smoking changed - see the Tobacco Control Profile for Bristol: www.tobaccoprofiles.info
[188] Data on smoking rates in young people and on smoking during pregnancy are in the JSNA **Child Health** section
[189] Annual Population Survey (APS), via PHOF, Aug 2016
[190] Bristol Quality of Life survey 2015-16 www.bristol.gov.uk/qualityoflife
[191] Hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, directly age standardised rate per 100,000 population. Source: Health and Social Care Information Centre, via Bristol Tobacco Control Profile 2016

## Smoking-related deaths

There were over 1,630 smoking-attributable deaths[192] in the 3 year period 2012-14. This is a rate of 291 smoking-related deaths per 100,000. This rate is falling, but is significantly higher than the England average (275 per 100,000) still (fig 6.4.4).

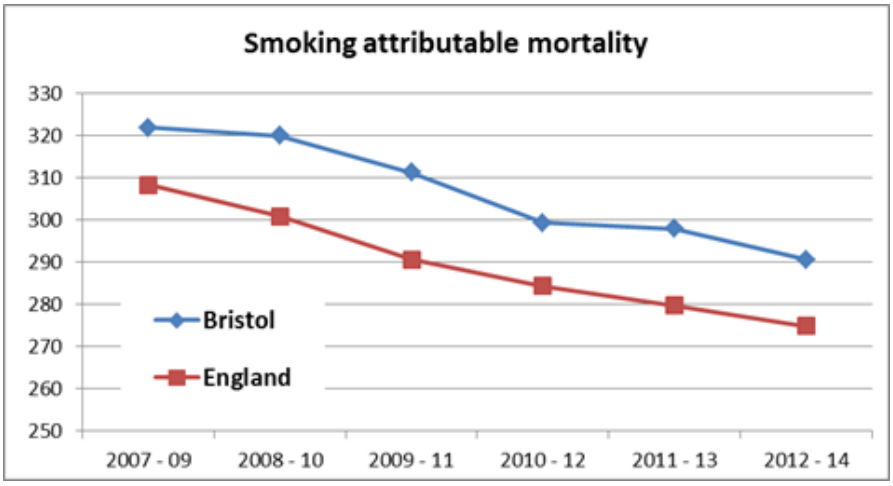



*Fig 6.4.4: Smoking attributable deaths in Bristol (rate per 100,000, aged 35+)*

## Smoking cessation services

The rate of "successful quitters at 4 weeks" per 100,000 smokers in Bristol has fallen in the last year[193] (2,546 per 100,000 in 2014/15) and is now significantly below the national average rate for smoking quitters (2,829 per 100,000). Overall, the rate of smokers quitting is also falling nationally.

Note - Public Health will target services to specific groups (eg in deprived wards where smoking rates are higher) and plan to shift approach to harm reduction – for example encouraging switching to e-cigarettes where a 4 week quit is difficult to achieve (part of the new "Switchover in Stoptober 2016" campaign).

## Further data

- Local Tobacco Control Profiles - a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level. See www.tobaccoprofiles.info/

[192] Public Health England, via Bristol Tobacco Control Profile 2016
[193] Public Health England, via Bristol Tobacco Control Profile 2016

## 6.5 Alcohol

Alcohol plays an important part in our social lives and in the local economy[194]. However, excessive intake of alcohol has clear negative effects on health and on crime. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities in Bristol have risen, and health problems caused by heavy drinking are being identified in young people[195]. Excessive drinking has been recognised as a major cause of a wide range of diseases and injuries.

### Alcohol consumption in Bristol

Modelled estimates[196] used in the draft Bristol Alcohol Strategy 2016-21 are:

• 16% of the Bristol population (16+) abstain from drinking;

• Of the remaining 84% who drink:

• 72.2% stay within the national low risk limits

• 20.3% drink at increasing levels that risk harm in the long term

• 7.5% drink at higher risk levels that harm themselves and others

• Also, 26.3% binge drink, and so are vulnerable to effects such as assault, falls and poisoning.

New data from Bristol Quality of Life survey[197] looks at how regularly people drink. 40% of Bristol residents said they had a break with at least 2 "alcohol-free days in a row" every week.

People living in deprived areas (57%) were significantly more likely to have at least 2 "alcohol-free days in a row". By ward, the range is from only 25% in Windmill Hill and Clifton, to 58% in Filwood and in Hartcliffe & Withywood (fig 6.5.1).

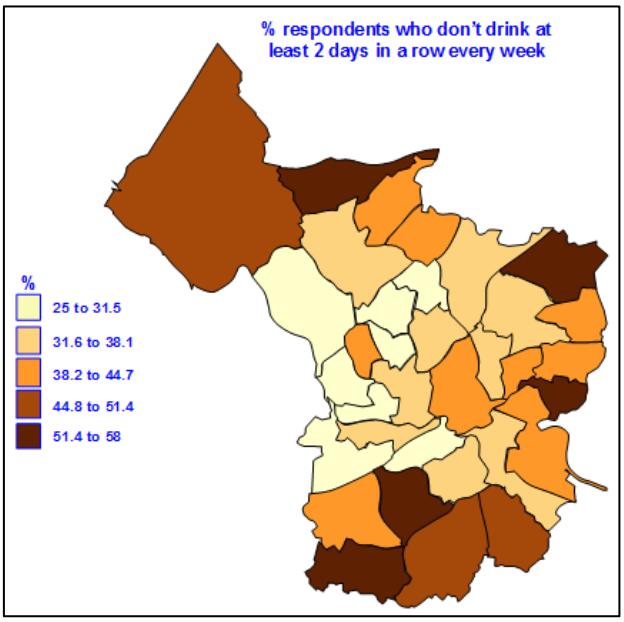



*Fig 6.5.1: % who have "at least 2 alcohol-free days in a row", QoL 2015-16*

**Gender:** Men were significantly *less* likely to abstain from drinking for at least 2 days in a row (32%) than women (47%)

### Safer levels of drinking

In 2016 new guidelines[198] were proposed to limit the health risks associated with the consumption of alcohol.

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink over 14 units / week, it is best to spread this evenly over 3 days or more (not heavy drinking sessions)
- The risk of developing a range of illnesses increases with any amount you drink on a regular basis.
- A good way to cut down the amount you're drinking is to have several drink-free days each week.

[194] Government Alcohol Strategy, 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf.
[195] See new section "4.13 Lifestyle behaviours of Young People"
[196] Data via 2014 Local Alcohol Profiles for England: www.lape.org.uk/data.html (2009 synthetic estimates, accessed 02/2016)
[197] Bristol Quality of Life survey 2015-16 www.bristol.gov.uk/qualityoflife
[198] UK Chief Medical Officers' Alcohol Guidelines Review, Jan 2016: www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf

## Hospital admissions[199]

There were over 3,000 hospital stays in Bristol due to alcohol-related harm[200] in 2014/15, a rate of 776 per 100,000 population. This is significantly worse than the national average (641 per 100,000) and consistently higher than England, and is not showing signs of improving (fig 6.5.2). However, compared to English Core Cities, Bristol is mid-ranking.

**Gender:** More men are admitted to hospital for alcohol-related harm than women, but Bristol rates for both are worse than national average. Of the 3,020 alcohol-related hospital stays in Bristol in 2014/15, 1860 were men (a rate of 990 per 100,000 males, significantly worse than national) and 1160 were women (a rate of 576 per 100,000, significantly worse than the national average for women).

A separate indicator for alcohol-related hospital admissions is the "broad definition"[201], which includes any alcohol-attributable secondary diagnoses. In 2014/15 the "broad" Bristol rate was 2,660 per 100,000, significantly worse than England average (2,140 per 100,000) and a significant rise on the last 2 years.

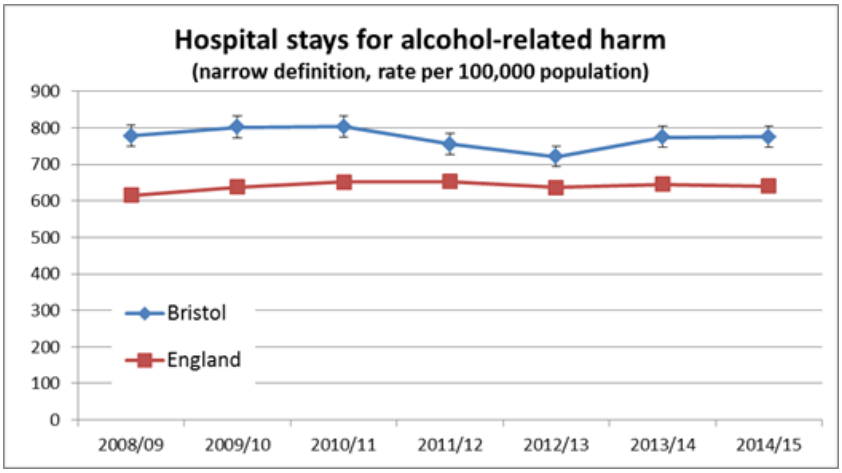



*Fig 6.5.2. Alcohol-related hospital admissions using the 'narrow definition'*

## Alcohol-related deaths

Local Alcohol Profiles[202] show Bristol has a significant issue with **alcohol-related mortality in males**. The Bristol rate is 28.5 deaths per 100,000, significantly higher than the national rate of 16.1 per 100,000 (2012/14) and rising. The rate of alcohol-related mortality in females in Bristol is 7.9 per 100,000, similar to national (7.4). See fig 6.5.3.

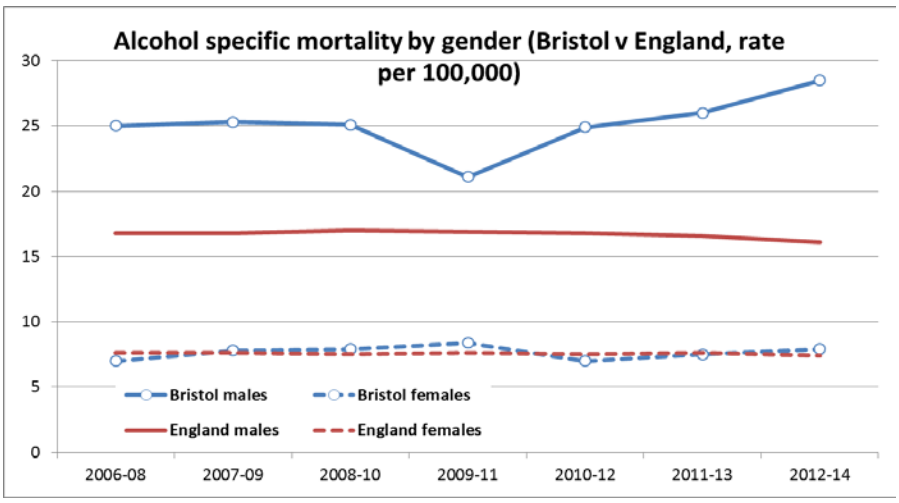



*Fig 6.5.3. Alcohol-specific mortality by gender; Source Public Health England*

## Further data

- Local Alcohol Profiles - see https://fingertips.phe.org.uk/profile/local-alcohol-profiles

[199] Data via 2016 Bristol Alcohol Profile; http://fingertips.phe.org.uk/profile/local-alcohol-profiles

[200] Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population. Source: Public Health England, via PHOF / Health Profile / Local Alcohol Profile 2016

[201] This includes the primary admissions from the "narrow definition", plus any where "the secondary diagnoses are an alcohol-attributable code" plus any child admissions due to alcohol-specific conditions or low birth weight. Source: Local Alcohol Profiles

[202] Bristol Alcohol Profile (May 2016): http://fingertips.phe.org.uk/profile/local-alcohol-profiles

## 6.6 Substance misuse

Substance misuse causes serious harm to individuals, families and communities[203]. The proportion of Bristol residents using drugs is relatively small but the impact is extensive.

The links between substance misuse and crime are well established. Drug use also has health implications such as the blood borne viruses, drug related deaths, long term health conditions and a negative impact on mental health. Treatment helps to reduce the strain on local health and criminal justice services plus improves the wellbeing of individuals and communities.

It is also important to recognise the longer term consequences. The children of drug-using parents are at an increased risk of abuse or neglect and have a higher likelihood of developing substance misuse problems themselves. Parental drug use was cited as a risk factor in a third of all serious case reviews.

### 6.6.1 Bristol opiate & crack prevalence

Bristol has an estimated 5,400 opiate and/or crack users[204]. Whilst the proportion of Bristol residents using drugs is relatively small the impact can be extensive.

Bristol has the largest estimated rate of opiate and/or crack users of the core cities – (fig 6.6.1) and the largest proportion of very high complexity clients which makes them more likely to be in treatment for longer and need specific support.

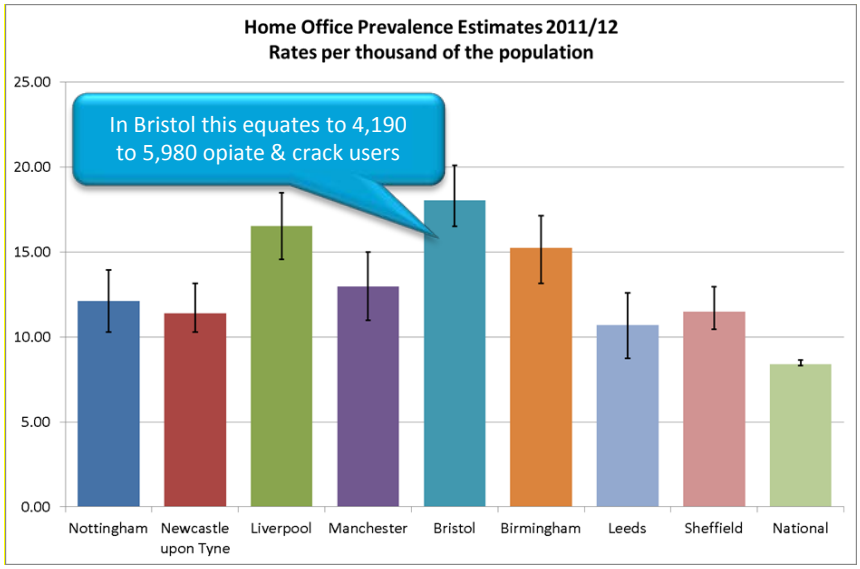



*Fig 6.6.1: Estimated rates of Opiate & Crack Users per 1,000 population*

In line with national trends, the number of new clients with opiate issues is gradually reducing; however with an ageing population of opiate users in treatment, this presents different challenges.

### 6.6.2 Treatment completion rates

Bristol's treatment success rate[205] for opiate users (7.5%) is broadly similar to the national average (6.7%) (fig 6.6.2a), but is one of the highest rates of core cities (2015).

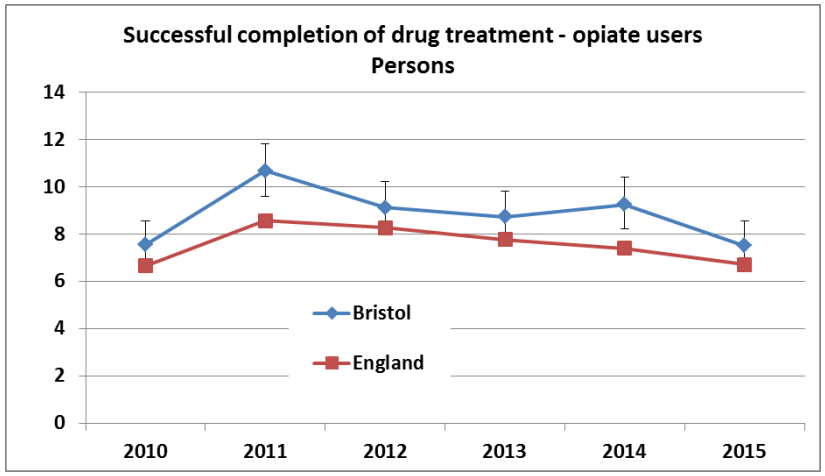



*Fig 6.6.2a: Treatment success rates – opiate; Source National Drug Treatment Monitoring System via PHOF (Nov 2016)*

[203] Also see new section "4.13 Lifestyle behaviours of Young People"
[204] Bristol Substance misuse needs assessment 2016

[205] % of opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months

However, for non-opiate users, the treatment success rate[206] in Bristol (30%) has fallen sharply in recent years and is now significantly worse than national (37.3%) (fig 6.6.2b) and is mid-ranking for core cities (2015).

Bristol also had a significantly lower rate (31.1%) of people successfully completing alcohol treatment, compared to nationally (38.4%) in 2015.

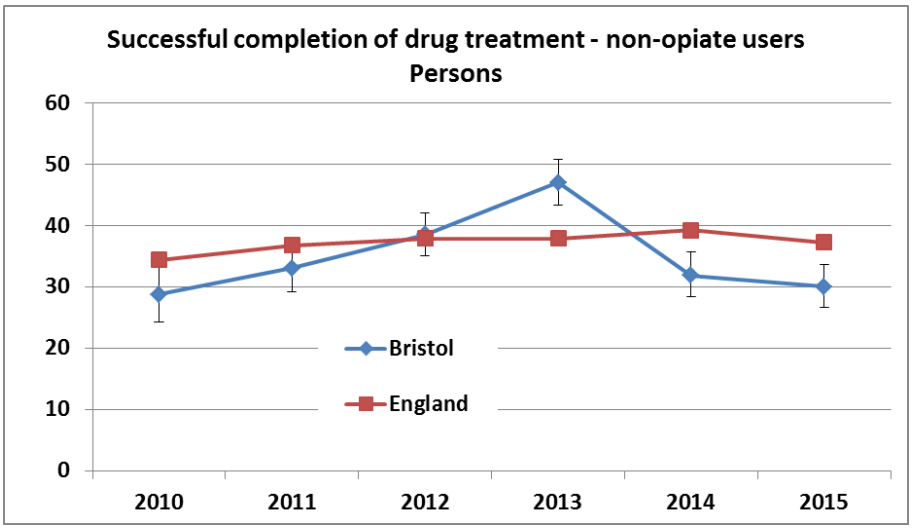



*Fig 6.6.2b: Treatment completion rates – non-opiate users; Source National Drug Treatment Monitoring System via PHOF (Nov 2016)*

### 6.6.3 Drug Related Deaths

Bristol has a significantly higher rate of deaths from drug misuse (6.0 per 100,000) than nationally (3.9 per 100,000) -fig 6.6.3, though this rate is mid-ranking for Core Cities (2013-15)

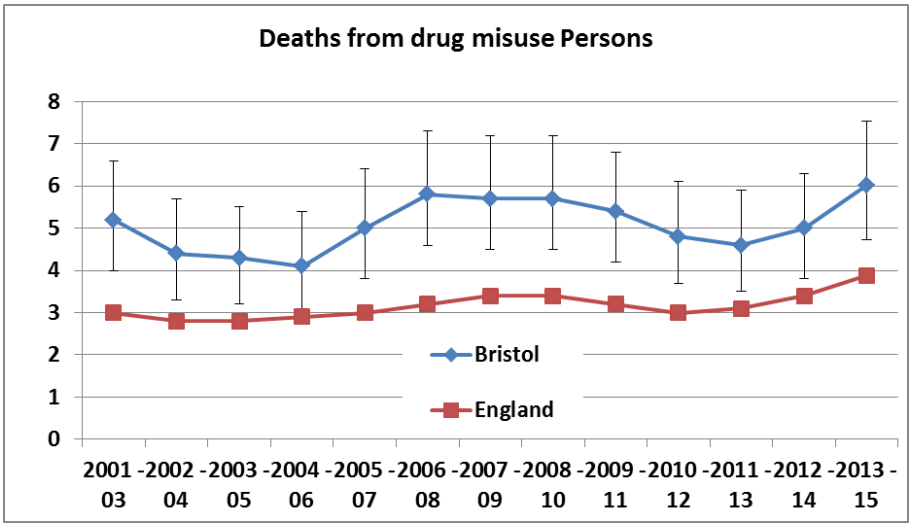



*Fig 6.6.3: Deaths from drug misuse per 100,000, via PHOF (Nov 2016)*

### Further information

- See "Substance misuse needs assessment 2016", published Sept 2016 - www.bristol.gov.uk/social-care-health/substance-misuse-treatment-services-tender

[206] % of non-opiate drug users that left drug treatment successfully who do not re-present to treatment within 6 months

# Section 7 Health Protection and Sexual Health

## Summary points

**Health Protection** seeks to prevent or reduce the harm caused by communicable and non-communicable diseases, and minimise the health impact from environmental hazards.

The new health protection duty for local authorities came into force on the 1st April 2013 as part of the Health and Social Care Act 2012.

Health Protection covers communicable disease control, infection prevention and control, emergency planning, environmental health, and screening and immunisation programmes, as well as Antimicrobial Resistance.

**Sexual health** covers the provision of information, advice and services around relationships, pregnancy prevention, sexually transmitted infections (STIs) including HIV and abortion.

Local authorities are mandated to provide or make arrangements to secure the provision of open access sexual health services in their area.

**Sexual Health**

- The rate of new STI diagnoses in Bristol (excluding chlamydia in under 25s) for 2015 (1024 per 100,000 population) is considerably higher than the national average (660 per 100,000).

**Chlamydia**

- Bristol has above average coverage for chlamydia screening (27% of 15 to 24 year olds were screened in 2015).
- However chlamydia detection rates were 1,633 per 100,000 in 2015, which is significantly below the national recommendation of 2,300 per 100,000

**HIV**

- The diagnosed prevalence rate of HIV has risen in recent years and is now similar to the national average. Bristol is considered to be over the threshold for expanded testing for HIV.
- 43% of new HIV diagnoses are considered to be “late” – but this is falling and is similar to national

**TB**

- The TB rate for Bristol is almost twice as high as the rate for England, and is 2$^{nd}$ highest of 16 comparable authorities

**Flu**

- The risk of complications from flu is greater in children under six months of age, older people, pregnant women and those with underlying conditions such as diabetes and liver disease.
- Flu vaccinations for people 65 and over have now fallen to 72.4%, below the 75% target

**Antimicrobial Resistance**

- Infection prevention and control is fundamental to stop the spread of infectious and communicable disease
- Overuse and incorrect use of antibiotics are major drivers of antibiotic resistance; Rates of “broad-spectrum antibiotics” use are consistently higher (worse) in Bristol but are now falling

## 7.1 Sexual Health[207]

Efforts to improve the sexual health of the population are a public health priority. Sexually transmitted infections (STIs) can have lasting long-term and costly complications if not treated and are entirely preventable. There are also health benefits from people with HIV being diagnosed and starting treatment earlier, minimising the use of health and social care services.

Unplanned pregnancies have a major impact on individuals, families and the wider society. Prevention of unintended pregnancies and control over reproductive choices preserves good mental and psychosexual health. Poor relationships, coercion and sexual bullying can have a lasting effect on an individual's mental wellbeing, self-esteem and confidence.

Although progress has been made (eg in the reduction in teenage conceptions and increasing access to sexual health services), high levels of need still exist.

Bristol has a relatively young population compared to England as a whole and this is predicted to rise. The city is ethnically diverse and has areas of high deprivation. There is an active lesbian, gay, bisexual and transgender (LGBT) scene. These factors mean sexual health is a priority for Bristol.

### 7.1.1 Inequalities

Sexual ill health contributes to health inequalities in Bristol. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), young people, certain black and minority ethnic groups, people involved in sex work, people with learning difficulties and homeless people. Young people in care and care leavers are also at increased risk. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Being exposed to domestic and sexual violence and abuse (DSVA) as a child or young person can be extremely detrimental. An NSPCC study (2011) found 23.7% of 18–24s had been exposed to domestic violence between adults in their homes during childhood.

### 7.1.2 Sexually transmitted infections

High diagnosis rates of STIs have been observed in Bristol. The rate of new STI diagnoses in Bristol (excluding chlamydia in under 25 year olds) is 1,024 per 100,000 population which is considerably higher than the national average (660 per 100,000).

Whilst this is in part due to improved testing it is also likely to be due to increased infection rates in the population which reflects ongoing unsafe sexual behaviours. In particular there have been sharp increases in gonorrhoea, syphilis and genital warts. The rise in STIs amongst the MSM population is of considerable concern.

**Further data**

- Sexual and Reproductive Health Profiles – to monitor the sexual and reproductive health of the population. See https://fingertips.phe.org.uk/profile/sexualhealth

[207] Note – this section is largely unchanged from JSNA 2015 - based on the Bristol Sexual Health Needs Assessment (Sept 2015)

## 7.2 Chlamydia

Chlamydia is the most common STI in England. Infection has no symptoms for 50% of men and 70-80% of women, and as a result the majority of infections remain undiagnosed. Without treatment, chlamydia can spread to other parts of the body and lead to serious long term health problems such as pelvic inflammatory disease and infertility.

The Avon Chlamydia Screening Programme supports chlamydia screening for young people in Bristol aged 15-24, to reduce chlamydia prevalence.

Bristol compared well to England and neighbouring local authorities in respect of the population coverage of chlamydia testing for 15-24 year olds, with coverage at 26.7% of the eligible population (national average 25%).

However, Bristol's testing programme has been falling short of the recommended diagnostic rate of 2,300 diagnoses per 100,000 people in the appropriate age group. 2015 data on the detection of chlamydia (fig 7.2.1) shows that Bristol (1,633 diagnoses per 100,000) has fallen significantly below the national average (1,887 per 100,000). Bristol has one of the lowest rates of the English Core Cities (fig 7.2.2).

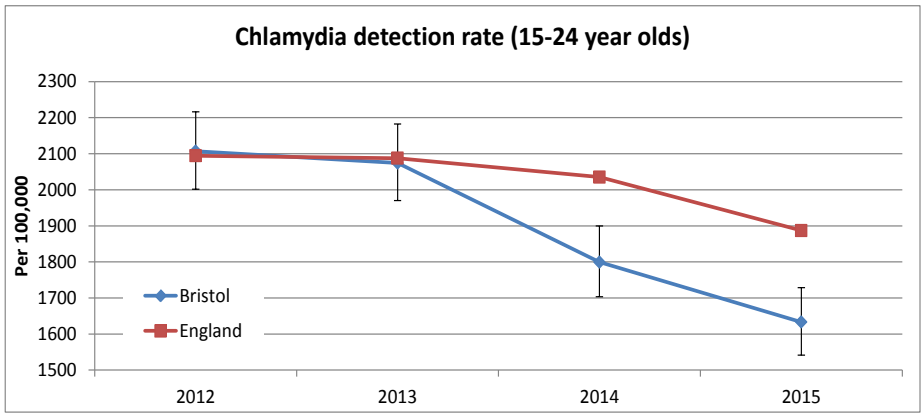



*Fig 7.2.1: Chlamydia detection rate, Bristol v England, via Public Health Outcomes Framework 2016*

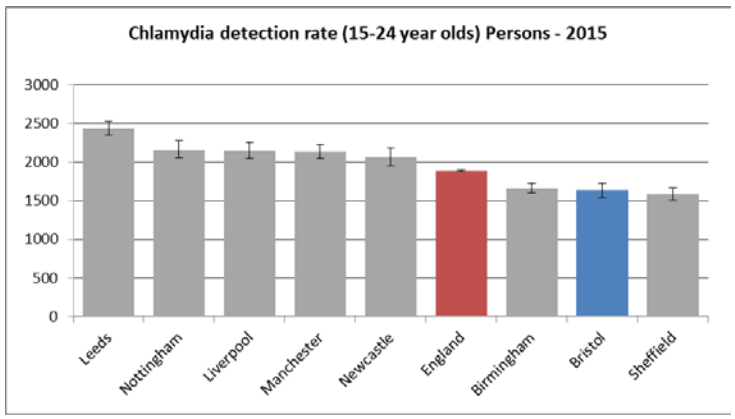



*Fig 7.2.2: Chlamydia detection rate for Core Cities 2015, via Public Health Outcomes Framework 2016*

**Gender:** In 2015 there were 1,190 diagnoses of chlamydia among 15-24 year olds in Bristol. Of these cases, 360 were males, and 830 were females. This may reflect different levels of engagement with screening services.

Local research from the ALSPAC[208] cohort study participants found that prevalence was strongly associated with measures of deprivation, with participants whose mothers had the lowest level of educational achievement being ten times more likely to test positive than participants whose mothers had the highest level of educational attainment.

[208] Avon Longitudinal Study of Parents and Children www.bristol.ac.uk/alspac/

## 7.3 HIV

HIV is associated with considerable morbidity and mortality and requires long-term care and treatment. Drug therapies have reduced the incidence of HIV-related deaths but it remains a life-threatening infection. Living with HIOV continues to be a stigmatising condition with many individuals discriminated against on a daily basis.

There are now more people living with HIV in the UK than ever before. Due to effective treatment, there are few HIV-related deaths. In 2014 it was estimated that 103,700 people were living with HIV in the UK, 17% of whom were unaware of their infection. HIV affects all sectors of the community, but there are some groups that are disproportionately affected, including men who have sex with men and the black African population.

The diagnosed HIV prevalence rate for Bristol increased in recent years and in 2015 was 2.14 per 1,000 population (aged 15-59), which is similar to the national rate (2.26 per 1,000 population)[209]. Bristol is considered to be over the threshold for expanded HIV testing.

However, the Bristol rate of new diagnoses of HIV in the last year is 8.1 per 100,000 population (15 & over), lower than the national average (12.1 per 100,000). In 2015 there were 30 people newly diagnosed with HIV in Bristol.

HIV surveillance data[210] shows that, of the people with a new HIV diagnosis in Bristol in 2013-15, 43% are considered to have a "late diagnosis". This rate is gradually falling and is similar to the national average of 40% (fig 7.3.1). Compared to other cities, Bristol is mid-ranking for HIV late diagnosis against Core Cities and our "CIPFA nearest neighbours".

Being diagnosed late, that is after treatment should have begun, is linked with increased rates of illness, hospital admission and reduced life expectancy for the individual, as well as increased onward transmission of HIV. Heterosexuals and black Africans are at higher risk of late diagnosis.

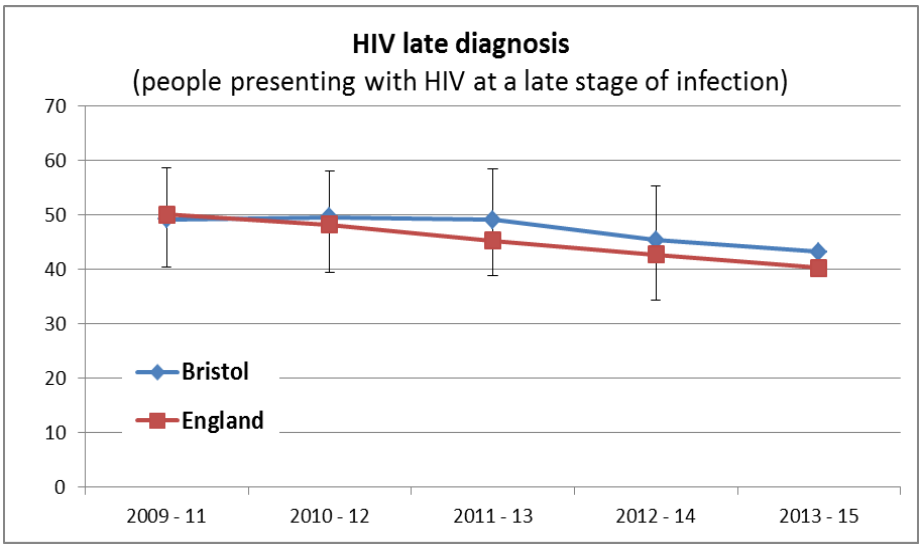



*Fig 7.3.1 % of new HIV diagnoses considered to be "late"; Source: Public Health England via Sexual and Reproductive Health Profiles, Oct 2016*

### Further data

- Sexual and Reproductive Health Profiles – to monitor the sexual and reproductive health of the population. See https://fingertips.phe.org.uk/profile/sexualhealth

[209] HIV 2015 data tables (Oct 2016) https://www.gov.uk/government/statistics/hiv-annual-data-tables

[210] via Public Health Sexual and Reproductive Health Profiles , Oct 2016

## 7.4 TB (Tuberculosis)

TB is caused by the bacterium Mycobacterium tuberculosis. It is a notifiable disease in the UK.

UK TB incidence has been higher than most other Western European counties and the USA. England has not seen the consistent reductions that have been achieved in some comparable counties. In England TB has been identified as a public health priority due to the health, social and economic burden of the disease. The rates of TB and the risks of delayed diagnosis, drug resistance, and onward transmission are greatest among socially marginalised, under-served populations such as illicit drug users and the homeless.

In Bristol, incidence rates of TB are significantly higher than the England average, being almost double. Where there has been a year on year decrease nationally since 2011, locally the numbers had been rising, though most recently this rise appears to have levelled off – fig 7.4.1.

The rate of TB in Bristol (2013-15) is 20.6 notified cases per 100,000 population, compared to 12 per 100,000 nationally and 5.7 per 100,000 South West average. Compared to other cities, Bristol is 3rd highest of English Core Cities, and 2nd highest of "CIPFA nearest neighbours"- fig 7.4.2.

In 2014, a high proportion of TB cases in Bristol (18.2%) were found to have infections with resistance to at least one first line drug (South West average 3.0%).

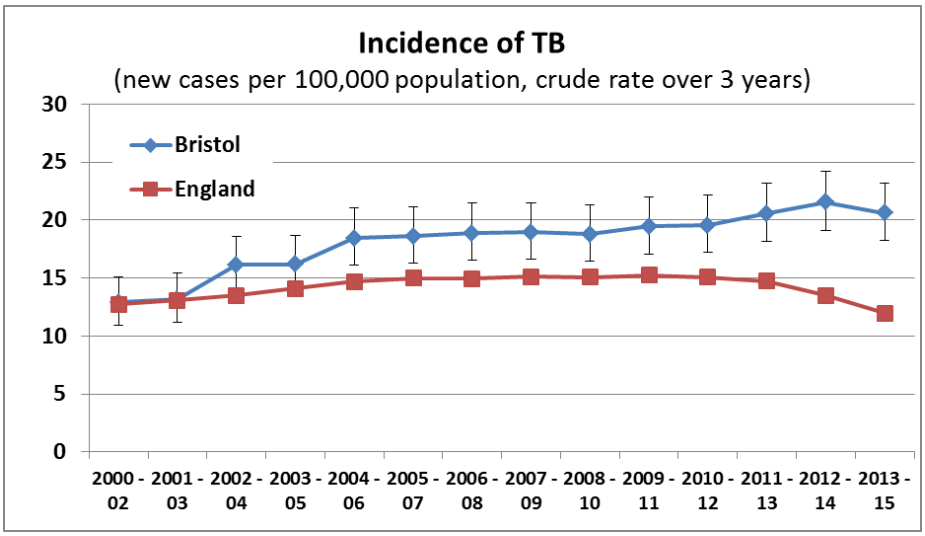



*Fig7.4.1: TB incidence rates, 2000/02-2013/15; Source: Enhanced Tuberculosis Surveillance system and ONS, via PHOF, Nov 2016*

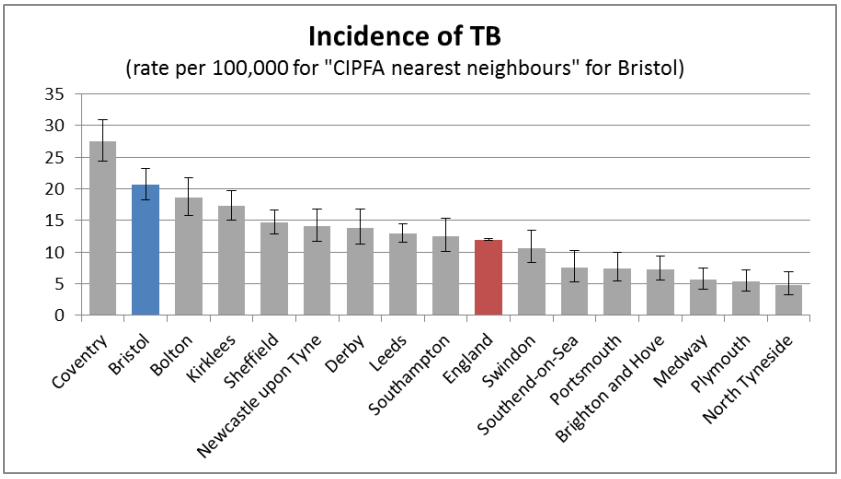



*Fig7.4.2: TB incidence rates, 2013/15 for comparable cities; Source: Enhanced Tuberculosis Surveillance system and ONS, via PHOF, Nov 2016*

The number of new cases per year places a notable demand on the health care system. TB "contact tracing" provides an opportunity to identify unrecognised cases and is key to management of TB, and with new testing tools latent TB can be identified (that could otherwise wake up and cause active disease) and appropriate action taken to support these people.

There is an established TB service operating across Bristol which leads on the clinical management of cases, contact tracing and works with Public Health England in response to more complex TB incidents or outbreak situations.

### Further data

- TB Strategy Monitoring Indicators: https://fingertips.phe.org.uk/profile/tb-monitoring

## 7.5 Flu Immunisations

Influenza is an acute viral infection of the respiratory tract characterised by a fever, chills, headache, muscle and joint pain, and fatigue. For otherwise healthy individuals, flu is an unpleasant but usually self-limiting disease.

However, flu is easily transmitted and people with mild or no symptoms can still infect others. The risk of serious illness from flu is greater in children under six months of age, older people, pregnant women and those with underlying health conditions and can therefore have a significant impact at population level.

Bristol's flu immunisations are in line with the national average for seasonal flu, with the exception of those with existing medical conditions (fig 7.5.1). However, for people 65+, vaccinations have now fallen to 72.4%, below the 75% target (fig 7.5.2).

Improving uptake in the Under 65 at risk groups, amongst pregnant women, Health Care Workers and children are priorities for Bristol. During 2015/16 Bristol saw a small increase in flu uptake for pregnant women, which was higher than the national picture, which saw a small decrease

Childhood flu vaccination for young children (Years 1 & 2) was implemented in Bristol in 2015/16, using a pharmacy-based model. For 2016/17, a school-based model will be used, which should see much higher levels of uptake.

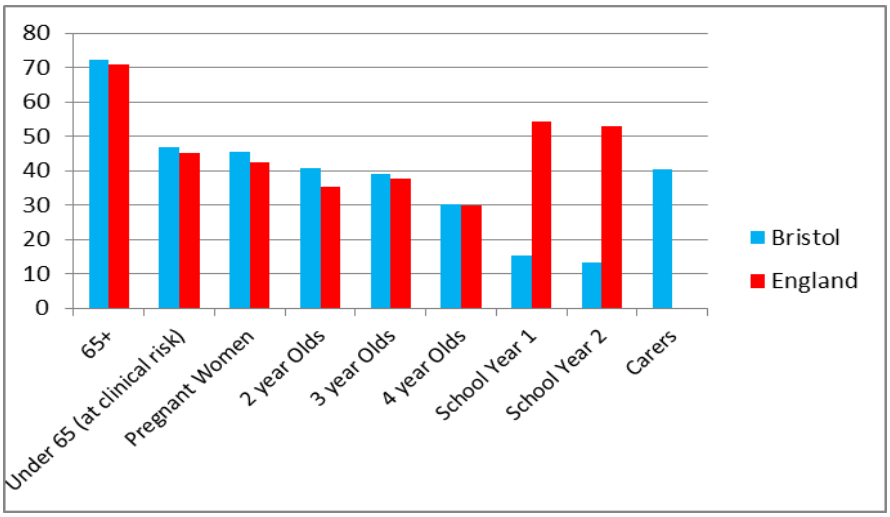



*Fig 7.5.1: Source: Seasonal flu vaccine uptake figures, 2015/16*
*https://www.gov.uk/government/collections/vaccine-uptake*

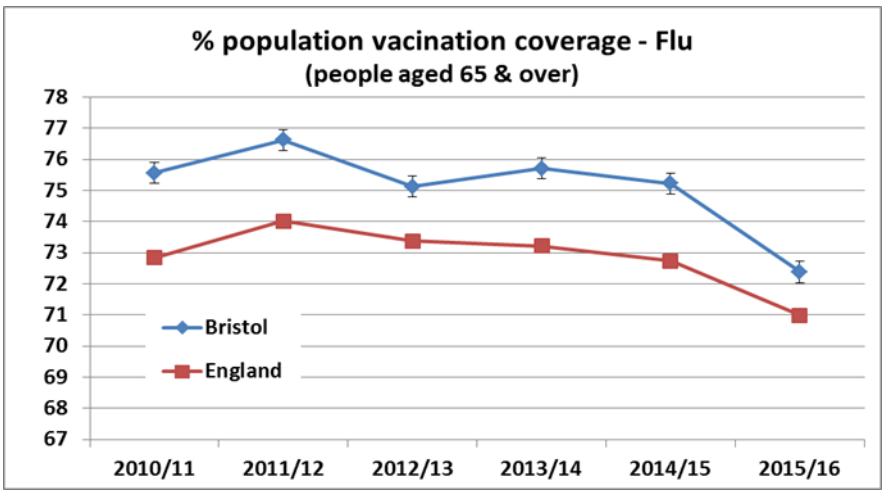



*Fig 7.5.2: Source: via Public Health Outcomes Framework, 2016*

When looking at the cohorts by age category, it can be seen that the lowest uptake is among those that are also the most at risk of complications from flu (children). It is suggested that for 2016/17, focused attention is paid to improving uptake in this age group. Whilst the numbers are small, the implications of better uptake in this group could be significant.

Against a backdrop of flu vaccination rates declining nationally amongst pregnant women, the South West saw an increase across all localities. For 2016/17, this work should continue including the implementation of maternity service based delivery models and continuing to resolve denominator issues.

## 7.6 Antimicrobial Resistance (inc antibiotics)

Antimicrobial resistance arises when the micro-organisms that cause infection survive exposure to a medicine that would normally kill them or stop their growth.

This is a particular concern with antibiotics. Many of the medical advances in recent years need antibiotics to prevent and treat the bacterial infections that can be caused by the treatment. Without effective antibiotics, even minor surgery and routine operations become high risk procedures[211].

Local guidance on the use of antibiotics in primary care[212] helps prescribers to choose the most appropriate and encourages the use of narrow-spectrum antibiotics rather than broad-spectrum[213].

In terms of rates for the total number of prescribed antibiotics, Bristol is consistently lower (better) than national, but for broad-spectrum antibiotics Bristol is consistently higher (worse) but is now falling – see fig 7.6.1. A new national target (2015-16) is to reduce the prescribing of broad spectrum antibiotics by 10%.

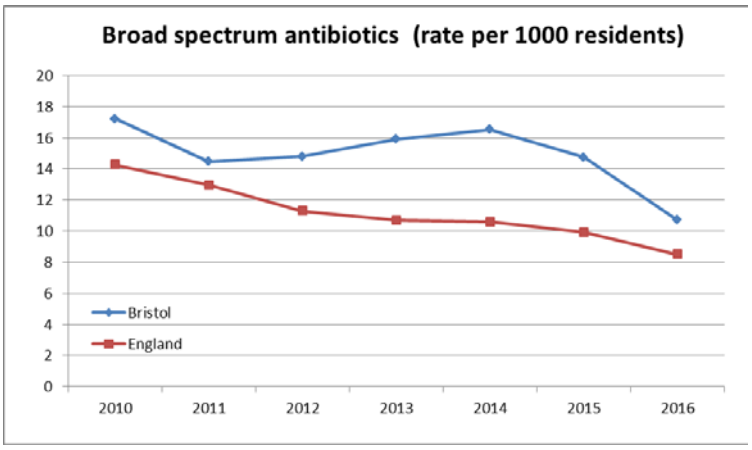



*Fig 7.6.1: Antibiotic (broad) prescription rates per 1,000 (Q1 2010 – Q1 2016)*

Bristol has not reduced the rate of healthcare associated infections as much as intended. Infections from "C.diff" have been falling in Bristol, but not the rate from MRSA (fig 7.6.2).

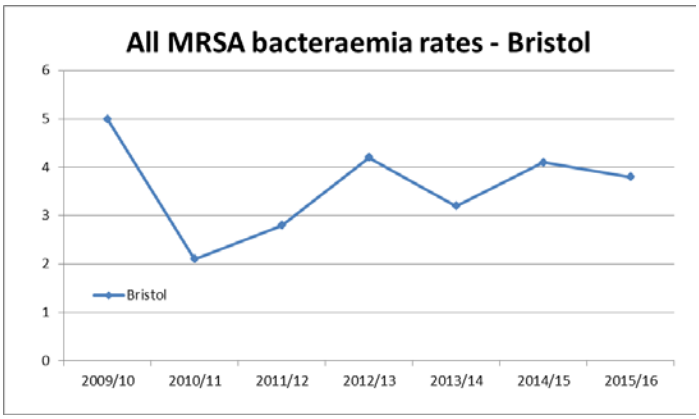



*Fig 7.6.2: Rate of MRSA infections per 100,000 (2009/10 – 2015/16)*

### Antibiotic Guardians

Improved prescribing practice of antibiotics needs to be maintained so the right people receive the right antibiotics at the right time, and reduce patient demand when they're not required.

"Antibiotic Guardians"[214] is a Public Health campaign to encourage improved behaviours around the use and prescription of antibiotics with the public and healthcare professionals - open to everyone to join! Bristol has 25.1 Antibiotic Guardians per 100,000 people in 2015, this has dropped significantly from 2014 (35.3) but is above the England average (19.5).

### Further data

- AMR local indicators – see https://fingertips.phe.org.uk/profile/amr-local-indicators

[211] www.gov.uk/government/collections/antimicrobial-resistance-amr-information-and-resources

[212] NHS Bristol, North Somerset and Gloucestershire (BNSSG) (2015) Antimicrobial Prescribing Guidelines for BNSSG Health Community 2015

[213] Cephalosporin, quinolone and co-amoxiclav, which are associated with an increased risk of Clostridium difficile (C. diff) infection and antimicrobial resistance

[214] http://antibioticguardian.com/

# Section 8
# Long Term Conditions

## Summary points

### Cardiovascular Disease

Early deaths due to cardiovascular disease remain significantly higher than the national average.

The rate of early deaths from CVD in men is significantly higher than for men nationally, and is more than twice the rate for women.

Significant variation in rates of CVD early deaths across the city

### Cancer

The rate of early deaths due to cancer in Bristol is falling, but more slowly than nationally and remains significantly higher than England. This has been the case for men, and now for women also.

Overall more men than women die early every year due to cancer, both in Bristol and nationally.

Screening coverage for breast, cervical & bowel cancer in Bristol are all significantly lower than the England average.

### Diabetes

Recorded rates of diabetes continue to rise in Bristol as in England overall. Estimates from Public Health England suggest that almost 10% of those over 16 years in Bristol have raised blood sugar levels indicating increased risk of diabetes. This is almost 35,000 people across Bristol.

### Respiratory

In Bristol, rates of early deaths from respiratory disease are significantly higher than the England average. These rates are significantly higher for both men and women.

Admission rates to hospital for COPD and for Asthma are both significantly lower in Bristol than the England average.

### Liver Disease

Early deaths from liver disease in Bristol overall are broadly similar to the England average, but are significantly higher for men. Rates are over twice as high in men than women in Bristol.

Most liver disease is due to alcohol, obesity and viral hepatitis. Rates of alcohol specific hospital admissions are significantly higher than England for both men and women, and hospital admission rates for liver disease are higher for men.

### Musculoskeletal

Musculoskeletal conditions are the main cause of years lived with disability (YLD) in England, accounting for 24% of all YLD

Modelled data estimates that 16,000 people in Bristol have hip osteoarthritis and 26,500 have knee osteoarthritis

### Preventable mortality

Preventable mortality rates in Bristol remain higher than England, though significantly lower than in most core cities. There are around 675 “preventable deaths” per year in Bristol.

Rates for preventable mortality are significantly higher in men than women.

## 8.1 Prevalence of common long-term conditions

Records from GP registers[215] in Bristol shows the percentage of adult patients diagnosed with selected Long-Term Conditions (LTCs) by GP Practice. [Note: data shows conditions recorded on GP registers (as a crude rate, divided by number of patients in that area), not actual population "prevalence", as some cases will be undiagnosed]

This data indicates Bristol has a similar or lower % of patients than national average on most indicators (partly due to Bristol's younger population profile) except asthma (same as national) and kidney disease (recorded prevalence is slightly higher than national) - see fig 8.1.1 / table 8.1.2.

Within Bristol, North & West (inner) has a substantially lower % of patients with almost all long-term conditions, except cancer. North & West (outer) is the opposite, with one of the highest rates, along with South Bristol. Bristol East is generally similar to Bristol average. The Inner City area shows relatively low recorded prevalence for cancer and kidney disease (which would fit with the younger population profile for the Inner City).

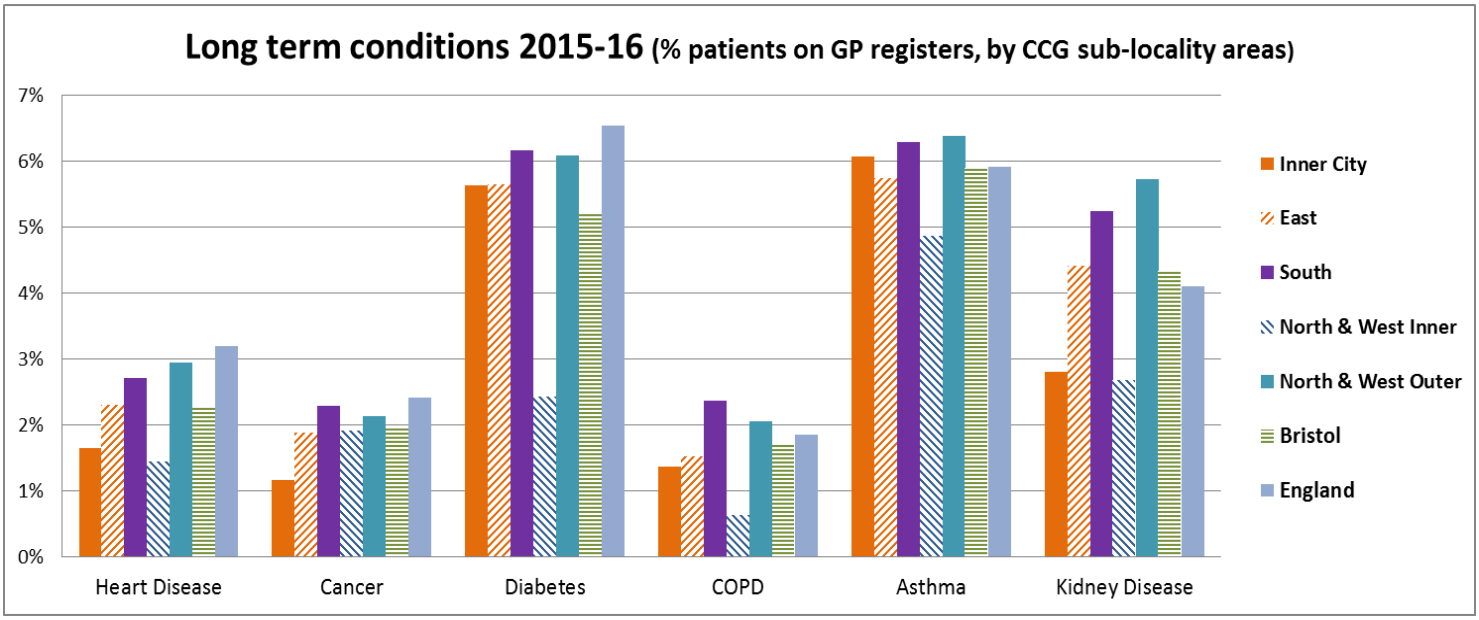



*Fig 8.1.1: Long-term conditions by area; Source: NHS Quality Outcomes Framework 2015/16*

| Patients on GP Registers (2015-16) | Coronary Heart Disease | | Cancer (all types) | | Diabetes | | Chronic Obstructive Pulmonary Disease | | Asthma | | Chronic Kidney Disease | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sub Locality Area | Number | % | Number | % | Number | % | Number | % | Number | % | Number | % |
| Inner City | 1,023 | 1.6 | 726 | 1.2 | 2,836 | 5.6 | 848 | 1.4 | 3,767 | 6.1 | 1,397 | 2.8 |
| East | 2,020 | 2.3 | 1,660 | 1.9 | 4,064 | 5.7 | 1,346 | 1.5 | 5,032 | 5.8 | 3,135 | 4.4 |
| South | 4,342 | 2.7 | 3,664 | 2.3 | 7,835 | 6.2 | 3,777 | 2.4 | 10,034 | 6.3 | 6,583 | 5.2 |
| North & West Inner | 1,421 | 1.4 | 1,883 | 1.9 | 2,042 | 2.4 | 632 | 0.6 | 4,794 | 4.9 | 2,240 | 2.7 |
| North & West Outer | 2,656 | 2.9 | 1,932 | 2.1 | 4,330 | 6.1 | 1,857 | 2.1 | 5,758 | 6.4 | 4,026 | 5.7 |
| **Bristol** | **11,462** | **2.30** | **9,865** | **1.98** | **21,107** | **5.22** | **8,460** | **1.70** | **29,385** | **5.91** | **17,381** | **4.35** |
| **England** | **1,839,330** | **3.20** | **1,392,577** | **2.42** | **3,033,529** | **6.55** | **1,066,471** | **1.85** | **3,400,679** | **5.91** | **1,872,808** | **4.10** |

*Table 8.1.2: Long-term conditions by area, 2015-16*

[215] Source: NHS Quality Outcomes Framework (QOF) 2015/16 (released Oct 2016) – NB these are crude rates

## 8.2 Premature mortality from cancer and cardiovascular diseases

In Bristol almost half of all premature deaths (under 75 years) are due to cancers and coronary heart disease (38% cancer, 10% coronary heart disease)[216] (fig 8.2.1)

Table 8.2.2 shows that early death rates due to cancer, all cardiovascular diseases (CVD), and heart disease are significantly lower in North & West (inner) than the Bristol average. In the Inner City rates for CVD (and for all causes combined) are worse than average, and more than double that of North & West (inner).

**Gender:** Rates of premature mortality among males are higher than among females across all causes noted. For males, early death rates for cancer, CVD and heart disease are lower in North & West (inner) than the Bristol average. For CVD (and for all causes combined) rates are significantly higher in the Inner City. For females, early death rates for cancer (and for all causes combined) are significantly lower in North & West (inner) than average. In North & West (outer) female premature mortality rates are significantly higher than the Bristol average for all causes combined.

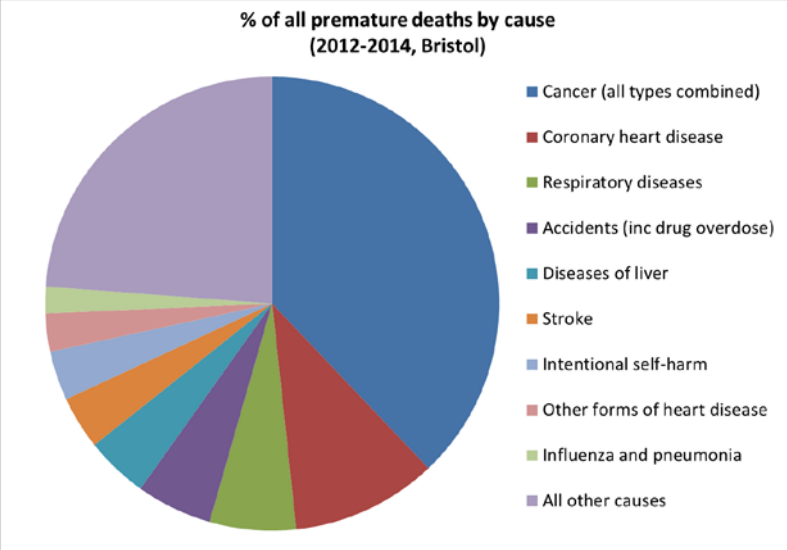



*Fig 8.2.1 Source Bristol City Council Public Health Knowledge Service (2016)*

| Premature mortality rates per 100,000 population (2012-14) All Persons | | | | | | |
|---|---|---|---|---|---|---|
| Mortality rates per 100,000 population | **Bristol** (average) | **Bristol East** | **Inner City** | **Bristol South** | **North & West - inner** | **North & West - outer** |
| Premature mortality, Cancer | **154** | 142 | 173 | 171 | 104 | 172 |
| Premature mortality, CVD (all Cardiovascular) | **86** | 94 | 124 | 82 | 49 | 106 |
| Premature mortality, CHD (Heart Disease) | **43** | 44 | 55 | 43 | 25 | 57 |
| Premature mortality, Stroke | **16** | 19 | 27 | 13 | 10 | 18 |
| **All causes** | **387** | 399 | 481 | 400 | 237 | 459 |
| **Males** | | | | | | |
| Mortality rates per 100,000 population | **Bristol** (average) | **Bristol East** | **Inner City** | **Bristol South** | **North & West - inner** | **North & West - outer** |
| Premature mortality, Cancer | **173** | 160 | 186 | 195 | 117 | 191 |
| Premature mortality, CVD (all Cardiovascular) | **123** | 144 | 182 | 118 | 66 | 144 |
| Premature mortality, CHD (Heart Disease) | **65** | 69 | 86 | 64 | 38 | 83 |
| Premature mortality, Stroke | **20** | 28 | 37 | 18 | 9 | 18 |
| **All causes** | **475** | 502 | 601 | 487 | 297 | 545 |
| **Females** | | | | | | |
| Mortality rates per 100,000 population | **Bristol** (average) | **Bristol East** | **Inner City** | **Bristol South** | **North & West - inner** | **North & West - outer** |
| Premature mortality, Cancer | **135** | 124 | 159 | 147 | 91 | 154 |
| Premature mortality, CVD (all Cardiovascular) | **49** | 44 | 60 | 47 | 33 | 71 |
| Premature mortality, CHD (Heart Disease) | **21** | 19 | 22 | 22 | 12 | 32 |
| Premature mortality, Stroke | **12** | 10 | 17 | 9 | 11 | 17 |
| **All causes** | **301** | 296 | 347 | 316 | 180 | 377 |

Green = lower (better) than Bristol average; Red = higher (worse) than average; Unshaded = not significantly different to average

*Table 8.2.2 Source Bristol Public Health Knowledge Service (2016)*

[216] 2012-14 data provided by Bristol Public Health Knowledge Service (2016)

## 8.3 Cardiovascular Disease

Early deaths due to cardiovascular disease (CVD) in Bristol have remained significantly higher than the national average, whilst falling broadly in line with the national trend[217]. In 2013-15, Bristol rates are 82.3 per 100,000, England 74.6 per 100,000.

**Gender:** The male CVD early death rate (125 per 100,000) is significantly higher in Bristol than for men nationally, and is more than twice the rate for women (fig 8.3.1). Women (53 per 100,000) are similar to national average.

Local data[218] on variation across the city (fig 8.3.2, and table 8.2.2) shows rates in the Inner City are significantly higher than the Bristol average. In the Inner City and North & West (outer) rates are now over twice as high as North & West (inner), which is significantly lower than the city average

### Coronary Heart Disease (CHD)

Data from GP registers[219] shows in Bristol, the average recorded prevalence (2.3%) of Coronary Heart Disease (CHD) is lower than the England average (3.2%). However, in North & West outer this is 2.9% and is almost twice the rate of the North & West inner and Inner City areas (fig 8.3.3). [Note – these are crude rates]

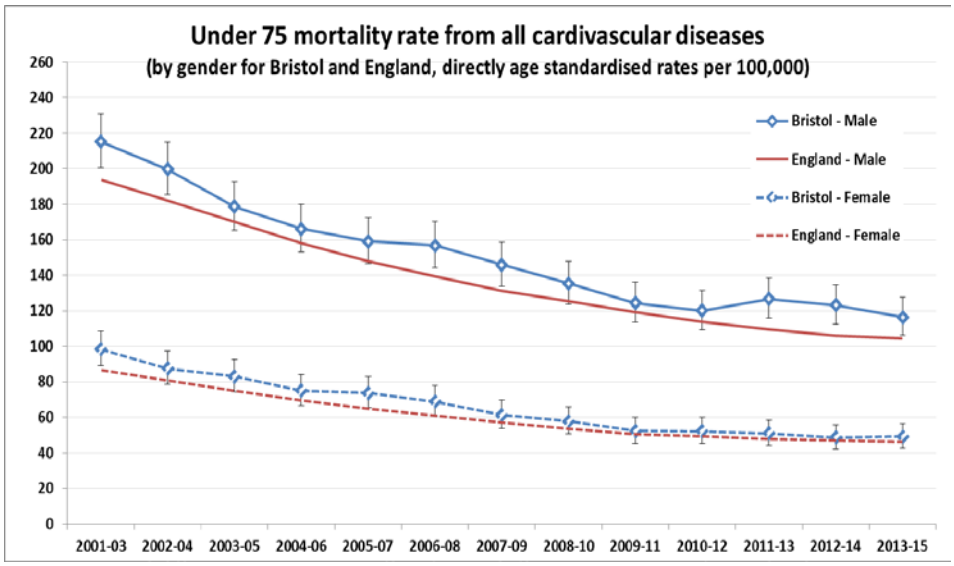
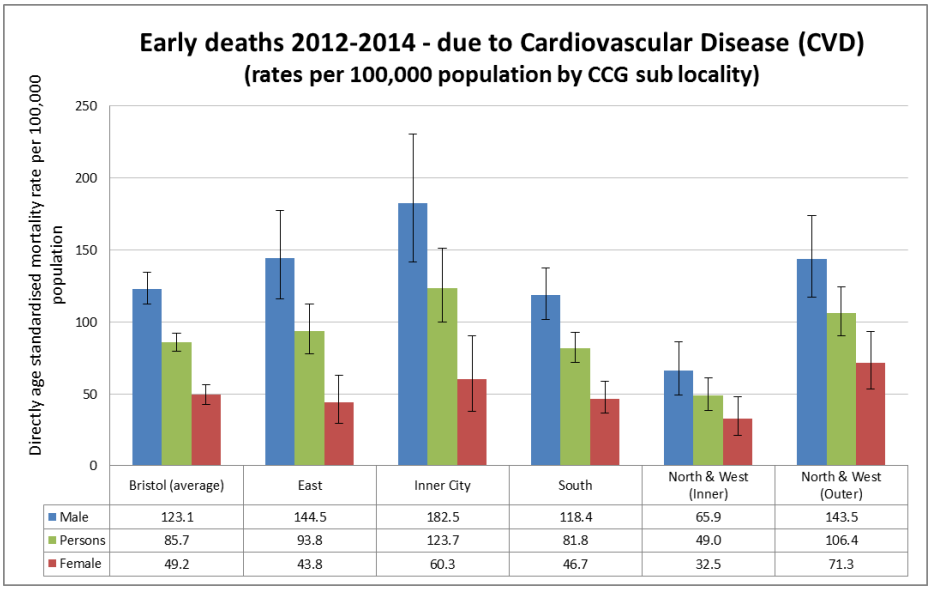



*Fig 8.3.1: Early deaths – CVD (Source via PHOF, Nov 2016)*




| | Bristol (average) | East | Inner City | South | North & West (Inner) | North & West (Outer) |
|---|---|---|---|---|---|---|
| Male | 123.1 | 144.5 | 182.5 | 118.4 | 65.9 | 143.5 |
| Persons | 85.7 | 93.8 | 123.7 | 81.8 | 49.0 | 106.4 |
| Female | 49.2 | 43.8 | 60.3 | 46.7 | 32.5 | 71.3 |

*Fig 8.3.2: Early deaths by area for CVD (Source BCC Public Health Knowledge Service, Aug 2016)*

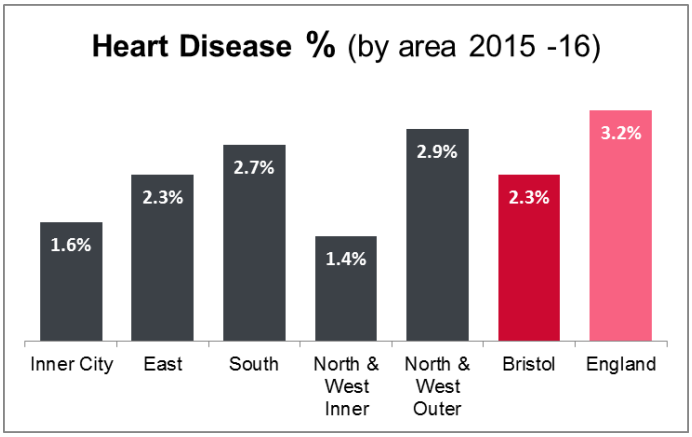



*Fig 8.3.3: NHS Quality Outcomes Framework (QOF) 2015-16 (supplied by BCC Performance Information & Intelligence)*

[217] 2013-15; Source: Public Health Outcomes Framework, Nov 2016
[218] 2012-14 locality data provided by Bristol Public Health Knowledge Service (2016)
[219] Source: NHS QOF data 2015-16

Local data[220] for early deaths from CHD shows rates in North and West (inner) remain significantly lower than the city average.

**Gender:** CHD early death rates are 3 times higher for men than for women in Bristol (fig 8.3.4).

### Stroke

In Bristol, the recorded prevalence of stroke (2014-15) and early death rates from stroke were similar to the national rates. Early death rates from stroke vary across the city with over twice the rate in the Inner City than in North & West (inner). Overall in Bristol, over 50% more men than women die early from stroke (fig 8.3.5).

### High Blood Pressure (Hypertension)

Hypertension increases risk of heart disease or stroke. Crude rates of hypertension vary across the city[221], with highest rates in the South and North & West (outer), and lowest in North & West (inner) and the Inner City (table 8.3.6).

The 10.8% recorded cases are lower than the 22% estimated prevalence in Bristol (table 8.3.6), suggesting that only half of adults with hypertension are diagnosed.

### Further data

- CVD Profile: https://fingertips.phe.org.uk/profile/cardiovascular

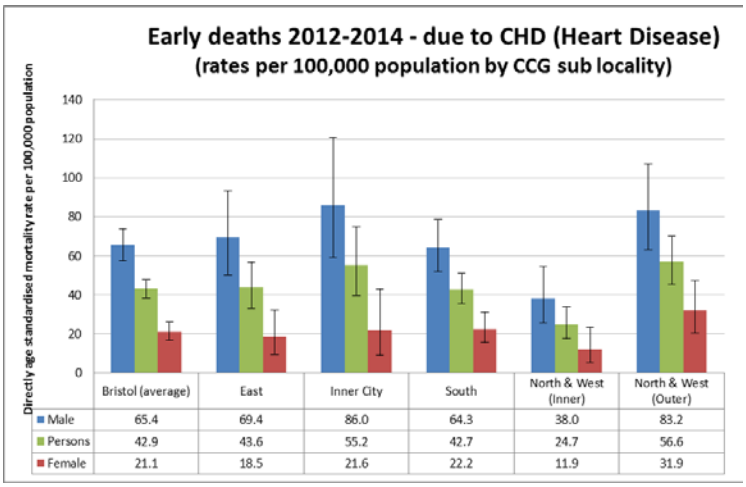



*Fig 8.3.4: Early deaths by area for CHD (Source BCC Public Health Knowledge Service, Aug 2016)*

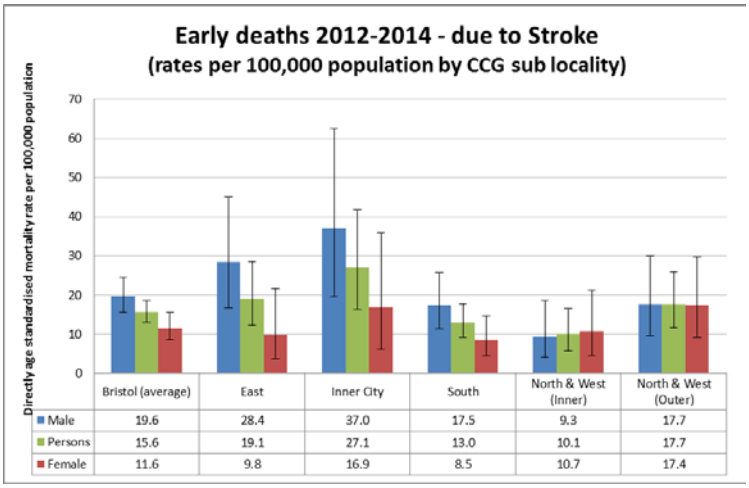



*Fig 8.3.5: Early deaths by area – Stroke (Source BCC Public Health Knowledge Service, Aug 2016)*

| Patients on GP Registers (2015-16) | Hypertension (recorded cases) | | Estimated prevalence % |
|---|---|---|---|
| **Sub Locality Area** | **Number** | **%** | |
| **Inner City** | 5,235 | 8.4 | |
| **East** | 9,844 | 11.2 | |
| **South** | 20,347 | 12.8 | |
| **North & West Inner** | 7,379 | 7.5 | |
| **North & West Outer** | 10,966 | 12.1 | |
| **Bristol** | **53,770** | **10.8** | **22.0** |
| **England** | **7,949,270** | **13.8** | **24.7** |

[220] 2012-14 locality data provided by Bristol Public Health Knowledge Service (2016)
[221] Source: NHS Quality Outcomes Framework (QOF) 2015/16

*Table 8.3.6 Hypertension recorded diagnoses; Source: QOF 2015-16 and Public Health England for estimated prevalence*

## 8.4 Cancer

The rate of early deaths due to cancer in Bristol is falling, but slower than nationally and remains significantly higher (153.1 per 100,000) than England (138.8) (2013-15). The rate is broadly similar to comparable cities[222].

**Gender:** In men, Bristol rates for early deaths due to cancer (171.2 per 100,000) are significantly higher than England (154.8) whilst, the rate for women in Bristol (136 per 100,000) is also now significantly higher than for England (123.9) - see fig 8.4.1.

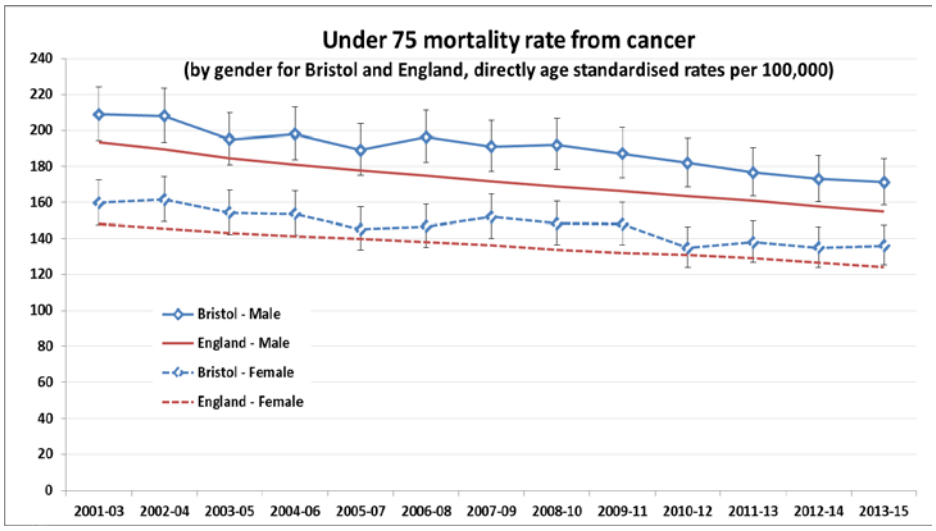
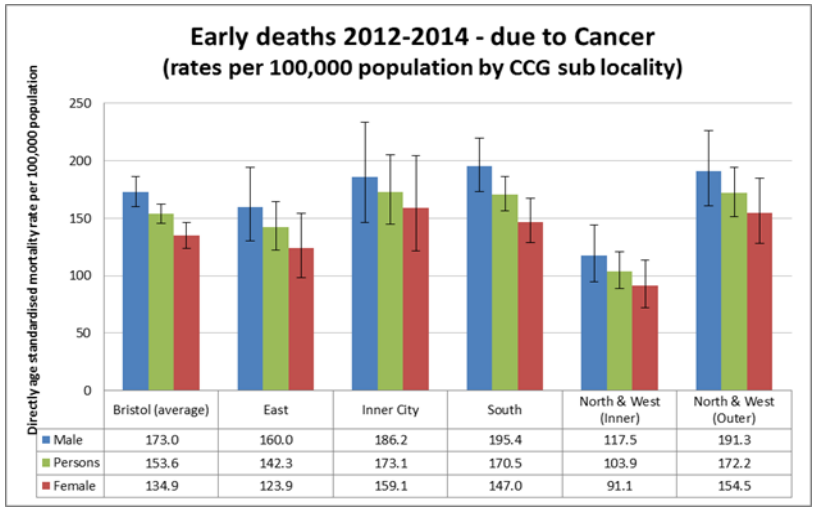



*Fig 8.4.1: Early deaths due to Cancer, Bristol and England by gender Source via Public Health Outcomes Framework, PHOF, Nov 2016*

Premature mortality rates are higher in the South, North & West (outer) and Inner City areas than the Bristol average, and lower in North & West (inner) for both men and women (fig 8.4.3)[223].




| | Bristol (average) | East | Inner City | South | North & West (Inner) | North & West (Outer) |
|---|---|---|---|---|---|---|
| Male | 173.0 | 160.0 | 186.2 | 195.4 | 117.5 | 191.3 |
| Persons | 153.6 | 142.3 | 173.1 | 170.5 | 103.9 | 172.2 |
| Female | 134.9 | 123.9 | 159.1 | 147.0 | 91.1 | 154.5 |

*Fig 8.4.2: Early deaths – Cancer (2012-14 by area and gender) (Source BCC Public Health Knowledge Service, Aug 2016)*

Premature mortality rates due to cancer (directly standardised rates per 100,000 population) have been reducing in Bristol overall, and in most locality areas, although this is not apparent in the Inner City (fig.8.4.3).

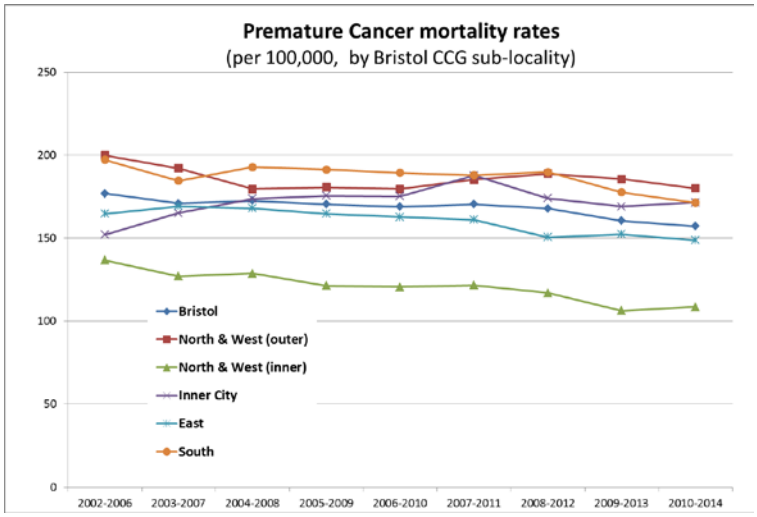



*Fig 8.4.3: Early cancer deaths in Bristol by locality areas (Source: Bristol Public Health Knowledge Service, 2016)*

[222] 2013-15; Compared to CIPFA and Core Cities using PHOF, Nov 2016
[223] Source: Bristol Public Health Knowledge Service, (2016)

GP data[224] shows diagnoses of cancer continue to rise (fig 8.4.4). The rate for Bristol (2%) remains lower than England average (2.4%), but is higher in the South and North & West (outer) than other parts of Bristol. Diagnosis rates in the Inner City remain lowest, at half those in South (NB GP data is not standardised and so differences are partly due to a younger age profile in Inner City).

Overall, the rate of Bristol patients with emergency admissions to hospital due to cancer (353 per 100,000 population) is lower than it is nationally (539 per 100,000)[225] and has been lower since 2012/13

### 8.4.1 Types of cancer

In Bristol, the highest numbers of premature cancer deaths (2011-15) were due to lung cancer (122 per year), followed by cancer of digestive organs (109 per year), then breast cancer (32 per year)[226].

Bristol mortality rates per 100,000 of the relevant population[227] (to compare to national average) for these cancers for 2012-2014 are:

154 for all cancers (England 142)

41.8 lung cancer (England 33.6)

19.5 breast cancer (England 22)

15.4 colorectal cancer (England 13.1)

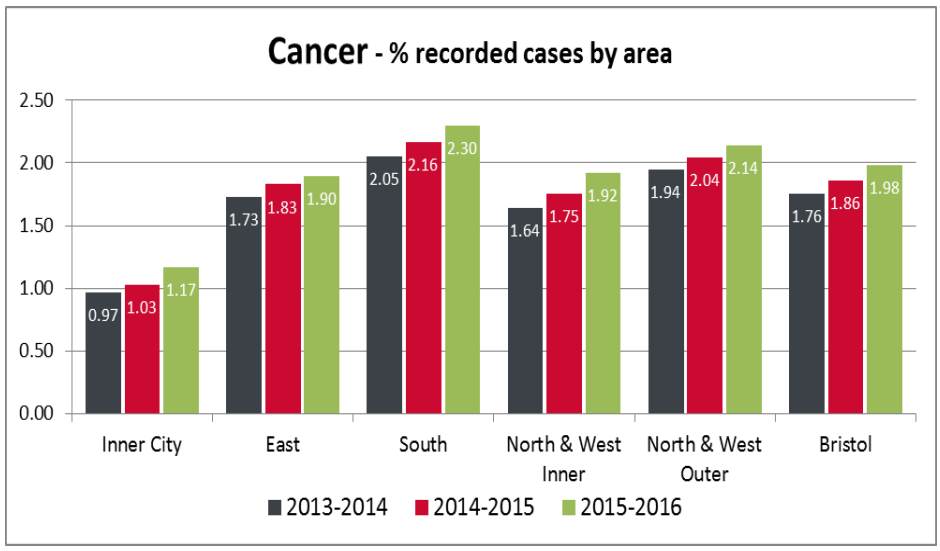



*Fig 8.4.4: Source: NHS Quality Outcomes Framework (QOF) 2015-16 (supplied by BCC Performance Information & Intelligence)*

### 8.4.2 Cancer Screening[228]

Screening coverage for **breast and cervical cancer** in Bristol between 2010 & 2015 has consistently been significantly lower than the England average (and other cities with a similar population). In 2015, Bristol's screening rates were 73.2% for Breast cancer (England 75.4%) and 70.9% for cervical cancer (England 73.5%).

In 2015 new data was released on screening coverage for **bowel cancer**. The rate for Bristol (50.7%) is also significantly worse than the national average (57.1%).

### Further data

- Cancer Services Profile: https://fingertips.phe.org.uk/profile/cancerservices

[224] Source: NHS QOF data 2015/16
[225] 2014/15 via PHE General Practice Profiles (2016): https://fingertips.phe.org.uk/profile/general-practice
[226] Calculated by Bristol Public Health Knowledge Service using ONS mortality data
[227] HSCIC: https://indicators.hscic.gov.uk/webview/
[228] Source: Health and Social Care Information Centre, via Public Health Outcomes Framework, Nov 2015

## 8.5 Diabetes[229]

Diabetes prevalence continues to rise in Bristol as nationally, and there are now 21,100 Bristol patients with Diabetes[230].

As a crude rate this is 5.2% of all adult patients, below the England average (6.5%) - fig 8.5.1. Age is a key factor in diabetes prevalence, and the lower rate compared to England may reflect Bristol's relatively younger age profile.

Data from GP registers[231] shows diabetes prevalence varies across the city (fig 8.5.2). The North & West outer and South Bristol areas have recorded diabetes prevalence above 6% and rising, in contrast with inner North & West where prevalence is much lower at 2.4%.

90% of people with diabetes will have Type 2 diabetes, which in many cases is preventable. Risk of developing Type 2 diabetes rises with excess weight.

Non-diabetic hyperglycemia (also known as pre-diabetes or impaired glucose regulation) refers to blood glucose levels that are high, but not diabetic. People with this are at high risk of developing diabetes, as well as other cardiovascular conditions.

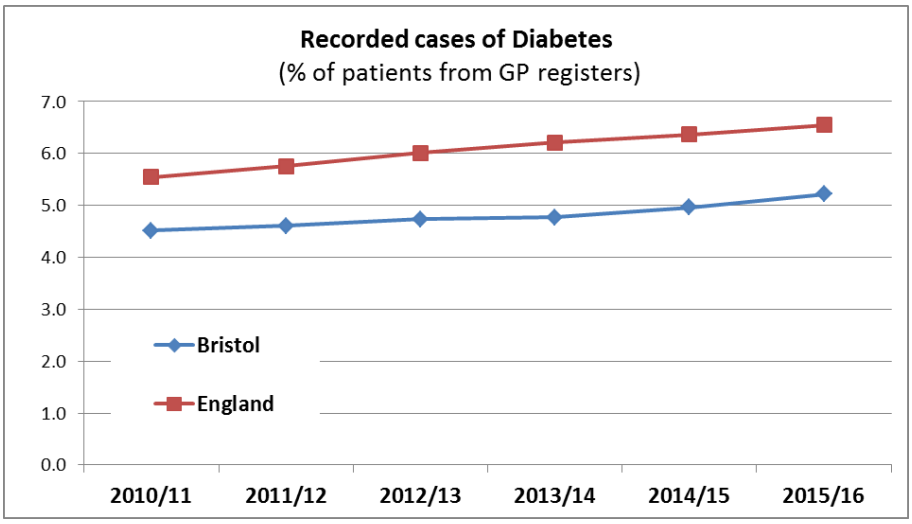



*Fig 8.5.1: Source: NHS Quality Outcomes Framework (QOF)*

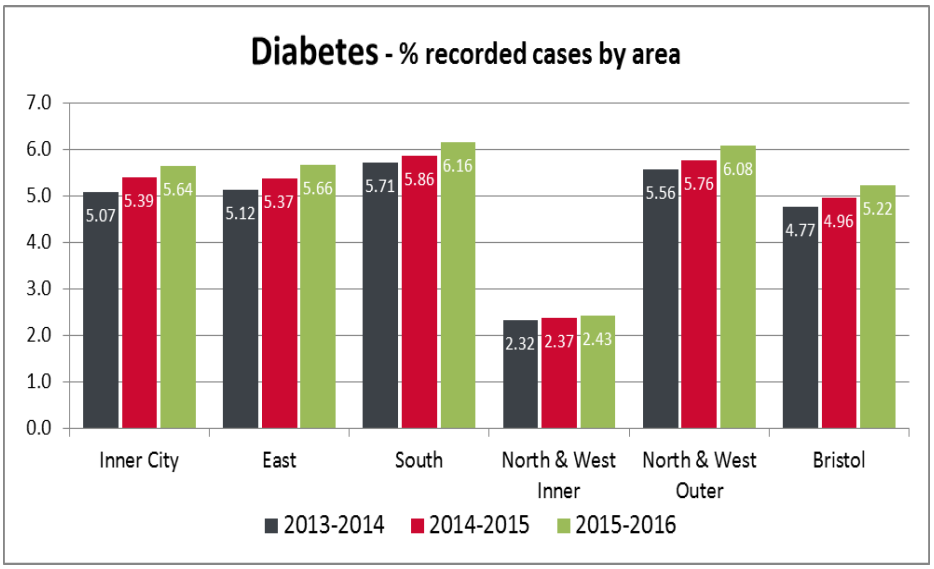



*Fig 8.5.2: Source: NHS Quality Outcomes Framework (QOF) 2015-16 (supplied by BCC Performance Information & Intelligence)*

Estimates from Public Health England suggest that almost 10% of those over 16 years in Bristol have non–diabetic hyperglycemia and are therefore at increased risk of diabetes- this is almost 35,000 people across Bristol.

Behavioural interventions to reduce body weight, increase physical activity and improve diet can significantly reduce the risk of developing Type 2 diabetes in those at high risk.

### Further data

- Diabetes Profile: https://fingertips.phe.org.uk/diabetes
- Healthier Lives: Diabetes: http://healthierlives.phe.org.uk/topic/diabetes

[229] Further data, see Bristol Diabetes profile: http://fingertips.phe.org.uk/diabetes
[230] Source: NHS QOF data 2015/16. QOF is a crude rate per population
[231] Source: NHS QOF data 2015/16

## 8.6 Respiratory Disease

In Bristol, early death rates from respiratory disease[232] (39.6 per 100,000) are significantly higher than the England average (33.1 per 100,000). Compared to other English Core Cities though, Bristol has the 2nd lowest rate.

**Gender:** Rates of early deaths due to respiratory disease are significantly higher in Bristol than nationally for both men and women (fig 8.6.1). Locally, rates for women had been rising, but not in the last year (2013-15).

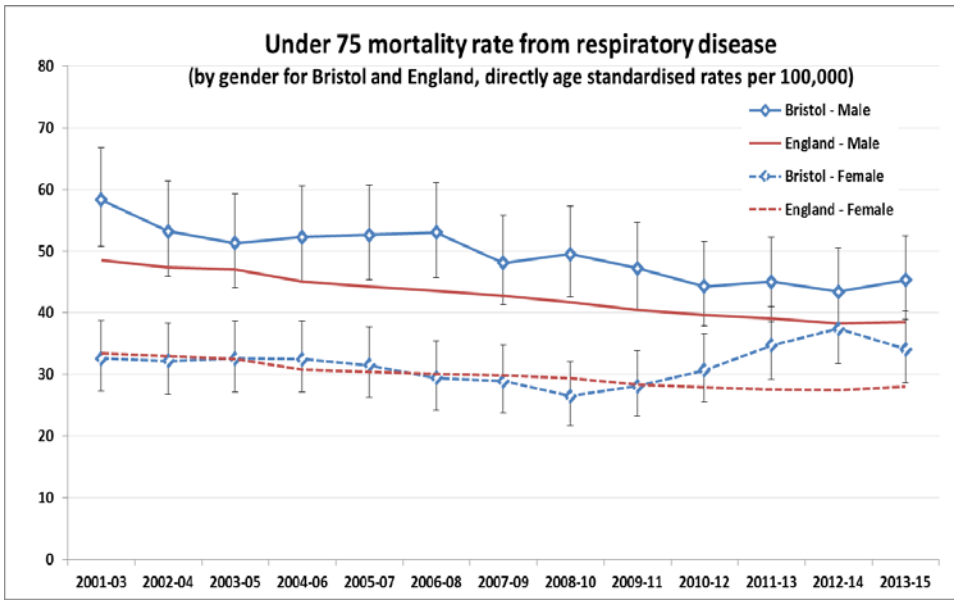



*Fig 8.6.1: Early deaths due to respiratory disease (via PHOF, Nov 2016)*

### 8.6.1 COPD

GP register data[233] shows 8,460 Bristol patients with chronic obstructive pulmonary disease (COPD). This is 1.7% of all adult patients (England average: 1.85%). Rates are highest in the South and North & West outer areas, at more than three times that of the lowest rate (North & West inner) (fig 8.6.2).

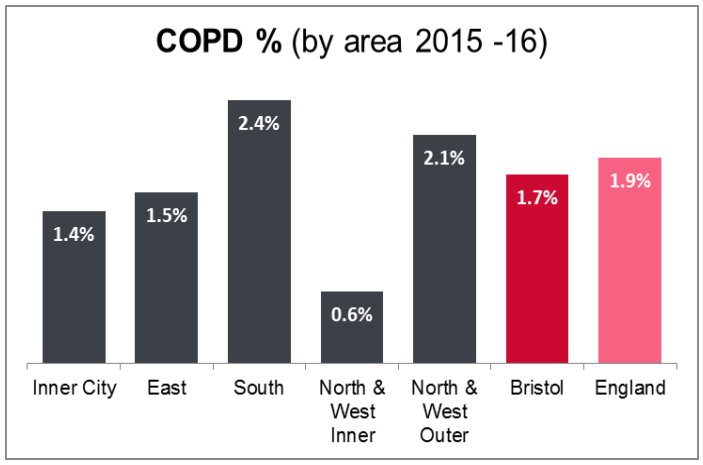



*Fig 8.6.2: Prevalence of COPD; Source: NHS QOF 2015/16*

Variations in recorded COPD prevalence compare similarly to variations in smoking rates across areas of the city.

The 1.7% recorded cases are lower than the 3.32% estimated prevalence in Bristol, suggesting that only 46% of COPD cases are recorded in Bristol (57% England average)[220].

### 8.6.2 Asthma[234]

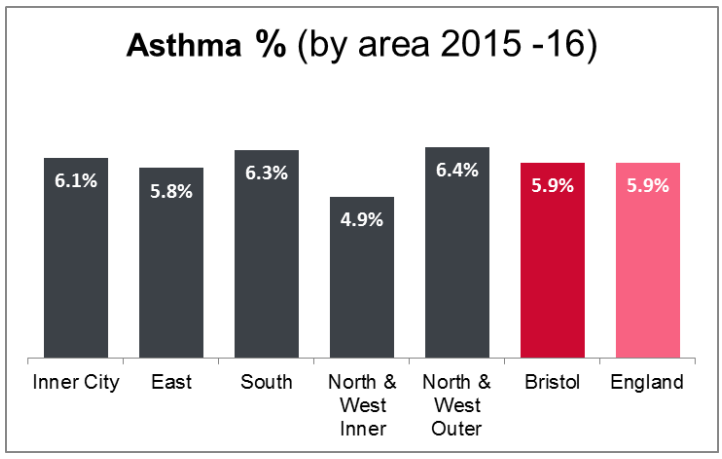



*Fig 8.6.3: Prevalence of Asthma; Source: NHS QOF 2015/16*

[232] 2013-15. Source: Public Health England, via PHOF, Nov 2016
[233] Source: NHS QOF data 2015/16 [Note – these are crude rates]
[234] For Childhood Asthma – see JSNA section **4.6 Chronic Childhood Illnesses**

GP register data[235] shows 29,385 Bristol patients with Asthma. As a prevalence rate this is 5.9% of all adult patients (England average: 5.9%). Rates vary across Bristol, with South and North & West outer much higher than North & West inner - fig 8.6.3 [Note – these are crude rates].

Data on hospital admissions for asthma[236] indicates that although the Bristol average in 2015-16 is broadly similar to last year, there is variation across the city with rates continuing to rise in the Inner City and North & West (outer) areas – fig 8.6.4.

Detailed analysis (using 3 year pooled data) shows this variation by individual wards – fig 8.6.5.

**Gender:** In 2013-2016 (3 year combined data) there were 1,500 emergency hospital admissions due to asthma. This was 660 males and 835 females.

Admission rates to hospital for COPD and for Asthma are both significantly lower in Bristol than England average[237].

### Further data

- Inhale - Interactive Health Atlas of Lung conditions in England Profile: https://fingertips.phe.org.uk/profile/inhale

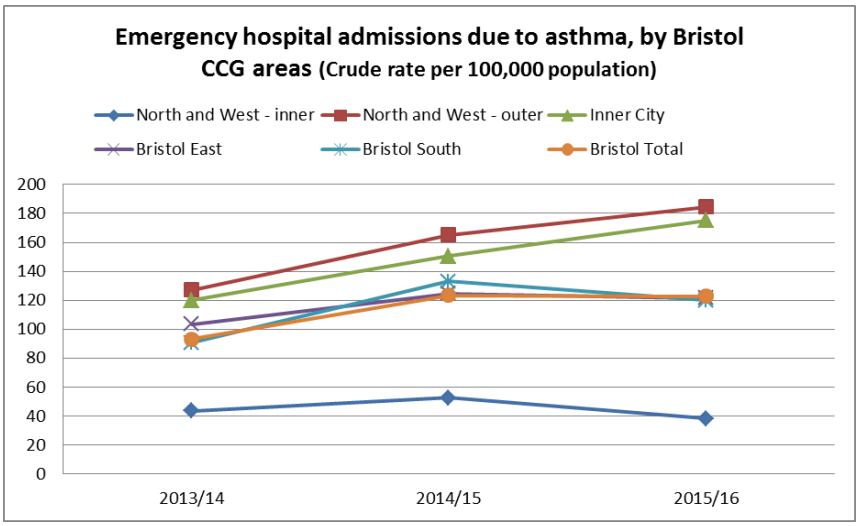



*Fig 8.6.4: Asthma admissions by CCG locality area; Source: Hospital episode statistics, Supplied by Public Health Knowledge Service, 2016*

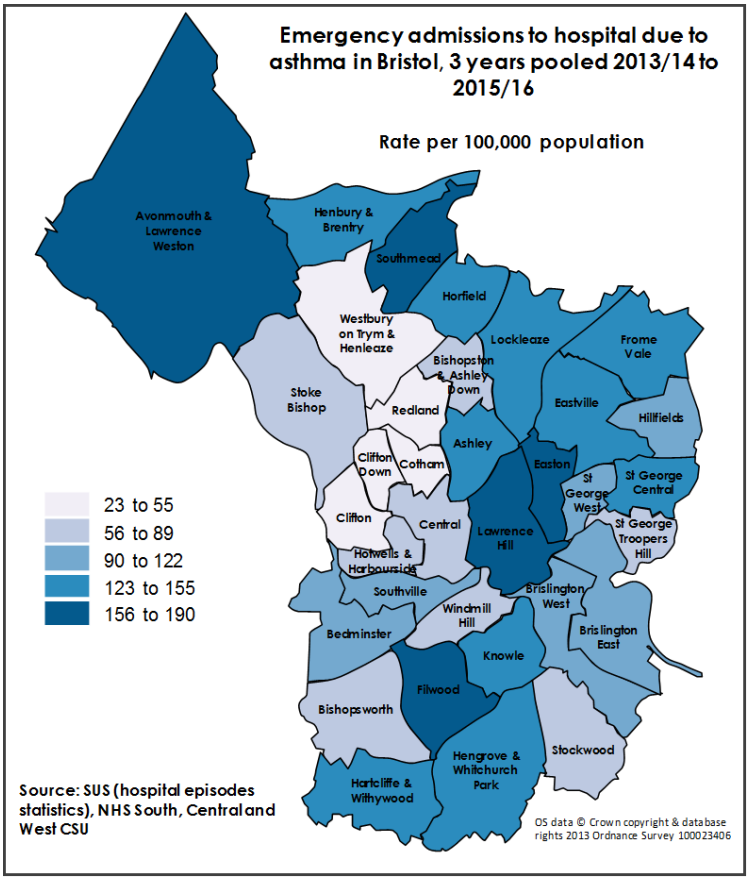



*Fig 8.6.5: Asthma admissions by ward, 2013/14 – 2015/16 Source: Hospital episode statistics, Supplied by Public Health Knowledge Service, 2016*

[235] Source: NHS QOF data 2015/16
[236] Emergency admissions to hospital due to asthma in Bristol, crude rate per 100,000 population, 2013/14 to 2015/16
[237] Per 1,000 population, 2012/13 – See Interactive Health Atlas of Lung Conditions

## 8.7 Liver Disease

Most liver disease is due to alcohol, obesity and viral hepatitis, and is largely preventable.

Rates of early death from liver disease in Bristol (19.8 per 100,000) are broadly similar to the England average (18 per 100,000)

**Gender:** Bristol rates of early death from liver disease are over twice as high in men than women. Male early deaths due to liver disease (28.5 per 100,000) are significantly above England (23.7) whilst female early deaths (11.1 per 100,000) are similar to England (12.5) – fig 8.7.1.

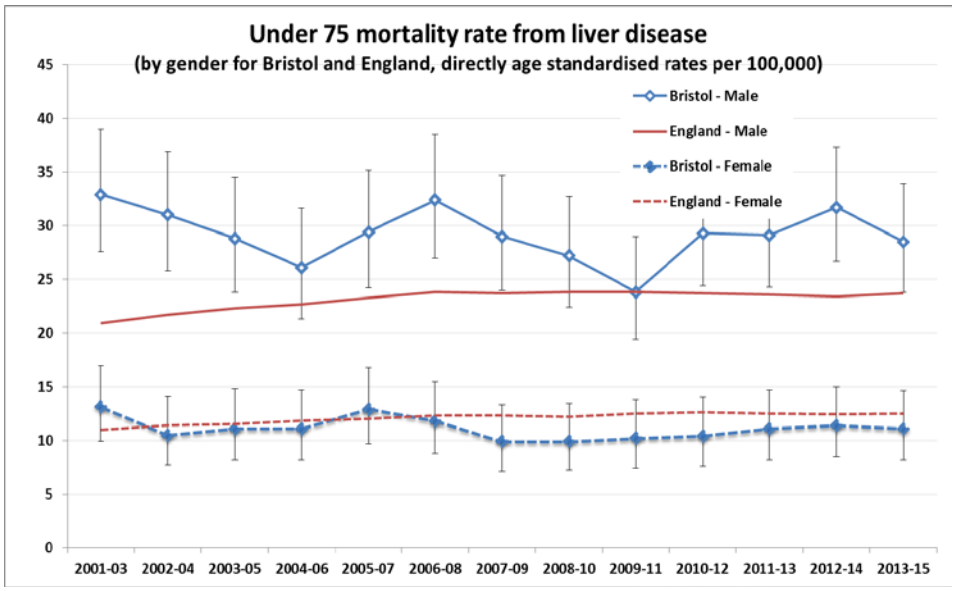



*Fig 8.7.1: Early deaths due to liver disease, (Source via PHOF, Nov 2016)*

### Hospital admissions

Hospital admission rates[238] for liver disease are significantly higher than England, due to higher rate for men. Rates of alcohol-specific hospital admissions are significantly higher than England for both men and women.

In Bristol, over the 3 years 2013/14 to 2015/16, there were 1710 hospital admissions due to liver disease (1130 males and 580 female). Liver disease admission data for the last 3 years by ward shows variation across the city. Trend data by CCG locality (fig 8.7.2) show that crude rates have risen in some areas, and are now highest in Bristol South, but rates have decreased in the Inner City[239].

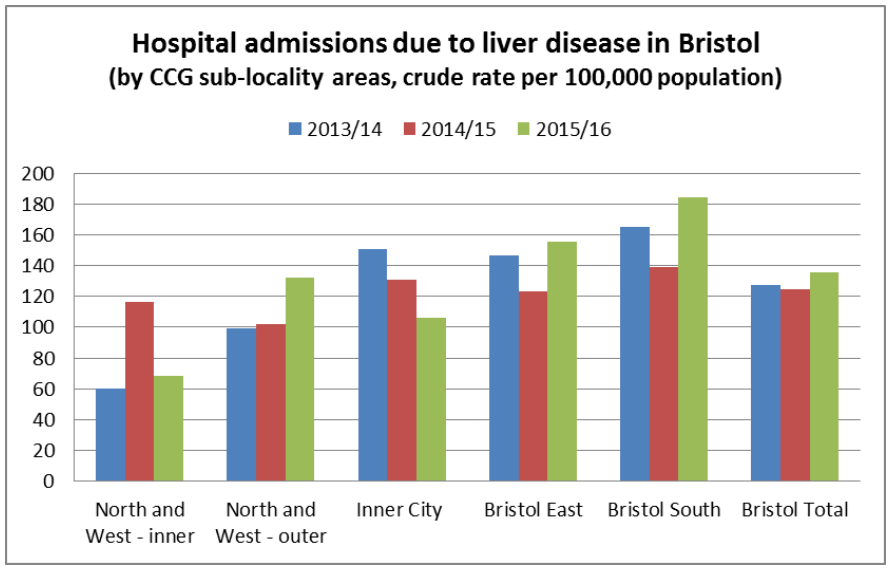



*Fig 8.7.2. Rate of hospital admissions for liver disease, 2013/14 to 2015/16*

### Further data

- Liver Disease Profiles: https://fingertips.phe.org.uk/profile/liver-disease

[238] 2014/15 – See Liver Disease Profile
[239] SUS Hospital episodes data, via Bristol Public Health Knowledge Service (2016)

## 8.8 Musculoskeletal (MSK)[240]

Musculoskeletal (MSK) conditions are those affecting the nerves, tendons, muscles and supporting structures (eg spinal discs). They are the leading cause of disability in England[241], accounting for 24% of all years lived with disability (YLD)[242]. Within this, low back and neck pain accounted for 18% of all YLD. The disability due to MSK disorders is expected to rise further with increases in obesity and sedentary lifestyles, which are significant risk factors[243], alongside an ageing population.

The impacts of MSK conditions are significant as sufferers can live with them for many years, resulting in a long-term burden of pain and impaired functioning, and possibly mental health issues. There is also a substantial economic burden due to work days lost and healthcare costs. Also, only a small proportion of those with MSK conditions present to health services (eg only 20% of those with low back pain go to their GP[244]), so there are many more self-managing at home.

### Osteoarthritis

Modelled data using prevalence figures from Arthritis UK[245] applied to the 45+ population estimates that 16,000 people in Bristol have hip osteoarthritis (10.8% of people 45+) and 26,500 have knee osteoarthritis (17.8% of 45+).

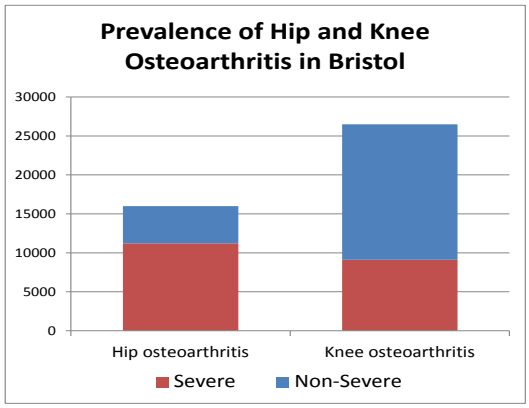



*Fig 8.8.1 Estimated population prevalence of osteoarthritis Source: BCC Performance, Information & Intelligence using Arthritis UK estimates*

### Rheumatoid arthritis

Data from GP registers[246] shows there are 2,300 Bristol patients (16+ years) with rheumatoid arthritis. This is 0.57% of all patients, lower than the national prevalence of 0.73%. This is to be expected due to Bristol's younger population profile.

### Long term back and joint problems

8.6% of Bristol patients report having a "Long-term back problem" (slightly lower than 9.9% nationally)[247], and 11.9% of Bristol patients reported having "Arthritis or long-term joint problem" (slightly lower than 12.8% nationally).

### ESA claimants due to musculoskeletal issues

12.2% of Bristol Employment and Support Allowance (ESA) claimants[248] are due to musculoskeletal conditions, which is lower than the national average of 13.4%.

### Further data

- See "Musculoskeletal Conditions" for NHS Bristol CCG in the "National General Practice Profiles": http://fingertips.phe.org.uk/profile/general-practice/data

[240] The data is extracted from the draft MSK Needs Assessment 2016 for Bristol, N Som and S Glos, supplied via S Glos Council
[241] Global Burden of Disease study, 2013
[242] http://vizhub.healthdata.org/gbd-compare/england via Nottingham JSNA 2016
[243] Arthritis UK www.arthritisresearchuk.org/
[244] NICE (2009) Low back pain in adults:, via Nottingham JSNA 2016
[245] 148,400 people 45+, applied to statistical model via www.arthriti/sresearchuk.org/
[246] NHS QOF data 2014/15, 16 and over
[247] GP patient survey, Dept of Health, 2014-15
[248] Work & Pensions Longitudinal Study, DWP via NOMIS, Nov 2015

## 8.9 Neurological conditions

There are many conditions within the term “neurological conditions”, including (but not limited to) [249]:

Epilepsy; Central nervous system infections; Motor neurone disease and Spinal muscular atrophy; Multiple sclerosis; Neuromuscular diseases; Sleep disorders; Traumatic brain and spine injury; Tumours of the nervous system; Headaches and migraine.

Rates of emergency admissions to hospital[250] for all Neurological conditions are significantly higher in Bristol (3,971 per 100,000) than England (3,410).

### 8.9.1 Epilepsy

GP register data indicates there are over 3,000 adults with epilepsy in Bristol[251]. This is 0.76% of all adult patients (England average: 0.80%).

Rates of emergency admissions to hospital[252] with a primary diagnosis of epilepsy are significantly higher in Bristol (137 per 100,000) than England (121) – fig 8.9.1. Rates for admissions with a “mention of epilepsy diagnosis” are also significantly higher.

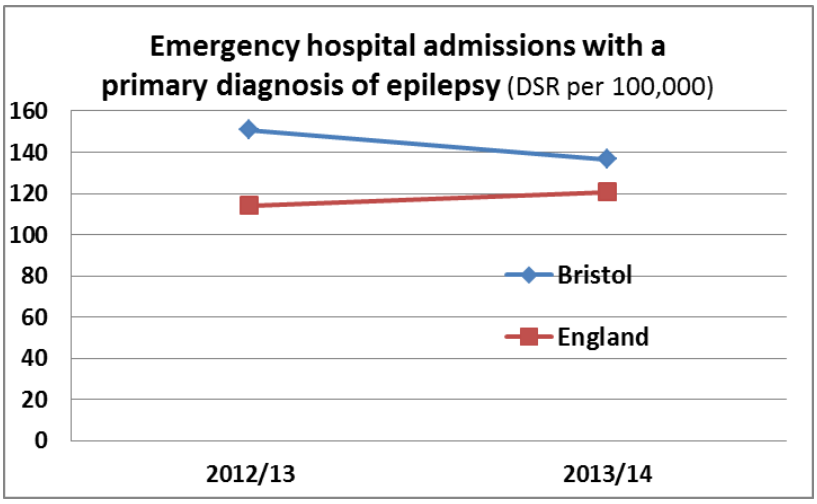



Fig 8.9.1 Emergency hospital admissions for epilepsy.
Source: Hospital Episode Statistics via PHE Neurology Profile

### Further data

- Neurology Profiles – indicators on Neurology services; Epilepsy care; and Emergency hospital admissions for other neurological conditions: http://fingertips.phe.org.uk/profile-group/mental-health/profile/neurology

[249] See Neurology Profiles for more
[250] DSR for people 20+, 2013/14 – Source: Health and Social Care Information Centre
[251] Source: NHS QOF 2015/16
[252] DSR, 2013/14 – see Neurology Profiles

## 8.10 Preventable mortality

Public Health England defines preventable mortality as death that could potentially be avoided by public health interventions[253].

This includes tuberculosis, Hepatitis C, HIV/AIDS, some cancers, diabetes mellitus, alcohol related diseases, illicit drug use disorders, ischaemic heart disease, deep vein thrombosis (DVT), aortic aneurysm, influenza, COPD, transport accidents, injuries, suicide and self-inflicted injuries and homicide/assault.

Using this definition, over the 3 years 2013-15 there were over 2,000 "preventable deaths" in Bristol (around 675 per year). This is a preventable mortality rate of 206.2 deaths per 100,000, which is consistently higher (worse) in Bristol than the England average (184.5 per 100,000). However, preventable mortality in Bristol is significantly better than in most core cities (fig 8.9.2)

**Gender:** Rates for preventable mortality are significantly higher in men than women. Male preventable mortality rates in Bristol (261.8 per 100,000) are significantly above England average for men (232.5). Bristol female preventable mortality rates (151.6 per 100,000) are also significantly higher than national average (139.6) – see fig 8.9.1.

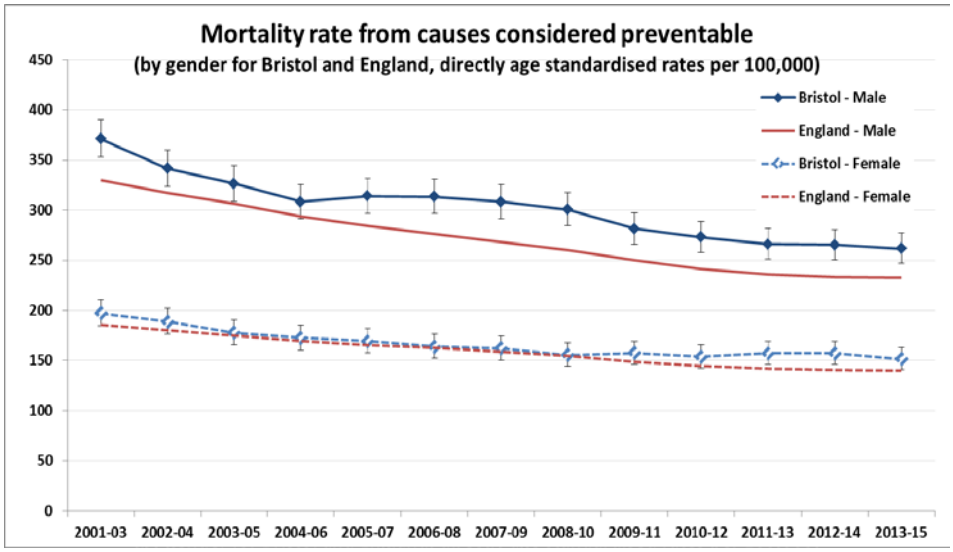



*Fig 8.9.1 Rates of deaths from causes considered preventable, by gender for Bristol and England average (Source via PHOF, Nov 2016)*

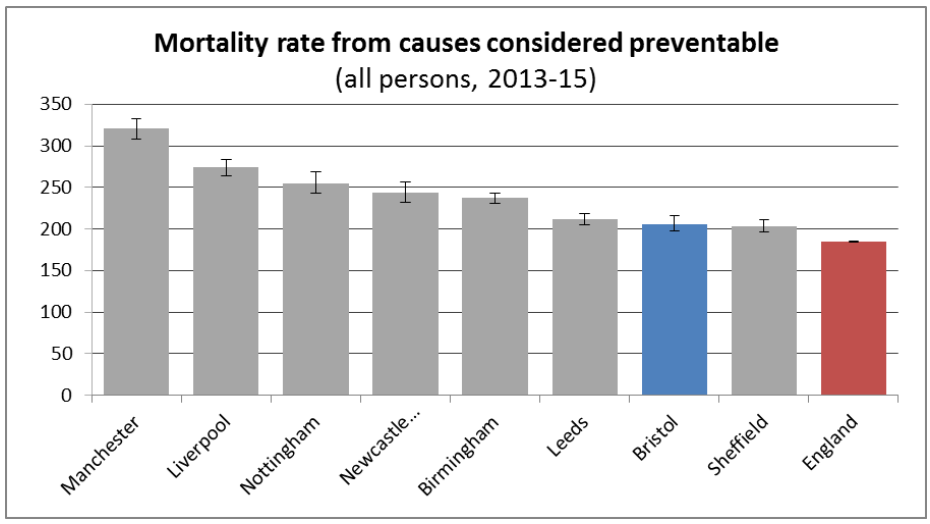



*Fig 8.9.2 Core city comparison for preventable mortality, 2013-15 (Source via PHOF, Nov 2016)*

[253]The trend data was revised in 2016, as the ONS definition of "preventable mortality" was updated slightly- see PHOF 2016: https://www.ons.gov.uk/file?uri=/aboutus/whatwedo/statistics/consultationsandsurveys/allconsultationsandsurveys/reviewofavoidablemortalitydefinition

# Section 9

# Mental Health

## Summary

Mental health conditions are one of the biggest contributors of years lived with disability in England (18.4%)[254]. They are very common, often of long duration, and have adverse effects on many areas of people's lives. Mental health problems often begin early in life and cause disability when those affected would otherwise be at their most productive (unlike most physical illnesses).

Improved mental health is associated with a range of better outcomes. These include better physical health & life expectancy, better educational achievements, increased skills, reduced health-risk behaviours such as smoking & alcohol misuse, reduced suicide deaths, reduced anti-social behaviour & criminality, improved employment rates & productivity, and higher levels of social interaction and participation.

**Further data** - via "Mental Health, Dementia and Neurology" profiles: http://fingertips.phe.org.uk/profile-group/mental-health

### Depression

- 35,200 Bristol patients (8.8%) have a diagnosis of depression, above the England average (8.3%), and is highest in Bristol North & West (outer) at 10.7%.
- 5,200 patients (1.3%) had a new diagnosis of depression in 2015-16, above England average (1.1%)

### Self-harm

- In Bristol during 2015-16 there were 1,345 emergency admissions for self-harm; 869 females and 476 males
- Waiting times for self-harm patients are at their highest since the Register started in 2010.
- There is a correlation between higher rates of self-harm and people living in more deprived areas.

### Suicide

- Bristol's suicide rate is significantly higher than England average. The majority of suicides are men, similar to nationally. However, the suicide rate for women in Bristol is now significantly higher than nationally and rising.
- The incidence of suicide and undetermined death is highest amongst people in the most deprived areas.

### Physical health of people with mental health issues

- Excess mortality rate in adults with serious mental illness is higher in Bristol than nationally.

### Mental wellbeing

- 6.8% of Bristol residents reported a low life satisfaction score, significantly more than nationally (4.8%), 2014/15.
- Local data shows 13% have "below average mental wellbeing", but significantly more in deprived areas (20%).

### Emotional health and wellbeing of children & young people

- Young people report lower life satisfaction than nationally.
- Almost 10% of children and young people may be experiencing emotional health problems at any time – estimate 7,100 children and young people (5-17 years)
- Self-harm hospital admission rates for young people (10-24 year olds) exceed the England average.

### Perinatal mental health

- Up to one in five women and one in ten men are affected by mental health problems in the perinatal period.

[254] Global Burden of Disease 2013 http://vizhub.healthdata.org/gbd-compare/england/

## 9.1 Depression

Depression is one of the most widespread psychological disorders. It is estimated that 4-10% of people in England will experience depression in their lifetime[255].

Recorded cases on GP registers in Bristol show that 35,200 Bristol patients (over 18) have an *unresolved record of depression in their patient record*[256] (2015-16). **Correction** – this is not the number of *new* diagnoses, as indicated in JSNA 2015.

Depression affects 8.8% of all adult patients (NHS QOF 2015-16), which increased from 7.6% (30,100 patients) the previous year (and 7% the year before). Bristol has a higher rate than the England average (8.3% of patients, 2015-16), although the rate nationally is also rising. [Note – these are crude rates]

Within Bristol, the highest prevalence of depression is in North & West (outer) (10.7%), South Bristol (9.7%), and Inner City (9.5%), which all rose sharply in the last year - fig 9.1.1. However, North & West inner has significantly lower (5.8%) recorded depression, although rates increased as across the City.

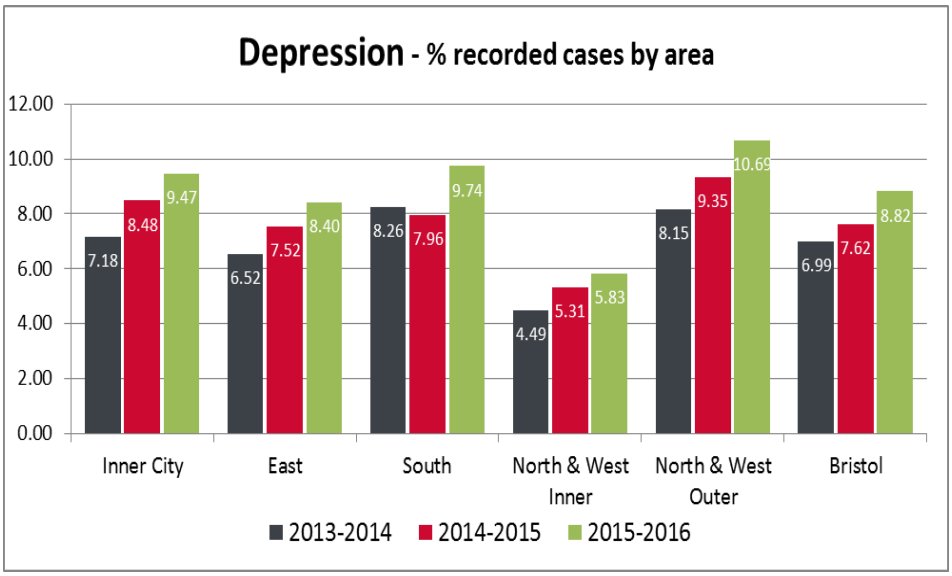



*Fig 9.1.1: % Depression by Bristol CCG locality area 2013-14 to 2015-16*
*Source: NHS Quality Outcomes Framework (QOF) 2015-16*
*Supplied by BCC Performance Information & Intelligence, Nov 2016*

### New diagnoses of depression

Data[257] on "patients (18+) with depression recorded on practice disease registers for the first time" indicates that 5,200 patients in Bristol received a new diagnosis of depression in 2015-16. Provisionally, this is 1.3% of all Bristol CCG patients, slightly higher than the national average (1.1%) but no longer rising.

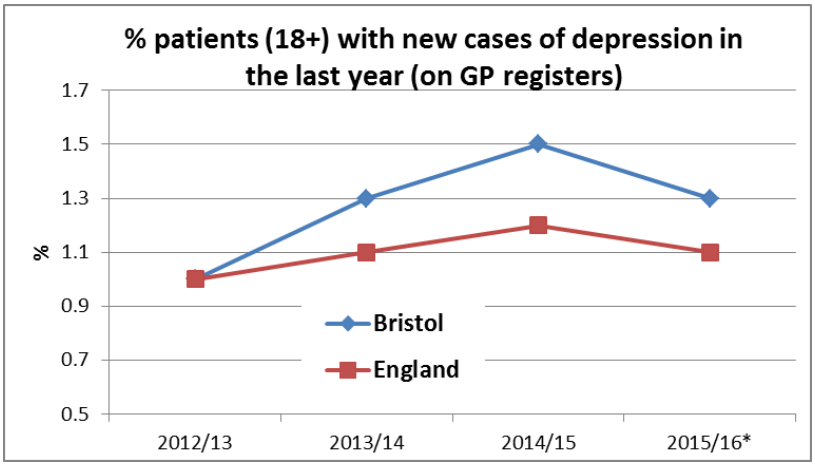



*Fig 9.1.2: % Incidences of new cases of depression (Bristol CCG patients)*
*Source: NHS Quality Outcomes Framework (QOF) via Community Mental Health Profiles [*Data for 2015/16 added directly from QOF, not yet in Community Mental Health Profiles]*

[255] McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (eds), 2009. *Adult Psychiatric Morbidity in England 2007: results of a household survey*. NHS Information Centre for Health and Social Care: www.hscic.gov.uk/pubs/psychiatricmorbidity07

[256] Diagnosed on or after 1 April 2006. Source: NHS Quality Outcomes Framework (QOF) 2015/16 (Oct 2016). Note - QOF data shows conditions recorded on GP registers (as a crude rate, divided by number of patients). Not all patients are diagnosed.

[257] Source: NHS Quality Outcomes Framework (QOF), via Community Mental Health Profiles http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp

## 9.2 Self-harm

Women and men of all ages[258] and backgrounds do things that are harmful to themselves, especially during times of pressure and emotional distress. Self-inflicted injuries caused by cutting, burning, biting, thumping oneself or another object, swallowing objects or substances and overdosing, are examples of what is usually termed self-harm. Whilst much self-harm will go on unrecorded by professionals, many individuals require treatment for self-inflicted injuries in a hospital.

Self-harm is a major public health concern. It accounts for an estimated 200,000 Emergency Department attendances annually in England and up to a third of these individuals go on to repeat self-harm in the next 12 months.

Self-harm is also associated with suicide. A fifth of all suicides have attended A&E for self-harm in the year prior to their deaths and over a third have a history of self-harm. Therefore self-harm attendances in hospitals are an important opportunity for interventions to prevent suicide. *Hospital admissions* for self-harm is also an indicator for population mental health.

In Bristol during 2015-16 there were 1,345 emergency admissions for self-harm; 869 by females and 476 by males.

Fig 9.2.1 shows Bristol hospital admission *rates* for intentional self-harm (all ages, rates per 100,000) by gender:

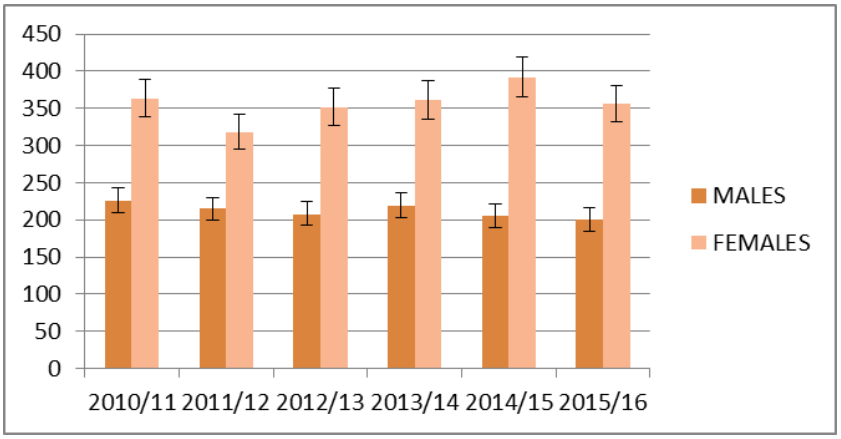



*Fig 9.2.1: Source Hospital Episode Statistics via Secondary User Service (SUS) – collated by Bristol Public Health Knowledge Service*

### Bristol data

In 2010 Bristol Public Health commissioned Bristol University to develop a Self-harm Surveillance Register[259]. This records detailed information on patients presenting to hospital for self-harm. It should be noted that around a third of those presenting to Bristol's Emergency departments were treated for relatively minor injuries and discharged without admission therefore they are not included in the admission statistics.

Data from the Register shows that the proportion of patients receiving a psychosocial assessment was 65.4% in 2015. Compared to 2012, this represents a 17% increase, which is a significant change in practice. A likely explanation is the recent expansion of liaison psychiatry services at the BRI.

Rates of self-harm vary considerably across Bristol. There is a link between self-harm and areas of deprivation (fig 9.2.2).

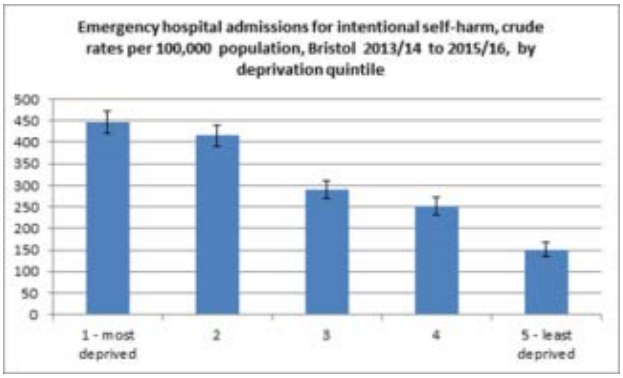



*Fig 9.2.2 Source: Bristol Public Health Knowledge Service*

[258] For Young People, see **9.6.2 Self-harm in Young People**

[259] A database maintained by the Emergency Department of the Bristol Royal Infirmary, part of University Hospitals Bristol NHS Foundation Trust

## 9.3 Suicide Rates

It is estimated that around 1 million people will die by suicide worldwide each year and a person may be more likely to become suicidal if they have a mental health condition. People in contact with mental health services represented 37% of deaths by suicide (in Bristol, 2001-14); so 63% were not known to services and may have been exposed to a range of other risk factors.

Reduction of the suicide rate is a continuing objective in local and government strategies.

During 2013-2015, Bristol's average mortality rate[260] from suicide and undetermined death was 12.8 per 100,000 population. This is now significantly higher than the England average of 10.1 per 100,000 and highest of Core Cities. The number of suicides in Bristol was 147 in this period.

**Gender:** The majority of these suicides, 102, were males. This is a rate of 17.9 per 100,000, broadly similar to the England average (15.8). However, although the number of female suicides (45 in Bristol) is lower than for males, the female rate in Bristol (7.7 per 100,000) is significantly higher than the England average for women (4.7) and appears to be rising. See fig 9.3.1.

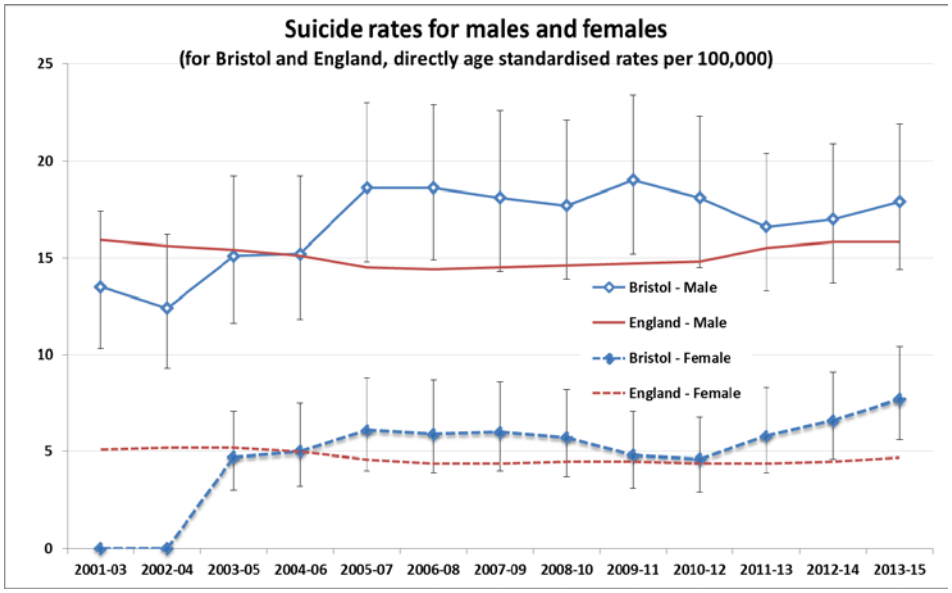



*Fig 9.3.1: Suicide rate per 100,000 for males and females (via PHOF, 2016)*

Men in their mid-life (35-64 years) have the highest rates of suicide, which mirrors the national picture but is significantly higher for this group in Bristol[261]. Compared to other English Core Cities, the overall suicide rate is broadly similar. However, for females the suicide the rate in Bristol is significantly higher than in several Core Cities.

The incidence of suicide and undetermined death in Bristol is highest amongst people in the most deprived areas – fig 9.3.2.

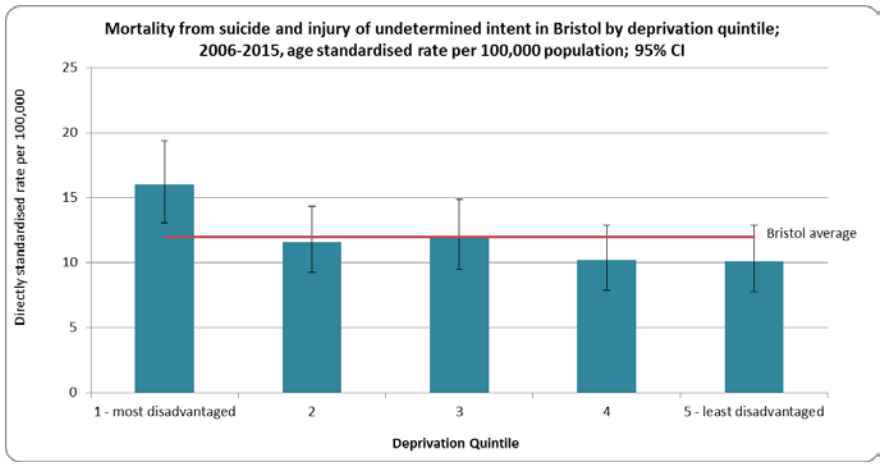



*Fig 9.3.2: Bristol suicide rate 2006-15 by deprivation quintile*
*Source: Primary Care Mortality Database 2015, via Bristol Public Health*

[260] Directly standardised rate. ONS via Public Health Outcomes Framework, Nov 2016 www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000044/pat/6/par/E12000009/ati/102/are/E06000023/iid/41001/age/285/sex/1

[261] 5 year average: 2010-2014, Crude rate per 100,000. Source: Public Health England Suicide Profile 2014, using ONS population estimates

## 9.4 Physical health of people with poor mental health

Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. ***(The Five Year Forward View for Mental Health*** *Mental Health Task Force, 2016)*

There can also be a lack of physical healthcare for people with mental illness and fear of stigma and discrimination may prevent people with poor mental health seeking help for physical symptoms.

Data on "Excess mortality rate in adults with serious mental illness" shows the ratio (as a percentage) of the "observed number of deaths in adults in contact with secondary mental health services to the expected number of deaths in that population based on age-specific mortality rates in the general population of England". The data for 2013-14 indicates that the rate in Bristol is significantly higher than the national rate. The rate in Bristol is high but broadly similar to other core cities.

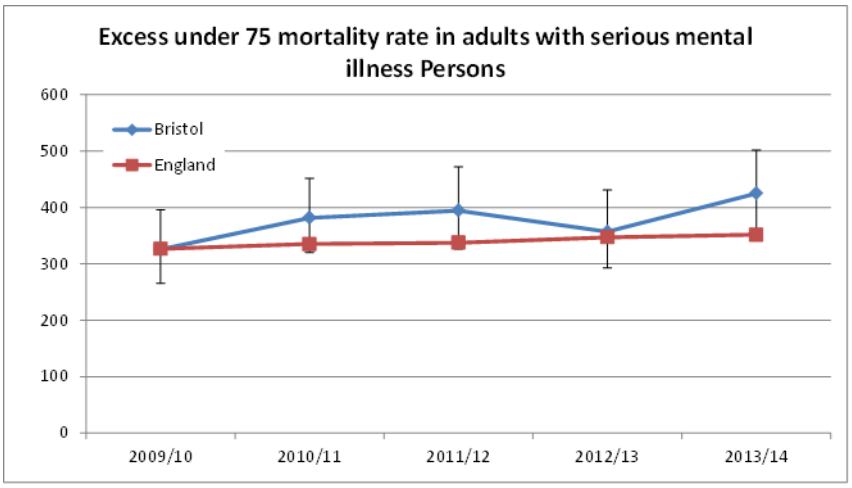



Fig 9.4.1. Source: Health and Social Care Information Centre (HSCIC) via PHOF (extract Aug 2016)

### Further data

- Community Mental Health Profile for NHS Bristol CCG: http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp

## 9.5 Mental Wellbeing

Emotional health and wellbeing covers a spectrum of activities and behaviours. Wellbeing is closely linked with the physical, cultural and global environment and includes personal, interpersonal and collective needs, which influence each other.

Positive emotional health & wellbeing is essential for healthy development and good physical health, and can be defined as:

*"…not simply the absence of disorder but a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"*.[262]

This section looks mainly at low mental wellbeing. One approach that seeks to improve wellbeing is Social Prescribing[263], which is a way of linking patients visiting their GP surgery with sources of support within the community. It provides GPs with non-medical referral options, such as social or activity-based groups.

6.8% of Bristol residents report low life satisfaction scores[264], significantly more than England average (4.8%), see fig 9.5.1, though similar to other core cities.


*Fig 9.5.1: Respondents with low life satisfaction scores, ONS via PHOF 2016*

Locally, the Bristol Quality of Life survey 2015-16 reports74% of people satisfied with life, which has been stable for several years. However, in deprived areas only 59% of people report this. By ward the range is from 87% in Westbury on Trym & Henleaze to only 59% in Hartcliffe & Withywood. Only 39% of disabled people are satisfied. There is no difference by gender.

More detailed QoL data on positive mental health and wellbeing uses the "Short Warwick-Edinburgh Mental Wellbeing Scale"[265]. A low score reflects a lower level of mental wellbeing. Only 13% of respondents have below average mental wellbeing in 2015-16, an improvement from 18% in 2013-14. However, significantly more people in deprived areas have low mental wellbeing scores (20%). There is significant and distinct geographical variation, such as only 35% of people in Filwood with below average mental wellbeing, but only 5% "next door" in Knowle – fig 9.5.2.

By equality group, 40% of Disabled people reported below average mental wellbeing (the highest proportion), and 27% of Lesbian, gay and bisexual people.

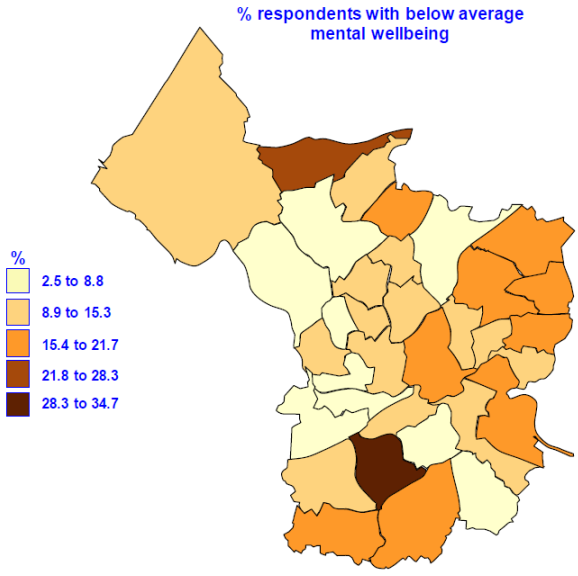



*Fig 9.5.2: Source: Bristol Quality of Life 2015-16*

[262] World Health Organisation (2010) *Mental Health: strengthening our response*.
[263] Also known as: Pathways to Health / Ways to Wellbeing / Healthy Alternatives.
[264] Score of 0-4 out of 10; Source: ONS Annual Population Survey 2014-15
[265] Used as part of the Bristol Quality of Life (QoL) survey (2013-2015) www.bristol.gov.uk/qol. Responses to 7 questions are scored 1-5.

## 9.6 Emotional Health and Wellbeing of Children & Young People

Emotional or mental health and wellbeing of children & young people is a priority area for Bristol and BCC is refreshing the 2014/15 needs assessment[266] which will inform the children and young people's section of the Mental Health and Wellbeing Strategy in 2017.

Overall, in the WAY survey[267], 16.7% (of 15yr olds) reported "low life satisfaction", significantly worse than nationally (13.7%). A further measure is the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), also asked in the WAY survey. In Bristol, the mean score (for 15 yr olds) was 46.9, again significantly worse than the England average (47.6). (*Note – Public Health England have noted some concerns regarding the quality of this data*).

Bristol City Council also conducts a "Pupil Voice" survey directly in schools, including WEMWBS questions to assess positive mental wellbeing. 2300 young people at Secondary school (years 8 and 10) took part in 2015. 27% of boys had a low or medium low wellbeing score, and 42% of girls. This shows that girls are reporting worse mental wellbeing than boys, but large numbers of both score low for mental wellbeing.

Also, over 3300 children in Primary school (years 4 and 6) were surveyed in Pupil Voice. 13% of boys and 12% of girls had low or medium low scores that indicate poor mental wellbeing[268].

The forthcoming needs assessment and strategy will expand upon this data and develop a plan to improve the mental wellbeing in children and young people.

### 9.6.1 Prevalence of children with mental health disorders

It is estimated that 9.6% of children and young people (aged 5-16) in Bristol may be experiencing emotional health problems at any one time[269], including:

- 3.7% have an emotional disorder (e.g. anxiety, depression, and obsessions)
- 5.8% a conduct disorder (e.g. troublesome, aggressive, antisocial behaviours)
- 1.6% a hyperkinetic disorder (inattention and over-activity)
- 1.3% a less common disorder (e.g. autism, tics, eating disorders, selective mutism)

(NB many have more than 1 disorder, so figures do not add to 9.6%)

When these national prevalence estimates are applied to Bristol's estimated population of 5-16 year olds in 2015, in the region of 5,400 children and young people[270] have some level of emotional ill health likely to require support from trained workers However, these estimates (table 9.6.1) are likely to underestimate the true level of need. Diagnoses of mental health disorders increase with age through childhood and are more common in boys for all conditions except emotional disorder and self-harm.

Most data available on service use reflects services for children and young people with the most severe mental health needs; e.g. those being admitted to hospital, attending emergency

[266] Emotional Health and Wellbeing In Bristol Needs assessment (Aug 2015) via www.bristol.gov.uk/jsna
[267] What About YOUth survey 2014/15; https://fingertips.phe.org.uk/profile/what-about-youth/
[268] For Primary children the Stirling wellbeing scale was used, similar to WEMWBS but validated for use in younger children.
[269] ONS (2005); Mental Health of Children and Adolescents in Great Britain (***Note*** – *Public Health England have noted some concerns regarding the quality of this data*, and the underlying estimates are being updated nationally)
[270] National prevalence applied to 2015 ONS Mid-year population estimates for Bristol

services, or accessing Tier 3 or 4 CAMHS services. The data on children with lower levels of need is not available, nor is data on long term outcomes for children with such needs.

### 9.6.2 Mental health disorders in young people age 16 and 17

There are an estimated 1,700 young people (16-17 yrs) with common mental disorders[271] (table 9.6.2). Not specified mental health disorders (also known as "mixed anxiety and depression"), are most common, affecting an estimated 750 16-17 yr olds.

**Gender:** Mental health disorders are up to three times more prevalent in women than men. The overall prevalence estimate for all mental health disorders is 10% in males, 28.2% in females and 18.9% overall.

| Condition | All children (5-16) | | |
|---|---|---|---|
| | Boys | Girls | All |
| Conduct disorders | 2200 | 1100 | 3200 |
| Emotional Disorders | 900 | 1200 | 2000 |
| Hyperkinetic Disorders | 700 | 100 | 900 |
| Other conditions (eg Autism, eating disorders, tics, mutism) | 600 | 200 | 800 |
| **Any mental health problem** | **3300** | **2100** | **5400** |

*Table 9.6.1 Estimated prevalence of mental disorders, 5-16 years, by sex*
*Note – figures may not sum due to rounding to nearest 100*

| | General Anxiety Disorder | Depress-ive Episodes | Phobias | Obsessive Compulsive Disorder | Panic Disorders | CMD NOS* | Any |
|---|---|---|---|---|---|---|---|
| Male | 175 | 40 | 60 | 55 | 20 | 260 | 460 |
| Female | 390 | 170 | 240 | 105 | 100 | 495 | 1235 |
| All (16-17 yrs) | 570 | 210 | 300 | 160 | 110 | 750 | 1700 |

*Table 9.6.2 Estimate of 16-17 year olds with Common Mental Disorders*
*Source: Adult Psychiatric Morbidity Survey, 2014 [Note – figures are rounded]*
** CMD NOS stands for common mental disorder not otherwise specified. In previous waves this category was referred to as 'mixed anxiety/depression'.*

### 9.6.3 Self-harm in Young People[272]

500 young people (10-24 years) were admitted to hospital as a result of self-harm in 2014/15. This is a rate of 514 per 100, 000, significantly higher than England (398 per 100,000), and the rate in Bristol has been higher England over the last 3 years (fig 9.6.3). Self-harm in young people will be addressed in the Emotional Health and Wellbeing Strategy.

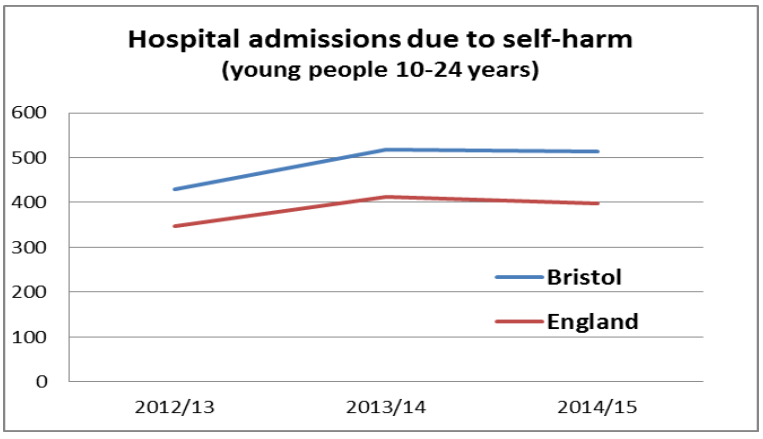



*Fig 9.6.3 Hospital admissions due to self-harm (young people 10-24 years) via Bristol Child Health Profile, 2016*

[271] Source: Adult Psychiatric Morbidity Survey 2014; Prevalence estimates for 16-24 year olds applied to the 2016 population estimates of 16-17 year olds

[272] Further details in "4.11.2 Injuries in young people"

**Gender:** Nationally, levels of self-harm are higher among young women than young men.

### 9.6.3 Risk factors for poor mental health

An individual's mental health can be influenced by events and circumstances before their birth. There is a strong body of evidence to show the importance of attachment by babies to their primary caregiver for subsequent emotional development. Post-natal depression among new mothers can contribute to sub-optimal attachment. Negative experiences within the home or at school can have a damaging effect on development. Supportive parenting, a secure home life and a positive learning environment in schools are key protective factors in building and protecting mental wellbeing in young children.

Risks to mental health include
- family violence or conflict,
- negative life events
- a low sense of connection to schools
- a parent with a mental illness or substance use disorder
- poor housing or living conditions

The table below (fig 9.6.3) is a snapshot of "measurable" risk factors and the current rate for these factors in Bristol and nationally.

| Risk Factor | Bristol | England |
|---|---|---|
| Children under 16 in poverty: % of dependent children under 16* (2014, DWP) | 23.2% (number: 18,900) | 20.1% |
| % children under 15 who provide unpaid care (2011 Census) | 1.1% (number: 860) | 1.1% |
| Family Homelessness (rate per 1 000 families) (2014/15, DCLG) | 3.5 | 1.8 |
| Lone parents: % of households that have lone parents with dependent children (2011 Census) | 8.2% (number: 14,900) | 7.1% |
| Families out of work: % of households with dependent children where no adult is in employment (2011 Census) | 5.2% (number: 9,500) | 4.2% |
| Long term illness in 15 yr olds: % with a long term illness, disability or medical condition (2014/15 WAY survey) | 13.5% | 14.1% |
| Domestic abuse: incident rate per 1,000 population (2014/15 ONS) | 17.3 | 20.4 |
| Parents in drug treatment: rate per 100,000 children (2011/12, PHE) | 241.4 | 110.4 |

*Fig 9.6.3 Risk factors (and rates) for developing mental health problems*[273]
**This indicator updated in line with new data*

### 9.6.4 Further data

- A range of indicators on emotional wellbeing, plus bullying and "lifestyle" choices, are in the What About YOUth (WAY) survey 2014/15. https://fingertips.phe.org.uk/profile/what-about-youth/
- Children's and Young People's Mental Health and Wellbeing Profiling Tool – on risk, prevalence and services that support children with, or vulnerable to, mental illness. https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh
- Updated JSNA Chapter on "Mental health and wellbeing for children and young people" – Jan 2017

[273] Taken from the PHE Children's and Young People's Mental Health and Wellbeing tool: http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/

## 9.7 Perinatal mental health

During the "perinatal period" that lasts from conception to one year after birth, mothers are at greater risk of developing new mental health conditions such as depression and anxiety. They are also at greater risk of experiencing a worsening of existing psychiatric conditions or a recurrence of a former mental health illness. Up to one in five women and one in ten men are affected by mental health problems in the perinatal period[274]. Unfortunately, only 50% of these are diagnosed.

The potentially stigmatising effects of mental health illness can lead to reluctance to seek the treatment and support needed to support recovery and reduce harm.

Untreated and on-going perinatal mental health issues can affect the mother-infant emotional attachment and adversely affect child health outcomes that may last into adulthood.

### Perinatal Psychiatric Disorders

In 2015 there were 6,200 maternities in Bristol.

Rates (per 1,000 maternities) of new mothers with Perinatal Psychiatric Disorders are shown in table 9.7.1 below, along with estimates of how many women are affected locally:

| **Severe perinatal MH conditions** | **Rates** (per 1,000 maternities) | **Estimated numbers in Bristol** (2015) |
|---|---|---|
| Post-partum psychosis | 2 per 1000 | 12 |
| Chronic serious mental illness | 2 per 1000 | 12 |
| Severe depressive illness | 30 per 1000 | 186 |
| Mild / moderate depressive illness and anxiety states | 100-150 per 1000 | 620 - 930 |
| Post-traumatic stress disorder | 30 per 1000 | 186 |
| Adjustment disorders and distress | 150-300 per 1000 | 930 - 1860 |

*Table 9.7.1 Rates of Perinatal Psychiatric Disorder (per 1000 maternities)*
*Source: Royal College of Psychiatrists, 2012* www.rcpsych.ac.uk/pdf/perinatal_web.pdf
*Supplied via Bristol Public Health Knowledge Service, 2016*

The Confidential Enquiry into Maternal Deaths in the UK[275] shows that nationally suicide continues to be a leading cause of maternal death with psychiatric causes as a whole accounting for 25% of all maternal deaths or 3.7 deaths per 100,000 maternities. Nationally 101 women died from suicide during the perinatal period in 2009-13 and a further 58 died as a result of substance abuse [MBRRACE 2015].

[274] Royal College of GPs: www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

[275] MBRRACE 2015 / http://www2.le.ac.uk/departments/health-sciences/research/timms/projects/mbrrace-uk

# Section 10

# Older People

This section focuses on the health and social care issues of older people, but it should be noted that older people make a significant contribution to Bristol's society and economy as promoted by the annual Bristol "Celebrating Age Festival"[276]

## Summary points[277]

### Population

- There are 59,300 people aged over 65 in Bristol. This is 13.2% of the population, lower than the 17.9% nationally
- There are projected to be 7,700 more people 65 & over by 2024, a 13% rise (and potentially a 44% rise by 2039).
- For people 85 & over, projected to be 1,100 more by 2024, a 12% rise (but potentially an 84% rise by 2039).
- In recent years most of the 65+ population rise has been in wards in the Bristol North & West (inner) area, which is different to other age groups

### Older People's Health

- It is estimated that there are around 4,100 people over 65 living with dementia in Bristol, with around 69% have a GP diagnosis (England 67%)
- The number of people with dementia (65+) is projected to rise by 14% by 2024, and by 66% by 2039 (due to the high projected rise in people 85+)
- We can reduce the risk of dementia by leading a healthy lifestyle - not smoking, eating well, and being active.
- Bristol's hospital admission rates following a fall (in people 65+) are significantly higher than the England average, but are now showing signs of reducing
- Rates of hip fractures (in people 65+) are showing signs of reducing and are no longer higher than the England average
- There were 289 "excess winter deaths" in Bristol (2014/15), a significant rise in the last year, the same as nationally. In particular the ratio of excess winter deaths for women rose sharply (2 out of 3 excess winter deaths were women).
- The cost of excess winter emergency hospital admissions in Bristol was estimated to be at least £750,000 (2014).
- More people in Bristol are able to die at home than nationally.

### Social care and wider determinants

- There are 15,000 income-deprived older people[278] in Bristol, which is 20% of all older people (over 60) in Bristol
- 4,240 adults received a community-based social care support service (Community Support Service) at end 2015-16: 2,270 older people, which has been stable, and 1,970 people 18-64 years, which has been rising
- A rise in the number of older people in BCC-funded care homes or extra care housing, but reduction in those receiving home care services (at end 2015-16)
- There are estimated to be between 6,300 and 11,400 older people who are socially isolated in Bristol[279]

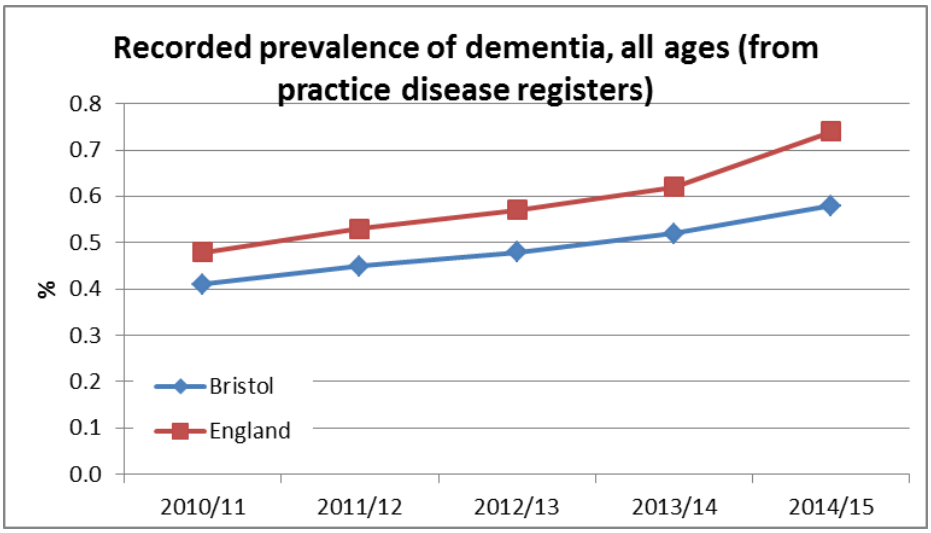
[276] https://celebratingagefestival.co.uk/#
[277] These cover all relevant Older People areas from throughout the JSNA sections.
[278] See section **5.2 Income deprivation**
[279] See section **5.16 Social Isolation**

## 10.1 Dementia

It is estimated that there are around 4,100 people over 65 living with dementia[280] in Bristol. Of this estimate, around 69% in Bristol have a recorded diagnosis of dementia (nationally this is 67%).

**2,830 people in Bristol have a diagnosis of dementia recorded by their GP[281].** This is 0.58% of all Bristol GP patients, but is rising – see fig 10.1.1. The Bristol rate is lower than the England average (0.74%), which may be linked to having a younger population. As a proportion of patients aged 65 and over, 4.5% in Bristol are recorded as having dementia, which is higher than England (4.3%).

NICE clinical guidelines on dementia[282] state that a blood test should be done as part of a "basic dementia screen to exclude potentially reversible or modifying cause for the dementia and to help exclude other diagnoses". In Bristol, 76.6% of diagnosed dementia patients have had this blood test, which is higher than England[283].




*10.1.1: Recorded prevalence of dementia; via Public Health Outcomes Framework, Aug 2016*

Although dementia is not a natural part of ageing, the biggest risk associated with the condition is age. At the age of 65 years, it is estimated that 1 in 50 people have dementia, but this rises to 1 in 5 for those aged 85 to 89[284].

However, we can reduce the risk of dementia by leading a healthy lifestyle. Choices that are good for the heart and circulation, such as not smoking, eating well, and being active, also lower the risk of dementia[285].

Projections estimate that the number of people aged over 65 in Bristol will increase by 13% by 2024, and by 44% by 2039[286]. The number of people with dementia aged over 65 is projected to rise by 14% by 2024, and by 66% by 2039[287]. This much higher rise is in large part due to the projected increase in the older age range (85+), who have much higher prevalence rates for dementia.

**Gender:** More women than men develop dementia as women live longer on average, but at any given age there is no significant gender difference. However, more women than men care for people with dementia. 60-70% of carers of people with

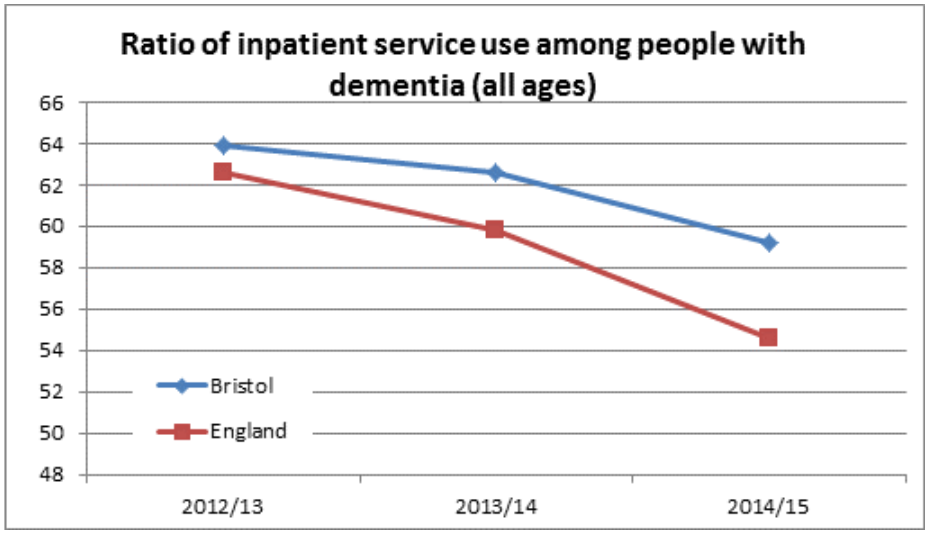
[280] Source: Estimated dementia prevalence (65+), NHS England, July 2016: www.england.nhs.uk/mentalhealth/dementia/monthly-workbook/
[281] QOF 2014-15, via Public Health Dementia Profile: http://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia
[282] https://www.nice.org.uk/guidance/cg42
[283] Quality Outcomes Framework (QOF) 2014/15, via Dementia Atlas. https://shapeatlas.net/dementia/#9/51.3555/-2.6807/l-btr/b-11H
[284] Alzheimer's Research UK, 2015
[285] www.alzheimersresearchuk.org/about-dementia/helpful-information/reducing-the-risk/
[286] ONS 2014-based Sub-national Population Projections - these are trend-based projections, which means assumptions for future levels of births, deaths and migration are based on observed levels. Projections become increasingly uncertain the further they are carried forward due to the inherent uncertainty of demographic behaviour.
[287] Prevalence rates from "Dementia UK: report into the prevalence and cost of dementia" (Alzheimer's Society, 2007) applied to ONS population projections. Supplied by Bristol City Council's Performance, Information and Intelligence service

dementia nationally are women. They report that this affects them economically (20% of working-age give up work or reduce their hours), physically (50%) and emotionally (62%)[288].

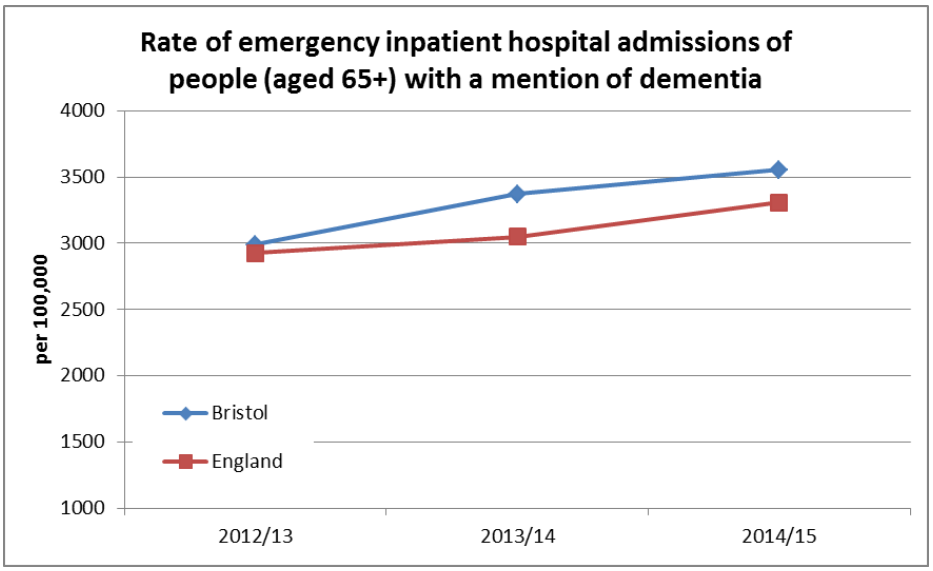
There is little current data about the prevalence of dementia amongst BME communities living in the UK. Bristol is currently working on research to further understand access to and experience of dementia services by BME communities.

Care and support for people with dementia, their families and carers should be provided within people's local communities, and avoid unnecessary emergency admissions and hospital stays.

Whilst the ratio of people with dementia using hospital inpatients services to recorded dementia diagnoses (all ages) has fallen in Bristol from 64% in 2012/13 to 59.2% in 2014/15, it is still higher than the England average of 54.6% (fig 10.1.2). In contrast, emergency admissions rates for people with dementia are increasing both in Bristol and nationally, and the Bristol rate for emergency admissions is higher than the rate for England (fig 10.1.3).




*10.1.2: via Public Health Outcomes Framework, Aug 2016*




*10.1.3: via Public Health Outcomes Framework, Aug 2016*

The Bristol rate of mortality with a recoded mention of dementia is 751 per 100,000 people which has increased from 2012 to 2014 and is very similar to England rate. This rise in mortality rate is likely to be due to increase in diagnosis of dementia.

The majority of people with dementia in Bristol die at home (72.9%) compared to (67.5%) across England.

[288] Alzheimer's Research UK, 2015

## 10.2 Falls

Fear of falling contributes to social isolation which reduces the quality of many older people lives, and increases the need for care and support services. But falling is not an inevitable part of ageing. The risks of falling, sustaining injury following a fall and of being admitted to hospital following an injury can all be reduced.

Bristol's rate of emergency admission for injuries due to falls is significantly higher than the England average (fig 10.2.1). During 2014/15, 1,640 people in Bristol aged over 65 were admitted to hospital in an emergency following a fall.

Further analysis of falls in people 65 and over shows that the majority of falls in Bristol, 69%, are people aged 80 and over. Over the last 5 years, the rate of falls per 100,000 persons aged 80+ has been increasing (fig 10.2.2).

**Gender:** The majority, 68%, of falls-related admissions (aged 65+) are females. However, trend data for Bristol shows that over the last 5 years the average rate per 100,000 males (65+) is increasing (fig 10.2.2).

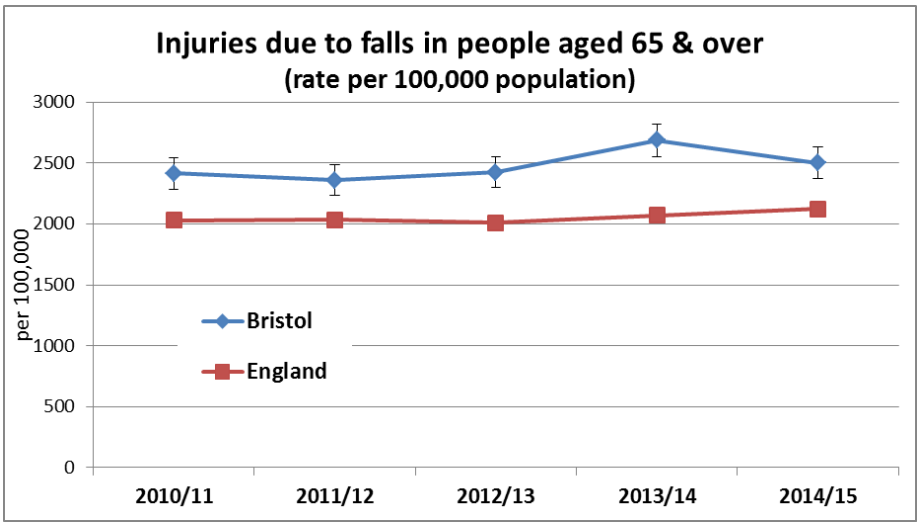



*Fig 10.2.1 Hospital admissions from injuries due to falls (65+) via Public Health Outcomes Framework, Aug 2016*

| Public Health Outcomes Indicator | Bristol | | Region | England | Bristol trend (rate/100,000) over last 5 yrs |
|---|---|---|---|---|---|
| | Number | Rate / 100,000 | Rate/ 100,000 | Rate/ 100,000 | |
| Injuries due to falls in people aged 65 and over (persons) | 1,639 | 2,501 | 1,962 | 2,125 | no significant change |
| Injuries due to falls in people aged 65 and over (Male) | 523 | 2,147 | 1,565 | 1,740 | increasing |
| Injuries due to falls in people aged 65 and over (Female) | 1,116 | 2,855 | 2,360 | 2,509 | no significant change |
| Injuries due to falls in people aged 65-79 (Persons) | 502 | 1,250 | 901 | 1,012 | no significant change |
| Injuries due to falls in people aged 65-79 (Male) | 213 | 1,136 | 720 | 826 | Insufficient trend data |
| Injuries due to falls in people aged 65-79 (Female) | 289 | 1,364 | 1,082 | 1,198 | Insufficient trend data |
| Injuries due to falls in people aged 80+ (Persons) | 1,137 | 6,128 | 5,041 | 5,351 | increasing |
| Injuries due to falls in people aged 80+ (Male) | 310 | 5,077 | 4,014 | 4,391 | Insufficient trend data |
| Injuries due to falls in people aged 80+ (Female) | 827 | 7,178 | 6,068 | 6,312 | Insufficient trend data |

*Figure 10.2.2 Falls-related emergency admissions (PHOF, August 2016)*

Analysis of 2012/13 to 2014/15 data showed that 7% of all falls-related admissions were from residential and nursing care homes, and 93% were from those living at private addresses (including Extra Care Housing and Supported Housing Accommodation).

Rates of falls-related emergency admissions of people living independently were highest in Knowle, Lawrence Hill and Hartcliffe & Withywood, and lowest in Hotwells & Harbourside (fig 10.2.3).

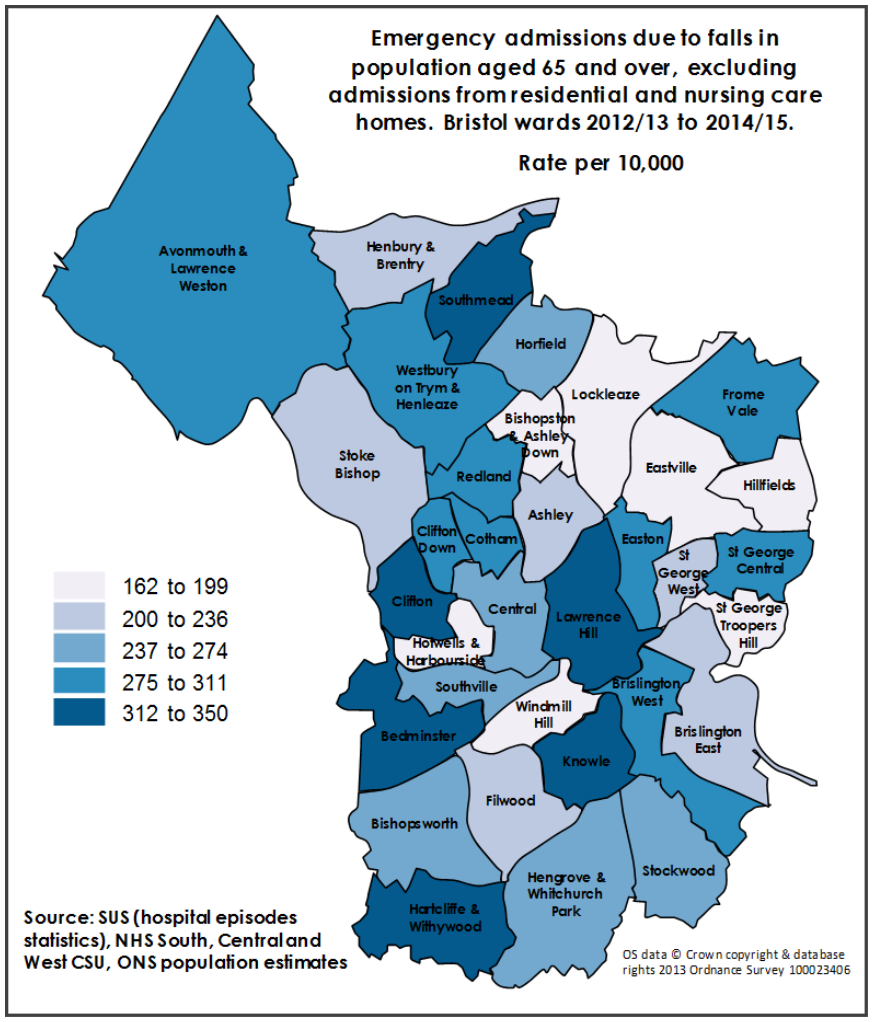



*Fig 10.2.3 Source: Bristol Public Health Knowledge Service, 2016*

## Hip fracture

One of the most common injuries resulting in emergency admission following a fall is fractured neck of femur (or hip fracture). During 2014/15, Bristol's rate of hip fractures (527 per 100,000) fell significantly, and is no longer worse than the national average (fig 10.2.4). 350 people aged 65 & over were admitted with hip fractures in 2014/15, 70 less than the year before.

The rate of emergency admissions for hip fractures is higher for women (635 per 100,000 aged 65+) than males (419 per 100,000 aged 65+). These are similar to national rates with no significant changes recently[289].

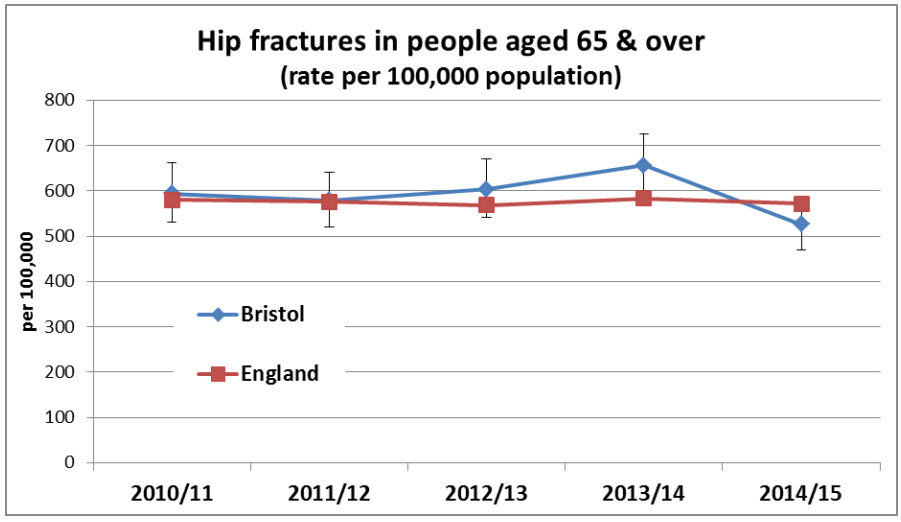



*Fig 10.2.4 via Public Health Outcomes Framework, Aug 2016*

[289] Public Health Outcomes Framework (PHOF)

## 10.3 Excess Winter Deaths

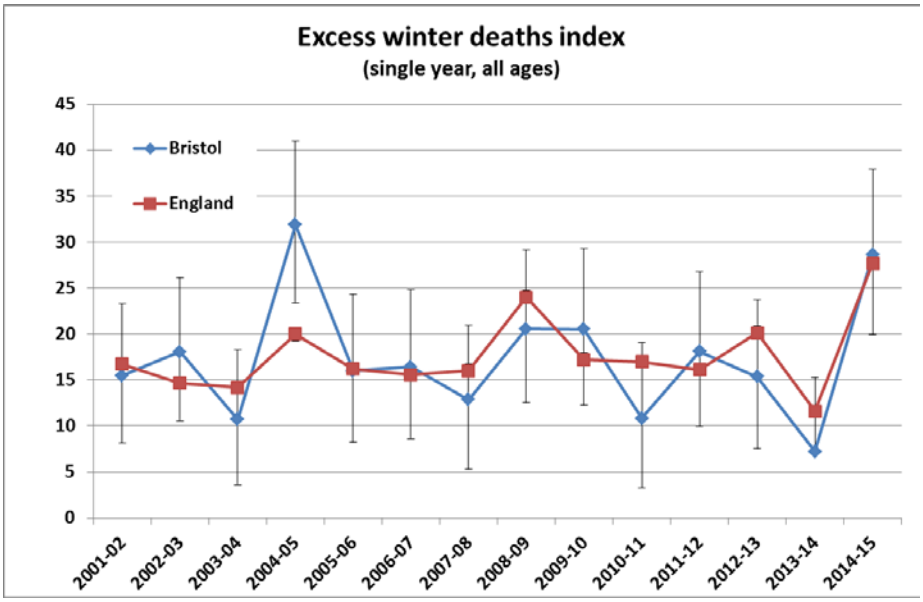
The number of excess winter deaths (EWD)[290] depends on the temperature, levels of influenza & other diseases in the population and other factors, such as how well equipped people are to cope with the drop in temperature.

Public Health England reports that 21.5% of EWD are attributable to the coldest 25% of homes and 10% are directly attributable to fuel poverty[291]. Most deaths are due to circulatory and respiratory diseases, and the majority occur amongst people over 75.

Seasonal Flu vaccinations[292] are an important prevention measure for EWD. In 2014/15 the highest number of EWD were for women aged 85 and over and 52% more people died from dementia or Alzheimer's disease in the winter than in the non-winter months[293].

Mortality during winter increases more in England and Wales compared to countries with colder climates, suggesting that many of these deaths could be prevented[294].

The ratio of Excess Winter Deaths in Bristol rose significantly in the last year. In 2014/15, there were 289 excess winter deaths in Bristol, which is 28.6% more people dying in the winter months compared with the non-winter months; in 2013/14 that ratio was only 7.2%. However, large annual fluctuations in EWDs are not uncommon (fig 10.3.1), and the EWD ratio for England also rose to 27.7% in 2014/15, the highest ratio of EWD nationally for 15 years. Bristol now has one of the higher EWD values of the Core Cities (although confidence intervals are very wide meaning there high levels of uncertainty in the data).




*10.3.1: Excess Winter Deaths index. Source: ONS: Annual Births and Mortality Extracts via Public Health Outcomes Framework, Nov 2016*

NICE estimates for every death there are 8 non-fatal admissions to hospital, (1,320 preventable admissions). In 2014 the Centre for Sustainable Energy estimated the cost of excess winter emergency hospital admissions in Bristol to be at least £750,000.

**Gender:** 2 out of 3 excess winter deaths (EWD) were women. The EWD index for Bristol women rose significantly from 5.9 in 2013/14 to 38.2 in 2014/15, in line with the England rise. For men the EWD index rose slightly (not significantly) from 8.6 in 2013/14 to 18.7 in 2014/15, in line with England.

[290] A measure of how many more people die in the winter. The index is a ratio between the extra deaths from all causes, and the number of deaths that would be expected to occur if the number of winter deaths was the average of the number of non-winter deaths.

[291] www.gov.uk/government/uploads/system/uploads/attachment_data/file/355790/Briefing7_Fuel_poverty_health_inequalities.pdf
**Also see section 5.13 Fuel Poverty**

[292] **See section 7.6 Flu Immunisations**

[293] www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/201415provisionalandprovisional201314final#excess-winter-mortality-ewm-by-sex-and-age

[294] www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E12000009/ati/102/are/E06000023/iid/90641/age/1/sex/4

## 10.4 Adult Social Care

This section covers adults and older people.

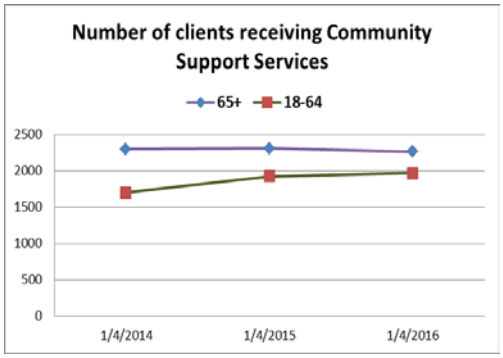
Further data will be available through the Adult Social Care Outcome Framework (ASCOF) indicators (new national website under development)[295].

### 10.4.1 Community Support Services (CSS)

Bristol City Council (BCC) is changing how Community Support Services (CSS) are provided to adults (18+) with social care needs in the community or at home[296]. CSS are social care support services, including:

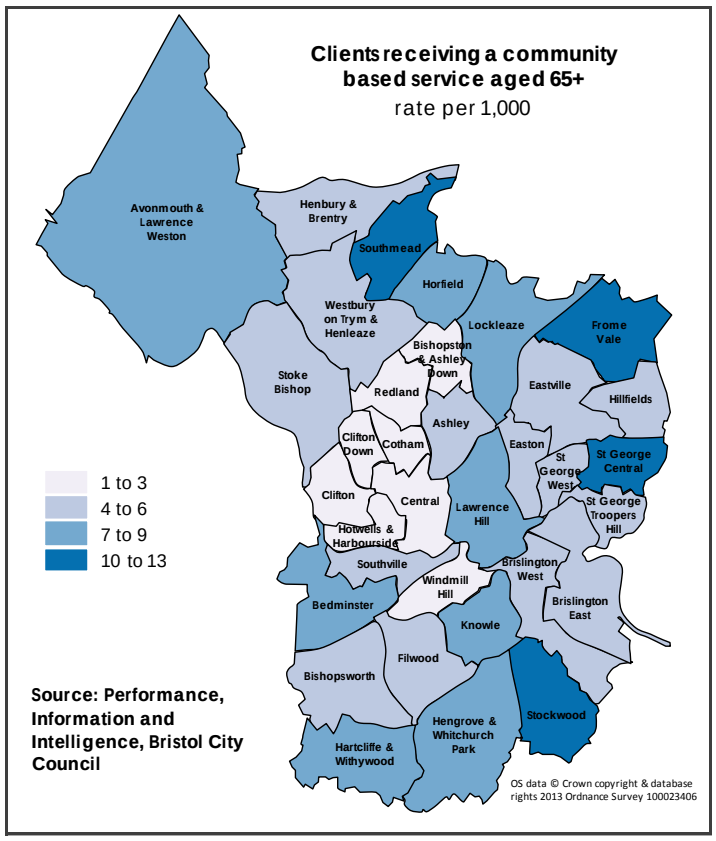
- Accommodation Based Support
- Community Outreach
- Commissioned Day Services
- Carers Sitting Services

At the end of 2015-16 around 4,240 adults received these services: 2,270 older people, which has been stable, and 1,970 people 18-64 years, which has been rising – see fig 10.4.1a.



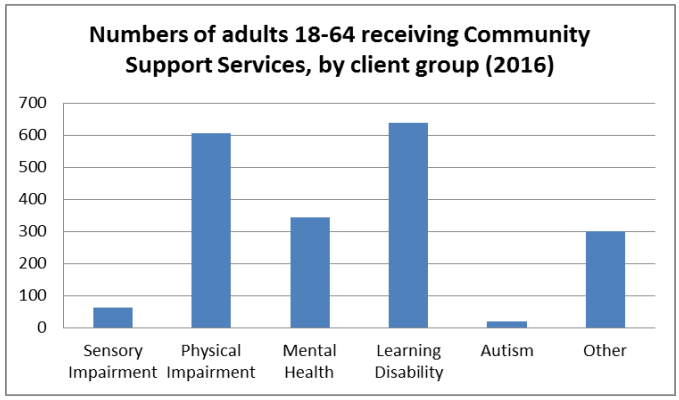

*10.4.1a: All CSS clients; BCC 2016*

Across the city, there are large differences in the 2016 rates (per 1,000 population, 65+) of older people receiving CSS services. The lowest rates (under 2 per 1,000) are in Central, Cotham, Clifton Down and Bishopston & Ashley Down, rising to 12 per 1,000 or more in Southmead and Frome Vale (fig 10.4.1b).




*10.4.1b: 2016 rate of CSS clients 65+ by ward; BCC Performance, Information & Intelligence 2016*

For CSS clients of working age (18-64 years) the majority have a learning disability (640), a physical impairment (600) or a mental health issue (340), plus sensory impairment (60), Autism (20) or Other (300) – see fig 10.4.1c. Numbers in all client groups rose in 2016, except "Other".

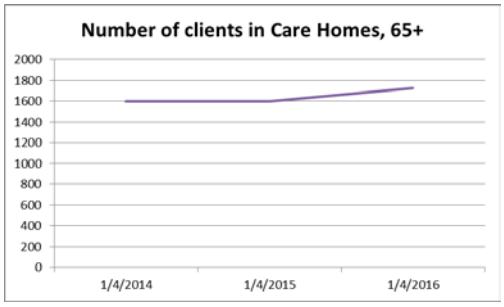



*10.4.1c: CSS clients 18-64 by client group; BCC 2016*

[295] http://content.digital.nhs.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF
[296] See www.bristol.gov.uk/csscommissioning

### 10.4.2 Care home placements

At the end of 2015-16, BCC funded 1,720 care home places for older people (65+), higher than the past two years where this had been around 1,600 (fig 10.4.2)

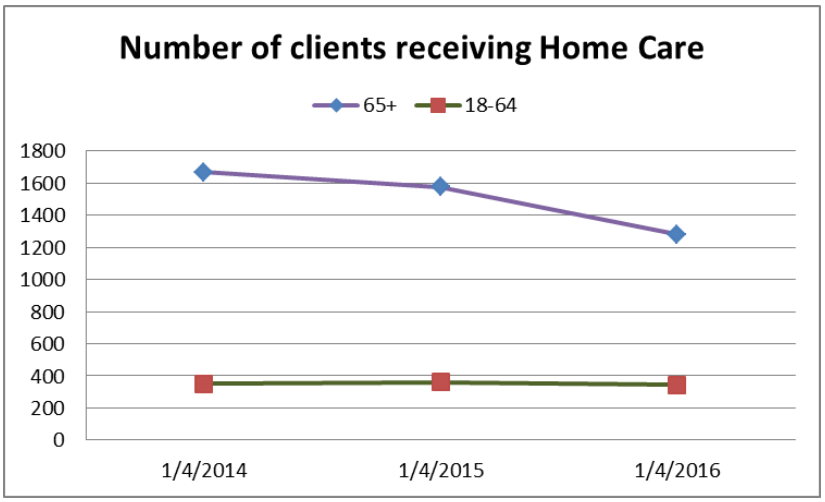



*10.4.2: Care home placements, via BCC Performance, Information & Intelligence 2016*

There has been continued pressure for care home places due to a combination of demand and supply factors. Bristol place people in appropriate care homes over the "Greater Bristol" area, and have been working to consolidate supply through improved contracts and also commission new Dementia care homes.

### 10.4.3 Home care packages

At the end of 2015-16, BCC funded 1,280 home care (aka domestic care) packages for older people (65+), a significant decrease from the previous two years. Home care packages for people of working age (18-64) have remained fairly stable for the past three years (currently 340 placements) – see fig 10.4.3.

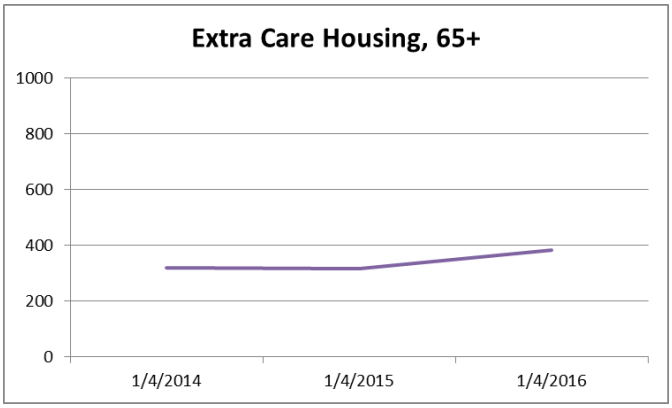



*10.4.3: Home care clients via BCC Performance, Information & Intelligence Service 2016*

Of the home care packages for people of working age (18-64), the majority are for clients with a physical impairment.

### 10.4.4 Extra care housing (ECH)

At the end of 2015-16, there were 380 ECH packages for older people (65+), which has risen from 320 over the last 2 years.




*10.4.4: Extra Care housing via BCC Performance Information & Intelligence Service 2016*

### 10.4.5 Additional services

Further BCC information for people who require "Support to live at home", including reablement, adaptations & equipment, meals and other services are at [www.bristol.gov.uk/social-care-health/support-to-live-at-home](www.bristol.gov.uk/social-care-health/support-to-live-at-home)

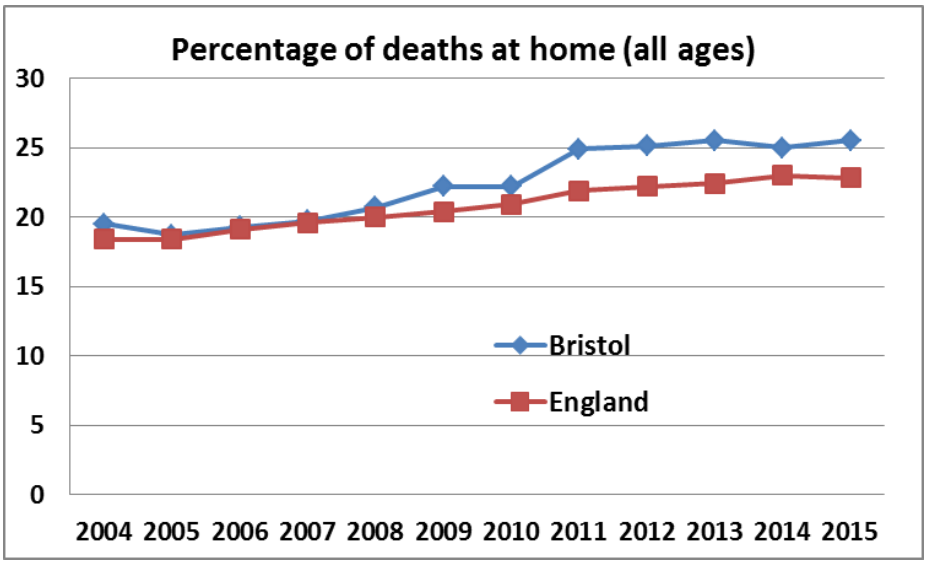
## 10.5 End of life care

Meeting people's preferences for place of care and place of death is a measure of the quality of end of life care. Surveys and research indicate that home is the preferred place of death for many people[297].

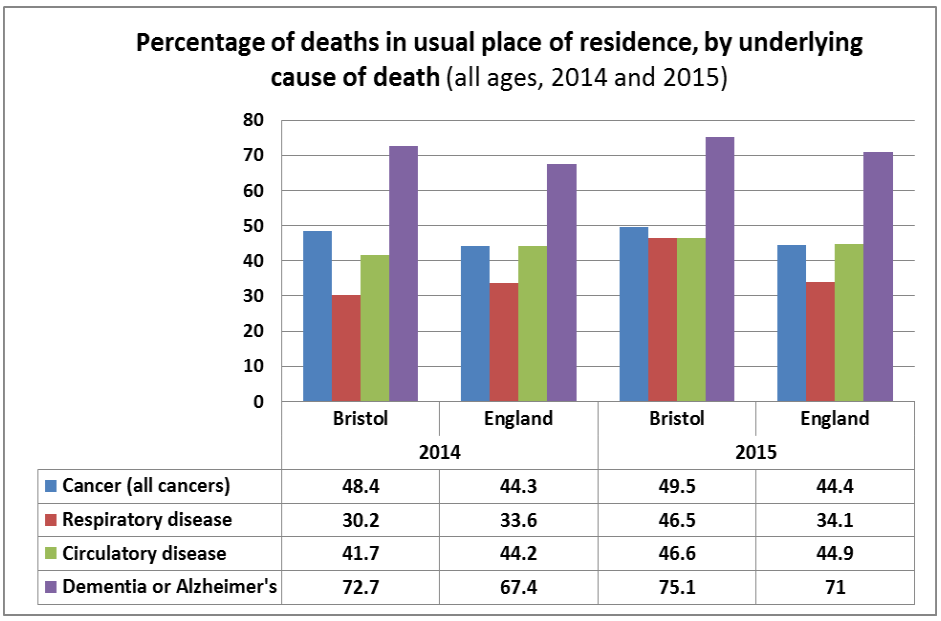
In 2015 Bristol had a significantly higher percentage of people of all ages dying at home (25.5%) than England (22.8%) and the South West average(23.8%) – fig 10.5.1. Of those that didn't die at home, 43% died in hospital (lower than national 47%), 24% died in a care home (similar to national 23%), 4% in a hospice (lower than national 6%) and 3% in other places.

This indicator can be further looked at by the underlying cause of death, to understand the variations as a proxy indicator for quality of end of life care.

In 2015, more people in Bristol (all ages) were able to die in their usual place of residence, compared to the national average, when the underlying cause of death was cancer (49.5% compared to 44.4%) and respiratory disease (46.5% compared to 34.1%). For respiratory disease this rate rose significantly in the last year. The Bristol rate was similar to the national average for circulatory disease (46.6%) and for dementia % Alzheimer's (75.1%)[298] – see fig 10.5.2.




*10.5.1: Percentage of deaths at home, all ages*
*Source: ONS Mortality File, for National End of Life Care Intelligence, Public Health England, via https://fingertips.phe.org.uk/profile/end-of-life*




| | Bristol 2014 | England 2014 | Bristol 2015 | England 2015 |
|---|---|---|---|---|
| Cancer (all cancers) | 48.4 | 44.3 | 49.5 | 44.4 |
| Respiratory disease | 30.2 | 33.6 | 46.5 | 34.1 |
| Circulatory disease | 41.7 | 44.2 | 46.6 | 44.9 |
| Dementia or Alzheimer's | 72.7 | 67.4 | 75.1 | 71 |

*10.5.2: Percentage of deaths in usual place of residence by cause of death*
*Source: ONS (Births and Deaths), for National End of Life Care Intelligence, Public Health England, via https://fingertips.phe.org.uk/profile/end-of-life*

### Further data

- End of Life Care Profiles: https://fingertips.phe.org.uk/profile/end-of-life

[297] PHE report: Patterns of end of life care in England, 2008 to 2010 (2013)
[298] Source: ONS via PHE End of Life Care Profiles (extracted 2016)

# Section 11

# Public Feedback

**Healthwatch Bristol** is a voice for children, young people and adults about health and social care. All Bristol residents can tell Healthwatch Bristol about their experiences of health or social care services and say what was good, and what was not good. Healthwatch then ensures service providers and commissioners hear this feedback and make changes.

Each quarter Healthwatch Bristol produces a report which contains an analysis of the feedback received, and this is used to plan project work to investigate the emerging themes from what people are telling us about health and social care services in Bristol.

In 2014/15 **access to services**, including difficulties accessing information about services and/or booking and attending appointments had been a key theme in the negative feedback gathered by Healthwatch Bristol. In contrast, services that were easy to access and focused on shaping treatment and support around the service user were positively regarded.

During 2015/16, Healthwatch Bristol worked with sections of the community who are most likely to experience difficulties accessing services. The feedback gathered was then used to inform service delivery. Examples of specific Healthwatch Bristol projects with different communities and details of the key themes in the feedback gathered are given below (for further detail and recommendations based on the feedback, see the full reports on the Healthwatch Bristol website as noted).

### 11.1 Deaf, deafened, hard of hearing and deafblind people's feedback on health and social care services[299]

**Theme 1:** A lack of consistency in the availability of interpretation services for GP and hospital appointments, especially when the appointment is needed at short notice. There was also a lack of communication between GPs and hospitals with regards to the patient's need for an interpreter.

**Theme 2:** Commentators reported difficulties in communicating with their GP Practice, for example with a receptionist, when trying to book an appointment and interpreter for that appointment. This was especially problematic when the commentator needed to contact their GP in an urgent situation.

**Theme 3:** Services, equipment and treatment within hospital settings was reported as not being accessible.

### 11.2 Access to services for people with Learning Disabilities (Healthwatch Bristol and The Hive)[300]

**Theme 1:** GPs were not accessible to all people with a Learning Disability. Many commentators said they asked a family member or carer to book their appointments at the GP rather than booking the appointment themselves and most people had never received a letter from their GP in an Easy Read format. Commentators wanted to be able to always see the same GP; those people who did always see the same GP said that this was good and most people who had received an annual health check had had a positive experience. In contrast, everyone who had used a pharmacy said they were very happy with the service they received.

**Theme 2:** Participants were asked about cancer screening checks. Very few respondents expressed any knowledge of cancer screening tests.

**Theme 3:** There was mixed understanding of mental health and where to get support for mental health issues. Commentators

[299] Web-link to full report: http://bit.ly/2bIT8VK

[300] Web-link to full report: http://bit.ly/1NpxRLd

did, however, say that they really valued the support they received from drop in groups and carers.

### 11.3 Homelessness and health and social care services[301]

**Theme 1:** Commentators reported difficulties accessing services and information about treatment and difficulties in getting a diagnosis/ poor follow ups from initial consultations with GP. Limited access to translation services by individuals whose first language is not English and not being able to register at a GP practice due to not having a fixed abode, contributed to the difficulties accessing health and social care support.

**Theme 2:** There were mixed experiences of getting referrals to other health and social care services when individuals are identified as having complex needs. For example, dual diagnosis, mental health issues with associated substance misuse or drug addiction problems.

**Theme 3:** Individuals with mobility issues found it difficult to access homeless services which are not centrally located and have to travel or walk long distances to access homeless services.

### 11.4 'Getting the conversation started' – older people-focused engagement (Healthwatch and Link Age)[302]

**Theme 1:** There was a variation in responses, but the majority of people said they could easily access the support they need when they need it from health professionals. On further questioning, most people said they would go to their GP for this support. Suggestions as to how to improve access to support included: access to professionals who they could talk to about issues before seeing a GP (and who may be able to spend more time listening/could offer suggestions/alternatives); open surgeries rather than a limited number of appointments that are only available by phoning on the day; joining up of services and sharing information on patients with multiple morbidities ("one stop shop – not being pushed from pillar to post"); better access to health professionals such as physiotherapists, opticians and dentists; signposting to local community groups/activities; more mental and emotional support. Only 20% of the people questioned at the BME Elders Consortium felt that they and their community could access the help and support that they need when they need it, compared to 70% of the people questioned at LinkAge Wellbeing Days.

**Theme 2:** Most people said they would go to their GP for advice on their health and wellbeing. There were requests for greater access to information and support outside of surgeries/in community venues (possibly in libraries). Some people wait until an issue becomes a real problem before seeking advice or support. Greater access to information and advice in community venues would be useful (especially someone to talk to).

**Theme 3:** People's access to community activities varied based on the areas of Bristol in which the respondent lived.

### 11.5 Ensuring public feedback influences strategic decision making

Data gathered by Healthwatch Bristol is available via Better Cared Bristol and Healthwatch Bristol website and should be used to support JSNA chapters.

- **Healthwatch Bristol**

Website: www.healthwatchbristol.co.uk

- **Better Cared Bristol**

Website: www.bettercared.org.uk

[301] Web-link to full report: http://bit.ly/1QTygdD
[302] Web-link to full report: http://bit.ly/2ciotLT

JSNA 2016-17 - Bristol City Council, Dec 2016

**www.bristol.gov.uk/jsna**

Bristol JSNA 2016-17 was compiled on behalf of Bristol City Council (BCC) and NHS Bristol Clinical Commissioning Group (CCG), through the Bristol Health and Wellbeing Board, by

- Strategic Intelligence and Consultation team (Performance, Information and Intelligence Service, BCC)
- Public Health Bristol (BCC)
- Healthwatch Bristol (http://healthwatchbristol.co.uk/)

**Documents available in other formats:**

**If you would like this information in another language, Braille, audio tape, large print, easy English, BSL video or CD rom or plain text, please contact:**

Nick Smith
Strategic Intelligence & JSNA Manager
jsna@bristol.gov.uk
Tel: 0117 903 7304