



Bristol Clinical Commissioning Group

## Bristol Health & Wellbeing Board

<b>Review of the Bristol JSNA</b>	
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<b>Report for: Discussion and Decision</b>	

### 1. Purpose of this Paper

To provide the HWB with a statistical update on health and wellbeing indicators for Bristol, from the JSNA 2015 data profile report.

### 2. Executive Summary

For many health indicators Bristol ranks as one of the healthiest of the Core Cities but despite this, there are a range of indicators where Bristol does significantly worse than the England average. For example, life expectancy has shown a gradual improvement over the last 20 years, but for men, remains significantly below the England average. Crucially, even on indicators where Bristol overall performs well, there are differences within the city and for different population groups. There are very affluent areas of Bristol with very good health outcomes alongside areas that rank amongst the most deprived in the country, and often these areas have significantly poorer health outcomes.

These stark health inequalities do not appear to be improving and there remain large differences in life expectancy for both men and women. The number of years lived in poor health also varies hugely and in some areas people are living over 30 years of their lives in poor health; overall around 72,000 people report themselves as having a limiting long term illness or disability. Although premature mortality rates are falling, they are significantly higher than England, with rates in some areas up to 3 times higher than other areas. Half of such deaths are due to cancer (39%) and coronary heart disease (11%). Uptake of cancer screening meanwhile remains low. Feedback from service users via Healthwatch indicates that accessing healthcare appointments or information about services and waiting times are key concerns for some.

We know that many of these health issues are caused by unhealthy lifestyles, and that poor diet, tobacco and obesity are the biggest contributors to the burden of early death and disability. Preventable deaths are gradually reducing in Bristol; smoking rates including maternal smoking have seen a steady decline and are now similar to the England average and obesity rates whilst still unacceptably high, are lower than those for England for adults and similar for children, but again these Bristol figures mask the large differences seen within different areas of the city. Harm from alcohol misuse meanwhile, does not appear to be improving with rising rates of hospital admissions due to alcohol and Bristol has the largest estimated rate of opiate and/or crack users of the Core Cities. Bristol also has a high rate of sexually transmitted infections and a higher rate of HIV late diagnosis. Rates of physical activity in Bristol are similar to the national average but are rising and active travel is rapidly increasing with more people in Bristol commuting to work by bicycle or foot than any other local authority.

Although these lifestyle issues are important, it is essential to appreciate that it is crucial to address the underlying or wider determinants of poor health and the choices people make as well as to consider mental health issues which are inextricably linked to physical health. We know giving children the best start in life is important, and yet 23% still live in poverty. A greater proportion of people are now living in the 10% most deprived areas in England, unemployment rates are high, homelessness is rising and housing has become increasingly unaffordable and social isolation rates are high. Education however has seen improvements over the last few years and the number of young people not in education or training is reducing but again there is considerable variation across the city.

This JSNA 2015 Data Profile highlights some of the key health and wellbeing challenges for Bristol. In order to address these challenges, it is clear that no one organisation can solve all these issues alone – improving health and wellbeing is everyone's business and reducing inequalities remains the biggest challenge for our city.

### **3. Context**

JSNAs analyse current and future health needs of the population in order to develop local evidence based priorities for commissioning, to improve the public's health and reduce inequalities. BCC and the CCG have equal and joint duties to prepare the JSNA through the Health and Wellbeing Board.

- The JSNA 2015 is a data profile to provide a review of key health and wellbeing indicators across the city, to inform the refresh of the Health and Wellbeing Strategy for Bristol.
- Due to the timescales required, the JSNA 2015 data profile has been a joint process primarily between Performance, Information & Intelligence (in Business Change) and Public Health.

- In future, the JSNA process will adopt a different approach as standard (previously agreed in June, currently used for 2 pilot areas only), working with all partners to go into more detail on priority topics, and to recommend actions. This will be on a rolling 3-5 year programme to be aligned to recommissioning timescales and priority areas.

#### **4. Main body of the report**

Please see Appendix A – JSNA 2015 data profile report (final draft v3)

#### **5. Key risks and Opportunities**

The challenge now is to ensure that the Health and Wellbeing Board and partners use the JSNA 2015 Data Profile to shape local strategic direction, commissioning and service delivery to improve health and wellbeing.

- Health and Wellbeing Strategy

The JSNA 2015 report and Summary will be a key document to inform the refresh of the Health and Wellbeing Strategy.

- Children and Families Partnership Board (C&FPB)

The JSNA summary of health and social care needs for children & young people is also a core data profile to support the C&FPB joint plans, and the shared vision for Early Intervention across the partnership.

- Informing commissioning activities

A good understanding of population and health needs is foundational to any commissioning activity. We need to develop further links with Commissioners through the enhanced JSNA Chapter process and develop a culture of evidence-based developments, inc the JSNA. Aspects of the JSNA 2015 data (and the detailed needs assessments that underpin some sections) have already been used to inform several commissioning programmes, including

- planning for new community children's health services
- re-commissioning of mental health services for children and young people
- joint re-commissioning of sexual health services

- Specific health needs

There are specific areas of health needs where JSNA data are used to develop the strategic direction (eg health inequalities across the city). This process needs to become standard through the JSNA Chapter approach.

- Partnership involvement

We need to enhance partnership involvement, to ensure more input around citizen views and joining up all intelligence sources more effectively

- Website development

As previously noted, there is an intention to improve access to JSNA data partly through the procurement of a Council-wide single data platform with enhanced functionality. This is now planned for 2016-17.

## **6. Implications**

There are no legal implications arising from this report (Note – delivery of a JSNA is a statutory duty for the HWB)

## **7. Conclusions**

The JSNA 2015 data profile report highlights the changes to health and wellbeing indicators for Bristol, differences in health outcomes within Bristol, and emerging challenges. It does not explicitly consider actions that may be needed, but is to support the refresh of the Health and Wellbeing Strategy and inform local strategic direction, commissioning decisions and service delivery to improve health and wellbeing.

See Executive Summary for key changes and issues.

## **8. Recommendations**

It is recommended that the HWB:

- 1) Approve the JSNA 2015 report and the priorities noted to inform the Health and Wellbeing Strategy
- 2) Also, note that there will now be a need for leadership to implement the agreed plans for the enhanced JSNA process with greater engagement and ownership across all partners.

## **9. Appendices**

- Appendix A – JSNA 2015 data profile report (final draft v3)



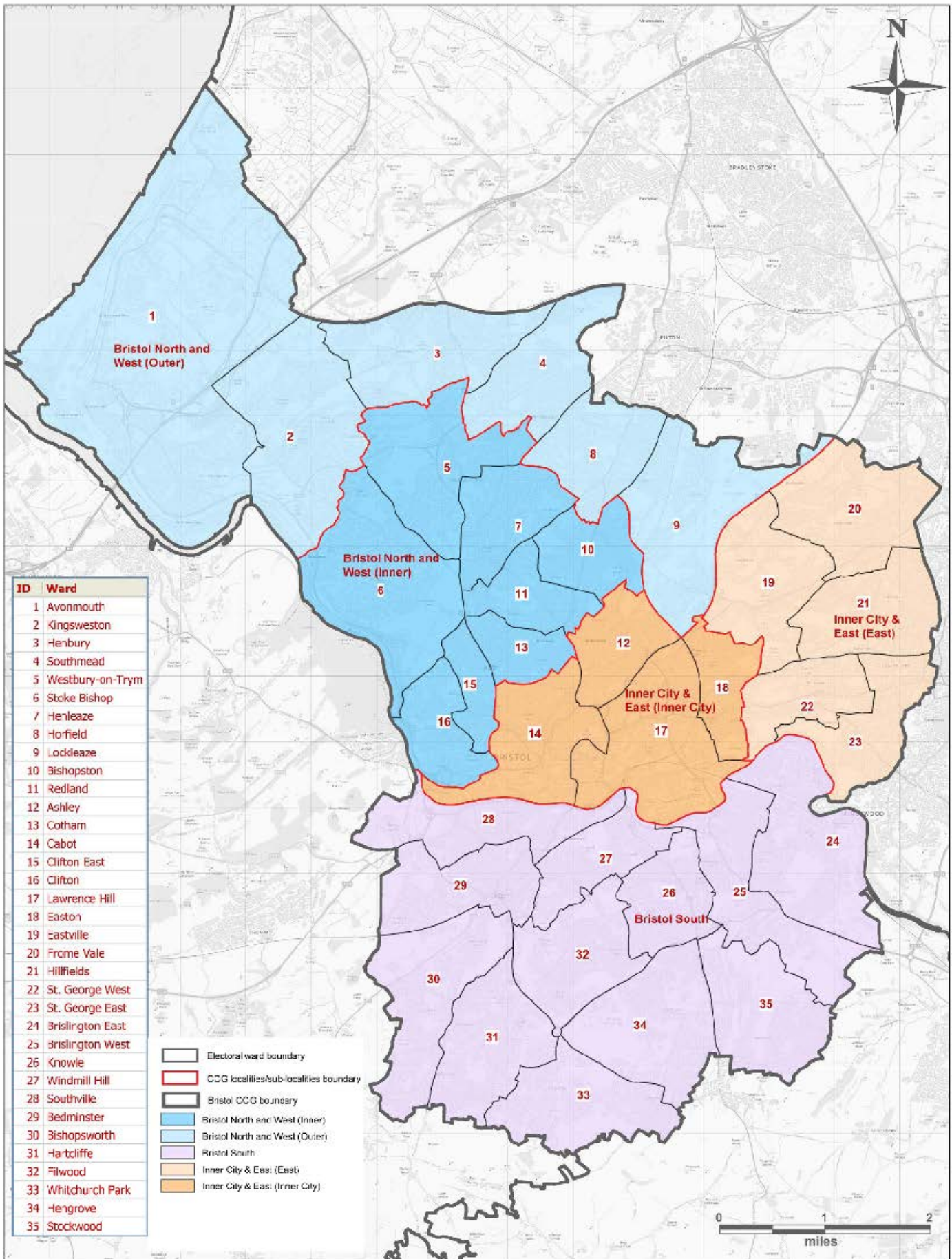
# Joint Strategic Needs Assessment (JSNA) report 2015

Data profile of Health and Wellbeing in Bristol

[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)



# Bristol wards and CCG sub-locality areas (2015)



Bristol CCG Localities and Sub-localities by Electoral Ward

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# Section 1

## Executive Summary

### Introduction

The Joint Strategic Needs Assessment (JSNA) is an ongoing process to identify the current and future health and wellbeing needs of the local Bristol population. It 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 Data Profile 2015 provides a broad overview of the changing health and wellbeing needs<sup>1</sup> in Bristol. It highlights the current challenges for Bristol and will inform the refresh of the Health and Wellbeing Strategy. In the future, the Bristol JSNA process will be complemented by a suite of detailed needs assessments around specific topics. These will not only look at the quantitative data included in the JSNA Data Profile, but will include information on community assets and current services, the evidence base and a greater focus on service user views. This will enable the JSNA to more effectively drive planning and commissioning across the city.

### JSNA 2015 Executive Summary

The JSNA Data Profile 2015 has shown that for many health indicators Bristol ranks as one of the healthiest of the Core Cities but despite this, there are a range of indicators where Bristol does significantly worse than the England average. For example, life expectancy has shown a gradual improvement over the last 20 years, but for men, remains significantly below the England average. Crucially, even on indicators where Bristol overall performs well, there are differences within the city and for different population groups. There are very affluent areas of Bristol with very good health outcomes alongside areas that rank amongst the most deprived in the country, and often these areas have significantly poorer health outcomes.

These stark health inequalities do not appear to be improving and there remain large differences in life expectancy for both men and women. The number of years lived in poor health also varies hugely and in some areas people are living over 30 years of their lives in poor health; overall around 72,000 people report themselves as having a limiting long term illness or disability. Although premature mortality rates are falling, they are significantly higher than England, with rates in some areas up to 3 times higher than other areas. Half of such deaths are due to cancer (39%) and coronary heart disease (11%). Uptake of cancer screening meanwhile remains low. Feedback from service users via Healthwatch indicates that accessing healthcare appointments or information about services and waiting times are key concerns for some.

We know that many of these health issues are caused by unhealthy lifestyles, and that poor diet, tobacco and obesity are the biggest contributors to the burden of early death and disability. Preventable deaths are gradually reducing in Bristol; smoking rates including maternal smoking

<sup>1</sup> Within this report, the term “significantly” is used to refer to a change or difference being “statistically significant”

have seen a steady decline and are now similar to the England average and obesity rates whilst still unacceptably high, are lower than those for England for adults and similar for children, but again these Bristol figures mask the large differences seen within different areas of the city. Harm from alcohol misuse meanwhile, does not appear to be improving with rising rates of hospital admissions due to alcohol and Bristol has the largest estimated rate of opiate and/or crack users of the English Core Cities. Bristol also has a high rate of sexually transmitted infections and of HIV late diagnosis. Rates of physical activity in Bristol are similar to the national average but are rising and active travel is rapidly increasing with more people in Bristol commuting to work by bicycle or foot than any other local authority.

Although these lifestyle issues are important, it is essential to appreciate that it is crucial to address the underlying or wider determinants of poor health and the choices people make as well as to consider mental health issues which are inextricably linked to physical health. We know giving children the best start in life is important, and yet 23% still live in poverty. A greater proportion of people are now living in the 10% most deprived areas in England, unemployment rates are high, homelessness is rising and housing has become increasingly unaffordable and social isolation rates are high. Education however has seen improvements over the last few years and the number of young people not in education or training is reducing but again there is considerable variation across the city.

This JSNA 2015 Data Profile highlights some of the key health and wellbeing challenges for Bristol. In order to address these challenges, it is clear that no one organisation can solve all these issues alone – improving health and wellbeing is everyone's business and reducing inequalities remains the biggest challenge for our city.

## Summary of key points from each section

### Life expectancy

- Life Expectancy in Bristol has increased by 4.4 years for men and 3.2 years for women in the past 20 years
- Despite the rise in life expectancy, Bristol is significantly worse than national average for men.
- Inequalities in life expectancy have not improved. The gap between the most deprived and least deprived areas is 8.9 years for men and 6.6 years for women.
- People in Bristol live for around 63 years in good health. Men have an additional 15 years in poor health and women have an additional 20 years in poor health.
- The number of years people are living in ill health has a vast range from 11 years to 31 years for females and from 10 years to 24 years in ill health for males.
- Premature mortality rates in some areas of Bristol are 3 times as high as other areas
- Preventable mortality is reducing but there are still around 675 preventable deaths per year in Bristol
- Dietary risks, tobacco and obesity are the biggest contributors to early death & disability

## Population

- The population of Bristol is around 442,500 people and is increasing. The population grew 11.8% since 2004 (compared to 8% in England and Wales) mainly due to the high number of births relative to deaths. This growth has been mainly concentrated in the inner city.
- The birth rate is high but has plateaued.
- The population is young, with a median age of 33.4 compared to 39.9 in England. There is a larger proportion of adults under 40 years old.
- Around 16% of the population are from BME backgrounds but amongst children it is 28%.
- The city is increasingly diverse with significant differences in ethnicity.
- There are 58,800 older people 65 and over in Bristol. This proportion (13.3%) is lower than nationally but has risen in the North & West (inner). There are projected to be 8,100 additional older people by 2022, a 14.2% rise.

## Wider determinants of health

- A greater proportion of Bristol's population live in the 10% most deprived areas in England in 2015 than in 2010; 16% compared to 14% in 2010
- 72,000 people (17% of Bristol population) are “income deprived” – in Lawrence Hill (36%) and Filwood (35%) it is more than 1 in 3. 20% of people over 60 are income deprived.
- Around 18 000 children live in low-income families in Bristol (23%) – this is significantly higher than the England average (18.6%), and there are stark inequalities across Bristol.
- Overall Bristol's education results are improving, but within there remains significant variation within the city. 55.2% of Bristol pupils attained 5 or more GCSEs at grade C or above (including English and Maths), a point rise of 20% since 2008. For the first time, Bristol exceeded the national average (53.4%) in 2014.
- Pupil absence is falling but is still higher than the national average
- There are 6.3% of 16-18 year olds in Bristol (2014) who are recorded as being not in education, employment or training (NEET). This is significantly worse than the national average of 4.7%, but is falling
- The rate of first-time entrants to the Youth Justice System in Bristol is almost double the rate for England
- There are around 700 looked after children in Bristol, this number has remained relatively stable
- The unemployment rate in Bristol remains high at 8.3% compared to 6.4% in England.
- Economic productivity in Bristol is high, but other areas are catching up.

- Housing affordability is a serious issue for Bristol. Over the past decade average house prices in Bristol increased by 29% compared to 16% for England and Wales.
- Rates of households considered statutorily homeless (in priority need) is rising
- There has been a considerable increase in private renting (and in rental costs)
- More people in Bristol commute to work by bicycle or on foot than in any other Local Authority
- Bristol's rate of road traffic injury is significantly lower than the national average
- Recorded crime trends in Bristol declined, but in recent years the rate of decline slowed and appears to have stopped falling
- Fear of crime has reduced (15% in 2014 compared to 26% in 2009), but varies considerably between wards.
- Domestic abuse incidents recorded by the police are increasing but may be due to improved recording
- 82% of residents say they are satisfied with their neighbourhood (2014), a steady improvement since 2009 (79%). Satisfaction was significantly lower than this in deprived areas of the city.
- Levels of regular volunteering are high at 29% and increasing (22% in 2009)

### **Children and Young People's Health**

- Infant mortality rates in Bristol are lower than the England average. More babies are born at a healthy birth weight than the national average but there remains inequality at a ward level.
- Breastfeeding initiation and continuation rates in Bristol are higher than nationally but within the city are lowest for women from White ethnic groups living in deprived wards.
- Maternal smoking rates at delivery are similar to nationally and are falling but there are very marked variations across the city.
- The proportion of Bristol children at school entry (23%) and end of primary school (34.8%) who are obese or overweight is similar to the national average but is a major concern nationally.
- Rates of dental decay for Bristol are similar to nationally but there is evidence of large inequalities across Bristol wards.
- Immunisation coverage for under 1s are above the national average. Immunisation rates for 2year olds are below the 95% target as nationally but have seen good improvement in the last few years.
- An estimated 10% of children and young people may be experiencing emotional health problems at any time, and self-harm hospital admission rates in 10-24 year olds exceed the England average.

## Healthy Lifestyles

- 1 in 3 people in Bristol report they take regular exercise, but rates vary across the city.
- 57% of the Bristol population are overweight or obese. Although the rate is lower than nationally and is relatively stable, since obesity is still a key factor in Type 2 Diabetes and coronary heart disease, this rate is of concern.
- Around half of people say they eat at least 5 portions of fruit & veg a day.
- Bristol's estimated level of smoking in adults has declined from 23.5% in 2010, to 18.9% in 2014 and is now similar to the England average of 18.0% but smoking-related deaths in Bristol remain significantly higher than the England average rate.
- Alcohol-related and alcohol specific hospital admissions in Bristol are consistently higher than the national average, and have been rising.
- Alcohol-related deaths in men are significantly higher in Bristol (rate of 26 deaths per 100,000; national 16.6)
- Bristol has the largest estimated rate of Opiate and/or Crack Users of the English Core Cities but has the highest rate of recovery for its opiate-using population.

## Health Protection & Sexual Health

- Levels of testing for Chlamydia in Bristol are higher than the national average, but the positive detection rate for Chlamydia has fallen significantly below the target rate and national average.
- Bristol has higher diagnosis rates of sexually transmitted infections including syphilis, gonorrhoea and genital warts. This is in part due to improved testing but also likely to be due to increased infection rates.
- The diagnosed prevalence rate of HIV in Bristol increased to 2.07 per 100,000 residents aged 15-59 years in 2014. Bristol is now considered as a high prevalence area for HIV. Men who have sex with men (MSM) make up the greatest proportion of HIV diagnoses in Bristol.
- Bristol has a higher rate of late diagnosis of HIV than that seen nationally. Heterosexuals and Black Africans are at higher risk of late diagnosis.
- Long Acting Reversible Contraception uptake remains low, particularly in young people. Conversely oral emergency contraception use is high amongst young people.
- Teenage pregnancies in Bristol have shown a steep decline since 2007 and are now only slightly higher than the England average (25.7 per 1,000).
- The annual rate of TB cases per 100,000 population is higher than the UK rate. Despite a small downward trend in annual TB incidence in the UK, Bristol's incidence is increasing.
- Overall Bristol performs slightly better than the England average for vaccine uptake for all eligible groups but rates are still low, particularly in clinical risk groups and healthcare workers



## Long Term Conditions and preventable mortality

- There are around 71,700 people in Bristol who report themselves as having a limiting long-term illness or disability.
- In Bristol half of all premature deaths under 75 years are due to cancer and coronary heart disease (39% cancer, 11% coronary heart disease). These rates are lowest in the affluent North & West (inner).
- Whilst early deaths due to cardiovascular disease (CVD) in Bristol have been falling since 2001, rates are significantly higher than the England average and the rate for men is more than twice the rate for women
- In Bristol, rates of early death due to cancer in both men and women have decreased since 2001, but remain significantly higher than the England average. More men than women die early from cancer.
- Screening coverage for breast, cervical & bowel cancer in Bristol are all significantly lower than the England average
- Recorded crude rates of diabetes (5%) are lower than the national average (6.4%) but continue to rise in Bristol as in England overall. Recent estimates suggest that almost 10% of those over 16 years in Bristol have raised blood sugar levels and are at increased risk of diabetes.
- Admission rates to hospital for all respiratory diseases are higher in Bristol than the England average. Recent data show that a third of all emergency admissions in Bristol, were for respiratory conditions (an increase on the previous year)
- In Bristol, early death rates from respiratory disease are significantly higher than the England average and for the South West
- Early deaths from liver disease in Bristol are significantly higher than in England. Rates are almost three times higher in men than women in Bristol. Most liver disease is due to alcohol, obesity and viral hepatitis.

## Mental Health

- 30,100 Bristol patients (7.6%) received a diagnosis of depression in the last year by GPs. Rates have been rising across Bristol, and the highest rate is currently in the North & West (outer) area (9.3%)
- There were 1,600 attendances for deliberate self-harm at the Bristol Royal Infirmary in 2014. 18% made a repeated attendance during the year. This number has remained stable since 2011
- There are around 500 admissions from self-harm for young people (10-24 year olds) in Bristol and this rate exceeds the England average.

- There are around 45 suicides a year amongst the Bristol population with middle aged men having the highest rate, mirroring the national picture. Around 37% of these were in contact with mental health services.
- An estimated 10% of children and young people may be experiencing emotional health problems at any time

### **Older People**

- An estimated 4,100 people in Bristol have dementia. Of these people, 68.7% have a diagnosis, compared with a national diagnosis rate of 66.1%. This number is rising in line with an ageing population.
- Bristol's hospital admission rates following a fall are significantly higher than the South West & England averages, and are increasing. The estimated health & social care costs of injuries following a fall are in excess of £11 million every year
- There are estimated to be between 6,300 and 11,400 older people socially isolated in Bristol. Socially isolated older adults have: longer stays in hospital, a greater number of GP visits and more dependence on homecare services.
- In Bristol, 35.3% of social care service users say they have as much social contact as they would like, which is significantly lower than the national average (44.2%).

### **Public feedback**

- Feedback from service users indicates that accessing appointments or information about services and waiting times are key concerns.
- Early intervention – people have praised social prescribing models and asked for more support in the community to engage in activities that support them with their wellbeing.

## Section 2

# Life Expectancy

### Summary points

- Life Expectancy in Bristol has increased by 4.4 years for men and 3.2 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 deprived and least deprived areas is 8.9 years for men and 6.6 years for women.
- People in Bristol live for around 63 years in good health. On average men have 15 further years in poor health and women have 20 further years in poor health.
- The number of years people are living in ill health has a vast 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

- Premature mortality rates in some areas of Bristol are 3 times as high as other areas

### 2.1 Life Expectancy for Bristol

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 4.4 years longer, and women live 3.2 years longer. Life expectancy in Bristol (2012-14) is 78.4 years for men and 82.9 years for women. This is significantly worse than the England average for men (79.5 years), but similar to the England average for women (83.2 years) (fig 2.1.1)

Further to a small apparent dip in life expectancy for the period 2011-2013, life expectancy has increased again in 2012-14. Female life expectancy is still below 2010-2012 level (albeit not significantly). It is not clear what caused this dip but higher than usual number of deaths occurred in spring 2013.

Life expectancy data for 2012-14 is only available at local authority level, therefore sub-Bristol graphs are still based upon older data up to and including 2013.

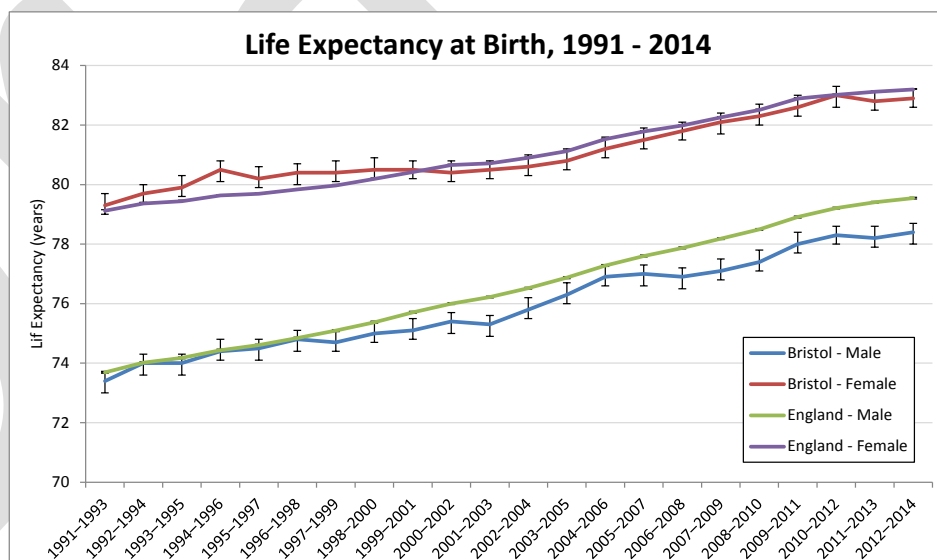


Fig 2.1.1: Life expectancy trends

Source: Office for National Statistics, November 2015

## 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 (81.6 years) and women (84.7 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 (81.4 years) in Bristol. Bristol’s worst male life expectancy is in Inner City (76.4 years). In contrast to male life expectancy in Inner City, female life expectancy in Inner City is 2<sup>nd</sup> highest in the city, after Bristol North West (Inner). The reason for this high female life expectancy is not clear but warrants further investigation.

There are large differences in life expectancy between the wards of Bristol. For both men and women Henleaze has the highest life expectancy, 85.0 years for men and 88.4 years for women. Southmead (74.8 years) has the lowest life expectancy in Bristol for men and Southville (78.3 years) and Southmead (78.4 years) are lowest for women. NB On average men and women in Henleaze live over 10 years longer than residents of Southmead and Southville.

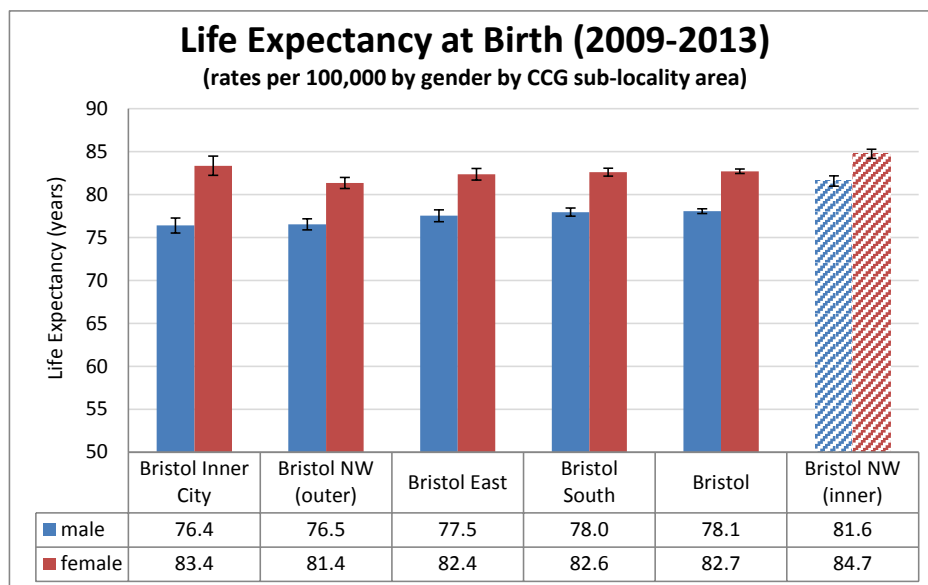


Fig 2.2.1: Life expectancy by sub locality, 2009-2013

Source: Bristol Public Health Intelligence Unit using ONS data (Aug 2015) for 2009-2013, shown by CCG sub-locality area

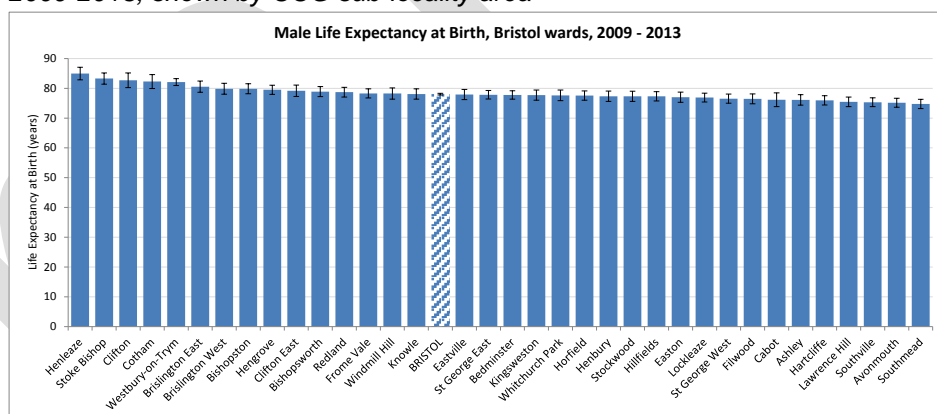


Fig 2.2.2: Male life expectancy by ward, 2009 – 2013

Source: Bristol Public Health Intelligence Unit using ONS data (Aug 2015) for 2009-2013

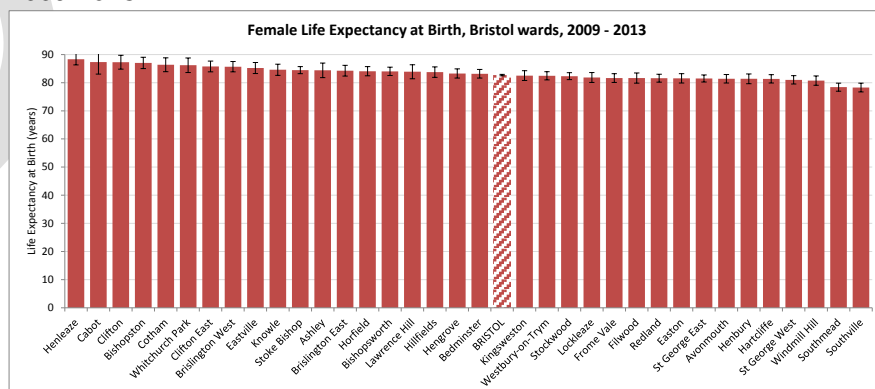


Fig 2.2.3: Female life expectancy by ward, 2009 – 2013

Source: Bristol Public Health Intelligence Unit using ONS data (Aug 2015) for 2009-2013

## 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 allows us monitor changes over time in a statistically robust manner.

The gap for men between the most deprived and least deprived groups is currently 8.9 years (fig 2.3.1) and for women is 6.6 years (fig 2.3.2). This gap has not shown any clear signs of reducing in the last 9 years. There has been an apparent increase in the gap in the latest available time period, due possibly to a fall in life expectancy in the most deprived parts of Bristol, however, this change is not statistically significant. Close monitoring of this gap needs to continue.

Compared to other core cities Bristol's slope index of inequality for men (fig 2.3.3) is in the middle of the group, and women's is second lowest (fig 2.3.4).

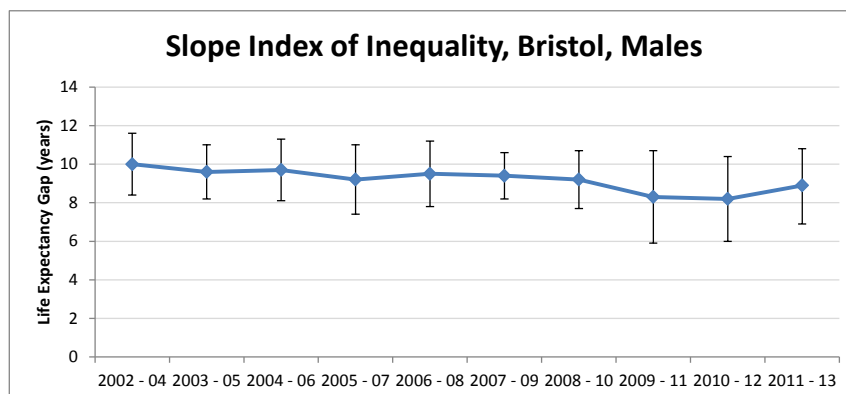


Fig 2.3.1: Male slope index of inequality

Source: Public Health Outcomes Framework, August 2015



Fig 2.3.2: Female slope index of inequality

Source: Public Health Outcomes Framework, August 2015

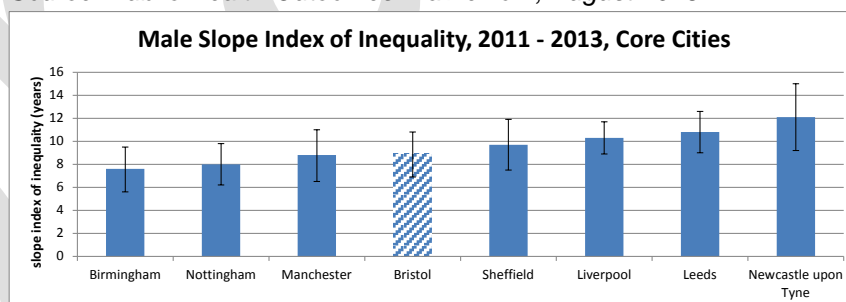


Fig 2.3.3 Male slope index of inequality by Core Cities

Source: Public Health Outcomes Framework, August 2015



Fig 2.3.4: Female slope index of inequality by Core Cities

Source: Public Health Outcomes Framework, August 2015



## 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 (2011-13, ONS) are 63.0 years men and 62.6 years women (fig 2.4.1), which are not significantly lower than the national average; Bristol has the highest healthy life expectancies of the Core Cities for both genders, though lower than our regional neighbours.

Men in Bristol live an average of 15.2 years in poor health, whilst women have 20.2 years of poor health; these figures are similar to England as a whole.

The Healthy Life Expectancy measure is fairly new, so limited trend data is available. The data that is available (fig 2.4.2) shows that there has been no significant change in healthy life expectancy in Bristol, whereas life expectancy as a whole in Bristol has significantly increased in the last five years.

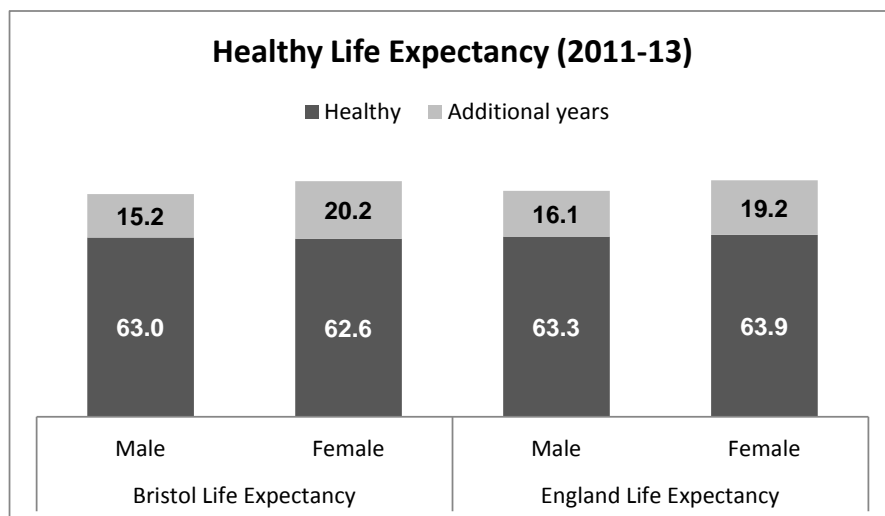


Fig 2.4.1: Healthy Life Expectancy  
Source: ONS via Public Health Outcomes Framework (Aug 2015)

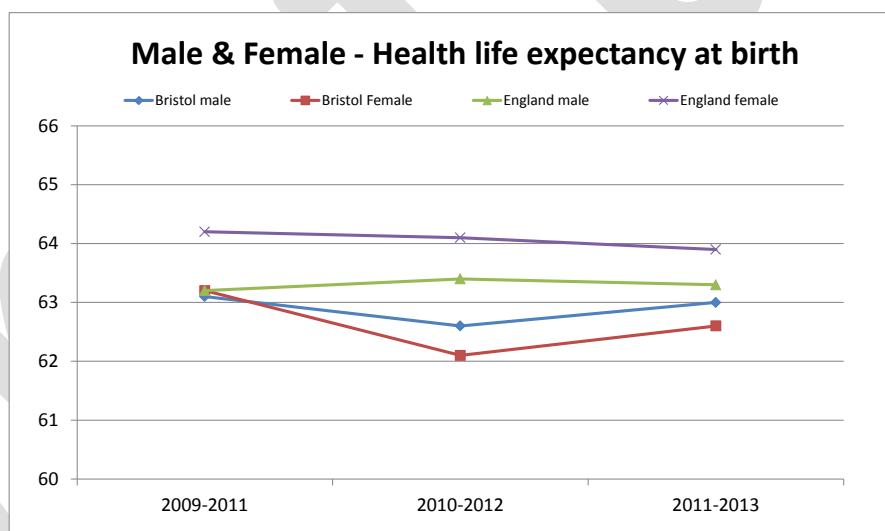


Fig 2.4.2: Healthy Life Expectancy trends  
Source: ONS via Public Health Outcomes Framework (Aug 2015)

## 2.5 Healthy Life Expectancy Gap

New data<sup>2</sup> is now 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<sup>3</sup> from 11 years to 31 years for females and from 10 years to 24 years for males.

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 27<sup>th</sup> worst and for females it is 23<sup>rd</sup> worst.

<sup>2</sup> 2009-2013 for Medium Super Output Areas (MSOA). Source: ONS, Nov 2015. Analysed by Bristol Public Health Intelligence Unit

<sup>3</sup> NB this is range for MSOA areas

Healthy Life Expectancy, Females, 2009 - 2013

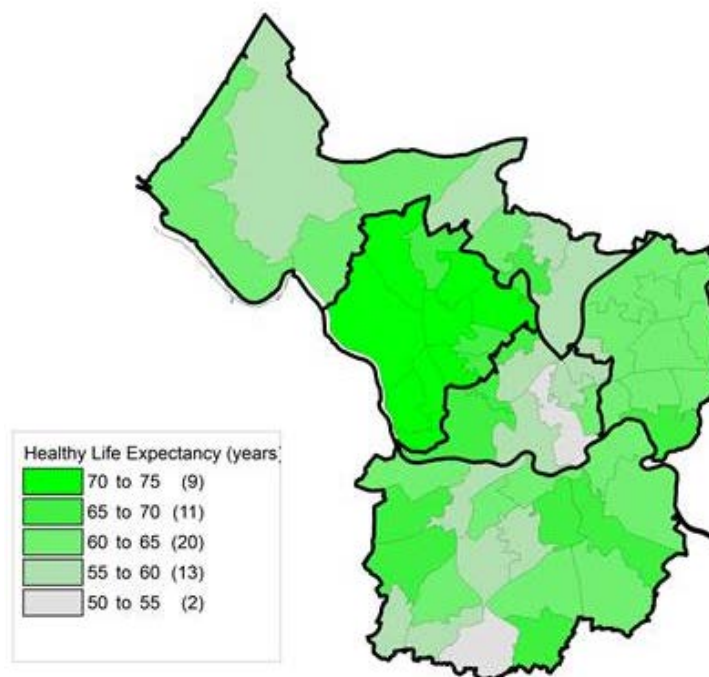


Fig 2.5.1: Healthy Life Expectancy by MSOA, Females, 2009-13

Healthy Life Expectancy, Males, 2009 - 2013

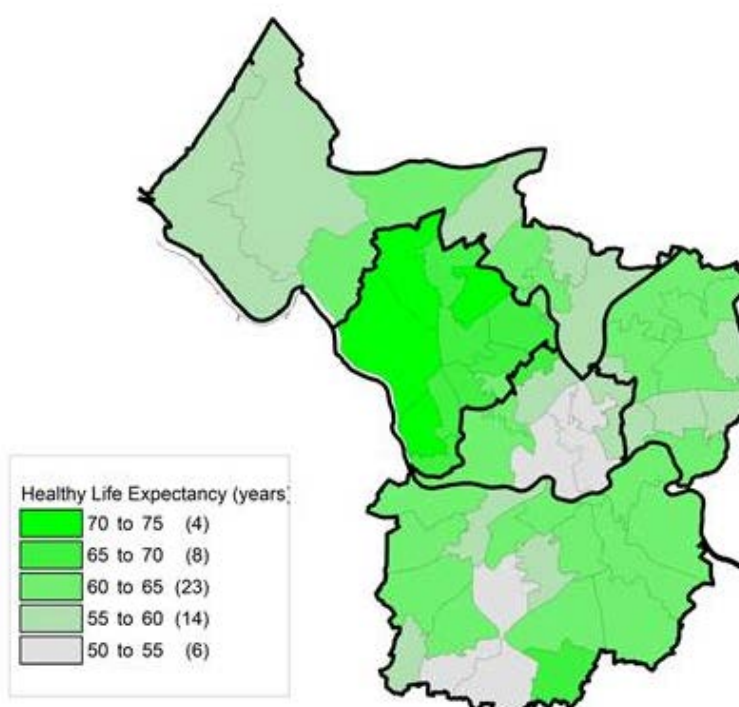


Fig 2.5.2: Healthy Life Expectancy by MSOA, Males, 2009-13

## 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, ie 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)

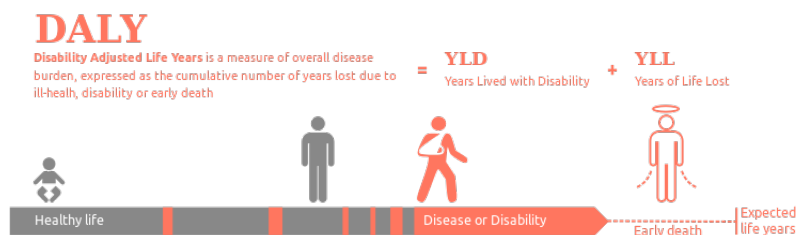


Fig 2.5.1: Method of calculating Disability Adjusted Life Years

Below are two graphs – fig 2.5.2 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. Dietary risks, tobacco smoke and high body-mass index are the three highest risk factors that lead to early death and disability. Dietary risks include, for example, diets low in fruit, vegetables and fibre and diets high in sodium, processed meat and trans fatty acids.

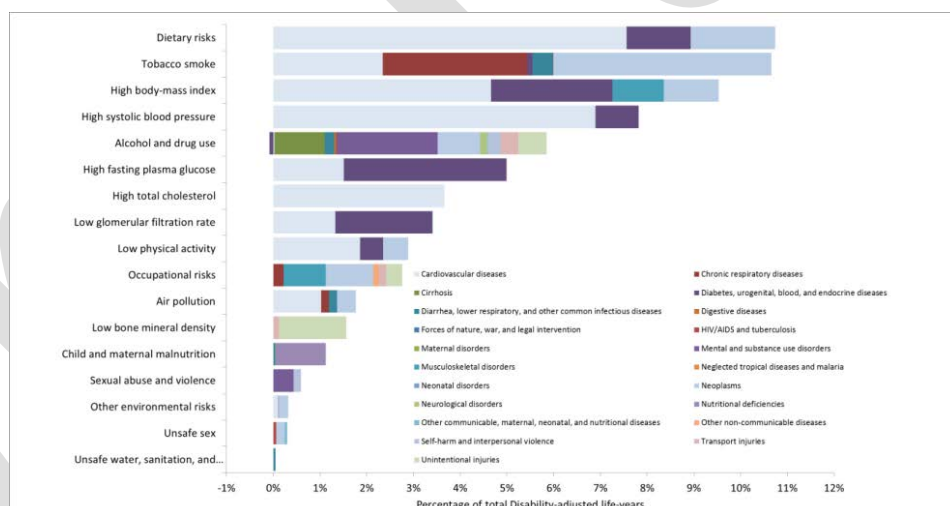


Fig 2.6.2: United Kingdom DALYs, 2013, by risk factor

Source: Global Burden of Disease, Institute of Health Metrics and Evaluation / Public Health England

Figure 2.5.3 shows that cardiovascular disease (CVD) is the largest cause of DALYs in the UK. Although mortality rates from CVD have reduced considerably, many people are living with this long term condition.

Further work will be undertaken locally to applying the national GBD results to Bristol's demographic profile. Alongside this we will look separately at years lived with disability and years of life lost as the size of each will vary depending upon the disease and the burden or cost (on health and care services or local economy for example) will also vary.

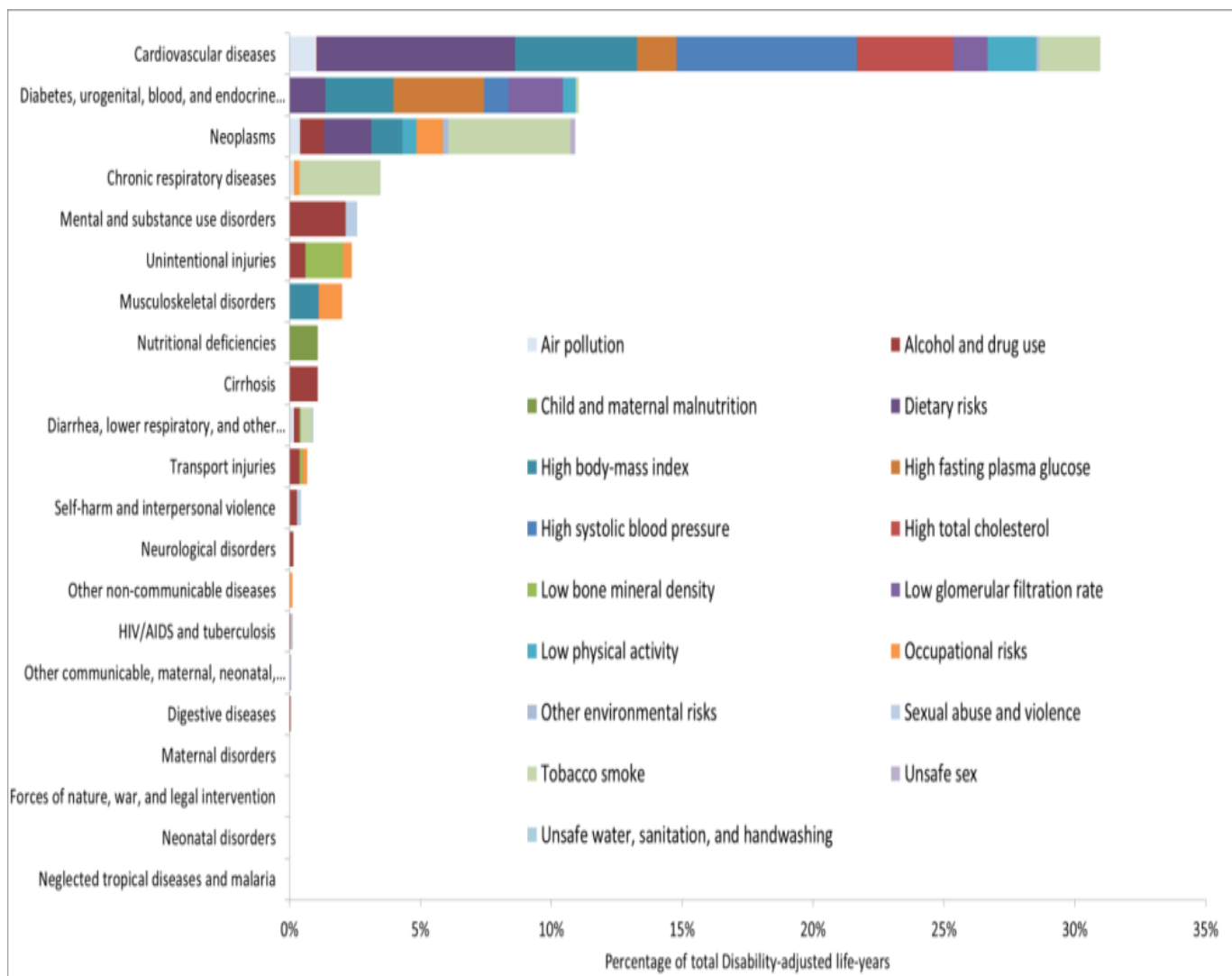


Fig 2.6.3: United Kingdom DALYs, 2013, by cause

Source: Global Burden of Disease, Institute of Health Metrics and Evaluation / Public Health England

## 2.7 Premature Mortality

Rates of premature (under 75 years) mortality are falling in Bristol and for both men and women the mortality rates are significantly lower than levels five years ago (fig 2.6.1). However, Bristol's premature mortality rates, for both men and women are significantly worse than the England rates.

At a sub-locality level both North & West (outer) and Inner City (males) have significantly higher premature mortality rates than Bristol as a whole. North & West (inner) has significantly lower rates (fig 2.6.2).

At a ward level there are large differences in premature mortality between wards in Bristol. Stoke Bishop has the lowest premature mortality rate for both men and women in Bristol and Lawrence Hill has the highest male mortality rate and Southmead has the highest female rate. For men Stoke Bishop's premature mortality rate is less than a third of the Lawrence Hill death rate and for women Stoke Bishop's mortality rate is almost a third of Southmead's rate.

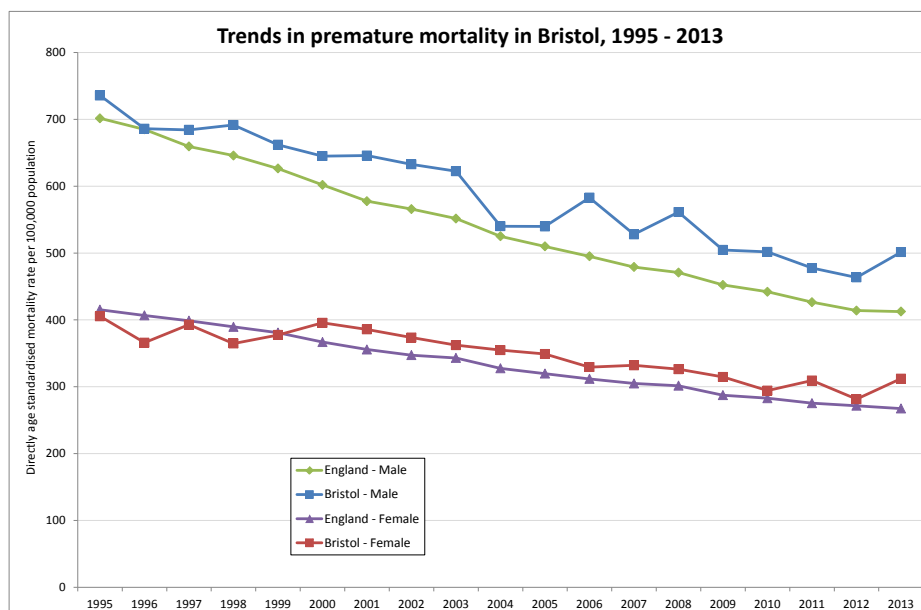


Fig 2.7.1: Premature mortality trends 1995 – 2013

Source: National Clinical Health Outcomes Database, HSCIC

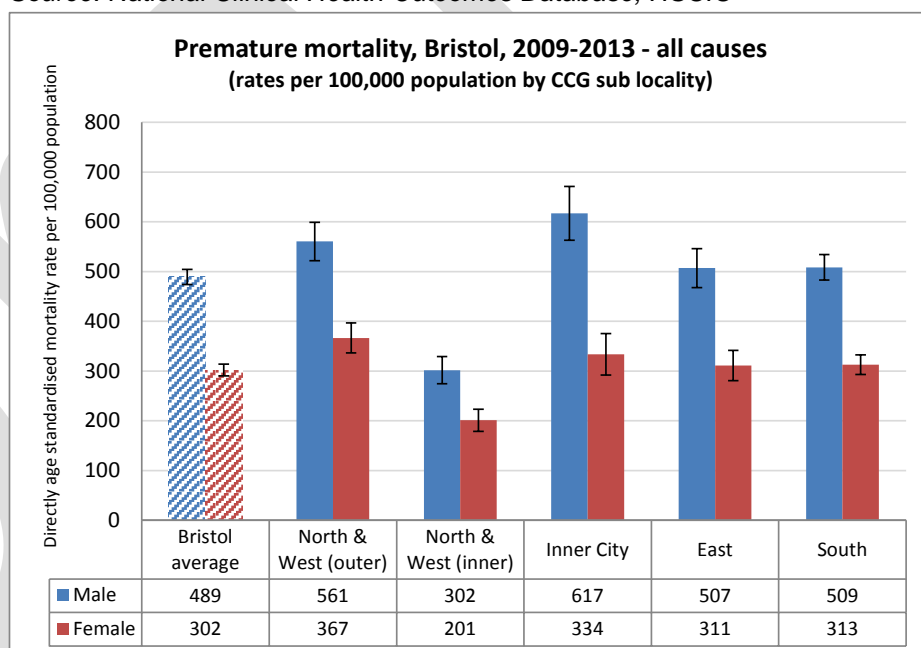


Fig 2.7.2: Premature mortality with Bristol by sub locality

Source: Bristol Public Health Intelligence Unit using ONS data (Aug 2015) for 2009-2013



In Bristol the top three causes of premature mortality are ischaemic<sup>4</sup> heart disease, cancer of the digestive organs (eg colorectal cancer and pancreatic cancer) and cancer of the respiratory and intrathoracic organs (eg lung cancer).

Generally, at a ward level the main causes of premature death tend to be the same. There are exceptions – in Ashley ward one of the main causes of death is accidental drug overdoses, in Cabot ward and Lawrence Hill alcohol related liver disease is one of the main causes of premature death and breast cancer is one of the main causes in Cotham and Stoke Bishop wards.

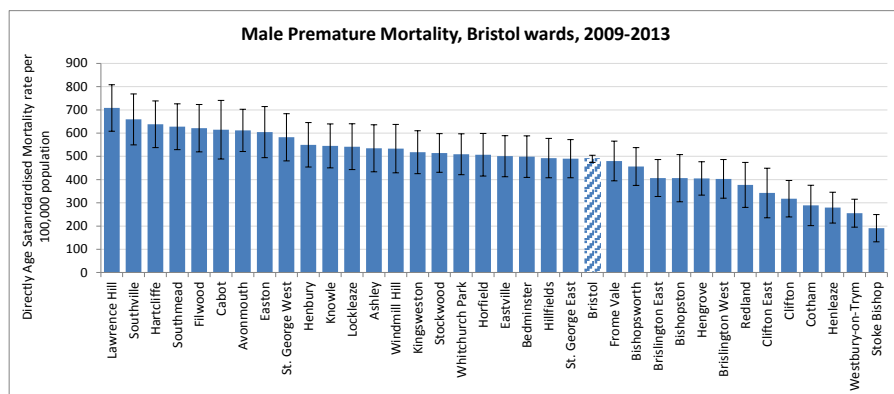


Fig 2.7.3: Male premature mortality, Bristol wards, 2009-2013  
Source: Bristol Public Health Intelligence Unit using ONS data (Aug 2015) for 2009-2013

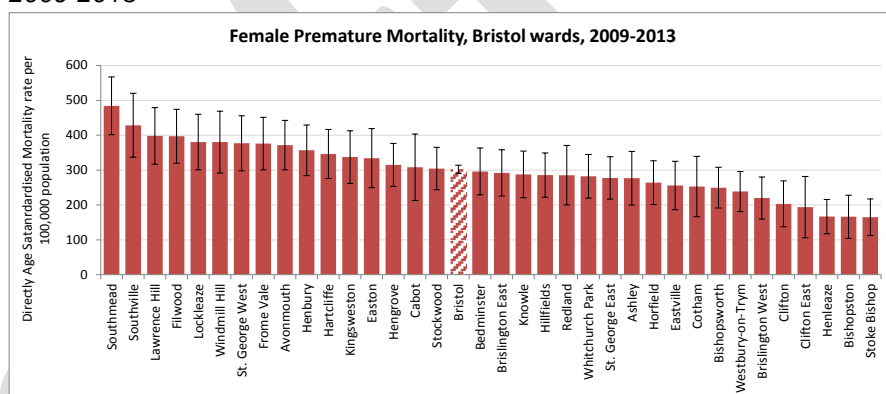


Fig 2.7.4: Female premature mortality, Bristol wards, 2009-2013  
Source: Bristol Public Health Intelligence Unit using ONS data (Aug 2015) for 2009-2013

<sup>4</sup> a restriction in blood supply to tissues, causing a shortage of oxygen and glucose needed to keep tissue alive

## Section 3

# Population<sup>5</sup>

### Summary points

- The population grew 11.8% since 2004 (8% nationally).
- Growth has been mainly concentrated in the inner city, especially young adults, and some wards are increasingly much more populated than others. The child population has risen across Bristol.
- Bristol's population is young, (median age of 33.4 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 child population has grown fastest. The birth rate is very high but has now plateaued.
- The proportion of older people 65 & over (13.3%) is lower than nationally (17.7%) but numbers are now rising, mainly in the North & West (inner). There are projected to be 8,100 additional older people by 2022, a 14.2% rise (from 2012).

### 3.1 Bristol population overview

The population of Bristol is estimated to be **442,500 people<sup>6</sup>**, the 8th largest city in England. Bristol has a relatively young age profile; the median age of people living in Bristol in 2014 was 33.4 years old, compared to 39.9 years in England and Wales.

Bristol has 82,800 children under 16 (18.7% of population), with a lower % of children under 10 than nationally (despite the rise in the child population). The working age (16-64 yr old) population is 300,900 (68%), which is a higher % than nationally (63%), especially young adults up to 40 years. The older people population (65 & over) is 58,800 (13.3%), lower than nationally (17.7%); in fact, Bristol has a lower proportion of older adults from 45 years upwards than nationally (fig 3.1.1)

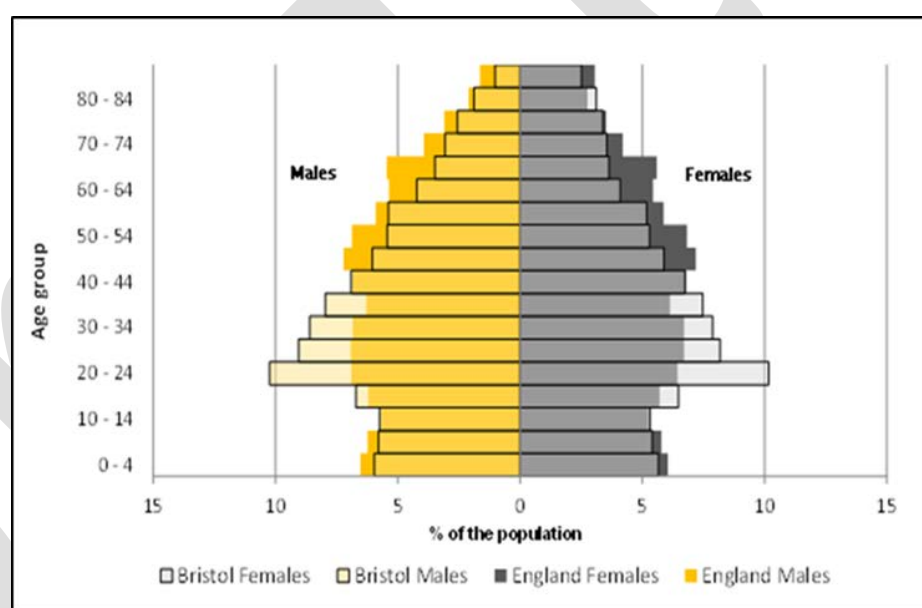


Fig 3.1.1 Mid-2014 Population pyramid for Bristol vs England

Source: ONS 2014 Mid-Year Population Estimates. Crown Copyright 2015

Age Band	Males		Females		Persons	
	number	%	number	%	number	%
0-15	42,100	19.1	40,700	18.4	82,800	18.7
16-24	34,000	15.4	34,400	15.5	68,400	15.4
25-49	86,500	39.2	81,400	36.7	167,900	37.9
50-64	32,100	14.5	32,600	14.7	64,600	14.6
65 and over	26,200	11.9	32,500	14.7	58,800	13.3
<b>All ages</b>	<b>220,900</b>	<b>100.0</b>	<b>221,500</b>	<b>100.0</b>	<b>442,500</b>	<b>100.0</b>

Table 3.1.2 Mid-2014 Population estimates by age and sex for Bristol

Source: ONS 2014 Mid-Year Population Estimates. Crown Copyright 2015

<sup>5</sup> See the Population of Bristol 2015 report [www.bristol.gov.uk/page/population-bristol](http://www.bristol.gov.uk/page/population-bristol)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

<sup>6</sup> ONS 2014 Mid-Year Population Estimate, released 2015

### 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 2014-15 there were 493,800 patients registered to GPs in Bristol, substantially higher<sup>7</sup> than the estimate of people living in Bristol (442,500). Mainly this difference is working age adults (fig 3.1.3). For comparison, GP records indicate 476,600 patients with a Bristol address (including 11,200 with a GP outside of Bristol).

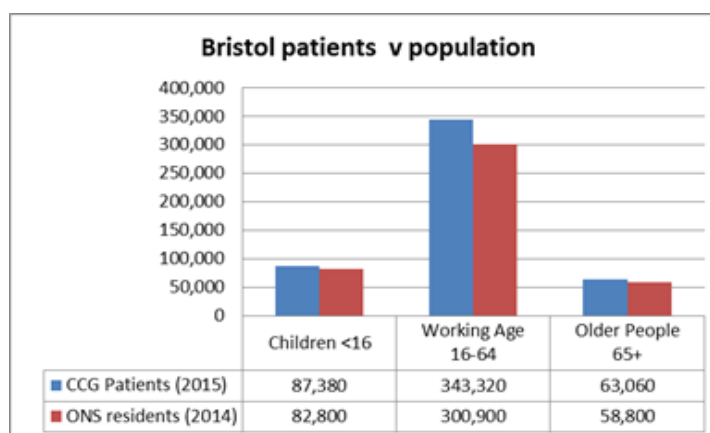


Fig 3.1.3: Source: South West Commissioning Support Unit and ONS

### Population within Bristol

Bristol's population density varies hugely across the city. Population is much higher in the Inner City wards (3 wards over 16,000) and lower in North & West (inner), and some South wards (fig 3.1.4)<sup>8</sup>.

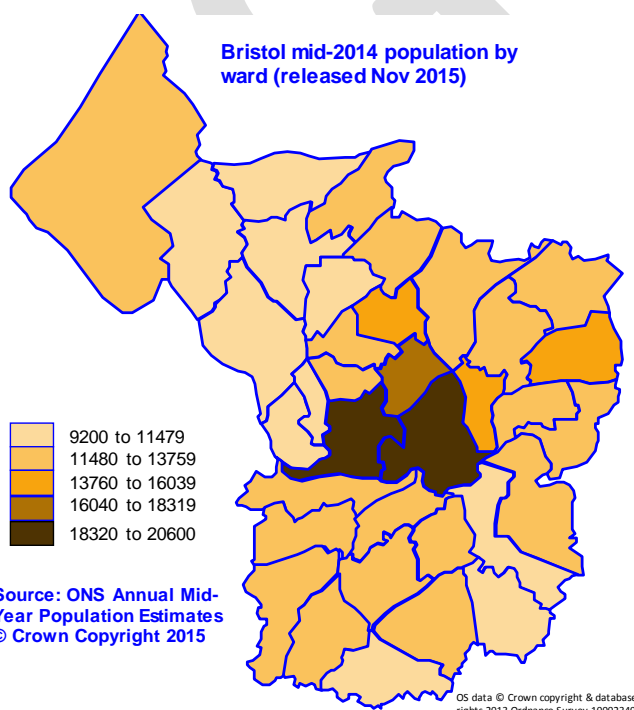


Fig 3.1.4: Bristol resident population by ward, 2014  
Source: ONS Annual Mid-Year Population Estimates, Nov 2015

Differences in the age profiles in Bristol areas highlight that there are less people 65 & over in Inner City & East (fig 3.1.5). Note - There are less people *in total* in Inner City & East locality as it has fewer wards.

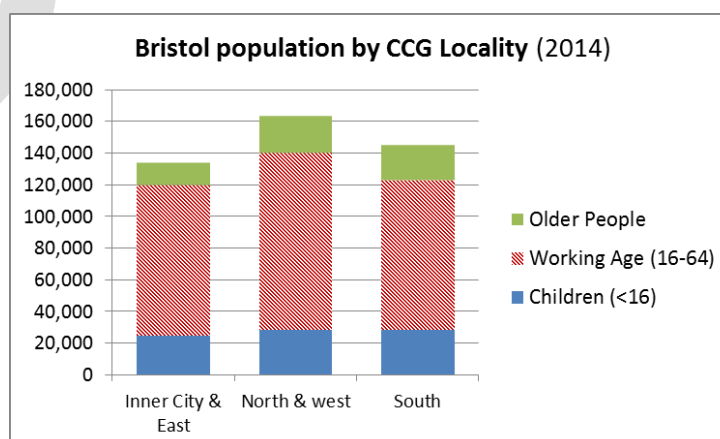


Fig 3.1.5: Population age profiles, 2014  
Source: ONS Annual Mid-Year Population Estimates, Nov 2015

<sup>7</sup> This is often referred to as "list inflation". Reasons include that some patients may be registered in more than one area, may have more than one NHS number, may remain on GP lists after having died or left the country, and that GPs have no real incentive to clean patient registers and remove people from lists. [www.adls.ac.uk/department-of-health/gp-patient-register-dataset/?detail](http://www.adls.ac.uk/department-of-health/gp-patient-register-dataset/?detail)

<sup>8</sup> Note – Bristol will have new wards in 2016, partly to reflect the changing population

## 3.2 Population changes

There has been over a decade of considerable population growth in Bristol. Since 2004 the population is estimated to have increased by 46,700 people (fig 3.2.1).

This increase of 11.8% compares to an England and Wales rise of 8% over the same period.

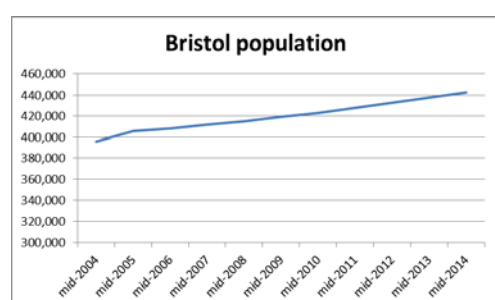


Fig 3.2.1 Source: ONS Annual Mid-Year Population Estimates

More recent change (2008-14) by age group shows the majority of increase was in the Inner City & East locality, with 15,800 more people (11,000 in the Inner City alone). This is due to the huge rise in working age people in this area (fig 3.2.2). Numbers of children rose across the city, but older people rose mainly in North & West (mainly in the 'inner' area).

This doesn't mean future growth will be in this ratio, but it is an indicator<sup>9</sup>. New housing in Bristol (2013/14-2017/18) is also focussed in the Inner City, with 56% of planned new dwellings being in Inner City & East (41% Inner City).

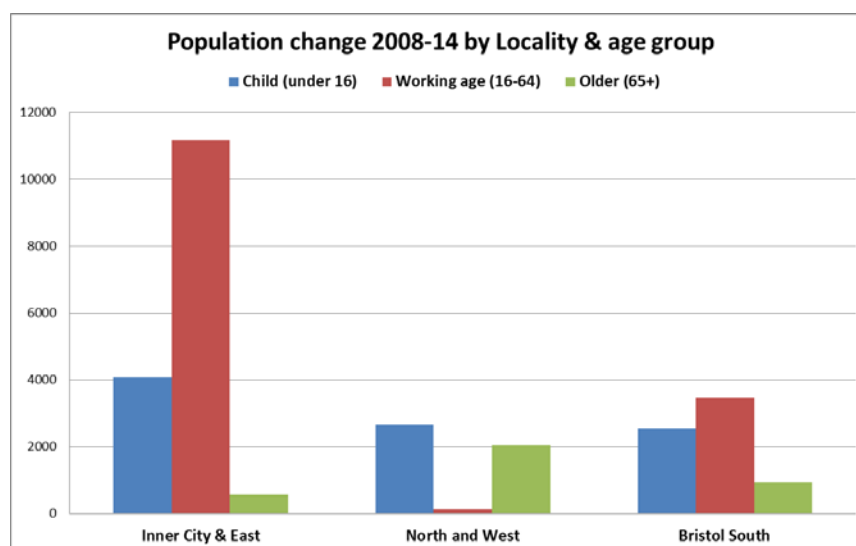


Fig 3.2.2: Population change 2008-14. Source: ONS Annual Mid-Year Population Estimates, Nov 2015

### Child population changes

Bristol has 82,800 children under 16 and 68,400 young people 16-24 with increases of around 1,000 children and 1,000 young people in the last year.

In the last decade, the number of children (aged 0-15) living in Bristol is estimated to have increased by 11,500 (16%) between 2004 and 2014, and are now at the highest level since the mid-1980's. This increase has been amongst the 0-10 year olds only and in particular amongst the 0-4 year olds (an increase of 35%). The growth in the number of under 5s in the last decade (+8,000) is the fourth highest nationally<sup>10</sup>. However, since 2012 the fastest rising group is those aged 5-9 (fig 3.2.3).

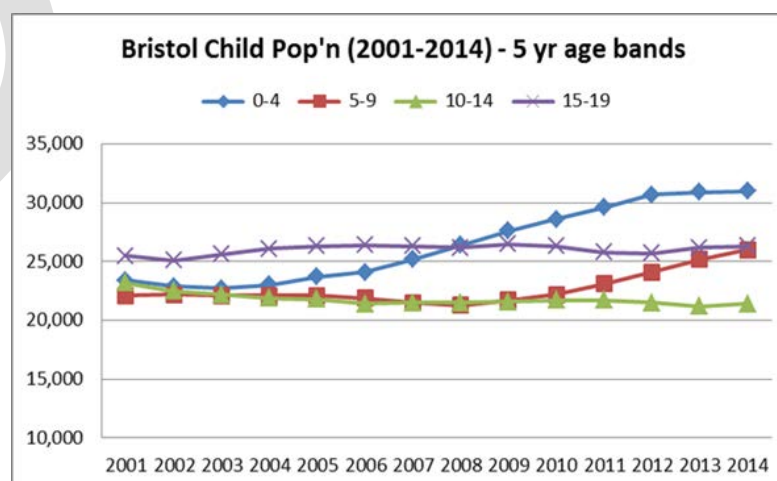


Fig 3.2.3, Source: Population Estimates Unit, ONS, 2015

<sup>9</sup> Ward-level dwelling-led forecasts are being prepared for end of 2015-16

<sup>10</sup> Population of Bristol 2015 report: [www.bristol.gov.uk/page/population-bristol](http://www.bristol.gov.uk/page/population-bristol)

Bristol's child population is rising in all areas, but has risen fastest in Inner City & East locality (fig 3.2.4). For young people (16-24 years), numbers have only risen in Inner City & East Bristol.

North & West and South localities have the highest *total number of children* under 16, but North & West locality has the lowest *average number in each ward*. Inner City & East has the *lowest total number of children* but the *highest average number of children per ward*. Within localities rates of change vary considerably between wards<sup>11</sup>, with implications for how services can manage demand and where services should most appropriately be located.

### Older people population changes

Bristol has 58,800 older people 65 & over, an increase of over 700 older people in the last year. Within that number are 9,100 people 85 & over, almost 200 more in the last year.

Over the last decade, after a period of the older population (65 & over) falling in Bristol, it is now rising year on year (fig 3.2.5). 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.

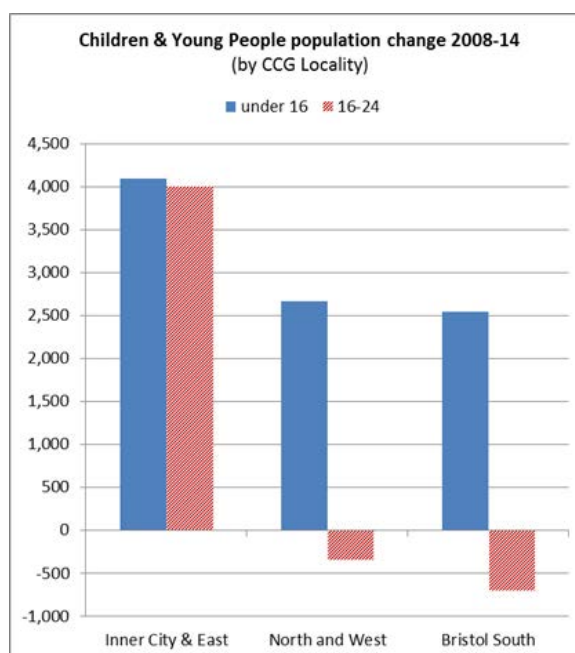


Fig 3.2.4, Source: 2014 ONS Mid-year estimates

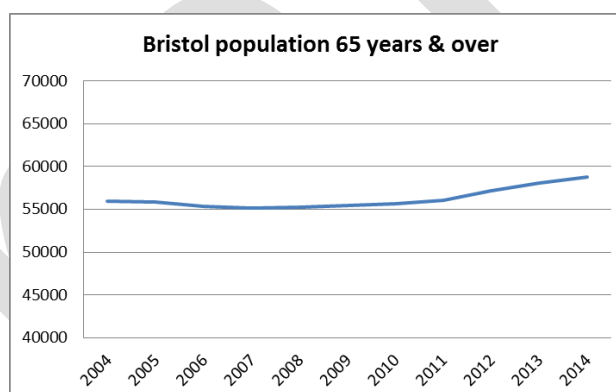


Fig 3.2.5, Source: ONS Mid-Year Population Estimates, 2004-14

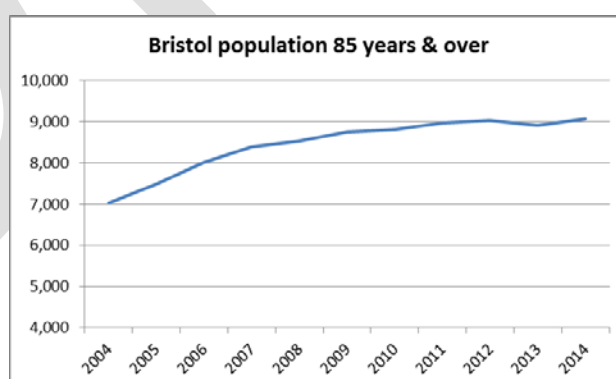


Fig 3.2.6, Source: ONS Mid-Year Population Estimates, 2004-14

<sup>11</sup> 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’<sup>12</sup>, 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<sup>13</sup>, 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<sup>14</sup>, 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; 50% of children in the Inner City & East are BME, compared with 20% in North & West and 13% in South (Fig 3.4.1). By ward, the figure ranges from 6% BME in Whitchurch Park to 83% in Lawrence Hill.

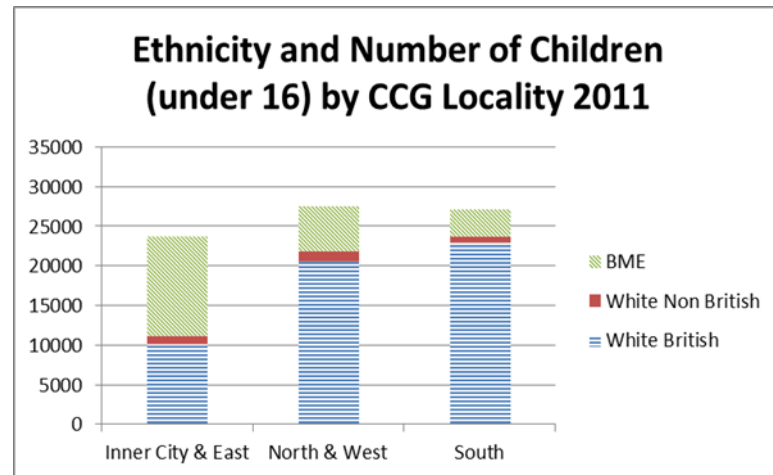


Fig.3.3.1, source: ONS 2011 Census

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 3.4.2) highlights that there are much higher % EAL pupils in Inner City & East Bristol.

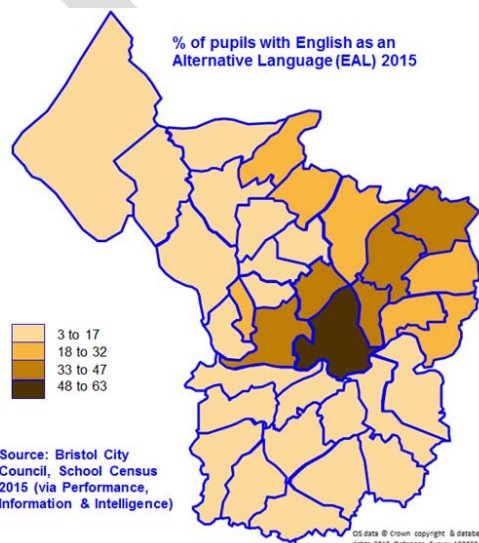


Fig 3.3.2, source: BCC School Census 2015

<sup>12</sup> 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

<sup>13</sup> Source: ONS Census 2011 and 2001

<sup>14</sup> Black or Minority Ethnic group (BME) population includes all groups with the exception of all White groups. Non-‘White

British’ population includes all groups with the exception of White British.



### 3.4 Births

The number of births in Bristol fell for the second year in a row but is still above average for the last decade (Fig 3.5.1). In 2014 there were **6,440 births in Bristol**<sup>15</sup>. Births in Bristol had risen 25% from 2005-2012, with the birth rate rising fastest in Inner City & East, resulting in the highest number of children under 5 in the city since 1980. Although births are no longer rising, in the 12 months to mid-June 2014 there were 3,100 more births than deaths, accounting for 62% of the population increase<sup>16</sup>.

Within Bristol though, numbers of births are remaining constant in South Bristol on average, and falling in the other localities (fig 3.5.2). By ward, annual numbers of new births in 2014 varied from 60 (Stoke Bishop) through 250 (Windmill Hill) and 270 (Easton) to 420 (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. Birth rates are falling in all areas except Bristol South and Bristol East.

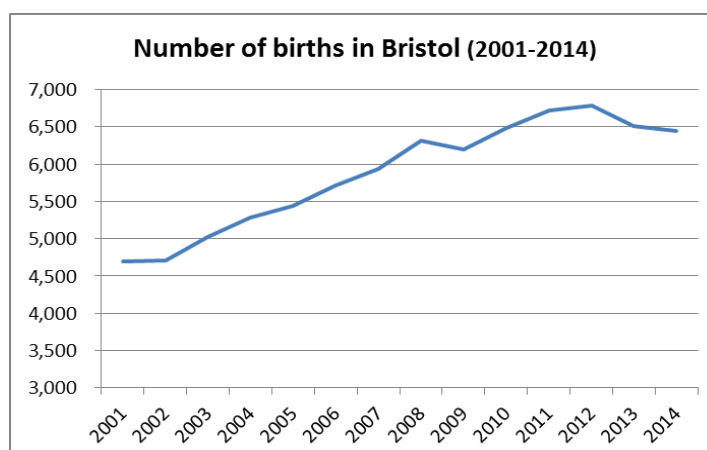


Fig 3.4.1 Source: ONS birth records data, collated by Public Health Intelligence Unit (Bristol City Council)

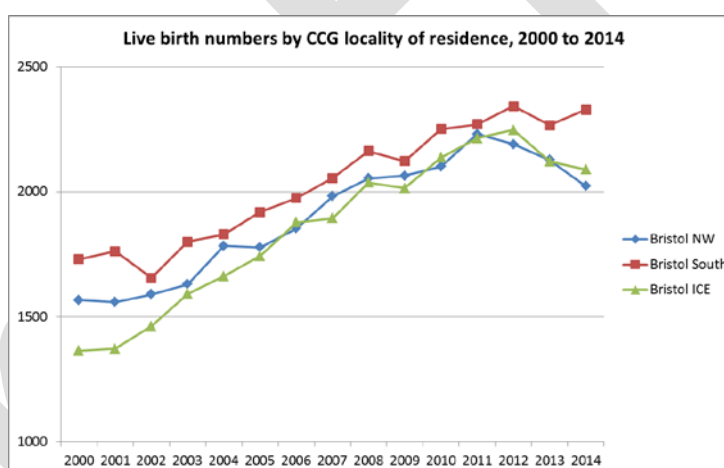


Fig 3.4.2 Source: Public Health Birth File, PHIU, Bristol City Council, 2015

Most births are to UK-born mothers (4,620 in 2014, having fallen from a peak of 4,970 in 2011). 28.3% (1820) of births in Bristol are to non-UK born mothers, and this figure has fallen slightly since 2012. Births to mothers from Somalia and increasingly from Poland are the most common countries of origin (Fig 3.5.3).

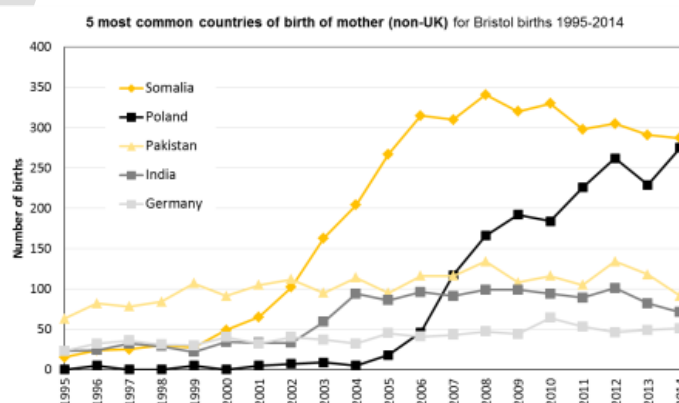


Fig 3.4.3 Source: Public Health Birth File, PHIU, Bristol City Council, 2015

<sup>15</sup> Source: Public Health Birth File, Public Health Intelligence Unit (PHIU), Bristol City Council, 2015

<sup>16</sup> ONS 2014, via Mid-2014 Population Estimates Briefing Note from [www.bristol.gov.uk/page/population-bristol](http://www.bristol.gov.uk/page/population-bristol)

### 3.5 Population projections

If recent trends continue, the population of Bristol is projected to increase 9.7% to 474,400 (2012-2022) and for the first time exceed half a million usual residents by 2029 (528,200 by 2037)<sup>17</sup>.

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

By 2022, there are projected to be 12,400 more children (15.4% rise), but the young person population (16-24 years) remains broadly stable. Other age groups are projected to rise at least 9%, and notably there are projected 8,100 more people 65 & over by 2022, a 14.2% rise, which is a new challenge (table 3.6.1 & fig 3.6.2).

#### Child projections

Most of the rise in the child population is now projected to be in the 5-9 years and 10-14 years age bands (an increase of 19.5% and 23.7% respectively) (table 3.6.3, fig 3.6.4). These increases in population numbers will have implications for health, education and social care services in the city.

<sup>17</sup> ONS 2012-based Sub-national Population Projections, published May 2014. Next update 2016. Note – These are trend-based projections, so assumptions for future levels of births, deaths and migration are based on levels observed 2008 to 2012. They show what the population will be *if* the 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.

Age	2012	2017	2022	Change to 2022	
0-15	80,700	86,700	93,100	12,400	<b>15.4%</b>
16-24	66,800	67,900	66,200	-600	<b>-0.9%</b>
25-49	163,900	171,500	178,600	14,700	<b>9.0%</b>
50-64	63,900	67,900	71,200	7,300	<b>11.4%</b>
65-74	29,100	32,300	33,100	4,000	<b>13.7%</b>
75 +	28,100	28,600	32,200	4,100	<b>14.6%</b>
All age	432,500	454,900	474,400	41,900	<b>9.7%</b>

Table 3.5.1 Source: ONS 2012-based Sub-national Population Projections

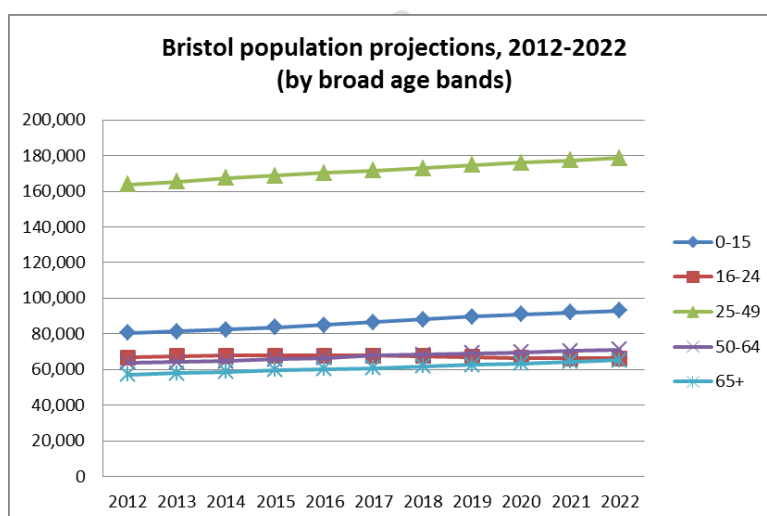


Fig 3.5.2 Source: ONS 2012-based Sub-national Population Projections

Age group	2012	2017	2022	% change 2012-22
0-4	30700	31600	32800	6.8%
5-9	24100	28000	28800	19.5%
10-14	21500	23000	26600	23.7%
15-19	25700	25500	26700	3.9%

Table 3.5.3 Source: ONS 2012-based Sub-national Population Projections

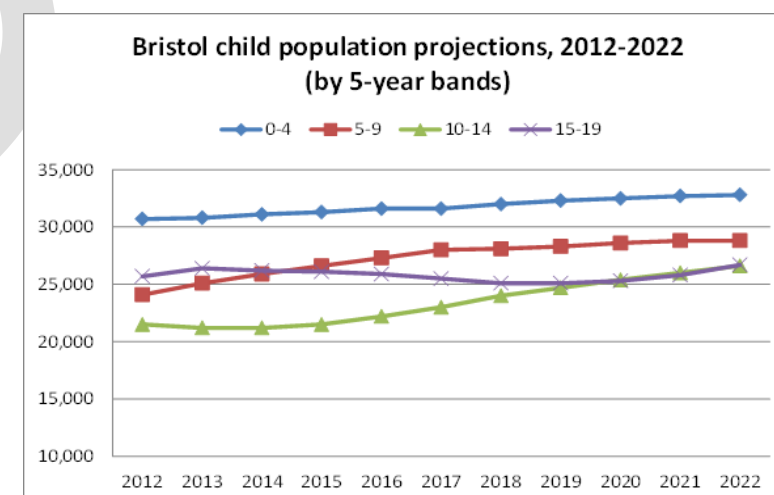


Fig 3.5.4 Source: ONS 2012-based Sub-national Population Projections

## Specific population groups

### 3.6 Carers

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](http://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<sup>18</sup> 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<sup>19</sup> (mainly mental health/social isolation/educational attainment impacts eg 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.

<sup>18</sup> Source: Bristol Carers Support Centre, using Becker and Dearden formula (Loughborough University) applied to ONS mid-2014 population estimates for Bristol

<sup>19</sup> Source: Children's Society Report 'Hidden From View', via Bristol Carers Strategy 2015–2020; [www.bristol.gov.uk/policies-plans-and-strategies/carer-strategy](http://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 when 17.8% of all people had a ‘long-term limiting illness’. However, the population of Bristol has increased considerably over the decade and the actual number of people whose day-to-day activities are limited has increased from 67,700 people to 71,700 people.

Of the 71,700 people who have a limiting long-term condition or disability, 34,550 (8%) have day-to-day activities that are limited a lot and 37,150 (9%) have day-to-day activities that are limited a little.

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.

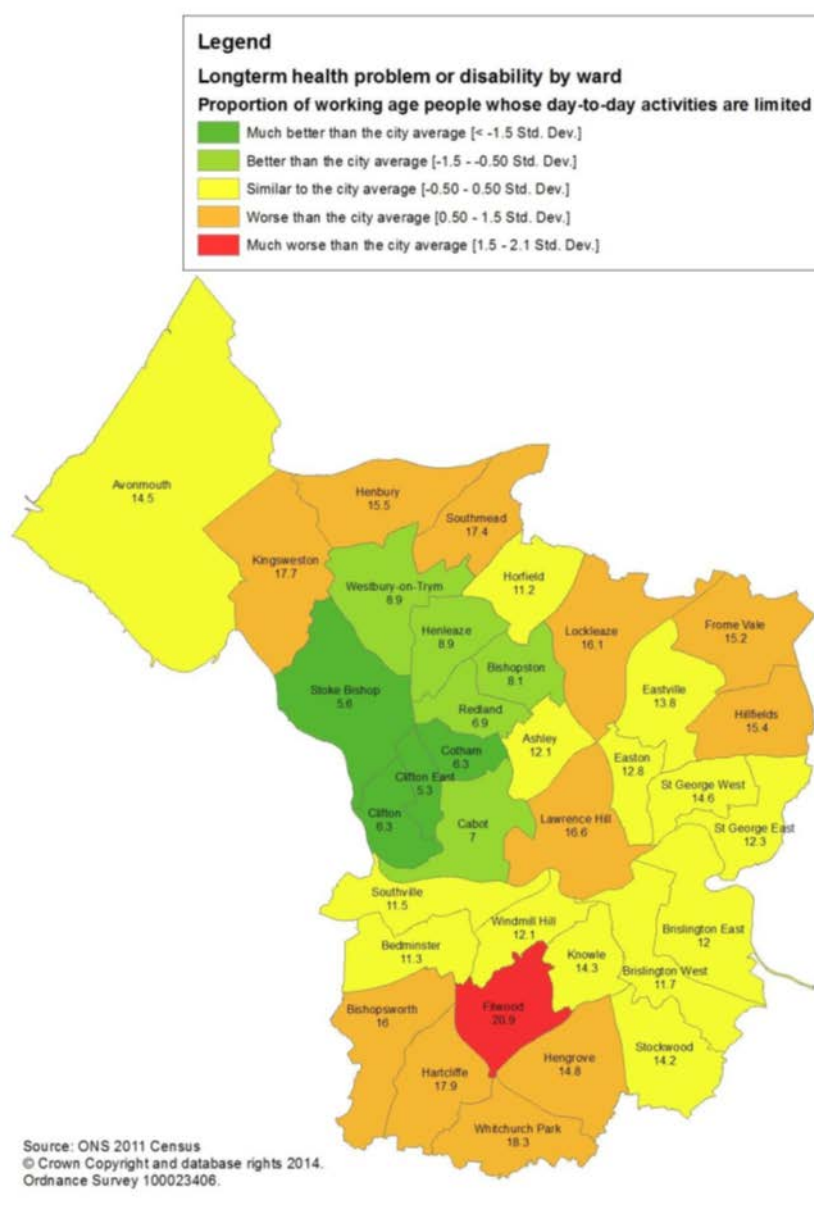


Figure 3.7.1: Long-term health problem or disability by Bristol ward  
 Source: 2011 Census ONS Crown Copyright Reserved [from Nomis on 5 June 2013]

## 3.8 People with Learning Difficulties and Autism

### 3.8.1 Learning Difficulties<sup>20</sup>

According to overall population estimates<sup>21</sup>, there are around 7,250 (18-64 years) and 1,230 (over 65's) adults in Bristol with some level of Learning Difficulty (or Learning Disability) in 2015.

Data from GP patient registers<sup>22</sup> indicates there are around 1,940 people recorded as having Learning Difficulties (LD) in Bristol. This will focus on those with moderate to severe LD who are most likely to require support. This represents 0.5% of the patient population, which is similar to the England average.

Further data details are available in the Public Health England Learning Disabilities profiles for each Local Authority area:

<http://fingertips.phe.org.uk/profile/learning-disabilities>

### 3.8.2 People with Learning Difficulties: health conditions & inequalities

A review of health checks for people with Learning Difficulties in Bristol (2012-13) suggests that this group have an increased number of health conditions and a significantly worse health profile compared to the overall % of Bristol patients.

These local findings reflect national research<sup>23</sup> showing increased rates of conditions including epilepsy, psychiatric disorders and coronary heart disease for people with learning difficulties, which also highlighted inequalities in life expectancy, as men with learning disabilities die an average 13 years sooner than the wider population and women die 20 years sooner.

### 3.8.3 Autistic Spectrum Conditions

In terms of overall population prevalence<sup>24</sup>, there are estimated to be 2,690 males and 290 females in Bristol with some level of autistic spectrum condition in 2015 (2,980 adults, 18-64 years).

In terms of people who require interventions from services, 42 adults were newly diagnosed as having autistic spectrum condition (ASC) in 2013-14 and referred to services (Bristol Autistic Spectrum Service). A further 113 were referred for an assessment. Many ASC people do not require formal interventions from services.

Data on ASC children will be reviewed in 2016, due to recent changes to definitions for categories of children with Special Educational Needs (SEN).

<sup>20</sup> Learning Difficulties is the locally used term in Bristol. Nationally the NHS uses the term Learning Disabilities.

<sup>21</sup> Institute of Public Care, POPPI and PANSI tools, [www.poppi.org.uk](http://www.poppi.org.uk); national 2004 prevalence estimate applied to the Bristol population; accessed Oct 2015

<sup>22</sup> via the NHS Quality Outcomes Framework, QOF, 2013/14 (released Oct 2014)

<sup>23</sup> "Confidential Inquiry into premature deaths of people with learning disabilities"; University of Bristol, 2013; [www.bristol.ac.uk/cipold](http://www.bristol.ac.uk/cipold)

<sup>24</sup> PANSI tool, [www.pansi.org.uk](http://www.pansi.org.uk); national 2007 prevalence estimate of 1% of adult population applied to the Bristol population; accessed Oct 2015



### 3.9 Gender

The Bristol population is 220,900 males and 221,500 females (or 49.9% men and 50.1% women). However, there are more men than women in the 25-49 year age group and more women than men aged 65 and over (fig 3.1.1).

Healthy Life Expectancy is broadly similar for men (63.0 years) and women (62.6 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 males (16.3 years gap) and females (16.7 years gap). However, there are many differences.

#### 3.9.1 Key Poor Health Headlines (for men)<sup>25 26</sup>

- Male life expectancy in Bristol is 4.5 years lower than for females [*England gap is 3.7 years, 2012-14*]
- Men are twice as likely as women to die from the 10 most common cancers (for both sexes)
- Men typically develop heart disease 10 years earlier than women
- Men under the age of 45 visit their GP half as often as women

- 16% of men die while still of working age compared with 6% of women
- Men are three times more likely to commit suicide than women
- Men tend to be reluctant to seek help and use health services until later in the course of a condition or illness, with a negative impact on their outcome
- Men find it difficult to come forward with mental or emotional problems, and many men lack social networks
- Men are more resistant to health promotion messages [*eg Quality of Life survey 2014 shows men are more likely to smoke, to be overweight or obese and less likely to eat healthily; also alcohol-related mortality in males is significantly higher than for females*]

#### 3.9.2 Key Poor Health Headlines (for women)<sup>27</sup>

- Whilst women live longer than men, they spend more years in poor health and with a disability.
- One in three women die from cardiovascular disease
- Women are more at risk of stroke than men and tend to be more seriously affected, needing long-term care.
- Women are more likely to suffer arthritis and rheumatism - the most common types of chronic diseases in the UK.
- In the last 20 years, rates of smoking & lung cancer fell for men, but rates increased and stabilised for women.
- Women in the most deprived areas have cervical cancer rates more than three times the rates in the least deprived areas.
- Women living in deprived areas have a lower survival rate for breast cancer.
- Recorded rates of depression and anxiety are more than twice as high for women than for men.
- Women are more likely to become socially isolated than men (*due to living longer*)
- Women and girls in the UK are more likely to have poor sexual health than their European counterparts.
- Many women have physical activity levels well below recommendations, increasing rates of overweight & obesity, and poor diets. These characteristics can be across all women but are significantly worse amongst deprived communities.

<sup>25</sup> NHS Bristol Single Equality Scheme 2009-2012 (April 09) <http://www.bristol.nhs.uk/about-us/equality/single-equality-scheme.aspx>

<sup>26</sup> "A Picture of Health? Men's Health and Wellbeing in Bristol", NHS Bristol, 2011

<sup>27</sup> Women's health and wellbeing in Bristol, Dec 2013 (Bristol Public Health)

### 3.10 Gypsy, Roma & Travellers

Gypsy, Roma & Travellers (GRT) have historically had the poorest outcomes of any ethnic group in England<sup>28</sup>. The obstacles and constraints facing GRT families are multiple and complex.

Local evidence suggests that there are around 500 Gypsy and Traveller families living in Bristol<sup>29</sup> 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 (i.e. boat dwellers) are often underrepresented in GRT data and provision but share similar health/educational outcomes.

#### 3.10.1 Health Outcomes

Gypsy, Roma & Travellers have poorer life outcomes than any other group, across a wide range of social indicators<sup>30</sup>. The average life expectancy of a GRT person is 50 years.

The most robust study (excluding New Age travellers) was undertaken by Parry et al. and compared the health needs of 293 Gypsies and Travellers in 5 areas in England (including Bristol), to the needs of 293 non-travelling adults, matched for age and sex in rural and deprived communities. Key findings from this study are included below (SWPHO, 2011:3 - 4)<sup>31</sup>

##### 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<sup>32</sup> shows that

- Domestic abuse is a notable health issue for GRTs. Estimated that 60% - 80% of women from travelling communities experience domestic abuse during their lives; compared to 25% of the wider female population.
- Suicide rates are 7 x higher than the general population

<sup>30</sup> Bhattacharyya et al. 2003; DfE, 2010 and Rowe and Goodman, 2014

<sup>31</sup> South West Public Health Observatory (SWPHO) report (October 2011).

<sup>32</sup> [www.twelvescompany.co.uk/cornwall/information-about-specialist-support/gypsies-travellers](http://www.twelvescompany.co.uk/cornwall/information-about-specialist-support/gypsies-travellers)

<sup>28</sup> Ofsted; Dec 2014 and SWPHO, 2011:3

<sup>29</sup> Bristol GTAA, 2013

### 3.11 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](http://www.bristol.gov.uk/people-communities/equalities-data-and-research)

Specific vulnerable groups to identify more detailed information on in future include the below, plus Disabled people, inc Sensory Impairment, Homeless people, Gypsy & Travellers, and to develop new sections on Offenders, Veterans, Sex Workers and others.

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

The government estimates that 5-7% of the population are lesbian, gay or bisexual, so Bristol may have 26,500 people who are lesbian, gay or bisexual (estimate 22,000 – 31,000).

Estimates from the Gender Identity Research and Education Society indicate 1 in every 4000 people (0.025% of population) are transgender. This indicates 110 transgender people living in Bristol.

A new survey commissioned by Bristol HealthWatch regarding LGBT Health Needs is due to be published at the end of 2015. The

results from this survey will be included in future JSNA reports.

#### 3.11.2 Migrant Health Needs

A Migrant Health Needs Assessment<sup>33</sup> (2012) reported on the health needs of migrants in detail. This particularly looked at the biggest groups of recent migrants to Bristol: Somali, Polish and Indian communities.

In terms of settled communities, Bristol has about 10-11,000 migrants from the A8 (Eastern Europe) countries, including 6-7,500 Polish; also 6,500 -10,000 Somalis and about 5,000 migrants from India. There are also around 6,000 international students at Bristol's universities. Asylum-seekers, new refugees, and failed asylum-seekers are estimated to be around 200-300, but with some of the highest levels of health need.

<sup>33</sup> Bristol Migrant Health Needs, Bristol NHS 2012

## Section 4

# Children & Young People's Health

### Summary points<sup>34</sup>

#### 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.
- The number of births has fallen slightly but a high number of births still accounted for 62% of the population increase in 2014.
- The 0-15 population is expected to rise by 15.4% by 2022.

#### Baby and maternal health

- The percentage of all live & stillbirths (inc premature) that had a low birth weight is lower than the national average but there remains inequality at a ward level.
- Infant mortality rates in Bristol are lower than the England average and comparable cities.
- Breastfeeding initiation and continuation rates in Bristol are higher than nationally but within the city are lowest for women

from White ethnic groups living in deprived wards.

- Maternal smoking rates at delivery are similar to nationally but there are very marked variations across the city. Rates in Bristol are falling in line with those nationally.

#### Children and Young People's Health

- An estimated 3250 children in Bristol have a limiting long-term illness or disability, a higher percentage of the child population than nationally.
- The proportion of Bristol children at school entry (23%) and end of primary school (34.8%) who are obese or overweight is similar to the national average but is a concern nationally.
- Rates of dental decay for Bristol are similar to nationally but there is evidence of large inequalities across Bristol wards.
- Immunisation coverage for child immunisations is above national average for under 1s, but are below the 95% target for under 2s as nationally.
- An estimated 10% of children and young people may be experiencing emotional health problems at any time, and self-harm hospital admission rates in 10-24 yr olds exceed the England average.
- Levels of testing for Chlamydia in Bristol are higher than the national average, but the detection rate for Chlamydia has fallen significantly below the national average.
- Teenage pregnancy rates have fallen and are now similar to the England average.

#### Social care and wider determinants

- The number of children living in poverty in Bristol is higher than the England average.
- There has been improvement in health assessments for looked after children, but recorded immunisations remains lower than nationally.
- The number of first-time entrants to the Youth Justice System in Bristol is significantly higher than nationally.

<sup>34</sup> These cover all relevant Children & Young People areas throughout the JSNA sections.

### 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) less than ideal conditions during pregnancy, e.g. poor health in the mother, smoking, drinking or taking drugs during pregnancy, or crowding (e.g. due to 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 broadly similar to the average for England (2.9%).

Babies born prematurely, i.e. before 37 weeks of pregnancy, are much more likely to be of low birth weight. In 2013, 5.7% of all Bristol live and stillbirths had a 'low birth weight', significantly better than the England average (7.4%)<sup>35</sup>.

As numbers of low birth weight babies are relatively small we use 5-year averages to allow comparison at ward level (fig 4.1.1). Across Bristol this average has fallen from 7.5% (2001-05) to 5.6% (2010-14). However, there remains inequality at ward level<sup>36</sup> with low birth rate ranging from 3.4% in Stoke Bishop & Clifton to 7.4% in Lawrence Hill & Filwood.

A project<sup>37</sup> to explore trends in childhood disability in Bristol linked information on birth weight with having special educational needs as reported in the local school census. The project showed that being of less than normal 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.

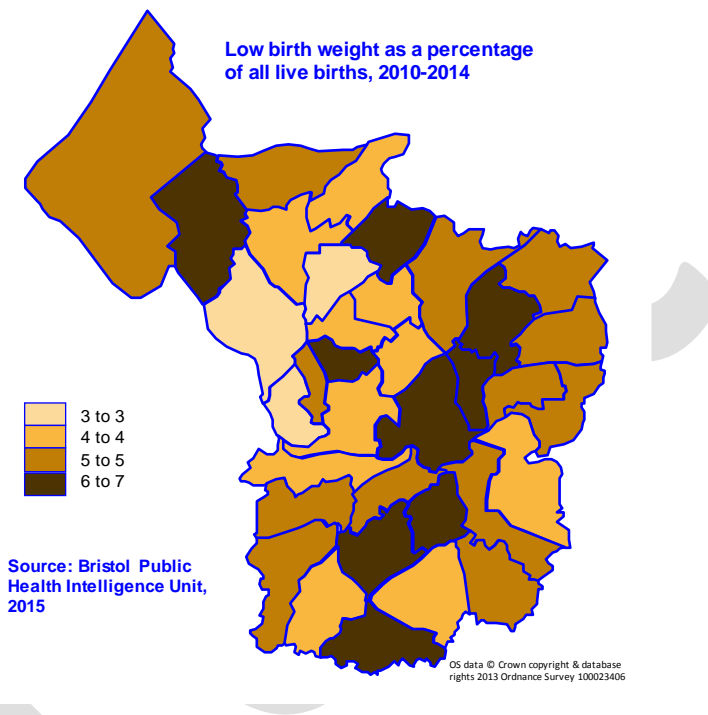


Fig. 4.1.1, source: Bristol Public Health Intelligence Unit, 2015

<sup>35</sup> Bristol Child Health Profile 2015

<sup>36</sup> Source: Bristol Public Health Intelligence Unit, 2015.

<sup>37</sup> 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<sup>38</sup> in Bristol is 3.3 deaths per 1,000 live births (2011-2013) which is lower than the England average (4.0 deaths per 1000 births), see Fig 14.2, and is lower than many comparable cities. The rate has risen in the last 2 years. The most likely reason for this is random variation in small numbers of cases, 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.

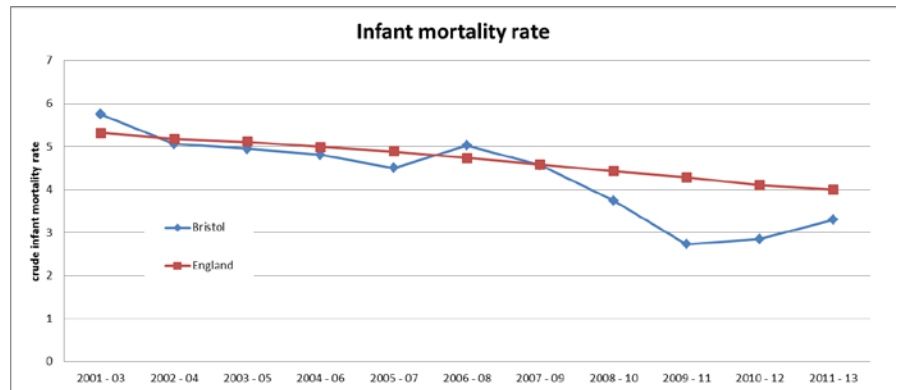


Fig 4.2.1: Infant mortality rates

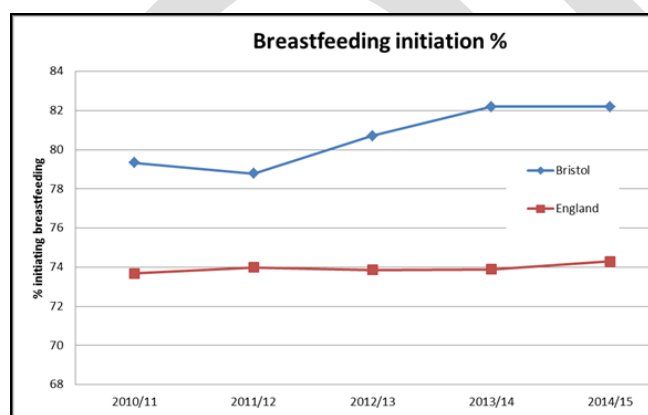
<sup>38</sup> Source: ONS mortality & birth data, via Public Health Outcomes Framework data tool (Aug 2015)

### 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<sup>39</sup>. 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%. 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. 4.3.1, source: via Public Health Outcomes Framework (Aug 2015)

#### 4.3.2 Breastfeeding (continuation)

The World Health Organisation recommends that all mothers should feed their babies only breast milk for the first six months of life. Data is not available to measure breastfeeding at 6 months. All mothers have contact with health services when their baby is 6-8 weeks of age, which is the time they have their first set of immunisations. We therefore measure breastfeeding continuation rates at 6-8 weeks. Whilst many mothers start breastfeeding, some find it difficult to continue; therefore rates are lower at this follow up. Bristol has significantly better breastfeeding continuation rates at 6-8 weeks (58.4% in 2014/15) than England as a whole (43.8%) and higher than most comparable cities<sup>40</sup>.

There is variation in breastfeeding continuation rates across Bristol. In general, rates are lowest in South Bristol (21% in Whitchurch Park & 23% in Hartcliffe), and highest in North and West (inner) locality (88% in Cotham and 84% in Redland). Generally, there is a higher rate of breastfeeding in BME communities.

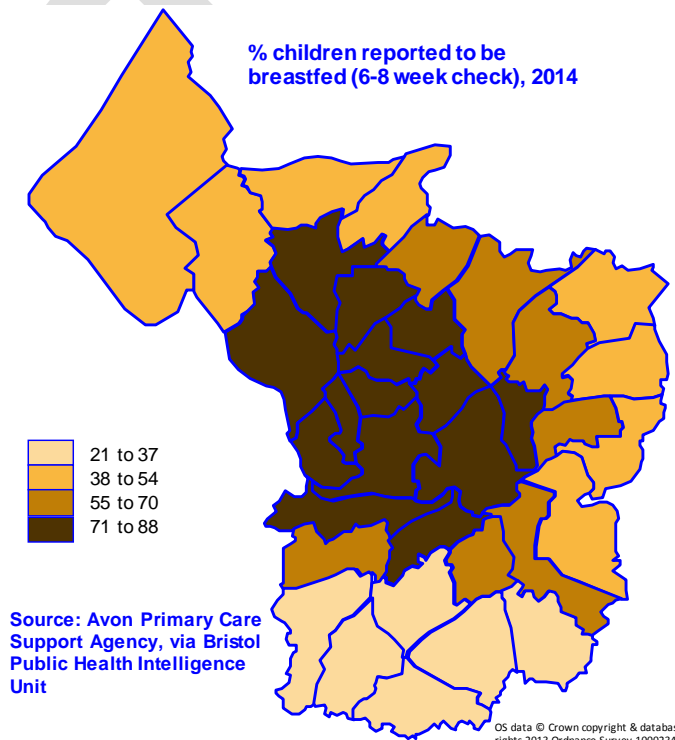


Fig 4.3.2, Source: Avon Primary Care Support Agency, via Public Health Bristol Intelligence Unit (Bristol City Council) 2015

<sup>39</sup> Source: NHS England 2013/14, via Public Health Outcomes Framework data tool (Aug 2015)

<sup>40</sup> Source: NHS England 2013/14, via Public Health Outcomes Framework data tool (Aug 2015)

### 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 figures for 2014-15 indicate **11.1% (over 720) pregnant mothers in Bristol self-reported as smokers**<sup>41</sup> (fig 4.4.1), which is now falling in line with England average (11.4%) where there has been a continuing downward trend.

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

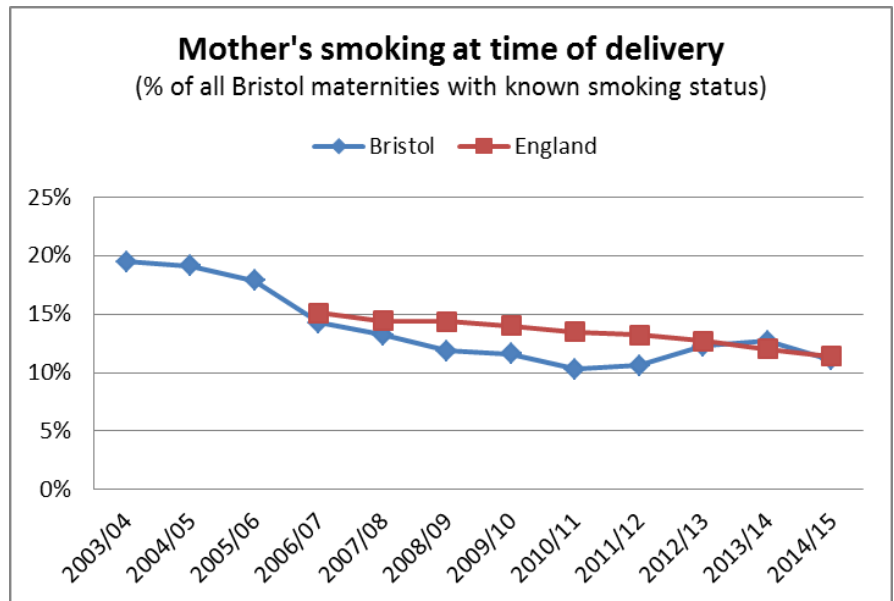


Fig. 4.4.1, source: Local NHS maternity providers; via Public Health Outcomes Framework (Nov 2015)

Updated local data is not yet available, 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. 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%).

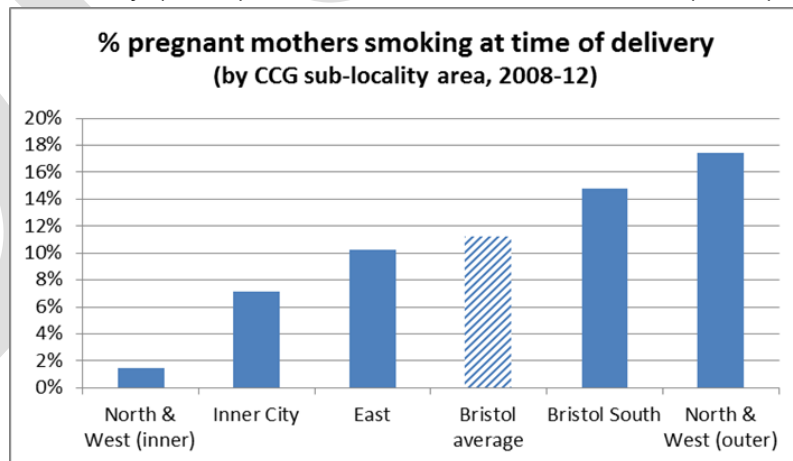


Fig. 4.4.2, source: Local NHS maternity providers; via Bristol Public Health Intelligence Unit, 2014

<sup>41</sup> Smoking Status at Time of Delivery, 2014-15; Copyright © 2015, Health and Social Care Information Centre

### 4.5 Children with limiting long-term illness and disability

According to the Census 2011, 3,250 children in Bristol have a “limiting long-term illness or disability”. This is 4.1% of the local child population, higher than the national average 3.8% (note – this is in contrast to the % of all population, where Bristol is below national % – see 3.8). Of these, 1,300 children (1.7% Bristol, 1.6% England) have their daily activities limited a lot and 2,000 children (2.5% Bristol, 2.2% England) limited a little.

Fig. 4.5.1 highlights that within Bristol there is variation in reporting from 2.7% in North & West (inner) to 4.6% in South and 4.8% in North & West (outer). The map (Fig 4.5.2) shows the combined % for Bristol wards, from 2% in Clifton East & Cotham to 5% in several outer wards and 6.1% in Filwood.

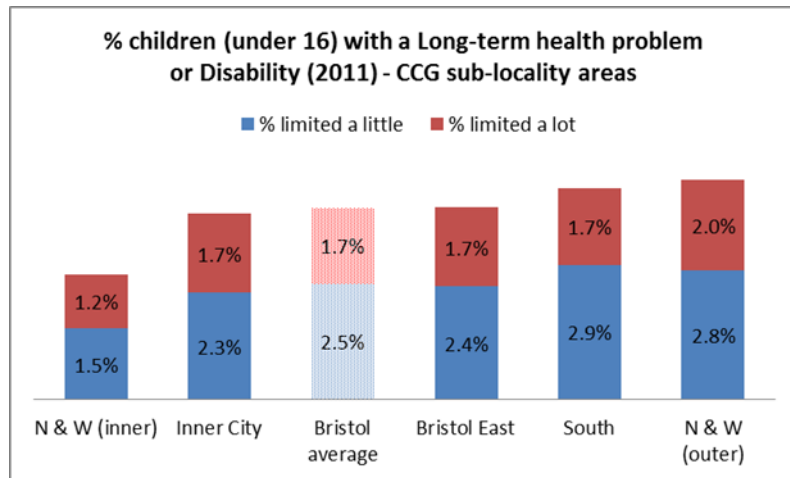


Fig 4.5.1: % Chart by sub-locality areas. Source: Census 2011, ONS

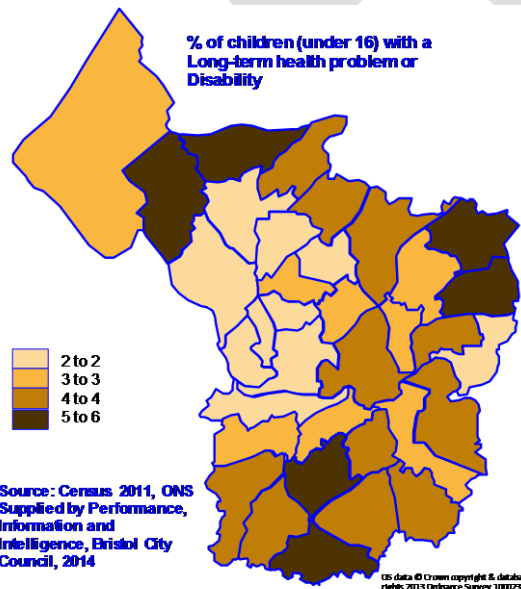


Fig 4.5.2: % Children with limiting condition

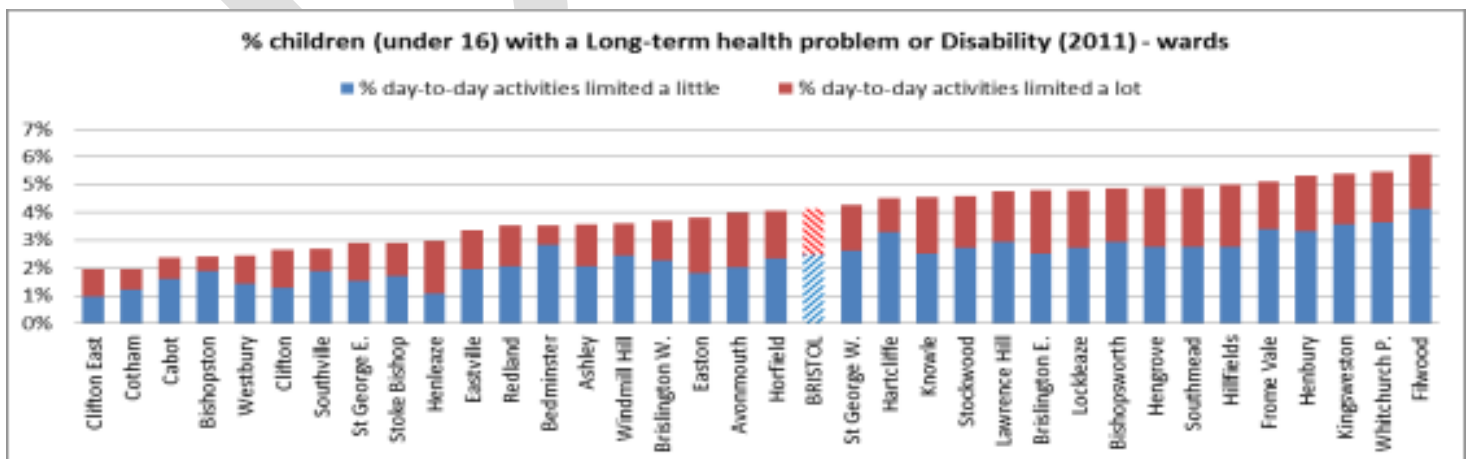


Fig 4.5.3 Source: Census 2011, ONS Supplied by Performance, Information and Intelligence, Bristol City Council, 2014

## 4.6 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 (10-11 year olds) to assess the proportion who are overweight or very overweight (obese). These data are 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 being obese as an adult, and adult obesity is linked to diabetes, heart disease, stroke and cancer. Tackling obesity is complicated as the causes are societal, cultural, environmental and economic as well as individual choices.

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

The proportion of children overweight or obese in England has been constant, between 22-23%, since the NCMP programme began in 2006/7. In Bristol, the rate was higher than the England average (around 25%, 2007-2010), but since 2009/10 had been falling. In 2013/14 the proportion of obese or overweight children aged 4-5 years in Bristol (23%) has risen slightly but remains statistically similar to that in England as a whole (22.5%) (fig 4.6.1). The rates in Bristol are similar to other comparable cities.

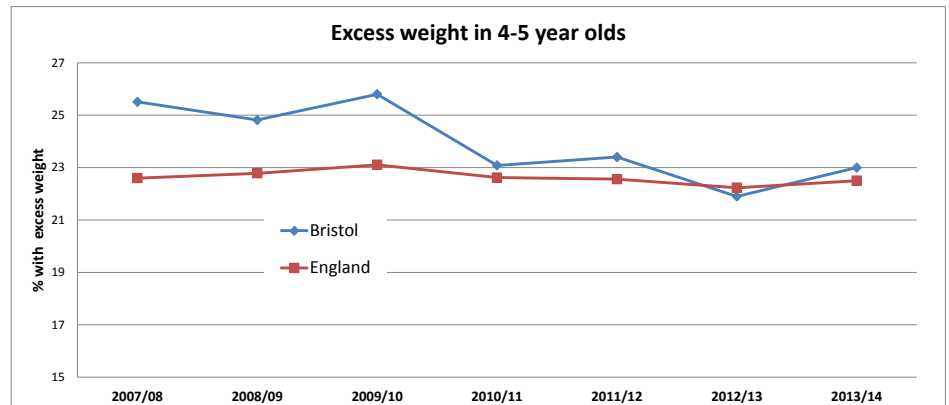


Fig 4.6.1 Source: National Childhood Measurement Programme (NCMP) via Public Health Outcomes Framework, 2015

Within Bristol, the proportion of 4-5y olds who are overweight or obese is lowest in North & West (inner) and highest in South, and North & West (outer) (Fig 4.6.2 chart). Due to the relatively small numbers, the data are presented as 3 year averages. The range is from 13% in Clifton East & Bishopston to over 30% in Cabot, Bishopsworth and highest 32% in Southmead (2011-14)<sup>42</sup>. In some wards one in three children by the time they start school 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.

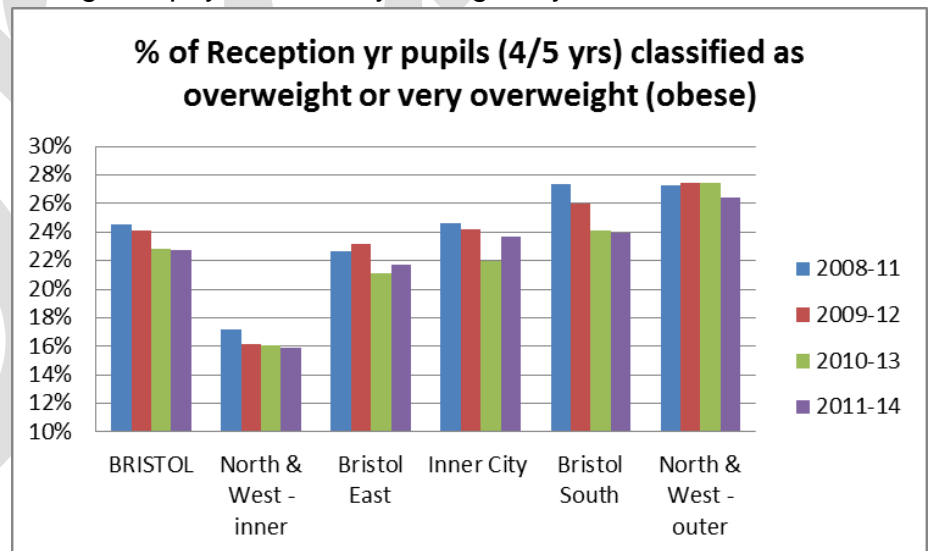


Fig 4.6.2 Excess weight in 4-5 yr olds by Bristol area, 2011-14 Source: NCMP via Bristol Public Health Intelligence Unit 2015

<sup>42</sup> Note – ward map is not shown but is available in the JSNA Atlas tool



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

The proportion of 10-11 year old children overweight or obese in England has been constant, between 32-33% since the NCMP programme began in 2006/7. In Bristol, the rate has consistently been similar to that in England as a whole, and in 2013/14 the proportion of 10-11 year olds who were obese or overweight was 34.8%, statistically similar to the national rate of 33.5%. Compared to similar cities across England, the rates in Bristol are similar or statistically lower than others.

Three year, ward level average rates, show variation across the city. As with the rates in younger children, 10-11y olds in North and West (inner) have much lower rates of overweight and obesity, whilst all other areas have more than one in three children overweight or obese by the time they leave primary school. (fig 4.7.2 – chart 4.7.3 ward map). There has been a particular increase in rates in Bristol East over the period 2008-11 to 2011-14. Ward level rates vary from 15% in Cotham & 17% in Redland to over 41% in Hartcliffe and Whitchurch Park (2011-14).

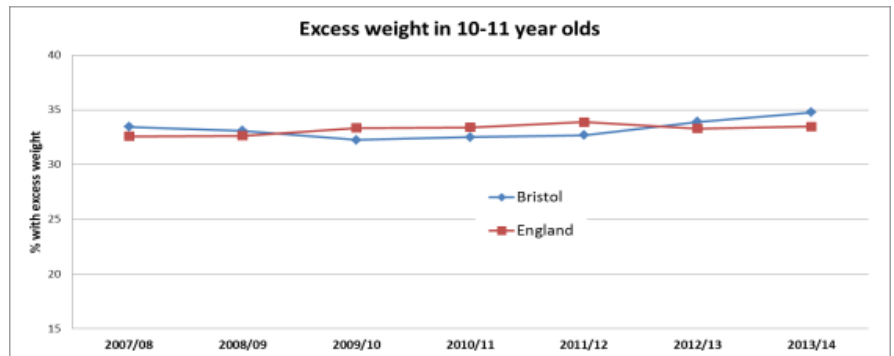


Fig 4.7.1: Source: National Child Measurement Programme (NCMP) via Public Health Outcomes Framework, 2015

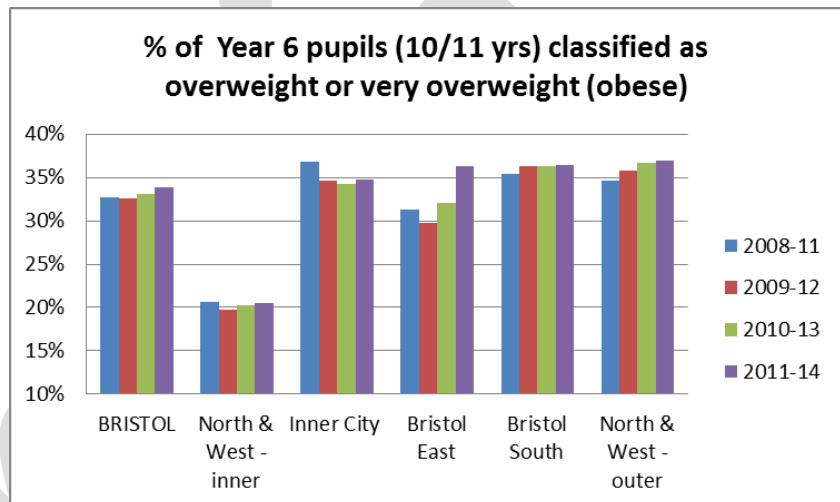


Fig 4.7.2: Excess weight in 10-11 yr olds by Bristol area, 2011-14  
Source: NCMP via Bristol Public Health Intelligence Unit 2015

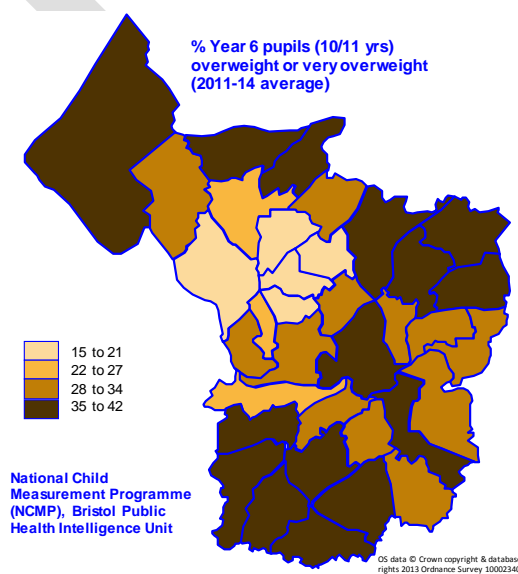


Fig 4.7.3: Excess weight in 10-11 yr olds by Bristol wards, 2011-14  
Source: NCMP via Bristol Public Health Intelligence Unit 2015

## 4.8 Dental health<sup>43</sup>

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 results for Bristol show that the proportion of 3 year olds (2013/4) with decay (15.3%) is higher than the England average (11.7%). 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 rate of dental decay in Bristol reception year children (survey of 5 year olds, 2011-12) was reported as (0.8 decayed, missing

or filled teeth per child) similar to the rate for England (0.9 decayed missing or filled teeth per child). However, this survey method is known to underestimate the true prevalence of dental decay, and in Bristol the number of children for whom parental consent was given was very low (3.5% of eligible 5 year olds) compared to the nationally consent rate of 21%. Reasons why the consent rate in Bristol was so low are unclear. It is likely that the parents of children with poor dental health were more likely to decline consent.

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

More children have not attended NHS dental services in the past 24 months in Bristol (33.4% of 0-17 year olds) than the England average (32.5%) (2014). The % of children and young people (0-19 years) admitted to hospital for extraction of one or more decayed primary or permanent teeth is higher (0.72 % of resident population, 2012/13) than the England average (0.48).

Some children are particularly vulnerable to poor dental health. Fewer looked after children in Bristol (74.5%) had received a dental check-up than nationally (82%) (2012/13)

Local data on dental payments for fillings in children under 5yrs and on children requiring a general anaesthetic for dental extraction of decayed teeth suggest that the dental health of children aged five in Bristol is poor. This may underestimate true rates since they only reflect children using dental services, and not all children have check-ups. Data on fillings in children under 5 yrs highlight inequality with rates per 1000 children ranging from 10 in St George East to over 100 in Southmead, Lawrence Hill & Ashley.

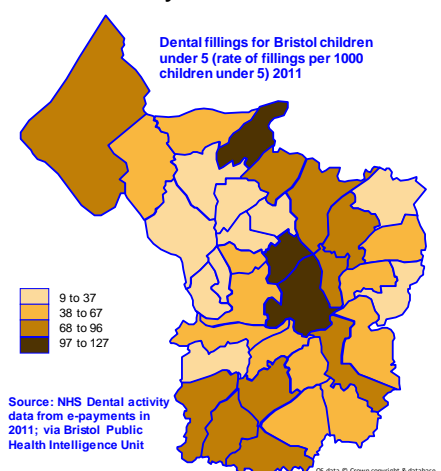


Fig. 4.8.1: Source: Dental activity data from e-payments provided to NHS in 2011, via Bristol PHIU 2014

<sup>43</sup> Via Profile for Oral health in Bristol. June 2015. Public Health England.

## 4.9 Childhood Immunisations

For most immunisations, achieving an uptake of over 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.

### 4.9.1 Immunisations due by 1 years 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 96% uptake in Bristol (2013/14) is significantly better than England as a whole (94.3%), and is one of the highest of the English Core Cities.

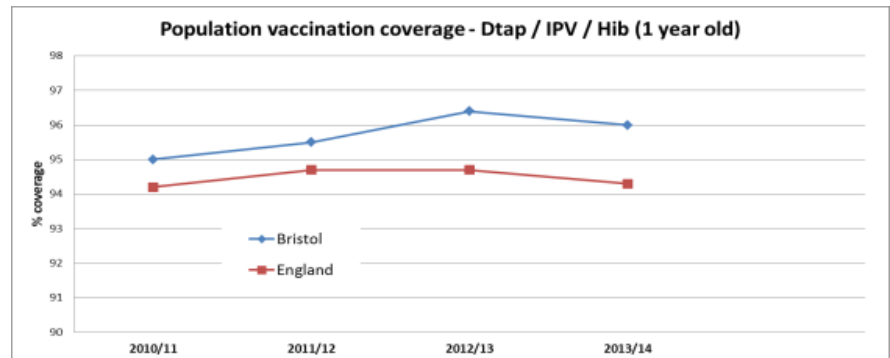


Fig. 4.9.1: Source: Cover of Vaccination Evaluated Rapidly 2013/14 data via Public Health Outcomes Framework, 2015

**b) MenC** - 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 C (MenC). The 95.4% uptake in Bristol by one year of age (2012/13) is statistically higher than the England average (93.9%). A vaccine against another type of meningitis (Meningitis type B) will be introduced to the routine childhood vaccination schedule from October 2015.

**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 95.6% uptake of this vaccine in Bristol (2013/14) is statistically significantly higher than the England average (94.1%).

### 4.9.2 Immunisations due by 2 years old

**a) DTaP/IPV/Hib** - By the age of two years a child is recommended to have been given 3 doses of the vaccine (NB same doses as above, due to be given by 1 years old). The 2013/14 uptake of this vaccine in Bristol by 2 years of age (97.3%) is significantly better than England (96.1%).

**b) PCV booster** – In addition to the 2 doses of the vaccine above, a booster dose is due at 12-13 months. The 2013/14 uptake of this booster dose in Bristol is 92.9%, significantly better than the England average of 92.4%.

**c) Hib / MenC booster** - A booster vaccination routinely offered about 12 months of age. The uptake in Bristol was 92.1% (2013/14), broadly similar to the

England average of 92.5%, although has been gradually increasing from about 84% in 2008/09. Nationally there remains room for improvement to reach the 95% target.

**d) MMR one dose** - MMR is a single vaccine that protects against Measles, Mumps and Rubella (German measles). One dose should be received by the age of 2 years (about 12 months of age). 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 has risen year on year to 92.3% in 2013/14 and for the first time is no longer significantly lower than the England average (92.7%).

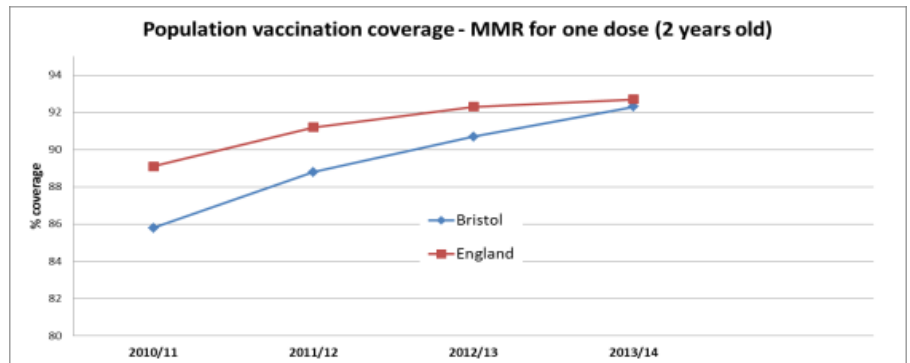


Fig. 4.9.2 Source: Cover of Vaccination Evaluated Rapidly 2013/14 data via Public Health Outcomes Framework, 2015

### 4.9.3 Immunisations due by 5 years old

**a) 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 2013/14 was 92.5%, higher than the England average of 91.9%.

**b) 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 three and a half years of age). In Bristol, uptake of the 1<sup>st</sup> MMR dose by age 5 rose to 94.3% in 2013/14, now similar to the England average (94.1%).

**c) 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 87% in 2013/14. This level has risen significantly in the last year, but remains statistically significantly lower than the England average (88.3%) and lower than most comparable cities, & neighbouring areas, so there is still work to do.

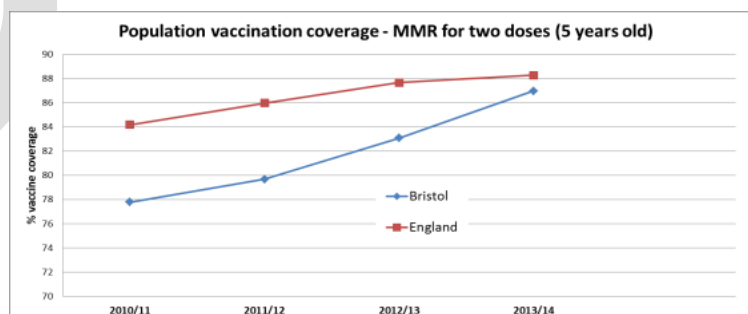


Fig. 4.9.3 Source: Cover of Vaccination Evaluated Rapidly 2013/14 data via Public Health Outcomes Framework, 2015

#### 4.9.4 Local vaccination coverage data 2014-15

Most recent local data for 2014/15 from NHS Bristol CCG highlights a pattern of differences across the city, with all immunisations (for all ages under 5) having higher uptake rates in South Bristol, and lower in Inner City & East. In particular:

- whilst Bristol on average meets the 95% target for all Immunisations due by 1 years old, Inner City & East is slightly below target for DTaP/IPV/Hib and PCV.
- for MMR vaccination (one dose by 2 yrs) South Bristol (95.3%) is now meeting the 95% target, but coverage in Inner City & East (86.4%) is still significantly below the target.

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

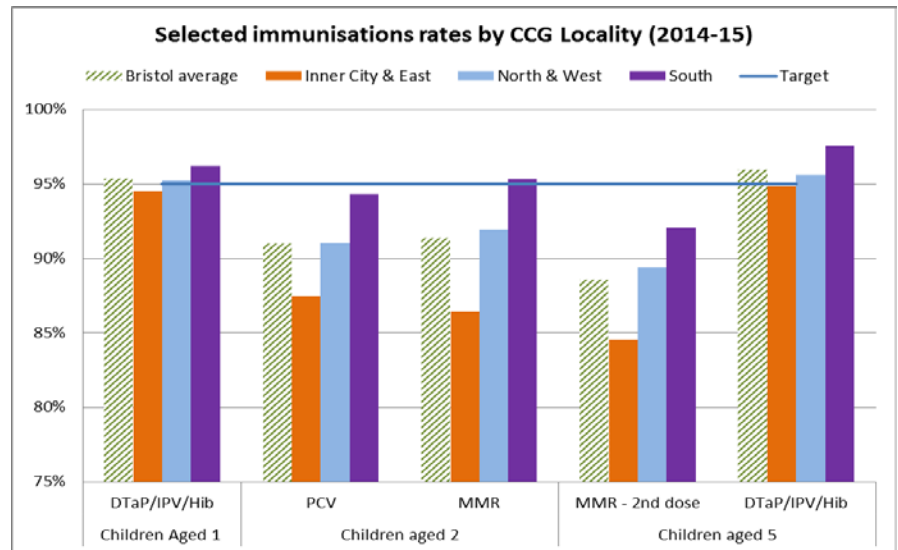


Fig. 4.9.4 Source: NHS Bristol CCG - Immunisation Rates summary, 2014-15, Commissioning Support Unit

#### 4.9.5 Immunisations due by 13 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 has risen to 76.6% (2013/14) but is still significantly below England average (86.7%). 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.



## 4.10 Injuries

### 4.10.1 Injuries in children

Rates of emergency hospital admissions caused by unintentional or deliberate injuries to children (2013/14)<sup>44</sup> in Bristol are similar to national rates. The rate for Bristol as a whole is 110 per 10,000 children aged 0-14y is less than the rate for England (112 per 10,000 children).

There is variation by ward within Bristol (fig 4.10.1) with the highest rates in wards in the South locality. The map shows hospital admission rates for children aged 0-14years using 3 year averages, 2012/13 - 2014/15.

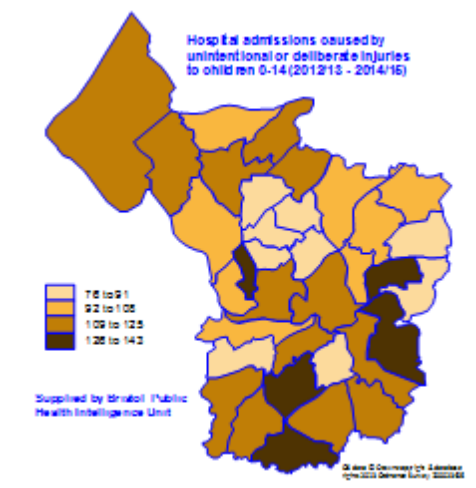


Fig. 4.10.1 Source: Bristol Public Health Intelligence Unit (2012/13-2014/15)

For children aged 0-4years the rate for Bristol (143 per 10,000) is higher but not significantly different to the rate for England (141 per 10,000).

The leading causes of preventable emergency admissions are falls; the single biggest cause is falls involving playground equipment (which may be at home, those provided by private enterprises or those managed by the local authority). Trampolines are associated with approximately 20% of playground equipment-related admissions. After falls, the next highest single cause is contact with hot drinks.

### 4.10.2 Injuries in young people

Rates of emergency hospital admissions in 2013/14 caused by unintentional or deliberate injuries in young people aged 15-24 yrs old in Bristol is 141 (per 10,000 population) and is similar to the national rate of 137 (per 10,000).

However, across Bristol rates vary (see map of 3 year average rate, 2012/13-2014/15) from 60 in Cotham to 253 in Hengrove (both per 10,000 population). Rates are highest in wards in South Bristol and North & West (outer).

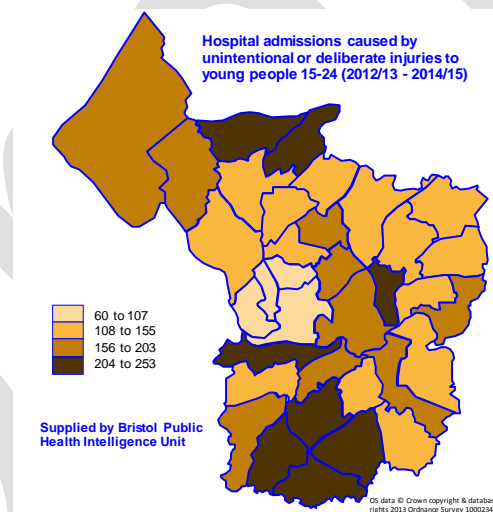


Fig. 4.10.2 Source: Bristol Public Health Intelligence Unit (2012/13-2014/15)

The leading cause of preventable emergency admission in this age group is deliberate self-harm<sup>45</sup>, which was the cause of 42% of unintentional or deliberate injuries during 2012/13 - 2014/15. This is followed by falls (13%), transport accidents & collisions (9%) and assaults (8%) as the major reasons.

<sup>44</sup> Crude rates of admissions per 10,000 resident population, Calculated by Public Health England, via PHOF tool, Aug 2015

<sup>45</sup> For more details about deliberate self-harm, see Emotional Health and Wellbeing of Young People (in JSNA section 9. Mental Health)

### 4.11 Childhood Asthma

Asthma is the most common chronic disease of childhood. The causes are not completely understood, but the strongest risk factors for developing asthma<sup>46</sup> 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.

Since the introduction of smokefree legislation in England in 2007, there has been a substantial decline nationally in the number of hospital admissions for childhood asthma. There are now around 400-500 emergency hospital admissions<sup>47</sup> each year due to asthma in children under 19 in Bristol. In 2014-15 there were 480 emergency admissions, with more in South Bristol than the other Localities (fig 4.11.1). By ward, the highest admissions were in Lawrence Hill, Southmead and Filwood, which are 3 of the most deprived wards in Bristol.

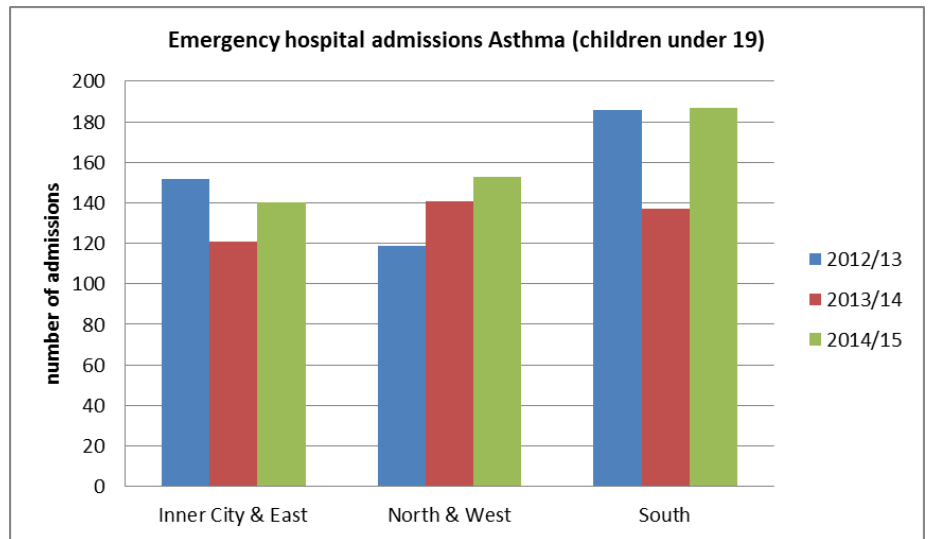


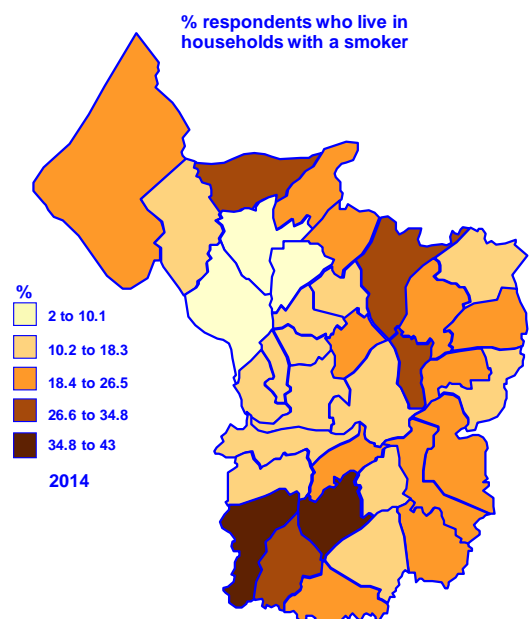
Fig 4.11.1. Source: SUS via ABI Data Warehouse 2015 (via South West Commissioning Support Unit)

### Asthma and second hand smoking

Asthma attacks can be triggered by second hand smoke and so lead to increased likelihood of admission to hospital. The principle source of exposure to second hand smoke for children is in the home<sup>48</sup>.

According to the Quality of Life (QoL) Survey 2014 for Bristol, 20% of respondents live in a household with a smoker and rates are highest in Filwood (43%), Bishopsworth (35%) and Easton (33%). Furthermore, there is a big difference in households

where someone smokes regularly inside the home; Quality of Life data shows rates in Filwood were 3 times the average for Bristol, and in Easton and Hartcliffe were twice the Bristol average. Smoking inside the home increases potential exposure to second hand smoke.



<sup>46</sup> World Health Organisation, Fact sheet on Asthma (No.307), Nov 2013

<sup>47</sup> Source: SUS via ABI Data Warehouse 2015; provided by: South West Commissioning Support Unit

<sup>48</sup> Action on Smoking and Health (ASH), Research report - Asthma & Smoking, 2015

## Section 5

# Wider Determinants

### Summary points

There are many factors which affect our ability to be healthy, known as the wider determinants of health. These include lifestyle, social & community influences, living & working conditions 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.

72,000 people (17% of Bristol population) are "income deprived" – in Lawrence Hill (36%) and Filwood (35%) is more than 1 in 3.

### Child Poverty

Bristol has 18,170 children under 16 (22.6%) living in low-income families, significantly more than the England average (18.6%)

### Young People

Overall Bristol's education results are improving, but within Bristol there remains significant variation.

NEET data highlights inequalities in opportunity for young people in

some of the most deprived areas of Bristol.

First-time entrants to the Youth Justice System is significantly higher than nationally and the gap appears to be widening

### Employment & Economy

Bristol's labour market was hit harder by recession than nationally and recovery has been slower. The unemployment rate in Bristol (8%, 2014) is higher than national.

Productivity in Bristol is high, but other areas are catching up.

### Housing

Serious shortage of affordable housing and rising homelessness.

House prices are rising, and a considerable increase in people private renting (and in rental costs).

### Crime

Recorded crime trends in Bristol declined to 2013, but the rate of decline slowed and appears to have stopped falling.

Residents noting fear of crime "affects their day-to-day life" has shown a significant fall over the last 5 years (from 26% to 15%).

### Social Isolation

It is estimated there are 20,000 people (18-64) & up to 11,400 older people (65 & over) experiencing social isolation in Bristol. Social isolation can have physically and emotionally damaging effects.

### Promoting Healthy Urban Environments

Bristol needs built environments that help people to be healthy

Bristol's rate of road traffic injury is significantly lower than the national average. Emergency admissions to hospital from travel-related causes are highest for cyclists and pedestrians.

### Domestic Abuse

Over 1 in 4 women will experience domestic abuse in their lifetimes. Incidents recorded by the police are increasing but still below estimated actual number, suggesting a need for cultural change and victim advocacy.

## 5.1 Deprivation<sup>49</sup>

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

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

The Indices of Deprivation 2015 reinforce previously identified patterns of deprivation across the city. The greatest levels of deprivation in Bristol are in Whitchurch Park, Hartcliffe, Filwood and Lawrence Hill (fig 5.1.1).

A greater proportion of Bristol's population live in the most deprived areas in England in 2015 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 live in the 10% most deprived areas.

Based on Local Authority citywide summary<sup>50</sup> measures, on the

majority of measures Bristol continues to have lower levels of deprivation relative to the other 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.

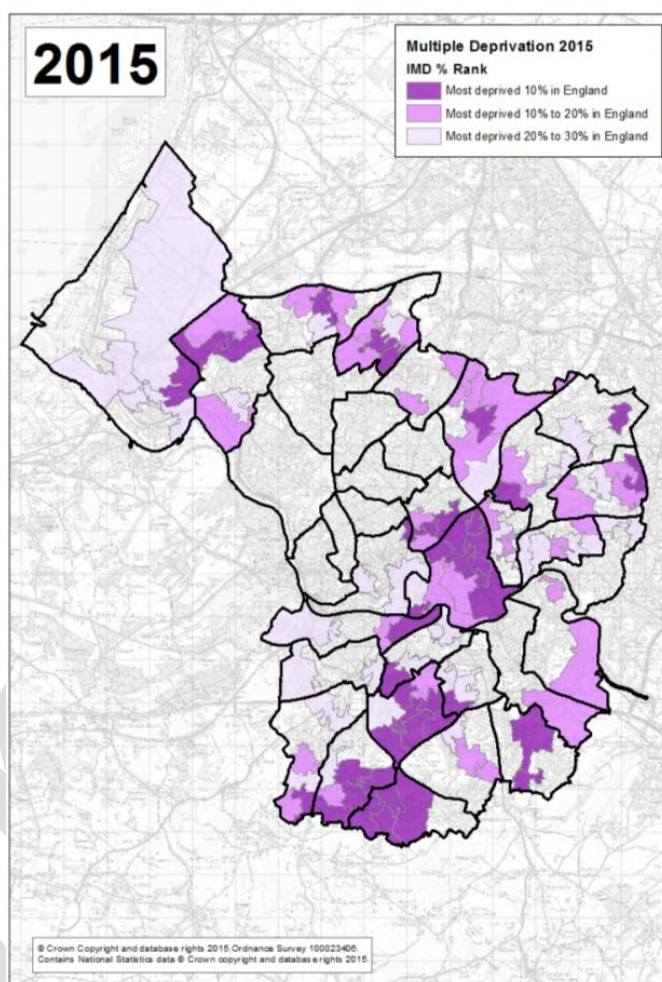


Fig 5.1.1: Multiple Deprivation 2015 - Bristol LSOA11 ranked in the most deprived 30% in England

Source: English Indices of Deprivation 2015, DCLG © Crown Copyright

Bristol has 42 “LSOA”s in the most deprived 10% in England for Multiple Deprivation. Of these 42 LSOAs, there are 26 in the most deprived 5% in England and 6 in the most deprived 1% in England (fig 5.1.2). In 2010, only 1 LSOA was in the most deprived 1%.

<sup>50</sup> There are 6 summary measures to help understand deprivation patterns for local authority areas, as the pattern of deprivation will be very varied. The measures identify the overall intensity of deprivation, how deprivation is distributed across the larger area, and the overall ‘scale’ of deprivation. No single summary is the ‘best’ measure, as each highlights different aspects of deprivation.

<sup>49</sup> See Deprivation in Bristol 2015 Briefing, [www.bristol.gov.uk/deprivation](http://www.bristol.gov.uk/deprivation)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)



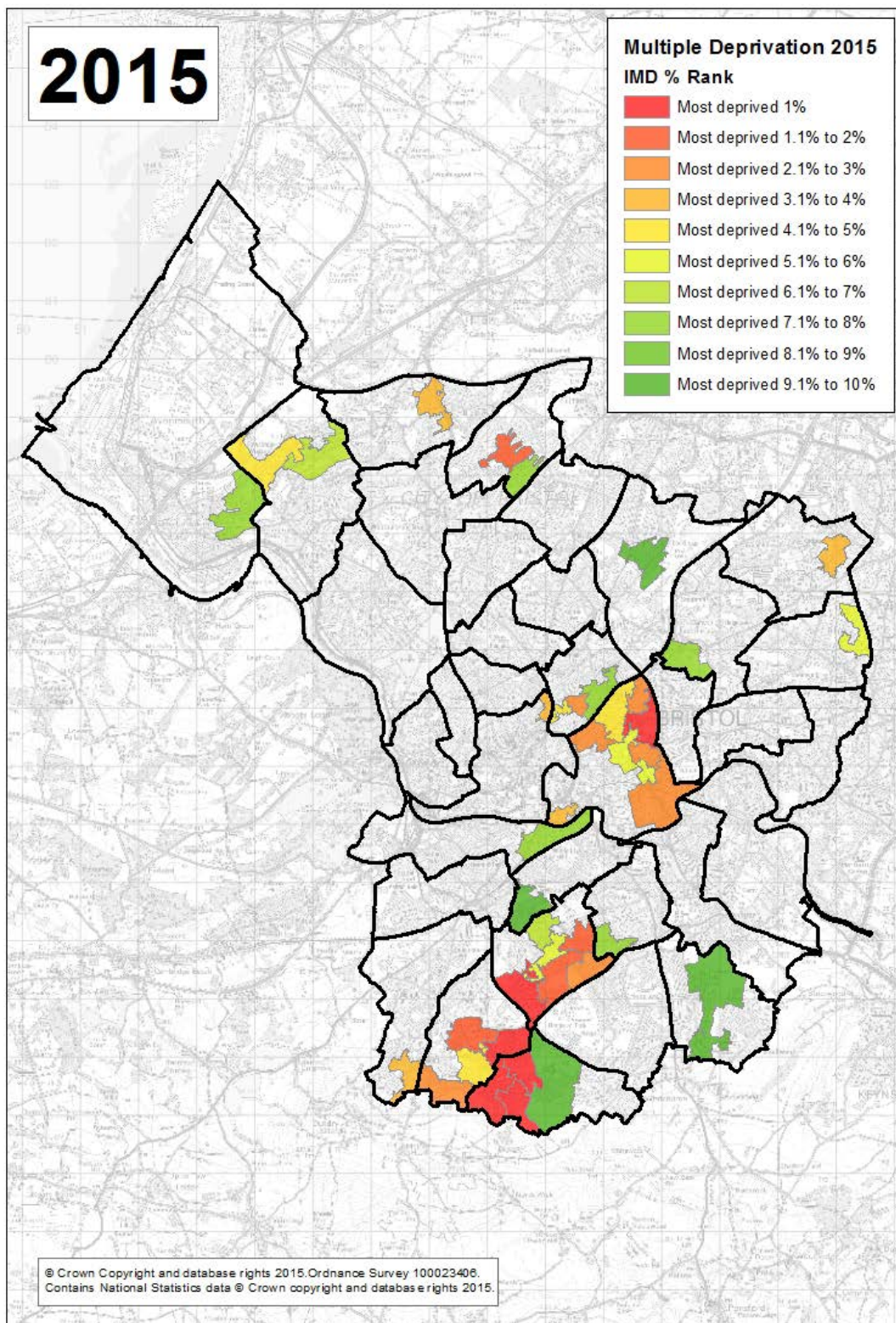


Figure 5.1.2: Multiple Deprivation 2015 – Bristol LSOA11 ranked 1% to 10% most deprived in England  
Source: English Indices of Deprivation 2015, DCLG © Crown Copyright 2015

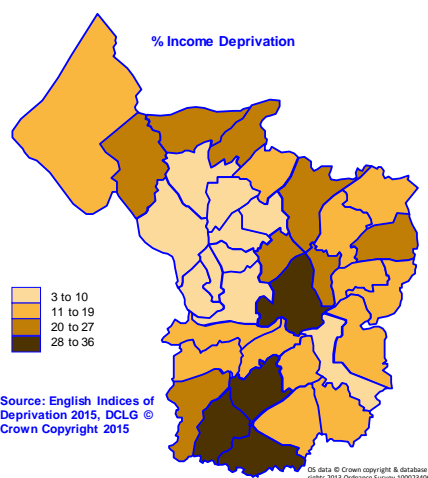


## 5.2 Income deprivation<sup>51</sup>

In Bristol as a whole almost 72,000 people (17% of the population) suffer from income deprivation. The proportion varies across the city.

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

By ward, more than a third of people are income deprived in Lawrence Hill (36%) and Filwood (35%).

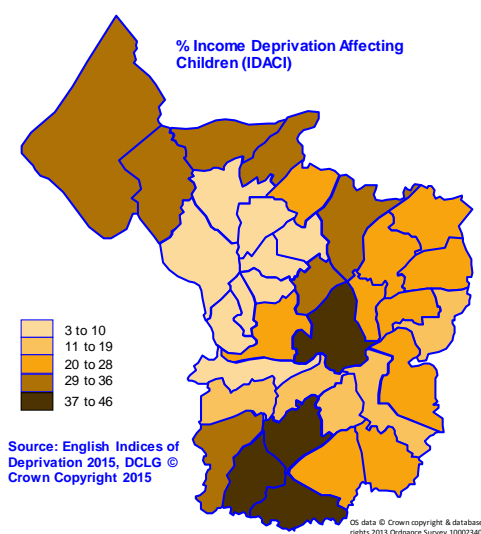


**Fig 5.2.1**  
**Income deprivation affecting children (IDAC)**

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 – 3 of these areas are in Hartcliffe, 3 in Whitchurch Park, 3 in Filwood, 2 in Lawrence Hill and 1 in Ashley ward.

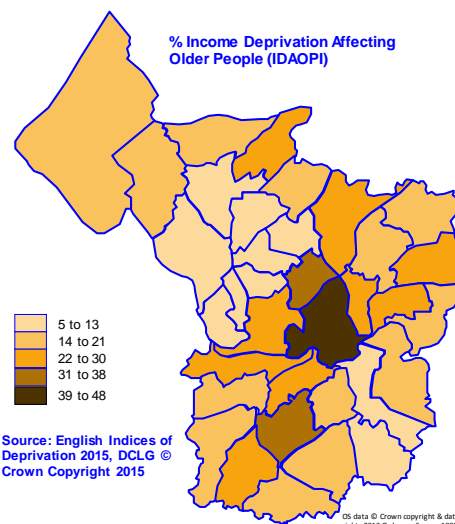
On a ward basis, more than a third of all children live in income deprived households in Lawrence Hill ward (46%), Filwood (45%), Whitchurch Park (43%), Hartcliffe, Kingsweston, Henbury and Bishopsworth ward (35%).



**Fig 5.2.2**  
**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 - 4 of these areas are in Lawrence Hill, 3 in Ashley, 1 in Cabot and 1 in Southville ward.

On a ward basis, more than a third of all older people live in income deprived households in Lawrence Hill (48%), Filwood (35%) and Ashley ward (35%).



**Fig 5.2.3**

<sup>51</sup> See Deprivation in Bristol 2015 [www.bristol.gov.uk/deprivation](http://www.bristol.gov.uk/deprivation)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

## People struggling financially

The question ‘How well would you say you yourself are managing financially these days?’ was asked in the 2014 Quality of Life survey. A small proportion, at 13% said they found it quite or very difficult to get by.

Three in ten of residents in Filwood said they had difficulty managing their finances. As might be expected, the pattern across the city reflected areas of deprivation (fig 5.2.4).

The variation by equalities groups was greater than that by ward. Almost a quarter (23%) of Disabled people and of people from Black and Minority Ethnic groups, and half (51%) of people of Muslim faith stated they were managing their finances with difficulty. Carers were also more likely to be experiencing financial difficulties (18%), whereas Older People (10%) were significantly less likely to be struggling financially.

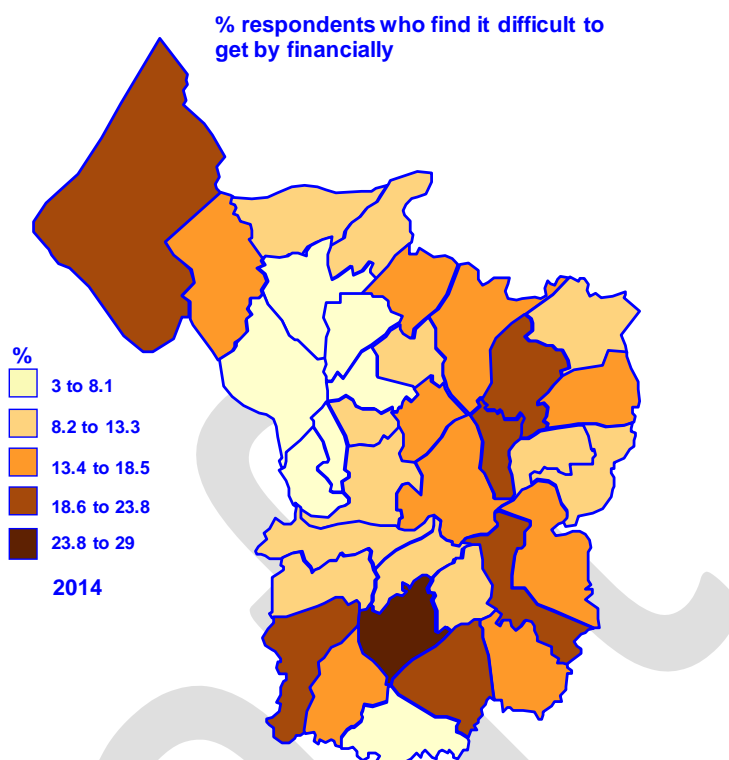


Fig 5.2.4 People who say they are struggling financially. Source: Bristol Quality of Life survey 2014

## Benefits cap

The nationally available income deprivation data uses actual benefits and income records from 2-3 years previously.

Recent local data<sup>52</sup> on the reductions to housing benefits to implement the “benefits cap” illustrates the impact of changes not yet reflected in the Child poverty or Income deprivation data. In Bristol, in 2015 there were over 200 households affected, and *on average* these households had their benefits reduced by £2,900 a year. Households affected are mainly in the Inner City and East Bristol, plus Filwood and Hartcliffe in South Bristol. There are several wards in North & West Bristol where no households are affected at all.

If current national proposals to reduce the benefits cap further (from £26,000 to £20,000 per year) are implemented, it is estimated 1300 households will be affected in Bristol. The impact on population-level deprivation figures is not known, but on an individual level this is affecting households in areas that already have high deprivation.

<sup>52</sup> Citizen Services (Universal Credit team), Bristol City Council, Nov 2015

### 5.3 Child Poverty

Living in relative poverty means that families tend to make lifestyle choices that are less healthy than those made by more affluent families. Data on families in receipt of benefits is a good indicator of the proportion of families living in relative poverty. Data for 2013 (released Sept 2015) shows that Bristol has **22.6%** of children under 16 living in low-income families<sup>53</sup>, which is significantly more than the England average (18.6%). If measured for all dependent children (under 20), the rate in Bristol is 22.1%, compared to national 18%. However, Bristol now has the 2nd lowest % of children in low-income families of the English Core Cities (for both measures). The rate in Bristol, as nationally, has been falling, from 27.1% (20,100 children under 16) in 2009 to 23.6% (18,700 children) in 2012, and now 22.6% (18,170 children under 16) in 2013. Note that these rates are based on actual benefits data that is released nationally 2 years in arrears. The data therefore does not reflect recent changes to benefits policy and uptake.

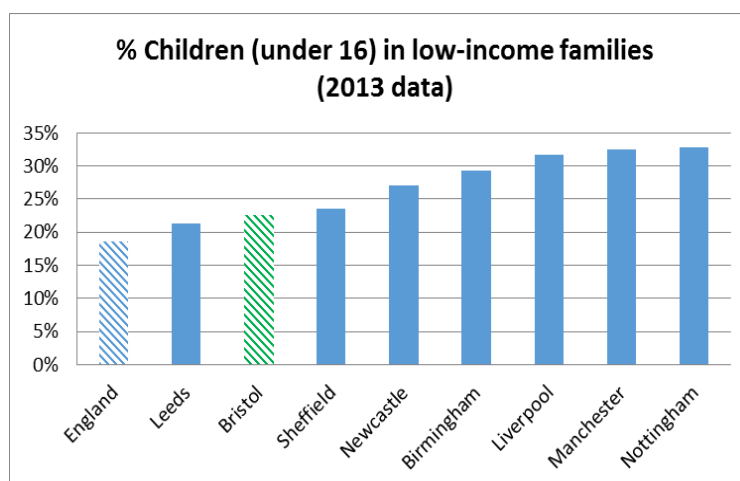


Fig 5.3.1: Source: DWP, Sept 2015

Within Bristol there is a considerable inequalities gap in the percentage of children living in low income families. This ranges from under 3% in Redland and Henleaze (2.4% lowest) to over 40% in Filwood & Lawrence Hill (45% highest).

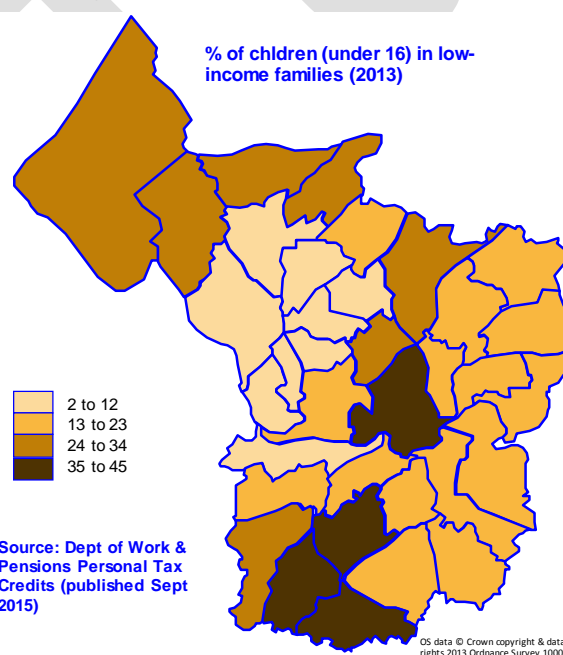


Fig 5.3.2: Source: DWP, via Bristol Performance, Information & Intelligence, 2015

As a comparison, local Free School Meals (FSM) figures for 2015 show 22.2% of Bristol pupils (aged 5-15) are eligible for FSM. This is in line with the children in low-income families figure above, and is lower than the Bristol 2013 figure of 24.2% pupils eligible for FSM.

<sup>53</sup> Snapshot (end of August) of the % of children under 16 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: DWP (Department of Work and Pensions), Personal Tax Credits, 2013 data released Sept 2015

## 5.4 Education

### 5.4.1 Educational development stages

a) 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 2014, 58% of children under 5 were assessed as having a good level of development at Foundation Stage, against an England average of 60%. Across Bristol in 2014, this ranged from 44% in Eastville & Hillfields to 77% in Stoke Bishop & Henleaze.

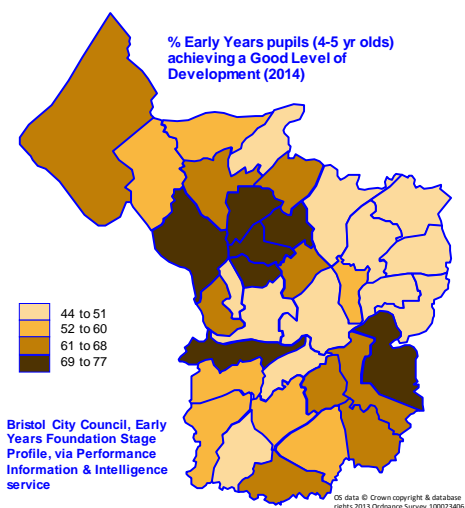


Fig 5.4.1: Source: Bristol City Council

b) Pupils in year 6 (aged 10/11) achieving a level 4 or above in Reading, Writing and Maths (SATs).

Level 4 is the level of attainment typical for an 11 year old. Of Key Stage 2 pupils in Bristol, assessed

in Year 6, 76% achieved level 4 or above in Reading, Writing and Maths combined (2014). This remained static on last year, and is now lower than the national rate (79%) and only joint 3rd of Core Cities. Across Bristol attainment at Level 4 ranged from 59% in Lawrence Hill to 96% in Westbury and Bishopston.

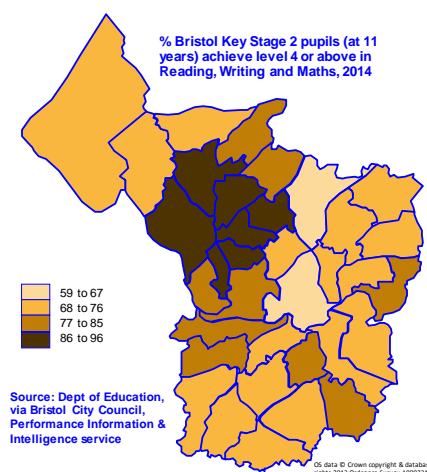


Fig 5.4.2: Dept of Education, via Bristol City Council, 2014 results

### 5.5 GCSE results

In 2014 55.2% of Bristol pupils attained 5 or more GCSEs at grade C or above (including English and Maths), a point rise of 20% since 2008. For the first time, Bristol exceeded the national average (53.4%) and Core Cities (52.4%).

However, within Bristol there remains significant variation, with over 90% children achieving this level of attainment in Redland & Clifton East, but only 35% in Lawrence Hill and 40% in some South Bristol wards (fig 5.4.3)

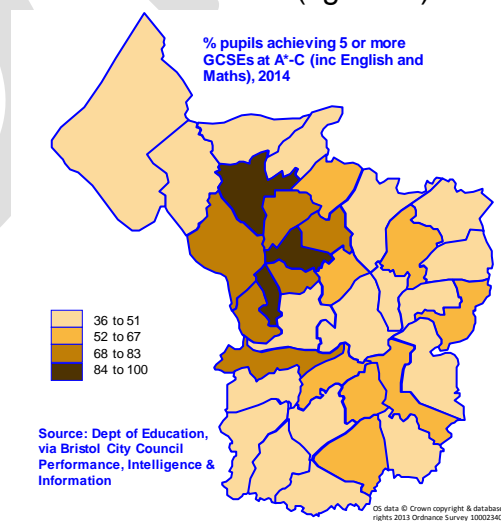


Fig 5.4.3: Dept of Education, via Bristol City Council, 2014 results

## 5.6 Pupil Absence

In 2013/14 the amount of school-time missed by pupils in Bristol schools<sup>54</sup> was 5.05%, which is significantly higher than the national average (4.51%), although this is falling. The trend chart (fig 5.6.1) shows Bristol is broadly reducing in line with national rates. 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.

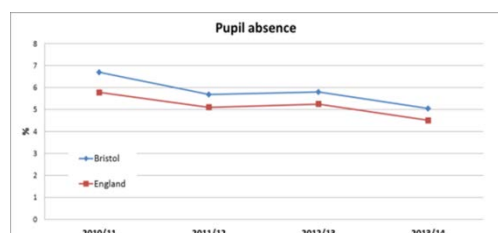


Fig 5.6.1 Source via PHOF (Aug 2015)

## 5.7 Special Educational Needs (SEN)

Overall, around 7,700 (17.9%) of Bristol school-children were recorded as having some level of Special Educational Needs in 2015<sup>55</sup> (all SEN incidents, including where the school provides additional support “in-house”). This is lower than the 9,800 (18.6%) recorded in 2014, but may reflect changes in 2015 to

the definition being used for national SEN recording.

Furthermore, detailed breakdown of SEN needs requiring higher levels of support (previously used as a proxy to indicate children with a likely disability or social care need) is not available in 2015 data due to the Dept of Education changes to code-sets, so can't get breakdown by Primary SEN need. This will be possible again from 2016, but will be a new dataset so not comparable.

Across Bristol numbers of children with SEN are higher in more deprived areas. By ward, numbers of pupils with SEN are highest in Filwood (550) and Lawrence Hill (480), followed by Southmead, Avonmouth, Kingsweston, Whitchurch, Hartcliffe & Lockleaze (all around 330-370). In contrast, there are less than 50 SEN children in Clifton. The map (fig 5.7.1) shows pupils with SEN as a % of all Bristol pupils in that ward.

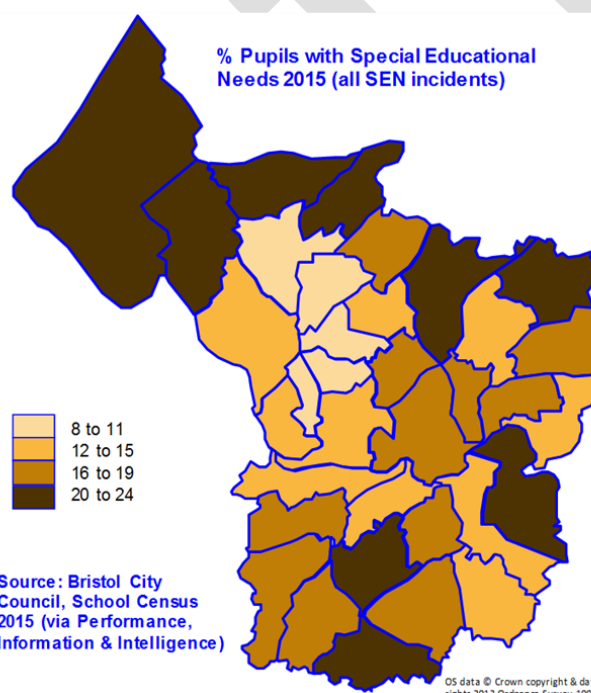


Fig.5.7.1: SEN. Source: Bristol City Council, Performance, Information & Intelligence

<sup>54</sup> Source: via Public Health Outcomes Framework, Aug 2015

<sup>55</sup> Source: January School Census 2015; Bristol City Council



## 5.8 Children in Need (Social Care)

Over the last 3 years there had been an increase in the numbers of children identified as “Children in need” (allocated to a Social worker), which is currently stable. By ward there is a large difference across Bristol, from under 10 in some wards to 230 (Filwood) and 190 in Hartcliffe. [NB Numbers not rates].

### 5.8.1 Children in care

There are just over 700 children in care in Bristol (a snapshot measure taken at the end of March 2015). This is very similar to the previous 3 years. This is not a static population though. Approximately 1000 individual children were in care for some period of time during the 12 months up to March 2014, higher than the 850 in care in the 12 months up to March 2007.

The number of long-term looked after children (in care continuously for a year or more) is not rising however, as more children come into care for shorter periods of time. In 2008 72% of children in care had been in care long-term (approx 620 children), but in 2013-14 this was only 60% (approx 600). These children however are at higher risk of needing additional support.

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

- 91% have completed Health Assessments (2014); compared to national rates of 87% in 2013
- 92% have completed Dental Checks (2014); compared to national rates of 82% in 2013
- 78.9% have all immunisations recorded as up-to-date (2014), which is an improvement locally but remains lower than the national rate of 83% in 2013.

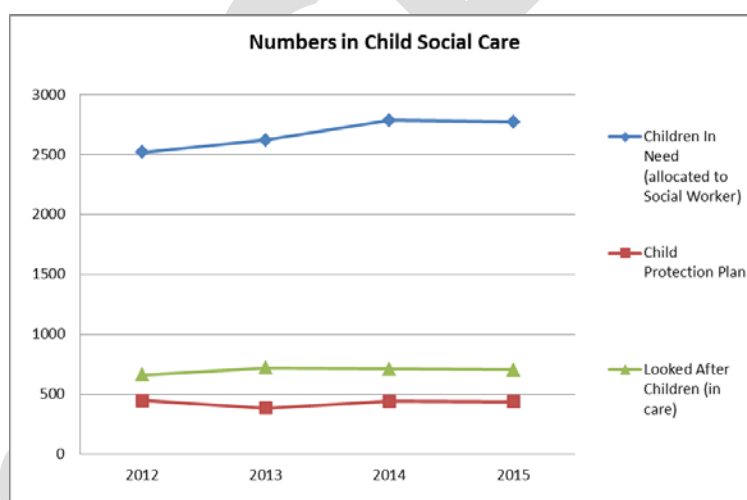


Fig 5.8.1: Children allocated to Bristol's Child Social Services (excluding those "in care" or on Child Protection register) on March 31st

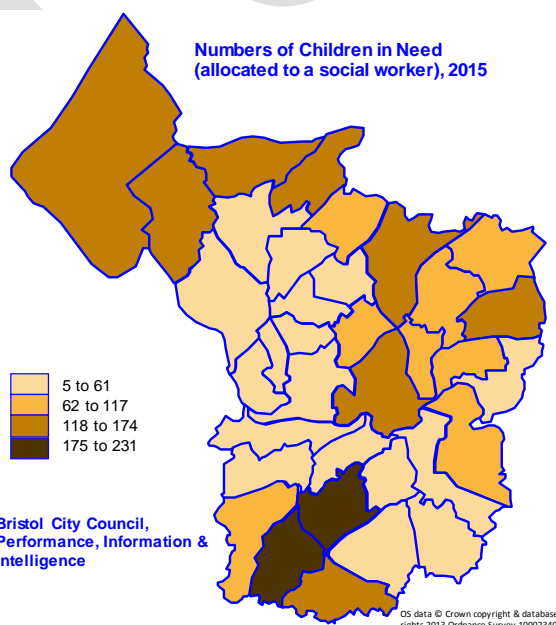


Fig 5.8.2: Supplied by: Bristol City Council, Performance, Information & Intelligence

## 5.9 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 **6.3% of 16-18 year olds** in Bristol<sup>56</sup> (2014) who are recorded as being “not in education, employment or training”. This is significantly worse than the national average of 4.7%, but is falling and Bristol has the 3rd lowest rate for NEET amongst the English Core Cities.

However, locally<sup>57</sup>, figures range from less than 2% in many wards in the inner North & West area, to 10% of young people in Whitchurch Park & Avonmouth and 13.5% in Filwood (see map), which highlights the inequalities in opportunity for young people in some of the most deprived areas of Bristol.

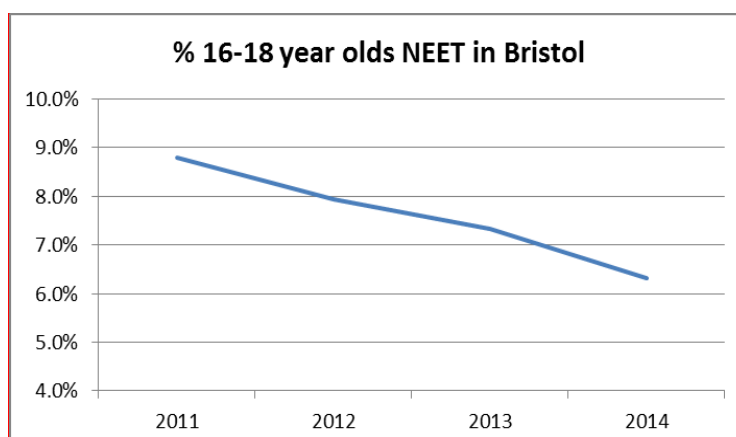


Fig 5.9.1 Source: Dept for Education (via Public Health Outcomes Framework, Aug 2015)

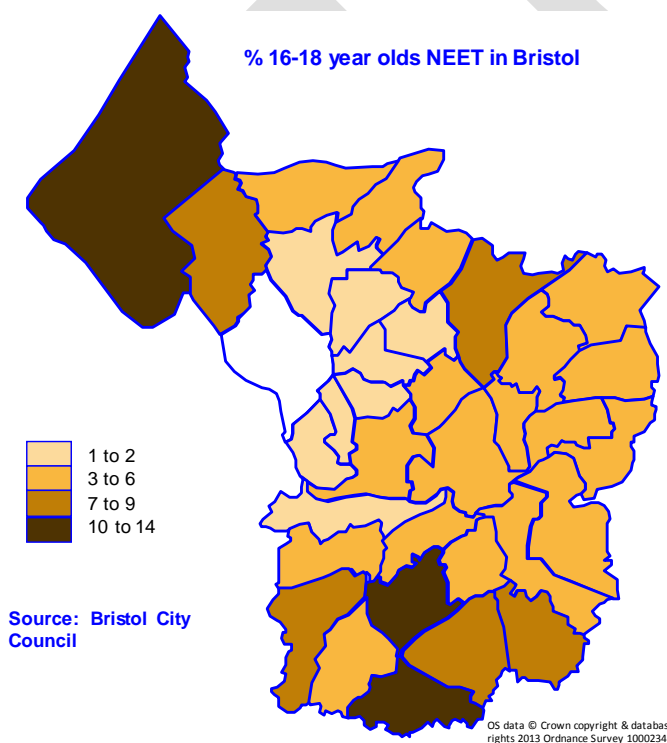


Fig 5.9.2 Via Public Health Outcomes Framework, Aug 2015

<sup>56</sup> Source: Dept for Education, 2015 (also via Public Health Outcomes Framework data tool, Aug 2015)

<sup>57</sup> Source: Learning Partnership West (Nov 2014-Jan 2015) via Bristol City Council, Performance Information & Intelligence

## 5.10 Young Offenders

Young people in the criminal justice system are more likely to make unhealthy life style choices, 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 which includes a specialist nurse enables young people to address aspects of lifestyle which may adversely affect their health, and to access mainstream services.

The rate of first-time entrants to the Youth Justice System<sup>58</sup> in Bristol is 809 per 100,000 (2014), very significantly higher than the national average (409 per 100,000) and most other core cities. The gap had appeared to be widening, and in 2014 Bristol was ranked 13<sup>th</sup> highest of 152 local authorities on this measure (where highest is worst). Interim data for mid-2015 indicates a slight fall in rates for Bristol and nationally.

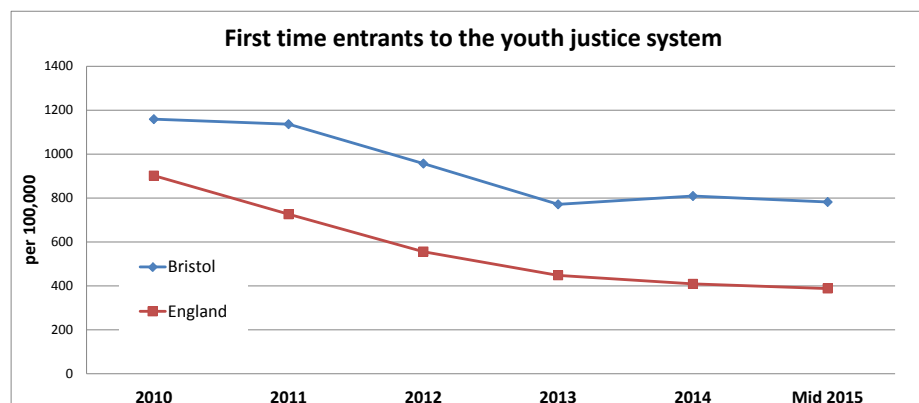


Fig.5.10.1: rate of young people aged 10-17 receiving their first reprimand, warning or conviction.

Source: via Public Health Outcomes Framework to 2014, updated via Police National Computer for June 2015

<sup>58</sup> 10-17 year olds receiving their first reprimand, warning or conviction. Source: Public Health Outcomes Framework tool, 2015

## 5.11 Employment<sup>59</sup>

The percentage of working age economically active people in Bristol (77.3%) in 2014 closely matched the England average.

The Unemployment rate in Bristol is higher than national average though. In 2014, 8.3% of economically active people in Bristol (of working age) were unemployed (i.e. out of work and looking for work). This was much higher than England (6.4%)

Employment is increasing since the recession (due to a rise in female employment) but remains below pre-recession levels (due to falling male employment).

Unemployment has continued to rise with no signs of recovery (fig 5.11.1). The rate of unemployed people claiming unemployment benefit (the claimant count rate) is recovering, but remains above the pre-recession rate. Unlike other labour market indicators, economic inactivity is now lower than before the recession.

In 2014, there were 16,400 economically inactive people who wanted a job, while 18,900 people were classed as unemployed. This meant that a total of 35,300 people were involuntarily workless. These represented 15.4% of the economically active population – higher than across England (13.6%).

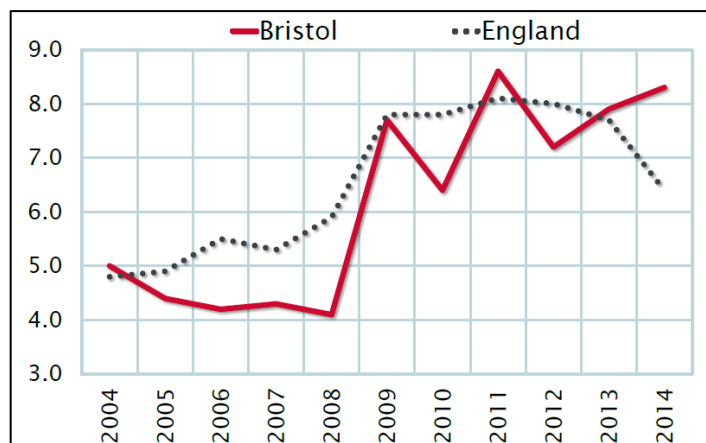


Fig 5.11.1 UNEMPLOYMENT RATE, 2004-2014

Source: Annual Population Survey, Office for National Statistics  
Supplied via: BRISTOL ECONOMIC ASSESSMENT 2015

### ECONOMIC PARTICIPATION AND UNEMPLOYMENT KEY FACTS

- Economic activity rate 2014: 77.3% (England 77.4%)
- Employment rate 2014: 70.9% (England 72.5%)
- Unemployment rate 2014: 8.3% (England 6.4%)
- Worklessness rate 2014: 15.4% (England 13.6%)
- Share of working age population claiming benefits in 2014: 11.0% (England 9.6%)

### ECONOMIC PERFORMANCE: KEY FACTS

- £12.6 billion in economic output in 2013 (1% of England total)
- Gross Value Added (GVA) per head: £28,900 in 2013 (England= £24,100)
- Between 2000 and 2012, the number of jobs in Bristol hardly changed - growth rate of 0.7%. This was much lower than across England (7.6%)
- 270,000 jobs in 2012 (1% of England's jobs)
- Productivity in Bristol is high, but other areas are catching up
- Productivity rate 2011: £47,700 GVA per job (GB = £44,700)

<sup>59</sup> Extract from draft BRISTOL ECONOMIC ASSESSMENT 2015

## 5.12 Housing<sup>60</sup>

There continues to be an undersupply of new homes, both for ownership and rent. House prices in Bristol are rising.

Serious shortage of affordable housing in the city and rising homelessness

Significant increase in private renting (and rental costs)

Limited number of development sites within Bristol itself

### 5.12.1 Housing Stock

According to the 2011 Census, some 15% of stock is owned by the city council, 6% by housing associations, 55% is owner occupied and 24% privately rented. The private rented sector has increased significantly since 2001, rising from 12.2% to 24% of all accommodation in Bristol. Private rental has overtaken the social sector, and is becoming the destination tenure for younger households and those who cannot afford to buy.

### 5.12.2 Homelessness

Homelessness is associated with severe poverty and is associated with adverse health, education and social outcomes. To be deemed “statutorily homeless” a household must have become unintentionally homeless and must be considered to be in priority

need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities.

In 2013/14, the rate of households accepted as statutorily homeless in Bristol rose to 2.6 (per 1,000 households), which is now above the national average (2.3 per 1,000) (fig 5.12.1).

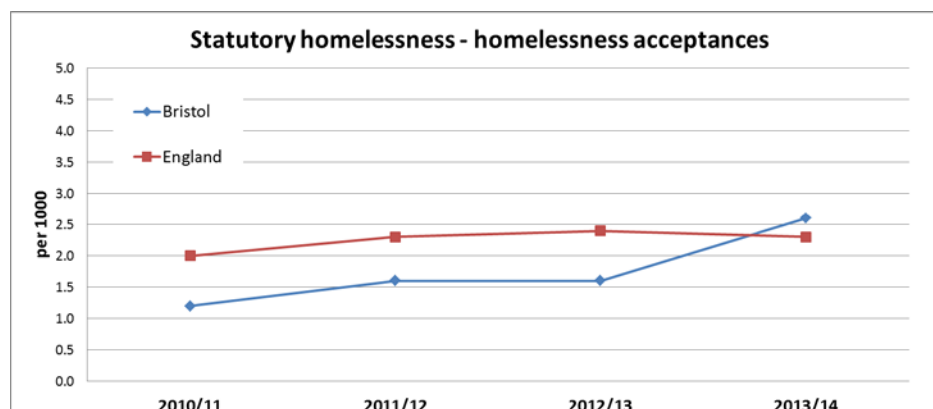


Fig.5.12.1: Homelessness acceptances per 1,000 households. Source: via Public Health Outcomes Framework, 2015

### Homelessness & health needs

Bristol's homeless population (inc non-priority need) have been able to receive health care at Compass Health. During the 3rd quarter of 2014 almost 500 homeless clients were treated, and almost 10% of those attended more than eight times which indicates the scale and complexity of health problems encountered. Clients may attend with physical ill health and mental distress, often compounded by drug and alcohol abuse. They may be isolated from friends and family and be poorly equipped with emotional and social skills.

A detailed Homeless health needs audit was conducted in 2010 with clients from a range of homelessness agencies in Bristol; this can be found at: [www.homeless.org.uk/health-needs-audit](http://www.homeless.org.uk/health-needs-audit)

Key findings were also reported in the 2010 JSNA.

### 5.12.3 Housing Need

The 2015 Strategic Housing Market Assessment (SHMA) was not published at time of writing, but according to the 2009 findings there is a shortage of affordable housing in Bristol. More than 1,500 new affordable homes would be required each year to house existing and newly forming households who cannot afford to buy or rent in the market. The need is predominantly for rented homes, with a shortage of smaller homes and larger

<sup>60</sup> Largely extract from “Bristol Housing Market in 2015 – A Summary”



houses for families. The SHMA 2009 found that the need for 4+ bedroom homes compared to supply from re-lets stood at 20:1, compared to 4:1 for one bedroom homes in Bristol.

#### 5.12.4 House Prices & Affordability

Land Registry House Price Index information for Feb 2015 indicates a 10.2% annual increase in house prices for the Bristol, with an average house price (all categories) of £198,556. Over the past decade (Feb 2005 to Feb 2015), average house prices in Bristol increased by £44,100, an increase of 29%. This compares with an increase of 16% for England and Wales over the same period.<sup>61</sup>

Housing affordability is a problem for all of the Core Cities. Proportionally they have fewer home owners (52%) compared to the national average (63%), and growth in home ownership has stalled over the past decade.

Affordability is measured by the relationship between the price of the cheapest homes and the lowest level earnings. In 1997 this ratio was 3.19 in Bristol, but rose to a peak of 7.91 in 2007 (ie. the cost of the cheapest home was almost eight times the annual earnings of lower income households). Recent data

indicates a ratio for Bristol of 6.83. A similar ratio (6.24) applies when average earnings are compared to average house prices for Bristol.

#### 5.12.5 Private Rented Sector

The private rented sector represents a growing proportion of the housing market nationally and locally and the only housing option for many households priced out of owner occupation but ineligible for affordable housing. Figures<sup>62</sup> for Oct 2013 to Sept 2014 indicate an average rent for Bristol (across all rented property categories - from single room rental to 4+ bedroom properties) of £828 a month.

Regional data for April 2014 - March 2015 from HomeLet indicated that the average rental cost rose in 11 out of 12 UK regions. Notably, the region with the fastest growing rental prices was the south west, with an annual increase of 13.7 per cent.

In the 2013 Housing Market report, it was noted that, as part of its programme of welfare reform, the government were placing a number of restrictions on Local Housing Allowance (LHA), which determines the amount of housing benefit an individual can receive if they rent from a private landlord. In 2014 the government introduced measures to ensure that any increase in LHA would be capped at actual rent inflation, or 1%, whichever is the lower figure. This capping has continued in 2015, which would tend to indicate a growing disparity between housing benefit rates and actual market rents across the city.

For the foreseeable future private renting will remain the default option for younger households. While interest rates remain low and are set to remain low until at least 2016, there remains a serious 'affordability gap' for many younger people as house prices continue to rise.

Rising rents and restricted benefit levels are set to continue to squeeze households on the lowest incomes and may well be a contributing factor to the trend towards increasing homelessness noted for the city. In an already tight and expensive housing market, the ongoing shortage of housing supply means that the trend towards high or even higher prices to rent or buy are likely to continue.

<sup>61</sup> House Price Index. Data produced by Land Registry © Crown copyright 2015

<sup>62</sup> Source: Valuation Office Agency

### 5.13 Internet connectivity

The official data from the Office for National Statistics (ONS) shows that 91.3% of Bristol adults (328,000 adults over 16) have “Used the internet in the last 3 months”. This data is for the first quarter (Q1) of 2015. Fig 5.13.1 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, and conversely Bristol has the lowest % of people who have “never used” the internet out of the English core cities (fig 5.13.2).

For comparison, this is a rise of 20,000 adults in Bristol in the last 2 years (from 85%), and Bristol’s 91.3% of connected citizens is significantly higher than the England average of 86.2%.

However, the ONS report that accompanies this does highlight that, nationally, “there are digital divides between the young and old, and even across gender”. Even with Bristol’s very high rates of internet usage there are still 31,000 adults who have not used the internet at all in the last 3 months (or longer), although this figure is reducing rapidly.

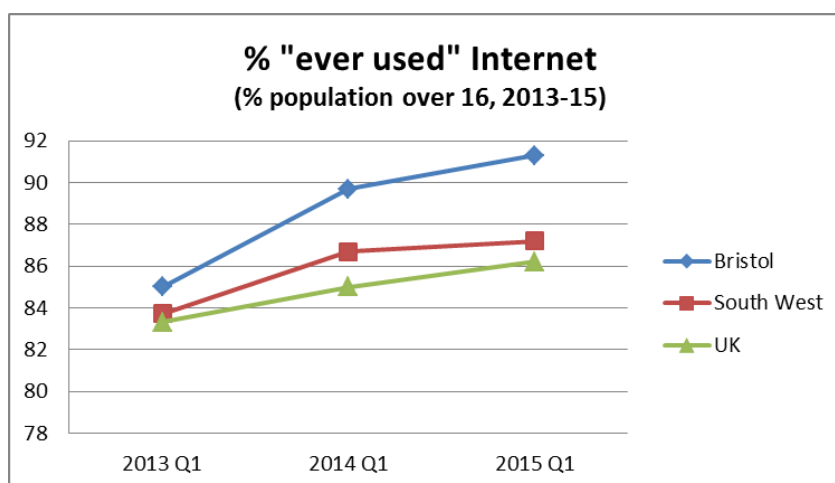


Fig 5.13.1 Source: ONS Internet Access Quarterly Update, May 2015

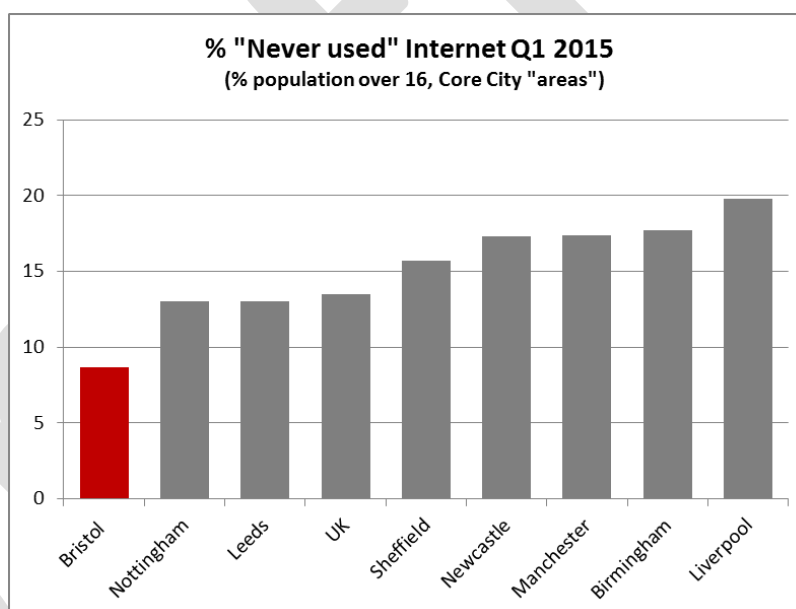


Fig 5.13.2 Source: ONS Internet Access Quarterly Update, May 2015

### 5.14 Crime<sup>63</sup>

In recent years, annual recorded crime trends in Bristol have shown a decline, though the rate of decline has slowed (fig 5.14.1). Improvements in recording practices and identification of incidents may serve to explain this reduction in the rate of decline.

However, under-reporting of crimes is an ongoing issue.

Deprivation and inequalities between wards & residents in Bristol may increase the likelihood of victimisation or becoming an offender. Particular challenges are how to address issues around the growing young population - a group who experience disproportionate victimisation. There is a need to understand issues for first time offenders and identify suitable interventions and work with repeat offenders to address causes of offending.

Substance misuse remains linked to criminality and victimisation.

Reducing incidents of repeat victimisation in Bristol is an issue. A new victim team within the Police will help to identify and provide support to persistently targeted victims.

There remain gaps around understanding hate crime levels in Bristol. Estimates suggest considerable under-reporting of incidents.

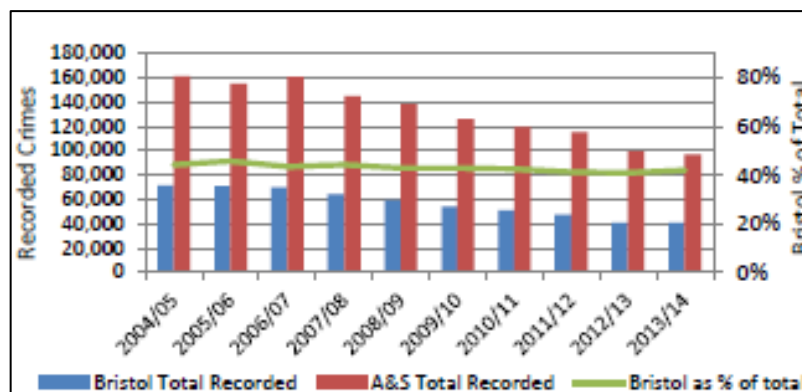


Fig 5.14.1 Recorded Crime across Avon & Somerset and Bristol

In 2014, 15% of residents said fear of crime affected their day-to-day life, a significant improvement compared to 2009 when 26% of residents said they were affected. There was significant variation between wards, with Filwood (39%), Southmead (30%) and Hartcliffe (28%) higher than Clifton (5%), Clifton East (6%) and Stoke Bishop (6%). A higher proportion of people (26%) in deprived areas were afraid of crime.

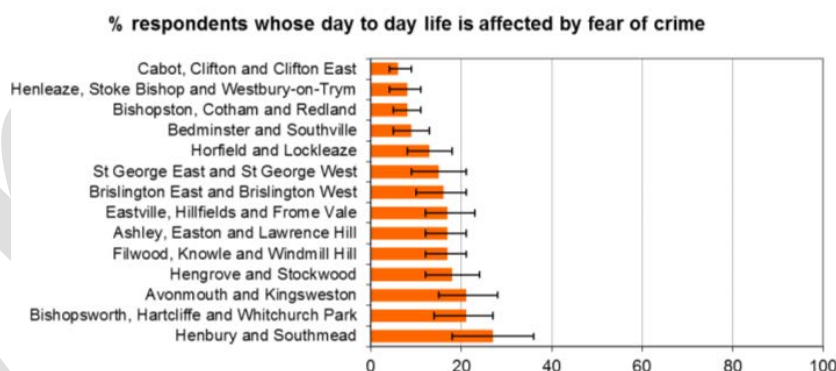


Fig 5.14.2 Source: Bristol Quality of Life survey 2014

In 2014, 27% of residents thought anti-social behaviour was a problem in their local neighbourhood, which is a significant improvement on 38% in 2009. In deprived areas of the city though, 46% of residents note a problem from anti-social behaviour in 2014.

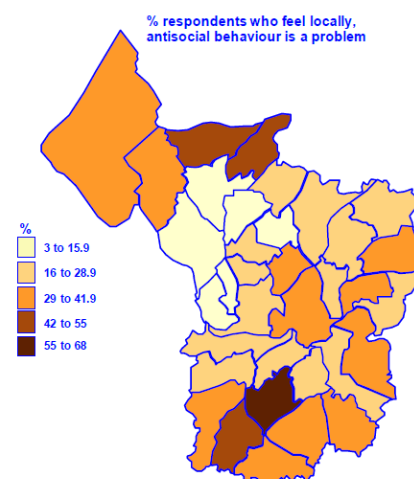


Fig 5.14.3 Source: Quality of Life 2014

<sup>63</sup> Extract from Safer Bristol Crime and Disorder Strategic Assessment, 2015  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

## 5.15 Social Isolation<sup>64</sup>

Social isolation<sup>65</sup> 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<sup>66</sup>.

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](http://www.bristol.gov.uk/socialisolation) which also covers health impacts<sup>67</sup>.

### 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

<sup>64</sup> Extract from [www.bristol.gov.uk/policies-plans-strategies/social-isolation](http://www.bristol.gov.uk/policies-plans-strategies/social-isolation)

<sup>65</sup> 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.'

<sup>66</sup> Social Isolation in Bristol (2013), Initial Findings Report,

[www.bristol.gov.uk/socialisolation](http://www.bristol.gov.uk/socialisolation)

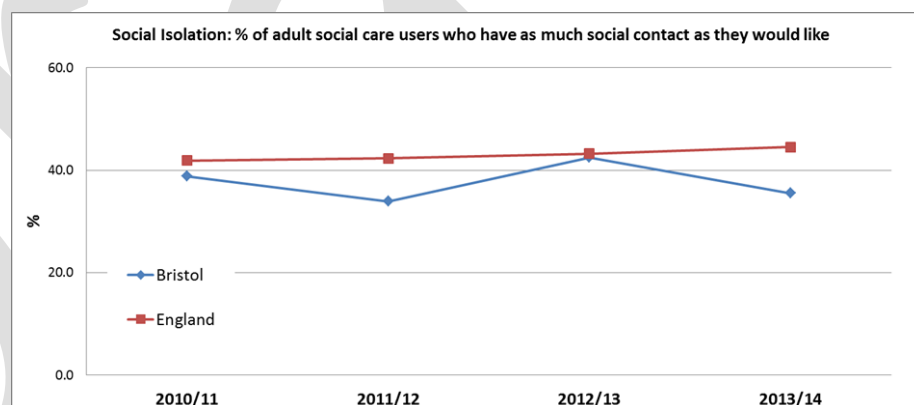
<sup>67</sup> Research on health impacts are also at: [www.campaigntoendloneliness.org/threat-to-health/](http://www.campaigntoendloneliness.org/threat-to-health/)

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%<sup>68</sup>.

In Bristol, 35.3% of service users say they "have as much social contact as they would like", which is significantly lower than the national average (44.2%) (fig 5.15.1). Although Bristol's average of 35.3% is towards the low end of range for English local authorities, the confidence intervals attributed to each local authority's performance mean that there is only a significant difference between Bristol and (approximately) the top quartile of performers – in other words we are not significantly different from the majority of other local authorities. Even so, we are significantly below the national average. The subjectivity and overlapping nature of the categories into which responses are grouped mean the results should be treated with caution.



5.15.1 Source via PHOF (Aug 2015)

### Social isolation of carers

The Personal Social Services Survey provides information about the indicator relating to the social isolation of carers. We only have data for 2012/13, which shows that 46.2% of carers in Bristol say they "have as much social contact as they would like", which is significantly better than the English average (41.3%).

<sup>68</sup> Adult Social Care Survey - a random sample of social care users run each year by local authorities following Department of Health guidance



## 5.16 Promoting Healthy Urban Environments

Promoting a healthy urban environment will enable economic prosperity and also a population with better physical health outcomes, more positive mental health and higher self-esteem, which contribute to overall wellbeing. There are many initiatives supporting the creation of healthy urban environments, including Bristol Green Capital, food plan, sustainable transport plan, spatial planning, housing and a built environment that encourages active living.

The physical environment is a major determinant of health, wellbeing, morbidity and premature mortality. Research<sup>69</sup> shows associations and causality between the environments people experience in their everyday lives and public health challenges. Everyday urban environments may also exacerbate health inequalities.

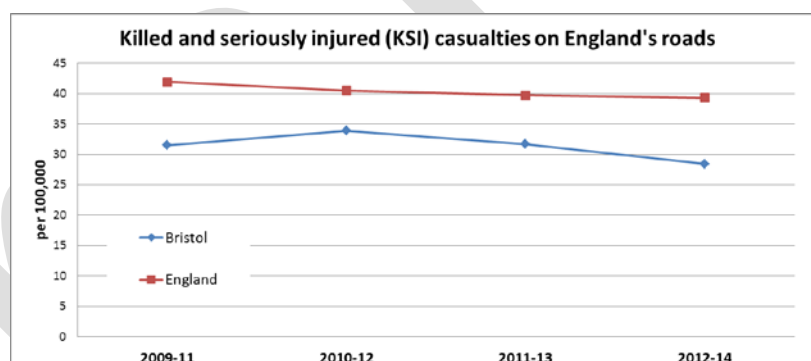
An important element is the public realm of streets, squares, parks and open spaces that are important settings for social interaction and provide links between home, work, commerce and leisure. Aspects of the public realm are amenable to interventions that can reduce health risks and promote healthier lifestyles.

For more, see 6.1 Physical activity for data on Active Travel, and Essential Evidence for research: [www.travelwest.info/evidence](http://www.travelwest.info/evidence)

### 5.16.1 Road Traffic Injuries data

Bristol's rate of road traffic injury<sup>70</sup> (28.4 per 100,000) is significantly lower than the national average (39.3 per 100,000) (fig 5.16.1), and Bristol had the second lowest rate amongst the Core Cities. During 2014, 116 people were killed or seriously injured on Bristol's roads.

This does not tell the whole story. The rate of serious injury & fatalities tends to be higher on rural roads, (which may affect comparison with the national figure), and the data under-reports injuries sustained by pedestrians and cyclists. Hospitals treat and record a larger number of injuries, (table 5.16.2). The West of England Road Safety Partnership has prioritised injuries to cyclists, the majority of which don't involve other road users. Bristol's Road Safety Strategy recognises walking as a means of transport and pedestrian falls as a transport safety issue.



5.16.1 Source via PHOF (Nov 2015)

	Emergency admissions to hospital from travel and transport related causes	
	Bristol residents	All England
Cyclists (collisions)	80	5,844
Pedestrians	84	9,180
Car Occupants	82	14,242
Cyclists (non-collisions)	113	10,934
Motorcyclists	55	8,618
Other	56	11,278
<b>Total</b>	<b>470</b>	<b>60,096</b>

Table 5.16.2: Number of emergency admissions to hospitals in Bristol and England during 2013-14. Source: Health and Social Care Information Centre.

<sup>69</sup> References for research available [www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

<sup>70</sup> Police data, Dept of Transport 2012-14



### 5.17 Domestic Abuse

More than one in four women experience domestic abuse in their lifetimes, with negative impacts on mental and physical health and further impacts on family members including children.

The rate of domestic abuse incidents recorded<sup>71</sup> by the Police in Bristol was 14.1 incidents per 1000 population (2013/14). This was a significant increase compared with each of the three years since 2010/11 (fig 5.17.1), though this is too early to confirm as an upward trend. The Police and Crime Commissioner (PCC) has prioritised tackling domestic abuse which may have led to more victims coming forward.

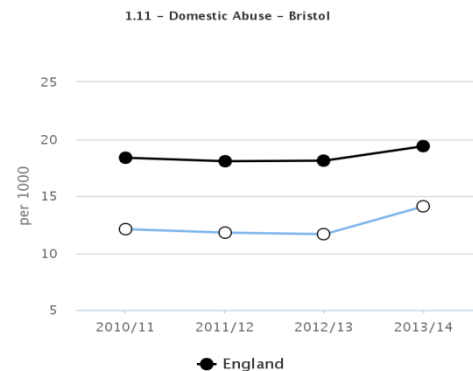


Fig 5.17.1: Rate of domestic abuse incidents recorded by the Police per 1000 population over 16 years of age.

Bristol recorded fewer domestic abuse incidences per 1000 population than the South West region (15.2) and England (19.4). A 2014 review<sup>72</sup> found significant

<sup>71</sup> Rate per 1000 population over 16 years of age; via Public Health Outcomes Framework  
<sup>72</sup> <http://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf>

variation in domestic abuse recording practices across police forces. Avon and Somerset Police were the 7th lowest of 43 forces in recording domestic abuse. In view of this variation in recording, it is unlikely that the Bristol data accurately reflects the number of victims and repeat victims

The 2014 Quality of Life survey found that only 7% of people agreed domestic violence was a private matter, a significant reduction on the 2009 figure of 14%. There is variation between Bristol wards with the most agreement in Kingsweston (16%) and the least in Redland (under 1%) (fig 5.17.2).

Fig 5.17.2 Source: Bristol Quality of Life survey 2014

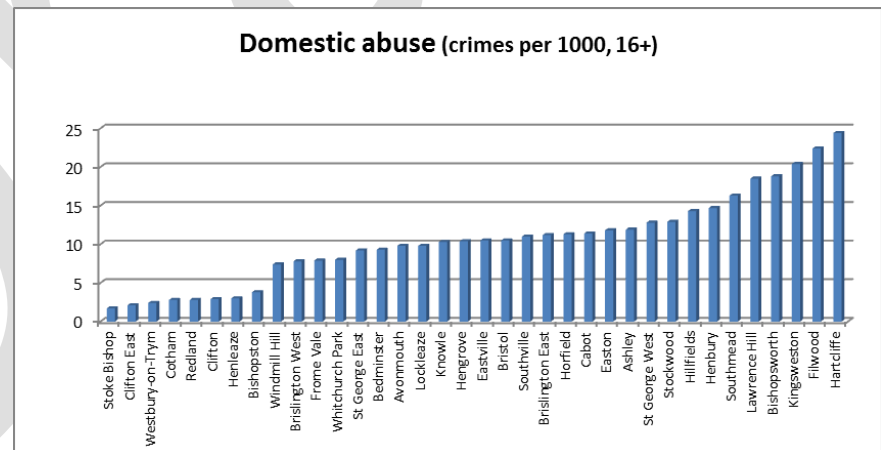
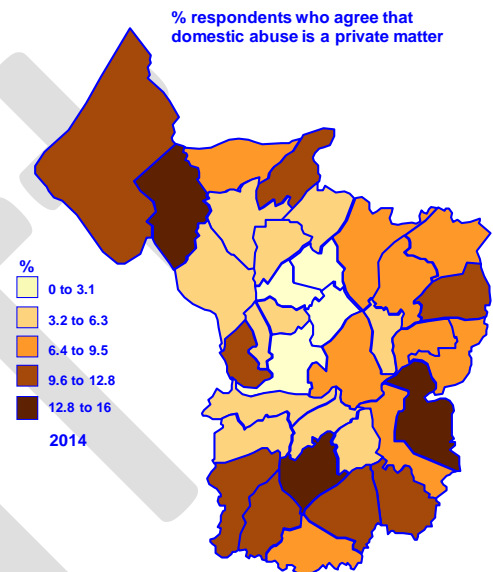


Fig 5.17.3 Source Police data 2014/15

Figure 5.17.3 shows the rate of domestic abuse crimes recorded by the Police per 1000 population over the age of 16 (2014/15). The lowest rate is found in Stoke Bishop with 1.7 per 1000 and the highest in Hartcliffe with 24.4 per 1000 population. An incident will be recorded as a 'Crime' for offences against a victim if, on the balance of probabilities the circumstance reported amount to a crime defined by law and there is no credible evidence to the contrary.

The Crime Survey for England and Wales (2014/15) indicates over 1 in 4 women (27.1%) and 13.2% of men had experienced one or more incidents of domestic abuse since the age of 16, with 8.2% of women and 4% of men experiencing domestic abuse in the last year.

Women were more likely than men to have experienced intimate violence across all headline types of abuse, for example, 19% of women and 3.8% of men having experienced some form of sexual assault (including attempts) since age 16<sup>73</sup>.

Applying these statistics to the Bristol 2014 mid-year population (16–64 yr olds), 15,498 women and 7,788 men may have experienced one or more incidents of domestic abuse in the previous year. This is discounting those over 65 yrs, so the actual figure will be higher. This is significantly more than the 3,730 police recorded domestic abuse crimes.

Avon and Somerset police data (fig 5.17.4) shows a significantly higher number of female victims than males, with females aged 20–29 (c.1080 incidents) and males aged 29 – 34 (c.215 incidents) as victims<sup>74</sup>.

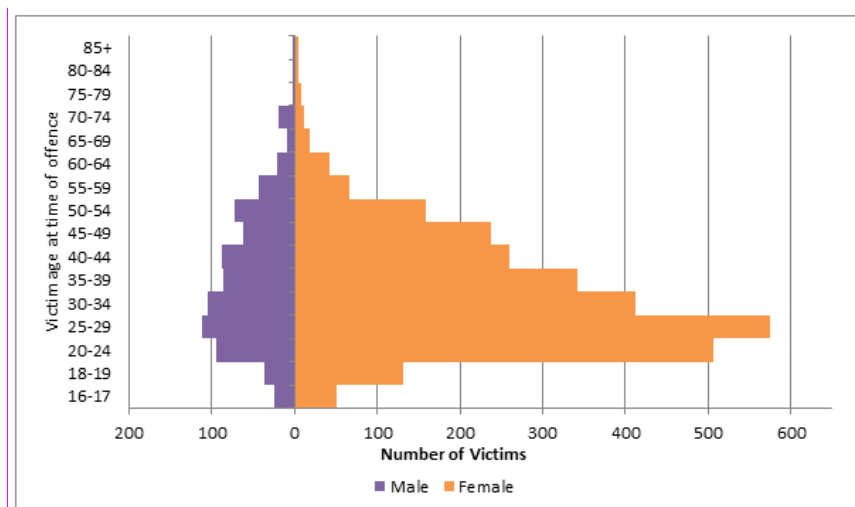


Fig 5.17.4 Number of domestic abuse victims. Source: Avon and Somerset police data

<sup>73</sup> <http://www.ons.gov.uk/ons/publications/reference-tables.html?edition=tcn%3A77-373428> 06. Supplementary Tables; S39-41

<sup>74</sup> Victim age and gender at time of offence, Bristol, 2014/15 (some victims will be repeat incidences).

## 5.18 Community Assets<sup>75</sup> Neighbourhoods

82% of residents said they are satisfied with their neighbourhood (2014), a steady and significant improvement since 2009 (79%).

Satisfaction was significantly lower in deprived areas of the city (69%), and for disabled people (75%). Most satisfied were in Clifton & Henleaze (97%) but almost all areas were over 70% satisfaction with the notable exception of Filwood at 45%.

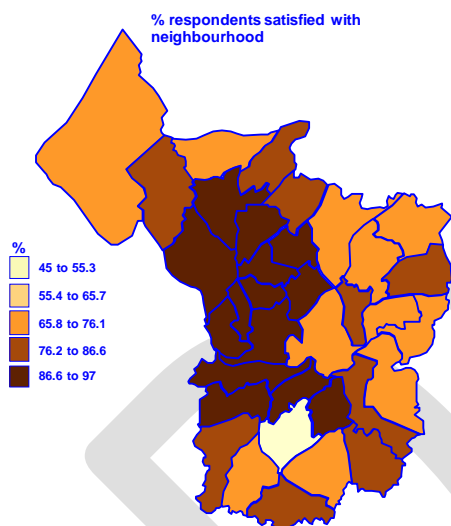


Figure 5.18.1 Source: Bristol Quality of Life survey 2014

### 5.18.1 Volunteering

29% of people volunteer regularly for a charity or local community (at least 3 times a year, 2014), significantly up from 22% of residents in 2009.

The pattern across the city has volunteering highest in “better off” North & West wards, particularly

Henleaze, Westbury-on-Trym, Redland and Stoke Bishop (40% or more), but also in Ashley. Bedminster, Hillfields, Hengrove and Whitchurch Park are wards where less than 20% of people volunteer.

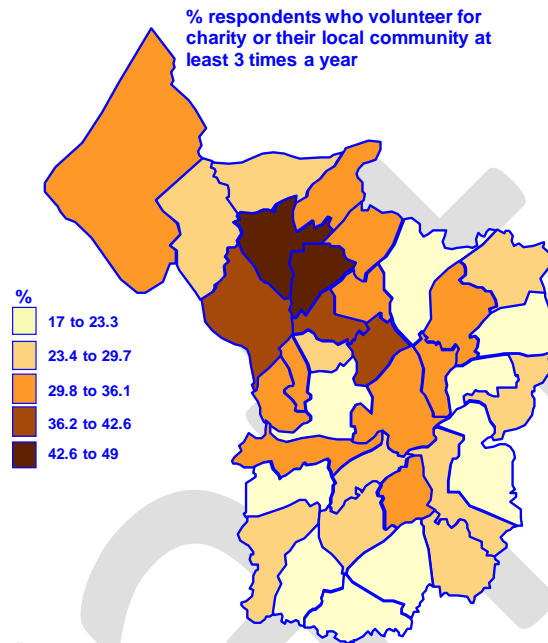


Figure 5.18.2 Source: Bristol Quality of Life survey 2014

### 5.18.2 Influence Local Decisions

A quarter of residents (25%) feel they could influence decisions about their local area, a gradual increase over the 5-years (23% in 2009).

In several wards results were low (Brislington West, Henbury, Filwood & Hengrove all <15%), whereas more residents in Knowle, Clifton, Henleaze & Southville feel influential (>35%).

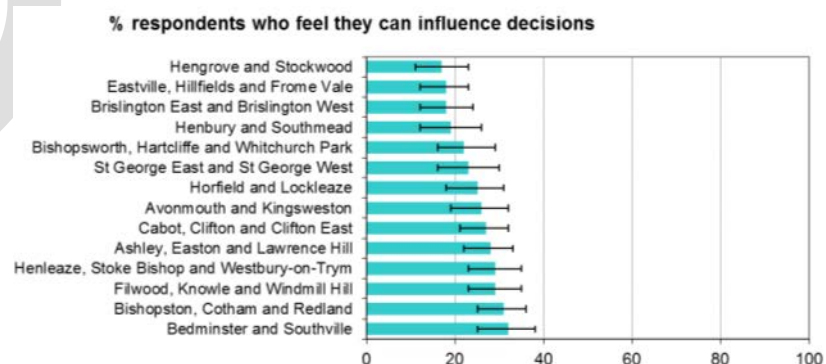


Fig 5.18.3 Source: Bristol Quality of Life survey 2014

<sup>75</sup> Source: Bristol Quality of Life 2014-15  
[www.bristol.gov.uk/qualityoflife](http://www.bristol.gov.uk/qualityoflife)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

## Section 6

# Healthy Lifestyles

### Summary points

#### Physical activity

- Only 1 in 3 people in Bristol take regular exercise
- More people in Bristol commute to work by bicycle or on foot than in any other Local Authority

#### Obesity

- Over half the Bristol population are overweight or obese (56.9%)
- Data from the Quality of Life Survey suggests that excess weight in Bristol adults (overweight and obese) is relatively stable. However, as obesity is still a key factor in Type 2 Diabetes and coronary heart disease, it is important to continue to reduce these levels.

#### Healthy eating

- 4 out of 10 people in Bristol are a healthy weight (Active People Survey 2012-14)
- Around half of respondents to Bristol's Quality of Life survey (52%, 2014) stated that they eat at least 5

portions of fruit & veg a day; a slightly improving trend on previous years.

#### 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 18.9% in 2014 which is similar to the England average of 18.0%
- Smoking-related deaths in Bristol are significantly higher than the England average rate

#### Alcohol

- Alcohol-related deaths in men is significantly higher in Bristol (rate of 26 deaths per 100,000; national 16.6)
- Alcohol-related hospital admissions in Bristol is significantly higher than the England average, and is rising locally & nationally
- Bristol has seen an unprecedented amount of referrals into the alcohol treatment services

#### Substance misuse

- Bristol has the largest estimated rate of Opiate and/or Crack Users of the English Core Cities
- Over 50% of clients are referred into treatment in Bristol from GP referrals (nationally under 10% come from GPs)
- Bristol has the highest rate of recovery for its opiate-using population compared to Core Cities, but not for those leaving non-opiate and/or alcohol services

## 6.1 Physical activity

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.

Analysis<sup>76</sup> of Census 2011 results shows that 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 to a workplace between 2km and 5km away”. Promotion needs to continue on supporting active travel for groups with poorer health outcomes.

However, only 1 in 3 people in Bristol take regular exercise. 35% in Bristol’s Quality of Life survey<sup>77</sup> stated they do some form of exercise (including active travel) for at least 30 mins, 5 times per week, a rate which has been broadly consistent for several years). Across Bristol this rate ranges from only 19% in parts of South Bristol (Bishopsworth & Whitchurch Park) to 47% in Clifton (fig 6.1.1).

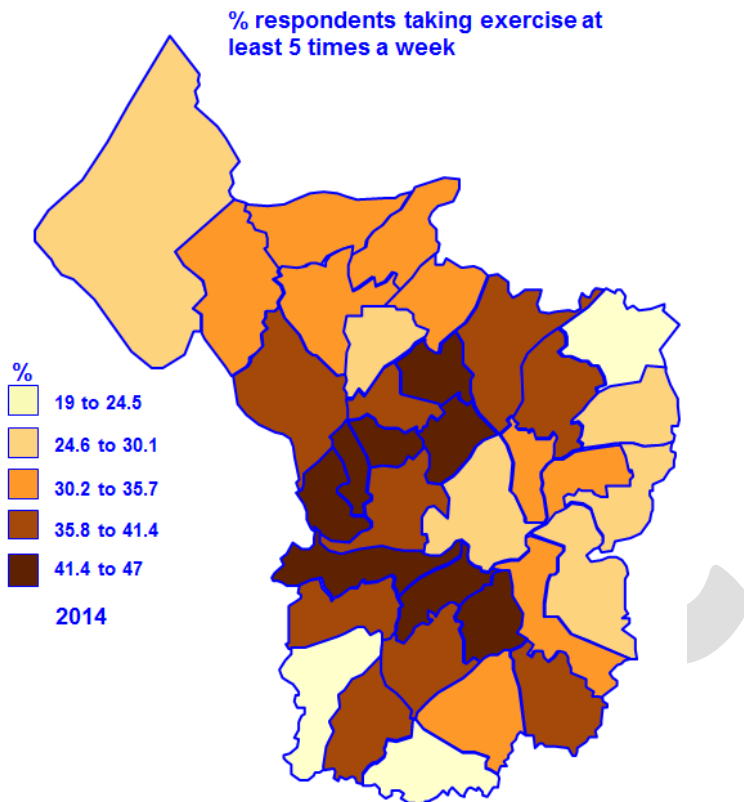


Fig 6.1.1: People taking regular exercise. Source: Quality of Life survey 2014

Alternatively, national survey data for physically active adults<sup>78</sup> indicates that 61% of Bristol adults<sup>79</sup> are considered “active”, similar to national average (57%) but rising (fig 6.1.2).

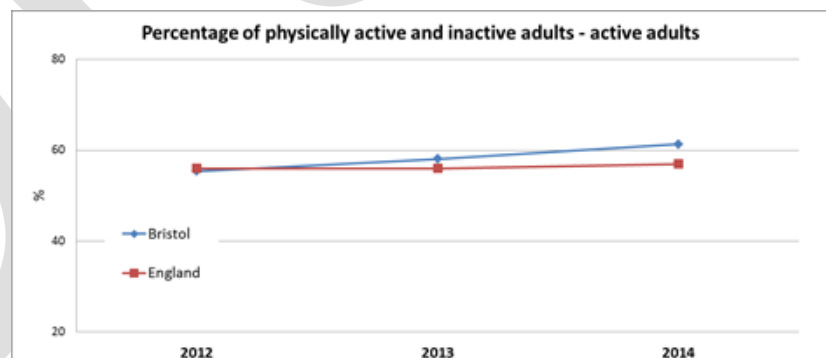


Fig 6.1.2: Physically active adults - Bristol

23% of people (Active People survey) use the outdoor spaces for exercise/ health reasons. 49% of people (Quality of Life, 2014) stated they participate in sport at least once a week. In more deprived areas though, this rate is only 34%.

<sup>76</sup> “Who cycles to work?” 2011 Census Topic Report, Bristol City Council Performance Information & Intelligence, July 2014

<sup>77</sup> Bristol Quality of Life survey 2014-15 [www.bristol.gov.uk/qualityoflife](http://www.bristol.gov.uk/qualityoflife)

<sup>78</sup> % adults achieving at least 150 mins physical activity per week (Active People Survey, Sport England, 2014) via Public Health Outcomes Framework (Aug 2015)

<sup>79</sup> The emphasis on “physical activity” rather than “exercise” in this question gives a much higher result for “physically active adults” than in the Quality of Life survey



## 6.2 Obesity

Over half the Bristol population are overweight or obese (56.9%, Active People survey, 2012-14)<sup>80</sup>. However, this is significantly better than the national average (64.6%)

Local survey data (Quality of Life<sup>81</sup>, fig 6.2.1) provides a lower estimate, but the national Active People survey is considered more accurate<sup>82</sup>. However, Quality of Life can be used to highlight local differences:

- 52% men are overweight and 14% obese in Bristol
- 41% women are overweight and 16% obese in Bristol
- Variation across Bristol wards (fig 6.2) from around 1 in 4 in residents in Southville to almost 3 out of 4 residents in Filwood & Bishopsworth.
- Significantly more disabled people (66%) and older people (57%) overweight or obese than city average.

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 nearly 9,000 referrals in the last 4 years and numbers are increasing. 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.

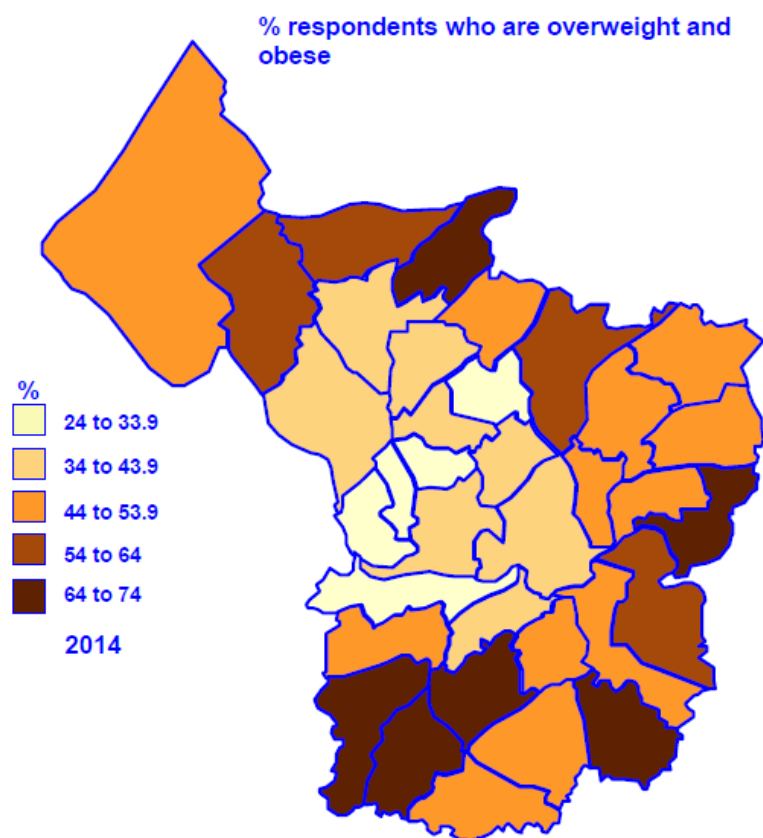


Fig 6.2.1: % Overweight & obese

<sup>80</sup> Active People survey via PHOF, Nov 2015

<sup>81</sup> Bristol Quality of Life survey 2014-15 [www.bristol.gov.uk/qualityoflife](http://www.bristol.gov.uk/qualityoflife)

<sup>82</sup> 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

Within Bristol, about a half of all residents (52%) say they ate 5 or more portions of fruit and vegetables a day, pretty much the same proportion over the past five years<sup>83</sup>. However, achieving 5-a-day of fruit & vegetables ranges from 32% in Bishopsworth to 68% in Westbury on Trym (fig 6.3.1). Also, men (47%) are significantly less likely to eat 5-a-day than women (56%).

Locally grown food - On average 52% of Bristol residents eat home grown food, produced by them or by people they know. This is a slight decrease from 2013 (Quality of Life 2014).

Achieving a healthy diet involves consuming a wide range of foods and limiting intake of foods high in fat, sugar and salt. These are difficult to measure so there is limited understanding of the intake of these in the diets of people in Bristol. In the future a useful measure would be the daily intake of sweetened sugary drinks. High intakes of these are likely to have an impact on levels of obesity and type 2 diabetes.

Bristol has one of highest densities of fast food outlets in the UK providing cheap, highly palatable and energy dense food, often lacking in nutritional value,

which will not help to encourage good eating habits (PHE, 2011).

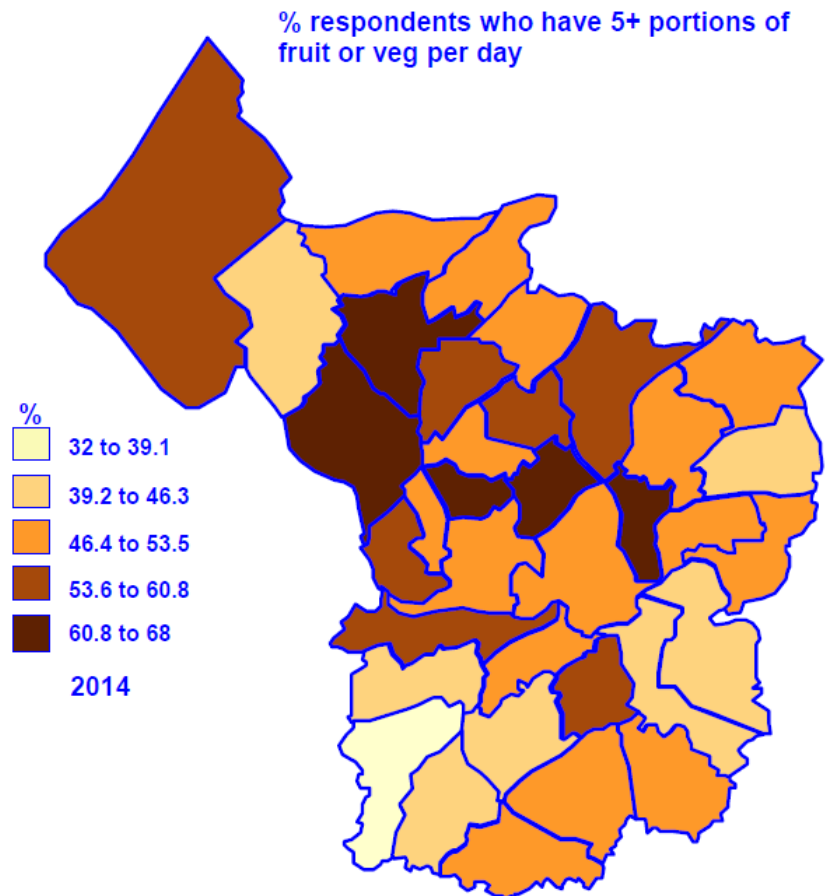


Fig 6.3.1: % eat 5-a-day

<sup>83</sup> Bristol Quality of Life survey 2014-15  
[www.bristol.gov.uk/qualityoflife](http://www.bristol.gov.uk/qualityoflife)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

## 6.4 Smoking<sup>84</sup>

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 18.9% in 2014 which is similar to the England average of 18.0%<sup>85</sup> (fig 6.4.1):

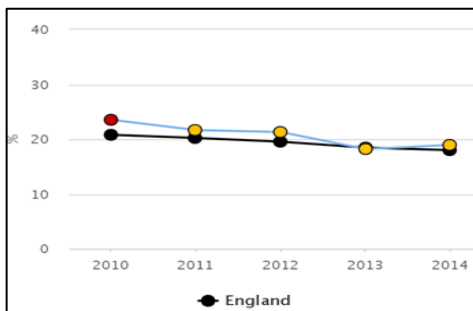


Fig 6.4.1: % Bristol adults who smoke

Smoking-related deaths in Bristol are significantly higher than the England average rate<sup>86</sup> (fig 6.4.2):

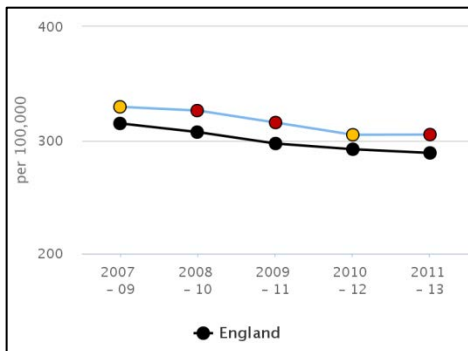


Fig 6.4.2: Smoking attributable deaths in Bristol (rate per 100,000, 35+)

Local data from Bristol’s Quality of Life Survey 2014 (fig 6.4.3) show that the number of households with a smoker is at a new low of 20%, following a five year

downward trend.<sup>87</sup> There is variation across the city, from less than 5% households with a smoker in Henleaze and Stoke Bishop to 30% & above in Lockleaze, Easton, Bishopsworth, and Filwood (highest at 43%).

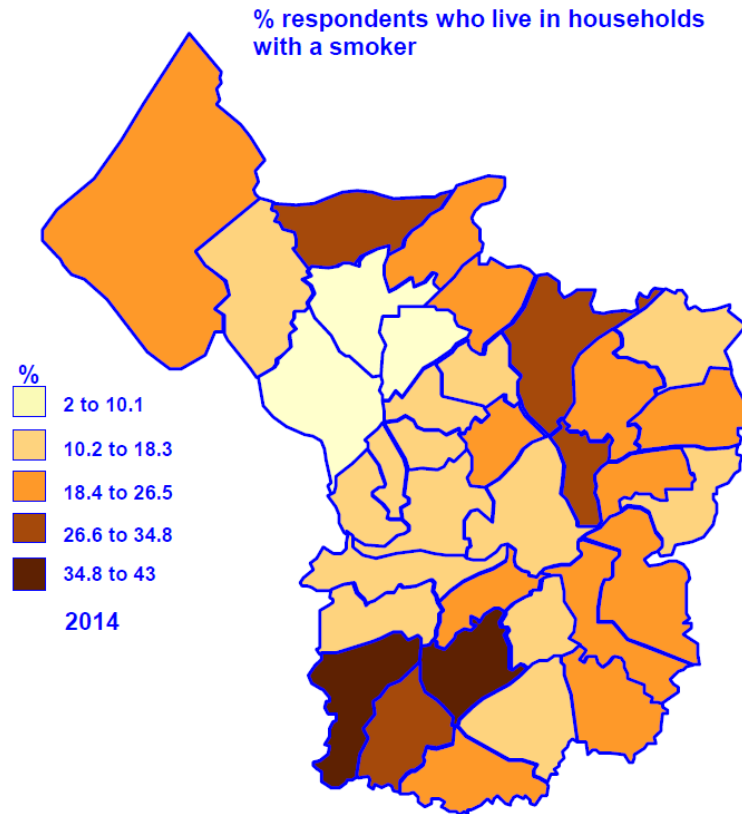


Fig 6.4.3: % smoking households

The percentage of women who smoke at the time of delivering their baby is 11.1% in Bristol, similar to the England average of 11.4%<sup>88</sup>. Also see the JSNA Child Health section.

The What About YOUth survey, conducted in England in 2014, shows that the estimated rate of smoking at age 15 (regular smokers) in Bristol is 7.8%, compared to the England average of 5.5%<sup>89</sup>.

<sup>84</sup> For more details, see Public Health England (PHE) Tobacco Control Profiles for Bristol: [www.tobaccoprofiles.info](http://www.tobaccoprofiles.info)

<sup>85</sup> PHE Tobacco Control profiles (%18+, 2014)

<sup>86</sup> PHE Tobacco Control profiles (2011-13 deaths)

<sup>87</sup> Bristol Quality of Life survey 2014-15 [www.bristol.gov.uk/qualityoflife](http://www.bristol.gov.uk/qualityoflife)

<sup>88</sup> PHE, Tobacco Control profiles (2014/15)

<sup>89</sup> What About Youth Survey 2014; Health and Wellbeing of 15 year olds in England: Smoking Prevalence. Available at <http://www.hscic.gov.uk>

## 6.5 Alcohol

Alcohol plays an important part in our social lives and in the local economy. It is a popular legal drug and brings benefits but can cause serious harm. Alcohol misuse is a major contributor to health inequalities.

It is estimated that of the adult drinkers in Bristol, 7.5% drink at levels that harm themselves and others, 20% drink at levels that risk harm in the long term, and 72.5% stay within low risk limits.

### 6.5.1 Alcohol-related deaths

Local Alcohol Profiles<sup>90</sup> show Bristol has a significant problem with **alcohol-related mortality in males** (Bristol rate of 26 deaths per 100,000, national rate 16.6 for 2011/13). The rate of alcohol-related mortality in females in Bristol was 7.4 in the same period (7.5 nationally). Alcohol-related chronic liver disease contributes most to the mortality rates. These deaths were preventable.

If all alcohol-related deaths in Bristol could be avoided then it is estimated life expectancy would increase by 16.1 months for men and 5.9 months for women.

### 6.5.2 Hospital admissions

The rate of hospital admissions for alcohol-related conditions (narrow

measure)<sup>91</sup> in Bristol (2013-14) was 774 per 100,000 population which is significantly higher than the England average (645 admissions per 100,000) and has been consistently higher than England since 2008/09 (fig 6.5.1).

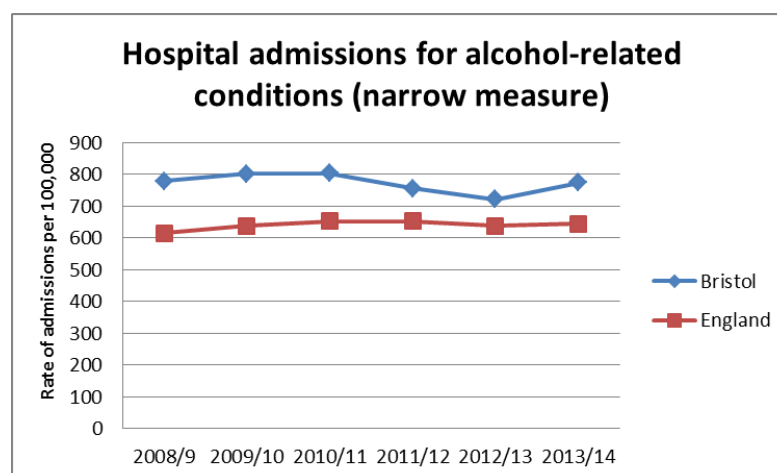


Fig 6.5.1. Alcohol-related hospital admissions using the 'narrow measure'

There are 48 health conditions that are specifically caused by or contributed to by alcohol misuse. The most common alcohol-related conditions are circulatory diseases, notably high blood pressure and heart disease. The 'broad' measure of alcohol-related admissions measures this. In 2013/14 the Bristol rate was 1,513 per 100,000 compared to the English rate of 1,253. Fig 6.5.2 illustrates that after a steadying of the admissions rate in 2010-12 in Bristol, it has risen again locally and nationally.

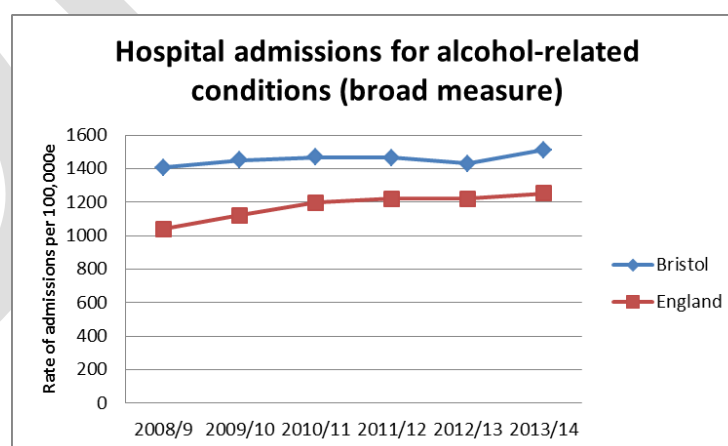


Fig 6.5.2. Alcohol-related hospital admissions using the 'broad measure'

<sup>91</sup> Public Health Outcomes Framework, [www.phoutcomes.info](http://www.phoutcomes.info); indicator 2.18 The 'narrow measure' includes primary causes of hospital admission that may be partially or wholly caused by alcohol or secondary causes of admissions (which are externally caused) that may be partially due to alcohol.

<sup>90</sup> Local Alcohol Profile data (used Oct 2015): <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

### 6.5.3 Alcohol treatment services

People in treatment for alcohol misuse (Recovery Orientated Alcohol & Drugs Services, ROADS) in Bristol are more likely to use alcohol alongside other drugs, which can make treatment challenging. Fig 6.5.3 compares the English averages with Bristol for adjunctive drug use.

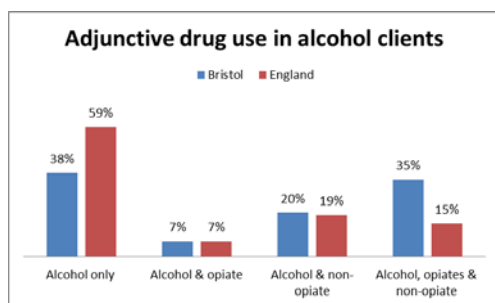


Fig 6.5.3. Additional drug use in alcohol clients of ROADS, 2014-15

There is increased demand for alcohol treatment in Bristol. Fig 6.5.4 compares the numbers in treatment and new referrals to ROADS between 1<sup>st</sup> quarter 2013/14 & 1<sup>st</sup> quarter 2015/16.

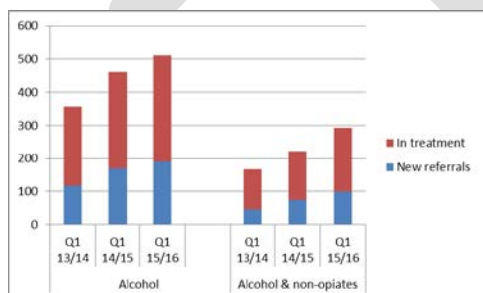


Fig 6.5.4 Numbers in treatment for alcohol misuse and new referrals

### 6.5.4 Affordability of alcohol

The increased affordability of alcohol is considered the major reason for the rise in harms caused by alcohol combined with widespread availability. Fig 6.5.5

illustrates that alcohol is more affordable compared to 1980. Public Health and many of our partners support removing inexpensive alcohol from the supply chain. Inexpensive alcohol is available through the off-trade rather than through pubs and clubs.

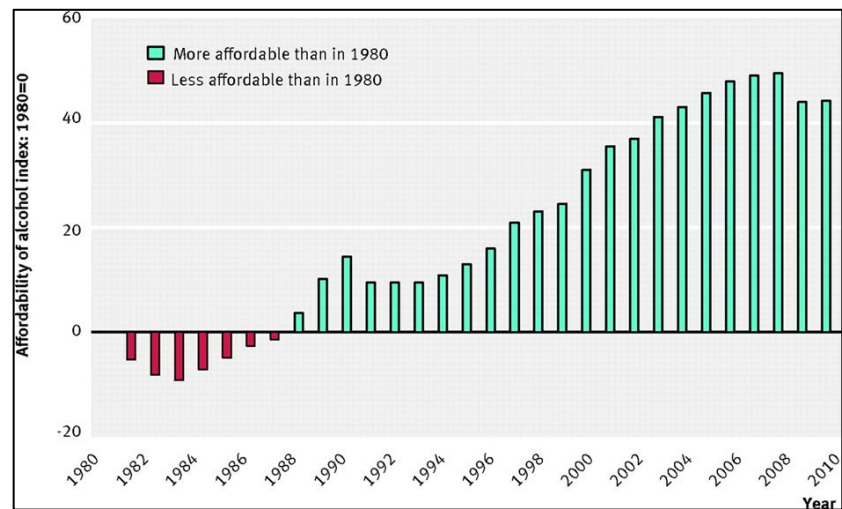


Fig 6.5.5: Affordability of alcohol compared to 1980



## 6.6 Substance misuse<sup>92</sup>

Substance misuse causes serious harm to individuals, families and communities. 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; a typical heroin user spends around £1,400 per month on drugs (Source PHE). It is important to maintain strong links between the Police and drug treatment services.

Drug use has obvious health implications such as the spread of 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 their communities.

It is also important to recognise the longer term consequences of substance misuse. 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 Opiates & Crack Prevalence

Bristol has the largest estimated rate of Opiate and/or Crack Users (OCU) of the English Core Cities (as a rate per 1000). With an estimated 5,000 OCUs in Bristol it is important to ensure that appropriate services are in place to meet this demand.

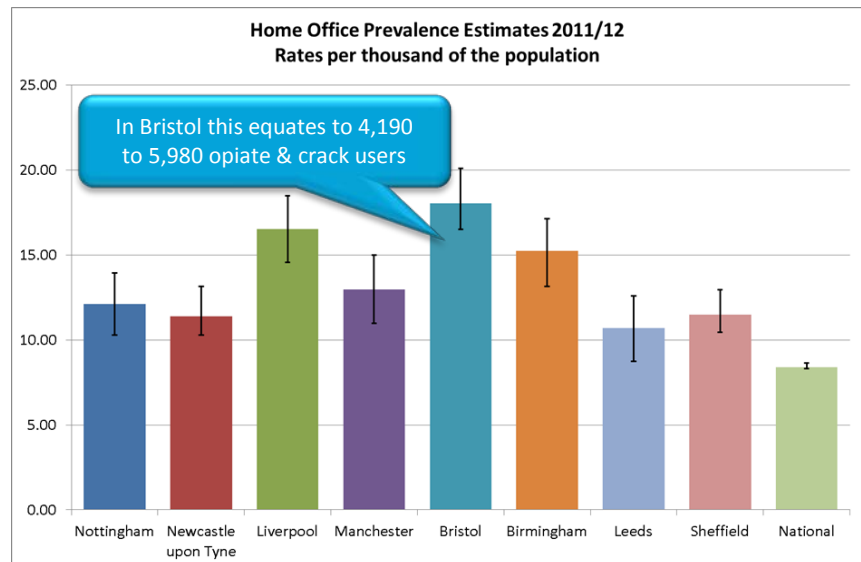


Fig 6.6.1: Estimated rates of Opiate & Crack Users per 1,000 population

A common route into treatment in Bristol is GP referrals (fig 6.6.2) which show a real strength in terms of the accessibility of services throughout the city. It is critical to maintain strong links with Criminal Justice agencies and GPs and to ensure these partners have a clear pathway into services.

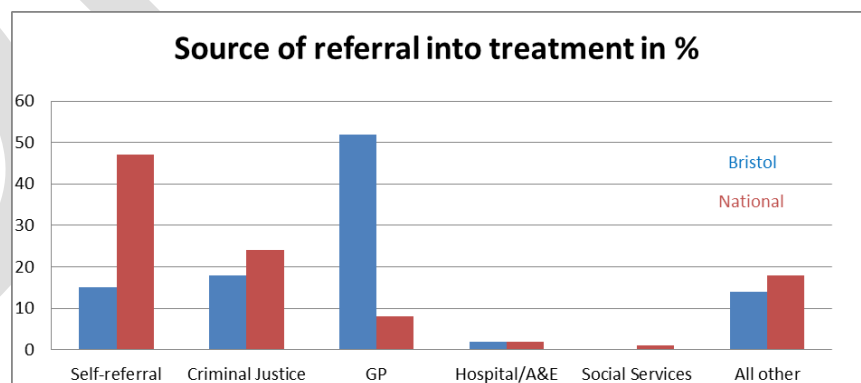


Fig 6.6.2: Treatment referral sources (by %): Bristol v national (2015)

### 6.6.2 Growth of clients in effective treatment

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. As a result of our focus on drugs and alcohol, Bristol has seen

<sup>92</sup> Section provided using Public Health England data for Q1 2015-16 unless otherwise stated

an unprecedented amount of alcohol referrals into the service (see fig 6.5.4 in Alcohol topic).

Treatment needs to be accessible across the city in a timely manner to seize the motivation of clients. 97% of opiate clients and 92% of non-opiate clients in Bristol access treatment within three weeks.

### 6.6.3 In Treatment

Bristol’s drug treatment system has a good track record of engaging opiate users with 52% of the estimated number of opiate users accessing treatment services (around 2,800 people, the 3<sup>rd</sup> highest number of the 8 English Core Cities).

Changes in criminal justice provision and the influx of alcohol clients has led to a decrease in non-opiate clients in treatment (around 200 people, the 2<sup>nd</sup> lowest number of the 8 English Core Cities). This is being addressed with key stakeholders to ensure clients’ needs are met.

Bristol has the largest proportion of very high complexity clients of all the core cities. The most complex clients are more likely to be in treatment for longer and need specific support. Over time these groups are growing so the treatment population locally has become more complex. Local work is targeting high complexity clients in treatment for longer periods to ensure they are

receiving the level of support needed.

### 6.6.4 Treatment completion rates

Bristol has favourable success rates for OCU clients being abstinent at the 6 month treatment review period, but not so for some other substance users (fig 6.6.3). This is being reviewed to inform current provision and help shape services in the future.

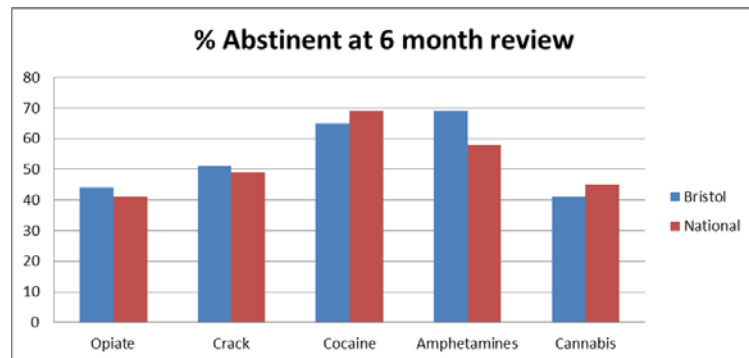


Fig 6.6.3: % abstinence after 6-month treatment: Bristol v national (2015)

Bristol has the highest rate of recovery for its opiate-using population compared to Core Cities, but not for those leaving non-opiate and/or alcohol services (fig 6.6.4).

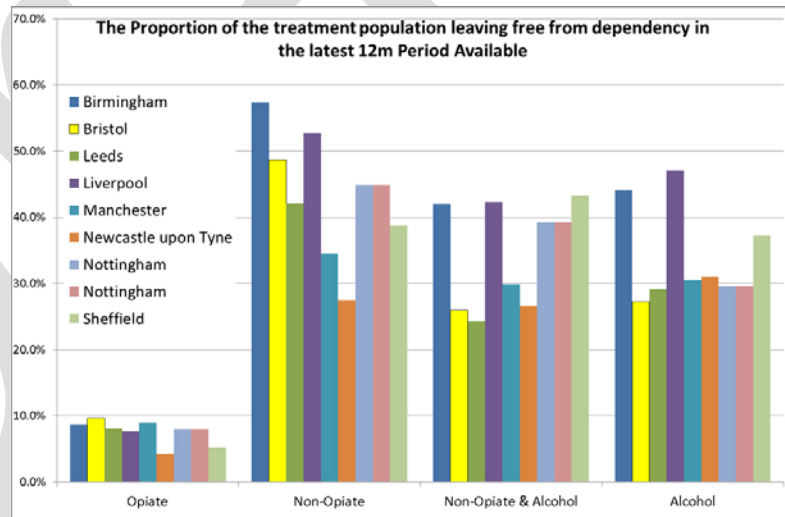


Fig 6.6.4: % leaving treatment free from dependency (Core Cities, Dec 2014)

### 6.6.5 Drug Related Deaths

In the last 2 years there has been an increase in the number of deaths of adults known to Bristol’s substance use treatment, from an average of 30 deaths/year for 2007/08- 2013/14 to 41 in 2014-15 & 33 in first half of 2015-16). On average 60% remain as drug-related (opiate overdose the biggest causal factor). Bristol treatment services are responding to this.

# 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 (section 6C Regulations).

Health Protection covers communicable disease control, infection prevention and control, emergency planning, environmental health, and screening and immunisation programmes.

**Sexual health** covers the provision of 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 is 989 per 100,000 population which is considerably higher than the national average (829 per 100,000).

### Chlamydia

- Bristol has good coverage for chlamydia screening (30% of 15 to 24 year olds were screened in 2014), but has fallen short of the recommended diagnostic rate of 2,300 diagnoses per 100,000 and is now significantly below the national average.

### Teenage Pregnancy

- Teenage pregnancies in Bristol have shown a steep decline since 2007 and are now only slightly higher than the England average (25.7 per 1,000).

### HIV

- The diagnosed prevalence rate of HIV in Bristol increased to 2.07 per 100,000 residents aged 15-59 years in 2014. Bristol is now considered to be over the threshold for expanded testing for HIV.

### TB

- The average incidence of TB in Bristol (21.6 cases per 100,000) is significantly higher than the England average (13.5 per 100,000)
- Nationally there has been a reduction in the incidence of TB cases. Bristol has seen a consistent rise in the incidence of TB since 2008-2010, widening the gap between Bristol and the English average.

### 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.
- Bristol performs above average for flu vaccine uptake for all eligible groups except healthcare workers

## 7.1 Sexual Health<sup>93</sup>

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.

Bristol hosts a comprehensive range of sexual health services. However although progress has been made (for example 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 989 per 100,000 population which is considerably higher than the national average (829 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.

<sup>93</sup> Extract based on the detailed Bristol Sexual Health Needs Assessment (Sept 2015)

## 7.2 Chlamydia

Chlamydia is the most common Sexually Transmitted Infection (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 compares well to the England average and neighbouring local authorities in respect of the population coverage of chlamydia testing<sup>94</sup> for 15-24 year olds, with coverage typically around 30% of the eligible population (national average 25%).

However, Bristol's testing programme has fallen short of the recommended diagnostic rate of 2,300 diagnoses per 100,000 people in the appropriate age-group. 2014 data on the detection of Chlamydia (fig 7.2.1) shows that Bristol (1,818 diagnoses per 100,000) has fallen significantly below the national average (2,012 per 100,000), though both are below the target rate (2,300).

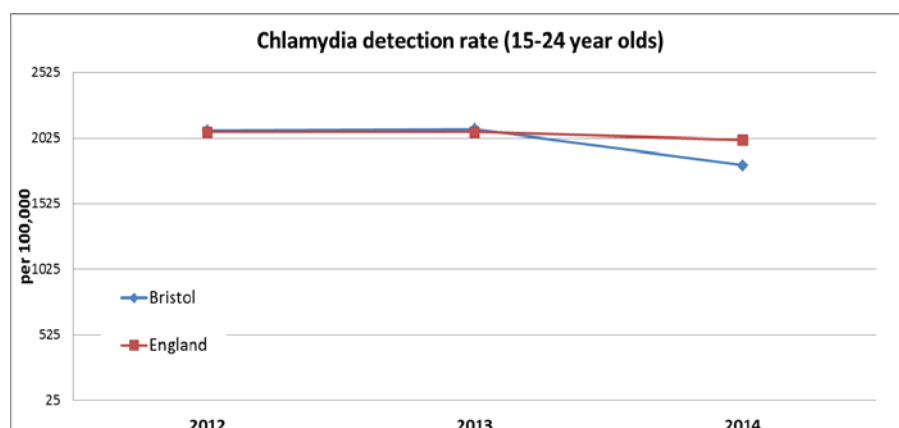


Fig 7.2.1: via Public Health Outcomes Framework, 2015

Locally the ALSPAC<sup>95</sup> cohort study participants were invited for a chlamydia test at the age of 17 years. The researchers found an overall adjusted prevalence of 2.0% in those who were sexually active. 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.

<sup>94</sup> 2013 data via Bristol Sexual Health Needs Assessment (Sept 2015)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

<sup>95</sup> Avon Longitudinal Study of Parents and Children [www.bristol.ac.uk/alspac/](http://www.bristol.ac.uk/alspac/)



### 7.3 Teenage pregnancy

Teenage pregnancies in Bristol have shown a steep decline since 2007 and are now only slightly higher than the England average (25.7 per 1,000).

Becoming a parent whilst a teenager has been associated with poorer health for the mother during and after pregnancy, under-achievement in education and lower levels of employment. Teenage parents are therefore more likely to be living on low incomes which can have health implications for both the mother and baby.

Bristol has had high rates of under 18 conceptions for many years, statistically higher than England as a whole. Since 2007 rates nationally have been falling, and have fallen in Bristol at a faster rate. The 2013 rate for Bristol (25.7 conceptions per 1,000 females aged 15-17, released 2015) was similar to the average rate in England (24.3) and is the lowest of the core cities. As actual numbers of teenage conceptions, this is a fall from 360 in 2007 to 167 (2013) for Bristol.

The proportion of the population affected by teenage conception is relatively small, in 2013 it was just over 1 in 40 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 12 women aged between 15 and 17 years of age conceived during an average year (2009 – 2011), while we can estimate that the risk was 10 times smaller in the wards with the lowest incidence. High rates of teenage conceptions correlate closely with higher levels of deprivation.

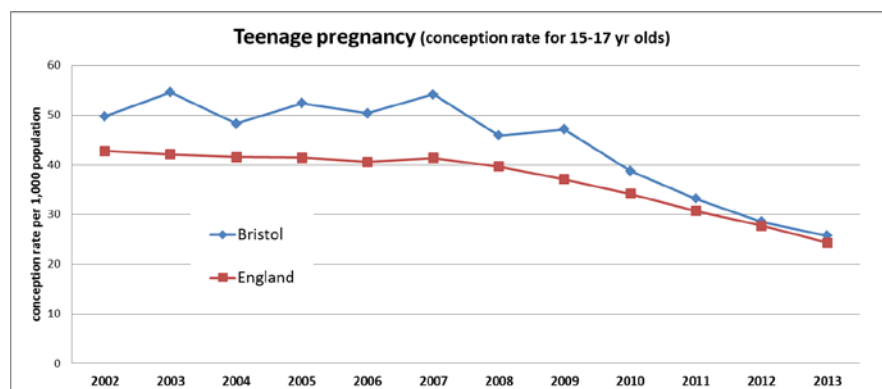


Fig. 7.3.1 Source: ONS, via Public Health Outcomes Framework, 2015

Within Bristol, this data can be shown locally by wards (and CCG sub-locality areas) to highlight the differences across the city. Due to the relatively small numbers locally they are shown as a 3 year average (2011-13). By CCG sub-locality areas, North & West (inner) has a significantly lower rate of teenage conceptions. Teenage conceptions are falling in all areas, and fell most in the Inner City which had been the highest rate.

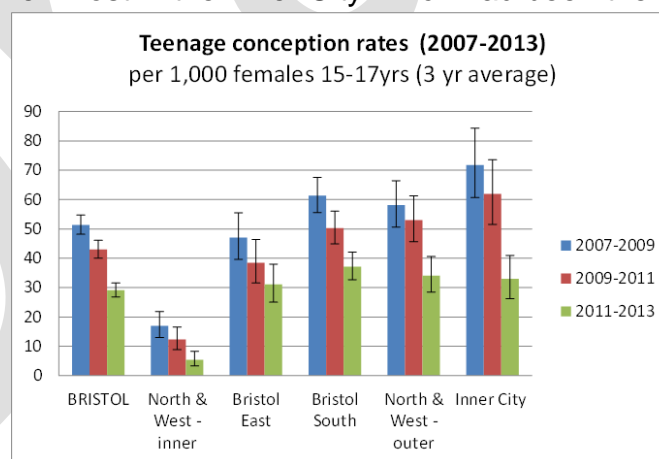


Fig 7.3.2. Source: Office of National Statistics, collated by Bristol Public Health Intelligence Unit, 2015

## 7.4 HIV

HIV is associated with considerable morbidity and mortality and requires serious long-term care and treatment. Drug therapies have reduced the incidence of HIV-related deaths but it remains a life-threatening infection.

It is estimated that over 100,000 people in the UK are currently living with HIV, but of these, it is estimated that 24% do not know they have the infection (HPA, 2013) and remain at risk of passing on their infection if having sex without condoms. Some groups in society are affected disproportionately by HIV, including MSM and the black African population.

The overall UK prevalence of HIV in 2014 was 2.8 per 1,000 population aged 15-59 years (1.9 per 1,000 women and 3.7 per 1,000 men). The overall HIV prevalence rate for Bristol increased in 2014 to 2.07 per 100,000 residents aged 15-59 year which means Bristol is now considered to be over the threshold for expanded HIV testing. Men who have sex with men make up the greatest proportion of HIV diagnoses in Bristol.

Recent HIV surveillance data<sup>96</sup> (fig 7.4.1) shows that, of the people with a new HIV diagnosis in Bristol in 2012-14, 45% are considered to have a “late diagnosis”. This rate

is slightly higher rate of late diagnosis of HIV than that seen nationally (42%). Late HIV diagnosis is a concern since it is clearly linked to increased rates of illness, hospital admission and mortality, as well as reduced life expectancy, for the individual concerned, in addition to increased onward transmission. Heterosexuals and black Africans are at higher risk of late diagnosis.

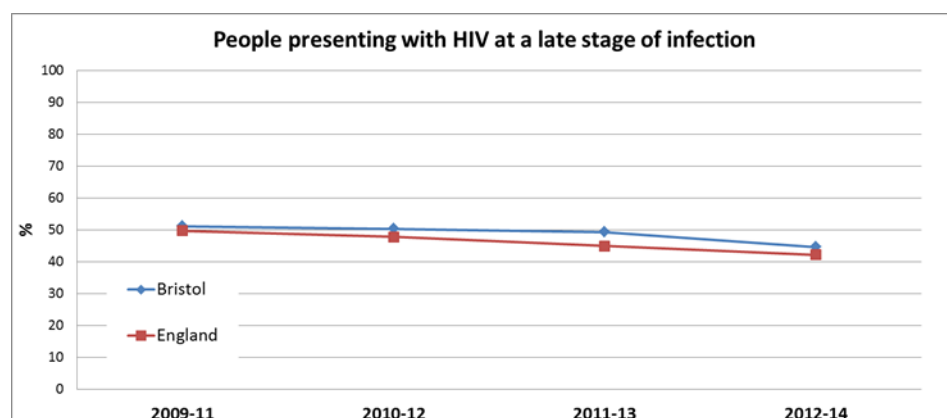


Fig 7.4.1 Source: via Public Health Outcomes Framework, Nov 2015

<sup>96</sup> via Public Health Outcomes Framework, Nov 2015

## 7.5 TB (Tuberculosis)

TB is caused by the bacterium *Mycobacterium tuberculosis*. It is a notifiable disease in the UK.

In 2012-14 there were 284 reported new cases of TB per year in Bristol. This is a rate of 21.6 new TB cases per 100,000 population, which is significantly higher than the national rate (13.5 cases). Despite a small downward trend in annual TB incidence in England, Bristol's incidence is increasing (fig 7.6.1).

The number of new cases per year in the Bristol area places a notable demand on the health care system in terms of clinical management and following up close contacts to see if they may have been infected. TB "contact tracing" is key to management of TB as it provides an opportunity to identify unrecognised cases, and with new smarter 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. This teams works closely with paediatric services in hospital settings who manage children affected by the disease.

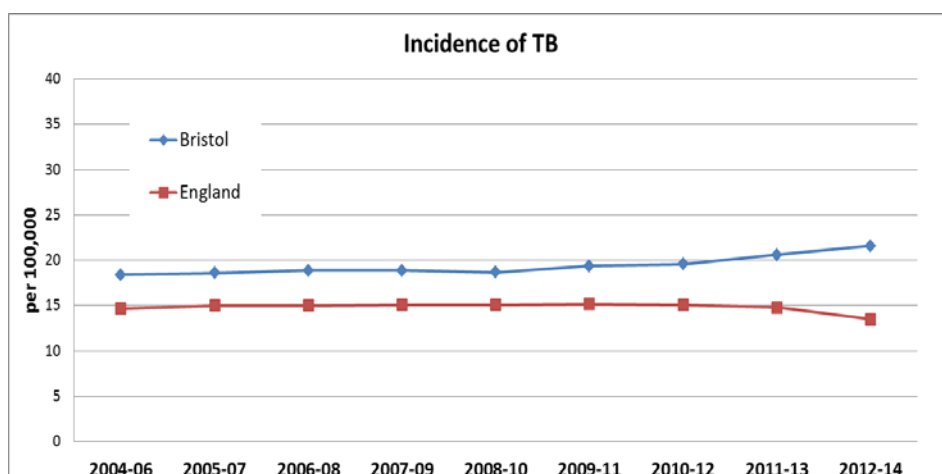


Fig 7.5.1 Source: via Public Health Outcomes Framework, Nov 2015

It is important to note that the continued increase in cases poses a risk to current services and the future capacity of these services to provide an adequate response.

## 7.6 Flu Immunisations

Influenza (flu) is an acute viral infection of the respiratory tract characterised by a fever, chills, headache, muscle and joint pain, and fatigue. The risk of serious illness or complications 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 serious impact at population level.

The impact of flu on the population varies over time and is influenced by changes in the virus, affecting the proportion of the population that may be susceptible to infection and the severity of the illness. Flu does, however, occur every winter in the UK.

Cumulative data of vaccinations administered between 1 Sept 2014 and 31 January 2015 was collected from 99.7% of GP practices across England. Uptake of the flu vaccination was 72.7% in those aged 65 years and over, 50.3% in those aged six months to under 65 years in a clinical at-risk group (excluding pregnant women without other risk factors), 44.1% in pregnant women, and 38.5%, 41.3% and 32.9% in children aged two, three and four years old respectively. Uptake rates by eligible cohort across Bristol during 2014/15 compared with the average for England are detailed in fig 7.6.1.

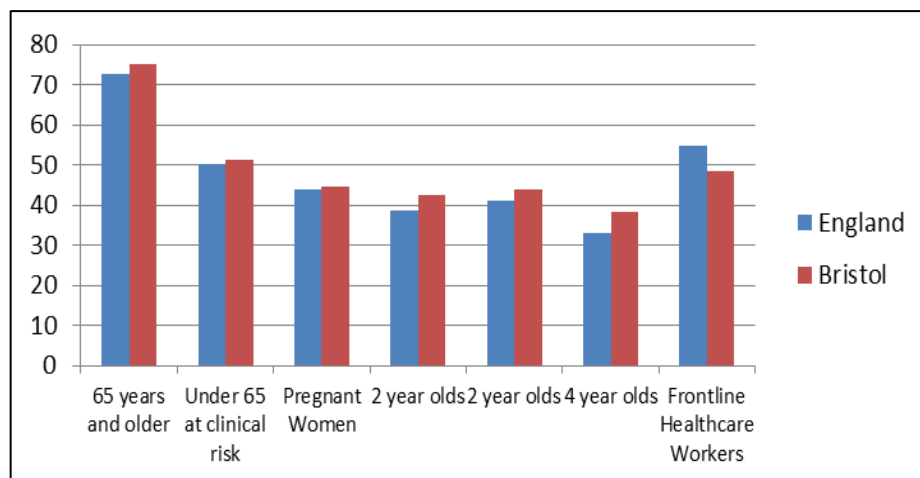


Fig 7.6.1: Source: Public Health

Overall Bristol performs better than the England average for vaccine uptake for all eligible groups (except Healthcare workers). For older people 65 & over Bristol has consistently had a better vaccination rate than nationally (fig 7.6.2) but for other at-risk groups this has only been in the last year (fig 7.6.3)

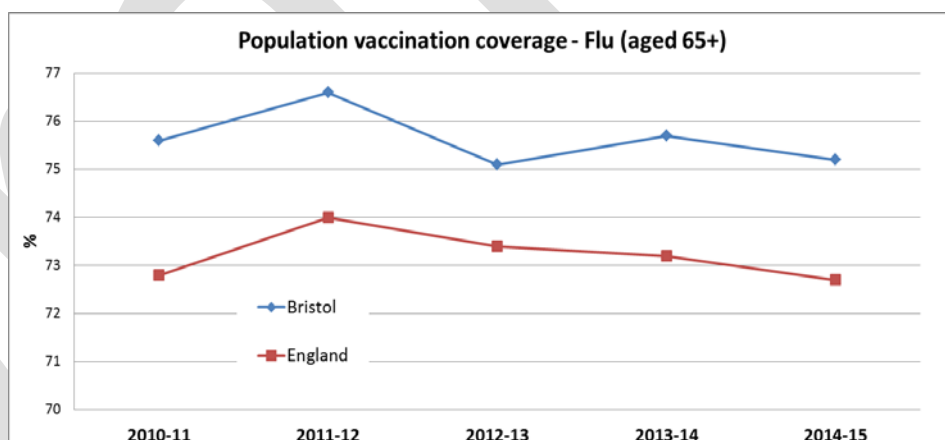


Fig 7.7.2 Source: via Public Health Outcomes Framework, Nov 2015

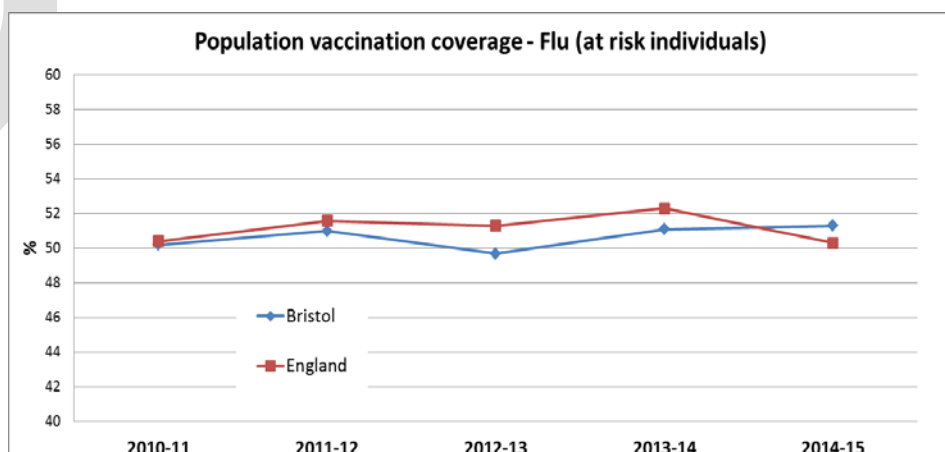


Fig 7.7.3 Source: via Public Health Outcomes Framework, Nov 2015

## Section 8

# Long Term Conditions

### Summary points

#### Cardiovascular Disease

Whilst early deaths due to cardiovascular disease (CVD) in Bristol have been falling since 2001, rates are significantly higher than the England average.

In Bristol, the early death rate for CVD among men is more than twice the rate than for women<sup>97,98</sup>.

#### Cancer

In Bristol, rates of early death due to Cancer in both men and women have decreased since 2001, but still remain significantly higher than the England average.

Overall in Bristol, more men than women die early every year due to Cancer.

Screening coverage for breast, cervical & bowel Cancer in Bristol are all significantly lower than the England average<sup>99</sup>

#### Diabetes

Recorded rates of diabetes continue to rise in Bristol as in England overall. Recent 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, early death rates from respiratory disease are significantly higher than the England average and for the South West<sup>100</sup>.

Admission rates to hospital for all respiratory diseases are higher in Bristol than the England average<sup>101</sup>. Recent data show that a third of all emergency admissions in Bristol, were for respiratory conditions (an increase on the previous year)<sup>102</sup>.

#### Liver Disease

Early deaths from liver disease in Bristol are significantly higher than in England. Rates are almost three times higher in men than women in Bristol.

Most liver disease is due to alcohol, obesity and viral hepatitis. The rate of alcohol specific hospital admissions in Bristol is significantly higher than the England average for both men and women<sup>103</sup>.

#### Preventable mortality

Overall, preventable mortality rates in Bristol remain higher than the England average. However, Bristol rates are similar to or better than other Core Cities and statistically similar cities.

<sup>97</sup> Based on data provided by Bristol City Council's Public Health Intelligence Unit (2015)

<sup>98</sup> PHE, Cardiovascular Disease Profile (2015). Available at <http://www.vhpho.org.uk/ncvincvd/>

<sup>99</sup> In place of: "Breast cancer is one of the three most common cancers in women, Breast screening coverage in Bristol is lower than the England average"

<sup>100</sup> PHE Public Health Outcomes Framework (2011-13)

<sup>101</sup> PHE, Interactive Health Atlas of Lung Conditions (Inhale) in England

<sup>102</sup> Based on hospital data provided by Commissioning Support Unit (2014-15)

<sup>103</sup> PHE Liver Disease Profiles



### 8.1 Prevalence of common long-term conditions

Records from GP registers<sup>104</sup> in Bristol shows the percentage of adult patients diagnosed with selected Long-Term Conditions 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 Kidney Disease, where the recorded prevalence is slightly higher than national (see fig 8.1.1)

Within Bristol, North & West (inner) has a substantially lower % of patients with almost all long-term conditions (LTC), other than Cancer. North & West (outer) however is the opposite, with one of the highest rates, along with South Bristol. The Bristol East area is more similar to Bristol average. The Inner City shows relatively low recorded prevalence for Cancer and Kidney Disease (which would fit with the younger population profile for the Inner City).

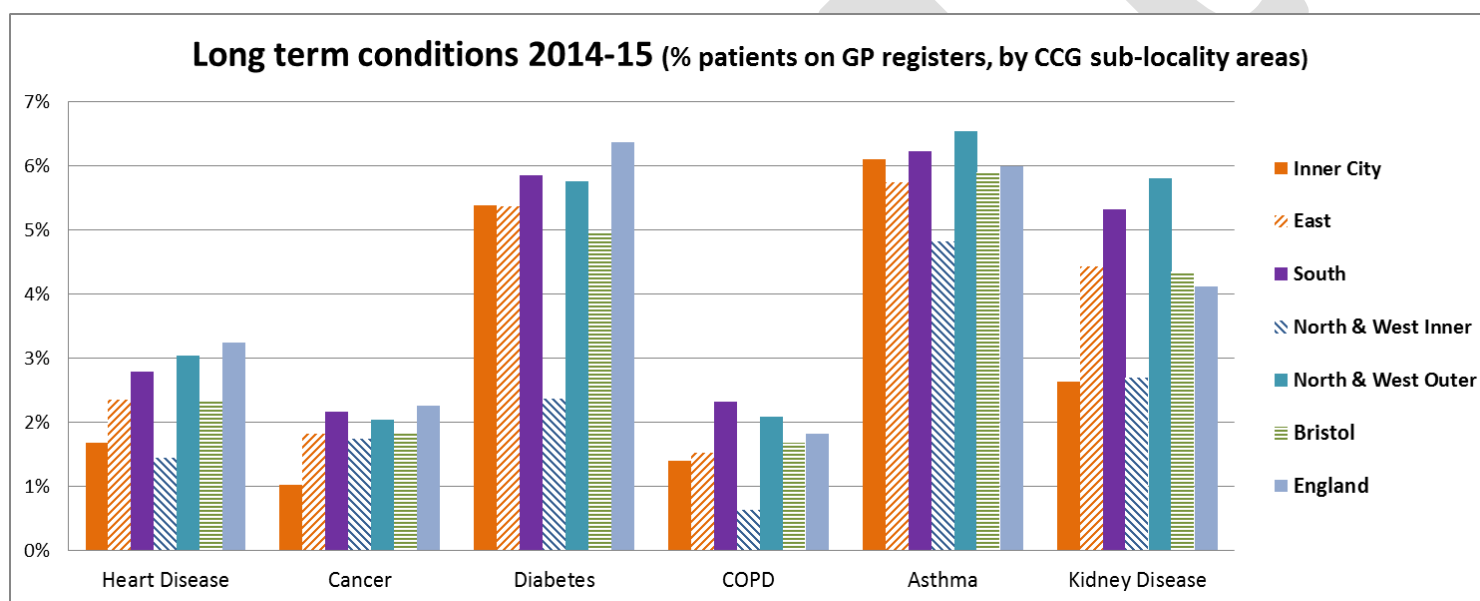


Fig 8.1.1: Long-term conditions by area, 2014-15

Patients on GP Registers (2014-15)	Coronary Heart Disease		Cancer (all types)		Diabetes (Mellitus, 17+)		Chronic Obstructive Pulmonary Disease (COPD)		Asthma		Chronic Kidney Disease	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Sub Locality Area												
Inner City	1,026	1.7	625	1.0	2,649	5.4	856	1.4	3,722	6.1	1,285	2.6
East	2,030	2.4	1,569	1.8	3,776	5.4	1,310	1.5	4,934	5.8	3,083	4.4
South	4,441	2.8	3,444	2.2	7,454	5.9	3,709	2.3	9,922	6.2	6,677	5.3
North & West Inner	1,436	1.5	1,736	1.8	2,011	2.4	634	0.6	4,772	4.8	2,267	2.7
North & West Outer	2,645	3.0	1,776	2.0	3,964	5.8	1,823	2.1	5,689	6.5	3,944	5.8
Bristol	11578	2.35	9150	1.86	19854	4.96	8332	1.69	29039	5.90	17256	4.36
England	1843813	3.25	1281811	2.26	2913538	6.37	1034578	1.82	3402437	5.99	1859963	4.13

Table 8.1.2: Long-term conditions by area, 2014-15

<sup>104</sup> Source: NHS Quality Outcomes Framework (QOF) 2014/15 (released Oct 2015).

## 8.2 Premature mortality of Cancer and Cardiovascular Diseases

In Bristol half of all premature deaths (under 75 years) are due to cancer (all types) and coronary heart disease (39% cancer, 11% coronary heart disease)<sup>105</sup> (fig 8.2.1)

The tables show that early death rates due to Cancer, all Cardiovascular Diseases, and heart disease are lower in the North & West (inner) than the Bristol average. In the Inner City and North & West (outer), rates for CVD are higher (worse) than average, and are double that of the North & West (inner). In the South of Bristol, rates for Cancer are higher (worse) than Bristol average.

For males, early death rates for Cancer and all Cardiovascular Diseases are lower in the North & West (inner) than the Bristol average. For Cancer, rates are higher in the South and for CVD they are higher in the North & West (outer) compared to the average rates for males in Bristol.

For females, early death rates from Cancer are lower in the North & West (inner) and higher in the North & West (outer) than the Bristol average.

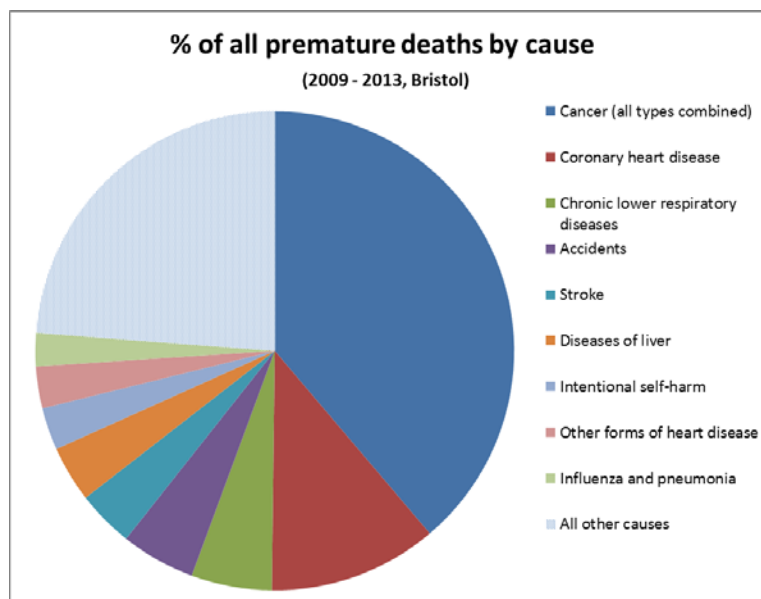


Fig 8.2.1 Source Bristol City Council's Public Health Intelligence Unit (2015)

2009-2013						
All People						
Mortality rates per 100,000 population (all persons)	Bristol (average)	Bristol East	Inner City	Bristol South	North & West - inner	North & West - outer
Premature mortality, Cancer	160	152	169	178	106	186
Premature mortality, CVD (all Cardiovascular)	92	98	113	92	58	112
Premature mortality, CHD (Heart Disease)	48	46	53	51	31	60
Premature mortality, Stroke	16	20	20	15	10	20
Male						
Mortality rates per 100,000 population (all persons)	Bristol (average)	Bristol East	Inner City	Bristol South	North & West - inner	North & West - outer
Premature mortality, Cancer	181	168	199	210	113	196
Premature mortality, CVD (all Cardiovascular)	130	143	153	128	82	161
Premature mortality, CHD (Heart Disease)	74	72	77	79	47	95
Premature mortality, Stroke	20	28	24	17	11	22
Female						
Mortality rates per 100,000 population (all persons)	Bristol (average)	Bristol East	Inner City	Bristol South	North & West - inner	North & West - outer
Premature mortality, Cancer	141	138	137	148	100	176
Premature mortality, CVD (all Cardiovascular)	55	55	69	58	36	65
Premature mortality, CHD (Heart Disease)	23	21	26	25	16	28
Premature mortality, Stroke	13	12	17	12	9	17

Green = lower (better) than Bristol average; Red = higher (worse) than average; Unshaded = not significantly different to average

<sup>105</sup> Based on data provided by Bristol City Council's Public Health Intelligence Unit (2015)

### 8.3 Cardiovascular Disease

Early deaths due to cardiovascular disease (CVD) in Bristol have been falling since 2001 in line with the trend in England overall (fig 8.3.1). Bristol rates increased in 2011-13, and in 2012-14 Bristol rates (85.4 per 100,000) remain significantly higher than the England average (75.7).

There is variation across the city (fig 8.3.2) with rates in the Inner City and North and West (outer) of Bristol almost twice as high as in the North and West (inner). Further analysis (*not shown*) indicates rates have fallen fastest in the South, where they are now equal to the average for the city. Overall in Bristol, the early death rate for CVD is more than twice the rate for men than for women. Rates have fallen faster for women than men.

Data from GP registers (fig 8.3.3) shows the recorded prevalence of long term conditions amongst adults. In Bristol, the average recorded prevalence (2.4%) of Coronary Heart Disease (CHD) is lower than the England average (3.2%). However, in the North & West outer recorded prevalence is similar to the national rate and almost twice the rate of the North & West inner and the Inner City.

In Bristol, recorded rates of CHD have seen a slight year on year decrease since 2012. The inner

city has seen a slight increase over 2013/14 rates.

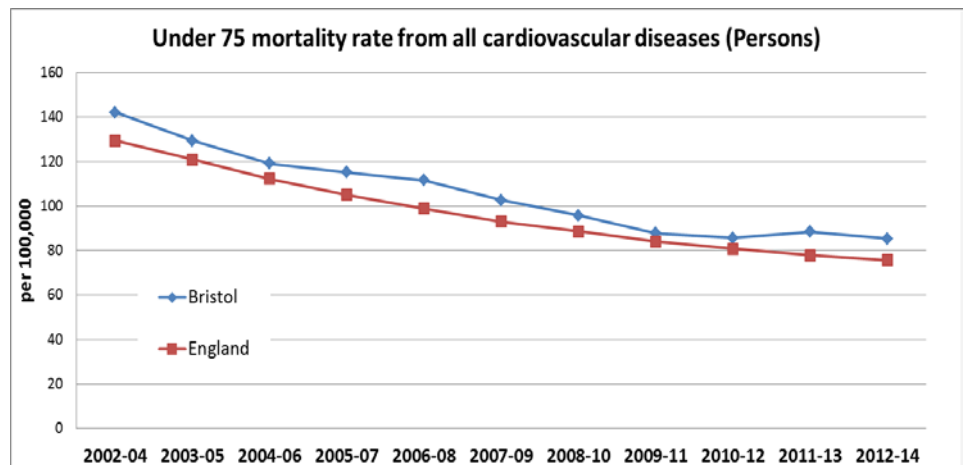


Fig 8.3.1: Early deaths – CVD (Source via PHOF, Nov 2015)

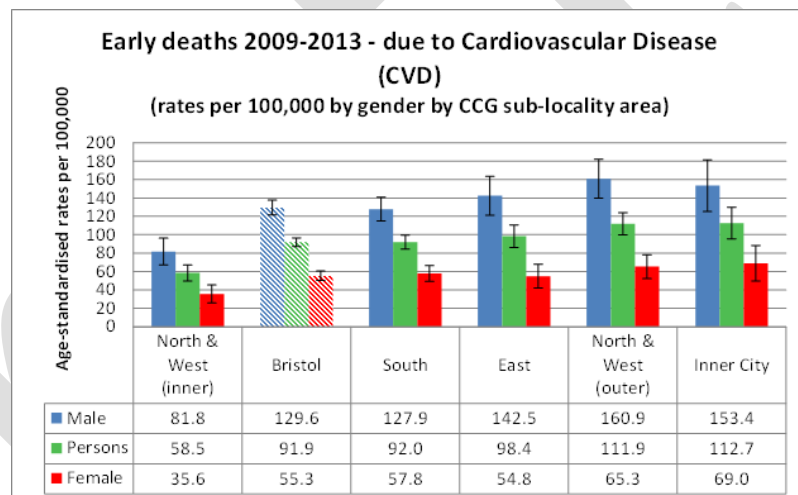


Fig 8.3.2: Early deaths by area – CVD (Source BCC Public Health Intelligence Unit, Aug 2015)

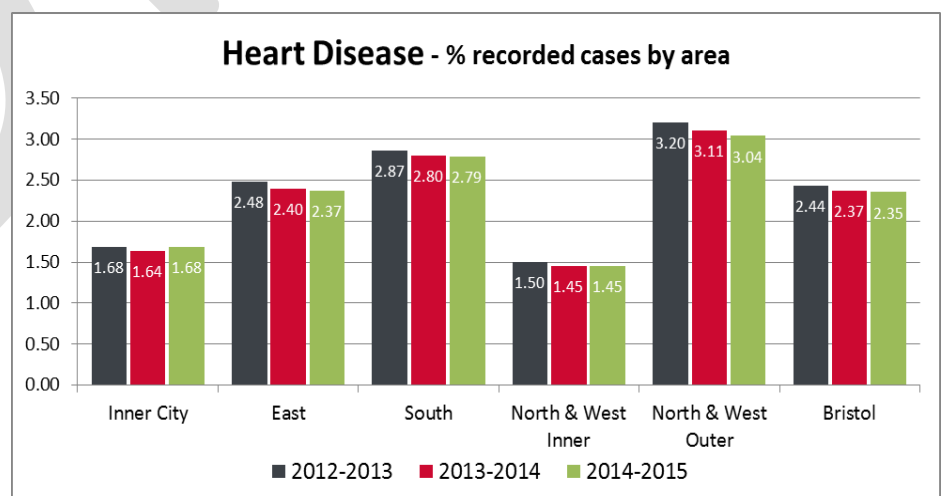


Fig 8.3.3: NHS Quality Outcomes Framework (QOF) 2014-15 (supplied by BCC Performance Information & Intelligence)

### Coronary Heart Disease (CHD)

Early death rates from CHD in Bristol are higher than the national rate. Rates in the North and West (inner) remain lower (better) than the city average, whilst other areas are similar to the average. CHD death rates are three times higher among men compared with women (Fig 8.3.4).

### Stroke

In Bristol, the recorded prevalence of stroke<sup>106</sup> (2014-15) and early death rates from stroke are similar to the national rates. Early death rates from stroke vary across the city with at least twice the rate in North & West Outer and the Inner City and East than in North & West Inner. Overall in Bristol, 50% more men than women die early from stroke (Fig 8.3.5).

### High Blood Pressure (Hypertension)

High blood pressure (hypertension) increases risk of heart disease or stroke. In Bristol, the recorded prevalence of hypertension is lower than the estimated prevalence, suggesting that 11.2% of adults could have hypertension that has not been diagnosed or not recorded<sup>107,108</sup>.

Rates of Hypertension vary across the city, with highest rates in the

South and North & West outer. Rates of hypertension are lowest in the North & West inner and the Inner City (Fig 8.3.6).

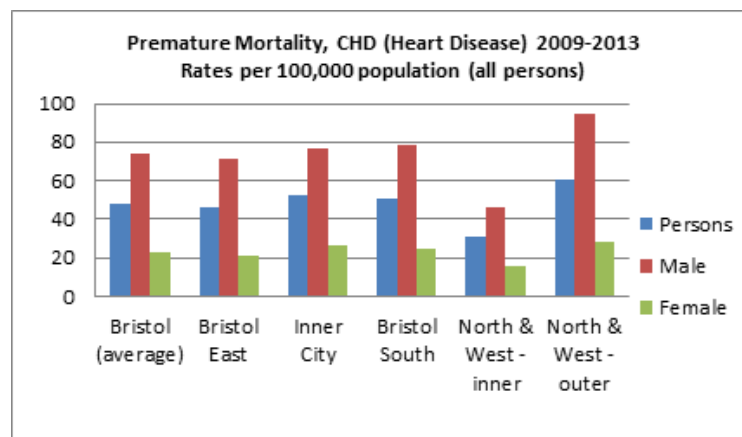


Fig 8.3.4

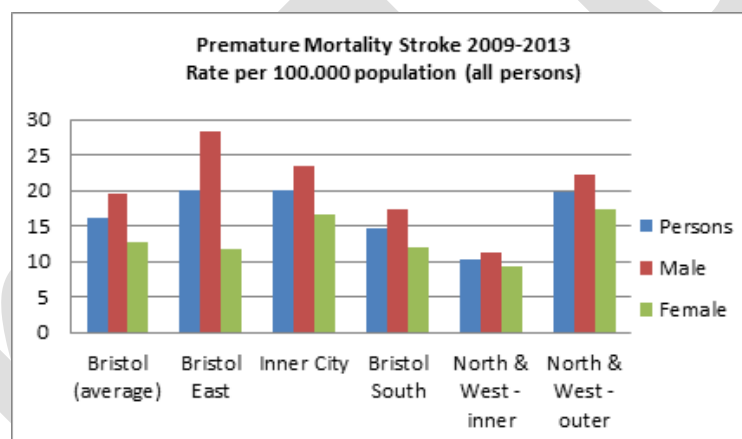


Fig 8.3.5

Patients on GP Registers (2014-15)	Hypertension	
	Number	%
Sub Locality Area		
Inner City	5,200	8.5
East	9,659	11.3
South	20,489	12.9
North & West Inner	7,479	7.6
North & West Outer	10,646	12.2
<b>Bristol</b>	<b>53473</b>	<b>10.87</b>
<b>England</b>	<b>7833779</b>	<b>13.79</b>

Fig 8.3.6

<sup>106</sup> Stroke and Transient Ischaemic Attack  
<sup>107</sup> Based on data provided by Bristol City Council's Public Health Intelligence Unit, PHIU (2015)  
<sup>108</sup> PHE, Cardiovascular Disease Profile (2015). Available at <http://www.yhpho.org.uk/ncvincvd/>

## 8.4 Cancer

In Bristol, whilst rates of early death due to Cancer in both men and women have decreased since 2001, 2012-14 rates in Bristol (153.6 per 100,000) remain significantly higher than the England average (141.5 per 100,000) (fig 8.4.1).

Overall in Bristol, more men than women die early every year due to Cancer, and male rates for Cancer premature mortality (173 per 100,000) are significantly higher than England (158). For women the Bristol rate (135 per 100,000) is broadly similar to national (127).

Rates are higher in the South of the city and in North & West (outer), and lower in North & West (inner) (fig 8.4.2). Rates among men are highest in the South and Inner City at almost twice the rate of inner North & West. For women rates are highest in the North & West outer<sup>109</sup>.

Data from GP registers (QOF) shows the percentage of patients diagnosed with cancer continues to rise (fig 8.4.3). Whilst the rate in Bristol overall (1.9%) remains lower than the England average (2.3%), rates in the South and North & West (outer) are similar to England. Rates in the Inner City remain the lowest, at half those in South and North & West outer.

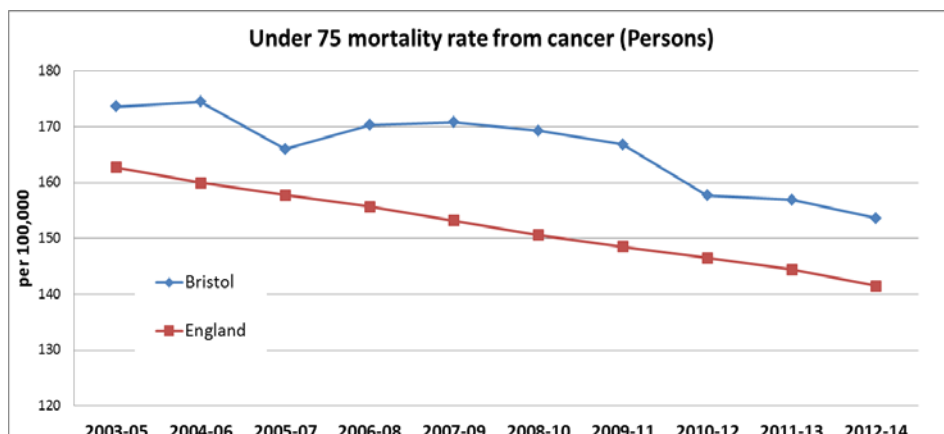


Fig 8.4.1: Early deaths – Cancer (Source via PHOF, Nov 2015)

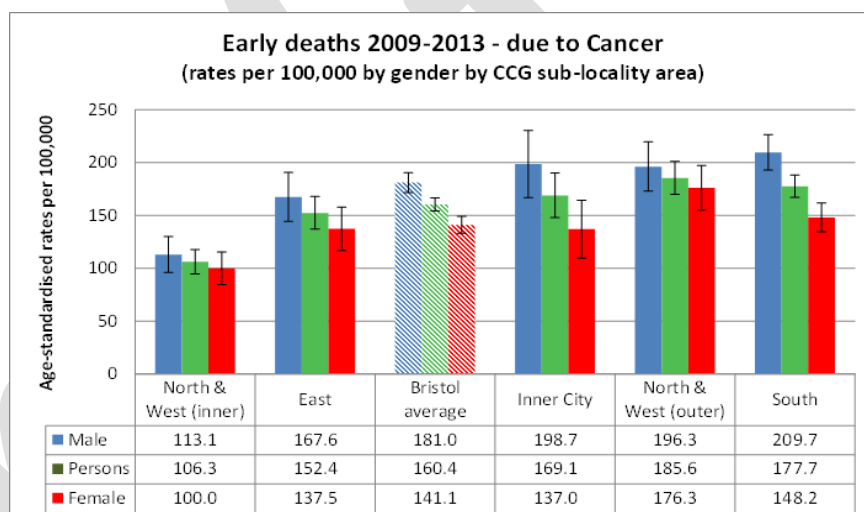


Fig 8.4.2: Early deaths – Cancer (2009-13 by area) (Source BCC Public Health Intelligence Unit, Aug 2015)

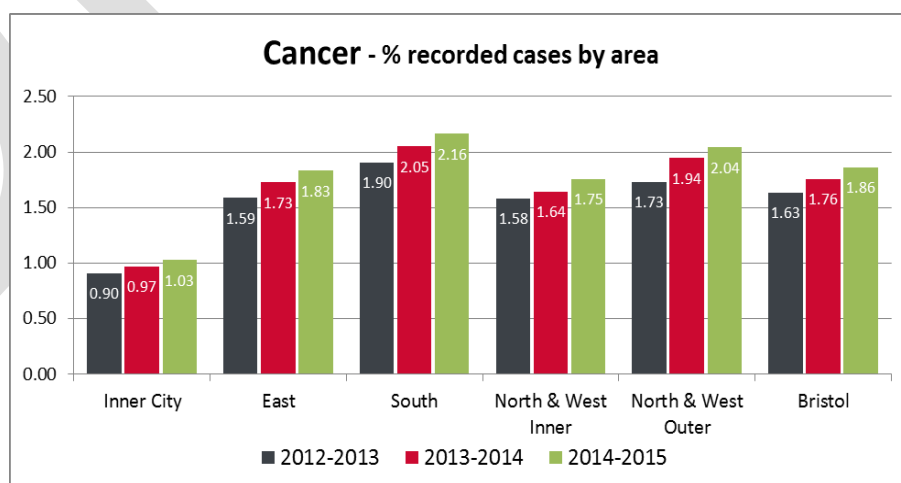


Fig 8.4.3: NHS Quality Outcomes Framework (QOF) 2014-15 (supplied by BCC Performance Information & Intelligence)

<sup>109</sup> Based on data provided by Bristol City Council's Public Health Intelligence Unit (2015)



Admissions to hospital due to cancer were higher in Bristol than England between 2009 and 2012. Then in 2013, the rate in Bristol dropped below the national rate<sup>110</sup>.

### 8.4.1 Types of cancer

The three most common cancers in men are prostate, lung and bowel; in women they are breast, lung and bowel. The incidence, mortality and survival rates for breast, prostate and bowel cancer in Bristol between 2010 and 2012 were similar to the England average. For Lung cancer, the incidence and mortality rates in Bristol between 2010 and 2012 were higher than the England average.

### 8.4.2 Cancer Screening

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 are 73.2% for Breast cancer (England 75.4%) and 70.9% for cervical cancer (England 73.5%).

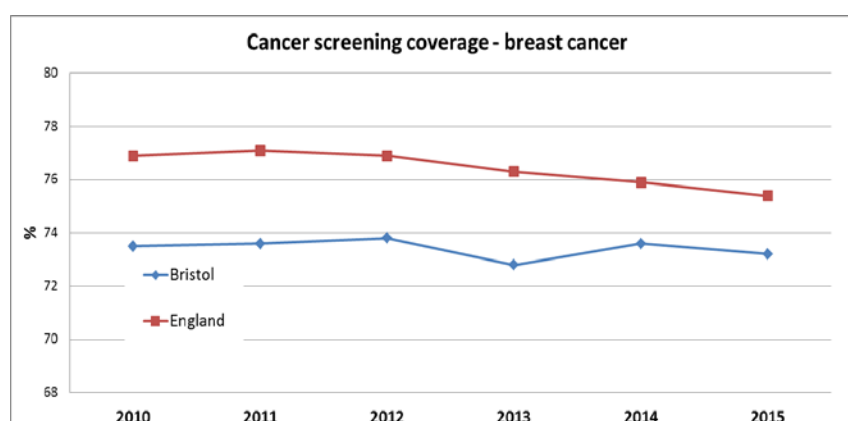


Fig 8.4.4: Cancer screening - breast (Source via PHOF, Nov 2015)

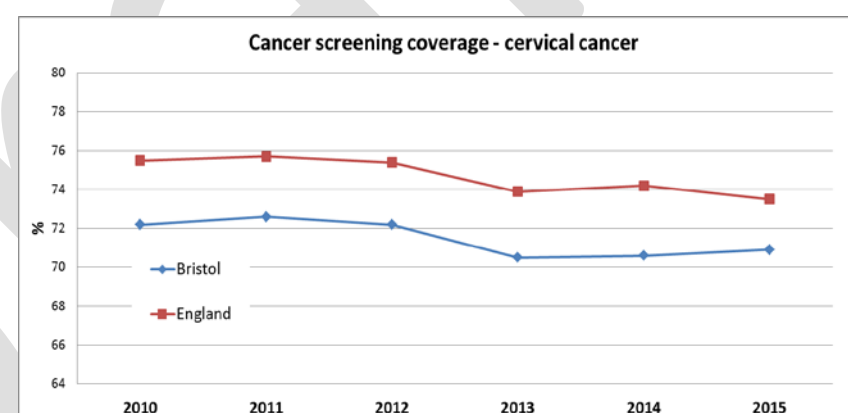


Fig 8.4.5: Cancer screening - cervical (Source via PHOF, Nov 2015)

In 2015 new data has been released on screening coverage for **bowel cancer**. The rate for Bristol (50.7%) is also significantly worse than the national average (57.1%).

### 8.4.3 Patient feedback

Local feedback on Cancer support services<sup>111</sup> noted that cancer patients need to be confident that support and advice would be easy to use, easy to locate and available whenever needed.

<sup>110</sup> PHE, General Practice Profiles (2015) [www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

<sup>111</sup> HealthWatch - see Section 11 Public feedback. Also further feedback in HealthWatch Cancer services report, Dec 2014 <http://goo.gl/rDzKFb>

## 8.5 Diabetes

Diabetes prevalence<sup>112</sup> continues to rise in Bristol as in England overall (see fig 8.5.1). Age is a key factor in diabetes prevalence, and the relatively low prevalence in Bristol compared with England may reflect Bristol's relatively younger age profile<sup>113</sup>. Diabetes prevalence is also higher in more deprived areas, and among those from Black and Asian ethnic groups.

Recorded data from GP registers shows there are 19,850 Bristol patients with Diabetes. As a crude rate this is 5.0% of all adult patients, below the England average (6.4%). Diabetes prevalence varies across the city (fig 8.5.2). The outer North & West, Inner City, East and South Bristol areas all have recorded Diabetes prevalence above 5% 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 increases with increasing overweight/obesity.

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 Type 2 diabetes, as well as at increased risk of other cardiovascular conditions.

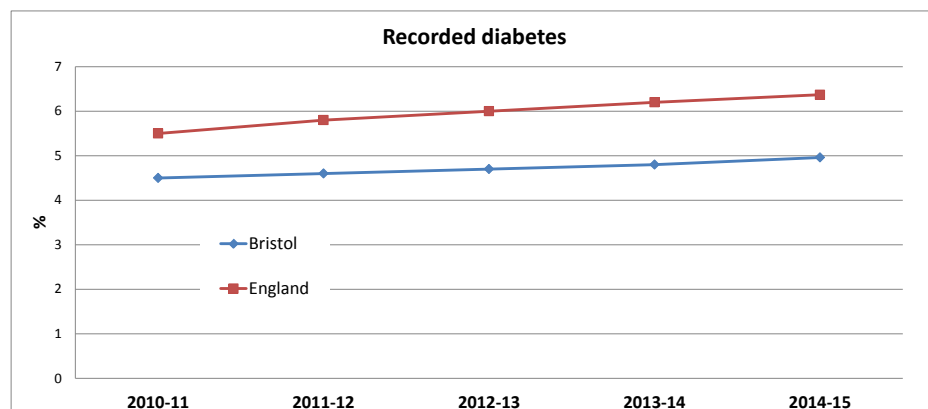


Fig 8.5.1: Recorded rates of diabetes (Source QOF 2014-15)

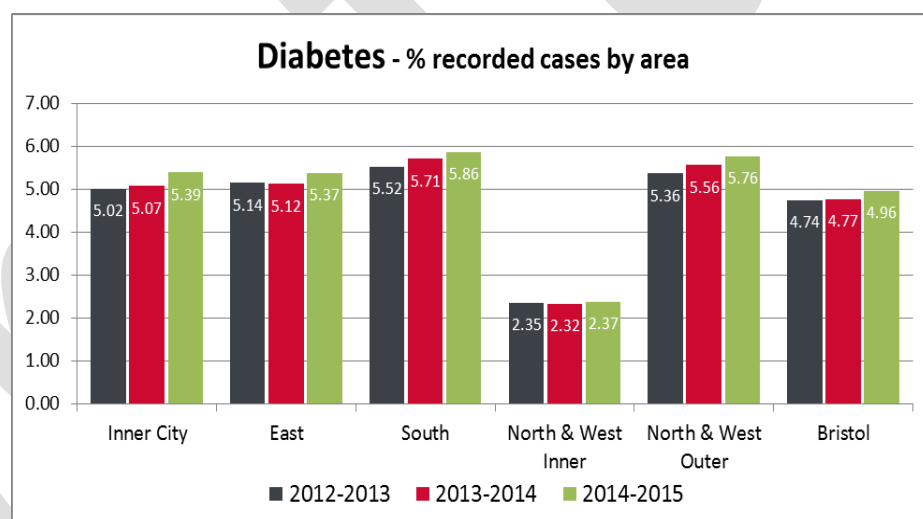


Fig 8.5.2: Source: NHS Quality Outcomes Framework (QOF) 2014-15 (supplied by BCC Performance Information & Intelligence)

Recent 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.

<sup>112</sup> NHS Quality and Outcomes Framework (QOF) 2014/15 data

<sup>113</sup> QOF is a crude rate per population, unlike the age standardised rates used for premature mortality

## 8.6 Respiratory Disease

In Bristol, early death rates from respiratory disease in Bristol (40.4 per 100,000) are now significantly higher than the England average (32.6 per 100,000), as well as higher than the South West average. Rates are higher in men than women<sup>114</sup>. Recent data shows a small rise in early respiratory deaths in Bristol (fig 8.6.1), due to a rise in female respiratory deaths.

### COPD

Recorded GP register data<sup>115</sup> shows 8,330 Bristol patients with chronic obstructive pulmonary disease (COPD). As a prevalence rate this is 1.7% of all adult patients, just below the England average (1.8%). There is variation across Bristol, with highest rates in the South and North & West outer area at more than three times that of the lowest rate (North & West inner) (fig 8.6.2).

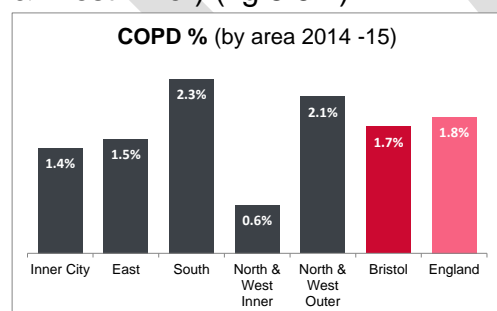


Fig 8.6.2: Source: NHS QOF 2014/15)

Variations in recorded COPD prevalence correlate with variations in smoking rates across

areas. Estimated COPD prevalence rates (including undiagnosed cases) are higher than the rate recorded on GP registers. From this, it is estimated that in Bristol, around 46% of COPD cases were diagnosed & recorded (57% in England).

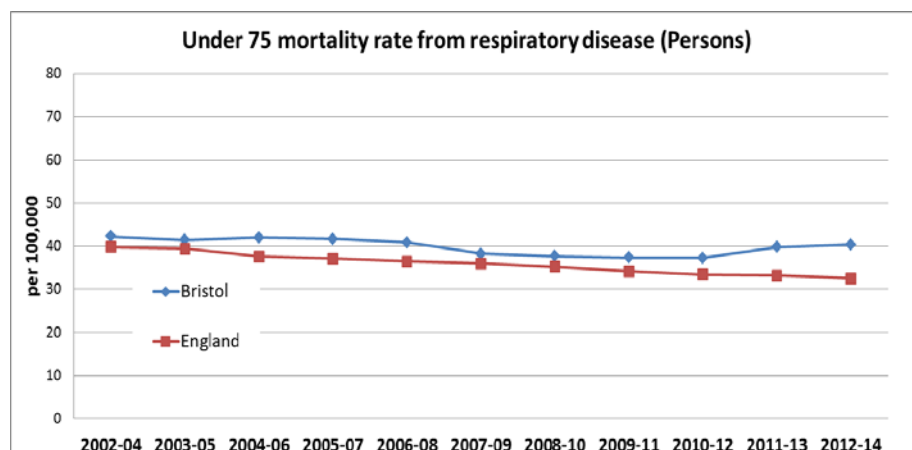


Fig 8.6.1: Early deaths – Respiratory (Source via PHOF, Nov 2015)

### Asthma<sup>116</sup>

GP register data shows 29,040 Bristol patients with Asthma. As a prevalence rate this is 5.9% of all adult patients, similar to the England average (6%). There is variation across Bristol, with the highest rates in South and North & West outer much higher than the lowest rate in North & West inner (fig 8.6.3)

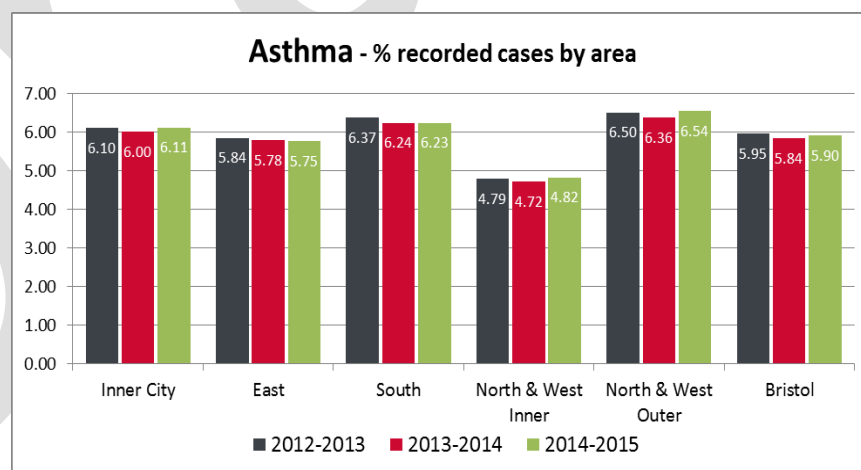


Fig 8.6.3: NHS Quality Outcomes Framework (QOF) 2014-15

Admission rates to hospital for all respiratory diseases are higher in Bristol than the England average<sup>117</sup>. In 2014-15 in Bristol, 33% of all emergency admissions (all ages), were for respiratory conditions, compared to 30% in the previous year<sup>118</sup>.

<sup>114</sup> PHE Public Health Outcomes Framework (2012-14)

<sup>115</sup> NHS QOF data 2014/15

<sup>116</sup> Childhood Asthma is JSNA section 4.11 in Child Health

<sup>117</sup> PHE, Interactive Health Atlas of Lung Conditions (Inhale) in England

<sup>118</sup> Based on hospital data provided by the Commissioning Support Unit (2014-15)

## 8.7 Liver Disease

Liver disease is largely preventable. Most liver disease is due to alcohol, obesity and viral hepatitis.

Early deaths from liver disease across England have been rising slowly since 2001. Data for Bristol show a less clear trend but in recent years has been rising and in 2012-14 Bristol now has a significantly higher rate (21.6 per 100,000) than the England average (17.8 per 100,000).

There are significant differences by gender. Rates of early death from liver disease are almost three times higher in men than women in Bristol. Male early deaths due to liver disease (31.7 per 100,000) are significantly above average (23.4) whilst female early deaths (11.4 per 100,000) are similar to England average (12.4 per 100,000).

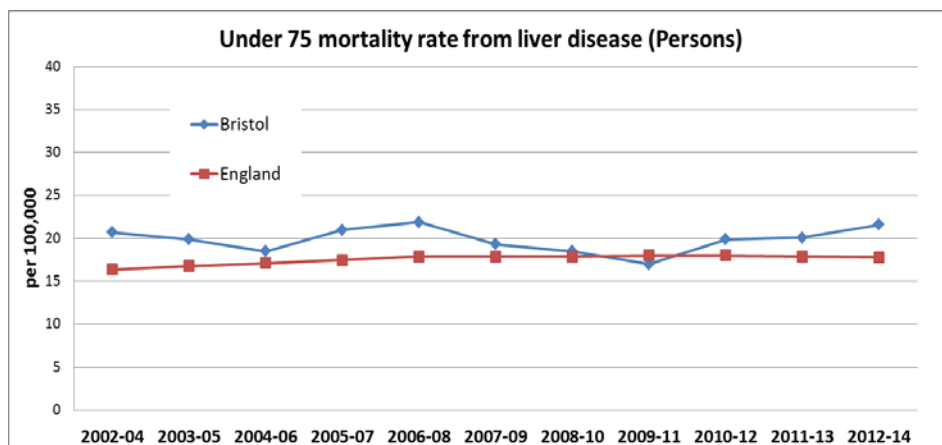


Fig 8.7.1: Early deaths – Liver disease (Source via PHOF, Nov 2015)

There were 2015 alcoholic specific hospital admissions in Bristol in 2012/13 (1376 male and 639 female). The rate of alcohol specific hospital admissions in Bristol is significantly higher than the England average for both men and women<sup>119</sup>. [Note – also see 6.5 Alcohol]

There is variation across the city for liver disease emergency admissions. Data from the last two years (fig 8.7.2) show that rates have decreased in the Inner City and East, whereas they have increased in other areas and in Bristol overall<sup>120</sup>.

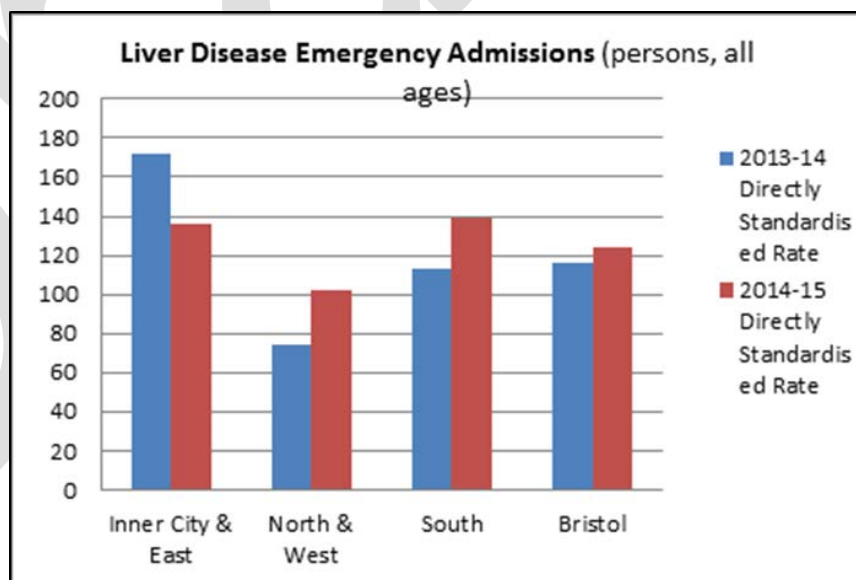


Fig 8.7.2: Hospital admissions – Liver disease

<sup>119</sup> PHE Liver Disease Profiles

<sup>120</sup> Data provided by Bristol City Council's Public Health Intelligence Unit (2015)

## 8.8 Preventable mortality

Public Health England defines preventable mortality as death that could potentially be avoided by public health interventions<sup>121</sup>.

These include 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, chronic obstructive pulmonary disorder (COPD), transport accidents, accidental injury, suicide and self-inflicted injuries and homicide/assault.

Using this definition, over the 3 years 2012-14 there were over 2,000 “preventable deaths” in Bristol (around 675 per year). This is a preventable mortality rate of 208.4 deaths per 100,000, which is consistently higher (worse) in Bristol than the England average (182.7 per 100,000) (fig 8.8.1).

Rates in Bristol (2011-13) are similar to four of seven cities considered statistically similar, apart from Salford and Newcastle upon Tyne. Preventable mortality in Bristol is better than five of the eight ‘core cities’ (fig 8.8.2. & 8.8.3)

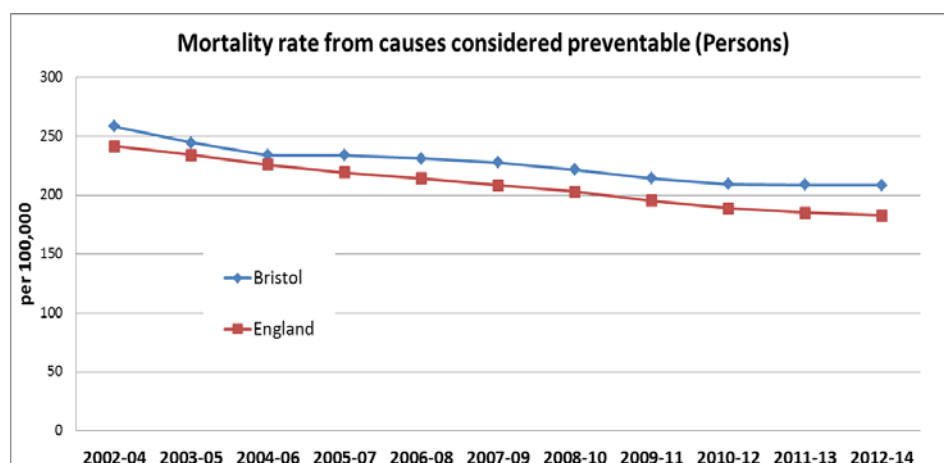


Fig 8.8.1 (Source via PHOF, Nov 2015)



Fig 8.8.2 2011-13 data (Source via PHOF, Aug 2015)

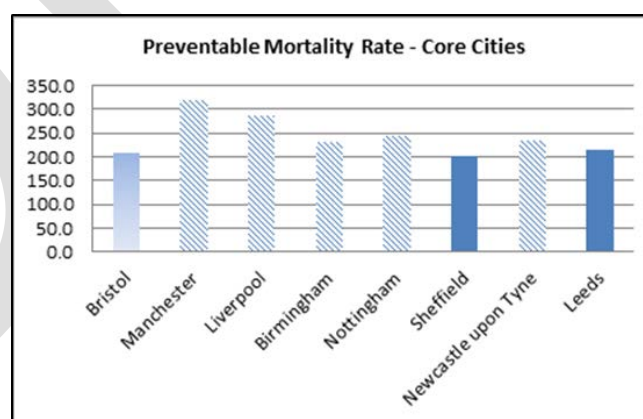


Fig 8.8.3 2011-13 data (Source via PHOF, Aug 2015)

<sup>121</sup>ONS Definition of avoidable mortality, via PHOF 2015:  
[www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E12000009/ati/102/are/E06000023/iid/40301/age/1/sex/4](http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E12000009/ati/102/are/E06000023/iid/40301/age/1/sex/4)  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)



## Section 9

# Mental Health

### Summary

Mental health problems 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).

Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability. Nearly 11% of England's annual secondary care health budget is spent on mental health. More than £2 billion is spent annually on social care for people with mental health problems. There are also incalculable costs to the individual, their family and community of lost potential and productivity.

Improved mental health is associated with a range of better outcomes for people of all ages & backgrounds. 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 details are in the Public Health England "Mental Health, Dementia and Neurology" profiles:

<http://fingertips.phe.org.uk/profile-group/mental-health>

### Depression

- 30,100 Bristol patients (7.6%) received a new diagnosis of depression in the last year, above the England average (7.3% of patients)
- The highest % of new diagnoses of depression is in North & West outer (9.3%), but figures rose across the city.

### Self-harm

- There were 1,600 attendances for deliberate self-harm at the Bristol Royal Infirmary in 2014, by 1,066 people. 18% made a repeated attendance for self-harm during the year
- The number and age/sex distributions of self-harm presentations has remained stable since 2011
- Approximately 1 in 25 self-harm presentations to the hospital requires admission to the intensive treatment unit.
- The prevalence of unemployment is particularly high among the self-harm patients (57%), particularly males.

### Suicide

- Men in their mid-life years currently have the highest rates of suicide in Bristol, which mirrors the national picture.
- The incidence of suicide and undetermined death is highest amongst the most socially disadvantaged.
- The average annual number of suicides among individuals in contact with mental health services (2001-14) was approximately 14.5 deaths per year. This represents 37% of all suicides in Bristol during that period.

### Emotional Health and Wellbeing of Children & Young People

- An estimated 10% of children and young people may be experiencing emotional health problems at any time (estimate of 5,400 children and young people, 2014)
- 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.
- Self-harm hospital admission rates for young people (10-24 year olds) exceed the England average.

## 9.1 Depression

Depression is one of the most widespread psychological disorders. In England, depression accounts about £9 billion per year, mainly in lost productivity.

Recorded cases on GP registers<sup>122</sup> in Bristol show that 30,100 Bristol patients (over 18) received a new diagnosis of depression in the preceding year (2014-15)<sup>123</sup>. This is 7.6% of all adult patients, which is an increase from 7% (27,700 patients) the previous year (and 6.2%, or 23,700 patients, the year before). Bristol also has a higher rate than the England average (7.3% of patients in 2014-15, which also increased from 6.5% the previous year), although is mid-table for the English Core Cities and for statistically similar cities (using 2013-14 data).

Within Bristol, the highest percentage of diagnoses of depression is now in North & West (outer) (9.3%) and Inner City (8.5%), which both rose sharply in the last year (fig 9.1.1). It should be noted that although Bristol South appears to be the only area not to rise, this is very likely an under-estimate<sup>124</sup>. The inner area of North & West Bristol has

significantly lower (5.3%) recorded depression, although rates have increased in the last year as across the City.

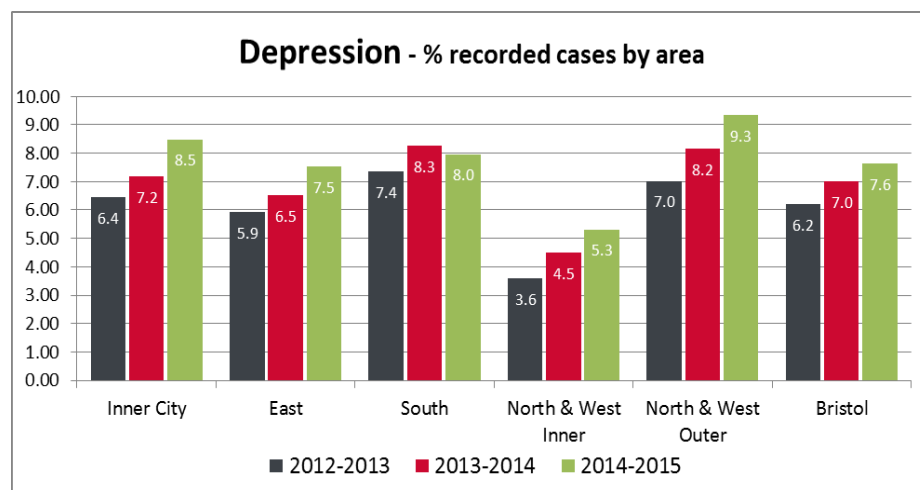


Fig 9.1.1: % Depression by Bristol CCG locality area 2012-13 to 2014-15  
Source: NHS Quality Outcomes Framework (QOF) 2014-15  
Supplied by BCC Performance Information & Intelligence, Nov 2015

<sup>122</sup> Source: NHS Quality Outcomes Framework (QOF) 2014/15 (Oct 2015)

<sup>123</sup> Note: QOF data shows conditions recorded on GP registers (as a crude rate, divided by number of patients). Not all patients will be diagnosed.

<sup>124</sup> There are data issues with this indicator for 2014-15 in 3 GP practices in South

## 9.2 Self-harm<sup>125</sup>

Women and men of all ages and backgrounds do things that are harmful to themselves, especially in times of pressure and emotional distress. Self-inflicted injuries caused by cutting, burning, biting, thumping self or another object, swallowing objects or substances, overdosing are examples of self-harm. Whilst much of self-harm will go on unrecorded by professionals, many individuals require treatment for self-inflicted injuries in the 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 quarter of these individuals go on to repeat self-harm in the next 12 months.

Self-harm is strongly associated to suicide. A fifth of all suicides attend A&E for self-harm in the year prior to their death and over a third of all suicides have a past history of self-harm. Therefore self-harm attendances provide an important opportunity for intervention to prevent suicide. Hospital admission for self-harm is one of the newly introduced standard outcome indicators used to monitor population mental health and wellbeing.

Fig 9.2.1 is for emergency hospital admissions in Bristol for

intentional self-harm (all ages, rates per 100,000) by gender 2004/05-2014/15. This shows an apparent rise in admissions for self-harm for females over the last 4 years. The rate for males is significantly lower.

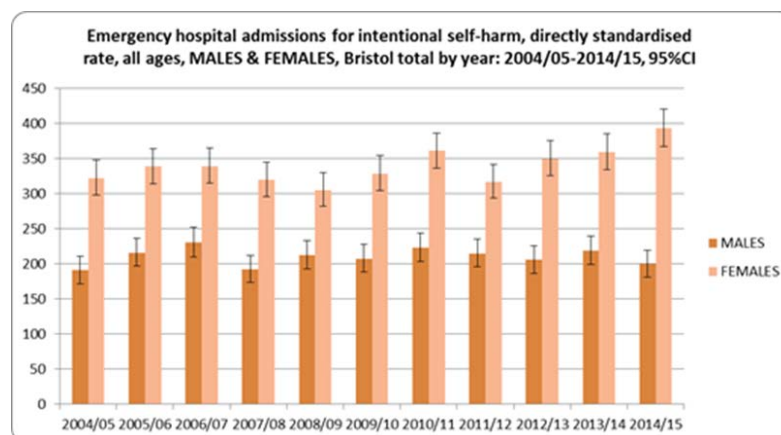


Fig 9.2.1: Source Hospital Episode Statistics via Secondary User Service (SUS) – collated by Bristol Public Health Unit

In 2010 Bristol Public Health commissioned Bristol University to develop a Self-harm Surveillance Register<sup>126</sup>. This has been recording detailed information on patients presenting to hospital for self-harm for the past 5 years.

Information<sup>127</sup> recorded on the register enables an assessment of i) the incidence of hospital-presenting self-harm in Bristol, ii) trends in the incidence of self-harm and its management; iii) the impact of changes in service delivery on patient management and outcomes and iv) risk factors for repeat self-harm and suicide; v) the medicines taken in overdose. This data also provide insight into the management of patients for clinicians and managers while also allowing the evaluation of services against NICE guidelines for treatment of self-harm patients.

In 2014 there were 1,600 self-harm presentations to the Bristol Royal Infirmary's Emergency Department in 2014, a similar value as in 2013. The 1,600 attendances were made by 1,066 individuals, therefore approximately one in three attendances were repeated episodes. Female patients made up a greater proportion of the self-harm patient population than males.

<sup>126</sup> A database maintained the Emergency Department of the Bristol Royal Infirmary, part of University Hospitals Bristol NHS Foundation Trust. Now financially supported also by UHB and AWP NHS Trust

<sup>127</sup> This information contributes to local prevention efforts and to the STITCH (Services and Trusts Integrating to Transform Care in Self-harm) Health Integration Team

<sup>125</sup> Also noted in Emotional Health and Wellbeing of Children & Young People

### 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. Those in contact with mental health services in Bristol represent, on average over the last 12 years, 37% of the total deaths by suicide; meaning that 63% are not known to services and may have been exposed to a range of other risk factors.

Men in their mid-life years have the highest rates of suicide in Bristol, which mirrors the national picture. The incidence of suicide and undetermined death is highest amongst those most socially disadvantaged.

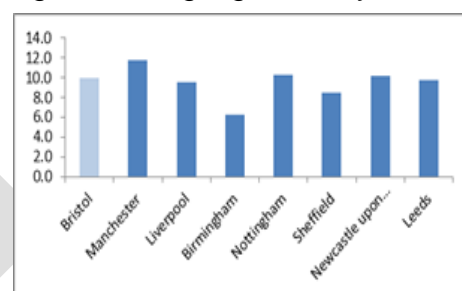
Reduction of the suicide rate has been an objective in government Strategies over time and the Public Health Outcomes Framework has an indicator comparing local rates with the national average.

In the 3 years 2011-2013, Bristol's average mortality rate<sup>128</sup> from suicide and undetermined death was 10 per 100,000 population, which is statistically similar to the England average rate of 8.8 per 100,000. [The number of suicides was 129 in this period].

The majority of these suicides, 97, were males. This is a rate of 14.8

per 100,000, also statistically similar to the England average (13.8).

However, given the variations between areas, another useful measure is the Core Cities comparator. By this measure, Bristol is now mid-table, with only Birmingham being significantly lower than Bristol statistically. In the main, Bristol is broadly similar to the other Core cities and to the national average. Bristol has improved in the last 3 years from having the highest rate among those 8 cities.



Bristol is experiencing a greater rise in deaths by suicide among older men. In recent years, most male deaths occurred among men in their mid-life years. This is noteworthy. In the whole of the United Kingdom, in 2013, men aged between 45 and 59 had the highest suicide rate out of any age group (25.1 deaths per 100,000 population, see fig 9.3.1) having risen since 2007. The rate for 60-74 year old men also increased significantly in 2013 to 14.5 per 100,000. Source: HSCIC

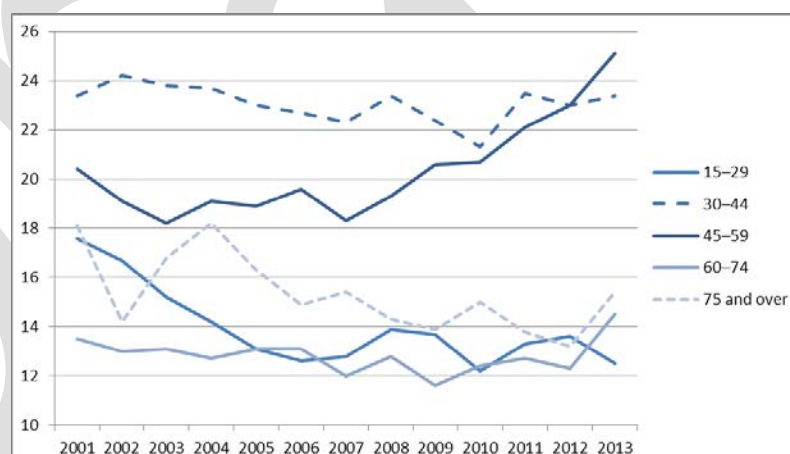


Fig 9.3.1: Age-specific suicide rate, males, deaths registered from 2002 to 2013

In Bristol the number and the rate of suicide and undetermined intent deaths among men aged 45 to 59 increased between 2013 and 2014. In 2013 there were 10 deaths (rate of 25.6 per 100,000) while in 2014, this rose to 20 deaths (rate of 53.7 per 100,000). However, given the fluctuations which occur annually in numbers, a longer period will need to be monitored to establish whether this is a definite pattern.

<sup>128</sup> Directly standardised mortality rate, 2011-13. Public Health Outcomes Framework, 2015



### 9.4 Mental Wellbeing

Wellbeing is complex and multifaceted. It is considered as a state and a process. Wellbeing is intimately intertwined with the physical, cultural and global environment and includes personal, interpersonal and collective needs, which influence each other.

Interventions to enhance wellbeing may take different forms, at individual, community and society levels. Interventions need to recognise diversity and inequalities within communities. Bristol Public Health works with a wide range of organisations to deliver actions that have positive impact on wellbeing and improve mental health outcomes for individuals and communities.

Feedback from HealthWatch<sup>129</sup> notes that people praised social prescribing models and asked for more support in the community to engage in activities that support them with their wellbeing.

One of the ways to find out about the levels of wellbeing of people is from surveys. On the national ONS Average Happiness scale (fig 9.4.1), Bristol residents scored 7.2 out of 10 (10 being the highest score for happiness). Similar figure of 7.6 (fig 9.4.2) was recorded on the Average "Feel things in my life are worthwhile"

score. On both scores Bristol is somewhat behind other Core Cities as well as England average. However, the figures for all cities within both scores are very similar.

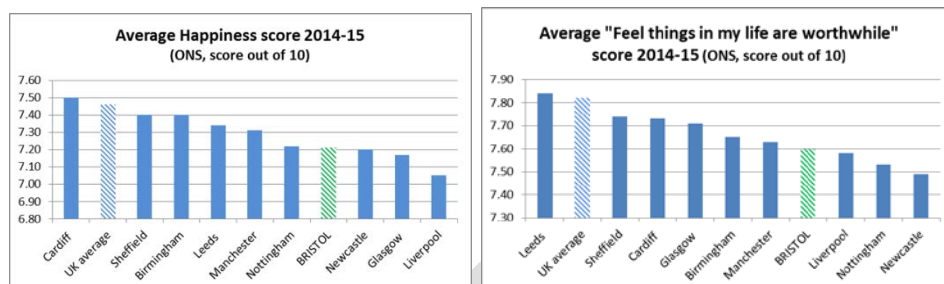


Fig 9.4.1: Source: ONS, via BCC Performance, Information & Intelligence  
On the scale of Average Life Satisfaction, Bristol has a relatively high % of people who score themselves as having high or very high life satisfaction (a score of 7 or above):

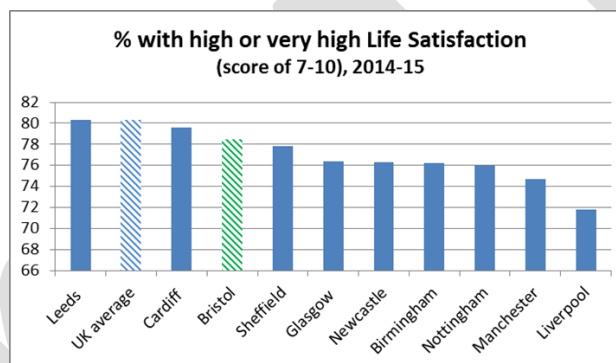
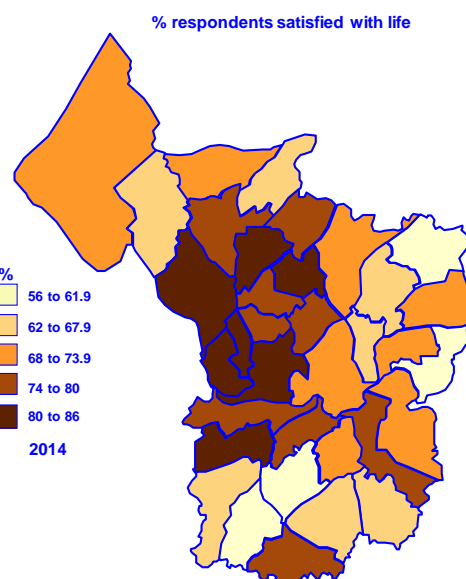


Fig 9.4.2: Source: ONS, via BCC Performance, Information & Intelligence  
The local Quality of Life in Bristol 2014 survey shows that there is a range in response from different areas within Bristol, and different groups.

The Bristol average has been stable for several years, but by ward the range is from 56% in Filwood to 86% in Henleaze. There was generally more people satisfied with life in the more affluent areas, but the biggest variation was between the equalities groups. The lowest satisfaction was for disabled people (43%).



<sup>129</sup> Mental Health and Wellbeing report, June 2015 <http://goo.gl/hyv9tV>



Further data on positive mental health and wellbeing from the Bristol Quality of Life survey (2014) uses a measure called the Short Warwick-Edinburgh Mental Wellbeing Scale<sup>130</sup>. Scores range from 7 to 35, with a higher score reflecting a higher level of mental wellbeing.

The mean SWEMWBS score in Bristol is 25.1, close to the national figure of 25.3<sup>131</sup>.

Mental wellbeing was lower in deprived areas (24.4), notably St George East (22.9), Frome Vale (23.3) and Filwood (23.6).

Disabled people had the lowest mean SWEMWBS score of all groups, at 22.4. Further analysis suggests that having higher qualifications was associated with higher levels of mental wellbeing. Groups with lower levels of mental wellbeing were people on means tested benefits (23.3), living in social housing (23.2), living alone (24.1), in their forties or early fifties (24.6) and men (24.9).

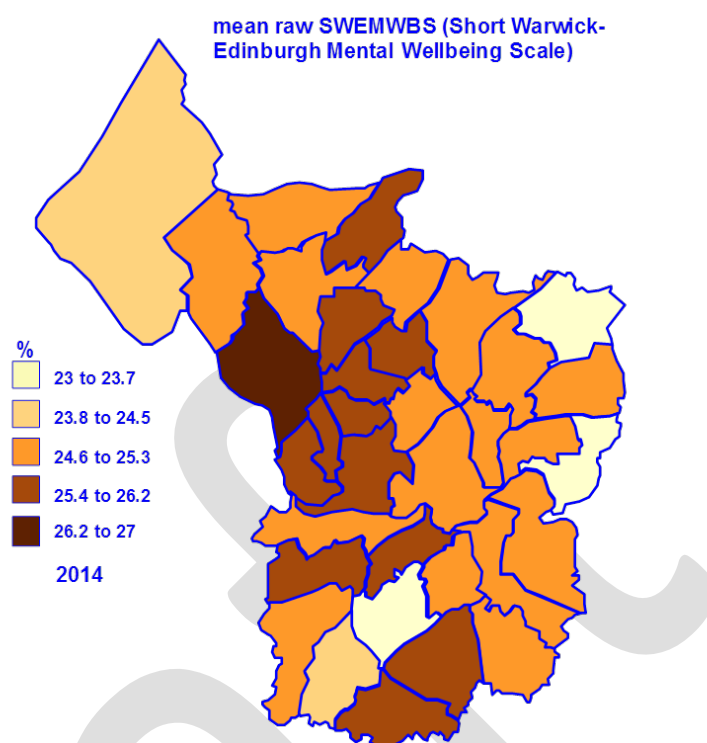


Fig 9.4.3: Source: Bristol Quality of Life survey, 2014

<sup>130</sup> SWEMWBS, NHS Health Scotland, University of Warwick and University of Edinburgh

<sup>131</sup> Understanding Society, the UK's Household longitudinal study 2011

## 9.5 Emotional Health and Wellbeing of Children & Young People<sup>132</sup>

Emotional health and wellbeing is a wider concept than poor mental health. It covers a whole spectrum of activities and behaviours, and promoting and maintaining emotional health and wellbeing needs to be a system-wide and integrated activity. Good emotional health and wellbeing is essential for healthy development and good physical health.

Positive emotional health 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.”*<sup>133</sup>

Due to the importance of emotional health and wellbeing in childhood, in 2014-15 Bristol City Council led on a detailed needs assessment (Emotional Health and Wellbeing In Bristol, Aug 2015) to draw together information on the emotional health and wellbeing of children and young people in Bristol. This uses national rates of mental health

problems applied to the Bristol population to estimate need. Risk factors for poor emotional health are similarly estimated. Data on current services are described, and the views of children, young people, their parents and carers are included on how local services should be developed. This is to provide an information resource on which to develop a five year Emotional Health and Wellbeing Strategy for children and young people in the city and an associated action plan.

Service users are clear that they want services for children and young people to be joined-up, across the whole system, with a well-trained workforce. Ease of access, choice and timeliness are very important and services should recognise the potential of using digital and communication technology to improve service delivery and experience.

### 9.5.1 Prevalence of children with mental health disorders

It is estimated that 10% of children and young people may be experiencing emotional health problems at any one time<sup>134</sup>.

More specifically, this national survey<sup>14</sup> indicates just under 1 in 10 children aged 5-16 have a clinically diagnosable mental disorder, where:

- 4% have an emotional disorder (eg anxiety, depression, and obsessions)
- 6% a conduct disorder (eg troublesome, aggressive, antisocial behaviours)
- 2% a hyperkinetic disorder (inattention and over-activity)
- and 1% a less common disorder (eg autism, tics, eating disorders, selective mutism)

(NB many have more than 1 disorder, so figures do not add to 10%)

The Children and Maternal (ChiMat) Health Intelligence Network have applied these national prevalence estimates to Bristol's estimated population of 5-16 year olds in 2014 indicates that in the region of **5,400 children and young people** have some level of emotional ill health likely to require support from trained workers – see fig 32 below. However, these figures are likely to underestimate the true level of need. Diagnoses of mental health disorders increase with age through childhood and are commoner in boys for all conditions except emotional disorder and self-harm.

<sup>132</sup> See Emotional Health and Wellbeing In Bristol - Needs assessment (August 2015)

<sup>133</sup> World Health Organisation (2010) *Mental Health: strengthening our response*. Factsheet 220 in Guidance for Commissioners of Child & Adolescent Mental Health Services' (Oct 2013)

<sup>134</sup> ONS (2005), *The Mental Health of Children and Adolescents in Great Britain*, London.

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 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.

### 9.5.2 Self-harm in Young People<sup>135</sup>

In 2013/14, almost 500 young people 10-24 years in Bristol were admitted to hospital as a result of self-harm. As a rate this is 519 admissions per 100,000 population (directly standardised), which is considerably higher than the 2012/13 rate of 430 per 100,000, and significantly higher than the England average (412 admissions per 100,000). This rate has been above the national average for several years and is showing no signs of reducing.

Nationally, levels of self-harm are higher among young women than young men.

Condition	5 to 10 year olds			11 to 16 year olds			All children (5-16 yrs)		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Conduct disorders <sup>a</sup>	1100	445	1545	1080	675	1755	2180	1120	3300
Emotional disorders <sup>b</sup>	335	390	725	595	780	1375	930	1170	2100
Hyperkinetic disorders	460	80	540	325	55	380	785	135	920
Autistic spectrum conditions, tics, eating disorders, <u>mutism</u>	340	95	435	225	105	330	565	200	765
<b>Any mental health problem</b>	1600	790	2390	1685	1320	3005	3285	2110	5395

Fig 9.5.1 Estimated number of children in Bristol with mental health disorders, 2014

Source: 2014 ONS Mid-year population estimates for Bristol applied to ONS report; Mental health of children and young people in Great Britain, 2004 (via Emotional Health and Wellbeing In Bristol - Needs assessment, Aug 2015)

Notes: <sup>a</sup> Conduct disorders are characterised by awkward, troublesome, aggressive and antisocial behaviours. <sup>b</sup> Emotional disorder includes depression, anxiety and obsessions. Factors associated with having an emotional disorder included living in a stepfamily, having parents with no educational qualifications and having poorer physical health. 27% may have another clinically recognisable mental disorder

### Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

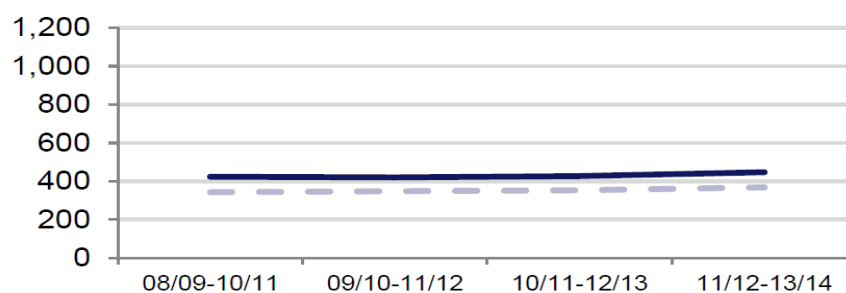


Fig 9.5.2 via Bristol Child Health Profile, 2015

<sup>135</sup> Further details in Self-harm topic above

## Section 10

# Older People

### Summary points<sup>136</sup>

#### Population

- There are 58,800 older people over 65 in Bristol. This is 13.3% of the population, lower than the 17.7% nationally
- There are projected to be 8,100 additional older people by 2022, a 14.2% rise
- In the last 5 years most of the 65+ population rise has been in Bristol North & West, which is different to other age groups

#### Older People's Health

- An estimated 4,100 people in Bristol have dementia.
- The number of people with dementia in Bristol is predicted to rise by 51% by 2037, due to the aging population.
- An estimated 17,640 people over 65 are at risk of falling. Falls are the leading external cause of emergency hospital admission for people over 65.
- Bristol's hospital admission rates following a fall are significantly higher than the

South West & England averages, and are increasing.

- In Bristol, estimated health & social care costs of injuries following a fall are in excess of £11 million every year.
- Excess winter deaths are preventable, and led to the premature death of an estimated 165 Bristol residents (2012-13).
- The cost of excess winter emergency hospital admissions in Bristol (2014) is estimated to be at least £750,000.

#### Social care and wider determinants

- There are 15,060 income-deprived older people<sup>137</sup> in Bristol, which is 20% of all older people (over 60) in Bristol
- Across Bristol, income deprivation in older people varies from around 5% in Stoke Bishop & Henleaze to 35% in Ashley & Filwood, and 48% in Lawrence Hill
- Bristol City Council has 600 units of Extra Care Housing and plans to add over 200 more units
- There are estimated to be between 6,300 and 11,400 older people socially isolated in Bristol<sup>138</sup>
- Socially isolated older adults have: longer stays in hospital, a greater number of GP visits and more dependence on homecare services

<sup>137</sup> Income Deprivation Affecting Older People (IDAOPI), Indices of Deprivation, 2015, [www.bristol.gov.uk/deprivation](http://www.bristol.gov.uk/deprivation)

<sup>138</sup> Social Isolation in Bristol (2013), Initial Findings Report, [www.bristol.gov.uk/socialisolation](http://www.bristol.gov.uk/socialisolation)

<sup>136</sup> These cover all relevant Older People areas throughout the JSNA sections.

## 10.1 Dementia

The current estimate is that **4,100 people in Bristol have dementia.**

Of these people, 68.7% have a diagnosis, compared with a national diagnosis rate of 66.1% (HSCIC August 2015).

Although dementia is not a natural part of ageing, the biggest risk associated with the condition is age. Thus, at the age of 65 years, it is estimated that 1 in 100 people have dementia. This risk doubles every five years until, at age 90, roughly 32% of the population has some form of dementia.

In 2014 there were 58,800 people aged 65 and over in Bristol; this number is predicted to increase by 52% to 85,100 by 2037 and to lead to a rise of 51% in the number of people with dementia.

More women than men develop dementia simply because they live longer, but at any given age there is no significant gender difference; and more women than men care for people with dementia.

Nationally, 60-70% of carers of people with dementia 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%)<sup>139</sup>.

There is little current data about the prevalence of dementia amongst BME communities living

in the UK. Bristol is planning to carry out research this winter into diagnosis rates, access to and experience of dementia services.

<sup>139</sup> Alzheimer's Research UK, 2015  
[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)



## 10.2 Falls

Falls are the leading external cause<sup>140</sup> of emergency admission in the over 65 age group. 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 (2,685 per 100,000) is significantly worse than the England average. Fig 10.2.1 shows the Bristol rate is increasing, and the gap widening. During 2013/14, 1,720 people aged over 65 were admitted in an emergency following a fall.

Bristol's rate is also significantly worse than the rates for most statistical comparators and English Core Cities (fig 10.2.2).

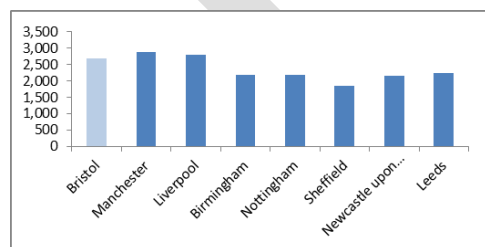


Fig 10.2.2: Falls injury rate by Core Cities

Falling is a common cause of injury, but is not an inevitable part of ageing and well-evidenced interventions can reduce the risks.

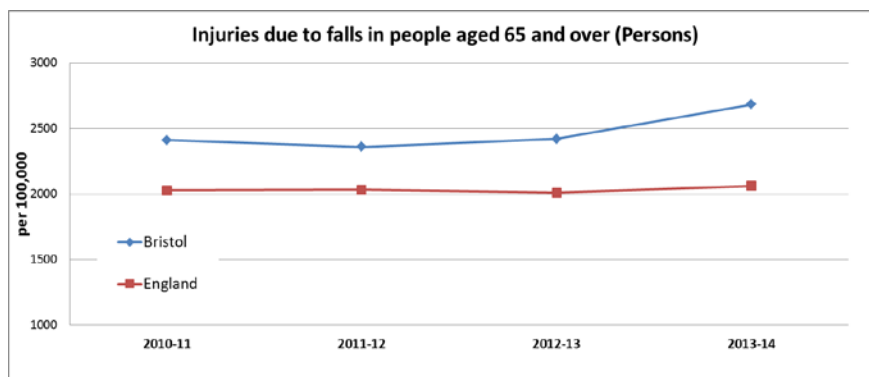


Fig 10.2.1 via Public Health Outcomes Framework, Aug 2015

During 2013/14, Bristol's rates were significantly higher than comparators in the South West region and the England average.

Indicator	Bristol		Region	England
	Number	Rate / 100,000	Rate/ 100,000	Rate/ 100,000
Injuries due to falls in people aged 65 and over (Persons)	1,720	2,685	1,950	2,064
Injuries due to falls in people aged 65 and over (Male)	570	2,390	1,584	1,661
Injuries due to falls in people aged 65 and over (Female)	1,150	2,979	2,316	2,467
Injuries due to falls in people aged 65 and over - aged 65-79 (Persons)	550	1,378	925	989
Injuries due to falls in people aged 65 and over - aged 65-79 (Male)	230	1,260	754	799
Injuries due to falls in people aged 65 and over - aged 65-79 (Female)	315	1,497	1,095	1,180
Injuries due to falls in people aged 65 and over - aged 80+ (Persons)	1,170	6,473	4,924	5,182
Injuries due to falls in people aged 65 and over - aged 80+ (Male)	340	5,669	3,991	4,162
Injuries due to falls in people aged 65 and over - aged 80+ (Female)	840	7,277	5,857	6,201

During 2013/14, 29% of all falls-related admissions were from residential accommodation including care homes with nursing, and dementia care homes. Extra Care Housing settings had the highest rates.

<sup>140</sup> "External causes" are the environmental events and circumstances which cause injury, poisoning and other adverse effects.

Most admissions result from people who fall in their own homes. The majority of admissions (70.5%) are of women. During 2013/14, the most common injury resulting in emergency admission following a fall was also the most serious - fractured neck of femur - which caused 400 admissions in people aged over 65 (fig 10.2.4). 72% of hip fractures occurred to people aged over 80 years old. It is estimated that 20% of hip fracture patients die within 1 year.

People with dementia are at greater risk of falling, and their risk of fracture is also higher. The prevalence of osteoporosis amongst dementia sufferers living in the community has been reported to be higher than among similar aged people without dementia. People with dementia may be less likely to have osteoporosis diagnosed and be prescribed bone health medication, and so are at greater risk of fracture following a fall. Antipsychotic medications increase the risks of falling.

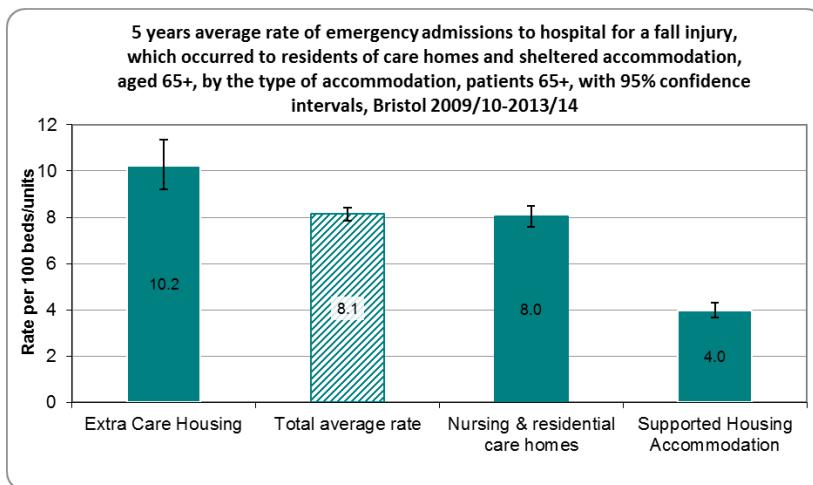


Fig 10.2.3 Source: Bristol Public Health Intelligence Unit, 2015

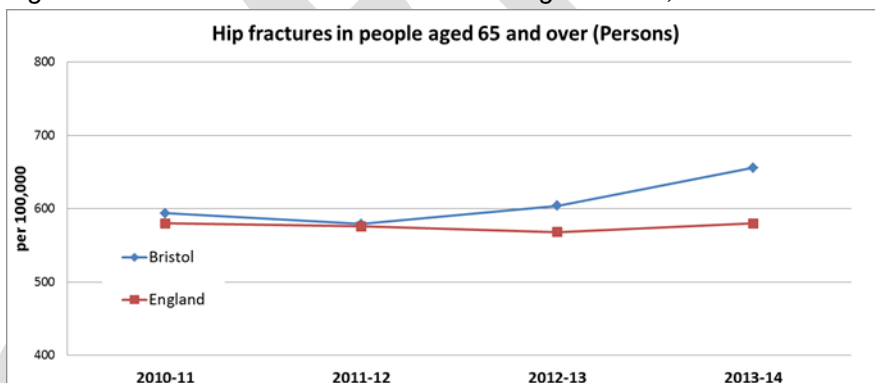


Fig 10.2.4 via Public Health Outcomes Framework, Aug 2015

Other groups of people at more risk of falling include people who:

- Have already fallen, (especially people who have had more than one fall);
- Have a diagnosis of Parkinsons disease or stroke
- Are taking more than four medications each day
- Who have (or report) problems with balance and walking

NHS Bristol has estimated that treating patients with falls-related injury cost health and social care services in Bristol at least £11.35 million during 2011/12. This figure excludes major costs such as GP and health centre attendances.

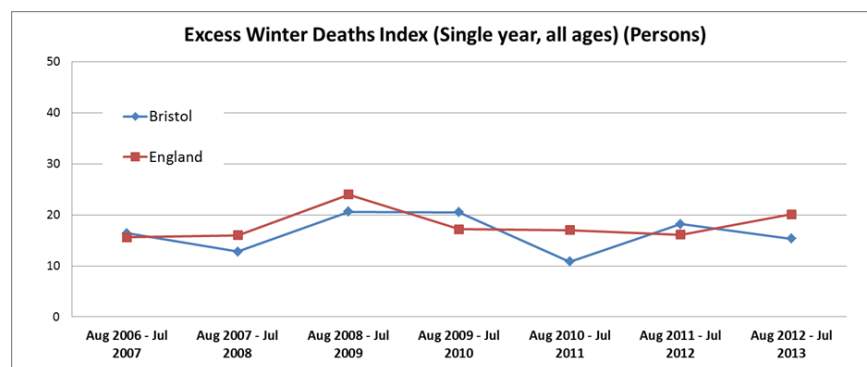
### 10.3 Excess Winter Deaths

The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature. Public Health England reports that 21.5% of excess winter deaths are attributable to the coldest 25% of homes and 10% are directly attributable to fuel poverty. Most deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population. Mortality during winter increases more in England and Wales compared to countries with colder climates, suggesting that many of these deaths could be prevented<sup>141</sup>.

The excess winter death index is a measure of how many more people die because its winter. The index is a ratio between the extra deaths from all causes, and the number of deaths that would be expected to occur in the winter months if the number of winter deaths was the average of the number of non-winter deaths.

There is no significant difference between Bristol's index value and the English average (fig 10.3.1). However, excess winter deaths are preventable, and led to the premature death of 165 Bristolian

residents between August 2012 and July 2013. NICE estimates that for every death there are 8 non-fatal admissions to hospital, (1,320 preventable admissions).



10.3.1: via Public Health Outcomes Framework, Aug 2015

People most vulnerable to cold-related death resulting from living in a cold home include: people with cardiovascular conditions, people with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma), people with mental health conditions, people with disabilities, older people (65 and older), households with young children (from new-born to school age), and pregnant women people on a low income.

The Centre for Sustainable Energy has estimated the cost of excess winter emergency hospital admissions in Bristol during 2014 to be around £750,000. This figure is likely to be a considerable underestimate of the whole cost to health and social care services because it does not include costs to GPs, mental health services, social care and other health services as a result of increased illness and death during the winter months.

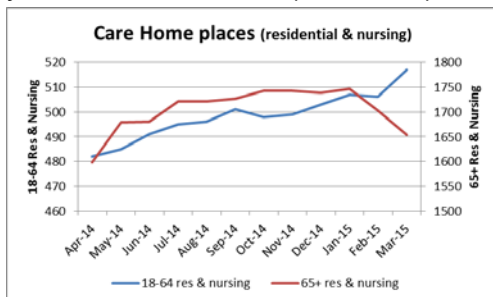
<sup>141</sup> [www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E1200009/ati/102/are/E06000023/iid/90641/age/1/sex/4](http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E1200009/ati/102/are/E06000023/iid/90641/age/1/sex/4)

## 10.4 Adult Social Care

### Care home placements

Pressure for Care home places continues due to a combination of demand and supply factors. This is particularly the case with the availability of Dementia places. Bristol are placing people in appropriate care homes over the Greater Bristol area.

At the end of 2014-15, Bristol City Council (BCC) funded 1,650 care home places for Older People (65+), which had risen and then fallen back similar to the number a year before. Care home places for people of working age (18-64) are less but rose throughout the year, to almost 520 (from 480).



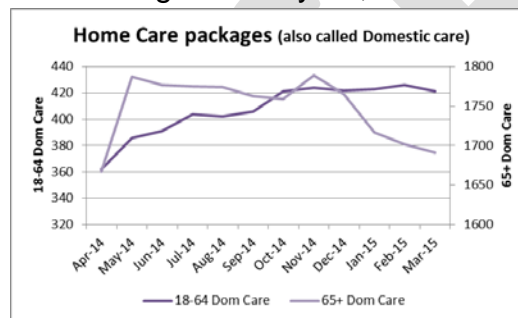
BCC is currently re-commissioning Care homes, which is intended to consolidate supply (eg through introduction of some block contracts in areas of under supply). BCC are also commissioning new build capacity in the Dementia care home market which will see approx 180 new beds over the next two years.

Some specialist placements for people with complex needs in Mental Health and Learning Difficulties (LD) can also be

difficult to source. This remains a national supply issue. Where possible (especially for people with LD), BCC will look to move capacity from care homes to Supported Living in the community.

### Home care placements

At the end of 2014-15, Bristol City Council (BCC) funded 1,690 home care packages for Older People (65+), which had risen and then fallen back similar to the number a year before. Home care packages for people of working age (18-64) are less but rose throughout the year, to almost 420 (from 360).

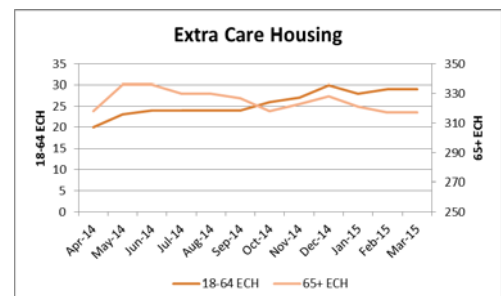


There are also supply issues for home care caused largely by difficulties in agencies recruiting staff. Bristol City Council (BCC) has recently re-commissioned Home care in order to consolidate contracts with fewer geographically zoned providers who will have volume of work to recruit staff with less travel times and able to pay Living Wage.

### Extra Care Housing (ECH)

Bristol City Council currently has 600 units of Extra Care Housing (ECH) in Bristol and plans to add over 200 more units.

At the end of 2014-15, there were 320 ECH packages for Older People (65+), and 30 ECH for people of working age (18-64).



At the same time BCC is re-commissioning the original 600 units in order that they can support more complex people to offer an alternative to residential care to address some of the capacity issues there.

## Section 11

# Public Feedback

**Healthwatch Bristol**<sup>142</sup> is a strong voice for children, young people and adults in health and social care. Anyone can speak 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 an issues and concerns report<sup>143</sup> of the feedback from services users and members of the public about their experiences of health and social care services. In 2014 and 2015, the following key themes have been identified:

**Access to services:** difficulty accessing information about services and/or booking and attending appointments was a key theme in the negative feedback. Services that were easy to access and focused on shaping treatment and support around the service user were positively regarded. There was frustration about appointment booking systems in GPs and hospital services that were difficult to use and around the length of waiting times for appointments.

People who did not speak English and/or had physical or learning disabilities commented that difficulties accessing services prevented them from getting the treatment & support they needed.

**Communication:** commentators often rated the quality of a service based on the manner in which the health or social care professional communicated with the patient, family and/or carer and involved them in decisions.

**Transition and communication between services:** commentators gave examples of when miscommunication had happened between services such as between hospitals and GPs including notes not being shared. Some commentators linked a lack of communication between services with a poor level of aftercare (for example after discharge from hospital). Commentators asked for more signposting to voluntary and community sector services and groups that could support them with their health and wellbeing after discharge from hospital.

As well as producing the quarterly issues and concerns reports, Healthwatch Bristol also selects a focus for each quarter's work plan. The focus topic is selected based on feedback Healthwatch Bristol has received from service users, members of the public, voluntary and community sector services, statutory services and commissioning organisations. The topics Healthwatch Bristol has or will cover in 2014 & 2015 and the associated reports are:

Quarter focus topic	Links to reports
Cancer services (October – December 2014)	<a href="http://goo.gl/rDzKFb">http://goo.gl/rDzKFb</a>
Children and Young People's services (January – March 2015)	<a href="http://goo.gl/ltLMcP">http://goo.gl/ltLMcP</a>
Mental Health and Wellbeing (April–June 2015)	<a href="http://goo.gl/hyv9tV">http://goo.gl/hyv9tV</a>
Services in the Community (July – September 2015)	Still to be produced. See below
Carers, the Care Act and the Children and Families Act (Oct – Dec 2015)	Still to be produced. Report will be published on the Healthwatch Bristol website: <a href="http://goo.gl/SsHzfn">http://goo.gl/SsHzfn</a>

*Fig 11.1 Table of Healthwatch Bristol topic reports 2014-15*  
Healthwatch Bristol produces Engagement Summary reports to share the feedback individual groups tell us about the services they use. Examples of Engagement Summary reports include those based on Healthwatch work with: ESOL (English Speakers of Other Languages) for Health classes; Self Injury Support; Bristol City College; and the Islamic Cultural Fayre. Engagement Summary reports are published on the Healthwatch Bristol website.

- Adult focused engagement: <http://goo.gl/SsHzfn>
- Young people focused engagement: <http://goo.gl/5C6ngC>

<sup>142</sup> <http://healthwatchbristol.co.uk/>

<sup>143</sup> Healthwatch Bristol quarterly issues and concerns reports: <http://goo.gl/SsHzfn>



Bristol City Council, Nov 2015

[www.bristol.gov.uk/jsna](http://www.bristol.gov.uk/jsna)

Bristol JSNA compiled by

- Consultation and Strategic Intelligence (Performance, Information and Intelligence Service, Business Change Directorate)
- Public Health Bristol

**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:**

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