

Agenda Item 8

Paper for Neighbourhood Scrutiny Commission, 23rd November 2015

Report title: Health and Social Care needs of children and young people (JSNA update 2015)

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Purpose of briefing

This item will present an update of the Joint Strategic Needs Assessment (JSNA) summary for children and young people. We will draw out a number of ways in which these data are shaping local strategic direction, commissioning and service delivery to improve health and wellbeing for children and young people.

There are a number of immediate uses of this data profile.

1) Informing the strategic direction – Health and Wellbeing Strategy

The JSNA summary (this children's summary, together with the updated sections for other age groups) will be a key document to inform the refresh of the Health and Wellbeing Strategy by the Health and Wellbeing Board in December 2015. The current Health and Wellbeing Strategy has "To ensure the best start in life" as one of its key priorities. This is in line with the recommendations of Michael Marmot's strategic review of health inequalities¹, where ensuring the best start in life was identified as one of the six policy objectives. This priority was reinforced by the Chief Medical Officer's Annual report, focusing on improving child health outcomes².

2) Informing the strategic direction – Children and Families Partnership Board

The JSNA summary of health and social care needs for children will support the development of the joint plans of the Children and Families Partnership Board, and the shared vision for Early Intervention across the partnership.

3) Informing the strategic direction – specific health needs

There are specific areas of health needs where JSNA data are currently being used to develop the strategic direction for Bristol. For example, there is evidence of inequalities in oral health across the city. These data are underpinning the development of the Oral Health Strategy by the West of England Public Health Partnership and the oral health promotion delivery plan for Bristol.

The Department of Health are due to release a national strategy around childhood obesity later this year. Our understanding around trends and variations in childhood

¹ Fair society, healthy lives. 2010.

<http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthy lives.pdf>

² Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays

obesity in Bristol, as presented in this report, will enable us to develop our local response to this strategy in the coming months.

4) Informing current commissioning activities

A good understanding of health needs is foundational to any commissioning activity, and these data are informing several commissioning programmes currently.

An understanding of the changes in the demographics of the child population in Bristol, has informed the planning for the recommissioning of the community children's health services, and the future capacity that will be required in many of these services, for example the universal public health nursing services (health visiting and school nursing).

There is a focus nationally on additional investment in mental health services for children and young people. As a result of this and the recommissioning of CAMHS services locally, a more detailed emotional health needs assessment has been undertaken, extracts of which have been included in this summary.

The sexual health services for both young people and adults will be recommissioned across Bristol, North Somerset and South Gloucestershire. A detailed sexual health needs assessment has been conducted, and summary points relating to young people are included in the document attached.

Future development of the JSNA

The JSNA is due to be developed further in 2016 into a chapter format. This will enable us to look in more detail at specific health needs and the health inequalities experienced, both using quantitative data, and incorporating the views of residents and services users. The chapters will also include summaries of the evidence for addressing these needs, and recommendations for specific areas of commissioning and delivery. For example, the recent Emotional Health needs assessment for children and young people, and the Sexual Health needs assessment will be developed into this format. We hope to use this new approach will enable us to go into more depth where we have only been able to include brief summaries in the document attached. For example, we hope to look at more detail into the health needs of looked after children.

Appendices:

Appendix 1: Health and Social Care Needs of Children JSNA update 2015

Note - Appendix 2: Presentation for Neighbourhoods Scrutiny Commission meeting on 23rd November 2015 will be circulated in advance of the meeting

Agenda Item 8 - Appendix 1

Children & Young People: JSNA 2015 **Health & wider determinant indicators v5**

Summary

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 live and stillbirths 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.
- Childhood injuries for 0-4yrs are higher than the rate for England
- 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.

1. Population

1.1 Rising child population in Bristol

The latest estimate of the Bristol population is 442,500¹. By broad age group, **Bristol has 82,800 children under 16** (18.7% of the population), and **68,400 young people 16-24** (15.4%), increases of 1,000 children and 1,000 young people in the last year. [See Appendix 1 for ward & area map]

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 (Fig 1). This increase has been amongst the 0-10 year olds only and in particular among 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 nationally². However, since 2012 the fastest rising group is those aged 5-9 (Fig 2).

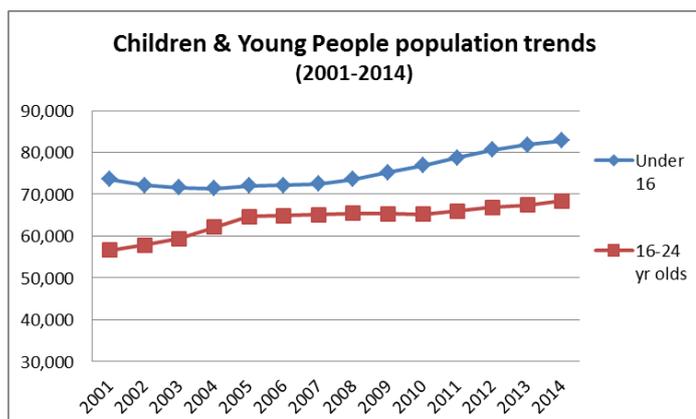


Fig 1, Source: Population Estimates Unit, ONS: Crown Copyright 2015

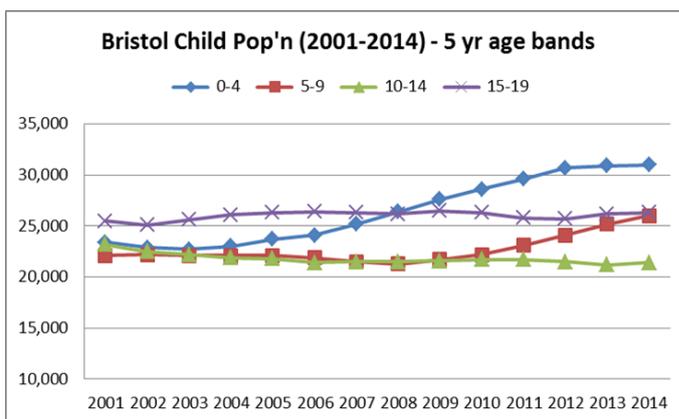


Fig 2 Source: Population Estimates Unit, ONS, 2015

Bristol's child population is rising in all areas, but has risen fastest in Inner City & East locality (fig 3). For young people, numbers have only risen in Inner City & east Bristol. *Local data is based on 2013 figures, as 2014 data by ward is not released until Dec 2015.*

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 wards³, with implications for how services can manage demand and where services should most appropriately be located. [Further detail due when the new data is released]

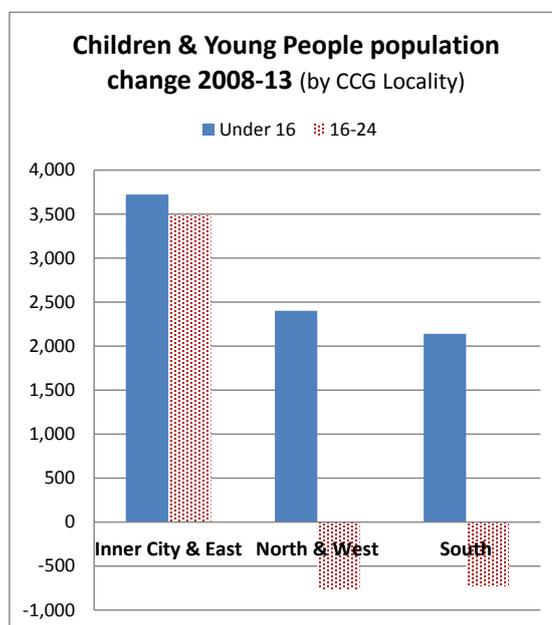


Fig.3, source: 2013 ONS Mid-year estimates

¹ 2014 Mid-year estimate, Office of National Statistics (ONS), released 2015

² Population of Bristol 2015 report: www.bristol.gov.uk/page/population-bristol (to be released late Oct 2015).

³ Further data available via on-line JSNA Atlas: <http://ias.bristol.gov.uk/> or on request.

1.2 Ethnicity

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 average for the total Bristol population of 16% BME. Using an alternative definition of population diversity⁴, 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 4). By ward, the figure ranges from 6% BME in Whitchurch Park to 83% in Lawrence Hill.

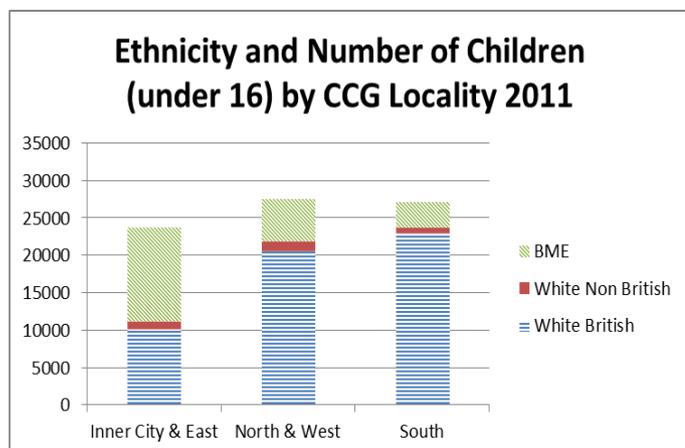


Fig. 4, source: ONS 2011 Census

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 Alternative Language (EAL), 18.7% of students 5-15 yrs, higher than 18% in 2014. The map (fig 5) highlights that there are much higher % EAL pupils in Inner City & East Bristol.

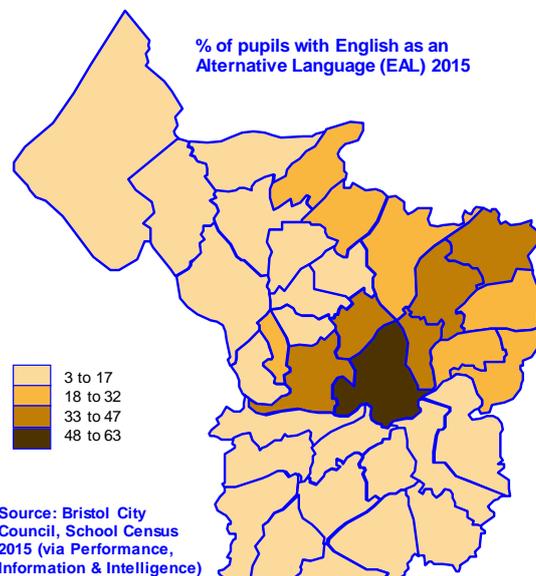


Fig.5, source: BCC School Census 2015

1.3 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 estimates⁵ based on research with young people, it is estimated that there are 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 needs⁶ (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.

⁴ 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.

⁵ Source: Bristol Carers Support Centre, using Becker and Dearden formula (Loughborough University) applied to ONS mid-2014 population estimates for Bristol

⁶ Source via Bristol Carers Strategy Refresh, 2015 – 2020

1.4 Numbers of 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 6). In 2014 there were **6,440 births in Bristol**⁷. Births in Bristol rose 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. In the 12 months to mid-June 2014 there were 3,100 more births than deaths, accounting for 62% of the population increase⁸.

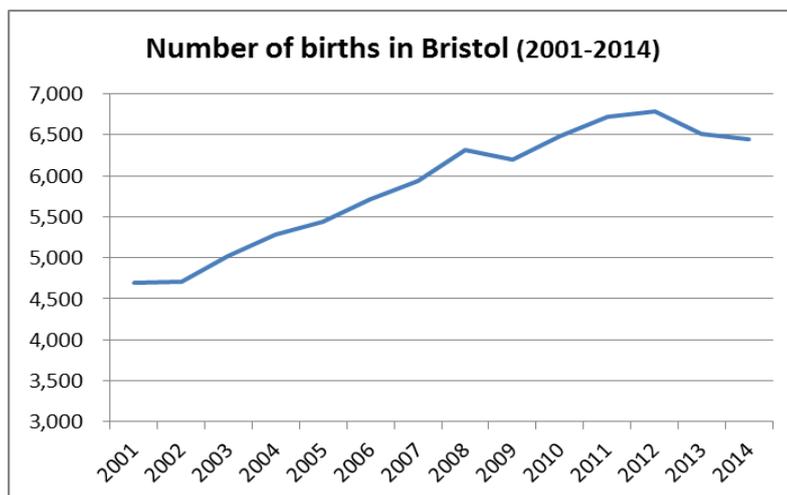


Fig6. Source: ONS birth records data, collated by Public Health Intelligence Unit (Bristol City Council)

Within Bristol though, numbers of births are remaining constant in South Bristol on average, and falling in the other localities (fig 7). 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.

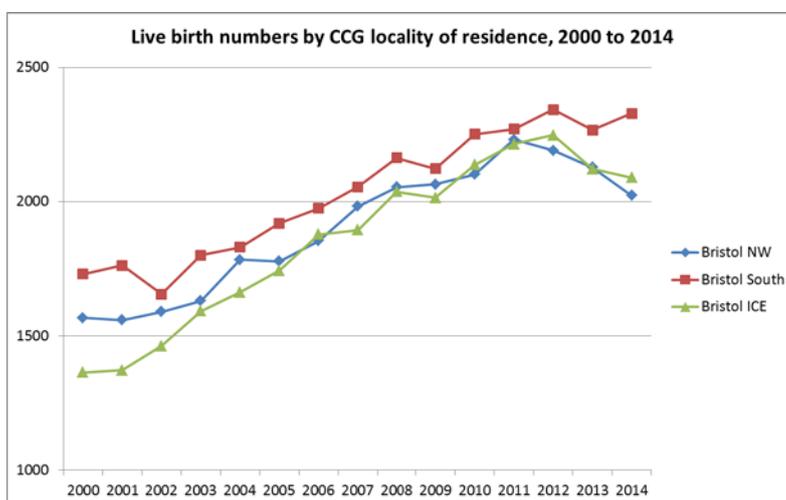


Fig7. Source: Public Health Birth File, PHIU, Bristol City Council, 2015

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 (Fig 8) and this figure has fallen slightly since 2012. Births to mothers from Somali have plateaued, whilst births to mothers from Poland continue to rise.

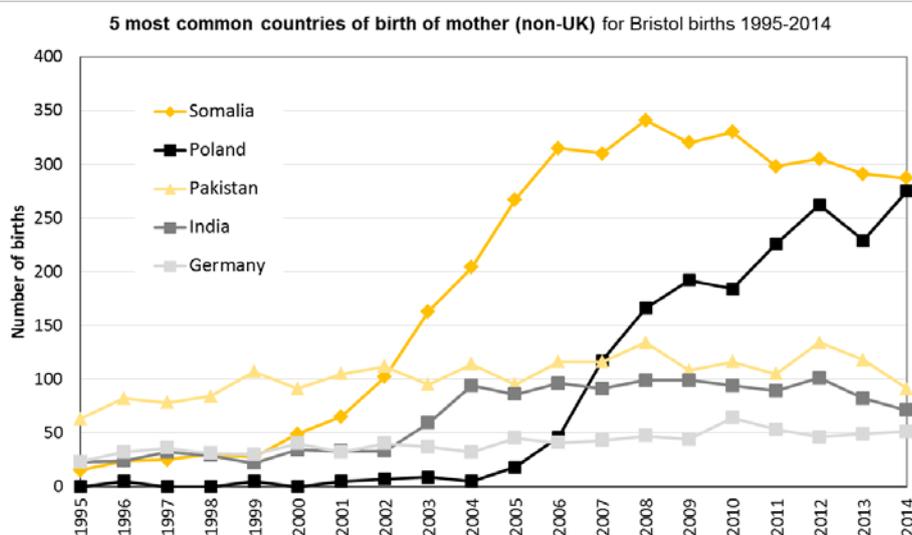


Fig8. Source: Public Health Birth File, PHIU, Bristol City Council, 2015

⁷ Source: Public Health Birth File, Public Health Intelligence Unit (PHIU), Bristol City Council, 2015

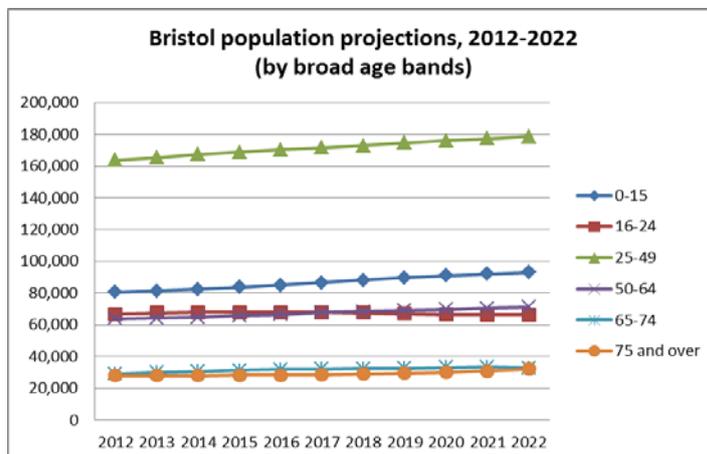
⁸ ONS 2014, via Mid-2014 Population Estimates Briefing Note from www.bristol.gov.uk/page/population-bristol

1.5 Child population projections

The population of Bristol is projected to increase to 474,400 by 2022 and to 528,200 by 2037 according to latest official projections⁹. The main drivers of population growth are expected to be due to natural change (i.e. more births than deaths) rather than migration. The child population 0-15y is projected to rise fastest by 2022, by 15.4% (12,400 children), whilst the young person population (16-24y) remains stable (Table 1, Fig 12).

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

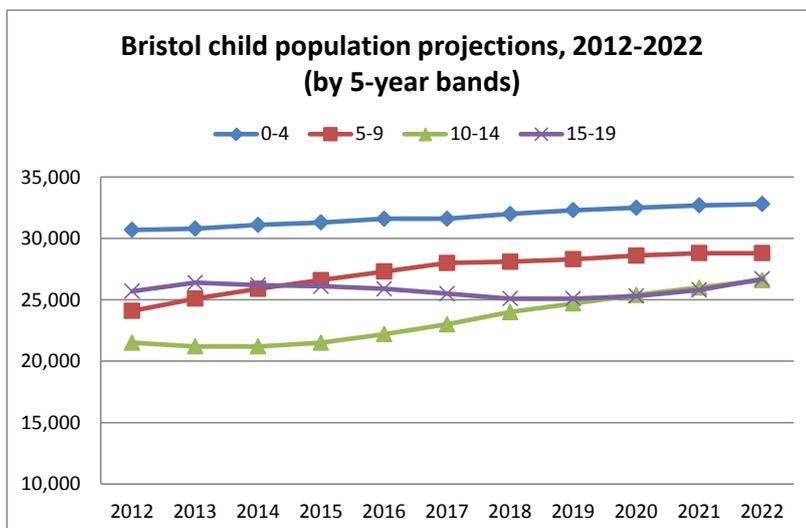
Fig 9 (inc table), Source: 2012-based Sub-national Population Projections, ONS (© 2014)



Most of the change in the child population is projected to be in the 10-14y and 5-9y age bands an increase of 23.7% and 19.5% respectively (Table 2, Fig 13). These increases in population numbers will have implications for health, education and social care services in the city.

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%

Fig 10 (inc table) Source: 2012-based Sub-national Population Projections, ONS. Crown copyright 2014



⁹ 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.

2. Baby and maternal health

2.1 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 2012, 2.3% of term births (i.e. those born after 37 weeks of pregnancy) were of low birth weight. This is significantly less than the average for England (2.8%).

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%)¹⁰.

As numbers of low birth weight babies are relatively small we use 5-year averages to allow comparison at ward level (fig 11). Across Bristol this average has fallen from 7.5% (2001-05) to 5.6% (2010-14). However, there remains inequality at ward level¹¹ with low birth rate ranging from 3.4% in Stoke Bishop & Clifton to 7.4% in Lawrence Hill & Filwood.

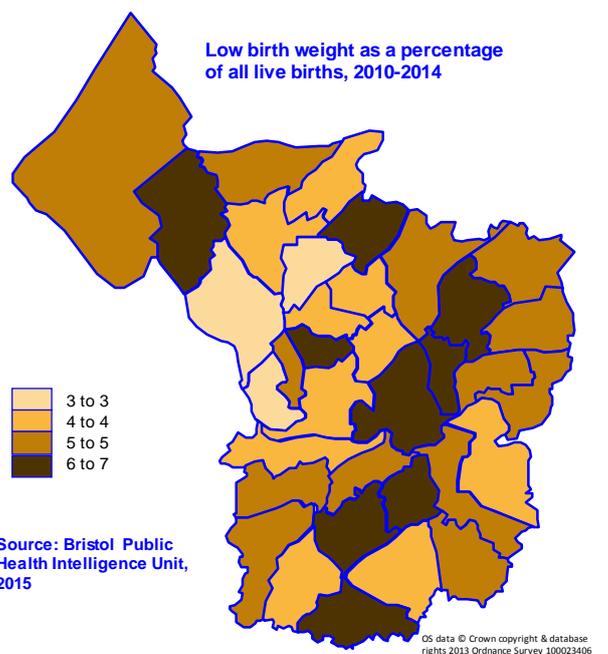


Fig. 11, source: Bristol Public Health Intelligence Unit, 2015

A project 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 reported results in April 2014 and showed that being of less than normal birth weight was strongly associated with having special needs, with a graduated effect; the lower the birth weight, the greater the risk. For the few babies born at extremely low birth weight (less than 1000g) the association with having Special Educational Needs was over eight times that of being a normal birth weight. For those with a birth weight between 1000 and 1500g the increased chance of having SEN was three times and for those weighing 1500-2500g the risk was two times that of being a normal birth weight.

¹⁰ Bristol Child Health Profile 2015

¹¹ Source: Bristol Public Health Intelligence Unit, 2015. Further details in JSNA Atlas

2.2 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 mortality¹² 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 12, 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.

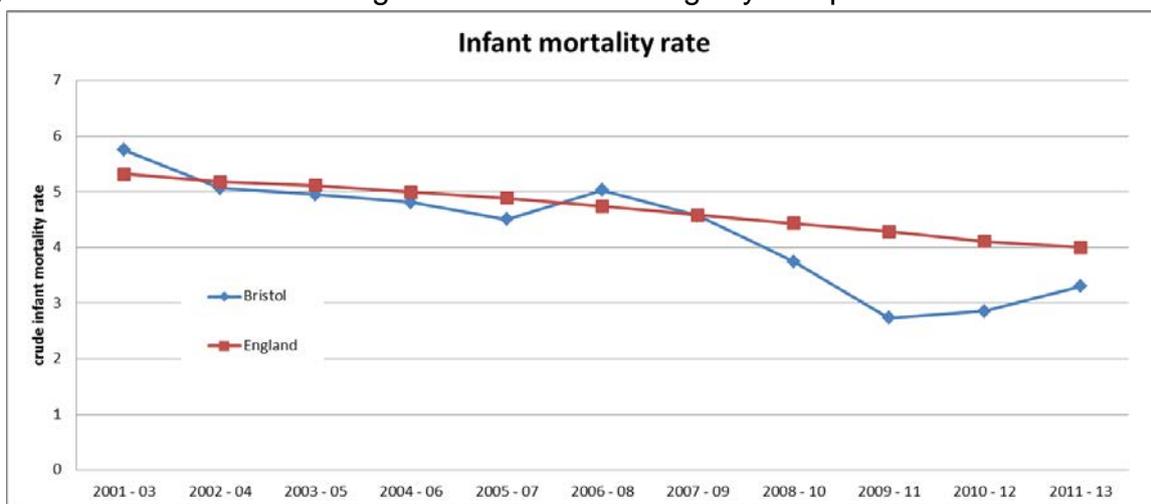


Fig. 12, source: via Public Health Outcomes Framework (Aug 2015)

2.3 Breastfeeding

2.3.1 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 baby¹³. In Bristol this rate has been much higher than average for several years (see fig 13). In 2013/14 the Bristol rate rose to 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.

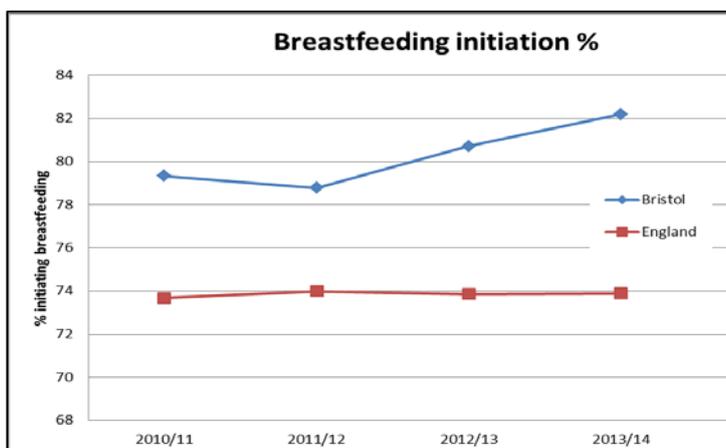


Fig. 13, source: via Public Health Outcomes Framework (Aug 2015)

¹² Source: ONS mortality & birth data, via Public Health Outcomes Framework data tool (Aug 2015)

¹³ Source: NHS England 2013/14, via Public Health Outcomes Framework data tool (Aug 2015)

2.3.2 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 (58.5% in 2013/14) than England as a whole (45.8%) and higher than most comparable cities¹⁴.

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 .

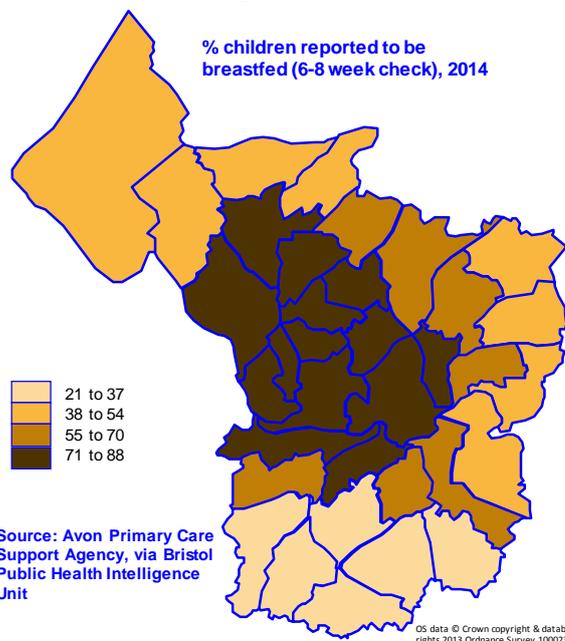


Fig 14, Source: Avon Primary Care Support Agency, via Public Health Bristol Intelligence Unit (Bristol City Council) 2015

2.4 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**¹⁵ (fig 15), which is now falling in line with the England average (11.4%) where there has been a continuing downward trend. Local data on smoking during pregnancy can help us to understand these changes and plan a response.

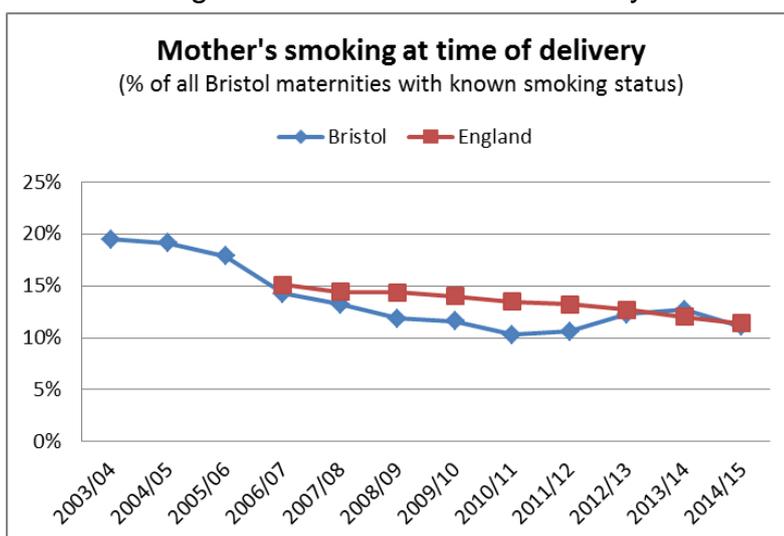


Fig. 15, source: Local NHS maternity providers; via Public Health Outcomes Framework (Nov 2015)

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

¹⁵ Smoking Status at Time of Delivery, 2014-15; via Public Health Outcomes Framework, Nov 2015

Figure 16 shows that all areas have seen reductions in the proportion of women smoking during pregnancy since 2003-7, but the rates remain highest in areas of greatest deprivation. Updated local data is not yet available, but during the period 2008-2012 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%). There are likely to be several reasons for the rise in the Bristol rate of smoking during pregnancy. These may include; more women smoking who then become pregnant, those who report smoking at the time of booking are less interested in quitting, and the changing demographics of pregnant women in the city.

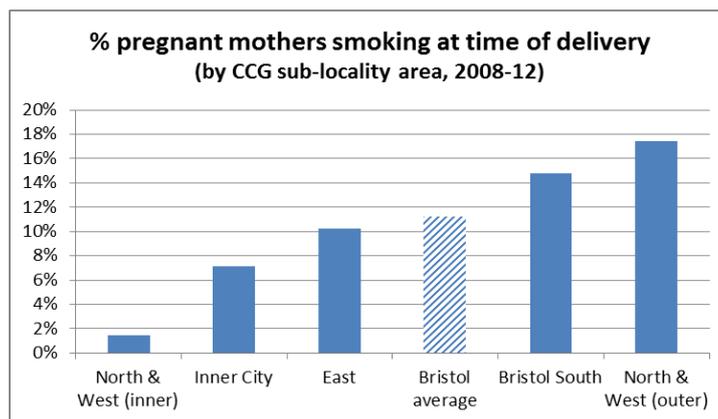


Fig. 16, source: Local NHS maternity providers; via Bristol Public Health Intelligence Unit, 2014

Changes in the demographics of mothers in Bristol over recent years (Fig 17), such as a greater share of births to White British mothers and to mothers living in more deprived parts of the city, will have contributed in part to the increase in the proportion of mothers smoking at the time of delivery seen over the same period. These groups are more likely to be smokers than the average for the city, and in addition have seen a greater increase in these rates than other groups during the period. There has also been improved reporting of the data through electronic reporting systems.

These trends suggest that more targeted support to women who are smoking at the time of booking for antenatal care is needed, and such services are being considered. The Department of Health is reported to be considering the option to introduce a test for smoking during the last period of pregnancy.

Midwives are expected to CO (carbon monoxide) monitor all pregnant women at ante-natal booking clinic and ask about their smoking status. Those that are smoking should automatically be referred to the stop smoking services unless they choose to opt out of the referral.

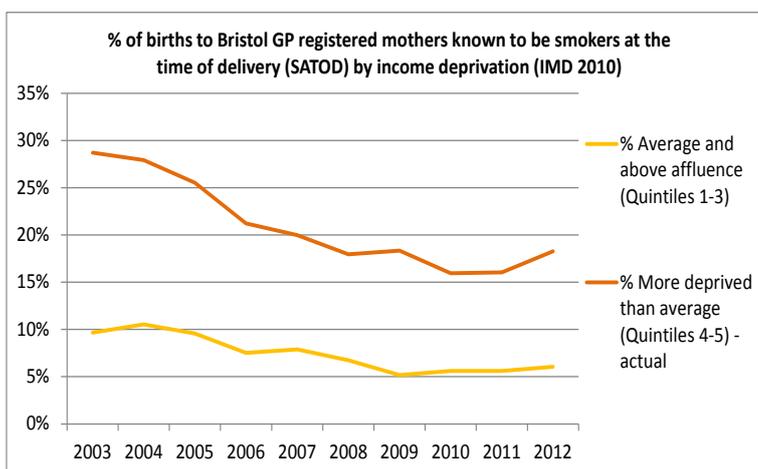


Fig. 17, source: Local NHS maternity providers; via Bristol Public Health Intelligence Unit, 2014

3. Children and Young People’s Health

3.1 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% (for all ages, Bristol % is below national). 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. 18 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 19) shows the combined % for Bristol wards, from 2% in Clifton East & Cotham to 5% in several outer wards and 6.1% in Filwood.

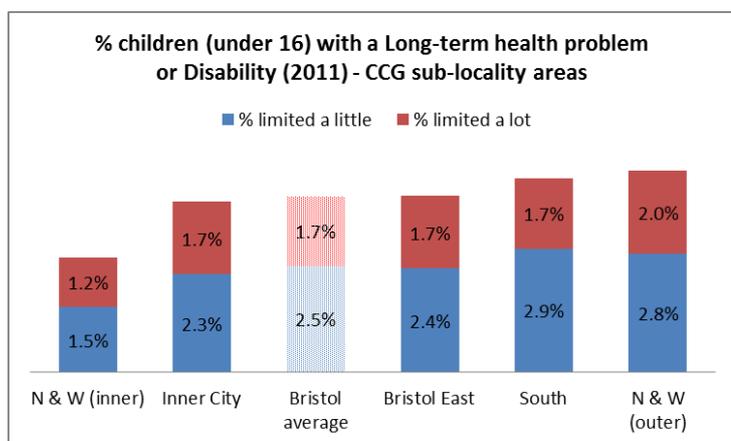


Fig 18. Chart by sub-locality areas. Source: Census 2011, ONS

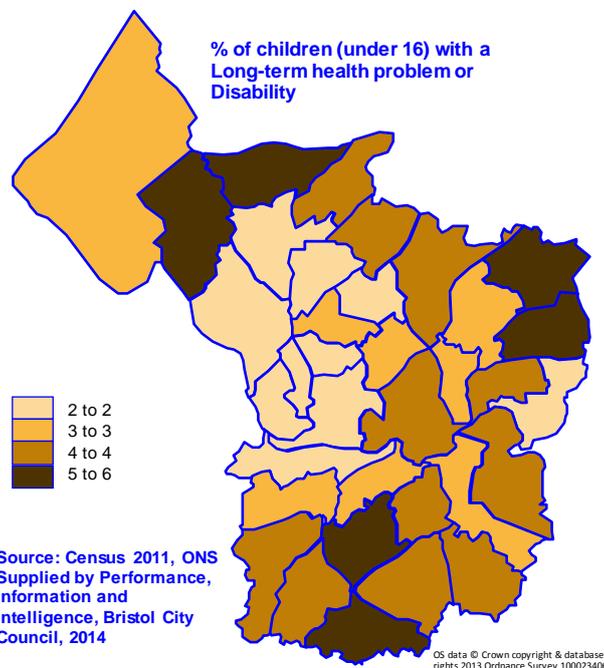


Fig 19. Map by wards

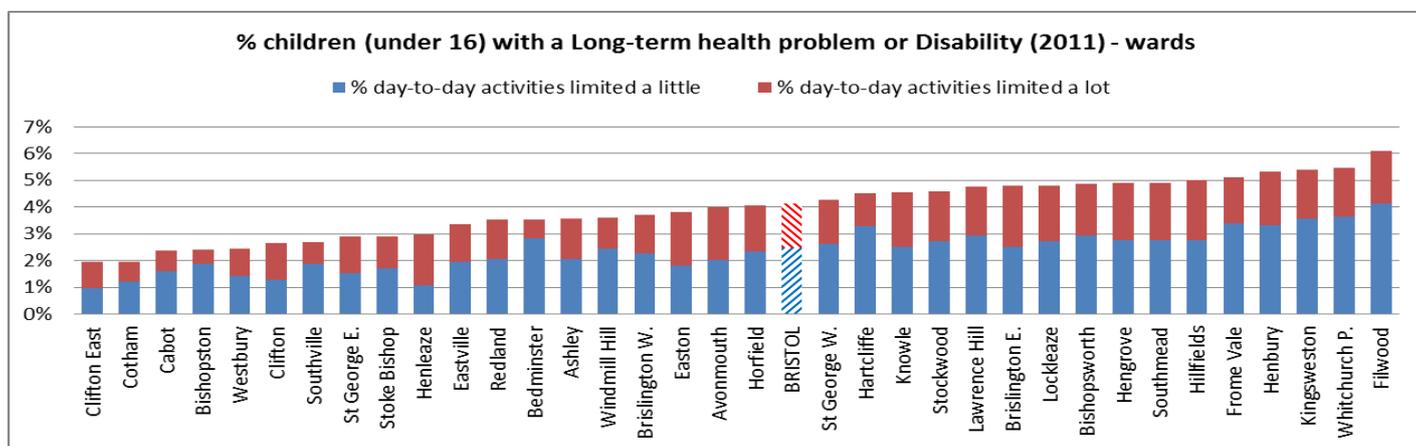


Fig 20. Source: Census 2011, ONS Supplied by Performance, Information and Intelligence, Bristol City Council, 2014

3.2 Healthy Weight

The National Child Measurement Programme (NCMP) measures the height and weight of children in Reception year (4-5year olds) and in Year 6 (10-11year 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.

3.2.1 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 children aged 4-5 years who are obese or overweight in Bristol (23%) has risen slightly but remains statistically similar to that in England as a whole (22.5%), fig 21. The rates in Bristol are similar to other comparable cities.

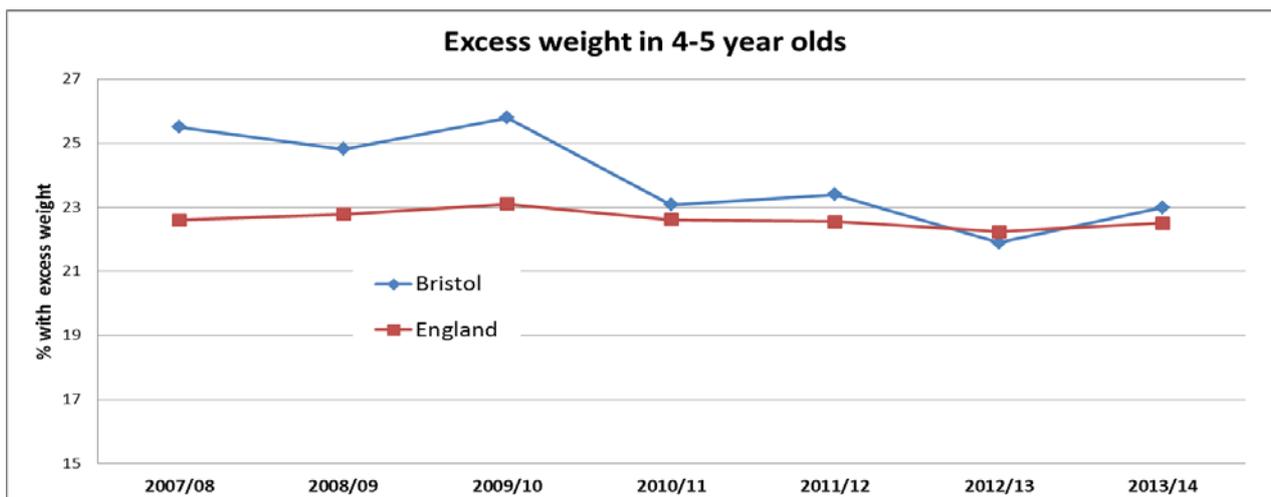


Fig 21 Source: National Childhood Measurement Programme (NCMP) via Public Health Outcomes Framework, 2015

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 22 chart and ward map). Note that 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). These data show that 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.

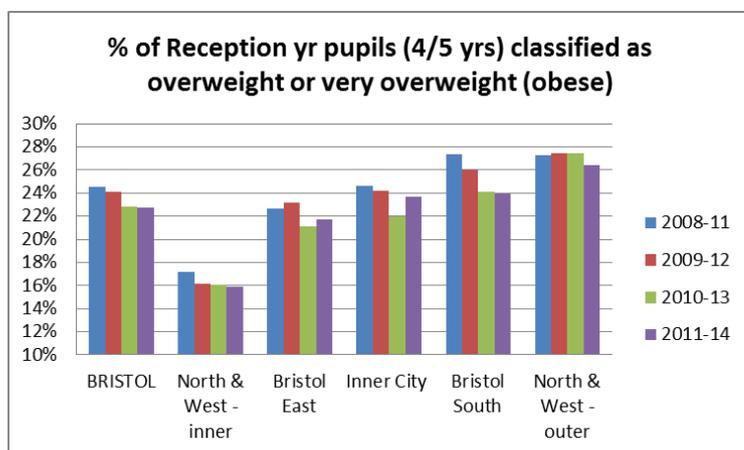


Fig 22. Excess weight in 4-5 yr olds by Bristol area, 2011-14
Source: NCMP via Bristol Public Health Intelligence Unit 2015

3.2.2 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 national (33.5%). Compared to similar cities across England, the rates in Bristol are similar or statistically lower than others.

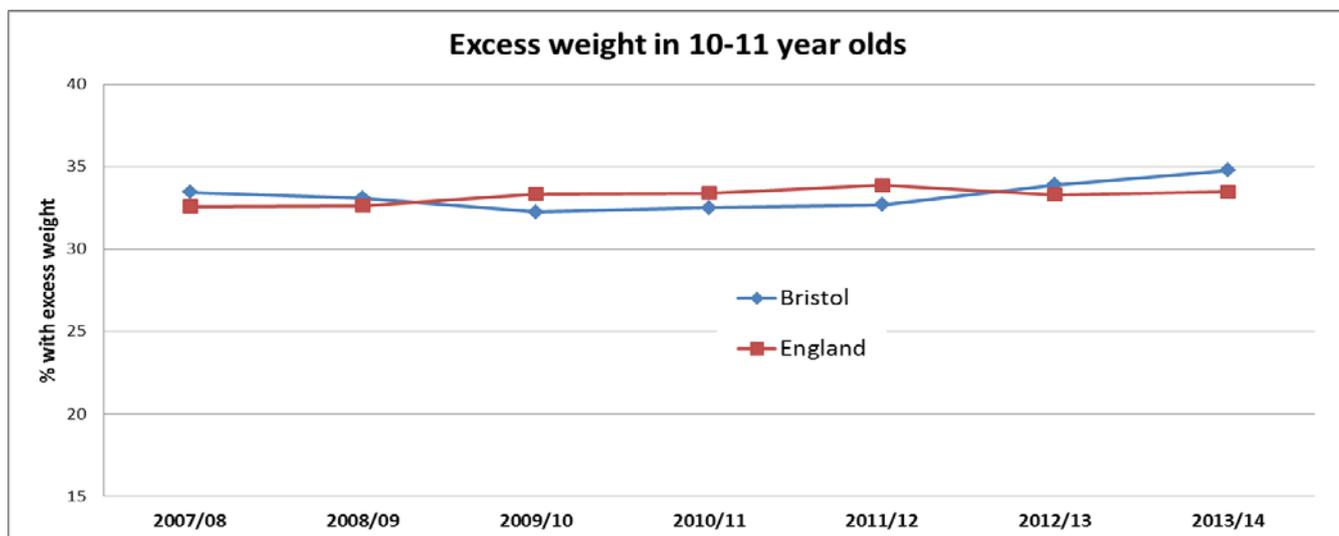


Fig 23. Source: National Child Measurement Programme (NCMP) via Public Health Outcomes Framework, 2015

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 24 – chart and 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).

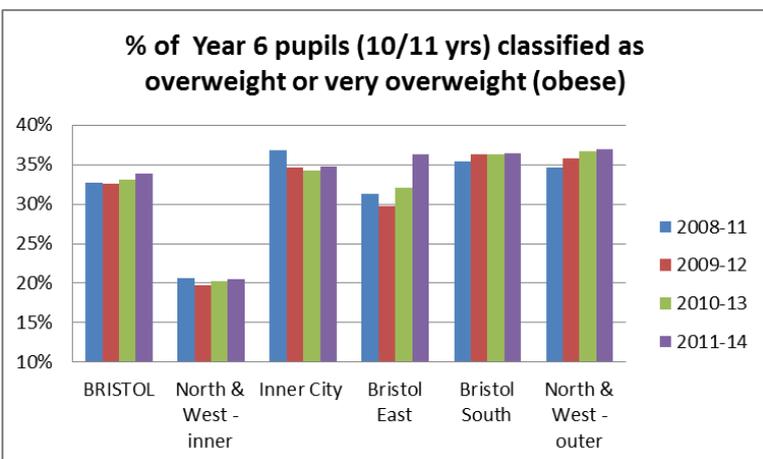
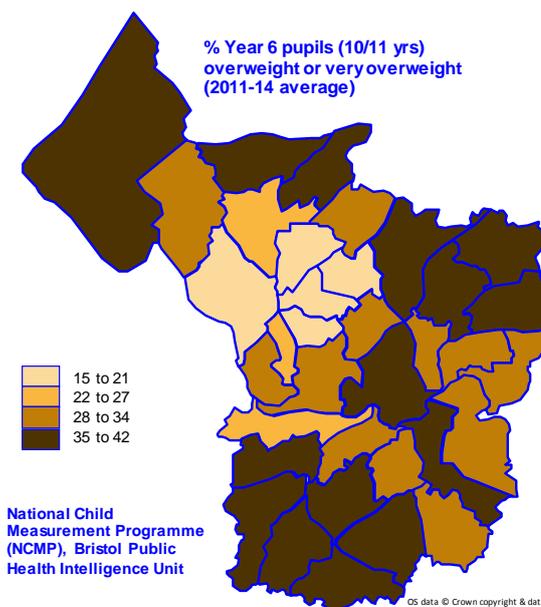


Fig 24. Excess weight in 4-5 yr olds by Bristol area, 2011-14
Source: NCMP via Bristol Public Health Intelligence Unit 2015



3.3 Dental health¹⁶

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.

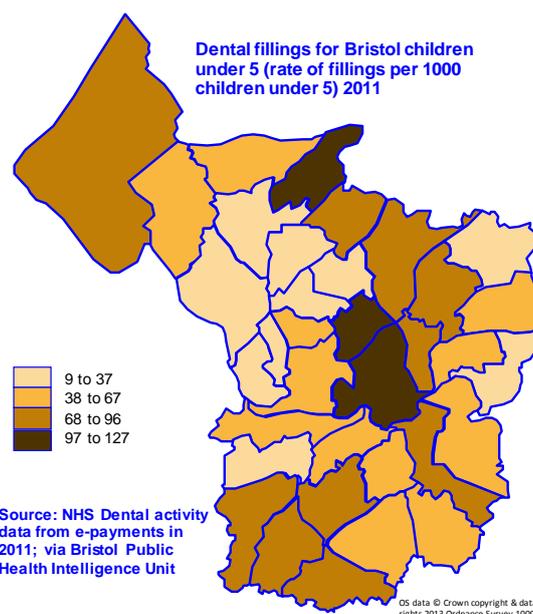


Fig. 25, Source: Dental activity data from e-payments provided to NHS in 2011, via Bristol PHIU 2014

¹⁶ Via Profile for Oral health in Bristol. June 2015. Public Health England.

3.4 Childhood Immunisations¹⁷

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.

3.4.1 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.

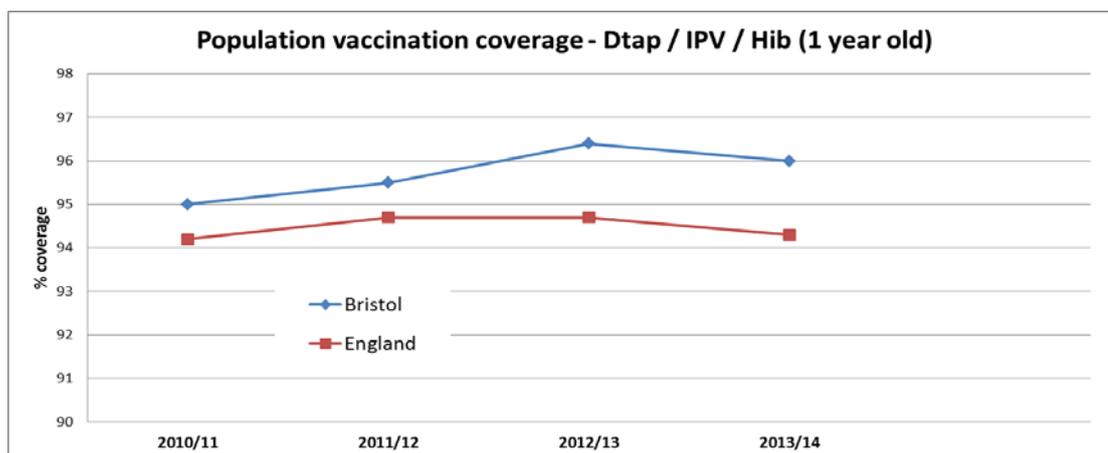


Fig. 26, Source: Cover of Vaccination Evaluated Rapidly 2013/14 data via Public Health Outcomes Framework, 2015

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%).

¹⁷ Data for all Bristol vs England vaccination coverage via Public Health Outcomes Framework, Aug 2015

3.4.2 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%).

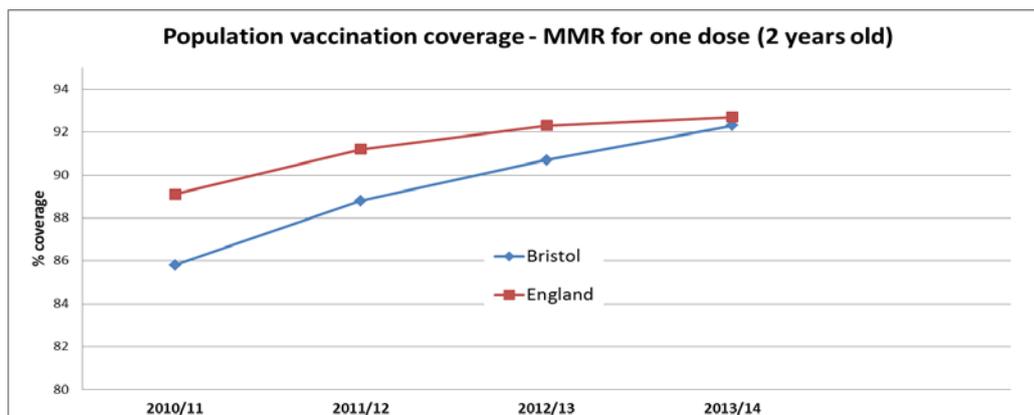


Fig. 27, Source: Cover of Vaccination Evaluated Rapidly 2013/14 data via Public Health Outcomes Framework, 2015

3.4.3 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 1st 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.

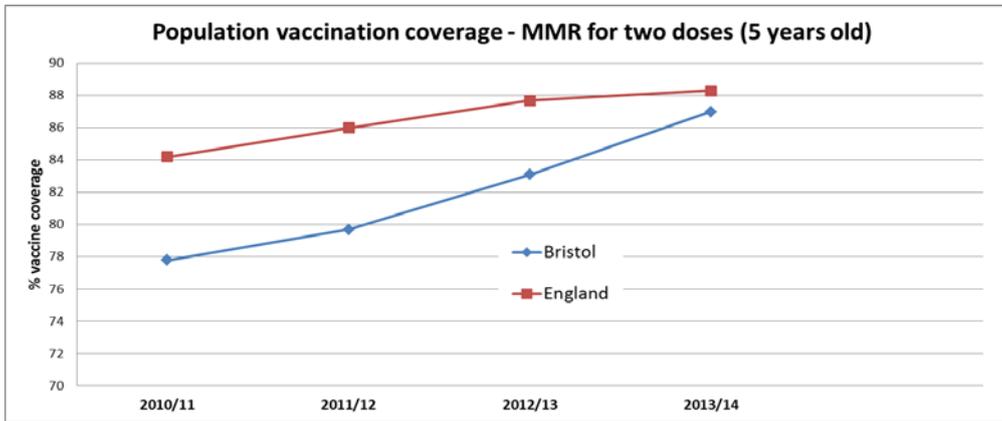


Fig. 28, Source: Cover of Vaccination Evaluated Rapidly 2013/14 data via Public Health Outcomes Framework, 2015

3.4.4 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.

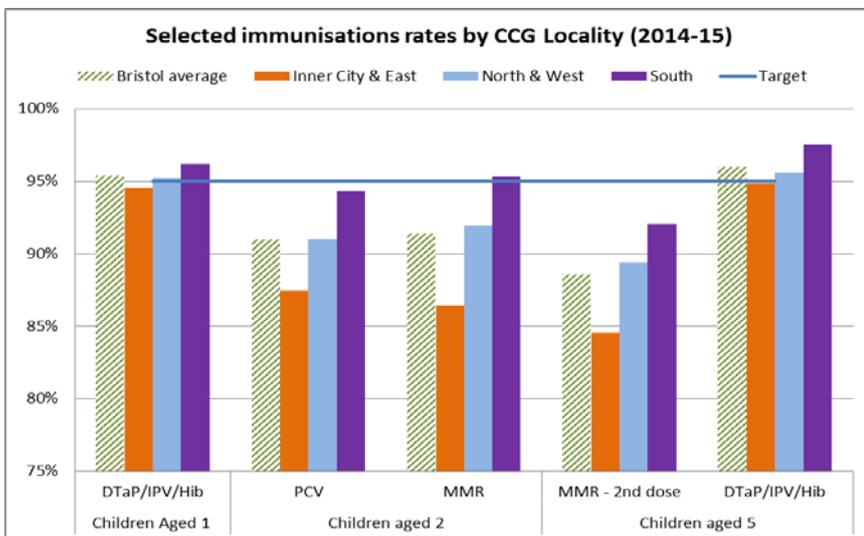


Fig. 29, Source: NHS Bristol CCG - Immunisation Rates summary, 2014-15, Commissioning Support Unit

3.4.5 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.

3.5 Injuries

a) Injuries in children

Rates of emergency hospital admissions caused by unintentional or deliberate injuries to children (2013/14)¹⁸ in Bristol are similar to national rates. The rate for Bristol as a whole is 109.7 per 10,000 children aged 0-14y is less than the rate for England (112.2/10,000 children).

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.

There is variation by ward with the highest rates in wards in the South locality. The map shows hospital admission rates for children aged 0-14y using 3 year averages, 2012/13-2014/15. For children aged 0-4y the rate for Bristol is 142.7 per 10,000, higher than the rate for England (140.8 per 10,000 children).

b) 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 141.1 (per 10,000 population) and is similar to the national rate of 136.7 (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)

The leading cause of preventable emergency admission in this age group is deliberate self-harm¹⁹, 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.

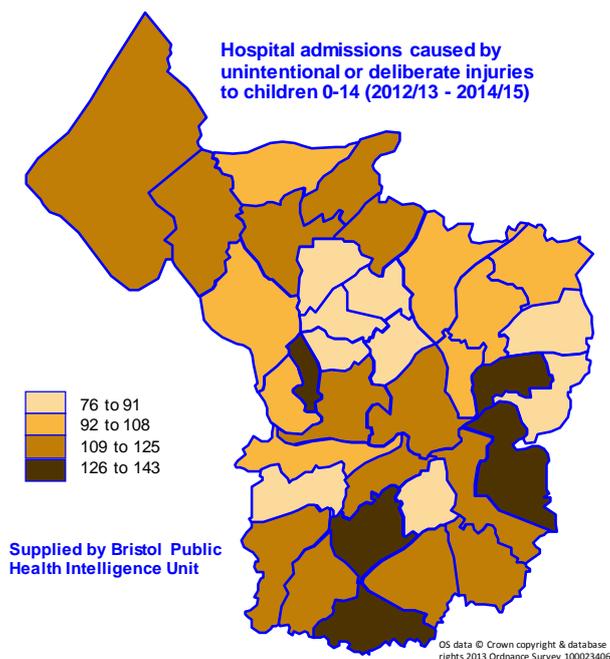


Fig. 30, Source: Bristol Public Health Intelligence Unit

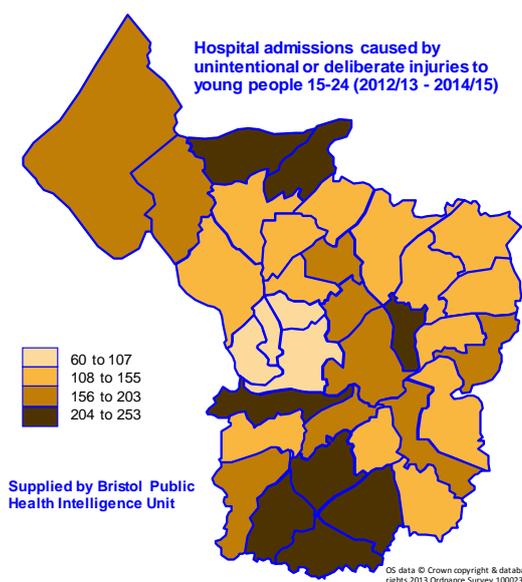


Fig. 31, Source: Bristol Public Health Intelligence Unit

¹⁸ Crude rates of admissions per 10,000 resident population, Calculated by Public Health England, via PHOF tool, Aug 2015

¹⁹ For more details about deliberate self-harm, see section 3.6 Emotional Health and Wellbeing.

3.6 Emotional Health and Wellbeing²⁰

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”.*²¹

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.

3.6.1 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 time²². More specifically, this national survey¹⁴ 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.

²⁰ See Emotional Health and Wellbeing In Bristol - Needs assessment (August 2015)

²¹ World Health Organisation (2010) *Mental Health: strengthening our response*. Factsheet 220 in Guidance for Commissioners of Child & Adolescent Mental Health Services' (October 2013; page 5).

²² ONS (2005), *The Mental Health of Children and Adolescents in Great Britain*, London.

Fig 32: Estimated number of children in Bristol with mental health disorders, 2014

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 ^a	1100	445	1545	1080	675	1755	2180	1120	3300
Emotional disorders ^b	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, mutism	340	95	435	225	105	330	565	200	765
Any mental health problem	1600	790	2390	1685	1320	3005	3285	2110	5395

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: ^a Conduct disorders are characterised by awkward, troublesome, aggressive and antisocial behaviours. ^b 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

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.

3.6.2 Self-harm

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.

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)

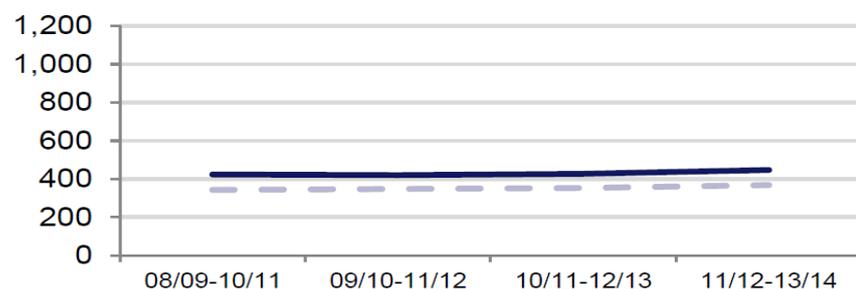


Fig 33. Provided via Bristol Child Health Profile, 2015

3.7 Sexual Health²³

It is important that young people are supported to develop a positive and respectful approach to sexual relationships, and ensuring that they are not at risk of poor sexual health. This includes education around relationships, and prevention of abuse and violence, access to contraception, and prevention of sexually transmitted infections and unplanned pregnancy. Due to the importance of this subject, and the forthcoming re-commissioning of sexual health services, Bristol City Council developed a detailed report (Sexual Health Needs Assessment, Sept 2015).

According to the World Health Organisation (WHO), the definition of sexual health is:

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

Efforts to improve the sexual health of the population are a public health priority. Sexually transmitted infections can have lasting long-term complications if not treated such as infertility and are entirely preventable. STIs can also increase the risk of acquiring chronic infections such as HIV. Poor relationships, coercion and sexual bullying can have a lasting effect on an individual's mental wellbeing, self-esteem and confidence.

Sexual ill health also contributes to health inequalities. 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), teenagers, young adults and black and minority ethnic groups. Similarly HIV infection in the UK disproportionately affects MSM and Black Africans. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

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 supported by an LGBT-friendly businesses and entertainments district. These factors mean sexual health is a priority for Bristol.

Findings of particular relevance to Young People include:

- Young people are at increased risk of poor sexual health due to sexual development at this age and societal changes such as sexualised imagery and social media. There are also particular sub-groups of young people that are vulnerable to poor sexual health. These include Looked After Children and care leavers and youth offenders.
- Long Acting Reversible Contraception uptake remains low, particularly in young people. Conversely oral emergency contraception use is high amongst young people. As LARC methods are more effective forms of contraception, consideration should be given to increasing uptake.

²³ See Sexual Health Needs Assessment (Sept 2015)

- The condom distribution scheme has been praised by professionals as a way to engage with more people, especially young men. The number of condoms distributed has been decreasing so efforts are required to maintain the effectiveness of this service.
- Specific support should be offered to the groups at particular risk of poor sexual health such as people involved in sex work, BME groups, people with physical and learning disabilities, LGBT and MSM, homeless people and young people.
- Services need to ensure they are accessible at times of the day and week that will have higher demand. This includes Saturdays and Sundays, particularly for young people. Flexible drop in sessions and short waiting times are also key. The clinic environment should be relaxed and informal. Different methods of booking appointments should be available (such as text message, telephone and online).
- Programmes such as the 4YP initiative have been welcomed by professionals at improving knowledge of sexual health and access to services amongst young people. 4YP (www.4ypbristol.co.uk/) provides information to young people about sexual health and services, sets standards for providers to make sure they are young people friendly, provides training for professionals and information for parents and carers.
- 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.
- Abuse within young people’s relationships is also an area gaining national recognition, with children as young as 13 reported to have experienced DSVA. Being in a relationship with an older partner, and especially a ‘much older’ partner, is a significant risk factor for young women.
- Young people’s experiences of sexual harassment, sexual bullying and sexism have been found to be every day experiences and heavily normalised amongst this generation.

3.7.1 Chlamydia²⁴

Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health. The Avon Chlamydia Screening Programme supports chlamydia screening for young people aged 15-24, as part of the National Chlamydia Screening Programme which aims to reduce chlamydia prevalence.

• Bristol compares well to the England average and neighbouring local authorities in respect of the population coverage of chlamydia testing for 15-24 year olds, with coverage typically around 30% of the eligible population, compared to a national average of 25%.

• Bristol’s testing programme is below 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 34) shows that Bristol (1,818 diagnoses per 100,000) has fallen significantly below the national average (2012 per 100,000), though both are below the target rate (2,300).

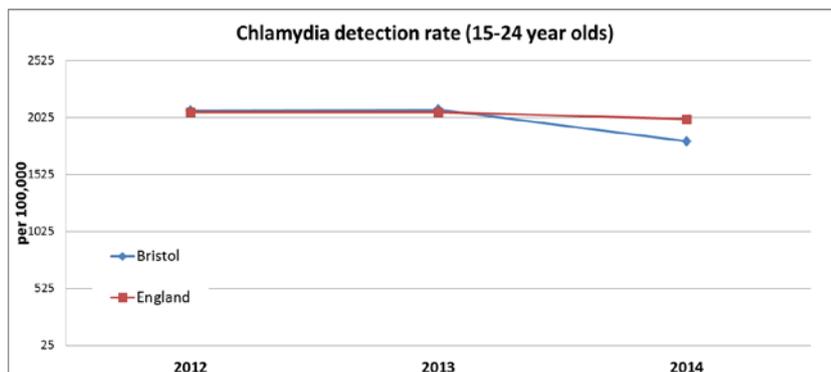


Fig 34. via Public Health Outcomes Framework, 2015

²⁴ See Sexual Health Needs Assessment (Sept 2015)

3.7.2 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 conceptions in women under the age of 18 years 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 to other comparable cities. As actual numbers of teenage conceptions, this is a fall from 360 in 2007 to 167 (2013) for Bristol.

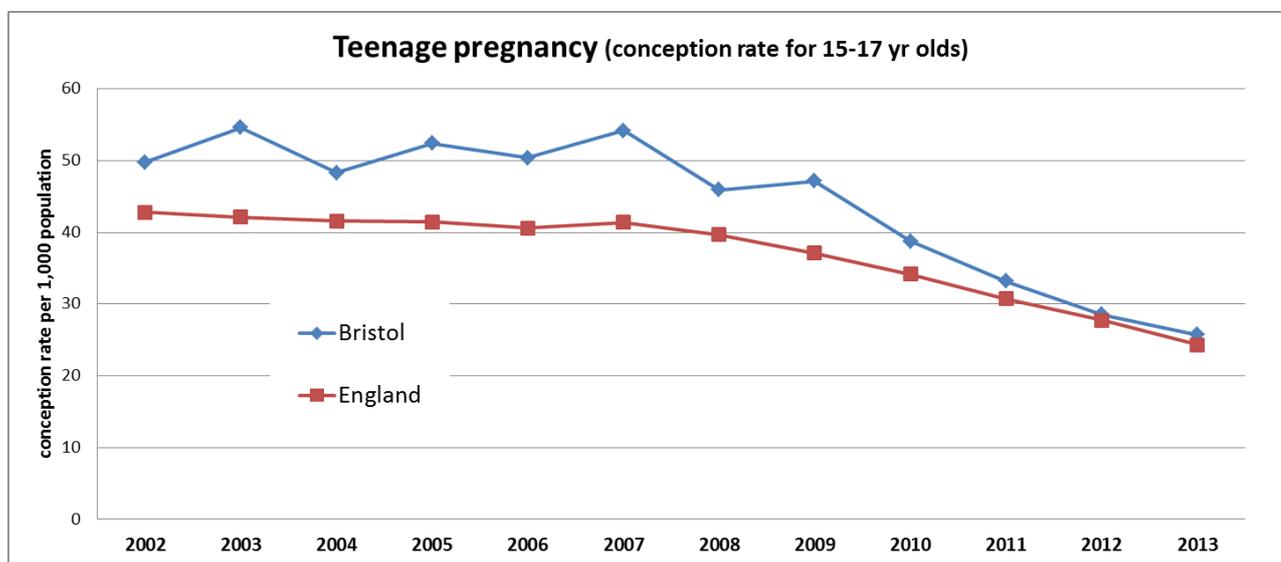


Fig 35. Source: Office of National Statistics, via Public Health Outcomes Framework, 2015

Within Bristol, this data can be shown locally by wards (and CCG sub-locality areas) to highlight the differences across the city. However, 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.

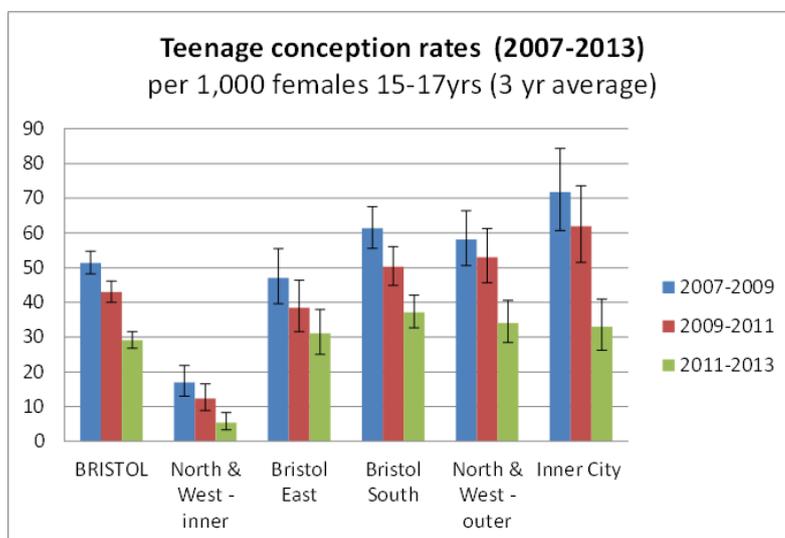


Fig 36. Source: Office of National Statistics, collated by Bristol Public Health Intelligence Unit, 2015

4. Social Care & Wider Determinants

4.1 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 families²⁵, 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.

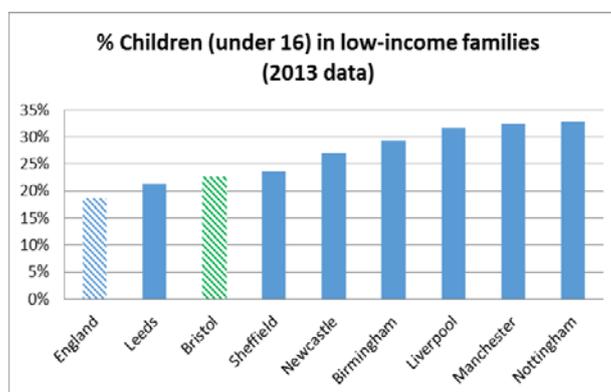


Fig 37. Source: DWP, Sept 2015

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). The Bristol Child Poverty Strategy is to reduce the number of families with children living in relative poverty and to reduce the impact of low income.

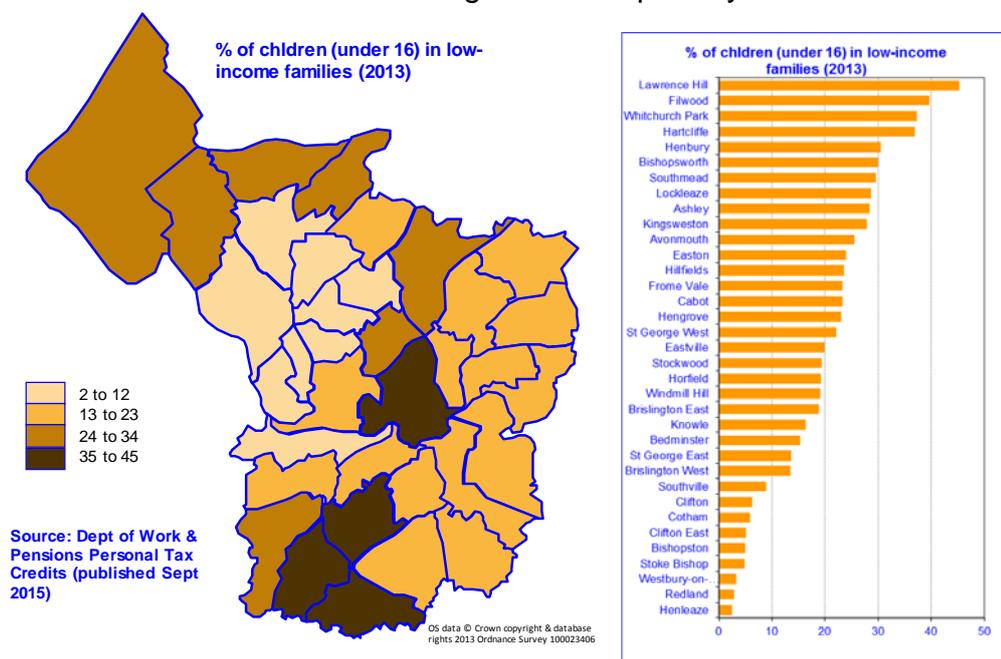


Fig 38. Source: DWP, via Bristol Performance, Information & Intelligence, 2015

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.

²⁵ 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

4.2 Education

4.2.1 Pupil Absence

In 2013/14 the amount of school-time missed by pupils in Bristol schools²⁶ was 5.05%, which is significantly higher than the national average (4.51%), although this is falling. The trend chart 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.

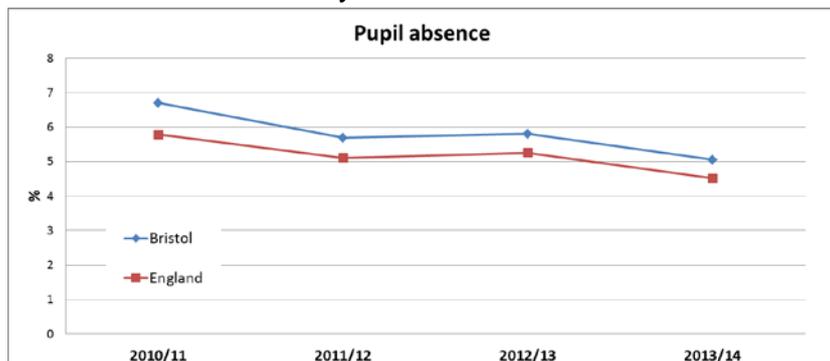


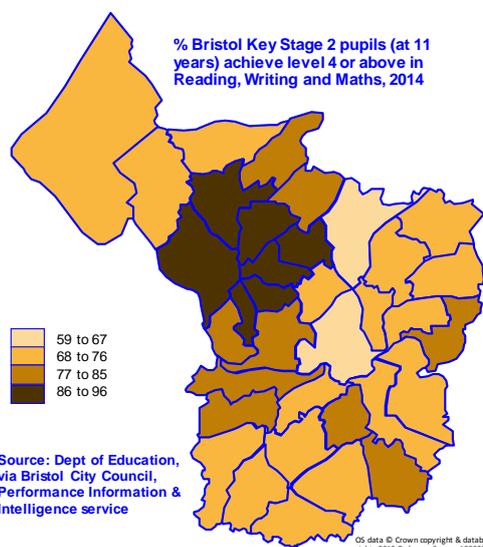
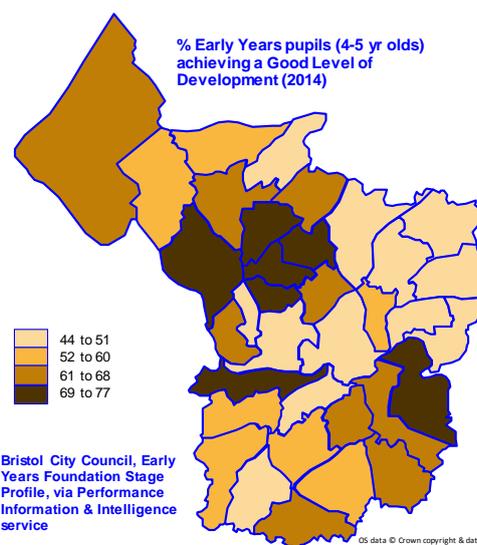
Fig 39. Via Public Health Outcomes Framework, Aug 2015

4.2.2 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.



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

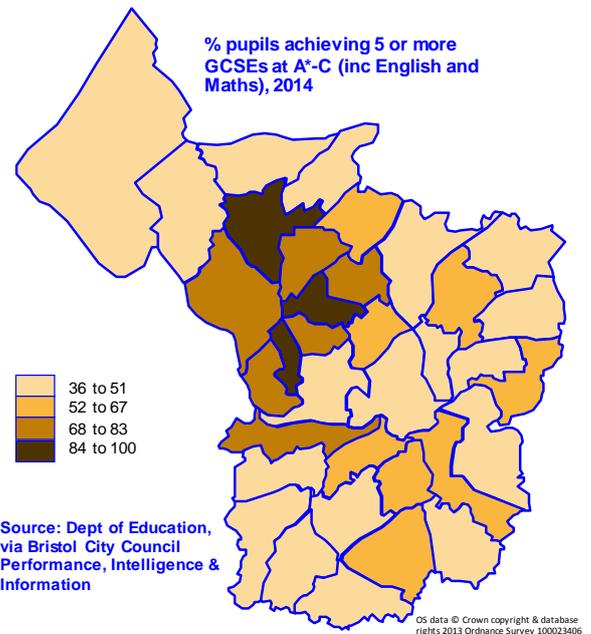
Level 4 is the level of attainment typical for an 11 year old. Of Key Stage 2 pupils in Bristol, assessed in Year 6, 76% achieved level 4 or above in Reading, Writing and Maths combined (2014). This remained static on last year, and is now lower than the national rate (79%) and only joint 3rd of Core Cities. Across Bristol attainment at Level 4 ranged from 59% in Lawrence Hill to 96% in Westbury and Bishopston.

²⁶ Source: via Public Health Outcomes Framework, Aug 2015

4.2.3 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.²⁷



4.2.4 Not in Education, Employment or Training (NEET)

Young people who are “not in education, employment or training” (NEET) 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 Bristol²⁸ (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 amongst the English Core Cities.

Fig 43. Via Public Health Outcomes Framework, Aug 2015

However, locally²⁹, 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.

²⁷ Dept of Education, via Bristol City Council, 2014 results

²⁸ Source: Dept for Education, 2015 (also via Public Health Outcomes Framework data tool, Aug 2015)

²⁹ Source: Learning Partnership West (Nov 2014-Jan 2015) via Bristol City Council, Performance Information & Intelligence

4.3 Child Social Care

4.3.1 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].

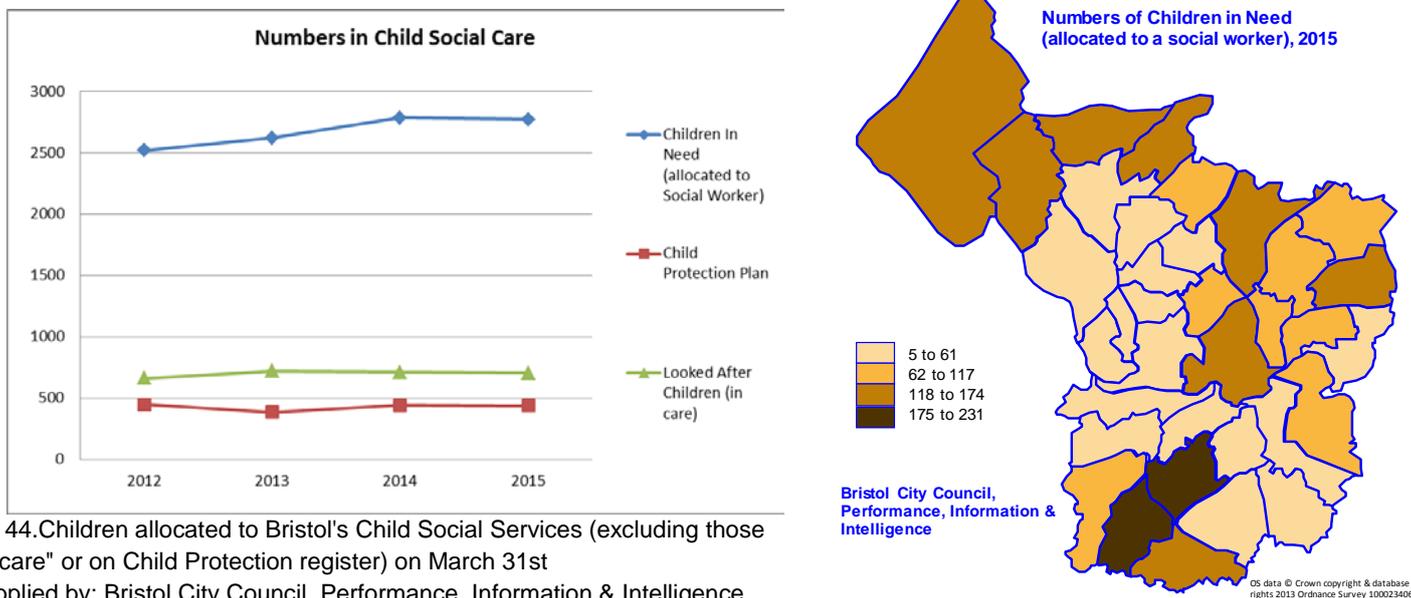


Fig 44.Children allocated to Bristol's Child Social Services (excluding those "in care" or on Child Protection register) on March 31st
Supplied by: Bristol City Council, Performance, Information & Intelligence

4.3.2 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:

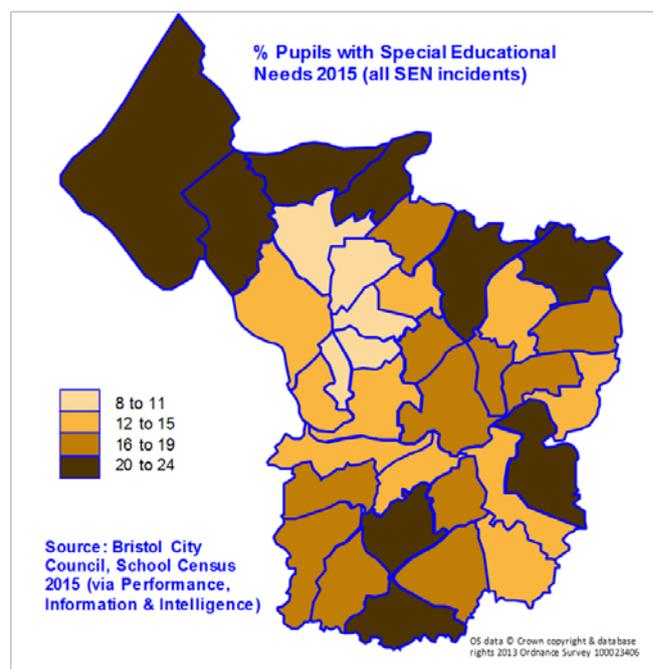
- 91% have completed Health Assessments (2014); compared to national rates of 87% in 2013
- 92% have completed Dental Checks (2014); compared to national rates of 82% in 2013
- 78.9% have all immunisations recorded as up-to-date (2014), which is an improvement locally but remains lower than the national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

4.4 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 2015³⁰ (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 shows pupils with SEN as a % of all Bristol pupils in that ward.

Fig.45, SEN. Source: Bristol City Council, Performance, Information & Intelligence



4.5 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 System³¹ 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 appears to be widening, and Bristol is currently ranked 13th highest of 152 local authorities on this measure (where highest is worst).

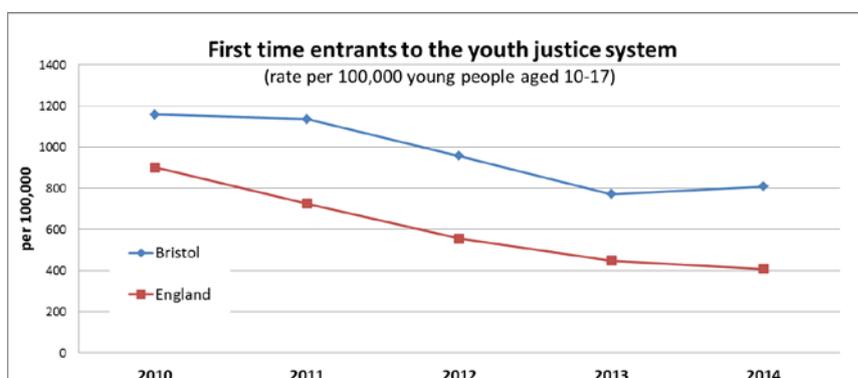


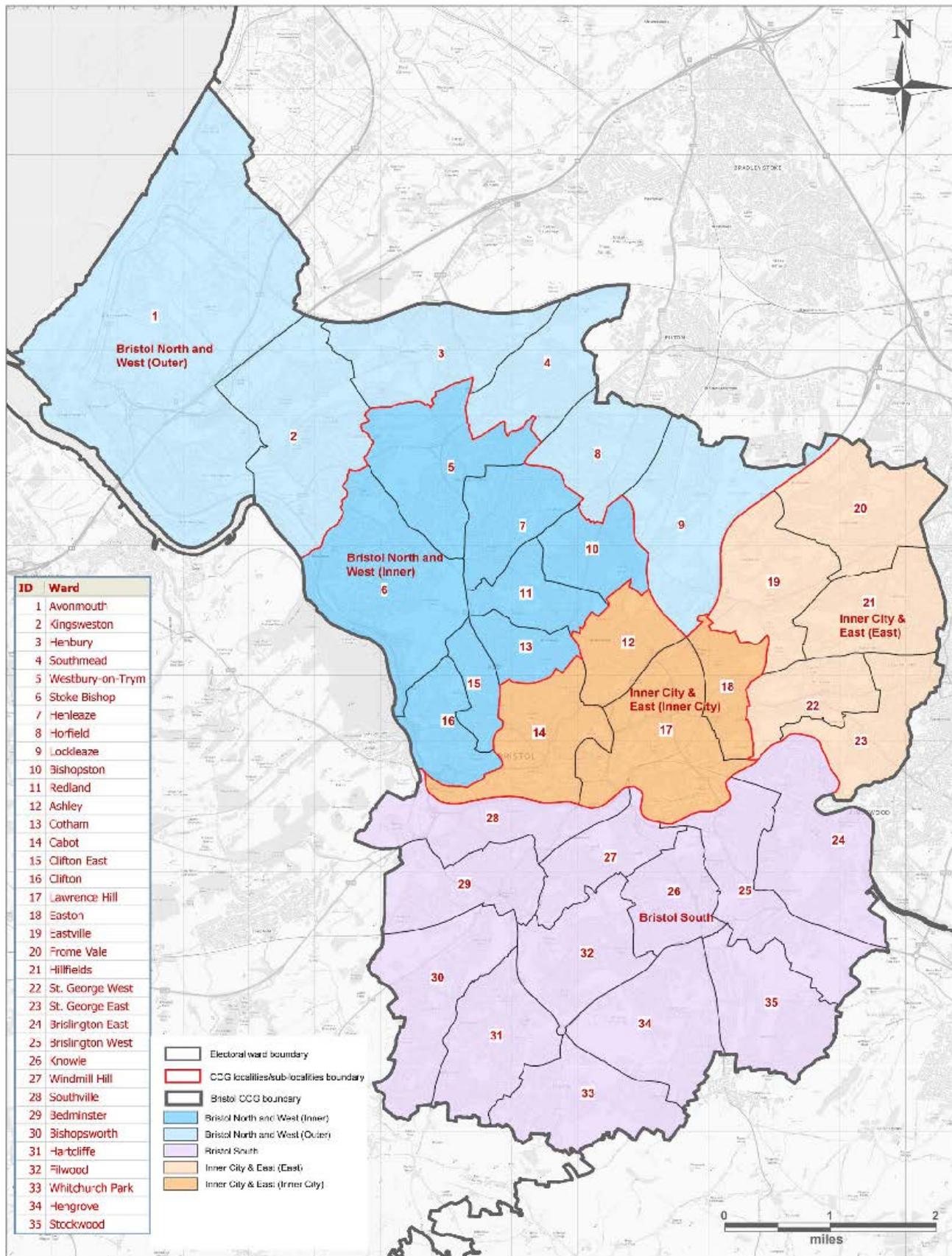
Fig.46, rate of young people aged 10-17 receiving their first reprimand, warning or conviction. Source: via Public Health Outcomes Framework, 2015

³⁰ Source: January School Census 2015; Bristol City Council

³¹ 10-17 year olds receiving their first reprimand, warning or conviction. Source: Public Health Outcomes Framework tool, 2015

Appendix 1

Map of Bristol wards and CCG sub-locality areas used in analysis



ID	Ward
1	Avonmouth
2	Kingsweston
3	Henbury
4	Southmead
5	Westbury-on-Trym
6	Stoke Bishop
7	Henleaze
8	Horfield
9	Lockleaze
10	Bishopston
11	Redland
12	Ashley
13	Cotham
14	Cabot
15	Clifton East
16	Clifton
17	Lawrence Hill
18	Easton
19	Eastville
20	Frome Vale
21	Hillfields
22	St. George West
23	St. George East
24	Brislington East
25	Brislington West
26	Knowle
27	Windmill Hill
28	Southville
29	Bedminster
30	Bishopsworth
31	Hartcliffe
32	Filwood
33	Whitchurch Park
34	Hengrove
35	Stockwood

- Electoral ward boundary
- CCG localities/sub-localities boundary
- Bristol CCG boundary
- Bristol North and West (Inner)
- Bristol North and West (Outer)
- Bristol South
- Inner City & East (East)
- Inner City & East (Inner City)

Bristol CCG Localities and Sub-localities by Electoral Ward

South West Commissioning Support
 NWS
 Wang Zhong - 9 February 2014
 © Crown copyright and database rights 2013
 Ordnance Survey 100069577
 © Data Royal Mail Ltd © Royal Mail
 2014 and database right 2013
 © 1998, © 2011, © 2012, © 2013
 Bristol_CCG_Localities_Wards_10m_01.mxd



Bristol Clinical Commissioning Group

Health and Social Care Needs of Children & Young People

*JSNA 2015 update
(Nov 2015)*

Becky Pollard; Director of Public Health

Nick Smith; BCC Consultation &
Strategic Intelligence Coordinator

JSNA children's update 2015

1) Informing strategic direction for improving health and wellbeing for children and YP

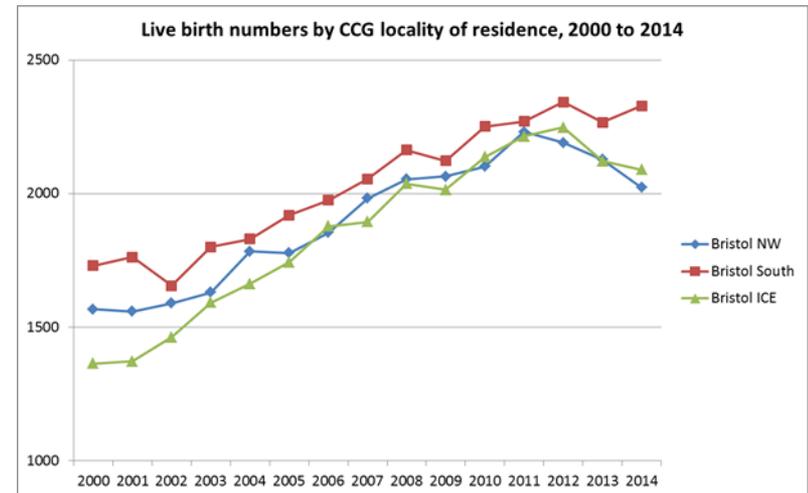
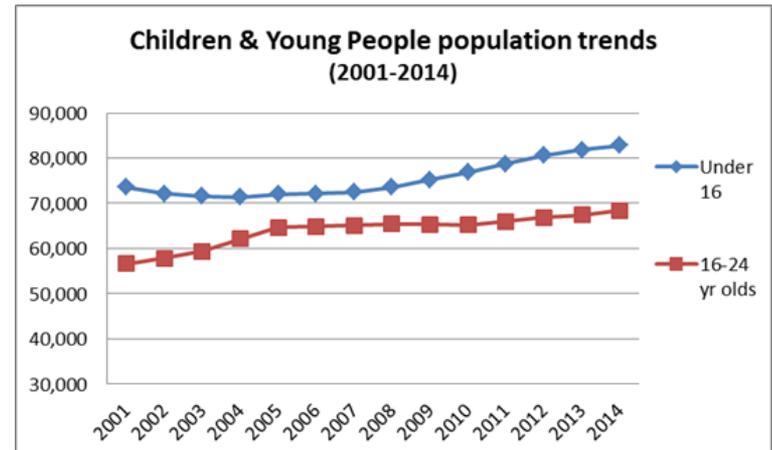
- JSNA update - to inform the Health and Wellbeing Strategy (via Health and Wellbeing Board in 2015)
- Children and Families Partnership Board plans and vision for Early Intervention

2) Focus on current priorities:

- Shaping strategic direction for specific issues, e.g. maternity strategy; oral health strategy, child obesity strategy
- Current re-commissioning programmes, e.g. Children's Community Health Services; sexual health services

Child Population changes

- Rising Child Population
 - 82,800 children under 16 (18.7%)
 - 68,400 young people 16-24 (15.4%)
- Highest since '80's, esp under 5's but now 5-9s rising fastest
- Rise has been focussed in Inner City & East (esp Young People), but younger ages rose in all areas
- Births dropping off – pressures remaining in South Bristol
- Increasingly diverse - children 28% BME and 50% in Inner City & East
- 19% children have English as Additional Language (2015)

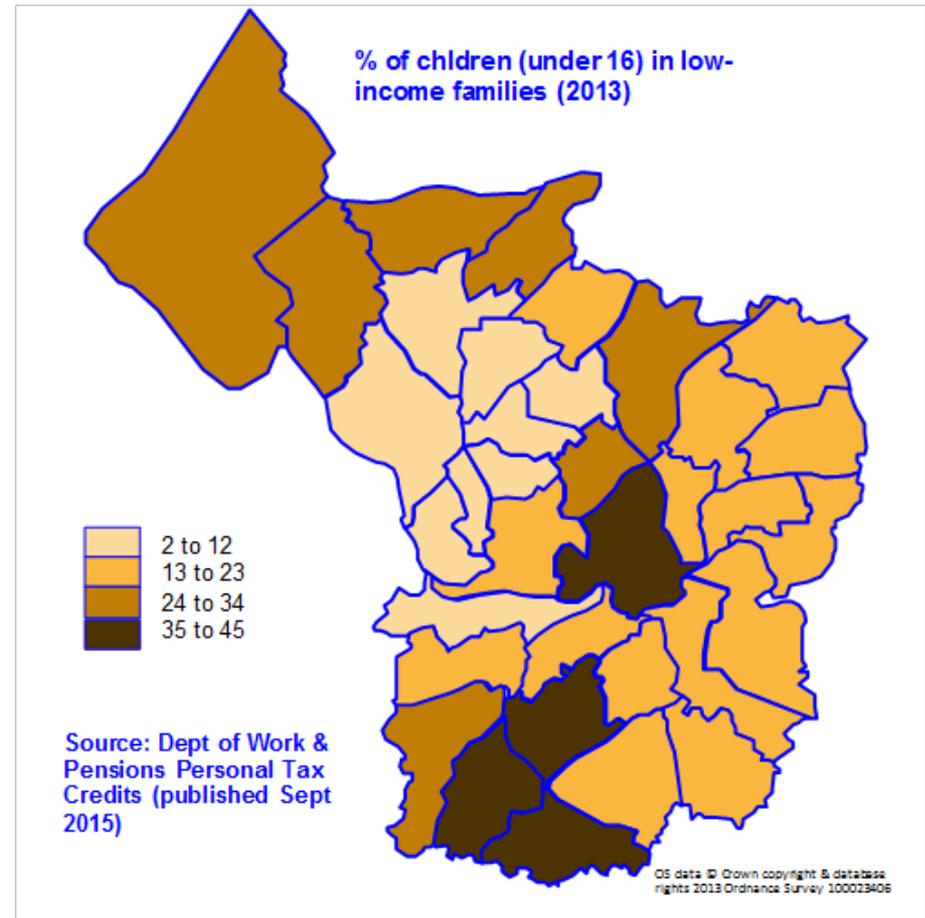


Child Poverty

- Almost 1 in 4 (22.6% or 18,200 children under 16) in **low income families** (above national 18.6%, 2013)
- Falling (from 27.1% in 2009) and now 2nd lowest % of English Core Cities
- **Inequalities:** 2% Henleaze to 45% Lawrence Hill. Issue in South Bristol.

Free school meals as local proxy

- 2015: 22.2% of Bristol school children entitled to FSM

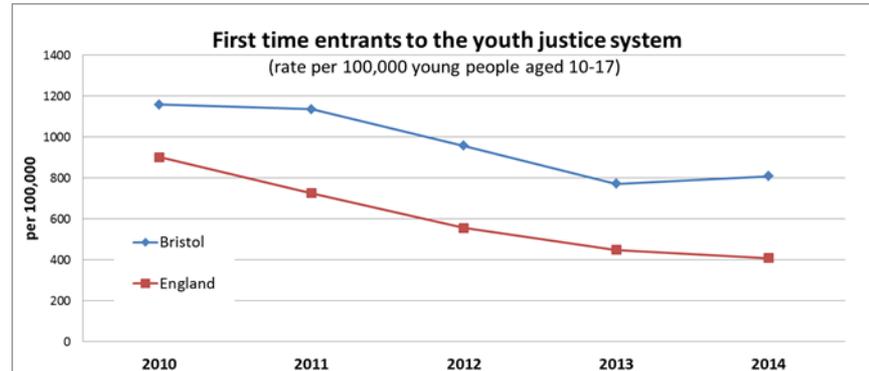




Other wider determinants

Youth Offending

- First time entrants to criminal justice system – above national & rising in 2014



Domestic Violence

- Being exposed to domestic and sexual violence and abuse as a child or young person can be extremely detrimental
- NSPCC Study: 23.7% of 18–24s had been exposed to domestic violence

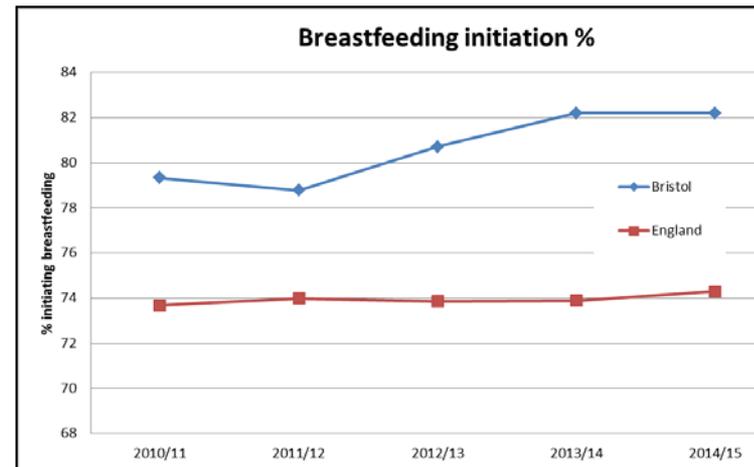
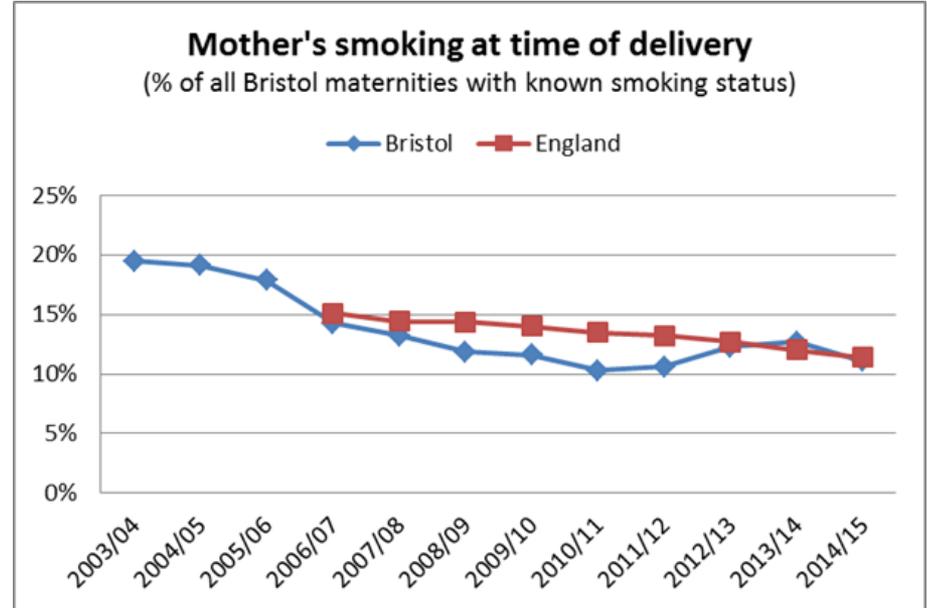
NEETs

- 6.3% of 16-18 year olds are not in education, employment or training (2014).
- NEET rate is falling year-on-year and similar to Core Cities, but above national average
- Range <2% to 13.5% in Filwood



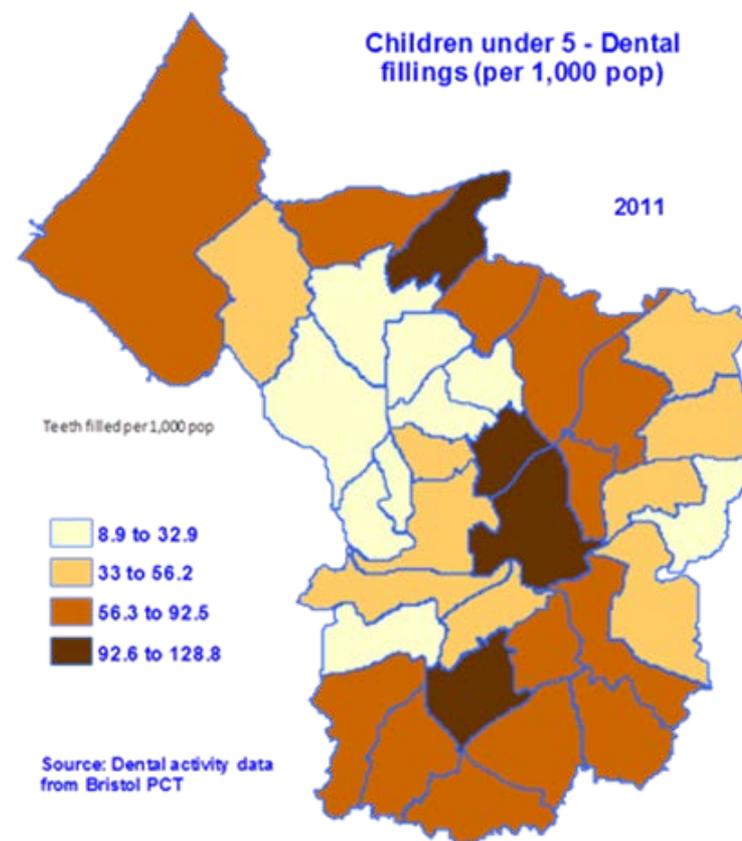
Maternal & baby health

- **% women smoking in pregnancy** (11.1%, 2014/15) had risen but now falling in line with the England average
- Inequalities: ward 1% to 28% (2008-2012)
- **Breastfeeding** – rates significantly higher (82%) than national (74%) for initiation
- Inequalities - low in South Bristol; very high in Inner City & inner North & West



Oral Health

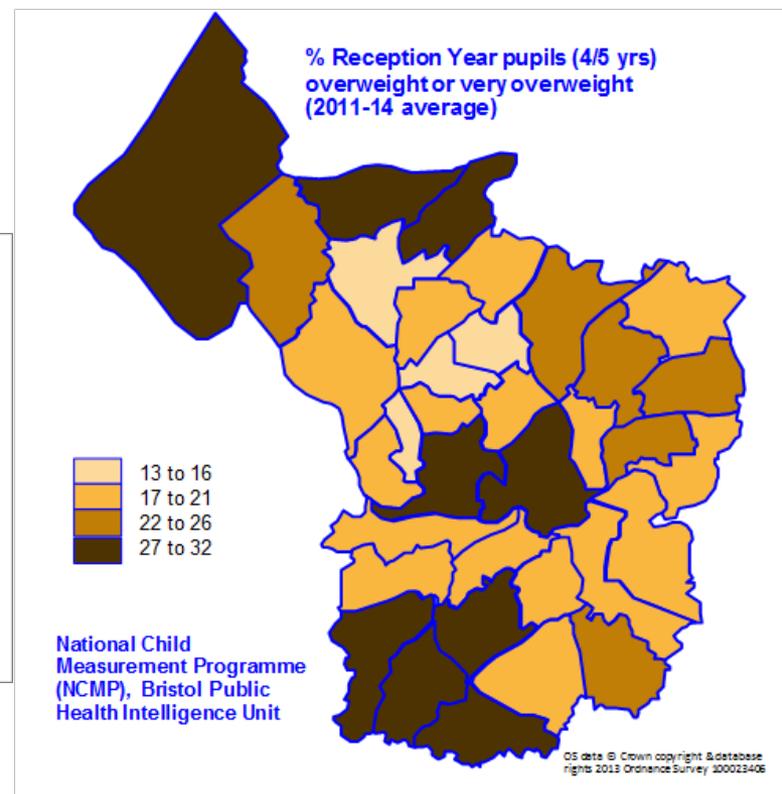
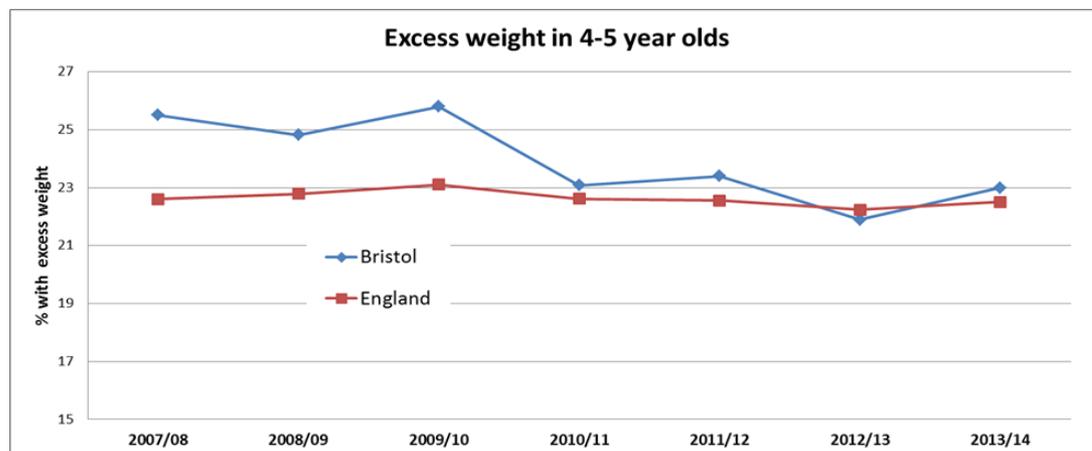
- 15.3% of 3 year olds with decay, higher than England average (11.7%), 2013-14
- Rate of fillings (under 5's, per 1000 children, 2011) ranges from 9 to 128 fillings per ward. Link to areas of deprivation
- More 0-17s yr olds in Bristol (33.4%) have not attended a dentist in past 2 years than nationally (32.5%).





Children % overweight or obese

- Reception (4/5yrs): 23% (2013/14)
- Year 6 (10/11yrs): 34.8% (2013/14)
- Both similar to national
- Consistent Inequalities across Bristol linked to deprivation



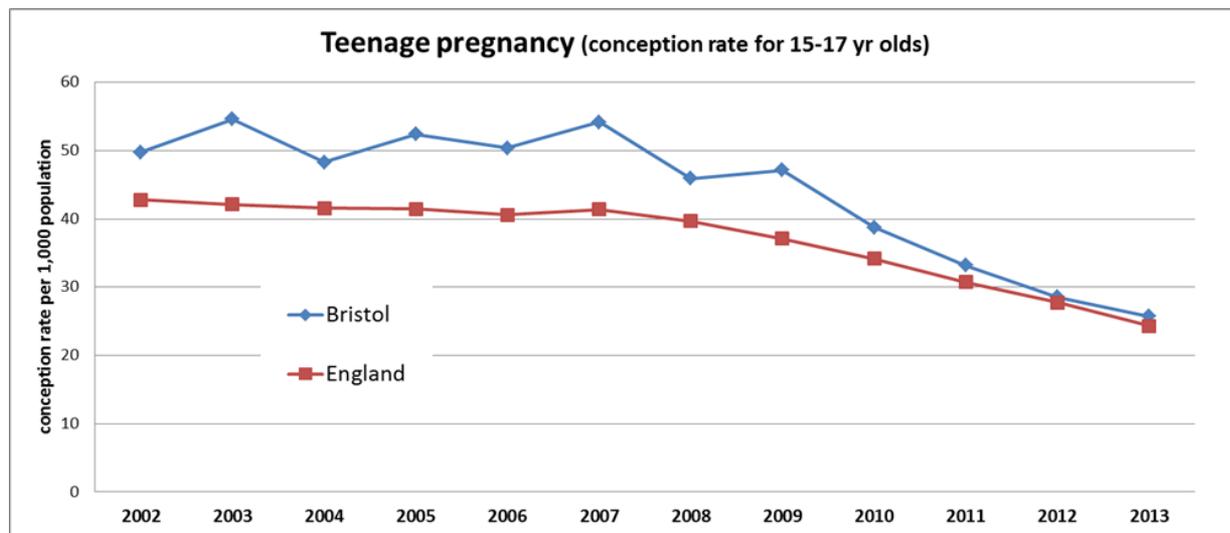


Sexual Health

Sexual health Needs Assessment

- Young people are at increased risk of poor sexual health
- Looked After Children, Care leavers and youth offenders are esp vulnerable to poor sexual health
- Experiences of sexual harassment, sexual bullying and sexism have been found to be normalised amongst this generation.

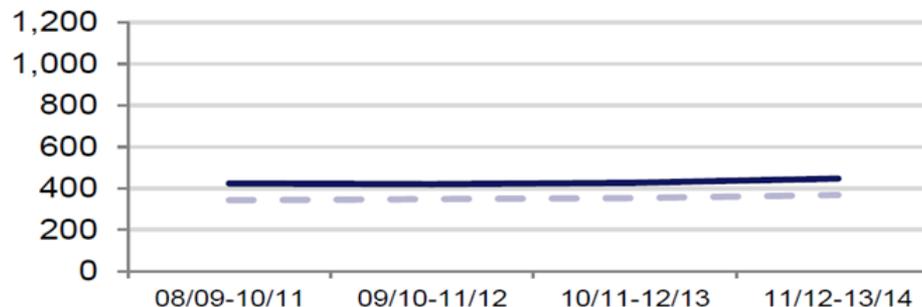
Teenage pregnancy rates
 - falling and now similar to national average
 (2013: 25.7 per 1,000 in Bristol; England 24.3)



Emotional and Mental Health

- More than “mental health” - impact of poor emotional health & wellbeing on physical health, behaviour and academic performance.
- 10% of children & young people affected by poor emotional health
- Locally, 2014 estimate is 5,400 of 5-16 year olds have emotional ill health likely to require support (3300 boys & 2100 girls)
- **Deliberate Self-Harm (DSH)** is of increasing concern - 500 young people admitted to hospital for self-harm - rate significantly above national and no sign of reducing (below), but may be due to adhering to NICE guidelines around admissions:

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)



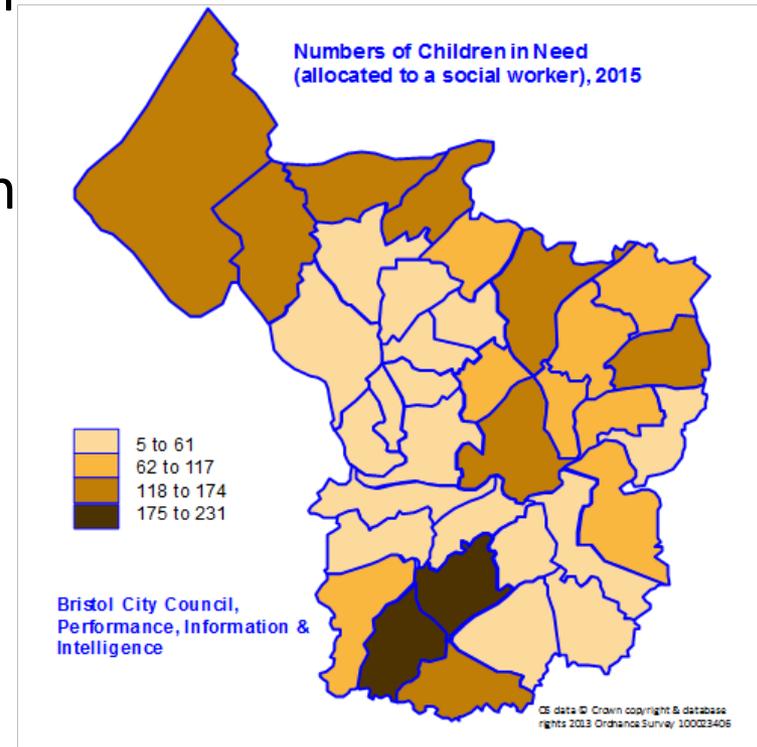


Social Care

- **“Children in need”** (allocated to Social worker) differs by ward: under 10 in some wards to over 200
- **Child Protection Plans** - gradual rise in rate of CPP since 2013
- **Looked after children** – total is stable around 700 (at any given time)

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

- 91% have completed Health Assessments (2014); compared to national 87%
- 92% have completed Dental Checks (2014); compared to national rates of 82%
- 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.



What more do we need to know?

More data access – inc ward level data

- JSNA reports / webpage: www.bristol.gov.uk/jsna
- Data site: <http://profiles.bristol.gov.uk>

More interpretation

- So what do we need to do about it?
- How can we **prevent** these things?
- What are the **inequalities**?
- How can we work more effectively **together**?
- Recommendations for Service change - What is the **evidence**?



Enhanced Bristol JSNA plans

- Develop **JSNA 'Chapters'** for more in-depth intelligence (from 2016):
 - Quantitative and qualitative data
 - Evidence, user views and current services/assets
 - Led by Public Health with BCC/CCG commissioners
 - Determine gaps & recommendations for action
- Better **access to information** to improve usability & transparency and drive commissioning process
 - Add links to wider range of information 'products'
- Better **integration** of intelligence functions between council, NHS and other partners



Bristol Clinical Commissioning Group

FURTHER QUESTIONS?