

Health and Wellbeing Board Agenda



BRISTOL CCG

Date: Wednesday, 24 October 2018

Time: 2.30 pm

Venue: The Writing Room - City Hall, College Green,
Bristol, BS1 5TR

Distribution:

Councillors: Dr S Milner, Mayor Marvin Rees, Hayley Richards, A Young, Julia Clarke, Robert Woolley, Julia Ross, Justine Rawlings, Dr A Bolam, Dr J Jensen, Asher Craig, Vicki Morris, Keith Sinclair and Elaine Flint

Copies to:

Issued by: Claudette Campbell, Democratic Services

City Hall College Green Bristol BS1 5TR

Tel: 0117 35 26162

E-mail: democratic.services@bristol.gov.uk

Date: Tuesday, 16 October 2018



Agenda

1. Welcome, Introductions and Safety Information

Please note: if the alarm sounds during the meeting, everyone should please exit the building via the way they came in, via the main entrance lobby area, and then the front ramp. Please then assemble on the paved area between the side entrance of the cathedral and the roundabout at the Deanery Road end of the building.

If the front entrance cannot be used, alternative exits are available via staircases 2 and 3 to the left and right of the Council Chamber. These exit to the rear of the building. The lifts are not to be used. Then please make your way to the assembly point at the front of the building. Please do not return to the building until instructed to do so by the fire warden(s).

2. Apologies for Absence and Substitutions

3. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a **disclosable pecuniary interest**.

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Minutes of Previous Meeting

To agree the minutes of the previous meeting as a correct record.

(Pages 5 - 9)

5. The Health Component of the draft One City Plan

Sally Hogg, Consultant in Public Health, BCC

2.45 pm

(Pages 10 - 18)

6. Children & Young People's Mental Health & Wellbeing Local Transformation Plan

Kirsten Wilson, Transformation Manager Mental Health, NHS BNSSG CCG

3.15 pm

(Pages 19 - 51)



7. Bristol Health Partners Presentation

Andrea Young, Chief Executive, North Bristol NHS Trust

3.25 pm

(Pages 52 - 55)

8. Annual Health Protection Report

Thara Raj, Consultant in Public Health, BCC

3.35 pm

(Pages 56 - 98)

9. Health and Wellbeing in Bristol 2018 (JSNA 2018 data profile)

Update on refreshed core JSNA product

3.45 pm

(Pages 99 - 247)

Andrea Dickens, Public Health Programme Manager and Nick Smith, Strategic Intelligence and Performance Manager BCC

10. Standing Items

4.00 pm

These items for brief updates:

a) STP Update

Julia Ross, CEO, BNSSG CCG and Robert Wooley, CEO UHB

b) Forward Plan

Sally Hogg, Consultant in Public Health, BCC

- Discussion about the ‘theme’ for December’s HWB

(Pages 248 - 250)

11. Public Forum

4.20 pm

Any member of the public or Councillor may participate in Public Forum. Public Forum items should be emailed to democratic.services@bristol.gov.uk.

Please note that the following deadlines will apply in relation to this meeting:-

Questions about agenda items - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest by 5 pm on Thursday 18th October 2018. A maximum of 2 questions pre individual is permitted.

Petitions and Statements about agenda items - Petitions and statements must be



received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest by 12.00 noon on Tuesday 23rd October 2018.



Bristol City Council Minutes of the Health and Wellbeing Board

20 June 2018 at 2.30 pm



Board Members Present:

Dr S Milner, Woolley, Justine Rawlings, Dr J Jensen, Asher Craig, Vicki Morris and Elaine Flint, Robert Woolley, Jacqui Jensen

Officers present:

Sue Milner, Interim Director of City Wellbeing, Resilience and Strategic Partnerships, Sally Hogg Interim Service Director - Public Health, Steve Gregory

Also present:

Councillors Helen Godwin, Helen Holland

1. Welcome, introductions and safety information

Alison Bolam took the Chair, welcomed all present and led introductions.

2. Apologies for absence

The following apologies were given:

- Mayor Marvin Rees
- Keith Sinclair
- Hayley Richards
- Julia Clarke (sub by Aileen Fraser)
- Julia Ross
- Andrea Young

3. Declarations of interest

None

4. Minutes of meeting held on 21 February 2018



The Board were asked to agree the minutes of the previous meeting.

Resolved:

That the Minutes of the meeting held on the 21st February 2018 be confirmed as a correct record.

5. Health and Wellbeing Board - Terms of Reference and Ways of Working

Sue Milner advised members that following the informal meeting of the Board in April there had been no changes made to the Terms of Reference but new ways of working had been agreed, this had included the number of members on the Board and reducing 'demand' from sub groups seeking the Boards input on a wide range of topics. A list had been compiled for Board Members regarding which topics should be prioritised for the Board's consideration.

Key points made during discussion -

1. Governance structure around 'better Care Fund' to be given urgent priority – Action Sue Milner and Sally Hogg;
2. The wording in point 13 of the ToR to be amended to say 'contribute' or endorse' instead of 'involved' regarding the process of developing and signing-off Clinical Commissioning Group plans;
3. Alison Bolam should be referred to as Commissioning representative not 'provider';

Board Members were asked to consider the document and inform Sue/Sally if they felt any further changes were necessary.

Subject to the above, the Board noted the Terms of Reference and Ways of Working paper.

6. JSNA Annual Report 2017-18 and Proposed Work Programme 2018-19

Sue Milner emphasised the need to reduce the number of topics being included on the Work Programme and the importance of pursuing a more specific approach to the work of the Board. It was considered that there was a 'yawning gap' between what the Board would like to do and what was feasible. For the future the focus would be on 'Core Products' and fewer in depth assessments, the next JSNA would do further work with a focus on just three or four topics. It was essential that nominated members attend the Steering Group meetings for this to work well.

With regard to data protection, specifically in relation to General Data Protection Regulation (GDPR), it was essential that there was 'one source' for all partners to be able to access at an early stage to achieve improved cost effectiveness.

Resolved:



1. To note the JSNA programme and the progress made too date;
2. To agree the revised approach to delivering the JSNA;
3. To make further suggestions, amendments, additions as appropriate.

7. Healthier Together - update

1. Healthier Together – update

Robert Wooley introduced the paper which set out the progress being made regarding the Healthier Together product emphasising that work on the 'Prevention Strategy' had seen continued progress and strengthening of collaborative working arrangements and that these had already helped to deliver meaningful improvements in care and services provided including increased mental health services.

Particular emphasis was placed on the need to invest more resources into early discharge from hospital and into community care and it was envisaged that improved coordination could be achieved through increased working with local GP boards and the wider community including the voluntary sector, the public and citizen panels.

The Board was asked to consider how it would support the work of the partnership in the next phase.

It was considered important that the 'Prevention Strategy' be shared with the wider community and that more emphasis be put on mental health issues. The Board was advised that a timescale for this had not been devised at the current time but this would be checked and reported back. The Board noted that initiatives had been taken regarding the greater use of Apps to access services, this was seen as increasingly important amongst children and young people. Also noted that membership of the Institute of Mental Health was free and was a useful resource for access.

Resolved: that the report be noted and that the 'direction of travel' currently being pursued be supported.

8. One City Approach - Health Theme

The Board was advised that work on the 'One City Approach' was completed two weeks ago and that it was now important for the H&WB to play a pivotal role to drive this forward to enable resolution to long term problems. The 'One City Plan' would by default be a public health plan and would be include important issues affecting the City ie, economic growth , jobs, transportation, climate change.

Many issues had been discussed at the 'City Gathering' however it was apparent that attitudes and cultures would need to change, it was acknowledged that this could take a long time. The approach chosen to accommodate this was to look forward to 2050 and work back on what needed to be done or changed. It was proposed that the H&WB would be the core driving force behind a 'Governance Structure' that would aim to give children and young people the best start in life and this would involve the cooperation of key stakeholders working together.



All inputs for the H&WB would go into the 'One City Plan' and shape the City's priorities in respect of issues such as air quality, healthcare and clinical issues. The 2050 concept was essentially a synopsis outlining the city's aspirations and vision for the future.

Members considered the 2050 concept and emphasised strongly that with particular regard for children's services the pace of change of new technology was increasing exponentially and needed to be built into any plan for the future. It was agreed that a specific 'task and finish working group' needed to be set up to deal with this.

It was considered important to ensure accurate measurement of data including outcomes and what was being done and by whom. An assurance was given that the Plan would be brief and fully signposted and that a mechanism would also need to be devised to translate concepts to outcomes. The Board noted information about the 'One City Plan for New York' and the possibility of plagiarising positive practices from that.

Resolved: that the update be noted and that a 'Task and Finish' Working Group be set up as soon as possible in relation to the above discussion.

9. Health and Wellbeing Board forward plan

The Board was advised that about six formal meetings would be required, possibly more, and that the forward plan would need to include groups who looked toward the H&WB for governance. Routine business would comprise half the Board's work with the other half looking at specific or themed products eg, children, mental health. Development sessions would be set up to enable more focus to be given.

It was agreed that all potential forward plan items be channelled through Sue Milner to avoid too many items being included on the Plan and slowing overall progress.

10 Director of Public Health annual report

Resolved: that the report be noted.

11 Public forum - about items included on the agenda

A public forum statement from Councillor Donald Alexander (and on behalf of Councillors Massey, Kirk, Godwin and Phipps) in respect of agenda item 7 was read out to the Board concerning Looked after Children. The statement was noted.

A statement/question from Councillor Kirk regarding Bristol's health and social care workforce: recruitment and retention, mental health and wellbeing was also received and noted.



The Chair said that a response would be given to both submissions in due course.

Meeting ended at 4.00 pm

CHAIR _____

Meeting ended at 4.00 pm

CHAIR _____





Bristol Health & Wellbeing Board

Title of Report	
Author, including organisation	Sue Milner / Sally Hogg, Bristol City Council
Date of meeting	24.10.18
Report for Discussion and Sign Off	

1. Purpose of this Paper

This paper contains the proposed health narrative and a timeline of key milestones for the health theme of the One City Plan.

The One City Plan will be launched in January 2019, as a cross sector/cross organisation plan that sets out how the city intends to achieve the following agreed ambition:

By 2050, Bristol is a fair, healthy and sustainable city. A city of hope and aspiration, where everyone can share in its success.

The overarching purpose of the plan is to:

a) Align our intentions:

- Inclusive systems leadership
- Whole city engagement
- Buy-in from strategic delivery partners and boards

b) Focus our resources

- Collective power of public, private, voluntary organisations and our communities
- Catalyse change for systemic city challenges
- Attract new investment to the city

c) Sequence our actions

- Review of city strategies, projects and infrastructure
- Coordinate and prioritise actions at a city scale to tackle the right challenges at the right time.

There are a number of themes reflected in the One City Plan; culture, economy, transport, health, children and young people, learning, homes, communities, connectivity and environment.

The health component of the One City Plan provides high level statement of intent, which sets out our collective vision for health and wellbeing within the city by 2050. The health narrative in the One City Plan will be underpinned by key strategies and documents that are already in existence to provide detail, key performance indicators and further context. The reader will be signposted to these from the One City Plan.

2. Recommendations for the HWB

The Health and Wellbeing Board is asked to endorse the proposed health component of the One City Plan as a reflection of the local health and wellbeing ambitions until 2050.

3. Appendices

One City Plan – health theme (Draft)

Timeline of key milestones (Draft)

Health Theme

What is this theme about?

Our vision for the health and wellbeing of Bristol's population by 2050 and the things we will need to do together, as a city, to achieve that vision. The Health and Wellbeing theme of the One City Plan has been developed by the Health and Wellbeing Board. It reflects a focus on prevention, ensuring people who suffer ill-health are able to live as independently as possible in the optimum health for them, whilst encouraging a city that actively promotes and encourages a positive, health enhancing environment.

There is a separate theme on children and young people in the One City Plan, which specifically focuses on giving children the best start in life and reducing the number of adverse childhood experiences (ACEs) suffered by children. This is vital if we are to achieve our health and wellbeing ambition by 2050.

There are many factors that affect our health and wellbeing. People are living longer and in many cases living longer in poor health. Care is more complex, with advanced medical interventions and better survival rates for many diseases. The number of people living with one or more long-term conditions is increasing and our culture and environment has changed so that it promotes unhealthy behaviours, which contribute to long term conditions and non-communicable diseases such as obesity. In addition, we have not managed to reduce health inequalities significantly, with 16% of residents (69,000 people) living in deprived areas (Indices of Deprivation, 2016).

The journey to 2050 will be enabled by cross cutting enabling themes, exploiting the use of digital technology, and people taking responsibility for their own health and wellbeing.

Our Health and Wellbeing vision

Our overarching vision for this theme:

By 2050 everyone in Bristol will have the opportunity to live a life in which they are mentally and physically healthy.

Our vision has four sub-themes:

- Parity of esteem where mental health is as important as physical health in Bristol
- Health inequalities and the gap in Healthy Life Expectancy will be significantly reduced
- Bristol communities will be resilient, with individuals being as independent as possible

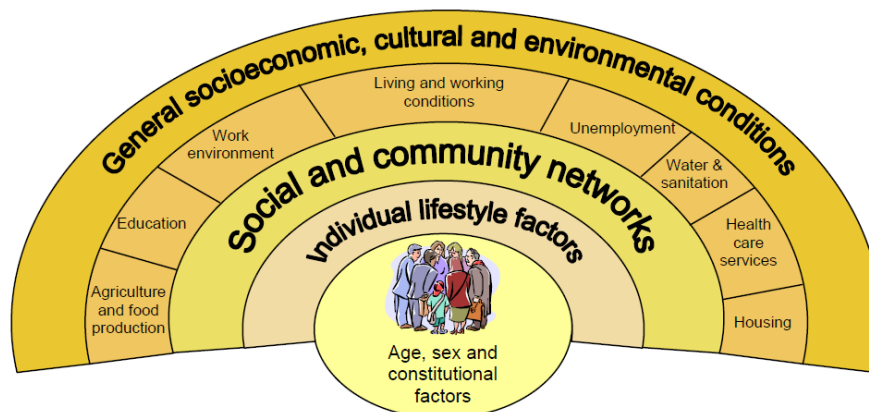
- Health and social care services will be fully integrated and sustainable with a focus on prevention and early help.

Why is this important?

Life expectancy in Bristol is 78 years for males (lower than the England average) and 83 years for females (the same as the England average), with a gap of approximately 10 years between the least deprived and most deprived wards in Bristol. Healthy life expectancy – the number of years an individual is expected to live in good health is an important consideration when thinking about the burden of ill-health. Men in the least deprived areas of the city are expected to live 16 years (women 17 years) longer in good health than individuals living in the most deprived areas.

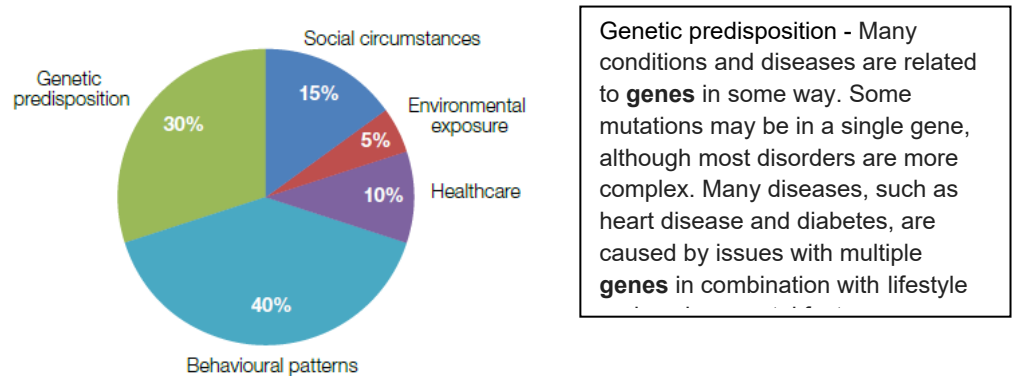
The health of our population is impacted by a wide range of social determinants (Dalgren & Whitehead, 1991) that influence health throughout the life course. There is a social gradient across many of the factors that contribute to our health, with poorer individuals experiencing worse health outcomes than those who are better off. Children who grow up in deprived areas often suffer disadvantages throughout their lives, ranging from their educational attainment to employment prospects, which, in turn affect mental and physical wellbeing. A healthy standard of living with adequate income and housing are associated with positive health outcomes.

The Social Model of Health – Dalgren & Whitehead (1991)



The Marmot Review: Fair Society, Healthy Lives (2010) states that action on health inequalities requires action across all of the social determinants, but in order to reduce the steepness of the social gradient in health, actions should be universal, with a scale and intensity that is proportionate to the level of disadvantage - proportionate universalism.

These wider factors are estimated to influence between 15% and 43% of our health, and illustrate why it is important not just to focus on our NHS health services and Social Care provision.



Source: From evidence to action: Opportunities to protect and improve the nation’s health. Public Health England, 2014

National reports and policies including the NHS Five Year Forward View (2014) recognise the importance of good health and wellbeing in reducing levels of long term disease and premature death and placing a priority on investing in prevention.

Health in all Policies (Public Health England, 2016) recommends a systematic approach to ensuring that all policies with the council and other major partnerships maximise the collective beneficial impact on health and the wider /social determinants of health, with the overarching aim of improving the health of the population and reducing inequity.

Achievement of a healthy, resilient Bristol by 2050 is reliant on a place based; whole city approach rather than health services alone and will only be possible if we recognise:

- the importance of the social environment including individual relationships, families and social networks
- the role that organisations and institutions play for example; schools, health care, businesses, faith groups, charities and clubs
- the built and natural physical environment including transport links

Wider health and wellbeing outcomes are therefore reflected in the other timelines of the plan, recognising health and wellbeing is everyone’s collective responsibility, and includes the citizens of Bristol.

Our ask to the city

To enable us to achieve our vision for 2050, we need to encourage health being an integral part of everyone’s agenda, therefore putting health on the non-health agenda.

- To focus on prevention at primary, secondary and tertiary level with prioritisation based on identified need.
- To work with communities, families and individuals to make healthy choices the easy choice e.g. taking action to change the obesogenic environment, reducing harm from alcohol and tobacco and developing opportunities for people to be physically active.
- To adopt an evidence-based and cost-effective steps to build resilience and promote wellbeing and positive mental health.
- To increase our focus on information systems and assistive technology that enable people to live at home and be independent.
- To acknowledge the changes in the way people lead their lives with increased digitalisation and use of technology and an expectation that information and support is readily available (PHE, 2017).
- To make the city accessible for all groups e.g. dementia / age / disability friendly.

Our vision for Health and Social Care

- Healthier Together, Sustainability and Transformation Partnership, a whole system partnership of 13 local NHS and social care organisations, is working to transform the way health and social care is delivered to ensure that prevention is delivered systematically and at scale throughout the system.
- People will access and receive care based on their needs and will feel responsible for their own health and wellbeing. They will have timely access to the right GP service, which is provided by staff that understand their needs and have time to care.
- We will be able to prioritise based on a good understanding of the needs of the population with innovation based on a sound evidence base.
- We will focus on digital solutions to prevention, health care and social care challenges e.g. assistive technology
- Health and Social Care will concentrate on doing all three of the following things: improving patient outcomes, improving population outcomes and improving the use of resources (i.e. getting more from the resources we have partly by reducing the amount of “low value” interventions done and using the time, people and money freed up to put into more “high value” interventions).
- We will keep people at home where possible, and if admitted to hospital discharge them as soon as possible.
- We will have developed personalised medicine through genomics
- We will develop and sustain an appropriate workforce

What success will look like?

- There will be a new paradigm (the usual and accepted ways of doing things currently are completely changed) based on creating the conditions for people

to live their lives in a way that optimises wellbeing: 'having someone to love, somewhere to live and something meaningful to do' (Duncan Selbie, 2017).

- Residents in Bristol will understand that changing their lifestyle behaviour prevents future illness or further deterioration in their health.
- Residents will be able to realise their potential, cope with normal stresses in life, work productively and make a contribution to their community (McCay.L. Director of the Centre for Urban Design and Mental Health).
- Communities will feel valued and in control as we actively listen and work alongside them.
- Different sectors across Bristol will be health creating by putting 'what matters to me' on an equal footing with 'what's the matter with me' (National Health Executive, 2017).
- Healthcare delivered at home with the use of mobile devices will be the norm.
- People will have access to their own healthcare information and will be well informed about their healthcare needs.
- We will have a coherent, well thought out plan for city investors.
- We will get the best return on investment through using the evidence of what works.
- Inequalities will be significantly reduced.
- Bristol will be a healthy place to live and work.

Timeline of proposed key milestone

(will be formatted into a suitable graphic)

2018 Launch of a city-wide mental health programme – Thrive Bristol.

2019 WHO Age-Friendly City Status achieved.

2020 Bristol will have a consistent city wide approach to Social Prescribing.

2021 There will be a city wide systematic approach to assessing the health impact of all key policies.

2022 Bristol will have a resilient and thriving primary care sector which provides access to high quality care 24 hours, 7 days per week.

2023 BNSSG Sustainability and Transformation Programme (STP) -Healthier Together will be systematically transforming the way we deliver health and social care to local people.

2028 Adult Social Care will have efficient processes in place, making optimum use of technology, enabling staff to work in an agile way and providing best quality outcomes with high staff morale.

2029 Bristol will be a mentally healthy city free from stigma and discrimination

2030 Bristol will be the most active core city in the country with at least 65% of people in all parts of the city achieving the CMO's recommended amount of physical activity.

2032 Bristol will be a healthy weight city with an environment that makes healthy choices available, accessible and affordable for everyone.

2035 Application of technology and genomics in prevention and health care (awaiting Sarah Nadin, UHB following meeting on Friday 21st Sept).

2040 Digital solutions to prevention, health care and social care challenges will have been optimised.

2040 Significant progress to variation in access and outcomes from NHS services which will match the levels of the best performing health economies.

2045 The gap in health inequalities and in healthy life expectancy will have been significantly reduced.

2047 Bristol is a national leader recognised for its health promoting environment enabling citizens to make healthy choices which support their physical and mental health.

2050 Everyone in Bristol will have the opportunity to live a life in which they are mentally and physically healthy.



Bristol Health & Wellbeing Board

Bristol Local Transformation Plan Refresh 2018	
Author, including organisation	Keirsten Wilson, Transformation Manager Mental Health – NHS BNSSG CCG
Date of meeting	28 th Sept 2018
Report for Decision	

1. Purpose of this Paper

NHS BNSSG CCG lead on the development of an annual refresh of the Children and Young People’s Local Transformation Plan (CYP LTP) with the aim of meeting as many of the Key Lines of Enquiry (KLOEs) as possible. This is developed in partnership with the Local Authority including Public Health.

In April 2018, NHS Bristol Clinical Commissioning Group (CCG) merged with NHS South Gloucestershire and North Somerset CCGs to form Bristol North Somerset & South Gloucestershire (BNSSG) CCG. As this is new we have continued with specific LTPs, however from 2019 the intention is for the plans to be more aligned. Our Bristol LTP links closely with our local BNSSG Sustainability and Transformation Plan (STP).

BCC Public Health has led on the development of the all age Thrive Mental Health Strategy which when published will inform future Transformation plans.

The plan requires sign off by each area Health & Wellbeing Board and as part of that approval pathway; the Children & Families Partnership Board. Along the way NHSE requires three submissions of the plans with subsequent feedback for improvements. At this time; the second has gone with feedback from the first submission incorporated. We are now waiting for the second round of feedback.

2. Executive Summary –

The LTP (see Appendix a) includes the following –

2017/18 achievements

- CASCADE (CAMHS & Partnership) Training delivered to all 94% of schools with new referral pathways from schools to CAMHS.
- Establishment of school mental health network meetings
- Bristol Healthy Schools’ award mental health and wellbeing badge
- 10 Heads of Wellbeing pilot
- Kooth on-line counselling now substantively sub-contracted within the Community Children’s Services contract.
- Refreshed on-line directory.
- Further system wide training

- Early Years developments
- Extension of the CAMHS Triage Assessment and Outreach (CTAO) service to weekday evenings and 9-5pm at weekends.
- New mental health and speech and language posts to support children in the YOT and at risk of offending.

Plans for 2018/19 and beyond

- Achieving the access target of 32% of children with a diagnosable condition are able to access evidence-based services by April 2019
- Ensure our community eating disorder team enables 95% of children and young people to receive treatment within four weeks of referral for routine cases and one week for urgent.
- Development of the i-Thrive whole system approach alongside Strengthening Families programme.
- The BSG Transforming Care Partnership Plan pilot for children with autism avoiding out of area placements is in progress.
- The Integrated Personalised Commissioning pilot for children in care and Care Leavers is in progress.

Note additional £1.25 million CCG investment in CYP mental health services across BNSSG. The focus will be on expanding and developing the current BSG CTAO to cover BNSSG and to operate 24/7, develop BNSSG eating disorder services and enhance core CAMHS. The aim is to develop more integrated BNSSG services.

Note the challenge of increasing levels of demand and challenges relating to workforce recruitment.

3. Recommendations for the Health & Wellbeing Board –

- To sign off Bristol Children and Young people's Emotional Health Transformation Plan annual refresh in readiness for final submission to NHS England and Health & Wellbeing Board on the 31st October.

4. Report

Evidence of need and the case for change

The case for prevention and early intervention in relation to children's mental health is well documented:

- 50% of all lifetime mental ill health begins by age 14, 75% by 18.
- In Bristol it is estimated that at least 2500 children aged 2-5, 5100 children aged 5 – 16 and 1700 16 and 17 year olds have a diagnosable mental health problem¹, based on prevalence rates calculated in 2005 (ONS). This is likely to be a conservative estimate with new prevalence data due to be made available in early 2019.
- At our current state of knowledge at least 33% of people with significant mental health problems will still have the same level of difficulties or worse even after the most evidence-based and specialised input.²

¹<https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+March+2017/0d364755-31a1-7d6e-0512-4eacdb3231e9>

² Warren et. al. 2010

In 2017/18 we achieved NHS England's access target whereby 30%³ of children and young people with a diagnosable mental health condition receive treatment from an NHS-funded community mental health service

In Qtr. 4: CYP with Eating Disorders

- 100% of urgent CYP were seen within one week
- 90% of routine CYP were seen with four weeks

Healthwatch provided recommendations for service improvement following a review and CAMHS undertake service user feedback to inform their service development.

Development of the LTP is a national requirement based on the Five Year Forward View for Mental Health (2016)⁴ with policy directive set out in 'Future in Mind' (2015)⁵ – 5 year transformation programme for children and young people's emotional health.

i. Evidence of effectiveness of proposed solution/initiative/new service –

All pilots are evaluated before commissioned.

ii. Impact on health inequalities –

Various aspects of the plan positively impact on vulnerable children such as those in care and young offenders.

iii. Financial and legal implications – N/ A

Section 75 Pooled budget for CAMHS in place. Agreed financial expenditure and budget included in plan as required.

5. Appendices

- a) Bristol children and young people's emotional health and wellbeing transformation plan refresh 2018/19

³ NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

⁴ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

⁵ <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

Children and Young People's Mental Health and Wellbeing Local Transformation Plan 2018-2020

Bristol

October 2018 Refresh

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DRAFT

1. Introduction

In summer 2015, the Departments of Health and Education published a joint five year strategy 'Future in Mind'¹ to transform services for children and young people's emotional health and wellbeing.

In response we published a comprehensive transformation plan for Bristol; refreshed each year in order to update in relation to key achievements and proposed activity as we work towards the provision of a joined-up and comprehensive approach to children's mental health across the City.

Our vision for 2015 to 2020 remains to ensure that every child, everywhere, receives the right support, as early as possible via a whole system, whole City approach to emotional health and wellbeing. Much broader than just Children and Adolescent Mental Health Services (CAMHS), this includes working with schools, the local authority, universal and primary services such as GPs and school nurses, as well as the voluntary and community sector.

In July 2016, NHS England published 'Implementing of the Five Year Forward View for Mental Health'². This guidance identified new areas for us to focus on and this has again been included in our plans for 2018/19. This plan does not include our work on perinatal mental health, as that is covered elsewhere.

In April 2018, NHS Bristol Clinical Commissioning Group (CCG) merged with NHS South Gloucestershire and North Somerset CCGs to form Bristol North Somerset & South Gloucestershire (BNSSG) CCG. Our Bristol LTP links closely with our local BNSSG Sustainability and Transformation Plan (STP) and contributes to the Integrated Assessment Framework. The key headlines are:

- Priority across BNSSG to improve access and waiting times for children and young people who need evidence based interventions for diagnosable mental health conditions, providing parity of esteem with physical services.
- Building resilience through the delivery of training to non-specialist workforces to improve capacity and capability to support children and young people in community settings
- Services are part of the children and young people's Improving Access to Psychological Therapies Collaborative, but this needs to be developed in both specialist and wider children and young people's workforce

¹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

²<https://www.england.nhs.uk/mentalhealth/taskforce/>

- Work towards a sustainable 24/7 urgent and emergency mental health service
- Provide community eating disorder services, compliant with access targets and independently accredited
- Improve access to and quality of perinatal and infant mental health care
- Deliver improved access to mental health support to children and young people at risk of or in the early stages of criminal justice involvement.
- Ensure data quality and transparency - increase digital maturity to support interoperability of healthcare records

The STP plans on a page relating to this area of work can be found in Appendix 1.

From April 2017 we have had a new contract for community children's health services led by Sirona with Avon Wiltshire Partnership delivering the CAMH and Off The Record services. The new service specification was informed by:

- Around 900 young people
- Over 300 parents and carers
- 19 schools
- 38% of those we spoke to were from the Black Minority Ethnic community
- 21% were from 'seldom heard' communities
- 61% were females and 39% were males

We have spoken to people with different protected characteristics from communities such as Gypsy Roma Travelling (GRT), Black Minority Ethnic, Polish, Somali, faith groups and those with sensory impairments

The emphasis on participation continues in the new service developments including expanding sessional and performance review feedback and supported by the new participation contract with Barnardos. In addition, we continue to work closely with Off The Record's campaign group Mentality along with the Youth Council and Freedom of Mind Community Interest Company.

Recent feedback from young people and their families report that the CAMH service is non-stigmatising, accessible and delivered in a joined up way with other services for young people. From 2017/18 Experience of Service Questionnaire responses:

I feel that the people who have seen me are working together to help me – 90% (243/270)

I feel that the people who saw me listened to me – 94% (255/270)

I was treated well by the people who saw me – 92% (257/270)

My appointments are usually at a convenient time (e.g.; don't interfere with school, clubs, college, work) – 87% (234/270)

There are agreements in place regarding sharing out of hours support with Tier 4 inpatient provision. Our evidence-based Early Intervention Psychosis service is available for all children and young people with Early Intervention Psychosis (EIP) taking the lead from age 16 and CAMHS taking the lead under 16.³

There are monthly performance meetings for the new contract with Local Authority and Clinical Commissioning Group commissioners; all NHS commissioned CYP mental health services are outcome commissioned (CAMHS, OTR, Kooth). Our Children and Young People's Local Transformation Plans are progressed across Bristol, North Somerset and South Gloucestershire (BNSSG) through our BNSSG STP/Emotional Health Transformation meetings.

The Mayor of Bristol, Marvin Rees has continued to make the emotional wellbeing of children and young people a priority. It is also one of four priorities in Bristol's Strategy for Children, Young People and Families 2016⁴ – 2020. In addition, the Youth Mayors have included reducing stigma and focusing on male mental health as part of their manifesto⁵. The recently updated JSNA chapter on children's mental health⁶ is being used to inform Public Health and wider system work via the development of an all-age mental health strategy, an important aspect of our whole-city Thrive approach⁷. The all-age strategy includes a dedicated 0-25 years' strand, the development of which is being supported by the Centre for Mental Health. The JSNA references various groups of children more at risk of mental health issues and inequalities such as those who have been abused or neglected. This is an opportunity to build on our work to date and ensure a wide range of stakeholders are also involved with the development of this programme of work.

This transformation plan has been developed with the involvement of the Health and Wellbeing Board, the Children and Families Board and the Joint

³ NHS England feedback on 2016/17 LTP requested more details about EIP in the 2017/18 LTP: In 2017/18 the EIP service supported 4 under 16s and 12 16 – 17s in Bristol.

⁴ www.bristol.gov.uk/cyf

⁵ https://www.bristol.gov.uk/en_US/youth-council-youth-mayors

⁶ <https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+March+2017/0d364755-31a1-7d6e-0512-4eacdb3231e0>

⁷ <https://www.bristol.gov.uk/mayor/thrive-bristol>

Health Outcomes Challenge sub-group and the TCP Steering Group. Relevant reports are taken to the Bristol Children's Safeguarding Board. We also work closely with colleagues across the region and play an active part in the Strategic Clinical Network. Nationally we learn from other areas with similar issues or that have implemented innovative ways of delivering services.

We will keep engaging with a variety of stakeholders to develop our plans over the course of the programme, which runs until 2020.

2. What have we achieved since our last transformation plan in 2017/18?

We have continued to develop, build on and implement our programme of transformation since we published our last transformation plan refresh in October 2017⁸. This has built on our work since 2015 and supports our vision of ensuring that every child, everywhere, receives the right support, as early as possible.

In September 2017, Bristol was one of the ten areas chosen for inspection by the CQC as part of a Thematic Review of whole-system CYP mental health services. Chosen due to the work undertaken by Bristol in relation to the roll out of CASCADE (CAMHS & Partnership) Training to 94% of schools, learning was used to inform the *Transforming children and young people's mental health provision* Green Paper published in December 2017.

Our May 2016 survey of schools informed us that schools either deliver or commission the following:

⁸<https://www.bristol.gov.uk/documents/20182/305531/CYP+Emotional+Health+and+Well+Being+Transformation+Plan+refresh+2017+to+18/455cdb91-2433-4bf8-8b7e-5bebd97bc60f>



What's happening in Bristol schools?

Children & Families
PARTNERSHIP

Primary:

- Play Therapy
- SEAL
- Mindfulness
- Restorative Justice
- Nurture
- Thrive
- Friends
- Mentoring
- Lego Therapy
- Pastoral Support Team
- Family Link Worker
- Learn Together
- Educate together
- Core Skills inc. Edison
- Conflict Resolution
- JIGSAW
- Behavioural Support
- Consultation and supervision around cases
- Educational psychology
- Group Counselling
- Individual Counselling
- Learning Mentor
- Parent Support Advisor
- Parenting Programme
- Staff training
- Staff wellbeing support
- Thrive training

Secondary:

- MAST
- Anxiety Groups
- Butterfly therapy
- SEAL
- Mindfulness
- Restorative Justice
- Nurture
- Thrive
- Friends
- Behavioural Support
- Consultation and supervision around cases
- Educational psychology
- Group Counselling
- Individual Counselling
- Learning Mentor
- Parent Support Advisor
- Parenting Programme
- Staff training
- Staff wellbeing support
- Thrive training



Bristol Clinical Commissioning Group

Work with schools has progressed as follows:

Work with Schools

Following CASCADE (CAMHS & Partnership) Training which was commissioned and successfully rolled out to 94% of Bristol schools, including special schools, between January and May 2017 there have been a number of sustainability initiatives and development opportunities put in place to support schools in relation to their emotional health and wellbeing work:

Mental Health Area Network Meetings were set up in consultation with schools. The networks, facilitated by Public Health colleagues, aim to support the ongoing development and sharing of good practice across education settings. They are run termly (3 times per year) and on a locality basis across North, South and East Central Bristol. As well as Mental Health Leads, the Networks are also attended and supported by other professionals such as CAMHS Primary Mental Health Specialists, Early Help (Families in Focus staff) and beyond. Over 80 people attended the second round of meetings and feedback has been consistently positive.

The newly launched Public Health **Bristol Healthy Schools' Award Mental Health & Wellbeing Badge** has been well received by Bristol schools who are encouraged to sign up and work towards achieving the badge which is focussed around a 'whole school approach' to mental health. It is comprised of a set of standards, developed in partnership with Bristol schools and in line with Public Health England and NICE guidance. The award is part of a wider Bristol Healthy Schools award and is endorsed by Bristol's elected Mayor. Thirty-four schools are actively working towards the badge and forty have registered their interest. Eight schools have achieved the award with one of these having achieved the advanced level.

The **10 Heads of Wellbeing** from Bristol primary, secondary and special schools residing in the most deprived areas of the City are coming to the end of their pilot year. Headlines are as follows⁹:

- In the majority of pilot schools the role will be continuing; two of the academies have created a trust-wide lead for mental health.
- As of the end of the academic year 2017/18, half of the pilot schools have achieved the Mental Health & Wellbeing Badge. The remainder are due to submit early in the next academic year.
- Across the schools a vast number of interventions and activities have been initiated and implemented; anti-bullying programmes, positive behaviour management and reward systems, whole school activities to celebrate diversity and tackle racism, the development of more robust systems to identify and support children who need additional input, the delivery of evidence based interventions, etc.

The pilot will be fully evaluated by Bristol Educational Psychologists. In the meantime, emerging practice is being disseminated via the Schools' Mental Health Networks during May and Nov/Dec 2018 meetings.

Key factors impacting upon the role can be summarised as follows:

- The size and structure of secondary settings pose challenges to establishing/embedding the role.
- The ability of the professional within role to lead and influence a whole school approach is influenced by their status, prior experience, knowledge and skills.
- Senior Leadership Team buy-in is key to the success of the role.
- The current school context is very challenging with factors such as staff capacity issues and stress levels impacting upon the success of the role. In two of the settings, the person in the role has changed over the course of the pilot.

Primary Mental Health Specialists from CAMHS continue to work with schools (including BESD) to provide training, consultation and some direct work and our newly commissioned providers of 11-18 counselling (Off The Record) and online provider (Kooth) are working closely with schools in the City (see below).

New CAMHS referral pathways which have allowed schools to directly refer in to the service have been in place since Autumn 2017 with new arrangements being closely monitored.

In December 2017, commissioners along with colleagues from Public Health and CAMHS presented at Public Health England's South-west Mental Health in Schools Masterclass, detailing our transformation journey across schools and the wider system. In June 2018, commissioners presented at the

⁹ NHS England feedback on 2016/17 LTP requested the detail of progress against the Heads of Wellbeing Pilot in the 2017/18 LTP.

University of Manchester's Institute of Education's inaugural conference entitled Mental Health & Education: Building Relationships to share information and learning about the whole-system approach to CYP mental health transformation in Bristol.

Progress of work across other aspects of the system is as follows:

- **Online Directory**

Published in June 2017, our Online Directory for 0-25 year olds, their families, carers and professionals has undergone its first refresh in following consultation with stakeholders, including young people earlier this year.¹⁰

- **Training**

Between 2015 and 2018 we made significant investment to ensure the additional capacity and capability of the Bristol workforce in order to support the principles of prevention and early intervention. Previous plans give details of the following training:

- 402 social care and early help (Families in Focus) staff; emotional trauma with a focus on self-harm and suicidal ideation.
- 48 school nurses, sexual health nurses & Youth Offending Team practitioners; Mental Health First Aid (MHFA) Training.
- Incredible Years Parenting Courses; 22 practitioners trained with 16 going on to deliver courses. 86 parents completed the evidenced-based programme via a total of 12 courses.
- 126 Youth Workers trained in Youth MHFA.
- 115 Children's Centre staff received training in 2016/17 with sharing undertaken across the wider networks.

Further progress has been made since our last LTP refresh:

An additional Incredible Years parenting course was delivered in Autumn 2017 as part of the original commission outlined above; a total of 100 parents trained over a total of 13 courses.

The first wave of Youth Mental Health First Aid courses to Youth Workers across the City resulted in high demand. Additional funding allocated has ensured sustainability of approach with the training of two staff as part of a MHFA train the trainer programme. To date, those trained have delivered 2 x 16 hour courses to Families in Focus team (Early Help) and to faith-based Youth Workers; 32 people in total. The two trainers will also go on to become

10

https://media.bnssgccg.nhs.uk/attachments/Emotional_health_and_wellbeing_directory_FINAL_2018_1HObjhB.pdf

MHFA Lite trainers allowing them to offer a menu of training options in the future.

Bristol CCG and the South West Strategic Clinical Network Innovation Fund funded Off The Record to develop open access drop-ins (called Youth Hubs) each week in both established premises and on a pop-up rotational basis in local youth and community settings. This project built upon and expanded existing support which combines quality participation (hubs are co-delivered by OTR Engagement staff and trained Peer Navigators aged 18-25) with information, signposting, psychological education and wrap-around specialist support (including counselling, creative therapies, IAPT and CYP-IAPT therapies, group work, online therapies, and specialist youth groups for issues of gender and sexuality as well as race and ethnicity). Activity covered the period December 2017 – May 2018 and focussed on the following outcomes:

- More CYP can access flexible, responsive and open Youth, Information, Advice and Counselling Services (YIACS) within their local communities
- Reduced demand on primary and secondary care services (including reduced CYP hospital admissions for mental health conditions and self-harm; reduced A&E attendances)
- Improved support for young people with emotional wellbeing and mental health needs
- Increased number of CYP in crisis responded to in community settings (away from A&E)
- Improved outcomes for vulnerable and disadvantaged CYP

In addition, the following, which was not funded from the CYP Emotional Health Transformation fund, has been supported over the life of Transformation to date:

- 24 secondary school staff trained in MHFA as part of first wave of a three year Government pilot to ensure at least one member of staff trained in all secondary settings.
- All Children's Centres have accessed professional development with 'Five to Thrive' – supporting healthy attachment and emotional development in the earliest years <https://www.fivetothrive.org.uk/>
- The pre-natal Mental Health HIT is strengthening pathways for new parents who may be experiencing mental health challenges
- Children's Centres also work with Bluebell and commission Rockabye – a programme that promotes the formation of secure attachment.
- Four Children's Centres host Drop-In Services for Gypsy, Roma and Traveller (GRT) families, working with a dedicated Health Visitor. Over 300 GRT families have accessed Health Services for the first time through this route

- Children's Centres play a key role in Bristol's strategy to support children affected by parental imprisonment (CAPI)
- Strengthening the Circle' training, funded by Health Education England has recently been delivered in Bristol. This training aims to strengthen the skills, confidence and competence of the joint agency non-specialist workforce – those who provide the circle of support around individual vulnerable children and young people.

Additional whole-system developments have also been made during the course of transformation:

•Online counselling and support

Our online counselling and support service for all 11-19 year olds in Bristol www.kooth.com continues to be well utilised having been widely promoted across secondary schools and colleges by an Involvement and Participation Worker. From the 1st April 2018 the service forms part of the Community Children's Health Partnership and has fully integrated care pathways with Off The Record and CAMHS.

Within Off The Record there are 6 qualified Psychological Wellbeing Practitioners¹¹ (PWPs) posts and 3 who are currently in training until March 2019. All work to a strict referral criteria and are supervised by trained supervisors who have been through the CYP-IAPT programme in Exeter. The PWP build relationships with schools and utilise physical space, safeguarding leads and other school staff in order to support referrals for young people who would benefit from short term, low intensity Cognitive Behavioural Therapy (CBT) interventions. Referrals are for young people with low mood and anxiety along with a range of other presentations. The work, which is short-term and focused on self-care and home practice, is young person centred and driven by the desire to reach young people where they are before the issues they are experiencing become entrenched and problematic.

Working with GPs and primary care

The information available on the GP referral support tool has been reviewed and updated. This provides GPs and other primary care staff with information on how to signpost and support children and young people and their families to a wider range of services and resources than just those commissioned by

¹¹ The Health Education England led programme to create Psychological Wellbeing Practitioners is a response to the target for offering an evidence based intervention to 70,000 more children and young people annually by 2020, by training up 1700 new staff in evidence based treatments, outlined in Implementing the Five Year Forward View for Mental Health. These posts will enhance services, to ensure they are equipped to see children and young people who wouldn't otherwise reach local thresholds for CAMHS; they will be distinct roles, not assistants to existing therapists or working from specialist settings.

the NHS. It also includes a link to our newly refreshed online directory, first published in June 2017¹².

A crisis risk screen tool which was developed by CAMHS and GPs is also included. This supports GPs in assessing children and young people who present in mental health crisis and in providing an appropriate level of response.

Self-harm

Self-harm is a manifestation of emotional distress rather than a primary disorder. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the motivation or intent¹³. Young people are at high risk of self-harm, with a hospital admission rate of 404.6/100,000 among 10-24 year olds in England in 2016/17, compared to 185.3/100,000 for all ages¹⁴. Risk factors for self-harm include socio-economic disadvantage, being socially isolated, stressful life events, mental and physical health problems, and alcohol or drug misuse.¹⁵

The Partnership Outreach Service (CAMHS/Off the Record/UHB/Families in Focus (Early Help) commenced in Sept 2015 as a pilot. This service and the Central Intake Team provided assessments for children who presented with urgent mental health needs primarily to the Emergency Department and provides an outreach service for those not engaged in a service. The pilot has since been fully evaluated and these two teams merged to form the CAMHS Triage, Assessment and Outreach (CTAO) Team. GPs are now referring to this service rather than the child presenting to the Emergency Department.

The CTAO Team triage referrals and see all young people who present in crisis at the hospitals and who require urgent appointments following referral. The service has recently extended the hours of provision to 8am-10pm weekdays and 9am-5pm at weekends. The team provides limited outreach work through Off The Record staff who require additional supervision and routinely work alongside a qualified member of staff.

Recently agreed transformation funding will further support the expansion of this service¹⁶. Nationally and locally the number of young people presenting in crisis has significantly increased. This data has only been captured accurately since 2017; it is therefore difficult to review trends. The number of children accessing these services has increased across Bristol and South

¹²

https://media.bnssgccg.nhs.uk/attachments/Emotional_health_and_wellbeing_directory_FINAL_2018_1HObjhB.pdf

¹³<https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/15/par/E92000001/ati/6/are/E12000004/iid/21001/age/1/sex/4>

¹⁴<https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/0/gid/1938133090/pat/6/par/E12000009/ati/102/are/E06000023/iid/92796/age/7/sex/4>

¹⁵

<https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+March+2017/0d364755-31a1-7d6e-0512-4eacdb3231e0>

¹⁶ For further details of additional CCG investment, please see Section 4. Where are we now?

Gloucestershire from 315 in 2014 to 364 in 2015 and 391 in 2016 and 456 in 2017/18.

The initiatives above all aim to contribute to reducing self-harm but nationally it is increasing due to a range of issues including the impact of social media.

As outlined above, suicidal ideation and self-harm training was run for social care and Families in Focus staff to support increased confidence, capacity and capability in relation to early identification and to enhance the support of Practice Leaders within the teams. Practice Leaders are still developing an assessment tool and are clear about their roles:

- Leading on practice
- Equipped in completing initial assessments of a child or young person's health and social care needs
- Producing the assessment tool
- Developing and supporting safety plans and risk assessments with children, young people and their families.
- Mentoring staff
- Offering a network of support
- Sharing knowledge and skills within their service
- Linking with multi-agency partners when required.

Health & Justice

The review of mental health support for children and young people involved in the criminal justice system¹⁷ prioritised 3 areas for BNSSG:

- Additional mental health support embedded in the YOS
- DBT provision – supporting CYP with Trauma
- Specialist speech and language therapy (SALT) for CYP in the community and secure care home Vinney Green

The speech and language therapy (SLT) service into Youth Justice was set up June 2017 following a successful bid for funding by the South Gloucestershire Clinical Commissioning Group to NHS England. The recurrent funding provides for 4 SLT days a week into South Gloucestershire Youth Offending Service, Bristol Youth Offending Service and Vinney Green Secure unit.

Delivery of Trauma and Recovery training as part of an Enhanced Case Management approach has been undertaken by professionals from the Youth Offending Services and multiagency professionals who work with CYP with criminal justice system involvement.

From Spring 2018, the Bristol YOS have directly employed a Primary Mental Health Specialist working within Bristol's multi-agency Families in Focus

¹⁷ NHSE (2016) Review of Health and Justice Pathways for the CAMHS Transformation NHS England South (South West and South Central); A,Hewitt.

(Early Help Team). The role is still in its infancy with the post-holder working with a variety of organisations and professionals to clarify priorities and approaches to this sensitive area of work.

Forensic CAMHS for Bristol is provided by Oxford Health covering South West 'North'. Care pathways are outlined within the attached service specification at Appendix Four.¹⁸

3. What are we planning in 2018/19 and beyond?¹⁹

Improving Access

The Five Year Forward View for Mental Health (MH5YFV) highlights children and young people as a priority group. It highlights the importance of prevention at key moments in life, mental health promotion and commits to "by 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it". A recent Healthwatch report, the result of capturing the views of residents in Bristol, North Somerset and South Gloucestershire who had used CAMHS in the last 12 months, recommended that wait times be reduced in order that young people can access the service as quickly as possible.

The *2017-2019 NHS operating planning and contracting guidance*²⁰ stipulates:

- More high quality mental health services for children and young people (32% of children with a diagnosable condition are able to access evidence-based services by April 2019).
- Commission community eating disorder teams (95% of children and young people receive treatment within four weeks of referral for routine cases and one week for urgent).

There is a national ambition that by 2020/21, at least 35% of children and young people with a diagnosable mental health conditions receive treatment from an NHS-funded community services. This data is currently reported to NHSE every two weeks.

In addition there is other activity; for example, voluntary sector activity along with any work happening in schools. For example, it is acknowledged that some schools employ their own counsellors, learning mentors and family support workers. In addition, we know that schools also commission services to support mental health, often from the rich mix of VCS organisations within the City. However, within the current environment of challenging school finances we are aware that these additional pastoral resources and

¹⁸ NHS England feedback on 2016/17 LTP requested information re. pathways for CYP in contact with health and justice in relation to specialised commissioning in the 2017/18 LTP.

¹⁹ NHS England feedback on 2016/17 LTP requested inclusion of sustainability plans beyond 2020 (future work/planning) in the 2017/18 LTP.

²⁰ <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>

commissions cannot be considered secure and may, in many cases, be reducing. However, Local Authority Early Help services are being remodelled and will include a Team around the School (TaS) approach which is outlined in further detail below. In addition, we are also developing an all age mental health strategy which will link in with the developing work resulting from CAMHS i-Thrive, both of which are also detailed below.

We aim to continue to improve the level of access to NHS funded services. We are awaiting publication of the results of the 2018 ONS survey which will provide updated national prevalence data. We expect to see prevalence rates rise which would affect the number of children that services would be expected to treat in order to achieve the 2018/19 access target of 32%.

In 2017/18 we achieved NHS England’s access target whereby 30%²¹ of children and young people with a diagnosable mental health condition receive treatment from an NHS-funded community mental health service. This is based on our activity figures from our providers (CAMHS, Off The Record, www.kooth.com). The percentage is calculated based on figures for our child and young people population in Bristol using data from the refreshed JSNA chapter on children and young people’s emotional health and wellbeing, as referenced elsewhere within our LTP. MHSDS data is flowing from Bristol CAMHS and Off the Record already and will be from Kooth following a national data flow solution which is in development and should be available in October.

The new access times are being monitored as part of the Key Performance Indicators within the new service specifications with the aim of reducing Emergency Department Crisis referrals to be seen within 2 hours, urgent referrals to being assessed within one week and routine within 4 weeks.

Commissioners work closely with the Children and Young People’s Programme Manager within the South West Strategic Clinical Network to ensure adherence national and local expectations with regard to data recording and reporting. This also involves participating in regular webex/teleconference sessions and attending regional training and information sessions as required. Monthly meetings are in place with the lead provider to monitor the scorecard performance data of CAMHS, Off The Record and Kooth and to ensure they are up to date with data reporting requirements.

Following a recent demand and capacity analysis undertaken by our CAMHS provider, the following posts are required in order to support demand within urgent and crisis care:

Service	WTE	Banding	Cost
CTAO	6.20	3 x band 5, 3 x band 6	£220,180
Eating Disorder Team	4.20	2 x band 4, 2 x band 7	£155,187

²¹ NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

Recently negotiated transformation funding will support achievement of trajectories. Agreed milestones are detailed in a recently developed Gantt chart.

In terms of access waiting times, the percentage of patients seen in month within 18 weeks was 82.5 % in 2017/18. The increased funding will support the service to reduce waits, as will the ongoing implementation of the i-Thrive model.²²

A Psychiatry Liaison BNSSG project relating to 16 and 17 year olds was completed to increase clarity and more alignment of pathways across BNSSG. There has been training for adult Emergency Department staff. The pathways will be reviewed with future investment.

A joint CQUIN is in place regarding improving Transition. A Transition protocol has been developed and is being implemented and monitored quarterly against four key milestones across CAMHS and AMHS:

- Sending provider to undertake Casenote Audit assessing those who transitioned out of CAMHS.
- Sending provider to undertake assessment of discharge questionnaires for those who transitioned out of CAMHS.
- Receiving provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS to CAMHS.
- Sending & Receiving providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via Unify2 Collection.

In Q4 2017/18, 18 young people transitioned out of community CAMHS teams during; 9 to the care of their GP and 9 into Adult Mental Health Services²³.

Remodelling of Local Authority Early Help Services

Bristol's Early Help (Families in Focus) offer is in the process of being remodelled with a focus on understanding and supporting Adverse Childhood Experiences (ACEs). At the heart of the approach will be a Team around the School (TAS) offer, recognising that existing knowledge of, and relationships with families, are key to improving outcomes for children and families. Key principles of this approach will be to:

- Refocus resources on prevention rather than crisis intervention.

²² NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

²³ NHS England feedback on 2016/17 LTP requested numbers of children transitioning from CAMHS to AMHS in the 2017/18 LTP.

- Strengthen multi-agency partnership working in localities.
- Identify options for support for children and young people who have additional needs but do not require specialist services, preventing difficulties escalating to crisis point.
- Provide an opportunity for early conversations to take place about children and young people where schools have concerns.
- Support and engage with families more efficiently in relation to school related issues, identifying and removing barriers to learning and closing the gap for vulnerable groups in each locality.

Improve outcomes for children with SEND, ASD and severe behaviour problems.

Health are working closely with the local authority on the quality and timeliness of mental health input into Education, Health and Care Plans and engaging strategically with community children's health SEND governance.

Following the undertaking of a needs assessment of Social Communication and Interaction Needs (SCIN) and autism, which included the views of parents, gaps in services were identified. A multi-agency deep dive workshop included parents, social care and education with health as part of a wider whole system review of services for children with autism and social communication and interaction needs. This workshop focussed on identifying the needs of those at risk of hospitalisation, home or out of area school or social care placements with a view to if and how these needs could be met locally.

Building on our Intensive Positive Behaviour Support Service for children with Learning Disabilities Bristol and South Gloucestershire CCGs and Local Authorities submitted a bid to NHS England as part of the Bristol, North Somerset and South Gloucestershire (BNSSG) Transforming Care Partnership Plan. The pilot is extending our Positive Behaviour Support Service to meet the needs of children and young people with ASD/ Asperger's without a moderate or severe learning disability in order to reduce out of area and costly social care and education placements, also hospital inpatients. Early indicators are encouraging and initial outcome information will be available in due course. Schools benefit from the modelling by the IPBS whose techniques are then used with wider groups of children.

New basic training relating to autism is being accessed by the wider workforce and more specialist training is being developed CAMHS as part of the Increasing Access to Psychological Therapies (IAPT).

In terms of the Families in Focus Team around the School (TaS) one of key areas will be to identify options for support for children and young people who have additional needs but do not require specialist services, preventing difficulties escalating to crisis point.

For children presenting in crisis who have Autism/LD, the Crisis Triage Assessment & Outreach (CTAO) team establish if there is a specialist team already involved with the young person and, if so, liaise with them on how best to support. The options available would involve undertaking a joint assessment (utilising staff with LD/ASD expertise) or for the specialist team to lead. Decisions would be made based on what approach is in the best interest of the child or young person whilst liaising with the family in terms of previous input.

Integrated Personal Commissioning for Looked After Children (IPC LAC) Project

Bristol, supported by NHS England, are exploring new ways of working in a pilot known as Integrated Personal Commissioning (IPC). Looked-after children and care leavers aged 14-21 who meet specific criteria are being supported by way of small personal budgets to support equipment/activities aimed at improving their mental health and wellbeing. In relation to the small budgets, the project is currently working with 60 young people and has 40 live budgets with 20 at the referral stage. In addition, a small number of larger budgets have also been provided to support higher levels of need.

Those with early personal budgets are being encouraged to help shape the ongoing design of the project to ensure co-production with support provided by Barnardo's. Sustainability options are currently being explored in order to support the mainstreaming of the initiative.

Improve Data reporting²⁴

We are continuing to work closely with our providers to ensure comprehensive and high-quality data is submitted to the Mental Health Minimum Data Set²⁵. We are focusing on improving both the quality and quantity of the information available about service delivery and who is being seen. This intelligence will allow us to make more informed and transparent commissioning decisions in the future.

Develop new i-Thrive children and adolescent mental health model

Our new CAMHS providers are leading the development of this whole-system model with multi-agency partners. The model sets out four domains related to getting advice, getting help, getting more help and getting risk support. Children's mental health commissioners along with senior CAMHS managers have been closely involved in the development of Bristol's 0-25 mental health strategy to ensure the programmes, objective and subsequent outcomes are joined-up. Governance will include monitoring of outcomes at the Joint Health Outcomes Group.

²⁴ NHS England feedback on 2016/17 LTP asked us to report on the continued prioritisation of data access in the 2017/18 LTP.

²⁵ <http://content.digital.nhs.uk/mhds>

The Bristol context is characterised by a strong and diverse VCS who play a vital role in supporting children's mental health through a wide variety of programmes, initiatives and interventions. Some of these are commissioned directly by schools whereas others are embedded within specific communities – both geographic and cultural. Taking a strategic approach to the development of system-wide mental health services for children and young people's mental health is key to the success of both i-Thrive and our mental health strategy work. Working this way will continue to support our ability to understand and find innovative ways to address emerging gaps in the system for all age groups.

Improve Eating disorders service

With recent increased investment we will have, an evidence-based community eating disorder services for children and young people will be in place across Bristol within the next year. We are working towards ensuring that 95% of children receive treatment within one week for urgent cases, and four weeks for routine cases.

New NICE guidelines for the treatment of eating disorders were published in May 2017²⁶. We will ensure that eating disorders services in Bristol reflect the recommendations made and underpin the joint service across Bristol, North Somerset and South Gloucestershire, working towards being Maudsley Model compliant.

All referrals for young people with suspected eating disorders are diverted at the point of referral to the Specialist Eating Disorder Service. They make contact with the family or young person within 24 hours, Monday to Friday, and arrange to see urgent referrals within one week and routine referrals within four weeks. Young people are usually assessed within the national waiting targets however the total caseload is increasing which makes delivering ongoing treatment more challenging.

Both Routine and Urgent targets have improved over 2017/18 year. In Qtr. 4:

- 100% of urgent CYP were seen within one week
- 90% of routine CYP were seen with four weeks²⁷

Our CAMHS provider has additional staff in post, funded by transformation monies. Recently secured additional transformation funding will support the ongoing development of this team. They are continuing to develop a model of

²⁶ <https://www.nice.org.uk/guidance/ng69/chapter/Recommendations>

²⁷ NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

care that covers BNSSG and are a member of the Quality Network for Community CAMHS – Eating Disorders²⁸.

We also funded a research project with stakeholders to get a better understanding of how we can improve primary care for children and young people with eating disorders via Bristol Health Partners²⁹. This involved exploring with patients, their families and GPs how children and young people with eating disorders can best be supported by primary care providers.

Improve Crisis care and reduce inpatient treatment

We are working with colleagues in NHS England and across our Sustainability and Transformation Plan footprint to develop a collaborative plan for commissioning pathways including inpatient beds. The intention is to develop appropriate community services and potentially home treatment to reduce the need for inpatient admissions, especially in out of area facilities.

We developed an initial BNSSG wide collaborative commissioning plan with our local NHS England team by December 2016. Since then, we have engaged with NHS England to explore how we can develop and improve services further.

We are also working in partnership with the Local Authority, the police and hospitals to get a better understanding of the needs of children and young people in crisis, and identify if there are gaps in the services provided.

For more information about our CTAO, please see information outlined elsewhere within our LTP.

- **Develop the workforce**

We continue to prioritise workforce development, as outlined within our LTP. In Bristol we are part of Wave 2 of the South West CYP Improving Access to Psychological Therapies (CYP IAPT) Collaborative Programme. Historically, this has included NHS Bristol making a financial contribution to the salary support costs of CYP IAPT training from our transformation funding. Again, additional CCG funding has been secured in 2017/18 to support the IAPT programme and ensure sustainability³⁰. Our CAMHS and Off The Record service are commissioned to be CYP IAPT compliant and we continue to promote and integrate the principles and values throughout the wider workforce. Aggregated routine outcome measures will be available in Sept to set as a baseline prior to agreeing trajectories of improvement. Feedback from CYP is gathered via the use of ROMs and used to inform ongoing therapeutic support. Parents/carers feedback is given via the Experience of Service Questionnaire. six months into treatment.

²⁸<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/childandadolescent/communitycamhsqncq/qncc-ed.aspx>

²⁹ <http://www.bristolhealthpartners.org.uk/health-integration-teams/eating-disorders/projects-and-activities>

³⁰ NHS England feedback on 2016/17 LTP requested information regarding sustainability for CYP-IAPT in the 2017/18 LTP.

Demand and capacity modelling identified additional staffing needs and as a result investment has been made available through the Mental Health Investment Standard³¹. This will ensure a sustainable plan is in place beyond 2020. Additional investment has been provided to also ensure sustainability of IAPT. As a result of consulting with recent CAMH service users the recent Healthwatch report referred to above also outlined the need to improve staff understanding and attitude in order to ensure that patients feel listened to, treated with compassion, respect and kindness via the provision of holistic care. We will continue to work to ensure these standards are met via workforce development opportunities that influence both individual approaches and organisational culture.

Specialist training, including trauma recovery model training for a range of practitioners in Bristol working with vulnerable and complex children and young people, such as those who have been abused or neglected, took place in Autumn 2017. This training was funded by NHS England Health and Justice Collaborative Commissioning.

Parenting support has been identified in the JSNA and will feature within the 0-25 strand of the all-age mental health strategy. Over the course of the next 2-3 years the LA aim to roll out a universal parenting programme called Parent Gym for all parents with children starting at primary school. The offer will consist of taking part in a 6 week parenting course hosted by their school as part of their journey through their child's education process. As a result it is hoped that their relationship with their child will measurably improve as will their confidence in their own parenting ability along with their mental wellbeing. It is hoped that the course will support the formation of friendships and will lead, in some cases, to parents meeting regularly in a parent-led support group. This will in turn support the establishment of the parent/school relationship, supporting future communications and boosting the school's community engagement. Parent Gym was independently evaluated by UEL in 2011, and Canterbury Christ Church University in 2012 – which found that two months or more after they had completed the programme 100% of parents interviewed reported that their relationships with their children had improved. Parent Gym has subsequently been independently evaluated by the University of Hertfordshire (2014) and the University of Warwick (2014 & 2016).

We are also rolling out MHFA training to primary school staff. To support future sustainability, in late 2017/18 we commissioned a Youth MHFA Train the Trainer course which resulted in a multi-agency cohort of 10 trainers for Bristol. These trainers are now delivering courses to staff from primary settings. To date five two-day courses have been run with 64 staff trained. More courses have been arranged for the Autumn term 2018/19. Following feedback from schools in relation to their capacity to undertake training, these will be MHFA Lite courses. It is hoped that this shortened approach to the

³¹ NHS England feedback on 2016/17 LTP requested information regarding our continued prioritisation of workforce development, Identifying additional staff required (in addition to a workforce plan & CPD) in 2017/18 LTP.

training will increase the number of primary schools who are able engage with the opportunity.

We have also been approached by MHFA E as part of the Government pilot for secondary settings (see above) with regard to providing 'mop up' training for those Bristol settings not captured by the first wave of the training programme.

4. Where are we now?

Please see the table below for how much we spent in 2017/18 and plans for 2018/19:

Actuals				
Description	2014-15 Bristol CCG	2015-16 Bristol CCG	2016-17 Bristol CCG	17-18 Bristol CCG
Main block CAMHS	4,467,377	4,557,362	4,334,741	4,334,741
Total Block	4,467,377	4,557,362	4,334,741	4,336,131
Other				
Off the record	50,895	60,215	62,360	106,476
Crisis Outreach Pilot	400,000	61,724	-	-
CHC Children's	311,365	421,225	291,422	378,395
ED and transformation	-	869,411	1,028,551	998,576

CYP IAPT	-	51,250	196,750	171,000
Total other CAMHS	762,260	1,463,825	1,579,082	1,653,027
Combined Total	5,229,637	6,021,187	5,913,823	5,989,188

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BNSSG CCG - Bristol
Children and Young People's Mental Health and Wellbeing Transformation
Plan 2018 - 2019

Description	Planned 2018/19 BNSSG CCG -Bristol

CCHP (Sirona) CAMHS	£4,335,000
Total Block	£4,335,000
<u>Other</u>	
ED and transformation schemes	£1,217,000
Total Other CAMHS	£1,217,000
Combined Total	£5,552,000

In addition to the above, there will be

- £1.25 million that has been identified and agreed recurrently across Bristol, North Somerset and South Gloucestershire CAMHS. A proportion of this will be spent in 2018/19 in Bristol.
- further spending for the TCP autism pilot across Bristol / South Gloucestershire – funded by NHS England
- further spending for the Bristol Integrated Personalised Commissioning Pilot – funded by NHS England
- further spending on Continuing Care Children’s mental health.
- further spending from NHS England for IAPT.

Bristol City Council Spend and Budget

	14/15 - Actual Spend	15/16 - Actual Spend	16/17 – Actual Spend	17/18- Actual Spend	18/19 - indicative
CAMHS	864,595	878,516	992,854	897,234	970,620**
Social Care - Positive Behaviour Support Service (PBSS)	30,000	30,000	30,000	30,000	30,000
MTFC	0	93,781	105,255	79,767	72,637
Troubled Families	49,534	72,836	148,000	162,689	162,689
Early Years - Emotional Needs	9,063	12,642	23,708	32,744	32,744
SEN - PBSS	30,000	30,000	30,000	30,000	30,000
Youth Services - Counselling			84,000	84,000	*
	983,192	1,117,775	1,413,817	1,316,434	1,298,690

*The 84K shown here in previous years is incorporated in the CAMHS figure above **

There are other funding sources that include emotional health but these have not been possible to disaggregate such as Healthy Schools Programme, social care or educational support.

Please see the tables below for details of the workforce and activity of our specialist providers in 2017/18:

CAMHS Workforce 2017/18

Specialised CAMHS

Specialised CAMHS		
Position	WTE	NHS Band
Admin & Clerical	0.6	2
Admin & Clerical	2.5	3
HCA	2	3
Admin & Clerical	2.2	4
Assistant Psychologist	2.5	4
Nurse	1	5
Specialist Practitioner	0.8	6
Nurse	3.44	6
Social Worker	1.6	6
Therapist - Social services	0.7	7
Social Worker	0.5	7
Nurse	4.83	7
Psychologist	2.2	7

Nurse manager	0.6	8a
Psychologist	1	8a
Psychologist	0.7	8b
Psychologist	0.6	8c
Psychotherapist	1.8	8a
Psychotherapist	1	8b
Consultant	1.4	

Total WTE = 31.97

Bristol East and Central CAMHS

CAMHS East & Central		
Position	WTE	NHS Band
Admin & Clerical	1	2
Admin & Clerical	2	3
Admin & Clerical	0.5	4
Occupational Therapist	0.8	6
Nurse	3.53	7
Psychologist	2.51	7
Social Worker	2	7
Psychotherapist	2.02	8a
Psychologist	0.8	8b
Consultant Psychiatrist	1.22	

WTE total = 16.38

Bristol North CAMHS

CAMHS North		
Position	WTE	NHS Band
Admin & Clerical	1.65	2
Admin & Clerical	1.33	3
Admin & Clerical	1	4
Nurse	4.2	7
Team Manager	0.5	7
Psychologist	1.8	7
Psychotherapist	2.5	7
Psychologist	2.1	8a
Psychotherapist	1.5	8a
Psychotherapist	1	8b
Art/Music/Drama Therapist	1	8a
Clinical Service Manager	0.5	8a
Consultant Psychiatrist	1.55	

WTE total = 20.63

Bristol South CAMHS

CAMHS South		
Position	WTE	NHS Band
Admin & Clerical	1.6	2
Admin & Clerical	2.6	3
Admin & Clerical	1.81	4
Social Worker	0.6	6
Social Worker	1	7
Nurse	3.2	7
Team Manager	0.5	7
Occupational Therapist	1.8	7
Scientific Therapeutic Therapist	1	A
Psychologist	1.6	7
Psychotherapist	0.9	7
Psychologist	1.63	8a
Psychotherapist	0.5	8b
Psychotherapist	1	8d
Clinical Service Manager	0.5	8a
Trainee Psychiatrist	1	
Consultant Psychiatrist	2	

WTE total = 23.24

CAMHS activity 2017/2018

Total number of referrals for year	1385
Total number accepted	1188
DNA rate	5.80%

Off The Record workforce 2017/18 – Bristol & South Glos

WTE	NHS Band Equivalent
2.86	3
2.2	4
8.6	4/5
15.16	5
6	5/6
2.6	6
1.2	7

0.8	7/8a
1	8b

WTE = 40.42

Off The Record activity 2017/18

Total number of referrals to OTR	1529 (referred to treatment)
Total number seen in CCG services	2710 (1-1 = 590, groups = 60, Wellbeing Practitioner = 109 HUBS/ POP UP = 1951)
DNA rate for CCG funded services	7.3%

Kooth workforce 2017/18 (including staff working in Bristol service)

Kooth staffing and NHS Banding equivalent

WTE	NHS Banding
2	1
1	2
10	3
8.5	4
55.4	5
17.1	6
11.7	7
2	8A

Total WTE = 107

Kooth activity April 1st 2017- March 30th 2018

Total number referrals (registrations)	2,631
Total number YP receiving counselling	552
DNA-	0

5. Risk and Mitigation³²

Risk	Mitigation
Workforce/recruitment: National workforce capacity issues, slow recruitment processes within larger	Workforce Development Plan in place, BNSSG planning underway to support area-wide recruitment/sharing

³² NHS England feedback on 2016/17 LTP requested the outline of key risks and mitigating responses in our 2017/18 LTP.NHSE feedback.

organisations	of staff, continued participation in IAPT programme, comprehensive planning of projects and programmes.
Austerity: Reduced capacity due to cuts in funding across the wider mental health system including schools, VCS, Local Authorities (including Public Health)	Continue work develop whole-system, whole-city approaches to mental health to ensure resources can be maximised and gaps minimised, e.g.; Thrive and i-Thrive.
Co-ordination of work in schools: Academisation of education system poses challenges for the LA co-ordination of support/initiatives to schools.	Continued Public Health work (restructure allowing) to support whole-school approaches to mental health, support sharing of information and best-practice between schools via area-based Schools' Mental Health Network, support in relation to PSHE curriculum. Continue to work with senior LA and Education leaders to disseminate/share information and influence practice.
Merge of Bristol, North Somerset and South Gloucestershire CCGs; resulting restructure and change in staff roles, integration of services across BNSSG.	Clear inductions/handovers in place to support knowledge and understanding in child mental health commissioning and contract management. Detailed plans to support the integration of services across the STP footprint for CAMHS.

Appendix 1 STP BNSSG CYP Emotional Health Plans on a page



Appendix 2

AWP Bristol SGlos CYP emotional health joint workforce plan



AWP Bristol SGlos
CYP emotional health

Appendix 3

CYP emotional health Tier 4 Co-commissioning plan



CYP_emotional_health
h_Tier_4_co-commiss

Appendix 4

FCAMHS Service Specification



Community Forensic
Child and Adolescent

DRAFT



Bristol Health & Wellbeing Board

Title of Report	
Author, including organisation	Lisa King, Bristol Health Partners
Date of meeting	24 October 2018
Report for Discussion	

1. Purpose of this Paper

To explore opportunities for Bristol Health Partners (BHP) to collaborate with the HWB and support its objectives.

2. Executive Summary – to include the main points for the HWB to consider

BHP is a strategic collaboration between the city region's major health institutions, covering the Bristol, North Somerset and South Gloucestershire area. These include its three NHS trusts, its clinical commissioning group, two universities and Bristol City Council. These organisations have formed Bristol Health Partners voluntarily, and we are funded by contributions from five of the partners.

Our unique Health Integration Team (HIT) model

Our Health Integration Teams tackle health priorities by working in new ways, harnessing the best research, innovation, care and education to make a difference to people's health. Our HITs must evaluate, involve patients and the public and have a whole system approach. This pioneering approach to research, health service and public health integration can help solve the challenges our City faces today.

Using Data Better

Alongside our HITs, we also have a strategic programme of work called 'Using Data Better'. Using data better has been a strategic priority for Bristol Health Partners since 2015.

It recognises that the routinely collected information across health and social care in our region is an underused resource, that can benefit from academic input and collaborative work.

Collaborative Working

Much of the work we already do, particularly through our Health Integration Teams, is already in collaboration with other networks and initiatives across the BNSSG Health and Social Care system.

For example we;

- support Healthier Together work programmes such as Prevention,
- contribute to JSNA chapters,
- mobilise capability around topics such as fuel poverty and cold homes,
- work to empower patients to take the lead role in their care.

HIT work broadly falls into 4 categories;

- a) Chronic health conditions
- b) Public health interventions
- c) Mental Health
- d) Equitable, appropriate and sustainable health and healthcare

Through their work, the HITs are addressing the priorities set out by the HWB (such as Alcohol and Suicide Prevention). Their work will also help the City deliver the long-term aims set out in the Health theme of the One City Plan.

Our Better Use of Data programme also supports key elements of the One City Plan such as;

- empowering patients to take the lead role in their care,
- efficient processes, systems and technology, empowers staff to deliver high quality and outcome focussed services,
- digital solutions to prevention, health care and social care challenges

3. Recommendations for the HWB to Agree

The Board is asked to discuss how we might build on existing collaborative activity and strengthen the links between BHP and the HWB. A consideration of future opportunities could include;

- Supporting a One City Approach
- Utilising the HIT model as a platform for collaboration and implementation of change
- Addressing health inequalities
- Mobilising capability to solve health challenges and improve population health
- Promoting the Bristol brand, locally, nationally and internationally
- Leveraging external funds into the region

4. Main body of the Report

As a membership organisation, we are able to understand and serve the needs of our partners and local population, rather than the agenda of a distant funding body.

The partnership includes commissioning and public health, which is rare among England's health partnerships, giving a broader interpretation of health and its determinants. This broader membership means we do not focus solely on illness, but also address lifelong health and how to prevent illness in the first place.

Our purpose

We exist to improve the health of those who live in and around Bristol and to improve the delivery of the services on which they rely, and to act as a mechanism for change in our health and care community and our city region.

Our vision

Our shared vision is for those who live in the Bristol city region to enjoy the highest possible quality of life and experience of care. We want our area and health and care system to be known for:

- Equality of access, experience and outcome
- Excellence in research
- Promotion of innovation
- Connectedness and collaboration

HITs

HITs are maximising and integrating research, service delivery and prevention. Bristol has considerable health and social care research strengths, and we help make the most of them through integrating academia, the health service, public health, social care and commissioning. We apply science to service delivery and improvement, so that change is more effective and likely to succeed. Involving patients and the public is essential to success, and the partnership empowers health professionals, commissioners and policy makers to make the most of opportunities to do this.

Location

We focus on the people of the Bristol city region, which includes Bristol, South Gloucestershire and North Somerset. We also aim to develop close links with other organisations in our wider region and neighbouring regions. But what works here will very likely work elsewhere: our work and research has national and international impact.

Using Data Better - What is the programme trying to achieve?

- **Connecting** the wide array of health & care informatics initiatives and professionals in our region across NHS, local authority and academic organisations
- **Promoting** the use of data to improve health and care outcomes through research and service planning.
- **Developing** health & care informatics resources that help people in our region to collaborate.

We are currently operating 5 workstreams;

1. Health Data Source Inventory - mapping the different data sources held in NHS, academic and local authority organisations across our region. This is to help us better understand what can be used for research and service planning
2. Patient and public engagement - we run events about what routine data can be used for, and public contributors have been involved throughout our work.
3. Exemplar projects - we are supporting a small number of projects that demonstrate the value of working with our local data
4. Advanced analytics and AI – we have a role in supporting conversations about the potential of AI in healthcare
5. Placements - we are helping to connect up students and academics with provider and commissioner organisations to help bring in data analytics skills.

Bristol Health & Wellbeing Board

Title of Report	
Author, including organisation	Thara Raj, Bristol City Council on behalf of Sue Milner
Date of meeting	24.10.2018
Report for Information – short presentation to highlight key areas from the report	

1. Purpose of this Paper

This report is part of a locally agreed assurance process that was put in place following the 2012 Health and Social Care Act (section 6C regulations). Bristol City Council (BCC) has a critical role in protecting the health of its population. It has set up a local Health Protection Committee (HPC) whose role is to ensure, on behalf of the HWB, that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

2. Executive Summary – to include the main points for the HWB to consider

The Interim Director of City Wellbeing, Resilience and Strategic Partnerships is assured that arrangements are robust and has provided the attached Health Protection Committee report.

3. Recommendations for the HWB to Agree

To note the progress that has been made in 2017/18 to ensure that sustainable and effective local systems are in place for protecting the health of Bristol residents and their neighbours.

4. Main body of the Report

Please see attached Bristol Health Protection Annual Report 2017/18.



BRISTOL HEALTH PROTECTION ANNUAL REPORT 2017/18



**Bristol, North Somerset
and South Gloucestershire**
Clinical Commissioning Group

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OVERVIEW OF HEALTH PROTECTION ARRANGEMENTS IN BRISTOL

This is the fourth annual report to be presented to the Bristol Health and Wellbeing Board (HWB). This report is part of a locally agreed assurance process that was put in place following the 2012 Health and Social Care Act (section 6C regulations). Health protection arrangements are governed by a range of statutory regulation which applies to a number of organisations, including Bristol City Council (BCC).

Bristol City Council (BCC) has a critical role in protecting the health of its population. BCC has set up a local Health Protection Committee (HPC) whose role is to ensure, on behalf of the HWB, that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

Health protection seeks to prevent or reduce the harm caused by communicable and non-communicable diseases, and minimise the health impact from environmental hazards.

Achieving success in health protection relies on strong working relationships at a local level. The Health Protection Committee (HPC) helps facilitate these relationships, ensuring that clearly defined roles and responsibilities are in place that underpin the local response to public health threats, outbreaks and major incidents. This report has been written to a framework that was agreed by the HPC and Appendix 1 outlines progress to date against the following health protection areas:

- Infectious and communicable diseases
- Screening and immunisation
- Emergency preparedness, resilience and response (EPRR)
- Environmental hazards to health, safety and air quality

In an attempt not to overload this assurance report with detail we have presented this detail in Appendix 1. Appendix 2 outlines the different health protection responsibilities for partner organisations and Appendix 3 has a glossary of terms used in this report. Points of note for 2017/18 are:

Bristol was mandated to reduce Nitrogen Oxide (NOx) emissions as part of its overall work to improve air quality and proposals to achieve this in the shortest time possible are being scrutinised and consulted on.

Immunity gaps in the Bristol population have been highlighted through the spread of measles in Bristol particularly in under immunised communities. Some measles cases were critically ill and were hospitalised. Promoting routine childhood vaccinations is the best defence against vaccine preventable diseases including measles. Data for 2017/18 shows that the uptake of the first dose of measles, mumps and rubella (MMR) vaccine was 89.1% (as measured at 24 months of age) and uptake of the second dose was 86.2% by the time children are school ready (this equates to 827 children) . These vaccination levels are similar to the previous year however we did not experience an outbreak of measles last year. What was different this year was that across England there was an increase of measles cases and localised outbreaks and we saw this pattern within Bristol, particularly in geographical areas with under-immunised communities. As a way of addressing pockets of poor coverage across Bristol, GP practices were invited to bid for monies to develop innovative practice for increasing MMR uptake and we will be able to report on the outcomes in the next Health Protection Committee annual report.

Last winter, despite flu vaccination uptake being much higher than the preceding year (for example uptake in the 65s and over was 74.8%), our communities and services were severely affected by flu because of the particular strains that were circulating. The flu vaccine and good infection prevention and control (for example washing and drying hands) remain our best defence. The child flu vaccination programme was delivered in primary schools across Bristol and is a key public health intervention for interrupting transmission.

Infections that should remain in history books, such as syphilis, have made a comeback in Bristol. Across the South West some cases were detected through antenatal screening therefore it is important to ensure that all women come forward for timely antenatal screening.

Tuberculosis (TB) is still of concern in Bristol and the latent TB screening that is being offered to migrant communities through GP practices is an important intervention in the local TB strategy. The appointment of a specialist TB nurse to lead this work is welcome.

Antimicrobial resistance (resistance to antibiotics) remains an urgent health protection risk for Bristol residents and appears on the national risk register of civil emergencies. Therefore initiatives such as working with Bristol's scientists, residents and 'We The Curious' (formerly @Bristol) for World Antibiotic Awareness Week was important.

ASSURANCE STATEMENT

The Interim Director of City Wellbeing, Resilience and Strategic Partnerships is assured that arrangements are robust and has provided this report highlighting areas that could be strengthened to the Health and Wellbeing Board in line with their statutory responsibility to ensure that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

RECOMMENDATION

To note the progress that has been made in 2017/18 to ensure that sustainable and effective local systems are in place for protecting the health of Bristol residents and their neighbours.

Appendix 1: Progress made on areas of health protection

1. Infectious and communicable disease

1.1 Tuberculosis (TB)

TB is a priority issue for Bristol as identified by the Health Protection Committee. TB is caused by the bacterium *Mycobacterium tuberculosis*. It is a notifiable disease in the UK.

A Collaborative Tuberculosis Strategy for England 2015 – 2020 has been in place since January 2015. The strategy was jointly launched by PHE and NHS England, aiming to achieve a year-on-year decrease in TB incidence, a reduction in health inequalities, and ultimately the elimination of TB as a public health problem in England.

In 2016, which is the most recent published data that we have, there were 5,664 TB cases notified in England, down from 5,727 in 2015. Following a sustained annual decline of at least 10% in the number of TB cases since 2012, the decline slowed to 1% in 2016, the reasons for this are as yet unclear and likely to be multifactorial. The incidence rate of TB was 10.2 per 100,000 in 2016, compared with 10.5 per 100,000 in 2015, the lowest rate since 2000¹. UK TB incidence is higher than most other Western European countries and the US² (8 per 100,000 France, 8 per 100,000 Germany and 3 per 100,000 US).

People with social risk factors (SRF) are at increased risk of developing TB, are more likely to have drug resistant TB, to have worse TB outcomes, and are approximately twice as likely to be lost to follow-up or to have died. In 2016, in England, there was a small decrease in both the number and proportion of TB cases with at least one social risk factor (SRF), with 11.1% of TB cases having at least one SRF, down from 11.7% in 2015 but still higher than seen prior to 2015. The proportion of UK born cases with at least one SRF (20%) was more than double that of non-UK born cases (8%). TB in England remains a public health priority due to current rates and the health, social and economic burden of the disease.

Annual TB incidence rates in Bristol remain considerably higher than in the rest of the South West and England (figure 1). At its peak in 2014, the rate of TB in Bristol was 22.4/100,000. In 2016 the rate has decreased to 14.8/100,000. Among isolates from TB cases that underwent antibiotic sensitivity testing in 2016, a lower proportion of cases in Bristol (7.9%) were resistant to at least one first line drug compared to the remainder of the South West (13.6%). Furthermore, the rate of resistant TB in Bristol has reduced when compared to 2015 (12.2%). The rate of TB that is multi-drug resistant in Bristol remains relatively stable in 2016 at 2.6%, compared to 2.4% in 2015. The proportion of TB cases in Bristol that reported at least one social risk factor was 19.7%, which is higher than the remainder of the South West (12.9%).

There were five Medium Super Output Areas (MSOAs) in Bristol with a three year average TB rate (2014-2016) greater than 40.0 per 100,000 population and the highest rate for a single MSOA was 121.3 per 100,000 population (figure 2). The highest MSOA rates were

¹ Tuberculosis in England 2017 report (presenting data to end of 2016)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686185/TB_Annual_Report_2017_v1.1.pdf London: Public Health England

² World Health Organization (WHO) estimates of tuberculosis incidence by country, 2016
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/677927/WHO_estimates_of_tuberculosis_incidence_by_country_2016.pdf London: Public Health England

concentrated in central Bristol within the electoral wards of Easton, Lawrence Hill and Ashley.

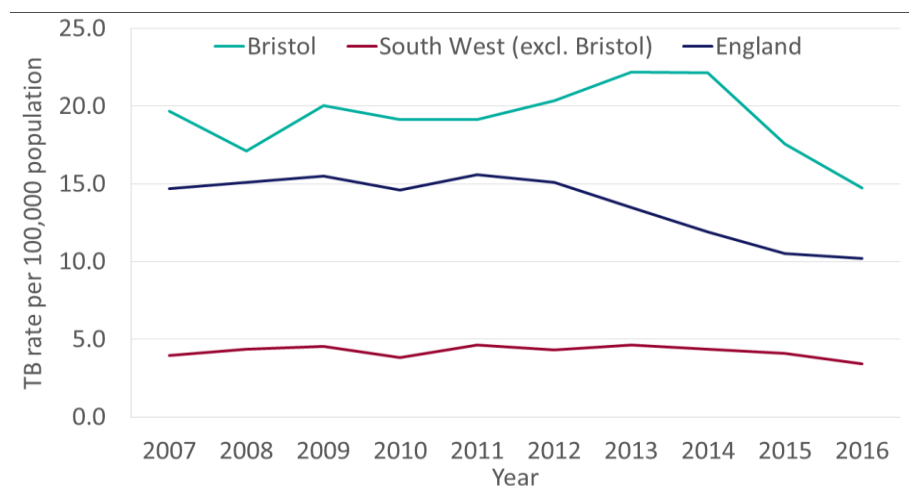
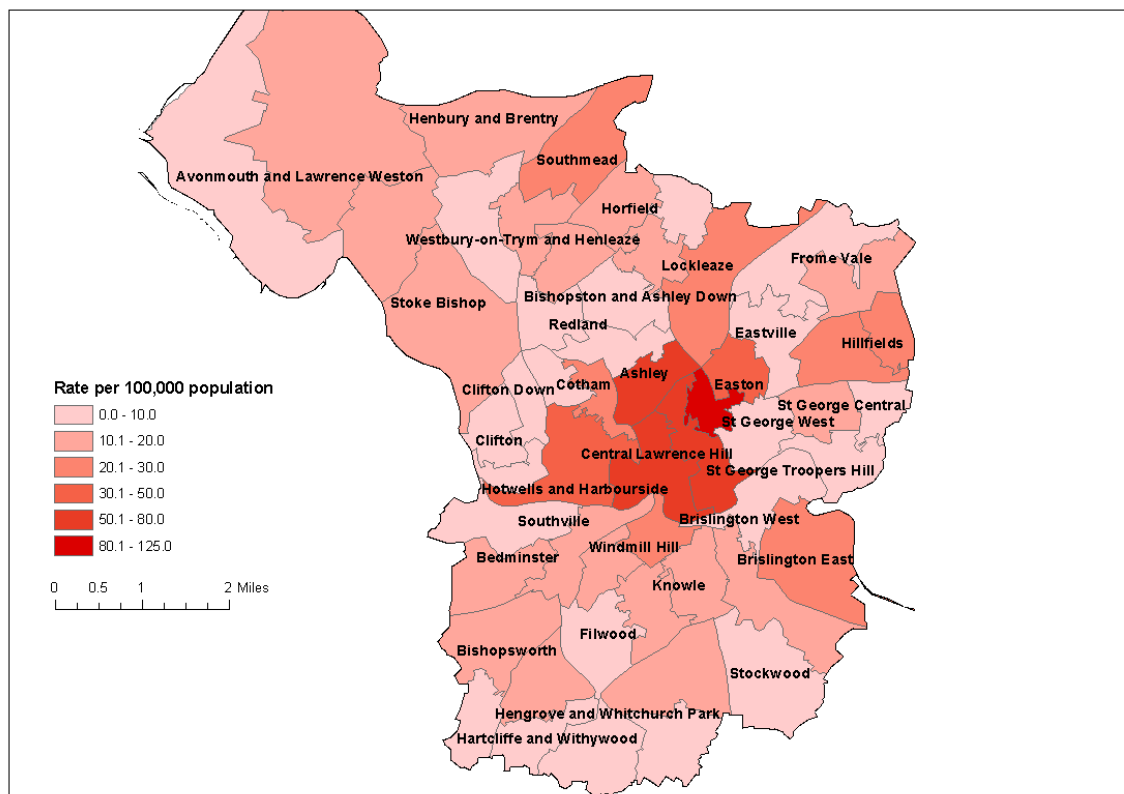


Figure 1. Annual TB rates per 100,000 population, 2007-2016

Data source: Enhanced Tuberculosis Surveillance (ETS). Data extracted: September 2017.

Figure 2. Three year average annual TB rate per 100,000 population by MSOA, Bristol, 2014-2016 (electoral ward labels)



Data source: Enhanced Tuberculosis Surveillance (ETS). Data extracted: September 2017.

Table 1 Epidemiology of TB in Bristol and the South West. The South West figure excludes data from Bristol

TB CASES REPORTED IN 2016 (most recent published data)		
TB INCIDENCE	Bristol	South west*
Number of TB cases notified (proportion pulmonary TB)	67 (68.7%)	172 (63.5%)
Rate per 100,000 population	14.8	3.4
DRUG RESISTANCE		
Proportion of culture confirmed cases with any first line resistance	7.9%	13.6%
Proportion of culture confirmed cases with multi-drug resistance**	2.6%	1.8%
SOCIAL RISK FACTORS (history of past or current homelessness, imprisonment, drug and/or alcohol misuse)		
Proportion of cases with any social risk factor	19.7%	12.9%
TREATMENT COMPLETED within 12 months ***		
Number completing treatment in 2015 (Proportion completing)	47 (78.3%)	138 (74.6%)

* South West excluding Bristol upper tier local authority

**Resistant to at least isoniazid and rifampicin

***Excluding those with rifampicin resistance, CNS, spinal, miliary or cryptic disseminated TB, patients with these forms of disease may have planned treatment for 12 months or longer

Successes/progress

TB Control Board and the Bristol, North Somerset and South Gloucestershire (BNSSG) TB Network/Strategy Group

The TB Control Board for the South of England covers Bristol and has been operational since September 2015. This has resulted in coordinated leadership across Bristol, North Somerset & South Gloucestershire at a time when we are seeing more and more complex TB cases.

Good progress has been made against the six areas outlined in the TB Strategy and incidence of TB continues to decrease in Bristol (14.8 per 100,000 population in this reporting year compared to 17.6 per 100,000 population in the previous year). An evaluation of the Find and Treat project to identify active TB in vulnerable and hard to engage with groups was completed. This highlighted the importance of third-sector engagement and how

education across a wider community of stakeholders can support early identification and referral. Additionally, this work concluded that a community perceived as hard to reach can be reached successfully.

The TB nurse team are leading a piece of work, delivering awareness raising educational sessions for voluntary agencies, identified as working with underserved populations. The Network has also been overseeing work to improve early identification of TB and diagnosis and this continues to be a priority area for action.

Tuberculosis Cohort Review

Much of the work undertaken by the Network is informed by quarterly TB Cohort Review meetings of patients being treated within their geographical boundaries. These reviews continue to strengthen the prevention and control of TB by comparing local outcomes to agreed targets. They also provide an opportunity to identify unmet health and social care needs of cases and highlight system issues in the TB control pathway.

Latent TB screening programme for migrants

The majority of active TB cases diagnosed in England are a result of reactivation of Latent TB Infection (LTBI). Systematic screening and treatment of people at highest risk of LTBI should significantly reduce the incidence of TB. This is one of the key interventions supported in the Collaborative Tuberculosis Strategy for England³ and is supported by NICE⁴ as being a cost-effective intervention.

Bristol received funding from the TB Control Board for new migrant LTBI testing and treatment services in areas with high incidence (>20 per 100,000 population). Phase one of the Bristol LTBI testing and treatment service has been running since January 2016 and in 2017 a dedicated TB nurse was recruited to lead this programme. As a result a majority of GP surgeries (including the Haven) with the highest incidence of active TB in Bristol started offering IGRA blood tests to migrants who have moved to the UK in the previous 5 years. In 2016/17 104 LTBI tests were carried out and 14 of those were positive for latent infection (13.5% positive). Treatment uptake for positive cases was 52.9%. Treatment completion of those who started was 88.9%. In 2017/18 151 LTBI tests were carried out and 31 were positive for latent infection (12.5% positive). Treatment uptake for positive cases was 47.6%. Treatment completion of those who started was 72.2%. This data is cumulative and current as of June 2018. Activity levels were based on laboratory reports and not practice data which may differ and therefore the data may not be complete.

There have been some challenges in identifying existing residents eligible for the screening programme (aged 16-35, having arrived in the UK within the last 5 years, and from a high incidence country). However, 'Flag Four' data is being produced by the national team to identify all eligible patients, and a designated nurse has been commissioned to help support practices increase uptake.

³ PHE & NHS England (2015) *Collaborative Tuberculosis Strategy for England 2015 to 2020*. (Jan 2015).

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/403231/Collaborative_TB_Strategy_for_England_2015_2020_.pdf London: Public Health England

⁴ National Institute for Health and Care Excellence (2016) *Tuberculosis* (NICE Guideline 33). <https://www.nice.org.uk/guidance/ng33/resources/tuberculosis-1837390683589>

Key current risks

Under-served populations: TB is not only a serious infectious disease but it also has major social impacts for those affected. TB is associated with marked inequalities in health; with deprived populations more likely to get TB and suffer worse outcomes. The local health needs assessment (HNA) indicated that TB incidence in Bristol is related to deprivation, with the highest incidence rates observed in the most deprived groups. Sixty six percent of TB cases notified were among individuals who live in the two most deprived quintiles. Of TB cases where occupation status is recorded, 20% were unemployed. Some areas where we have seen high prevalence have been in areas with a high population of white, UK born residents. In addition, a substantial proportion of notified TB cases possess at least one social risk factor. Under-served and vulnerable populations are continuously highlighted in the qualitative findings of the HNA as well as in literature as groups requiring more support to engage with health services and complete treatment.

Areas for focus in 2018-19

- To consider the development of a Service Level Agreement between Bristol agencies to fund accommodation for those TB patients who have no recourse to public funds so that their health and welfare needs can be met for the duration of their treatment and to avoid onward transmission of TB within vulnerable communities.

1.2 Infection Prevention and Control (IPC)

Preventing healthcare associated infections (HCAI) is an important component of infection prevention and control, and patient safety. National Institute for Health and Care Excellence (NICE)⁵ estimated that 300,000 patients a year in England acquire a healthcare associated infection as a result of care in the NHS. Healthcare associated infections are estimated to cost the NHS approximately £1 billion a year and £56 million of this is estimated to be incurred after patients are discharged from hospital.

All patients identified with MRSA (Methicillin-resistant *Staphylococcus aureus*) blood stream infections are subject to a comprehensive post-infection review (PIR), which upon completion, is submitted to Public Health England. The purpose of the PIR is to identify how each case occurred and to agree actions to prevent the same circumstances recurring.

Similarly all cases of *Clostridium difficile* are subject to a root cause analysis (RCA) investigation to identify learning and share best practice to reduce the incidence of infections.

The NHS set an ambition in April 2017 to halve the numbers of healthcare associated Gram-negative BSIs by 2021. BNSSG is addressing *Escherichia coli* (*E.coli*) blood stream infections in 2018/19 with a focus on patients who have a urinary catheter.

Successes/progress

Healthcare associated infections

A healthcare associated infection (HCAI) Group meeting is held bi-monthly chaired by Bristol North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG). Membership is drawn from commissioners (CCG and NHS England) hospital and community providers, Local Authority and Public Health England across Bristol, South Gloucestershire and North Somerset (BNSSG). The aim of the group is to ensure that the appropriate governance systems and processes are in place to prevent avoidable healthcare associated infections. The group provides regular updates and assurances on performance, antimicrobial stewardship, identified trends and associated work for improvement including sharing best practice and lessons learned from post infection reviews. In bringing together all commissioning bodies the group also supports improved oversight of infection prevention and control outside hospital settings.

MRSA Steering Group/ Report into MRSA in people who inject drugs

During 2017/18 BNSSG CCG continued the work that began back in 2015 to reduce the incidence of MRSA amongst intravenous drug users (IVDU). This work included educating individuals on alternatives to injecting, safer injecting, skin and injecting site care, skin preparation prior to injecting, signs and symptoms of infection and signposting for prompt clinical intervention. These interventions have been taken forward by the Bristol Drugs Project.

⁵ NICE (2012) Healthcare-associated infections: prevention and control in primary and community care Healthcare-associated infections: prevention and control in primary and community care. CG139.

In addition, during 2016, funding was obtained to undertake a joint research project by University of Bristol and Public Health England, to look at intravenous drug users and transmission networks to identify interventions to reduce MRSA BSI and onward transmission, including a baseline assessment for evaluating impact of targeting and distributing chlorhexidine wipes allied to suppression strategies.

In July 2017 the findings of the Elizabeth Blackwell study were shared in a briefing paper with the BNSSG HCAI group and GP practices. The study identified that there was a high MRSA colonisation rate and a large increase in the number of invasive MRSA infections in Bristol that held a close genetic relationship (i.e. unique to Bristol).

Three factors were identified with the increase in MRSA infections including

- Injecting intravenous drugs outside,
- Hospital contact in the past month and
- Injecting in groups of more than three

The MRSA task and finish group was reconvened in September 2017. This sub group of the BNSSG HCAI group was tasked initially with identifying short and long term actions to reduce MRSA bacteraemia in patients who inject drugs.

Actions completed by the group include:

- Access to Connecting Care and the HCAI database for Community Provider Infection Prevention and Control Leads to enable prompt identification and actions to address MRSA in patients in community settings.
- Literature Review undertaken by PHE to identify and develop targeted interventions to reduce bacterial infections amongst people who inject drugs.
- Discussion and planning for a patient focus group to ensure targeted interventions are acceptable to people who inject drugs.
- Planning for an evaluation of a recognised intervention to reduce bacterial infections in people who inject drugs

The national zero tolerance target for MRSA was not achieved in 2017/18. Between April 2017 and March 2018 there were 49 cases of MRSA identified as attributable to BNSSG CCG and their acute providers. This is an increase of 29% from 2016/17 and in actual numbers is 11 cases. Twenty cases were assigned to "Third Party" following post infection review as it was deemed there was no healthcare involvement or evidence of failings in healthcare. The Bristol locality reported the highest number of cases of MRSA bacteraemia (39)

BNSSG CCG has significantly more cases of MRSA reported than other CCGs in the South West. Review of the data identified that the skin was the most commonly occurring source of infection across all cases comprising breaches of skin integrity including wounds, cellulitis and leg ulcers. Forty-one percent of cases related to people who inject drugs, the majority of which related to people who injected via their groin. In four cases the source of the MRSA bacteraemia was identified to be urinary.

The post infection review of all cases identified learning in relation to screening and decolonisation therapy arising from the MRSA post infection reviews including information

not being shared with primary care that the patient was colonised with MRSA and missed opportunities to undertake screening for MRSA.

Action to address this learning has been put in place by providers. The learning from all the cases has been shared across the local health economy.

Clostridium difficile (C. diff) CDI review meetings

Clostridium difficile post infection review meetings with Acute Trust Providers and a multi-disciplinary CCG meeting with community providers are held each month. Representatives at the meeting included BNSSG CCG, public health specialist, microbiologist and infection control specialists from the NHS. A review of every case of both pre and post 72-hour Clostridium difficile cases is undertaken to identify any learning that can be addressed and shared to improve practice.

In 2017/18 NHS England assigned an ambition of a maximum of 312 cases across BNSSG which includes both the acute hospital trusts and the community apportioned cases. The total number of CDI cases reported was 190 cases which sits within the objective set by NHS England and of these for the Bristol 63 cases were apportioned against an objective of 131.

A root cause analysis tool is sent electronically to GP Practices across BNSSG to complete and results are collated. Review of the RCA forms returned identified that 66 of 71 cases had no identified lapses in the care pathway. Six out of 71 forms returned identified that antibiotics had been prescribed outside of the BNSSG prescribing guidance most notably for the treatment of urinary tract infection and were therefore recorded as a lapse in the care pathway. Feedback was provided to GPs where prescribing outside of BNSSG guidance was identified to support individual learning.

Escherichia coli (E.coli)

E. coli bacteraemia is the largest most prevalent group of gram negative blood stream infections (GNBSI). A Quality Premium was set for CCGs that consists of three parts:

Part a) reducing gram negative blood stream infections (BSI) across the whole health economy

Part b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care

Part c) sustained reduction of inappropriate prescribing in primary care

To establish the causes and themes associated with E. coli bacteraemia and inform the work plan to achieve the reduction of 10% and reduce inappropriate prescribing, it was agreed by the HCAI group to undertake a review of cases of E. coli bacteraemia and these were completed for community acquired cases in Bristol. The Bristol based medicines management team led a retrospective review of 45 E. coli bloodstream infection (BSI) cases between April 2016 and March 2017 which was undertaken in May 2017. The review concluded that, no significant trends could be identified however urinary was the main source of E. coli bacteraemia, despite the low number of patients reported to have a catheter. The audit also concluded that it would be important to ensure catheter care is of a high standard reducing the risk of infection.

As part of the BNSSG work plan a BNSSG E. coli BSI sub group was set up in February 2018. It was agreed at this group that a BNSSG catheter passport would be implemented

across BNSSG for patients with indwelling catheters. The aim of this passport is to provide patients or carers with all the necessary information to enable self-care or care for a urinary catheter. The passport will also provide a useful form of communication between other healthcare professionals. The format of a BNSSG passport has been agreed by the three trusts and community services across the local health economy and will be implemented in 2018.

BNSSG CCG was set an objective by NHS England of reducing the incidence of E. coli blood stream infections by 10% based on 2016 reporting. The threshold set in total for BNSSG was 514 cases with the Bristol threshold set at 229 cases. Bristol exceeded the threshold by 23% with 281 cases.

Antimicrobial Resistance (AMR)

Public awareness is a key objective of the UK Antimicrobial Resistance Strategy. Bristol marked World Antibiotic Awareness Week (WAAW) and the 20th anniversary of the Bristol Stool Chart by working with scientists and communities across the city and 'We The Curious' (formerly @Bristol) to host a Live Lab to promote awareness of the need to use antibiotics wisely.

Another key objective in the UK Antimicrobial Resistance Strategy is optimising prescribing. The BNSSG Medicines Optimisation team continues to work on antibiotic stewardship to help address antibiotic resistance. The focus in 2017/18 has been urinary tract infections to assist the aim to reduce gram negative bacteraemia. To promote appropriate prescribing in UTIs antibiotic guidelines have been revised and guidelines for nursing homes including a check list to aid communication with GP surgeries when a resident has a suspected UTI has been released. All patients prescribed long term prophylaxis for recurrent UTIs in BNSSG have been reviewed with the aim to stop long term antibiotics supported by a new guideline. The quality premium on prescribing for urinary tract infections; reducing the Trimethoprim: Nitrofurantoin ratio and reducing the number of Trimethoprim items prescribed to patients 70 years and greater by 10% was met by the CCG.

There has also been a quality premium in 2017/18 on the number of antibiotic items per STAR-PU (Specific Therapeutic Group Age-sex Related Prescribing Unit) the CCG met the target of 1.161.

These quality premiums are continuing into 2018/19 with further reductions required. In addition to the 2018/19 quality premiums BNSSG CCG will focus on the prescribing of broad spectrum antibiotics (cephalosporins, quinolones and co-amoxiclav) during the year. We identify the overall proportion of broad spectrum antibiotics that were prescribed where a narrow spectrum antibiotic should have been used. This is a key plank in reducing the risk of resistance or *Clostridium difficile* developing.

To support the appropriate prescribing of antimicrobials across BNSSG, local, evidence based guidelines are produced in conjunction with local clinicians. These encourage the use of narrow spectrum antibiotics rather than broad spectrum and are reviewed every two years or more frequently if there are significant changes to the recommendations. Antimicrobial targets and audits are included in the Medicines Optimisation Quality Scheme for GP

practices across BNSSG. The 2018/19 scheme includes audits on broad spectrum antibiotic prescribing and pyelonephritis.

Key current risks

Infection prevention and control is fundamental to stop the spread of infectious and communicable disease. Performance in Bristol has improved in terms of reducing the number of C. diff infections, but neither the MRSA zero target was met or the required reduction in Escherichia coli cases for 2017/18 achieved.

Areas for focus in 2018/19

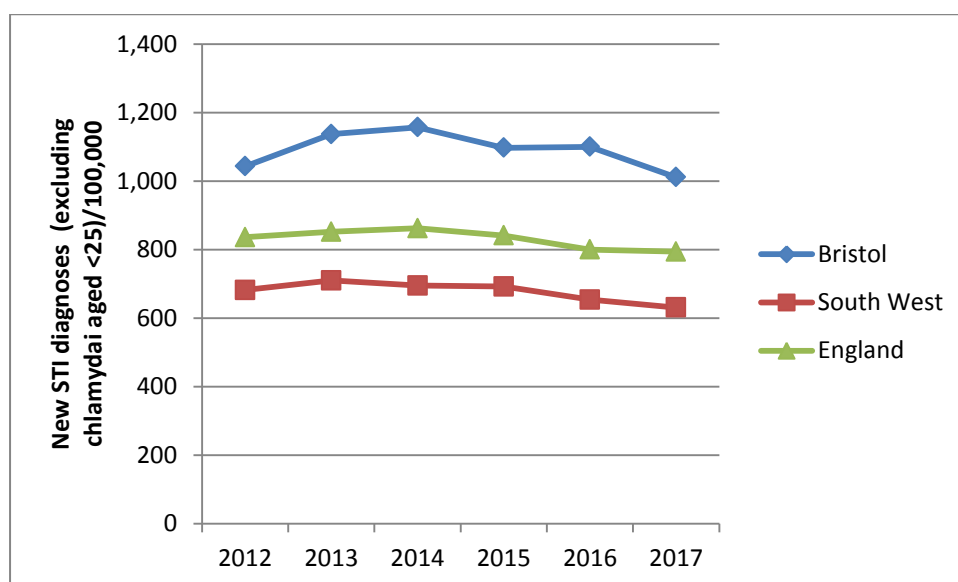
- Multiagency approach to tackling healthcare associated infections to ensure sustained emphasis on reducing MRSA, C. diff and E. coli.
- Achieve the zero target for pre 48 hour MRSA blood stream infections
- Maintain a reduction in the number of Clostridium Difficile pre 72-hour community cases
- Maintain a reduction in the number of Escherichia coli reported cases for BNSSG
- To launch the BNSSG wide Catheter Passport alongside a focus on hydration to reduce urinary tract infections
- Continued focus to reduce the prescribing of broad spectrum antibiotics including cephalosporin, quinolone and co-amoxiclav
- Reduce the number of trimethoprim items prescribed to patients aged 70 years or greater by 30% on baseline data (June15-May16)
- Maintaining an oversight of infection prevention and control both inside and outside hospital settings, to ensure all different commissioning bodies including the local authority, CCG, NHS England and Public Health England are sighted and aligned on infection prevention and control risks.
- Improved prescribing practice of antibiotics including broad spectrum antibiotics needs to be maintained so that the right people receive the right antibiotics at the right time.

1.3 Sexually Transmitted Infections

Sexually Transmitted Infections (STIs) is a term used to describe a variety of infections passed from person to person through unprotected sexual contact. STIs can have lasting long term and costly complications if not treated and are entirely preventable.

The rate of new STIs (excluding chlamydia in under 25 year olds) diagnosed in genitourinary medicine (GUM) clinics has continued to be significantly higher than the England average, although rates in Bristol did decline between 2016 and 2017. **Figure 1** shows the trends in new STI diagnoses between 2012 and 2017. Bristol's rate of new STI diagnoses in 2017 was 1,011 per 100,000 (excluding chlamydia in the under 25s). The Bristol rate was higher than the national average of 794 per 100,000 and decreased from the previous year.

Figure 1. Rate per 100,000 population of new STI diagnoses in England (2012 to 2017)
(Data from Sexual and Reproductive Health Profiles, Public Health England)



The syphilis diagnosis rate per 100,000 population in Bristol increased from 6.4 in 2016 to 8.8 in 2017, which reflects increases that have been seen across the South West and also nationally. The increase has continued and has been particularly notable since October 2017, with cases diagnosed at primary, secondary and early latent stages of infection. The increase in syphilis diagnoses is a concern and is being monitored, and enhanced surveillance questionnaires have been instigated. Control measures including awareness raising with the public and healthcare professionals have been put in place.

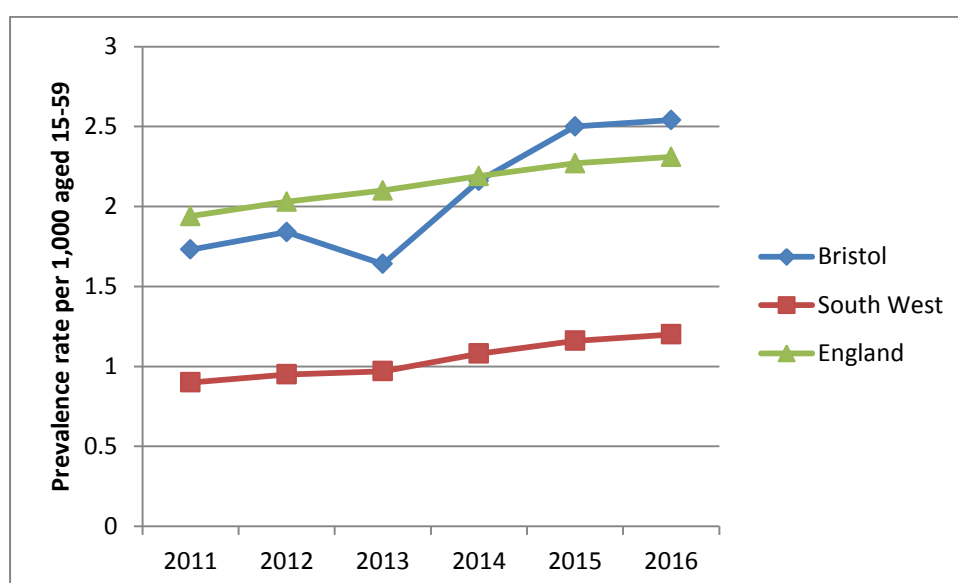
There is variation in the distribution of the most commonly diagnosed STIs by age, gender, sexual orientation and ethnicity as outlined below.

- Young people (15-24 year olds) continue to experience the greatest burden of STI diagnoses.
- Diagnoses of chlamydia, syphilis and gonorrhoea are more likely to be reported in men who have sex with men than other groups.
- There is wide variation in the rates of STIs diagnosed within different ethnic groups. The highest rates of STI diagnoses are found among persons of black ethnicity, and

the majority of these cases were among persons living in areas of high deprivation, especially in urban areas.

HIV is associated with considerable morbidity and mortality and requires significant long-term care and treatment. Drug therapies have reduced the incidence of HIV-related deaths but it remains a life-threatening infection. The overall prevalence of HIV for Bristol increased in 2016 to 2.14 per 1,000 residents aged 15-59, which means Bristol is now considered to be over the threshold for expanded HIV testing (see **figure 2**). The prevalence rate is now slightly above the national average. Some groups in society are affected disproportionately by HIV, including MSM and black African communities. Late diagnosis of HIV remains a concern, with 44.1% of people in Bristol presenting at a late stage of infection between 2014 and 2016, which is slightly higher than the national rate of 42.9%.

Figure 2. HIV diagnosed prevalence rate per 1,000 population (2012-2015) (Data from Sexual and Reproductive Health Profiles, Public Health England)



Successes/progress

Transformation of new integrated sexual health services

Unity Sexual Health, the new integrated sexual health service for Bristol, North Somerset and South Gloucestershire (BNSSG) was launched in June 2017 following a successful procurement and mobilisation. University Hospitals Bristol NHS Foundation Trust is the lead provider for the service, which also includes major third sector providers Brook, British Pregnancy Advisory Service, Marie Stopes International, Terrence Higgins Trust and the Eddystone Trust, as well as Weston Area Health Trust in North Somerset. Local authority and CCG commissioners are now working closely with Unity to overcome the challenges arising from reduced local authority budgets, combined with increasing demand for services. The contract has year on year financial reductions in line with reductions to the public health grant. This has given an opportunity to implement a number of service innovations at the start of the contract designed to deliver value for money whilst focusing on improving sexual health outcomes during the following years. Examples include the introduction of online STI testing for asymptomatic patients, a rapid STI clinic with same day results for high risk groups and symptomatic patients, and a centralised partner management service for STIs diagnosed in primary care.

Sexual Health Improvement Programme Health Integration Team (SHIP HIT)

To support the transformation of the sexual health service the Sexual Health Improvement Programme (SHIP) is now closely aligned with Unity's research and evaluation work. The SHIPP is a multiagency multidisciplinary Health Integration Team (HIT) from Bristol Health Partners which was set up to promote the commissioning of evidence-based services. The team is made up of commissioners, academics, clinicians and public health specialists working in the field of sexual health and this combination is reflected in the leadership. The strength of this partnership enables a whole system approach to improving sexual health outcomes, and it is hoped the work will have a wider impact beyond the BNSSG footprint.

HIV PrEP Trial

Pre-exposure prophylaxis for HIV (PrEP) has been shown to reduce transmission of HIV. A national trial was launched last year, with 10,000 trial places made available to people who are at high risk of HIV, available to those attending specialist sexual health services. Unity Sexual Health joined the trial in December 2017. Initially Bristol (Central Clinic) was allocated 60 places and Weston (WISH centre) was allocated 20 places. Unity central filled 75% of places very quickly and therefore was given a further 66 places. So far, 101 out of its 126 allocated spaces have been recruited to (as at June 2018). The clinic has not filled all spaces due to a lack of new appointments and some spaces have been saved for non MSM clients but these have been more difficult to recruit to. Weston has filled 18 slots with MSM, but the two slots which are available to non-MSM, have not been recruited to. This challenge of recruiting non MSM clients is proving to be the case nationally not just in Bristol. An additional 20 slots were allocated to the Concord clinic in South Gloucestershire recognizing its status as a Level 3 service.

Key current risks

The local authority continues to need to achieve financial efficiencies in spend on sexual health services whilst managing an increasing demand for the services.

Increases in infectious syphilis diagnosed at genitourinary medicine clinics from October 2017, predominantly in men who have sex with men but also heterosexual cases.

Late diagnosis of HIV.

Antimicrobial resistance in sexually transmitted infections, including gonorrhoea and mycoplasma genitalium.

Areas for focus in 2018-19

- Prepare sexual health services for antimicrobial resistant bacteria
- Ensure schools are prepared to deliver high quality relationship and sex education ahead of the subject becoming statutory in all secondary and primary schools in October 2019
- Continued involvement in the national trial of HIV PrEP
- Strengthen local prevention efforts focused on groups at highest risk, including young adults, black ethnic minorities and MSM and to reduce late diagnosis of HIV
- Further explore the opportunities to utilise new technologies to offer increased access to STI testing.

1.4 Foodborne illness

Foodborne illness (more commonly referred to as food poisoning) is any illness that results from eating contaminated food. Foodborne illness can originate from a variety of different foods and be caused by many different pathogenic organisms at some point in the food chain, between farm and fork. Although the majority of cases in the UK are mild they are unpleasant, result in absences from education or the workplace and place a significant demand on healthcare services. Occasionally foodborne illness can lead to complications or even death.

Access to safe food and water is one of the most fundamental human needs. Latest figures from the Food Standards Agency state that there are over 500,000 cases of food poisoning per year across the UK from identified causes and if the unidentified causes were to be included this figure would more than double. In Bristol, there were 772 confirmed cases of gastrointestinal infection between April 2017 and March 2018 (see **Table 1**).

Table 1: Confirmed cases of gastrointestinal infection recorded on HPZone (the Public Health England national database used to record health protection incidents) in residents of Bristol local authority, April 2017 to March 2018*

Infection	Total confirmed cases recorded on HPZone
Campylobacter	494
Cryptosporidium	53
E. coli VTEC	<5
Giardia	136
Shigella	8
Salmonella	74
Paratyphoid Fever	<5
Typhoid Fever	<5

*Cases were extracted and analysed based on date entered onto HPZone

Food Standards Agency Audit Report

The food safety service was audited by the Food Standards Agency in 2015, and as a result an action plan has been agreed with the agency. Follow up visits have been undertaken by the FSA in 2017-18. A key action included identifying additional funding from the public health ring fenced budget in order to act as a catalyst to address barriers to the food businesses inspection programme and to develop a new Healthy Eating Award for the city with public health.

Additional budget was secured for 2016-18 and a number of fixed term EHOs have been recruited, due to difficulties retaining fixed term contract staff, executive leadership agreed to the recruitment of 3 additional permanent EHO posts and these started in April 2018. This has led to an increase in the percentage of inspections undertaken from 38% to 46% for the

2016-17 year and to 53% for 2017-18. Although there has been an increase the FSA require the backlog is reduced at a faster pace and the target for 2018-19 is to achieve 70%.

Sexual Health History Training for EHOs

The last annual report (for 2016-17) identified that some cases of Shigella may be associated with sexual health practices. Sexual health history training has been provided to the Environmental Health team and EHOs are aware of this and can refer these cases to the Health Protection Team at PHE if further investigation is needed.

The development of the Bristol Eating Better Award

Bristol Eating Better is a reward scheme for food businesses in Bristol providing meals and ready to eat food. The scheme rewards and promotes businesses who (a) make efforts to put healthier options on their menus and (b) consider the environmental impact of their business. Small actions count, and businesses are awarded one of four levels - Commitment, Bronze, Silver or Gold, depending on how much they do.

Actions such as; reducing the amount of salt sugar and fat added to the food; sourcing local ingredients where possible, and making efforts to reduce food and catering waste, are considered. Sugar Smart actions may also entitle them to the Sugar Smart Bristol Award. The online application process is free and takes no longer than an hour at: www.bristol.gov.uk/eatingbetteraward. 63 businesses in Bristol have been awarded so far. Social media marketing have been a big driver in promoting this award scheme. With nearly 500 followers on Instagram, the Bristol Eating Better messages are far reaching and with lots of potential to grow.

Key current risks

The key risks relate to the ability to clear the backlogs and sustain the service on a long term basis. This is related to the ability of Environmental Health to recruit/retain suitably qualified EHOs to undertake this work and the availability/affordability of Environmental Health contractors.

Areas for focus in 2018-19

- To continue to clear the backlog of Food Safety Inspections prioritising the highest risk rated premises and new businesses. The aim is to undertake 70% of the inspections that are due.

1.5 Communicable Disease Management

Through close partnership working, Public Health England South West (North) Health Protection Team (HPT) aims to provide 'assurance that infection prevention and control measures are in place to ensure the protection of those members of the Bristol community that may be vulnerable to acquiring an infection both in the general population and whilst in a health or social care setting'.

The PHE Health Protection Team responds to any Notifications of Infectious Diseases (NOIDs). In 2017/18 the team managed a range of enquiries, cases and outbreaks in Bristol. The majority of outbreaks the team managed in Bristol were Norovirus and Gastroenteritis in care homes and school settings.

Health Protection Team Incidents of Note

Group B Meningococcal infections associated with an education setting in Bristol

PHE worked in partnership with NHS colleagues, the local authority and staff from the affected education setting and arranged chemoprophylaxis and vaccination to protect against group B meningococcal infections for a social network group connected with a case who sadly died, which consisted of approximately 150 contacts. This incident resulted in a heightened level of public concern across the Bristol area.

Influenza in care home residents

During the winter season 2017/18 influenza activity in England showed increases across all surveillance indicators, including notable increases in respiratory outbreaks, influenza confirmed hospitalisations and the proportion of laboratory samples positive for influenza in primary and secondary care. Syndromic surveillance data indicated that the 2017/18 season is the most significant flu season in England since 2010/11 in terms of GP consultations for influenza-like illness. This national picture was reflected in the South West activity, with outbreaks in nursing/care homes markedly higher than in previous seasons.

Increase in reported measles cases

There was an increase in cases of measles reported in the South West area in early 2018. Cases were reported across the South West (North) area, with most cases in Bristol. There is evidence that transmission occurred within the South West, with several identified epidemiological contexts including schools, nurseries, healthcare settings and workplaces.

Increase in cases and outbreaks of scarlet fever

There was a national increase in the number of notifications of scarlet fever made in 2017/18 winter season compared to previous winter seasons. Notifications of scarlet fever in patients from England were more than double the average seen for the same time period since the upsurge in Scarlet Fever began in 2013/14. This increase has been reflected in the South West.

Successes/progress

Development of a part 2A order algorithm

Under the Health Protection Regulations 2010, Local Authority Environmental Health Officers are able to serve a restrictive order on places, persons, or things in order to stop the

spread of communicable disease. A task and finish group was stood up to develop an algorithm for EHOs to use to obtain a part 2A both in and out of hours. Awareness training has been provided to all EHOs on the Bristol City Council infectious disease rota so that appropriate actions can be taken in the event an order is required. A joint training day has also been held locally, hosted by Public Health England, to outline the part 2A legislation with input from agencies across the South West.

Key current risks

No additional risks identified.

Areas for focus 2018-19

To adapt the forthcoming mass response to communicable diseases template for Bristol that is being developed by the Avon and Somerset Local Health Resilience Partnership (LHRP).

2. Immunisations and Screening

2.1 Immunisation

Immunisation is one of the most effective ways of protecting against serious infectious diseases. Immunisations are given at various points across a person's lifetime, at times when they are vulnerable to disease, and when they will develop the best immune response to the vaccine. Performance across the range of immunisation programmes is improving. However, coverage is variable and this requires attention to ensure that the local population is protected and does not become susceptible to outbreaks of these diseases.

In Bristol, there were 131 cases of vaccine preventable diseases notified between April 2017 and March 2018 (see Table 1).

Table 1: Cases of vaccine preventable infections in Bristol Local Authority between April 2017 and March 2018

Infection	Confirmed Cases on HPZone residents of City of Bristol Local Authority, April 2017 to March 2018
Measles	12
Mumps	13
Rubella	0
Diphtheria	0
Tetanus	0
Pertussis	96
Polio	0
Meningococcal	10
HiB	0

Source: Public Health England HPZone record system

Successes/progress

Maintain and improve current performance across all immunisation programmes.

Table 2: Uptake of immunisations 2016/17 and 2017/18

	2016/17	2017/18
Child Immunisations (Source: NHS Digital)		
Dtap/IPV/Hib (12 months)	93.3	93.7*
PCV (12 months)	93.4	93.7*
Dtap/IPV/Hib (24 months)	95.9	95.3
Hib/Men C (24 months)	90.1	89.7
PCV booster (24 months)	90.1	89.8
MMR 1 dose (24 months)	89.2	89.1
MMR 1 dose (5 years)	95.5	95.8
HIB / Men C booster (5 years)	95.0	95.1
MMR 2 doses (5 years)	86.5	86.2

HPV	76.4	Data not yet available
Prenatal Pertussis (source: Immform)	75.4	Data not yet available
Flu (source: Immform)		
Flu (aged 65+)	72.4	75.1
Flu (at risk)	49.6	50.5
Flu (pregnant)	43.3	45.7
Flu (2-4 year olds)	38.7	38.5
Flu (reception Y4)		56.0
Flu (Year 1 5-6 year olds)	44.6	50.4
Flu (Year 2 6-7 year olds)	37.4	47.1
Flu (Year 3 7-8 year olds)	36.9	44.6
Shingles (source: Immform)	43.4	42.7 (as of June 2018)
PPV (source: Immform)	71.2	70

Overall, uptake has remained close to, or has improved from 2016/17. Within child immunisations, uptake of primary immunisations has increased but there remains some variance for immunisations given to slightly older infants. It is encouraging that uptake of the first dose of MMR given by the age of two has been maintained and slightly increased but this remains below the national target of 95%. Collaborative work between the local authority, CCGs, PHE and NHS England needs to continue to develop innovative approaches to raising awareness and encouraging acceptance to reach at least 95% coverage in order to provide population protection.

Uptake of the influenza vaccine has increased in adults and primary school aged children but dipped very slightly in young children. It should be noted that for all immunisations the number of eligible individuals and hence the denominator has increased year on year. This means that more individuals are receiving vaccinations despite there not being significant increases in reported (%) uptake.

Uptake of vaccinations for older people (apart from flu), has declined and more focus on these vaccinations is required for 2018/19.

Reducing variability in coverage within and between programmes, with a focus on the Inner City Bristol locality.

Work during 2017/18 has focused on responding to, and preventing measles outbreaks within the city. Whilst this has not been restricted to inner city Bristol, additional work has taken place there as a consequence of historically lower MMR vaccine uptake in this area. This work has included a number of events to engage with the Somali community; an innovation fund being established to incentivise GP Practices with low immunisation uptake rates to develop creative responses to improving uptake; development of a best practice guide for GP practices; and support visits by the Screening and Immunisation Team to GP practices with low uptake to help develop plans to implement best practice. The team have delivered training to health visitors, including 'myth-busting' to help reduce variability in coverage. A pilot has also been implemented to test a leaflet developed for the Somali community aimed at supporting a health visitor conversation with parents about MMR to improve uptake within that population. During the pilot 18/29 parents who previously had refused vaccination, had their child vaccinated for MMR within a month of the conversation.

Extension of the Childhood Flu programme

School Health Services are commissioned to provide a schools-based programme, which includes provision for children that are home schooled or attend non-mainstream education. The programme was extended to include reception aged children alongside an improvement in uptake for children in older year groups to include Year 4. The PHE team continue to work with and support local providers to deliver a schools-based flu vaccination programme. Uptake has improved.

Uptake of flu and pertussis vaccines by pregnant women.

Annual data for the pertussis vaccination is not yet available. However, providers have been engaged in promoting and delivering this vaccination to women and there has been ongoing work with midwifery services to improve uptake of this vaccination. Uptake of the flu vaccination among pregnant women has increased from 43.3% to 45.7%. Midwives are delivering pertussis and will be delivering flu for 2018/19 therefore it is likely that uptake will increase next year.

The Bristol Immunisations Group

The Bristol locality immunisation group has multi-agency representation and provides the forum for reviewing the performance of local immunisation programmes. The group has an established action plan which is reviewed regularly. The locality group links to the Bristol Immunisation Group Health partners Integration Team (BIG HIT) which is a collaborative between clinicians, PHE, NHSE and academic partners developed to strengthen the provision of the universal programme; and to progress innovation and research to strengthen the impact of immunisation programmes on the population of Bristol and beyond. Examples of projects supported by the BIG HIT includes an NHIR study into 'self-consent for HPV vaccine'; involvement in a Meningitis B carriage study in teenagers and a study involving administration of RSV vaccine to pregnant women.

Implementation of the hexavalent vaccine

From 1st August 2017, universal Hepatitis B immunisation was introduced in to the routine childhood immunisation programme. This was accomplished by the move to a hexavalent vaccine, combining 6 different vaccines, replacing the pentavalent vaccine. The enhanced HepB vaccination programme continues for babies born to HepB+ mothers. Webex training was delivered across the region and support provided to Practice Nurses through forums, bulletins and the team generic inbox. The vaccine was introduced without any significant issues.

National issues with supply of BCG vaccine

In 2015, stock of the only UK-licensed BCG vaccine was interrupted. In response, PHE issued advice on prioritisation of BCG vaccine stock for neonates and infants of recognised high-risk groups for tuberculosis or to tuberculin negative children under 6 years of age. In 2016, PHE secured an interim supply of BCG vaccine but this was unlicensed in the UK. This was made available to support the programme until a new supply of UK licensed vaccine became available, initially only to the above two priority groups but since August 2017, to all those who are eligible. A new UK licenced BCG vaccine has now been procured and this will become available in the near future.

Movement to school based vaccination for Td/IPV

A sub-group of the Bristol locality immunisations group was formed to address poor uptake and delivery via the school nursing team in September 2017. Improvements in systems and practices have resulted in improvement in both coverage and uptake.

Improvement of the school based programmes

PHE continues to work with providers to deliver an effective schools based programme. Bristol is part of a national study looking at self-consent for HPV and the coordinator within the PHE Screening and Immunisation Team has been instrumental in driving this work forward.

During 2017/18, NHS England undertook a procurement for school aged immunisations for the whole of the South West. North Somerset Community Trust is the new provider for the provision of the Childhood Flu programme for school aged children in Bristol. They are working with Bristol Community Health to deliver this programme and the service is currently being mobilised ready for the start of term in September 2018. A key focus of the procurement was for the service to be fully accessible to young people, to improve uptake and reduce inequalities, and to make use of technology such as e-consent, and developments such as self-consent.

Child Health Information Services

During 2017/18, NHS England has completed a successful procurement of Child Health Information Services for the South West area. The new provider, Health Intelligence, will be prioritising the move to electronic data flow between GP practices and the Child Health Information System, and moving towards a greater role in failsafe and follow-up of children who have incomplete vaccination schedules. It is hoped this will greatly improve the timeliness, accuracy and completeness of immunisation data and contribute to improvement in coverage rates.

Key current risks

Measles and MMR

A large outbreak of measles occurred in Europe in 2017/18 and there has been a subsequent increase in the number of reported cases of measles within the South West, and particularly Bristol. Cases have occurred in a number of contexts including schools, nurseries, healthcare settings and workplaces. As of March 2018 the median age of cases was 15 years but age of cases has ranged from under 1 year to 74 years. Whilst there has been an effective multi-agency response to the management of outbreaks, on-going multi-agency support is needed to build on the preventive work that is currently taking place within Bristol and to continue to increase uptake in the routine MMR programme for children to reduce the potential for further outbreaks of measles in all age groups.

Pertussis

Pertussis was the most notified vaccine preventable disease in Bristol in 2017/18. Ensuring that coverage remains high amongst children and pregnant women will help to ensure that the most vulnerable are protected. Maternity services have been commissioned to deliver immunisations to women in maternity settings to improve access and choice within this programme and services are currently being developed. More detailed work is required to ensure reporting processes are fully embedded as the new services are developed to ensure performance fully reflects activity.

Influenza

In 2017/18, the key changes in the South West seasonal flu programme were the:

- successful continued expansion of the child flu programme to include all children aged 2, 3 and 4, and to all children in school years 1, 2, 3 and 4
- inclusion of patients who are morbidly obese in the GP offer
- local roll-out across SW providers of the maternity service offer to pregnant women

- delivery of the programme to care home workers and social workers as an addition to access through their employer occupational health scheme
- continuation of the Advanced Community Pharmacy Seasonal Influenza Vaccination programme
- extension of the CQUIN for frontline health care workers for a second year.

Areas for focus in 2018-19

- Continue, and further develop, the multi-agency approach to improving uptake of MMR (across all ages)
- Continue to develop and implement local plans for multiagency collaborative activity via the Bristol Locality Immunisation group
- Improve uptake of vaccinations to pregnant women
- Improve uptake of vaccinations delivered in school, including delivery of the self-consent pilot
- Review uptake of immunisations for older people (shingles and PPV)
- Focused work on improving uptake of the flu vaccine in all eligible groups, with specific focus on 2-3 year olds, the school-age programme, pregnant women, at risk groups aged under 65 and frontline health and social care workers.
- Planning for the implementation of the expansion of the adolescent HPV programme to boys (as announced in July 2018)

2.2 Screening

The UK National Screening Committee defines screening as “The process of identifying apparently healthy people who may be at increased risk of a disease or a condition so that they can be offered information, further tests and appropriate treatment to reduce their risk and/or complications arising from the disease or condition.”

There are currently three national cancer screening programmes: [breast](#), [bowel](#) and [cervical](#); and eight non-cancer screening programmes: six antenatal and new-born ([Fetal Anomaly](#), [Infectious Diseases in Pregnancy](#), [Sickle Cell and Thalassaemia](#), [New-born and Infant Physical Examination](#), [New-born Blood Spot](#) and [New-born Hearing](#)) and two young person and adult ([Abdominal Aortic Aneurysm](#) and [Diabetic Eye](#)).

Successes/progress

Strengthened collaborative multi-agency action plans to target areas of poor uptake and coverage for each of the screening programmes.

Each of the screening programmes report to a local governance board at which achievement of key performance indicators including uptake and coverage are reviewed. A key issue for the programmes is to improve coverage and reduce variation, ensuring that the service is both equitable and accessible to all of the eligible populations in Bristol, including those in hard to reach groups and those with protected characteristics.

A number of projects have been developed to better understand barriers to accessing the services and to improve responsiveness and access where necessary. These include focus

groups with representatives of the Somali community to explore issues relating to uptake of the FoBT Bowel Screening programme, and the Avon Breast Screening Unit developing a DVD for women with Learning Disabilities supported by the PHE Quality Assurance Team.

Quality Assurance (QA) visits to programmes to ensure compliance with national standards and continuous service improvement.

All of the screening programmes that provide a service to the Bristol population are subject to external review by the PHE Quality Assurance (QA) Team. Recommendations made through these visits have been incorporated into programme board agendas and are reviewed at these meetings. Additionally, providers are supported to address challenging recommendations by the Screening and Immunisation Team.

Close monitoring of demand and capacity, and care pathways within the cancer screening programmes

This continues to be monitored through contractual meetings and programme boards. Quarterly assurance reports are reviewed by the Director of Public Health. Escalating concerns promptly and reviewing pathways of care, as required, to maintain service effectiveness, ensure waiting times remain within acceptable standards, and to meet any increase in demand.

Key current risks

Breast screening

A national shortage of specialist staff including radiographers and pathologists is putting pressure on the Avon Breast Screening Unit to deliver services. This is not a unique situation as similar capacity issues are being felt in other units and this has been escalated nationally. Whilst there are mitigation plans in place, this is a current risk.

Bowel screening

Following national consultation, a decision has been taken to introduce FIT120 as a screening test in to the bowel screening programme to replace the current faecal occult blood test. Current planning is for FIT120 to go live from December 2018 or April 2019 at the latest, with a phased rollout. Detailed operational guidance and funding agreements are awaited. National survey data in 2017 indicated that many providers, including those in the South West would have difficulty rolling out FIT due to the expected increase in the number of colonoscopies. The Bristol and Weston programme are a high performing service and have almost fully rolled out Bowel scope screening. They have indicated that they will be able to implement the new FIT testing by April 2019 as planned. The Public Health Commissioning Team and the Screening and Immunisation Team are working closely with these providers to support local planning.

A South West cancer alliance pilot to introduce FIT for symptomatic testing in primary care, which is also being introduced this year, is likely to put additional pressure on endoscopy services.

Cervical screening

National work is underway to plan for and roll-out primary HPV testing. This is the largest ever change to the programme and includes national procurement of a small number of primary HPV screening labs and the development of a new national cervical screening IT system.

For women, the experience of the cervical screening programme will be the same but the samples will be checked first for HPV infection and only those that are positive for high risk infection will go forward for cytology and more frequent screening. The aim of this change is to more effectively identify women at greatest risk of developing cancer, and at the same time return a high proportion of women who are HPV negative (and at lower risk of cancer) back to routine screening intervals.

Laboratories that process cytology samples are being re-configured across the South West. Avon have already converted to HPV primary testing being a pilot site for this programme, and is also supporting other areas by taking samples from areas which have experienced backlogs of samples and increased turn-around times as a result of the changes occurring to the infrastructure to achieve full roll out of this new programme. HPV primary testing of cervical samples is due to be implemented in all services by December 2019.

Diabetic Eye Screening

During 2017/18, NHS England South West is undertaking a large procurement for all South West Diabetic eye screening services. The new provider/s will be in place for 1st April 2019. A key focus of the procurement is the approach to locality working and access for patients to improve uptake and reduce inequalities.

The Screening and Immunisation Team has been working closely with the provider teams to facilitate an improvement in the accuracy and completeness of screening registers. These rely on information being shared and validated by both the GP practice and the screening team. Audits have been undertaken to assess accuracy and work to improve this has been undertaken where needed. During the last year, all providers are now moving towards implementation of GP2DRS, which enables details of registered patients eligible for screening to be automatically extracted. This should improve the timeliness and accuracy of the identification of the eligible cohort, as long as GP practices continue to ensure accurate coding of diabetes in patient records.

The current programme invites all eligible patients for annual screening. During 2018/19, screening intervals will be extended and those patients whose screening history identifies them to be at lower risk of retinopathy will be invited every two years. Other patients will continue to be invited every year.

Antenatal and Newborn Screening

Services in Bristol have been working hard to improve KPIs but there are still concerns around some of these including achieving the KPI for avoidable repeats of blood spot tests and achieving sufficient screening of babies that move in to Bristol after they are born.

Areas for focus in 2018-19

- Support initiatives to improve access to a screening for all eligible populations
- Plan and implement FIT120 testing for bowel screening
- Monitor the impact of HPV primary testing and lab reconfiguration on cervical screening and achieve implementation of the new programme within the required timescales
- Mobilise Diabetic Eye Screening provider once procurement is complete
- Reduce avoidable repeats, improve sample transport times, and improve coverage of 'movers in' for the Ante-natal and New Born Screening Programme.

3. Emergency Preparedness, Resilience and Response (EPRR)

The local health economy needs to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident.

The Civil Contingencies Act 2004 (CCA2004) requires health organisations to show that they can deal with such incidents while maintaining services. Organisations must have effective, well-practiced emergency plans in place in order to protect the population of Bristol.

In Bristol, EPRR is facilitated by two fora; the Local Health Resilience Partnership and the Local Resilience Forum.

Successes/ progress

Learning from recent incidents

Snow and freezing temperatures: a multi-agency debrief took place after the severe weather experienced in February/March 2018. This identified a number of areas to improve. Much of this centred around the ability of health and social care workers to get to work during snow, particularly in more rural areas. Whilst the responsibility for this lies primarily with individual agency business continuity plans, the ability to coordinate voluntary agency 4x4 support was also identified and arrangements to activate a '4x4 Support Cell' have been improved.

The Kerslake report, identifying learning from the 2017 Manchester attacks is currently being examined by the LRF. The only Local Authority focused recommendation concerned the ability to collect and distribute financial donations made by the public following incidents. Bristol City Council have signed a Memorandum of Understanding with the Quartet Community Foundation and Bristol Charities to provide this function.

The learning from the Grenfell tragedy is still emerging. Whilst much work was done following the tragedy with regards to fire safety in tower blocks and reassurance to residents, the Grenfell Inquiry is likely to identify further learning for responders.

Local Authority Training and Exercising

A significant programme of training has taken place in Bristol City Council based on the learning from the incidents above. This has been focussed on expanding the Council's ability to support individuals and communities affected by incidents by:

- Increasing the Council's ability to open and staff rest centres and other emergency centres
- Establishing a call out list of social workers and care workers to support the response to incidents
- Improving the Council's ability to manage incidents by incorporating the incident management system into the Bristol Operations Centre
- Re-writing and testing recovery arrangements.

Emergency Mortuaries, Mass Fatalities and Excess Deaths

The LRF Emergency Mortuary and Mass Fatalities Plan has been re-written and signed off the Avon and Somerset LRF Executive Group. With the demise of the Home Office held National Emergency Mortuary Arrangements (NEMA) contract, Bristol City Council has taken possession of the South West's share of national emergency mortuary equipment, with Flax Bourton Public Mortuary set to become a regional 'emergency mortuary'.

Associated arrangements for the deployment and use of this equipment across the region is under development. Following a cold winter that saw an increase in seasonal mortality put mortuary capacity across the region under pressure, increased mortuary capacity in Flax Bourton Public Mortuary and North Bristol Trust will be in place for the coming winter.

National Health Protection Audit

In July 2017 Local Health Resilience Partnership (LHRP) co-chairs were asked to participate in an assurance exercise about planning and preparedness for responding to threats to the public's health in their area. This exercise was as a result of a recommendation by the House of Commons Health Select Committee in its report on the public health system post 2013. This was published in September 2016, and it asked Public Health England to lead an audit of local health protection arrangements.

The audit took the form of an online questionnaire and submissions were reviewed by a steering group comprising the key statutory and membership organisations working in public health, namely:

In November 2017 the LHRP co-chairs received an anonymised report sharing the initial analysis of the data from all LHRPs. The report shows a summary score for each question and an overall score as well as showing each response as either red, amber or green.

There are three areas of concern that require further work locally, with regards to;

- Radiation monitoring – national guidance remains outstanding
- Role of pharmacy/GPs in Pandemic Flu
- Role of GPs in mass vaccination/prophylaxis

The LHRP (Local Health Resilience Partnership) has set up a series of task and finish groups to work on the above areas of concern.

Key current risks

The ASLRF Risk Assessment Working Group (RAWG) currently has 4 very high and 5 high risks identified on the Avon and Somerset Community Risk Register:

- Very High: Coastal flooding, Fluvial flooding, Pandemic Flu, Chemical release
- High: Industrial accidents, Severe weather – snow and freezing temperatures, Fuel supply disruption, Electricity failure (this risk is still under review), Heatwave).

The RAWG have compared multi-agency capabilities against these risks and this is informing training and exercising programmes moving forward.

Areas for focus in 2018-19

- The continued learning from Grenfell is likely to inform work programmes going forward, as is the ongoing focus on the risk of electricity failure.
- Exercise Spitfire will test the Off Site COMAH Plan (Control of Major Accident Hazards) in November.
- Renewed central government guidance regarding pandemic flu is expected to be published imminently and will activate a review of pandemic flu preparedness.

4. Environmental hazards to health, safety and pollution control

Air Quality

Poor air quality can have an impact on health at all stages of life, from being associated with low birth weight, impacts on lung function development in children, an increased risk of chronic disease and acute respiratory exacerbations, to acute and chronic premature death. Latest evidence is linking air pollution with impacts on cognitive function. All these health impacts can impact upon a person's quality of life. The most vulnerable are the young and old.

Air quality in Bristol is sufficiently poor in many locations for the health impacts described in the previous paragraph to be experienced by citizens in Bristol. Monitoring data shows continued exceedances of the annual mean nitrogen dioxide (NO₂) air quality objective close to roadside locations in the city centre and along the main arterial routes. Concentrations of NO₂ do, however, appear to be declining but further urgent action is needed to comply with legal limits.

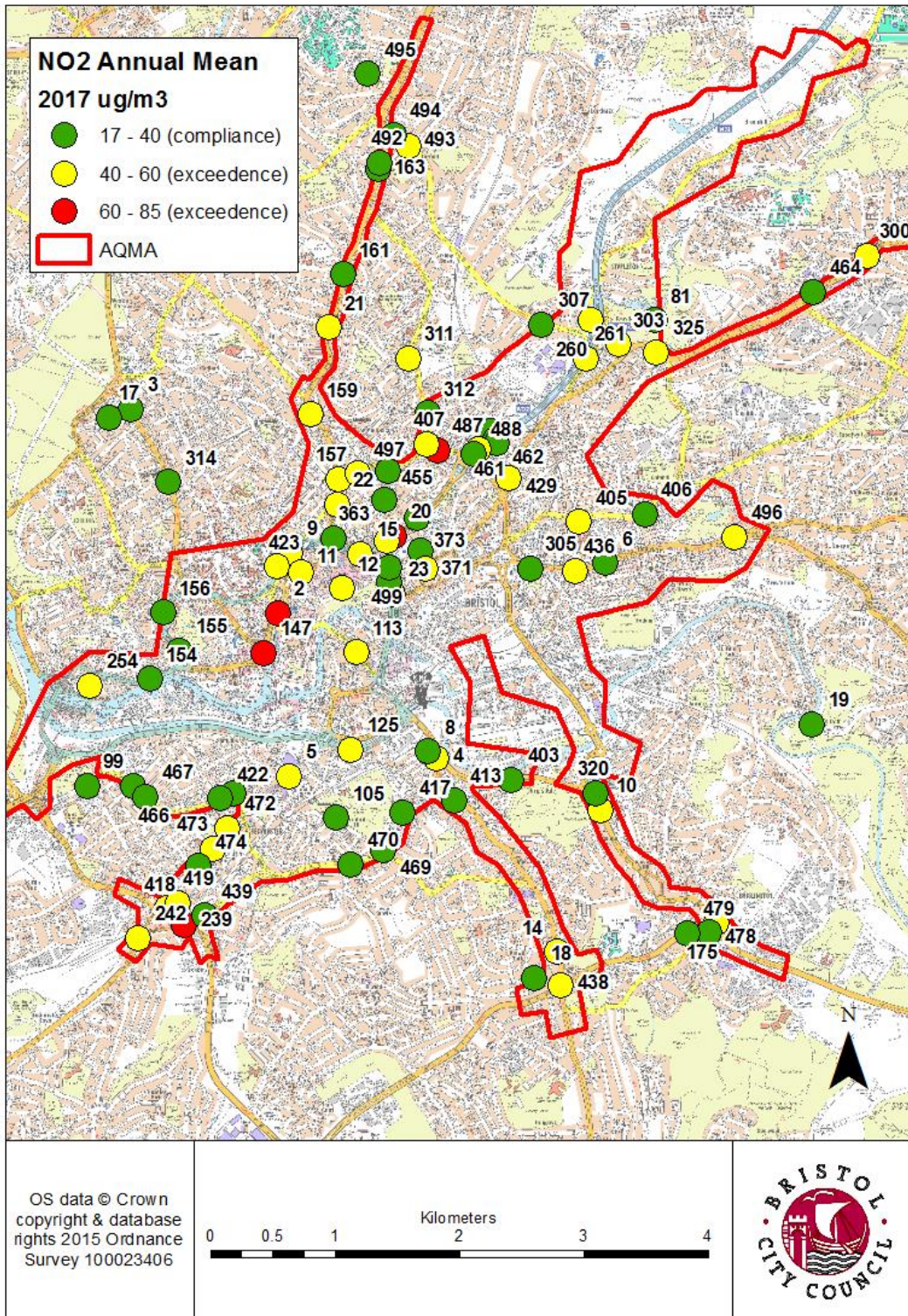
A report commissioned by BCC⁶ calculated that approximately 300 deaths of Bristol residents can be attributed to air pollution (particulate matter - PM_{2.5} and nitrogen dioxide – NO₂). In 2013 this equates to 8.5% of all deaths in Bristol annually. These deaths attributed to air pollution compare, on average, to 9 people killed in road traffic collisions in Bristol each year.

Local authorities are required to declare an Air Quality Management Area (AQMA) (see figure 5) where exceedances of air quality objectives occur and people are present for the relevant averaging period. The current air quality management area for Bristol is shown in Figure 3 and covers those locations where exceedance of objectives for NO₂ has been measured and relevant exposure to this pollution occurs. Once an air quality management area has been declared, an air quality action plan is required in order to identify measures aimed at achieving compliance with the air quality objectives. BCC has been instructed by government to deliver compliance with EU limit values in the shortest possible time.

Monitoring of NO₂ concentrations in the Avonmouth and Lawrence Weston areas showed compliance with the objective and no requirement for an AQMA to be declared. The situation will continue to be monitored closely.

⁶ Air Quality Consultants (2017). Health Impacts of Air Pollution in Bristol.: Air Quality Consultants Ltd

Figure 5. Bristol Air Quality Management Area and recent NO2 measurements



Avonmouth Nuisance Dust Monitoring

Due to concerns from residents the Environment Agency and Bristol City Council carried out monitoring of Air Quality in Avonmouth from August 2014 until September 2015 in response to resident concerns about air quality. The Bristol City Council monitoring station measured the very small particles in the air which we can't see, finer than the kind of dust which people see on car window screens or window sills. These small particles can get past the body's natural filters and into people's lungs. They are measured at 10 microns ('PM10') and 2.5 microns ('PM2.5'). The results after 12 months of monitoring showed that all the

measurements were well under the European Union Air Quality limits. The dust monitoring also analysed the heavy metal content in the Avonmouth samples.

A second phase of monitoring was undertaken in 2016 which focused on larger particles; this is dust which can be seen, typically appearing on cars windscreens and other locations. All results were well below available standards and sample contents did not indicate any dominant/industrial source. These results were fed back to the Community via an officer presentation at the community hall in 2017-18. Officers continue to monitor and investigate complaints when they are made.

At the time of the 2016-17 monitoring the results indicated that there is no underlying depositional dust issue for residents from industrial activities in and around Avonmouth. However with all industrial areas should there be an acute dust episode residents are advised to continue to report concerns to the Pollution Control Team by calling the Customer Service Centre on 01179 222500 Option 3. During 2017-18 the results of the dust monitoring were fed back to the community. During the year a small number of complaints were received about potential nuisance dust which officers investigated, they will continue to monitor the situation when reports are made.

Successes/progress

Mayoral Air Quality Working Group

A Mayoral Air Pollution Working Group (MAPWG) has been established tasked with improving air quality in the city. The key focus of the group is to provide a positive impact on health and wellbeing for all communities including the most vulnerable, support a flourishing local economy and accelerate the transition to a zero emission city. The group is co-chaired by the cabinet member for transport and cabinet member for health and wellbeing.

Key objectives of the MAPWG are;

- To advise on the implementation of the Administration's Air Quality Commitments.
- To guide the development of a new Air Quality Action Plan that improves health and addresses compliance with the exceedances of air quality objectives and fulfils the council's statutory duty.
- To develop plans for the implementation of a Clean Air Zone as part of the Air Quality Action Plan.
- To contribute to national policy and guidance such as from DEFRA and NICE.
- To monitor the impact of interventions on air quality and public health in Bristol.

The Group is attended by Bristol City Council officers from across the authority, including Public Health, who seek to engage with all stakeholders on the impact of poor air quality on public health and wellbeing, communities, economics and the need for city wide air quality improvement measures in order to promote less polluting lifestyle and business choices.

Key current risks

Maintaining an effective dialogue with Bristol residents about environmental hazards to health.

Areas for focus in 2018-19

- Work with the BCC Sustainable City and Climate Change Service and Strategic

Transport to develop a new air quality action plan for Bristol. This will include developing the business case for measures to achieve compliance with roadside NO2 limits in line with the ministerial Direction issued to BCC in July 2017. An important part of this will be to ensure the right messages are communicated to citizens and stakeholders with regards to the health impacts associated with current levels of pollution in Bristol. The aim, and legal requirement, is to implement measures to achieve compliance with air quality objectives in shortest time possible. Promoting a wider understanding of the health issue associated with air pollution is considered to be a vital part of the consultation process for air quality action plan measures. BCC has set up a [website](#) to engage and consult with people about the council's emerging plans.

- Continue to build neighbourhood relations with community members and representatives from the Avonmouth Industrial companies to discuss improvements in community impacts and improve the working relationship/good neighbours culture.

Appendix 2: Roles and responsibilities in the prevention and control of infectious disease outbreaks or health protection incidents in Bristol

<p>PHE Centre (AGW)</p> <p>The Centre Director will ensure that PHE, through the health protection team will lead the epidemiological investigation and provide the specialist health protection response to public health outbreaks / incidents. They or their designate (Deputy Director of Health Protection / Consultant in Communicable Disease Control / Health Protection Consultant) have the responsibility to declare a health protection incident, major or otherwise.</p>	<p>Preparation</p> <ul style="list-style-type: none"> • Providing advice (through the Local Health Resilience Partnership) to local NHS providers and commissioners regarding any preparation that they might need to undertake to ensure an effective and timely response when a public health outbreak / incident occurs; • supporting local authorities to understand and respond to potential threats; • collection, analysis, interpretation of surveillance data; • providing expert advice on hazards that pose a risk to the public's health and effective interventions to prevent and respond accordingly; • coordinating an out of hours rota for the delivery of specialist health protection advice by qualified personnel; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents; • providing access to regional and national PHE expertise as required; • advising on the requirement for prophylactic treatment and immunisation for all health protection incidents; • keeping the DPH informed about significant health protection issues and actions being taken to overcome them; • providing the local authority with information to support the Joint Strategic Needs Assessment and Joint Health and Wellbeing Board strategies as required; • supporting local authorities to develop a trained and knowledgeable workforce in the area of health protection. <p>Response</p> <ul style="list-style-type: none"> • Leading the Public Health response to declared Major Incidents; receiving and investigating notifications (with partners); • initiating immediate control measures when required; providing expert epidemiological advice through field epidemiology teams to support incident / outbreak investigation (both in the response and recovery phases); • sharing information concerning incidents / outbreaks with the local authority through the Director of Public Health; • chairing the 'Outbreak/Incident Management Team' and keeping health protection risks under review throughout the incident; communicating to partners when an Outbreak/Incident Management Team is established; • providing updates until the outbreak/incident is declared
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	<p>over;</p> <ul style="list-style-type: none"> • coordinating public communications / media response in collaboration with the local authority, CCG and NHS England.
<p>BCC Public Health</p> <p>Through the Director of Public Health, the Local Authority has overall responsibility for the strategic oversight of an incident / outbreak impacting on their population's health. They should ensure that an appropriate response is put in place by NHS England South West and PHE supported by the CCG.</p> <p>In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health and that risks have been identified, are mitigated against and adequately controlled.</p>	<p>Preparation</p> <ul style="list-style-type: none"> • Preparing for and leading the local authority's response to incidents that present a threat to the public's health; providing information, advice, challenge and advocacy; • chairing the Bristol Health Protection Committee to ensure that the health protection system is meeting the needs of its local authority population and that risks identified are adequately mitigated against and control arrangements are in place; • coordinating the Joint Strategic Needs Assessment to support the understanding of local health protection risks; • reporting local health protection arrangements and escalating health protection risks to the Health and Wellbeing Board; • ensuring that relevant commissioned services (including providers of sexual health services, drug and alcohol services and school health services) can provide an appropriate response to any incident that threatens the public's health and that business continuity plans are in place; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. <p>Response</p> <ul style="list-style-type: none"> • Collaborating with PHE to lead the PH response to a major incident; • participating (as required) in Outbreak/Incident Management Teams, to help inform decision about the appropriate level of NHS response from providers AND working alongside PHE and the CCG to agree and source through agreed plans the resources needed to be released; • briefing Local Authority colleagues and elected members regarding health protection incidents/outbreaks; • mobilising local authority resources required to support an incident (e.g. Scientific Services and Animal Health and Welfare & Trading Standards).
<p>BCC Environmental Health</p> <p>Local authorities have defined health protection functions</p>	<p>Preparation</p> <ul style="list-style-type: none"> • Ensure that relevant services and providers have effective health protection and business continuity arrangements in place to guarantee an appropriate response to any incident that threatens the public's health; • exercising powers under the health protection regulations to prevent or limit the spread of an infectious disease;

<p>and statutory powers in respect of environmental health and health and safety.</p>	<ul style="list-style-type: none"> • prosecuting environmental and public health offenders; • informing the Drinking Water Inspectorate of an outbreak of illness associated with, or suspected to be associated with, a private water supply; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. <p>Response</p> <ul style="list-style-type: none"> • With the Public Health England Centre, supporting local leadership in responding to communicable disease incidents and outbreaks; • inform Director of Public Health / Public Health England Centre of any emerging outbreaks/incidents; • with the Public Health England Centre, investigating clusters and outbreaks of foodborne infectious diseases; • participating (as required) in Outbreak/Incident Management Teams to help inform decisions about the appropriate level of Environmental Health (specialist and administrative) resources required to support the incident response; • provide specialist help and advice on the environmental aspects of the outbreak; • when required, undertake inspections, collection of specimens and investigations of implicated premises; • as an Health and Safety enforcement authority, execute the statutory duty to investigate infectious disease linked to workplace settings, undertake inspections, regulate; • as a Port Authority, responding to any outbreak of infectious or gastrointestinal disease at Bristol Seaports (Avonmouth and Royal Portbury Dock).
<p>Bristol North Somerset and South Gloucestershire CCG</p> <p>The primary role of the CCG is to ensure through contractual arrangements with provider organisations that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening/diagnostic and treatment services).</p>	<p>Preparation</p> <ul style="list-style-type: none"> • Ensuring provider organisations commissioned by the CCG are able to respond adequately to health protection incidents / outbreaks where screening, diagnosis, treatment or vaccination might be required; • disseminating information as required by PHE or the local authority regarding the prevention of / response to, health protection incidents/ outbreaks across the local system of health care; • with regards to planning and preparedness, obtain appropriate advice from persons with the professional expertise in the protection or improvement of public health; • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. <p>Response</p> <ul style="list-style-type: none"> • Participating (as required) in Outbreak/Incident Management Teams to help inform decisions about the appropriate level of NHS response from providers and any

	<p>CCG resources needed to be released;</p> <ul style="list-style-type: none"> • Providing (if requested by NHS England South West), clinical support for the prescribing and administration of medication.
<p>NHS England</p> <p>Has responsibility for managing/overseeing the NHS response to the incident, ensuring that relevant NHS resources are mobilised and commanding / directing NHS resources as necessary. Additionally NHS England South West is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.</p>	<p>Preparation</p> <ul style="list-style-type: none"> • Planning and securing the health services needed to protect the public's health; • with regards to planning and preparedness, obtaining appropriate advice including from persons with a broad range of professional expertise in the protection or improvement of public health. • participating in arrangements for exercising and testing plans to respond to outbreaks / incidents. <p>Response</p> <ul style="list-style-type: none"> • Mobilising NHS resources in response to incidents and outbreaks; • participating (as required) in Outbreak/Incident Management Teams to help inform decisions about the appropriate level of NHS response from providers and working alongside the CCG to agree the resources needed to be released; • co-ordinating the primary care response to the incident with the Area Team Pharmacy Advisor (as required); • Supporting CCGs to coordinate any response required by Community Trusts and/or Acute Trusts.

Appendix 3: Glossary

AGW	Avon, Gloucestershire and Wiltshire
AMR	Antimicrobial Resistance
AQMA	Air Quality Management Area
ASLRF	Avon and Somerset Local Resilience Forum
BCC	Bristol City Council
BCG	Bacillus Calmette-Guerin
BNSSG	Bristol, North Somerset and Gloucestershire
BSI	Bloodstream infections
CBRN	Chemical Biological Radiological Nuclear
CCG	Clinical Commissioning Group
CDI	Clostridium difficile (C.diff) infection
COMAH	Control of Major Accident Hazards
CPE	Carbapenemase-producing Enterobacteriaceae
DTaP	Diphtheria, Tetanus and Polio
EPPR	Emergency preparedness, resilience and response
EVD	Ebola Virus Disease
GI	Gastro Intestinal
HWB	Health and Wellbeing Board
HCAI	Healthcare associated infections
HIB	Haemophilus influenzae type b
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
HPC	Health Protection Committee
HPV	Human Papilloma Virus
IGAS	Invasive Group A Streptococcal
IPC	Infection, Prevention and Control
IPV	Inactivated Polio Vaccine
LHRP	Local Health Resilience Partnership
LTBI	Latent Tuberculosis Infection
MDR TB	Multi drug resistant tuberculosis
MMR	Measles Mumps and Rubella
MRSA	Methicillin Resistant Staphylococcus Aureus
NHS E	NHS England
NICE	National Institute for Health and Care Excellence
NOIDs	Notifiable Infectious Diseases
PCV	Pneumococcal conjugate vaccine
PHE	Public Health England
PIR	Post-infection review
QP	Quality premium
RCA	Root cause analysis
STAR-PU	Specific Therapeutic group Age-sex Related Prescribing Unit
STI	Sexually Transmitted Infections
TB	Tuberculosis
Td	Tetanus and diphtheria
WHO	World Health Organisation



Bristol Health & Wellbeing Board

<p>Health and Wellbeing in Bristol 2018 (Joint Strategic Needs Assessment (JSNA) 2018 data profile)</p>	
<p>Author, including organisation</p>	<p>Nick Smith, Strategic Intelligence and Performance Manager (BCC) <i>on behalf of</i> <i>Sue Milner, Interim Director of Public Health</i></p>
<p>Date of meeting</p>	<p>24th October 2018</p>
<p>Report for Information</p>	

1. Purpose of this Paper

To inform the Bristol Health & Wellbeing Board of the completed “Health and Wellbeing in Bristol 2018 (JSNA 2018 data profile)”

Local authorities and clinical commissioning groups (CCGs) have an equal and joint statutory duty to prepare a Joint Strategic Needs Assessment through the Health and Wellbeing Board in order that the health and social care needs of the population are assessed and plans and services can be put in place. The HWB delegates this function to the Director of Public Health as the Chair of the JSNA Steering Group.

The JSNA is to support local evidence-based priorities to inform decision-making and commissioning, to improve the public’s health and reduce inequalities. It is relevant to BCC, CCG and partners (eg Healthwatch and the VCS).

2. Executive Summary – to include the main points for the HWB to consider

- The “Health and Wellbeing in Bristol 2018 (JSNA 2018 data profile)” provides the data and analysis to identify and support local evidence-based priorities to inform decision-making and commissioning.
- It highlights outcomes for the most disadvantaged and some of the intractable issues that need to be addressed by the longer term One City approach.
- It provides the data to underpin decision-making across Health and Social Care.
- It provides evidence and data to inform work to address inequalities.

- The JSNA is published on behalf of the Bristol Health & Wellbeing Board, with a Foreword by the HWB co-Chairs.

3. Recommendations for the HWB to Agree

The Board is asked to:

- note the contents
- endorse and promote the publication of the “Health and Wellbeing in Bristol (JSNA 2018)” report

4. Main body of the report

This JSNA 2018 data profile is a core product that provides a wide-ranging evidence base for other services to use. It includes a summary of data indicators for Children and Adults, across Health and Wellbeing needs as well as Social Care, plus wider determinants covering data across Education, Housing etc. It assesses how Bristol is performing compared to England and Core Cities plus also highlights outcomes and inequalities within Bristol.

Please note the Executive Summary for the overview of key messages being highlighted.

In addition, the JSNA Steering Group has agreed that a survey to clarify user experiences of the JSNA and any products / issues to improve in future will be launched alongside the publication of the JSNA 2018 report.

5. Appendices

See Appendix 1: “**Health and Wellbeing in Bristol 2018 (JSNA 2018 data profile)**” final draft (Note – the Foreword will be added next week)



Health and Wellbeing in Bristol 2018

Joint Strategic Needs Assessment (JSNA)
2018 data profile

www.bristol.gov.uk/jsna

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Foreword from the Co-chairs of the Bristol Health and Wellbeing Board

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

Currently being written – Mayor of Bristol and Chair of BNSSG CCG

DRAFT

JSNA 2018 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. Bristol City Council (BCC) and NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) have equal and joint duties to prepare the JSNA through Bristol's Health and Wellbeing Board. The JSNA should inform decisions about how we design, commission and deliver services (both now and in the future), to improve and protect health and wellbeing across the city, while reducing health inequalities. The JSNA also provides the data to update Bristol's Health and Wellbeing Strategy and will inform the emerging One City approach.

This **Health and Wellbeing in Bristol 2018** report is the title of the Joint Strategic Needs Assessment (JSNA) 2018 data profile. It provides an updated and expanded overview of the changing health and wellbeing needs¹ in Bristol, and highlights the current challenges. The JSNA uses standard data-sets, such as the Public Health Outcomes Framework (or PHOF), for benchmarking Bristol overall against national indicators and other English Core Cities, and also uses local data from within Bristol City Council plus the CCG and Healthwatch Bristol in order to give a more detailed view of differences and inequalities within the city. It includes a focus on data by gender, with many indicators broken down for males and females, and where possible by ethnicity and deprivation.

The Bristol JSNA is also complemented by a range of other core products:

- Ward data profiles – A selection of JSNA data-sets for each of the 34 Bristol wards
- The “State of the City: Key Facts” report – a summary of major facts and infographics about Bristol, including Health and Wellbeing - see www.bristol.gov.uk/statistics for latest version
- Population of Bristol report - see Population page for latest version
- Open Data Bristol - A new site for accessing and sharing open data, including Dashboards to visualise data – will be the source to access the underlying JSNA 2018 data.
- JSNA Chapters - additional needs assessments which provide more detail on specific topics, plus information on current services, the evidence base and service user views.

JSNA 2018 Summary

The population of Bristol is estimated to be almost 460,000 people and has grown at a faster rate than nationally. However, the population growth varies across Bristol – some areas have increased by up to 50% in the last 10 years whereas other areas have seen the size of their population decrease. The population of Bristol is much younger than the national average and there is a correspondingly smaller proportion of elderly people, though numbers of people 75 years and over are projected to rise substantially in future (although less than the rise nationally). By 2026, there are projected to be 10,900 more children under 16 (a 13% increase compared to 5% nationally) with most of the increase now projected to be in the 10-15 years age band. The city is increasingly ethnically diverse, especially amongst children; however, this varies considerably across the city.

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

Life expectancy in Bristol has shown a gradual improvement over the last 25 years in line with national trends, although for men it remains significantly below the England average. The gap in life expectancy between the most and least deprived areas of Bristol has not changed significantly in recent years for either men or women.

Premature mortality rates have been gradually falling in Bristol, mostly due to reducing cardiovascular disease, with a smaller contribution due to fewer early cancer deaths. Premature mortality remains significantly higher than nationally, however, and rates vary significantly within Bristol. Cancer remains the leading cause of early death, followed by cardiovascular disease.

There has been a significant reduction in the number of children living in relative poverty in Bristol. However, around 20% of children live in relative poverty in Bristol – significantly higher than the national average of 17%. Bristol has high breastfeeding rates overall, with breastfeeding rates up to 90% in some parts of the city. However, in some areas rates are only 30% - the lowest rates are seen amongst white women living in deprived areas. Overall levels of obesity in Bristol school children remain stable and are similar to national levels. Almost 10% of 4-5 year olds in Bristol are obese, which rises to almost 20% for 10-11 year olds. Around 24% of 4-5 year olds are either overweight or obese – significantly higher than the national average. There have been large increases in recent years in the levels of MMR vaccinations in Bristol, though at 86% Bristol is still well below the 95% target. Bristol has seen a dramatic fall in teenage pregnancy rates since 2007, with the rate now being well below the national average.

Bristol's rate of young first time offenders has improved from being one of the worst in the country to one of the best amongst core cities. Only around 31% of young people in Bristol go on to higher education compared to 38% nationally. Within Bristol it varies considerably with some areas of Bristol seeing up to 100% of young people going on to higher education and other areas having some of the lowest levels in the whole of England. Young people not in education, employment, training or not known is higher in Bristol (8.6%) than England as a whole (5.5%).

Bristol's unemployment rate has fallen to 4.3%, continuing a downward trend from a high of 8% in 2015. Bristol has the highest gross weekly earnings of all the English Core Cities. Bristol's housing market remains buoyant; the average house price is £275,600, higher than the national average of £243,300. Housing is becoming increasingly unaffordable in Bristol with the cost of Bristol's cheapest homes being over 9 times the annual earning of lower income households. The number of rough sleepers in Bristol is rising – the average number recorded rose from 5 in 2010/11 to 69 in 2017/18.

More people commute by bike or foot in Bristol than any other local authority in the country. Bristol's rate of people killed or seriously injured in road traffic incidents is significantly lower than the national level and the second lowest of the English Core Cities.

Over 40,000 people in Bristol have a diagnosis of depression and new diagnoses of depression have risen sharply. Emergency hospital admissions for self-harm are significantly higher than the national average and are not falling. Bristol's suicide rate at 12.7 deaths per 100,000 is significantly higher than the national average of 9.9 per 100,000.

In terms of crime Bristol has an increasing rate of violence against person offences and is over 50% higher than the England average and is the 2nd highest of the English Core Cities. Sexual offences are also significantly high compared to the national average and are rising.

We know that many of the health issues among our population are preventable with a significant proportion resulting from unhealthy lifestyles, with poor diet, obesity, tobacco smoking, harmful alcohol consumption and low physical activity being the biggest lifestyle contributors to ill health.

Physical activity levels in Bristol are high - according to national survey data over 70% of Bristol adults reported doing 150 minutes or more activity per week, one of the highest levels amongst all Local Authorities in England and significantly higher than the national average. However, over half of the Bristol population are overweight or obese. 65% of Bristol adults eat the recommended 5 fruit and vegetables a day, significantly better than the national average. Levels of smoking have fallen sharply in Bristol to around 11% (down from 21% in 2012) and are now significantly better than the England average. However, across Bristol wards there is a large variation in the number of households that have a smoker - ranging from 3% up to 40%. Deaths due to smoking remain significantly higher than the national average. The rate of alcohol related hospital admissions remains stable. Bristol has significantly higher rates of alcohol related harm than the national average and Bristol's drug related deaths remain significantly high compared to the national average.

Rates of sexually transmitted infections remain high compared to the national average. TB incidence rates in Bristol are improving and are at their lowest rate since 2003.

Bristol JSNA 2018 - Summary data points from each section

Life expectancy

- Life Expectancy in Bristol has increased by 1.9 years for men and 1.7 years for women in the past 10 years.
- Despite the rise in life expectancy Bristol is significantly worse than the England average for men.
- Inequalities in life expectancy have not improved. The gap between the most and least deprived areas is 9.5 years for men and 7.4 years for women.
- Men in Bristol live for around 59 years in good health; women live for around 63 years in good health. On average both men and women have 20 further years in poor health.
- The number of years people are living in ill health within Bristol range from 11 years to 31 years for females and from 10 years to 24 years for males.
- Dietary risks, tobacco and obesity are the biggest contributors to early death and disability. Also, alcohol & drug misuse and lack of physical activity are key lifestyle risk factors.
- Premature mortality rates in some areas of Bristol are over 3 times as high as other areas

Population

- The population has grown 11.5% since 2007 (8.0% nationally).
- Growth has been mainly concentrated in the inner city, especially young adults. The child population has risen across Bristol.
- Bristol's population is young, median age of 32.7 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%.
- Since 2012 births in Bristol have fallen gradually. In 2017 the number of live births fell to 5,960, the first time for a decade that births have been below 6,000 per annum.
- The population is projected to increase 9.2% to 498,100 by 2026. The child population is projected to rise 12.8% by 2026 (10,900 more children).
- The proportion of older people is lower than nationally but numbers are rising, especially for people aged 75 and over. Projected to rise 18.9% by 2026 (5,300 more people 75 & over).

Children & Young People's Health

- Since 2012 births in Bristol have fallen gradually. In 2017 the number of live births fell to 5,960, the first time for a decade that births have been below 6,000 per annum.
- Infant mortality rates in Bristol appear to have risen and are now similar to national rates. Nationally, the UK has an excessive infant and child mortality rate in comparison with other EU countries.
- Breastfeeding rates are higher than national. 6-8 weeks rates range from 30% (parts of South Bristol) to 90% (Redland).
- The % of pregnant mothers known to be smokers (10.2%) is falling, but significant socio-economic inequalities remain.
- Almost 5,000 under 25's are in receipt of Disability Living Allowance or Personal Independence Payments in Bristol
- Child hospital admissions for asthma across Bristol fell in 2016/17 but remain high in some areas such as the Inner City. Two of three admissions across Bristol are for boys.
- 1 in 4 (24.2%) of Bristol children 4-5 years have excess weight which is significantly more than nationally, and 1 in 3 (33%) of 10-11 year olds (similar to national average).
- 22.5% of 5 year old children have at least one or more decayed, missing or filled teeth, similar to national. Rates for tooth extractions in hospital are higher than nationally, especially 5-9 year olds (twice the national average).
- Overall, local immunisation coverage for most vaccines appears to be falling and are significantly below target. Coverage rates are lowest in Inner City and East Bristol.
- Rates of emergency hospital admissions from injuries are now significantly worse than national. For children (0-14) the rate is higher in boys, but for young people (15-24) is much higher for girls (due to high levels of self-harm).
- Almost 10% of children and young people experience emotional health problems, and self-harm hospital admission rates (10-24 years) have risen in recent years and continue to significantly exceed the England average.
- The rate of teenage conceptions in Bristol has fallen in the last decade and is similar to the England average.
- More 15 year olds smoke in Bristol than nationally, and significantly more have tried cannabis (2014/15 survey)
- Bristol has above average coverage for chlamydia screening (25.8% of 15 to 24 year olds screened in 2016).
- 20.1% of children under 16 live in low income families in Bristol, higher than 16.8% nationally
- Education inequalities across the city remain.
- For children in care, Health assessments have improved and more have up-to-date immunisations than nationally
- First-time entrants to the Youth Justice System in Bristol are significantly higher than nationally, but are falling.

Wider Determinants

- Deprivation - 16% of Bristol's population live in the "10% most deprived areas in England" in 2015. The greatest levels of deprivation are in Hartcliffe, Filwood and Lawrence Hill.
- Child Poverty - In 2015 there were 16,500 children under 16 in low-income families in Bristol; this is 20.1% of children, significantly higher than the England average of 16.8%. The greatest levels of child poverty are in Hartcliffe & Withywood, Filwood and Lawrence Hill.
- Education - 41% of Bristol pupils (2017) got a 'strong pass' (grade 5+) in both English and Maths GCSE (above national %) but only 16.1% of those on Free School Meals did
- Just over 9,800 children and young people (0-25) are known to have some level of Special Educational Needs (SEN)
- Over 600 children are "in care" in Bristol at any given time.
- The rate of 16-18 year olds "not in education, employment or training (NEET)" is worse in Bristol than nationally. Rates of young people going to Higher Education are below national, and "Bristol South" includes the lowest in the country.
- First-time entrants to the Youth Justice System are significantly higher than nationally, but the rate in Bristol is falling and one of the lowest amongst English Core Cities.
- Employment and Economy - The unemployment rate in Bristol (4.3% in 2017) has fallen and is now similar to the national average. Bristol has high average earnings, but the 10% highest paid earn 6 times as much every week as the 10% lowest paid.
- Sickness absence rates have risen and are now similar to national and one of the highest of the English core cities.
- Housing – The rise in house prices is outstripping earnings and shortage of affordable housing. Private renting sector is growing rapidly.
- Homelessness - The average annual rough sleeper street count in Bristol rose to 69 per week in 2017/18 from 37 per week in 2016/17.
- Fuel poverty - Over 24,600 households in Bristol are "fuel poor"; 12.9% of Bristol households, higher than the England average
- Air pollution - A modelled estimate is around 300 deaths a year in Bristol can be attributed to air pollution, which is 8.5% of all deaths.
- Promoting Healthy Urban Environments - More people in Bristol commute to work by bicycle or on foot than elsewhere. 71% of people are satisfied with parks and green spaces in Bristol, but only 56% in deprived areas. The rate of road traffic injuries is significantly below national.
- Crime - Numbers are rising (esp violent crime and theft). Rates of violent crime are the second highest of core cities.
- Reported Anti-social behaviour incidents rose in 2017/18. Numbers of reported sexual offences rose by 9% in Bristol last year (13% nationally). 73% of victims were female (2017/18).
- Domestic Abuse - the rate of recorded domestic abuse incidents and crimes is lower than nationally and one of the lowest of core cities.

Healthy Lifestyles

- Around 2 in 3 (64%) people in Bristol are physically active. Bristol has higher rates of regular physical activity than nationally or other cities
- Over half of adults in Bristol (55.2%) are overweight or obese, though this is lower than nationally (61.3%) and lowest of core cities. Men are significantly more likely to carry excess weight than women, but women are more likely to be “morbidly obese”
- Obesity is a key factor in the causes of premature death in Bristol from coronary heart disease and some cancers, and is a main cause of Type 2 Diabetes. Quality of Life survey (2017) suggests that significantly more residents in deprived areas are obese or overweight.
- Almost 55% of adults responding to Bristol’s Quality of Life survey 2017 report having “5 a day” fruit & veg but there is significant variation across Bristol
- There are 4 times as many Takeaways (including Takeaway Café/Coffee & Sandwich shops) than businesses selling fresh food ingredients (including supermarkets, butchers, bakers, greengrocers, etc.)
- 62 food businesses have so far achieved a Bristol Eating Better Award.
- Bristol’s estimated level of smoking has continued to fall faster than nationally – only 11.1% of Bristol adults smoke in 2017, down from 21% in 2012, and below the national average (14.9%).
- Smoking-related deaths in Bristol remain significantly higher than the England average rate.
- 22.3% of people in Bristol drink more than the recommendation of no more than 14 units per week, similar to nationally (25.7%).
- Alcohol-related hospital admissions in Bristol remain significantly higher than the England average for both men and women.
- Alcohol-related deaths in men are significantly higher than nationally, but rates are starting to fall
- Drug treatment completion rates in Bristol appear to be falling for opiate users (similar to national), and remain significantly worse than nationally for non-opiate users
- The rate of Bristol deaths from drugs misuse remains significantly higher than the national rate

Health Protection and Sexual Health

- The 2017 rate of new STI diagnoses in Bristol (excluding chlamydia in under 25’s) is considerably higher than the national average. From October 2017 there has been a notable increase in syphilis cases diagnosed in local sexual health services
- Bristol has above average coverage for chlamydia screening (24.6% of 15 to 24 year olds were screened in 2017). However chlamydia detection rates (1,691 per 100,000 in 2016) are significantly below the national recommendation of 2,300 per 100,000
- The diagnosed prevalence rate of HIV has risen in recent years and is similar to the national average. The increase reflects people living longer with HIV as a result of effective treatment, rather than an increase in new diagnoses. 44% of new HIV diagnoses are considered to be “late” in Bristol, higher than the national average of 40.1%

- The TB rate for Bristol is significantly higher than the rate for England but has reduced to 14.8 new cases per 100,000 population in 2016, the lowest annual incidence rate since 2003.
- The risk of complications from flu is greater in children under six months of age, older people, pregnant women and those with underlying conditions such as diabetes and liver disease.
- Flu vaccinations for school children in Years 1 and 2 has improved significantly over a two year period from 15.3% to 50.4% (Year 1) and from 13.4% to 47.1% (Year 2) following a switch from a pharmacy based model to a school based model
- Overuse and incorrect use of antibiotics are major drivers of antibiotic resistance. Rates of “broad-spectrum antibiotics” in Bristol have historically been significantly higher (worse) than the national average but are now falling and reducing the gap

Long Term Conditions

- Early deaths due to cardiovascular disease (CVD) continue to fall slowly and are similar to the national average.
- The rates of early CVD deaths for men and women are now similar to national rates. However, for men the rate of early CVD deaths remains double that for women, and for Coronary Heart Disease it is triple. There is significant variation in rates of early deaths across the city for CVD overall, CHD and Stroke.
- The rate of early deaths due to cancer in Bristol remains significantly higher than England.
- The rate of Cancer early deaths for men (176.3 per 100,000) is higher than nationally, but for women (133 per 100,000) the rate is now broadly similar to the national average.
- Early cancer deaths are now rising in some localities.
- Screening coverage for breast, cervical & bowel cancer in Bristol are all significantly lower than the England average.
- Recorded rates of diabetes continue to rise in Bristol overall as nationally. There are significant variations across the city, with much lower rates in the North & West inner.
- People in the most deprived 10% areas accounted for 18% of emergency hospital admissions of Bristol patients for diabetes.
- 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.
- In Bristol, rates of early deaths from respiratory disease are significantly higher than the England average. These rates are significantly higher for both men and women.
- COPD (chronic lung disease) recorded prevalence varies 4-fold across localities.
- People in the most deprived 10% areas accounted for 14% of emergency hospital admissions of Bristol patients for respiratory disease, and 18% for asthma (2016/17).
- Early death rates from liver disease in Bristol overall are broadly similar to the England average, for men and women. However, rates are almost three times as high in men as women in Bristol.

- Rates of alcohol-related hospital admissions are significantly higher than England for both men and women, and hospital admission rates for liver disease are higher for men.
- Musculoskeletal conditions are the main cause of years lived with disability (YLD) in England, accounting for 24% of all YLD
- Diagnoses of osteoporosis in Bristol have risen to 1,720 (1.2% of patients 50+, 2016/17) from 740 (0.6% of patients 50+, 2015/16). Bristol is over double the England average (0.5%, 2016/17)
- Preventable mortality rates in Bristol remain higher than England, though lower than in most core cities. There are around 672 “preventable deaths” per year in Bristol.
- Rates for preventable mortality are significantly higher in men than women.

Mental Health

- 40,400 Bristol patients (10%) have a diagnosis of depression, above the England average (9.1%), and is highest in Bristol North & West (outer). 8,700 patients (2.2%) had a new diagnosis of depression in 2016-17, above England average (1.5%)
- In Bristol during 2016-17 there were 1,460 emergency admissions for self-harm in Bristol (1030 females and 430 males), a rate of 291.3 per 100,000 population. There is a correlation between lower rates of self-harm and people living in less deprived areas.
- Bristol’s suicide rate is significantly higher than the England average. The majority of suicides are men, as is the case nationally, but the suicide rate for women in Bristol is significantly higher than for women nationally.
- Excess mortality rate in adults with serious mental illness is higher than national, but one of the lowest of core cities.
- 3.5% of Bristol residents reported a low life satisfaction score, similar to national (4.5%)
- Local data shows 18% have “below average mental wellbeing”, but rises to 28% in the most deprived areas
- Almost 10% of children and young people may be experiencing emotional health problems at any time
- In Bristol it is estimated that at least 5,100 children aged 5–16 and 1,700 16 & 17 year olds have a diagnosable mental health problem
- Young people report lower life satisfaction than nationally.
- Self-harm hospital admission rates for young people (10-24 year olds) in Bristol have risen in recent years and continue to significantly exceed the England average.
- Up to one in five women and one in ten men are affected by mental health problems in the perinatal period. In Bristol, it is estimated 1000 women each year will develop mild to moderate perinatal depression

Older People's Health and Social care

- It is estimated that there are over 4,200 people (65+) living with dementia in Bristol, with 3,120 having a GP diagnosis. The number of people with dementia (65+) is projected to rise by 13% by 2026, and by 41% by 2036 (linked to the high projected rise in people 85+)
- Dementia risk can be reduced by leading a healthy lifestyle - not smoking, eating well, and keeping active.
- Bristol's hospital admission rates following a fall (people 65+) are significantly higher than the England average. Bristol's rate of hip fractures in people 65+ remained at a similar rate to the previous year but is slightly higher than the England average
- There were 192 "excess winter deaths" in Bristol (2015/16), a significant decrease on the previous year (which experienced an uncommon high). Females accounted for 61% of deaths compared to 39% for males.
- More people in Bristol are able to die at home than nationally.
- 4,000 adults received a community-based social care support service (Community Support Service) during 2017/18. 2,020 of these were older people and 1,975 people aged 18-64 years, both of which are consistent with the previous year. 1,650 care home places were funded for older people in 17/18, lower than the past two years
- There are estimated to be between 6,300 and 11,400 older people who are socially isolated in Bristol

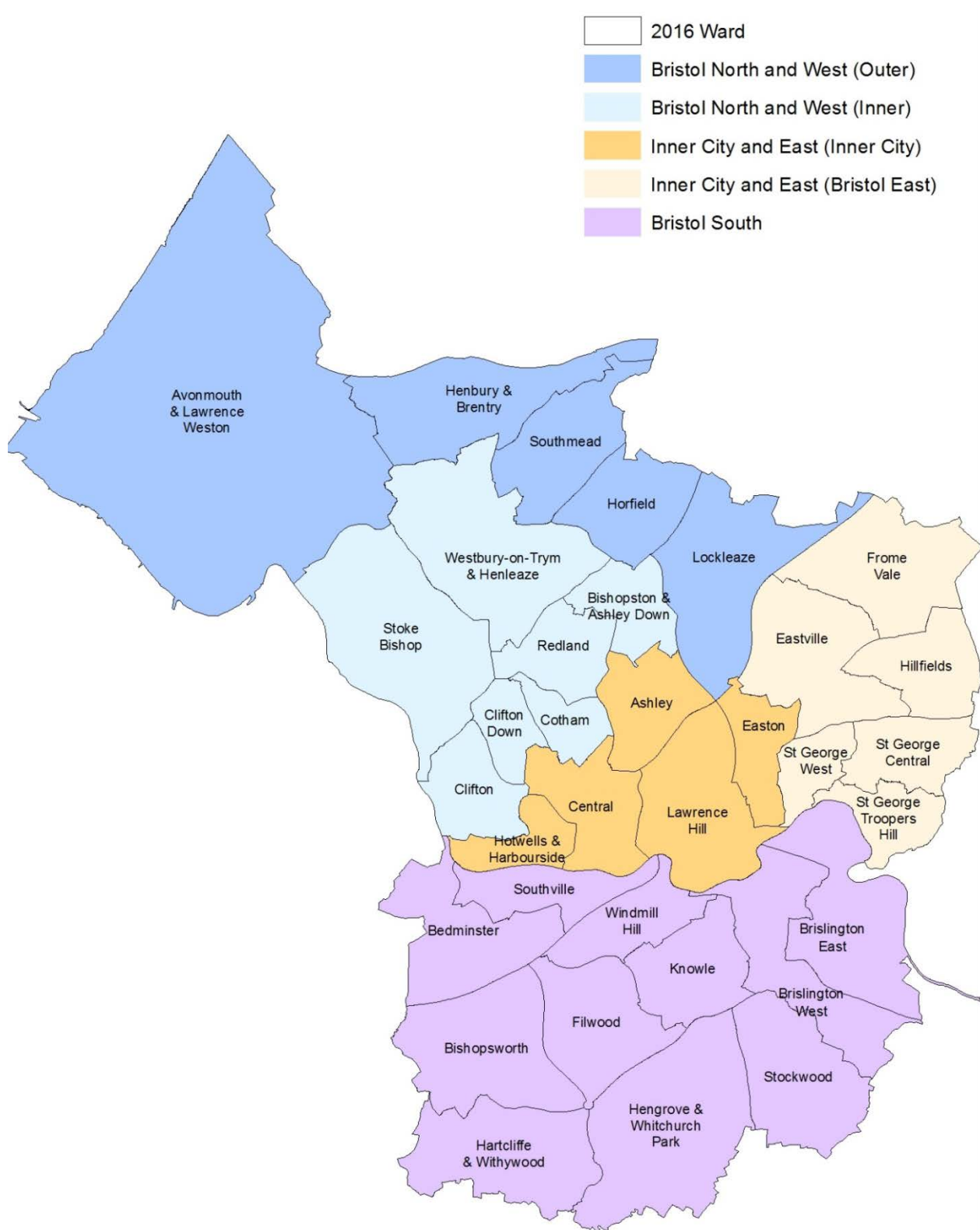
Public Feedback

- In 2017/18, Healthwatch visited 178 local services, reached over 3500 people on Twitter and Facebook and gave over 900 people information and advice. They have produced several reports tackling issues ranging including prostate cancer, mental health, 16-25 Independent people, University of the West of England sexual health and autism in the Somali community

Further data – useful overarching links and profiles

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

Map of Bristol wards and CCG sub-locality areas



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Section 2

Life Expectancy

Summary points

- Life Expectancy in Bristol has increased by 1.9 years for men and 1.7 years for women in the past 10 years.
- Despite the rise in life expectancy Bristol is significantly worse than the England average for men.
- Inequalities in life expectancy have not improved. The gap between the most and least deprived areas is 9.5 years for men and 7.4 years for women.
- Men in Bristol live for around 59 years in good health; women live for around 63 years in good health. On average both men and women have 20 further years in poor health.
- The number of years people are living in ill health within Bristol range from 11 years to 31 years for females and from 10 years to 24 years for males.
- Dietary risks, tobacco and obesity are the biggest contributors to early death and disability. Also, alcohol & drug misuse and lack of physical activity are key lifestyle risk factors.
- Premature mortality rates in some areas of Bristol are over 3 times as high as other areas

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. It is possible to extend life expectancy if people adopt healthy lifestyles, if improvements are made to the wider determinants of health such as employment, and if vulnerable people are supported through their life course, for instance by averting and mitigating the impact of Adverse Childhood Experiences.

People in Bristol are living longer. Compared to 10 years ago, men in Bristol now live 1.9 years longer, and women live 1.7 years longer.

Gender: Life expectancy for men in Bristol (78.8 years) is just below the England average of 79.5 years. For women life expectancy in Bristol (82.8 years) is broadly similar to the England average (83.1 years).

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

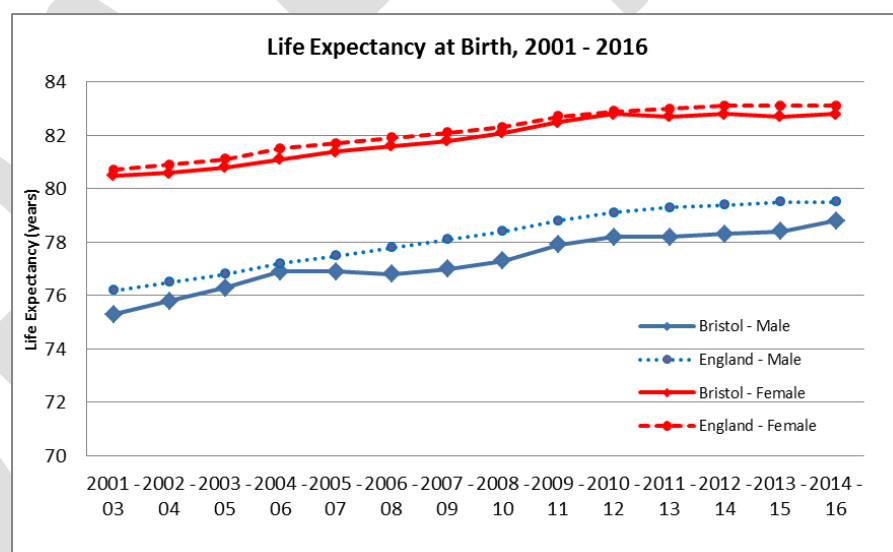


Fig 2.1.1: Life expectancy trends. Source: PHOF, August 2018

Life expectancy at 65 is the average number of years at age 65 a person would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life after that age. At age 65, men in Bristol will live a further 18.3 years on average, just below the England average of 18.8 years. Women in Bristol will live a further 21.1 years on average, the same as the England average.

Further information

- Healthy Life Expectancy in Bristol 2018 – see [JSNA Chapters](#)

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 (82.0 years) and women (85.6 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 (81.7 years) in Bristol.

Bristol’s worst male life expectancy is in Inner City (77.7 years). Male life expectancy in Inner City is unexpectedly low compared to female life expectancy in that area. Further investigation is needed to identify the reason for the low male life expectancy in Inner City.

There are large differences in life expectancy between the wards of Bristol. For both men and women Hotwells & Harbourside has the highest life expectancy: 85.4 years for men and 96.2 years for women (although the female life expectancy for Hotwells & Harbourside has a great deal of uncertainty and is not significantly different to any other wards in Bristol). Hartcliffe and Witherwood (74.1 years) has the lowest life expectancy in Bristol for men and Southmead (79.2 years) is lowest for women.

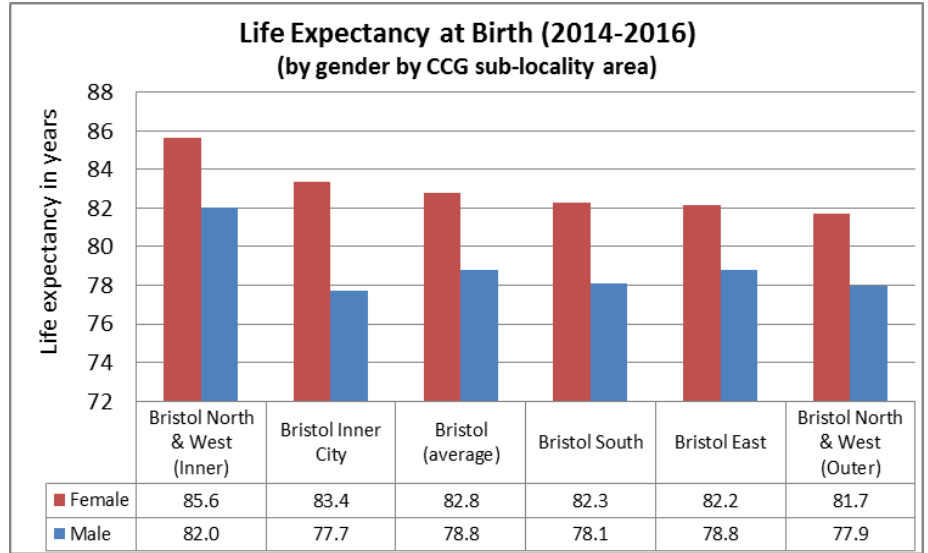


Fig 2.2.1: Life expectancy by sub locality, 2014-2016

Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

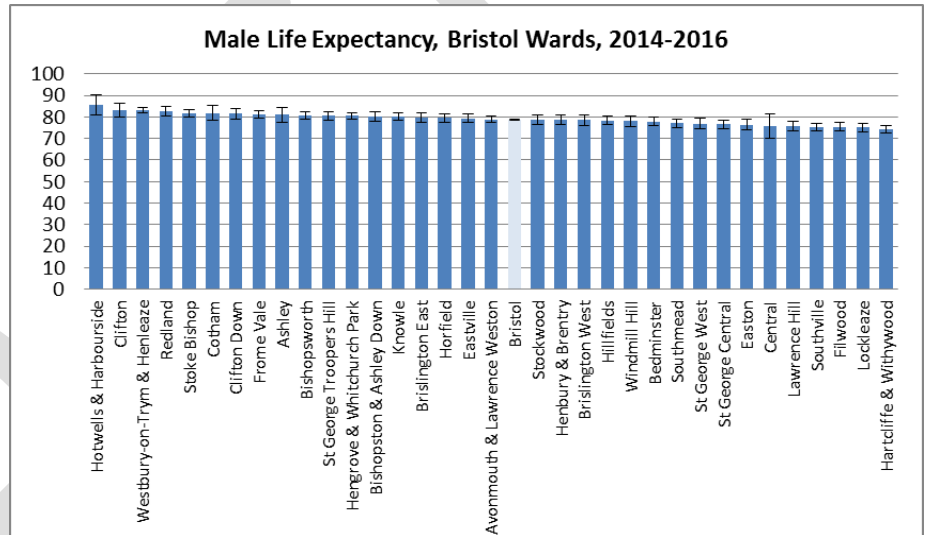


Fig 2.2.2: Male life expectancy by ward, 2014 – 2016

Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

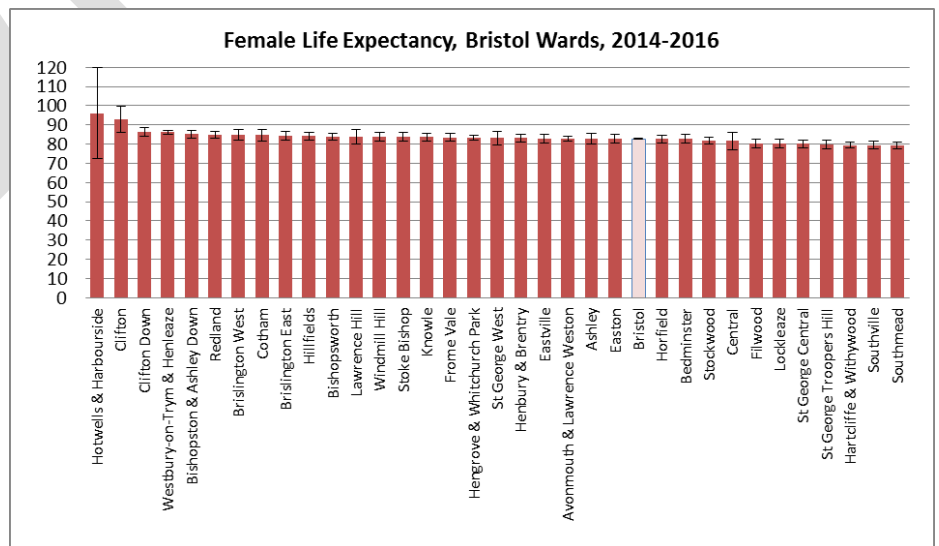


Fig 2.2.3: Female life expectancy by ward, 2014 – 2016

Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

2.3 Life Expectancy Gap

The standard national measure of inequality in life expectancy is the Slope Index of Inequality (SII) statistic. This measures the estimated difference (using a line of best fit) in life expectancy (in years) between the most deprived 10% of the population and the least deprived 10% within Bristol. This measure allows us to compare Bristol's inequalities to other local authorities and to monitor changes over time in a statistically robust manner².

The gap in life expectancy between the most deprived and least deprived groups is currently 9.5 years for men (fig 2.3.1) and 7.4 years for women (fig 2.3.2). This gap has not shown any clear signs of reducing over recent years.

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

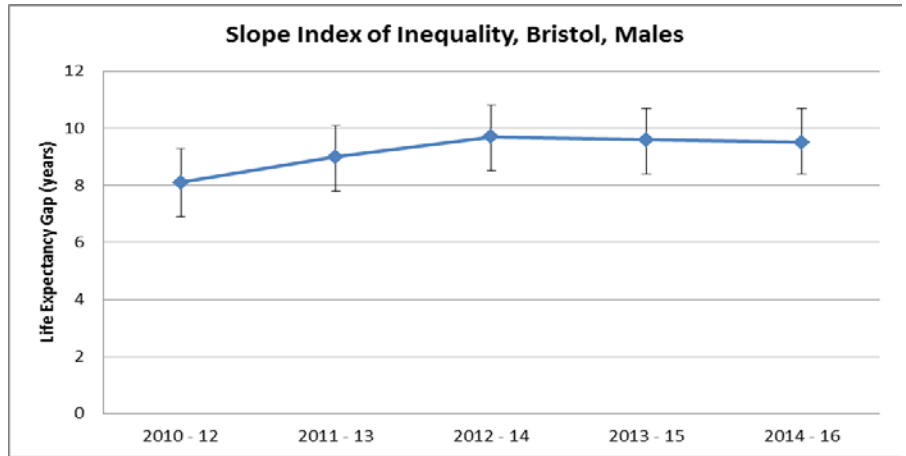


Fig 2.3.1: Male slope index of inequality
Source: Public Health Outcomes Framework, August 2018

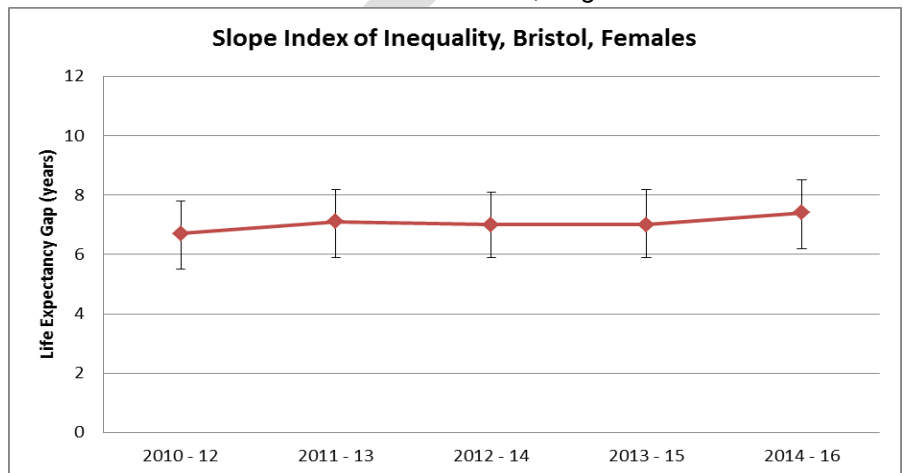


Fig 2.3.2: Female slope index of inequality
Source: Public Health Outcomes Framework, August 2018



Fig 2.3.3 Male slope index of inequality by Core Cities
Source: Public Health Outcomes Framework, August 2018

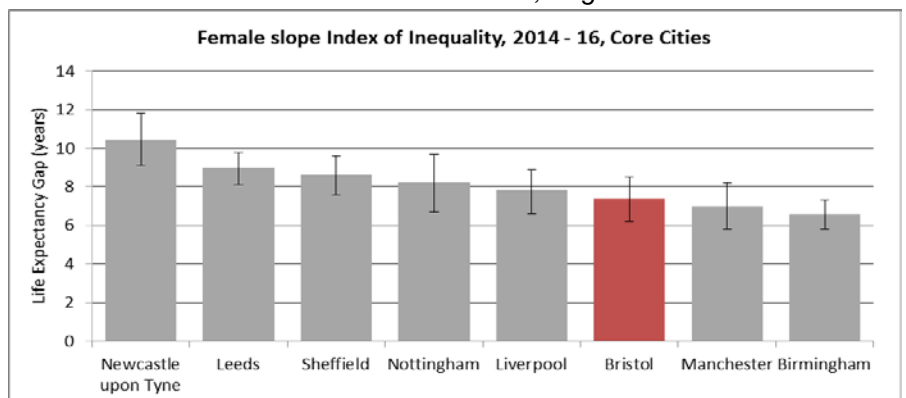


Fig 2.3.3 Female slope index of inequality by Core Cities
Source: Public Health Outcomes Framework, August 2018

² NB Due to these reasons, the Slope Index of Inequality is used as the primary measure of the gap in life expectancy, not the difference between the individual wards with the lowest and highest figures.

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 (2014-16, ONS) are 58.9 years for men and 62.9 years for women (fig 2.4.1). Whilst female healthy life expectancy is broadly similar to the national average, male healthy life expectancy is 4.4 years below the national average. Bristol has the second highest healthy life expectancy of the Core Cities for females, and the 5th highest for males (in 2012-14 Bristol had been highest ranking for both).

Gender: Both men and women in Bristol live an average of 19.9 years in poor health. This is similar to England as a whole for women but 3.7 years worse than the England average for men.

The Healthy Life Expectancy measure (fig 2.4.2 and fig 2.4.3) shows the trend data over a number of years. For women living in Bristol there has been no statistically significant change in healthy life expectancy since the measure was introduced in 2009/11. For men living in Bristol it is a very different picture, with healthy life expectancy significantly worse than the England average since 2013-15 with further decreases into 2014-16. Further investigation is needed to understand the reasons for the drop in male healthy life expectancy.

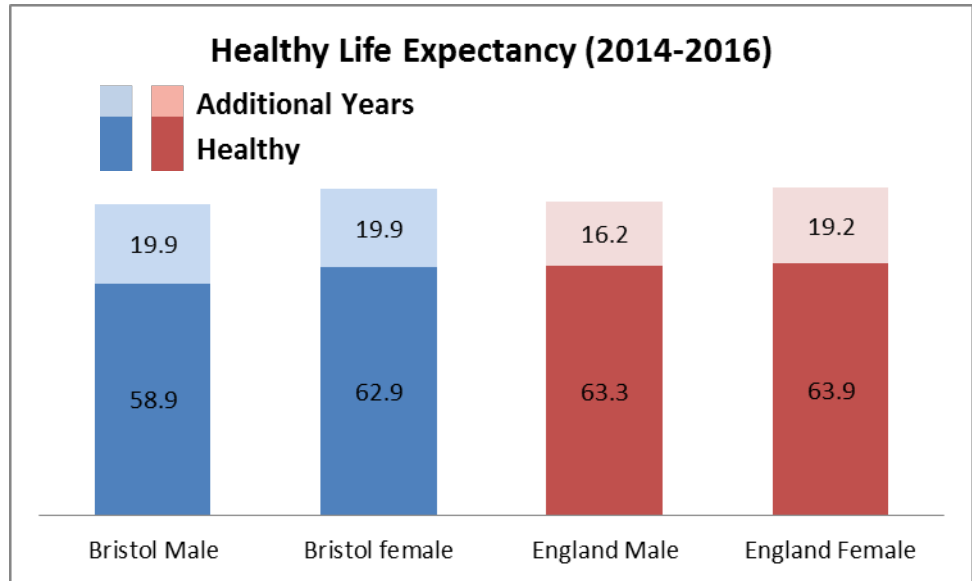


Fig 2.4.1: Healthy Life Expectancy and overall Life Expectancy
Source: ONS via Bristol Public Health Knowledge Service, August 2018

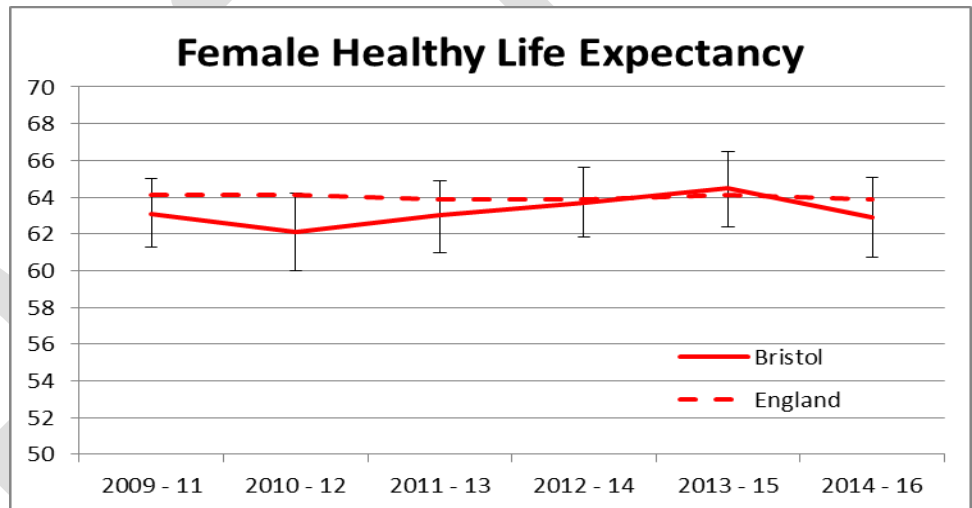


Fig 2.4.2: Healthy Life Expectancy trends- Female
Source: ONS via Public Health Outcomes Framework, August 2018

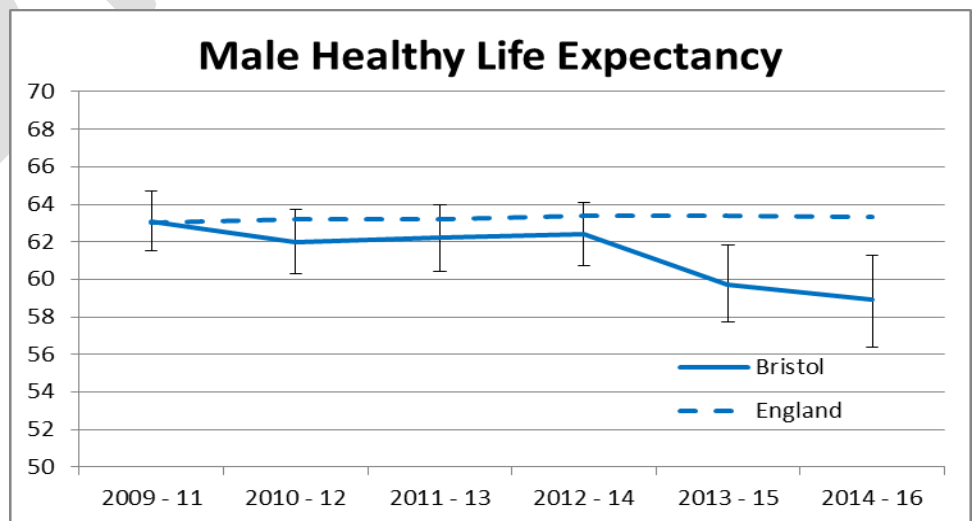


Fig 2.4.3: Healthy Life Expectancy trends- Male
Source: ONS via Public Health Outcomes Framework, August 2018

2.5 Healthy Life Expectancy Gap³

Small area data⁴ from Office for National Statistics is available for Healthy Life Expectancy within Bristol, and this highlights the gap within the city. It is not ward-level data, but for smaller areas.

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

The gap in healthy life expectancy between the most deprived 10% and the least deprived 10% within Bristol (i.e. 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 range⁵ from 11 years to 31 years for females and from 10 years to 24 years for males between areas.

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

Healthy Life Expectancy, Females, 2009-2013

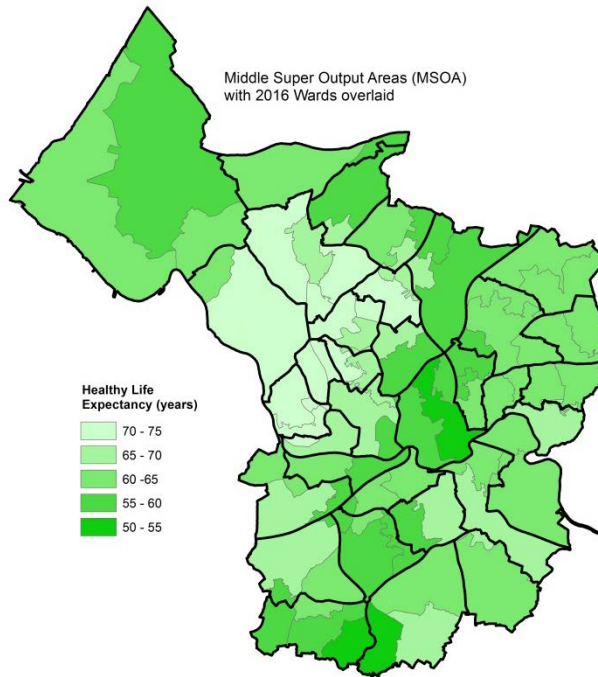


Fig 2.5.1: Healthy Life Expectancy by MSAO, Females, 2009-2013

Healthy Life Expectancy, Males, 2009-2013

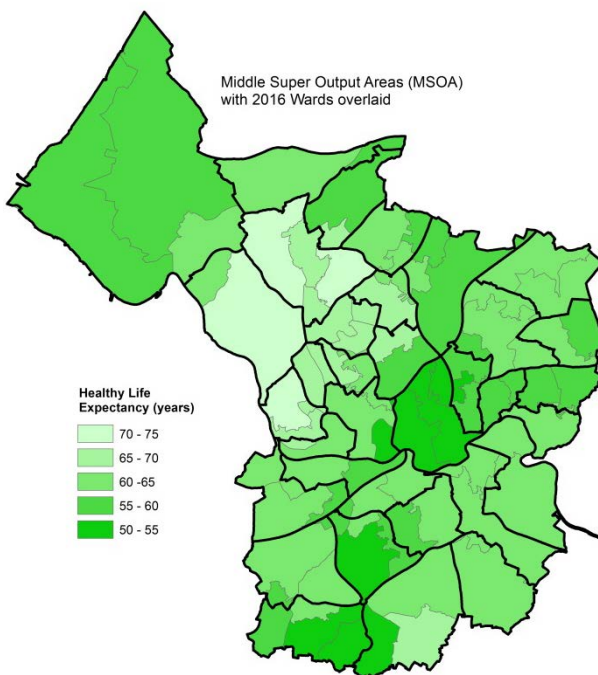


Fig 2.5.2: Healthy Life Expectancy by MSAO, Males, 2009-13

³ This is not updated annually

⁴ 2009-2013 for Medium Super Output Areas (MSOA). Source: ONS, Nov 2015. Analysed by Bristol Public Health Knowledge Service

⁵ NB this is range for MSAO areas

2.6 Global Burden of Disease

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

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

In the UK overall the number of

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

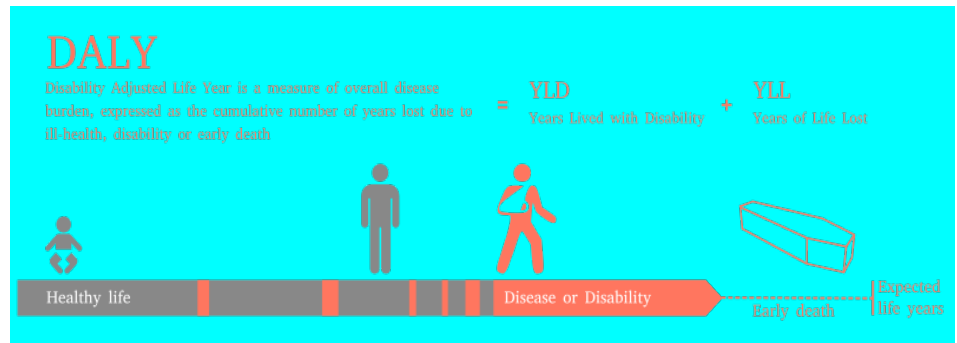


Fig 2.6.1: Method of calculating Disability Adjusted Life Years

Figure 2.6.2 below shows the risk factors split by related cause of death and disability. This is calculated by applying the UK results of the Global Burden of Disease project to Bristol’s population. Tobacco smoke, dietary risks (eg diets low in fruit, veg & fibre and diets high in sodium, processed meat and trans-fatty acids), and high systolic blood pressure are the three highest risk factors that lead to early death and disability. In addition, high body-mass index and alcohol & drug misuse are key lifestyle risk factors.

Tobacco is now the lead risk factor, having been on the same level as dietary issues in 2013. One factor that could be behind this change may be that Cancer is behind an increasingly large proportion of premature mortality in comparison to Cardiovascular disease.

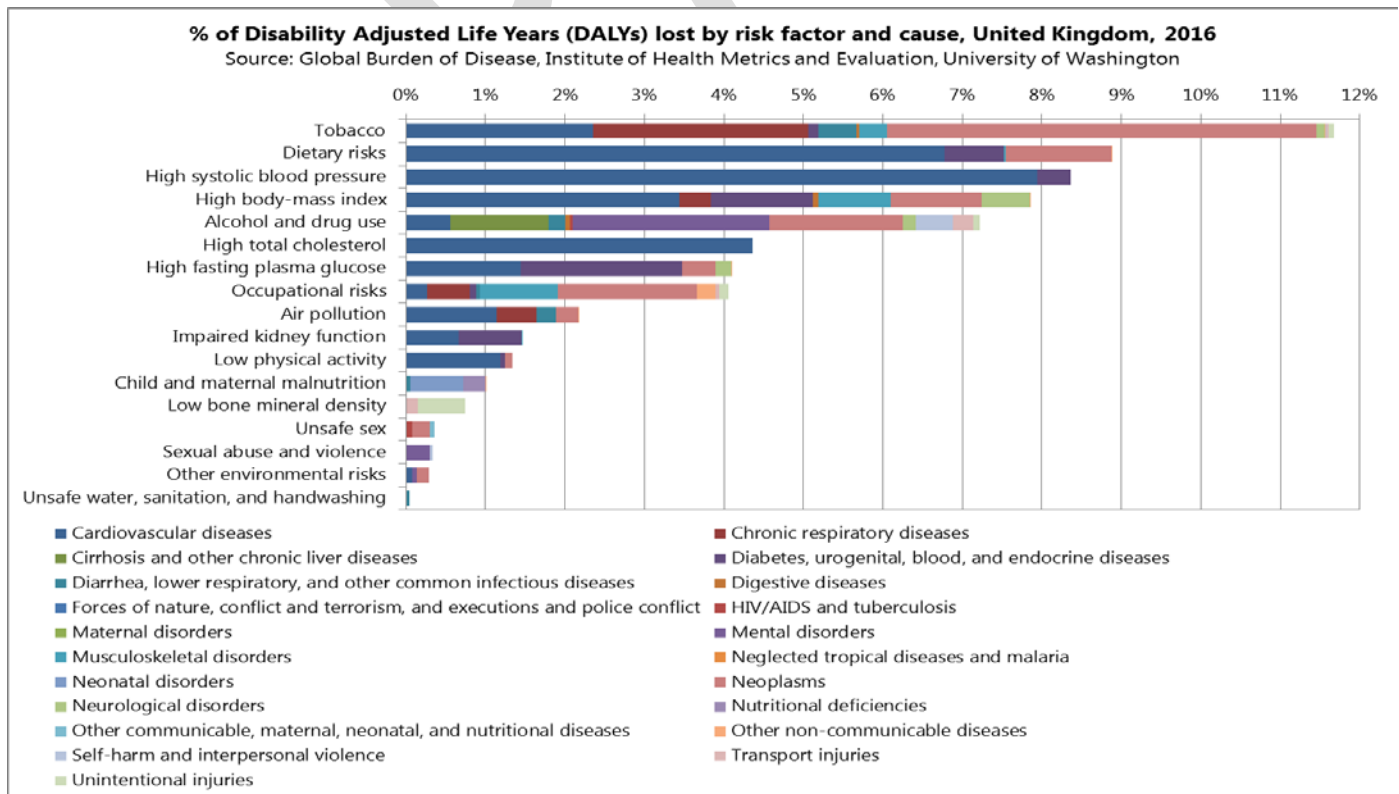


Fig 2.6.2: Estimated DALYs, 2016, by risk, based on Global Burden of Disease, Institute of Health Metrics and Evaluation / Public Health England. Source: Bristol Public Health Knowledge Service

2.7 Premature Mortality

Rates of premature (under 75 years) mortality are falling in Bristol and for both men and women the mortality rates in 2016 were significantly lower than levels ten years earlier (fig 2.7.1). However, Bristol’s premature mortality rates, for both men and women are significantly worse than the England rates. The gap in mortality rate between men in Bristol and men in England is 63 per 100,000 population and the gap for women is 29 per 100,000 population.

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

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

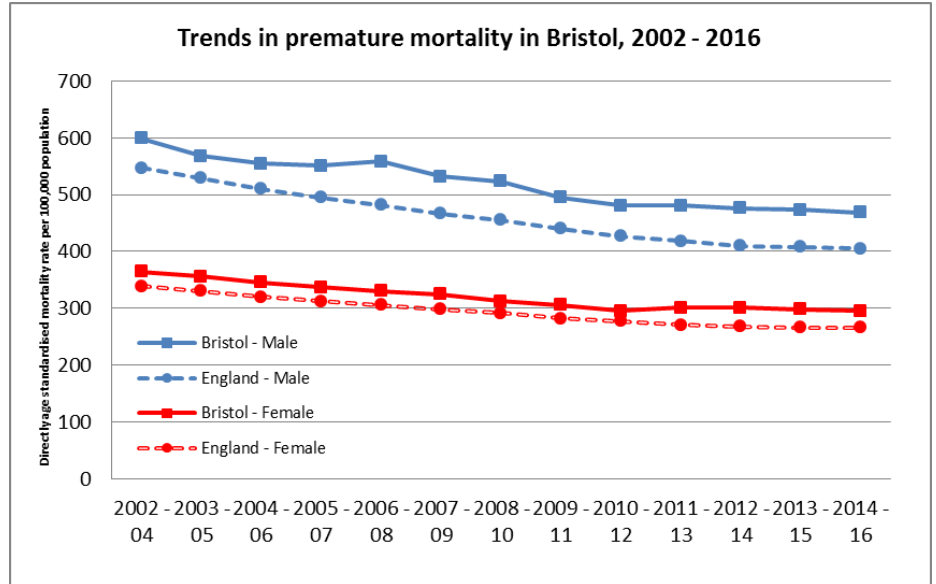


Fig 2.7.1: Premature mortality trends 2002 – 2016

Source: Public Health profiles, <https://fingertips.phe.org.uk/>

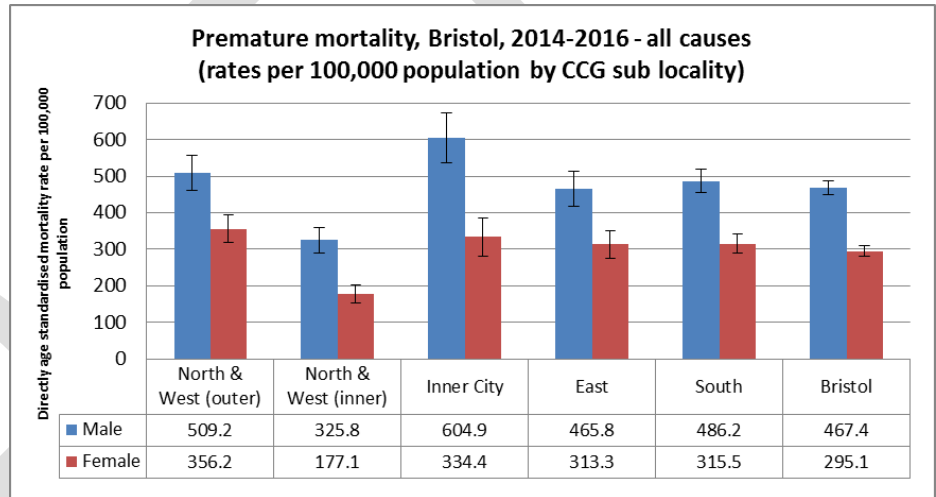


Fig 2.7.2: Premature mortality with Bristol by sub locality; 2014-2016

Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

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

Hotwells and Harbourside ward has the lowest male premature mortality rate and for females, Clifton Down has the lowest rate. Central has the highest male premature mortality rate and Hartcliffe & Withywood has the highest female rate.

For men Hotwells and Harbourside's premature mortality rate is nearly a fifth of Central's death rate and for women Clifton Down's mortality rate is over a third less than Southville's rate.

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

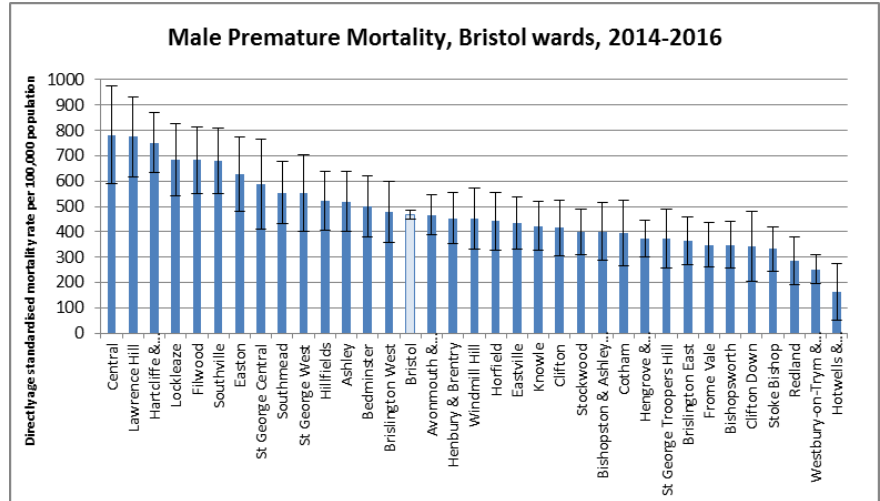


Fig 2.7.3: Male premature mortality, Bristol wards, 2014-2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

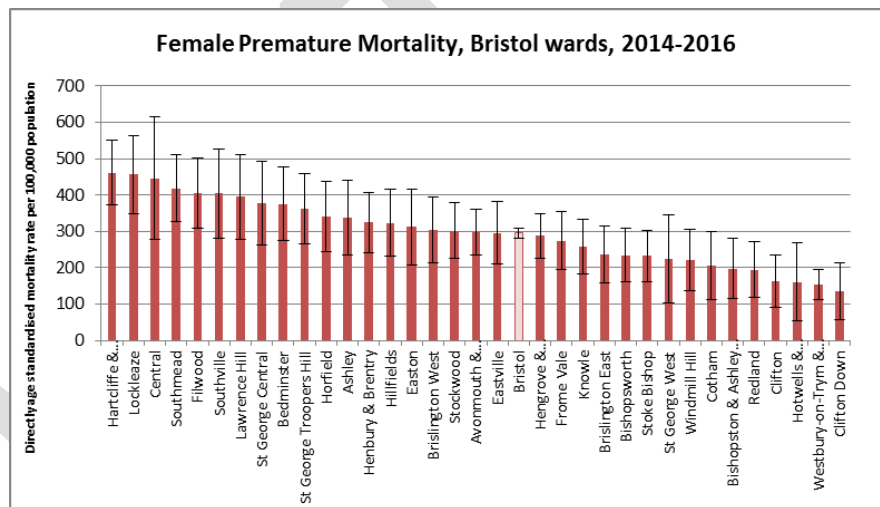


Fig 2.7.4: Female premature mortality, Bristol wards, 2014-2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

Further data

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

Section 3 Population⁶

Summary points

- The population has grown 11.5% since 2007 (8.0% nationally).
- Growth has been mainly concentrated in the inner city, especially young adults. The child population has risen across Bristol.
- Bristol's population is young, median age of 32.7 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%.
- Since 2012 births in Bristol have fallen gradually. In 2017 the number of live births fell to 5,960, the first time for a decade that births have been below 6,000 per annum.
- The population is projected to increase 9.2% to 498,100 by 2026. The child population is projected to rise 12.8% by 2026 (10,900 more children).
- The proportion of older people is lower than nationally but numbers are rising, especially for people aged 75 and over. Projected to rise 18.9% by 2026 (5,300 more people 75 & over).

3.1 Bristol population overview

The population of Bristol is estimated to be **459,300 people⁷**, the 8th largest city in England. Bristol has a relatively young age profile; the median age of people living in Bristol in 2017 was 32.7 years old, compared to 39.9 years in England and Wales.

There are more children living in Bristol than people aged 65 and over. Bristol's 85,400 children make up 18.6% of the total population, slightly lower than England and Wales at 19.1% (despite the rapid rise in the child population). The working age (16-64 year olds) population is 314,100 (68.4%), which is a higher % than nationally (62.8%), especially young adults up to 40 years. The older people population (65 & over) is 59,800 (13.0%), lower than nationally (18.2%) (fig 3.1.1 and 3.1.2).

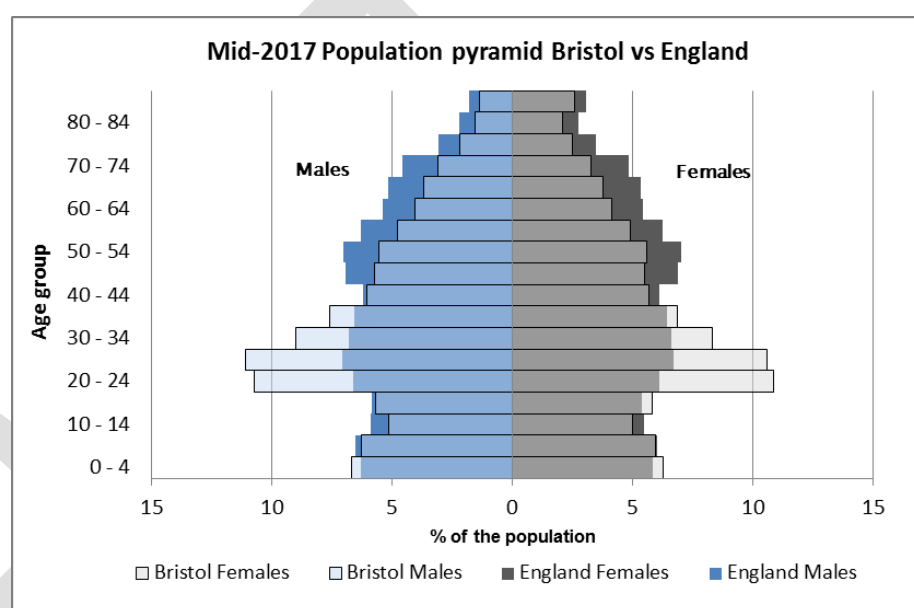


Fig 3.1.1: Mid-2017 Population pyramid Bristol vs England
Source: ONS 2017 Mid-Year Population Estimates; June 2018

Age Band	Males		Females		Persons	
	number	%	number	%	number	%
0-15	43,600	19.0	41,800	18.2	85,400	18.6
16-24	35,600	15.5	36,300	15.8	71,900	15.7
25-49	90,700	39.4	84,900	37.0	175,500	38.2
50-64	33,000	14.3	33,600	14.7	66,600	14.5
65 and over	27,100	11.8	32,800	14.3	59,800	13.0
All ages	230,000	100.0	229,300	100.0	459,300	100.0

Table 3.1.2 Mid-2017 Population estimates by age and sex for Bristol
Source: ONS 2017 Mid-Year Population Estimates; June 2018

⁶ See "Population of Bristol" report www.bristol.gov.uk/population

⁷ ONS 2017 Mid-Year Population Estimate, released June 2018

Bristol CCG patient population

It should be noted that NHS Bristol CCG primarily works with the registered GP patient population. At the end of June 2017 there were 507,800 patients⁸ registered to GP practices in Bristol, substantially higher than the ONS population estimate of people living in Bristol (459,300 in June 2017). Partly this is due to patients who live just outside the Bristol wards boundary, but also due to “list inflation”⁹.

During 2017-18, Bristol residents attended Accident & Emergency (A&E) on 200,600 occasions¹⁰. Whilst two-thirds (67%) of Bristol resident A&E attendances were patients registered to GPs in Bristol CCG, a third (33%) were from patients living in Bristol and registered to other CCGs. Working age adults (16-64) and children under 16 follow a similar pattern to this but out of those over 65 years a bigger proportion are registered with another CCG (41%). [NB this is attendances, not individual patients, as some will attend multiple times]

Attendances to A&E also showed that not all Bristol CCG patients lived in Bristol. Almost 9,500 patients (7% of all Bristol CCG patients) attending A&E did not have a Bristol address.

⁸ Source: GP Practice Capitation report, Q1 for 2017/18; via Bristol CCG
⁹ List inflation - Some patients may be registered in more than 1 area, have more than 1 NHS number, remain on GP lists after having died or left the country; also GPs have no clear incentive to remove people from lists. http://www.adls.ac.uk/department-of-health/gp-patient-register-dataset/?detail#ds_jump_dataquality
¹⁰ Source: Bristol CCG, June 2018

Population within Bristol

Ward-level population is shown for the new 2016 wards (fig 3.1.3). Total population size ranges from 5,400 in Hotwells & Harbourside to 21,200 in Avonmouth & Lawrence Weston. Note – Bristol wards are no longer equal in size, with 5 larger wards represented by three councillors and 3 smaller wards represented by one councillor each.

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

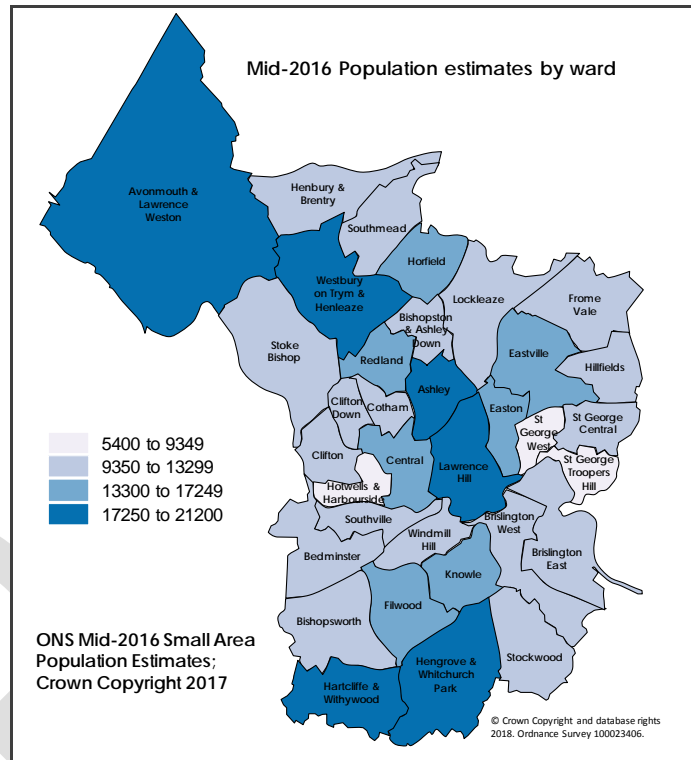


Fig 3.1.3: Mid-2016 population estimates by ward
 Source: ONS Mid-2016 Small Area Population Estimates; 2017

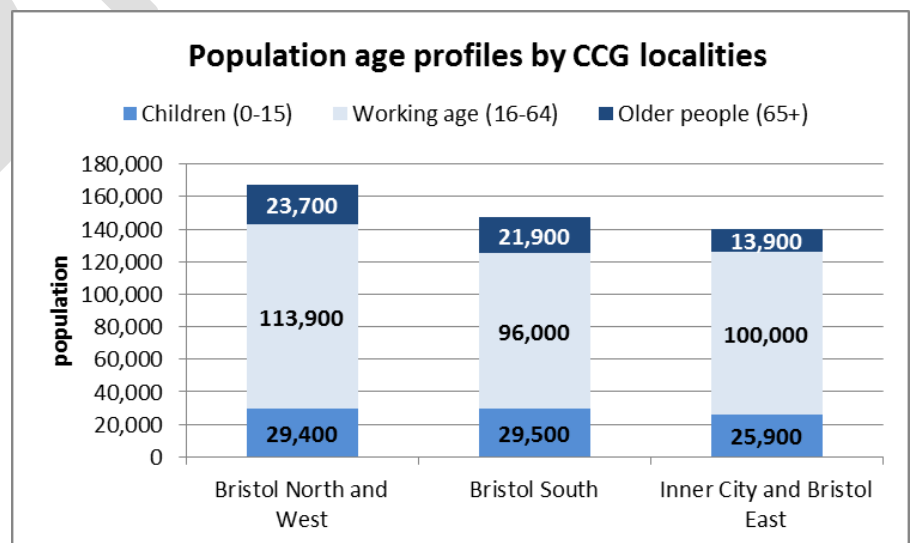


Fig 3.1.4: Mid-2016 Population age profiles by CCG localities
 Source: Insight, Performance and Intelligence, Bristol City Council, using ONS Mid-2016 Small Area Population Estimates; 2017

3.2 Population changes

There has been a period of considerable population growth in Bristol since 2002. Over the last decade alone the population is estimated to have increased by 47,400 people (fig 3.2.1). This increase of 11.5% compares to an England and Wales rise of 8.0% over the same period.

Figure 3.2.2 shows population change between 2006 and 2016 by ward. Whilst there have been increases in population across most wards in Bristol over the last decade, there has been exceptional increases in the central area of Bristol. The greatest increases have been in Central ward (54%), Hotwells and Harbourside ward (43%) and Lawrence Hill ward (41%). Over the decade, a quarter (25%) of the total increase in population in Bristol took place in Central and Lawrence Hill wards alone. Other wards which have experienced an increase in population of 20% or more since 2006 are Bedminster (24%), Lockleaze (24%) and St George West (23%).

By CCG locality, over the last decade (2006-16), half of the 45,800 rise in Bristol population was in the Inner City & East. By broad age group, the majority of increase (63%) was due to the 29,000 rise in working age people, with almost half in the Inner City (fig 3.2.3). In contrast there was only a nominal increase in the working age population in North and West Inner.

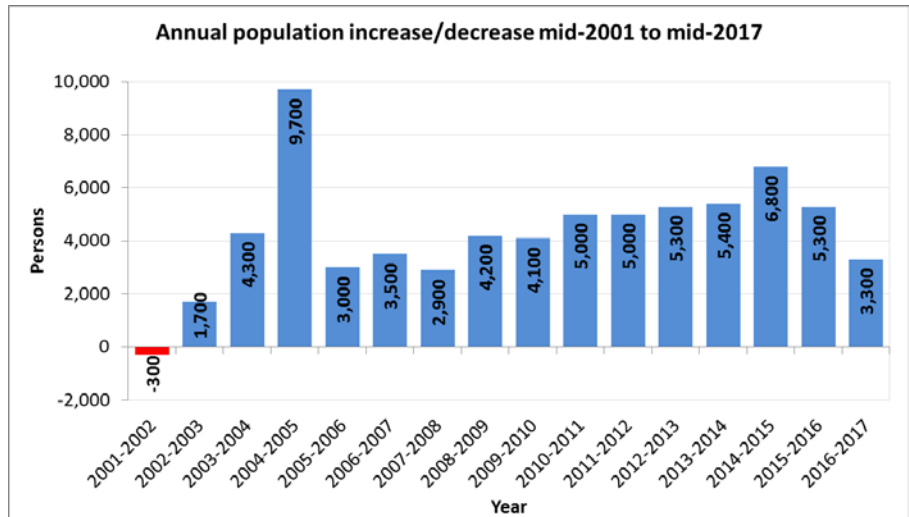


Fig 3.2.1: Annual population increase/decrease Mid-2001 to Mid-2017
Source: ONS Mid-Year Population Estimates; June 2018

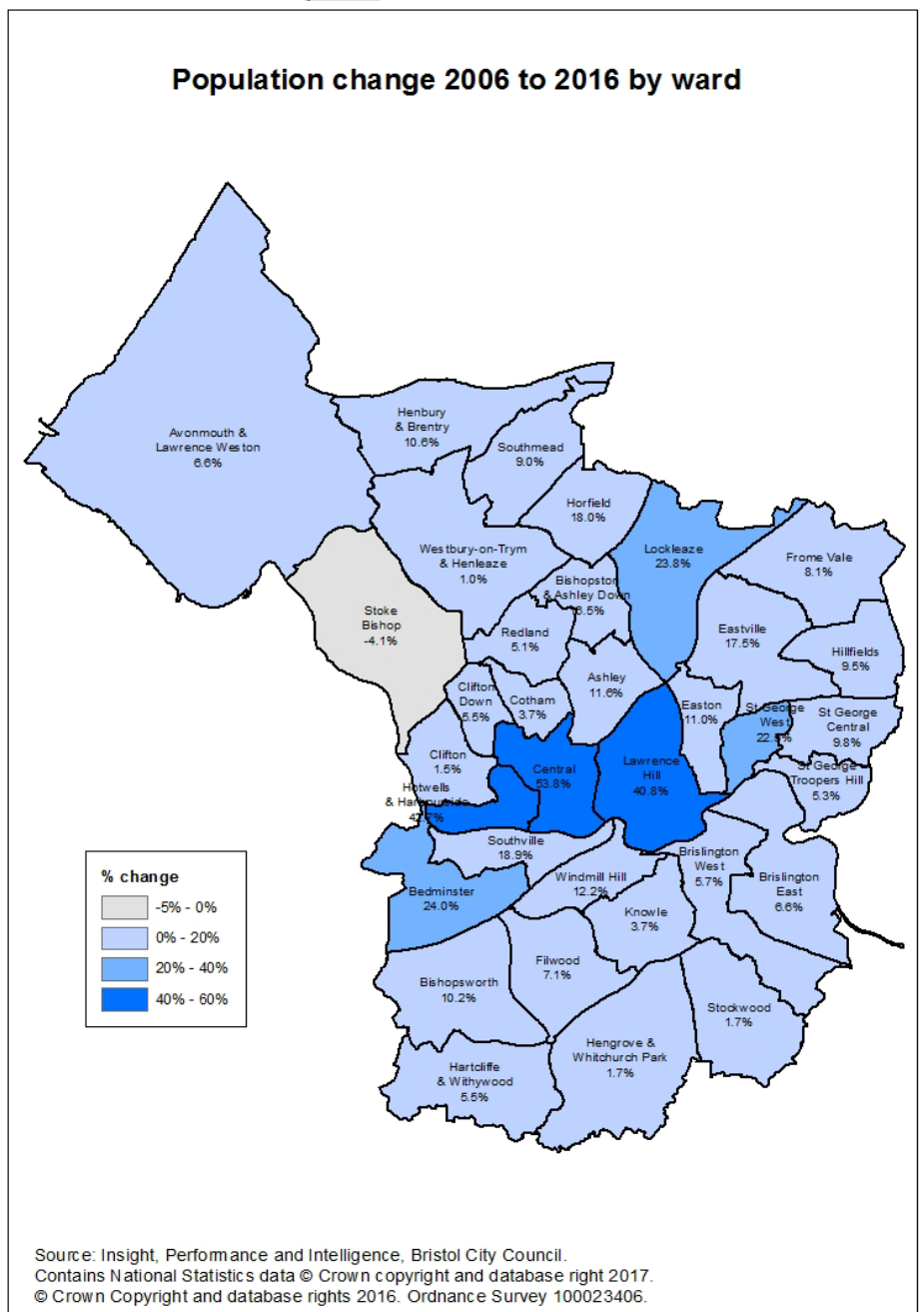


Fig 3.2.2: Population change 2006-16 by ward
Source: Insight, Performance and Intelligence, Bristol City Council using ONS Small Area Population Estimates; 2017

Child population changes

Bristol has 85,400 children under 16 and 71,900 young people 16-24 with increases of around 500 children and 1,000 young people in the last year (ONS MYE 2017).

In the last decade (2007-17), the number of children living in Bristol is estimated to have increased by 12,900 (17.8%). This increase has been largely amongst the under 10s (fig 3.2.3) and in particular among the 4-7 year olds (an increase of 35%). The growth in the number of under 10s in Bristol in the last decade (+11,300) is the fifth highest nationally.

Over the last decade Bristol's child population increased in all areas. The biggest increase in the numbers of children was in Bristol South (3,700), although by far the largest increase proportionately was in the Inner City which saw a 26.7% (2,700) increase (fig 3.2.4).

For young people (16-24 years), the majority of the increase was in the Inner City area, which saw an extra 5,800 16-24 year olds i.e. 41% increase - the majority of these are likely to be students.

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

Older people population changes

Bristol has 59,800 older people 65 & over. Within that number are 9,100 people 85 & over. Over the last decade, after a period of the older population (65 & over) falling

in Bristol, it is now rising year on year (fig 3.2.5). This rise has been mainly in the North & West Inner area (fig 3.2.4). Although the number of older people increases year-on-year, Bristol does not have an ageing population according to the official definition¹¹.

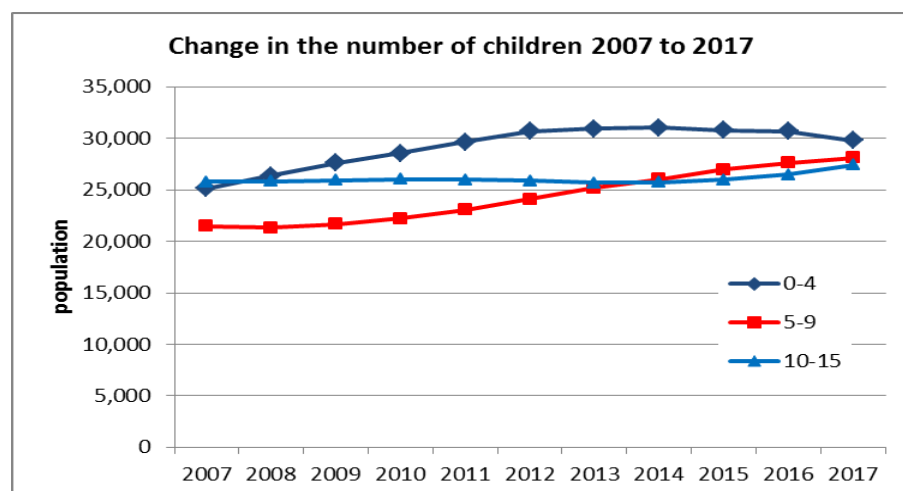


Fig 3.2.3: Change in the number of children Mid-2007 to Mid-2017
Source: ONS Mid-Year Population Estimates. Crown Copyright; 2018

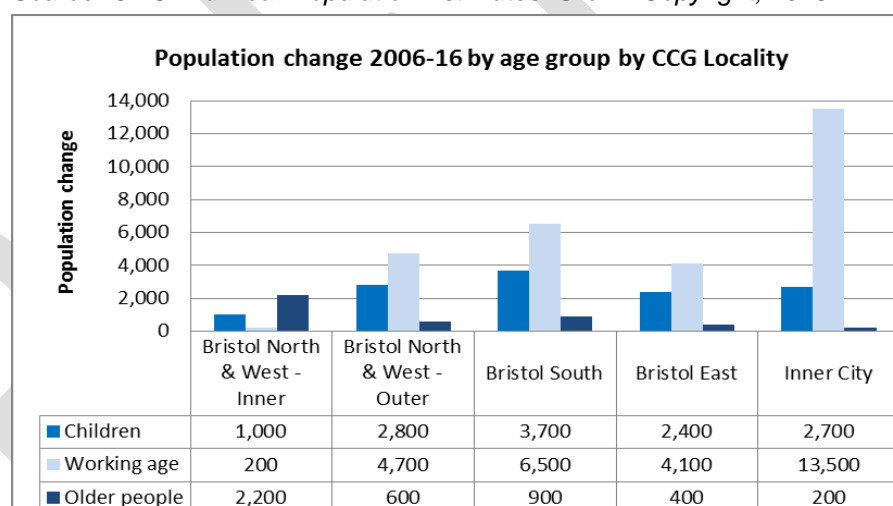


Fig 3.2.4: Population change 2006-16 by age group by CCG Locality.
Source: Insight, Performance and Intelligence, BCC using ONS SAPE; 2017

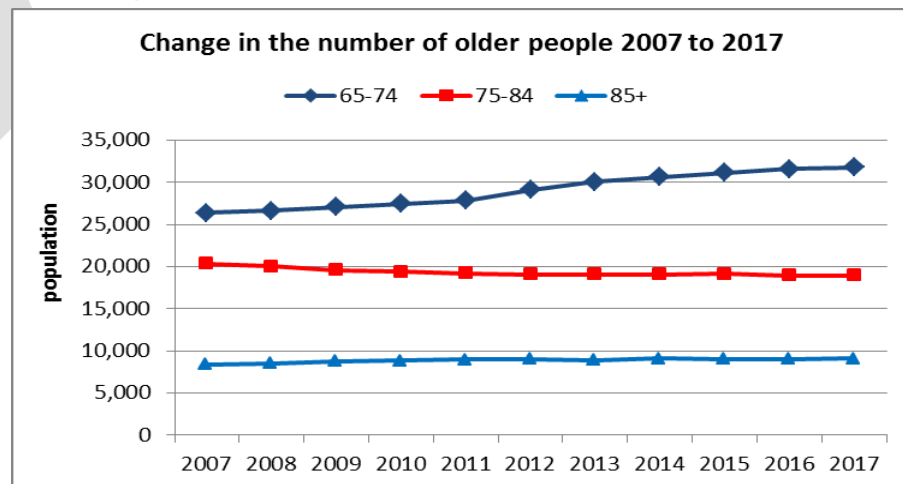


Fig 3.2.5: Change in the number of older people Mid-2007 to Mid-2017
Source: ONS Mid-Year Population Estimates. Crown Copyright; 2018

¹¹ Ageing of the population refers to both increase in the median age of the population and increase in the number and proportion of older people in the population.

3.3 Population diversity¹²

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’¹³, 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 decade¹⁴, 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 population diversity

Bristol’s child population is increasingly ethnically diverse. 28% of Bristol children (under 16) belong to a Black or Minority Ethnic (BME) group (2011 Census), compared to the Bristol average of 16% BME. Using the alternative definition of diversity, 32% of children belong to the non-‘White British’ population, compared to the Bristol population average of 22%. Ethnic diversity varies considerably across the city; 53% of children under 16 in

the Inner City & East are BME, compared with 21% in North & West and 13% in South Bristol (fig 3.3.1). By ward, the figure ranges from 4% BME in Bishopsworth to 60% in Lawrence Hill.

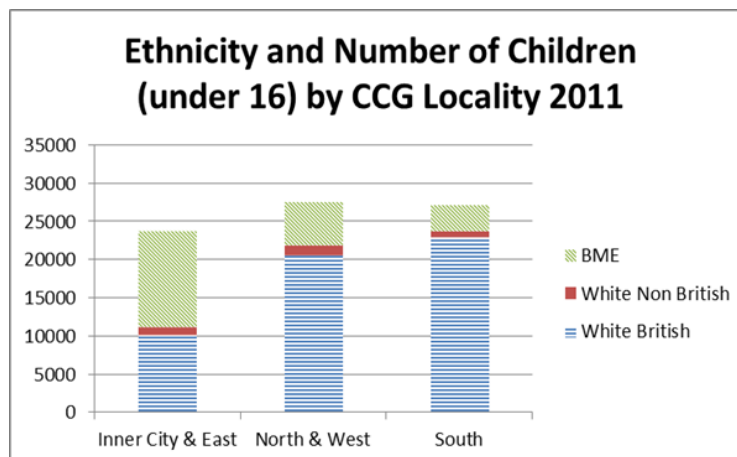


Fig.3.3.1: Ethnicity and Number of Children by CCG Locality
Source: ONS 2011 Census

According to the 2018 School Census, there were 17,400 BME school pupils in Bristol council-maintained schools and academies (29.2% of all pupils).

Also, there are 12,100 pupils with English as an Additional Language (EAL), 20.9% of pupils aged 5-15, up from 17.7% in 2014. The map (fig 3.3.2) highlights that there are much higher % EAL pupils in Inner City & East Bristol. By far the highest proportions of pupils with English as an Additional language are in are in Central ward at 56% and Lawrence Hill at 66%.

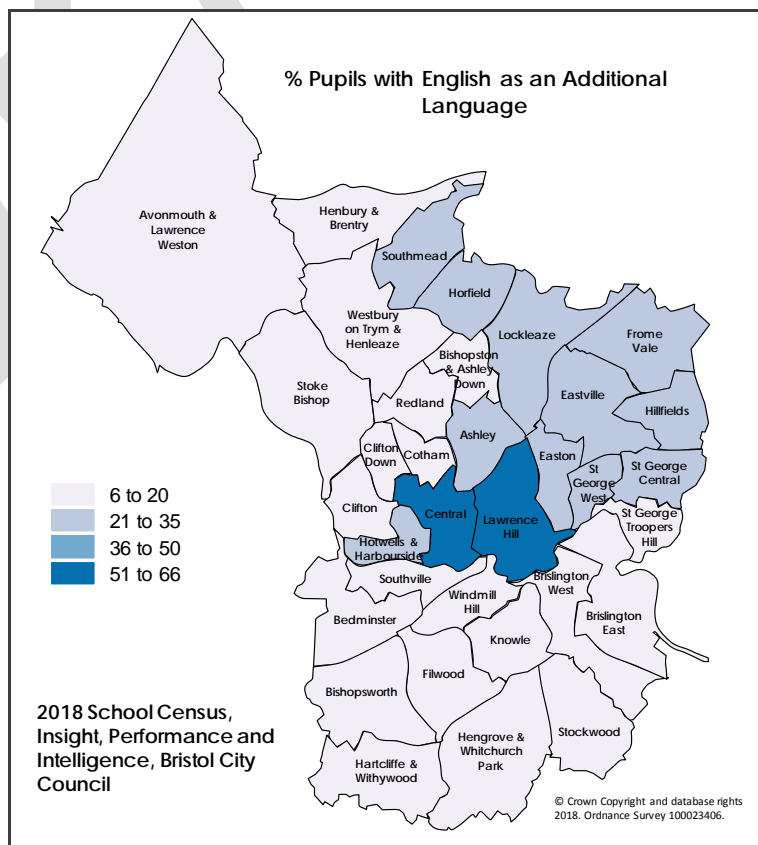


Fig 3.3.2: Source: 2018 School Census, Bristol City Council

¹² In addition, detailed **Equality Profiles** (using 2011 Census data) for different groups are at: www.bristol.gov.uk/census

¹³ 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

¹⁴ Source: ONS 2001 and 2011 Census

3.4 Births

In Bristol, there are more live births than deaths resulting in an increase in the population due to natural change. Over the last decade (2007-2017) there were a total of 64,200 births and 33,700 deaths, resulting in a population increase of 30,500 people. Natural change accounts for almost two thirds (64%) of the total population change in Bristol over the decade. This is in contrast to the national picture where net international migration remains the largest component of population change.

The number of births in Bristol gradually increased from the year 2000 onwards, reaching a peak of 6,800 births in 2012. Since then births in Bristol have fallen gradually. In 2017 the number of births fell to 5,960, the first time for a decade that births have been below 6,000 per annum (fig 3.4.1).

Overall, the Total Fertility Rate in Bristol in 2017 was 1.58 children per woman, down from 1.72 in 2016, and lower than the England and Wales average of 1.76.

Changes in total fertility rate are driven mainly by women born in the UK as they make up the majority of the population of childbearing age. However, non-UK born women made up an increasing share of the population, which also acted to push fertility rates upwards. The % of births in Bristol to non-UK born mothers has increased from 13% in 2001 to 29.5% in 2016.

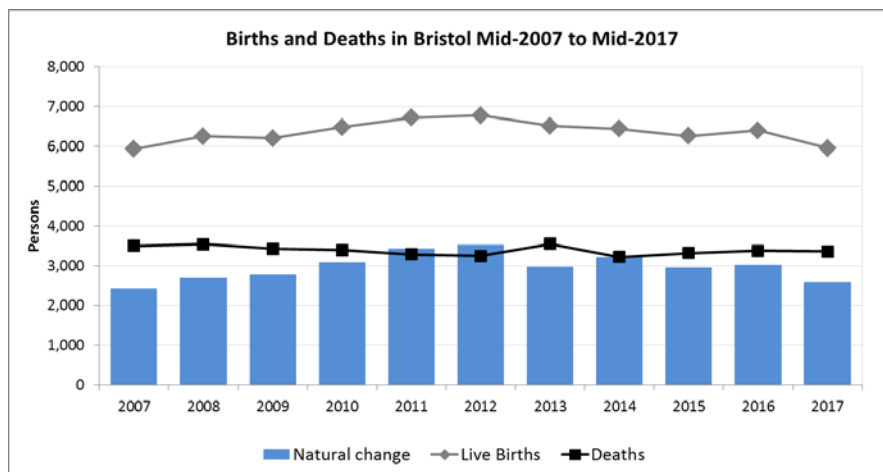


Fig 3.4.1: Births and Deaths in Bristol by 2007 to 2017
Source: ONS Vital Statistics by calendar year; July 2018

Figure 3.4.2 shows trends in numbers of live births since 2005 in Bristol of the top five countries (not including UK born mothers). Somalia and increasingly Poland are the most common countries of the mother's origin for Bristol births to non-UK born mothers.

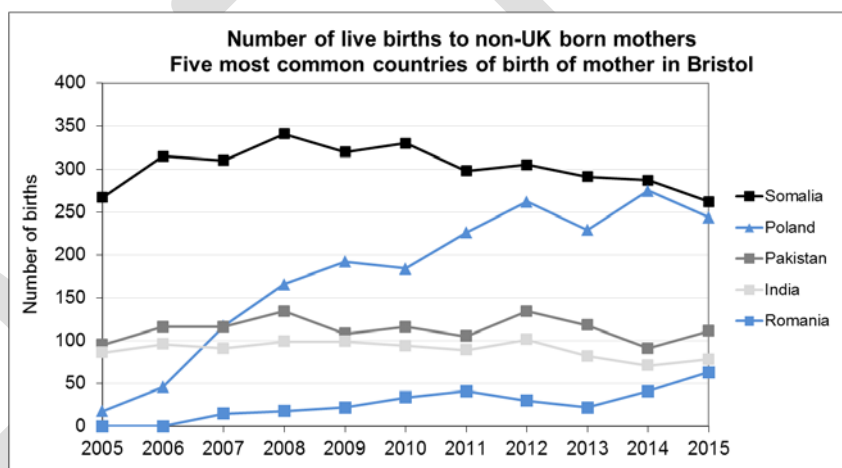


Fig 3.4.2: Live births in Bristol to non-UK born mothers for the 5 most common countries of birth of mother 2005-2015
Source: ONS Birth Data, 2016

The recent fall in births is seen across the city. All CCG Localities are following the recent downward trend in the number of live births per annum (fig 3.4.3).

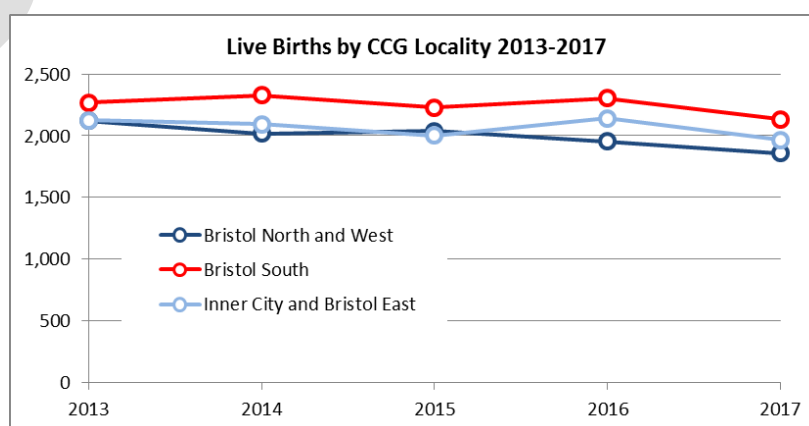


Fig 3.4.3: Source: ONS Vital Statistics by calendar year; July 2018

3.5 Population projections

The population of Bristol is projected to increase 9.2% to 498,100 by 2026 (figs 3.5.1 & 3.5.2) and potentially rise to 534,900 by 2036¹⁵. All age groups are expected to increase.

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

Child projections

By 2026, there are projected to be 10,900 more children – a 12.8% increase compared to 4.9% nationally. The Young person population (age 16-24) is projected to increase by 5.9%.

Most of the increase in the child population (2016-26) is projected to be in the 10-15 years age band – a 23.5% increase compared to 17.6% nationally (figs 3.5.3 & 3.5.4). This will impact on secondary school age services, but numbers of young children are also projected to increase 10.3%.

Older People projections

There are projected to be 6,800 more people 65 & over by 2026, a 11.3% rise (and potentially a 29.3% rise by 2036) (fig 3.5.5).

For people 75 & over, there is projected to be an 18.9% rise by 2026 (5,300 more people 75 & over), and potentially a 40.4% rise by 2036. However, projected increases in older people in Bristol

are much lower than the projected increases nationally.

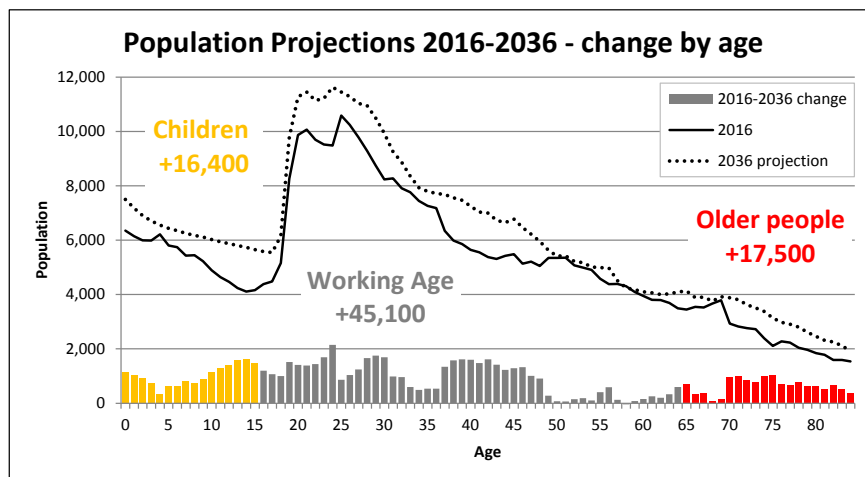


Fig 3.5.1: Population Projections 2016-2036 - change by age
Source: ONS 2016-based Sub-national Population Projections

Age	2016	2026	2036	Change 2016-26		
				number	Bristol %	England %
0-15	84,800	95,700	101,200	10,900	12.8	4.9
16-24	70,900	75,100	83,800	4,100	5.9	0.3
25-49	174,400	192,200	203,500	17,800	10.2	-0.5
50-64	66,200	68,700	69,400	2,600	3.9	8.6
65-74	31,600	33,100	37,800	1,500	4.7	7.8
75+	28,000	33,300	39,300	5,300	18.9	33.5
All Ages	456,000	498,100	534,900	42,200	9.2	5.9

Fig 3.5.2: Population Projections by Broad age band
Source: ONS 2016-based Sub-national Population Projections

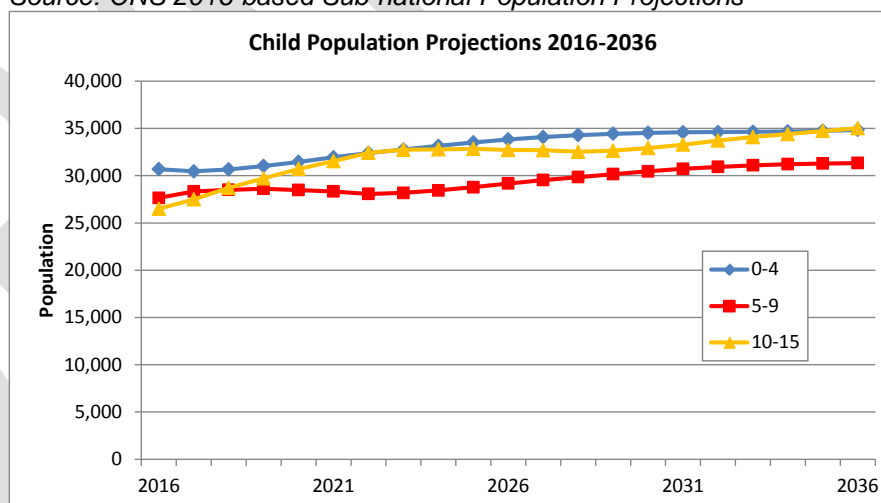


Fig 3.5.3: Child Population Projections 2016-2036
Source: ONS 2016-based Sub-national Population Projections

Age	2016	2026	2036	Change 2016-26		
				number	Bristol %	England %
Age 0-4	30,700	33,800	34,800	3,200	10.3	-3.3
Age 5-9	27,600	29,200	31,300	1,500	5.5	-0.4
Age 10-15	26,500	32,700	35,000	6,200	23.5	17.6

Fig 3.5.4: Child Population Projections 2016-36
Source: ONS 2016-based Sub-national Population Projections

Age	2016	2026	2036	Change 2016-26		
				number	Bristol %	England %
Age 65-74	31,600	33,100	37,800	1,500	4.7	7.8
Age 75-84	19,000	23,500	25,500	4,600	24.0	37.4
Age 85 and over	9,000	9,800	13,800	700	8.0	24.1

Fig 3.5.5: Older Person Population Projections 2016-36
Source: ONS 2016-based Sub-national Population Projections

¹⁵ ONS 2016-based Sub-national Population Projections, published May 2018. These are trend-based projections. Assumptions for future levels of births, deaths and migration are based on the 2001 to 2016 trend. They show what the population will be if trends continue. They do not attempt to predict the impact of future policies, economic conditions, local development or other factors.

Specific population groups Young Carers

3.6 Carers¹⁶

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

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 estimates¹⁷ based on research with young people, in 2016 it was estimated that there may be as many as 7,600 young carers in Bristol.

This study indicated that the majority of these young carers would have been caring for between 3-5 years (3,390) with 2,770 caring for 2 years or less. 82% of them (6,320) would be providing emotional support and supervision with 18% (1,390) carrying out personal care.

Young carers are known to have particular health needs¹⁸ (mainly mental health/social isolation/educational attainment impacts e.g. Young carers are one and half times more likely to have a special educational need or a long-standing illness or disability).

At present we do not collect specific indicators locally on Young Carers and their needs.

¹⁶ This section uses 2011 Census data and is mainly unchanged from JSNA 2017

¹⁷ Source: Bristol Carers Support Centre, using Becker and Dearden formula (Loughborough University) applied to ONS mid-2014 population estimates for Bristol
¹⁸ Source: Children's Society Report 'Hidden From View', via Bristol Carers Strategy 2015–2020; www.bristol.gov.uk/policies-plans-and-strategies/carer-strategy

3.7 People with Long-term health problems or disability

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

This is a lower proportion than in 2001 (was 17.8% with a ‘long-term limiting illness’), but this is due to the overall population increase.

The actual number of people whose day-to-day activities are limited has increased from 67,700 people to 71,700 people in 2011.

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

Gender: There are more women (17.8%) than men (15.6%) living with a “limiting long-term illness or disability” in Bristol. This is mainly due to women living longer.

By ward, the Census 2011 data – see fig 3.7.1 - highlights that in the most deprived South Bristol wards of Filwood and Hartcliffe & Withywood, over 20% of working age adults have a long-term health problem or disability. This figure is also high in Lawrence Hill and the “outer” North & West wards and some in East Bristol.

3.7.1 Physical disability

Overall population estimates¹⁹ for working age adults indicate 26,750 people have a moderate or serious physical disability in 2018.

¹⁹ Institute of Public Care, POPPI and PANSI tools, www.pansi.org.uk; national 2001 prevalence applied to the Bristol population; accessed Sept 2018

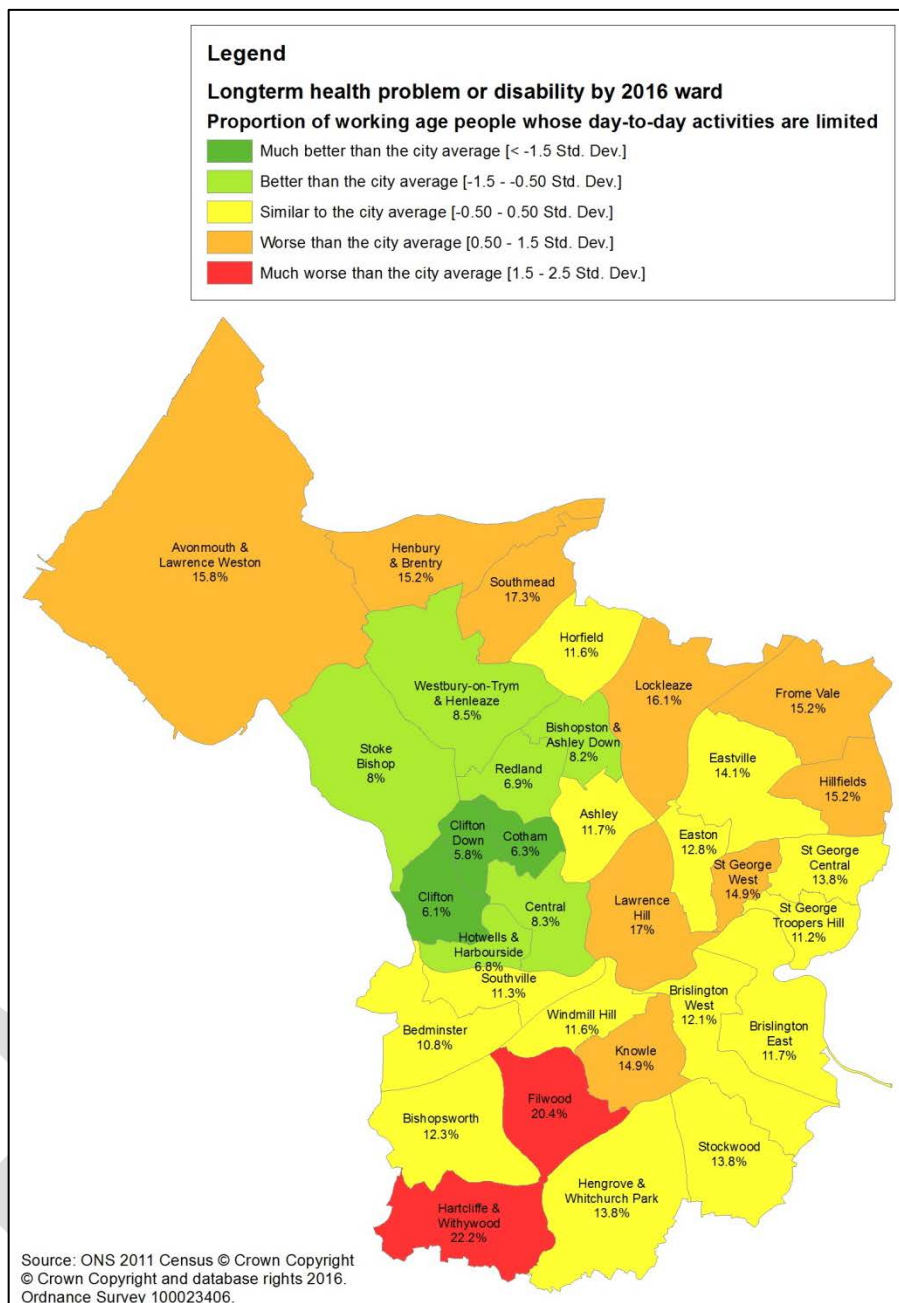


Figure 3.7.1: Long-term health problem or disability by Bristol ward
Source: 2011 Census ONS Crown Copyright Reserved [updated to Bristol wards 2016, BCC Insight, Performance & Intelligence]

3.7.2 Sensory impairment

Overall population estimates²⁰ for adults in Bristol indicate around 5,570 people have a moderate or severe visual impairment in 2018, and 6,400 are estimated to have severe hearing loss (with over 60,200 people estimated to have *some level* of hearing loss).

²⁰ Institute of Public Care, POPPI and PANSI tools, www.poppi.org.uk; national 2006 prevalence applied to the Bristol population; accessed Sept 2018

3.8 People with Learning Disabilities and Autism

3.8.1 Learning Disabilities

Data from GP patient registers²¹ indicates there are around 2,530 people (all ages, including children) recorded as having a Learning Disability (LD) in Bristol. This will focus mainly on those with moderate to severe LD who are more likely to require support. This represents 0.50% of the patient population, which is similar to the England average (0.47%).

For adults, overall population estimates²² indicate around 8,820 adults in Bristol with *some level of* Learning Disability in 2018. Of these, around 1,890 adults are estimated to have a moderate or severe learning disability.

BCC Adult Social Care data (end March 2018) shows around 710 people with a Learning Disability (aged 18-64) receive a community support service. This number has been rising steadily from around 500 in 2014, showing an increase in people with LD being supported to live in the community.

Gender: Of these clients with LD in the community, 62% (440) were men and 38% (270) women.

For children, in 2017 there were around 1,640 pupils²³ recorded with a Learning Disability in Bristol schools, around 150 have “Severe LD” and over 100 have “Profound & Multiple Learning Disabilities”.

²¹ NHS Quality Outcomes Framework, QOF, 2016/17.

²² Institute of Public Care, POPPI and PANSI tools, www.pansi.org.uk; national 2004 prevalence estimate applied to the Bristol population; accessed Sept 2018

²³ Source: Bristol school census 2017 – see section 5.6 Special Educational Needs

3.8.2 People with Learning Difficulties: health inequalities

People with learning disabilities have poorer health than the general population; a lot of this is avoidable. Difficulties in getting effective healthcare when it is needed can make them worse²⁴.

National research²⁵ has shown that men with learning disabilities die an average 13 years sooner than the wider population and women die 20 years sooner, and that there are increased rates of health conditions for people with learning disabilities, including epilepsy, mental health and heart disease.

Further information

- **Learning Disability Profiles** - a range of data about people with learning disabilities at Local Authority level
- Bristol City Council services: [Help for people with learning difficulties](#)

3.8.3 Autistic Spectrum Conditions

In terms of overall population prevalence²⁶, for adults there are estimated to be 3,670 adults in Bristol with some level of autistic spectrum condition in 2018 (18+, including 560 people over 65)

Gender: The adult estimate is 90% (3,300) males and 10% (370) females.

Note – Many people with Autistic Spectrum Conditions do not require formal interventions from services.

For children, more detailed information is available through Special Educational Needs data. There were over 1,000 pupils²⁷ recorded with an Autistic Spectrum Disorder in Bristol schools in 2017.

Further information

- JSNA Chapter on [Children & young people with Social and Communication Interaction Needs](#) (inc Autism)
- Bristol City Council services: www.bristol.gov.uk/social-care-health/autism

²⁴ Statement from Public Health England [Learning Disability Profiles](#)

²⁵ “Confidential Inquiry into premature deaths of people with learning disabilities”; University of Bristol, 2013; www.bristol.ac.uk/cipold

²⁶ Institute of Public Care, POPPI and PANSI tools, www.pansi.org.uk; national 2007 prevalence estimate of 1% applied to the Bristol population; accessed Sept 2018

²⁷ Source: Bristol school census 2017 – see section 5.6 Special Educational Needs

3.9 Gypsy, Roma & Travellers

Gypsy, Roma & Travellers (GRT) (also known as ethnic travellers) have historically had the poorest outcomes of any ethnic group in England²⁸. 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 Bristol²⁹ although there are fluctuations in number due to seasonal travel.

- 25% of the ethnic Traveller population in the southwest reside in Bristol city area with only 5% residing in caravans;
- Bristol is part of a large and historical Traveller trade route;
- Most of Bristol's GRT communities are housed (due to lack of site provision).

There is strong evidence that GRT communities have higher levels of unmet health needs, with poor access to health services.

In addition to ethnic travellers there are also a high number of occupational travellers (Show people, circus people, new travellers and boat dwellers). Bristol has a relatively large New Traveller population. These, as well as Boat Dwellers are often underrepresented in GRT data and provision but share similar health/educational outcomes.

3.9.1 Health outcomes

Gypsy, Roma & Travellers have poorer life outcomes than any other group, across a wide range

of social indicators³⁰. The average life expectancy of a GRT person is 50 years.

A robust study compared the health needs of 293 Gypsies and Travellers in 5 areas in England (including Bristol), to the needs of 293 non-travelling adults. Key findings from this study are included below (SWPHO, 2011:3 - 4)³¹

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;
- Carer for dependent relative(s) with chronic illness or disability (16% compared to 8% of the general population)
- Over-represented in the care system (3 times more likely to be taken into care when compared to other children). ([FFT, 2017](#))

Adult Health for Gypsy, Roma & Travellers

- 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%);
- Higher prevalence of deaths from respiratory diseases and cardiovascular diseases and suicides (approx. seven times higher than the general population ([House of Commons Briefing May 2018:47](#)))

Further research³² shows that domestic abuse is a notable issue for GRTs. Estimated that 60%-80% of women from travelling communities experience domestic abuse during their lives. Suicide rates are 7 times higher than the general population ([FFT, 2017](#))

²⁸ Ofsted; Dec 2014 and SWPHO, 2011:3
²⁹ Bristol GTAA, 2013

³⁰ Bhattacharyya et al. 2003; DfE, 2010 and Rowe and Goodman, 2014

³¹ South West Public Health Observatory (SWPHO) report (October 2011) / Excluding New Age travellers; undertaken by Parry et al.

³² www.twelvescots.org.uk/gypsies-travellers

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

There is no currently accepted national estimate of the LGB population. In 2004 this was estimated³³ to be between 5-7%, but subsequent work recorded a lower figure, such as the National Sexual Attitudes and Lifestyle Survey (2013) with 2.8% of males and 2.7% of females as being LGB. It noted that this figure may be higher in major cities.

Locally, the Bristol Quality of Life survey – a large random sample of Bristol residents³⁴ – found in both 2014/15 and 2015/16 that 4% of the Bristol adult population identified as LGBT.

Based on the 2017 population, the QoL 4% figure suggests there are around 15,000 Lesbian, Gay and Bisexual adults in Bristol, though this is a very broad estimate.

There is also no accepted estimate of the Trans population. A conservative estimate (from US sources) is that transgender people make up 0.2% of the population, though the Gender Identity Research and Education Society (GIREs) in 2009 estimated 1% are on a “gender variant spectrum”.

3.10.1 Bristol LGBT Health & Wellbeing needs

A 2016 survey commissioned by Bristol Healthwatch regarding LGBT Health Needs³⁵ identified:

- 61% of participants had sought help for anxiety or depression
- 32% had hurt or injured themselves (known as self-harm)
- 20% were feeling unhappy and depressed in recent weeks.
- 59% had thought about suicide or tried to kill themselves.
- Most people would seek help from friends (54%) or a partner (52%) when they are unwell.
- 35% stated they had a physical health condition expected to last 12 months or more.
- 34% stated they had a mental health condition expected to last 12 months or more.
- 68% said they had felt discriminated against because of their gender identity and / or their sexual orientation.
- 55% of participants had experienced discrimination on the streets, 48% whilst at work, 44% in bars and clubs and 37% whilst at school.
- 67% were “out” in their local area and 25% weren’t “out”
- Awareness of LGBT+ issues, as well as making assumptions and stereotyping LGBT+ people, among some health care professionals was a concern for many participants.
- LGBT+ people fear holding their (same-sex) partner’s hand in public for fear of attack, especially when on the streets.

3.10.2 Bristol Trans community Health & Wellbeing needs

During 2017-18 Healthwatch Bristol worked with the Diversity Trust and other partners³⁶ to identify health inequalities, and discrimination, experienced by Trans and Non-Binary people and communities across the South West.

The project worked with over 200 Trans and Non-Binary people, aged from 16 to 80. Headline figures / findings include:

- 1 in 5 participants said they felt unsafe
- 71% of participants had thought about suicide
- 71% of participants had sought help for anxiety or depression
- 60% of participants have felt discriminated against because of their gender identity
- 30% of participants felt discriminated against in the health care system

The full report is available on the Healthwatch Bristol web-site: [Trans Health, Care and Wellbeing Report 2018](#)

³³ Department of Trade and Industry. Source: Final Regulatory Impact Assessment: Civil Partnership Act 2004

³⁴ The survey was not carried out in 2016/17 and in 2017/18 used a different methodology.

³⁵ Source: ‘Evidence for Change’, Bristol Lesbian, Gay, Bisexual and Trans Health and

Wellbeing Research Report September 2016 by The Diversity Trust & Bristol Healthwatch <http://healthwatchbristol.co.uk/wp-content/uploads/2016/06/Diversity-Trust-Report-2016.pdf>

³⁶ Source: Trans Health, Care & Wellbeing research report, April 2018. Healthwatch Bristol and The Diversity Trust – full link: <https://healthwatchbristol.co.uk/wp-content/uploads/2018/04/Healthwatch-Trans-Health-Care-and-Wellbeing-Report-03.04.18.pdf>

3.11 Migrant Health Needs

3.11.1 Migrants by Country of Birth³⁷

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

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

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

3.11.2 Migrants by age and sex

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

3.11.3 Migrants and where they live in Bristol

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

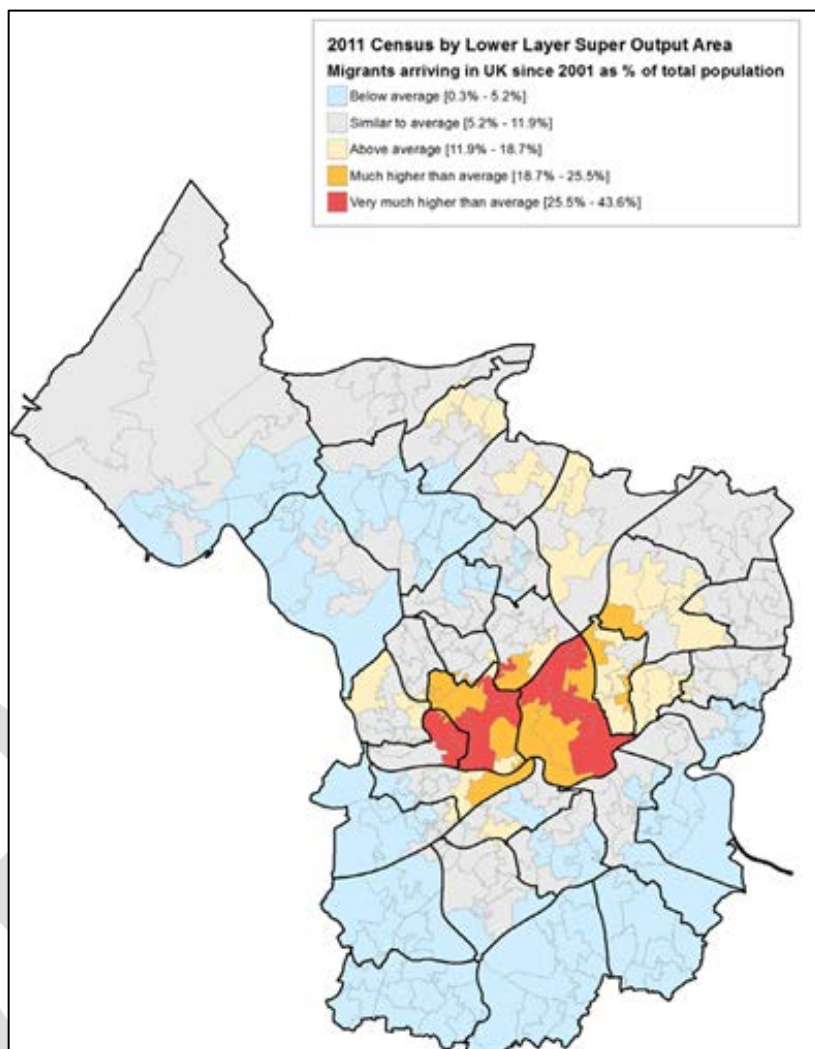


Fig 3.11.4: Migrants arriving in UK since 2001 as % of total population
Source: 2011 Census ONS © Crown Copyright 2013 [from Nomis]

3.11.4 Language

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

English is the main language spoken in Bristol followed by Polish and Somali. Overall 9% of people do not speak English as their main language. 1.6% of people cannot speak English or cannot speak English well.

³⁷ This section uses 2011 Census data and is mainly unchanged from JSNA 2017

3.12 Gender - headlines

This section focuses on outcomes for men and women, using “Gender” points from throughout this JSNA 2018 Data Profile³⁸.

In Bristol, there are substantially more males than females in the 25-49 year old age groups, and more females in the over 65's. Overall, Bristol currently has 49.9% females and 50.1% males.

See section **3.1 Bristol population overview** for data and background information.

3.12.1 Headlines for women

- Preventable mortality rates for Bristol women are significantly higher than the England average (2014-16).
- Females in Bristol accounted for 70% (1,030 of 1,460) of emergency hospital admissions relating to self-harm (2016/17) and has risen significantly from the last year
- Emergency hospital admissions for injuries in young people (15-24 years, 2016/17) was higher for girls (177.4 per 10,000) than boys (122.4 per 10,000), The main causes for admission in young women was intentional self-poisoning and intentional self-harm (2014/15 to 2016/17).
- Bristol rates for early deaths due to respiratory disease for women are significantly higher than England (2014-16).
- More than half of emergency hospital admissions in Bristol relating to asthma were female patients, over the three year period 2014/15 to 2016/17.
- Of recorded hospital admissions for 2016/17, 64% of fall related admissions (65+ years) and 71% of hip fractures (65+ years) were from female patients. The rate per 100,000 for hip fractures is above the England average.
- Police data 2017/18 records 73% of sexual offence victims were female, 12% male and 15% were not determined.
- Police data 2016/17 records 63% of domestic abuse incident victims were female.
- Women (62%) are less likely to be physically active than men (67%), but are significantly more likely to eat healthily (“5-a-day”) (women 60%, men 50%) (2018).
- The suicide rate for women in Bristol (7.4 per 100,000) is significantly worse than the England average (4.8) for women (2014-16)
- 61% of Excess Winter Deaths in Bristol during 2015/16 were women, and 39% men. The Excess Winter Death index for Bristol women is 22.75 and is significantly above the England average of 16.23.
- Of those children and young people (0-24) in receipt of Disability Living Allowance and Personal Independence Payments in Bristol (Nov 2017) 3,310 were female and 1,690 were male.
- Nationally, girls at 15 are more likely to be a smoker than males (very different to the adult picture) and more likely to have had an alcoholic drink than boys (2016).
- Girls at Secondary School report worse mental wellbeing than boys. 42% girls and 27% boys had a low or medium low wellbeing score (Bristol Pupil Voice, 2015).

³⁸ Sources are in the relevant sections

3.12.2 Headlines for men

- Life expectancy for men in Bristol (78.8 years) is below the England average (79.5 years) and less than women in Bristol (82.8 years) (2014-16).
- Men in Bristol have a Healthy Life Expectancy that is 4.4 years less than the England average for men, whilst women in Bristol are similar to average (2014-16). Both men and women in Bristol live an average of 19.9 years in poor health, even though men die an average of 4 years earlier.
- During 2012/13 to 2016/17 there were 1,000 childhood asthma hospital admissions. Of this number, 620 were boys and 380 girls.
- More boys than girls in Bristol are overweight or obese (23.2% boys 4-5 years old to 22.1% girls / 36% boys 10-11 years; 32.4% girls) (2014-17).
- At each stage of education 2017, from early years to key stage 4, achievement amongst boys was less than girls. Pupil absence 2017 from school was equal amongst girls and boys.
- A rough sleeper's count in 2017 reported 64 were male, 18 female and 4 not determined.
- Men (56%) are significantly more likely to be overweight than women (47%) (2017/18).
- Men (16.8%) are significantly more likely to smoke than women (13%) (2017).
- Alcohol related deaths per 100,000 amongst men in Bristol are higher than the England average and more than three times higher than females in Bristol (2014-16).
- More men (971 per 100,000) in Bristol were admitted to hospital for alcohol related harm than women (599 per 100,000) (2016/17). 71% of emergency admissions were male and 29% female.
- Early deaths of men in Bristol (106 per 100,000) from cardiovascular disease are more than twice that of women in Bristol (48 per 100,000).
- Prevalence of Coronary Heart Disease, using GP registers, in Bristol (2.3%) is lower than the England average (3.2%) 2016-17. However, early death rates in Bristol men are 3 times higher than Bristol women. Men also make up 60% of Bristol patients with emergency hospital admissions for coronary heart disease related issues (2016-17).
- Bristol rates (152.1 per 100,000) for early deaths for men due to cancer are significantly higher than the England male average (133 per 100,000) (2014-16).
- Bristol rates for early deaths due to respiratory disease for men are significantly higher than England (2014-16).
- Bristol rates for male early deaths from liver disease are similar to the England average but they are almost three times higher than the Bristol women rate. This is reflected in the hospital admissions for liver disease over the 3 year period 2014/15 to 2016/17, where 65% of patients were male.
- Preventable mortality rates in Bristol are significantly higher in men than women. They are also significantly higher than the England average (2014-16). This is reflected in the emergency hospital admissions record 2016/17, where 37% of admissions were from male patients.
- Most suicides in Bristol during 2014-16 were men (97 of 140) though at a rate of 18.0 per 100,000 are broadly similar to the England average (15.3).
- Over the last 5 years, trend data for men (65+ years) shows the rate per 100,000 for fall related emergency hospital admissions is increasing. Hospital admissions for hip fractures 2016/17 are lower in Bristol men than women (65+ years) but still above the England average.

3.13 Ethnicity - headlines

This section focuses on outcomes for people in Minority Ethnic groups, using points drawn from throughout this JSNA 2018 Data Profile³⁹. For most indicators though, data is not routinely available by ethnicity.

Also see section **3.3 Population diversity** for background information.

In addition, there are detailed **Equality Profiles** (using 2011 Census data) for different ethnicities as well as faith communities on:

www.bristol.gov.uk/census

Key headlines by ethnic group

- One of the highest % of people struggling financially (Bristol Quality of Life, 2017/18) are people from black & minority ethnic (BME) groups (22%); the Bristol average was 12%.
- 72% of 'white British' pupils were assessed as having a good level of development, and only 62.5% of BME pupils and 59% of 'white minority ethnic'.
- Achievement of pupils at Key Stage 2 (at 11 years) achieving level 4 reading, writing and maths (2017) shows 64% of 'white British' pupils achieved the Expected Standard or above but only 55% of BME pupils (46% in those of 'black or black British' ethnicity)
- However, at GCSE pupils of 'white British' ethnicity had the poorest Progress 8 score

(minus -0.41) based on their progress since the end of primary school. Despite a Progress 8 score of +0.11, those of black ethnicity had the lowest Attainment 8 score (39.4) and lowest % getting a 'strong pass' in English and Maths (31.6%). Pupils of Asian and Chinese ethnicities made joint highest Progress (+0.49) and high Attainment 8 score (46.8) and highest % that got a 'strong pass' in English & Maths GCSEs (48.5%). Pupils of 'white minority ethnic' groups also had joint highest Progress (+0.49) and the highest Attainment 8 score (47.4).

- Pupil absence (2017) was lowest amongst those of 'black or black British' ethnicity (4.6%) and highest amongst those of 'white Minority' ethnicity (5.7%).
- Those of white ethnicity make up two-thirds (65%) of 'children in need' and 67% of 'looked after' children. Of those children with child protection plans 77% are of 'white' ethnicity (as at March 2018).
- Breastfeeding initiation rates are lowest for white women living in deprived wards. There is a higher rate of breastfeeding in Black & Minority Ethnic communities (2016/17).
- In the Quality of Life Survey 2017/18; more BME people (19%) say fear of crime affects their day to day lives compared against a Bristol average of 10%.

³⁹ Sources are in the relevant sections

3.14 Deprivation headlines

This section focuses on outcomes for people who live in the 10% most deprived areas *within* Bristol, using points drawn from throughout this JSNA 2018⁴⁰

Also see section 5.1 Deprivation for background information.

Key headlines by Deprivation

- Inequalities in life expectancy have not improved. The gap in life expectancy (between the most deprived 10% and the least deprived 10% in Bristol) is 9.5 years for males and 7.4 years for females (2014-16).
- Local data shows that tooth extraction rates (under general anaesthetic) are around 3 times higher in the most deprived wards compared to the least deprived ones.
- There were 16,500 children under 16 in low-income families in Bristol (2015); this is 20.1% of children and significantly higher than 16.8% nationally. The rate is highest in Hartcliffe & Withywood, Filwood and Lawrence Hill.
- Educational achievement of children at early years (4-5 years) pupils living in the 10% most deprived areas was 59%, compared to 68% for Bristol as a whole
- In 2017, the Attainment 8 score for Bristol pupils was 44.0 points but for 'dis-advantaged pupils' was 33.8. Only 16.1% of pupils on free school meals got a 'strong pass' in English and Maths GCSEs, and their Progress 8 score was (minus) -0.63 (worse than the -0.22 Bristol average).
- Almost a quarter (24%) of 'children in need' are from the most deprived 10% of the population, whilst 57% are from the most deprived 30%. For "looked after children" 20% come from the most deprived 10% areas, and for children with child protection plans, 33% are from the most deprived 10% areas and 63% from the most deprived 30% (end March 2018).
- In Bristol, the 2017 median earnings of the highest earning 10% in work was £899, compared to £154 for the lowest paid 10%. So, the highest paid 10% earned 6 times as much every week as the bottom 10%.
- In the Quality of Life Survey 2017/18:
 - 25% of people in the most deprived 10% areas feel that fear of crime affects their day to day lives, compared to a Bristol average of 10%.
 - 21.5% of people in the most deprived 10% areas said they were struggling financially (city average was 12%)
 - Those who feel anti-social behaviour is a problem locally range from 9% in the least deprived 10% to 58% in the most deprived 10%.
 - 55.9% of those in the most deprived 10% were satisfied with their local area against 94.7% of those in the least deprived 10%.
 - 32% of those in the most deprived areas play sport weekly against a Bristol average of 45%.
 - 29.1% in the most deprived 10% areas said there was a smoker in the household, Bristol average was 21.6%
 - 57% of those people in the most deprived 10% are satisfied with life against a Bristol average of 69%.
 - 28% those in the most deprived 10% reported having a below average mental wellbeing compared to the Bristol average of 18%.
- Hospital admissions data (2016/17) records 18% of Bristol patients admitted for diabetes were living within the most deprived 10% areas, as were 14% of emergency patient admissions for respiratory disease and 18% for asthma.
- Rates of self-harm vary considerably across Bristol, with a link between self-harm and areas of deprivation. People in the least deprived areas are significantly less likely to be hospitalised for self-harm (2014/15 to 2016/17).

⁴⁰ Sources are in the relevant sections

Section 4

Children & Young People's Health

Summary points⁴¹

Population

- Bristol has 85,400 children under 16 and 71,900 young people 16-24 (ONS 2017).
- Bristol's child population has risen across the city.
- Since 2012 births in Bristol have fallen gradually. In 2017 the number of live births fell to 5,960, the first time for a decade that births have been below 6,000 per annum.
- 0-15 population is projected to rise by 12.8% from 2016 to 2026. Primarily this is projected in the 10-15 years age band.
- The child population is ethnically diverse, with 28% of children under 16 from BME backgrounds (Census 2011).

Baby and maternal health

- Infant mortality rates in Bristol appear to have risen and are now similar to national rates. Nationally, the UK has an excessive infant and child mortality rate in comparison with other EU countries.
- Breastfeeding rates are higher than national. 6-8 weeks rates range from 30% (parts of South Bristol) to 90% (Redland).
- The % of pregnant mothers known to be smokers (10.2%) is falling, but significant socio-economic inequalities remain.

Children and Young People's Health

- Almost 5,000 under 25's in receipt of Disability Living Allowance or Personal Independence Payments in Bristol
- Child hospital admissions for asthma across Bristol fell in 2016/17 but remain high in some areas such as the Inner City. Two of three admissions across Bristol are for boys.
- 1 in 4 (24.2%) of Bristol children 4-5 years have excess weight which is significantly more than nationally, and 1 in 3 (33%) of 10-11 year olds (similar to national average).
- 22.5% of 5 year old children have at least one or more decayed, missing or filled teeth, similar to national. Rates for tooth extractions in hospital are higher than nationally, especially 5-9 year olds (twice the national average).
- Overall, local immunisation coverage for most vaccines appears to be falling and are significantly below target. Coverage rates are lowest in Inner City and East Bristol.
- Rates of emergency hospital admissions from injuries are now significantly worse than national. For children (0-14) the rate is higher in boys, but for young people (15-24) is much higher for girls (due to high levels of self-harm).
- Almost 10% of children and young people experience mental health problems, and self-harm hospital admission rates (10-24 years) have risen in recent years and continue to significantly exceed the England average⁴².
- The rate of teenage conceptions in Bristol has fallen in the last decade and is similar to the England average.
- More 15 year olds smoke in Bristol than nationally, and significantly more have tried cannabis (2014/15 survey)
- Bristol has above average coverage for chlamydia screening (25.8% of 15 to 24 year olds screened in 2016).

Social care and wider determinants

- A higher % of children under 16 living in low income families in Bristol (20.1%) than nationally (16.8%).
- Education inequalities across the city remain.
- For children in care⁴³, Health assessments have improved and more have up-to-date immunisations than nationally
- First-time entrants to the Youth Justice System in Bristol are significantly higher than nationally, but are falling.

Further data

- JSNA Chapters on [Children and young people](#)
- PHE [Child health profiles](#) - an annual snapshot of key child health and wellbeing indicators

⁴¹ These cover all relevant Children & Young People areas throughout the JSNA sections.

⁴² See **9.6 Emotional Health and Wellbeing of Children & Young People**

⁴³ See **5.7 Children's Social Care** and the relevant JSNA Chapter for more details

4.1 Low birth weight

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

In 2016, 2.9% of term births (i.e. those born after 37 weeks of pregnancy) were of low birth weight (fig 4.1.1). This is again similar to the England average (2.8%) after a spike in 2015, and Bristol still has one of the lowest rates of English Core Cities – fig 4.1.2.

Babies born prematurely (i.e. before 37 weeks of pregnancy) are much more likely to be of low birth weight. In 2016, 6.1% of all Bristol live births had a 'low birth weight'; significantly better than the England average (7.3%)⁴⁴.

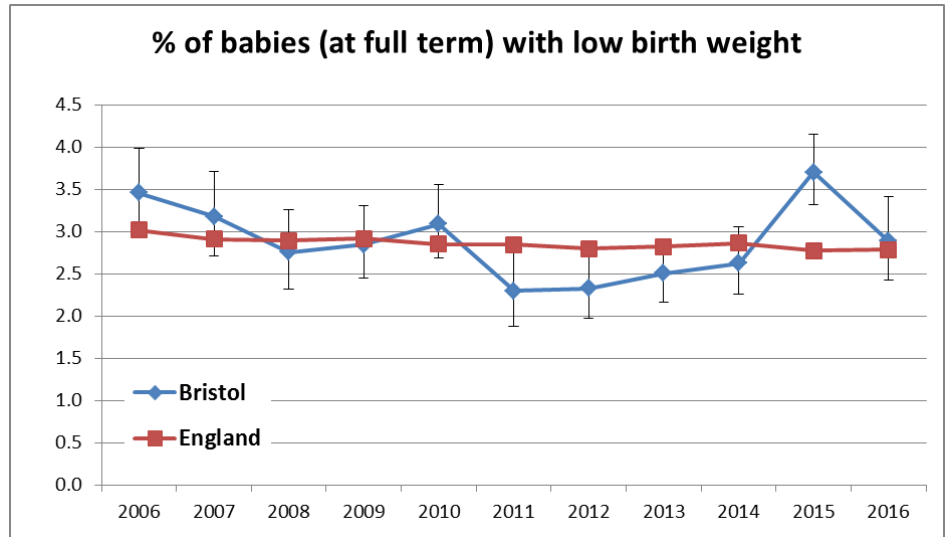


Fig. 4.1.1: % of all live births at term with low birth weight. Source: ONS, via Public Health Outcomes Framework, 2018

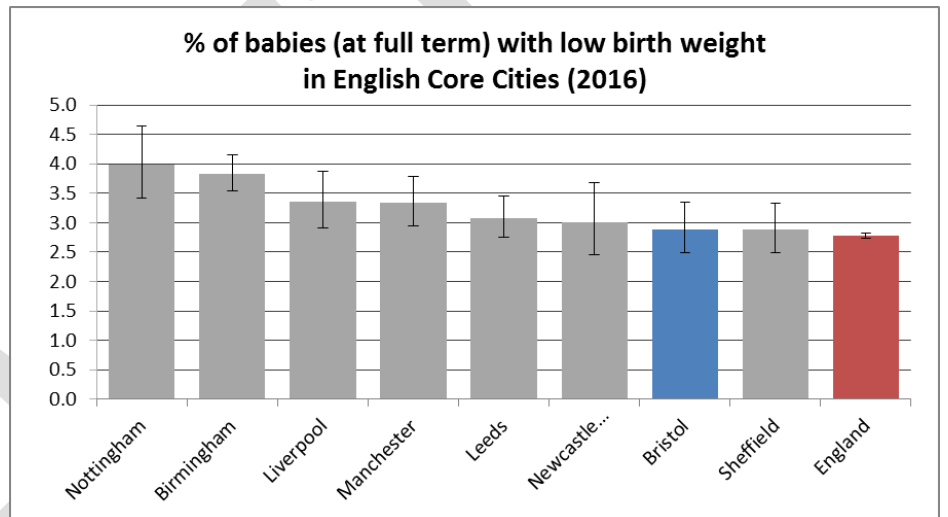


Fig. 4.1.2: % of all live births at term with low birth weight for English Core cities. Source: ONS, via Public Health Outcomes Framework, 2018

A project⁴⁵ to explore trends in childhood disability in Bristol linked individual data on birth weight and children with special educational needs over a 10 year period. This showed that low birth weight was strongly associated with the child having special needs when they reached school age, with a graduated effect: the lower the birth weight, the greater the risk.

Further data

- PHE [Pregnancy and birth Profile](#)

⁴⁴ ONS, via PHE “Pregnancy and birth” Profile

⁴⁵ 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 rates are higher in children born into poverty, to teenage mothers, to mothers who have not accessed antenatal care or have lifestyle choices that increase vulnerability of their infants (e.g. smoking, alcohol or drug misuse).

Whilst infant mortality in England is at an all-time low, the rate did not fall in the last year. Nationally, a new “State of child health” report⁴⁶ (2017) highlights that the UK has an excessive infant and child mortality rate in comparison with other EU countries, as evidenced by “The UK ranks 15 out of 19 Western European countries on infant mortality”. Also, “Social inequalities play a role in almost all the leading causes of infant death”.

The rate of infant mortality⁴⁷ in Bristol was 3.6 deaths per 1,000 live births (2014-16), similar to the national average (3.9 deaths per 1,000 births).

From a low in 2009-11, the Bristol rate appeared to rise and has been relatively static since 2011-13 - fig 4.2.1. However, Bristol is still one of the lowest of English Core Cities – fig 4.2.2.

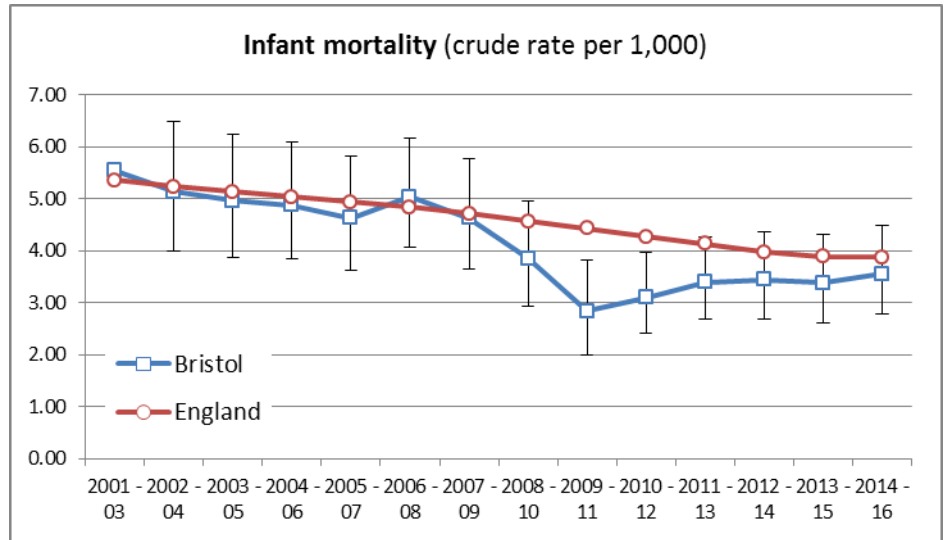


Fig 4.2.1: Rate of Infant mortality (age under 1 year) per 1000 live births
Source: ONS via Public Health Outcomes Framework, 2018

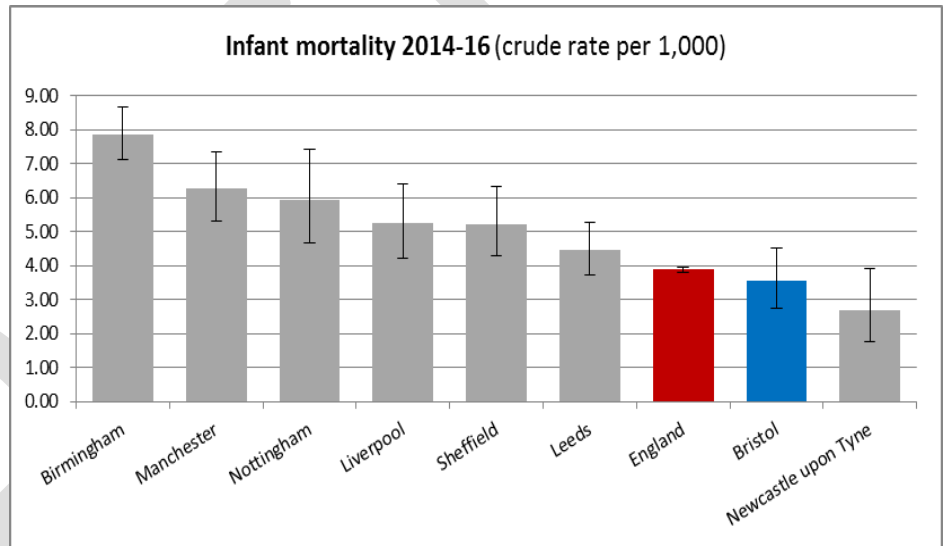


Fig 4.2.2: Rate of Infant mortality (age under 1 year) per 1000 live births for English Core Cities. Source: ONS via PHOF, 2018

We will monitor this trend carefully so that action can be taken. A new National Child Mortality Database has been created in 2018 and is being hosted at Bristol University.

Further information:

- State of child health report 2017
www.rcpch.ac.uk/resources/state-child-health-report-2017

⁴⁶ [State of Child Health report 2017](http://www.rcpch.ac.uk/resources/state-child-health-report-2017)

Royal College of Paediatrics and Child Health

⁴⁷ Source: ONS birth & deaths data, via Public Health Outcomes Framework (2018)

4.3 Breastfeeding

4.3.1 Breastfeeding (initiation)

Breastfeeding provides optimal nutrition, enhances emotional attachment and improves health. Breastfed babies have fewer infections, are less likely to become overweight, develop diabetes or an atopic illness. Mothers who breastfeed have lower rates of breast and ovarian cancer, diabetes, postnatal depression and improved weight loss after pregnancy.

Nationally, 3 out of 4 mothers start breastfeeding⁴⁸. In Bristol this rate has been significantly higher than average for several years (see fig 4.3.1) and in 2016/17 the Bristol rate was 82.1%, the highest of the English Core Cities.

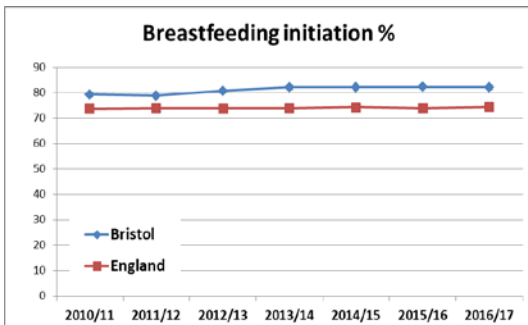


Fig. 4.3.1- Breastfeeding initiation rates. Source: NHS England via Public Health Outcomes Framework (2018)

Ethnicity: Breastfeeding initiation rates are lowest for white women living in deprived wards. There is a higher rate of breastfeeding in BME communities.

Further data

- PHE [Pregnancy and birth Profile](#)

4.3.2 Breastfeeding (continuation)

The World Health Organization (WHO) advise that babies are breastfed for the first six months, and continue for as long as they wish (2 years and beyond). As mothers have contact with health services when baby is 6-8 weeks, breastfeeding continuation is measured then (not at 6 months). Continuation rates are lower as mothers may encounter barriers to successful breastfeeding.

Previous data to 2014/15 had shown that Bristol had significantly better breastfeeding continuation rates than England and other Core Cities⁴⁹, but no formal rate has been published for Bristol in the last 2 years due to ‘data quality reasons’. However, the raw data⁵⁰ (un-validated) indicates that 50% of babies *due* a 6-8 week review in Bristol continue to be totally or partially breastfed at 6-8 weeks (2016/17), compared to 44% nationally (2016/17).

Local data for 2016/17 (as a % of those *with a valid feeding status recorded*) indicates 63% of babies were breastfed at 6-8 weeks, but with significant variation across Bristol. Rates range from around 30% in Hartcliffe & Withywood and Hengrove & Whitchurch Park to 90% in Redland. Overall they are higher in North & West (inner) and lower in South Bristol – fig 4.3.2.

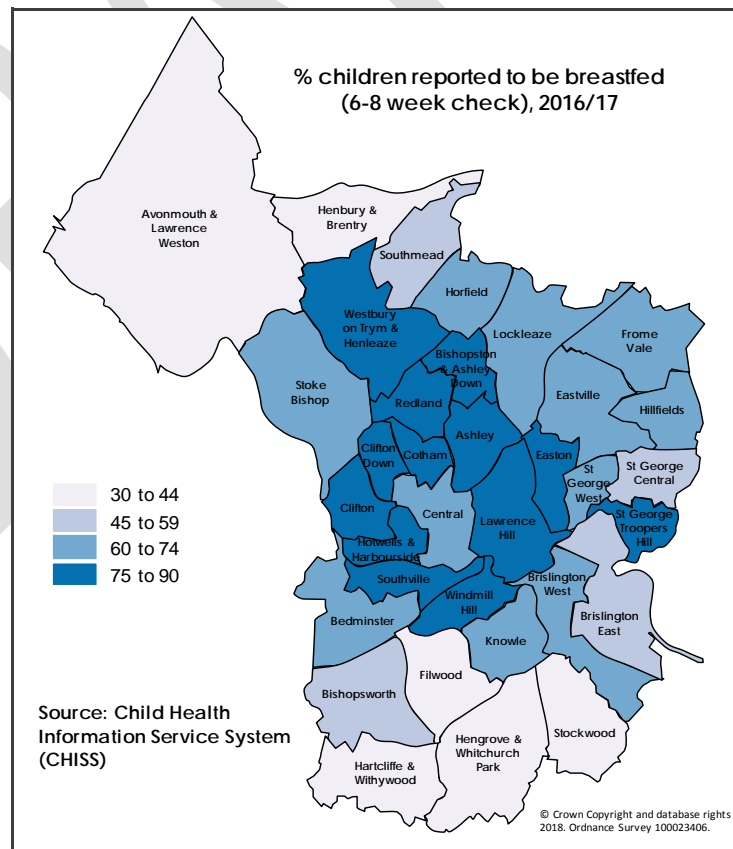


Fig 4.3.2: 2016/17 Breastfeeding rates at 6-8 week. Source: Child Health Information Service System, via Bristol Public Health Knowledge Service 2018

⁴⁸ Source: NHS England, via Public Health Outcomes Framework (2018)

⁴⁹ Breastfeeding continuation rates, historical method; via PHOF (Feb 2018)
⁵⁰ % of infants *due* a 6-8 week review; Source: Public Health England, 2016/17;
www.england.nhs.uk/statistics/statistical-work-areas/maternity-and-breastfeeding/

4.4 Smoking during pregnancy

All smoking is harmful. Smoking during pregnancy can be harmful for the baby, potentially leading to reduced blood supply to the developing baby and poor growth. It is the major risk factor associated with miscarriage, still birth, premature birth and neonatal mortality.

Although Bristol’s rates for neonatal death and still-birth (related to smoking) are similar to the English average, further work is required to understand the geographical variations across the city. For more information refer to the Local Tobacco Control Profiles - see ‘Further data’ below.

Pregnant women who smoke are encouraged and supported to give up. Women are asked to self-report their smoking status at their first antenatal appointment and at the time of delivery of their baby.

In 2017/18, over 600 pregnant mothers self-reported as still smoking at the time of delivery⁵¹. As a rate, this is 10.2% of all maternities in Bristol where mothers are known to be smokers.

This has fallen over the last year - fig 4.4.1. In 2016/17 the rate was 11.2%, similar to the England average of 10.7% and one of the lowest rates for English Core Cities.

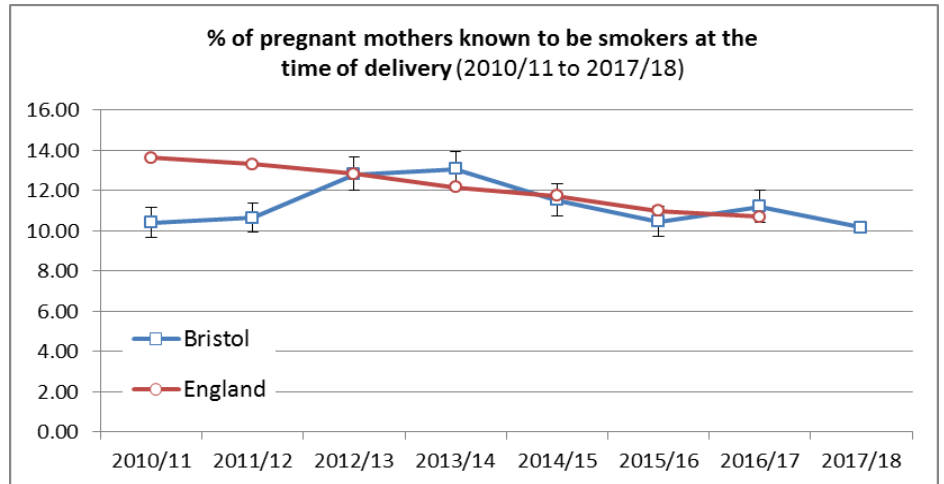


Fig. 4.4.1: Source: Health and Social Care Information Centre; via Bristol Public Health Knowledge Service / PHOF 2018

However, there is still significant variation with rates associated with deprivation and socio-economic inequalities. Socially excluded groups i.e. lone parents, BME groups, people with mental health issues, are associated with higher smoking rates⁵².

Further local analysis⁵³ in 2018 using local referral data (from maternity services to Bristol City Council stop smoking services) shows that pregnant women who smoke in Bristol are more likely to be living in: Right to buy estates (12.1%), Low income large families in social rented semis (11.6%), Social rented flats, families and single parents (10.9%) and Deprived areas and high-rise flats (9.4%) - see fig 4.4.2.

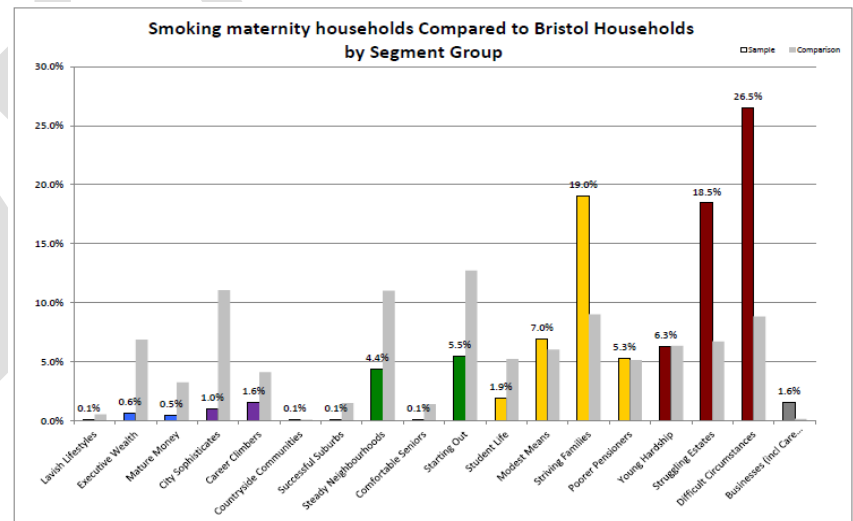


Fig. 4.4.2: Source: Health and Social Care Information Centre; CACI Acorn segmentation

Further data

- PHE [Pregnancy and birth Profile](#)
- PHE [Local Tobacco Control Profiles](#)

⁵¹ Smoking Status at Time of Delivery, 2017/18. NHS Bristol CCG.

⁵² Amanda Amos: Health Inequalities & Smoking – an overview, April 2016

⁵³ Analysis by Bristol City Council Public Health and GIS teams using Acorn (a tool that categorises the UK’s population into demographic types), 2018

4.5 Disabled children⁵⁴

According to the Census 2011, 3,250 children (under 16) in Bristol have a “limiting long-term illness or disability”⁵⁵. This is 4.1% of the local child population, higher than the national average 3.8% (*note – this is in contrast to the all-age population, where Bristol is below national % – see section 3.7*). Of these, 1,300 children (1.7% of Bristol children) have their daily activities *limited a lot* and 2,000 children (2.5%) *limited a little*. Across Bristol (fig. 4.5.1), the Census data highlights the variation from 2.7% in North & West (inner) to 4.6% in South and 4.8% in North & West (outer).

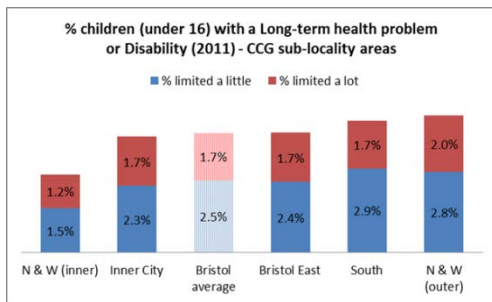


Fig 4.5.1: % Children with long-term health problem or disability by CCG sub-localities. Source: ONS Census 2011

The main disabling condition for 0-24 year olds that apply for Disability Living Allowance or Personal Independence Payments is a physical disability.

- For 0-5 and 11-15 year olds the main disabling condition is physical disability.
- For 5-10 year olds, cognition & learning is the main disabling condition.
- For the 16-24 year old age range, ‘unknown’ becomes the main disabling condition.

Gender: Of the approx. 5,000 children and young adults aged 0-24, 1690 are disabled males and 3310 are disabled females

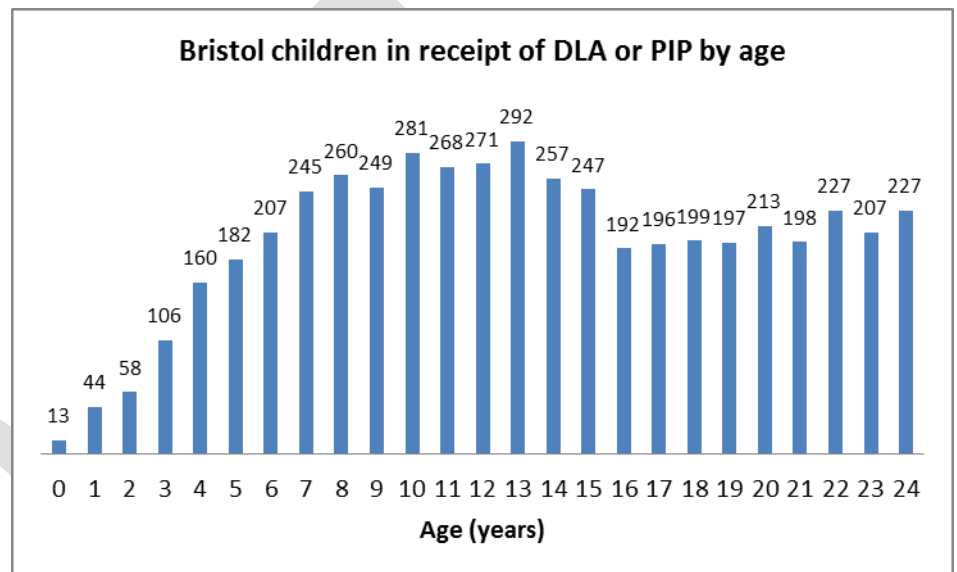


Fig 4.5.2: Number of 0-25 year olds entitled to Disability Living Allowance or PIP in Bristol.⁵⁶

More recent data, for children and young adults aged 0-24 (from Department of Work and Pensions, Nov 2017) states there are almost 5,000 children and young people in receipt of Disability Living Allowance or Personal Independence Payments in Bristol - fig 4.5.2 for detailed breakdown by ages. This is significantly higher than the average for Bristol’s Statistical Neighbours (3,910).

Further data

- See the JSNA Chapter on Special Educational Needs and Disability (SEND) due end 2018 - [Bristol JSNA Chapters](#)

⁵⁴ Also see **5.6 Special Educational Needs**
⁵⁵ Children under 16, Source: ONS Census 2011 – as in JSNA 2015

⁵⁶ The DLA data used refers to children and young adults ‘DLA eligible’. The PIP data used refers to ‘PIP Claims in Payment’.

4.6 Chronic Childhood Illnesses

4.6.1 Asthma

Asthma is the most common chronic disease of childhood. The strongest risk factors for developing asthma⁵⁷ are a combination of genetics with exposure to inhaled particles that may provoke allergic reactions or irritate the airways, such as: indoor allergens, outdoor allergens (eg pollens and moulds), tobacco smoke and air pollution.

In 2016/17, there were 188 child (0-18) emergency admissions to hospital due to asthma⁵⁸, a rate of 190 per 100,000 children. This rate is lower than the last 2 years, but similar to previous years – see fig 4.6.1a. However, within Bristol the rate remains highest in the Inner City (292 per 100,000) and lowest in the North & West (inner) at 79 per 100,000.

By ward, 5 year average rates for hospital admissions⁵⁹ were highest in Lawrence Hill and Central (over 350 per 100,000), and Southville, Bedminster and Easton all had rates over 300 per 100,000. The lowest were Clifton Down (40 per 100,000) and Westbury-on-Trym & Henleaze (68 per 100,000) - fig 4.6.1b.

Gender: Of the 1000 childhood asthma admissions from 2012/13 to 2016/17, 620 were boys and 380 girls. Male admission rates were highest in Lawrence Hill, Bedminster and Central (over 440 per 100,000). Female rates were highest in Southmead and Southville (333 per 100,000).

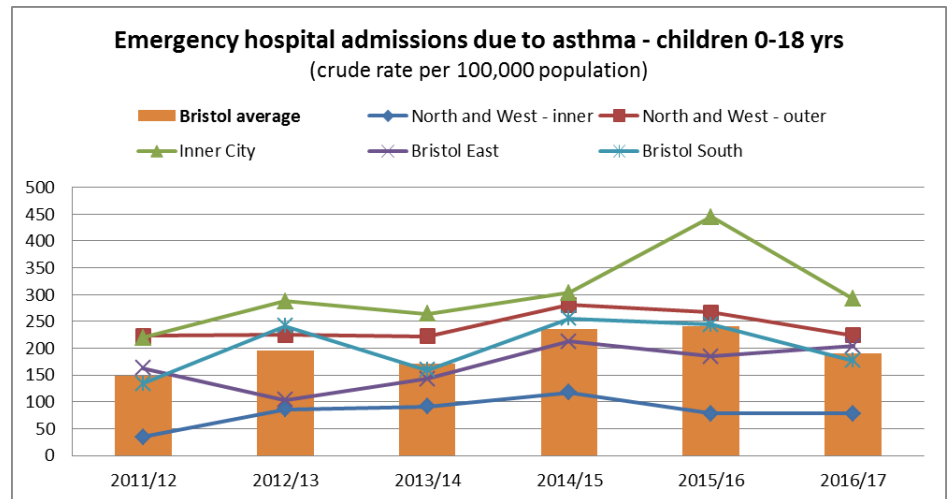


Fig 4.6.1a: Child hospital admissions for asthma, crude rates per 100,000 by CCG sub-locality; Source: Bristol Public Health Knowledge Service, 2018

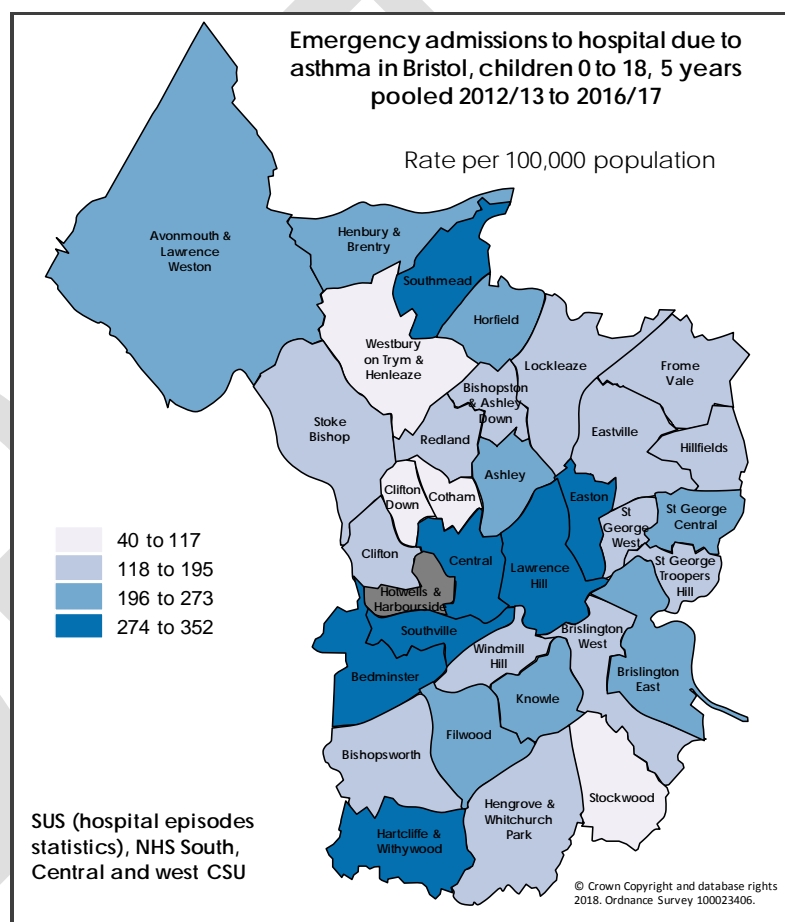


Fig 4.6.1b: Child hospital admissions for asthma, 5-year pooled crude rate per 100,000 by ward; Source: Bristol Public Health Knowledge Service, 2018 [Note - Hotwells and Harbourside is suppressed due to very small population]

Asthma and second hand smoke

Asthma attacks can be triggered by second hand smoke, and the main source of exposure for children is inside the home⁶⁰. The Bristol Quality of Life survey 2017/18 notes 6% of people live in houses where someone smokes regularly inside the home - highest in Hartcliffe & Withywood (16%) and Lawrence Hill (14%)

⁵⁷ World Health Organisation, Fact sheet on Asthma (No.307), Nov 2013

⁵⁸ Admissions directly due to asthma, 0-18 yrs. Source: Hospital episode stats via Bristol Public Health Knowledge Service, 2018

⁵⁹ Local ward data is a pooled rate for the 5 years 2012/13 – 2016/17. Bristol average is 207 per 100,000 for this time period.

⁶⁰ Action on Smoking and Health (ASH), Research report - Asthma & Smoking, 2015

4.6.2 Epilepsy⁶¹

Epilepsy is the most common neurological disorder in children affecting around 1 in 220 children nationally. It is characterised by a tendency to have seizures. Diagnosis is challenging and misdiagnosis rates are high.

Epilepsy can occur in isolation or be associated with other conditions, such as learning difficulties or cerebral palsy. The commonest cause of epilepsy has no identifiable cause (idiopathic epilepsy), but approx. a third are considered symptomatic (secondary epilepsy) which may be associated with a brain injury, congenital abnormalities or genetic conditions.

Epilepsy is associated with the risk of premature death (as seizures can be potentially life threatening), poor educational and social outcomes and mental health issues. Seizure management is important as a significant number of people could become seizure free and good control reduces the risk of these adverse consequences.

Based on national estimates and local GP data, there are around 1000 children with a diagnosis of epilepsy in the Bristol, North Somerset and South Glos area and around 100 new cases per year⁶². Within Bristol there are almost 500 children with a diagnosis of epilepsy recorded.

In 2015/16, 57 Bristol children were admitted as an emergency to hospital. This admission rate of 58.2 per 100,000 is now better than the national average of 76.6 per 100,000 (fig 4.6.2).

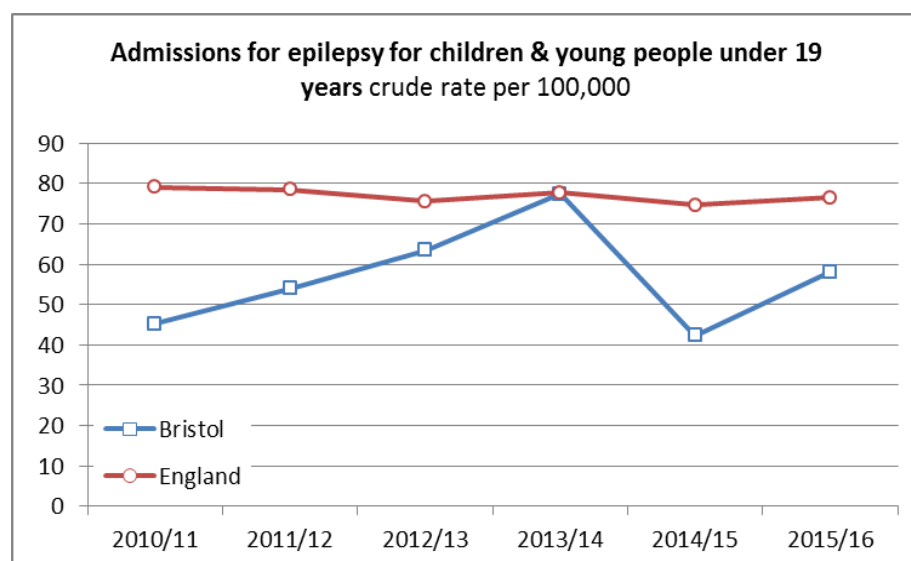


Fig 4.6.2: Rates of child hospital admissions due to epilepsy. Source: Hospital Episode Statistics, NHS Digital via ChiMat Disease Management Information Tool (DMIT)

Further data

- JSNA Chapter on [Childhood Epilepsy in Bristol, North Somerset and South Gloucestershire \(2017\)](#)

4.6.3 Diabetes

The incidence of child (0-18) emergency admissions due to diabetes in 2015/16 was 53.1 per 100,000 population in Bristol, similar to the national average (55.4 per 100,000) – fig 4.6.3.

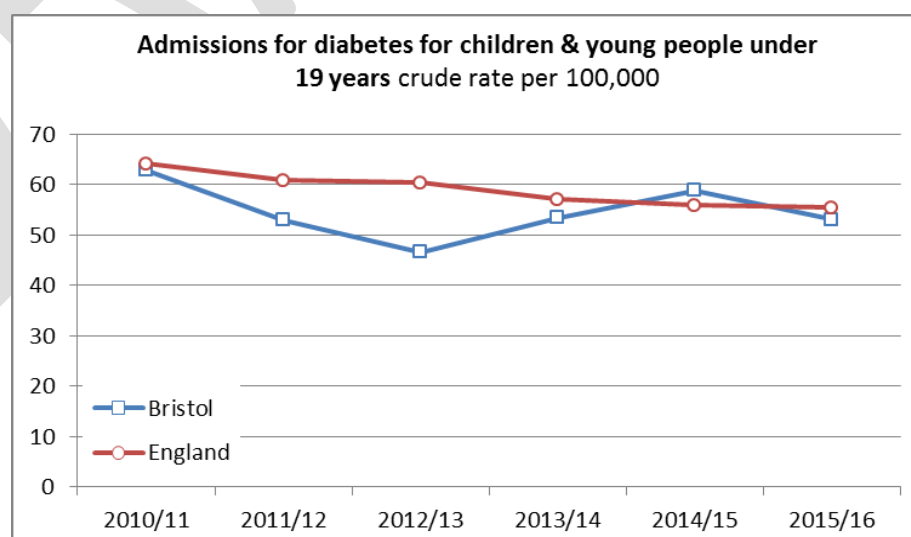


Fig 4.6.3: Rates of child hospital admissions due to diabetes. Source: Hospital Episode Statistics, NHS Digital via ChiMat Disease Management Information Tool (DMIT)

⁶¹ Section mainly extracted from the Childhood Epilepsy JSNA Chapter, 2017

⁶² Epilepsy incidence and prevalence from Joint Epilepsy Council, 2011; via JSNA Chapter 2017

4.7 Healthy Weight

Reducing childhood obesity is both a local and national priority⁶³. The World Health Organisation, 2015, states ‘obesity in childhood is associated with serious health complications and an increased risk of premature onset of illnesses, including diabetes and heart disease’. The Governments A Plan for Action 2016⁶⁴ stated “nearly a third of children are overweight or obese and younger generations are becoming obese at earlier ages and staying obese for longer” and “The burden is falling hardest on children from low-income backgrounds”.

The National Child Measurement Programme (NCMP) measures the height and weight of all Reception year children (4-5 year olds) and in Year 6 (10-11 year olds) to assess the % overweight or very overweight (obese). This data is used to inform planning & delivery of services for children.

4.7.1 Excess weight in 4-5 year olds

The Bristol data for 2016/17 indicates that the prevalence of excess weight of 4-5 year olds in reception year (24.3%) is higher than the England average (22.6%) to a statistically significant extent. (fig 4.71a).

Bristol is mid-ranking for English Core Cities.

9.7% of 4-5 year olds are classed as obese⁶⁵, similar to national (9.6%).

Gender: Nationally, 23.2% of 4-5 year old boys had excess weight and 22.1% of girls⁶⁶.

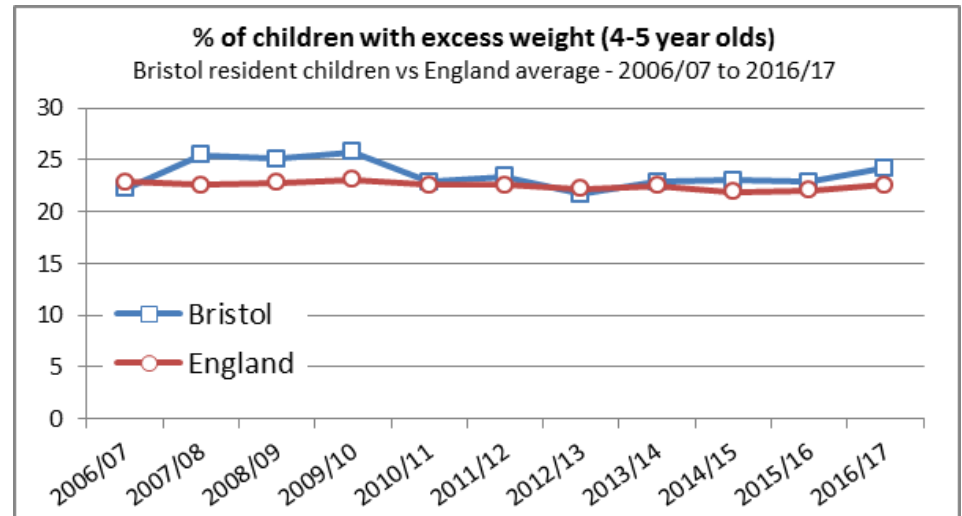


Fig 4.7.1a: Source: NCMP via PHOF, May 2018

Within Bristol, local data⁶⁷ for 2014/15-2016/17 (a 3 year average) shows the proportion of 4-5 year olds who are overweight or obese is much lower in North & West (inner) (17%) and highest in North & West (outer) (27%) - fig 4.7.1b. Due to the relatively small numbers, the data are presented as 3 year averages. By ward, the range is from 13% in Clifton Down to over 30% in Filwood and Hartcliffe & Withywood (33%). In some wards, by the time they start school almost 1 in 3 children have a weight likely to cause health problems later in life.

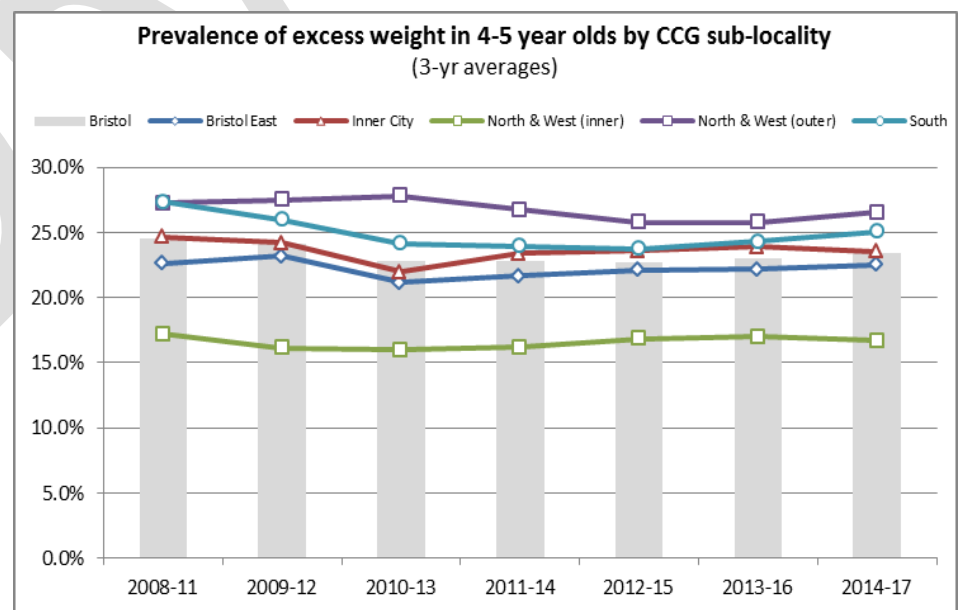


Fig 4.7.1b: Excess weight in 4-5 year olds by Bristol area, 2014-17 Source: NCMP via Bristol Public Health Knowledge Service, 2018

⁶³ Extracts from JSNA Chapter on [Healthy Weight in Children and Young People \(2017\)](#)

⁶⁴ A Plan for Action, 2016

⁶⁵ Source: NHS Digital & NCMP, via PHE [Child health profiles](#), 2018

⁶⁶ Public Health Outcomes Framework, 2018

⁶⁷ Source: National Child Measurement Programme, 2014/15 to 2016/17; via Bristol Public Health Knowledge Service, 2018

4.7.2 Excess weight in 10-11 year olds

The proportion of Year 6 pupils (10-11 year olds) with excess weight in Bristol was 33% in 2016/17, which is now statistically similar to the England average (34.2%) - fig 4.7.2a. Bristol currently has the lowest rate of the English Core Cities.

19.8% of 10-11 year olds are classed as obese⁶⁸, now similar to the national average (20%).

Gender: Nationally, more 10-11 year old boys (36%) had excess weight than girls (32.4%)⁶⁹.

Within Bristol, local data⁷⁰ (using an average of the last 3 years due to small numbers) shows the differences by ward. The % of overweight or very overweight 10-11 year olds ranges from 17% in Redland to 43% in Filwood and Hartcliffe & Worthywood (fig 4.7.2b).

By CCG sub-locality areas, the proportion of 10-11 year olds overweight or obese rose sharply in Bristol East in recent years, to 39%. The lowest area is consistently North & West (inner), 21%, whilst all other areas have more than 1 in 3 children overweight or obese by the time they leave primary school⁷¹.

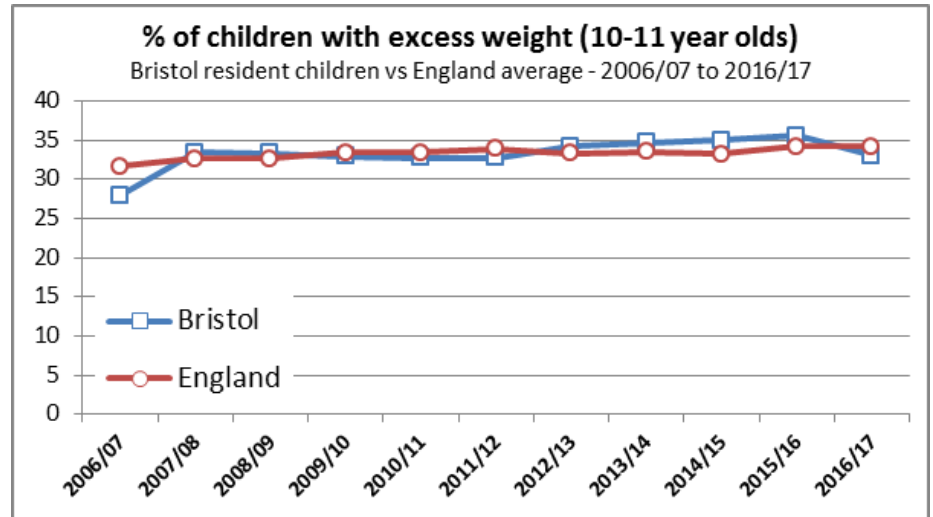


Fig 4.7.2a: Source: National Childhood Measurement Programme (NCMP) via PHOF, May 2018

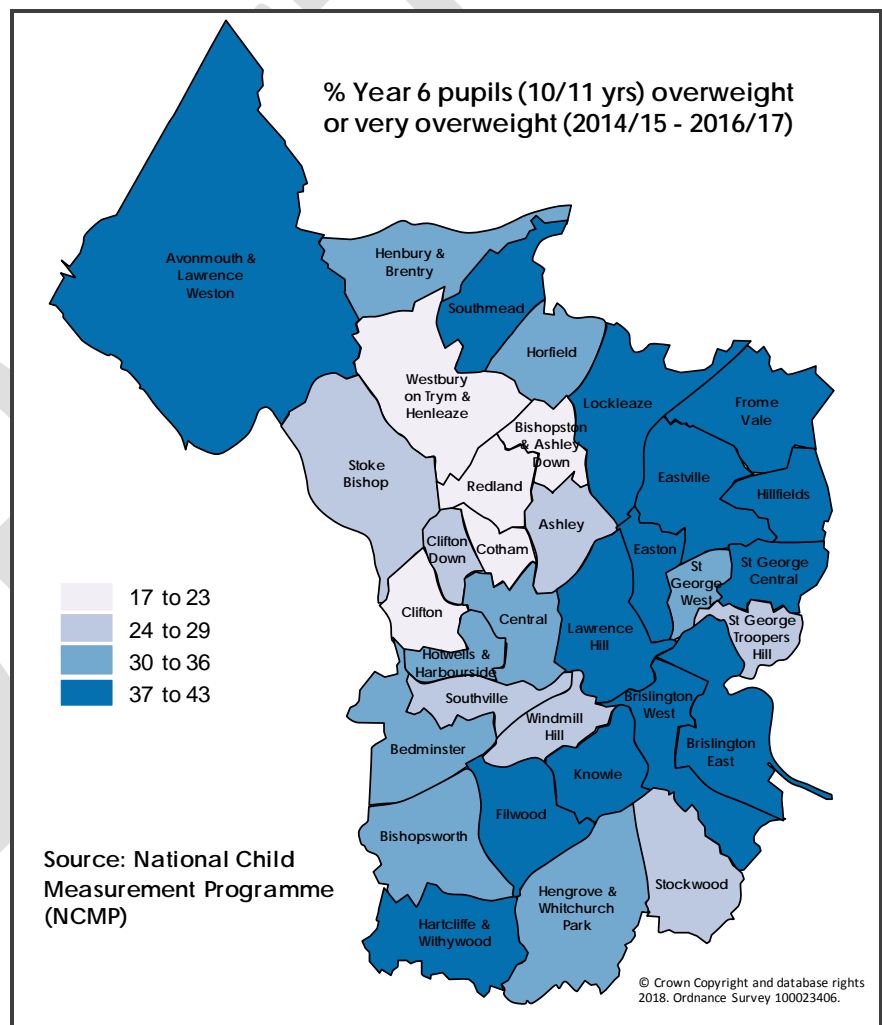


Fig 4.7.2b: Excess weight in 10-11 year olds by Bristol wards, 2014/15 - 2016/17 Source: NCMP via Bristol Public Health Knowledge Service, 2018

⁶⁸ Source: NHS Digital & NCMP, via PHE [Child health profiles](#), 2018

⁶⁹ Public Health Outcomes Framework, 2018

⁷⁰ Source: National Child Measurement Programme, 2014/15 to 2016/17; via Bristol Public Health Knowledge Service, 2018

⁷¹ Source: NCMP, 2014/15 to 2016/17; via Bristol PHKS, 2018

Further data

- JSNA Chapter on [Healthy Weight in Children and Young People \(2017\)](#)
- [Child health profiles](#) - an annual snapshot of key child health and wellbeing indicators

4.8 Dental health

Oral diseases can have a considerable impact on a child’s general health and wellbeing. Poor oral health is associated with being underweight and a failure to thrive, and affects a child’s ability to sleep, speak and play 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 three, five, and twelve year olds. They involve looking at numbers of decayed, missing or filled teeth across a sample of mainstream schools.

The most recent survey was in 5 year olds (2016-17), and reported that 22.5% of 5 year old children had at least one or more decayed, missing or filled teeth. This is broadly similar to nationally (23.3)⁷². The average number of decayed, missing or filled teeth (dmft) in five year olds in Bristol is 0.81, similar to the rate for England (0.78). However, the Bristol sample was small. Nonetheless, the survey results highlight the importance of oral health in young children.

Other data which is unchanged:

- 15.3% of 3 year olds (2013/4) had tooth decay, higher than the England average (11.7%)⁷³.
- The average number of decayed, missing or filled teeth in 12 year olds (2008/9) was

higher (1.1) than national (0.74)⁷⁴

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

Tooth extractions

In 2016/17, 865 Bristol children and young people (0-19 years) were recorded as admitted to hospital for extraction of one or more decayed primary or permanent teeth⁷⁵. As a rate this is 0.8% of the resident population, against an England average of 0.5%.

Tooth extraction is more prevalent amongst children 5-9 years old. In Bristol, this accounted for 1.6% of 5-9 year olds, double that of the England average (0.8%) – fig 4.8.1.

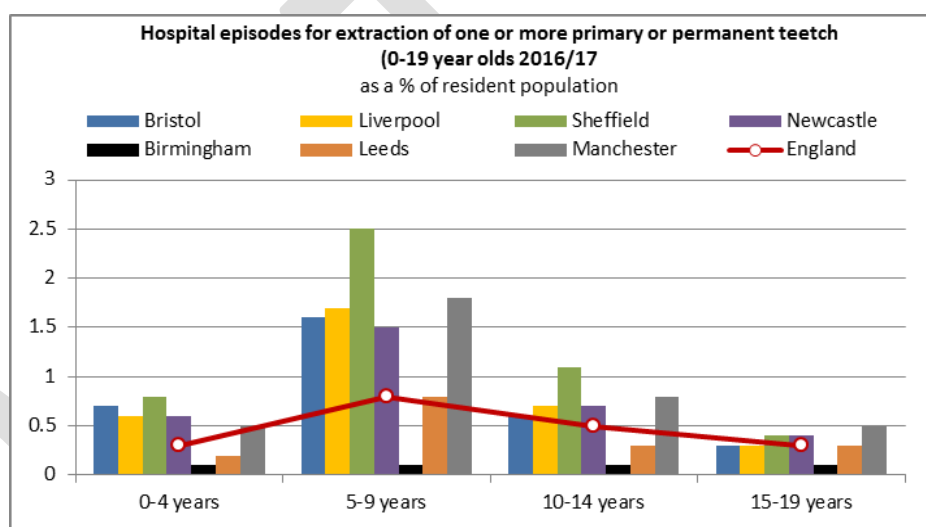


Fig 4.8.1: Source; Public Health England, Dental Public Health Intelligence Programme, 2016/17

Local data⁷⁶ (covering Bristol, South Glos and North Somerset using Bristol Dental Hospital records) shows that tooth extraction rates (under general anaesthetic) are around 3 times higher in the most deprived wards compared to the least deprived ones.

Further data

- [Oral Health Profile](#) (Public Health England)
- University of Bristol paper on [Neighbourhood incidence rate of paediatric dental extractions under general anaesthetic in South West England](#)

⁷² Source: Oral health survey of 5 year old children; via PHE [Child health profiles](#), 2018
⁷³ Via Oral health profile. The 2013/14 survey has not yet been repeated.

⁷⁴ Via Oral health profile. The 2008/09 survey has not yet been repeated.
⁷⁵ Dental Public Health Intelligence Programme, 2016/17.
⁷⁶ British Dental Journal, volume 224 (Feb 2018). Paper also published via University of Bristol: [Neighbourhood incidence rate of paediatric dental extractions under general anaesthetic in South West England](#)

4.9 Childhood Immunisations⁷⁷

For most immunisations, the World Health Organisation state a target of immunising at least 95% of all children 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 circulating in the community.

4.9.1 Immunisations due by 1 year old

a) DTaP/IPV/Hib is a single vaccination that protects children against five serious diseases; Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio and Haemophilus influenza 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 uptake in Bristol appears to have been falling since 2012/13, and after years of being better than the national average, uptake in Bristol (93.3%) is now similar to England

(93.4%) – see fig 4.9.1. Bristol is now mid-ranked amongst the English Core Cities.

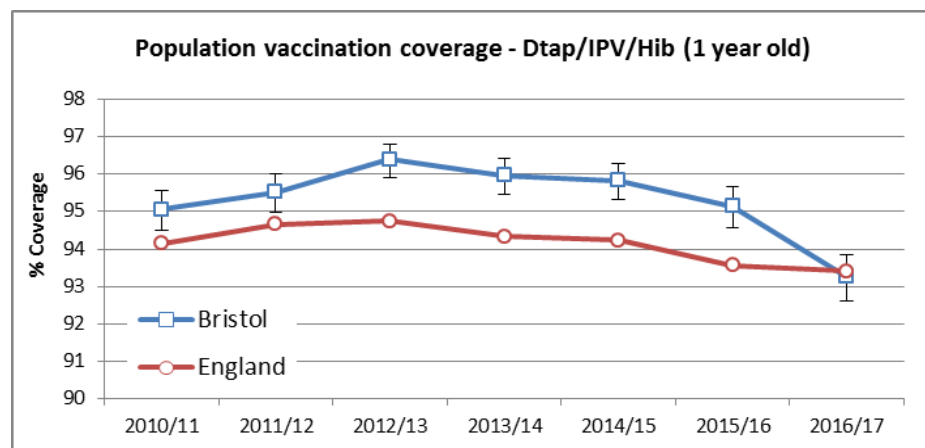


Fig. 4.9.1: Source: Cover of Vaccination Evaluated Rapidly 2016/17 data via Public Health Outcomes Framework, 2018

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),

In 2015/16, 96.1% of babies in Bristol had had the MenC vaccine by the age of 1, higher than the 95% target.

c) PCV (or pneumococcal conjugate vaccine) protects against an infection which can cause pneumonia, meningitis and septicaemia. By the age of one year, a child is recommended to have been given two doses of the vaccine. The uptake of the vaccine in Bristol dropped in 2016/17 and at 93.4% is now similar to the England average of 93.5%.

d) Hepatitis B - Infants born to hepatitis B virus (HBV) infected mothers are at high risk of acquiring HBV infection themselves, so are due 3 doses of the hepatitis B vaccine by the age of 1.

The uptake of the vaccine⁷⁸ in Bristol was 83.3% in 2016/17. [NB This is only for relevant babies, so numbers are very small]

4.9.2 Immunisations due by 2 years old

a) DTaP/IPV/Hib - By the age of two years old, a child should have been given 3 doses of the vaccine (NB same doses as above, due to be given by 1 years old). The 2016/17 uptake of this vaccine in Bristol, by 2 years of age, (95.9%) is still better than England average (95.1%) and the 95% target, but has been falling since 2013/14.

b) PCV booster – In addition to the 2 doses of the PCV vaccine by age 1, a booster dose is due by age 2. Uptake in Bristol has

⁷⁷ All data source is "Cover of Vaccination Evaluated Rapidly (COVER)" via PHOF 2018, compared to the national average.

⁷⁸ Source: Cover of vaccination evaluated rapidly data from PHE, via PHOF May 2018

been falling since 2013/14. In 2016/17 Bristol is 90.1%, now similar to the England average of 91.5% but below the 95% target.

c) Hib / MenC booster - A booster vaccination offered about 12 months of age. The 2016/17 uptake (by age 2) in Bristol at 90.1%, remains similar to the England average of 91.5%.

d) MMR one dose - MMR is a single vaccine that protects against Measles, Mumps and Rubella (German measles). One dose should be received by 2 years age (usually at 12 months). Nationally, MMR uptake was low during the 1990s, partly due to the reported link between MMR, bowel disease and autism. This link has since been discredited, and uptake has risen.

The uptake of one dose of MMR by age 2 years has been falling since 2013/14 in Bristol, at a greater rate than the England average. At 89.2%, uptake in Bristol for 2016/17 is worse than the England average of 91.6% and well below the 95% target - see fig 4.9.2. Amongst the English Core Cities, Bristol is mid-ranking.

4.9.3 Immunisations due by 5 years old

a) MMR first vaccination – Two MMR doses should have been received by the age of 5 years (one at about 12 months and one at about 3 & ½ years of age). In Bristol, uptake of the 1st MMR dose by age 5 rose to 95.5% in 2016/17, better than the England target (95.0%).

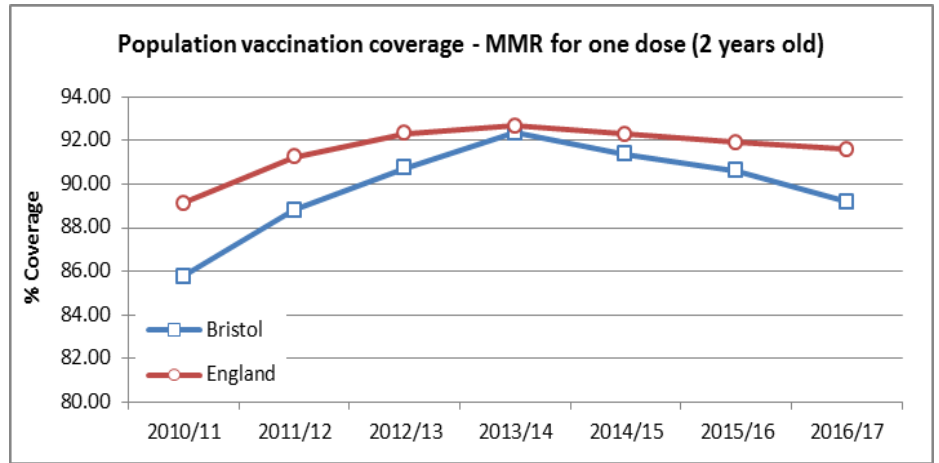


Fig. 4.9.2: Source: Cover of Vaccination Evaluated Rapidly 2016/17 data via Public Health Outcomes Framework, 2018.

b) MMR second vaccination – after managing similar uptake to the England average in the last couple of years, uptake in Bristol appeared to drop slightly to 86.5% in 2016/17. The Bristol rate is below the England average (87.6%) and significantly below the 95% target. Bristol continues to be mid-ranking amongst the English Core Cities.

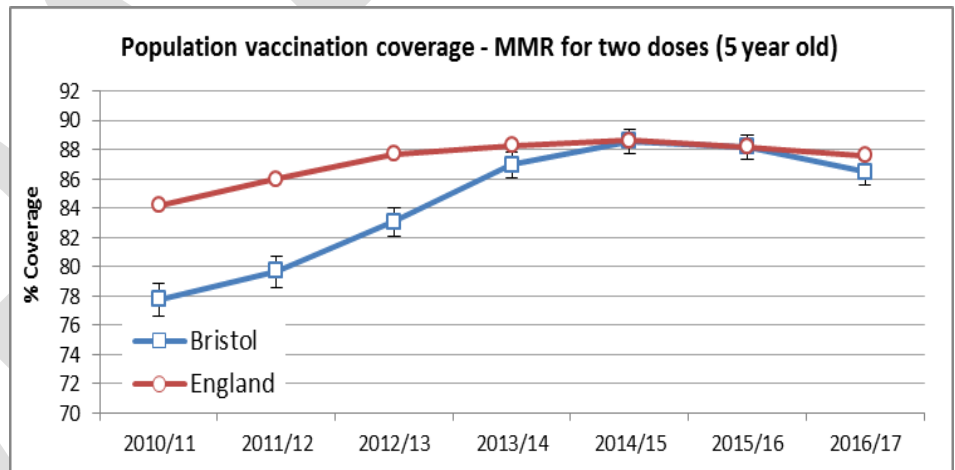


Fig. 4.9.3: Source: Cover of Vaccination Evaluated Rapidly 2016/17 data via Public Health Outcomes Framework, 2018.

c) Hib / Men C booster - A booster vaccination routinely offered around 12 months of age (as above). Uptake of this vaccine by 5 years old has been steadily increasing for several years. The uptake in Bristol for 2016/17 was 95.0%, higher than the England average of 92.6%.

4.9.4 Local vaccination coverage data

Recent local data⁷⁹ for 2016/17 (fig 4.9.4) highlights the pattern of differences across the city:

- all immunisations have the lowest uptake rates in Inner City & East.
- Inner City & East is below 90% coverage for immunisations from age 2 onwards.
- all but one immunisation have highest uptake rates in South Bristol.
- uptakes of new immunisations is lower in older infants, as is the case nationally

This data highlights the need to continue targeted work to promote childhood immunisations in the Inner City and East locality, which continues to be a local priority for the Screening and Immunisations Team (PHE).

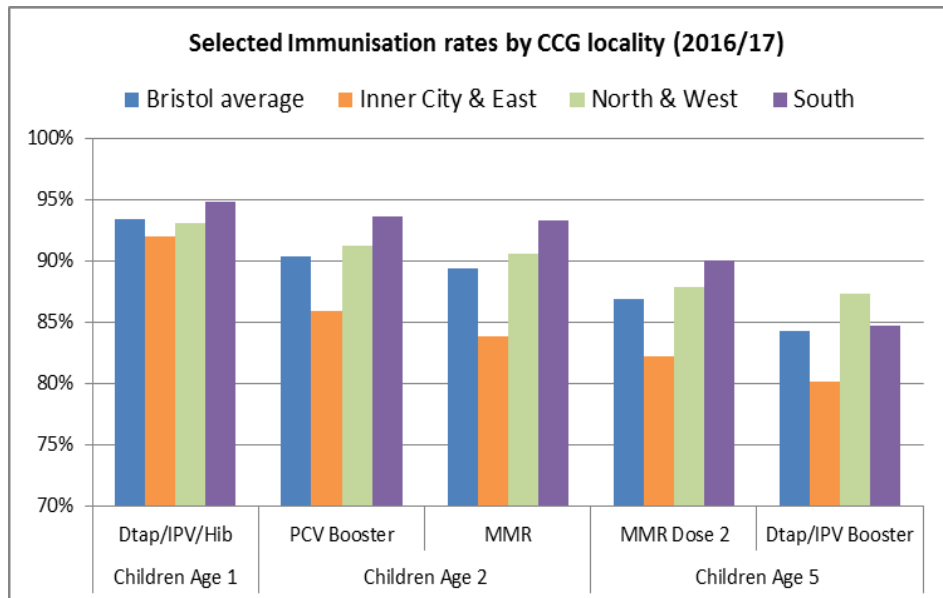


Fig. 4.9.4: Source: NHS Digital. Supplied by Bristol Public Health Knowledge Service 2018.

4.9.5 Immunisations due by 14 years old

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). Since 2014/15 it has been run as a 2 (not 3) dose vaccine, to enable protection from infection.

Uptake of the first dose of this vaccine⁸⁰ in 12-13 year old girls fell two years ago, and has remained at the lower level. The uptake in Bristol for 2016/17 was 76.4%, significantly lower than both the England average (87.2%) and the goal of 90% coverage.

Uptake of the second dose in girls 13-14 years was 73.6% in 2016/17, also significantly lower than the England average (83.1%) and the goal of 90% coverage.

4.9.6 Children in care immunisations

See section 5.7 Children’s Social Care

Further information:

- Childhood Flu immunisations in JSNA **7.5 Flu Immunisations**

⁷⁹ Source: NHS Digital via Bristol Public Health Knowledge Service, 2018.

⁸⁰ Source: Public Health England, via PHOF, May 2018

4.10 Injuries

4.10.1 Injuries in children (0-14)

The rate of emergency hospital admissions⁸¹ from unintentional or deliberate injuries to children aged 0-14 in Bristol has been above the national average since 2015/16 – see fig 4.10.1a. In 2016/17 the Bristol rate was 111.7 per 10,000 children aged 0-14, significantly worse than the England average (101.5 per 10,000) but mid-ranking for English Core Cities.

Gender: Bristol admission rates for injuries (0-14 years) are worse for boys, 124.2 per 10,000, and lower for girls (98.7 per 10,000)⁸²

Using local data⁸³, there are differences in injury rates between Bristol wards. Ranging from Westbury-on-Trym & Henleaze (63 per 10,000) to over 140 per 10,000 in Clifton, Avonmouth & Lawrence Weston, Brislington East and Bedminster (highest at 149 per 10,000) - fig 4.10.1b.

The leading cause of injury-related emergency admissions in children 0-14 is falls (37% of all injuries, the only category above 10%).

Young children (under 5)

For children aged 0-4 years, the rate of emergency hospital admissions from unintentional or deliberate injuries for Bristol (136 per 10,000) is now similar to the rate for England (126 per 10,000), and mid-ranking for Core Cities.

Gender: Bristol rates⁸⁴ are 157.1 per 10,000 for boys under 5, significantly higher than the rate for girls, of 114.8 per 10,000

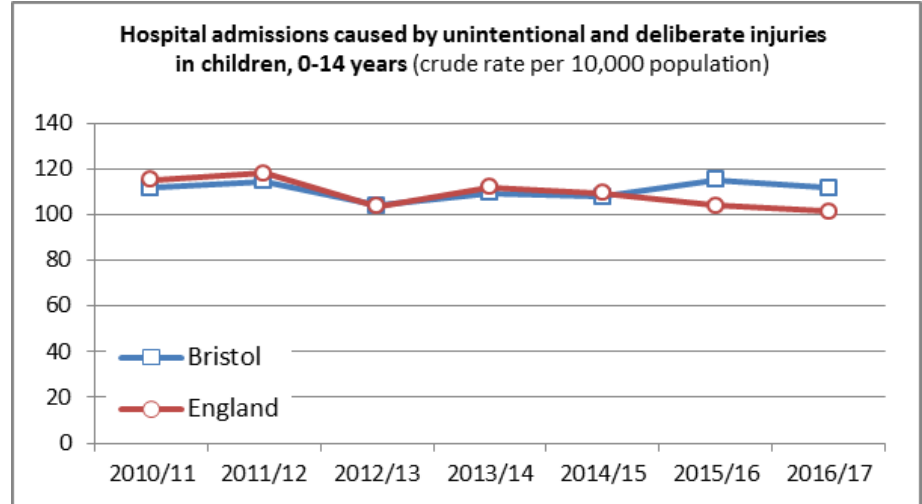


Fig. 4.10.1a: Source Hospital Episode Statistics, NHS Digital via PHOF 2018

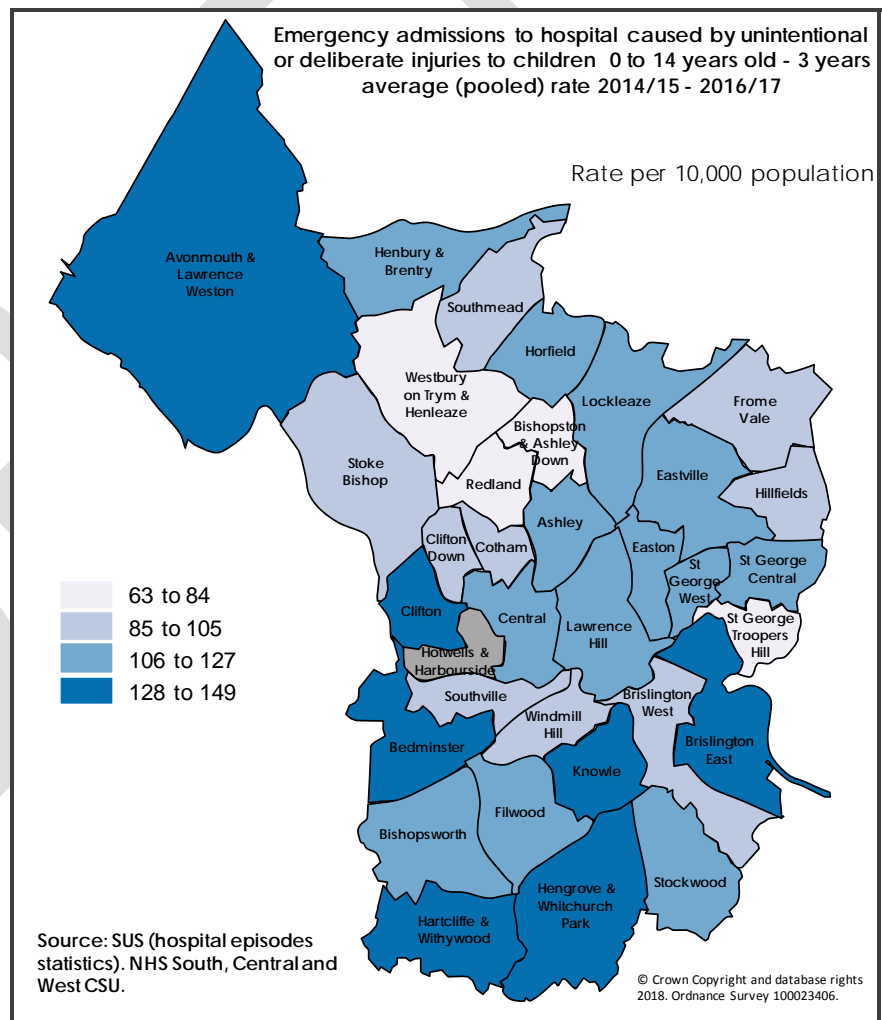


Fig. 4.10.1b: Source: Bristol Public Health Knowledge Service (2014/15 - 2016/17) [Note - Hotwells and Harbourside is suppressed due to very small population]

⁸¹ Crude rates of emergency admissions per 10,000 population, via PHOF, May 2018.

⁸² 2016/17, via PHOF, May 2018.

⁸³ 2014/15-2016/17 (3 year pooled data), Source: Bristol Public Health Knowledge Service (PHKS), 2018

⁸⁴ 2016/17, via PHOF, May 2018.

4.10.2 Injuries in young people

Bristol rates of emergency hospital admissions (2016/17) caused by unintentional or deliberate injuries in young people aged 15-24 years are 150.2 per 10,000 population, now significantly higher than the England average of 129 per 10,000 – see fig 4.10.2a. This is one of the highest rates of the English Core Cities.

Gender: The picture⁸⁵ is very different for young people than for children. Bristol admission rates for injuries (15-24 years) are worse for girls, 177.4 per 10,000, and lower for boys (122.4 per 10,000).

Further analysis of local data⁸⁶ (for 3 years 2014/15–2016/17) shows the main causes for young women were intentional self-poisoning and intentional self-harm, jointly accounting for 65% of admissions. For young men the main causes were falls and intentional self-poisoning, each accounting for 18% of admissions, followed by assaults and transport accidents & collisions. The main cause of the overall rise in admissions in 2016/17 was a rise in intentional self-poisoning cases recorded.

Using local data⁸⁷, we can see variation by ward ranges from Cotham (57 per 10,000) to St George Troopers Hill (360 per 10,000). Easton and Henbury &

Brentry also have a rate above 250 per 10,000 - fig 4.10.2b.

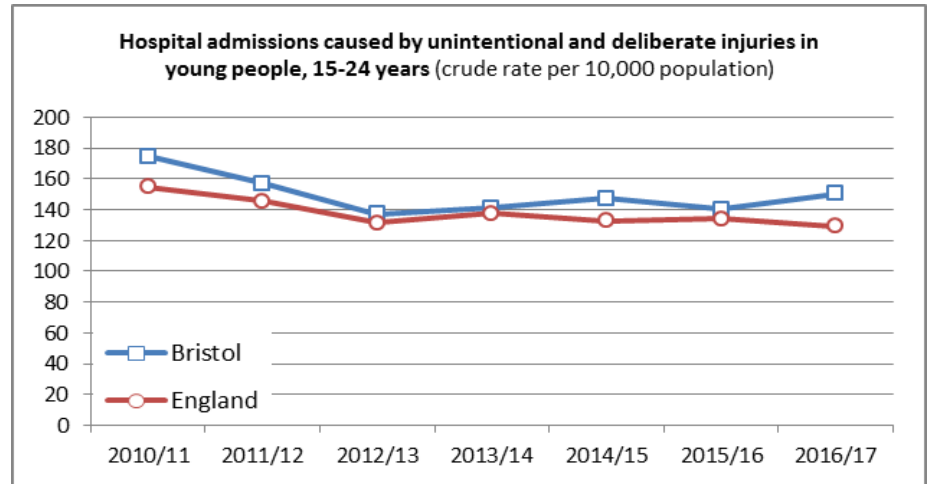


Fig. 4.10.2a: Source Hospital Episode Statistics via PHOF 2018

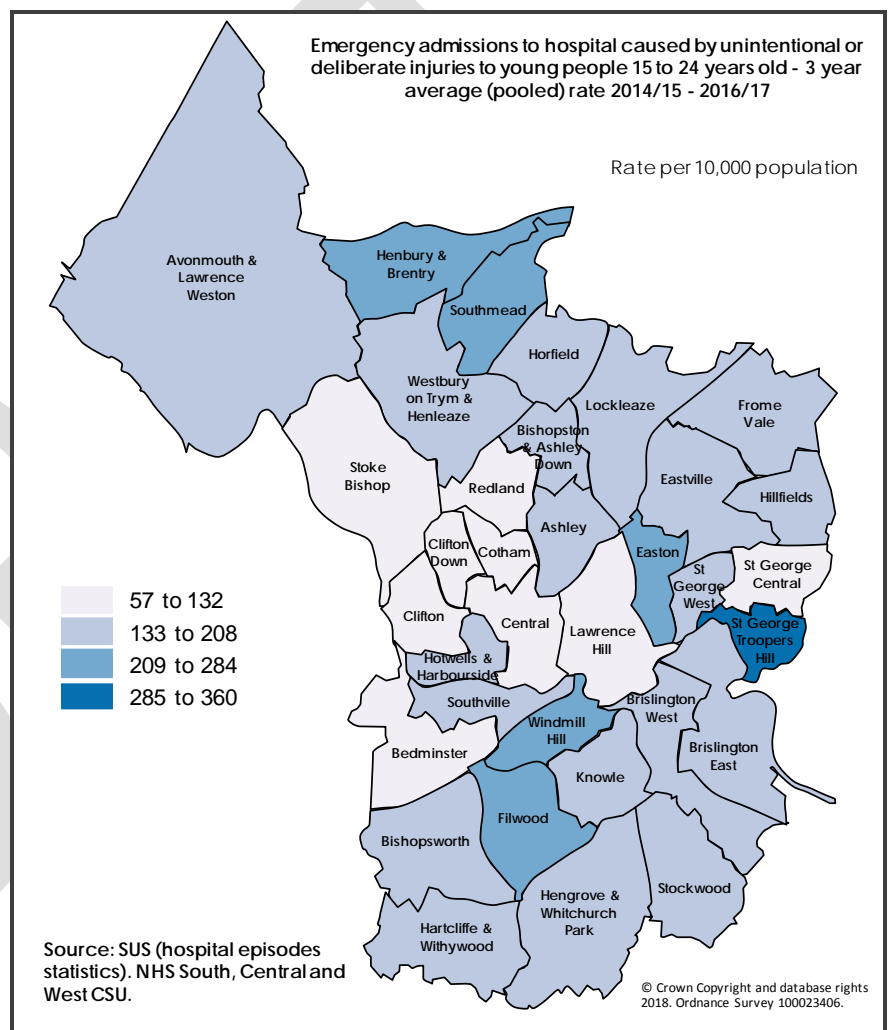


Fig. 4.10.2b: Source: Bristol Public Health Knowledge Service (2014/15 - 2016/17)

Further data

- Bristol JSNA Chapters 2017-18 on **Childhood Injury and Children and Young People Emotional and Mental Health and Wellbeing** – see JSNA Children and young people chapters

⁸⁵ Source: Hospital Episode Statistics (HES) 2016/17, via PHOF, May 2018.

⁸⁶ Source: Bristol Public Health Knowledge Service (PHKS), 2018

⁸⁷ 2014/15 to 2016/17 (3 year pooled data), Source: Bristol PHKS, 2018

4.11 Teenage pregnancy

Most teenage pregnancies are unplanned and around half end in an abortion⁸⁸. Research has shown that teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural issues.

The rate of teenage conceptions in Bristol per 1,000 females aged 15-17 years has shown a steep decline since 2007. In 2016, the Bristol rate was 17.2 conceptions per 1,000 girls aged 15-17, now similar to the England average of 18.8 per 1,000 - fig 4.11.1. In actual numbers⁸⁹, under 18 year old teenage conceptions in Bristol fell from 360 in 2007 to 111 in 2016.

For conceptions in younger girls, the rate of teenage conceptions per 1,000 females aged 13-15 years old was 2.6 per 1,000 in 2016, similar to the England average of 3.0 per 1,000.

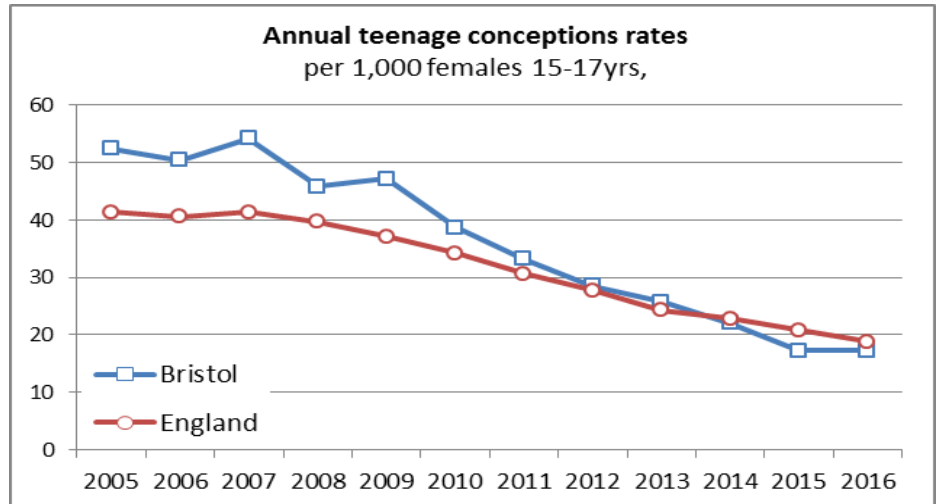


Fig. 4.11.1: Source: Office of National Statistics, via Bristol Public Health Knowledge Service 2018

Although the numbers of under 18 conceptions has fallen, from data reported by specialist teenage pregnancy staff working in the city it seems likely that many of those conceiving have complex needs and require a high level of support. Higher rates of teenage conception are found where deprivation is higher, and teenage conception can be both a cause and symptom of disadvantage, helping to embed and perpetuate poorer outcomes.

Using local data⁹⁰ to look at teenage conception rates over a 3 year average (2013-2015), by CCG sub-locality the biggest reduction was achieved in Bristol East - fig 4.11.2. North and West (inner) continues to have the lowest rate (5 per 1,000) whilst Bristol South remains the highest (31 per 1,000) whilst Bristol South remains the highest (31 per 1,000). However, all CCG areas saw a drop in conception rates for this period.

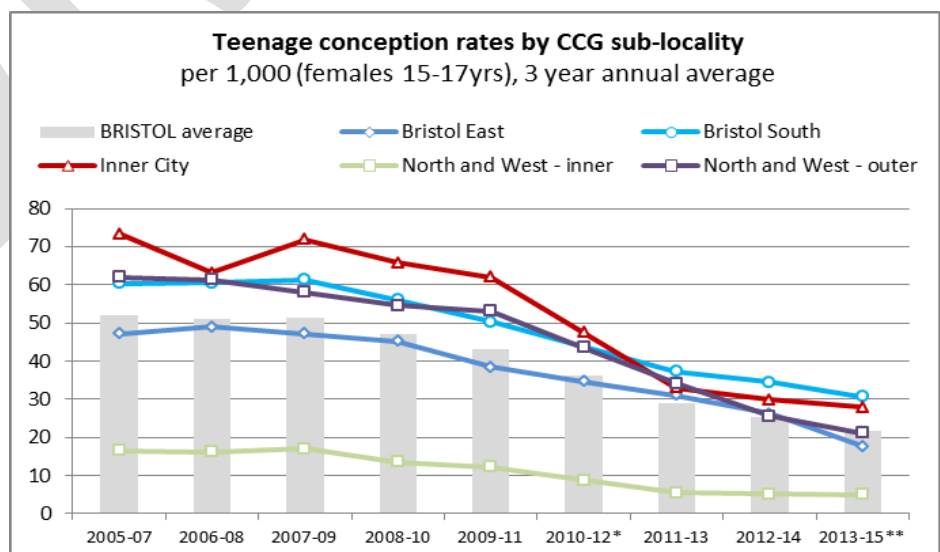


Fig. 4.11.2: Source: Bristol Public Health Knowledge Service April 2018
*Imputed values for missing data **Ward estimates from MSOA data

⁸⁸ Intro from PHE, via PHOF 2.04

⁸⁹ Source: Office for National Statistics (ONS), via PHOF, May 2018

⁹⁰ Teenage conception rate, per 1,000 (F15-17yrs) by CCG sub-locality of residence; Source: Bristol Public Health Knowledge Service, May 2018

4.12 Lifestyle behaviours of Young People

Note – sections 4.12.2 onwards are as reported in JSNA 2016/17, as the source (What About YOUth survey 2014-15) is still the most recent data. However, Bristol figures for these behaviours are high and worthy of noting again.

4.12.1 Diet

Bristol's local "Pupil Voice" survey (2015) saw **29% of primary pupils** report that they had at least 5 portions of fruit or vegetables yesterday, while 13% reported having had none at all.

22% of secondary pupils said that they had at least 5 portions of fruit or vegetables yesterday, while 14% reported having had none at all.

About a quarter of all pupils said that they had at least **5 portions of fruit or vegetables** yesterday, while over 10% reported having had none at all

Breakfast

6% of primary pupils responded that they **had nothing to eat or drink before lessons** on the day of the survey, while 9% said they had a cooked breakfast.

15% of secondary pupils responded that they didn't have anything to eat or drink for breakfast on the day of the survey, while 6% had a cooked breakfast.

The proportion of children and young people in Bristol who reported eating nothing for breakfast on the day of the survey is over 5%; with older pupils more likely to do so.

4.12.2 Physical activity

The What About YOUth (WAY) survey⁹¹ 2014-15, estimates that every day 17% of Bristol's 15 year olds take part in at least an hour of physical activity. This is significantly higher than the national average of 13.9%.

The Pupil Voice survey estimates that around 90% take part in exercise / physical activity or sport at least once a week. In all year groups, boys took part more often than girls. **Walking** forms a significant proportion of regular activity for many pupils

Nearly one-third of primary school boys reported more than three hours screen use during the previous day.

4.12.3 Smoking

The What About YOUth (WAY) survey⁹² 2014-15, estimates that "current smokers" at age 15 in Bristol is 11.3%, significantly higher than England (8.2%).

WAY survey data on "regular smokers"⁹³ at age 15 shows that Bristol is 7.8%, significantly higher than England average of 5.5%.

Gender: Nationally, females at age 15 are significantly *more* likely to be a smoker than males, which is very different to the adult picture⁹⁴. WAY data is not available by gender for Bristol. However, the local "Pupil Voice" survey also indicates that more girls than boys are smoking in year 10.

Additional local Bristol Pupil Voice survey (2015) data indicates that 25% of boys and 28% of girls report having tried a cigarette, while 18% of all year 10 respondents report that they have tried an e-cigarette. Of those that smoke, most smoke 1-5 cigarettes per week.

Smoking prevalence can be much higher in certain groups within the population, even at a relatively young age. An analysis⁹⁵ of local 2015 data from young offenders in contact with services in Bristol indicated that 65% of those aged 15 or less were current smokers. Again, girls in this cohort were more likely to smoke.

⁹¹ What About YOUth (WAY) survey 2014-15.

<http://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132846/pat/6/par/E12000009/ati/102/are/E06000023>

⁹² What About YOUth (WAY) survey 2014-15. Smoking Prevalence also via www.tobaccoprofiles.info

⁹³ usually smoke at least 1 cigarette per week

⁹⁴ See 6.4 Smoking in Healthy Lifestyles

⁹⁵ Analysis carried out by Bristol Public Health Knowledge Service, 2015

4.12.4 Alcohol

The What About YOUth (WAY) survey⁹⁶ 2014-15, estimates that 66.7% of 15 year olds in Bristol have had an alcoholic drink at some time, which is significantly higher than nationally (62.4%).

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

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

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

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

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

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

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

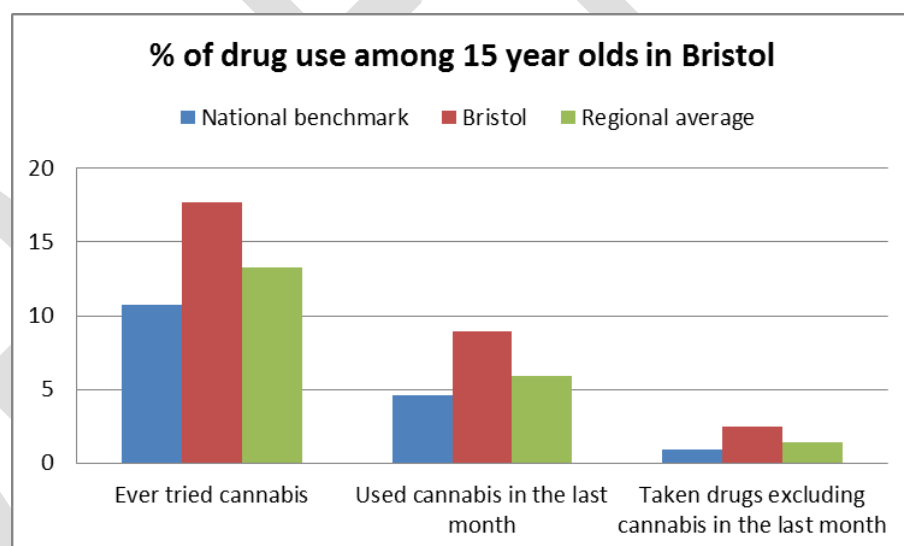


Fig 4.12.5: Drug use in 15 year olds; Source: What About YOUth (2014/15)

4.12.5 Drug misuse

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

Further data / information

- Health behaviours in young people – What About YOUth? Survey: <https://fingertips.phe.org.uk/profile/what-about-youth>
- [Bristol Pupil Voice report 2015-16](#)
- [Bristol Healthy Schools](#)

⁹⁶ What About YOUth (WAY) survey 2014-15. Smoking, drinking and drugs <http://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132874/pat/6/par/E12000009/ati/102/are/E06000023>

Section 5

Wider Determinants

Summary points

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

Deprivation

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

Child Poverty

- In 2015 (data released Feb 2018) there were 16,500 children under 16 in low-income families in Bristol; this is 20.1% of children, significantly higher than the England average of 16.8%.
- The greatest levels of child poverty are in Hartcliffe & Withywood and Filwood in South Bristol, and Lawrence Hill.

Education and Young People

- 41% of Bristol pupils (2017) got a ‘strong pass’ (grade 5+) in both English and Maths GCSE (above national %) but only 16.1% of those on Free School Meals did
- Just over 9,800 children and young people (0-25) are known to have some level of Special Educational Needs (SEN)

- Over 600 children are “in care” in Bristol at any given time.
- The rate of 16-18 year olds “not in education, employment or training (NEET)” is worse in Bristol than nationally.
- Rates of young people going to Higher Education are below national, and “Bristol South” includes the lowest in the country.
- First-time entrants to the Youth Justice System are significantly higher than nationally, but the rate in Bristol is falling and one of the lowest amongst English Core Cities.

Employment & Economy

- The unemployment rate in Bristol (4.3% in 2017) has fallen and is now similar to the national average.
- Bristol has high average earnings, but the 10% highest paid earn 6 times as much every week as the 10% lowest paid.
- Sickness absence rates have risen and are now similar to national and one of the highest of the English core cities.

Housing

- Rise in house prices outstripping earnings and shortage of affordable housing. Private renting sector is growing rapidly.
- The average annual rough sleeper street count in Bristol rose to 69 per week in 2017/18 from 37 per week in 2016/17.

Fuel Poverty

- Over 24,600 households in Bristol are “fuel poor”; 12.9% of Bristol households, higher than the England average

Air pollution

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

Promoting Healthy Urban Environments

- More people in Bristol commute to work by bicycle or on foot than elsewhere. 71% of people are satisfied with parks and green spaces in Bristol, but only 56% in deprived areas.
- The rate of road traffic injuries is significantly below national.

Crime

- Crime numbers are rising (esp violent crime and theft). Rates of violent crime are the second highest of core cities.
- Reported Anti-social behaviour incidents rose in 2017/18. Numbers of reported sexual offences rose by 9% in Bristol last year (13% nationally). 73% of victims were female (2017/18).

Domestic Abuse

- The rate of recorded domestic abuse incidents and crimes is lower than nationally and one of the lowest of core cities.

5.1 Deprivation⁹⁷

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

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

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

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

Bristol has 42 “areas” in the most deprived 10% in England. Of these 42 areas, 26 are in the most

deprived 5% and 6 areas⁹⁸ are in the most deprived 1% in England. In 2010, only 1 area was in the most deprived 1%.

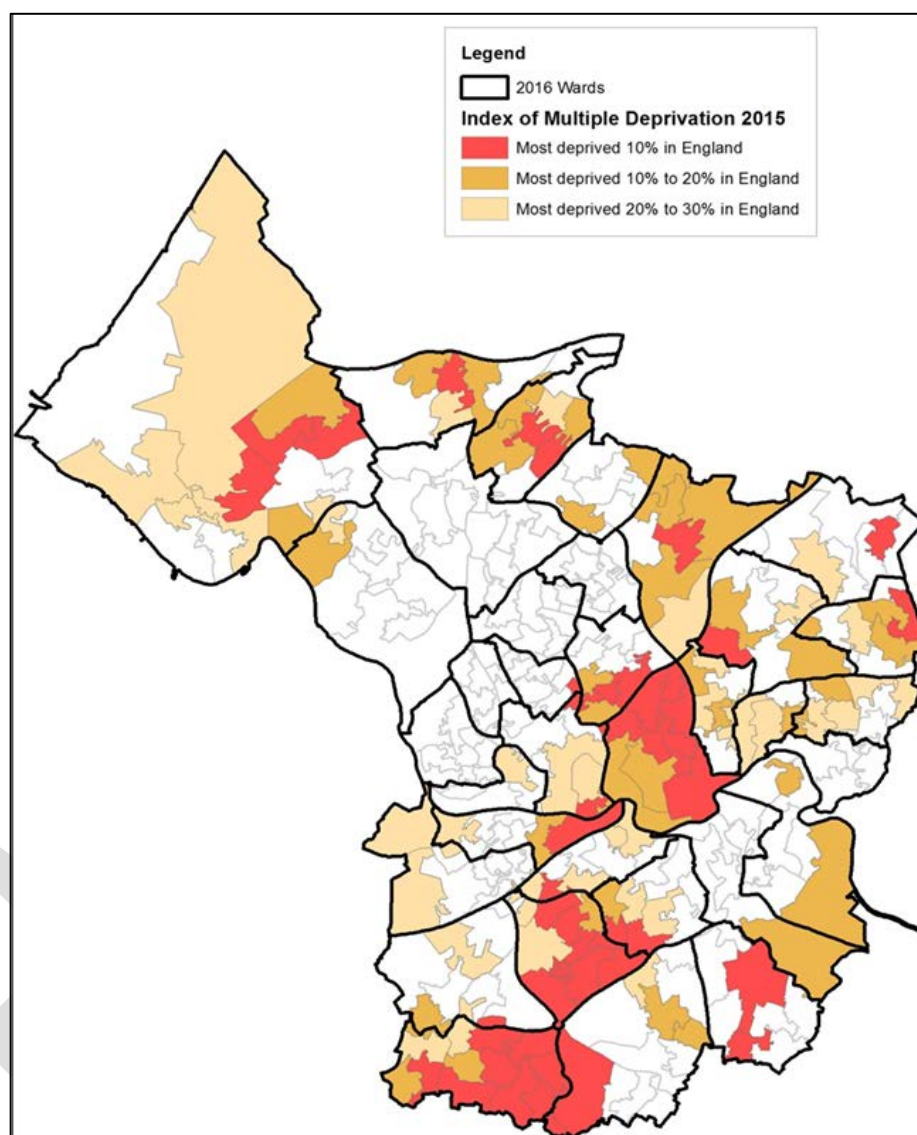


Fig 5.1.1: Multiple Deprivation 2015 - Bristol LSOA⁹⁹ areas ranked in the most deprived 10-30% in England (with new 2016 ward boundaries overlaid)
Source: English Indices of Deprivation 2015, DCLG © Crown Copyright

The overall IMD 2015 score¹⁰⁰ for Bristol is 27.2, higher than the England average score of 21.8 (though lower than all but 1 of the English Core Cities). However, since 2010 Bristol's relative rank in terms of Multiple Deprivation has increased (got worse) more than the other Core Cities, but from a less deprived starting point

⁹⁸ 4 of these are in Hartcliffe & Withywood, 1 in Filwood and 1 in Lawrence Hill

⁹⁹ Lower Super Output Areas; areas of about 1,500 population for national comparison

¹⁰⁰ Source: DCLG via PHE Health Profile. **Note** - This is 1 of 6 summary measures to help understand deprivation patterns across local authority (LA) areas. The pattern and scale of deprivation will vary, for example, some LAs have pockets of concentrated deprivation whilst some LAs have more widespread deprivation.

⁹⁷ See Deprivation in Bristol 2015 Report, www.bristol.gov.uk/deprivation

5.2 Income deprivation¹⁰¹

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

There are 37 Lower Super Output Areas (LSOAs)¹⁰² in Bristol in the most income deprived 10% nationally; of these 17 are in Bristol South, 12 are in Inner City, 5 in Bristol North and West (outer) and 3 in Bristol East. In all these areas more than 30% of residents are income deprived.

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

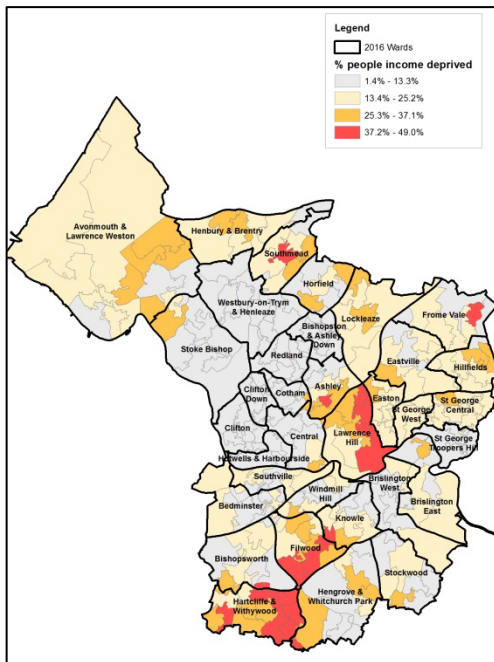


Fig 5.2.1: Income deprivation (all age)

Income deprivation affecting children (IDAC)

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

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

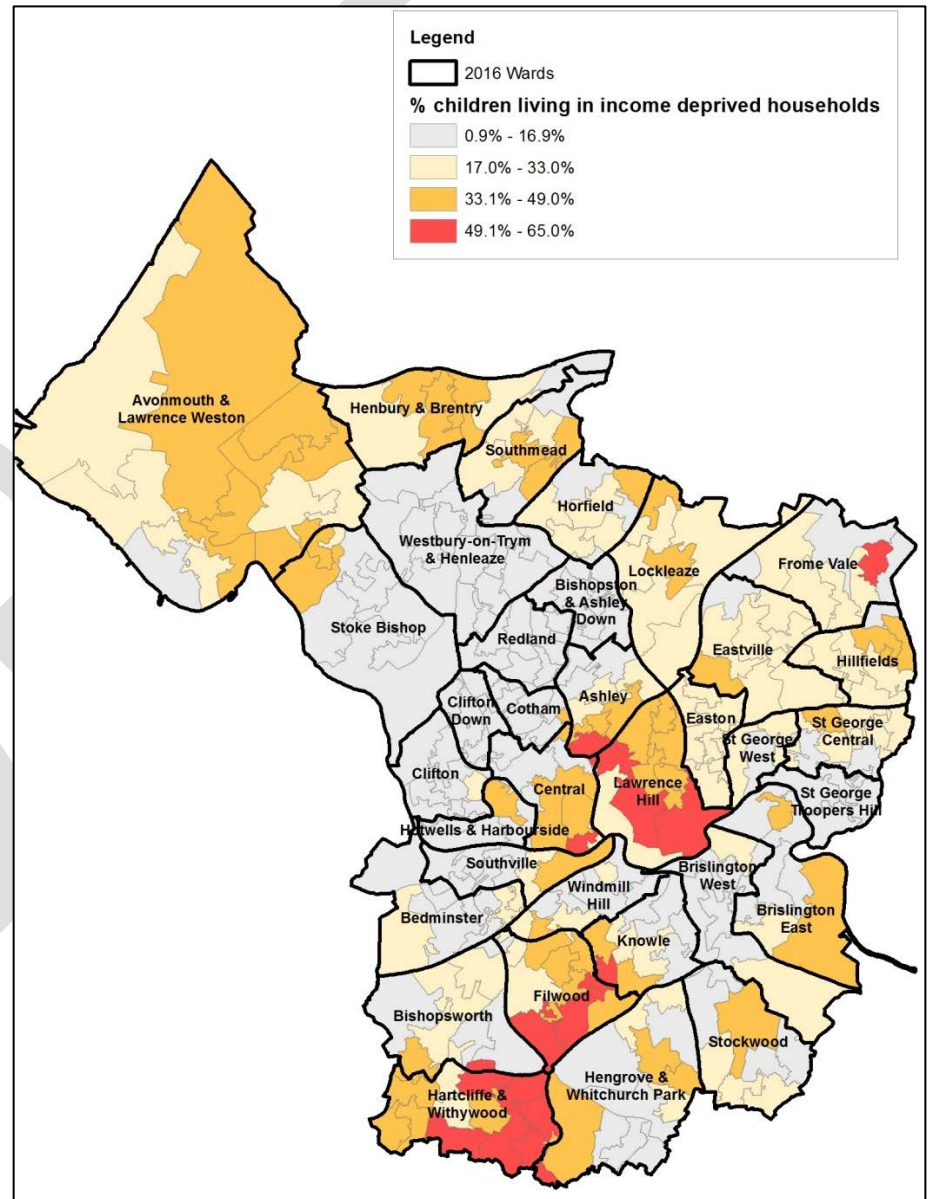


Fig 5.2.2: Income deprivation affecting children, shown by LSOA area (2015)

¹⁰¹ See Deprivation in Bristol 2015

www.bristol.gov.uk/deprivation

¹⁰² LSOA are statistical areas of about 1,500 population, used for national comparisons

Income deprivation affecting older people (IDAOP)

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

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

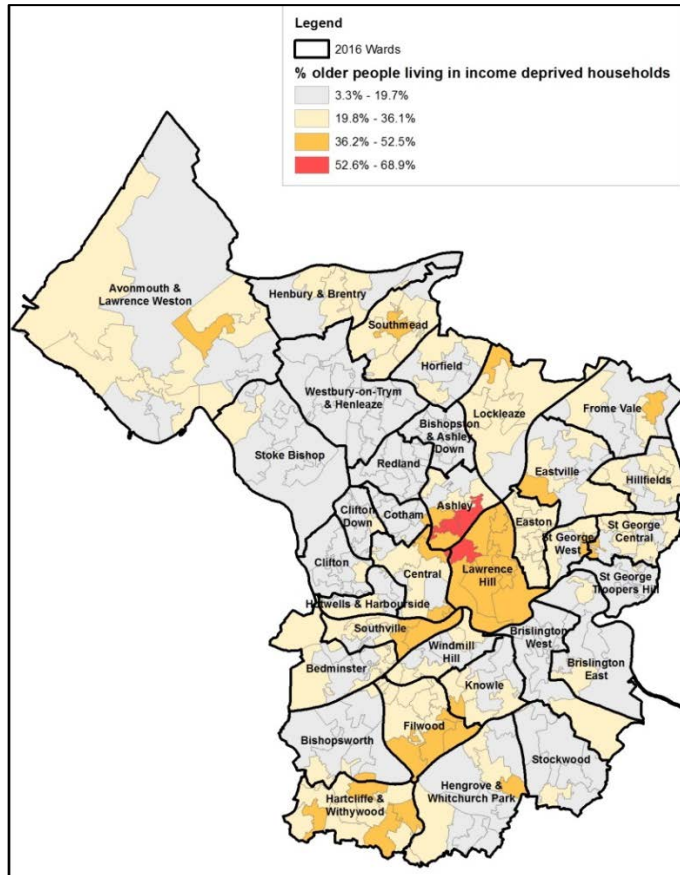


Fig 5.2.3: Income deprivation affecting older people, by LSOA area, 2015

People struggling financially

On average, 12.1% of people in Bristol said they were struggling financially¹⁰³. However, when looked at by ward, deprivation and equality group, it shows significant variances across the city.

Of people in the 10% most deprived areas, 21.5% said they were struggling financially.

By wards, the range is from under 5% in Redland and Knowle to around 20% in Lockleaze and Lawrence Hill – see fig 5.2.4.

By Equality groups, the highest levels of people struggling financially were reported amongst disabled people (28%) and black & minority ethnic groups (22%).

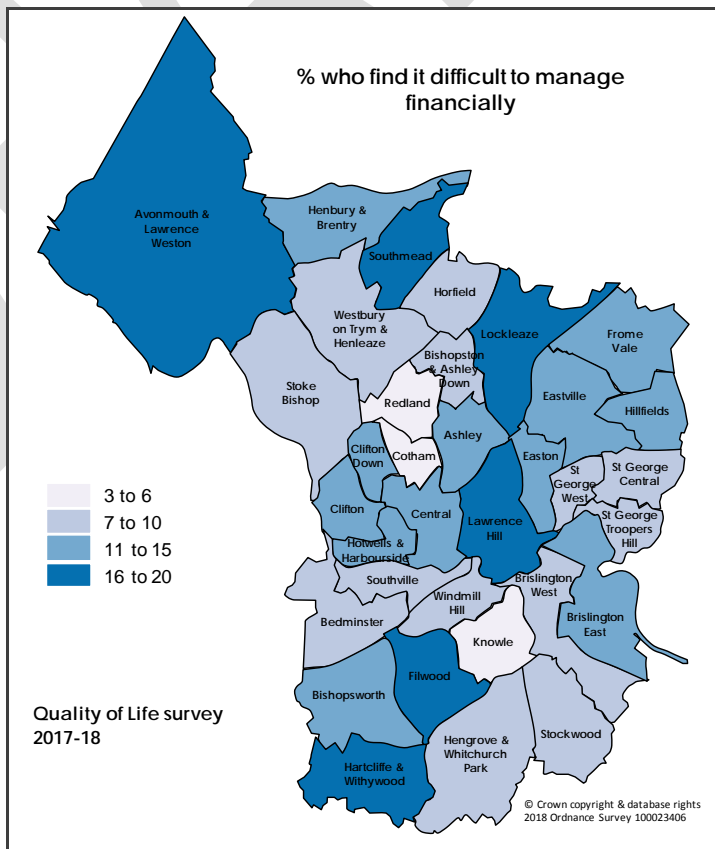


Fig 5.2.4: People who say they are struggling financially
Source: Bristol Quality of Life survey 2017-18

¹⁰³ Bristol Quality of Life survey, 2017/18

5.3 Child Poverty

Living in relative poverty means that families may be less able to make healthy lifestyle choices than more affluent families. Data on **children living in low-income families**¹⁰⁴ is a good indicator of the proportion of families living in relative poverty.

In 2015 (data released Feb 2018) there were 16,500 children under 16 in low-income families in Bristol; this is 20.1% of children, significantly higher than the England average of 16.8%. If measured for all children (under 20), the rate in Bristol is 20% (nationally 16.6%). The number and % of children living in low-income families¹⁰⁵ has an overall downward trend (fig 5.3.1), in Bristol and nationally.

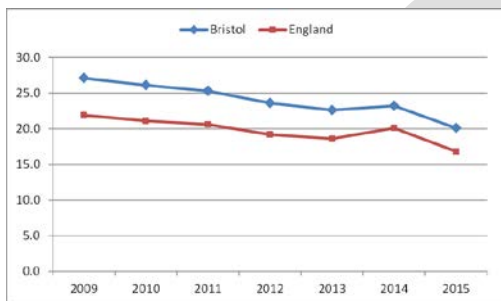


Fig 5.3.1: Children living in low-income families; Source: DWP, Feb 2018

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

¹⁰⁴ Note these rates are based on actual benefits data released nationally 2 years in arrears. The data therefore has a delay in reflecting changes to benefits policy & uptake.
¹⁰⁵ Snapshot of the % of children living in families (using Child Benefit data) in receipt of out-of-work benefits (Income Support or income-based Job Seekers Allowance) or of child tax credits with an income less than 60% of the national median income. Source: Dept. of Work & Pensions, Personal Tax Credits, 2015 data released Feb 2018

The greatest levels of child poverty are in Hartcliffe & Withywood and Filwood in South Bristol, and Lawrence Hill (fig 5.3.2). More than half (50.1%) of children in the Whitchurch Lane area in Hartcliffe live in low income families compared to less than half a percent in parts of Henleaze and Stoke Bishop.

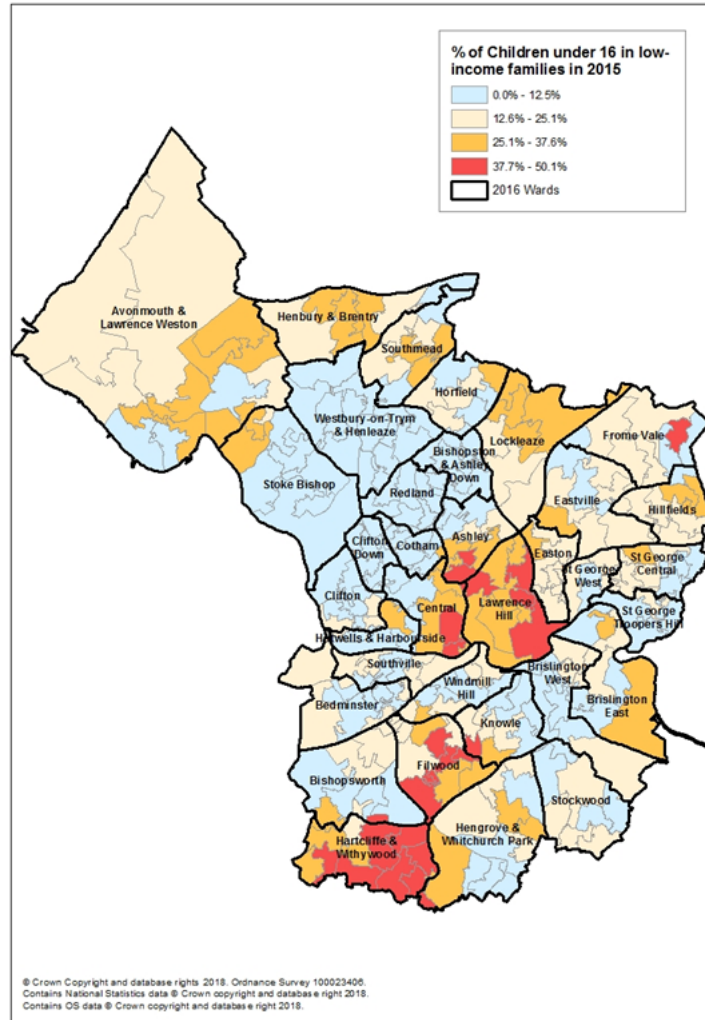


Fig 5.3.2: % of children (under 16) in low income families by LSOA; Source: DWP 2018

When averaged to the 5 Bristol CCG sub-locality areas, all sub-localities saw a decrease in the proportion of children living in low income families. Inner City 29.3%, North and West (outer) 23.7% and South 22% all have levels of child poverty higher than the city average 20.1%.

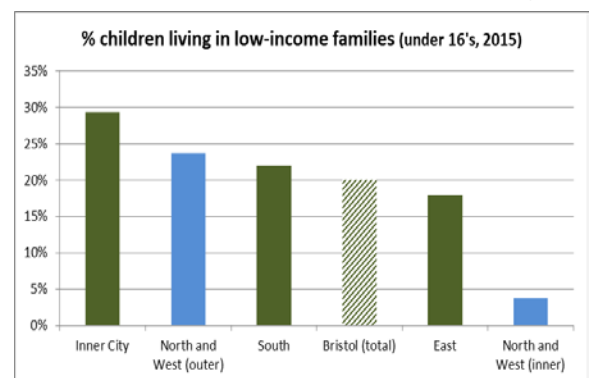


Fig 5.3.3: % children (under 16) in low-income families by CCG locality; Source DWP 2018. Analysed by BCC Insight, Performance & Intelligence

5.4 Education

5.4.1 Early Years

The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children’s development (4-5year 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 2017, 68% of children under 5 were assessed as having a good level of development at Foundation Stage, against an England average of 71%. Across Bristol in 2017, this ranged from 54% in Hartcliffe & Withywood to 83% in Westbury-on-Trym & Henleaze.

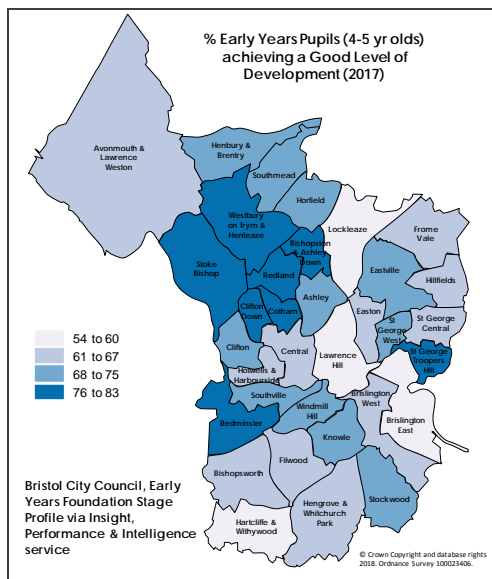


Fig 5.4.1: Source: Bristol City Council

Gender: 73.5% of girls achieved a good level of development compared to 62.5% of boys.

Ethnicity: 72% of ‘white British’ pupils were assessed as having a good level of development, and only 62.5% of BME pupils and 59% of ‘white minority ethnic’.

Deprivation: Achievement amongst pupils living in the 10% most deprived areas (IMD) was 59%.

5.4.2 Key Stage 2 (SATs)

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

61% of Key Stage 2 pupils in Bristol (assessed in Year 6) achieved the Expected Standard or above in Reading, Writing and Maths combined (2017). This is in line with the national average (61%) and is one of the highest amongst the English Core Cities, which range from 55% to 62%.

Across Bristol this ranged from 39% in Hartcliffe & Withywood to 88% in Bishopston and Ashley Down.

Gender: 65% of girls achieved the Expected Standard or above in reading, writing and maths combined, but only 57% of boys.

Ethnicity 64% of ‘white British’ pupils achieved the Expected Standard or above but only 55% of BME pupils (lowest in those of ‘black or black British’ ethnicity at 46%)

Deprivation: Achievement amongst pupils living in the 10% most deprived areas (IMD) was 59%.

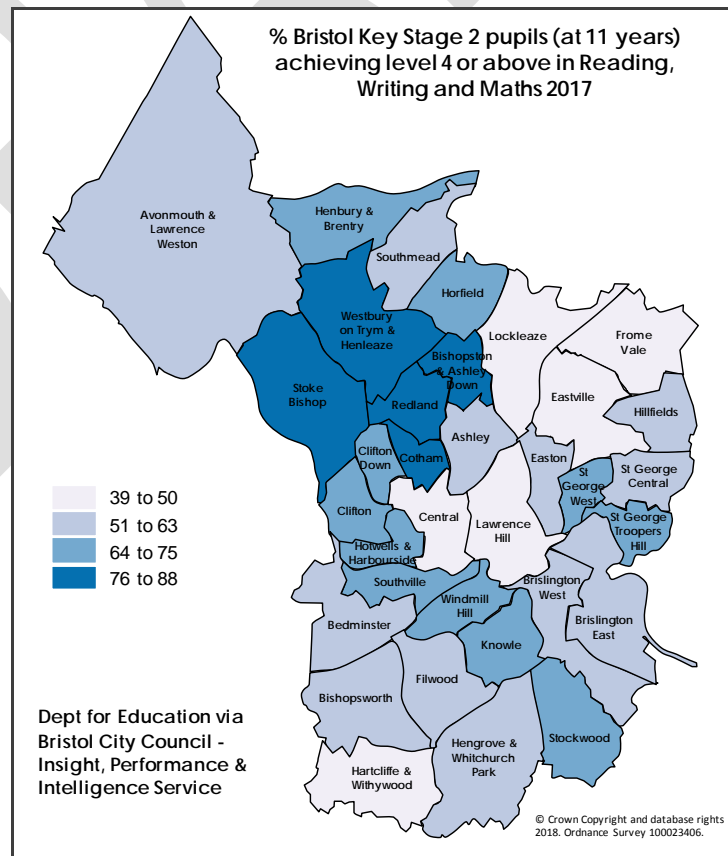


Fig 5.4.2: Dept. for Education, via Bristol City Council, 2017 results

5.4.3 Key Stage 4 (GCSEs)

In 2016, the Department for Education introduced a new system for tracking GCSE results¹⁰⁶. Headline measures in this new system include:

- Progress across 8 qualifications (Progress 8), where a score of zero is average, a negative is worse and a positive better.
- Attainment across the same 8 qualifications (Attainment 8).
- % of pupils entering English Baccalaureate
- % of pupils achieving grade 4 or above in English and Maths (a “standard pass”).
- % of pupils achieving grade 5 or above in English and Maths (a “strong pass”).

In 2017, the Attainment 8 score for Bristol pupils was 44.0 points, similar to the England average, 44.6. The Progress 8 score was (minus) -0.22 in Bristol, below the national benchmark of 0.00.

There is significant variation by ward (based on pupil address), with Attainment 8 scores ranging from 34.2 in Filwood to 61.3 in Redland – see fig 5.4.3.

Also in 2017, 59.3% of Bristol pupils achieved a “standard pass” (grade 4 and above) in both English and Maths GCSE, similar to the national average of 59.1%, and 41% of pupils in Bristol achieved a ‘strong pass’ (grade 5 and above) in both English and Maths GCSE. The strong pass rate was higher than the England

average of 39.6% and is the highest of the English Core Cities.

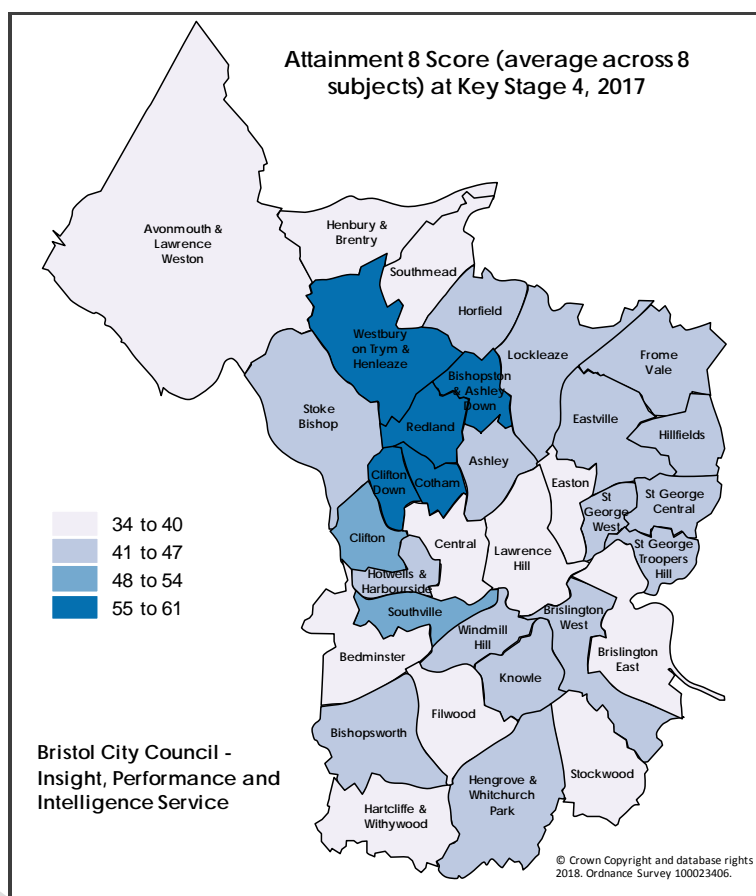


Fig 5.4.3: Attainment 8 Score per pupil averaged by ward, 2017. Source: Dept. for Education, via Bristol City Council.

Gender: Boys achieved an Attainment 8 score of 40.7 and Progress 8 score of (minus) -0.47. Girls achieved an Attainment 8 score of 47.4 and Progress 8 of 0.04. 35.9% of boys achieved a ‘strong pass’ in both English and Maths, but 46.1% of girls.

Ethnicity: Those of ‘white British’ ethnicity had the poorest Progress 8 score (-0.41) based on their progress since the end of primary school. Despite a Progress 8 score of 0.11, those of black ethnicity had the lowest Attainment 8 score (39.4) and lowest % getting a ‘strong pass’ in English and Maths (31.6%). Pupils of Asian and Chinese ethnicities made joint highest Progress (+0.49) and high Attainment 8 score (46.8) and highest % that got a ‘strong pass’ in English & Maths GCSEs. Pupils of ‘white minority ethnic’ groups also had joint highest Progress (+0.49) and the highest Attainment 8 score (47.4).

Deprivation: The Attainment 8 score for those pupils living in the 10% most deprived areas within Bristol was 35.8, and Progress 8 was (minus) -0.44. Only 24% of pupils from these areas achieved a ‘strong pass’ in both English and Maths GCSEs, compared to the 41% Bristol average.

¹⁰⁶ www.gov.uk/government/publications/progress-8-school-performance-measure

In addition, results by pupil characteristics - fig 5.4.4 – show Progress and Attainment scores are also much worse for SEN pupils and those on Free School Meals. Eg only 16.1% of pupils on free school meals got a ‘strong pass’ in English and Maths GCSEs, and their Progress 8 score was (minus) -0.63 (worse than the -0.22 Bristol average).

5.4.4 Key Stage 5 (A levels)¹⁰⁷

During 2017, pupils in Bristol achieved an average point score of 30.93 per entry which equates to grade C. This is similar to the England average of 32.39 (C+).

5.4.5 Higher Education

Only 30.6% of young people in Bristol go on to higher education, significantly less than the 37.8% for the UK (2009-15)¹⁰⁸.

This rate is the number of entrants to higher education against the population. It is based on those aged 18 and 19 years who could have entered higher education between 2009/10 to 2014/15.

Within Bristol, rates for young people going to higher education vary significantly - see fig 5.4.5. Rates are lowest in Bristol South at just 17.5%, less than half the UK rate. Moreover, 3 of the 5 worst performing areas¹⁰⁹ in the entire country are in Bristol South

– Worthywood (5.6%), Hartcliffe (6.1%) & Knowle (7.2%).

	Free School Meals (pupils known to be eligible)	SEN Support (pupils receiving)	Disadvantaged pupils	Pupils whose first language is other than English	ALL PUPILS
Progress 8 score (average)	-0.63	-0.53	-0.58	0.51	-0.22
Attainment 8 score (average)	31.6	31.6	33.8	44.3	44
% achieving 9-5 ('strong pass') in English & Mathematics	16.1%	19.3%	21.8%	40.2%	41%

Fig 5.4.4: Bristol Key Stage 4 results by pupil characteristics, 2017. Source Dept. for Education

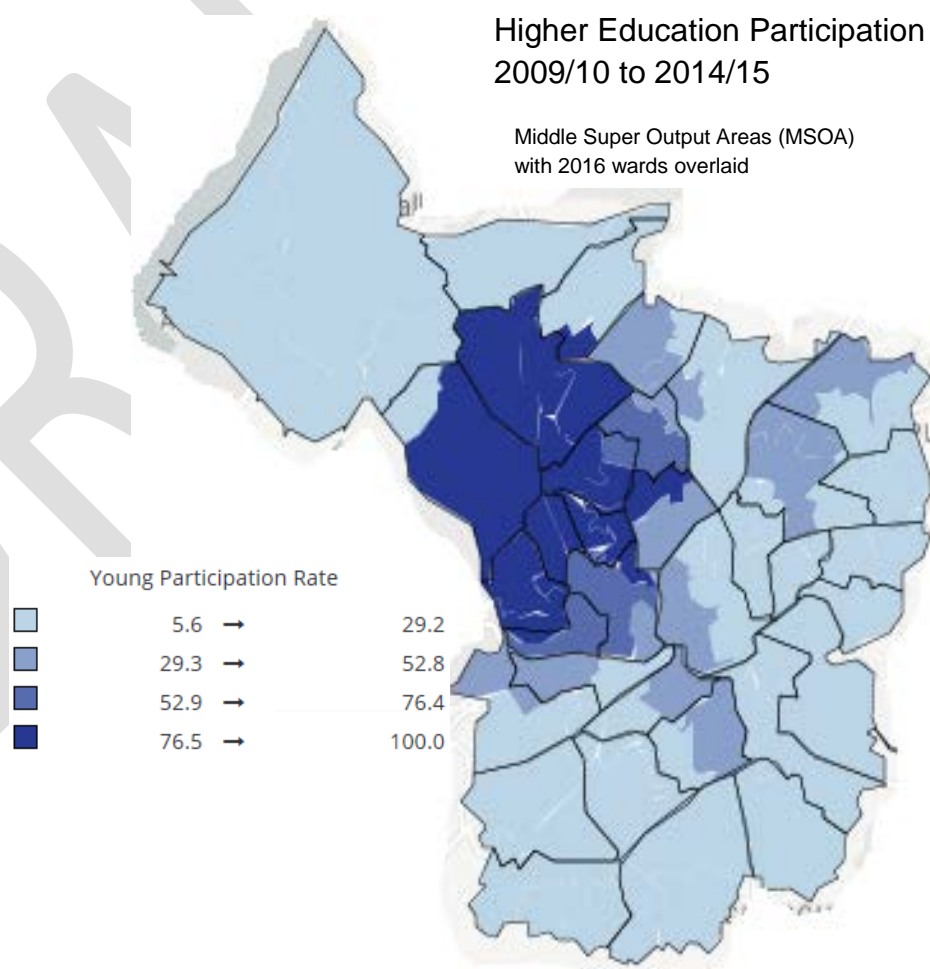


Fig 5.4.5: Estimate of young participation rates by area in higher education. Rates by MSAOA, with ward boundaries overlaid. Source: Office for Students. 2009/10 – 2014/15

¹⁰⁷ www.gov.uk/government/statistics/a-level-and-other-16-to-18-results-2016-to-2017-revised

¹⁰⁸ www.officeforstudents.org.uk/data-and-analysis/polar-participation-of-local-areas/

¹⁰⁹ Middle Super Output Areas (MSOAs)

5.5 Pupil Absence

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

In 2016/17 the amount of school-time missed by pupils in Bristol schools¹¹⁰ was 5.3%. The trend chart (fig 5.5.1) shows Bristol is worse than the national rate at 4.6%, but with similar annual trend changes.

Locally¹¹¹, the wards with the highest absence rates during 2017 were Filwood (8.3%), Hartcliffe & Withywood (8.1%) and Bedminster (7.2%). The lowest rates of absenteeism were in Westbury-on-Trym & Henleaze (3.5%), Redland (3.9%) and Cotham (4.1%).

Gender: absence amongst boys (5.3%) and girls (5.2%) was equal.

Ethnicity: absence was lowest amongst those of 'Black or Black British' ethnicity (4.6%) and highest amongst those of 'White Minority' ethnicity (5.7%).

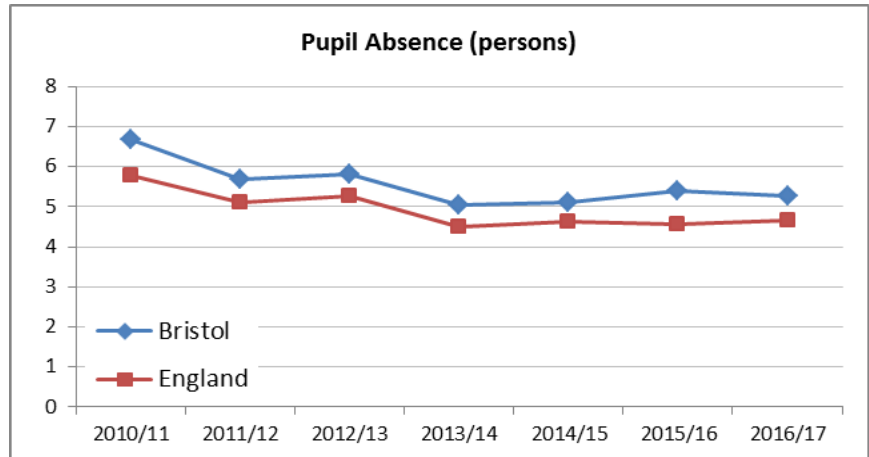


Fig 5.5.1: Source: School Census, via PHOF (Sept 2018)

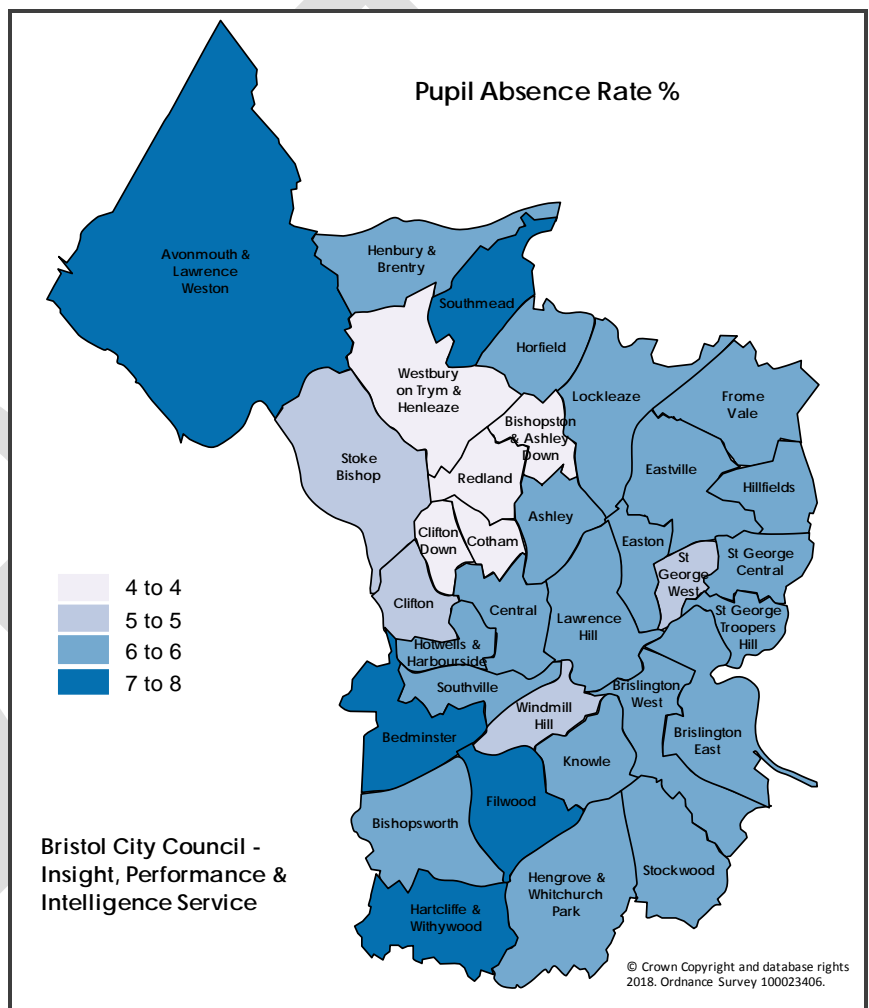


Fig 5.5.2: Pupil absence rate by ward, 2017.

¹¹⁰ % of half days missed by pupils due to overall absence; Source: Department for Education via Public Health Outcomes Framework, 2018

¹¹¹ Ward absence rates are taken from a different source than the national rates. Local results include pupils who live outside of the Bristol area but go to school inside

5.6 Special Educational Needs (SEN)

Bristol considers the needs of all children and young people (0 to 25) with Special Educational Needs and/or Disability (SEND)¹¹².

"A child or young person has SEND if they have a learning difficulty or disability which calls for special educational provision to be made for them".

A child of compulsory school age or a young person has a learning difficulty or disability if they have:

- a) a significantly greater difficulty in learning than the majority of others of the same age; or
- b) a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for others of the same age in mainstream school or mainstream post-16 institutions.

A child under compulsory school age has special educational needs if they fall within definition at a) or b) above or would do so if special educational provision was not made for them."¹¹³

Statutory guidance¹¹⁴ introduced new classifications of SEN Support and Education, Health and Care Plans (EHCP). For more, see [Bristol's current SEND Strategy](#).

¹¹² Part 3 of Children and Families Act 2014

¹¹³ Clause 20, Children & Families Act 2014

¹¹⁴ [SEND Code of Practice 0-25 years](#) (Jan 2015). 2014/15 was the start of a transitional period leading to the national phasing out of School Action, School Action Plus and Statements of SEND. Please also note the [Special Educational Needs and Disability Regulations 2014](#).

This section is primarily looking at SEN data¹¹⁵.

Latest local data (Sept 2018) shows just over 9,800 children and young people known to have some level of Special Educational Needs (SEN) in Bristol¹¹⁶.

This is comprised of:

- 7,600 pupils on SEN Support (school-based support in education settings early years, school age and post 16). Approx 700 of school age pupils are in receipt of Top Up¹¹⁷
- 2,200 children and young people with Education, Health and Care Plans (EHCPs) – those aged 0-25 who have additional support needs that are in addition to and different from that generally available through SEN school support.
 - 1,370 CYP with EHCPs receive Top Up and 1,160 of these are school age (Source: Bright, as of Aug 2018)

See fig 5.6.1 for SEN needs by age group over recent years¹¹⁸.

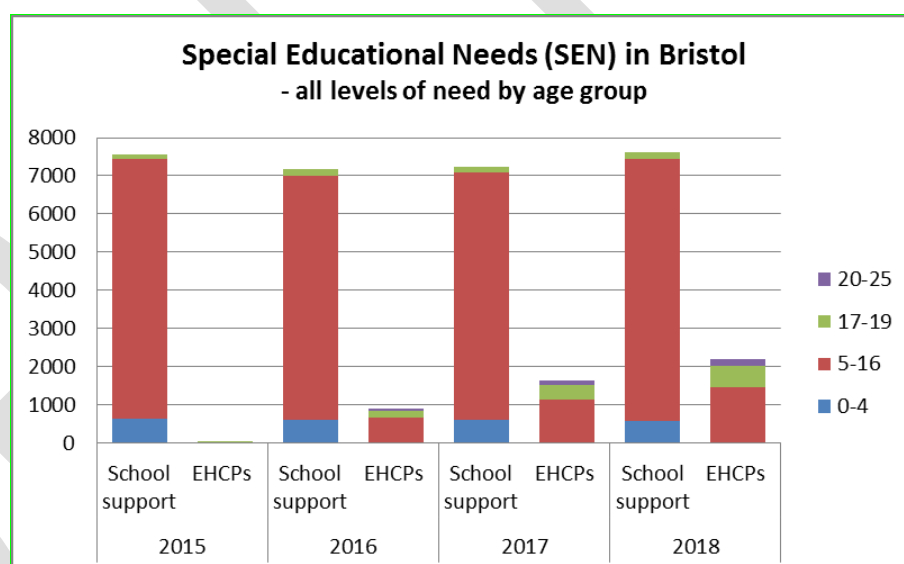


Fig 5.6.1 All SEN in Bristol: SEN School Support (Source: Bristol Early Years and School Census, Jan 2018) and Education, Health and Care Plans, EHCPs (Source: BCC Bright data-base – extracted Sept 2018)

¹¹⁵ Also see [4.5 Disabled Children](#)

¹¹⁶ Source: Bristol Early Years and School Census (Jan 2018) plus additional data via BCC Bright data-base

¹¹⁷ Schools/settings have a statutory requirement to meet the needs of all pupils from their school based funding, making sure that any child or young person with SEND gets the support he/she needs. If a setting considers that a pupil's needs cannot be fully met by provision from existing school based funding, they may apply for additional High Needs Block (HNB) Top up funding

¹¹⁸ Data is for pupils in Bristol schools. For EHCP, Bright includes EY, Post 16, Independent schools, and those CYP in receipt of School Age and GFE Top Up at SEN Support level. This does not reflect the whole SEN Support (School Support) population. Bristol children who attend schools out of area are only included if Child in Care status or "Looked after" by the LA or on EHCP.

Note – in Bristol all Statements to Special Educational Needs were converted to EHCPs as of 31 May 2018 in line with DfE Conversion timescales.

Using nationally reported data¹¹⁹ for 2017/18, 15.4% of Bristol pupils were receiving SEN support, higher than 14.9% nationally.

Within Bristol, 2017 School Census data¹²⁰ for all SEN needs shows the variation by ward - fig 5.6.2. This ranged from 9% of pupils with SEN in Cotham and in Hotwells & Harbourside to 24.5% of pupils in Hartcliffe & Withywood.

Primary Need: Using 2017 School Census data, the biggest category of SEN primary need in Bristol is Speech, Language and Communication – see fig 5.6.3.

The greatest increase (since 2016) has been 250 more pupils with Autistic Spectrum Disorder.

Note – in fig 5.6.3 some sub-categories of need have been merged into the overarching categories of Learning Disabilities (LD) and Physical & Sensory Impairment. Also, “specific learning difficulties” (eg Dyslexia) have been included in Other.

Additional data analysis:

Deprivation: Numbers of children with SEN are higher in more deprived areas.

School Exclusions: In 2016/17, 23 of 43 (53%) of Bristol pupils permanently excluded from school had a special educational need.

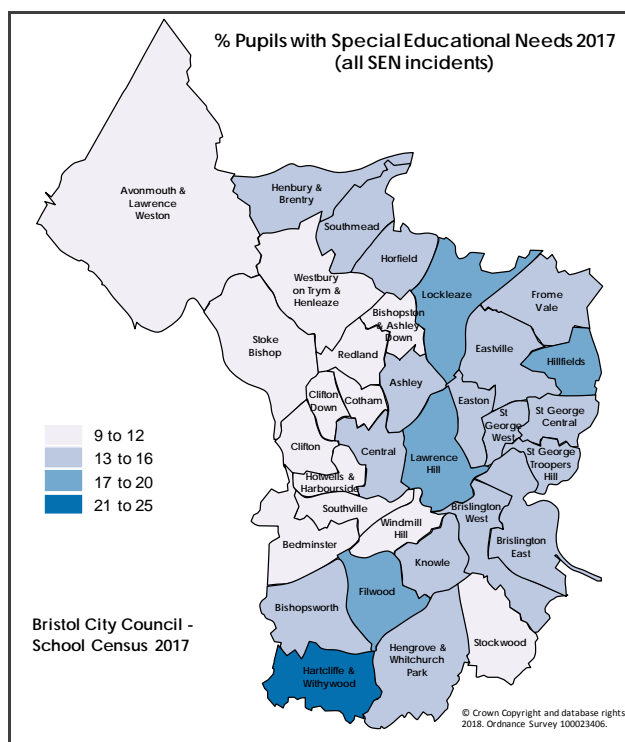


Fig.5.6.2: SEN 2017; Source: BCC - Insight, Performance & Intelligence

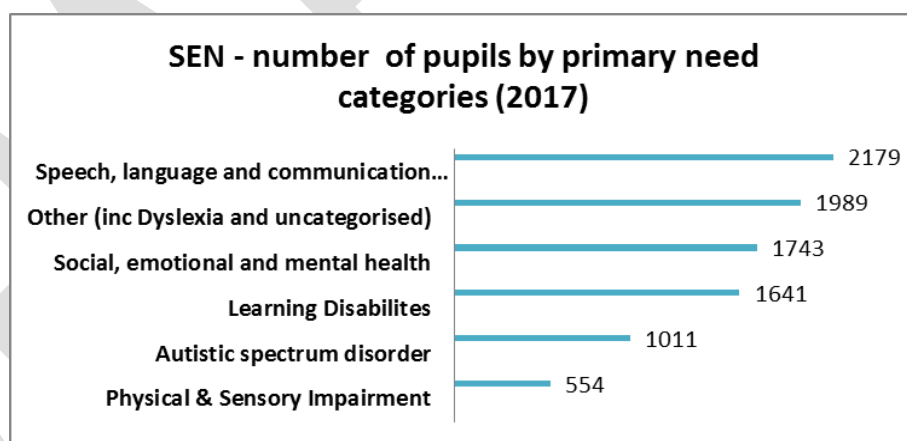


Fig.5.6.3: SEN Primary Need Breakdown 2017. Source: BCC - Insight, Performance & Intelligence

Further data

- JSNA Chapter on [Children’s Social Communication and Interaction Needs in Bristol \(2017\)](#)
- JSNA Chapter on SEND (due end 2018) – see [JSNA Chapters - children-and-young-people](#)
- [Local authority interactive tool \(LAIT\)](#) - An interactive spreadsheet for comparing data about children and young people (inc SEND) across all local authorities
- LGA [Local area SEND report](#)

¹¹⁹ Source: Dept for Education “Local area SEND report” via LG Inform, 2017/18. Note – this is all pupils attending schools in Bristol, not Bristol children in schools out of area

¹²⁰ SEN pupils as a % of all Bristol pupils in that ward; Source: Jan 2017 School Census

5.7 Children Social Care

Children may become involved with Social Care for a variety of reasons, but the proportion who have a primary category of abuse and neglect, especially among looked after children, is considerably higher than those who have other primary categories. Neglect and abuse in childhood are significant risk factors for poor physical health, poor mental health and low educational attainment and can have an impact on the whole life course.

Children who experience neglect are also likely to have missed routine health checks and immunisations, leaving them at risk of a variety of harmful childhood and adult diseases. Poor health outcomes among children in care and those subject of child protection plans are often exacerbated by other factors, such as deprivation.

There are 3 main categories of children requiring some level of support from Child Social Care – children in care, children subject of a child protection plan, and those in need of support (S17 Children Act 1989) for other reasons (which includes Disabled children). Fig 5.7a shows a snapshot of the numbers of children in Bristol in these 3 categories of support at the end of each reporting year.

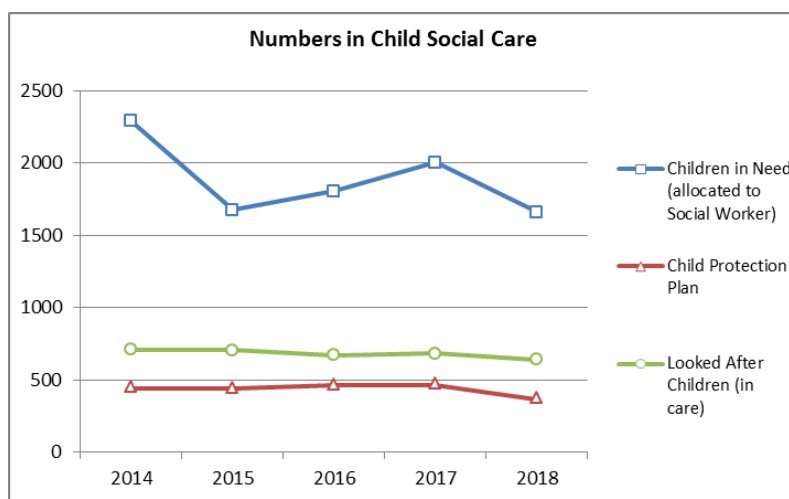


Fig 5.7a: Children known to Bristol Social Services at end March each year. Supplied by: Bristol City Council, Insight, Performance & Intelligence

5.7.1 Looked after Children (Children in care)

There were 640 children in care at the end of March 2018 (fig 5.7a shows snapshot measure taken at the end of March each year), which is broadly similar to previous years.

If you look at the number of looked after children, expressed as a rate per 1,000 of the child population you can compare the wards across Bristol. These range from; Clifton (0) and Redland (0.7) to Henbury & Brentry (13.8) and Hartcliffe & Withywood (15.5).

Gender & Ethnicity: more boys were taken into care than last year. They now form 55% of the children in care, with girls at 45%. Two-thirds of children in care (67%) are of white ethnicity.

Deprivation: of those in care 20% are from the Most Deprived 10% and 53% from the most deprived 30% of the population.

However, it should be noted Children in care is not a static population. For example, there were approx. 916 individual children in care for some period of time during the 12 months 2017/18.

Health assessment figures for Bristol children in long term (over 12 months) care during 2017/18:

- 85% have completed Health Assessments (an increase from 81% in 2016/17). This compares to a national rate in of 89%;
- 84% have completed Dental Checks, similar to last year. This compares to a national rate of 83%;
- 95% have all immunisations recorded as up-to-date, higher than the national rate of 84%.

During 2017/18, over 350 children in care in Bristol were measured by the Strengths and Difficulties Questionnaire, which assesses emotional health and wellbeing: 142 (40%) were categorised as cause for concern whilst 29 (8%) were categorised as having borderline cause for concern.

5.7.2 Children subject of a Child Protection Plan

There were 366 children recorded as subject of a Child Protection Plan at end March 2018, compared to 468 at the end of March 2017 (fig 5.7a).

When expressed as a rate per 1,000 of the child population over half the wards have less than 3 children per 1,000 with child protection plans. The highest are; Filwood (8.9) and Hartcliffe & Withywood (11.9).

Gender & Ethnicity: the split between male and female is similar but those of white ethnicity make up three-quarters (77%) of children subject of child protection plans as at the end of March 2018. This compares to 71% at the end of March 2017.

Deprivation: a third (33%) of children subject of child protection plans at the end of March 2018 were for children from the most deprived 10% of the population. Furthermore, 63% were from the most deprived 30%.

5.7.3 Children in Need

According to S17 of the Children Act (1989) a child is in need if:

- they are assessed as being unlikely to achieve or maintain a reasonable standard of health or development, or to have the opportunity to do so, without provision of services from the Local Authority;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority
- they have a disability.

There were over 1,600 “Children in need” (allocated to a Social worker) at end March 2018¹²¹ (see fig 5.7a).

Gender & Ethnicity: the split between male and female is very similar but those of white ethnicity make up two-thirds (65%) of ‘children in need’.

Deprivation: almost a quarter (24%) of ‘children in need’ are from the most deprived 10% of the population, whilst 57% are from the most deprived 30%.

There are sizeable differences across Bristol by ward. For children in need, figures range from none in Clifton Down to 2 (per 1,000 child population) in Cotham to 33 in Filwood and 36 in Hartcliffe & Withywood – see fig 5.7b.

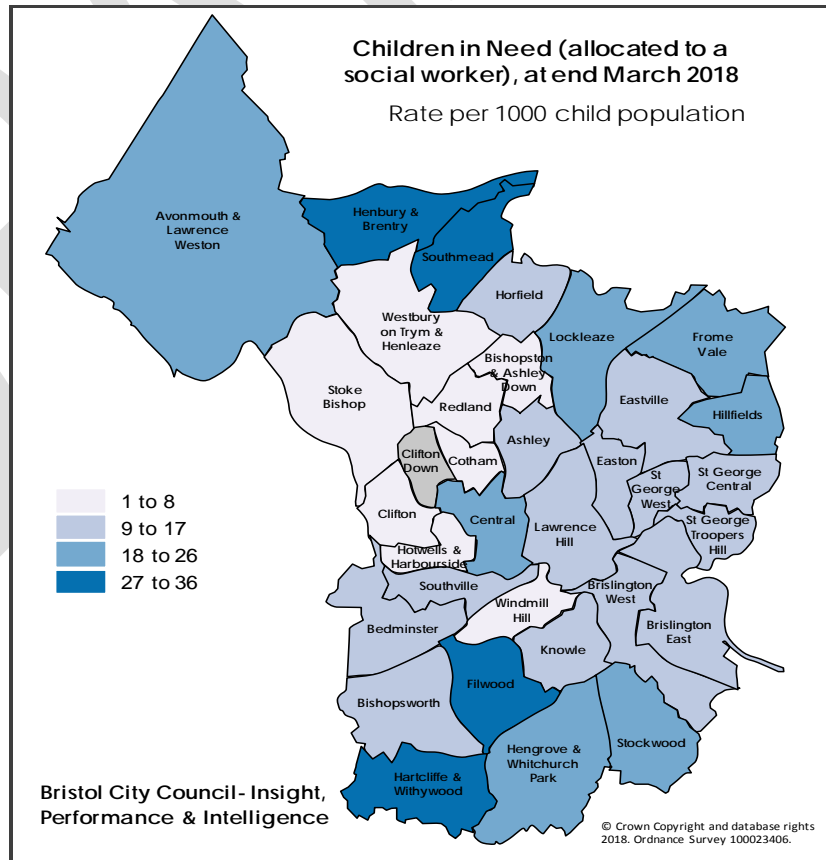


Fig 5.7b: Children allocated to Bristol's Child Social Services by ward (excluding those "in care" or on Child Protection register), 31 March 2018,

¹²¹ Source: Bristol City Council, Insight, Performance & Intelligence, 2018

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

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. Where young people’s activity is not established we are unable to gain contact to determine if support is needed and supply it where required.

There are **8.6% of 16-17 year olds** in Bristol¹²² (2017-18) who are recorded as being “not in education, employment or training” or their current situation is not known. This is higher than the England average of 5.5%, and 2nd worst of English Core Cities – fig 5.8.1. Bristol also has a high NEET-only figure (4%), worse than the national average of 2.7%.

Locally using 2017-18 data¹²³, there are over 300 16 to 17 year olds Not in Education or Training (NEET), lowest in the Bristol North & West (Inner) areas at less than 3% (see fig 5.8.2). The highest percentage of 16 to 17 year old NEETs on a ward basis are; Filwood (9.8%) and Avonmouth & Lawrence Weston (9.4%). However, higher levels of 16-17 year old NEET (i.e. 6% and above) are in the Bristol South and Bristol North & West (Outer) areas of Bristol.

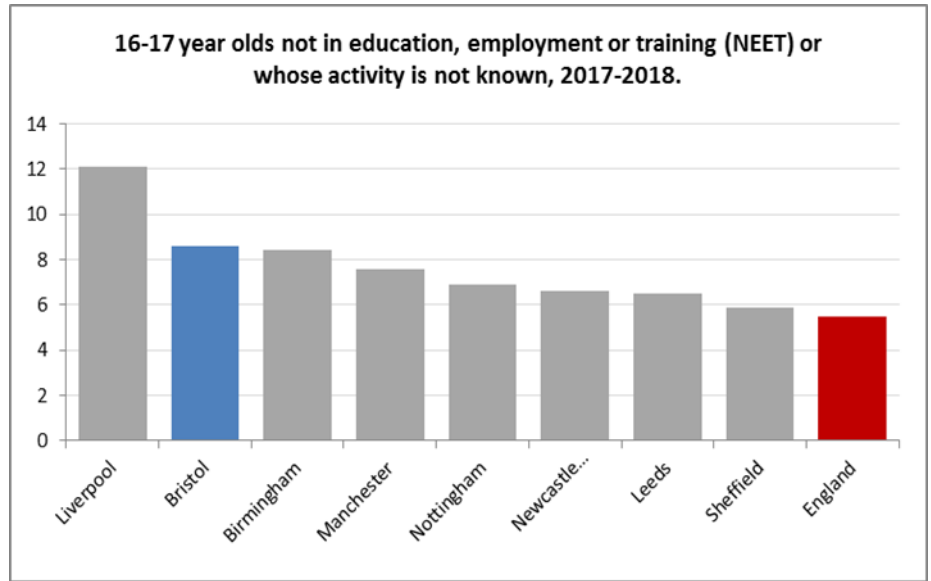


Fig 5.8.1: Source: Bristol City Council, Insight, Performance & Intelligence

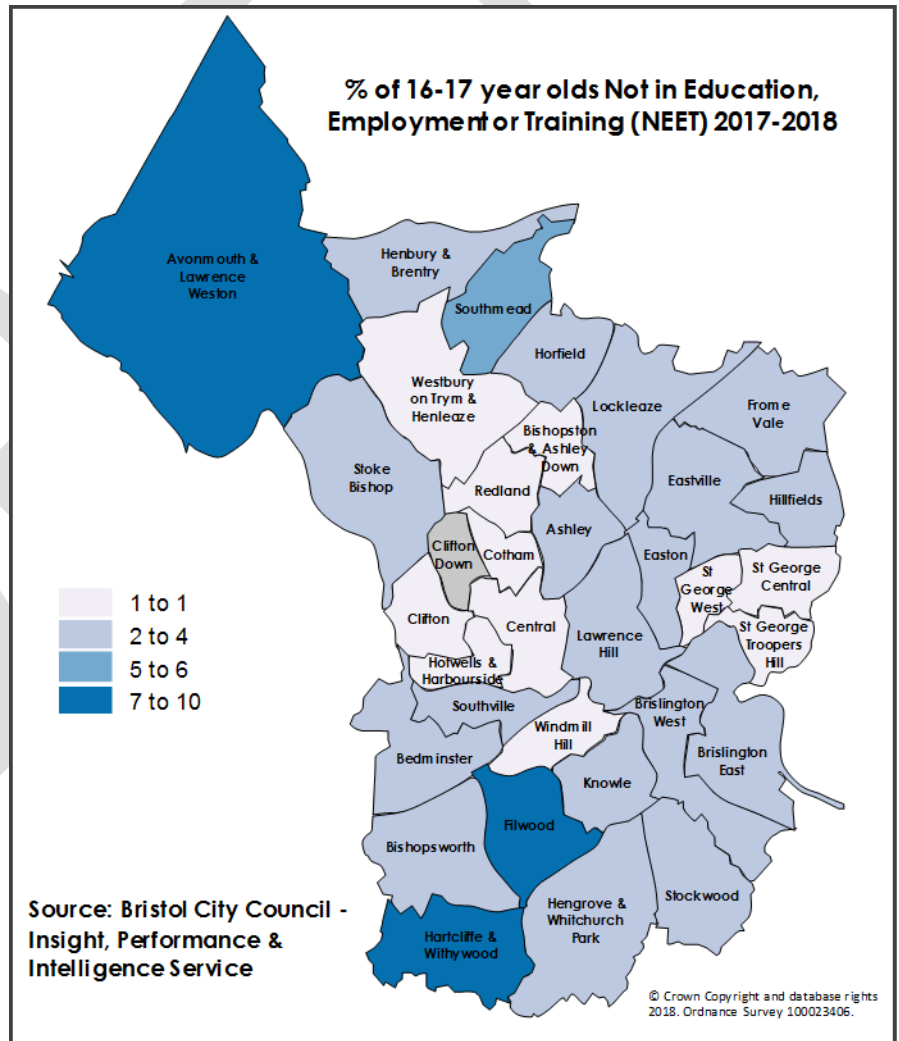


Fig 5.8.2: 16-17 year olds NEET by ward as a % of total NEETs (2017-18 data)

¹²² Source: Dept. for Education, 2018

¹²³ Source: Bristol City Council, Insight, Performance & Intelligence Service

5.9 Young Offenders

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

The rate of first-time entrants to the Youth Justice System¹²⁴ in Bristol is 407 per 100,000 (12 months to December 2017), higher than the national average (292 per 100,000) but is falling - fig 5.9.1.

As individuals, there were over 140 young people who entered the Youth Justice System for the first time in 2017, down from 170 in 2016.

At the end of 2017, Bristol had fallen from one of the highest first-time entrants in 2015 to one of the lowest amongst the English Core Cities. The trend has been a reducing Bristol rate since 2010, with the biggest annual reduction in 2016. The Bristol rate is also falling faster than most other cities and faster than national average.

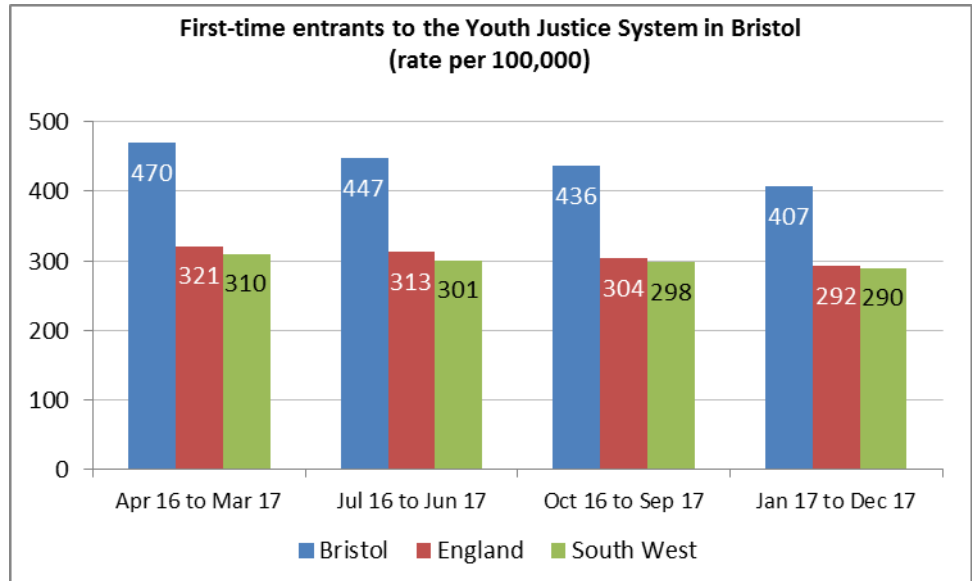


Fig.5.9.1: Rate of young people aged 10-17 receiving their first reprimand, warning or conviction. Source: Police National Computer via BCC YOT team

Local data shows 334 individual youth offenders¹²⁵ in Bristol in 2016-17). By ward, this ranges from 0 in some inner city wards (eg Clifton, Clifton Down, Cotham) to 29 per 1,000 (aged 10-17) population in Hotwells & Harbourside (fig 5.9.2). This is based on the address of the offender and not the crime.

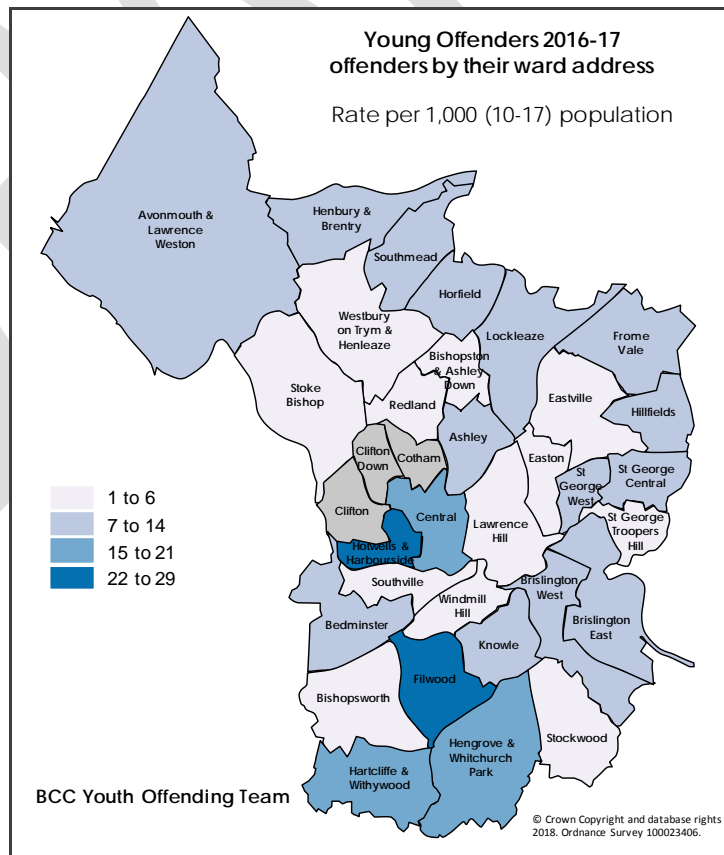


Fig.5.9.2: Rate of individual Youth Offenders 2016-17 (Youth Offending team)

¹²⁴ 10-17 year olds receiving their first reprimand, warning or conviction. Source: Police National Computer database via Bristol City Council Youth Offending Team, 2018

¹²⁵ Source: Police National Computer database via BCC Youth Offending Team, 2018

5.10 Employment

In 2017, the percentage of working age economically active people in Bristol (81.8%) was broadly similar to the average for England (78.6%).

Having fallen sharply to 5.2% in 2015 the unemployment rate¹²⁶ for Bristol fell further to 4.3% in 2017. This compares to 4.5% for England and 4.3% for pre-recession 2007 (fig 5.10.1).

Employment has increased since the recession (due in significant part to a 10% rise in female employment) and as of December 2017 was 78.2% which compares to 73.4% in December 2007. The rate (and numbers) of unemployed people claiming unemployment benefit (the claimant count rate) fell more or less continually in 2013, 2014 and 2015. As a consequence it had fallen to the levels of pre-recession 2007 by December 2015. Both claimant count and rate have remained substantially unchanged throughout 2016 and 2017. From December 2017 to March 2018 the claimant count increased by 8.9% (i.e. 5,075 to 5,550).

In 2017, there were 9,300 economically inactive people who wanted a job, while 11,000 people were classed as unemployed. This meant that a total of 20,300 people were involuntarily workless. These represented 7.8% of the economically active

population – lower than across England (10.3%).



Fig 5.10.1: Unemployment rate (% people 16-64) England & Bristol, 2004-17

Economic participation and unemployment: key facts¹²⁷

- Economic activity rate 2017: 81.8% (England 78.6%)
- Employment rate 2017: 78.2% (England 75.1%)
- Unemployment rate 2017: 4.3% (England 4.5%)
- Worklessness rate 2016: 9.2% (England 8.3%)
- 11.5% of working age claiming benefits 2016 (England 11.0%)

Economic performance: key facts

- £14.31 billion in economic output in 2016 (0.96% of England total); rise of 23.4% since 2011 compared to 19.8% for the UK.
- Gross Value Added (GVA) per head: £31,513 in 2016 (UK £26,621); rise of 16.3% since 2011 (15.5% for the UK).
- Workplace-based jobs in Bristol increased significantly by 12% from 231,000 to 258,000 between 2012 and 2016
- GVA per hour worked¹²⁸ for Bristol in 2016 was £31.0 (England £33.7); rise of 9.5% since 2012 (8.2% for England)

Earnings and Earnings Gap¹²⁹

In 2017, Bristol had the second highest median (& mean) total gross weekly earnings of the English Core Cities

In Bristol, the 2017 median earnings of the highest earning 10% in work was £899, compared to £154 for the lowest paid 10%.

¹²⁶ NB the % of economically active working age people who were out of work and looking for work

¹²⁷ For regular updates, see BCC Economic Quarterly Briefings at www.bristol.gov.uk/business-support-advice/economic-information-and-analysis

¹²⁸ Data are nominal and are not adjusted for inflation.

¹²⁹ Data for Bristol "home region" not work region; Source: Annual Survey of Hours and Earnings, 2017

So, the highest paid 10% earn almost six times as much every week as the bottom 10%.

Between 2002 and 2015, this gap in Bristol’s weekly earnings grew at an average rate of £14.9 each year, more or less identical to the growth in the gap for England (£14.8 per year).

Furthermore, taking 2017 data as a starting point and assuming the “top 10%” earnings grow at 3% per year, even if the “bottom 10%” grew 3 times as quickly (9%), the gap between the two would take over 15 years to start closing.

Job Seekers Allowance (JSA) claimants by gender

As of January 2018, there were 3,340 male and 1,895 female JSA/Universal Credit claimants resident in Bristol. These numbers are 63.6% and 54.5% below the highest of 2011 to 2012 respectively¹³⁰.

Thus whereas prior to the 2008 recession there were about 3 times as many male as there were female claimants there are currently under twice (1.76) as many males as females claiming JSA/Universal Credit in Bristol. The female population of Bristol has fared worse than males during the post-recession period 2009 to date.

In September 2017, the employment rate for Bristol was 77.6%, higher than the England average of 74.4%. Bristol also has the highest employment rate amongst the English Core Cities¹³¹.

Since the end of 2012 the gender gap of the employment rate has closed significantly – fig 5.10.2. In Dec 2012 the employment rate for working age (16 to 64) men was 77.8% compared to 64.3% for working age women, a gap of 13.5 percentage points. With male and female employment rates of 80.5% and 74.6%, respectively, in September 2017 the gap was only 5.9 percentage points.

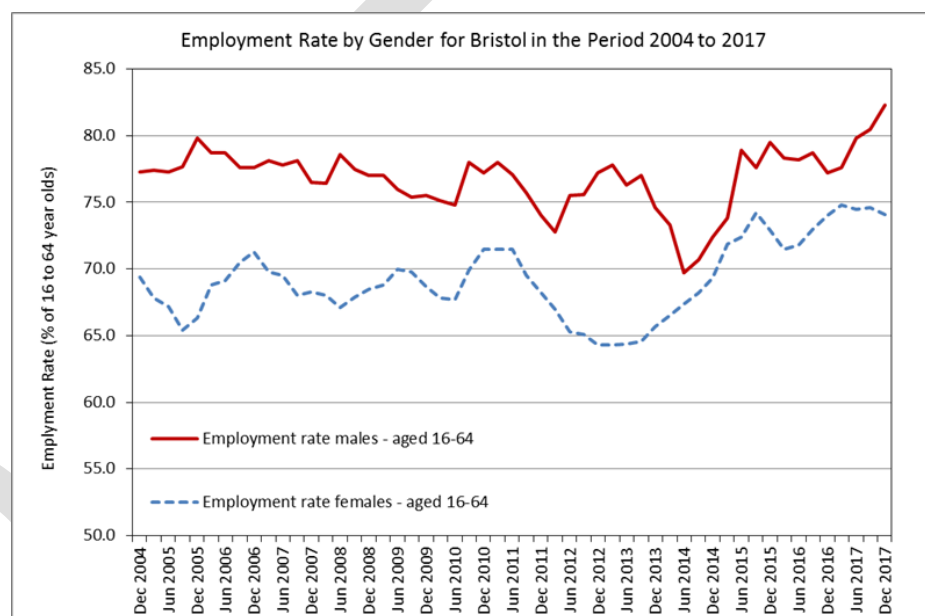


Fig 5.10.2 Unemployment rate by gender for Bristol in the period 2004 to 2017

Youth Unemployment

In January 2018 the number of young claimants, aged 18 to 24 years, resident in Bristol was 925. This was 68% down on that for January 2013 (2,865) and only 4% above the lowest number (i.e. 890 in September 2017) on record (i.e. since June 1985). The proportion of claimants aged 18 to 24 years (17.7%) is also close to the lowest on record.

Unemployment amongst 50 to 64 Year Olds

In January 2018 the number of claimants aged 50 to 64 years (1,350) was up (23.3%) on that of January 2016 (1,095). It remains over double the pre-recession level of January 2008 (660). The proportion of claimants who are aged 50 to 64 years (25.8%) continues to increase at a trend rate of 2.1% per annum and remains at a historic high.

¹³⁰ September 2011 for female claimants and February 2012 for male claimants.

¹³¹ Annual Population Survey 2018, Nomis, .O.N.S., ©Crown Copyright

5.10.1 Employment and health

Sickness Absence

Overall, 1.3% of working days are estimated to be lost due to sickness absence¹³² in Bristol. This remains similar to the national average (of 1.2%) but has risen slightly whereas the national rate is falling – see fig 5.10.3. Bristol also has one of the highest rates of the English core cities.

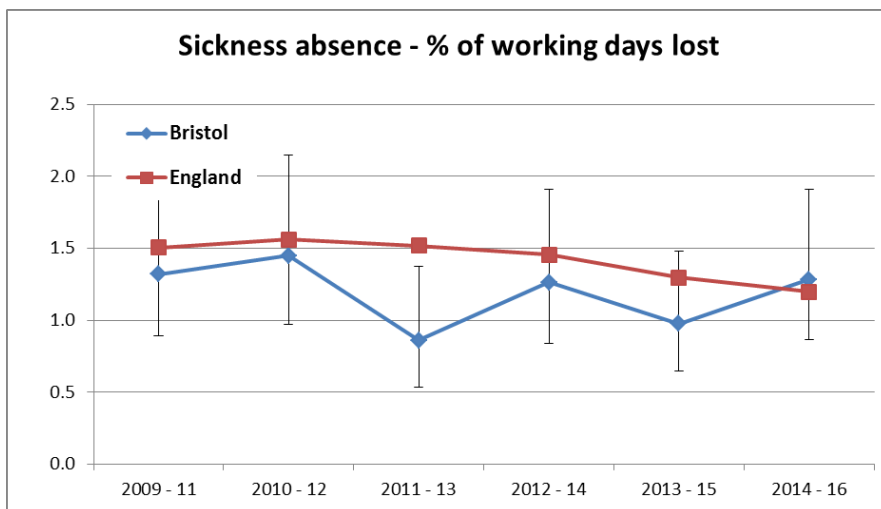
Similarly, the % of employees who had at least 1 day off in the last week¹³³ appears to have been rising in Bristol (2.4% in 2014-16, from 1.3% in 2011-13).

Local 2013 research¹³⁴ highlighted

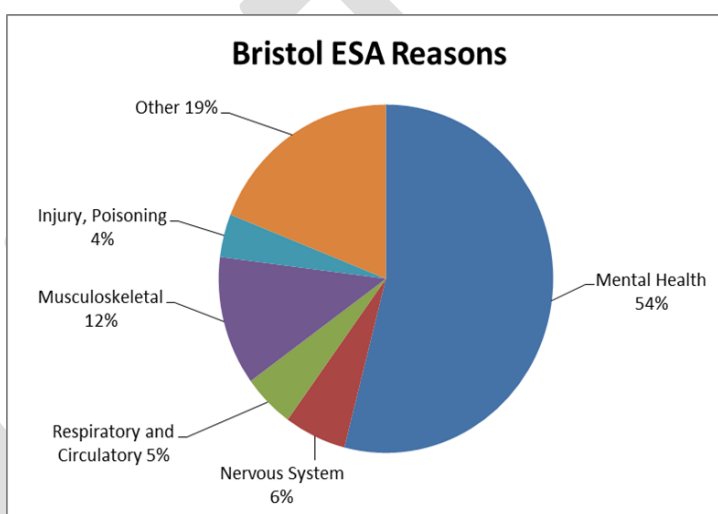
- 10 million working hours were lost to sickness or injury in 2010 at a cost to the Bristol economy of £240 million.
- Sickness absence rates were higher amongst public sector and older workers (50+)
- By sector, rates were highest in manufacturing, construction and agriculture.

Causes of sickness absence

The largest cause of Employment and Support Allowance (ESA) claims¹³⁵ in Bristol (2016) was poor mental health (54%), followed by musculoskeletal conditions (12%)¹³⁶ – fig 5.10.4. This broadly mirrors issues found nationally.



5.10.3: Labour Force Survey via Public Health Outcomes Framework 2018



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

Sickness absence resulting from work-related stress

Local 2013 research¹³⁷ into stress and absence identified that:

- 1 in 4 days lost to sickness absence in Bristol were work-related – i.e. the ill health symptoms/condition were considered to be a result of work or made worse by work.
- Stress, depression or anxiety accounted for 36% of work-related ill health.
- The average spell of sickness absence for stress, depression or anxiety was 7.6 days compared to an average of 4.7 days for all sickness absence.
- Workload was the most frequent cause of job stress.

Further data

- More detail on the above issues are in the JSNA Chapter on [Work and health \(2017\)](#)

¹³² 2014-16; Source: ONS Labour Force Survey via PHOF (Sept 2018)

¹³³ 2014-16; Source: ONS Labour Force Survey via PHOF (Sept 2018)

¹³⁴ Profiling Sickness Absence Within the City of Bristol, A. Weyman, A. Buckingham, University of Bath, Feb 2013 (2010 data)

¹³⁵ Source: ONS statistics, NOMIS, Oct 2016

¹³⁶ See JSNA sections: **8.8 Musculoskeletal and 9. Mental Health**

¹³⁷ Profiling Work-Related Stress Sickness Absence Within the City of Bristol, A. Buckingham and A. Weyman, University of Bath, October 2013 (using 2010 data)

5.11 Housing

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

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

There has been a significant increase in the private rented sector, with rents also rising.

5.11.1 Housing Stock

As of April 2017 there are 198,400 residential properties¹³⁸ in Bristol. Almost 2 in 3 properties (124,200) are in Council Tax bands A and B (the 2 lowest bands).

According to the 2011 census, 55% of Bristol housing is owner-occupied, 24% privately rented and 21% social rented (15% owned by the council and 6% by housing associations). The private rented sector increased significantly from 12% in 2001 to 24%, overtaking the social sector.

Further, a 2017 study¹³⁹ indicates that private rented in Bristol has now risen to 29%, with 18% social rented and 53% owner occupied.

5.11.2 Housing Need

Bristol's [Housing Delivery Plan 2017 - 2020](#) notes that the emerging West of England (WoE) Joint Spatial Plan will provide the framework for 105,000 net additional homes, and identifies a

need for 32,200 affordable homes between 2016 and 2036 (across WoE). The emerging target for Bristol is around 33,000 homes and the need for affordable homes in Bristol is projected to be an additional 18,800 between 2016 and 2036.

The current Bristol Local Plan Core Strategy (adopted 2011) states a need for at least 26,400 dwellings to be delivered in Bristol between 2006 and 2026. Based on this, and noting that 19,880 were delivered in 2006-2017, for 2017-22 Bristol needs to develop at least 3,620 dwellings, and has a 5 year "deliverable supply" of 7,370 dwellings already available for this period¹⁴⁰.

5.11.3 House Prices & Affordability

House prices in Bristol are rising. The average house price in Bristol in Nov 2017 was £275,600, higher than the England average of £243,300¹⁴¹.

In the year from Nov 2016 to Nov 2017, average house prices in Bristol increased by £16,200 (+6.2%), compared to a £12,200 (+5.3%) rise in England. Since the 2007-08 dip in prices, average house prices in Bristol rose by £110,800 (from Nov 2008), a 67.2% rise, compared to a 44.6% rise in England.

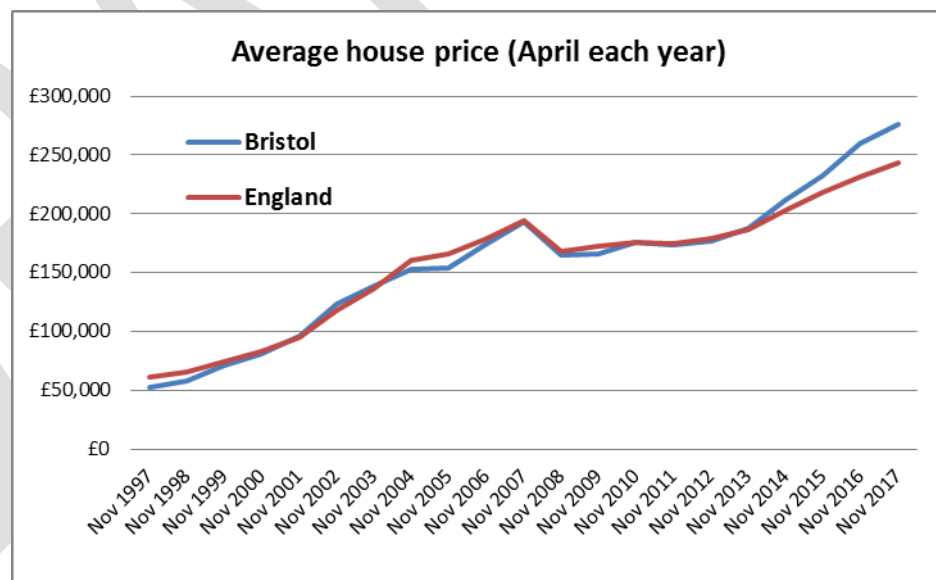


Fig 5.11a: Average house prices, Source: UK House Price Index, Land Registry, Nov 1997 to Nov 2017

Earnings in Bristol are similar to the national average and other English Core Cities, but house prices are significantly higher, resulting in affordability issues. ONS calculate "affordability ratios" which measure the relationship between the price of the

¹³⁸ Source: Valuation Office Agency, 1/4/17, via [Bristol Housing Market 2017](#)

¹³⁹ [BRE Integrated Dwelling Level Housing Stock Modelling and Database for Bristol City Council](#)

¹⁴⁰ Source: [5 Year Housing Land Supply 2017-22](#), Bristol City Council, Strategic City Planning Team, Jan 2018

¹⁴¹ [UK House Price Index data](#), HM Land Registry, Nov 2017

cheapest homes and the lowest level earnings of people living in Bristol.

In 2002 this ratio was 5.45 in Bristol, rising to a peak of 8.21 in 2007 before falling for two years. However, since 2010 the ratio has been rising again, and in 2016 set a new peak of 9.01 (i.e. the cost of the cheapest homes in Bristol were over 9 times the annual earnings of lower income households). This is higher than the England ratio of 7.16 and the highest of the English Core Cities (not including London), all of whom have affordability ratios lower than the national average.

5.11.4 Private Rented Sector

As noted in Housing Stock above, the Bristol private rented sector is growing in size, and also in cost. Between Oct 2016 and Sept 2017 the average Bristol rent had risen to £1,043 a month¹⁴² (3 years previously the average rent was £828 a month).

The Bristol Quality of Life¹⁴³ Survey 2017-18 looked at the issue of housing. In comparison to home owners, housing association and local authority tenants, private tenants were least satisfied with the cost of their rent or mortgage, the cost of heating their homes and the security of their tenure.

For satisfaction with the cost of rent or mortgage:

- owner occupiers were most satisfied (61%)
- private tenants were least satisfied (40%)

For the cost of heating their home:

- private tenants were least satisfied (37%)
- Housing Association tenants were the most satisfied (53%)

For security of tenure:

- private tenants were the least satisfied (44%)
- local authority tenants were the most satisfied (86%).

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

Further information

- See BCC [Housing Strategy and supporting strategies](#) webpage

¹⁴² Valuation Office Agency, [Private rental market summary statistics – Oct 2016 to Sept 2017](#)

¹⁴³ See www.bristol.gov.uk/qol

5.12 Homelessness

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

Many people who sleep rough will suffer from multiple health problems, such as mental health problems and they are also in greater danger of violence than in the general population. Other health impacts associated with rough sleeping include higher rates of communicable diseases such as TB, HIV and hepatitis. Research indicates that the average life expectancy of a homeless person is 47 years old and even lower for homeless women (43 years), compared with 77 for the general public¹⁴⁴.

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

During 2016/17, 80 people were eligible as homeless but ‘not in priority need’. A significant drop from 152 in 2015/16. As a rate this is 0.4 per 1,000 households¹⁴⁵; half that of last year and half the national average (0.8 per 1,000).

Bristol now has one of the lowest rates amongst the English core cities and other comparable cities.

The number of statutory homelessness acceptances reached its peak in 2015/16 at 1,006 (5.30 per 1,000 households), a rise from 324 (1.76 per 1,000 households) in 2012/13. However, this has been falling over the last two years and as at 2017/18 there are 721¹⁴⁶ (fig. 5.12.1)

It is difficult to pinpoint a single reason for the rise and fall in the number of homelessness acceptances. However, the single biggest contributory factor has been private landlords seeking possession of their properties (i.e. Section 21 notices) for financial reasons. In particular, concerns over changes to the housing benefit system affecting payments (e.g. benefits cap).

Future numbers in homelessness acceptances is uncertain. New legislation (Homelessness Reduction Act) came into force April 2018 requiring more prevention and relief work is undertaken before a homelessness duty is accepted. This may reduce the acceptance level or be ‘counter-balanced’ by a possible rise due to further welfare benefit changes (i.e. universal credit) resulting in more landlords seeking possession.

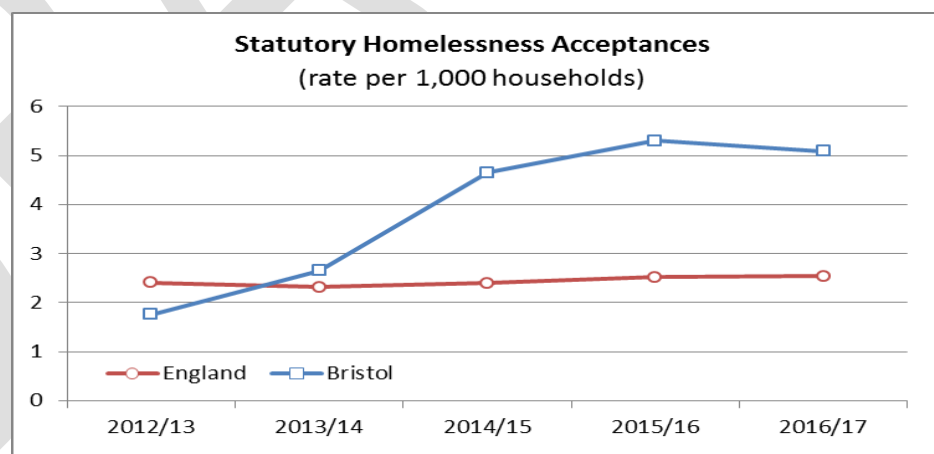


Fig.5.12.1: Ministry of Housing, Communities & Local Government (table 784 local authorities action under homelessness provisions of the Housing Acts).

¹⁴⁴ Bethan Thomas, *Homelessness Kills*, University of Sheffield and Crisis, 2012

¹⁴⁵ Crude rate; Source: Dept. for Communities & Local Government, via PHOF 2018

¹⁴⁶ <https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness>

Over 530 people in temporary homeless accommodation in Bristol in March 2017, continuing an upward trend. As a rate this has been rising since 2013/14 and is now (2016/17) 2.8 per 1,000 households¹⁴⁷. This places Bristol with the 3rd highest of English Core Cities. However, it is still better than the national average of 3.3 per 1,000 (fig 5.12.2).

- 9 were under 25 years, 63 were over 25 & 14 unknown,
- 64 were male, 18 female and 4 unknown

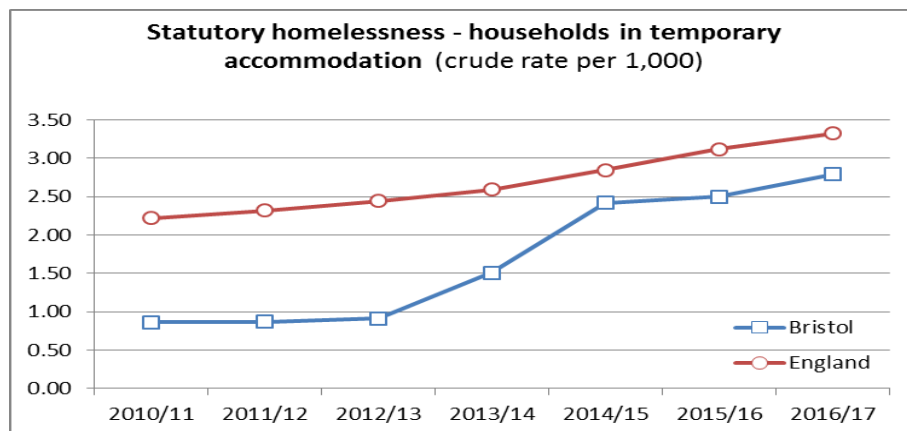


Fig.5.12.2: Source: via Public Health Outcomes Framework, 2018

Rough Sleepers

When aggregated, the annual average number of rough sleepers identified at hotspot counts up to Quarter 3 2017/18 was 69 per week. This is a rise from 5 per week in 2010/11 – fig 5.12.3. This figure is a mean statistical average for each count and not the actual number of rough sleepers at any one time.

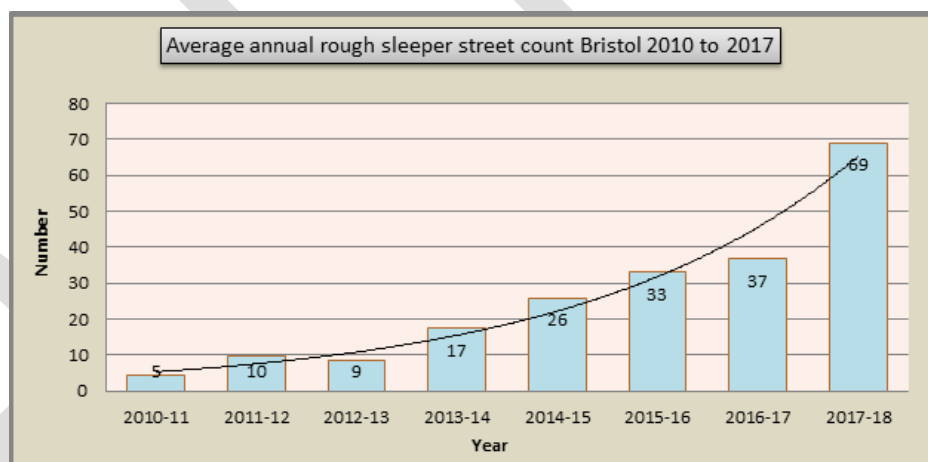


Fig.5.12.3: Average rough sleepers. Source: Monthly hotspot count, St Mungos Rough Sleeper Outreach team, 2018

Bristol City Council reported 74 Rough Sleepers at the National; Rough Sleeper Count in November 2016. The following year it reported 86 Rough Sleepers¹⁴⁸. This is the sixth highest number nationally and represents a 16% increase on 2016

- Of the 86 reported in November 2017, 57 were UK nationals, 12 were EU non-UK nationals, 12 non-UK nationals and 5 unknown,

¹⁴⁷ Crude rate; Source: Dept. for Communities & Local Government, via PHOF 2018

¹⁴⁸ <https://www.gov.uk/government/statistics/rough-sleeping-in-england-autumn-2017>

5.13 Fuel Poverty

Fuel poverty is a term that is typically used to describe a person on a low income who's struggling to afford their energy costs. The drivers of fuel poverty are low income, poor energy efficiency and high energy prices. Living in fuel poverty and experiencing a cold home have been shown to have a significant impact on mental and physical health. Several large scale evidence reviews have suggested that living in a cold home and coping with unaffordable fuel bills can have significant adverse implications for a range of outcomes, including health, educational and social outcomes (Marmot Review Team, 2011; CSE. 2016; NICE. 2015). Also, it has been estimated that at least 1 in 10 of excess winter deaths are caused by fuel poverty¹⁴⁹.

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

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

Based on the LIHC definition, there are an estimated 20,709 fuel poor households in Bristol, 10.8% of all households (BEIS, 2018). This is higher than the rest of South West where 10.2% are fuel

poor, but lower than England overall, where 11.1% are fuel poor (BEIS, 2018) – fig 5.13.1.

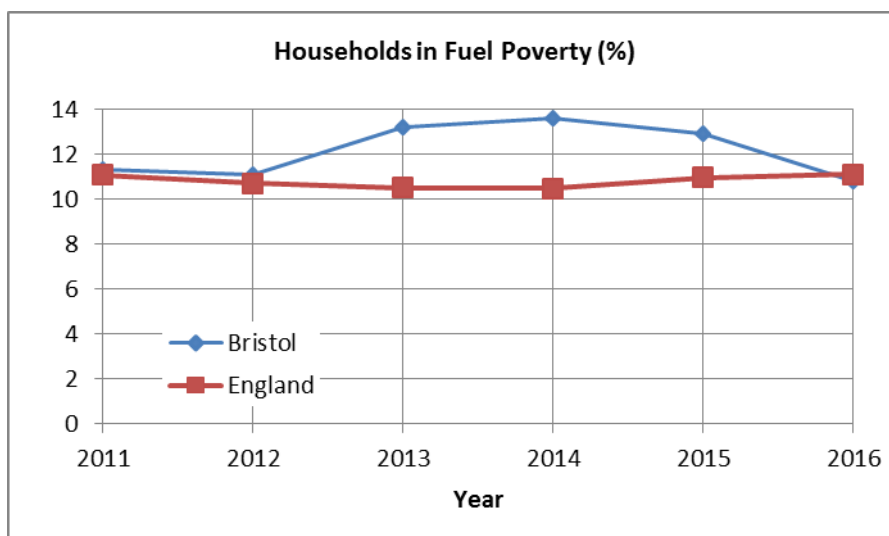


Fig 5.13.1 Percentage of households in Fuel Poverty (based on low income, high cost), Source Business for Business, Energy & Industrial Strategy 2016 data

When compared with statistically similar cities¹⁵⁰, Bristol is mid-ranking – fig 5.13.2.

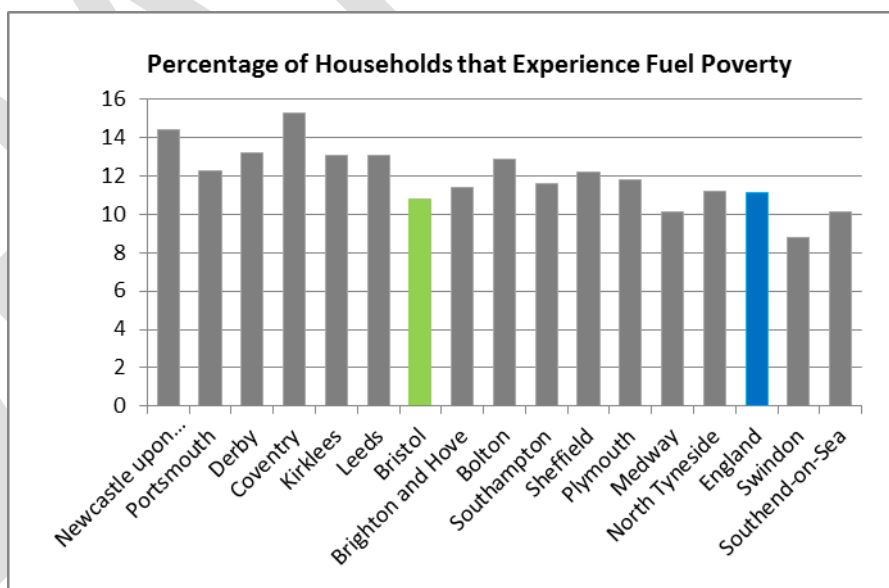


Fig 5.13.2: Percentage of households in Fuel Poverty (for CIPFA nearest neighbours) Source Department for Business, Energy & Industrial Strategy, 2016 data

Further data

- JSNA Chapter on Fuel Poverty - [see JSNA chapters](#)
- CSE. 2016. [Understanding the Characteristics of Low Income Households Most at Risk from Living in Cold Homes.](#)

¹⁴⁹ See section 10.3 Excess Winter Deaths

¹⁵⁰ "CIPFA nearest neighbours" for Bristol

5.14 Food Poverty

The terms food poverty and food insecurity are often used interchangeably. The DoH define food poverty as the inability to afford, or have access to, food to make up a healthy diet. It is not just about hunger but also about being appropriately nourished to maintain health. The causes of food poverty are complex and multiple and include:

- financial – relating to income and to the price of locally available healthy food
- social – relating to cultural norms, skills, social networks, and the impact of marketing of unhealthy foods
- physical – relating to access to shops and cafes selling affordable healthy food, to cooking facilities, to transport.

Quantifying food poverty is difficult as there is no universal measure currently used in the UK. Most recent information for Bristol comes from a report by Joy Carey produced for the Feeding Bristol initiative¹⁵¹

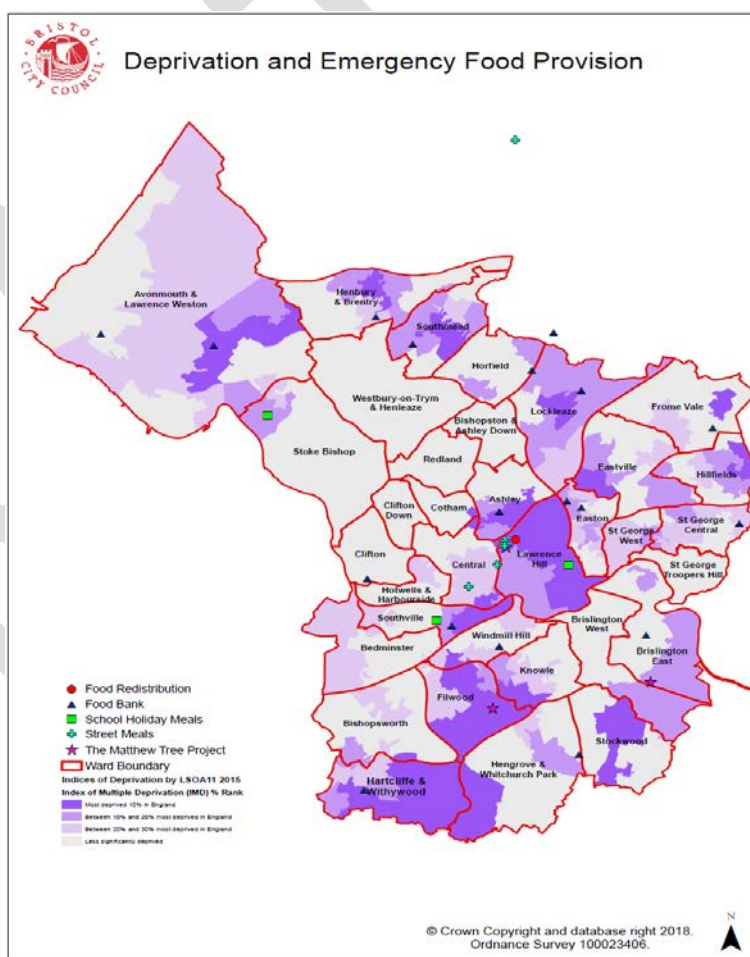
Levels of Food Insecurity

- 10.1% over 15 year olds or 8.4 million people in UK in 2014 (UN figures using [FIES scale](#) quoted in Food Foundation 2016 p3¹⁵²

- 7,309 individuals accessed Trussell Trust food banks in Bristol during 2017/8 (Carey 2018)
- 27.2% of referrals to these food banks were because of low income. (Carey 2018)

Food bank usage estimated to be 17% of those classed as food insecure (Loopstra and Tarasuk quoted in Food Foundation¹⁵³). This equates to almost 43,000 people food insecure in Bristol.

The [interactive map](#) below shows Bristol Wards overlaid with information about access to food and growing opportunities. This demonstrates the complexities of the food environment in the City.



Further information:

- [The Food Foundation: Too Poor to Eat report, 2016](#)

¹⁵¹ Understanding the extent of food insecurity in Bristol; draft report June 2018

¹⁵² Source: The Food Foundation <https://foodfoundation.org.uk/>

¹⁵³ Loopstra R and Tarasuk V, 2015, <https://www.cambridge.org/core/journals/social-policy-and-society/article/food-bank-usage-is-a-poor-indicator-of-food-insecurity-insights-from-canada/DF0BCAA2EBC765500AF6FFFEF689B019>

5.15 Internet connectivity

2017 estimates from the Office for National Statistics (ONS) showed that 89% of Bristol adults (321,000 people) had recently used the internet (in the last 3 months)¹⁵⁴, down from 94.9% in 2016; while 10.7% had not used the internet recently (never used or not used the internet at all in the last 3 months), up from 5.1% in 2016. Bristol’s 89% of connected citizens is similar to the UK average of 88.9%.

Although the proportion of the population using the internet dropped in the last 12 months, the general trend is an increase in users. In Bristol, almost 35,000 more adults had recently used the internet in 2017 (89%) than in 2011 (79.3%).

Fig 5.15.1 shows that the percentage of people who have “Used the internet in the last 3 months” was rising faster in Bristol than nationally up to 2016. In 2017 however, Bristol, the South West and UK have similar proportions.

However, the ONS report that accompanies the data does highlight that, nationally, “Virtually all adults (99%) aged 16 to 34 years were recent internet users, in contrast with 41% of adults aged 75 years and over. However, recent internet use among women aged 75 and over had almost trebled from 2011. In 2017 22% of disabled adults had never used the internet, down 25% in 2016.”

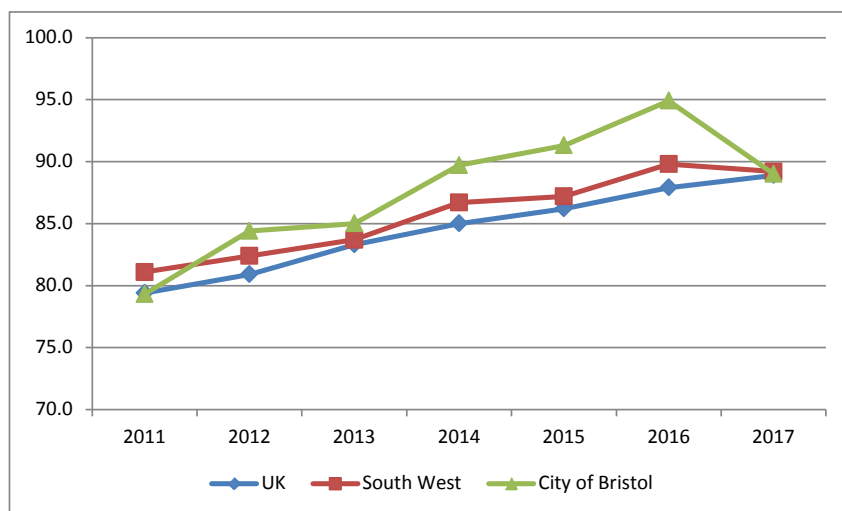


Fig 5.15.1: Adults who have “Used the internet in the last 3 months”
Source: 2017 Internet users, ONS 2017

¹⁵⁴ # Internet users (January to March quarter); ONS 2017
<https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/datasets/internetusers>

5.16 Social Isolation

Social isolation¹⁵⁵ 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 & over¹⁵⁶.

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 including background report which also covers health impacts¹⁵⁷.

Social isolation of older people

Socially isolated older adults have:

- longer stays in hospital
- a greater number of GP visits and
- more dependence on homecare services

Social isolation amongst older people is being addressed by [Bristol Ageing Better](#) and partners to develop local solutions.

¹⁵⁵ 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.’
¹⁵⁶ Social Isolation in Bristol Initial Findings Report (2013)

¹⁵⁷ Research on health impacts are also at: www.campaigntoendloneliness.org/threat-to-health/

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%¹⁵⁸.

In Bristol, 48.8% of service users (in 2016/17) said they “have as much social contact as they would like”, still broadly similar to the national average (45.4%) - see fig 5.16.1. This figure appears to be rising though and is one of the highest of the Core Cities.

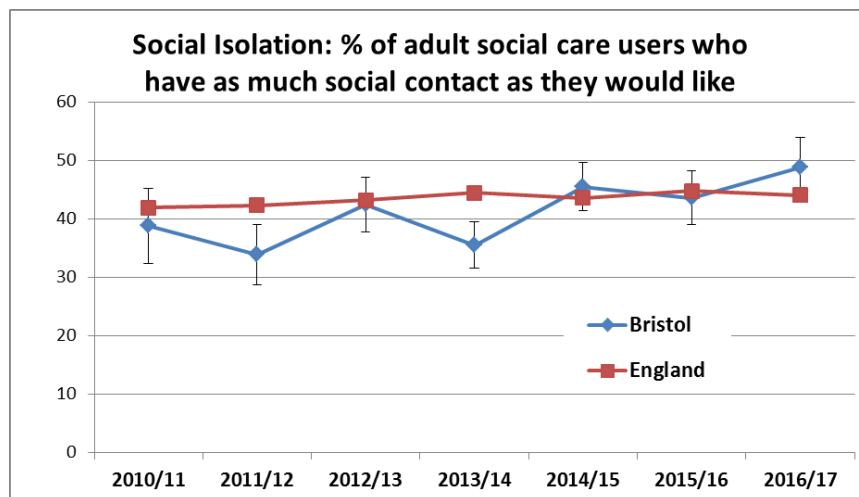


Fig 5.16.1: Source: Adult Social Care Survey via PHOF (Sept 2018)

Social isolation of carers

The Personal Social Services Survey provides information about the indicator relating to the social isolation of carers. Only 29.1% of carers in Bristol (2016/17) say they “have as much social contact as they would like”, which has fallen significantly since 2012/13 (46.2%) and is worse than the English average (35.5%) – fig 5.16.2.

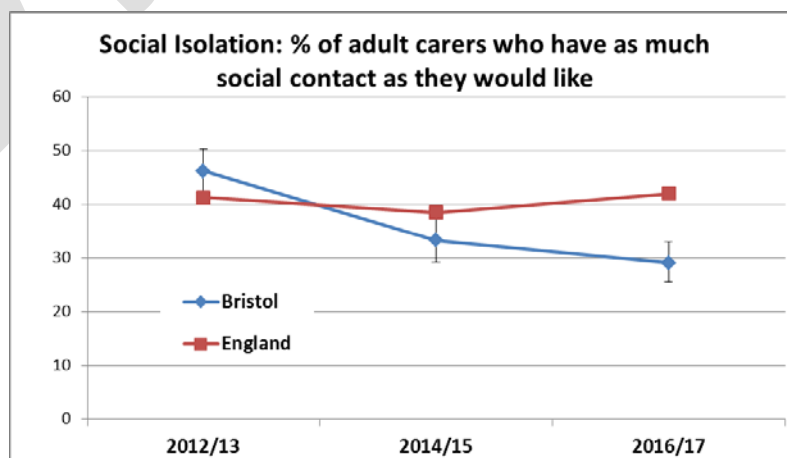


Fig 5.16.2: Source Personal Social Services Survey via PHOF (Sept 2018)

¹⁵⁸ Source: Adult Social Care Survey - a random sample of social care users run each year by local authorities following Department of Health guidance

5.17 Air pollution

Health Impact

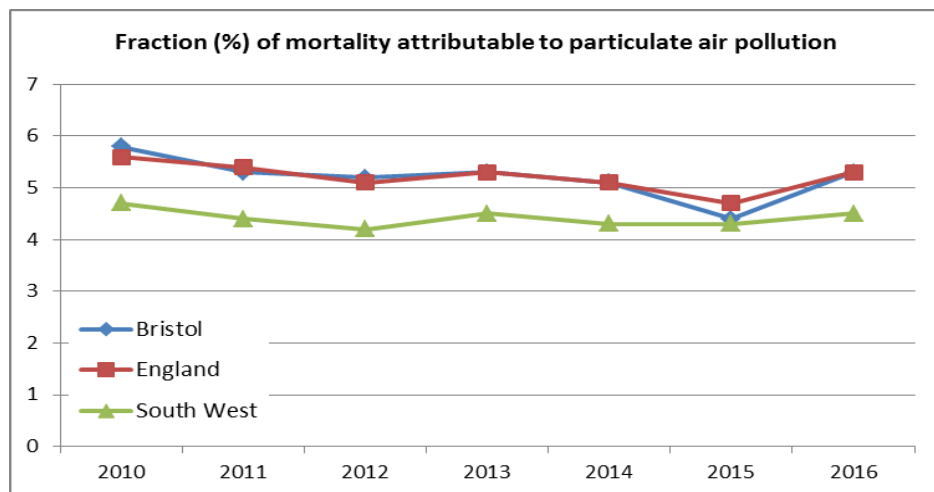
Air pollution generated from human sources such as the combustion of fuels for heat, electricity and transport is having an adverse effect on the health of Bristol’s communities. In 2016, 5.3% of “all-cause adult mortality” in Bristol was considered attributable to “anthropogenic particulate air pollution”¹⁵⁹, which is the same as the national proportion (5.3%) (fig 5.17.1) and is mid-ranking for English Core Cities.

In addition, a recent local report¹⁶⁰ estimates that around 300 deaths each year in Bristol can be attributed to exposure to both nitrogen dioxide (NO₂) and fine particulate matter. This represents about 8.5% of deaths in Bristol being attributable to air pollution. [NB this is higher as the local report considers NO₂ as well].

As part of a project involving partners across the city, the Clean Air Plan¹⁶¹ is looking at ways we can reduce nitrogen dioxide (NO₂) pollution.

The proportions of deaths attributable to air pollution vary across the city in relation to pollutant concentrations, from around 7% in some wards to around 10% in others.

Concentrations are highest in the centre of the city and therefore so are deaths attributable to air pollution.



5.17.1: Mortality attributable to particulate air pollution.

Source: Background annual average PM_{2.5} concentrations, using a national air dispersion model, and calibrated using concentrations taken from sites in Defra’s Automatic Urban and Rural Network. Via PHOF, 2018

Long-term exposure to air pollution contributes to the development of cardiovascular disease, lung cancer and respiratory disease¹⁶². Those at particular risk include children aged 14 and under, older people aged 65 and over, pregnant women and not unexpectedly people with pre-existing respiratory or heart conditions¹⁶³. Lower socio-economic communities suffer the greatest consequences of air pollution¹⁶⁴.

Air Quality Management Area

Road transport is a major source of particulate matter and nitrogen oxides (NO_x) accounting for 34% of nitrogen oxides and 12% of primary particulate matter (PM_{2.5}) emissions in the UK¹⁶⁵. At busy roadside locations the contribution of traffic to nitrogen oxides can be greater than 80%.

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

¹⁵⁹ Via Public Health Outcomes Framework (PHOF), 2017

¹⁶⁰ Air Quality Consultants (2017). [Health Impacts of Air Pollution in Bristol](https://www.cleanairforbristol.org)

¹⁶¹ <https://www.cleanairforbristol.org>

¹⁶² World Health Organization (2016). Ambient (outdoor) air quality and health factsheet. <http://www.who.int/mediacentre/factsheets/fs313/en/> (accessed 23.11.16)

¹⁶³ National Institute for Health and Care Excellence (2015). Air pollution – outdoor air quality and health. Final scope. London: NICE

¹⁶⁴ Marmot, M (2010). Fair Society Healthy Lives. Marmot Review.

¹⁶⁵ Department for Environment, Food and Rural Affairs (2018). Clean Air Strategy 2018.

Fig 5.17.2 indicates the boundary of the Air Quality Management Area (AQMA) for Bristol, inside which air quality is at risk of exceeding government objectives.

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

Domestic solid fuel burning is a re-emerging area of concern. Recent evidence shows that this source contributes to 38% of all PM^{2.5} emissions nationally¹⁶⁶.

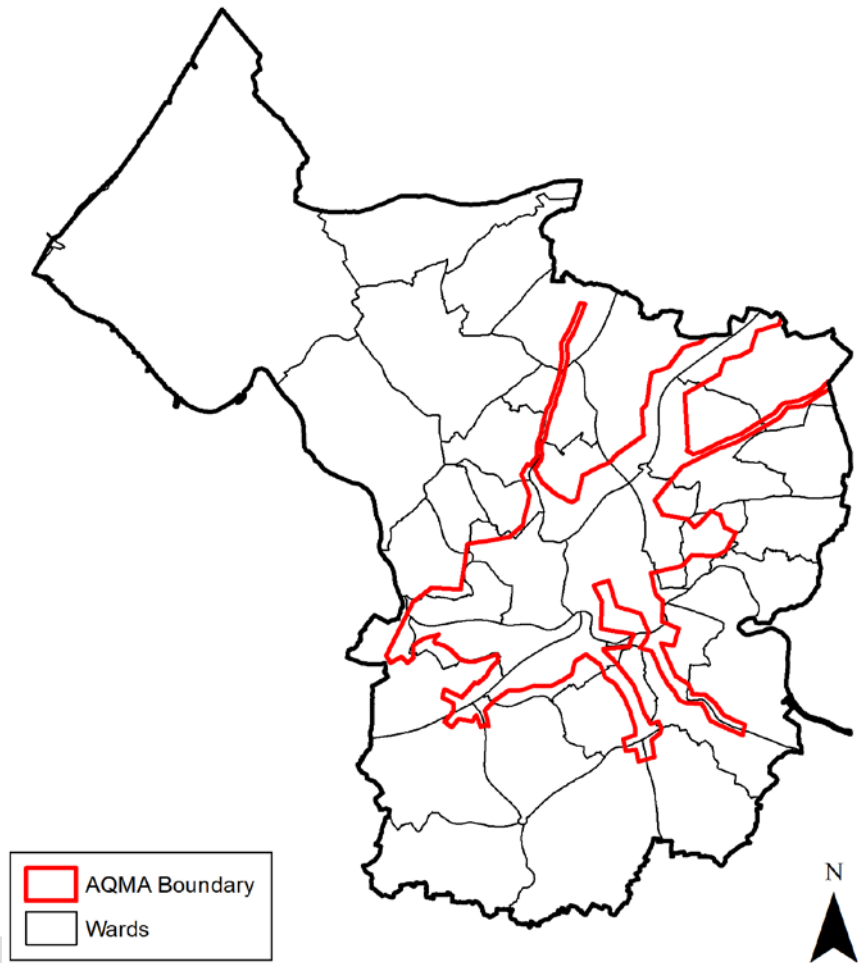


Fig 5.17.2 Map of Bristol's Air Quality Management Area (AQMA)

Consideration of trends in NO₂ concentrations at a selection of kerb/roadside sites on the busiest road corridors throughout Bristol since 1994 show a very similar pattern in all parts of the city. Figure 5.17.3 shows consistent exceedance of the annual objectives for NO₂ at a selection of city centre monitoring sites. Concentrations in 2016 are similar to those recorded in 1994 or the year 2000 depending on when readings at a particular site began. The red line at 40µg/m³ represents the annual EU and UK objective for nitrogen dioxide.

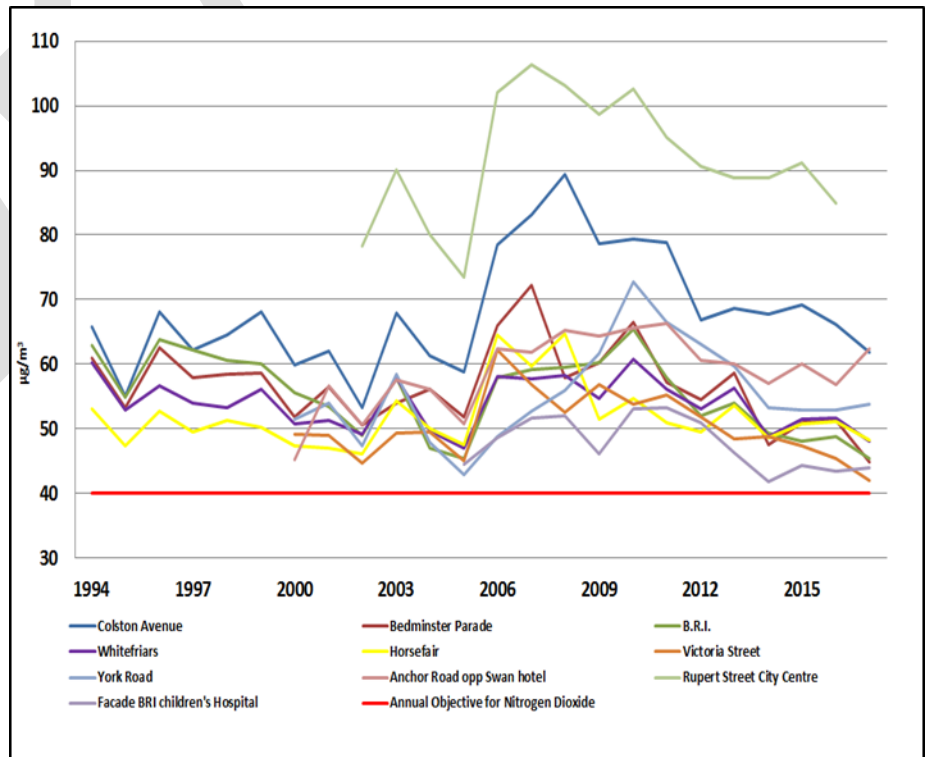


Fig 5.17.3: Trend of NO₂ at city centre diffusion tube sites since 1994

¹⁶⁶ Department for Environment, Food and Rural Affairs (2018). Clean Air Strategy 2018.

5.18 Promoting Healthy Urban Environments

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

There are many Bristol initiatives supporting the creation of healthy urban environments: including the Joint Spatial Plan, the Local Plan, Bristol Transport Strategy, Bristol Green Capital Partnership, Sustainable Food City status and Age Friendly City

The physical environment is a major determinant of health, wellbeing and premature mortality. Research¹⁶⁷ has shown a link between the environments people experience in their daily lives and health challenges & inequalities¹⁶⁸

A reducing number of people in Bristol (11%) use outdoor space for exercise/health reasons, lower than nationally (18%)¹⁶⁹. A model which predicts the number of visits to green spaces¹⁷⁰ estimates welfare values of £73m per year, although these benefits are not spread equally between socioeconomic groups.

Locally¹⁷¹, 76% of people are satisfied with their local area as a place to live but only 56% in the 10% most deprived areas. 71% of people are satisfied with the quality of parks and green spaces

in Bristol – fig 5.18.1 – but only 53% in the most deprived areas (and they are least likely to visit parks & green spaces weekly).

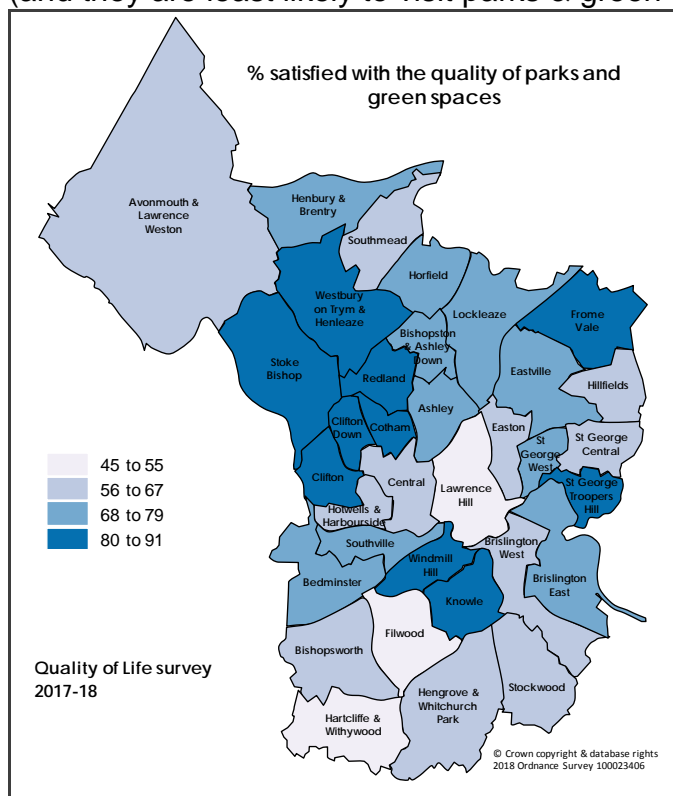


Fig 5.18.1: Bristol Quality of Life survey 2017-18

Active Travel

More people in Bristol commute to work by bicycle or on foot than in any other Local Authority¹⁷². Cycle use almost doubled (rose 94%) and walking rose 40% 2001-11. The majority of people under 40 in Bristol in employment choose not to commute by car. Promotion needs to continue to support all-age active travel in order to benefit those with poorer health outcomes.

Road traffic injuries

Bristol's rate of killed and seriously injured casualties¹⁷³ for 2014-16 (26 per 100,000) is significantly lower than the national average (40 per 100,000) and the lowest of English Core Cities. In 2016, 109 people¹⁷⁴ were killed or seriously injured on Bristol's roads, the second lowest of the English Core Cities. Bristol also has one of the lowest reported casualty rates. Despite this, Bristol has the highest casualty rates amongst the English Core Cities for pedal bikes and motorbikes.

The Bristol [Safe System approach to road safety 2015-24](#) sets out the evidence-based approach for adapting the urban environment to protect vulnerable road users and communities.

¹⁶⁷ Further links between transport and health at "Essential Evidence": www.travelwest.info/evidence

¹⁶⁸ Bird, E., Ige, J., Burgess-Allen, J., Pinto, A. and Pilkington, P. and Public Health and Wellbeing Research Group (2017) [Healthy people healthy places Technical Report](#)

¹⁶⁹ Natural England: MENE survey 2015-16, via PHOF (Sept 2018)

¹⁷⁰ Outdoor Recreation Valuation Tool (ORVal) developed by the Land, Environment, Economics & Policy Institute (LEEP) at The University of Exeter

¹⁷¹ Bristol Quality of Life survey 2017-18

¹⁷² Census 2011, Topic reports: www.bristol.gov.uk/census

¹⁷³ Police data, Dept. of Transport 2014-16 via PHOF (2018)

¹⁷⁴ www.gov.uk/government/statistical-data-sets/ras30-reported-casualties-in-road-accidents

5.19 Crime

The total number of recorded crimes in Bristol during 2017/18 was over 49,700. This has dropped slightly from last year but remains high in comparison to previous years (fig 5.19.1).

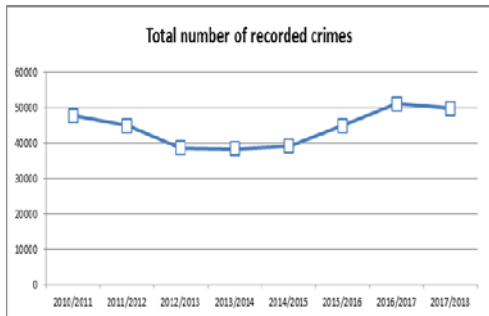


Fig 5.19.1 Number of all recorded crimes in Bristol; Source: Police data

The main areas of recorded crime are; theft and handling stolen goods and violence against the person. Violence against the person is the only crime with an upward trend (19,400 in 2017/18).

For comparison, “violence against the person” offences, (with and without injury, as a crude rate) indicate there were 31.4 violent offences (per 1,000 population) in Bristol in 2016/17, above the national average of 20.0 (fig 5.19.2). This is the second highest rate of all the English Core Cities, and 3rd highest of 16 comparable local authorities.

Gender: Police data for “violence against the person” (2017/18): 45% of victims were female and 40% male (15% unknown).

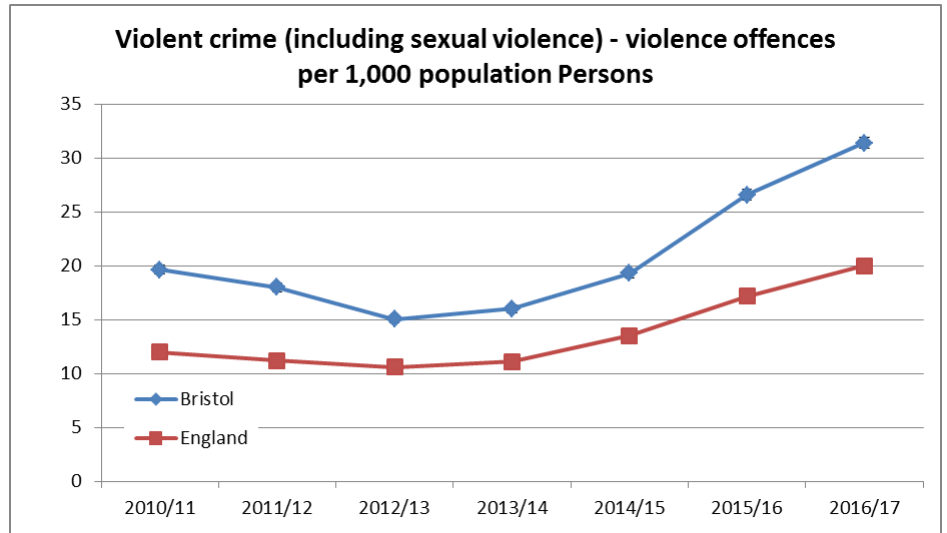


Fig 5.19.2: Recorded violent crime; Source: Home Office via PHOF, 2018

The 2017/18 crime rate (all crimes) is 110 per 1,000 population. The rates in the Central ward (428) and Hotwells & Harbourside (371) remain the highest in Bristol. Clifton, Stoke Bishop and St George Troopers Hill are lowest (under 50 crimes per 1,000) - fig 5.19.3.

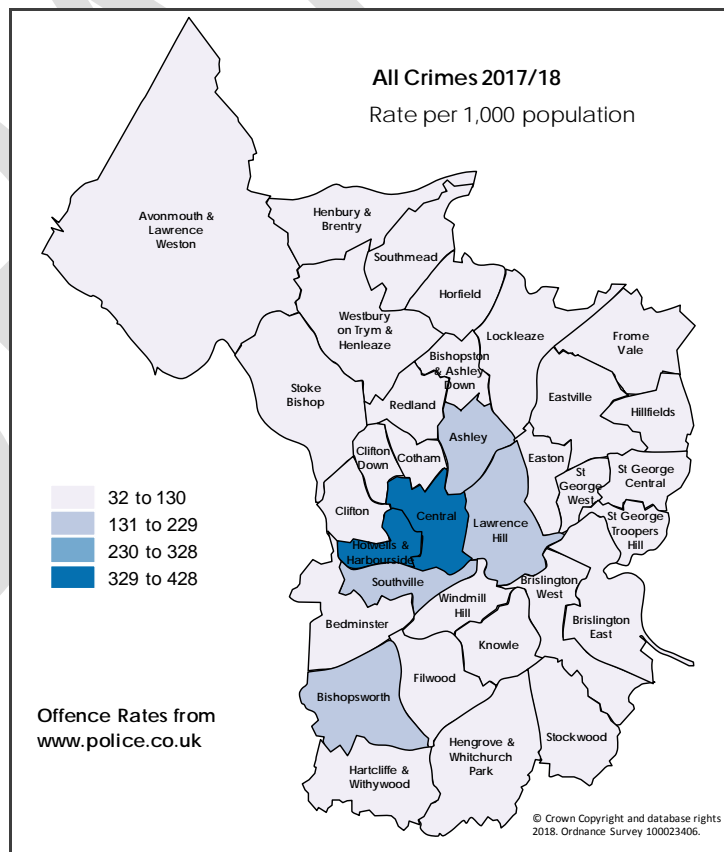


Fig 5.19.3 Rates of all recorded crimes 2017/18; Source: Police data

In 2017-18, 10% of residents said fear of crime affected their day-to-day life. However, significantly higher rates of concern were from BME people (19%), disabled people (20%) and those

in most deprived 10% (25%). By ward, the highest rates of concern were people in Lawrence Hill (24%), Filwood (22%) and Hartcliffe & Withywood (20%) – see fig 5.19.4.

Anti-Social behaviour

In 2017/18 there were 14,560 Anti-Social behaviour (ASB) incidents reported to police in Bristol. Around 85% were ‘ASB-Nuisance’ (12,470), 8% were ‘ASB-Environmental’ (1,110) and 7% were ‘ASB-Personal’ (980).

The overall number of Anti-Social behaviour incidents reported to police is driven by ASB-Nuisance incidents – see fig 5.19.5.

In 2017-18, 30% of residents thought anti-social behaviour was a problem in their local area¹⁷⁵. There is a strong link with deprivation, from 9% of people in the least deprived 10% areas to 58% in the most deprived 10% who thought anti-social behaviour was a problem locally.

By ward, Filwood (54%) and Hartcliffe & Withywood (61%) reported the most problem with this – fig 5.19.6.

Further data:

- Avon and Somerset Police and Crime Needs Assessment, 2018

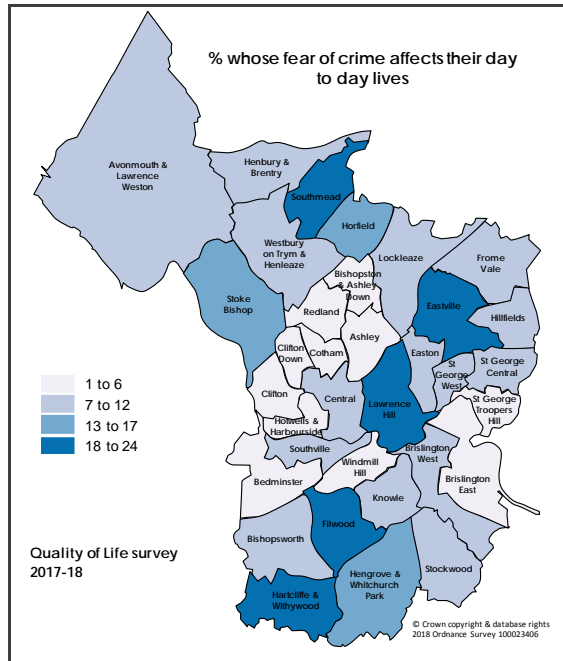


Fig 5.19.4: Fear of crime affecting daily life; Source: Quality of Life 2017-18

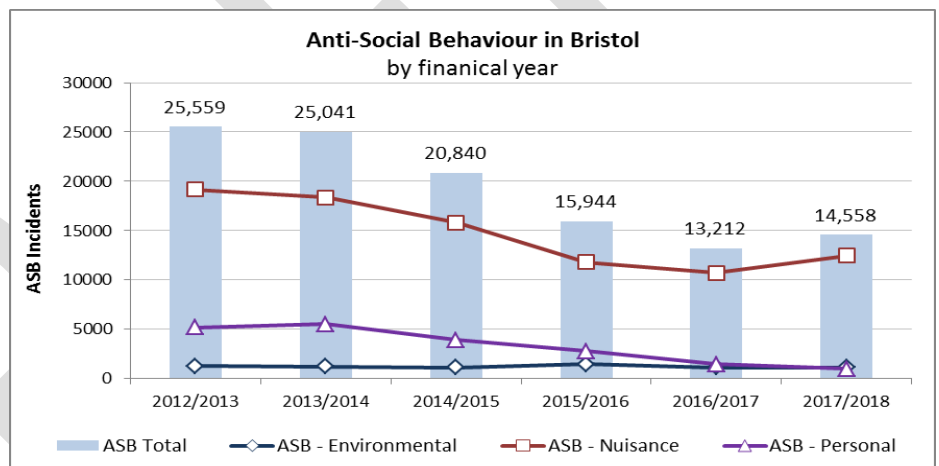


Fig 5.19.5: ASB incidents in Bristol by financial year; Source: Police data

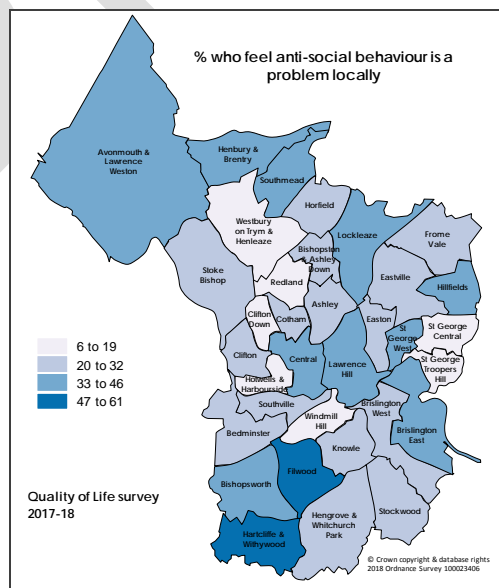


Fig 5.19.6: % who feel anti-social behaviour is a problem locally; QoL 2017-18

¹⁷⁵ Source: Quality of Life survey, 2017/18

5.20 Sexual violence and harassment

Nationally, the Crime in England and Wales survey¹⁷⁶ 2017 indicates a rising trend in Police recorded data for “Sexual offences” over the last few years. [Note - this is thought to reflect an improvement in the recording of sexual offences by the police and an increased willingness of victims to come forward to report crimes, including historical crimes¹⁷⁷].

Whilst sexual offences are still rising, the rate of increase has dropped. In Bristol the rate rose by 9% in 2016/17 from that of last year, compared to a 12% rise nationally - fig 5.20.1.

Locally, organisations such as “Somerset and Avon Rape and Sexual Abuse Support (SARSAS)” report a rise in demand for their services over the last three years to 2016/17. Of those supported 74% suffer multiple assaults and 92% know who assaulted them.¹⁷⁸

Gender: Bristol police data for “Sexual offences” in 2017/18 shows that 73% of victims were female and 12% male (with 15% unknown).

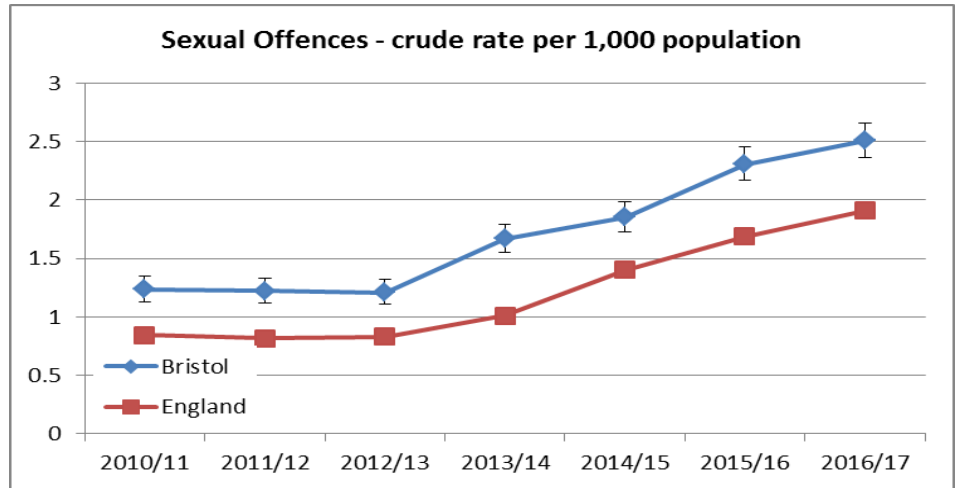


Fig 5.20.1: Rate of sexual offences; Source: Home Office via PHOF, 2018

Self-reported data from the Bristol Quality of Life survey 2017-18 indicates on average 34.9% of people feel that “sexual harassment is an issue in Bristol”. The most deprived 10% is higher at 43.8% but there is no direct connection with the level of deprivation people face. Amongst equalities groups 56.2% of 16 to 24 years and 52.7% of lesbian gay bisexual felt that sexual harassment was an issue. By ward, the highest percentages are in Eastville (53%), Lawrence Hill (48%), Easton (48%) and Southville (46%) – see fig 5.20.2.

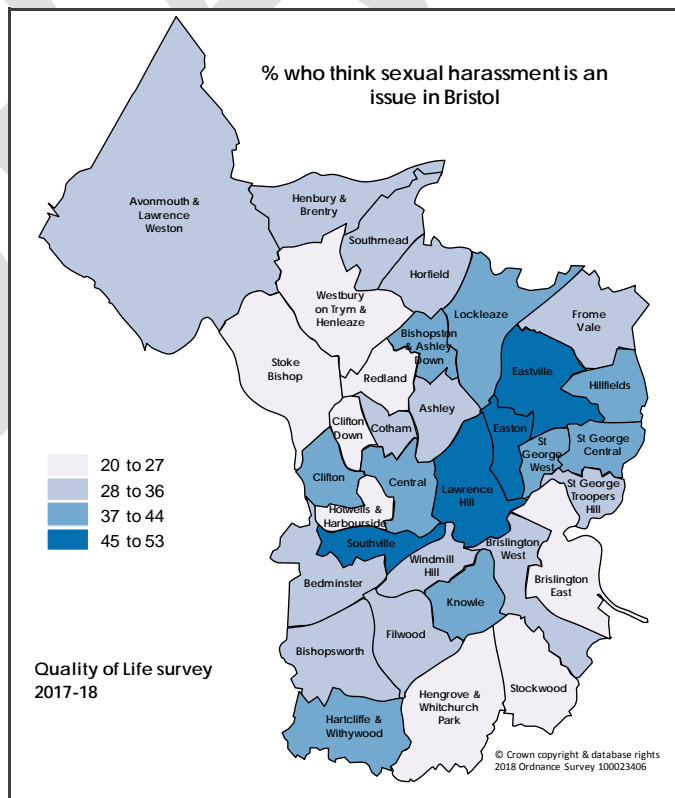


Fig 5.20.2: Source: Bristol Quality of Life survey 2017-18

¹⁷⁶ <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingdecember2017>

¹⁷⁷ Police analysis indicates that, due to newly-reported historical crimes & other issues, recorded crime data currently is not a reliable indication of trends in sexual offences.
¹⁷⁸ SARSAS Annual Report 2016/17; based on Apr 2016 to Mar 2017.

5.21 Domestic Abuse

Nationally, it is estimated 1.9 million adults (16 to 59 years) experienced domestic abuse in the year ending March 2017. Of those domestic abuse related incidents and crimes recorded by the police 46% were recorded as domestic abuse related crimes¹⁷⁹.

In 2016/17, the Bristol rate per 1,000 of 19.3 is lower than the England average (22.5 per 1000) and 2nd lowest of English Core Cities (fig 5.21.1). Note - from 2015/16, Police reporting of domestic abuse changed, so there is limited trend data. The intention is to help the Police focus on more effective interventions.

Gender: National survey data indicates that for people (16 – 59 years) who experienced partner abuse in 2016/17, 66.4% were women and 33.6% were men.¹⁸⁰

Local data on the rate of domestic abuse incidents¹⁸¹ by ward (2017/18) highlights a significant variation in rates across the city, from 2.5 per 1000 in Westbury-on-Trym & Henleaze to 28 per 1000 population in Hartcliffe & Withywood (fig 5.21.2).

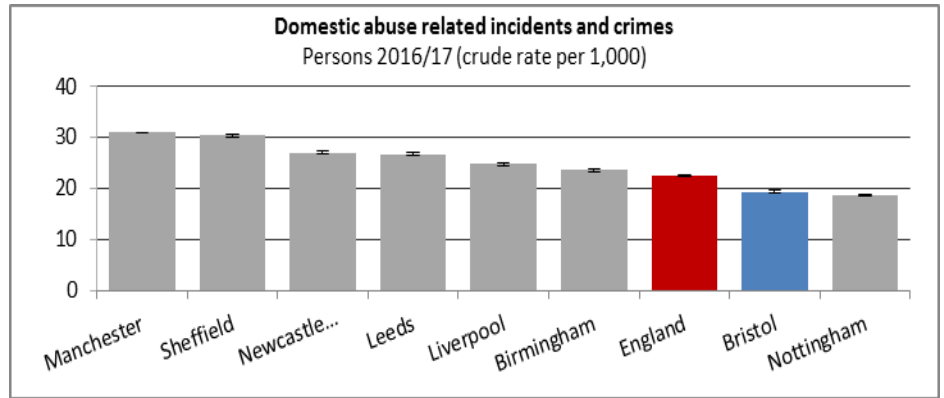


Fig 5.21.1: Rate of domestic abuse related incidents and crimes (per 1000 population over 16 years of age). Source: Police (via PHOF, 2018)

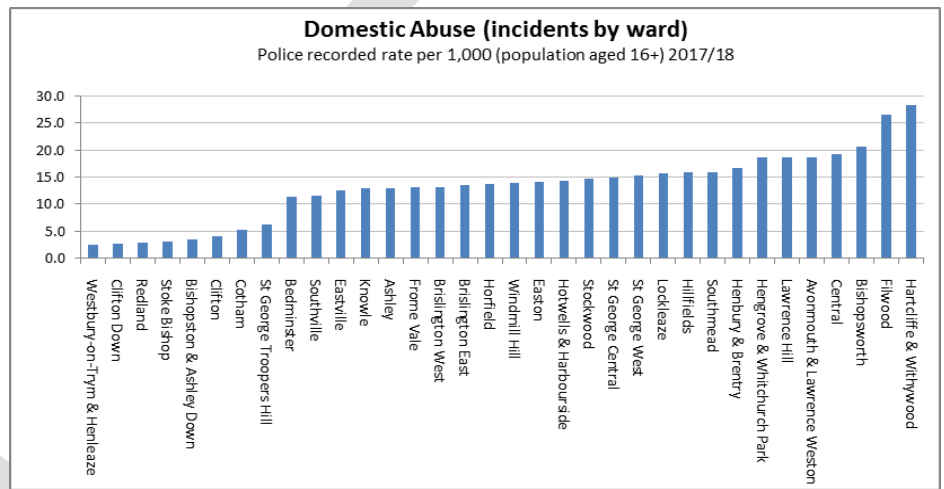


Fig 5.21.2: Rate of domestic abuse incidents 2017-18; Source Police data

The 2017-18 Quality of Life survey found 4.5% of people perceive domestic violence as a private matter. In the most deprived 10% areas, this doubled to 9.5%. By ward, this varies from 0.7% in Frome Vale who think domestic abuse is a private matter to 13.6% in Avonmouth & Lawrence Weston (fig 5.21.3). By equality group, 9.5% of those aged over 65 years thought it was a private matter.

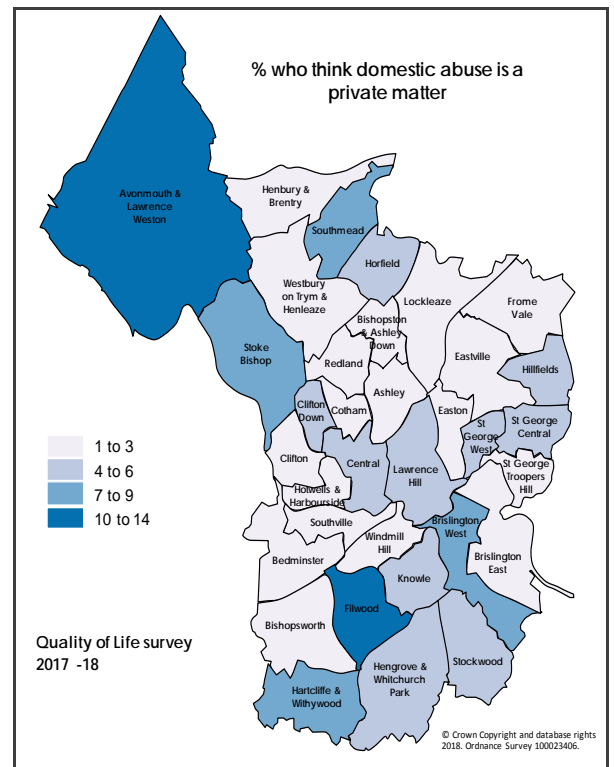


Fig 5.21.3: Source: Quality of Life survey 2017-18

¹⁷⁹ ONS [Domestic abuse in England and Wales: year ending March 2017](#)

¹⁸⁰ Crime Survey for England and Wales 2017

¹⁸¹ Police recorded data per 1000 population over the age of 16. **Note;** this local data is for Domestic Abuse Incidents only, not "Crime and incidents". Also, this data is unlikely to reflect the true extent of offending and should be used with caution. It is from the Police live data system so may change. Rates are per incident not per person, so could include multiple offences against 1 victim.

5.22 Female Genital Mutilation (FGM)

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

The FGM Enhanced Dataset¹⁸² (FGMED) supports the Department of Health's FGM Prevention Programme. Data is collected by healthcare providers in England and it is mandatory (a legal requirement) for acute hospital providers, mental health providers and GP practices to submit to the FGMED.

Because of the hidden nature of the practice of FGM and the location of the physical signs of the procedure, data is partial at best and it is not possible to assess how many UK or Bristol based women undergo FGM in a given time period. The FGM procedures could have taken place at any time (not necessarily in the last year).

Nationally, during the year April 2017 to March 2018 there were 4,495 newly recorded cases (5,585 in 2016/17).

Almost half of newly recorded cases relate to woman and girls referred in the Greater London Boroughs (44.5%), whilst 12%

were referred in the South of England.

During 2017-18 there were 200 newly-recorded FGM cases in Bristol. This is a significant decrease on the previous year resulting in 135 less cases - see fig 5.22.1.

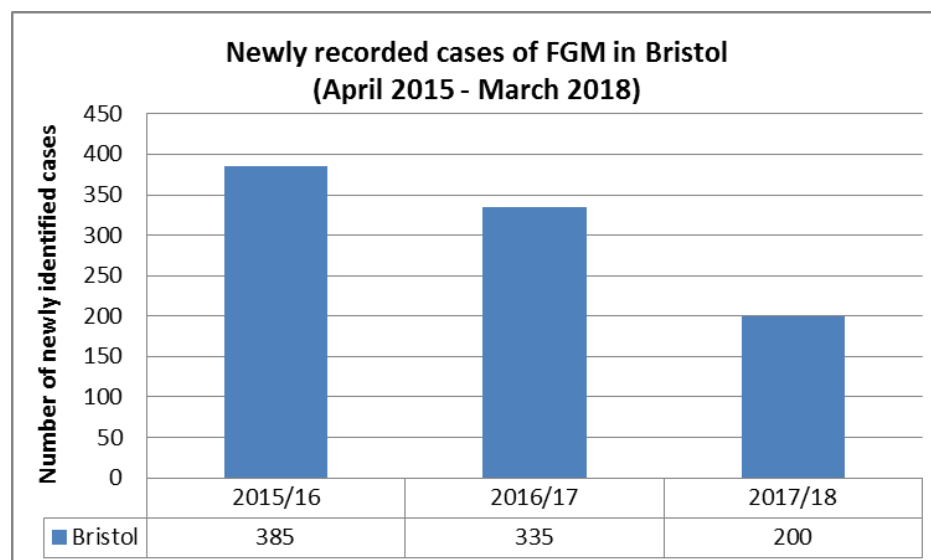


Fig 5.22.1: Numbers of newly-reported cases of FGM in Bristol; Source: BCC Public Health Knowledge Service

This data presents a picture of the prevalence of FGM amongst women and girls in Bristol (women and girls who have undergone FGM at some point in their lives).

As such we would expect the numbers of newly recorded cases to decrease each year as those living with FGM become more likely to have been captured in the data from previous years.

Bristol has a strong reputation for FGM awareness and we would therefore expect local medical staff to be able to identify FGM and record appropriately.

¹⁸²<http://digital.nhs.uk/pubs/fgm1617>

5.23 Community Assets¹⁸³

5.23.1 Neighbourhoods

76% of Bristol residents said they are satisfied with their local area (2017-18), but this varies across the city. The less deprived an area is, the more satisfied people tend to be living there, from 55.9% satisfied in the 10% most deprived areas to 94.7% in the 10% least deprived. By ward – see fig 5.23.1 - the most satisfied were in Cotham (96%) and Westbury on Trym & Henleaze (93%) and the lowest Hartcliffe & Withywood (50%) and Filwood (51%).

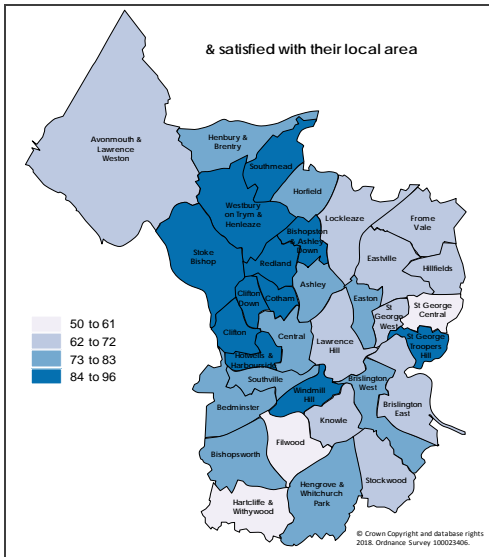


Figure 5.23.1 Source: Bristol Quality of Life survey 2017-18

Amongst equalities groups, the main difference was less disabled people (62.2%) being satisfied with their local area.

5.23.2 Volunteering

Two-thirds of all residents (66%) volunteer or “help out” at least 3 times a year. People in the most deprived 10% (68%) are as likely

to volunteer regularly as the least deprived 10% (71%). By ward, regular volunteering ranges from 50% in St George West to 80% in Bishopston & Ashley Down.

Overall, the most common category was “helping out neighbours” – fig 5.23.2.

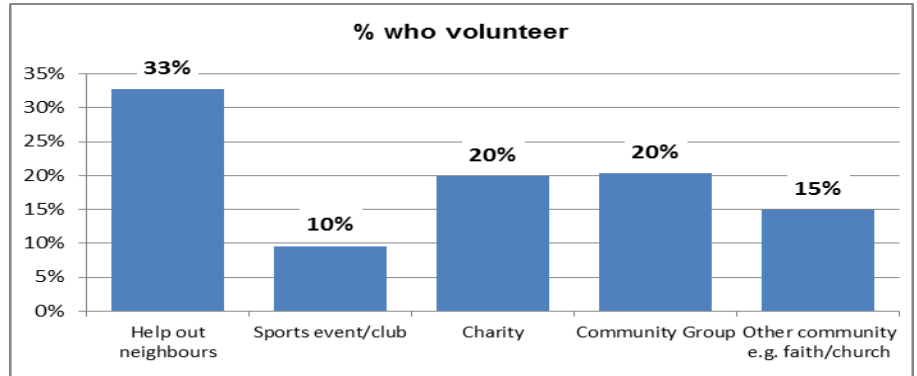


Figure 5.23.2: Source: Bristol Quality of Life survey 2017-18

Amongst equalities groups people aged 16 to 24 years were the least likely to volunteer regularly (51%), with both carers and those over 65 years most likely to (80%).

5.23.3 Influence Local Decisions

A quarter of residents (26% in 2017-18) feel they can influence decisions about their local area. Those living in outlying areas tended to feel they had less influence, but there is no discernible pattern based on deprivation. Clifton (36%) and Windmill Hill (42%) felt they had most influence, whilst St George Central (12%) and Stockwood (7%) felt they had least – fig 5.23.3.

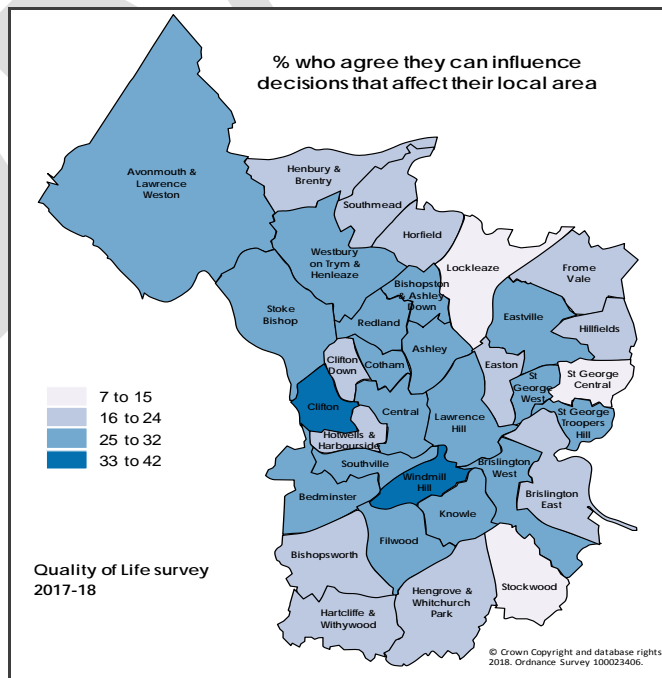


Fig 5.23.3: Source: Bristol Quality of Life survey 2017-18

¹⁸³ Source: Bristol Quality of Life 2017-18 www.bristol.gov.uk/qualityoflife

Section 6

Healthy Lifestyles

Summary points¹⁸⁴

Physical activity

- Around 2 in 3 (64%) people in Bristol are physically active (QoL 2017/18)
- Bristol has higher rates of regular physical activity than nationally or other cities (Active Lives 2016/17)

Healthy Weight

- Obesity is a key factor in the causes of premature death in Bristol from coronary heart disease and some cancers, and is a main cause of Type 2 Diabetes.
- Over half of adults in Bristol (55.2%) are overweight or obese, though this is lower than national (61.3%) and lowest of core cities
- Men are significantly more likely to carry excess weight than women, but women are more likely to be “morbidly obese”
- Significantly more residents in deprived areas are obese or overweight.

Healthy Eating

- Almost 55% of adults report having “5 a day” fruit & veg (QoL 2017/18) but there is significant variation across Bristol
- There are 4 times as many Takeaways (including Takeaway Café/Coffee & Sandwich shops) than businesses selling fresh food ingredients (including supermarkets, butchers, bakers, greengrocers, etc.)
- 62 food businesses have so far achieved a Bristol Eating Better Award.

Smoking

- Bristol’s estimated level of smoking has continued to fall faster than nationally – in 2017, only 11.1% of Bristol adults smoke, down from 21% in 2012, and now below the national average (14.9%).
- However, smoking-related deaths in Bristol remain significantly higher than the England average rate.

Alcohol

- Health advice is not to drink more than 14 units per week, to keep health risks from drinking alcohol to a low level. 22.3% of people in Bristol drink more than this, similar to nationally (25.7%).
- Alcohol-related hospital admissions in Bristol remain significantly higher than the England average for both men and women.
- Alcohol-related deaths in men are significantly higher than nationally, but rates are starting to fall

Substance misuse

- Drug treatment completion rates in Bristol appear to be falling for opiate users (similar to national), and remain significantly worse than nationally for non-opiate users
- The rate of Bristol deaths from drugs misuse remains significantly higher than the national rate

¹⁸⁴ This section looks at adults. Issues for Children and Young People are in Section 4

6.1 Physical activity

People who are not physically active have a 20-30% higher risk of coronary heart disease, stroke, diabetes and cancer compared to those who are active¹⁸⁵. Regular physical activity (even just in bouts of 10+ minutes) can also improve mental health and increase lifespan by 3–5 years.

Bristol’s Quality of Life survey 2017/18 found 64% of people are physically active¹⁸⁶ (taking at least 150 mins a week of moderate or 75 mins a week of vigorous exercise).

Across Bristol the rate varies from 45% in Avonmouth and Lawrence Weston to 76% in the wards of Clifton, St George West and Hotwells & Harbourside - see fig 6.1.1.

Also, national survey data¹⁸⁷ asks the same question, but has a different population group and approach to weighting the results which may not be an accurate picture for Bristol. However, it is useful for comparing to other places. This figure of 74.3% of Bristol adults being physically “active” is significantly higher than the national average (66%) and the highest of Core Cities. However, 1 in 4 do not get sufficient physical activity, and 16.9% are “inactive” (less than 30 mins/wk moderate exercise).

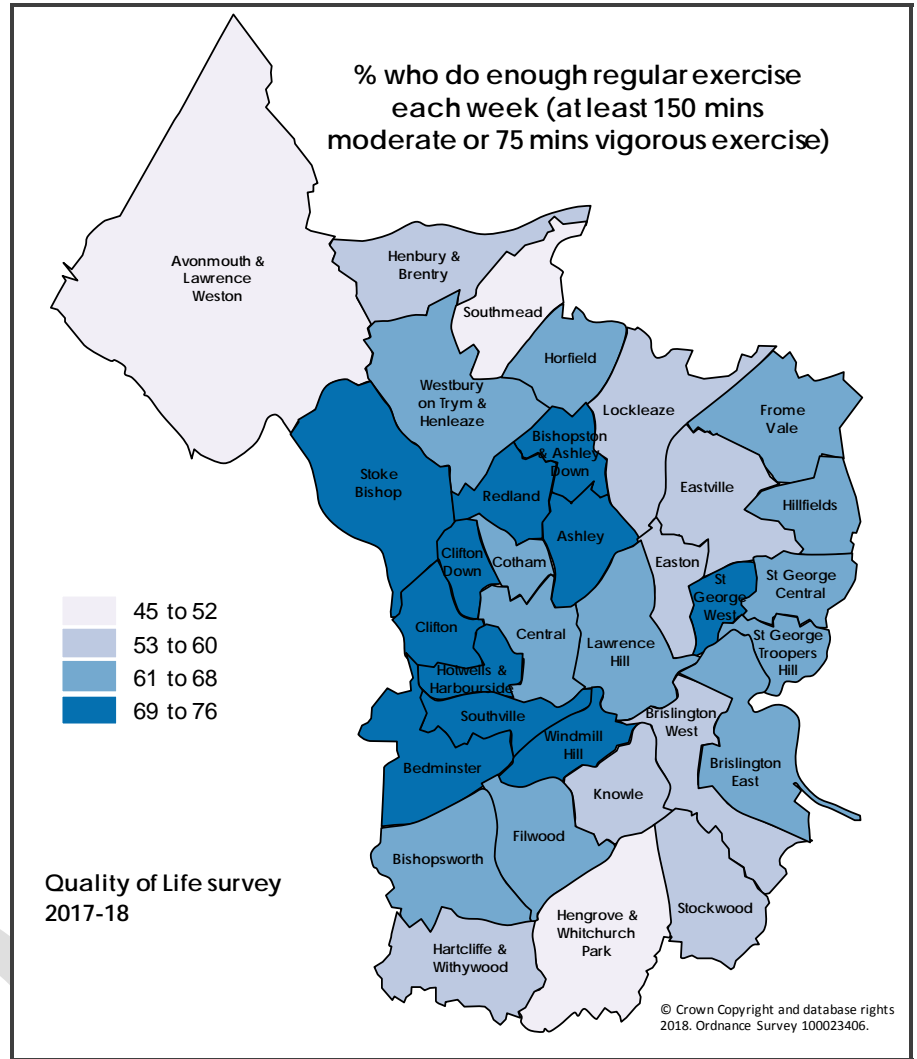


Fig 6.1.1: Physically active people. Source: Quality of Life survey 2017-18

Further population breakdowns available through the Bristol Quality of Life survey 2017/18 include:

Gender: Women (62%) are less likely to be physically active than men (67%)

Ethnicity: BME groups (52%) are less likely to be physically active

Deprivation: 59% of people living in the 10% most deprived areas undertake regular exercise, broadly similar to the Bristol average (64%)

In addition, 45% of people in Bristol stated they play sport at least once a week¹⁸⁸. In the most deprived areas though, only 32% of people play sport weekly - a significant gap of 13%.

¹⁸⁵ Source: Public Health England (PHOF) / Also see BCC & TravelWest briefing note on [The harms of physical inactivity](#) (May 2018)

¹⁸⁶ Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

¹⁸⁷ Source: Active Lives survey 2016/17, Sport England; (via PHOF May 2018). New methodology: % adults doing 150+ mins/wk of moderate physical activity or 75+ mins/wk of vigorous

¹⁸⁸ Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

6.2 Healthy Weight

Over half of the Bristol population are overweight or obese (55.2%, Active Lives survey, 2016/17)¹⁸⁹. However, this is significantly better than the national average (61.3%) and is the lowest of core cities.

Locally, the 2017/18 Quality of Life survey¹⁹⁰ provides a slightly lower estimate of 51% adults with excess weight (BMI ≥ 25)¹⁹¹, but can be used to highlight local differences:

- Variation across Bristol wards (fig 6.2.1) is from only 34% of residents in Cotham to 70% of residents in Stockwood and in Henbury & Brentry. In particular variance between lower rates in more central wards and higher in more outlying ones, but this is likely partly linked to age and deprivation patterns.
- Significantly more disabled people (68%) and people over 50 (61%) have excess weight than the city average (51%).
- Further Quality of Life data indicates that over 18% of residents in Bristol are “obese” (BMI ≥ 30).
- **Gender:** Men (56%) are more likely to carry excess weight than women (47%), but women

are more likely to be “morbidly obese” (BMI ≥ 40).

- **Ethnicity:** BME groups (53%) are similar to average
- **Deprivation:** 60% of people living in the 10% most deprived areas have excess weight, significantly above the 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.

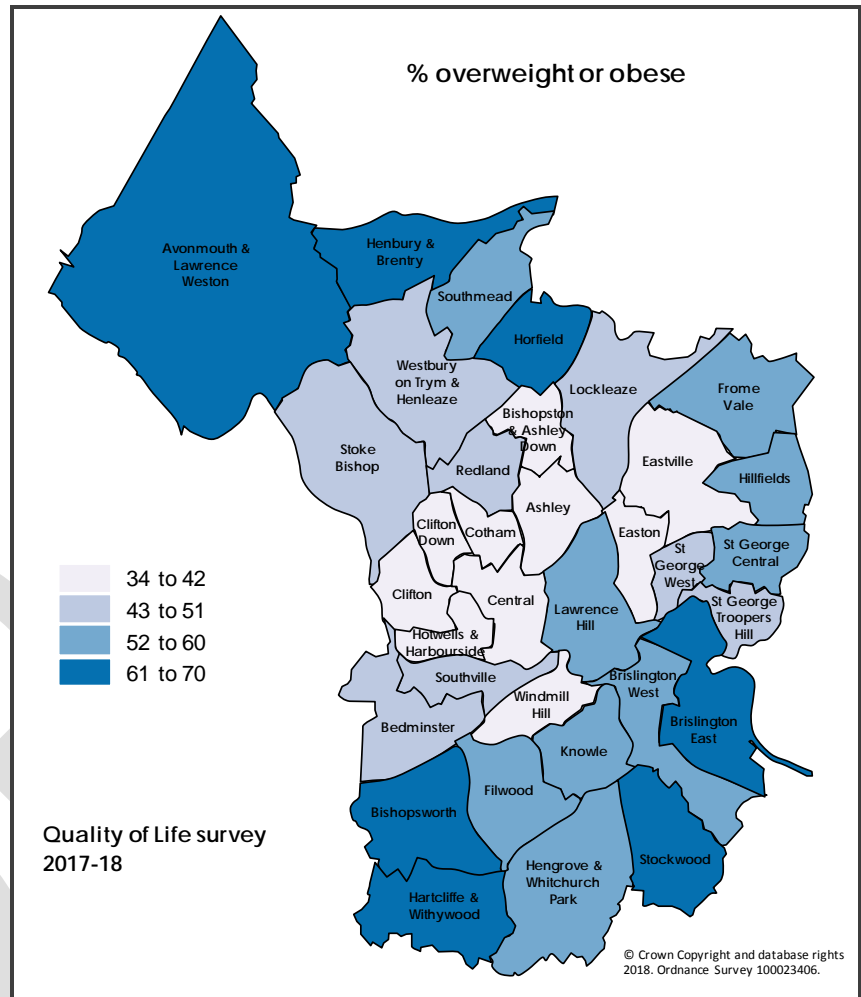


Fig 6.2.1: % Overweight & obese, Source: Quality of Life survey 2017-18

Some of the larger outer lying areas of the city have the higher levels of obesity where most central wards have lower levels.

To tackle the issue of obesity there will be further work to support changes to the obesogenic environment (an environment that promotes gaining weight and is not conducive to weight loss) and encourage healthier lifestyles.

¹⁸⁹ Active Lives survey, Sport England, 2016/17 (via PHOF Sept 2018)

¹⁹⁰ Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

¹⁹¹ 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 is adjusted for this to estimate the likely actual height and weight of individuals, and so produce more accurate BMI estimates.

Normal BMI is 18.5 – 24.9 kg/m2.

6.3 Healthy eating

The Eatwell Guide (PHE 2016) details the government’s recommendations for achieving a healthy diet. It is recognised that people living in more deprived areas are less likely to achieve these recommendations

Fruit & Vegetable consumption

Bristol’s Quality of Life Survey¹⁹² indicates 54.8% of adults in Bristol are meeting the recommended “5 or more portions of fruit and vegetables a day”. This is higher than the previous year (50.5%), with national survey estimates indicating that a higher proportion of Bristol residents are eating 5-a-day than the national average.

By ward, people having 5-a-day of fruit & veg ranges from 37% in St George Troopers Hill to 66% in Southville (fig 6.3.1), but 5-a-day figures show no clear relationship with deprivation.

Public Health England’s model estimate suggests Bristol adults consume an average of 2.6 portions of fruit & veg/day.

Sugar consumption

An average of 43% of Bristol residents eat more than the recommended daily max amount of sugar (7 teaspoons)¹⁹³. Three wards in the most deprived areas (Hartcliffe & Withywood; Henbury & Brentry; and Southmead) show 60% of residents eating more than the recommended daily max amount of sugar.

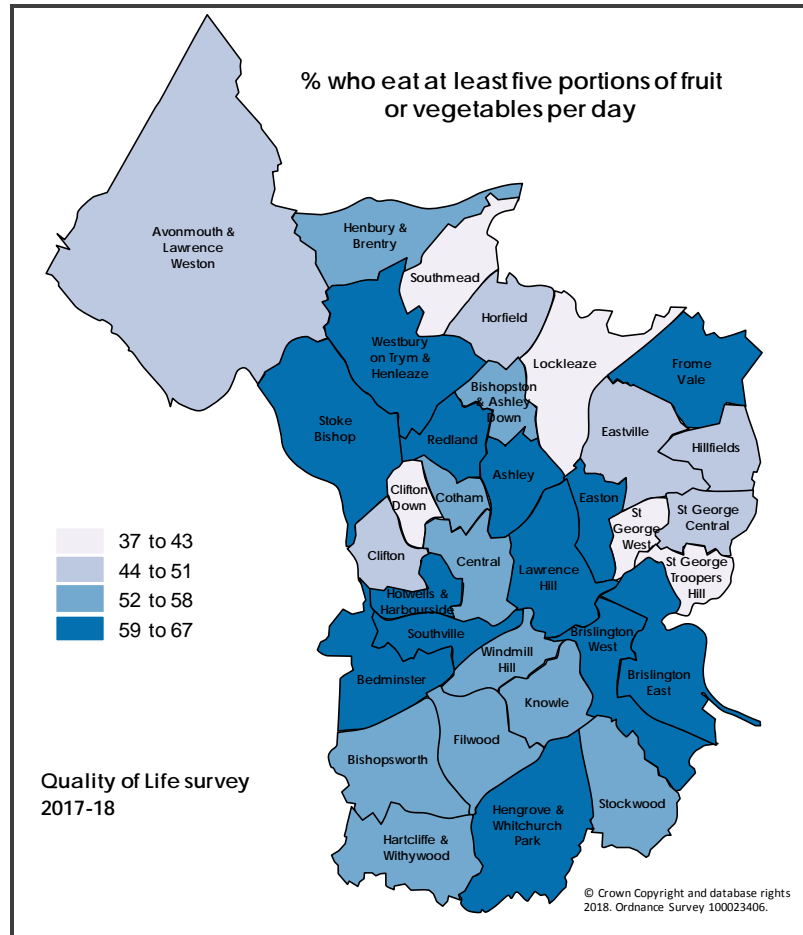


Fig 6.3.1 % eat 5-a-day, Source: Quality of Life survey 2017-18

Food outlets

2018 Food Premises data¹⁹⁴ indicates there are approximately 500 Hot Food Takeaways, 600 Café/Coffee /Sandwich shops and a further 300 convenience stores/newsagents in Bristol. In contrast to this there are only 250 businesses selling fresh food ingredients (eg. supermarkets, butchers, bakers, greengrocers)

Eating out or using takeaways is on the increase, with 65.3% of survey respondents reporting they eat out or get a takeaway at least once per week¹⁹⁵

Nationally, there is an association between obesity rates, deprivation and areas with the highest densities of fast food outlets. Locally, outside the city centre, Lawrence Hill, Easton and Ashley wards have the highest number of Hot Food Takeaways¹⁹⁶. Work is underway to encourage healthier ‘out of home’ food provision, including the recent Bristol Eating Better Award Scheme, which currently has awarded 62 food outlets.

Further information: Refer to section 4.12 for eating behaviours of Children and Young People.

¹⁹² Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

¹⁹³ Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

¹⁹⁴ BCC Registration of Food Premises data (Civica database 2018)

¹⁹⁵ Bristol Citizens’ Panel survey April 2017, BCC Insight Performance & Intelligence

¹⁹⁶ PHE Density of fast food outlets in England. Summary LA Data (2018)

6.4 Smoking¹⁹⁷

The number of smokers in Bristol is falling. In 2017, 11.1% of Bristol adults smoke¹⁹⁸, down from 21% in 2012. It is now better than the national average for 2017 of 14.9% (fig 6.4.1).

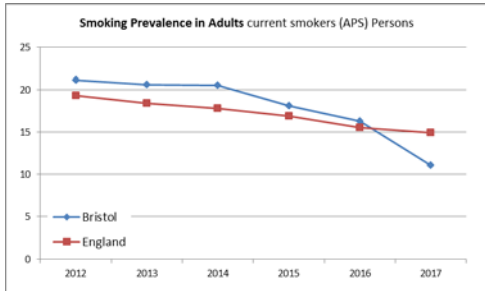


Fig 6.4.1: Smoking prevalence in adults – current smokers 2017.

Gender: Women (13%) were significantly less likely to smoke than men (16.8%) in 2017.

Local Quality of Life Survey¹⁹⁹ data shows the number of households with a smoker is 21.6%. However, this is significantly higher in the most deprived areas (29.1%).

Variation across the city is from 3% of households in Hotwells and Harbourside to 40% in Hartcliffe & Withywood (fig 6.4.2).

Ethnicity: BME groups (22%) are less likely to live with a smoker than the WME groups (29%)**Error! Bookmark not defined.** Prevalence rates vary between different ethnic groups, more work is required to understand local variations and

potential interventions to meet needs.

Disability: 20% of the disabled group live with a smoker

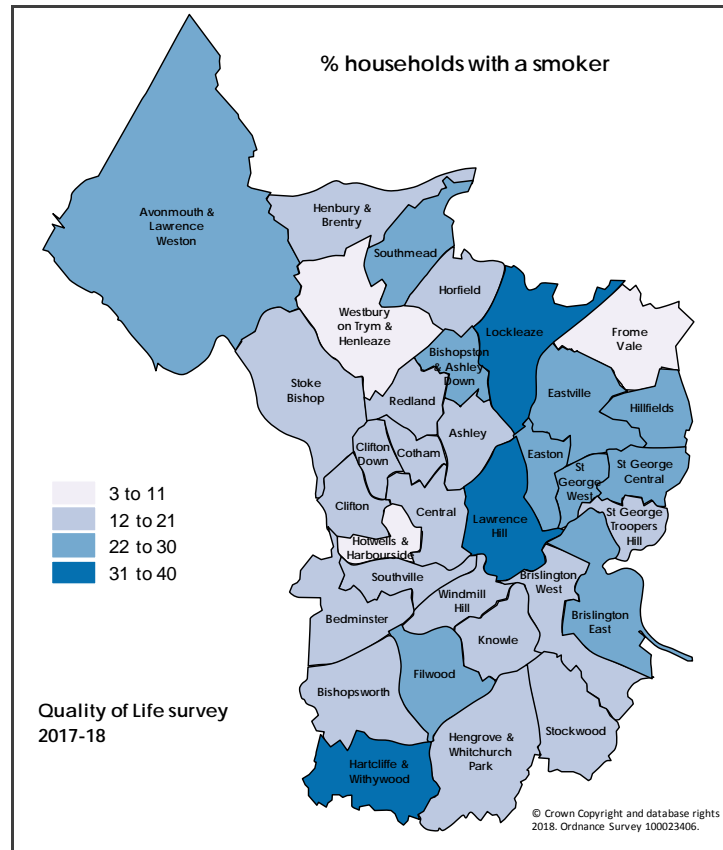


Fig 6.4.2: % Households with a smoker, Source: Quality of Life 2017-18

Hospital admissions

There were over 4,100 smoking-related hospital stays²⁰⁰ in Bristol in 2016/17, a rate of 2,162 per 100,000 population. This is significantly worse than the national average (1,685 per 100,000) and has stayed largely the same as last year (fig 6.4.3).

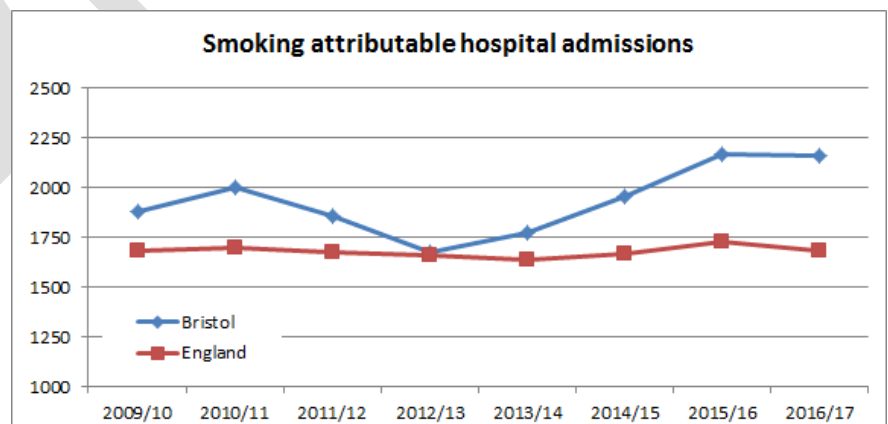


Fig 6.4.3: Smoking attributable hospital admissions: Source: NHS Digital-Hospital Episode Statistics (HES), Office for National Statistics (ONS) via PHOF Feb 2018

¹⁹⁷ Data on smoking rates in young people and on smoking during pregnancy are in the JSNA **Child Health** section

¹⁹⁸ Annual Population Survey (APS) 2016, via PHOF, Feb 2018

¹⁹⁹ Bristol Quality of Life survey 2017/18

²⁰⁰ Hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, directly age standardised rate per 100,000 population. Source: Health and Social Care Information Centre, via Bristol Tobacco Control Profile 2016

Smoking-related deaths

There were 1,745 smoking-attributable deaths²⁰¹ in the 3 year period 2014-16. This is a rate of 306 smoking-related deaths per 100,000 which is significantly worse than the England average (272 per 100,000) (fig 6.4.4).

Historically Bristol had high smoking rates (linked to being a centre for cigarette manufacture) and to at least a limited extent, this may be responsible for our unusually high smoking-related mortality rates. Further work is required to fully identify the reasons for this difference.

Smoking cessation services

The rate of “successful quitters at 4 weeks” per 100,000 smokers in Bristol has continued to fall²⁰² (1,538 per 100,000 in 2016/17). This rate is falling nationally, but Bristol remains significantly lower than the national average rate for smoking quitters (2,248 per 100,000).

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

Smoking attributable deaths

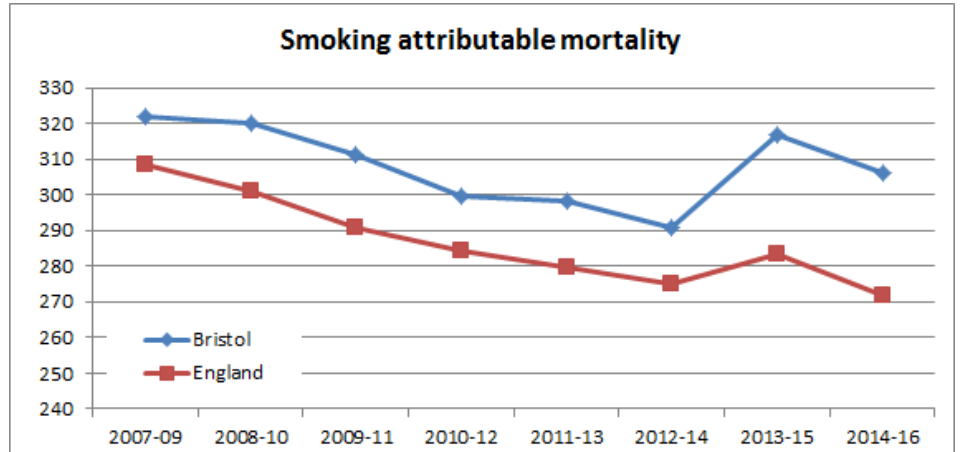


Fig 6.4.4: Smoking attributable deaths. Source: ONS mortality file via PHOF Feb 2018

Further data

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

²⁰¹ Source: ONS and smoking status from Integrated Household Survey / Annual Population Survey, plus Health and Social Care Statistics on Smoking – via Bristol Tobacco Control Profile 2018

²⁰² Public Health England, via Bristol Tobacco Control Profile 2018

6.5 Alcohol

Alcohol plays an important part in our social lives and in the local economy, but excessive intake of alcohol has clear negative effects on health and on crime²⁰³. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities in Bristol have risen, and health problems caused by heavy drinking are being identified in young people²⁰⁴. Excessive drinking has been recognised as a major cause of a wide range of diseases and injuries.

Safe levels of drinking

2016 guidelines²⁰⁵ to limit the health risks associated with the consumption of alcohol include:

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink over 14 units / week, it is best to spread this evenly over 3 days or more (not heavy drinking sessions)
- The risk of developing a range of illnesses increases with any amount you drink on a regular basis.
- A good way to cut down the amount you're drinking is to have several drink-free days each week.

Alcohol consumption in Bristol

Health Survey for England data²⁰⁶ (2011-14) has been used to estimate that for adults in Bristol:

- 15.6% do not drink at all, similar to nationally (15.5%)
- 22.3% drink more than 14 units a week, similar to nationally (25.7%)
- 18.4% “binge drink” at least once a week (women more than 6 units in a day, men more than 8 units), similar to nationally (16.5%)

The Bristol Quality of Life survey 2018 will be used to provide a local update on some of these figures in future.

Hospital admissions²⁰⁷

There were over 3,000 hospital stays in Bristol due to alcohol-related harm²⁰⁸ in 2016/17, a rate of 776 persons per 100,000 population. This remains significantly worse than the national average (636 per 100,000) - fig 6.5.2. Amongst the English Core Cities, Bristol is mid-ranking.

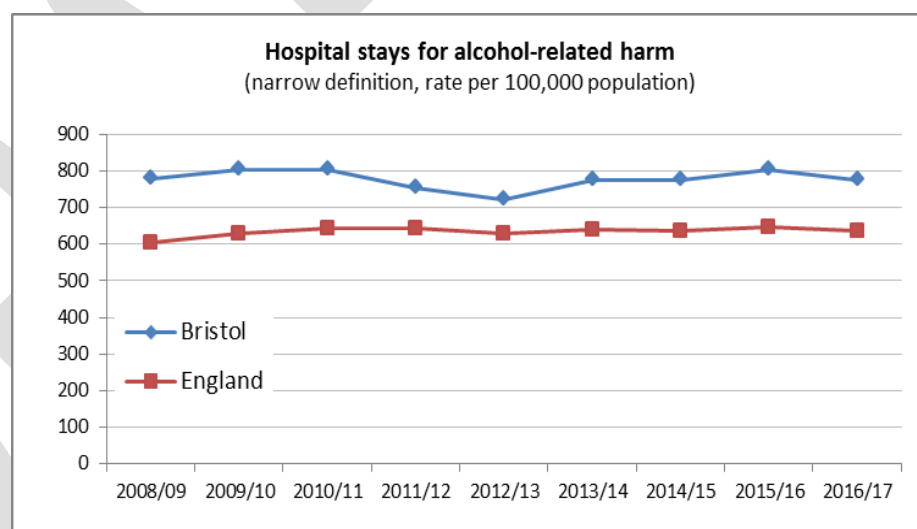


Fig 6.5.2. Alcohol-related hospital admissions (using the ‘narrow definition’)

Gender: Of the 2016/17 Bristol hospital admissions due to alcohol-related harm, 1,800 were men and 1,240 women. As rates, 971 men and 599 women per 100,000 were admitted – both rates are significantly worse than nationally.

Deprivation: Local data²⁰⁹ on emergency hospital admissions in 2016/17 show that 14% of alcohol-related emergency hospital

²⁰⁶ Source: Health Survey for England 2011-14, via PHE [Local Alcohol Profiles](#) (accessed Sept 2018)

²⁰⁷ Data via PHE [Local Alcohol Profiles](#) (accessed Sept 2018)

²⁰⁸ Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population.

Source: Public Health England, via PHOF / Health Profile / Local Alcohol Profile 2018

²⁰⁹ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

²⁰³ [Government Alcohol Strategy, 2012](#)

²⁰⁴ See section “4.13 Lifestyle behaviours of Young People”

²⁰⁵ [UK Chief Medical Officers’ Low Risk Drinking Guidelines, Aug 2016](#)

admissions of Bristol patients (2016/17) were people living in the 10% most deprived areas. However, a further 16% of emergency alcohol-related admissions had no recorded address, which includes patients of no fixed abode.

A separate indicator for alcohol-related hospital admissions is the “broad definition”²¹⁰, which includes any alcohol-attributable secondary diagnoses. In 2016/17 the “broad” Bristol rate was 2,729 per 100,000, significantly worse than England average (2,185 per 100,000).

Treatment

During 2017, there were over 800 Bristol clients in treatment for alcohol use²¹¹. Of these, 30.7% completed treatment successfully (did not re-present to treatment within 6 months), still significantly below the national average (38.9%) – see fig 6.5.3.

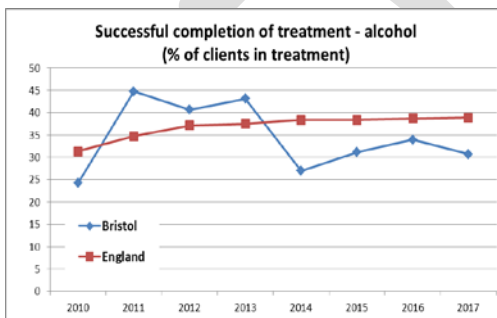


Fig 6.5.3: Treatment success rates – alcohol; Source: National Drug Treatment Monitoring System (June 2018)

Gender: Almost two thirds (63%) of clients in treatment for alcohol use²¹² in Bristol are male, and 37% female

Alcohol-related deaths²¹³

There were 131 Alcohol-specific deaths in Bristol in 2014-16, a rate of 12.5 per 100,000 population. This is significantly worse than nationally (10.4 per 100,000), but does appear to be falling.

Gender: Of the 2014-16 Alcohol-specific deaths in Bristol, 100 were men and 31 women. The Bristol male rate is 19.1 deaths per 100,000, higher than nationally (14.2), but the female rate is 6.0 per 100,000, similar to national (6.8) - see fig 6.5.4.

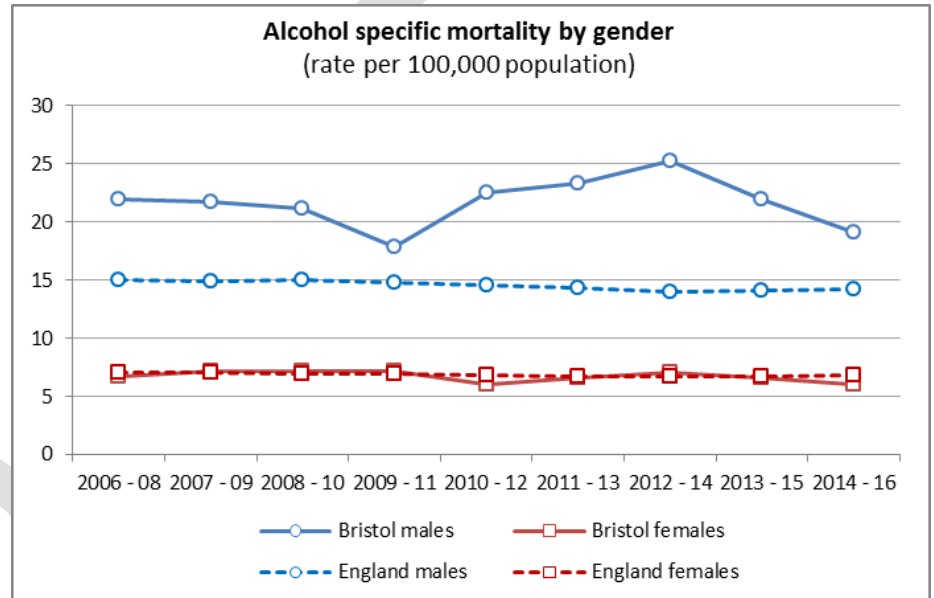


Fig 6.5.4. Alcohol-specific mortality by gender; Source Public Health England

Further data and information

- PHE [Local Alcohol Profiles](#)
- JSNA chapter - [Alcohol misuse: adults 2017](#)
- [Bristol city-wide Alcohol Strategy 2016–20](#)

²¹⁰ This includes the primary admissions from the “narrow definition”, plus those where “the secondary diagnoses are an alcohol-attributable code” plus any child admissions due to alcohol-specific conditions or low birth weight. Source: PHE [Local Alcohol Profiles](#)

²¹¹ Jan-Dec 2017; Source: National Drug Treatment Monitoring System <https://www.ndtms.net/>

²¹² Local Drug Treatment Monitoring data for 2017; Source: BCC Insight, Performance & Intelligence

²¹³ Data via PHE [Local Alcohol Profiles](#) (accessed Sept 2018)

6.6 Substance misuse

Substance misuse causes serious harm to individuals, families and communities²¹⁴. The proportion of Bristol residents using drugs is relatively small but the impact is extensive.

The links between substance misuse and crime are well established. Drug use also has health implications such as the blood borne viruses, drug related deaths, long term health conditions and a negative impact on mental health. Treatment helps to reduce the strain on local health and criminal justice services plus improves the wellbeing of individuals and communities.

It is also important to recognise the longer term consequences. The children of drug-using parents are at an increased risk of abuse or neglect and have a higher likelihood of developing substance misuse problems themselves. Parental drug use was cited as a risk factor in a third of all serious case reviews.

6.6.1 Bristol opiate & crack prevalence

Bristol has an estimated 4,700 opiate and/or crack users²¹⁵. Whilst the proportion of Bristol residents using drugs is relatively small the impact can be extensive. Bristol has the second largest estimated rate of opiate and/or crack users (per 1,000 population) of the core cities and the largest proportion of very high complexity

clients which makes them more likely to be in treatment for longer and need specific support.

In line with national trends, the number of new clients with opiate issues is gradually reducing; however with an ageing population of opiate users in treatment, this presents different challenges.

6.6.2 Treatment completion rates

Bristol had over 2,600 clients in treatment for opiate use in 2017, and over 700 for non-opiate use.

The percentage of opiate drug users that left drug treatment successfully and did not re-present to treatment within 6 months has been falling in recent years and by 2017 was down to 6.9%, similar to the national average (6.5%) - fig 6.6.2a – though compares well to core cities.

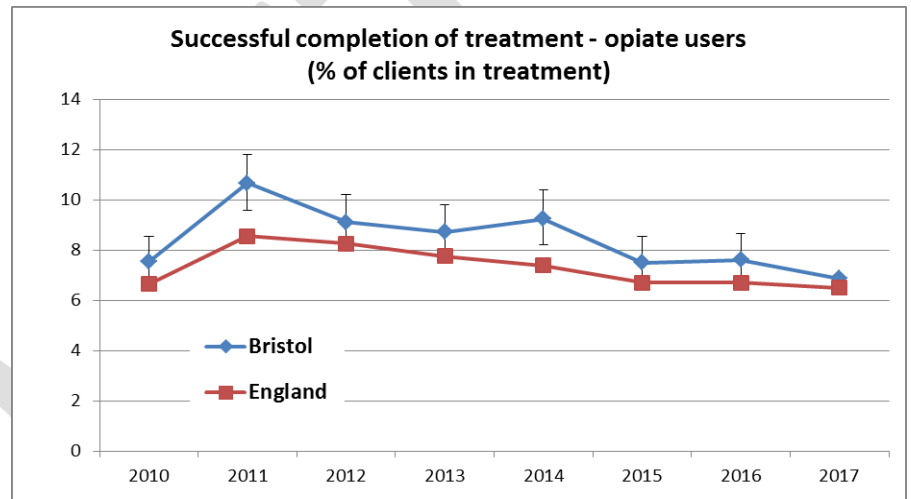


Fig 6.6.2a: Treatment success rates – opiate; Source National Drug Treatment Monitoring System (June 2018)

The success rate for non-opiate users (who left drug treatment successfully and did not re-present to treatment within 6 months) was 31.4%, significantly worse than the national average (36.9%) - fig 6.6.2b.

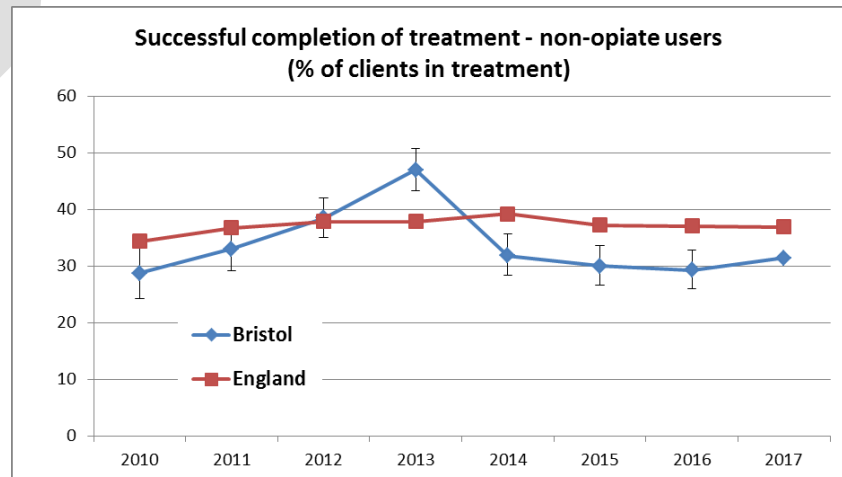


Fig 6.6.2b: Treatment completion rates – non-opiate users; Source National Drug Treatment Monitoring System (June 2018)

²¹⁴ For Children and Young People, see “4.13 Lifestyle behaviours of Young People”

²¹⁵ 2014/15 Opiate & crack cocaine use: prevalence estimates

Gender: Over two thirds (72%) of opiate users in treatment²¹⁶ in Bristol are male, and 28% female

6.6.3 Drug Related Deaths

Bristol deaths from drugs misuse per 100,000 remains significantly higher than the national rate. For the period 2015-17, Bristol had 6.7 per 100,000 deaths from drug misuse, compared to 4.3 per 100,000 nationally (fig 6.6.3). However, Bristol is mid-ranking when compared to the English Core Cities.

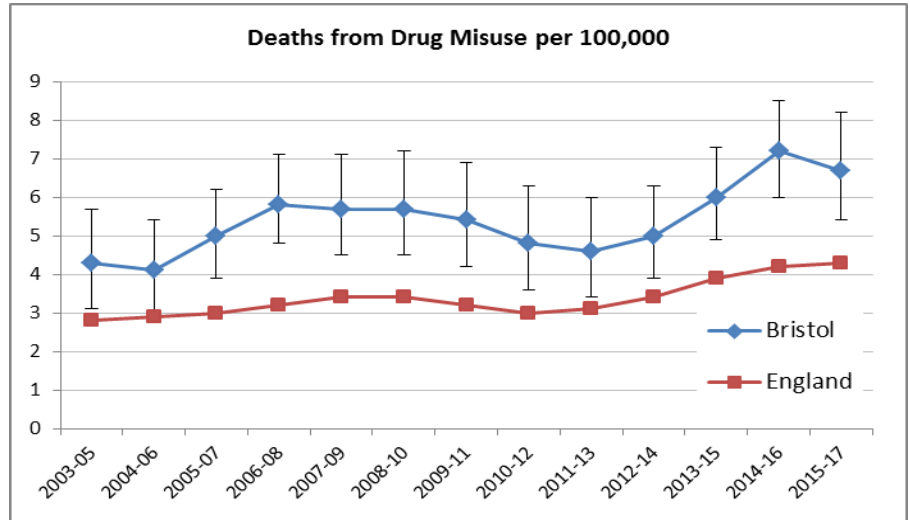


Fig 6.6.3: Deaths from drug misuse per 100,000, via PHOF (2018)

Further data and information

- National Drug Treatment Monitoring System <https://www.ndtms.net/>

²¹⁶ Local Drug Treatment Monitoring data for 2017; Source: BCC Insight, Performance & Intelligence

Section 7

Health Protection and Sexual Health

Summary points

Sexual health is not just about preventing disease or infection. It also means promoting good sexual health in a wider context, including relationships, sexuality and sexual rights.

Local authorities are mandated to provide or make arrangements to secure the provision of open access sexual health services in their area. This includes the testing and treatment for sexually transmitted infections (STIs) and the full range of contraception.

STIs

- The 2017 rate of new STI diagnoses in Bristol (excluding chlamydia in under 25's) is considerably higher than the national average
- From October 2017 there has been a notable increase in syphilis cases diagnosed in local sexual health services

Chlamydia

- Bristol has above average coverage for chlamydia screening (24.6% of 15 to 24 year olds were screened in 2017).
- However chlamydia detection rates (1,691 per 100,000 in 2016) are significantly below the national recommendation of 2,300 per 100,000

HIV

- The diagnosed prevalence rate of HIV has risen in recent years and is similar to the national average. The increase reflects people living longer with HIV as a result of effective treatment, rather than an increase in new diagnoses.
- 44% of new HIV diagnoses are considered to be "late" in Bristol, higher than the national average of 40.1%

Health Protection seeks to prevent or reduce the harm caused by diseases, and minimise the health impact from environmental hazards.

Health Protection covers communicable disease control, infection prevention and control, emergency planning, environmental health, and screening and immunisation programmes, as well as antimicrobial resistance (anti-biotics).

TB

- The TB rate for Bristol is significantly higher than the rate for England but has reduced to 14.8 new cases per 100,000 population in 2016, the lowest annual incidence rate since 2003.

Flu

- The risk of complications from flu is greater in children under six months of age, older people, pregnant women and those with underlying conditions such as diabetes and liver disease.
- Flu vaccinations for school children in Years 1 and 2 has improved significantly over a two year period from 15.3% to 50.4% (Year 1) and from 13.4% to 47.1% (Year 2) following a switch from a pharmacy based model to a school based model

Antimicrobial resistance

- Infection prevention and control is fundamental to stop the spread of infectious and communicable disease
- Overuse and incorrect use of antibiotics are major drivers of antibiotic resistance. Rates of "broad-spectrum antibiotics" in Bristol have historically been significantly higher (worse) than the national average but are now falling and reducing the gap

7.1 Sexual Health²¹⁷

Efforts to improve the sexual health of the population are a public health priority. Sexually transmitted infections (STIs) can have lasting long-term and costly complications if not treated and are entirely preventable. There are also health benefits from people with HIV being diagnosed and starting treatment earlier, minimising the use of health and social care services.

Unplanned pregnancies have a major impact on individuals, families and the wider society. Prevention of unintended pregnancies and control over reproductive choices preserves good mental and psychosexual health. Poor relationships, coercion and sexual bullying can have a lasting effect on an individual's mental wellbeing, self-esteem and confidence.

Although progress has been made (eg in the reduction in teenage conceptions and increasing access to sexual health services), high levels of need still exist.

Bristol has a relatively young population compared to England as a whole and this is predicted to rise. The city is ethnically diverse and has areas of high deprivation. There is an active lesbian, gay, bisexual and trans (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), trans community, 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.

7.1.2 Sexually transmitted infections (STIs)

There are high diagnosis rates of STIs in Bristol²¹⁸. The rate of new STI diagnoses in Bristol in 2017 (excluding chlamydia in under 25 year olds) is 1,011 per 100,000 population which continues to be significantly higher than the national average (794 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. The impact of STIs remains greatest in young heterosexuals aged 15 to 24 years, black ethnic minorities and men who have sex with men.

A current concern has been the observed increase in syphilis cases diagnosed by local sexual health services. Cases have been seen in MSM but women and heterosexual men have also been affected. These cases have been diagnosed at various stages of syphilis infection; primary, secondary and early latent. Similar increases have been seen in other parts of the South West and nationally.

The diagnosis rate for gonorrhoea (57.5 per 100,000) fell in Bristol in 2017 and is no longer higher than the national average (78.8).

Further data

- Sexual and Reproductive Health Profiles – to monitor the sexual and reproductive health of the population: <https://fingertips.phe.org.uk/profile/sexualhealth>
- [JSNA Chapter on Sexual Health \(2016\)](#)

²¹⁷ Note – this section is largely based on the [JSNA Chapter on Sexual Health \(2016\)](#)

²¹⁸ Source: Public Health England via Public Health Outcomes Framework, May 2018

7.2 Chlamydia

Chlamydia is the most common STI in England. Infection has no symptoms for 50% of men and 70-80% of women, and as a result the majority of infections remain undiagnosed. Without treatment, chlamydia can spread to other parts of the body and lead to serious long term health problems such as pelvic inflammatory disease and infertility.

The Chlamydia Screening Programme supports opportunistic screening for young people in Bristol aged 15-24, to increase the detection and reduce chlamydia prevalence.

Bristol compared well to England and neighbouring local authorities in 2017 in respect of the population coverage of chlamydia testing for 15-24 year olds, with coverage at 24.6% of the eligible population (national average 19.3%).

However, Bristol's testing programme has been falling short of the recommended diagnostic rate of 2,300 diagnoses per 100,000 people in the appropriate age group. 2017 data on the detection of chlamydia (fig 7.2.1) shows that Bristol (1,691 diagnoses per 100,000) has fallen significantly below the national average (1,882 per 100,000). Bristol has the lowest rates of the English Core Cities (fig 7.2.2).

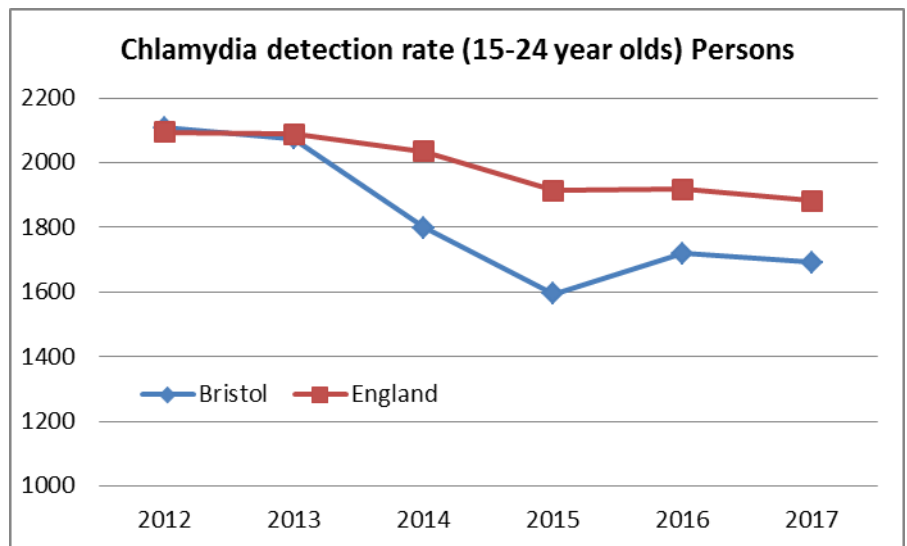


Fig 7.2.1: Chlamydia detection rate, Bristol v England, via Public Health Outcomes Framework 2018

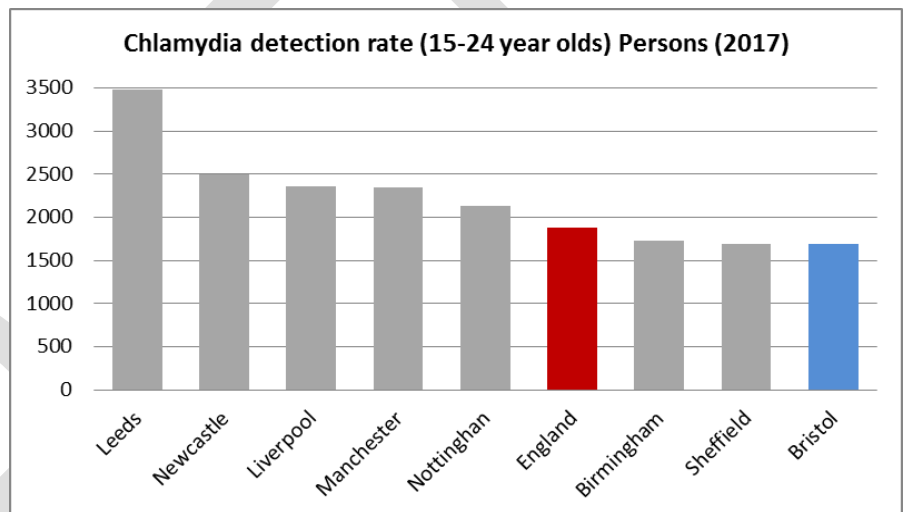


Fig 7.2.2: Chlamydia detection rate for Core Cities 2017, via Public Health Outcomes Framework 2018

Gender: In 2017 there were 1,270 diagnoses of chlamydia among 15-24 year olds in Bristol. Of these cases, 380 were males, and 890 were females. This is likely to reflect different levels of engagement with screening services.

7.3 HIV

HIV is associated with considerable morbidity and mortality and requires long-term care and treatment. Drug therapies have reduced the incidence of HIV-related deaths but it remains a life-threatening infection. Living with HIV continues to be a stigmatising condition with many individuals discriminated against on a daily basis.

HIV affects all sectors of the community, but there are some groups that are disproportionately affected, including men who have sex with men and the black African population

HIV diagnosed prevalence

Around 750 Bristol residents were living with diagnosed HIV in 2016 (the latest full year of data). As a rate, this is 2.54 per 1,000 population (aged 15-59), similar to the national rate (2.31 per 1,000)²¹⁹ – fig 7.3.1. The diagnosed HIV prevalence rate for Bristol has increased in recent years, which is related to people with HIV growing older as a result of effective treatment.

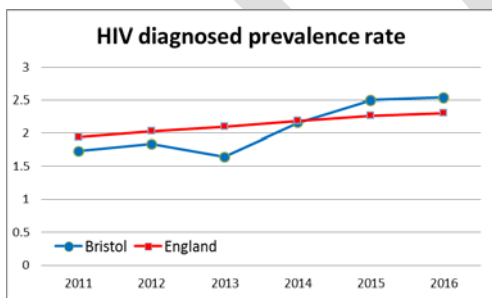


Fig 7.3.1. HIV diagnosed prevalence, rate per 1,000 people aged 15-59; Source: via PH Sexual and Reproductive Health Profiles 2018

New HIV diagnosis rate

The 2016 Bristol rate of new diagnoses of HIV is 12.0 per 100,000 population (aged 15 & over), slightly above the national average (10.3 per 100,000). In 2016 there were 45 people aged 15+ newly diagnosed with HIV in Bristol

HIV late diagnosis

HIV surveillance data²²⁰ shows that, of the people with a new HIV diagnosis in Bristol in 2014-16, 44% are considered to have had a “late diagnosis”. This rate has increased from 42% in 2013-2015 and is higher than the national average of 40.1% (fig 7.3.2). Compared to other cities, Bristol is mid-ranking for HIV late diagnosis against Core Cities and our “CIPFA nearest neighbours”.

Being diagnosed late is linked with increased rates of illness, hospital admission and reduced life expectancy for the individual, as well as increased onward transmission of HIV. Heterosexuals and black Africans are at higher risk of late diagnosis.

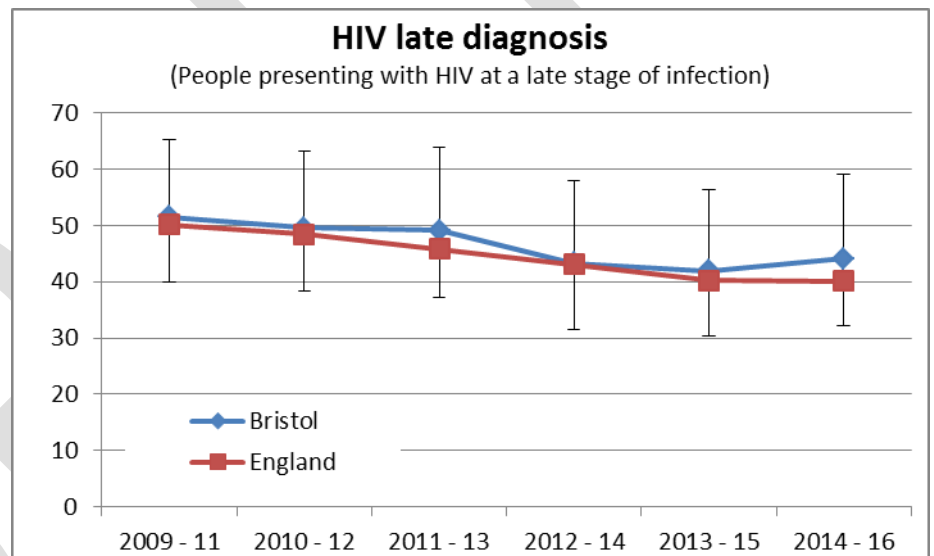


Fig 7.3.2 % of new HIV diagnoses considered to be “late”; Source: via Public Health Outcomes Framework 2018

Nationally there have been declines in new HIV diagnoses amongst MSM for the first time since the epidemic was detected 30 years ago. This is due to reduced HIV transmission as a result of a combination of strengthened prevention efforts. This includes condom use, expanded HIV testing, prompt treatment and the availability of pre exposure prophylaxis (PrEP).

Further data

- Sexual and Reproductive Health Profiles – to monitor the sexual and reproductive health of the population: <https://fingertips.phe.org.uk/profile/sexualhealth>

²¹⁹ Public Health England, via Sexual and Reproductive Health Profiles, 2018

²²⁰ Public Health England via Public Health Outcomes Framework, May 2018

7.4 TB (Tuberculosis)

TB is a “notifiable disease”, so must be reported to government authorities. In England TB has been identified as a public health priority due to the health, social and economic burden of the disease. The rates of TB and the risks of delayed diagnosis, drug resistance, and onward transmission are greatest among socially marginalised, under-served populations such as illicit drug users and the homeless.

Over a three year period In Bristol, incidence rates of TB are significantly higher than the England average²²¹ – see fig 7.4.1. The rate of TB in Bristol (2014-16) is 18.1 notified cases per 100,000 population (reducing to 14.8 in 2016 alone), compared to 10.9 per 100,000 nationally, and 5.1 per 100,000 South West average. Compared to other cities, Bristol is 3rd highest of English Core Cities, and joint 2nd highest of “CIPFA nearest neighbours”- fig 7.4.2.

There were five Medium Super Output Areas (MSOAs) in Bristol with a three year average TB rate (2014-2016) greater than 40.0 per 100,000 population and were concentrated in central Bristol within the electoral wards of Easton, Lawrence Hill and Ashley.

In 2016, 33.6% of pulmonary TB cases started treatment within two months of symptoms²²² (England average 39.4%) and 69% within 4 months of symptoms (England average 69.3%).

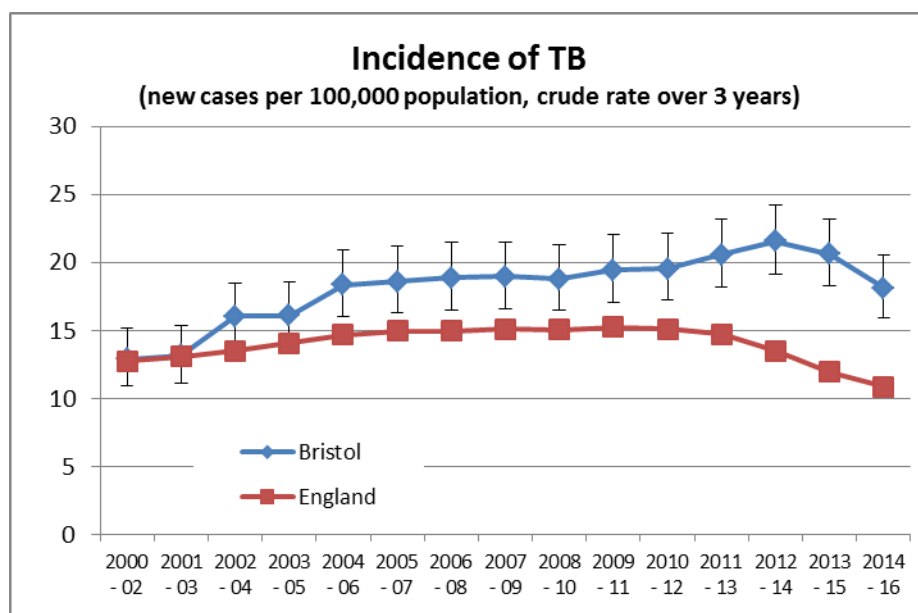


Fig7.4.1: TB incidence rates, 2000/02-2014/16; Source: via Public Health Outcomes Framework 2018

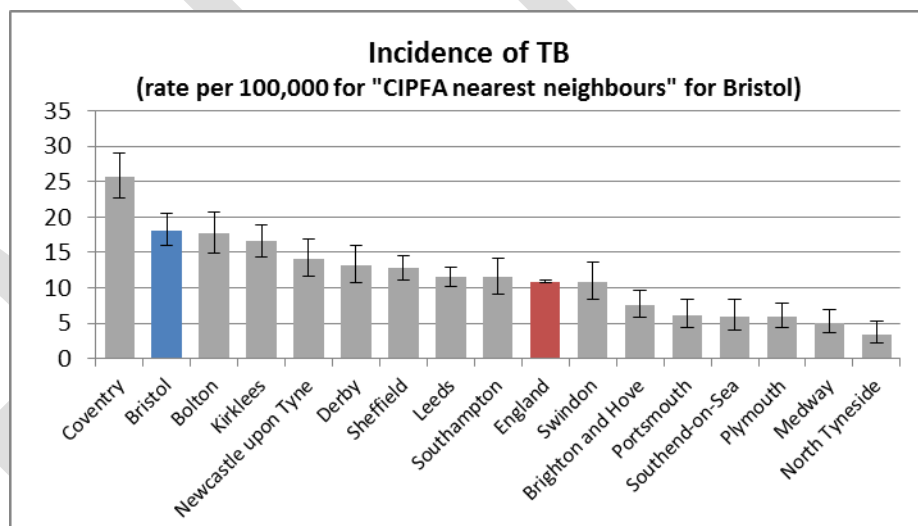


Fig7.4.2: TB incidence rates, 2014/16 for comparable cities; Source: via Public Health Outcomes Framework 2018

The number of new cases per year places a notable demand on the health care system. TB “contact tracing” provides an opportunity to identify unrecognised cases and is key to management of TB, and with new testing tools latent TB can be identified (that could otherwise wake up and cause active disease) and appropriate action taken to support these people.

There is an established TB service operating across Bristol which leads on the clinical management of cases, contact tracing and works with Public Health England in response to more complex TB incidents or outbreak situations.

Further data

- TB Strategy Monitoring Indicators: <https://fingertips.phe.org.uk/profile/tb-monitoring>

²²¹ Public Health England via Public Health Outcomes Framework, May 2018

²²² Public Health England via TB Strategy Monitoring Indicators, 2018

7.5 Flu Immunisations

Influenza (flu) is an acute viral infection that is easily transmitted. For otherwise healthy individuals, flu is an unpleasant but usually self-limiting disease. However, the risk of serious illness from flu is greater in babies under six months, older people, pregnant women and those with underlying health conditions and can therefore have a significant impact at population level.

Bristol's flu immunisations are in line with the national average for seasonal flu, with the exception of young children in school (fig 7.5.1). **Childhood flu**

vaccination for young children (Years Reception, 1 & 2) was implemented in Bristol in 2015/16, using a pharmacy-based model. Since 2016/17, a school-based model is being used, resulting in significantly higher levels of uptake - from 15.3% to 50.4% for Year 1 children and from 13.4% to 47.1% for Year 2 children, over the two year period.

For **older people (65 & over)**, vaccination coverage improved in 2017/18 (fig 7.5.2) to 74.8% from 72.4% in 2016/17 and is just below the 75% target²²³.

Also, a new measure²²⁴ of vaccination coverage for Shingles (for people 70 years old) shows only 43.4% of relevant people in Bristol received this in 2016/17, compared to 48.3% nationally, and now significantly below the target of 60% of all 70 year olds receiving this vaccination.

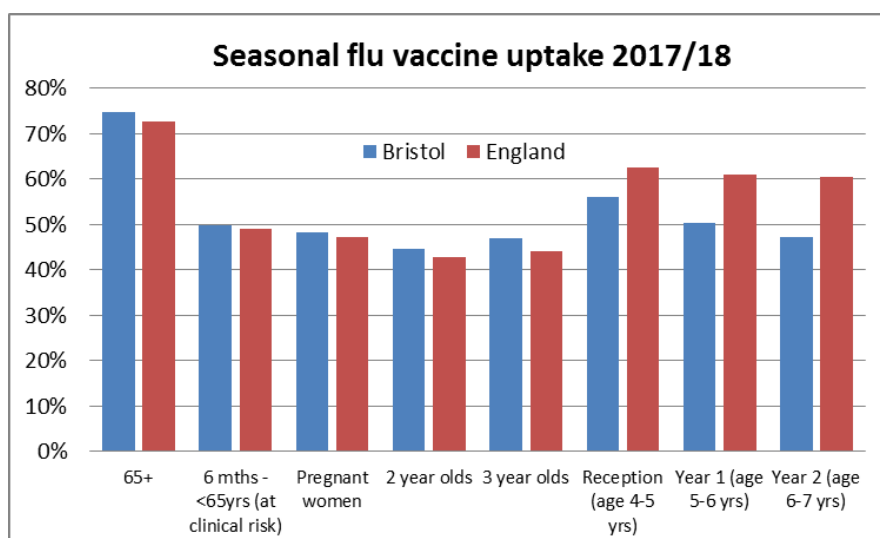


Fig 7.5.1: Source: Seasonal flu vaccine uptake figures, 2017/18 <https://www.gov.uk/government/collections/vaccine-uptake>

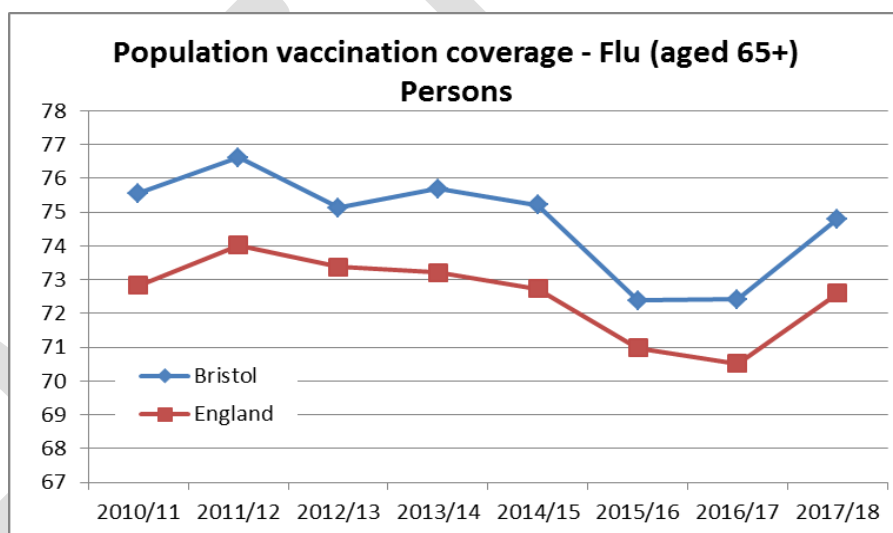


Fig 7.5.2: Source: via Public Health Outcomes Framework, 2018

When looking at the cohorts by age category, it can be seen that the lowest uptake is among those that are also the most at risk of complications from flu (children). The new school-based model was successful in 2016/17 and 2017/18 for Year 1 and 2 children, as these results are 3x higher than the 2015/16 figures, but attention needs to continue in this area as Bristol still performs well behind the national average. We also need to target younger children aged 2 – 3 where the uptake is behind that of our regional neighbours by a minimum of 11 percentage points. Whilst the numbers are small, the implications of better uptake in this group could be significant.

During 2016/17 Bristol saw a small increase in flu uptake for pregnant women (45.8%), which was higher than the national picture of 44.9%.

Improving uptake in the under 65 at risk groups, amongst pregnant women, Health Care Workers and children are priorities for Bristol.

²²³ Public Health England via Public Health Outcomes Framework, May 2018

²²⁴ Public Health England via Public Health Outcomes Framework, May 2018

7.6 Antimicrobial Resistance (inc antibiotics)

Antimicrobial resistance arises when the micro-organisms that cause infection survive exposure to a medicine that would normally kill them - this is a particular concern with antibiotics.

Many of the medical advances in recent years need antibiotics to prevent and treat the bacterial infections that can be caused by the treatment. Without effective antibiotics, even minor surgery and routine operations become high risk procedures²²⁵.

Local NHS guidance on the use of antibiotics in primary care helps prescribers to choose the most appropriate, and encourages the use of narrow-spectrum antibiotics rather than broad-spectrum²²⁶.

In terms of rates for the total number of prescribed antibiotics, Bristol is consistently lower (better) than national. In 2017, Bristol had an average ratio of 0.90 prescribed antibiotic items²²⁷, lower than the England average of 1.04 prescribed antibiotic items.

However, for broad-spectrum antibiotics Bristol is higher (worse), although this has noticeably reduced in the last two years – see fig 7.6.1. Improved prescribing practice of antibiotics including broad spectrum

antibiotics needs to be maintained so that the right people receive the right antibiotics at the right time.

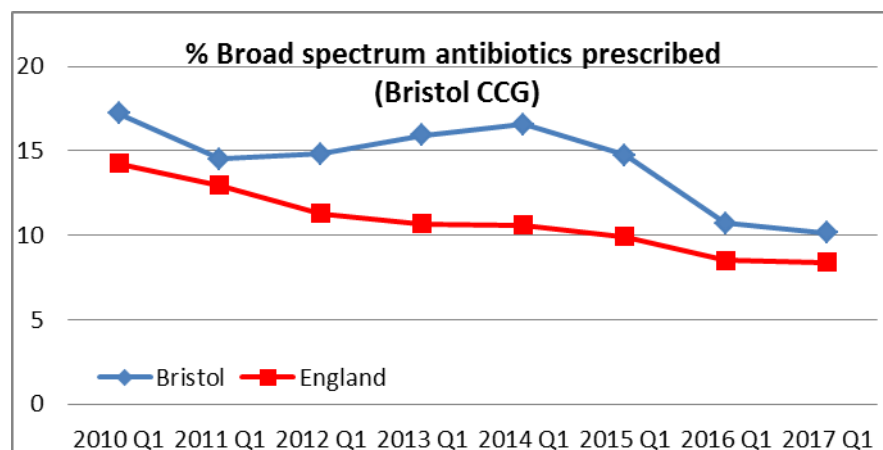


Fig 7.6.1: Source: % Prescribed antibiotics (broad spectrum) (Q1 2010 – Q1 2017) via <https://fingertips.phe.org.uk/profile/amr-local-indicators>

Bristol has not reduced the rate of healthcare associated infections as much as intended. Infections from “C.diff” have been falling in Bristol, but the rate from MRSA has increased during 2016/17 and is well above the national average (fig 7.6.2).

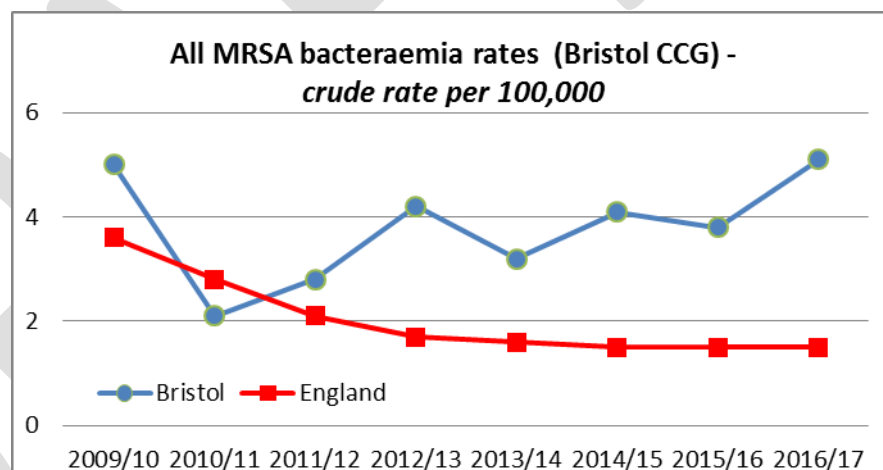


Fig 7.6.2: Source: Rate of MRSA infections per 100,000 (2009/10 – 2016/17) via <https://fingertips.phe.org.uk/profile/amr-local-indicators/>

Antibiotic Guardians

“Antibiotic Guardians” (<http://antibioticguardian.com/>) is a Public Health campaign to encourage improved behaviours around the use and prescription of antibiotics with the public and healthcare professionals - open to everyone to join! In 2017 NHS Bristol CCG had 20.9 Antibiotic Guardians per 100,000 people; this is similar to the England average (20.7)²²⁸ but has dropped significantly from 2016 (31.8).

Further data

- Antimicrobial Resistance (AMR) local indicators: <https://fingertips.phe.org.uk/profile/amr-local-indicators>

²²⁵ www.gov.uk/government/collections/antimicrobial-resistance-amr-information-and-resources

²²⁶ Cephalosporin, quinolone and co-amoxiclav, which are associated with an increased risk of Clostridium difficile (C. diff) infection and antimicrobial resistance

²²⁷ Prescribed antibiotic items per STAR-PU (Specific Therapeutic group Age-sex weightings Related Prescribing Unit). Source: Public Health England via PHOF, Aug 2018

²²⁸ Public Health, via AMR local indicators 2018

Section 8

Long Term Conditions

Summary points

Cardiovascular Disease

Early deaths due to cardiovascular disease continue to fall slowly and are similar to the national average.

The rates of early CVD deaths for men and women are now similar to national rates. However, for men the rate of early CVD deaths remains double that for women, and for Coronary Heart Disease it is triple.

There is significant variation in rates of early deaths across the city for CVD overall, CHD and Stroke.

Cancer

The rate of early deaths due to cancer in Bristol remains significantly higher than England.

The rate of Cancer early deaths for men (176.3 per 100,000) is higher than nationally, but for women (133 per 100,000) the rate is now broadly similar to the national average.

Early cancer deaths are now rising in some localities.

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

Diabetes

Recorded rates of diabetes continue to rise in Bristol overall as nationally. There are significant variations across the city, with much lower rates in the North & West inner.

People in the most deprived 10% areas accounted for 18% of emergency hospital admissions of Bristol patients for diabetes.

Estimates from Public Health England suggest that almost 10% of those over 16 years in Bristol have raised blood sugar levels indicating increased risk of diabetes. This is almost 35,000 people across Bristol.

Respiratory

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

COPD recorded prevalence varies 4-fold across localities.

People in the most deprived 10% areas accounted for 14% of emergency hospital admissions of Bristol patients for respiratory disease, and 18% for asthma (2016/17).

Liver Disease

Early death rates from liver disease in Bristol overall are broadly similar to the England average, for men and women. However, rates are almost three times as high in men as women in Bristol.

Rates of alcohol-related hospital admissions are significantly higher than England for both men and women, and hospital admission rates for liver disease are higher for men.

Musculoskeletal

Musculoskeletal conditions are the main cause of years lived with disability (YLD) in England, accounting for 24% of all YLD

Diagnoses of osteoporosis in Bristol have risen to 1,720 (1.2% of patients 50+, 2016/17) from 740 (0.6% of patients 50+, 2015/16). Bristol is over double the England average (0.5%, 2016/17)

Preventable mortality

Preventable mortality rates in Bristol remain higher than England, though lower than in most core cities. There are around 672 "preventable deaths" per year in Bristol.

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

8.1 Prevalence of common long-term conditions

Records from GP registers²²⁹ in Bristol shows the percentage of adult patients diagnosed with selected Long-Term Conditions (LTCs) by GP Practice. [Note: data shows conditions recorded on GP registers (as a crude rate, divided by number of patients in that area), not actual population “prevalence”, as some cases will be undiagnosed]

As indicated by the data (i.e. Fig 8.1.1 & Table 8.1.2), Bristol has a lower % of patients than the national average on most indicators, with the exception of asthma (same as nationally) and kidney disease patients (higher than nationally). In both Bristol and nationally the recorded prevalence of these long term conditions has increased since last year, particularly cancer and diabetes (as highlighted in sections 8.4 and 8.5).

Within Bristol, the Inner City and North & West inner areas report a lower prevalence of most long term conditions. Exceptions are asthma and cancer. Highest recorded prevalence of all long term conditions is found in the North & West Outer and South Bristol areas.

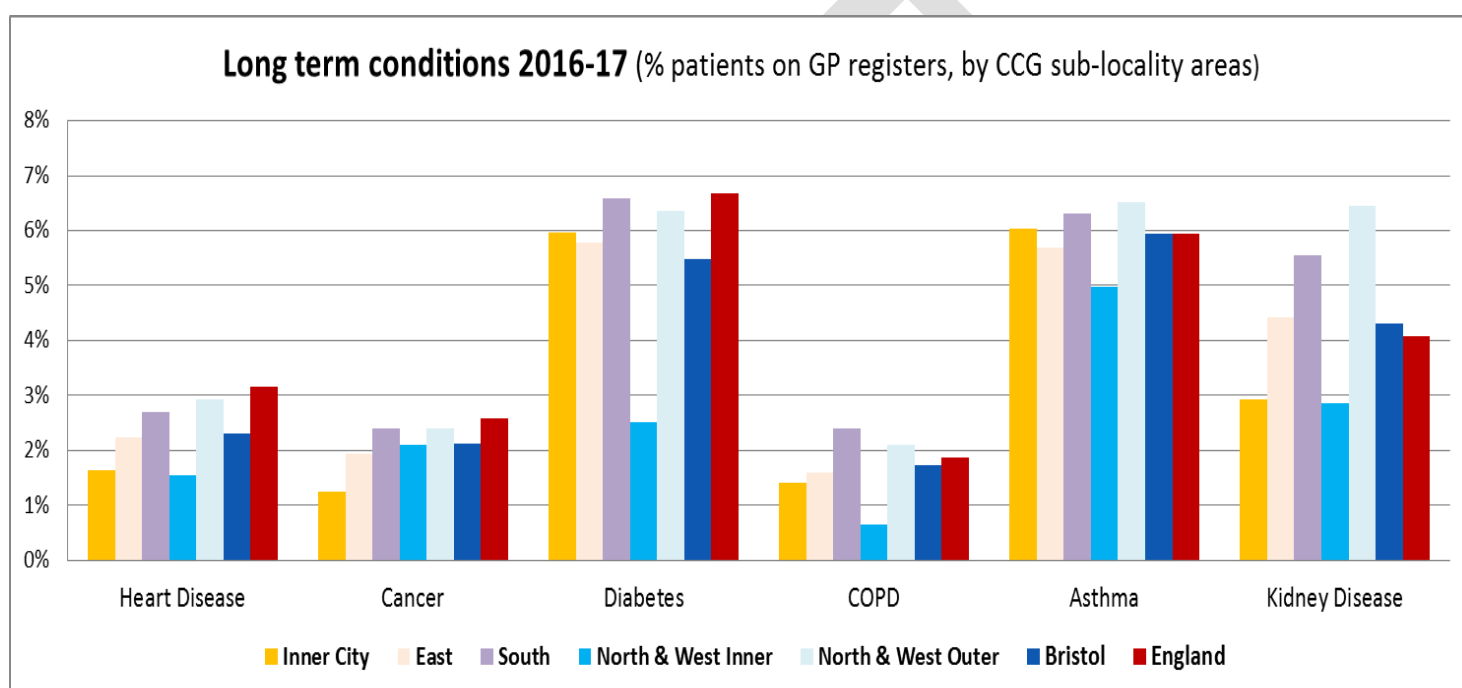


Fig 8.1.1: Long-term conditions by area; Source: NHS Quality Outcomes Framework 2016/17 (Supplied by BCC Insight, Performance & Intelligence, 2018)

Patients on GP Registers (2016-17)	Coronary Heart Disease		Cancer (all types)		Diabetes		Chronic Obstructive Pulmonary Disease		Asthma		Chronic Kidney Disease	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Sub Locality Area												
Inner City	1,033	1.64	793	1.26	3,054	5.96	883	1.40	3,807	6.04	1,453	2.92
East	2,021	2.24	1,744	1.93	4,282	5.77	1,433	1.59	5,127	5.69	3,133	4.42
South	4,344	2.70	3,887	2.41	8,449	6.59	3,870	2.40	10,140	6.30	6,555	5.54
North & West Inner	1,508	1.54	2,040	2.09	2,102	2.51	632	0.65	4,855	4.97	2,308	2.87
North & West Outer	2,674	2.92	2,197	2.40	4,592	6.35	1,926	2.10	5,982	6.52	4,067	6.45
Bristol	11,580	2.30	10,661	2.12	22,479	5.49	8,744	1.74	29,911	5.94	17,516	4.32
England	1,829,777	3.15	1,495,711	2.58	3,116,399	6.67	1,087,908	1.87	3,444,218	5.94	1,885,665	4.09

Table 8.1.2: Long-term conditions by area 2016/17

²²⁹ Source: NHS Quality Outcomes Framework (QOF) 2016/17 [NB these are crude rates, so do not account for age differences in areas]

8.2 Premature mortality from cancer and cardiovascular diseases

In Bristol, almost half of all early deaths²³⁰ under 75 years are due to cancers (38.9%) or coronary heart disease (9.8%) - see fig 8.2.1.

The North & West (inner) area of Bristol has significantly lower early death rates than the Bristol average - Table 8.2.2. Inner City rates for CVD conditions are worse than average and more than double that of North & West (inner).

Gender: Rates of premature mortality among males are higher than among females across all causes noted, particularly cardiovascular and coronary heart diseases.

The North & West (inner) has the lowest rates for both male and female, across all identified causes. Male early death rates are highest in the Inner City. The female early death rate for all causes is highest in the North & West (outer). However, female cancer is highest in the Inner City and Bristol South; female early death from stroke is highest in both the Inner City and North & West (outer).

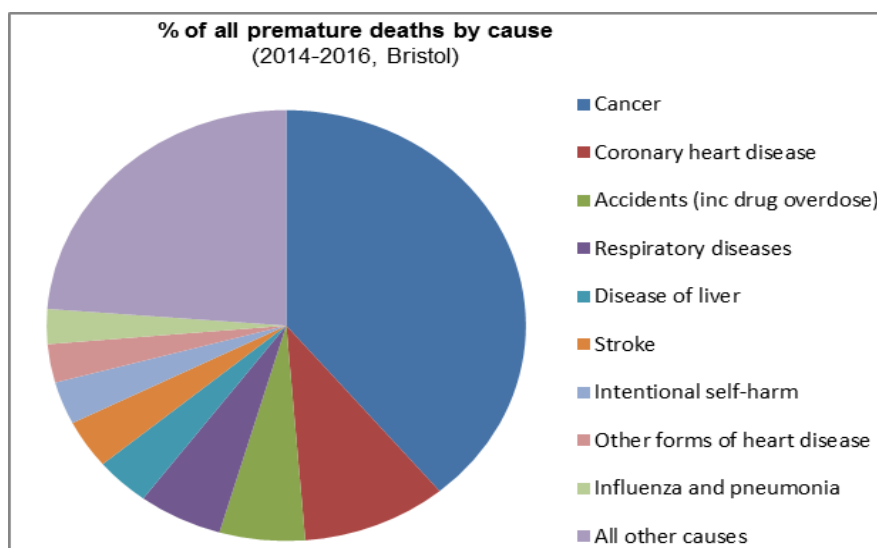


Fig 8.2.1 Source Bristol City Council Public Health Knowledge Service (2018)

Premature mortality rates per 100,000 (2014-2016)						
All Persons						
Mortality rates per 100,000 population	Bristol (average)	Bristol East	Inner City	Bristol South	North & West - Inner	North & West - outer
Premature mortality - Cancer	154	159	187	170	116	146
Premature mortality - CVD (all Cardiovascular)	77	67	119	83	41	90
Premature mortality - CHD (Heart Disease)	40	38	53	42	22	50
Premature mortality - Stroke	15	12	24	15	8	19
All causes	380	390	477	399	249	430
Males						
Mortality rates per 100,000 population	Bristol (average)	Bristol East	Inner City	Bristol South	North & West - Inner	North & West - outer
Premature mortality - Cancer	176	181	202	192	140	169
Premature mortality - CVD (all Cardiovascular)	106	86	181	110	64	119
Premature mortality - CHD (Heart Disease)	60	57	82	59	39	77
Premature mortality - Stroke	15	8	31	16	8	19
All causes	468	466	605	486	326	509
Females						
Mortality rates per 100,000 population	Bristol (average)	Bristol East	Inner City	Bristol South	North & West - Inner	North & West - outer
Premature mortality - Cancer	133	138	170	150	94	124
Premature mortality - CVD (all Cardiovascular)	48	48	51	57	20	62
Premature mortality - CHD (Heart Disease)	20	20	23	26	6	24
Premature mortality - Stroke	14	15	16	14	8	18
All causes	295	313	334	315	177	356

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

Table 8.2.2 Source Bristol Public Health Knowledge Service (2018)

²³⁰ 2014-16 data provided by Bristol Public Health Knowledge Service (2018)

8.3 Cardiovascular Disease

Early deaths due to cardiovascular disease (CVD) continue to decline in Bristol, as nationally.²³¹ In 2014-16, Bristol rates were 76.6 per 100,000, similar to the England rate of 73.5 per 100,000.

Gender: The Bristol male CVD early death rate (106 per 100,000) remains over twice that for women (48 per 100,000) but has fallen more in recent years – see fig 8.3.1. Both male and female rates are now similar to national averages.

Local data²³² on variation across the city (fig 8.3.2, and table 8.2.2) show rates in the Inner City and North & West (outer) area are significantly higher than the Bristol average. The North & West (inner) area is significantly lower than the Bristol average.

Coronary Heart Disease (CHD)

Data from GP registers²³³ shows recorded prevalence of Coronary Heart Disease (CHD) across Bristol and in England is similar to last year.

Bristol recorded prevalence (2.3%) is lower than the England average (3.2%). However, in North & West outer this is 2.9% - almost twice the rate of the North & West inner and Inner City areas (fig 8.3.3).

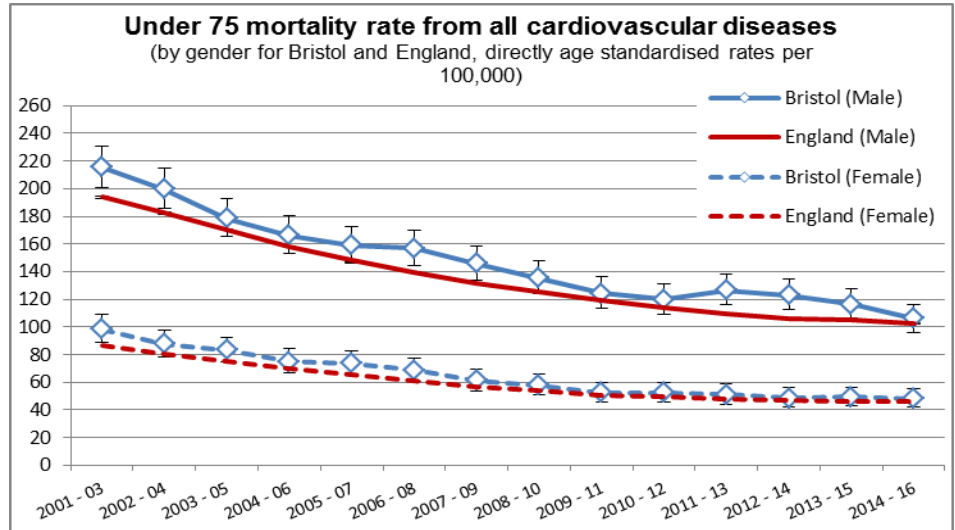


Fig 8.3.1: Early deaths – CVD (Source via PHOF, Feb 2018)

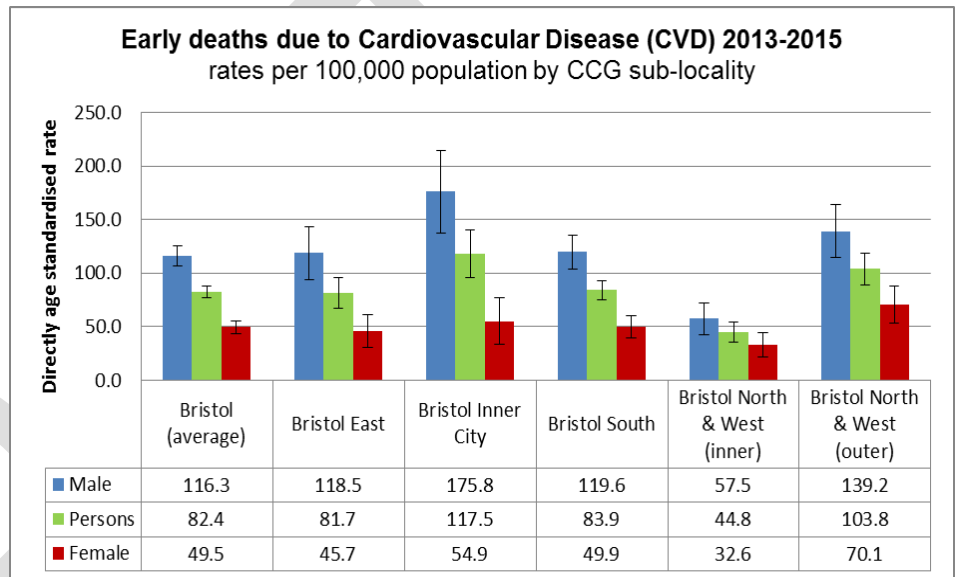


Fig 8.3.2: Early deaths by area for CVD (Source BCC Public Health Knowledge Service, 2018)

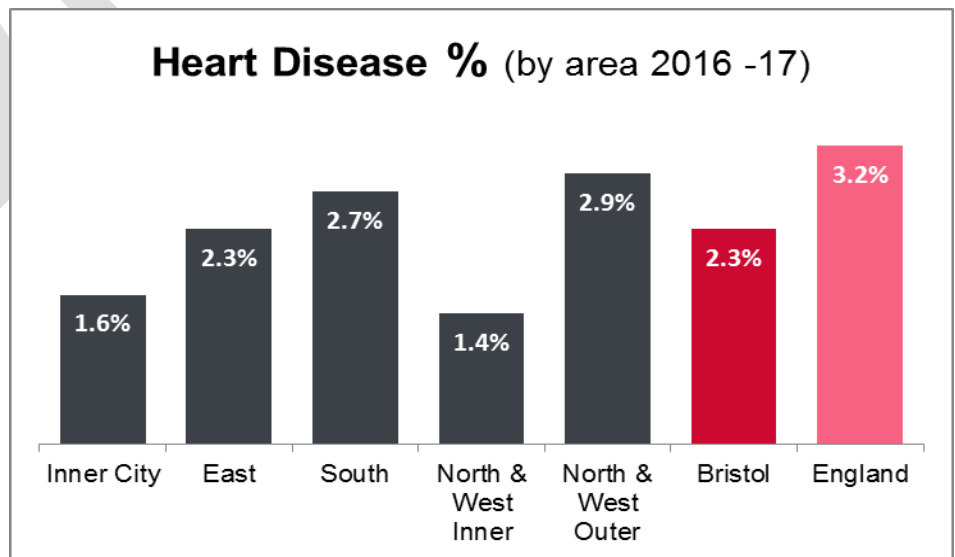


Fig 8.3.3: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, 2018)

²³¹ 2014-16; Source: Public Health England (based on ONS data), via PHOF, Feb 2018
²³² 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)
²³³ Source: NHS QOF data 2016/17 [Note – these are crude rates]

Local data²³⁴ for early deaths from CHD shows rates in North and West (inner) remain significantly lower than the city average.

Gender: CHD early death rates are 3 times higher for men than for women in Bristol (fig 8.3.4).

Emergency hospital admissions for CHD during 2016/17 record 60% of Bristol patients were male and 40% were female²³⁵.

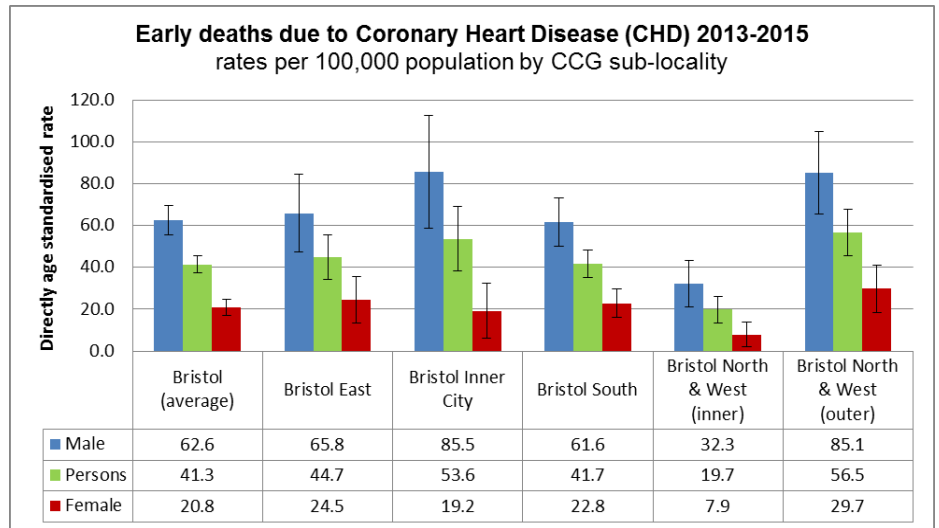


Fig 8.3.4: Early deaths by area for CHD (Source BCC Public Health Knowledge Service, 2018)

Stroke

The early death rate²³⁶ from stroke is highest in the Inner City. For males it is almost as high in Bristol East and for females it is similar in North & West (outer). Overall in Bristol, over 50% more men than women die early from stroke (fig 8.3.5).

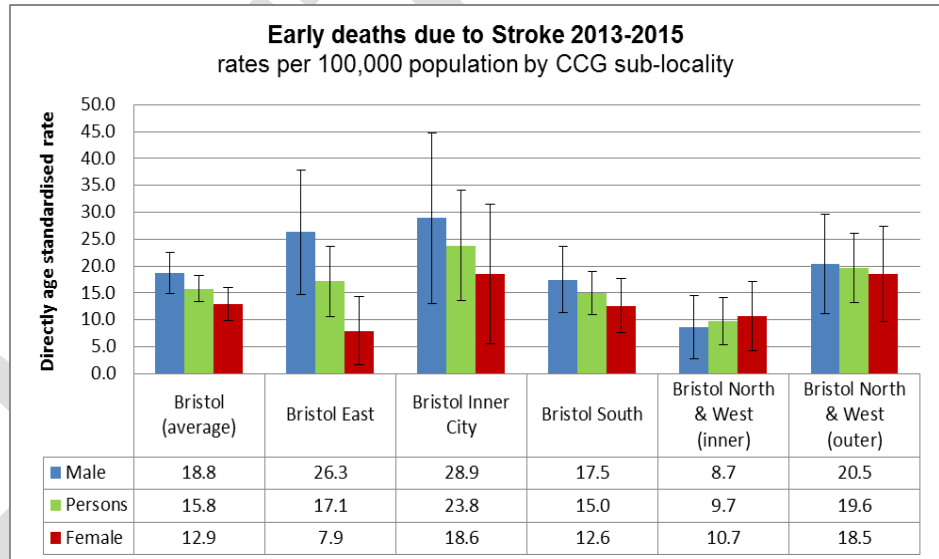


Fig 8.3.5: Early deaths by area – Stroke (Source BCC Public Health Knowledge Service, 2018)

High Blood Pressure (Hypertension)

Hypertension increases risk of heart disease or stroke. Crude rates of recorded hypertension vary across the city²³⁷, with highest rates in the South and North & West (outer), and lowest in North & West (inner) and the Inner City (Fig 8.3.6).

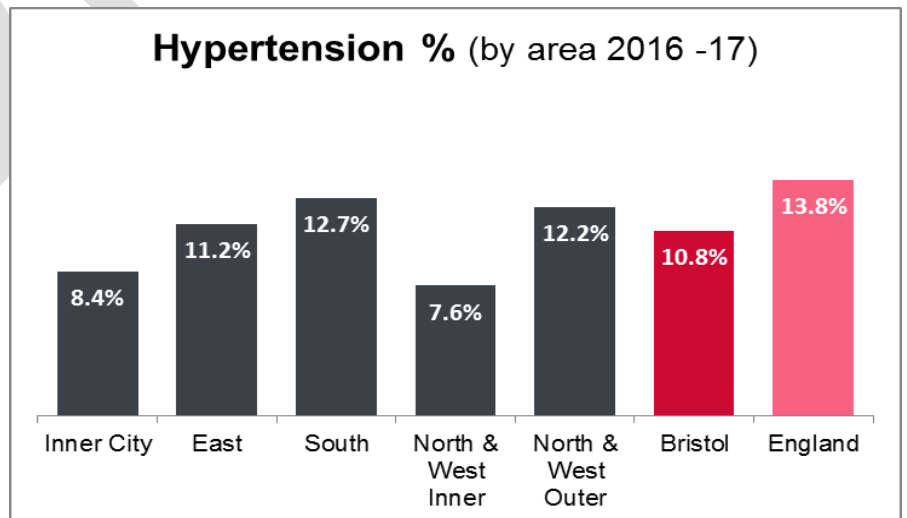


Fig 8.3.6 Hypertension recorded diagnoses; Source: QOF 2016-17 and Public Health England for estimated prevalence

Further data

- CVD Profile: <https://fingertips.phe.org.uk/profile/cardiovascular>

²³⁴ 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)

²³⁵ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

²³⁶ 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)

²³⁷ Source: NHS Quality Outcomes Framework (QOF) 2016/17

8.4 Cancer

8.4.1 Early deaths

The rate of early deaths due to cancer in Bristol is 154.1 per 100,000, significantly higher than nationally (England rate is 136.8 per 100,000 for 2014-16). Bristol is mid-ranking against comparable cities²³⁸. Early death rates from cancer continue to decline slowly.

Gender: For men, Bristol rates for early deaths due to cancer (176.3 per 100,000) are significantly higher than the national average for men (152.1), and significantly higher than the Bristol rate for women (133 per 100,000) – see fig 8.4.1. The rate for women appears higher than nationally, but is within confidence intervals so is broadly similar to the national average for women (122.6).

Early cancer deaths by CCG sub-locality²³⁹ show premature mortality rates highest in Bristol South and the Inner City (fig 8.4.2). They are lowest in the North & West (inner) area.

Variation across the city is not as significant as for other major causes of early death.

Local data²⁴⁰ (using 5-year averages to show trends for the CCG sub-locality areas) shows that premature mortality rates due to cancer in most areas are falling over time. However in the Inner City and East there

appears to have been an increase in the last few years (fig.8.4.3).

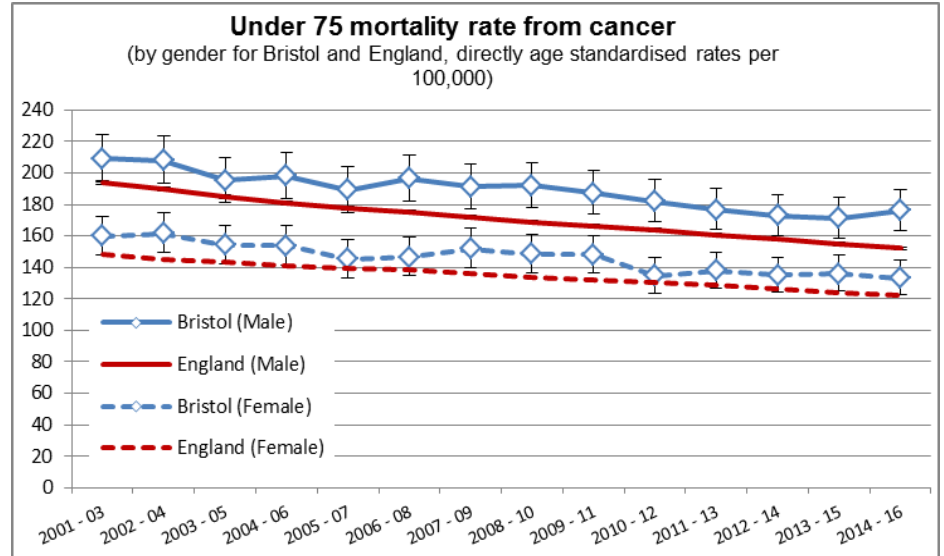


Fig 8.4.1: Early deaths due to Cancer, Bristol and England by gender
Source via Public Health Outcomes Framework, PHOF, Feb 2018

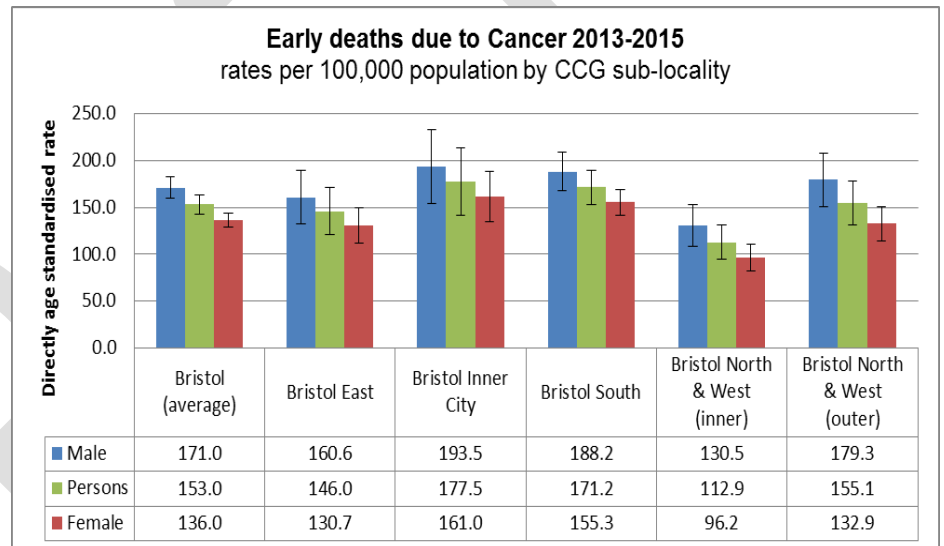


Fig 8.4.2: Early deaths – Cancer (Source BCC Public Health Knowledge Service, 2018)

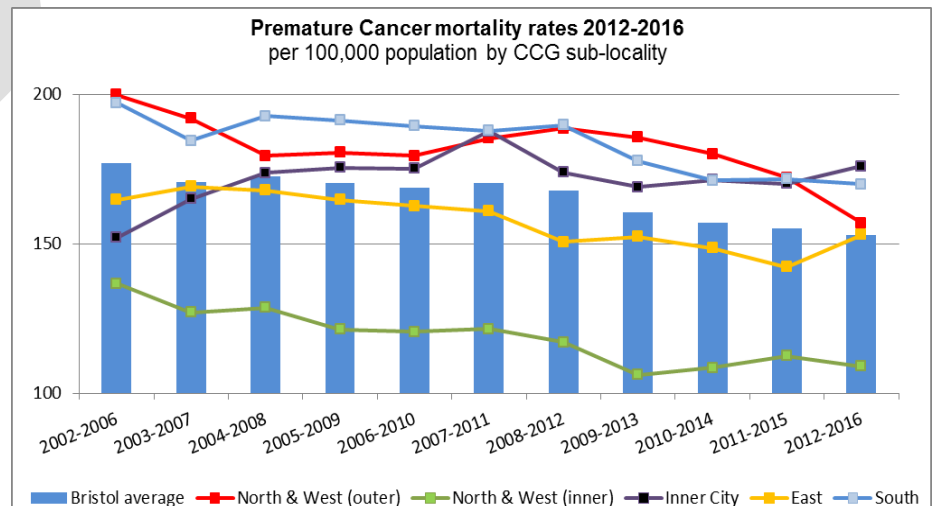


Fig 8.4.3: Early cancer deaths in Bristol by locality areas (Source: Bristol Public Health Knowledge Service, 2018)

²³⁸ 2014-16. Source: Public Health England (based on ONS source data), via PHOF, Feb 2018. Compared to CIPFA and Core Cities

²³⁹ Source: Bristol Public Health Knowledge Service (2018)

²⁴⁰ Source: Bristol Public Health Knowledge Service (2018). Directly standardised rates per 100,000 population

8.4.2 Diagnoses & admissions

GP data²⁴¹ show recorded diagnoses of cancer continue to rise across the city (fig 8.4.4). The rate for Bristol (2.1%) remains lower than England average (2.6%). The South and North & West (outer) localities remain higher than the Bristol average. Diagnosis rates in the Inner City remain lowest, at almost half that in the South (Note - these are crude rates so differences are partly due to a younger age profile in Inner City).

Overall, the 2016/17 rate of Bristol patients with emergency admissions to hospital due to cancer (337 per 100,000 population) remains lower than it is nationally (543 per 100,000)²⁴².

8.4.3 Types of cancer

Latest available data on premature cancer deaths (still 2011-15) indicates that in Bristol, the highest numbers were due to lung cancer (122 per year), followed by cancer of digestive organs (109 per year), then breast cancer (32 per year)²⁴³.

Latest published data (still 2012-14) on mortality rates per 100,000 of the relevant population²⁴⁴ for these cancers in Bristol and nationally are:

- 154 for all cancers (England 142)
- 41.8 lung cancer (England 33.6)
- 19.5 breast cancer (England 22)
- 15.4 colorectal cancer (England 13.1)

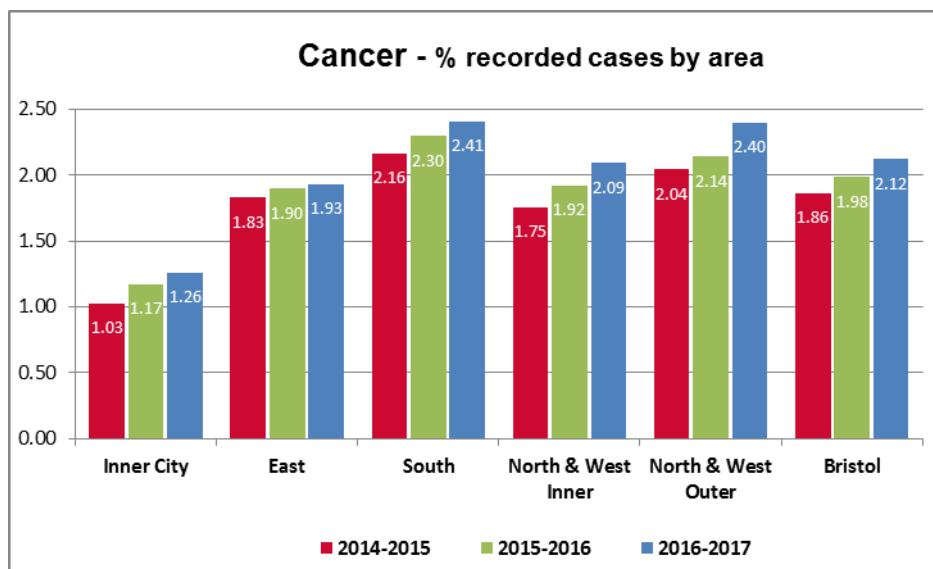


Fig 8.4.4: Source: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, 2018)

8.4.4 Early diagnosis / Screening

Diagnosis at an early stage is associated with much improved survival chances. Public health interventions such as screening programmes and information campaigns aim to improve rates of early diagnosis.

Experimental data suggests that 53% of all new cases of cancer in Bristol were diagnosed at an early stage²⁴⁵ in 2016, similar to the national average (52.6%).

Screening coverage²⁴⁶ for **breast, cervical and bowel cancer** in Bristol is consistently significantly lower (worse) than the England average (though mid-ranking against English core cities for all 3 indicators). In 2017 Bristol's screening coverage rates were:

- 73.0% for breast cancer (England 75.4%)
- 70.7% for cervical cancer (England 72.0%)
- 54.5% for bowel cancer (England 58.8%)

Further data

- Cancer Services Profile: <https://fingertips.phe.org.uk/profile/cancerservices>
- Bristol JSNA Chapter 2017-18: [Cancer in Bristol](#)

²⁴¹ Source: NHS QOF data 2016/17

²⁴² PHE General Practice Profiles (2017): <https://fingertips.phe.org.uk/profile/general-practice>

²⁴³ Calculated by Bristol Public Health Knowledge Service using ONS mortality data

²⁴⁴ HSCIC: <https://indicators.hscic.gov.uk/webview/>

²⁴⁵ Breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin, diagnosed at stage 1 or 2. Source: National Cancer Registry 2016, via PHOF (May 2018)

²⁴⁶ Source: Health and Social Care Information Centre, via Public Health Outcomes Framework, Aug 2018

8.5 Diabetes²⁴⁷

Diagnoses of diabetes continue to rise in Bristol as nationally, and in 2016/17 there were almost 22,500 Bristol patients with Diabetes²⁴⁸.

As a rate this is 5.5% of all adult patients, below the England average of 6.7% - fig 8.5.1. Age is a key factor in diabetes, so the lower rate may reflect Bristol's relatively young age profile.

Public Health England estimate the recorded diagnosis rate²⁴⁹ in Bristol is 74.1% of the full prevalence of diabetes, compared with 77.1% recorded nationally.

Recorded GP diagnoses²⁵⁰ show rates of diabetes vary across the city (fig 8.5.2). The relatively low prevalence of 2.5% in the North & West Inner area reduces the Bristol average. Most areas have recorded diagnosis rates close to or above 6%, highest in North & West outer and South Bristol.

Deprivation: Hospital admissions data records 18% of Bristol patients admitted for diabetes were living within the most deprived 10% areas²⁵¹.

Around 90% of people with diabetes will have Type 2 diabetes, which in many cases is preventable. Risk of developing Type 2 diabetes rises with excess weight.

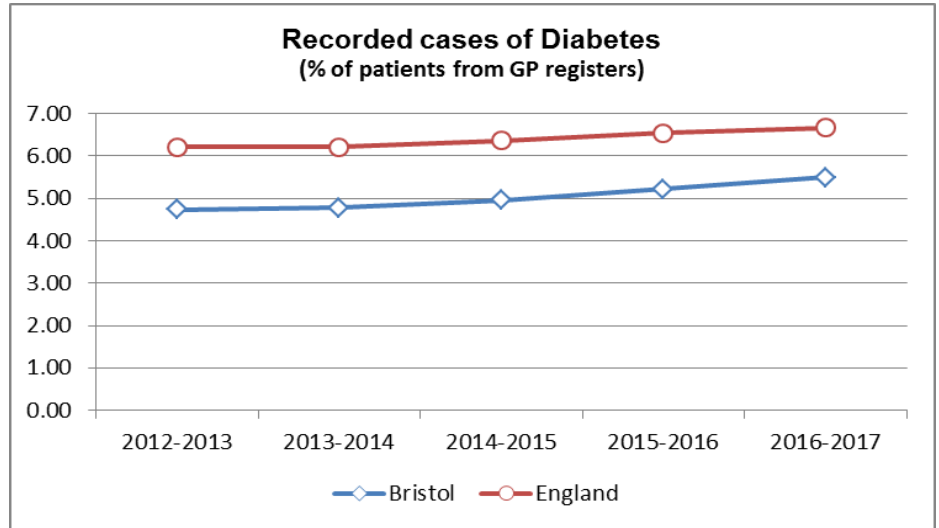


Fig 8.5.1: Source: NHS Quality Outcomes Framework (QOF)

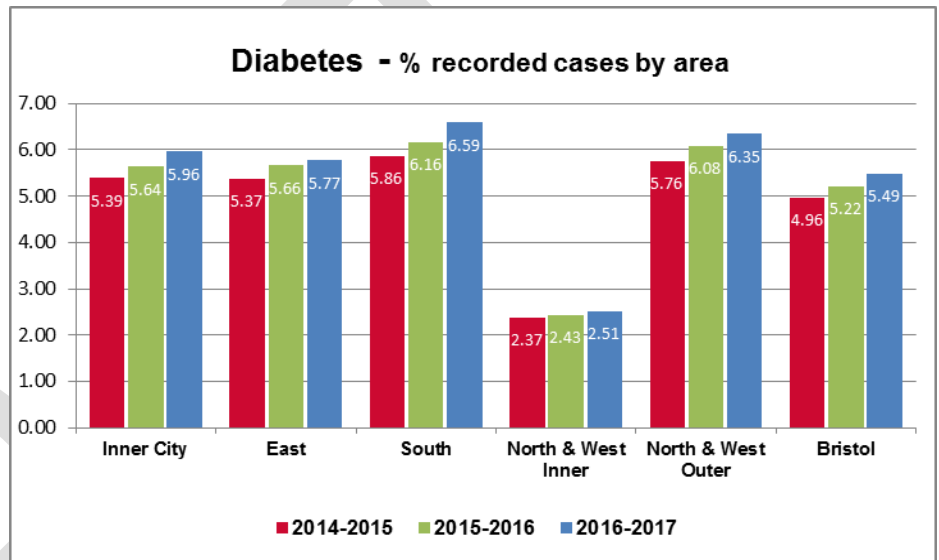


Fig 8.5.2: Source: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, 2018)

Non-diabetic hyperglycemia (also known as pre-diabetes or impaired glucose regulation) refers to blood glucose levels that are high, but not diabetic. People with this are at high risk of developing diabetes, as well as other cardiovascular conditions. 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.

Lifestyle changes to reduce body weight, increase physical activity and improve diet can significantly reduce the risk of developing Type 2 diabetes in those at high risk.

Further data

- Diabetes Profile: <https://fingertips.phe.org.uk/diabetes>
- Healthier Lives: Diabetes: <http://healthierlives.phe.org.uk/topic/diabetes>

²⁴⁷ Further data, see Bristol Diabetes profile: <http://fingertips.phe.org.uk/diabetes>

²⁴⁸ Source: NHS QOF data 2016/17. QOF is a crude rate per population

²⁴⁹ 2016/17 Source: PHE via PHOF, May 2018

²⁵⁰ Source: NHS QOF data 2016/17

²⁵¹ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018

8.6 Respiratory Disease

In Bristol, early death rates from respiratory disease²⁵² (41.0 per 100,000) are significantly higher than the England average (33.8 per 100,000). However, compared to other English Core Cities, Bristol has 2nd lowest rate of eight.

Gender: Early death rates due to respiratory disease are significantly higher in Bristol than nationally, for both men and women (fig 8.6.1). Rates for men appear to be rising, while for women the recent rise in rates appears to have flattened.

Deprivation: 14% of emergency hospital admissions²⁵³ of Bristol patients for respiratory disease (2016/17) were people living in the most deprived 10% areas.

8.6.1 Chronic Obstructive Pulmonary Disease

GP register data²⁵⁴ show 8,744 Bristol patients with chronic obstructive pulmonary disease (COPD). This is 1.7% of all adult patients (England average: 1.9%). Rates are highest in the South and North & West outer areas, at least three times the lowest rate (North & West inner) and higher than the England average – see fig 8.6.2.

Variations in recorded COPD prevalence mirror variations in smoking rates across areas of the city.

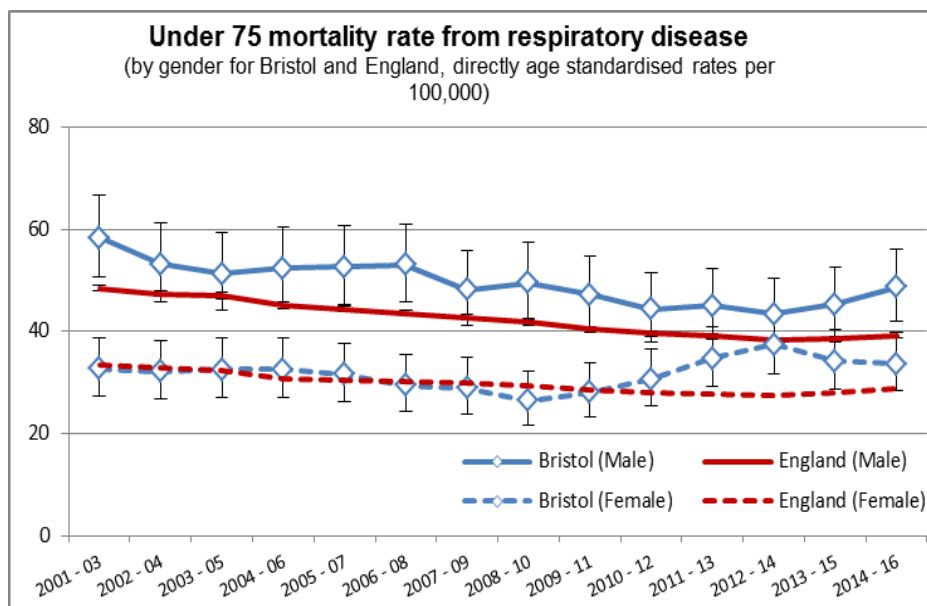


Fig 8.6.1: Early deaths due to respiratory disease (via PHOF, Feb 2018)

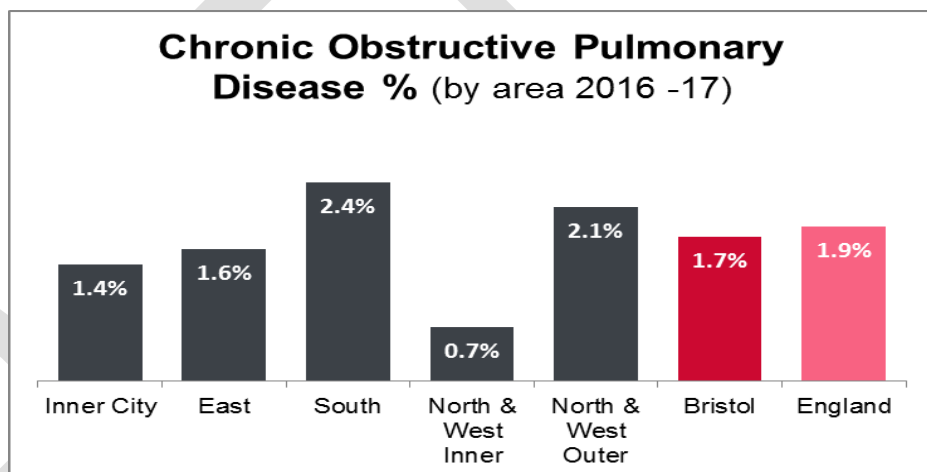


Fig 8.6.2: Prevalence of COPD; Source: NHS QOF 2016/17

8.6.2 Asthma²⁵⁵

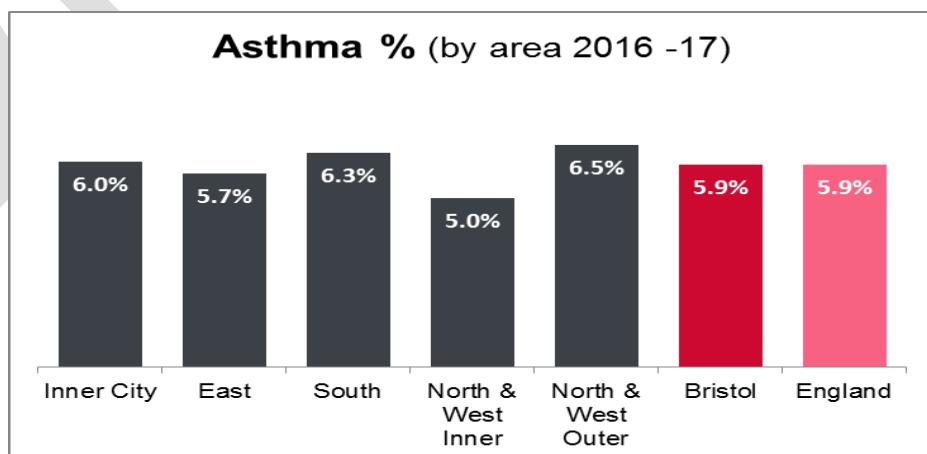


Fig 8.6.3: Prevalence of Asthma; Source: NHS QOF 2016/17

GP register data²⁵⁶ show 29,911 Bristol patients with Asthma. This is a prevalence of 5.94% of all adult patients, similar to the

²⁵² 2013-15. Source: Public Health England, via PHOF, Feb 2018

²⁵³ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

²⁵⁴ Source: NHS QOF data 2016/17

[Note – these are crude rates]

²⁵⁵ For Childhood Asthma – see JSNA section 4.6.1 Chronic Childhood Illnesses

²⁵⁶ Source: NHS QOF data 2016/17

England average. Rates vary across Bristol, with South and North & West outer much higher than North & West inner - fig 8.6.3 [Note – these are crude rates].

Data on emergency hospital admissions²⁵⁷, all ages, for asthma indicate the Bristol average rate of admissions (111 per 100,000) in 2016-17 fell slightly from the last 2 years. However, there is significant variation across the city with rates highest in North & West (outer) and lowest in North & West (inner) – fig 8.6.4.

Ward level analysis²⁵⁸ (using 3 year pooled data) for all ages shows variation across individual wards. Rates of emergency hospital admissions for asthma range from less than 30 per 100,000 in Cotham and Clifton Down to over 200 per 100,000 in Southmead and Lawrence Hill – see fig 8.6.5.

Gender: Over 2014/15-2016/17, the majority of emergency hospital admissions due to asthma²⁵⁹ (all age) were female. There were 1,590 admissions during this 3 year period: 690 males and 900 females.

Deprivation: 18% of emergency hospital admissions²⁶⁰ of Bristol patients for asthma (2016/17)

were living in the most deprived 10% areas.

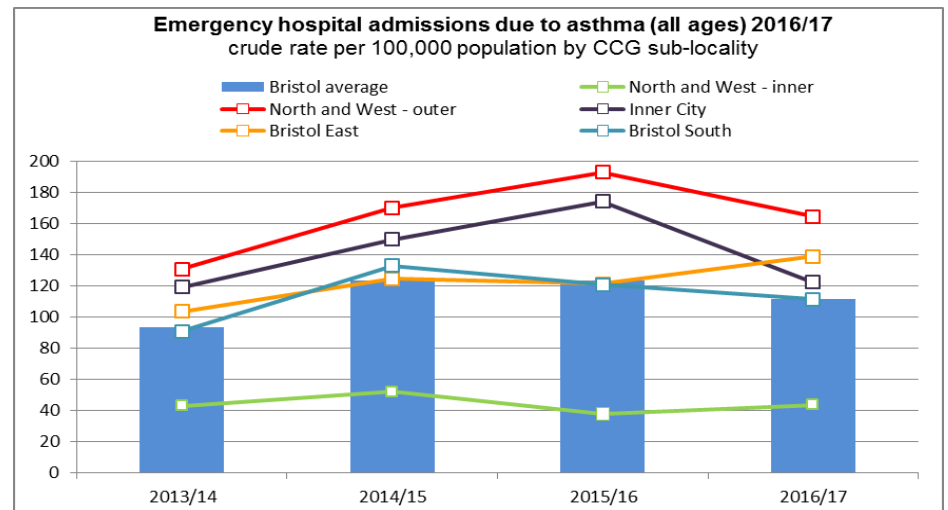


Fig 8.6.4: Asthma admissions by CCG locality area; Source: Hospital episode statistics, Supplied by Public Health Knowledge Service, 2018

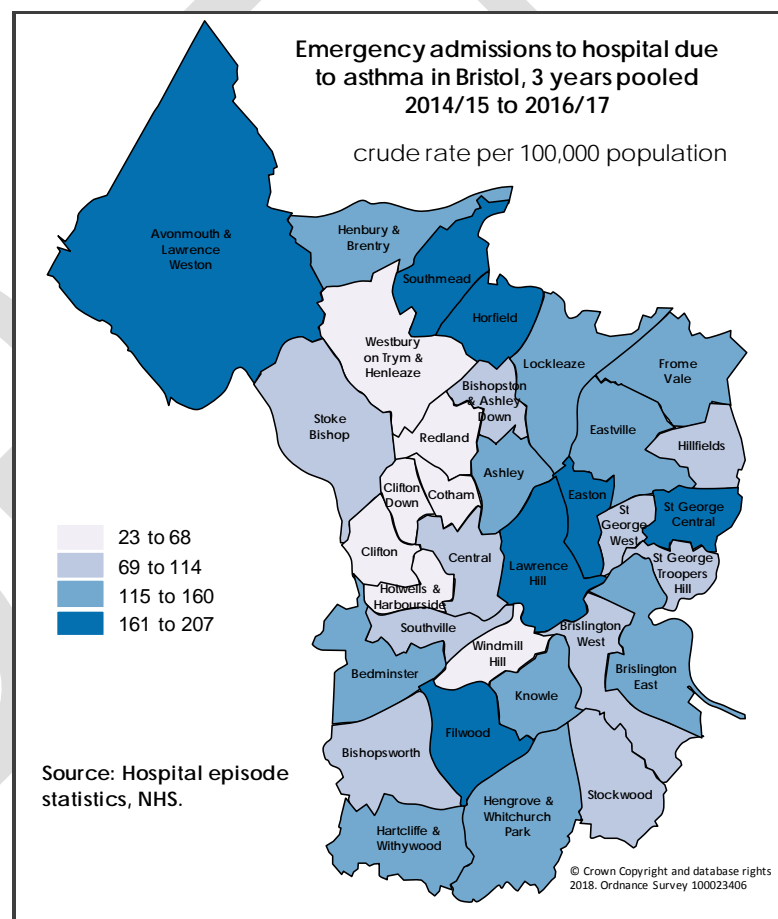


Fig 8.6.5: Asthma admissions by ward for all ages, 2014/15 – 2016/17. Supplied by Public Health Knowledge Service, 2018

²⁵⁷ Emergency admissions to hospital due to asthma in Bristol, crude rate per 100,000 population, 2013/14 to 2016/17

²⁵⁸ SUS Hospital episodes data, 2014/15 to 2016/17, via Bristol Public Health Knowledge Service (2018)

²⁵⁹ SUS Hospital episodes data, 2014/15 to 2016/17, via Bristol PHKS (2018)

²⁶⁰ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

Further data

- Inhale - Interactive Health Atlas of Lung conditions in England Profile: <https://fingertips.phe.org.uk/profile/inhale>
- Bristol JSNA Chapter 2017-18: [Adult Respiratory Disease in Bristol, North Somerset and South Gloucestershire](#)

8.7 Liver Disease

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

The rate of early death from liver disease in Bristol (18.5 per 100,000), is similar to the England average (18.3 per 100,000)

Gender: Bristol rates for early death from liver disease (2014-16) are almost three times higher in men than women.

The rate for male early deaths due to liver disease (27.7 per 100,000) appears higher than nationally, but is within confidence intervals so is broadly similar to national average (23.9). Likewise, female early deaths (9.4 per 100,000) appear lower than nationally, but is within confidence intervals so is broadly similar to national (12.8) – fig 8.7.1

Hospital admissions

The overall Bristol rate of hospital admissions due to liver disease (130 per 100,000 population) has been broadly similar over the last few years²⁶¹. However, analysis by CCG sub-locality (fig 8.7.2) shows crude rates rose significantly in Bristol East. In contrast rates in the Inner City have fallen.

In addition, for rates of alcohol-related hospital admissions see **section 6.5 Alcohol**.

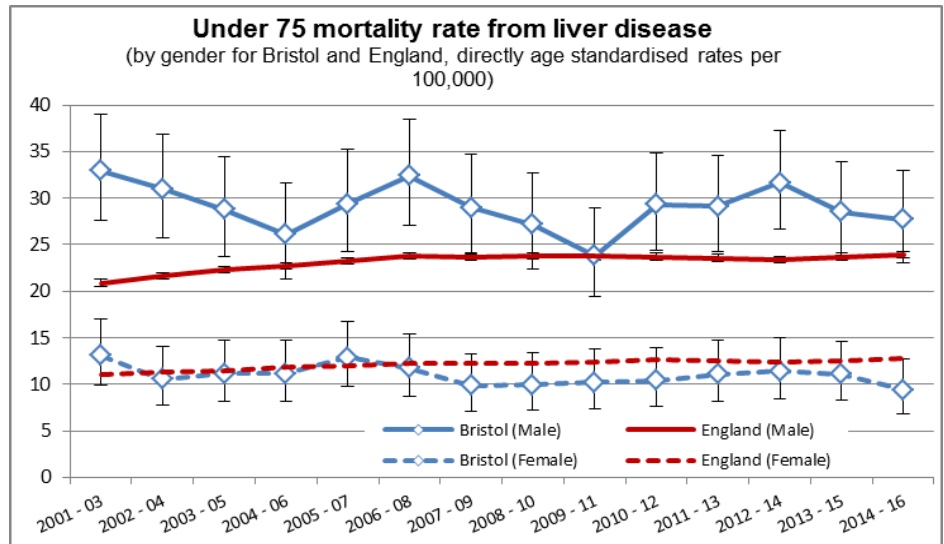


Fig 8.7.1: Early deaths due to liver disease, (Source via PHOF, Feb 2018)

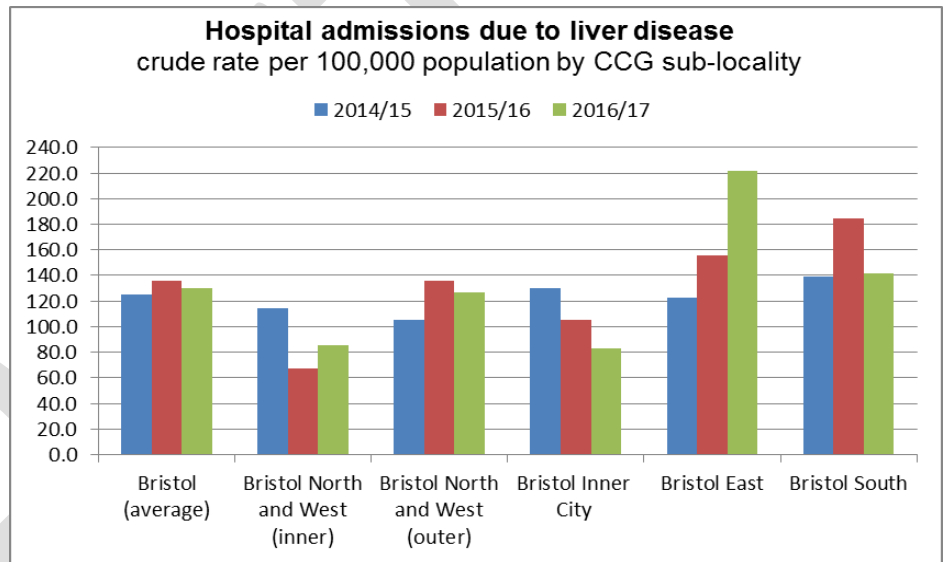


Fig 8.7.2. Rate of hospital admissions for liver disease, 2014/15 to 2016/17

Pooled data for 2014/15- 2016/17 for liver disease hospital admissions by ward show significant variation across the city. Crude rates range from 24.9 admissions per 100,000 population in Stoke Bishop to 210.3 admissions per 100,000 in Filwood, almost a 10-fold difference.

Gender: In Bristol, over the 3 years 2014/15 to 2016/17 there were 1740 hospital admissions due to liver disease. This breaks down as 1,130 male admissions and 610 female admissions, so almost double the number of men being admitted.

Further data

- Liver Disease Profile: <https://fingertips.phe.org.uk/profile/liver-disease>

²⁶¹ SUS Hospital episodes data, 2014/15 to 2016/17, via Bristol Public Health Knowledge Service (2018)

8.8 Musculoskeletal (MSK)

Musculoskeletal (MSK) conditions are those affecting the joints, ligaments, tendons, muscles and nerves and supporting structures of the limbs and back (eg spinal discs). They are the leading cause of disability in England²⁶², accounting for 24% of all years lived with disability (YLD)²⁶³. Within this, low back and neck pain accounted for 18% of all YLD. The disability due to MSK disorders is expected to rise further with increases in obesity and sedentary lifestyles, which are significant risk factors²⁶⁴, alongside an ageing population.

The impacts of MSK conditions are significant as sufferers can live with them for many years, resulting in a long-term burden of pain and impaired functioning, and possibly mental health issues. There is also a substantial economic burden due to work days lost and healthcare costs. Only a small proportion of those with MSK conditions present to health services (eg only 20% of those with low back pain go to their GP²⁶⁵), so there are many more self-managing at home.

Osteoporosis

GP register data²⁶⁶ show 1,720 Bristol patients with osteoporosis (2016/17), a significant rise in

diagnoses from 740 a year before. This is now 1.2% of all adult patients aged 50+ years, double the Bristol rate of 0.6% in 2015/16. Bristol is also more than double the England average of 0.5% (2016/17).

Gender: Hospital admissions for hip fractures during 2016/17 record 67% of Bristol patients were female and 33% were male²⁶⁷. Hip fractures are usually caused by a fall or an injury to the side but are also more common in women, who are more susceptible to osteoporosis²⁶⁸.

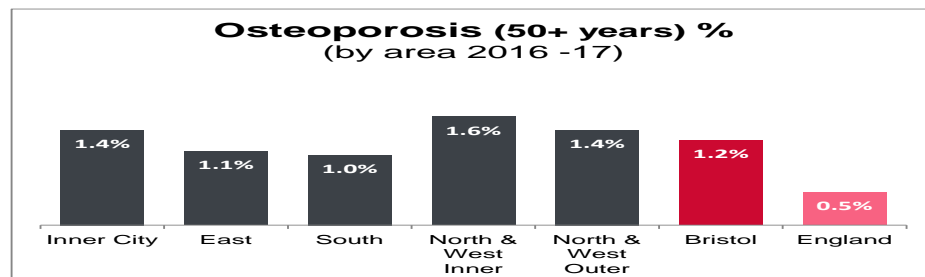


Fig 8.8.1: Prevalence of Osteoporosis; Source: NHS QOF 2016/17

Osteoarthritis

11.3% of Bristol patients²⁶⁹ reported problems with osteoarthritis or joint problems compared to an England average of 12.4%, whilst 9.2% of Bristol patients reported long-term back pain, compared to an England average 9.6%.

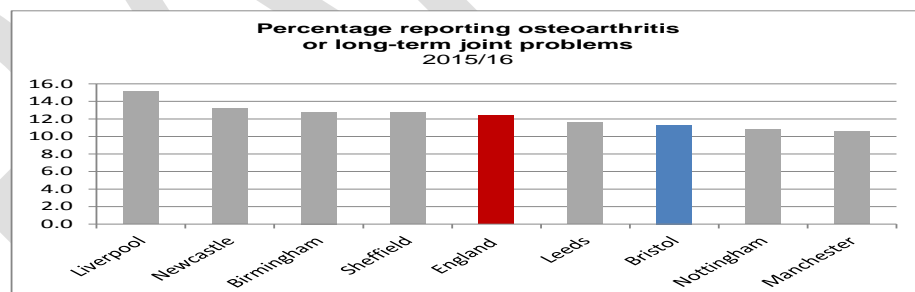


Fig 8.8.2 Estimated prevalence of osteoarthritis or long-term joint problems (patients 18+). Source: GP Patient Survey 2015-16 via MSK Profile

Rheumatoid arthritis

Data from GP registers²⁷⁰ show there are 2,425 Bristol patients (16+ years) with rheumatoid arthritis. This is 0.6% of all patients, lower than the national prevalence of 0.7%. This may be expected due to Bristol's younger population profile.

Further data

- Musculoskeletal Diseases Profile: <https://fingertips.phe.org.uk/profile/msk>
- [Musculoskeletal \(MSK\) Needs Assessment for Bristol, North Somerset and South Gloucestershire 2016/17](#)

²⁶² Global Burden of Disease study, 2013

²⁶³ <http://vizhub.healthdata.org/gbd-compare/england> via Nottingham JSNA 2016

²⁶⁴ Arthritis UK

www.arthritisresearchuk.org/

²⁶⁵ NICE (2009) Low back pain in adults:, via Nottingham JSNA 2016

²⁶⁶ Source: NHS QOF data 2016/17

[Note – these are crude rates]

²⁶⁷ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

²⁶⁸ www.nhs.uk/conditions/hip-fracture/

²⁶⁹ Source: GP Patient Survey 2015-16, Dept. for Health & Social Care

²⁷⁰ NHS QOF data 2016/17, 16 and over

8.9 Neurological conditions

There are many conditions within the term “neurological conditions”, including (but not limited to):

Epilepsy; Central nervous system infections; Motor neurone disease and Spinal muscular atrophy; Multiple sclerosis; Neuromuscular diseases; Sleep disorders; Traumatic brain and spine injury; Tumours of the nervous system; Headaches and migraine.

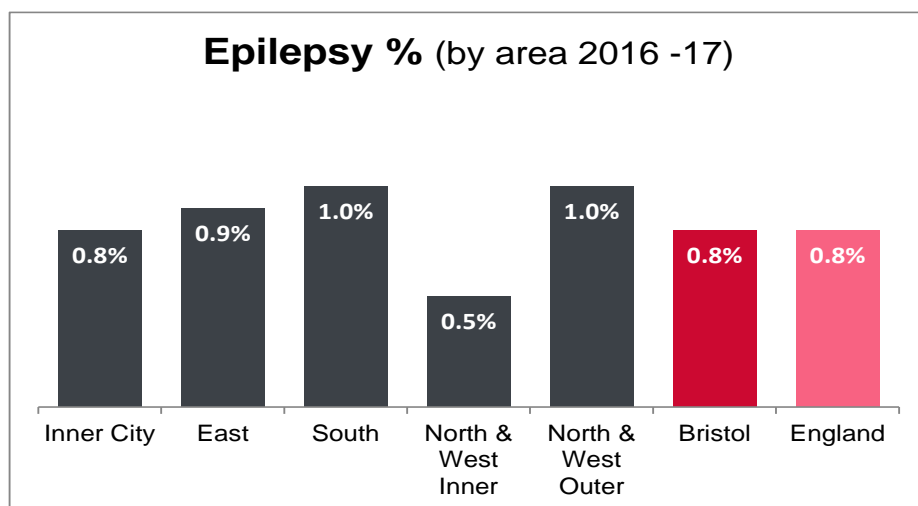


Fig 8.9.1: Prevalence of Epilepsy; Source: NHS QOF 2016/17

8.9.1 Epilepsy

GP register data indicate there are over 3,135 adults with epilepsy in Bristol²⁷¹. This is 0.77% of all adult patients (England average: 0.80%).

Epilepsy prevalence rates are highest in the South and North & West outer areas, twice the lowest rate (North & West inner) - fig 8.9.1.

Further data

- The Neurology Hospital Activity Compendium is at www.gov.uk/government/publications/neurology-services-hospital-activity-data
- Neurology data and analysis: a guide for health professionals: www.gov.uk/guidance/neurology-data-and-analysis-a-guide-for-health-professionals
- The PHE Neurology Profiles were discontinued in 2017

²⁷¹ Source: NHS QOF 2016/17

8.10 Preventable mortality

Public Health England defines preventable mortality as death that could potentially be avoided by public health interventions²⁷².

This includes tuberculosis, Hepatitis C, HIV/AIDS, some cancers, diabetes mellitus, alcohol related diseases, illicit drug use disorders, ischaemic heart disease, deep vein thrombosis (DVT), aortic aneurysm, influenza, COPD, transport accidents, injuries, suicide and self-inflicted injuries and homicide/assault.

Using this definition, over the 3 years 2014-16 there were over 2,000 “preventable deaths” in Bristol (around 672 per year).

The Bristol ‘all persons’ preventable mortality rate of 204.0 deaths per 100,000, is consistently higher than the England average, now 182.8 per 100,000. However, preventable mortality in Bristol is significantly better than in most core cities (fig 8.9.2)

Gender: Rates for preventable mortality are significantly higher in men than women. Male preventable mortality rates in Bristol (261.1 per 100,000) are significantly above the England average (230.4). Bristol female preventable mortality rates (149.0 per 100,000) are also significantly

higher than the England average (138.5) – see fig 8.9.1.

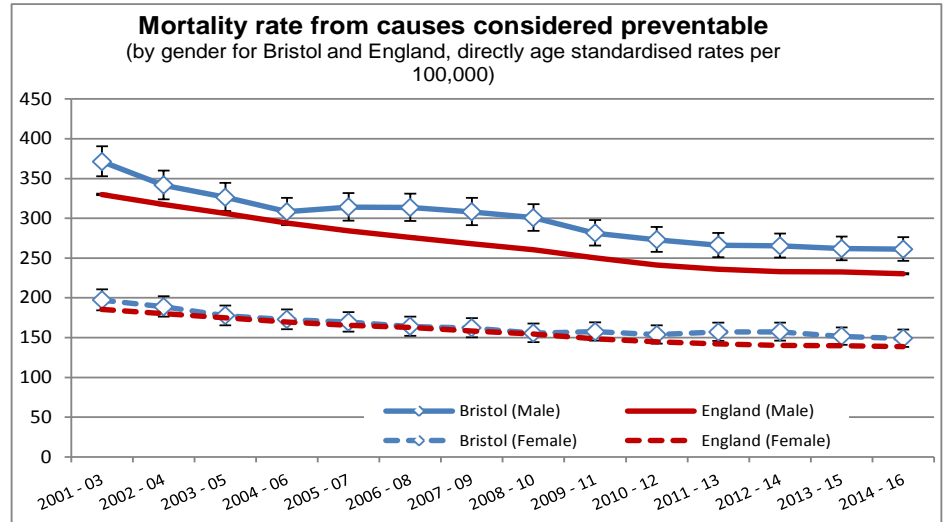


Fig 8.9.1 Rates of deaths from causes considered preventable, by gender for Bristol and England average (Source via PHOF, Feb 2018)

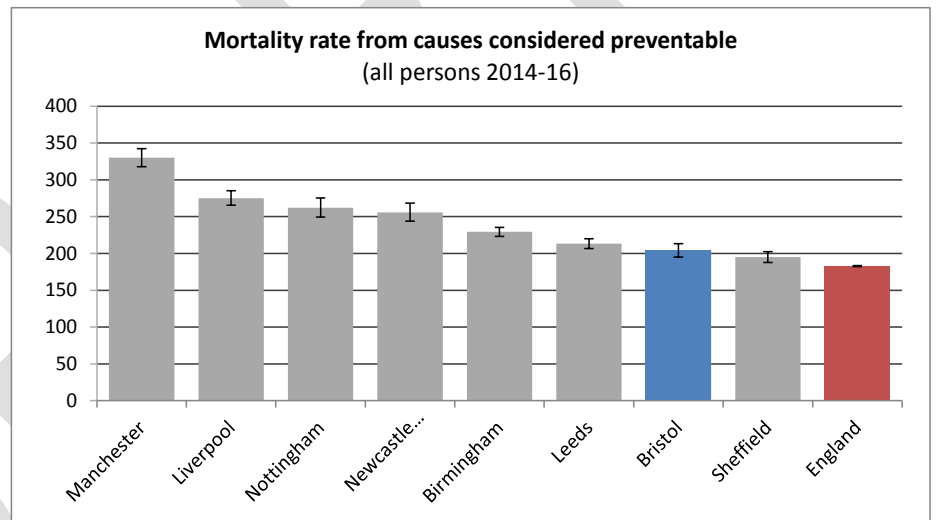


Fig 8.9.2 Core city comparison for preventable mortality, 2013-15 (Source via PHOF, Feb 2018)

Gender: Emergency hospital admissions data for 2016/17 record 63% of emergency admissions were female compared to 37% male. However, accident & emergency attendance and elective hospital admissions were broadly similar²⁷³.

Deprivation: 13% of all emergency hospital admissions²⁷⁴ of Bristol patients (2016/17) were people living in the 10% most deprived areas, as were 13% of all A&E attendance. For elective (planned) admissions, 10% came from the 10% most deprived areas.

²⁷²The trend data was revised in 2016, as the ONS definition of “preventable mortality” was updated slightly- see PHOF 2018: [Review of Avoidable Mortality Definition - Office for National Statistics](#)

²⁷³ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

²⁷⁴ 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

Section 9

Mental Health and Wellbeing

Summary

We all have mental health and good mental health is more than the absence of a mental health problem.

Mental health conditions are very common, often of long duration, and have adverse effects on many areas of people's lives. Mental health problems often begin early in life and cause disability when those affected would otherwise be at their most productive (unlike most physical illnesses).

Improved mental health is associated with a range of better outcomes. These include better physical health & life expectancy, better educational achievements, increased skills, reduced health-risk behaviours such as smoking & alcohol misuse, reduced suicide deaths, reduced anti-social behaviour & criminality, improved employment rates & productivity, and higher levels of social interaction and participation.

Depression

- 40,400 Bristol patients (10%) have a diagnosis of depression, above the England average (9.1%), and is highest in Bristol North & West (outer)
- New diagnosis of depression in 2016-17 has risen sharply to 8,700

patients (2.2%), above England average (1.5%)

Self-harm

- In Bristol during 2016-17 there were 1,460 emergency admissions for self-harm in Bristol, a rate of 291.3 per 100,000 population
- By gender, 1030 emergency admissions for self-harm were females (2016/17), and 430 were males.
- There is a correlation between lower rates of self-harm and people living in less deprived areas.

Suicide

- Bristol's suicide rate is significantly higher than the England average.
- The majority of suicides are men, as is the case nationally, but the suicide rate for women in Bristol is significantly higher than for women nationally.

Physical health of people with mental health issues

- Excess mortality rate in adults with serious mental illness is higher than national, but one of the lowest of core cities.

Mental wellbeing

- 3.5% of Bristol residents reported a low life satisfaction score, similar to national (4.5%), 2016/17.
- Local data shows 18% have "below average mental wellbeing", but rises to 28% in the most deprived areas

Emotional health and wellbeing of children & young people

- Almost 10% of children and young people may be experiencing mental health problems at any time
- In Bristol it is estimated that at least 5,100 children aged 5–16 and 1,700 16 & 17 year olds have a diagnosable mental health problem
- Young people report lower life satisfaction than nationally.
- Self-harm hospital admission rates for young people (10–24 year olds) in Bristol have risen in recent years and continue to significantly exceed the England average.

Perinatal mental health

- Up to one in five women and one in ten men are affected by mental health problems in the perinatal period.
- In Bristol, it is estimated 1000 women each year will develop mild to moderate perinatal depression

Further data

"Mental Health and Wellbeing JSNA" profiles:
<https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna>

9.1 Anxiety and depression

Common mental health disorders comprise different types of depression and anxiety. They can range in severity from mild to severe. Around one in six adults were identified with symptoms of common health disorders²⁷⁵.

Recorded cases on GP registers in Bristol show that 40,400 patients (aged 18+) had an unresolved record of depression²⁷⁶ in 2016-17. This represents almost 10% of all patients, higher than the England average of 9.1%. Last year 35,200 Bristol patients (8.8%) had unresolved cases of depression recorded. [Note – these are cumulative crude rates for all diagnoses that have not been noted as resolved, so would be expected to rise. However, the rise has been greater in Bristol than nationally].

Across Bristol, there continues to be significant disparities between different areas²⁷⁷. As shown in fig 9.1.1 the recorded prevalence of depression in ‘North & West outer’ area (13.36%) is almost double that of ‘North & West inner’ (7.21%). During 2016/17, the highest rises were in the South and North & West Outer areas.

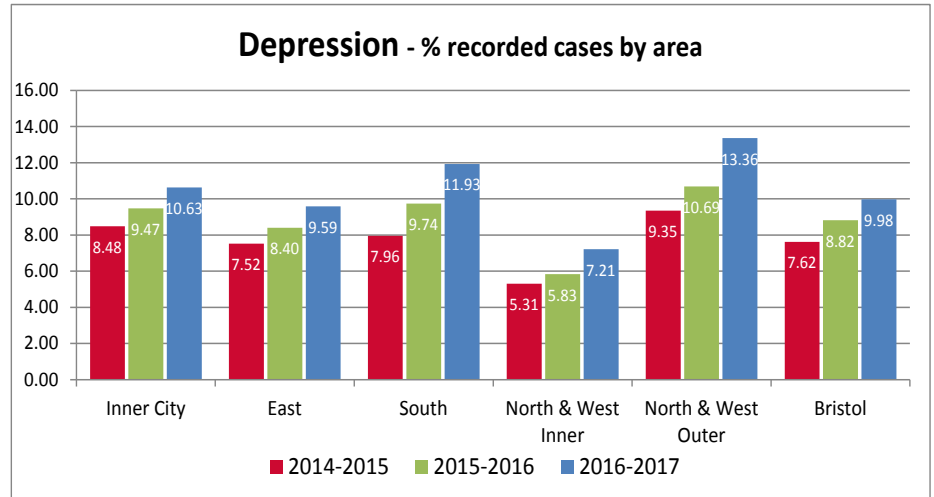


Fig 9.1.1: Source: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, Feb 2018)

New diagnoses of depression

In 2016/17, 8,700 Bristol patients received a new diagnosis of depression²⁷⁸ for the first time, which is a recorded incidence of 2.2% of patients (18+). There has been a sharp rise in the last few years, as under 5,000 patients had a new diagnosis in 2013/14, and Bristol continues to be significantly higher than the England average (1.5% in 2016/17).

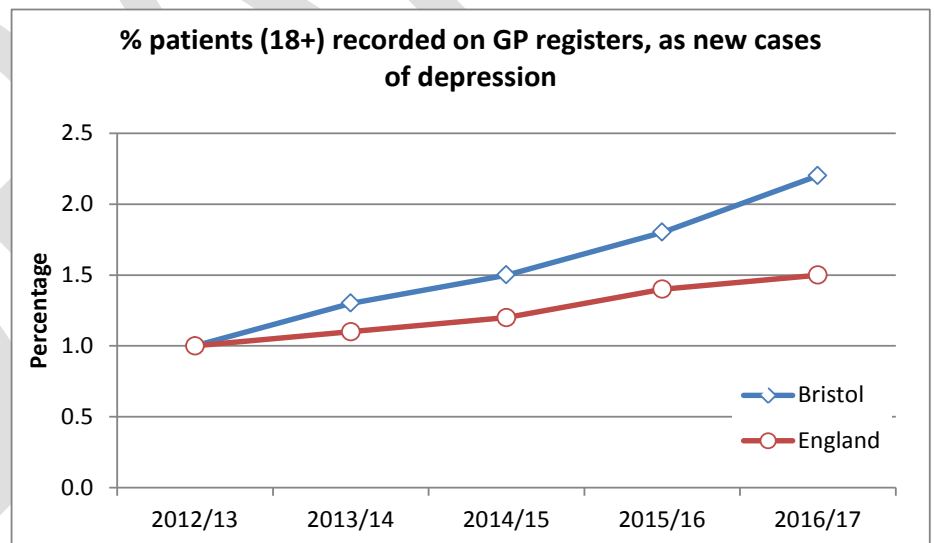


Fig 9.1.2: % Incidences of new cases of depression (Bristol CCG patients) Source: NHS QOF via Mental Health and Wellbeing JSNA profiles

²⁷⁵McManus S, Bebbington P, Jenkins R, Brugha T, (eds), 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014* Leeds: NHS digital:

²⁷⁶ All patients 18+ diagnosed since April 2006, with an unresolved record of depression in their patient record (a crude rate, divided by number of patients). Source: NHS Quality Outcomes Framework (QOF) 2016/17.

²⁷⁷ Note – 2015/16 QOF rates have been recalculated using only practices included in 2016/17.

Further data

- “Mental Health and Wellbeing JSNA” profiles: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna>

²⁷⁸ Source: NHS Quality Outcomes Framework (QOF) 2016/17 via Mental Health and Wellbeing JSNA profiles, 2018

9.2 Self-harm

Women and men of all ages²⁷⁹ and backgrounds do things that are harmful to themselves, especially during times of pressure and emotional distress. Self-harm refers to an intentional act of self-poisoning or self-injury. Common examples include overdosing, cutting, burning, biting, taking substances or self-strangulation. Whilst much self-harm will go on unrecorded by professionals, many individuals require hospital treatment for self-inflicted injuries.

Self-harm is also associated with suicide, and a fifth of all suicides have attended A&E for self-harm in the year prior to their deaths. Hospital admissions for self-harm are an indicator for population mental health, and an opportunity for interventions to prevent suicide. During 2016-17, Bristol had 1,460 emergency admissions for self-harm²⁸⁰, a rate of 291.3 per 100,000, similar to previous years.

Gender

In 2016-17, there were 1,030 female admissions in Bristol, a rate of 402.1 per 100,000 (fig. 9.2.1), a significant rise on the last year. Male admissions were less than half the female number at 430, a rate of 182.8 per 100,000.

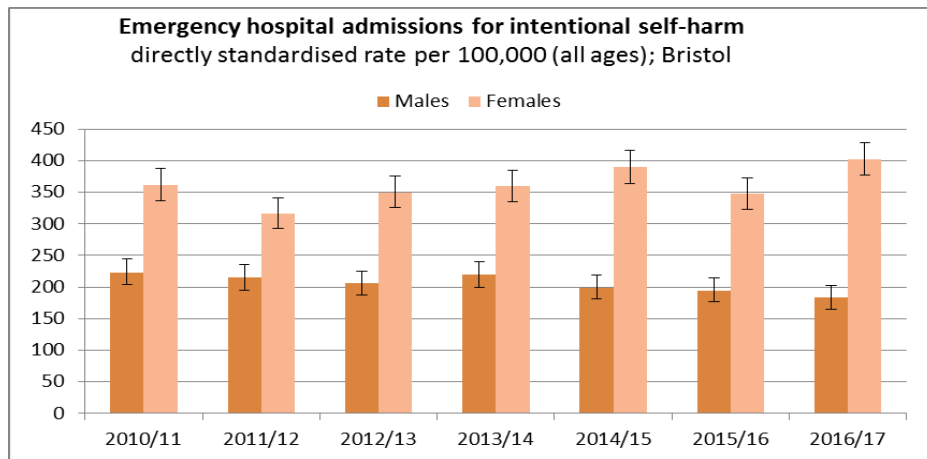


Fig 9.2.1: Source Hospital Episode Statistics via Secondary User Service (SUS) – collated by Bristol Public Health Knowledge Service, 2018

Rates of self-harm vary considerably across Bristol, with a link between self-harm and areas of deprivation. People in the least deprived (better off) areas are significantly less likely to be hospitalised for self-harm - fig 9.2.2 shows the five quintiles of deprivation with crude rates of hospitalisations for self-harm.

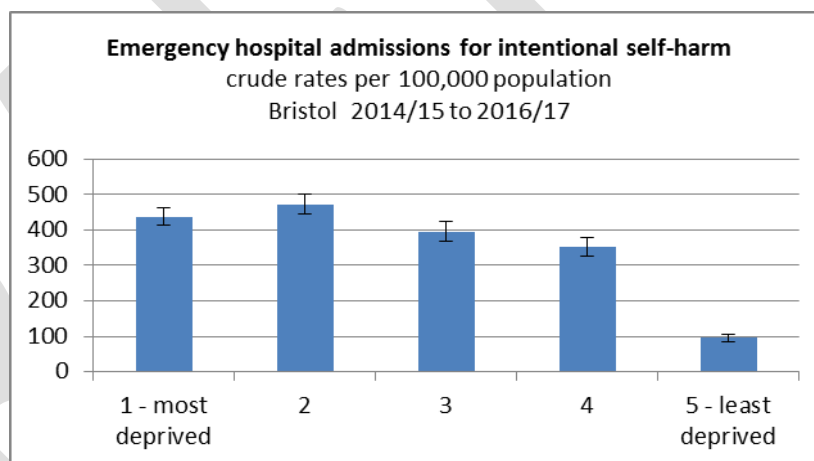


Fig 9.2.2 Source: Bristol Public Health Knowledge Service, 2018

Local data

The Bristol Self-harm Surveillance Register²⁸¹ is a database maintained in the Emergency Department of Bristol Royal Infirmary. This records detailed information on patients presenting to hospital for self-harm. There were 1,535 self-harm presentations to the Bristol Royal Infirmary’s Emergency Department in 2016. Roughly one in three were repeat episodes. Females were more likely to present with self-harm and there has been an increase in the female to male ratio. Data from the Register shows that the proportion of patients receiving a psychosocial assessment was 64.1% in 2016.

²⁷⁹ For Young People, see 9.6.2 Self-harm in Young People

²⁸⁰ Source: Hospital Episode Statistics via Secondary User Service, 2016/17

²⁸¹ Bristol Self-Harm Surveillance Register Annual Report 2016

9.3 Suicide Rates

Approximately 800,000 people will die by suicide worldwide each year. Certain risk factors are known to be associated with increased risk of suicide. These include unemployment, drug and alcohol misuse and people with a diagnosed mental health condition.

Reduction of the suicide rate is a continuing objective in local and government strategies.

During 2014-2016, there were 140 deaths²⁸² from suicide (and injury of undetermined intent) in Bristol, a rate of 12.7 per 100,000 population. This is significantly higher than the England average of 9.9 per 100,000 and the highest of English Core Cities.

Gender:

The majority of suicides are male. During 2014-16, 97 of the 140 suicides were men. The male suicide rate in Bristol is 18.0 per 100,000, similar to the England average for men (15.3 per 100,000, 2014-16).

The female suicide rate in Bristol is 7.4 per 100,000 women, which is still significantly worse than the England average for women of 4.8 per 100,000 - see fig 9.3.1.

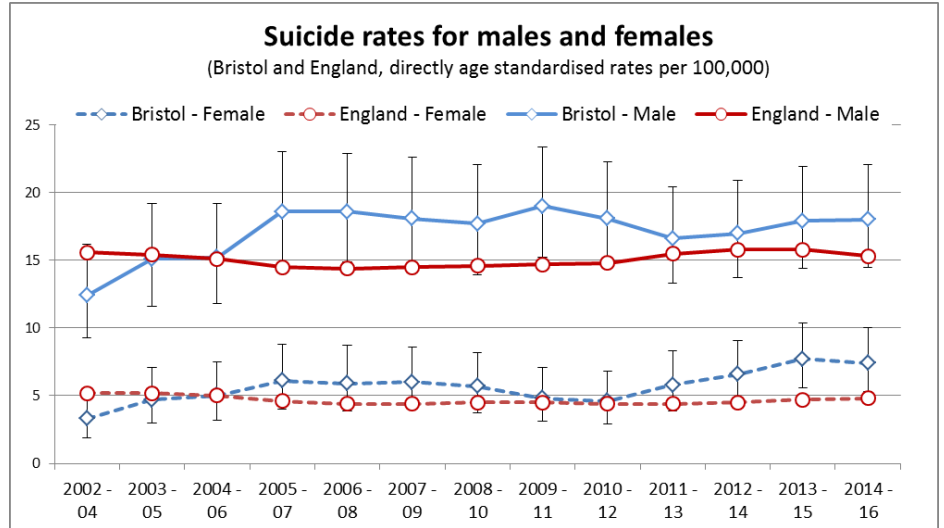


Fig 9.3.1: Suicide rate per 100,000 for males & females (via PHOF, Feb 2018)

Data²⁸³ indicates that the England average suicide rates in both men and women are at their highest during mid-life (35-64). In this age group male suicide is significantly higher. This is true for Bristol, although the male suicide rate is higher than the England average and third of eight highest amongst the Core Cities. Female suicide rates are expressed at a region based level, which show the South West has a higher rate than the England average and the highest of the Core Cities regions.

The incidence of suicide and undetermined death in Bristol over the last decade (2008-2017) has been highest amongst people in the most deprived areas – fig 9.3.2.

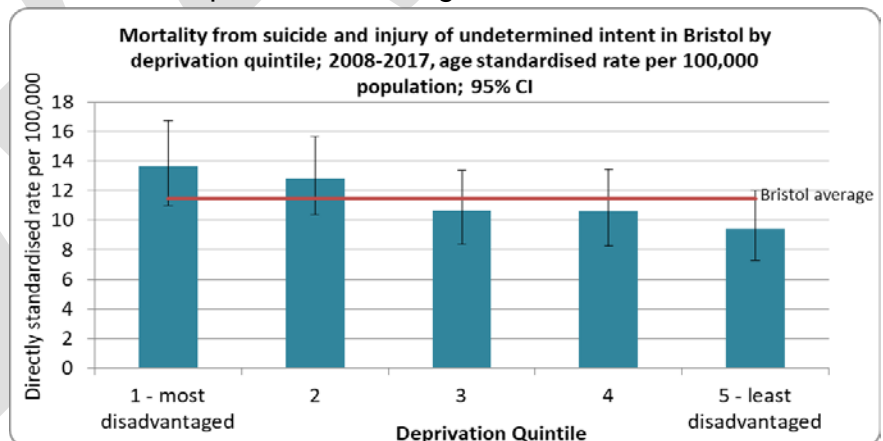


Fig 9.3.2: Bristol suicide rate 2008-2017 by deprivation quintile Source: Primary Care Mortality Database, via Bristol Public Health Knowledge Service

Further data

- “Suicide Prevention Profile” profile: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide>

²⁸² Source: ONS via Public Health Outcomes Framework (PHOF), Feb 2018

²⁸³ 5 year average: 2011-2015, Crude rate per 100,000. Source: Public Health England Suicide Prevention Profile, using ONS population estimates

9.4 Physical health of people with poor mental health

Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. (*The Five Year Forward View for Mental Health Mental Health Task Force, 2016*)

There can also be a lack of physical healthcare for people with mental illness and fear of stigma and discrimination may prevent people with poor mental health seeking help for physical symptoms.

Data on “Excess mortality rate in adults with serious mental illness” shows the ratio (as a percentage) of the “observed number of deaths in adults in contact with secondary mental health services to the expected number of deaths in that population based on age-specific mortality rates in the general population of England”.

The latest available data for this indicator (2014-15) indicates that the rate in Bristol is higher than the national rate. However, Bristol has one of the lowest rates when compared to other English core cities.

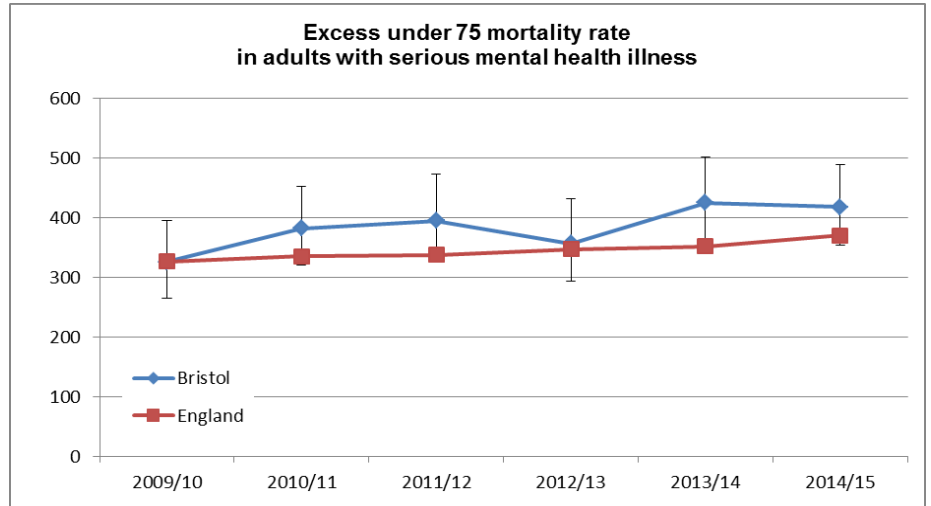


Fig 9.4.1. Source: NHS Digital via PHOF (Aug 2018)

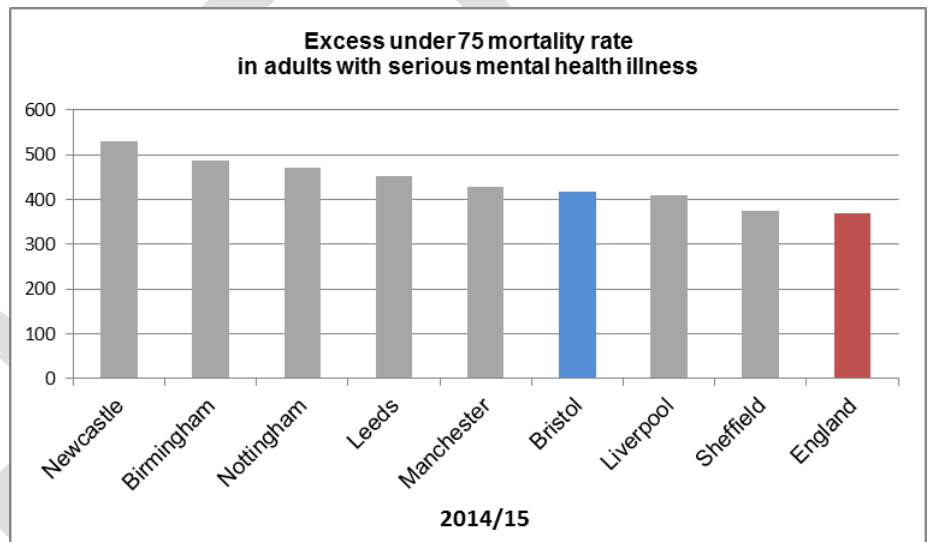


Fig 9.4.2. Source: NHS Digital via PHOF (Aug 2018)

Further data

- Mental Health, Dementia and Neurology Profile: <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp>

9.5 Mental Wellbeing

Emotional health and wellbeing covers a spectrum of activities and behaviours. Wellbeing is closely linked with the physical, cultural and global environment and includes personal, interpersonal and collective needs, which influence each other.

Positive emotional health & wellbeing is essential for healthy development and good physical health, and can be defined as:

*“...not simply the absence of disorder but a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.*²⁸⁴

Only 3.5% of people in Bristol reported 'low life satisfaction scores'²⁸⁵ in 2016/17, a significant improvement over the past 3 years (see fig 9.5.1). This is broadly similar to the England average of 4.5%, but is the lowest (best) percentage of people reporting low life satisfaction of the English core cities.

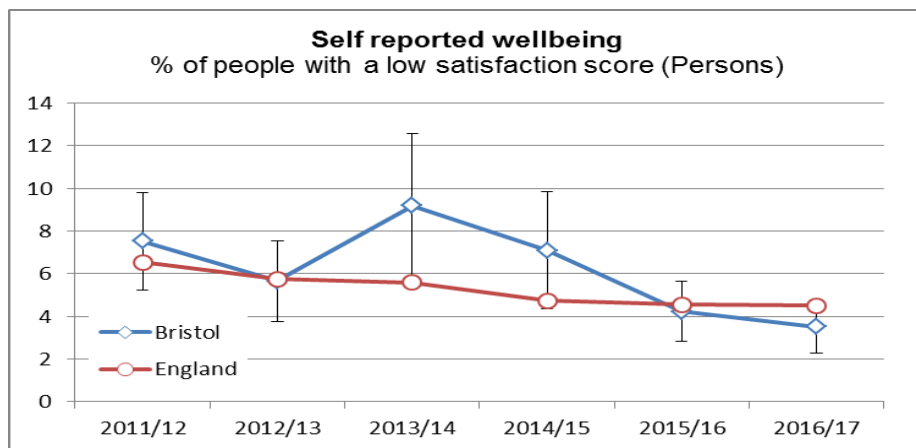
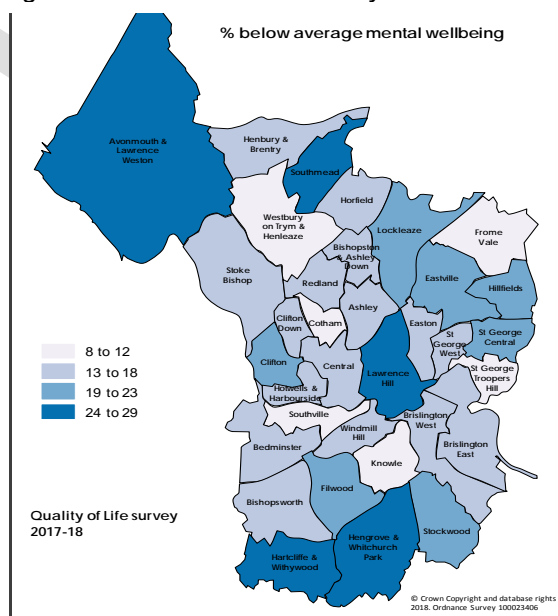


Fig 9.5.1: Respondents with low life satisfaction scores, ONS via PHOF 2018

The local Bristol Quality of Life (QoL) survey 2017-18 reports 69% of people satisfied with life. However, in the 10% most deprived areas, this figure drops significantly to 57%. By ward this ranges from 86% in Cotham to 48% in Hartcliffe & Withywood. Disabled people are the least satisfied with life (34%), with older people 65 & above the most satisfied (76% in 2017-18). There is little difference by gender, but only 60% of BME groups report being satisfied with life.

More detailed data on positive mental health and wellbeing uses a set of questions²⁸⁶ where a low score reflects a lower level of mental wellbeing. In 2017-18, 18% of respondents have below average mental wellbeing. But in the most deprived areas this rises significantly to 28% - see fig 9.5.2.

Fig 9.5.2: Source: Bristol Quality of Life 2017-18



By equality group, disabled people are the highest proportion (44%) reporting below average mental wellbeing in 2017-18, and 24% of young people (aged 16-24), compared to 9.7% of older people 65+. There are no significant differences recorded by sex or ethnicity.

²⁸⁴ World Health Organisation (2010) *Mental Health: strengthening our response*.

²⁸⁵ Score of 0-4 out of 10; Source: ONS Annual Population Survey, via PHOF 2018

²⁸⁶ The “Short Warwick-Edinburgh Mental Wellbeing” Scale includes 7 questions with responses scored 1-5, in the Bristol Quality of Life survey www.bristol.gov.uk/qol.

9.6 Emotional Health and Wellbeing of Children & Young People

Emotional and mental health and wellbeing of children and young people has been a priority area for Bristol and in 2017 BCC produced a detailed JSNA chapter²⁸⁷ on this.

Mental ill-health impacts upon the young people themselves, their families, friends and communities. Good mental health is vital for children and young people to develop the resilience they need to grow, learn and achieve through childhood and as adults.

In Bristol it is estimated that at least 5,100 children aged 5–16 and 1,700 16 and 17 year olds have a diagnosable mental health problem²⁸⁸.

There are also children and young people who do not have a diagnosable mental health problem yet do not have good emotional health. This could be described as not thriving and struggling to cope with everyday stresses. This in itself is a problem, but it also increases risk of developing further mental health problems. The “What About YOUth?” survey²⁸⁹ reported that in Bristol 16.7% reported low life satisfaction, significantly worse than nationally (13.7%) 55% of children had been bullied, and only 47.3%

regarded themselves to be the right size.

Bristol City Council also conducts a “Pupil Voice” survey directly in schools, including questions on positive mental wellbeing²⁹⁰. In 2015, 27% of boys at Secondary school had a low or medium low wellbeing score, and 42% of girls. This shows that girls are reporting worse mental wellbeing than boys, but large numbers of both score low for mental wellbeing.

Also, 13% of boys in Primary school and 12% of girls had low or medium low scores that indicate poor mental wellbeing.

9.6.1 Prevalence of children with mental health disorders

It is estimated that 1 in 10 of children and young people (aged 5-16) in Bristol may be experiencing mental health problems at any one time²⁹¹, including:

- 3.7% have an emotional disorder (e.g. anxiety, depression, and obsessions)
- 5.8% a conduct disorder (e.g. troublesome, aggressive, antisocial behaviours)
- 1.6% a hyperkinetic disorder (inattention and over-activity)

(NB many have more than 1 disorder, so figures do not add to 9.6%)

When these national prevalence estimates are applied to Bristol’s estimated population of 5-16 year olds in 2016, in the region of 5,100 children and young people²⁹² have some level of mental ill health likely to require support from trained workers (see table 9.6.1). However, this is likely to underestimate the true level of need, as diagnoses of mental health disorders increase with age through childhood.

Children in Bristol with mental health disorders, 2016 (estimate)	All children (5-16)		
	Boys	Girls	All
Conduct disorders	1985	970	2955
Emotional disorders	785	1030	1810
Hyperkinetic disorders	690	100	800
Other conditions	410	70	480
Anxiety Disorders	730	920	1650
Depression	140	250	390
Less Common mental health problems	530	180	700
Any mental health problem	3070	2030	5100

Table 9.6.1 Estimated number of children (5-16 years) in Bristol with mental health disorders in 2016, by sex. Note – figures may not sum due to rounding

Gender: Mental health problems are more common in boys for all conditions except emotional disorders, anxiety and depression, where girls are most affected.

²⁸⁷ Bristol JSNA Chapter 2017-18: [Children and Young People Emotional and Mental Health and Wellbeing](#)

²⁸⁸ Estimates via JSNA Chapter 2017-18

²⁸⁹ Source: Public Health England What About YOUth (WAY) survey 2014/15

²⁹⁰ See [Bristol Pupil Voice report 2015-16](#)

²⁹¹ ONS Survey; Mental Health of children and young people in Great Britain 2004

²⁹² National prevalence applied to 2016 ONS Mid-year population estimates for Bristol

9.6.2 Mental health disorders in young people age 16 and 17

There are an estimated 1,700 young people (16-17 years) with common mental disorders²⁹³ - see table 9.6.2.

Gender: Mental health disorders are almost 3x more prevalent in 16-17 year old females than males.

16-17 year olds in Bristol with mental health disorders, 2016 (estimate)	Young People 16-17		
	Male	Female	All
General Anxiety Disorder	175	390	570
Depressive Episodes	40	170	210
Phobias	60	240	300
Obsessive Compulsive Disorder	55	105	160
Panic Disorders	20	100	110
Common Mental Disorder - not otherwise specified	260	500	750
Any Common Mental Disorder	460	1240	1700

Table 9.6.2 Estimate of 16-17 year olds with Common Mental Disorders
Source: Adult Psychiatric Morbidity Survey, 2014 [Note – figures are rounded]

9.6.3 Self-harm in young people²⁹⁴

During 2016/17, 611 young people aged 10-24 years (609 per 100,000) in Bristol were admitted to hospital due to self-harm. This is a significant rise from previous years and further increases the gap above that of England (405 per 100,000), (fig 9.6.3).

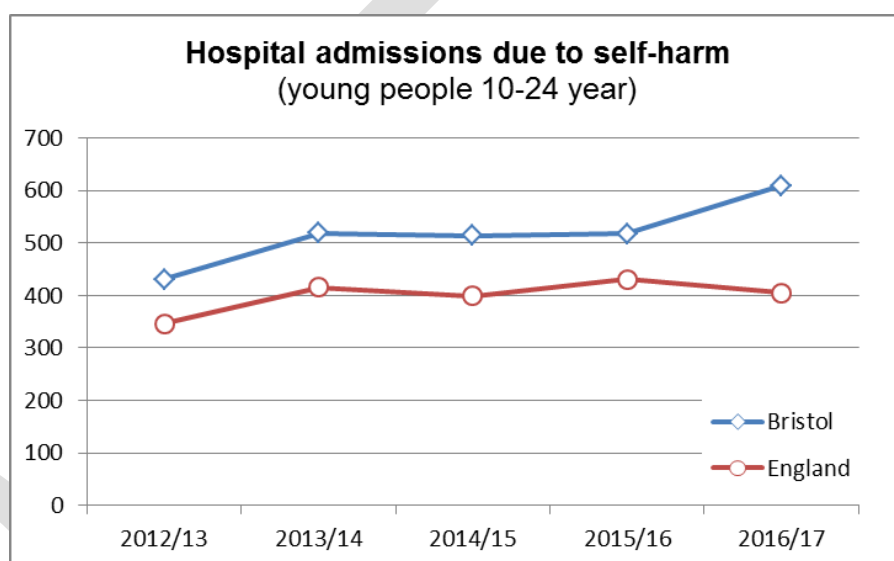


Fig 9.6.3 Hospital admissions due to self-harm (young people 10-24 years) via Children & Young People’s Mental Health & Wellbeing Profile (Public Health England)

9.6.4 Further data

- Children and Young People’s Mental Health & Wellbeing Tool: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh>
- Young People Profile: <https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-young-people>
- Bristol JSNA Chapter 2017-18: [Children and Young People Emotional and Mental Health and Wellbeing](#)

9.6.5 Adverse Childhood Experiences

Risk factors for poor mental health include poverty, experiences of inequalities in childhood, and Adverse Childhood Experiences.

Work on Adverse Childhood Experiences (ACEs) shows that ACEs are common and are a major predictor of future mental health problems.

Adverse Childhood Experiences (ACEs) include

- Direct harms: physical, sexual, emotional or verbal abuse and physical or emotional neglect
- Indirect harms (‘household challenges’): domestic violence, parental drug/alcohol misuse, parental criminal behaviour/incarceration, parental mental illness and bereavement (linked to death or separation)

²⁹³ Source: Adult Psychiatric Morbidity Survey 2014; Prevalence estimates for 16-24 year olds applied to the 2016 population estimates of 16-17 year olds

²⁹⁴ Further details in “4.10.2 Injuries in young people”

9.7 Perinatal mental health

During the “perinatal period” that lasts from conception to one year after birth, mothers are at greater risk of developing new mental health conditions such as depression and anxiety. They are also at greater risk of experiencing a decline in existing psychiatric conditions or a recurrence of a former mental health illness.

Up to one in five women and one in ten men are affected by mental health problems in the perinatal period²⁹⁵. Unfortunately, only 50% of these are diagnosed.

In Bristol, it is estimated that almost 1000 women each year will develop mild to moderate depression in the perinatal period²⁹⁶.

The potentially stigmatising effects of mental health illness can lead to reluctance to seek the treatment and support needed to support recovery and reduce harm.

Untreated and on-going perinatal mental health issues can affect the mother-infant emotional attachment and adversely affect child health outcomes that may last into adulthood.

Perinatal Psychiatric Disorders

Rates (per 1,000 maternities) of new mothers with Perinatal Psychiatric Disorders are shown in table 9.7.1 below, along with estimates of how many women are affected locally:

Severe perinatal MH conditions	Rates (per 1,000 maternities)	Estimated numbers in Bristol (2013/14)
Post-partum psychosis	2 per 1000	15
Chronic serious mental illness	2 per 1000	15
Severe depressive illness	30 per 1000	195
Mild / moderate depressive illness and anxiety states	100-150 per 1000	650 - 975
Post-traumatic stress disorder	30 per 1000	195
Adjustment disorders and distress	150-300 per 1000	975 – 1950

Table 9.7.1 Rates of Perinatal Psychiatric Disorder (per 1000 maternities)
 Source: Royal College of Psychiatrists, 2012 www.rcpsych.ac.uk/pdf/perinatal_web.pdf
 Updated local estimates taken from JSNA Chapter 2017-18: [Children and Young People Emotional and Mental Health and Wellbeing](#)

Confidential Enquiry into Maternal Deaths

The Confidential Enquiry into Maternal Deaths in the UK 2009-2014²⁹⁷ shows that nationally, suicide was the leading ‘direct’ cause of maternal deaths occurring within a year after the end of pregnancy. The World Health Organisation re-classified suicides as a direct cause of maternal death, formerly it was classed as an indirect cause. Nationally, 111 women died from suicide during the perinatal period during 2009-2014.

For the period 2012 to 2014, 323 women died between six weeks and one year after the end of pregnancy. Of this number, 15% was due to suicide and a further 11% as a result of drug and alcohol/psychiatric causes.

²⁹⁵Royal College of GPs:
www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

²⁹⁶ Estimate via JSNA Chapter 2017-18:
[Children and Young People Emotional and Mental Health and Wellbeing](#)

²⁹⁷ MBRRACE 2016 / [MBRRACE-UK Reports | MBRRACE-UK | NPEU](#)

Section 10

Older People

This section focuses on the health and social care issues of older people, but acknowledges the significant contribution made by older people to Bristol's society and economy.

Summary points²⁹⁸

Population

- There are 59,800 people aged over 65 in Bristol (ONS 2017). This is 13% of the population, lower than the 18% nationally
- There are projected to be 6,800 more people 65 & over by 2026, an 11% rise (and potentially a 29% rise by 2036).
- For people 85 & over, there are projected to be 700 more by 2026, an 8% rise (and potentially a 52% rise by 2036).
- In recent years most of rise in the 65+ population has been in wards in the Bristol North & West (inner) area, which has a different age profile to other areas of the city

Older People's Health

- Staying active as people get older is really important – see www.bristolactivecity.org.uk/older-people/
- It is estimated that there are over 4,200 people (65+) living

with dementia in Bristol, with 3,120 having a GP diagnosis

- The number of people with dementia (65+) is projected to rise by 13% by 2026, and by 41% by 2036 (linked to the high projected rise in people 85+)
- We can reduce our risk of dementia by leading a healthy lifestyle - not smoking, eating well, and keeping active.
- Bristol's hospital admission rates following a fall (people 65+) are significantly higher than the England average
- Bristol's rate of hip fractures in people 65+ remained at a similar rate to the previous year but is slightly higher than the England average
- There were 192 "excess winter deaths" in Bristol (2015/16), a significant decrease on the previous year (which experienced an uncommon high). Females accounted for 61% of deaths compared to 39% for males.
- More people in Bristol are able to die at home than nationally.

Social care and wider determinants

- There are 15,000 income-deprived older people²⁹⁹ in Bristol, which is 20% of all older people (over 60) in Bristol
- 4,000 adults received a community-based social care support service (Community Support Service) during 2017/18. 2,020 of these were older people and 1,975 people aged 18-64 years, both of which are consistent with the previous year
- 1,650 care home places were funded for older people in 17/18, lower than the past two years
- There are estimated to be between 6,300 and 11,400 older people who are socially isolated in Bristol³⁰⁰

Further data:

Older People's Health and Wellbeing Profile summary
<https://fingertips.phe.org.uk/profile/older-people-health>

²⁹⁸ These cover all relevant Older People areas from throughout the JSNA sections.

²⁹⁹ See section 5.2 Income deprivation

³⁰⁰ See section 5.16 Social Isolation

10.1 Dementia

Nationally, it's estimated that 7.1% of people over the age of 65 have dementia³⁰¹, which broadly equates to 4,300 people (65+) with dementia in Bristol³⁰².

3,120 people in Bristol have a diagnosis of dementia recorded by their GP³⁰³. This is 0.62% of all Bristol GP patients, but is rising – see fig 10.1.1. The Bristol rate is lower than the England average (0.76%), which may be expected given Bristol's younger population. As a proportion of patients aged 65 and over, 4.8% in Bristol are recorded as having dementia, which is higher than in England (4.3%).

NICE clinical guidelines on dementia³⁰⁴ state that a blood test should be done as part of a “basic dementia screen to exclude potentially reversible or modifying cause for the dementia and to help exclude other diagnoses”. Previous data in the Dementia Atlas (2014/15) showed that 76.6% of diagnosed dementia patients in Bristol had had this blood test, which is higher than in England³⁰⁵.

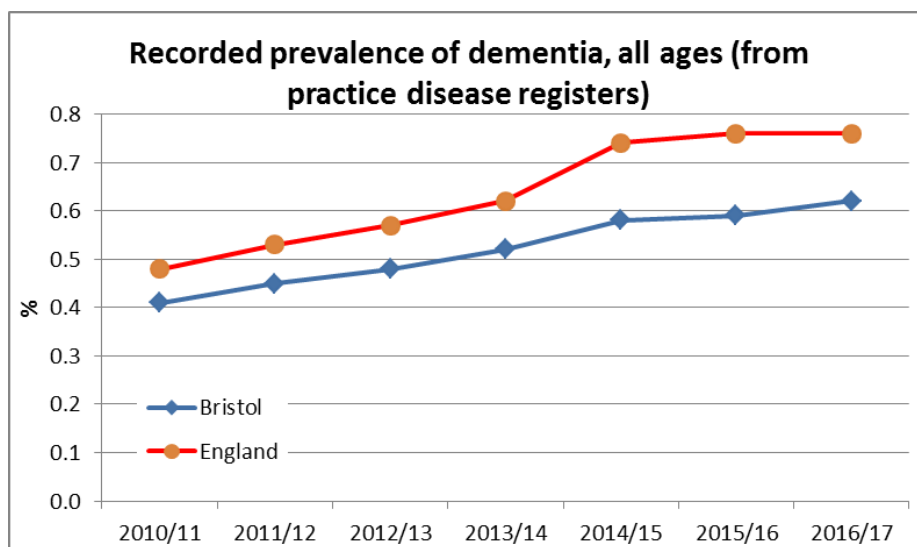


Figure 10.1.1: Recorded prevalence of dementia; QOF via Public Health England Dementia Profile, Apr 2018

The biggest risk associated with the development of dementia is age. A person's risk of developing dementia rises from 1 in 14 over the age of 65, to 1 in 6 over the age of 80³⁰⁶.

We can reduce the risk of dementia by leading a healthy lifestyle. Choices that are good for the heart and circulation, such as not smoking, eating well, and being active lower the risk of dementia³⁰⁷.

Projections estimate that the number of people aged over 65 in Bristol will increase by 11.3% by 2026, and by 29% by 2036³⁰⁸. The number of people with dementia aged over 65 is projected to rise by 13% by 2026, and by 41% by 2036³⁰⁹. This higher rise is largely due to the projected increase in the older age range (85+), who have much higher prevalence rates for dementia.

Gender: In 2018 we estimate³¹⁰ there are 1,500 men 65+ with dementia in Bristol and 2,800 women 65+. More women than men develop dementia as women live longer on average.

Ethnicity: The number of people with dementia from BME communities is expected to increase significantly faster than the national average³¹¹.

³⁰¹ Source: Dementia UK: Update 2nd Edition report by King's College London and the London School of Economics for the Alzheimer's Society (2014)

³⁰² Estimate for 2018; Source: "Dementia UK: Update Second Edition report (2014)" applied to 2016-based ONS population projections

³⁰³ QOF 2016/17 via Public Health Dementia Profile: <http://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>

³⁰⁴ <https://www.nice.org.uk/guidance/cg42>

³⁰⁵ Dementia Atlas using Quality Outcomes Framework (QOF) 2014/15

³⁰⁶ Source: Dementia UK: Update 2nd Edition report by King's College London and the London School of Economics for the Alzheimer's Society (2014)

³⁰⁷ www.alzheimersresearchuk.org/about-dementia/helpful-information/reducing-the-risk/

³⁰⁸ ONS 2016-based Sub-national Population Projections - these are trend-based projections, which means assumptions for future levels of births, deaths and migration are based on observed levels. Projections become increasingly uncertain the further they are carried forward due to the inherent uncertainty of demographic behaviour.

³⁰⁹ Prevalence rates from "Dementia UK: Update Second Edition report (2014)" applied to 2016-based ONS population projections; Supplied by BCC Insight, Performance & Intelligence service

³¹⁰ BCC IPI team using Dementia UK 2014 prevalence rates applied to Bristol pop'n

This increase is mostly due to immigration patterns that have resulted in an ageing BME population, though there is some evidence to suggest that more people from BME communities have dementia compared to white British people³¹². Vascular dementia (caused by problems with the supply of blood to the brain) is thought to be more common among Asian and Black Caribbean people because they are more prone to important risk factors for vascular dementia such as cardiovascular disease, hypertension and diabetes.

Living with dementia

Care and support for people with dementia, their families and carers should be provided within people's local communities, and avoid unnecessary emergency admissions and hospital stays.

The ratio of people with dementia (all ages) using hospital inpatients services appears to have risen in the last two years with 62.2 people per 100 using services in 2016/17 (fig 10.1.2). The *ratio* in Bristol is significantly higher than the England average.

Emergency hospital admission rates for people with dementia are increasing both in Bristol and nationally, and the Bristol rate is

higher than the rate for England (fig 10.1.3).

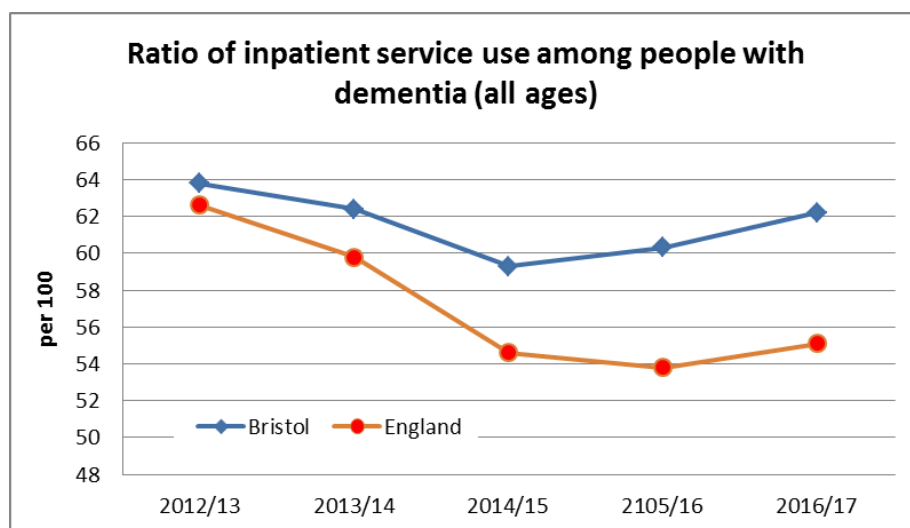


Figure 10.1.2: via Public Health England Dementia Profile, Apr 2018

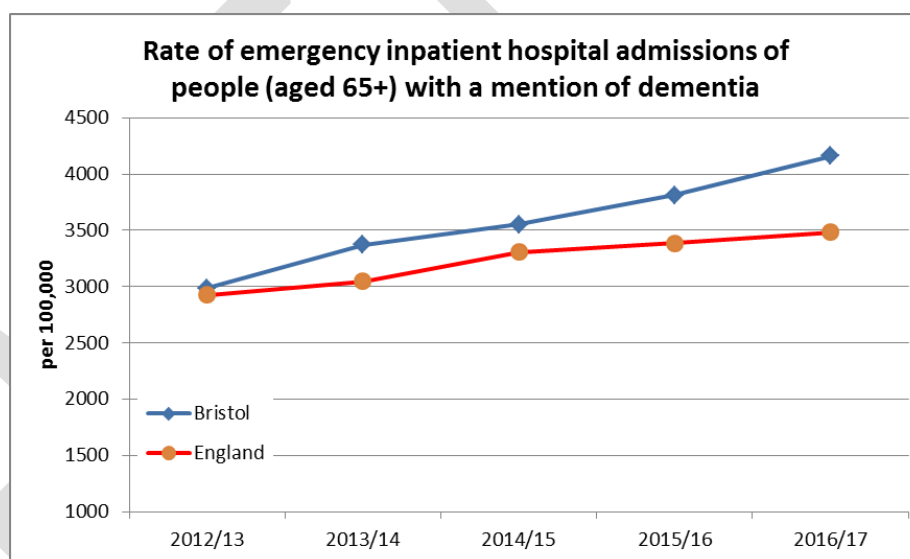


Figure 10.1.3: via Public Health England Dementia Profile, Apr 2018

Mortality

The Bristol rate of mortality with a recoded mention of dementia is 874 per 100,000 people which has increased significantly from 2011 (590 per 100,000 people). It is now very similar to the England rate of 868 per 100,000. This rise in mortality rate is likely to be due to increase in diagnosis of dementia.

The majority of people with dementia in Bristol die at home (73.0%) compared to (67.9%) across England.

Further data

- PHE Dementia Profile: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>
- Dementia Statistics Hub: www.dementiastatistics.org/

³¹¹ Source: All-Party Parliamentary Group on Dementia (2013). Dementia does not discriminate. The experience of black, Asian and minority ethnic communities.

³¹² Adelman, S. (2010) 'Prevalence and recognition of dementia in primary care: a comparison of older African-Caribbean and white British residents of Haringey', PhD thesis, University College London.

Further references available on request

10.2 Falls

Fear of falling contributes to social isolation which reduces the quality of many older people lives, and increases the need for care and support services. But falling is not an inevitable part of ageing. The risks of falling, sustaining injury following a fall and of being admitted to hospital following an injury can all be reduced.

Bristol’s rate of emergency admission for injuries due to falls is significantly higher than the England average (fig 10.2.1). During 2016/17, 1,757 people in Bristol aged over 65 were admitted to hospital with an injury due to a fall.

Of the falls in people 65 and over in Bristol, 68% are people aged 80 and over. Over the last 5 years, the rate of falls per 100,000 persons aged 80+ has been increasing and is significantly higher than the England average (fig 10.2.2).

Gender: The majority, 64%, of falls-related admissions (aged 65+) are females. However, trend data for Bristol shows that over the last 5 years the average rate per 100,000 males (65+) is increasing whilst the rate for females has not changed significantly (fig 10.2.2).

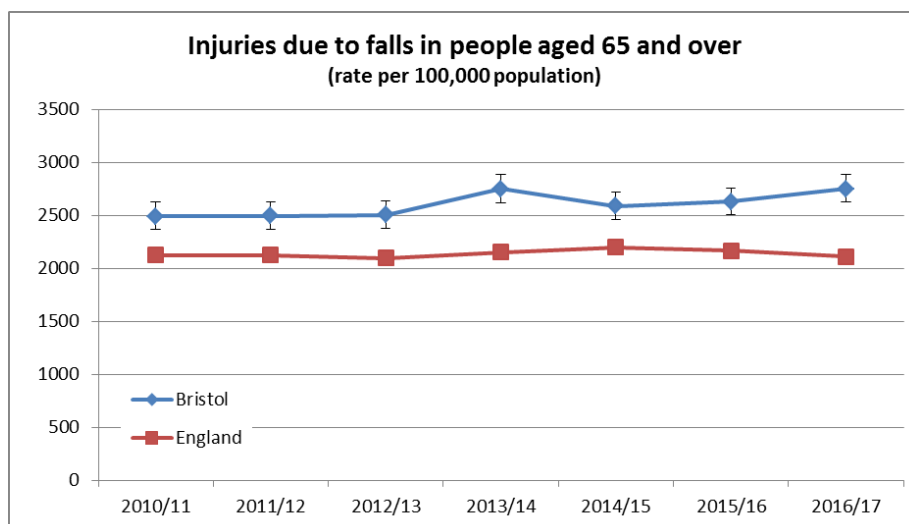


Figure 10.2.1 Hospital admissions from injuries due to falls (65+) via Public Health Outcomes Framework, May 2108

Public Health Outcomes Indicator	Bristol		England	Bristol trend (rate/100,000) over last 5 yrs.
	Number	Rate / 100,000	Rate/ 100,000	
Injuries due to falls in people aged 65 and over (persons)	1,757	2,753	2,114	no significant change
Injuries due to falls in people aged 65 and over (Male)	633	2,512	1,714	increasing
Injuries due to falls in people aged 65 and over (Female)	1,124	2,913	2,395	no significant change
Injuries due to falls in people aged 65-79 (Persons)	558	1,363	993	no significant change
Injuries due to falls in people aged 65-79 (Male)	257	1,304	814	Increasing
Injuries due to falls in people aged 65-79 (Female)	301	1,415	1,152	no significant change
Injuries due to falls in people aged 80+ (Persons)	1,199	6,786	5,363	increasing
Injuries due to falls in people aged 80+ (Male)	376	6,018	4,328	increasing
Injuries due to falls in people aged 80+ (Female)	823	7,261	6,000	no significant change

Figure 10.2.2 Falls-related emergency admissions (PHOF, April 2018)

Analysis of 2014/15 to 2016/17 data showed that 13% of all falls-related admissions were from residential and nursing care homes, and 87% were from those living at private addresses (including Extra Care Housing and Supported Housing).

Rates of falls-related emergency admissions of people living independently were highest in Southmead and Hartcliffe & Withywood, and lowest in St George Troopers Hill and Hotwells (fig 10.2.3).

Hip fracture

One of the most common injuries resulting in emergency admission following a fall is fractured neck of femur (or hip fracture). During 2016/17, Bristol's rate of hip fractures (631 per 100,000) remained at a similar rate to the previous year but is worse than the national average of 575 per 100,000 (fig 10.2.4). 401 people aged 65 & over were admitted with hip fractures in 2016/17.

Gender: Females accounted for 71% of hip fracture admissions in 2016/17, (284 admissions) a rate of 740 admissions per 100,000 aged 65+. Males accounted for 29% of admissions, (117 admissions) a rate of 473 per 100,000 aged 65+. Rates for females and males are both above the national average³¹³.

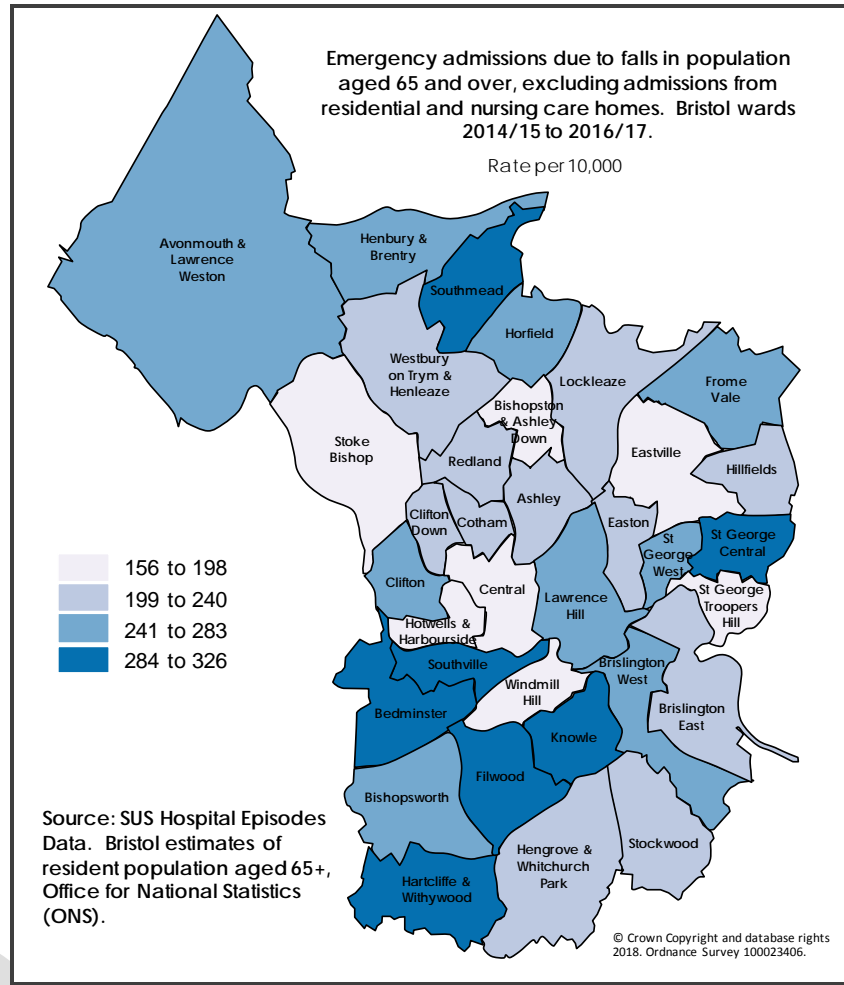


Figure 10.2.3 Source: Bristol Public Health Knowledge Service, 2018

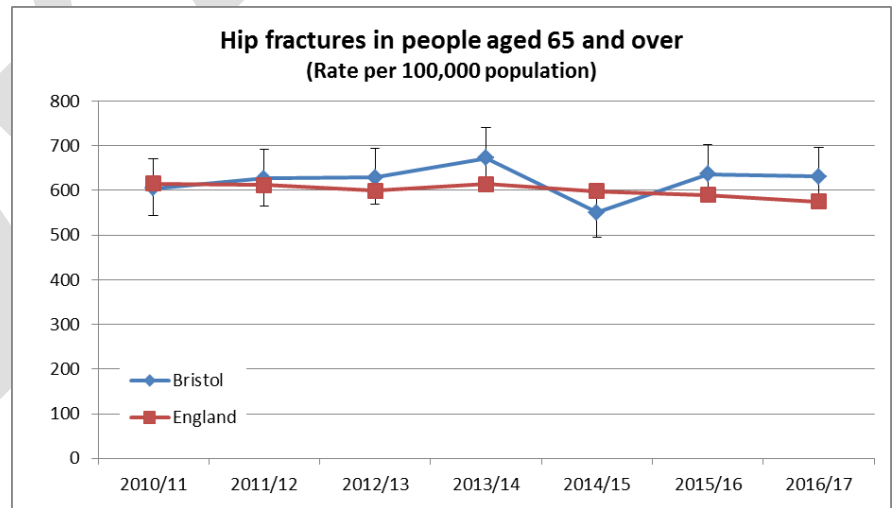


Figure 10.2.4 via Public Health Outcomes Framework, April 2018

³¹³ via Public Health Outcomes Framework (PHOF), 2018

10.3 Excess Winter Deaths

The number of excess winter deaths (EWD)³¹⁴ depends on the temperature, levels of influenza & other diseases in the population and other factors, such as how well equipped people are to cope with the drop in temperature.

Public Health England reports that 21.5% of EWD are attributable to the coldest 25% of homes and 10% are directly attributable to fuel poverty³¹⁵. Most deaths are due to circulatory and respiratory diseases, and the majority occur amongst people over 75. Seasonal Flu vaccinations³¹⁶ are an important prevention measure for EWD. In 2014/15 the highest number of EWD were for women aged 85 and over.

In 2014/15, 52% more people died from dementia or Alzheimer’s disease in the winter than in the non-winter months³¹⁷.

Mortality during winter increases more in England and Wales compared to countries with colder climates, suggesting that many of

these deaths could be prevented³¹⁸.

The number of Excess Winter Deaths in Bristol dropped significantly last year. In 2015/16, there were 192 excess winter deaths in Bristol, which is 18.4% more people dying in the winter months compared with the non-winter months; in 2014/15 that ratio was 28.6% but in 2013/14 was only 7.2%. Large annual fluctuations in EWDs are common (fig 10.3.1), with the EWD ratio for England dropping to 15.1% in 2015/16 compared to 27.7% in 2014/15, and 11.6% in 2013/14. Bristol has the third highest EWD values of the Core Cities (although confidence intervals are very wide meaning there high levels of uncertainty in the data).

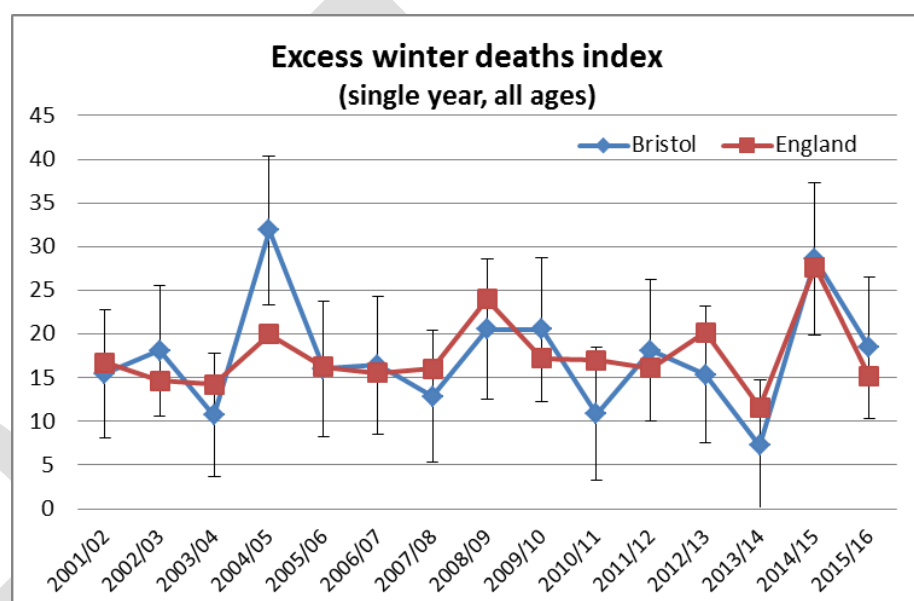


Figure 10.3.1: Excess Winter Deaths index. Source: Public Health Outcomes Framework, Apr 2018

Gender: Of the 192 excess winter deaths in 2015/16, 61% (118) were female and 39% (74) were male. The EWD index for Bristol women is 22.75 and is significantly above the England average of 16.23. For men the EWD index is 14.15, in line with the England average of 13.94.

³¹⁴ A measure of how many more people die in the winter. The index is a ratio between the extra deaths from all causes, and the number of deaths that would be expected to occur if the number of winter deaths was the average of the number of non-winter deaths.

³¹⁵ www.gov.uk/government/uploads/system/uploads/attachment_data/file/355790/Briefing7_Fuel_poverty_health_inequalities.pdf

Also see section 5.13 Fuel Poverty

³¹⁶ See section 7.6 Flu Immunisations

³¹⁷ www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/201415provisionaland201314final#excess-winter-mortality-ewm-by-sex-and-age

³¹⁸ www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E12000009/ati/102/are/E06000023/iid/90641/age/1/sex/4

10.4 Adult Social Care

This section covers adults and older people.

Further data is available through the Adult Social Care Outcome Framework³¹⁹ which measures how well care and support services achieve the outcomes that matter most to people.

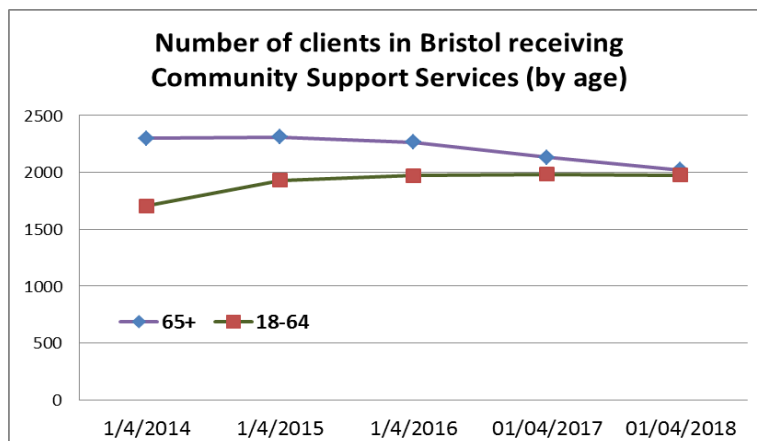
Full information about Bristol’s strategic priorities for Adult Social Care is available in the [Market Position Statement](#)³²⁰

10.4.1 Community Support Services (CSS)

Community Support Services (CSS) in Bristol are adult social care support services for adults (18 years+) with eligible social care needs that are delivered within community settings or at home³²¹. Services included are:

- Supported Living
- Support to Access the Community
- Day Services
- Time for You

At the end of 2017/18, 4,000 adults receive Community Support Services in Bristol: 2,020 older people, consistent with the previous year, and 1,975 people 18-64 years, which now accounts for 49.4% of clients – see fig 10.4.1a.



10.4.1a: Snapshots of CSS client, 2014 to 2018; Source: BCC 2018

Gender: In 2017/18, women accounted for 55% (2,200) of the take up of services, with 45% for men (1,800). For older people, women accounted for 63% of the take up, with 37% for men.

Across the city, there are large differences in the rates (per 1,000 population, 65+) of older people receiving CSS services. The range is from under 11 per 1,000 in Clifton Down and Cotham to 93 per 1,000 in Lawrence Hill - fig 10.4.1b.

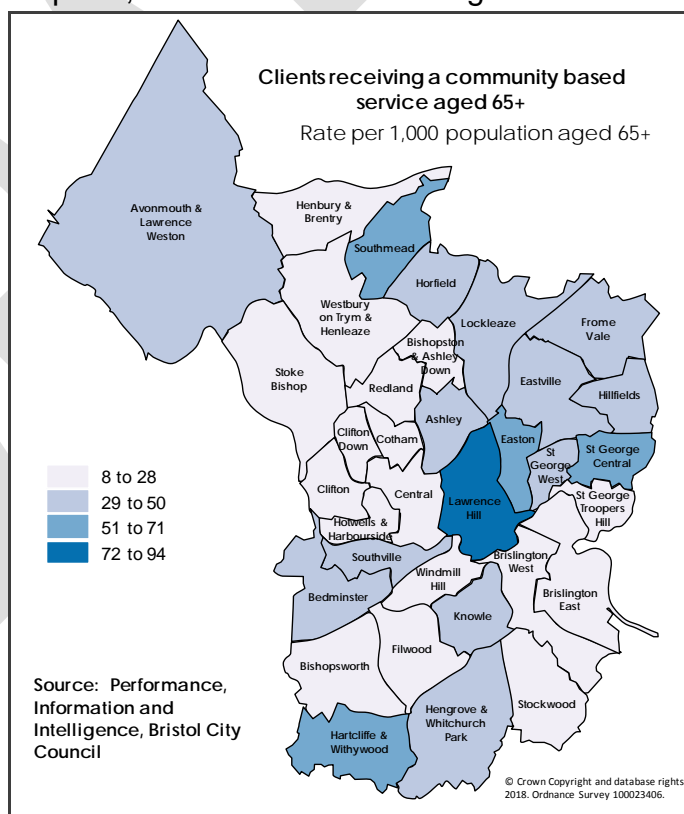


Figure 10.4.1b: 2017/18 rate of CSS clients 65+ by ward; Source: BCC 2018

For CSS clients of working age (18-64 years) the majority have a physical impairment (830), a learning disability (710), or a mental health issue (410), plus sensory impairment (60), Autism (50) or Other (250) – see fig 10.4.1c. Numbers in all client groups rose in 2017/18, except “Sensory impairment” and “Other”.

³¹⁹ <http://content.digital.nhs.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF>

³²⁰ Bristol City Council “Working with us for Better Lives”, June 2018

³²¹ See www.bristol.gov.uk/csscommissioning

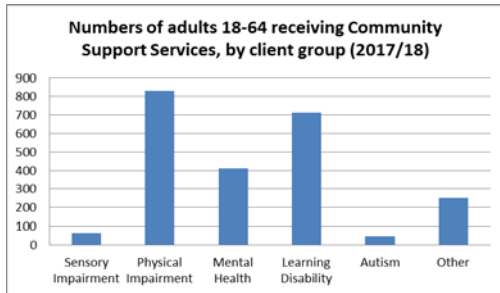


Figure 10.4.1c: CSS clients 18-64 by client group; BCC 2018

10.4.2 Care home placements

At the end of 2017/18, BCC funded 1,650 care home places for older people (65+), lower than the past two years which averages out at 1,710 (fig 10.4.2).

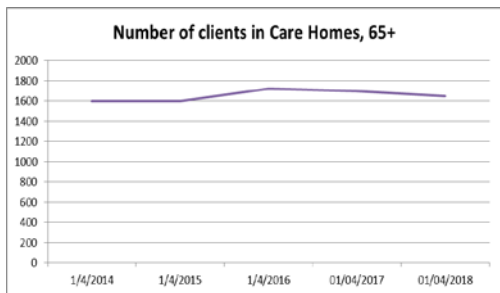


Figure 10.4.2: Care home placements; Source: BCC 2018

Gender: Nearly two thirds of care home places (65+) were given to women (64.4%) in 2017/18 and just over a third to men (35.6%).

There is evidence to suggest that BCC places more people in residential and nursing placements than in other comparator local authorities. However the number of placements made in residential and nursing care is forecast to reduce as BCC builds and commissions alternatives to this care e.g. more Extra Care Housing and home care supply.

10.4.3 Home care packages

At the end of 2017/18, BCC funded 1,103 home care (aka domestic care) packages for older people (65+), 33 less packages compared to the previous year and significantly below the levels of 2013/14 and 2014/15. Home care packages for people of working age (18-64) increased in 2017/18 by 9 packages to a total of 302 packages – see fig 10.4.3. It is expected that demand for home care will stabilise.

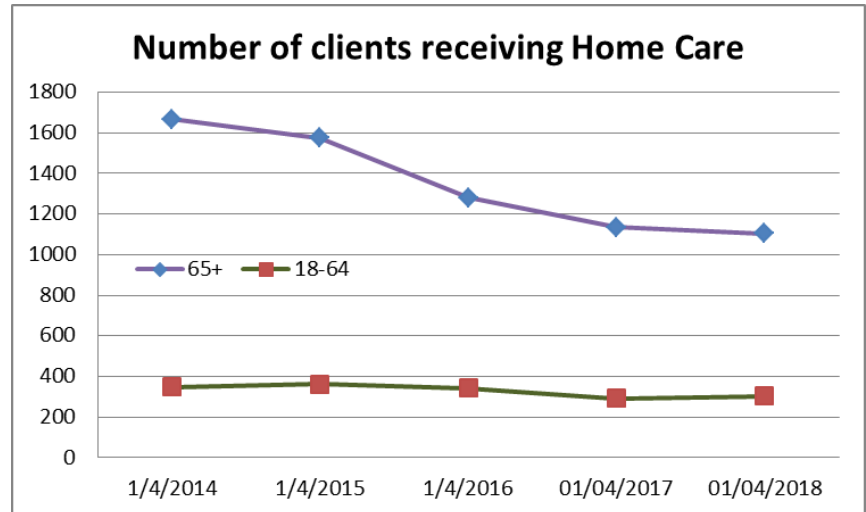


Figure 10.4.3: Home care clients via BCC Insight, Performance & Intelligence Service 2018

Of the home care packages for people of working age (18-64), the majority (58.6%) are for clients with a physical impairment.

10.4.4 Extra care housing (ECH)

At the end of 2017/18, there were 337 ECH packages for older people (65+), which is a decrease of 15 packages when compared with the previous year.

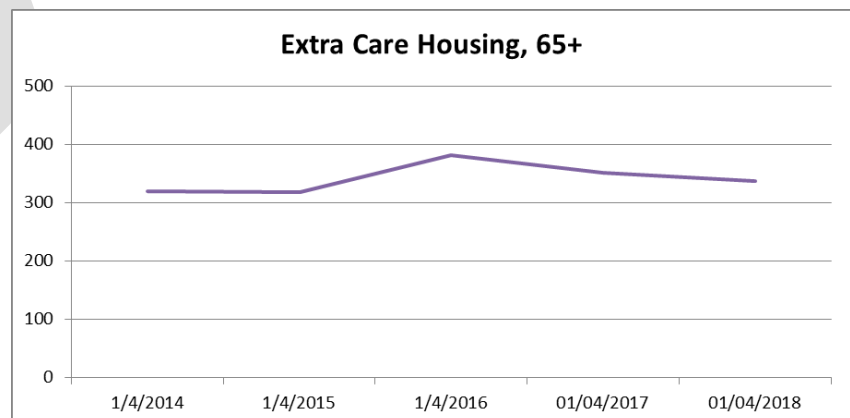


Figure 10.4.4: Extra care housing via BCC Insight, Performance & Intelligence Service 2018

10.5 Delayed Transfer of Care (DToC)

A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

A patient is ready for transfer when:

- a. A clinical decision has been made that patient is ready for transfer **AND**
- b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
- c. The patient is safe to discharge/transfer.

There are several reasons why a delay may occur and which are attributable to either the NHS or social care in the Local Authority, or sometimes due to both (a joint delay). Examples where the Local Authority may be responsible for delay include where a patient is awaiting a residential or nursing home placement or awaiting a care package in their own home.

In 2017/18, Bristol experienced 22,505 delayed days, of which 12,949 (57.5%) were attributable to social care, ranking Bristol as 145th out of 150. This is a decrease in performance compared to the previous year when social care was accountable for 48.7% of delays.

Benchmarking with other core cities (see figure 10.5.1) shows the range of ‘number of delayed days to social care per 100,000 population’ from 120 days in Newcastle to 3870 in Birmingham, and 3590 in Bristol.

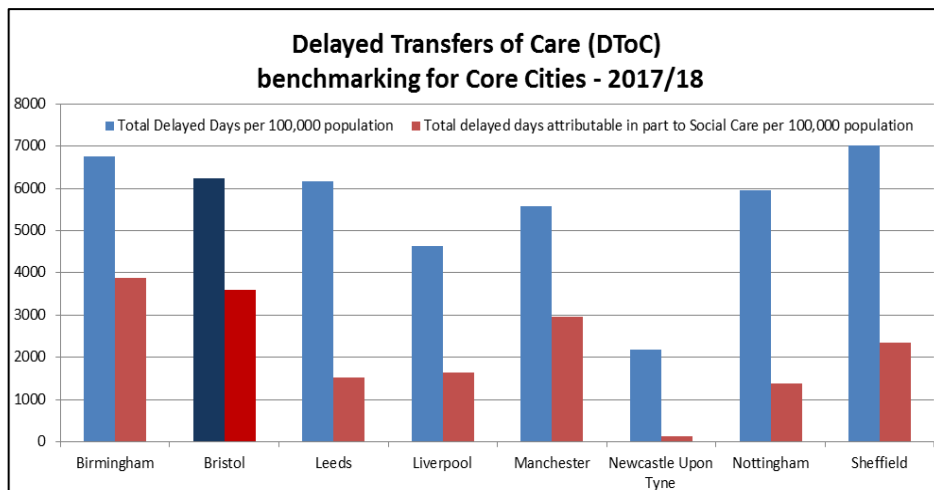


Figure 10.5.1: Core City Delayed Transfers of Care 2017/18 via NHS England

BCC has developed a DToC action plan to reduce the number of delayed transfers of care, which includes taking a “Home is best” approach to ensure everyone has the opportunity to return home in the first instance. Current investment in Reablement will improve capacity to maximise independence for all patients, while continued investment in home care will also increase home care capacity and improve recruitment of care workers in the city. Other initiatives include:

- The development of a greater range of community based services that can support timely discharge from hospital
- Greater use of Assistive Technology to support people to return home
- Developing the Integrated Discharge services within Acute Hospitals

Additional information

- Further BCC information for people who require “Support to live at home”, including reablement, adaptations & equipment, meals and other services are at www.bristol.gov.uk/social-care-health/support-to-live-at-home

10.6 End of life care

Meeting people’s preferences for place of care and place of death is a measure of the quality of end of life care. Surveys and research indicate that home is the preferred place of death for many people³²².

In 2016 Bristol had a significantly higher percentage of people of all ages dying at home (27.5%) than England (23.5%) and the South West average(24.7%) – fig 10.6.1. Of those that didn’t die at home, 44.3% died in hospital (lower than national 46.9%), 21.4% died in a care home (similar to national 21.8%), 4% in a hospice (lower than national 5.7%) and 2.8% in other places.

This indicator can be further looked at by the underlying cause of death, to understand the variations as a proxy indicator for quality of end of life care.

In 2016, more people in Bristol (all ages) were able to die in their usual place of residence, compared to the national average, when the underlying cause of death was cancer (49.1% compared to 44.5%). The Bristol rate was similar to the national average for respiratory disease (32.1% compared to 32.2%) and circulatory disease (46.7% compared to 44.8%)³²³.

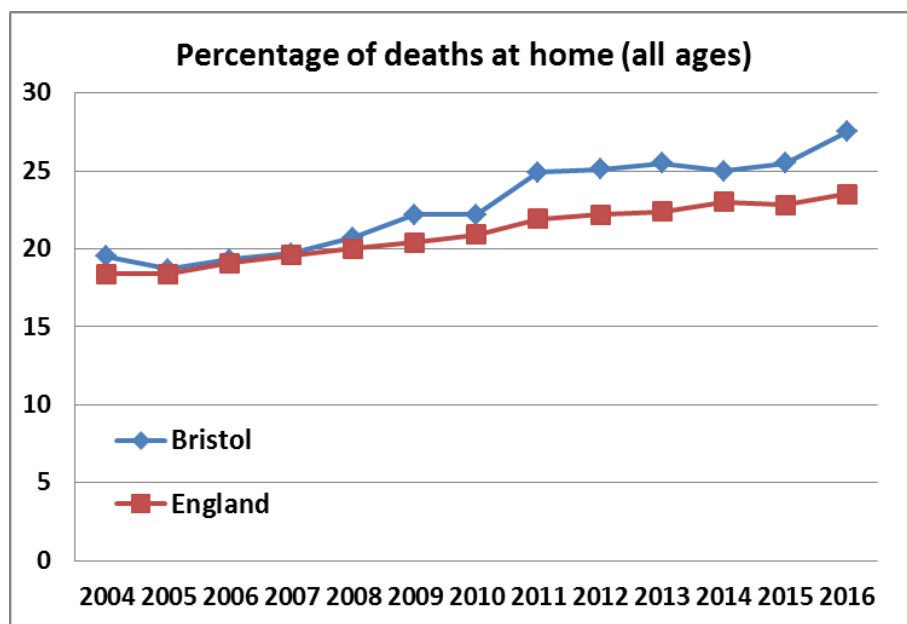


Figure 10.6.1: Percentage of deaths at home, all ages

Source: ONS Mortality File, for National End of Life Care Intelligence, Public Health England, via <https://fingertips.phe.org.uk/profile/end-of-life>

In addition, further details by underlying cause of death are available in the End of Life Profile, for all deaths whether at home or not – see ‘Further data’.

For most categories, Bristol is similar to the national average, other than having a lower % of deaths where circulatory disease is the underlying cause of death for people of all ages (23.1% Bristol, 25.5% England, 2016) and especially lower for people over 85 (23.6% Bristol, 27.8% England, 2016).

Further data

- End of Life Care Profiles: <https://fingertips.phe.org.uk/profile/end-of-life>

³²² PHE report: [Patterns of end of life care in England, 2008 to 2010 \(2013\)](#)

³²³ Source: PHE End of Life Care Profiles (extracted August 2018)

Section 11

Public Feedback

Healthwatch Bristol is a voice for children, young people and adults about health and social care. All Bristol residents can tell Healthwatch Bristol about their experiences of health or social care services and say what was good, and what was not good. Healthwatch then ensures service providers and commissioners hear this feedback and make changes.

In 2017/18, Healthwatch³²⁴

- Heard from 718 people on their feedback
- Visited 178 local services
- Reached over 3500 people on Twitter and Facebook
- Gave over 900 people information and advice
- Produced reports tackling issues ranging from cancer to mental health

How Healthwatch has worked with the Bristol community:

Prostate Cancer

A large focus of Healthwatch's work during 2017/18 has been increasing awareness in the BME population of prostate cancer - 1 in 4 black men will get the disease. A local man, Errol Campbell started a local group with friends and family, as they had started to notice too many of their loved ones were getting prostate cancer, and to quote Errol, "we were attending too many funerals."

Errol's mission was to get earlier screening and speak to Public

Health Bristol about this work, the evidence base and working with the University of Bristol on latest research. Errol held an in event in May 2017, spoke at a Cancer Day for the public in September 2017 and also came and spoke at the Healthwatch Bristol conference in March 2018. Future events are planned to raise awareness further.

Mental Health

During 2017/18 Healthwatch heard that priorities for Bristol and nationally would be mental health. Healthwatch visited two mental health secure wards at Southmead Hospital, under the jurisdiction of Avon and Wiltshire Mental Health Partnership Trust (AWPMHT). The full report on this can be found here:

<https://healthwatchbristol.co.uk/MentalHealth>

16-25 Independent People

16 to 25 Independent People charity provides support to young people between the ages of 16 to 25 years of age who are homeless, are at risk of homelessness or care leavers. One of their projects is the service user forum. The forum enables the young people in attendance to voice their views on the services they access at the project or any personal issues that are affecting them. The Project invited Healthwatch Bristol to speak at their service user's forum and to conduct a workshop with the young people to highlight some of the issues they are faced with when accessing health and social care services. The full report is here:

<https://healthwatchbristol.co.uk/16-to-25-Service-User-Forum>

University of the West of England Sexual Health Report:

Healthwatch engaged with students studying at the University of the West of England to find out their experiences and thoughts on access to contraceptive services, and researched what method they have in place in order to ensure they have adequate contraception whilst studying at university. The questionnaire aimed to find out which university or health services students had used for support, what was good about their experiences and what students think could be improved.

The full report can be found here:

<https://healthwatchbristol.co.uk/UWE-Sexual-Health-Report>

³²⁴ [Healthwatch Bristol Annual Report 2017-18](#)

Autism in the Somali Community

In 2017 Autism Independence and Healthwatch Bristol engaged with Somali families affected by autism to find out their experiences of using health services and their understanding of the condition. This work aimed to find out whether Somali families access adequate support from mainstream health and social care services and whether they face particular barriers in accessing care in Bristol. Since publishing the report, the regional Quality Surveillance Group (QSG) has discussed the findings and will be talking to local providers about providing better reasonable adjustments for both people with Autism, but also with Somali as their first language.

How Healthwatch experiences are helping to influence change:

Healthwatch Bristol worked with stakeholders, partners and statutory organisations over the last year, such as the Care Quality Commission to discuss areas of concern and working together on Enter and View visits.

The quarterly reports and impact reports are now shorter, more impactful and more readable for the public. Healthwatch Bristol have gathered case studies which are also sent to Healthwatch England. Two local projects that Healthwatch Bristol has been involved in have been nominated for the Healthwatch England Awards.

Helping residents find the answers

Well Aware is the health and wellbeing information and signposting service for the areas of Bristol and South Gloucestershire. The Well Aware website covers services, groups, events and activities running in these two areas and also has a free-phone number. The service works closely with community groups and statutory services to guide the content, language and accessibility of the information.

Well Aware signposts to a number of different services, whether it is helping people to find activities to reduce isolation or reconnect with hobbies and sports they enjoy, signposting to advocacy services, providing information on care at home services, support for specific health conditions or local nature and wellbeing activities that can benefit mental and physical health that are taking place in Bristol.

This year Well Aware collaborated with Active Ageing Bristol and LinkAge to produce What's on Guides for over 55s covering North Bristol, Central and East and South Bristol using the information on the Well Aware website.

Further information

- **Healthwatch Bristol website:** www.healthwatchbristol.co.uk
- **Healthwatch Bristol reports**, including a range of Impact reports on specific topics: <https://healthwatchbristol.co.uk/about-us/meeting-and-reports/>
- **Well Aware** - to get in touch with Well Aware, contact: www.wellaware.org.uk or free-phone 0808 808 5252

Health and Wellbeing in Bristol 2018 (JSNA data profile)

Bristol City Council, October 2018

www.bristol.gov.uk/jsna

Bristol JSNA 2018 was compiled on behalf of the Bristol Health and Wellbeing Board, including Bristol City Council (BCC) and NHS Bristol Clinical Commissioning Group (CCG), by

- BCC Strategic Intelligence and Performance team (part of Insight, Performance and Intelligence Service, IPI)
- Public Health Bristol (BCC)
- Healthwatch Bristol (<http://healthwatchbristol.co.uk/>)

If you require this document in another format, please contact:

BCC Strategic Intelligence and Performance team

research@bristol.gov.uk

Tel: 0117 922 2704

Health and Wellbeing Board Forward Plan 2018/19

20th June 2018 Agenda Item Chair: TBC	Purpose	Lead	Organisation
HWB TOR and ways of working	For final sign off	Sue Milner, DPH	Bristol City Council
JSNA annual report and proposed work programme (inc. refreshed TOR)	For information and approval	Sue Milner, DPH	Bristol City Council
Development of Health Theme for the One City Plan	Update on work completed so far and determination of next steps	Marvin Rees, Chair	Bristol City Council
Director of Public Health Annual Report	For information only	Sue Milner, DPH	Bristol City Council
Standing Items:			
Healthier Together (STP)	Verbal update	Julia Ross, CEO Robert Woolley	BNSSG CCG UHB FT
Forward Plan	Sign off	All	
22nd August 2018 (meeting cancelled) Agenda Item Chair: Alison Bolam	Purpose	Lead	Organisation
SEND Action Plan	Sign off	Sue Rodgers, Director of Education and Nakita Singh	Bristol City Council
Thrive Progress Report	To update the Board on the implementation of the Thrive Programme	TBC Chair of Thrive Board	TBC
Suicide Prevention and Response Strategy	Sign off	Sue Milner, DPH	Bristol City Council
Standing Items:			
Healthier Together (STP)	Verbal update	Julia Ross, CEO	BNSSG CCG

		Robert Woolley	UHB FT
One City Plan Health Theme	Update	Sue Milner, DPH	Bristol City Council
Forward Plan	Sign off	All	
24th October 2018 Agenda Item Chair: Marvin Rees	Purpose	Lead	Organisation
CYP Emotional Health Transformation Plan Refresh	Sign off	TBC	Bristol City Council. BNSSG CCG
Annual Health Protection Report	Information	Thara Raj	Bristol City Council
SEND	Information	Nakita Singh	Bristol City Council
Bristol Health Partners Presentation	Information	Andrea Young	North Bristol Trust
One City Plan – Health Story	Update and Sign Off	Sally Hogg	Bristol City Council
Standing Items:			
Healthier Together (STP)	Verbal update	Julia Ross, CEO Robert Woolley	BNSSG CCG UHB FT
Forward Plan	Sign off	All	
12th December 2018 Agenda Item Chair: Alison Bolam	Purpose	Lead	Organisation
Thrive Progress Report	To update the Board on the implementation of the Thrive Programme	TBC Chair of Thrive Board	TBC
Themed session focusing on Children and Families		Jacqui Jenson / Sue Milner	TBC
Standing Items:			
Healthier Together (STP)	Verbal update	Julia Ross, CEO Robert Woolley	BNSSG CCG UHB FT
One City Plan Health Theme	Update	Sue Milner, DPH	Bristol City Council
Forward Plan	Sign off	All	

27th February 2019 Agenda Item Chair: Marvin Rees	Purpose	Lead	Organisation
Suicide Prevention and Response Strategy	Sign off	Sue Milner, DPH	Bristol City Council
Fuel Poverty			Bristol City Council
Women's Health Strategy	Information / sign off	Penny Game	
Standing Items:			
Healthier Together (STP)	Verbal update	Julia Ross, CEO Robert Woolley	BNSSG CCG UHB FT
One City Plan Health Theme	Update	Sue Milner, DPH	Bristol City Council
Forward Plan	Sign off	All	