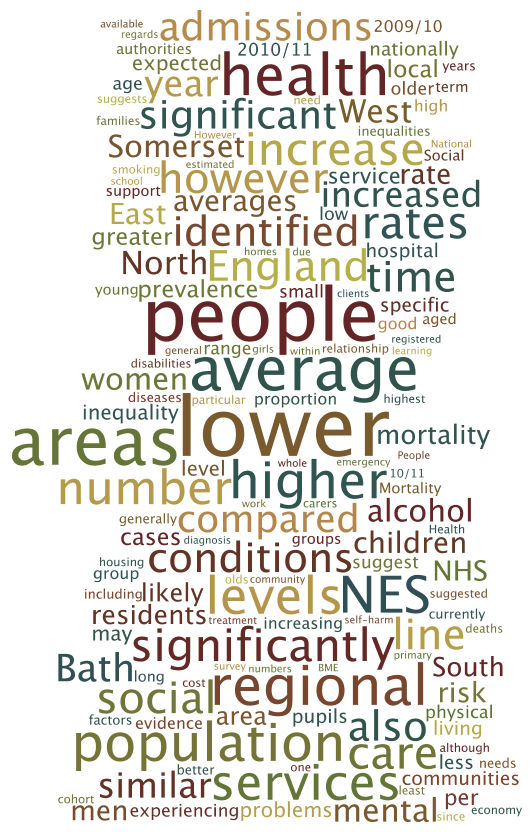
**Bath and North East Somerset**

**Joint Strategic Needs Assessment**

**Executive Summary**



***V1.5 – 20/04/12***

**Part 1 – General overview and trends**

* 1. **The Population at a glance.**

There were 179,900 residents in Bath and North East Somerset (B&NES) in 2010, an increase of 1.1% (2000 people) since 2009, slightly greater than regional and national levels. There has been a 7.7% increase in the population between 1981 and 2009 (from 161,000 to the current figure). This is greater than the national, but lower than the regional increase. This increase has been largely experienced due to ‘migration and other’ factors. In particular, the number of students in the two Universities doubled between 1995 and 2009.

The age and sex profile remains largely consistent compared to previous years, with a 49%/51% male/female split. The age profile is largely consistent with the UK as a whole, except for the 20-24 age range, which represents the significant student population. Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West.

88% of residents are likely to define their ethnicity as White British. White other (3.66%) is the most significant non-white British ethnicity by volume which is likely to include EU Accession state residents, followed by “Asian Indian” (1.97%), “Other ethnic background” (0.96%) and “Black African” (0.9%)

* 1. **Demographic change**

The Office of National Statistics (ONS) project that the population of B&NES will increase by 12% to 198,800 by 2026. This increase is expected to mainly be in older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026.

**1.3 Mortality and life expectancy**

The health of people in Bath and North East Somerset is generally better than the England average. Over the last 10 years, mortality rates for all causes have fallen. All-cause mortality has decreased from 731 per 100,000 in 1993 to 495 per 100,000 in 2010, (-32%) this downward trend is reflected in England and similar authorities. Female life expectancy is three years longer than men and women experience lower mortality rates.

Mortality from treatable conditions is also significantly lower than the England average. In addition, all-cause mortality has decreased in the under 75s, and the current rate for the area is lower than national, regional and comparator areas. Infant mortality rates are similar to the England average (however numbers are very small) and child mortality rates are lower.

The four leading causes of mortality in B&NES (conditions of the heart, cancer, conditions of the lungs and diseases of the bowels, liver, kidney, stomach) are also the four leading causes of mortality for England and Wales (and in the same order). Levels of all these conditions are lower than England and South West rates.

Excess Winter Mortality peaked between 2006/7 and 2008/09 and was at that point significantly above England and South West figures (third highest nationally). In reality, however, this increase was caused by a slight increase in winter deaths against a larger drop in summer deaths, and since 2008/9 the figure has dropped considerably and is unlikely to remain significantly higher than England and South West figures in the future.

* 1. **Long term conditions & disability**

The World Health Organisation (WHO) defines long term conditions (also called chronic conditions) as health problems that require ongoing management over a period of years or decades. With regards to these conditions, the health of people in Bath and North East Somerset is generally better or in line with the England average. However, prevalence of all conditions is rising, in line with national and regional rates.

* **Cancer** incidence is rising in Bath and North East Somerset, alongside similar authorities, the South West and England. However mortality from cancer is decreasing and the B&NES area has lower rates of mortality than those in similar areas. Cancer mortality in the under 65s is also decreasing, but less steeply than some comparators.
* **Colorectal** and **breast** cancers are increasing in line with national, regional and similar areas, while **lung** cancer is lower than similar areas and decreasing at a similar rate. Screening programmes are generally meeting targets, apart from cervical screening, where rates for younger women are lower than recommended.
* Mortality from **circulatory diseases** has been decreasing over time in line with similar areas. **Hypertension** prevalence is slightly lower than England and it is thought there may be a gap in diagnosis. **Coronary heart disease (CHD)** is in line with national levels and it is suggested that there are good levels of diagnosis. Emergency admission rates for CHD are significantly lower than England and regional rates. **Stroke** prevalence is in line with national levels; however emergency admission rates are higher than England and the South West. There is a lower proportion of stroke patients aged 75+ discharged back to their home or usual place of residence compared to national levels. In addition, mortality from stroke in under 65 year olds is not decreasing in line with comparator areas, with significant year-on-year fluctuation compared to a distinct downward trend at a national and regional level.
* Prevalence of **diabetes** is significantly lower than national rates. Prevalence is expected to increase by approximately 150-200 per annum, which relates to an approximately 34% increase from 2005 to 2025. Some of this increase (particularly type 2 diabetes) has been linked to childhood obesity. Screening for diabetic retinopathy is in line with national averages.
* **Respiratory conditions**: Mortality from **pneumonia** is decreasing in line with comparator areas over time. Prevalence of **chronic obstructive pulmonary disease (COPD**) - a range of diseases which limit lung function (e.g. Bronchitis) is lower than national levels while mortality rates have remained relatively flat. The prevalence of **asthma** (all ages) in B&NES for 2010/11 is 6.2%, which is higher than the England average of 5.9%. Admissions and costs related to asthma are below average for England and the South West. Mortality from asthma has decreased over time and is in line with similar areas.
* Mortality from **chronic liver disease** has increased with time, however at a slower rate than regional and national trends. Mortality from **gastric, duodenal and peptic ulcers** has decreased with time in line with regional and national trends. **Chronic renal failure** mortality has shown limited change over time and rates are very low.
* **Epilepsy** prevalence is in line with national levels. Mortality from epilepsy has remained stable, with very small numbers.
* The total number of admissions for **neurological conditions** has been consistently below the South West and national average since 2005/06. Total costs are consistently lower than South West and national averages.
* With regards diseases of the **nervous system,** synthetic estimates suggest that there would be 12 people with m**otor neurone disease** (MND) in the area, and currently 14 are known to the MND association suggesting good levels of diagnosis. Synthetic estimates suggest there are approximately 350 residents with **Parkinson’s disease** and specialist provision is in line with National Institute for Health and Clinical Excellence (NICE) guidelines. It is estimated that there are 291 residents with **multiple sclerosis**, which affects almost twice as many women as men. The neurological rehabilitation service has been identified by the Motor Neurone Society as providing a good level of service. However, a gap has been identified with regards capacity of neurology services in the Royal United Hospital.
* Census estimates suggested that there are likely to be over 3500 people in B&NES with a **learning disability**, which is about 2% of the population. National research suggests local services are likely to be aware of a quarter of this population (815) and GPs had 658 registered people on learning disabilities registers in 2010/11, which is in line with national levels. People with learning disabilities have a shorter life expectancy than the population as a whole, particularly those with Down’s syndrome. However, life expectancy for people with Down’s syndrome is increasing and there is early evidence that it may be approaching that of the general population. This group also have poorer physical and mental health and are vulnerable to other broader risk factors. The proportion of this group in stable accommodation has increased significantly in 10/11.
* An estimated 7% of population (8603) aged 18-24 has a moderate **physical disability** and 2% (2507) have a serious physical disability. An approximate increase of 6%in the number of people with physical disabilities is expected by 2030. Physical disability is the most common reason for receiving local authority care in the 65+ population.
* Estimates of **sensory impairment** suggest 12% of the adult population have moderate or severe hearing loss (in line with the South West and England), 0.28% (n=~400) have profound hearing loss (also in line with the South West and England). It is expected that residents experiencing hearing loss will increase by around 44% by 2030 (lower than regional and national increases). The percentage of the population registered as hard of hearing with Adult Social Services is significantly lower than regional and national levels. Estimates suggest that approximately 2.6% of the adult population have a visual impairment. Estimates suggest that there are just over 1000 deafblind people in the area, which is expected to increase to over 1700 by 2030. There are 49 people registered as deafblind with social care services. Hospital admissions for problems with vision are higher (and costs are higher) than South West and national rates, whilst admissions for problems with hearing are lower.
* Estimates suggest that **Autism** prevalence was 1666 in 2010, (1% of population, men 1.8%). Increased prevalence of psychiatric disorder is particularly marked for people with autism. 55% of those with autism have an IQ below 70. The percentage of school children with Autism Spectrum Disorder (ASD) in B&NES is higher than the regional average and is in the second highest quintile nationally (8% B&NES, 6% nationally).

Consultation with service users suggests that more intelligence is needed with regards to this cohort. Although specialist services and referral pathways were felt to be of good quality, training needs in broader services were identified.

* In 2011 there were 716 pupils with statements of **special educational needs (SEN -** formal identification of condition and action needed) attending schools in B&NES (2.5% of all pupils, 2.8% nationally, 2.7% regionally). There are 4055 pupils defined as SEN without statements. Generally, education achievement for SEN statement pupils is higher than national, (and increased from 5-14% (5+ GCSE’s at A-C including Maths & English) between 2008 and 2009). Over 25% of pupils with SEN statements or at ‘school action plus’ in primary school have speech, language and communication needs. However, this decreases to 10% in secondary school.

SEN boys’ achievement (18%) matched the national average and outperformed girls (16%) who attained below the national average of 20%.

* Unscheduled emergency bed days for long-term conditions are consistently lower than regional and national levels. This is likely to represent good management of conditions in the community.
* The level of residents with long term conditions who smoke is less than national and regional averages.
* 12.5% dwellings are occupied by at least one person who considered themselves disabled or who has a long term illness.
* Take up of the flu vaccine in people with long term conditions has been similar to the South West and national averages, though is (statistically significantly) lower in those with chronic obstructive pulmonary disease. Early data on NHS health checks suggests a 38% take-up which is expected to increase as the scheme beds in.
  1. **Mental Health**

Estimates suggest that over 18,500 people aged 16-64 have a common mental disorder 2010/11 And 8,337 have 2 or more psychiatric disorders. There were 3735 adults accessing specialist NHS mental health services in 2009/10, and 2505 out of work benefit claimants with mental health (MH) as a primary diagnosis against 1380 clients with primary MH diagnosis receiving services by adult social services provided by the council in 10/11.

There are low hospital admissions generally, but these are high for elective admissions for adults and those who self-harm. There is varying identification and management of MH conditions in primary care. Outpatient attendances have been below national and regional averages in general since 2004, although child and adolescent psychiatry attendances have been above both national and regional averages in 2009/10 and 10/11.

**Depression** prevalence is high, with 12.8% for 2010/11 (national 11.2%). This means that there are nearly 1000 more people diagnosed with depression than we would expect from national rates. Psychosis in B&NES in 2010/11 (for all ages) is the same as the national average (0.8%).

The prevalence of reported **Dementia** in B&NES in 2010/11 (for all ages) is slightly lower (0.4%) than the national average (0.5%) and there is likely to be significant under-reporting. Dementia cases are expected to increase by 23% for females and 43% for males between 2010 and 2025. However, there are more dementia cases in women (1549 predicted to increase to 1916) compared with 853 predicted to increase to 1225 cases in men (2010-2025). The B&NES Care Network facilitated a focus group which highlighted the benefits for the carers and the person they care for of earlier diagnosis. Feedback from the LiNK survey (2009) suggested that Dementia and Alzheimer’s were the specific conditions of most concern to the community.

Black and Minority Ethnic (BME) groups have been identified as risk in this area, where uptake of services is variable. There are lower levels of awareness of problems such as depression and dementia within BME communities. Mental health community teams (Q3 2011):, Crisis team, 17% of referrals were from a BME community, Court assessment and referral service 12.5% BME, Community eating disorders service 17% BME, ADHD service 17% BME, Liaison service 18% BME

The number of admissions for **eating disorders** in B&NES has increased although this may be due to changes in diagnosis rather than an actual increase in prevalence. The highest prevalence is in 16-24 year old girls/young women.

Admissions for **self-harm** are statistically significantly higher for both men and women in B&NES (229 per 100,000) compared to the national average (198 per 100,000) for 2009/10. This has been consistent over time; intentional self-poisoning was the most common form of self-harm, alcohol was involved in 38% of the self-poisoning cases in men and 28% of the self-poisoning cases in females.

**Mortality from suicide** is lower than regional and national averages and has fallen overall in the last decade (B&NES ~10 cases each year). Most suicide cases are men who are not in current contact with the mental health service but many of whom had depression, were out of work and had some history of self-harm. Male cases continue to drop (female cases levelled) and are dropping at a greater rate than similar ONS clusters.

Based purely on service indicators, the quality of primary mental health services is generally in-line or better than national average. The Improving Access to Psychological Therapies (IAPT) programme has achieved the highest mean combined reduction in anxiety and depression scores of the 14 IAPT services in the South West and 89% of clients report satisfaction.

* 1. **Safeguarding**

**1.6.1 Children and Young People**

In 2010/11 14,016 referrals where made to **Children’s Social Care**. The rate of referrals to Child Social Care is in line with that for similar authorities, and is much lower than the England average. Care leavers in unsuitable accommodation have also been highlighted as a risk.

There has been a steady increase in the number of children with **child protection plans** over time. However, they are at a lower rate than that of similar authorities and of England as a whole. The increase has been identified as resulting from a number of factors, including increasing complexity of cases, quality of risk assessments and general increased awareness following the ‘Baby Peter’ case. The number of **children in care** has also increased over time although rates remain lower than national levels and in line with similar authorities.

**1.6.2 Adults**

From 2005-11 there have been year-on-year increases in the number of **safeguarding referrals**, with 293 being made in 10/11. Physical abuse is the most common concern raised and there has also been a significant rise in the proportion of referrals for neglect. Adults with learning difficulties had the highest number of cases with substantiated outcomes.

There is little current evidence that personal budgets have increased safeguarding risks. However, as more vulnerable people are given the opportunity to arrange their own care, additional support may be required to reduce the risk of abuse — for example: safe recruitment practices, managing finances safely, setting standards of care and monitoring the quality of support.

Demographic trends indicate that safeguarding referral numbers will continue to rise as the older population continues to grow. Advances in medicine will increase longevity and the number of people living with complex health needs (including dementia), and disability is expected to rise.

PANSI (Projecting Adult Needs and Service Information) estimates 4,144 men and 9,072 women were predicted to be survivors of childhood sexual abuse in B&NES (2011).

* 1. **Carers**

11% of the adult population have self-defined as a carer through the Council’s Voicebox survey and there are 1,462 carers known to the Council. The majority of carers responding to the local carers’ survey are satisfied with the support provided by social services (3.5% dissatisfied). However 78% feel that the support or services received by the person being cared for in the last 12 months has not made any difference to the carer, (11% feel that it has made things worse, 11% better)

Carers from BME groups and/or those who are living in secluded rural areas of B&NES or those who have never had any contact with social services in relation to their care needs have been identified as specifically significant groups.

There are currently 155 young carers registered with the young carers’ service. However, 23% of secondary school and 12% of primary school pupils surveyed said they cared for family members after school on the day before the survey.

* 1. **Service use and quality**

**1.8.1 NHS**

Overall there is a significantly lower rate of outpatient attendances than the national average. Planned and unplanned admissions are lower than national averages.

The number of patients who died following treatment at the RUH in 2010/11 (1,928) was lower than the number expected to die, and the RUH performs better than the England average for lower than expected deaths.

B&NES has the second lowest prescribing cost per weighted prescribing unit in the South West- approximately 19% less than NHS England, 8% less than NHS South West and 4% less than NHS Wiltshire. If local prescribers were prescribing at the same cost per unit as the national level, it would cost an additional £4.56 million a year.

Current Care Quality Commission (CQC) ratings for NHS organisations are as follows:

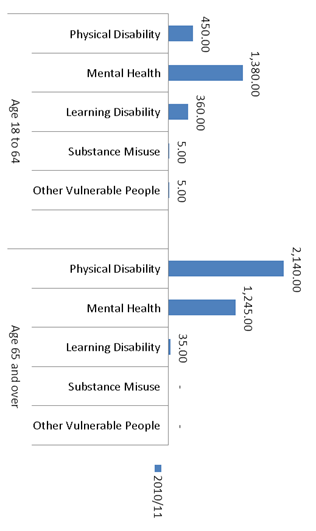
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| Healthcare organisation | Overall quality of services\* | Financial Management score\* |
| **Royal United Hospital Bath NHS Trust** | Good | Good |
| **Bath & North East Somerset PCT** | Good | Good |
| **Avon & Wiltshire Mental Health Partnership NHS Trust** | Fair | Good |
| **Great Western Ambulance Service NHS Trust** | Weak | Fair |
| **Royal National Hospital for Rheumatic Diseases NHS**  **Foundation Trust** | Good | Fair |

**1.8.2 Social Care**

There were 5310 recipients of adult social care in 2010/11. 3140 were aged 65+ and 2170 aged18-64. There has been a reduction in the number of 65+ clients over time; however this has been largely due to a change in recording practice. 63% of clients surveyed in 2010/11 were satisfied with the service they received, which is higher than national levels. Other satisfaction and independent living metrics are also positive. The breakdown of service use by condition is provided in fig 1.

Out of the 500 providers of care within a 20 mile radius of Bath, eleven have been highlighted as needing to improve standards by CQC. Six social care providers have been highlighted as needing to improve the standards of providing care, treatment & support and meeting people’s needs; five for standards of caring for people’s safety and protecting them from harm, three for standards of staffing and four for standards of management.

*(For Children & Young People social care, see Safeguarding).*



**1.8.3 Overall spending & value for money**

Fig 1 – Social Care clients by primary condition

Overall NHS B&NES spent £1,834 per head on healthcare in 2010/11 which is greater than the level for similar areas. Total expenditure has increased by 34% (between 2006/07 and 2009/10) from £136 million per 100,000 population to £182 million per 100,000.

Over the last 5 years the five areas of highest NHS spend are mental health, services provided by general practices, problems of circulation, cancers and tumours, and problems of the musculoskeletal system. The care setting with the highest area of spend is secondary care (including hospital care), though NHS B&NES spend in this care setting is lower than similar PCTs, South West and national averages. Spend is higher than similar PCTs, South West and national averages in the “GP, dental and ophthalmic care settings”, and in “health and social care in other settings”.

* Local NHS spending on mental health and GP services is increasing. Mental health spend is higher than similar authorities but in line with national and regional averages.
* Local NHS spending on “problems of circulation” is lower than similar PCTs, the South West and national averages. B&NES is achieving good outcomes (better than average) for its spend suggesting that the programme is achieving good value for money.
* NHS B&NES spend on the musculoskeletal system is higher than average.
* NHS B&NES spend on cancers and tumours is above average and is increasing over time.
* Local authority spending on older people’s social care is lower than unitary authority averages, and is in the second quartile nationally. Spending on social care for under 65 year olds is greater than unitary authority averages and is in the third quartile nationally. National indicator performance varies, from being relatively poor for adults with learning difficulties to being significantly high for adults with physical disabilities.
* Spending on schools, welfare and inclusion is below average cost and performance is high. Spending on children’s social services is significantly lower than average and performance is varied (see also Safeguarding).

**1.8.4 Voluntary Sector Capacity**

There are over 700 registered community groups active in B&NES working on a wide range of topics and with a wide range of communities. There are a further (approximate) 500 sports organisations. The national third sector survey for B&NES suggests small increases in perceptions of collaboration with local decision making, although overall levels are still low.

Consultation with care forum members suggested that 70% of local agencies feel commissioners are currently meeting the needs of their clients.

Respondents saw service user focussed consultation, flexibility and personalisation, maximising the role of volunteers and communities and a focus on the preventative agenda as being the greatest opportunities for the sector. Funding, information sharing and responding to new ways of working were identified as the biggest threats.

* 1. **Health improvement & protection**
     1. **Infectious diseases**

In general there are very low levels of infectious diseases in B&NES. However, evidence suggests a large amount of food poisoning goes unreported. Mortality from infectious and parasitic diseases has shown a small increase over time, which may relate to the fact that nationally, admissions for these conditions have increased by 10%. Uptake of influenza vaccines amongst over 65s is higher than nationally, although there is some notable variation between GP practices.

*C. difficile* rates are higher than national comparisons, although actual numbers are small. There has been a decrease in time consistent with national patterns.

* + 1. **Emergency preparedness**

The Civil Contingencies Act 2004 defines NHS B&NES as a Category 1 responder to a local emergency. This means that in partnership with local authorities, emergency services and other health bodies, we are part of the first line of response in any emergency affecting our population.   NHS B&NES therefore has a major role to play in preparing for, mitigating against and responding to any serious incident, such as Olympic preparedness, pandemic, major incident, terrorist attack, disruption to road fuel supplies, floods, heat wave or severe weather. Although all of us hope that incidents like these won't happen, the trust does a lot of work behind the scenes to make sure we are ready if the worst does happen.

The trust has plans in place to make sure health services continue to function in a crisis, and to let the public know what to do if they are affected. The PCT is part of a multi-agency group called the Local Resilience Forum (LRF), which helps local councils, health and emergency services and other organisations plan for and work together to respond to a major incident.

During a major incident, NHS B&NES will be responsible for several key areas including:

* The co-ordination of NHS resources
* Mobilising health care for those affected by the incident, including psychological support
* Assisting acute (hospital) trusts to release patients from hospitals to allow the hospital to treat people who are acutely ill as a result of the major incident
* Obtaining emergency medication for people should they have to leave their home as a result of the incident

The ultimate objectives being to:

* Minimise the effects of an emergency as far as possible
* Contain the immediate effects
* Preserve essential services
* Protect the population and the environment and
* Restore normality as quickly as possible
  + 1. **Sexual health**

**Chlamydia** in B&NES has increased (23% in 2010/11), but is lower than the national average (25%) Screening coverage is high compared to the South West, but low compared with national rates. HPV vaccine uptake is higher than national levels.

The rate of **abortions** is in line with or lower than regional and national averages across all groups. Repeat abortions are lower than in the South West and England, with a greater number carried out at less than 10 weeks compared with the South West and England

The rate of GP prescribed **long acting reversible contraceptives** (LARCs) amongst the 15-44 female population has increased significantly over time, is lower than the regional rate but higher than the national one. Practices do not currently prescribe the full range of available LARCs. Spending is comparably high for palliative and end of life services for people with cancer and other diseases.

There is significant variation between men and women identified at a national level with regard to **Chlamydia** testing; 73% of Chlamydia tests conducted in 15-24 year olds are for women (2010-2011 National Chlamydia Screening Programme)

28% of Children and Young People (CYP) surveyed through the Schools and Students Health Education Unit (SHEU) get information about sexually transmitted diseases from their family, 20% from doctor/nurse, with 25% aware of GUM sexual health clinics. However, over 70% of pupils at year 10 knew where to get condoms free of charge.

Teenage conception rates are significantly lower than national rates and the lowest in the South West, which is a reduction of 21.9% since the 1998 baseline. Teenage conceptions ending in abortion are higher than the England average.

* + 1. **Injuries**

There are lower admissions than other areas. The number of hospital admissions of under 18 year olds (per 10,000 children) caused by unintentional and deliberate injuries to children and young people have reduced from a recent high of 434 in 2005/06 to 393 in 2008/09. Reductions have been seen for the 10 – 14 and 15 – 17 age bands. The rate locally is better than for the South West. Admissions for assaults are significantly lower than national averages; however have significant variation by age.

More men are admitted as an emergency hospital admission for assault than women (420 men (77 women) (2004-09)).

There were 393 emergency admissions for **hip fractures**, in line with national and regional averages; mortality levels are significantly lower than nationally and regionally. This may be due to good prevention measures, but there may also be an issue with recording primary cause of death.

There were 1,165 **road traffic collisions** recorded by Transport and Highways in 36 months prior to December 2011. Accidents involving pedal cyclists have increased with time, however overall there has been little change in emergency admissions for road traffic accidents over time (apart from a peak in 2006) with an average of 191 per annum.

The Council met its 40% reduction target set for all people killed or seriously injured in road traffic accidents in 2010/11, together with a 50% reduction target for children.

* 1. **Lifestyle determinants**
     1. **Pregnancy & maternity**

There were 1834 live births in 2010. The number of births is increasing over time, in line with national trends but lower than regional trends. There is a lower fertility rate for women aged 15-44 compared with regional and national rates.

In 59% of live births the mother is over 30, which is significantly higher than national and regional rates and there are a number of identified complications with older mothers. There is a higher elective caesarean rate and more women transferring from home birth to hospital care than other areas.

**Breastfeeding** initiation is the highest in the region and above the national average, but a quarter of those who start have stopped by 6 weeks.

10% of expectant mothers **smoke during pregnancy** (all expectant mothers who smoke are referred to the specialist stop smoking midwife at booking but not everyone who is referred attends their appointments).

* + 1. **Child health**

An above average population increase is expected in the 4-11 age range, which is projected to increase from 14,500 to 16,900. (however this is dependent on the nature of housing development remaining consistent over time).

The health of children is generally better or in line with the national average.

There has been a year on year increase in respiratory tract infections for children under the age of 1 year old.

More children are seen by a dentist than compared to regional and national levels. Despite good availability to NHS dentists there is a view amongst practitioners that people may not be accessing dental treatment for their children due to a perception of poor access.

There are generally similar uptake rates for childhood immunisations when compared with the South West and high uptake for children in care. For the first half of 2011 immunisations of Measles, Mumps and Rubella by 2nd birthday was, however, above regional and national averages. Vaccinations are now delivered by practice nurses rather than health visitors and there is significant variation between GP practices.

* + 1. **Obesity, physical activity and diet**

Prevalence for 2010/11 of overweight and obese year 6 pupils is 31% and for reception year pupils, 24%.The percentage of pupils from year 6 who are obese is higher than the target of 12.5% at 17% for 2009/10 - and it has remained the same for 10/11. Local consultation with parents has suggested that use of the words ‘overweight’ and ‘obesity’ can be stigmatising and a barrier to accessing services. In 2010/11, 75% of reception year pupils at a healthy weight stood at 75.9% compared with 76.4% nationally. The year 6 rate is higher than national levels.

Between 74-90% of adults are not currently taking enough exercise to maintain their health. 84% of adults have an idea that they should at least be doing 3-4 (30mins) exercise sessions a week i.e. doing more exercise than they are doing. 4% of respondents to a local survey said they cycled to work, whilst 19% walk. The number of GP registered residents identified as obese is lower than the national average. This is lower than would be expected and could be a result of under-diagnosis.

Cost and time are seen as the most significant reason for not taking part in more organised events. Residents would like to see more beginner sports classes and running groups available. A decrease in satisfaction with sports and leisure facilities has been observed over time. Driver behaviour and road safety are perceived to be the principle barriers to walking and cycling more.

B&NES generally has a higher rate of known fruit and veg consumption than the national rate. Model based estimates suggest that around 30% of the population of B&NES consume 5 pieces of fruit and veg a day (26% England). However, there has been an increase in hospital admissions for malnutrition for patients aged 75+, although numbers remain small and there is evidence of under-diagnosis. 12% of residents in sheltered housing in B&NES and Wiltshire are at risk of malnutrition.

* + 1. **Smoking**

20% of adults are currently smoking, with the prevalence being lower than the national England average. There are fewer deaths from smoking related diseases in B&NES per population than nationally, aside from strokes which are in line with the England average. However it remains one of the leading causes of premature death in the area. 56% of smokers say they would like to quit. There is some evidence of success at a national and local level of activity to reduce smoking which is seen to be reflected in the reducing lung cancer rate. Just under 4000 residents joined the quit smoking service between 2008 and 2011 of whom 41% were verified as having quit smoking and a further 15% self-reported as quit.

* + 1. **Poisoning**

There has been a decrease in admissions over time between 2005- 2009 (892, 08/09). 47% of all overdose admissions are for consumption of painkillers, with no significant variation against regional or national averages. Alcohol was involved in 38% of self-poisoning cases in men (28% women).

* + 1. **Alcohol**

Estimates suggest that B&NES has 7,021 people aged 18-64 dependent on alcohol, at risk of associated conditions who could benefit from support. Of these about 600 people are thought to have significant problems. 7,629 individuals were admitted to hospital either wholly or partly due to alcohol. Admissions for these conditions are increasing at a significantly higher level than regional levels; however the actual rate remains lower than national and regional rates. 28% of those admitted had repeat admissions during 09/10. The quality of data produced by the government on people receiving alcohol related treatment is too poor to allow for accurate analysis.

Peak age alcohol attributable hospital emergency admissions for women is in the 15–19 age group (40-49 in men).This difference in gender in under 18s is likely to come from ethanol poisoning. 24% of girls got drunk at least once in the last week compared with 16% of boys in year 10. Over a 6 year period (2004-2011) 55 women accounted for 604 hospitals emergency admissions for self-harm compared with 23 men accounting for 216 admissions.

There are a greater number of men admitted for alcohol specific and attributable admissions compared with women (2009/10). Of alcohol-specific admissions, 66% are men, 34% women (a similar rate to the region).

The leading cause of admission for alcohol -specific conditions was mental and behavioural disorders due to use of alcohol, accounting for 63.4% of all alcohol specific admissions. Alcoholic liver disease was the second largest cause of alcohol specific admission, followed by ethanol poisoning.

There are significant crime and disorder impacts attributable to alcohol. 32% of violent crime is recorded during key night-time economy periods (Friday and Saturday 9pm – 3am). Hate crime is also strongly correlated with both night time economy and anti-social behaviour; there are also correlations between night time economy, antisocial behaviour and domestic violence.

Alcohol is also identified as having a significant relationship with mental illness and is linked to anxiety, depression, self-harm, suicide and psychosis. 22% of Southside Family Project clients for Domestic Violence also attend services for drug and alcohol problems.

Alcohol specific admissions in under-18 year olds in B&NES are significantly higher than England. Survey responses suggest that young people in B&NES are drinking less frequently than the England average but when they do drink are drinking more.

* + 1. **Illicit substance misuse**

There are a lower number than national opiate and/or crack users (842, 7.1 per 1000 15-64 population, 8.9 nationally). The drugs market in B&NES is well understood by the police. However there has been no decrease in drug demand over time.

The proportion of drug users who complete their treatment free of dependency is generally lower in B&NES than nationally. However, successful completions as a proportion of the total number in treatment is 11% (14% nationally), but here have been significant improvements since 2009/10.

Hospital admission rates for substance misuse for children and young people are significantly lower than national and regional averages.

* 1. **Social determinants and wider wellbeing**

1. **Education**

Pupils in Foundation stage, key stages 1, 2 and 4 continue to attain well compared with other local authorities and beyond national expectations. For GCSE, overall attainment boys vs girls 5+ A\*-C (2008-09) boys average of data available 79.5% girls 84.6%, 5+ A\*-C including Mathematics and English – boys 49%, girls 62%

Participation in Post 16 education by young people in B&NES stands at 88.7% (July 2011). This is higher than national participation and B&NES is first among its statistical neighbours.

There were 413 pupils excluded in the academic year 10/11, with twenty permanent exclusions by head teachers of which thirteen have been upheld by Governors with one outstanding. This compares with eight permanent exclusions over the same period last year.

Bullying complaints are in line with national rates and comparator authorities. In the ‘Tellus’ Survey 2008/09, nearly half of children (48%) reported that they felt that their school dealt ‘not very well’ or ‘badly’ with bullying. In 2009/10 this has improved to 27%.

Absence levels are in line with national and regional rates and have not changed significantly over time except in the case of special schools where absence is higher than both regional and national comparators.

1. **NEET**

5.5% of current 16-18 year old are NEET (Not in Education, Employment or Training) (October 2011). Numbers have increased over time, although remain lower than similar areas and nationally. NEET numbers are expected to increase whilst job opportunities are limited. Rates are higher in specific groups of 16-19 year olds: 49% of teenage mothers, 11% of those with learning difficulties and 39% of 19 year old care leavers and a high percentage of those in deprived communities are NEET.

1. **Child poverty & social inequalities**

The government produces statistics which compare small areas across England on a number of different data sources which have been identified as representing social inequalities. B&NES is one of the lowest ranked authorities in the country, ranking 247 out of 326 English authorities. It is ranked 49 out of 56 unitary authorities. Following the publication of the Marmot review a number of indicators have been developed to assess the comparative impact of inequalities at a local authority level. For all of these indicators the area is either significantly better or in line with national and regional levels.

The proportion of children who are eligible for Free School Meals aged 4 -11 is lower than national average (12% B&NES; 15% national). The proportion of children in ‘Out of Work Benefit’ households is also lower than national levels.

Despite these comparably low levels there is a strong relationship between communities experiencing these inequalities and a range of health and wellbeing outcomes (see Section 2.4 for more information).

1. **Benefits and employment**

There are lower rates of residents claiming benefits in B&NES than in the South West Region as a whole and compared with the UK. Increases over time are in line with and follow national trends. Of the long term unemployed claiming benefits (not including Jobseekers Allowance (JSA)), there are 4040 claimants on Employment Support Allowance, Incapacity Benefit or Severe Disablement Allowance for 2 or more years.1200 claimants are likely to move off benefits altogether following the review of incapacity benefit. A specific risk group has been identified: the older cohort who are recently unemployed – who have a lack of transferable skills and experience of modern job market (210 JSA claimants over 50 claiming for less than 6 months).

The main industries in the area are manufacturing, environmental and related industries, professional business services, accommodation, publishing, creative, arts and entertainments. The public sector is a significant employer. Encouraging students to stay in the area to work has been identified as a key priority for the local economy.

The three ‘high level’ occupation groups, including managers, professionals and associate professionals, account for 48.5% of employed residents in B&NES, similar to the West of England but above the regional and national average. There is evidence that the B&NES resident-based economy is more advanced than its workplace economy.

1. **Housing**

This is an area of high housing demand but housing growth is constrained. In consequence average house prices are over 21% above the national average and there is a significant rental sector (16% social rented, 17.7% private rented). There is a greater than the national proportion of older housing (30% built before 1919) and there is a correlation between falls and non-decent housing. 24.5% of private sector housing is considered non-decent and 11.9% have a significant health and safety hazard. It is estimated that 17.9% of households live in fuel poverty.

54% of newly formed households were in need of affordable housing in 2009. 9% of B&NES households are currently on the social housing register, waiting times are typically in excess of 18 months.

Changes to Housing Benefit will decrease the number of affordable private rentals available to those claiming Housing Benefit. It is estimated that the number of homes that will be lost is 3100, leaving 4123 properties available to rent for 3180 recipients. Whilst this seems to still leave a surplus in available housing, local factors (such as volume of students in the affordable rental market or other factors we know about) might impact on this.

The 3 main causes of homelessness are being asked to leave by friends or family, receiving Notice to Quit a private tenancy & relationship breakdown. 50% of homelessness applications in B&NES are from people aged under 25. Numbers of rough sleepers is low, however this cohort experience significant harms (see section 2.3).

1. **Stronger communities & social capital**

There is capacity in all areas of B&NES for communities to do more to help themselves. However, different methods will prove effective in different communities and some will need more intensive support to realise this.

Just over half of the people who live alone who responded to an Independent Living Service survey have regular contact with friends and family and, considering the sample as a whole, 53% of respondents feel they have good community connections.

1. **Crime and disorder**

There are historically low levels of crime: low compared to national levels and also low or in line with similar areas.

Adult re-offending has dropped by 1% since 2007/8 and does not significantly differ from regional and national rates. The difference between actual and expected offending is higher than regional and national levels, but this may be a result of smaller numbers.

The number and proportion of young people sentenced to custody reduced significantly in 2010-11 (the lowest annual number of youth custodial sentences in B&NES since 2000). The rate of re-offending in the latest cohort of young people to be monitored fell significantly compared with the 2005 baseline.

**Domestic violence** remains a significant volume of crime

* 42% cases recorded as involving children; increases in number of children with “Notifications of children with Domestic Violence”
* Under reporting (there is about 17-20% reporting)
* Offenders tend to be young and male (61% under 30)
* Women are more likely to be victims of domestic violence compared with men 78% women, 22% men victims, and there is significant evidence of under-reporting
* There is a strong link with alcohol related incidents (see alcohol)

1. **Cultural activities**

The areas cultural sector is a significant industry and the city of Bath is designated a world heritage site. 70-80% of residents attend art galleries and museums, although only approximately 12% are regular (monthly attenders). 42.2% of respondents have less than 2 hours of leisure time per day.

1. **Climate change**

Increasingly severe weather events have the most direct impact on health conditions. However, indirect impacts are also identified, particularly rising prices for fossil fuels. Nearly 30,000 households in the area have insufficient insulation.

As climate and oil impacts intensify, so will food poverty and its health impacts. This includes those in energy inefficient homes, people in rural areas relying on oil-fuelled transport and heating, those living in affected geographic areas such as the central Bath and Chew Valley flood zones and those living on steep slopes where the risk of subsidence is increased by extreme weather. This is within the context of an increasing and ageing population. There is emerging evidence that significant cost savings can be realised in the health service by making homes more energy efficient.

**1.11.10 The natural & built environment**

Access to the natural environment can also have positive effects on mental health.

People living in areas with high levels of greenery are thought to be three times more likely to be physically active and 40% less likely to be overweight or obese than those living in areas with low levels of greenery.

Calls to the council about environmental cleansing and protection have decreased over time, including fly tipping, street sweeping and emptying litter bins. There is a significant geographic concentration in City and Town centres (which may relate to alcohol consumption and the night time economy), Bath has been awarded a ‘purple flag’ for good city centre environmental management.

Water safety has been raised as a concern; with specific significant concerns about riverside safety in Bath City. (The early evidence is that short-term actions have mitigated this risk).

* + 1. **Air quality**

Some areas within B&NES are identified as having Nitrogen dioxide (NO2) concentrations greater than the government’s objectives (Annual average NO2 concentration greater than 40 µg/m3) These areas run through the centre of Bath and a the main road through Keynsham. In addition a small section of the A4 in Saltford has been identified as a risk.

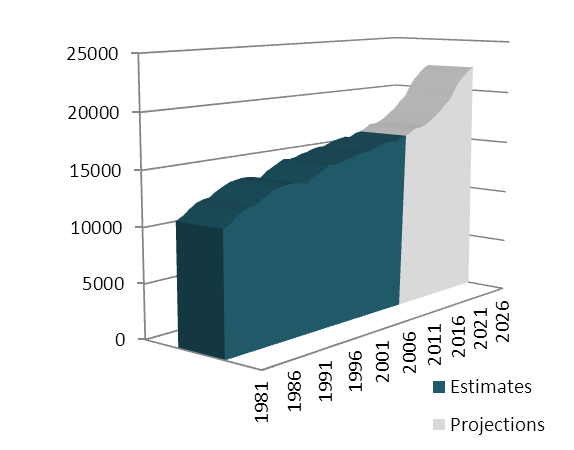
There is a link between increased exposure to particulate matter and increased risk of death, hospital admissions, symptoms and other effects. Exposure can irritate lungs, inflame airways, affect lung function and may cause increased incidents of acute respiratory illness depending on levels of exposure. The effects on life expectancy are bigger than public smoking and motor vehicle accidents. Children, the elderly and those already suffering from respiratory illnesses are more vulnerable.

**Part 2 – Cross-cutting issues**

While specific demographic groups have been referenced within the main document, there are a number of additional factors which have emerged as cutting across a number of the topics identified in part 1. In addition, a more comprehensive analysis of data collected in this project broken down by key equalities dimensions will be published as an appendix to this document.

**2.1 Complex families**

The government believes that there are 220 families in B&NES experiencing a range of complex needs including children known to social services, mental health problems and domestic violence. It is estimated that these families cost public services between **£55 and £72 million** p.a. (National estimates suggest the cost of these families is £330,000 per annum, although research by Somerset CC suggests this may be nearer £250,000).



Early work to identify these families by services indicates that nearly 500 individuals who are members of complex families. There are strong geographical concentrations of these families.

Two thirds of all young people in treatment at Project 28 from 2004 to 2010 were also recorded as Children and Family Services’ clients, with 44 having a care history. The bi-annual report of the Child Protection Conference Chair notes that in 50% of cases that come to conference, one or other parent has a history of alcohol problems and in 35% of families there is a history of drug use.

There is little information about the number of lone parents. There are 970 in receipt of Lone Parent Allowance, but an unknown number claiming JSA.

**2.2 An aging population**

The increase in life expectancy recorded at a national level will create significant changes to our local population. Although the older population is not significantly over represented in B&NES, the area will still be strongly impacted upon by this change. For example, in 1981, 7% of the local population was aged 75+ and by 2026 current projections suggest this will have increased to 11%. The 80+ population will have increased from 3% of the total population in 1981 to 7% in 2026 (5,600 – 13,900).

At present one in five houses have older residents, and as the population ages, the demand for appropriate housing will grow. Rates of medium or urgent housing need are much higher amongst older people with 18.5% of over 60s being in that category.

B&NES has a higher than average number of people aged 65 and over who are permanent residents of residential and nursing care homes (92 people per 10,000, 2009/10). A lower than average percentage of all people discharged from hospital are discharged directly to a residential home (2009/10). The percentage of people who die in their own homes is higher than average (20%, 2009/10).

With increasing age, the profile of disease and cause of death changes, with increased prevalence of physical and mental frailty during the years and months prior to death. For example, 19% of 65-74 year olds have moderate or severe hearing loss compared to 85% of the 85+ population (compared to 12% for all ages). This changing pattern will increase pressure on public, private and voluntary care provision. For example over 4700 older people are likely to be acting as carers by 2026. Older people with long term conditions surveyed in 2011 felt significantly less confident in managing their health than respondents from other age ranges.

Impoverished older people and older people living alone are socio-economic groups identified as being at particular risk of alcohol misuse.

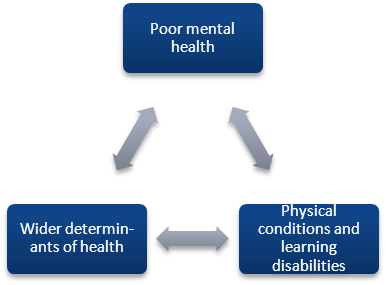
National research notes that older people are at risk of poor diet, particularly malnutrition & food poisoning, which can be linked to an increased risk of hip fractures, increased length of hospital stays and complications during surgery. 12% of sheltered housing residents were considered ‘at risk’ of malnutrition (approximately 200 in B&NES).

A substantial proportion of the older population do not have regular access to, or do not regularly use the internet (with 31% regularly accessing). However this appears to be changing as 64% of the 45-74 year old population are regularly using the internet. This group have reported that they feel less able to influence decisions in their local area.

Consultation with the older population has suggested that there is a strong desire to play a more active role in improving their own wellbeing, get involved in groups and communities (including intergenerational activities), and receive improved information and targeted services (both finance and support). Consultation with the care forum suggests that befriending services and activities which support independence may help to address these needs.

**2.3 People experiencing multiple conditions/needs (co-morbidity)**

People experiencing mental and physical disabilities are at risk of a wide range of associated disorders and conditions.



46% of people with a mental health problem also have a long term condition, and 30% of people with a long term condition also have a mental health problem. Chronic physical health problems have been shown to exacerbate depression and vice versa. There are higher rates of poverty and unemployment amongst disabled people, and it is estimated that over 800 will be found fit to work following benefit reform.

It is estimated that co-morbid mental health problems can raise costs by up to 45% per person. There is evidence that this cohort gain large benefits from inclusion in self-management support programmes and national research suggests a need for greater inter-agency co-operation with regards to these cases.

Amongst people with moderate to profound learning disabilities, deaths from dementia are more common in men than women.

Sensory impairment is associated with physical disabilities (70% of those registered have additional physical disabilities) and up to 50% of deaf children are likely to have mental health problems.

80% of single homeless people have one or more physical health conditions (70% have mental health conditions) and this cohort cost services nearly four times as much as the general population. A link has been made between alcohol misuse, homelessness, mental health conditions and criminal behaviour (in particular domestic violence, both as perpetrator and victim).

**2.4 Social and economic differences**

Despite relatively low levels of social inequality, there are small geographical areas with notable issues. These areas are largely comprised of social housing estates. Overall, five areas are within the most notable 20% of the country across a range of data: Twerton West, Whiteway, Twerton, Fox Hill North, and Whiteway West.

Social inequality has a significant relationship with a wide range of health and social care needs. When talking about social inequality we look at the difference between the 20% of the district experiencing the greatest level of inequality compared to the 20% who experience the least inequality based on a combined measure used by the government to allow national comparisons between areas.

*Life expectancy, mortality & long term conditions*

People living in these areas live significantly shorter lives compared to other areas. In B&NES, a man born in one of these communities can expect to die 6.3 years younger than a man born in the 20% experiencing the least inequality. For women the gap is smaller, though there is still a difference of 3.5 years. A greater rate of people die in these communities compared to those experiencing the least inequality.

If everyone in B&NES had a similar health experience to those who suffer the least inequalities, then it may be possible to prevent 40% of premature deaths in males and 9% of premature deaths in females (over 220 deaths over a three year period).

This group also have a 60% higher prevalence of long term conditions and 60% higher severity of conditions than those people living in areas suffering least inequalities and as such are more likely to be users of health and social care services.

Engagement with practitioners working in Twerton and Southdown (two wards which have areas experiencing notable social inequalities) has suggested that alcohol misuse and mental health are significant factors for this group. Cost and physical access to services were identified as important

*Health and lifestyle determinants*

This cohort has been identified as being at particular risk of premature births and breastfeeding initiation and continuation rates are significantly lower. Babies born to mothers in this group are more likely to have lower birth weight linked to maternal factors.

A significant relationship has been identified between hospital admissions for self-harm and social inequalities.

There is poor dental health in wards experiencing greater social inequalities, particular with regards decayed, missing or filled teeth. There is a notable variation in dietary habits linked to social inequalities at a national level.

There are greater levels of smoking in these areas, and those areas experiencing greater social inequality have some of the lowest levels of successful quit rates through smoking cessation services.

People living in these areas were also over four times more likely to be admitted to hospital for alcohol specific conditions and over twice as likely to be admitted for alcohol attributable conditions; there is also a strong relationship with emergency admissions for poisoning.

*Social and environmental factors*

This cohort has been identified as a particular priority for education and significant improvements have been seen amongst children in this group following targeted activities.

As of May 2011, Twerton West, Twerton and Fox Hill North had over 20% of their resident working age population claiming out of work benefits, significantly greater than the B&NES population as a whole, the South West and national rates. There is a significant relationship between the proportion of a small area that is defined as NEET (Not in Education, Employment or Training) and social inequality.

There is a relationship between all major crime types and social inequality, when the night-time economy is excluded as a factor.

Climate change will affect the poorest and most vulnerable residents; increased energy costs will affect all those on lower incomes. However those in energy inefficient homes are not always in the areas of more traditional inequality.

There is limited engagement with traditional art and cultural activities from residents in these communities.

Community capacity (the ability of a community to do things for itself), is strongly linked to social inequality, with less natural capacity being observed in this cohort. There is some emerging evidence of effectiveness surrounding targeted engagement activity designed to build social capital. A study in one small area of B&NES has suggested that a substantial proportion of residents in these areas want to be more involved in their local area, but do not feel they have a say at the moment – however these perceptions can vary on a street-by-street basis.

**2.5 Rural areas**

Those in energy inefficient homes, people living in rural areas relying on oil-fuelled transport and heating and those living in areas such as Chew Valley have been identified as being at specific risk of fuel poverty.

A number of complex families can also be identified as living in rural areas. However they are not geographically clustered in the same way as with areas experiencing higher levels of social inequality.

The Care Forum consultation highlighted difficulties in accessing these areas for staff, particularly with increasing fuel costs. Consultation with carers living in these areas has been highlighted as a priority for engagement by the Clinical Commissioning Group.

14 small areas in B&NES have been identified as being in the most notable 20% for the Access to Housing and Services domain used to measure social inequality.

On a positive note, however, rural communities in the area have been identified as possessing a greater than average level of natural capacity for taking self-determined action.