Health and Wellbeing in Bristol 2018

Joint Strategic Needs Assessment (JSNA) 2018 data profile

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NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BRISTOL

BRISTOL CITY COUNCIL

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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:

Dr Alison Bolam
– NHS Bristol, North Somerset & South Gloucestershire CCG

Marvin Rees
– Mayor of Bristol

Bristol is often described as a vibrant, innovative and progressive place to live, a city of opportunity. It frequently tops the lists of the best places to live in the UK, receiving accolades and recognition. However, we know that this is only part of the truth.

Many in the city experience a very different reality because of their economic, health, housing and social conditions. The Joint Strategic Needs Assessment (JSNA) will help us define our priorities by showing us our progress and where our biggest challenges lie. This is vital if we are to tackle inequalities.

Bristol's reputation and increasing popularity is reflected in its growing population, which has risen at a faster rate than the national average. By 2026 we project there will be 10,900 additional children, so we must ensure they have the best possible start in life, and in turn make Bristol a city of opportunity for all.

Within the data there is opportunity to celebrate; the rate of young first time offenders has improved from being one of the worst in the country to one of the best amongst England's 'core' cities. The unemployment rate has fallen to just over 4 percent from a high of 8% in 2015. Teenage pregnancy rates have fallen dramatically over the last decade.

However the data in the JSNA 2018 report is crucial in highlighting the continuing inequalities within our city. Bristol has high average earnings, but the 10% highest paid are earning 6 times as much every week as the 10% lowest paid. Rising house prices are outstripping earnings leading to a shortage of affordable housing for many.

Life expectancy in Bristol has increased by 1.9 years for men and 1.7 years for women in the past 10 years. However overall life expectancy for men in Bristol remains significantly worse than the England average. In addition healthy life expectancy (the average number of years a person would expect to live in good health) shows significant gender difference and over the last two years this has dropped significantly for men.

People living in the most deprived areas experience worse health outcomes than people living in the least deprived areas. Obesity, alcohol misuse and poor mental health remain major public health challenges with the most deprived being disproportionally affected. We know it is far easier to support someone early on, than provide crisis interventions later on, so early intervention must be a priority.

If we don't tackle health inequalities and the wider determinants of population health such as poverty, education and crime, then we will be unable to have a stable, thriving economy. This is not the responsibility of one institution or single organisation but a whole city.

The Bristol Health and Wellbeing Board bring together Bristol City Council and NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group with other partners to promote more joined-up decision-making between organisations. We are committed to working as one, focused on delivery and with agreement that we will work towards reducing and eliminating inequality. As co-chairs of the board, we will ensure that we put the people of Bristol at the heart of all our decision making.

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 needs[1] 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%, and 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. And around 24% of 4-5 year olds have excess weight (either overweight or obese), which is 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 annual rough sleeper street count rose to 86 in 2017 from 41 in 2014 (and 8 in 2010).

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).
- Also see pages on "Specific population groups" for relevant points

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 annual rough sleeper street count in Bristol rose to 86 in 2017 from 41 in 2014 (and 8 in 2010).
- 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, and 12% male (with 15% not recorded).
- 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

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.

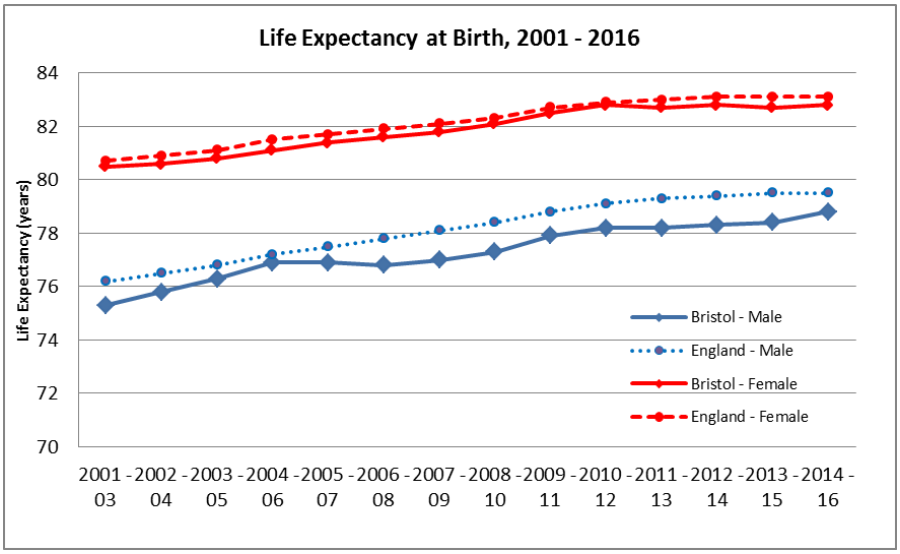


Fig 2.1.1: Life expectancy trends. Source: PHOF, August 2018

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

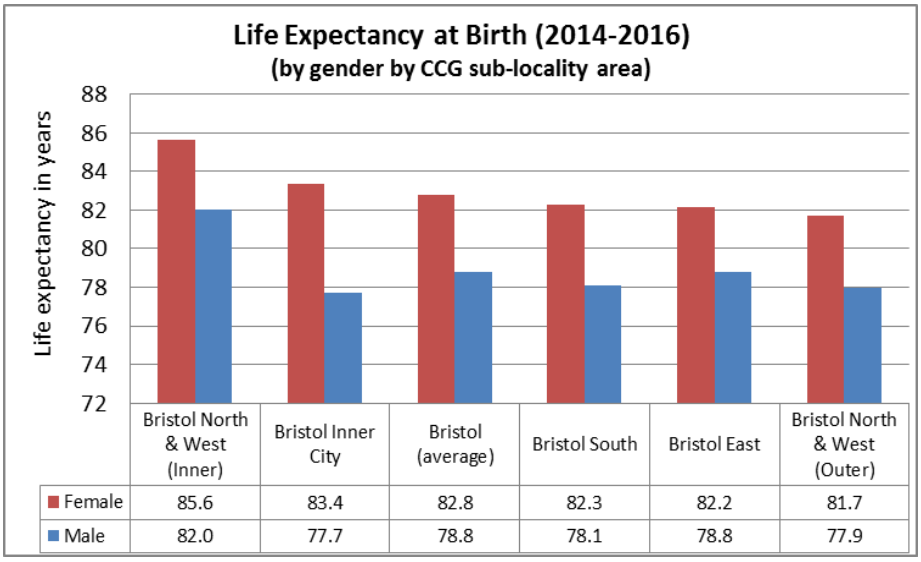
- Healthy Life Expectancy in Bristol 2018 – see JSNA Chapters

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 Withywood (74.1 years) has the lowest life expectancy in Bristol for men and Southmead (79.2 years) is lowest for women.



	Bristol North & West (Inner)	Bristol Inner City	Bristol (average)	Bristol South	Bristol East	Bristol North & West (Outer)
Female	85.6	83.4	82.8	82.3	82.2	81.7
Male	82.0	77.7	78.8	78.1	78.8	77.9

Fig 2.2.1: Life expectancy by sub locality, 2014-2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

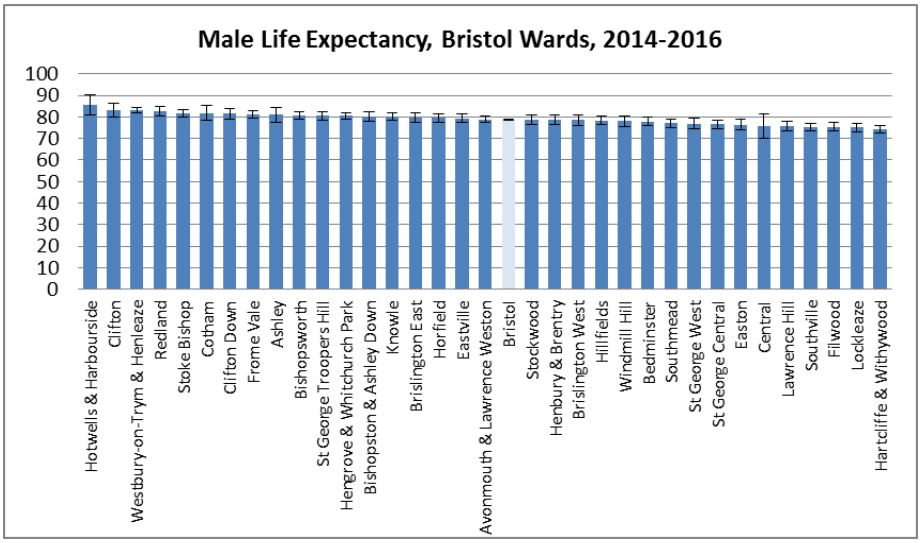


Fig 2.2.2: Male life expectancy by ward, 2014 – 2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

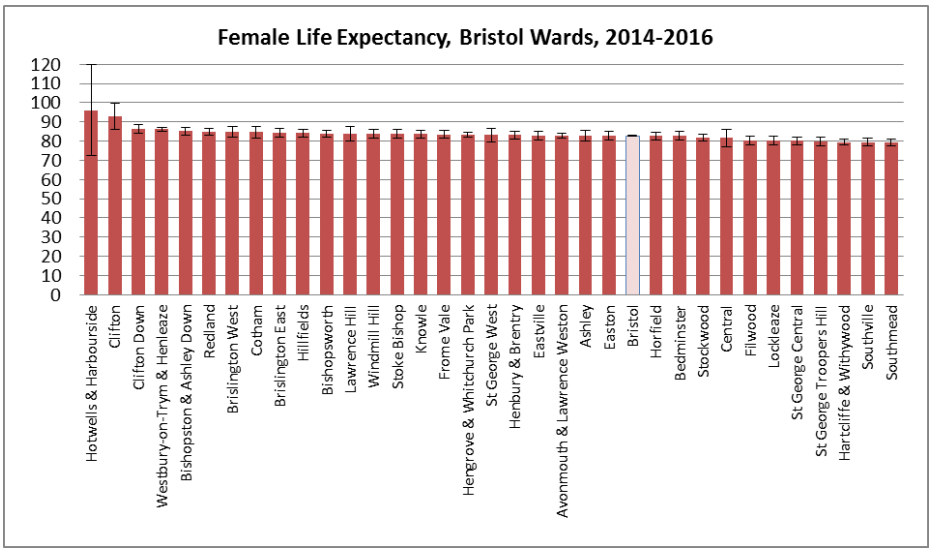


Fig 2.2.3: Female life expectancy by ward, 2014 – 2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

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 manner[2].

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.

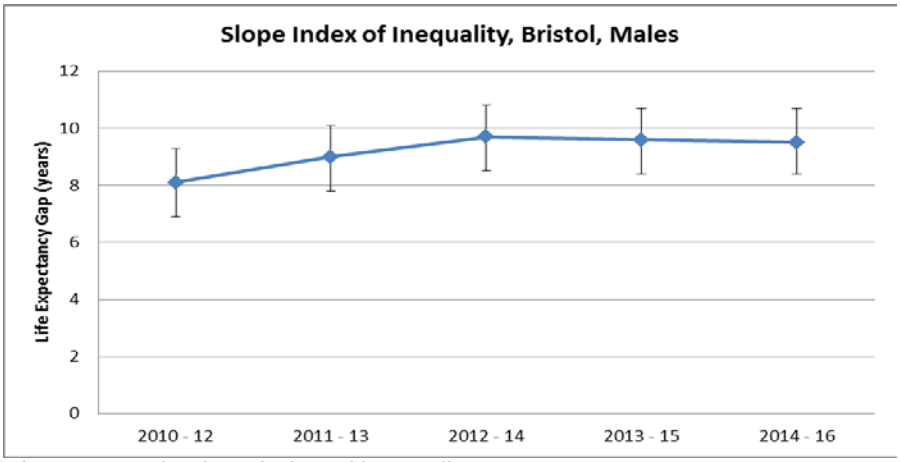


Fig 2.3.1: Male slope index of inequality
Source: Public Health Outcomes Framework, August 2018

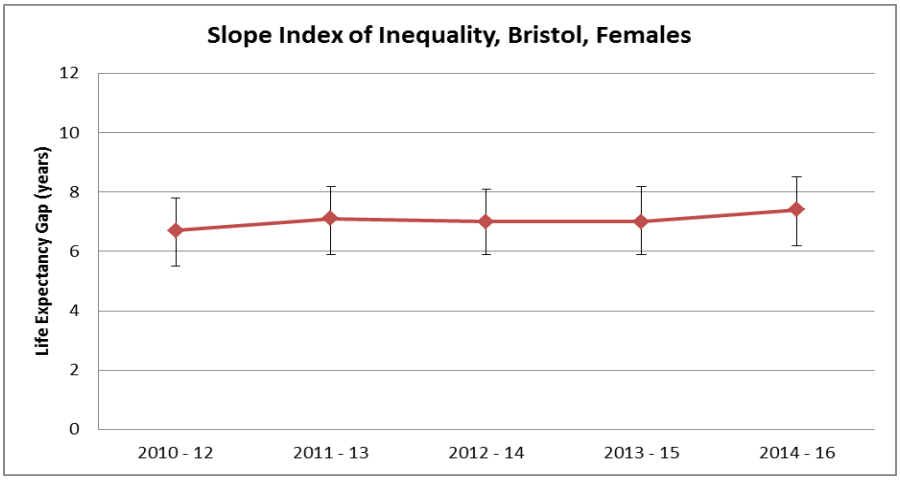


Fig 2.3.2: Female slope index of inequality
Source: Public Health Outcomes Framework, August 2018

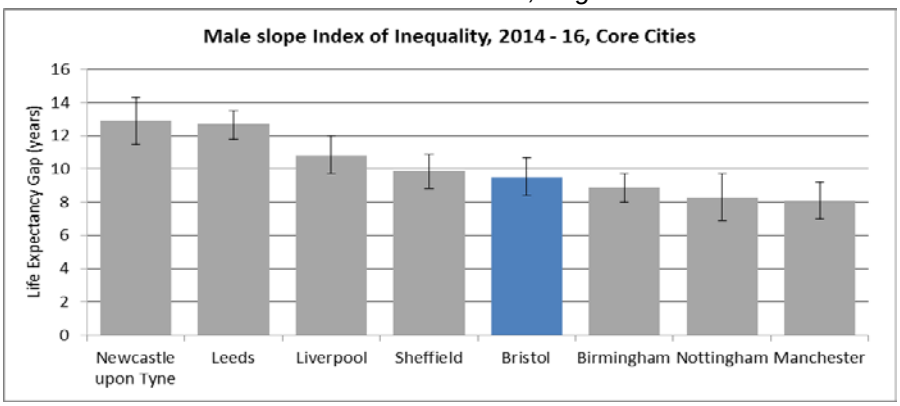


Fig 2.3.3 Male slope index of inequality by Core Cities
Source: Public Health Outcomes Framework, August 2018

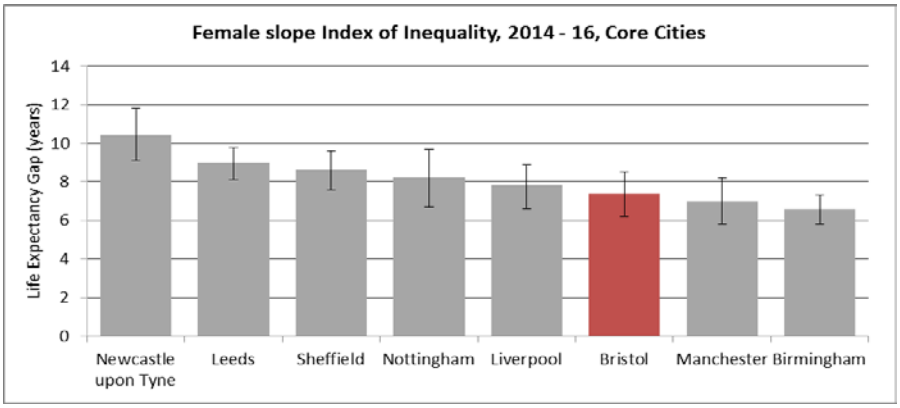


Fig 2.3.3 Female slope index of inequality by Core Cities
Source: Public Health Outcomes Framework, August 2018

[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.

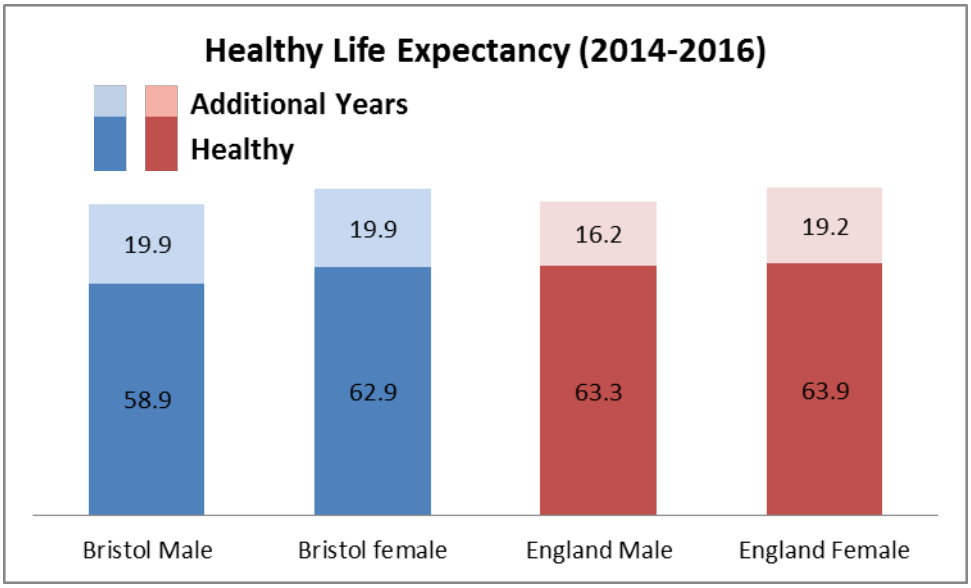


Fig 2.4.1: Healthy Life Expectancy and overall Life Expectancy
Source: ONS via Bristol Public Health Knowledge Service, August 2018

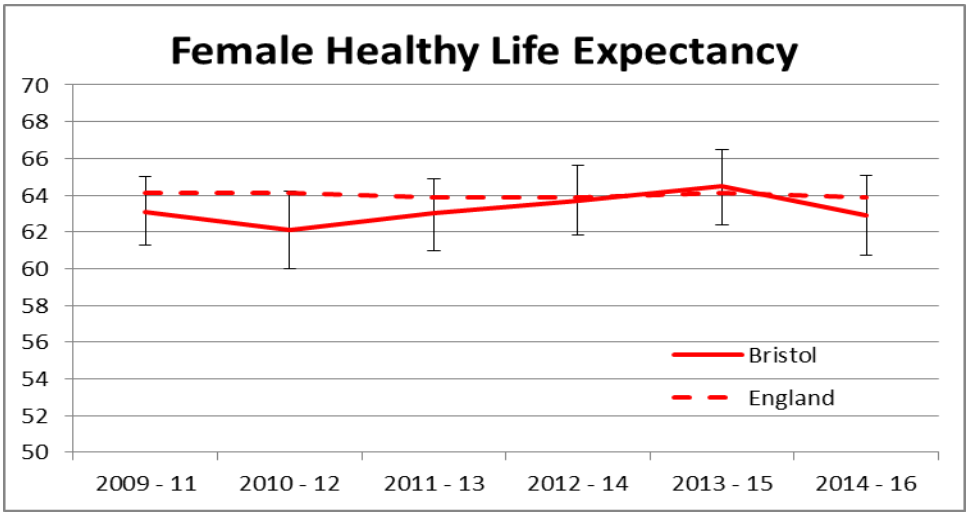


Fig 2.4.2: Healthy Life Expectancy trends- Female
Source: ONS via Public Health Outcomes Framework, August 2018

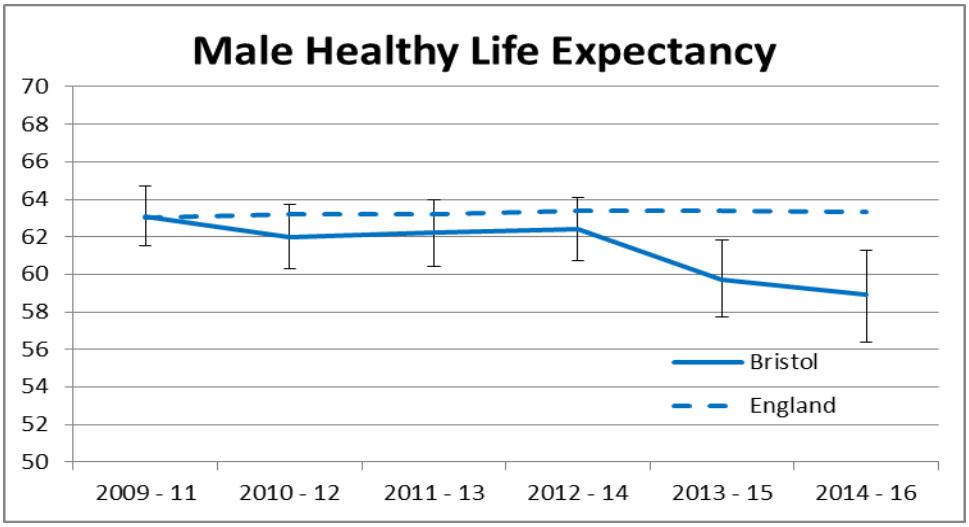


Fig 2.4.3: Healthy Life Expectancy trends- Male
Source: ONS via Public Health Outcomes Framework, August 2018

2.5 Healthy Life Expectancy Gap[3]

Small area data[4] 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 range[5] from 11 years to 31 years for females and from 10 years to 24 years for males between areas.

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

Healthy Life Expectancy, Females, 2009-2013

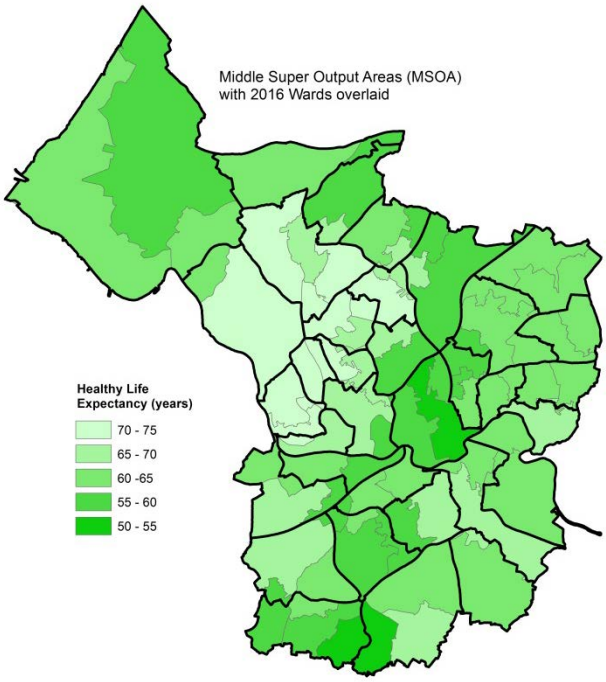


Fig 2.5.1: Healthy Life Expectancy by MSOA, Females, 2009-2013

Healthy Life Expectancy, Males, 2009-2013

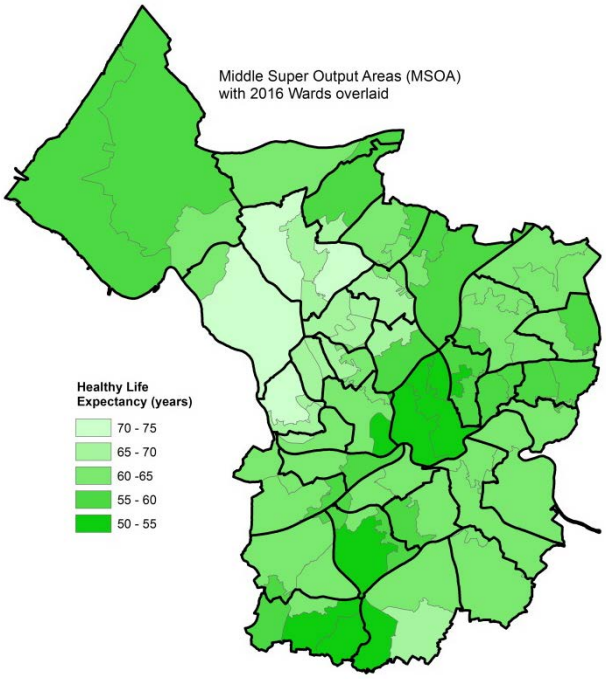


Fig 2.5.2: Healthy Life Expectancy by MSOA, Males, 2009-13

[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 MSOA 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)

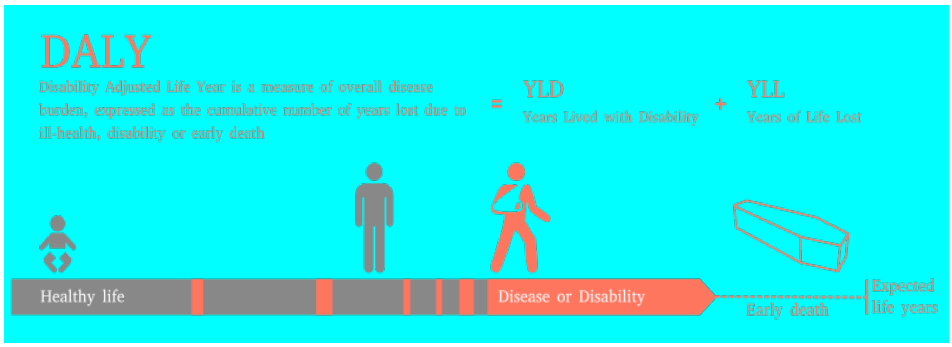


Fig 2.6.1: Method of calculating Disability Adjusted Life Years

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.

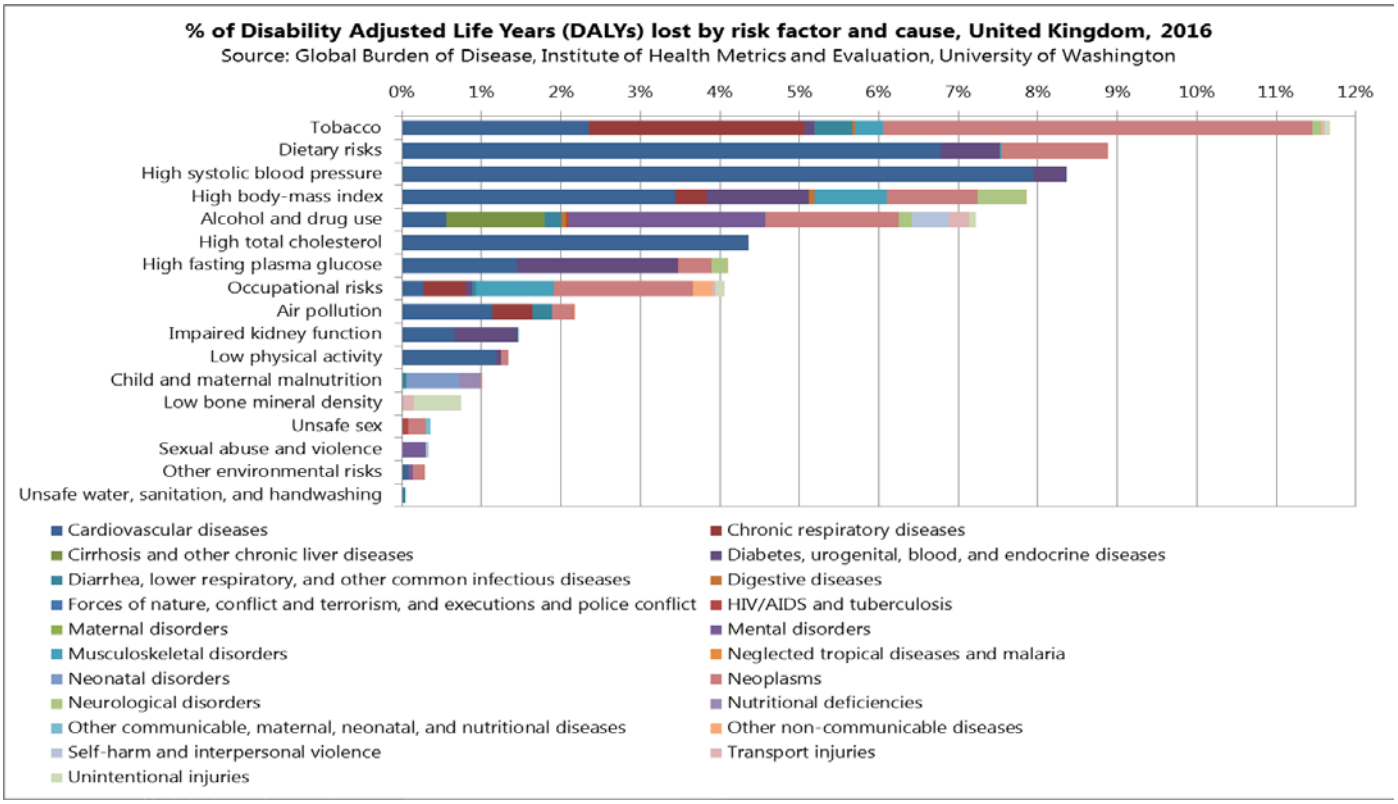


Fig 2.6.2: Estimated DALYs,2016, by risk, based on Global Burden of Disease, Institute of Health Metrics and Evaluation / Public Health England. Source: Bristol Public Health Knowledge Service

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).

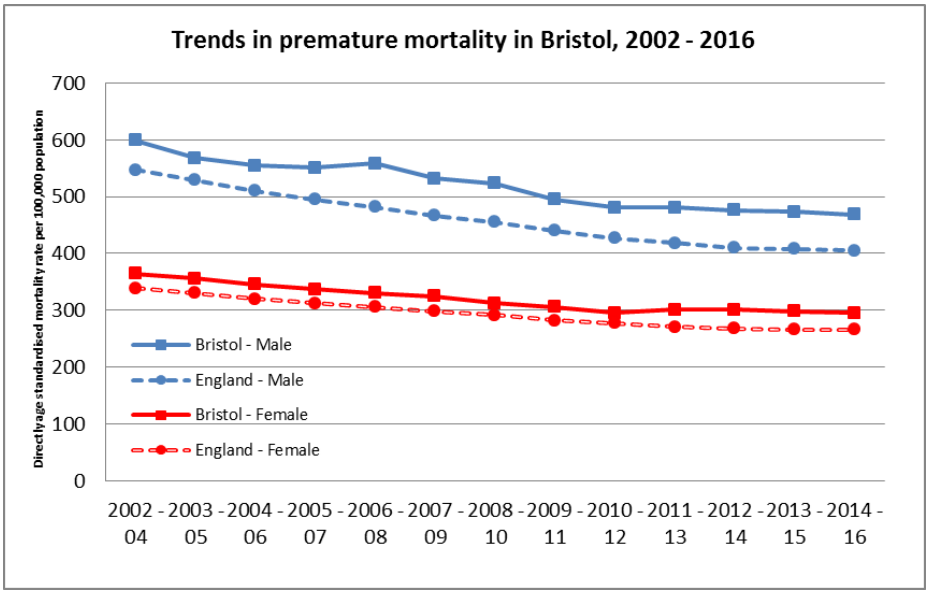


Fig 2.7.1: Premature mortality trends 2002 – 2016
Source: Public Health profiles, https://fingertips.phe.org.uk/

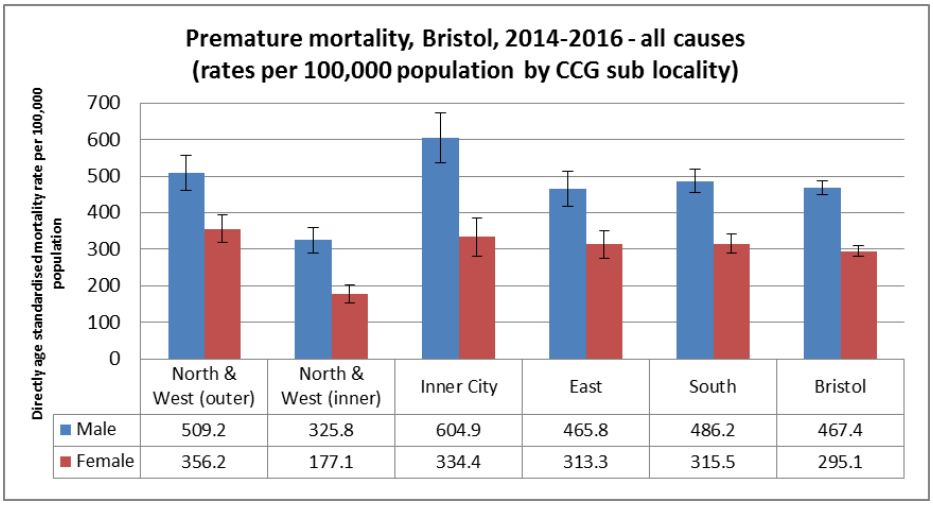


Fig 2.7.2: Premature mortality with Bristol by sub locality; 2014-2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

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.

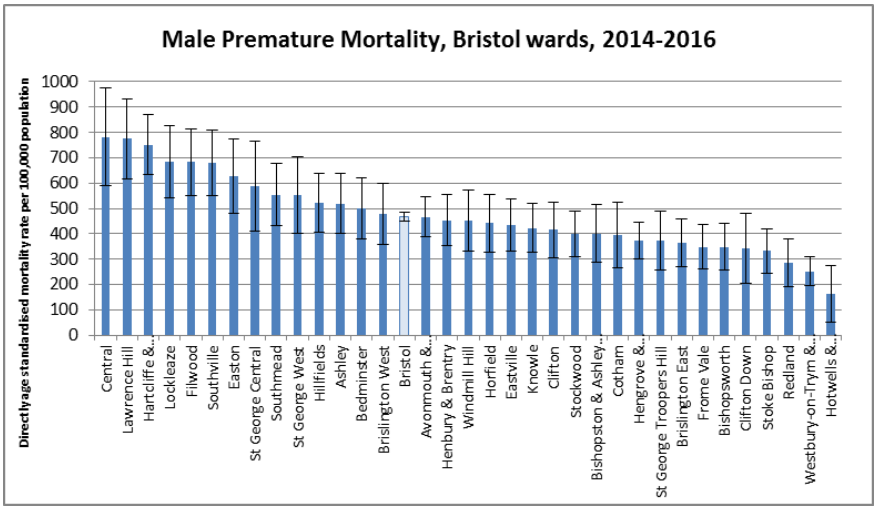


Fig 2.7.3: Male premature mortality, Bristol wards, 2014-2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

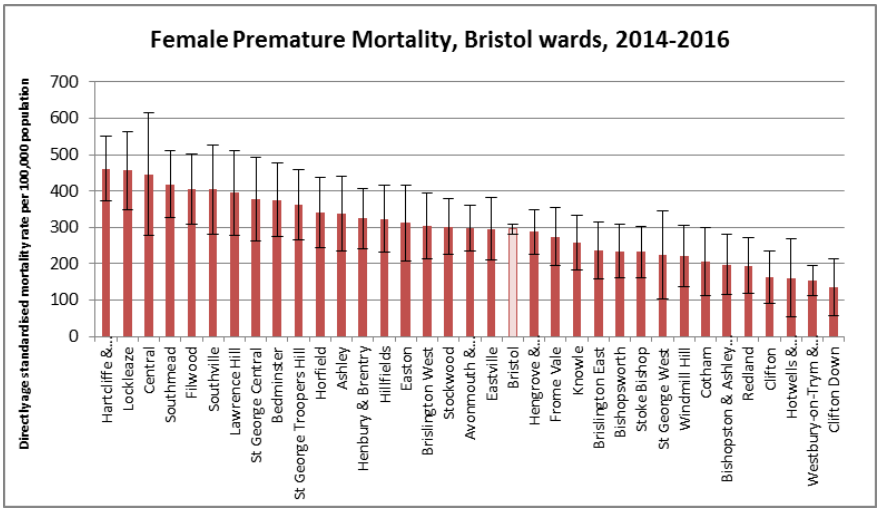


Fig 2.7.4: Female premature mortality, Bristol wards, 2014-2016
Source: Bristol Public Health Knowledge Service using ONS data (Aug 2018)

Further data

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

Section 3
Population[6]

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 people**[7], 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).

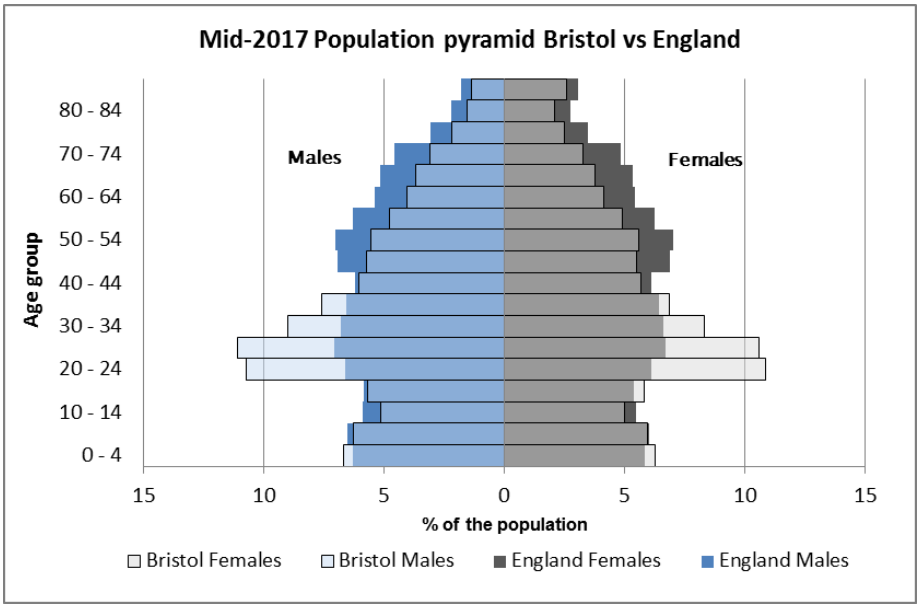


Fig 3.1.1: Mid-2017 Population pyramid Bristol vs England
Source: ONS 2017 Mid-Year Population Estimates; June 2018

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 patients[8] 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 occasions[10]. 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.

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.

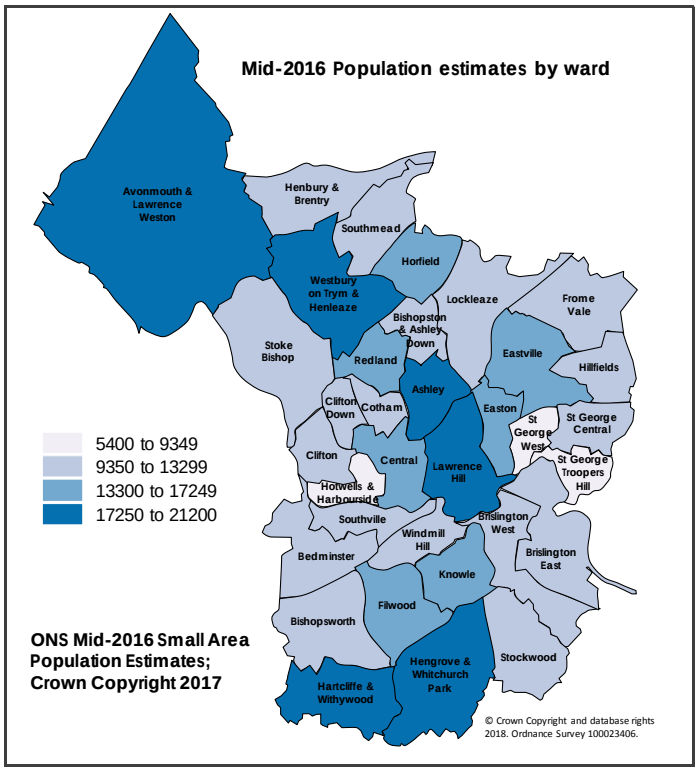


Fig 3.1.3: Mid-2016 population estimates by ward
Source: ONS Mid-2016 Small Area Population Estimates; 2017

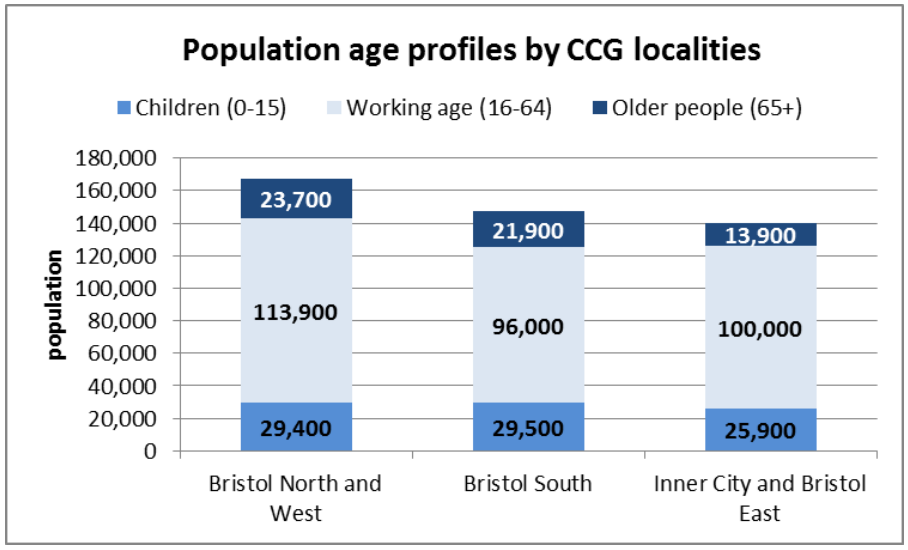


Fig 3.1.4: Mid-2016 Population age profiles by CCG localities
Source: Insight, Performance and Intelligence, Bristol City Council, using ONS Mid-2016 Small Area Population Estimates; 2017

[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

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.

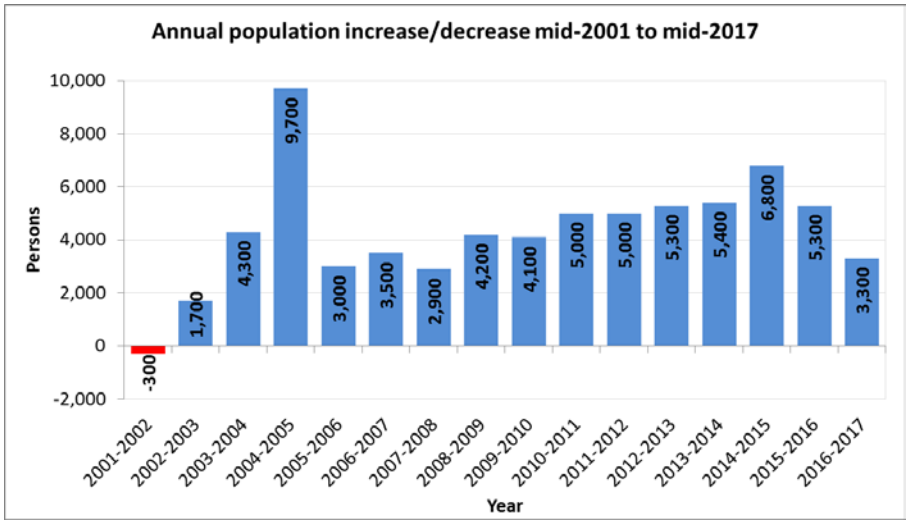


Fig 3.2.1: Annual population increase/decrease Mid-2001 to Mid-2017
Source: ONS Mid-Year Population Estimates; June 2018

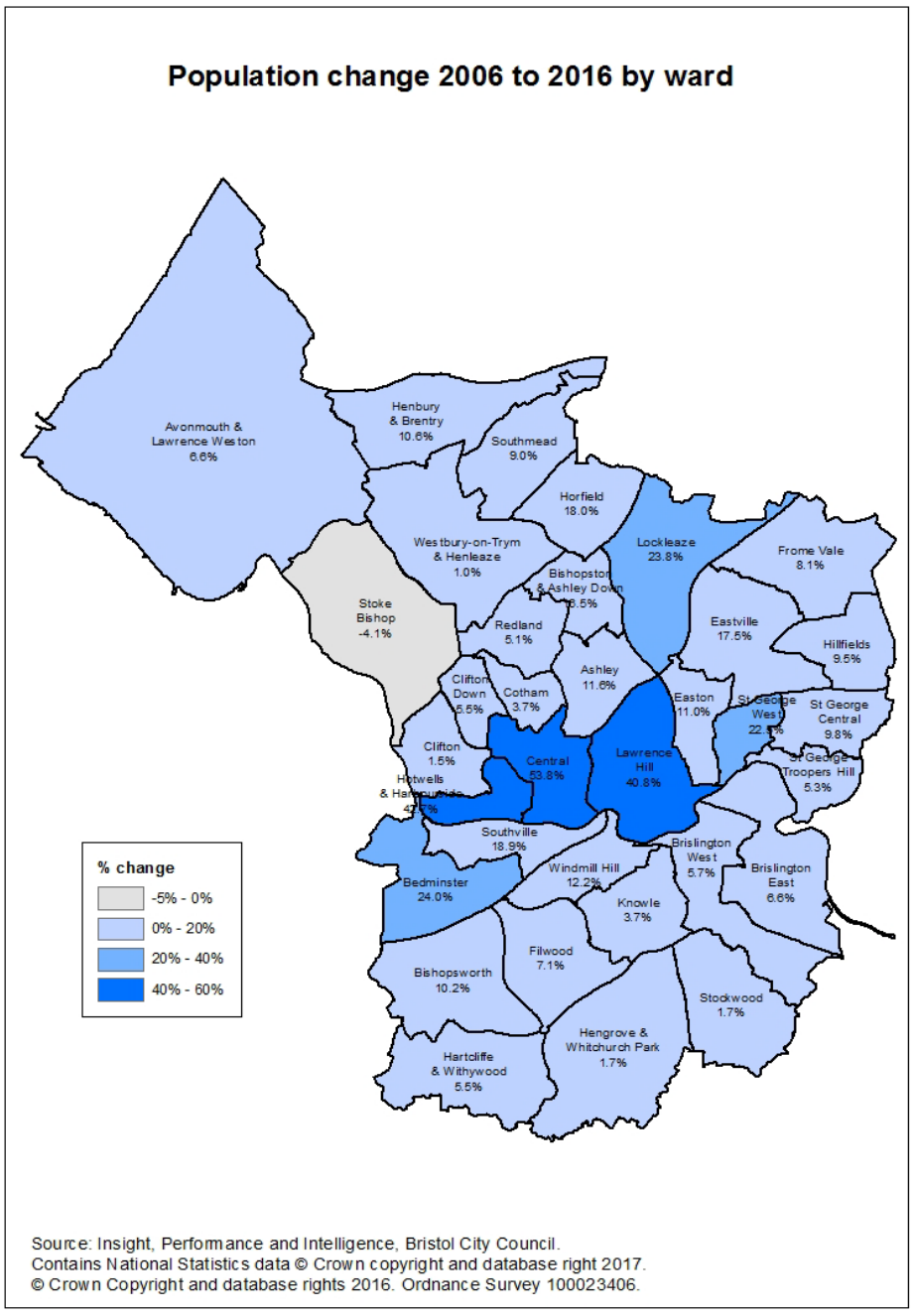


Fig 3.2.2: Population change 2006-16 by ward
Source: Insight, Performance and Intelligence, Bristol City Council using ONS Small Area Population Estimates; 2017

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 definition[11].

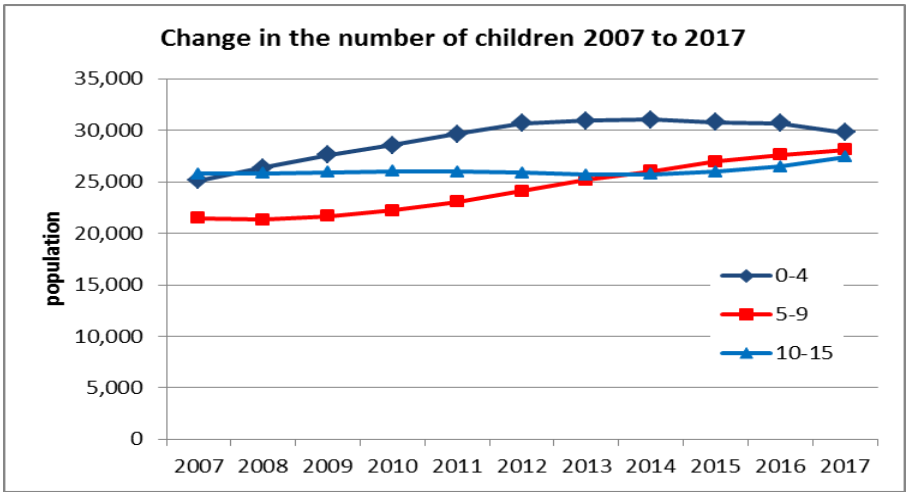
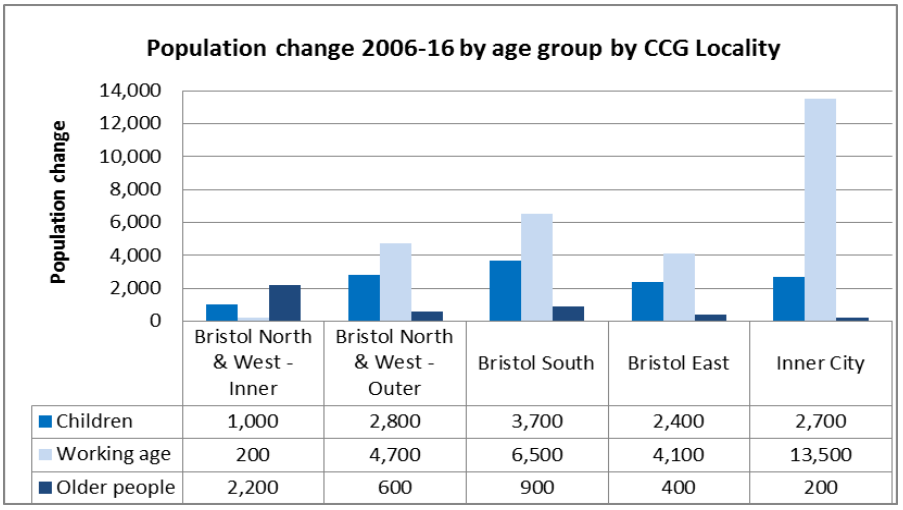


Fig 3.2.3: Change in the number of children Mid-2007 to Mid-2017
Source: ONS Mid-Year Population Estimates. Crown Copyright; 2018



	Bristol North & West - Inner	Bristol North & West - Outer	Bristol South	Bristol East	Inner City
Children	1,000	2,800	3,700	2,400	2,700
Working age	200	4,700	6,500	4,100	13,500
Older people	2,200	600	900	400	200

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

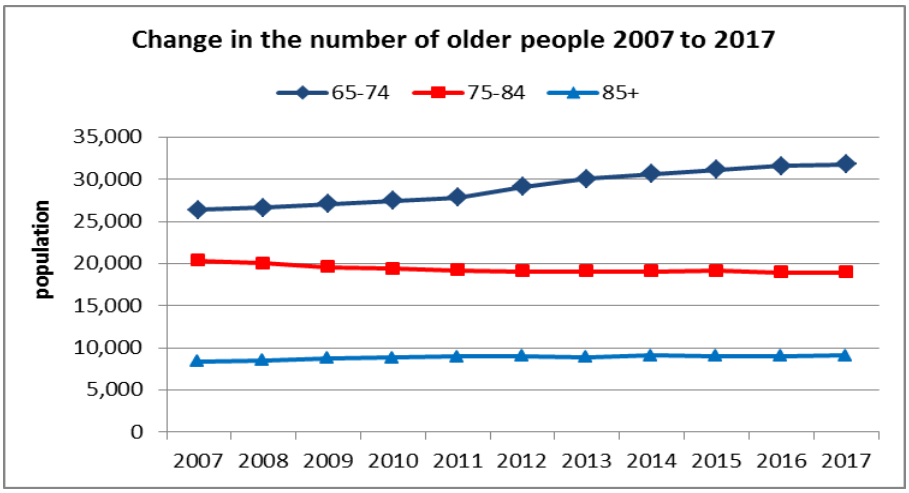


Fig 3.2.5: Change in the number of older people Mid-2007 to Mid-2017
Source: ONS Mid-Year Population Estimates. Crown Copyright; 2018

[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 diversity[12]

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 decade[14], 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.

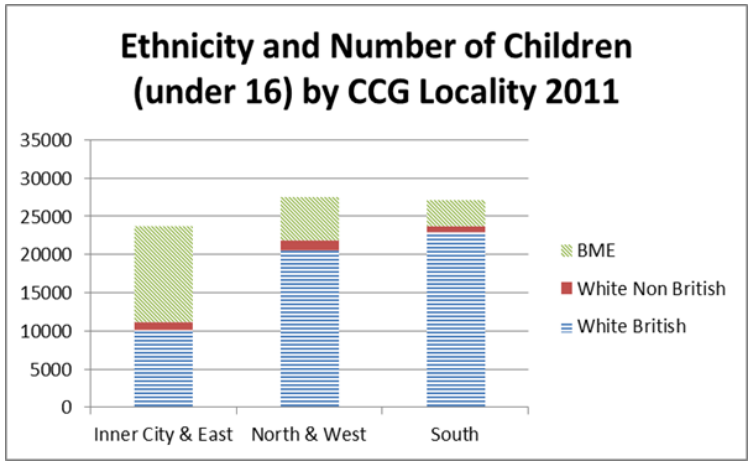


Fig.3.3.1: Ethnicity and Number of Children by CCG Locality
Source: ONS 2011 Census

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%.

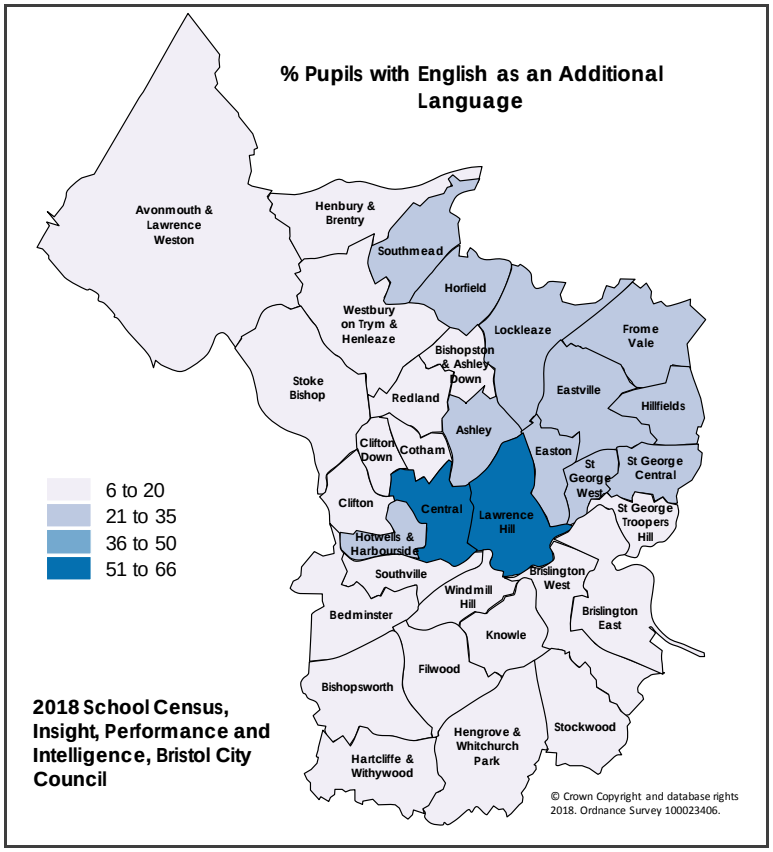


Fig 3.3.2: Source: 2018 School Census, Bristol City Council

[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.

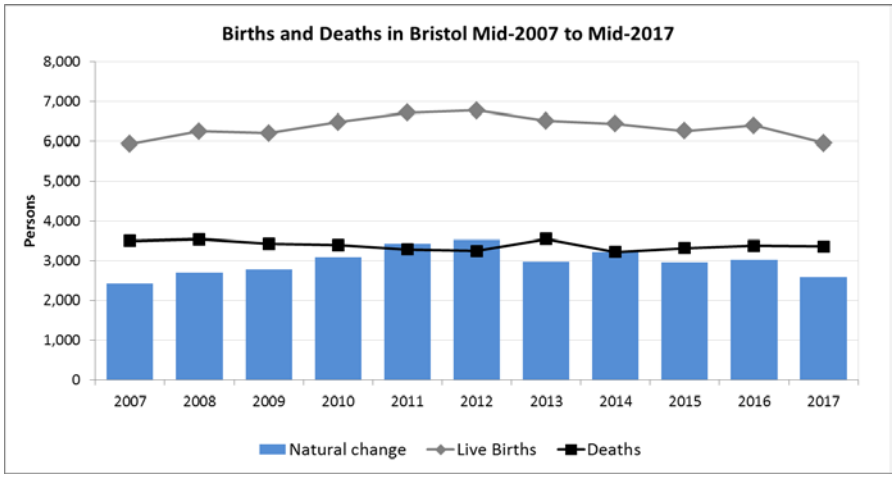


Fig 3.4.1: Births and Deaths in Bristol by 2007 to 2017
Source: ONS Vital Statistics by calendar year; July 2018

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.

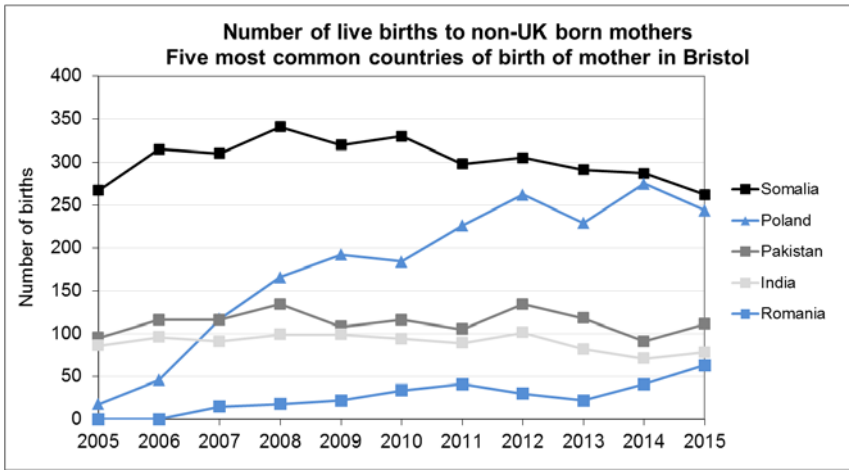


Fig 3.4.2: Live births in Bristol to non-UK born mothers for the 5 most common countries of birth of mother 2005-2015 Source: ONS Birth Data, 2016

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).

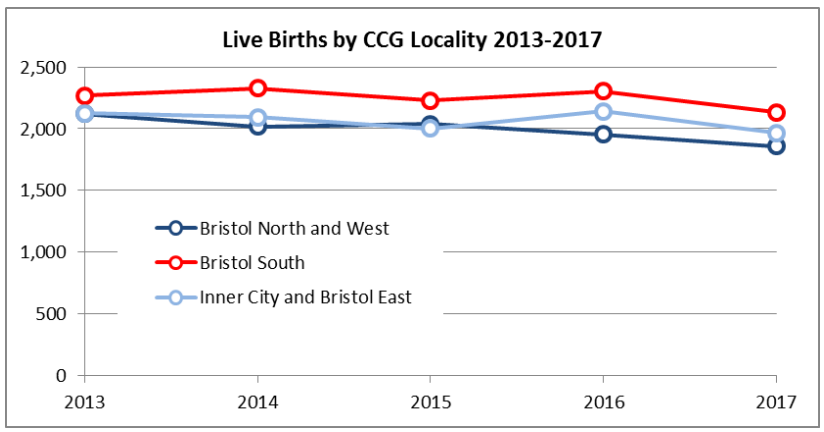


Fig 3.4.3: Source: ONS Vital Statistics by calendar year; July 2018

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 2036[15]. 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.

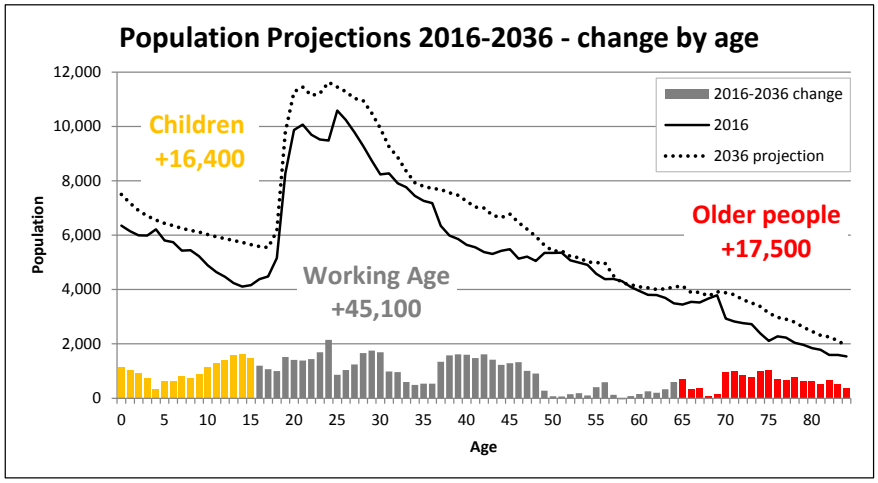


Fig 3.5.1: Population Projections 2016-2036 - change by age
Source: ONS 2016-based Sub-national Population Projections

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

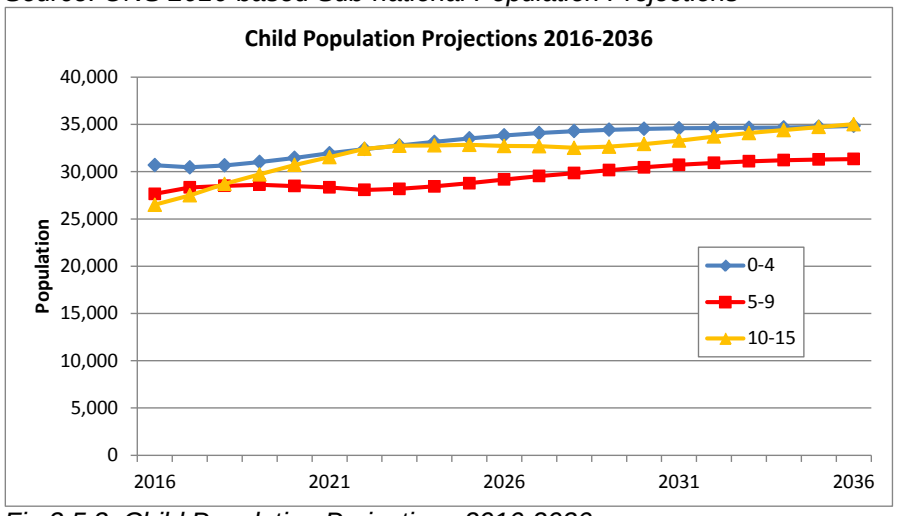


Fig 3.5.3: Child Population Projections 2016-2036
Source: ONS 2016-based Sub-national Population Projections

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

3.6 Carers

According to the 2011 Census, there are over 40,100 carers in Bristol (all ages), which is just under 1 in 10 of the population (9.4%). Between the 2001 and 2011 Census, the number of unpaid carers increased by 5,000, but the proportion stayed the same (9.3% in 2001) as Bristol's population has risen considerably.

However, a more recent 2015 estimate[16] indicates there are almost 42,300 carers in Bristol, an increase of 20.4% since 2001. This report indicates the value of the care provided is £793m per year.

Further 2011 Census detail shows the majority of adult carers (25,700) are caring under 20 hours a week but just over 9,000 provide unpaid care for 50 hours or more each week.

Of the 40,100 unpaid carers identified in the 2011 Census, 8,300 were over 65 years of age (15% of all people over 65 in Bristol). 40% of people in this age category (3,350 people) provide care for over 50 hours a week, which is disproportionately high.

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

Young Carers

According to the 2011 Census, there were 860 children under 16 and 2,700 young people aged 16-24 who were carers. However, it is expected 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.

Recent 2018 national research[17] indicates that the extent of caring by children is higher than had been thought, with 22% of children, who responded to a questionnaire, stating they are young carers. Secondary school pupils, who responded, lived with a family member who had an illness or disability *and* carried out caring duties. Nearly a third (32%) of those children are responsible for 'high-level caring' (carrying out a role ordinarily expected of an adult). These figures suggest that 1 in 5 secondary school aged children are young carers, as many as 6 per classroom.

Previous national prevalence estimates[18] based on research with young people of primary and secondary school age, estimated that there may be 7,600 young carers in Bristol (2016 figures), and that most of them would have been in a caring role for more than 3 years. 82% would be providing emotional support and supervision with 18% carrying out personal care.

Locally, Bristol's "Pupil Voice" survey (2015) indicated that 7.9% of pupils[19] were 'young carers', and 9% answered 'don't know'. Applying these rates to the 2016 population estimates for the city, this indicates at least 5,400 school age young carers in the city, with the full total being higher as a further 6,150 were unsure whether they were a 'young carer' or not.

Young carers are known to have particular health needs[20] - 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. And local data indicates almost half (46%) of young carers[21] reported experiences of frequent bullying, significantly higher than average (28%).

Further information – outcomes for Young Carers listed in the results tables in Bristol Pupil Voice report 2015-16

[16] Carers UK, Valuing Carers 2015 - The rising value of carers' support (via Bristol Carers Support Centre)

[17] National survey by the University of Nottingham and BBC News - www.nottingham.ac.uk/education/news/news-items/news1718/child-carers.aspx

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

[19] Pupil Voice survey of over 5,000 Primary and Secondary age children in Bristol. % based on pupils who answered question on whether or not they were a "young carer"

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

[21] Bristol Pupil Voice survey 2015. Bullying "often or daily in the last month"

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 estimates[22] for working age adults indicate 26,750 people have a moderate or serious physical disability in 2018.

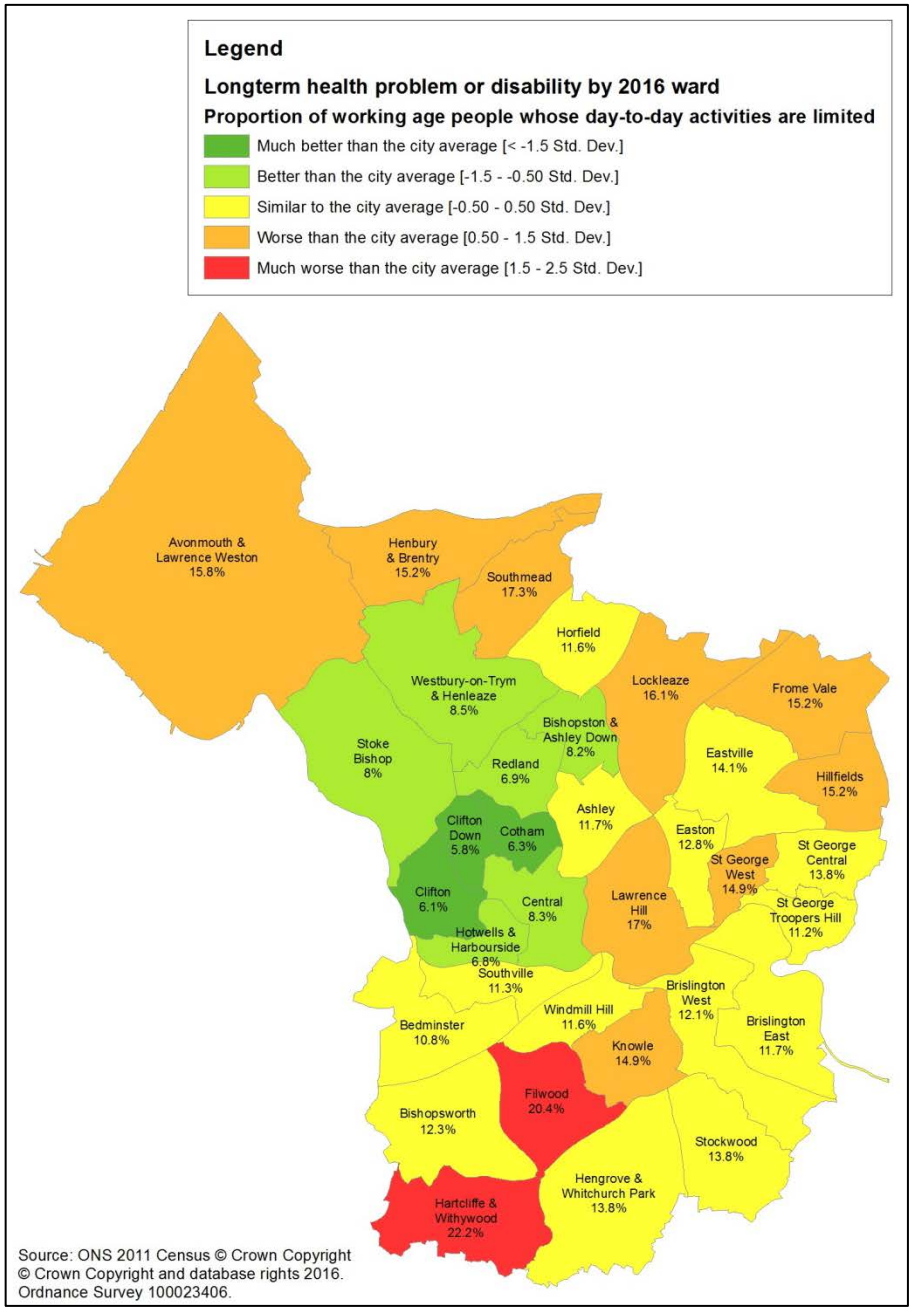


Figure 3.7.1: Long-term health problem or disability by Bristol ward
Source: 2011 Census ONS Crown Copyright Reserved [updated to Bristol wards 2016, BCC Insight, Performance & Intelligence]

3.7.2 Sensory impairment

Overall population estimates[23] 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).

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

[23] 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 registers[24] 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 estimates[25] 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 pupils[26] recorded with a Learning Disability in Bristol schools, around 150 have "Severe LD" and over 100 have "Profound & Multiple Learning Disabilities".

[24] NHS Quality Outcomes Framework, QOF, 2016/17.
[25] Institute of Public Care, POPPI and PANSI tools, www.pansi.org.uk: national 2004 prevalence estimate applied to the Bristol population; accessed Sept 2018
[26] 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 worse[27].

National research[28] 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 prevalence[29], 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 pupils[30] 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

[27] Statement from Public Health England Learning Disability Profiles
[28] "Confidential Inquiry into premature deaths of people with learning disabilities"; University of Bristol, 2013; www.bristol.ac.uk/cipold
[29] 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
[30] 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 England[31]. The obstacles and constrains facing GRT families are multiple and complex.

Local evidence suggests that there are around 500 Gypsy and Traveller families living in Bristol[32] 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 indicators[33]. The average life expectantly of a GRT person is 50 years.

A robust study compared the health needs of 293 Gypsies and Travellers in 5 areas in England (including Bristol), to the needs of 293 non-travelling adults. Key findings from this study are included below (SWPHO, 2011:3 - 4)[34]

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 research[35] 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)

[31] Ofsted; Dec 2014 and SWPHO, 2011:3
[32] Bristol GTAA, 2013
[33] Bhattacharyya et al. 2003; DfE, 2010 and Rowe and Goodman, 2014
[34] South West Public Health Observatory (SWPHO) report (October 2011) / Excluding New Age travellers; undertaken by Parry et al.
[35] www.twelvescompany.co.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 estimated[36] 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 residents[37] – 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 Needs[38] 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 partners[39] 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

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

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

[38] 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

[39] Source: Trans Health, Care & Wellbeing research report, April 2018. Healthwatch Bristol and The Diversity Trust – full link: https://healthwatchbristol.co.uk/wp-content/uploads/2018/03/Healthwatch_Trans_Health__Care_and_Wellbeing_Report_03.04.18.pdf

3.11 Migrant Health Needs

3.11.1 Migrants by Country of Birth[40]

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)

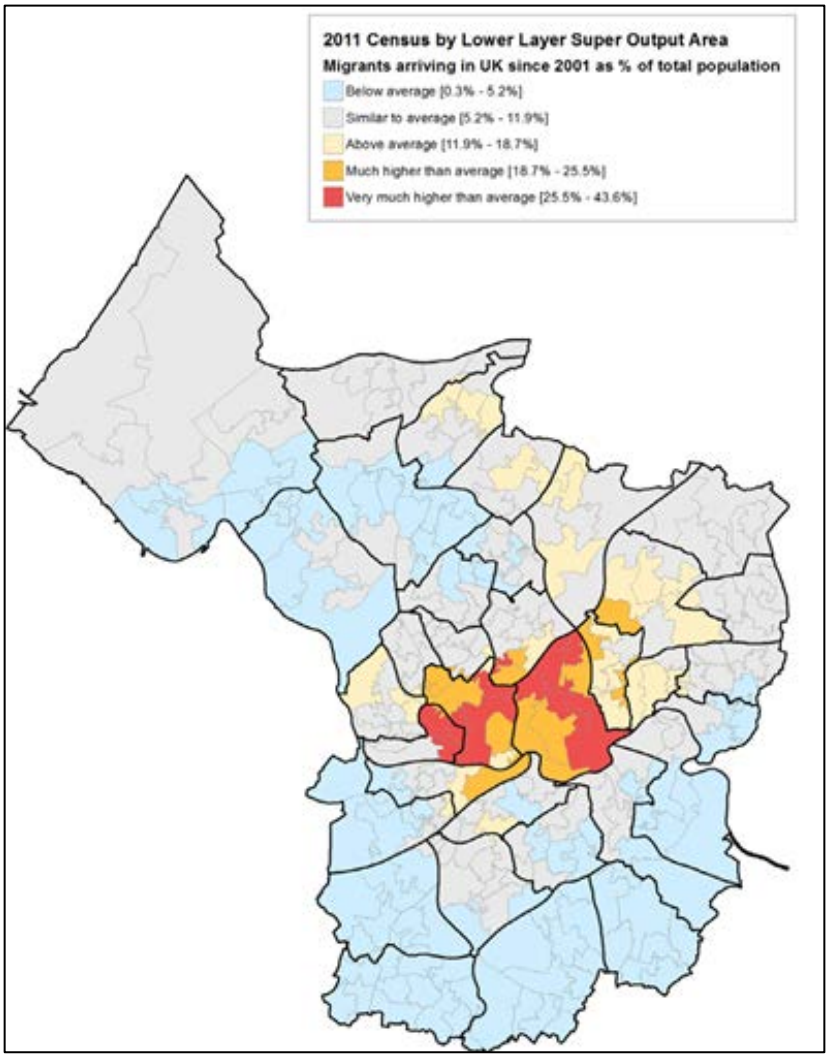


Fig 3.11.4: Migrants arriving in UK since 2001 as % of total population
Source: 2011 Census ONS © Crown Copyright 2013 [from Nomis]

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.

[40] 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 Profile[41].

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.
- 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).

[41] 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.
- 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).
- During 2012/13 to 2016/17 there were 1,000 childhood asthma hospital admissions. Of this number, 620 were boys and 380 girls.
- 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 Profile[42]. 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%.

[42] 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 2018[43]

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 0f 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).

[43] Sources are in the relevant sections

Section 4
Children & Young People's Health

Summary points[44]

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 average[45].
- 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 care[46], 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

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

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

[46] 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%)[47].

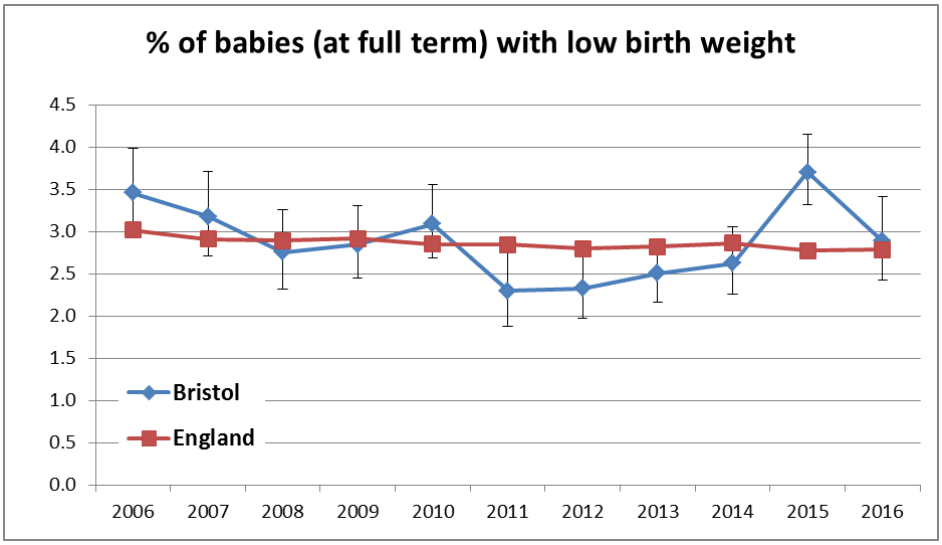


Fig. 4.1.1: % of all live births at term with low birth weight. Source: ONS, via Public Health Outcomes Framework, 2018

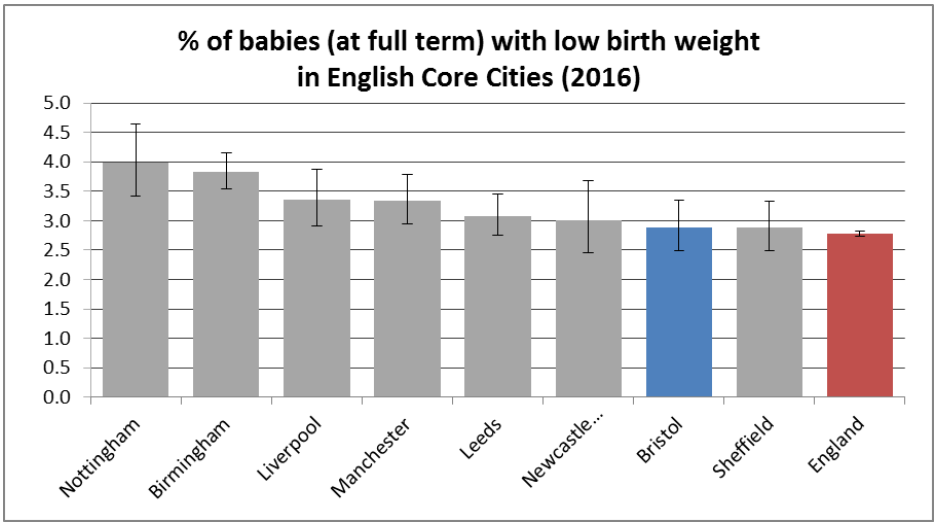


Fig. 4.1.2: % of all live births at term with low birth weight for English Core cities. Source: ONS, via Public Health Outcomes Framework, 2018

A project[48] 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

[47] ONS, via PHE "Pregnancy and birth" Profile

[48] 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" report[49] (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 mortality[50] 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.

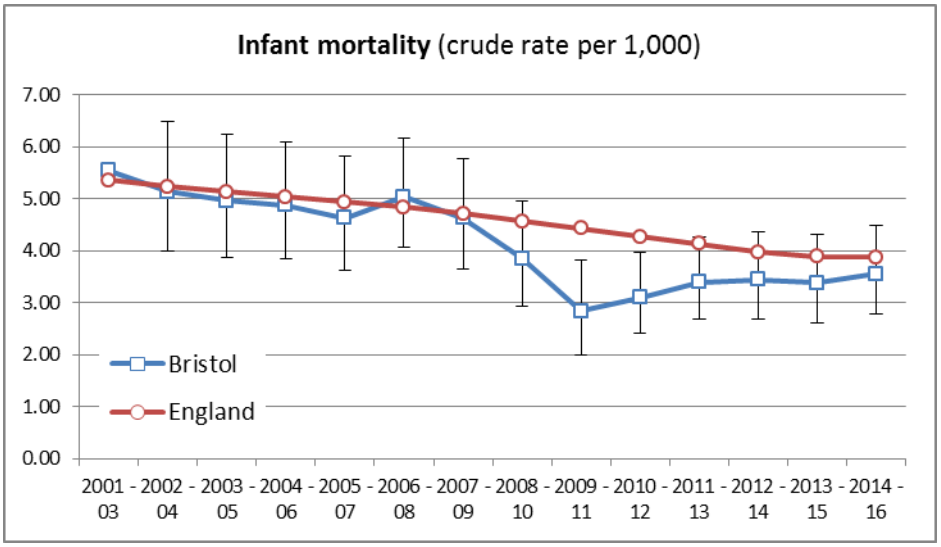


Fig 4.2.1: Rate of Infant mortality (age under 1 year) per 1000 live births Source: ONS via Public Health Outcomes Framework, 2018

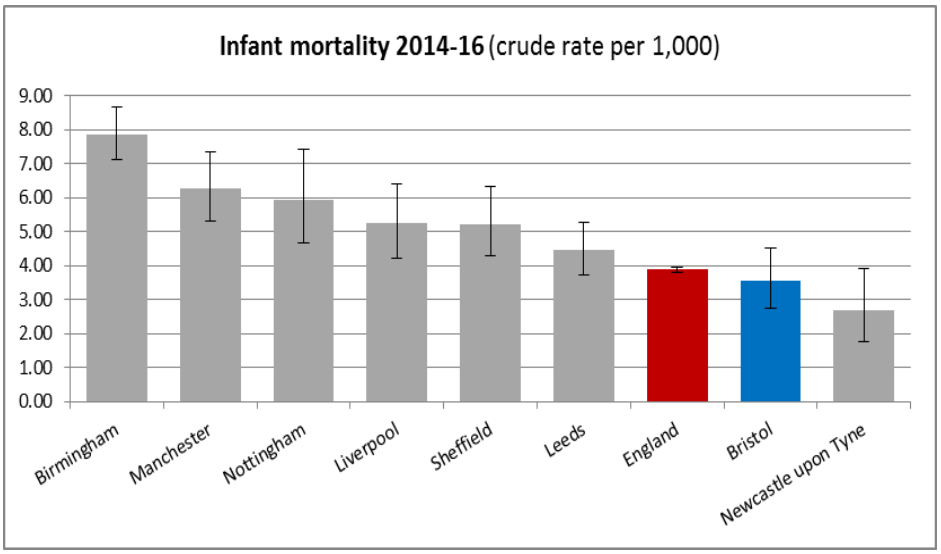


Fig 4.2.2: Rate of Infant mortality (age under 1 year) per 1000 live births for English Core Cities. Source: ONS via PHOF, 2018

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

[49] State of Child Health report 2017 Royal College of Paediatrics and Child Health
[50] 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 breastfeeding[51]. 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.

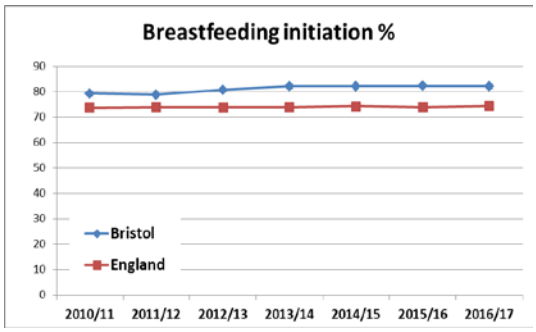


Fig. 4.3.1- Breastfeeding initiation rates. Source: NHS England via Public Health Outcomes Framework (2018)

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 Cities[52], but no formal rate has been published for Bristol in the last 2 years due to 'data quality reasons'. However, the raw data[53] (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.

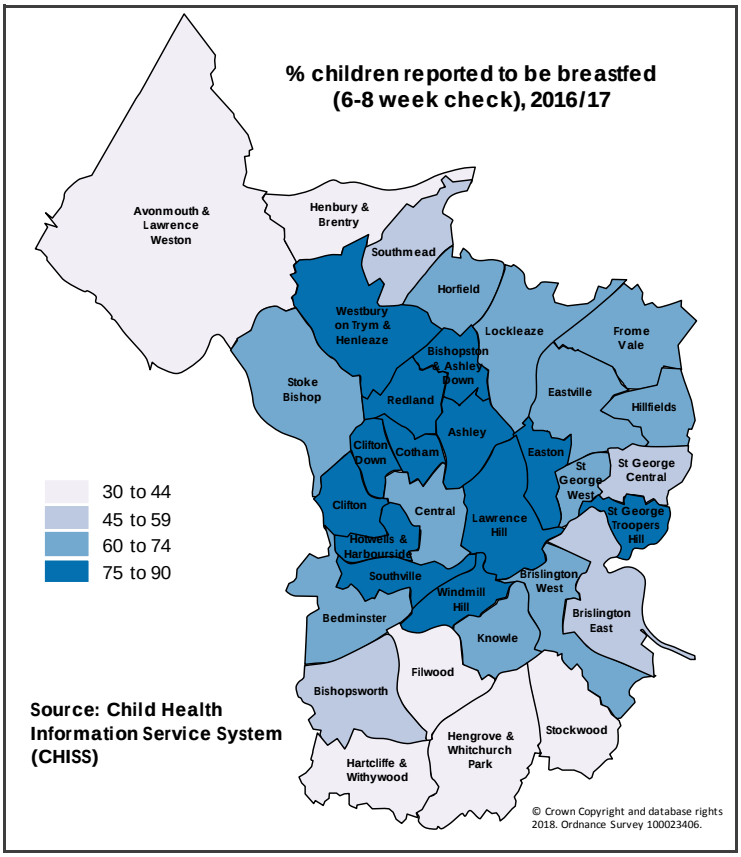


Fig 4.3.2: 2016/17 Breastfeeding rates at 6-8 week. Source: Child Health Information Service System, via Bristol Public Health Knowledge Service 2018

[51] Source: NHS England, via Public Health Outcomes Framework (2018)

[52] Breastfeeding continuation rates, historical method; via PHOF (Feb 2018)

[53] % 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 delivery[54]. 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.

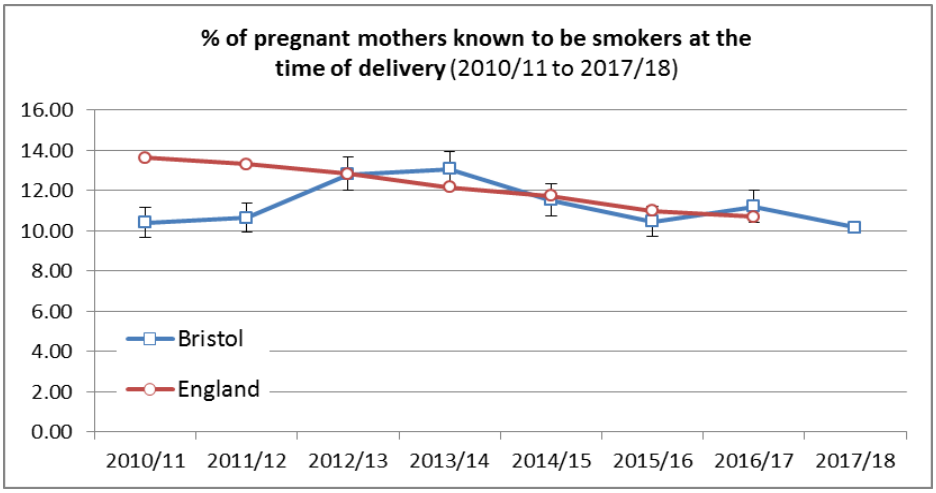


Fig. 4.4.1: Source: Health and Social Care Information Centre; via Bristol Public Health Knowledge Service / PHOF 2018

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 rates[55].

Further local analysis[56] 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.

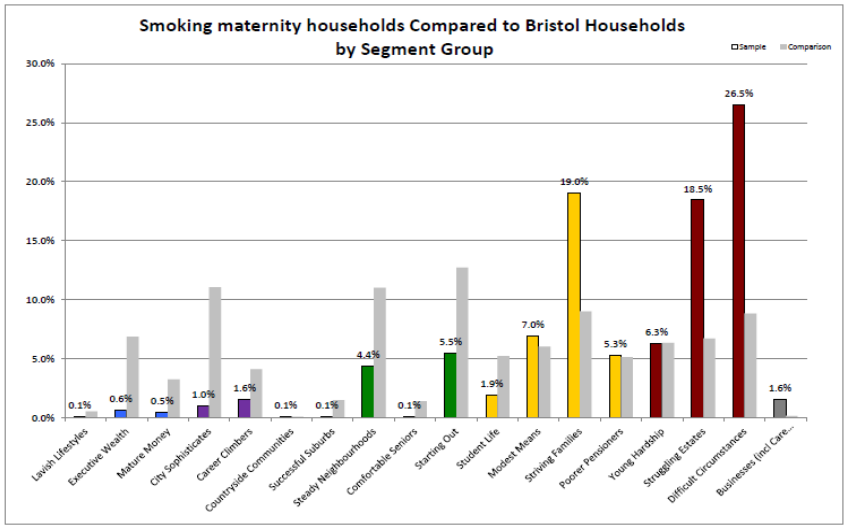


Fig. 4.4.2: Source: Health and Social Care Information Centre; CACI Acorn segmentation

Further data

- PHE Pregnancy and birth Profile
- PHE Local Tobacco Control Profiles

[54] Smoking Status at Time of Delivery, 2017/18. NHS Bristol CCG.

[55] Amanda Amos: Health Inequalities & Smoking – an overview, April 2016

[56] 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 children[57]

According to the Census 2011, 3,250 children (under 16) in Bristol have a "limiting long-term illness or disability"[58]. 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).

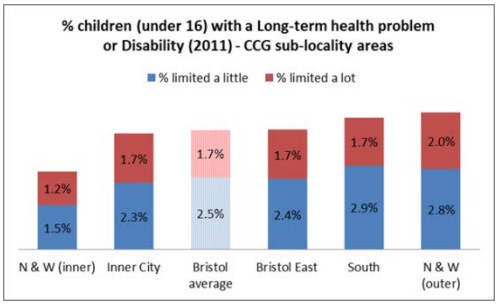


Fig 4.5.1: % Children with long-term health problem or disability by CCG sub-localities. Source: ONS Census 2011

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).

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.

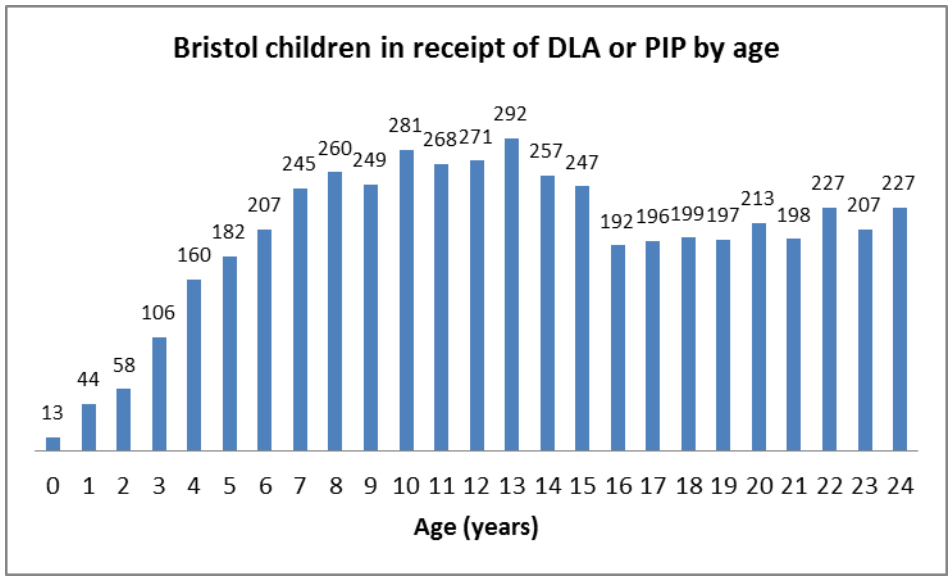


Fig 4.5.2: *Number of 0-25 year olds entitled to Disability Living Allowance or PIP in Bristol.*[59]

Further data

- See the JSNA Chapter on Special Educational Needs and Disability (SEND) due end 2018 - Bristol JSNA Chapters

[57] Also see **5.6 Special Educational Needs**
[58] Children under 16, Source: ONS Census 2011 – as in JSNA 2015
[59] 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 asthma[60] 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 asthma[61], 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 admissions[62] 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).

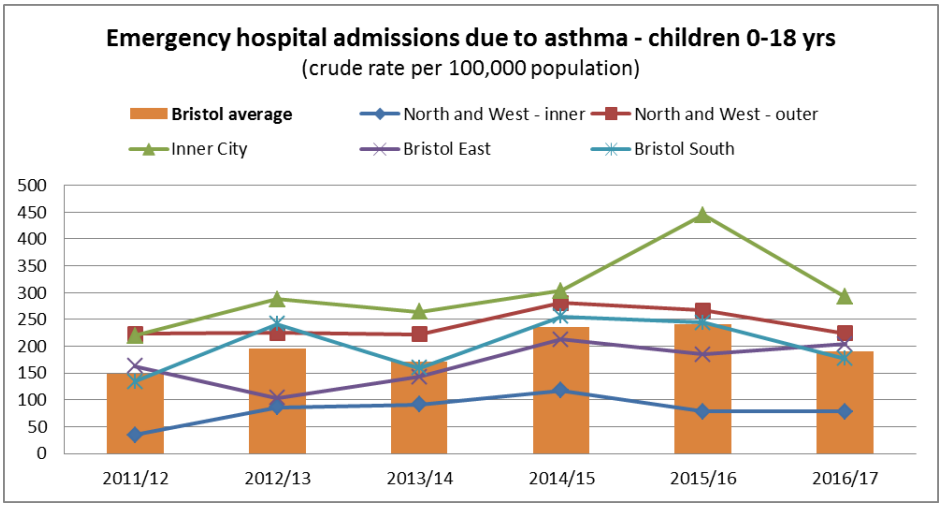


Fig 4.6.1a: Child hospital admissions for asthma, crude rates per 100,000 by CCG sub-locality; Source: Bristol Public Health Knowledge Service, 2018

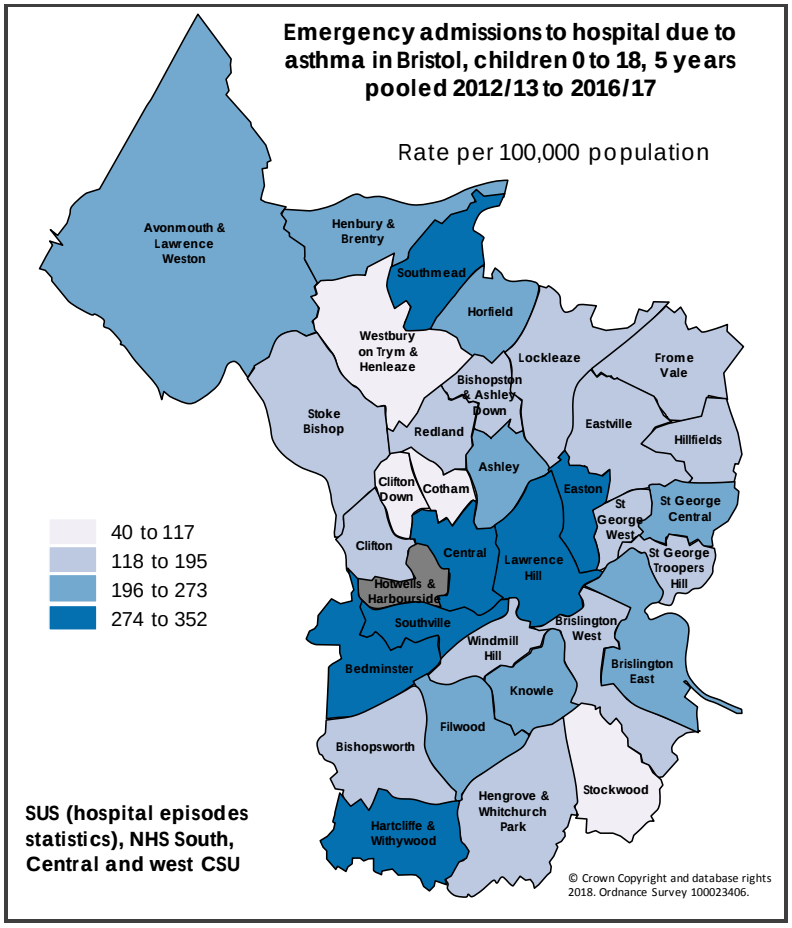


Fig 4.6.1b: Child hospital admissions for asthma, 5-year pooled crude rate per 100,000 by ward; Source: Bristol Public Health Knowledge Service, 2018 [Note - Hotwells and Harbourside is suppressed due to very small population]

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 home[63]. 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%)

[60] World Health Organisation, Fact sheet on Asthma (No.307), Nov 2013
[61] Admissions directly due to asthma, 0-18 yrs. Source: Hospital episode stats via Bristol Public Health Knowledge Service, 2018
[62] 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.
[63] Action on Smoking and Health (ASH), Research report - Asthma & Smoking, 2015

4.6.2 Epilepsy[64]

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 year[65]. 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).

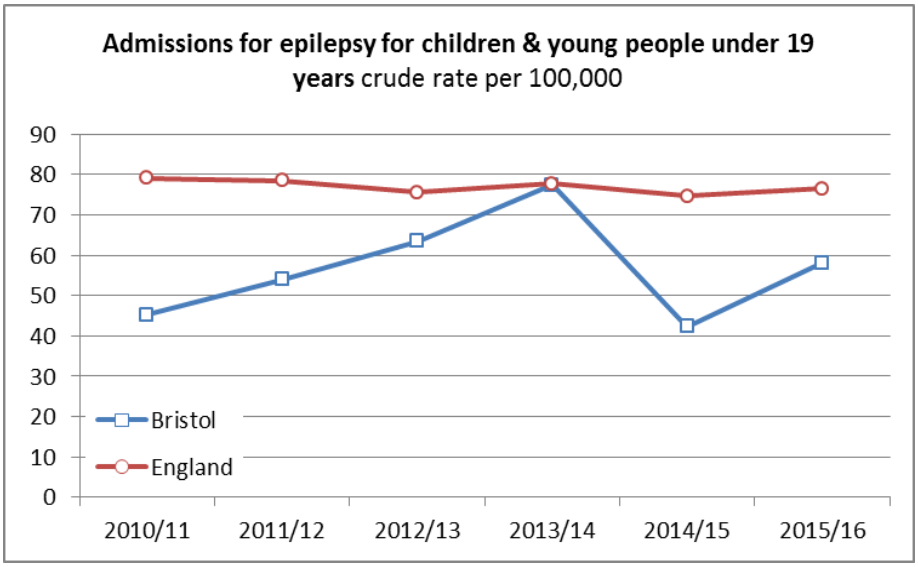


Fig 4.6.2: Rates of child hospital admissions due to epilepsy. Source: Hospital Episode Statistics, NHS Digital via ChiMat Disease Management Information Tool (DMIT)

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.

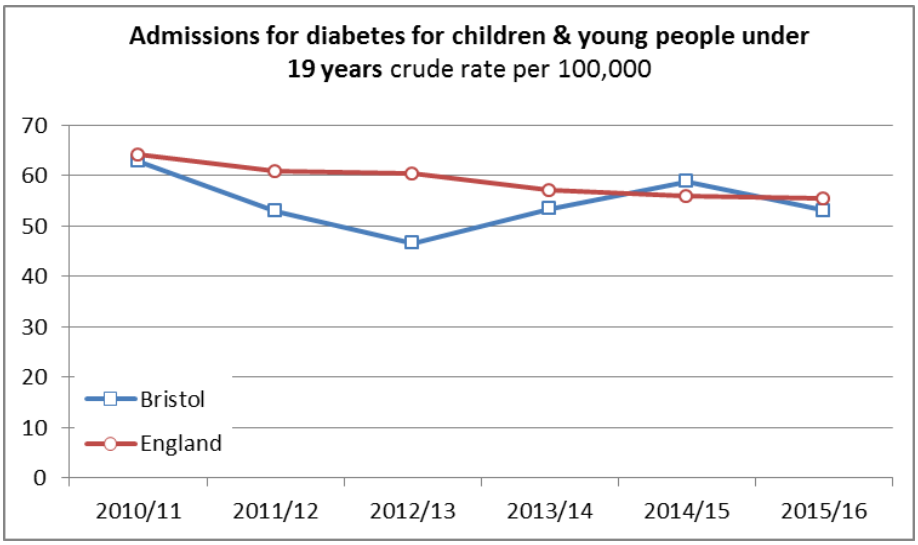


Fig 4.6.3: Rates of child hospital admissions due to diabetes. Source: Hospital Episode Statistics, NHS Digital via ChiMat Disease Management Information Tool (DMIT)

[64] Section mainly extracted from the Childhood Epilepsy JSNA Chapter, 2017
[65] 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 priority[66]. 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 2016[67] 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 (10-11year 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 obese[68], similar to national (9.6%).

Gender: Nationally, 23.2% of 4-5 year old boys had excess weight and 22.1% of girls[69].

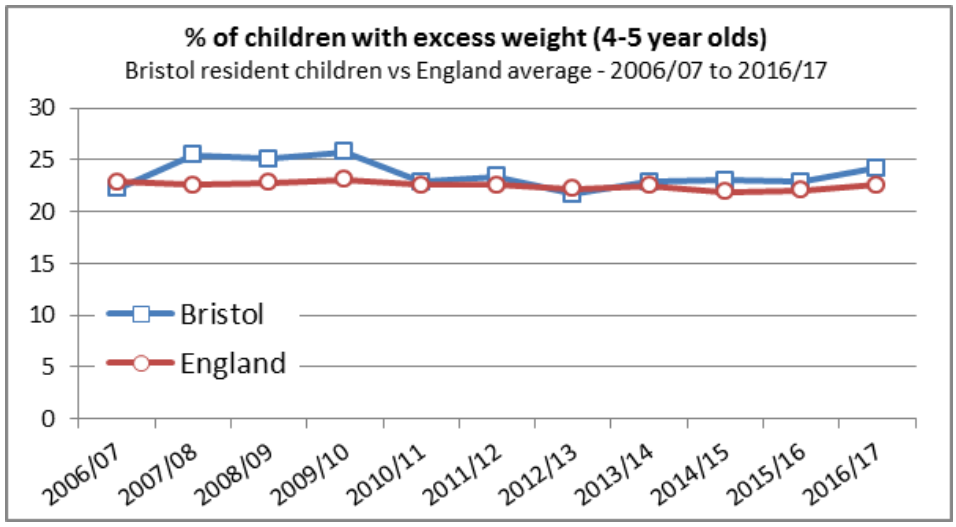


Fig 4.7.1a: Source: NCMP via PHOF, May 2018

Within Bristol, local data[70] 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.

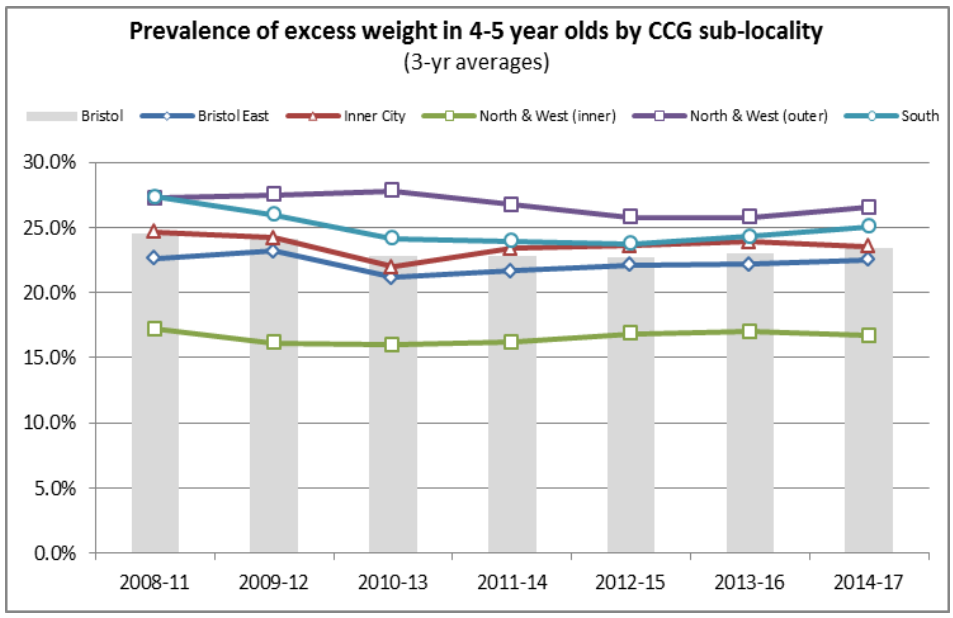


Fig 4.7.1b: Excess weight in 4-5 year olds by Bristol area, 2014-17
Source: NCMP via Bristol Public Health Knowledge Service, 2018

[66] Extracts from JSNA Chapter on Healthy Weight in Children and Young People (2017)
[67] A Plan for Action, 2016
[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

4.7.2 Excess weight in 10-11 year olds

The proportion of Year 6 pupils (10-11year 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 obese[71], now similar to the national average (20%).

Gender: Nationally, more 10-11 year old boys (36%) had excess weight than girls (32.4%)[72].

Within Bristol, local data[73] (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 & Withywood (fig 4.7.2b).

By CCG sub-locality areas, the proportion of 10-11year 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 school[74].

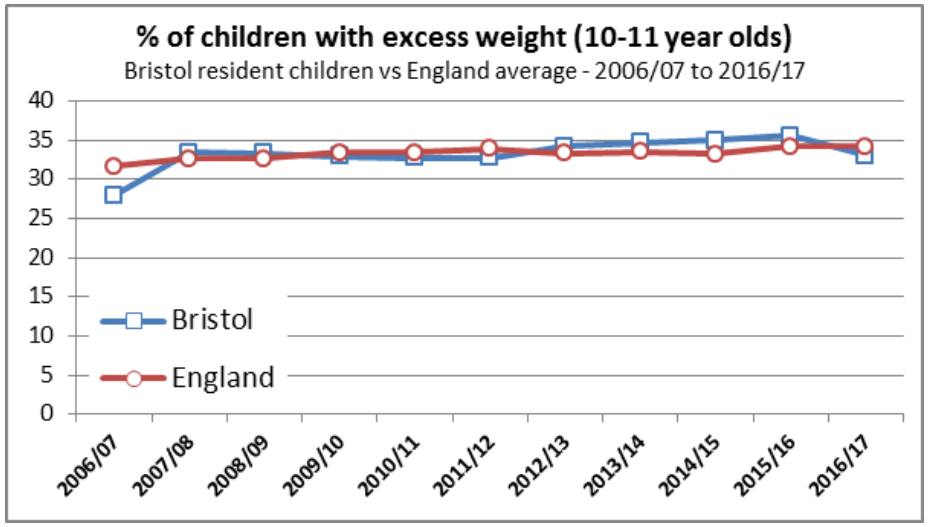


Fig 4.7.2a: Source: National Childhood Measurement Programme (NCMP) via PHOF, May 2018

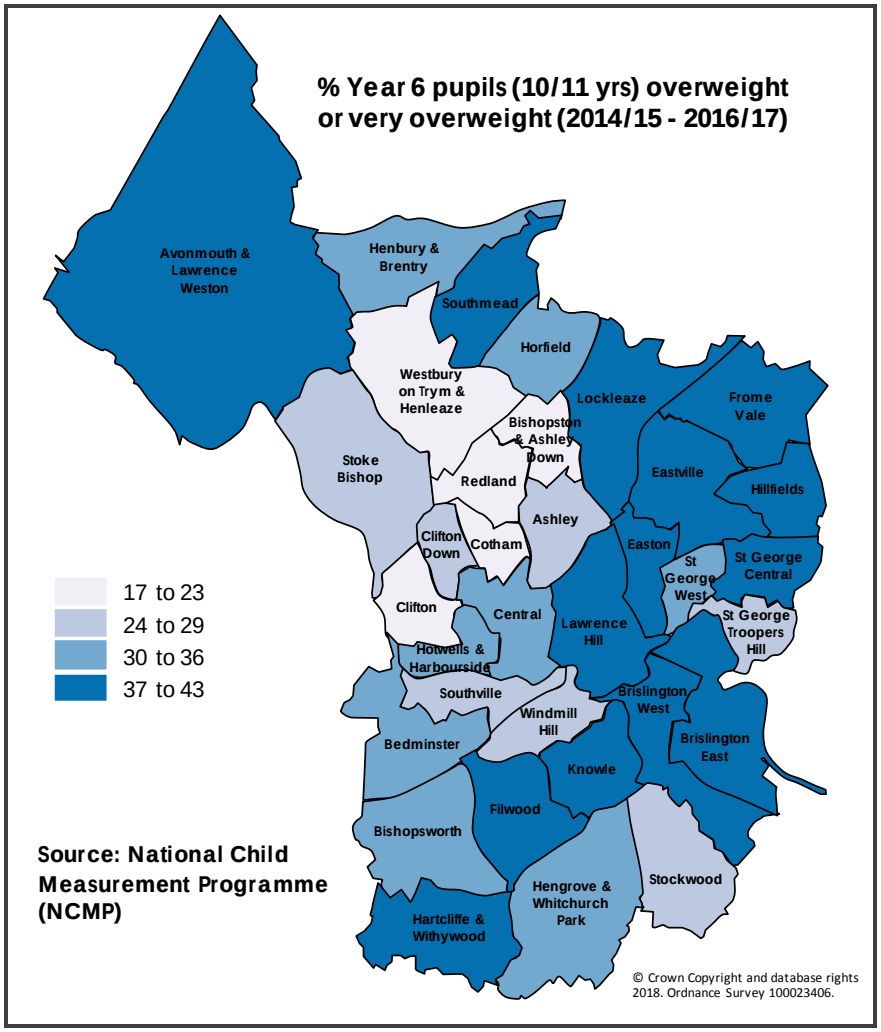


Fig 4.7.2b: Excess weight in 10-11 yea. olds by Bristol wards, 2014/15 - 2016/17 Source: NCMP via Bristol Public Health Knowledge Service, 2018

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

[71] Source: NHS Digital & NCMP, via PHE Child health profiles, 2018
[72] Public Health Outcomes Framework, 2018
[73] Source: National Child Measurement Programme, 2014/15 to 2016/17; via Bristol Public Health Knowledge Service, 2018
[74] Source: NCMP, 2014/15 to 2016/17; via Bristol PHKS, 2018

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)[75]. 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%)[76].
- The average number of decayed, missing or filled teeth in 12 year olds (2008/9) was higher (1.1) than national (0.74)[77]
- 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 teeth[78]. 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.

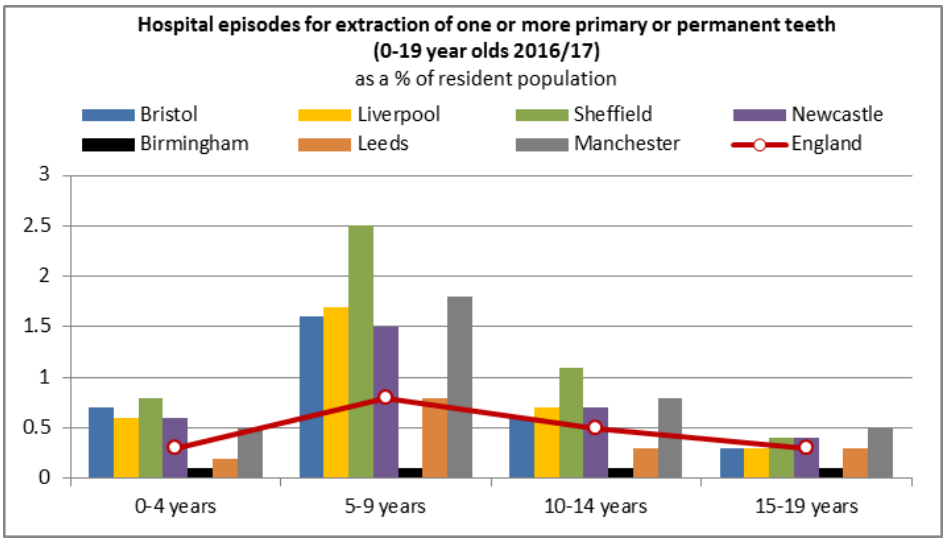


Fig 4.8.1: Source; Public Health England, Dental Public Health Intelligence Programme, 2016/17

Local data[79] (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

[75] Source: Oral health survey of 5 year old children; via PHE Child health profiles, 2018
[76] Via Oral health profile. The 2013/14 survey has not yet been repeated.
[77] Via Oral health profile. The 2008/09 survey has not yet been repeated.
[78] Dental Public Health Intelligence Programme, 2016/17.
[79] 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 Immunisations[80]

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.

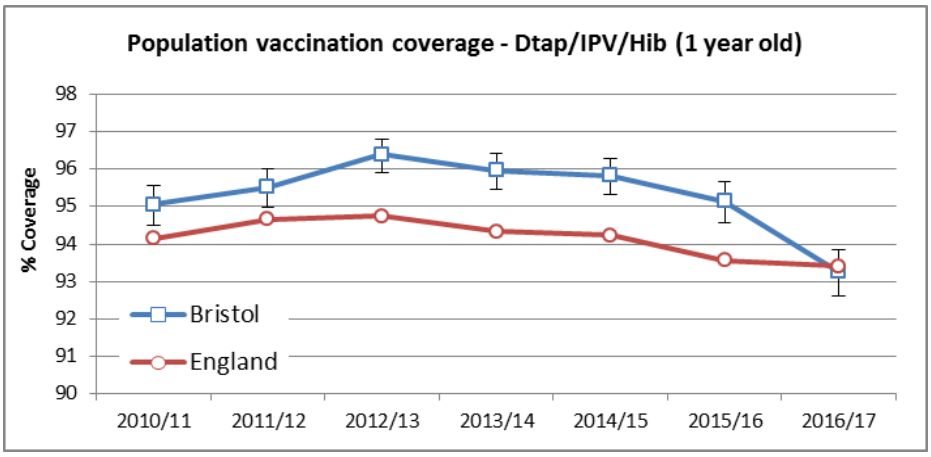


Fig. 4.9.1: Source: Cover of Vaccination Evaluated Rapidly 2016/17 data via Public Health Outcomes Framework, 2018

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 vaccine[81] 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

[80] All data source is "Cover of Vaccination Evaluated Rapidly (COVER)" via PHOF 2018, compared to the national average.

[81] 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.

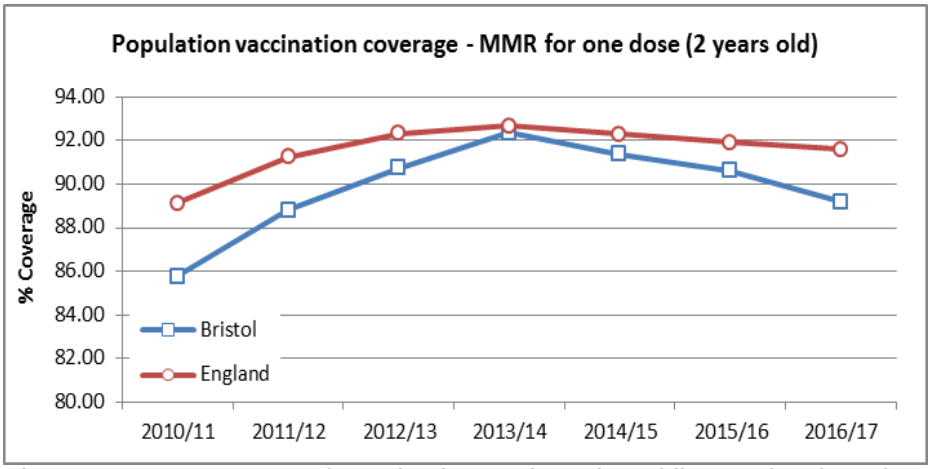


Fig. 4.9.2: Source: Cover of Vaccination Evaluated Rapidly 2016/17 data via Public Health Outcomes Framework, 2018.

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.

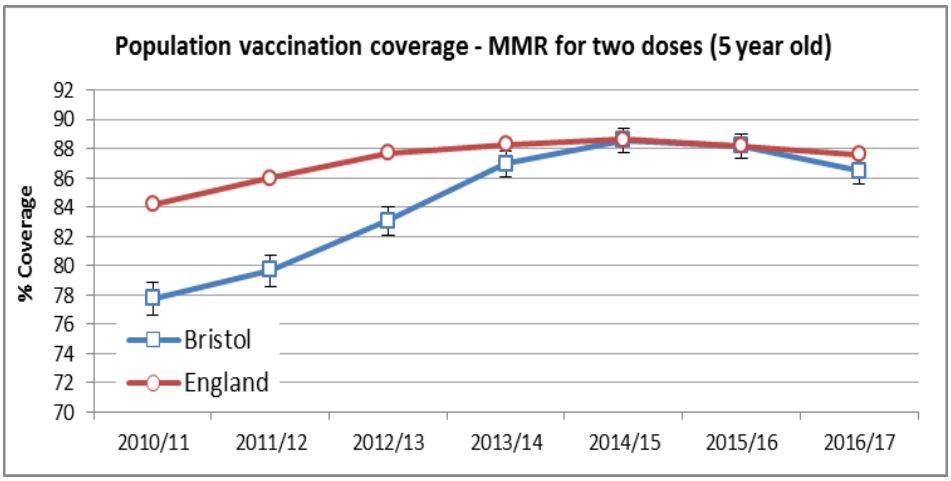


Fig. 4.9.3: Source: Cover of Vaccination Evaluated Rapidly 2016/17 data via Public Health Outcomes Framework, 2018.

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%.

4.9.3 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%).

4.9.4 Local vaccination coverage data

Recent local data[82] 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).

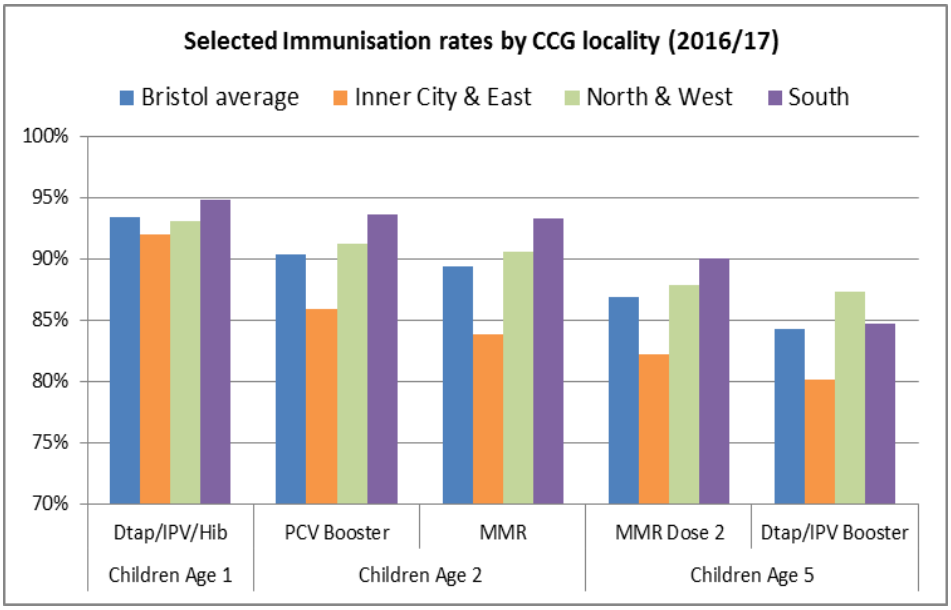


Fig. 4.9.4: Source: NHS Digital. Supplied by Bristol Public Health Knowledge Service 2018.

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 vaccine[83] 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**

[82] Source: NHS Digital via Bristol Public Health Knowledge Service, 2018.

[83] Source: Public Health England, via PHOF, May 2018

4.10 Injuries

4.10.1 Injuries in children (0-14)

The rate of emergency hospital admissions[84] 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)[85]

Using local data[86], 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 rates[87] are 157.1 per 10,000 for boys under 5, significantly higher than the rate for girls, of 114.8 per 10,000

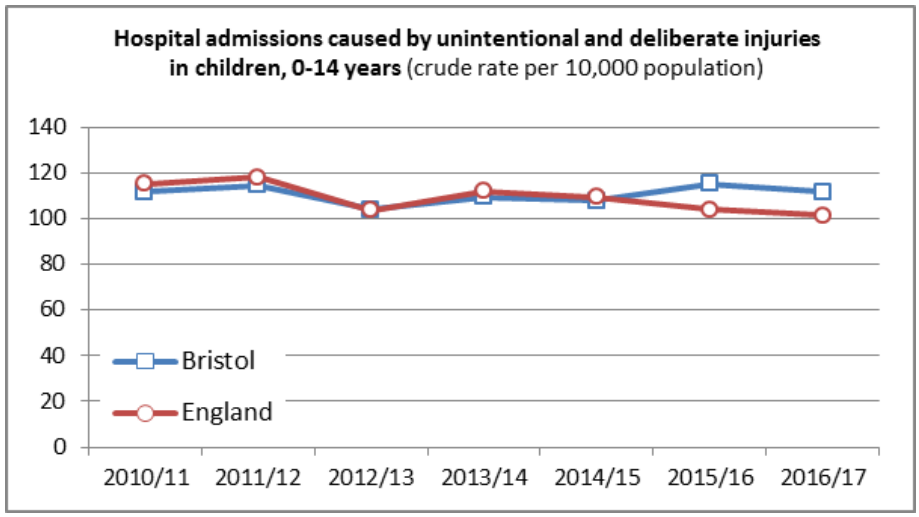


Fig. 4.10.1a: Source Hospital Episode Statistics, NHS Digital via PHOF 2018

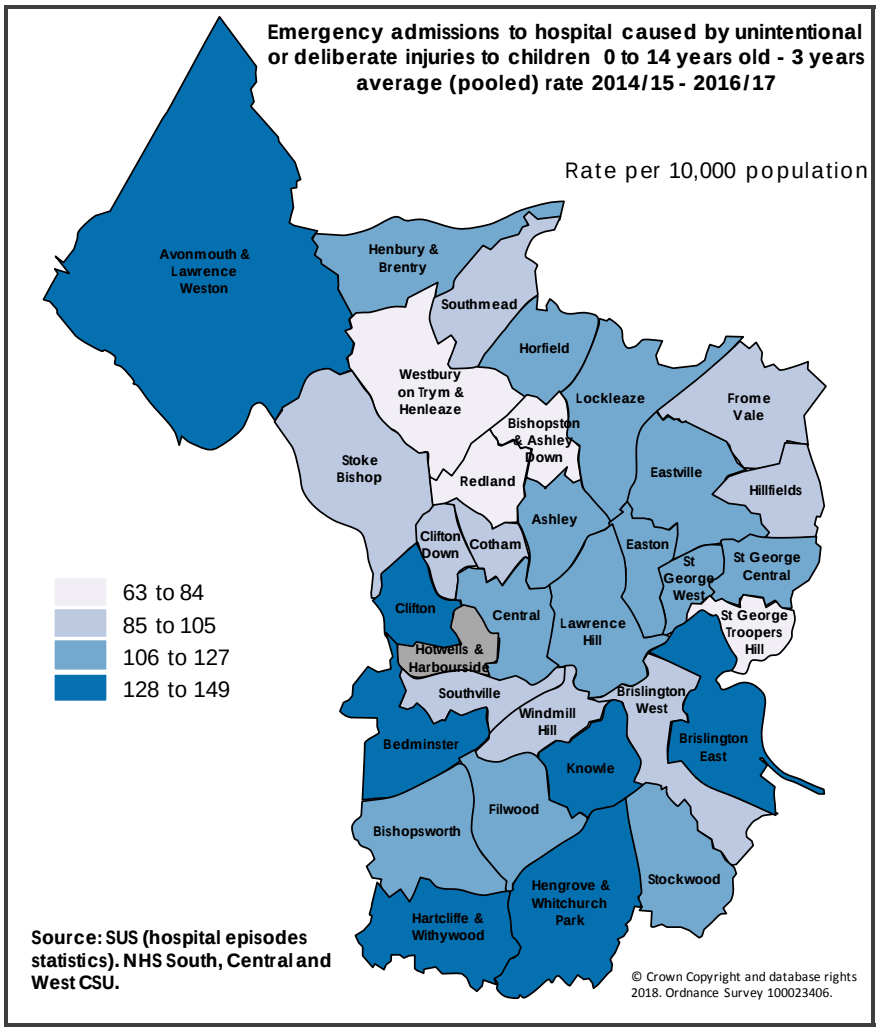


Fig. 4.10.1b: Source: Bristol Public Health Knowledge Service (2014/15 - 2016/17) *[Note - Hotwells and Harbourside is suppressed due to very small population]*

[84] Crude rates of emergency admissions per 10,000 population, via PHOF, May 2018.
[85] 2016/17, via PHOF, May 2018.
[86] 2014/15-2016/17 (3 year pooled data), Source: Bristol Public Health Knowledge Service (PHKS), 2018

[87] 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 picture[88] 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 data[89] (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 data[90], 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.

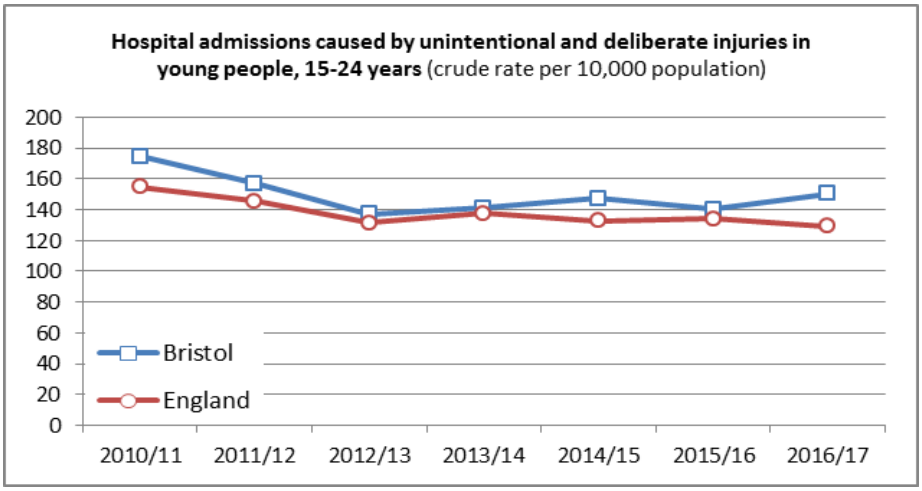


Fig. 4.10.2a: Source Hospital Episode Statistics via PHOF 2018

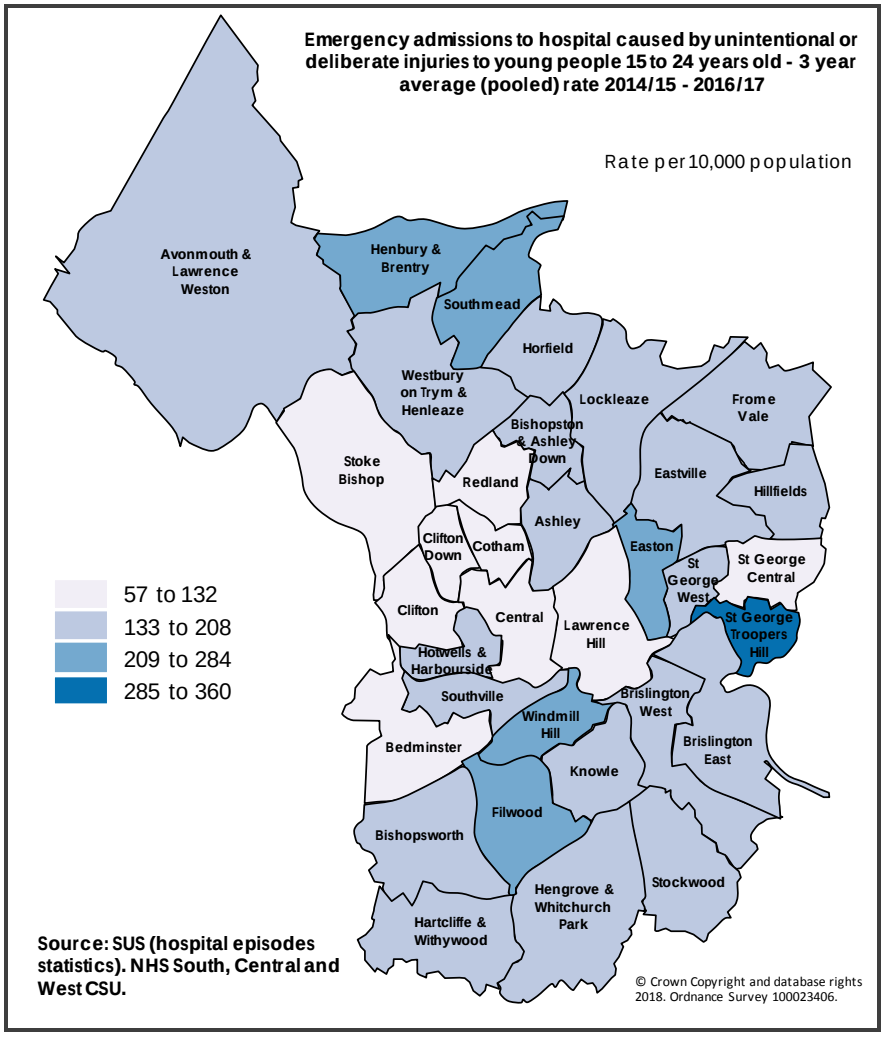


Fig. 4.10.2b: Source: Bristol Public Health Knowledge Service (2014/15 - 2016/17)

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

[88] Source: Hospital Episode Statistics (HES) 2016/17, via PHOF, May 2018.
[89] Source: Bristol Public Health Knowledge Service (PHKS), 2018
[90] 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 abortion[91]. 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 numbers[92], 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.

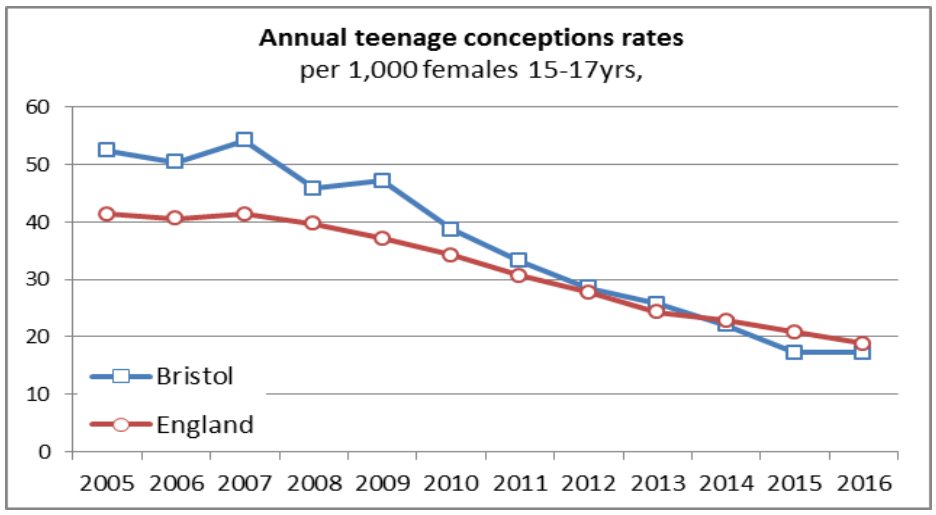


Fig. 4.11.1: Source: Office of National Statistics, via Bristol Public Health Knowledge Service 2018

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 data[93] 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). However, all CCG areas saw a drop in conception rates for this period.

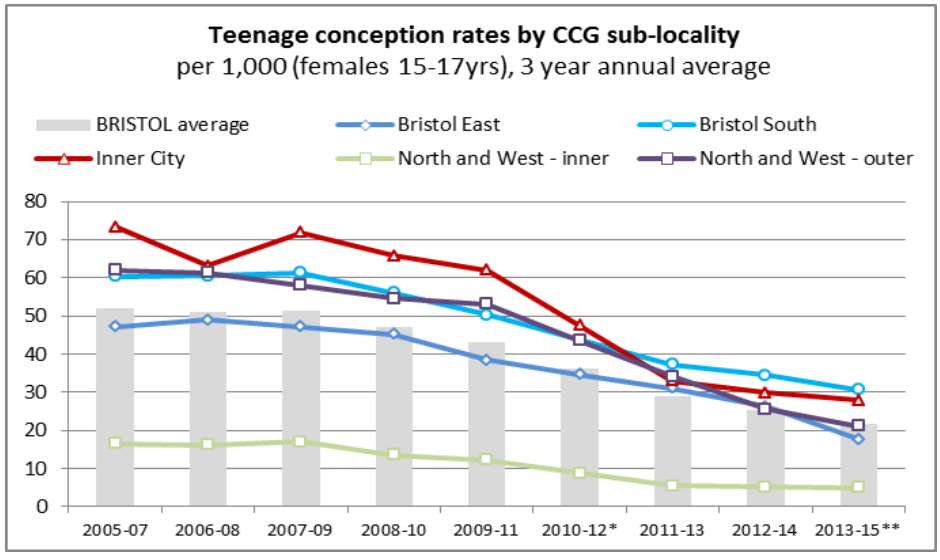


Fig. 4.11.2: Source: Bristol Public Health Knowledge Service April2018
**Imputed values for missing data **Ward estimates from MSOA data*

[91] Intro from PHE, via PHOF 2.04
[92] Source: Office for National Statistics (ONS), via PHOF, May 2018
[93] 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) survey[94] 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) survey[95] 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"[96] at age 15 shows that Bristol is 7.8%, significantly higher than England average of 5.5%.

Gender: Nationally, females at age 15 are significantly *more* likely to be a smoker than males, which is very different to the adult picture[97]. WAY data is not available by gender for Bristol. However, the local "Pupil Voice" survey also indicates that more girls than boys are smoking in year 10.
Additional local Bristol Pupil Voice survey (2015) data indicates that 25% of boys and 28% of girls report having tried a cigarette, while 18% of all year 10 respondents report that they have tried an e-cigarette. Of those that smoke, most smoke 1-5 cigarettes per week.

Smoking prevalence can be much higher in certain groups within the population, even at a relatively young age. An analysis[98] 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.

[94] 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
[95] What About YOUth (WAY) survey 2014-15. Smoking Prevalence also via www.tobaccoprofiles.info
[96] usually smoke at least 1 cigarette per week
[97] See 6.4 Smoking in Healthy Lifestyles
[98] Analysis carried out by Bristol Public Health Knowledge Service, 2015

4.12.4 Alcohol

The What About YOUth (WAY) survey[99] 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.

4.12.5 Drug misuse

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

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

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

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

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

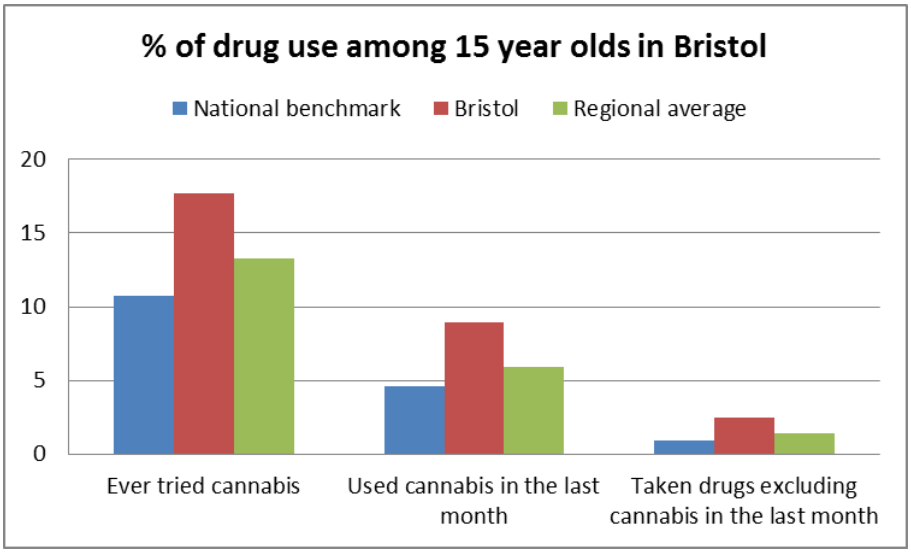


Fig 4.12.5: Drug use in 15 year olds; Source: What About YOUth (2014/15)

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

[99] 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

Many factors 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 & Withywood, 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 annual rough sleeper street count in Bristol rose to 86 in 2017 from 41 in 2014 (and 8 in 2010).

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 (12% male).

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 Deprivation[100]

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 areas[101] are in the most deprived 1% in England. In 2010, only 1 area was in the most deprived 1%.

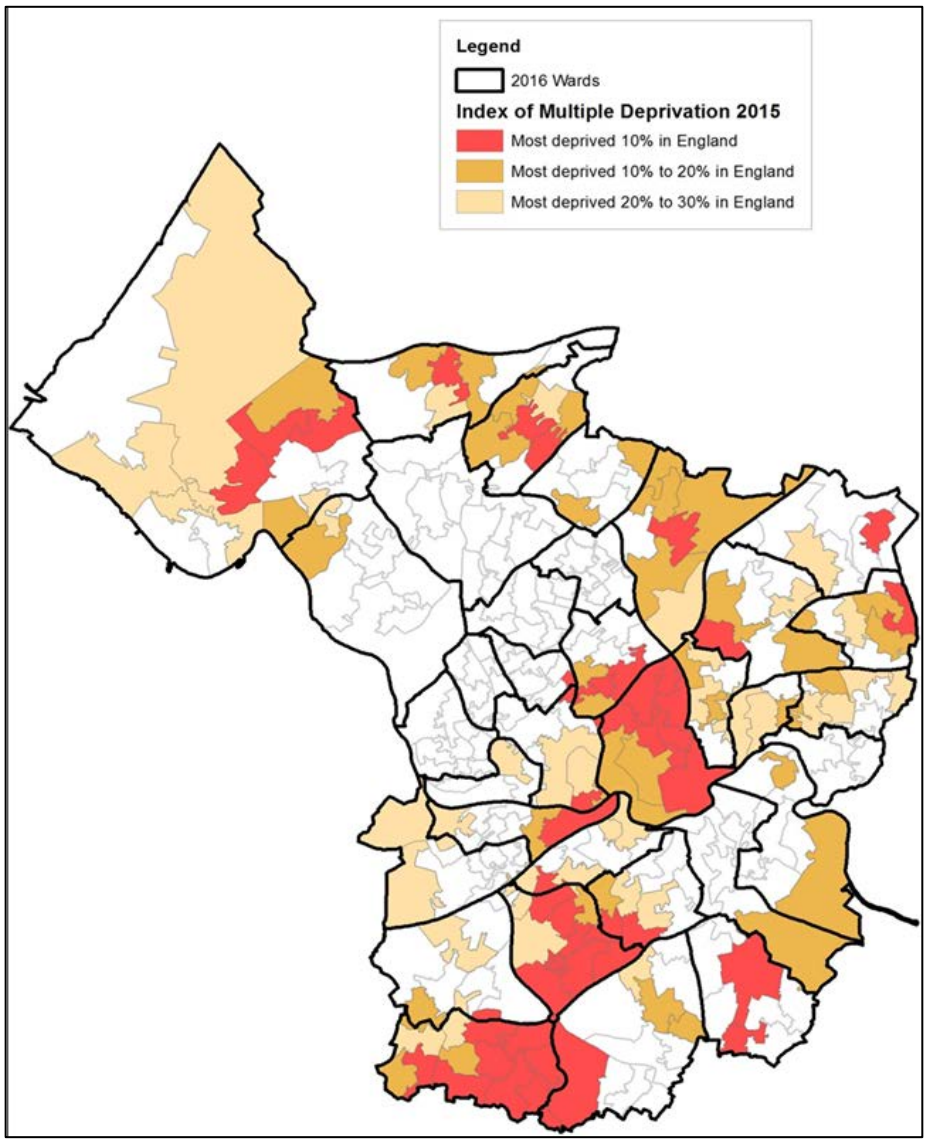


Fig 5.1.1: Multiple Deprivation 2015 - Bristol LSOA[102] areas ranked in the most deprived 10-30% in England (with new 2016 ward boundaries overlaid) Source: English Indices of Deprivation 2015, DCLG © Crown Copyright

The overall IMD 2015 score[103] 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

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

[101] 4 of these are in Hartcliffe & Withywood, 1 in Filwood and 1 in Lawrence Hill

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

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

5.2 Income deprivation[104]

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)[105] 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).

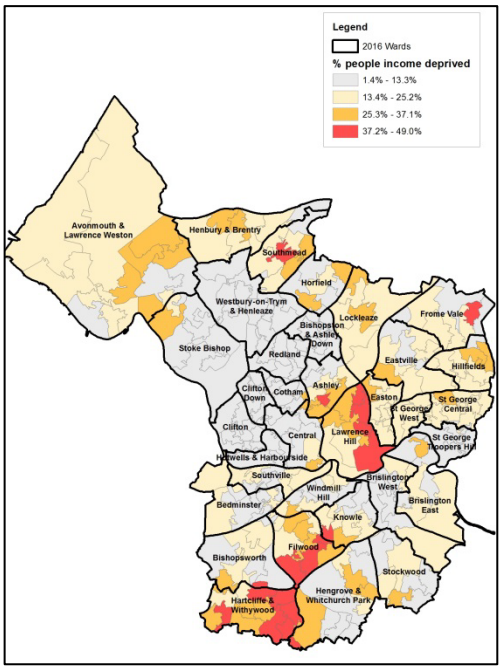


Fig 5.2.1: Income deprivation (all age)

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.

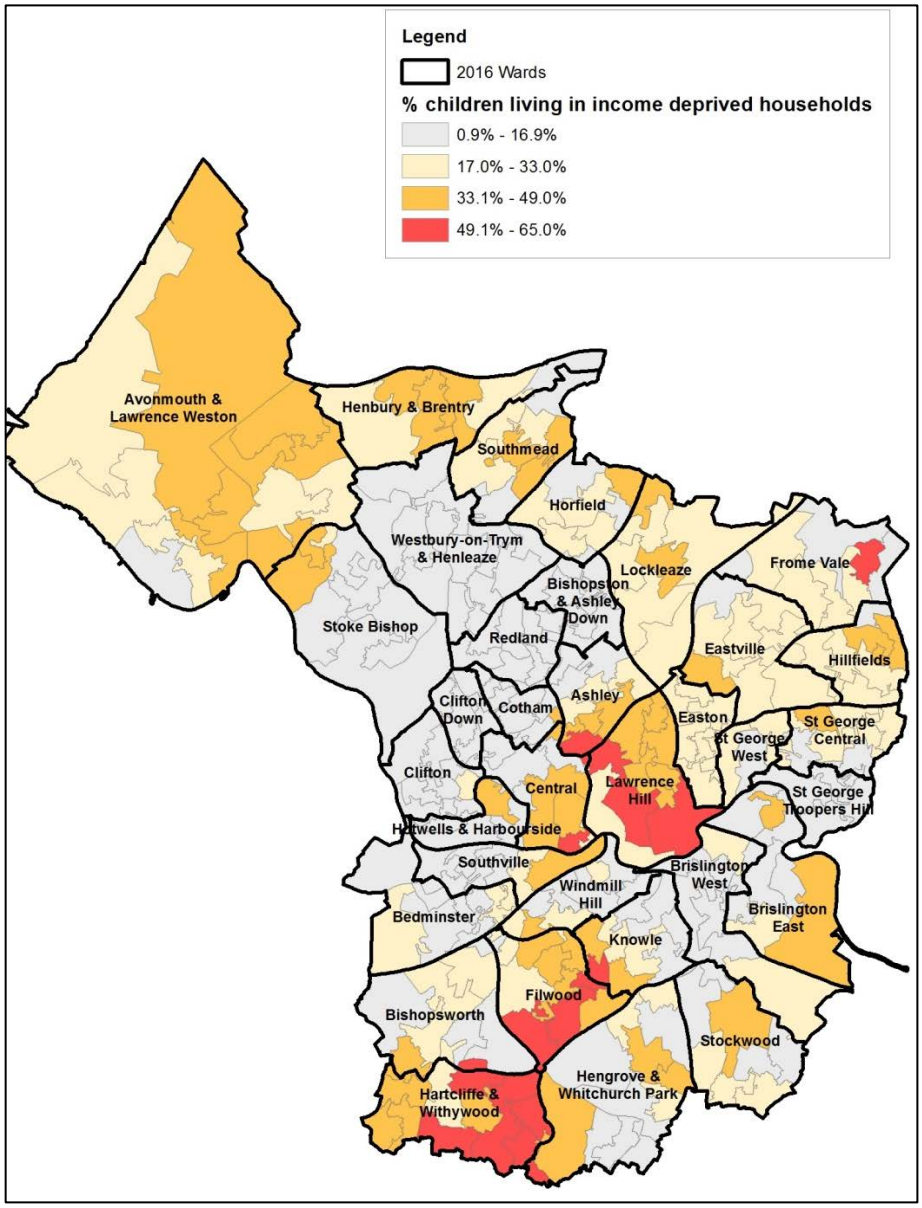


Fig 5.2.2: Income deprivation affecting children, shown by LSOA area (2015)

[104] See Deprivation in Bristol 2015 www.bristol.gov.uk/deprivation
[105] 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.

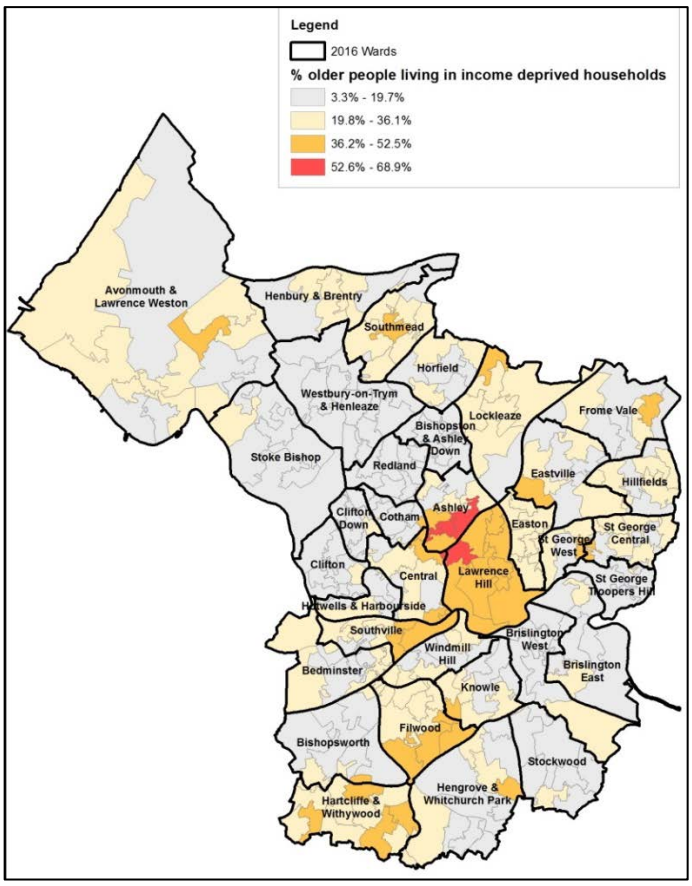


Fig 5.2.3: Income deprivation affecting older people, by LSOA area, 2015

People struggling financially

On average, 12.1% of people in Bristol said they were struggling financially[106]. 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%).

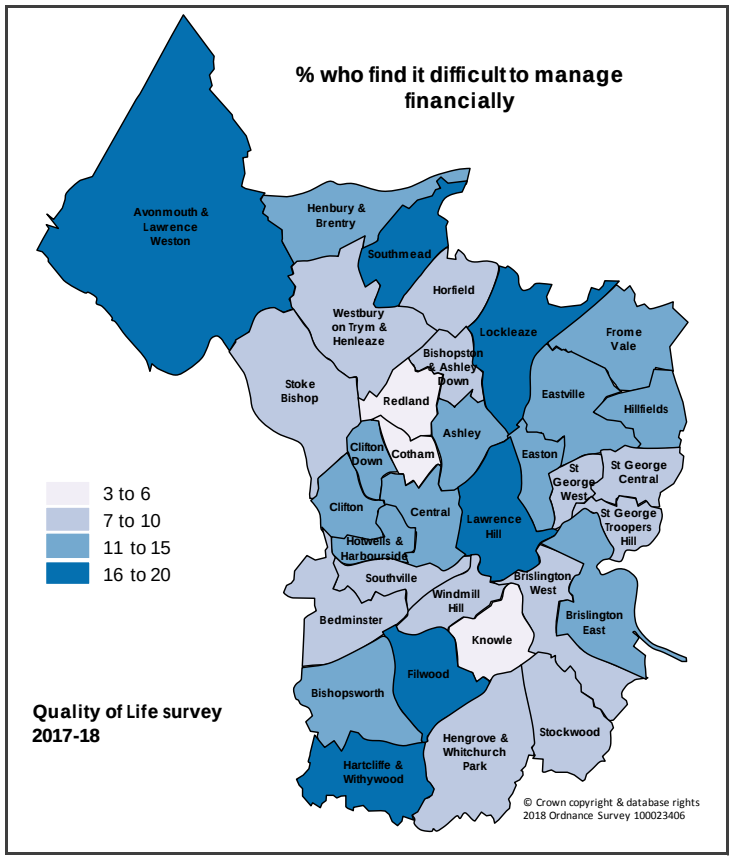


Fig 5.2.4: People who say they are struggling financially
Source: Bristol Quality of Life survey 2017-18

[106] 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**[107] 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 families[108] has an overall downward trend (fig 5.3.1), in Bristol and nationally.

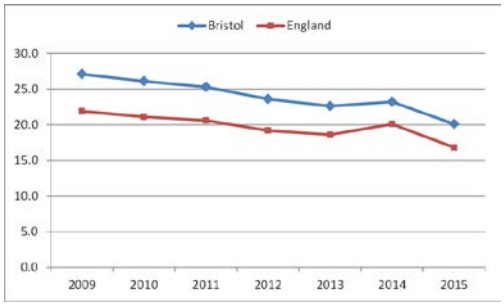


Fig 5.3.1: Children living in low-income families; Source: DWP, Feb 2018

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

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.

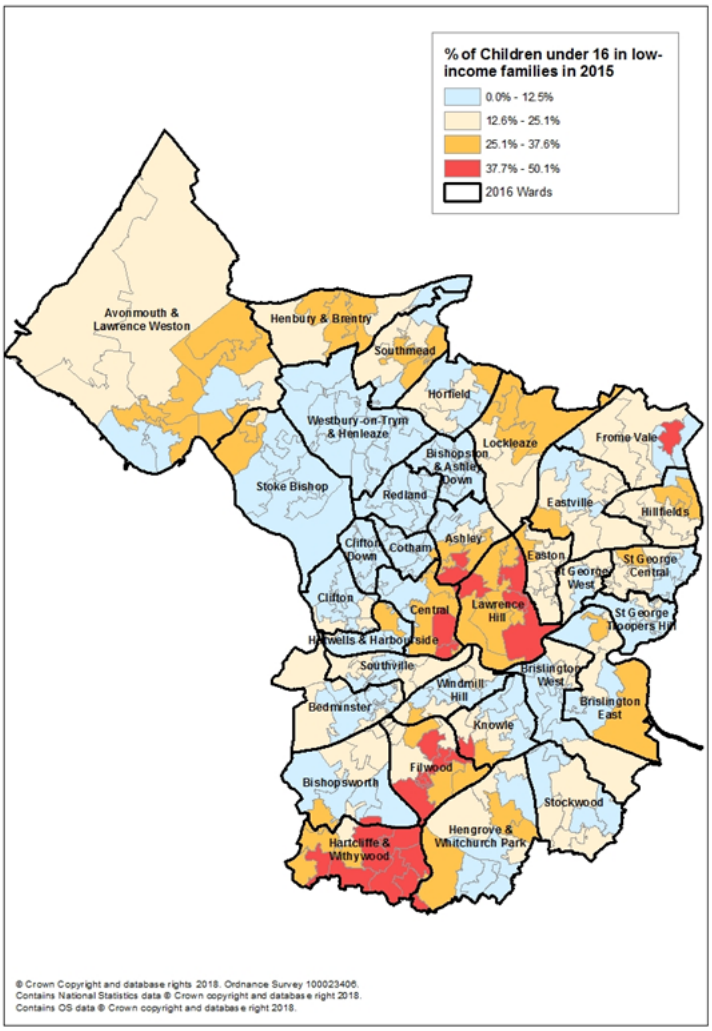


Fig 5.3.2: % of children (under 16) in low income families by LSOA; Source: DWP 2018

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%.

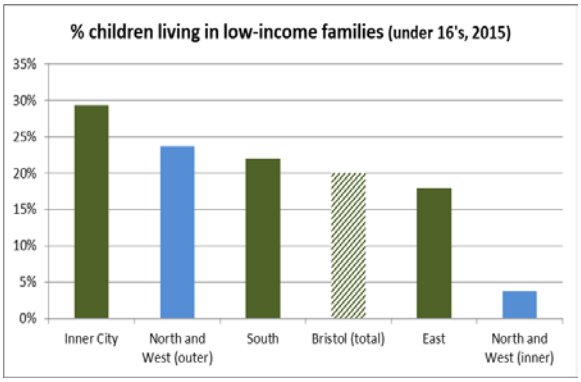


Fig 5.3.3: % children (under 16) in low-income families by CCG locality; Source DWP 2018. Analysed by BCC Insight, Performance & Intelligence

[107] 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.

[108] 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

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.

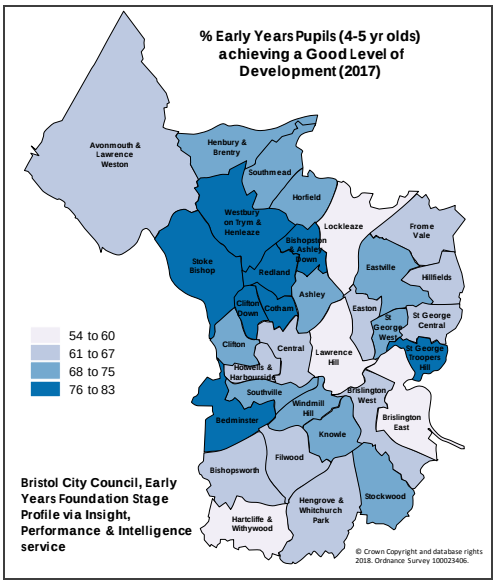


Fig 5.4.1: Source: Bristol City Council

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%.

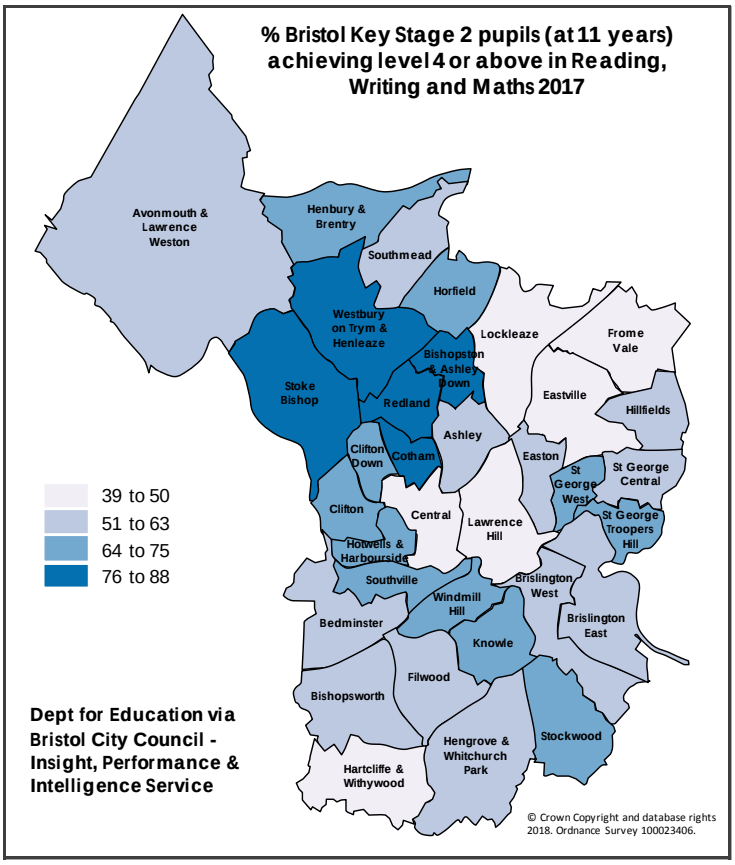


Fig 5.4.2: Dept. for Education, via Bristol City Council, 2017 results

5.4.3 Key Stage 4 (GCSEs)

In 2016, the Department for Education introduced a new system for tracking GCSE results[109]. 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.

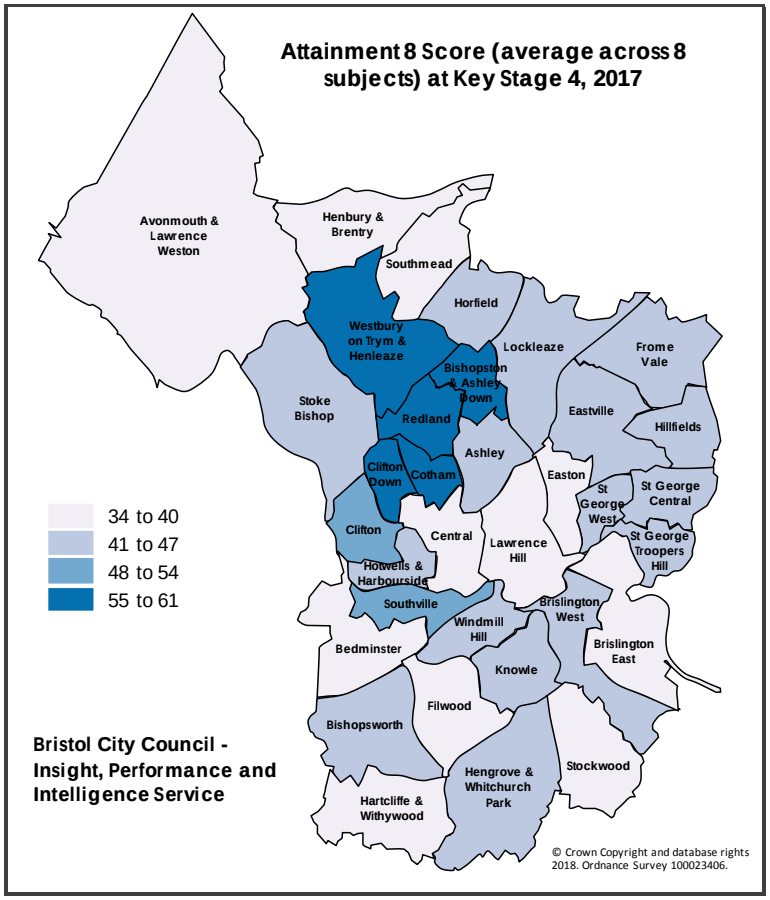


Fig 5.4.3: Attainment 8 Score per pupil averaged by ward, 2017. Source: Dept. for Education, via Bristol City Council.

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.

[109] 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)[110]

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) [111].

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 areas[112] in the entire country are in Bristol South – Withywood (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

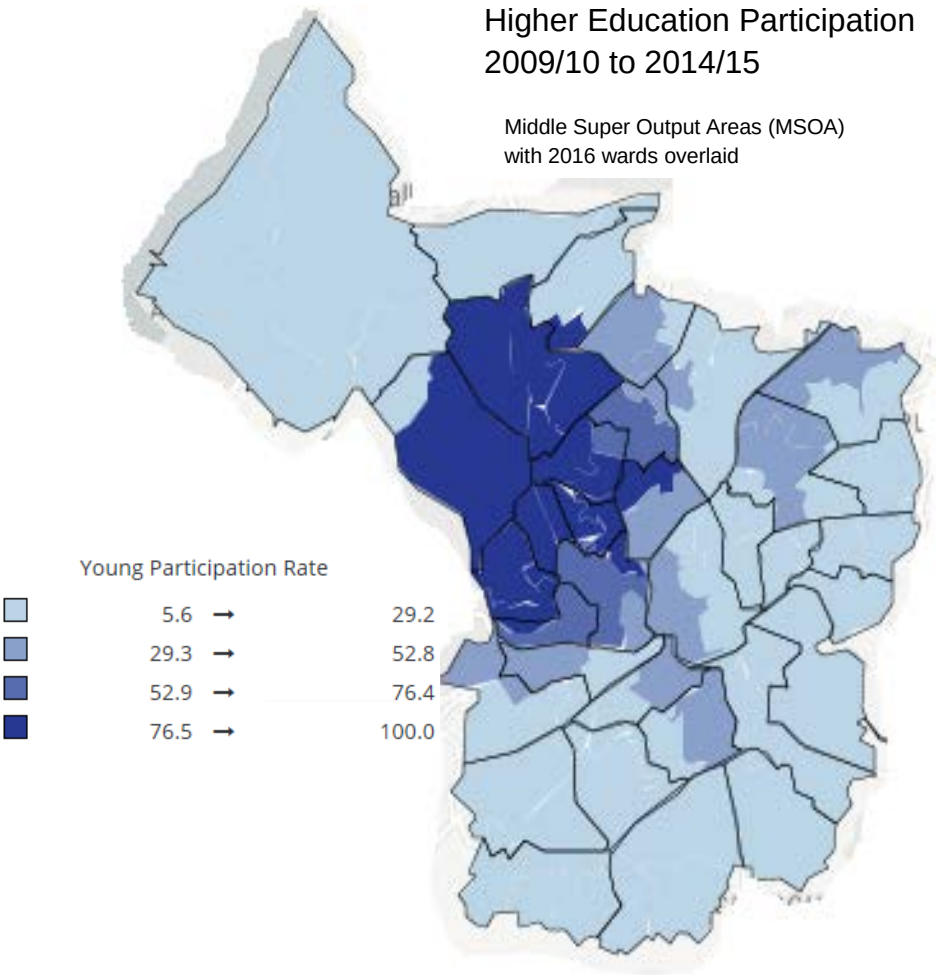


Fig 5.4.5: Estimate of young participation rates by area in higher education. Rates by MSOA, with ward boundaries overlaid.
Source: Office for Students. 2009/10 – 2014/15

[110] www.gov.uk/government/statistics/a-level-and-other-16-to-18-results-2016-to-2017-revised
[111] www.officeforstudents.org.uk/data-and-analysis/polar-participation-of-local-areas/
[112] 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 schools[113] 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.

Locally[114], 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%).

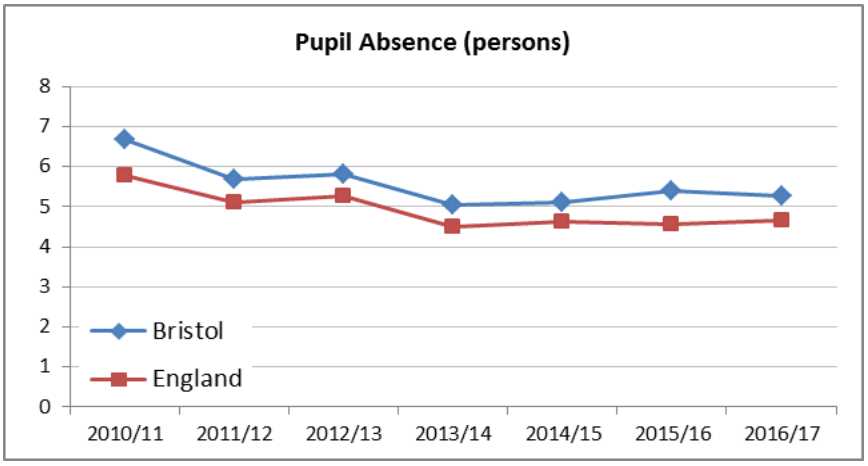


Fig 5.5.1: Source: School Census, via PHOF (Sept 2018)

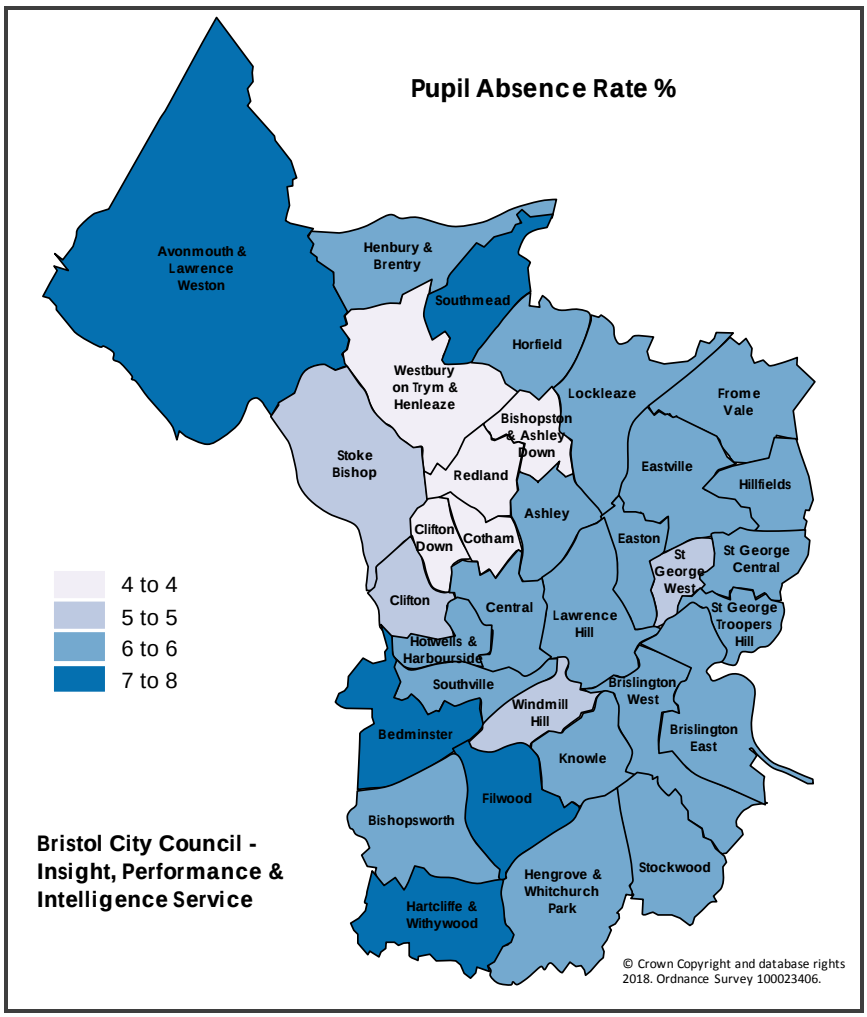


Fig 5.5.2: Pupil absence rate by ward,2017.

[113] % of half days missed by pupils due to overall absence; Source: Department for Education via Public Health Outcomes Framework, 2018

[114] 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)[115].

"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."[116]

Statutory guidance[117] introduced new classifications of SEN Support and Education, Health and Care Plans (EHCP). For more, see Bristol's current SEND Strategy.

This section is primarily looking at SEN data[118].

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 Bristol[119].

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 Up[120]
- 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 years[121].

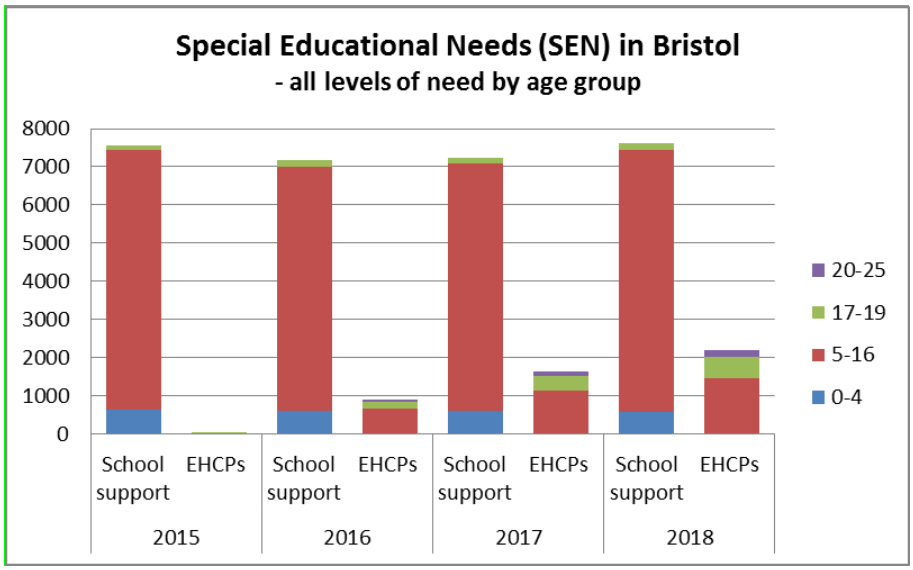


Fig 5.6.1 All SEN in Bristol: SEN School Support (Source: Bristol Early Years and School Census, Jan 2018) and Education, Health and Care Plans, EHCPs (Source: BCC Bright data-base – extracted Sept 2018)

[115] Part 3 of Children and Families Act 2014
[116] Clause 20, Children & Families Act 2014
[117] SEND Code of Practice 0-25 years (Jan 2015). 2014/15 was the start of a transitionary 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.

[118] Also see **4.5 Disabled Children**
[119] Source: Bristol Early Years and School Census (Jan 2018) plus additional data via BCC Bright data-base
[120] 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
[121] 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 data[122] for 2017/18, 15.4% of Bristol pupils were receiving SEN support, higher than 14.9% nationally.

Within Bristol, 2017 School Census data[123] 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.

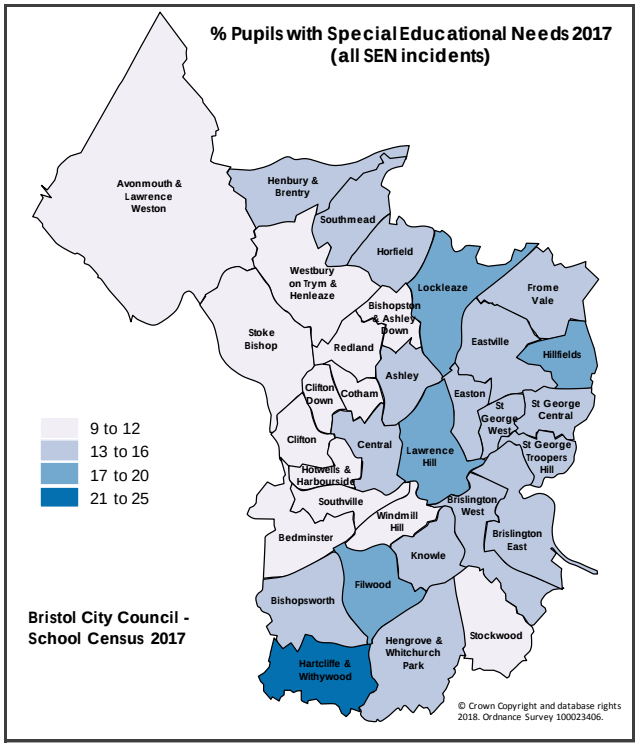


Fig.5.6.2: SEN 2017; Source: BCC - Insight, Performance & Intelligence

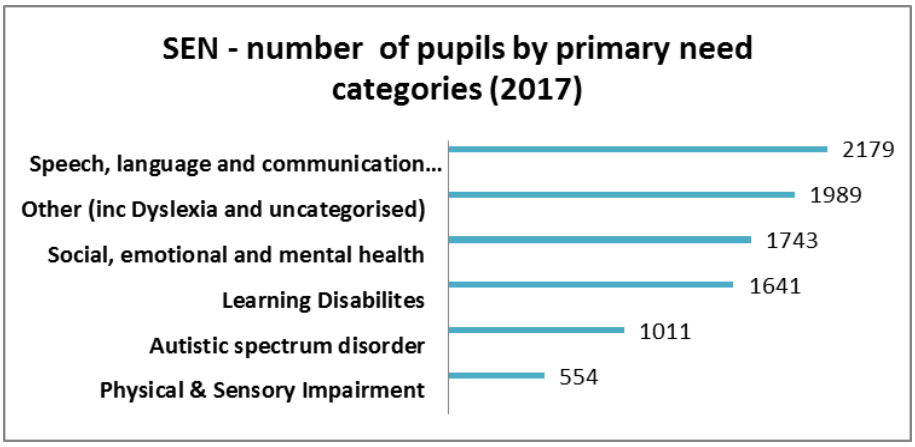


Fig.5.6.3: SEN Primary Need Breakdown 2017. Source: BCC - Insight, Performance & Intelligence

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

[122] 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

[123] 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.

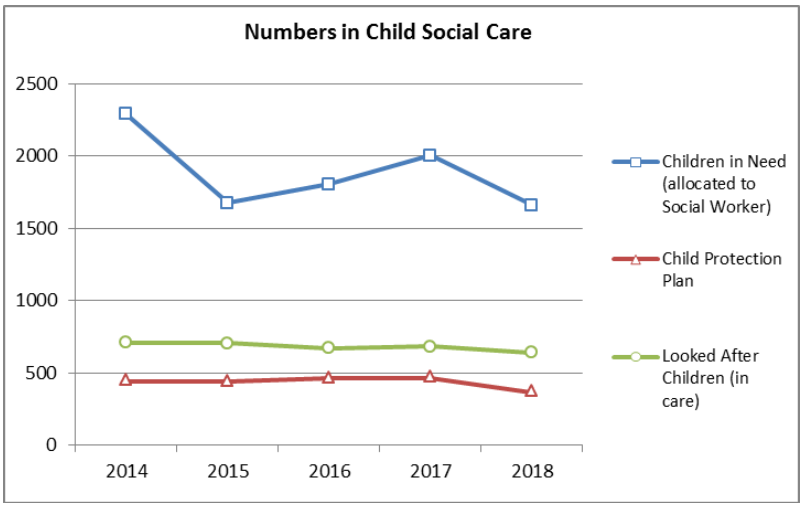


Fig 5.7a: Children known to Bristol Social Services at end March each year. Supplied by: Bristol City Council, Insight, Performance & Intelligence

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 2018[124] (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.

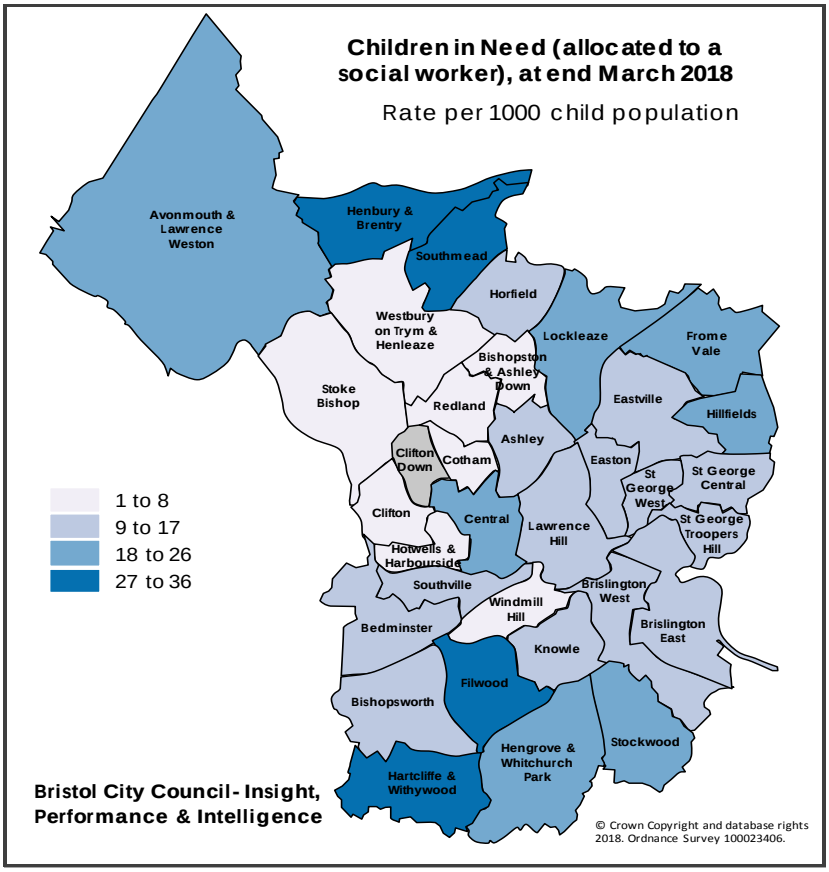


Fig 5.7b: Children allocated to Bristol's Child Social Services by ward (excluding those "in care" or on Child Protection register), 31 March 2018,

[124] 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 Bristol[125] (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 data[126], 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.

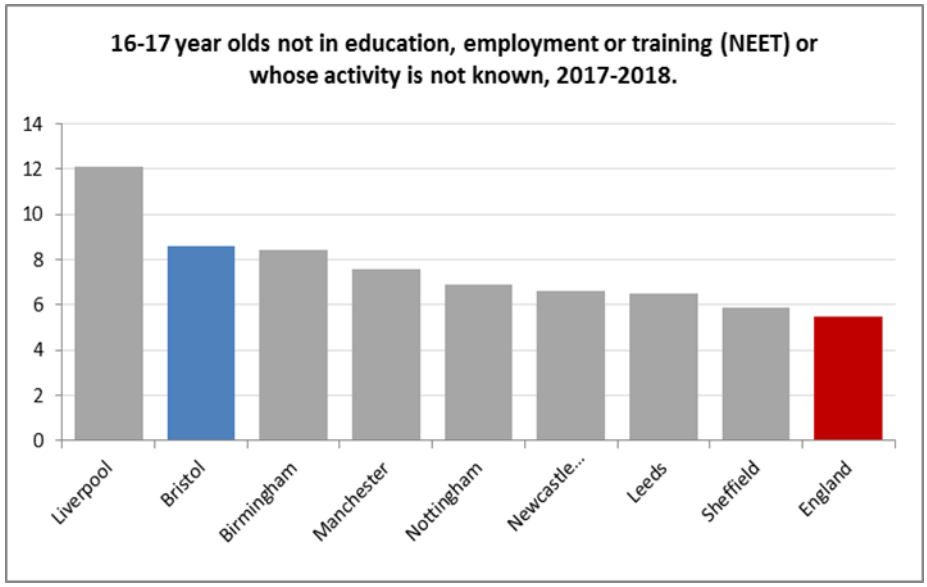


Fig 5.8.1: Source: Bristol City Council, Insight, Performance & Intelligence

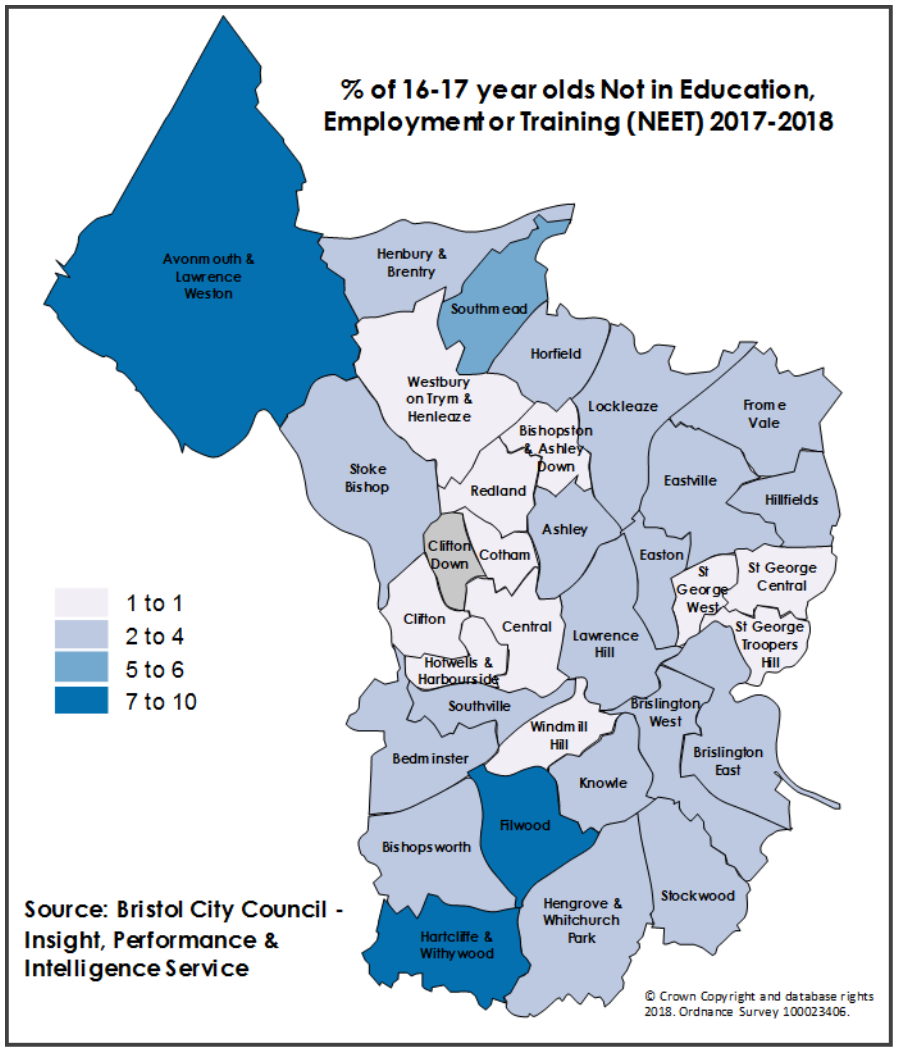


Fig 5.8.2: 16-17 year olds NEET by ward as a % of total NEETs (2017-18 data)

[125] Source: Dept. for Education, 2018
[126] 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 System[127] 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.

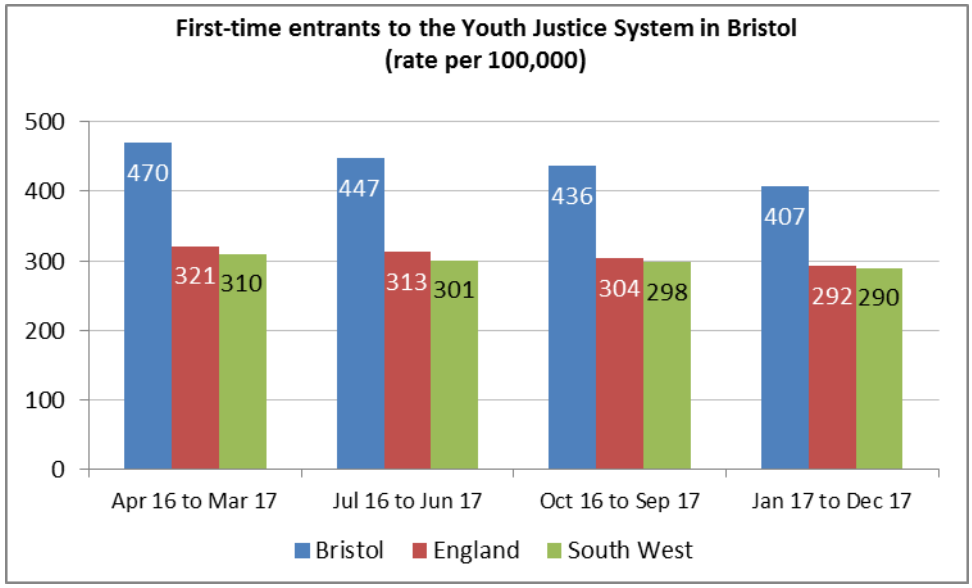


Fig.5.9.1: Rate of young people aged 10-17 receiving their first reprimand, warning or conviction. Source: Police National Computer via BCC YOT team

Local data shows 334 individual youth offenders[128] 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.

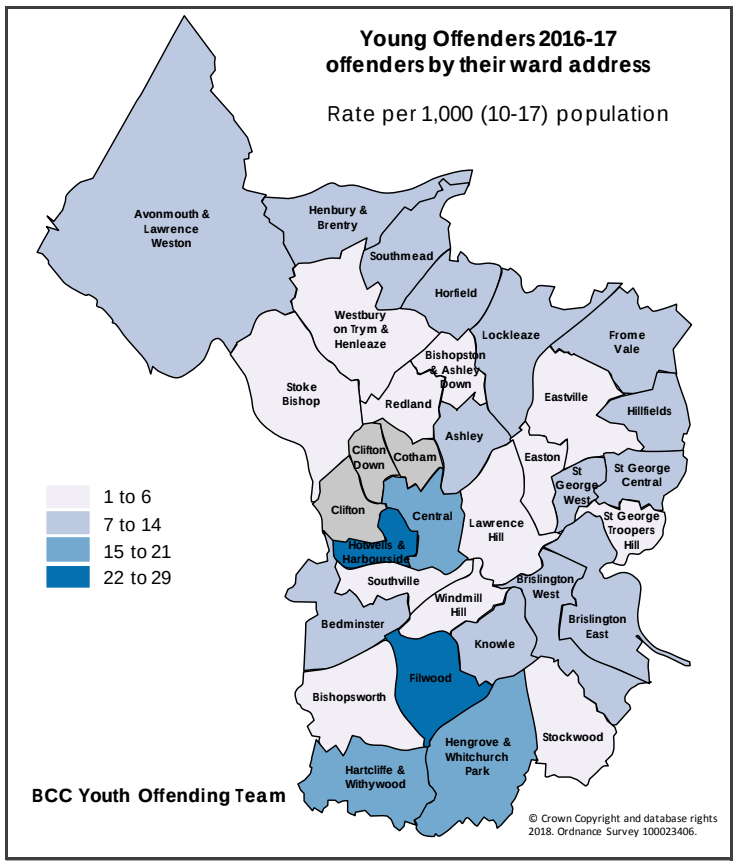


Fig.5.9.2: Rate of individual Youth Offenders 2016-17 (Youth Offending team)

[127] 10-17 year olds receiving their first reprimand, warning or conviction. Source: Police National Computer database via Bristol City Council Youth Offending Team, 2018

[128] 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 rate[129] 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%).

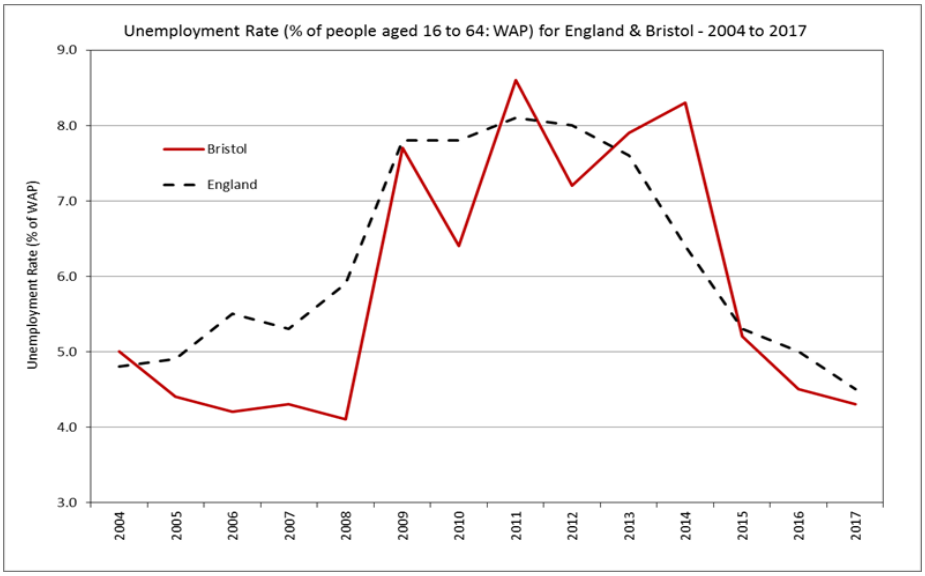


Fig 5.10.1: Unemployment rate (% people 16-64) England & Bristol, 2004-17

Economic participation and unemployment: key facts[130]

- 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 worked[131] for Bristol in 2016 was £31.0 (England £33.7); rise of 9.5% since 2012 (8.2% for England)

Earnings and Earnings Gap[132]

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%.

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

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

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

[132] 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 respectively[133].

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 Cities[134].

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.

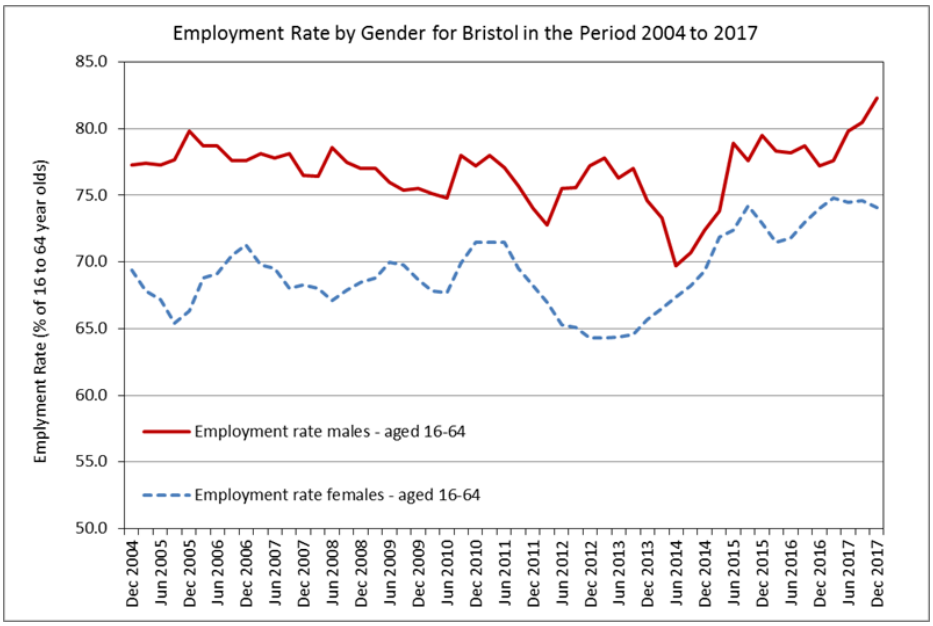


Fig 5.10.2 Unemployment rate by gender for Bristol in the period 2004 to 2017

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.

[133] September 2011 for female claimants and February 2012 for male claimants.

[134] 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 absence[135] 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.

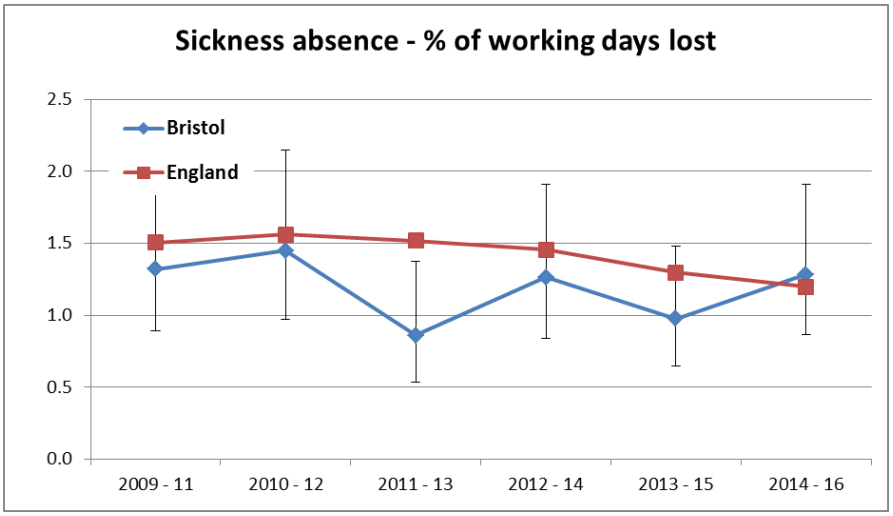
Similarly, the % of employees who had at least 1 day off in the last week[136] appears to have been rising in Bristol (2.4% in 2014-16, from 1.3% in 2011-13).

Local 2013 research[137] highlighted

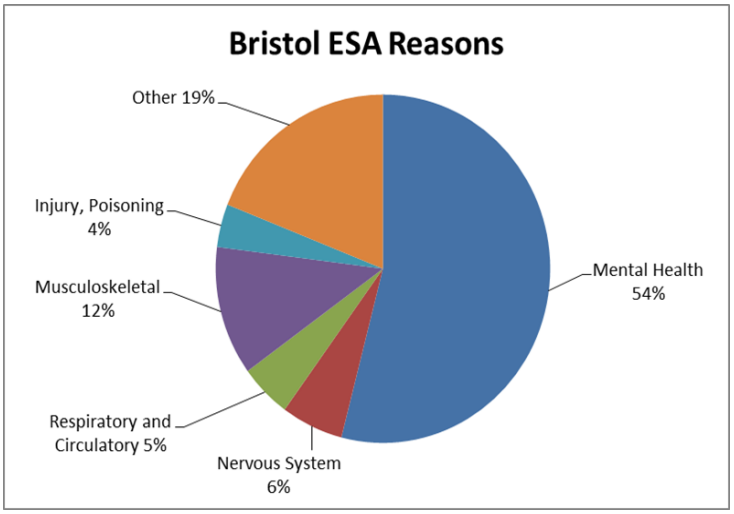
- 10 million working hours were lost to sickness or injury in 2010 at a cost to the Bristol economy of £240 million.
- Sickness absence rates were higher amongst public sector and older workers (50+)
- By sector, rates were highest in manufacturing, construction and agriculture.

Causes of sickness absence

The largest cause of Employment and Support Allowance (ESA) claims[138] in Bristol (2016) was poor mental health (54%), followed by musculoskeletal conditions 12%)[139] – 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 research[140] 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)**

[135] 2014-16; Source: ONS Labour Force Survey via PHOF (Sept 2018)
[136] 2014-16; Source: ONS Labour Force Survey via PHOF (Sept 2018)
[137] Profiling Sickness Absence Within the City of Bristol, A. Weyman, A. Buckingham, University of Bath, Feb 2013 (2010 data)
[138] Source: ONS statistics, NOMIS, Oct 2016
[139] See JSNA sections**: 8.8 Musculoskeletal and 9. Mental Health**
[140] 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 properties[141] 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 hosing 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 study[142] 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 period[143].

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 £243,300[144].

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.

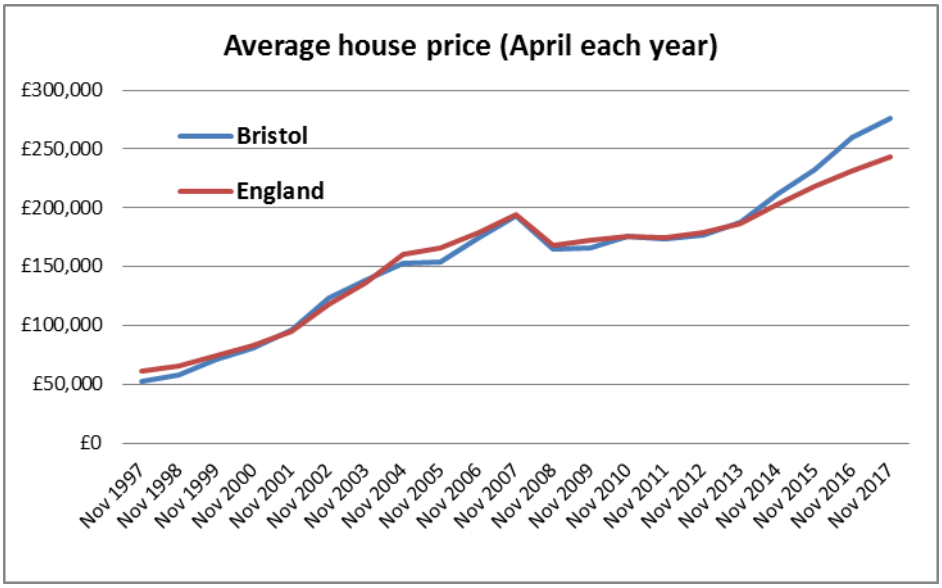


Fig 5.11a: Average house prices, Source: UK House Price Index, Land Registry, Nov 1997 to Nov 2017

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

[141] Source: Valuation Office Agency, 1/4/17, via Bristol Housing Market 2017
[142] BRE Integrated Dwelling Level Housing Stock Modelling and Database for Bristol City Council
[143] Source: 5 Year Housing Land Supply 2017-22, Bristol City Council, Strategic City Planning Team, Jan 2018
[144] 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 month[145] (3 years previously the average rent was £828 a month).

The Bristol Quality of Life[146] 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 tenant 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

[145] Valuation Office Agency, Private rental market summary statistics – Oct 2016 to Sept 2017

[146] 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. National research (2012) indicated 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 public[147].

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.

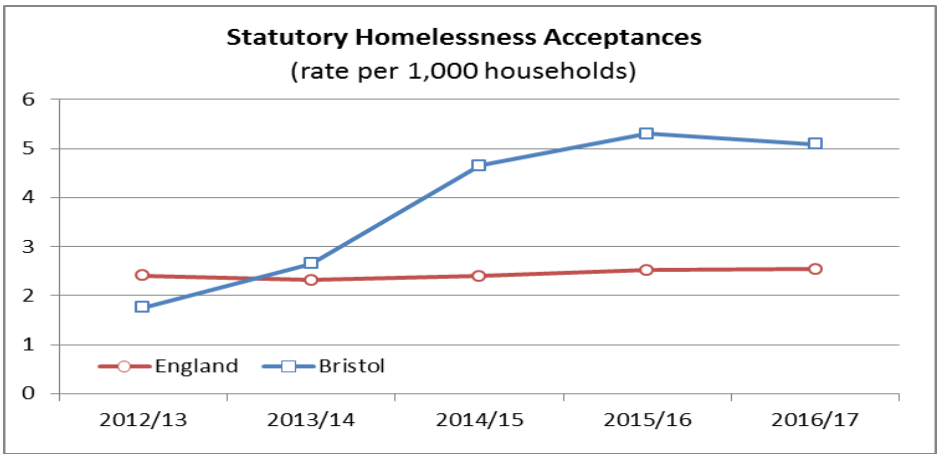
During 2016/17, 80 people were eligible as homeless but 'not in priority need'. A significant drop from 152 in 2015/16. As a rate this is 0.4 per 1,000 households[148]; half that of last year and half the national average (0.8 per 1,000).

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, as a number this has been falling over the last two years[149] and for 2017/18 there were 721. This is shown as a rate (per 1,000 households, up to 2016/17) in 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 behind the rise had been private landlords seeking possession of their properties (i.e. Section 21 notices) for financial reasons, often due to 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).

[147] Bethan Thomas, Homelessness Kills, University of Sheffield and Crisis,2012

[148] Crude rate; Source: Dept. for Communities & Local Government, via PHOF 2018

[149] 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 2012/13 and in 2016/17 was 2.8 per 1,000 households[150]. 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).

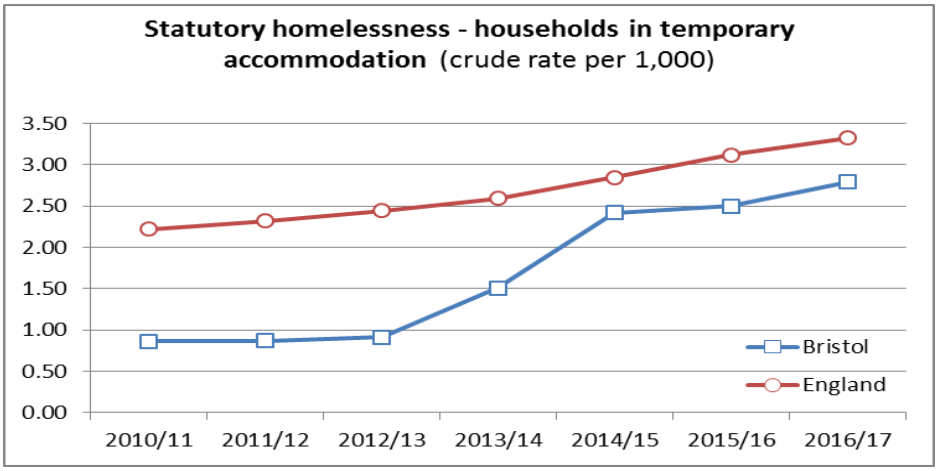


Fig.5.12.2: Source: Department for Communities and Local Government via Public Health Outcomes Framework (PHOF), Sept 2018

Rough Sleepers

In late 2017 Bristol City Council reported 86 rough sleepers in the National Rough Sleeper Count[151], the sixth highest number nationally. This was a rise on the 74 recorded as sleeping rough in 2016, and 41 in 2014 – fig 5.12.3 – and from the 8 estimated in 2010 and 2011.

A count is a single night snapshot of the number of rough sleepers in a local authority area. Each Local Authority either conducts a street count or provides an estimate. Counts are independently verified by Homeless Link.

Of the 86 reported in 2017:

- 57 were UK nationals, 12 were EU non-UK nationals, 12 non-UK nationals and 5 unknown
- 9 were under 25 years, 63 were over 25 & 14 unknown
- 64 were male, 18 female and 4 unknown

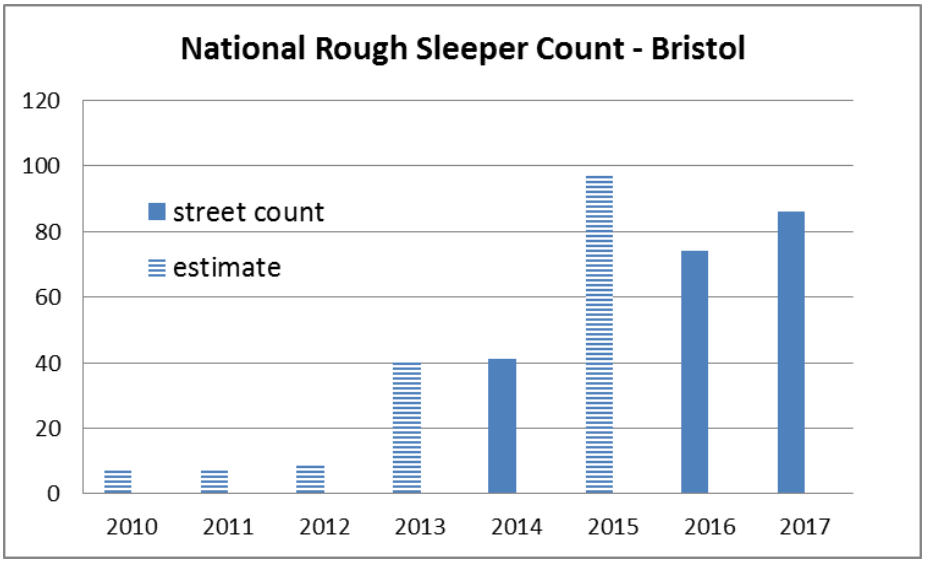


Fig.5.12.3: Number of rough sleepers in Bristol, 2010 – 2017 (snapshot on a single night) at National Rough Sleeper Count. Source: Rough sleeping in England: autumn 2017 (released Jan 2018)

Alternative data on numbers of rough sleepers comes from the "Monthly hotspot count" carried out on behalf of Bristol City Council by St Mungos Rough Sleeper Outreach team. When aggregated, the annual average number of rough sleepers identified at hotspot counts up to Quarter 3 of 2017/18 was 69 per week. This is a significant rise from 5 per week in 2010/11. [Note - This figure is a mean statistical average for each count and not the actual number of rough sleepers at any one time].

[150] Crude rate; Source: Dept. for Communities & Local Government, via PHOF 2018
[151] Rough sleeping in England: autumn 2017 (released Jan 2018) 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 poverty[152].

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.

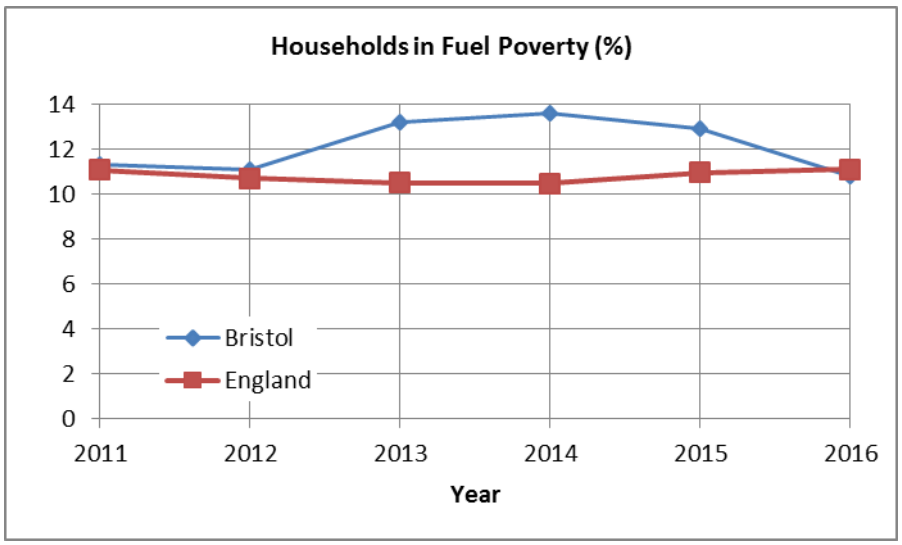


Fig 5.13.1 Percentage of households in Fuel Poverty (based on low income, high cost), Source Business for Business, Energy & Industrial Strategy 2016 data

When compared with statistically similar cities[153], Bristol is mid-ranking – fig 5.13.2.

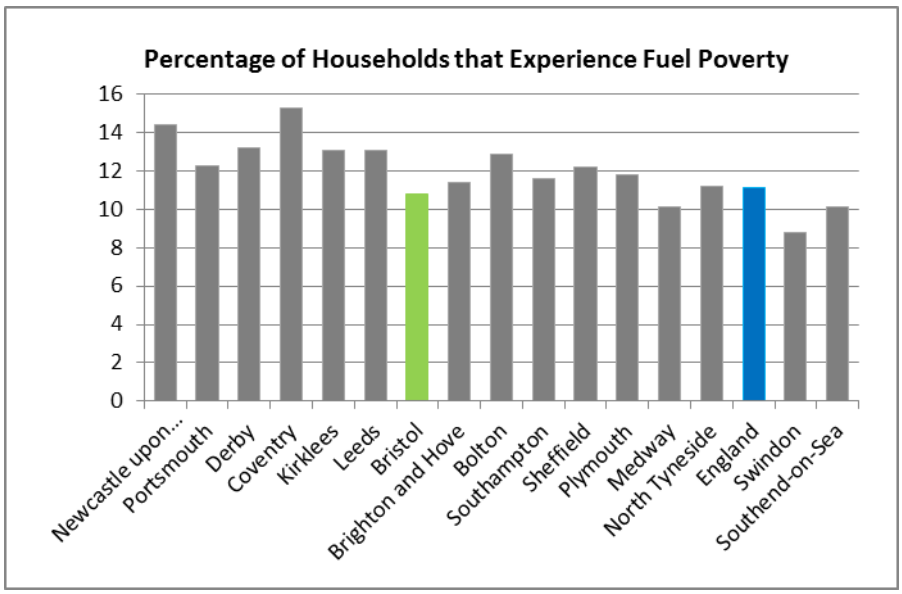


Fig 5.13.2: Percentage of households in Fuel Poverty (for CIPFA nearest neighbours) Source Department for Business, Energy & Industrial Strategy, 2016 data

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.

[152] See section **10.3 Excess Winter Deaths**

[153] "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.

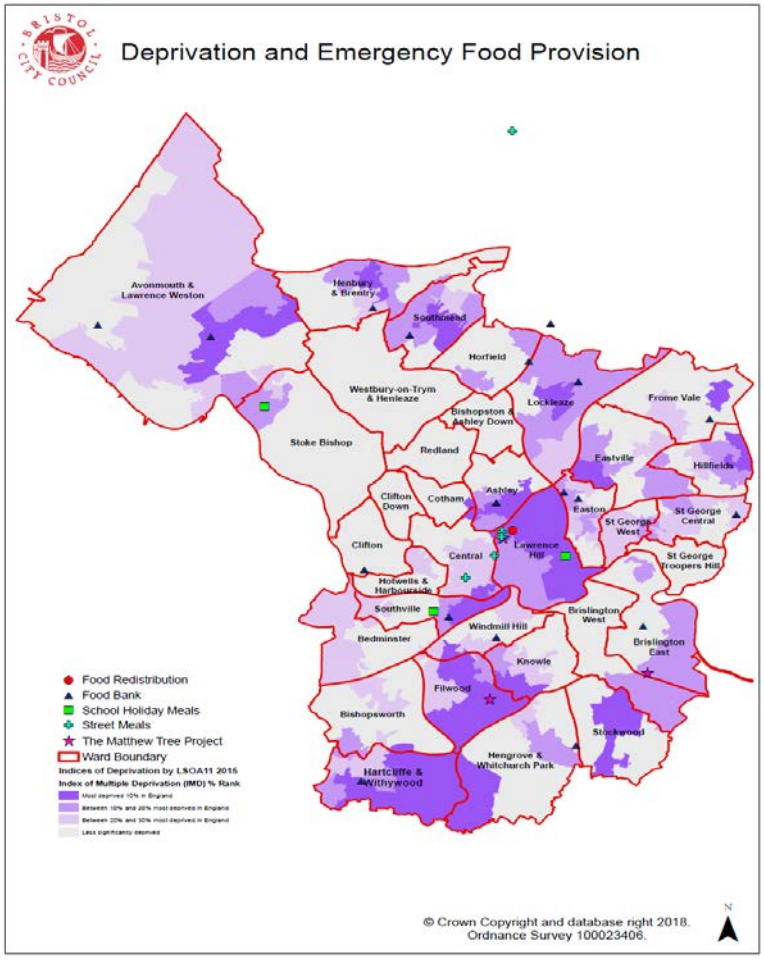
Quantifying food poverty is difficult as there is no universal measure currently used in the UK. Most recent information for Bristol comes from a report by Joy Carey produced for the Feeding Bristol initiative[154]

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 p3[155]
- 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 Foundation[156]). 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

[154] Understanding the extent of food insecurity in Bristol; draft report June 2018
[155] Source: The Food Foundation https://foodfoundation.org.uk/
[156] 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)[157], 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%.

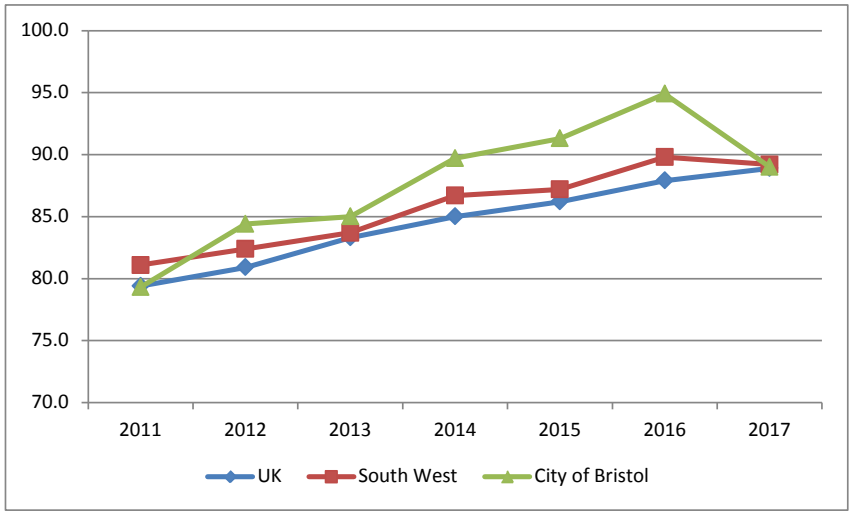


Fig 5.15.1: Adults who have "Used the internet in the last 3 months"
Source: 2017 Internet users, ONS 2017

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."

157 # Internet users (January to March quarter); ONS 2017 https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/datasets/internetusers

5.16 Social Isolation

Social isolation[158] can have physically and emotionally damaging effects resulting in:
•depression •poor nutrition
•decreased immunity •anxiety
•fatigue •social stigma.

Using Public Health England estimates, there could be 20,000 people aged 18-64 experiencing social isolation in Bristol as well as between 6,300 and 11,400 people aged 65 & over[159].

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 impacts[160].

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.

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%[161].

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.

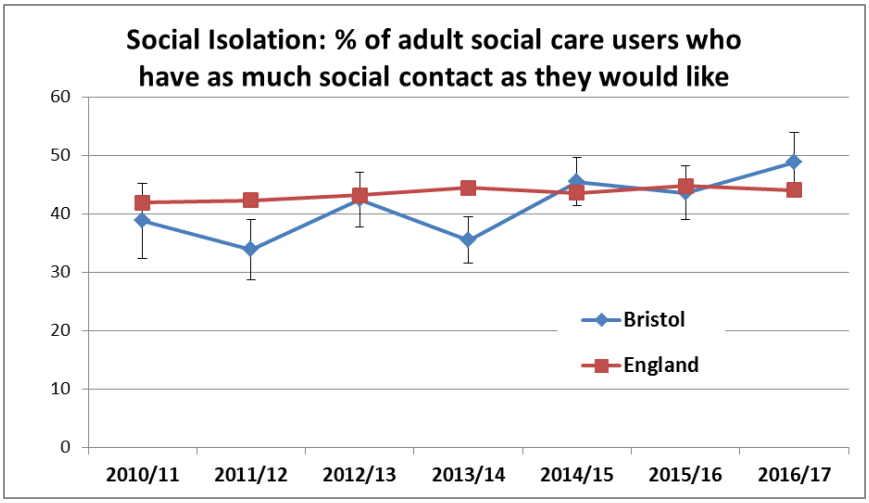


Fig 5.16.1: Source: Adult Social Care Survey via PHOF (Sept 2018)

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.

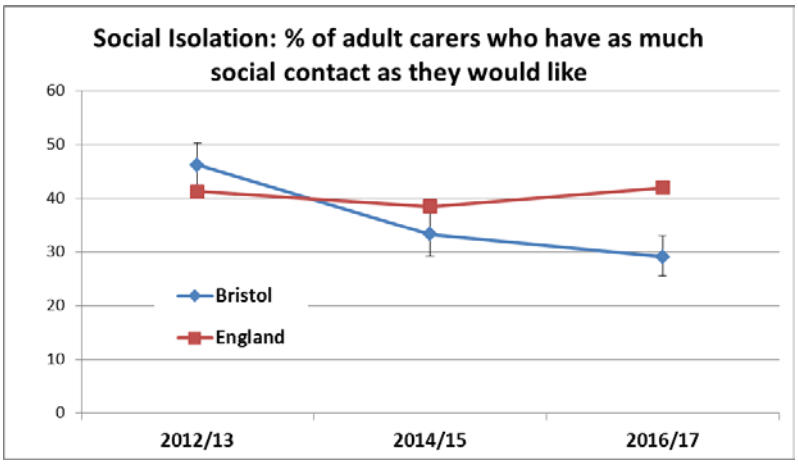


Fig 5.16.2: Source Personal Social Services Survey via PHOF (Sept 2018)

[158] 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.'
[159] Social Isolation in Bristol Initial Findings Report (2013)
[160] Research on health impacts are also at: www.campaigntoendloneliness.org/threat-to-health/
[161] 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

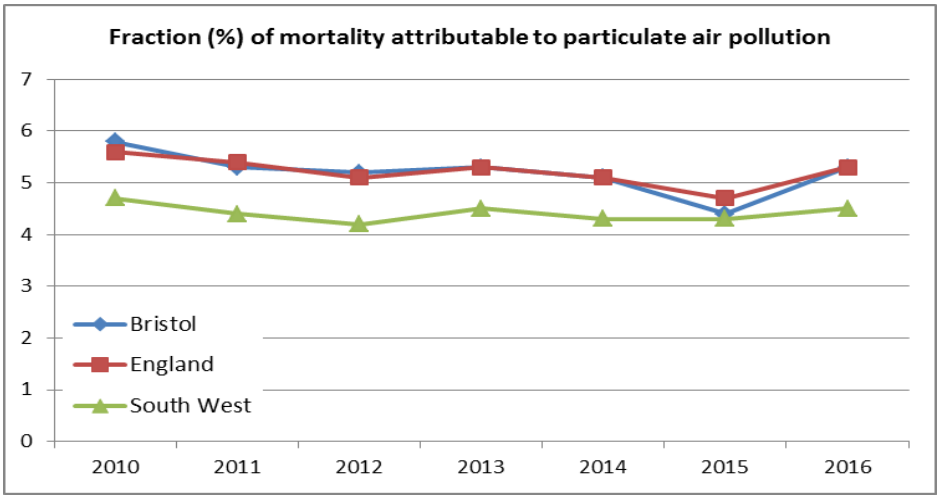
Health Impact

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"[162], 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 report[163] estimates that around 300 deaths each year in Bristol can be attributed to exposure to both nitrogen dioxide (NO_2) and fine particulate matter. This represents about 8.5% of deaths in Bristol being attributable to air pollution. [NB this is higher as the local report considers NO_2 as well].

As part of a project involving partners across the city, the Clean Air Plan[164] is looking at ways we can reduce nitrogen dioxide (NO_2) 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 PM2.5 concentrations, using a national air dispersion model, and calibrated using concentrations taken from sites in Defra's Automatic Urban and Rural Network. Via PHOF, 2018

Long-term exposure to air pollution contributes to the development of cardiovascular disease, lung cancer and respiratory disease[165]. Those at particular risk include children aged 14 and under, older people aged 65 and over, pregnant women and not unexpectedly people with pre-existing respiratory or heart conditions[166]. Lower socio-economic communities suffer the greatest consequences of air pollution[167].

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 UK[168]. 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.

[162] Via Public Health Outcomes Framework (PHOF), 2017
[163] Air Quality Consultants (2017). Health Impacts of Air Pollution in Bristol
[164] https://www.cleanairforbristol.org
[165] World Health Organization (2016). Ambient (outdoor) air quality and health factsheet. http://www.who.int/mediacentre/factsheets/fs313/en/ (accessed 23.11.16)
[166] National Institute for Health and Care Excellence (2015). Air pollution – outdoor air quality and health. Final scope. London: NICE
[167] Marmot, M (2010). Fair Society Healthy Lives. Marmot Review.
[168] 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 nationally[169].

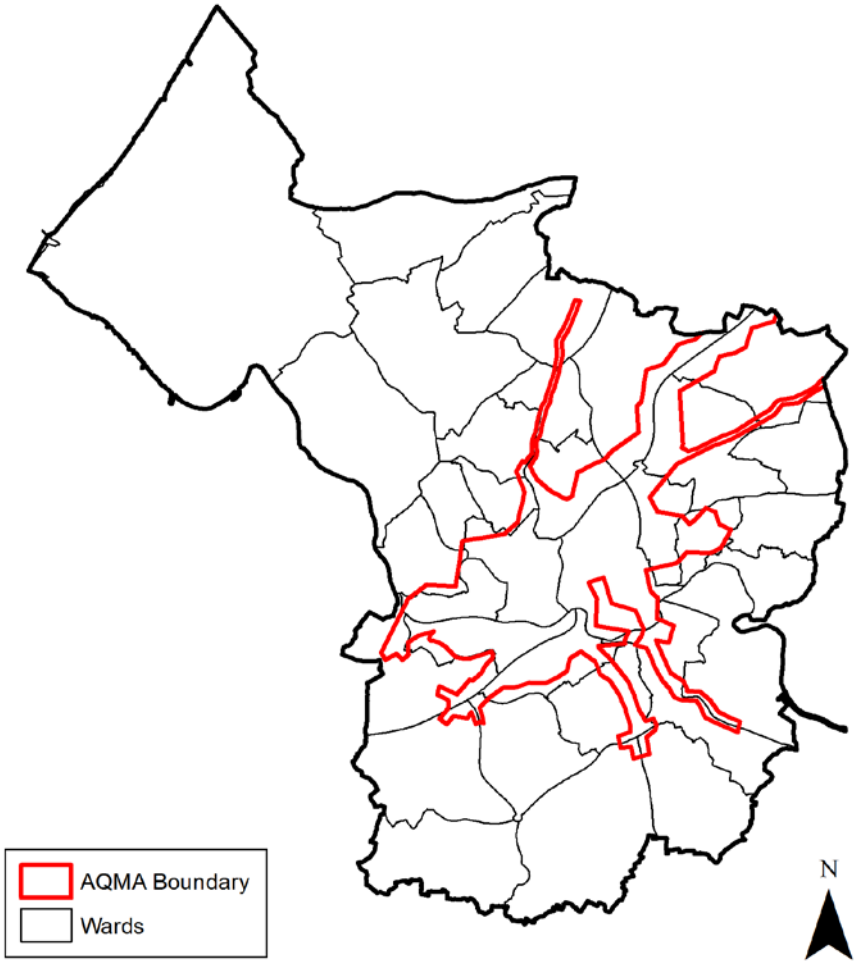


Fig 5.17.2 Map of Bristol's Air Quality Management Area (AQMA)

Consideration of trends in NO_2 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 NO_2 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/m^3 represents the annual EU and UK objective for nitrogen dioxide.

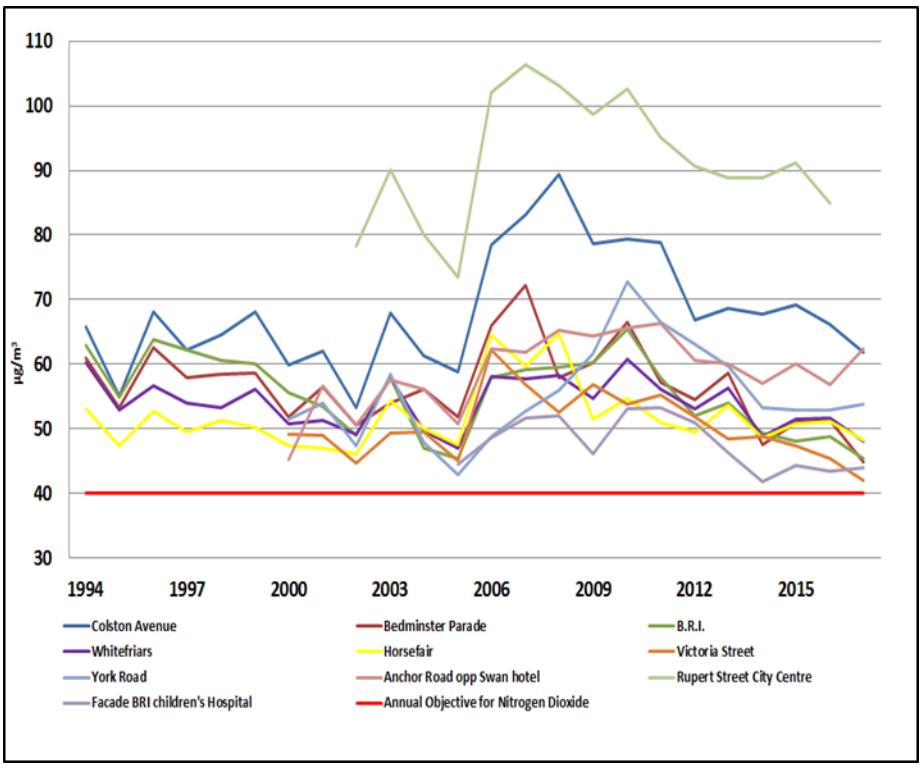


Fig 5.17.3: Trend of NO_2 at city centre diffusion tube sites since 1994

[169] 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. Research[170] has shown a link between the environments people experience in their daily lives and health challenges & inequalities[171].

A reducing number of people in Bristol (11%) use outdoor space for exercise/health reasons, lower than nationally (18%)[172]. A model which predicts the number of visits to green spaces[173] estimates welfare values of £73m per year, although these benefits are not spread equally between socioeconomic groups.

Locally[174], 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).

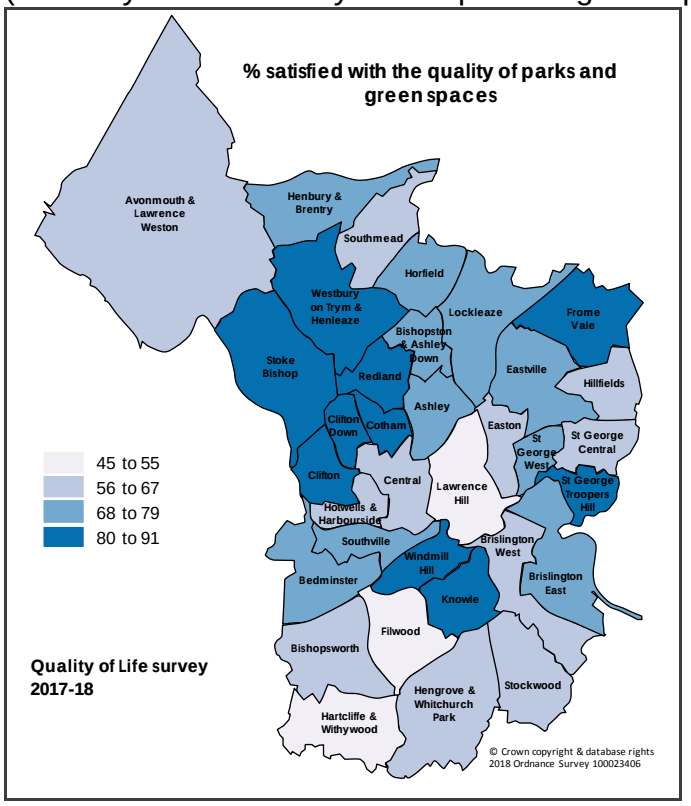


Fig 5.18.1: Bristol Quality of Life survey 2017-18

Active Travel

More people in Bristol commute to work by bicycle or on foot than in any other Local Authority[175]. 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 casualties[176] 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 people[177] 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.

[170] Further links between transport and health at "Essential Evidence": www.travelwest.info/evidence
[171] 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
[172] Natural England: MENE survey 2015-16, via PHOF (Sept 2018)
[173] Outdoor Recreation Valuation Tool (ORVal) developed by the Land, Environment, Economics & Policy Institute (LEEP) at The University of Exeter
[174] Bristol Quality of Life survey 2017-18
[175] Census 2011, Topic reports: www.bristol.gov.uk/census
[176] Police data, Dept. of Transport 2014-16 via PHOF (2018)
[177] 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).

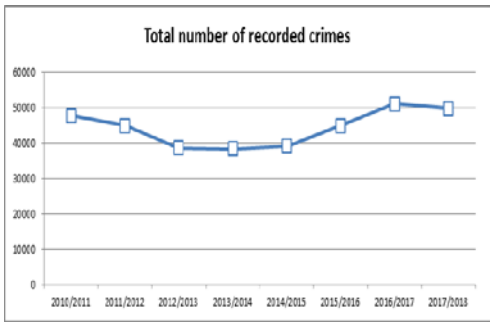


Fig 5.19.1 Number of all recorded crimes in Bristol; Source: Police data

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).

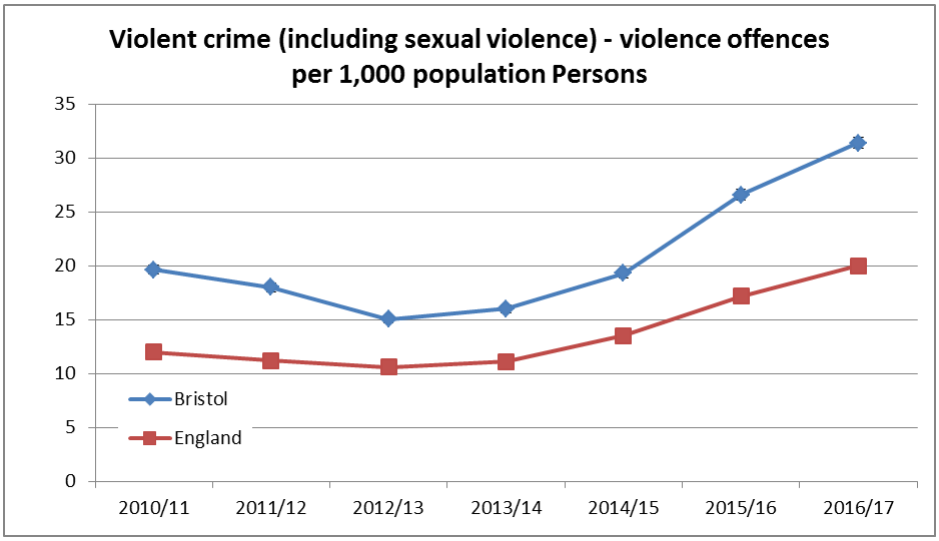


Fig 5.19.2: Recorded violent crime; Source: Home Office via PHOF, 2018

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.

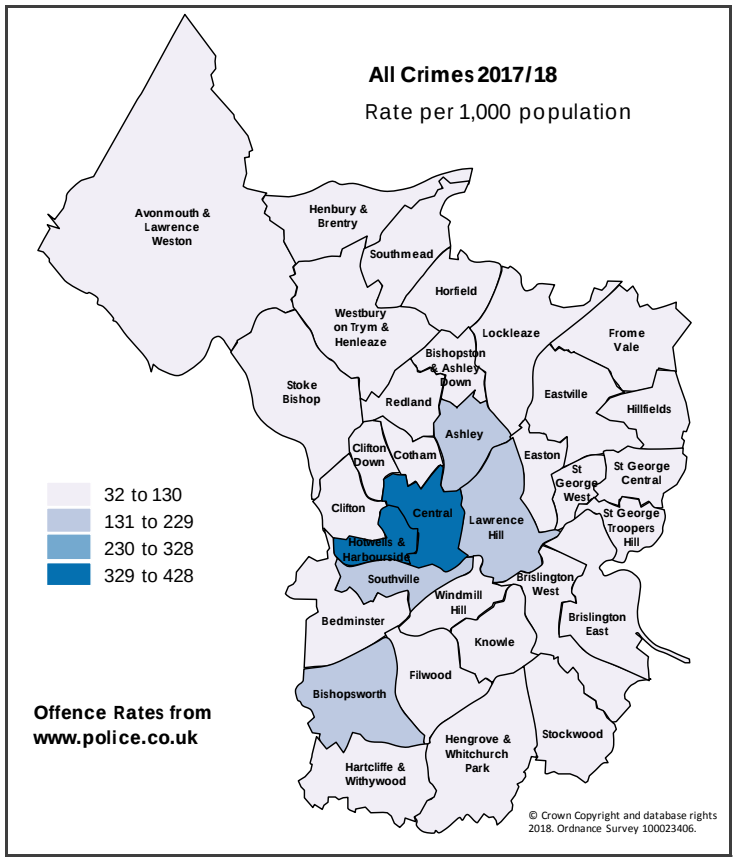


Fig 5.19.3 Rates of all recorded crimes 2017/18; Source: Police data

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 area[178]. 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

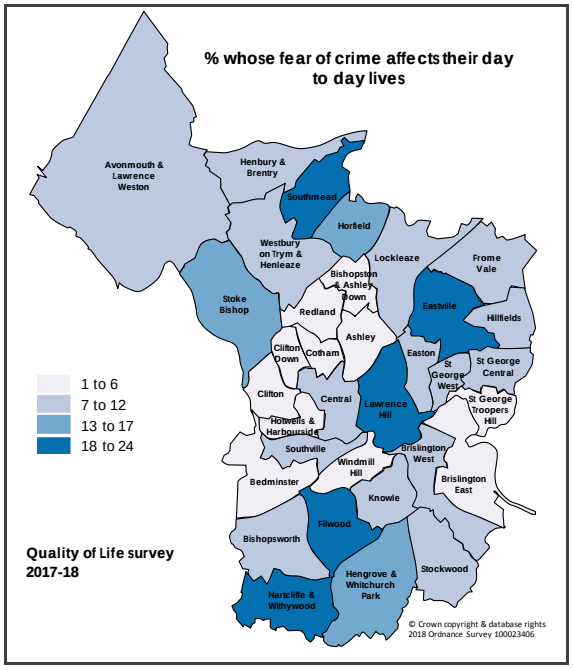


Fig 5.19.4: Fear of crime affecting daily life; Source: Quality of Life 2017-18

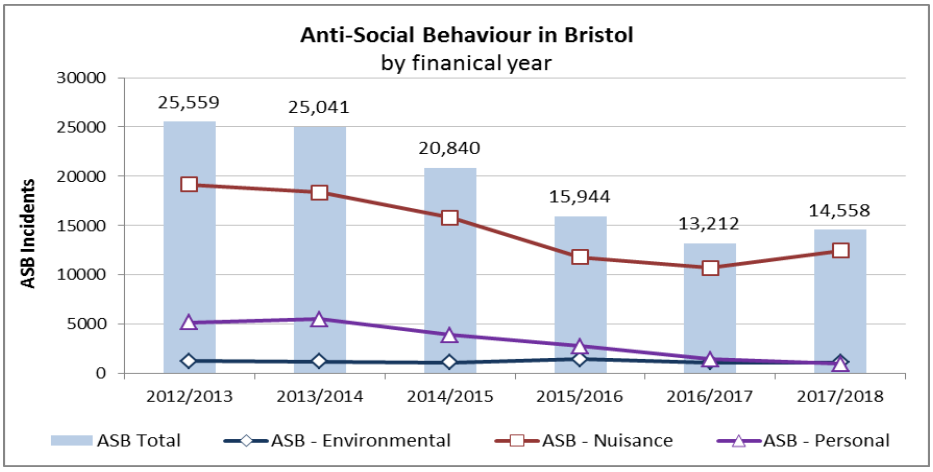


Fig 5.19.5: ASB incidents in Bristol by financial year; Source: Police data

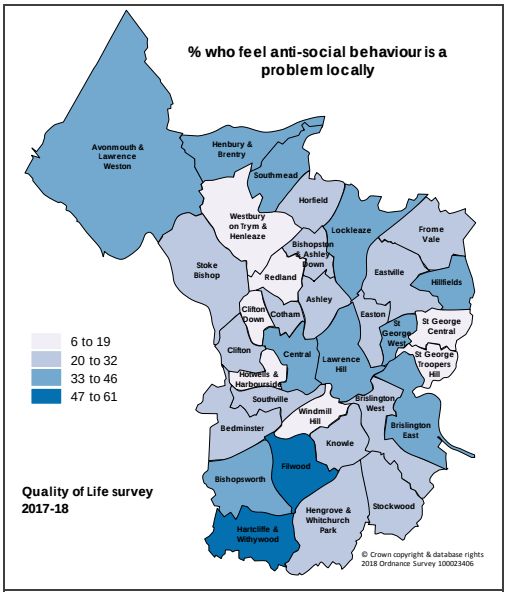


Fig 5.19.6: % who feel anti-social behaviour is a problem locally; QoL 2017-18

[178] Source: Quality of Life survey, 2017/18

5.20 Sexual violence and harassment

Nationally, the Crime in England and Wales survey[179] 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 crimes[180]].

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)" reported 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[181].

Gender: Bristol police data for "Sexual offences" in 2017/18 shows that 73% of victims were female and 12% male (with 15% unknown).

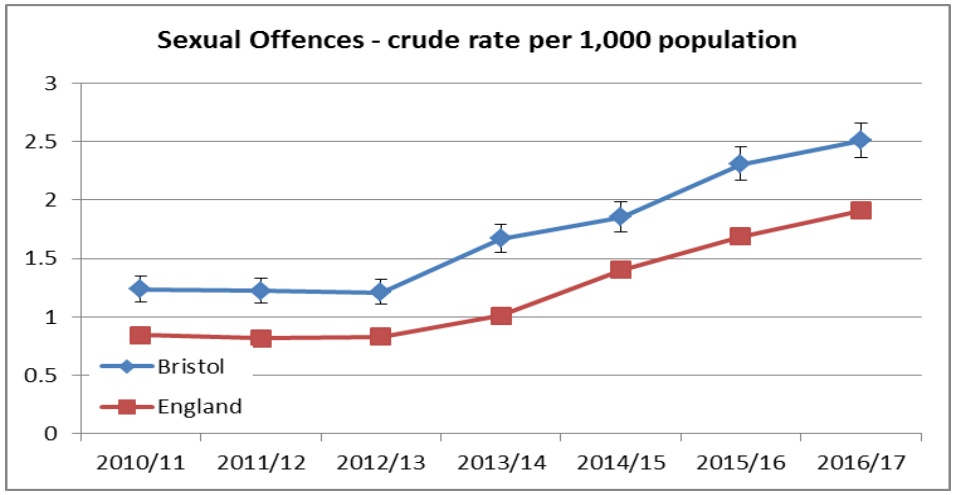


Fig 5.20.1: Rate of sexual offences; Source: Home Office via PHOF, 2018

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.

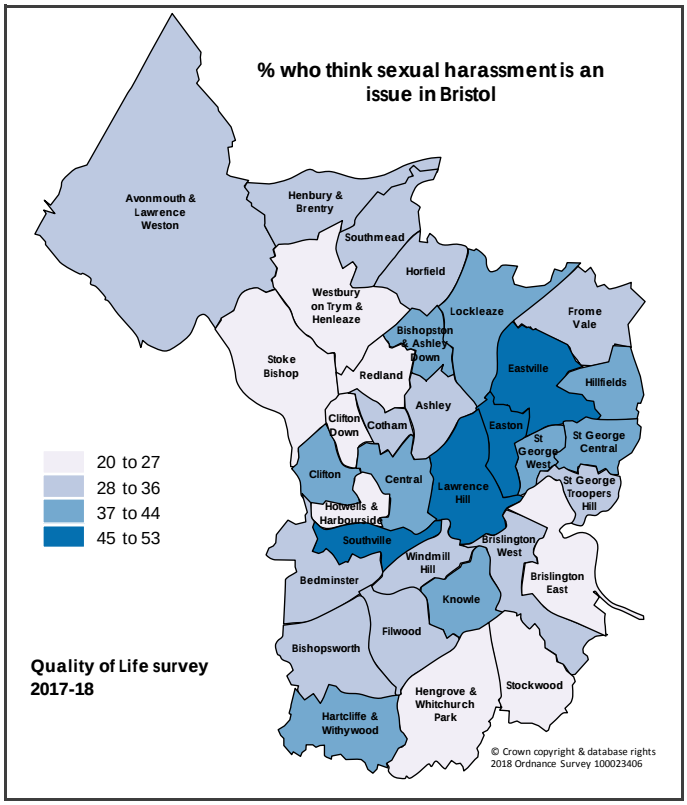


Fig 5.20.2: Source: Bristol Quality of Life survey 2017-18

[179] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingdecember2017

[180] 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.

[181] 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 crimes[182].

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.[183]

Local data on the rate of domestic abuse incidents[184] 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).

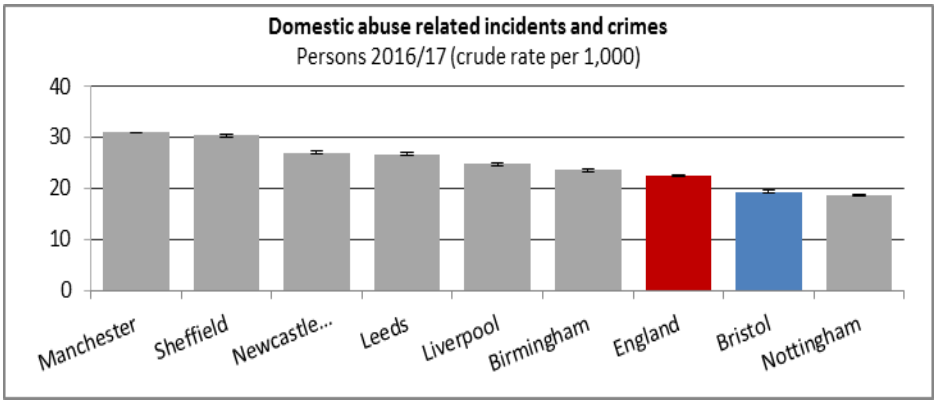


Fig 5.21.1: Rate of domestic abuse related incidents and crimes (per 1000 population over 16 years of age). Source: Police (via PHOF, 2018)

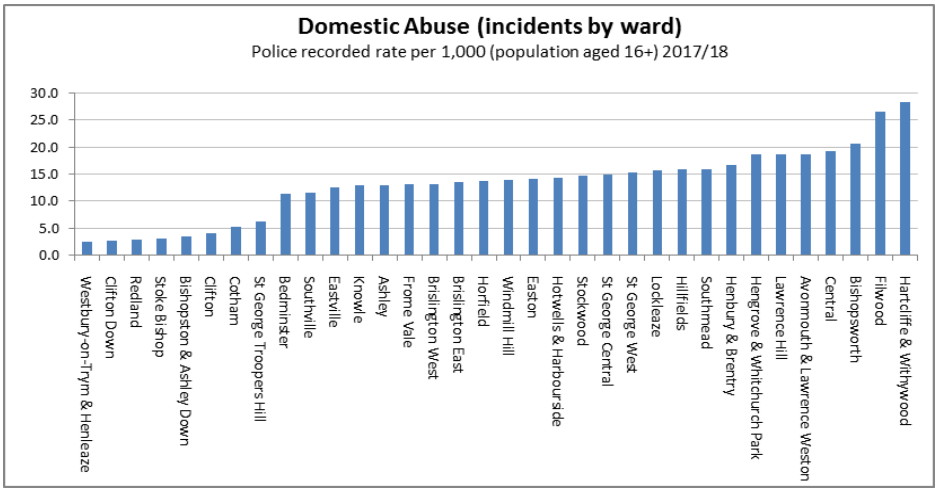


Fig 5.21.2: Rate of domestic abuse incidents 2017-18; Source Police data

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.

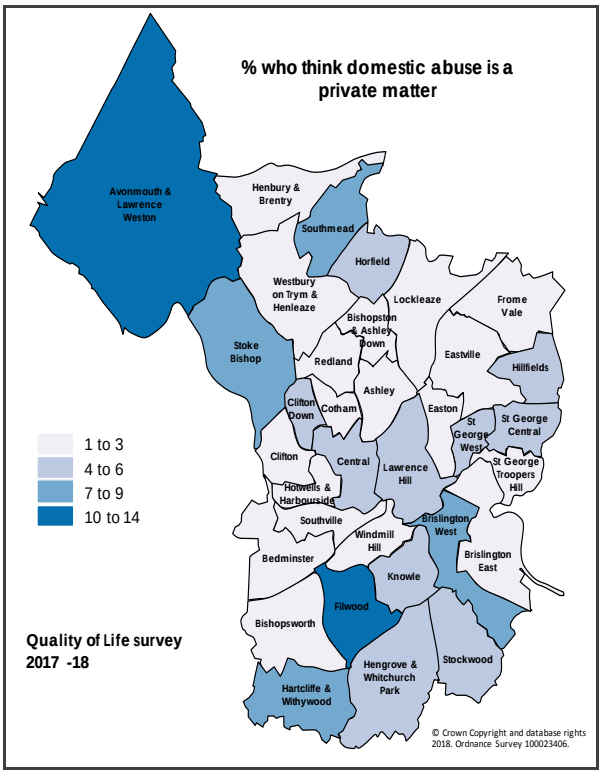


Fig 5.21.3: Source: Quality of Life survey 2017-18

[182] ONS Domestic abuse in England and Wales: year ending March 2017

[183] Crime Survey for England and Wales 2017

[184] 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 Dataset[185] (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.

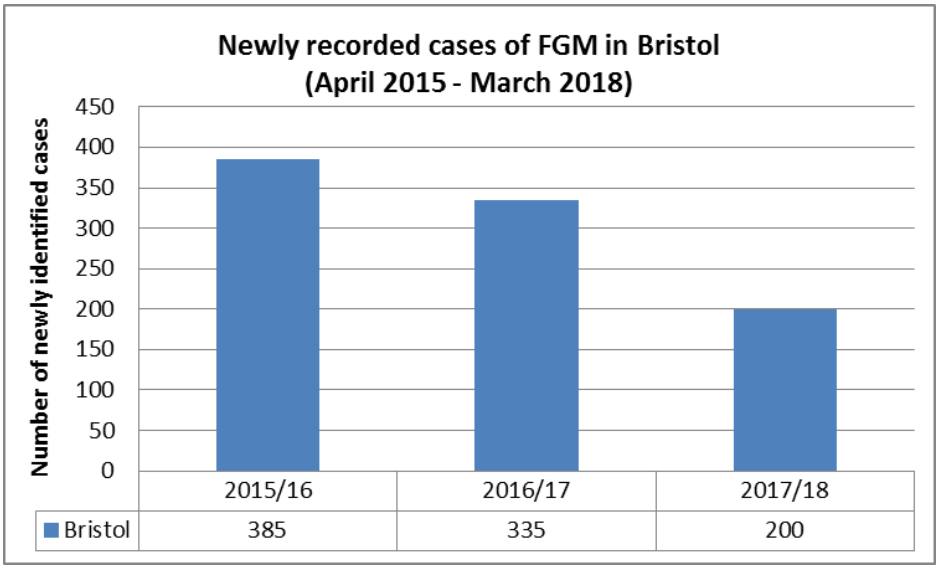


Fig 5.22.1: Numbers of newly-reported cases of FGM in Bristol; Source: BCC Public Health Knowledge Service

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.

[185] http://digital.nhs.uk/pubs/fgm1617

5.23 Community Assets[186]

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%).

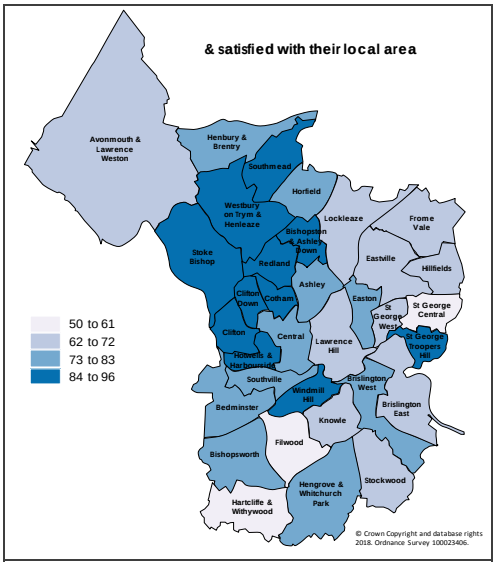


Figure 5.23.1 Source: Bristol Quality of Life survey 2017-18

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.

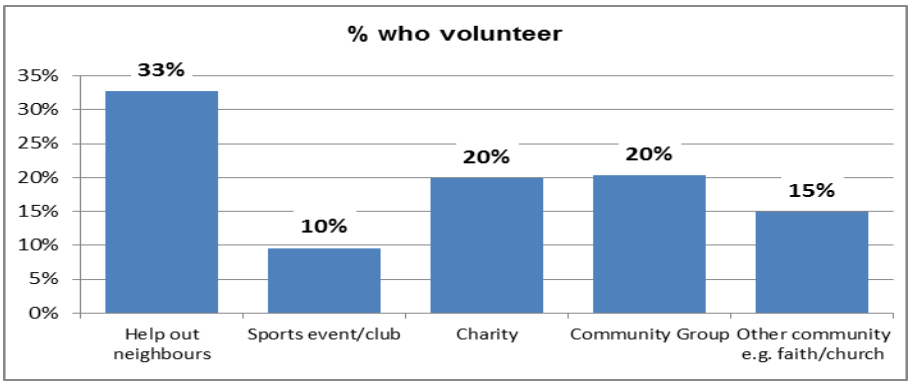


Figure 5.23.2: Source: Bristol Quality of Life survey 2017-18

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.

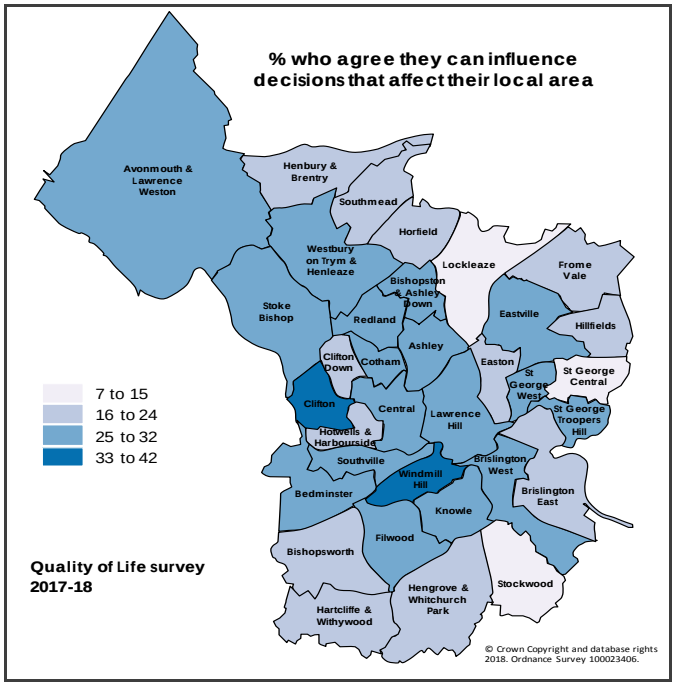


Fig 5.23.3: Source: Bristol Quality of Life survey 2017-18

[186] Source: Bristol Quality of Life 2017-18 www.bristol.gov.uk/qualityoflife

Section 6
Healthy Lifestyles

Summary points[187]

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

[187] 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 active[188]. 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 active[189] (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 data[190] 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).

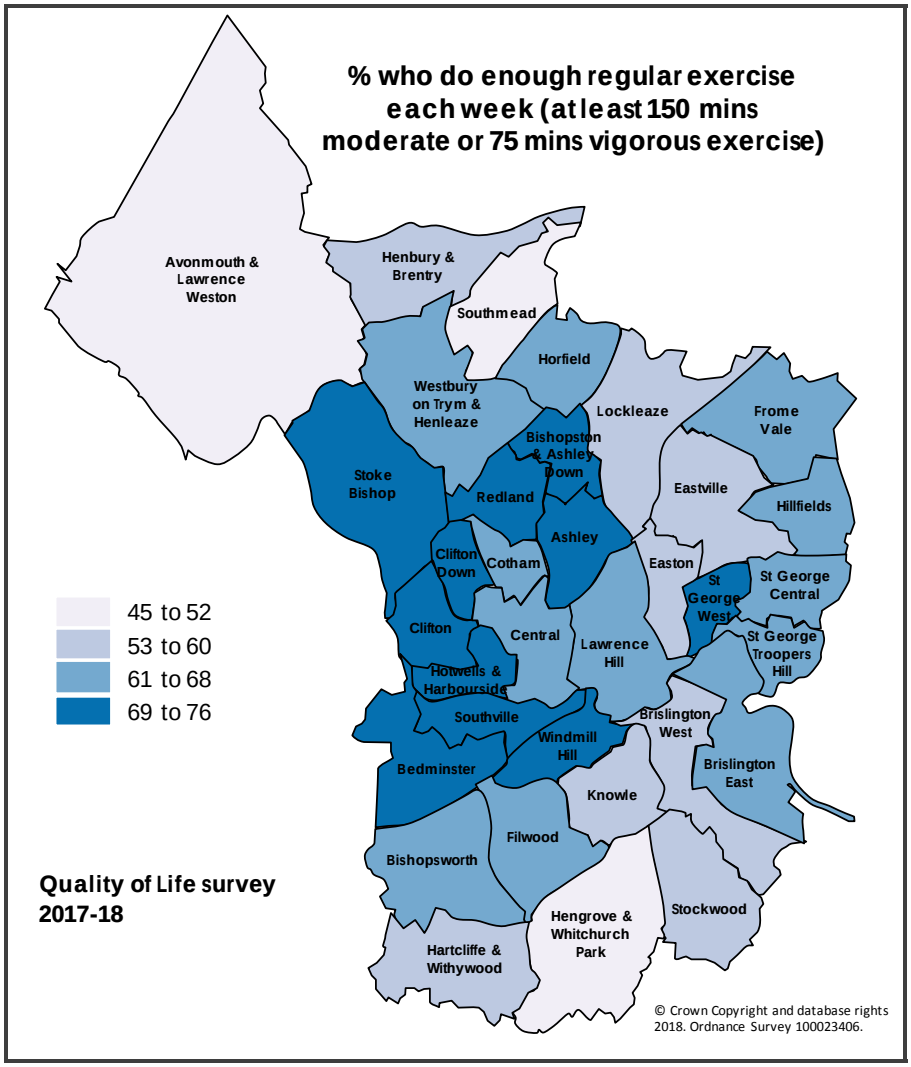


Fig 6.1.1: Physically active people. Source: Quality of Life survey 2017-18

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 week[191]. In the most deprived areas though, only 32% of people play sport weekly - a significant gap of 13%.

[188] Source: Public Health England (PHOF) / Also see BCC & TravelWest briefing note on The harms of physical inactivity (May 2018)

[189] Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

[190] 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

[191] 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)[192]. 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 survey[193] provides a slightly lower estimate of 51% adults with excess weight (BMI ≥ 25)[194], 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.

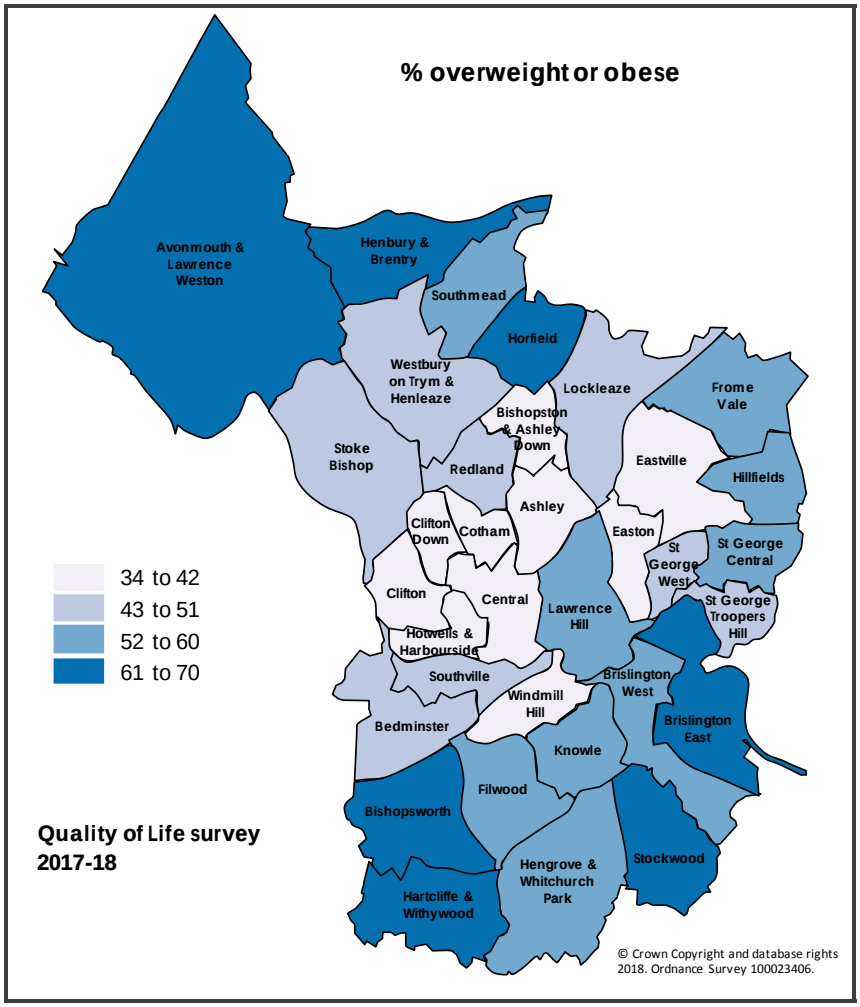


Fig 6.2.1: % Overweight & obese, Source: Quality of Life survey 2017-18

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.

[192] Active Lives survey, Sport England, 2016/17 (via PHOF Sept 2018)
[193] Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife
[194] 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 Survey[195] 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)[196]. 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.

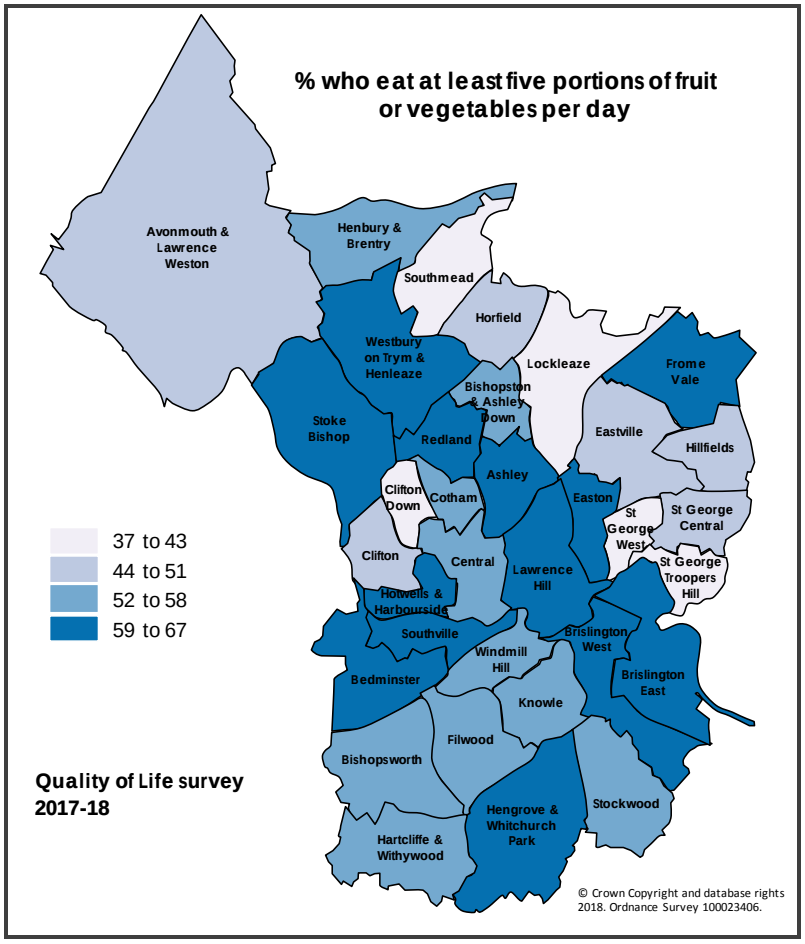


Fig 6.3.1 % eat 5-a-day, Source: Quality of Life survey 2017-18

Food outlets

2018 Food Premises data[197] 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 week[198]

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 Takeaways[199]. 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.

[195] Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife
[196] Source: Bristol Quality of Life survey 2017/18 www.bristol.gov.uk/qualityoflife

[197] BCC Registration of Food Premises data (Civica database 2018)
[198] Bristol Citizens' Panel survey April 2017, BCC Insight Performance & Intelligence
[199] PHE Density of fast food outlets in England. Summary LA Data (2018)

6.4 Smoking[200]

The number of smokers in Bristol is falling. In 2017, 11.1% of Bristol adults smoke[201], down from 21% in 2012. It is now better than the national average for 2017 of 14.9% (fig 6.4.1).

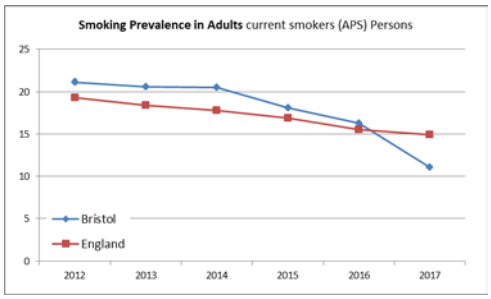


Fig 6.4.1: Smoking prevalence in adults – current smokers 2017.

Gender: Women (13%) were significantly less likely to smoke than men (16.8%) in 2017.

Local Quality of Life Survey[202] 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

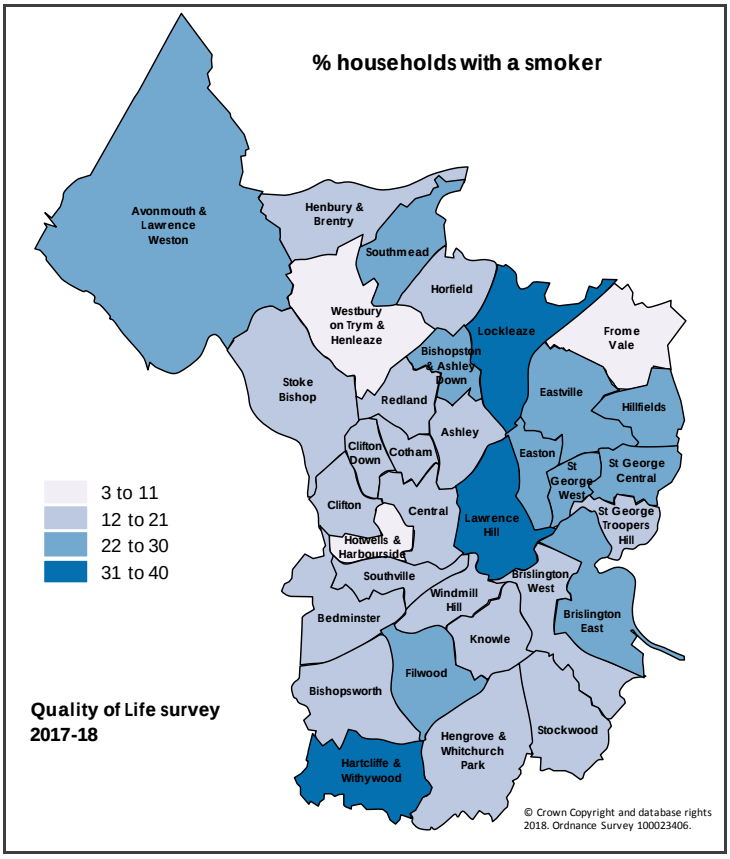


Fig 6.4.2: % Households with a smoker, Source: Quality of Life 2017-18

Hospital admissions

There were over 4,100 smoking-related hospital stays[203] 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).

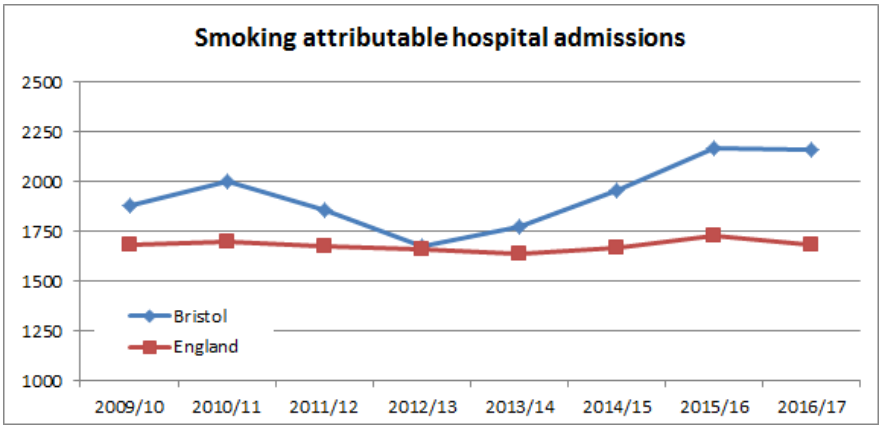


Fig 6.4.3: Smoking attributable hospital admissions: Source: NHS Digital-Hospital Episode Statistics (HES), Office for National Statistics (ONS) via PHOF Feb 2018

[200] Data on smoking rates in young people and on smoking during pregnancy are in the JSNA **Child Health** section

[201] Annual Population Survey (APS) 2016, via PHOF, Feb 2018

[202] Bristol Quality of Life survey 2017/18

[203] 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 deaths[204] 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 fall[205] (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

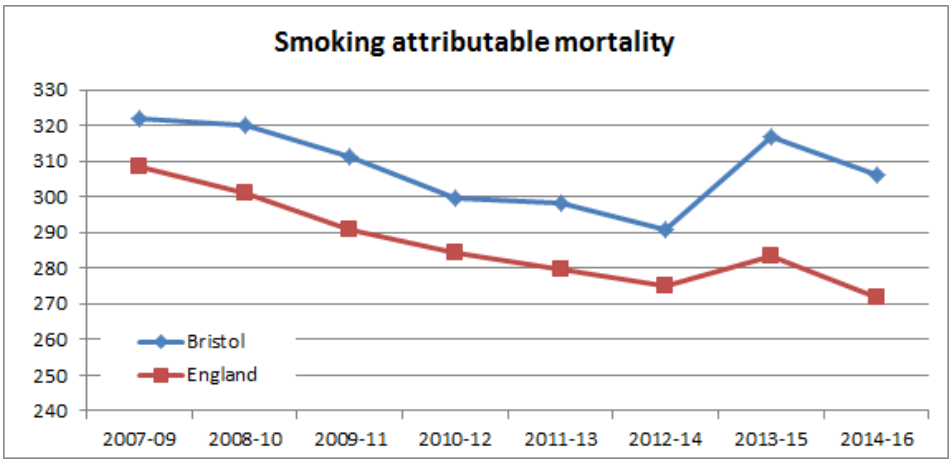


Fig 6.4.4: Smoking attributable deaths. Source: ONS mortality file via PHOF Feb 2018

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/

[204] 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

[205] 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 crime[206]. Levels of alcohol-related harm to the health and wellbeing of individuals, families and communities in Bristol have risen, and health problems caused by heavy drinking are being identified in young people[207]. Excessive drinking has been recognised as a major cause of a wide range of diseases and injuries.

Safe levels of drinking

2016 guidelines[208] 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 data[209] (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 admissions[210]

There were over 3,000 hospital stays in Bristol due to alcohol-related harm[211] 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.

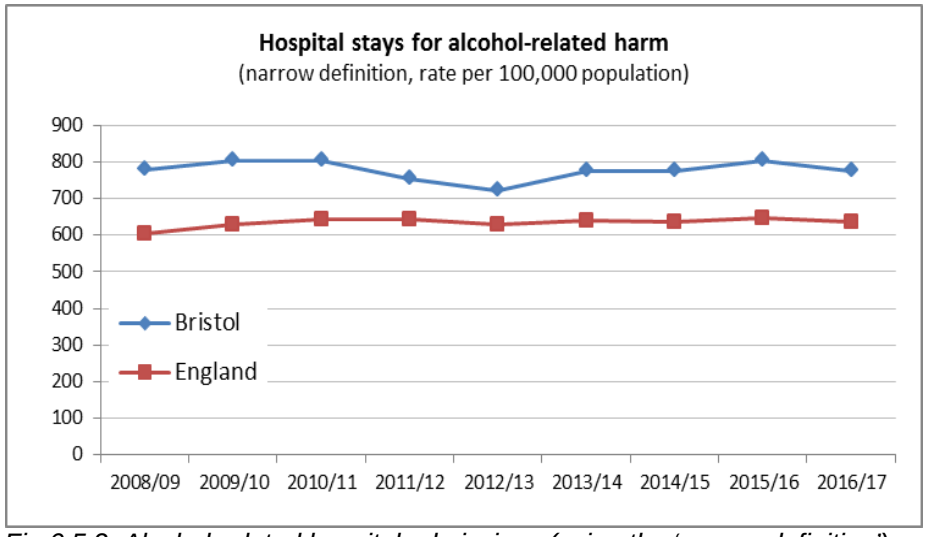


Fig 6.5.2. Alcohol-related hospital admissions (using the 'narrow definition')

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 data[212] on emergency hospital admissions in 2016/17 show that 14% of alcohol-related emergency hospital

[206] Government Alcohol Strategy, 2012
[207] See section "4.13 Lifestyle behaviours of Young People"
[208] UK Chief Medical Officers' Low Risk Drinking Guidelines, Aug 2016

[209] Source: Health Survey for England 2011-14, via PHE Local Alcohol Profiles (accessed Sept 2018)
[210] Data via PHE Local Alcohol Profiles (accessed Sept 2018)
[211] 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
[212] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

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"[213], 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 use[214]. 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.

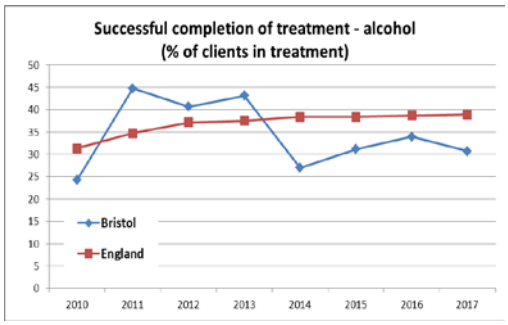


Fig 6.5.3: Treatment success rates – alcohol; Source: National Drug Treatment Monitoring System (June 2018)

Gender: Almost two thirds (63%) of clients in treatment for alcohol use[215] in Bristol are male, and 37% female

Alcohol-related deaths[216]

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.

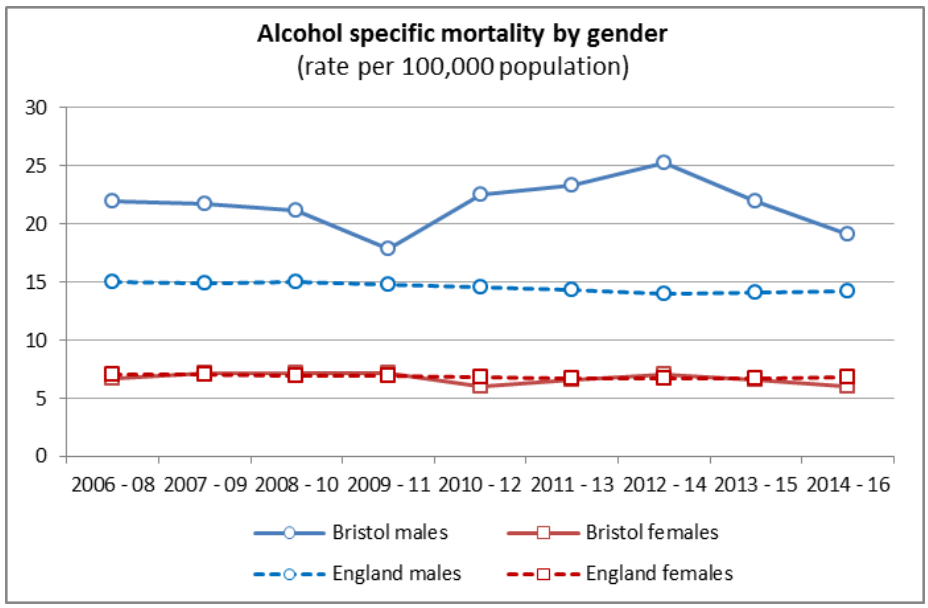


Fig 6.5.4. Alcohol-specific mortality by gender; Source Public Health England

Further data and information

- PHE Local Alcohol Profiles
- JSNA chapter - Alcohol misuse: adults 2017
- Bristol city-wide Alcohol Strategy 2016–20

[213] 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

[214] Jan-Dec 2017; Source: National Drug Treatment Monitoring System https://www.ndtms.net/

[215] Local Drug Treatment Monitoring data for 2017; Source: BCC Insight, Performance & Intelligence

[216] Data via PHE Local Alcohol Profiles (accessed Sept 2018)

6.6 Substance misuse

Substance misuse causes serious harm to individuals, families and communities[217]. 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 users[218]. 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.

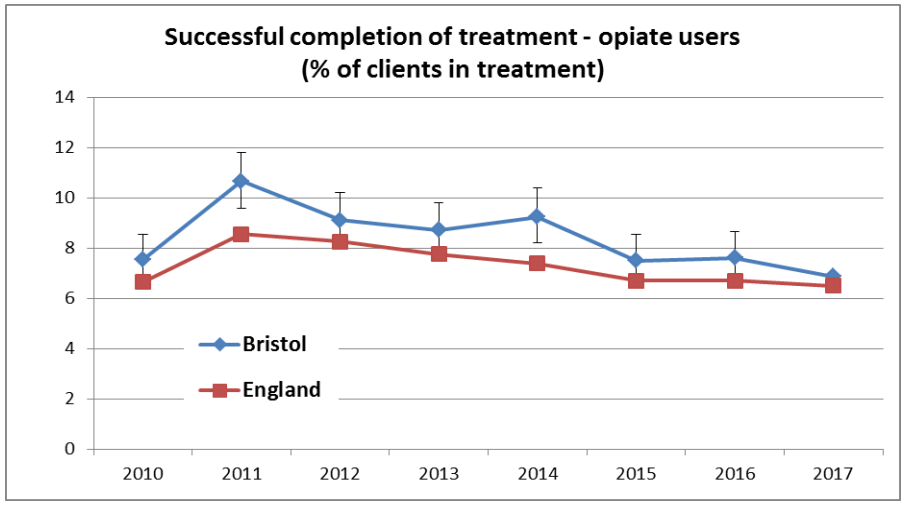


Fig 6.6.2a: Treatment success rates – opiate; Source National Drug Treatment Monitoring System (June 2018)

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.

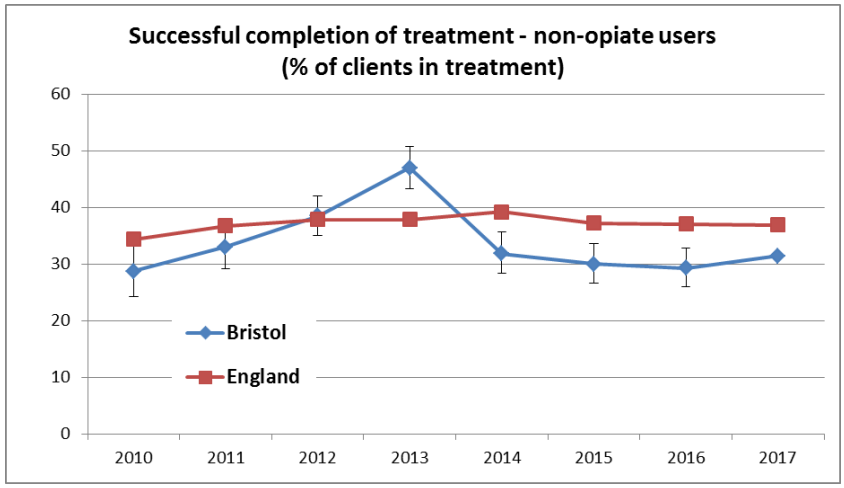


Fig 6.6.2b: Treatment completion rates – non-opiate users; Source National Drug Treatment Monitoring System (June 2018)

[217] For Children and Young People, see "4.13 Lifestyle behaviours of Young People"
[218] 2014/15 Opiate & crack cocaine use: prevalence estimates

Gender: Over two thirds (72%) of opiate users in treatment[219] 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.

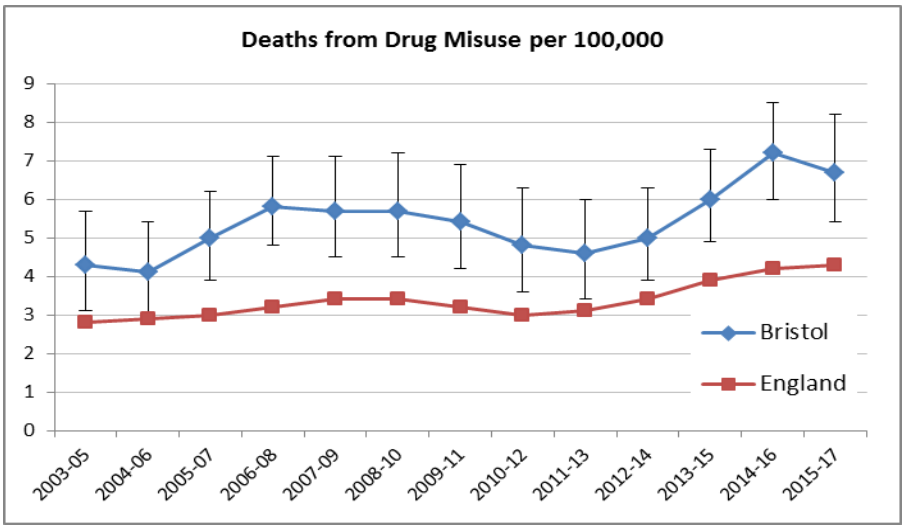


Fig 6.6.3: Deaths from drug misuse per 100,000, via PHOF (2018)

Further data and information

- National Drug Treatment Monitoring System https://www.ndtms.net/

[219] 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 Health[220]

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 Bristol[221]. 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)

[220] Note – this section is largely based on the JSNA Chapter on Sexual Health (2016)

[221] 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).

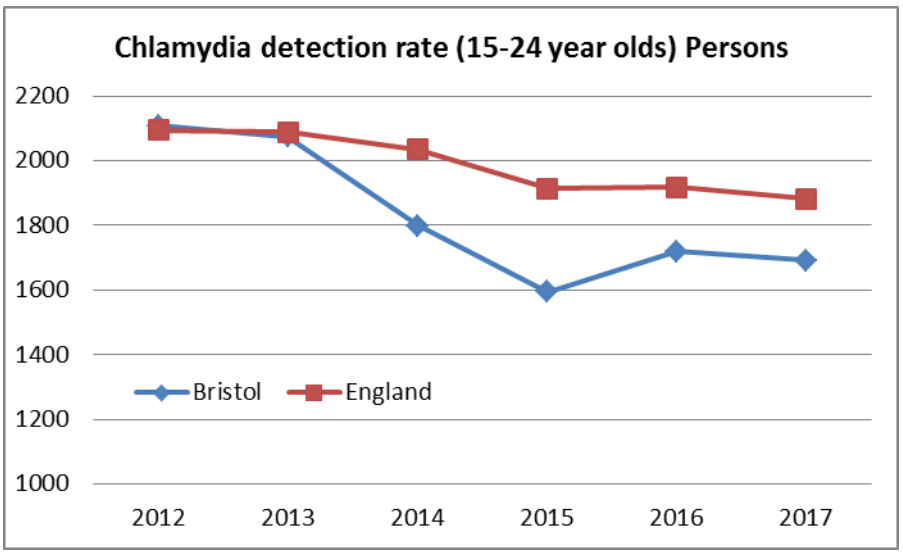


Fig 7.2.1: Chlamydia detection rate, Bristol v England, via Public Health Outcomes Framework 2018

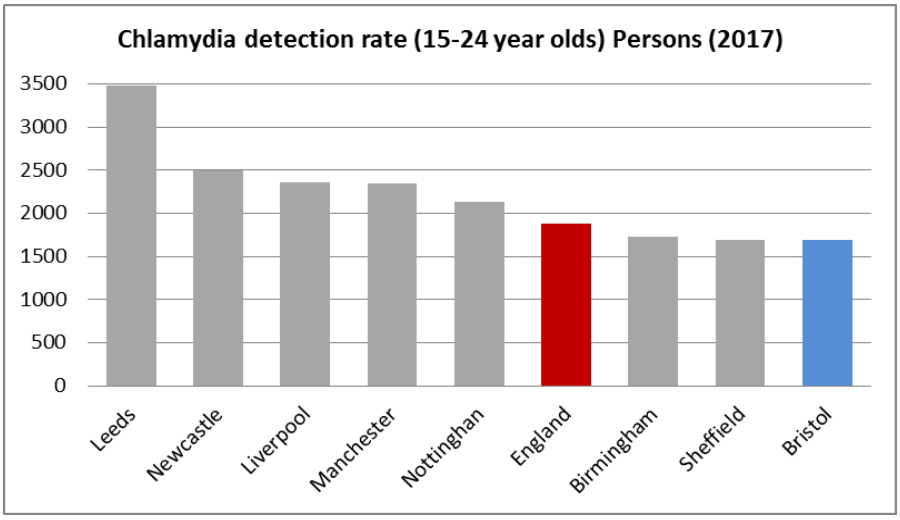


Fig 7.2.2: Chlamydia detection rate for Core Cities 2017, via Public Health Outcomes Framework 2018

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)[222] – 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.

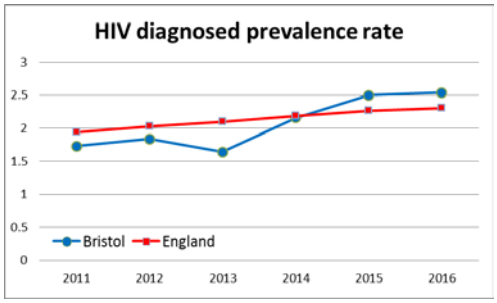


Fig 7.3.1. HIV diagnosed prevalence, rate per 1,000 people aged 15-59; Source: via PH Sexual and Reproductive Health Profiles 2018

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 data[223] 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.

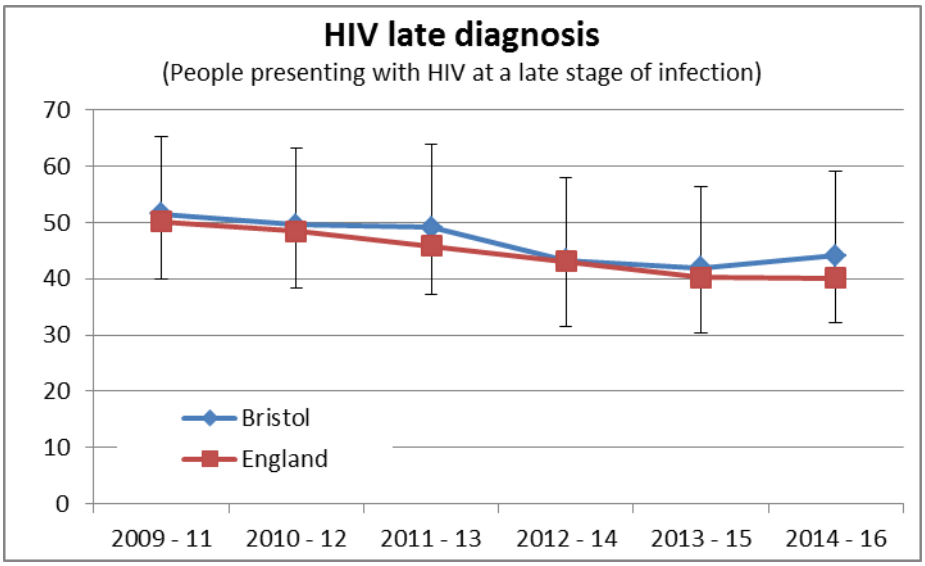


Fig 7.3.2 % of new HIV diagnoses considered to be "late"; Source: via Public Health Outcomes Framework 2018

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

[222] Public Health England, via Sexual and Reproductive Health Profiles, 2018

[223] 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 average[224] – 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 symptoms[225] (England average 39.4%) and 69% within 4 months of symptoms (England average 69.3%).

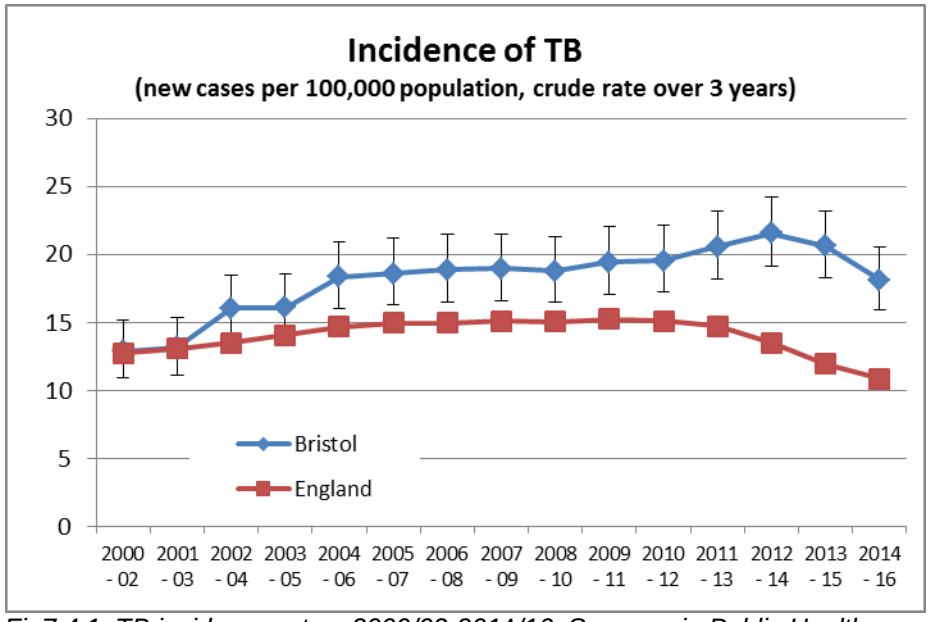


Fig7.4.1: TB incidence rates, 2000/02-2014/16; Source: via Public Health Outcomes Framework 2018

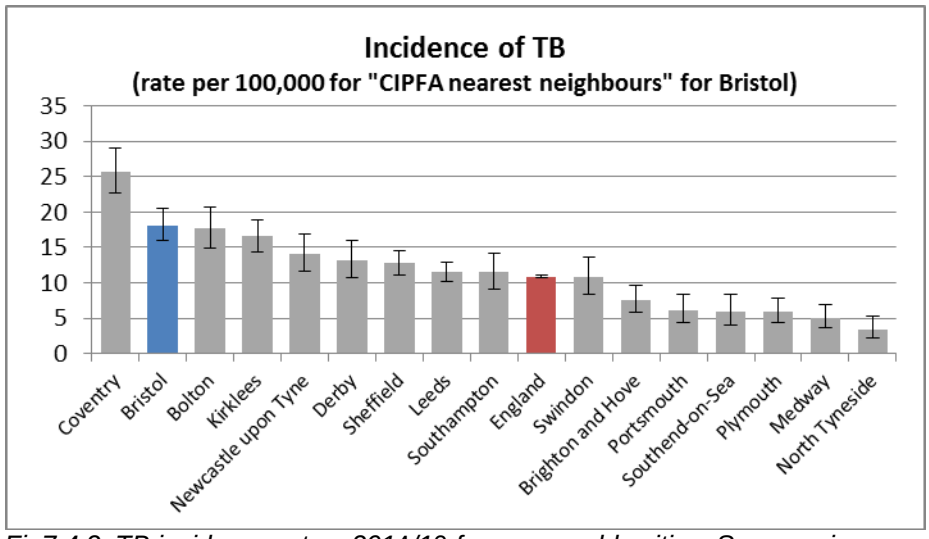


Fig7.4.2: TB incidence rates, 2014/16 for comparable cities; Source: via Public Health Outcomes Framework 2018

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

[224] Public Health England via Public Health Outcomes Framework, May 2018
[225] 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% target[226].

Also, a new measure[227] 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.

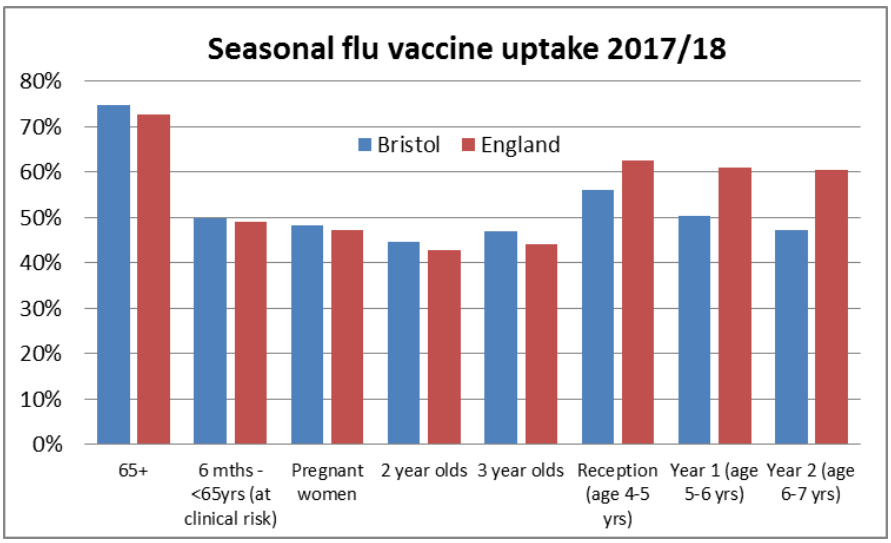


Fig 7.5.1: Source: Seasonal flu vaccine uptake figures, 2017/18
https://www.gov.uk/government/collections/vaccine-uptake

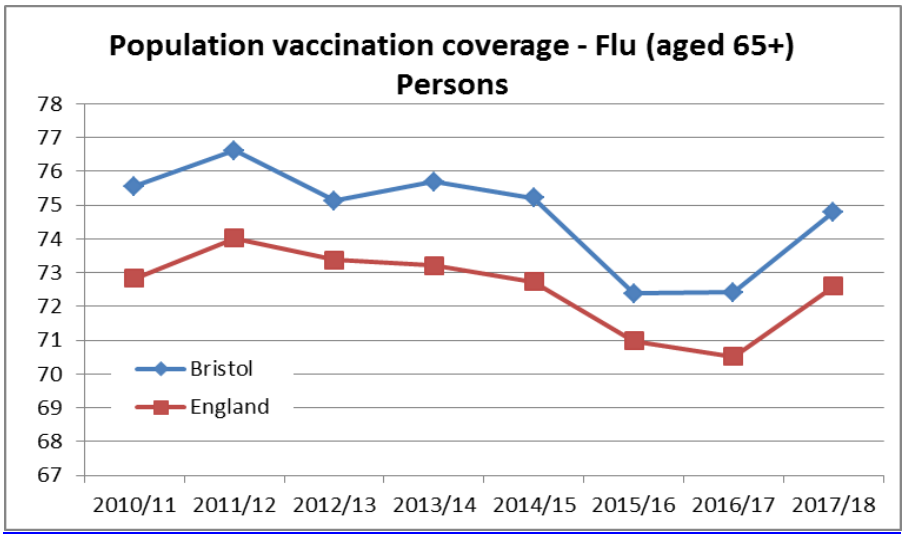


Fig 7.5.2: Source: via Public Health Outcomes Framework, 2018

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.

[226] Public Health England via Public Health Outcomes Framework, May 2018
[227] 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 procedures[228].

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-spectrum[229].

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 items[230], 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.

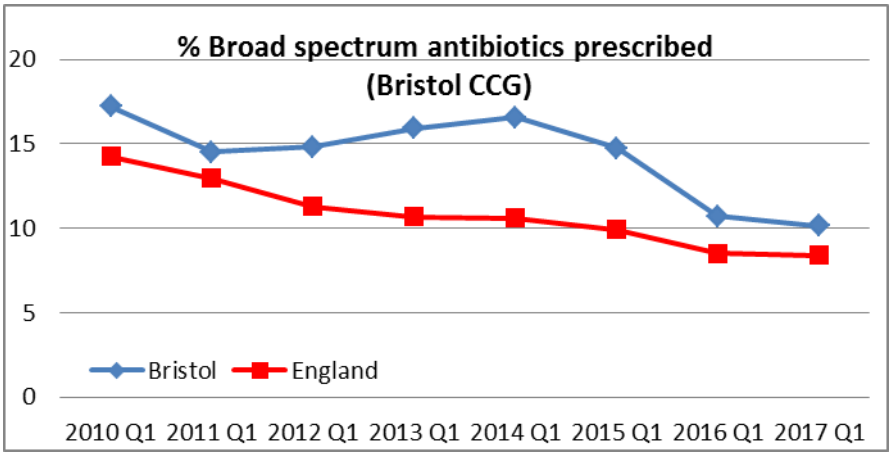


Fig 7.6.1: Source: % Prescribed antibiotics (broad spectrum) (Q1 2010 – Q1 2017) via https://fingertips.phe.org.uk/profile/amr-local-indicators

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).

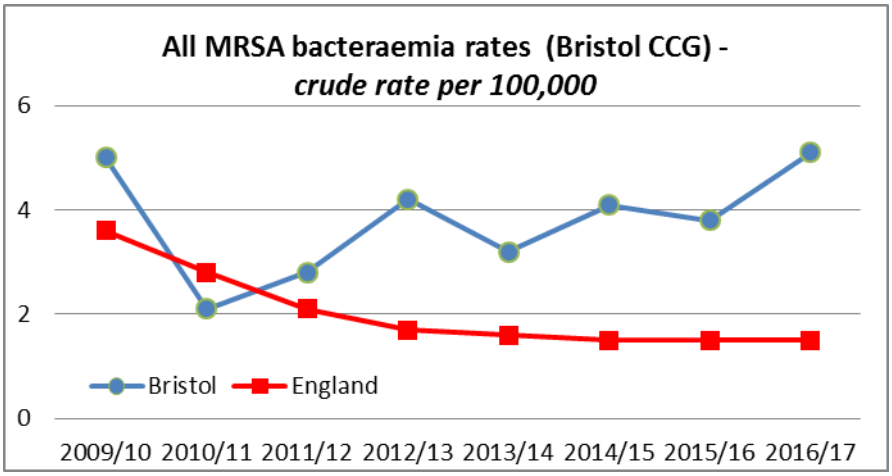


Fig 7.6.2: Source: Rate of MRSA infections per 100,000 (2009/10 – 2016/17) via https://fingertips.phe.org.uk/profile/amr-local-indicators/

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)[231] but has dropped significantly from 2016 (31.8).

Further data

- Antimicrobial Resistance (AMR) local indicators: https://fingertips.phe.org.uk/profile/amr-local-indicators

[228] www.gov.uk/government/collections/antimicrobial-resistance-amr-information-and-resources

[229] Cephalosporin, quinolone and co-amoxiclav, which are associated with an increased risk of Clostridium difficile (C. diff) infection and antimicrobial resistance

[230] Prescribed antibiotic items per STAR-PU (Specific Therapeutic group Age-sex weightings Related Prescribing Unit). Source: Public Health England via PHOF, Aug 2018

[231] 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 registers[232] 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.

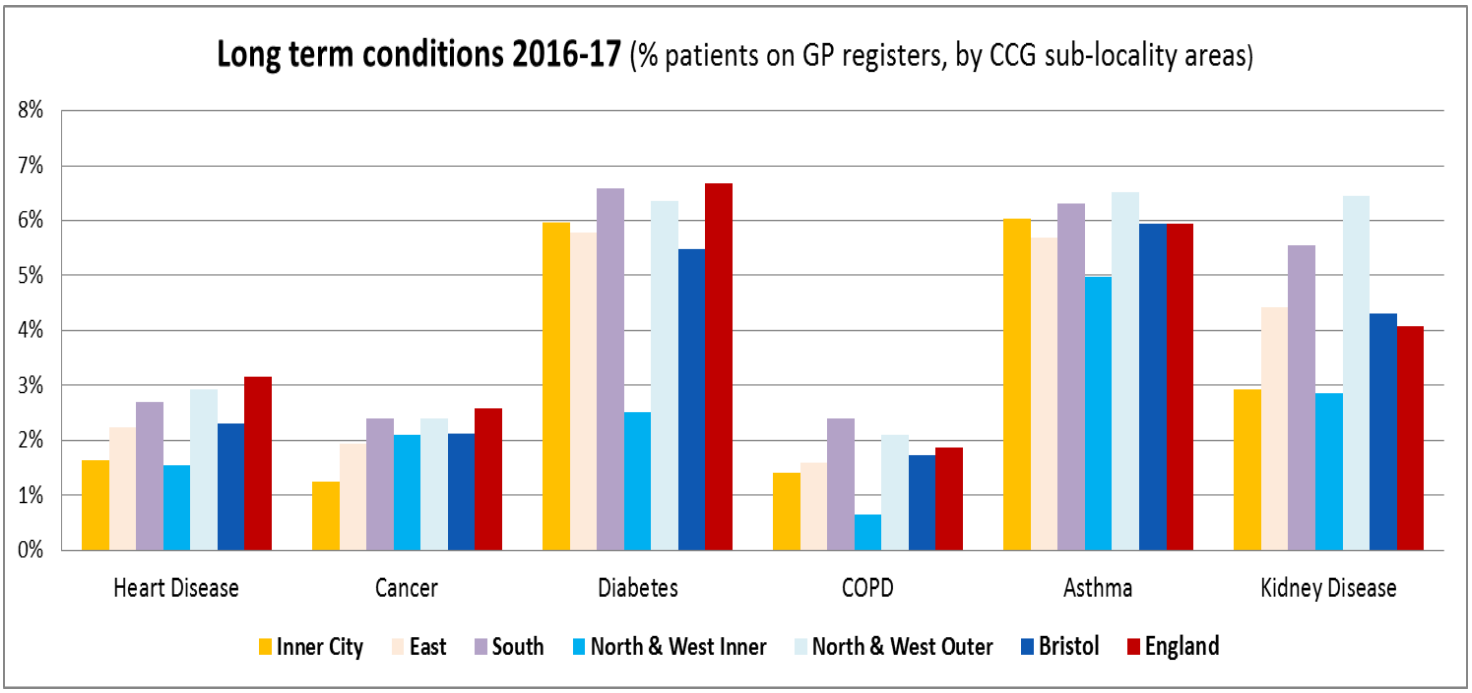


Fig 8.1.1: Long-term conditions by area; Source: NHS Quality Outcomes Framework 2016/17 (Supplied by BCC Insight, Performance & Intelligence, 2018)

Patients on GP Registers (2016-17)	Coronary Heart Disease		Cancer (all types)		Diabetes		Chronic Obstructive Pulmonary Disease		Asthma		Chronic Kidney Disease	
Sub Locality Area	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
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

[232] 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 deaths[233] 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).

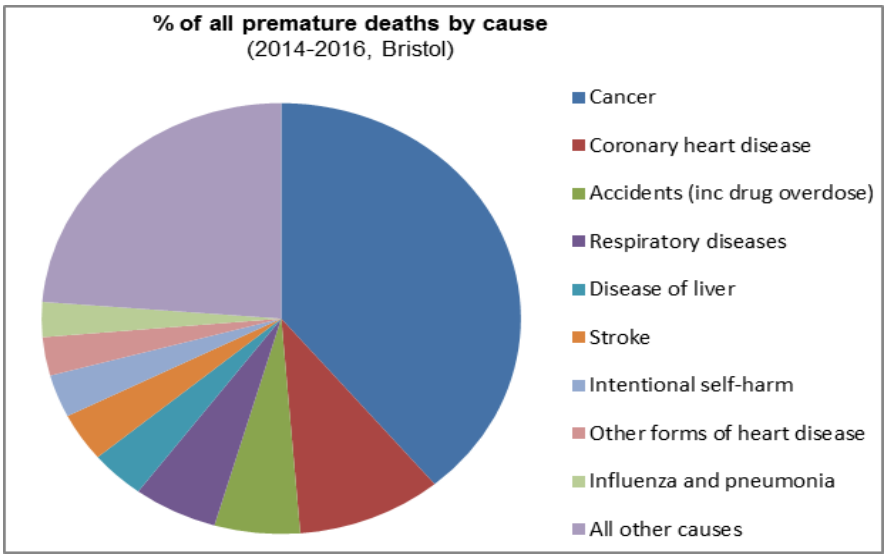


Fig 8.2.1 Source Bristol City Council Public Health Knowledge Service (2018)

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)

[233] 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.[234]. 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 data[235] 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.

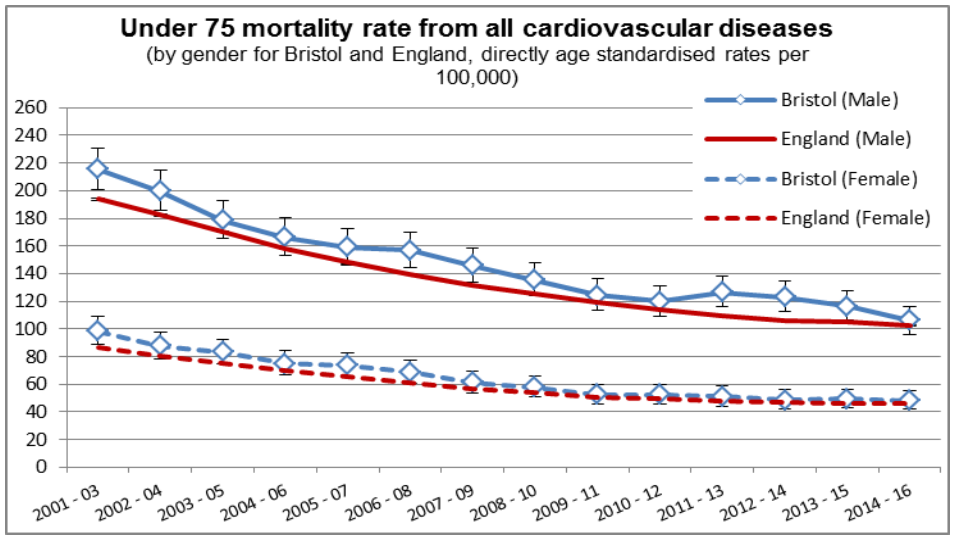
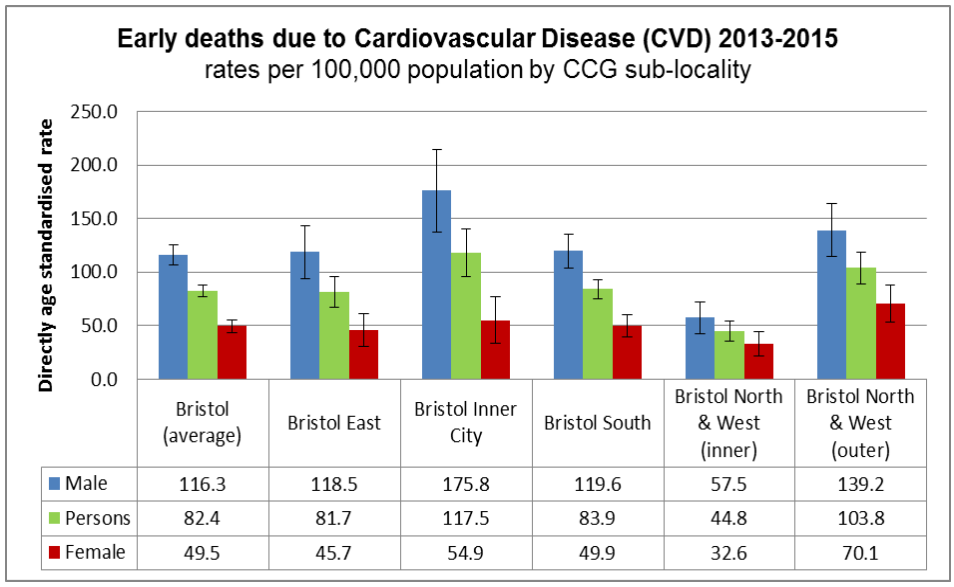


Fig 8.3.1: Early deaths – CVD (Source via PHOF, Feb 2018)



	Bristol (average)	Bristol East	Bristol Inner City	Bristol South	Bristol North & West (inner)	Bristol North & West (outer)
Male	116.3	118.5	175.8	119.6	57.5	139.2
Persons	82.4	81.7	117.5	83.9	44.8	103.8
Female	49.5	45.7	54.9	49.9	32.6	70.1

Fig 8.3.2: Early deaths by area for CVD (Source BCC Public Health Knowledge Service, 2018)

Coronary Heart Disease (CHD)

Data from GP registers[236] 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).

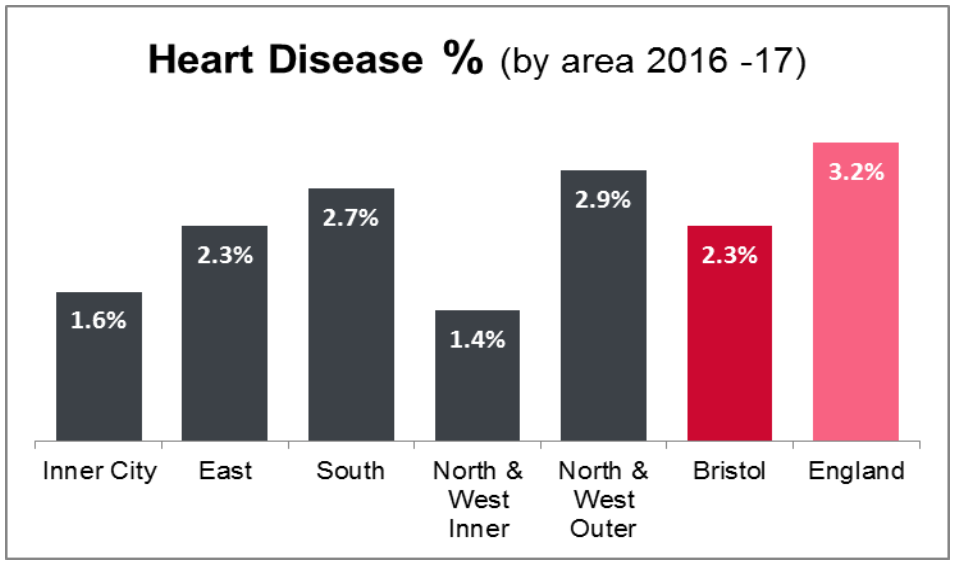


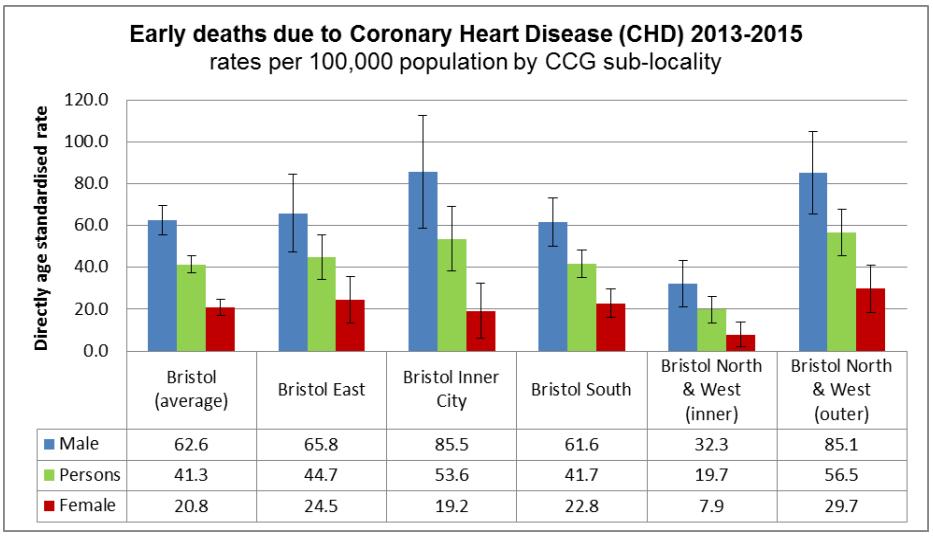
Fig 8.3.3: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, 2018)

[234] 2014-16; Source: Public Health England (based on ONS data), via PHOF, Feb 2018
[235] 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)
[236] Source: NHS QOF data 2016/17 [Note – these are crude rates]

Local data[237] 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 female[238].

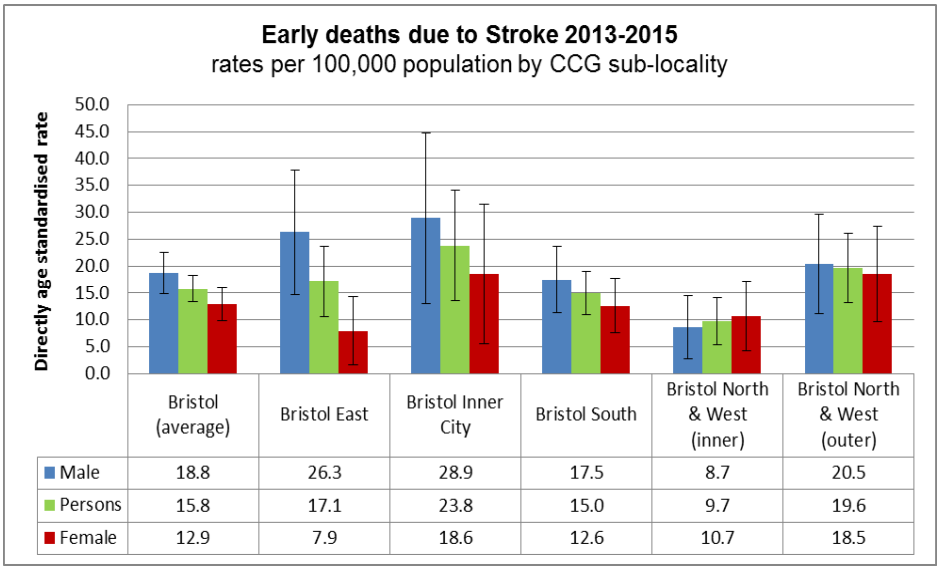


	Bristol (average)	Bristol East	Bristol Inner City	Bristol South	Bristol North & West (inner)	Bristol North & West (outer)
Male	62.6	65.8	85.5	61.6	32.3	85.1
Persons	41.3	44.7	53.6	41.7	19.7	56.5
Female	20.8	24.5	19.2	22.8	7.9	29.7

Fig 8.3.4: Early deaths by area for CHD (Source BCC Public Health Knowledge Service, 2018)

Stroke

The early death rate[239] 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).



	Bristol (average)	Bristol East	Bristol Inner City	Bristol South	Bristol North & West (inner)	Bristol North & West (outer)
Male	18.8	26.3	28.9	17.5	8.7	20.5
Persons	15.8	17.1	23.8	15.0	9.7	19.6
Female	12.9	7.9	18.6	12.6	10.7	18.5

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 city[240], with highest rates in the South and North & West (outer), and lowest in North & West (inner) and the Inner City (Fig 8.3.6).

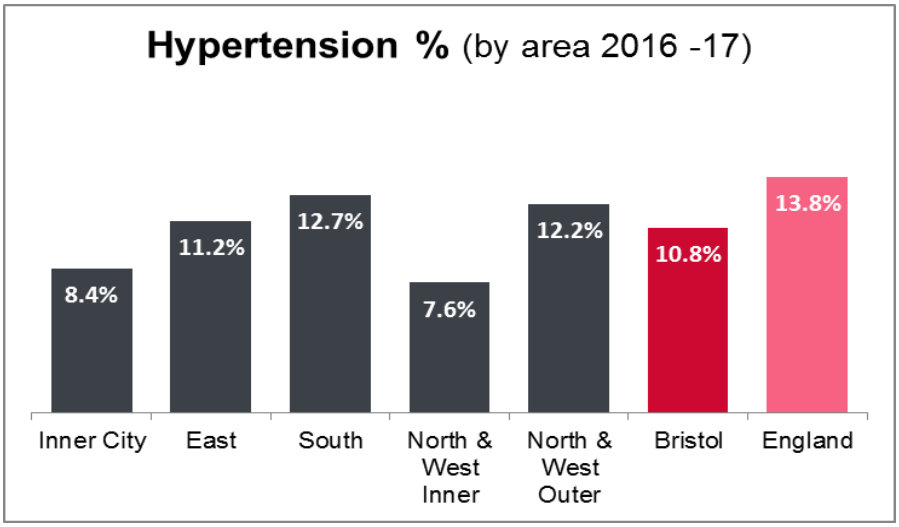


Fig 8.3.6 Hypertension recorded diagnoses; Source: QOF 2016-17 and Public Health England for estimated prevalence

Further data

- CVD Profile: https://fingertips.phe.org.uk/profile/cardiovascular

[237] 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)
[238] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.
[239] 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)
[240] 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 cities[241]. 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-locality[242] 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 data[243] (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).

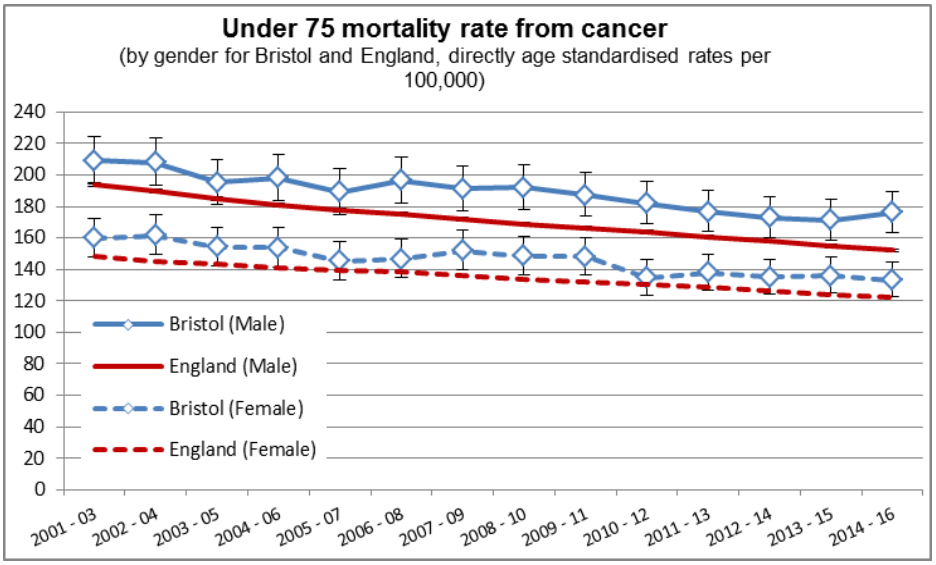
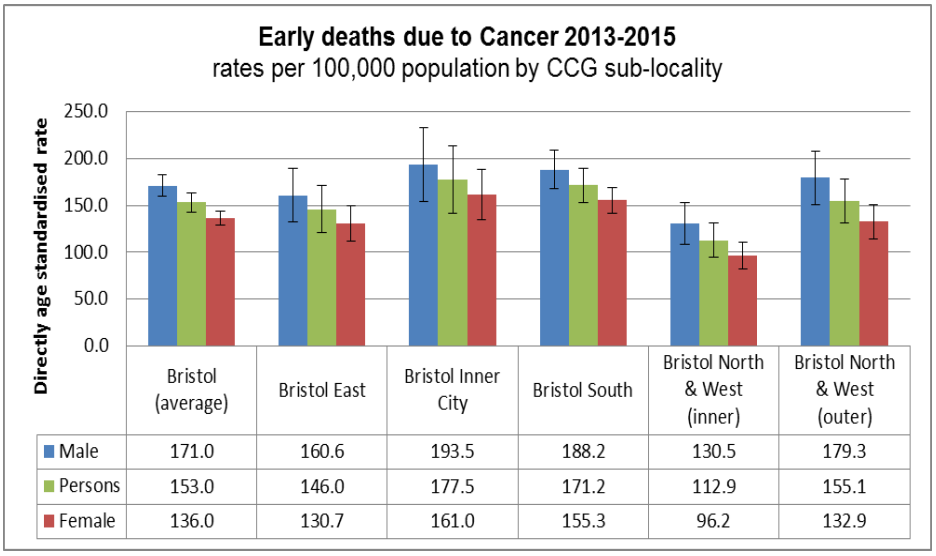


Fig 8.4.1: Early deaths due to Cancer, Bristol and England by gender
Source via Public Health Outcomes Framework, PHOF, Feb 2018



	Bristol (average)	Bristol East	Bristol Inner City	Bristol South	Bristol North & West (inner)	Bristol North & West (outer)
Male	171.0	160.6	193.5	188.2	130.5	179.3
Persons	153.0	146.0	177.5	171.2	112.9	155.1
Female	136.0	130.7	161.0	155.3	96.2	132.9

Fig 8.4.2: Early deaths – Cancer (Source BCC Public Health Knowledge Service, 2018)

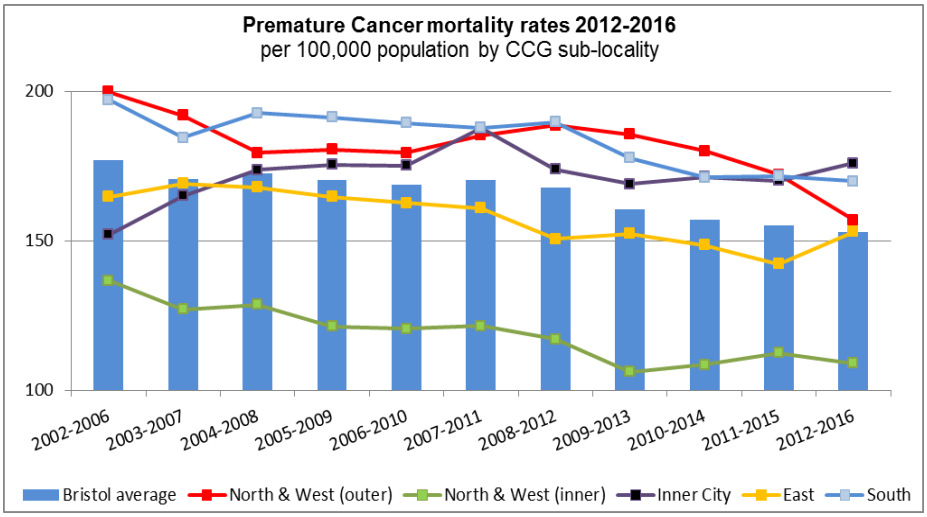


Fig 8.4.3: Early cancer deaths in Bristol by locality areas (Source: Bristol Public Health Knowledge Service, 2018)

[241] 2014-16. Source: Public Health England (based on ONS source data), via PHOF, Feb 2018. Compared to CIPFA and Core Cities
[242] Source: Bristol Public Health Knowledge Service (2018)
[243] Source: Bristol Public Health Knowledge Service (2018). Directly standardised rates per 100,000 population

8.4.2 Diagnoses & admissions

GP data[244] 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)[245].

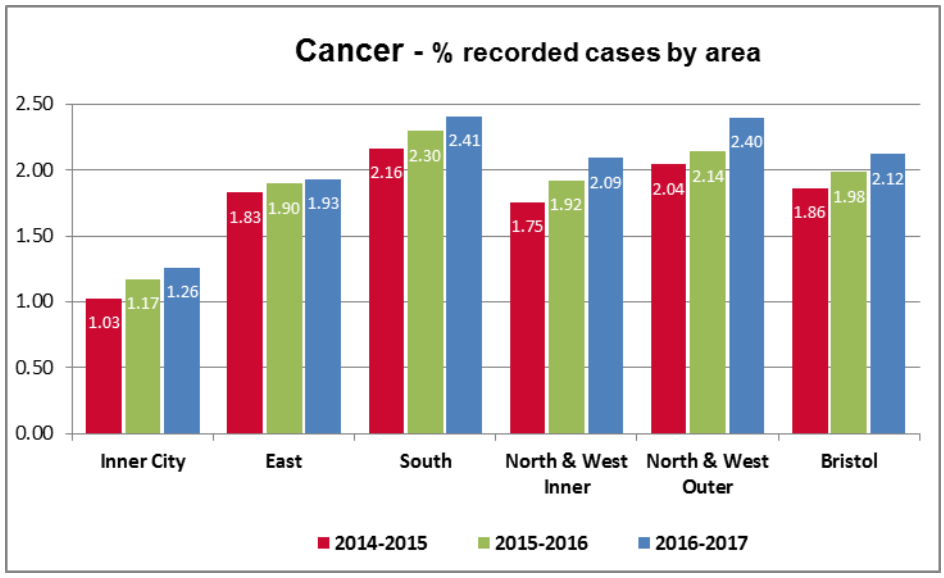


Fig 8.4.4: Source: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, 2018)

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)[246].

Latest published data (still 2012-14) on mortality rates per 100,000 of the relevant population[247] 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)

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 stage[248] in 2016, similar to the national average (52.6%).

Screening coverage[249] 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

[244] Source: NHS QOF data 2016/17
[245] PHE General Practice Profiles (2017): https://fingertips.phe.org.uk/profile/general-practice
[246] Calculated by Bristol Public Health Knowledge Service using ONS mortality data
[247] HSCIC: https://indicators.hscic.gov.uk/webview/

[248] 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)
[249] Source: Health and Social Care Information Centre, via Public Health Outcomes Framework, Aug 2018

8.5 Diabetes[250]

Diagnoses of diabetes continue to rise in Bristol as nationally, and in 2016/17 there were almost 22,500 Bristol patients with Diabetes[251].

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 rate[252] in Bristol is 74.1% of the full prevalence of diabetes, compared with 77.1% recorded nationally.

Recorded GP diagnoses[253] 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% areas[254].

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.

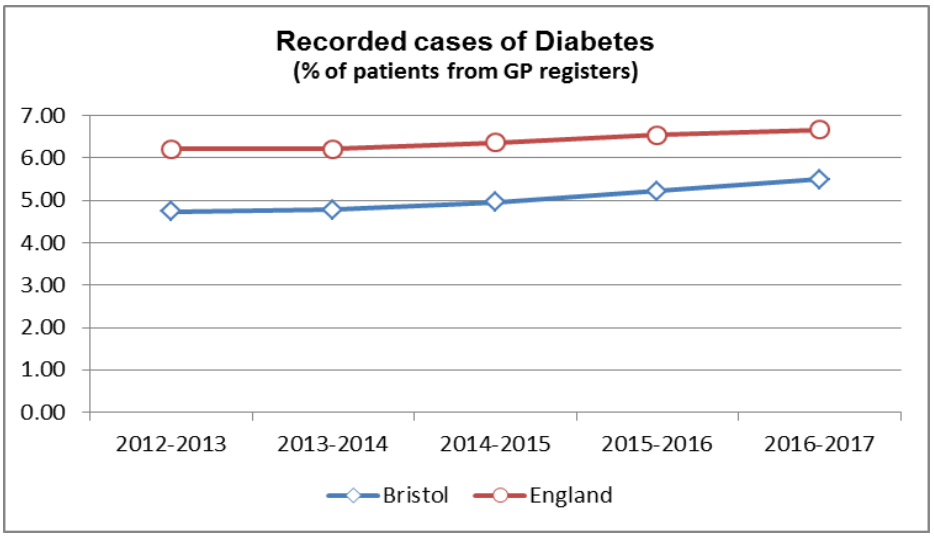


Fig 8.5.1: Source: NHS Quality Outcomes Framework (QOF)

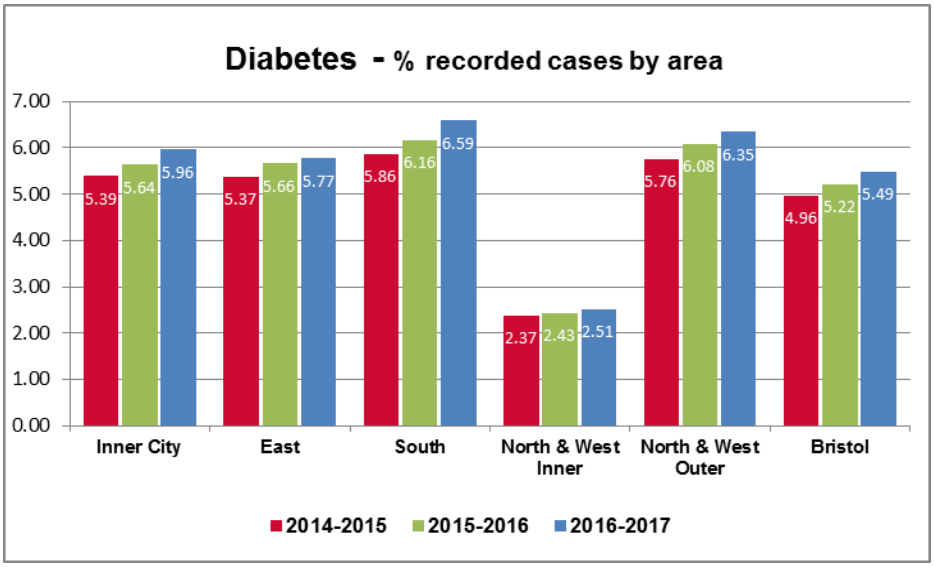


Fig 8.5.2: Source: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, 2018)

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

[250] Further data, see Bristol Diabetes profile: http://fingertips.phe.org.uk/diabetes
[251] Source: NHS QOF data 2016/17. QOF is a crude rate per population
[252] 2016/17 Source: PHE via PHOF, May 2018
[253] Source: NHS QOF data 2016/17
[254] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018

8.6 Respiratory Disease

In Bristol, early death rates from respiratory disease[255] (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 admissions[256] 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 data[257] 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.

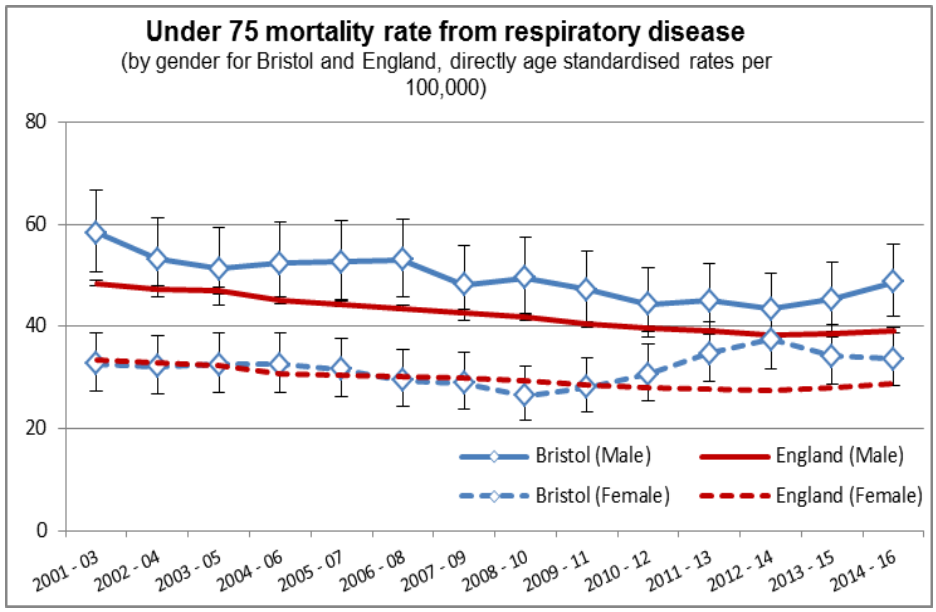


Fig 8.6.1: Early deaths due to respiratory disease (via PHOF, Feb 2018)

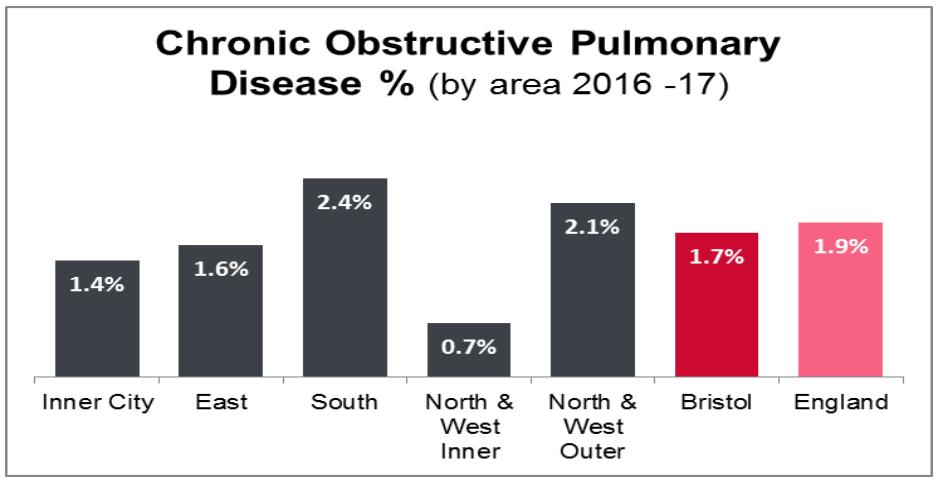


Fig 8.6.2: Prevalence of COPD; Source: NHS QOF 2016/17

8.6.2 Asthma[258]

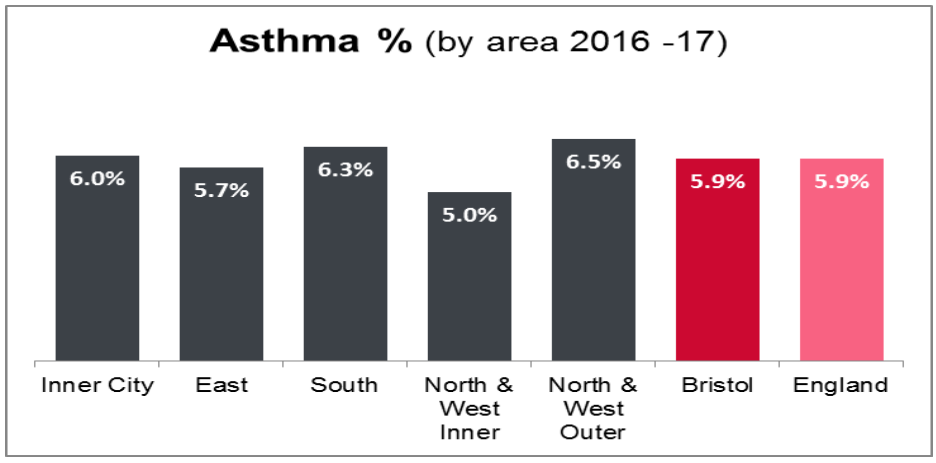


Fig 8.6.3: Prevalence of Asthma; Source: NHS QOF 2016/17

GP register data[259] show 29,911 Bristol patients with Asthma. This is a prevalence of 5.94% of all adult patients, similar to the

[255] 2013-15. Source: Public Health England, via PHOF, Feb 2018
[256] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.
[257] Source: NHS QOF data 2016/17 [Note – these are crude rates]

[258] For Childhood Asthma – see JSNA section **4.6.1 Chronic Childhood Illnesses**
[259] 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 admissions[260], 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 analysis[261] (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 asthma[262] (all age) were female. There were 1,590 admissions during this 3 year period: 690 males and 900 females.

Deprivation: 18% of emergency hospital admissions[263] of Bristol patients for asthma (2016/17) were living in the most deprived 10% areas.

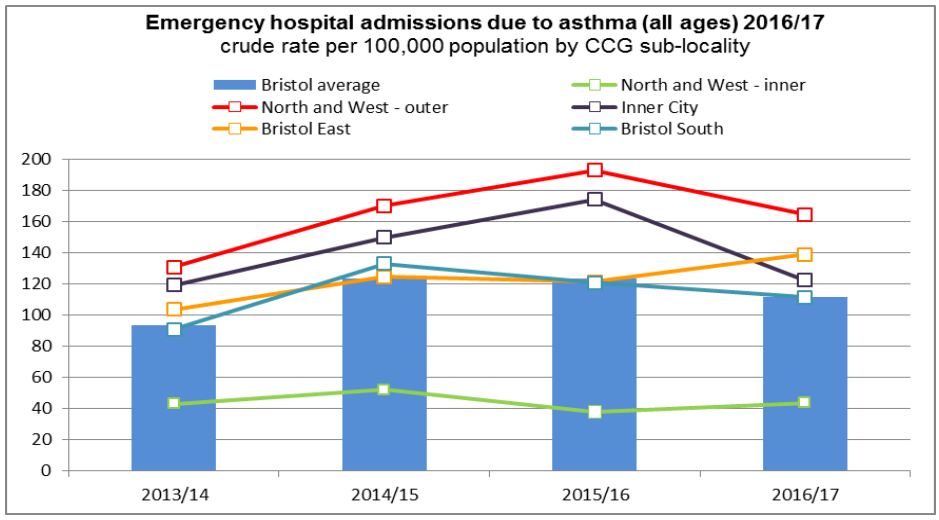


Fig 8.6.4: Asthma admissions by CCG locality area; Source: Hospital episode statistics, Supplied by Public Health Knowledge Service, 2018

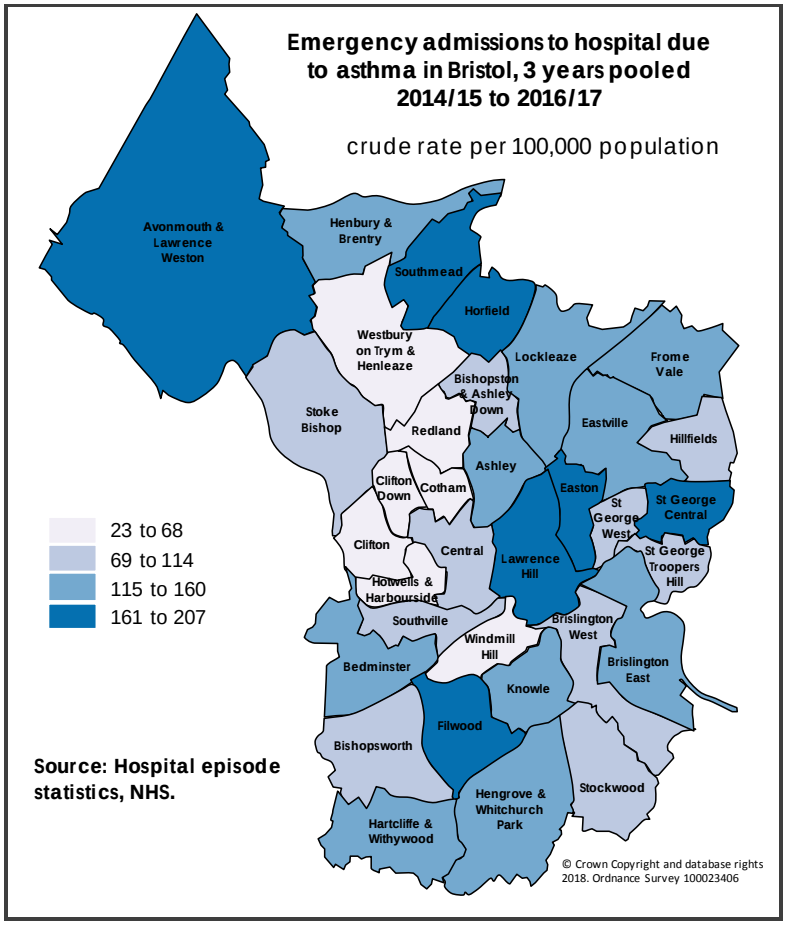


Fig 8.6.5: Asthma admissions by ward for all ages, 2014/15 – 2016/17. Supplied by Public Health Knowledge Service, 2018

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

[260] Emergency admissions to hospital due to asthma in Bristol, crude rate per 100,000 population, 2013/14 to 2016/17
[261] SUS Hospital episodes data, 2014/15 to 2016/17, via Bristol Public Health Knowledge Service (2018)
[262] SUS Hospital episodes data, 2014/15 to 2016/17, via Bristol PHKS (2018)
[263] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

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

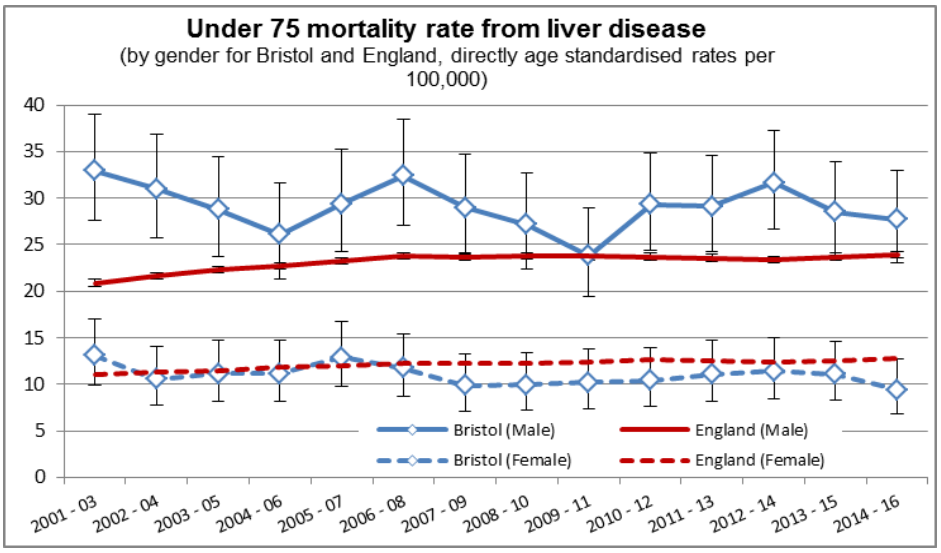


Fig 8.7.1: Early deaths due to liver disease, (Source via PHOF, Feb 2018)

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 years[264]. 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**.

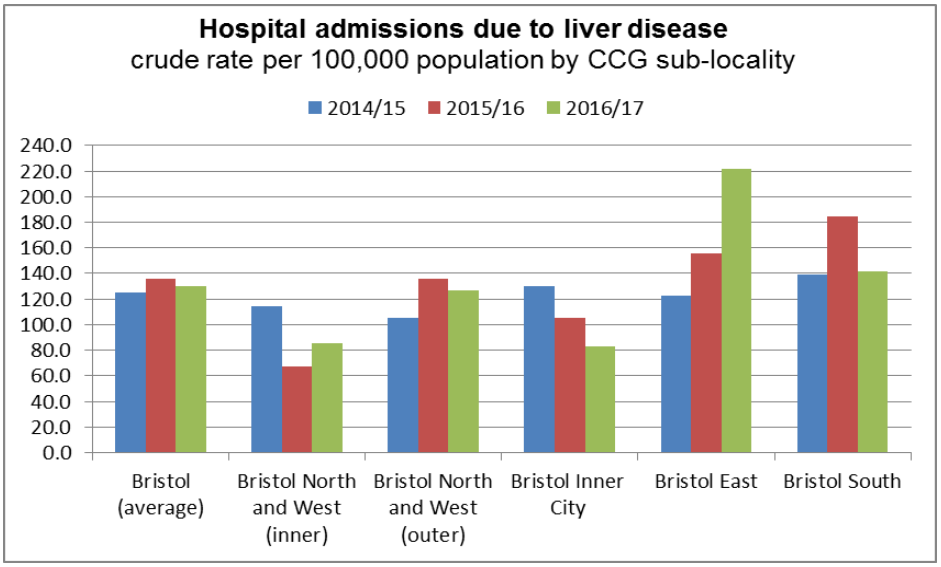


Fig 8.7.2. Rate of hospital admissions for liver disease, 2014/15 to 2016/17

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

[264] 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 England[265], accounting for 24% of all years lived with disability (YLD)[266]. Within this, low back and neck pain accounted for 18% of all YLD. The disability due to MSK disorders is expected to rise further with increases in obesity and sedentary lifestyles, which are significant risk factors[267], 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 GP[268]), so there are many more self-managing at home.

Osteoporosis

GP register data[269] 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 male[270]. 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 osteoporosis[271].

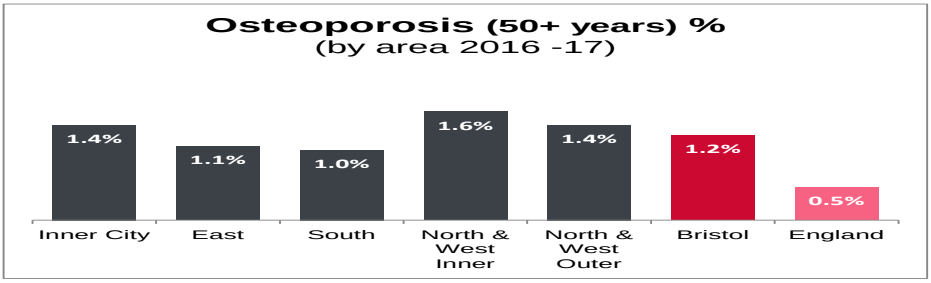


Fig 8.8.1: Prevalence of Osteoporosis; Source: NHS QOF 2016/17

Osteoarthritis

11.3% of Bristol patients[272] 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%.

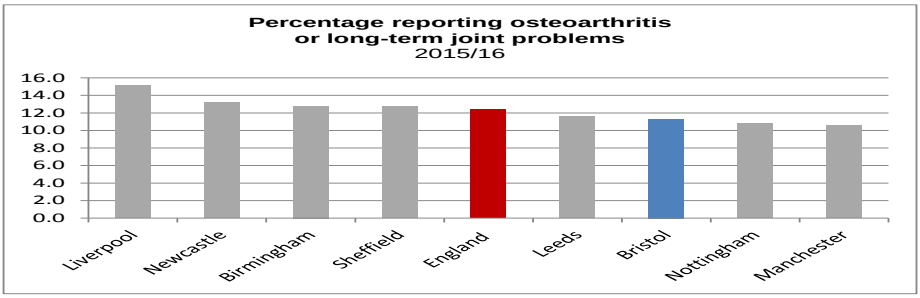


Fig 8.8.2 Estimated prevalence of osteoarthritis or long-term joint problems (patients 18+). Source: GP Patient Survey 2015-16 via MSK Profile

Rheumatoid arthritis

Data from GP registers[273] 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

[265] Global Burden of Disease study, 2013
[266] http://vizhub.healthdata.org/gbd-compare/england via Nottingham JSNA 2016
[267] Arthritis UK www.arthritisresearchuk.org/
[268] NICE (2009) Low back pain in adults:, via Nottingham JSNA 2016
[269] Source: NHS QOF data 2016/17 [Note – these are crude rates]
[270] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.
[271] www.nhs.uk/conditions/hip-fracture/
[272] Source: GP Patient Survey 2015-16, Dept. for Health & Social Care
[273] 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.

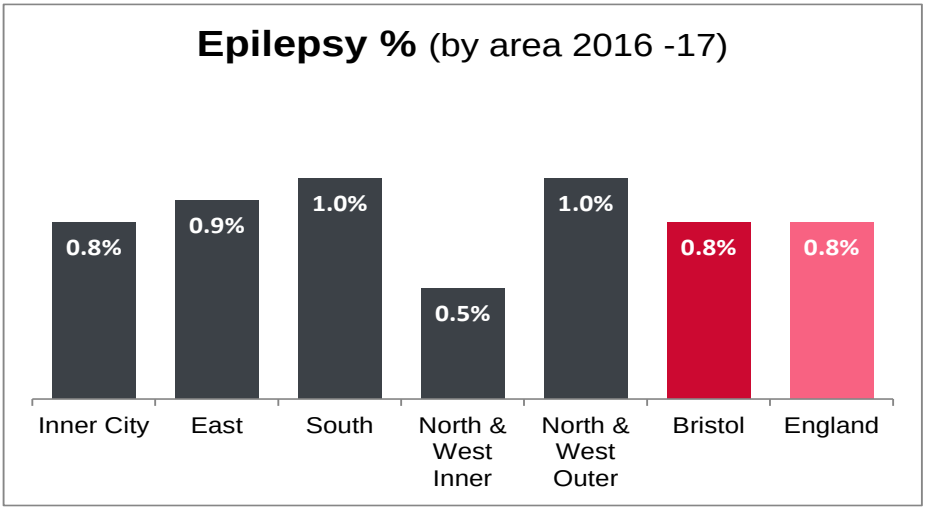


Fig 8.9.1: Prevalence of Epilepsy; Source: NHS QOF 2016/17

8.9.1 Epilepsy

GP register data indicate there are over 3,135 adults with epilepsy in Bristol[274]. 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

[274] 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 interventions[275].

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.

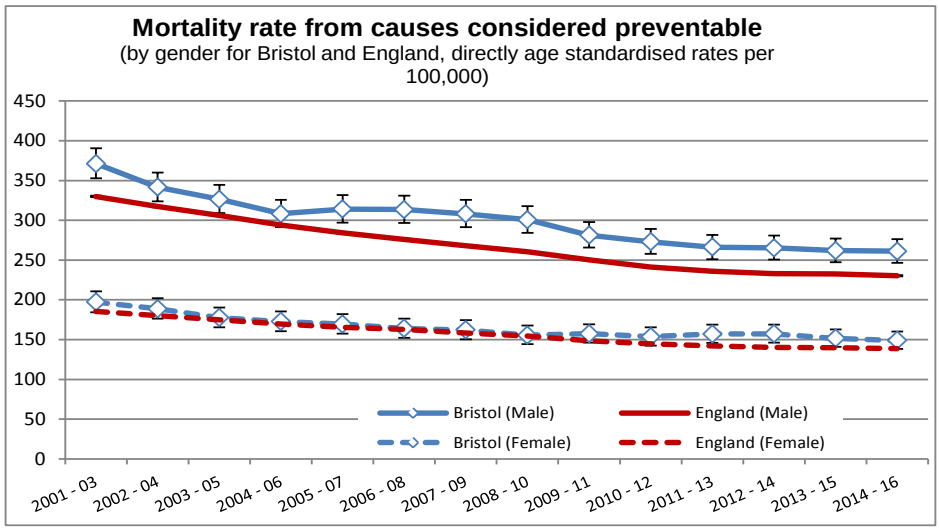


Fig 8.9.1 Rates of deaths from causes considered preventable, by gender for Bristol and England average (Source via PHOF, Feb 2018)

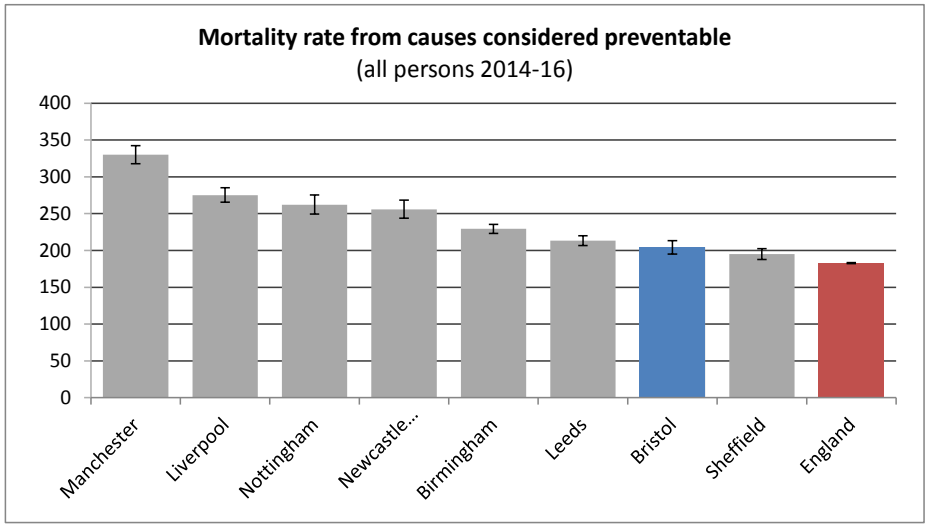


Fig 8.9.2 Core city comparison for preventable mortality, 2013-15 (Source via PHOF, Feb 2018)

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 similar[276].

Deprivation: 13% of all emergency hospital admissions[277] 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.

[275] The 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

[276] 2016/17 Emergency hospital admissions for Bristol patients, Bristol CCG Feb 2018.

[277] 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 disorders[278].

Recorded cases on GP registers in Bristol show that 40,400 patients (aged 18+) had an unresolved record of depression[279] 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 areas[280]. 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.

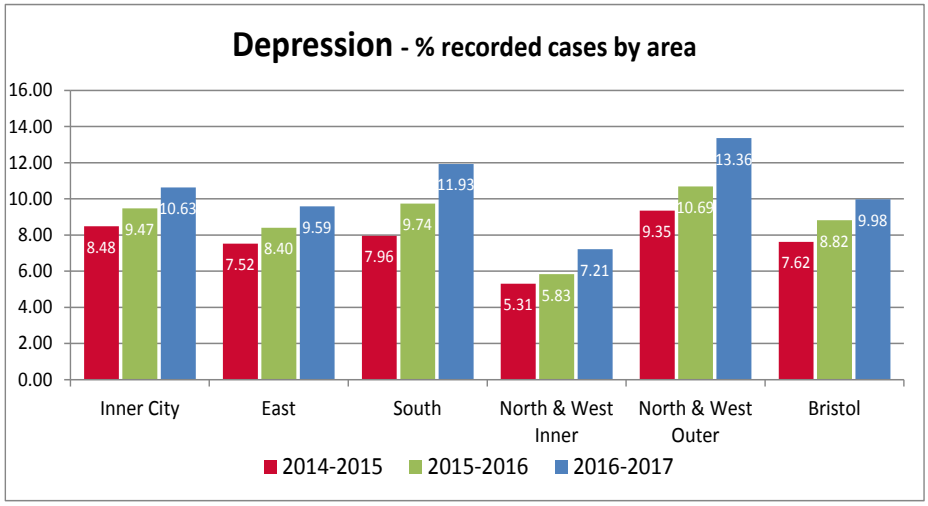


Fig 9.1.1: Source: NHS Quality Outcomes Framework (QOF) 2016-17 (supplied by BCC Insight, Performance & Intelligence, Feb 2018)

New diagnoses of depression

In 2016/17, 8,700 Bristol patients received a new diagnosis of depression[281] 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).

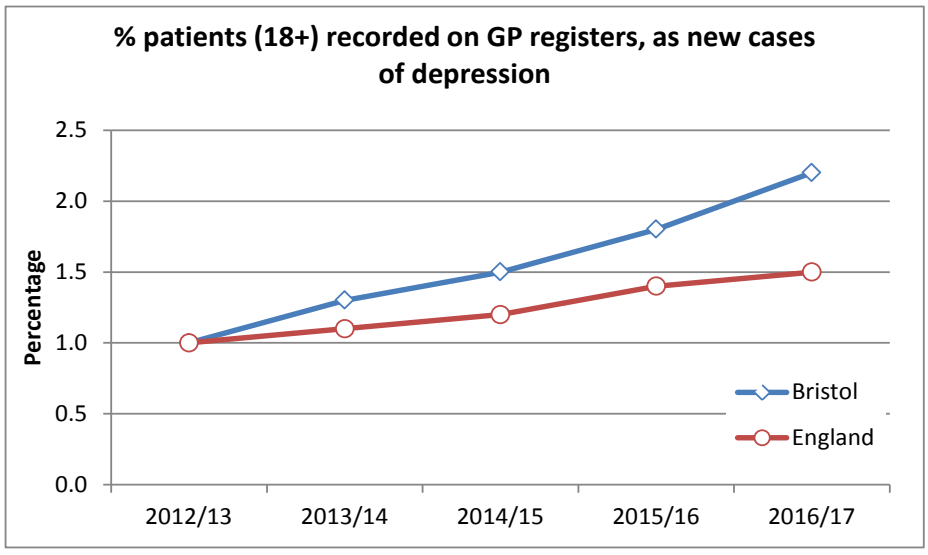


Fig 9.1.2: % Incidences of new cases of depression (Bristol CCG patients) Source: NHS QOF via Mental Health and Wellbeing JSNA profiles

Further data

- "Mental Health and Wellbeing JSNA" profiles: https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna

[278] McManus S, Bebbington P, Jenkins R Brugha T, (eds), 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014 Leeds:* NHS digital:

[279] 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.

[280] Note – 2015/16 QOF rates have been recalculated using only practices included in 2016/17.

[281] 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 ages[282] 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 example 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-harm[283], 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.

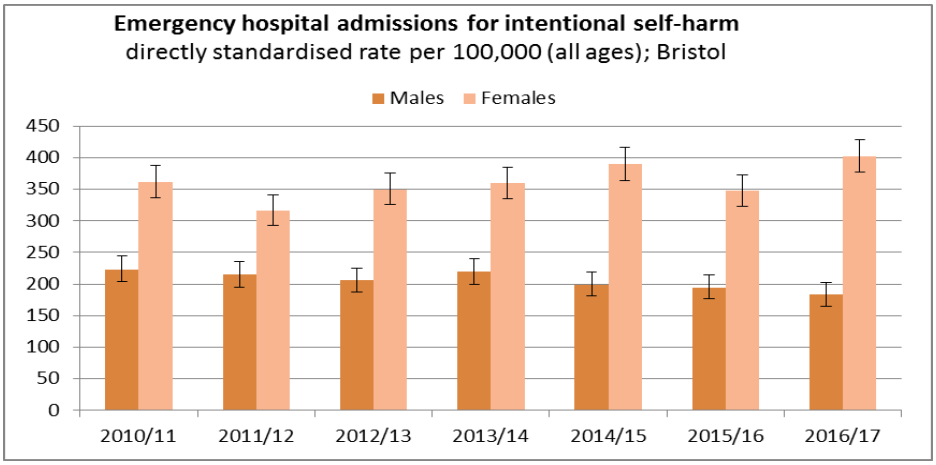


Fig 9.2.1: Source Hospital Episode Statistics via Secondary User Service (SUS) – collated by Bristol Public Health Knowledge Service, 2018

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 significantgly 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.

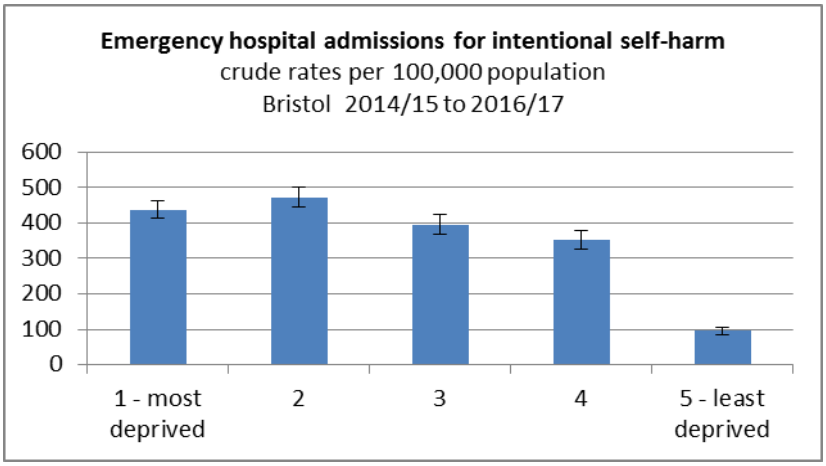


Fig 9.2.2 Source: Bristol Public Health Knowledge Service, 2018

Local data

The Bristol Self-harm Surveillance Register[284] 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.

[282] For Young People, see **9.6.2 Self-harm in Young People**

[283] Source: Hospital Episode Statistics via Secondary User Service, 2016/17

[284] 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 deaths[285] 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.

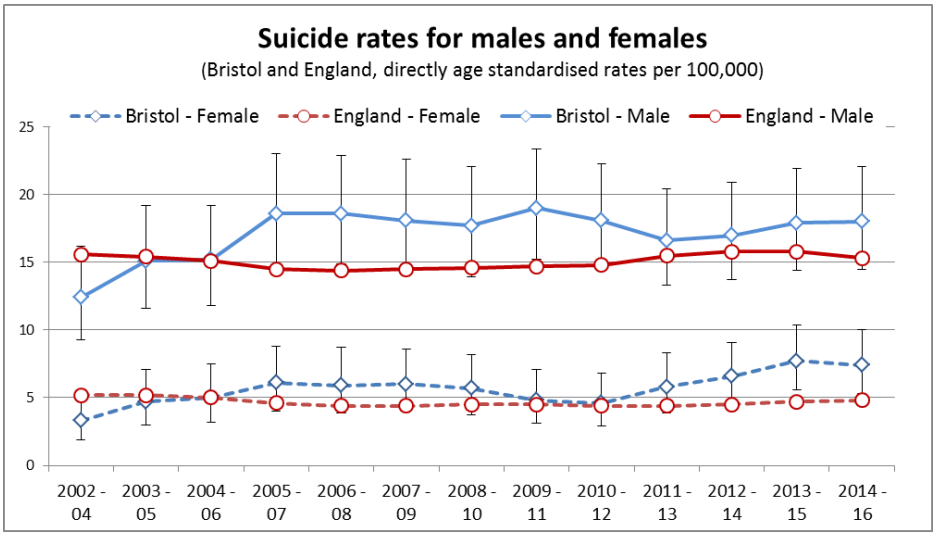


Fig 9.3.1: Suicide rate per 100,000 for males & females (via PHOF, Feb 2018)

Data[286] 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.

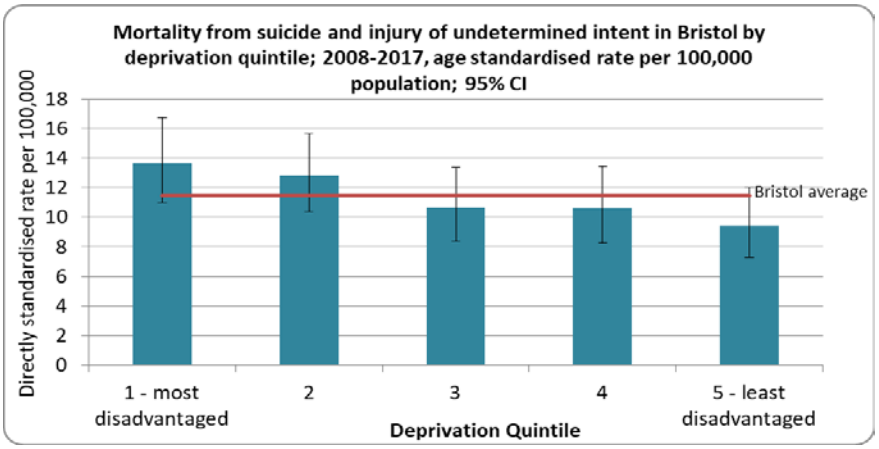


Fig 9.3.2: Bristol suicide rate 2008-2017 by deprivation quintile Source: Primary Care Mortality Database, via Bristol Public Health Knowledge Service

Further data

- "Suicide Prevention Profile" profile: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

[285] Source: ONS via Public Health Outcomes Framework (PHOF), Feb 2018

[286] 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.

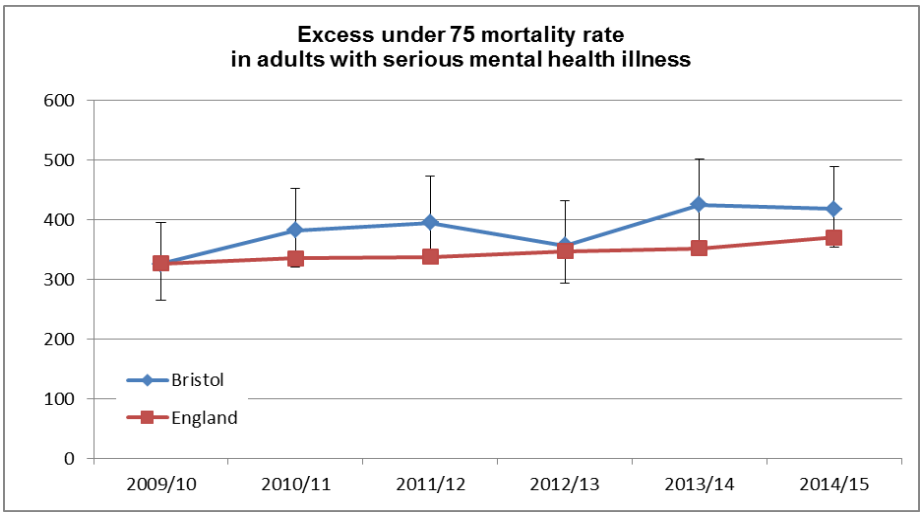


Fig 9.4.1. Source: NHS Digital via PHOF (Aug 2018)

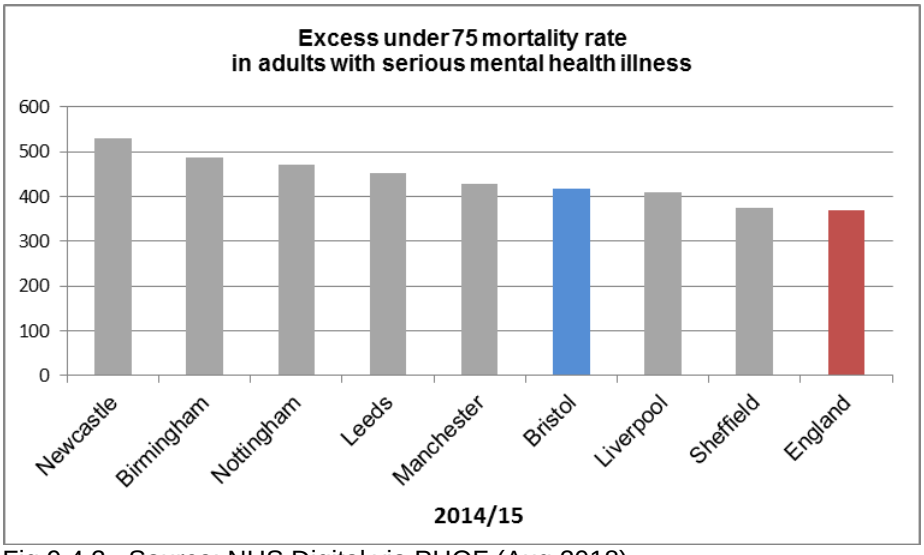


Fig 9.4.2. Source: NHS Digital via PHOF (Aug 2018)

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".[287]

Only 3.5% of people in Bristol reported 'low life satisfaction scores'[288] 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.

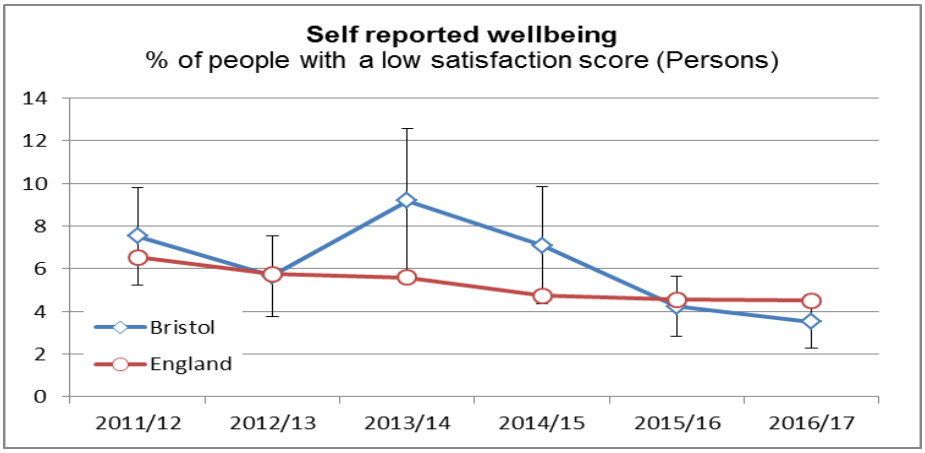
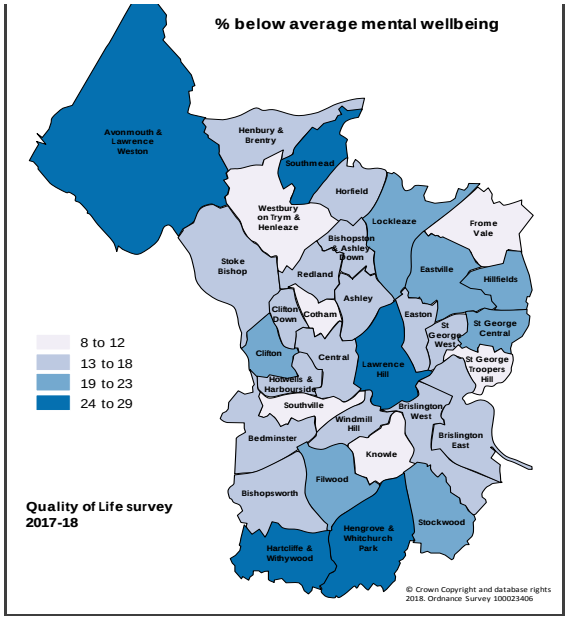


Fig 9.5.1: Respondents with low life satisfaction scores, ONS via PHOF 2018

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 questions[289] 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.

[287] World Health Organisation (2010) *Mental Health: strengthening our response*.

[288] Score of 0-4 out of 10; Source: ONS Annual Population Survey, via PHOF 2018

[289] 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 chapter[290] 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 problem[291].

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?" survey[292] 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 wellbeing[293]. 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 time[294], 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 people[295] 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.

[290] Bristol JSNA Chapter 2017-18: Children and Young People Emotional and Mental Health and Wellbeing
[291] Estimates via JSNA Chapter 2017-18
[292] Source: Public Health England What About YOUth (WAY) survey 2014/15
[293] See Bristol Pupil Voice report 2015-16
[294] ONS Survey; Mental Health of children and young people in Great Britain 2004
[295] 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 disorders[296] - 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 people[297]

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).

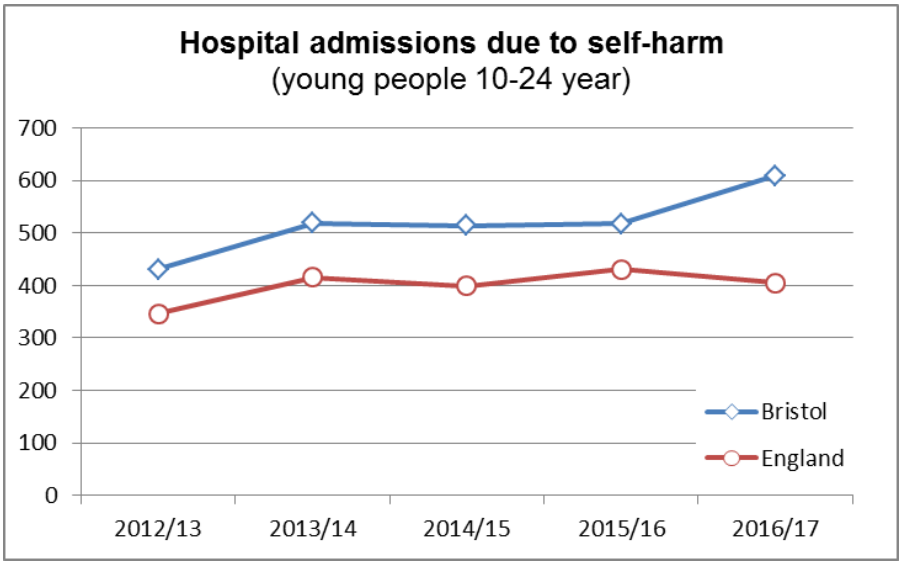


Fig 9.6.3 Hospital admissions due to self-harm (young people 10-24 years) via Children & Young People's Mental Health & Wellbeing Profile (Public Health England)

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)

[296] Source: Adult Psychiatric Morbidity Survey 2014; Prevalence estimates for 16-24 year olds applied to the 2016 population estimates of 16-17 year olds

[297] 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 period[298]. 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 period[299].

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 2009-2014[300] 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.

[298] Royal College of GPs: www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

[299] Estimate via JSNA Chapter 2017-18: Children and Young People Emotional and Mental Health and Wellbeing

[300] 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 points[301]

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 people[302] 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 Bristol[303]
- **Further data:**
  Older People's Health and Wellbeing Profile summary
  https://fingertips.phe.org.uk/profile/older-people-health

[301] These cover all relevant Older People areas from throughout the JSNA sections.

[302] See section **5.2 Income deprivation**

[303] See section **5.16 Social Isolation**

10.1 Dementia

Nationally, it's estimated that 7.1% of people over the age of 65 have dementia[304], which broadly equates to 4,300 people (65+) with dementia in Bristol[305].

3,120 people in Bristol have a diagnosis of dementia recorded by their GP[306]. 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 dementia[307] 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 England[308].

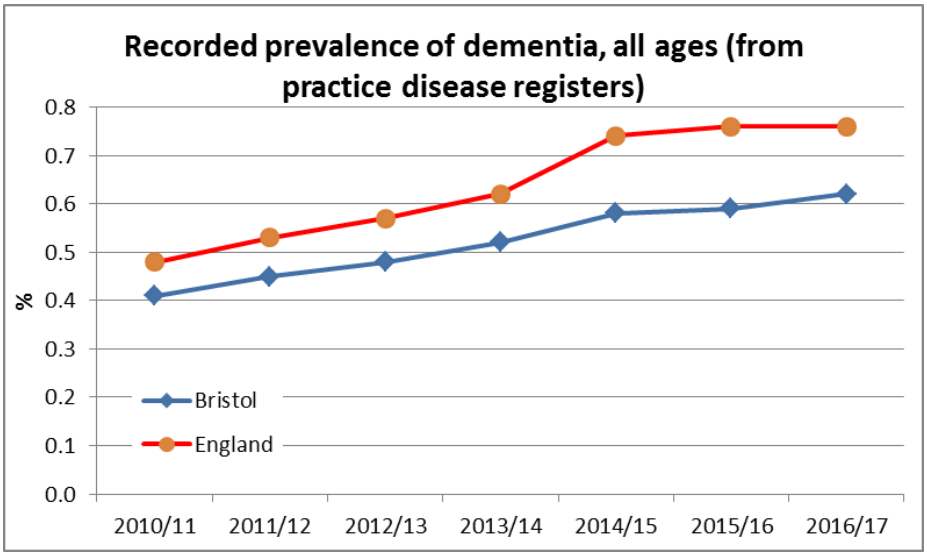


Figure 10.1.1: Recorded prevalence of dementia; QOF via Public Health England Dementia Profile, Apr 2018

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 80[309].

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 dementia[310].

Projections estimate that the number of people aged over 65 in Bristol will increase by 11.3% by 2026, and by 29% by 2036[311]. The number of people with dementia aged over 65 is projected to rise by 13% by 2026, and by 41% by 2036[312]. 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 estimate[313] 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 average[314].

[304] Source: Dementia UK: Update 2nd Edition report by King's College London and the London School of Economics for the Alzheimer's Society (2014)
[305] Estimate for 2018; Source: "Dementia UK: Update Second Edition report (2014)" applied to 2016-based ONS population projections
[306] QOF 2016/17 via Public Health Dementia Profile: http://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia
[307] https://www.nice.org.uk/guidance/cg42
[308] Dementia Atlas using Quality Outcomes Framework (QOF) 2014/15
[309] Source: Dementia UK: Update 2nd Edition report by King's College London and the London School of Economics for the Alzheimer's Society (2014)
[310] www.alzheimersresearchuk.org/about-dementia/helpful-information/reducing-the-risk/
[311] 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.
[312] Prevalence rates from "Dementia UK: Update Second Edition report (2014)" applied to 2016-based ONS population projections; Supplied by BCC Insight, Performance & Intelligence service
[313] 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 people[315]. 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).

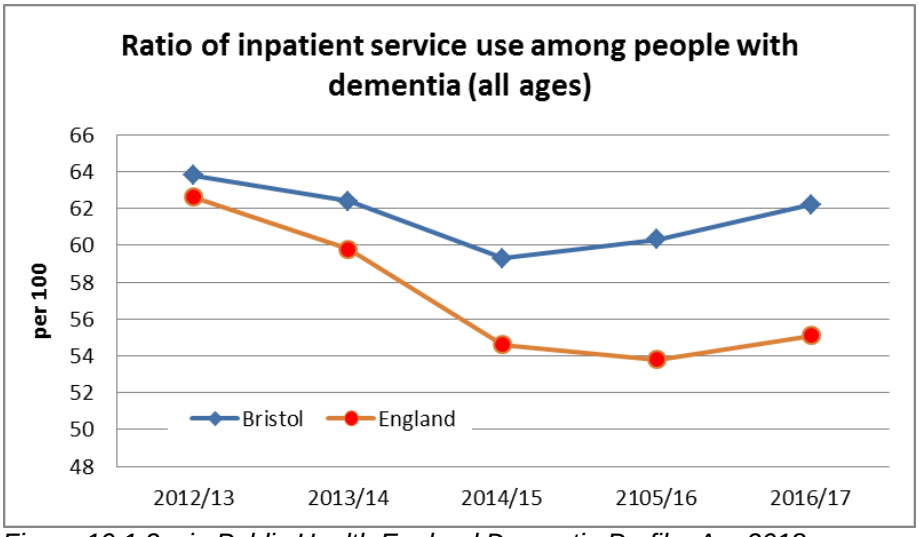


Figure 10.1.2: via Public Health England Dementia Profile, Apr 2018

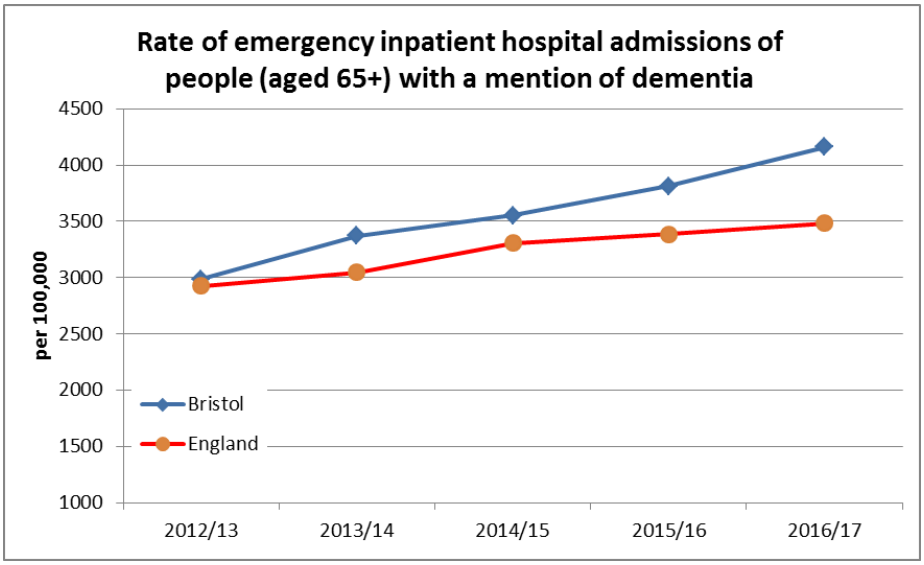


Figure 10.1.3: via Public Health England Dementia Profile, Apr 2018

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/

[314] Source: All-Party Parliamentary Group on Dementia (2013). Dementia does not discriminate. The experience of black, Asian and minority ethnic communities.
[315] 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).

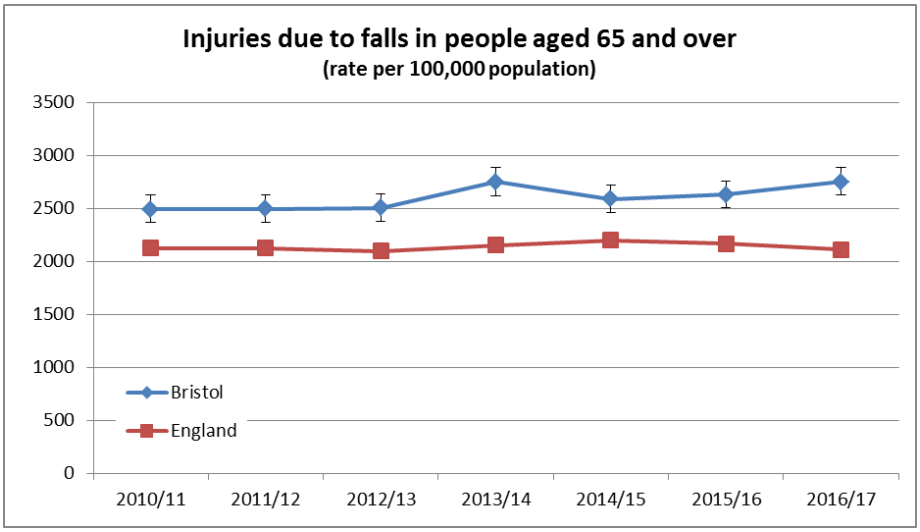


Figure 10.2.1 Hospital admissions from injuries due to falls (65+) via Public Health Outcomes Framework, May 2108

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 & Harbourside (fig 10.2.3).

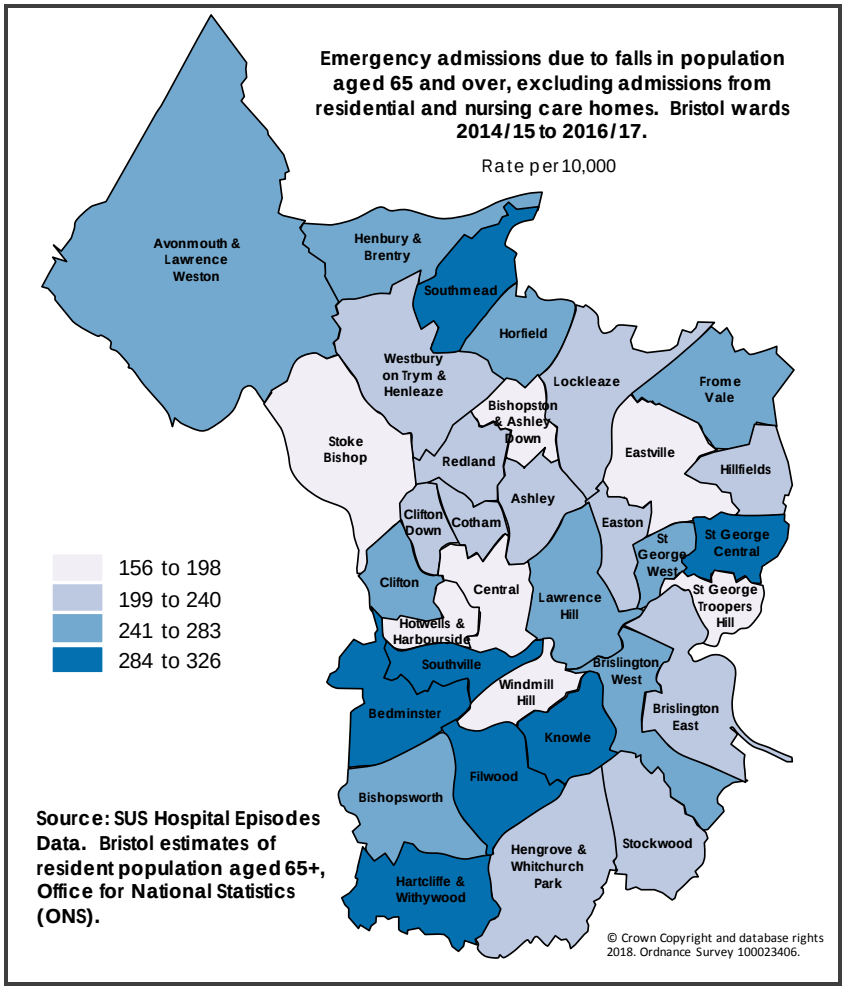


Figure 10.2.3 Source: Bristol Public Health Knowledge Service, 2018

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.

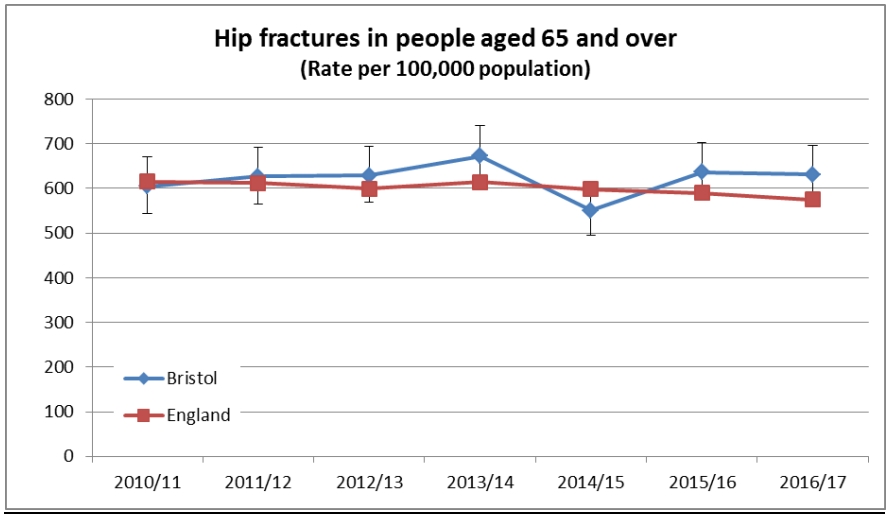


Figure 10.2.4 via Public Health Outcomes Framework, April 2018

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 average[316].

[316] via Public Health Outcomes Framework (PHOF), 2018

10.3 Excess Winter Deaths

The number of excess winter deaths (EWD)[317] depends on the temperature, levels of influenza & other diseases in the population and other factors, such as how well equipped people are to cope with the drop in temperature.

Public Health England reports that 21.5% of EWD are attributable to the coldest 25% of homes and 10% are directly attributable to fuel poverty[318]. Most deaths are due to circulatory and respiratory diseases, and the majority occur amongst people over 75. Seasonal Flu vaccinations[319] 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 months[320].

Mortality during winter increases more in England and Wales compared to countries with colder climates, suggesting that many of these deaths could be prevented[321].

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).

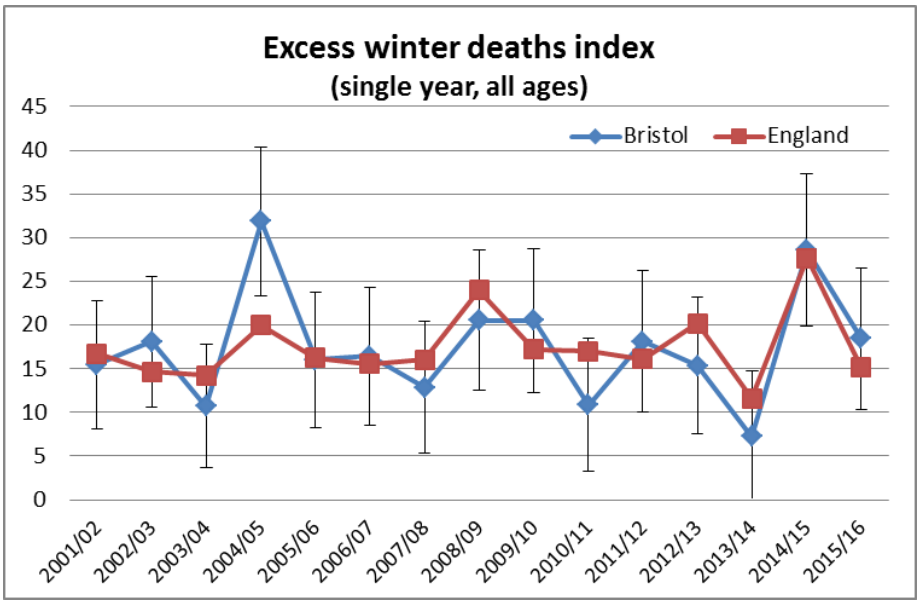


Figure 10.3.1: Excess Winter Deaths index. Source: Public Health Outcomes Framework, Apr 2018

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.

317 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.

318 www.gov.uk/government/uploads/system/uploads/attachment_data/file/355790/Briefing7_Fuel_poverty_health_inequalities.pdf
Also see section 5.13 Fuel Poverty

319 **See section 7.6 Flu Immunisations**

320 www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/excesswintermortalityinenglandandwales/201415provisionalandand201314final#excess-winter-mortality-ewm-by-sex-and-age

321 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 Framework [322] which measures how well care and support services achieve the outcomes that matter most to people.

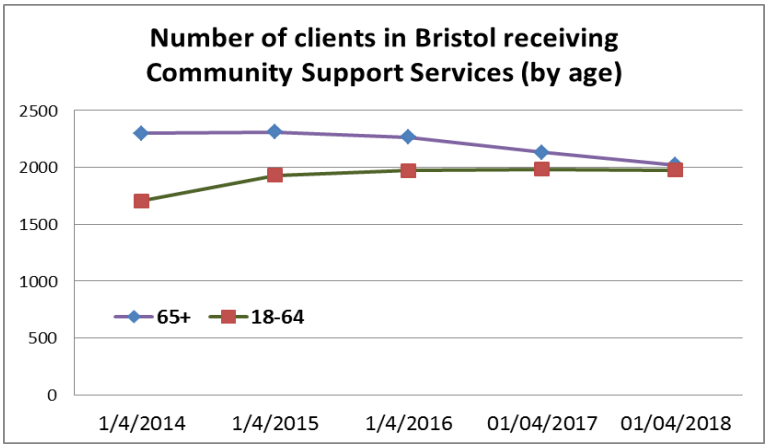
Full information about Bristol's strategic priorities for Adult Social Care is available in the **Market Position Statement**[323]

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 home[324]. 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.

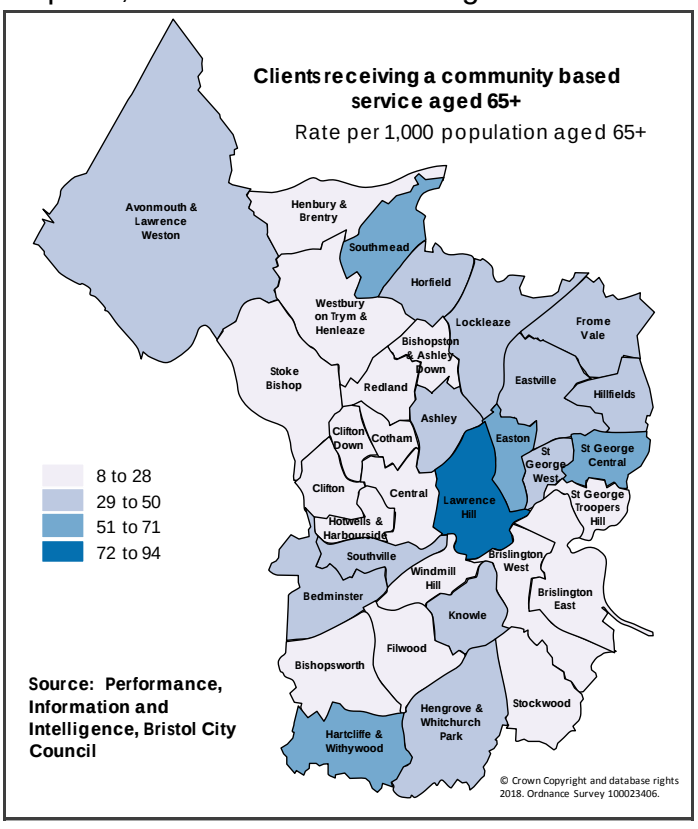


Figure 10.4.1b: 2017/18 rate of CSS clients 65+ by ward; Source: BCC 2018

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".

[322] http://content.digital.nhs.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF
[323] Bristol City Council "Working with us for Better Lives", June 2018
[324] See www.bristol.gov.uk/csscommissioning

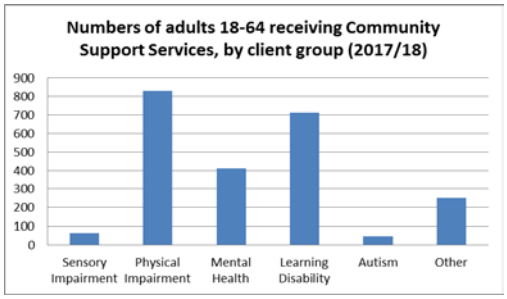


Figure 10.4.1c: CSS clients 18-64 by client group; BCC 2018

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).

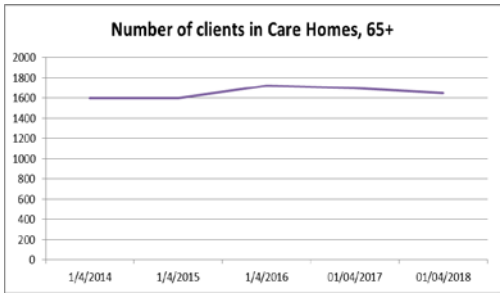


Figure 10.4.2: Care home placements; Source: BCC 2018

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 homecare will stabilise.

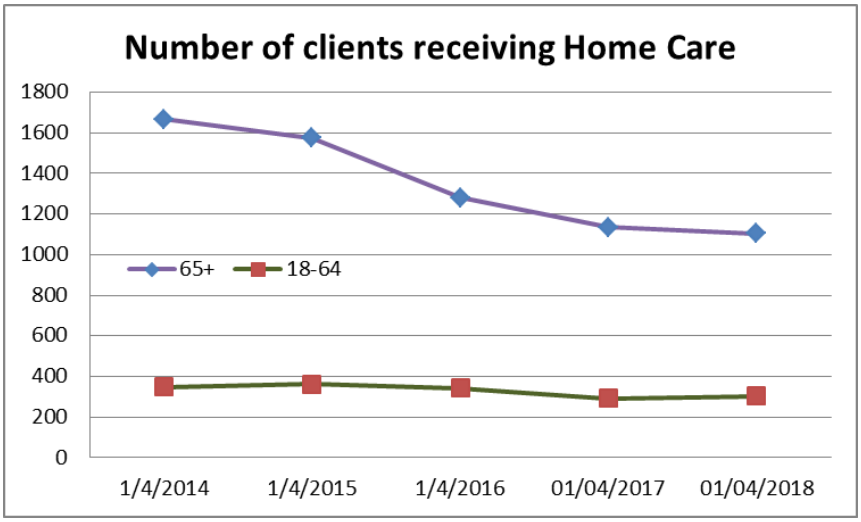


Figure 10.4.3: Home care clients via BCC Insight, Performance & Intelligence Service 2018

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.

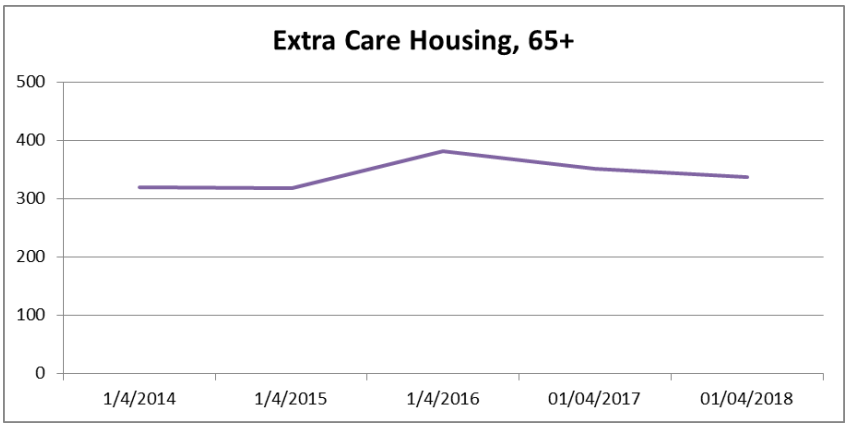


Figure 10.4.4: Extra care housing via BCC Insight, Performance & Intelligence Service 2018

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.

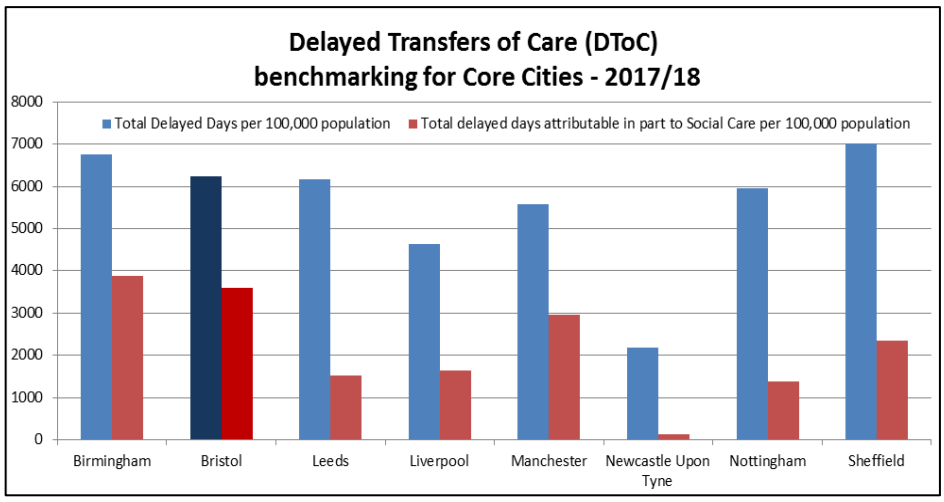


Figure 10.5.1: Core City Delayed Transfers of Care 2017/18 via NHS England

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 people[325].

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%)[326].

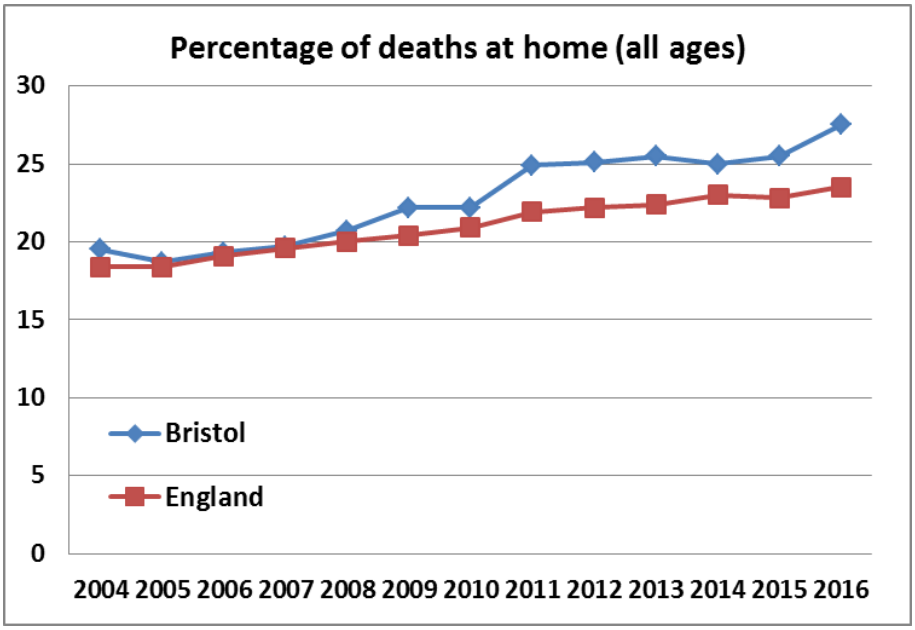


Figure 10.6.1: Percentage of deaths at home, all ages
Source: ONS Mortality File, for National End of Life Care Intelligence, Public Health England, via https://fingertips.phe.org.uk/profile/end-of-life

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

[325] PHE report: Patterns of end of life care in England, 2008 to 2010 (2013)
[326] 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, Healthwatch[327]

- 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

[327] 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/)

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