













South Gloucestershire Joint Strategic Needs Assessment 2013

our area our future

NHS South Gloucestershire

South Gloucestershire Council

Produced on behalf of
South Gloucestershire's Health & Wellbeing Board

Prepared jointly by:

South Gloucestershire Public Health Directorate
South Gloucestershire Clinical Commissioning Group
South Gloucestershire Council Department for Children, Adults & Health

Further copies of this report can be obtained from:

www.ourareaourfuture.org.uk/JSNA

Or telephone Wendy Lawton on 01454 864592

Acknowledgement
We would like to thank all the authors and contributors to this Joint Strategic Needs Assessment (JSNA)

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Introduction to the Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) provides a picture of the current and future health and wellbeing needs of the local population.

The production of a JSNA is a statutory duty which currently rests with local councils and NHS primary care trusts (PCTs) as required by the Local Government and Public Involvement in Health Act (2007). From April 2013, local councils and NHS Clinical Commissioning Groups (CCGs) will have equal and explicit obligations to prepare a JSNA and this duty will be discharged by the Health & Wellbeing Board in accordance with the Health and Social Care Act (2012).

The Health & Wellbeing Board will use the JSNA to agree overarching priorities in order to inform the development of the Joint Health & Wellbeing Strategy (JHWS). The strategy will, in turn, inform local health and social care commissioning plans.

The JSNA:

- is concerned with wider social factors that have an impact on people's health and wellbeing such as housing, poverty and employment
- looks at the health of the population with a focus on behaviours which affect health such as smoking, diet and exercise
- provides a common view of health and care needs for the local community
- identifies health inequalities
- provides evidence of effectiveness for different health and care interventions
- documents current service provision
- identifies gaps in health and care services, documenting unmet needs.

Who is the JSNA for?

The main audience for the JSNA are health and social care commissioners who use it to plan services.

It can also be used as an evidence base for preparing bids and business cases by the voluntary and community sector, to ensure that community needs and views are represented by service providers to assist in the future development of their services, and by the public to scrutinise local health and wellbeing information, plans and commissioning recommendations.

Principles of the new JSNA

Government guidance on the purpose of JSNAs and the method for carrying them out has changed recently in line with the Health and Social Care Bill.[1] The new JSNAs are intended to be more strategic, involve more community engagement and be a more direct precursor of action. There will be a focus on the assessment of 'assets' as well as 'needs', so that gaps can be identified and addressed.

In particular the new JSNA will involve a greater emphasis on:

- the role of the JSNA in the development of the Joint Health & Wellbeing Strategy by the main statutory partners, the local authority, public health, and the Clinical Commissioning Group.
- the importance of not only identifying needs in the community, but also assets. Assets include existing services and community-based assets such as the voluntary sector and other social networks.
- making recommendations for commissioning decisions, including areas with potential for efficiency gains and with potential for decommissioning in the light of the economic downturn and budget constraints.

What does the JSNA look like in South Gloucestershire?

JSNAs are flexible and enable local areas to focus on the priorities and present information in the way most relevant to them.

The JSNA itself is presented in two parts.

1. A series of in-depth topic documents arranged in nine sections, the first three of which describe what is known about people who live in South Gloucestershire and the factors which influence their health and wellbeing, and then a series of needs assessments which follow the life course from birth to death.

   These documents can be regarded as essential background for decision makers and are based on the latest information available. The intention is to bring these documents up to date on a regular basis and refine their content over the years.

   There is so much information that the best way to access them is through the South Gloucestershire Partnership website www.ourareaourfuture.org.uk

   Paper versions will be available on request. Please telephone 01454 862356.

[1] Department of Health, Local Government Improvement and Development Healthy Communities Programme (commissioned by) April 2011 JSNA Toolkit: Joint Strategic Needs Assessment: A Springboard for Action

2. A high-level summary document (see below) which provides a structured way of assimilating the information in the in-depth JSNA documents. It is designed to identify and flag key pieces of information about the health and wellbeing needs of people who live in South Gloucestershire and about local health inequalities for specific population groups.

   It also sets out recommendations from the JSNA authors for commissioners and providers of services and policy makers.

The purpose of the JSNA is to identify local needs to support local strategy development. In order to understand whether we are achieving good health and care outcomes locally, it is useful to benchmark outcomes in South Gloucestershire against those in other areas.

The government has published three outcomes frameworks to support local areas in doing this.

- The Public Health Outcomes Framework http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
- The NHS Outcomes Framework http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_131700
- The Social Care Outcomes Framework http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_131059

Who is involved in producing the JSNA in South Gloucestershire?

Under the Health and Social Care Act 2012, local Health and Wellbeing Boards are responsible for producing the JSNA. Health and Wellbeing Boards will collaborate to understand their local community's needs, agree priorities and encourage organisations involved in health and care to work in a more joined up way.

During 2012/13, whilst local boards are being established they will be in shadow form. They officially come into force from April 2013.

Members of the Shadow South Gloucestershire Health & Wellbeing Board include representatives from local authorities and the NHS in South Gloucestershire, local councillors and other community representatives. The current membership list can be found at www.sglos-pct.nhs.uk

The JSNA steering group has been responsible for overseeing and guiding the development of the JSNA, and it includes representatives from the local authority, CCG, Public Health and the voluntary and community sector.

The JSNA authors' group has been responsible for planning and coordinating the analysis of information and has included representatives from the NHS, council and other local services.

These two groups have helped to ensure that a broad range of different organisations and communities were involved in the JSNA production in South Gloucestershire.

Health and Wellbeing Boards are responsible for the production of the Joint Health and Wellbeing Strategy, which is a strategy to address the needs identified in the JSNA, and set the health and wellbeing priorities of the board accordingly.

The South Gloucestershire Joint Health & Wellbeing Strategy will be published at the end of June 2013.

Foreword to the summary and recommendations

The Joint Strategic Needs Assessment (JSNA) begins with a description of the population and the key characteristics of the area which broadly influence health and wellbeing and is in three sections.

- People in South Gloucestershire
- Major health problems
- The wider determinants of health and wellbeing

There follows a series of needs assessments which cover the life-course.

- Maternal health and the first five years
- School age children and young people
- Working age adults
- Ageing and supporting independence
- Safeguarding vulnerable people
- Communicable disease and health protection

The full picture is set out on the South Gloucestershire Partnership website www.ourareaourfuture.org.uk (and in print on request) and each section and sub-section will be updated on a regular basis.

Further information on these topics can be obtained from the authors (see Appendix 1).

This summary document is designed to provide a snapshot of conditions in South Gloucestershire and is taken from the JSNA as it stands in 2013.

In general, each needs assessment summary contains:

- a description of the topic, including the scale and scope of the issue as it affects people in South Gloucestershire, together with the assets and facilities available to meet their needs
- a list of key issues for now and the future
- a list of recommendations for commissioners, providers of services and policy makers.

Included in places throughout this document, there are references to the in-depth JSNA topic documents where further details may be found. When this high-level document is read online, these references will take the reader directly to the relevant sections.

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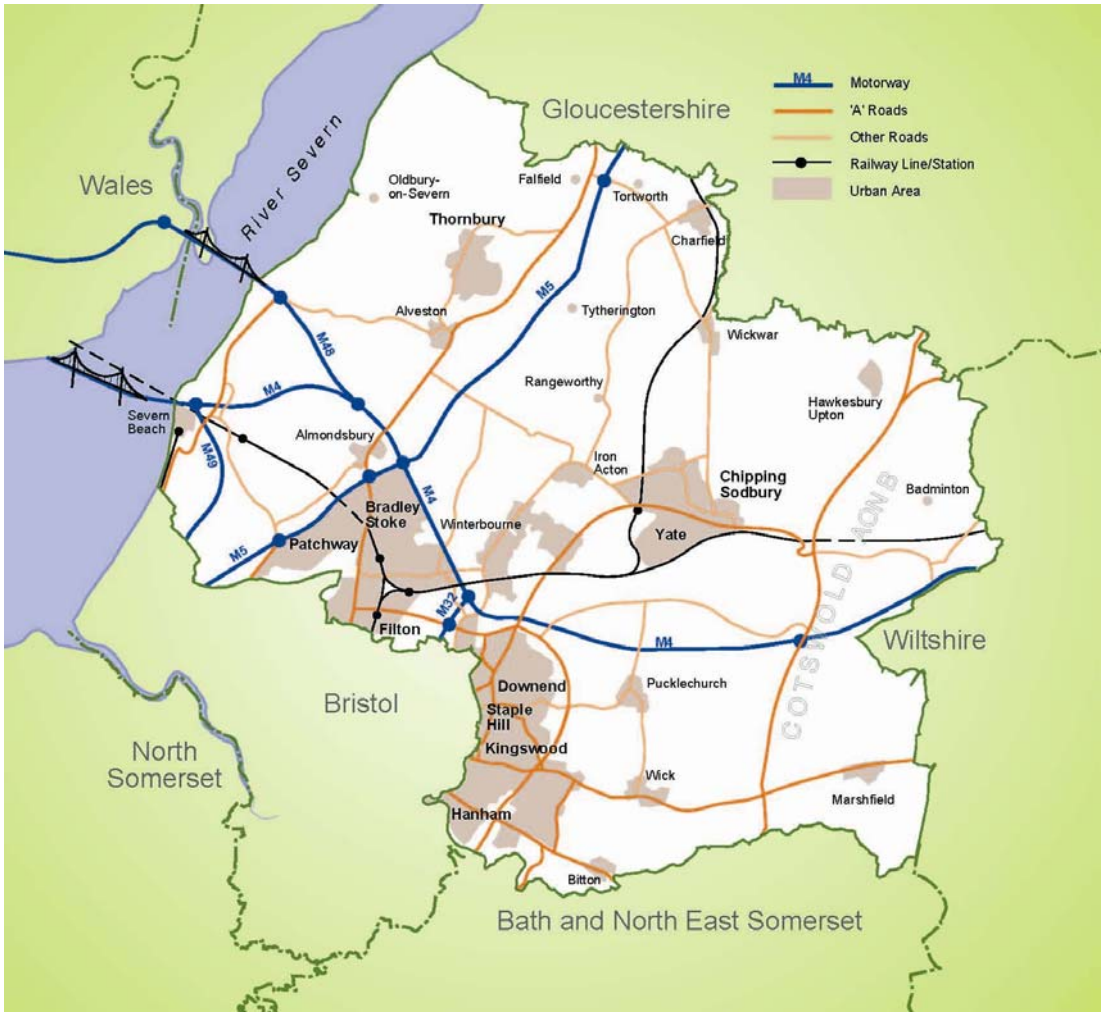
Section 1: People in South Gloucestershire

Who lives in South Gloucestershire?

The 263,400 people in South Gloucestershire (Census 2011)[2] live in urban areas surrounding the city of Bristol (around 60%), in small towns to the north and in the rural areas in between.

South Gloucestershire



Public services are largely administered, or provided, by South Gloucestershire Unitary Authority (the Council), NHS commissioners serving the same area, 29 general practices, community health services and North Bristol Hospitals NHS Trust. In addition, there is a wide range of commercial care services and voluntary organisations.

[2] Please note that the latest census data has only recently been published, so many statistics are based on estimates made in 2010. Where the latest census data is used, this is stated in the text.

The age profile of South Gloucestershire's population is broadly consistent with the national average, although the population age structure varies considerably across the district. For example, in Alveston parish around 30% of the population is aged 65 or above compared to Bradley Stoke, where around five per cent of the population is within the same age bracket.

According to the latest Office of National Statistics (ONS) figures from the 2011 census, 5.7% of South Gloucestershire's population is estimated to be of Black and minority ethnic (BME) origin – which is around half the national average (see section 1.4).

South Gloucestershire is host to the University of the West of England which has some 35,000 students, most of whom live in the area during term time.

In South Gloucestershire, 10.5% of people (27,639) provide one hour or more of unpaid care per week compared to the England average of 10.2% (2011 Census).

People in South Gloucestershire are relatively affluent compared with the national average. Only about ten per cent of local authorities in England are better off than South Gloucestershire when measured by the Index of Multiple Deprivation – a well recognised scale of social and economic standing.

Few people live in areas ranked as the most deprived in the country, but within South Gloucestershire itself, there are marked differences – the most deprived areas include Staple Hill, Kingswood, Patchway, Filton, Cadbury Heath and Yate (see sections 1.5 and 1.6). Because of the important link between deprivation and health and indeed, other aspects of life experience and opportunity, these areas are regarded as 'Priority Neighbourhoods' for attention throughout the JSNA.

In addition, child poverty has a major impact on health and wellbeing both in childhood and in later life. In South Gloucestershire, about one in nine children and young people live in poverty (defined as household income less than half the national average).

How might this change?

The population will grow – to an estimated 283,700 by 2018 and 313,600 by 2035. This is largely the result of births exceeding deaths and to a lesser extent, net inward migration. Recent trends have favoured immigrants from the Indian sub-continent and Eastern Europe but it is not clear whether these trends will continue.

The population will become older up to 2035 as life expectancy increases and people from the post-war 'baby boom' age. This is shown in Table 1 and graphically in Figure 1 as a 'population pyramid' – with the predicted number of males and females in each age group both now (in solid colours) and in 2035 (in open colours).

This will have a profound effect on services in the near and the long term for two reasons. Firstly, people of 85 years and over are in need of health and care services to a much greater extent than those in younger age groups. In South Gloucestershire as a whole, their numbers will nearly triple from an estimated 5,400 in 2010 to 15,300 in 2035.

The second issue concerns the balance between older and younger people. In 2010, the so-called 'dependency ratio' of people aged 0-15 years and 65 years and over, as a percentage of people of working age 16-64 years, was 54%; in 2035 it will be nearly 68%. In 2010, there was an estimated four working age people to every person over 85 years; this is expected to fall to three by 2035.

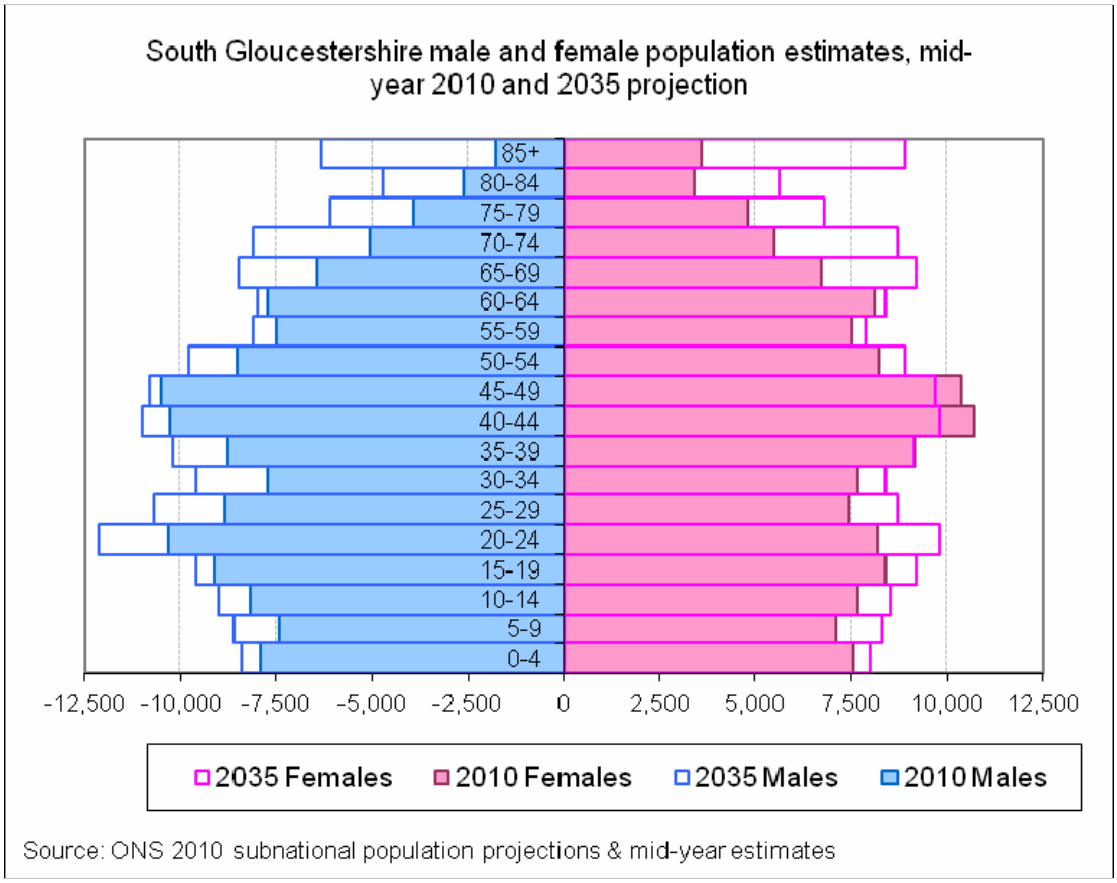
In particular, the numbers of family members in the middle age groups – traditionally those who provide much informal care to elderly relatives – will fall during this time, at the same time as the number of people in very old age rises.

Table 1: Population projections for key age groups, South Gloucestershire 2013, 2018 and 2035 (ONS 2010 estimates)

Age group					Percentage growth from 2013 (%)	
	2013	**2018**	**2035**		**2018**	**2035**
0-4	16,300	17,000	16,400		4.29	0.61
5-19	47,400	48,200	53,200		1.69	12.24
20-64	161,200	165,100	171,000		2.42	6.08
65+	48,200	53,400	72,900		10.79	51.24
85+	6,000	7,600	15,200		26.67	153.33
All ages	273,100	283,700	313,600		3.88	14.83

Source: ONS 2010 estimates

Figure 1: 'Population pyramid' for 2010 and 2035



There has been a small but significant rising trend in births in the last ten years or so that is predicted to continue until around 2018-2020. This will raise demand for pre-school and school places which, until recently, have been in decline.

It is important to understand that these official ONS population projections are based on recent local trends in fertility, mortality and migration. This means that the level of new housing development proposed in South Gloucestershire's Core Strategy (around 28,300 new homes over the period 2006-27) is not factored into these official projections.

In reality, therefore, the level of future population growth in the area is likely to be much higher.

These effects will be felt more in some areas of South Gloucestershire than others, but it is not clear whether neighbourhoods will retain the same age and social make-up as they have at present (see sections 1.2 and 1.3)

Section 2: Major health problems

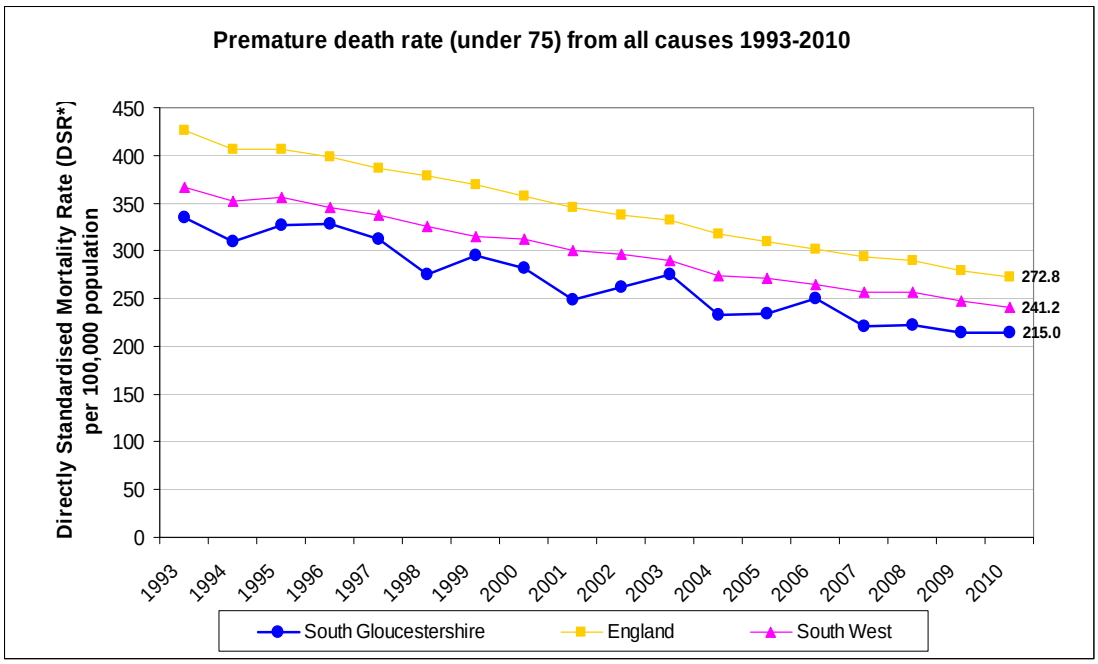
Life and death

Life expectancy is a good indicator of trends in the overall health of a community. It has shown a continuous improvement for the last 20 years, both nationally and in South Gloucestershire, where it has remained consistently about two years higher than England and Wales for men (in 2008-10, it was 80.6 years) and 1.6 years higher for women (it was 84.2 years during this same period).

Mortality among people aged 75 years or younger (so-called 'premature deaths') is a good indicator of ill health caused by conditions which can be prevented, either by people improving their lifestyle, or by receiving the right care and treatment which delays the onset of serious illness.

This death rate has also improved – down by 36% in the last 20 years and it is better than the national rate (see Figure 2).

Figure 2: Premature death rate from all causes 1993 – 2010. England, South West Health Region and South Gloucestershire



Source: NHS Information Centre Indicator Portal - https://indicators.ic.nhs.uk/webview/

* Directly Standardised Mortality Rate (DSR): Age standardisation is a technique used to better allow populations to be compared when the age profiles of the populations are different. It applies the number of deaths in any given area to a standard population structure and enables different areas with different age profiles to be directly compared against each other. It also enables the comparison of rates over time.

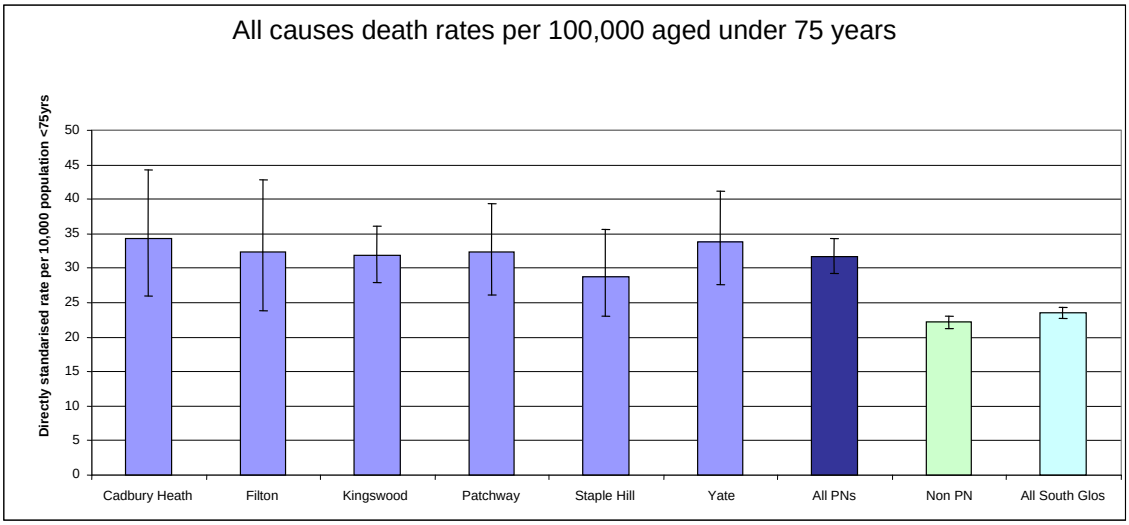
Inequalities of health

However, comparing premature mortality rates in localities in South Gloucestershire, the Priority Neighbourhoods are worse off than the non-Priority Neighbourhoods and this indicates a substantially greater burden of ill health among people living in these parts of South Gloucestershire (see Figure 3 and section 2.1).

This mirroring of poorer health and greater deprivation among communities in South Gloucestershire can be seen throughout the life course and is illustrated in many of the JSNA sections. For example, among people living in households or communities identified as deprived in terms of material assets, or lifetime achievements, there is greater:

- low birth weight and later poorer outcome in infancy (section 2.2)
- injury (section 4.2), obesity and poorer oral health (sections 5.1 and 4.2), substance misuse (section 5.2.1), tobacco use (section 5.2.2) and teenage pregnancy (sections 5.2.3 and 6.1.4) – all leading to adverse health outcomes – in childhood and teenage
- obesity, smoking and substance abuse (sections 6.1.1, 6.1.2 and 6.1.3), diabetes (section 6.2.5.1), respiratory disease (section 6.2.5.2), poorer mental health outcomes (section 6.2.4) and cardiac and cancer mortality (sections 2.2 and 6.2.6) in adulthood and old age
- physical and mental impairment and disability (sections 6.2.1, 6.2.2, 6.2.3 and 6.2.4) although the emergence of ill health of any kind may itself lead to much poorer life chances.

Figure 3: Premature death rate from all causes, pooled data 2005-2009. South Gloucestershire as a whole, the 'Priority Neighbourhoods' (defined by population deprivation indices) and non-Priority Neighbourhoods.



Source: National Centre for Health Outcomes Development

Cancer and cardiovascular disease

The two main causes of death in South Gloucestershire are cancer and cardiovascular disease (see section 2.2). However, death rates from cardiovascular disease have fallen dramatically in the last forty years in both men and women and to a lesser extent in the last twenty years from cancer.

Cancer is now the main cause of premature deaths in South Gloucestershire but shows a different pattern among men and women.

For men, lung cancer is the leading cause of death from cancer but is falling steadily and indeed the incidence of new cases has fallen sharply in recent years in line with falling rates of smoking.

In the UK as a whole, deaths from prostate cancer have fallen recently but the incidence of new cases has risen considerably. This seems to be because more cases are being identified and the similar pattern seen for bowel cancer may have a similar explanation.

For women, whilst the lung cancer death rate is lower than among men, it is still the leading cause of death but, unlike for men, both death rates and incidence are rising. This probably indicates the increase in smoking among women which started twenty years ago – it is falling now but not among young women aged 16-24 years.

There has been a striking reduction in deaths from breast cancer as more cases are identified through the screening programme and treatment outcomes have improved.

Ill health among older people

The most important factor for predicting ill health is increasing age and as the proportion of older people in the population rises, so too will the burden of illness in South Gloucestershire.

Key conditions for older people are cancer, cardiovascular disease, diabetes, respiratory conditions and dementia (see section 2.3).

Diabetes is an important condition because it is a major cause of cardiovascular disease and because it is becoming more common as more people in South Gloucestershire and the rest of the UK become overweight and obese. Nearly five per cent of the population have the disease now with the highest proportion among older people.

Premature death from chest diseases is becoming less common in the population as a whole as smoking declines, but they are still a major cause of death and illness among older people in South Gloucestershire.

Dementia (a group of progressive and incurable diseases largely confined to older people, but also affecting younger age groups, with a major impact on both individuals and their families) leads to loss of intellectual function and severe disability which place great strain on carers.

Estimates for South Gloucestershire indicate that there are over 3,000 people with dementia now and this is set to rise to an estimated 3,454 in 2015, 4,053 in 2020 and 5,583 in 2030 – an increase of 62% in 15 years.

Accidents

Deaths and serious injury from accidents have been falling for some time but remain a substantial cause of preventable ill health.

Few deaths occur in childhood and the majority happen in the working age groups, but between 2008 and 2010, about one third of the total were among people aged over 75 years.

In 2010, 86 people were killed or seriously injured on South Gloucestershire roads, nearly a quarter of them, pedestrians.

Suicide

The rate of 'completed' suicide in South Gloucestershire has remained stable for many years at around five per 100,000 people.

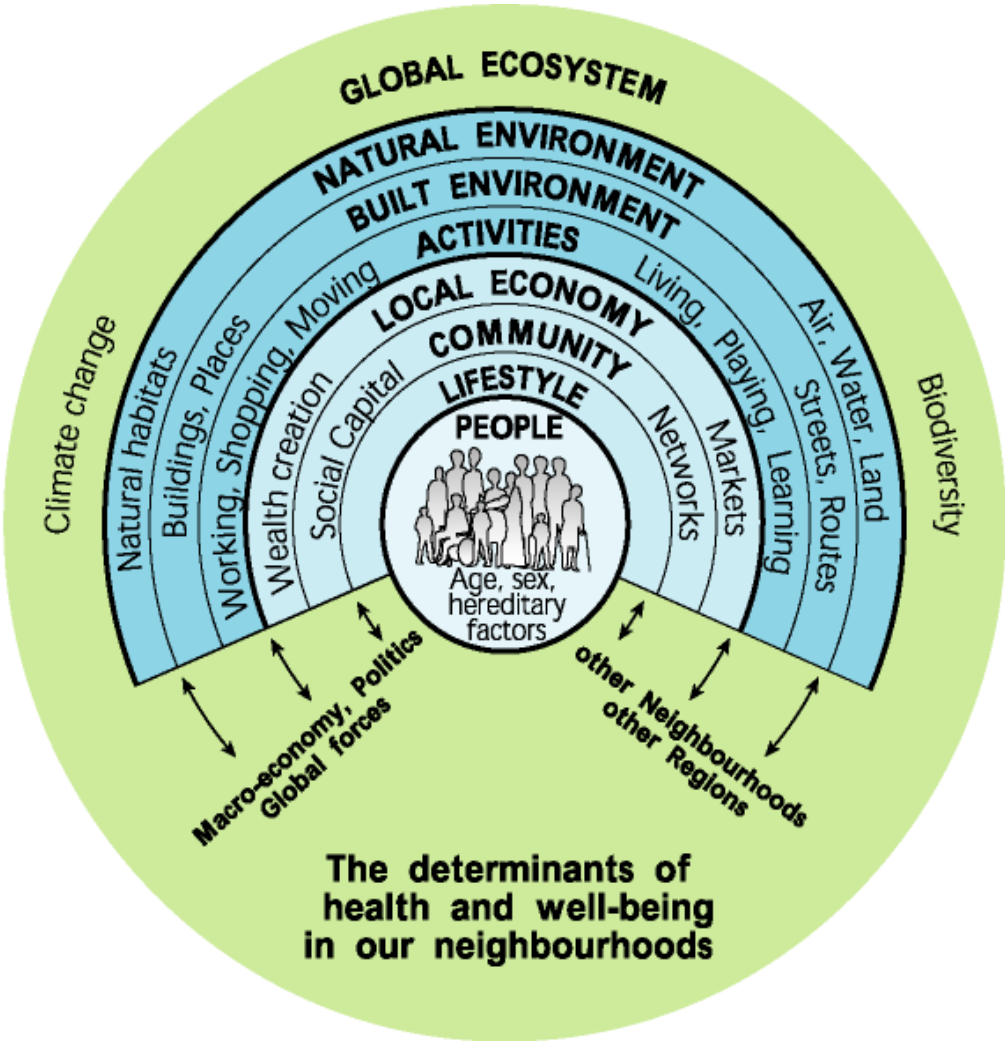
Rates are higher for men compared with women and have risen in the age groups 15-44 years in the last 30 years; rates among women have fallen in all age groups.

Section 3: Wider determinants of health and wellbeing

The 'causes of the causes'

The social determinants of health have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. The JSNA aims to map these wider determinants of health and wellbeing within South Gloucestershire and examine their influence and their capacity to improve health.

Figure 4: Determinants of health



Source: Barton H. and Grant M. 2006 'A health map for the local human habitat' in Journal of the Royal Society for the Promotion of Health Vol 126 (6) pp252-253. ISSN 1466-4240

Diversity and equality in South Gloucestershire

It is important that the JSNA reflects the needs of different groups of people living in the community and wherever their health experience is known to be different from that of the general population, an assessment has been made in each of the detailed JSNA sections. People can be considered in this way in terms of, for example, race, disability, gender, age, marital status, religion and sexual orientation. Some of these health differences between people arise from innate characteristics but some undoubtedly reflect problems and difficulties in the way people access and are provided with services (see section 3.2). Some general issues include the following.

- **Race:** several disease entities have a higher prevalence amongst different ethnic groups, for example compared with the general population, men of South Asian origin are more likely to die prematurely from cardiovascular disease; stroke is more common among South Asian and African Caribbean men; young Black men are more likely to be treated compulsorily for mental illness, and infant mortality is higher for children born to mothers from Pakistan. Whilst some of these characteristics are likely to reflect genetic differences, a recent LINk report has pointed to cultural misunderstandings by both the several ethnic groups and service providers.
- **Disability:** limitation in activities of daily living (a form of words used in the decennial census) is reported by nearly 15% of the population in South Gloucestershire – a lower rate than is found in England and Wales. Again, there are health consequences connected to the disability itself and issues with the way disabled people negotiate their use of services. For example, compared with the general population, people with a learning difficulty have a shorter life expectancy, a higher prevalence of psychiatric problems and some riskier lifestyle behaviours which are difficult for service providers to address.
- **Gender:** there are many obvious differences in health experience between men and women. Some that are less clear include the higher prevalence of anxiety and depression among women and the higher rates of suicide and harmful addiction amongst men. Women are much more likely to seek help for health problems than men.
- **Age:** as a general rule ill health is more common as people age and some disorders, such as dementia, are largely confined to older people. Health and use of services by older and younger people are explored in detail in the relevant sections of the JSNA.
- **Faith and religion:** religious views can have a powerful effect on promoting health with evidence to suggest better outcomes of hospital care. Religious faith can influence cultural practice which determines access to health services and the way they are used.
- **Sexual orientation and gender orientation:** lesbian, gay, bisexual and transgender people constitute an estimated five to seven per cent of the population. There is ample evidence that they experience prejudice and difficulties in accessing health and care services.

The local economy

Employment and the economy

The employment rate in South Gloucestershire (the percentage of economically active working age population) is 76.4%. This represents a reduction on the rate in 2004-05 (83%), but the employment rate in South Gloucestershire remains higher than both the West of England and national averages (72.5% and 70.3% respectively).

As a consequence of the economic downturn, the unemployment rate in South Gloucestershire has risen in recent years and currently stands at 5.9% (2011/2012). However, this rate remains below both the sub-regional and national averages (7.6% and 8.1% respectively).

The number of jobs available in South Gloucestershire has grown in recent years, despite the recession, and there are more jobs at present than the estimated number of economically active residents. Industry and services north of Bristol are key employers and this will be enhanced as Filton Airfield closes and the Council's Core Strategy for development there is implemented. There is potential on this site – one of three Enterprise Areas in South Gloucestershire – to generate more than 3,700 jobs which will more than offset job losses at the airfield (see section 3.4.1).

Public finances

Plans over the short and medium term (2013 – 2016 and 2015 - 2020) are severely affected by the national outlook for public spending. Over the next few years, both NHS and local authority commissioners must find efficiency savings of up to 25% of their budgets – albeit in the case of the NHS with no real terms reductions in its income.

Some, or all, of these savings will be reinvested in hard-pressed services to enable the public sector to cope with widely anticipated demand – for care for a growing and ageing population and for improvements in the quality of services (see section 3.4.2).

At the same time, the NHS is going through a major reorganisation (see section 3.3.2). By 2013/14, most commissioning decisions in South Gloucestershire will be in the hands of Clinical Commissioning Groups supported by an infrastructure which covers the Avon and Somerset area. The council will have new responsibilities for public health.

The total revenue available to the NHS in South Gloucestershire in 2012/13 is £388 million and includes nearly £10 million to cover previous deficits. Plans to eliminate this deficit depend on making changes to the structure of health services across the former Avon area.

The key financial risks for the NHS over the next three years include:

- **hospital and specialist care** – the required savings can be found if demand is reduced, either by diverting patients to another part of the NHS, or elsewhere; experience has shown this to be problematic so plans do not make any assumptions of this kind. Savings in this sector will therefore have to come from greater productivity and efficiency.
- **long term care for vulnerable people** – the present budget does not provide for any further expenditure in this area. This presents a financial risk which will need to be mitigated through the continued achievement of efficiency savings.
- **primary care** – whilst South Gloucestershire has amongst the lowest levels of GP prescribing in the country, the predicted growth in prescribing still outweighs the funding that will be available. This represents a financial challenge as it is volatile to changes in volume and cost growth.

Local services

Education

Research evidence strongly supports the relationship between health and education in both directions – that good health is linked to good educational outcomes and a better educated community has better health over an individual's lifetime and indeed in subsequent generations.

At any one time, South Gloucestershire schools educate more than 40,000 children and young people. The number of primary school children is projected to grow steadily from now until 2033; secondary school numbers will fall until 2016 and then rise.

Educational outcomes for earlier school-age Key Stages are good, though not so good for later stages compared to national levels. For South Gloucestershire children at Key Stage 4 (related to GCSE results), attainment is significantly worse among pupils living in deprived circumstances such as those found in the Priority Neighbourhoods (see section 3.5.1).

Recommendations for consideration by commissioners

- Considering the evidence that education and health are so inextricably linked, it is vital that attainment gaps are closed (or at the very least narrowed) in South Gloucestershire.
- At the same time, attainment levels for all pupils need to rise if young people are to have the best chance of growing up as healthy adults and, therefore, have the best chance of maximising available opportunities.
- Improving maternal and childhood health and wellbeing will also maximise children's chances of achieving their potential.
- Increasing service capacity will be necessary to meet rising numbers of primary school-age children and in the medium term rising secondary school rolls.

Access and other issues for people in rural communities

About 20% of the people in South Gloucestershire live in rural areas – small villages and the countryside in between. Comparing rural with non-rural places in South Gloucestershire, it seems that health in general is better, but because rural areas are relatively sparsely populated, these indicators can mask pockets of deprivation related to poverty (as employment in agricultural industries fall) and poor access to services and jobs (see section 3.5.2).

Indirect indicators of 'barriers to housing and services' and other housing related indicators show that large parts of South Gloucestershire rank among the worst off 20% of small areas in the country.

Around half of people in South Gloucestershire can access health care in under half an hour and over 98% of rural dwellers have access to a car.

The environment

The quality of our surroundings has a major impact on health and wellbeing both directly, as with pollution, and indirectly in terms of the way the look and feel of a place can influence our state of mind and behaviour. The issues considered here concern air quality, noise, land contamination, transport, housing, energy use and climate change (see sections 3.6.1 and 3.7).

Air quality

Air pollution is a potent contributor to several respiratory diseases, cardiovascular disease and cancer and its impact is directly related to the amount of pollution present. The principle pollutants are monitored at a large number of locations in South Gloucestershire and since road transport is the main source of air pollution, this shows high levels along major roads.

For nitrogen dioxide, main roads in Kingswood and Staple Hill exceed national standards and an Air Quality Action Plan is being implemented which focuses on transport measures.

A national standard for small particulates in the atmosphere will be introduced in 2013. Increasing levels of these pollutants are implicated in increasing levels of several respiratory diseases, especially asthma and chronic obstructive pulmonary disease.

Noise

Ambient noise can severely affect people's wellbeing. The extent of this is unknown but, as an indicator, the council dealt with over 1,000 complaints in 2011.

Better mapping of environmental noise is under way in the Bristol area (including parts of South Gloucestershire) and when in place should allow better control measures through the planning process.

Contaminated land

This generally is part of the legacy of previous industrial development. Local authorities are required to identify contaminated sites and lead a process for planning remedial action and assigning responsibility for carrying this out.

Key priorities for the council's Environmental Protection Team include:

- continued monitoring of local air pollution and, in particular, respond to any new central requirements regarding $PM_{2.5}$
- implementation of the Air Quality Action Plan will require active support from the public, stakeholders and businesses to be effective
- continue to implement our risk-based strategy to deal with potentially contaminated land sites that have been identified as posing potentially high risk to human health, or eco-systems
- reduce incidents of noise nuisance across the district
- maintain capacity for preventative work by environmental health staff
- work closely with partner agencies to tackle envirocrime and antisocial behaviour.

Transport and health

The link between transport and health relates to the direct effect of pollution caused by road, rail, air and sea traffic, the heavy reliance on car transport, which makes for a sedentary existence (with risks to health), the danger of injury through the use of transport systems, the use of cycling and walking as a form of exercise (with benefits to health) and benefits to people's way of life which results from greater connectedness (see section 3.6.2).

South Gloucestershire is part of the West of England Joint Local Transport Plan which aims to integrate transport developments (including local rapid transit schemes) and share good practice. Part of this is an Active Health Strategy and in South Gloucestershire there are initiatives to encourage walking to school and cycle safety.

Housing

Housing conditions are a key contributor to health and wellbeing and effects range from the direct impact of a damp house on people with respiratory problems to the sense of wellbeing and solidarity with neighbours which comes from a well ordered neighbourhood. The Private Housing Stock Condition Survey from 2011 provides an important insight into housing conditions and health (see section 3.6.3).

In South Gloucestershire, 90% of houses are in private ownership (82% nationally) with 77% of these householders being owner-occupiers. Nearly 30% of private households are in receipt of income or disability related benefits; 30% include a resident aged over 65 years and 16% include a resident with a disability.

More than one in five private homes do not meet the 'Decent Homes Standard' – they contain significant hazards (most of which relate to excessive cold, or potential for residents to fall), are in a state of disrepair, or do not have modern comforts.

More than 20% of residents reported a long term ill health condition in the household – some 19,590 dwellings – of whom two per cent felt their housing contributed to their problem. Small as this proportion is, this represents an estimated 400 homes in South Gloucestershire and many also report significant hazards.

Fuel poverty – where more than ten per cent of net income is spent on heating, lighting etc – affects 11% of households. Of these, 87% include a resident aged 65 years or more.

Cold in the winter months is a particular hazard for older people and is highly likely to contribute to the regularly observed excess of deaths amongst older people during winter, compared with the rest of the year. The extent of this varies from year to year – in 2006 to 2009 this excess was 16.4% and in 2007 to 2010 it was 17.5% in South Gloucestershire, but lower in both periods than the national average.

Homelessness

Homelessness is a condition which goes beyond having nowhere to live and sleeping rough. As a state of living, it includes people who have no legal right to be where they are, or who live in unsuitable or harmful conditions. On this basis, South Gloucestershire Council accepted a statutory duty to accommodate 155 people in 2011/12 (see section 3.6.4).

The main reasons for homelessness include a person who can no longer continue to live in the family home, sudden loss of private accommodation, and the breakdown of a relationship. Three quarters of homeless individuals had dependant children (180 children were involved), nearly 20% were single people or vulnerable because of health or disability and a small number were also aged 16-17 years.

As well as those in urgent need, 1,787 people approached South Gloucestershire's advice service in varying degrees of risk.

Climate change

It is clear that changes in global temperatures are already altering weather patterns with an accompanying rise in sea level and extreme weather conditions. This will affect the UK with flood and drought expected to be more commonplace in the next 30-40 years (see section 3.7).

The impact of these changes on health and wellbeing can arise from direct exposure to extreme weather resulting in injury from trauma, or heat and cold, or inundation. Indirect exposures to a contaminated environment (for example, involving air and water and changes to the ecosystem leading to vector borne disease) may well lead to more damage. And disruption to social and economic conditions will have a huge impact on service provision.

Two strategies are being pursued both locally and on a global stage – that of prevention by lowering the output of human actions which lead to climate change, and of adaptation to the inevitable effects of climate change. Public sector services all have plans to reduce their greenhouse gas emissions and given the scale of activities in, for example, the health service, this may have profound effect over the years.

Work is already in hand in South Gloucestershire to adapt to a range of possible future effects of climate change on health. For example, there are plans for dealing with a heat wave, with flooding and with service provision in cold weather.

Capacity in the community for improving health and wellbeing

The population has at its disposal a considerable range of assets which work to improve the health and wellbeing of people in South Gloucestershire. Three areas, in particular, are examined in detail in the JSNA:

- people working together as communities for themselves, as volunteers providing services for those in need and as concerned citizens helping to plan more formal provision
- the local authority with its democratic mandate, commissioning and providing services to promote health and to support those disabled by ill health

- the Health Service which also commissions and provides services aimed at reducing the burden of ill health through effective and timely treatment.

The capacity of these three enterprises must change from time to time as the needs of the population change and most sections of the JSNA reflect this.

Below is a short summary of the way this is being addressed in South Gloucestershire.

People and networks

Community capacity is:

> *'..the combined influence of a community's commitment, resources, and skills that can be deployed to build on community strengths and address community problems.'*

The voluntary and community sector (VCS) - volunteers, community buildings, social networks, families, schools - and the participation, inclusion, engagement and empowerment of local people are all factors in community capacity. Building community capacity is important because the factors listed above are fundamental to health, wellbeing, and independence (see section 3.3).

- **Social networks:** a person's social network includes friends, family, neighbours and work colleagues and is key to maintaining wellbeing and health. Equally, social networks play an important part in monitoring and caring for people in need. There are around 150 voluntary sector organisations in South Gloucestershire which provide social support and activities for residents.
- **The voluntary and community sector (VCS):** the Care Forum has recently mapped VCS organisations in the community and shown them to provide a varied and committed level of service. South Gloucestershire Council commissioned 41 VCS organisations to provide support to vulnerable adults in 2012/13 at a cost of £0.8m. Whilst South Gloucestershire Council has maintained its level of investment in the voluntary and community sector in relation to the health and wellbeing agenda in recent years there is concern within the sector about the possibility of reductions in the future as local authority budgets come under greater pressure.
- **Volunteering:** about a quarter of adults volunteer in some capacity at least once per month. In South Gloucestershire, a survey in 2012 showed that 40% were employed, 26% were unemployed, 15% were students and 8% retired. Volunteering not only provides people with practical help and support but also benefits the volunteers who gain confidence and skills in the process.

- **Informal caring:** this is the main form of care in any community. In South Gloucestershire, 27,639 people provide one hour or more of unpaid care per week. Two per cent of people (5,384) in South Gloucestershire provide more than 50 hours of unpaid care per week compared to 2.4% in England (Census, 2011). Just over half of carers are women and, overall, about 20% of carers are forced to give up work. Those who provide high levels of care are twice as likely to be sick or disabled themselves and households where care is provided live in poverty.
- **Engagement in decision making:** the evidence suggests that this improves self-confidence and sense of wellbeing. In South Gloucestershire, there are many opportunities including 20 community safety groups, 46 parish and town councils, community led groups in each of the Priority Neighbourhoods and many locality and care group forums which are consulted over service provision and monitor local services.

This brief description of community capacity in South Gloucestershire illustrates the richness of support for and by vulnerable people and of interest by people in the life of the community. However, support for these efforts is under pressure, partly because of health and local authority budget constraints and prospects for addressing gaps in services are limited.

Local authority – children and young people

The vision and strategy for promoting health and wellbeing among South Gloucestershire's children and young people is provided by a partnership comprising the local authority, health services, police and other emergency services, voluntary organisations and other services, for example, Connexions.

The vision is for children and young people to enjoy a healthy life, to have every opportunity to achieve their full potential whatever their background, to feel valued and to make a positive contribution to the community and to take responsibility for their own lives (see section 3.3.3). Priorities for action over the next four years include:

- to improve standards of educational achievement at age 16 years and beyond
- to close the gap between the performance of vulnerable children and young people and their peers
- to ensure that high quality education, childcare, play and social and leisure opportunities are available to meet the needs of the increasing young population and those who have disabilities, or are financially disadvantaged, or are vulnerable in other ways
- to ensure that all young people have the opportunity to engage in positive activities and decision making and to avoid becoming involved in antisocial behaviour, crime, or drug and alcohol misuse

- to support disadvantaged, vulnerable and troubled families to gain the skills they need to give their children the best possible start in life
- to focus our work to ensure that children in the early years thrive and develop positive relationships, to reduce obesity, and to improve emotional resilience and mental health
- to identify and support young carers so that they experience the same life chances as their peers
- to work to ensure that children and young people at risk of harm or neglect are protected.

Local authority – adults and older people

In line with the government's vision, in South Gloucestershire we are working to promote individuals' independence and wellbeing and supporting people to live full and independent lives.

We are seeking to prevent, or postpone, the need for care and support, seeking to work in ways which put people's needs, goals and aspirations at the centre of support, supporting people to make their own decisions and to realise their potential and to pursue life opportunities (see section 3.3.3).

In South Gloucestershire, there is a thriving and diverse social care market with a range of providers across the independent and voluntary sector supporting both a significant number of people funding their own care and those who are supported by the council.

In addition, the council is currently a provider of a range of social care services including a day and employment service, community meals, telecare responder service, a small home care service and three care homes (currently midway through a programme of reprovision).

The council is working together with its partners to ensure all older and vulnerable people living in South Gloucestershire should:

- feel valued and respected as part of their community
- be able to live full and active lives in safe and secure surroundings
- have every opportunity to remain independent, to have freedom of choice and control over how they live their lives.

Increasing demand for care from the growing population will present social and housing services with major challenges, not least the need to work with health and voluntary sector partners on finding innovative ways of coping.

The Health Service

From April 2013, most health services will be commissioned by a Clinical Commissioning Group (CCG) led by local GPs representing all general practices in South Gloucestershire. It will be supported by a Local Area Team and a Commissioning Support Unit which cover South Gloucestershire and CCGs in Bristol, North Somerset and Somerset, which have been working together on shaping capacity to meet demand for care in the wider conurbation in and around Bristol.

The main aim is to secure the highest quality care for people in South Gloucestershire, but there are two key background factors which will also shape capacity. Firstly, the growth in the population – older people in particular – which will push up activity; and secondly, the limited prospects for investment in the future.

The CCG, therefore, has priorities for development which are services for older people and people with long term conditions and better ways of meeting demand for urgent care.

- Long term conditions are those which cannot be cured but that, with the right medication and/or therapy, can be managed for many years. Examples include cardiovascular diseases such as coronary heart disease and stroke, respiratory conditions, mental illness, diabetes and dementia. Overall, 16% of the population have one such condition and a further five per cent have two. They use about half of all GP appointments and three quarters of all hospital bed-days. Most people over 65 years will have at least one long term condition.

  The strategic direction is to encourage people to stay healthy, to look after themselves if they develop a long term condition, with help from professionals and when intervention is called for, to minimise the use of complex hospital resources and access care as close to home as possible.

  This framework operates across all the main care groups and services and the CCG's Commissioning Plan, when published early in 2013, will reflect this in detail.

- South Gloucestershire commissioners are working with Bristol and North Somerset under the auspices of the 'Healthy Futures Programme' to coordinate plans and then to procure the right services to meet them. This continuing project will share expertise in, for example, quantifying demand for services and also look for reconfigurations of services, for example complex cancer care where it is sensible to do this.

  The key innovation in what in the past has often been a controversial exercise is to involve patients and the public closely and at all stages. All aspects of the work are available to examine on the Healthy Futures Programme website. http://www.avon.nhs.uk/healthyfutures/

- Additional demand for health care over the next few years from population growth alone can be predicted for each of the main types of hospital activity among South Gloucestershire residents. Urgent admissions will rise – if medical practice does not change – by 1.6% per annum, planned admissions (for operations mainly) by 1.4% per annum and attendances at accident and emergency departments by 1.1% per annum.

  The main specialties affected over the next five years will be general medicine (including care of the elderly), cardiology, urology, nephrology and ophthalmology. Problems with vision (including cataracts) and kidneys, pneumonia and stroke will increase.

  These cumulative pressures, if managed in the same way as now, will overwhelm current capacity in hospitals used by South Gloucestershire people and will call for innovation and efficiency in the way ill health is managed, if care pathways are to be maintained in the current climate. This is particularly important for urgent care which is so resource intensive but which, for obvious reasons, has to be managed with great care.

- Urgent care involves all health and social services and many options for providing assistance to an acutely ill person other than the emergency department and hospital admission. There must be a well organised and clear-cut way of calling for help, facilities on hand at all hours and the means of conveying people from place to place. Decisions to investigate and treat people must be proportionate so that they are not assigned to the wrong place and the care they receive should be humane and personal during a time when people are most vulnerable.

  All aspects of this pathway, with all its many options, are now under scrutiny by the CCG and colleagues in the community health and social services and the hospital sector. New ways of working are already being examined, for example placing GPs in emergency departments, extending community services across all seven days of the week and providing rapid access clinics with senior advice on hand so that admission to hospital can be avoided.

  This work will appear in short to medium term plans of the CCG which will be published early in 2013.

Section 4: Maternal health and the first five years

Reproductive health and pregnancy

Each year, just under 3,000 women in South Gloucestershire use maternity services (see section 4.1). The majority use community midwifery services provided by North Bristol NHS Trust and give birth at Southmead Hospital. A small number use St Michael's Hospital, the Royal United Hospital, Bath or have a home birth. The number of births will remain stable until 2018-20 and then fall slightly over the following few years.

Services focus on helping mothers achieve a healthy pregnancy for mothers themselves and their babies. They aim to encourage mothers to book early with antenatal services, give up smoking and consider breastfeeding, as well as encouraging healthy diet and exercise.

Of the women who book their delivery, 94.2% go on to give birth, some lose their babies in pregnancy and a small number of babies (14 in 2011) are stillborn.

During 2007-09, the under-18 years conception rate was 30 for every 1,000 young women aged 15-17 years – lower than the national average.

Low birthweight among South Gloucestershire babies – an important risk factor for early health problems – is less prevalent than in England as a whole and mortality around birth (perinatal mortality) at 5.8 per 1,000, is also lower.

Most South Gloucestershire births take place at Southmead Hospital where there is a midwife-led unit for low risk deliveries. Choice of where to give birth is important – there are two other hospital units within reach and a new midwife-led birth centre is to open soon at Cossham Hospital in Fishponds. Around two per cent of births take place at home. The neonatal intensive care units at Southmead and St Michael's Hospital care for sick babies and all those who require surgery are managed at St Michael's.

Community midwives are located in all parts of the area and mainly work from GP surgeries.

National strategies for improving outcomes for mothers and babies focus on promoting uncomplicated so-called normal birth and reducing surgical intervention. Among South Gloucestershire mothers, over 25% of deliveries were by caesarian – 15% as an emergency and 10% planned. This is in accord with the wishes of most mothers who also want to choose the place and style of delivery when it is safe to do so.

Recommendations for consideration by commissioners

- Encourage antenatal care attendance by all mothers, both to offer screening for foetal abnormalities and for the early detection of potential problems, so that mothers are advised correctly on where to deliver their babies.
- Promote a healthy lifestyle among women, both before conception and during pregnancy, particularly with regard to smoking, alcohol and nutrition.
- Encourage and commission choice of services for low risk pregnancies.

Healthy early years

Of the many contributors to health in the early years, six issues are important in relation to impact on future development and service provision: breast feeding, early diet, physical activity and obesity; oral health; poverty; cognitive development; injury prevention and help with childcare (see section 4.2).

Key issues

- Younger mothers and those in manual jobs are less likely to initiate and sustain breastfeeding than older mothers, or those in professional/managerial jobs.
- Levels of 'overweight' and 'very overweight' in school reception classes (as measured in the national school measurement programme) are below the national average in South Gloucestershire, but above the national average by Year 6 (as they are in adulthood).
- Compared with other children, those living in the most materially deprived households are more likely not to have access to a nutritionally adequate diet. Furthermore, for some families, simply being able to afford to buy enough food can, at times, be a significant issue.
- Lone parent families, families with four or more children, children who have younger parents, children with disabilities, children with disabled parents, Black and minority ethnic children and Traveller, Roma and Gypsy children are more likely to experience poverty than other groups.
- Nationally, take-up rates of income related benefits for families have been declining and there is likely to be a significant number of families who are not claiming their full entitlement to income related benefits. Even though figures are not available, there is a high probability that this is also the case in South Gloucestershire.
- By the age of five, lower cognitive development is more likely to be seen among boys than girls. It is also more commonly seen in children of either gender who face socio-economic disadvantage, those who have special educational needs (SEN) and those who have English as an additional language.

- Children from the most disadvantaged families are more likely to be admitted to hospital as a result of suffering an accident and to be admitted with more severe injuries. This is more marked for 0-4 year olds than 5-14 year olds. The children most likely to suffer unintentional injury are those who have a disability or impairment, belong to some ethnic minority groups, have low-income families, or live in poorer quality housing.
- Some of the small percentage of families who do not take up their entitlement to free childcare for two, three and four year olds are generally reluctant to engage with public services and may, therefore, be at risk of multiple disadvantages.

Recommendations for consideration by commissioners

Breastfeeding, early nutrition, physical activity and obesity

- The breastfeeding peer support programme should be continued.
- The HENRY programmes and Let's Get Healthy with HENRY programme should continue.
- Early years' physical activity must be promoted with opportunities for structured physical activity sessions in all relevant settings.

Oral health

- Oral health promotion is required to encourage and support families to maintain a good diet, to maintain good levels of oral hygiene and to attend the dentist regularly.

Poverty

- Services such as Job Centre Plus and the provision of accessible adult learning opportunities should be maintained where they exist and should be further extended to vulnerable families who are not resident in Priority Neighbourhoods.
- Undertake work to better understand and improve the take-up of benefits and services by low income families.

Cognitive development

- South Gloucestershire should aim to meet its duty to provide information, advice and training to childcare providers (Childcare Act 2006, Duty 13) and to achieve further improvement in the proportion of provision judged to be 'good' or 'outstanding'.
- There is a need to continue to enhance the pool of well-trained, highly qualified staff in South Gloucestershire's early years' settings.

Recommendations for consideration by commissioners (continued)

Injury prevention

- South Gloucestershire should ensure sufficient resource to identify the causes and locations of unintentional injuries and to undertake appropriate interventions with target groups, or in identified neighbourhoods.
- To expand capacity for injury prevention training for all staff who regularly work with children.
- It is recommended that funding continues to be found to ensure the delivery of the successful free safety equipment scheme to vulnerable South Gloucestershire families, and thereby help reduce the risk of injuries in the home.
- A series of training sessions should be delivered to parents attending Children Centres in South Gloucestershire to ensure key safety messages are delivered to families living in the six Priority Neighbourhoods.

Free childcare

- The South Gloucestershire programme to ensure that eligible two year olds receive their entitlement to free early education should be supported by sufficient financial and human resource to be effective.

Section 5: School age children and young people

Healthy foundation

As with the first five years, the social, physical and emotional environment of school age children, too, has a profound effect on a young person's wellbeing and later health and social life (see section 5.1).

Key issues

- In South Gloucestershire, it has been estimated that the costs of disease relating to overweight and obesity in 2012 was £54.8 million and expected to rise to £60.8 million in 2015. Data from the National Child Measurement Programme (NCMP) for South Gloucestershire in 2011/12 shows that 19% of reception age children and 29.2% of Year 6 children were overweight or obese. These figures are lower than the national average.

  Local analysis of child obesity data by deprivation quintile shows that for both reception and Year 6 children there is a clear socio-economic gradient where prevalence of obesity is higher amongst our more deprived communities.

- Nationally there is a decline in sports participation of 16-25 year olds, particularly once young people leave school. In 2006/7, the costs of physical inactivity to NHS South Gloucestershire were estimated at more than £3.8 million.

- Over the last few years there has been a considerable increase in the number of children in South Gloucestershire who are the subject of a Child Protection Plan (CPP) and a smaller increase in the number of children who are in care. There has also been an increase in the number of referrals to social care where the referrer is concerned about the welfare of the child, but the circumstances do not meet the social care threshold for intervention.

  With the potential impact of the economic downturn on families who may already be struggling, there is likely to be an increased need for a coordinated, multi-agency response to support those families and prevent an escalation of problems.

- Particular concerns in relation to parental capacity to adequately care for their children and significant reasons why children go into care, or become subject to Child Protection Plans, are parental alcohol/substance misuse, parental mental ill-health and domestic abuse – referred to as a 'toxic-trio'. Alleviating and preventing occurrences of these issues within families has the potential to greatly reduce the incidence of acute family stress.

- Educational attainment in the early Key Stages is relatively high in South Gloucestershire (top quartile nationally) but outcomes for vulnerable pupils were significantly lower in 2010/11, i.e. children from South Gloucestershire's six Priority Neighbourhoods, pupils from a Traveller and Irish Heritage/Gypsy Roma background, those entitled to free school meals and those with special educational needs. Attainment at Key Stage 4 is relatively weaker (third quartile nationally) with vulnerable groups significantly lower.
- Young carers may not attend and achieve their full potential at school because they are caring for their parents who may have disabilities, mental ill-health or misuse alcohol or drugs.

Recommendations for consideration by commissioners

- Children and young people should have access to complete evidence-based care pathways for the treatment of obesity.
- Long term commitment to the commissioning of weight management services for children aged 2-18 years and their families.
- Commission a 'Healthy Schools' intervention that supports a whole-school approach to promote healthy eating and physical activity.
- Commission services that promote walking and cycling to school.
- Commission a physical activity service that increases participation in physical activity and sport by engaging inactive and semi-active individuals/groups.
- Widen access and physical activity opportunities to those with mental health and physical disabilities.

Social and emotional resilience, parenting support and bullying

- Commission services to support parents and carers (including young carers) who need additional support (including support for families under the Troubled Families Initiative).
- Commission free and confidential counselling services for young people in South Gloucestershire (this is currently a significant gap).
- Address activity in relation to children's emotional wellbeing, resilience and bullying.
- Address the likely gaps in the provision of diagnosis and treatment services for alcohol/substance misuse and mental ill health among parents.
- Address the likely shortfall in services provided to families who experience domestic abuse.

Recommendations for consideration by commissioners (continued)

Educational achievement

- Within the context of deficit reduction, changes in school types and changing arrangements for services involved with raising attainment outcomes for children, the local authority needs to:
  - ensure that all educational establishments provide high quality education and that 'satisfactory' is not good enough.
  - improve the quality of teaching and learning in South Gloucestershire. This includes the use and evaluation of the effectiveness of the new Pupil Premium.
  - promote the engagement of parents and carers, especially where pupils have low prior attainment.
  - promote the value of programmes linked to the social and emotional aspects of learning that improve young people's confidence, social, emotional and behavioural skills, giving them more of a sense of control over their actions and lives.

Healthy lifestyle and risky behaviour

Lifestyle and risk taking can have a profound and direct impact on the health of young people and also determine their health and life expectancy in later years. Three areas are particularly important – substance misuse, tobacco smoking and sexual health.

Substance misuse

This is defined as intoxication by, or regular excessive consumption of, and/or dependence on psychoactive substances leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs, including alcohol when used alongside other substances (see section 5.2.1).

A survey of young people in South Gloucestershire in 2011 estimated that within the school age group, ten per cent use cigarettes daily and 14% and 2.8% use alcohol and cannabis respectively on a weekly basis.

National estimates are that in 2010/11, one in five young people aged 16-24 years had used at least one illicit drug in the previous year.

Data from the National Treatment Agency shows that 74 young people living in South Gloucestershire (aged 16-24 years) were treated for problematic substance misuse in 2010-11.

Monitoring information from the South Gloucestershire treatment services for young people shows that nearly 90% of young people in treatment leave the service in a planned way, compared with about 75% nationally.

Key issues

- There are longer term cost benefits to addressing substance misuse in children and young people. There is substantial evidence that many of these young people would, in the absence of treatment, impose significant economic and social costs on society, as well as impacting on their individual health status.
- Local data indicates a range of substance misuse amongst the young people of South Gloucestershire.

Recommendations for consideration by commissioners

- The predicted increase in numbers of young people experiencing substance misuse will require additional financial investment.
- The National Treatment Agency indicates that it is vital that 'specialist substance misuse services are commissioned within wider children's services to address young peoples' needs as a whole.'
- Review service provision against the Quality Centre June 2012 practice standards.
- Implement outcomes monitoring for all young people in treatment.

Smoking

The long term effects of tobacco smoking on life expectancy and on the incidence of many disabling and lethal conditions are well known. It is also clear there is a strong likelihood that a smoking habit among older people begins in adolescence – indeed, surveys show that very few people smoke for the first time after 25 years of age.

Estimates from national statistics that are applied to the South Gloucestershire population show that 25% of children aged 11-15 years have smoked and five per cent were regular smokers in 2011 (see section 5.2.2).

Smoking prevalence amongst young people in South Gloucestershire (the percentage of children who reported that they had smoked at least one cigarette in the last four weeks) is higher than regional and national averages (Child and Maternal Health Observatory: 2012). An evidence based smoking prevention programme is commissioned to support only half of local secondary schools.

Recommendations for consideration by commissioners

- As a minimum, to continue to commission the delivery of the ASSIST programme until the expiry of the current licence.
- To commission additional capacity to deliver the ASSIST programme across all schools annually.
- To consider commissioning a local 'healthy schools' programme that takes an integrated approach to addressing health issues in schools and facilitates behaviour change as demonstrated in the regional Healthy Schools Plus programme.
- To continue to commission Smokefree South West to deliver the campaign and mass media elements of their work programme.
- To develop capacity across professionals and organisations to deliver appropriate training and support for young people.

Teenage pregnancy

South Gloucestershire has lower than average teenage pregnancy rates but between 2002 and 2005 local rates were seen to rise. Following improved coordination of the strategy, increased investment in targeted services and a better-trained workforce, South Gloucestershire Teenage Pregnancy Partnership has now established a firm downward trend in under 18 conceptions.

Key issues

- The economic downturn and rise in youth unemployment may start to have a negative effect on this outcome area as poverty, low aspirations and being out of education or work are well known risk factors for teenage pregnancy.
- Repeat abortions in under 19s continue to be higher than the regional average.
- Reduced professional capacity to support young people means young people will receive limited education and information about healthy relationships, sexual health and access to services. This may lead to an increase in teenage conceptions and sexually transmitted infections (STIs).
- There is a risk that the integration of teenage pregnancy into broader commissioning areas may lead to a reduced focus on this outcome and that teenage pregnancy rates will rise.
- There is currently a lack of clear leadership and routes to improve young people’s education in relationships and sexual health in secondary school/college and non-school settings.

Recommendations for consideration by commissioners

- Maintain strategic leadership, coordination and funding for work to reduce teenage pregnancies.
- Commission additional clinical outreach services to reach more pupils in South Gloucestershire. Include targeted support post-abortion in order to reduce the relatively high repeat abortion rate.
- Commission an appropriate level of training for all professionals and community and voluntary sector workers working with young people around relationships, sexual health and managing risk.
- Commission integrated care pathways and services across, and between, agencies to improve education, information and access to services relating to relationships and sexual health.
- Identify the mental health needs of young mothers and service development to meet these needs.

Children and young people with particular health needs

Identifying children and young people with a disability and those with special educational needs (SEN) is fraught with difficulty due to issues of definition and problems with measurement. However, based on recent data from numbers of children aged 0-18 years in South Gloucestershire with either a statement of SEN or on School Action Plus programmes, around five per cent of the population in this age group have a significant disability. This is somewhat fewer than indicated from national surveys, although comparison between different places in the country is difficult.

The specific primary categories are (from highest to lowest proportions of the total):

- behavioural/emotional and social difficulties (22%)
- speech, language or communication difficulty (18%)
- moderate learning difficulties (17%)
- autistic spectrum disorder (11%)
- physical disability (6%)
- severe learning difficulties (5%)
- sensory impairment (5%)
- those with very complex health needs (1%)

(see section 5.3).

Service provision is multi-professional and multi-agency and contributions vary over time as children grow. A consistent theme from family and carers is for better coordination and better information about how to access what is needed. Families are often under great financial and emotional pressure and need support from most aspects of the welfare system.

Planning to meet future needs across the area needs to take account of the growth in the population anticipated for the next 20 years, the changes in medical technologies which make survival in the neonatal period more likely and improvements in identification which will mean that services become aware of more children in need.

Recommendations for consideration by commissioners

- Consider the suitability of new housing design and transport infrastructure for families with disabled children.
- Ensure that information is readily available through different media, as well as the internet – do not rely on one media source for information.
- More focused and integrated support at key stages throughout childhood – e.g. at diagnosis and at transition to adulthood.
- Consider more advice on behavioural interventions and managing difficult behaviour.
- Consider improved methods of data collection to incorporate health data and, where possible, data from other departments or agencies to improve the authority's knowledge of the social circumstances of families with disabled children.
- Commissioning of a round-the-clock community paediatric nursing service to meet the needs of acutely unwell children in the community. This could be delivered across Bristol, North Somerset and South Gloucestershire to achieve effective economies of scale.
- Adaptation of the adult district nursing service specification for South Gloucestershire to include young people who may be appropriately managed by adult services.

Children and young people with additional needs

Some of South Gloucestershire's children and young people have additional needs that are often not directly related to their health or disability (although a small number of children are taken into care due to the nature of their disability). They are children in care, young people involved in offending behaviour, young carers, children and young people living in unsatisfactory housing and bereaved children. Of course, this is not a homogenous group of young people and their needs vary (see section 5.4).

Children in care

Key issues

- South Gloucestershire Council looks after around 200 children who are unable to remain in the care of their parents. There has been a substantial rise in numbers since 2007 but this is beginning to slow now.
- Recently, the number of younger children placed for adoption has risen.
- A high incidence of children needing to be cared for because of parental drug and alcohol abuse is evident and shows no sign of diminishing. Often the recovery period for the parent is longer than childhood timescales. The readiness of some parents to address their difficulties is sometimes out of step with the availability of services and this can prolong the process.
- The Legal Aid, Sentencing and Punishment of Offenders Act 2012 has introduced changes to require any young person between the ages of 16 and 18 to be remanded to the care of the local authority. This will require additional resources and closer working with the Youth Offending Service (YOS) to prevent admission to a Young Offenders Institution, or secure accommodation. There will be financial incentives for successful interventions that prevent young people from being sent for remand and financial penalties for lack of success. The majority of young people on remand require residential placements because the seriousness of their offences makes it unlikely for mainstream carers to offer care.

Recommendations for consideration by commissioners

- Commissioning needs to support Family Group Conferencing to ensure that care from within a family can be utilised prior to recourse to public services where it is safe to do so.
- Ensure that looked after children are fully engaged in the development and delivery of the 'Being Healthy' agenda.
- Enhance support to children with autistic spectrum disorders to include 'behavioural interventions' to allow them to live at home or close to home.
- The parents of disabled children with complex health needs due to premature birth and late diagnosis of autism need information at the diagnosis stage and support post diagnosis, without which they are known to have reduced resilience in parenting, which can lead to the children requiring specialist care (see section 5.3).
- Resources for meeting the needs of children in care with highly complex needs and behaviours and for supporting their carers, are a priority.
- Enhance opportunities for children in care and care leavers to engage in meaningful education, employment and training.

Young people involved in offending behaviour

Recommendations for consideration by commissioners

- The availability to the Youth Offending Service (YOS) of a pathway to address the physical needs of young people involved with the YOS as recommended in HMIP/CQC report '*Reactions: A Third Review of Healthcare in the Community for Young People Who Offend*.'
- Early engagement with the Police & Crime Commissioner to ensure continued commitment to young people's substance misuse prevention and reduction.
- Considerations could be given to the employment of a Health Engagement Worker with specific responsibility to support the more hard to engage young people and their families to access services for any identified health related concern.

Young carers

Key issues

- There remains a significant gap between the number of identified young carers in South Gloucestershire and the likely prevalence, based on robust national research.
- Research and practice shows that young carers may not experience the same life chances as their peers. Their own personal and physical development may be affected, as well as their educational and social opportunities. The impact on their childhood may also impact on their adult life.
- Transition to adult services is a key issue for young carers and there is a national drive to recognise that 18-25 year old young adult carers need tailored support, rather than being passed on to adult services.

Recommendations for consideration by commissioners

- Improved identification and increased support especially at the universal level.
- Develop a coherent range of support for 18-25 year old young carers within universal, targeted and specialist provision.
- Training within adult mental health services about the need to identify, assess and refer young carers.
- Identify funding to support a young carers forum to improve participation.
- Consider development of a pledge to support young carers, to be signed up to by all schools.

Children and young people living in unsatisfactory housing

It is estimated that around one in five families in South Gloucestershire live in housing classified as 'non-decent' – mainly due to poorly insulated and/or heated homes in the private owner-occupied or private rented housing sectors.

Key issues

- Non-decent housing is a particular issue for lone parent families in the private rented sector where over half live in housing classified as non-decent. Many of these lone parent families living in non-decent private rented housing are likely to live in low rise purpose built, or converted, flats.

Recommendations for consideration by commissioners

- Social workers, health visitors and other community professionals who have day-to-day contact with families should be aware of the non-decent housing standard and overcrowding criteria, so they can recommend to families they apply to the Housing Register for assessment and/or make a service request to Private Sector Housing for assessment of housing condition.
- Measures need to be taken to expand the stock of family-suitable medium sized 2- and 3-bed housing units in the social rented sector in South Gloucestershire.
- Work should be commissioned to establish the extent of overcrowding among large families in South Gloucestershire.

Bereavement

Key issues

- Children and young people who have been bereaved of a parent, sibling, close relative or friend lack a coordinated and dedicated service to cater for their specialist needs.

Recommendations for consideration by commissioners

- Investigate the feasibility of systematically identifying and recording all children who have been bereaved.
- All bereaved children and their families should be assessed as to whether they would benefit from receiving appropriately coordinated evidence-based advice and/or intervention(s) which should be tailored to the needs of the individual child and/or their family.
- Ensure an appropriate evidence-based service is offered in cases where children are bereaved of a friend, especially if this is outside of the school context.
- Schools need to move from purely reactive responses to more proactive systems to improve their ability to identify and support children and young people experiencing bereavement.

School leavers – students and those not in education, employment or training

Understanding the needs of this group of young people – full and part time students in higher education, or further education, and those not in education, employment or training (NEETs) – is fraught with problems of definition involving employment/unemployment, economic activity and study. They are united in that they are going through the transition between school and the world of work and independent living (see section 5.5).

Key issues

- In the UK around one in ten young people aged 16-18 are not in education, employment or training (NEET). This is a long-term issue that pre-dates the recent recessions and goes back until at least the 1980s. Unlike the younger cohort though, there has been a rising proportion of 18-24 year olds, currently one in five, who are now unemployed. Largely this is a cyclical issue due to the current economic difficulties. However, even with this older age group, there is a serious structural issue of long-term rising levels of young people who are not in work or in some form of learning.
- In South Gloucestershire, one in twenty 16-18 year olds are not in any form of education, employment or training. Kingswood, Staple Hill and Yate all have relatively high NEET rates.
- In South Gloucestershire, 18-24 year olds have fared badly compared to other working age adults when it comes to those claiming Jobseeker's Allowance (JSA) – having the highest rate compared to all other age groups for at least the last ten years. Furthermore, this is the only age group where rates of JSA remain in a steep upward trend. Locally, rates are high in Staple Hill and Kingswood.
- NEETs are not a homogeneous group with around four in ten of them, nationally and locally, being classified as 'sustained' NEET. This is the group that includes the most vulnerable teenagers and all are likely to need intensive support to re-engage.
- Being in work is better for your health – both physically and especially mentally. Being out of work when you are young has long-term negative consequences that are not only present when people are unemployed, but also persist into adult life. These effects include lower wages and poorer mental and physical health.
- Almost half of young people aged 16 in South Gloucestershire's schools do not achieve a grade A*-C in the two key GCSE subjects of English and mathematics. This is a significant risk indicator of young people becoming NEET.
- South Gloucestershire's further education (FE) and school sixth form providers will be affected by a short to medium term drop in their cohort over the next six years.

- School sixth forms deliver predominately Level 3 provision, therefore vulnerable young people who have low Key Stage 4 attainment have to travel to FE colleges and training providers. This creates a barrier because they are less likely to leave their neighbourhood and, added to this, there are transport costs.

Recommendations for consideration by commissioners

- Commissioners should commission services so that the risk factors for becoming NEET are minimised, for example by preventing substance misuse, teenage pregnancies, youth offending etc (see sections 5.2.1, 5.2.3).
- Progression opportunities for vulnerable groups, especially those living in South Gloucestershire's Priority Neighbourhoods, need to be developed. Extending opportunities for vulnerable young people to access work experience, internships, or pre-apprenticeship programmes where they can develop employability skills will assist their successful entry into the labour market.
- Commissioners should address the high level of 'Not Known' young people and those in 'Jobs Without Training' and identify them and how they can be supported into education, or employment with training.
- There needs to be more effective transference of data between key stakeholders so that during transition and progression vulnerable young people are fully supported.
- Vulnerable young people need tailored support that allows them to move into sustained engagement in education, or employment with training.
- Evidence-based 'Job Ready' programmes should be commissioned for young people identified to be at risk of NEET, or who are already 'sustained' NEET.
- A piece of work needs to be commissioned with Jobcentre Plus to better understand the circumstances of local young people who at, or beyond, the age of 18 claim Jobseeker's Allowance.

Section 6: Working age adults

Healthy lifestyle

Preventing future ill health by individuals changing risky lifestyles and behaviours and by society, as a whole, promoting a healthy environment within which to live well are both important strategies for improving health. Components of this enterprise examined here are – tackling obesity, promoting physical activity and healthy eating, reducing smoking amongst adults, reducing harm from alcohol and drugs, promoting sexual health and providing NHS health checks.

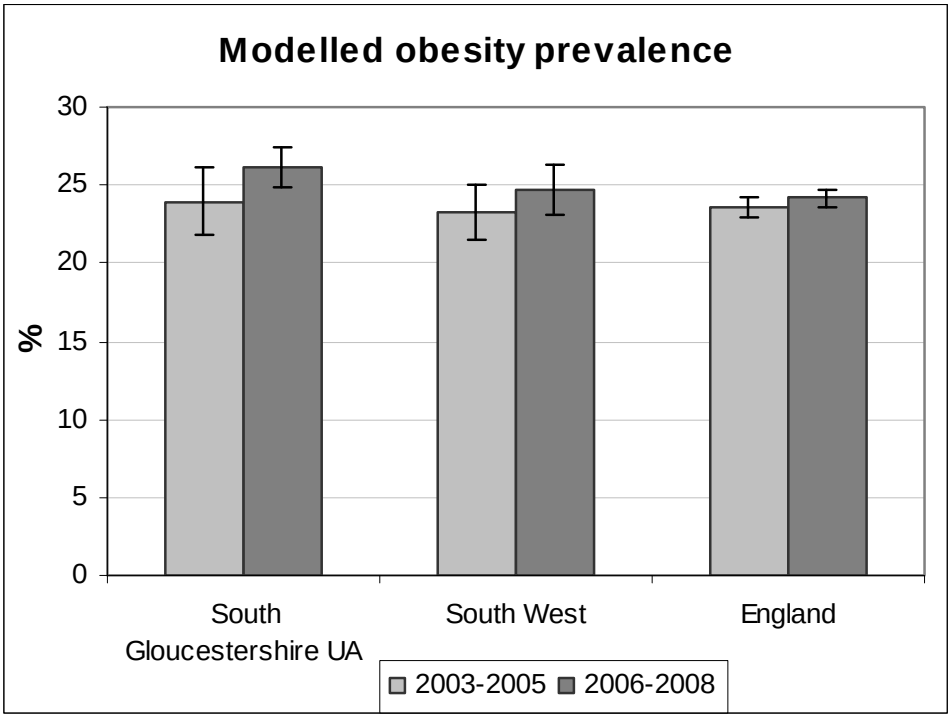
Obesity

Obesity levels are rising nationally and represent one of the biggest threats to the future health of the population (see section 6.1.1).

The risks to the health of an individual (short and long term) and the economic and social impact of overweight, obesity and physical inactivity are well documented.

Data from a variety of sources indicates that the prevalence of adult obesity (16+) in South Gloucestershire is higher than both regional and national figures.

Figure 5: Model-based estimates of adult obesity in South Gloucestershire, the South West health region and England



Source: Health Survey for England

Latest estimates are that over a quarter of adults in South Gloucestershire are defined, in this context, as obese. People with this degree of overweight can expect on average to live two to four years less than others (see Figure 5).

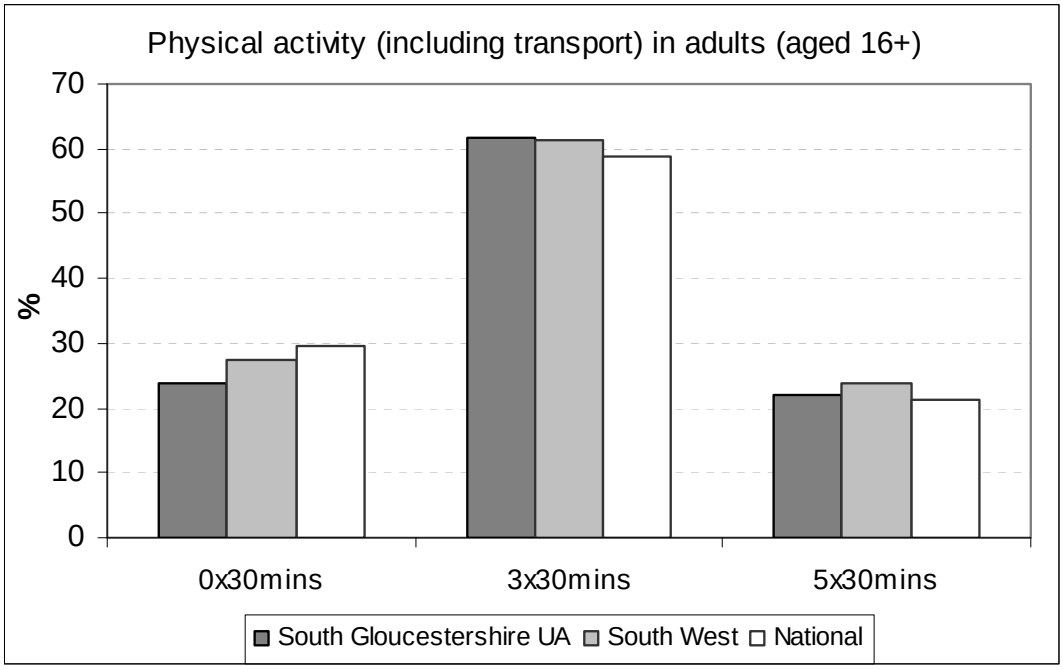
Effectively addressing obesity requires consideration of energy intake and energy expenditure and the elements that impact on both of these. It is estimated that nearly a quarter of adults in South Gloucestershire do not exercise to any great extent.

Delivery of the obesity agenda is being taken forward by the South Gloucestershire Healthy Weight Strategy Group.

Physical activity

Physical activity data shows that 78% of adults in South Gloucestershire do not achieve the recommended levels of physical activity (see Figure 6).

Figure 6: The number of adults (aged 16 and over) participating in sport and/or undertaking some form of physical activity at moderate intensity.



Source: Data derived from quarters three and four of APS 4, and quarters one and two of APS 5, covering the period of April 2010, to April 2011.)

Healthy eating

There are few measures of eating habits available at a local level. However, modelled estimates indicate that 71.1% of adults in South Gloucestershire do not eat the recommended five portions of fruit and vegetables per day, which is not significantly different to the England average of 71.2% (Health Profile 2012).

Key issues

- There is not currently a comprehensive local healthy weight care pathway in place.
- A comprehensive pathway would include accessible information and advice for individuals, the promotion of a health sustaining environment which would need to include aspects such as town and road planning and transport arrangements, tiered weight management support at different levels, and bariatric surgery assessment and intervention.

Recommendations for consideration by commissioners

Obesity

- Commission Tier 2 and Tier 3 adult weight management services to ensure a complete healthy weight care pathway.
- Commission healthy weight services for women before, during and after pregnancy and agree a body mass index (BMI) threshold which is consistent with all three trust providers to trigger consultant-led care.

Physical activity

- Improve participation in physical activity, particularly in groups where uptake is lower (females, school leavers, older people and people who are classified as being from poorer socio-economic groups).
- Improve services for people with long term conditions and those with physical and mental disabilities.
- Promote opportunities in primary care settings to screen all adults (16 years+) for physical inactivity and signpost to appropriate interventions.
- Commission adequate capacity to ensure that services can deliver support for the risks associated with obesity and physical inactivity as identified through NHS Health Checks.

Smoking

The dangers to health of tobacco smoking are well known – it is a major factor in the development of all the main causes of death and disease in South Gloucestershire and the single cause of several lethal cancers (see section 6.1.2).

The link between smoking and age related macular degeneration (AMD), the UK's leading cause of blindness, is as strong as the link between smoking and lung cancer. Smokers double their risk of developing AMD compared to non-smokers, but also tend to develop it earlier.

Smoking rates are lower at all ages in South Gloucestershire than in the country as a whole at under 20% in the adult population and they have been falling steadily in recent years. This partly reflects the change in attitude to smoking by the general public which does not as a rule tolerate smoking in public places and disapproves of smoking in general.

Alongside this, there is consistent promotion of the benefits of not smoking by every level of the public sector and locally by South Gloucestershire's public health service. It also reflects the work of several services in primary care and other community settings which help smokers quit the habit on a large scale. These services are effective and have made a substantial impact in the last ten years.

Key issues

- The quit rate can be improved further (to levels seen in comparable areas).
- The quit smoking service can be scaled up further by extending the work of pharmacies and by more group working.

Recommendations for consideration by commissioners

- Identify and commission additional capacity for Level 2 services from new providers to improve the local quit rates.
- Maintain commissioning of Level 2 services through general practices and widen the provision of Level 2 services from pharmacies.
- The current cost of commissioning Smokefree South West has to be considered in the light of current budgets and value for money.
- Commission an independent prescribing pharmacist model to improve access to Champix for patients who wish to use services provided through pharmacies.
- Commission a range of additional support specifically for smokers in Priority Neighbourhoods (including pregnant smokers).

Drug and alcohol misuse

Drug and alcohol misuse is a complex issue. While the number of people with a serious problem is small, their behaviour affects everybody, including themselves and their health, their families, friends, communities and society as a whole (see section 6.1.3). Effective treatment is the best way of tackling the harm that drugs can cause. It offers individuals the opportunity to manage their addiction and get on the road to recovery – most who come into treatment do want to end their dependency. It also gives communities a break from drug-related crime and antisocial behaviour.

Recent estimates of the numbers of problem drug users are that there may be 1,228 resident in South Gloucestershire (confidence interval 1010-1822) of whom about half are in active treatment.

Problem alcohol use is much more common and can have serious consequences for the health of individuals and their families and communities and for the economy. Recent estimates are that nearly 40,000 people in South Gloucestershire drink regularly to an extent that it is a serious risk factor for their future health, with an impact mainly on the development of cardiovascular disease.

Structured advice at an early stage is effective, especially when delivered in a primary care setting, and can prevent susceptible people going on to become one of the estimated 7,000 people in South Gloucestershire who are dependant on regular alcohol intake. This group faces an immediate risk to their health and life chances and can seriously disrupt the lives of others.

Key issues

- Treatment will be delivered in line with need and continue to broadly follow the original philosophy as set out in the national 'Models of Care' guidelines and ensure key priorities set out within the document are met. It is recognised by the South Gloucestershire Partnership (for substance misuse services) that these guidelines do not fit exactly into the local situation and that local arrangements and variations will need to be implemented taking into account the diverse needs of the service user group.
- All Integrated Substance Misuse Services are overseen by the Prison Health Partnership Board/Joint Commissioning Group which is a joint commissioning partnership between prison governors, PCT commissioning managers and Community Drug and Alcohol Action Team (DAAT) commissioning managers. A robust performance management framework will ensure that an accountable structure is developed led by these three statutory key partners.
- Rates of alcohol related hospital admissions have significantly increased since the last reporting period. In the years 2009/10-2010/11, the rate of hospital admissions related to alcohol was 50.3 per 10,000, as compared to 40.7 per 10,000 in 2005/6-2006/7. Alcohol specific hospital admission rates may have reduced slightly in the year since 2009/10, but when data are pooled for recent years (2009/10-2010/11) and compared to 2005/6-2006/7, there has been an overall increase in admission rates.
- Rates of alcohol specific hospital admissions and repeat admissions are higher in Priority Neighbourhood areas than South Gloucestershire as a whole.
- Repeat admissions account for a substantial contribution to all alcohol specific hospital admissions.

Recommendations for consideration by commissioners

- Develop procedures with Arrest Referral / DIP (Drug Intervention Programme) referrers to increase referrals into treatment.
- Increase treatment providers' involvement in GP training to promote awareness of treatment services and increase referrals from this source.
- Providers to audit the number of clients in treatment for two years or more, to clarify if the clients remain in treatment / have not been closed in the case management system. Remaining long term clients should have their care/ recovery plans refreshed in line with the commissioning for recovery agenda.
- Joint commissioners to identify funding to develop a cocaine service, taking into account the profile of the users and the potential need for extended service hours.
- Launch the Hepatitis Service across South Gloucestershire during 2012/13.
- Provide more treatment initiatives in relation to mental health (anxiety, depression) and family relationships, to assist in improving client's health scoring.
- Strengthen and develop the throughcare service taking into account the views of service users and the need to establish a service which promotes 'moving on' from recognised drug and alcohol services to promote recovery and reintegration.
- Review the causes of repeat admissions for alcohol problems, particularly in Priority Neighbourhoods, and assess where improvements can be made to case management.
- Maintain a focus on prevention of alcohol misuse through the implementation of the alcohol strategy. This will require sustained investment in new initiatives over the next few years if the trends in alcohol-related ill health are to be reversed.
- Continue to support the increase in the use of brief interventions, including taking opportunities within the NHS Health Checks.
- Support all efforts to improve understanding of the dangers of problem drinking in the community and to promote responsible marketing of alcohol.

Sexual health

Sexual health involves issues of unwanted pregnancy (especially among very young women) access to and use of contraception, sexually transmitted infection (STI) and sexual abuse and violence (see section 6.1.4).

Key issues

- Good sexual health involves being able to make informed choices. Ensuring informed choice may be more challenging for people with learning difficulties, or similar problems, in interpreting and comprehending information.
- Cultural practices in some communities may influence or limit choice for some people such as in the use of contraception.
- Young people have the greatest burden of overall sexually transmitted infections (such as chlamydia in those under 25).
- Certain infections are more common in particular risk groups, for example men who have sex with men have a higher incidence of gonorrhoea and human immunodeficiency virus (HIV) infection.
- Sex workers are at risk from increased exposure to a range of sexually transmitted infections as well as sexual violence.
- Women are more likely to experience domestic and sexual violence.
- South Gloucestershire has a number of prison estates. Offenders, particularly young offenders and female prisoners, are at risk of poor sexual health.

Recommendations for consideration by commissioners

- Approaches to commissioning sexual health services should be reviewed to ensure a full range of services is available to local residents.
- Consideration should be given to ensuring a specialist Level 3 sexual health service is more locally available for South Gloucestershire residents.
- The recent regional sexual health peer review identified the need for a comprehensive workforce development strategy for sexual health practitioners. This would require funding.
- In order to support practices in providing the full range of LARC (long-acting reversible contraception) additional funding would be needed.
- HIV testing in general practices should be considered for funding.

NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease (see section 6.1.5). Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk.

A key feature of the programme is that each person who receives a NHS Health Check is given appropriate lifestyle advice to lower or manage their risk. Advice includes guidance on managing cardiovascular disease risk factors such as reducing stress, promoting healthy eating, increasing physical activity, stopping smoking and reducing alcohol consumption.

NHS Health Checks is a five-year rolling programme with 20% of the eligible population invited each year. During 2011/12, 6,306 people received a health check – about 40% of the eligible population. Of these, 42% were found to be at high risk and received treatment or advice.

This is a relatively new programme but experience to date shows that it is possible to offer large numbers of people at risk a series of tests and appropriate advice. Research also indicates that this can prevent, delay and reverse the impact of disease in the population.

Recommendations for consideration by commissioners

- Strong links are required between primary care practitioners and local authority public health commissioners.
- Future developments for NHS Health Checks include supporting practices to deliver all elements of the lifestyle guidance.
- Multiple methods of delivering invitations to the populations will be needed to maximise uptake rates.
- Links to any future arrangements with Avon IM&T (Information Management and Technology) will need to be maintained.

Adults with particular needs

Physical impairment and disability

A person has a disability if the person has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities (The Equality Act 2010) (see section 6.2.1).

Almost sixteen per cent (15.8%) of people in South Gloucestershire reported a long term illness or disability that restricted their daily activities in the 2011 census, which is lower than the England average (17.6%). Of those aged 16-64, 6.6% have a long-term illness or disability that restricts daily activity. A recent snapshot from four local authorities suggests that 50% of people aged 18–65 receiving social services support have a neurological condition such as multiple sclerosis, acquired brain injury, or Parkinson's disease.

Among adults there are increasing numbers of people reporting mental illness and behavioural disorders, while the number of people reporting physical impairments is decreasing.

Key issues

- The full involvement in society of disabled people, including opportunities to work and travel.
- The personalisation of services and the development of a market place that is geared to meet individual need and preference.
- Delivering services and improvements in relation to the Department of Health Long Term Conditions Strategy, expected late 2012.
- The potential for changes in services and commissioning as a result of the Day Services, Employment and Volunteering Review.

Recommendations for consideration by commissioners

- Disabled people need full participation in their communities whether through employment, education, leisure, or any other aspect of community life that is enjoyed by all South Gloucestershire residents.
- All need access to prompt diagnostic, assessment, treatment and rehabilitation services.
- The way health and social care services are commissioned to enable disabled people to achieve as independent a lifestyle as possible should be kept under regular review and changed if necessary.
- Health and social care commissioners, local communities and service providers must work in partnership to meet the challenges and realise the opportunities of the 2012 Care and Support White Paper.
- Commissioners to consider the evidence base for the Expert Patient Programme and the potential to establish this in South Gloucestershire.
- To consider how user-led organisations feature in commissioning plans and exercises.
- Carers should be recognised as expert partners in care and should be asked to be involved in planning and decision making as they make valuable contributions.

People with learning difficulties

Learning difficulties is a term which describes people who have a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising, or managing money – which affects someone for their whole life (MENCAP www.mencap.org.uk). It covers a wide variety of causes and manifests in an equally wide range of disabilities.

National research indicates that within South Gloucestershire there are approximately 5,000 adults with learning difficulties of whom just over 4,000 are estimated to be aged between 18-64 years. Just over 1,000 aged 18 and over are predicted to have a moderate or severe learning disability with approximately 250 people aged 18-64 predicted to have a severe learning disability (see section 6.2.2).

Key issues

- Key statistics for South Gloucestershire residents indicate that 854 adults with severe learning difficulties were known to GPs; 615 adults with learning difficulties (85.7%) received a GP annual health check (England average 48.64%); 720 adults (18 to 64) with learning difficulties were known to local authorities.
- Median age at death for people with learning difficulties in South Gloucestershire is 59 years (England median age is 55).
- Nationally, the proportion of admissions to general hospitals which happen as emergencies is substantially larger for people with learning difficulties than for people who do not have learning difficulties (50.0% versus 31.1%; in South Gloucestershire the proportion in 2008-2009 was 50.07%).
- In South Gloucestershire, general hospitals are better than the England average at identifying people with learning difficulties.
- In South Gloucestershire, psychiatric in-patient services are significantly worse than the England average at identifying people with learning difficulties.
- Rates of referral for abuse of a vulnerable person with learning difficulties are significantly lower in South Gloucestershire than the England average.
- There are significantly more adults with learning difficulties in paid employment in South Gloucestershire compared with the England average.
- South Gloucestershire has fewer people with learning difficulties living in settled accommodation than the England average (50.69% versus 58.98%) but a significantly higher percentage of adults with learning difficulties for whom no information about accommodation is available to the local authority than the England average.

- There is no significant difference in South Gloucestershire between the prevalence of people with learning difficulties known to local authorities and the prevalence of people with learning difficulties on GP practice lists.
- National research suggests that people with learning difficulties are living longer than in the past which will result in the numbers of people requiring support and services increasing over time. It is predicted that the highest proportional increase will be in those with complex need and in older people. This highlights the importance of effective service planning for the future.
- Some people with learning disabilities are caring for a partner or friend. Sometimes as families grow older the person with learning difficulties who is being cared for by their parents may start to care for their elderly parent.
- There is a high prevalence rate of sight loss amongst adults with learning disabilities. An estimated 96,500 adults with learning disabilities in the UK, including 42,000 known to the statutory services, are blind or partially sighted. Nearly one in ten adults with learning disabilities is blind or partially sighted. Adults with learning disabilities are ten times more likely to be blind or partially sighted than the general population.[3]

[3] Eric Emerson and Janet Robertson 2011 The estimated prevalence of visual impairment among people with learning disabilities in the UK . RNIB and SeeAbility

Recommendations for consideration by commissioners

Access to health should be improved

- Better access to, and support from, doctors, dentists, opticians, pharmacy, chiropody and ambulance staff.
- Accurate recording of people needing health checks; health action plans.
- Better information to inform equalities work and access to screening services.
- Continued emphasis on access to screening and prevention services.
- Ensure that people with learning difficulties are involved in staff recruitment and training in all services and with commissioners and their experiences are used to improve services.
- Ensure that all complaints processes are accessible.
- Co-production of transition planning.
- Focus on mental health providers and ambulance service providers to improve access to health services for people with learning difficulties.

Governance, assurance and quality

- Build upon substantial ‘access to health’ work in local acute services with learning difficulties liaison nurses.
- Improve use of mental capacity act within all service providers to protect people with learning difficulties.
- Improve the safeguarding practices within the mental health, learning difficulties and ambulance service providers.
- Improve the governance processes within the mental health, learning difficulties and ambulance service providers to ensure that people with learning difficulties are involved in assessing the quality of services provided.
- Family carers of people with learning disabilities are often unique amongst carers. For many, they will be experiencing a lifetime of caring, as a son, daughter or sibling with learning disabilities. For carers, finding support, such as support groups, and getting the best and most appropriate services must be seen in the context of this lifetime of caring.
- Existing data on the registration numbers of people with a learning disability should be examined. If a disparity is shown between the numbers of people with learning disability that are registered blind or partially sighted compared to prevalence levels it may indicate that some targeted work needs to be undertaken.
- Commissioners should review what services are in place to support adults with learning disabilities and a visual impairment and look at Community Eye Care Pathway for Adults and Young People with Learning Disabilities.

Recommendations for consideration by commissioners (continued)

Recommendations from reports on Winterbourne View

- CCG commissioners and local authority commissioners to review policy, strategies and monitoring for those whose behaviour challenges services, and, in particular, ensuring that there is a clear focus on preventing escalation within community settings and develop criteria for situations in which specialist placements outside of mainstream services are required.
- Ensure that annual reviews are carried out and that services commissioned continue to meet the individual needs.
- Ensure that the Deprivation of Liberty Safeguards are being applied systematically in relation to all relevant people with learning difficulties.
- NHS contracts and contracts used by the local authority with care providers should be shared between commissioners to ensure that both organisations are assured that robust and appropriate governance is in place for the safety of people with learning difficulties.
- Consider joint enhanced quality assurance framework to be used by both health and social care in the assessment of potential service providers for people with learning difficulties.
- Ensure that people receiving care and their families are listened to by staff and commissioners.

Autistic spectrum conditions

Autism spectrum conditions (ASCs) are disorders of communication in which empathy with others is disturbed (see section 6.2.3). As the name suggests, ASCs can manifest in a wide variety of ways and with varying degrees of severity. They are developmental disorders and not mental health problems.

If they are not identified and diagnosed in childhood, adults with autism who do not also have a learning disability (a group typically referred to as having Asperger syndrome), in particular, can struggle to receive the support they need to lead fulfilling and rewarding lives. Equally, about a third of people with a learning difficulty (of all degrees) also have an autistic spectrum condition.

Nationally it is estimated that there is a prevalence of one per cent amongst adults. In South Gloucestershire, there are an estimated 1,710 adults aged 18-64 years with autistic spectrum conditions.

Key issues

- The number of people known to services is not known with any accuracy because people may have an ASC but are registered under another category, for example they may have a speech and language, or a behavioural problem.

- The pathway to comprehensive support and care is confused and confusing to carers. There are few specialist services to take an overview during adult years.
- Recognition of the needs of people with ASC is poor so that housing, employment and health and social care is fraught.

Recommendations for consideration by commissioners

- Require better individual data collection within health, social care and housing IT systems and carry out an autism needs assessment.
- Review the governance arrangements for the autism planning group ensuring closer alignment with the Health & Wellbeing Board.
- Ensure through service redesign that mainstream services are accessible to people with autism.
- Ensure that advocacy is available to support people with autism.
- Focus on ensuring that support and opportunities exist to maximise chances for people with autism to become and remain economically active.
- Ensure appropriate housing options and support is available by identifying the housing needs of people with autism and ensuring they are explicitly referenced within the housing strategy.
- Work together across health and social care to ensure adults with autism are benefiting from the personalisation agenda and can access personal budgets.
- Focus on preventing the escalation of behaviour that could result in people entering the criminal justice system.
- Take a collaborative approach that values and harnesses the knowledge, skills and views of adults with autism, their families and carers, the third sector and other professionals and partners organisations.
- Involve carers of adults with autism in planning and decision-making processes that affect the person they care for (with their consent) and their own needs identified with signposting to relevant support services.

People with mental illness

Mental illness manifests in a wide variety of forms and is common in the community. One in four people will experience identifiable mental illness during their lifetime, for example about half of all adults will experience clinically defined depression at some time.

People with long term mental illness can be very disabled and find themselves struggling to find friends, work and shelter, often because of the stigma which is attached to their condition. People at the margins of society, for example prison inmates and homeless people, commonly have a history of mental illness (see section 6.2.4).

Modern drugs and the change in culture of mental health services have resulted in the ability to provide effective and quick treatment for a number of people who otherwise would have a long standing dependency and links with mental health services. However, all welfare services and the community at large are needed to support and help sufferers.

The number of people referred to health and social services gives a rough indication of the burden of mental illness in South Gloucestershire, although there is little information about the resulting severity. Around one third of GP consultations have a mental illness component.

In 2011/12 over 4,000 people were referred for cognitive therapy and most had mental health problems. In 2010/11, 1,149 people aged 18 to 65 years and 350 older people were referred to the main mental health service and 456 people were referred to the memory clinic.

Key issues

- The overall strategy is to reduce stigma and encourage more people to seek help at an early stage. Services have been re-configured and developed to increase the capacity for early intervention and prevention.
- People are living longer and the likelihood of experiencing mental health difficulties is likely to increase proportionately.
- Social inequalities are a cause and effect of poor mental health and there are clear links between physical illness and mental health difficulties.
- A number of specialist areas are identified for improvement, in addition to the need to improve the engagement of service users and carers.

Recommendations for consideration by commissioners

- To commission local specialist assessment and follow up services for people with attention deficit-hyperactivity disorder (ADHD).
- To commission a local service for people with suspected Aspergers syndrome to include specialist assessment and, in conjunction with the local authority, to provide ongoing therapy, support and practical assistance.
- To consider the options appraisal in respect of improvements to the alternative health based 'Place of Safety'.
- To support the development of service user and carer engagement in service planning and delivery.
- To work with key providers to improve community services for people considered to have a personality disorder.
- To work with the local authority and other key agencies to develop an action plan related to 'No Health without Mental Health'.
- To look at options for developing **local** residential provision which has intensive staff support for people with complex needs, for whom out of area placements are currently necessary.
- To work with providers to increase the availability of Talking Therapies within secondary mental health providers.
- To promote the maintenance and further development of employment schemes for people with mental health difficulties, including those with ADHD and Aspergers.

Long term conditions

Long term conditions (LTCs) are those which cannot be cured but, with the right medication and/or therapy, can be managed for many years. Conditions considered in the 2013 JSNA are diabetes, chronic obstructive pulmonary disease, neurological conditions and stroke (see section 6.2.5).

Themes running through the care pathways for all long term conditions are:

- **risk profiling** – using a validated risk profiling system locally clinicians are able to identify a list of patients (or 'virtual ward') that are most at risk of admission and put systems in place to maintain them in the community
- **integrated systems of care** – by working together, the multi-professional health and social care team supporting those people most at risk of admission due the complexity of their LTC (the virtual ward) can ensure that their care is streamlined and coordinated

- **self management** – empowering people to effectively manage their condition through education and support and providing them with choice in the context of the management of their condition.

Diabetes

Diabetes is a profound disorder of the metabolism – the processes which provide the body with energy from nutrients. The main disturbance is with the release of energy from sugar, either because the body does not produce enough of the key hormone insulin, or because cells become resistant to the effects of insulin.

Without adequate treatment, diabetes can lead to complications including problems with eyesight (retinopathy), blood supply to lower limbs and increased risk of kidney failure and cardiovascular disease. The risk of developing diabetic complications can be minimised by maintaining target levels of blood glucose, blood pressure and cholesterol (see section 6.2.5.1).

Some people develop diabetes in childhood (Type 1) and require lifelong insulin by injection. Much more common is the slow development of diabetes (Type 2) in later life – a form of the disease which is strongly related to obesity and which also needs continuing treatment, usually with oral drugs and often, insulin.

Most research points to the need for accurate and continuous control of blood sugar levels and to the benefit of rigorous monitoring and early intervention for dealing with complications as they develop. For this reason, people who may be at risk, for example those overweight or obese, should be tested either through the NHS Health Check service or, opportunistically, as they visit a GP surgery for another reason. Equally, people who are on treatment for diabetes should receive an annual check-up to monitor progress and look for signs of complications.

Nearly five per cent of the population in South Gloucestershire is thought to have a form of diabetes. It is most common among older people and is expected to become more common as the population ages.

Key issues

- Nearly 60% of Type 1 and 47% of Type 2 diabetics in South Gloucestershire have not received all aspects of the basic standard of care. It is important that commissioners and service providers ensure robust arrangements are put in place for everyone with diabetes to receive an annual review covering all nine care processes.
- In South Gloucestershire, 68% of people with Type 1 diabetes and 34% of people with Type 2 diabetes did not have a most recent HbA1c measurement of 7.5% or less, making long-term complications of diabetes more likely.

- In South Gloucestershire, 52.5% of people with diabetes aged 17 years and over who are not excepted from the Quality and Outcomes Framework have a HbA1c of seven per cent or less. This is statistically significantly lower than PCTs with populations with similar diabetes risk factors and statistically significantly lower than England as a whole.
- People of all ages with diabetes are more than 50% more likely to have an emergency re-admission than people of a similar age who do not have the condition.
- NHS South Gloucestershire is an outlier in terms of its admissions of patients with emergency ambulatory care sensitive conditions, of which diabetes is one.
- NHS South Gloucestershire does not currently have a community diabetes specialist nurse service.
- Diabetic retinopathy is the leading cause of blindness in people of working age (Diabetes NST, 2008). Early diagnosis with appropriate intervention is essential. In 2012/13, the uptake of diabetic retinopathy screening in South Gloucestershire was 77.6% (England range 54 - 91.8%). Smoking may accelerate the development of, or worsen, diabetic retinopathy further because smoking also damages blood vessels.
- Diabetes is the most common cause of lower limb amputation (non-traumatic).

Recommendations for consideration by commissioners

- All diabetics should receive the basic standard of care – an annual review with attention to all nine care processes recommended as good practice. Most of these reviews will take place in primary care but it is important that commissioners and service providers ensure robust arrangements are put in place so that no one slips between GP and specialist.
- Local-level data should be used to investigate variation among primary (GP) and secondary (hospital) providers to identify where support to improve diabetes care may be required.
- At least one specialist nurse is required to support patients who are having difficulty managing their diet and treatment.
- Review the uptake of diabetic retinopathy screening services between GP practices and amongst different population groups in South Gloucestershire.

Chronic obstructive pulmonary disease (COPD)

This smoking related condition affects large numbers of people, is often progressive as people age, and can also lead to or exacerbate heart disease. Treatment is effective in slowing the rate of progression but COPD is a substantial cause of disability and death (see section 6.2.5.2).

There are no reliable data on the extent of the condition in South Gloucestershire, but it is among the most common reasons for attendance at GP surgeries and admission to hospital during an acute exacerbation.

Prompt treatment of infection is important and for those whose lives are restricted, specific rehabilitation programmes and the provision of oxygen supplies at home are effective in maintaining function.

Key issues

- As the population ages, more people with COPD will need treatment and rehabilitation; this will be offset in future because of the fall in smoking rates.
- Early and then continuing intervention is important to promote self-management and integrated care by primary and specialist care.

Recommendations for consideration by commissioners

- There is greater potential for establishing admission avoidance schemes within the community setting for patients with chronic obstructive pulmonary disease.
- Pulmonary rehabilitation is effective and could be expanded (60 places are currently provided by North Bristol Trust).
- There is a nationally recognised need to identify patients with COPD via primary care diagnostic spirometry.
- Clinical input is required to support assessment and provision of oxygen; consider the potential for rolling out the nurse-led model which has been developed in North Somerset.

Long term neurological conditions

These conditions affect the brain, spinal cord or the peripheral nerves. They can be the result of traumatic injury to the brain and spinal cord at birth or later in life, manifest as epilepsy for which there is often no cause identified and diseases of unknown origin which produce loss of motor or sensory function.

The impact of these diseases varies considerably but many can be severely disabling. Some are non-progressive such as cerebral palsy (from birth) and traumatic injury later in life; some are progressive such as multiple sclerosis (MS) and Parkinson's disease until there is an almost total loss of function (see section 6.2.5.3).

There are no reliable data for South Gloucestershire but it is estimated that there are up to 1,200 people with brain injury, 5-600 people with cerebral palsy, 3-400 people with multiple sclerosis and 500 people with Parkinson's disease. Another 4-500 people have other significant neurological disease and around 2,000 have epilepsy.

Key issues

- At present there is a lack of a clearly defined pathway for long-term neurological conditions. Third sector services and users' feedback is that services are fragmented and their needs are not clearly understood by more general services when contact is made with them. Navigation of services is also a challenge for users who often look to the third sector for assistance.
- Access to specialist equipment is also a local issue due to the cost associated with more complex, bespoke pieces of equipment that people with neurological conditions require. Again, some charities supply equipment to service users where the NHS is not able to provide funding. This is a significant issue with access to bespoke wheelchairs.
- It is reported that users of neurological services are often required to use an 'exceptional funding route' for the services and equipment they require. There is a need for a review of services and equipment being applied for via this route to consider whether there is scope to negotiate more robust and cost effective contracts with providers.
- Parkinson's Disease UK, The Motor Neurone Disease Association and MS Society are working together to develop a Neurological Alliance which associates with the Care Forum (and in the future 'Health Watch') in order to get the voices of people experiencing long-term neurological conditions heard.
- It is suggested that pathways based on the 'type' of long term neurological condition should be developed. These include: static or stable conditions such as cerebral palsy and polio; acquired conditions such as brain injury; progressive conditions such as MS and motor neurone disease (MND); and intermittent conditions such as epilepsy.

Recommendations for consideration by commissioners

Services and procedures need to be put in place to allow access to:

- early recognition, prompt diagnosis and treatment
- emergency and acute management of conditions
- early and specialist rehabilitation
- community rehabilitation and support
- vocational rehabilitation
- equipment and accommodation
- personal care and support
- palliative care
- support for family and carers
- care for people with neurological conditions who are in a hospital or social care setting.

Development of integrated pathways of care for each of the four categories of neurological condition. With the development of joint health and social care commissioning arrangements and the commissioning of integrated health and social care teams which will result in:

- rapid access to support at home
- rapid access to equipment
- patient-led consultations
- allocation of keyworkers
- specialist nurse/keyworker posts
- single patient-held record
- family and carer support.

Stroke and cerebrovascular disease

Stroke is a sudden loss of function caused by damage to the brain following either a blocked or a bleeding blood vessel. The result may be overwhelming and cause death in the short term, or less severe but with widely varying loss of function.

Recovery in this last group is possible to some extent but is usually not complete and specific rehabilitation can make a big impact on a person's life after the event.

Treatment in the form of drugs to shrink or dissolve a blood clot is also possible for selected patients but must be administered within hours if it is to make a difference. For this reason, services are considered in two parts – in the acute phase, patients with signs of stroke must be investigated and treated, if possible, in a hospital with round-the-clock facilities; later in the recovery phase, rehabilitation specific to stroke is provided.

At this time, a review of these services is underway as part of the ‘Healthy Futures’ programme in South Gloucestershire and neighbouring areas to determine the best way to provide them between the four main hospitals (see section 6.2.5.4).

Early intervention is also effective in preventing or delaying the onset of stroke. Risk factors such as smoking, high blood pressure and abnormal heart rhythm can be detected and controlled in primary care settings and the early signs of a problem (transient ischaemic attacks) can be identified and treated.

Damage resulting from stroke can impact on the visual pathway of the eyes which can result in visual field loss, blurry vision, double vision and moving images. In addition, there may be inability to read (alexia) or to write (agraphia). Around 60% of stroke survivors have some sort of visual dysfunction following stroke. The most common condition is homonymous hemianopia, a loss of half a person's visual field, which occurs in 30% of all stroke survivors.

Key issues

- Local acute trusts providing stroke services are not consistently meeting the standard that expects 80% of people with stroke to spend 90% of their time on a stroke unit. This inconsistent performance appears to be predominantly related to the bed management policies and procedures employed by North Bristol NHS Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHB).
- Current models of stroke care do not provide adequate psychological and emotional support to stroke users and carers.
- The absence of adequate community-based specialist stroke rehabilitation services. (All services currently available providing specialist rehabilitation are provided by acute services, with early supported discharge teams that reach out into the community on a limited basis).
- There is an absence of coordinated 'life after stroke' services available within the community.
- There is a lack of knowledge around the consistency and quality of six week and six month post discharge reviews completed in the community. This issue will be particularly pertinent from July 2012 when the joint contract with the Stroke Association for the provision of six month reviews, ceases.

Recommendations for consideration by commissioners

- Targets for meeting minimum standards in acute settings must be met.
- Rehabilitation services should be provided in community settings by appropriate providers.

Heart conditions

The commonest heart condition is coronary (or ischaemic) heart disease which in turn has several manifestations from acute heart attack (or myocardial infarction) when blood vessels supplying the heart muscle become blocked and which is life threatening, to chronic heart failure in which restricted blood flow to the heart reduces the efficiency with which it pumps blood round the body (see section 6.2.6).

Cardiac services in hospital deal with acute problems such as heart attack where drugs or surgical procedures can re-open blocked blood vessels to the heart. As with the similar treatment for stroke, this has to be initiated within hours and hence requires round-the-clock, specialist attention.

The Bristol Children's Hospital manages infants and children with congenital heart disease and all major hospitals have cardiac departments which also deal with sophisticated treatments.
Long term heart conditions are largely managed in the community by GPs and specialist nurses. At present, a review of all these services is underway as part of the 'Healthy Futures' programme to determine the best configuration across the Greater Bristol area.

Much of the work promoting health is devoted to helping people to reduce their risk of coronary heart and cerebrovascular disease, either by informing the public at large and individuals about healthy lifestyles, or promoting a healthy environment to make possible healthy behaviour.

Key issues

- BNP (brain natriuretic peptide) testing and arrhythmia management do not currently feature in the community heart failure service model provided across Bristol and South Gloucestershire.
- A review of cardiac activity across Bristol, North Somerset and South Gloucestershire is due to commence in July 2012. This may highlight additional issues concerning cardiac services across the cluster for consideration by local commissioners.

Recommendations for consideration by commissioners

- Extend the community heart failure service to include BNP testing and arrhythmia management as part of the service.
- Continued investment in the in-reach service at North Bristol Trust hospitals if projected reductions on outpatient activity and shifts from long to short stay are achieved.
- Outcomes from the cardiac review should help guide and inform clinical commissioning intentions for next year.

Offender health

People in the criminal justice system have distinct but often neglected needs for better health. A survey of issues at the local women's and men's prisons (Eastwood Park and Leyhill respectively, for which South Gloucestershire PCT has commissioned health services) shows high levels of smoking and substance abuse, poor nutrition and self harming behaviour among women, high risk for acquiring blood-borne viruses and a high incidence of obvious mental illness.

Further assessments are being made for other institutions and settings in South Gloucestershire – Vinney Green secure children's home, Ashley Young Offender Institute, police custody, court custody and in other settings in the community which feature various forms of restraint (see section 6.2.7).

Key issues

- Learning Disability Services in custody and effective screening tools at the point of custody.
- Police / Court Custody Healthcare Liaison and Diversion which is being piloted and will be in all custody areas by 2014
- Older prisoners / end of life care in custody.
- Health based Place of Safety – including provision for young people detained by the police under S136 of the Mental Health Act. The current provision is low for the population it serves (one bed for 1.4 million people). There is no provision for people under 18 and they will always default to police custody at present.
- Consistent provision of Liaison Services in acute care hospitals.
- Housing for offenders at the point of release and thereafter.
- Specialist assessment for people with Aspergers and attention deficit hyperactivity disorder (ADHD) is currently accessed via the Bristol Autism Specialist Service which needs to be expanded and provided locally, including increased capacity to provide ongoing relationship, behaviour-related therapy and to work closely with social care and housing and employment support.
- Access to post traumatic stress disorder (PTSD) assessment and services where undiagnosed people are over represented in criminal justice contact because of links with alcohol use and aggression (including domestic violence).

Recommendations for consideration by commissioners

- Partnership working with the prison to implement the National Drug Strategy for Recovery/ Drug Free Wings.
- Develop Older People Strategy including management of end of life care.
- Joint working with the prison and council on provision of social care for prisoners.
- Male prisoners are likely to be remanded to either HMP Bristol or HMP Gloucester so links with both need to be established.
- Partnership working with the prison to re-commission substance misuse services as part of the transfer of responsibilities for commissioning by the NHS with the council based Drug and Alcohol Action Team.
- Partnership working with the unit to assume NHS commissioning responsibility for health care services transferring from the Ministry of Justice at Vinney Green.
- Partnership working with the police to prepare for NHS commissioning responsibility for health care services transferring from the Home Office expected in 2014.
- Partnership working with the police, NHS trusts and neighbouring PCTs to develop an alternative Place of Safety for young people detained under S136.
- Partnership working with the courts and police to help identify health care liaison and diversion services.
- More flexible, local arrangements for health based Place of Safety, including more consistent and robust arrangements for people under 18 who are detained by the police.
- Incentives to be included in the contract for the Talking Therapies Service to encourage the preconisation of offenders in the community.
- A commissioned local service to replace the current case-by-case access to the Bristol Autism Specialist Service.

Carers

A carer is someone of any age who provides support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled, or has mental health or substance misuse problems. All the care they give is unpaid (see section 6.2.8).

Carers can be any age, including children. Three in five people will become carers at some point in their lives and the number of carers is set to rise as the population ages. There are 27,639 people in South Gloucestershire who provide more than one hour of unpaid care per week, and 5,384 who provide more than 50 hours per week (Census, 2011).

Carers are the largest source of care and support in each area of the UK. It is in everyone's interest that they are supported.

- Taking on a caring role can mean facing a life of poverty, isolation, frustration, ill health and depression.
- Many carers give up an income, future employment prospects and pension rights to become a carer.
- Many carers also work outside the home and are trying to juggle jobs with their responsibilities as carers.
- The majority of carers struggle alone and do not know that help is available to them.
- Carers say that access to information, financial support and breaks in caring are vital in helping them manage the impact of caring on their lives.

There are three broad categories of support to carers:

- 'replacement support' which aims to relieve the burden of care such as home care, sitting services, day care and short breaks.
- direct support through payment from the council. This was given to 110 people in 2011/12.
- services open to all carers through, for example, the Carers Support Centre.

Key issues

- The ongoing identification of carers and the provision of timely support and information
- Caring has a detrimental impact on mental health with 87% of carers reporting this in a recent Carers UK survey.
- Effective use of resources
- The development of a straightforward system to offer carers personal budgets and improvements to the social care system for carers, particularly in relation to assessment and information

- The development of informal support provided and enabled by the community and voluntary sector, particularly for people who are not eligible for social care and/ or are willing to pay for support
- Support for the cared-for person when carers fall ill, or are unable to care for a period of time.

Recommendations for consideration by commissioners

- Develop carers' personal budgets and implement a transparent system of allocation of funding for carers, so that increasing numbers of carers are enabled to meet their needs and outcomes.
- Work should continue on improvements to processes for assessing and offering information to carers.
- Options for emergency provision are reviewed.
- Consider how to ensure that the available support and information is accessible for Black and other ethnic minority carers.
- Continue to explore the needs of working carers and innovative ways of meeting their needs.
- Consider repeating the successful Carers Conference 2012.
- Continue to monitor the South Gloucestershire Carers Strategy.
- The impacts of the introduction of the Fairer Charging Policy should be monitored.
- The NHS reports on its level of funding for carers' breaks and the numbers of breaks provided.
- The NHS considers providing health checks for carers, taking account of the results of the national pilot and the other health checks now offered.

Urgent care

The Department of Health's definition of urgent care is:

> *'Urgent care is the range of response that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using the services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.'* (see section 6.2.9).

Urgent care is unscheduled care that is not pre-booked with the patient's GP (e.g. urgent appointments) or any unplanned care (e.g. attendance at an emergency department, minor injuries unit or walk-in centre).

Emergency admissions - that is, admissions that are not predicted and happen at short notice because of perceived clinical need - represent around 65% of hospital bed days in England (34 million bed days and 4.75 million emergency admissions in 2007/8) (Hospital Episode Statistics 2007/8).

Approximately 35% of all hospital admissions in the NHS in England are classified as emergency admissions, costing about £11 billion a year.

Avoiding unnecessary emergency hospital admissions is a major concern for the NHS, not only because of the high and rising unit costs of emergency admission compared with other forms of care, but also because of the disruption it causes to elective health care – most notably inpatient waiting lists – and to the individuals admitted (Audit Commission 2009).

Trends within South Gloucestershire show that the number of emergency hospital admissions has decreased over 2011/12 but the average length of stay in hospital is higher than average and home care support is increasing.

South Gloucestershire is amongst the highest 20% of PCTs for accident and emergency attendances, admissions with emergency ambulatory care conditions (those that can potentially be avoided) and admissions from residential and nursing homes.

A large range of services are available to people who require urgent health care:

- acute hospitals, primarily North Bristol Trust, University Hospitals Bristol and the Royal United Hospital at Bath
- 29 South Gloucestershire GP practices
- South Gloucestershire Community Health Services (hosted by North Bristol Trust)
- Frendoc Out of Hours GP service, Brisdoc Out of Hours GP service, Wiltshire Medical Services Out of Hours GP service
- Great Western Ambulance Service
- NHS Direct (to be replaced by NHS 111 provided by Harmoni from 1st April 2013)
- The Red Cross – discharge support services
- reablement pilot (provided by Brunelcare) to support patients with reablement needs following discharge from hospital
- step up / step down 'blue beds' to provide rapid interim social care placements from hospital.

Key issues

- Insufficient capacity within community health services rapid response teams in South Gloucestershire to maximise prevention of avoidable admissions to hospital. (In an audit, over 50% of patients whose admissions could potentially have been avoided were admitted due to a lack of capacity in community health services rapid response teams.).
- NHS South Gloucestershire is an outlier in terms of its high emergency department attendances (within the top 20% of English PCTs).
- NHS South Gloucestershire is an outlier in terms of its high admissions from residential and nursing homes (within the top 20% of English PCTs).
- NHS South Gloucestershire is an outlier in terms of its admissions of patients admitted with ambulatory care sensitive conditions (within the top 20% of English PCTs).

Recommendations for consideration by commissioners

- There is a case for increasing resources to community services rapid response teams as part of future business planning.
- Improving support services to patients in nursing and residential homes through education and support of staff to support capability improvements in partnership with South Gloucestershire Council.
- Work with local providers of primary care to ensure that patients with ambulatory care sensitive conditions receive timely and appropriate care to manage their conditions outside of an acute hospital setting.
- Work with emergency departments to ensure that they see patients who are clinically appropriate for emergency departments and patients with primary care needs are redirected to their GP.
- Evaluate and learn from the reablement pilot to determine an effective model for a full scale service that will provide services across South Gloucestershire to support preventative work in the community, as well as following a hospital admission.
- Further analysis is required on the level of step up / step down social care beds required in South Gloucestershire to support hospital discharge.
- Work should be undertaken to facilitate effective discharge and reduce admission rates by involving and supporting carers during the discharge process.
- There should be a review of the arrangements for care when a carer is taken ill as this has a significant impact on the cared for person.

Planned care

Elective care is pre-arranged, non-emergency care that includes scheduled operations. It is provided by medical specialists, usually in a hospital or other secondary care setting; however, less invasive procedures can also be performed within primary care. Patients are usually referred from a primary care professional such as a GP (see section 6.2.10).

The NHS constitution provides patients with a right to start consultant-led treatment within a maximum of 18 weeks from referral. If this is not possible, the NHS constitution requires the NHS to take all reasonable steps to offer patients a range of suitable alternative providers. In 2011/12, over 93% of patients in South Gloucestershire were treated within 18 weeks from the date of referral for non-urgent conditions. Ninety-nine per cent of patients waited for less than six weeks for a diagnostic investigation.

Investigation and treatment for suspected cancer is a special case – maximum waits for referral to clinic is two weeks, referral to treatment is 62 days, and referral to a decision to treat or not is 31 days – and all targets in South Gloucestershire are met.

Members of the public take a great interest in waiting times and regard them with concern, both in that they as individuals may suffer for longer than necessary, and also as a measure of the adequacy of the NHS. The government is keen to encourage the widest choice of service provider for individuals when seeking planned care so as to make use of all available resources and to stimulate the most efficient pathway. The 'Choose and Book' system is now well established and used in about three quarters of all routine GP referrals.

Key issues

- Whilst NHS South Gloucestershire meets the national waiting times standards, the achievement of the 18 week referral to treatment standard across all individual specialties remains a challenge. Of particular concern is within the specialty of orthopaedics.
- South Gloucestershire patients generally access secondary care orthopaedic services at North Bristol NHS Trust. Referral to treatment performance within orthopaedics is challenged by the levels of sub-specialist work which has led to the subsequent growth in backlogs. Action plans are in place to clear these backlogs and ensure sustainable achievement of 18 weeks going forward; involving waiting list validation and strategies to maximize the use of available orthopaedic capacity across the Bristol, North Somerset and South Gloucestershire PCT cluster area, including available capacity within the independent sector.

Recommendations for consideration by commissioners

- Commissioners to ensure that future provision proactively assists patients in the achievement of the 18 week 'referral to treatment' time for all specialties.
- Commissioners to ensure that young adults are treated in the clinical environment that is most suited to their condition and maturity.
- Commissioners should use evidence of changing health trends, such as the dramatic reduction in cardiovascular disease, to periodically review the balance of investment in health services.
- In a difficult financial context, combined with rising demands on the health care system, commissioners should ensure that commissioning decisions are made on best available evidence and all services provided is value adding to patients.
- Increasing investment in, and capacity of, services to meet the twin challenge of ageing population and population growth. The capacity will be needed at all levels of provision from local community facilities, as well as elective hospital provision.

Section 7: Ageing and supporting independence

Maintaining independence

Society in the UK is changing. More people are living longer in greater prosperity. Over the next decades the numbers of people over 50, over 65 and over 80 will all increase to levels never previously seen.

Older people's aspirations and expectations of services, support, wellbeing and quality of life are changing. Older people are defined as 50+ in the South Gloucestershire Strategy (see section 7.1).

An ageing society is too often seen solely in terms of increasing dependency. Older people make a positive contribution to our community, both in old age and during their working lives and later life is a time to enjoy the rewards of their lifelong contribution.

Many older people are carers, often caring for grandchildren or parents and sometimes both. Many older carers also care for each other – making their situations very fragile. As older people become an ever more significant proportion of the population, society will increasingly depend upon the contribution they can make.

Services for older people to help them maintain independence are wide ranging, resource intensive and in great demand. They are provided by the council and health services, a range of voluntary organisations and the commercial sector and can be categorised as:

- **services helping older people to live life independently** – for example, assistive technology, promoting a healthy lifestyle, combating isolation through library and befriending schemes, help with repairs to the home and advice services
- **services for older people who require social care support at home** – for example, occupational therapy and home adaptations, home care (1,580 users in 2011/12), day services and reablement schemes. Access to home care is by assessment and people are offered a personalised budget which they can use to commission their care from the council, or other providers. In 2011/12, 4,508 reviews were carried out and 2,262 people received a budget.
- **health services** – for example, community nursing, GP health checks, physiotherapy and occupational therapy and a range of assessment and rehabilitation programmes, such as the falls service and stroke rehabilitation.

- **housing and accommodation services** – for example, ‘extra care accommodation’ (self-contained flats specially adapted for independent living – 700 will be developed by 2016, 300 at affordable rent and the remainder for homeowners), sheltered accommodation provided by a voluntary organisation and care homes (1,864 older people were living in a care home in South Gloucestershire in 2012).

Key issues

- Continuing to provide services to an increasing ageing population and continuing to develop preventative services in a period of reduced budgets.
- Older people will remain the highest users of health and social care. The role of self care in the management of long term conditions and supporting older people to direct their own social care support are key issues in relation to control, quality outcomes and value for money.
- Social isolation has been identified as a national and local priority and a number of initiatives under the Precious Time Project are working to find solutions. If successful, the sustainability of these projects beyond the first year of funding will be a key issue. The development of an overarching approach and strategy to tackle social isolation will also be an important development.
- The continued creation of suitable housing, either through adaptation or new build, which helps older people to maintain their independence.
- Lesbian, gay, bisexual and transgender (LGBT) carers in older age have expressed concern that if services are not LGBT friendly they will have to spend their last years hiding their sexuality.
- Working with partners to implement the White Paper and, when finalised, the new arrangements for the funding of social care.

Recommendations for consideration by commissioners

- That commissioners evaluate and build on the outcomes from the Precious Time Project and the community capacity-building work with the Local Government Association.
- That support and information to self funders is improved.
- That further exploration of the potential of telehealth is undertaken.
- That commissioners consider the outcomes and findings of the reablement pilot, to inform the future shape and extent of reablement provision in South Gloucestershire.
- Long term conditions need to be more proactively detected in primary care; approaches to self care and local joint working would also benefit from further exploration. Well managed long term conditions will help to reduce death and hospital admissions.
- Minimising non-elective acute hospital admission by commissioning and developing capability and capacity of services that provide more appropriate community-based alternatives, as well as supporting timely discharge for those acute admissions of older people that cannot be avoided.
- Smoking, alcohol problems, physical inactivity and nutrition should be addressed in older people.
- Primary care to continue to develop ways of working with partners to identify vulnerable people and put in place packages of support to maintain independence.
- Older people and their carers should be able to proactively access advice on benefits, housing issues and other services.
- Older people should be consulted on strategic plans which affect their wellbeing.
- Ensure older people have real choice and control over their support through effective self-directed support processes and development of the social care market and community capacity building.
- That partners across the sector work to implement the White Paper, *Caring for Our Future: Reforming Care and Support*.
- To continue to monitor the supply and effectiveness of services, particularly in the light of the projected increase in the older population. This work will include community and residential services and will encompass those areas where risks have been highlighted already, for example the supply of residential and nursing accommodation for people with dementia. It will also include the options and recommendations of the *What People do During the Day* Review.
- To continue to develop techniques for demand forecasting.
- To continue to develop innovative methods of service delivery.
- To develop ways in which older people can be involved in monitoring the quality of services.
- To continue to consider how transport provision can be improved.
- To continue to deliver mixed tenure Extra Care Housing Schemes, where older people can experience a new lease of life.

Older people with particular needs

Hearing impairment

Hearing loss is common at older ages and progressive – moderate or severe hearing loss affects around 20% of the age group 65-74 years and about 85% of those aged 85 years and more. Profound hearing loss affects about four per cent of those over 85 years. In South Gloucestershire, it is estimated that about 300 people use signing and 100 are deaf and blind (see section 7.2.1).

As the population ages in South Gloucestershire, the estimated numbers of people aged 65 years and over with a moderate to severe hearing loss will rise from about 20,000 in 2012 to over 30,000 in 2030. Those with a profound hearing loss will increase from about 500 to around 850.

Services for deaf people in South Gloucestershire are provided by the audiology service at North Bristol NHS Trust, council services for supporting disabled people, and the voluntary sector.

Key issues

- Ensuring wider access to services and opportunities for people with a sensory impairment in line with *Improving the Life Chances of Disabled People.*
- Increasing awareness amongst the general population and social care providers of the effects of hearing loss and techniques for managing communication.
- Increasing use of hearing loops in public buildings.
- Increasing awareness of equipment available that promotes communication and independence for people with hearing loss.
- As people live longer, the incidence of hearing loss will increase. To keep pace with the needs of this population will require continued investment in health and social care.
- Understanding and tackling social isolation, particularly amongst older people with a hearing loss.
- Ensuring that health and social care professionals receive high quality deaf awareness training.

Recommendations for consideration by commissioners

- To consider how the Hearing Impairment Support Service can become sustainable.
- To consider how direct access by deaf people to council services, particularly social care, can be improved.
- To continue to work with the multi-agency Deaf, Deafened and Hard of Hearing Group to address the key issues above.

Visual impairment

Visual impairment affects all age groups but predominantly older people with age-related macular degeneration the most common cause of registrable sight loss in older people. Three quarters of people registered severely sight impaired, or sight impaired, are aged over 70 years. By the age of 60 years, one in twelve people can expect some degree of sight loss, one in eight by the age of 75 and one in four by the age of 80.

Currently in South Gloucestershire, 763 people are registered as visually impaired – 418 severely sight impaired. People aged 75 years and over with a registrable condition are predicted to increase from about 1,300 in 2012 to over 2,000 in 2030.

Services are provided in primary care (ophthalmic opticians) and through the Eye Hospital in Bristol for outpatient and surgical care. In addition, Action for Blind People (partly funded by the council) provides advice and support and the council's home support services provide equipment and adaptations (see section 7.2.2).

Sixty-six per cent of visually impaired people (who are of working age) find themselves outside of employment (Network 1000, 2006). Blind and partially sighted people are also 15% more likely to be unemployed in comparison to other disability groups (DWP, Employment of Disabled People, 2006), with nine out of ten employers stating that it is either difficult or impossible to employ a person who is blind or partially sighted (DWP, 192 Report, 2004).

Key issues

- For older people, particularly those with other impairments, adapting to sight loss can be a difficult process. This can impact on people's confidence and aspirations in many areas of life.
- The prevalence of sight impairment is set to rise dramatically with the ageing population. One in five people aged 75 and over and one in two people aged 90 and over are living with sight loss in the UK. By 2020, the number of people in the UK living with sight loss is set to increase by 22% and will double by 2050. As the population ages, services will be challenged to keep pace with the growing numbers of people affected by sight loss. The associated costs and demands on NHS outpatient services are high with ophthalmology nationally having the second highest attendances in 2010 – 2011.
- It is vital that people attend regular eye tests to ensure that they are wearing the correct glasses. A sight test is also a health check, where sight loss conditions such as age related macular degeneration, cataracts, glaucoma and diabetic retinopathy (as well as other eye conditions) can be identified.

Recommendations for consideration by commissioners

- Services should ensure that people do not lose their sight unnecessarily. Steps to support this include:
  - inclusion of eye health and sight loss in the Health and Wellbeing Strategy; data collected on the three major causes of sight loss to meet the Public Health Framework for Sight Loss will support this work
  - incorporating eye health messages into health campaigns concerning obesity, smoking cessation and the management of diabetes and glaucoma and developing a targeted public health campaign to raise awareness of the importance of regular sight tests
  - improving the uptake of diabetic retinopathy screening.
- Sustainable, joined up services are available for the future to support people at the time of sight loss and throughout their journey. To support this:
  - a course for people with sight loss, *'Living with Sight Loss' programme*, should be extended
  - the impact of the reduction of the rehabilitation service is monitored and analysed and appropriate action taken
  - the needs of visually impaired people, particularly in relation to rehabilitation, are considered in the further development of the reablement project
  - an eye health needs analysis, incorporating medical and social aspects of the eye care journey, should be conducted alongside a review of local eye care pathways to ensure the efficient and effective use of existing assets
  - a targeted expansion of the Department of Work and Pensions employment programmes, namely the 'Work Choice and Work Programme for blind and partially sighted people' to provide intensive employment support to those looking for work
  - statutory partners to work alongside Action for Blind People to explore how counselling and befriending services can become sustainable in the longer term
  - services developed around dementia, stroke, and learning disabilities should also take into consideration the additional impact of sight loss
  - commissioners, partners and service users and carers should refresh and develop the Low Vision Group Action Plan, to take forward the key aims of *Good Practice in Sight* and the *UK Vision Strategy*, as well as contributing to the recommendations in this report.

Dementia

Dementia is a clinical syndrome characterised by a widespread loss of mental function which may include memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character.

Dementia may be caused by certain diseases which affect the brain, for example Alzheimer's disease which is gradually progressive, or as a result of cerebrovascular disease which is characterised by a series of abrupt episodes of deterioration in cognitive function (see section 7.2.3).

Key issues

- Dementia is rare at ages less than 65 years but progressively common as people age, so that almost one in five will have signs of the disease at 85 years and over. It is estimated that nearly 3,500 people aged over 65 years show signs of dementia in South Gloucestershire today, rising to 4,000 in 2020 and 5,500 in 2030. This is because more elderly people will survive to reach old age in the next 10-20 years.
- There is no definitive treatment for any of the forms of dementia although some variants can respond to medication designed to slow progression.
- Disability due to dementia varies among individuals. Alzheimer's disease is the most common form and can progress steadily to complete dependence on others for basic care. Support for family and carers is therefore critical and a range of help must be available to enable people to continue to live in a domestic setting for as long as possible. This includes expert assessment and treatment by mental health services and general practitioners, home care and nursing, respite day and residential care and sympathetic care if hospital admission is required. This support should be provided in an integrated fashion and, in South Gloucestershire, a partnership approach has been in operation between the several statutory and voluntary organisations involved for the last five years.
- The views of dementia sufferers and carers are very important – to enable people to live as well as possible and to inform service providers of the best support to give. South Gloucestershire LINk has hosted several workshops for this purpose and more will be needed as time goes on.
- Residential or nursing home care will be under increasing pressure as numbers rise. Local provision will depend heavily on the government's plans for funding in the future.

Recommendations for consideration by commissioners

- Include the views of people with dementia and their carers in all plans and developments. A methodology for this exists and is accessible to all, including the Clinical Commissioning Group.
- Evaluate the impact of the local shared care initiative.
- Support the promising 'Post Diagnosis' Partnership between local clinicians and the Alzheimers Society to improve the provision of information and advice during the weeks after diagnosis – a 'Dementia Challenge' initiative.
- Develop the patient pathway to address the need for continuity in ongoing clinical support for all patients and also the needs of people with a learning difficulty.
- Partnership between the local authority and health commissioners to enable local voluntary organisations to increase the quantity and variety of opportunities available to people living with dementia, with particular reference to geographical access and support for carers.
- Partnership between the local authority and health commissioners to support local care homes to provide a quality service for residents with dementia.
- Develop and implement the Joint Dementia Workforce Strategy including its recommendations for increasing public awareness of their contribution.
- Support the Dementia Action Alliance planned for the Cribbs / Patchway area in 2012/13, and seek other opportunities to make South Gloucestershire more 'dementia friendly' over the next few years - another 'Dementia Challenge' initiative.
- Support the work of the recently recognised Healthy Bristol Dementia Partnership to develop local health and social care research in dementia.

Frail elderly people

The presence of frailty increases with age. Frail elderly have a higher risk of disabilities, falls, hospitalisation, institutionalisation and death compared to non-frail elderly.

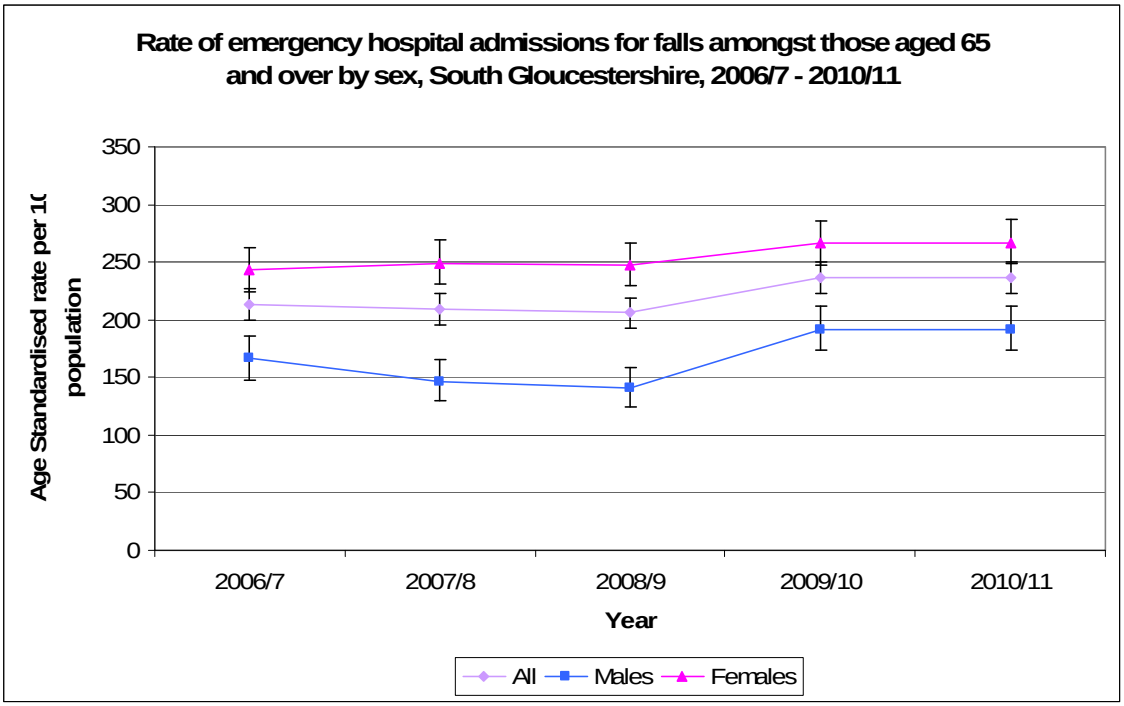
The risk of falling increases with age, particularly in those 65 and over (APHO 2008). People who have been admitted to hospital following a fall are at increased risk of falling again in the next 12 months, experiencing loss of confidence and fear of falling, and of losing their independence through entering a residential care home.

Thirty-five per cent of over 65s are at risk of falling each year, rising to 45% of people aged 80 and over. Between 10 - 25% of these fallers will sustain a serious injury. Between 22% and 60% of older people suffer injuries from falls, 10-15% suffer serious injuries from falls, 2-6% suffer fractures and 0.2-1.5% suffer hip fractures (Masud et al 2001).

Regardless of the outcome, falls are associated with a loss of confidence, and a subsequent restriction in physical activity which leads to a further loss of capacity and bone density. This increases the risk of another fall and also the likelihood of entering residential care.

Figure 7 below shows the rate of emergency admissions for falls amongst those age 65 and over in South Gloucestershire.

Figure 7: Rate of hospital admissions for falls amongst over 65s in South Gloucestershire 2006/7 - 2010/11



The term 'frail elderly people' has been coined by the 'Healthy Futures Project' – an initiative by NHS commissioners in South Gloucestershire, Bristol and North Somerset to plan a coordinated set of developments in many health services for the next few years – and refers to people over 75 years of age who have complex health needs.

Much of this work has been covered in previous sections of the JSNA (for example, section 3.3.2 on NHS capacity and earlier parts of section 7) – the following concentrates on organisational issues which are designed to enable work to continue (see section 7.2.4).

Key issues

- Strong links with members of the public, representatives of voluntary organisations and service providers have been developed and are essential for success.
- From this partnership, design standards for issues such as prevention, case-finding and care have been generated and turned into an assessment tool for evaluating services on offer or planned.
- This strand of development will now merge with others, namely work on long term conditions and urgent care (see the relevant sections above) to lead to a coordinated set of plans.

Recommendations for consideration by commissioners

- Commissioners in the reorganised health service need to continue as a partnership, both across the South Gloucestershire, Bristol and North Somerset area in which the residents use a set of common hospital and community services, and with the local authority and voluntary organisations.
- Further needs assessment needs to be carried out to establish whether there is a real increase in frail elderly people actually falling in South Gloucestershire, or whether there has been a change in hospital admission policies which would explain the increase.

End of life care

Palliative care (or end of life care) is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (World Health Organisation 2012).

Implicit is that individuals should die in the place and with people of their preference (see section 7.3).

Services for people at the end of their lives are provided in acute hospitals (North Bristol NHS Trust has eight beds for people with complex needs), the community and primary care, the Palliative Care Home Support Service, the Continuing Health Care service, the Marie Curie nursing service and St Peter's Hospice.

Key issues

- The views of users and carers are consistently that fewer people wish to die in hospital. In 2011/12, 53% of people at the end of their lives died in hospital and a local target has been set to reduce this to 51%.
- More deaths by preference at home will increase pressure on community health and social care staff.
- People dying with non-cancer conditions are less likely to access specialist services and more likely to die in hospital.
- More work on teenage end of life care needs to be done.

Recommendations for consideration by commissioners

- Following funding from the Marie Curie 'Delivering Choice' programme, North Somerset has an end of life coordination centre which is a model that could be replicated in various different forms in South Gloucestershire. North Somerset has reduced the number of deaths in hospital to 46%.
- Commissioners must continue to monitor the access by non-malignant patients to end of life services.
- Assess the possibility of commissioning a local bereavement counselling service which extends in scope from before death to long afterwards.

Section 8: Safeguarding vulnerable people

Safeguarding children

Ensuring that South Gloucestershire's children are safe from harm is a key priority. Safeguarding in this context includes:

> *'...protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully'* (Department for Education 2010).

Maltreatment can include physical abuse, sexual abuse, psychological or emotional abuse, or neglect (see section 8.1).

The actual level of abuse is hard to estimate because much of it is hidden. A recent review of surveys in this field estimated that between four and sixteen per cent of children are physically abused each year and ten per cent are psychologically abused.

Data from referrals to the child protection team in South Gloucestershire show that in 2011/12, 225 children were the subject of a Child Protection Plan (CPP) – three times the number five years previously. In the same period, referrals had doubled, indicating that members of the public and generalist professionals have become more aware of maltreatment and also that child protection professionals had become much more likely to take action.

These changes are seen throughout the country and arise because of recent very high profile cases which had escaped effective action before it was too late. Of those subject to a CPP, half were because of emotional abuse, 26% because of neglect, 20% because of physical abuse and five per cent because of sexual abuse.

Key issues

- The focus on early intervention continues to be a key priority ensuring children with additional needs are identified early and receive the right intervention to prevent their needs escalating.
- Services and practitioners are equipped to identify risk and understand their responsibilities in responding to it, including an awareness of the need to 'think family' in relation to risk.
- Services and practitioners must be effectively trained in relation to new issues such as female genital mutilation, or forced marriage.

Recommendations for consideration by commissioners

- Ensure all planning processes routinely seek the views of parents and children when developing and commissioning services.
- Training for social workers and their managers to ensure consistent evidence-based assessment and decision making using consistent frameworks and models.
- Training for social care managers and quality reviewing managers in improving outcome-based SMART planning for looked after children and children the subject of a CPP. Training for this same group of staff to improve quality assurance and critical appraisal, as well as positive challenge of assessments and care plans.
- To ensure all practitioners and services fully understand their roles and responsibilities in relation to early intervention and that processes support the use of the Common Assessment Framework (CAF).
- Training and policies and procedures are revised in the light of emerging issues and changes in population.
- To ensure that when vulnerable children move to adult services, their needs are met in terms of adult safeguarding procedures and practices.
- To ensure that a consistent and good quality service for assessing and assisting children and young people who exhibit sexually harmful behaviour, or have sexually abused other children within South Gloucestershire, is commissioned in the near future, e.g. ‘Be Safe’.
- To ensure that a consistent and good quality service for assessing and assisting children and young people who are at risk of being sexually exploited within South Gloucestershire is commissioned in the near future. e.g. Barnardo’s Against Sexual Exploitation (BASE) Project.
- To ensure that consistent and good quality provision is in place for assessing antenatal risks associated with potential difficulties in parenting for pregnant women and future biological or social fathers.
- For commissioners to fully utilise enhanced quality frameworks when reviewing placements or services that truly ensure safeguarding policies and practices including training, supervision, safe recruitment (including Criminal Records Bureau [CRB] checking), quality of workforce, staff turnover and retention are compliant with the South Gloucestershire Safeguarding Children Board (SGSCB) requirements.

Recommendations for consideration by commissioners (continued)

- That commissioners ensure safeguarding policies and procedures include processes in relation to concerns or allegations in respect of volunteers or professionals who work with children or young people.
- That commissioners ensure services provided for adults who may be parents, carers, or pose a risk to children are aware of their responsibilities in relation to safeguarding children and are monitored with the same enhanced quality framework as are services who provide services for children and families.
- That future training for all staff working with children and young people in all agencies is based on the evidence of what works outlined in section 5, in order to improve knowledge, skills and experience of the child care workforce.

Safeguarding adults – domestic abuse

Domestic abuse is the use, attempt, or threat of violence; whether physical, emotional, sexual, psychological, or economic within an intimate and/or family-type relationship. Domestic abuse forms a pattern of coercive and controlling behaviour (see section 8.2.1).

Domestic abuse is common – nationally, nearly one million women experience at least one incident each year, two women are killed each week by a partner or ex-partner and most incidents are repeat. Children are abused when they witness domestic abuse in the home. The South Gloucestershire police district dealt with 2,744 incidents in 2010/11 of which 53% led to an offender being sanctioned in some way. From survey data it is estimated that there may be as many as 13,000 domestic abuse incidents in South Gloucestershire each year.

Services involved in dealing with domestic abuse aim to:

- prevent abuse from happening by training front line staff to recognise and respond to evidence
- protect victims through police and criminal justice measures and voluntary organisations which provide support in a crisis
- provide for victims and mitigate the damage done.

Key issues

- It is difficult to assess the true level of need due to significant under-reporting of domestic abuse incidents. There is ongoing work to support victims to report incidents.

- South Gloucestershire has a strong partnership working on domestic abuse, and the South Gloucestershire Safer and Stronger Partnership has identified supporting vulnerable victims as a strategic priority for 2012/13 in the Joint Strategic Assessment 2012.
- Many aspects of the services are well established to provide for and protect victims of domestic abuse. However, there are areas which need continuity of investment, or further development, as indicated in the recommendations below.

Recommendations for consideration by commissioners

Investment in prevention

- Awareness raising and information campaigns in the community, particularly targeted for specific community groups.
- There is a need to invest in a community-based programme for perpetrators of domestic abuse.

Provision of services

- Develop care pathways, particularly in the health sector including mental health services and drugs and alcohol services, with clear links between agencies.
- To seek to maintain three whole time equivalent (WTE) provision of Independent Domestic Violence Advisors (IDVAs) in South Gloucestershire (only one of which is currently funded by statutory agencies) to support high risk victims of domestic abuse.
- Maintain close partnership links to service providers for victims of domestic abuse e.g. Survive, Victim Support, Next Link and Barnardo's.
- Invest more resources for women in refuge, to enable more early intervention and support for emotional needs during their stay. Increase the provision of refuge accommodation overall.
- Continue to implement the IRIS project in primary care, to support identification and referral of victims.
- Continue to implement provision in accident and emergency for victims of domestic abuse, to improve identification and referral of victims.
- Ensure that all statutory agencies promote training for staff in provider services.
- Ensure through recording of data on domestic abuse disclosures in health agencies and recording of the care provided and onward referral.

Protection

- Continue to implement a high quality MARAC (multi-agency risk assessment conference) for high risk victims of domestic violence and to monitor repeat victimisation rates.

Safeguarding vulnerable adults

Vulnerable adults include older people who are dependent on others for part, or all, of their care; similarly people of any age with learning difficulties, mental illness or physical disability.

For example, national estimates are that 2.6% of people aged 65 years and over living in private households had experienced mistreatment involving a member of the family, close friend, or care worker in the past year – four per cent of incidents involving neighbours and acquaintances (see section 8.2.2).

Physical abuse was the most common mistreatment (30%), followed by neglect (23%), financial abuse (20%), emotional abuse (16%) and sexual abuse (6%).

Safeguarding alerts in South Gloucestershire are increasing each year. The majority of alerts about people aged 64 years or younger concern people with a learning difficulty; the majority of alerts for people over 65 years concern people with dementia.

Key issues

- Our population is ageing and this has resulted in an increased prevalence of age-related conditions that were less prevalent 50 years ago, for example dementia.
- Recent changes in the domestic environment involving family structure and economic circumstances are important when examining causes of adults at risk of physical or emotional abuse, financial abuse and social isolation.
- The increased focus on personalisation, choice and control is allowing for the use of unregulated services to provide care and support.

Recommendations for consideration by commissioners

- To commission respite care for ‘unseen carers’ who care for people with dementia and long term neurological conditions – as two examples.
- To ensure that providers are contractually held to account for safeguarding adults deemed at risk.
- To ensure that when vulnerable children move to adult services, their needs are met in terms of adult safeguarding procedures and practices.
- For commissioners to fully utilise enhanced quality frameworks when reviewing placements or services that truly consider adult safeguarding policies and practices including quality of workforce, CRB checking, staff turnover and recruitment and retention.
- Closer collaboration between all agencies including the regulatory bodies i.e. The Care Quality Commission.
- To consider preventative approaches and measures to reduce the likelihood of abuse of adults at risk.

Section 9: Communicable disease and health protection

Whilst many infectious diseases have reduced dramatically over the years due to improved social measures and housing and the availability of antibiotics and vaccines, several infectious diseases are still seen to disable (for example, meningitis and hearing loss) and kill (for example, influenza).

It is also worth remembering that new infections such as the human immunodeficiency virus (HIV) have emerged since the 1980s and persistent infections such as tuberculosis (TB) remain a problem. A global influenza pandemic emerged in 2008. For these reasons, it is important that monitoring infectious disease among South Gloucestershire residents continues and control measures are taken to prevent its spread.

The following short notes describe issues concerning infectious diseases relevant to South Gloucestershire residents (see section 9).

Food borne illness

Food poisoning is the most common infection locally producing a usually short-lived attack of diarrhoea and vomiting. The major contributors are campylobacter and salmonella infection, the former nearly always associated with poultry and the latter with a range of different food types.

The majority of outbreaks of diarrhoea and vomiting and, indeed, of all infectious disease are due to norovirus. This is not food borne but easily spread from person to person.

Tuberculosis

The incidence of TB is low (13 cases in South Gloucestershire in 2011) and stable but is on the rise elsewhere in the country. For this reason awareness of the illness should remain to ensure prompt detection and treatment.

Influenza

Although most people will recover within weeks of an attack of flu, people in risk groups – older people, those with long term illness – can become very ill and even die. In 2010/11, 67% of the more than 500 people who died from influenza infection were in a risk group. People in these groups are offered vaccination which is known to be effective in reducing serious illness – nationally just over half take up the offer. In South Gloucestershire, nearly 80% of people over 65 years received the vaccination.

Human papilloma virus (HPV)

Nearly all cases of cancer of the cervix can be ascribed to HPV infection. A vaccine effective against the two most common strains of the virus is offered to girls aged 12-13 years and is effective in preventing 70-80% of cancers. Vaccine uptake in South Gloucestershire is around 76% - slightly lower than the 80% target which will make the whole programme cost effective.

Health care associated infection (HCAI)

Two key infections are associated with a stay in hospital although not all originate there – many cases are brought into hospital from the community. Methicillin resistant staphlococcus aureus (MRSA) can lead to wound and tissue infection which is difficult to treat because it is resistant to many antibiotics. Clostridium difficile causes severe and dangerous diarrhoea especially among older people. Rates of both infections are falling in local hospitals as control measures take effect following a national campaign.

Blood borne viruses (BBVs)

The two most important blood borne viruses are HIV and hepatitis C (HepC). HIV is mainly a sexually transmitted infection but both are transmissible by injecting drug use – HepC almost exclusively so. HepC, if untreated, can lead to liver cirrhosis and sometimes, liver cancer. A respected modelling tool estimates that nearly 700 people have the virus in South Gloucestershire and that as many as 500 are eligible for treatment. Most people are unaware they carry the virus and treatment may not start until most of the liver is damaged. Early testing and treatment among injecting drug users is therefore very important and a big part of the work of local drug and alcohol services.

Immunisation

The primary immunisation course in infancy is a highly effective way of preventing serious disease. Whilst uptake rates for most of the components of the programme are excellent and at a level that will prevent outbreaks, the uptake rate for mumps, measles and rubella (MMR) has still not recovered from adverse publicity surrounding the now discredited link with autism.

Key issues

- A number of infections continue to show a rising trend which inevitably brings an increased demand for services and treatment.
- Many people are unaware of their infection status, particularly for blood borne viruses such as hepatitis C and HIV. Testing and follow-up pathways for those in risk groups must be robust.
- Many infections (such as TB, hepatitis, HIV and chlamydia) if left undiagnosed until a late stage can lead to serious morbidity and consequently higher treatment costs.

- Immunisation uptake needs to be increased to a level to prevent susceptibility in the general population. This is currently not being achieved for the measles, mumps and rubella vaccine.

Recommendations for consideration by commissioners

General

- Maintaining strategic oversight during organisational change where there are significant changes in responsibilities and arrangements.
- Ensuring priorities are consistent with the public health outcomes framework.
- Strong partnership working between the local authority, commissioning groups and Public Health England to monitor and react to changes in the local epidemiology of infections.

Specific

- Maintaining and improving vaccination coverage for the 2, 3, 4 month primary course, as well as the MMR vaccination, HPV and seasonal influenza vaccinations.
- Increase the testing of risk groups for HIV and other BBVs as well as increasing the chlamydia screening coverage.
- Ensure communication campaigns for health protection advice are coordinated, clear and timely across organisations.
- Preparedness and resilience for outbreaks and incidents both from known and emerging, or unexpected, events need to be robust.
- A long term view to mitigate and prepare for potential changes as a result of climate change e.g. increases in food borne and waterborne illness, vector borne diseases and respiratory infections.

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Appendix 2: Glossary and abbreviations

ADHD	Attention deficit hyperactivity disorder
ASC	Autism spectrum conditions
ASSIST	A smoking prevention programme which aims to reduce adolescent smoking prevalence
Avon IM&T	Avon Information Management and Technology Consortium
BASE	Barnardo's Against Sexual Exploitation
BBVs	Blood borne viruses
BME	Black and minority ethnic
BNP	Brain natriuretic peptide
CAF	Common Assessment Framework
CCG	Clinical Commissioning Group
COPD	Chronic obstructive pulmonary disease
CPP	Child Protection Plan
CRB	Criminal Records Bureau
DH	Department of Health
FSM	Free school meals
HCAI	Health care associated infection
HENRY	Health, Exercise and Nutrition in the Early Years
HepC	Hepatitis C
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
JSA	Job Seeker's Allowance
JSNA	Joint strategic needs assessment
LINk	Local involvement network
MMR	Measles, mumps and rubella
MS	Multiple sclerosis
NEETs	Those not in education, employment or training
PCT	Primary care trust
SEN	Special educational needs
SMART	A mnemonic to guide people when they set objectives - . the letters broadly conform to the words Specific, Measurable, Attainable, Realistic and Time-sensitive.
STI	Sexually transmitted infection
TB	Tuberculosis
VCS	Voluntary and community sector
YOS	Youth offending service

Appendix 3: Extract from the Health Profile for South Gloucestershire 2012

Health summary for South Gloucestershire

E06000025

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	1219	0.5	19.8	83.0		0.0
	2	Proportion of children in poverty ‡	6040	12.3	21.9	50.9		6.4
	3	Statutory homelessness ‡	173	1.6	2.0	10.4		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1807	55.5	58.4	40.1		79.9
	5	Violent crime	2789	10.6	14.8	35.1		4.5
	6	Long term unemployment	371	2.2	5.7	18.8		0.9
Children's and young people's health	7	Smoking in pregnancy ‡	325	11.1	13.7	32.7		3.1
	8	Breast feeding initiation ‡	2267	79.0	74.5	39.0		94.7
	9	Obese Children (Year 6) ‡	414	16.1	19.0	26.5		9.8
	10	Alcohol-specific hospital stays (under 18)	20	35.8	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	131	27.2	38.1	64.9		11.1
Adults' health and lifestyle	12	Adults smoking ‡	n/a	19.2	20.7	33.5		8.9
	13	Increasing and higher risk drinking	n/a	23.8	22.3	25.1		15.7
	14	Healthy eating adults	n/a	28.9	28.7	19.3		47.8
	15	Physically active adults ‡	n/a	11.5	11.2	5.7		18.2
	16	Obese adults ‡	n/a	26.2	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	43	16.1	13.6	26.8		2.7
	18	Hospital stays for self-harm ‡	500	196.6	212.0	509.8		49.6
	19	Hospital stays for alcohol related harm ‡	5680	1774	1895	3276		910
	20	Drug misuse	1228	7.1	8.9	30.2		1.3
	21	People diagnosed with diabetes ‡	9937	4.8	5.5	8.1		3.3
	22	New cases of tuberculosis	20	7.6	15.3	124.4		0.0
	23	Acute sexually transmitted infections	1251	472	775	2276		152
	24	Hip fracture in 65s and over ‡	237	400	452	655		324
Life expectancy and causes of death	25	Excess winter deaths ‡	109	17.5	18.7	35.0		4.4
	26	Life expectancy – male	n/a	80.6	78.6	73.6		85.1
	27	Life expectancy – female	n/a	84.2	82.6	79.1		89.8
	28	Infant deaths ‡	7	2.2	4.6	9.3		1.2
	29	Smoking related deaths	324	164	211	372		125
	30	Early deaths: heart disease and stroke ‡	137	47.0	67.3	123.2		35.5
	31	Early deaths: cancer ‡	287	98.6	110.1	159.1		77.9
	32	Road injuries and deaths ‡	75	28.7	44.3	128.8		14.1

‡ Substantially similar to indicator proposed in the Public Health Outcomes Framework published January 2012

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2009 3 Crude rate per 1,000 households, 2010/11 4 % at Key Stage 4, 2010/11 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2010/11 6 Crude rate per 1,000 population aged16-64, 2011 7 % mothers smoking in pregnancy where status is known, 2010/11 8 % mothers initiating breast feeding where status is known, 2010/11 9 % school children in Year 6 (age 10-11), 2010/11 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2008-2010 12 % adults aged 18 and over, 2010/11 13 % aged 16+ in the resident population, 2008/2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % aged 16 and over, Oct 2009-Oct 2011 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2006-2008 18 Directly age sex standardised rate per 100,000 population, 2010/11 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2009/10 21 % people on GP registers with a recorded diagnosis of diabetes 2010/11 22 Crude rate per 100,000 population, 2008-2010 23 Crude rate per 100,000 population, 2010 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2010/11 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.07-31.07.10 26 At birth, 2008-2010 27 At birth, 2008-2010 28 Rate per 1,000 live births, 2008-2010 29 Directly age standardised rate per 100,000 population aged 35 and over, 2008-2010 30 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 31 Directly age standardised rate per 100,000 population aged under 75, 2008-2010 32 Rate per 100,000 population, 2008-2010

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@sepho.nhs.uk












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