Worcestershire Health and Well-being Board Joint Strategic Needs Assessment (JSNA)

Joint Strategic Needs Assessment Intelligence Update

September 2016

www.worcestershire.gov.uk/jsna

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Executive Summary

This is the first JSNA summary since the adoption of the new Health and Wellbeing Strategy, with the three new priorities, keeping active at every age, preventing alcohol harm at all ages and good mental health and wellbeing at all ages. The report gives a brief overview of information relating to these priorities as well as a short summary of some new issues or issues that are on the horizon that provide challenges for health and wellbeing. Also included is a short summary and link to each of the JSNA products that have been published over the last year.

Keeping active at every age[1]

- The estimated rate of physically active adults in Worcestershire has fallen slightly in 2015. This is now similar to the national average and the rates of the CIPFA nearest neighbours[2], and better than the regional average.
- The estimated percentage of physically *inactive* adults in Bromsgrove, Malvern Hills and Worcester has increased since 2014.
- Over the last few years the proportion of adults in Worcestershire participating in sport and active recreation has increased slightly, but is still just less than a quarter. In contrast, more than half in the latest survey had not done any sport or active recreation in the previous four weeks.
- When it comes to older people's[3] participation in these activities the figures fall further, with only 15% doing so – lower than in other similar areas.

Preventing alcohol harm at all ages

- The rate at which under 18s are admitted to hospital for alcohol-specific conditions has decreased in Worcestershire, bringing us into line with the national average and other similar areas.
- However, the rate for people of all ages has increased and is now also in line with the national average. This increase has been greatest in middle aged women and this rate is now significantly higher than average and is the highest it has been for 6 years.
- The latest rate of males admitted to hospital for alcohol-related conditions in Worcestershire is significantly better than the national average, but it has increased from 729 per 100,000 population in 2011/12 to 791 in 2014/15.
- Both alcohol-specific and the wider definition of alcohol-related mortality have increased steadily in Worcestershire and are at the highest they have been since 2006-08.
- The rate of successful completion of treatment for alcohol clients in Worcestershire is lower than the national average for 2015/16. This has been in steady decline since 2013/14, whilst the national average has remained stable.

[1] Unless otherwise stated this report refers to 'older people' as those aged 65+
[2] 'Statistical neighbours' are areas or authorities with similar demographic and socio-economic characteristics.
[3] In this instance 'older people' means those aged 55+

Good mental health and wellbeing at all ages

- Recorded prevalence[4] of dementia in Worcestershire is lower than the national average.
- Recorded prevalence[3] of depression is significantly higher in Worcestershire than England and has increased from the previous year.
- Emergency admissions to hospital for self-harm are similar to the national average.
- Mortality from suicide is similar in Worcestershire to the national average.
- Self-reported well-being in Worcestershire is similar to both the national and regional average.
- Social isolation rates are significantly lower in Worcestershire than England.
- There are a number of 'at risk' groups which include: (i) those with dual diagnosis; (ii) people with long term physical illness or disability; (iii) Looked after children, particularly those in residential care and (iv) carers.

Emerging Issues

As well as giving the background data and analysis for these priorities the report flags up some additional issues that are emerging from routine analysis and data as being new or emerging as challenges for Worcestershire. These emerging issues are:

- *The narrowing gap* between Worcestershire and England; this is important because we must ensure health and wellbeing remains better in Worcestershire than the England average. Currently this differential is reducing in some key areas including cardiovascular disease and cancer mortality.
- *The rapid growth in housing;* this is important as it will potentially mean large changes in the population of the county, most likely a steeper increase than is currently being projected. The housing projects also provide an opportunity to encourage development plans which maximize opportunities for health and wellbeing through the application of health impact assessments (HIA) and a Health SPD.
- *Homelessness* can have a severe impact on health and wellbeing particularly for those who are categorized as 'rough sleepers'. Parts of Worcestershire have higher rates of homelessness than might be expected.
- *Sexual Violence* – Rates and numbers of recorded sexual violence have increased rapidly in Worcestershire as they have nationally. It is thought that this is due to much increased willingness of victims to report such crimes and better recording by the police.
- *Autistic Spectrum Disorder (ASD)* – this is important because children and adults with ASD need specialist support and care, but there is no definitive information about the prevalence of the condition in Worcestershire.
- *Migrant Health/Social Cohesion* – the health and wellbeing of migrant populations can be compromised due to social isolation and difficulties accessing healthcare.

Briefings Summary

Finally the report contains summaries of the data briefings produced for the JSNA over the last year. These briefings, along with other briefings, reports and needs assessments can all be found on the Worcestershire JSNA website at:

http://www.worcestershire.gov.uk/jsna

Briefings this year have been produced on:

(i) *Gender differences in health and wellbeing* – In all conditions (except excess winter deaths) mortality is higher amongst men than women; this is particularly noticeable in suicide and cardiovascular disease. Reasons for this discrepancy are complex and

[4] Number of people aged 65+ recorded with dementia or depression on GP practice disease registers; this is probably an underestimate of the actual occurrence in the population. However estimated prevalence of dementia is not available at a sub-national level.

poorly understood but may include differences in access to health services, particularly attending a GP with early signs of poor physical or mental health.

(ii) *Rural health* – Worcestershire is a very rural county; in some districts the population is very dispersed. Isolation and loneliness is a risk to health and wellbeing, particularly for older people living in rural areas.

(iii) *Road Safety* - The latest reported national casualty figures reveal that there has been an increase in the number of older people killed in road traffic collisions in Great Britain.

(iv) *Fuel Poverty* - Malvern Hills is the district with the highest rate of fuel poverty at 14.1% of households, an increase on the previous year and significantly worse than the national average.

(v) *Older People* – a key point here is that the number of people aged over 65 with a Long Term Limiting Illness (LTLI) in Worcestershire is projected to rise over the next 15 years by 41%. This has potential implications for individual health and wellbeing outcomes and also social care costs.

(vi) *Sexual Health* – Sexual health outcomes in Worcestershire are better than the national average; however poor sexual health is more common in areas of greater deprivation.

(vii) *Childhood obesity* - focusing on results from the National Childhood Measurement Programme (NCMP) 2014/15. The most deprived areas of Worcestershire have higher rates of children with excess weight than the least deprived areas. The gap between the most and least deprived areas increases with the age of the child.This is important as obesity in childhood frequently endures as obesity into adulthood.

(viii) *Teenage pregnancy* - Higher numbers of teenage conceptions occur in deprived areas. Worcester City, Redditch and Wyre Forest council district areas have the higher teenage conception rates in Worcestershire

(ix) *Smoking in pregnancy* - Despite being higher than the England average, the percentage of women smoking at delivery in Worcestershire is showing a gradual downward trend.

(x) *Self-harm in Children and Young People* - Social deprivation is strongly associated with self-harm, with the highest emergency hospital admission rates. Girls and female adolescents are at higher risk of self-harm compared to males, with evidence of a shift in age distribution towards young females (10-14 years).

(xi) *Early years district profiles* - Considerable inequality in good levels of childhood development is evident, with the most deprived areas having levels less than half those in the least deprived areas. New data for those eligible for free school meals shows much lower levels of attainment in this group than the general population (regardless of where they live).

(xii) *Learning Disabilities* - Estimates of prevalence suggest that there could be as many as 8,000 adults aged 18-64 in Worcestershire with a learning disability; but only around 2,413 people are recorded on GP registers as having a learning disability. Approximately 1,275 adults (aged 18-64) with a learning disability are getting long term support from the Local Authority and these numbers are falling.

(xiii) *Domestic abuse and violence* - There is a clear positive association between deprivation and reported incidents and crimes; in Worcestershire the rate of domestic abuse in the most deprived areas is almost 25 times that in the least deprived areas.

(xiv) *Sexual violence* – (To be added)

(xv) *Viewpoint survey results* - In Worcestershire as a whole, *overweight and obesity* is seen as by far the greatest threat to health (mentioned by 59% of respondents), followed by *physical inactivity* (37%). When asked about the importance of a healthy lifestyle; two thirds strongly agree that "a healthy lifestyle will reduce their chances of getting ill" but only a quarter of Worcestershire residents strongly agree they "live a healthy lifestyle".

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Introduction

Purpose of the JSNA Annual Summary

The JSNA Annual Summary is intended to provide a 'one stop shop' for the latest information and data on public health topics, namely the three Health and Wellbeing Board priorities and any emerging issues. A link is provided to the relevant documents on the JSNA website if people are interested in finding out more detail about the topic.

Demographics

Population now

Table 1: 2015 Mid-year estimates by Worcestershire district

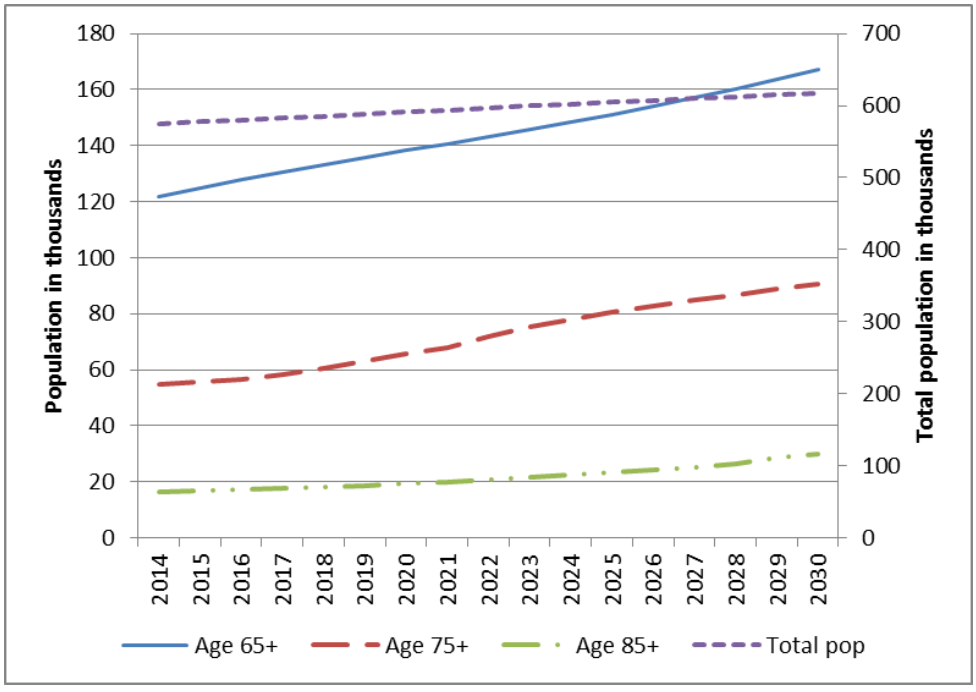
District in Worcestershire	Total Population
Bromsgrove	95,800
Malvern Hills	75,700
Redditch	84,700
Worcester City	101,300
Wychavon	121,500
Wyre Forest	99,500
Worcestershire	**578,600**

Source: Office for National Statistics

The current population in Worcestershire is estimated to be around 578,600; a breakdown by district is included (Table 1) revealing Wychavon as having the largest proportion of the total population in the county followed by Worcester City and Wyre Forest.

Population in the future

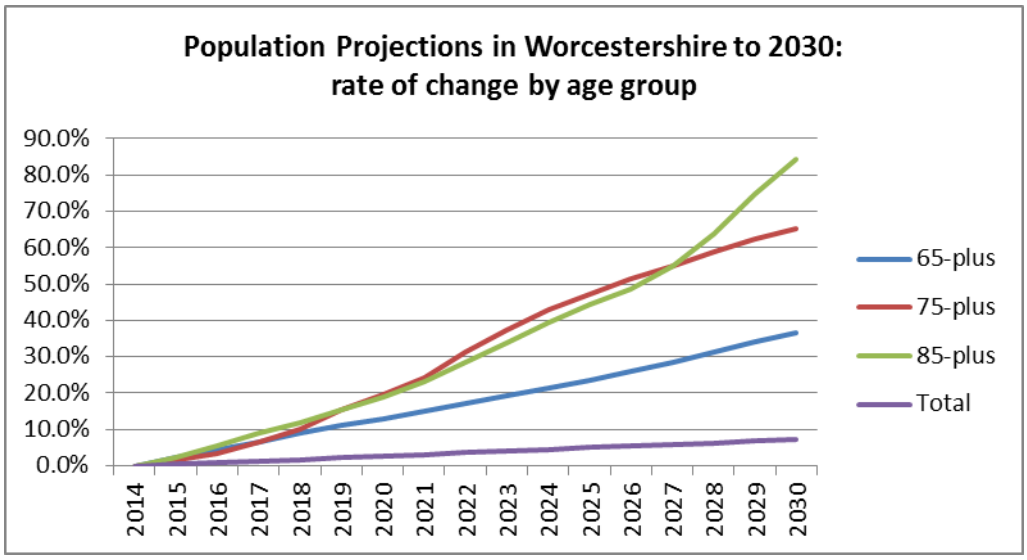
Figure 1: Aged 65+ Population projections in Worcestershire to 2030



Source: Office for National Statistics [2014 based population projections]

The population aged 65+ is projected to increase steeply to 2030 and beyond in Worcestershire; a slower increase is expected when all age groups are included (Figure 1). Within the older population (65+ age groups), the rate of increase is steeper for oldest age groups (Figure 2), with the rate of change for the 75+ population predicted to increase steeply post 2021, and the rate of change for the 85+ population to show a sharp increase from around 2027.

Figure 2: Aged 65+ Population projections to 2030: rate of change by age group



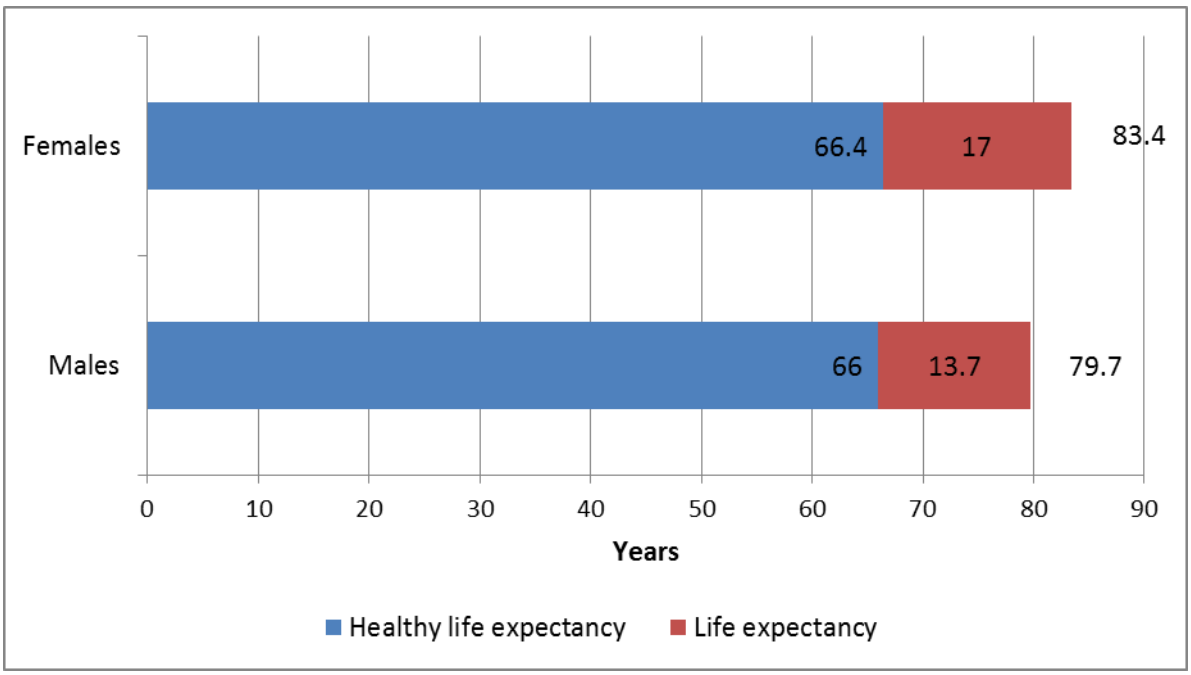
Source: Office for National Statistics 2014 based population projections

These population projections are estimated nationally by the Office for National Statistics and do not necessarily take into account any local conditions, such as planned housing developments. Local estimation work to model the potential impact of these local conditions on the projected population is underway at Worcestershire County Council and is due for completion in 2017. From initial work, we expect that the ONS projections shown above are likely to be an underestimation of the future Worcestershire population.

Life expectancy/HLE

The continued improvement in life expectancy, particularly for women, has been widely documented (ONS, 2015) and is a welcome by-product of modern medical and social care advances. Women are generally expected to live longer than men; this is true at Worcestershire county level where life expectancy is greater than the national average. Reasons for this can be complex, encompassing considerations including variance in lifestyles, free time and money availability and occupational hazards. However there is much more parity in healthy life expectancy between genders; women are living longer but in poorer health (Figure 3).

Figure 3: Healthy life expectancy shows parity between genders in Worcestershire 2012-14



Source: Public Health Outcomes Framework

New Health and Wellbeing Priorities

1. Keeping active at every age

Summary

- The estimated rate of physically active adults in Worcestershire has fallen slightly from 59.9% in 2014 to 58.3% in 2015. This is now similar to the national average and the rates of the CIPFA nearest neighbours, and better than the regional average[5].
- The estimated rate of physically inactive adults in Worcestershire has risen slightly from 24.8% in 2014 to 26.4% in 2015. This is still significantly better than the national and regional average, and similar to the rates of the CIPFA nearest neighbours.
- The rate of adults that participate in sport and active recreation in Worcestershire increased from 21.7% for the period October 2005-October 2006 to around 24% in the period April 2015-March 2016[6].
- Worcestershire has a higher percentage of adults that have not participated in any sport and recreation over the previous four weeks (51.9%) when compared to Warwickshire (49.9%) and Gloucestershire (49.8%). There are also noticeable differences in the rates of participation in sport and active recreation at the Worcestershire district level.
- Worcestershire has a lower percentage of adults aged 55 and over participating in sport and active recreation (14.9%) when compared to Warwickshire (16.7%), Gloucestershire (16.9%) and Suffolk (16.0%). There are also noticeable differences in participation rates in sport and active recreation between different age groups at the Worcestershire district level.
- The estimated utilisation of outdoor space for exercise/health reasons in Worcestershire has fallen over the period 2011-12 to 2014-15, but is not significantly different from the national and regional averages or the rates of the Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours.

Key indicators

Table 2 below shows the key indicators around physical activity from the Public Health Outcomes Framework for Worcestershire, the West Midlands and England in 2015.

Table 2: Comparison of Worcestershire against national and regional averages on key physical activity indicators from the PHOF

PHOF Indicator	Period	Units	England	West Midlands	Worcestershire	Trend
2.13i - Percentage of physically active and inactive adults - active adults	2015	%	**57.0** (LCI 56.8 - 57.3 UCI)	**55.1** (LCI 54.3 - 55.8 UCI)	**58.3** (LCI 56.5 - 60.0 UCI)	↓
2.13ii - Percentage of physically active and inactive adults - inactive adults	2015	%	**28.7** (LCI 28.4 - 28.9 UCI)	**30.9** (LCI 30.2 - 31.6 UCI)	**26.4** (LCI 24.8 - 27.9 UCI)	↑

Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, August 2016

Key

[5] As these data are synthetic estimates based on survey sample data these changes may represent 'regression to the mean'; i.e. any change is merely return to the average response and tends to even out over time.

[6] The participation rates are defined as the percentage of the adult population (age 16 and over) who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week). This includes light intensity activities (bowls, archery, croquet, yoga and Pilates) for those age 65 and over.

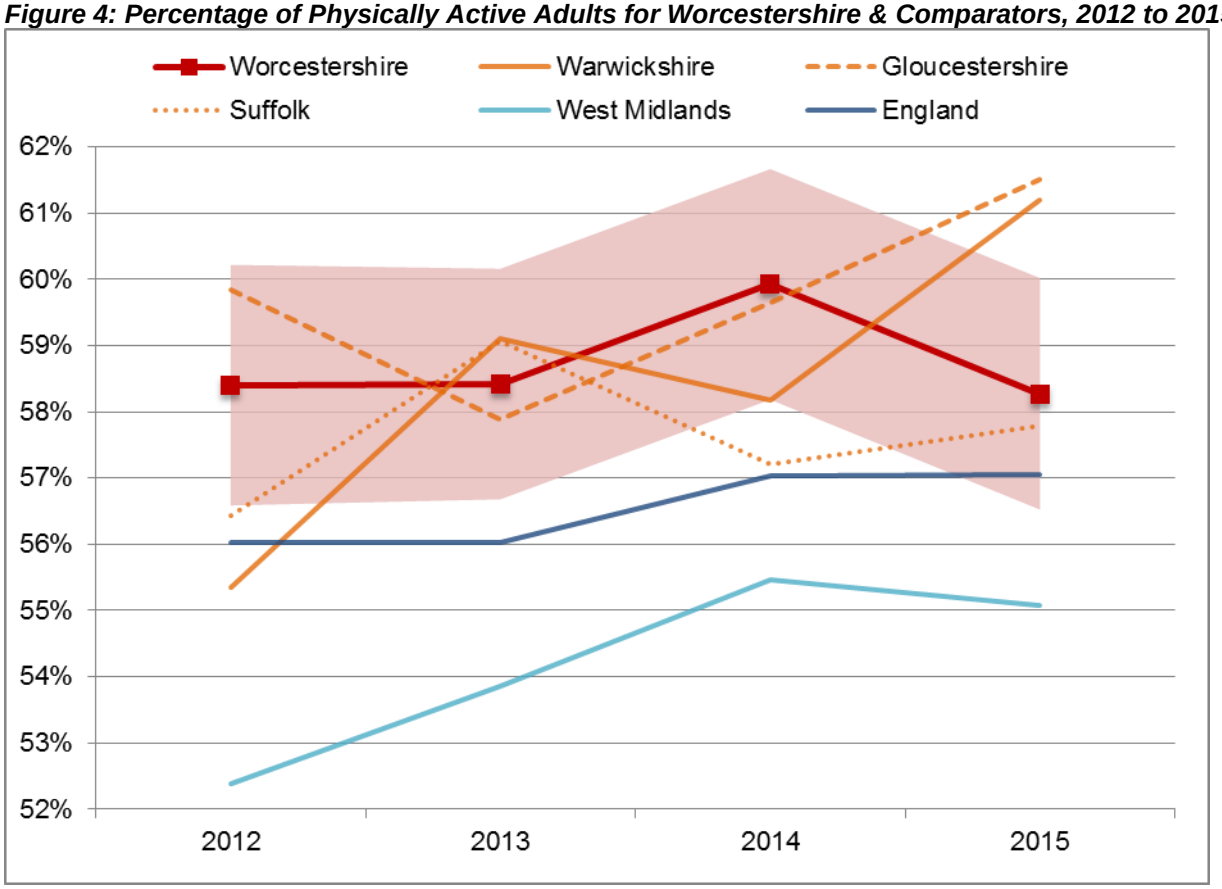
Compared with National benchmark:	Better	Similar	Worse	Lower	Similar	Higher	Not Compared

Note: LCI refers to Lower Confidence Interval and UCI refers to Upper Confidence Interval.

It can be seen from the table that, compared to the national averages, Worcestershire currently has a similar rate of physically active adults and a significantly better rate of inactive adults. However, the trend for both indicators in Worcestershire shows that performance is deteriorating. It is important to note the definitions of physically active and inactive[7].

Figure 4 below shows the estimated percentage of physically active adults for Worcestershire and comparators for the period 2012 to 2015.

Figure 4: Percentage of Physically Active Adults for Worcestershire & Comparators, 2012 to 2015



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, August 2016

It can be seen that;

- The level of active adults in Worcestershire has decreased slightly from 58.9% in 2014 to 58.3% in 2015. This is now similar to the national average and previous levels experienced in Worcestershire.
- The percentage of active adults in Worcestershire also remains similar to that of CIPFA nearest statistical neighbours Warwickshire, Gloucestershire and Suffolk, although it is worth noticing that levels of activity in Warwickshire and Gloucestershire have increased over the time period.

It is also worth noting that;

- [7] Active is defined as the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16 and over. Inactive is defined as the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing less than 30 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days.

- The estimated percentage of physically active adults in Bromsgrove, Malvern Hills and Worcester has fallen in 2015 compared to 2014. Each of these areas has moved from having an estimated percentage of physically active adults that was significantly better than the national average in 2014, to one that is similar to the national average in 2015.
- All of the Worcestershire districts now have a similar percentage of physically active adults to that of the National average when confidence intervals are taken into account.
- The level of inactive adults in Worcestershire has increased from 24.8% in 2014 to 26.4% in 2015, but remains significantly better than the national average.
- Rates of inactive adults in Worcestershire are similar to those of CIPFA nearest neighbours Warwickshire, Gloucestershire and Suffolk, although it is worth noticing that levels of inactivity in Warwickshire and Gloucestershire have decreased over the time period.

It is also worth noting that;

- The estimated percentage of physically inactive adults in Wychavon has fallen since 2013 and is now significantly better than the national average.
- The estimated percentage of physically inactive adults in Bromsgrove, Malvern Hills and Worcester has increased since 2014. Each of these areas has moved from having an estimated percentage of physically inactive adults that was significantly better than the National average to one that is similar to the national average.
- All of the Worcestershire districts, with the exception of Wychavon, now have a similar percentage of physically inactive adults to that of the national average when confidence intervals are taken into account.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6471/2015_briefing_on_physical_activity

To find out more about Sport England's Active People Survey and the local area estimates of adult participation in sport and active recreation, see http://www.sportengland.org/research/about-our-research/what-is-the-active-people-survey/.

2. Preventing alcohol harm at all ages

Summary

- The rate of under-18s admitted to hospital for alcohol-specific conditions in Worcestershire has fallen considerably from 86.8 per 100,000 population in 2006/07 – 2008/09 to 34.0 in 2012/13 – 2014/15. This is now similar to the National average, the regional average, and the rates of the CIPFA nearest neighbours.
- Although the latest rate of all persons admitted to hospital for alcohol-related conditions in Worcestershire is similar to the National average, it has increased from 598 per 100,000 population in 2013/14 to 641 in 2014/15.
- The latest rate of females admitted to hospital for alcohol-related conditions in Worcestershire is significantly worse than the national average, and has increased to 505 per 100,000 population in 2014/15 compared to 467 in the previous year. It is now at its highest level over the period 2008/09 to 2014/15.
- The latest rate of males admitted to hospital for alcohol-related conditions in Worcestershire is significantly better than the national average, but it has increased from 729 per 100,000 population in 2011/12 to 791 in 2014/15.
- The latest rate of alcohol-specific mortality in Worcestershire is similar to the national average, but has steadily increased from 10.1 per 100,000 population in 2009-11 to 12.0 in 2012-14. It is now at its highest level over the period 2006-08 to 2012-14.
- The latest rate of alcohol-related mortality in Worcestershire is similar to the national average, but has steadily increased from 40.8 per 100,000 population in 2011 to 47.3 in 2014. It is now at its highest level over the period 2008 to 2014.
- The rate of successful completion of treatment for alcohol clients in Worcestershire is lower than the national average at 26.7% for 2015/16. This has been in steady decline since 2013/14, whilst the national average has remained stable.

Key indicators

Table 3 below shows the key indicators around alcohol from the Public Health Outcomes Framework (PHOF) and the Local Alcohol Profiles for England (LAPE) for Worcestershire, the West Midlands and England in 2015/16.

Table 3: Key Alcohol Indicators for Worcestershire and West Midlands and National comparators

PHOF/LAPE Indicator	Period	Units	England	West Midlands	Worcs	Trend
2.18 Admission episodes for alcohol-related conditions - narrow definition (Persons)	2014/15	DSR per 100,000 pop	**640.78** (LCI 638.59 – 642.97 UCI)	**697.04** (LCI 690.01 – 704.12 UCI)	**641.24** (LCI 620.72 – 662.25 UCI)	↑
2.18 Admission episodes for alcohol-related conditions - narrow definition (Male)	2014/15	DSR per 100,000 pop	**826.92** (LCI 823.30 – 830.54 UCI)	**873.00** (LCI 861.57 – 884.54 UCI)	**790.87** (LCI 758.10 – 824.67 UCI)	↑
2.18 Admission episodes for alcohol-related conditions - narrow definition (Female)	2014/15	DSR per 100,000 pop	**474.24** (LCI 471.63 – 476.87 UCI)	**539.88** (LCI 531.26 – 548.60 UCI)	**505.17** (LCI 479.77 – 531.56 UCI)	↑
2.01 Alcohol-specific mortality	2012-14	DSR per 100,000 pop	**11.61** (LCI 11.44 – 11.78 UCI)	**13.69** (LCI 13.12 – 14.27 UCI)	**12.03** (LCI 10.45 – 13.76 UCI)	↑
4.01 Alcohol-related mortality	2014	DSR per 100,000 pop	**45.54** (LCI 44.95 – 46.13 UCI)	**50.96** (LCI 49.05 – 52.92 UCI)	**47.34** (LCI 41.97 – 53.18 UCI)	↔

PHOF/LAPE Indicator	Period	Units	England	West Midlands	Worcs	Trend
9.01 Admission episodes for alcohol-related conditions (Broad)	2014/15	DSR per 100,000 pop	**2,139** (LCI 2,135 – 2,143 UCI)	**2,231** (LCI 2,218 – 2,244 UCI)	**1,855** (LCI 1,820 – 1,890 UCI)	↑
6.01 Persons admitted to hospital for alcohol-specific conditions	2014/15	DSR per 100,000 pop	**364.44** (LCI 362.80 – 366.08 UCI)	**340.27** (LCI 335.38 – 345.21 UCI)	**285.82** (LCI 272.04 – 300.11 UCI)	↔
5.01 Persons under-18 admitted to hospital for alcohol-specific conditions	2012/13 – 14/15	DSR per 100,000 pop	**36.61** (LCI 35.97 – 37.25 UCI)	**32.78** (LCI 30.97 – 34.67 UCI)	**33.97** (LCI 28.09 – 40.71 UCI)	↓
15.01 Successful completion of treatment for alcohol*	2015/16	%	**39.2**	**n/a**	**26.7**	↓

Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, June 2016, and Local Alcohol Profiles for England, http://fingertips.phe.org.uk/profile/local-alcohol-profiles, June 2016.

* Taken from National Drug Treatment Monitoring System (NDTMS), https://www.ndtms.net, July 2016

Key

Compared with National benchmark:	Better	Similar	Worse	Lower	Similar	Higher	Not Compared

Note: LCI refers to Lower Confidence Interval and UCI refers to Upper Confidence Interval.

It can be seen from the table that, compared to the national average, Worcestershire currently has significantly better rate of hospital admissions for alcohol-related conditions for males, but a significantly worse rate for females.

Examining the data in more detail, the increasing rate of alcohol-related conditions for females in Worcestershire is largely driven by an increase in the rate of women aged 40-64 year old and over 64 admitted to hospital for alcohol-related conditions (see LAPE indicator '10.07 - Admission episodes for alcohol-related conditions (Narrow) - 40-64 years. (Female)' http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/3/gid/1938132982/pat/6/par/E12000005/ati/102/are/E10000034/iid/92320/age/287/sex/2).

Alcohol Specific Hospital Admissions for Under-18 year olds

Figure 5 below shows the rate of under-18s admitted to hospital for alcohol-specific conditions (narrow definition) per 100,000 population for Worcestershire, the CIPFA nearest neighbours of Warwickshire, Gloucestershire, and Suffolk, the West Midlands, and England.

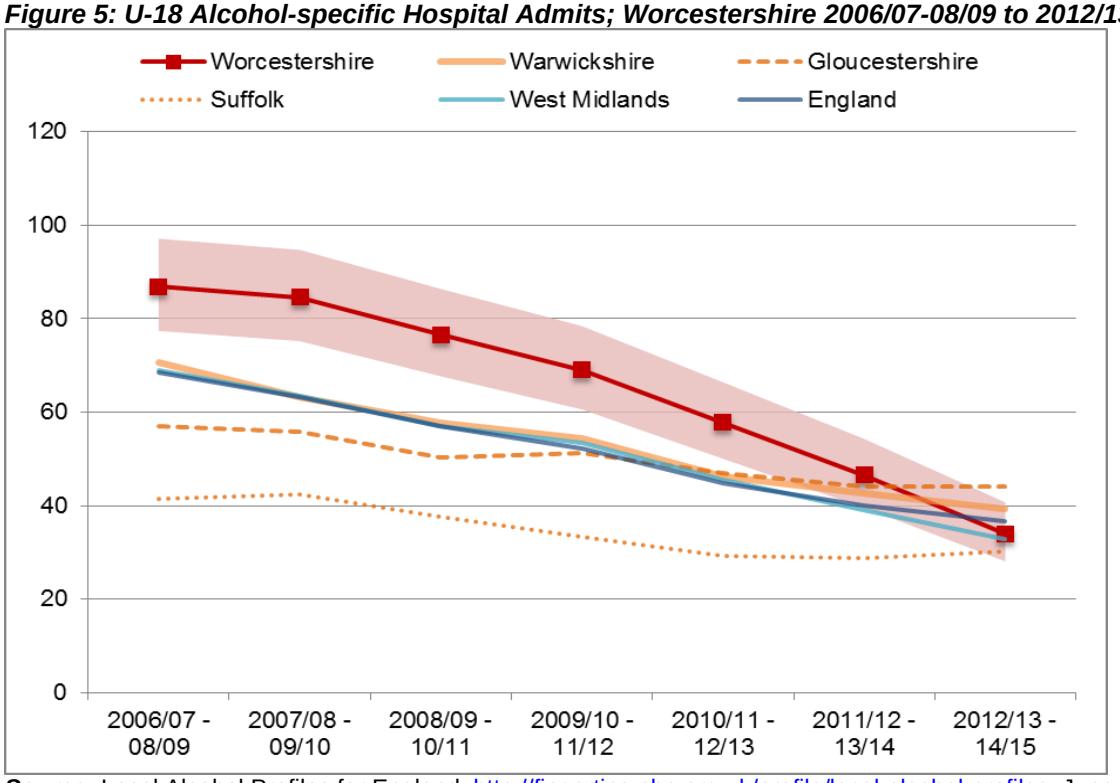
It can be seen that;

- The rate of under-18s admitted to hospital for alcohol-specific conditions in Worcestershire has fallen considerably over the time period and is now similar to the national average, the rates of the CIPFA nearest statistical neighbours, and the West Midlands.

It is worth noting that;

- The number of under-18s admitted to hospital for alcohol-specific conditions in Worcestershire was 117 in 2012/13-14/15 compared to 307 in 2006/07-08/09.
- At the District level, the rate of under-18s admitted to hospital for alcohol-specific conditions in Redditch is no longer significantly worse than the national average, as it was in previous years. The current rates for each district are now all similar to that of the national average.

Figure 5: U-18 Alcohol-specific Hospital Admits; Worcestershire 2006/07-08/09 to 2012/13-14/15

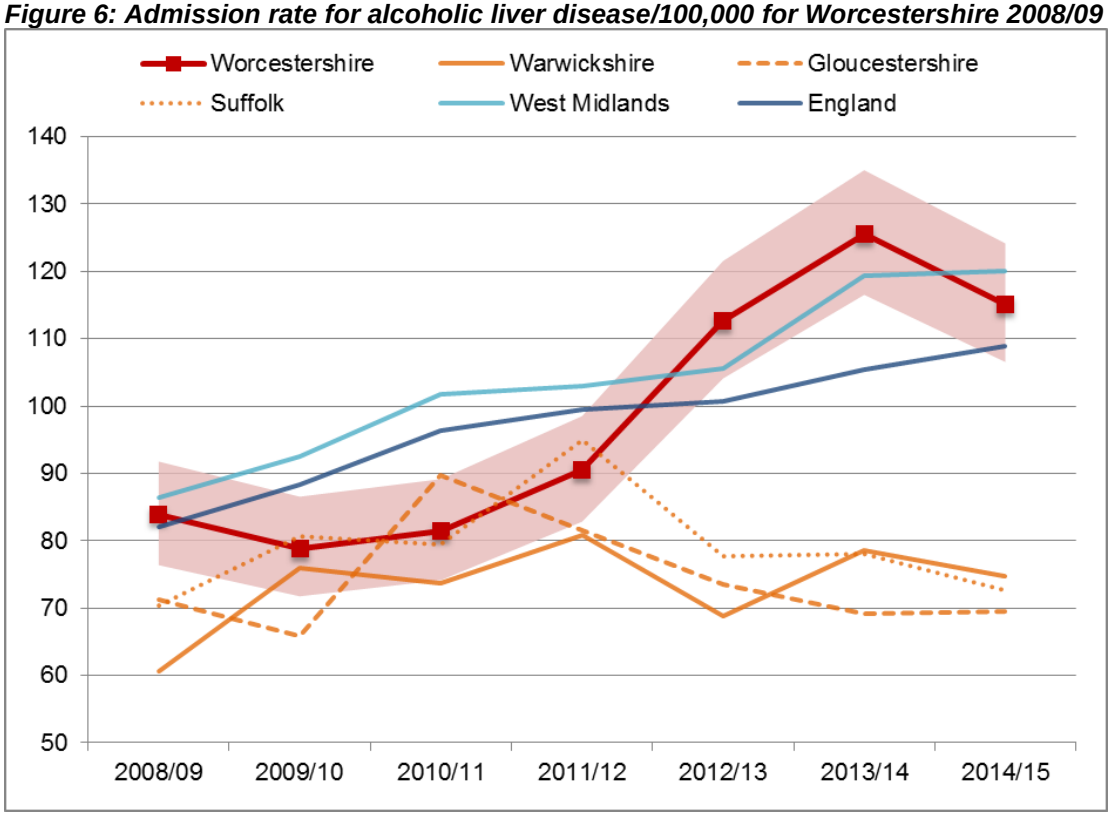


Source: Local Alcohol Profiles for England, http://fingertips.phe.org.uk/profile/local-alcohol-profiles, June 2016

Hospital Admission Episodes for Alcoholic Liver Disease Condition

Figure 6 below shows the rate of hospital admission episodes for alcoholic liver disease condition (broad definition) per 100,000 population for Worcestershire, the CIPFA nearest neighbours of Warwickshire, Gloucestershire, and Suffolk, the West Midlands, and England.

Figure 6: Admission rate for alcoholic liver disease/100,000 for Worcestershire 2008/09 to 2014/15



Source: Local Alcohol Profiles for England, http://fingertips.phe.org.uk/profile/local-alcohol-profiles, June 2016

It can be seen that;

- The rate of hospital admission episodes for alcoholic live disease condition (broad definition) in Worcestershire has fallen from 125.5 per 100,000 population in 2013/14 to 115.1 per 100,000 population in 2014/15. This is now similar to the national and West Midlands averages, but significantly higher than the rates of the CIPFA nearest neighbours.
- The rate of hospital admission episodes for alcoholic liver disease condition (broad definition) in Worcestershire was significantly higher than the national average in 2012/13 and 2013/14.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/2874/2016_briefing_on_alcohol

3. Good mental health and wellbeing at all ages

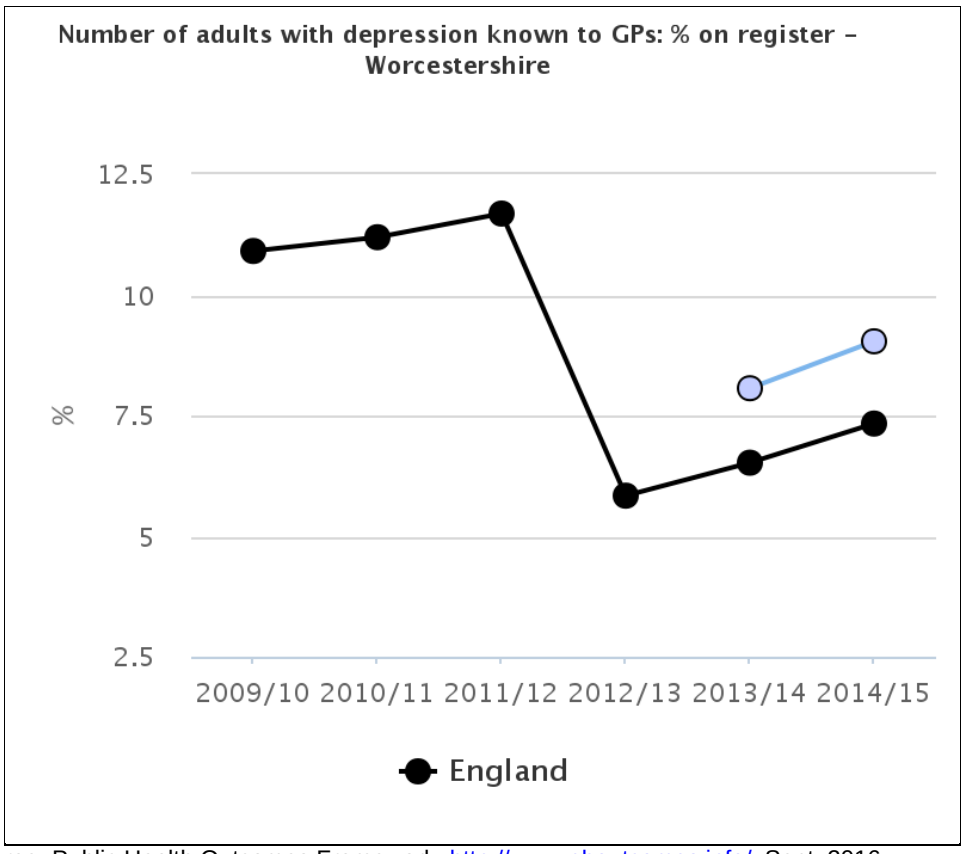
Summary

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can deal with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community.

Mental health underlies physical health. Compared with the general population, individuals with mental illness die prematurely, particularly those with schizophrenic and bipolar disorders who experience on average 25 years shorter life expectancy (RCPsych, 2010).

- Prevalence of dementia[8] in Worcestershire is lower than the national average
- Prevalence of depression[9] is significantly higher in Worcestershire than England, at 9.0% and has increased from the previous year (Figure 7).

Figure 7 – Depression in Worcestershire is significantly higher than the national average



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, Sept. 2016.

- Emergency admissions to hospital for self-harm are similar to the national average.
- Mortality from suicide is similar in Worcestershire to the national average
- Self-reported well-being in Worcestershire is similar to both the national and regional average.
- Social isolation rates are significantly lower in Worcestershire than England

[8] Proportion of patients with dementia within a GP registered population.
[2] Proportion of adult patients diagnosed with depression.
[3] Proportion of patients with schizophrenia, bipolar affective disorder and other psychoses in GP registered population

- Proportion of population using outdoor space for exercise/health reasons is similar to national average but lower than the West Midlands average. It is also much lower than similar areas including Shropshire.

Background: protective factors and vulnerable groups

The World Health Organization highlights the fact that mental health and well-being needs to be firmly embedded in the public health agenda.

- There is a higher prevalence of common mental disorders such as depression and anxiety in Worcestershire and many cases go undiagnosed as many people do not seek treatment; either due to difficulty in recognizing anxiety disorder or due to the stigma attached to mental illness (NICE, 2011).
- Awareness of the essential elements of wellbeing is increasing; a majority of people understand what steps they can take to improve it, such as taking a walk, or spending time with family and friends (PHE, 2016).
- A rapid increase in dementia, due to the ageing demographic, is a significant issue for Worcestershire which has a higher proportion of people aged 65+ than the national average.
- The mental and physical health of carers is a major concern: better support is needed for people who care for others. People caring for 50 or more hours per week are twice as likely to report their general health as "not good" (DoH, 2014).
- There are a number of 'at risk' groups (McManus et al, 2007) which include:
  - those with dual diagnosis (comorbid substance misuse);
  - people with long term physical illness or disability.
- An estimated 45% of looked after children having a mental health disorder, rising to almost three quarters of those in residential care. The government mental health strategy identifies 'looked after children' (LAC) as one of the particularly vulnerable groups and a priority for local authorities and the NHS (DoH, 2011).
- There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage (Marmot, 2010 and Maas et al, 2009).
- Health and happiness are closely connected – a higher proportion of people who report their health to be 'very good' also rate 'high' or 'very high' happiness (Figure 8).

Figure 8 – Happiness is linked with good self-reported health

Source: ONS Personal Wellbeing in the UK 2012-14

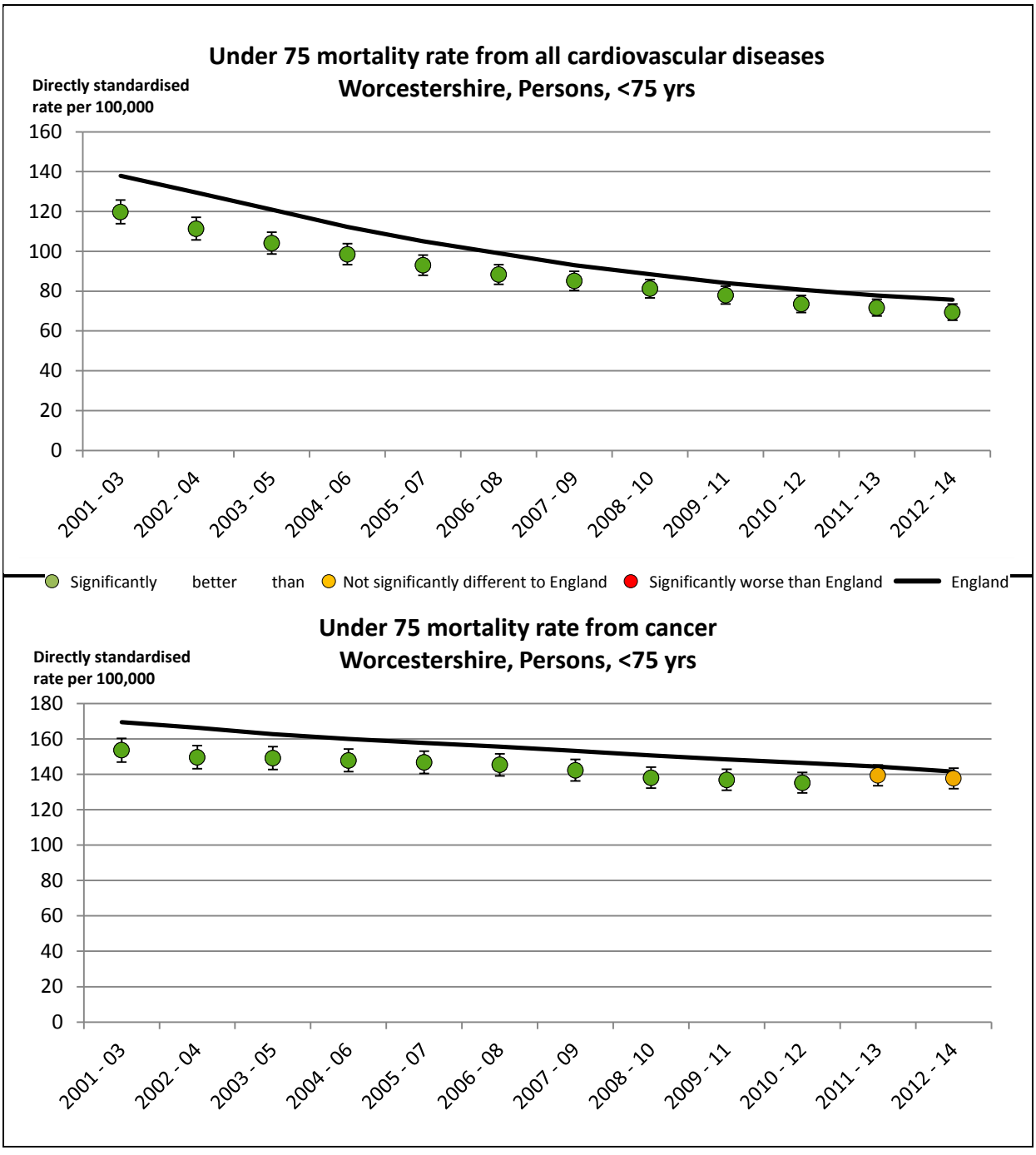
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/2885/2015_briefing_on_mental_health

Emerging Issues

1. The narrowing gap between Worcestershire and England

Overall Worcestershire has good health outcomes; however there is a general pattern of decreasing the gap between ourselves and England, particularly for the principal mortality measures. As can be seen in the charts below (Figure 9) for cardiovascular diseases and cancers (the two biggest causes of mortality) for under 75s, the gap between the England average and Worcestershire has narrowed over a long period. For cancers the latest two years are no longer significantly below average.

Figure 9 - The gap between England and Worcestershire is narrowing – U75 mortality rates

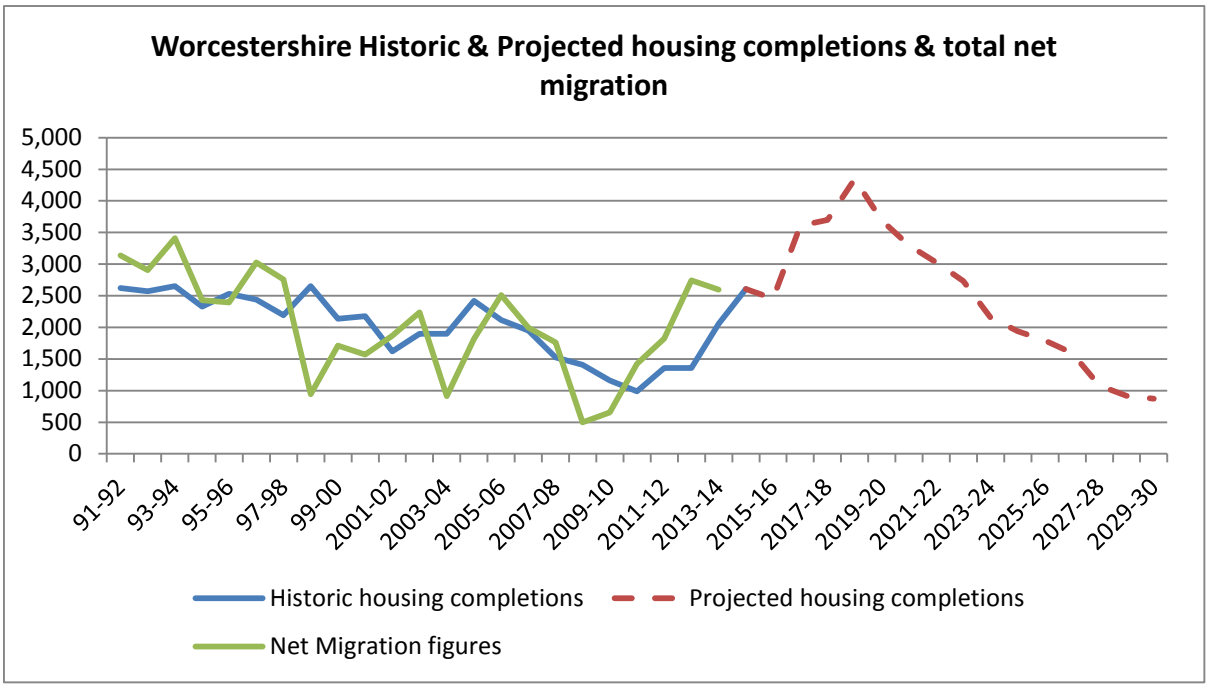


Data Source: Public Health England

2. Rapid growth in housing

One issue over the next few years in Worcestershire as in many other areas will be the projected rapid increase in house building in the local plans. For Worcestershire, if the housing projections contained in the plans are fulfilled it will mean an unprecedented increase in the number of new houses built in the County over the next 10-15 years. In total there are 37,622 new homes to be built in the 2014-30 period[10] at an average of 2,351 per year. However these will be front-loaded, such that in each of the next 9 years, more houses will be built than in any one year previously, as seen in the chart below (Figure 10).

Figure 10 – Projected change in housing completions in Worcestershire



Source: Housing completions taken from DCLG live tables on house building & Worcestershire Strategic Housing Market Assessment Monitoring Reports. Migration figures taken from ONS components of change 1991-2015

Such a rapid increase in housing, especially in those areas with the big new developments, will have a big impact on local infrastructure and especially transport. Having large new developments can also be an opportunity to plan in infrastructure that can have a positive impact on health such as good opportunities for active travel, well designed access to green space and leisure and open play spaces and developments which can encourage healthy lifestyles and support independent living for older people.

[10] Source: District Housing plans, as available at:
Redditch: http://www.bromsgrove.gov.uk/media/1665216/Redditch%20Updated%20Five%20Year%20Housing%20Land%20Supply.pdf
Bromsgrove: http://www.bromsgrove.gov.uk/media/748665/CD-12-BDP-Proposed-Submission-tracked-changes.pdf
Wyre Forest: http://www.wyreforestdc.gov.uk/media/1294518/SHLAAA-2015-Final-document2.pdf
South Worcestershire (covers Malvern Hills, Worcester City and Wychavon): http://www.swdevelopmentplan.org/wp-content/uploads/2015/09/Updated_Housing_Trajectories_17August2015.pdf

3. Homelessness

- Homelessness is an important social determinant of health and is associated with severe poverty, adverse mental and physical health and, particularly for children, poor social outcomes (including poor educational outcomes).
- Homelessness can contribute to health inequalities.
- Typically there are a higher proportion of men recorded as single homeless; however, slightly more female single homeless people were recorded in the most recent year (2014).
- Latest data suggests that Worcester City and Wyre Forest districts have homelessness rates significantly higher than the England average. However, the other districts in Worcestershire have homelessness rates significantly lower, and numbers are small.
- People who experience homelessness generally have a shorter life expectancy; for example the life expectancy of a rough sleeper in the UK is equivalent to a person living in a nation that has the lowest life expectancy in the world (NHS, 2013; ONS, 2014).
- The average age of death of a rough sleeper is 30 years earlier than average population (Source: Sheffield University/Crisis, 2012).
- 80% of homeless people report some form of mental health issue, 45% have a diagnosed mental health condition, compared to 25% of the general population (Homeless Link, 2014; Mental Health Network, 2014).
- Homeless people are also at higher risk of suicide; one in four will commit suicide (Mental Health Foundation, 2007).
- Despite the higher rates of mental ill health, less than a third of homeless people receive treatment (Mental Health Foundation, 2007).
- 41% of homeless people report a long-term health condition, compared with 28% of the general population.

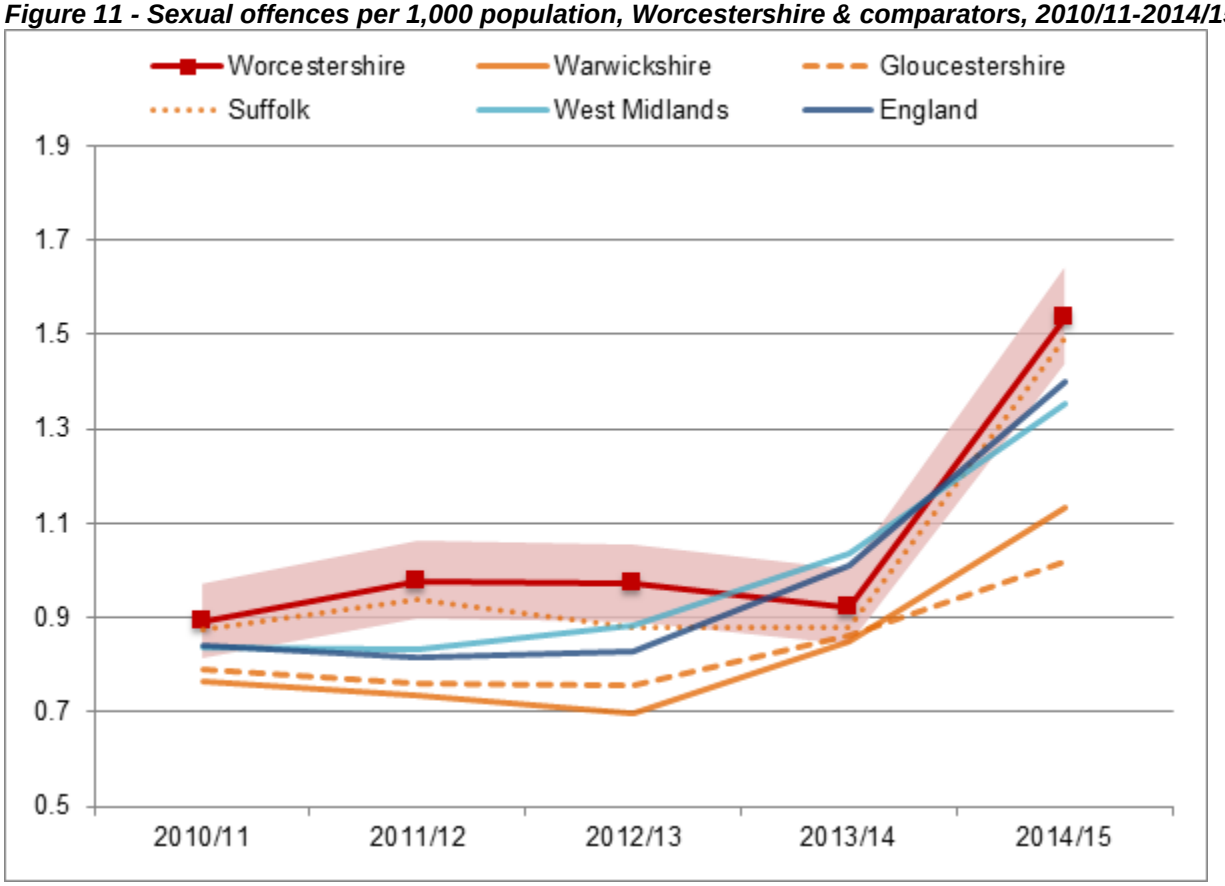
4. Sexual Violence

Estimates of the prevalence of sexual abuse are wide-ranging. The latest Crime Survey for England and Wales reported that 2.5% of females and 0.4% of males said that they had been a victim of a sexual offence (including attempts) in the previous 12 months.

Nationally the numbers of police recorded sexual offences have risen to their highest numbers ever recorded. These increases are considered to be due to greater victim confidence and a willingness of victims to report such crimes together with improved recording by the police rather than more sexual assaults taking place. It is also important that these increases are viewed in the context of the effects of police operations such as Operation Yewtree and other high profile cases involving sexual abuse that increased the willingness of people to report abuse and improved compliance with recording standards. Nonetheless, only about 11% of sexual abuse is estimated to be reported to the Police.

The rate of sexual offences significantly increased in Worcestershire in 14/15 to 1.54 per 1000 as it did nationally but this rate was higher than the national average (1.40) and our statistical neighbours. The number of sexual offences recorded in Worcestershire was 880 in 2014/15 compared to 524 in the previous year.

Figure 11 - Sexual offences per 1,000 population, Worcestershire & comparators, 2010/11-2014/15



Source: Public Health Outcomes Framework, http://www.phoutcomes.info/, May 2016

Sexual offences are governed by the Sexual Offences Act 2003 (England and Wales) and include sexual activity with a child under 18 years of age. The definitions of sexual offences outlined in the Act include rape, sexual assault, serious sexual assault and sexual activity with a child under 16. Child sexual exploitation (CSE) is a form of child sexual abuse and is covered by the Sexual Offences Act 2003. People can also experience sexual violence through intimate partner violence and abuse, chiefly domestic violence.

5. Autism Spectrum Disorder[11]

- Autism Spectrum Disorder (ASD) is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them.
- The latest prevalence studies of ASD (2007) indicate that 1.1%* of the population in the UK may have autism. This means that over 695,000 people in the UK may have autism, an estimate derived from the 1.1% prevalence rate applied to the 2011 UK census figures.
- There are no estimates of the overall numbers of people with ASD in Worcestershire. An epidemiological survey would be needed to provide this figure.
- According to the Department for Education, the number of pupils in January 2016 with an SEN statement for Autistic Spectrum Disorder (ASD) in Worcestershire were 173 (138 in Jan 2010) and 238 (242 in Jan 2010) for primary and secondary schools respectively. (https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2016). This data refers only to those giving ASD as a primary type of need so is likely to under-represent the numbers with ASD.
- Information from reports received by Health watch Worcestershire from four service users (Feb 2016) suggested the following issues:
  - A need for better ASD specific training for social care staff that are assessing support needs.
  - Need for better provision of appropriate ways for people with ASD to be meaningfully engaged.
  - Need for supported living which meets the specific needs of adults with ASD.
  - Lack of appropriate support for mental health issues for adults with Asperger syndrome.
- Further research is needed to better assess the needs of those with ASD in Worcestershire.

[11] 'Autism spectrum disorder' (ASD) is now likely to become the most commonly given diagnostic term Source: National Autistic Society website

6. Migrant Health/Social Cohesion

- The numbers of migrants from EU countries – particularly accession states - have been increasing in Worcestershire.
- Accurate numbers are hard to come by but some indication is given by figures from the Census of Population showing an increase from 7,000 to 14,500 between 2001 and 2011 in the numbers of people with "white other" ethnicity (most but not all EU migrants will have this ethnicity).
- In 2008 it is estimated that around 4,000 nationals of EU accession states were living in Worcestershire. The highest population rates were in the Worcester, Kidderminster, Redditch and Evesham areas.
- Other migrants include refugees fleeing conflicts around the world. In 2016 Worcestershire is expected to receive 50 refugees from the Syrian crisis for example. The needs of these groups will often be greater than those for economic migrants,
- According to a recent report (Migration Observatory, 2014) barriers to access and use of health care for migrants include:
  - inadequate information, particularly for new migrants unfamiliar with health care systems in the UK.
  - insufficient support in interpreting and translating for people with limited English fluency, lack of access to reliable transport because of poverty and poor services in areas of deprivation where many recent migrants live,
  - confusion around entitlement to some types of services particularly among migrants with insecure immigration status as well as among service providers.
  - cultural insensitivity of some front line health care providers.
- Action to alleviate the above barriers can help to improve social cohesion and health of migrants in Worcestershire.

Summary of New JSNA products 2015/16

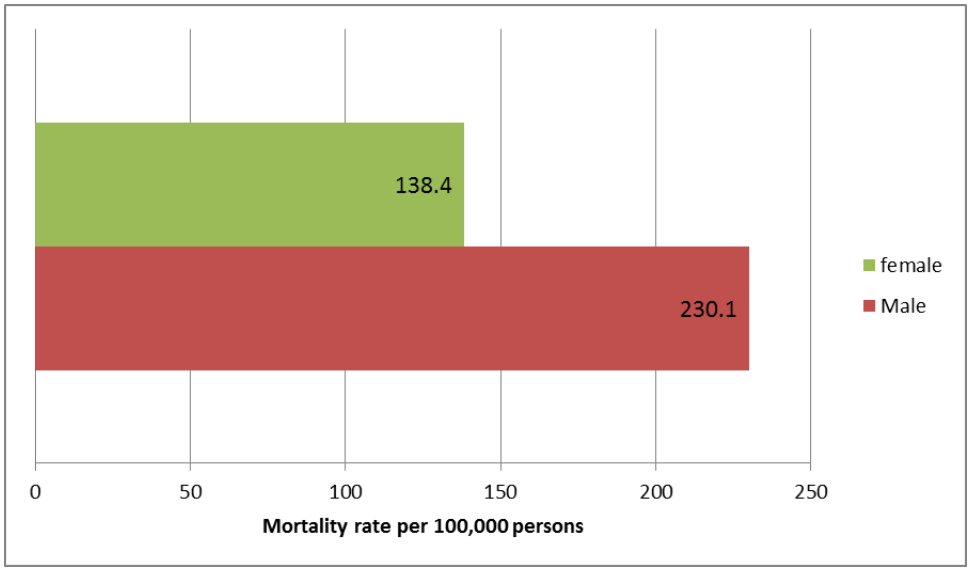
(i) JSNA Profile on gender differences in health and wellbeing

"Gender equality in health means that men and women across the life course and in all their diversity, have the same opportunities to realize their full rights and potential to be healthy…Achieving gender equality in health often requires specific measures to mitigate barriers" (WHO, 2015a)

Summary

- Gender differences in health and well-being endure but are changing. For example, although life expectancy is still higher amongst women, years spent in good health (healthy life expectancy) is now similar for women and men.
- Smoking, traditionally, is more common amongst men with consequent higher mortality; however, evidence suggests that the rate of smoking is now highest in young women.
- There are gender-specific reasons for certain conditions; for example weight gain; these differences need to be taken into account when tackling overweight and obesity.
- More cancers are registered in males than females across most cancer sites; there are also gender differences in the experience of cancer care, with men being more positive.
- Men are less likely to have common mental disorders than women. Gender stereotypes affect the diagnosis of mental ill health with women more likely to be diagnosed with depression than men, even when presenting with identical symptoms.
- In all conditions (except excess winter deaths) mortality is higher amongst men than women; this is particularly noticeable in suicide and cardiovascular disease (Figure 11). Reasons for this discrepancy are complex and poorly understood but may include differences in access to health services, particularly attending a GP with early signs of poor physical or mental health.

Figure 12 – All cause mortality (England) and suicide is higher amongst men 2012



Source: Public Health Outcomes Framework

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/7159/2016_august_gender_differences_profile

(ii) Rural Health

Summary

- Worcestershire is a predominantly rural county with some urban areas (categorized as having over 10,000 population). 85% of the area of Worcestershire is categorised as rural; 74% of the population of Worcestershire live in urban areas. Rural areas may have specific health and wellbeing challenges frequently related to access to services e.g. high stroke mortality and social isolation.
- From the physical activity perspective, active travel has been found to be 65% higher amongst urban residents than rural residents (Hutchinson et al, 2014), with a resulting inequality in health and wellbeing benefits.
- Previous research suggests that there are significant differences in health between urban and rural areas. For example research in Scotland established large ratios for ischemic heart disease (IHD) and cancer amongst the remote elderly (Levin & Leyland, 2006). Analysis of cancer rates reveals lower age standardized incidence of lung cancer and higher rates of breast, prostate and colorectal cancers in rural areas (NCIN, 2011).
- Social isolation and loneliness is more of an issue in rural areas (Bernard, 2013) and is of particular concern because of the ageing population in Worcestershire. Loneliness has a significant impact on health and wellbeing (SCIE, 2012) adversely affecting cardiovascular health and immune function.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6594/2016_Briefing_on_rural_health

(iii) Road Safety

Summary

- Research has found that people over 70 years old in Britain make more journeys on foot than as car drivers (except in rural areas). This means there is a higher proportion of elderly pedestrians than in other age groups. Their vulnerability is increased by the fact that damage caused by collisions is more severe for older pedestrians with the risk of fatality increasing rapidly from aged 70 years due to physical frailty.
- The latest reported national casualty figures (DfT, 2015) reveal that there has been an increase in the number of older people killed in road traffic collisions in Great Britain. The reasons for this are twofold:
  (i) The proportion of the population aged 65+ is increasing, particularly amongst the older old (85+) – this will impact on the numbers of casualties and is particularly relevant to Worcestershire demographic projections.
  (ii) This increase is expected to be particularly large amongst the oldest old – i.e. those aged 85+. These people are most vulnerable to serious injury or death in road traffic collisions and as pedestrians due to frailty.
- Fear of swift traffic is common amongst older people as well as fears of falling (NICE, 2012); this fear may be due to uneven pavements and car parks not designed for pedestrians. Another factor is the slower walking speed in this group, meaning they have difficulty walking across pedestrian crossings in time before the lights change (Asher et al, 2012).

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6591/2016_briefing_on_road_safety_and_older_people

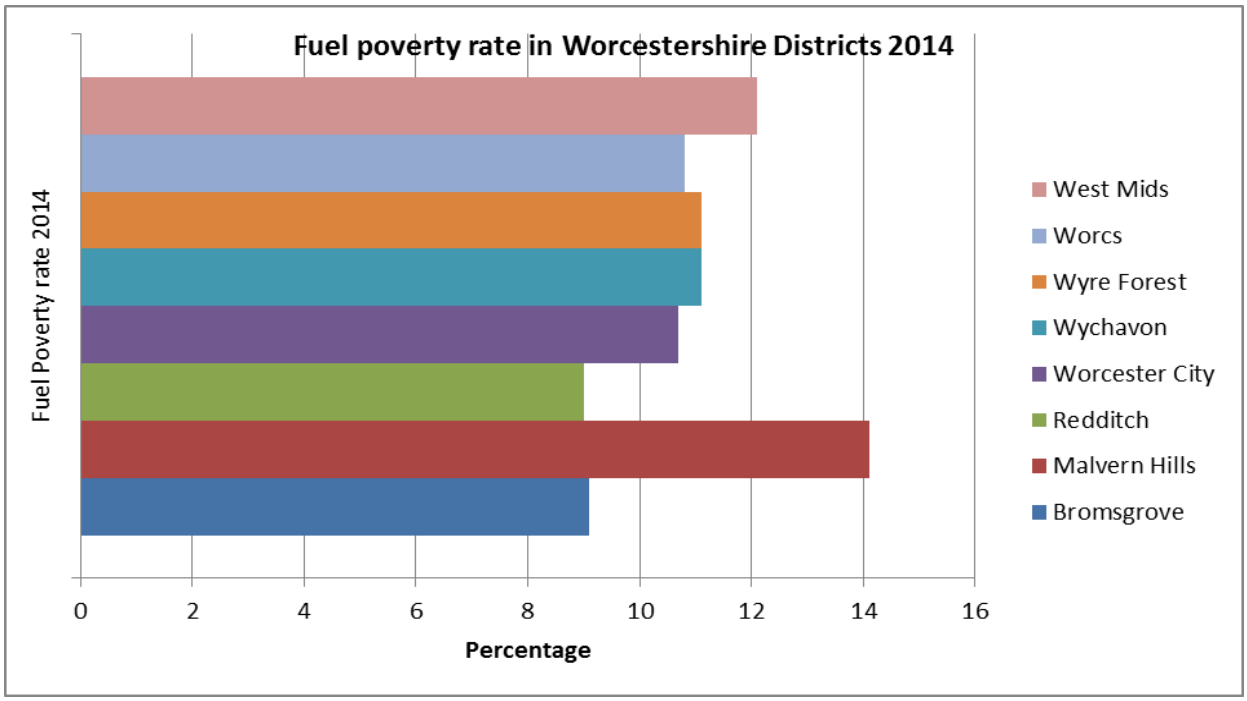
(iv) Fuel Poverty

"Addressing fuel poverty is essential for creating a more equitable and healthy society where all households are able to keep themselves warm and healthy" [12]

Summary

- Fuel poverty is driven by three main factors: income, current cost of energy and energy efficiency of the home (PHE, 2014). Consequently, a social gradient in fuel poverty exists, contributing to social and health inequalities (PHE, 2014).
- Fuel poverty is similar in Worcestershire to the England average, affecting just under 11% (around 26,000 in total) of households in 2014 compared with 10.4% in England as a whole. This is an improvement on the 2013 situation when Worcestershire was significantly worse.
- However, Malvern Hills has experienced an increase in the fuel poverty rate on the previous year and is significantly worse than the national average (Figure 12).
- Fuel poverty is focused in dwellings occupied by older householders (aged over 65) which are three times more likely to be fuel poor than dwellings with younger residents (13.9% versus 3.4%).

Figure 13** - **Comparison of fuel poverty rate in Worcestershire districts



Source: Department for Energy and Climate Change

- It is estimated that fuel poverty and cold homes cost the NHS around £200 million per year; the actual costs may be a lot higher if other factors are considered, including educational underperformance of children in fuel poverty.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6902/2016_Briefing_on_fuel_poverty

[12] Source: climatejust.org.uk

(v) Older People Briefing

Summary

- In 2014 Worcestershire had an older population than nationally (17.3%). The highest proportion of older people is in Malvern Hills, and the lowest proportion is in Worcester.
- The population of people aged 65 and over in Worcestershire is projected to grow by over a third between 2015 and 2030. This increase will be concentrated in the oldest age groups.
- The population of ethnic minority older people in Worcestershire is relatively small (966 or just under 1% in 2011).
- Life expectancy for men and women is higher than regionally and nationally. By 2019-21, male life expectancy in Worcestershire is projected to rise from its 2011-13 level by 2 years to 81.8 years and female life expectancy to rise by 1.5 years to 85 years.
- Smoking prevalence, while below national levels, is a major cause of premature deaths in the county. Redditch has a significantly high smoking prevalence compared to national levels.
- The number of people aged over 65 with a Long Term Limiting Illness (LTLI) in Worcestershire is projected to rise over the next 15 years by 41%.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/3773/2016_briefing_on_older_people

(vi) Sexual Health Briefing

Summary

- The 15-44 population (reproductive age) in 2015 of Worcestershire is estimated to total 198,000. Over the next 10-15 years the population aged 15-44 is projected to decrease slightly.
- Sexual health outcomes in Worcestershire are better than the national average with lower rates of sexually transmitted infections (STIs), HIV, unintended pregnancies and abortions and high rates of prescribing of all methods of contraception. However, of concern are teenage pregnancy rates in some parts of the county, poor chlamydia screening rates amongst young people and the variability of sex and relationship education provision.
- In Worcestershire poorer sexual health is more common amongst young people/adults, men who have sex with men (MSM), black and minority ethnic (BME) populations and in areas of greater deprivation. The sexual health needs of more at risk groups such as deprived young people, looked after children & care leavers, MSM, BME and needs of the rising older population are likely to increase.
- Within the county sexual health outcomes are poorer in Worcester and Redditch districts, with significantly higher STI and teenage conception rates and lower rates of contraceptive and long acting reversible contraception (LARC) prescribing in primary care. In comparison Wyre Forest has similar STI and teenage conception rates to the rest of the county and has high rates of contraception and LARC prescribing.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/7007/2016_briefing_on_sexual_health

(vii) JSNA Briefing on childhood obesity focusing on Results from the National Childhood Measurement Programme (NCMP) 2014/15

Summary
The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children. This data is used both at a national and local level to support local public health initiatives and inform the local planning and delivery of services for children. The NCMP was set up in line with the Government's strategy to tackle obesity.

- Coverage in Worcestershire has been consistently higher than the target of 85% of the eligible population since 2008/09.
- In Worcestershire the percentage of children with excess weight (overweight and obese combined) in Reception year has decreased during 2014/15 bringing them to their lowest levels since measuring began. This has narrowed the gap considerably between Worcestershire and England as a whole, however, Worcestershire still has a higher percentage than England.
- For the first time since data collection started, Worcestershire had a lower percentage of overweight children in Year 6 (age 10-11) in 2014/15 than England. This, combined with Worcestershire continuing to have a lower percentage of obese Year 6 children, meant that the overall percentage of children with excess weight for Year 6 in Worcestershire dropped to 30.7% compared to 33.2% in England as a whole. This is 2.5 percentage points difference which is the widest gap since data collection began.
- In both year groups, boys have higher percentages of excess weight than girls. The gap widens between the sexes between Reception and Year 6.
- Wyre Forest and Wychavon have significantly higher percentages of children with excess weight for Reception year than the Worcestershire average in the 3 years pooled data 2012/13 – 2014/15. However, the time trend for Wyre Forest does indicate an improvement in the percentage of Reception children with excess weight.
- In the same time period, Wyre Forest had the highest percentage of Year 6 overweight and obese children.
- The most deprived areas of Worcestershire have higher rates of children with excess weight than the least deprived areas. The gap between the most and least deprived areas increases with the age of the child.
- Encouragingly, if we treat 2009/10 as the first year of measurement, as this was the first year in which coverage exceeded 90% for both year groups, the percentage excess weight (overweight and obese) trend looks steadily downward.

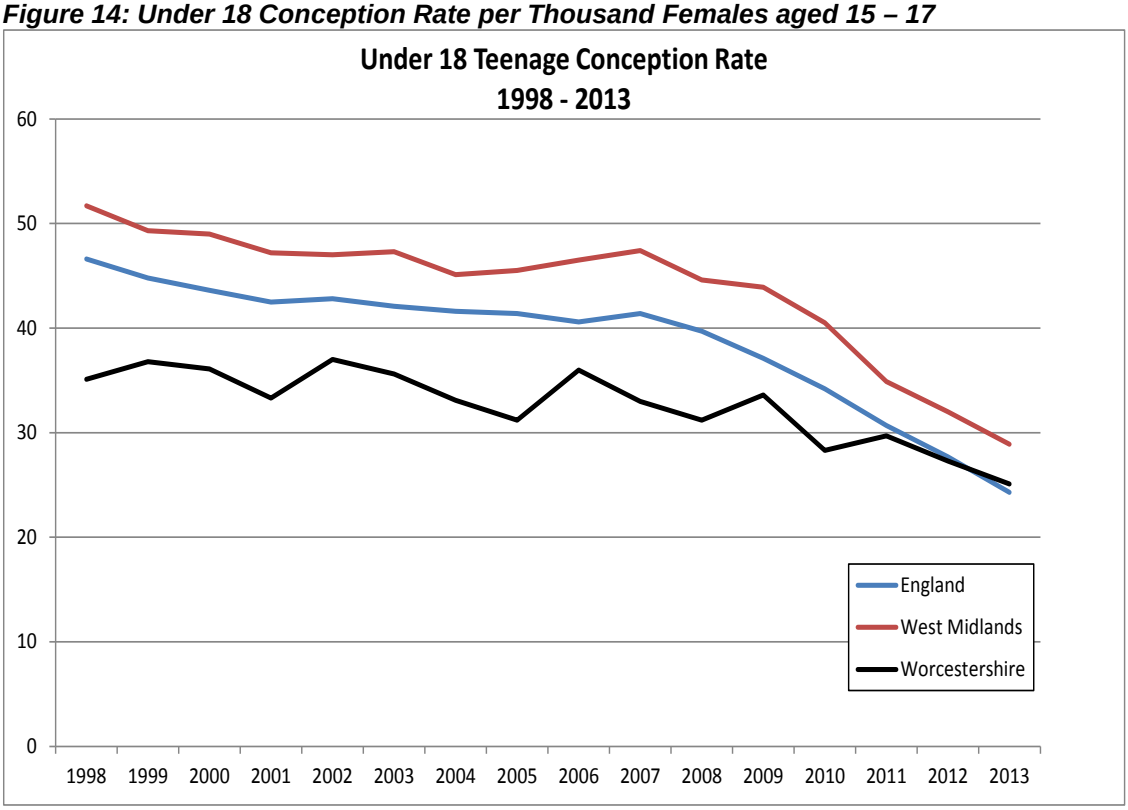
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6553/2015_briefing_on_childhood_obesity

(viii) JSNA Briefing on Teenage pregnancy

Summary

- Most teenage pregnancies are unplanned and around half end in an abortion. For some young women having a child when young can represent a positive turning point in their lives.
- Having a child at a young age often results in poor outcomes for both the teenage parent and the child; in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.
- The teenage pregnancy rate in Worcestershire was statistically significantly lower than England, until the last 3 years. This does not mean that the rate in Worcestershire is getting worse, just that the rate in England has decreased more rapidly than the Worcestershire rate in recent years (Figure 13).

Figure 14: Under 18 Conception Rate per Thousand Females aged 15 – 17



Source: National and local data analysed by Worcestershire PHIT

- Each year there are is an average of 280 teenage conceptions in Worcestershire of which approximately half of these lead to an abortion.
- This means that every year, 140 mothers aged under 18 make the choice to have a child in Worcestershire.
- Higher numbers of teenage conceptions occur in deprived areas.
- Worcester City, Redditch and Wyre Forest council district areas have the higher teenage conception rates in Worcestershire

Update: Since publishing the briefing more recent figures have just been published which show that the Worcestershire rate for 2014 is now once again lower than England.

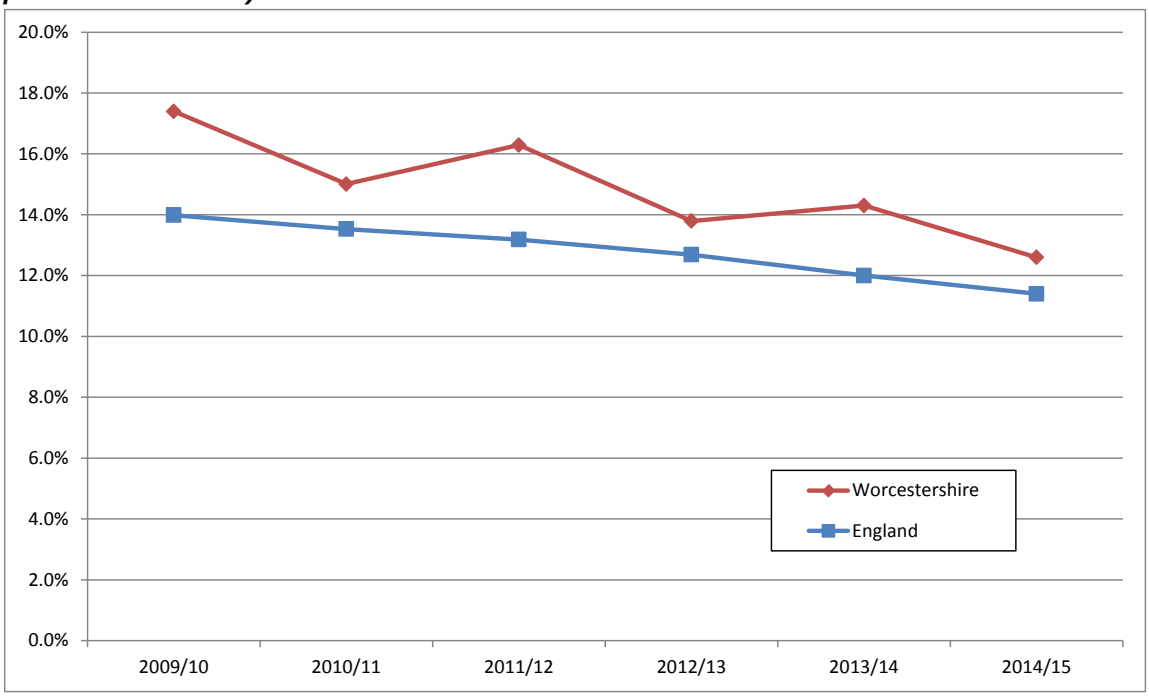
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6245/2015_briefing_on_teenage_pregnancy

(ix) JSNA Briefing on Smoking in pregnancy

Summary

- Smoking during pregnancy has many serious health implications for both the mother and unborn child, causing up to 2,200 premature births, up to 5,000 miscarriages and 300 perinatal deaths every year in the UK. It is the major modifiable risk factor in relation to low birth weight and increases the risk of developing a range of longer term conditions.
- Although rates are lower than in the past, over 12% of women in Worcestershire still smoke at the time of delivery, which translates into more than 660 infants born to smoking mothers each year. Across the UK the figure is a shocking 76,000 infants.
- In Worcestershire as nationally, smoking in pregnancy is strongly linked to deprivation and age, with mothers under 20 years showing higher rates of smoking compared to older mothers.

Figure 15: Smoking in Pregnancy (Percentage of women who currently smoke at time of delivery per 100 maternities)



Source: National and local data analysed by Worcestershire PHIT

- Reducing smoking during pregnancy is one of the three national ambitions in the Tobacco Control Plan published in March 2011, which is "to reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth)".
- Worcestershire has consistently been statistically significantly worse than the England average over the last 5 years. However, despite this, the percentage of women smoking at delivery in Worcestershire is showing a gradual downward trend (Figure 14).
- In line with national trends mothers aged under 20 years in Worcestershire are showing higher rates of smoking at delivery compared to older mothers. Mothers living in deprived areas are more likely to be smoking at delivery compared with mothers in less deprived areas.

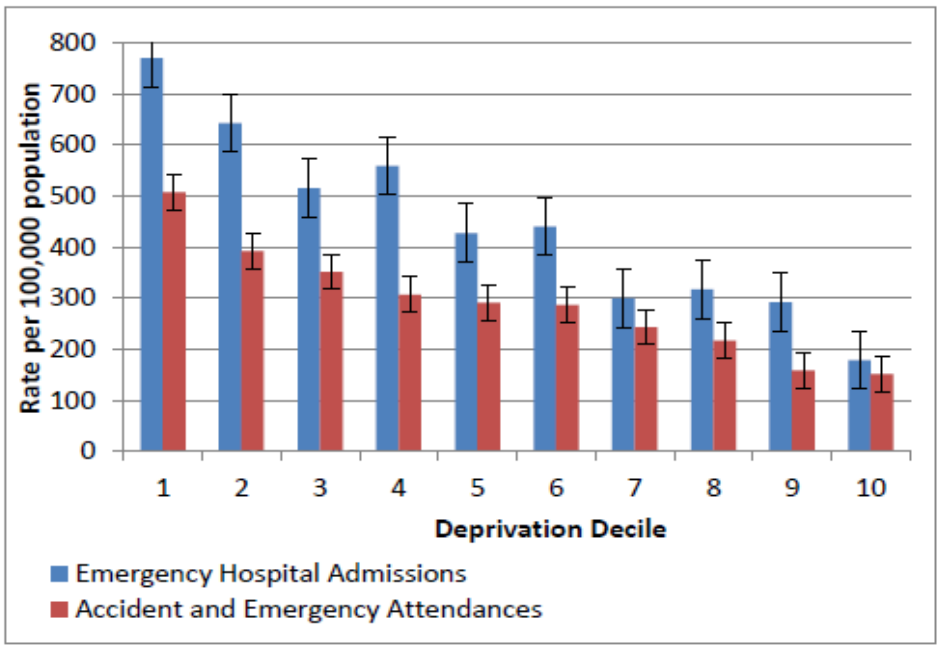
Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6983/2016_briefingon_smoking_in_pregnancy

(x) JSNA Briefing on Self-harm in Children and Young People

Summary

- Self-harm is defined as any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. Rates of self-harm have increased over the past decade in the UK and are among the highest in Europe.
- The majority of people who self-harm are aged between 10 and 24 years, with the highest risk occurring in female adolescents.
- Self-harm in children and young people is considered to be an expression of personal distress and is frequently an indicator of other adverse influences on mental wellbeing including psychiatric illness, dysfunctional family relationships, substance misuse, bullying and physical or sexual abuse.
- Self-harm is also a significant and persistent risk factor for future suicide, increasing the lifetime risk by between 50 and 100-fold above baseline population risk.
- Girls and female adolescents are at higher risk of self-harm compared to males, accounting for 72% of emergency hospital admissions and 63% of Accident and Emergency attendances between 2011 and 2014.
- There is evidence of a change in the age distribution of self-harm, with an increase among young females (10-14 years), and a decline among young adults of both sexes (aged 20-24 years) between 2010 and 2014.
- Social deprivation is strongly associated with self-harm, with the highest emergency hospital admission rates and Accident and Emergency attendances occurring among the most socially deprived population groups (Figure 15).
- Self-poisoning accounts for approximately 90% of self-harm episodes.
- Approximately three-quarters of self-harm incidents resulting in a hospital admission occur in the home setting.

Figure 16: Emergency hospital admission and Accident and Emergency attendance rates for self-harm in children and young people aged 10-24 years in Worcestershire are highest in more deprived deciles (Pooled data 2011-2014)



Source: SUS Hospital admissions and A&E data supplied by Arden Commissioning Support Unit, analysed by Public Health Intelligence Team at Worcestershire County Council.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/6364/2015_briefing_on_self_harm

(xi) Early years district profiles

Summary

- The population of 0-4 year olds is expected to decrease in Worcestershire between 2015 and 2030. All the districts are expected to see a decline in population with the exception of Bromsgrove where levels will remain stable.
- High level indicators such as life expectancy and infant mortality tend to be similar to or better than national benchmarks.
- Considerable inequality in levels of childhood development (good level of development or GLD) is evident, with the most deprived areas having levels less than half those in the least deprived areas. New data for those eligible for free school meals shows much lower levels of attainment in this group than the general population (regardless of where they live). All districts are below the national level on this indicator.
- Indicators for phonics in year 1 show a similar pattern with good overall figures but subpar values for children who are eligible for school meals.
- Other areas of concern are the levels of teenage pregnancy in Worcester and Redditch, and variable take up of breastfeeding.

Full reports available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/download/572/joint_strategic_thematic_needs_assessments_and_profiles

(xii) Learning Disabilities

Background

The term 'learning disability' can be defined as:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with
- A reduced ability to cope independently (impaired social functioning);
- Which started before adulthood (18 years) with a lasting effect on development.

It covers a range of disabilities including Downs Syndrome and chromosomal disorders, but does not include specific 'learning difficulties' such as dyslexia. Many people with a learning disability have additional health, sensory and mobility problems, and a number have additional mental health problems. People with a learning disability are frequently marginalised and discriminated against in society.

Summary

- There are around 2,413 people recorded on GP registers as having a learning disability in Worcestershire, and approximately 1,275 adults (aged 18-64) with a learning disability getting long term support from the Local Authority.
- Estimates of prevalence suggest that there could be as many as 8,000 adults aged 18-64 in Worcestershire with a learning disability[13].
- National research indicates that between 2015 and 2030, there will be a 3.5% decrease in the total number of adults aged 18-64 with a learning disability in Worcestershire.
- 1,109 adults with a learning disability received a GP health check in 2013-14. This represents almost 54% of all eligible adults with a learning disability in Worcestershire.
- In 2014-15 there were 950 adults with a learning disability receiving community services supported by the Local Authority. These numbers are steadily falling.
- The number of supported adults with a learning disability who are in paid employment is less than 100.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/5724/2015_briefing_on_learning_disabilities

[13] PANSI, www.pansi.org.uk, 2015.

(xiii) Domestic abuse and violence

Summary

- There are significant limitations to the reliability of data relating to domestic abuse incidents and crimes. These stem from differences in definitions used across the system and over time, and mean that some caution should be exerted in conclusions drawn from the data.
- Local and national figures are known to be an under-reporting of the true incidence of domestic abuse and violence. One study has found that women typically experience 35 incidents of abuse or violence before reporting this to authorities[14].
- Changes in estimated and actual numbers are difficult to interpret because an increase in reported rates may be a sign that police are more able to recognise and deal with domestic abuse than they were in the past, meaning that historically established criminal behaviours are now being addressed assertively by police, so there is no significant change in incidence.
- However, as awareness grows about more engaged policing on domestic abuse, women and other agencies may be more likely to involve the police. Conclusions about the validity or significance of increased rates are hard to draw.
- Despite the estimated nature of the data, it seems likely that 28% of women and 15% of men will experience domestic abuse or violence at some time between the ages of 16 and 59 years. Local estimates using national data would suggest about 19,000 female victims in the past year in Worcestershire[15]
- The issue of under-reporting is supported by actual data though which shows that 9,200 domestic abuse incidents were reported to police in Worcestershire in 2014/15, representing only 2,485 victims. In Emergency Departments, only 50 victims of domestic abuse were reported in a 9 month period.
- Police data shows the rates of domestic abuse incidents per 1,000 population were stabilising and reducing slightly in Worcestershire, but increased in 2014/15 (17.8 from 15.5).
- Of those who do report to the police, there are some clear patterns:
    - women are far more likely to be a victim than are men (1,840 women and 644 men);
    - men are far more likely to be perpetrators (695 male and 93 female perpetrators).

- There is clear positive association between deprivation and reported incidents and crimes, and in Worcestershire the rate of domestic abuse in the most deprived areas is almost 25 times that in the least deprived areas. It should be noted again that these figures are based on incidents being reported to the police and this may itself be heavily influenced by deprivation.

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/7081/2016_domestic_abuse_and_violence_needs_assessment

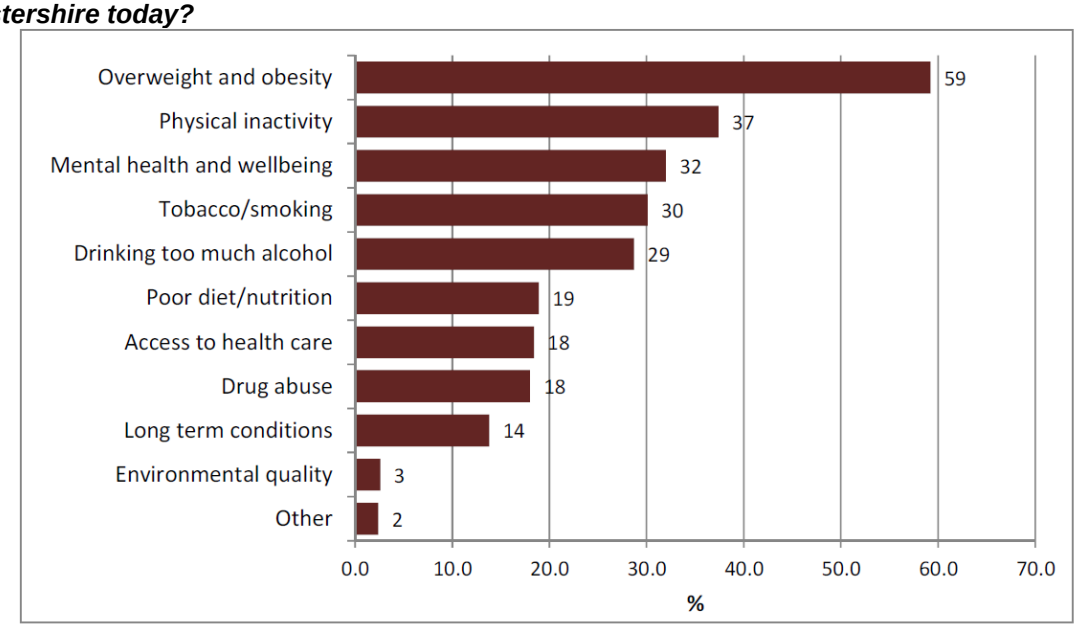
[14] Yearnshaw, S (1997) "Analysis of Cohort", in Bewley, S, Friend J and Mezey G (eds.) Violence Against Women, London: Royal College of Obstetricians and Gynaecologists.
[15] Violence Against Women and Girls Ready Reckoner, http://webarchive.nationalarchives.gov.uk/20100104215220/http:/crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence072.htm

(xiv) Viewpoint survey results

Summary

- This survey represents an important strand of community engagement, as prescribed by the 2012 Health and Social Care Act; the legislation demands that the Joint Strategic Needs Assessment (JSNA) should "involve the people who live or work in the area". There were over 2,750 responses to the survey.

Figure 17 - What do you consider to be the three most important threats to health facing people in Worcestershire today?



Source: Worcestershire Viewpoint May 2015 Analysis

- In Worcestershire as a whole, there is resonance between the public opinion of the greatest threat to public health and the health and wellbeing priorities in the county i.e. obesity and physical activity, mental health, and drinking too much alcohol (Figure 16).
- When asked about the importance of a healthy lifestyle the responses reveal a good deal about the attitudes to people's own health and wellbeing. While two thirds strongly agree that "a healthy lifestyle will reduce their chances of getting ill"; only a quarter of Worcestershire residents strongly agree they "live a healthy lifestyle" and even fewer "intend to change to a healthier lifestyle".

Full report available on the JSNA website at:
http://www.worcestershire.gov.uk/downloads/file/4593/viewpoint_residents_survey_2015

Summary of current JSNA reports on website

JSNA Summary documents

Viewpoint Residents Survey 2015

2015 JSNA Summary

2014 JSNA Summary

2013 JSNA Summary

Strategic guidance on JSNAs and HWB strategies

Worcestershire Census atlas 2014

JSNA Briefings

2016 briefing on alcohol
2016 Briefing on fuel poverty
2016 Briefing on older people
2016 Briefing on road safety and older people
2016 Briefing on rural health
2016 Briefing on sexual health
2016 Briefing on smoking in pregnancy
2016 Briefing on childhood obesity
2016 Briefing on early help
2015 Briefing on homelessness
2015 Briefing on learning disabilities
2015 Briefing on mental health
2015 Briefing on physical activity
2015 Briefing on self-harm
2015 Briefing on teenage pregnancy
2014 Briefing on alcohol
2014 Briefing on Bromsgrove district
2016 Briefing on physical activity
2014 Briefing on excess winter deaths
2014 Briefing on obesity
2014 Briefing on substance misuse
2014 Briefing on Wyre forest district
2014 Briefing on wellbeing in older people
2013 Briefing on breastfeeding
2013 Briefing on cancers
2013 Briefing on cardiovascular disease
2013 Briefing on COPD
2013 Briefing on communicable disease
2013 Briefing on Malvern Hills district
2013 Briefing on Redditch district
2013 Briefing on sensory impairment
2013 Briefing on Wychavon district
2013 Briefing on smoking
2013 Briefing on Worcester City district

Needs assessments and profiles

2016 Bromsgrove early years district profile
2016 Bromsgrove Health and wellbeing profile
2016 Domestic abuse needs assessment
2016 Malvern Hills early years district profile
2016 Redditch and Bromsgrove CCG profile
2016 Redditch early years district profile
2016 sexual health profile
2016 South Worcestershire CCG profile
2015 Primary care mental health NA
2015 Pharmaceutical needs assessment
2015 Sexual health needs assessment
2015 Worcester City HWB profile
2015 Wychavon HWB profile
2014 Adult MH needs assessment
2014 Ophthalmology profile
2014 R&B Dermatology profile

2016 SALT needs assessment
2016 Worcester City early years profile
2016 Wychavon early years profile
2016 Wyre Forest early years profile
2016 Wyre Forest early years profile
2015 Early help needs assessment
2015 Malvern Hills health and wellbeing profile
2013 Wyre Forest CCG needs assessment
2014 Wyre Forest Dermatology Profile
2014 Substance misuse needs assessment
2014 Wellbeing in older people profile
2013 Ageing Well needs assessment
2013 Redditch HWB profile
2013 R & B CCG needs assessment
2013 SW CCG needs assessment
2012 Obesity Needs Assessment

Glossary

BME = Black and ethnic minority
BRE = Building Research Establishment
CIPFA = Chartered Institute of Public Finance and Accountancy
CYP = Children and young people
DECC = Dept. of Energy and Climate Change
DfT = Department for Transport
DoH = Department of Health
DSR = Directly standardized rate
EWD = Excess winter deaths
GP = General practitioner
HLE = Healthy life expectancy
HWB = Health and wellbeing
IHD = Ischemic heart disease
JSNA = Joint strategic needs assessment
LAC = Looked after children
LAPE = Local alcohol profiles England
LARC = Long acting reversible contraception
LD = Learning disability
LTLI = Long term limiting illness
MSM = Men who have sex with men
NCIN = National cancer intelligence network
NCMP = National child measurement programme
NDTMS = National drug treatment monitoring service
NHS = National Health Service
NICE = National Institute for Health and Care Excellence
ONS = Office for National Statistics
PACTS = Parliamentary advisory council for transport safety
PANSI = Projecting adult needs/service information system
PHE = Public Health England
PHIT = Public health information team
PHOF = Public Health Outcomes framework
POPPI = Projecting older people population information system
SCIE = Social care institute for excellence
SH = Sexual health
SRE = Sex and relationship education
STI = Sexually transmitted infections
WHO = World health organization

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Associated documents and information:

ALL JSNA PRODUCTS ARE AVAILABLE ON THE WORCESTERSHIRE JSNA WEBSITE AT http://www.worcestershire.gov.uk/homepage/109/joint_strategic_needs_assessment

Further information & feedback

This profile has been created by Worcestershire County Council's Public Health Intelligence Team with contributions from members of the JSNA Working Group. We welcome your comments on our work please do contact us if you have any:
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