Understanding Herefordshire

Joint Strategic Needs Assessment 2016

Version 1.1
Herefordshire Council Strategic Intelligence Team
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CONTENTS

1. INTRODUCTION

The purpose of the Joint Strategic Needs Assessment (JSNA) is to provide an integrated assessment of the current and future health and wellbeing needs of people of Herefordshire.

The JSNA in Herefordshire, the online evidence base (that is the facts and figures website) and the JSNA are commonly referred to as 'Understanding Herefordshire' which forms the basis for the development of the Joint Health and Wellbeing Strategy. *Understanding Herefordshire* is viewed as a key enabler of effective commissioning, linked to plans and strategies, to improve the health and wellbeing outcomes of the residents of Herefordshire.

The 2016 refresh of the JSNA highlights the current position of the county regarding key inequalities experienced by its residents. The report takes a life-course approach; considering pregnancy and the postnatal period; the health of school children; and lifestyle factors in school age children and adults, as well as particular issues for older people.

ABOUT HEREFORDSHIRE

Herefordshire covers a land area of 2,180 square kilometres (842 square miles) (excluding inland water), and is a predominantly rural county (95 per cent of land area classified as such), with the fourth least densely populated area in England (86 persons per square kilometre).

Situated in the south-west of the West Midlands region bordering Wales, Herefordshire's principal urban locations are the city of Hereford, and the market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

2. INEQUALITIES

The JSNA 2016 reports on the findings of the index of multiple deprivation[1] which is a combined measure of the individual determinants of health and quality of life within the context of the wider determinants of health and wellbeing. The JSNA also provides a data and information profile of health inequalities, as well as the wider determinants of health.

Herefordshire has affluent areas where residents enjoy good health and wellbeing outcomes, alongside areas which rank amongst the most deprived in England where residents have significantly poorer outcomes.

Herefordshire, as a whole, experiences fairly 'average' levels of multiple deprivation being around the 60 per cent most deprived out of all county or shire council authorities in England; relatively more deprived than its neighbours Shropshire, Worcestershire and Gloucestershire. The most deprived areas of the county are in Hereford city and the market towns of Leominster, Ross-on-Wye and **for the first time Bromyard**. There are currently 12 LSOAs[2] in the county that are in the 25 per cent most deprived nationally; **four more** than there were in 2010.

Addressing the challenges highlighted in the report requires a fuller understanding of the complex workings and inter-relationships between the different dimensions of human existence – material, biological, social and cultural. To treat any part in isolation would fail to place importance on the scale of the threat to health and well-being of Herefordshire's residents who are adversely affected by the circumstances of their birth and/or the circumstances in which they find themselves. Everything is connected in some way, and the health map below captures the implicit drivers that determine the health and wellbeing for Herefordshire's citizens. This JSNA 'tells the story' of how big a challenge that might be for Herefordshire.

[1] The Indices of Deprivation 2015 provide a set of relative measures of deprivation across England, based on seven different domains of deprivation - (i) income; (ii) employment; (iii) education, skills & training; (iv) health & disability; (v) crime; (vi) barriers to housing and services and (vii) living environment

[2] LSOA refers to Local Super Output Area, representing a geographical area with a minimum size of 5000 residents and 2000 households, or an average population size of around 7,500. LSOAs improve the reporting of small area statistics.

The Wider Determinants of Health: The Health Map

Source: Barton, H and Grant, M. (2006): A health map for the local human habitat, Journal of the Royal Society for the Promotion of Public Health.

3. POPULATION

- The **resident population** **is 187,200** [mid-2014 estimate]; a 0.6 per cent rise from last year, and a seven per cent growth from 2001.

- **The population is dispersed** right across its 842 square miles. Just under a third (60,000 people) lives in Hereford city and just over a fifth (40,500) in one of the five market towns, but over two-fifths (79,400) lives in areas classified as 'rural village and dispersed'.

- One thousand more people moved to Herefordshire in 2013-14 than left it, 150 more than the year before. Natural change (births minus deaths) remained at zero, as it has been since births grew to the same level as deaths in 2009 (around 1,900 of each a year).

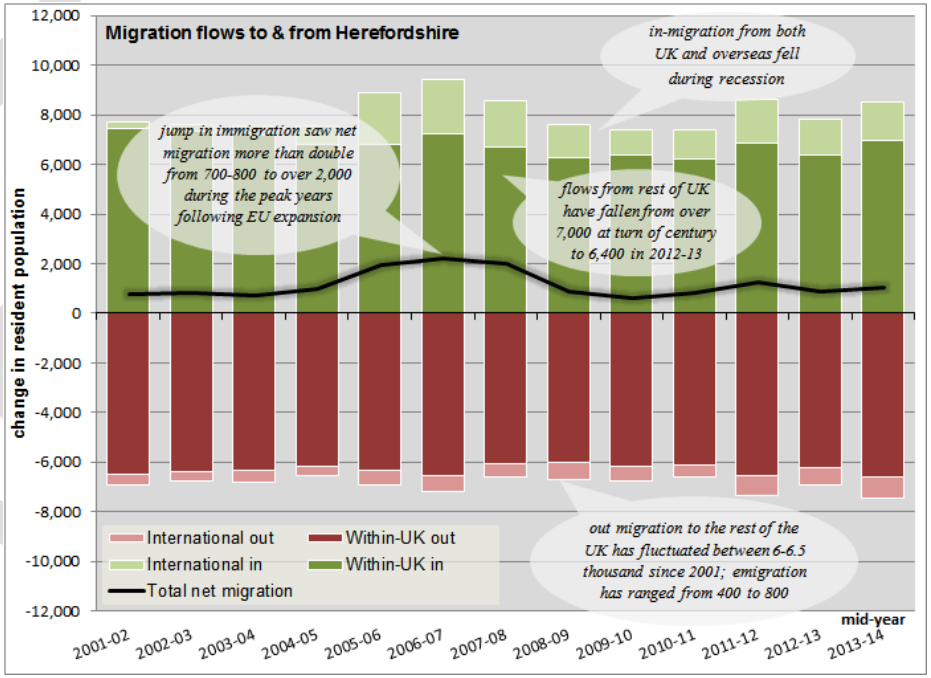
- **Since the 1990s, migration has been the sole driver of population growth in the county**. Since 2005-06 just less than three quarters of net migration has been from overseas. Although net international migration is

larger than within UK migration, moves between Herefordshire and other parts of the UK are much more important in terms of actual flows of people, (see Figure 1). Over half of international migrants to Herefordshire are aged between 20 and 40; and over half are males. Overall, the county receives annual net inflows of people of all ages except 18-20.

- Female migrants have also driven the increase in the number of births, with one in ten babies now born to a mother from 'new' Europe.

- In the most recent **school census** of all primary and secondary schools (October 2015), the year groups with the highest number of pupils were Reception (1,976), Year 1 (1923) and Year 3 (1900). The significance of the three largest year groups being in the first years of the primary phase reflects the increase in the population of young children seen locally and nationally in recent years.

Figure 1: Annual migration flows to and from Herefordshire



Source: Office for National Statistics (ONS) mid-year estimates. Crown copyright

- Herefordshire still has a relatively **older** **age structure** **compared to England and Wales.** Twenty-three per cent of residents (43,200 people) are aged 65+, compared to 18 per cent nationally. See Figure 2.

- The **older population has grown disproportionately** (+28 per cent since 2001 compared to seven per cent for the total population), and this trend is set to continue (+404 per cent to over 62,500 by 2031) as the post-war 'baby boomers' move into older age.

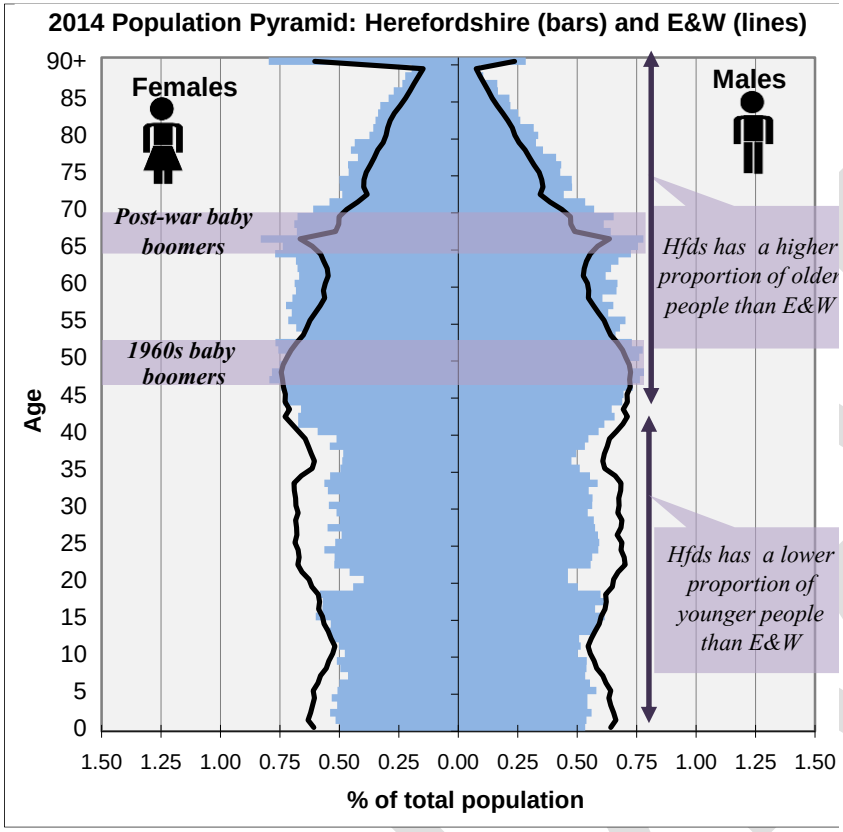
- If recent trends were to continue, this same natural ageing of the population structure would see the **working age population fall** from 112,300 to 109,700 in 2031 (two per cent) – with the sharpest decline after 2025 when the second generation of 'baby boomers', those born in the 1960s, begin to move into retirement age.

- Herefordshire has a slightly **lower proportion of younger children** than nationally (11 per cent aged under ten compared to 12 per cent in England and Wales), although a similar proportion of 10-17 year-olds. See Figure 3.

- **Latest projections** (2014 based) suggest that the total population would increase to 203,500 by 2031 (+9 per cent) if recent demographic trends were to continue.

- There has been no update to the **ethnic diversity** profile since the 2011 Census which reported that Herefordshire's largest ethnic minority group were those residents who are identified themselves as 'white other' (3.9 per cent). The 2011 Census also reported that 6.3 per cent of the population (11,600 people) were from an ethnic group other than 'white British' (the BAME population).

Figure 2: Age structure of population, mid-2014



Source: ONS mid-year estimates. Crown copyright.

4. VULNERABLE POPULATIONS

4.1 CHILDREN IN CARE

The current population of children looked after in Herefordshire is 280 (end of May 2016). For 2014/15, the rate (per 10,000 people) for Herefordshire was 75.5, marginally higher than the West Midlands (74.9) and significantly higher than England at 69.5.

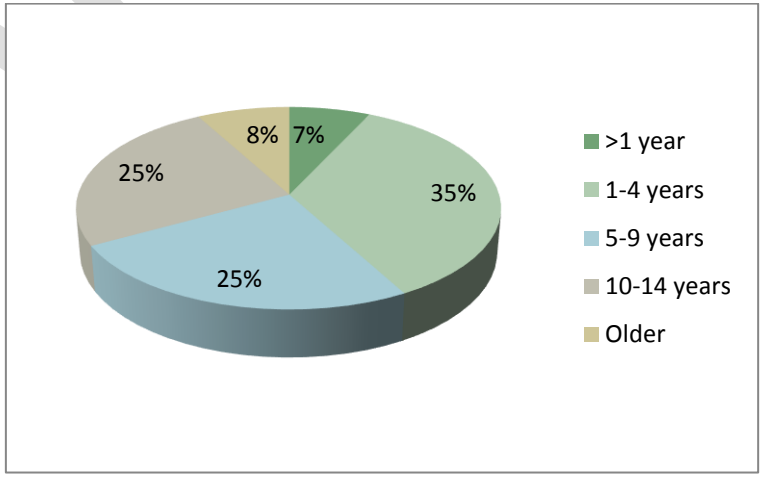
4.2 CHILDREN WHO ARE SEXUALLY EXPLOITED (CSE)

Sexual exploitation of children and young people under 18 is a form of child abuse. Children and young people who are sexually exploited will experience difficulty and/or confusion around their autonomy to make choices, and their understanding around sex, sexuality and the sexual activity into which they have been coerced. This makes them all the more vulnerable to continued abuse and to repeat victimisation. A multi-agency CSE project is underway to understand the prevalence of CSE in Herefordshire. This will enable agencies to capture local intelligence in order to better safeguard vulnerable children and young people.

CHILDREN EXPOSED TO DOMESTIC VIOLENCE AND ABUSE

In the year to September 2015, West Mercia police recorded **1,174 children exposed to domestic abuse**, as a witness to or resident at the address where the incident or crime took place. West Mercia Women's Aid (WMWA) recorded a monthly average of 101 service user children in the year ending September 2015. See figure 3.

Figure 3: Age breakdown of children supported by WMWA.



4.3. CARERS

In March 2016, Herefordshire Carers' Support (HCS) had **4,963 carers registered**, made up of 3708 adult carers, 910 parent carers, 30 young adult carers and 345 young carers. All carers provide unpaid care and support to frail, ill and disabled members of families and friends.

The majority of **young carers** are aged between 10 and 15 years old, consistent with national figures. Young carers are a largely hidden group, since they may not be recognised within the family as young carers, and young people themselves may not identify themselves with that role. Young carers have particular needs. Evidence suggests that young carers are one and half times more likely to have special educational needs or a long standing illness or disability, and are more prone to mental health issues and social isolation.

The number of **adult carers** known to the Herefordshire council at March 2016 was 1,882, around a hundred more carers than at the same time last year. The largest proportion of carers was aged 45-64 with the next highest proportion aged 65–80. This suggests that there will be more elderly carers in the future in line with the ageing demographic.

Over 910 **parent carers** are registered with Herefordshire Carers Support.

The Adults Social Care Outcomes Framework measures carer satisfaction' and 'carer-reported quality of life'. In respect of satisfaction, Herefordshire's carers are less happy compared than carers in England as a whole (38.6 per cent compared to 41.2 per cent). The carers' 'carer-reported quality of life' score is similar to the scores reported regionally (7.8) and nationally (7.9) scores. Out of a possible score of 12, Herefordshire scored 7.6, where higher scores suggest a better quality of the life. Herefordshire's male carers have a marginally better result than females (7.7 compared to 7.6), and carers aged under 65 were less satisfied than those aged 65+ (7.3 compared to 7.8).

The caring contribution is worth an estimated £119 billion a year to the UK economy – more than the total cost of the NHS.

Valuing Carers (2011) Carers UK and Leeds University

4.4 PEOPLE WITH LEARNING DISABILITIES

An estimated[3] 2,600 people aged 18-64 in Herefordshire currently have a learning disability (LD). Of these, 600 are estimated to have a moderate or severe learning disability, and hence likely to be in receipt of services - 200 of whom (28 per cent) currently live with their parents. Just over 500 people aged 18-64 are currently in receipt of social care services from Herefordshire Council because of a learning disability

A further 950 people aged 65+ are estimated to have an LD; 150 classed as moderate or severe. Around 60 people aged 65+ receive social care support related to an LD.

Assuming that prevalence of LD remains the same, predicted demographic changes will not have any significant impact on the numbers of people with LD in Herefordshire by 2030.

Citizens in receipt of council-funded domiciliary or home care for needs related to a learning disability have a much younger age profile compared to those with other needs (e.g. physical support), with 80 per cent aged under 50.

4.5 PEOPLE WHO RECEIVE SOCIAL CARE SUPPORT

In Herefordshire, approximately 2,400 people are in receipt of long-term support[4] from adult social care at any one time, 1,600 (two-thirds) of whom are supported in some way to live in their own homes (the remaining 800 are in permanent residential placements).

The majority (75 per cent) of the 800 clients receiving domiciliary (home) care services commissioned by Herefordshire Council are aged 65+, of which the largest proportion (42 per cent of the total) are aged 85+, and just

[3] Source: PANSI (Projecting Adult Needs & Service Information System), using rates from Emerson & Hatton - Institute for Health Research (2004)

[4] Defined as permanent residential or nursing placements; domiciliary care; day opportunities; extra care housing; supported living; Skills for Daily Living; or Direct Payments.

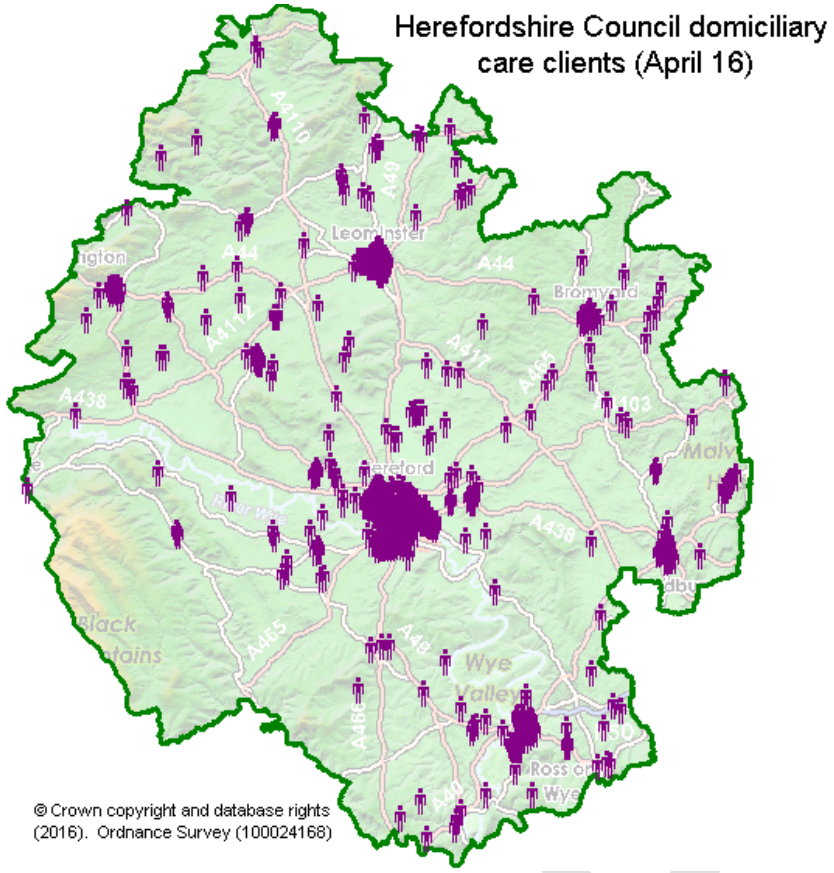
over two-thirds of all domiciliary care users are female, although this varies with age group (highest for older ages). The vast majority of clients (91 per cent) aged 50+ are in receipt of 'physical support', whereas the 90 clients aged under 50 are most likely to be receiving support in relation to a learning disability (half of them). See Figure 4.

The Mosaic Public Sector[5] profile of people in receipt of domiciliary (home) care reveals that they are most likely to be elderly people reliant on state support, characterised by low incomes, a reliance on a state pension, living alone, not having a car, being unable to look after their home anymore, and being in poor health with a high likelihood of emergency hospital admission. Around one in five live in isolated rural communities where there is a strong sense of community and reluctance to depend on the state despite low incomes, often in homes that might benefit from investment in bathrooms and insulation.

Elderly care needs are not static, changing as new circumstances come to bear. A fall, an illness or other factor may precipitate people to seeking health and social care support. Effective demand for social care is related to a person's inability to undertake 'instrumental activities of daily living'. An estimated 17,900 people aged 65+ in Herefordshire are unable to undertake at least one domestic task for themselves (e.g. shopping, washing up, cleaning windows inside, vacuuming floors, dealing with personal affairs, undertaking practical activities). An estimated 14,700 are unable to perform at least one self-care activity (i.e. bathe, shower or wash all over; dress/undress; wash hands and face; feed themselves; cut toenails; take medicines).

[5] A customer segmentation tool developed by Experian, which classifies the UK population into one of 15 groups and 69 types, based on over 1,500 variables

Figure 4: Geographical distribution of people in receipt of home care commissioned by Herefordshire Council.



4.6 REFUGEES AND ASYLUM SEEKERS

Herefordshire council has agreed to the Home Office's request to accept the re-settlement of Syrian Refugees and Unaccompanied Asylum Seeker Children (UASC) only. At present, the council is not offering to take young adult asylum seekers. All three groups each have different legal status and consequently different rights in the UK. Vulnerable Syrian refugees (60 individuals in 15-20 family groups) from United Nations High Commission for Refugees (UMHCR) camps in Syria are being re-settled from September 2016, as part of a five year government funded programme. Seven UASC are supported in foster placements with a further six in the next few months. Children are expected to remain in the UK at least until they are 18, and the authority receives funding up to this age. A range of support is planned starting with an orientation service to help settle refugees to their new life which will connect them to key services and promote community inclusion and cohesion. There is significant support for welcoming refugees to the county and the Diocese of Hereford has been co-ordinating dialogue across organisations and with the council to provide appropriate support.

4.7 YOUNG PEOPLE NOT IN EDUCATON, EMPLOYMENT OR TRAINING (NEET)

A **NEET** is a young person who will always be either unemployed or economically inactive (not employed and not in training). An estimated 260 NEET young people were known to the local authority in 2015, or 4.5 per cent of all 16-18 year olds resident in the county, compared to 4.3 per cent in the West Midlands. This represents a reduction from 5.7 per cent in 2014, 6.4 per cent in 2013 and 6.2 per cent in 2012.

As at March 2016, there were 266 NEET young people in Herefordshire; 123 (46.2 per cent) were male and 143 (53.8 per cent) female. 70 or 26 per cent of this NEET cohort were eligible to free school meals when they were in compulsory education.[6] Of those in the NEET cohort with an identified ethnicity, 94 per cent were of White British ethnicity.

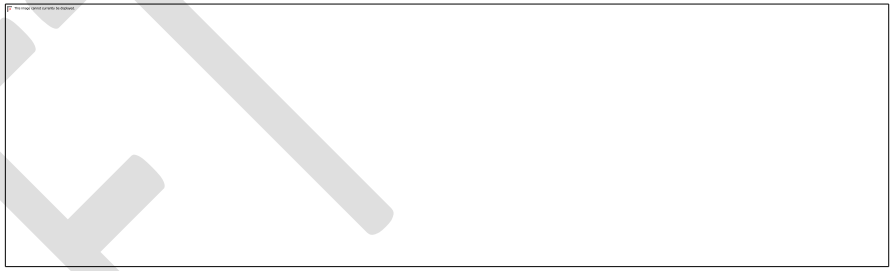
[6] School Census Spring 2016

5. CHILDREN STARTING WELL -KEY INEQUALITIES

By starting well in life, a child's chances of good physical, mental and emotional health and wellbeing are vastly increased into adulthood.

Smoking during pregnancy harms an unborn child's development. Available data shows a year on year increase of mothers smoking during pregnancy, rising from 11 per cent (2011/12) to 14 per cent in 2013/14 which is significantly higher than the national rate (12 per cent) and the West Midlands (13 per cent). **Smoke inhalation** damages foetal growth contributing to premature birth, low birth weight, cot death, respiratory and other illnesses. In 2014, the proportion of babies delivered at full term with low weight in Herefordshire was 3 per cent of all full term deliveries which is not significantly different than rates for England and the West Midlands, but nevertheless nearly double the rate of 1.6 per cent in 2011 for the county.

According to the Marmot Review "*low birthweight in particular is associated with poorer long-term health outcomes and the evidence also suggests that maternal health is related to socio-economic status*". Babies born to women who smoke weigh, on average, 200 grams less than babies born to non-smokers.



Children and young people up to the age of 19 years are offered routine **immunisations** to protect them from preventable infections and communicable diseases. In Herefordshire, primary vaccine uptake is comparable with regional and national levels, although still marginally lower than the World Health Organisation (WHO) target of at least 95 per cent coverage since 2012-13. In 2014/15 the uptake of pre-school boosters improved over the previous year continuing a trend evident since 2010/11. MMR (measles, mumps and rubella) immunisation coverage at five years is steadily improving (87.6 per cent in 2014/15).

The benefits of **breast feeding** are established; it protects children from asthma, viruses and other infections. The incidence of breast cancer is lower in women who breast feed. More babies are being breastfed in Herefordshire at 6-8 weeks after birth since 2010/1. In 2014/15 the rate in Herefordshire was 48.8 per cent, an increase on the previous year's value of 48 per cent, and significantly higher than the 2014/15 rate for England of 43.8 per cent[7]. It is also known that mothers living in deprived communities are less likely to breast feed.

Key consideration. All women are offered an antenatal face to face contact with a Health Visitor to identify individual health, social and psychological needs from 28 weeks gestation. However, uptake of this service is varied across the county; for example, in Bromyard, for the period October 2014-September 2015, 44 per cent of the 78 women contacted, with regard to an antenatal visit, either declined or delivered early. There is a need to better understand the barriers and facilitators that make it difficult for women, (particularly those at high risk of materno-foetal outcomes), who are late in accessing or not at all for antenatal care. The **health visitor service** is well placed to support women as the service includes an antenatal check, new birth visit and 6-8 week review. Locally, more could be done to support mothers to breastfeed their babies for longer.

[7] Public Health England - Children and Young People's Health Benchmarking Tool.

6. CHILDREN & YOUNG PEOPLE DEVELOPING WELL: KEY INEQUALITIES

Inequalities in health and social factors affect children's education, health and social outcomes into adult-hood.

In Herefordshire, **4,300 children** (14 per cent) under the age of 16 **live in income deprived households**. There are ten areas of the county where more than one out of every four children live in income deprivation. Six of these areas fall within the 20 per cent most deprived in England – all in Leominster and south Hereford; the other four are in the 25 per cent most deprived. 'Leominster Ridgemoor' remains the most deprived area, with almost two in every five children (38 per cent) experiencing income deprivation.[8]

[8] *Source: The English Indices of Deprivation 2015. Department for Communities and Local Government*.

EDUCATION

Education is a major determinant of a person's economic wealth and social wellbeing, and a decisive factor in enabling young people to succeed in employment.

The key performance measure in early years is the achievement of a **Good Level of Development** (or GLD) at the end of reception year and the **phonics screening check** which assesses if pupils have learned to read quickly and skilfully by the age of six. Herefordshire did very well in 2015 for both measures broadly in line with national results. However, attainment at **key stage levels** (in reading, writing and mathematics) shows a mixed picture again in Herefordshire.

The performance of children whose parents claim **Free School Meals (FSM) for** their children is still performing below their peers nationally. At all key stages (1, 2 and 4), the gap in attainment between pupils who have FSM and those who do not, remains wide as it has been for the past three years.

Of the 266 NEET (Not in Education, Employment or Training) young people in Herefordshire in 2016, 70 (or 26 per cent) were eligible to free school meals during the years of compulsory education.

Whilst the attainment of pupils in Herefordshire with a first language of English is in line with national average, pupils with **English** as an **Additional Language** (EAL) are currently 13 percentage points behind their peers nationally. Some progress was made in the Early Years Foundation Stage (EYFS) where the gap between EAL and non-EAL pupils reduced by two percentage points in 2015, having fallen in consecutive years. However, it still **greatly exceeds** the **national gap by two and half times.**

Countries of Eastern Europe, including Bulgaria, Hungary, Lithuania, Latvia, Poland, Romania, Croatia, Slovakia, Slovenia and Ukraine accounted for 984 of the 1,579 EAL pupils, or over 62 per cent in Spring 2015[9], representing an increase of almost 68 per cent from 941 in Spring 2012. In Spring 2012 a total of 51 different languages other than English were recorded in the school census. By Spring 2015, 63 different languages other than English were spoken by at least one pupil.

The performance of **Special Needs Education** (SEN) support pupils in Herefordshire also continues to present a mixed picture. The inequality gap between SEN and non-SEN pupils in Herefordshire has widened to 45 percentage points compared to 40 percentage points nationally.

Key consideration.

Better understanding, better evidence and better knowledge of 'what works' of best practice in education can better support all children and young people to improve their chances in life and achieve their educational potential. Children who are disadvantaged as identified above have the most to gain from this.

[9] 'Spring 2015' refers to the spring academic term.

PHYSICAL HEALTH

For 2013/14 19 per cent of reception year children (aged four to five years) locally were either **obese or overweight**, while 31 per cent of children in year 6 were either obese or overweight – both obesity rates were significantly lower than in England as a whole. However, research indicates that obese children often grow up to be over-weight adults, and therefore, it is essential to address nutrition and diet during childhood as a preventative measure. The prevalence of obesity among year 6 children in Herefordshire is generally estimated to be higher in urban areas than in the 'countryside'. Childhood obesity has a wider social impact with children who are overweight experiencing more emotional and behavioural problems as a result of stigmatisation, bullying and low self-esteem.

Recent Public Health England (PHE) data (mid-2014)[10] on tooth decay among five year olds showed that 41 per cent of children in Herefordshire have **tooth decay**, compared to our statistical neighbor Shropshire where 21 per cent of five year olds have tooth decay. A contributory factor for tooth decay is recognised as being the absence of fluoridated water in Herefordshire, and that using toothpaste alone for children is insufficient in reducing the risk of dental caries (Public Health England, 2013). Tooth decay is preventable.

[10] 16.5% of the 5 year old population in England took part in the PHE Oral Health survey (May 2016)

TEENAGE PREGNANCY

Teenagers in Herefordshire are having fewer pregnancies with a downward trend evidence since 1998 which reflects the national trend. However, compared to the CIPFA comparator group[11] the Herefordshire pregnancy rate for 2014 was higher than the five areas considered which, when combined, had an average pregnancy rate of 14.2 per 1,000 girls compared to 20.4 per 1,000 girls (or 65 pregnancies) for Herefordshire. In 2014, there were 10 pregnancies (that is, a rate of 3.3 conceptions per 1,000 of under 16+ girls) showing a steady decline. Those who are most at risk of unplanned or unintended pregnancy include women who have had a previous termination, young women who have had repeat pregnancies in adolescence and some women in areas of deprivation.[12] High risk populations include those who are in care, young offenders, and those not in education, employment or training.

Thirty of Herefordshire's 2016 cohort of NEET young people are parents, and 12 were pregnant; patterns which support evidence that teenage mothers are more likely to have fewer educational and employment opportunities compared to other teenagers.

Key consideration. Whilst acknowledging the reality of teenage sexual activity, research shows that sex and health education play an important role in reducing risky sexual behaviours in young people, and in reducing the health inequalities gap for sexual health. Risk factors for adolescent pregnancies are forced sexual activity and lack of connectedness with parents. The **school nursing service** presents new opportunities for bringing about positive outcomes for young people across both health and local authority services.[13]

[11] The comparator group includes the most statistically similar areas to Herefordshire as determined by the Chartered Institute of Public Finance and Accounting (CIPFA) which are, in descending order of similarity, Shropshire, South Cheshire, Bath and North East Somerset, Wiltshire and Rutland; Worcestershire is also included as a geographical neighbour.

[12] The Sexual Health and Blood Bourne Virus Framework 2011-2015, Scottish Government (2011)

[13] The Department of Health's guidance to support commissioning of public health provision for school aged children 5-19 stipulates that additional or targeted school nursing support can be planned as identified in the JSNA.

7. ADULTS BEING WELL - KEY INEQUALITIES

Public Health England Outcomes Framework (2013-2016) aims for two achievements:

(i) Increased healthy life expectancy

(ii) Reduced differences between life expectancy and health life expectancy between communities.

These measures reflect not just on how long people live (life expectancy) but also the quality of their lives or how well people live (health life expectancy). The second outcome focuses on reducing health inequalities.

People living in Herefordshire enjoy higher life expectancies than nationally.[14] For several years, both male and female life expectancies in Herefordshire have remained significantly higher than national and regional levels since 2000.

In 2012-14 **life expectancy for males** born in Herefordshire is **80.7 years**, having risen by one year from 2010-2012, significantly higher than the national life expectancy (79.5 years) and regional life expectancy for the West Midlands (78.9 years). A similar pattern is evident **for females** born in Herefordshire in 2012-14 where the **life-expectancy of 84.2** years is higher than both the national (83.2 years) and regional (82.9 years) levels.

People are living longer, but improvements in **healthy life expectancy** have not kept up, meaning that residents are having extended lives but are living it in poor health. The proportion of life expected to be lived in good health has fallen consistently during the last thirty years, from 82 per cent for men born in England in 1981 to 80 per cent in 2011/13, and from 79 per cent for women to 77 per cent (for the same period).

The 2011 Census found that:

- 32,500 people (18 per cent of the population) in Herefordshire households[15] have a long standing condition (or long term limiting condition/LTLC).

[14] In terms of how long people born in a particular year can be expected to live, based on a statistical average.

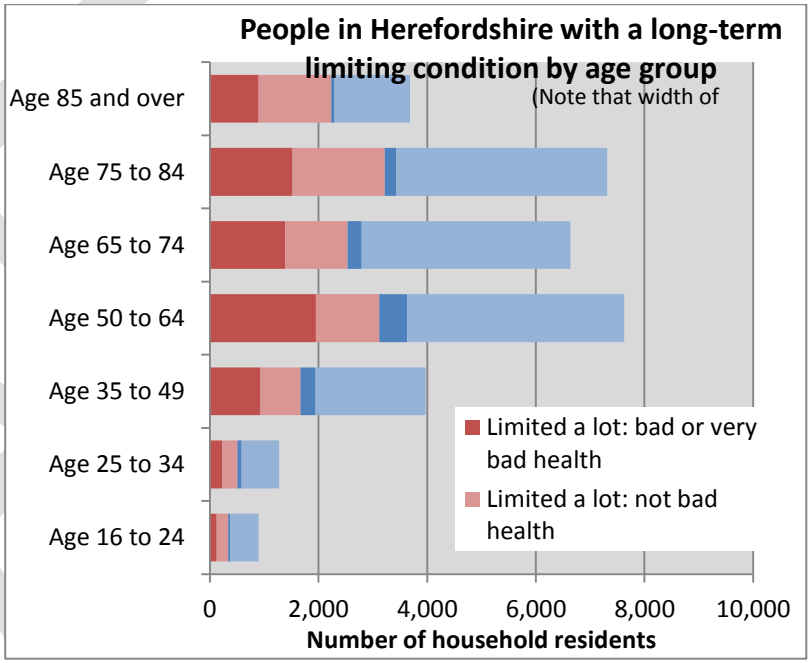
[15] Excluding those living in communal establishments such as care homes

- 14,100 have their activities appreciably limited by their condition, and 7,200 of these consider themselves to be in bad / very bad health (4 per cent of the total population).

- 17,000 people are in fair health, limited a little by their condition.

Prevalence of LTLCs increases with age, and because of Herefordshire's aging population structure, the largest number of people who have an LTLC and are in bad/very bad health are aged 50-64 (2,000 people). See Figure 4. The impact of multi-morbidity has far reaching consequences; for the individual – poor quality of life and poor clinical outcomes that often results in longer hospital stays and institutional care; and for health professionals and social care commissioners this is the most costly group of patients/service users. Evidence further suggests that people with LTLC tend to get poorer treatment than others.[16]

Figure 4: People in Herefordshire with LTLC by age group



Source: Strategic Intelligence, Herefordshire Council

[16] The King's Fund, 2010. http://www.kingsfund.org.uk/sites/files/kf/field/field_document/managing-people-long-term-conditions-gp-inquiry-research-paper-mar11.pdf

MORTALITY AND PREMATURE MORTALITY

Mortality is related to the risk of death. In Herefordshire, those that live in deprived communities have a higher risk of death than if they lived elsewhere in the county. Over the last five years, the mortality rate has increased by 1.4 per cent (from 2006-10 to 2010-14) in the most deprived[17][18] areas of the county, compared with a marginal 0.3 per cent in the county as a whole.

While increases have occurred for other causes of death, there has been a reduction in the numbers of deaths as a result of strokes (16 per cent). Notably, increases in alcohol specific deaths are more evident in the most deprived areas, (10 per cent across Herefordshire and 27 per cent in the most deprived areas).

The difference between **mortality** rates in the most and least deprived areas is referred to as the 'mortality gap'. For all ages and across all causes of mortality combined this gap has increased from 20 per cent in 2006-10 to 22 per cent in 2010-14. Where it relates to gender-specific, the mortality gap has widened for both males and females (temporal trends).

The four **leading causes of death** in Herefordshire are: **coronary heart disease (CHD), respiratory diseases, alcohol specific and smoking related deaths**.

Over the period 2006-2010 and 2010-14, the mortality gap widened for the above four disease groups while notably, the gaps for cancer and stroke fell in the county.

In terms of **premature mortality (deaths under 75 years)** the mortality gap has also widened across all disease groups; by 21 per cent across all causes pooled to as much as 60-70 per cent for alcohol-specific and smoking-related conditions. A more detailed investigation into the disease groups with worst-performing trends revealed that among the most deprived quartile of population **male mortality rates** were **higher for respiratory diseases** (by seven per cent) and smoking-related conditions (by two per cent). In contrast, among the county population as a whole male mortality rates reduced across each disease group.

[17] *Source: The English Indices of Deprivation 2015. Department for Communities and Local Government*.

[18] Mortality rate is the rate of death in a population, expressed per 1000 per year.

Female mortality rates among the most deprived quartile of population are significantly **higher for alcohol-specific conditions** (by 102 per cent) and respiratory diseases (6 per cent). Increases of 49 per cent and 3 per cent respectively were recorded for alcohol-specific conditions and respiratory diseases for the county as a whole.

LIFE STYLE CHOICE

As people live longer but in bad health, the focus on lowering morbidity (that is, their level of ill-health) is on educating and encouraging people throughout the life course to create healthy habits, to monitor their own health outcomes, and receive regular check-ups to promote lifelong health before any signs of disease or disability occur. Better lifestyle choices, such as not smoking, responsible drinking, and regular physical activity can reduce risk factors that contribute to a range of conditions such as heart disease, respiratory conditions, cancers, and dementia. Crucially, these life style issues have strong associations with deprivation and poverty in Herefordshire.

Falls

In the UK, **falls** are the most common cause of **injury related deaths** in people over the age of 75, and the most common cause of emergency hospital admissions over the age of 65 years. Between 1 April 2015 to 30 March 2016, 189 Herefordshire residents were admitted to hospital (emergency admissions) for falls related to age or unclear health conditions, each spending an average of 66 days in hospital. Estimates suggest this is currently around 900 per year in Herefordshire [1,1] but expected demographic changes would see this increase to 1,100 (+16 per cent) by 2020. High risk groups are women and those living in deprived communities. Falls is a major reason for people moving from their own homes to long term residential or nursing care.

SMOKING

A good estimate of **smoking** prevalence is the proportion of GP registered patients recorded as smokers as measured by the Quality and Outcomes Framework (QOF). In 2014/15 the smoking prevalence across the county as a whole was 17.5 per cent, slightly lower than the national rate of 18.6 per cent. Prevalence varied across Herefordshire GP practices, from 10.4 per cent at Much Birch to 25.4 per cent at Belmont, which are respectively within the least and most deprived areas of the county. The full data indicated that people living in more deprived areas smoke more and therefore, are at greater risk of contracting respiratory illnesses as a result compared to the general population. Further evidence shows that the rate of hospital admission related to smoking-attributable conditions in the most deprived quartile is 56 per cent higher than that of the least deprived quartile and also significantly higher (45 per cent) than across the county as a whole.

Chronic obstructive pulmonary disease (COPD) is a common disabling respiratory condition with a high mortality. The prevalence of COPD in Herefordshire has shown an increasing trend since 2009/10 rising from 1.6 per cent of GP registered patients to 2 per cent in 2014/15, significantly higher than national (1.82 per cent) and that recorded for the West Midlands (1.76 per cent). The Herefordshire prevalence was also significantly higher than those recorded in comparator CCGs which were all lower than the national rate. The prevalence of COPD in Herefordshire has risen year on year representing a proportional increase of 32 per cent from 2009/10 to 2014/15. It is estimated that, by 2030, over 1,000 residents of Herefordshire aged 65+ years will have a longstanding health condition caused by bronchitis or emphysema[19].

Key consideration. Persons residing in the most deprived areas are more than twice as likely to die (and also to die prematurely) of chronic lower respiratory disease as those in the least deprived areas, and this variation is statistically significant. Similarly rates of hospital admission due to chronic lower respiratory disease are more than 50 per cent higher than expected in these areas.

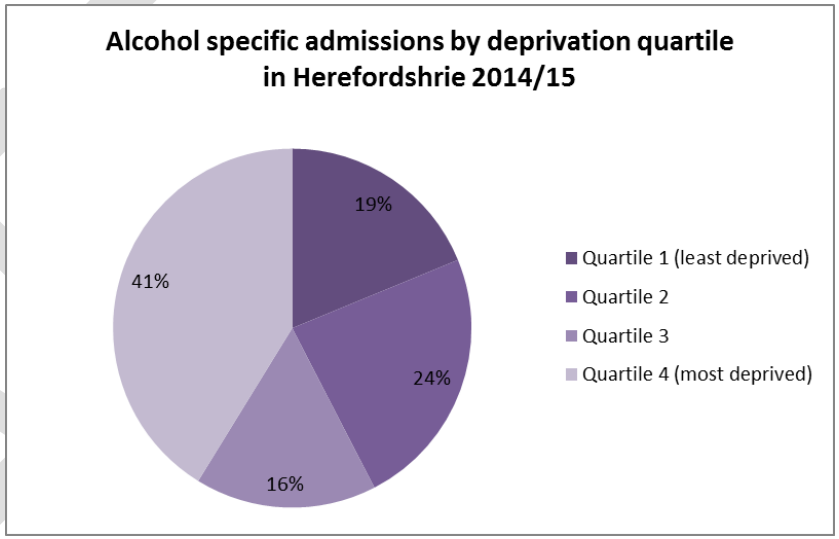
[19] Data from POPPI - Projecting Older People Population Information System

Key consideration. Whilst it is important to improve health across all socio-economic groups, the Local Tobacco Control Profile reported that for 2014 smoking prevalence among routine and manual workers across the county was 25 per cent (compared to a county wide rate of 14 per cent). Given that the largest employer in Herefordshire is the manufacturing industry, there is greater need to improve health for each step down in the socio-economic group.

ALCOHOL

Although, **alcohol-related admissions** for Herefordshire residents have also remained fairly stable over the last few years, with significantly better rates than those seen regionally and nationally, around **45 per cent of all alcohol-specific admissions are from residents living in the most deprived communities of the county.** In other words, a person residing in the most deprived areas of the county is over three times as likely to be admitted to hospital due directly to alcohol consumption as someone resident in the least deprived area of the county. See Figure 5.

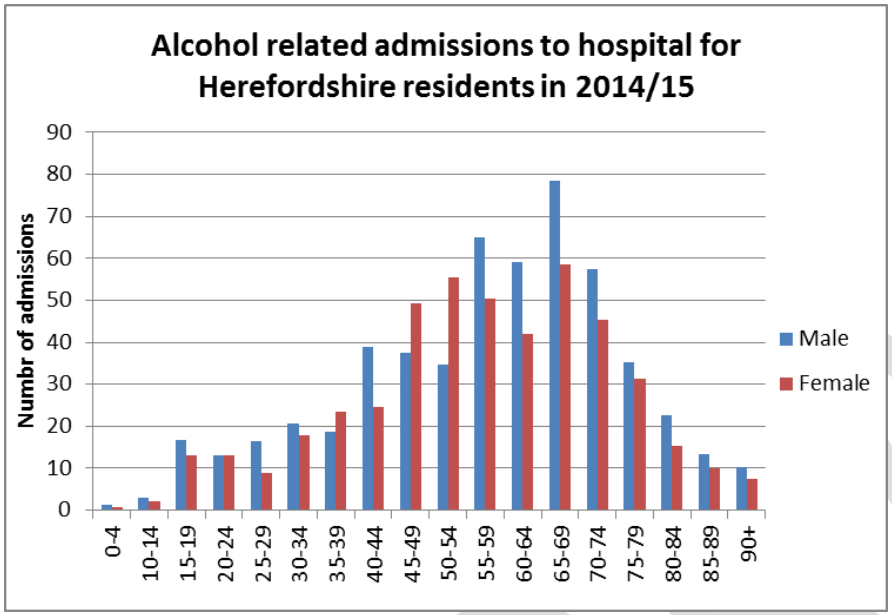
Figure 5: Alcohol-specific admissions by deprivation quartile for Herefordshire residents in 2014/15.



Source: Strategic Intelligence, Herefordshire Council

In 2014/15, the largest proportion of admissions was in the 65-69 age bracket. Generally more men were likely to be admitted, although women accounted for almost 60 per cent of admissions in the 45 to 54 age bracket. See Figure 6.

Figure 6: Alcohol related admissions to hospital for Herefordshire residents in 2014/15



Source: Strategic Intelligence, HC

OBESITY

Being **overweight** or **obese** increases the risk of hyper-tension, coronary heart disease (CHD), type 2 diabetes, some types of cancer and mental health problems. Obesity can reduce life expectancy by an average of three years, and severe obesity can reduce it by an average of 8-10 years.[20]

Approximately 15,300 adults registered with a Herefordshire general practitioner (GP) practice in 2014 were recorded as obese (10 per cent of all patients aged 16+), although the number is likely to be underestimated.

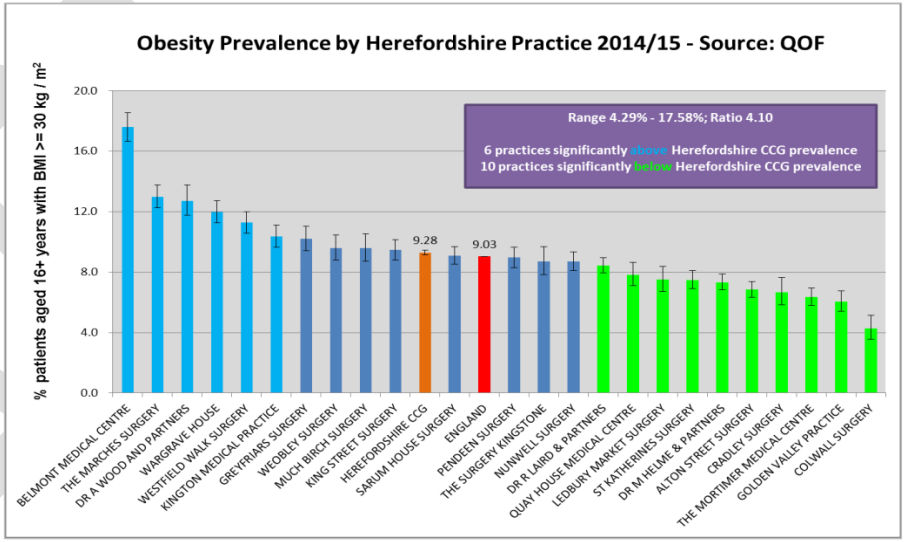
Obesity does not affect all groups equally, being more common amongst people in deprived communities. In 2014/15 the obesity prevalence at Herefordshire GP practices ranged from 4.3 per cent at Colwall to 17.6 per cent at Belmont. High levels of obesity were also recorded at Westfield Walk and The Marches and cumulatively these three practices represent 21 per cent of all recorded obesity in Herefordshire Clinical Commissioning Group. See Figure 7.

[20] Dent, M. & Swanston, D (2010), Briefing Note: Obesity and Life Expectancy, Oxford, National Obesity Observatory

Type 2 diabetes is linked to overweight and obese individuals while age can also be a factor. There is a clear correlation between diabetes prevalence and rate of obesity in Herefordshire GP practices although no relationship was evident between diabetes prevalence and those aged 65 and over. In 2014/15, thirteen out of the county's 24 practices report diabetes prevalence above the national average (6.4 per cent), although no reported prevalence is significantly higher than the national level. Five practices with the highest rates of diabetes had above average proportion of their populations living in the most deprived areas of the county.

***Key consideration*:** Obesity is a complex condition impacting on individuals, communities and places a burden on wider systems such as the health economy, on employers due to lost productivity, and on families who might need to care for people who have long term chronic disability arising from obesity such as back and sleep problems. Public Health England estimates that health costs between 2010 and 2030 will be £2 billion.

Figure 7: Diagnosed Obesity Prevalence among Adults 2014/15.



Source: Strategic Intelligence Team, Herefordshire Council

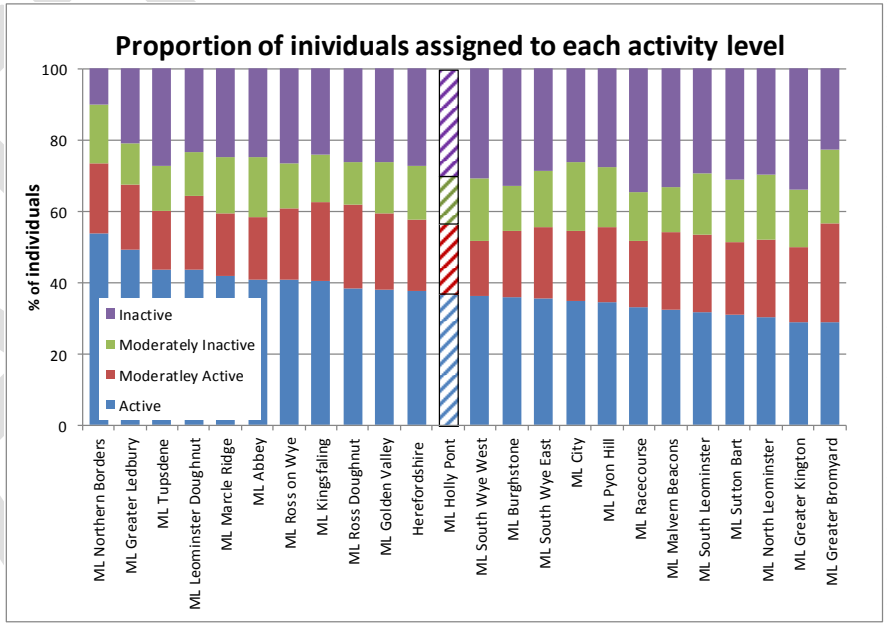
PHYSICAL ACTIVITY AND DIET

The general pattern evident across Herefordshire is where there are higher levels of obesity, people are less engaged in physical activity, and conversely, where there are high levels of physical activity the prevalence of obesity in the population is lower.

It is estimated that **26 per cent of adults** in Herefordshire are **physically inactive**. In 2013/15 a wide variability in the prevalence of active individuals was evident between MSOA[21]s throughout Herefordshire with a range of between 29 per cent at Greater Bromyard to 53 per cent in the Northern Borders (figure 8), indicating significant differences between proportions of active individuals across the county along the socio-economic gradient.

As part of a healthy diet the Government recommends that adults consume at least **five portions of a variety of fruit** and vegetables each day**;** one adult portion corresponds to 80 grams of fresh fruit or vegetables[22].

Figure 8: Proportion of all activity categories in population in each MSOA.



Source: Strategic Intelligence Team, Herefordshire Council

[21] MSOA = middle super output area

[22] http://www.nhs.uk/Livewell/5ADAY/Pages/Portionsizes.aspx.

In 2009, the direct healthcare cost of all CVD in the UK was £8.7 billion, and the total economic cost (healthcare, informal care and loss of productivity) was £18.9 billion.

The average cost of a hospital admission for a CVD event is estimated to be £4,614.

British Heart Foundation National Centre: Physical Activity + Health Evidence Briefing, Loughborough University, 2010

Information collected from over 8,000 individuals across Herefordshire during in the Hereford Health Check Programme (October 2015 – April 2016) were assessed for consumption of fruit and vegetables per day. It found that more than 60 per cent of individuals consumed five portions or above of fruit and vegetable per day, while less than 1 per cent consumed no fruit and vegetable per day. Furthermore, less than 3 per cent of participants had one portion, and less than 15 per cent of individuals consumed either three or four portions a day, respectively.

The greatest proportion of individuals consuming 5+ portions per day lived in the Northern Borders MSOA (89 per cent) and the lowest in Hereford City (45 per cent). The greatest proportion of individuals consuming no fruit or vegetables was recorded in the Hereford City (2.4 percent) while of those living in the Golden Valley and Greater Kington none reported consuming no fruit and vegetables.

Key Consideration

Sustained changes to better lifestyle choices will require whole system changes to food, physical activity and social environments. The above evidence makes a case for a greater role for health in local spatial planning, such as new developments and food outlets when establishing the engineering university in Herefordshire.

An organisation employing 1000 people could have an average of £126,000 a year of loss in productivity a result of sickness absenteeism for back and sleep problems.

National Institute for Care and Health Excellence, Workplace Health, NICE advice (LGB2] 2012.

Dementia

The average prevalence of dementia for Herefordshire is higher than the national average but the difference is not statistically significant. There is very little variability in the prevalence of dementia across the county with a difference of less than 10 per cent observed between the lowest value in the Golden Valley and the highest at Leominster. More deprived communities tend to show higher levels of dementia. A greater awareness of the role of vascular risk factors (for example, smoking, hypertension, and high cholesterol), in developing dementia would help educate the general public that health lifestyle choices can help prevent some forms of dementia. Managing other risks such as depression diabetes, and poor care environments will also help people with dementia to live healthier lives, which in turn improves the lives of their families and carers.

8. LIFE'S PROSPECTS – KEY INEQUALITIES

8.1 WORKING WELL

The latest Business Register and Employment Survey (BRES) estimates a total of 71,700 employees in 2014 in the county, a two per cent increase from 2013 (70,000). BRES also confirms that in 2014, the four industries employing the largest numbers of people (manufacturing, health, retail and education sectors) is unchanged from previous years. See Figure 9.

In Herefordshire, nearly two third of employees (64 per cent) work full time, five percentage points less than that for West Midlands. The proportion of employees working part time was higher in public sector (53 per cent) compared to the private sector (32 per cent).

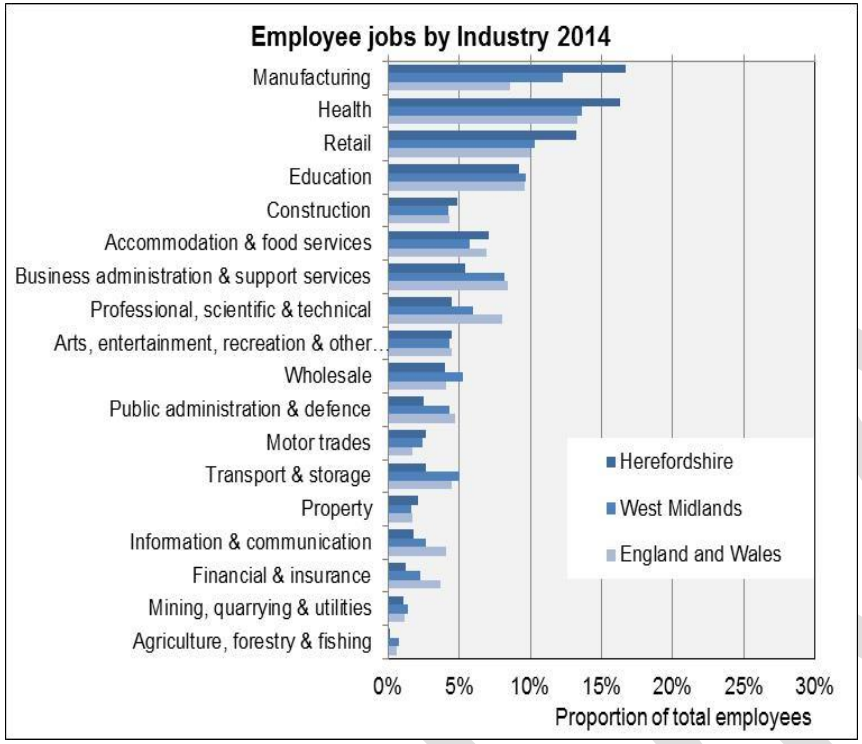
EARNINGS AND HOURS OF WORK

- In 2015, Herefordshire's earnings were 14 per cent lower than the West Midlands and 21 per cent lower than England's.
- According to the Annual Survey of Hours and Earnings (ASHE) in 2015, the median weekly earnings for people who work in Herefordshire were £421.90 significantly lower than those in the West Midlands region £493.10 and England £532.40.

GENDER GAP

In 2015, Herefordshire gender pay gap was large compared to most of the West Midland's and neighbouring authorities (women's earnings were 23 per cent lower than men's); the overall gap in the West Midlands was 20 per cent and 17 percent in England.

Figure 9: Percentage of total employees by industry sector (Source: BRES 2014).



INCOME DEPRIVATION

Income deprivation is mostly seen in areas of the city and the market towns, and more scattered in rural areas.

Across Herefordshire as a whole, 11 per cent (around 20,500 people) of the population are living in income deprivation. The most income deprived areas of Herefordshire are in south Hereford, Leominster, Bromyard and Ross – all in the 25 per cent most deprived in England with at least one in five residents affected. 'Golden Post-Newton Farm' in south Hereford & 'Leominster Ridgemoor' are in the 10 per cent most income deprived in England, affecting one in three residents.

13 per cent of all people aged 60 or over in Herefordshire live in income deprived households, equating to 7,100 people. 15 areas fall within the 25 per cent most deprived in England - most are in either north or south Hereford with a further three in Leominster and one each in Bromyard, Ross and ledbury. 'Leominster Ridgemoor' and Hereford city's 'Hunderton' and 'College Estate' had the greatest proportions, each with 34 per cent.

Overall 8,900 people or 43 per cent of those experiencing income deprivation live in **rural areas** of Herefordshire (31 per cent in 'rural village and dispersed' areas and 12 per cent in 'rural town and fringe').

EMPLOYMENT DEPRIVATION

Similarly 3,800 people or 40 per cent of people experiencing employment deprivation live in **rural Herefordshire** (29 per cent in 'rural village and dispersed' and 11 per cent in 'rural town and fringe'). Nine per cent of the county's working age population is living in employment deprivation – 9,500 people. 'Golden Post-Newton Farm' in south Hereford is one of the 10 per cent most employment deprived areas in England – affecting one in four working age residents.

Significantly, **the 10 most employment deprived areas are also the most income deprived**. The 'top three' most employment deprived areas are in the south of Hereford city.

ADULT SKILLS DEPRIVATION

Four LSOAs in south Hereford and one in Leominster are in the 10 per cent most deprived in England for **adult skills deprivation**. Adult skills – which includes qualification levels and the ability to speak English – is a particular issue for the county.

In Spring 2012 a total of 51 different languages other than English were recorded in Herefordshire's school census. By Spring 2015, 63 different languages other than English were spoken by school children.

8.2 THE PLACE ASPECT OF LIVING

HOUSING AFFORDABILITY

While the average (median) house price in Herefordshire is similar to the national average (£205K [23] compared to a national average (median) of £208K[23]), the average (median) gross annual earnings for a full time worker on adult rates in Herefordshire is considerably worse than the national figure (£22K[24] compared to a national average (median) of £28K[24]). This means that **houses at the lower end of the market costs around 8.4 times the annual earnings of the lowest earners**.

Herefordshire has the **worst affordability level** out of all the 14 West Midlands Authorities (unitary, counties and metropolitan boroughs). Provision of subsidised housing is therefore a priority for Herefordshire that needs to be addressed through partnership working between Herefordshire Council and Registered Providers.

[23] Across all property types, for the period October to December 2015. Based on Land Registry Price paid data. (Department for Communities & Local Government).
[24] Based on provisional figures from the Annual Survey of Hours and Earnings (ASHE) 2015.

POOR HOUSING AND HEALTH

Evidence shows that living in unsuitable living conditions (poor heating, mould, damp and structural defects) can lead to respiratory and cardiovascular problems as well as anxiety and depression. According to the Indices of Deprivation (2015), the 'indoor living environment', as defined by condition of housing and the availability of central heating, is Herefordshire's biggest type of deprivation - almost two-thirds of areas are in the 25 per cent most deprived in England, the majority being in rural areas.

HOUSING PROVISION FOR OFFENDERS

In a county where on average 12 properties become available a week, it is improbable that a person ranked red on the housing register, as most offenders are, is likely to be housed in the short term. Homelessness and re-offending have a complex relationship where for many they are both the cause and effect of each other.[25] Homelessness has been found to

[25] Homeless Report 2011: http://www.homeless.org.uk/sites/default/files/site-attachments/2.Better%20Together%20-%20full%20report.pdf

increase the chances of re-offending; if a prisoner is released homeless, they are twice as likely to re-offend when compared to those in stable accommodation[26].

8.3 BEING SAFE, STAYING SAFE

The majority of residents in Herefordshire feel safe. Around 59 per cent of people feel very or completely safe (remaining stable since 2011/12) but the proportion of people not feeling safe increased from five per cent in 2011/12 to nine per cent in 2014/15. Further information on crime and safety can be found in the 2015 Community Safety Strategic Assessment.

SEXUAL OFFENCES

The number of other sexual offences saw the largest rise in the county with a reported 87 in 2011/12 to 291 in 2015/16. The rise in reported sexual offences has been mirrored across the county; a reported 29 per cent year-on-year increase in reported rapes in 2015[27]. The reasons behind the rise have been attributed to improvements in the handling and reporting of allegations by the police and increased victim confidence. Further analysis of rape and other sexual offences is underway to better understand the threat and risk associated with the increase in reporting. See Figure 10.

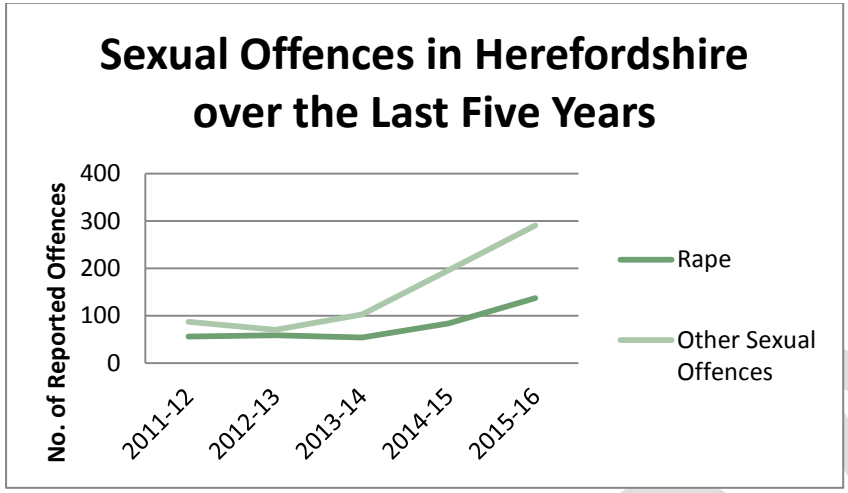
Key Consideration

Evidence suggests that the prison population has people who come through the state care system at some point with 50 per cent of women in prisons known to have been in care. Offending at an early age can disproportionately set young people who are looked after onto a path of unnecessary criminalisation with lifetime consequences.

[26] Homeless Link, SNAP 2011

[27] Office of National Statistics (ONS)

Figure 10: Five year trend of sexual offences in Herefordshire



Source: Strategic Intelligence, HC

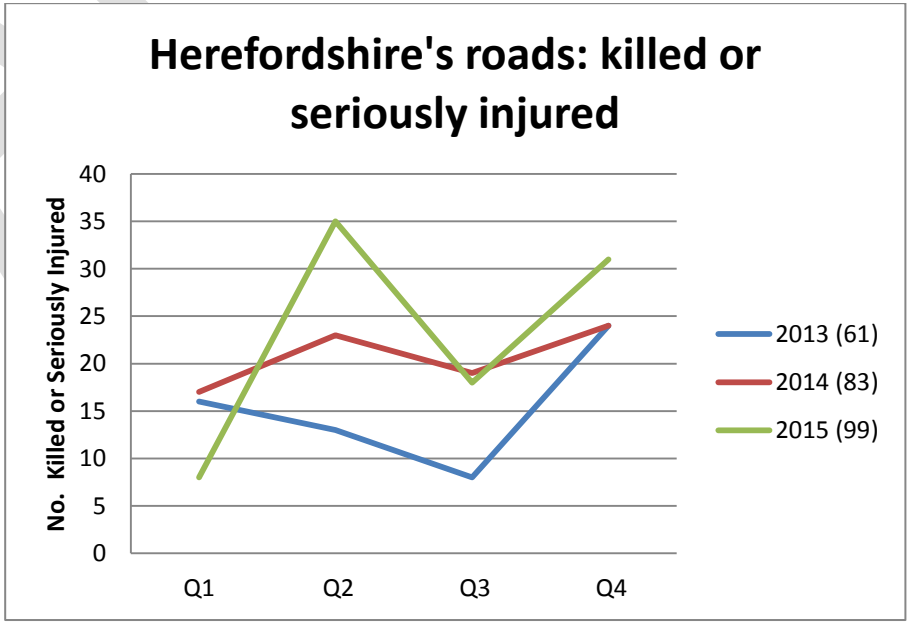
ROAD SAFETY

The number killed or seriously injured (KSI) on the Herefordshire road network in the years 2013-15, show that there has been a year-on-year increase in the numbers killed or seriously injured. See Figure 14. The number of fatal collisions, a component of the KSI figure, fell from 13 in 2014 to 7 in 2015. In 2015, there were 40 child casualties (0-15 years). The top three age categories for casualties were: 20-29 year olds (134); 30-29 years (85) and 40-49 years (80).

The distribution of casualties is comparable with those in previous years.

The road network is vital to supporting the socio-economic viability of Herefordshire, with road safety being a priority concern for all road users. Accidents are complex and variable events so simple headline analysis cannot be undertaken.

Figure 11: Number KSI over past three years in Herefordshire



Source: Strategic Intelligence, HC

End of Report

For further information regarding this report, please email

researchteam@herefordshire.gov.uk