APPENDIX 1

UNDERSTANDING HEREFORDSHIRE 2018

A joint strategic needs assessment summary

Version 0.20 (DRAFT)

Herefordshire Council Intelligence Unit

April 2018

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ABOUT THE JSNA

It is the statutory duty of Herefordshire Council and Clinical Commissioning Group, through the Health and Wellbeing Board, to produce a joint strategic needs assessment (JSNA) of the health and social care needs of the local area. The JSNA should provide the basis for service planning and commissioning decisions by the local authority and health organisations.

JSNAs take different forms in different areas, and in Herefordshire the approach has been to produce an annual summary, *Understanding Herefordshire*, that highlights the key findings from all of the intelligence that has been generated over the previous year. This summary is underpinned by an online evidence base, *Facts and Figures about Herefordshire*, which is updated throughout the year. Hyperlinks to the more detailed underlying evidence are provided throughout this document.

Each year, routine analysis of a wide range of open source data about the characteristics of Herefordshire and its population is supplemented by a programme of more detailed analysis and needs assessments. During the last year, the main areas of focus for the integrated evidence base have been:

- an integrated older person's needs assessment
- a needs assessment for adults with learning disabilities in Herefordshire
- an improved understanding of trends in users of adult social care services

The JSNA is produced by Herefordshire Council's intelligence unit, with contributions from other areas of the council and partner organisations, including West Mercia Police. Governance is provided by the JSNA steering group – a sub-committee of the Health and Wellbeing Board, with membership from the council, clinical commissioning group, 2Gether NHS Foundation Trust, Wye Valley NHS Trust, Healthwatch Herefordshire, Herefordshire Voluntary Organisation Support Services (HVOSS) and Herefordshire Carers' Support.

Informed by last year's JSNA, the Health and Wellbeing Board have identified four priority areas where improvements will make the biggest difference to health and wellbeing in Herefordshire. Evidence to support these is highlighted where it appears throughout the report.

- Giving our children a good start in life by maintaining a healthy weight and looking after their teeth.
- Supporting people with dementia to remain as independent as possible within their community, ensuring that people are well cared for when nearing the end of life.
- Supporting the development of resilient communities, where people help each other to remain independent and in control of their own lives.
- Keeping people warm so they are less likely to develop enduring health problems and become acutely ill when it is cold.

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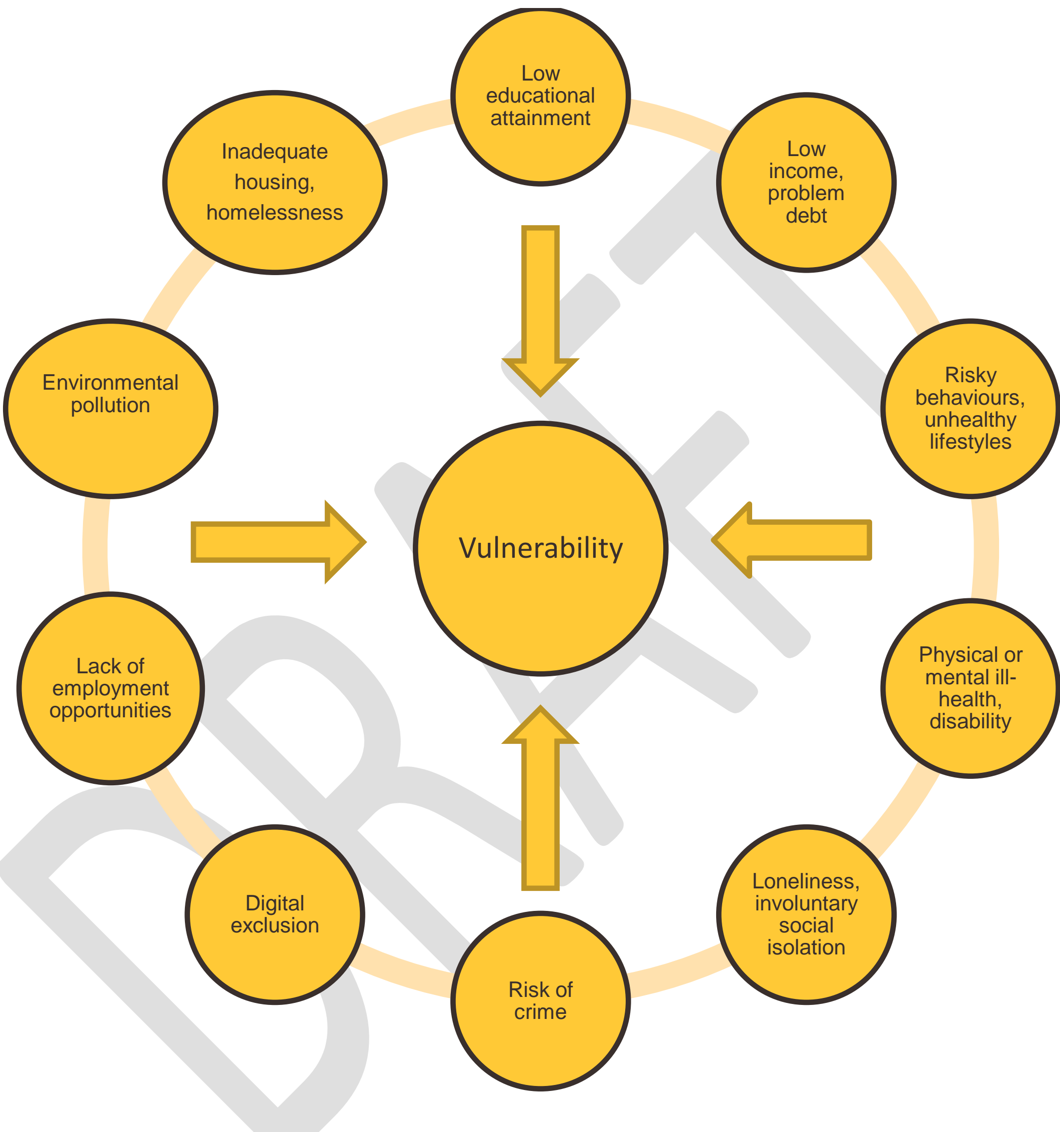
Herefordshire Council's and Herefordshire Clinical Commissioning Group's focus is on prevention, early intervention and demand management in order to deliver better outcomes, whilst also managing the challenges of scarce public resources. This requires an understanding of the full range of socio-economic and lifestyle factors that affect the health and wellbeing of Herefordshire's people and communities, and an appreciation of the links between the wider determinants of health, the factors that contribute to multiple deprivation, and vulnerability.



ACTION POINTS

This section summarises all of the points that have been highlighted as an area for improvement, either compared to other areas, or because of a changing trend locally. More detail can be found by following the link to the relevant section of the report.

EARNINGS: At around £450 per week in 2017 (£23,400 per year), average earnings for employees working in Herefordshire remain significantly lower than nationally and regionally, although the gap does appear to have narrowed slightly since 2013. They are the fourth lowest of all 113 council areas in England.

HOUSING AFFORDABILITY: Herefordshire is the worst area within the West Midlands region for housing affordability. House prices at the lower end of the housing market are 8.6 times higher than lower quartile annual earnings. Herefordshire's affordability ratio has been consistently worse than in both the West Midlands region and England and Wales since at least the turn of the century.

PRIORITY

FUEL POVERTY: 13,300 Herefordshire households were in fuel poverty in 2015 (17 per cent); a higher proportion than nationally and regionally. The majority of households affected by fuel poverty live in rural areas. Sixty per cent of Herefordshire's older people (65+) live in rural areas, where lack of access to mains gas and properties with poor thermal efficiency increase the risk of fuel poverty. Older people are more susceptible to ill health (including the risk of death in the winter) as a result of residing in cold homes. The detrimental effects of fuel poverty pose a considerable threat to the health and wellbeing of older people living in Herefordshire.

DIGITAL INCLUSION: Herefordshire is rated 'high' for likelihood of overall digital exclusion. One fifth of adults have never used the internet, or used it over three months ago. . This is not solely a broadband connectivity issue, and more research is needed to identify digitally excluded households to support those who wish to learn digital skills, and to assess the impact of digital exclusion on access to services.

ADULT SOCIAL CARE: The **recruitment and retention** of care workers in what has traditionally perceived as a low-wage, low-skill sector is a concern, at a time when this workforce needs to increase substantially to meet the demands of an ageing population.

Given Herefordshire's relative levels of wealth and ageing demographic, it is likely that there are a considerable number of people who are **self-funding** their personal care needs. There is only limited support available to self-funders to help them make appropriate care choices, but if they exhaust their own resources they are likely to need local authority funded care. Work is underway to improve the understanding of this cohort.

CARERS: In Herefordshire, less than a quarter (23 per cent) of adult carers reported in 2016/17 having as much social contact as they would like, significantly fewer than in the West Midlands region (37 per cent) and England (36 per cent). In 2014/15, the carer-reported quality of life score in Herefordshire was higher than in 2012/13 and similar to regionally, but lower than nationally.

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LEARNING DISABILITIES (LD): Although a higher proportion of adults with LD receive an annual health check in Herefordshire than in comparator areas, the rate is lower than in 2014/15 and is now below that reported nationally. There is also no information available about the results of health checks, or whether subsequent treatment plans have been put in place as per NICE guidelines.

The uptake of cancer screening amongst eligible adults with learning disabilities in Herefordshire is low, which is reflected in the relatively low cancer prevalence, suggesting late or missed diagnosis. As a result, outcomes are likely to be poorer and premature mortality from cancer more likely.

AUTISTIC SPECTRUM DISORDER (ASD): Significantly fewer children at state funded county schools are known to have an ASD (eight per thousand) than nationally or regionally (both 13 per thousand). As there is no reason to assume prevalence is lower in the county, this suggests diagnosis rates need to be improved so appropriate support can be provided.

COMMUNITY SAFETY: Of concern is a spike in the number of sexual orientation focused hate crimes between 2017/18. In addition, Herefordshire continues to experience issues related to “county line” drug supply network activity. The presence of these networks presents significant threat, harm and risk to the most vulnerable within the local community with systematic criminal, physical, mental and sexual exploitation usually occurring in addition to the drug supply aspect. This activity resulted in one murder during the period 2017/18.

DELIVERIES BY CAESAREAN SECTION: In 2015/16, a significantly higher proportion of deliveries in Herefordshire were by caesarean section than nationally or regionally.

HOSPITAL ADMISSIONS OF BABIES AND CHILDREN: The county is experiencing relatively high rates of hospital admission of babies under 14 days old, and of children aged 2-4 for gastroenteritis. Work has been identified for the coming year to better understand the reasons behind this.

HUMAN PAPILLOMA VACCINE (HPV): In September 2014 the routine Human Papilloma Vaccine (HPV) programme was changed from a three to two-dose schedule. In 2015/16 the coverage for two doses in Herefordshire was 81 per cent - lower than both the national (85 per cent) and regional (86 per cent) rates. Action may need to be taken to improve take-up.

PRIORITY

ORAL HEALTH: Significantly fewer five year-olds were free from dental decay locally in 2014/15 (59 per cent) than nationally (75 per cent) and regionally (77 per cent), and no better than in 2007/08 (61 per cent). The average five year-old has 1.43 decayed, missing or filled teeth, almost double the 0.72 regionally.

INEQUALITIES IN EDUCATION: As nationally, it remains the case that certain groups of pupils do less well, on average, than their peers. This includes the expected standard in reading writing and maths at key stage 2 and the new ‘attainment 8’ score at key stage 4 of those in receipt of free school meals, those classed as ‘disadvantaged’, and those whose first language is not English.

ALCOHOL HARM: Hospital admissions due to alcohol consumption remain significantly lower than the national rate (319 per 100,000 in 2016/17 compared to 563), and the rate amongst under 18s continues to fall locally – narrowing the difference compared to nationally (41 per 100,000 in 2014/15 to 2016/17 compared to 34 per 100,000 in England). However, people from the most deprived areas of the county are still more than three times as likely to be admitted to hospital due to alcohol as those from the least deprived. Success rates for alcohol treatment were lower in Herefordshire than in comparator areas in 2016.

PRIORITY

OBESITY: 23 per cent of reception year children in county schools were overweight or obese in 2015/16, more than two-fifths of whom were obese (10 per cent of children). Obesity rates double by Year 6. The concentration of fast food outlets in more deprived areas is also an area of concern.

SMOKING: Although smoking-related hospital admissions remain relatively low overall, certain groups of the local population are still more likely to be smokers. Adults in routine and manual occupations locally are much more likely to smoke than the population overall (24 per cent compared to 14 per cent in 2016). Men are a third more likely to smoke than women, and smoking is more common in the most deprived areas with residents aged 35+ a third more likely to be admitted to hospital as a consequence of their smoking than the rest of the county, and 40 per cent more likely to die of smoking-related conditions. Quit rates are significantly lower than in Herefordshire than in comparator areas and have fallen in recent years.

LIFE EXPECTANCY: People born in Herefordshire can, on average, expect to live longer lives and remain in good health for longer than nationally and regionally, but females born in the most deprived areas of Herefordshire can expect to live 2.6 years less than those living in the least deprived areas; males 3.9 years less. However, this gap is one of the smallest amongst areas with similar levels of deprivation.

LONG-TERM CONDITIONS: The prevalence of stroke, coronary heart disease (CHD) and hypertension (high blood pressure) in Herefordshire is greater than in England as a whole, suggesting more work is needed on prevention and awareness strategies. Currently, those living in the most deprived areas of Herefordshire are 29 per cent more likely to die prematurely (under 75 years of age) likely to die of coronary heart disease and over 71 per cent as likely to die prematurely of cerebrovascular disease.

CANCER: remains one of the biggest causes of premature mortality in Herefordshire, although rates are amongst the lowest in England. Prevalence of cancer has risen locally and is significantly higher than nationally (3.4 per cent in 2016/17 compared to 2.6 per cent), however mortality rates have fallen consistently over the last 20 years. Those living in the most deprived areas of Herefordshire are 22 per cent more likely to die prematurely (under 75 years of age) of cancer.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): The number of people suffering with COPD in Herefordshire has increased steadily during the last decade to 2.2 per cent in 2016/17. Since 2011/12 the local prevalence has been higher than the national figure whereas prior to 2009/10 the opposite pattern was observed. Respiratory diseases

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account for over a third of all excess winter deaths in Herefordshire. Those living in the most deprived areas are over two and half times likely to die prematurely of chronic lower respiratory disease than those in the least deprived areas.

RHEUMATOID ARTHRITIS: In Herefordshire, the prevalence of rheumatoid arthritis in persons aged 16yrs+ in 2015/16 was significantly higher than that recorded nationally and regionally. Since 2013/14 there has been no temporal change in prevalence locally or nationally.

DIABETES: The overall prevalence of diabetes (type 1 or 2) remains similar to, and has risen in line with, the national rate (seven per cent of adults aged 17+ registered with Herefordshire GPs in 2016/17). However, diabetes rates amongst older patients (65+) are significantly higher: 24 per cent compared to 17 per cent both regionally and nationally. A significantly lower proportion of all diabetes patients achieved the three treatment targets (HbA1c, cholesterol and blood pressure) locally in 2016/17.

MENTAL HEALTH: In 2016/17, the hospital admission rate for mental health disorders in children and young people aged 0 to 17 tears significantly higher than in England as a whole and in the West Midlands region. The rate has been increasing since 2012/13 and the gap between Herefordshire and England is widening.

Reflecting the situation nationally, the incidence of **suicide** in men is much higher than in women and residents of the most deprived areas of Herefordshire are approximately 19% more likely to die as a result of suicide than the county population in general.

PRIORITY

DEMENTIA: At the beginning of 2017, only 59 per cent of people aged 65+ with dementia had a formal diagnosis, lower than nationally (68 per cent) and regionally (66 per cent) and yet to reach the NHS England target of 67 per cent.

FALLS: Falls are common in residential and nursing home settings. Systematic recording of falls occurring in these settings would be helpful in order to develop more effective prevention strategies.

A considerably smaller proportion of people aged 75 and over presenting with fragility fractures are treated with a bone sparing agent (a treatment for osteoporosis) in Herefordshire compared to other clinical commissioning groups, suggesting that there is an opportunity to improve outcomes for people with osteoporosis by enhancing treatment coverage.

PRIORITY

END OF LIFE CARE: End of life care services in Herefordshire are generally good, and a significantly higher proportion of people die in their usual place of residence than elsewhere (51 per cent in 2015). However, there is scope for further work to proactively raise the profile of issues relating to death and dying with the wider community, provide training and support for those non-clinical staff who work with terminally ill people or their families, and to recognise and accommodate the specific needs of minority groups.

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HEREFORDSHIRE: THE PLACE AND ITS PEOPLE

Herefordshire is situated in the south-west of the West Midlands region bordering Wales. The city of Hereford lies in the middle of the county and other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington. The county has beautiful unspoilt countryside with remote valleys and rivers and a distinctive heritage. The River Wye divides the county, flowing east from the Welsh border through Hereford city before turning south through the Wye Valley 'Area of Outstanding Natural Beauty'. The Malvern Hills rising to 400m border the east of county, while the south-west is dominated by the western reaches of the Black Mountains with altitudes of more than 600m. Herefordshire covers 2,180 square kilometres (842 square miles). 95 per cent of the land area is 'rural' and 53 per cent of the population live in rural areas. Being a predominantly rural county presents opportunities in, for example, tourism and agriculture, but also presents challenges, for example in geographical barriers to services.

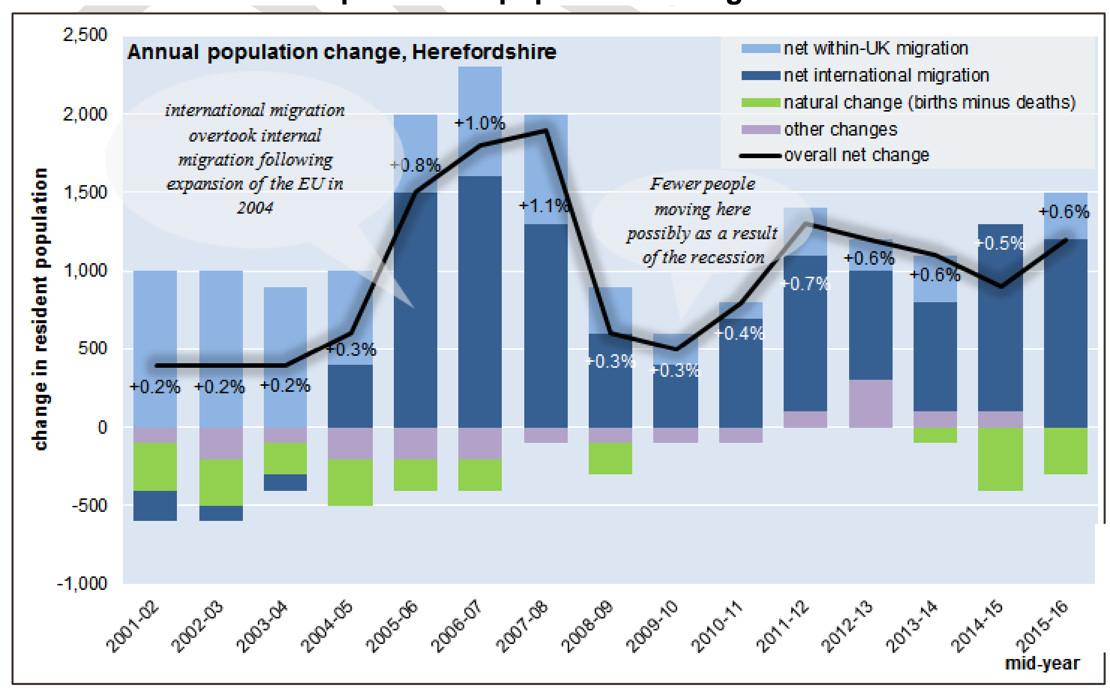
POPULATION

Herefordshire's demographic composition pre-disposes the county to challenges associated with an ageing and dispersed rural population.

In mid-2016, Herefordshire's population was estimated to be 189,300; an increase of 1,200 people (0.6 per cent) since mid-2015. Between 2001 and 2016, the county's population grew by eight per cent – a lower rate than England and Wales (11 per cent) and the West Midlands region (10 per cent).

The number of deaths (around 2,000 a year) in Herefordshire generally outnumbers the numbers of births (currently around 1,600 a year). This means that population growth is entirely driven by migration; since 2005-06 mainly from overseas.

Annual overall and components of population change in Herefordshire



Source: ONS mid-year estimates © Crown Copyright

Two in five Herefordshire residents (40 per cent) live in the most dispersed rural areas and the county has the fourth lowest population density in England; 87 people per km^2. Population density varies from 13 people per km^2 in areas of the north-west and south-west of the county to 8,400 per km^2 in an area of north-east Hereford.

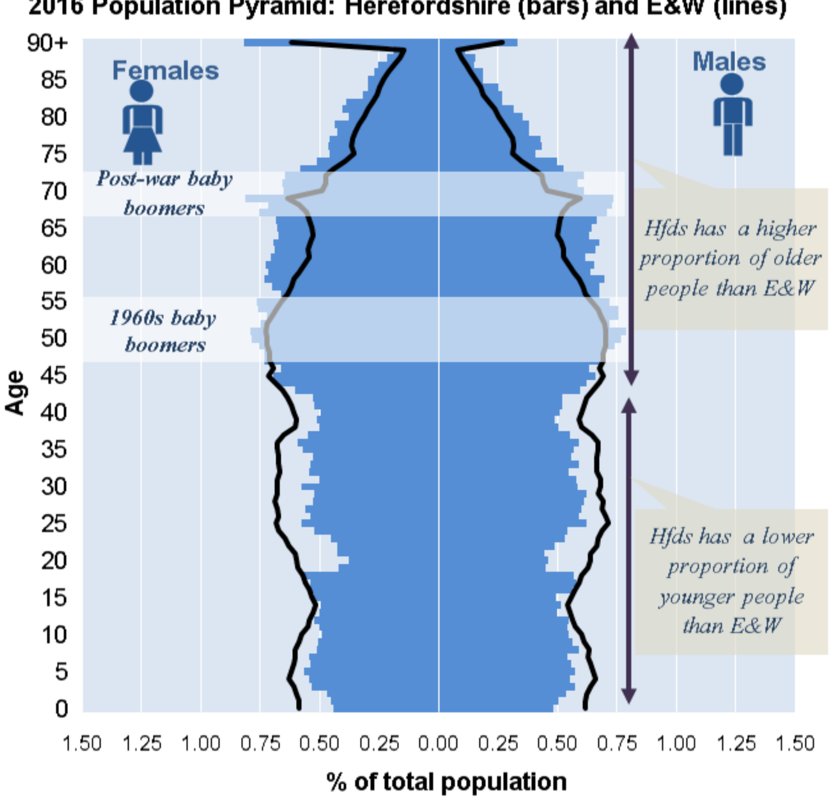
One in three residents live in Hereford (60,800) and one in five in market towns: Leominster (12,000), Ross on Wye (11,200), Ledbury (10,000), Bromyard (4,700) and Kington (3,300).

Herefordshire has an older age structure than England and Wales, with 24 per cent of the population aged 65 years or above (44,800 people), compared to 18 per cent nationally. There are 33 per cent more people aged 65+ than there were in 2001, compared with a 26 per cent increase nationally. The number aged 65-84 is projected to grow at a similar rate as during the last decade, but the number aged 85+ will rise even more rapidly.

There are a similar proportion of under-16s (17 per cent) as nationally (19 per cent). Numbers of children have declined by around seven per cent over the last decade. However, the number of under-fives and births has been rising for the best part of the last decade. The next five years are expected to yield a gradual increase in the numbers of children, to around 33,200 by 2023.

Herefordshire has a relatively small, but growing, Black, Asian and Minority Ethnic (BAME) population; 6.4 per cent in 2011 compared with 19.5 per cent nationally.

Age structure of Herefordshire compared with the equivalent for England and Wales (mid-2016 estimates).



Source: Annual Mid-Year Population Estimates for the UK, Office for National Statistics (ONS) © Crown Copyright 2017

If recent trends were to continue and nationally determined assumptions about future fertility, mortality and migration were to be realised, the total population of Herefordshire is projected to increase to 192,300 by 2019 (an increase of two per cent); and to 205,600 people by 2034 (an increase of nine per cent), or 0.5 per cent per year over this period. This is a lower annual rate of growth than that projected for England as a whole (0.7 per cent per year).

ECONOMY

Herefordshire's population of working age (16-64) was 112,700 in 2016. It has a lower proportion of younger working age adults (from the age of 16 to mid-forties) and a higher proportion of older working age adults (mid-forties to the age of 64) compared with England and Wales as a whole.

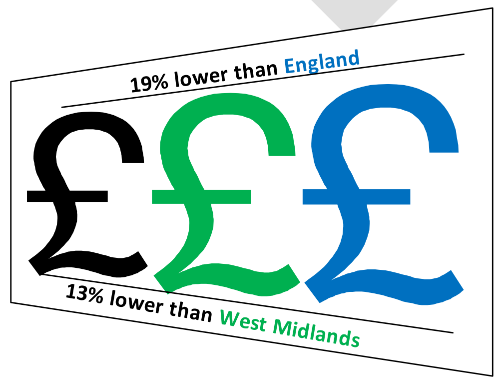
Changes in the working age population are driven by migration and the natural ageing of the population structure (deaths have relatively little effect on numbers). Numbers have fallen by a few hundred since 2009, and if recent trends in migration were to continue, natural ageing would see the population aged 16-64 three per cent by 2031 – with the sharpest decline after 2025 when the second generation of 'baby boomers', those born in the 1960s, begin to move into retirement age.

Earnings

At around £450 per week in 2017 (£23,400 per year), average earnings for employees working in Herefordshire remain significantly lower than nationally and regionally, although the gap does appear to have narrowed slightly since 2013. Among the 113 'upper tier' local authorities (i.e. county councils, unitary authorities and metropolitan boroughs) in England, Herefordshire's median weekly earnings ranked 4th lowest in 2017 – and have been among the bottom seven over the past five years. The equivalent figures for England are £555 per week (£29,000 pa) and the West Midlands are £515 per week (£26,850 pa).

Women earn, on average, ten per cent less than men per hour (excluding overtime) – a similar gender pay gap to that seen in England as a whole, but lower than the twelve per cent for the region.

Gap in Herefordshire earnings in 2017:



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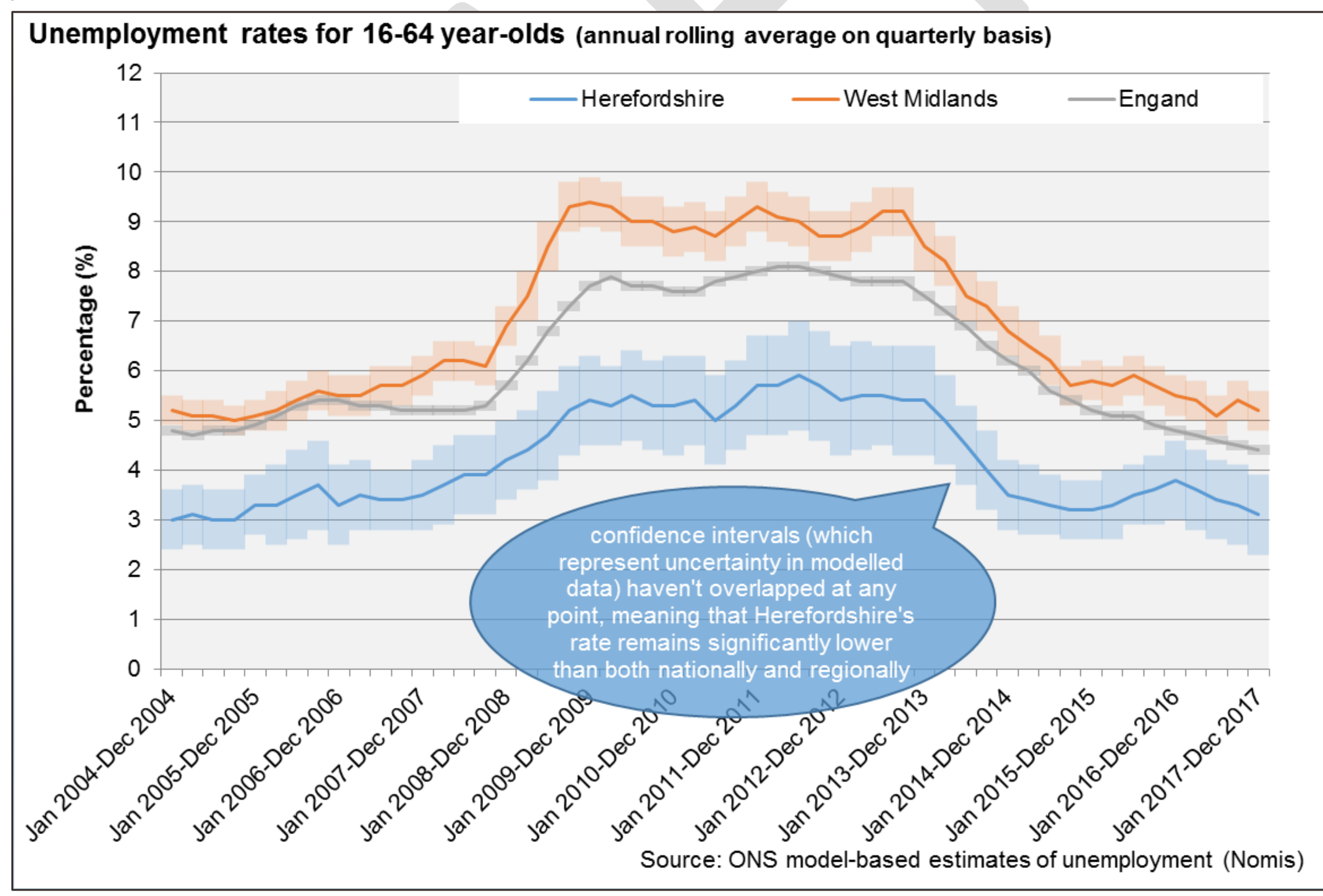
Type of employment

Possible reasons for the persistently low wages in the county include relatively high levels of employment in traditionally low value industries. Employment in the health, manufacturing, retail and accommodations and food services sectors is more common locally than nationally and regionally, and makes up over half (53 per cent) of Herefordshire's 73,000 employee jobs[1]. Furthermore, there is a relatively high rate of part-time working (36 per cent vs. 32 per cent across the whole West Midlands region). Reflecting the picture elsewhere, this is much more common in the public sector than the private (47 per cent compared to 35 per cent).

There is also a relatively high number of people in Herefordshire who are self-employed – 15 per cent of all working age people (16-64) compared to 11 per cent in England.

Unemployment

The estimated unemployment rate amongst 16-64 year-olds in Herefordshire was 3.1 per cent (3,000 people) in the year to December 2017, statistically significantly lower than both regionally (5.4 per cent) and nationally (4.4 per cent). This is the lowest it has been since 2004/2005 and continues the downward trend seen since a local post-recession spike of 3.8 per cent in 2016.



Source: Model-based estimates of unemployment, ONS. Crown copyright

[1] Note that this data source (ONS' Annual Survey of Hours and Earnings) does not cover small businesses or the self-employed – so it doesn't reflect Herefordshire's agricultural sector very well.

In addition, the number and rate of people who are claiming Job Seekers Allowance remains lower in Herefordshire (0.6 per cent of 16-64s compared to 1.0 per cent for England and 1.5 per for the West Midlands region), and continues to fall: in October 2017, 650 Herefordshire residents were claiming JSA – 16 per cent lower than the year before. As nationally, the majority (70 per cent) of claimants are usually employed in 'sales occupations'. The highest number of claimants live in Leominster and south Hereford.

Broadband

Research has shown that poor internet connections and slow speeds have a damaging economic effect and that the gap between rural and urban areas is widening. This is a disincentive to business investment and adds to costs in the rural economy. It is predicted that although the urban-rural gap 'will begin to narrow as superfast reaches more rural areas…better-connected (mostly urban) areas will also increase speeds at a high rate.'[2]

Access to a good broadband service has long been an issue for those living and working in rural Herefordshire, and the Fastershire project has ensured that by 2018 78 per cent of homes and businesses can obtain download speeds of more than 30Mbps[3]. Current contracts should deliver this capability to a total of 98 per cent by 2020. A solution is still to be found for the remaining two per cent of eligible households and businesses (around 4,000 properties).

However, only 41 per cent of those covered by the programme at the end of October 2017 had chosen to take up superfast broadband. Take-up is likely to be affected by the relationship between how much households or businesses feel they need the service, and how much it costs. Little is known about the reasons driving this low take-up rate in Herefordshire, so the topic would benefit from more research. See the digital inclusion section for further discussion.

Fastershire, a partnership between Gloucestershire County Council and Herefordshire Council, is tasked with bringing faster broadband to the two counties. Phase 1 of the project, in partnership with BT, aimed to provide 90 per cent of Gloucestershire and Herefordshire with fibre broadband with a minimum speed of 2Mbps by 2016. Phase 2 of the project, delivered by Gigaclear, will extend fibre coverage further across the county. The ultimate aim is that by the end of 2019/20 there will be access to fast broadband for all who need it. Herefordshire Council is committed to ensuring that each business or resident who can prove the need for a Next Generation Access (NGA) connection of over 24Mbps is able to get one.

[2] Two-speed Britain: Major study reveals impact of gap in Internet access between rural and urban area, University of Aberdeen, 2 September 2015. Available at https://www.abdn.ac.uk/news/8127/
[3] 30Mbps is the minimum download speed for 'superfast' broadband according to Ofcom, the UK regulator

TRANSPORT

Key facts:

- Herefordshire Council is responsible for over 2,000 miles of road, more than 700 road bridges and 11,700 street lights. This does not include trunk routes such as A49 and the M50 motorway, which are the responsibility of Highways England.
- Ninety-five per cent of Herefordshire's land area is classified as 'rural' and over half of the population live in rural areas.
- With only four railway stations in the county, Herefordshire is particularly dependent on road transport.
- The road network comprises mainly rural 'C' or unclassified roads leading off single carriageway 'A' roads.
- The majority of residents who travel to get to work do so by driving themselves in a car or a van (70 per cent).
- Herefordshire has a greater proportion of people travelling to work by car or van or on foot than England and Wales, but smaller proportions using a bus or train.
- Cycling levels are well above the national average.

The *Herefordshire Local Transport Plan* sets out programmes of work for achieving the council's objectives for transport.

Development of the Hereford Transport Package (HTP) is underway, including public consultation. The HTP sets out a suite of transport and infrastructure improvements with the objectives of facilitating economic growth, improving regional connectivity, encouraging sustainable lifestyles, encouraging sustainable development, providing network resilience, improving air quality and reducing noise, reducing severance and improving safety.

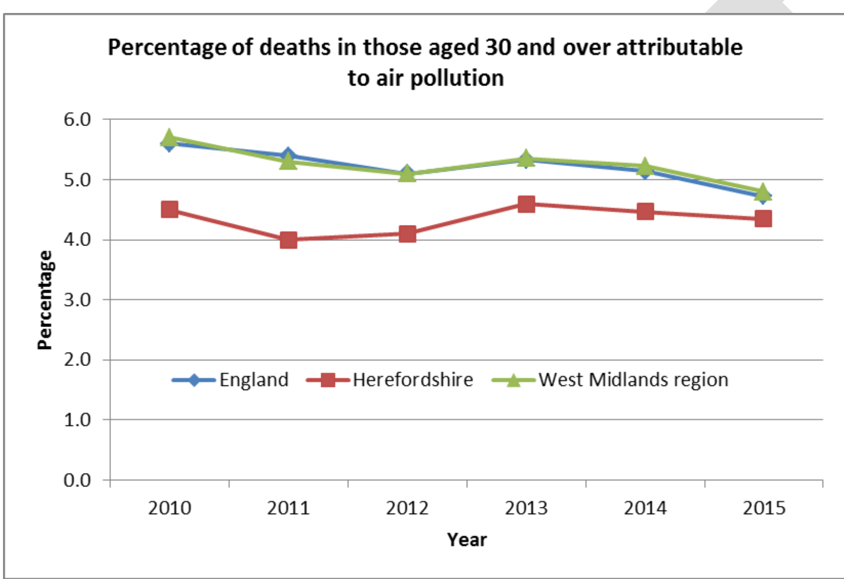
The recently opened City Link Road will unlock brownfield land for new affordable housing and regeneration in the centre of Hereford. A southern link road in the South Wye area will reduce congestion on Belmont Road and provide improved access to the Enterprise Zone at Rotherwas. A planned Hereford Relief Road (HRR) will provide an alternative route for through traffic.

ENVIRONMENT

Access to open space and nature is increasingly being recognised as beneficial to both physical and mental health[4], and Herefordshire's natural and historic environment is important for residents, businesses and tourism.

Generally, Herefordshire has low levels of air pollution - although there are still two air quality management areas where levels of nitrogen oxide are higher than government standards.

Mortality attributable to **particulate air pollution** is a Public Health protection indicator. Figures for Herefordshire have remained relatively stable since 2010 (between four and five per cent of all deaths of those aged 30+) and are consistently below both national and regional figures – although the gap appears to be narrowing.



Source: Public Health England.

Water quality in parts of the rivers Wye and Lugg is such that measures are needed to ensure that there is not a long-term adverse effect on protected species; a nutrient management plan is in place to address the issue.

Reducing **greenhouse gas emissions** is essential to help mitigate the multiple threats posed by climate change. Herefordshire Council's *Carbon Management Plan 2017-2021* sets out a pathway for achieving a 40 per cent reduction in its emissions CO2e from 2008/09 levels by 2020/21.

By 2016/17, the council's total emissions had been reduced by almost one third, to just over 18,600 tonnes of carbon dioxide equivalent (CO2e). The latest Greenhouse Gas Summary Report notes that "innovation, resource and resilience are required" to meet the target.

[4] Connecting with nature offers a new approach to mental health care, Natural England, 9 February 2016. Available at: www.gov.uk/government/news/connecting-with-nature-offers-a-new-approach-to-mental-health-care

COMMUNITIES AND PROTECTING THE VULNERABLE

HOUSING

The links between poverty, inadequate or unsuitable housing and ill-health are well-established. Herefordshire faces a range of challenges associated with housing affordability and the costs associated with maintaining and insulating an aged housing stock with relatively large numbers of properties without mains services.

Key facts:

- The 2011 census recorded 78,300 households in Herefordshire, 25,400 in Hereford city, 17,800 in the market towns and 35,200 in rural areas. By 2015, the total had risen to an estimated 79,800.
- A slightly higher proportion of these households were lone pensioners (14 per cent) compared to the West Midlands (13 per cent) and England and Wales (12 per cent).
- In 2011, Herefordshire had a higher proportion of households who own their home outright and a lower proportion who own their home with a mortgage, compared with England and Wales. It had a slightly lower proportion that privately rent their home from a landlord or letting agency and a lower proportion that were in social rented accommodation, compared with nationally.
- As of May 2018, there were 84,800 residential properties registered for council tax in Herefordshire; of which 39 per cent were in the lowest value bands A and B and 26 per cent were in the highest value bands E to H. This compares with 44 per cent and 19 per cent, respectively, for England. There is great variation in the distribution of banding between urban and rural areas.

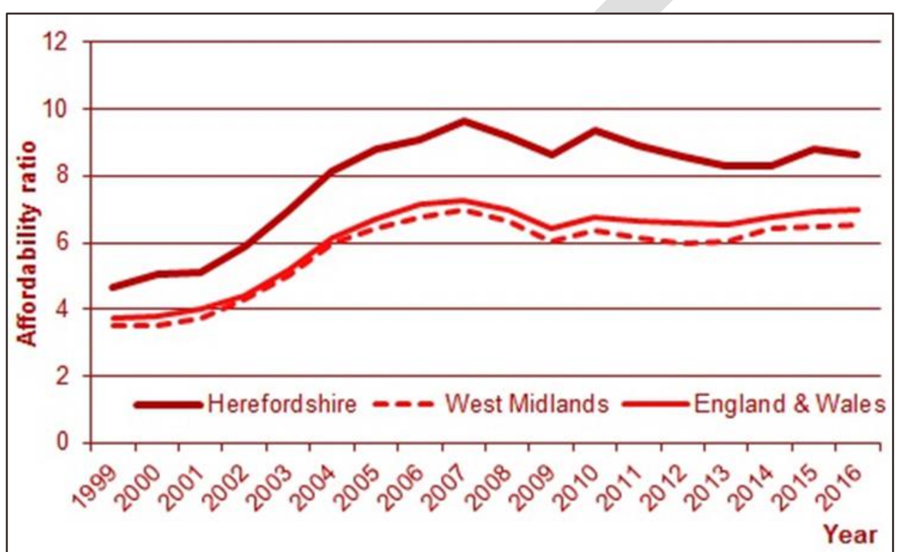
Herefordshire Council's adopted Core Strategy identified a need for 16,500 new dwellings (both open market and affordable) to be built between 2011 and 2031. The allocation is split between Hereford city (6,500), other market towns (4,700) and rural settlements (5,300). A local housing requirements study commissioned in 2014 determined that this level of development would be enough to meet the level of economic and demographic growth predicted at that time.

There are currently no up-to-date forecasts to indicate what effect the anticipated house building will have on the population around the county, but this has been identified as a priority for 2018.

Housing affordability

Herefordshire is the worst area within the West Midlands region for housing affordability. House prices at the lower end of the housing market are 8.6 times higher than lower quartile annual earnings. Herefordshire's affordability ratio has been consistently worse than in both the West Midlands region and England and Wales since at least the turn of the century.

Affordability ratio in Herefordshire compared to the West Midlands region and England and Wales



Source: Ratio of house price to workplace-based earnings (lower quartile and median). Office for National Statistics © Crown Copyright 2017

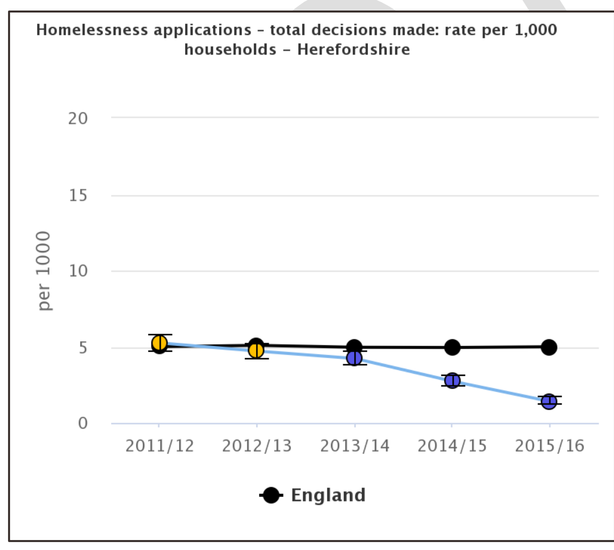
Between 2001 and 2011, there was a shift in housing tenure away from owner occupation towards the private rented sector. Rental levels in Herefordshire in 2016 were just under the median point for all English authorities excluding London. Within the West Midlands region, Herefordshire is ranked as the third most expensive unitary or shire authority when median rents for all dwelling sizes are compared.

The Herefordshire *Interim Housing Strategy 2016 – 2020*, identified ensuring a programme of affordable housing development, consistent with local housing need and national and local targets, as one of the key priorities for the county.

Homelessness

Homelessness can be associated with severe poverty and is a social determinant of mental health. It can also have a severe impact upon an individual's physical health and homeless people are more likely to be victims of crime. The causes of homelessness are often complex so that preventing homelessness is a difficult issue to address. There is a statutory duty for local authorities to provide advice and assistance to households who are homeless, or threatened with homelessness, and in some cases to provide suitable accommodation. In certain circumstances there is also a duty to provide emergency accommodation.

The Homelessness Reduction Act 2017 made far-reaching changes to homelessness legislation and significantly amended the Housing Act 1996. It came into force in April 2018. Under the Act, local housing authorities will be required to intervene at earlier stages in order to prevent homelessness and to take reasonable steps to help those who become homeless to secure accommodation, or to maintain their existing accommodation. Its main purpose is to ensure that everyone who approaches a local authority because they are either facing homelessness or actually homeless should receive some assistance, whether they are in priority need or not, and irrespective of whether they may be considered intentionally homeless.



In Herefordshire the number of homelessness applications has declined in recent years. In 2015-16 there were 114 applications, representing a rate of 1.4 per 1,000 households, well below the rate for England of 5.0 per 1,000. The rate of statutory homelessness was 0.5 per 1,000 households in 2015-16; lower than in both England (2.5) and the West Midlands region (3.5).

Source: Public Health England.

In 2016-17 in Herefordshire, the rate of those considered to be statutory homeless but not in priority need of 0.1 per 1,000 households was lower than in England (0.8) and had fallen from a rate of 0.5 in 2013-14.

Although numbers are difficult to establish with certainty, the number of **rough sleepers** in Herefordshire was estimated at 11 in 2017, down from 21 the previous year. The Hereford Winter Shelter was open between December 2016 and March 2017. In this period a total of 66 individuals (59 men and 7 women) stayed for a total of 861 nights. The approximate average stay per person was 13 nights. This compares to a total of 79 individuals staying for a total of 1,124 nights in 2015-16, which was an approximate average stay per person of 14.2 nights.

The Herefordshire *Homelessness prevention strategy 2016-2020* sets out a series of actions aimed at reducing homelessness and rough sleeping in the county.

Fuel poverty

Fuel poverty is defined as occurring when a household has required fuel costs that are above average, and after spending that amount, they are left with an income that is below the official poverty line.[5] Whether a household is in fuel poverty is determined by the interplay of three key factors:

1. the energy efficiency of the property
2. the household income
3. fuel/energy prices

National analysis of fuel poverty data indicates that households in fuel poverty are more likely to occupy large, older houses, and be owner-occupiers and families.[6]

Herefordshire, like other rural counties, has a considerable number of dwellings without access to the mains gas grid. The Healthy Housing Survey (2011) identified that mains gas was available to only 69 per cent of properties in Herefordshire, compared to 87 per cent nationally.[7] Being off the mains gas grid significantly increases the risk of a household being in fuel poverty, as the fuel options for off-grid homes are often more expensive and less energy efficient than gas. Furthermore, rural households are also more likely to be living in

[5] Annual Fuel Poverty Statistics Report, 2017, Department for Business Energy and Industrial Strategy, 2017. This definition is based on the Low Income, High Cost (LIHC) methodology which became the official fuel poverty indicator in 2013. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/639118/Fuel_Poverty_Statistics_Report_2017_revised_August.pdf. .
[6] Cutting the cost of keeping warm: A fuel poverty strategy for England, Department of Energy and Climate Change, 2015. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf
[7] Healthy Housing, Michael Dyson Associates Ltd on behalf of Herefordshire Council, 2012. Available at:https://factsandfigures.herefordshire.gov.uk/media/12674/healthy_housing_final_report_3rd_oct_2012.pdf

older and less thermally efficient dwellings, and to have a lower than average household income. [8]

Fuel poverty adversely impacts upon health and wellbeing through associated financial hardship as well as increased risk of conditions such as respiratory illness, high blood pressure, and hypothermia.

The physiological effects of exposure to cold room temperatures are well documented and cold homes are known to contribute to excess winter deaths.[9] Older people, children and people with disabilities and long-term illnesses are particularly vulnerable to the adverse effects of fuel poverty. In addition, cold can worsen arthritic pain and/or contribute to a general feeling of illness.[10] Fuel poverty can exacerbate involuntary social isolation, making those affected less able to afford to go out, or fearful of going out knowing they will come in, already feeling cold, to a cold home; or reluctant to invite friends into a cold house.

In 2015, 16.6 per cent of estimated 79,800 households in Herefordshire were in fuel poverty (13,300); a higher proportion than in the West Midlands region (13.5 per cent) and England (11 per cent). The majority of households affected by fuel poverty live in rural areas.

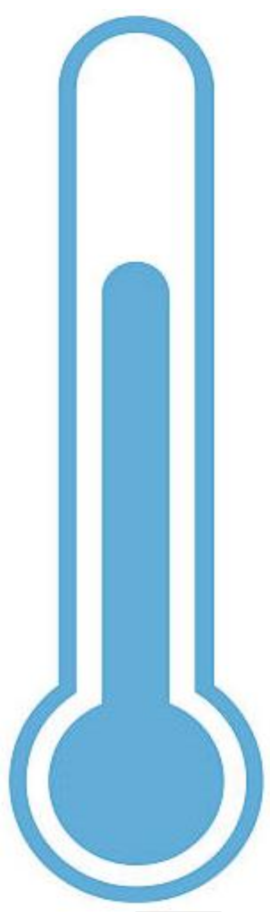
Older people are more susceptible to ill health (including the risk of death in the winter) as a result of residing in cold homes. An estimated 60 per cent of people aged 65 and over live in rural parts of Herefordshire, where access to mains gas may not be possible, and properties with poor thermal efficiency are more common, both of which increase the risk of fuel poverty. The detrimental effects of fuel poverty pose a considerable threat to the health and wellbeing of older people living in Herefordshire.

[8] Energy Advice Pack for Homes Off-Mains Gas: Practical advice on saving energy and reducing fuel costs for homes off the mains gas grid, National Energy Action Cymru. 2017. Available at: www.nea.org.uk/wp-content/uploads/2017/03/calor_off_gas_advice_booklet.pdf

[9] Cold comfort: The social and environmental determinants of excess winter deaths in England, 1986–1996, Wilkinson P, Landon M, Armstrong B, et al., Joseph Roundtree Foundation, 7 November 2001. Available at: www.jrf.org.uk/report/cold-comfort-social-and-environmental-determinants-excess-winter-deaths-england-1986-1996 .

[10] The UK Fuel Poverty Strategy: The causes and effects of fuel poverty, Department of Trade and Industry, 1998. Available at: http://webarchive.nationalarchives.gov.uk/+/http:/www.dti.gov.uk/energy/consumers/fuel_poverty/chp1.pdf

The impact of various room temperatures upon health



21°C

Comfortable temperature for all, including older people, in living rooms during the day.

18°C

Minimum recommended night-time temperature for those with no health risk, although older and sedentary people may feel cold.

Under 16°C

Resistance to respiratory diseases may be diminished.

9-12°C

Exposure to temperatures between 9°C and 12°C for more than two hours causes core body temperature to drop, blood pressure to rise and increased risk of cardiovascular disease.

5°C

Significant increase in the risk of hypothermia.

Source*:* Fuel Poverty and Health – A Guide for Primary Care Organisations, and Public Health and Primary Care Professionals, Press, V., National Heart Forum, 2003. Available at: www.fph.org.uk/uploads/toolkit_fuel_poverty.pdf

Recognising that fuel poverty is a particular challenge locally, Herefordshire's Health and Wellbeing Board have made it a priority area. In 2016, Herefordshire Council published the *Herefordshire Affordable Warmth Strategy 2016-19*. The strategy provides further insight into fuel poverty in Herefordshire, and details the actions being taken to tackle the issue.

FOCUS AREA: REFUGEES AND ASYLUM SEEKERS

Herefordshire is providing much-needed safe accommodation in the community for refugees under the Syrian Vulnerable Person's Resettlement Scheme (SVPRS). The SVPRS has worked well to date, with no significant issues or pressures. The first Syrian families were welcomed to Herefordshire in November 2016. Further families arrived in January and March 2017 with the final family arriving in June 2017. Currently 60 Syrian refugees have been resettled in Herefordshire under the scheme, comprising 14 households. Families coming to Herefordshire under the SVPRS have been housed in privately rented accommodation in Hereford city, or within 3 miles of the city centre, and are provided with an orientation and support service from Refugee Action for their first 12 months. For the earliest arrivals this is now coming to an end, but the families continue to receive some support with access to English language classes, managing housing and developing skills for employment through projects such as Building Better Opportunities. Herefordshire has agreed in principle to re-settle a further 35 individuals through the SVPRS and the Vulnerable Children Resettlement Scheme (VCRS). The reason for resettlement of those through the VCRS must be in relation to vulnerability of a child, although the child will be accompanied by a parent or guardian and may be resettled with other family members. Individuals resettled through the VCRS may be from any country in the Middle Eastern and North African (MENA) region. There is no financial risk to the council arising from further commitment to the SVPRS or VCRS as both schemes are funded by the Home Office.

Herefordshire Council has also agreed to the dispersal of up to forty asylum seekers to the county under the General Asylum Dispersal scheme. G4S have been contracted by the Government for the region to secure accommodation and provide transport for this group. No asylum seekers have yet been dispersed to Herefordshire under the scheme and concerns around the shortage of suitable, affordable accommodation and the lack of any registered providers of asylum advice in the county have been highlighted to G4S and Home Office. A small number of Unaccompanied Asylum Seeker Children (UASC) have arrived in the county either through the National Transfer Scheme (which was set up to help alleviate pressure on areas of the country where large clusters of asylum seekers occur), or through 'spontaneous drops' (where asylum seekers finish their journey, or are being deposited by traffickers spontaneously in any location). The council is working towards fulfilling its pledge to provide support for up to 25 young people classed as UASC. Children under the age of 16 are placed with foster carers and those aged 16 and over may be placed in foster care, shared accommodation or supported lodgings. The children cease to be categorised as UASC upon reaching age 18. UASC's are considered as Looked After Children and upon reaching their 18th birthday, as Care Leavers.

Refugees and asylum seekers are particularly vulnerable groups and face multiple challenges. While younger children can rapidly reach a good level of attainment in English, this becomes progressively harder with age. Lack of English can make it difficult for adults to find work and to access services. The three biggest challenges faced by refugees are usually finding employment, the cost of housing (which often exceeds the amount they can claim in housing benefit) and family reunification. Recruitment of foster carers and supported lodging providers for children and young people has been a success and one shared house with support has been established, but to date it has been challenging to work with colleges to meet the educational needs of the young people aged 16+ and to provide them with a range of educational opportunities. Some children placed in Herefordshire through the National Transfer Scheme have felt they 'stand out' and would prefer to be re-settled in more diverse localities. Refugees and asylum seekers are more likely to experience hate crime, have lower educational attainment due to language barriers, and need urgent dentist and optician appointments due to lack of basic healthcare where they have been living, or to suffer from ill health related to, for example, previous poor diet and living conditions, or psychological trauma.

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LONELINESS AND INVOLUNTARY SOCIAL ISOLATION

'Loneliness is a subjective, negative feeling experienced where there is a discrepancy between the amount and quality of social contacts one has, and the amount and quality one would like to have. It is related to, but distinct from, social isolation which is an objective state where there is an absence of social contacts and social connectedness'.[11]

Emerging evidence indicates that loneliness is associated with poor health and wellbeing outcomes including hypertension, coronary heart disease, stroke, depression and mortality.

Living alone has been found to be a risk factor associated with loneliness and involuntary social isolation, as well as multiple falls, functional impairment, poor diet, smoking, and three self-reported chronic conditions; arthritis and/or rheumatism, glaucoma, and cataracts. Loneliness is caused by a number of intrinsic and extrinsic factors. While loneliness can occur at any age, it can be exacerbated by major life events that typically correspond with ageing such as bereavement, loss of mobility and declining physical health.

The 2012 Herefordshire Quality of Life Survey found that, while most people (60 per cent) had contact with family, friends or neighbours most days of the week, for one in twenty the contact is once a month or less and a similar proportion (five per cent) felt lonely most or all the time (regardless of age or where they lived in the county). Those who live alone are most likely to experience this kind of isolation; according to the 2011 Census 28 per cent of county households comprise one person – half of whom are over 65. The highest proportions of lone pensioner households are found in Hereford and the market towns.

The English Longitudinal Study of Ageing (ELSA) found that the percentage of people who feel lonely 'some of the time' or 'often' increases among those aged 60 and over. 23 per cent of participants between 60 and 69 years of age said they sometimes felt lonely and six per cent said they often felt lonely. When those over 80 years of age were asked the same question 29 per cent of people reported feeling lonely some of the time and 17 per cent often felt lonely. [12]

Estimates produced by The Institute of Public Care suggest that in 2017 there were 16,600 older people living alone in Herefordshire, with a greater proportion (67 per cent) being female. It is predicted that the number of older people living alone in Herefordshire will increase by 47 per cent to an estimated 24,300 people by 2035.[13]

As well as elderly people living alone, informal carers are more likely to experience loneliness and social isolation than the general population.

[11] 'Hidden Citizens: how can we identify the most lonely older adults?', Campaign to end loneliness, April 2015. Available at: www.campaigntoendloneliness.org/hidden-citizens/
[12] See www.elsa-project.ac.uk/publicationDetails/id/6367
[13] Projecting Older People Population Information (POPPI) Available at: www.poppi.org.uk/index.php?pageNo=338&PHPSESSID=bom9f45gr9jg57kot94fsfism2&sc=1&loc=8306&np=1

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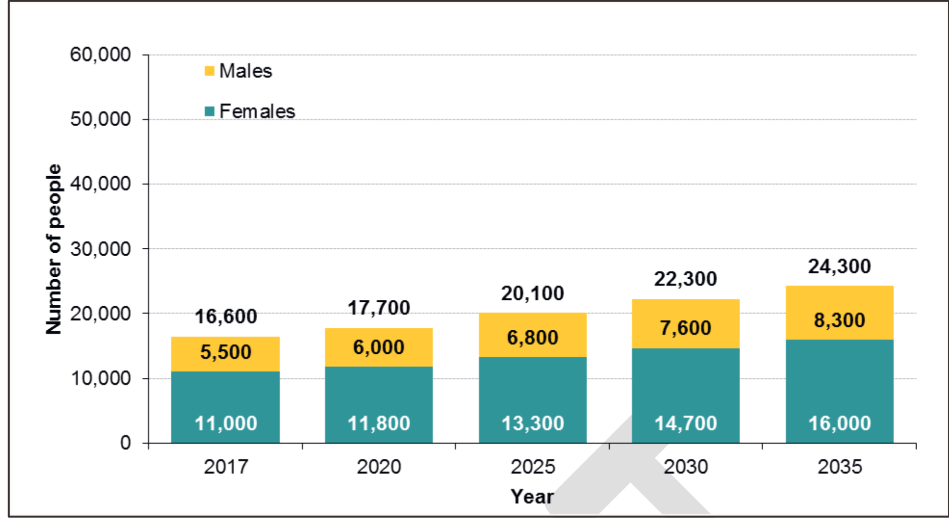
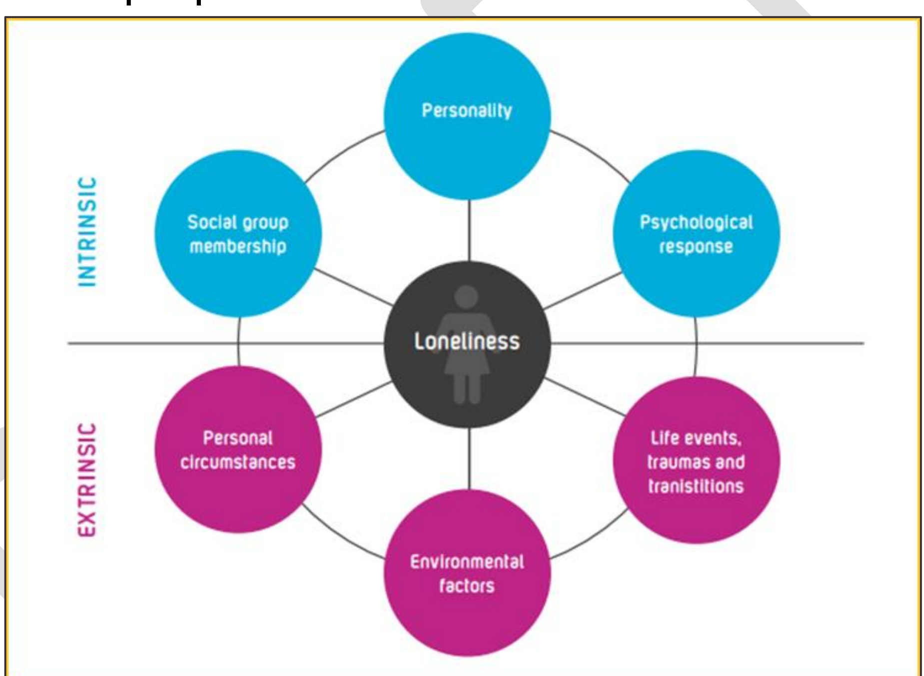
Number of people aged 65+ predicted to live alone in Herefordshire, 2017-2035



Source: The Institute of Public Care, 2017. Numbers may not total due to rounding.

Factors which can precipitate loneliness



Source: Campaign to End Loneliness, April 2015. www.campaigntoendloneliness.org/hidden-citizens/

Early intervention provides an opportunity to reduce health risks associated with loneliness, with some researchers suggesting that doing so may be cost effective, by improving longer-term health outcomes and reducing the number of healthcare interventions.

See Older People's Integrated Needs Assessment, 2018

FOCUS AREA: ARMED FORCES PERSONNEL AND VETERANS

In April 2017, 1,600 members of the regular UK Armed Forces were stationed (not necessarily living) in Herefordshire, the majority being Army personnel[14]. This number has remained fairly consistent since 2014, but is significantly larger than a decade ago. Including family members, in 2011, the Armed Forces Community *living* in Herefordshire comprised 2,650 people; 48 per cent of family members were children and 42 per cent were women aged 25+.

Schools can apply for additional Service Pupil Premium funding to ensure additional support is available for challenging times and the negative impacts of family mobility or parental deployment. Across Herefordshire, 78 schools were receiving the Service Pupil Premium for 905 pupils in 2017-18; 68 per cent were in primary schools and 32 per cent were in secondary schools.

The 2016 Annual Population Survey (APS) estimated there to be 13,600 veterans living in Herefordshire; one per cent of the UK veteran population (i.e. people who have ever served). National projections have predicted a decline in the veteran population with the ageing of those who served during the period of conscription and national service. The Royal British Legion estimate a 37 per cent decline between 2014 and 2030.

Issues facing the Armed Forces and Veteran Community include:

Health. In 2017, 981 people in Herefordshire were receiving pensions and compensation from the MoD for injuries as a result of serving in the Armed Forces. Although military service is stressful and dangerous the APS 2016 found no difference between the self-reported health of veterans and non-veterans (although this may be skewed by selection criteria that exclude people with some specific long-term health conditions from the sample). The use of improvised explosive devices in recent overseas engagements, coupled with advancements in medical care in the field, have resulted in an increased number of younger service personnel surviving with **multiple amputations** and co-morbidities.

The length of operational deployments correlates with **alcohol misuse.**[15] Various studies have found that excessive alcohol consumption is most common in military personnel who are younger, women, have been deployed, have undertaken a combat role, have problems at home during or after deployment and various other deployment specific conditions. Early leavers (those who served four or less years) are over four times more likely to be heavy drinkers than other veterans.

There is some uncertainty as to the impact of military service and particularly combat operations on **mental health**. However, a significant number of studies have identified an increased incidence of acquired mental health problems in serving personnel and veterans. Increased rates of mental health problems have also been identified in **Reservists** following deployment, although not necessarily related to number of deployments. **Early leavers** have

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[14] Quarterly Location Statistics Report, Ministry of Defence, October 2017.
[15] 'Patterns of drinking in the UK Armed Forces', Fear NT, Iversen A, Meltzer H, Workman L, Hull L, Greenberg N, Barker C, Browne T, Earnshaw M, Horn O, Jones M., *Addiction*, Vol.102, No.11, (November 2007), pp.1749-59.

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also been highlighted as vulnerable to an increased risk of poor mental health, social issues and heavy drinking.

The stigma around mental health conditions in the Armed Forces which continues in veterans can prevent people seeking help. Studies have found that the main barriers were 'not knowing where to seek help', 'not having adequate transport' and the stigma of 'my bosses would blame me for the problem'. Stigma is reportedly lower when service personnel can consult with someone who has knowledge and expertise of military matters.

Housing. Most service personnel are housed in subsidised living accommodation or service families' accommodation organised by the MoD. Around 300 Herefordshire properties (0.4 per cent of the total) are exempt from Council Tax as Armed Forces accommodation.

The 2016 APS found similar levels of home ownership amongst veterans as in the general population. However, research has highlighted some veterans are disadvantaged when applying for social housing. Veterans are considered to be in 'priority need' if they are vulnerable as a result of having been in the services, but the lack of priority given to single men in the priority rating system appears to be a factor.

The *Veteran's Transition Review*[16] found that Early Service Leavers are more vulnerable to homelessness than those with longer careers, especially those with pre-existing problems such as family/relationship breakdowns and low levels of educational attainment prior to joining. The route into homelessness tends to be similar in the veteran and general homeless population[17].

Education. According to the 2016 APS, veterans across Great Britain are significantly less likely to have a degree but more likely to have a GCSE or A-Level equivalent qualification than the non-veteran population[18]. This is to be expected based on a large proportion of UK Armed Forces personnel being recruited on leaving compulsory education.

Employment. There was no difference between the employment status of working-age veterans (78 per cent employed) and non-veterans (79 per cent) nationally in 2016. The biggest difference between industry of employment was in 'public administration and defence': 12 per cent of veterans work in this industry compared to six per cent of non-veterans. This is thought to relate to the wide range of emergency and security services jobs this industry encompasses, which veterans are likely to possess the required transferable skills to fulfil. Similar numbers work in manufacturing and transport and storage.

Crime. The majority of veterans successfully transition into civilian life and do not offend. In 2010, the Ministry of Justice estimated that 3.5 per cent of prisoners were veterans, the majority (77 per cent) of whom had previously served in the army. Veterans are more likely than the general population to commit violence against the person offences (veteran: 33 per cent, non-veterans: 29 per cent) and sexual offences (veterans: 25 per cent, non-veterans:

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[16] The Veteran's Transition Review, Lord Ashcroft, 2014. Available at: www.veteranstransition.co.uk/
[17] Homelessness within ex-Armed Forces Personnel, Riverside, 2011. Available at www.riverside.org.uk/care-and-support/veterans/veterans-supported-housing/
[18] Annual Population Survey, Office for National Statistics, 2016. Available at: www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/methodologies/annualpopulationsurveyapsqmi

11 per cent). A 2011 study[19] identified three contributory factors that consistently occur in relation to veterans offending: social isolation and exclusion; alcohol, in particular relating to violent offences; and financial problems – although these are not unique to veterans.

Health: The Defence Medical Services (DMS) provide specialist healthcare to service personnel and reservists (dependent on condition) in the UK. However, veterans' healthcare is primarily the responsibility of the local NHS. A range of nationally-funded NHS services are available for veterans such as Veteran's Mental Health Services and the Veteran's Trauma network (regional hub is in Birmingham) and they receive priority NHS access to secondary care for service-related conditions. Further support is available through charities such as the Royal British Legion's Veterans Hearing Fund who support veterans with acquired hearing loss that have a wellbeing need that cannot be met through statutory services.

Housing: In Herefordshire, there is now a range of short term accommodation units for ex-services personnel, and planning permission for a residential training centre for veterans to learn farm based and commercial skills has been obtained.

Offending: Remember Veterans is a two-year local project running from July 2017 which is designed to support offenders who are veterans, victims of crimes committed by veterans, frontline practitioners, professionals, or volunteers. The project aims to identify veterans within the criminal justice system and improve services and support for them including welfare, work, mental health issues and accommodation. For former members of the UK armed forces who have been discharged from the service because of criminal behaviour and convictions and are resettling in the West Midlands area, Unique Partnerships aims to provide a holistic level of support through case management and peer support focusing on common issues.

Extracted from draft *Armed Forces in Herefordshire* report, 2018. Contact the Intelligence Unit for more information.

[19] Report of the Inquiry into Former Armed Service Personnel in Prison, Nutting, J., The Howard League for Penal Reform, 2011. Available at: https://howardleague.org/wp-content/uploads/2016/05/Military-inquiry-final-report.pdf

DIGITAL INCLUSION

Digital exclusion (the inability to access online products or services or to use simple forms of digital technology (such as smart phones and tablets) can contribute to loneliness and social isolation as well as making it difficult to access information and services and secure employment.[20] In 2014, the government estimated that the number of people who have never been online is decreasing at three per cent a year, but the proportion of people who do not have basic digital capabilities has only been decreasing at about one per cent of the adult population per year.[21]

One fifth of adults in Herefordshire (20.6 per cent) have never used the internet, or used it over three months ago. Herefordshire has been rated 'High' for likelihood of overall digital exclusion[22]. More research is needed to identify digitally excluded households to support those who wish to learn digital skills, and to assess the impact of digital exclusion on access to services.

The Government's *Digital Inclusion Strategy* (2014) identified that:

- 37 per cent of those who are digitally excluded are social housing tenants.
- 17 per cent of people earning less than £20,000 never use the internet, as opposed to two per cent of people earning more than £40,000. 44 per cent of people without basic digital skills are on lower wages or are unemployed.
- 33 per cent of people with registered disabilities have never used the internet. This is 54 per cent of the total number of people who have never used the internet.
- Over 53 per cent of people who lack basic digital skills are aged over 65, and 69 per cent are over 55.
- Six per cent of people who lack digital skills are between 15 and 24 years. Only 27 per cent of young people who are offline are in full-time employment.[23]

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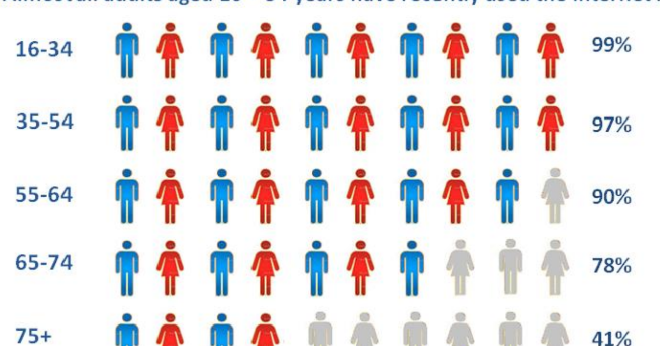
[20] The role of digital exclusion in social exclusion, Martin, C., Hope, S. and Zubairi, S., Ipsos MORI Scotland, 2016. Available at: www.carnegieuktrust.org.uk/wp/wp-content/uploads/sites/64/2016/09/the-role-of-digital-exclusion.pdf
[21] Government Digital Inclusion Strategy, Cabinet Office, 2014. Available at: www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy
[22] http://heatmap.thetechpartnership.com
[23] *Ibid.*

Almost 9 in 10 adults in the UK have recently used the internet (89%)

Almost all adults aged 16 – 54 years have recently used the internet …



… but just 4 in 10 adults aged 75+ years have used the internet in the last 3 months

Source: Office for National Statistics, Crown Copyright.

It is forecast that 90 per cent of all jobs will soon require some form of digital capability and the UK faces a major shortage of digital skills at all levels. Common causes of digital exclusion are:

- Skills and the confidence to use them.
- Access to infrastructure, fast broadband and local amenities.
- Cost including devices, broadband subscription or monthly fees for mobile data.
- Motivation and the personal aspiration that makes gaining digital skills relevant and important.[24]

Consideration: Commissioners and service providers should give consideration to the impact that moving services to online-only platforms will have on accessibility for older people, taking action to mitigate this impact wherever possible.

Action! The Fastershire project is looking to better understand whether its digital inclusion activities, which include grant funding opportunities and beginners' training workshops, can increase digital skills and whether this has an impact on broadband adoption.

[24] Digital exclusion. The Tech Partnership, Available at: www.thetechpartnership.com/basic-digital-skills/digital-exclusion/

ADULT SOCIAL CARE

In England, local authorities are responsible for co-funding care services for individuals who have social care needs and insufficient financial means to meet the cost themselves. The rising demand and increasing cost of providing adult social care at a time of prolonged fiscal austerity presents a major challenge for public services across the country. The key drivers of demand in Herefordshire are the ageing population structure and the associated increase in age-related disability.

In 2015-16, local authorities spent £16.8 billion (2017-18 prices) on adult social care, with ring fencing of budgets resulting in spending on adult social care increasing from 34 per cent to 39 per cent of total service spending between 2009-10 and 2015-16.[25] Nevertheless, between 2009-10 and 2016-17 spending fell by eight per cent in real terms. According to the Local Government Association (LGA), 'the consequences of underfunding include an ever more fragile provider market, growing unmet need, further strain on informal carers, less investment in prevention, continued pressure on an already overstretched care workforce, and a decreased ability of social care to help mitigate demand pressures on the NHS.'[26]

Herefordshire Council's approach is to focus services upon those in greatest need, recognise personal abilities, fully utilise community assets and networks and preventative strategies to enable people to live independently for as long as possible. Herefordshire's *Adults and Wellbeing plan 2017 to 2020* sets out a 'whole system outcomes' model which draws on the strengths of individuals and the wider community to provide holistic support for clients.

Whole System Outcomes Model

Determine outcomes
Self
Carer
Community
Formal care
Holistic support and care plan
I can…
I am good at…
I enjoy…
I used to enjoy…

- Strengths, hobbies, abilities, wishes,
- Support networks, their strengths, abilities, knowledge
- Needs, challenges, risks

- Maximise carer support
- Offer from carer to help people needing care to achieve their goals

- Community relationships that last long after social care involvement
- Community resources, skills and expertise

- Statutory and paid services looking at filling the gaps

Herefordshire Council

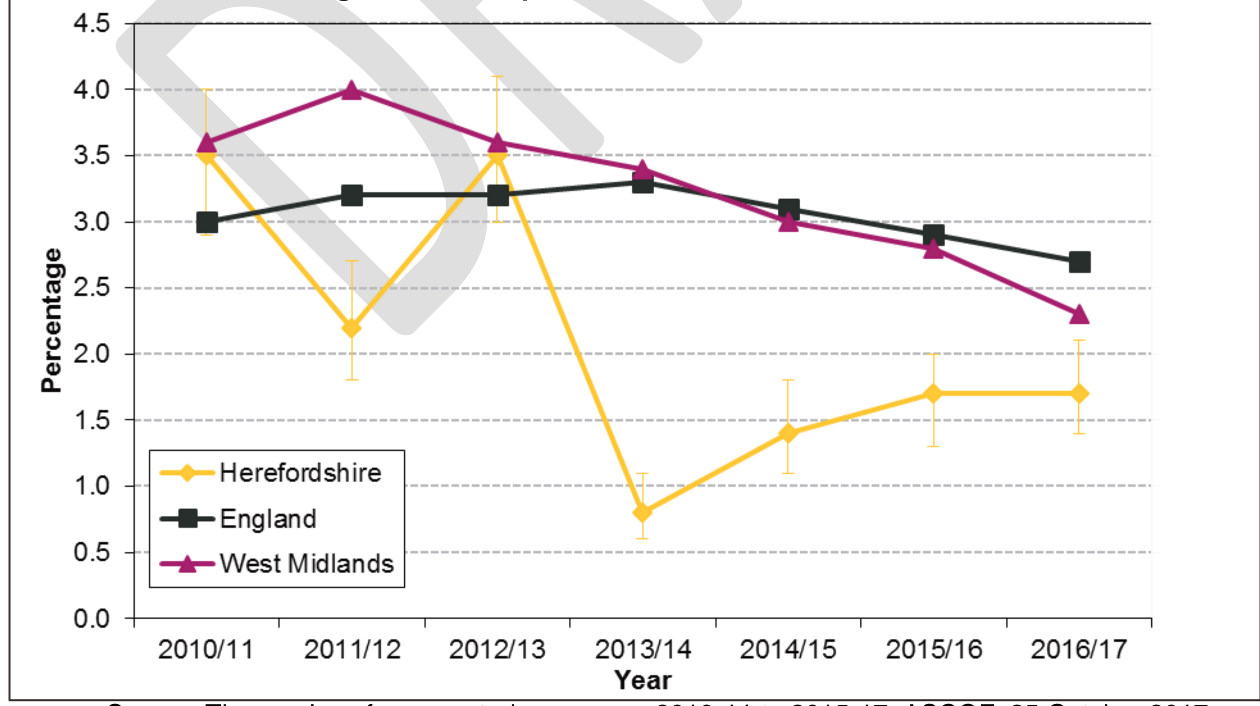
[25] Public spending on adult social care in England. IFS Briefing Note BN200, Simpson, P., Institute for Fiscal Studies, 2017. Available at: www.ifs.org.uk/uploads/publications/bns/BN200.pdf
[26] Adult social care funding state of the nation 2017, Local Government Association, 2017. Available at: www.local.gov.uk/sites/default/files/documents/1.69%20Adult%20social%20care%20funding-%202017%20state%20of%20the%20nation_07_WEB.pdf

In order to meet expected demand for social care in England an estimated 350,000 to 700,000 new workers will be needed between 2016 and 2030, representing growth of between 21 and 44 per cent. However, **staff recruitment and retention** in what has traditionally perceived as a low-wage, low-skill sector has been challenging. This was illustrated in a report by Skills for Care in 2017, which estimated that around a third of the workforce were new starters in caring jobs during the previous year (either completely new to, or moving within, the industry). There is also concern nationally about the potential impact of Britain leaving the European Union on staffing in the social care sector; seven per cent of the 1.3 million UK care workers are from other European countries, and there has been a fall in the number of EU nationals taking jobs in the sector since the referendum in 2017.

Herefordshire Council has launched the *Care Heroes* project to support the local adult social care sector in building a resilient workforce fit for the challenges that lie ahead.

Intermediate care services act to prevent unnecessary hospital admission, maximise independence following discharge from hospital and prevent premature hospital admissions. Locally, intermediate care services have been reasonably effective in assisting older people to return home following hospital discharge. However, between 2013/14 and 2016/17 a statistically significantly smaller proportion of older people have had access to intermediate care locally compared to nationally.

People aged 65 and over who were expected to return home and received re-ablement or rehabilitation following discharge from hospital as a proportion of all people aged 65 and over discharged from hospital, 2010/11-2016/17



Source: Time series of aggregated measures, 2010-11 to 2015-17, ASCOF: 25 October 2017.

Delayed transfers of care from hospital are detrimental to the health and wellbeing of older people, disrupt the flow of incoming patients, and are costly. Herefordshire's delayed transfers of care rates have been lower than those for the West Midlands region and England. Locally, the majority of delayed transfers of care are caused by patients awaiting a nursing home placement or availability (25 per cent), awaiting a care package in their home (24 per cent), and awaiting completion of an assessment (17 per cent).

Home First, a new intermediate care service, was launched in November 2017 with the long-term ambition of providing rehabilitation and re-ablement for all people with rehabilitation potential who require ongoing social care following a hospital admission. It is intended to help reduce delayed transfers of care, and prevent decisions about ongoing social care packages being made in hospital, at a crisis point, and before a person's longer term functional dependency levels are apparent.

Residential homes offer 24-hour care and support to ensure an individual's personal needs are met. Nursing homes are similar to residential homes but are able to provide more specialist care for medical conditions by trained nurses. There are (November 2017) 81 residential and nursing homes registered with the Care Quality Commission in Herefordshire with a total of 2,000 beds. Most (89 per cent) had ratings of 'good' or 'outstanding'. In January 2018, Herefordshire Council was funding around 470 people to live in residential homes and 300 in nursing homes. The number of nursing placements has remained fairly stable since 2015, whilst the number of residential placements has fallen slightly.

Domiciliary care comprises additional support to enable people to maintain their independence and quality of life at home. At any time, Herefordshire Council funds some element of domiciliary care for around 800 people. Three-quarters are aged 65+; almost 40 per cent are 85+. The majority (78 per cent) receive care packages of 15 hours or less per week.

Given Herefordshire's relative levels of wealth and ageing demographic, it is likely that there are a considerable number of people who are **self-funding** their personal care needs. There is only limited support available to self-funders to help them make appropriate care choices, but if they exhaust their own resources they are likely to need local authority funded care. Although the council provides advice regarding care choices to all who want it, not all choose to seek such advice and it is currently difficult to establish the size of this cohort, or what proportion of self-funders eventually go on to need local authority funded care. Increasing the availability of data in this area has been highlighted as a priority for Adults' Social Care commissioning.

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CARERS

People who provide informal care often do not recognise themselves as “a carer” and can therefore miss out on relevant information, support and advice.

Key facts:

- It is estimated that there are 21,300 informal carers living in Herefordshire.
- Women aged between 55 and 64 are the group most likely to provide informal care. However, from the age of 75 and over, a higher percentage of men provide care.
- It is estimated that just over 14 per cent of people aged 65 and over living in Herefordshire provide some degree of informal care, a figure similar to that observed nationally. The number of older carers is set to increase by more than a quarter (26.5 per cent) between 2017 and 2035, from 6,600 to 9,000 people.

Locally, GP surgeries are being encouraged to identify carers and document carer status on patient medical records in order to ensure that carers receive appropriate support from primary care services. However, evidence suggests that carers are still not being routinely identified and recorded as having caring responsibilities by their GP surgeries.

Carers are time poor, making it difficult for them to access services, find that their quality of life deteriorates, have less time to socialise and pursue activities that they enjoy. Loneliness and involuntary social isolation are more common among carers. In 2015, approximately 8 out of 10 carers nationally reported feeling lonely or being socially isolated. Over half (57 per cent) reported that they had lost touch with friends and family members, and 49 per cent had experienced additional stress in their relationship with their partner as a result of the demands of their caring role.

In Herefordshire, less than a quarter (23.2 per cent) of adult carers reported having as much social contact as they would like in 2016/17, significantly fewer than in the West Midlands region (36.9 per cent) and England (35.5 per cent).

An overarching measure of the quality of life of carers, based on outcomes identified through research by the Personal Social Services Research Unit, combines individual responses to six questions measuring different outcomes related to overall quality of life. In 2014/15, the carer-reported quality of life score in Herefordshire was 7.6; an increase from 7.4 in 2012/13 and similar to the West Midland Region (7.8), but lower than for England (7.9).

Carer self-reported quality of life in Herefordshire is trailing national and regional figures, but this issue is being addressed as part of Herefordshire Council and Herefordshire Clinical Commissioning Group’s *A Joint Carers Strategy for Herefordshire 2017 – 2021* , which sets out six priorities for better supporting carers in the county.

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LEARNING DISABILITIES

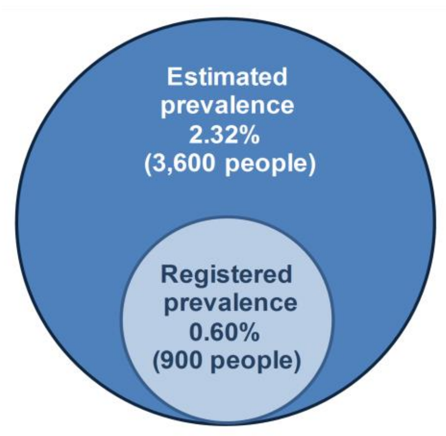
'Learning disabilities' (LD) is a poorly defined term. Its meaning differs depending on the context (such as in education or medical settings) and interpretations also vary between different professionals and lay people. Overall, it can be considered an umbrella term that covers a range of neurological disorders in learning with varying degrees of severity that lead to varying degrees of impairment in social, intellectual and practical skills. It is recognised that people with LD can also have specific health needs. Some people with LD live independently without much support, but others may require 24-hour care and help with performing most daily living tasks.

People with learning disabilities: key points

Just under 900 adults (aged 18+) were registered as having a learning disability at GP practices in Herefordshire in 2015/16. This represents a prevalence of 0.6 per cent of the adult population, which is significantly higher than in England and the West Midlands (both 0.5 per cent). The majority (59 per cent) are men, and are aged 25 to 54 (63 per cent).

The number has increased by 10 per cent since 2009/10 (around 80 people), notably less than nationally (20 per cent) and regionally (18 per cent). There is not expected to be any notable change in the total number of registered adults with an LD by 2035, but those who are will have a much older age profile than currently – and likely more complex needs related to their age.

Modelled estimates suggest that GP registers reflect less than a quarter of all adults with LD, and that the true number in Herefordshire is likely to be around 3,600 people (2.3 per cent of the adult population). This is predicted to increase by around 300 (eight per cent) by 2035 – although again, disproportionately in the number aged 65+.



Herefordshire Council currently provides long-term social care support to around 600 adults because of a learning disability – nine per cent more than in 2009/10.

They are mainly aged 18-64. There are 36 establishments across Herefordshire providing residential accommodation for adults with LD. Currently, around 150 people with LD are provided with day opportunities at seven locations across the county.

Although having a learning 'difficulty' does not always imply a learning 'disability', the likelihood is that for the majority of individuals this will be the case. In Herefordshire, in 2017, 25 per 1,000 pupils in state funded primary, secondary and special schools were known to have moderate learning difficulties; significantly lower than the proportion nationally (30 per 1,000) and regionally (45). As there is no evidence to indicate that actual prevalence is any lower in Herefordshire than elsewhere, this suggests that identification is not as effective. Conversely however, the proportion of children identified as having severe learning difficulties was significantly higher in Herefordshire than nationally or regionally. The proportion of children with learning disabilities known to schools (33 per 1,000) is similar to nationally (35 per 1,000), but significantly lower than regionally (50 per 1,000).

A needs assessment for adults with learning disabilities was undertaken as part of this year's JSNA. Both a full and summary report can be found on the [Facts and Figures about Herefordshire] website; key observations include:

- Improved recording of people learning disabilities would aid accurate assessment of future need for services, and the identification of those who are not currently known to the local authority would improve the targeting of low-level interventions which could help maintain an individual's continued independence. Improved sharing of relevant information between primary care and the local authority would enable this understanding.

- Some under-recording may be due to a missed childhood diagnosis, or an individual "dropping off the radar" when transitioning from children's to adults' services. This could be improved if throughout an individual's lifetime contact with health professionals any indicators of LD are recorded and acted upon appropriately collaboratively by all relevant practitioners and carers.

Although a higher proportion of adults with LD receive an annual health check in Herefordshire (63 per cent in 2016/17) than in comparator areas, the rate is lower than in 2014/15 (81 per cent) and is now below that reported nationally (67 per cent). There is also no information available about the results of health checks, or whether subsequent treatment plans have been put in place as per NICE guidelines.

Cancer screening rates for eligible individuals with LD in Herefordshire are broadly similar to national and regional levels, but are lower than for the general population. In 2015/16:

- 26 per cent of eligible patients with LD had been screened for cervical cancer, compared to 71 per cent of the county population as a whole
- 51 per cent were screened for breast cancer, compared to 70 per cent
- 84 per cent were screened for colorectal cancer, compared to 86 per cent.

This is an important factor which can lead to late and missed diagnosis as indicated by the local prevalence of cancer amongst individuals with LD, which is approximately one third of that in the population as a whole. As a result outcomes are likely to be poorer and premature mortality from cancer more likely. Currently, the availability of health data relating to adults with LD in Herefordshire is poor. Improved sharing of data concerning all aspects of health care (health check, screening, diagnosis, stage of presentation, outcomes, etc.) would facilitate the assessment of the health of the individual and of the LD community as a whole across the county.

According to CQC reports on care homes and home care providers, Herefordshire is providing some of the best care for adults with LD in the West Midlands. At the same time, expenditure locally is lower than elsewhere – highlighting the good value for money obtained for services supporting adults with LD in the county.

- Currently there is no available data monitoring what is happening to young people with LD when they leave full-time education. Collection of such information could be used to monitor the progress of such individuals which would facilitate the identification of any support requirements and could also be used to monitor the success of current support initiatives.

- Although services provided for adults with LD are generally performing well, as evidenced by the West Midlands Quality Review Service (WMQRS) and Adult Social Care Outcomes Framework (ASCOF) improvements can still be made. It would appear appropriate that all relevant services work closely with adults with LD and their carers/support workers to understand their particular needs and experiences within the health and social care system. This should include:
    - consultation with individuals who currently access services to identify areas that require improvement;
    - as life expectancy increases there should be special emphasis on working with older adults with LD in order to determine requirements of this group and inform the design of service to that which will best meet these needs.

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FOCUS AREA: AUTISTIC SPECTRUM DISORDER (ASD)

ASD is a lifelong, developmental disability, involving a spectrum of different needs. It affects how a person communicates with and relates to other people, and how they experience the world around them.[27] It is estimated that more than half a million people in England have autism. This is equivalent to more than one per cent of the population and similar to the number of people that have dementia.[28] Presently, four times as many boys as girls are diagnosed with autism.[29] Data from Herefordshire GP practices indicate that in March 2017 there were 718 patients recorded as having ASD (0.4 per cent of all patients).

ASD is neither a learning disability nor a mental health problem, although mental health problems can be more common among people with autism and it is estimated that one in three adults with a learning disability also have autism.[28] While people with autistic spectrum disorders (ASD) may also receive support through learning disability services their needs may be different to the requirements of those with learning disabilities.

The government's autism strategy *Fulfilling and Rewarding Lives* (2010, updated in 2014) charged public services in England with ensuring people with ASD are able to lead fulfilling and rewarding lives and are treated fairly and equally. This includes providing a range of support that meets individuals' needs and making reasonable adjustments to ensure people with autism are not disadvantaged with regard to access to services, jobs, healthcare, etc.

Children with ASD are more likely to experience bullying, be excluded from school and have lower levels of educational attainment compared to their peers. Fewer than one in four school leavers with autism stay in further or higher education. School children with ASDs can find changes to routine very unsettling. Pupils need to be informed and prepared in advance of any changes. Some get special support in mainstream school, and some attend specialist schools. Only certain levels of ASD are given Statements of Special Needs.[30]

In Herefordshire, the rate of children known to have an ASD attending state funded school primary, secondary and special schools is 8.1 per thousand, significantly lower than the rate in both England (12.5 per thousand) and the West Midlands region (12.8 per thousand). This suggests diagnosis is not as good as elsewhere (rather than Herefordshire having a lower proportion of autistic children in school). Not all of those identified in this category in the statistics will have been formally assessed.

Herefordshire Council is developing a *Joint Autism Strategy for Herefordshire* in partnership with Herefordshire Clinical Commissioning Group, 2Gether Foundation Trust and Wye Valley NHS Trust. It describes the vision, aims and outcomes for people with ASD who live in the county. It also seeks to shape the local approach in implementing the requirements of the National Autism Strategy *Fulfilling and Rewarding Lives* (2010).

See Adults with Learning Disabilities in Herefordshire Needs Assessment, 2018

[27] What is autism?, The National Autistic Society, Available at: www.autism.org.uk/about/what-is.aspx
[28] Think Autism: Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an update, Department of Health, 2014. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/299866/Autism_Strategy.pdf
[29] Stats and facts, Ambitious about Autism, Available at: www.ambitiousaboutautism.org.uk/stats-and-facts
[30] Learning disability profile (Public Health England), Herefordshire Council Intelligence Unit

CRIME AND COMMUNITY SAFETY

Herefordshire is generally a low crime rate area and crime per 1,000 population continues to be at or below the average for West Mercia as can be seen below. The most common crime

SECTION AWAITING APPROVAL FROM WEST MERCIA POLICE

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DEVELOPING WELL

STARTING WELL: MOTHERS, BABIES AND CHILDREN

The Marmot Review identified that 'giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood.'[31]

Teenage pregnancy is defined as under-18 conceptions including those leading to live births and terminations. Fewer teenagers are getting pregnant or having babies in Herefordshire. In 2015, there were 45 under-18 conceptions, representing a rate of 14.3 per thousand, lower than for the West Midlands region (23.7) and England (20.8). In particular, the rate amongst the youngest girls almost halved between 2008-10 and 2012-14, from 6.5 to 3.7 per thousand girls; following the declining trend both nationally and regionally from 2009 to 2014.

In 2016, 1.5 per cent of all live births at term in Herefordshire had a **low birth weight**; a significantly lower proportion than nationally (2.8 per cent) and regionally (3.2 per cent).

Caesarean sections are often required for a number of maternal and infant reasons. By their very nature (i.e. they are used when there are complications) they are likely to be associated with an increased risk of problems. In 2015/16, 29.6 per cent of deliveries in Herefordshire were by caesarean section, a significantly higher proportion than nationally (26.3 per cent) and regionally (27.1 per cent).

The **breastfeeding** rate in Herefordshire has shown a continual increase since 2010/11 and compares very well with the national rate. In 2015/16 the proportion of mothers in Herefordshire who breastfed their babies for at least six to eight weeks after birth was 52.3 per cent, a figure significantly higher than that reported for England (43.2 per cent). The health and wellbeing benefits of exclusively breastfeeding infants from birth up to the age of six months are well known, and mothers who are unable to breastfeed for health or other reason are encouraged to provide a good milk supplement for their infants.

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[31] *Fair society, healthy lives: Strategic review of health inequalities in England post-2010* (The Marmot Review), Marmot MG, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Geddes I., 2010, p.22. Available at: www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

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High levels of hospital admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. In Herefordshire in 2015/16 the crude rate of **hospital admissions of babies under 14 days** was 113.7 per 1,000; much higher than nationally (66.3 per 1,000) and regionally (63.7 per 1,000). In 2015/16, the crude rate of **hospital admissions for gastroenteritis in infants aged 2, 3 and 4 years** was also significantly higher in Herefordshire (93.2 per 10,000) than nationally (53.7 per 10,000) and regionally (66.6 per 10,000).

Immunisation protects children and young people from diseases and infections that can be prevented by vaccines, and Herefordshire is now mostly doing well in terms of local uptake:

- In 2015/16 local **Dtap/IPV/Hib7 immunisation** rates exceeded the 'herd immunity' uptake target of 95 per cent and were higher than national and regional figures.
- Similarly, the local uptake for **Haemophilus Influenza type B/Meningitis (Hib/MenC)** and **Mumps, Measles and Rubella (MMR)** first and second doses have increased since 2010/11 and in 2015/16 all exceeded the target of 95 per cent for the first time and were higher than both the national and regional figures.

The **Human Papilloma Vaccine (HPV)** vaccine is offered to girls aged between 12 and 18 to protect against cervical cancer. In September 2014, the routine programme was changed from a three to two-dose schedule. Between 2014/15 and 2015/16 the coverage of the initial dose of the HPV vaccine in Herefordshire increased from 81.4 to 83.6 to per cent, while for England the coverage decreased over this time, although the national figure in both years was higher than that for Herefordshire. In 2015/16 the coverage for two doses in Herefordshire was 81.4 per cent which was lower than the national rate of 85.1 and the West Midlands region rate of 86.0. There has not been an HPV vaccination programme in Herefordshire for the past two years.

ORAL HEALTH

Tooth decay is predominantly preventable and is often linked to high levels of consumption of sugar-containing food and drink, which also contribute to obesity. The British Medical Association (BMA) has stated that 'tooth decay [is] continuing to represent a significant public health threat in socially deprived areas'.[32] The oral health of children in Herefordshire is of ongoing concern, with the county performing poorly compared to England and the West Midlands region across a range of indicators. Herefordshire is not currently part of a fluoridation scheme, but a recent report by Public Health England, *Water Fluoridation*, concluded that 'five-year-olds in areas with water fluoridation schemes were much less likely to experience tooth decay, and less likely to experience more severe decay than in areas without schemes' and 'children from both affluent and deprived areas benefitted from fluoridation, but children from relatively deprived areas benefitted the most.'[33] However, fluoridation is a divisive issue and continues to attract vocal opposition from some groups.

In 2014/15, the proportion of Herefordshire five-year-olds free from dental decay (59.0 per cent) was significantly lower than the figures for both England (75.2 per cent) and the West Midlands region (76.6 per cent). The proportion is no better than in 2007/08 (61.3 per cent), and it is significantly worse than all comparator areas.

The average (mean) number of decayed, missing or filled teeth in five-year-olds in Herefordshire was 1.43, much higher than in the West Midlands region (0.72) and in England as a whole (0.84). Herefordshire is also the worst performing authority of its comparator group for this indicator and is performing poorly compared to other areas where the water supply is not fluoridated.[34]

In 2015, the National Dental Epidemiology Programme survey of five-year-olds found that the proportion of children with dental decay was slightly higher in Leominster wards than Hereford, although the level of decay (i.e. the number of decayed, missing or filled teeth) was higher in Hereford.

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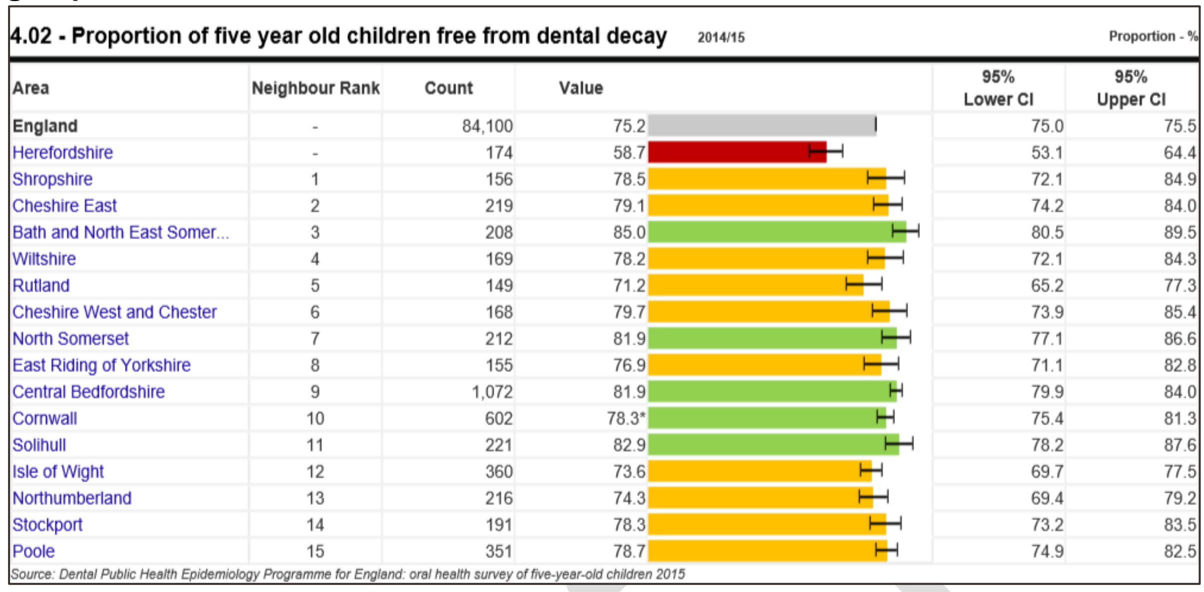
[32] Fluoridation of water: A briefing from the BMA Board of Science – February 2009, British Medical Association, 2009. Available at: www.bma.org.uk/-/media/files/pdfs/news views analysis/bma_fluoride.pdf

[33] Water fluoridation: health monitoring report for England 2018. Public Health England, 2018. Available at: https://www.gov.uk/government/publications/water-fluoridation-health-monitoring-report-for-england-2018

[34] Using the UK fluoride map – Typical fluoride levels in zones during 2012, Ordnance Survey, 2012. Available at: http://www.dwi.gov.uk/consumers/advice-leaflets/fluoridemap.pdf

Proportion of five year olds free from dental decay – Herefordshire and comparator group



4.02 - Proportion of five year old children free from dental decay 2014/15 Proportion - %

Area	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	-	84,100	75.2	75.0	75.5
Herefordshire	-	174	58.7	53.1	64.4
Shropshire	1	156	78.5	72.1	84.9
Cheshire East	2	219	79.1	74.2	84.0
Bath and North East Somer...	3	208	85.0	80.5	89.5
Wiltshire	4	169	78.2	72.1	84.3
Rutland	5	149	71.2	65.2	77.3
Cheshire West and Chester	6	168	79.7	73.9	85.4
North Somerset	7	212	81.9	77.1	86.6
East Riding of Yorkshire	8	155	76.9	71.1	82.8
Central Bedfordshire	9	1,072	81.9	79.9	84.0
Cornwall	10	602	78.3*	75.4	81.3
Solihull	11	221	82.9	78.2	87.6
Isle of Wight	12	360	73.6	69.7	77.5
Northumberland	13	216	74.3	69.4	79.2
Stockport	14	191	78.3	73.2	83.5
Poole	15	351	78.7	74.9	82.5

Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

Source: Oral Health Profile, Public Health England: https://fingertips.phe.org.uk/profile/oral-health

Oral health indicators – Herefordshire compared to England and the West Midlands region

Compared with benchmark: Better, Similar, Worse; Lower, Similar, Higher, Not Compared; Low – High

Benchmark Value; Worst/Lowest, 25th Percentile, 75th Percentile, Best/Highest

Indicator	Period	Herefs Count	Herefs Value	Region Value	England Value	England Worst/Lowest	England Range	England Best/Highest
Children with one or more decayed, missing or filled teeth	2014/15	-	41.3%	23.4%	24.8%	56.1%		14.1%
4.02 - Proportion of five year old children free from dental decay	2014/15	174	58.7%	76.6%	75.2%	43.9%		85.9%
Incisor caries prevalence in three year olds	2012/13	11	5.6%	3.0%	3.9%	16.1%		0.0%
Proportion of three year olds free from dental decay	2012/13	137	78.3%	90.0%	88.4%	0.0%		98.7%
dmft in three year olds	2012/13	-	0.71	0.28	0.36	1.17		0.00
Percentage of the population who are five years old	2016	2,165	1.14	1.29	1.27	0.91		1.88
dmft (decayed, missing or filled teeth) in five year olds	2014/15	-	1.43	0.72	0.84	2.46		0.37
Proportion of twelve year olds free from dental decay	2008/09	149	55.9%	67.9%	66.4%	43.4%		87.7%
DMFT in twelve year olds	2008/09	-	1.05	0.69	0.74	1.49		0.22
Percentage of the population who are twelve years old	2016	2,023	1.07	1.16	1.11	0.67		1.39
Elective admissions (rate per 1000 population) aged under 5 years	2015/16	872	88.4	52.3	54.0	96.7		28.6
Elective admissions (rate per 1000 population) aged 5 to 9 years	2015/16	796	78.8	44.2	48.0	95.2		19.6
Elective admissions (rate per 1000 population) age 10-14 years	2015/16	989	102.4	44.2	42.3	102.4		24.5
Elective admissions (rate per 1000 population) age 1-4 years	2015/16	559	69.2	50.5	53.1	102.7		29.5
Access to NHS dental services - successfully obtained a dental appointment	2015/16	799	96.5%	-	94.7%	83.3%		98.8%
Hospital admissions for dental caries (0-4 years)	2013/14 - 15/16	6	20.2	*	241.4	9.2		1,143.2

Source: Oral Health Profile, Public Health England: https://fingertips.phe.org.uk/profile/oral-health

LEARNING WELL: CHILDREN IN EDUCATION

Educational attainment in Herefordshire schools

Key facts:

- The **total number of pupils on roll** in state funded Herefordshire schools has risen by almost 450 from 22,750 in spring 2013 to 23,200 in spring 2017, representing a 1.9 per cent increase in total numbers over the four years.
- In 2017, the highest numbers of pupils were in Year R (Reception), Year 1 and Year 2, with fewest pupils in national curriculum Years 6, 11, and 10.
- In spring 2017, the school census recorded 51.5 per cent of the pupil population were boys. The gender gap has been closing in terms of pupil numbers since spring 2015.
- Between spring 2016 and spring 2017 the total number of pupils with **statements of special educational need (SEN) or education and health care plans (EHCP)** increased from 591 to 660 (267 Statements - 0.4 per cent of pupils and 393 EHCP - 2.6 per cent of pupils).
- Most Reception children in Herefordshire were able to attend the **school of their choice** at the start of the 2017/18 academic year. 93.6 per cent of children received their first preference of primary school with 97.5 per cent receiving one of their three expressed preference schools. By comparison, across England only 90 per cent of children received their first preference primary school with 97.2 per cent one of their top three preferences. In the secondary phase 95.9 per cent of children were offered their first choice of Herefordshire school and 98.4 per cent one of their first three preferences. This is considerably higher than the England figure of 83.5 per cent (first preference) and 94.6 per cent (one of top three preferences).
- The number of **pupils recorded as white British** fell by around 200 between spring 2013 and spring 2017, from 91.0 per cent to 88.2 per cent of the school population. The number and percentage of pupils recorded as belonging to **black and minority ethnic groups** (BME) has increased annually, from 1,950 (8.5 per cent) in 2013 to 2,650 (11.4 per cent) in 2017. Those of white Eastern European ethnic origin are the largest single BME group.

In 2017, Herefordshire was in the top quartile of local authorities in England for children achieving a **good level of development (GLD)** at the end of the Reception year and Herefordshire youngsters also out-performed pupils nationally in the **Year 1 phonics screening check,** an area where until 2016 Herefordshire had been consistently below the national average.

At the end of **Key Stage 1** the percentage of pupils reaching the **expected standard** in reading, writing and mathematics was higher in each case than across state-funded schools in England as a whole. However, at **Key Stage 2** the proportion of pupils who reached the **expected standard** in reading, writing and maths was slightly lower than across both all schools in England and state-funded schools in England.

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At the end of **Key Stage 4 (Year 11)**[35] the average **Attainment 8 score** was slightly below that recorded across state-funded schools in England. The average **Progress 8** score in Herefordshire schools was higher than in English state-funded schools as a whole.

In **English and Mathematics,** Herefordshire pupils out-performed pupils nationally and regionally in achieving grade 4 or better and achieving at least a grade 5. The proportion of Herefordshire pupils who entered **English Baccalaureate (Ebacc)**, and who then passed, or achieved a strong pass, was higher in each case than regionally and nationally.

	Herefordshire %	England %	West Midlands %
Good Level of Development at end of Reception	75	70.7	
Year 1 phonics screening check	84	81	
Key stage 1 expected standard - reading	78	76	
Key stage 1 expected standard - writing	72	68	
Key stage 1 expected standard - mathematics	77	75	
Key stage 2 expected standard	60	62	59
Key stage 2 higher standard	8	9	
Key stage 4 - attainment 8	45.7	46.4	45.4
Key stage 4 - progress 8 score	0.01	-0.03	-0.08
Key stage 4 - grade 4 in English and mathematics	65.1	64.2	61.2
Key stage 4 - grade 5 in English and mathematics	44.4	42.9	39.8
English Baccalaureate (Ebacc) - entered	42.8	38.4	36.3
English Baccalaureate (Ebacc) - pass**	24.4	23.9	21.7
English Baccalaureate (Ebacc) - strong pass***	21.8	21.4	19.7

*state-funded sector
** including 9-4 in English and mathematics
*** including 9-5 in English and mathematics

Source: Herefordshire Council.

Inequalities in education

Free School Meals (FSM)

FSMs are claimed for children by parents who receive a qualifying state benefit. In the Spring school census in 2017 there were 319 fewer pupils eligible and claiming FSMs than recorded in the Spring census in 2014; in 2014 there were 2,254 (9.8 per cent of pupils) and in 2017 1,935 (8.3 per cent of pupils).

At key stage 2 (KS2) 47 per cent of Herefordshire FSM pupils achieved the expected standard in reading, writing and maths. Under the *Diminishing the difference*

[35] A new secondary school education accountability system was implemented in 2016, which saw changes to the headline accountability measures. These now include Attainment 8 and Progress 8 as well as performance in English and mathematics and the English Baccalaureate (EBacc). In 2017 there were further reforms to English and mathematics grading. Grades A*-C were replaced by numerical grades 9-1, with 4 being a classed as a standard pass and 5 being classed as a strong pass. Further subjects will convert to numerical grading in 2018.

agenda, performance or FSM pupils is benchmarked against the national performance of pupils not eligible for FSMs, which in 2017 was 65 per cent.

At key stage 4 (KS4), the average Attainment 8 score of FSM pupils across Herefordshire was 31.7. Nationally the Attainment 8 score for non FSM pupils was 48.2.

Disadvantaged Children

The DfE defines a disadvantaged pupil as those eligible for FSMs at any time during the last 6 years, or those children who are looked after by the local authority for at least one day, or who have left care through adoption, residence order, special guardianship order, or child arrangement order.

At KS2 47 per cent of Herefordshire disadvantaged pupils achieved the expected standard in reading, writing and maths. Nationally, 68 per cent of pupils who were not classed as disadvantaged achieved the expected standard.

At KS4 the average Attainment 8 score for disadvantaged pupils was 34.3. The average Attainment 8 score across England for non-disadvantaged pupils was 49.9.

English as an Additional Language (EAL)

The largest language groups other than English in the spring 2017 school census were Polish (774 pupils), Lithuanian (148 pupils), Romanian (101 pupils) and Portuguese (75 pupils). In spring 2013, a total of 58 first languages other than English were recorded in the school census. By spring 2017, 67 first languages other than English were recorded in Herefordshire schools.

The performance of pupils whose first language is other than English will be affected by the length of time that they have resided and been educated in England. Those with several years of state education are likely to perform better than newly arrived pupils with fewer English speaking skills.

At KS2, 59 per cent of Herefordshire EAL pupils achieved the expected standard in reading, writing and maths. EAL performance is benchmarked against the performance of all pupils nationally, which in 2017 was 62 per cent.

At KS4, the average attainment 8 score of EAL pupils was 42.7. The average Attainment 8 score for all pupils across England was 46.4.

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FURTHER AND HIGHER EDUCATION AND TRAINING

Under the *Raising of the Participation Age* agenda between 2013 and 2015 the government increased the age that all young people will continue in education or training from 17 years to 18.

Young people not in education and training

Since April 2017, the Not in Education, Employment, or Training (NEET) and 'not known' figures have been reported individually and as a combined figure by the Department for Education (DfE).

According to annual figures published by the (DfE) the percentage of 16 and 17 year olds reported as NEET and 'not known' (combined) for 2016 in Herefordshire was 6.5 per cent with NEET at 3.3 per cent and not known 3.2 per cent, Nationally, comparative figures were 6.0 per cent combined (NEET 2.8 per cent and not known 3.2 per cent). Across the West Midlands region the figure was 7.3 per cent (2.7 per cent and 4.6 per cent).

Higher education

In 2016/17 4,665 students from Herefordshire enrolled for United Kingdom university courses. Of these, 3,820 were for first degrees or other undergraduate level study and 845 for postgraduate study (taught and research).[36] Not all of these people leave the county to study (the 2011 census recorded around 3,000 living away from a Herefordshire home), but a proportion do leave and do not return on completion of their studies.

Herefordshire is one of only three English counties currently without a university. It is recognised that high quality higher education facilities are an absolutely foundational part of economic development and social and cultural regeneration, exemplified by cities such as Lincoln, Canterbury and Winchester. The planned New Model in Technology & Engineering (NMiTE) university for Hereford is intended to address the shortfall of 40,000 engineering graduates in the UK economy, and encourage more women to work in the industry. The new university will be an independent, not-for-profit, world class engineering university with dedicated student accommodation across the city. With a particular focus on advanced manufacturing, agriculture-engineering, data, defence, resources security and sustainable / smart living technology sectors it will accept its first 300 students at a purpose-built city centre campus in Hereford in September 2020. It will have 5,000 students by 2032. The university will make Herefordshire a more attractive place for young people to live and study, and will have a projected economic impact up to £120m per annum on the local and national economy.

[36] 'Where do students come from? HESA. Available at: www.hesa.ac.uk/data-and-analysis/students/where-from

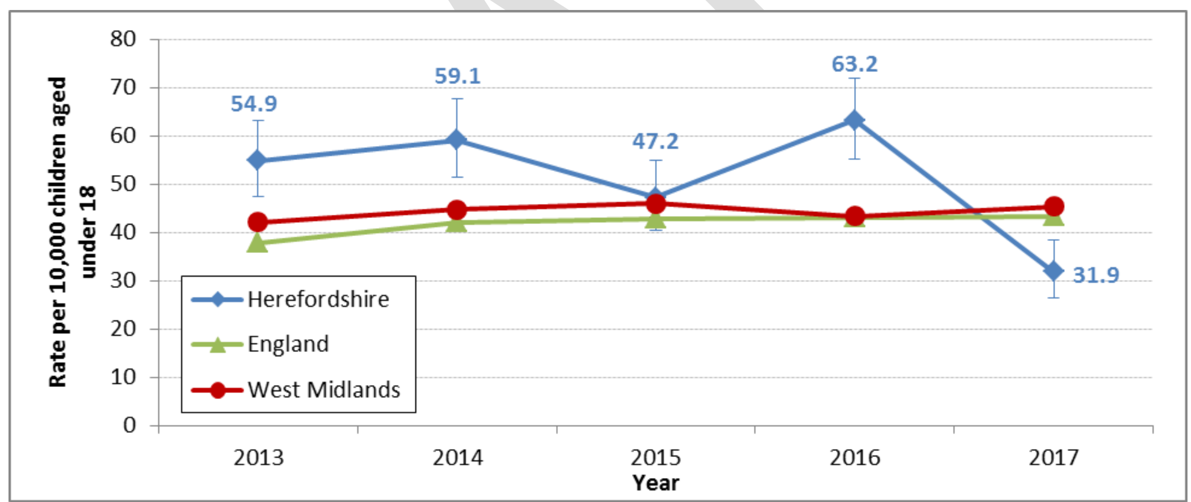
CHILDREN IN NEED

Child Protection Plans

At the end of March 2017 Herefordshire was supporting 115 children subject to a child protection plan. The local rate of children with a child protection plan in place was 31.9 per 10,000 children, statistically significantly lower than the rates for the West Midlands region and England (45.3 and 43.3 per 10,000 children respectively).

This reflected a statistically significant decrease in the local rate of children with protection plans (from 63.2 per 10,000 children the year before, with 113 (49.3 per cent) fewer children being subject to a child protection plan between the two time points. Local performance analysis indicates that a risk adverse response was likely to be contributing to the previously high rates of children subject to a child protection plan. In response, during 2016, a more rigorous approach was taken to applying the thresholds for implementing child protection plans, which contributed to the fall by 2017.

Rate of children with a child protection plan in place in Herefordshire, the West Midlands region and England as of the 31st of March, 2013-2017



Sources: Characteristics of children in need 2012 to 2013 through to 2016 to 2017, DfE, 2/11/17[37].

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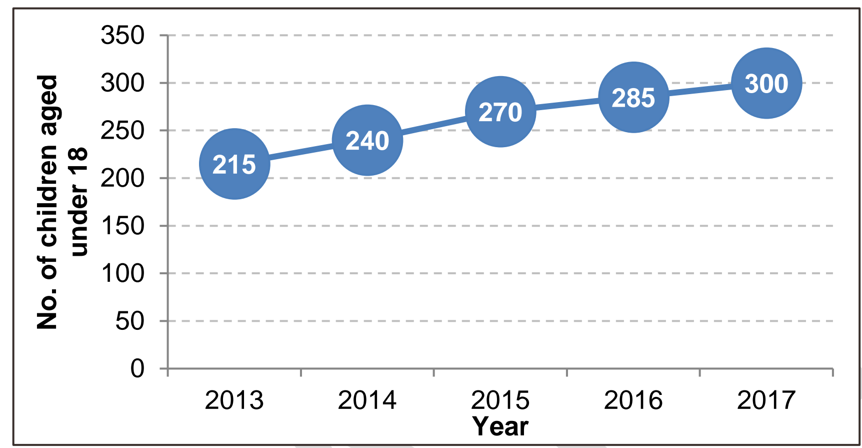
Looked After Children (LAC)

At the end of March 2017 there were 300 looked after children (LAC) in Herefordshire. This is an increase from the previous year, and contributes to a five year upward trend in the number of LAC. In 2017 Herefordshire's rate of LAC was 84 per 10,000 children aged under 18; statistically significantly higher than the average rate for the five most similar local authorities, and the England rate. Local performance analysis indicates that the reason for a high LAC population is partly due to a 'risk averse' response, with action being taken to ensure that need thresholds are applied appropriately. It is worth highlighting that fewer

[37] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656395/SFR61-2017_Main_text.pdf

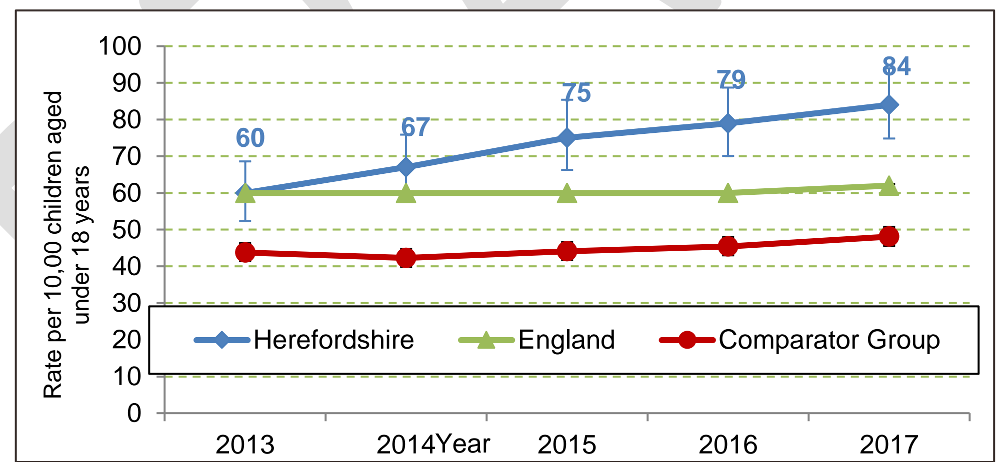
children started to be looked after in 2016/17 than in the previous five years; with the increased number and rate of LAC being explained by fewer children ceasing to be looked after. This finding is not surprising, as once a child comes under local authority care; it is often difficult to reunite them with their families. Therefore, it is expected that the local rate of LAC will gradually decrease over time; with the legacy of high LAC numbers taking some years to reduce as those currently under local authority care grow up.

Number of looked after children in Herefordshire as of 31st March, 2013-2017



Source: Children looked after in England including adoption: 2016 to 2017, DfE, September 2017[38]

Rate of looked after children in Herefordshire, England and a Comparator Group comprised of the five most similar local authorities as of the 31st of March, 2013-2017



Sources: Office for National Statistics Mid-Year Population Estimates and Children looked after in England including adoption: 2016 to 2017, Department for Education, 2017.

More An integrated children's needs assessment will be undertaken during 2018. It will focus on specific topic areas to provide an evidence base on which effective commissioning decisions can be made. These topics will include 'early help'; drivers of trends in child protection plans and looked after children; obesity and dental health.

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[38] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656395/SFR61-2017_Main_text.pdf

LIVING WELL – HEALTHY LIFESTYLES

ALCOHOL

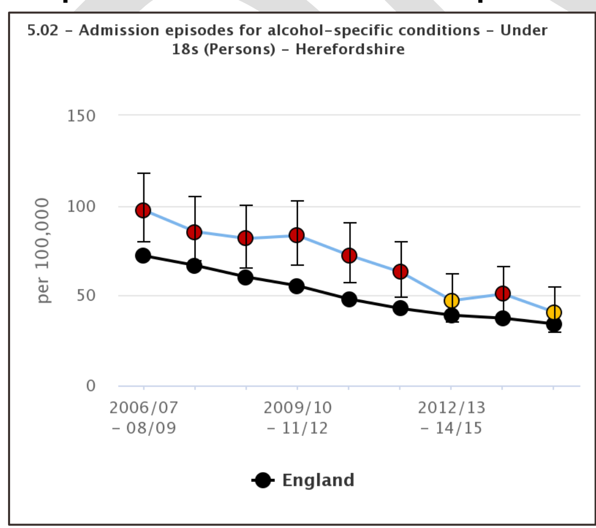
Alcohol consumption has doubled in the UK since the 1950s and is a contributing factor in hospital admissions and deaths from a wide range of conditions. The misuse of alcoholic beverages is also linked to a proportion of violent crimes, particularly related to the night time economy, and it is also implicated in the escalation of domestic abuse.

The latest set of Local Alcohol Profiles for England (LAPE) estimate that 25.9 per cent of Herefordshire adults drink over 14 units of alcohol a week and 21 per cent of all adults binge drink (2011-14 estimates).[39] In the same period, 14.4 per cent of Herefordshire adults reported they abstain from drinking alcohol.

In 2016/17, there were 618 hospital admissions for alcohol-specific conditions (those caused exclusively by the consumption of alcohol) in Herefordshire, which equates to a rate of 319 per 100,000 population; significantly lower than the rate for both the West Midlands region (543 per 100,000) and England (563 per 100,000). The local admission rate for adults has remained relatively consistent between 2008/09 and 2016/17.

The admission rate for those aged under 18 has shown a decrease since 2006/07 and although the rate has remained above both the national and regional rates, the gap has reduced over this period. In the period 2014/15 to 2016/17 the rate was 40.7 per 100,000 compared to 34.2 per 100,000 across England and 28.5 in the West Midlands region.

Hospital admissions for alcohol-specific conditions, under 18s



Source: Local Alcohol Profiles for England, Public Health England.

[39] Estimate of the percentage of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more for women).

Consideration: Individuals from the most deprived areas of the county are over three times as likely to be admitted to hospital due directly to alcohol consumption as those living in the least deprived areas.

In 2014/16 the age-standardised rate of alcohol specific mortality in Herefordshire was 7.8 per 100,000, significantly lower than the in the West Midlands region (12.9) and lower than in England as a whole (10.4), though not significantly so. The rate has remained relatively stable since 2006/8.

In Herefordshire, in 2016 the proportion of alcohol users leaving alcohol treatment successfully who did not re-present to treatment within 6 months was significantly lower than in the West Midlands region, England and all but one of Herefordshire's comparator group.

Successful completion of treatment for alcohol – Herefordshire and comparator group

15.01 - Successful completion of treatment for alcohol 2016 Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	31,562	38.7	38.4	39.0
Herefordshire	→	-	52	21.4	16.7	27.0
Shropshire	↑	1	202	36.1	32.3	40.2
Cheshire East	↑	2	139	39.9	34.9	45.2
Bath and North East Somer...	→	3	87	39.2	33.0	45.7
Wiltshire	↑	4	253	41.3	37.4	45.2
Rutland	–	5	-	*	-	-
Cheshire West and Chester	↑	6	224	44.4	40.1	48.7
North Somerset	↓	7	114	39.7	34.2	45.5
East Riding of Yorkshire	↑	8	175	38.8	34.4	43.4
Central Bedfordshire	→	9	120	36.0	31.1	41.3
Cornwall	↓	10	257	28.4*	25.6	31.5
Solihull	→	11	192	33.6	29.8	37.5
Isle of Wight	↑	12	74	53.2	45.0	61.3
Northumberland	↓	13	218	32.9	29.5	36.6
Stockport	→	14	189	36.6	32.6	40.9
Poole	→	15	72	40.9	33.9	48.3

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Source: Local Alcohol Profiles for England, Public Health England. Available at: https://fingertips.phe.org.uk/profile/local-alcohol-profiles

See Alcohol in Herefordshire report, 2017.

OBESITY AND PHYSICAL ACTIVITY

PRIORITY

Obesity is commonly measured using weight and height to give a Body Mass Index (BMI) metric. Poor diet (containing a high proportion of foods high in fat, sugars and salt) and lack of exercise can lead to obesity, which in turn is a risk factor for non-communicable diseases such as cardiovascular disease and some forms of cancer.

In England, child BMI is measured at Reception Year (age 4-5 years) and Year 6 (aged 10-11 years) through the mandatory National Child Measurement Programme (NCMP). For the majority of children excess weight gain is the result of eating more calories than needed and/or undertaking too little physical activity to match calorie intake, or a combination of both.

In 2016/17, data from the NCMP indicate that 9.8 per cent of reception year children in Herefordshire were obese, while the combined proportion of obese and overweight was 22.9 per cent. For year 6 children, the prevalence of obesity was 19.2 per cent, while the combined figure for obese and overweight children was 34.8 per cent. For both age groups there were no significant differences between the local and national figures.

Consideration: In Herefordshire, as a year group passes from reception to year 6 the proportion of obese children increases by 102 per cent, a pattern similar to that seen both nationally and regionally. Children most at risk of becoming obese when older are those where one or both parents are overweight or obese, suggesting that tackling adult obesity has to run in tandem with addressing childhood obesity.

It is never too late to change behaviours since dietary improvements made in older age significantly reduce the risk of chronic diseases and life-limiting illnesses.

In 2015-16, 63.2 per cent of adults in Herefordshire were estimated to be overweight or obese, similar to the national figure of 61.3 per cent and the West Midlands region figure of 63.9 per cent.

Comparison with GP records indicates that it is highly probable that obesity prevalence is under-recorded. In 2016/17, approximately 15,000 adults registered with a Herefordshire GP practice were recorded as obese, which represents 9.9 per cent of all patients aged 18 years and over. Across Herefordshire GP practices the prevalence of obesity ranged between 6.0 and 14.9 per cent, while the highest locality prevalence (10.6 per cent) was recorded in North and West and the lowest (8.8 per cent) in South and West.

Results from the What About YOUth (WAY) survey suggest that in 2014/15 an average of 2.48 portions of fruit and 2.54 portions of vegetables were consumed daily at age 15 in Herefordshire; more than nationally or regionally.

Data from Sport England's Active Lives survey suggests that in 2015/16, the average number of portions of vegetables consumed daily by Herefordshire adults was 3.06, significantly more than in England (2.68) and the West Midlands region (2.62). The average number of portions of fruit consumed daily was 2.88; also more than nationally (2.63) and regionally (2.65).

Consideration: There is a growing body of evidence pointing to the association between exposure to fast food outlets and obesity. Although the density of fast food outlets in Herefordshire is low compared to nationally and regionally, the concentration of fast food outlets in more deprived areas is a concern (see map on next page).

Physical inactivity is the fourth leading risk factor for mortality in the world, accounting for six per cent of deaths globally. People who have a physically active lifestyle have a 20 - 35 per cent lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon and breast cancer and with improved mental health. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year.

Department of Heath physical activity guidelines recommend that over a week adults should undertake a total of at least 150 minutes of at least moderate physical activity such as brisk walking, cycling, gardening and housework, or various sports and exercise. Alternately, an adequate level of activity can be achieved over a week by undertaking 75 minutes of vigorous intensity activity such as running, football or swimming. All adults should also aim to improve muscle strength on at least two days a week and minimise sedentary activities.

In 2016/17, 71.1 per cent of adults in Herefordshire (aged 19+) met the recommendation for physical activity (150+ moderate intensity equivalent minutes per week), a higher proportion than in England (66.0 per cent) and the West Midlands region (62.6 per cent). In the same period 17.2 per cent of adults were physically inactive, a significantly lower proportion than in England (22.2 per cent) and the West Midlands region (25.0 per cent). As Sport England has replaced the Active People Survey with Active Lives, a new survey that provides the same indicators but with a changed methodology, it is not possible to compare these figures with those in earlier years.

See *Overview of Obesity in Herefordshire*, 2016.

Physical activity levels among those aged 65 and over living in Herefordshire are higher than regional and national levels. However, physical activity levels in over half of this age group are below what is recommended in order to realise health benefits. In addition, older adults who engage in physical activity are more likely to maintain their functional capacity, which is vital to living independently.

See *Older People's Integrated Needs Assessment*, 2018

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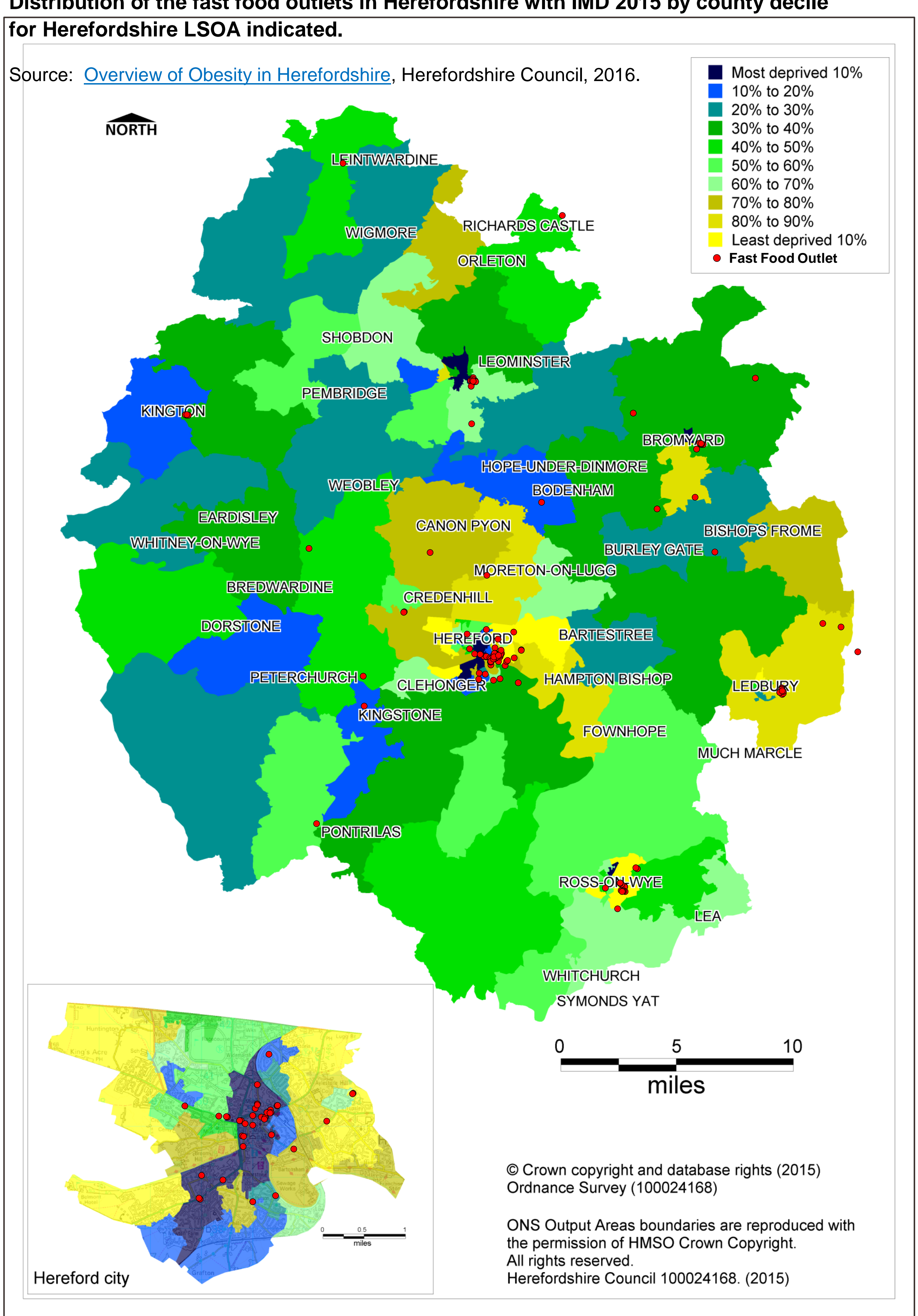
Distribution of the fast food outlets in Herefordshire with IMD 2015 by county decile for Herefordshire LSOA indicated.

Source: Overview of Obesity in Herefordshire, Herefordshire Council, 2016.



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SMOKING

Smoking is the most important cause of preventable ill health and premature mortality in the UK and a major risk factor for many diseases, including lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and the health of the mother. Pregnancy-related health problems associated with smoking include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant. The Tobacco Control Plan contained a national ambition to reduce the rate of smoking throughout pregnancy to 11 per cent or less by the end of 2015.[40]

In 2016/17 the proportion of mothers in Herefordshire who were smokers when giving birth was 13.8 per cent, above the national ambition of 11 per cent and significantly higher than the proportion nationally (10.7 per cent) and in the West Midlands region (11.8 per cent). However, it should be noted that there are currently data quality issues surrounding this indicator, which are being addressed by Herefordshire CCG.

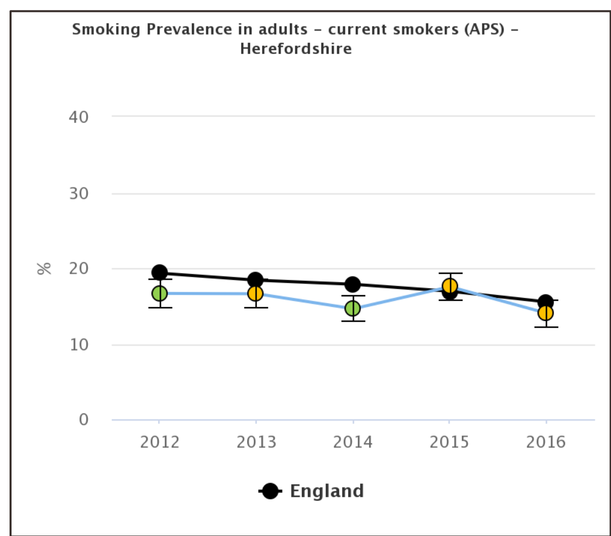
In 2016, 14 per cent of adults in Herefordshire were self-reported smokers, not significantly different to the proportion in England or the West Midlands region. Between 2010 and 2016 the proportion has not changed significantly and although, with the exception of 2015, the local prevalence was below that recorded nationally and regionally, the difference has not been significant.

In 2016, smoking prevalence in adults in routine and manual occupations in Herefordshire was 24.6 per cent. In Herefordshire males are a third more likely to smoke than females. Smoking prevalence is greater in areas of high deprivation and the prevalence of smoking in adults in routine and manual occupations in Herefordshire, despite falling remains significantly higher than that recorded for the adult population as a whole.

In addition, adults (35+ years) residing in the most deprived areas are a third more likely to be admitted to hospital as a consequence of their smoking than the population of Herefordshire overall, and smoking related mortality rates are over 40% higher among the most deprived population quartile than in the County overall.

[40] Healthy Lives, Healthy People: A Tobacco Control Plan for England, Department of Health, 2011. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

Prevalence of smoking among persons 18 years and over from the Annual Population Survey (APS)



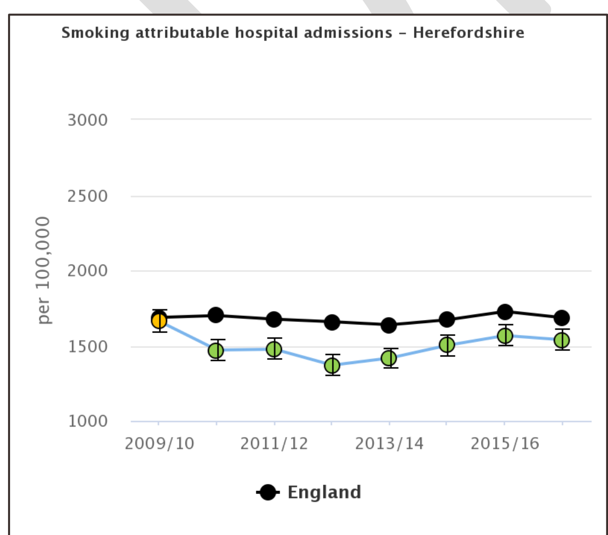
Source: Local Tobacco Control Profiles for England, Public Health England.

In 2016, 28.4 per cent of adults in Herefordshire were ex-smokers.

In 2016/17 53.6 per cent of adults in Herefordshire had never smoked, a significantly lower proportion than in England as a whole (56.9 per cent) and the West Midlands region (58.2 per cent).

In 2016/17, the smoking related hospital admission rate in Herefordshire of 1,538 per 100,000 of population was significantly lower than the national figure of 1,685 and the West Midlands region figure of 1,697. This pattern has been evident since 2010/11.

Directly standardised rate of Smoking Attributable Admissions in people aged 35 and over



Source: Local Tobacco Control Profiles for England, Public Health England.

See Smoking in Herefordshire Overview, 2017.

In 2016/17, the rate of successful smoking quitters at four weeks in Herefordshire was 571 per 100,000, much lower than in England (2,248) and the West Midlands region (2.159) and was the lowest among Herefordshire's comparator group. Between 2013/14 and 2016/17 the rate at which individuals successfully quit smoking declined by 1,208 points from 1,725 per 100,000.

Successful quitters at 4 weeks per 100,000 smokers - Herefordshire and comparator group

Successful quitters at 4 weeks 2016/17 — Crude rate - per 100,000 smokers aged 16+

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	155,875	2,248*	-	-
Central Bedfordshire	–	9	1,275	5,518	-	-
Cheshire West and Chester	–	6	1,076	3,326	-	-
Cornwall	–	10	2,224	3,080	-	-
Solihull	–	11	610	3,046	-	-
North Somerset	–	7	558	2,750	-	-
Northumberland	–	13	1,086	2,434	-	-
Shropshire	–	1	910	2,024	-	-
Stockport	–	14	577	2,014	-	-
East Riding of Yorkshire	–	8	663	1,924	-	-
Rutland	–	5	69	1,747	-	-
Bath and North East Somer...	–	3	368	1,728	-	-
Poole	–	15	355	1,725	-	-
Wiltshire	–	4	942	1,714	-	-
Cheshire East	–	2	546	1,324	-	-
Herefordshire	–	-	126	571	-	-
Isle of Wight	–	12	-	*	-	-

Source: Risk Factors Intelligence Team, Public Health England

Source: Local Tobacco Control Profiles, Public Health England. Available at: https://fingertips.phe.org.uk/profile/tobacco-control

SEXUAL HEALTH

Sexual health is a key public health issue and the Department of Health has outlined its ambition for good sexual health in *A Framework for Sexual Health Improvement in England,* which describes key principles of best practice in sexual health commissioning with the aim of improving the sexual health of the whole population.[41]

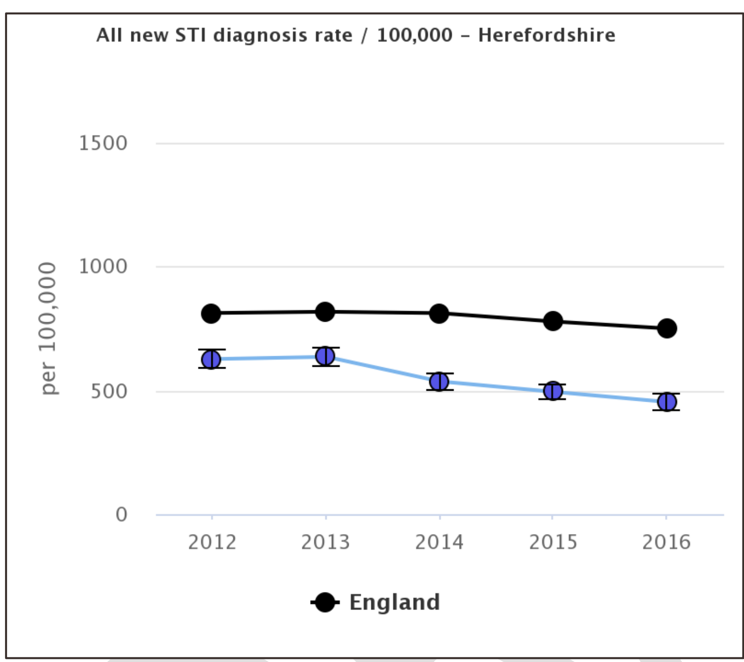
In 2016 there were 852 new cases of sexually transmitted infections (STIs) diagnosed in Herefordshire, corresponding to a rate of 453 per 100,000 of population,

[41] A Framework for Sexual Health Improvement in England, Department of Health, 2013. Available at: https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

compared to a rate of 750 per 100,000 of population in England and 663 per 100,000 of population in the West Midlands region.

The Herefordshire rate has shown a general decline between 2012 and 2016. Throughout this period, the local rate has been significantly lower than that for England. While the national rate has also fallen (by 7.6 per cent) over this period, the Herefordshire rate has fallen faster, so that in 2015 the local rate was 39.6 per cent lower than the national rate, compared to 22.9 per cent lower in 2012.

All new sexually transmitted infection (STI) diagnosis rate per 100,000 of population



Source: Sexual and Reproductive Health Profiles, Public Health England.

Chlamydia is one of the most common sexually transmitted infections (STIs) in the UK. It is passed on from one person to another through unprotected sex and is particularly common in sexually active teenagers and young adults. If left untreated, the infection can spread to other parts of the body and lead to long-term health problems.[42] The National Chlamydia Screening Programme (NCSP) recommends that all sexually active under-25 year old men and women be tested for chlamydia annually, or on change of sexual partner (whichever is more frequent). The Department of Health Public Health Outcomes Framework recommends that local areas aim to achieve a chlamydia detection rate among 15 to 24 year olds of at least 2,300 per 100,000.

⚠ In Herefordshire, in 2016, the detection rate for chlamydia in males was 883 per 100,000; significantly lower than in England (1,269 per 100,000 of population) and the West Midlands region (1,145 per 100,000). For females the rate was 1,682 per 100,000, again significantly lower than for England (2,479 per 100,000) and the West Midlands region

[42] Chlamydia, NHS Choices. Available at: https://www.nhs.uk/conditions/chlamydia/

(2,305 per 100,000). For both males and females detection rates have declined since 2013. 15.3 per cent of 15 to 24 year olds were screened for chlamydia in 2016; a significantly lower proportion than in England (20.7 per cent) and the West Midlands region (16.4 per cent).

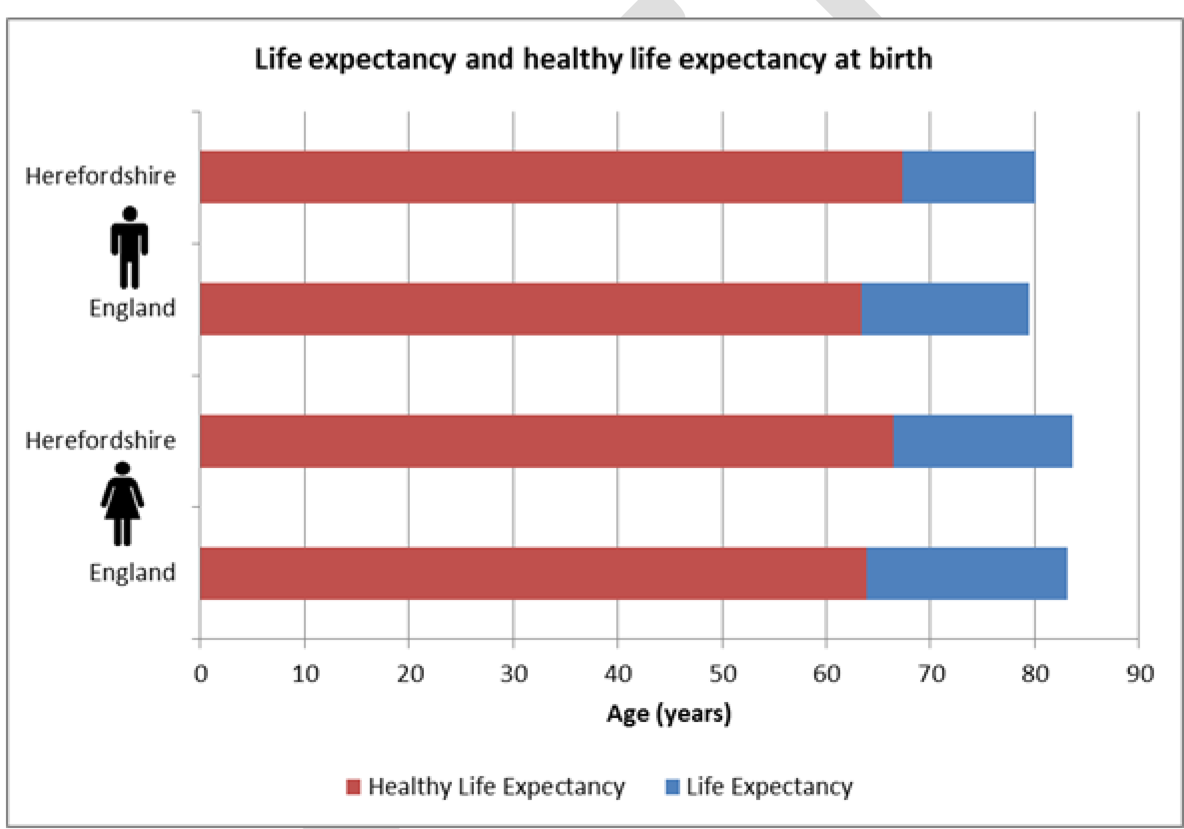
See *Sexual Health in Herefordshire Overview*, 2017

BEING WELL AND LIVING LONGER

LIFE EXPECTANCY

Life expectancy: For males born in Herefordshire in 2014-16 the average life expectancy is 80.1 years, while for females it is 83.6 years. Both figures have declined slightly since 2012-14, but for males is similar to England and higher than the West Midlands region and for females, higher than for both.

Healthy Life Expectancy: In 2014-16 the healthy life expectancy in Herefordshire was 67.4 years for males and 66.5 years for females, both higher than the national figures.



Data source: Public Health England.

People born in the most deprived ten per cent of areas in Herefordshire have a shorter life expectancy at birth than those living in the least deprived ten per cent by an average of 3.9 years for males and an average of 2.6 years for females. However, this gap is one of the smallest amongst counties with a similar level of overall deprivation to Herefordshire.

MORTALITY AND PREMATURE MORTALITY

Key points:

In 2016, 2,100 Herefordshire residents died, 530 of them prematurely (i.e. before the age of 75). This equates to one in four deaths, compared to one in three nationally in 2015[43].

The all cause directly age standardised mortality rate for Herefordshire was 937 per 100,000, lower than the England rate (960) and representing an overall downward trend from 1,054 in 2007.

In Herefordshire, in 2016 ischaemic heart disease accounted for 11.6 per cent of all deaths, compared to 10.9 per cent in England; cerebrovascular diseases 7.1 per cent of deaths compared to 6.2 per cent in England; chronic lower respiratory disease 5.8 per cent of deaths compared to 6.0 per cent in England. Dementia and Alzheimer disease accounted for 10.6 per cent of deaths, compared to 12.1 per cent in England and 12.0 per cent in the West Midlands region.

Premature mortality rates are greater among men than women. The most common causes of premature mortality are cancer, heart disease, stroke, lung disease and liver disease which between them account for 79 per cent of all premature deaths in England. Of these deaths it is estimated that two thirds could be avoided either through prevention, earlier diagnosis and access to the highest quality treatment and care.[44] Therefore, analysis of premature mortality statistics can assist in identifying areas for improving local health care provision.

Between 1995 and 2014 the directly standardised premature mortality rate in Herefordshire has shown a steady downward trend, falling from 540 to 280 per 100,000 of the population (a fall of 38 per cent – similar to the 39 per cent seen nationally and amongst comparators). (530 deaths).

In 2014, Herefordshire's premature mortality rate was 16 per cent lower than the national rate and 0.7 per cent lower than the comparator group rate. Between 1995 and 2014 Herefordshire's premature mortality rate was consistently lower than the national rate (by 14 per cent on average), and on average 4 per cent higher than the comparator group mean rate.

[43] Longer Lives: Premature Mortality, Mortality Rankings, Public Health England, 2016. Available at: http://healthierlives.phe.org.uk/topic/mortality/comparisons#are//par/E92000001/ati/102/pat/
[44] Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality, Department of Health, 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf

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Between 2014 and 2016, there were 1,716 premature deaths in Herefordshire. Herefordshire's overall premature mortality rate was 299 per 100,000 of the population, ranking 38th out of 150 English local authorities (among the best). Herefordshire's premature mortality rates were ranked as being among the "best" or "better than average" for eight of the nine major causes of premature mortality, with the local premature mortality rate for injuries judged as being "worse than average".

Herefordshire's rank and outcome based on analysis of premature mortality rates for the nine major causes (based on 2014-2016 data)

Major cause of premature mortality	Rank of all English authorities (1 to 150, with 1 = best)	Outcome compared to other authorities
Lung cancer (all ages)	4	Best
Cancer	22	Best
Stroke	23	Better than average
Liver disease	35	Better than average
Colorectal cancer	36	Better than average
Heart disease	44	Better than average
Lung disease	55	Better than average
Breast cancer	55	Better than average
Injuries	114	Worse than average

Source: Longer Lives: Premature Mortality, Public Health England.

See *Mortality and Premature Mortality*, 2016.

LONG TERM CONDITIONS

A long term condition (LTC) is defined as a condition that cannot at present be cured but can be controlled by medication and/or other therapies. Nationally, people with LTCs account for 50 per cent of all GP appointments, 64 per cent of all hospital outpatient appointments and over 70 per cent of all inpatient bed days.[45]

[45] Long Term Conditions Compendium of Information: Third Edition, Department of Health, 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

Long-term conditions (LTC) in Herefordshire: comparison with national, local trend and variation by GP practice

	Prevalence*		Local trend	Variation (by GP practice)		
Condition	**Herefordshire CCG**	**England**		**Highest**	**Lowest**	
Cancer	3.4	2.6	↑	4.8	2.0	⚠
Coronary Heart Disease	3.5	3.2	→	4.3	2.3	⚠
Stroke	2.3	1.7	→	3.2	1.5	⚠
Hypertension	16.1	13.8	↑	18.7	13.7	⚠
Diabetes	6.8	6.7	↑	7.8	5.2	
Chronic kidney disease	4.7	4.1	↓	6.7	1.9	
Asthma	6.3	5.9	→	7.8	4.6	⚠
Chronic obstructive pulmonary disease (COPD)	2.2	1.9	↑	3.6	1.9	⚠
Depression (18+)	8.1	9.1	↑	14.7	4.2	
Learning Disabilities	0.5	0.5	→	0.8	0.2	
Dementia	0.9	0.8	↑	1.5	0.5	
Osteoporosis	0.6	0.5	↑	2.7	0.1	
Rheumatoid Arthritis	1.0	0.7	→	1.3	0.8	⚠
Overall LTC Prevalence	**55.5**	**53.5**	→	**65.4**	**42.6**	

*The percentage of patients with the condition as recorded on practice disease register.
Data source: Public Health England

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⚠ Coronary Heart Disease (CHD) prevalence in Herefordshire has shown little change and in 2016/17 was still 3.5 per cent, a figure significantly higher than that recorded for England (3.2 per cent). Those living in the most deprived areas of Herefordshire are 29 per cent more likely to die prematurely (under 75 years of age) of coronary heart disease.

⚠ Hypertension (high blood pressure) is the single biggest risk factor for stroke and also plays a significant role in heart attacks. Risk factors include being overweight or obese,

lack of physical activity, and being diabetic. In 2016/17 prevalence in Herefordshire was 16.1 per cent compared to 13.8 per cent across England as a whole, while prevalence in Herefordshire GP practices ranged between 13.7 and 18.7 per cent.

Since 2009/10 the **stroke** prevalence in Herefordshire has not changed appreciably, ranging between 2.2 and 2.3 per cent, although the local figure has been consistently higher than that reported for England as a whole. Those living in the most deprived areas of Herefordshire are over 71 per cent more likely to die prematurely (under 75 years of age) of cerebrovascular disease (including stroke).

Between 2001 and 2015 the number of new malignant **cancer** cases diagnosed annually in Herefordshire has increased steadily; the local 2015 age standardised incidence rate of 632 per 100,000 was greater than the national figure of 548 per 100,000. Similarly, prevalence has increased locally and in 2016/17 was 3.4 per cent, a figure significantly higher than that reported nationally (2.6 per cent). In 2015, there were 557 cancer specific deaths in Herefordshire. Those living in the most deprived areas of Herefordshire are 22 per cent more likely to die prematurely (under 75 years of age) of cancer.

However, between 1995 and 2015 the **cancer mortality rate** in Herefordshire fell from 304 per to 263 per 100,000 of population and the local rate was consistently below both the national and regional rates. The most common causes of cancer-related deaths in Herefordshire were lung, urological and upper and lower gastro-intestinal cancers.

More

See *Overview of Cancer in Herefordshire, 2017*.

The number of people suffering with **chronic obstructive pulmonary disease** (COPD) in Herefordshire has increased steadily since 2005/06. Since 2011/12 the local prevalence has been higher than the national figure whereas prior to 2009/10 the opposite pattern was observed. In 2016/17 the Herefordshire COPD prevalence was 2.2 per cent compared to 1.9 per cent across England as a whole. People living in the most deprived areas are over two and half times likely to die prematurely (under 75 years of age) of chronic lower respiratory disease than those in the least deprived areas.

The local prevalence of **asthma** has shown little change since 2005/06 and has been consistently higher than the national figure; in 2016/17 the local asthma prevalence was 6.3 per cent compared to the England figure of 5.9 per cent, ranging between 4.6 and 7.8 per cent across GP practices in the county.

Respiratory diseases remain the most prominent underlying cause of excess winter deaths, accounting for over a third (35 per cent). There were 41 per cent more deaths from respiratory diseases in the 2015/16 winter months than in the non-winter months, equating to 8,600 deaths.

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In Herefordshire, the prevalence of **rheumatoid arthritis** in persons aged 16yrs+ in 2015/16 was significantly higher than that recorded nationally (0.7 per cent) and regionally (0.8 per cent). Since 2013/14 there has been no change in prevalence either locally or nationally.

FOCUS AREA: DIABETES

Diabetes mellitus is one of the common endocrine diseases affecting all age groups with over one million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes, is undertaken by the GP and members of the primary care team.

Type 1 diabetes is a serious, lifelong condition where blood glucose levels are too high because the body does not produce insulin. Type 1 diabetes is an auto-immune condition and is not caused by lifestyle factors. Around 10 per cent of people living with diabetes in the UK have Type 1 diabetes. It's the most common type of diabetes in childhood but it can develop at any age.[46]

Type 2 diabetes is also a serious, lifelong condition where blood glucose levels are too high because the body does not produce sufficient insulin or the insulin it does produce does not function properly. Around 90 per cent of people living with diabetes in the UK have Type 2 diabetes, and it's the most common type in adults. Type 2 diabetes starts gradually, usually later in life, although people are being diagnosed at a younger age. Family history, age and ethnic background can affect the likelihood of developing Type 2 diabetes and people who are overweight or obese are at higher risk of developing the condition.[46]

The prevalence of diabetes in Herefordshire rose between 2012/13 and 2016/17 in line with the trend nationally. In 2016/17 the prevalence rate in Herefordshire adults (17 plus) was 6.8 per cent, similar to the rate of 6.7 per cent nationally. Prevalence in Herefordshire GP practices ranged between 5.2 and 7.8 per cent. The highest prevalence was recorded in North and West Locality and the lowest in East Locality. However, the prevalence rate of diabetes in older adults (65 plus) was 24.2 per cent in Herefordshire; significantly higher than that in the West Midlands NHS Region (16.9 per cent) and in England (17.3 per cent).

In 2016/17, in the Herefordshire CCG area 13 per cent of people aged 12 years and over with type 1 diabetes achieved all three treatment targets (HbA1c, cholesterol and blood pressure), a significantly lower proportion than nationally (19 per cent) and regionally (18.8 per cent). In the same period, 36.2 per cent of people aged 12 years and over with type 2 diabetes achieved all three treatment targets (HbA1c, cholesterol and blood pressure), again a significantly lower proportion than nationally (41.1 percent) and regionally (42.4 per cent).

Herefordshire CCG has partnered with Reed Momenta to offer individuals at high risk of Type 2 diabetes a place on the new *Healthier You: NHS Diabetes Prevention Programme*. They will benefit from services to help them make healthier lifestyle choices and reduce their risk of developing the disease. Herefordshire Council are supporting the alignment of this programme to build up healthy lifestyle changes for health improvement.

[46] Diabetes: the basics, Diabetes UK. Available at: www.diabetes.org.uk/diabetes-the-basics

MENTAL HEALTH

Approximately one in four people in the UK will experience a mental health problem each year[47] and in England one in six people report experiencing a common mental health problem (such as anxiety and depression) in any given week.[48]

Women are more likely to report that they suffering from a mental health problem than men (33 per cent compared to 19 per cent) and people from lower income households are more likely to be diagnosed with a mental health problem (27 per cent of men and 42 per cent of women in the lowest income quintile, compared to 15 per cent of men and 25 per cent of women in the highest quintile).[49]

By 2030, it is estimated that there will be approximately two million more adults in the UK with mental health problems than there were in 2013.[50]

In 2014/15, nearly two million people in England were in contact with mental health and learning disability services at some point in the year, an increase 5.1 per cent on the previous year.[51]

Improving mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds, including:

- improved physical health and life expectancy
- better educational achievement
- increased skills
- reduced health risk behaviours such as smoking and alcohol misuse
- reduced risk of mental health problems and suicide
- improved employment rates and productivity
- reduced anti-social behaviour and criminality
- and higher levels of social interaction and participation.[52]

Depression is one of the most common mental health problems. In 2016/17, 8.1 per cent of patients aged 18 and over on Herefordshire GP practice registers had depression; a significantly lower proportion than nationally (9.1 per cent) and regionally (8.9 per cent).

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[47] Adult psychiatric morbidity in England, 2007: results of a household survey. McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. The NHS Information Centre for health and social care, 2009. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey

[48] Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014, McManus S, Bebbington P, Jenkins R, Brugha T. (eds.). Leeds: NHS digital, 2016. Available at: https://www.gov.uk/government/statistics/adult-psychiatric-morbidity-survey-mental-health-and-wellbeing-england-2014

[49] Key facts and trends in mental health: 2016 update, NHS Confederation, 2016. Available at: http://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/MHN-key-facts-and-trends-factsheet_Fs1356_3_WEB.pdf

[50] *Ibid.*

[51] *Ibid.*

[52] About Mental Health, NHS England. Available at: https://www.england.nhs.uk/mental-health/about/

Reflecting the national trend the prevalence of depression has increased year on year since 2012/13. In 2016/17, the incidence of new diagnoses of depression as a proportion of GP practice registers (aged 18+) in Herefordshire was 1.3 per cent; lower than nationally (1.5 per cent).

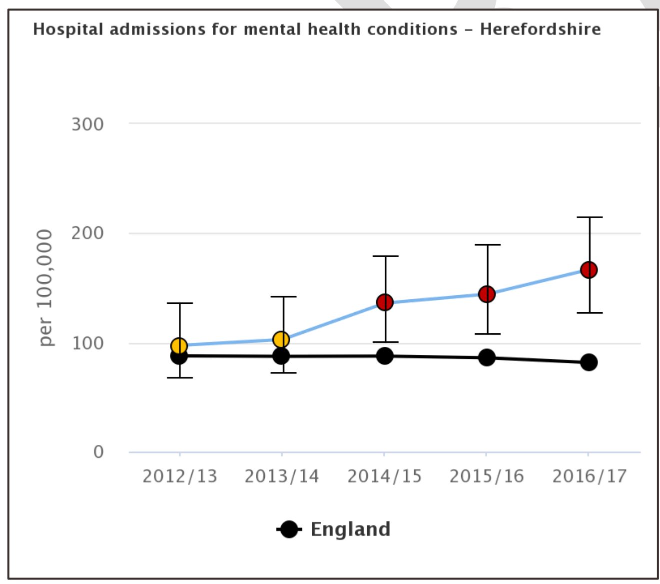
In 2015/16, 0.81 per cent of people of all ages on GP practice registers in Herefordshire had a **severe mental illness** (schizophrenia, bipolar affective disorder or other psychoses), a lower proportion than nationally (0.90 per cent).

The Disability Rights Commission has reported on serious inequalities experienced, in terms of reduced life expectancy, by those with severe mental illness. There is extensive published evidence that people with severe mental illness, such as schizophrenia, die between 15 and 25 years earlier than the average for the general population.

One in ten children aged 5-16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14.

In 2016/17, the **hospital admission rate for mental health disorders in children and young people** aged 0 to 17 tears was 166.8 per 100,000 population in Herefordshire; significantly higher than in England as a whole (81.5 per 100,000) and in the West Midlands region (84.3 per 100,000). The rate has been increasing since 2012/13 and the gap between Herefordshire and England is widening.

Hospital admissions for mental health conditions in under 18s.



Source: Public Health England

Hospital admissions for **self-harm in children** have also increased in recent years, with admissions for young women being much higher than admissions for young men.

In Herefordshire, the rate of hospital admissions as a result of self-harm in persons aged 10 to 24 years was 365.6 per 100,000 in 2016/17; lower than nationally (404.6 per 100,000) and regionally (413.9 per 100,000).

Mental health problems are common among those needing treatment for alcohol misuse and alcohol misuse is common among those with a mental health problem.

In 2016/17, the rate of **admissions to hospital for mental and behavioural disorders due to alcohol** in Herefordshire was 31.5 per 100,000; much lower than in England as a whole (72.3 per 100,000) and the West Midlands region (76.6 per 100,000).

In 2014/15, the **excess under 75 mortality rate** in adults with serious mental illness, measured as a ratio of observed to expected mortalities and expressed as a percentage was 247.6 per cent in Herefordshire; significantly lower than nationally (370.0 per cent) and regionally (400.7 per cent).

Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. Suicide is a major issue for society and a leading cause of years of life lost.

In 2014/16, the age-standardised mortality rate from suicide and injury of undetermined intent in Herefordshire was 11 per 100,000 population; higher than nationally and regionally (both 10 per 100,000), but not significantly so.

The suicide rate among men is much higher than among women. In 2014/16, the male suicide rate in Herefordshire was 17.5 per 100,000; the highest it has been since 2004/06 and higher than nationally (15.3 per 100,000) and regionally (15.9 per 100,000), although none of these differences are statistically significantly. Residents of the most deprived areas of Herefordshire are approximately 19 per cent more likely to die as a result of suicide than the county population in general.

In 2014/16, the female suicide rate in Herefordshire was 4.6 per 100,000; with no significant change since at least the turn of the century and similar to nationally (4.8 per 100,000) and regionally (4.4 per 100,000).

AGEING WELL: PEOPLE AGED 65 YEARS AND OVER

A larger proportion of Herefordshire's population is aged 65 and over (24 per cent) compared to England and Wales (18 per cent). The number of residents aged 65-84 is projected to grow at a similar rate as during the last decade (average of two per cent a year), but the number aged 85+ will rise even more rapidly (average of five per cent compared to just under three per cent a year since 2001). By 2031, there are projected to be 49,800 65-84 year-olds (28 per cent more than in 2016), whilst the number age 85+ will increase by 50 per cent by 2031 and more than double to 10,800 by 2034.

Herefordshire's 44,800 residents aged 65 and over are scattered across the county, although those aged 65-84 are more likely to live in rural villages and dispersed areas than the population as a whole (50 per cent of 65-84s; 42 per cent of all people). The very elderly (85+) are slightly more likely to be living in rural town and fringe areas (Bromyard, Kington, Ledbury, Credenhill): 15 per cent compared to 11 per cent of the total population.

Many older people in Herefordshire are active and well, and many are an asset to the community – reducing the burden on public services by providing large amounts of informal care to friends and family and volunteering for third sector organisations. Rates of limiting long-term illness amongst those aged 65-84 are lower than nationally, and people turning 65 in the county can expect to live longer, both overall and in good health, than those elsewhere.

Nevertheless, the natural ageing of the population, as the post-war 'baby-boomers' become very elderly, is expected to continue to place considerable strain on the health and social care system. As Herefordshire's population is already older, it is expected that such strains will be more pronounced locally than nationally. However, anticipatory action can be taken at a local level to ensure that Herefordshire's health and social care services are able to provide good quality care, appropriate to the needs of older people living in the county.

More

A particular focus for the 2018 JSNA has been the production of an integrated older people's needs assessment. Jointly commissioned by Herefordshire Council and Herefordshire Clinical Commissioning Group, it provides an overview of health and wellbeing issues affecting those aged 65 and over living in Herefordshire.

The needs assessment found evidence of action being taken, or strategies being drawn up, to address the vast majority of the challenges identified. In most cases the responses being planned or implemented were holistic and multi-agency in their approach, evidencing a clear commitment to improving integrated partnership working to achieve improvements the health of older people.

Some of the issues already identified in this report are particularly relevant, or present particular issues, for older people: fuel poverty, loneliness and social isolation, digital exclusion, adult social care services, and informal care. Other issues highlighted by the older people's needs assessment are presented below.

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DEMENTIA

PRIORITY

The increasing incidence of **dementia** nationally is also reflected in Herefordshire and is likely to demand greater resources, not only in providing residential care, but in enabling dementia sufferers to enjoy as good a quality of life as possible and support them to remain in their own home for as long as they safely can. Risk factors for dementia include smoking, excessive alcohol consumption, obesity, diabetes, hypertension, coronary heart disease, and stroke.

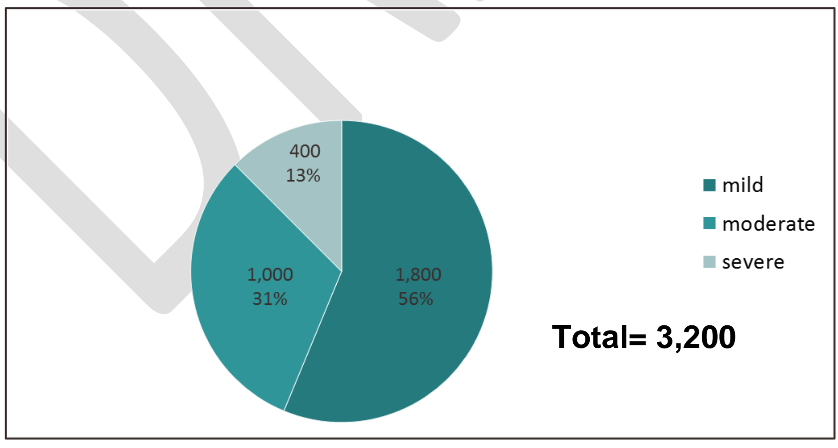
Key points:

It is estimated that there are approximately 3,200 people aged 65 and over with dementia living in Herefordshire. The number of older people with dementia in Herefordshire is estimated to increase to 5,500 by 2035.

In 2017, dementia related costs among over 65s in Herefordshire are estimated to be in the region of £104 million, with the highest proportion of the cost (£46 million, 44 per cent) being attributed to the provision of informal care.

In 2015/16, the percentage of people diagnosed with dementia accessing inpatient hospital care is significantly lower in Herefordshire (46.4 per cent) compared to the West Midlands region (58.5 per cent) and England (53.8 per cent).

Estimated proportion of people aged 65 and over with mild, moderate and severe dementia in Herefordshire in 2017



Sources: Projecting Older People Population Information System, Institute of Public Care, 2017 and Dementia UK: Update. Second edition, Prince, M., *et al,* 2014.

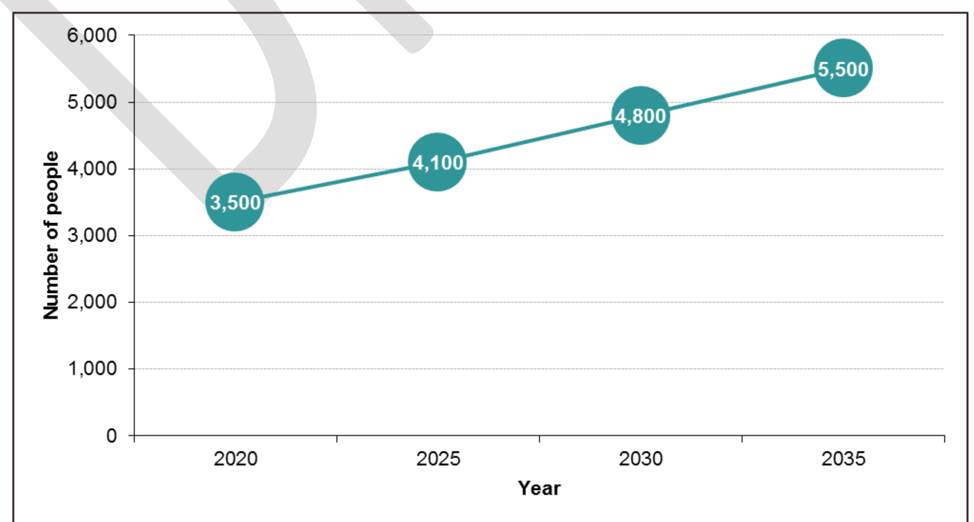
At the beginning of 2017, in Herefordshire only 59.3 per cent of people with dementia aged 65 and over had a formal diagnosis; lower than the NHS England target of 66.7 per cent and the rates reported both nationally (67.9 per cent) and regionally (65.6 per cent).

The *Herefordshire Dementia Strategy* is currently being refreshed. It will be rooted in local dementia care pathways focused around three key outcomes; driving a Herefordshire wide culture change through raising awareness and understanding; increasing availability of early diagnosis of dementia and support; and supporting people with dementia, carers and families to live well with dementia.

Recorded dementia prevalence (prevalence of dementia diagnosis) among those aged 65 and over is lower than what might be expected, with 3.81 per cent of over 65s having a formal diagnosis of dementia as of April 2017. This is a lower rate than regionally (4.13 per cent) and nationally (4.29 per cent). This finding is consistent with Herefordshire's lower diagnosis rates.

Informal carers make a significant contribution to the wellbeing of people living with dementia, with informal care accounting for an estimated 44 per cent of dementia related health and social care costs(4). Providing informal care for someone living with dementia can be challenging and can have negative effects on the psychological wellbeing of caregivers. Timely and appropriate support can reduce carer stress and prevent people living with dementia being prematurely admitted to care homes. There are some good examples of local community support available to people living with dementia and their carers, some named examples being the Dementia Adviser Service and the Leominster Dementia Meeting Centre. In 2016/17 in Herefordshire, among informal carers providing care for a person living with dementia, the average self-reported quality of life score was 7.6 out of 12, the same as it was in 2014/15 and similar to the average scores for England (7.5) and the West Midlands region (7.7).

Estimated number of people aged 65 and over with dementia in Herefordshire 2020-2035



Source: Projecting Older People Population Information System, Institute of Public Care, 2017.

FRAILTY

Frailty is "a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves".[53] Frailty is not an inevitable part of ageing, but an under recognised health state. Older people with frailty are more vulnerable to minor illnesses and are at an increased risk of hospitalisation, admission to a care home and death.

It is estimated that in 2016 there were 4,600 people aged 65 and over with frailty living in the community in Herefordshire. However, this does not take into account the number of people with frailty living in care homes. By 2035, the number of people aged 65 and over with frailty living in the community in Herefordshire is estimated to rise by approximately 67 per cent to approximately 7,700 people.

Fragmented health and social care services are known to cause poor outcomes for older people with frailty. Benchmarking results indicate that there is room for improvement, particularly in the provision of rapid crisis support and discharge planning. Those who participated in the benchmarking exercise spoke of the commitment to improvement that exists among those who work within the health and social care system. Actions are currently being taken to put in place a local integrated care pathway for the management of people with frailty, resultant improvements should be evident were this benchmarking exercise to be repeated in the future.

FALLS AND FRACTURES

It is estimated that in 2017 nearly 12,200 people aged 65 and over living in Herefordshire will experience a fall, with the number expected to rise to over 18,100 by 2035. Falling can result in fracture, admission to hospital, disability, and admission to residential or nursing home, or in some cases death.

Evidence from a recent benchmarking exercise indicates that in Herefordshire, people have acceptable access to falls prevention interventions. The Falls Prevention Service has seen considerable growth in the number of referrals it receives (300 per cent increase between 2012 and 2016), indicating that it is well utilised. The Falls Responder Service in Herefordshire has been in operation since 2014, providing 24/7 non-medical support and referral (if required) for falls at home that do not result in an injury. There is evidence that the service could be better utilised, with an indication that some of the callouts made by West Midlands Ambulance Service could be attended by a falls responder instead; actions are being taken to address this missed opportunity.

Falls are common in residential and nursing home settings. Systematic recording of falls occurring in these settings would be helpful in order to develop more effective prevention strategies.

[53] Fit for Frailty Part 1: Consensus best practice guidance for the care of older people living in community and outpatient settings, British Geriatrics Society, 2014. Available at: http://www.bgs.org.uk/campaigns/fff/fff_full.pdf

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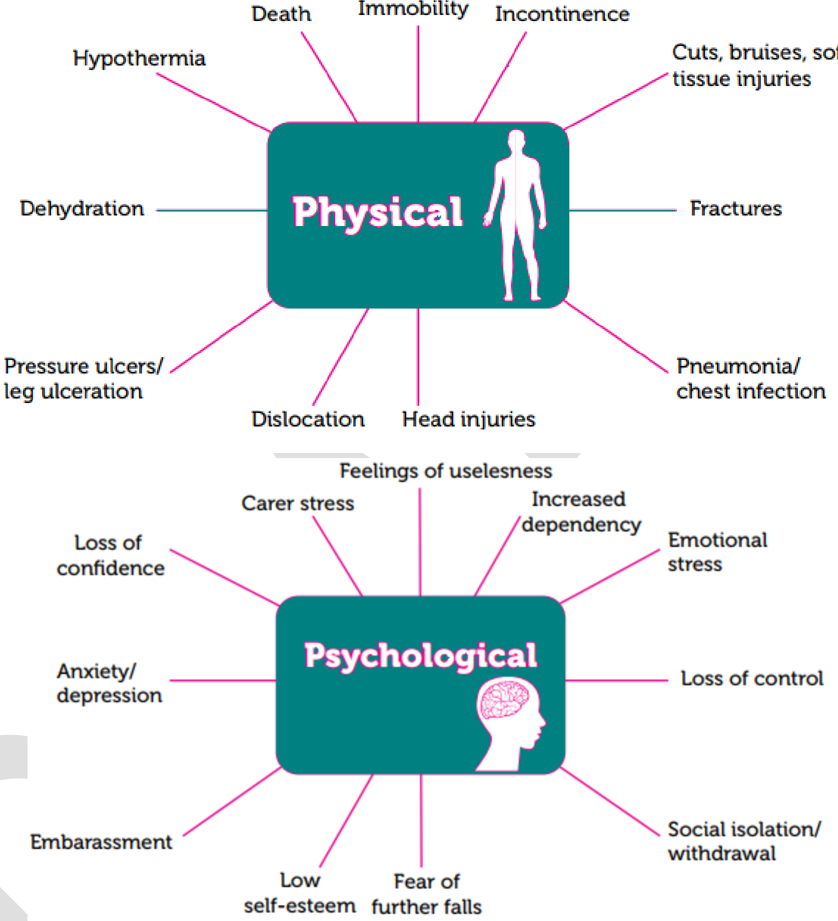
NHS RightCare has identified that in Herefordshire a considerably smaller proportion of people aged 75 and over presenting with fragility fractures are treated with a bone sparing agent (a treatment for osteoporosis) compared to other clinical commissioning groups, suggesting that there is an opportunity to improve outcomes for people with osteoporosis by enhancing treatment coverage.[54]

Physical and psychological consequences of a fall



Source: Managing Falls and Fractures in Care Homes for Older People – good practice resource: Revised edition. NHS Scotland; Care Inspectorate, 2016. Available at: http://www.careinspectorate.com/images/documents/2712/Falls%20and%20fractures%20new%20resource%20low%20res.pdf

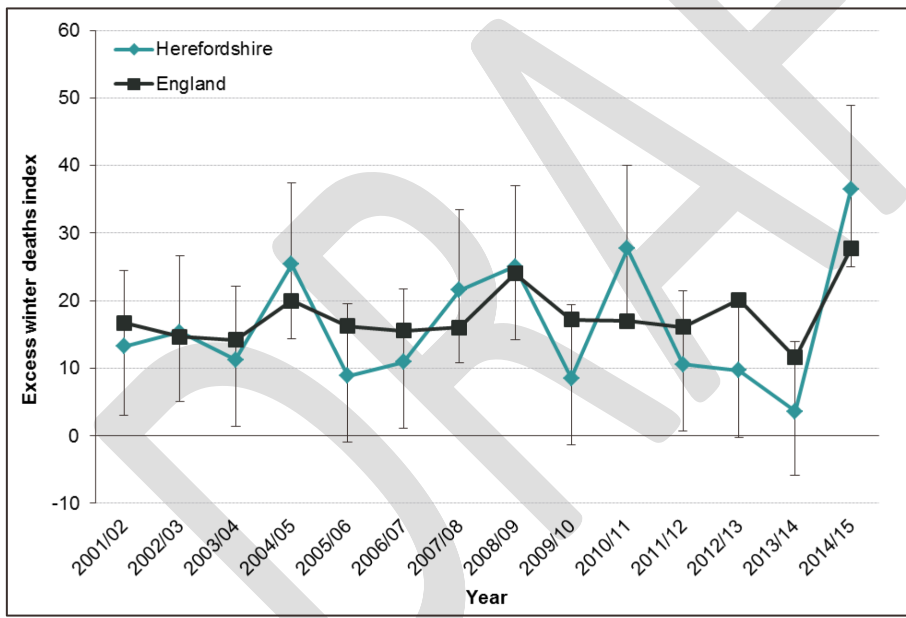
[54] Commissioning for Value Where to Look pack: NHS Herefordshire CCG January 2017, NHS RightCare, 2017. Available at: https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/01/cfv-herefordshire-jan17.pdf

EXCESS WINTER DEATHS

More people in the UK die in the winter period (December to March) than at any other time of year. The majority of these 'excess winter deaths' occur among older people with serious underlying health conditions – for example cerebrovascular diseases, ischaemic heart disease and respiratory disease. Physiological evidence indicates that colder home temperatures cause high blood pressure among older people, increasing the risk of a cardiovascular event. Poor thermal efficiency is a particular issue among Herefordshire's housing stock, and so is fuel poverty.

Between 2001/02 and 2014/15, there were a total of 1,376 excess winter deaths in Herefordshire. Almost two-thirds (63 per cent) were women, and more than half (53 per cent) were people aged 85+. The number fluctuates each year, but the annual index is similar to that seen in England as a whole – including a spike in 2014/15. An Office for National Statistics investigation concluded that the main reason the UK saw such high numbers of excess winter deaths that year was moderate 'flu levels caused by the 'flu vaccine only being 34 per cent effective, combined with the dominant 'flu strain being one which is particularly virulent in older people

Excess winter deaths index* for Herefordshire and England, 2001/02-2014/15



* Number of excess winter deaths divided by the average number of non-winter deaths.
Source: Public Health England.

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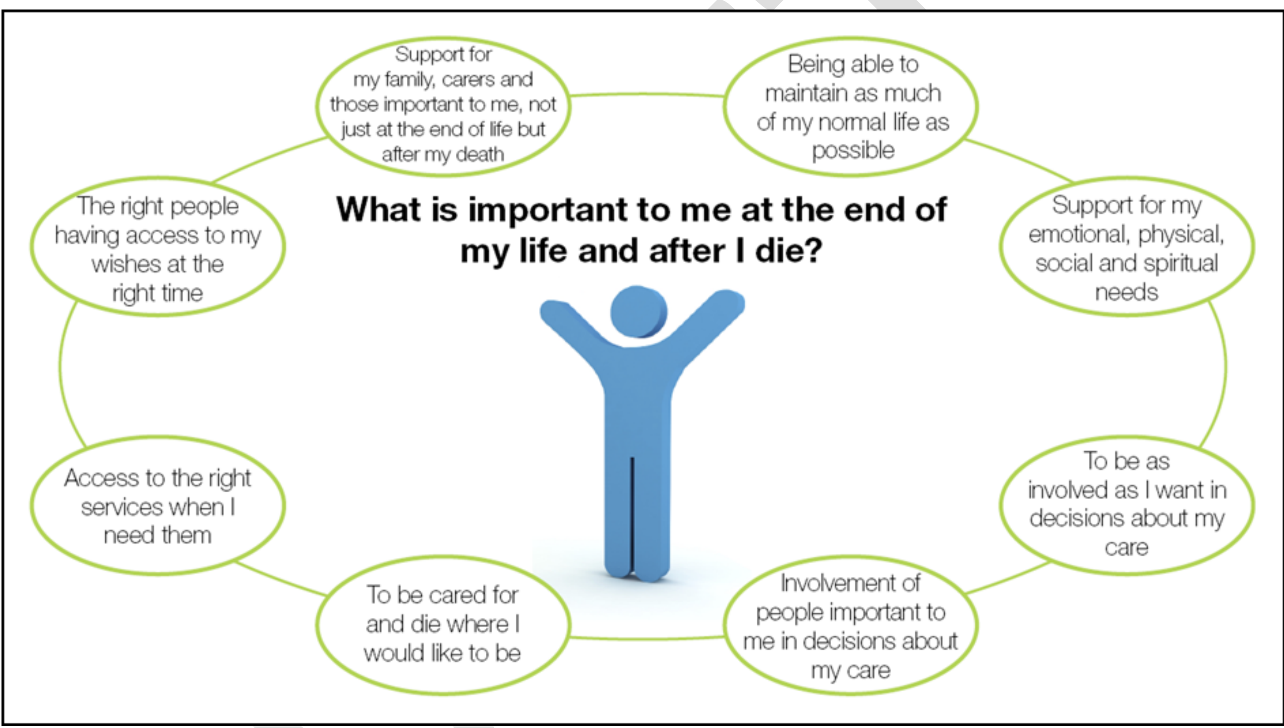
END OF LIFE CARE

End of life care, is the care of someone who is considered to be in their last year of life and forms an important part of palliative care.[55] Hospice UK have stated that 'the last year of someone's life is generally the time when they have the most contact with the health and care system, and their care costs the most.'[56] During this time the primary objective of end of life care should be to ensure that person has a 'good death',[57] the key elements of which are:

- Being treated as an individual, with dignity and respect;
- Being without pain and other symptoms;
- Being in familiar surroundings; and
- Being in the company of close family and/or friends.[58]



Source: What's important to me. A Review of Choice in End of Life Care The National Council for Palliative Care, The Choice in End of Life Care Programme Board, February 2015. Available at: http://www.ncpc.org.uk/sites/default/files/CHOICE%20REVIEW_FINAL%20for%20web.pdf

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Recognition by healthcare professionals of when a person is nearing the end of their life and then responding appropriately plays an essential role in determining whether or not that person has a good death. In addition, effective end of life care involves not only excellent clinical decision-making, but timely, empathetic, communication and provision of suitable support tailored to the needs of the individual, their relatives and carers. Care decisions should be made in consultation with the individual and the family, be respectful of their cultural values and religious beliefs, and wherever possible accommodate their wishes and needs, enabling them to discuss, plan and make informed decisions regarding the care they want.

Delivering high-quality, effective end of life care often involves multiple agencies working closely together to co-ordinate the support they provide. These agencies may include general practitioners, community nurses, domiciliary and adult social care services, hospital and ambulance services, pharmacies, specialist and allied health professionals, hospices and other voluntary sector organisations.

Research has shown that 'access to end of life care is inconsistent: it is organised and planned better in some areas than others.'[59] Currently, in England end of life care services show marked geographical variation across a range of indicators.[60] Furthermore, studies have found that 'for ethnic minority groups and their families, specific issues or barriers may arise related to culturally appropriate health care practices, cultural or religious differences, diverse health beliefs, and access to services for care and support during end-of-life conditions.'[61] Specific issues and barriers also arise for other minority or disadvantaged groups including LGBT,[62] prisoners,[63] homeless people,[64] and gypsies and travellers.[65]

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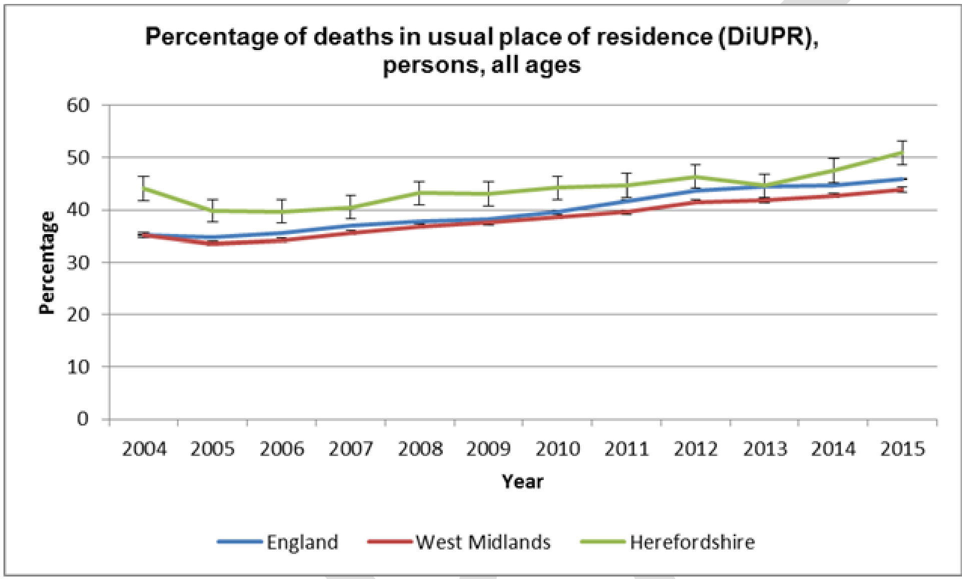
Consideration: Although it is important to recognise though that not everyone wants to die at home, or in their usual place of residence, most people given the choice want to die in familiar surroundings. However, nationally almost half die in hospital (www.hospiceuk.org/what-we-offer/publications)

In Herefordshire, in 2015 50.9 per cent of all deaths occurred in the deceased's usual place of residence, a significantly higher proportion than in England as a whole (46 per cent) and in the West Midlands region (43.9 per cent).

Percentage of deaths in usual place of residence (DiUPR), persons, all ages



Source: End of Life Care Profiles, Public Health England.

Between 2004 and 2015, home deaths in Herefordshire as a proportion of all deaths increased slightly from 21.2 per cent to 23.7 per cent. However, whereas in 2004 this proportion was higher than nationally and in the West Midlands the figure is now similar to both.

In 2015, hospital deaths as a proportion of all deaths were significantly lower than nationally and regionally; 40.9 per cent in Herefordshire compared to 46.7 per cent in England and 49.5 per cent in the West Midlands, representing a decline since 2004 of 4.6 percentage points.

End of life care services in Herefordshire are generally good, but there is scope for further work to proactively raise the profile of issues relating to death and dying with the wider community, provide training and support for those non-clinical staff who work with terminally ill people or their families, and to recognise and accommodate the specific needs of minority groups.

Herefordshire Clinical Commissioning Group's *Palliative and End of Life Care Strategy* sets out Herefordshire's vision and priorities to meet national palliative and end of life care strategies and standards, and to address local priorities for improving palliative and end of life care for people of all ages across all care settings in Herefordshire.