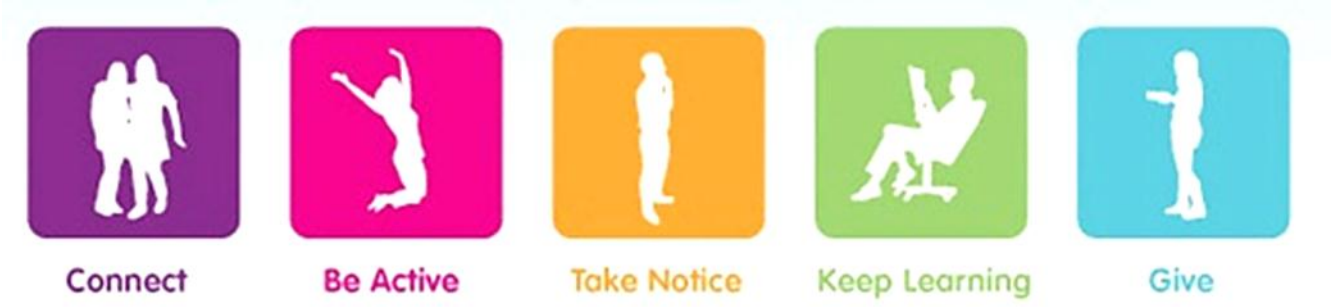
Liverpool City Council

Liverpool's Joint Strategic Needs Assessment
Statement of Need Update 2014



READER INFORMATION	
Title	**Liverpool's JSNA Statement of Need Update 2014**
Team	Public Health
Author(s)	Chris Williamson – Lead Public Health Epidemiologist
Contributor(s)	Liverpool Clinical Commissioning Group Liverpool Families Programme Liverpool Children's Services Liverpool Adult Services Liverpool Community Services City Safe – Community Safety Partnership
Reviewer(s)	Dr Sandra Davies – Director of Public Health
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Purpose / Description	The purpose of this report is to provide an update of some of the key headlines relating to health & wellbeing in Liverpool and it is underpinned by the more detailed topic reports which are publicly available on the JSNA website: www.liverpool.gov.uk/jsna
Contact details	We welcome any comments or feedback on the JSNA process, or if there are specific issues you feel are important. Contact us via: healthandwellbeing@liverpool.gov.uk

Contents

1. Liverpool's JSNA

1.1 Purpose of this update

The purpose of this report is to provide an update of some of the key headlines relating to health & wellbeing in Liverpool. It does not contain all the detail of the JSNA topic reports, but highlights areas of significance for the city. The report is structured around the life-course, highlighting key issues to tackle to improve health and wellbeing in the city. The more detailed JSNA topic reports are available on the JSNA website: www.liverpool.gov.uk/jsna .

1.2 JSNA Structure

Due to the complexity of health and wellbeing in the city, it is not possible to cover all issues within one report. With that in mind, a tiered approach has been adopted for Liverpool's JSNA. The overarching Statement of Need provides a high level summary of some of the key health and wellbeing issues. The aim of this document is to provide readers with an overview of the city, rather than going into great detail.

Statement of Need (this document)				
Children & Young People Themed Reports e.g. emotional health	**Adults & Older People Themed Reports** e.g. mental health	**Wider Determinants Themed Reports** e.g. Housing	**Risk Factor Themed Reports** e.g. Alcohol	**Specific Population Group Themed Reports** e.g. Learning Disabilities

The Statement of Need is underpinned by a series of themed reports, where each topic is considered in-depth looking at issues of need, inequalities and local action and policy context. Having separate topic reports allows us to refresh our understanding of issues as and when the local picture changes, rather than at a set point in time. These updates could be through receiving new data or intelligence, changes to local services or new national priorities / areas of focus. The topic reports are framed around a number of key headings:

- *Why is it important?*
- *The Liverpool Picture*
- *Who is at risk?*
- *What are we doing and why?*
- *Community and stakeholder views*
- *Challenges*

All of these topic reports are available via the City Council website: www.liverpool.gov.uk/jsna

1.3 Community & Stakeholder Views

A key element of the JSNA process is developing our understanding of what is important to local people. In 2013, we revised the way we produced the JSNA in Liverpool to ensure greater input and involvement from partners and community bodies across the city. With the help of Liverpool Charitable & Voluntary Services and HealthWatch, a wide range of groups and organisations have contributed to our JSNA.

1.4 Developments since 2013

As mentioned previously, the JSNA is an on-going process rather than a standalone document. Building on the progress made during 2013, and the principles set out regarding greater public and community involvement, there have been a number of developments through over the past year.

- A topic report has been developed on Diabetes, and is now available on the JSNA webpage. The report includes a range of information on how the condition is affecting the local population, and also incorporates findings from a series of "listening events" which were held in 2013 with diabetic patients that aimed to better understand the views and needs of people living with diabetes. An engagement event was also held with clinicians and stakeholders in January 2014 which echoed many of the patient views. The report is available to download from: www.liverpool.gov.uk/jsna

- A detailed Health Needs Assessment has been carried out looking at the health needs of asylum seekers and refugees in the city. This includes a review of literature and evidence, along with national and local data relating to the numbers, characteristics and trends in people seeking asylum. Importantly, a number of scoping meetings were held with key organisations and groups in the city who provide support to asylum seekers, to gain a more detailed understanding of the health needs of this vulnerable group. The report is available from: healthandwellbeing@liverpool.gov.uk

- Detailed Health Needs Assessments have recently been completed on Alcohol and Dementia. Both assessments involved a wide range of partners, and are being used to help inform the future areas of focus for both issues. These are available from: healthandwellbeing@liverpool.gov.uk

- We have worked with partners across the Liverpool City Region on a number of health needs assessments, including one on the health needs of people with learning disabilities and another looking at the health needs of homeless people. These are available from: healthandwellbeing@liverpool.gov.uk

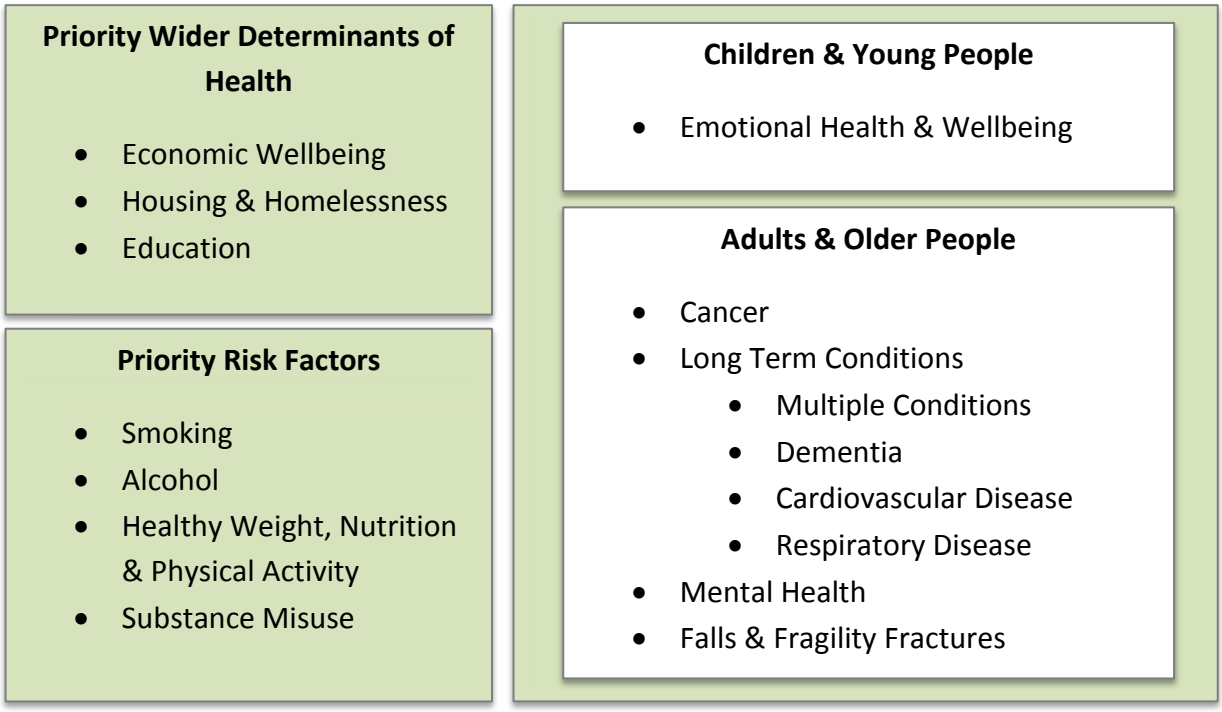
- A JSNA Bulletin has been developed to help keep the community and voluntary sector engaged and informed in the JSNA process. The first bulletin was released in the summer, and further updates will be released periodically. A website for the Health & Wellbeing Board is also being developed, and will act as a source of information on the Board and health and wellbeing in the city.

1.5 Liverpool's Health & Wellbeing Priorities

In deciding the health & wellbeing priorities for the city from the range of issues raised during the JSNA process, a number of criteria were used. The purpose of using these was to screen out issues which have a low impact on the health & wellbeing of local people, or which are less amenable to local action. While these criteria are based on work done by NICE, it is important to recognise that any prioritisation is subjective and in-perfect in its nature.

- Scale & Severity – how does this impact on Liverpool?
- Can we change things through local action?
- Will action reduce health inequalities?
- Will action on this help address other issues too?
- Does the issue link to other priorities, locally or nationally defined?

In September 2013, the Health & Wellbeing Board agreed on a number of priorities based on the criteria above. As part of the process, it was agreed that the priorities would span a number of years, in order to underpin the Joint Health & Wellbeing Strategy, rather than being revised on an annual basis.



Liverpool's Health & Wellbeing Priorities

In addition to the priorities above, a particular focus on certain groups in the population was identified, specifically: Carers, looked after children, children with special educational needs and families with multiple needs.

While the Health & Wellbeing Board have identified the priorities above as areas that when tackled together can bring some of the greatest improvements in health, we recognise that there are many other challenges facing the city in addition to these which are also important.

1.6 Links to the Joint Health & Wellbeing Strategy

Joint Health & Wellbeing Strategy for the city has a vision of creating a "***Fairer, Healthier, Happier Liverpool***". The strategy is the city's overarching approach to improving the health and wellbeing of children and adults, based on the Joint Strategic Needs Assessment and on-going engagement with partners and local communities. The strategy seeks to reduce health inequalities within Liverpool and relative to the rest of the country. It also recognises the needs of those people with protected characteristics who face additional challenges in society for improving their health and wellbeing, over and above their physical and emotional needs.

In responding to the issues identified within the JSNA, the strategy identifies four key health and wellbeing priorities for the city, which all partners on the Health & Wellbeing Board work towards:

1. Giving children the best start in life

Children and young people are at the centre of Liverpool's future sustainability. There is strong evidence that good health and future life chances arise early in childhood, during pregnancy, and even before a baby is conceived. Understanding the importance of key transition points where significant changes occur, such as moving from primary to secondary school, is important in developing policies and interventions that effectively improve health in early years, and give children the best start in life.

2. Health and independence for all

Building on the skills and experiences we develop through our lives is essential to helping us manage our health and maintain our independence. It is important that support to local people is provided in a way that is based on their needs and circumstances, with greater levels of joined up working between services, in the right place, and at the right time.

3. Liverpool people are engaged in improving health and wellbeing

No single organisation in the city has the knowledge, skills or resources to bring about sustainable improvement in health and wellbeing on its own. A collaborative approach is required, bringing together all sectors of society and the public, with on-going engagement built into policy making and the design of services.

4. Building resilient and safe communities

Resilience is the capacity of people to confront and cope with life's challenges; to maintain their wellbeing in the face of adversity at an individual, family and community level. Understanding and harnessing the expertise and assets of local communities is a key element to how they are able to respond to health and wellbeing needs.

The full strategy is available via the City Council website: www.liverpool.gov.uk/jhws

The JSNA is also a resource to inform the development of other plans and strategies for the city, such as the Healthy Liverpool Programme, Children & Young People's Plan and more specific strategies such as the Liverpool Dementia Strategy.

2. Needs & Assets

"**Real gains can be made if Health and Wellbeing Boards look beyond needs to examine how local assets, including the local community itself can be used to meet identified needs. Not only does this approach generate energy and make the best use of all available resources, but it also stimulates innovation, for example through joining up services, to find truly local solutions to address local issues**."

DH 2012, Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategies draft guidance

2.1 What is an Asset?

A health asset is: "any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses." (Foot and Hopkins, 2010)

Examples would include:

- the practical skills, capacity and knowledge of local residents
- the passions and interests of local residents that give them energy for change
- the networks and connections – known as 'social capital' – in a community, including
- friendships and neighbourliness
- the effectiveness of local community and voluntary associations
- the resources of public, private and third sector organisations that are available to support a community
- the physical and economic resources of a place that enhance well-being.

2.2 Asset based working

Asset based working is an approach that aims to strengthen individuals and communities so they can stay well, or better deal with illness. Asset based work takes different forms, including:

- building or supporting resilience in communities e.g. community development work
- working with local assets to extend the reach of existing treatment and support services e.g. using mother and toddler groups to deliver immunisation programmes
- Using assets to reduce the impacts of established problems e.g. health trainers linking individuals into lifestyle programmes locally

2.3 Asset based working - models

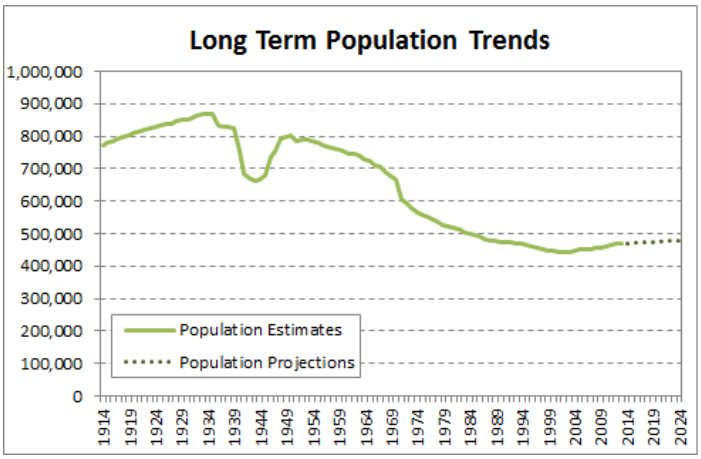
There has been a great deal written about asset based working, and there are a number of models which describe different approaches. Asset based work does represent a very different perspective from traditional services, but offers potential to make a great deal of difference to communities including those most in need. Asset based working fits well with the Marmot principles for reducing health inequality.

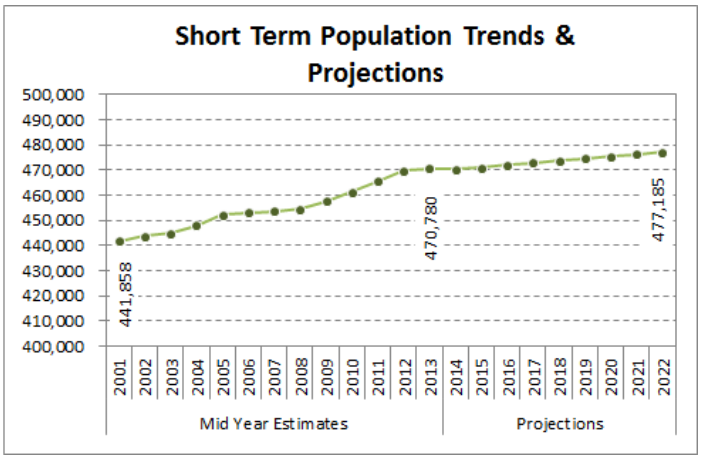
3. Demographics

3.1 Population Trend & Projections

Latest population estimates from the Office for National Statistics show there are currently around 470,800 people living in Liverpool, representing a 7% increase in the population since 2001. Population projections suggest the increase will continue in the medium term, with the number of local residents increasing by a further 6,400 by 2022.

The increase in the population in recent years marks a welcome shift in the long term trend of population decline in Liverpool. The chart below shows how the city's population peaked just prior to the Second World War, when there were almost twice as many people living in Liverpool as there are today. While there was a recovery following the slump in population during the war, this marked the period when the large scale migration from Liverpool began, and led to a rapid decline in population.





Source: Office for National Statistics

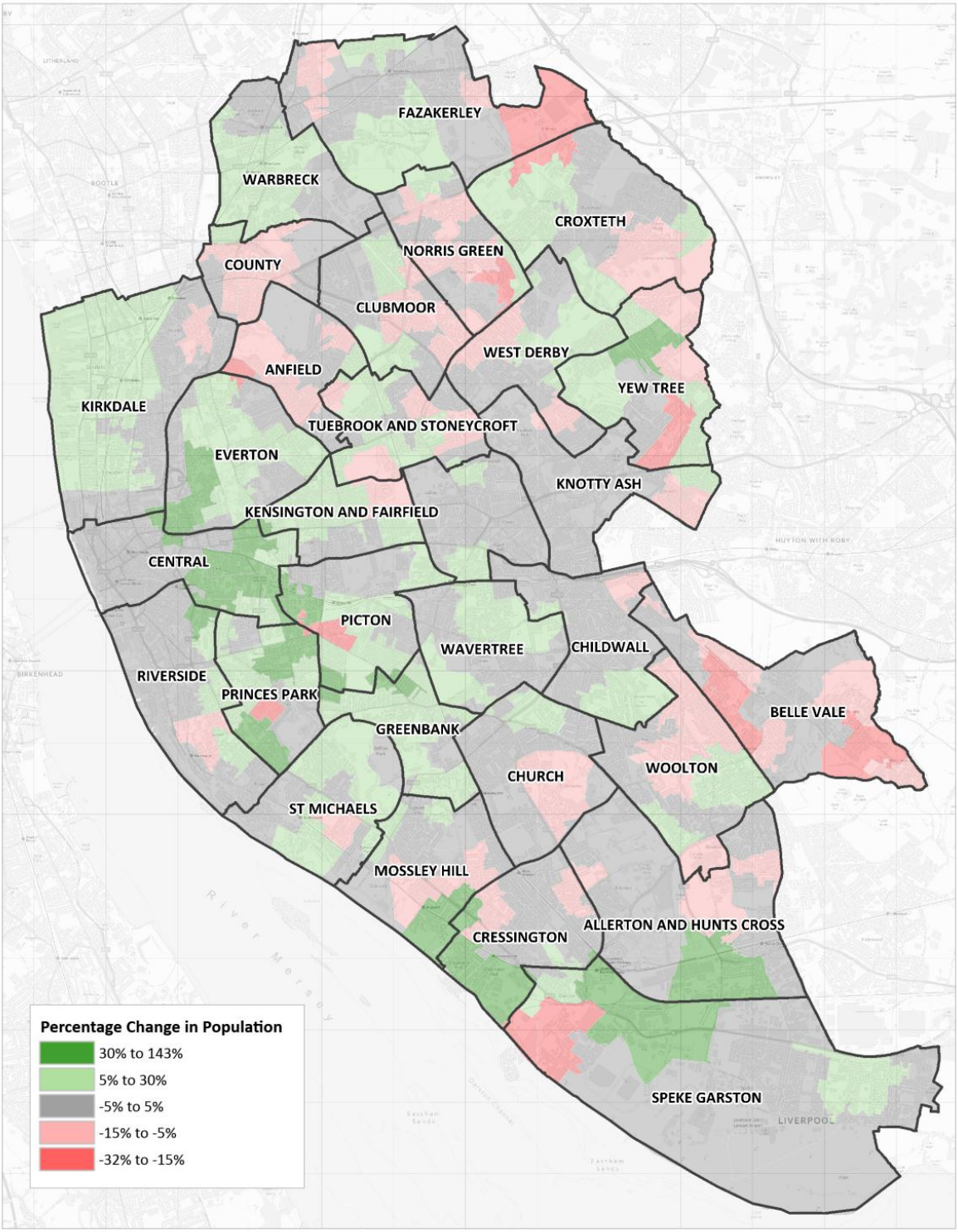
3.2 Internal Population Change

While there has been an overall increase in the population in Liverpool in recent years, this trend has not been uniform across the city. The map opposite shows the change in population within Liverpool between the 2001 and 2011 Census.

The areas of the city shaded grey are those where the population has remained relatively stable over the decade shown, increasing or decreasing by just 5%. Those communities shaded dark red have experienced a large decline in the number of residents, of up to a third. This is particularly notable in Belle Vale ward.

At the opposite end of the spectrum, those areas shaded green have experienced a growth in their population. It is apparent that there have been pockets of growth right across the city, and in some instances this has taken place in communities that are adjacent to areas of population decline. There have been notable increases in the population just outside of the city centre, along with areas in the south of Liverpool.

Such changes in number of residents in local communities will have implications for the location and provision of services.



Population change between the 2001 Census and 2011 Census

Date created: 30/9/2014

Liverpool City Council I Millennium House I Victoria Street I Liverpool L1 6JD

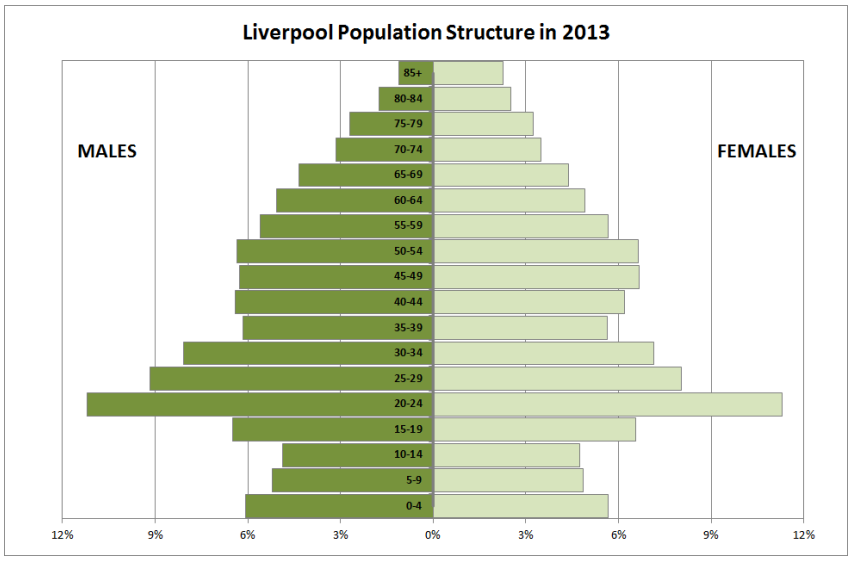
Public Health Liverpool I E: chris.williamson@liverpool.gov.uk

Liverpool City Council

3.3 Population Age Profile

Liverpool has a relatively young population when compared to the rest of the country, with an average age of 37.8 years compared to 39.5 years for England. The average age of the population has remained steady in recent years, despite the increase experienced in other areas.

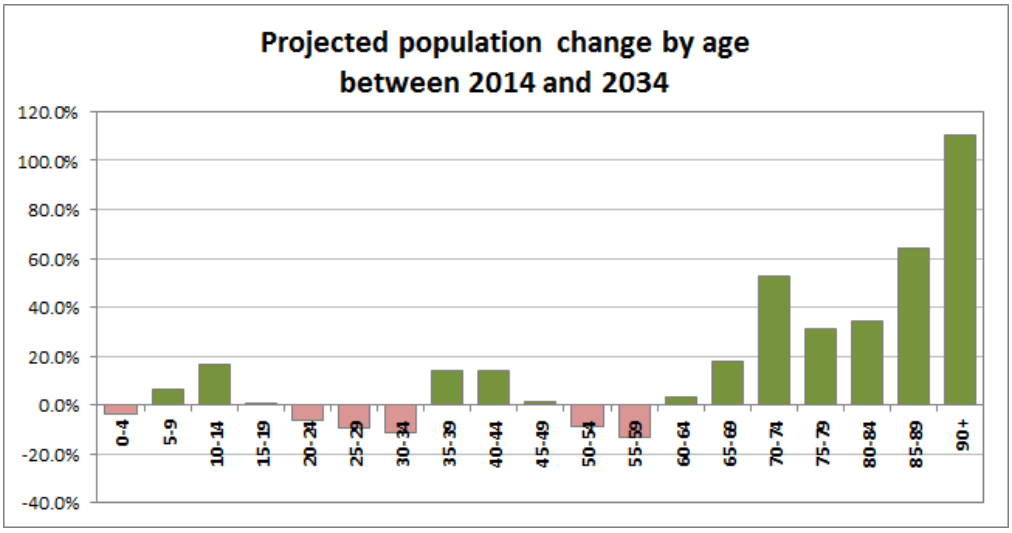
The chart below shows the current population structure of the city. The large 20-24 population is immediately apparent, and is reflective of the large student population within Liverpool. There are over 53,000 people in this age group, representing more than 11% of the population, compared to 7% in England.



Age Band	Males	Females	Persons
Under 1	2,890	2,800	5,690
1-4	11,220	10,680	21,900
5-9	12,120	11,600	23,720
10-14	11,350	11,290	22,640
15-19	15,100	15,650	30,750
20-24	26,070	26,940	53,010
25-29	21,340	19,150	40,480
30-34	18,790	17,010	35,800
35-39	14,290	13,460	27,750
40-44	14,930	14,780	29,710
45-49	14,600	15,880	30,480
50-54	14,750	15,800	30,550
55-59	13,020	13,520	26,540
60-64	11,780	11,710	23,490
65-69	10,130	10,420	20,550
70-74	7,320	8,300	15,630
75-79	6,250	7,730	13,970
80-84	4,100	6,000	10,100
>84	2,600	5,430	8,030
Total	**232,640**	**238,140**	**470,780**

Source: Office for National Statistics, 2013 Mid-Year Estimates

While the city has a relatively young population, the Office for National Statistics project a substantial increase in the number of children and older people in Liverpool over the coming decade. The chart below shows that over the next 20 years, the biggest change in population in Liverpool will be the increase in those aged 60 and over. It is estimated that the number of people in this age group will increase by almost 30%, the equivalent of an additional 27,300 people. The number of elderly people 90 and over in Liverpool is projected to more than double over the period, to 5,900.



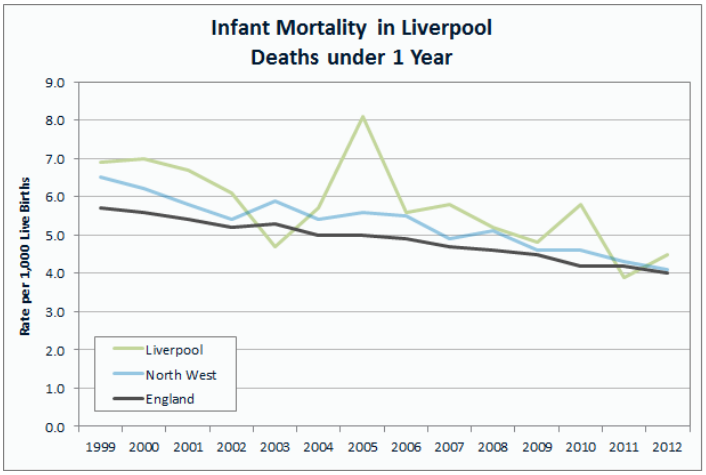
Source: Office for National Statistics, 2012 SNPP

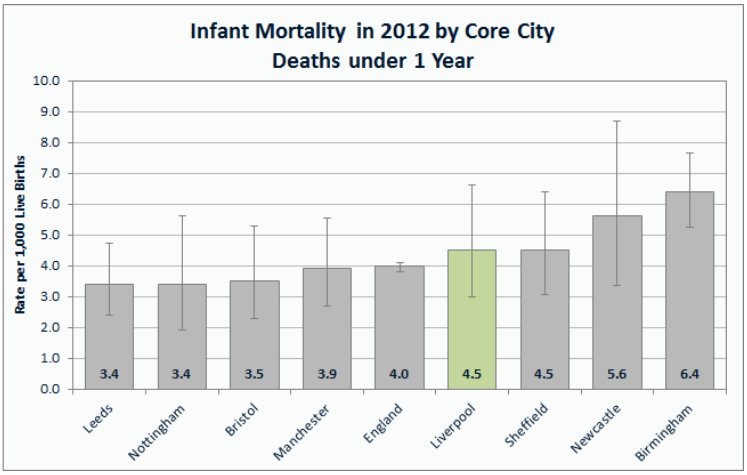
4. Healthy Start - Early Years & Childhood

4.1 Infant Mortality

Infant mortality is often used as a measure of the overall health and wellbeing of the population, reflecting a wide range of factors that influence health, such as economic development and living conditions as well as issues of illness and disease.

In 2012 there were 27 deaths in Liverpool which occurred within the first year of life. While the infant mortality rate in Liverpool increased slightly between 2011 and 2012, the long term trend is a positive one, with a reduction of more than a third since 1999. While the infant mortality rate in the city is above regional and national levels, confidence intervals show the difference is not statistically significant. In addition the gap in the infant mortality rate between Liverpool and England is significantly lower in 2012 than in 1999.





Source: NHS Outcomes Framework

4.2 Births

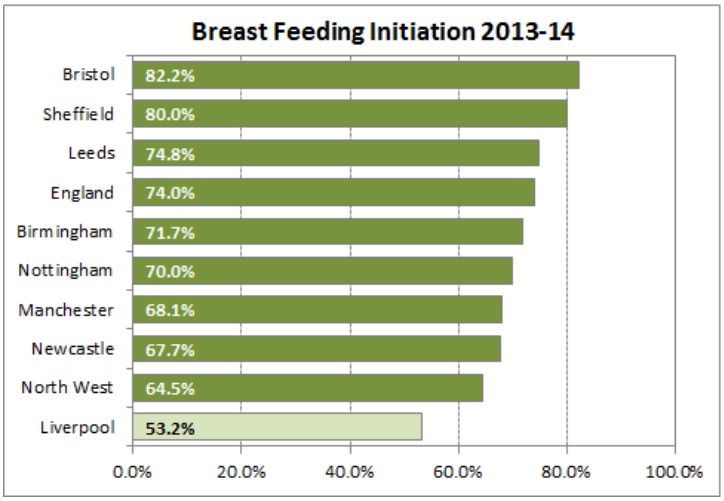
In 2012 there were 5,942 live births in Liverpool. This represents an increase of over a fifth since 2002 (20.7%). While the number of births in the city is increasing, fertility rates remain below national levels. The total period fertility rate (TPFR) measures the average number of children which would be born to a woman if they experienced the same age specific fertility rates throughout her life. Figures for Liverpool show the TPFR in 2011 was 1.66 – a rate considered below replacement level (2.1).

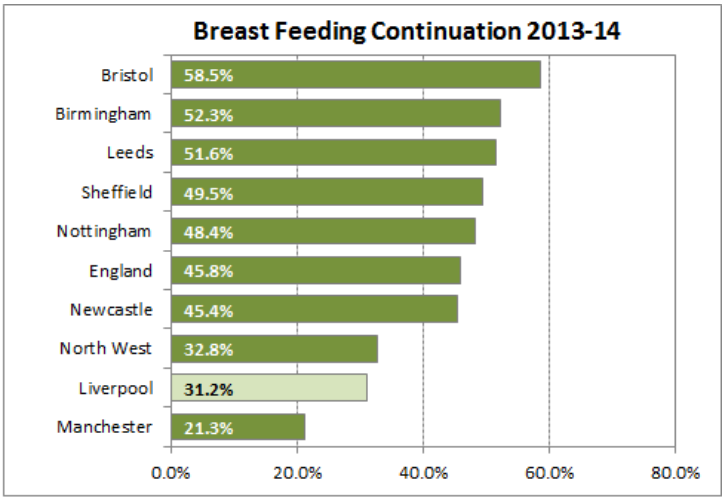
4.3 Breast Feeding

Breast feeding has huge health benefits to both mother and baby. Breastfeeding mothers enjoy benefits such as reduced risk of breast and ovarian cancer as well as weight loss post-delivery. Breast fed babies have reduced risk of infections such as ear, respiratory, urinary tract and gastroenteritis, they learn appetite control so as adults are less like to over eat, they gain protection against developing diabetes and have a lower risk of sudden infant death syndrome.

The percentage of women in Liverpool initiating breast feeding within the first 48hrs after birth has increased slightly over the last few years, from 48% in 2005-06 to 53.2% in 2013-14. Latest results show that the prevalence of breast feeding initiation in Liverpool is the lowest among the 8 core cities, and significantly below both regional and national levels.

As with breast feeding initiation, the levels of breast feeding at 6-8 weeks from birth in Liverpool have increased slightly since monitoring began. However, a large number of records at this stage do not include a feeding status, making it difficult to understand the true prevalence of breast feeding continuation. Latest figures show that breast feeding at 6-8 weeks in Liverpool is the second lowest among the 8 core cities in England, and almost half that of Bristol.

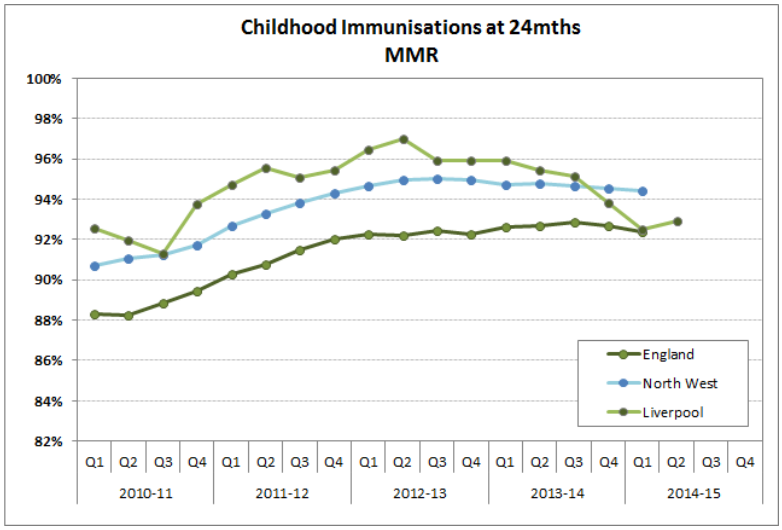




Source: NHS England

4.4 Immunisations

Immunisation is one of the most effective public health interventions, saving lives and promoting good health. It is the process of protecting individuals from infection through passive or active immunity and protects individuals and the population against serious diseases. If a person is not immunised, they will be at risk from catching the disease and will rely on other people being immunised to avoid becoming infected. Low uptake of the national childhood immunisation among the population increases the risk of disease outbreaks, as seen with recent cases of measles.



The chart opposite shows the trend in uptake of the MMR vaccine among children prior to their 2nd birthday.

From 2010 there was a steady increase in uptake of the vaccine both locally and nationally. However in Liverpool, this increase peaked in the summer of 2012, and has since fallen to 92.9% of children. While this is comparable with national uptake, this is below the recommended 95% threshold.

Source: Public Health England – COVER statistics

4.5 Oral Health

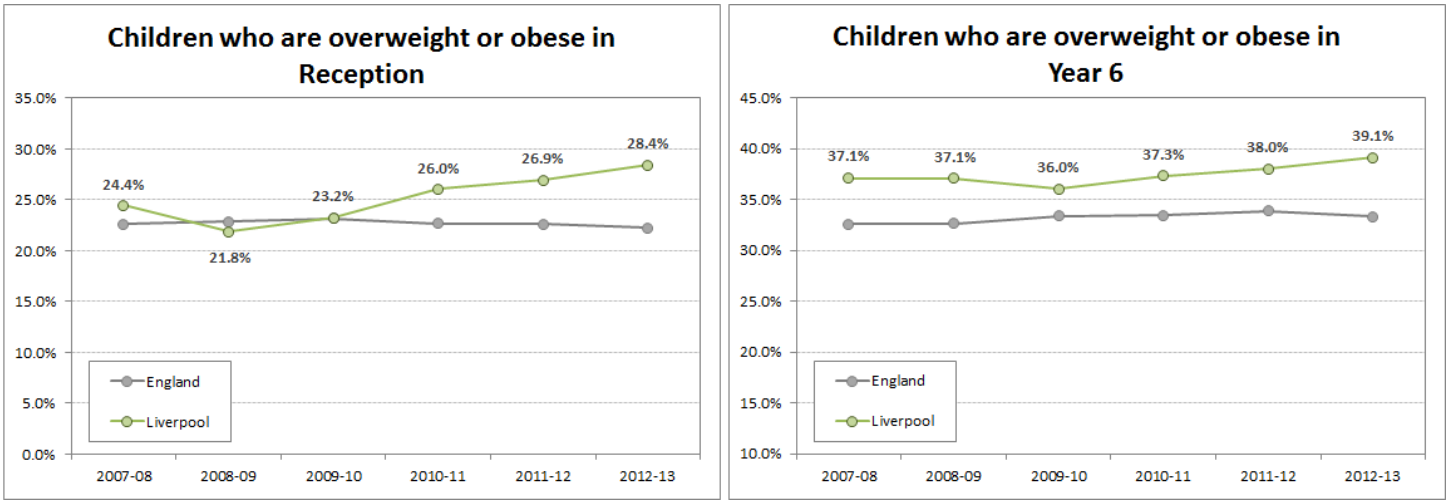
Good oral health is an integral part of general health and well-being, and trends indicate that children's oral health has been improving over the past 30 years in the UK. In spite of this, national surveys highlight persistent inequalities in oral health which are strongly associated with deprivation and social background. Children with disabilities, looked after children and other 'vulnerable' children may be at particular risk of poor oral health, and improvements in the oral health of 5 year olds have not been as great as in 12 and 15 year old children.

Severe tooth decay remains a problem among young children in disadvantaged communities, with the associated dental problems of toothache, abscesses and extractions. The 2012 Oral Health Survey shows that in England, 27.9% of five-year-old children had experience of dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries. The remaining 72.1% were free from visually obvious dental decay. This compares to more than a third of children in Liverpool (35.8%).

4.6 Healthy Weight

Childhood obesity is one of the most serious public health challenges of the 21st century. Overweight and obese children are likely to stay obese into adulthood and more likely to develop non-communicable diseases like diabetes and cardiovascular diseases at a younger age.

Data collected through the National Child Measurement Programme indicates that prevalence of children in Reception who are overweight or obese is increasing year on year in Liverpool, whereas the national prevalence is stable. In 2012-13, 28.4% of children were overweight or obese, compared to 22.2% in England.



Source: National Child Measurement Programme (NCMP) & Public Health Epidemiology Team

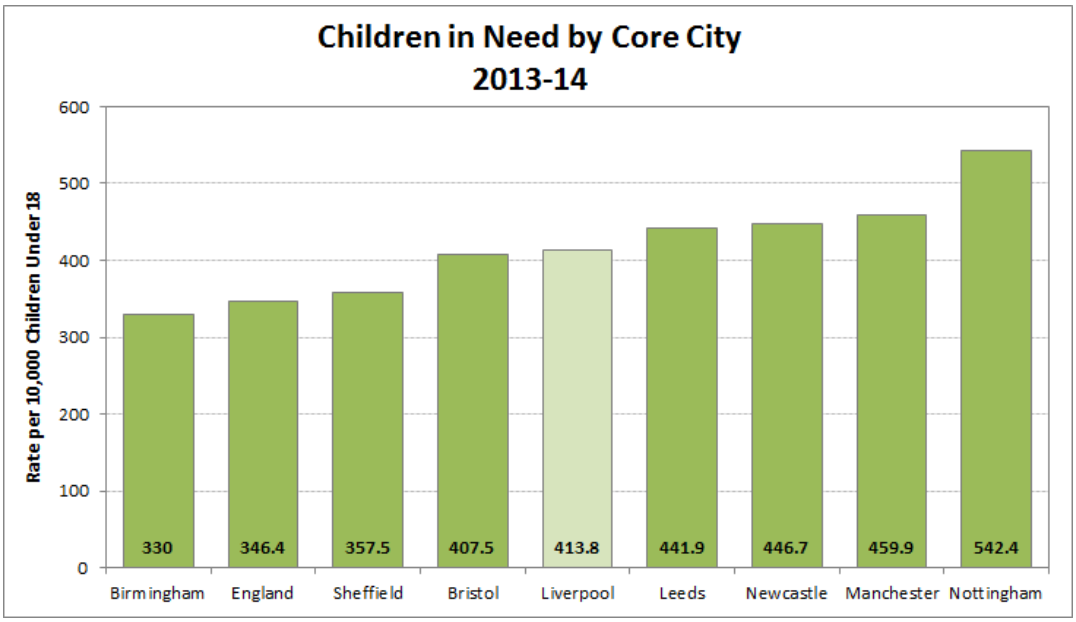
By Year 6, the prevalence of children who are overweight or obese increases again. In 2012-13, around 4 in 10 children were considered to be overweight or obese. While trends indicate this has remained relatively stable in recent years, this represents a significant proportion of the population.

More detailed information on the childhood obesity and healthy weight is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

4.7 Children in Need

Families are perhaps the most important factor in children's lives and whilst the vast majority of children can rely on their families to provide them with the care and support they require, some families struggle. Children in Need (CIN) are those who have been assessed by children's social care to be in need of services. These services can include, for example family support (to keep together families who are experiencing difficulties), leaving care support (to help young people who have left local authority care), adoption support, or disabled children's services (including social care, education and health provision).

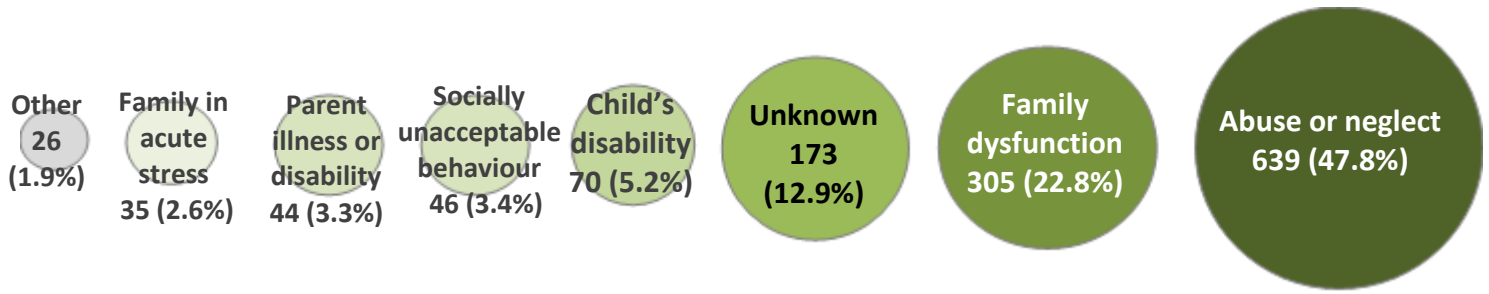
At 31st March 2014, there were 3,686 children in need in Liverpool. While the rate of children in need in the city is above national levels, it is comparable with the core city average.



Source: Department for Education

The reasons that children under-five are designated CIN in Liverpool are shown in below. Abuse and Neglect is the cause of almost half of all CIN in Liverpool. Persistent failures to meet a child's basic physical and or psychological needs, and exposure to violent behaviour, are each likely to lead to a serious impairment of a child's health or development.

Causes of CIN in under-fives, Liverpool

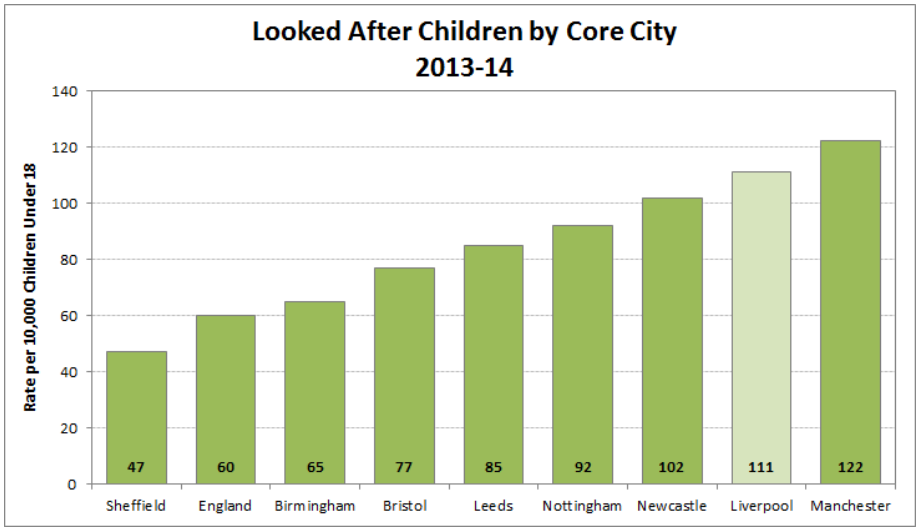


Source: Liverpool Children's Services

4.8 Looked After Children

Entering care is strongly associated with poverty and deprivation and with emotional and mental health problems. The majority of young people that enter the care system do so because of abuse or neglect and family difficulties. Outcomes for children and young people in care are poorer than the general child population; additional support is required if they are to have the same life chances as their peers.

In Liverpool, 990 Children are in Care. The chart below shows the rate of Looked After Children per 10,000 of the under 18 population in the core cities. Figures indicate the city has a relatively high number of Looked After Children in comparison to other major cities, behind only Manchester.



Source: Department for Education

4.9 Families

The Families Programme was launched by the government in 2011 with the intention to break the cycle of disadvantage and turn the lives around of 120,000 families nationwide by 2015. A 'troubled family' is characterised as being a family where adults are not working, children do not attend school and members of the family are involved in anti-social behaviour (ASB) or crime (DCLG, 2012).

To date, the Families Programme has worked with 2,308 families across Liverpool. There is distinct geographical disparity across the city with high numbers of families located around the city centre, in north Liverpool and in Speke-Garston; excluding Speke-Garston, wards in the south of the city tend to have comparatively low numbers of families.

The focus of the programme has been extended; alongside the existing strategic priorities agreed at the outset (whole-family approach; intelligence-led early intervention; public sector coordination; sustainability; aligning social and economic outcomes), the focus for the future will be: Early Years, NEETs and mental health. The broader focus will allow the programme to take a more preventative approach.

The new focus on Early Years has resulted in the headline problem of 'children who need help'. The new headline enables local authorities and their partners to go beyond families with school age children who have poor attendance or are involved in youth crime. Three additional, related groups will be identified:

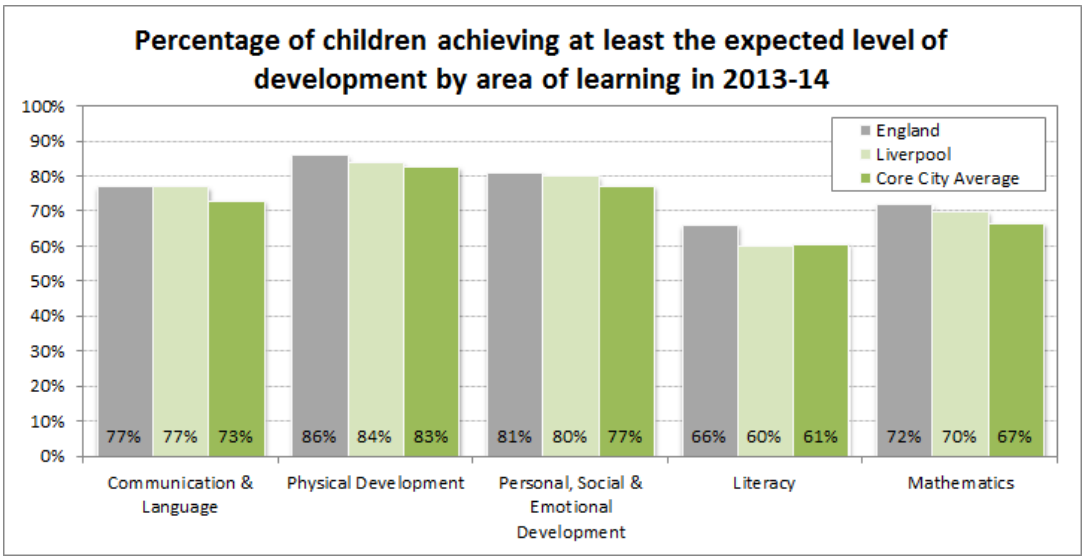
- Those with younger children;
- Children of all ages who are known to services as having problems, but do not yet reach the threshold for a statutory intervention;
- Those whose problems are serious enough that they reach the threshold for a statutory intervention.

4.10 School Readiness

The Early Years Foundation Stage (EYFS) is the framework which sets standards for child development. A child is deemed to have reached a 'good level of development' and is 'school ready' if they have achieved at least the expected level of development in early learning in all of the following areas:

- Communication and Language
- Physical Development
- Personal, Social and Emotional Development
- Literacy
- Mathematics

In Liverpool 53% of children achieve a good level of development across all early learning goals, compared to 58% of children nationally. There is a significant gender gap (mirroring national patterns), with 62% of girls achieving a good level of development compared to 43% of boys. The chart below shows the percentage of children achieving at least the expected level of development, across the main areas of learning in 2013-14. It is apparent that while achievement in Liverpool is slightly behind national levels, we are ahead of the core city average. Achievement is lowest in areas of literacy and mathematics, mirroring national patterns. Girls outperform boys across all of the early learning goals, with the gap widest in Literacy.



Source: Department for Education

5. Healthy Transition - Young Adulthood

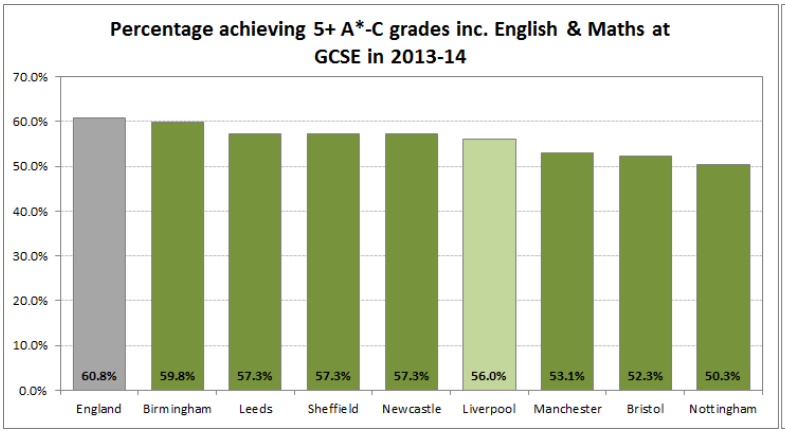
5.1 Education

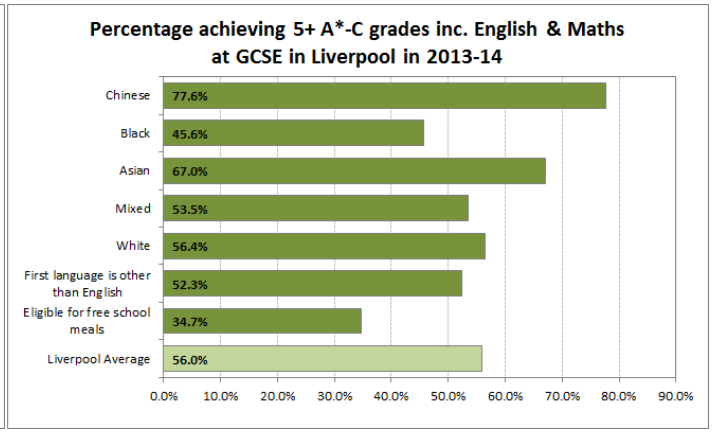
Education is one of the most important wider determinants of health, with poor education associated with poorer health outcomes and lower life expectancy. Not only is education strongly linked to health outcomes, there is also a large body of evidence which shows that education is linked to health behaviours such as smoking, alcohol and substance abuse and diet. These links have been shown to exist even when other factors such as income are taken into account. In addition to influencing healthy outcomes, education can impact on broader health issues such as social engagement.

The Marmot Review in 2010 highlighted that the influence of families on educational attainment is one of the most important influencing factors, and emphasises the need for strong links between schools, families and other services to ensure children achieve the best start in life.

GCSE results for 2013-14 show that the number of children achieving 5+ A*-C has been above national levels for the past five years. The Liverpool average for the year was 56%, slightly below the national average of 60%. Levels of educational attainment in Liverpool are in line with the core city average (55.5%), and are above those in Manchester, Bristol and Nottingham. However, attainment varies markedly within different groups in the city, with just over a third of those eligible for free school meals achieving 5+ GCSEs grade A* to C. When comparing different ethnic minorities, attainment among those from a chinese background is 32% higher than those from black minority groups.

Educational attainment of Children in Care is of particular concern; the attainment gap is the widest of any group both locally and nationally. In 2012, only 15% of LAC in Liverpool gained 5 A*-C GCSEs including English and maths, compared with 56.8% of all Liverpool children. Young people who do not achieve five or more GCSEs are more likely to become NEET after leaving school.





Source: Department for Education

More detailed information on education and health is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

5.2 NEET

Significant numbers of young people who are not in education, employment or training (NEET) are becoming one of the most serious social problems in the UK. Young people who are NEET often experience a number of long term issues, including:

- **Disconnection from the expectations of the labour market –** particularly employability skills.
- **Wage scarring** – adults who were NEET as a young person tend to earn lower wages than peers who were not.
- **'Churn'** – NEET young people are more likely to be repeatedly unemployed as adults than those who were not.
- **Greater propensity to mental illness –** NEETs are more likely to suffer from stress and depression.
- **Increased participation in crime –** high numbers of NEETs are particularly involved in property crime.
- **Decreased self-confidence –** which can hamper the likelihood of employment.

Preventing young people from becoming NEET can reduce the likelihood of them being unemployed adults. Young people become NEET for a variety of reasons; some are looking for work but lack skills and work experience, others have caring responsibilities, while others have long-term disabilities or health conditions.

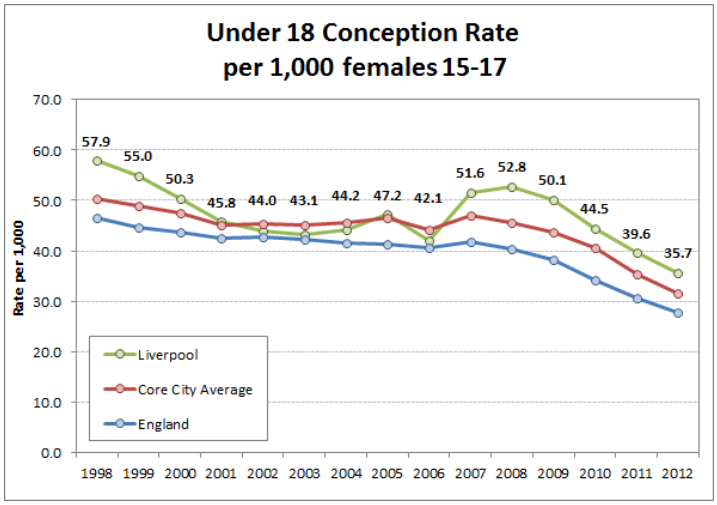
There are currently 1,500 young people in Liverpool who are NEET, with particularly high concentrations in north Liverpool, around the city centre, and in Speke Garston.

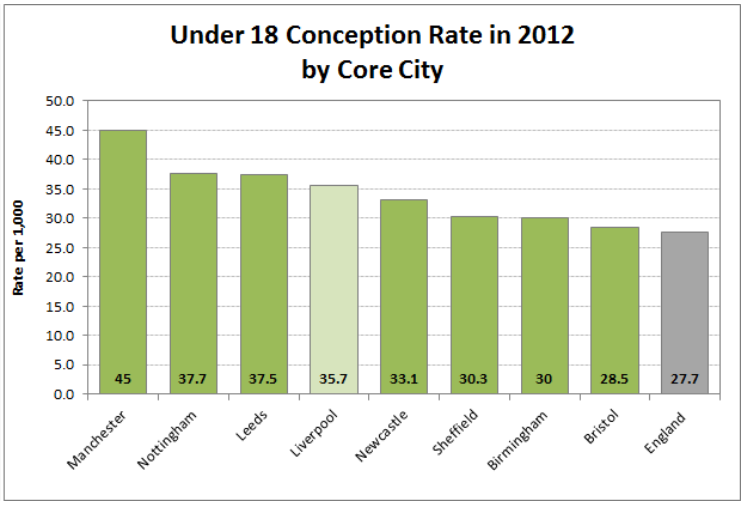
Being NEET is often connected to other issues such as teenage pregnancy, substance abuse and Children who are, or have previously been, in Care (LAC). The three most predominant complex characteristics of the NEET cohort in Liverpool are: Teenage Mothers, Learning Difficulties or Disabilities (LDD) and Looked After Children (LAC).

5.3 Teenage Pregnancy

There is a wide body of literature highlighting the importance of tackling teenage pregnancy. Babies born to teenage mothers are more likely to experience a range of negative outcomes later in life, and are up to 3 times more likely to become teenage parents themselves (DCLG, 2007). Tackling teenage pregnancy can therefore help to reduce health inequalities and tackle social exclusion.

Liverpool's under 18 conception rate was 57.9 per 1,000 15-17 year olds (total of 492 conceptions) in the baseline year of 1998, and has fallen significantly to a rate of 35.7 in 2012 (total of 278 conceptions). This represents a 38.3% reduction in the rate since 1998. While the reduction is less than that seen nationally (40.6%), it is greater than that for the North West (37.2%). When compared to other core cities in England, Liverpool is ranked 4th highest, behind Manchester, Nottingham and Leeds.





Source: Office for National Statistics & Public Health Epidemiology Team

More detailed information on the emotional health & wellbeing of children and young people is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

5.4 Emotional Health & Wellbeing

Poor emotional health has an impact on a wide range of issues, such as physical health, education, employment, parenting, relationships, smoking, substance misuse, unwanted pregnancy, and crime. Research by the Office for National Statistics in 2005 suggested that just under 1 in 10 children aged under 16 will have some form of mental disorder, with the prevalence increasing with age.

The research indicates the most prevalent condition is emotional disorders, with up to 1 in 27 young people aged 5 to 16 having the condition. Lack of robust local information makes it difficult to obtain a true picture of the extent of mental health problems affecting children and young people; however the table below provides an indication based on national prevalence rates.

Condition	National Prevalence			Local Estimates		
	Boys	Girls	All	Boys	Girls	All
Emotional Disorders	3.1%	4.3%	3.7%	893	1,202	2,100
Conduct Disorders	7.5%	3.9%	5.8%	2,161	1,090	3,292
Hyperkinetic Disorders	2.6%	0.4%	1.5%	749	112	851
Less Common Disorders	1.9%	0.8%	1.3%	547	224	738
Any Disorder	11.4%	7.8%	9.6%	3,284	2,180	5,449

Source: ONS, 2005

Note: Figures may not tally due to individuals having more than one condition.

More detailed information on the emotional health & wellbeing of children and young people is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

5.5 Young Carers

A young carer is a child or young person under the age of 18, who provides care to another family member usually an adult, who has a physical illness/disability; mental ill health; sensory disability; has problematic use of drugs or alcohol or is HIV positive. The level of care they provide would usually be undertaken by an adult and as a result of this has a significant impact on their normal childhood.

Results from the 2011 Census show that over 5,100 people in Liverpool aged under 25 identified themselves as providing unpaid care, equating to 3.5% of that group. The level of unpaid care provided by young people in the city is the highest among the eight core cities in England, and significantly above both national and regional levels.

Over 1,000 children under the age of 16 in the city provide unpaid care, with more than 200 of these doing so for more than 20hours per week. Considerable effort needs to be put into improving the identification of young carers in Liverpool and quality of available data. Data captured by Barnardos Liverpool Action With Young Carers Service is the most reliable source of information about young carers in Liverpool. In 2012-13 the service supported 156 Young Carers.

Of that cohort, the primary illness or disability of the person being cared for was mental illness, accounting for over a third of young carers. Mental illness was also a factor identified in caring for people with drug & alcohol issues and physical disabilities.

More detailed information on young carers is contained in the JSNA topic report, available from:
www.liverpool.gov.uk/jsna

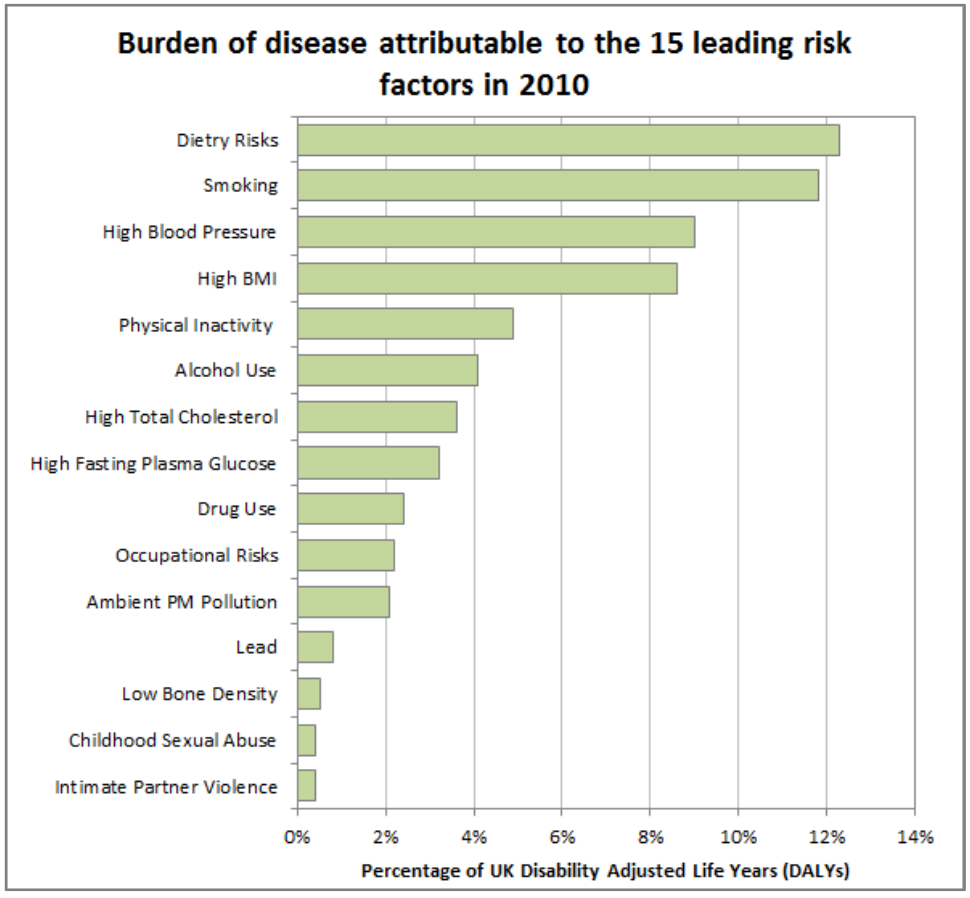
6. Healthy Adulthood

6.1 Risk Factors

Disability adjusted life years (DALYs) are a measure of both premature mortality and disability. They are used as a way of monitoring the overall burden of illness or disease within the population. Research by the Institute for Health Metrics & Evaluation shows that three risk factors account for the most disease burden in the United Kingdom:

- dietary risks
- tobacco smoking
- high blood pressure

Together, these 3 factors account for a third of the burden of disease in the country. The leading risk factor for both children under 5 and adults aged 15-49 years was tobacco smoking in 2010 (tobacco smoking as a risk factor for children is due to second-hand smoke exposure). The chart below shows the overall burden of disease in the UK which can be attributed to the top 15 risk factors. Together, these factors account for two thirds of the burden of disease in the country, underlining the importance of prevention in improving health and wellbeing. Alongside these factors, the prevalence of key lifestyle behaviours in Liverpool are shown



98,000 adults smoke (25%)

30,150 adults drink at "increasing risk" and 11,500 drink at "high risk"

Over half of adults are overweight or obese (55%)

1 in 4 adults have fast food at least once a week

2 in 3 adults are physically inactive

Source: Institute for Health Metrics & Evaluation and Liverpool Lifestyle Survey 2012-13

The analysis by the World Health Organisation highlights the importance of unhealthy lifestyle behaviours in determining the burden of disease and illness within the population. The diagram below highlights some of the key lifestyle behaviours in Liverpool. More detailed information on these issues is contained within the JSNA themed reports, available on the JSNA webpage: www.liverpool.gov.uk/jsna

Diet	• 38% of Liverpool adults eat 5 portions of fruit & vegetables a day • Women and BME groups are significantly more likely to eat 5 a day, compared to others • 1 in 4 adults eat fast food at least once a week
Smoking	• 1 in 4 Liverpool adults are current smokers, equating to 98,000 people • Smoking in the home takes place in around a fifth of Liverpool households • 13% of Liverpool adults have tried e-cigarettes
Healthy Weight	• Just over 2 in 5 Liverpool adults are a healthy weight (43%) • Just over a third are overweight (34%), with an additional 21% being obese • Men are significantly more likely to be overweight, and prevalence increases significantly with age.
Alcohol	• Over half of those who drink alcohol, do so one to three times a week • 30,150 adults drink at "increasing risk", and a further 11,500 drink at "high risk"
Physical Activity	• 1 in 3 Liverpool adults (34%) take part in 30mins of sport or physical activity a week • 2 in 3 adults are physically inactive
Substance Misuse	• The Liverpool rate of opiate use/crack use is significantly higher than England and the highest among core cities • Over 4,500 adults are currently in treatment for substance misuse

Source: Merseyside Lifestyle Survey 2012-13

In 2011, the Chief Medical Officer highlighted the fact that many cases unhealthy lifestyle behaviours cluster together. The Health Survey for England shows that approximately 25% of those aged 16 and over report one lifestyle risk factor, 33% two risk factors, 23% three risk factors and 12% four or more risk factors. Only 7% of adults have no risk factors. This clustering underlines the importance of taking a person centred approach, and understanding how these different behaviours interact is crucial to improving the health of local people, and in reducing health inequalities.

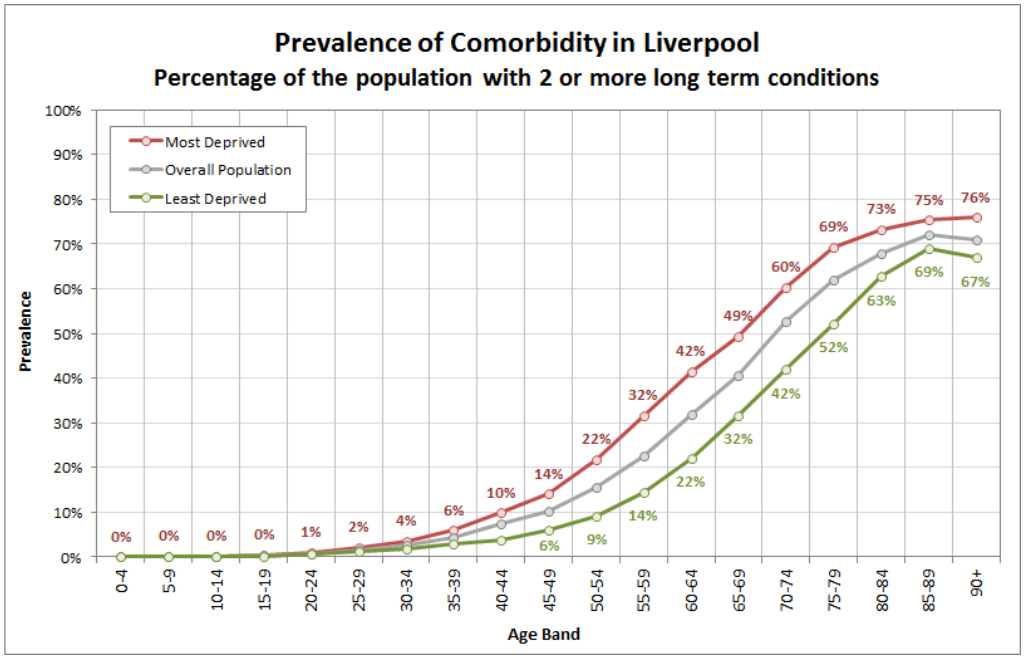
6.2 Burden of Disease

The increasing prevalence of co-morbidities (people living with 2 or more long term conditions) is one of the major challenges facing the health and care system. People with multiple long term conditions require more complex care and support packages, and often face poorer health outcomes. Nationally, the overall prevalence of long term conditions is projected to remain relatively stable over the next 10 years, however the prevalence of comorbidities is expected to increase by more than 50%. The Department of Health has identified two distinct population groups at risk of co-morbidity:

- Younger, socially deprived populations, with greater exposure to risk factors. In particular smoking, obesity, alcohol and physical inactivity due to challenging personal, occupational and societal factors throughout the life course.
- Older population whose comorbidity is mainly driven by increased life expectancy and longer exposure to risk factors over the course of their life.

These different groups require very different interventions and support, with prevention (both primary and secondary prevention) and action on the wider determinants of health more important for the first group, and support to maintain independence and day to day activities more relevant to the latter.

In Liverpool, 1 in 5 people have a single long term condition (equating to roughly 92,400 people), with just over 1 in 10 people having 2 or more long term conditions (equating to roughly 49,500 people). The diagram below shows the percentage of people in Liverpool with two or more long term conditions by age and deprivation in September 2014.

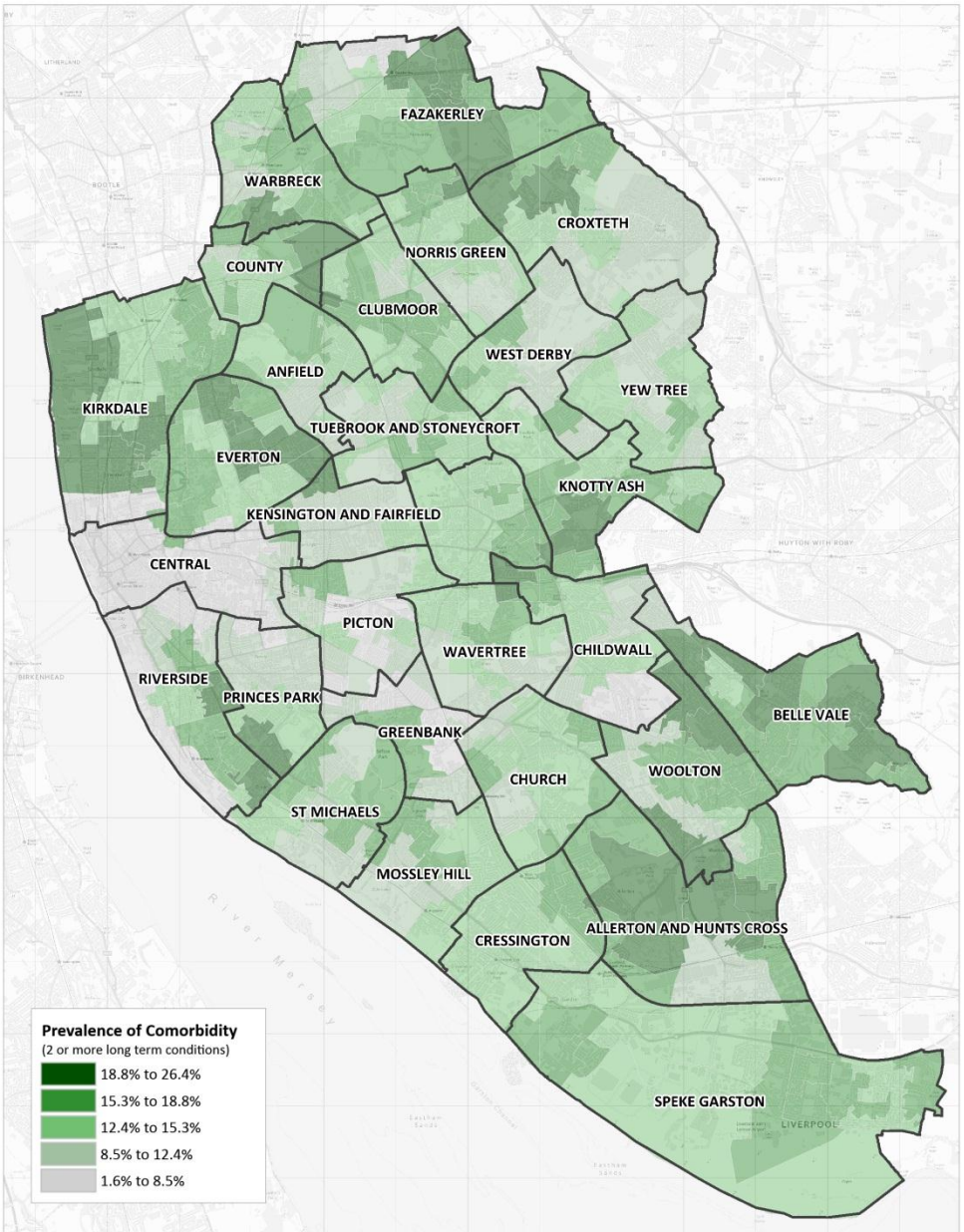


Source: Liverpool CCG – Primary Care Extract, September 2014

As expected, the prevalence of comorbidity increases with age, peaking at just over 70% for those aged between 85 and 89. However, there is a clear distinction between the most deprived and least deprived areas of the city, with the prevalence increasing at an earlier and faster rate among the most deprived communities. From the age of 30, the difference in co-morbidity between the most and least deprived communities becomes statistically significant.

The map below shows how the prevalence of co-morbidity varies across the city, based on patients registered with Liverpool General Practices and living within the city. It is apparent that prevalence is lowest in the city centre area, going out through Picton and parts of Greenbank and Wavertree wards. This is likely to be driven by the relatively young population, with many students living those communities.

Areas with a high prevalence of co-morbidity are dotted across Liverpool, however there is a concentration across the north of the city, in addition to Belle Vale and Allerton & Hunts Cross.



Prevalence of Comorbidity (2 or more long term conditions) in 2014

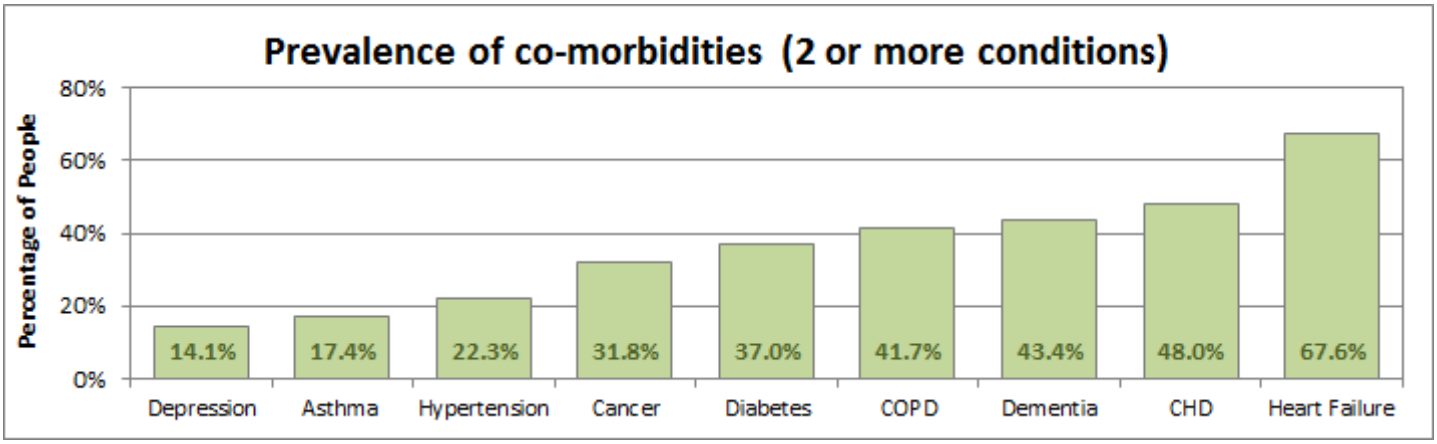
Date created: 21/10/2014

Liverpool City Council I Millennium House I Victoria Street I Liverpool L1 6JD

Public Health Liverpool I E: chris.williamson@liverpool.gov.uk

Liverpool City Council

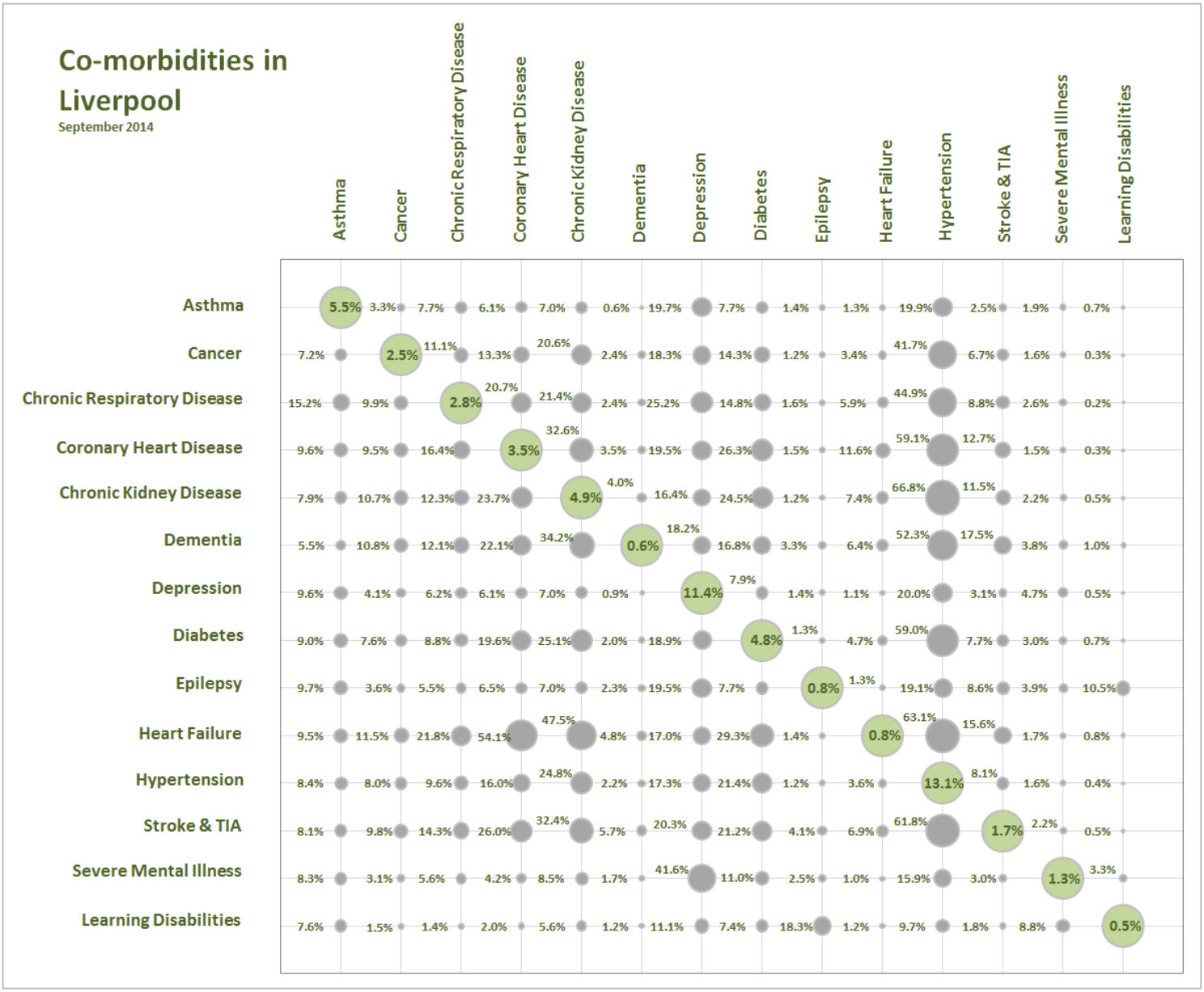
While the overall prevalence of co-morbidities is just over 10% of the population, this varies markedly by condition. For example, 14.1% of people with Depression have been diagnosed with 2 or more long term conditions (in addition to depression), and this increases to 67.6% of people who have been diagnosed with Heart Failure.



Source: Liverpool CCG – Primary Care Extract July 2014

The impact of having multiple long term conditions on the overall health and wellbeing of the individual varies depending on the conditions concerned. Those people with mental health conditions experience poor health outcomes when they have additional long term conditions, with the prevalence of mental health conditions often masking the presence of other physical health conditions.

The diagram below illustrates the diagnosed prevalence of various long term conditions among the Liverpool population, shown in the green circles, and also shows the prevalence of co-morbidity for people with each condition.



Case Study: Diabetes

4.8% of the population has been diagnosed with Diabetes.

Of these patients:

- **18.9%** also have a diagnosis of Depression, compared to **11.4%** for the general population.
- **2.0%** also have a diagnosis of Dementia, compared to **0.6%** of the general population.
- **19.6%** also have a diagnosis of Coronary Heart Disease, compared to **3.5%** of the general population.
- **59%** also have a diagnosis of Hypertension, compared to **13.1%** of the general population.

Source: Liverpool CCG – Primary Care Extract June 2014

The diagram below presents some of the key facts for the main health conditions in Liverpool. Together, these account for the majority of illness and premature mortality. More detailed information for each of these is conditions, and action being taken to improve health outcomes is available from the JSNA webpage: www.liverpool.gov.uk/jsna

Cancer

- There are around 11,800 people in Liverpool who have been diagnosed with cancer. Lung cancer is the most prevalent cancer among men, whereas breast cancer is the most prevalent cancer among women.
- Cancer is the leading cause of premature death (38%), and survival rates are below the core city average.
- Uptake of the three cancer screening programmes in Liverpool is comparatively low.

Cardiovascular Disease

- There are around 45,800 people in Liverpool who have been some form of cardiovascular disease.
- Cardiovascular disease is the second leading cause of premature death (24%), however mortality rates have more than halved since 1995.
- Uptake of NHS HealthChecks in Liverpool is improving, with more than half of those offered a check recieving one.

Respiratory Disease

- More than 13,100 people have been diagnosed with chronic respiratory disease (COPD), with 29,600 people diagnosed with asthma.
- Respiratory illnesses are the third leading cause of prematrure mortality (19%). Mortality rates have fallen by 16% since 1995.
- Respiratory problems were the second largest cause on emergency admissions to hospital in 2013-14.

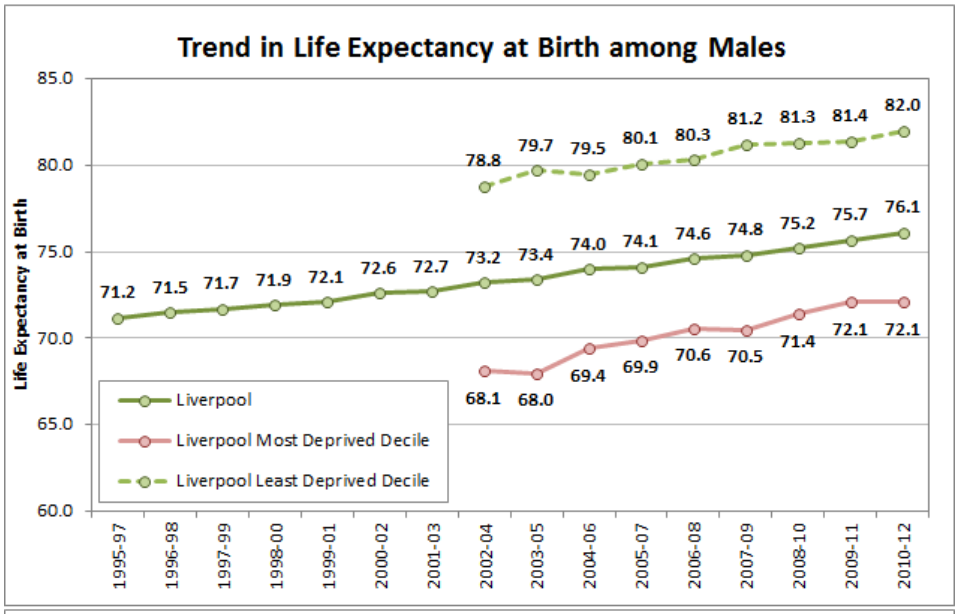
Mental Health

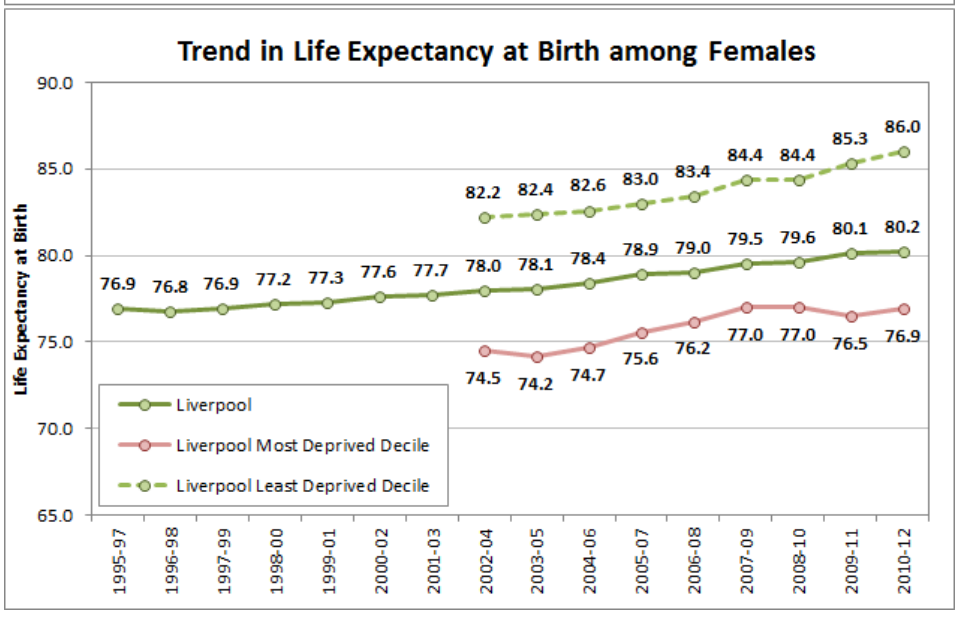
- Mental health problems are estimated to effect a quarter of the population at any one time.
- Liverpool has the second highest prevalence of mixed anxiety & depressive disorders among the core cities.
- Over 53,200 people have been diagnosed with depression, and almost 6,000 with severe mental illness.
- Physical health outcomes for people with mental illness are poorer than the general population.

7. Healthy Ageing – Older People

7.1 Life Expectancy

Life expectancy at birth is used as an overarching measure of the health of the population. The charts below show how there has been a steady increase in life expectancy in Liverpool, with males expected to live 4.9 years longer than they were in 1995-97 and females 3.3 years longer. Current life expectancy in Liverpool stands at 76.1 years for males and 80.2 years for females. This compares to national levels of 79.2 and 83.0 respectively.





The charts also show the trend in life expectancy within the most deprived and least deprived areas of the city, and it is apparent that the overall increase for Liverpool as a whole masks wide variation.

Men born in the least deprived areas of Liverpool at expected to Liverpool 9.9 years longer than their counterparts in the most deprived areas. Encouragingly, this gap does appear to be narrowing, down from 10.7 years in 2002-04.

In contrast, the life expectancy gap for females in Liverpool is widening, from 7.7 years in 2002-04 to 9.1 years in 2010-12. This has been driven by a leveling off in life expectancy among women in the most deprived communities in the city in recent years.

Source: Office for National Statistics & Public Health England

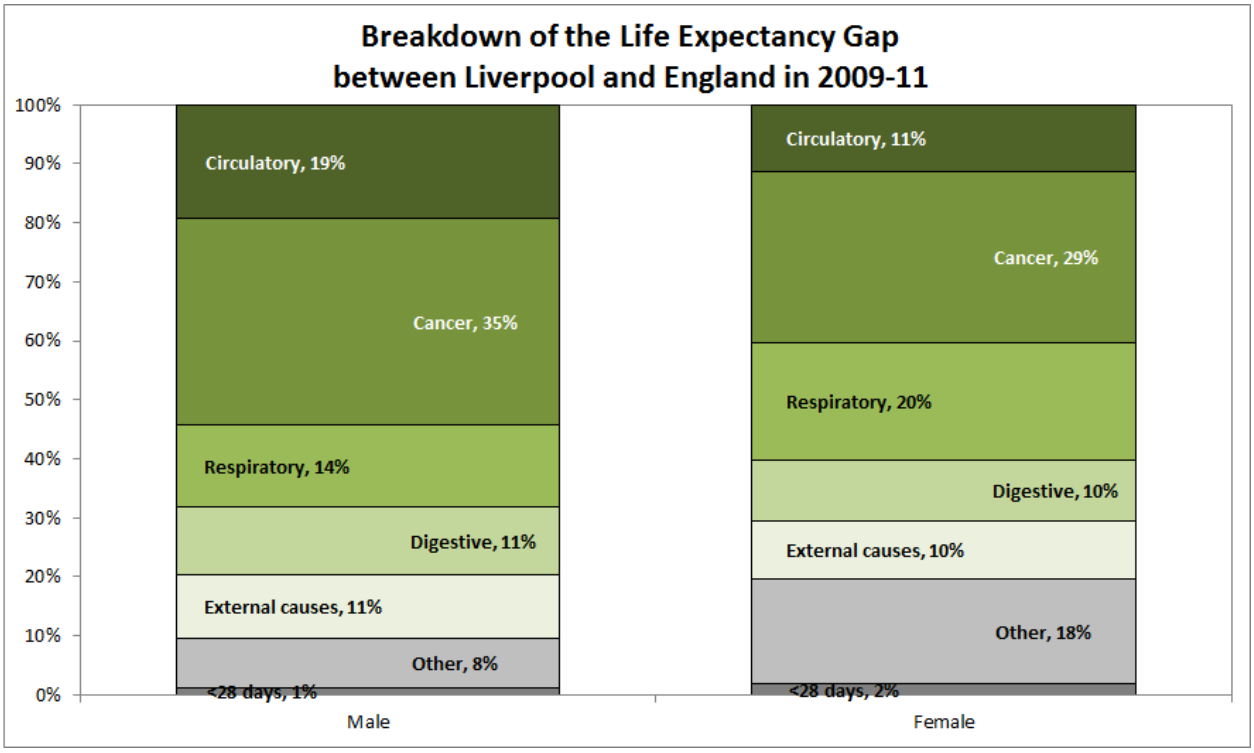
7.2 Causes of the Life Expectancy Gap

There is a significant gap in life expectancy between Liverpool and England, with males in the city living 3.1 years less and females living 2.8 years less. Through monitoring different causes of death it is possible to identify which conditions are driving this gap, enabling commissioners and policy makers to target those areas where the greatest impact can be made.

The chart below shows the main causes of the gap in life expectancy in Liverpool, broken down by sex. For both males and females, Cancer accounts for the majority of the gap with an estimated 585 excess deaths among men and 418 excess deaths among women. Lung cancer accounts for the bulk of these.

Circulatory diseases, such as heart disease and stroke, are the second major cause of the life expectancy gap among males in Liverpool. However, among females, respiratory diseases such as COPD play a much larger role, accounting for 20 percent of the life expectancy gap, compared to 14% among men.

"Other" causes of the gap include infections and mental & behavioural disorders, amongst other conditions. Together this group accounts for 472 excess deaths in the city, compared to England.

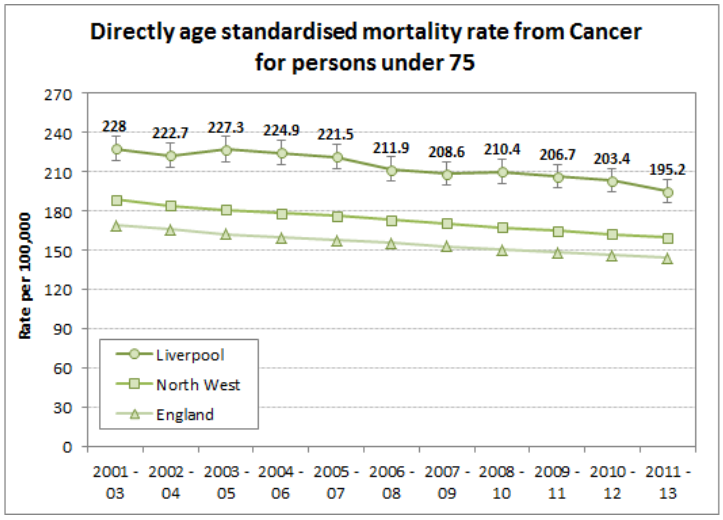


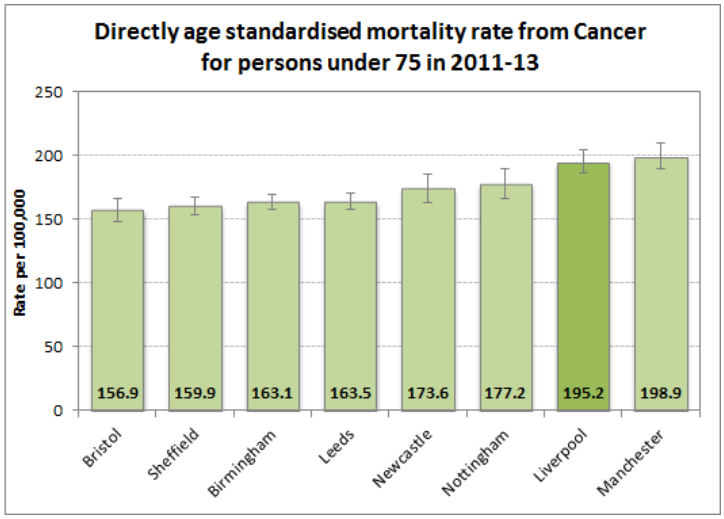
Source: Public Health England – Life Expectancy Segmentation Tool

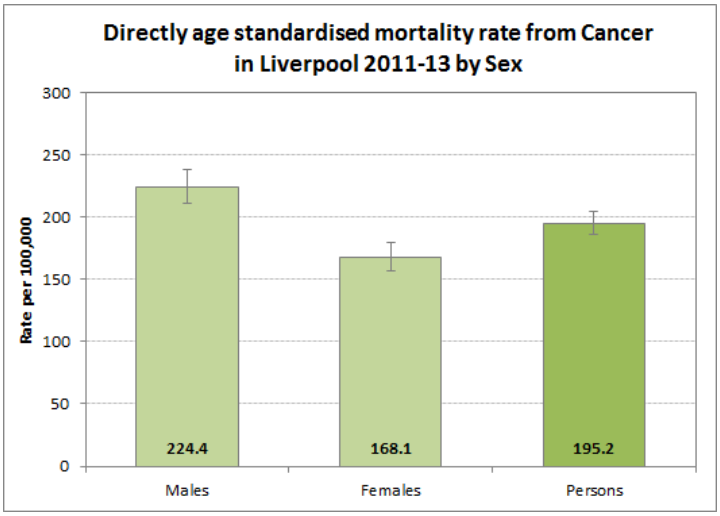
7.3 Premature Mortality from Cancer

Cancer is the leading cause of premature mortality in Liverpool. Between 2011 and 2013 there were around 650 deaths from cancer that occurred under the age of 75. The mortality rate in Liverpool is significantly above both national and regional levels and is the second highest among the core cities, behind only Manchester. However, trends indicate there has been a statistically significant reduction in the mortality rate in the city, falling by just over 14% since 2001-03. In addition, the inequality gap with England has also reduced, falling by just over 13%.

While there have been significant improvements in Cancer outcomes in recent years, it is important to recognise that the disease is largely preventable. Cancer is heavily influenced by lifestyle, with research suggesting up to half of all cancers could be prevented by changes to lifestyle behaviours such as: smoking, physical activity, and alcohol consumption.







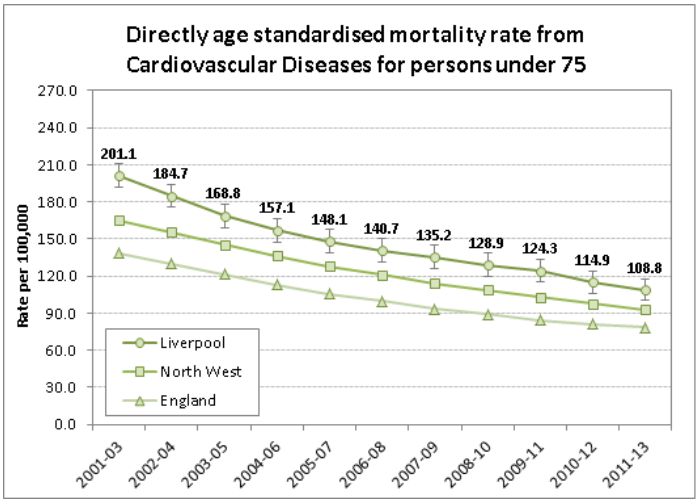
Within Liverpool there is substantial variation in the cancer mortality rate. Figures indicate the mortality rate among men is significantly above that for women. In fact, the rate is almost a third higher.

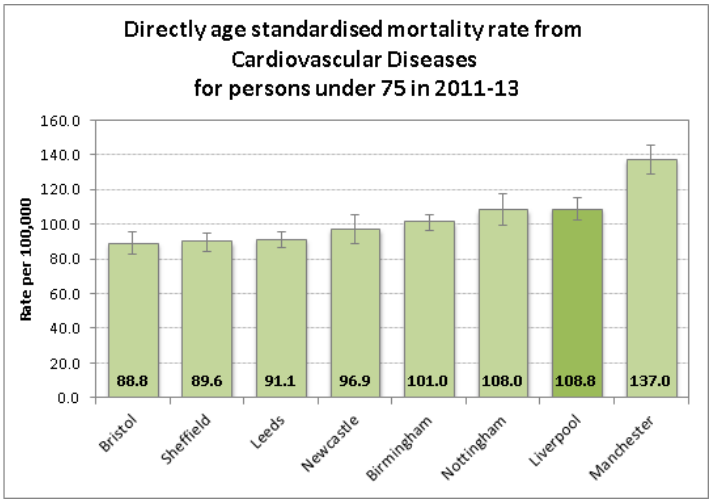
There is a strong correlation between cancer mortality and deprivation. People living in Liverpool's most deprived communities are more than 50% more likely to die of cancer than those living in the least deprived.

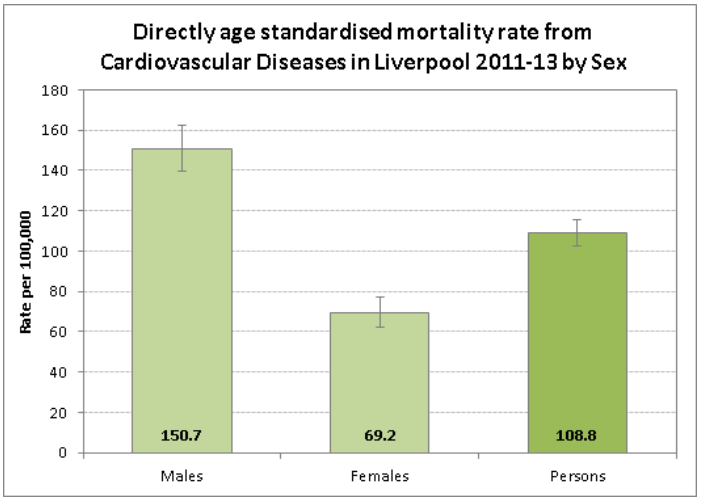
7.4 Premature Mortality from Cardiovascular Diseases

Cardiovascular Disease is a term which relates to a disease of the heart or blood vessels. It covers a range of conditions including Heart Disease, Stroke, Peripheral Arterial Disease and Aortic Disease. Following Cancer, Cardiovascular Diseases are the second largest cause of premature death in Liverpool, accounting for almost 360 early deaths every year. The mortality rate in Liverpool is significantly above both national and regional levels, and is the second highest among the core cities, behind only Manchester. However, trends indicate there has been a statistically significant reduction in premature deaths from Cardiovascular Diseases, with rates falling by 46% since 2001-03. In addition, the inequality gap with England has reduced by more than half over the period.

While there has been a significant improvement in Cardiovascular Disease outcomes, with an ageing population and the current levels of obesity and diabetes, past gains will not be sustained unless there are further improvements in prevention.







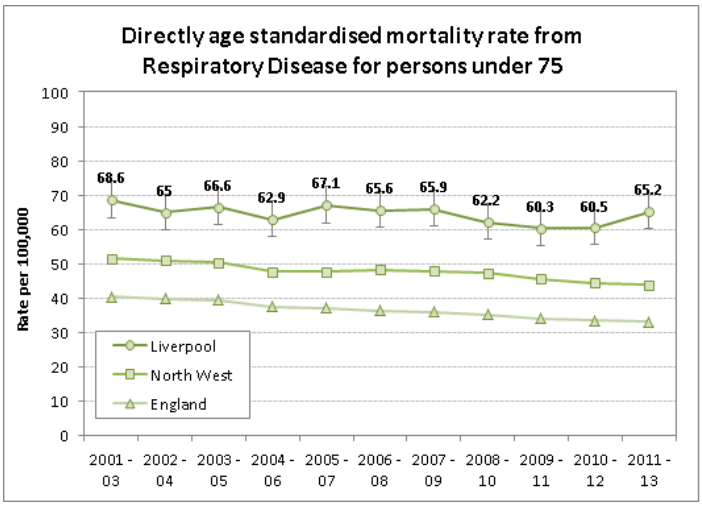
Within Liverpool, there is substantial variation in Cardiovascular Disease mortality. Figures indicate the mortality rate among men in the city is significantly higher than among their female counterparts. Indeed, the rate is more than twice as high.

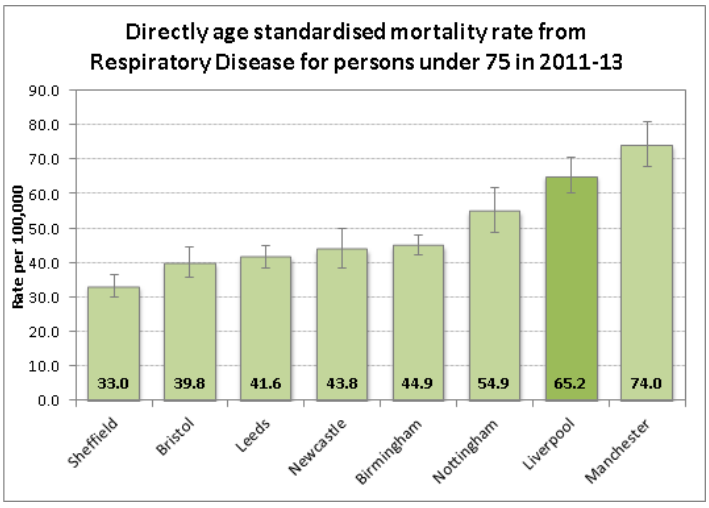
There is a strong positive correlation between premature mortality and deprivation in Liverpool. Figures show that the mortality rate in the most deprived areas of Liverpool is twice as high as the mortality rate for people who live in the least deprived areas of the city.

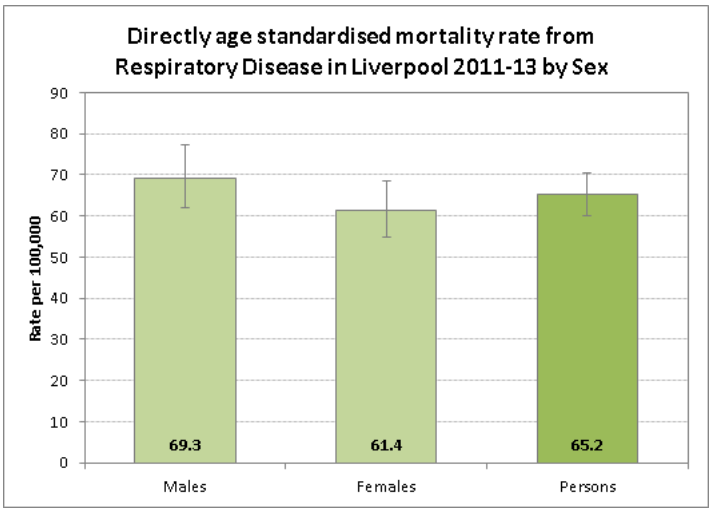
7.5 Premature Mortality from Respiratory Diseases

Respiratory Diseases are chronic diseases affecting the airways and other structures of the lungs. Some of the most common chronic respiratory diseases are asthma and chronic obstructive pulmonary disease (COPD). Respiratory Diseases are the third largest cause of early death in Liverpool, with over 200 cases a year. The premature mortality rate in the city is significantly above both national and regional levels and is the second highest among the core cities, behind only Manchester. Unlike Cancer and Cardiovascular Diseases, the mortality rate from Respiratory Diseases has remained relatively stable over recent years, falling by just 5% over the last decade. In addition, latest figures indicate the inequality gap with England has increased by 14%.

Smoking is the most common cause of Respiratory Diseases and around 86% of COPD deaths are attributable to smoking status. Furthermore, Respiratory Diseases often coexist with other conditions that share tobacco smoking as a risk factor, such as Heart Disease and Lung Cancer.





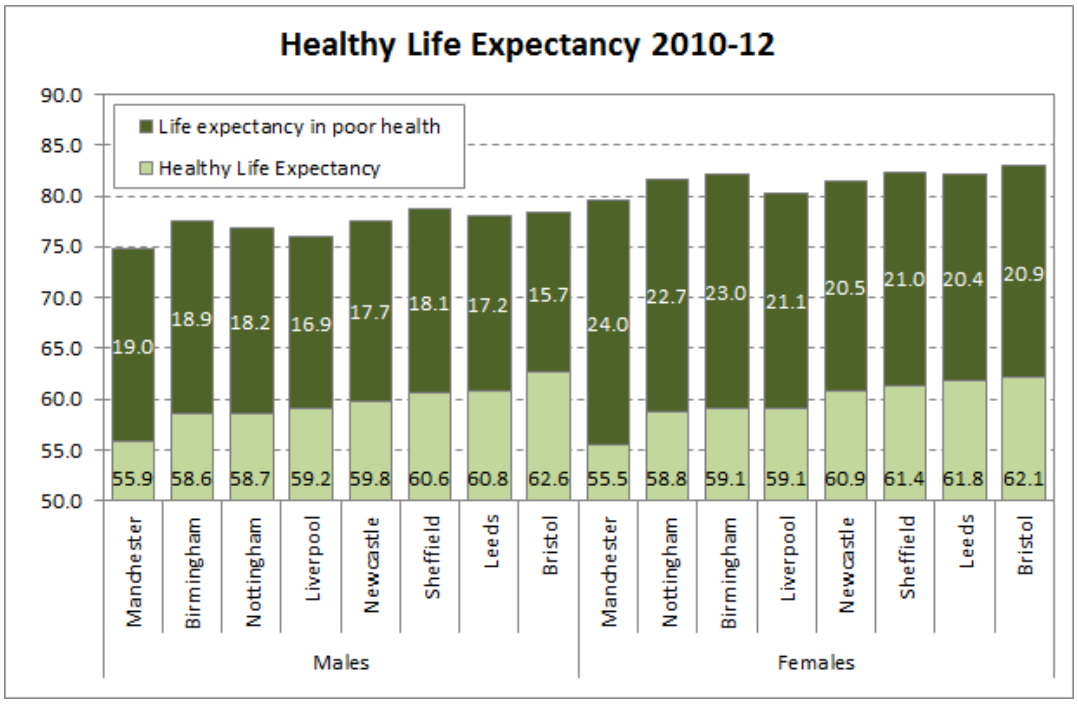


While the mortality rate from Respiratory Disease is higher among men than women, latest figures indicate the difference is not statistically significant.

As with other conditions, there is a strong correlation between the premature mortality rate and deprivation. Indeed, the rate in the most deprived communities in the city is almost 4 times higher than the rate in the least deprived communities.

7.6 Healthy Life Expectancy

Healthy life expectancy is often described as a measure of not just whether years are being added to life, but whether life is being added to years i.e. are people living healthier as well as longer lives. Work carried out by the Office for National Statistics suggests that while females in Liverpool live longer than their male counterparts, this does not translate into years of good health, with healthy life expectancy for both standing at around 59 years.



Source: Office for National Statistics

7.7 Dementia

The term 'dementia' describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and damage caused by a series of small strokes.

Dementia is progressive, which means the symptoms will gradually get worse. How fast dementia progresses will depend upon the individual person and what type of dementia they have. Each person is unique and will experience dementia differently.

Some individuals may have noticed problems with their memory, but a doctor may feel that the symptoms are not severe enough to warrant a diagnosis of Alzheimer's disease or another type of dementia, particularly if a person is still managing well. When this occurs, some doctors will use the term 'mild cognitive impairment' (MCI). Recent research has shown that individuals with MCI have an increased risk of developing dementia. The conversion rate from MCI to Alzheimer's is 10-20 per cent each year, so a diagnosis of MCI does not always mean that the person will go on to develop dementia.

Prevalence of dementia increases with age and is estimated to be approximately 19.7% for males and 25.2% for females at 85 years of age and over, with prevalence higher in women due to their longer lifespan. Dementia prevalence in Liverpool is significantly lower than the England average (0.55% compared to 0.57% nationally). In 2012/13 there were just over 2,700 registered patients in the city with a diagnosis of dementia, up 250 patients from 2011/12 (QOF, 2012/13).

When dementia prevalence by age and sex was compared to consensus estimates of population prevalence of dementia there was an estimated shortfall of 2,107 patients. More patients than expected have been diagnosed with dementia among men aged between 60-64 and women aged between 55-59 and 60-64. The category with the greatest number of undiagnosed patients was women aged 85+.

It is estimated that in 2011 there were 25,000 people with dementia from black, asian and minority ethnic groups in England and Wales. This number is expected to double to 50,000 by 2026 and rise to over 172,000 by 2051. This is a nearly a seven-fold increase in 40 years, compared to just over a two-fold increase in the numbers of people with dementia across the whole UK population in the same time period.

The proportion of older people from minority ethnic groups in the UK is increasing rapidly, as the numbers of older people from these groups increases. However, a report by the All Party Parliamentary Group on dementia into dementia among people from BAME groups found they were under-represented in services and often diagnosed at a later stage of the illness, or not at all.

More detailed information on the emotional health & wellbeing of children and young people is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

7.8 Falls

The Royal Society for the Prevention of Accidents (ROSPA) estimates that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year-olds and older. Approximately 5% of older people in the community who fall in a given year experience a fracture or require hospitalisation (Rubenstein et al. 2001). Falls can have a number of consequences:

Physically - they can result in injuries ranging from minor to severe. The more severe injuries include fragility fractures - these are defined as fractures sustained after falling from a standing position and often include fractures of the pelvis, wrist, upper arm or hip. Hip fractures (fractured neck of femur, including pertrochanteric fractures) are the most serious consequence, and significantly reduce life expectancy. The Department of Health suggest that 20% of people experiencing a fractured neck of femur (FNOF) die within four months, and 30% within a year after such an injury. Recovery following a hip fracture significantly reduces the individual's ability to live independently. Evidence suggests that 40% of people who fall and fracture their hip will have sustained a non-hip fracture through a previous fall.

Psychologically - one of the greatest impacts of a fall is development of a 'fear of falling'. This is where the patient's reaction to the possibility of falling again can significantly reduce their quality of life and confidence (Friedman et al 2002). Two of the greatest concerns around falling are loss of mobility and loss of independence which can also impact and greatly reduce an individual's quality of life. Both conditions can develop from any type of fall regardless of physical injury. Such a response can hinder recovery, reducing muscle strength through lack of activity and access to Vitamin D from sunlight and thereby potentially lead to a greater risk of recurrent falls.

Using Department of Health analysis and Liverpool's registered practice population, it is estimated that:

- 34.4% (24,505 patients) over 65 will fall each year
- 14.8% (10,600) of this population will fall twice or more in a year. Though most will not seek help
- An estimated 4.8% (3,476) will call an ambulance, and the same number will attend accident and emergency (A&E) department
- Around 2.7% (1,973) will sustain a fracture, of which 28% (568) will be a hip fracture
- These estimates are in keeping with the fracture related, non-elective (emergency) admission data for Liverpool, although actual 2012 figures are slightly lower

More detailed information on falls and fragility fractures is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

7.9 Loneliness & Social Isolation

Loneliness is a subjective, negative feeling associated with lack or loss of companionship. If you feel lonely, you are lonely. 'Social isolation' is a sociological category relating to imposed isolation from normal social networks. This can lead to loneliness and can be caused by loss of mobility or deteriorating health. It is possible to be lonely whilst not isolated, for example amongst those caring for a dependent spouse with little help.

Research on loneliness and social isolation has tended to focus on older people as they are especially vulnerable to loneliness, due to loss of friends and family, loss of mobility or loss of income. The Campaign to End Loneliness (CEL) estimate that between 6 and 13 percent of people aged 60 and over often or always feel lonely, equating to between 5,500 and 11,900 people in Liverpool. As the population ages over the next decade, the number of older people experiencing loneliness is projected to increase to between 6,500 and 14,100 people.

A number of groups have been identified as being at high risk of social isolation and loneliness by the CEL, including:

- Lone pensioners
- Older carers
- People over 75

- Recently bereaved people
- Older people with sensory impairment
- People over 65 living in deprived areas

7.10 End of Life

Good quality end of life care is important in ensuring that those people (and their families) approaching the end of their life are treated to optimise their quality of life and with dignity and respect. One of the aims is to enable people to be supported and die in a location of their own choosing. Research suggests many people would prefer to die in their home rather than in hospital, and around a third of those who do die in hospital could be managed in other settings.

The percentage of people who die in their usual place of residence has increased in Liverpool since 2005, though the change is not statistically significant. Figures for 2012 show that of the 4,259 deaths in the city, 36.7% occurred in the usual place of residence, up from 34.5% in 2005. Figures also indicate that more women die in their usual place of residence than men; 36.9% compared to 34.8%.

An audit of primary care systems in Liverpool indicates that of the 3,028 patients which are on the End of Life register, just over a quarter (770) had a preferred place of death in their records, with just over 1 in 10 (408) having a preferred place of care noted.

Evidence suggests there is a low uptake of end of life care among ethnic minority groups. This is due to a number of factors, including: lower referrals rates when compared to white British people; lower awareness of the services which are available; previous experience; language barriers and family/religious values.

More detailed information on end of life is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

7.11 Additional Information

A comprehensive health needs assessment on older people is currently being produced. The assessment is based around 5 key themes, identified as part of the Healthy Liverpool Programme:

- Carers
- Care Homes
- Dementia
- End of Life
- Re-ablement

The final version of this document will be available early in 2015.

8. Health Inequalities

8.1 Health of Ethnic Minority Groups in Liverpool

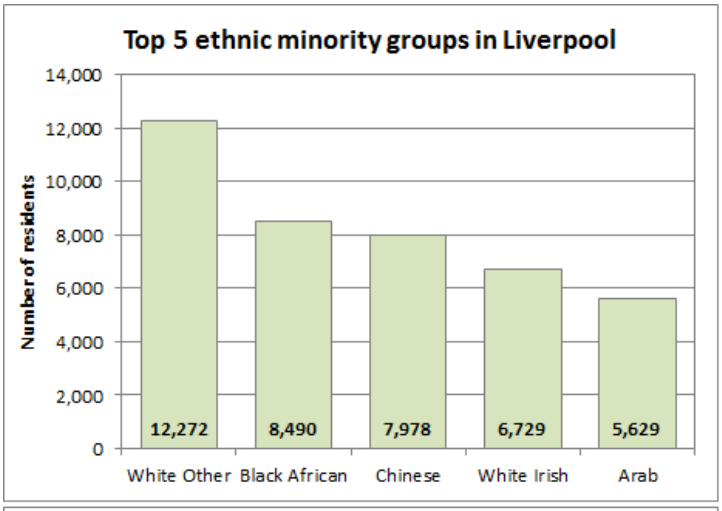
Figures from the 2011 Census indicate that 84.8% of the population define themselves as being "White - English/Welsh/Scottish/Northern Irish/British", with 15.2% of the Liverpool population classing themselves as part of a minority ethnic group, equating to almost 71,000 residents. This is slightly higher than the regional average (12.9%), but lower than England (20.2%). The largest ethnic minority groups in the city are:

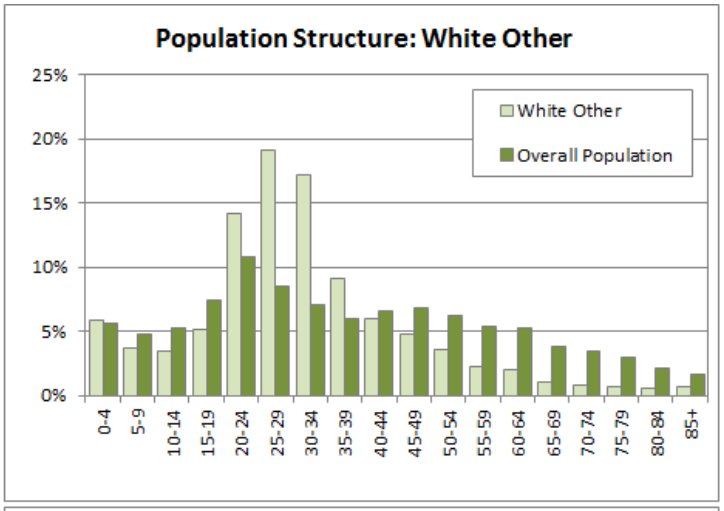
- White Other (including eastern European),
- Black African,
- Chinese,
- White Irish,
- Arab.

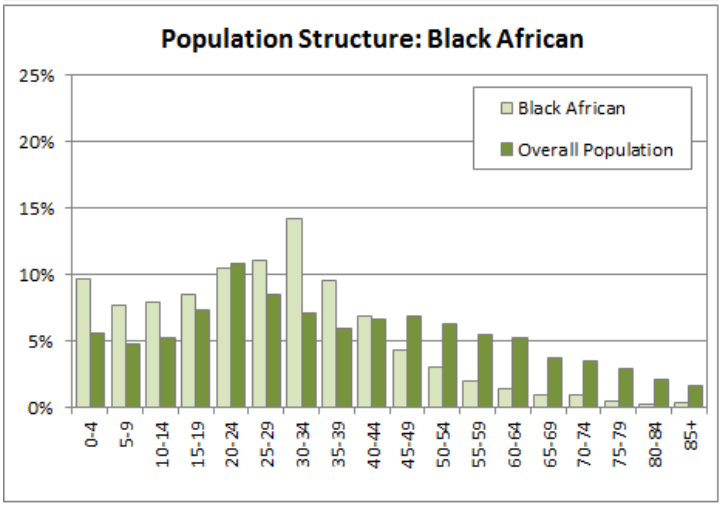
Ethnic Group	Liverpool		England	
	Number	Percentage of Total	Number	Percentage of Total
All usual residents	**466,415**	**100.0%**	**53,012,456**	**100.0%**
White	**414,671**	**88.9%**	**45,281,142**	**85.4%**
English/Welsh/Scottish/Northern Irish/British	395,485	84.8%	42,279,236	79.8%
Irish	6,729	1.4%	517,001	1.0%
Gypsy or Irish Traveller	185	0.0%	54,895	0.1%
Other White	12,272	2.6%	2,430,010	4.6%
Mixed/multiple ethnic groups	**11,756**	**2.5%**	**1,192,879**	**2.3%**
White and Black Caribbean	3,473	0.7%	415,616	0.8%
White and Black African	3,164	0.7%	161,550	0.3%
White and Asian	2,283	0.5%	332,708	0.6%
Other Mixed	2,836	0.6%	283,005	0.5%
Asian/Asian British	**19,403**	**4.2%**	**4,143,403**	**7.8%**
Indian	4,915	1.1%	1,395,702	2.6%
Pakistani	1,999	0.4%	1,112,282	2.1%
Bangladeshi	1,075	0.2%	436,514	0.8%
Chinese	7,978	1.7%	379,503	0.7%
Other Asian	3,436	0.7%	819,402	1.5%
Black/African/Caribbean/Black British	**12,308**	**2.6%**	**1,846,614**	**3.5%**
African	8,490	1.8%	977,741	1.8%
Caribbean	1,467	0.3%	591,016	1.1%
Other Black	2,351	0.5%	277,857	0.5%
Other ethnic group	**8,277**	**1.8%**	**548,418**	**1.0%**
Arab	5,629	1.2%	220,985	0.4%
Any other ethnic group	2,648	0.6%	327,433	0.6%

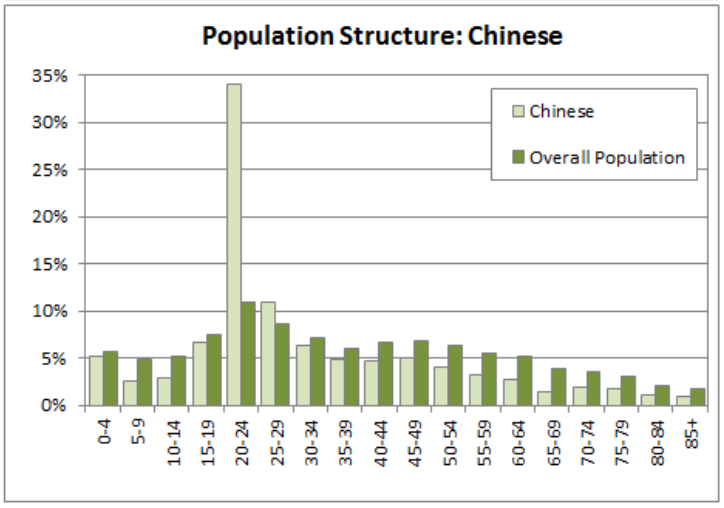
Source: 2011 Census

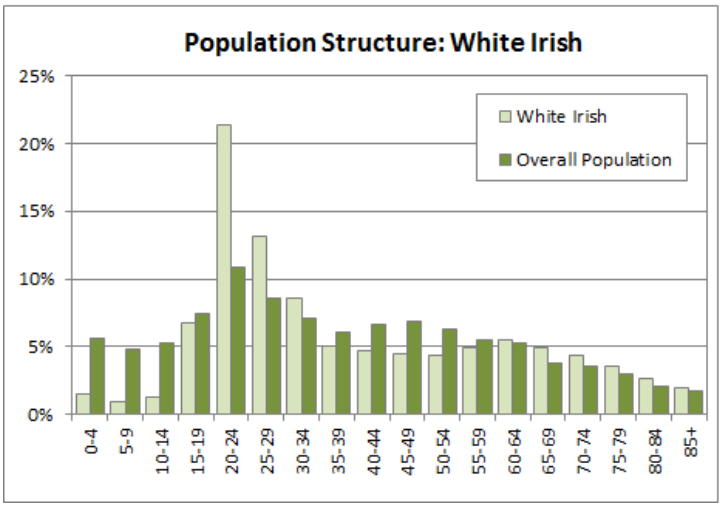
The diagrams below illustrate the age profile of these groups in Liverpool compared to the overall city population. With the exception of the White Irish population, it is apparent that each of the minority groups, has a much younger population than that of the city as a whole. The large peaks in the 20 year old population may be a reflection of the student population coming to the universities in the city.

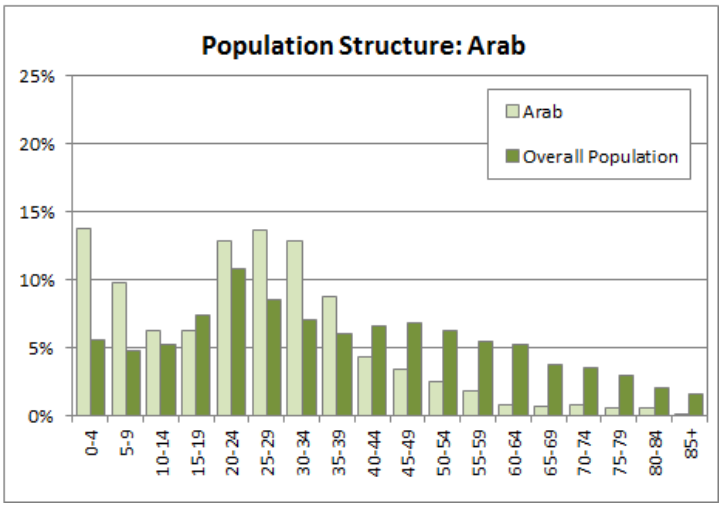






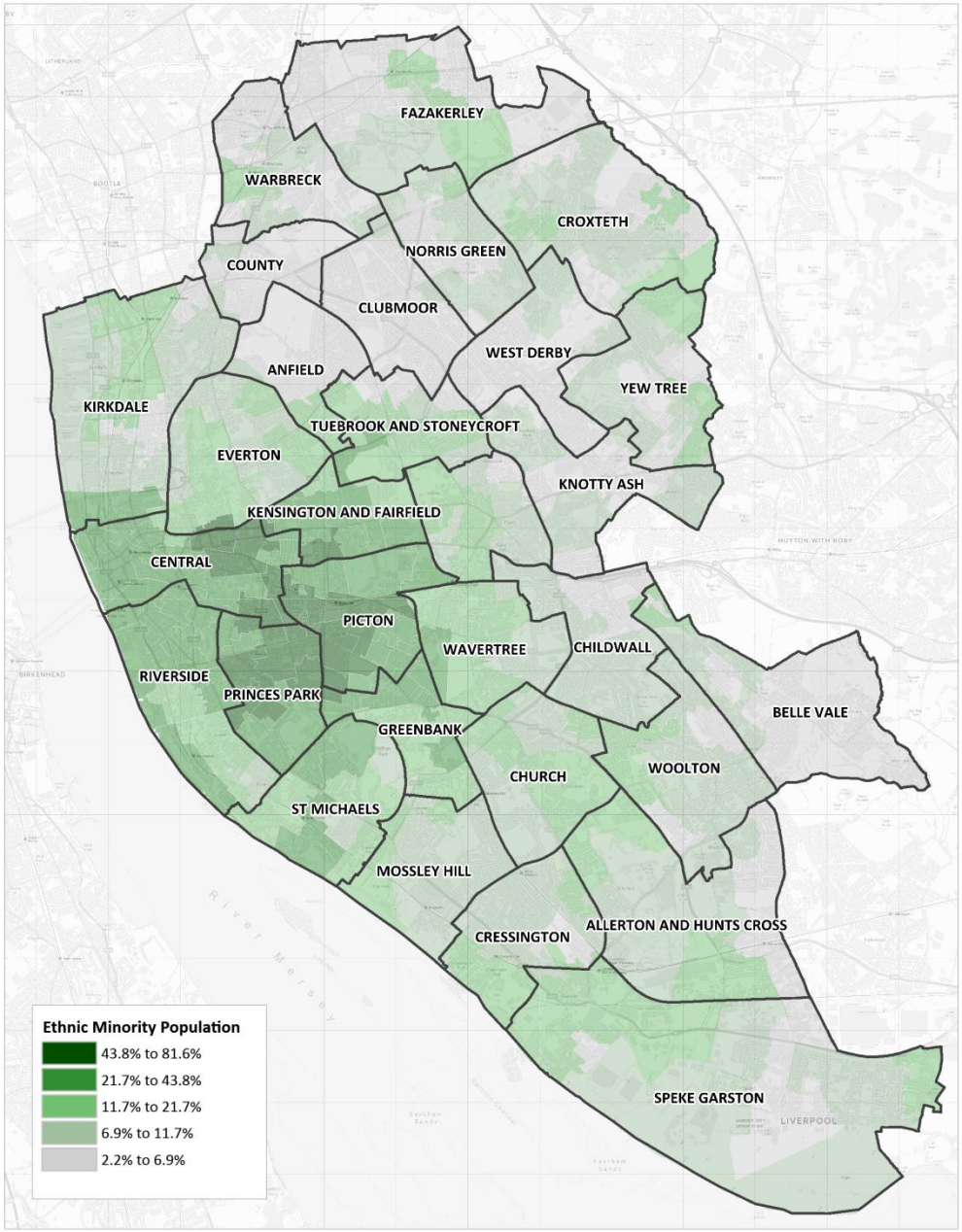






Source: 2011 Census

The map below shows there is a significant concentration of the ethnic minority population in the Princes Park, Picton and Central wards in the city, with far fewer people from minority groups living in neighbourhoods on the periphery of the city



Ethnic minority population in Liverpool in 2011

Date created: 30/9/2014

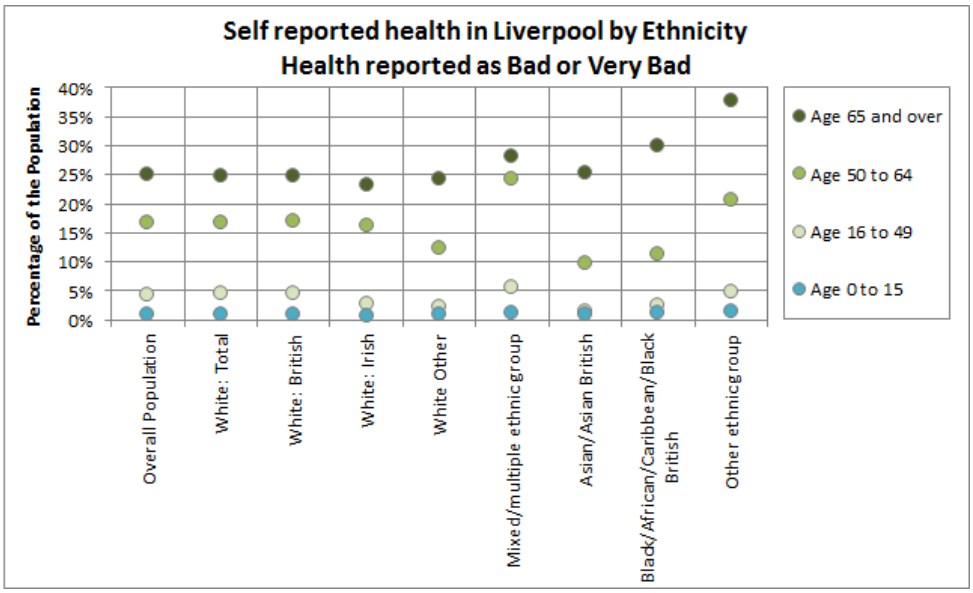
Liverpool City Council I Millennium House I Victoria Street I Liverpool L1 6JD

Public Health Liverpool I E: chris.williamson@liverpool.gov.uk

Liverpool City Council

Good health is driven by many different factors, such as lifestyle, income, housing, and employment through access to good healthcare. Research indicates that many of the social determinants which influence health outcomes are unequally distributed among ethnic groups. However, the picture is complex, with patterns of inequality varying from one health condition to the next.

While there is a significant amount of research and evidence that highlights the inequality in health outcomes among minority groups, local evidence is less available. However, the 2011 Census provides us with one source of information, and the chart below gives an overview of the self-reported health status of ethnic minority groups in Liverpool by age group.



Source: 2011 Census

Results indicate that levels of poor health among those aged 0-15 and 16-49 is relatively consistent across all ethnic minority groups in the city, with around 5% or less of these age groups reporting bad or very bad health. However, from the age of 50 inequalities between ethnic minorities in Liverpool become more pronounced, mirroring national research.

Among the mixed/multiple ethnic group aged 50-64, around 25% considered themselves in bad or very bad health, compared to 17% of the general population, and around 10% of the Asian/Asian British population in Liverpool.

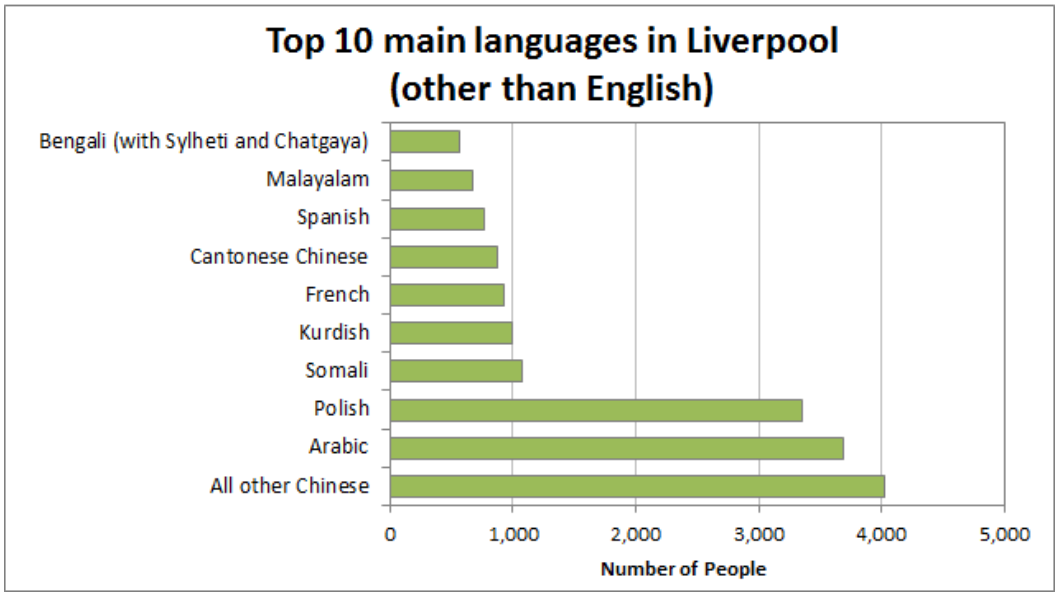
Unsurprisingly, levels of poor health are greatest among those aged 65 and over. Around 25% of the general population in this age group consider themselves in bad or very bad health. Levels are notably higher among: mixed/multiple ethnic group (28%), Black/African/Caribbean/Black British (30%) and those from other ethnic groups (38%).

The individual JSNA topic reports include further information on the disparity in health between groups for each specific issue, where this information is available. We aim to strengthen this evidence base further over time.

In 2013 the BHA produced a detailed report on the health of ethnic minorities in the UK. The report is available from: www.thebha.org.uk/files/jsna_report_single_page.pdf

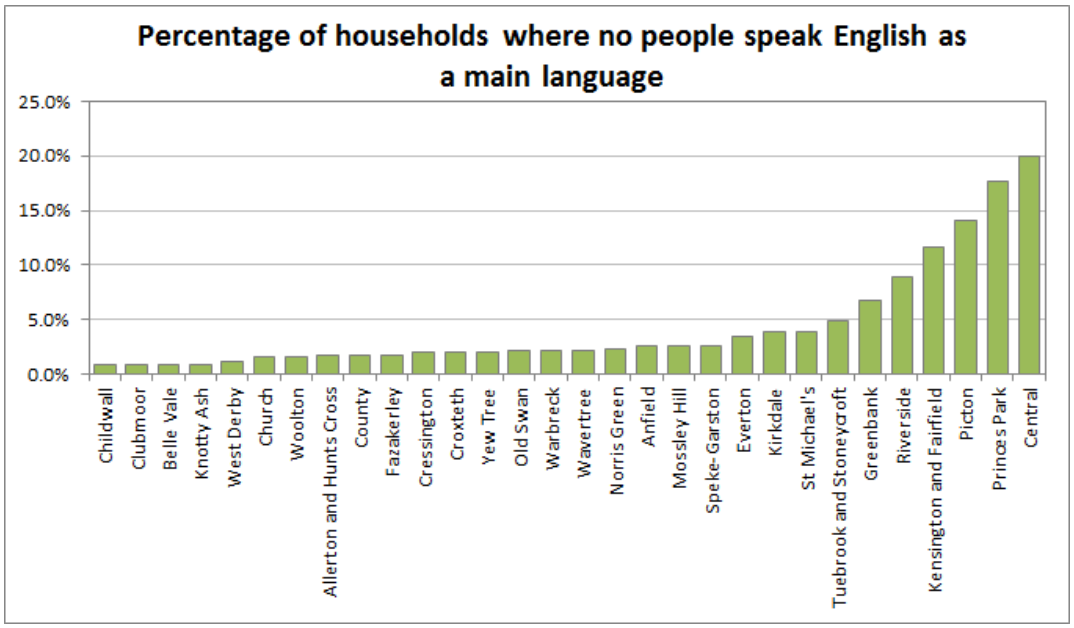
8.2 Main Language

At the time of the 2011 Census, just under 28,400 Liverpool residents reported that their main language was not English, representing just over 5% of the population. The chart below illustrates the top 10 main languages in the city other than English. “All other chinese”, Arabic and Polish are by far the largest languages in the city, influenced by the main ethnic minorities in the city. Together these three languages account for almost half of non-native languages.



Source: 2011 Census

Across Liverpool, there are just under 10,000 households where no residents speak English as a main language. In four electoral wards in the city, this exceeds 10% of households, more than double the Liverpool average (4.7%).



Source: 2011 Census

8.3 People with Learning Disabilities

Learning disability is defined in Valuing People as the presence of "a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning) which started before adulthood (18 years), with a lasting effect on development". The term does not include specific learning difficulties such as dyslexia, specific social/communication difficulties such as Asperger's syndrome, people with a higher level autistic spectrum disorder who may be of average or above average intelligence or people with difficulty in learning and understanding acquired later in life.

People with learning disability have shorter life expectancy compared to the general population; they are 58 times more likely to die before the age of 50 and 4 times more likely to have a preventable cause of death (NPCRDC, 2010). They also have higher levels of epilepsy, sensory impairment and behaviour disorders and the evidence base suggests that the health needs of this population group are inadequately addressed.

An audit of GP clinical systems in Liverpool in September 2014 showed there were 2,230 patients with a learning disability known to their GP, equating to less than 0.5% of the population. Research indicates this substantially underestimates the number of people with learning disabilities, with an estimated prevalence of 2%, or just over 10,000 people. Males in Liverpool were more likely to have a learning disability than females (60% of patients on the register were males) which means there are 1.5 males to every female. General Practice data indicates that around 15% of the population diagnosed with learning disabilities are aged 60 and over, compared to almost 20% of the general population.

A range of issues and areas of concern have been raised through the Liverpool Learning Disability Making It Happen Partnership and its Task Groups, as well as through the Getting Involved Group and in meetings with family carers. These include:

- People with a learning disability are often unintentionally discriminated against because they are unable to fully express their needs because of an inability to project their needs for the future. Even if they were able to do this they do not understand the routes to obtain services and to whom to express that need in order to have it met.
- The need for better information and access to housing and support for individuals with learning disabilities, so they can plan for the future with their families
- Increased support for older carers to plan for the future with their family members
- The difficulties and uncertainties faced by many young people with disabilities and their families when making the transition from child to adult services. These uncertainties are often to do with differing criteria and thresholds for entitlement to services between child and adult social care services. There are additional complexities, if young people have significant health problems and conditions.
- Protection of vulnerable adults and children from abuse and disability hate crime
- The lack of real employment prospects for people with learning disabilities – and the lack of awareness on the part of most employers about what people with disabilities can offer
- Changes to welfare benefits leading to uncertainty and anxiety about future entitlement

More detailed information on the health of people with learning disabilities is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna. An in depth health needs assessment has also recently been completed for the Liverpool City Region, further information on this is available from: healthandwellbeing@liverpool.gov.uk

8.4 People with Physical Disabilities

Physical disabilities can have a substantial impact on a person's ability to carry our normal every day activities. Barriers that people with impairments and disability face include discrimination, inaccessible buildings, public transport or information as well as lack of support to access opportunities to improve their quality of life.

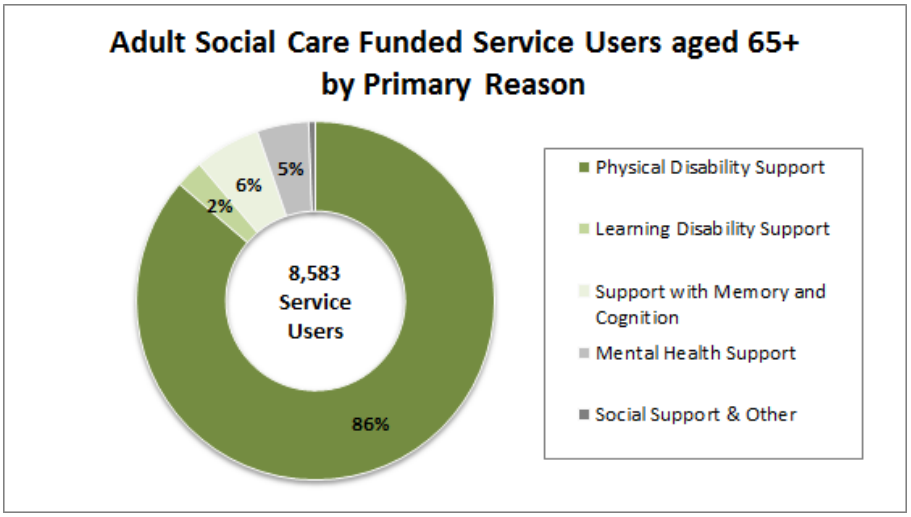
Using information from the Health Survey for England, PANSI estimate that around 22,600 working age adults in Liverpool have a moderate physical disability, with a further 6,400 who have a severe physical disability. Prevalence of both levels of disability increases substantially with age, and as the population in the city ages over the coming decade, numbers of people with a physical disability are also projected to increase.

Age	2013 Pop	Prevalence of Physical Disability		Estimate of Physical Disability in Liverpool	
		Moderate	Serious	Moderate	Serious
18-24	68,302	4.1%	0.8%	2,800	546
25-34	76,208	4.2%	0.4%	3,201	305
35-44	57,459	5.6%	1.7%	3,218	977
45-54	61,031	9.7%	2.7%	5,920	1,648
55-64	50,029	14.9%	5.8%	7,454	2,902

Source: Projecting Adult Needs & Service Information (PANSI)

Research by Projecting Adult Needs & Service Information (PANSI) suggests that around 16,900 people aged 65 and over in Liverpool have a long term illness that limits their daily activities, with a further 25,960 people whose daily activities are limited a lot. This represents a substantial proportion of the older population (62%) in the city, and is projected to increase as the population ages.

Adult Services currently provide physical disability support to 9,590 residents in the city. Physical disability support is the most common support provided to those service users aged over 65, accounting for 7,405 people (86% of all service users). Far fewer service users under the age of 65 receive support for physical disability (2,185). While the proportion of service users receiving residential/nursing support is low, it increases substantial with age, from 7% of services users under 65, to 19% of service users aged 65+.



Source: Adult Social Care

8.5 People with Visual Impairment

Good vision care impacts on other aspects of health such as the ability of patients to manage other chronic conditions and the avoidance of injurious falls. People with visual impairment are more likely to require residential and community care and additional support through adaptations of their environment.

In Liverpool 2,510 people were registered either blind or partially sighted in 2013-14, however estimates by the RNIB indicate that over 11,800 people in the city are believed to live with some degree of sight loss. This suggests that only around a 1 in 5 cases are registered. The prevalence of sight loss increases with age, with more than half of people registered blind in Liverpool aged over 75. With this being the case, many people also live with additional health needs. More than half (56%) of people in Liverpool who are registered blind have additional disabilities, with the most common need identified being physical disability (1 in 5 people). As the number of older people in the city increases further, projections indicate there will be a corresponding increase in the number of people who are visually impaired.

Estimated Prevalence of Sight Threatening Conditions in Liverpool

Condition	Description	Prevalence
Age-Related Macular Degeneration (AMD)	Age-related macular degeneration is a condition commonly affecting people over the age of 50 and is the leading cause of blindness in people over the age of 65. **Wet AMD** can develop quickly affecting central vision in a short period of time. Early identification and treatment of wet AMD is vital. Treatment can halt the further development of scarring but lost sight cannot be restored. **Dry AMD** can develop slowly and take a long time to progress to its final stage. There is currently no treatment for dry AMD.	**3,810 people**
Wet AMD		**2,590 people**
Dry AMD		**1,210 people**
Cataracts	This is a common eye condition that is prevalent in older people. The lens becomes less transparent and turns misty or cloudy. Cataracts over time can get worse and impact upon vision. A straightforward operation replaces the lens with an artificial one.	**3,900 people**
Glaucoma	This is a group of eye conditions in which the optic nerve is damaged due to changes in eye pressure. Damage to sight can usually be 46inimized by early diagnosis in conjunction with careful regular observation and treatment. Many glaucoma patients will attend regular appointments and take eye drops for the rest of their lives to prevent deterioration of vision. Some forms of glaucoma can be treated with laser surgery.	**3,760 people**
Diabetic Retinopathy	This is a complication of diabetes and is the leading cause of blindness in the working population in the developed world. Diabetic retinopathy, if left untreated, can lead to sight loss which can have a devastating effect on the individual and their families. By promptly identifying and treating the disease, these effects can be reduced or avoided completely.	**2.7 per 100,000**
People with sight loss		**11,810 people**

Source: RNIB Sight Loss Tool, 2013 & Public Health Outcomes Framework

A detailed Eye Health Needs Assessment for Merseyside has been produced by NHS England, and is available from: healthandwellbeing@liverpool.gov.uk

8.6 People with Hearing Loss

Deafness, and hearing loss in general can be very disabling. Hearing loss and deafness can lead to barriers to inclusion and feelings of isolation. As the prevalence of hearing loss increases with age, many people also live with additional long term conditions, and managing hearing loss is an important factor in effectively managing these conditions. With the projected growth in the number of elderly people in the city, this will become increasingly important.

There are different levels of hearing loss and deafness:

- **Moderate deafness**: People with moderate deafness have difficulty in following speech without a hearing aid. The quietest sounds they can hear in their better ear average between 35 and 49 decibels.
- **Severe deafness**: People with severe deafness rely a lot on lip-reading, even with a hearing aid. British Sign Language (BSL) may be their first or preferred language. The quietest sounds they can hear in their better ear average between 50 and 94 decibels.
- **Profound deafness**: People who are profoundly deaf communicate by lip-reading. BSL may be their first or preferred language. The quietest sounds they can hear in their better ear average 95 decibels or more.

The World Health Organisation predict that by 2030 adult onset hearing loss will be in the top ten disease burdens in the UK, above diabetes and cataracts. The table below illustrates the estimated prevalence of hearing loss in Liverpool. Current estimates suggest that there are around 40,320 adults in the city with some form of hearing loss, the equivalent of around 1 in 10 people. The majority of these are elderly, with 55% of those with moderate or severe hearing loss and 62% of those with profound hearing loss aged over 75. Projections indicate the number of people with some form of hearing loss in the city will increase by almost 10,000 by 2030, driven by the increasing number of elderly people.

Age	Moderate or Severe Hearing Loss	Profound Hearing Impairment
18-24	109	-
25-34	343	-
35-44	807	-
45-54	3,414	28
55-64	5,767	63
65-74	7,016	224
75-84	14,995	152
85+	7,045	357
Total	**39,496**	**824**

Source: Projecting Adult Needs & Service Information (PANSI)

8.7 People with Long Term Neurological Conditions (LTNCs)

Neurological conditions result from damage to the brain, spinal column or nerves, caused by illness or injury. Many of the precise causes of neurological conditions are not yet known. A number of conditions are life threatening, and some will severely affect the person's quality of life, reducing their independence and ability to carry out day to day activities. It is also important to recognise that neurological conditions have a significant impact on the health and wellbeing of families and carers.

There are many types of LTNCs and people's experiences, disease course, needs for services and support vary significantly. LTNCs can be categorised as those that are:

- of sudden onset e.g. acquired or traumatic brain injury
- intermittent and unpredictable conditions e.g. epilepsy
- progressive conditions e.g. multiple sclerosis (MS), Parkinson's disease (PD) or motor neuron disease (MND) where deterioration over time may lead to increased need for services
- stable conditions with changing needs due to age e.g. cerebral palsy in adults

The table below illustrates the estimated prevalence of a number of key long term neurological conditions in Liverpool. Further work is required to better understand the health needs of people with LTNCs in the city.

Condition	Description	Estimated Prevalence
Epilepsy	The main feature of epilepsy is repeated seizures. These can take place when you are awake or asleep and are classified as either partial or generalised seizures depending on whether only part of most/all of the brain is affected. Epilepsy usually begins in childhood but can start at any age.	**2,354 – 4,708 people** (500-1,000 per 100,000) Source: NICE
Multiple Sclerosis (MS)	MS is a disease of the central nervous system. Symptoms may include vision problems, problems with balance, and fatigue. MS can also affect memory and thinking. MS is the most prevalent neurological condition among young people in the UK, and in most cases symptoms are first seen between the ages of 20 and 40. Women are almost twice as likely to develop MS as men.	**471 - 565 people** (100-120 per 100,000) Source: NICE
Parkinson's Disease (PD)	Parkinson's Disease is a movement disorder which is characterized by symptoms such as rigidity, tremor at rest, fatigue and others. PD is one of the most common neurological conditions among older people in the UK.	**753 people** (160 per 100,000) Source: Parkinson's Disease Society
Motor Neurone Disease MND)	Motor neurone disease (MND) is a rare but devastating illness which leads to progressive paralysis and eventual death. As the condition develops, those with MND find it increasingly difficult to control muscle activity e.g. gripping, walking, swallowing. While prevalence increases with age, the condition is rare.	**33 people** (7 per 100,000) Source: MND National Service Framework 2005

8.8 Asylum Seekers & Refugees

People seeking asylum are individuals who have been forced to leave their home country due to a well-founded fear of persecution. Refugees are individuals whose request for asylum has been accepted.

Asylum seekers and refugees are among some of the most vulnerable groups in society. Before arriving in the UK, they may have experienced violence, war, torture and may have been separated from, or even lost family members and friends. For hundreds of years, Liverpool has welcomed people coming to the city from around the globe. The support and friendliness shown by neighbours, communities and organisations means that Liverpool is frequently a sanctuary for those escaping troubled times and places.

The health needs of people seeking asylum may be complex. Although many people seeking asylum will have no identified pre-existing medical needs, issues may emerge following entry into the UK. Some factors that predispose asylum-seekers to increase risk of poor health include:

- Lack of knowledge of available health services and entitlements
- Difficulties in accessing services
- Language barriers among some, but not all people seeking asylum, including the need for access to translation and interpretation services.

Liverpool is one of 5 cities in the UK designated as initial accommodation sites for asylum seekers. During initial accommodation (a process that takes approximately 2-3 weeks), people seeking asylum are housed at three locations in the city: Birley Court (L8), Greenbank Drive Centre (L17), and Seiont House (L8).

In 2013 just under 3,000 asylum seekers placed in initial accommodation were given a health check. Common medical issues identified include psychological distress and mental illness, incomplete vaccination schedules in children, pregnancy requiring assessment and minor ailments such as skin conditions, dental problems, upper respiratory tract infections and on-going chronic medical problems (e.g. pre-existing high blood pressure requiring treatment).

Individuals assessed in initial accommodation centres in Liverpool by age group and year

	2009	2010	2011	2012	2013
0-5 years old	358	230	306	250	332
5-16 years old	354	219	347	235	366
16 years or older	2440	1923	2120	2137	2272
Total	**3152**	**2372**	**2773**	**2622**	**2970**

Source: UC24

A comprehensive health needs assessment on asylum seekers and refugees was conducted in 2014, containing more detailed information on the health needs of this group. The report is available from: healthandwellbeing@liverpool.gov.uk

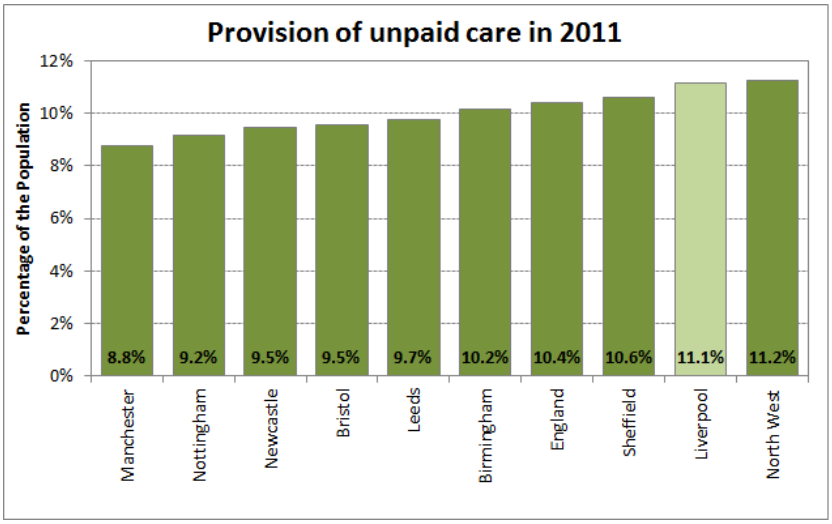
8.9 Carers

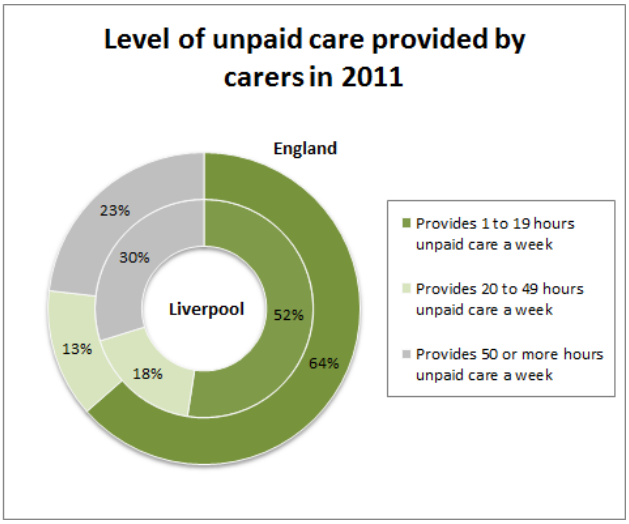
A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

A wealth of evidence identifies that there are significant risks associated with caring and keeping healthy and well. The risks are associated for with a variety of issues from the physical strain of lifting and moving people, the emotional stress of providing around the clock care, through to social isolation and being unable to find employment. The Royal College of GPs (RCGP) 'Supporting Carers in General Practice Guide' states that:

- Up to 40% of carers experience psychological distress or depression
- Carers have an increased rate of physical health problems. For example, providing high levels of care is associated with a 23% higher risk of stroke.
- Older carers who report 'strain' have a 63% higher likelihood of death in a year than non carers or carers not reporting strain
- One in five gives up work to care
- More than half fall into debt as a result of caring

According to the 2011 Census, over 50,100 people in Liverpool stated they provided unpaid care. While the number of people in the city providing unpaid care is comparable to regional levels, figures indicate that Liverpool has the greatest level among the eight core cities, in addition to being above national levels. The percentage of carers in the city providing greater than 20 hours of care (48%) is significantly above national levels, with the percentage providing more than 50 hours of care the highest among the core cities.





Source: 2011 Census

Carers pay a significant health penalty for caring and there is now strong evidence to suggest that the longer you provide care and the more of it you give, the more likely you are to be in poor health yourself. Although figures for 2012-13 indicate most carers rate their health as fair or good, of those who don't', caring has a significant impact on health. At the assessment stage, the most frequent health problems identified by carers in Liverpool included: Feeling tired, stress, and disturbed sleep.

More detailed information on the health of people with learning disabilities is contained in the JSNA topic report, available from: www.liverpool.gov.uk/jsna

9. Wider Determinants of Health

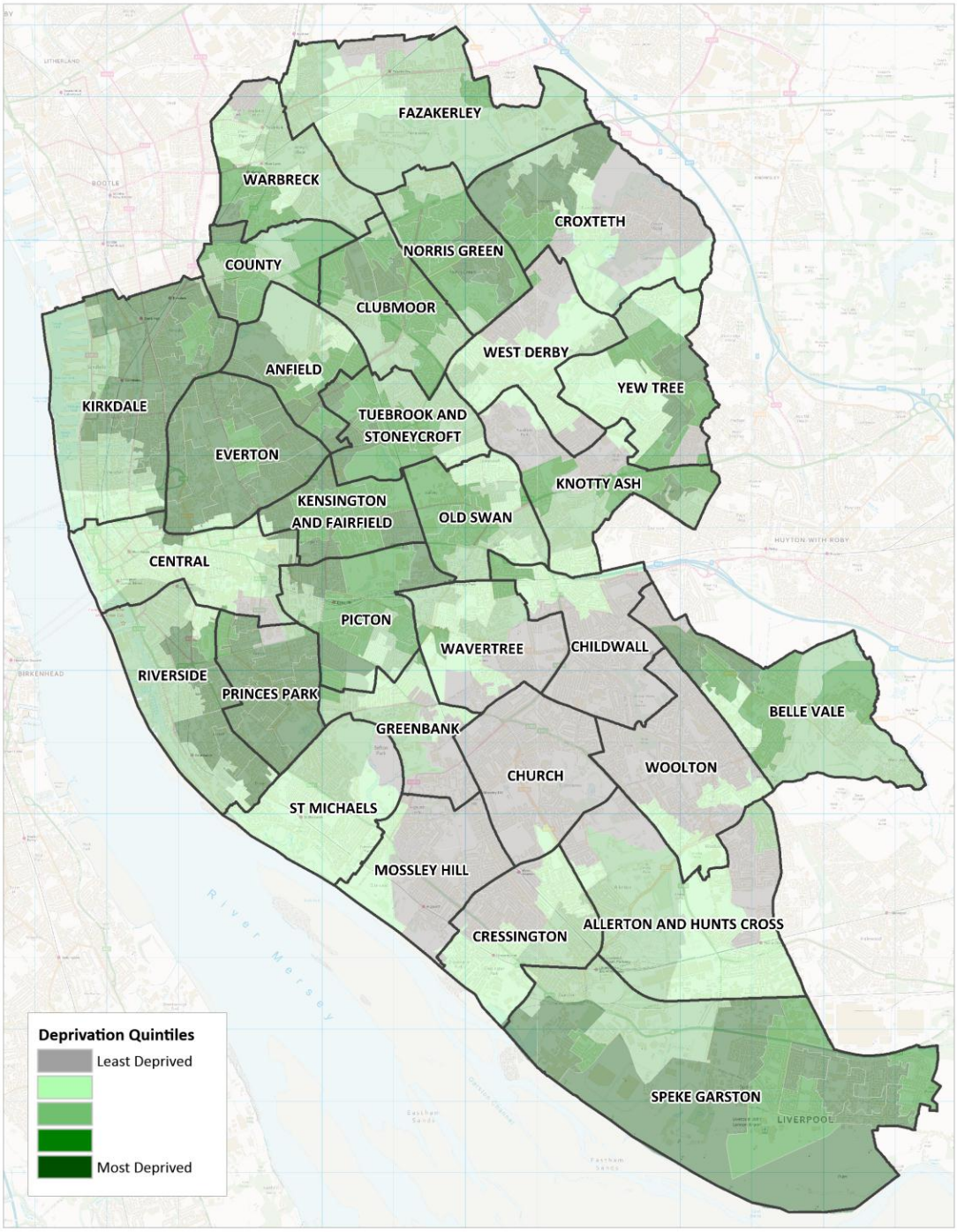
9.1 Indices of Deprivation

The English Indices of Deprivation 2010 (ID 2010) combine a range of economic, social and housing indicators to provide the most up to date and comprehensive picture of deprivation in England. They provide a measure of relative deprivation, i.e. they measure the position of areas against each other. Results show that Liverpool remains the most deprived local authority in the country, with its position unchanged from the 2004 and 2007 indices.

City	Rank of Average Score	Average Rank	Extent	Local Concentration	Income	Employment
LIVERPOOL	**1**	**5**	**4**	**2**	**3**	**2**
Manchester	4	4	5	8	2	3
Birmingham	9	13	10	20	1	1
Nottingham	20	17	17	35	17	13
Newcastle	40	66	35	15	29	20
Sheffield	56	84	48	33	6	7
Leeds	68	97	59	44	4	4
Bristol	79	93	73	57	14	9

Note: 1 = most deprived, 326 = least deprived

Levels of deprivation within Liverpool are particularly high in the north of the city, where virtually all of the neighbourhoods are ranked in the most deprived one or ten percent nationally. The map below shows that large areas of Everton, Anfield and Kirkdale are particularly deprived. This concentration of high deprivation also encircles the City Centre, this “inner core” area goes from Everton in the north through Kensington and on to Princes Park and Riverside to the south of the City Centre. Outside of the inner core, Speke Garston, Croxteth and Norris Green also have some of the highest levels of deprivation in the country.



Deprivation within Liverpool

Date created: 6/10/2014

Liverpool City Council I Millennium House I Victoria Street I Liverpool L1 6JD

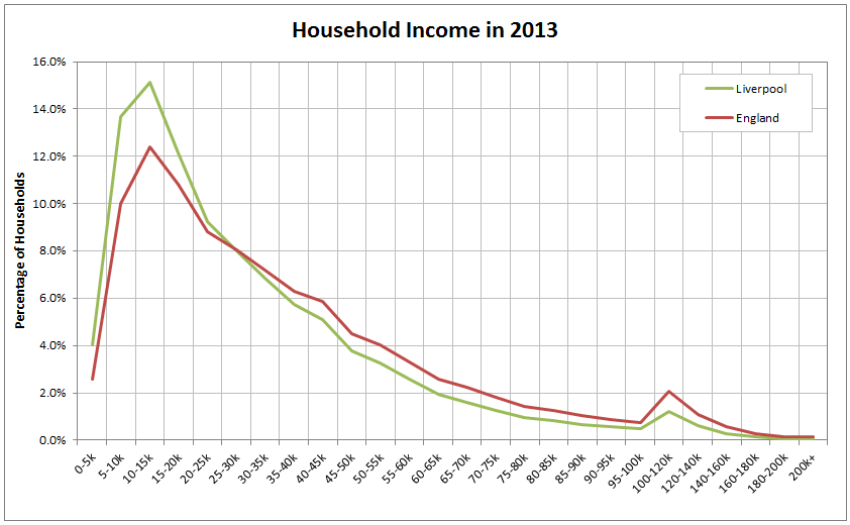
Public Health Liverpool I E: chris.williamson@liverpool.gov.uk

Liverpool City Council

9.2 Income & Welfare Reform

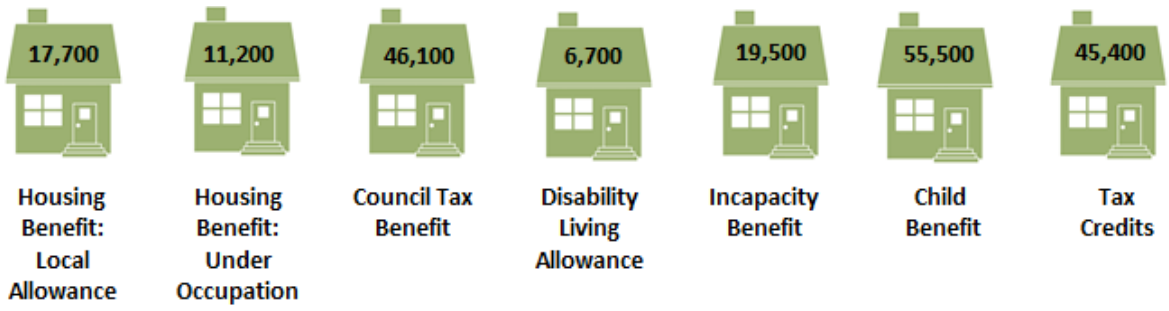
Low income and poverty are significant public health issues, impacting on both physical and mental health. Household income in Liverpool during 2013 was the second lowest of the eight core cities in England, with a median income of £22,739 per household. This measure does not take into account the number of people living in that household being supported by that income, therefore the higher the number of people in that household then the lower the standard of living.

The chart below shows the percentage of households within each income bracket in 2013. Analysis indicates Liverpool has a much higher proportion of its homes in the lower income brackets when compared to the national average, with around a third of households earning under £15,000 per year, compared to roughly a quarter nationally.



Source: CACI

The welfare reform programme being adopted nationally will have a substantial financial impact on local people, principally through reform to incapacity benefits, tax credits and the 1 per cent up-rating to most working age benefits. A report by Sheffield Hallam University looked into the impact of the changes to welfare in England and found that as a general rule the more deprived the local authority, the greater the financial impact of the reforms, a consequence of which will be to widen the inequality gap between the best and worst local economies. Their analysis showed that Liverpool is ranked 4th among Local Authorities with the largest absolute financial loss due to welfare reforms of £227million. This equates to an average loss per working age adult of around £700 per year. The diagram below illustrates the number of households in the city affected by changes to each of the key benefits. It's important to note that many will be affected by changes to multiple benefits, amplifying the effect.



9.3 Child Poverty

Broadly speaking, child poverty has meant growing up in a household with low income. Extensive research and data show that children who grow up in poverty face a greater risk of having poor health, being exposed to crime and failing to reach their full potential. Figures for 2013 indicate that around a third of children in Liverpool live in poverty, equating to 25,530 children (defined as living in a household where at least 1 parent is in receipt of out of work benefits). Child poverty levels are amongst the highest in the core cities, behind only Nottingham.

9.4 Education

A well educated population is key to the success of the economy, and underpins good health and wellbeing. Results from the Annual Population Survey 2013 indicate that 14.3% of adults in Liverpool have no qualifications, significantly above national levels, equating to an estimated 43,500 adults. While higher than England, levels in Liverpool have fallen by more than half since 2004, when 29.5% of adults in the city had no qualifications.

While it is apparent that a significantly lower proportion of adults in Liverpool are qualified to the highest levels e.g. degree level or higher, the pattern is evident across the qualification spectrum. Lower levels of education among the working age population in the city impacts not only on the local economy, but at an individual level on issues such as health literacy i.e. the ability to read and understand health information and make informed decisions on issues impacting on your health.

9.5 Housing & Homelessness

Access to good quality housing is an important influencing factor on health and wellbeing, with the link between poor housing and overcrowding and the onset or worsening of poor health being well established. Inability to access affordable housing also places families on lower incomes at greater risk of debt and homelessness.

Poor housing conditions are implicated in 500 deaths and 5,000 illnesses in the city. Liverpool Healthy Homes Team have identified 25,000 properties in priority need. The team has assessed the health and housing needs of occupants and carries out health and safety inspections in the worst 4,300 properties. The initiative is helping to reduce the income gap by income maximisation to ensure people receive the welfare benefits they are entitled to.

Figures for 2012 indicate 14.4% of Liverpool households live in fuel poverty, equating to almost 29,500 homes. While high, levels are comparable with the core city average of 14.8%.

In 2012/13, 524 people in Liverpool applied for assistance under the Housing and Homelessness Acts. Of these, 187 (36%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region). The most common reason for statutory homelessness in Liverpool was 'violent relationship breakdown with partner' (28%). There were also relatively high levels of homeless acceptances due to leaving asylum support (11.0%, compared to 2.8% nationally) and prison (3.2%, compared to 0.8% nationally) (Jan 2010 to June 2013).

An in-depth Homelessness Needs Assessment has been conducted by University of Liverpool for the City Region, and is available on request from: healthandwellbeing@liverpool.gov.uk

9.6 Community Safety

The level of crime and fear of crime is one of the most commonly cited influences on people's quality of life. There are many links between crime and health relating to both causes e.g. alcohol and substance misuse, and consequences such as psychological and physical impacts. In addition to the direct health impacts of crime, there can be consequences for the victims in a range of other areas, such as employment where people experiencing physical and emotional injury need to take time off work.

Crime in Liverpool has been reducing in recent years, however this year for the first time a number of crime types have seen increases, particularly around violence with injury offences, domestic violence offences and acquisitive crimes. What is a concern for Liverpool is the fact that many offenders are young, with studies showing that the main offenders are aged under 25, particularly violence offences, gun crimes, knife crime and drugs offences.

Whilst the city centre continues to have the highest crime rates in over half of all crime categories studied, including violent crime, sexual crime, vehicle crime, robbery, hate crime and drugs, these rates may well be artificial due to the high transient population and the low number of residents in the city centre. There are areas in Liverpool with issues particularly Anfield, County and Kensington & Fairfield wards. These wards rank in the top three wards for a number of crime types including gun crime, knife crime, acquisitive crime, violent crime, hate crime, domestic violence crime and ASB and whilst Liverpool is seeing reductions in these types of offences, these areas are actually showing increases in some of these crime types.

Two major categories or crime impacting on health and wellbeing are outlined below:

- **Violence with Injury** has increased for the first time in a number of years, seeing increases of 11%. Liverpool is now ranked 5th among our most similar areas, having been positioned at 4th last year. Between September 2012 and August 2013, there were 2,966 “violence with injury” offences reported in Liverpool. Alcohol continues to be the biggest contributory factor for violence and the city centre wards continue to have the highest rates in Liverpool and both have seen slight increases this year.

- **Domestic Violence** reported to Merseyside Police and also cases referred to MARAC have increased during the most recent 12 months examined, up 26% and 2% respectively. Between September 2012 and August 2013 there were 1,934 domestic violence incidents recorded by Merseyside Police. This compares to 1,535 the previous year. Victims aged between 20 and 29 were the most likely victims and Black/Black British were also overrepresented as victims. Offenders were predominantly males aged between 30 and 34. Anfield and County wards had the highest rate of domestic violence and both saw quite large increases since the previous year. Just over a third (34%) of all domestic abuse has been recorded as alcohol related or linked to a licensed premises.

City Safe are in the process of refreshing their Strategic Intelligence Assessment, where this information will be updated. A JSNA themed report is currently being developed with a range of partners, looking at the issue of Domestic Violence in more detail.

9.7 The Environment

Air Quality

In 2011, the Chief Medical Officer underlined the fact air pollution continues to have a significant adverse impact on health, particularly among older people and those with existing health conditions such as chronic respiratory disease. Nationally, around 29,000 deaths are attributable to air pollution, and estimates suggest that if all man made particles were removed from the air, life expectancy would increase by 6months.

Locally, Public Health England estimate that around 4.5% of deaths in Liverpool could be attributable to air pollution. This would equate to around 190 deaths a year. When compared to other core cities in England, Liverpool has comparatively low levels of mortality that is attributable to air pollution, with only Newcastle having lower levels.

Green Infrastructure

Green infrastructure is a term that is used to cover all the vegetation and open water in and around the city, whether it is rare or common, private or public, in the city centre or the city suburbs - Croxteth Park or a single street tree. Green infrastructure planning is a new approach, going beyond business as usual, focused on the benefits that can be delivered.

Around 62% of Liverpool can be classed as green infrastructure, with the largest single type being domestic gardens, accounting for 16% of the area of the city, followed by coastal habitat (9.7%). Parks such as Sefton, Calderstones and Croxteth are key strategic assets for Liverpool. In addition, significant improvements to the waterfront make this a major green infrastructure resource for the city.

In the Green Infrastructure Strategy for Liverpool launched in 2010, the Mersey Forest organisation highlighted 5 key health benefits that can be achieve through improving green infrastructure planning:

- Increasing physical activity
- Improving air quality
- Improving mental health and wellbeing
- Improving social cohesion
- Increasing opportunities to grow food locally

Access to green infrastructure in the city is linked with deprivation, with the more affluent areas having 18% more than the more deprived areas. Lower levels of green infrastructure are also associated with higher levels of poor health, such as heart disease and mental ill-health.

Further information on the Green Infrastructure Strategy, and the links between health and access to green space is available via: www.ginw.co.uk/liverpool

10. Next Steps

The JSNA is an on-going process of developing our understanding of health and wellbeing issues in Liverpool. This report does not contain all of the detail of the JSNA, but provides a short update on developments and provides a brief overview of some of the key issues in the city. More detailed information on the wide range of topics is available on the JSNA webpage: www.liverpool.gov.uk/jsna

There are a number of work areas currently in development:

- Over the coming months, an in-depth report is being developed looking at the health needs of older people in Liverpool. This is being produced with a wide range of partners, and will consider issues such as re-ablement, dementia, carers, care homes and end of life care. The final report will be available early in 2015.

- Building on the life-course approach to the JSNA, we aim to develop a more detailed report looking at early years. This will bring together many of issues identified through the JSNA into a more holistic view of children at the start of their lives. As part of this piece of work, we are also collaborating with partners across Merseyside to develop our understanding of child sexual exploitation.

- A dental health needs assessment is being developed with partners across Cheshire & Merseyside, looking at issues of dental health and availability of dental services across the area. The final report will be ready towards the end of 2014.

- In collaboration with a number of partners, a themed report is currently being developed looking at the issue of Domestic Violence in the city. This builds on previous work undertaken in Liverpool by the Ending Violence Against Women and Girls network, as well as reports produced by the sub-group of the Mental health Consortium – "What Women Want".

- The Pharmaceutical Needs Assessment for Liverpool is in development. This looks at the provision of a range of services through pharmacies against levels of need. This is being developed in partnership with NHS England, Liverpool CCG, HealthWatch and the Local Pharmaceutical Committee. The final report will be released in March 2015.

We welcome your thoughts on the JSNA process, including anything you feel is a particular issue for Liverpool, or how we have presented the information. If you have any comments, or would like to be involved please contact us via: healthandwellbeing@liverpool.gov.uk

Appendix 1: Liverpool Ward Health Matrix

Key:

	Significantly worse than Liverpool average
	Worse than Liverpool average, but not significantly
	Better than Liverpool average, but not significantly
	Significantly better than Liverpool average

Theme	Demographics					Wider Determinants								Child Health									Lifestyle					Mortality			
Outcome	Total Population	Not White British or Irish (%)	Main Language English (%)	Male Life Expectancy at Birth	Female Life Expectancy at Birth	Indices of Deprivation 2010 (Rank)	CACI Household Income (Mean)	Housing Tenure - Registered Social Landlord (%)	Children in low-income families (%)	No cars or vans in household (%)	GCSE Attainment - Students Gaining 5+ A* - C Including English & Maths (%)	ESA/IB Claimaints	Anti-Social Behaviour Rate per 1,000	Number of Live Births	Low Birth Weight (Births <2500g) (%)	Breastfeeding at New Born Visit (%)	Breastfeeding at 6 weeks (%)	Excess weight in 4-5 year olds - Reception Year	Excess weight in 10-11 year olds - Year 6	% of children immunised at 5 years - MMR (1st and 2nd dose)	Tooth decay in children aged 5	Under 18 Conception Rate per 1,000	Adults who smoke (%)	Admission episodes for alcohol related conditions rate per 100,000	Adults who undertake moderate or vigorous exercise (%)	Adults who are overweight or obese (%)	Adults with a long term illness, disability, or health problem (%)	All Age Mortality Rate per 100,000 - All Causes	All Age Mortality Rate per 100,000 - Cardiovascular	All Age Mortality Rate per 100,000 - Cancer	All Age Mortality Rate per 100,000 - Bronchitis, emphysema & other COPD
Time Frame*	2012	Census 2011	Census 2011	2010-12	2010-12	2010	2013	Apr-13	2011	2011	2013	May-13	2012/13	2012	2012	2011/12-2012/13	2011/12-2012/13	2009/10-2011/12	2009/10-2011/12	2012/13	2012	2009-11	2011/12	Q2-2013/14	2012/13	2012/13	2012/13	2010-12	2010-12	2010-12	2010-12
Liverpool LA	**469,690**	**13.7**	**93.7**	**76.1**	**80.2**	**1**	**£30,100**	**26.5**	**32.5**	**46.1**	**56.6**	**11.0**	**54.4**	**5,942**	**7.6**	**36.1**	**29.1**	**27.1**	**38.5**	**91.5**	**35.8**	**40.4**	**29.4**	**3,048**	**37.7**	**53.6**	**24.6**	**687.9**	**164.3**	**222.3**	**47.0**
Core Cities Average				77.2	81.5				29.4	38.5	56.5			7,988	8.0		45.5	25.2	38.1	86.0	33.1	42.8		2,467				620.9	162.9	194.0	36.5
North West		11.9	94.9	77.7	81.7				22.1	28.0	59.9				7.2		33.0	24.3	35.6	90.7	34.8	39.2	22.1	2,402				596.9	162.1	181.35	32.6
England		19.2	92.0	79.2	83.0		£36,400		20.1	25.8	60.8	6.2			7.3		47.2	23.7	34.8	87.7	27.9	34.0	20.0	1,951				529.5	144.2	166.58	25.8
Allerton and Hunts Cross	14,742	7.4	97.3	78.1	82.8	26	£35,500	12.6	16.8	25.2	72.5	6.7	25.7	156	4.2	37.5	31.9	24.3	35.1	93.7	15.0	16.0	8.2	2,223	52.0	49.2	14.8	564.4	136.0	207.2	19.3
Anfield	14,442	6.8	96.5	73.2	76.5	8	£25,600	20.7	41.9	57.2	54.1	18.2	60.8	195	8.7	23.0	18.6	30.7	43.4	87.0	40.4	58.8	42.8	3,777	36.2	55.5	26.6	874.9	205.4	257.1	63.3
Belle Vale	15,048	5.7	98.5	76.9	81.1	13	£26,200	42.8	34.1	46.6	44.7	13.4	29.1	177	7.6	24.1	16.2	25.3	42.6	92.8	47.5	44.3	30.1	3,206	42.3	57.3	35.5	657.5	172.8	246.9	53.9
Central	21,519	36.9	75.8	78.0	88.4	18	£33,800	12.6	42.7	65.5	46.7	2.7	115	102	8.6	66.8	55.2	26.5	42.7	75.3	-	26.8	34.4	4,266	31.6	45.3	16.4	712	154.6	206.4	34.6
Childwall	13,894	6.2	98.3	83.6	85.2	27	£38,500	5.9	10.1	20.3	75.3	5.9	20.1	156	4.9	43.0	35.9	24.4	30.4	94.9	16.4	19.9	21.8	1,824	45.6	56.0	28.6	406.1	97.0	152.7	20.9
Church	14,119	10.1	96.9	82.3	84.0	30	£41,300	2.2	7.6	21.0	78.3	4.1	20.8	144	10.5	63.1	52.5	20.7	30.0	93.0	24.0	24.1	13.0	1,567	74.1	49.2	12.9	441.4	101.4	152.3	23.7
Clubmoor	15,220	3.4	98.6	73.8	80.2	9	£24,500	43.7	39.3	49.1	46.8	16.3	62.3	166	8.1	23.4	17.4	30.1	40.4	93.7	50.0	44.8	33.2	2,841	22.8	56.1	39.6	735.0	166.7	260.6	57.3
County	14,022	4.5	98.0	73.1	80.4	7	£25,500	21.0	40.3	57.3	47.7	16.5	84.1	242	7.6	17.1	13.3	27.6	37.0	95.0	37.5	56.3	27.1	3,246	45.6	46.2	17.2	744.4	165.6	269.2	48.6
Cressington	14,691	9.2	96.9	78.2	81.3	24	£36,800	16.0	16.6	28.7	63.4	9.0	19.3	159	7.5	42.2	28.9	24.3	30.6	93.9	28.6	28.2	23.0	2,008	35.2	52.7	17.7	588.0	157.9	160.4	30.5
Croxteth	14,530	7.9	96.7	74.0	76.7	20	£33,500	26.9	24.5	33.2	56.6	10.8	53.7	192	6.7	27.2	20.3	23.6	34.2	94.6	25.0	31.6	29.3	2,455	26.3	58.0	36.6	871.8	188.6	239.0	63.5
Everton	14,734	11.4	94.9	75.0	77.4	1	£22,100	55.7	50.8	65.5	42.6	23.1	66.6	180	9.4	22.9	15.7	29.9	44.2	88.3	39.1	54.3	31.3	5,166	23.5	46.2	32.9	806.5	206.4	284.5	66.6
Fazakerley	16,791	6.0	97.2	76.0	81.1	17	£30,500	15.3	23.3	36.8	50.8	11.0	50.2	224	7.0	27.6	23.0	23.9	34.4	97.0	39.3	36.5	23.8	2,349	53.8	52.6	35.5	717.0	167.5	217.0	48.4
Greenbank	16,324	20.7	92.0	75.6	78.7	23	£30,400	20.9	25.5	49.1	53.1	5.1	26.1	138	5.7	65.2	57.0	23.8	39.8	81.5	28.6	52.3	29.1	2,991	55.8	34.4	10.3	810.4	190.4	241.4	32.0
Kensington and Fairfield	15,694	30.3	85.1	74.3	79.5	5	£23,300	27.1	45.8	63.9	49.5	15.7	77.4	261	8.3	44.9	42.3	31.8	45.4	86.4	44.8	58.5	33.3	3,965	22.2	40.3	7.0	767.1	202.0	267.3	50.9
Kirkdale	16,212	9.7	95.2	71.5	75.7	2	£25,600	44.2	50.1	62.7	41.0	16.5	82.9	203	8.0	21.0	14.7	33.4	41.6	85.1	40.0	70.9	32.1	5,126	37.8	59.4	39.1	947.0	213.1	293.9	82.2
Knotty Ash	13,250	5.4	98.4	77.5	79.7	19	£30,300	28.7	29.8	41.0	61.7	12.7	68.8	149	7.2	27.1	19.4	30.4	37.8	91.0	27.0	31.0	29.9	2,758	31.0	59.8	43.3	710.3	195.3	200.9	39.5
Mossley Hill	13,628	8.7	96.7	78.4	85.4	28	£40,300	9.8	8.2	22.6	78.1	5.5	14.6	156	6.9	62.4	50.2	21.6	34.7	93.6	15.5	25.3	16.9	1,902	36.0	43.3	25.7	497.4	121.0	155.7	12.5
Norris Green	15,380	6.8	96.3	75.1	78.1	6	£24,400	52.3	43.7	52.2	49.5	13.4	62.1	254	7.4	15.1	12.0	27.0	41.5	91.5	55.1	49.1	39.5	2,924	27.6	60.7	40.4	791.9	200.6	287.1	68.5
Old Swan	16,373	8.9	96.4	74.6	78.3	15	£28,700	19.2	30.1	48.2	60.2	12.2	52.1	233	7.9	29.3	23.1	26.4	45.0	94.4	37.3	44.5	30.6	3,428	36.4	57.5	18.8	811.7	205.4	261.6	62.9
Picton	17,360	39.8	80.2	72.4	78.4	12	£23,300	29.6	48.8	62.6	40.6	11.8	60.7	284	8.6	54.1	44.0	25.0	46.0	84.7	52.8	54.0	39.5	3,567	39.2	42.2	8.2	852.7	217.7	291.8	71.4
Princes Park	17,650	51.2	77.7	73.0	80.2	3	£24,300	55.1	55.1	67.3	36.4	15.4	67.6	280	9.1	61.3	50.4	29.9	43.2	82.3	51.3	43.8	31.0	4,408	28.4	54.7	16.4	778.2	168.8	251.6	71.1
Riverside	18,662	20.4	90.2	75.3	78.1	11	£32,500	32.0	44.9	54.4	38.0	10.1	79.4	221	10.1	40.5	33.3	29.1	38.1	89.9	54.2	37.5	35.9	3,093	42.7	57.8	40.2	821.6	181.2	263.7	62.6
St Michael's	12,856	15.5	94.6	76.1	81.7	21	£35,800	19.8	25.4	40.1	63.1	10.4	39.6	165	6.3	63.3	54.7	29.9	32.6	91.4	25.0	47.7	38.1	3,624	53.6	44.1	14.1	669.0	164.0	182.5	50.6
Speke-Garston	20,527	8.4	96.0	75.1	80.1	4	£24,600	45.8	42.4	51.9	47.8	13.0	53.0	336	7.9	21.9	17.8	24.6	35.0	91.4	38.9	57.3	34.4	3,570	26.4	65.3	19.1	715.8	175.8	234.7	72.6
Tuebrook and Stoneycroft	16,658	11.0	94.5	75.0	82.0	10	£27,700	15.2	36.4	51.0	50.9	13	101	256	7.5	28.2	21.7	34.1	41.6	90.0	35.4	46.6	35.5	4,880	26.5	53.4	14.2	684	158	249	40.0
Warbreck	16,438	5.9	97.2	77.8	81.4	16	£31,000	14.1	26.7	39.9	53.8	9.3	46.2	213	8.6	31.9	24.5	24.9	37.9	95.8	26.1	41.7	35.1	2,796	43.5	65.7	27.8	604.6	144.9	220.6	36.1
Wavertree	14,834	12.4	95.9	78.3	81.8	22	£33,200	14.7	20.8	37.3	70.8	8.6	36.6	199	7.2	44.8	36.9	23.8	36.6	91.4	17.3	32.4	22.7	2,710	33.1	63.0	7.4	573.7	160.2	167.8	34.2
West Derby	14,375	4.7	98.0	79.3	82.8	25	£35,600	10.8	14.0	27.8	73.0	8.5	34.1	137	5.6	31.0	23.1	27.8	36.0	94.4	19.0	17.8	16.3	2,002	52.0	52.2	31.6	532.7	123.5	160.1	34.0
Woolton	12,988	8.6	97.2	82.0	85.0	29	£39,500	12.4	8.3	23.5	80.2	6.0	24.2	100	3.9	50.7	39.3	21.6	28.0	93.0	31.0	16.0	8.0	1,906	76.7	58.2	28.3	430.9	121.9	149.2	14.0
Yew Tree	16,729	9.3	96.1	74.3	80.0	14	£31,600	31.9	32.6	39.9	51.3	11.4	51.7	264	6.7	26.2	18.8	31.6	42.0	93.7	38.6	32.9	28.4	2,816	45.9	54.9	39.2	772.0	196.0	214.6	47.0

Appendix 2: Key issues to tackle for a healthy life

For a Healthy Start

- Almost 6,000 births a year in the city
- Just under 8% of babies are born with a low birth weight
- Around 1 in 6 mothers are smokers at the time when the give birth
- Levels of breast feeding are improving but remain low compared to other areas, with less than a third of babies being breast fed at 6weeks
- Uptake of MMR at 2years is comparable to England, but on a downward trend
- More than a third of children aged 5 have poor oral health
- Childhood obesity is increasing among Reception (28.4%) and Year 6 (39.1%)
- Levels of Children In Need are comparable with the Core City average.
- Around a third of children in Liverpool live in poverty (25,360 children)

For a Healthy Transition

- Around 1 in 10 children experience some form of mental disorder (5,500 children)
- More than half of children achieve 5 GCSEs grade A*to C (inc English & Maths)
- There are around 1,500 NEETs in Liverpool
- Levels of teenage pregnancy are falling, with 278 conceptions in 2012
- Prevalence of sexually transmitted infections are higher in Liverpool than in the North West or England. Levels peak in the late teens and early 20s.

For a Healthy Adulthood

- A quarter of adults in Liverpool smoke (98,000 people)
- 30,150 adults drink at levels of increasing risk, with a further 11,500 drinking at high risk
- Over half of adults in the city are overweight of obese (55%)
- 1 in 4 adults have fast food at least once per week
- 2 in 3 adults are classed as physically inactive
- 1 in 10 people have 2 or more long term conditions (49,500 people)
- Number of people with long term conditions:
- CHD = 3.5%
- Diabetes = 4.8%
- Stroke = 1.7%
- Depression = 11.4%
- Severe Mental Illness = 1.3%
- Dementia = 0.6%

For Healthy Ageing

- Life Expectancy in 2010-12:
  - Males = 76.1 years
  - Females = 80.2 years
- Men and women born in the least deprived areas of Liverpool live around 10years longer than their counterparts born in the most deprived areas.
- Healthy Life Expectancy in 2010-12:
  - Males = 59.2 years
  - Females = 59.1 years
- Around 2,700 people have been diagnosed with Dementia
- 1 in 3 older people will fall each year, leading to almost 2,000 hip fractures.
- Upto 16% of older people suffer from loneliness (14,100 people)
- Almost 26,000 older people have a long term illness that limits their day to day activities a lot.