Joint Strategic Needs Assessment 2018:

Appendix A

Background to *Improving Lives 2019-28*

What this is…

Somerset's Health and Wellbeing Board recognises that to take actions that genuinely improve people's lives there needs to be a complete understanding of the factors that influence their health and wellbeing. Every Health and Wellbeing Board is required to report on the health, care and wellbeing needs of the population in its area, called a Joint Strategic Needs Assessment (JSNA). For Somerset, this is made up of annual themed reports backed up by a website (http://www.somersetintelligence.org.uk/jsna/). The JSNA contains information about all the influences on people's health and wellbeing; this includes 'wider determinants' such as transport, housing, environment and the economy. The Improving Lives Strategy (2019-2028) describes the four priority areas the Somerset Health and Wellbeing Board agrees will make the biggest difference to improving the lives of the population. This summary describes why these priorities are important and describes why the board believe these will be the key areas to focus on.

and what it isn't.

This short summary cannot cover all the health and wellbeing needs, and wider determinants that exist in Somerset. It only shows those aspects that have emerged as priorities when the JSNA has been discussed. Similarly very local concerns, such as single GP practices or individual bus services, are not included.

What makes a good priority?

The Board felt that priority areas should be:

Improves wellbeing without disadvantaging specific groups	The Board want to improve lives for all, and will focus on reducing inequality
Distinctly Somerset	An issue that matters particularly to the county and should be addressed in the county
Challenging but deliverable	Something to stretch the performance of the Board and its members
Fits the collective powers of the Health and Wellbeing Board	A cross-cutting issue that is best delivered by the Board working as a partnership
The right size	An issue that affects a good proportion of the people and families in the county, and has a time-scale that is part of the ten year strategy

The Board has used these criteria to study the evidence from published sources and has extensively engaged stakeholders. The Board welcomes contributions from everyone on whether these are the right priorities, and how the strategy will help and Improve Lives in Somerset over the next ten years.

JSNA on a page

healthy, safe and independent

7.7% of adults on GP registers are recorded for depression

The last 16 years of life are typically spent in ill health; dementia is set to double

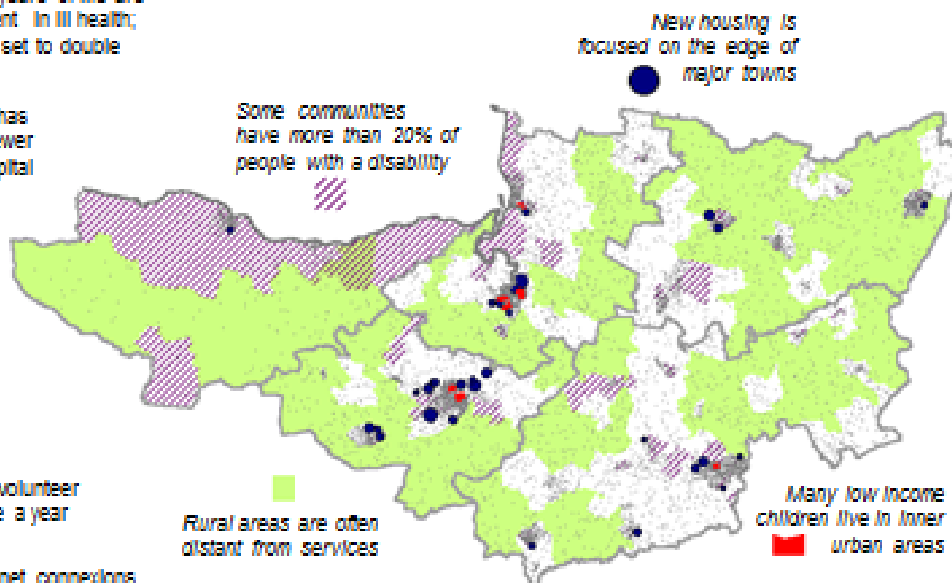
'Home first' has seen 35% fewer delayed hospital discharges

strong and productive local economy

Unemployment (3.9%) is consistently lower than England

Somerset's productivity gap with the UK is about 13%

Somerset average income is £20,636 p.a compared to £23,350 nationally



70% adults volunteer at least once a year

58% of internet connexions are >10mps

33,500 people aged over 65 live on their own

Improving Lives

strong, vibrant, balanced communities

91% of schools are good or better

Breastfeeding rates are 19% lower in deprived communities

421 households were accepted as homeless in 2016/17

fairer life chances

Key indicators

Healthy life expectancy 2014-16 (years)	Men	64.8
	Women	68.4
Gap in healthy life expectancy between most and least deprived neighbourhoods (years)	Men	8.9
	Women	8.0

Priority one: A county infrastructure that drives productivity, supports economic prosperity and sustainable public services

http://www.somersetintelligence.org.uk/economy-and-jobs.html

Why does it matter?

The economy is one of the most important ‘wider determinants of health’, and can support health in a number of ways. It is a complex relationship with the economy contributing to good health and conversely good health contributing to the economy.

Most obviously, perhaps, a strong economy is needed to pay for services. Less obviously, good work is good for our health. As well as giving us income, which pays for decent housing and good food, and the security essential for mental health and wellbeing, work can provide a sense of purpose and is, for many adults, the source of much social contact. Work is usually very beneficial so long as it is not exploitative, with excessive hours, unsafe conditions or stress beyond a healthy level – and in these circumstances can be positively harmful.

Productivity

Productivity underlies prosperity. It is a measure of how much value is produced on average by each person in an area, so a productive economy will usually have a high proportion of people working full time in well-paid, skilled jobs using modern equipment

In 2017, 30% of employees in Somerset were employed part-time, compared to the England average of 24%. Whilst this may well suit the individuals concerned, they are necessarily less well-paid than their full-time equivalents. Figure 1 shows a similar pattern of employment in the types of job available in the county: Somerset has a lower proportion of workers in managerial, professional and technical jobs, and higher proportions in trade, leisure and sales jobs. These reflect the number of jobs in caring for Somerset’s generally older population and tourism sectors, and are likely to be part-time and to be lower paid. It is no surprise, then, that the average income in Somerset is £20,636 per year, compared to a national average of over £23,350 per year.

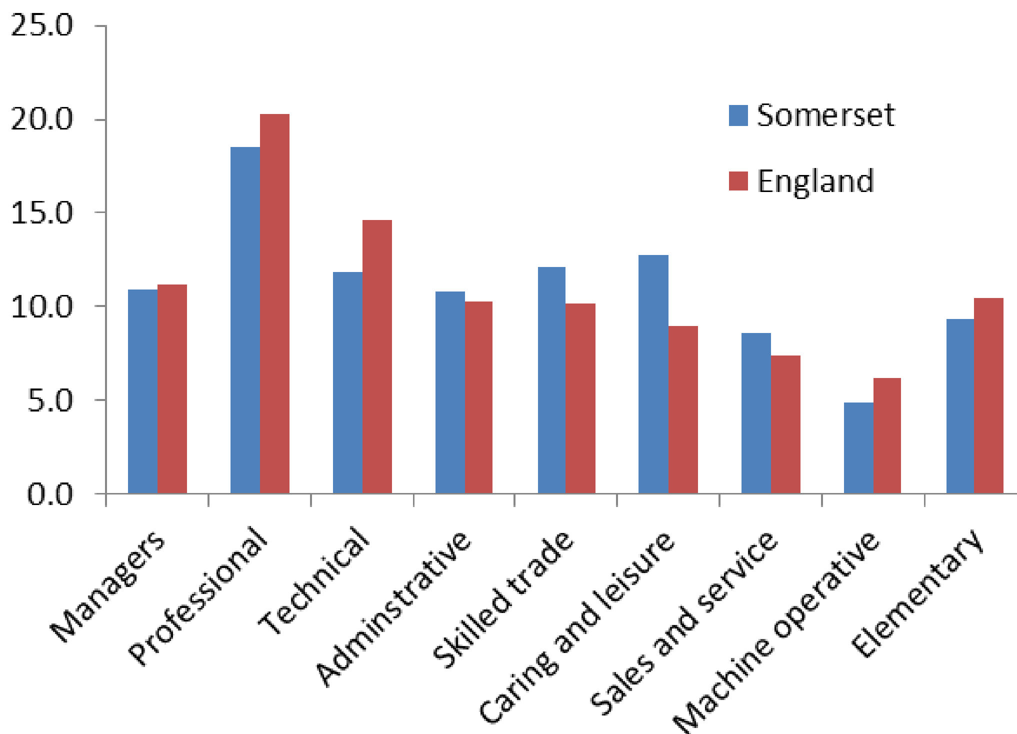


Figure 1: Types of Employment

Productivity in Somerset

Raising productivity is key to raising incomes for workers, the quality of jobs and revenues to pay for public services. The sluggish growth in UK productivity since the recession is a national cause for concern, and Somerset's workers produce, on average, 13% less 'value' than the national average. Somerset is at a 'natural' disadvantage because of its elderly population structure, meaning that however effectively those of working age (from 16 to the qualification age for the state pension do their jobs, they make up a smaller proportion of the total than in many other areas of the country. This working age group also generally makes less use of health and care services than younger and older people. By 2039 the proportion of Somerset's population of working age (16-64) will fall by 8%. Economic drivers of productivity include investment in workforce skills and equipment, and competition between firms. Productivity is also closely related to infrastructure, so that firms are able work better with good transport links and, of course, digital connectivity.

Employment and unemployment

Given the health benefits of work, *Improving Lives* cannot overlook the importance of moving people from being out of work to being in employment. Economists tend to focus on the working age population, and indeed the 2017 JSNA on *Ageing Well* found that the rates of economic activity – people either in work or looking for work -

fell from about 70% for those aged 50-64 to about 10% for those aged over 65. This dramatic drop can be a ‘cliff-edge’ for individuals with powerful financial, social and health ill-effects. The ‘young elderly’ are an asset for the county, and the Board was told of the value of ‘*still using the skills, knowledge and experience you’ve gained working into your retirement*’. A focus on current employment should not distract from the value of older people’s work – including voluntary work.

There are already many positive aspects to the Somerset labour market. The proportion of people unemployed and looking for work has been consistently lower than the England average for many years, and the proportion of the workforce who are in work has also been consistently higher (these normally go together, but as people may be out of work ‘voluntarily’ to look after families or study this isn’t always the case).

Figure 2 shows how employment has been rising and unemployment falling since 2011. This is clearly good for the individuals concerned and for Somerset as a whole. It does, though, pose a challenge as many people who are now seeking work are difficult to employ – for many reasons (63% of those receiving jobseekers allowance have been doing so for more than six months), and many of the economically inactive are content to be studying, looking after homes and children or retired early. Continued growth in the economy, including the public sector, may be held back by difficulties recruiting staff, especially if international migration is reduced in line with government policy.

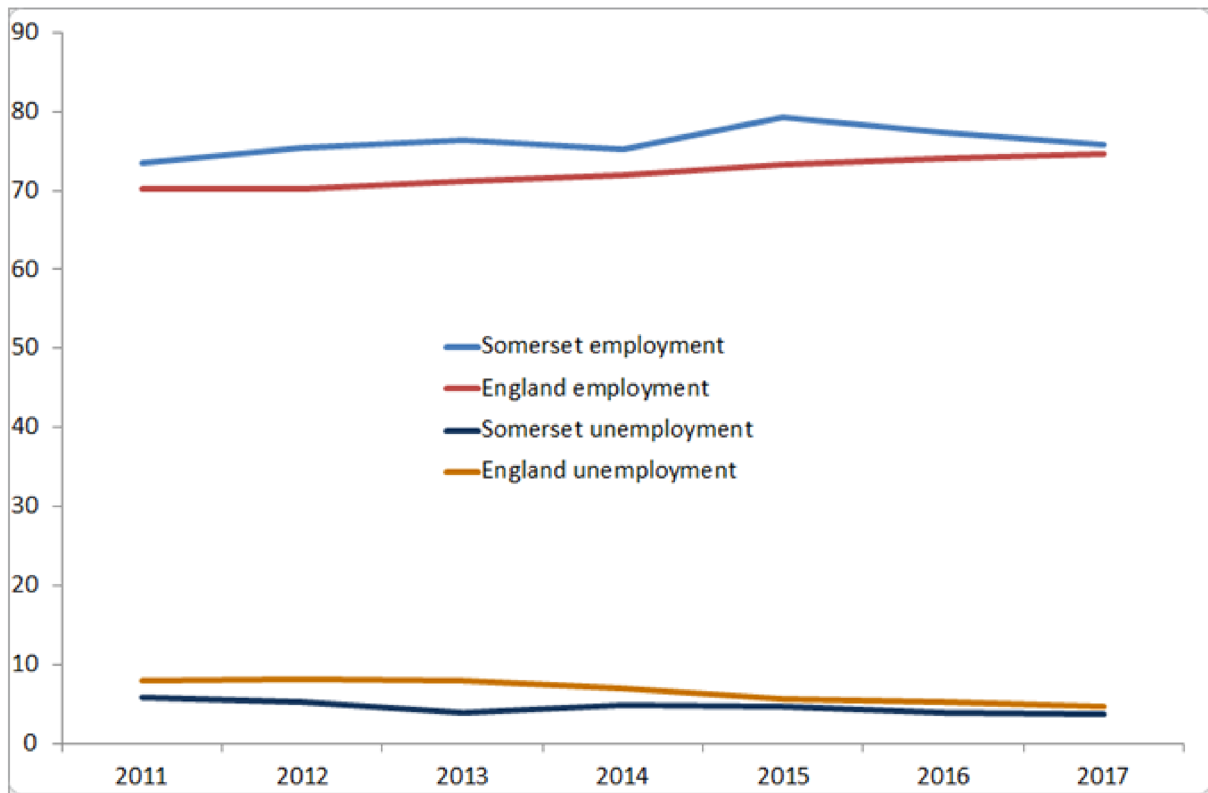


Figure 2: Employment and Unemployment

Unemployment in Somerset is very low. It is often thought that 'full' employment for a labour market area includes one or two percent unemployed, as people move between jobs or first enter the labour market. Figure 3 shows that for many wards in Somerset unemployment is below 1.5%, and is only above 2.5% in a few communities, mainly in larger urban areas. These contrasts emphasize the need to take into account localities' differences in implementing the strategy. These figures are based on people claiming unemployment-benefits; they do not reflect the overall level of unemployment based on surveys that can be reported at a county level, and the recent introduction of Universal Credit means they cannot be compared with figures based on earlier benefits.

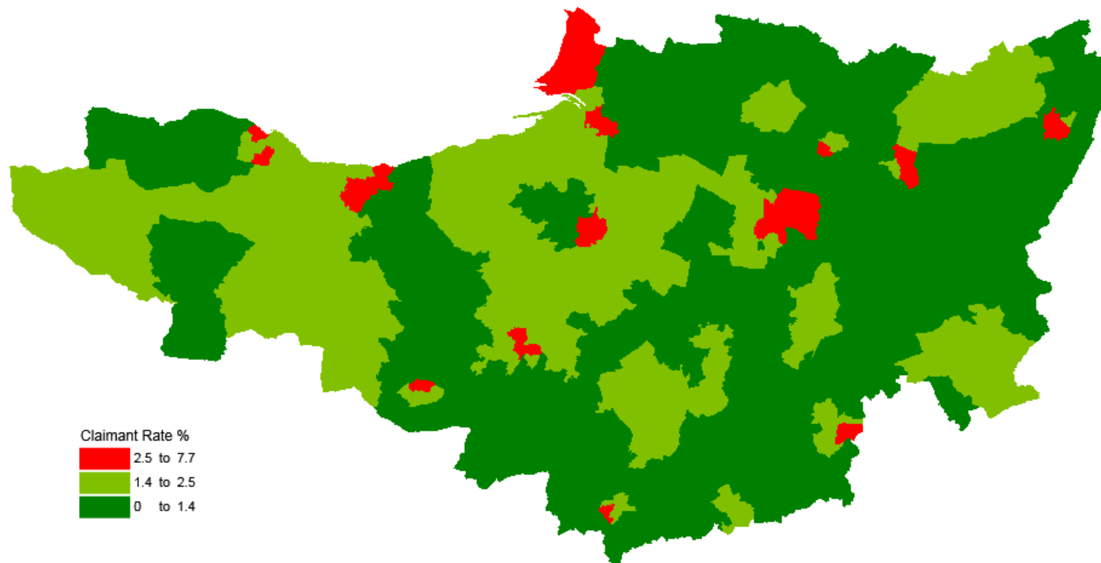


Figure 3: Claimant Count Unemployment by Ward January 2018

Skills

Productive and rewarding jobs tend to be those with the highest skills. It will help the Somerset economy to become more productive if it can draw on a skilled workforce. As Figure 4 shows, the county workforce has a skills mix broadly similar to England. There is about the same proportion of people with no qualifications, but rather more people with level 1 (GCSE D-G), 2 (GCSE A-C) and apprentice qualifications and fewer at level 3 (A level) and 4 (NVQ 4). Jobs available to these people are likely to be less well paid and less productive than those needing higher skills. It may make it harder to attract employers who need highly skilled workers to the county.

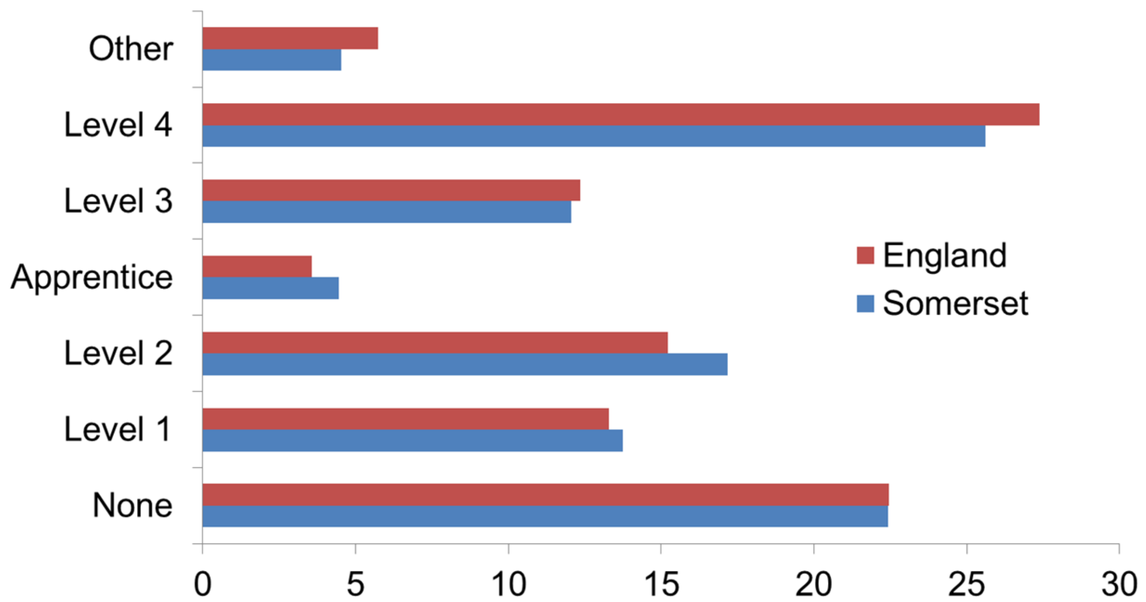


Figure 4: Skills of the Somerset workforce

Summary

Somerset's economy has many people working, and few looking for work. The jobs, though, generally require lower skills than nationally, and are more poorly paid. Raising productivity offers the opportunity to increase wages and job satisfaction, and produce more money for services. Improving productivity requires good infrastructure, a skilled workforce and other factors such as the quality of the environment and schools that can help attract businesses to the county.

Priority 2: Safe, vibrant and well-balanced communities able to enjoy and benefit from the natural environment

http://www.somersetintelligence.org.uk/jsna/#WiderDeterminants

Why does it matter?

For most people, living in a safe and attractive community adds hugely to personal wellbeing, and opportunities to exercise and meet other people improve mental and physical health. Family, friends and communities build the foundations of good health through positive relationships and networks, community cohesion, opportunities for social participation and shared ownership and empowerment. Somerset ranges from some of the sparsest populated parts of England to large towns close to trunk roads and motorways, and the *Improving Lives* strategy, through the JSNA, demonstrates an understanding of these different communities' needs. The strategy is taking a 'place-based' approach and is framing communities as groups of people living within the geographical area. Other types of communities, such as online communities, cannot be ignored and play an important part in the lives of many of Somerset's residents.

Community Safety

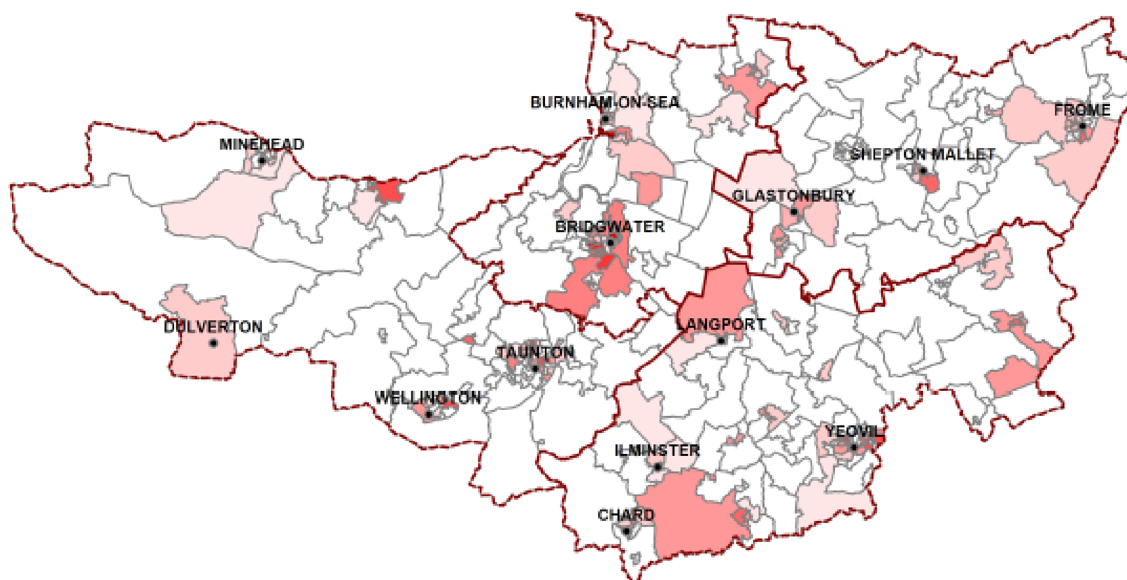


Figure 5: Incidence of Domestic Violence

Feeling safe is a fundamental human need, for most people, most of the time, Somerset is a safer place to live, with a total crime rate lower than for England.

However, the risk of crime is very different for different people, at different times and in different places. Some people may be afraid of crime even when the risk is negligible. Figure 5 shows how the *recorded* incidence of one crime - domestic violence - varies across the county, with a higher rate apparent in towns and especially the more deprived urban areas. Domestic violence and abuse affects whole families and has a harmful influence on children’s lives. However it is very difficult to identify and is under-reported, so these patterns may not reflect the actual distribution. Higher rates in some areas might also reflect that services and communities are working effectively to support victims.

Social Contact and Loneliness

Being lonely has been found to have the same adverse impact on health as smoking 15 cigarettes a day. Loneliness can affect people at all ages and in all circumstances, and whilst old age or rural isolation are undoubtedly contributors Figure 6 shows how the cumulative risk, based on factors such as living alone, low income and transport, is highest in the more deprived communities. Groups such as widowed, older homeowners living alone and unmarried, middle-aged people (with long term conditions) and younger, ‘rootless’ renters have a high risk of loneliness.

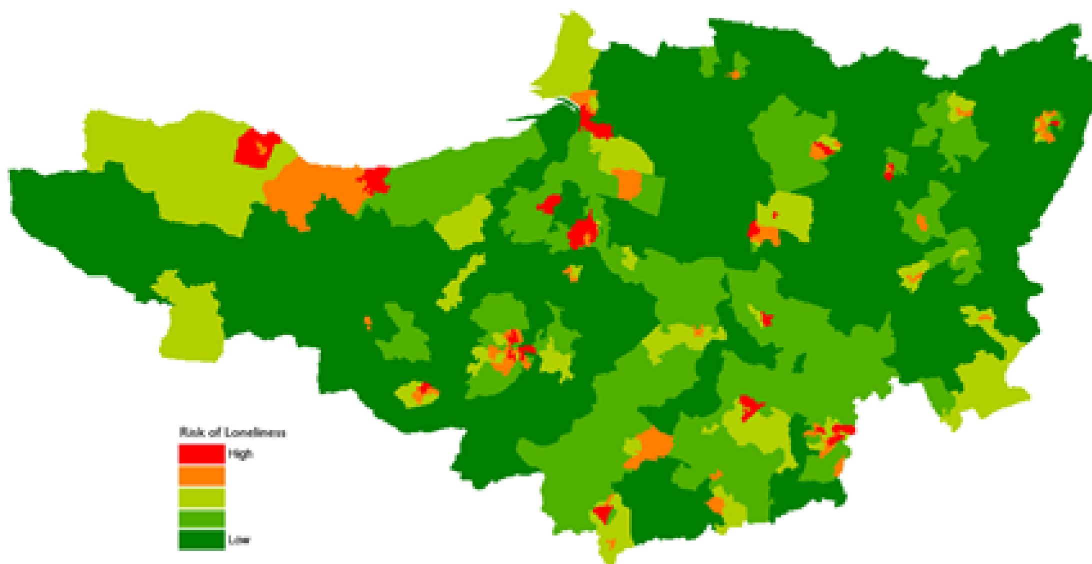


Figure 6: Risk of Loneliness

Rurality

Much of Somerset’s distinctiveness comes from its rurality, with 48% of the population living in areas described as ‘rural’ by the Office for National Statistics. Many people who live in rural areas do so by choice: they accept the distance from

services in return for the environmental quality, and the opportunity for exercise and contemplation in the countryside is a huge asset in promoting health and wellbeing in the county.

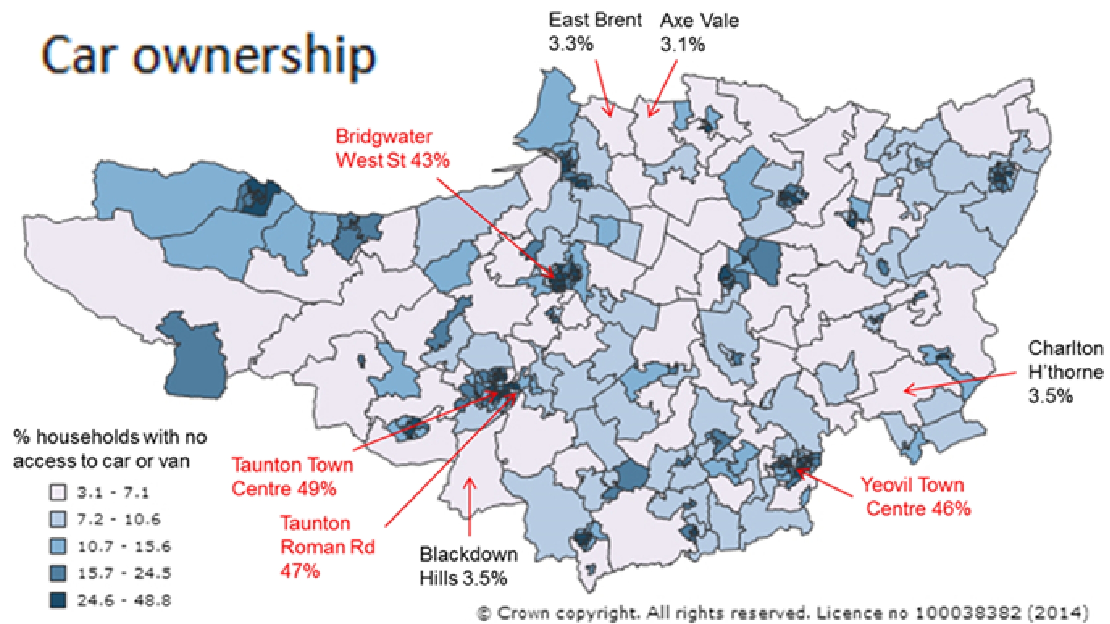


Figure 7: Car Ownership in Somerset

As Figure 7 shows, living in a rural area makes owning a car almost essential, and the proportion of households without a car is less than 10% in most of the countryside. However, just because a household has a car, it does not mean that all members of the household have access to it all the time: when one member takes the car to work, the other members may be left alone – and this may often be a mother and her children. Figure 8 seems to demonstrate a related phenomenon, that in some households (this is a survey of people receiving social care) women can be dependent on husbands to drive, and that when that support disappears through age-related illness or death, the wife or widow can find herself isolated through a lack of transport. This gender difference was not apparent in urban areas or rural towns. Young people who have not passed their driving tests, or cannot afford a car (or insurance) are similarly isolated.

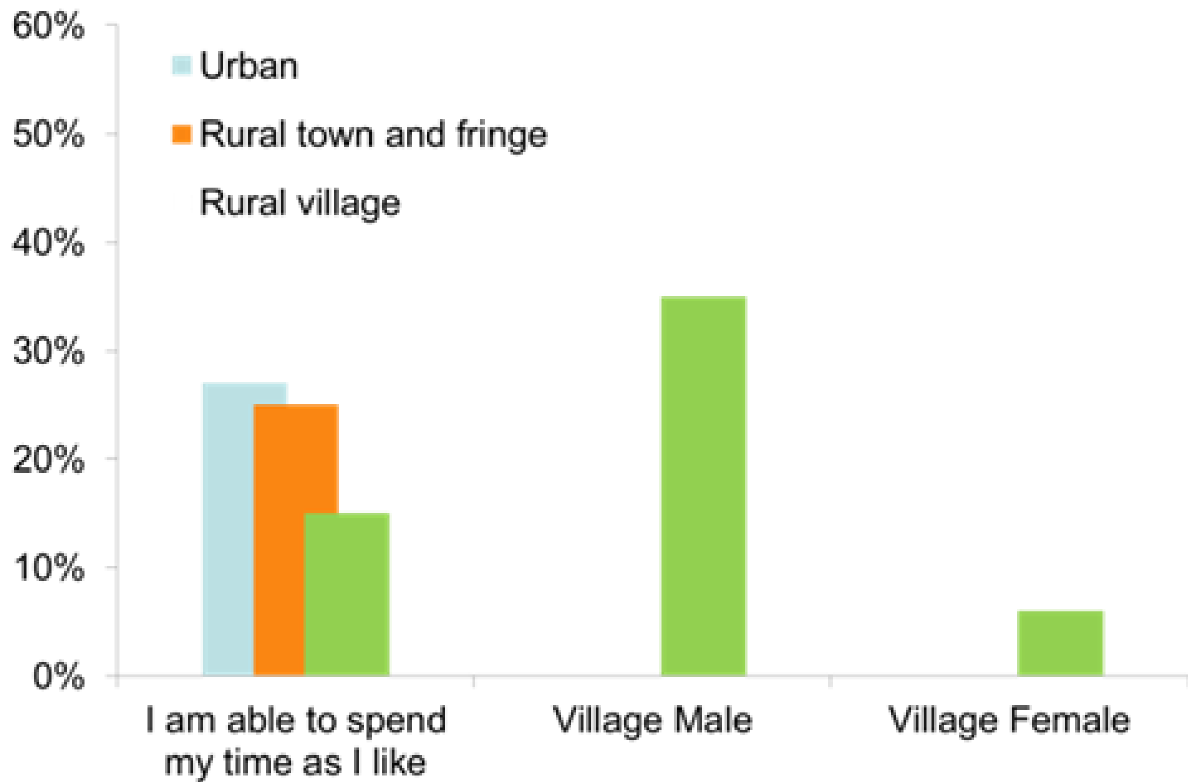


Figure 8: Independence in social care users in rural and urban areas

Transport and access in rural areas are particularly vulnerable to winter snow and floods can hit communities hard. In the first few months of 2014 villages such as Moorland and Muchelney were flooded and cut off respectively, as shown in Figure 9. It is at times like this that community resilience – both in living through the difficulties and recovering afterwards – comes to the fore. These events can have long term impacts on mental health. Global climate change is likely to increase the risk of severe weather in coming decades.

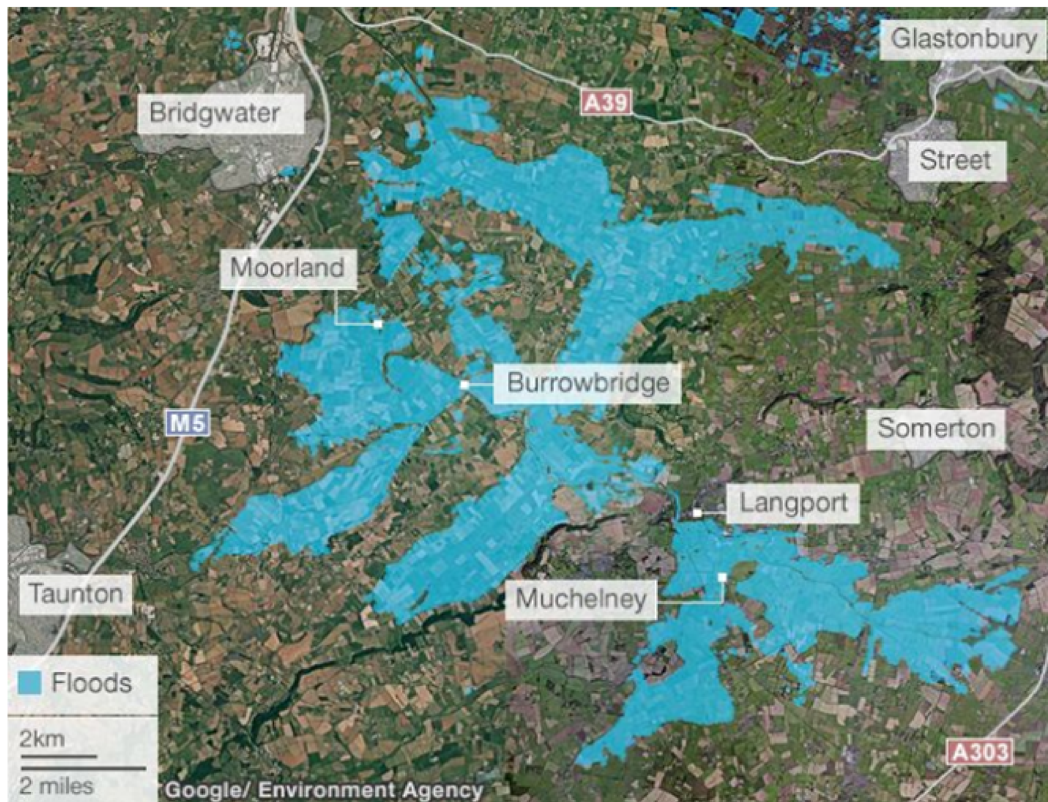


Figure 9: Flooding in February 2014

Population groups

There are not only 'communities of place', but also 'communities of identity' who may have particular needs based on age, gender or other status. Many such characteristics are protected in law by the Equalities Act 2010, and within Somerset military status and rurality are also taken into consideration in policy. Understanding such differences is essential to promoting good health without increasing inequality. As an example, men who have sex with men may have particular health risks that need to be taken into account. However small a proportion members of minorities make up, such as those who are not 'White British' (shown in Figure 10), their needs as groups cannot be overlooked. Many people have, of course, many such characteristics.

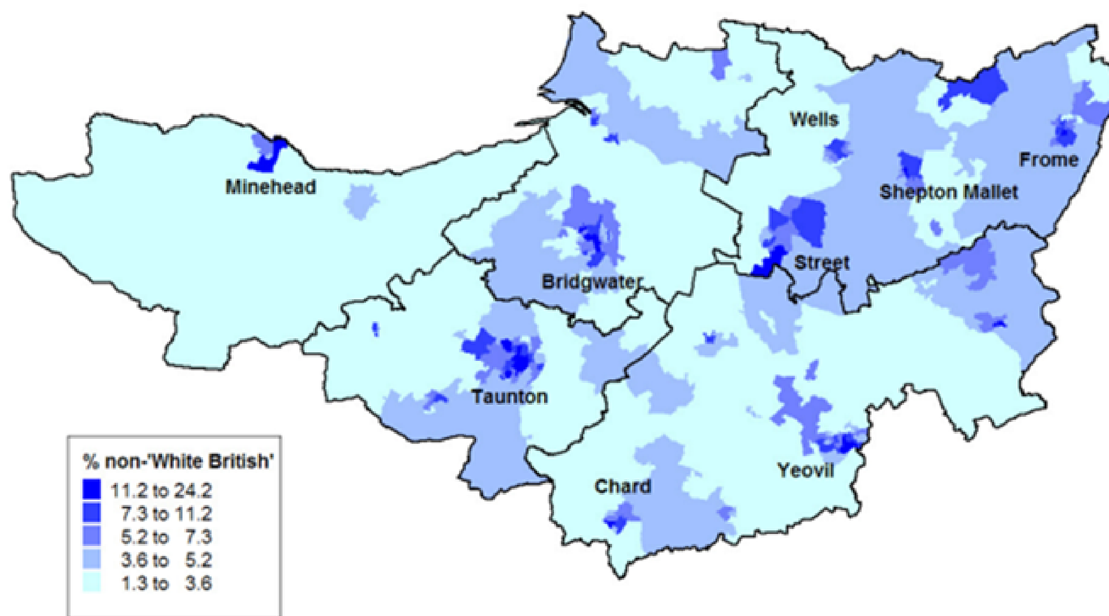


Figure 10: Percentage 'non-White British' in 2011 Census

More recently, 'virtual communities' have emerged as a new but significant phenomenon. The internet means that individuals with common interests can find each other more easily and stay more connected despite physical distance. One young person said, '*We use technology more in rural areas because we're more isolated*'. Figure 11 shows that internet access varies considerably across the county, and slow speeds create difficulties for individuals – not only the young – and businesses.

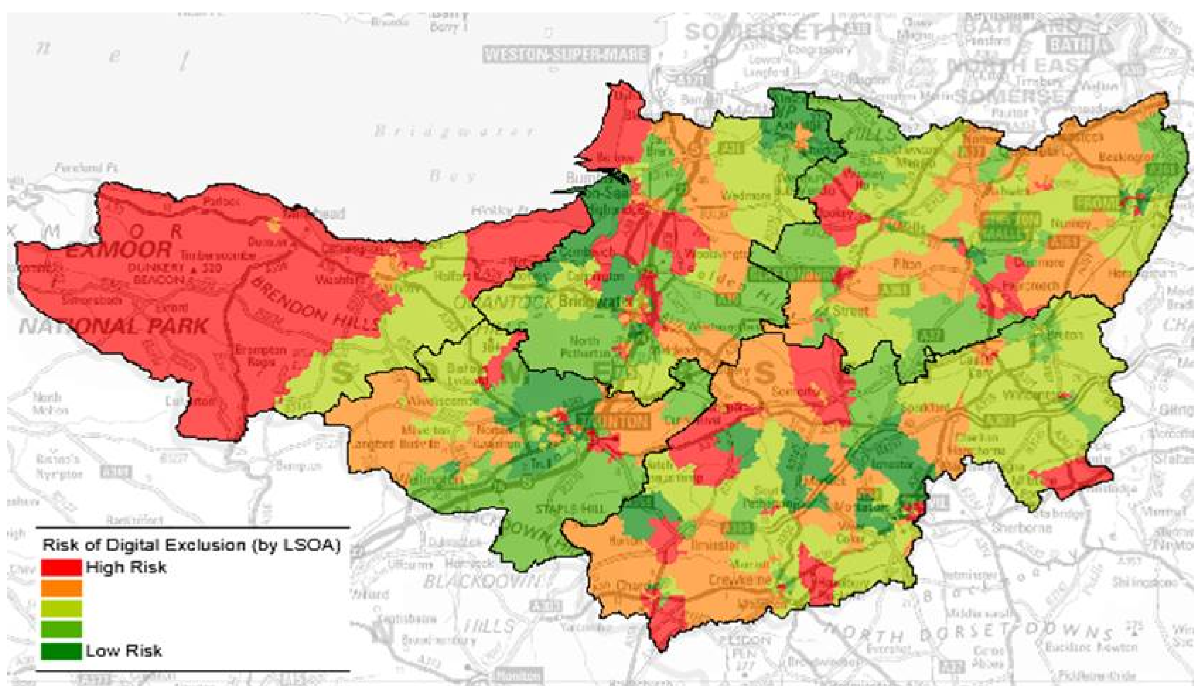


Figure 11: Risk of digital exclusion

Summary
Safe and resilient communities are essential for healthy and contented lives. It may be hard to measure a community's strength but its characteristics – such as neighbours helping each other, formal volunteering, or being able to walk and cycle safely to the shops – are easily seen. The needs and resources of Somerset's local communities vary considerably, and what works in an urban housing estate may be inappropriate for sparsely populated Exmoor.

Priority 3: Fairer life chances and opportunity for all

http://www.somersetintelligence.org.uk/cyp/

Why does it matter?

Health and Wellbeing Boards are specifically charged with reducing inequality within their areas. This summary has already shown how population groups and communities vary greatly in their needs and resources. Inequality in children's wellbeing is especially important because the effects of a good start can last for a whole lifetime. Conversely, the harm of a poor start in diet, exercise and education, or exposure to trauma, for example, has the potential to create specific and limiting difficulties throughout life.

Low Income

Low income can contribute to poor health and wellbeing through a number of ways. Low income makes it harder to access material resources; adopt and maintain healthy lifestyle behaviours and is often associated with increased exposure to stress. Children living in poverty experience many stressors and it can have a lasting impact on cognitive development, skill development and educational attainment.

Figure 12 shows the neighbourhoods with the highest concentration of children in low-income households, with 10% of these children living in just 0.07% of Somerset's land area. This concentration is an opportunity for addressing the needs of a significant number of children with a focused, localized approach.

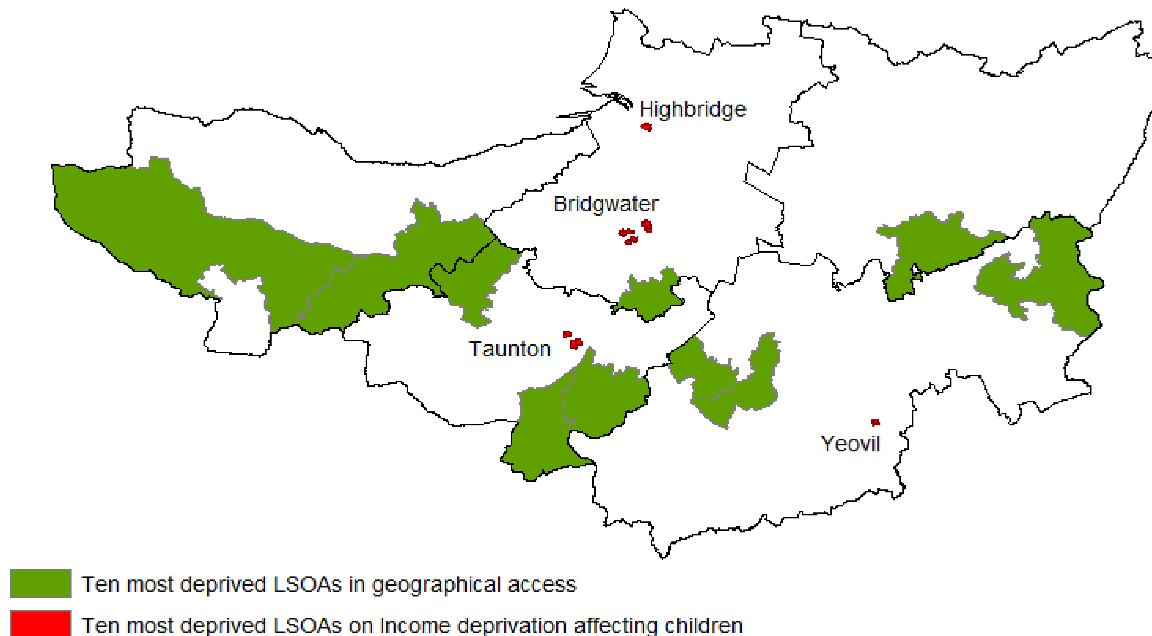


Figure 12: Income deprivation affecting children, and sparsity

Figure 12 also shows the ten most deprived neighbourhoods in terms of geographical access to services – in other words, the most sparsely populated parts of the county - which tend to have a much more elderly population than the towns. This does not mean, of course, that there are no children in need in these areas: indeed identifying them and their needs, and addressing them presents particular challenges.

The best start in life

Figure 13 shows a clear example of how babies born in less deprived communities experience some early life advantages compared to their more deprived peers. Not only are the initiation rates for breastfeeding somewhat higher but the continuation rates at about seven weeks are noticeably higher, exacerbating the existing inequalities between the two groups. Breastfeeding helps with emotional development and promotes resistance to illness, so those children from wealthier communities are likely to take that advantage into improved nursery and school attendance and self-esteem. Early exposure to adverse childhood experiences including abuse and neglect are more likely to occur in more deprived areas. These experiences are an established risk factor for later physical and mental health and wellbeing, and should be a target for prevention efforts.

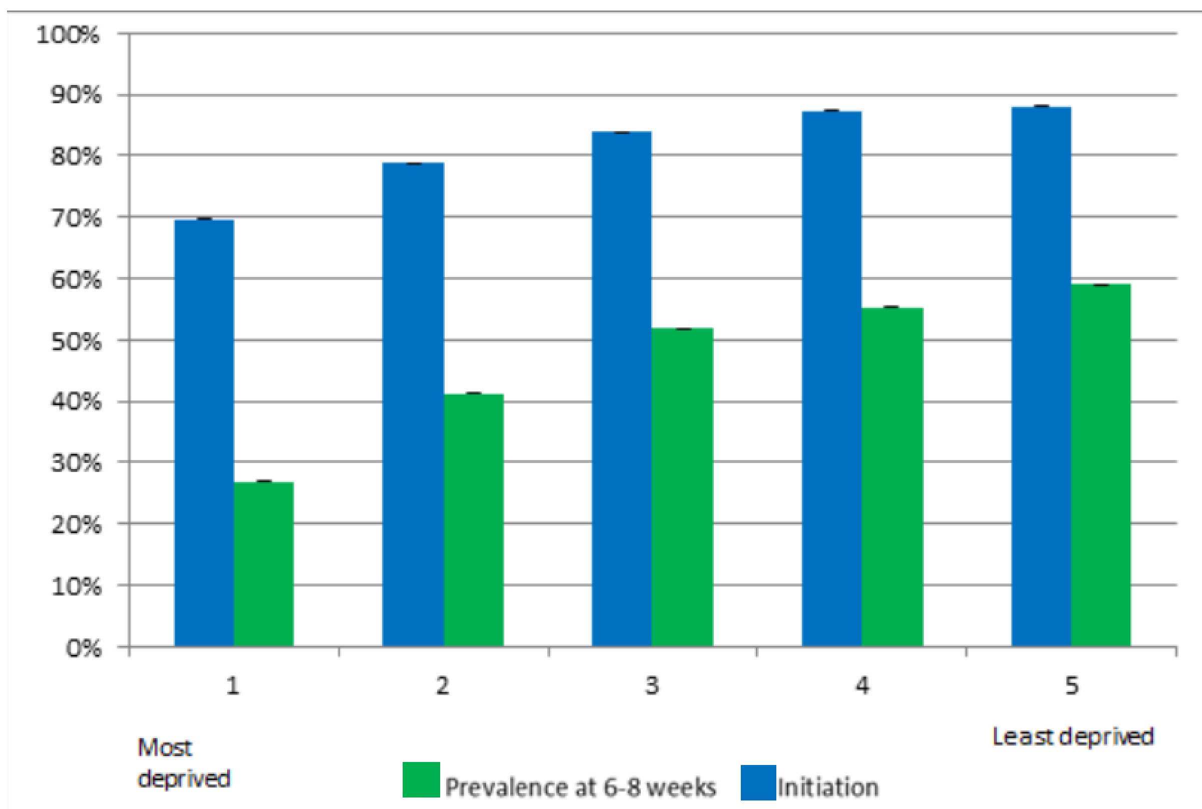


Figure 13: Breastfeeding and community deprivation

Young People's Mental Health

Recent years have seen broad efforts to give mental ill-health 'parity of esteem' with physical illness. Mental health problems affect an increasing number of children and young people, latest data suggesting that one in ten has some clinically diagnosable mental health disorder. As Figure 14 shows, referrals to the Child and Adolescent Mental Health Service (CAMHS) in Somerset show the familiar pattern of concentration in more deprived urban parts of the county. These maps must be treated with the caveat that they show *treatment*, and that may not be a perfect reflection of need. Their conditions may be complex: one young person described her needs as '*management of my eating disorder, therapy, help with social anxiety and help with suicidal ideation* [thoughts]'.

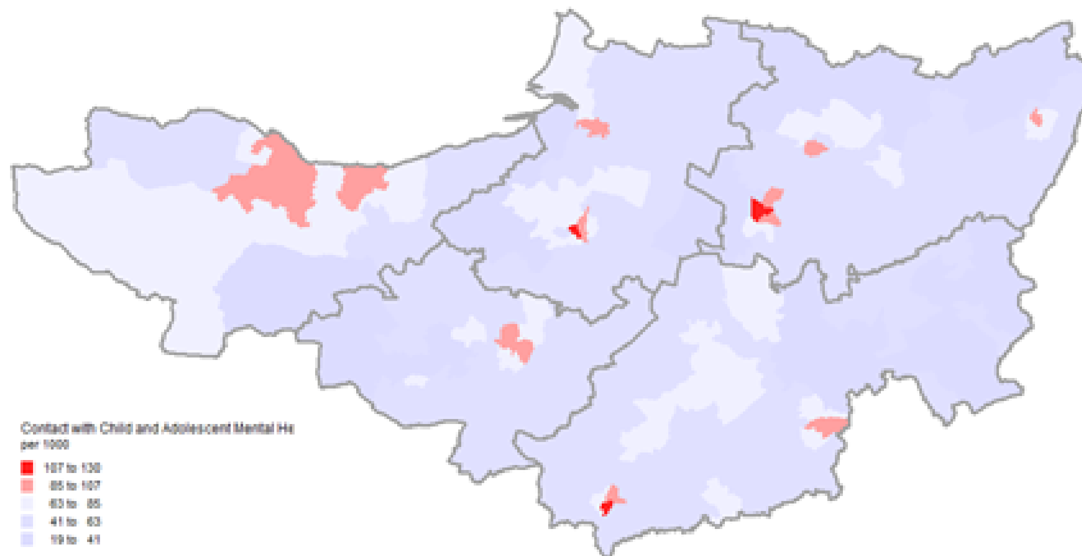


Figure 14: Referrals to Child and Adolescent Mental Health Services (CAMHS)

Somerset appears to have particular high rates of self-harm hospital admissions compared to most other parts of England. Whatever the explanation, this is a serious concern in itself, not least because of the possible links to suicide, and because of the steady rise in rates that we have identified.

Overweight and Obesity

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception (aged 4-5 years) and year 6 (aged 10-11 years) in state primary schools nationally. In Somerset in 2016/17 22.3% of children in reception were measured as overweight or obese, lower than the national average (22.6%). In Year 6 this proportion increased to 30.3%, below the national average of 34.2%. The percentage of obese children in Year 6 (16.4%) is well above that of Reception age (8.7%). Not only does this suggest a worsening in weight status as children grow up, but there appears to be increasing prevalence of overweight in more deprived communities, exacerbating inequality, shown in Figures 15 & 16.

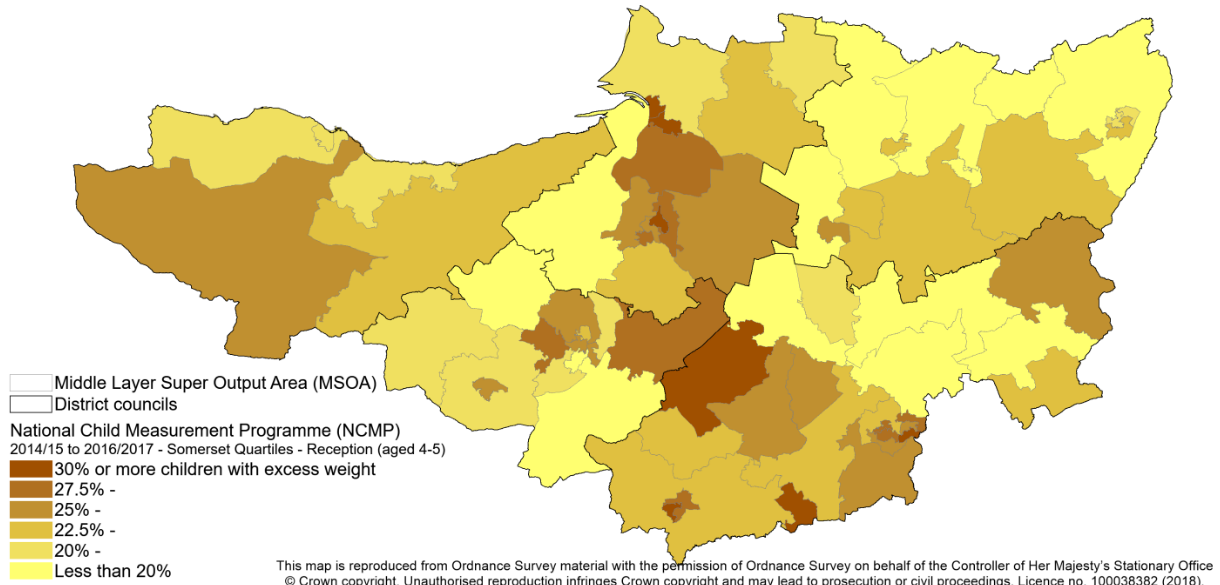


Figure 15: Overweight and Obesity - Reception age children 2014/15-16/17

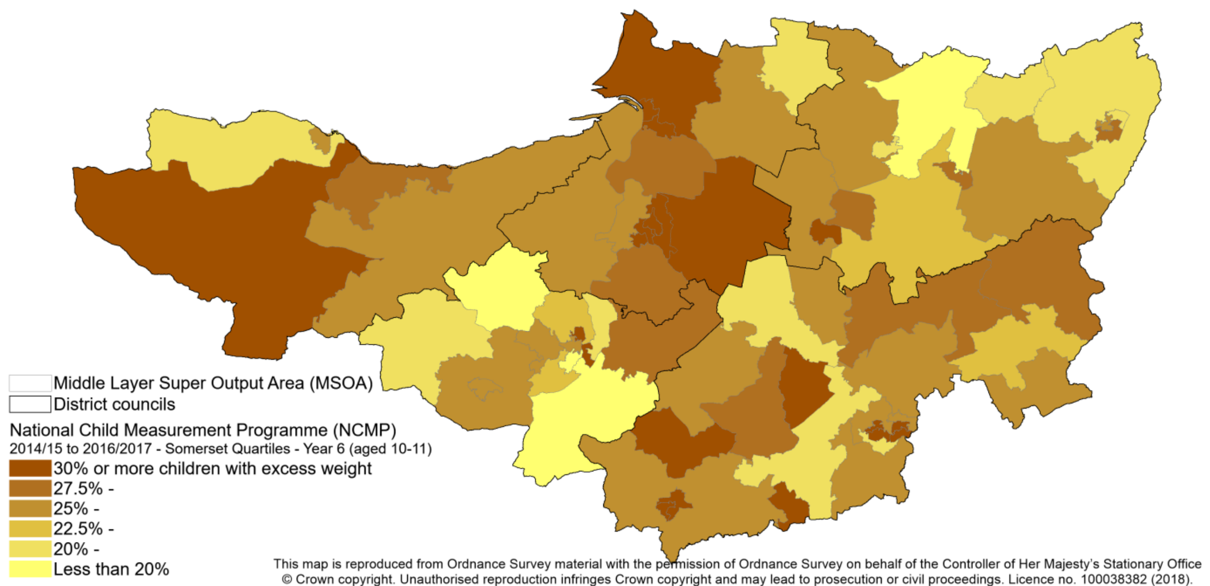


Figure 16: Overweight and Obesity – Year 6 Children 2014/15-16/17

A similar pattern is seen if we examine rates of tooth decay in children and young people across Somerset. The prevalence of tooth decay in twelve year olds in Somerset is slightly higher than seen nationally (37% vs 33%). The figures are

relatively high in West Somerset (46), Taunton Deane (41%) and Sedgemoor (39%). More severe decay is also evident in West Somerset and Sedgemoor.

Social Mobility

The Social Mobility Index is calculated on behalf of the Social Mobility and Child Poverty Commission. It was first published in 2016, and updated in 2017. It compares the chances that a child from a disadvantaged background will do well at school and get a good job across each of the 324 local authority district areas of England. Table 1 shows that none of the districts in Somerset perform well, with West Somerset having the lowest social mobility in the country. There are particular issues for young people who want to stay in rural Somerset, with a small number of jobs and housing very expensive relative to wages. Somerset does not have a University and therefore some prospective higher education students have to leave the county to study.

Table 1: Social Mobility

Local Authority	Overall	Early Years	Schools	Youth	Adulthood
West Somerset	**324**	324	194	195	324
Sedgemoor	**258**	173	226	229	279
Mendip	**231**	284	125	142	242
South Somerset	**229**	208	127	249	240
Taunton Deane	**206**	251	177	128	187

Summary

Although the majority of Somerset's children grow up in supportive environments, some suffer disadvantage – often multiple disadvantages. These children tend to be concentrated in more deprived communities. Young people growing up in rural areas face challenges around transport, poor digital infrastructure and unaffordable housing. For some, these disadvantages can persist for a lifetime, and without help can increase over time and increase inequalities.

Priority 4: Improved health and wellbeing and more people living healthy and independent lives for longer

http://www.somersetintelligence.org.uk/conditions-and-disease.html

Why does it matter?

A long and healthy life is an almost universal human desire, and central to the Health and Wellbeing Boards' responsibilities. Positively, life expectancy in Somerset – currently 80.5 years for men and 84.1 for women - has been rising steadily, if with a pause in recent years, and is consistently higher than for England (79.2 and 82.9 years respectively). However, the gap between total and *healthy* life expectancy is increasing, and an average person can expect to spend the last 16 years of life in ill health, as shown in Figure 17. As the Somerset population structure becomes more aged over time and if life expectancy continues to rise we can expect to see more of the population experiencing ill health.

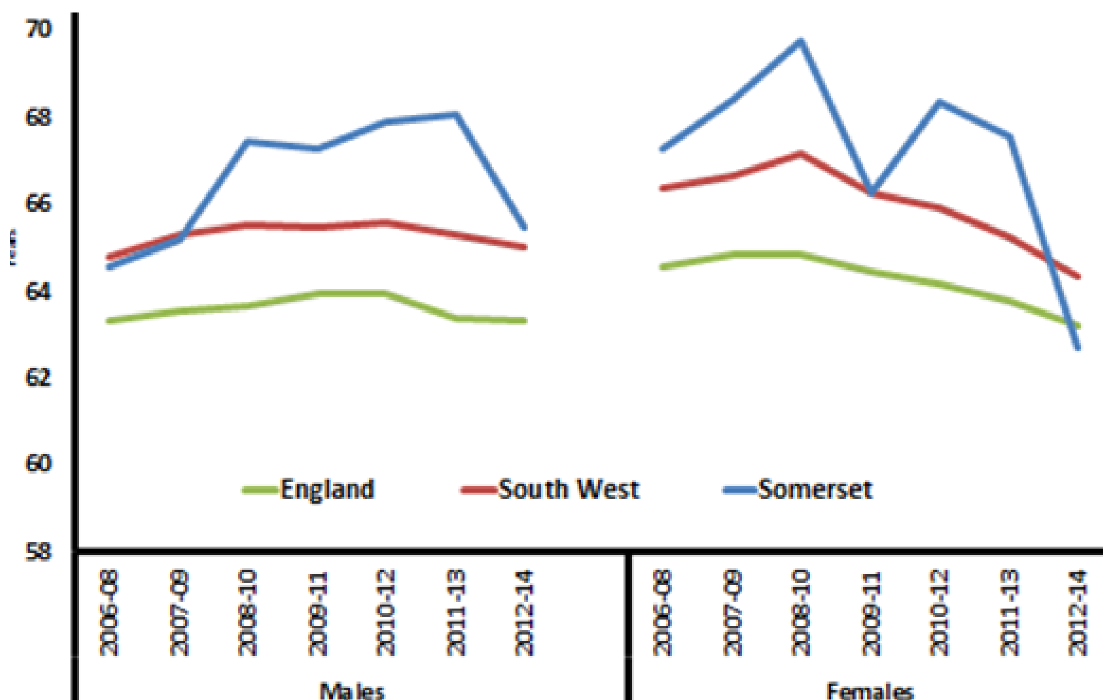


Figure 17: Healthy and disability-free life expectancy

Ageing

The ageing profile of Somerset is shown in Figure 18. In 2013 many areas of the county had less than 20% of the population aged over 65. By 2033 some neighbourhoods – notably coastal areas of West Somerset and Sedgemoor – will have more than half the people over approximate retirement age. While the structure and numbers of people under the age of 65 will remain fairly static (increasing from 416,800 in 2014 to 422,200 in 2039): the population aged 65 and

over is set to increase considerably (from 41,600 to 67,100); this is especially for those aged 85 and over, the number of whom will more than double from to around 18,100 to 45,250.

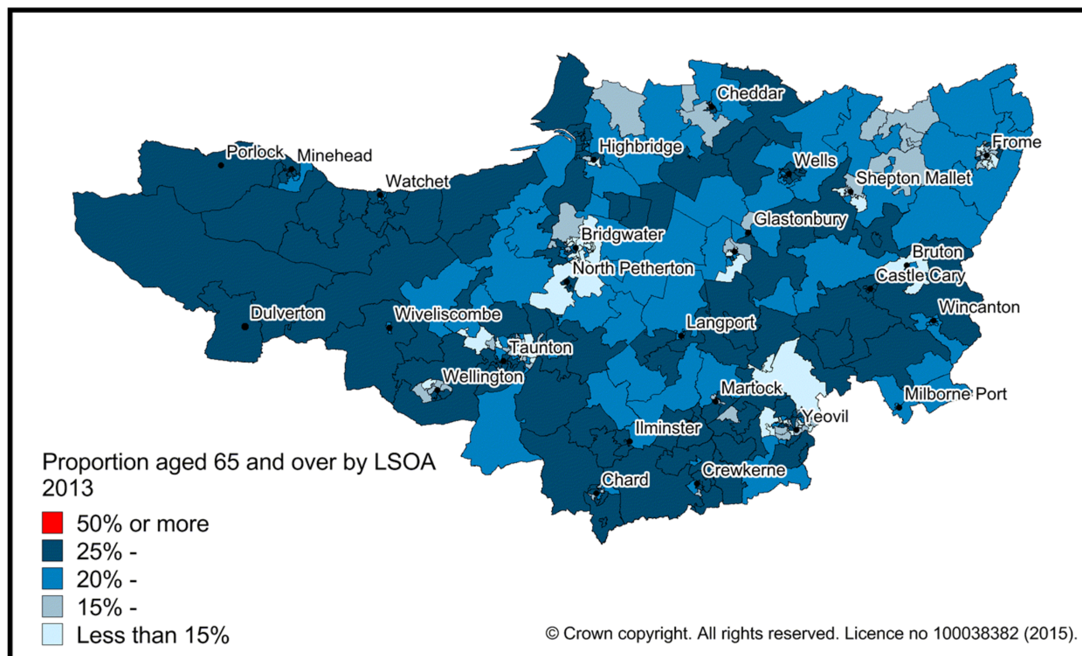


Figure 18: Somerset population by age in 2013

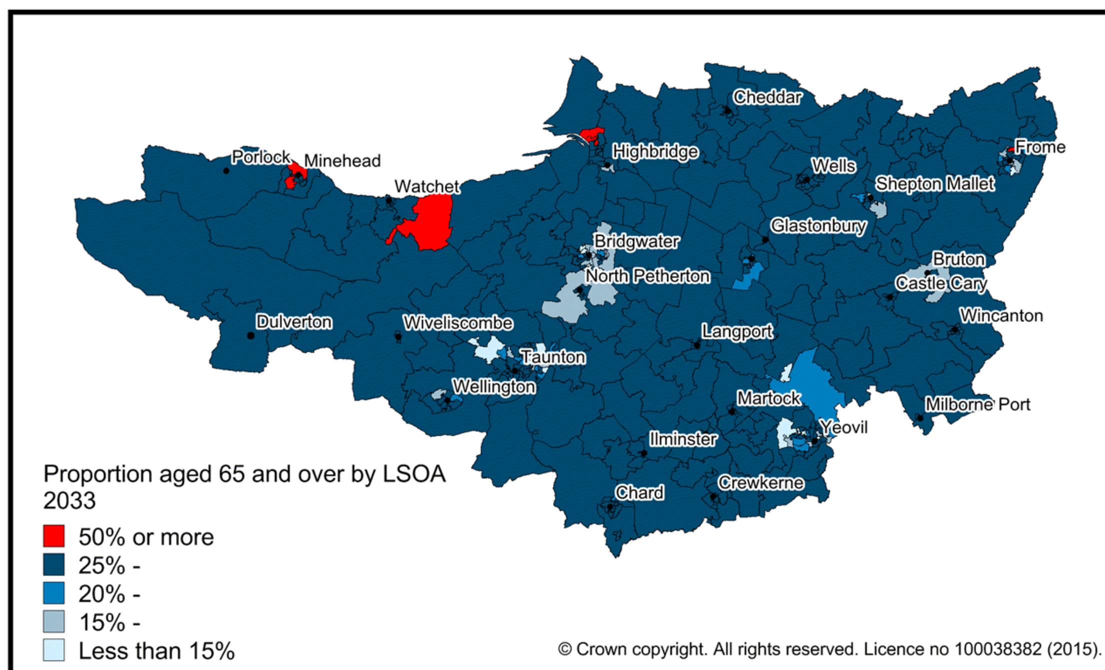


Figure 19: Somerset population by age in 2033

Health and Social Care integration

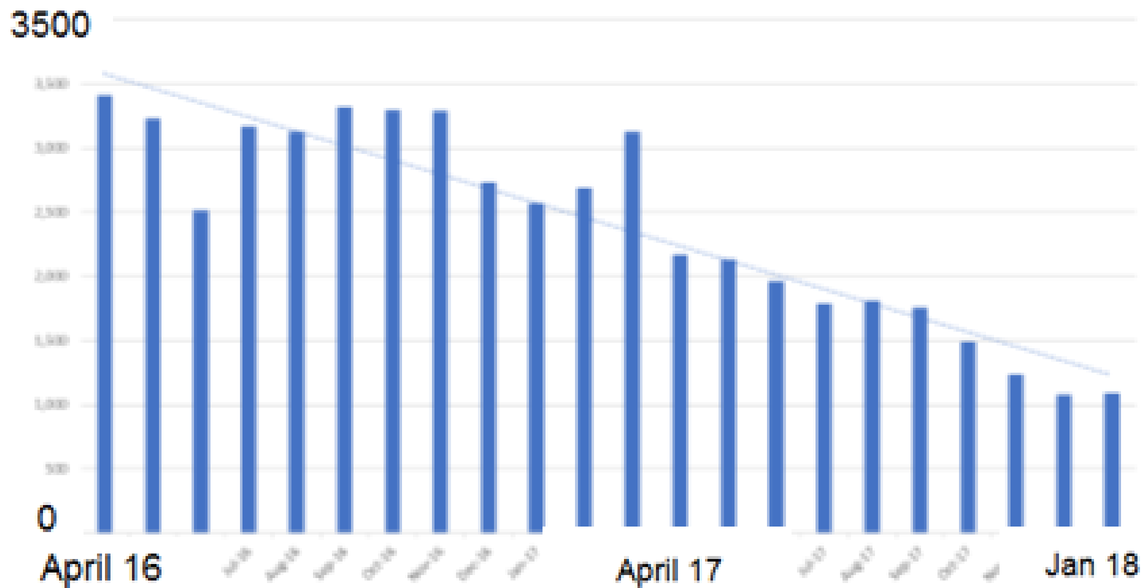


Figure 20: Delayed Transfers of Care (cumulative days spent in hospital by patients fit for discharge)

We tend to have increasing health and care needs as we get older. The JSNA in 2017 looking at *Ageing Well* found that most people wanted social contact and freedom– '*just having somewhere to meet and chat with people*' and '*a sense of independence and safety*' - as they aged. Being 'stranded' in hospital takes away independence and often leads to poorer health outcomes, and home care that merely 'looks after' someone can promote dependence. Instead, health and care services in Somerset have been working together to help get people home from hospital (*Home First*) to have their needs assessed in a familiar environment where they can be 're-abled' to look after themselves. This helps provide what patients want and the whole system works more efficiently. Figure 19 demonstrates the impact interventions like Home First can have on enabling people to be discharged from hospital once medically fit.

Long term conditions and multimorbidity

For many people, getting older can involve accumulating 'long-term conditions' such as high blood pressure, diabetes and chronic kidney disease. Morbidity is the state of having a disease and is related to mortality which is the cause(s) of death. Figure 20, using Somerset 'Symphony' data, shows how most people are born with none of these long term conditions, but by the age of about 50 half the population has at least one; at the age of 90 two thirds of people have two or more. Having more than one condition is 'multimorbidity', with patients needing 'complex' care. This explains

why the rising number of very old people presents such a challenge to Somerset health and care services.

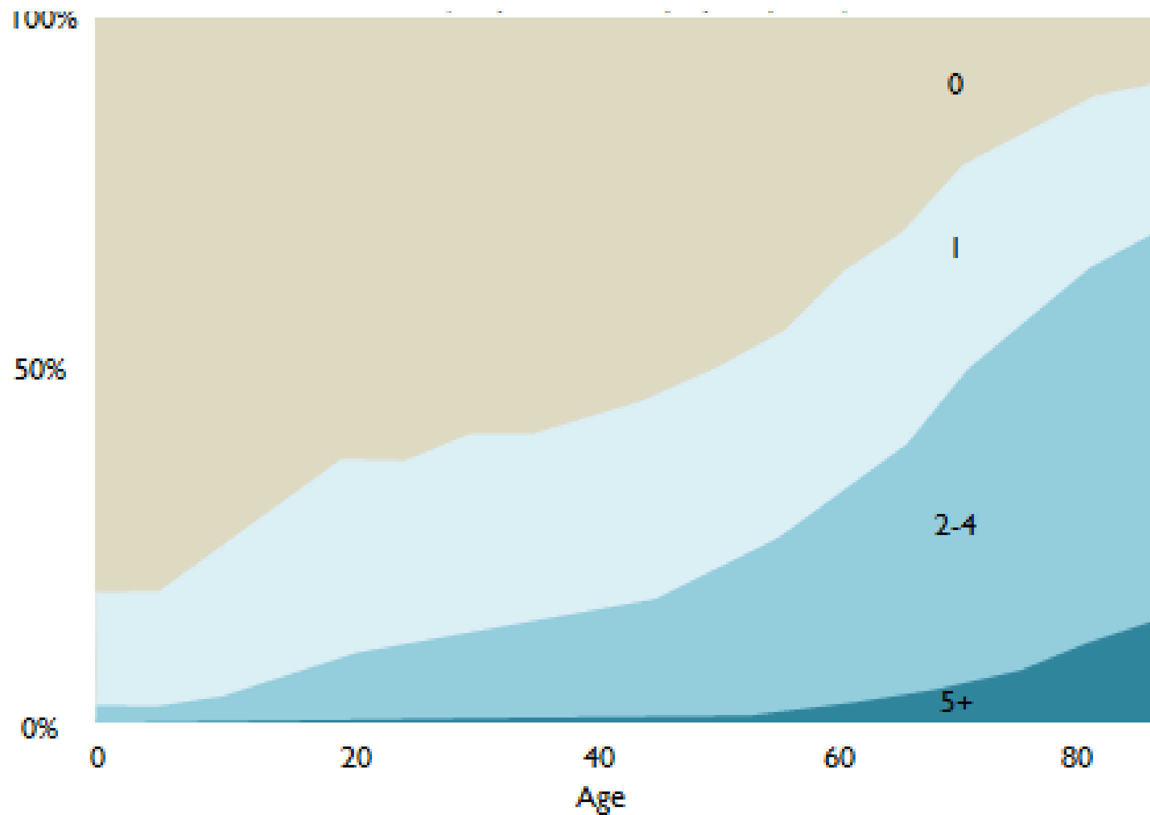


Figure 21: Number of long term conditions in Somerset by age

The patterns of age and illness in Figure 19 are not only matters for the people's health but have a profound impact on the entire health and care 'system'. It might be thought that the costs of treating conditions would start to plateau as numbers increase – but in fact the costs increase exponentially so that each additional condition adds *even more* to the cost than the previous. For example, someone who has developed diabetes can help take care of their own health, but if that patient also develops dementia then this may be impossible. The impact is that the treatment and care needed by the 4% of patients in Somerset with most complex needs make up half of total spending, shown in Figure 21.

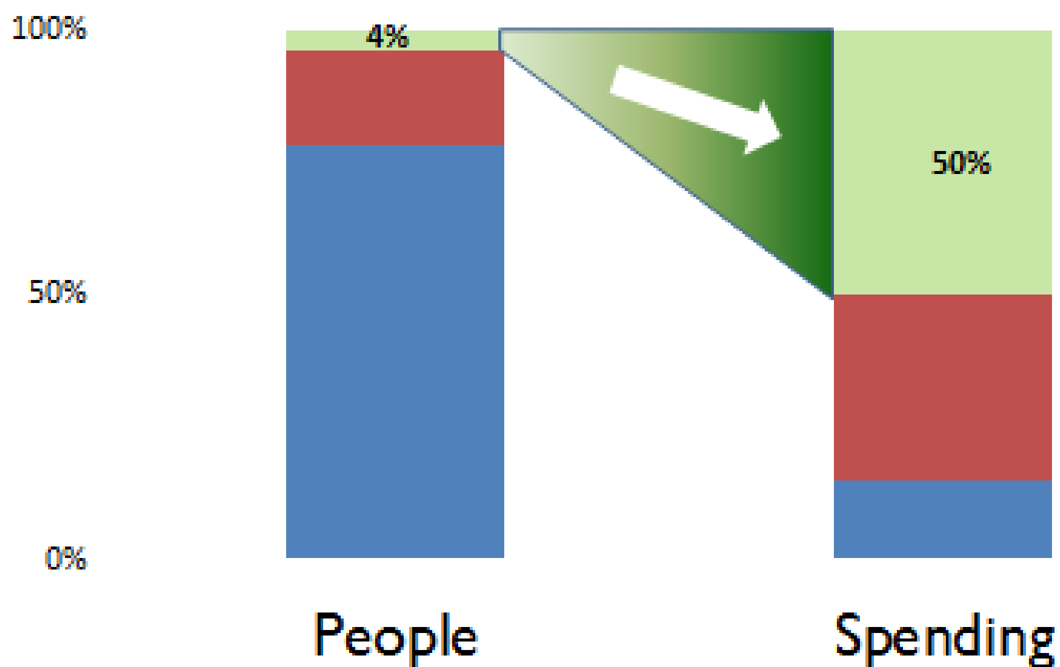


Figure 22: Complexity of illness and costs of health and care

Disease and Ill-health

Figure 22 shows graphically the conditions that have the biggest impact on years of life lost under 75. This is a more useful measure than all mortality because these deaths at earlier ages are the ones most likely to be 'avoidable'. The main cause of early death is cancer, followed by circulatory disease. Suicide, drugs and mental disorders come third, which is a reflection of their prevalence (7.7% of adults on GP registers are recorded for depression) and their impact on young people.

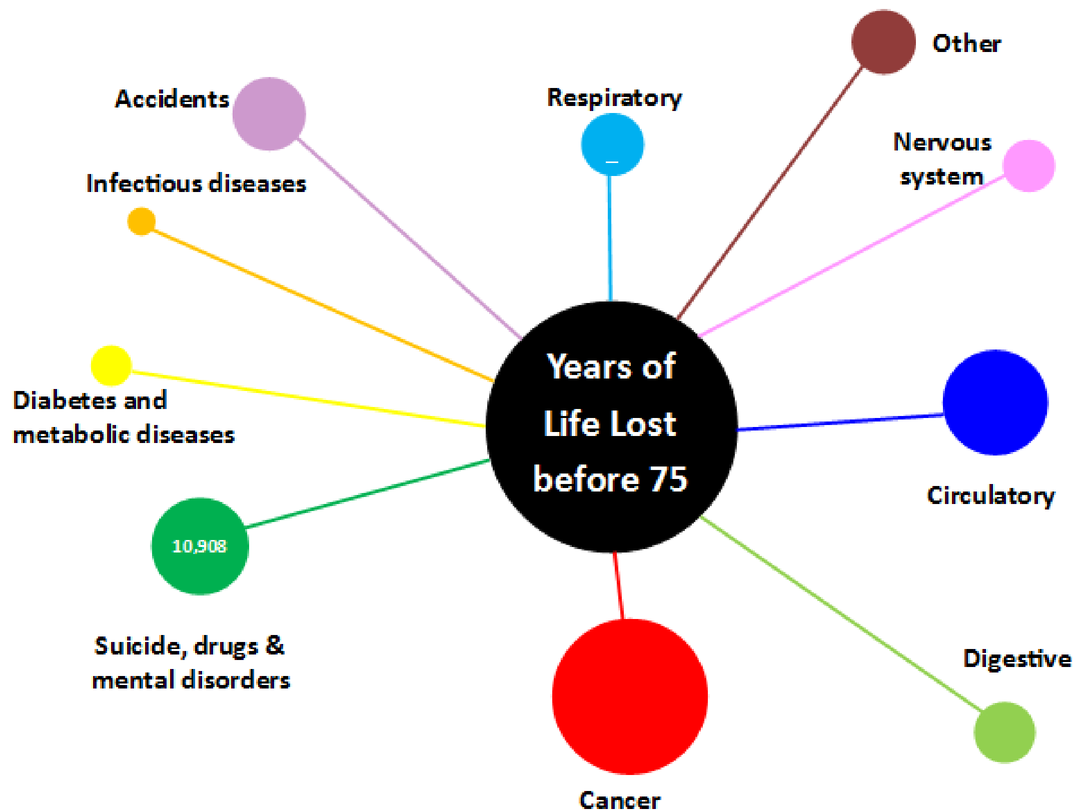


Figure 23: Years of life lost before 75 in Somerset during 2012-16 (all causes: 94,874)

Prevention

One thing that the long term conditions described have in common is that their onset may be delayed or even prevented by appropriate lifestyle choices. The risk of cancer, heart disease, diabetes and dementia (the numbers of people with which are set to double in the next 20 years) can be reduced by relatively simple improvements in lifestyle. Figure 22 shows how tobacco, exercise, diet and alcohol affect the risks of such physical illness. With Figure 20, this demonstrates how a focus on this prevention (as well as screening and early detection) not only improves individuals' health and well-being, but makes financial sense for the health and care system.

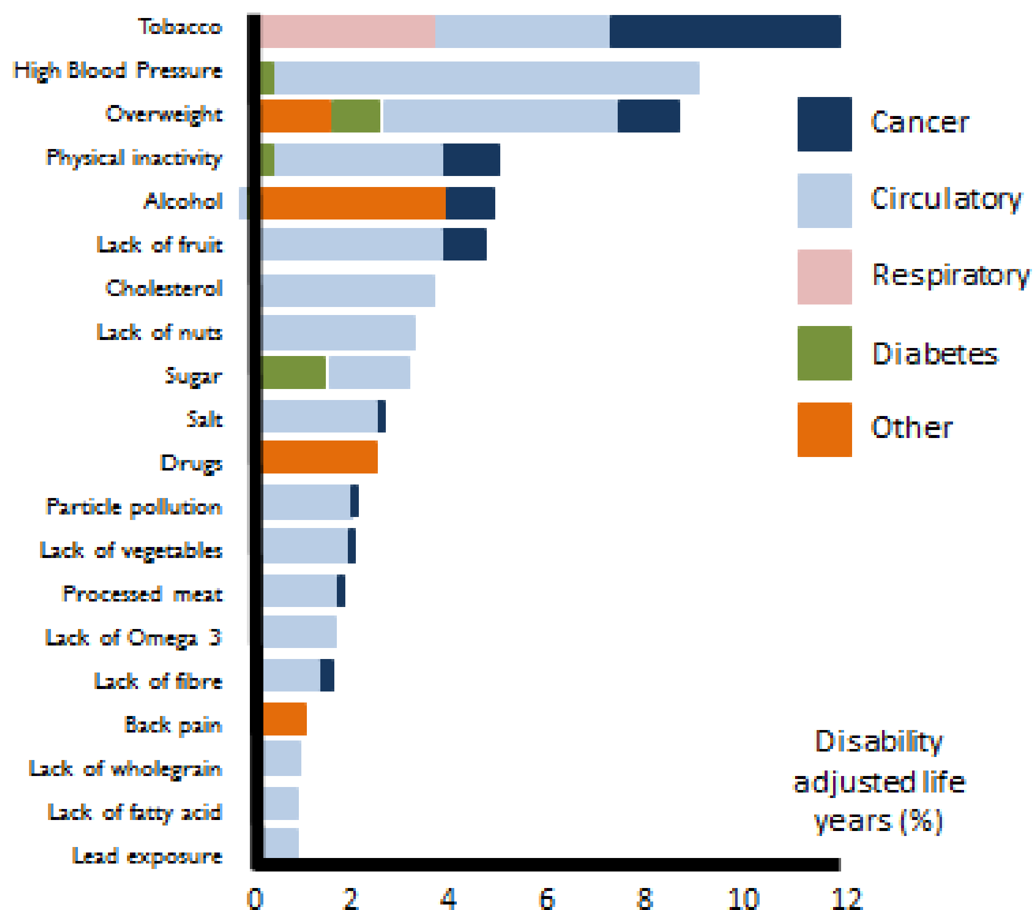


Figure 24: Lifestyle contributions to ill health

Mental Health

Figure 22 does not directly include mental ill-health, which contributes approximately 25% of the total burden of illness. The factors behind mental ill-health are numerous and complex, although the lifestyle factors already described certainly play a part. It is clear that loneliness is a major contributor, so that promoting social connectivity through safe, vibrant and well-balanced communities and in other way can help to prevent mental ill health developing and reduce its impact on people affected..

Summary

Population ageing will be the biggest driver of health needs in Somerset over the course of the *Improving Lives* strategy. Without change, this could lead to a population in poorer health and leave an unsustainable demand on services. There are, though, opportunities to improve health and wellbeing while reducing costs to services if the wider determinants of health and lifestyle are given the emphasis suggested by the evidence.

Where can I find out more?

This short summary has described a range of health needs that can be addressed in the *Improving Lives* strategy. The headings have been derived from considering the evidence and the views of Health and Wellbeing Board members and stakeholders. A structure like this is a necessary part of creating a strategy, communicating its aims and turning ambitions into a series of actions.

However, such a structure makes the different elements seem far more discrete than they are in real life. In a more fluid form, digital accessibility, for example, would be shown as a major element in raising productivity, as well as community strength; plays an important part in children's opportunities in life as well as being a way to learn about healthy lifestyles. Other factors could similarly appear under more than one heading. For communities, families and individuals these factors all interact in multiple ways.

Similarly, inequality cuts across all these themes. It is notable that many of the major challenges to health and wellbeing are concentrated in the more deprived urban areas, with low income lying behind many of them. Rural areas often have fewer needs, but that can make them more challenging for those more deprived people who live there, especially in the very sparsely populated parts. An understanding of inequalities and communities' needs is essential in applying the strategy.

This interconnectedness is better presented on the web than in writing. The JSNA itself is the website at http://www.somersetintelligence.org.uk/jsna/. It covers the range of health and care needs, and the wider Somerset Intelligence website includes much information on the wider determinants – broader factors affecting health such as transport and housing. Each section of this report gives a suggested 'landing page' for the site. The website also includes full links to sources, including the latest published data from elsewhere, that have not been included here for space.

To discuss any of the information here please contact publichealth@somerset.gov.uk.

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