Joint Strategic Needs Assessment

December 2008

Acknowledgements

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1. Introduction

The Local Government and Public Involvement in Health Bill outlined a new responsibility on Directors of Public Health, Adult and Children's Services to undertake a Joint Strategic Needs Assessment (JSNA) every three years.

This report summarises stages 1and 2 of Bolton's 2008 Joint Strategic Needs Assessment (JSNA). It will outline our partnership and approach to the JSNA, summarise key health and well-being needs for Bolton's population now and in the future, including influences on health and well-being. It will also make recommendations for action to improve health and for the collection and analysis of information to better understand local health needs.

About Bolton

Bolton's story is one of determination and ambition, of a town built on aspiration and resilience. Since the middle of the 20th century the traditional manufacturing base has been completely re-shaped and other sectors have grown to replace manufacturing. Some production industries have modernised around new technology and the service sector has grown significantly.

The borough of Bolton is now one of ten metropolitan districts in Greater Manchester. It is bounded in the north by Lancashire and on the remaining sides by the districts of Wigan and Salford. The borough has a population of around 262,400 who live mainly in the main urban area of Bolton, Farnworth, Kearsley and Turton, and the freestanding settlements of Little Lever, Horwich, Blackrod and Westhoughton. About half of the area is built up, but the remainder is countryside, mainly in agricultural use or open moorland.

Our partnerships

Bolton has a clear vision and a committed local strategic partnership made up of private, public, voluntary, community and faith sector organisations. The JSNA has been produced on behalf of the Directors of Public Health, Adult Services and Children's Services by Bolton's Healthier Communities Steering Group.

Bolton's Sustainable Community Strategy - Bolton: Our Vision 2007-2017 sets out the vision for Bolton, two main aims and key themes. Our vision for Bolton in 2017 is for it to be a place where everyone has an improved quality of life and the confidence to achieve their ambitions. The two main aims are to narrow the gap between the most and least well off and to ensure economic prosperity. To support he achievement of these two main aims we have identified six priority themes:

- Healthy
- Achieving
- Prosperous
- Safe
- Cleaner and Greener
- Strong and Confident

Assessing local need

Health-related partnerships have a strong track record in assessing local health and well-being needs and using this intelligence to inform decision making. Previous approaches to assessment of health need and inequalities include:

- Bolton Health Survey – a population health survey of adults
- Schools health survey – a survey of children in primary and secondary schools
- Integrating health needs assessment into strategies as we develop them
- Engaging with communities to identify local people's perception of health need and barriers to accessing services.
- Assessing need in targeted neighbourhoods, presented in Neighbourhood Action Plans
- Undertaking comprehensive needs assessments on particular themes, e.g. the BSafe partnership's Strategic Threat Assessment
- Health equity audits on a range of topics

The Joint Strategic Needs Assessment

The JSNA aims to provide an overview of future health and well-being needs in Bolton and ensure that strategic decisions about improving health and well being are informed by the needs of Bolton's population

In order to influence key decisions, the JSNA will be a process rather than a one-off document. The first year of the JSNA will have two stages, as shown in the table on page 4.

In order for the JSNA is to influence priority setting and commissioning, we have developed a process which we hope will maximise the ownership of individuals across the Council, PCT and other partners. This process is summarised below:

- Establish a working group made up of intelligence specialists across public health, adult services and children's services
- Develop a framework for the collection and analysis of data
- Map data sources for their availability
- Inform key groups about the JSNA (PCT commissioning team, adult and children's services Directorate Management Teams

- Analyse and summarise data
- Present summarised data to an extended meeting of the Healthier Communities Steering Group (HCSG)
- Interpretation of data and development of recommendations by HCSG and extended membership
- Produce stage 1 report
- Produce action plan for stage 2 including resource requirements
- Disseminate JSNA widely across partnerships

Table 1: Bolton's JSNA 2008

	Stage 1	**Stage 2**
When will it be delivered?	▪ March 2008	▪ By December 2008
What will it inform?	▪ New LAA ▪ Neighbourhood Action Plans	▪ Corporate Business planning processes ▪ Strategic commissioning for health and well-being ▪ LDP ▪ Neighbourhood Action Plans
What data will it include?	▪ Data already (or easily) available (Where possible integrated to describe health and care needs).	▪ Local people's views of their health and well-being needs ▪ Finance data ▪ Forecasting future need ▪ Findings of health equity audits undertaken into areas identified in stage 1

2. Bolton's population

Population in Bolton

According to the mid-2006 population estimates (ONS) Bolton was home to approximately 262,400 people, with 128,800 males and 133,600 females. This is a decrease of -0.1% over the previous revised 2005 estimate of 262,600. Bolton's population has increased slightly since 2000, and there has been an overall increase of around 2,300 people, or 1% of the population in the past ten years.

Births, Deaths and Migration

Bolton has a relatively high birth rate, meaning that it has a relatively high rate of natural change compared to England and Wales. Between 2005 and 2006 there were an additional 940 people as a result of natural change, i.e. there were 940 more births than deaths. However, during this time Bolton suffered a net loss in its population due to migration, whereas as England & Wales experienced significant gains. Between 2005 and 2006 Bolton's population is estimated to have decreased by around 130 people.

Official population estimates use estimates of long term migration within the migration calculations. Long term migration is defined as lasting over a year. However, short term migration also creates changes in the population of the borough, and this is currently not factored in the official population calculations as only partial information is available on this.

Age Structure

The age structure of Bolton's population is very similar to the national profile, although the borough has a higher proportion of children and a slightly lower proportion of working age and older people compared with England and Wales. Around 1 in 5 of the population in Bolton is a dependent child (aged 0-15), and slightly less than 1 in 5 is of pensionable age (aged 60+ for women, and 65+ for men).

Population Projections

According to the revised 2004-based population projections, Bolton's population is set to increase by around 7% in next twenty-five years, from 262,800 in 2004 to 282,100 in 2029.

Bolton's age structure is also predicted to significantly change in the next twenty-five years. The proportion of the population aged 65 and above is set

to increase from 15.0% in 2004 to 20.6% in 2029. Bolton's working age population is set to increase by around 4.5%, but the proportion of working age people in the population as a whole will reduce slightly. The number of dependent children is set to remain roughly the same throughout that period, but the proportion of children within decline.

At a national level household projections predict that the average household size will fall following increasing numbers of one person households.

Ethnicity

According to the 2001 Census, 28,671 residents of Bolton, constituting 11% of the population, considered themselves to be part of one of the non-White ethnic groups. Overall 22% of Bolton's population is under 16. The ethnic minority population of Bolton has a very young age profile with almost a third (32.5%) of the minority population aged under 16.

The largest of Bolton's minority ethnic groups is that of Indian background. With 15,884 people, 6.1% of the Borough's population, this is the largest such community in North West England. Bolton's population of Pakistani background numbered 6,487 people in 2001, 2.5% of the Borough's population. This makes it the sixth largest such community in North West England. None of the other minority ethnic groups exceeds 1% of the Borough's population.

Bolton's White population consists of 232,366 people or 89% of the total. The majority identify as British but there are just over 2,200 people in the White Irish group and about 2,500 people in the Other White group.

In Bolton, between 1991 and 2001, the population identifying themselves as Indian grew by about 2,500 people, and the population identifying as Pakistani grew by about 2,200 people. Experimental statistics produced by ONS for ethnic group for 2005 suggest that in Bolton, the proportion from minority ethnic groups has increased slightly since 2001.

The distribution of Black and Minority Ethnic groups is concentrated in areas around the town centre, particularly in areas of Crompton, Halliwell, Rumworth and Great Lever wards.

Population Strategic Priorities

- Undertake analysis to understand patterns of residential mobility and how population turnover varies across Bolton's neighbourhoods

- Undertake further analysis of current patterns of migration in and out of the borough and how these are changing, particularly in terms of short term (i.e. less than one year) migration.

3. Health and Well-Being in Bolton

This section of the Joint Strategic Needs Assessment aims to provide a brief overview of the priority health needs in Bolton and makes recommendations about strategic action that needs to be taken to identify these needs. It also highlights areas where further information is needed to inform strategies to address needs identified.

A boy born in Bolton can expect to live for 74.6 years and a girl 76.9 years. Whilst life expectancy for Bolton residents, like the country as a whole, has increased over the last 20 years, the gap in average life expectancy between Bolton and England has widened. On average men in Bolton live 2.3 years less than nationally and women live 2.1 years less.

Within Bolton there are also significant differences in life expectancy between deprived and affluent areas of the borough. There is a 15 year gap in life expectancy between the central area of Bolton (in which average life expectancy is 67.5) and the Bradshaw and Harwood area (in which average life expectancy is 82.5).

Local partner agencies in Bolton have identified the gap in life expectancy between Bolton and England and between deprived and affluent areas of the borough, as the main indicator of health inequalities within the community strategy.

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Causes of reduced life expectancy

When developing strategies to address the life expectancy gap, it is important to understand the causes of early death in Bolton. The table below shows these causes in descending order of contribution.

Table 2 – causes of reduced life expectancy in Bolton (2006)

Males	Females
1. Coronary heart disease	1. Digestive disorders (mainly alcohol related)
2. Digestive disorders (mainly alcohol related)	2. Respiratory (other than bronchitis and COPD)
3. Infant mortality	3. Coronary heart disease
4. Other circulatory disease	4. Stroke
5. Overdose and poisoning	5. Infant mortality

It is important to be aware that the contribution that infant mortality and overdose and poisoning make to reduced life expectancy is not due to the numbers of lives lost to these causes, but due to the years of potential life lost through those affected dieing at a young age.

The past decade has seen a changing trend in the causes of reduced life expectancy in Bolton, with a reducing contribution made by coronary heart disease and other circulatory diseases and an increasing contribution made by alcohol related diseases and respiratory conditions.

Mortality

In 2004- 2006, there were an average of 2,689 deaths among Bolton residents each year. The main causes of death in Bolton were circulatory diseases (979 deaths each year), cancer (659 deaths each year) and respiratory diseases (344 deaths each year). These causes of death account for about 80% of deaths in Bolton. The number of deaths from circulatory disease are falling each year, but the number of deaths from cancer are increasing. This is similar to national trends.

Understanding trends in the number of deaths in Bolton helps us to understand need for health services now and in the future. However it is also useful to compare death rates within Bolton with those in England using standardised mortality ratios (SMRs). Bolton has high SMRs for chronic liver disease (especially in women - 162), pneumonia (151), bronchitis and emphysema (132), circulatory disease (120) and lung cancer (especially in women - 120).

Ill health

Information from the Bolton Health Survey (2007) found that Angina symptoms are three times as prevalent in the most deprived areas compared with the most affluent areas, yet people living in the most deprived areas were less likely to have visited their GP with these symptoms. There are already plans in place to encourage people in deprived areas with chest pain to visit their GP about their symptoms. Case finding people with symptoms of ill health will be one of the roles of a new general practice which is being established in Bolton.

The Health Survey also found that 16% of people aged 65 and over in Bolton have diabetes. The prevalence of diabetes is twice as high in the most deprived areas. If we assume all black and minority ethnic groups in Bolton have the same age structure, we estimate that he prevalence of diabetes is 24% in the Pakistani heritage community and 17% in the Indian heritage community compared to only 7% in the population as a whole. Over the next 10 to 15 years, as the South Asian population ages, the number of people in Bolton with diabetes will increase significantly. This will have implications for services to support the management of diabetes. Priority should be given to delivering Interventions to prevent diabetes and encourage early presentation among the South Asian communities.

The North West Cancer Intelligence Service predict that the number of new cases of cancer will increase by 37% by 2020 as the population ages. The

commissioning of cancer treatment services to enable them to provide timely effective services to an increasing number of people will need to be a priority. Maximising screening uptake and early detection and implementing cancer prevention strategies should also be priorities.

Almost a quarter of adults (19% men, 28% women) report nervous trouble/ depression in the previous 12 months. This rises to 31% in the most deprived areas. Pakistani and mixed race groups have the highest prevalence. The Health Survey included questions on symptoms of psychiatric ill health. This found that 21% of adults had symptoms of mental ill health, rising to 26% in 18-19 year olds and 23% in the 75 and over population. The PCT has undertaken a specific older people's mental health needs assessment. This has found that many older people with mental health problems also have significant physical health problems and very low levels of social support. Mental health promotion strategies should particularly target young people and older people.

Disability

Musculo skeletal problems cause illness and disability among a significant proportion of Bolton's population. A third of Bolton's adults report recurring backache and this increases to 42% in people aged 75 and over. More than half of people aged over 75 have difficulties walking, reaching and gripping or bending and keeping their balance. Over half of those aged 75 and over have difficulties hearing compared to 20% of adults as a whole. A quarter of people aged 75 and over have difficulties with their sight compared to only 8% of all ages. All of these disabilities are significantly more prevalent in Bolton's most deprived areas. Keeping physically active can prevent many musculo skeletal disorders. There will be a significant burden on musculo skeletal services in the next 20 years as the population ages. Work to increase physical activity levels in adults aged over 45 is already a priority through the local cardio-vascular disease programme.

Health behaviours

Alcohol misuse is a major cause of health problems and premature death in Bolton. The Bolton Health Survey 2007 found that there is increasing consumption of alcohol across all socio-economic groups. According to the survey, drinking over the recommended limits is more prevalent in the most affluent areas of Bolton. However rates of alcohol related hospital admissions and mortality are highest in the most deprived central areas of the town. The survey also found that a third of full time workers drink over the recommended alcohol limits compared to 25% of whole population. Workplace alcohol interventions should be developed as part of Bolton's Healthy Workplace programme.

The percentage of Bolton adult residents who smoke has reduced from 29.5% in 2001 to 23% in 2007. However there are still large variations in smoking

prevalence across Bolton; ranging from 12.8% in the most affluent areas to 35% in deprived areas. Rates of smoking have reduced at similar rates across deprivation levels, indicating that inequalities in smoking have not changed between 2001 and 2007. Efforts to reduce smoking prevalence in deprived areas should continue to be a priority.

Overweight and obesity are increasing rapidly in Bolton as they are nationally. According to the Bolton Health Survey the proportion of the population that is overweight rose form 47% in 2001 to 52% in 2007. The prevalence of obesity rose form 13% in 2001 to 18% in 2007. Obesity in Bolton is associated with deprivation, with higher rates in deprived areas. These rates of overweight and obesity are likely to be an underestimate as they are based on self reported height and weight measures. If the prevalence of obesity continues to increase at this rate there will be significant impact on diabetes, cancer and circulatory disease in the future. Obesity correlates with deprivation. Therefore halting the rise in obesity should be a priority to prevent future disease and demands on health and social care services.

Children's health

A more detailed analysis of the health needs of children and young people is contained within Bolton's Children and Young People's plan. A summary of the main health needs is presented here.

Infant mortality rates in Bolton are higher than average and infant mortality makes a significant contribution to reduced life expectancy. There are also higher than average levels of low birth weight babies born to Bolton women. Low birth weight is highest among women form Bolton's most deprived areas and from the south Asian community. Smoking in pregnancy is one of the causes of low birth weight. In 2005 almost a quarter of women continued to smoke until delivery. Only half of women continue to breastfeed after leaving hospital and many more had stopped by 8 weeks.

In line with national trends, obesity in childhood is rising each year in Bolton, with 11% of reception children and 18% of year 6 children obese in the 2006-7 school year. If childhood obesity continues to increase, there will be a significant impact on diabetes, cancer and heart disease when these children are adults, and subsequent increased demands on health services.

There are higher than average admissions for alcohol specific hospital conditions among under 18s in Bolton, mirroring the trend in adults locally. Bolton has the third highest rate of frequent emergency admissions in the North West. Further analysis should be undertaken to enable us to understand the profile of the children frequently admitted to hospital to identify whether this is an indicator of specific unmet need.

U18s conceptions in Bolton are higher than the regional and national rates and the target to reduce them by 50% is very challenging. The rates are still

only 6.2% below the 1998 baseline. The outcomes for teenage mothers and their babies are poor and include:

- they are more likely to live in poverty and in workless households
- 70% are lone parents
- many have low educational attainment
- a higher than average incidence of post natal depression and mental health problems for 3 years after delivery
- babies are more likely to have low birth weight
- children have more accidents
- infant mortality is 60% higher amongst babies of teenage parents

The health needs of people living in the most deprived areas

In section three, we have already outlined some examples of the poorer health status experienced by people living in the most deprived parts of Bolton. A more in depth analysis of such differences can be found in the Director of Public Health Annual Report 2008/09 which details the findings of the Bolton Health Survey 2007. However, below is a table of some of the health and lifestyle indicators from the survey that display the greatest variation by deprivation quintile (data has been standardised).

Health & lifestyle indicator	Most deprived quintile (%)	Least deprived quintile (%)
Poor health over the last 12 months	12.9	3.7
Has been told they have diabetes	10.3	4.7
Have suffered with symptoms of angina in the last year	14.5	4.8
Chronic obstructive pulmonary disorder	5.4	1.4
Have suffered with symptoms of asthma in the last year	23.9	12.6
Have suffered with severe bodily pain in the last 4 weeks	15.1	6.3
Have suffered with nervous trouble or depression in the last year	30.9	17.9
Possible mental health problems (GHQ12)	26.7	15.8
Current smoker	31.9	14.3

During the summer of 2008, with the help of the community ambassadors, people living in the Neighbourhood Renewal Strategy areas were consulted with for their views on their own health and how providers could help them improve their health. The most frequently suffered health problems mentioned by these residents include mental health, heart disease, diabetes, and they wanted help with tackling addictions (drugs, alcohol and smoking and their weight through support for healthy eating and exercise. Improvements to mental health services were also raised with particular emphasis on cognitive behaviour therapy and counselling services.

The mental health and wellbeing needs of older people

The Bolton Health Survey 2007 provides a breakdown of analysis of the health and lifestyles of older people in Bolton and so this is not repeated here. Subsequent JSNAs will need to take a more in depth analysis of the range of diseases and services used by older people, especially in terms of an expanding older population. In the meantime, this stage of the JSNA focuses on some work done with the older population concerning their mental health and wellbeing.

An older people's mental health and wellbeing needs assessment took place over spring and summer 2008. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was used to assess current wellbeing. After 'friends/ family', the most frequently mentioned things that respondents said would help them to feel better, were 'travel/ holidays / outings', 'mobility / get out more', 'physical activity', and 'health / healthcare'. Comments relating to 'mobility / get out more' were mentioned significantly more often by those people who scored in the lowest third on wellbeing (from their total WEMWBS score) when compared to the highest third. 'Nothing – ok already / more of the same' was mentioned significantly more often by those scoring in the highest third for wellbeing.

The most frequent comments in response to 'what, if anything is preventing you from doing these things' were 'health', 'money', 'get upset / worry', 'other commitments', and 'travel / mobility'. People whose wellbeing fell in the lowest third were significantly more likely to mention 'health', 'travel / mobility', 'company', and 'confidence' as barriers; whereas people whose wellbeing fell in the highest third were significantly more likely to report 'nothing really' as a barrier.

Respondents, when asked 'what would make it easier for you to do the things you want to do to make you feel better' were most likely to say 'health', 'travel / mobility', 'lack of service / facility', 'money' and 'company'. 'Lack of service / facility' was mentioned significantly more often by those with the lowest wellbeing.

Participants were asked what services they had used or were aware of for the following situations: 'many people for a variety of lifestyle reasons, sometimes feel unhappy and need to access some support to make them feel better', 'some people suffer with mental illness and need to access services that help them to recover', and 'some people become very unwell, they may not completely recover, and they need specialist care to meet their physical and mental health needs'.

The most frequently used activities 'to make them feel better' were 'physical activity' 'volunteering / caring', 'specific groups', 'learning', and 'creativity'. 'Physical activity, 'walking' and 'learning' were the most frequently mentioned activities that participants had not attended.

When asked about services to help people with mental health problems / mental illness to recover, GP practices were the most frequently mentioned as used and not used. Other services that had frequently been used included 'community psychiatric nurse', 'psychiatrist' and 'hospital'. Other services that were less often used but that were frequently mentioned included 'counselling', and 'voluntary organisations'. For services that had been used, the best thing was most often 'talking / being listened to', and for services not used the best thing was most often felt to be 'support / good service / make you feel better'.

The health needs of carers

Many people who provide unpaid care for family members or wider relatives do not see themselves as carers so it is difficult to gauge the exact number of carers amongst the Bolton population. The Census told us that over 28,000 people classified themselves as carers in Bolton in 2001. Of this number, 1,250 were aged under 18, the highest number of young carers in the North West. More recently, the results from the Bolton Health Survey 2007 reported that just over 12% of the adult population of the borough provide care for someone with a long term illness or disability, other than as part of their job. This amounts to more than 24,000 adult carers in Bolton. Women in Bolton were found to be slightly more likely to be carers than men (13.7% vs. 10.3%).

With the projected rises in the elderly population in the coming years, it is inevitable that there will be an increase in the number of people providing informal care.

In the Health Survey, people who were carers, were asked about the illness or disability of the person to whom they provide the most care. This was broken down as follows (more than one answer was possible):

Long term illness	37%
Physical disability	45%
Loss of sight	11%
Loss of hearing	14%
Learning disability	11%
Mental health problems	13%
Dementia (incl. Alzheimers)	12%
Other problems of age	32%
Other	15%

It is commonly understood that the health of carers generally suffers as a result of caring for others, particularly for those spending significant amounts of time caring. Personal health needs are often neglected when faced with the priority of caring for someone else. Isolation, long working hours, reduced income, being house bound and a lack of social support also can effect their emotional well being and ability to lead a healthy lifestyle.

Analysis of people who report to provide care in the Health Survey tends to agree with national and international evidence in the fact that carers in Bolton generally tend to have worse health than the general population. Carers are more likely to suffer from cardiovascular problems and have poor mental health. They are also more likely to have suffered recently with severe bodily pain and backache. Levels of obesity are also slightly higher in carers.

The health needs of workless people

- In August 2008 there were over 25,000 people in Bolton claiming either job seekers allowance, incapacity benefit, severe disablement allowance, income support or other income-related benefits.
- The worklessness rate for Bolton was 15.8% which was above the regional (14.8%) and national (11.9%) rate.
- The number of workless people in Bolton is likely to have risen since August 2008 as the recession has developed and may continue to rise for the foreseeable future.

Analysis of those claiming incapacity benefit and/or severe disablement in August 2008, shows that the majority (56%) had been claiming for five years or more, with a further 20% claiming for between two and five years. The medical reasons for people receiving these benefits are grouped into five main disease categories. The biggest category is mental health which accounts for 44% of all claimants. This is followed by musculoskeletal disorders which accounts for 17% of the claimants. Approximately 6% each are covered by disorders relating to the nervous system and injuries or poisonings. An 'other' diseases category accounts for 19% of all claimants.

The Bolton Health Survey 2007 included a question on employment status, so it has been possible to analyse the survey data to look at the main health needs of the workless population and compare how this differs to the general adult population of Bolton.

In agreement with the breakdown by disease of incapacity benefit and severe disablement claimants, the two areas that seem to be more prevalent in the workless population concern mental health and musculoskeletal problems. For instance, of the workless population answering the health survey, 35% had suffered from nervous trouble or depression in the last year and 40% showed signs of having some form of mental health problem. This is almost twice as high as in the general population. They are also almost twice as likely to suffer from a range of musculoskeletal problems as the general population. For instance: 22% have experienced severe or very severe bodily pain in the previous four weeks; 59% had experienced pain or stiffness in the joints in the past year; 48% had suffered from recurring or constant backache in the past year.

The workless population were also far more likely to have been in poor general health in the previous year (22.4%, 2.6 times higher than the general population). Other health needs that showed a higher prevalence in the workless population include some circulatory and respiratory related

conditions: chronic obstructive pulmonary disease (6.6%), symptoms of angina (14%). These conditions are possibly more prevalent to the higher smoking rate in this population group, where more than one in three smoke (35%) and almost 12% smoke more than twenty cigarettes a day.

In the summer of 2008, some local consultation with workless people occurred at three main sites of Bolton:

1. The Workshop – an initiative run by the council to try and help long term Incapacity Benefit claimants back in to work.
2. Job-centre Plus – run by Shaw Trust in Bolton
3. "Back to Work" roadshows organised by the Workshop, in areas of significant workless population who do not access the Workshop.

Once again, mental health and musculoskeletal problems outnumbered all other health problems in the group consulted with. In terms of getting back in to work the groups identified the improved access to the following types of treatment or support: physiotherapy; occupational therapy; cognitive behaviour therapy; condition management programmes; ergonomics advice in the workplace; counselling.

Existing use of resources

This section of the JSNA has summarised the key health needs of Bolton's population. In a strategic needs assessment, it is important to consider the extent to which current resources are deployed to meet these needs. Programme budgeting is a mechanism used to summarise NHS spending on service programmes. It enables local health economies to compare their spending on particular service programmes with other similar areas across the country.

A detailed analysis of Bolton's NHS programme budgeting has been carried out as part of this JSNA and the main findings of this are summarised below:

- *Cancers and tumours*. Bolton spends slightly less on cancer per head of population when compared to other similar PCT's, but performance is similar to or better than others. This suggests that we should consider increasing efficiency and spending.
- *Circulation problems*. Bolton spends relatively more on circulatory problems, but performs less well than other similar PCTs. This suggests that we should consider increasing efficiency to reduce spending and improve performance in this area.
- *Infectious diseases*. Bolton spends relatively more but performs less well than similar PCTs on infectious diseases. This suggests that we should consider increasing efficiency to reduce spending and improve performance in this area.
- *Endocrine, nutritional and metabolic problems* including diabetes. Bolton health economy spends relatively more than other similar PCTs and performs better than peers in terms of diabetes related mortality, less well in years of life lost under 75 and has higher than average prevalence of

diabetes. This indicates higher levels of need for diabetes services and a need to improve performance in prevention.

- *Maternity and reproductive health.* Bolton spends more than similar PCTs on maternal and reproductive health. Much of this may be explained by the relatively high birth rate in the area. The 2004-06 maternal death rate was higher than similar PCTs relative to spending. However, fortunately maternal deaths in childbirth are relatively rare in England so variations in mortality between areas may not be statistically significant.
- *Mental health problems.* Bolton spends relatively less than other similar PCTs on mental health services. Indicators of need available for comparison include suicide rates and dementia prevalence. Bolton has a relatively low suicide mortality rate but a relatively high prevalence of dementia. The data available here does not include prevalence of mild to moderate mental illness, which our own surveys indicate has a high prevalence locally. This indicates that we should consider increasing spending for dementia and mild to moderate mental illness.
- *Neonatal conditions.* Bolton spends more than other similar PCTs on this programme, with mixed performance against indicators of health needs and outcome. We should consider increasing efficiency to reduce spending and improve performance.
- *Respiratory system problems.* Bolton spends slightly less than other similar PCTs with variable performance on indicators. Consideration should be given to increasing spending and efficiency, particularly in respect of pneumonia.

In future JSNAs we will explore opportunities to identify the extent to which the spending of other local agencies is aligned to the needs identified.

Predicting future health needs

Analysis has been undertaken to predict future health needs for Bolton, based on the changing population. At this stage, this analysis has focused on a small number of health needs, however a more complete analysis will be available in the stage 2 report. The table below shows how the number of people with specific health needs is predicted to change over the coming years. It shows that there is likely to be a significant increase in the number of older people living alone in the next 20 years and a substantial increase in the number of alcohol harm related admissions to hospital. This information needs to be used to plan future health and well-being support services and to provide a focus for action to prevent future health needs emerging.

Table 3 – summary of predicted future health needs

	2008	2010	2015	2020	2025
Total population aged 65-74 predicted to live alone	5,481	5,765	6,698	6,715	6,515
Total population aged 75 and over predicted to live alone	8,801	8,798	9,429	10,582	12,614

Total population aged 65 and over predicted to have dementia	2,763	2,806	3,054	3,421	3,950
People aged 65 and over predicted to have depression: lowest estimated level of prediction	4,040	4,170	4,700	5,030	5,410
People aged 65 and over predicted to have depression: highest estimated level of prediction	6,060	6,255	7,050	7,545	8,115
Predicted number of alcohol harm related hospital admissions	6,095	7,247	10,125	13,003	15,306
Predicted number of people with diabetes	11,518	11,692	12,110	12,429	12,791
Predicted number of infant deaths	27	29	31	34	36
Predicted number of people that are obese	66,573	70,175			
Predicted number of people with a disability	17,633	18,599			
Predicted healthy life expectancy at 65 (in years)	9	9	11		
Predicted life expectancy at birth (in years)	77	78	79		

Future stages of the JSNA need to take this predicted future health needs analysis on some significant steps and needs to interpret what predicted changes to the numbers of people suffering with specific diseases and conditions will mean for commissioners.

Health and Well-Being Strategic Priorities

Analysis of the Health and Well-Being element of the Joint Strategic Needs Assessment, leads to the identification of the following priorities:

- Deliver interventions to prevent diabetes and encourage early presentation among the South Asian communities

- Review and commission cancer treatment services to enable them to provide timely effective services to an increasing number of people

- Maximise screening uptake and early detection and implementing cancer prevention strategies

- Mental health promotion strategies should ensure that they particularly target young people and older people.

- Workplace alcohol interventions should be developed as part of Bolton's Healthy Workplace programme.

- Continue to deliver interventions to reduce smoking prevalence in deprived areas

- Continue to develop, review and evaluate interventions to halt the rise in child and adult obesity, to prevent future disease and demands on health and social care services.

- Develop a maternal and child health strategy targeting pregnant women and babies up to the age of one year, to reduce the cycle of deprivation and address smoking in pregnancy, low birth-weight, breast feeding and infant mortality

- Undertake analysis to enable us to understand the profile of the children frequently admitted to hospital to identify alternative ways of meeting this health need.

4. Influences on health and well-being

Prosperity

How does prosperity affect health?

Economic prosperity, particularly income and employment have a significant protective affect on health. Unemployed people and their families have an increased risk of premature death, even after allowing for other factors[1]. This is most likely to be caused by a combination of three factors: lack of resources affecting living conditions (such as housing); the physical impact of living with low levels of stress for long periods of time caused by social exclusion; and unhealthy behaviours (such as smoking to help cope with stress, poor diet caused by reduced income and low levels of physical activity caused by changes to the structure of day to day life). These factors contribute to coronary heart disease, diabetes, some types of cancer, respiratory disease and mental health problems, which are more prevalent in unemployed people[1]. Supporting the workless population into employment has the potential to have a very positive affect on their health. It is predicted that Bolton will see significant economic investment in the next 10 years bringing new jobs to the area. If we address the health needs of local incapacity benefit claimants, they are more likely to be able to take up some of these new jobs, with a positive affect on their future health and well-being.

Summary of key issues

Average income and skills levels in Bolton are lower than the North West regional average. Fourteen percent of residents say their home is not well placed for jobs (rising to 37% in Hall I'th Wood).

There are 26,000 working age people in Bolton that do not work and are claiming working age benefits. 16,000 of these people are claiming incapacity benefit, which means that their ill health prevents them from working. Working age claimant rate ranges from 9.8% in the over Hulton area to 38.6% in central Bolton.

Almost half of those on working age benefits are aged 25-49 and 34% are 50-59. More than half of incapacity benefit claimants in Bolton have been on incapacity benefit for over 5 years, this means that this group is likely to need considerable support with developing new skills and managing their health problems if they are to successfully move back into employment.

[1] Brunner E, Marmot M (1999). Social organisation, stress and health in Marmot M, Wilkinson RG (eds). Social Determinants of Health. Oxford

Information is available on the main health problems for people on incapacity benefit. In Bolton, 44% of incapacity benefit claimants report that mental health problems prevent them from working and 17% report that musculo-skeletal disorders prevent them form working. However research indicates that people on incapacity benefit will often have more than one health problem. Among those that responded to the Bolton Health Survey, is a cohort of working age people not currently in employment. Analysis of the health needs of this cohort should be undertaken to inform the development of interventions to support this group into work. Research to establish what workless people feel their health needs are should also be undertaken to ensure that any interventions are acceptable to the target group.

Prosperity Strategic Priorities

- Programmes to support people who have been on Incapacity Benefit for more than 6 months into employment, should include condition management, cognitive behaviour therapy and swift access to rehabilitation services, as well as skills development and employment support.

- The capacity of Bolton's Healthy Workplace Programme should be increased to provide practical support to local workplaces to develop healthy working practices and prevent sick leave.

- The local public sector contribute to reducing worklessness in Bolton by participating in employment support programmes and providing job opportunities to socially excluded groups.

Achievement

How does achievement affect health?

There is considerable evidence that education is strongly linked to health and to determinants of health such as health behaviours, risky contexts and preventative service use. Well educated people experience better health than poorly educated, as indicated by high levels of self-reported health and physical functioning and low levels of morbidity, mortality and disability. In contrast, low educational achievement is associated with high rates of infectious diseases, self-reported poor health, shorter survival when sick and shorter life expectancy. The converse is also true that poor health, both for the individual concerned and for family and other dependents can have a detrimental impact on engagement with educational opportunities.

Those with more years of education tend to have better health and well-being and adopt healthier behaviours. Education is an important mechanism for enhancing the health and well-being of individuals because it increases the awareness and uptake of preventative care hence reducing the need for health care, the associated costs of dependence, lost earnings and human suffering. It also influences beliefs about health and health care helping to promote and sustain positive health behaviours including adopting healthy lifestyles, making positive health choices, which in turn impact on relationships and personal, family and community well-being.

Summary of key issues

An educated, achieving Bolton is a healthy Bolton.

The areas within Bolton where residents experience poor health outcomes including limiting long-term illness and lower life expectancy are those areas where residents have lower levels of achievement including qualifications and skills

The anticipated increase in job opportunities within the borough over the next 5 to 10 years will mainly be for those educated to level 2 and level 3. Average education and skills levels among 19-65 year olds in Bolton is lower than the North West regional average and significantly lower in the most deprived areas of the borough.

The percentage of 16 year olds in Bolton who achieve 5 or more good GCSE passes including English and Maths is below the national average particularly for those living in the more deprived areas of the borough. If the cycle of low achievement leading to poor health outcomes is to be broken then this needs to be addressed.

Access to and reasons for non-participation in opportunities to engage in learning, particularly in deprived areas and amongst hard to engage groups needs to be investigated.

The percentage of schools in Bolton achieving the National Healthy Schools Standard is lower than that regionally and nationally.

Safety

How does community safety affect health?

Feeling safe and secure protects against ill health for a number of reasons. In many areas of Bolton, rates of fear of crime are significantly higher than actual crime. Fear of crime acts as a significant barrier to participating in activities that have been shown to enhance health, such as community, physical or social activities outside the home. It can be a barrier to participating in healthy behaviours, for example, in Bolton, fear of crime has been found to predict an inactive lifestyle. Feeling unsafe also causes low level stress over long periods of time, which in turn have an impact on circulatory disease, mental health and ability to fight off infections.

Security devices within the home and Improvements to the local environment such as improved lighting, cutting hedges and even closed circuit TV have increased resident's feelings of security. These initiatives are most effective where local people are involved in identifying problems and solutions. In Bolton, local people are being encouraged to get involved in community safety interventions through the Greater Manchester Police's neighbourhood policing initiative.

Summary of key issues

Seven percent of adults in Bolton report that they do not feel safe walking alone in their area during the day time. This proportion rises to 13% in the most deprived areas of the borough and to 10% in those aged over 75. Forty-one percent of adults report feeling unsafe when walking alone in the area after dark. This increases to 57% of those aged 75 and over, and of those living in the most deprived areas. People of Pakistani origin are the group most likely to feel unsafe walking alone after dark.

Eleven percent of adults report that they feel unsafe in their home at night. This increases to 16% among 18-19 yr olds. Nineteen percent of people living in the most deprived areas, 18% of people of Pakistani origin and 20% of black people living in these areas do not feel safe in their homes at night.

Fifteen percent of adults report that nuisance from children is a serious issue in their area (rising to over 30% in some deprived areas).

Almost a quarter of people from black and minority ethnic groups state that they have been the victim of a racist attack in the area in the previous 12 months.

Black and minority ethnic groups, people living in deprived areas, young people and older people appear to be particularly vulnerable to crime and fear

of crime. Community safety interventions should particularly target these groups

Interventions to promote community cohesion and develop social capital should be a priority in addressing the health impacts of community safety

Safety strategic priorities

- Black and minority ethnic groups, people living in deprived areas, young people and older people appear to be particularly vulnerable to crime and fear of crime. Community safety interventions should therefore particularly target these groups

- Interventions to promote community cohesion and develop social capital should be a priority in addressing the health impacts of community safety.

Cleaner, Greener

How does a clean and green environment affect health?

The quality of the local environment affects in a number of ways. Poor air quality caused by traffic can affect respiratory conditions. Availability of safe and clean green spaces encourages outdoor physical activity such as play, walking and cycling. In Bolton, satisfaction with the quality of the local environment predicted physical activity according to the 2001 Bolton Health Survey. Spending time in outdoor green space has been shown to contribute to well-being. Litter and vandalism, on the other hand, can contribute to perceptions that an area is not safe and secure, and affect well-being negatively.

Summary of key issues

Sixty-five percent of Bolton residents report that they are satisfied with the quality of the environment in their local area. The following groups have the highest satisfaction rates: women, 25-44 yr olds, 65+ yr olds, able bodied residents, owner occupiers and those in affluent areas.

Fifty-two percent of residents state that rubbish and/or litter is a problem in their area and 35% stated vandalism is a problem. These rates increased in the most deprived areas.

Research into use of green open spaces found that those aged over 45 and those with disabilities are lowest users of parks and open spaces. People aged over 45 are a particular priority group for physical activity due to risk of health problems in the future. The Get Active Bolton consultation currently underway asks people aged 45 in the most deprived areas of Bolton, what would encourage them to use local open spaces for physical activity. The findings of this consultation should be used to provide intelligence about how to increase use of parks and green spaces as this will promote physical activity.

Research to identify barriers to walking using local public rights of way found that ill health, the poor condition of routes and lack of nearby routes were identified as the reasons why people did not walk in local green spaces. This research is informing priorities for footpath improvements.

Cleaner, Greener strategic priorities

- The Get Active Bolton consultation currently underway asks people aged 45 in the most deprived areas of Bolton, what would encourage them to use local open spaces for physical activity. The findings of this consultation should be used to provide intelligence about how to

increase use of parks and green spaces as this will promote physical activity.

- Improving the quality of outdoor and green spaces should remain a priority due to its positive affect on health

Strong and Confident

How do strong and confident communities affect health?

Strong and confident communities affect health in a number of ways. The availability of good quality affordable housing is associated with positive well-being and good health. Conversely cold damp homes can exacerbate respiratory conditions and heart disease.

There is evidence that good social support and networks are associated with positive health[2,3,4]. Social capital is a term for a combination of participation in community networks and activities, social support, contributing to local decision making, being involved in the daily life of the community and community cohesion. Social capital has been found to be associated with good health status and positive health behaviours, even when material deprivation is controlled for.

Social capital can be built using community development approaches. This is where local people are supported and empowered to take action themselves to address their concerns. Community development can be most effective when it is combined with personal development of community members and organisational development of the main agencies delivering services within the community.

Summary of key issues

Fifteen percent of adults in Bolton report that they are unable to afford to heat their homes in the winter. 13,722 homes in Bolton are estimated to be at risk of fuel poverty (15% of the total number of households). This calculation is based on income levels and energy efficiency ratings. Households in the most deprived areas and those made up of older people are most vulnerable to fuel poverty. Although Bolton is implementing an affordable warmth strategy, as fuel prices increase more and more people are likely to find themselves in fuel poverty. Bolton Council and Bolton PCT should continue to invest in affordable warmth programmes.

According to the Bolton Health Survey (2007) 18% of adults in Bolton are assessed as having a severe lack of social support. People aged 65 to 74 and younger age groups are most likely to lack social support. Prevalence of a severe lack of social support is 3 times higher in most deprived population and among the Pakistani group. Community development approaches should be

[2] Cooper H, Arber S, Fee L, Ginn J (1999) The Influence of Social Support and Social Capital on Health: a review of British data. Health Education Authority.
[3] Campbell C, Wood R, Kelly M (1999). Social Capital and Health. Health Education Authority.
[4] Stansfeld SA (1999). Social support and social cohesion. Marmot M, Wilkinson RG (eds). Social Determinants of Health. Oxford University Press.

used in Bolton's deprived areas to build social capital. These should also target Bolton's Pakistani community, which is the ethnic group with the lowest social support.

The Bolton Health Survey included a number of questions to elicit people's perceptions of their neighbourhood. The reputation of the area was identified as an increasing problem for residents of Hall ith' wood and Johnson Fold estates. Nine percent of Bolton residents feel they 'don't belong' to their area, however this rises to 37% in some deprived areas

Strong and confident strategic priorities

- Although Bolton is implementing an affordable warmth strategy, as fuel prices increase more and more people are likely to find themselves in fuel poverty. Bolton Council and Bolton PCT should continue to invest in affordable warmth programmes.

- Community development approaches should be used in Bolton's deprived areas to build social capital. These should also target Bolton's Pakistani community, which is the ethnic group with the lowest social support.

Summary of recommendations

Recommended priorities

Stages 1 and 2 of the JSNA aims to inform priority setting for Bolton's Local Area Agreement and the health economy's medium term strategic plan. A summary of priorities is included below:

- Future prevention of cancer, CVD and diabetes by focusing on child and adult obesity, alcohol and smoking
- Cancer screening and treatment services
- Encourage symptom recognition and early presentation for diabetes, cancer, cardio-vascular disease and respiratory disease
- Promoting mental health (especially older people, younger people and those in deprived areas)
- Services to support people on incapacity benefit into work,
- Back pain
- Increase capacity for treatment of digestive disorders as the trend in alcohol consumption continues
- Workplace health programme to develop healthy working practices, prevent sick leave and deliver alcohol interventions
- Reduce the number of under 18s conceptions and increase the numbers of teenage mothers accessing education, employment and training
- Improve maternal and child health, including by addressing smoking in pregnancy, breastfeeding, low birth weight, early access to maternity care, healthy diet and nutrition, and infant mortality
- Emergency admissions among children
- Pneumonia, hospital mortality and fuel poverty
- Community development to build social capital in deprived areas

Interventions should particularly target the following groups:

- BME groups (particularly the Pakistani community)
- 40-60 yr olds (to prevent future need associated with ageing population)
- Expectant and new parents (to break the cycle of deprivation)
- Carers
- The workless population
- Those living in the most deprived areas

Recommended further health needs assessment

- Understanding patterns of residential mobility how population turnover varies across Bolton's neighbourhoods
- Current patterns of migration in and out of the borough and how these are changing, particularly in terms of short term (i.e. less than one year) migration.
- Predict the future prevalence of a range of health problems and behaviours
- Collate and analyse findings of previous local research with black and minority ethnic groups
- Assessment of felt needs of communities in deprived areas (including 40-60's, parents)
- Undertake analysis to enable us to understand the profile of the children frequently admitted to hospital to identify alternative ways of meeting this health need.
- Assess the health needs of Bolton's adolescent population

In future stages of the JSNA we will explore opportunities to identify the extent to which the spending of other local agencies is aligned to the needs identified.

Glossary

Bolton Health Survey	The Bolton Health Survey is a postal questionnaire sent to 25,000 adults in Bolton in June 2007. The questionnaire included questions on symptoms of health problems, use of health services, health behaviours, perceptions of the community and socio economic characteristics. The survey achieved a 53% response rate.
Bolton Vision	Bolton's Community Strategy which sets out the priorities for the borough between 2007 and 2017
Circulatory disease	Diseases of the circulatory system including coronary heart disease and stroke
COPD	Chronic obstructive respiratory disease. This is a group of respiratory conditions which include bronchitis and emphysema
SMRs	Standardised Mortality Ratios. These estimate what the death rate would be if Bolton's population had the same age structure as England, and are presented as a percentage of the English death rate (100). A SMR of 120 means that we estimate that death rates would be 20% higher in Bolton than England is Bolton and England had the same population age structure. An SMR of 80 means that we

	estimate that the death rate in Bolton is 20% lower than England.