worcestershire county council

Worcestershire

Health and Wellbeing Board

Malvern Hills District Health and Wellbeing Profile

September 2015

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NHS
Wyre Forest Clinical Commissioning Group

NHS
South Worcestershire Clinical Commissioning Group

NHS
Redditch and Bromsgrove Clinical Commissioning Group

Malvern District Health and Wellbeing Profile

1. Executive Summary

Whilst Malvern Hills District overall has good health and wellbeing outcomes amongst its population this profile details a number of areas of concern. Many of these are already known about and have been incorporated into the various strategies at both district and county level by the Worcestershire Health and Wellbeing Board and local Malvern Hills Health and Wellbeing Group. However there are a few issues that should be highlighted as they are either of concern and have not yet been picked up or because the depth of the issue needs further exploration:

Population change over next 10 years

The forecast is for a significant increase in the over 75 year age population which is likely to create an additional burden to health and social care need / demand, and also the need for housing provision to be fit for purpose. With the planned additional housing developments there is also likely to be increased migration into Malvern Hills which could change the age profile (possibly bringing in additional 30-50 year old age groups)

Fuel Poverty

Malvern Hills has a statistically significant higher level of fuel poverty compared to England and its statistical neighbours. This is likely to be intrinsic to the housing stock across the district and the decreasing incomes of older people.

Antenatal and postnatal support

Smoking in pregnancy is above average when compared to both Malvern's statistical neighbours and the England rate. Breastfeeding rates are lower than average and have decreased over the last 3 years.

Obesity in childhood

Obesity prevalence is a key public health concern across England and although obesity levels are still below the England average Malvern is presenting an increasing trend of childhood obesity at year 6.

Pickersleigh Ward

There are some positive health and wellbeing outcomes being achieved in Pickersleigh, however some significant inequalities exist particularly in regard to child outcomes, emergency admissions for all ages and adult self-harm.

Deblin Green and Madresfield

This area has emerged as an area of concern based on the 'hotspot' calculations. It will need to be monitored to see if this is a true finding requiring action or a spurious one that can be discounted.

Sexual health screening

Screening for chlamydia is very low, not only in Malvern Hills but in Worcestershire and the West Midlands region.

Social Cohesion

This is currently good across Malvern Hills however with the changing population, ageing in particular, and housing developments there is an increasing need for social capital.

Although this profile points to individual indicators, it also acknowledges that many health outcomes are affected by the wider determinants of health, the quality of housing a person lives in, their household income, the levels of deprivation, education and exercise to name a few. Before making changes to services, commissioners are encouraged to undertake Health Impact Assessments to understand the true impact their service change may have on local communities.

2. Recommendations

It is recommended that further work be undertaken to:

- Strategically prepare for the increasing ageing population
    - Discussion with Malvern Hills residents on their likely future needs /wants; housing, social engagement / interaction, financial planning
    - Housing - developments are fit for purpose, existing housing is improved wherever possible in regard to insulation to support reduction in fuel poverty
    - Primary care provision – in the right place to support access
    - To prevent and diagnose dementia early

- Review maternity pathway / service to better understand challenges in regard to smoking in pregnancy and breastfeeding.

- Continue to prioritise areas with health inequalities, focus on the particular aspects that have been identified as significantly worse than average such as childhood outcomes in Pickersleigh.

- Develop a better understand and respond to prevent Self- harm in Pickersleigh, Link and Chase wards as they are significantly higher than the England expected level.

- Explore why screening uptake for chlamydia in 15-24 year olds is so low Malvern

- Ensure Health Impact Assessments (HIA) are completed on all planned housing developments to enable social capital to be fully considered

3. Worcestershire Health and Wellbeing Priorities

The Worcestershire Health and Well-being Board identified four health and well-being priorities for 2013-2016. These are:

• **Older people and management of long term conditions**

• **Mental health and well-being**

• **Obesity**

• **Alcohol**

These priorities will be addressed across the population but with added focus on the following groups:

• **Children and young people**

• **Communities and groups with poor health**

• **People with learning disabilities**

This profile will, in addition to other health and wellbeing factors, explore Malvern Hills position in regard to these priorities and note progress made towards improved outcomes.

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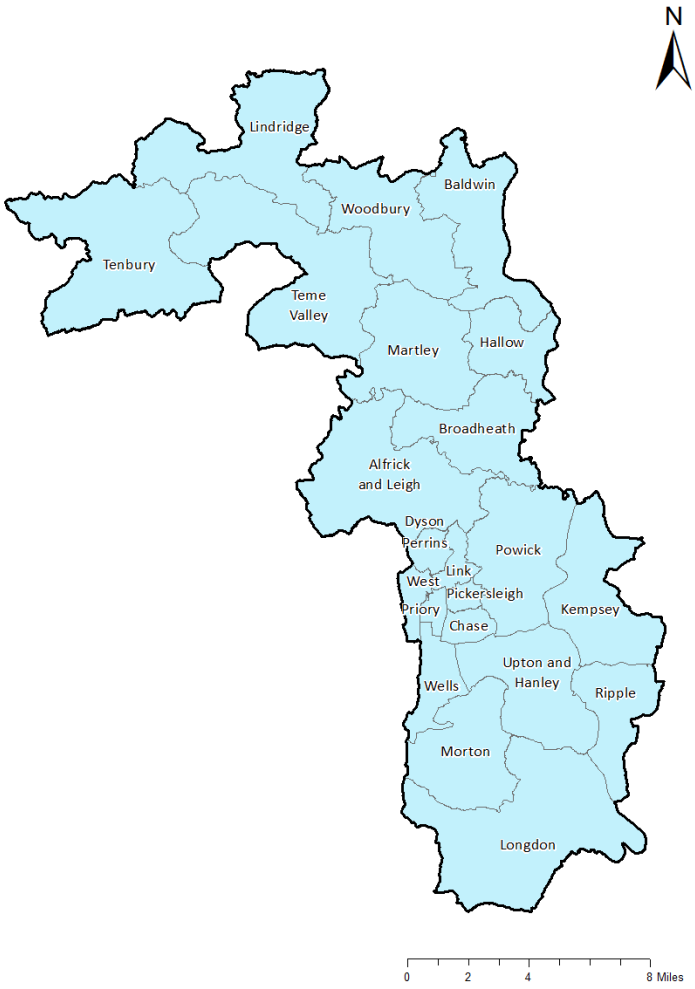
4. Introduction – Setting the context

Malvern Hills District is one of the six districts within the county of Worcestershire. It consists of 3 market towns – Tenbury Wells, Malvern, and Upton on Severn with the rest of the District population living in smaller hamlets and rural locations. Malvern Hills has 22 wards within its boundary (Figure 1 and appendix 1).

Figure 1 – Malvern Hills District Council ward boundaries



Source: ONS

Malvern Hills is recognised as an area of outstanding natural beauty and attracts visitors throughout the year. Malvern Hills is perceived as having high levels of health and wellbeing, and for many this is likely to be true however there are health inequalities that remain which this profile will aim to highlight. The profile will provide information on the general demographics of Malvern Hills. It will also present areas where Malvern Hills is performing well in regard to health and wellbeing compared to national. It will explore at a ward level concerns that have been raised locally as areas of concern and / or perhaps not being identified within other data sources. Where possible these will be measured against areas similar to Malvern Hills (statistical neighbours).

The Chartered Institute of Public Finance and Accountancy has a validated tool to identify statistical neighbours and the latest publication profile is shown below (Figure 2). The top 5 statistical neighbours (2014) will be used as the comparison.

Figure 2 - CIPHA Malvern Hills District statistical neighbours

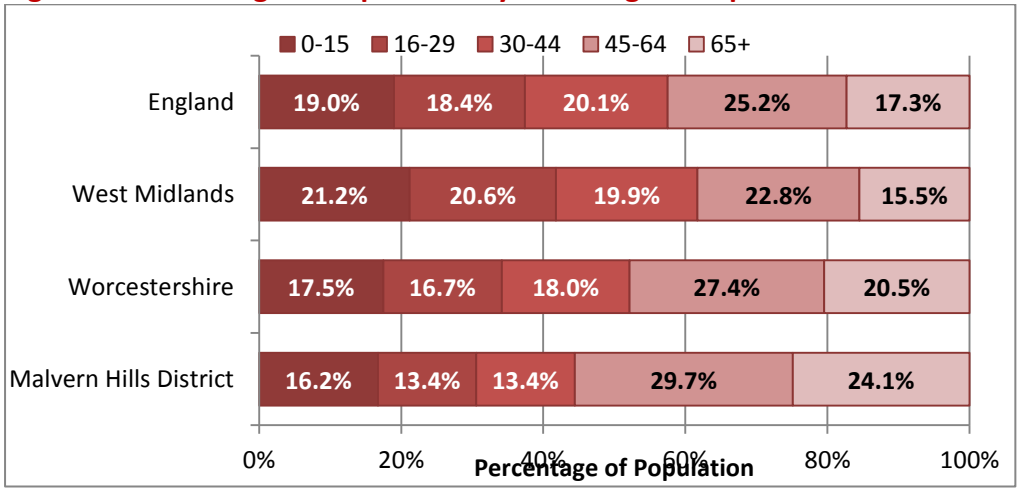
2014		2009
North Dorset	1	Derbyshire Dales
Wychavon	2	Craven
Maldon	3	Babergh
Babergh	4	Mid Devon
Hambleton	5	Cotswold
West Devon	6	Hambleton
Derbyshire Dales	7	Tewkesbury
Tewkesbury	8	North Dorset
Forest of Dean	9	Stroud
Stroud	10	Ryedale

Source CIPHA 2015

4.1 Malvern District population

Latest estimates show that Malvern Hills District has a total population 75,000 (2012 mid-year estimate ONS). This equates to just over 13% of the total population of Worcestershire (around 569,000). The District has an older population than Worcestershire as a whole. It should be noted that Worcestershire has an older than average population compared to England. The 65+ age group accounts for 24.1% of the total population in Malvern Hills District, compared to 20.5% of the population in Worcestershire, and 17.3% in England (Figure 3). In contrast only 43% of the Malvern Hills District population is under the age of 45, compared to 52.2% of the total population in Worcestershire and 57.5% in England.

Figure 3 - Percentage of Population by Broad Age Groups in 2013



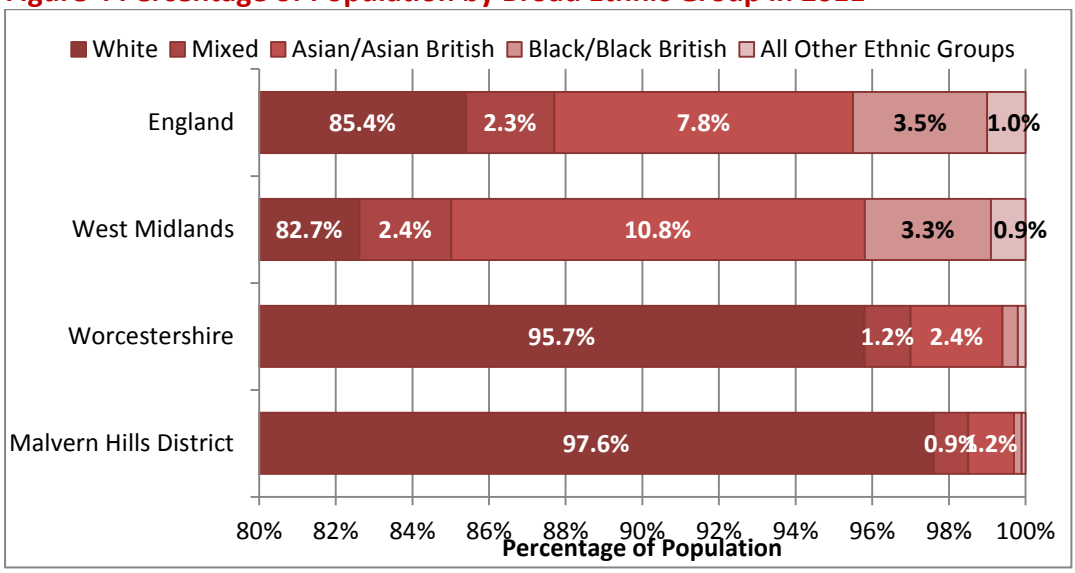
Source: Office for National Statistics, mid-year estimates, 2013

4.2 Ethnicity

Figure 4 below compares the population of Malvern Hills District against that of Worcestershire, the West Midlands and England by broad ethnic group.

Figures from the 2011 Census show that 97.6% of people in Malvern Hills District are from white ethnic groups. This compares to 95.7% in Worcestershire and 85.4% in England. The next largest group is Asian with Chinese accounting for 0.5% of the 1.2% population.

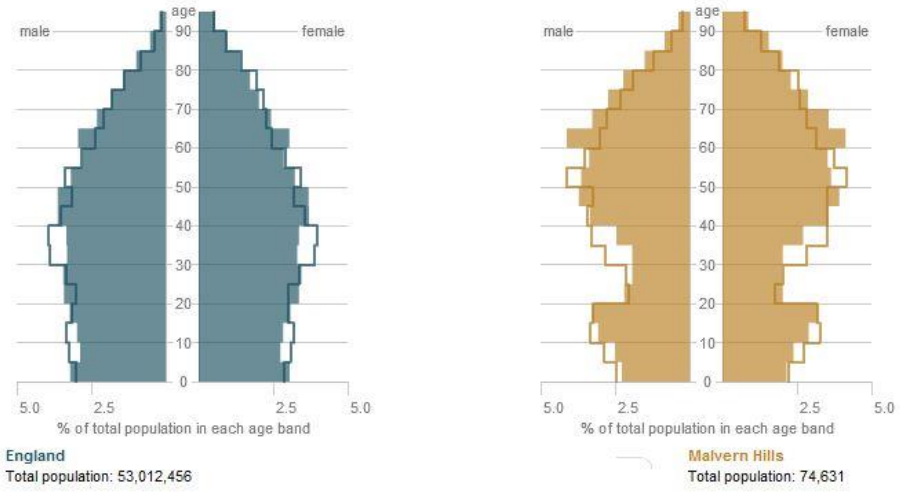
Figure 4 Percentage of Population by Broad Ethnic Group in 2011



Source: 2011 Census

Figure 5 compares the population of Malvern Hills District against that of England in more detail. This shows that the overall age and gender structure of Malvern Hills is different to that of England. There is a much lower % of 20-40 year olds in Malvern Hills compared to the England average although both have seen a drop since the 2001 census. Malvern Hills and England have both seen a % increase in the 60-70 age group, although Malvern Hills more dramatically since 2001.

Figure 5 Comparison of 2011 Census Population estimates for England and Malvern Hills District (outline shows 2001 population age profile)



Source: 2011 Census, 2001 Mid-Year Population Estimates. Graphic by ONS Data Visualisation Centre

4.3 Population forecast

The population is forecast to increase by 4.5% overall across Malvern Hills between 2014 and 2024. There is considerable variation however across age group (Figure 6). The over 75 year old age groups forecast a dramatic increases, whilst young adults (20-30 age groups) showing a substantial decrease, as do the 45-49 age group. **It is important to consider the likely health and wellbeing challenge that accompanies such a large increase in the older population.**

Figure 6 - Population projection 2014 – 2024, Malvern Hills District

Age Group	Population 2014	Population 2024	% change
<1	315	310	- 1.6%
1-4	1385	1360	- 1.01%
5-9	1840	1962	+ 6.6%
10-14	2020	2230	+10.4%
15-19	2109	1972	- 6.5%
20-24	1534	1149	**- 25.1%**
25-29	1503	1426	- 2.7%
30-34	1611	1712	+ 6.3%
35-39	1795	1950	+ 8.6%
40-44	2383	2166	- 9.1%
45-49	2952	2177	**- 26.2%**
50-54	2935	2723	- 7.2%
55-59	2660	3180	+ 19.5%
60-64	2770	3085	+11.3%
65-69	3076	2760	- 10.3%
70-74	2352	2751	+ 17%
75-79	1937	2841	**+ 46.7%**
80-84	1543	2030	**+ 31.6%**
85-89	1098	1433	**+31.5%**
90+	790	1141	**+44.4%**
All ages	38608	40358	+4.5%

4.4 Life Expectancy

Nationally we are living longer, but living longer with a disability/non-communicable disease. With the ageing population expected to grow, the Marmot Review (2010) found that the more affluent live longer than the less affluent and that the later years of the more affluent are spent in better health. Today most people now die from non-communicable diseases in old age, and the causes of premature death are linked to avoidable behaviours, such as smoking, drinking too much alcohol, physical inactivity and eating too much food high in fat, salt and sugar. There is greater awareness now of the close links between mental and physical health and we know that if people's mental health is improved, they are more likely to take part in physical activity which brings with it a reduction in the prevalence of coronary heart disease, diabetes, and obesity.

The 'social determinants of health' is an expression given to the number of elements which impact on an individual's health. These factors include where they were born, live and work, their age and any systems/legislation put in place to deal with health related issues, i.e. the social, economic and environmental factors. It is this complex set of causal factors which combine to create the

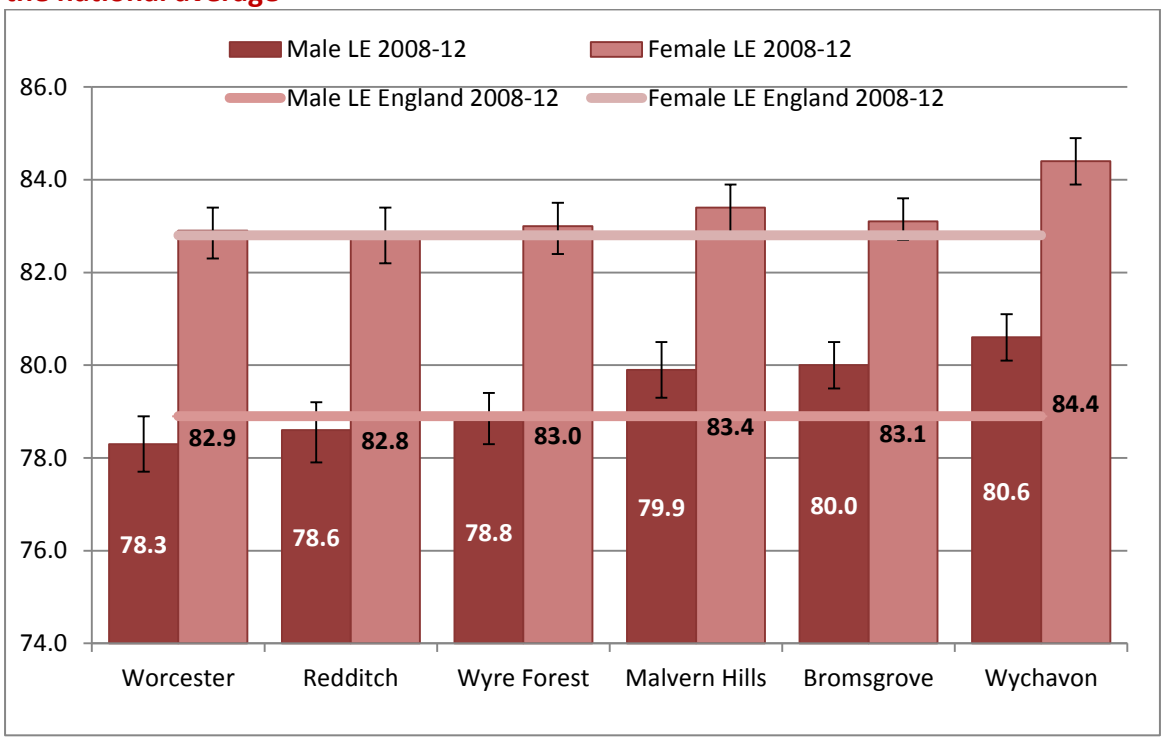
environment in which people live. Policies which change any one of these factors will have an impact on health, and the most significant impact will be evident when a whole system approach to change can be delivered.

An 'inequality in health' is a term to describe the differences in health status between individuals or groups, as measured by (for example) life expectancy, mortality or disease. Health inequalities are preventable differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. The Marmot Review (2010) calculated that nationally, inequality in health accounted for productivity losses of £31–33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year and additional NHS healthcare costs associated with inequality in excess of £5.5 billion per year.

Women in Malvern Hills are expected to live, on average, three and a half years longer than males. The average life expectancy at birth for males in Malvern Hills District is 79.9 years and for women is 83.4 years.

Figure 7 shows that Malvern Hills has a higher life expectancy compared to the England average, with male life expectancy statistically significantly higher than average. Only Wychavon District has a higher male and female life expectancy to Malvern Hills District.

Figure 7 - Life expectancy (LE) at birth (2008-12) for males and females by district against the national average



Source: ONS

When broken down to ward level, using the LE at birth (2008-12) dataset, there are some notable differences in life expectancy

In regard to males Lindridge and Woodbury present the longest life expectancy at 85.9 years and 84.0 years respectively compared to the shorter life expectancy in Alfrick & Leigh and Upton &

Hanley both presenting 77.2 years. **The gap between the best and worst life expectancy is 8.7 years.**

Based on the 95% confidence intervals men living in Alfrick & Leigh or Upton and Hanley wards have a statistically significant shorter life expectancy compared to men living in Lindridge ward.

For females the longest life expectancy wards are Woodley 87.1 years and Dyson Perrins and 86.4 years. Baldwin and Broadheath both present a life expectancy of 80.2 years. **The gap between the best and worst life expectancy across the District is 6.9 years.**

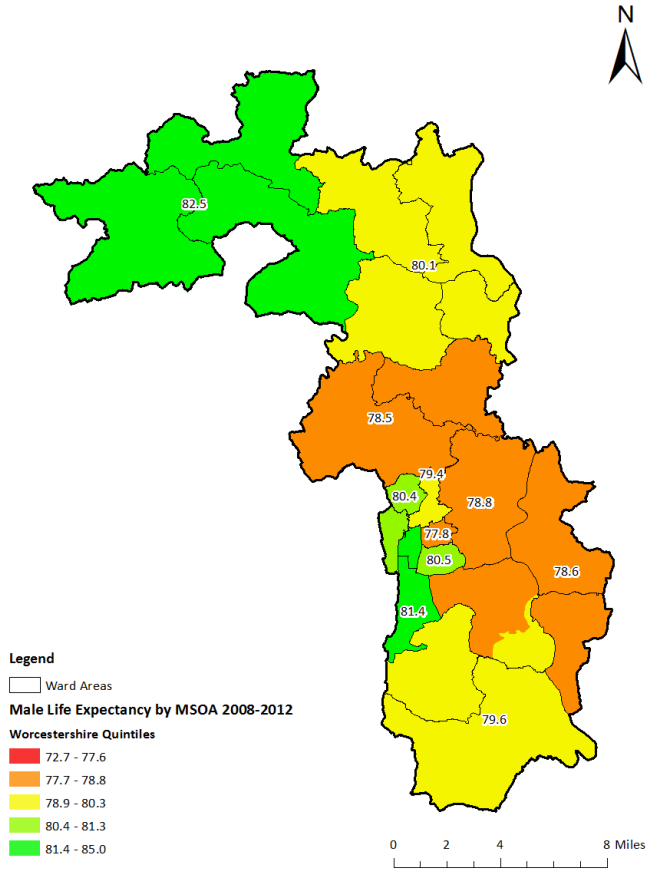
Based on the 95% confidence intervals females in Baldwin ward have a statistically significant shorter life expectancy compared to females living in either Woodbury Dyson Perrins wards. **Baldwin ward also has a statistically significant shorter life expectancy compared to the England average of 82.8**.

It is pertinent to note that **none of the most deprived wards, based on Index of Multiple Deprivation score, feature in regard to shorter than average life expectancy.**

When **rural deprivation is taken into account however, Upton & Hanley and Alfrick & Leigh wards present within the 30% most deprived rural wards nationally**

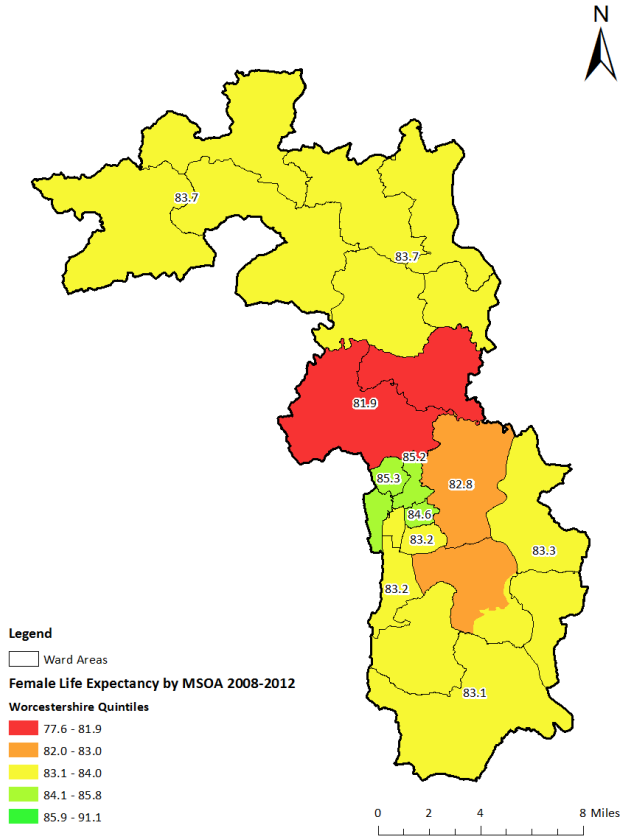
The following maps show the life expectancy for males and females in each Middle Super Output Area represented as Worcestershire quintiles. MSOA has been provided as this overcomes the issue of ward data suppression (Figure 8 and 9)

Figure 8 - Malvern Hills life expectancy at birth for males 2008-12 by MSOA



Source: Local Health
http://www.localhealth.org.uk/#z=347887,287037,81979,59203;v=map7;i=t4.le_f;l=en,

Figure 9 - Malvern Hills life expectancy at birth for females 2008-12 by MSOA



Source: Local Health
http://www.localhealth.org.uk/#z=347887,287037,81979,59203;v=map7;i=t4.le_f;l=en,

There are **a number of wards which have been excluded** within this data set for the following reasons

- Population size of less than 5000
- No deaths recorded to those aged 85+ years
- Wards where the confidence interval values were greater than 20 years in width.

It is therefore not possible to provide analysis on these. The wards excluded are shown in Figure 10.

Figure 10 Excluded wards in life expectancy analysis

Ward Name	Male	Female
Hallow	X	X
Martley	X	X
Morton	X	
Ripple	X	X
Teme Valley	X	X

4.5 Premature Mortality

Premature mortality is a good high-level indicator of the overall health of a population, being correlated with many other measures of population health: there are significant differences between the premature death rates in different areas, reflecting a wide range of underlying differences between these populations. Whilst the majority of Malvern Hills District population live a long life there remain a small number for whom life is shorter than expected. Premature mortality is defined as death before the age of 75. To enable comparison the across areas data is directly age-standardised.

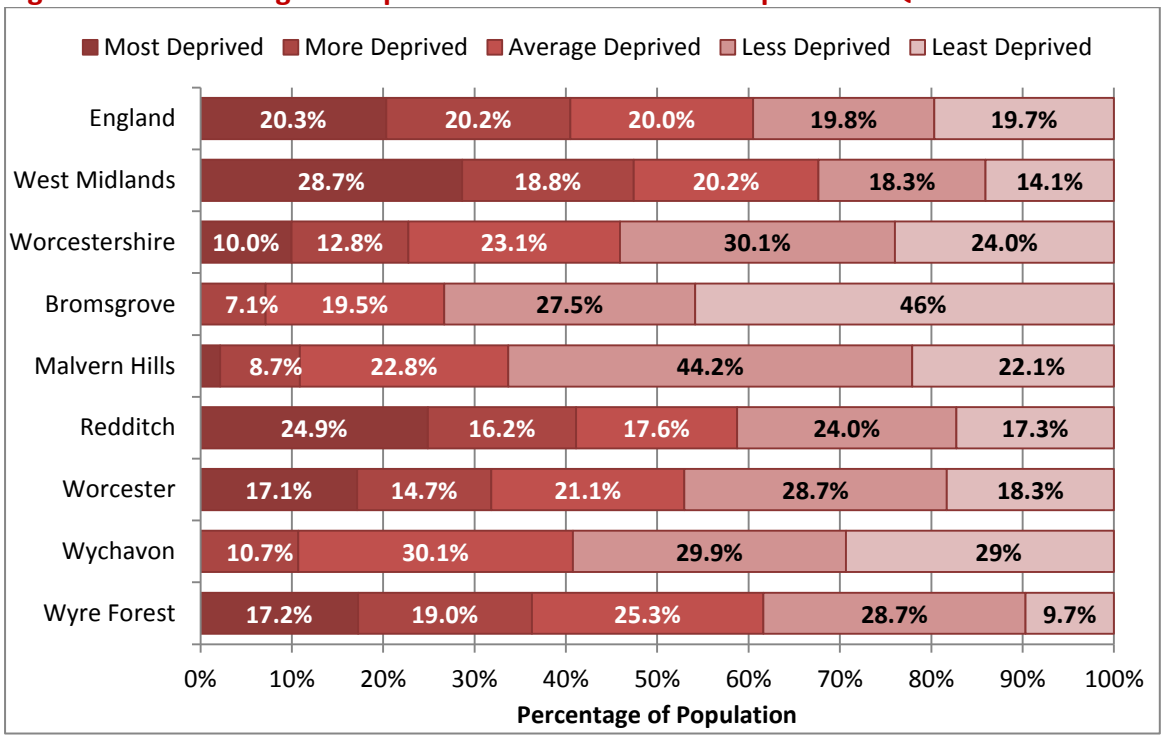
Malvern Hills had a total of 682 premature deaths in 2011-2013, of which 294 were cancer related 88 were due to heart disease, 34 to stroke, 53 to lung disease and 25 to liver disease. Data on premature death due to injury is not available.

When compared to the national average **Malvern Hills presents a higher than average number of deaths to colorectal cancer (count 32) and also stroke although it should be noted that these are small numbers.**

4.6 Deprivation

The Index of Multiple Deprivation 2010 (IMD) is a measure of multiple deprivation at lower layer super output area (LSOA) which is a geographical unit that has an average population of 1,500. The IMD is made up of 38 indicators covering seven domains and the result is a single score for a LSOA which is then ranked (1 = most deprived area in England and 32,482 = least deprived), these can be then grouped into deciles and quintiles. Figure 11 shows the percentage of the population in each deprivation quintile for England, the West Midlands, Worcestershire and the six Worcestershire districts.

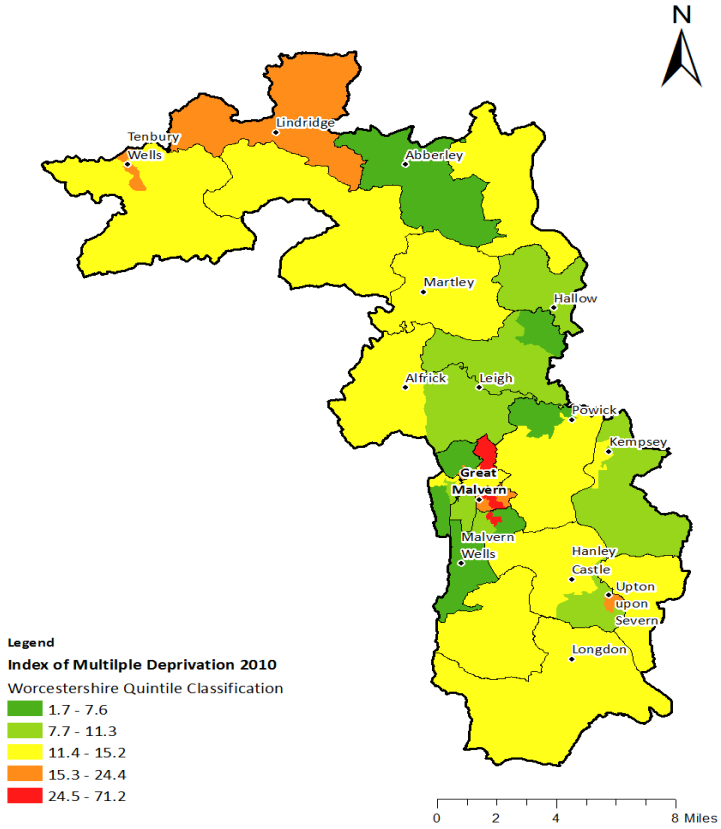
Figure 11 – Percentage of Population in each National Deprivation Quintile



Source: Index of Multiple Deprivation 2010, Association of Public Health Observatories, http://www.apho.org.uk

It can be seen from figure 12 that out of the six districts of Worcestershire, Malvern Hills has the lowest percentage of its population in the most deprived quintile at 2.2%. Over two- thirds of Malvern Hills residents are classified as being less / least deprived.

Figure 12 - IMD by quintile across Malvern Hills LSOA



There are 72 LSOAs across Worcestershire (figure 11) that feature in the most deprived quintile nationally. Four of these are within the Malvern Hills District (figure 13).

Figure 13 - Most deprived LSOA and associated Ward in Malvern Hills

LSOA Name	Ward	IMD Score
Sherrard's Green	Pickersleigh	49.21
Orford Way	Pickersleigh	32.73
Lower Howsell	Link	24.98
Pool Brook Road	Chase	24.85

5. Health of Malvern Hills at a glance

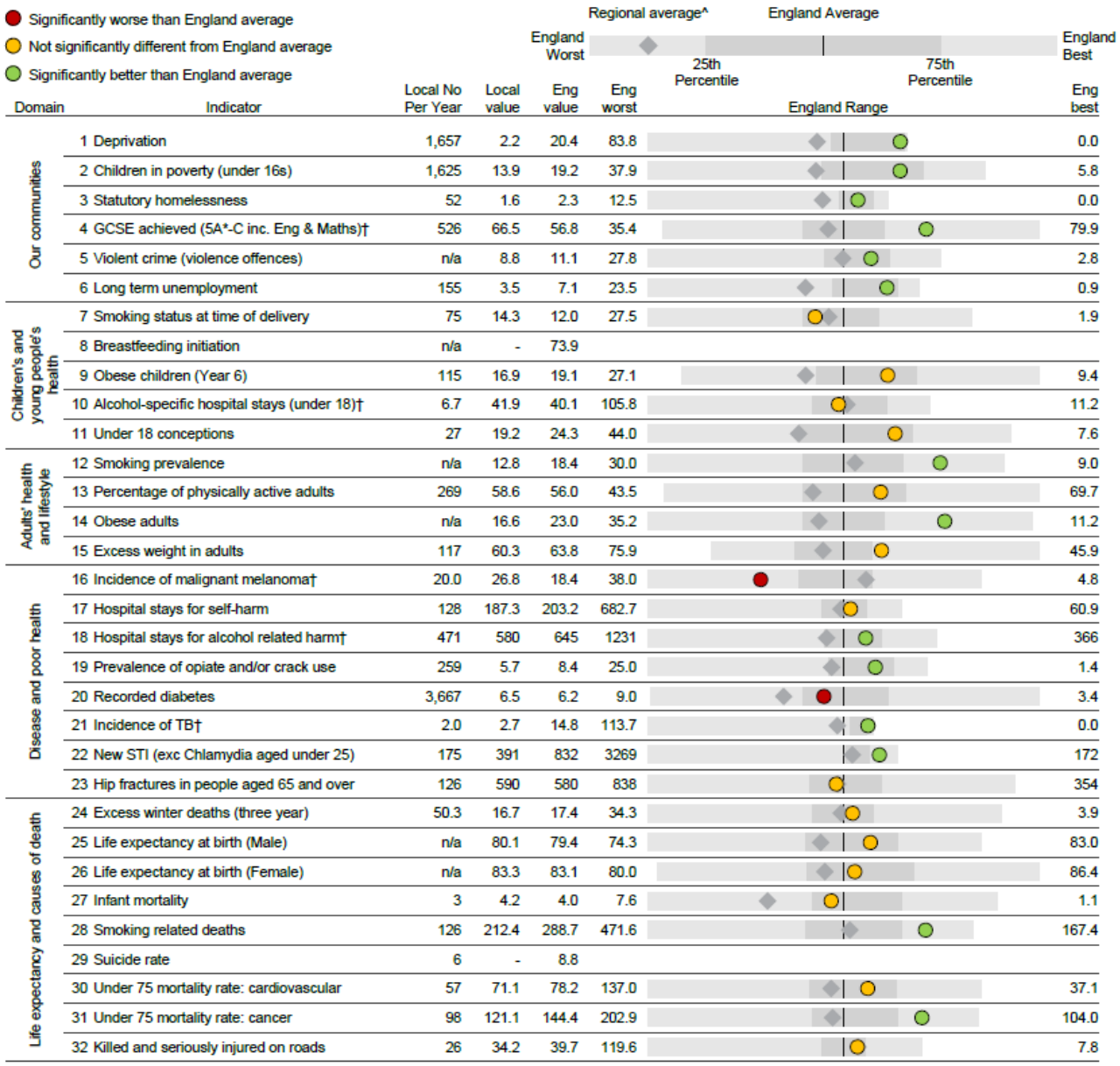
The Association of Public Health Observatories (APHO) produced Health Profiles in June 2015 which help to provide a snapshot of the overall health of the local population, and highlight potential problems through comparison with other areas and with the national average. For Malvern Hills, in summary;

- The health of people in Malvern Hills is varied compared with the England average.
- Deprivation is lower than average, however about 13.9% (1,600) children live in poverty.
- Life expectancy for both men and women is similar to the England average, although life expectancy is lower for men in the most deprived areas of Malvern Hills than in the least deprived areas.
- In Year 6, 16.9% (115) of children are classified as obese.
- The rate of alcohol-specific hospital stays among those under 18 was 41.9*. This represents 7 stays per year.
- Levels of GCSE attainment are better than the England average.
- In 2012, 16.6% of adults are classified as obese, better than the average for England.
- The rate of alcohol related harm hospital stays was 580*, better than the average for England. This represents 471 stays per year.
- The rate of self-harm hospital stays was 187.3*. This represents 128 stays per year.
- The rate of smoking related deaths was 212*, better than the average for England. This represents 126 deaths per year. Estimated levels of adult smoking are better than the England average.
- Rates of sexually transmitted infections and TB are better than average.
- The rate of new cases of malignant melanoma is worse than average but equate to only 20 cases per year.
- Rates of statutory homelessness, violent crime, long term unemployment, drug misuse and early deaths from cancer are better than average.

* per 100,000

The chart below (Figure 14) shows how the health of people in Malvern compares with the rest of England. Malvern's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always shown at the centre of the chart. The range of results for all areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however a green circle may still indicate an important public health problem

Figure 14 Malvern Health Profile 2015



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	1,657	2.2	20.4	83.8	0.0
	2	Children in poverty (under 16s)	1,625	13.9	19.2	37.9	5.8
	3	Statutory homelessness	52	1.6	2.3	12.5	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	526	66.5	56.8	35.4	79.9
	5	Violent crime (violence offences)	n/a	8.8	11.1	27.8	2.8
	6	Long term unemployment	155	3.5	7.1	23.5	0.9
Children's and young people's health	7	Smoking status at time of delivery	75	14.3	12.0	27.5	1.9
	8	Breastfeeding initiation	n/a	-	73.9		
	9	Obese children (Year 6)	115	16.9	19.1	27.1	9.4
	10	Alcohol-specific hospital stays (under 18)†	6.7	41.9	40.1	105.8	11.2
	11	Under 18 conceptions	27	19.2	24.3	44.0	7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	12.8	18.4	30.0	9.0
	13	Percentage of physically active adults	269	58.6	56.0	43.5	69.7
	14	Obese adults	n/a	16.6	23.0	35.2	11.2
	15	Excess weight in adults	117	60.3	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma†	20.0	26.8	18.4	38.0	4.8
	17	Hospital stays for self-harm	128	187.3	203.2	682.7	60.9
	18	Hospital stays for alcohol related harm†	471	580	645	1231	366
	19	Prevalence of opiate and/or crack use	259	5.7	8.4	25.0	1.4
	20	Recorded diabetes	3,667	6.5	6.2	9.0	3.4
	21	Incidence of TB†	2.0	2.7	14.8	113.7	0.0
	22	New STI (exc Chlamydia aged under 25)	175	391	832	3269	172
	23	Hip fractures in people aged 65 and over	126	590	580	838	354
Life expectancy and causes of death	24	Excess winter deaths (three year)	50.3	16.7	17.4	34.3	3.9
	25	Life expectancy at birth (Male)	n/a	80.1	79.4	74.3	83.0
	26	Life expectancy at birth (Female)	n/a	83.3	83.1	80.0	86.4
	27	Infant mortality	3	4.2	4.0	7.6	1.1
	28	Smoking related deaths	126	212.4	288.7	471.6	167.4
	29	Suicide rate	6	-	8.8		
	30	Under 75 mortality rate: cardiovascular	57	71.1	78.2	137.0	37.1
	31	Under 75 mortality rate: cancer	98	121.1	144.4	202.9	104.0
	32	Killed and seriously injured on roads	26	34.2	39.7	119.6	7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

The Public Health Outcomes Indicator Framework dataset (PHE 2015) also identified **fuel poverty** and **Chlamydia detection** as areas where Malvern Hills is presenting significantly worse than the England average.

5.2 Threats to health and wellbeing

The 2014 Viewpoint survey in Worcestershire asked residents what they considered to be the "three most important threats to health facing people in Worcestershire today". The choices were; overweight and obesity, physical inactivity, drinking too much alcohol, tobacco/smoking, mental health and wellbeing, drug abuse, poor diet/nutrition, access to healthcare, long-term conditons and environmental quality. Results were analysed by district to see if there were any differences in attitudes and perception of health risks in each area.

- In Worcestershire as a whole, *overweight and obesity* was seen as by far the greatest threat to health (mentioned by 65% of respondents). 70% of Malvern Hills district respondents stated this even though obesity is not a statistically significant issue amongst the Malvern Hills District population based on PH 2015 Profile.
- *Physical inactivity* was the next greatest threat with a relatively lower 39% of Worestershires respondents, Malvern Hills however reported a higher level at 44%. Again this issue was not seen in the PH profile as a statistically significant issue for Malvern HIlls).
- *Drinking too much alcohol* was reported as the third most important threat to Malvern respondents (35% of respondents) which was not particularly disimilar to other districts
- Although Malvern Hills didn't consider long-term conditions as a particularly important threat (17%) this was a higher proportion when compared to the other districts
- Access to healthcare was seen by ony 13% of respondents as a threat. This was the lowest proportion compared to all of the other districts.

6. Identified issues

Based on Figure 14 Malvern Hills appears to have few areas of concern, Malignant Melanoma and recorded Diabetes are the only indicators showing red. The PHOF dataset adding fuel poverty and Chlamydia.

6.1 Malignant Melanoma

About 13,300 people are diagnosed with melanoma in the UK each year. It is the 5th most common cancer overall in the UK, excluding non-melanoma skin cancer. Skin cancer rates are more than 5 times higher than they were in the mid 1970's in Great Britain. Above the age of 20 to 24, the incidence steadily rises with age. It is now the second most common cancer in people under the age of 50. The highest incidence is in people over 85.

Some of the increase in melanoma may be because doctors are better at watching people for signs of melanoma, and detecting it at an early stage. But doctors think that it is to do with a change in how much time we spend in the sun, such as more people taking holidays abroad. (Cancer Research UK 2015)

Although cases of malignant melanoma, across Malvern Hills, has doubled since 2010 this equates to a small number (10 new cases in 2010 and 20 new cases in 2015). Caution is therefore required in regard to interpreting the results. The higher incidence is most likely to be reflected by the ageing

demographic rather than any other factor. It may also be attributed to historical rural / agricultural activity during a time where safer sun exposure was less known about and / or improved diagnosis.

6.2 Diabetes

Diabetes is a common life-long health condition. There are 3.3 million people diagnosed with diabetes in the UK and an estimated 590,000 people who have the condition, but don't know it. There are 2 types of Diabetes, Type 1 which usually develops, at a younger age, during childhood, up to the age of 40, and accounts for approximately 5-15% of all cases. Injectable insulin is required as the treatment for the rest of the person's life.

Type 2 Diabetes usually develops in people over the age of 40, although in recent years is also increasingly becoming more common in children, adolescents and young people. Type 2 diabetes accounts for between 85 and 95 per cent of all people with diabetes. The risk of developing Type 2 diabetes can be reduced by changes in lifestyle and is treated with a healthy diet and increased physical activity. In addition to this, medication and/or insulin are often required particularly as the person gets older.

Risk factors for Type 2 diabetes include

- Being overweight or having a high Body Mass Index (BMI)
- Having a large waist (more than 80cm/31.5 inches in women, 94 cm/37 inches in men or 90cm/35 inches in South Asian men)
- Being from an African-Caribbean, Black African, Chinese or South Asian background and over 25
- Aged over 40
- Having a parent, brother or sister with diabetes
- Having ever had high blood pressure, a heart attack or a stroke
- Having a history of polycystic ovaries, gestational diabetes or have given birth to a baby over 10 pounds/4.5kg
- Suffering from schizophrenia, bipolar illness or depression, or you are taking anti-psychotic medication

Obesity is the most potent risk factor for Type 2 however whilst Malvern Hills has the highest recorded prevalence rate of diabetes out of the six Worcestershire districts, it has the lowest estimated rate for adult obesity. **This suggests that other factors may be influencing the recorded prevalence, namely the ageing population and its comorbidities such as high blood pressure, heart attack or stroke.**

It is also **pertinent to highlight that having a higher than expected recorded prevalence of Diabetes may be attributed to high levels of screening and diagnosis which is a sign of proactive primary care**, rather than a poorer than average level of health.

Nevertheless the prevalence of diabetes within Malvern Hills needs to be acknowledged and known risks of complications that arise, which can be a significant burden on the individual, their family and Health and Social Care considered.
The 2015 JSNA reported that across Worcestershire the percentage of people offered a diabetic retinopathy screening test who attended screening is lower than the England average.

Other co-morbidities associated with diabetes include

- Short-term complications include hypo glycaemia diabetic ketoacidosis (DKA), and hyperosmolar hyperglycaemic state (HHS).
- Long-term complications include how diabetes affects your heart (cardiovascular disease), kidneys (nephropathy), and nerves and feet (neuropathy).

All of these conditions are manageble through early screening, diagnosis, ongoing self-care and primary care support. The higher risk group are the undiagnosed, which based on the recording level of diagnosed diabetes across Malvern Hills is likely to be a smaller than average proportion.

6.3 Fuel Poverty

There are a number of factors which singly or in combination can increase the risk of individuals or families living in fuel poverty (DoH, 2010):

(1) Low income households which choose to prioritise other essentials above fuel. These households also tend to live in the poorest quality housing with the lowest thermal efficiency.

(2) Homes with poor energy efficiency measured using the SAP rating (Standard Assessment Procedure for energy rating of dwellings). Those suffering fuel poverty tend to live in properties with a SAP of <35. Many in fuel poverty live in houses with solid walls (particularly common in rural areas) and may also be outside mains gas network relying on more expensive forms of heating and old inefficient boilers.

(3) Fuel costs – those most at risk of fuel poverty are paying higher prices for fuel e.g. paying by cash or cheque (costing an estimated £100 extra per annum than paying by direct debit. Plus there has been a steep rise in fuel costs; they rose as much as 147% between 2003 and 2008 for electricity and 100% for gas.

(4) Under occupancy is another key factor, frequently representing older people living alone who are more likely to have lower income and live in larger houses, which are more costly to heat simply due to their size.

The Government commissioned an independent report into fuel poverty and, in March 2012, it was published, making several recommendations for how fuel poverty should be measured. It proposed a new measure: the Low Income High Cost (LIHC) indicator.

Under the "Low Income, High Cost" measure, households are considered to be fuel poor where:

1. They have required fuel costs that are above average (the national median level)

2. Were they to spend that amount, they would be left with a residual income below the official fuel poverty line.

The key elements in determining whether a household is fuel poor or not are:

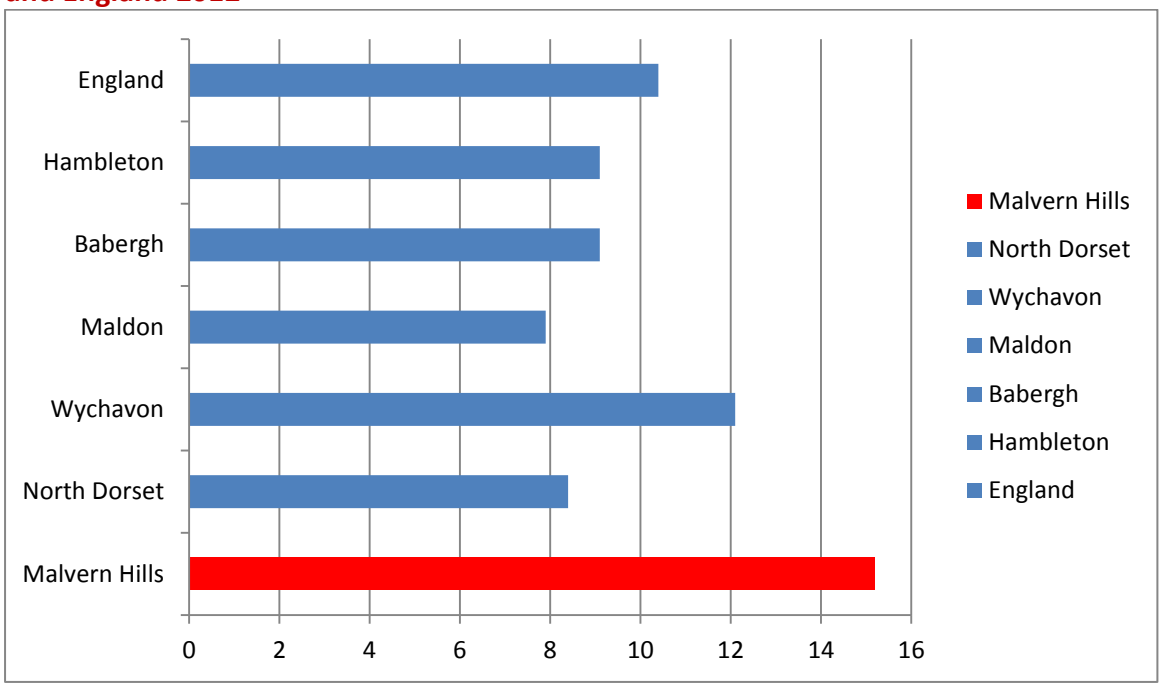
•Income

•Fuel prices

•Fuel consumption (which is dependent on the dwelling characteristics and the lifestyle of the household)

Using this indicator it shows that Malvern Hills has a statistically significant higher level of fuel poverty compared to England (15.2% to 10.4% respectively in 2012) When statistical neighbours are compared again Malvern Hills remains a clear outlier (Figure 15). It is pertinent to note that the West Midlands as a region has a high level of fuel poverty.

Figure 15 - % of households that experience fuel poverty in Malvern, statistical neighbours and England 2012



Source PHOF (2015)

The 2012 fuel poverty figure of 15.2% equates to 4774 of the total 31,487 households in Malvern Hills. Local data for 2013 shows a reduction in the % of households facing fuel poverty to 12.6% (4086 of the total 32,340 households in Malvern Hills).

The 2011 Census reported that 883 homes in Malvern have no central heating. In regard to heating fuel used estimates, based on the Green Deal and ECO options appraisal for Worcestershire (Encraft 2012,) show a wide variety of fuels used across the district

62.2% gas

18.4% oil

4.6% LPG

1.4% coal

12.9% electric

0.4% biomass

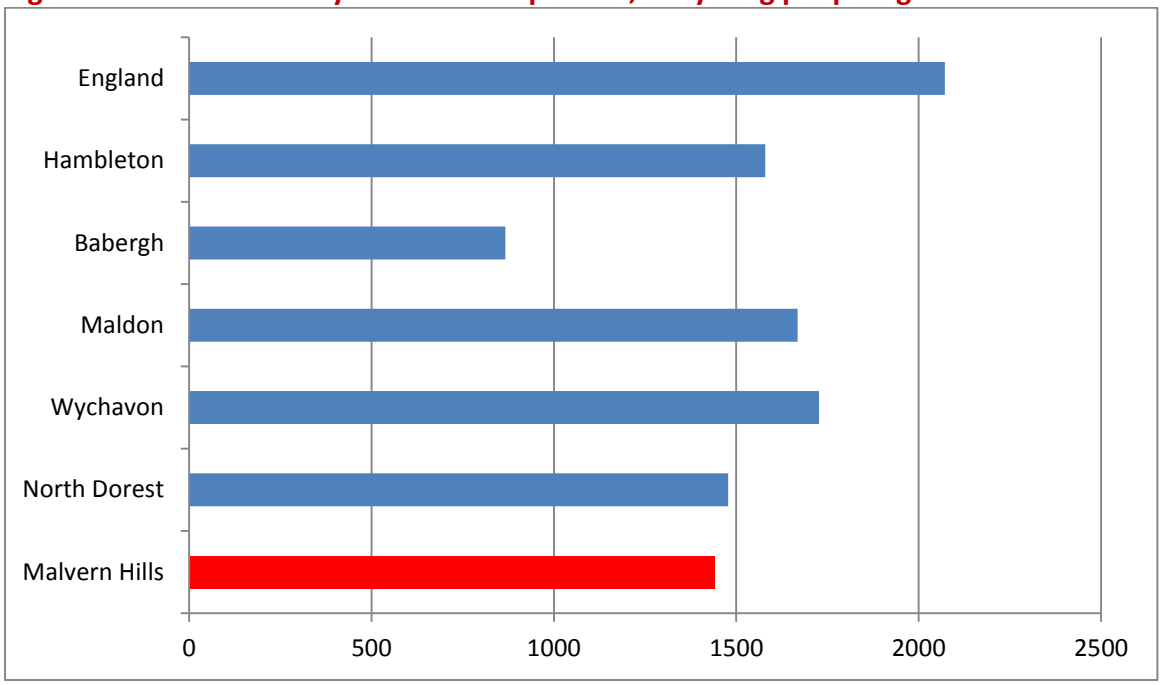
6.4 Chlamydia detection

Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia detection rate amongst under- 25 year olds is a measure of chlamydia control activities. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission onto others). Increasing detection rates indicates increased control activity: it is not a measure of morbidity.

Chlamydia screening is recommended for all sexually active people under 25 and on partner change. This indicator will allow progress in delivering accessible, high-volume chlamydia screening to be monitored. Public Health England recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population.

It is clear from Figure 16 that Malvern Hills is significantly below both the England rate and the expected rate of detection.

Figure 16 -Rate of Chlamydia detection per 100,000 young people aged 15-24



Source PHE Public Health Profiles 2012 – 2015

It has been questioned as to whether the low detection rate, in Malvern Hills and across Worcestershire, is due to low levels of screens being undertaken or a lower than average prevalence. The 2012 Worcestershire sexual health needs assessment identified that Malvern Hills has the lowest proportion of 15-24 year olds undertaking a screen compared to the other districts which may support the former viewpoint (Banerjee et al 2013)(Figure 17).

Figure 17 - Chlamydia screening performance by District: Worcestershire 2011/ 2012

	Tests	Positive	Coverage	Positivity	DR (per 100,000)
Bromsgrove	1138	88	11.6%	7.7%	893
Malvern Hills	980	56	12.1%	5.7%	689
Redditch	1415	84	15.4%	5.9%	913
Worcester	2404	152	19.0%	6.3%	1204
Wychavon	1499	111	12.7%	7.4%	943
Wyre Forest	1770	144	16.4%	8.1%	1336
Worcestershire	9206	635	**14.8%**	**6.9%**	**1018**

Significantly lower relative to Worcestershire
Not significant difference relative to Worcestershire
Significant higher relative to Worcestershire

Source: 2012 Worcestershire sexual health needs assessment

A new countywide sexual health needs assessment, strategy and commissioning process is in progress which will provide an update to this and some clarity on the local prevalence and screening uptake, along with priority actions for improvement. **Malvern Hills Health and Wellbeing Group will need to ensure the countywide sexual health strategy; including chlamydia screening actions are adopted locally.**

6.5 Other health and wellbeing indicators of interest

Rather than assume that Malvern District is performing well , based on the RAG ratings of the Indicator (Chart 1), trends over time for each of the indicators were assessed. A small number of indicators presented findings of interest**.**

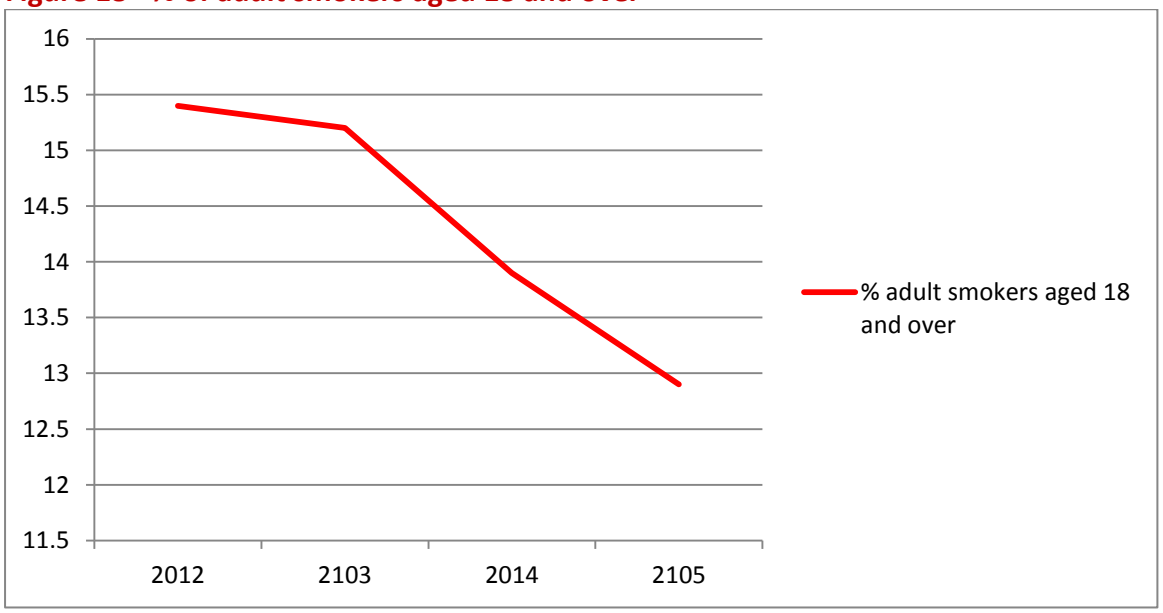
An overview of the remaining indicators has been included in appendix 2 providing a broader understanding of the health and wellbeing of Malvern Hills District.

The following indicators will be discussed in more detail within the main body of the profile, and statistical neighbours will be used as a more reliable benchmark where possible**; smoking prevelance, breastfeeding initiation, hip fractures, Alcohol –specific hospital stays (under age 18) and hospital stays for self harm.**

6.6 Smoking

The annual health profiles shows that the % of adults, aged over 18 who smoke has reduced from 15.4% in 2012 to 12.8% in 2015 (a 2.6% reduction)(figure 18). Although this may be considered a small % change it should be noted that Malvern Hills continues to remain significantly below the England average (5.6% lower). **Smoking is a key cause of mortality and morbidity this reduction should be commended.**

Figure 18 - % of adult smokers aged 18 and over



Source PHE Public Health Profiles 2012 – 2015

Smoking has many associated morbidites and is a leading cause of premature mortaility. Figure 19 shows that Malvern Hills, with its lower than average smoking prevelance, has a statistically significant lower level of many smoking attributed ill health outcomes.

Figure 19 - Malvern Hills tobacco associated mortality and morbidities

		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
1	Smoking Prevalence (IHS)	2013	12.8	18.4	30.0		9.0
2	Smoking prevalence - routine & manual	2013	18.5	28.6	59.3		5.8
3	Lung cancer registrations	2010 - 12	43.7	76.0	146.8		40.1
4	Oral cancer registrations	2010 - 12	14.6	13.2	21.6		6.4
5	Deaths from lung cancer	2011 - 13	36.3	60.2	111.6		32.3
6	Deaths from chronic obstructive pulmonary disease	2011 - 13	39.3	51.5	101.0		23.8
7	Smoking attributable mortality	2011 - 13	212.4	288.7	471.6		167.4
8	Smoking attributable deaths from heart disease	2011 - 13	26.8	32.7	65.5		16.4
9	Smoking attributable deaths from stroke	2011 - 13	10.7	11.0	21.5		4.8
10	Smoking attributable hospital admissions	2012/13	1062	1688	2884		906
11	Cost per capita of smoking attributable hospital admissions	2011/12	33.3	38.0	59.3		23.0

Source PHE tobacco profiles (2015)

6.6.1 Smoking in pregnancy

Women who smoke, or who are exposed to second-hand smoke, while pregnant are more likely to have a baby with low birth weight (less than 2,500 grams) than non-smoking mothers. Low birth weight babies are associated with higher risks of death and disease in infancy and early childhood, and also poorer long-term health and educational outcomes. Smoking during pregnancy increases the risk of complications during pregnancy and labour, including miscarriage. Smoking during, and after, pregnancy also increases the risk of sudden infant death ('cot death'). District level data on this measure

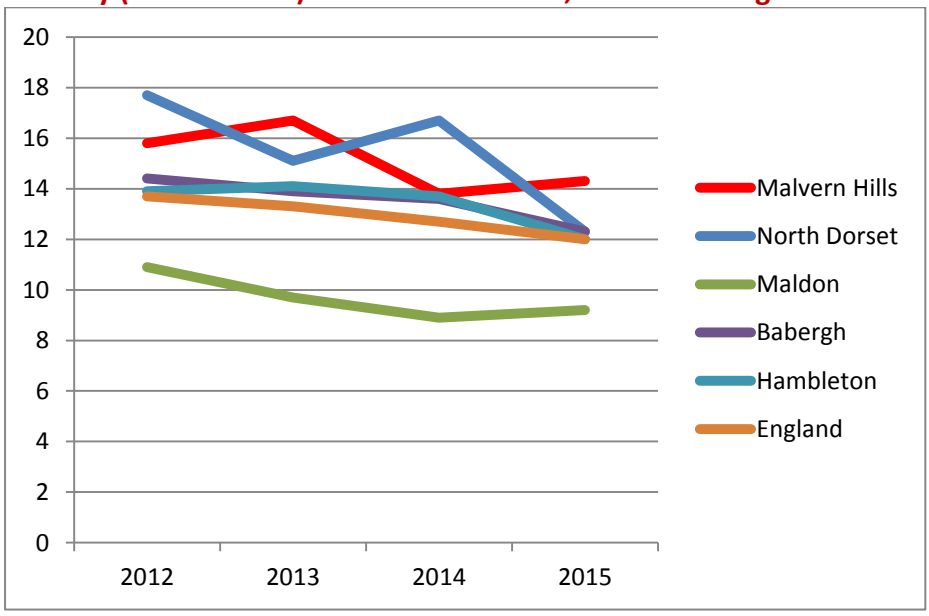
There is a clear link between smoking in pregnancy and social disadvantage; the greater the disadvantage, the higher the smoking prevalence. There is a need to reduce smoking in pregnancy for all women, with a focus on the needs of those who experience social disadvantage. Women who continue to smoke during pregnancy are younger and less educated; more likely to be single and in manual occupations and much less likely to perceive smoking as a risk to their baby compared with those who manage to stop. Evidence suggests that while women know that tobacco use is damaging their health, for many smoking is a means of coping with poverty, disadvantage and lack of control over other aspects of life.

The key factors that contribute to smoking in pregnancy are:

- Caring responsibilities;
- Access to material resources;
- having a partner who smokes.

The measure used for smoking in pregnancy has been adjusted during the last 4 years of reporting from being measured as 'smoking in pregnancy' (used during 2012 and 2013) to smoking status at time of delivery (2014 and 2015). The numerator of smokers known at each measurement point with the denominator being pregnancy or delivering in the year of interest. Whilst the change has been made it has been made across England and as such the trend in this case can be compared at a national and also statistical neighbour level.

Figure 20 - Smoking status during pregnancy (2012 & 2013) Smoking status at time of delivery (2014 & 2015) % for Malvern Hills, statistical neighbours and England



Source PHE Public Health Profiles 2012 – 2015

The above figure (20) shows that Malvern Hills District has maintained an above England average % of smoking in pregnancy (data for 2012 and 2013) and at point of delivery in 2014 and 2015. When comparing to CIPHA statistical neighbours it shows that Malvern has a fluctuating level of smoking in pregnancy but generally a higher proportion than most of its neighbours. **It may be helpful to seek information from Maldon District (in Essex) on their work with pregnant women as they have a significantly below average level of smoking in pregnancy, is this a true finding or due to a data collection / reporting difference**.

Worcestershire has a well-established Stop Smoking Service available across the county. There are a number of organisations within Malvern that offer the service, some specific to pregnant women https://ylyc.worcestershire.gov.uk/media/258813/stop-smoking-services-malvern.pdf

A care pathway has also been developed between Midwifery and the Stop Smoking Service (SSS) that has taken an 'opt out' position in referring women for stop smoking support during pregnancy.

In 2014-15 the (SSS) recorded a total of 12 pregnant women, across Malvern Hills, setting a date to stop smoking, of which 6 were successfully not smoking at 4 week post stop date (this is validated through carbon monoxide testing as per national expectation and in line with the 50% average quit rate). In addition to the 4 week measure the local SSS reports on a 12 weeks post quit date rate, which is not mandated nationally. In Malvern Hills 3 women were still not smoking (25% of original group)

6.7 Breastfeeding initiation

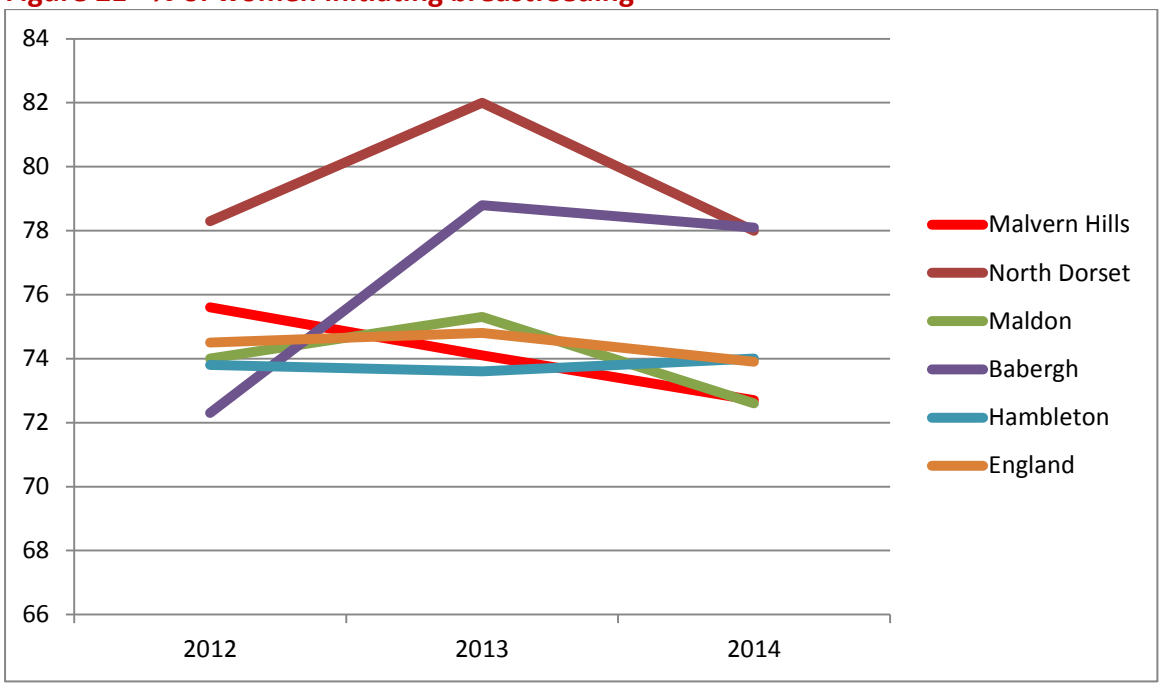
Breast milk provides the ideal nutrition for infants in the first stages of life.There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity. Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer (BMA Board of Science, 2009)

Current national and international guidance recommends exclusive breastfeeding for newborns and for the first six months of infancy (WHO 2001 & NICE 2008). Increasing rates of breastfeeding initiation and continuation is also recommended within the Healthy Child programme (DCSF 2009).

Malvern Hills has seen a downward trend of breastfeeding initiation between 2012 and 2014 (75.6% - 72.7%) (figure 21). It is now performing below the England average of 73.9% (2014). When compared to statistical neighbours Malvern Hills has the second lowest level of breastfeeding initiation (2014). **Whilst the % difference is small (2.9%) it is important to acknowledge the trend and establish what can be done to change its direction.**

Currently data for 2015 is not available nationally or locally but should be reviewed once released to see if any change has occurred.

Figure 21 - % of women initiating breastfeeding



Source PHE Public Health Profiles 2012 – 2014

7. Worcesterhire's Health and wellbeing priorities

Worcestershire's 4 health and wellbeing priorities for 2013-2016 were chosen because individually and collectively they:

- Were relevant to a range of age groups.
- Affected large numbers of people.
- Related to major causes of illness and death.
- Required substantial health and social care spend.
- Were of high importance to the local public.
- Had significant potential to improve outcomes.
- Required major transformational change in the way that services are provided in order to improve outcomes.
- Required strong leadership, political consensus and co-ordinated action across organisations and wider society to achieve change.

7.1 Alcohol

Alcohol is the leading risk factor for preventable death in 15-49 year olds. Nine million adults now drink at levels that increase the risk of harm, of which 1.6 million show signs of alcohol dependence. From 2001-2012, the number of people who died due to liver disease in England rose from 7,841 to 10,948 – a 40% increase and in contrast to other major causes of disease that have been declining. The harm of alcohol falls not just on individuals but on society as a whole. Overall, alcohol harm costs society £21 billion a year, with the costs to the NHS at £3.5 billion. Massive inequalities exist in where its impact is felt. People with mental illness are more likely to misuse alcohol; and the most deprived fifth of the population of the country suffers two to three times greater loss of life attributable to alcohol. (PHE 2014)

The prevalence of alcohol misuse in the adult population is normally presented as the proportion of individuals reporting, or estimated to be consuming, alcohol at levels of lower, increasing or higher risk, and those binge drinking. These are set out below:

Lower risk - A level of alcohol consumption that is within current recommended guidelines (2-3 units daily for females and 3-4 units daily for males).

Increasing risk - A level of alcohol consumption that is above recommended levels, and that carries a risk of physical or psychological harm. This is defined as the consumption of between 15 and 35 units per week for females, and 22 to 50 units per week for males.

Higher risk - Consumption of alcohol at levels which are likely to cause physical or psychological harm. This is defined as the consumption of over 35 units per week for females and over 50 units per week for males.

Dependent drinker - A sub-set of higher risk drinking, defined as an individual that feels unable to function without alcohol. The consumption of alcohol becomes an important, sometimes the most important, factor in their life. Often experiences physical or psychological withdrawal symptoms if their supply of alcohol is suddenly stopped.

Binge drinking - Defined as drinking more than two times the recommended daily level in one session. For females this means drinking 6 or more units, and for men, 8 or more units.

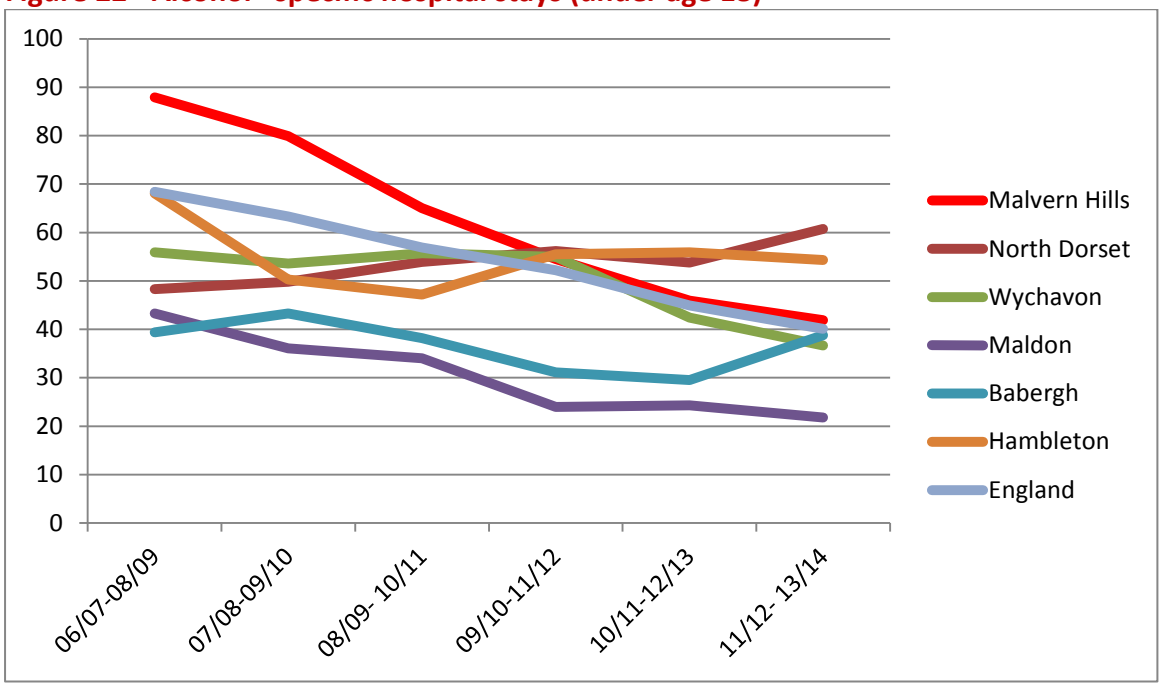
The local alcohol profiles for England (LAPE) provides synthetic estimates based on self-reported alcohol use. This reports that approximately 14% of the over 16 year old Malvern Hills population abstain from drinking. Of the remaining over 16 year old drinking population, almost 73% of the over 16 are reported as "lower risk" drinkers; just over 20% are reported as "increasing risk" and nearly 7% as "higher risk. These estimates are similar to the England and statistical neighbours.

Malvern Hills presents as approximately 18% of the over 16 population engage in binge drinking this again is similar to Malverns statistical neighbours and England proportion (PHE 2014).

Recent drinking trends, across England and among young people in particular, have shown that we are drinking less frequently compared with a decade ago. In fact, young adults (aged 16-24) are now as likely to be teetotal as adults over 65, after a jump in the proportion of young people who say they don’t drink alcohol at all. Binge-drinking since 2005 is also down dramatically among young adults. Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population.

In regard to alcohol related admissions of young people under the age of 18 there were 66 stays across Worcestershire in 2013/14. Numbers are not available for Malvern Hills. The figure below (22) shows the rolling figures for the rate of alcohol-specific hospital admissions for under-18 year olds over the past six years in Malvern Hills, its statistical neighbours and England. Although Malvern Hills had a higher than average rate initially, **the rate has fallen consistently since 2006/07, it is now closely aligned to the England rate and on a par with its statistical neighbours which is good news.**

Figure 22 - Alcohol –specific hospital stays (under age 18)



Source: PHE Local Alcohol Profiles for England

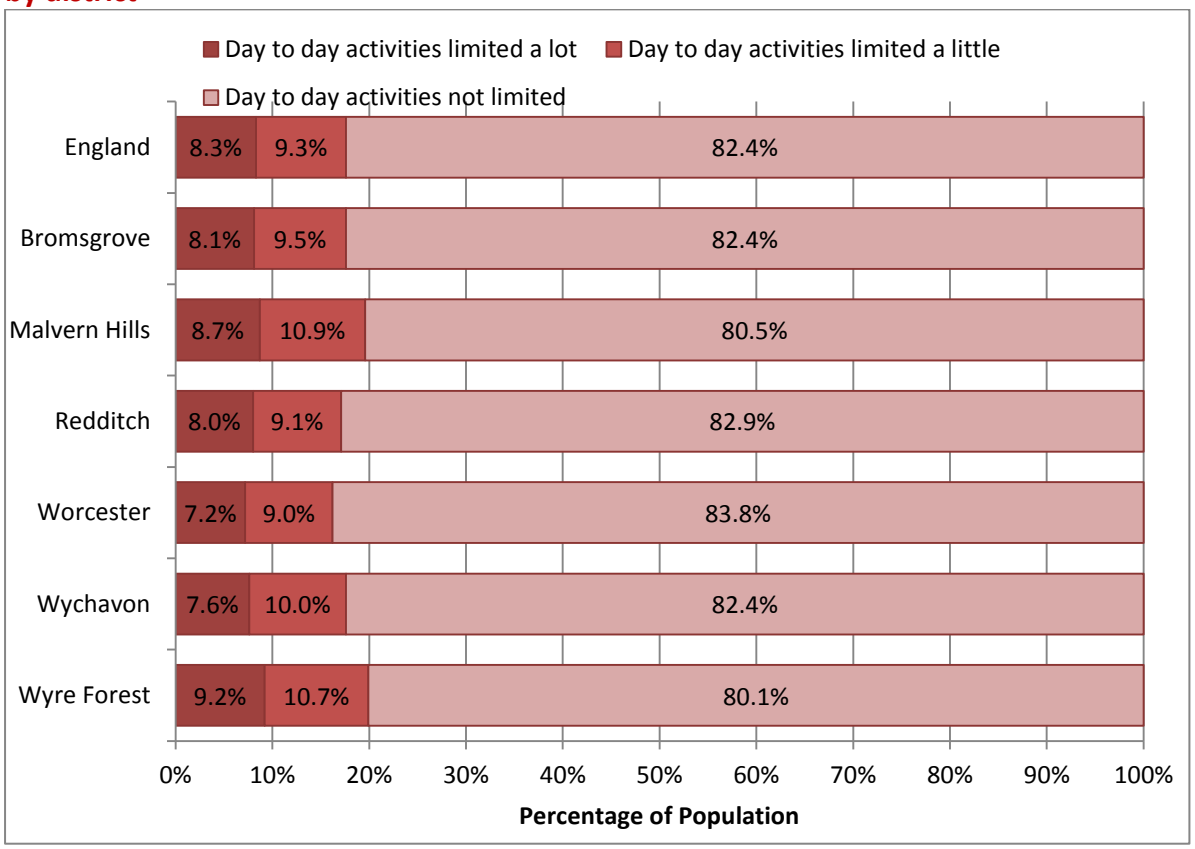
7.2 Older people and management of long term conditions

The 2011 Census is a reliable survey which is able to accurately measure the health and wellbeing of the population. It asked residents to self-report the level of their long-term health. Responses were categorised into three categories: day to day activates are not limited at all; day to day activities are limited a little; and, day to day activities are limited a lot.

The responses for the Worcestershire districts are displayed in figure 23 alongside the national average.

Malvern Hills district has the 2nd highest proportion of the population self-reporting that their 'day to day activities are limited a lot at 8.7%, above the national average of 8.3%. It is not surprising, perhaps, to find that day to day activities are more limited within Malvern Hills significantly older than average population. It should be noted however that Malvern Hills reports a higher proportion for both 'activities limited a lot' and 'activities limited a little', compared to Wychavon district which is one of Malvern Hills statistical neighbours.

Figure 23 - Percentage of the population self-reporting long-term health problems, 2011 by district



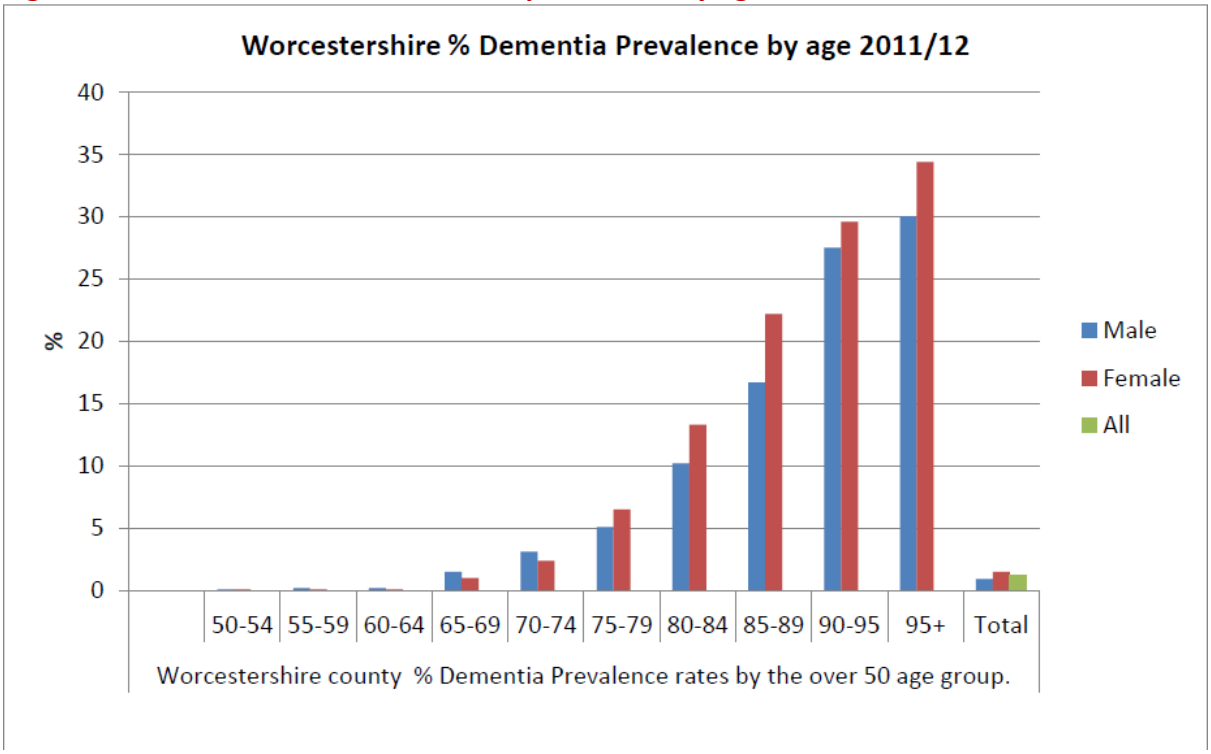
Source: ONS - Census 2011

7.2.1 Dementia

It is estimated that more than 800,000 people in the UK have dementia, and this is projected to increase to over 1 million by 2021 and over 2 million by 2051. Four-fifths of people over 50 fear that they will develop dementia. As well as the huge personal cost, the overall economic impact of dementia in the UK is estimated to be £26 billion per year. In the absence of a treatment or cure, it is important that action is taken to reduce the numbers of people getting dementia, postpone the onset of dementia and/ or mitigate its impact. The ground-breaking Blackfriars Consensus, published earlier this year, makes the case for concerted action to reduce people's risk of dementia by supporting them to live healthier lives and manage pre-existing conditions that increase their risk of dementia, such as depression or diabetes. Focusing particularly on avoiding or delaying the onset of dementia for people within ten years of retirement age will mean more people can enjoy a healthy and independent life for longer. Alongside a focus on dementia risk reduction, it is important to support people with dementia to live well to reduce its impact on individuals, their families and carers

Malvern's Ageing Well Needs Assessment (AWNA) in 2013 identified the following prevalence of Dementia across Worcestershire (figure 24). It shows that Worcestershire reflects the national picture of dementia being an age related condition.

Figure 24 - Worcestershire % dementia prevalence by age 2011/12



Source NHS Dementia Prevalence Calculator

Dementia is uncommon in those under 65 years and up until the age of 75 years males' present dementia prevalence more highly than females in Worcestershire. Females become increasingly more likely than males to present with dementia from age 75 onwards.

In regard to diagnosis the AWNA identified that some districts were performing better. The England average is 45% and Malvern Hills is diagnosing 40.7% (Figure 25). This is the second lowest of the six districts.

Figure 25 - Dementia Diagnosis by District

District	Dementia diagnosis rate
Bromsgrove	42.7%
Malvern Hills	40.7%
Redditch	46.3%
Worcester City	41.2%
Wychavon	36.58%
Wyre Forest	49%
England	45%

Source: NHS dementia Prevalence calculator

Another indicator of the high numbers and severity of dementia amongst older people in Worcestershire is the number of people living with dementia in residential care homes. As many as two thirds of residents in any care home will be suffering from some form of dementia, and the disease is likely to be at quite an advanced stage by the time they need full time care. Figure 26 shows that Malvern Hills has the second highest number of care homes in the county and provides nearly a quarter of all of the care home dementia provision within the county (28 Care Homes figure based on 2013 data). **This suggests that dementia care and support is a significant burden for Malvern Hills at both a lower, early identification and prevention level but also at a severe / complex need level**.

Figure 26 - Estimated number of people with dementia living in residential care, by District (2013)

District	Equivalent CCG	Number of care homes	Estimated No. People with dementia living in care	Proportion of dementia patients	Proportion total over 65s pop in District
Bromsgrove	Redditch and Bromsgrove CCG	30	628	28.2%	20.5%
Malvern Hills	S. Worcestershire CCG	28	541	24.3%	24%
Redditch	Redditch and Bromsgrove CCG	9	184	8.3%	14.1%
Worcester City	S. Worcestershire CCG	13	214	9.6%	14.8%
Wychavon	S. Worcestershire CCG	18	356	16%	21.4%
Wyre Forest	Wyre Forest CCG	21	301	13.5%	20.9%
Worcestershire total	-	119	2224	100%	19.3%

Source: NHS dementia Prevalence calculator

7.2.2 Stroke

In the UK, strokes are a major health problem. Every year, around 110,000 people have a stroke in England and it is the third largest cause of death, after heart disease and cancer. The brain injuries caused by strokes are a major cause of adult disability in the UK. Older people are most at risk of having strokes, although they can happen at any age – including in children. People of South Asian, African or Caribbean, origin are at greater risk. This is partly because of a predisposition (a natural tendency) to developing high blood pressure (hypertension), which can lead to strokes. Smoking, being overweight, lack of exercise and a poor diet are also risk factors for stroke, as are high cholesterol, atrial fibrillation and diabetes.

A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off. Strokes are therefore a medical emergency and urgent treatment is essential because the sooner a person receives treatment for a stroke, the less damage is likely to happen.

Emergency hospital admissions for stroke, using a standardised admission ratio, for 2008/9 - 2012/13 showed **Malvern Hills District as having a ratio of 91.2, significantly lower than the**

England average and Worcestershire SAR of 95. There were no wards presenting a statistically significant increased risk of stroke compared to Malvern as a whole. **This suggests that whilst Malvern has an older than average population the lifestyle factors underlying stroke are not compounding the risk.**

7.2.3 Falls

Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition. Falls are a common, but often overlooked, cause of injury. Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls. Most falls don't result in serious injury. However, there's always a risk that a fall could lead to broken bones, and it can cause the person to lose confidence, become withdrawn and feel as if they've lost their independence.

The natural ageing process means that older people have an increased risk of having a fall. In the UK, falls are the most common cause of injury related deaths in people over the age of 75.

Older people are more likely to have a fall because they may have:

•balance problems and muscle weakness

•poor vision

•a long-term health condition, such as heart disease, dementia or low blood pressure (hypotension), which can lead to dizziness and a brief loss of consciousness

A fall is also more likely to happen when:

•the floor is wet or recently polished, such as in the bathroom

•the lighting in the room is dim

•rugs or carpets aren't properly secured

•the person is reaching for storage areas, such as a cupboard, or is going down stairs

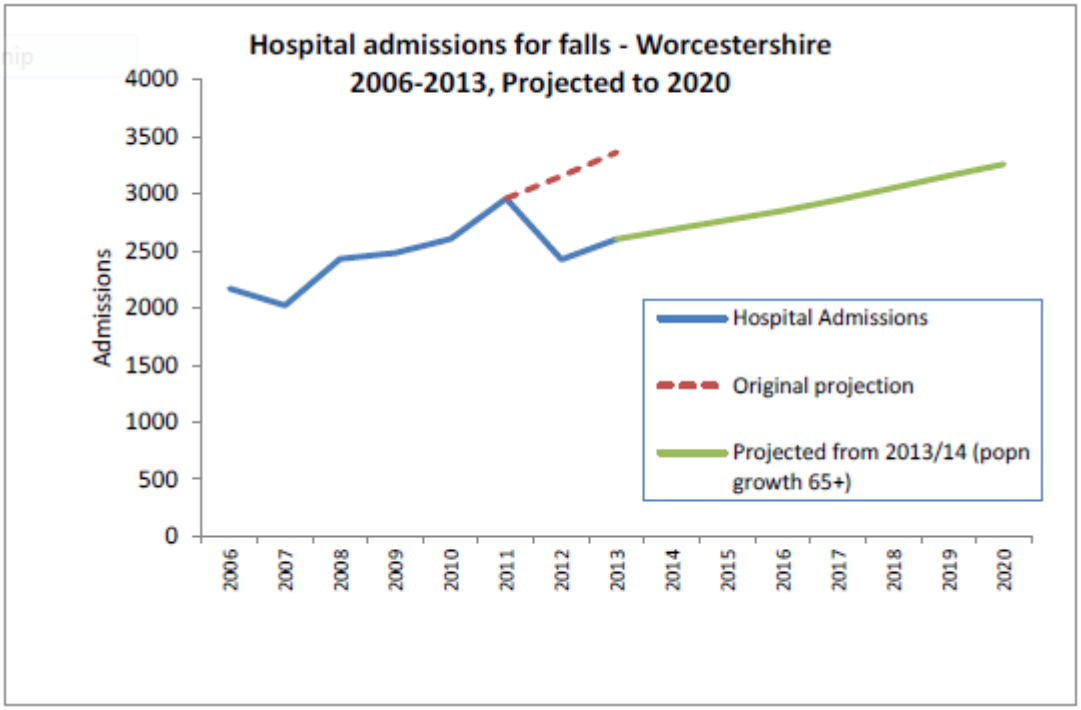
•the person is rushing to get to the toilet during the day or at night

Another common cause of falls, particularly among older men, is falling from a ladder while carrying out home maintenance work.

In older people, falls can be particularly problematic because osteoporosis is a fairly common problem. Osteoporosis can develop in both men and women, particularly in people who smoke, drink excessive amounts of alcohol, take steroid medication or have a family history of hip fractures. However, older women are most at risk, because it's often associated with the hormonal changes that occur during the menopause.

There are an estimated 5,000 falls in the 65+ population in Worcestershire every year.
Projections of the number of admissions due to falls are shown below. The original projection is based on data up to 2011 when a number of falls interventions were put in place and shows what would have happened had nothing changed. As it is we can see a drop in the number of falls but as the population ages the number of people at risk of falling will increase and projections based on the latest data show a steady rise if nothing were to change.

Figure 27 - Hospital Admissions for falls, Worcestershire 2006-2013, Projected to 2020



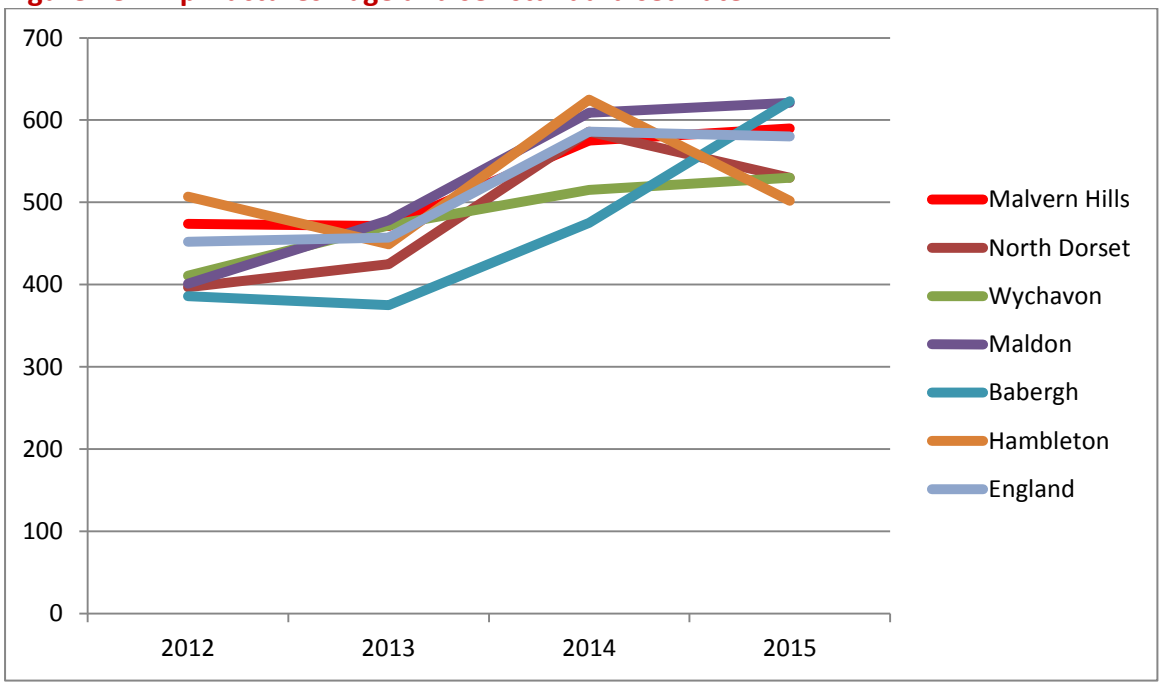
Source: Public Health Intelligence Team, Worcestershire County Council

Inpatient admissions for falls provide some useful data, but it should be noted that not all cases reach hospital, and amongst those which do, not all are recorded. The number of recorded falls for those aged 65 and over has been increasing in recent years, though this is likely to be partly due to improvements in recording. Local data shows that the majority, two thirds of recorded falls occur at home, one in ten are in residential homes, and about one in twenty in the street or highway. Falls in the street or highway are more common in Worcester (7%) than in other districts (5%). The proportion of falls resulting in hospital admission accounted for by residential institutions has been falling in recent years, from 13% in 2009 to 10% in 2012. Falls on ice and snow unsurprisingly vary according to weather conditions. In 2010, a year in which there were some exceptionally severe conditions, they accounted for one in twenty five of all falls.

7.2.4 Hip Fractures

Although Malvern Hills has a similar number of hip fractures compared to its statistical neighbours (Figure 28) and could be discounted as a priority for focus it is important to acknowledge the increasing incidence of hip fractures that occur. This is primarily due to the ageing population but this compounds likelihood of poorer recovery and independence**. The burden on the individual, wider family and health and social care is significant.** With many hip fractures occuring as a result of slips, trips and falls and prevention, as detailed above is imperative.

Figure 28 - Hip fractures - age and sex standardised rate



Source PHE Public Health Profiles 2012 – 2015

7.2.5 Caring for those with long-term conditions

It is estimated that 6.5 million people within the UK are carers. A carer is defined as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. It is recognised that many do not think of themselves as a carer even though they may be providing significant amounts of care. Whether or not to take on a caring role is a decision that many of people will have to make at some point in their life. Whilst being a carer can be rewarding, it can at times also feel overwhelming and demanding (The Care Trust).

Worcestershire Association of Carers mandates that all carers should be able to

- enjoy mental, physical and emotional wellbeing and be treated with dignity;
- undertake their caring responsibilities without undue consequential financial hardship;
- be recognised, respected and involved as expert partners in care;
- have a fulfilling life;
- have a meaningful influence on policymaking and planning for services that affect carers

Malvern Hills, based on the 2011 Census, has a total of 9,390 Carers within the district, 12.6% of the total population. This is above the proportion of Wychavon of 11.5% (13,434) and England 10.3% (5,430,016). This may be reflective of Malvern's above average older population. Those providing between 1 and 19 hours unpaid care per week are the largest group at 6,543 individuals. This was 2.1% higher than the England level (figure 29)

Figure 29 - Number and proportion of local population providing unpaid care, Malvern Hills district, Wychavon District and England

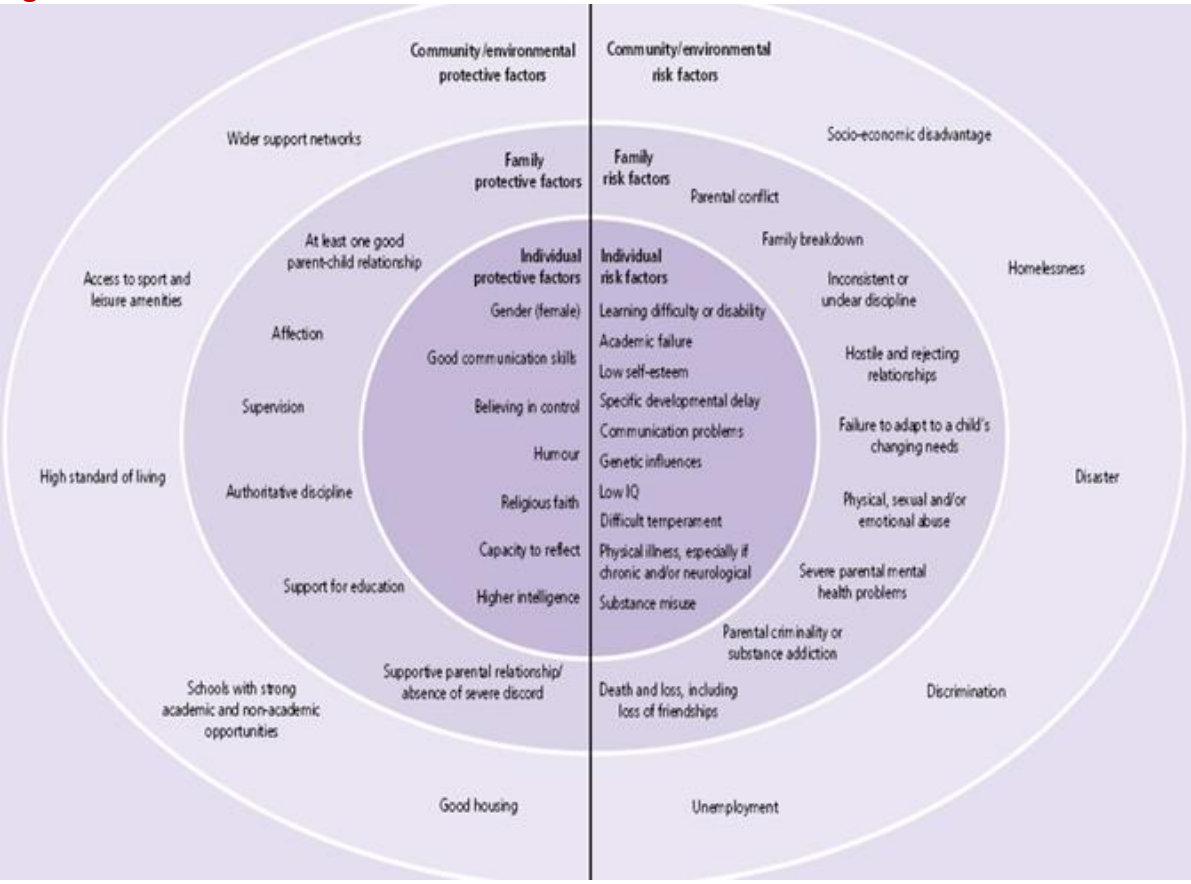
	Malvern Hills Count and (%)	Wychavon Count and (%)	England Count and (%)
All Usual Residents (Persons)	74,631	116,944	53,012,456
Provides No Unpaid Care (Persons)	65,241 **(87.4%)**	103,510 **(88.5%)**	47,582,440 **(89.8%)**
Provides 1 to 19 Hours Unpaid Care a Week (Persons)	6,543 **(8.6%)**	9,225 **(7.9%)**	3,452,636 **(6.5%)**
Provides 20 to 49 Hours Unpaid Care a Week (Persons)	1,000 **(1.3%)**	1,418 **(1.2%)**	721,143 **(1.4%)**
Provides 50 or More Hours Unpaid Care a Week (Persons)	1,847 **(2.5%)**	2,791 **(2.4%)**	1,256,237 **(2.4%)**

Source: ONS Neighbourhood Statistics

7.3 Mental Health and Wellbeing

Mental health and well-being is an important aspect of public health. Throughout life a high proportion of the population experience at least one episode of poor mental health. There is clear evidence of what can protect an individual from poor mental health and also a number of characteristics or environmental factors that can increase the risk (Figure 30). These are evident throughout the life-course but often early life experiences influence outcomes.

Figure 30 - Mental Health - Protective and risk factors

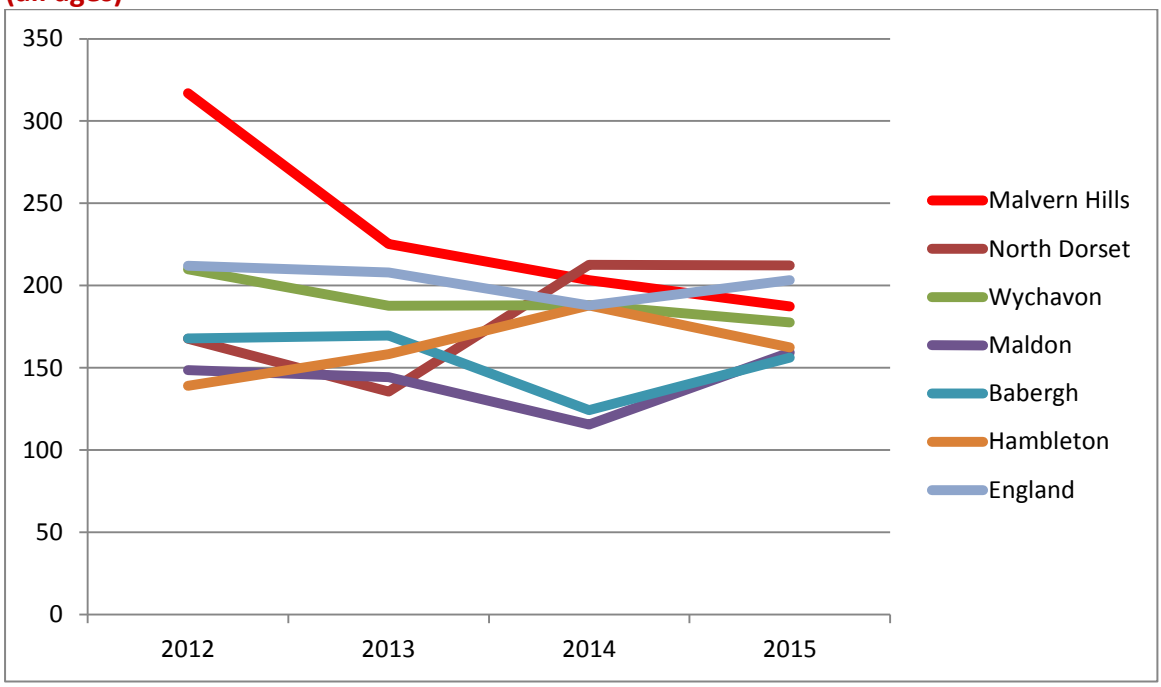


Source: Department of Health. Children and Young People in Mind; The final report of the National CAMHs Review. DH 2008

Whilst there does appear to be consensus that MH is usually better in rural areas (Nicholson 2008). Concerns about lack of anonymity and risk of stigma, linked to mental ill health, appear more prevalent within rural communities (Parr et al 2003). There is potential for data sources to be unreliable especially if reliant on service usage/uptake as there is evidence of reluctance to access services that are some distance from home even if the need is there. These factors should be considered across Malvern Hills as much of the district is rural.

The measure of intentional **self-harm** can only provide some evidence as it is not possible to include a suitable indicator representing all aspects of mental health and well-being. Deliberate self-harm ranges from destructive behaviours with no suicidal intent, but which relieves tension or communicates distress, through to attempted suicide. The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population. There is a high correlation between self-harming behaviour and mental health problems. People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past. People who have self-harmed are at significant risk of suicide. A study found that the risk of a person dying by suicide within a year of being treated for self-inflicted injury was 66 times the annual risk of suicide in England and Wales, and that there is a significant risk even many years later. Self-harm results in more than 98,000 inpatient admissions to hospital a year in England, 99% are emergency admissions.

Figure 31 - Hospital stays for self-harm decreased age / sex standardised rate per 100,000 (all ages)

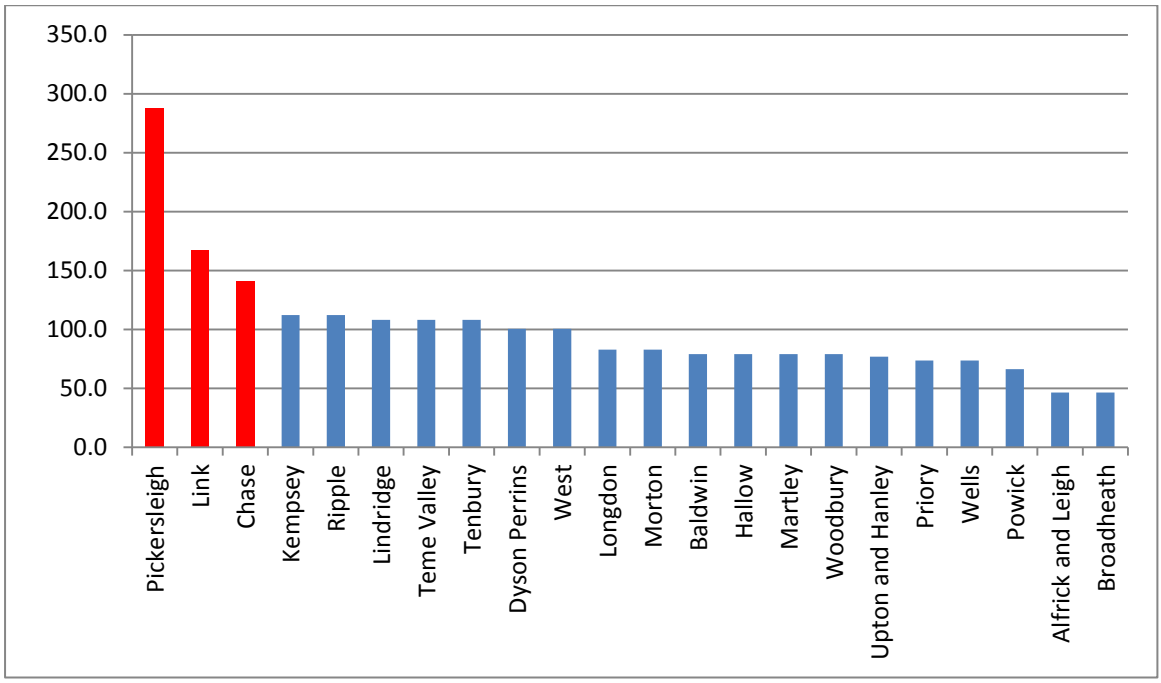


Source PHE Public Health Profiles 2012 – 2015

Although the overall profile for self-harm appears similar in Malvern Hills to its statistical neighbours (Figure31) upon further investigation there are significant differences within Malvern Hills at ward level (figure 32). **It is pertinent to acknowledge that reported self-harm is likely to significantly underestimate the true prevalence (Bateman 2014)**.

A standardised admission ratio is rate is used to enable comparison to be made with the rate of 100 being the point of 'no difference' (Y axis). Whilst a number of wards show above the 100 level we can be 95% confident that the true value could be below the 100 particularly where small numbers occur based on confidence interval (CI) measurement. The 3 areas shown in red are significantly higher than the 100, **Pickersleigh** presenting a ratio of 287.4 (CI's 245.9-333.8) suggesting that admissions for self-harm are at least 145% higher but could be as much as 233% higher than expected in England. **This equated to 171 admissions in 5 years from this ward although it should be noted that there were a small number of individuals who presented a high number of times**. **Link** ward presents a ratio of 167.5 (Ci's 135.2-205.2) suggesting admissions are at least 35% higher but up to 105% higher than England. **Chase** ward shows a ratio of 141.1 (CI 110.6-177.4) presenting between 10.6% and 77.4% increased admissions for self –harm compared to England.

Figure 32 - Ward Level - Hospital Stays for self-harm, 2008/9-2012/13, all ages using standardised admission ratio



Source: PHE Local Health

There is no particular age group that stands out in regard to reported self- harm across Malvern Hills, although predominantly it is amongst the under 60 population.

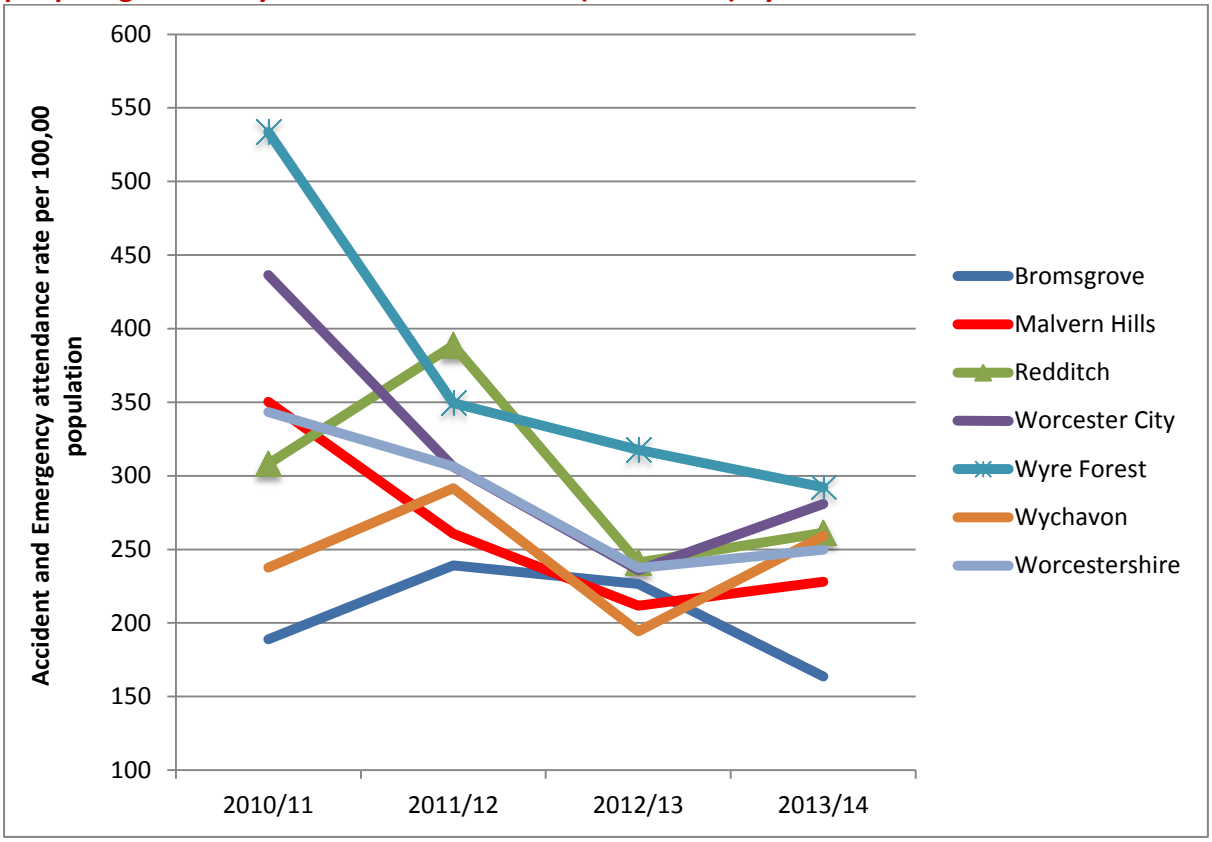
7.3.1 Self harm in children and young people

- There were 389 emergency hospital admissions in **Worcestershire** for self-harm in children and young adults aged 10-24 years in 2013/14.
- The overall emergency hospital admission rate for self-harm is stable but remains higher than the national average.
- The overall Accident and Emergency attendance rate for self-harm has declined over the last three years.
- Girls and female adolescents are at higher risk of self-harm compared to males, accounting for 72% of emergency hospital admissions and 63% of Accident and Emergency attendances between 2011 and 2014.
- There is evidence of a change in the age pattern of self-harm, with an increase in rates among young females (10-14 years), and a decline among young adults of both sexes (aged 20-24 years) between 2010 and 2014.
- Social deprivation is strongly linked to self-harm, with the highest rates of both emergency hospital admissions and Accident and Emergency attendances in the most socially deprived groups in Worcestershire.
- The predominant primary method of self-harm is self-poisoning, accounting for over 90% of self-harm episodes.

- Approximately three-quarters of self-harm incidents leading to hospital admission occur in the home setting.
- Young children (aged 10-14years) are more likely than adolescents and young adults to be admitted to hospital following an Accident and Emergency attendance for an episode of self-harm, however approximately one third are discharged directly from the Emergency Department.

Figure 33 shows that Malvern Hills has seen a reduction in A&E attendance for self-harm over the last 4 year period. It has a similar rate per 100,000 as its statistical neighbours.

Figure 33 - Accident and Emergency Attendance rate for self-harm in children and young people aged 10-24 years in Worcestershire (2010-2014) by Worcestershire Council District



Source: SUS Hospital admissions & A&E data supplied by Arden Commissioning Support Unit, analysed by Public Health Intelligence Team at Worcestershire County Council.

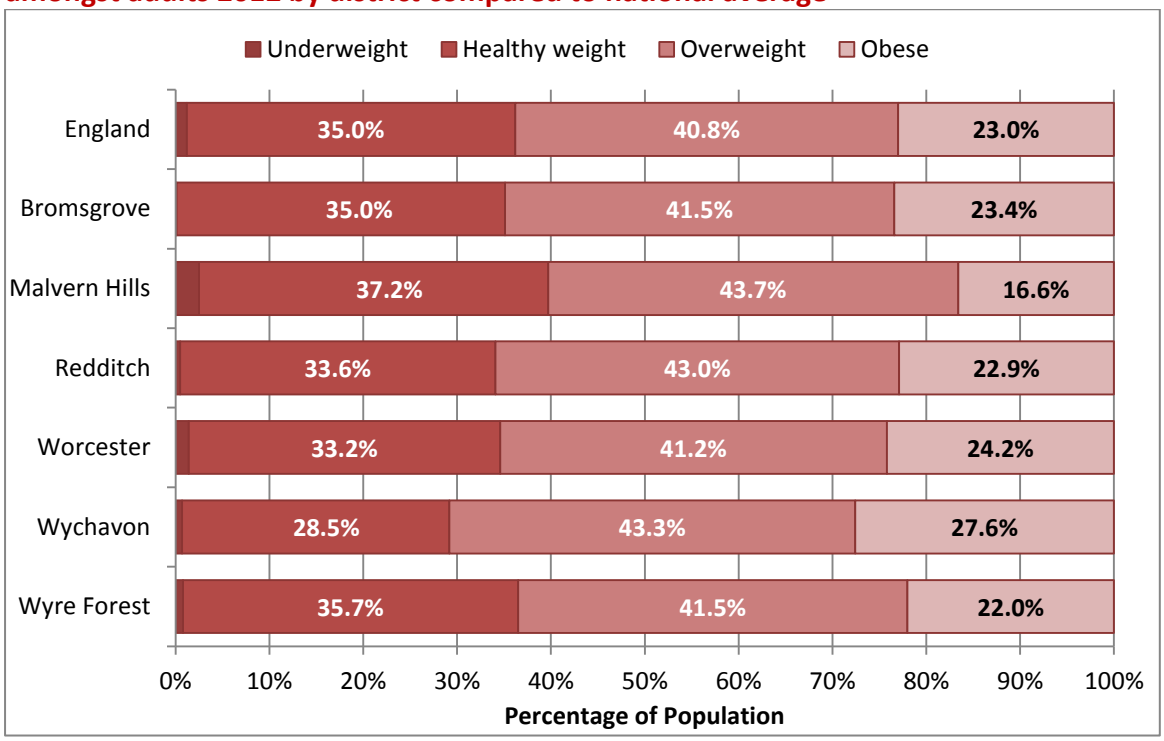
In regard to suicide, across all ages, the numbers are small across Worcestershire as a whole (approx. 50 per annum) and therefore it is not possible to report at a District level.

7.4 Obesity

Figure 34 below shows the estimated adjusted prevalence of underweight, healthy weight, overweight and obesity in Worcestershire compared to the national average. These are modelled estimates that are produced by the Association of Public Health Observatories and are based on individual-level data from the active people survey for 2006/2008. The active people survey is a large telephone survey commissioned by Sport England on sport and active recreation in the over 16 adult population in England

As can be seen, the prevalence of underweight is very low across the county, although Malvern Hills has the largest prevalence at 2.5%.

Figure 34 - Adjusted prevalence of underweight, healthy weight, overweight and obesity amongst adults 2012 by district compared to national average



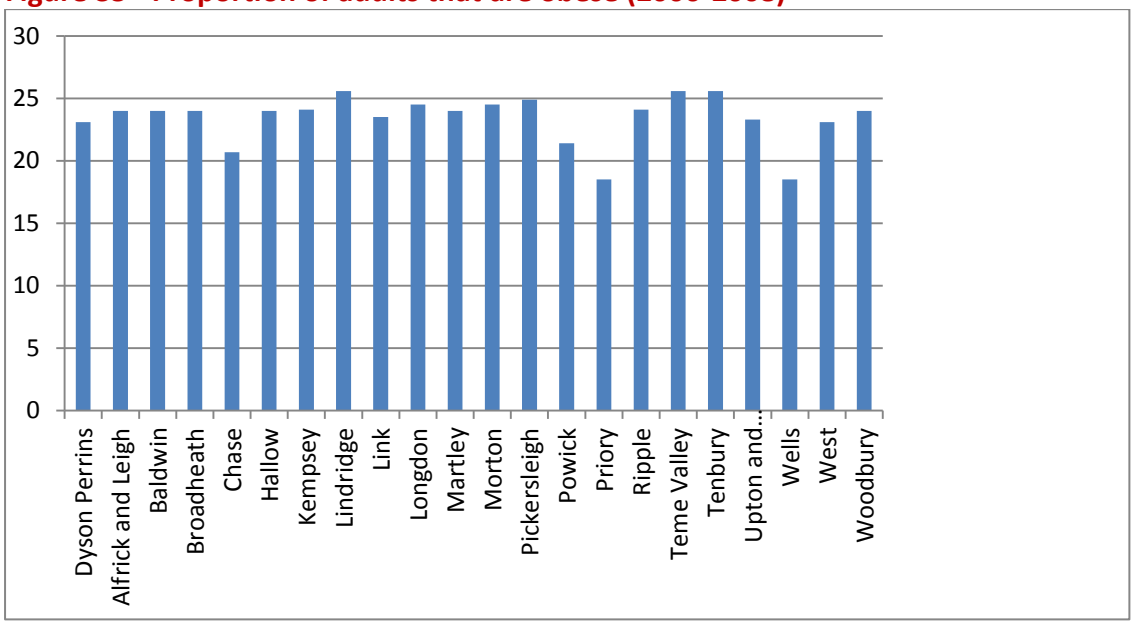
Source: Active people survey

Results weighted by sex, age, ethnicity, working status, household size and socio economic classification.

Similar to the national figures, around 2/3 of Worcestershire's adult population is classified as overweight or obese. Obesity proportion is defined as the estimated percentage of the population aged 16 and above with a body mass index of 30 or more) although Malvern Hills has the lowest prevalence of obesity (16.6%). Malvern Hills also has the highest proportion of its population reporting a healthy weight compared to the other districts.

When broken down to ward level (Figure 35) the data available is based on a modelled estimate of years 2006-2008. It shows the proportion adults who are obese as reasonably similar across the wards with Lindridge, Tenbury and Teme Valley presenting the highest levels 25.6% obese and Priory and Wells presenting the lowest levels at 18.5%.

Figure 35 - Proportion of adults that are obese (2006-2008)



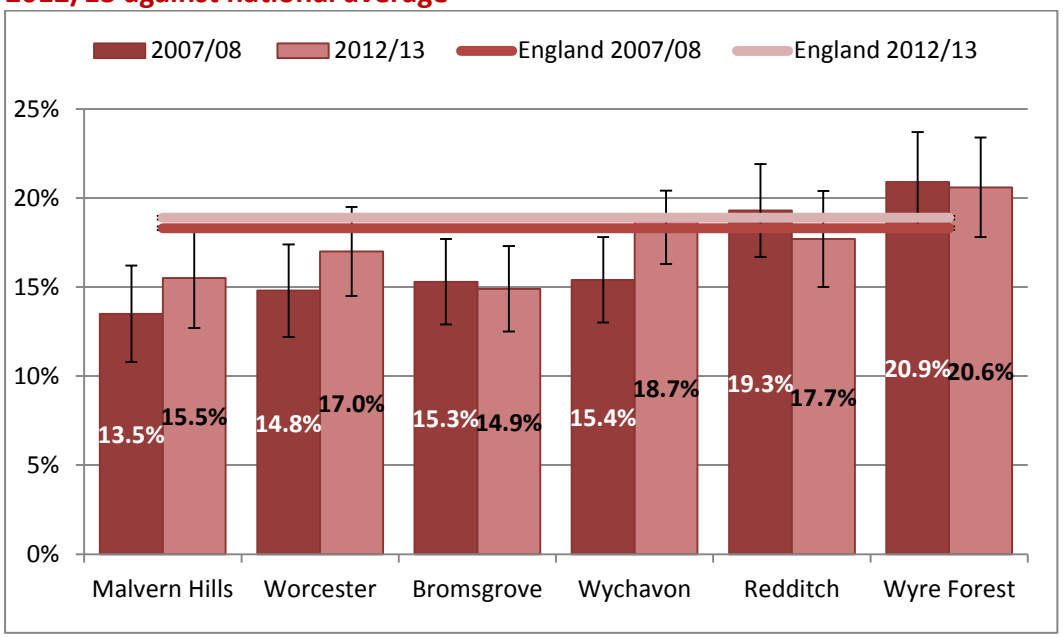
Source: Local Health

7.4.1 Obesity prevalence in Children

The national child measurement programme (NCMP) measures the weight and height of all school children in reception and in year 6. Figure 36 shows the estimated percentage of children that are obese in year 6 as determined by the National Childhood Measurement Programme (NCMP) in each of the Worcestershire districts for both the period 2007/08-2012/13.

It can be seen that Malvern Hills has the second lowest prevalence of children that are obese at year 6 in 2012/13. **There has however been upward trend, between the two time periods (13.5%-15.5%) and Malvern Hills is now only just statistically significantly lower than the national average.**

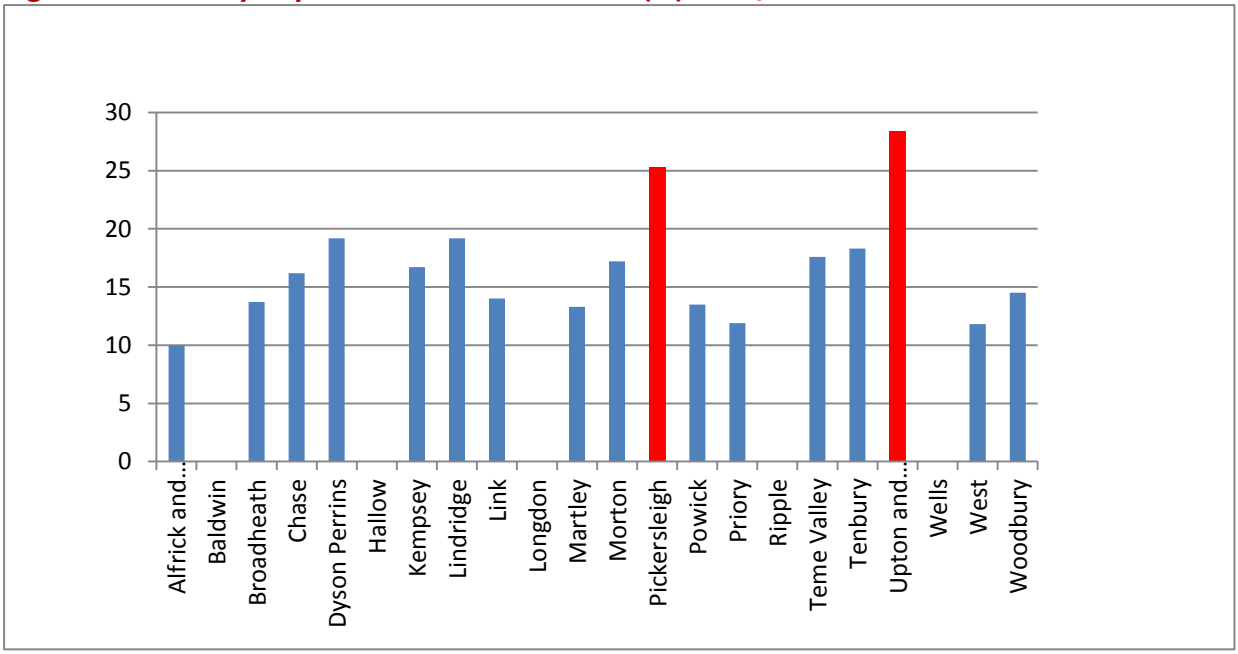
Figure 36 - Percentage of Children Obese at Year 6 in Worcestershire Districts 2007/08 and 2012/13 against national average



Source: Association of Public Health Observatories, http://www.apho.org.uk

At a ward level there are some differences, although due to small numbers data on some wards have been suppressed. As seen on figure 37 Upton and Hanley has the highest proportion of obesity amongst year 6 children (28.4%) with Pickersleigh presenting as second highest (25.3%) both are higher than the Malvern Hills average and statistically significant.

Figure 37 - Obesity in year 6 children ward level (%) 2012/13



Source: Local Health

8. Rurality

DEFRA categorise rural and urban into 4 groups

- urban, based on all settlements over 10,000 population;
- small town & fringe
- village; and
- hamlet & isolated dwellings.

The OSCI (2009) Rural Deprivation in Worcestershire report used the standard ONS/ Countryside Agency rural-urban classification to identify whether particular areas were 'rural' or 'urban'. They went on to combine the small town and fringe, village and hamlet & isolated dwellings categories into a single non-urban rural category. In other words, the rural area analysis was based on all areas outside settlements with populations of more than 10,000 people. The following wards were identified, measured and ranked by national deprivation. It showed 4 wards in Malvern in the highest 30% most deprived, which are shown in bold in Figure 38.

Figure 38 - Rural Deprivation in Malvern District by ward, (2009)

Output area code	Ward name	Settlement name	National rank (out of 165,665 OAs where 1 is most deprived)	National deprivation decile (e.g. 30% = in most deprived 30%)
47UCJK0006	**Upton and Hanley**	**Upton upon Severn**	**34,113**	**30%**
47UCJC0004	**Morton**	**Welland**	**34,730**	**30%**
47UCJE0009	**Powick**		**39,642**	**30%**
47UCHQ0010	**Alfrick and Leigh**		**40,558**	**30%**
47UCHR0003	Baldwin		50,812	40%
47UCHQ0005	Alfrick and Leigh		52,923	40%
47UCHR0004	Baldwin		63,024	40%
47UCJJ0002	Tenbury		63,691	40%
47UCJE0002	Powick		64,263	40%
47UCJJ0010	Tenbury	Tenbury Wells	64,790	40%
47UCJK0008	Upton and Hanley		65,396	40%
47UCHY0004	Lindridge		67,938	50%
47UCJJ0015	Tenbury	Tenbury Wells	68,774	50%
47UCJJ0009	Tenbury	Tenbury Wells	71,062	50%
47UCJK0010	Upton and Hanley	Upton upon Severn	71,473	50%
47UCHX0012	Kempsey		71,710	50%
47UCJA0006	Longdon		72,815	50%
47UCJK0003	Upton and Hanley	Hanley Swan	73,982	50%
47UCJJ0008	Tenbury		76,175	50%
47UCJB0004	Martley		76,229	50%

Source OSCI 2009

OSCI (2009) reported that the most deprived rural areas in Worcestershire are characterised by:

- High levels of unemployment – 5.5% of the economically active population are unemployed, compared with 2.9% across all rural areas and 3.7% across Worcestershire as a whole.

- Very high levels of adults with no qualifications (49% of all those aged 16 to 74), significantly above levels for rural areas (28%) and all areas (31%). Also, a very low proportion (13%) of adults with degree level qualifications or higher – well below the average for rural areas (25%) and all areas in Worcestershire (21%)

- Very high levels of households lacking central heating (30% of households in deprived rural areas lack central heating – significantly above the average for rural areas and Worcestershire as a whole – 6%).

- High levels of household overcrowding (12% of people in deprived rural areas live in overcrowded conditions, compared with 2.6% in rural areas in the county and 4% in Worcestershire as a whole

8.1 Accessibility

This has resulted in the paradox of vastly increased overall mobility versus poorer access to facilities for some, particularly for those rural residents who do not have access to a car. Accessibility is defined as the ability of people to get to locations, goods and services they need or want, allowing them to participate in work, training, education, healthcare, shopping and leisure activities. Having good accessibility means that people can lead a full and active life, and having good access not only means travelling with ease to services and facilities but also reducing the need to travel at all by locating goods and services in well-placed locations. In rural areas, increasing levels of car ownership have gone hand in hand with the centralisation of services, loss of local shops, and the reduced viability of public transport. At the same time it has resulted in greater car mileage, and therefore greater individual transport related carbon emissions especially for rural dwellers when compared to urban dwellers.

8.1.2 Transport

According to the 2014 Viewpoint survey on 31% of Malvern Hills respondents stated that they were very or fairly satisfied with local bus services, a similar level to Wychavon which is demographically similar (figure 39). In regard to the condition of public roads Malvern again was similar to the other districts however only 33% of respondents reporting they were very or fairly satisfied. The Viewpoint Survey also asked about what things needed improvement across the district and for Malvern Hills improvements to transport was the second most important issue.

Figure 39 - Satisfaction with local transport, by District

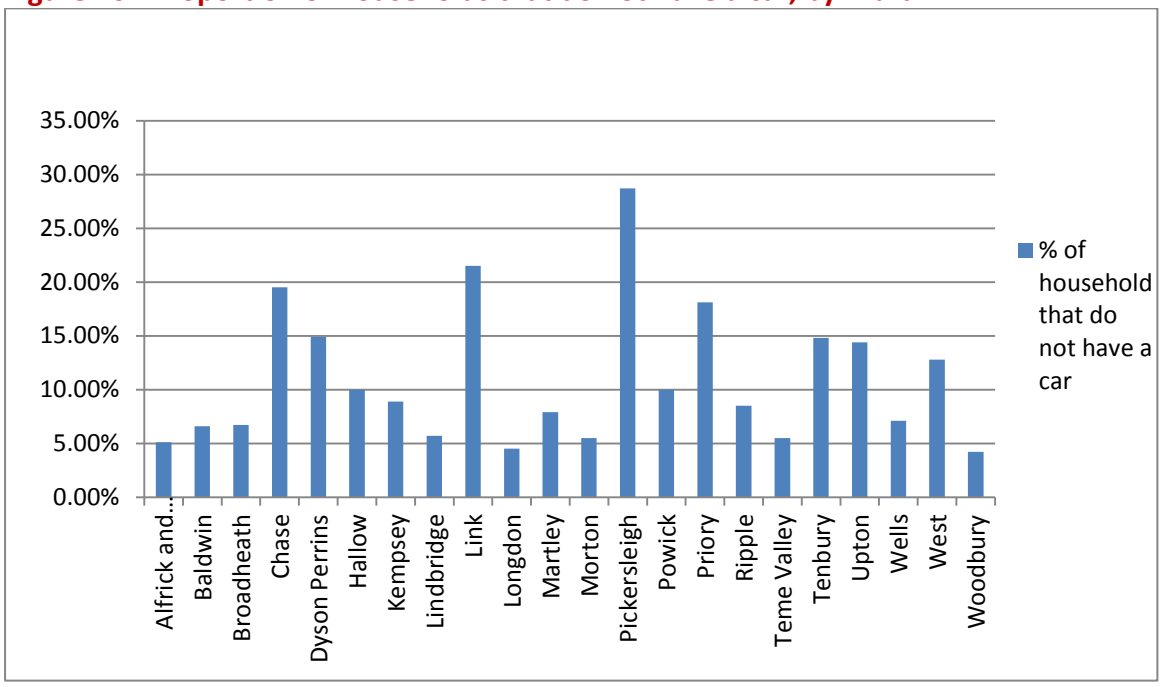
District	% very or fairly satisfied	
	Local Bus Services	Keeping public roads in a reasonable condition
Bromsgrove	28%	30%
Malvern Hills	**31%**	**33%**
Redditch	36%	27%
Worcester	39%	35%
Wychavon	34%	32%
Wyre Forest	28%	23%

Source: Viewpoint 2014

8.1.3 Car ownership

Of the total 32,212 households, identified within the 2011 Census, 4,333 does not have a car (13.45%). When broken down to ward level there are 7 wards with an above average proportion of households that do not have a car (figure 40) 3,041 of the total 4,333 car less households are within these 7 Wards.

Figure 40 - Proportion of households that do not have a car, by Ward



Source: Census 2011

8.2 Isolation and Loneliness

Reducing isolation and loneliness is a Worcestershire 'Future Lives' priority linked to reducing demand on health and social care (WCC 2013). There is research evidence nationally and internationally that social isolation, triggered at specific life changes as people become older [e.g. retirement, death of a partner, loss of mobility], contributes to the likelihood of someone requiring health and social care.

Holt-Lunstad et al. (2010) in their meta-analysis of “Social Relationships and Mortality Risk" found the impact of isolation and loneliness on mortality is equivalent to smoking 15 cigarettes a day. That isolation and loneliness are linked to depression, anxiety, declining mobility, high blood pressure and increased mortality rates

Steptoe et al (2013) in their UK research of isolation and loneliness concluded that although both isolation and loneliness impair quality of life and well-being, efforts to reduce isolation are likely to be more relevant to mortality.

Whilst there is not any specific data on isolation and loneliness across Malvern Hills measuring social capital may provide some evidence of whether isolation is prevalent across a community.

9 Social Capital across Malvern Hills District

Social capital describes the pattern and intensity of networks among people and the shared values which arise from those networks. Greater interaction between people generates a greater sense of community spirit.

Definitions of social capital vary, but the main aspects include citizenship, 'neighbourliness', social networks and civic participation.

Research has shown that higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates.
In other words, those with extensive networks are more likely to be 'housed, healthy, hired and happy' (ONS 2015)

9.1 Local Views

Recognising the importance of the local population, in regard to measuring, reporting and providing evidence of health and wellbeing, Worcestershire undertakes a Viewpoint survey annually. The Viewpoint survey of May 2014 was undertaken with a total of 956 surveys issued across Malvern Hills District, using email and postal method. The response rate for Malvern Hills, including panel members and a small number of randomly sampled addresses, was 46.8%. The Malvern Hills Viewpoint sample was overrepresented for the older people and men. The 'Affluent Achievers' ACORN category was also overrepresented in terms of response rate. Malvern Hills overall population compared to the Worcestershire population is wealthier and older.

9.2 Belonging

The strength of belonging is a way of measuring cohesiveness in the local area, arguably a key component of social capital.
Respondents were asked about the degree to which they feel they belong to their local area. Malvern Hills response was that 79% felt they 'strongly' or 'fairly strongly' belonged to their local area. Older respondents were more likely to feel they belonged to their local area, as were those who owned their property outright. Across Worcestershire there was a large difference between those from urban and rural areas, where rural residents are more likely to feel they belong to their local area.

9.3 What makes somewhere a good place to live and what needs improving

Respondents were asked to select the top five things that make somewhere a good place to live and also the top five things that need improving in their local area. Malvern Hills gave the following as the 'what makes somewhere a good place to live in?'

1. Health Services,
2. Level of Crime,
3. Education Provision,
4. Access to nature, and
5. Affordable Decent Housing

Things that they identified as 'need improving' were

1. Pavement Repairs
2. Public Transport

3. Affordable Decent Housing
4. Activities for Teenagers
5. Job Prospects

9.4 Being informed and involved

45% of Malvern Hills respondents stated that they felt very or fairly well informed on how to get involved in decision making locally. In regard to health services 42% stated they felt 'very or fairly well' informed about the work of health services in Worcestershire. Interestingly only 32.3% believed they could influence decision making locally. 63% of the residents who said they didn't feel they could influence decisions said this is because they didn't believe that input received from local residents was taken into account, (Worcestershire average 44%).

9.5 Volunteering

One of the better-known benefits of volunteering is the impact on the community. Unpaid volunteers are often the glue that holds a community together. Volunteering allows people to connect to their community and make it a better place. Furthermore volunteering can benefit the individual and their family as it helps people to make new friends, expand their network, and boost social skills. It can maintain and even improve physical and mental health and wellbeing can also give opportunity to develop employment skills.

Malvern Hills has the highest proportion of its residents volunteering (34%) compared to other Districts and Worcestershire (21%). Malvern also has an additional 12% stating they would be interested in volunteering (Viewpoint 2014)

The view that people in Malvern Hills do not feel *able to influence decision making locally* but a significant proportion of residents are involved in volunteering creates a dichotomous position in regard to social capital. Further detail was sought, from previous Viewpoint surveys, and it was found that *being able to influence decision making* has increased from the 2013 figure of 25.9% (2014 32.3%)

9.6 Building social capital further

Wychavon District Council, one of Malvern Hills statistical neighbours, within its 'Opportunity Vale of Evesham' project looked at several villages in some detail, finding out what made some very proactive and others less so. In doing this they mapped the communities, finding out what services were available, how people accessed them and how people found out about them. They discovered a number of key issues that impacted on rural communities which enabled the development a model of key factors that make up a successful and strong rural community (figure 41).

Figure 41 - Model of strong rural community

Source Shaping Services http://www.shapingservices.co.uk/about-us/

The project has led to the development of Wychavons Rural Communities Programme with a range of public community and voluntary partners involved. The programme's aims are:

- To support vulnerable individuals and communities in rural Wychavon.
- To implement a model for strong rural communities.
- To focus on building community capacity.
- To maximise uptake and impact of existing public, voluntary and community services.

This programme is likely to be well suited to adopt within Malvern Hills District as a way of improving community assets and social capital.

10 Health Hotspots

The Public Health Annual Report for Worcestershire in 2008 focused on health inequalities and the identification of local "health hotspots" which were areas with poor health outcomes compared to the rest of the County. The 2014 JSNA revisited that work to see if the hotspots had changed in any way. In order to target health and other interventions, it is important to know where these will have the biggest impact both in terms of overall improvement in health and in reducing inequalities. This can best be achieved by identifying areas where health outcomes are worst – our "health hotspots".

8.1 Hotspot Methodology

In order to identify hotspots 4 key indicators were used. These were:

- Overall Index of Multiple Deprivation for 2010 (IMD 2010)
- The health component of the IMD 2010
- All-cause mortality aged under 75
- Mortality from causes amenable to healthcare aged under 75

LSOAs were identified on the latter two by whether they had significantly higher mortality than the County average and on the former two by dividing the area into deciles of deprivation.

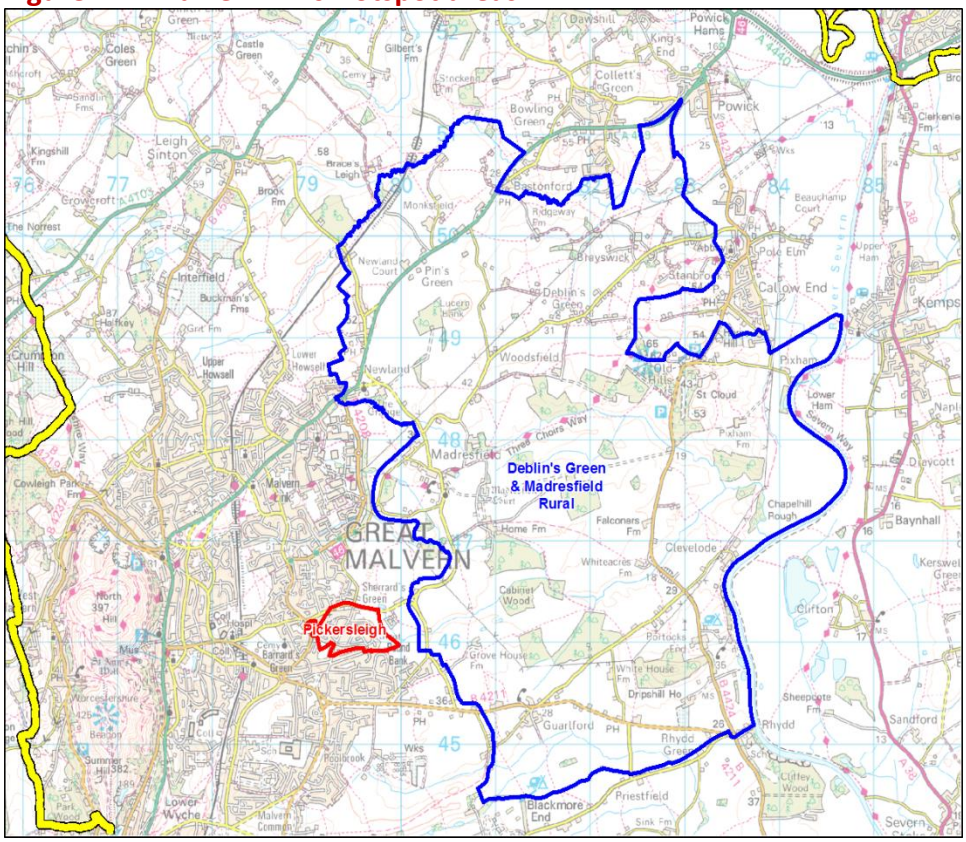
8.2 2014 Hotspot findings

Largely the hotspots, across Worcestershire, that were identified were the same as had previously been identified. It is important to note that health inequalities, particularly those with long-term outcomes do not change rapidly and therefore this was expected.

Pickersleigh was identified as a hotspot in 2008 and this remains the case in 2014.

In addition to this a rural area has also been identified, **Deblin's Green and Madresfield**. This area displays slightly different properties, but shows significantly high mortality rates from both all causes and amenable causes (figure 42). Further exploration of these 2 areas has therefore been undertaken within this profile.

Figure 42 - Malvern Hills Hotspot areas



Source Worcestershire JSNA (2014)

8.3 Pickersleigh

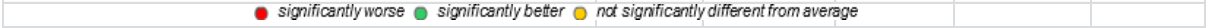
Pickersleigh has a long-term profile of socio-economic disadvantage and the impact of this can be seen in the outcome measures reported by Local Health (Figure 43). Significant focus has been put into Pickersleigh and there are some aspects that show positive outcomes. For example there are approximately 3000 households, of which 50% are provided through FORTIS social housing (previously known as Festival housing), most of which have central heating and are not overcrowded. This is better than the England average.

In regard to life expectancy, at birth, Pickersleigh is not statistically different to the England average. Premature mortality, which is measured as deaths prior to the age of 75 years, also shows a similar level to England and this has improved significantly between 2007-2009 and 2011 – 2013 which is good news. Smoking and cancer incidence across all ages also reflects the England average.

Areas that are statistically worse than England average are emergency admissions for a range of health conditions; this may be reflective of the above average level of bad or very bad general health reported and limiting long-term illness or disability. Numbers of older people and those who live alone are above average as is the level of provision of unpaid care. Childhood related outcomes from low birthweight, obesity later in childhood, early year's development through to GCSE achievement are worse than average.

Figure 43 - Pickersleigh Ward Health Profile

Indicators	*local value*	*Eng value*	*Eng worst*	*England*	*Eng best*
Income Deprivation (%)	24.3	14.7	49.8		1.1
Low Birth Weight Births (%)	10.3	7.4	13.8		1.4
Child Poverty (%)	31.5	21.8	79.8		1
Child Development at age 5 (%)	35.3	63.5	19.1		95
GCSE Achievement (5A*-C inc. Eng & Maths) (%)	32.4	58.8	21		100
Unemployment (%)	5.5	3.8	16.7		0.3
Long Term Unemployment (Rate/1,000 working age population)	15.3	10.1	68.2		0
General Health - bad or very bad (%)	7.1	5.5	16.7		0
General Health - very bad (%)	1.6	1.2	4.3		0
Limiting long term illness or disability (%)	21.8	17.6	41.5		2.2
Households with central heating (%)	98	97.3	44.1		100
Overcrowding (%)	7	8.7	47.7		0.2
Provision of 1 hour or more unpaid care per week (%)	11.5	10.2	17.6		1.7
Provision of 50 hours or more unpaid care per week (%)	3.1	2.4	7.9		0
Pensioners living alone (%)	37.5	31.5	63.3		11.4
Older People in Deprivation (%)	22.7	18.1	82.1		2.1
Obese Children (Reception Year) (%)	12	9.4	23.6		2.1
Children with excess weight (Reception Year) (%)	29.2	22.5	45.5		6
Obese Children (Year 6) (%)	25.3	19.1	36		4
Children with excess weight (Year 6) (%)	38.2	33.5	54.1		10
Children's and young people's admissions for injury (Crude rate/100,00	1407	1180.9	2647.8		412.7
Occasional smoker (modelled prevalence, age 11-15) (%)	2.3	1.5	4.2		0.1
Regular smoker (modelled prevalence, age 11-15) (%)	6.7	3.1	10.8		0.3
Occasional smoker (modelled prevalence, age 15) (%)	5	4	9.1		0.5
Regular smoker (modelled prevalence, age 15) (%)	14.4	8.7	21.7		1.5
Occasional smoker (modelled prevalence, age 16-17) (%)	7.4	5.9	13		0.8
Regular smoker (modelled prevalence, age 16-17) (%)	23.3	14.8	31.8		2.9
Deliveries to teenage mothers (%)	3.9	1.5	7.9		0
Admissions for injuries in under 5s (Crude rate per 10,000)	174.7	139.6	393.7		34
Emergency admissions in under 5s (Crude rate per 1000)	162.5	150	400.4		28.4
A&E attendances in under 5s (Crude rate per 1000)	515.9	509.5	2302.5		104.6
Obese adults (%)	24.9	24.1	34.8		5.9
Binge drinking adults (%)	20.4	20	56.4		3.3
Healthy eating adults (%)	22.5	28.7	12.3		54.1
Emergency hospital admissions for all causes (SAR)	112.7	100	224.9		27.2
Emergency hospital admissions for CHD (SAR)	140.3	100	425.3		27
Emergency hospital admissions for stroke (SAR)	106	100	257.7		28.4
Emergency hospital admissions for Myocardial Infarction (heart attack)	150.4	100	324.3		20.6
Emergency hospital admissions for Chronic Obstructive Pulmonary Dis	110	100	660.1		10.7
Incidence of all cancer (SIR)	105.6	100	146.6		47.8
Incidence of breast cancer (SIR)	126.3	100	180.1		43
Incidence of colorectal cancer (SIR)	101.9	100	200.1		33
Incidence of lung cancer (SIR)	84.4	100	302		23.4
Incidence of prostate cancer (SIR)	108.1	100	216.8		23.6
Hospital stays for self harm (SAR)	287.4	100	464.3		12.3
Hospital stays for alcohol related harm (SAR)	125.9	100	296.2		37.2
Emergency hospital admissions for hip fracture in 65+ (SAR)	113.2	100	218.2		31.8
Elective hospital admissions for hip replacement (SAR)	93.7	100	218.4		16.9
Elective hospital admissions for knee replacement (SAR)	84.7	100	215.3		21.4
Life expectancy at birth for males (years)	77.8	78.9	67.1		91.3
Life expectancy at birth for females (years)	84.6	82.8	73.9		98.4
Deaths from all causes, all ages (SMR)	91	100	279.2		19.9
Deaths from all causes, under 65 years (SMR)	136.3	100	320.9		0
Deaths from all causes, under 75 years (SMR)	119	100	286.1		0
Deaths from all cancer, all ages (SMR)	104.2	100	234.6		0
Deaths from all cancer, under 75 years (SMR)	129.1	100	274.5		0
Deaths from circulatory disease, all ages (SMR)	81	100	279.2		0
Deaths from circulatory disease, under 75 years (SMR)	91.4	100	319.1		0
Deaths from coronary heart disease, all ages (SMR)	83.4	100	596.2		0
Deaths from coronary heart disease, under 75 years (SMR)	91.3	100	569.8		0
Deaths from stroke, all ages (SMR)	70.4	100	711.9		0
Deaths from respiratory diseases, all ages (SMR)	91	100	373.2		0



Source PHE Local Health

http://www.localhealth.org.uk/#z=367244,254442,24316,15597;v=map4;l=en;sly=ward_2013_DR;sid=6604;i=t4.le_f

Although Smoking and alcohol have not been highlighted within the local health report as significantly different to other areas locally there has been concern raised around long-term drinking in men aged 40+ and its associated increased risk of housing eviction. Malvern Town Football Club has been working, as a partner, in delivering targeted activity to support alcohol reduction / behaviour.

The Pickersleigh project has been another example of action to improve understanding of local need and develop work to address and support improvement. Its four aims of
Improving Liveability, empowering local people, transforming neighbourhoods and improving access to local services led to actions delivered over a 5 year period up to 2014. The evaluation of this project identified in some evidence of improved outcomes in key areas.

Community safety
There is strong evidence that Anti-social behaviour rates are down and there appears to have been a significant drop in numbers of incidents since the end of 2012. Although it should be noted that reporting rates may be an influence on this
Environment
There are reduced levels of litter and the perception of litter as a problem. There has been a slight increase in satisfaction with the local area and some evidence from stakeholder interviews that there is a greater sense of community.
Influence
There has been increased satisfaction with district and county councils alongside an increase in people feeling well informed about services and agreeing that they can influence decisions.
Employability
Although there have been no significant shifts in absolute levels of NEETs or key out of work benefit claimants there has been a reduction in JSA claimants.
As a result of employability projects there are now a significant number of people characterised as „work ready".
Empowerment
Although limited to small numbers those who participated in the Empower Group became more confident and developed better knowledge and understanding of their community.
Partnership
Communications between partners and between organisations and residents has significantly improved. Improved communications and greater focus on the area has been assisted by a strong BPP brand.

8.4 Deblin's Green and Madresfield

Deblins Green and Madresfield have shown an increasing and statistically above average under 75 mortality rate. The Public Health Intelligence Team (WCC) have raised a note of caution that this may be an artefact and will need to be monitored over a longer timeframe before any robust conclusion can be made regarding its 'hot-spot' status.

11 Healthcare provision

11.1 Primary Care

As many people's first point of contact with the NHS, around 90 per cent of patient interaction is with primary care services. In addition to GP practices, primary care covers dental practices, community pharmacies and high street optometrists.

11.1.1 GP Practices

In regard to primary care here are 9 GP practices across Malvern Hills District, Figure 44. There are also 2 practices, shown in bold, across the border into Herefordshire that provide healthcare to a total of 1272 Malvern Hills residents (2015 data).

Figure 44 - GP Practices in Malvern Hills District

Practice Name	Address
St Saviours Surgery,	Merick Road, Malvern, WR14 1DD
Whiteacres Medical Centre	Maple Road, Malvern, WR14 1GQ
Link End Surgery	39 Pickersleigh Road, Malvern, WR14 2RP
New Court Surgery	300 Pickersleigh Road, Malvern, WR14 2GP
Malvern Health Centre	Prospect View, 300 Pickersleigh Road, Malvern, WR14 2GP
Great Witley Surgery	The Surgery, Worcester Road, Great Witley, Worcester, WR6 6HR
Knightwick Surgery	Bromyard Rd, Knightwick Worcester, WR6 5PH
Tenbury Wells Surgery,	34 Teme St Tenbury Wells Worcs WR15 8AA
Upton Surgery	Upton Surgery, Tunnel Hill, Upton Upon Severn, Worcester, WR8 0QL
Cradley Surgery	**Bosbury Road, Cradley, Nr. Malvern, WR13 5LT**
Colwell Surgery	**The Surgery, Stone Drive, Colwall, Malvern, WR13 6QJ**

The projected and known changes to Malvern Hills population in the next 5-10 years, as detailed above (figure 6, pg7) will have **considerable impact upon primary care and, in particular, the number of GP's per head of population.** This is particularly pertinent when the population increase is projected to be in the over 65 population who are statistically more likely to have co-morbidities and are therefore likely to take up a greater proportion of a GPs time.

Malvern Hills district is served by the South Worcestershire CCG. Current GP whole time equivalent figures based on registered patient numbers in each of the three Worcestershire CCG areas are shown in figure 45 below.

There were 317.8 whole-time equivalent GPs (WTEs) in July 2012 in the three Worcestershire CCGs combined, covering a registered population of 576,523 patients. This is equivalent to 1813.9 patients per WTE GP or 55.1 GPs per 100,000 registered population.

Figure 45 – GP Whole time equivalents (WTE) and registered patient numbers (July 2012)

CCG	GP WTE	List size	Patients per WTE	GPs per 100,000 population
Redditch and Bromsgrove	87.7	171,091	1,951.5	51.2
South Worcestershire	165.4	293,275	1,773.1	56.3
Wyre Forest	64.8	112,157	1,732.0	57.7
Total	317.8	576,523	1,813.9	55.1

Source: Exeter database and primary care contracts team, GP WTE and List sizes sourced from the South Worcestershire CCG Needs Assessment 2013

11.1.2 Pharmacy

The recent Worcestershire Pharmaceutical Needs Assessment (2015) found the following in regard to Malvern

- There are thirteen pharmacies service across the District, one of which is a 100-hour contract
- A service is provided from 8.00 until midnight, from Monday until Saturday.
- The morning openings are staggered between 8.00am and 9.00am and there are three lunchtime closures.
- Most pharmacies close at 18.00 but one remains open until 20.00 and one pharmacy provides a service until midnight from Monday to Saturday.
- On Saturday eleven pharmacies open to cover the hours from 8.00 until midnight. Four of these provide a service for half a day but the rest stay open until 17.30 and one provides a service until midnight.
- Two pharmacies open on Sunday to provide a service between them from 10.00 until 16.30.
- Six dispensing GP practices also provide a service to this locality

11.1.3 Dentists

Across Malvern Hills District there are 8 dental practices that offer NHS treatment, including the Dental Access Centre in Malvern Town centre (Figure 46).

Figure 46 - Malvern Hill Dental Practices

Name	Address
The Dental Surgery	Upton –Upon-Severn Health Centre, Tunnel Hill WR8 0QL
Malvern Hills Dental Care	172, Worcester Road, Malvern WR14 1AA

Name	Address
Malvern Spring Dental Practice	58 Spring Lane, Malvern Link, Worcestershire WR14 1AJ
Dental Access Centre	Osbourne Road, Malvern WR14 1JE
Richmond Dental Practice	Richmond Road, Malvern Link WR14 1NE
St Margaret's Dental Practice	Imperial Road, Malvern WR14 3AT
Tenbury Dental Centre	32 Teme Street, Tenbury Wells WR15 8AA
12 Teme Street	Tenbury Wells, Worcestershire WR15 8BA

11.1.4 Opticians

Across Malvern Hills District there are 9 optician practices (Figure 47).

Figure 47 - Malvern Hills Optician services

Name	Address
Barnards Green Opticians	113 Barnards Green Road, Malvern WR14 3LT
J & D Miller	38 Church Street, Malvern, Worcestershire, WR14 2AZ
G L & K R Holland	16 Graham Road, Malvern, Worcestershire WR14 2HL
Value Vision Opticians	3 Church Walk, Malvern, WR14 2XH
Waller & Waller	Lambert House, Edith Walk, Malvern, WR14 4QH
S.J Tromans	255 Worcester Road, Malvern, WR14 1AA
Upton Eyecare Limited	Old Street, Upton Upon Severn, Worcestershire WR8 0HA
Value Vision	38 Old Street, Upton Upon Severn, Worcestershire, WR8 0HW
A.C Jelley	14 Teme Street, Tenbury Wells, WR15 8BA

11.2 Secondary Care

There are 2 Minor Injury Unit's (MIU) within Malvern District. One located within Malvern Community Hospital and the other in Tenbury Community Hospital. Both units provide a nurse led service (no prior appointment necessary) for the treatment of soft tissue injuries, minor wounds/burns, fractures, minor eye/ foreign bodies in the ears/nose and throat and provision of emergency contraception. They are open 7 days per week between the hours of 9am and 9pm.

There is also inpatient, community based beds (General Practitioner supported) within both hospitals; Malvern Community Hospital has 24 beds and Tenbury 16 beds. A range of outpatient services are provided out of the community hospitals as a way of improving access.

For more serious / acute health problems Worcestershire Royal Hospital, located in Worcester, is for many the closest hospital. For some however Herefordshire County Hospital, located in Hereford city centre is more accessible.

12 Housing

The 2011 Census indicates that Malvern Hills has 32,212 households, of which 9,555 have only 1 person living in them; 5,006 aged over 65 years and 4,549 aged less than 65 years.

In regard to housing stock there are a high number of households that are under-occupied; i.e. have bedrooms that are not needed by household members to sleep in. Figure 48 provides a breakdown of this. In total there were 558 households that were deemed overcrowded, using Census specific calculation formula, and requiring additional bedrooms.

Figure 48 - Occupancy of households based on Bedroom

Occupancy (bedrooms)	Number of households
2 or more unoccupied	14,810
1 unoccupied	10,693
All occupied	6,151
1 additional required	500
2 additional required	58

Over two-thirds (23,146) of Malvern Hills homes are owner-occupier with 13,680 (nearly 60%) of these being owned outright (no mortgage). Social housing provided housing for 4,547 households, with WCC the provider for 558 of this group. The remaining 3720 households were provided through private rent arrangement.

These figures, in additional to the homeless data, appendix 2, suggest that there may be **sufficient housing stock, for the current population, across Malvern however it is not necessarily the most appropriate for the individuals / families living in them.**

The continued challenge in Malvern is that there are a high number of older/ period properties, and larger homes which are often harder to maintain, heat and, as people age, access fully with ease.

Remaining warm and well is a key concern, particularly for older people, the vulnerable and children, to prevent excess winter deaths and other poor outcomes. The majority of homes in Malvern Hills have central heating provision, only 883 homes are without. Of homes where central heating is in place 63.1% use gas with oil being the next most common, only a small number use solid fuel central heating (644). Although central heating is commonplace in Malvern Hills, affordability of use is unclear. Improving affordability and ecological / environmental outcomes through reduced emissions is a key priority and support through the Warmer Well programme to improve home insulation and boiler efficiency is available.
http://www.worcestershire.gov.uk/homepage/33/warmer_worcestershire

12.1 Residential Provision - Care and Nursing

The 2011 Census reported that Malvern Hills had a total of 43 Residential Care Homes of which 13 provide nursing care. A total of 997 individuals were resident within these homes; 403 within the nursing provision.

12.1.1 Extra Care

There has been a considerable move towards 'extra care' The term 'extra care' housing is used to describe developments that comprise self-contained homes with design features and on-site support services available to enable self- care and independent living, as well as easy access to care services. Malvern Hills has seen 2 recent Extra care developments Clarence Park, which opened in 2014, offering 101 apartments, for people aged 55 and over, that are allocated for rent, part and outright purchase. Cartwright Court is another similar development, in Malvern Hills, that has been built recently with 54 1 and 2 bedroom apartments

12.2 Local planning

In March 2012, the National Planning Policy Framework (NPPF) brought together revised guidance for local authority planners, including a specific requirement to promote healthy communities, and to draw on evidence of health and well-being need. To accompany this in March 2014 the Department for Communities and Local Government (DCLG) launched the Planning Practice Guidance web-based resource, which has a dedicated section on health and wellbeing, further detail of which can be found via this link http://planningguidance.planningportal.gov.uk/about/ (WCC 2015). Malvern Hills, jointly with Worcester City and Wychavon District have developed the South Worcestershire Development Plan (SWDP). The SWDP identified a number of locations for these to be built (figure 49) in 2013. This made provision for 4,598 dwellings.

Figure 49 - SWDP identified development locations

Location	**No of dwellings (proposed 2013)**	**No of dwellings (proposed 2015)**
Completions	2,235	2,235
North East Malvern	700	800
QinetiQ	250	300
Malvern: other allocated sites	147	530
Kempsey sites	138	315
Powick sites	30	119
Rushwick sites	58	112
Lr. Broadheath Sites	52	102
Tenbury sites	70	162
Upton Small Sites	100	138
Land adj the Crown (west), Martley	51	51
Malvern Villages Sites	205	508
Malvern windfall forecast	562	562
MALVERN HILLS TOTAL	**4598**	**5934 of the total 8590 proposed**

Later, in 2015, an independent Objectively Assessed Housing Need (OAHN) assessment was undertaken which indicated that Malvern Hills will need to have an additional 8590 homes built by 2030 rather than the original 4598. The SWDP has therefore been revised and was approved by

Malvern Hills District Council on the 22nd of September 2015 with 5934 of the 8590 total housing locations identified (SWDP 2015).

These developments may be a force for good. An example of this is the recent development at Malvern Vale.

Malvern Vale is the town's newest estate, being built on a former Ministry of Defence site known as 'North Site'. There are around 550 homes on the estate, with around 40% being either social housing or shared ownership. The estate is located in the Dyson Perrins ward, near the secondary school of the same name. It borders countryside (including the Worcestershire Way) and residential roads with a mix of exclusively private housing and social housing. The Section 106 agreement for Malvern Vale required the developer to fund several key elements for the benefit of the community; a children's play area, a community centre with adult and junior football pitches, and a part-time Community Development Worker for 3 years. Malvern Hills District Council saw the Community Development Worker role as an opportunity to empower the community to develop its own voice and to help make the estate a safe, happy and inclusive place to live.

The Community Development Worker project had 4 aims

1 Resident Involvement / Community Engagement
2 Community Cohesion
3 Improving Access to Services
4 Ensuring Sustainability of Changes

The final evaluation report showed that, in regard to aim 1, Malvern Vale, reported more than 3 times as many residents felt that a sense of community had developed either 'very much' or 'quite a lot' in 2014 (49%) as had felt this in 2011 (15%) (MV Residents' Surveys 2014).

Aim 2 showed outcomes on the development of an active Residents Group which had resulted in community-led events and the involvement of residents in producing and disseminating information newsletters. It had also helped individuals to feel more connected to the physical environment around them through increased influence. Several changes to the physical environment have come about as a result of pressure from residents.

The evaluation found that in regard to aim 3 the project had helped to improve partnership working, which should be of longer-term benefit to residents. One stake-holder commented that there was "a strong link between agencies to help dispel any worries or issues and build a working relationship with residents, creating a solid, supportive community".

In regard to ensuring the sustainability of changes the vision for the estate and action plan, for achieving it, was developed by a group of residents and community partners. One highlight of this process was commitments made for on-going support for the Residents' Group from Councillors (County, District and Town), the local policing team, YMCA and Festival Housing.

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WHO (2001) Infant Feeding recommendation http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/index.html

Worcestershire Pharmaceutical Needs Assessment (2015) http://www.worcestershire.gov.uk/downloads/file/5688/2015_pharmaceutical_needs_assessment

Appendix 1 Malvern District Wards

1) **Alfrick and Leigh** (Knightwick, Suckley, Storridge and Alfrick)
2) **Baldwin** (Dunley, Shrawley and Holt Heath)
3) **Broadheath** (Lower Broadheath and Rushwick)
4) **Chase** (Poolbrook and Pound Bank)
5) **Dyson Perrins** (Upper Howsell)
6) **Hallow** (Hallow, Sinton Green and Grimley)
7) **Kempsey** (Kempsey and Severn Stoke)
8) **Lindridge** (Newnham Bridge, Mamble and Stockton on Teme)
9) **Link** (Malvern Link and Lower Howsell)
10) **Longdon** (Longdon, Bushley and Pendock)
11) **Martley** (Martley, Ockeridge and Wichenford)
12) **Morton** (Castlemorton and Welland)
13) **Pickersleigh** (Barnards Green and Sherrards Green)
14) **Powick** (Powick and Callow End)
15) **Priory** (Malvern Town Centre)
16) **Ripple** (Ripple, Ryall)
17) **Teme Valley** (Clifton on Teme, Shelsley Walsh and Highwood)
18) **Tenbury** (Tenbury Wells, Stoke Bliss, Kyre Wood and Upper Rochford)
19) **Upton and Hanley** (Hanley Swan, Church End, Upton Upon Severn)
20) **Wells** (Lower and Upper Wyche, 3 Counties showground and Upper Welland)
21) **West** (Borders Herefordshire)
22) **Woodbury** (Abberley, Menithwood and Great Witley)

Appendix 2 Additional indicators

These indicators are shown in the Malvern Hills Health Profile 2015 (chart 1) published by the APHO. These indicators continue to be important and should be monitored to ensure that where outcomes are good this is maintained.

1. Children in poverty (under 16 years)

Child poverty is an important issue for public health. The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

Using the IMD 2010 data a total of 1,630 children across Malvern Hills are reported as living in poverty (12.3%) this compares to a Worcestershire figure of 15.2% and an England figure of 21.8 and a (Local Health 2015). Almost a third of these children live in Pickersleigh Ward (518). Link and Chase Wards also have high numbers of children in poverty presenting 162 and 130 respectively.

2. Statutory homelessness

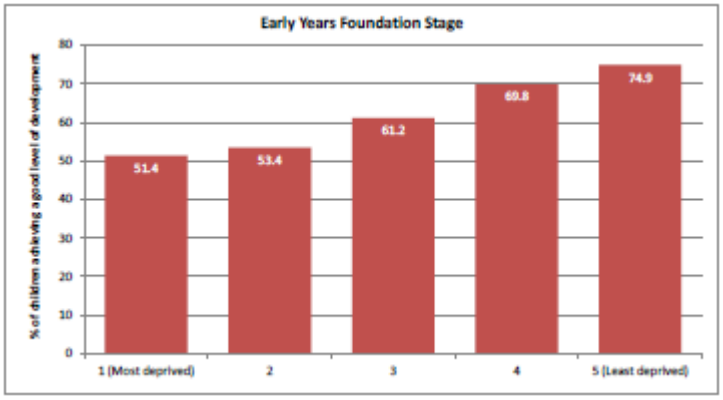
Homelessness is associated with severe poverty and is a social determinant of health. Homelessness is associated with adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector.

Statutory homeless households are reported as a crude rate per 1,000 estimated total households, all ages. **Malvern Hills has a rate of 1.59 per 1,000 which is significantly lower** than its statistical neighbour Wychavon (3.38), the West Midlands region (3.44) and England (2.32).

3. School Readiness

Inequalities for under- 5s can be summarised by looking at the results of the Early Years Foundation Stage (EYFS) which assesses all children against 7 learning areas in the final term of the year they turn 5. This indicator is often used as the indicator for school readiness. Across Worcestershire the % of children achieving a good level of development, (78 or above CLL PSE), for Early Years Foundation Stage ranges from 20% to 100% by LSOA. The average % score for children living in IMD 1 was 51% compared to 75% for those living in IMD 5.

Figure 50 - Early Years Foundation Stage achievement by IMD

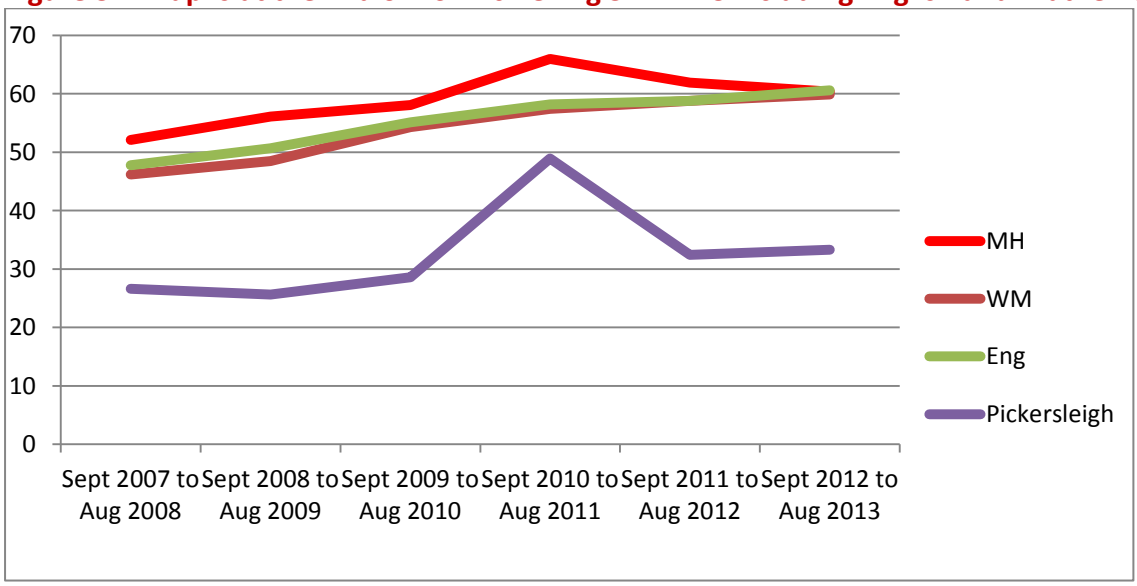


Source: PH Annual Report 2014

4. GCSE's achieved (5 A-C's Inc. English and Maths)

Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities. Figure 51 shows the percentage of pupils that achieve at least 5 GCSE's including Maths and English at grade A-C. Malvern Hills has consistently achieved above the West Midlands level and with the exception of 2012-13 an above England level of success. Malvern Hills District has an increasing trend of achievement. Pickersleigh Ward has been highlighted as one with lower than average attainment of GCSE's, although the latest available year shows a dramatic improvement. **Caution is however required due to likely small numbers, at ward level, which will fluctuate**.

Figure 51 - Pupils at the End of KS4 Achieving 5+ A* - C Including English and Mathematics



Source: Neighbourhood Statistics 2015

5. Violent Crime (violence offences)

Data on violent crime; offences against the person, is based on police recorded crime data, and reported as a crude rate per 1,000 population. Malvern Hills reports a rate of 8.8 per 1,000 population. This is significantly lower than the West Midlands Region (11.2) and the England rate of 11.1 per 1,000 people. Malvern Hills has a similar rate as Wychavon, one of its statistical neighbours.

6. Long-term unemployment

Unemployment is associated with an increased risk of ill health and mortality. There are relationships between unemployment and poor mental health and suicide, higher self-reported ill health and limiting long term illness and a higher prevalence of risky health behaviours including alcohol use and smoking. Links between unemployment and poor mental health have been explained by the psychosocial effects of unemployment: stigma, isolation and loss of self-worth. People with long term psychiatric problems are less likely to be in employment than those with long-term physical disabilities, despite indications that most people with severe mental illness would like to work. The average monthly claimants of jobseekers allowance who have been claiming for more than 12 months are counted and reported as the proportion, expressed as rate per 1000, of the working age population

Malvern Hills reports a rate of 3.54 per 1,000 in 2014. This is significantly lower than the regional rate of 10.36 per 1,000 and the England rate of 7.14. Ward level data is available for 2012/2013. There are a number of wards presenting at a level greater than 3.54, who also have a total number of long-term unemployed of more than 10 people. These are provided in figure 52.

Figure 52 - Wards with greater than average Long-term unemployment

Ward	Rate per 1,000 (count)
Pickersleigh	15.3 (58)
Chase	5.3 (18)
Dyson Perrins	4.5 (11)
Link	5.5 (20)
West	4.5 (12)

Source: Local Health (NOMIS dataset 2012/13)

7. Under 18's conceptions

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child.

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant

mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

Teenage pregnancy is reported as conceptions in women aged under 18 per 1,000 females aged 15-17. The latest data (2013) shows that Malvern Hills had a rate of 19.22 per 1,000 females aged 15-17 years. This is just below the Wychavon rate (21.9) but significantly below the West Midlands regional rate of 28.89 per 1,000 and the England rate of 24.35 per 1,000 (ONS 2015). In 2010-12 (latest data available) Pickersleigh was the only ward in the Malvern Hills District that had a teenage conceptions rate significantly higher than the Worcestershire and England rate.

8. % of physically active adults

Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £1.6 billion per year. The Chief Medical Officer currently recommends that adults undertake 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity or frequency.

This indicator is measured using Sport England's Active People Survey which is reports the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16.

In 2013 Malvern Hills reported that 58.6% were physically active, this was slightly above the Wychavon level of 57.71% and at a statistically significant level above the West Midlands and England proportions, 53.86% and 56.03% respectively. (Health Profile 2015)

9. Excess weight in adults

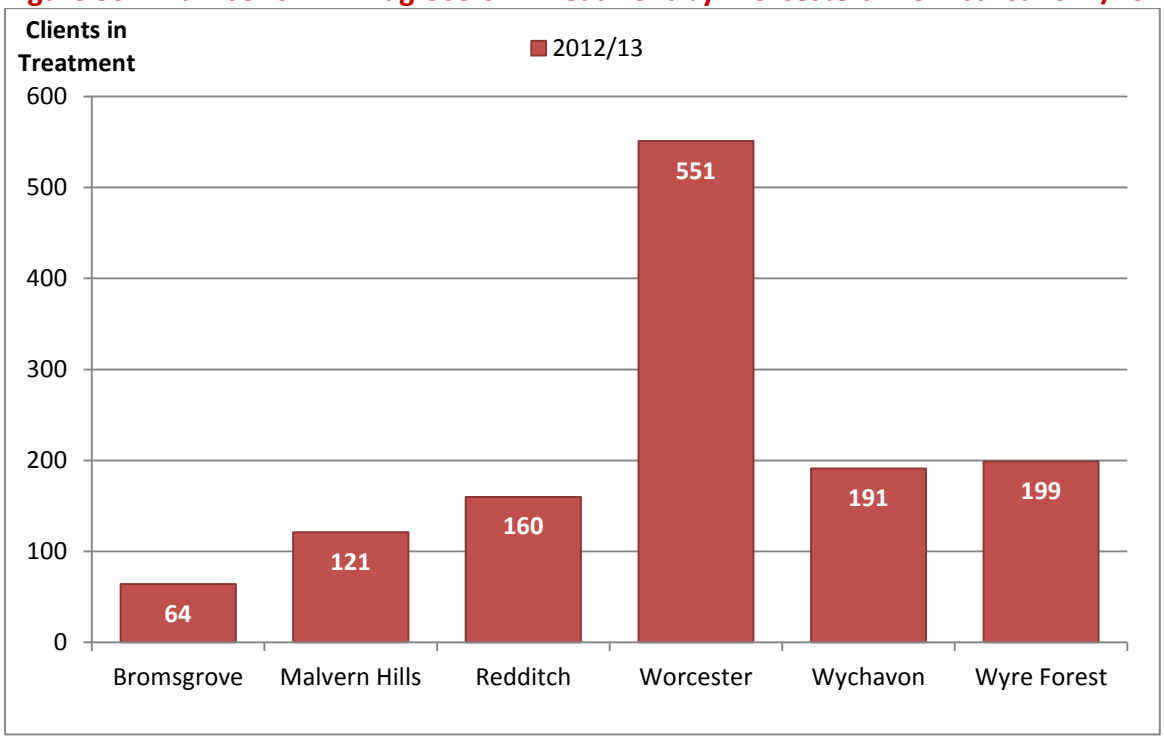
The Sport England's Active People Survey of 2012 was used to collect data on excess weight. Excess weight is defined as adults who have a body mass index (BMI) greater than or equal to 25kg/m2. This measure therefore also includes obese individuals (adults with a BMI greater or equal to 30kg/m2). In 2012 Malvern Hills reported 60.35% of its adult population as having excess weight. This is over 10% lower than Wychavon (70.81%) and at a statistically significant level below the West Midlands region (65.7%) and England level of 63.78%. (Health Profile 2015)

10. Prevalence of opiate and/or crack use

Accurate measurement of drug use prevalence is problematic. Estimates of the prevalence of opiate and/or crack cocaine users in an area are chosen as the best available estimate of drug use prevalence in an area. It also aims to help monitor likely health care burden from drug misuse. Prevalence is reported as a crude rate per 1,000 population, ages 15-64, persons. For the year 2011/12 Malvern Hills reported a rate of 5.74 per 1,000 not significantly higher than Wychavon (5.35) but a statistically significant lower rate than both the West Midlands region (9.45 per 1,000) and England (8.4 per 1,000). Data provided by Health Profile 2015.

The Marmot Review 'Fair Society, Healthy Lives' (Marmot 2010) highlights the significant positive correlation between the prevalence of problematic drug users aged 15–64 years and the deprivation indices of a local authority, and the positive association between the number of individuals in contact with structured drug treatment services per 1,000 population and the level of deprivation of each local authority.

Figure 53 – Number of All Drug Users in Treatment by Worcestershire District 2012/13



Source: National Drug Treatment Monitoring System, NDTMS, Quarterly Reports. Figure sourced from the Worcestershire Substance Misuse Needs Assessment 2014

Figure 53 shows that Malvern has the second lowest number of people in treatment for drugs across Worcestershire however it is important to note that this does not necessarily mean that Malvern has less residents with drug problems than the other districts; it could reflect that those adults with drug problems residing in other districts are more able, due to personal choice or accessibility, to engage with structured treatment.

11. Incidence of TB

TB re-emerged as a serious public health problem in the UK over the last two decades, with TB incidence rising above the European average. Although many local authority areas have low numbers of cases, others have high and sometimes rising rates. Whilst anybody can catch TB people at particular risk include those

- who live in, come from, or have spent time in a country or area with high levels of TB – around three in every four TB cases in the UK affect people born outside the UK
- in prolonged close contact with someone who is infected
- living in crowded conditions
- with a condition that weakens their immune system, such as HIV
- having treatments that weaken the immune system, such as corticosteroids, chemotherapy or tumour necrosis factor (TNF) inhibitors (used to treat some types of arthritis and certain gut conditions)

(Source: NHS Choices http://www.nhs.uk/Conditions/Tuberculosis/Pages/Causes.aspx)

TB is reported using a three-year average number of reported new cases per year (based on case notification) per 100,000 population. Malvern has a very low level of TB with only 2.67 per 100,000 new cases per year; Wychavon has slightly more at 4.53. This is significantly lower than the West Midlands region rate of 18.14 and England rate of 14.75 per 100,000. All of these are for the year 2011-2013 (Health Profiles 2015).

12. New STI (excluding chlamydia aged under 25)

While sexual relationships are essentially private matters, good sexual health is important to individuals and to society. It is therefore important to have the right support and services to promote good sexual health. Sexually transmitted infections continue to be a significant public health priority as

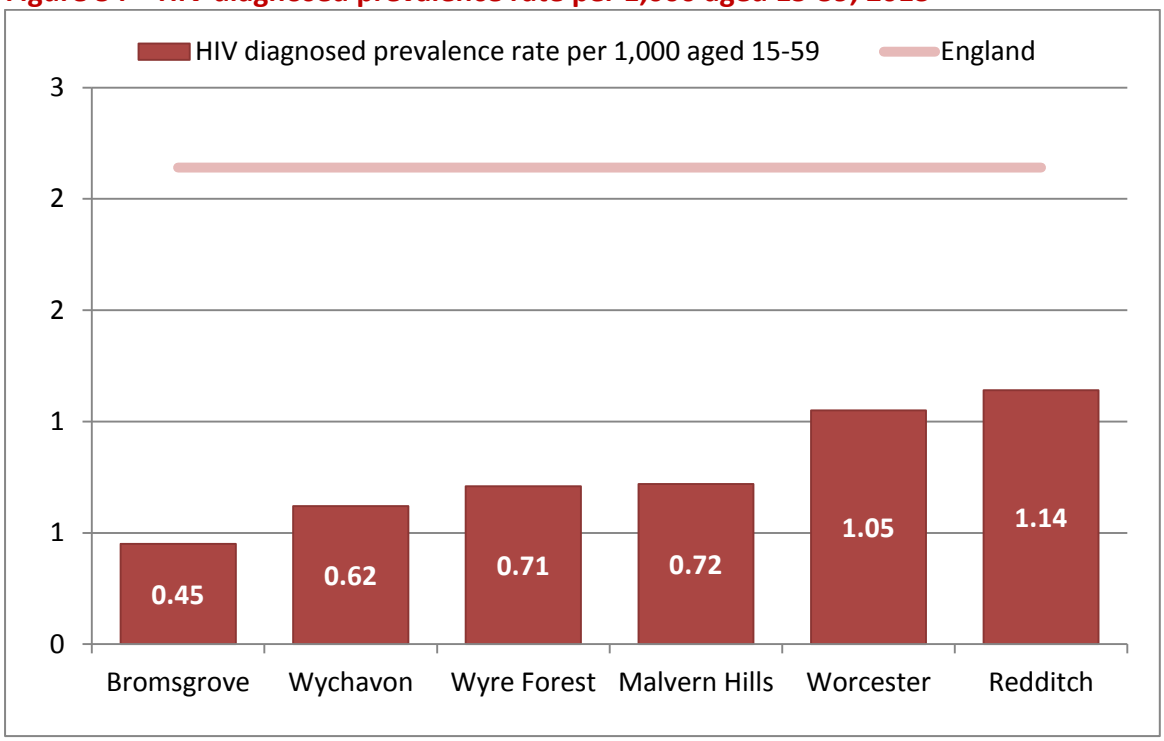
- In England during 2011, one person was diagnosed with HIV every 90 minutes.
- Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment.
- Rates of infectious syphilis are at their highest since the 1950's
- Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics
- In 2010, England was in the bottom third of 43 countries in the World Health Organization's European Region and North America for condom use among sexually active young people; previously, England was in the top ten.

(source A Framework for Sexual Health Improvement in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf)

STI data is provided on a crude rate per 100,000. Malvern Hills presented a rate of 390.86 per 100,000 in 2013, slightly lower than Wychavon at 443.02. The West Midlands rate was 726.39 and England 832.01 per 100,000.

Figure 54 shows the HIV diagnosed prevalence rate per 1,000 aged 15-59 in2013. Each of the districts in Worcestershire has prevalence rates that are much lower than the national average the diagnosis.

Figure 54 – HIV diagnosed prevalence rate per 1,000 aged 15-59, 2013



Source: PHE Sexual and reproductive health profiles 2014

It is pertinent to note that Malvern Hills has a statistically significant lower prevalence of recorded STIs; however STI reporting is likely to underestimate the true prevalence of many STIs, as many are asymptomatic and individuals do not seek medical diagnosis**. Continued promotion of good sexual health for all is therefore essential.**

13. Excess winter deaths (3 years)

The number of excess winter deaths depends on the temperature and the level of disease in the population as well as other factors, such as how well equipped people are to cope with the drop in temperature. Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur amongst the elderly population. Research has found that mortality during winter increases more in England and Wales compared to other European countries with colder climates, suggesting that many more deaths could be preventable in England and Wales.

Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. It is reported as a 3 year figure.

For the August 2010 - Jul 2013 period Malvern Hills reported 16.7% above expected level of deaths during the winter period compared to non-winter period. This was higher than in Wychavon (14.42%), but lower than both the West Midlands region (17.68%) and England (17.44%).

14. Infant mortality

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. It is reported base on the crude measure of Infant deaths under 1 year of age per 1000 live births per 3 years.

Malvern Hills has an infant mortality rate 4.22 per 1,000 live births based on 2011-13 data, higher than Wychavon 2.06 although this difference is not statistically significant due to the wide and overlapping confidence intervals. Malvern Hills does however have a statistically significant lower rate per 1,000 compared to the West Midlands (5.4). Malvern is similar to the England rate of 3.98 per 1,000.

15. Smoking related deaths

Smoking remains the biggest single cause of preventable mortality and morbidity in the world. It still accounts for 1 in 6 of all deaths in England, and there exist huge inequalities in smoking related deaths: areas with the highest death rates from smoking are about three times as high as areas with the lowest death rates attributable to smoking. Data is reported as a directly standardised rate per 100,000.

Malvern reported a rate of 212.39 smoking related deaths per 100,000 in 2011-2013. This was similar to Wychavon (232.16). Significantly lower than the West Midlands (283.13 per 100,000) and England (288.86).

16. Under 75 mortality rate: cardiovascular

Cardiovascular disease (CVD) is one of the major causes of death in under-75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment. It is reported as a standardised mortality rate per 100,000.

Malvern Hills reported a rate of 71.08 per 100,000 deaths under the age of 75 due to cardiovascular disease. This is above Wychavon's rate of 57.59, below West Midlands region (82.05) and England (78.21) although not at a statistically significant level.

17. Under 75 mortality rate: cancer

Cancer is the highest cause of death in England in under-75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment. There are a number of screening programmes in place to support early diagnosis in addition to health promotion messages and campaigns to increase awareness of lifestyle factors that can increase or reduce the risk of cancer and symptoms to look out for. This measure is reported as an age-standardised rate of mortality from all cancers in persons less than 75 years per 100,000 population.

In 2011-13 Malvern Hills reported a rate of 121.05 per 100,000, slightly below the Wychavon rate of 133.7. Malvern Hills had a significantly lower rate of under-75 mortality due to cancer compared to both West Midlands and England (147.75 and 144.36 per 100,000 respectively.

18. Killed and seriously injured on the road

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. For children and for men aged 20-64 years, mortality rates for motor vehicle traffic accidents are higher in lower socioeconomic groups. The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, and road infrastructure and vehicle safety. Data is presented as a rate per 100,000 and Malvern Hills, with a rate of 34.23 per 100,000, has a statistically similar rate of road deaths or serious injuries as Wychavon, West Midlands and England.