

Joint Strategic Needs Assessment

Devon Overview

Understanding the Different Needs Across the Life Course in Devon

EXECUTIVE SUMMARY

This overview was produced to provide a summary of health and wellbeing needs across the Devon County Council area. It contains a range of information about health and the factors that influence the health of the population from a range of sources.

The report is shaped by the life course approach and groups topics in relation to childhood, adulthood and older people, whilst acknowledging there is considerable overlap between groups. Listed below is a selection of themes emerging from the assessment which have a notable impact on the health of the population in Devon. A common factor with these themes is that they cannot be addressed by a single organisation alone, and represent areas where a joint partnership approach is necessary.

1 INTRODUCTION

This overview has been produced to provide a summary of health needs data across the Devon County Council area. It gives a broad range of information about health and factors which influence the health of the population of Devon to help inform and shape the planning and commissioning of services. It draws information from a number of different sources, some of which are produced specifically for the Joint Strategic Needs Assessment and others are documents which support the process from within partner organisations. These sources include the Devon Joint Strategic Needs Assessment town profiles and the topic pages on the Devon Health and Wellbeing website, economic data from Devonomics (the local economic assessment), the Adult Social Care Market position statement, the Annual Public Health Report and other more detailed Joint Strategic Needs Assessments and Health Needs Assessments.

The life course approach

The public health strategy for England, Healthy Lives, Healthy People, published in 2010 proposed that a life course approach is taken in tackling the wider social determinants of health. The Marmot review highlights the importance of childhood experiences in reducing health inequalities across the life course. This review highlights that the foundations for virtually all aspects of human development are laid in early childhood (Marmot Review 2010, www.marmotreview.org.) These experiences can have lifelong impacts on health and wellbeing and therefore to start to reduce inequalities, the social gradient in children's access to positive early experiences needs to be addressed. The life course approach aims to

understand and address how these experiences in childhood and adolescents influence socio economic position and risk of disease later in life.

This summary is largely grouped around different life course stages in Devon. Over the life course the health and wellbeing needs and requirements of the population change. Many needs are relevant in just one stage of the life course, where as others are relevant over many stages. This makes presenting information over the stages of the life course complicated. To reflect this, the report groups information in to three wider groups of children and young people, adults, and older people, grouping these needs according to where the impact is judged to be the greatest.

Outcomes frameworks

The NHS Outcomes Framework for England was first published in December 2010 and sets out the outcomes and corresponding indicators that will be used to hold the NHS to account for the outcomes it delivers through commissioning health services. The NHS Outcomes Framework for 2012/13 was published in December 2011 and includes 60 indicators across five domains.

The Adult Social Care Outcomes Framework was first launched in March 2011, following consultation on a broader, more transparent and outcome-focused approach to presenting information on what adult social care has achieved. It is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care.

The Public Health Outcomes Framework for England, 2013-2016 was published in January 2012 by the Department of Health. This follows a consultation paper on the proposed Public Health Outcomes Framework which was published in December 2010. The framework sets the context and 'strategic direction' for the new public health system with the vision of 'improving and protecting the nation's health while improving the health of the poorest fastest'.

The framework has two high-level outcomes which underpin the vision:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities (including differences between and within local authorities).

It is proposed that progress on relevant measures within these frameworks should be built into the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, and therefore inform the work and priorities of Health and Wellbeing Boards.

Equality and Diversity

The Equality Act is a piece of legislation that protects us from unfair treatment because of 'the way we are' - that is something we cannot control such as our age or sex. On 1st October 2010 the majority of the Act came into effect. The Act replaced all previous equality legislation, bringing everything together under one single Act including the Disability Discrimination Act, Sex Discrimination Act, Race Relations Act and many other Regulations and Acts and some new additional ones.

It is against the law to discriminate against someone because of any of the following protected characteristics (whether knowingly or not) – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

The Devon Joint Strategic Needs Assessment aims to help ensure that health and social care services do not discriminate against any of these nine groups and where possible help to identify populations and any problems that may be experienced in accessing services.

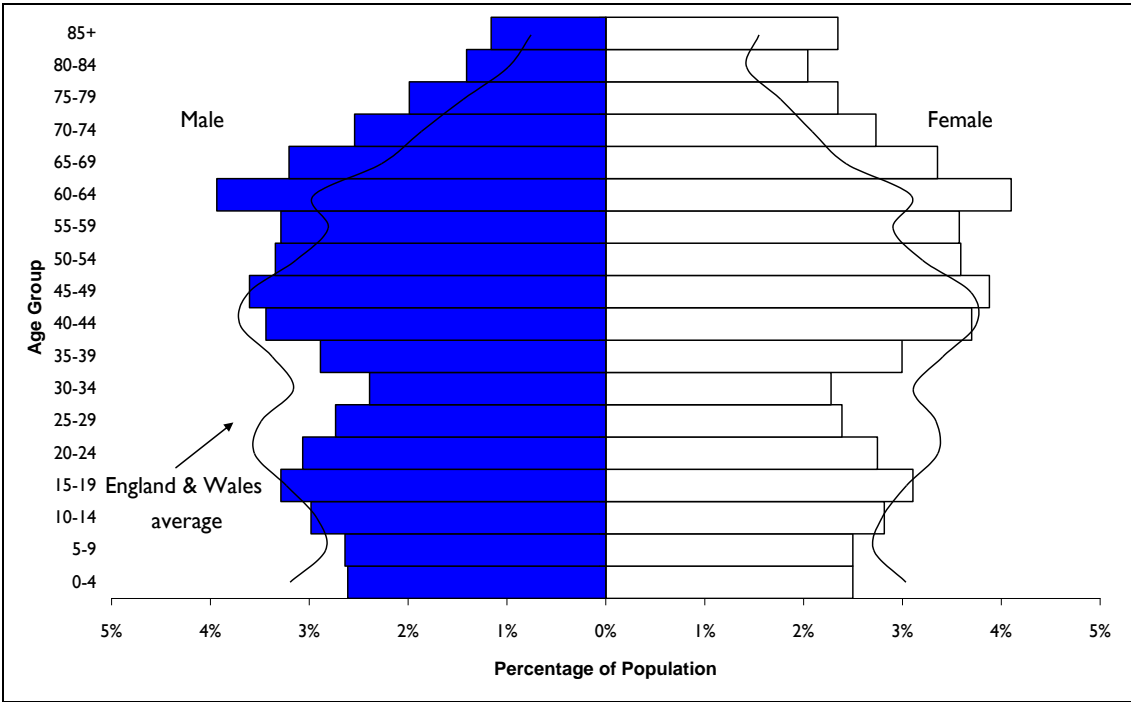
2 DEMOGRAPHICS

Population

Devon has an older population profile than nationally, with particular peaks in those aged 60 to 64 years of age, reflecting significant in-migration in these age groups, and those aged 85 years and over, reflecting an ageing population and longer life expectancy (Figure 2.1). The proportions of those aged 20 to 39 and those under 10 years are below the national average, particularly in those aged 25 to 34 where there is significant out-migration from Devon. This overall pattern is even more marked in areas of East Devon and South Hams, whilst the population in Exeter is more similar to the national average, but with an increased young adult population due to the university.

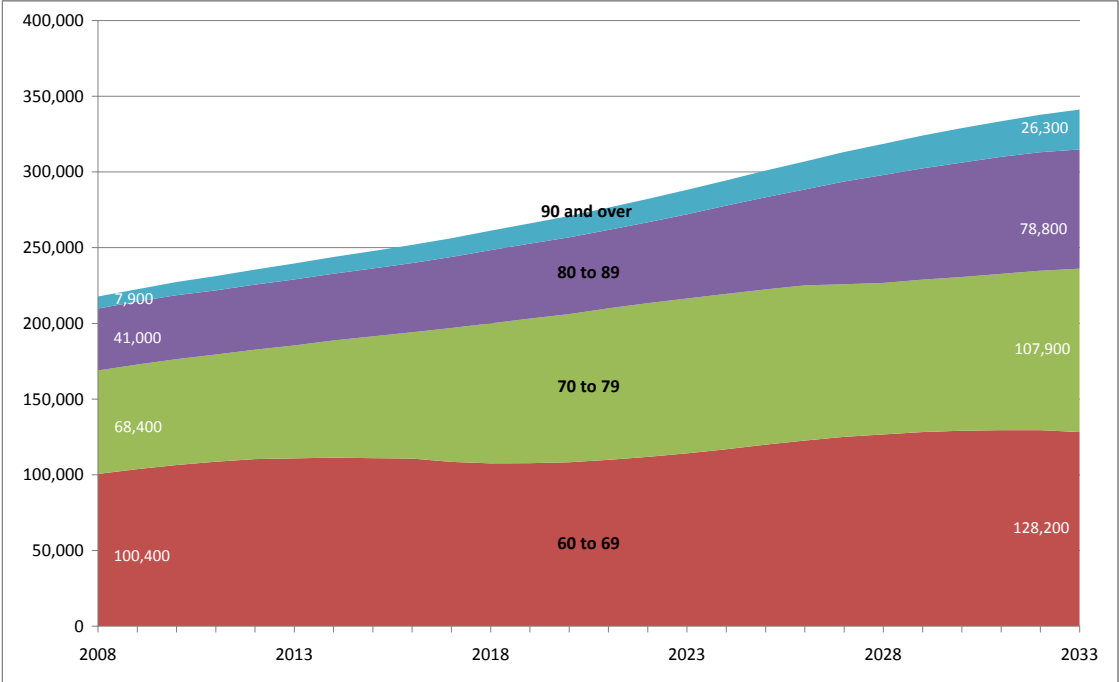
The 2008-based population projections published by the Office for National Statistics (ONS) in 2010, predicted a 20% increase in the Devon population from 746,800 in 2008 to 898,500 in 2033. Whilst modest growth is expected in those aged under 60, population growth is set to be greatest in older age groups (Figure 2.2). This includes a 28% increase in those aged 60 to 69, a 58% increase in those aged 70 to 79, a 92% increase in those aged 80 to 89 and a 233% increase in those aged 90 and above. The publication of the 2011 Census data will be used for estimating and projecting populations in the coming years.

Figure 2.1: Structure of the mid-year 2010 population in Devon compared with England and Wales



Source: Mid-Year Population Estimates, Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 2.2: The projected demographic change in the population structure of Devon, persons aged 60 and over by age group, 2008 to 2033

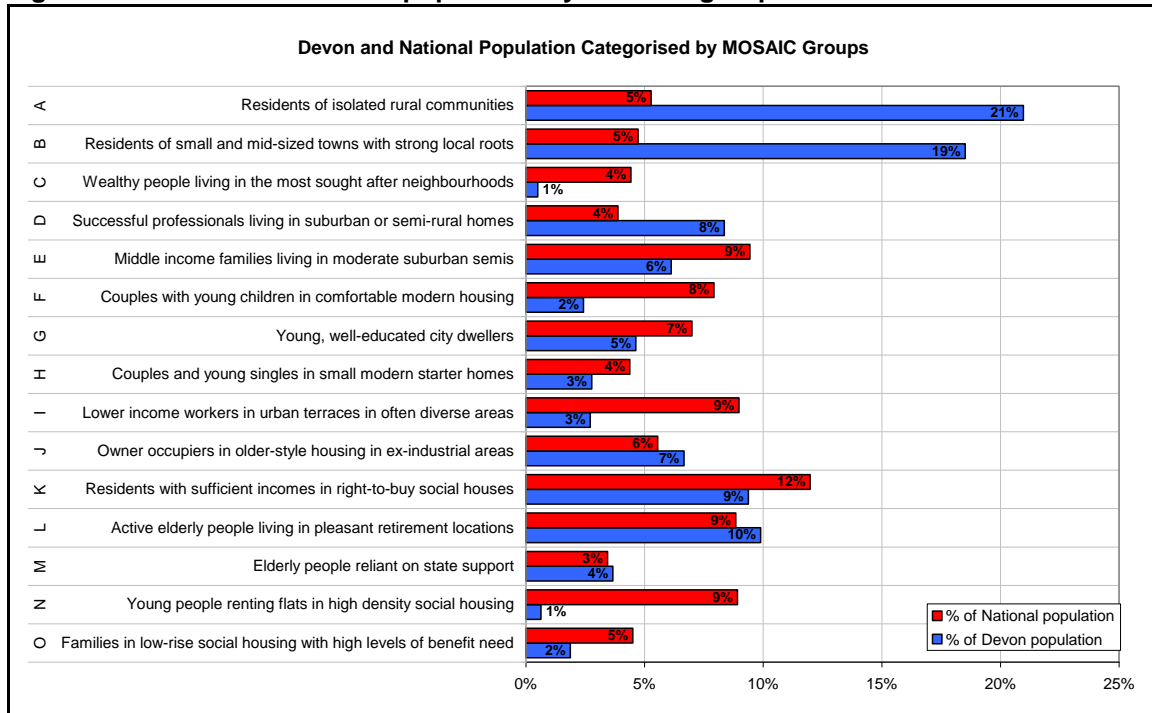


Source: Sub-national population projections, Office for National Statistics licensed under the Open Government Licence v.1.0

NHS Devon and Devon County Council both make use of MOSAIC to gain an additional insight in to the types of people who live in Devon. MOSAIC is a geodemographic profiling tool which classifies postcode areas or households into 15 groups based on characteristics and behaviours of households. The groups can be broken down further which enables areas more susceptible to particular health risks to be identified and targeted with preventative work.

The summary below shows the proportions of the Devon population in each MOSAIC group, compared to the national profile.

Figure 2.3: Devon and national population by MOSAIC group



As would be expected in Devon, the largest groups in Devon are group A – Residents of isolated rural communities and B – Residents of small and mid sized towns with strong local roots.

The 15 groups can be broken down further into 69 types. These give more specific groupings of characteristics and can be used to identify groups of people to enable interventions to be put in place reflecting the needs and characteristics of particular groups.

Ethnicity and Migration

The 2007 estimate of population by ethnic group in Devon local authority districts highlights that 3.4% of the Devon population are from non White ethnic groups, and around 3.0% are from other White groups (typically Irish or European). The highest proportions of people from non White ethnic groups (5.5%) and other White ethnic groups (5.0%) are seen in Exeter. Updated information on population by ethnic group should be available next year from the 2011 Census.

Table 2.4: Percentage of population by ethnic group and Devon district, 2007

Area	White British	White Irish	White Other	Mixed	Asian	Black	Chinese and other
East Devon	94.7%	0.6%	1.8%	0.8%	0.9%	0.5%	0.7%
Exeter	89.5%	0.6%	4.3%	1.2%	1.8%	0.8%	1.7%
Mid Devon	94.7%	0.5%	2.2%	0.7%	0.8%	0.5%	0.6%
North Devon	94.4%	0.6%	2.0%	0.8%	1.1%	0.6%	0.5%
South Hams	94.0%	0.6%	2.5%	0.9%	0.9%	0.6%	0.6%
Teignbridge	94.3%	0.6%	2.1%	0.7%	0.8%	0.5%	0.9%
Torridge	94.2%	0.6%	1.9%	0.8%	0.9%	0.6%	1.1%
West Devon	94.3%	0.6%	2.3%	0.8%	0.8%	0.6%	0.6%
Devon	93.6%	0.6%	2.4%	0.9%	1.0%	0.6%	0.9%
South West	92.0%	0.7%	2.6%	1.1%	1.6%	0.9%	1.0%
England and Wales	83.6%	1.1%	3.5%	1.7%	5.7%	2.8%	1.5%

Source: Neighbourhood Statistics, Office for National Statistics licensed under the Open Government Licence v.1.0

Devon Economy

Devon's position in the South West peninsula has encouraged the growth of major transport links on the eastern side of the county. The county attracts nearly six million visitors per year and the resident population is growing at over twice the national average. High levels of economic activity and relatively high employment rates sometimes mask the low productivity and low average wages within the county. Whilst there are some features that are shared with our neighbouring areas, the economy of Devon has its own unique profile. Shaped by the people that live here and its historic and cultural heritage the Devon economy has developed over the centuries to become vibrant, innovative and dynamic.

There are a number of features which make Devon stand out:

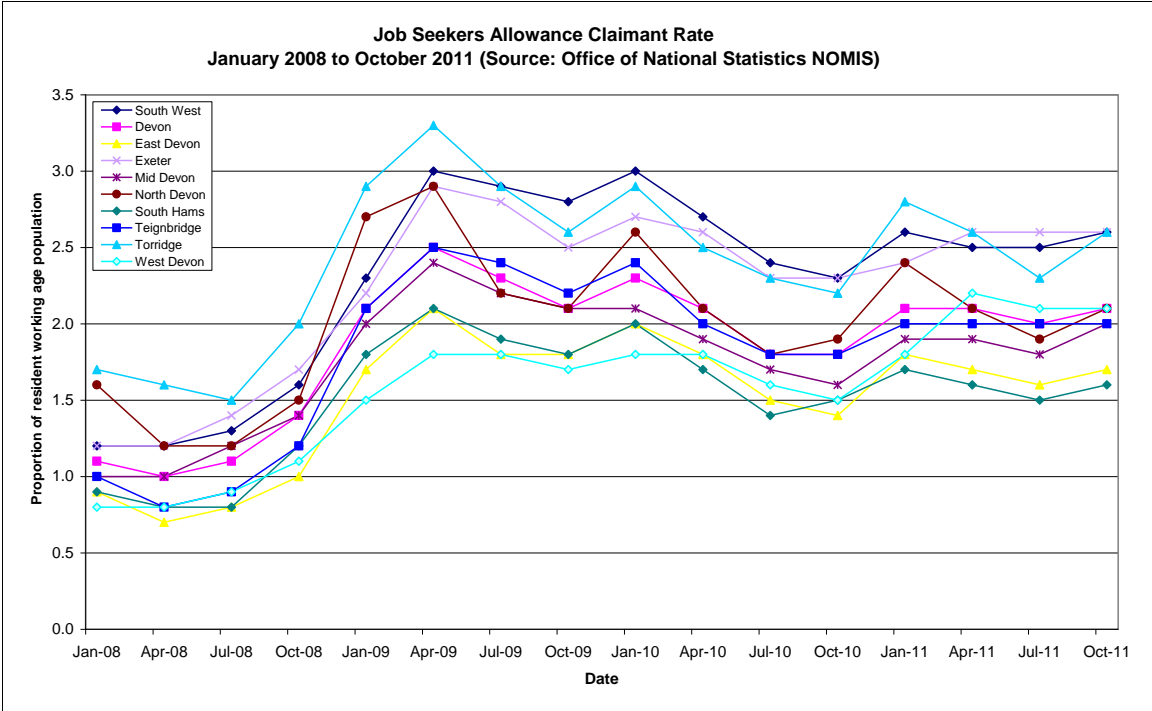
- The county has four times more agricultural activity than the national average
- There are twice as many tourism businesses in Devon than the national average
- Only 14% of employment is in the finance sector
- Almost a third of employment is in the public sector compared to 20% nationally
- Devon is characterised by many small businesses - over a quarter of all businesses are not registered to pay VAT or employ staff
- Well over a third of employees work on a part-time basis

Devon has a population of over 750,000 of which 58% are of working age. This is slightly lower than the national or regional averages. Devon has an older population, mainly due to the in-migration of people of older working age and retirees. Devon has a noticeably higher proportion of economically active people – those in work, self employment or actively seeking work. The number of employees (those working for someone else) is similar to the regional average (just over 64%) but is ahead of the national rate (which is just 63%). However, Devon has a higher proportion of self employed people compared to the national average (almost 13% for Devon compared to 9% for Great Britain).

As would be expected from strong employment performance, the level of benefit claimants (for working age people) is also lower than the national average. Just 12% of people in Devon claim some form of benefit compared to almost 16% nationally (based on average figures for November 2009 – the number claiming Job Seekers Allowance is at a recent historic high but is still below the national average).

Devon has been hit relatively hard by the downturn in the global economy, although it has fared better than some of its neighbouring authorities. The claimant count increased faster than the national rate (from a low point in June 2008 to June 2009, Job Seekers Allowance claimants across the whole of the UK increased by 87%) and regional rates (SW increased by 130% over the year). In Devon the increase was 131%. Figure 2.5 below shows the trend in Job Seekers Allowance claimants by local authority from January 2008 to October 2011. Unemployment is slightly higher among women than men, which is important in an economy with low average wages where families rely on dual incomes. Changes at a local level can have a major impact as well, with a number of business closures in Okehampton contributing to the West Devon claimant rate moving from one of the lowest to one of the highest in the county.

Figure 2.5: Job Seekers Allowance Claimant Rates by Devon District, January 2008 – October 2011



Devon has a large proportion of businesses which are seasonal which have been hit hard by the downturn in economy. These businesses have, as a result of the downturn in the economy, seen a reduction in this seasonal income at the same time as liquidity and borrowing facilities have decreased or where high interest rates have made borrowing prohibitive. This has created a difficult financial situation for many Devon businesses.

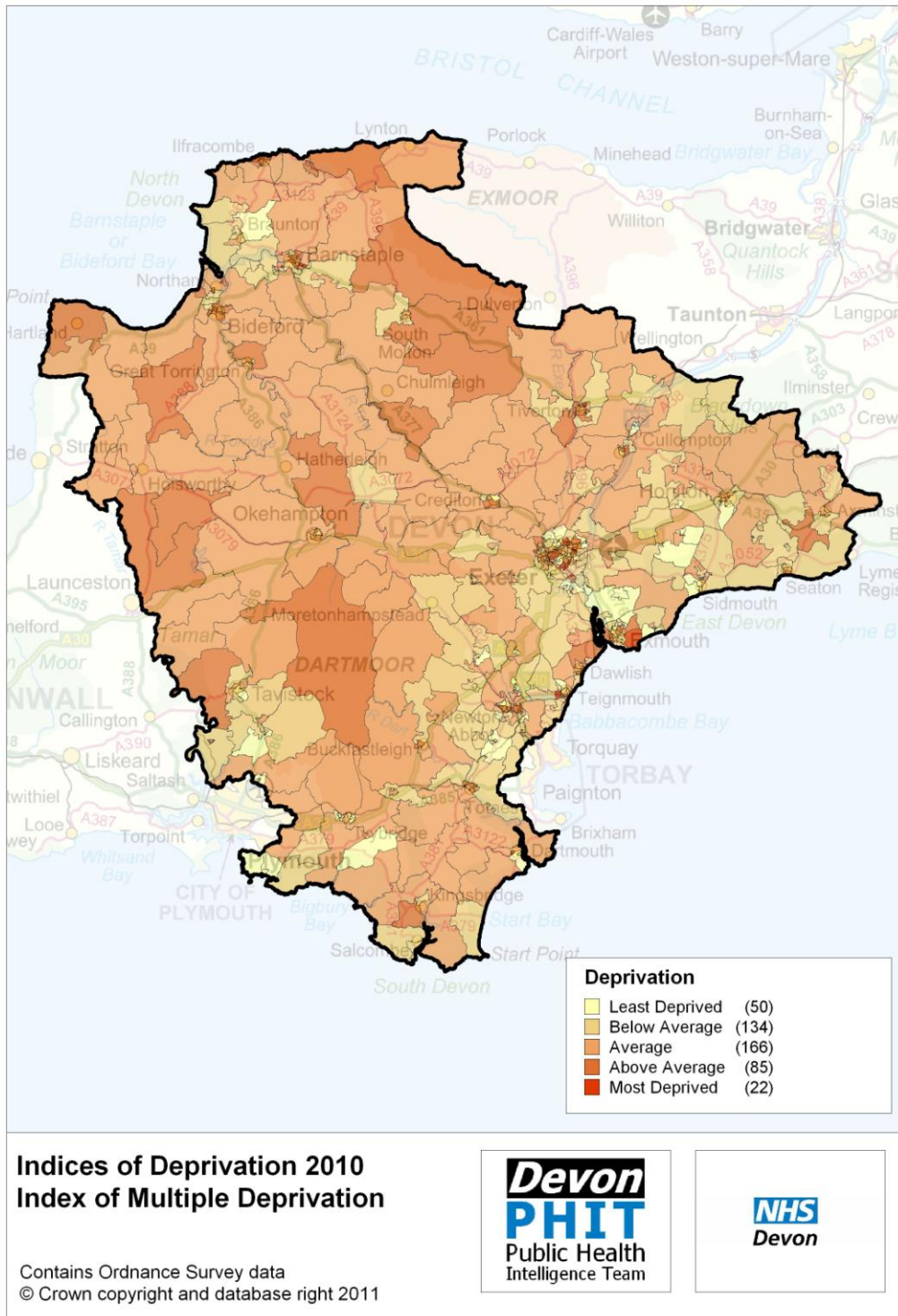
Devon has lower average wage levels than both nationally and regionally. Gross weekly pay in Devon is £430 compared to £460 for the South West and £491 for Great Britain. There is a lack of churn in Devon’s business sector with similar number of firms joining and leaving the VAT register each year. Although this is a reflection of some stability in the economy this is not always a good thing. Some level of change promotes competition which encourages, innovation and productivity improvements. The Devon economy is generally not very productive. The Gross Value Added (GVA) per employee in Devon is considerably lower than both nationally and regionally and also than other neighbouring authorities.

Deprivation

An updated version of the Index of Multiple Deprivation for 2010 was published in March 2011. Figure 2.6 shows Index of Multiple Deprivation 2010 figures by Lower Super Output Area (small areas of similar size created by the Office for National Statistics). This suggests

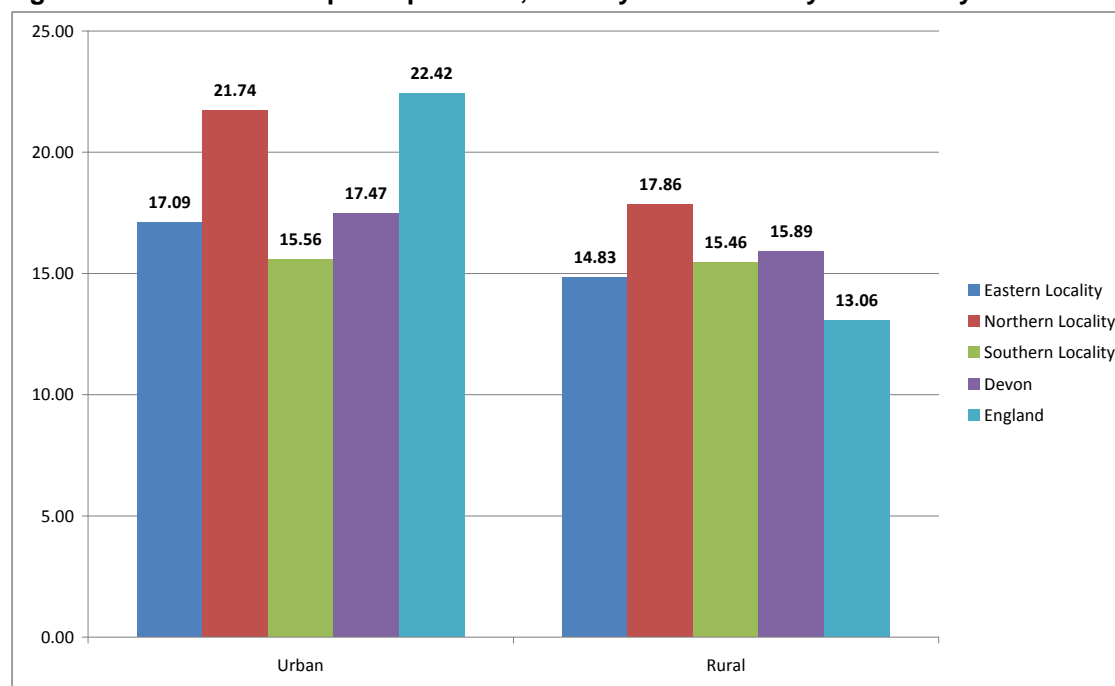
that just below 5% of the Devon population live in the most deprived national quintile (one-fifth). These areas include parts of Exeter, Ilfracombe, Barnstaple, Bideford, Dawlish, Dartmouth, Teignmouth, Newton Abbot and Tiverton. Just over 10% of the Devon population were in the least deprived quintile. While overall levels of deprivation across Devon are lower than the national average, there are issues in relation to rural and urban deprivation which seem to affect Devon differently than is experienced elsewhere. With Devon being a largely rural county this is an important difference to be explored. Figure 2.7 compares average deprivation scores for urban and rural areas in the three locality areas in Devon. This indicates that within Devon rural areas are generally more deprived than rural areas elsewhere in England, whilst urban areas are generally less deprived than urban areas nationally. Furthermore, while urban areas are usually more deprived than rural areas, the rural areas surrounding a number of towns in Devon are more deprived than the town itself, including Crediton, Great Torrington, Holsworthy, Honiton, Okehampton, South Molton and Tavistock.

Figure 2.6: Map of Devon showing Lower Super Output Areas according to Index of Multiple Deprivation, 2010



Source: Indices of Deprivation 2010, Department for Communities and Local Government, Crown Copyright

Figure 2.7: Index of Multiple Deprivation, 2010 by Devon locality and rurality



Source: Indices of Deprivation 2010/Urban and Rural Classification 2004, Department for Communities and Local Government, Crown Copyright

Rurality

Devon is the third largest county in the country, however, it is also one of the most sparsely populated with a population density well below national and regional averages. The rural nature of the area is what attracts many residents and tourists alike to Devon, however it makes planning and delivery of services to meet population needs a complex issue.

Rurality can create problems of accessibility. This can affect all parts of the population, and is a particular problem for people who rely on public transport and with the increasing cost of fuel this is beginning to affect even more people. The distance that people have to travel to access services has a profound effect on whether people will actively choose to access services. This distance decay effect has an impact on people accessing health services from rural areas in comparison with urban areas.

3 CHILDREN AND YOUNG PEOPLE – GETTING THE BEST START

This section looks at health and wellbeing issues which affect infants and children through to young adults. Some issues are specific to particular stages in childhood, whilst others may manifest first during childhood or have the greatest impact at a younger age. Experiences in childhood can shape behaviour throughout life so establishing a good foundation in this stage is vital. Data in this section can help identify priorities to help reduce inequalities experienced in the early years between different geographic areas and different socio economic groups.

Trends in Birth Rates

There are over 7,000 births per annum in Devon. Table 3.1 indicates that the number of births has increased steadily since 2001, with particularly significant increases in babies born to women aged 35 and over. Figure 3.1 presents this information as a rate per 1,000 females in each maternal age group, which reveals stable birth rates in younger age groups and increasing birth rates in older age groups. The birth rate for women aged 35 to 39 increased by 54% between 1997 and 2009 and is getting close to the rate for women aged 20 to 24, which has remained relatively stable across the time period.

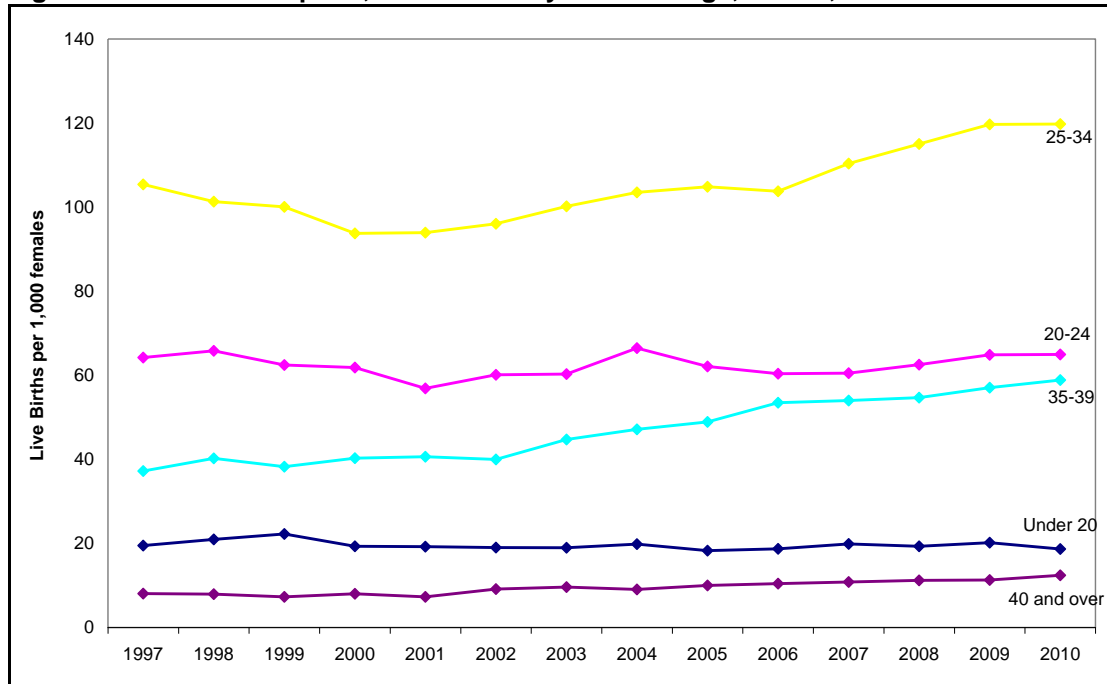
Total period fertility rates look at the mean average number of births per woman if they are to pass through childbearing years conforming to fertility rates by age of a given year. Within the European Union in 2008, the United Kingdom had a higher than average rate of 1.96 compared with 1.60. In Devon, the rate is also above the average but slightly lower than nationally at 1.82.

Table 3.1: Total births by maternal age, Devon, 1997 to 2010

Year	Under 20	20-24	25-34	35-39	40+	Total
1997	370	1,130	4,480	852	180	7,012
1998	411	1,112	4,296	946	180	6,945
1999	441	1,012	4,133	918	167	6,671
2000	383	1,014	3,816	991	189	6,393
2001	385	939	3,711	1,016	176	6,227
2002	384	1,004	3,621	1,019	226	6,254
2003	395	1,019	3,657	1,140	244	6,455
2004	423	1,143	3,664	1,202	237	6,669
2005	406	1,118	3,669	1,233	267	6,693
2006	417	1,141	3,622	1,337	285	6,802
2007	449	1,186	3,808	1,323	301	7,067
2008	442	1,232	3,876	1,313	309	7,172
2009	456	1,271	4,022	1,307	310	7,366
2010	420	1,293	4,049	1,278	333	7,372

Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

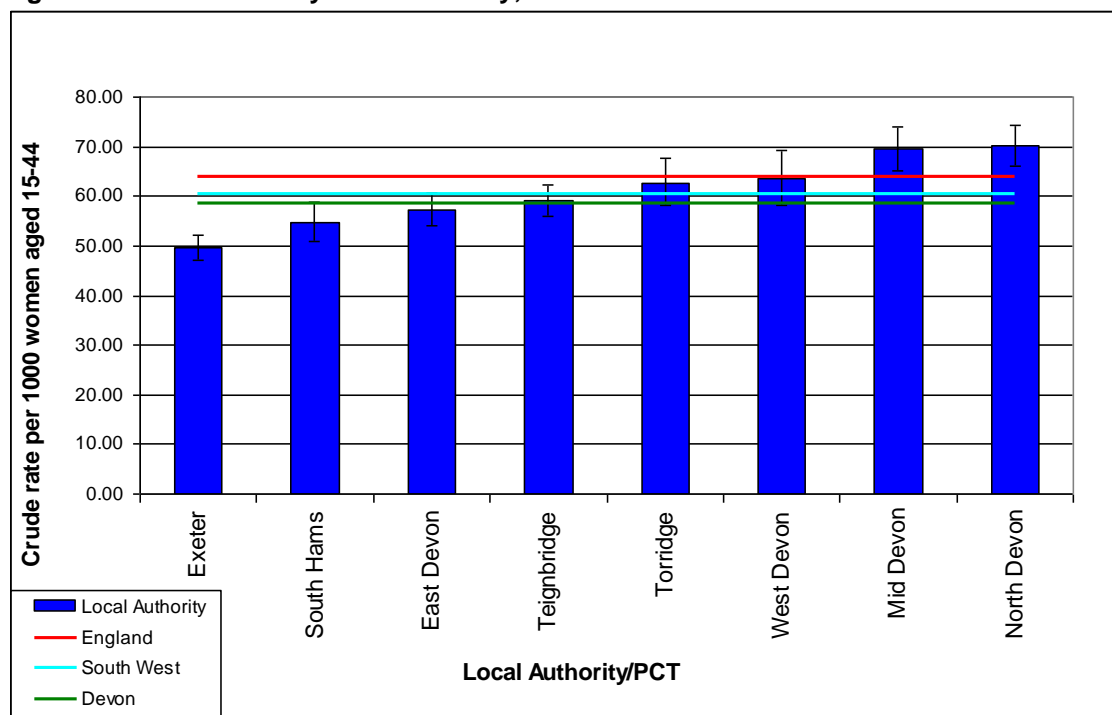
Figure 3.1: Live births per 1,000 females by maternal age, Devon, 1997 to 2010



Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Across Devon, there are differences between local areas in the birth rate. Figure 3.2 shows Exeter and South Hams both have statistically lower rates than the Devon average and Mid Devon and North Devon have statistically higher rates. Devon rates are generally lower than the England rate. Exeter, South Hams, East Devon and Teignbridge are all statistically significantly lower than the national rate with only North Devon being statistically higher.

Figure 3.2: Birth rates by local authority, 2010



Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Smoking in Pregnancy

In Devon around 1 in 8 women smoke in pregnancy (12%). Although this is better than the national average, the impact is startling. Smoking during pregnancy is estimated to contribute to 40% of all infant deaths, by increasing the risk of cot death, risk of premature birth and poorer lung function than babies born to non-smoking mothers. Children born to mothers who smoke are also more likely to become smokers themselves later in life. Highest smoking rates are in the deprived populations and are the leading factor in increased health inequalities amongst babies.

Breastfeeding

Breastfeeding rates in England remain amongst the lowest in Europe. Around 74% of mothers initiate breastfeeding but there is considerable drop off at each stage after this. By six months only around a quarter of mothers are still breastfeeding (UK Infant Feeding Survey 2005).

The World Health Organization (WHO) recommends that infants are fed exclusively on breast milk until the age of six months and then breastfed alongside food for as long as the mother and baby are happy. Evidence shows that as well as providing all the energy and nutrients that the child needs in its first few months of life, breast milk promotes sensory and cognitive development. It leads to slower, healthier weight gain, reducing the chance of later obesity. It provides greater protection from infectious and chronic disease. Babies breastfed for a minimum of six months are less likely to experience colic, constipation, vomiting, diarrhea, chest infections and thrush. Breastfeeding has also been shown to reduce the risk of ovarian and breast cancer in mothers (Department of Health, 2011).

Across Devon at the end of quarter 4 2011-12 76.3% of mothers initiated breastfeeding at birth, compared to 74.0% in England overall. The proportion of mothers still exclusively breastfeeding in Devon by the time of the primary birth visit, at between 10-14 days, is considerably lower at 52.1%. By 6-8 weeks the proportion of mothers exclusively breastfeeding their babies had dropped to 42.9%.

The proportions of mothers either exclusively breastfeeding or mix feeding at 6-8 weeks is monitored by the Department of Health quarterly. Figure 3.3 below shows the trend in both recording of feeding method and prevalence of breastfeeding and mixed feeding across Devon. In quarter 4 in 2011-12 53.7% of mothers were breastfeeding. Devon had a higher rate of breast and mix feeding at 6-8 weeks than both the South West and England average which is shown in Figure 4.5 below.

It is important to note that for initiation and continuation of breastfeeding there are variations between different population groups and geographies. There are significant differences in breastfeeding between the most and least deprived quintiles of the population, and also between different geographic areas across Devon. A detailed topic page is being developed around breastfeeding that explains this in greater detail and details what is being done to try to address this across Devon;

Figure 3.3: England and Devon trend 6-8 week breastfeeding prevalence and recording

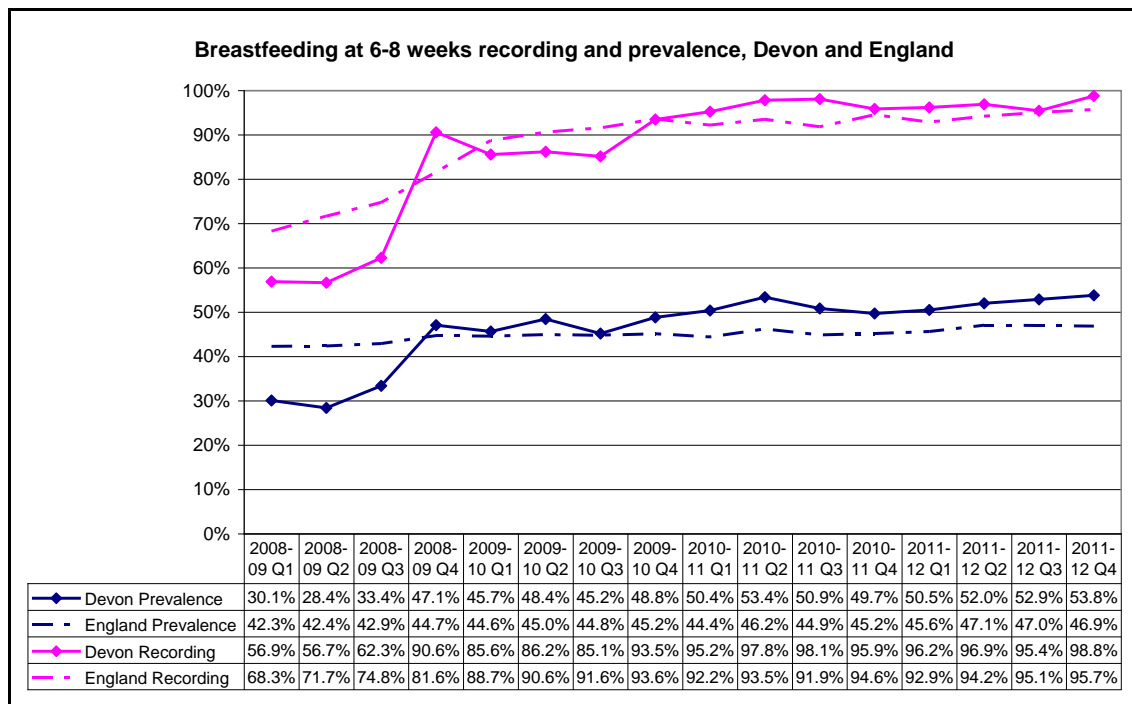
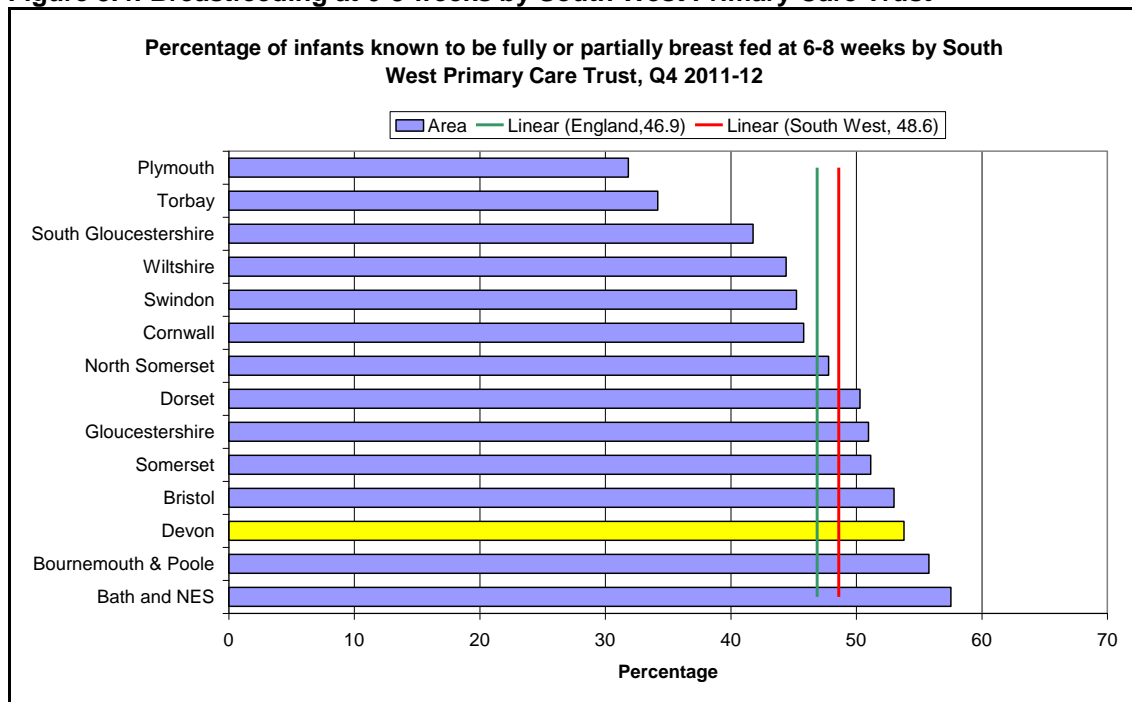


Figure 3.4: Breastfeeding at 6-8 weeks by South West Primary Care Trust

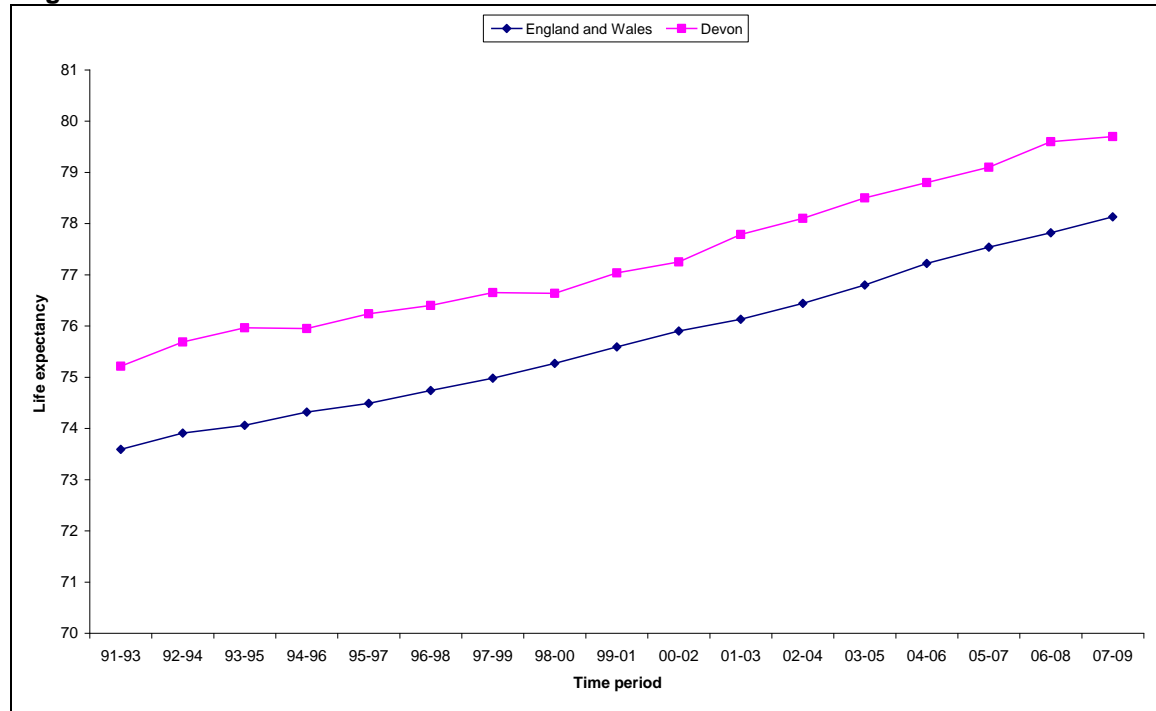


Life Expectancy at Birth

Life expectancy in Devon is above the national average, standing at 79.7 years for males and 83.6 for females compared with 78.1 and 82.2 nationally. Figures 3.5 and Figure 3.6 highlight increasing average life expectancy from 1991-93 through to 2007-09. Whilst Devon has longer life expectancy overall, there are some significant differences on a local level. Figure 3.7 shows overall life expectancy by locality and town in Devon for 2005-09, highlighting shorter life expectancy in northern Devon,

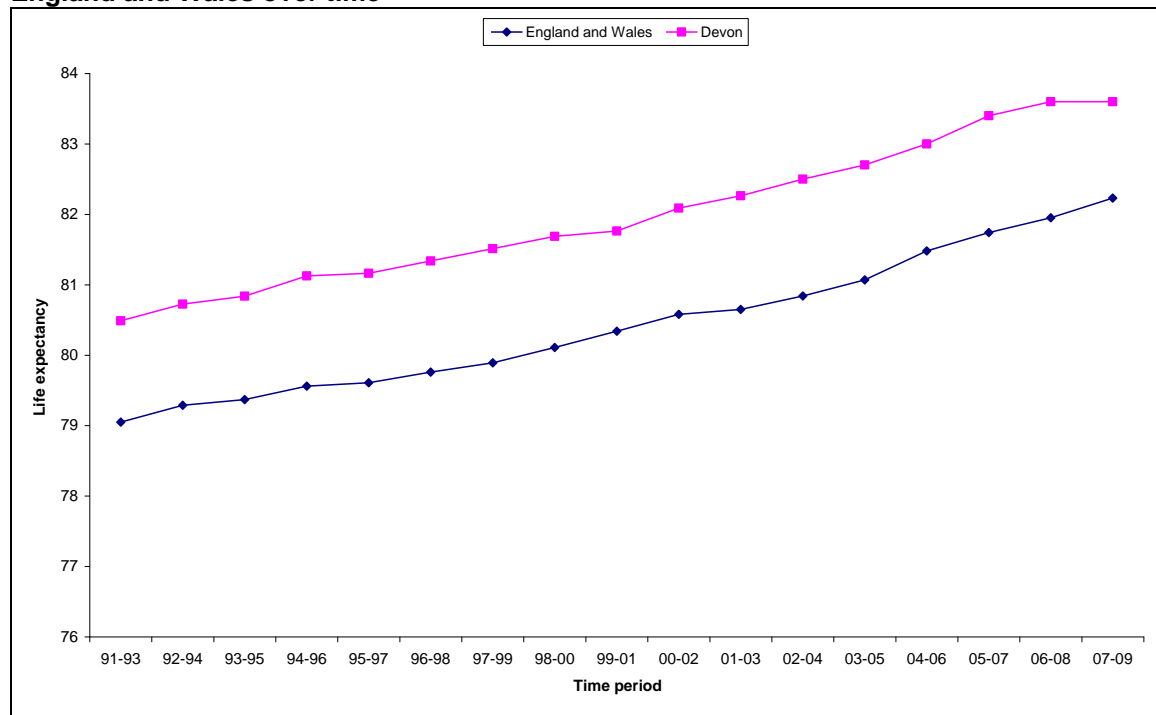
particularly in the towns of Ilfracombe and Bideford. Even greater differences are seen at ward level, as illustrated in Figure 3.8, which reveals a 13.7 year gap between the shortest life expectancy (Ilfracombe Central at 74.7) and the longest (Chagford at 88.4). There are also major differences within districts, such as the 11.7 year gap in North Devon (Ilfracombe Central at 74.7 to Marwood at 86.4), and the 9.6 year gap in West Devon (Lydford at 78.8 to Chagford at 88.4). Table 3.2 shows the life expectancy gap by different geographies across Devon. This clearly identifies the variation among smaller areas in Devon, with the life expectancy gap varying from 0.7 years between NHS Devon localities, and up to 18.9 years by lower super output areas in Devon.

Figure 3.5: Male life expectancy for NHS Devon for three-year periods compared with England and Wales over time



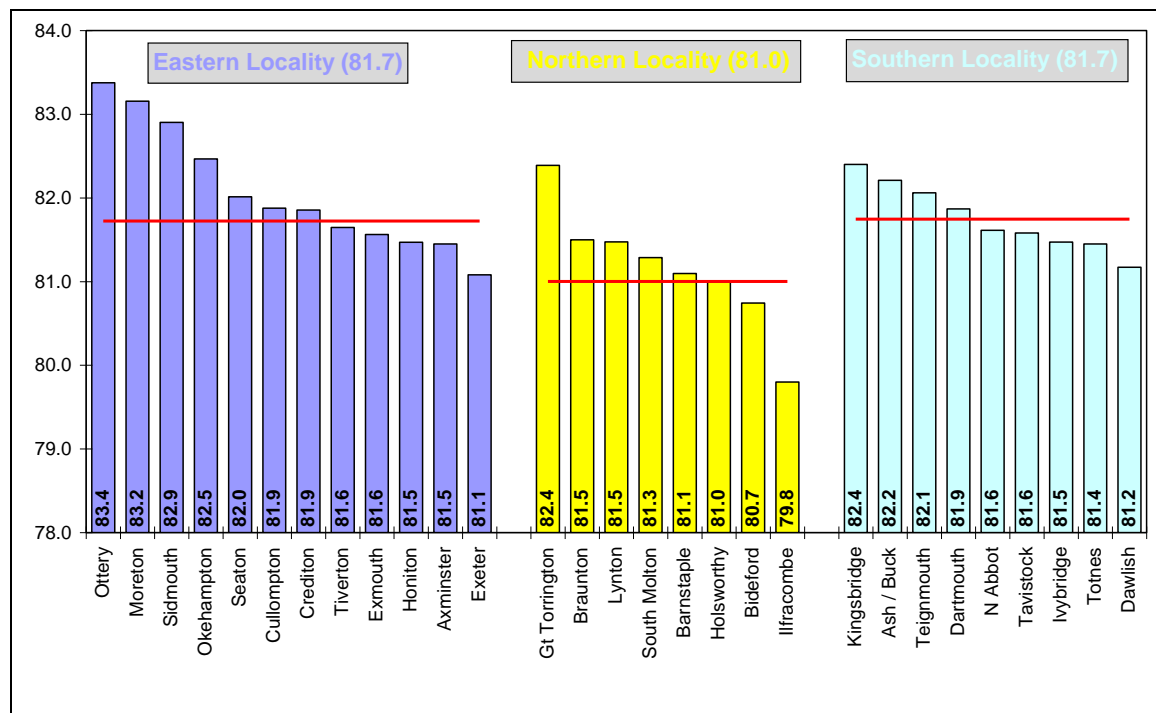
Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 3.6: Female life expectancy for NHS Devon for three-year periods compared with England and Wales over time



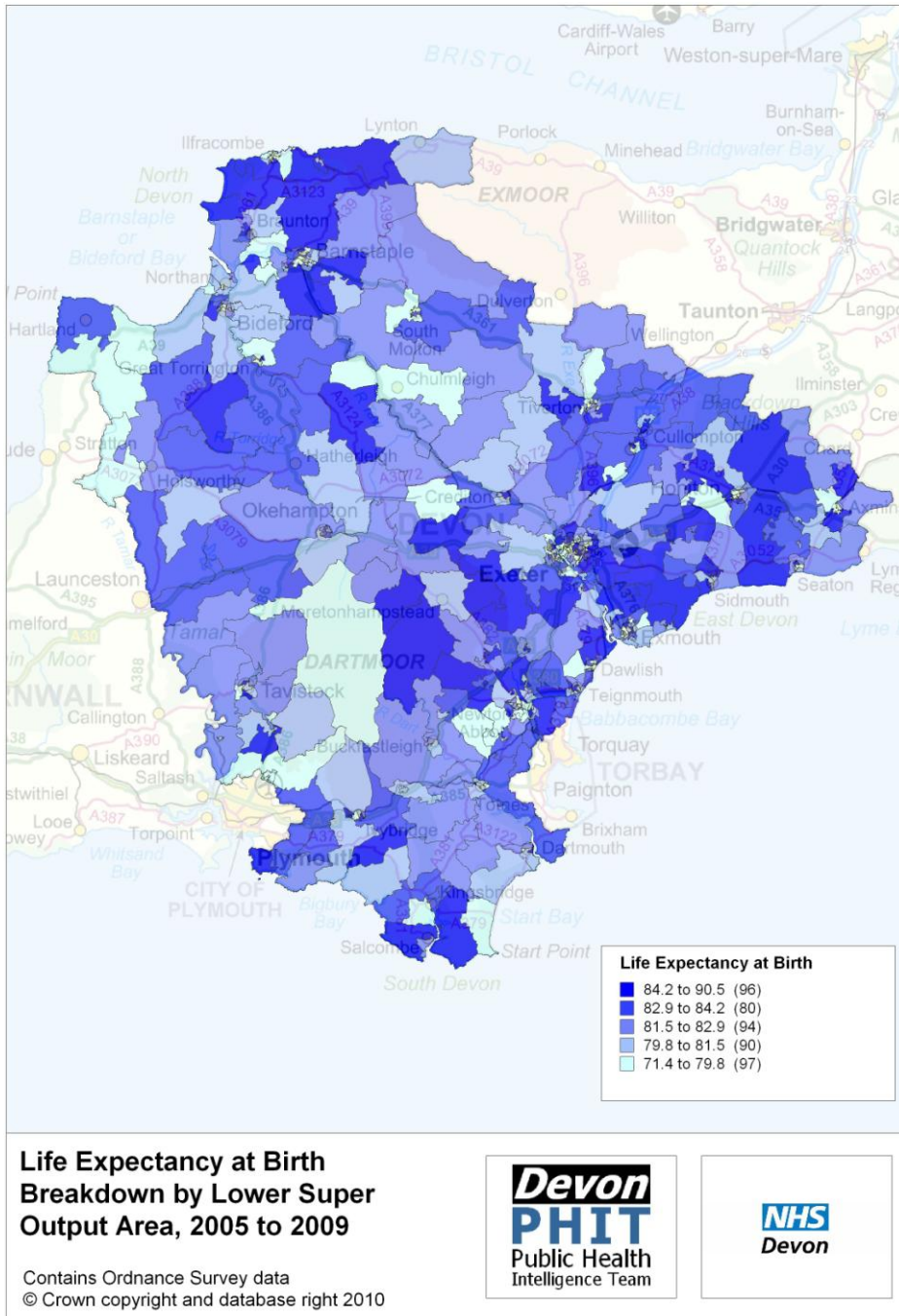
Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 3.7: Life expectancy at birth by Devon locality and town, 2005 to 2009



Source: Public Health Mortality Files, Office for National Statistics, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 3.8: Life expectancy at birth by Devon electoral ward, 2005 to 2009



Source: Public Health Mortality Files, Office for National Statistics, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Table 3.2: Life expectancy at birth by different Devon geographies, 2005-09

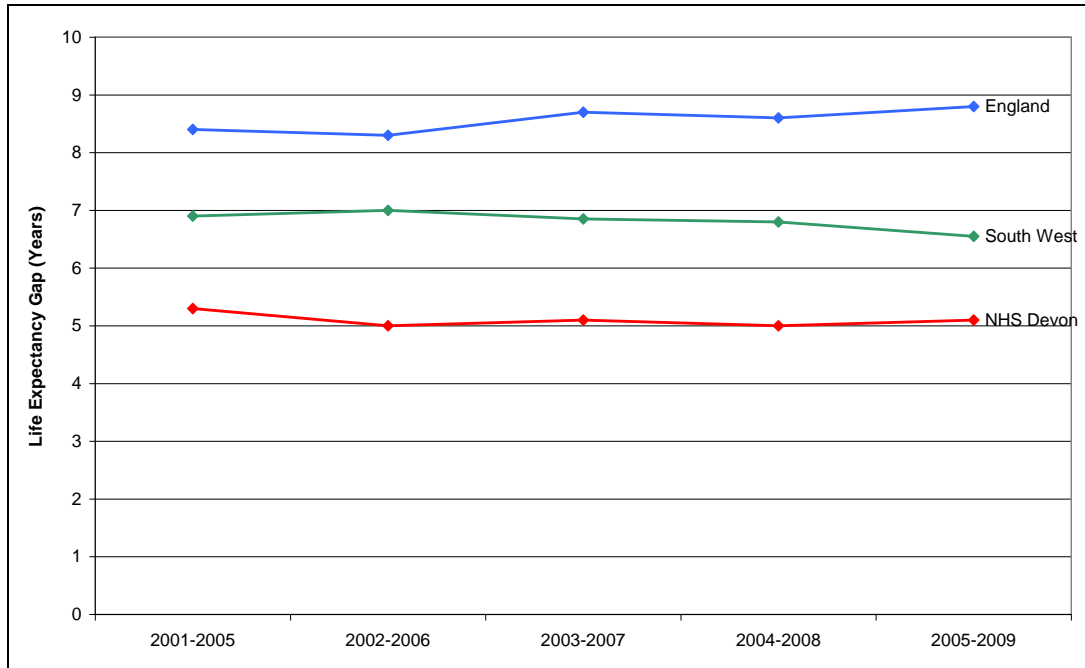
Area Type	Number of Areas	Longest Life Expectancy		Shortest Life Expectancy		Gap (Years)
		Area Name	LE	Area name	LE	
NHS Devon Locality	3	Southern	81.7	Northern	81.0	0.7
Devon County Council Locality	3	Southern	81.8	Northern	81.0	0.8
Consortium	7	Wakley	82.3	North Devon	81.0	1.3
Local Authority District	8	East Devon	82.1	Exeter	80.8	1.3
Devon Town	29	Ottery St Mary	83.4	Ilfracombe	79.8	3.6
Town Centres and Hinterlands	72	Ashburton/Buckfastleigh Hinterland	86.8	Ivybridge: Bickleigh	75.5	11.3
County Electoral Division	62	Exeter: St Loyes & Topsham	84.7	Exeter: St David's & St James	77.3	7.4
Electoral Ward	201	Chagford	88.4	Ilfracombe Central	74.7	13.7
Middle Layer Super Output Area	107	Exeter: University and Pennsylvania	85.3	Ilfracombe: Central and Eastern	75.5	9.8
Lower Layer Super Output Areas	457	Exeter: Gallows Bridge Area	90.4	Ilfracombe: High Street, Fore Street and Quay	71.5	18.9
National Deprivation Quintile	5	Least Deprived	81.6	Most Deprived	77.1	4.5
MOSAIC Group	15	C Wealthy people living in the most sought after neighbourhoods	83.8	N Young people renting flats in high density social housing	73.9	9.9

Source: Public Health Mortality Files, Office for National Statistics, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Slope Index of Inequalities

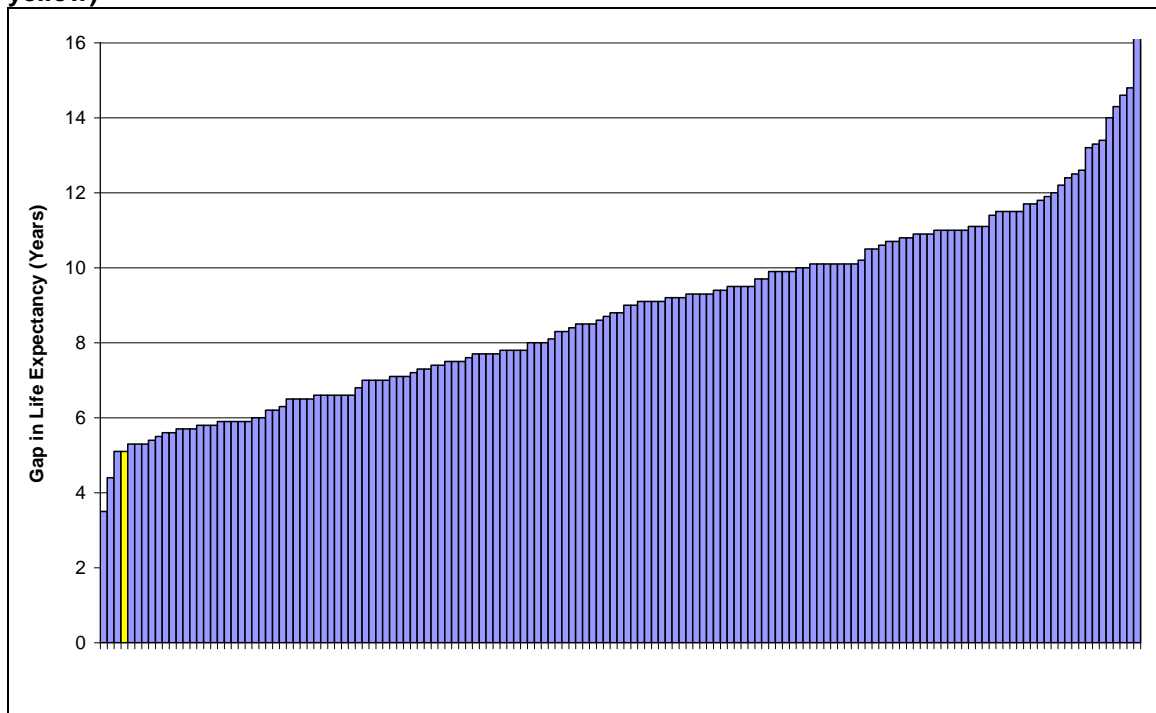
The Slope Index of Inequalities is a national indicator which compares life expectancy in the most deprived 10% of an area's population with the least deprived 10% to produce the 'gap' in life expectancy in years. Figure 3.9 compares the life expectancy gap for males in Devon with the South West and England figures, revealing a significantly smaller gap in Devon. The gap increased slightly between the last two data points both nationally and in Devon, whilst the gap narrowed in the South West region. Figure 3.10 shows the male life expectancy gap for all primary care trusts in England, illustrating that the Devon gap (in yellow) is the fourth smallest in the country. Figures 3.11 and 3.12 present the same analysis for females. Devon has a smaller gap in female life expectancy than nationally or regionally and the gap is reducing in Devon whilst it is increasing regionally and nationally. Devon has the seventh smallest gap in the country. One important element to note with this analysis is that Devon has very few areas which are either very deprived or very prosperous, and therefore does not contain the stark social inequalities seen in other areas across the country. Therefore, in Devon, the small gap in life expectancy shown by this analysis is not a true representation of the levels of social inequality experienced across the county.

Figure 3.9: Gap in average male life expectancy (years) between most deprived 10% and least deprived 10% of Devon population versus South West and England, 2001-05 to 2005-09



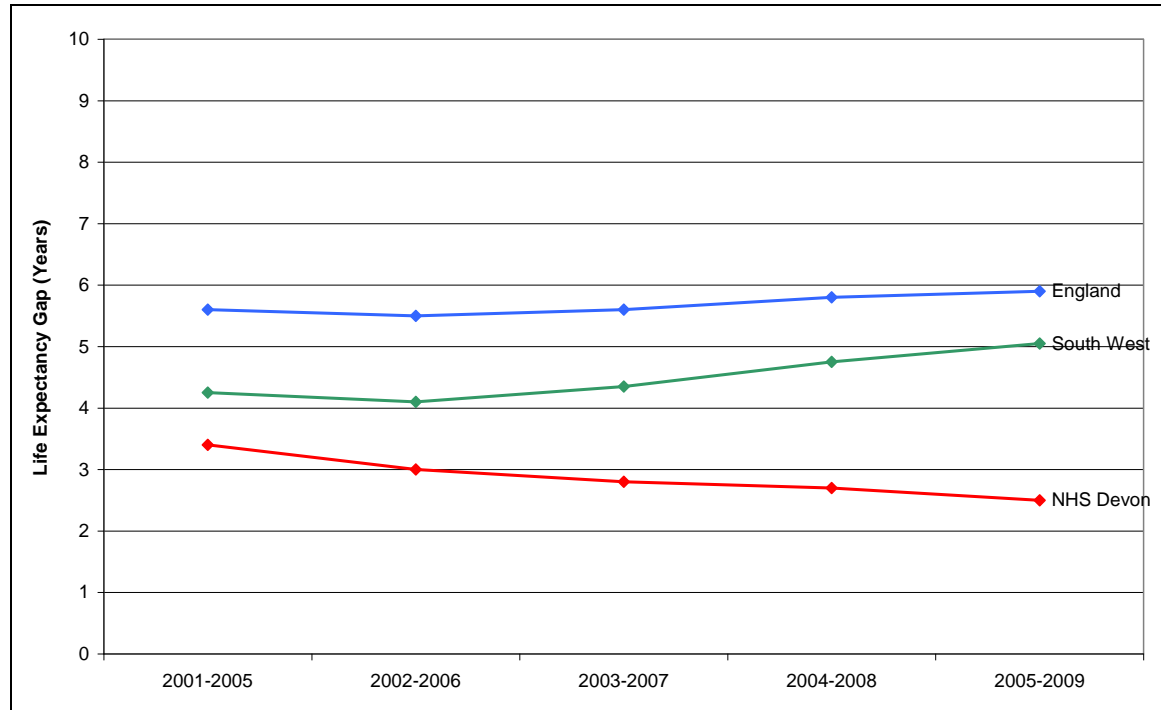
Source: Slope Index of Inequalities, Association of Public Health Observatories. Public Health Mortality Files, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0; and Indices of Deprivation 2010, © Crown Copyright 2011

Figure 3.10: Gap in average male life expectancy (years) between most deprived 10% and least deprived 10% of population by Primary Care Trust, England, 2005-09 (Devon in yellow)



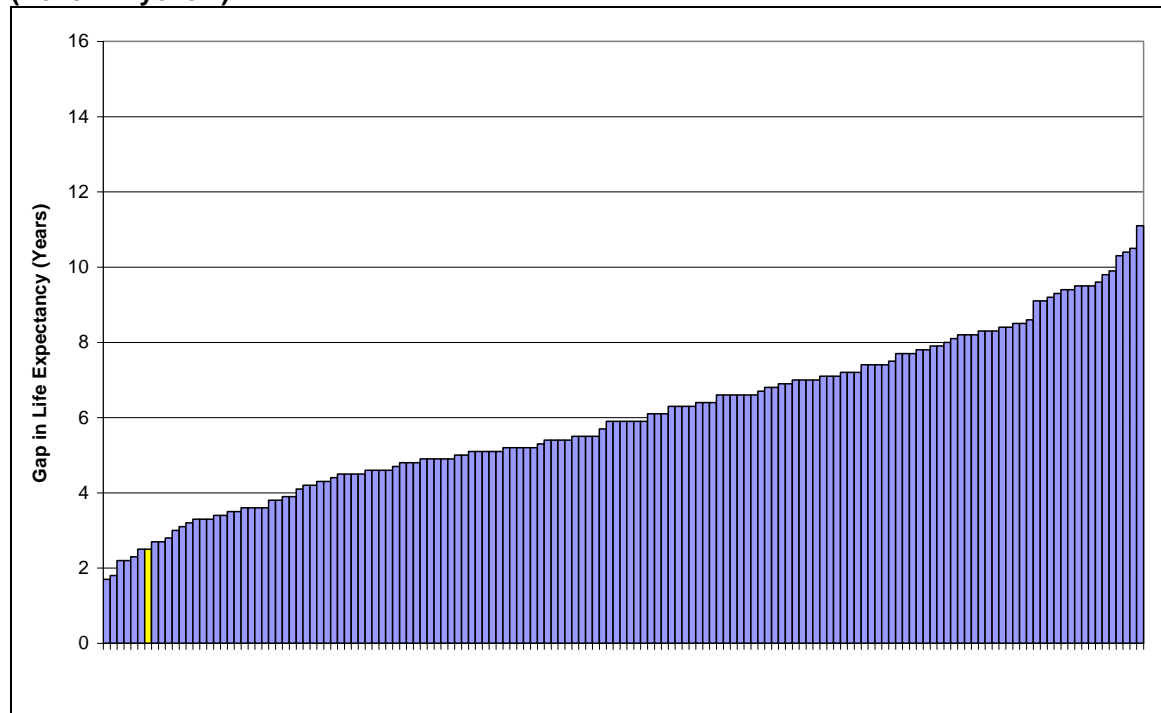
Source: Slope Index of Inequalities, Association of Public Health Observatories. Public Health Mortality Files, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0; and Indices of Deprivation 2010, © Crown Copyright 2011

Figure 3.11: Gap in average female life expectancy (years) between most deprived 10% and least deprived 10% of Devon population versus South West and England, 2001-05 to 2005-09



Source: Slope Index of Inequalities, Association of Public Health Observatories. Public Health Mortality Files, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0; and Indices of Deprivation 2010, © Crown Copyright 2011

Figure 3.12 Gap in average female life expectancy (years) between most deprived 10% and least deprived 10% of population by Primary Care Trust, England, 2005 to 2009 (Devon in yellow)



Source: Slope Index of Inequalities, Association of Public Health Observatories. Public Health Mortality Files, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0; and Indices of Deprivation 2010, © Crown Copyright 2011

Ethnicity in school children

In 2011 there were 4,663 pupils from a minority ethnic background in Devon schools (4,580 of which were resident in Devon). This represents 5.2% of the total maintained school population, an increase of around 5% in the last three years. Over 40 schools now have more than 10% of their roll recorded as Black and Minority Ethnic (BME). However, in contrast, there are still a few schools with no BME pupils. The largest numbers are White Eastern European (637) and White Western European (555).

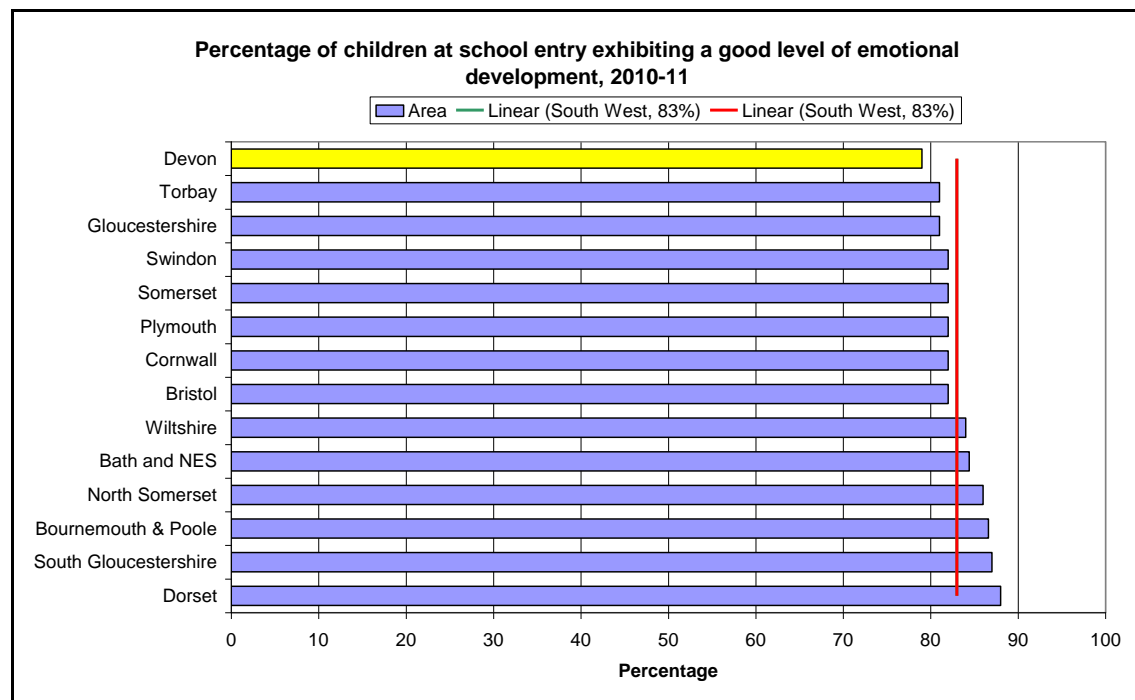
Children with English as an Additional Language

In 2011 there were 2,579 pupils speaking English as an additional language in Devon schools (2,551 of which were resident in Devon). This represents 2.9% of the total maintained school population, an increase of around 50% in the last three years (much of this increase is likely to be due to improved recording). There are around 100 different languages spoken by children and young people in Devon schools, the largest minority languages in 2011 being Polish (381) and Arabic (139) and 90+ speaking German, Bengali and Malayalam.

Education

The Early Years Foundation Stage Profile collects data on the emotional development of children aged five, based on teacher assessments of individual children. These are reported annually to the Department for Education, and the latest published results for 2011-12 indicate that whilst 83% of children nationally and 83% of children in the South West had a score indicating good emotional wellbeing, this figure was lower in Devon at 79%. This highlights that issues around the emotional development and wellbeing of children in Devon may require further attention.

Figure 3.13, Early Years Foundation Stage Profile 2010-11, Emotional Development, Devon in context



Key Stage 4 results improved again in 2010 (54.7% gaining 5 A*C including English and Maths), showing an improvement of nearly 3% on 2009, exceeding the national average by 1.7%. Girls are still outperforming boys with 60.4% to 49.1% gaining five

A*C (inc. E&M). 14.4% of students achieved the new recently introduced English Baccalaureate measure, in comparison to the national figure of 15.1%.

The Local Authority has established a 'Narrowing the Gap' Programme to improve the attainment of the lowest 20% of achievers, particular focus areas will be boys, pupils eligible for Free School Meal, pupils with Special Educational Needs status and Children in Care. There is also a 'Raising the Bar' programme to stretch the most able.++

Youth Offending

The principle aim of the Youth Justice System is to prevent offending by children and young people aged 10-17. The life chances of young people who receive a criminal conviction are adversely affected in both the short and long term. Evidence suggests that preventing the onset of offending and persistent re-offending will improve outcomes for those children and young people, their families and communities.

The level of offending by children and young people is relatively low in Devon. 947 young people offended in 2010/11, which equates to 9.8 offences per 1000 10-17 population. Of these, 496 of these were first time offenders, 330 were repeat offenders and 121 were persistent offenders.

The total number of young people aged 10-17 years who offended in Devon has fallen by 30% between 2007 and 2009 and the number of the overall number of offences committed has fallen by 34% within the same period. The highest number of offences committed in 2009 was violence against the person (24%), criminal damage (18%) and theft & handling (17%), whereas arson is the offence that has increased most significantly from 9 offences in 2007 to 33 in 2009 (267%).

Safeguarding Children

Safeguarding Children is the subject of a detailed Joint Strategic Needs Assessment (JSNA) in Devon. Whilst the overall Joint Strategic Needs Assessment process in Devon looks at health and wellbeing in the broadest sense, the Safeguarding Children JSNA collects evidence together for a field where cross-agency arrangements require strong leadership, shared intelligence and appropriate joint commissioning arrangements to be effective. Safeguarding means:

“Protecting children from maltreatment, preventing impairment of children’s health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.” (Working Together to Safeguard Children, 2010)

The Safeguarding Children JSNA is structured around the four themes underpinning the work of the Devon Safeguarding Children Board; protection from maltreatment, prevention of impairment to health and/or development, ensuring safe and effective care, and ensuring a safe environment.

The recommendations in the JSNA are divided into four categories, covering changes to commissioning processes, data collection and reporting procedures, areas requiring strategic development, and changes to working practices.

The full JSNA and a short synopsis of main findings can be found here:

<http://www.devonhealthandwellbeing.org.uk/health-and-wellbeing/groups/safeguardingchildren/>

Accidents and Unintentional Injuries

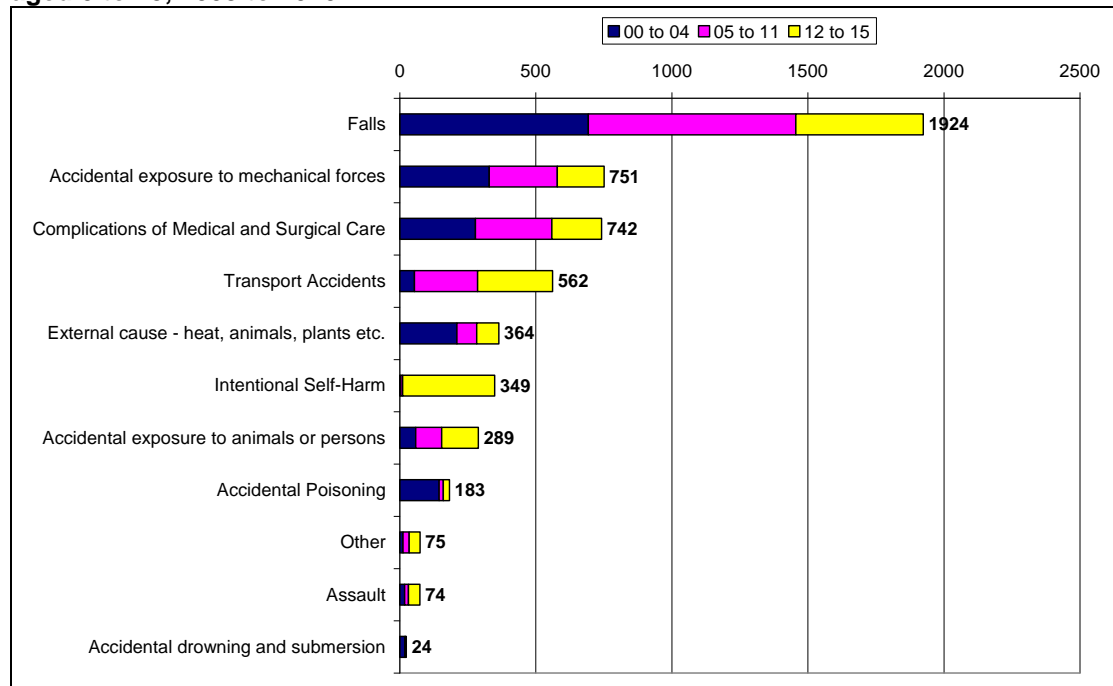
Accidents and unintentional injuries are the leading cause of death among young people between 1 and 14 years of age and cause more children to be admitted to hospital each year than any other reason. Falls are also a major cause of disability and the leading cause of death resulting from injury in people aged over 75 years in the United Kingdom (NICE, 2004).

There are widening inequalities between socioeconomic groups, with areas that experience high levels of deprivation having higher incidence of unintentional injury. In England children who live in the 10% most deprived wards are three times more likely to be hit by a car than children from the 10% least deprived wards (Tonwer and Dowswell 2001). A range of other factors also influence the likelihood of an unintentional injury including personal attributes such as gender, physical ability, medical conditions, an individuals approach to risk taking behaviour and the environment in which they live. However while a combination of these factors create the conditions in which unintentional injuries occur, many are preventable (Audit Commission and Healthcare Commission 2007).

There were a total of 238 accidental deaths in Devon in 2009, with 39 relating to land transport accidents and 199 to other causes. Deaths from land transport accidents are higher in younger age groups. A breakdown of hospital admissions due to injuries from external causes by age is presented in Figure 5.10. This highlights that falls are by far the largest cause of admissions in all age groups.

Falls prevention is identified as a top priority area within the Devon Prevention Strategy: Promoting Independence and Wellbeing for Adults, 2011 – 13 (2010) which builds on work undertaken over recent years within NHS Devon to identify older people at a higher risk of falling to be supported through preventive interventions.

Figure 3.14: Admissions to hospital for Injuries due to external causes by age, persons aged 0 to 15, 2008 to 2010



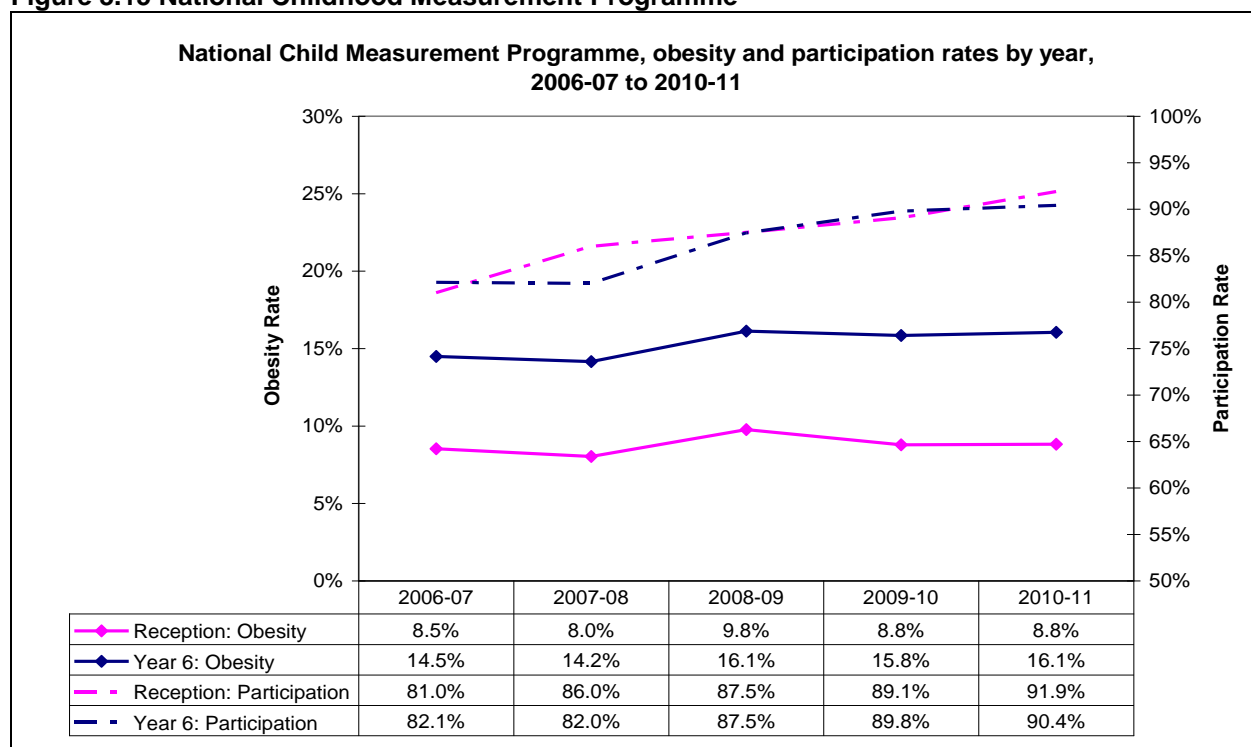
Source: Secondary Uses Service, Commissioning Dataset, National Health Service, Crown Copyright 2011

There were a total of 1,143 emergency admissions (0 to 15yrs) following an accident for the period 2009-10, and a total of 50,745 Accident and Emergency cases for the same age group within the same time period. It is estimated that approximately half of the accident and emergency cases for this age group is as a result of unintentional injuries. In 2009, NHS Devon published the 'Preventing unintentional injuries in children and young people in Devon strategy'. A multi-agency steering group has been established to take forward the recommendations from this strategy. As part of this, a Devon mapping exercise has been completed to identify all current interventions for preventing unintentional injuries. The steering group has also identified areas for improvement.

Obesity

The National Childhood Measurement Programme which weighs and measures children at school entry in Reception year and at the end of primary school in Year 6 is now in its 6th year. The graph below shows the trend shown in Devon over the past 5 years. The participation is now over 90% in both year groups and obesity has shown only a very slight increase. The latest nationally published data is for 2009/10 and shows Devon to be below the national average obesity prevalence rates of 9.8% in Reception year and 18.7% in Year 6.

Figure 3.15 National Childhood Measurement Programme



Sexual Health and Teenage Pregnancy

A sexual health needs assessment has been produced for Devon bringing together vast amounts of information from many sources to help highlight areas with the greatest sexual health needs and those areas with less equitable access to services.

Table 3.3 highlights that in Devon, rates of the main sexually transmitted infections (STIs), Chlamydia, gonorrhoea, syphilis, herpes and warts diagnosed in genitourinary medicine clinics in 2009 were lower than both regional and national rates. Variation in rates can however be seen across Devon with the highest rates of all sexually

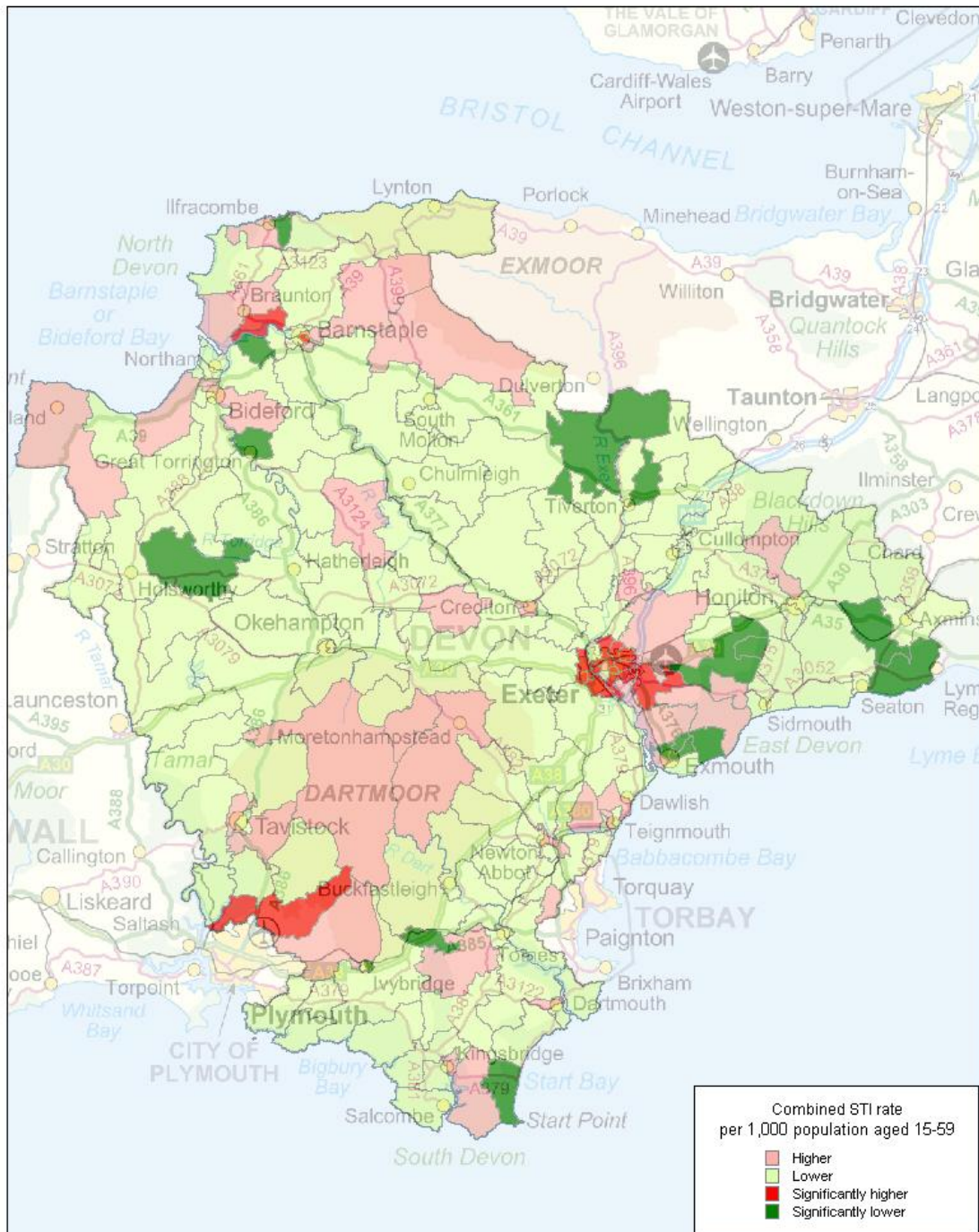
transmitted diseases seen in Exeter. There is also variation within local authorities and this highlights other areas where rates were also high. Figure 3.16 shows a map of all sexually transmitted diseases diagnosed in genitourinary medicine clinics and the variation from the Devon average by electoral ward. It shows a number of areas with statistically significantly higher rates than the Devon average. These are in Exeter, parts of Barnstaple and Bickleigh and Shaugh.

Table 3.3: Rates of selected sexually transmitted infections and acute sexually transmitted diagnoses per 100,000 population, by patient Primary Care Trust, 2009

PCT	Rates per 100,000 population: 2009						
	Chlamydia (by age group)		Gonorrhoea	Syphilis	Herpes	Warts	Acute STIs
	15-24	25+					
Bath & North East Somerset	1388.1	50.9	17.2	3.3	41.6	118.7	533.1
Bournemouth & Poole	1887.6	107.7	19.5	7.6	66.7	212.4	828.0
Bristol	2219.1	115.3	45.8	3.6	51.5	157.1	960.8
Cornwall & Isles of Scilly	2185.5	49.9	9.4	1.5	45.5	132.5	674.7
Devon	1846.4	49.4	9.8	2.1	39.9	118.3	558.7
Dorset	1741.1	61.1	6.9	0.5	33.8	133.1	735.6
Gloucestershire	2185.7	54.2	13.9	1.5	30.2	121.2	663.4
North Somerset	2852.5	91.9	22.2	1.5	63.8	96.2	705.0
Plymouth Teaching	2369.2	110.9	21.0	3.6	88.6	221.5	1049.6
Somerset	1822.3	43.4	8.0	0.8	31.0	102.5	467.1
South Gloucestershire	1820.6	40.7	17.1	1.2	15.9	100.1	476.1
Swindon	2167.3	106.6	14.1	6.6	71.2	160.1	841.6
Torbay Care Trust *	3214.6	71.8	19.4	2.2	47.8	150.0	744.6
Wiltshire	1790.8	51.7	6.6	1.8	31.4	102.1	481.9
South West	2035.3	65.9	15.1	2.3	43.4	132.6	669.1
England	2180.6	94.4	28.5	5.2	49.6	141.2	774.6

Source: Health Protection Agency Centre for Infections (GUMCAD)

Figure 3.16: Combined rates of sexually transmitted diseases compared to the Devon average, 2009



Combined Rates of Chlamydia, Gonorrhoea, Syphilis, Herpes and Warts Diagnosed in GUM Clinics by Electoral Ward, Comparison to the Devon Average Rate, 2009
 Source: GUMCAD Health Protection Agency, Centre for Infections

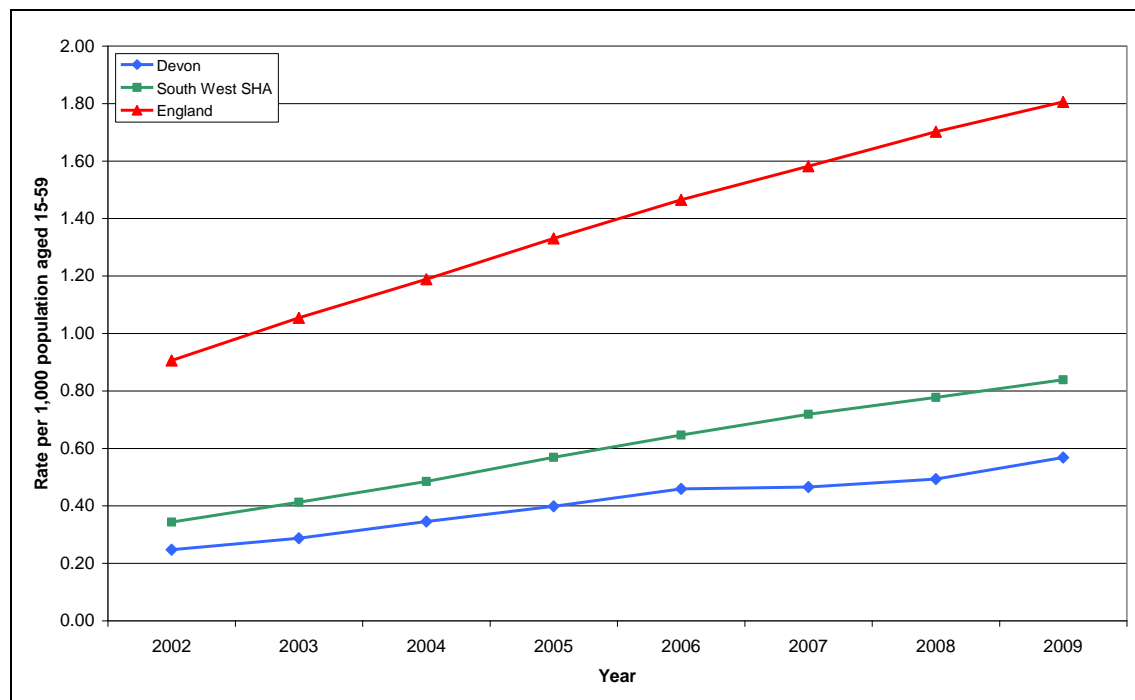
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Source: GUMCAD Health Protection Agency, Centre for Infections

HIV (Human Immunodeficiency Virus) remains one of the most serious communicable diseases in the United Kingdom, associated with morbidity, mortality and high numbers of years of life lost. There are high costs associated with both treatment and care. In the United Kingdom, health protection data shows an increase in HIV cases from under 2,000 in 2001 to nearly 3,800 in 2010. The numbers vary across the United Kingdom and Devon has a lower rate than the South West and United Kingdom average. Figure 3.17 shows the prevalence of HIV in Devon, the South West and England. Although the Devon rate is considerably lower than nationally, rates are increasing at a similar pace. Prevalence varies across local authorities with South Hams having the lowest prevalence (0.35 per 1,000 aged 15 to 59) and Exeter having the highest (0.96 per 1,000 aged 15 to 59).

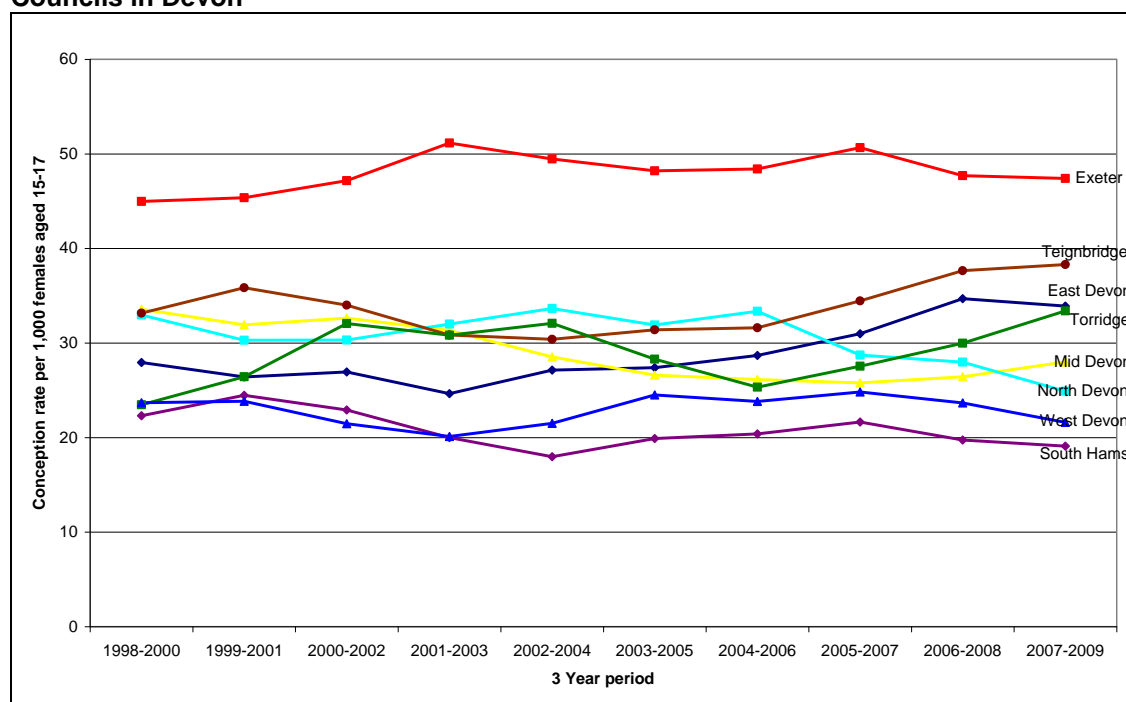
Figure 3.17: Prevalence of HIV Infection, rate per 1,000 population aged 15 to 59, 2009



Source: APHO Sexual Health Balanced Score Card

There is a strong association between deprivation and teenage conceptions, with rates four times higher in the most deprived areas compared with the least deprived areas of England. A similar pattern is seen locally, with the highest rates seen in parts of Exeter, and other deprived wards across the county. Rates in Teignbridge have been increasing year on year, and the latest data (2009) puts the rate just above the national average. Figure 3.18 shows teenage conception rates by District Council for Devon, highlighting that the highest rates are seen in Exeter, with rates above the Devon average also seen in Teignbridge and East Devon. Year-on-year fluctuations are seen, which are mainly due to the low number of conceptions involved at a district level, with overall rates generally unchanged over the last 10 years.

Figure 3.18: Under-18 conception rates per 1,000 15 to 17 year-old females for District Councils in Devon



Source: Teenage Pregnancy Unit, February 2011

NEETS, Education and Learning

By 2015 the target for the proportions of young people in learning is 100%. under the raising of the participation age legislation. The average proportion in learning over 2010-11 was 79.8%. In May 2011 82.4% of young people were in learning and this had increased to 84.6% by May 2012.

The proportion of young people NEET (Not in Education, Employment or Training) over 2011-12 was 5.5%. In May 2011 it was 5.2% and by May 2012 this had reduced to 4.8%. The Raising of the Participation Age strategy does appear to be having an effect with increasing percentages of young people entering learning post 16. However what is crucial is the availability of immediate and longer term sustainable opportunities in the labour market. Young people aged 18-24, looking to enter the labour market may find that, irrespective of their qualifications, they are competing in a market of ever increasing demand with ever reducing supply, a fact clearly supported by the most recent 18-24 unemployment statistics.

Complex and Multiple Needs

The Devon Safeguarding Children JSNA identifies many areas which can all have profound impacts for safeguarding and these risks are increased where there are complex and multiple needs. Complex and multiple needs cover both the breadth of need (more than one need, with multiple needs interconnected) and the extent of need (profound, severe, serious or intense needs). These needs, and combinations of needs, can vary widely from family to family and span the full breadth of health and social issues.

A Devon study in 2010 of 101 young people with a Child Protection Plan found that 99% were living in families with multiple and complex needs.

With respect to the needs and risk factors in the young people's parents

- 33% of young people were affected by both domestic violence and parental mental health issues
- 27% of young people had parents offending and parents with substance misuse
- 20% of young people had both poor housing (inc. homelessness, threat of eviction, unsafe/ overcrowded housing) and domestic violence.

In order to respond to the need for early intervention before social services thresholds are met work is currently being undertaken in Devon to establish the needs and risks impacting a wider range of families by creating a family needs profile of those using the Devon health visitor service. This work is still underway but initial findings suggest there are significant variations in needs, and combinations of needs between families, and that there are clear geographic hotspots for some of these needs. Of the 33 needs identified in the survey 30% of families had more than three needs identified and 12% had more than eight. Ilfracombe and parts of Exeter have a significantly higher percentage of families with multiple needs. For specific issues there was substantial variation by geographical location and by deprivation. Overall 13% of families were recorded as being impacted by domestic violence, rising to 30% in one area. It was most pronounced in areas of high deprivation (6% in the least deprived areas rising to over 25% in the most deprived areas).

Troubled families

A recent Government strategy revolves around Troubled Families. It is stated that £9 billion is spent per year on protecting the children of these 120,000 families and responding to the crime and anti-social behaviours the families perpetrate. Troubled Families Teams are being set up through the Department for Communities and Local Government. Government figures predict that there are 1,370 such troubled families in Devon. In Devon this estimate equates to 164.7 troubled families per 10,000 families.

Transition

The transition between child and adult status can be a vulnerable time for young people. The age of transition from 'child' to 'adult' status varies across services locally and nationally. Services for care leavers and persons with learning disabilities continue until the age of 25, whilst adult services for substance misuse start at age 19, and mental health at age 18. Whilst these transition ages align with national policy and practice, this staggered movement to adult services itself can be seen as a safeguarding risk. Thresholds for service eligibility can vary between child and adult services as well, meaning that in some cases support is effectively discontinued.

4 ADULTS – GETTING THE BALANCE RIGHT

The following section covers issues relevant to different stages of adulthood. There are many different stages in adulthood and some topics will be relevant to all stages and others just to part of adulthood, for example, adjusting from being teenagers to young adults' means that young adults have needs in some areas that are not relevant in later adulthood. This section aims to bring as many topics together as possible and if necessary identify the part of adulthood where they are particularly relevant.

Screening

The NHS Cervical Screening Programme was set up by the Department of Health in 1998. The aim of the programme is to detect cervical cell abnormalities which if left untreated could lead to cancer in a woman's cervix. It is estimated that national

programme saves up to 4,500 lives in England every year. The programme offers screening to all eligible women between the ages of 25 to 64 every three to five years depending on age.

The effectiveness of a screening programme is, in part, judged by its coverage rate. Evidence suggests that if an 80% coverage rate can be achieved over time, this will reduce death rates by 95%. Since 2005, NHS Devon has consistently maintained a coverage rate above 80%. This has remained consistently above the coverage rates for England and the South West for the same period.

Although overall Devon is performing well in relation to coverage, there is variation across practices. At the end of 2010-11 the Devon coverage rate was 81.6%, however, there was a 20% difference between the highest and lowest practice coverage which ranged from 71.0% to 91.8%. Analysis has also been done by deprivation, which has shown a relationship to coverage. Those practices in the most deprived areas generally have poorer coverage.

The NHS Breast Screening Programme was set up by the Department of Health in 1988. The aim of the programme is to detect and treat breast cancer at an early stage before symptoms become apparent. It estimated that 1,400 lives are saved each year. 96.4% of women who have had invasive breast cancer detected by screening are still alive five years later. The National NHS Breast Screening Programme offers screening to all eligible women between the ages 50-70 every three years.

The minimum recommended coverage rate is 70%. Data from the NHS information centre for Health and Social care indicated that between 2006 and 2010, NHS Devon has achieved above 70% during this period. Local data suggests that for 2010-11 this was 75.7%. A similar pattern is shown in practices with a 28% difference between highest and lowest practice coverage. A similar pattern is also shown around deprivation, with those practices in the most deprived areas generally having poorer coverage.

Uptake of screening in women with learning disabilities is known to be significantly lower than that of the general population. NHS Devon is able to identify individuals with learning disabilities who have been recorded on the Care First social care register and who are within the eligible age range for each of the national screening programmes.

This register is being used ensure that all eligible individuals who have not attended for screening are given the same opportunity as the general population. Although the register accounts for only 20% of individuals with learning disabilities across Devon, it is the most reliable and consistent data source we have. An audit undertaken in December 2011 indicates that within this group, 37% women attended cervical screening and 50% attended for breast screening. We hope that by putting in place a clear process to identify non attenders' and providing targeted support to these individuals that uptake will be improved across all screening programmes. To support this, learning disability screening pathways have recently been agreed with screening providers to create a process to ensure individuals are able to attend through informed choice or a 'best interest process' is initiated should the individual not be able to give consent.

Housing

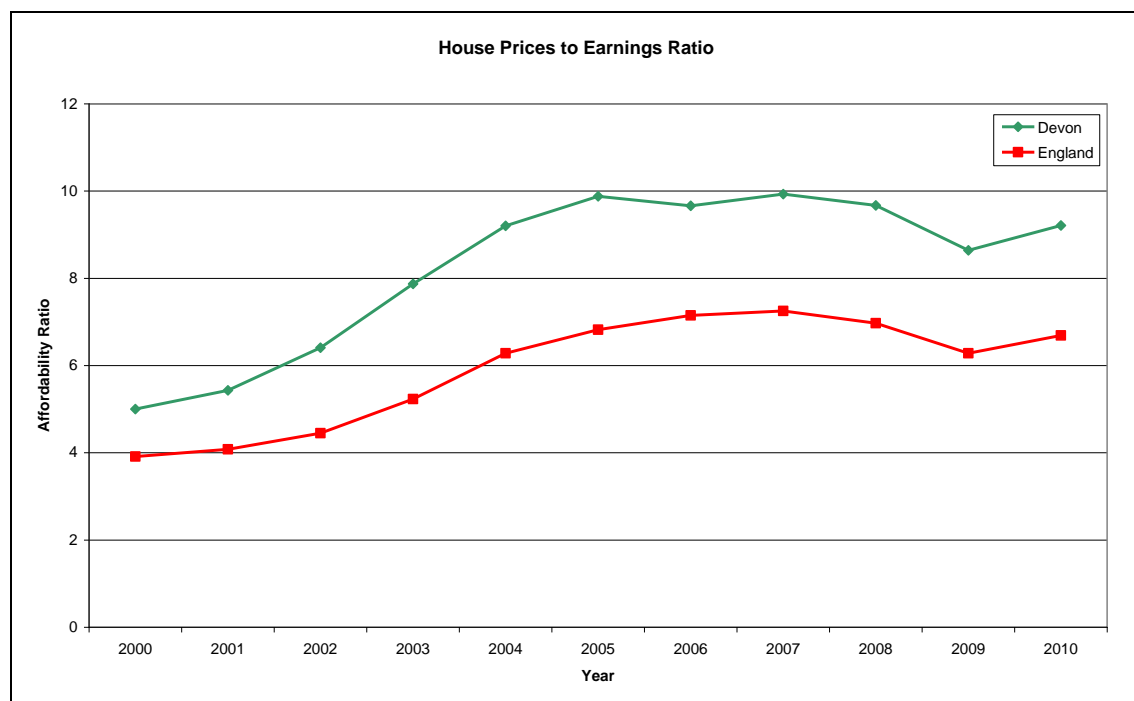
The standard of accommodation is a major contributory factor in attaining good health. Conversely poor housing can precipitate a range of physical and mental health conditions. Minimising the adverse effects of poor housing remains a challenge for health, local government and voluntary agencies. Poor Housing in England is costing the NHS in excess of £600 million a year, so money invested in dealing with poor housing will result in a financial benefit to health.

In relation to the links between housing and health inequalities it is useful to look at the housing tenure of vulnerable groups and the condition of that housing. Data shows that in Devon vulnerable households account for just under a fifth of the population living in private rented housing. In the South West region vulnerable households live in worse accommodation than anywhere else in the country.

In terms of decent homes, thermal discomfort (excess cold or heat) is the biggest health risk in Devon with trips and hazards and overcrowding also significant health risk factors. Appropriate housing is also a major contributory factor in the 'recovery process' for people with mental health or substance misuse problems. Conversely poor mental health or substance misuse can often lead to tenancy breakdowns and in the case of those with mental health could precipitate a hospital admission.

Health inequalities are related to the shortage of new homes and the affordability of housing in general. Affordability can lead to poor mental health; over six million households state that they are suffering from stress and depression due to their housing costs, whilst 14% of households live in houses that are too small for them. The ratio of house prices to earnings is one measure of how affordable it is to buy a property. The higher the ratio, the less affordable it is for households to get onto the property ladder. Figure 4.1 shows affordability ratios across Devon are higher than the national average. The ratios vary from district to district and in 2010 the highest ratio was in South Hams and the lowest in Mid Devon.

Figure 4.1: House Prices to Earnings Ratio, 2000-2010, Source: Devonomics



Homeless

Homelessness and, in particular, rough sleeping is often viewed as a problem which only exists in large cities. However, there is a significant number of people homeless and rough sleeping in Devon, not just in the larger urban areas such as Exeter, but also in the more rural and remote parts of the county.

Homelessness can have a considerable impact on an individual's health and wellbeing. It is also a complex issue that crosses departmental and organisational boundaries, covering health, social care, housing, criminal justice systems and welfare services.

Rough sleeping can be seen as the tip of the iceberg; it is the most visible form of homelessness, it is sometimes also referred to as chronic homelessness. The past two years has seen an increase in rough sleeping nationally. The evaluation method has been changed by the current government; arguably this combined with the economic downturn has seen numbers of rough sleepers rise. Data from outreach services based in Exeter and North Devon and Supporting People show that there were approximately 336 people who slept rough in Devon (April 2009 – March 2010). This indicates a high level of turnover in numbers over a year. Those individuals who experience 'chronic homelessness' (rough sleeping) tend to be predominately male, predominately white and predominately substance misusers (both drugs and alcohol).

The homeless population often have a range of complex needs which makes engagement with health, social and welfare agencies difficult. These needs in isolation often do not solicit a response from statutory services as they do not meet the threshold for an intervention, however combined with other issues including lack of accommodation, poor budgeting skills, trauma, a lack of social skills and 'anti social behaviour' some individuals are caught in a cycle of chronic exclusion, unable to get the support needed to cope with basic functions of every day life.

A Health Audit was carried out in November/ December 2010 focusing on Exeter, North Devon and South Devon. There were 259 respondents and the data was used to inform a Homelessness Health Needs Assessment. National data shows that a disproportionate number of people with mental health problems experience homelessness and end up rough sleeping (St Mungo's 2008). The Devon Health Audit showed a similar picture with 47% of homeless respondents reporting one or more diagnosed mental health need.

Migrants

In 2009 a health needs assessment was produced for migrant workers across Devon. Whilst human migration has taken place for centuries there has been an increase in world wide mobility in recent decades. Migration has the potential to be hugely beneficial to society. Migrant workers actively contribute to economic prosperity, they are often highly educated, and inward migration helps to balance the demographics (migrants typically being young adults). Nationally 85% of migrants, from European and non-European countries are aged between 15 and 44 years and tend to have general health needs similar to individuals of equivalent age and sex as the indigenous United Kingdom population. Migrant workers are a very heterogeneous group and can be classified in many different ways, for example by nationality, country of origin (which could be country or birth or country of last residence), ethnicity, language or religion. The South West was one of the regions considered to be a high net migration area in 2006 and was in the top three areas in the UK for migrants from Poland, Lithuania and Slovakia in particular but migration from these Eastern European A8 states has declined sharply in recent years. Commissioners can lack adequate data to be able to

satisfactorily assess the health needs of this specific community and assure themselves that any inequalities in access to health care are being addressed.

Travellers

Evidence suggests that Gypsy and Travellers of all ages experience more poor health than any other disadvantaged group living in England. Although we lack robust evidence around the number of Gypsies and Travellers nationally and also locally as there is no complete process of counting, there is sufficient evidence from a number of studies of the inequalities experienced by Gypsy and Traveller communities including in-equalities in health that must be addressed. The 2001 Census failed to include gypsy or traveller as an ethnic group and was therefore unable to offer information about this group as it was about others. The 2011 Census took place in April this year and this did include Gypsy or Irish Traveller as an option in the ethnic group question. This data will not be available until later in 2012 and correlated data of ethnicity and other indicators maybe later still. Depending on the response rate of Gypsy and Traveller groups, this will potentially provide an excellent insight in to both the size and characteristics of the Gypsy and Traveller population.

Crime

In the last three years, Devon has seen some significant reductions in key crime areas. Overall crime has decreased by over a quarter.

Although it was anticipated that serious acquisitive crime would increase due to the recession, this has not been the case. Overall, serious acquisitive crime has reduced by nearly a quarter over the last three years.

Reported violent crime has decreased over the last three years, however, between 2009/10 and 2010/11 there was a 1.5% increase. These figures include offences committed in previous years. Once crimes from earlier years are removed from the current reporting figures, it was apparent that the number of sexual assaults actually committed in 2010-2011 had decreased. Rapes have *increased* by 13.2%. Across Devon both crimes involving a firearm and those involving a blade have shown a decrease year on year.

In Devon Assault-Related Injury Database (ARID) is operational within the Accident and Emergency departments of the North Devon District Hospital and the Royal Devon and Exeter. The anonymised data is based on information supplied by patients who attended A&E seeking treatment for injuries sustained during assaults. Since the commencement of ARID in November 2009, within Devon only half of the assaults recorded by ARID were reported to the police and this shows the extent of under reporting of violent crime.

Anti-social behaviour overall has decreased year on year, however, in 2010-11 the number of reported incidents relating specifically to noise nuisance has increased. There has been a downward trend in the number of reported hate incidents.

There has been an increase in the number of drug offences across Devon and this was particularly evident during 2010/11. This was largely due to targeted police operations aimed at disrupting drug dealing networks.

Alcohol is a contributory factor in nearly half of all violent crimes in Devon and almost 7% of all road traffic collisions involving casualties. Over the last three years road traffic collisions resulting in a casualty have fallen year on year. However, in 2010/2011 serious injury collisions increased by over half compared to the previous year and the cause for this increase is as yet unclear. There has been a decrease

year on year in the proportion of assaults and ‘violence with injury’ offences which are drug/alcohol related.

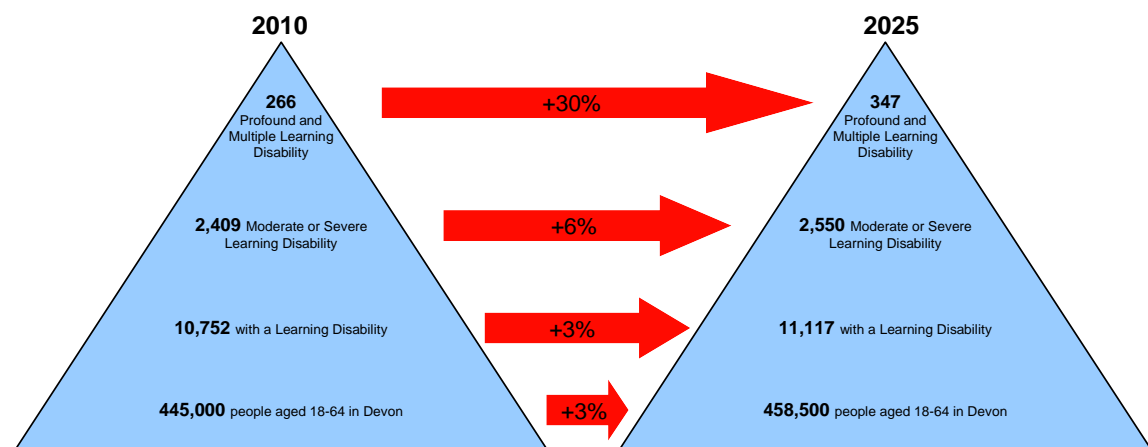
Learning Disabilities

A person with a learning disability is usually defined as having a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development.

10,752 people in Devon aged 18-64 are predicted to have a learning disability (baseline estimate). Based on population projections, this number will increase by 4% to 11,199 by 2030 (Source: CSED www.pansi.org.uk version 4.0. Crown copyright 2010). Most of these people have mild learning disabilities and are getting on with their lives in society without particular statutory support. However some of them may still be excluded from having equal access to universal services due to an inability to understand information provided or to respond as expected. This is further complicated by other people’s prejudices or unintended institutional prejudice. There are around 3,100 adults with learning disabilities on GP practice learning disability registers in Devon. Devon County Council supports around 2,100 with social care resources.

The total population of people with a learning disability is growing and while more individuals are using more accessible universal services to support themselves (leisure, employment etc.), the numbers of people needing specialist support due to having additional disabilities (sensory or physical) or life long health conditions (epilepsy) is increasing at 1.8% annually. Reasons for this increase includes, children surviving into adulthood following better perinatal and trauma outcomes and a longer life expectancy for people with a learning disability in general.

Figure 4.2: Predicted increase in numbers of people with Learning Disabilities in the population 2010-2025



Valuing People Now (2009) identifies five key areas to focus on to make a real difference to people’s lives: personalisation (increasing choice and control); how people spend their time (including paid work and leisure); better health (with full and equal access to NHS services); access to housing (particularly tenancies and home ownership); making sure that change happens (with more effective Partnership Boards). There are currently four key strategic priorities taken from this list that are being addressed by the Devon Learning Disability Health and Social Care Partnership

and Partnership Board over the next year; these are better health, employment, housing and hate/mate Crime.

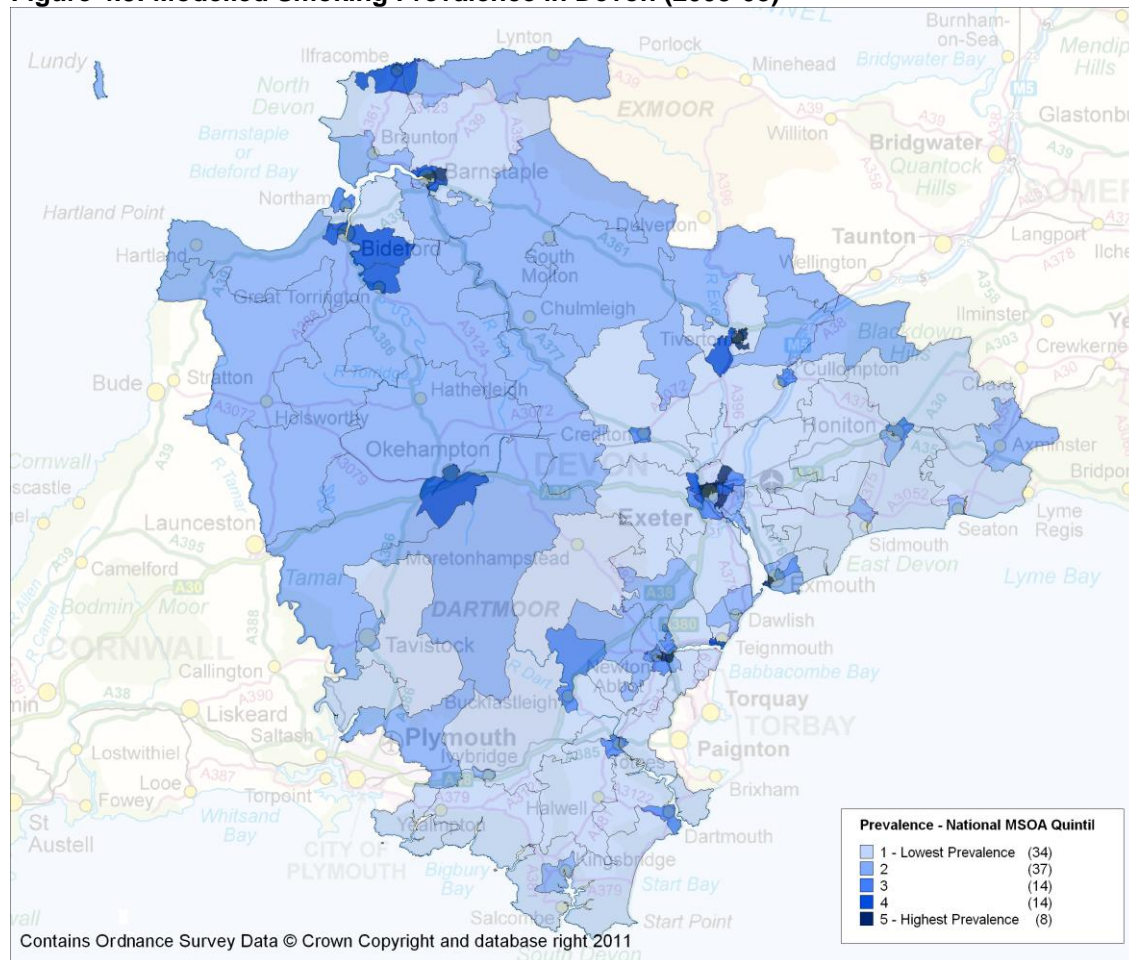
There are a number of different approaches that are known to help best support people with learning disabilities. These are increasing the awareness of people with a learning disability and those who support them on a day to day basis; involvement of people with learning disabilities and family carers in training into and auditing of, universal systems; access to a specialist advisor that has a good understanding of the needs of people with a learning disability and a good understanding of the universal system that is trying to make the reasonable adjustments; implementing the Mental Capacity Act and regular contact with a person and their support system around a specific aspect of their lives to identify difficulties earlier (e.g. annual health checks).

In Devon a number of actions are in place to support and raise awareness around learning disability. These include Liaison Nursing within GP surgeries and district general hospitals; Learning Disability Awareness sessions – training and supporting better work with individuals; Individuals' and carers' campaigns; Self-assessments when requested from regional bodies such as Valuing People team or the strategic health authority; Widening out the remit of Devon Housing Options to enable a range of shared housing tenancy arrangements to be advertised alongside other rental arrangements; Identifying how the current specialist health provision around people with a learning disability can be reorganised to support universal systems to provide better health outcomes to individuals; Working with Job Centre Plus on assisting the work programme to provide better employment outcomes for individuals; Undertaking safeguarding meetings and drawing together information to try and identify ways of assisting people with a learning disability to report hate crime and protect themselves from becoming victims of mate crime.

Smoking

Current smoking rates in England are 21% generally and 29% for routine and manual groups. For Devon the most recent estimated smoking rate is 18.5%. However, in the South West smoking rates for routine and manual groups are 25%. Although Devon overall has lower tobacco use than the national average, there are 76/201 electoral wards where tobacco attributable mortality is higher than expected and three regions (Exeter, North Devon and Torridge) where the indirectly standardised mortality ratio is higher than expected. This indicates there are pockets where there is a strong need for tobacco control work.

Figure 4.3: Modelled Smoking Prevalence in Devon (2003-05)



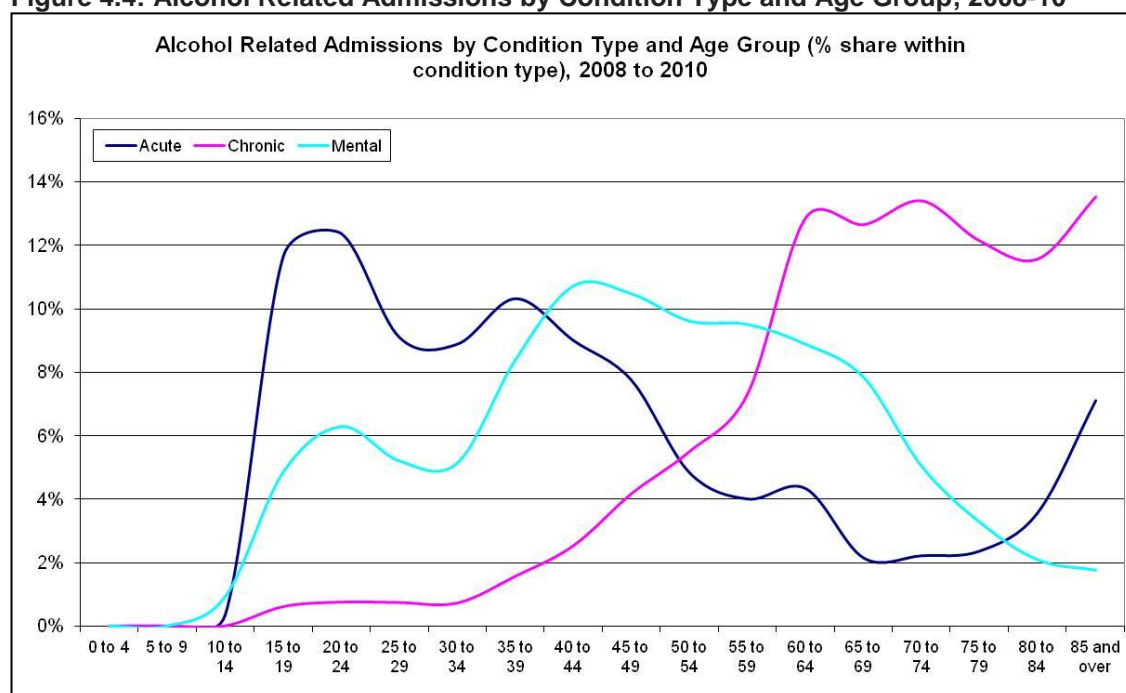
Alcohol

For the majority of adults in Devon, drinking alcohol is a pleasurable and routine activity. However, alcohol is also the most widely misused drug, legal or illegal, in Britain. Its misuse can have highly damaging direct or indirect consequences on people's lives. These consequences can be obvious or may be masked within a range of associated problems such as mental or physical ill health, family and relationship breakdown, or trouble at work or with money. The disinhibiting effects of alcohol can make people more prone to committing criminal and anti social acts and placing themselves at personal risk, particularly from injury, sexually transmitted diseases or unwanted pregnancy.

There are currently an estimated 118,600 adults in Devon at increased risk of harm from alcohol due to regularly drinking more than recommended limits. Whilst most of these people are currently in reasonable health their chances of developing problems due to alcohol consumption in the future is greatly increased. An estimated 25,800 fall into the increased risk category where the current level of alcohol consumption is likely to have an adverse impact on their current health.

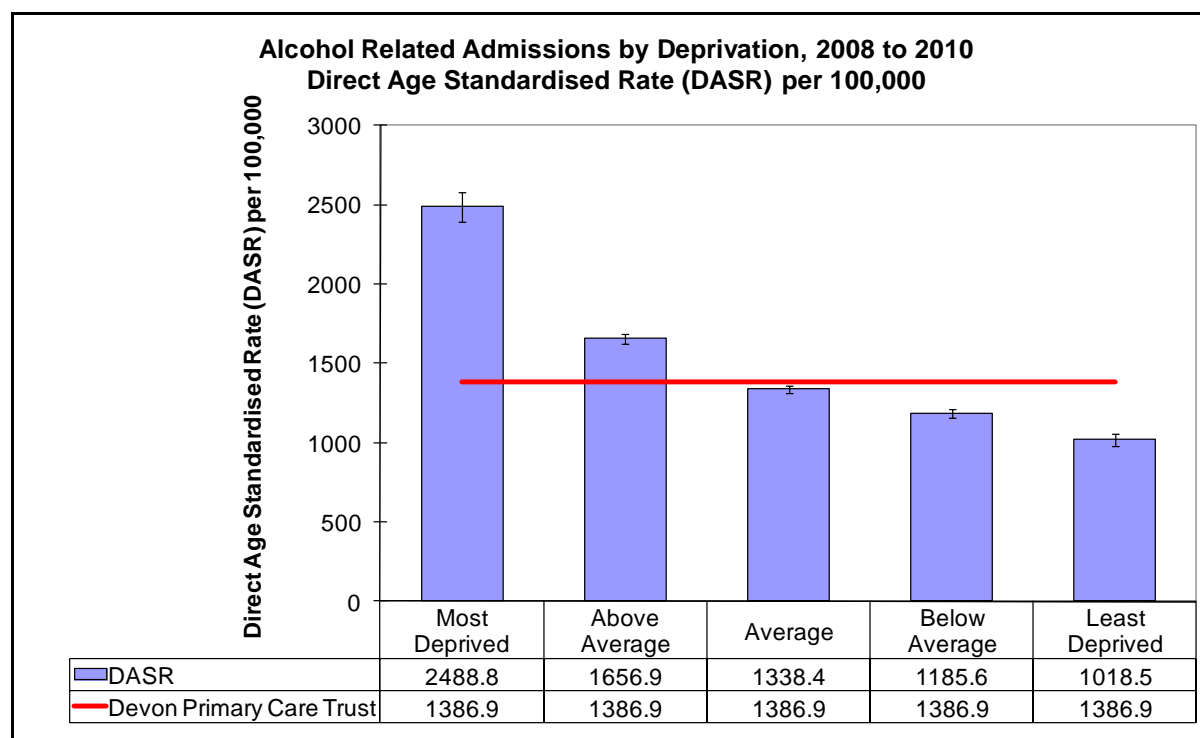
The pattern of alcohol consumption and the related health risks vary significantly by age. This is illustrated by the pattern of alcohol-related admissions by type and age shown in the chart below. Acute risks to health, such as accidents and poisoning occur in younger age groups, with admissions for alcohol-related mental health conditions peaking in the 40s and 50s and chronic long-term health conditions increasing in later life.

Figure 4.4: Alcohol Related Admissions by Condition Type and Age Group, 2008-10



There is a strong relationship between alcohol and deprivation, with much higher levels of alcohol-related ill health in more deprived areas, as illustrated in the chart below.

Figure 4.5: Alcohol Related Admissions by Age Group and Deprivation, 2008-10



There is a nine fold difference between the area with the highest alcohol-related admission rate in Devon (in central Exeter), and the lowest (in Western Sidmouth). Whilst there is a clear relationship between deprivation and alcohol use, availability

and local culture also comes into play. Areas with a high proportion of licensed premises and bar workers, also experience higher levels of alcohol-related ill health. This is particularly true in tourist areas appealing to the youth market, such as Braunton.

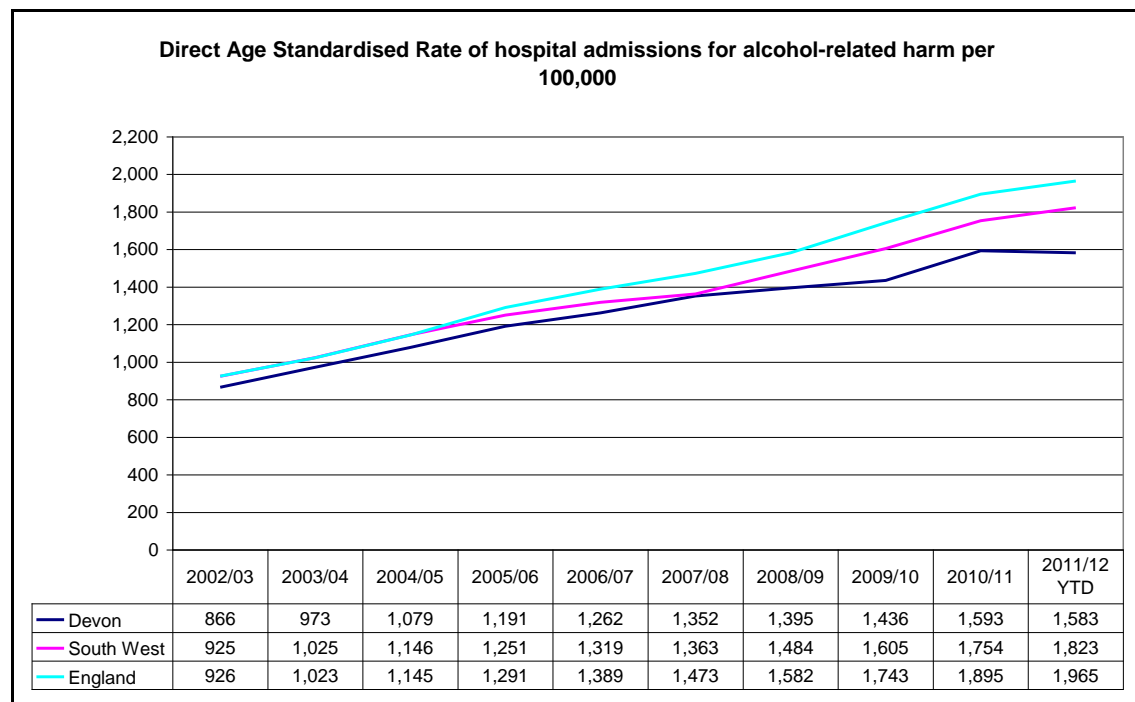
Across Devon there is a range of effective treatments available to suit a variety of different needs from a range of patients.

The treatment of alcohol problems is cost-effective. Alcohol misuse has a high impact on health and social care systems, where major savings can be made. Drinking also places costs on the criminal justice system, especially with regard to public order. Overall, for every £1 spent on treatment, £5 is saved elsewhere.

The Devon Alcohol Strategy and the resultant business case for services called for a tiered model focusing on brief interventions and screening for those drinking at hazardous and harmful levels, community-based treatments and interventions, and inpatient treatment and rehabilitation for particularly severe cases.

During the latter half of 2008/09 an additional £400,000 was invested in alcohol treatment services to support this, followed by £1 million in 2009/10 and £1 million in 2010/11. During this time, rising admission rates for alcohol-related conditions have slowed considerably, and as the chart below illustrates have diverged from the South West and National averages, which continue to increase by 8-10% per year, compared to just 2% in Devon. This reduction relative to the national increase has saved an estimated £4 million per annum in hospital admission costs alone.

Figure 4.6: Hospital Admissions for Alcohol Related Harm

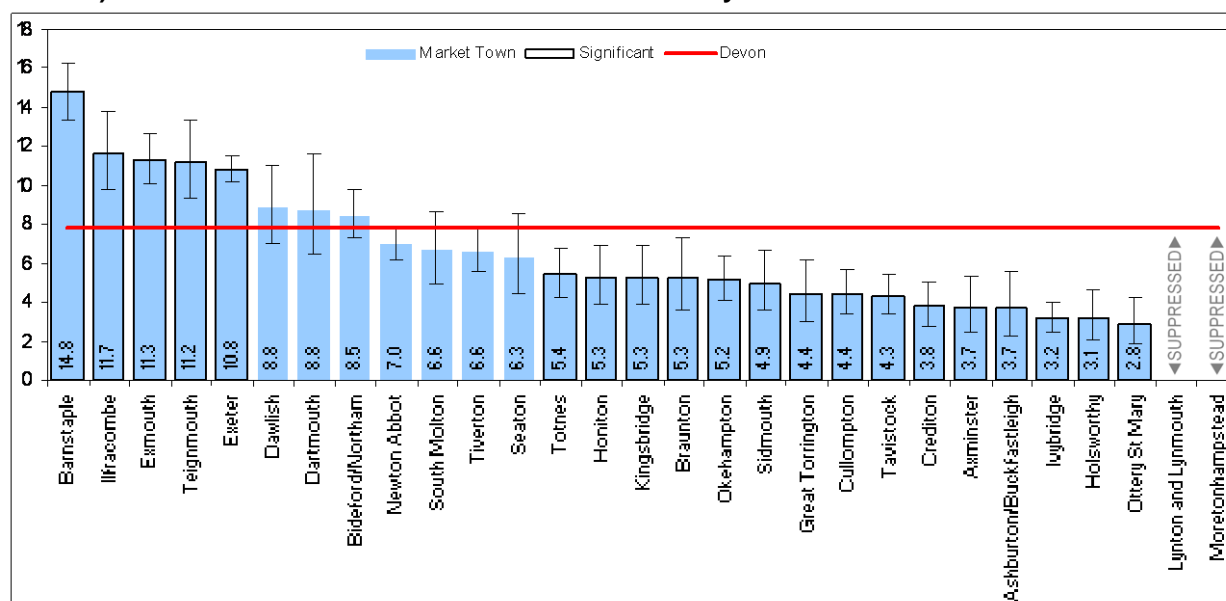


Alcohol Related Crime

Alcohol can be linked to a wide range of criminal offences and has become a concern to the public over the years as the number of alcohol related crimes has been perceived to increase. In Devon there is variation across the county in the rates of alcohol related crime seen. The graph below shows that in 2008-09 to 2009-10 the highest rates of alcohol related violent crimes were seen in the larger urban areas of

Barnstaple and Exeter and also larger seaside towns of Ilfracombe, Exmouth and Teignmouth.

Figure 4.7: Number of alcohol related crimes per 1000 population aged 18+ (2008-09 to 2009-10) - Data Source: Devon and Cornwall Constabulary Crime Data



Domestic Violence

Sexual violence and domestic abuse impacts on men, women, children and families. There is a critical relationship between health and wellbeing and domestic and sexual violence and abuse. Victims often suffer a series of injuries, both physical and mental. Perpetrators have high incidence of mental health needs and substance misuse.

Victims or survivors of violence are likely to have broader health and social needs beyond this aspect of their lives. Evidence suggests that they may be living on a low income; at risk of homelessness (15% of all cases accepted by Devon District Councils as homeless and in priority need relate to domestic violence); live in poor housing or in a deprived area; live in rural areas and have difficulty accessing certain types of services. Victims generally have worse physical health and may have mental health needs and/or substance misuse issues.

The hidden nature of violence and abuse means that there are barriers to individuals disclosing abuse, professionals enquiring about abuse and victims and perpetrators accessing services. The high level of underreporting of domestic and sexual violence and abuse means that improved intelligence is needed to better understand the number of people who may require support.

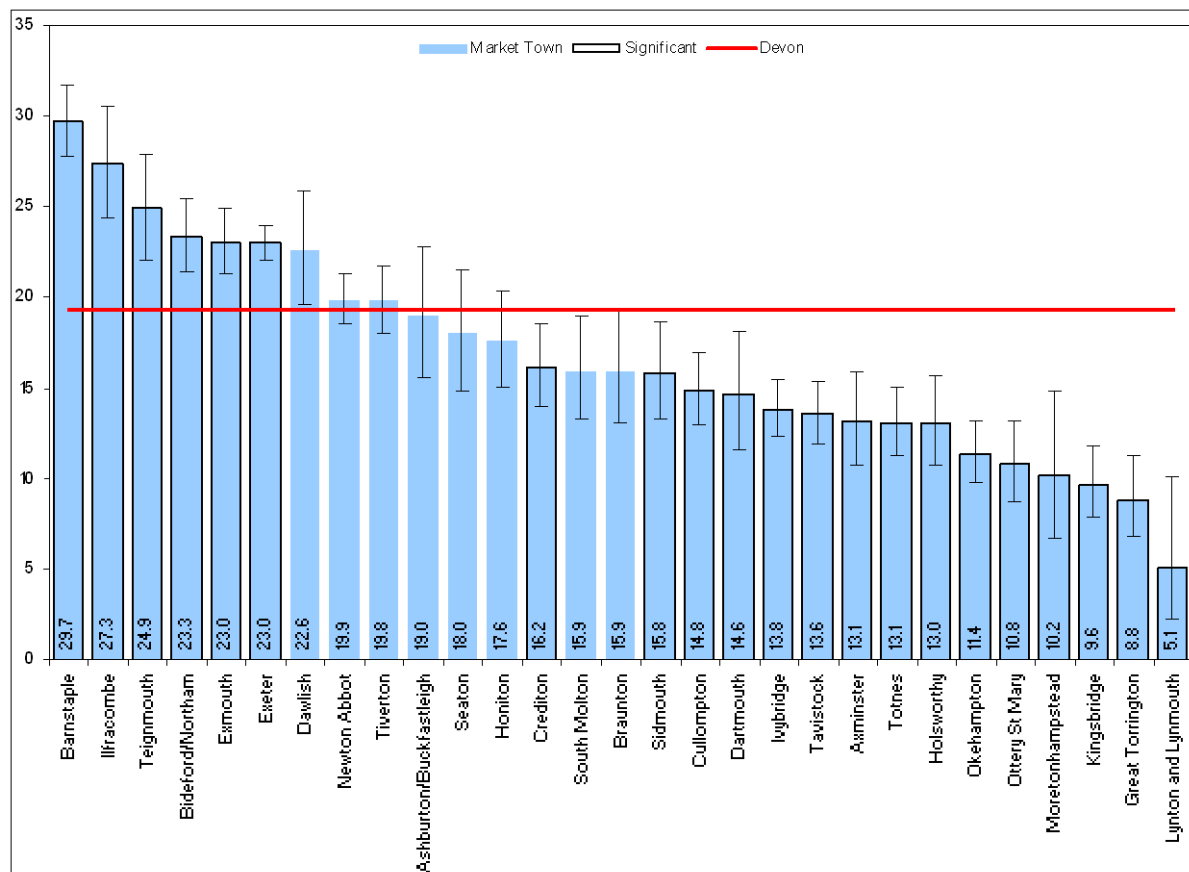
It is estimated that 13,972 (7%) women and girls in Devon aged 16 to 59 years have been a victim of domestic abuse and 4,657 (2.2% of 16-59 female population) a victim of sexual assault (Home Office Domestic Violence Ready Reckoner). This model does not account for the victims who are male and/or aged over 59 years old. We know that a further 122,400 women aged 60 years or older are living in Devon. Assuming the same victimisation levels a further 8,078 older women could be victims of domestic abuse.

Domestic Violence accounted for 24.1% of violent crime in Devon in 2010. Nationally, 35% of homicides are domestic violence related with 130 women and 30 men killed each year whilst in Devon 17% of homicides were domestic in the last 5 years. In Devon an average of 750 reports of domestic violence are received by Devon and

Cornwall Police each month. This figure represents only a small proportion of incidents as on average there have been 35 domestic violence assaults before a victim calls the Police (Povey et al, 2008), leading to large discrepancies between estimated victimisation rates and reported crime levels.

The graph below shows the rates of reported cases of domestic violence by Devon town in 2010-11. It shows the highest rates of reported cases were in Barnstaple, Ilfracombe, Teignmouth, Bideford/Northam, Exmouth and Exeter. The rates varied greatly across the county from 27.9 per 1,000 in Barnstaple to 5.1 per 1,000 in Lynton and Lynmouth.

Figure 4.8: Number of domestic violence cases per 1000 population aged 18+ (2010-11) - Data Source: Crime in England and Wales, Home Office



A number of support services and processes have been developed across Devon to help victims and perpetrators of domestic abuse and also their families. These include Multi-Agency Risk Assessment Conferences (MARAC) to ensure high risk victims of domestic violence receive a coordinated response from agencies; the establishment of Specialist Domestic Violence Courts (SDVC); the establishment of the Devon and Torbay Sexual Assault Referral Centre (SARC) which provides immediate physical and psychological help and support following a rape or sexual assault; building of partnerships with community and voluntary organisations to promote services, run education campaigns and provide training; a specific domestic violence Joint Strategic Needs Assessment was undertaken to establish the needs of the population and to make recommendations about how services could be changed in order to improve they those needs are met.

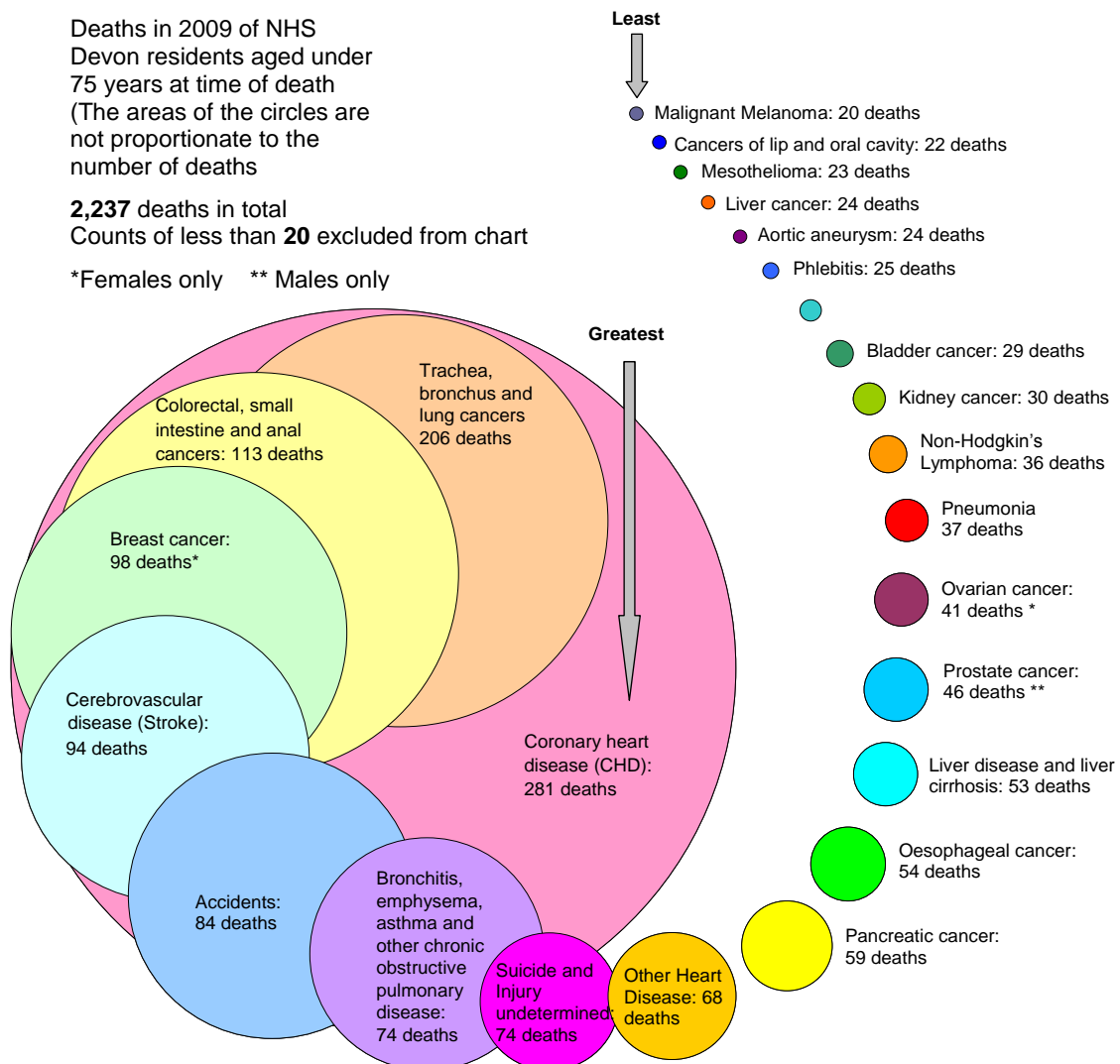
Obesity

Obesity is a major public health issue across the UK with rates of obesity increasing over the past 20 years. The most recent data from the Health Survey for England relates to 2009 and show that 22% of men and 24% of females in Devon are obese. When the proportions of people who are overweight are considered, this proportion rises to 61.3% which is nearly two thirds of the adult population. Risk factors associated with obesity include high blood pressure, high cholesterol, cardiovascular disease, type 2 diabetes and some cancers which explains why both nationally and locally reducing obesity is a priority for public health.

Disease and Mortality

The latest available mortality data is for 2009 and during that year there were 8,160 deaths in total in Devon, of which 2,237 were below the age of 75. Figure 4.9 displays the commonest causes of death in those aged under 75, with coronary heart disease (CHD) accounting for 281 deaths, followed by lung cancers with 206 deaths and cancers of the digestive system with 113 deaths.

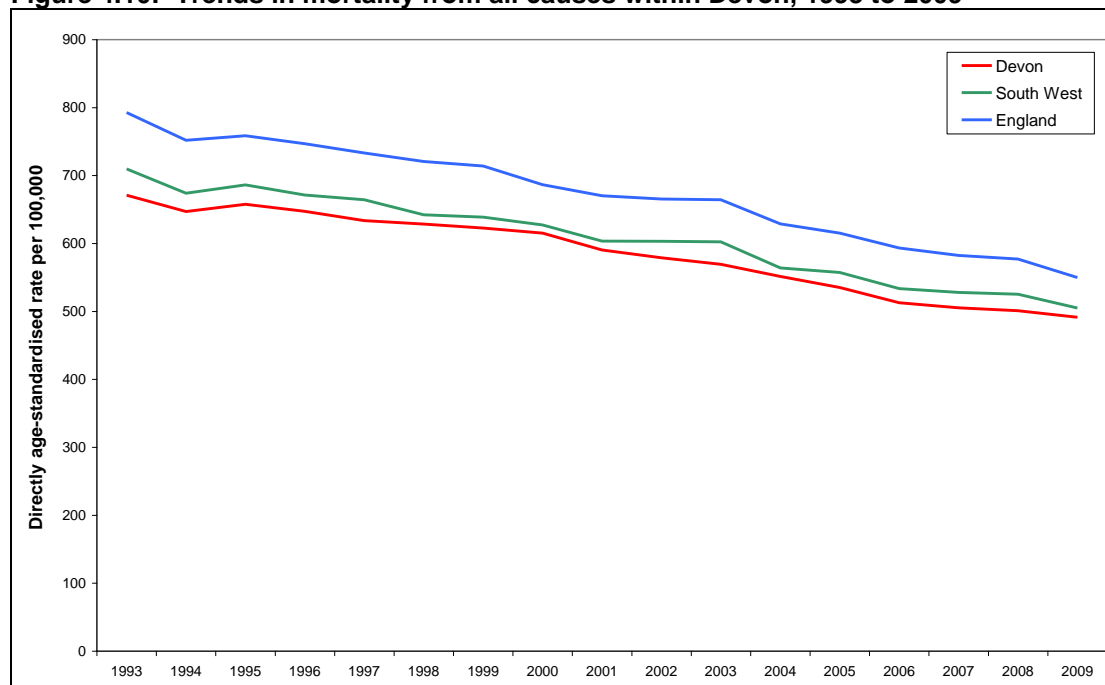
Figure 4.9: Deaths from selected causes under the age of 75 years



Source: Vital Statistics, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

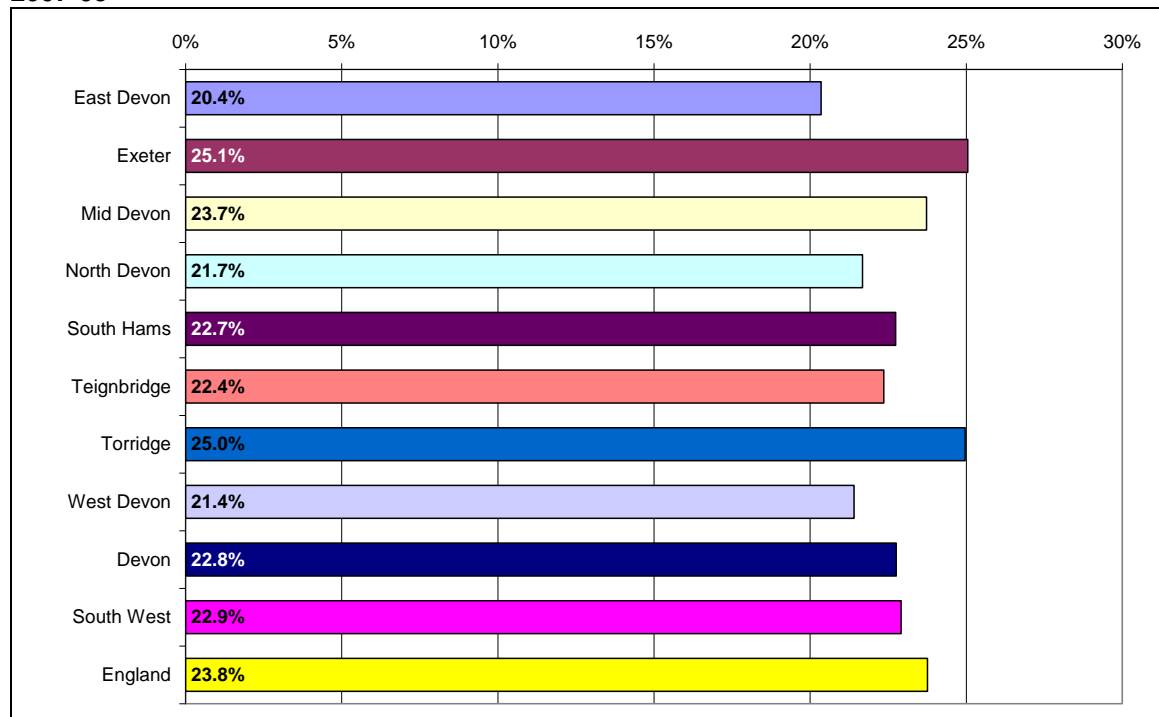
Figure 4.10 presents trends in overall mortality rates between 1993 and 2009, highlighting that mortality rates have fallen significantly over recent years. Devon rates have stayed consistently below South West and national rates, although between 1993 and 2009 the gap has slightly reduced, with mortality rates falling by 27% locally and 31% nationally. The reduction in mortality varies across the county and Figure 4.11 presents the reduction in mortality by Devon local authority districts between 1995 and 1997 and 2007 to 2009. Overall Devon saw a 22.8% reduction in mortality rates, with the highest decrease seen in Exeter (25.1%) and Torridge (25.0%). While mortality rates have fallen, there are notable differences between rates for males and females. Figure 4.12 highlights that whilst mortality rates are much higher for males, they have shown a greater reduction over recent years, with a 31% reduction between 1993 and 2009 compared with 24% for females. Specific areas where the reduction in mortality has been much greater for males include heart disease and chronic obstructive pulmonary disease (COPD), which are closely associated to lifestyle factors such as smoking.

Figure 4.10: Trends in mortality from all causes within Devon, 1993 to 2009



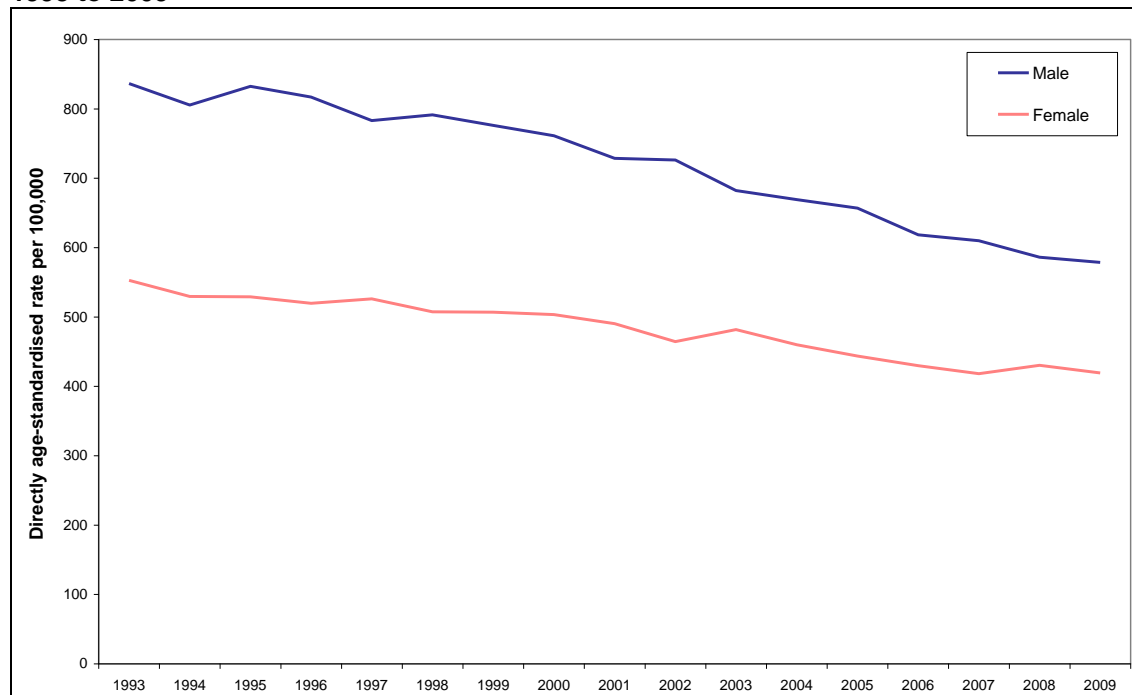
Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 4.11: Percentage reductions in mortality rates in Devon Districts, 1995-97 to 2007-09



Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 4.12: Trends in mortality from all causes for males and females within Devon, 1993 to 2009



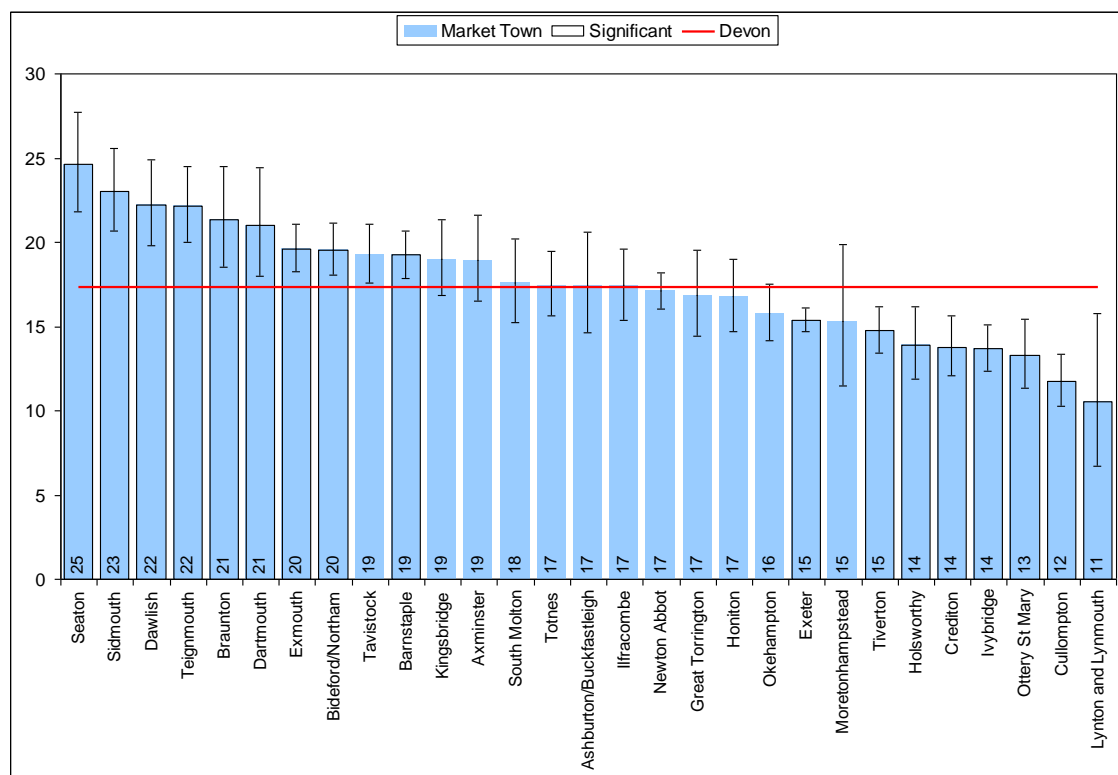
Source: National Compendium of Clinical Indicators, Crown Copyright 2009

Physical Disability

In Devon, during 2010, it is predicted 48,996 people aged 18-64 had a moderate or serious physical disability (46% of whom are aged 55-64 years). It is predicted that this number will increase by 4% (to 51,089) by 2030. Of the 48,996, 24% (11,579 people) are predicted to have a serious physical disability. Of the 48,996 people predicted to have a moderate or serious physical disability, 23,045 (47%) are estimated to require personal care. This is anticipated to increase by 5.8% to 24,371 by 2025. (Data Source: CSED www.pansi.org.uk version 4.0. Crown copyright 2010)

20,053 people 18-64 living in Devon during 2010 had a moderate or severe hearing impairment. It is predicted that this number will increase by 5% (to 21,022) by 2030. The NHS Information Centre statutory returns Registered Blind and Partially Sighted, and People Registered Deaf or Hard of Hearing indicate that in Devon 830 people aged 18-64 were registered blind or partially sighted (March 2011). 3,745 people across all age groups (0+) were registered blind or partially sighted (March 2011). 280 people aged 18-64 were registered as deaf (March 2010). There are known to be more people in Devon who have a visual impairment who are not registered. (Data Source: NHS IC Registered Blind and Partially Sighted Statutory Return 2010/11, Tables B1 and PS1).

Figure 4.13: Number of people with physical disabilities aged 18-64 receiving an assessment per 1000 population aged 18-64 (2010-11) - Data Source: CareFirst (Referrals, Assessments & Packages of Care Statutory Return 2010-11).



Mental Health

The following shows the 2010 estimates for people predicted to have various mental health conditions living in Devon:

- 71,733 People aged 18-64 predicted to have a common mental disorder
- 2,006 People aged 18-64 predicted to have a borderline personality disorder
- 1,550 People aged 18-64 predicted to have an antisocial personality

disorder

- 1,783 People aged 18-64 predicted to have psychotic disorder

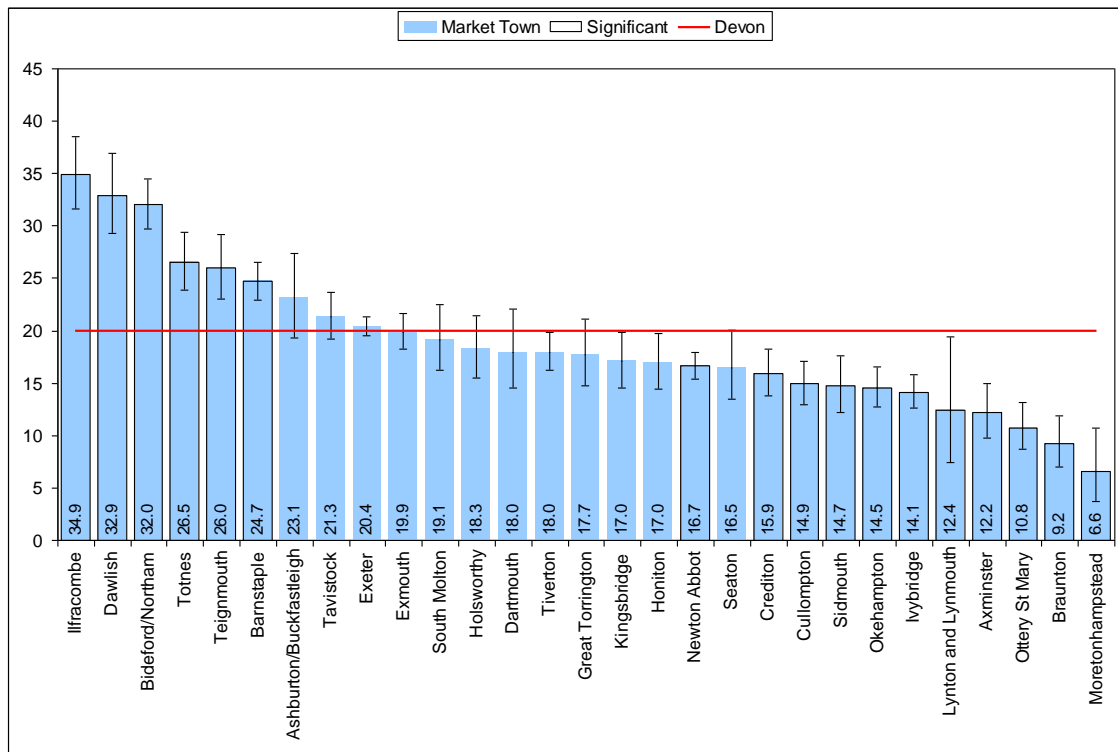
It is predicted that these figures will rise by 3% by 2030, with the exception of antisocial personality disorder which is predicted to increase by 5%. It is predicted that 221 people aged between 30 and 64 in Devon have early onset dementia of which 58% are male. This is predicted to rise by 6% to 235 by 2030. Early onset dementia is most prevalent in the 50-59 age group for both men and women.

15,095 people in Devon aged 18-64 were predicted to be dependent on drugs in 2010, with 66% of these being male. This is predicted to rise by 4% to 15,713 by 2030. 26,616 people in Devon age 18-64 are predicted to have alcohol dependence in 2010, with 72% of these being male. This is predicted to rise by 4% to 27,759 by 2030. (Data Source: CSED www.pansi.org.uk version 4.0. Crown copyright 2010).

Incapacity Claimant Benefit

The association between rates of mental illness and certain population characteristics, notably poverty, unemployment and social isolation, is well established. This association is evidenced when analysing Incapacity Benefit claimant rates for mental health reasons by Devon town (2011 rates), where we see that Ilfracombe has the highest claimant rate, followed by Dawlish and then Bideford & Northam. All three rank in the top five most deprived towns in Devon.

Figure 4.14: Incapacity Benefit / Severe Disablement Allowance Claimants at February 2011 - Data Source: DWP Information Directorate



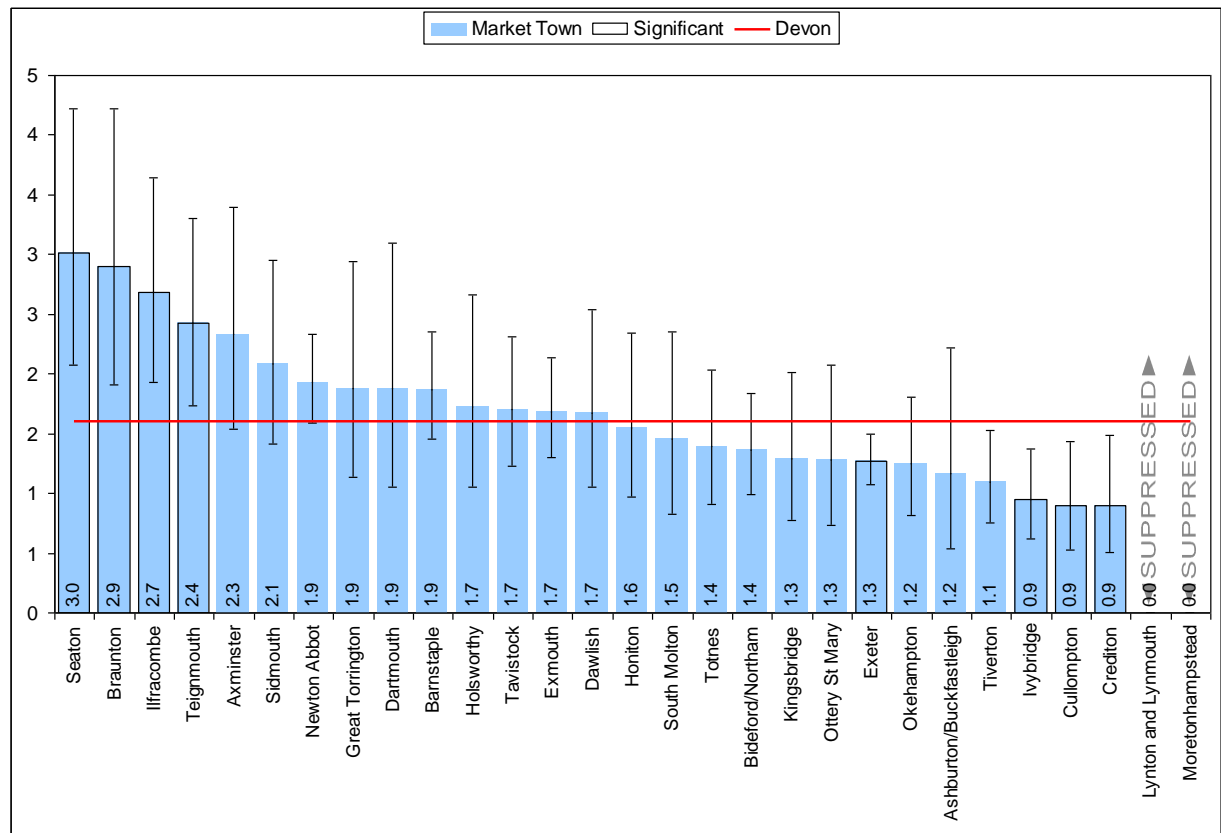
Older people aged 65 and above with mental health conditions

The most common mental health problems in older people are depression and dementia. Depression affects proportionately more older people than any other demographic group, because older people face more events and situations that may trigger depression: physical illness, debilitating physical conditions, bereavement, poverty and isolation. The majority of people who have depression make a full

recovery after appropriate treatment, and older people are just as responsive to treatment as younger people. Communities and support services can help older people address some of the causes of depression such as social isolation, financial problems, or difficulties with their accommodation.

Older people with dementia usually continue to live at home with support, but may benefit from specialist accommodation, including extra care housing. There were an estimated 12,561 people suffering from Dementia in Devon in 2010, this is predicted to rise significantly to 23,076 by 2026 (a rise of 84% in 16 years).

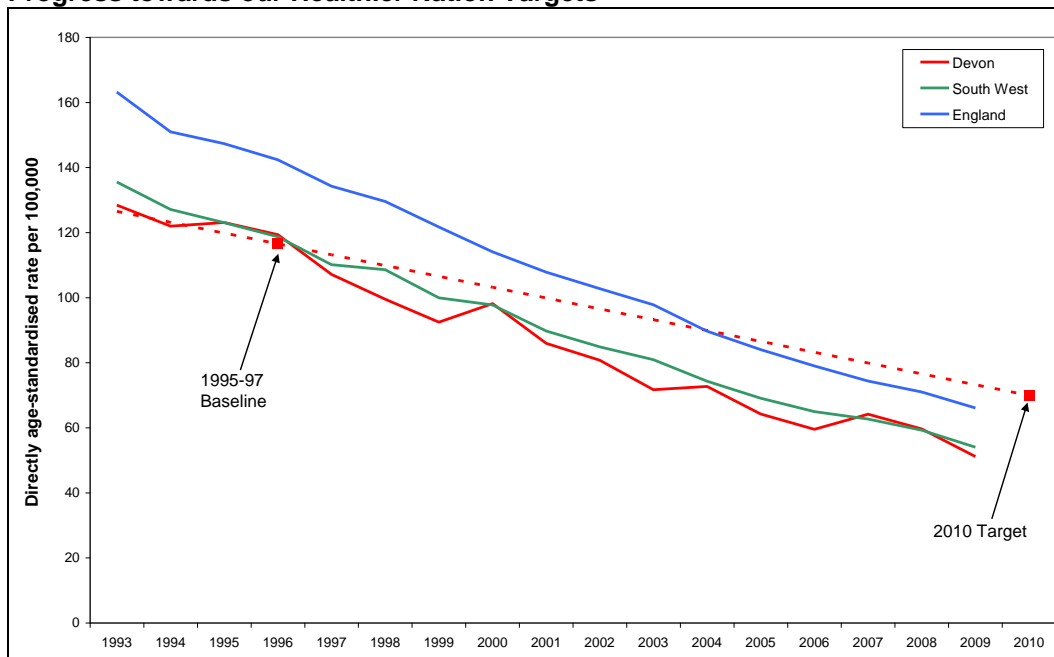
Figure 4.15: Proportion of population with a mental health condition receiving assessments during the year per 1000 population (2010-11)- Data Source: CareFirst (Referrals, Assessments & Packages of Care Statutory Return 2010-11)



Circulatory Disease (including heart disease and stroke)

The targets that were set back in 1999 for reductions in mortality by 2010 are coming to an end. Figure 4.16 illustrates that the target of a 40% reduction in premature deaths from circulatory disease from the 1995 to 1997 baseline was achieved several years ago, with rates continuing to decline. The current rate in Devon is 56% below the baseline. Similar decreases have also been seen nationally, and Devon has remained consistently below the national rate.

Figure 4.16: Trends in circulatory disease in people aged under 75 within NHS Devon: Progress towards our Healthier Nation Targets

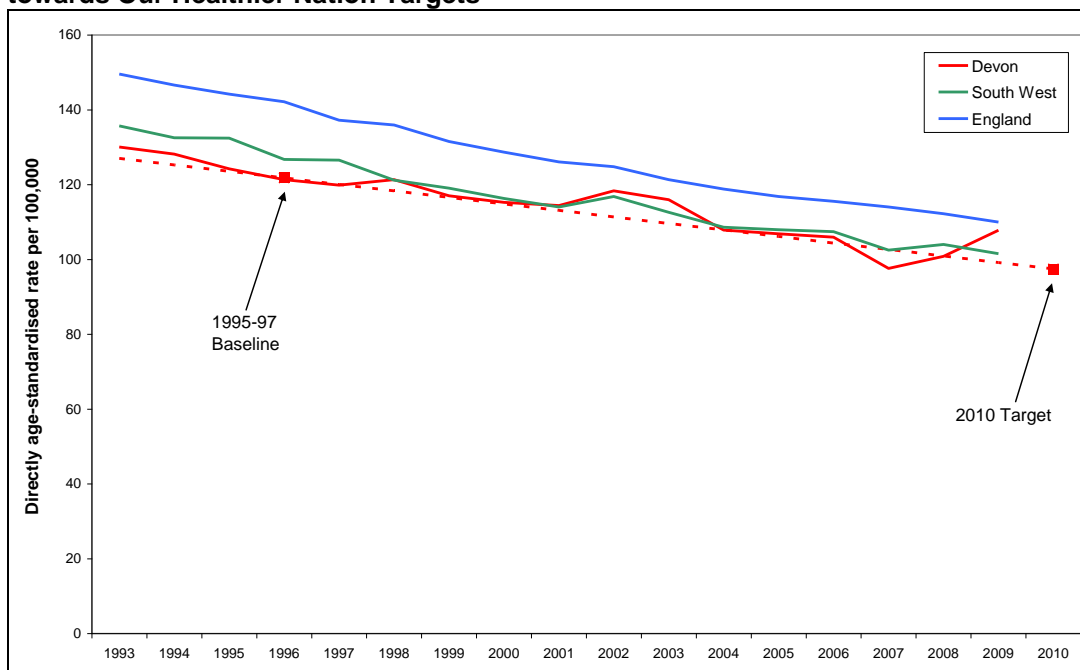


Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Cancer

Figure 4.17 indicates that up until the latest year, Devon was on trajectory to achieve a 20% reduction in premature mortality from cancer by 2010 from the 1995 to 1997 baseline. Some year-on-year variations are seen, including an increase between 2007 and 2009 which takes the rates above the trajectory towards the target.

Figure 4.17: Trends in cancer in people aged under 75 within NHS Devon: Progress towards Our Healthier Nation Targets

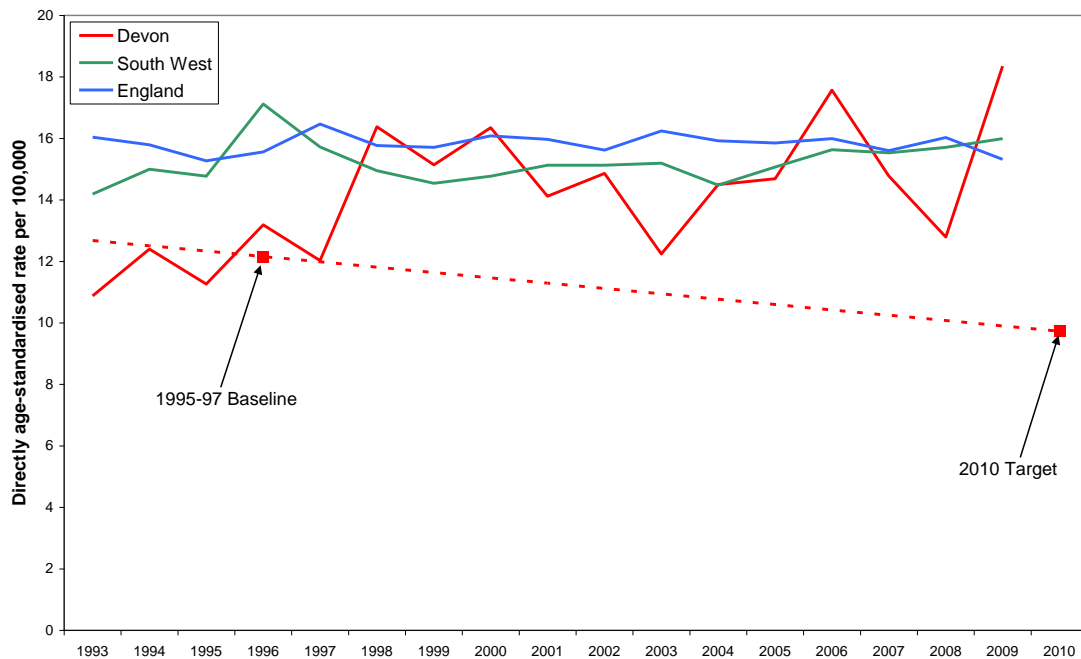


Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Accidents

Rates have increased and fluctuated greatly over the time period displayed. As a result, Devon is unlikely to achieve a 20% reduction in mortality from accidental causes by 2010 from the 1995 to 1997 baseline (Figure 4.18). This is largely due to an increase in accidental falls and further investigation is planned to establish whether this relates to improvements and changes in clinical coding of causes of deaths, demographic change or other factors.

Figure 4.18: Trends in mortality from accidents within NHS Devon: Progress towards Our Healthier Nation Targets

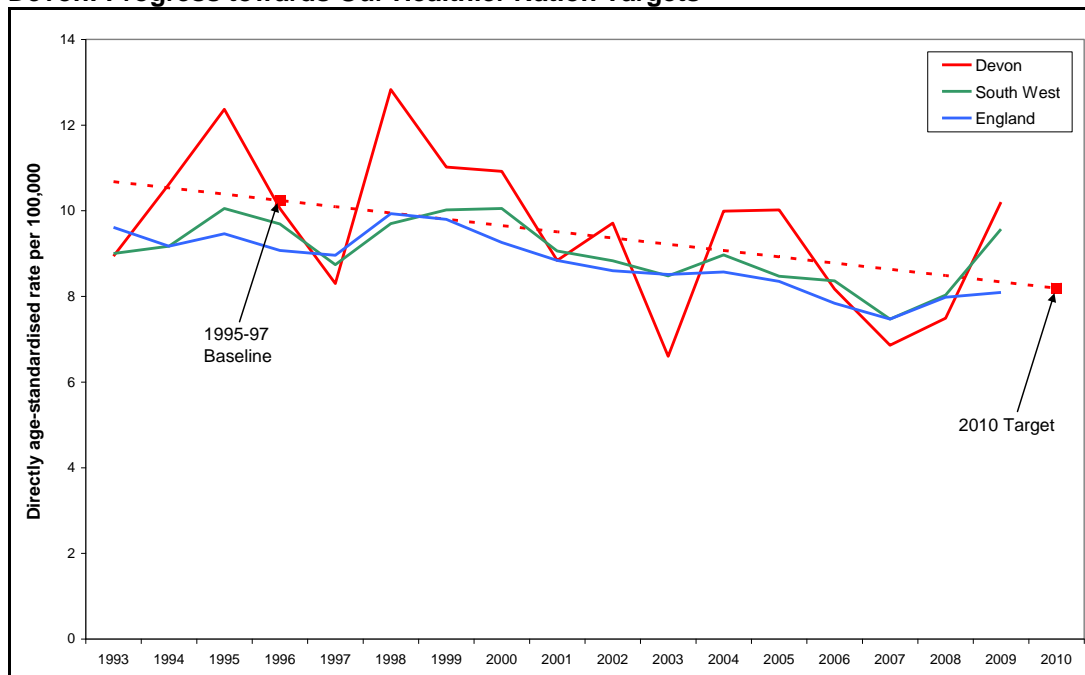


Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1

Suicide

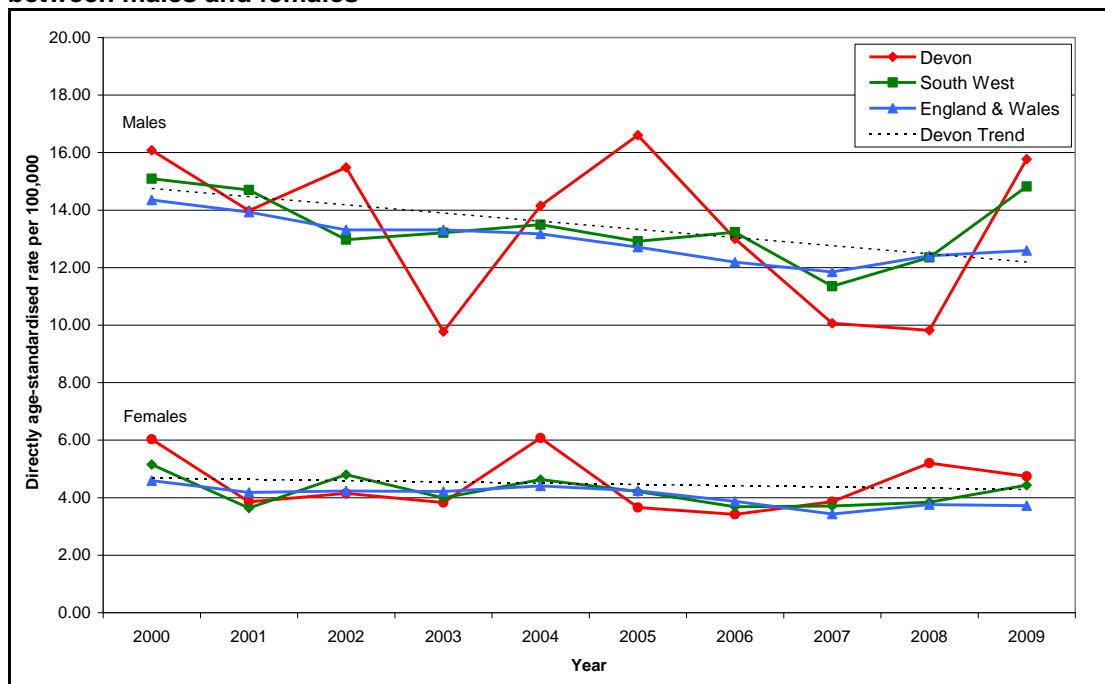
Rates of mortality from suicide and injury undetermined fluctuate greatly over time, largely due to the relatively low numbers of deaths involved, with less than one death per 10,000 people each year. Despite the low numbers, suicide and injury undetermined deaths are an important cause of death to monitor as they often result in much greater years of life lost. Figure 4.19 shows the annual rates of mortality from suicide and injury undetermined and shows that at present, Devon is not currently on course to achieve a 20% reduction in mortality from suicide and injury undetermined by 2010 from the 1995 to 1997 baseline, as set out in the Our Healthier Nation targets. Mortality rates from suicide tend to fluctuate widely and show wide confidence intervals around these rates. Looking at local data for deaths in 2010, the rate has dropped back down to just above the 2008 rate. Looking at Devon rates as a trend over time, the trend has been generally in line with the target trajectory to 2010. What is of concern is the possibility that the increase in suicide is linked to the recession, as we know from national research that as people lose their jobs, or experience family and relationship stress and the loss of social networks, the risk of suicide increases. This is particularly important as approximately three times as many men kill themselves as women (Figure 4.20). From our local suicide audits, we also know that alcohol plays a significant part in suicide.

Figure 4.19: Trends in mortality from suicide and injury undetermined within NHS Devon: Progress towards Our Healthier Nation Targets



Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 4.20: Trends in mortality from suicide and injury undetermined, comparison between males and females



Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Offender Health

Offenders and also ex offenders are more likely than the general population to have acute health needs. They often have particular needs around substance misuse and mental health, and also social care needs. Dealing with these problems can be difficult within prisons and particularly the transition of care outside of prison for ex offenders. A detailed prison health needs assessment has been completed for Devon

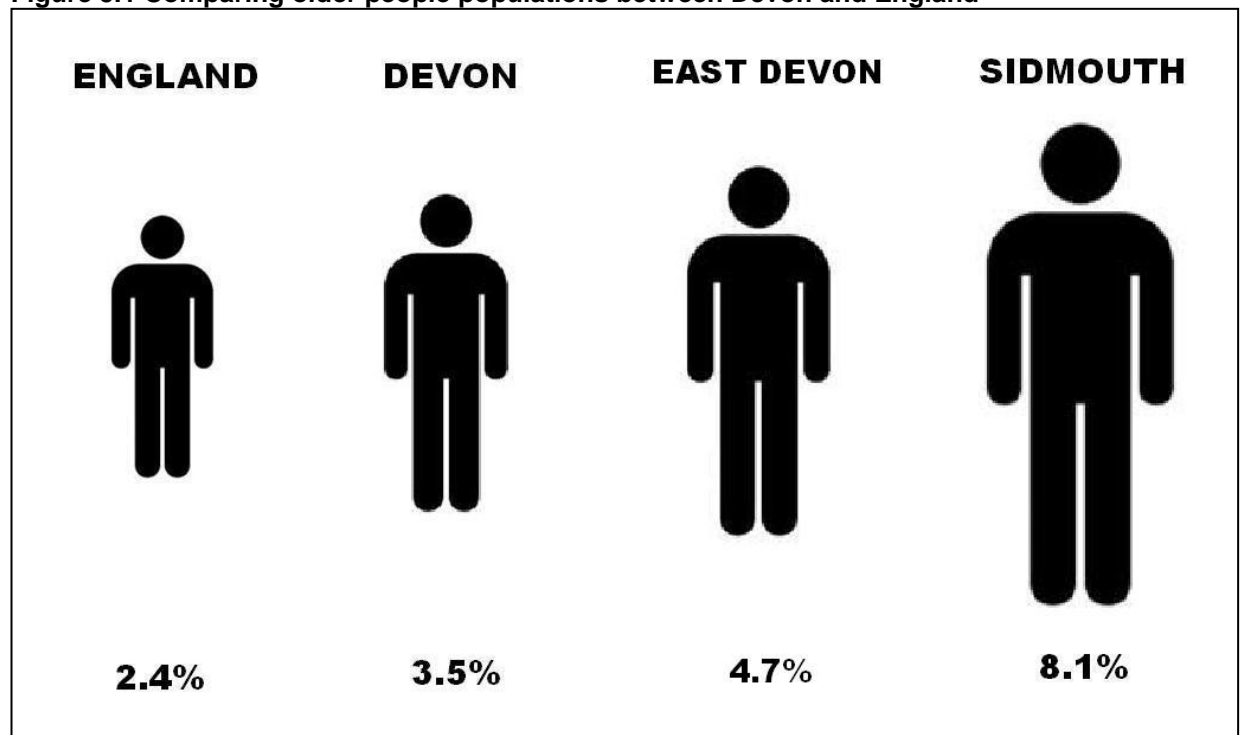
in 2012 and looks in more detail at the difficulties facing healthcare in prisons. Partnership work to address these needs is important to reduce both reoffending and health inequalities.

5 OLDER PEOPLE - AGING WELL

The following section aims to identify topics that are of particular concern to older people. As identified in section 2, Devon is expected to experience the greatest population growth in the older age groups, with a 28% increase in 60-69 year olds, a 58% increase in 70-79 year olds, a 92% increase in 80-89 year olds and a 233% increase in those aged 90 and above.

Devon is noted as having an older age profile than England generally. The following graphic shows how Devon compares to England. In 2012 it is estimated 2.4% of the population are aged 85 and above. In Devon this is higher at 3.5%. The district with the greatest proportion is East Devon and the town with the highest proportion people aged 85 and above at 8.1%. If the England population continued to grow as it is predicted at present, the proportion of older people seen currently in Sidmouth would be expected in England as far ahead 2076.

Figure 5.1 Comparing older people populations between Devon and England



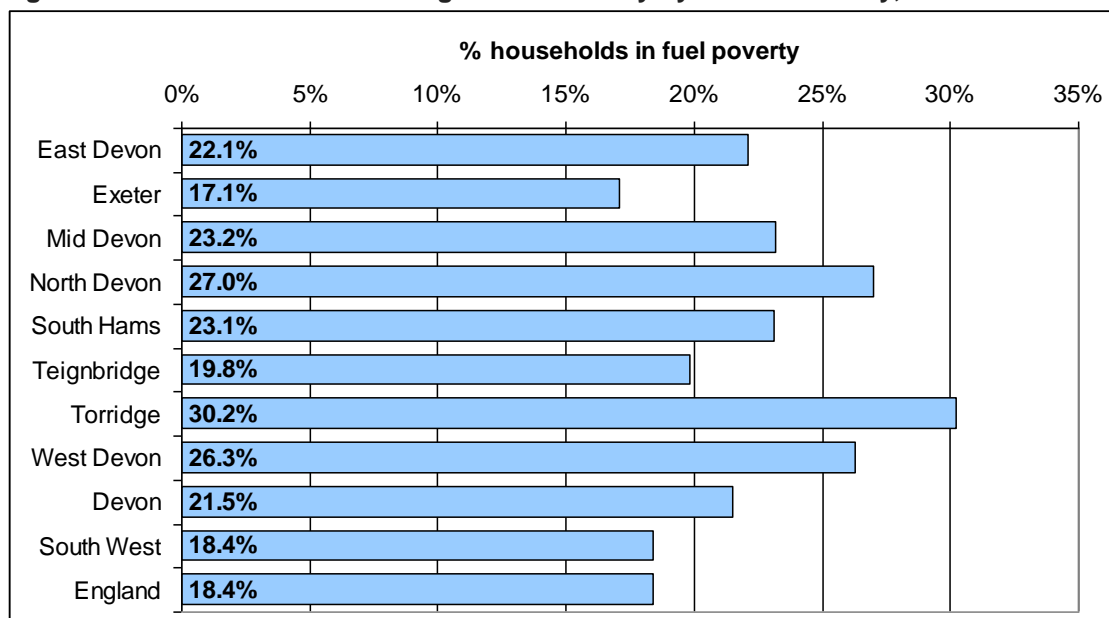
The topics identified will help to establish priorities for older people in Devon; however some topics and priorities identified in the adult section will also be relevant to older people.

Fuel Poverty

Fuel poverty in Devon is above the national average, with one in five rural households classed as fuel poor in the county. In recent years there has been a focus from central government to reduce fuel poverty by making grants available,

however increasing fuel prices has meant that numbers in fuel poverty continue to rise. Fuel poverty disproportionately affects older households, and rural districts of Devon where the housing stock is older and incomes are generally lower, as illustrated in the graph below.

Figure 5.2: % of Households Living in Fuel Poverty by Local Authority, 2009



Carers

The Devon Carers Health Needs Assessment 2008 indicates that more than 72,400 people (of all ages) in Devon have a caring role (Census 2001 figures), accounting for 10.6% of the total population, with the largest numbers of carers aged of 45 and 74, but with the largest proportions in older age groups. The 2001 Census indicates that in Devon there are just over 2,000 young carers aged up to 19 years (less than 3% of carers of all ages). Roughly half of young carers were aged below 16 years of age. Of the 8,700 carers in Devon aged 65+, 2,884 are providing unpaid care to a partner, family member or other person, but consider themselves to be in poor health.

Evidence shows that, of those for whom carers provide support:

- 62% have a physical disability
- 6% experience mental ill health, including dementia
- 18% have both a mental and physical disability – which could include learning disability, or dependence on drugs or alcohol
- 14% are older persons with age-related care needs

(Data Source: http://www.devon.gov.uk/devon_carers_strategy_finaldrafttargetted_consultation_sept_2009.pdf)

14,400 (20%) of carers provide more than 50 hours of care and support per week. Across the county the numbers vary with the highest proportion in several of the North Devon towns and the coastal areas of East Devon – those areas with a higher older-age population.

The Carers Health Needs Assessment 2008 indicates the impact of caring on carers' health:

- 47% of elderly carers report a limiting long-term illness compared to 41% of

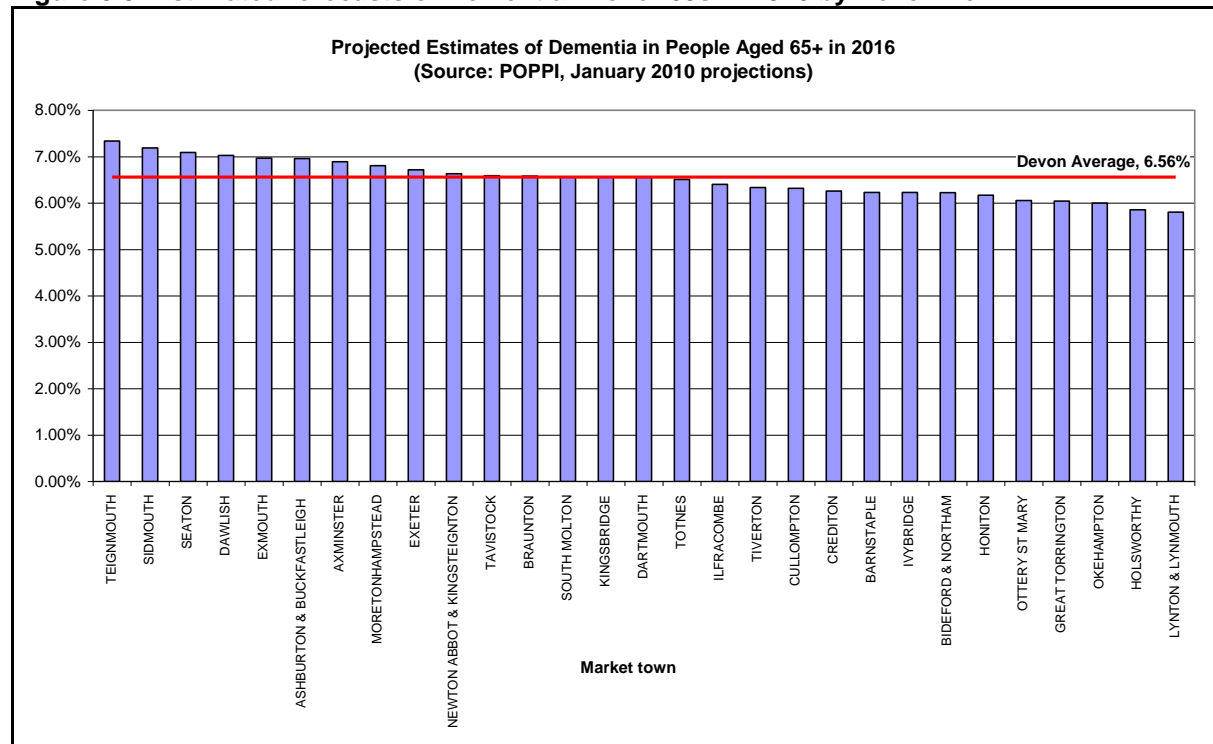
- people the same age in the general population.
- 39% of carers reported an impact on their physical and mental health.
- 20% reported feeling tired or had a general feeling of stress.
- 17% felt short tempered
- 14% reported feeling depressed or experienced disturbed sleep

If Devon is to achieve its ambition of increasing by 10% the number of people with moderate to severe dementia who are helped to remain at home by 2013, a range of support services for carers will be essential. The rising prevalence of chronic illness and the commitment to support people to stay in the community through self-care, choice and personalised care planning will have an impact on both current and future carers. Source: Devon Carers Health Needs Assessment, Devon Carers Strategy.

Dementia

Although Dementia is a common condition in older people, managing it can be hard for both the sufferer and family and friends around them. Although it can affect people at a younger age it predominantly affects people aged over 65. Devon has an older than average population and is also showing population growth in the older age groups. Figure 4.13 below shows the forecasted prevalence of dementia in people aged over 65 in 2016. The Devon average prevalence is 6.56% but ranges from 5.80% in Lynton and Lynmouth to 7.34% in Teignmouth.

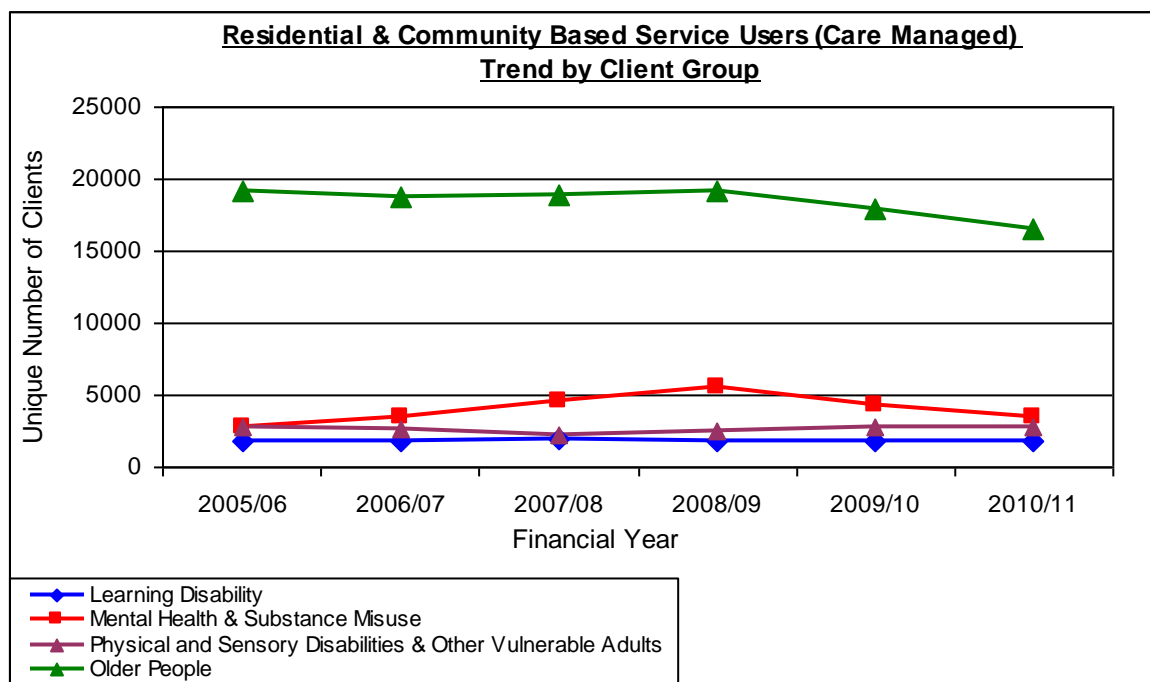
Figure 5.3: Estimated forecasts of Dementia in over 65s in 2016 by Devon Town.



Commissioned Social Care Activity in Devon - Care Managed Services provided following assessment)

The following is an analysis of overall service user volumes from 2005/06 to 2010/11, by client group, for those people receiving either a residential or community-based service, following an assessment and as part of a care-managed service package, during the reporting year. Individuals are only counted once within a client group, regardless of how many different services they have received.

Figure 5.4: Residential and Community based service users trend by client group

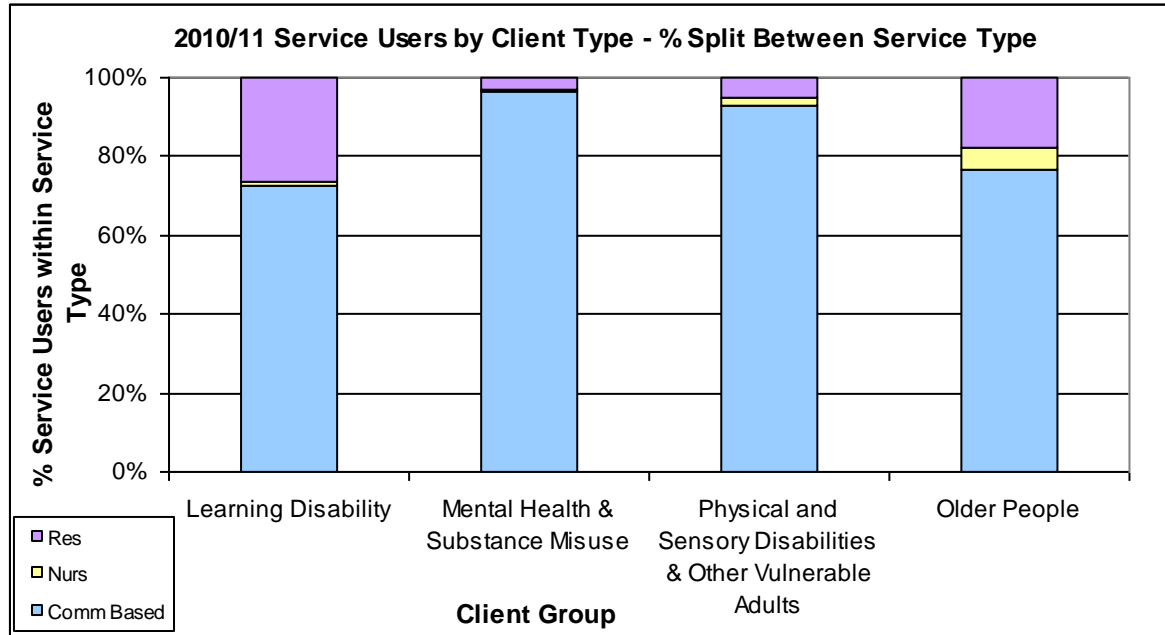


Source: Referrals, Assessments and Packages of Care Statutory Return, Form P1. Figures have been rounded to the nearest 5

The greatest proportion of service users are Older People aged 65+ who represented 67% of overall service users in 2010/11. Older people were however the only group to see a decrease in numbers over the five year time period analysed, showing a 13.8% drop. In part, this is likely to be due to the move away from more traditional care-managed services, improved information and advice and the development of services such as community mentoring which are not reflected in the above figures. The trend analysis is also affected by improvements to data capture and analysis across the years so should be considered with some caution. The highest growth in numbers has been seen in mental health services, showing an increase of 25% in the time period shown. There has however been significant improvement to data capture of mental health services which may account for some of this increase.

Figure 5.5 below breaks down the service user volumes into the broad service categories of community-based care, residential care or nursing care for each service user group in 2010/11. Learning Disabilities 18-64 has the highest proportion of clients within residential or nursing settings (27%), however this has decreased from 34% in 2005/06. 97% of current mental health services are community based. The number of people with mental ill health aged 18-64 in residential settings has decreased significantly between 2005/06 and 2010/11 (down from 210 to 120 – a 43% decrease). The number of people with physical and sensory disabilities aged 18-64 in residential settings between 2005/6 and 2010/11 has stayed constant. Currently 93% of this group are supported in the community. The most significant proportion of people in nursing care is Older People 65+ at 5%, with a further 18% in residential care. 77% are supported in the community, a relatively consistent position between 2005/06 and 2010/11.

Figure 5.5 Service Users by Client Type



Source: Referrals, Assessments and Packages of Care Statutory Return, Form P1. Figures have been rounded to the nearest 5.

Falls

The risk of an accidental fall increases rapidly with age, and higher levels evident in people living alone, people with existing medical conditions, and people living in more deprived areas. Most falls occur within the home.

The Projecting Older People Population Information System (POPPI) uses Health Survey for England data to predict the number likely to have had at least one fall during the last 12 months. The number of fallers increases from 46,675 in 2011 to 74,542 in 2030 in Devon (a 60% increase), from 11,261 to 16,553 in Plymouth (a 47% increase), and from 9,005 to 13,803 in Torbay (a 53% increase), highlighting greater increases in areas with older age profiles and higher projected future population growth. The rate of increase nationally from 2011 to 2030 is predicted to be 54%.

Standardised rates of admission for hip fracture are provided in the annual local authority health profiles for England, and highlight whether areas in the cluster have higher or lower rates once age has been controlled for. Figure 5.6 reveals that whilst most areas in the cluster are below the national average, no areas are statistically significantly different from the national rate, suggesting that for hip fractures there are no specific high risk areas locally.

Figure 5.6: Emergency admissions for hip fracture, 2009-10

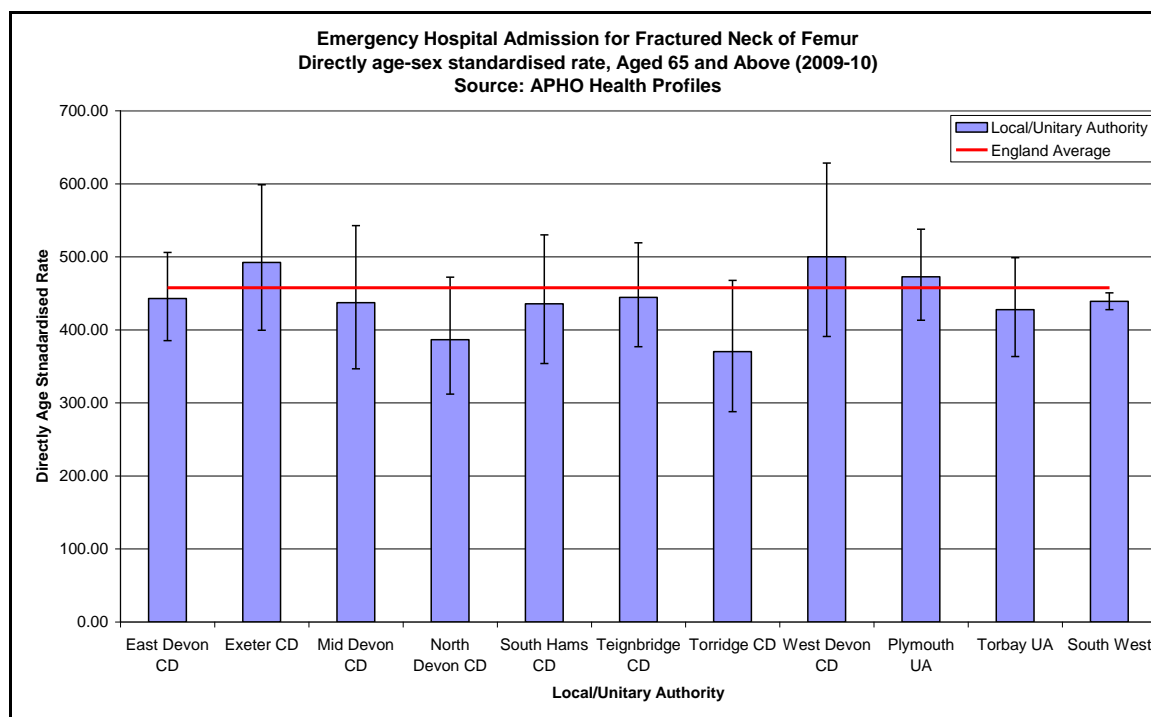


Figure 5.7 shows mortality rates in persons aged 75 and over where an accidental fall is recorded as the underlying cause of death. This reveals a pattern clustered around acute trust footprints, with rates well above the national average in areas facing acute trusts in Exeter and Plymouth (East Devon, Exeter, Mid Devon, West Devon and Plymouth), marginally above in Northern Devon (North Devon and Torrige) and well below in Southern Devon (Teignbridge and Torbay).

Figure 5.7: Mortality from accidental falls in persons aged 75 and above, 2008-10

