Public Health Devon

Devon County Council

Joint Strategic Needs Assessment Devon Overview 2015

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A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area. This document, the Devon Overview, looks at the overall pattern of health and care needs in the county, including the impact of population change, deprivation and economic conditions.

Chapter 3: Population

Around 760,000 people live in Devon. The county has an older population profile than England with a higher proportion in older age groups. All Devon districts have a higher proportion of those aged 85 and over than England, with particularly high concentrations in coastal and market towns such as Sidmouth, Teignmouth and Dartmouth. The population of the county is changing, with a projected increase in population of 100,000 over the next 20 years. This is illustrated by the number of persons aged 85 and over, which stood at 10,300 in 1981, 28,300 in 2015, and is set to rise to 64,900 by 2037, contributing to an increasing proportion of the population in older age groups, with consequences for both increased demand for health services and the availability of staff. Both in terms of volumes and net change, internal migration (movements within the UK) has a much more significant impact than international migration, with a strong net flow from the South East of England. The development and expansion of new towns, such as Cranbrook in East Devon and Sherford in the South Hams, coupled with continued housing and economic development in existing settlements will have an impact on local patterns of demand for health and care services.

Chapter 4: Equality and Diversity

The Equality Act 2010 identifies nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Act protects people from direct and indirect discrimination, harassment and victimisation because of a protected characteristic. The Act also includes a Public Sector Equality Duty (PSED), which requires public authorities to consider the extent to which they can eliminate discrimination, advance equality of opportunity and foster good relations in relation to the protected characteristics. The equality section of this report provides an overview of the population of Devon for each of the protected characteristics, a brief summary of health and wellbeing needs in respect of these characteristics, and links out to other documents and resources for further information. The Devon population is diverse in its needs and inequality can take many forms, resulting in differing health and care needs to which health and care commissioners need to respond.

Chapter 5: Economy

Devon has a culture of enterprise and resourcefulness. However average wages and productivity are low and given the variation across Devon, skills shortages present a barrier to growth in some parts of the county. Jobseekers Allowance claimant rates have decreased over recent years and are highest in Torridge. Average wages in Devon are below the England average and similar local authorities. The local authorities with the highest proportion of people with no qualifications are North Devon and West Devon and the lowest is Exeter. There is variation in the proportion of people claiming health-related benefits (Employment and Support Allowance and Incapacity Benefit) in Devon with the highest levels in North Devon and Torridge. Welfare reform is expected to have a considerable impact in Devon with estimates suggesting that more than £250 million will be taken out of the Devon economy in 2015-16. Food poverty, the inability to afford or have reasonable access to food which provides a healthy diet, is a significant issue and is increasing affecting people in low paid employment.

Chapter 6: Community and Environment

The Devon Strategic Assessment describes crime and community safety issues for Devon. Overall there has been a reduction in crime across Devon, although there is variation

between different crimes. There has been an increase in arson, domestic abuse, violence against a person, other thefts, shoplifting and hate crime. There has been a reduction in anti-social behaviour, criminal damage, vehicle crime, non-dwelling burglary, dwelling burglary, sexual offences and robbery. Natural Devon, the Devon Local Nature Partnership, was established in 2012 to protect and improve Devon's natural environment, to grow Devon's green economy and to reconnect Devon's people with nature. A 'State of the Environment' report was published in 2014 describing the current condition of the environment. Poor air quality can have a negative impact on health, and whilst mortality attributable to air pollution is below the South West and England average, a number of Air Quality Management Areas (AQMAs) exist where air quality is actively monitored. Whilst measures of social connectedness highlight that almost half of the people receiving care services in Devon have as much social contact as they would like. Housing conditions can have an adverse impact on health. The affordability of housing in Devon is also an issue on account of relatively high house prices and relatively low wages. Levels of homelessness in the county are relatively high, and are associated with a range of physical and mental health problems. As a large, predominantly rural county, there are additional challenges in Devon in terms of access to health and care services. Social interaction and social support play an important part in our health and wellbeing. Issues such as isolation, loneliness and mental health conditions such as anxiety and depression can influence physical health and reduced life expectancy is linked to chronic mental health problems such as schizophrenia.

Chapter 7: Socio-Economic Deprivation

The term socio-economic deprivation refers to the lack of material benefits considered to be basic necessities in a society. Around 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. 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. Whilst 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. The pattern varies across different domains in the Indices of Deprivation 2010, with relatively low levels or crime, road traffic accidents and generally good air quality mean the majority of areas in Devon are in the least deprived quintile nationally for the crime and outdoor environment domains. This is largely reversed in the barriers domain (accessibility and affordability of housing, and distance from local services) with 32.5% of the Devon population in the most deprived group nationally, and the indoor environment domain (houses failing to meet the decent homes standard or without central heating), with 47.3% of the Devon population in the most deprived group nationally.

Chapter 8: Starting Well – Children, Young People and Families

There are over 7,000 births per annum in Devon. Average age at birth is increasing with the rate of births to mothers aged 40 above the rate in under 20 year olds which is showing a gradual decrease. Inequalities in health start before birth. Whilst life expectancy at birth is above the national average and improving for Devon as a whole, there is a 15 year gap between the wards with the shortest (Ilfracombe Central, 74.6 years) and longest (Newton Poppleford and Harpford, 89.6 years) average life expectancies. Major differences are also seen in breast feeding rates, the number of women smoking during pregnancy, accident and emergency attendances, emergency hospital admissions and educational attainment. Levels of excess weight in childhood (overweight or obese) have been relatively stable over recent years, with levels above the national average at age four to five and below the national average at age 10 to 11. Teenage conception rates have fallen over recent years, but significant differences still exist with higher rates in more deprived areas. Common mental health problems in childhood include depression, generalised anxiety disorder, eating disorders and hyperactivity, along with post-traumatic stress disorder seen particularly in relation to cases of sexual and physical abuse. Rates of admissions for self-harm and levels of mental difficulties in looked after children are above the national average in Devon. Child Sexual Exploitation and Female Genital Mutilation have a major impact on the health and wellbeing of children and work is focused locally on identifying victims and working to prevent

future cases in Devon. Domestic violence and abuse affects many families in Devon with children and young people present in over a third (36%) of incidents reported to police in 2013-14.

Chapter 9: Living Well – Adults

Through the national NHS and Public Health England publication 'A Call to Action: Commissioning for Prevention' a strong emphasis is placed on identifying the risk factors associated with ill-health and premature death and working proactively to address these issues during adulthood. Rates of smoking have fallen over recent years, but significantly higher rates in more deprived areas still persist. Over 225,000 people in Devon are estimated to be affected by high blood pressure (Hypertension) with just over half known to GP services. Around three in five adults in Devon (60.6%) are recorded as overweight or obese, a figure which has increased over recent years. An estimated 60.9% of adults in Devon achieved at least 150 minutes of moderate physical activity per week in 2013. The pattern of alcohol use both nationally and locally is changing, with the sharpest falls in use in younger age groups, and regular use more common in those with higher incomes. However, alcohol-related illness and death remains more common in those on lower incomes or living in more deprived areas. The pattern of drug use is also changing, and whilst overall drug use is falling in both younger and older age groups, the use of powder cocaine and new psychoactive substances (formerly known as legal highs) have increased significantly over recent years. Mental health problems in adulthood vary by area, with the mood and anxiety disorder indicator from the 2010 Indices of Deprivation highlighting higher levels of need in parts of Exeter, Exmouth, Teignmouth, Dawlish, Newton Abbot, Totnes, Ilfracombe, Bideford and Barnstaple. Suicide rates in Devon have remained consistently above national levels in recent years. The pattern of risk factors coupled with an ageing population in Devon contribute to a growing number of people with long-term conditions in the county, which are typically higher in more deprived areas, with higher levels of complications in these age groups contributing to higher hospital admission and mortality rates. There is also a growing burden of those living with more than one long term condition (known as multi-morbidity) with around one in seven likely to have two or more conditions. Local and national evidence suggests people living in the most deprived areas are likely to experience multi-morbidity 10 -15 years earlier than those in the least deprived areas. There is also a strong relationship between mental health conditions and physical conditions with those on GP registers for depression and serious mental illness much more likely to also have physical long-term conditions.

Chapter 10: Ageing Well – Older People

The focus of prevention in older age groups is around healthy active ageing and supporting independence so older people area able to enjoy long and healthy lives, feeling safe at home and connected to their community. As with life expectancy at birth, variations also exist across Devon for life expectancy at the age 65, with 65 year olds in the least deprived areas (21.8 years) likely to live 3.4 years longer than those in the most deprived areas (18.4 years). An older population structure and stronger population growth in Devon mean that current and future demand for health and care services in Devon are likely to be greater than those seen nationally. Levels of frailty, accidental falls, visual impairment and dementia are higher than the national average and future growth will be greater. Similarly demand for general health and care services will also increase accordingly. Due to higher living costs and lower average household incomes, fuel poverty in Devon is higher than similar local authorities nationally, and particularly affects older age groups. The provision of unpaid care also has a major impact on older people, with those who are caring for 50 or more hours per week likely to experience more rapid deterioration in their own health as they get older.

Developing the JSNA in Devon

This document, the Devon Overview, is part of a wider suite of JSNA resources in Devon. Other elements include:

- Community Health and Wellbeing Profiles, providing a wide range of health and care information for geographic areas, including towns, local authorities, and GP practices

- The Devon Health and Wellbeing Outcomes Report, which monitors progress against the priorities identified in the Devon Joint Health and Wellbeing Strategy
- Locality Health Improvement Plans, which guide the work of the Public Health team and colleagues working in the NHS, the local authority and other organisations, identifying both priority issues and priority communities within local areas
- Outcomes reports, data downloads and links to other related documents
- A comprehensive library of topic based information, including needs assessments.

Detailed health needs assessments published since the last JSNA Devon Overview was completed in 2013 are available on the Devon Health and Wellbeing website http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/ and include:

- Domestic and Sexual Violence and Abuse JSNA 2013
- Mental Health and Wellbeing Health Needs Assessment 2013
- Eastern Locality Elder Care Health Needs Assessment 2013
- Care Home Residents Health Needs Assessment 2014
- Lesbian, Gay, Bisexual and Transgender (LGBT) Health Needs Assessment 2014
- Dementia Health Needs Assessment 2014
- South West Peninsula Veterans Health Needs Assessment 2014
- Safeguarding Children JSNA 2014-15
- Long-Term Conditions Health Needs Assessment 2015

Areas for ongoing development include the further development of information relating to the public sector equality duty and qualitative information about health and wellbeing services and issues locally, as demonstrated in the green 'Perceptions and Experiences' boxes in the main report.

Further to this, the Devon Health and Wellbeing website (www.devonhealthandwellbeing.org.uk) will be updated during 2015 and 2016 to improve content including interactive health and wellbeing profiles and outcomes reports, improved topic based information and document management, the publication of supporting data in open formats and a mapping interface displaying data on health needs and services.

Conclusion – the main challenges in Devon

The main health and wellbeing challenges in Devon are:

- An ageing population which is also growing faster than the national average increasing future demand for health and care services
- Increasing financial pressures affecting local authorities, Clinical Commissioning Groups and other agencies requiring changes to traditional patterns of service provision to ensure health and care services remain affordable
- A sparse and predominantly rural population, creating additional challenges around access to health and care services and the need for sophisticated models of home-based care, outreach and work to reduce social isolation. The effective utilisation of local resources, voluntary / community organisations and community assets will be critical
- Patterns of deprivation marked by isolated pockets and hidden need within communities and higher levels of rural deprivation, with groups experiencing health inequalities likely to be geographically dispersed. This creates additional challenges when addressing health inequalities and targeting services to those most in need
- A configuration of local authority and health organisations more complex than most other counties, with two-tier local authorities, and Clinical Commissioning Groups crossing local authority boundaries. This creates extra challenges in terms of the continuity of services, planning and effective partnership working
- Average earnings below the national average and house prices and cost of living above the national average which contribute to a number of issues including food poverty, housing-related health conditions, homelessness, mental health and wellbeing, and fuel poverty

- The need for a focus on prevention at all stages of the life course aimed at improving health in later life for all, as well as narrowing the 10 to 15 year gap in health status between those living in the most and least deprived areas. This will be critical to addressing the demographic and financial pressures that local organisations are facing
- The need for a focus on mental health and wellbeing throughout the life course with a particular emphasis on areas where outcomes are comparatively poor, and an understanding of the relationship between mental and physical health
- Changing patterns of health-related behaviours including smoking, excess weight, physical activity, diet, alcohol and drug use and ensuring that the planning of services addresses changing patterns of behaviour and demand
- The growing number of people with long-term conditions, sensory impairment, frailty, dementia, cancer and other health problems. This requires a particular focus on those living with multiple health conditions, as traditionally health systems have been largely configured for individual diseases rather than multi-morbidity
- The Devon population is diverse in its needs and inequality can take many forms, resulting in differing health and care needs to which health and care commissioners need to respond.

2. Introduction

2.01 The Joint Strategic Needs Assessment

A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and care services within a local authority area.

The JSNA:

- Is concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment
- Looks at the health of the population, with a focus on behaviours which affect health such as smoking, diet and exercise
- Provides a common view of health and care needs for the local community
- Identifies health inequalities

Who is the JSNA for?

The main audience for the JSNA are health and social care commissioners who use it to plan services.

It can also be used as an evidence base for preparing bids and business cases, by the voluntary and community sector to ensure community needs and views are represented, by service providers to assist in the future development of their services, and by the public to scrutinise local health and wellbeing information.

What does the JSNA look like in Devon?

JSNAs are flexible and enable local areas to focus on the priorities and present information in the way most relevant to them. JSNA resources in Devon can be found here www.devonhealthandwellbeing.org.uk/jsna and include:

- This document, the Devon Overview, which looks at the overall pattern of health and care needs in the county, including the impact of population change, deprivation and economic conditions
- Community Health and Wellbeing Profiles, providing a wide range of health and care information for geographic areas, including towns, local authorities, and GP practices
- The Devon Health and Wellbeing Outcomes Report, which monitors progress against the priorities identified in the Devon Joint Health and Wellbeing Strategy
- Locality Health Improvement Plans, which guide the work of the Public Health team and colleagues working in the NHS, the local authority and other organisations, identifying both priority issues and priority communities within local areas
- Outcomes reports, data downloads and links to other related documents
- A comprehensive library of topic based information, including needs assessments

Who is involved in producing the JSNA in Devon?

Under the Health and Social Care Act 2012 local Health and Wellbeing Boards are responsible for producing the JSNA. Health and Wellbeing Boards collaborate to understand their local community's needs, agree priorities and encourage organisations involved in health and care to work in a more joined up way. Members of the Devon Health and Wellbeing Board include representatives from local authorities and the NHS in Devon, local councillors and other community representatives. The current membership list can be found here: www.devonhealthandwellbeing.org.uk/board/members

A development group oversees and guide the development of the JSNA, including representatives from the NHS, local authority and voluntary and community sector. There is also an analysts group which plans and coordinates information analysis for the JSNA,

including representatives from the NHS, district and county councils, police, and other local services. These two groups help to ensure a broad range of different organisations and communities are involved in the JSNA in Devon.

Health and Wellbeing Boards are also responsible for the production of the Joint Health and Wellbeing Strategy, which is a strategy to address the needs identified in the JSNA, and set the health and wellbeing priorities of the board accordingly. The Devon Joint Health and Wellbeing Strategy is available here: www.devonhealthandwellbeing.org.uk/strategies

The board's terms of reference are to:

- Ensure the delivery of improved health and wellbeing outcomes for the population of Devon, with a specific focus on reducing inequalities
- Promote the integration of health, social care and public health, through partnership working with between the NHS, Social Care Providers, District Councils and other public sector bodies
- Promote an integrated health improvement approach to public health service provision
- Provide a local governance structure for the local planning of and accountability for all health and wellbeing related services
- Assess the needs and assets of the local population and lead the development of the statutory Devon Joint Strategic Needs Assessment (JSNA) in partnership with Clinical Commissioning Groups
- Similarly, produce and update a Devon Joint Health and Wellbeing Strategy to provide a strategic framework to meet the needs identified in the JSNA
- Promote joint and joined-up commissioning and pooled budget arrangements, where that makes sense as a means of promoting integration and partnership working across areas
- Ensure all commissioning plans and policies reflect the health and wellbeing priorities identified through the joint needs assessment process.

2.02 The Health and Care Landscape in Devon

Local Authorities

Devon has a two-tier local authority system, with services such as social care, education, public health, libraries, transport, strategic planning, waste management and consumer protection managed by the County Council and housing, environmental health, waste collection, council tax collection, local planning and licensing managed by eight smaller local authority districts. Whilst overall responsibility for health and wellbeing board functions sit with the County Council, local authority districts have a crucial role to play in terms of promoting and protecting the health of their citizens, work closely with Devon County Council and the NHS on health and related issues and are represented on the Devon Health and Wellbeing Board. Whilst Plymouth City Council and Torbay Council have their own Health and Wellbeing Boards, close working relationships exist on the health, social care and wellbeing agendas.

Table 2.1, Local Authorities in Devon

Name	Website	Type	Population (2013)
Devon County Council	www.devon.gov.uk	County	758,100
East Devon District Council	www.eastdevon.gov.uk	District	134,900
Exeter City Council	www.exeter.gov.uk	District	121,800
Mid Devon District Council	www.middevon.gov.uk	District	78,700
North Devon Council	www.northdevon.gov.uk	District	93,800
South Hams District Council	www.southhams.gov.uk	District	83,900
Teignbridge District Council	www.teignbridge.gov.uk	District	126,000
Torridge District Council	www.torridge.gov.uk	District	65,100
West Devon Borough Council	www.westdevon.gov.uk	District	53,900

Map of local authority districts in Devon: http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/04/Devon-Local-Authority-Boundaries.pdf

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) are groups of GPs responsible for designing local health services in England, and commissioning (buying) health and care services. There are two CCGs in the Devon, Plymouth and Torbay area, both of which are represented on the Devon Health and Wellbeing Board.

Table 2.2, Clinical Commissioning Groups in Devon

Name	Website	Districts covered	Registered Population*
Northern, Eastern and Western Devon CCG	www.newdevonccg.nhs.uk	East Devon, Exeter, Mid Devon, North Devon, Plymouth, South Hams (part), Torridge, Teignbridge (part), West Devon	897,500
South Devon and Torbay CCG	www.southdevonandtorbayccg.nhs.uk	South Hams (part), Teignbridge (part), Torbay	285,100

* registered population in April 2015

Map of CCGs in Devon: http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/08/Devon-CCGs-Aug-121.pdf
Map comparing CCGs and local authority districts: http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/09/Devon-CCGs-Localities-and-Lower-Tier-Local-Authorities.pdf

Healthwatch Devon and the Joint Engagement Board

Healthwatch Devon work to help people get the best out of their health and social care services and ensuring local voices are able to influence how local services are designed and delivered. Healthwatch Devon work in partnership with members of the public, patients, carers and service users to achieve the best quality care and more choice in the county and are represented on the Devon Health and Wellbeing Board.

Healthwatch Devon website: www.healthwatchdevon.co.uk/

The Joint Engagement Board in Devon ensure consultations on health and social care issues in Devon are shared with as many stakeholders as possible and play a vital role in giving people who receive support, opportunities to comment on the performance and development of services that affect them. The Devon Joint Engagement Board is represented on the Devon Health and Wellbeing Board.

Joint Engagement Board webpage: http://www.devon.gov.uk/index/socialcarehealth/have-your-say/jointengagementboard.htm

NHS England and Public Health England

NHS England has regional and local area teams (LATs), with responsibilities around immunisation, screening, primary care contract management and commissioning dental services. The Local Area Team is represented on the Devon Health and Wellbeing Board. Further this Public Health England have an overarching responsibility for protecting and improving the nation's health and wellbeing, and reduce health inequalities and are also divided into regional and local area teams.

Health and Care Providers

There are over 100 GP practices in Devon and a wide range of acute and community health and care services. Health services can be located using the NHS Choices website below:

NHS Choices website: www.nhs.uk/service-search

Further to this, the Devon Community Directory provides a comprehensive listing of a wider range of services and community groups across the county.

Devon Community Directory: www.directory.devon.gov.uk/kb5/devon/directory/home.page

2.03 Existing Strategic Priorities in Devon

Devon Joint Health and Wellbeing Strategy
www.devonhealthandwellbeing.org.uk/strategies/

Through the Health and Social Care Act 2010, local authorities and Clinical Commissioning Groups (CCGs) have equal and joint duties to prepare JSNAs and Joint Health and Wellbeing Strategies through the health and wellbeing board. Joint Health and Wellbeing Strategies are designed to address the needs identified in JSNA and set health and wellbeing priorities for local organisations. The commissioning plans of CCGs, NHS local teams, and local authorities are expected to be informed by relevant JSNAs and Joint Health and Wellbeing Strategies.

The Devon Joint Health and Wellbeing Strategy for 2013 to 2016 identified four overarching priorities for Devon. These are:

1. A focus on children and families
2. Healthy lifestyle choices
3. Good health and wellbeing in older age
4. Strong and supportive communities

Within these overarching priority areas are a number of more specific priorities, and progress and emerging priorities have been identified through updates to the strategy.

Devon County Council: Better Together
https://new.devon.gov.uk/bettertogether/

'Better Together' sets out a vision for 2020 and beyond for the County Council detailing how the council will work with partners to help people and communities control their own future. The vision is built around five themes:

Resilient – Supporting people and communities to become resilient by supporting voluntary and community groups, and creating opportunities for people to contribute.
Healthy – Enabling people to lead healthy lives in Devon's environment, supporting people to live in their own home as part of a supportive community, and focusing on reducing inequalities in health.
Prosperous – Supporting Devon's resourceful small enterprises, innovative high value businesses, agriculture and tourism industries and encouraging economic growth.
Connected – Helping people to connect to one another in order to form supportive and inclusive communities through good digital and transport connections.
Safe – Working to ensure everyone has the security, confidence and respect to live their life to the full, and where risks are present carefully targeting support to address the root causes of problems and offer protection from harm.

Underlying this vision is the need for **collaboration** (working with the public and other organisations to achieve the best outcomes), being **enterprising** (achieving good value and working efficiently and effectively), and being **innovative** (working in new and flexible ways).

Figure 2.1, The Vision for Devon

Source: Better Together: Devon 2014 – 2020, Devon County Council, 2014

There are also specific strategic priorities relating to particular areas of responsibility within the county council.

The Adult Social Care Annual Report identifies current issues and priorities (https://new.devon.gov.uk/adultsocialcareandhealth/guide/adult-social-care-in-devon-2014-annual-report/). Further to this, the vision for care and support for vulnerable adults in Devon (https://new.devon.gov.uk/adultsocialcareandhealth/files/2012/11/Vision-of-care-and-support-for-vulnerable-adults-in-Devon.pdf?75ae0b) sets out how the County Council, its partners and the citizens of Devon will work together to build supportive communities and independent individuals.

A number of Joint Commissioning Strategies cover areas where responsibilities are shared between Adult Social Care, Health Services and other agencies, and where strategic coordination is critical to achieving the best outcomes for Devon. Current Joint Commissioning Strategies are listed below:

- A mental health commissioning strategy for Devon, Plymouth and Torbay 2014-2017 https://drive.google.com/uc?export=download&id=0B7cD7ELh7rOMZzVnaEVlSERXRkE
- Living well with a learning disability in Devon 2014-2017 https://drive.google.com/uc?export=download&id=0B7cD7ELh7rOMcFc4WkpvWWFhZXc
- Living well with dementia in Devon – making progress 2014-2016 https://drive.google.com/uc?export=download&id=0B7cD7ELh7rOMQzd3TlZWWl9MUVE
- Carers in Devon: joint strategy 2014-2019 https://drive.google.com/uc?export=download&id=0B7cD7ELh7rOMeHZuMHpwUTJPdXc

Annual Public Health Reports provide an overview of public health issues locally and set priorities for the year ahead.

- Devon Annual Public Health Reports www.devonhealthandwellbeing.org.uk/aphr

Northern Eastern and Western Devon Clinical Commissioning Group: Local NHS Futures – Transforming Care in Devon and Plymouth
http://www.newdevonccg.nhs.uk/who-we-are/vision-mission-strategies--objectives/100271

The Northern, Eastern and Western Devon CCG vision agreed by the governing body in 2013 is 'healthy people, living healthy lives, in healthy communities'.

This vision is to be achieved through the commissioning of high quality sustainable services promoting wellbeing and caring for people when they are unwell, by focusing on working in partnership, making the best use of available resources and emphasising the prevention of ill health and the promotion of wellbeing, alongside helping people with long-term conditions to live well. The CCGs objectives are to:

- Commission services with partners to reduce health inequalities and improve people's lives
- Listen to people and take action on what they say about services
- Commission safe services and reduce avoidable harm
- Support people to make healthy lifestyle choices and understand the care, treatment and services available to them
- Develop people, and those who support them, to value strengths and personal qualities in all they do
- Innovate to increase productivity and reduce waste.

South Devon and Torbay Clinical Commissioning Group Strategic Plan
http://www.southdevonandtorbayccg.nhs.uk/about-us/our-plans/Pages/integrated-strategic-plan.aspx

The South Devon and Torbay CCG vision as documented in the 2014 Strategic Plan is for 'excellent, joined up care for everyone'.

The CCG highlight their responsibilities as reducing inequalities, achieving national requirements and achieving a sustainable financial balance. This is supported by three intentions which are an excellent experience of care and effective outcomes, a focus on collaborative working with communities, and a proud, motivated and skilled workforce. The priorities for the CCG are:

- Promoting self-care, prevention and personal responsibility
- Developing joined up community hubs closer to home, for all
- Leading a sustainable health and care system covering workforce, estates and IT.

2.04 Health Inequalities

Differences in health can be seen between many different groups in society – between the best-off financially and the poorest; between those with disability and those without; between men and women. Such diverse comparison groups expose a range of contributory factors to our health – some are inherited as part of genetic make-up, some are acquired, and some are created by the world we live in.

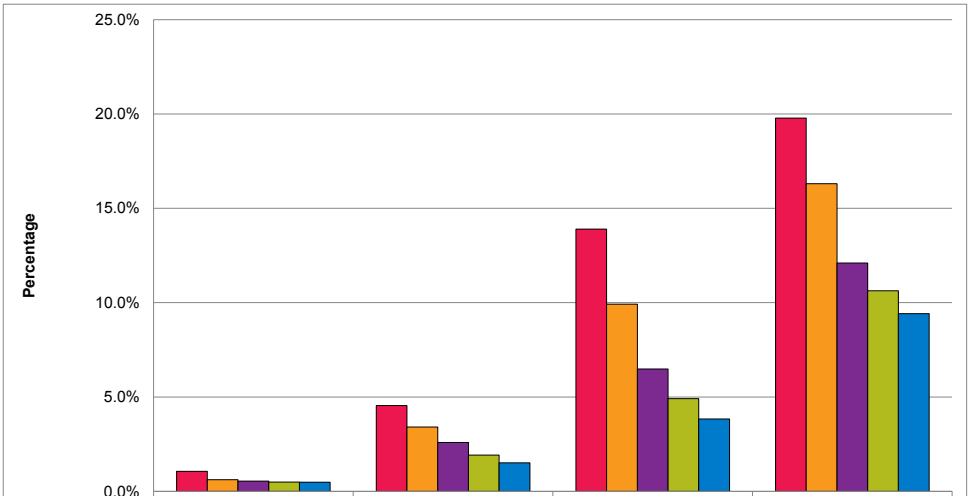
Figure 2.2 describes these factors, known as the 'wider determinants' of health and wellbeing, starting with the people and the lifestyles they lead, which is influenced by the families and communities they live in, the natural and built environment around them, and a wide range of social and economic factors at local, national and global levels. The areas in which local government and others can make a difference are wide ranging and diverse, highlighting that health and wellbeing is not just about traditional health and care services.

Figure 2.2, The Wider Determinants of Health and Wellbeing and the role of local government in making a difference

Source: Campbell F. The social determinants of health and the role of local government. London: LGA/IDeA, 2010

Differences between areas and different groups of the population have a significant influence on health and wellbeing. This is demonstrated in figure 2.3, which highlights poorer self-reported health in more deprived areas across all age groups.

Figure 2.3, Percentage whose self-reported health was bad or very bad by age and income deprivation category, Devon, 2011



	Age 0 to 15	Age 16 to 49	Age 50 to 64	Age 65 and over
Most Deprived	1.1%	4.5%	13.9%	19.8%
Above Average	0.6%	3.4%	9.9%	16.3%
Average	0.5%	2.6%	6.5%	12.1%
Below Average	0.5%	1.9%	4.9%	10.6%
Least Deprived	0.5%	1.5%	3.8%	9.4%

Source: 2011 Census, Office for National Statistics

2.05 Prevention

Both nationally and locally the recent focus has been on the integration of health and social care and on prevention. The Care Act has introduced a wider duty to consider physical, mental and emotional wellbeing of individuals needing care and a duty to provide preventative services to prevent reduce and delay needs. The Better Care Fund allows further pooling of health and social care funding and the ability to integrate services further. The NHS and Public Health England publication 'A Call to Action: Commissioning for Prevention' (http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf) was launched in 2013 and provides a case for prevention and a framework for local action.

The aim of this prevention work is for an upstream shift to preventive action to reduce health inequalities and reduce premature morbidity and mortality, and for preventative work streams align and form a cohesive whole. Work around prevention and the integration of health and social care will involve the work of local authorities and clinical commissioning groups, acute NHS trusts, mental health trusts and voluntary and community sector organisations.

Any prevention approach will need to consider the life-course following the principles of starting well, living well and ageing well. To impact on prevention, programmes need to support successful aging from middle age onwards rather than simply aiming to support elderly people to prevent worsening of chronic conditions. Successful aging enables people to have the knowledge to develop the behaviours and acquire the skills as they grow older to avoid the development of disease and stay active and positively healthy until a short time before death. Successful ageing will include; survival to an advanced age whilst maintaining physical and cognitive function, maintaining functional independence and living a full and active life. It means morbidity and disability are compressed into a relatively short period before death in line with the 'compression of morbidity' theory (http://www.ageing.ox.ac.uk/files/workingpaper_206.pdf).

A prevention strategy covering social care and health within Devon is currently in development.

3. Population

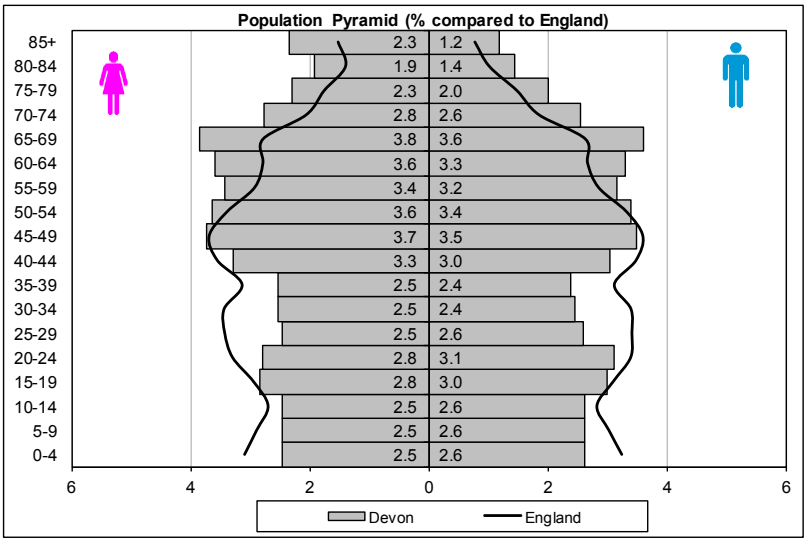
3.01 Population Structure

Devon has an older population profile than nationally, particularly in those aged 50 to 70 years of age, reflecting significant in-migration in this age group, and those aged 85 years and over, reflecting an ageing population and longer life expectancy (figure 3.1). The proportions of those aged under 40 years are below the national average, particularly in those aged 25 to 39 significant out-migration from Devon. As illustrated in table 3.1, this overall pattern is even more marked in East Devon, whilst the population in Exeter is similar to the national average, but with an increased young adult population due to the university. This population structure impacts on the use of health and social care service as older age groups are the highest users of these services. Figures 3.2 to 3.5 compare Devon Lower Super Output Areas (LSOAs) populations by broad age group with the national average. Most areas are below the national average for the under 16 population, with a handful of principally urban areas above the national average. Coastal areas and large parts of East and Mid Devon have lower proportions in the 16 to 64 age group. Most areas have a higher than national average proportion in the 65 to 84 age group, with particularly large concentrations in the South Hams and East Devon. The pattern for those aged 85 and older is similar but more mixed reflecting further population movements and care provision.

Figure 3.1, Population Structure, Devon vs England, 2013

Population Pyramid - Devon Population - 2013

The table and population pyramid below show the population broken down by age and sex for the area against England. The age and gender of your population can have a significant impact on their health and social care needs.



Age Group	Female	Male
0-4	18597	19923
5-9	18656	19842
10-14	18647	19954
15-19	21499	22712
20-24	21219	23626
25-29	18644	19689
30-34	19181	18559
35-39	19189	18074
40-44	24821	23100
45-49	28322	26576
50-54	27621	25795
55-59	25975	23923
60-64	27194	25114
65-69	29091	27331
70-74	20960	19374
75-79	17394	15245
80-84	14524	10884
85+	17775	9022
Total	**389309**	**368743**

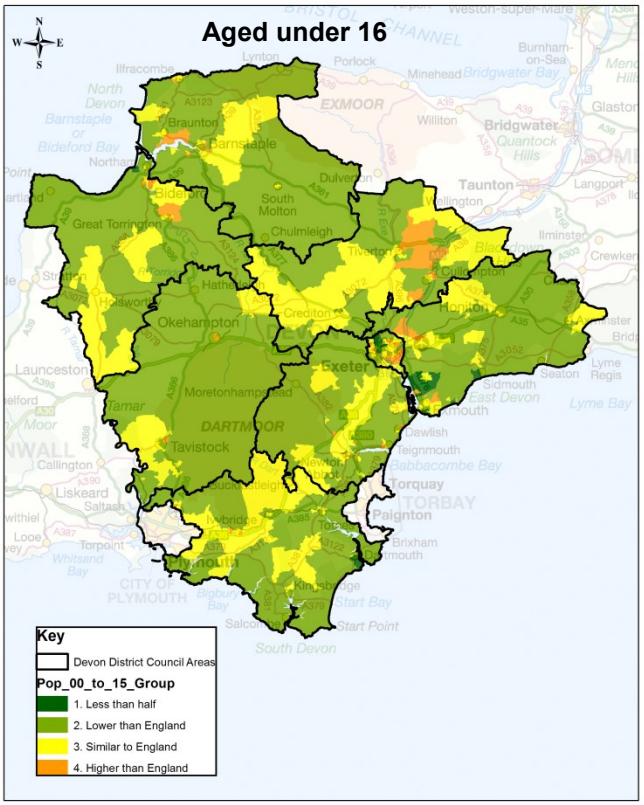
Source: ONS Mid-Year Population Estimate, 2013

Table 3.1, Population by Broad Age Group, Devon Districts, 2013

District	00 to 15	16 to 64	65 to 84	85 and over	Total
East Devon	20,814 (15.4%)	74,393 (55.1%)	33,178 (24.6%)	6,513 (4.8%)	134,898
Exeter	19,253 (15.8%)	83,274 (68.4%)	16,076 (13.2%)	3,197 (2.6%)	121,800
Mid Devon	14,557 (18.5%)	46,872 (59.6%)	14,895 (18.9%)	2,346 (3.0%)	78,670
North Devon	16,132 (17.2%)	55,275 (58.9%)	19,240 (20.5%)	3,178 (3.4%)	93,825
South Hams	13,371 (15.9%)	48,877 (58.3%)	18,715 (22.3%)	2,887 (3.4%)	83,850
Teignbridge	20,476 (16.3%)	74,026 (58.8%)	26,662 (21.2%)	4,837 (3.8%)	126,001
Torridge	10,661 (16.4%)	38,135 (58.6%)	14,262 (21.9%)	2,031 (3.1%)	65,089
West Devon	8,677 (16.1%)	31,659 (58.7%)	11,775 (21.8%)	1,808 (3.4%)	53,919
Devon	123,941 (16.3%)	452,511 (59.7%)	154,803 (20.4%)	26,797 (3.5%)	758,052
England	(19.0%)	(63.8%)	(15.0%)	(2.3%)	-

Source: ONS Mid-Year Population Estimate, 2013

Figures 3.2 to 3.5, Population in Selected Age Bands by LSOA compared to England, 2013



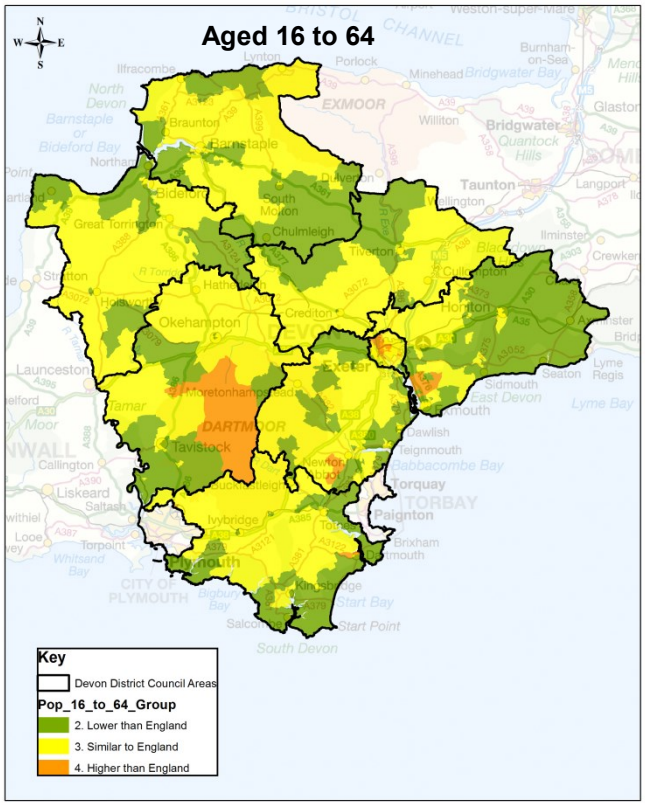
Map Title: Population aged under 16 compared to England average by LSOA, 2013

Date: 08 April 2015

Author: Devon Public Health Intelligence Team

Public Health Devon

0 7,500 15,000 30,000 Meters



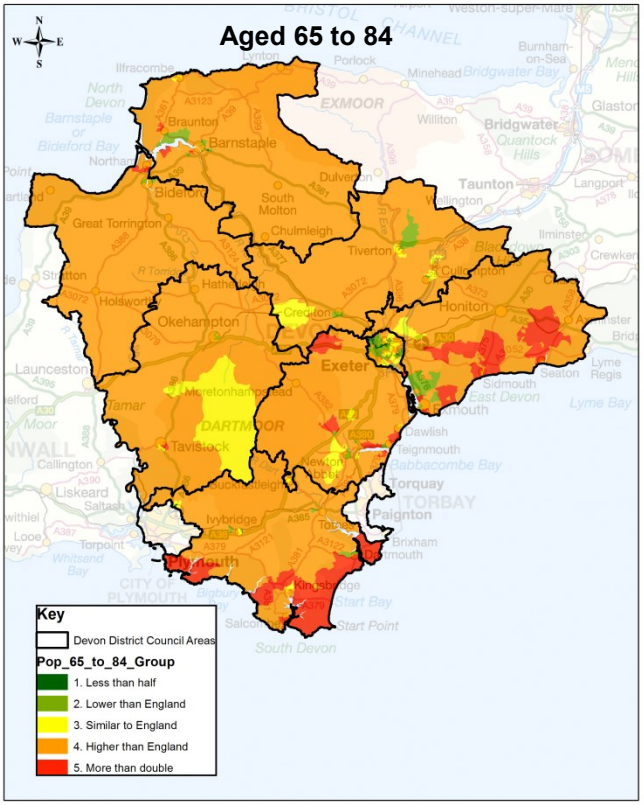
Map Title: Population aged 16 to 64 compared to England average by LSOA, 2013

Date: 08 April 2015

Author: Devon Public Health Intelligence Team

Public Health Devon

0 7,500 15,000 30,000 Meters



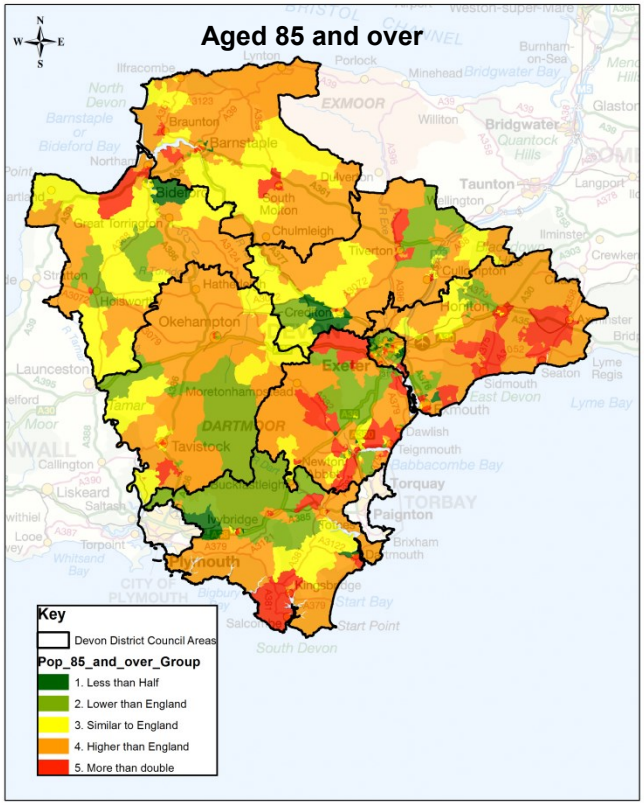
Map Title: Population aged 65 to 84 compared to England average by LSOA, 2013

Date: 08 April 2015

Author: Devon Public Health Intelligence Team

Public Health Devon

0 7,500 15,000 30,000 Meters



Map Title: Population aged 85 and over compared to England average by LSOA, 2013

Date: 08 April 2015

Author: Devon Public Health Intelligence Team

Public Health Devon

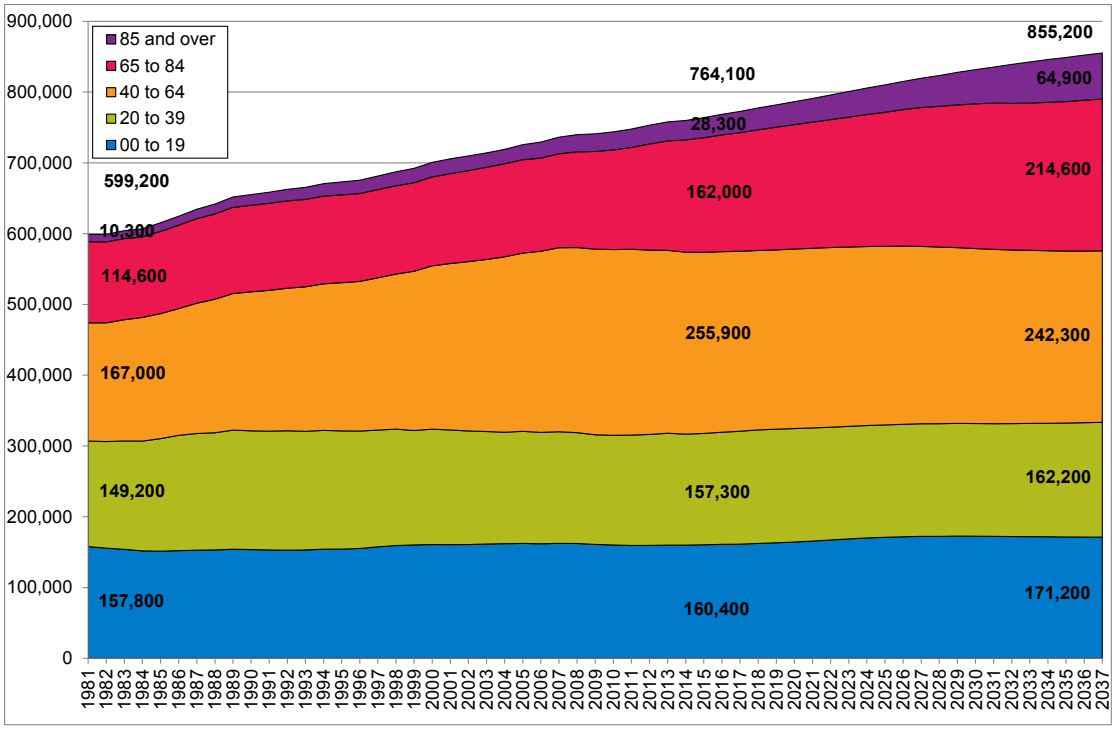
0 7,500 15,000 30,000 Meters

Source: ONS Mid-Year Population Estimate, 2013

3.02 Population Change

Figure 3.6 shows the actual and projected change in the number of people in Devon from 1981 to 2037. While there is relatively gradual change in the under-40 age groups, the major change occurs in the population over 60 years, both in numbers and as a proportion of the whole. The increase in the 85 and over population is particularly striking, increasing from 10,300 in 1981 to 28,300 in 2015, and projected to reach 64,900 by 2037.

Figure 3.6, Population Change by Age Group, Devon, 1981 to 2037

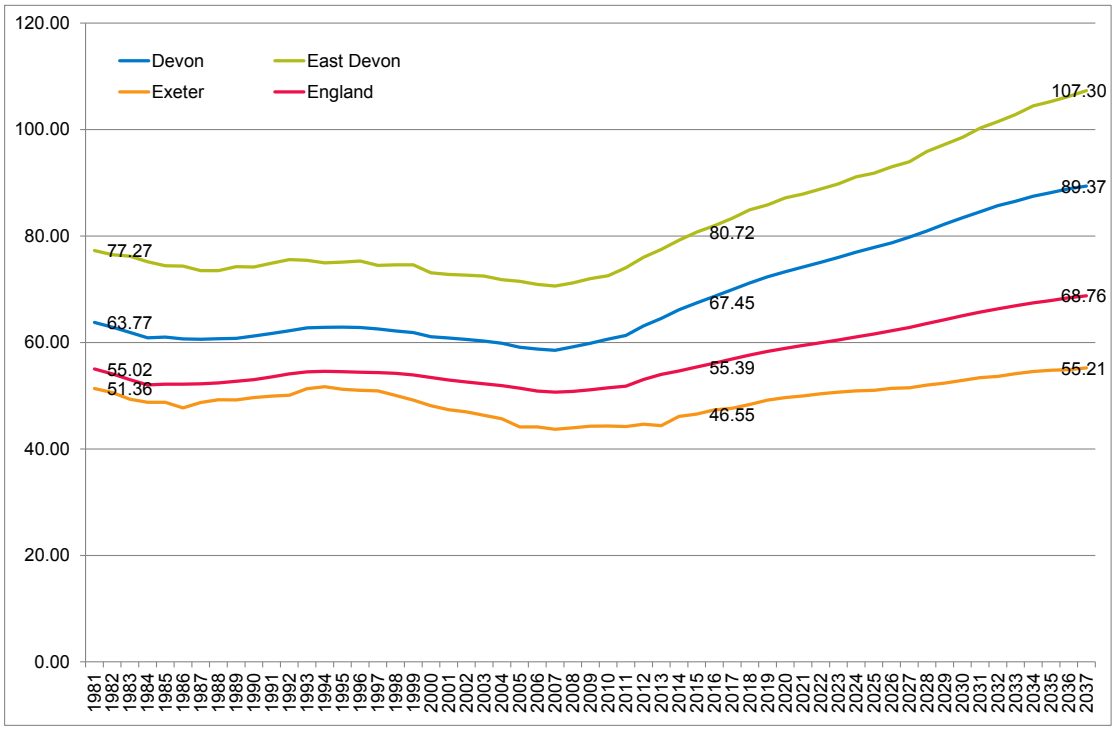


Source: ONS Mid-Year Population Estimates, 1981 to 2013, ONS Sub-National Population Projections, 2014 to 2037

The dependency ratio is a measure showing the number of people aged 0 to 14 or 65 and over, per hundred people aged 15 to 64. This means the higher the ratio is, the higher the proportion of people in these younger and older age groups. This is a measure used for international comparison and it should be noted these so called 'dependent' age groups do not necessarily reflect wider economic changes, which means people over the age of 65 are increasing likely to be economically active (rising from 10% in 2001 to 12% in 2011). However, it does give a useful indication of the impact of changing population structures, which in turn can have an impact on demands for health and care services and the workforce required to support these demands.

Figure 3.7 reveals the dependency ratio dropped between 1981 and 2007, largely as a result of the 'baby boom' generation born in the 1960s (when birth rates were higher than the 1950s and 1970s) entering the 15 to 64 age group, with the dependency ratio going down to 59 in Devon in 2007. However, persistent increases in the dependency ratio have been seen over recent years as a result of lower birth rates in the 1980s and 1990s (meaning fewer people joining the 15 to 64 age group), and the 'baby boom' generation of the late 1940s reaching the age of 65. Over the next 20 years the dependency ratio is set to continue to increase, and by 2037 is predicted to reach 89 in Devon, 69 in England, 107 in East Devon (the district with the highest ratio) and 55 in Exeter (the district with the lowest ratio). The current dependency ratio in Devon (67) is only marginally below the predicted England ratio for 2037 (69).

Figure 3.7, Dependency Ratio* for Selected Areas, 1981 to 2037



Source: ONS Mid-Year Population Estimates, 1981 to 2013, ONS Sub-National Population Projections, 2014 to 2037

* number of people aged 0 to 14 and 65 and over per 100 people aged 15 to 64

3.03 Migration

Human migration is the movement by people from one place to another with the intention of settling temporarily or permanently in the new location. A distinction is made between international migration, where people move from one country to another, and internal migration which covers movements within a country. Table 3.2 highlights the flow of international and internal migration into and out of Devon from 2004 to 2013. This does not include movements within the Devon County Council area from one address to another. This reveals internal migration is much more significant locally than international migrations, with more than nine times the number of internal movements than international movements. More people move into Devon (inflow) than out (outflow), contributing to population growth locally. The net flow of internal migrants is around 4,000 per annum in Devon, and the net flow of international migrants has stood at around 2,000 per annum for the last three years.

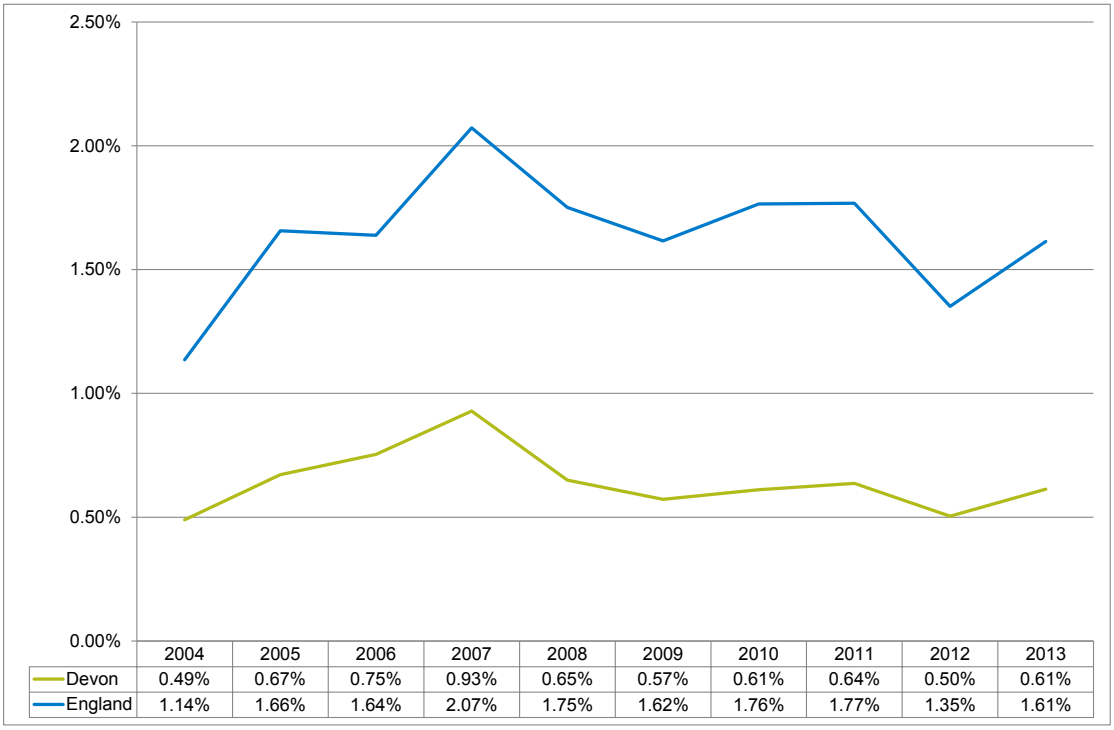
New National Insurance Number Registrations for international migrants give a further indication of migration patterns amongst those who are economically active. This is shown in figure 3.8 as a percentage of the working-age population (aged 16 to 64). The pattern in Devon has been relatively stable since 2008, falling from a peak of 0.93% in 2007 to 0.61% in 2013. The level of new registrations in Devon is less than half of the national rate (1.61% in 2013).

Table 3.2, International and Internal Migration into and out of Devon, 2004 to 2013

Year	Population	International Migration			Internal Migration		
		Inflow	Outflow	Net flow	Inflow	Outflow	Net flow
2004	718,800	3,600	4,000	-400	35,600	27,300	+8,300
2005	725,600	6,900	3,300	+3,600	32,600	26,900	+5,700
2006	729,600	3,700	3,600	+100	33,300	27,500	+5,800
2007	736,300	4,400	2,800	+1,600	34,700	27,700	+7,000
2008	739,900	3,500	4,600	-1,100	33,200	27,100	+6,100
2009	741,000	3,800	4,800	-1,000	30,400	26,600	+3,800
2010	743,900	4,000	3,000	+1,000	30,100	26,800	+3,300
2011	747,700	4,700	2,800	+1,900	30,300	27,000	+3,300
2012	753,200	3,800	1,900	+1,900	31,400	27,200	+4,200
2013	758,100	4,000	2,000	+2,000	30,200	26,400	+3,800

Source: Office for National Statistics, Migration by Local Authorities in England & Wales, 2014

Figure 3.8, New Migrant National Insurance Number Registrations as a percentage of persons aged 16 to 64, Devon vs England, 2004 to 2013

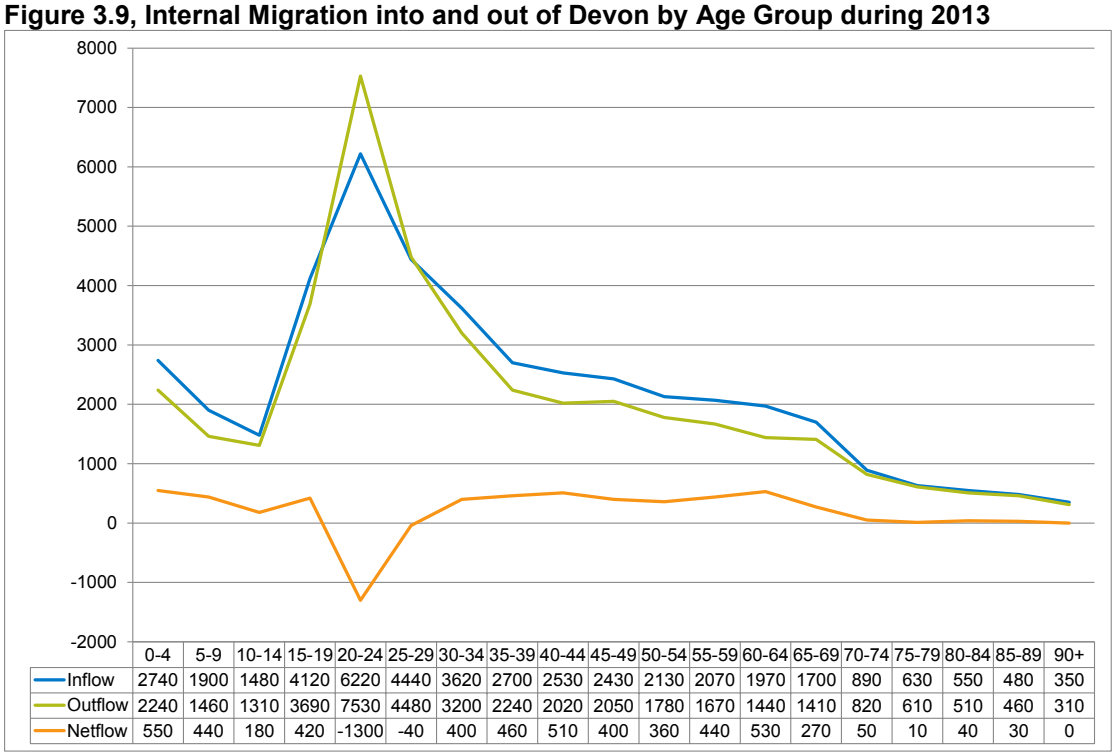


	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Devon	0.49%	0.67%	0.75%	0.93%	0.65%	0.57%	0.61%	0.64%	0.50%	0.61%
England	1.14%	1.66%	1.64%	2.07%	1.75%	1.62%	1.76%	1.77%	1.35%	1.61%

Source: Office for National Statistics, Migration by Local Authorities in England & Wales, 2014

Figures 3.9 and 3.10 shows the pattern of internal migration into and out of Devon by age group in 2013. The only age groups in which more people leave Devon than arrive are the 20 to 29 age groups, which is largely due to people leaving to attend university or employment. High net flows contributing to population growth in Devon are seen in the 30 to 69 age group, which also contributes to higher net flows in under 20s as people move to Devon later in their working life or at retirement. The net flow for those aged 70 and over is relatively low.

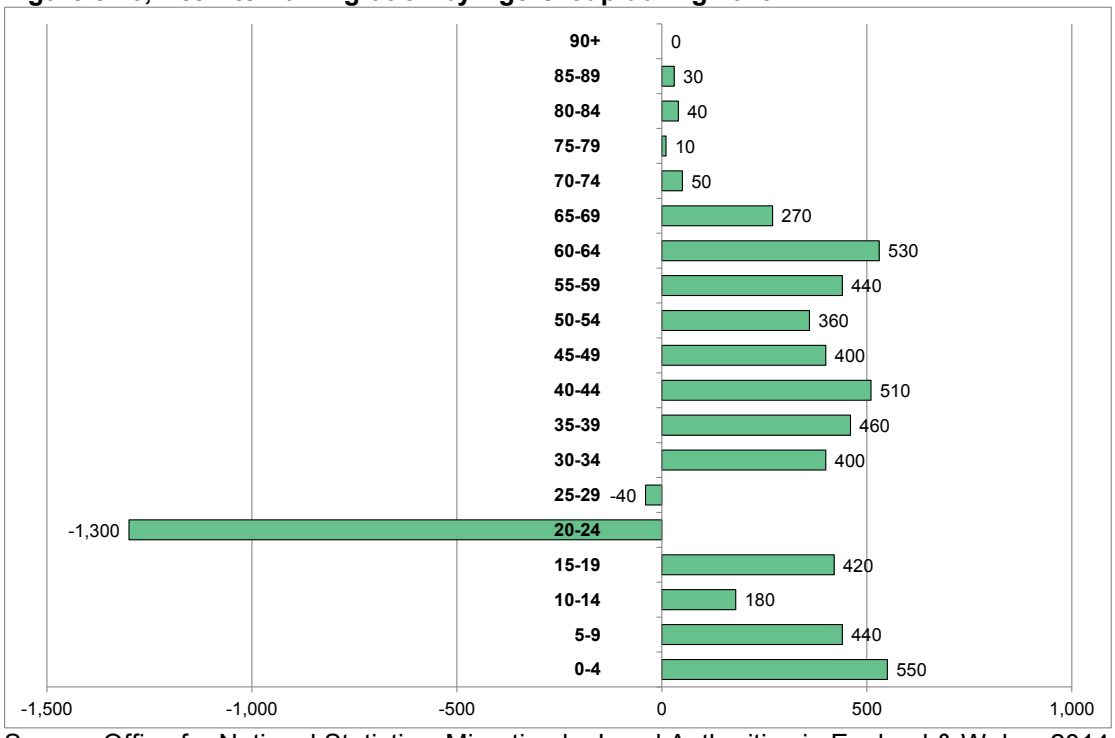
Figure 3.9, Internal Migration into and out of Devon by Age Group during 2013



	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
Inflow	2740	1900	1480	4120	6220	4440	3620	2700	2530	2430	2130	2070	1970	1700	890	630	550	480	350
Outflow	2240	1460	1310	3690	7530	4480	3200	2240	2020	2050	1780	1670	1440	1410	820	610	510	460	310
Netflow	550	440	180	420	-1300	-40	400	460	510	400	360	440	530	270	50	10	40	30	0

Source: Office for National Statistics, Migration by Local Authorities in England & Wales, 2014

Figure 3.10, Net Internal Migration by Age Group during 2013



Source: Office for National Statistics, Migration by Local Authorities in England & Wales, 2014

A further analysis of internal migration reveals movements by region into and out of Devon. As table 3.3 reveals, as around 42% of movements in and 46% of movements out are within the South West, the pattern is fairly even and the net flow relatively low (+422). The largest net flow is from the South East (+1,466), with fairly sizeable net flows from the East of England (+543), and the West Midlands (+482). Table 3.4 shows net migration by age group and region for 2013. This highlights a significant net flow of people from Devon to London in the 16 to 39 age group (-558), with higher net flows from London to Devon in other age groups.

Table 3.3, Internal Migration into and out of Devon by Region during 2013

Region	Movements In	Movements Out	Net Flow
East Midlands	1,139	1,001	138
East of England	1,949	1,406	543
London	2,779	2,504	275
North East	224	246	-22
North West	1,156	819	337
Northern Ireland	77	83	-6
Scotland	460	505	-44
South East	5,670	4,204	1,466
South West	12,622	12,199	422
Wales	1,274	1,235	39
West Midlands	2,022	1,540	482
Yorkshire and The Humber	853	704	149
All Regions	30,225	26,446	3,780

Source: Office for National Statistics, Migration by Local Authorities in England & Wales, 2014

Table 3.4, Net Migration into and out of Devon by Region and Age Group during 2013

Region	00 to 15	16 to 39	40 to 64	65 and over	Total
East Midlands	17	-6	88	39	138
East of England	126	124	276	18	543
London	224	-558	440	169	275
North East	12	-42	0	8	-22
North West	71	95	160	11	337
Northern Ireland	-13	16	-6	-2	-6
Scotland	-11	2	-37	1	-44
South East	305	201	792	168	1,466
South West	317	-63	251	-82	422
Wales	-21	63	-9	6	39
West Midlands	93	77	224	89	482
Yorkshire and The Humber	43	37	37	33	149
All Regions	1,161	-55	2,216	458	3,780

Source: Office for National Statistics, Migration by Local Authorities in England & Wales, 2014

3.04 New developments and infrastructure

Population change and growth in Devon increase the requirement for housing and employment land, and other changes to the local infrastructure to accommodate population growth and economic development. Local Development Frameworks produced by local authority districts allocate housing and employment land over the next 15 to 20 years. Table 3.5 reveals that across Devon over 59,000 dwellings and over 360 hectares of employment land are planned. The greatest planned increases in dwellings are seen in East Devon, where over 16,000 new dwellings are planning which represents a quarter of existing housing stock in the district. Considerable expansion of employment land is planned in the Exeter, East Devon and Teignbridge areas connected to ongoing economic growth in the Exeter and Heart of Devon economic area, and in North Devon. Table 3.6 sets out any current housing allocations containing 1,000 or more dwellings. The continued expansion of the new town of Cranbrook, when added to the existing population suggests the population will be similar to Barnstaple in 10 to 20 years' time (20,000). Around 5,500 dwellings are planned for the new community of Sherford in the South Hams. Other sizeable allocations relate to the expansion of Exeter, centred around five major development sites on the outskirts of the city, and the expansion of towns including Cullompton, Newton Abbot, Tiverton, Axminster and Exmouth.

Table 3.5, Current Planning Allocations for Housing and Employment by District, Devon

District	Dwellings (2014)	Planned Dwellings (n)	Planned Dwellings as % of existing dwellings	Planned Employment Land (hectares)
East Devon	65,530	16,393	25.0%	112.9
Exeter	52,110	6,283	12.1%	44.5
Mid Devon	34,870	7,206	20.7%	12.2
North Devon	45,330	5,505	12.1%	47.4
South Hams	43,930	7,925	18.0%	33.9
Teignbridge	59,390	9,170	15.4%	61.4
Torridge	31,250	5,160	16.5%	36.5
West Devon	24,950	1,540	6.2%	13.0
Devon	357,370	59,182	16.6%	361.8

Source: Department for Communities and Local Government Dwelling Stock Tables and Devon County Council Planning, Transportation and Environment Team, 2015

Table 3.6, Current Planning Allocations for Housing with 1,000 or more dwellings, Devon

Allocated Site	District	Residential Dwellings
Cranbrook	East Devon	7,769
Sherford New Community	South Hams	5,500
Monkerton/Hill Barton	Exeter	2,500
Newcourt	Exeter	2,300
East Cullompton	Mid Devon	2,100
South West of Exeter Urban Expansion	Teignbridge	2,000
Newton Abbot (Houghton Barton)	Teignbridge	1,800
Tiverton Eastern Urban Expansion	Mid Devon	1,520
Newton Abbot (Wolborough)	Teignbridge	1,500
Axminster	East Devon	1,481
North of Blackhorse	East Devon	1,480
Pinhoe	East Devon	1,314
Exmouth	East Devon	1,229
North West Cullompton	Mid Devon	1,200

Source: Devon County Council Planning, Transportation and Environment Team, 2015

4. Equality and Diversity

The Equality Act 2010 www.legislation.gov.uk/ukpga/2010/15/contents identifies nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act protects people from direct and indirect discrimination, harassment and victimisation because of a protected characteristic. The Act's scope covers the provision of goods and services, including things provided for free, employment (work), associations, education and premises. The Act allows positive action where certain conditions are met and requires reasonable adjustments to be made for disabled people. A reasonable adjustment can include removing a barrier, providing the service in a different way and changing the way information is provided. The Act requires an organisation to *anticipate* what disability adjustments may be needed in *advance*. In relation to health and wellbeing, as well as ensuring equality in terms of people's experience of treatment by health services, it is important to understand the impact of these characteristics on health, and to ensure groups have equitable access to health services in relation to the health, care and wellbeing needs they exhibit. Figure 4.1 and Table 4.1 describe the nine characteristics.

Figure 4.1, Protected Characteristics from the Equality Act 2010

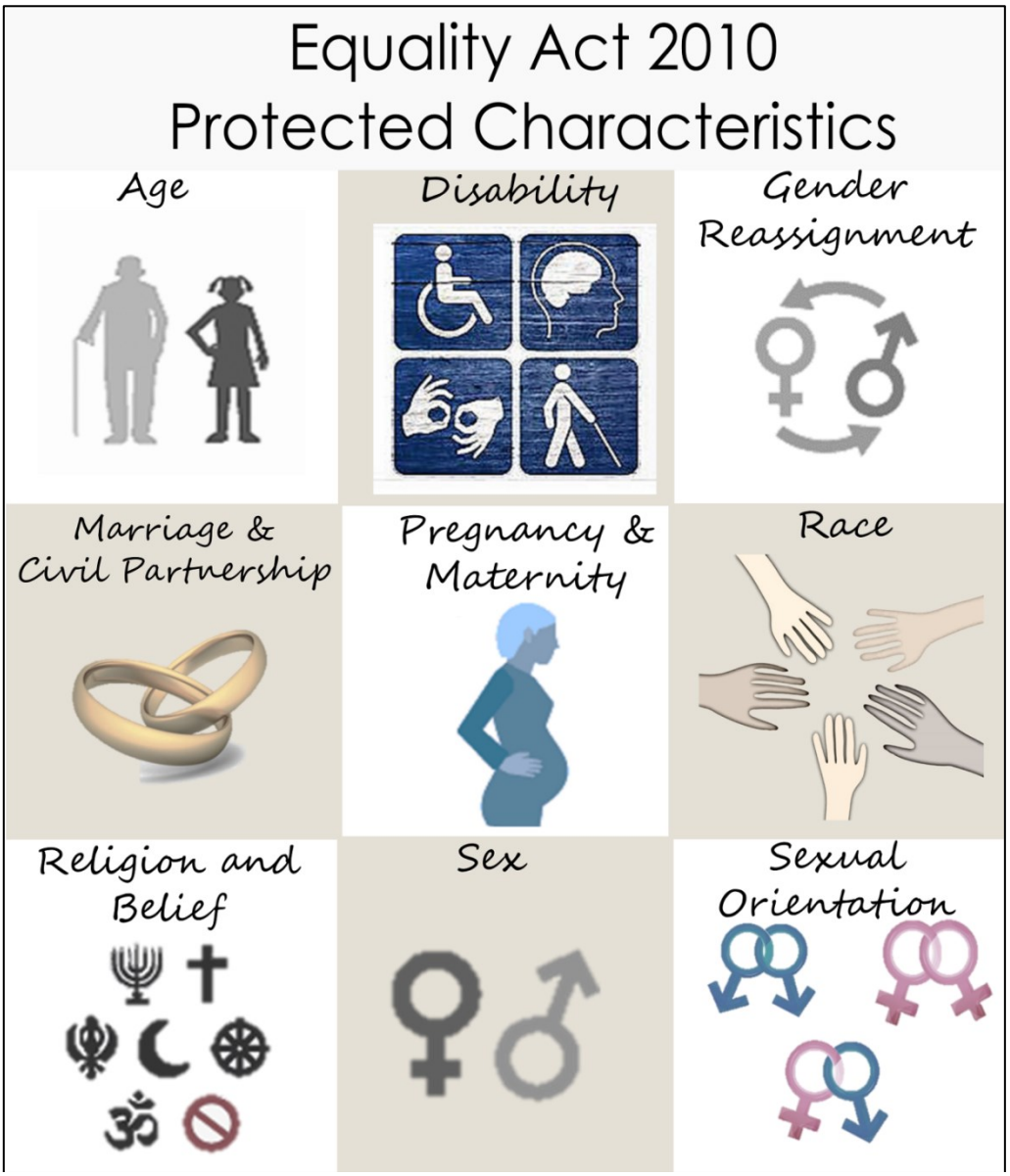


Table 4.1, Definitions of the nine protected characteristics in the 2010 Equality Act

Protected Characteristic	Definition
Age	A particular age (for example, 32 year old) or a range of ages (for example, 18 - 30 year olds)
Disability	A person who has, or has had, a physical, sensory or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities
Gender reassignment	A person who is proposing to undergo, is undergoing or has undergone gender reassignment (this may or may not include surgical or medical intervention)
Marriage and civil partnership	A legally recognised union between two people
Pregnancy and maternity	Maternity includes 26 weeks after giving birth and breastfeeding
Race	Colour, nationality, ethnic or national origin
Religion and belief	Religious and philosophical beliefs including lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition
Sex	A man or a woman
Sexual orientation	A person's attraction towards someone of the same sex (lesbian or gay), the opposite sex (heterosexual) or to both sexes (bisexual)

The Act also includes a Public Sector Equality Duty (PSED). The duty applies to all public authorities and those providing a public service (where this is transferred out). The PSED requires public authorities to 'give due regard to the need to' (consider the extent to which it can): eliminate discrimination, advance equality of opportunity and foster good relations in relation to the protected characteristics. The duty to advance equality of opportunity includes the need to remove or minimise disadvantage, meet people's needs, take account of disabilities and encourage participation in public life (such as consultation and decision making). The PSED also places specific duties on public authorities to publish equality objectives and information about how people are affected by policies and practices.

A person's health is influenced by a wide range of factors, known as wider determinants of health (page 15, figure 2.2) such as individual characteristics (age, sex and genetics), lifestyle, community involvement and local economy. Where protected characteristic groups experience differences in these wider determinants of health this can lead to health inequalities. For example, taking the protected characteristic of age, if older people experience higher levels of isolation than younger groups this can result in poorer health outcomes than if they were not isolated in older age. Their isolation could be because of their individual characteristic of age (they are the surviving partner, close friends are no longer alive), lifestyle (they are less active because of old age, they have led a previously unhealthy lifestyle), community (there are no activities for them locally, they are rurally isolated and digitally excluded) and economic (they are a pensioner on a low, limited income).

Equity in health implies no-one should be disadvantaged from reaching their full health potential because of any socially-determined characteristic or position.

> "It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill." (Whitehead and Dahlgren, 2007)

In terms of health and wellbeing, our response to the Equality Act should lead to a healthier population because it includes:

- Ensuring no-one is discriminated against in the delivery of services (including the provision of health information). Discrimination includes indirect discrimination which is a 'provision, criteria or practice' that puts a person at a disadvantage and cannot be justified. This means ensuring that people feel they have equal access to and quality of healthcare treatment, which may mean they are treated differently in order to meet a particular need or overcome a barrier to accessing the service

- Having a better understanding of people's needs by analysing and publishing information about health outcomes for different protected characteristic groups
- Considering the duty to advance equality by setting specific and measurable objectives and targets to reduce health inequalities between protected characteristic groups.

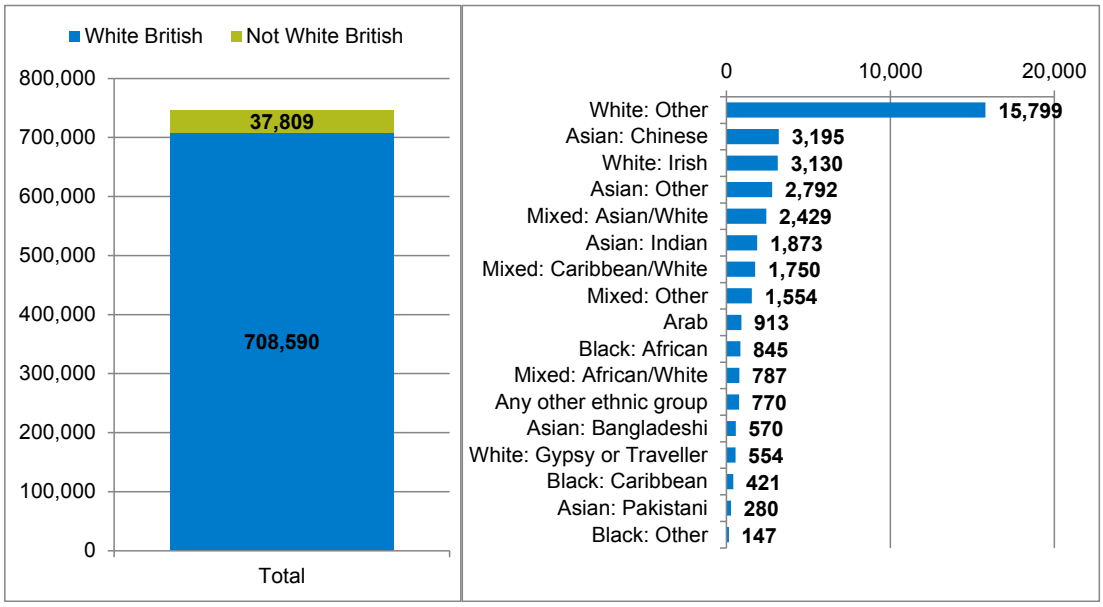
Devon County Council has an equality strategy which sets out local priorities: www.devon.gov.uk/fairforall.pdf

The following sections provide an overview of the population of Devon for each of the protected characteristics, a brief summary of health and wellbeing needs in respect of these characteristics, and links out to other documents and resources for further information.

4.01 Race and Ethnicity

According to the 2011 census the vast majority of people in Devon (94.9%) are from a White British ethnic background, which is higher than the South West (91.8%) and England (79.8%) proportions. Figure 4.2 highlights that around 38,000 in Devon are from a non-White British background. The largest ethnic group is 'White: Other', which tends to be European in origin.

Figure 4.2, Devon Population by Ethnicity, 2011



Source: 2011 Census

Health, Care and Wellbeing Needs

All ethnic minority groups in England are more likely to live in deprived neighbourhoods than the White British population, with more than one in three from Bangladeshi and Pakistani ethnic groups living in a deprived neighbourhood. However, this, proportion is decreasing. The unemployment rate of ethnic minorities is more than twice that of the White British population, with disparities greatest for Black ethnic groups.

The White Gypsy or Irish Traveller group has the poorest health, with men and women having rates of long-term limiting illness twice that of the White British group. Persistent health inequalities are also seen in the health of Pakistani and Bangladeshi women with illness rates 10% higher than in White British women. By comparison, the Chinese ethnic group persistently reports better health in both men and women.

The British Heart Foundation report the prevalence of cardiovascular disease does not vary considerably by ethnic group for females, and in men, rates were highest in Irish and White British and lowest in Black African men.

Black Caribbean, Indian, Bangladeshi and Pakistani men have a considerably higher prevalence of diabetes than the overall population.

Cancer research UK report higher mortality rates in White British groups, although survival rates for breast cancer are lower in Asian and Black ethnic groups.

Risk factors also vary across different ethnic groups. Smoking is most prevalent in Bangladeshi men, and binge drinking is much lower across ethnic minority groups. Individuals from different ethnic groups store fat in different places of the body resulting in different body shapes. Obesity, as measured by BMI, is much lower in South Asian groups and Chinese men than the overall population. Breastfeeding rates tend to be higher in black and minority ethnic groups.

Further Information

- Plymouth and Devon Racial Equality Council http://plymouthanddevonrec.org.uk/
- The Dynamics of Diversity: evidence from the 2011 Census available at http://www.ethnicity.ac.uk/research/outputs/briefings/dynamics-of-diversity/
- East Midlands Public Health Observatory available at http://www.empho.org.uk/themes/ethnicity/inequalities.aspx
- Fair Society Healthy Lives (The Marmot Review) available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

4.02 Disability

A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

According to the 2011 Census, 8.6% of Devon residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months (including problems related to old age), with 10.9% reporting their day-to-day activity were limited a little, a total of just under one in five (19.5%). The national value was 8.3%. According to the 2011 Census, 46.1% of Devon residents reported their general health as 'very good'; this increased to 80.8% when also including those who reported their health as 'good'. In England 81.4% of people reported their general health as either 'very good' or 'good'. Devon's combined value is therefore similar the national average.

A person with a learning disability is usually defined as having a significantly reduced ability to understand new or complex information and learn new skills, with a reduced ability to cope independently, which has a lasting effect on development.

People with learning disabilities can also find it much harder than other people to access assessment and treatment for general health problems that have nothing directly to do with their disability.

Health, Care and Wellbeing Needs

People with a physical disability require additional support from health and care services and are more likely to experience general ill health and poorer wellbeing than those without a physical disability. The Learning Disabilities Observatory 'Improving Health and Lives' has highlighted health inequalities for people with learning disabilities https://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf

- The prevalence rate of epilepsy amongst people with learning disabilities is at least twenty times higher than for the general population
- People with learning disabilities are 8-200 times more likely to have a vision impairment compared to the general population. Approximately 40% of people with

learning disabilities are reported to have a hearing impairment, with people with Down's syndrome at particularly high risk of developing vision and hearing loss
- People with learning disabilities are much more likely to be obese than the general population. The high level of overweight status amongst persons with learning disabilities is likely to be associated with an increased risk of diabetes
- People with Down's Syndrome are more likely to have thyroid problems than within the general population. Around 10% of people with Down's syndrome have thyroid problems. This is generally underactive thyroid resulting in weight gain and lethargy
- People with learning disabilities are at a higher risk of mental health problems. The prevalence of psychiatric disorders is significantly higher among adults whose learning disabilities are identified by GPs, when compared to general population rates
- The prevalence of dementia for people aged 65 and over with learning disabilities is 22% compared to 6% of the general population. People with Down's syndrome are at particularly high risk of developing dementia, with the age of onset being 30-40 years younger than that for the general population
- People with learning disabilities have shorter life expectancy, although it has increased over recent years. All-cause mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, and are particularly high in young adults, women and people with Down's Syndrome.

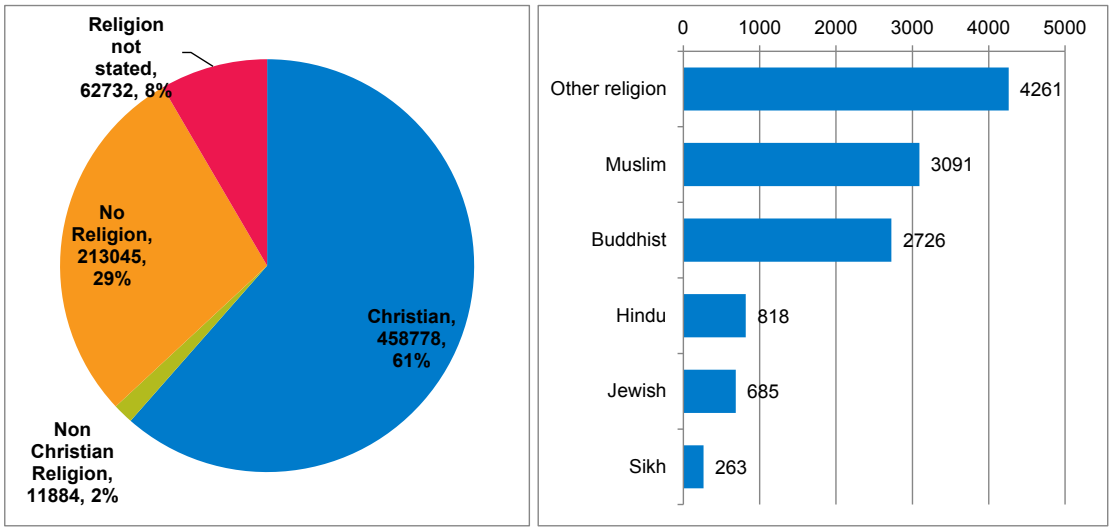
Further Information

- Living Options Devon http://www.livingoptions.org/
- Improving Health and Lives Learning Disabilities Observatory https://www.improvinghealthandlives.org.uk/
- Health Inequalities and Persons with Learning Disabilities in the UK, 2010 https://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf
- Disability Rights Commission – Equal Treatment: Closing the Gap https://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf
- World Health Organisation: Disability and Health http://www.who.int/mediacentre/factsheets/fs352/en/
- NHS Choices: Living with Disability http://www.nhs.uk/livewell/disability/Pages/Disabilityhome.aspx

4.03 Religion or belief

Figure 4.3 shows the stated religion for Devon residents in the 2011 Census, with 61% stating they were Christian, 29% stating they had no religion and 8% choosing not to state their religion in the Census. 11,884 people had a religion other than Christian with the largest faiths being Muslim (3,091) and Buddhist (2,726).

Figure 4.3, Population by Religion or Belief, Devon, 2011



Source: 2011 Census

Health, Care and Wellbeing Needs

The impacts of religious belief on mental health are generally positive, with the strongest association being the link between religious belief and a reduction in depression, as well as reduced anxiety and suicide risk, and to a lesser extent, reduced psychotic disorders. Religious belief was also found to be important in helping people to recover from traumatic events.

However, the way people translate their religious beliefs and practices to help them cope with life events (for example, if the coping strategy includes questioning the power of God, expressions of discontent with the congregation or clergy or punitive religious appraisals of negative situations) and the religious motivation of individuals (for example, to use religion to achieve other ends, such as status, security or social opportunities) can both have a negative impact on mental health.

Religious belief is associated with a reduced likelihood of engaging in risk behaviours such as alcohol and drug abuse and cigarette smoking. Reductions in the risk of suicide and certain risky behaviours are especially large for young people.

These positive effects may be negated by exposure to religious discrimination.

Further Information

- Devon Faith and Belief Forum http://www.devonfaiths.org.uk/
- Religion or Belief: A practical guide for the NHS http://www.clatterbridgecc.nhs.uk/document_uploads/EqualityandDiversity/ReligionorbeliefApracticalguidefortheNHS.pdf

4.04 Age

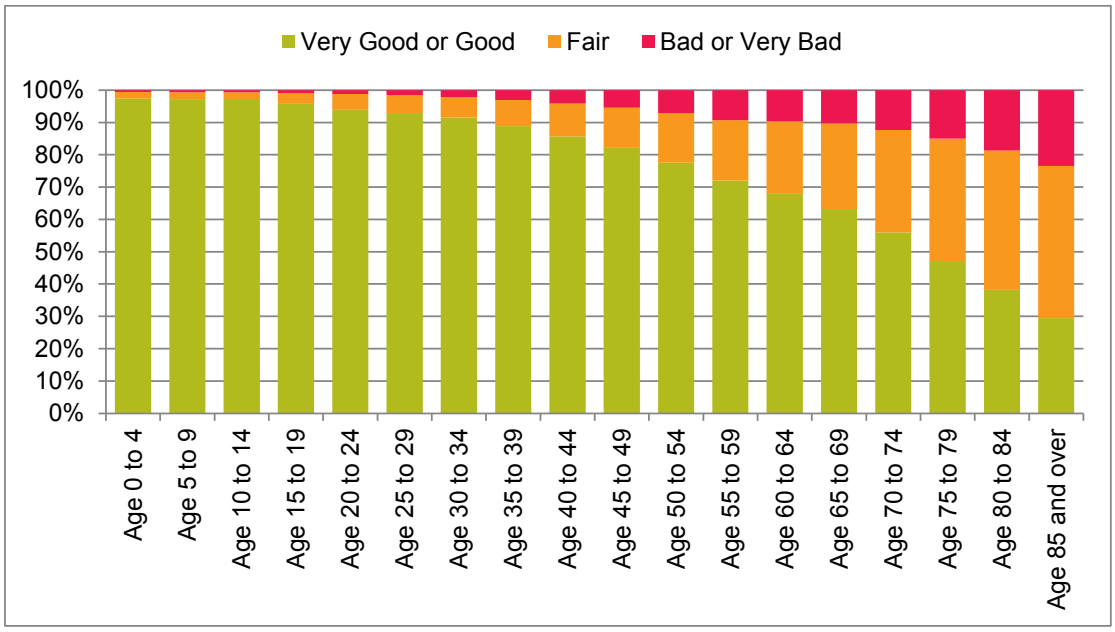
Age is continuous from birth until death. It is a broad equality area, which has implications for all people. Age equality is not just about eliminating discrimination: it means delivering equitable outcomes for people with different needs at different stages in life. Devon currently has a population of 758,100 (Office of National Statistics 2013 mid-year population estimates). The age structure varies by district with all areas except Exeter showing a lower proportion of 20-40 year olds compared to the England average. Exeter has a slightly younger population structure compared to England, with a significantly high proportion of 20-24 year

olds due to students from Exeter University residing in the city. Overall Devon has a higher older population than nationally and this is the age range that is predicted to increase.

Health, Care and Wellbeing Needs

As figure 4.4 reveals health tends to deteriorate with age, with well over 90% of those aged under 30 stating that they were in very good or good health in the 2011 census, compared with 30% in the 85 and over age group.

Figure 4.4, Self-Reported General Health by Age, Devon, 2011



Source: 2011 Census

Transitions between child and adult health and care services can also be a factor. It is important to note that 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 potential risk factor. Thresholds for service eligibility can vary between child and adult services as well meaning that in some cases support may be discontinued.

Table 4.2 sets out measures from the Public Health Outcomes Framework and the age groups most affected.

Table 4.2, Public Health Outcomes Framework indicators by age group most affected

Age Group	Public Health Outcomes Indicator
Children and Young People	Children in poverty, school readiness, pupil absence, youth justice system entrants, 16-18 year olds not in education employment or training, killed or seriously injured on road, low birth weight, breastfeeding, smoking at time of delivery, under 18 conceptions, excess weight in childhood, hospital admissions for unintentional and deliberate injuries, self-harm admissions, emotional wellbeing of looked after children, smoking at age 15, Chlamydia detection rate, population vaccination, infant mortality, tooth decay in children
Working Age Adults	Life expectancy gap, adults in stable accommodation (learning disability and mental health), mental health in prison, employment rate long-term condition, sickness absence, violent crime, re-offending levels, homelessness, excess weight in adults, physical activity in adults, smoking prevalence, successful completion of drug treatment, substance dependence in prison, recorded diabetes, alcohol-related admissions, NHS health check coverage and uptake, preventable mortality, under 75 death rates for cancer respiratory disease circulatory disease and liver disease, under 75 mortality for people with serious mental illness, suicide rate
Older People	Life expectancy at 65, fuel poverty, social isolation, older people's perceptions of community safety, injuries due to falls, preventable sight loss, health-related quality of life for older people, hip fractures, excess winter deaths, dementia diagnosis rate
All	Life expectancy at Birth, healthy life expectancy at birth, domestic abuse, air pollution, noise complaints, utilisation of outdoor space, fruit and vegetable consumption, alcohol-related admissions, cancer diagnosed at an early stage, screening coverage, self-reported wellbeing, air pollution mortality, TB treatment and incidence, sustainable development and health protection plans, deaths from communicable diseases, emergency readmission rate

Source: Public Health Outcomes Framework, 2015

Further Information

- Young Devon http://www.youngdevon.org/
- Devon Senior Voice http://www.seniorcouncildevon.org.uk/
- British Nutrition Foundation – Healthy Ageing: The Role of Nutrition and Lifestyle http://www.nutrition.org.uk/bnfevents/pastevents/healthy-ageing.html
- Devon Safeguarding Children Joint Strategic Needs Assessment http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2015/03/Devon-Safeguarding-Children-JSNA-2014-15.pdf
- Devon Annual Public Health Report 2008-09 (theme: young people) http://www.devonhealthandwellbeing.org.uk/aphr/2008-09/
- Devon Annual Public Health Report 2010-11 (theme: older people) http://www.devonhealthandwellbeing.org.uk/aphr/2010-11/

4.05 Sexual Orientation

There is also no definitive reliable estimate of the size of the Lesbian, Gay and Bi-sexual (LGB) population locally or nationally. A number of estimates exist, and a frequently cited estimate is that 5-7% of the population are LGB (Department of Trade and Industry 2004), leading to an estimated population of approximately 47,600 - 66,600 LGB people in Devon, Plymouth and Torbay. The Integrated Household Survey introduced a sexual identity question in 2009. The 2011-12 survey found that 1.5% of adults in the UK identified themselves as gay, lesbian or bisexual which would equate to around 10,000 people in Devon. Prevalence differed by age with 2.7% of 16 to 24 year olds in the UK identifying themselves as gay, lesbian or bisexual compared with 0.4% of those aged 65 and over.

The 2012 South West survey, 'Pride, Progress and Transformation', identified mental health (45%), followed by sexual health (35%), as their most frequent health concerns. However, over half did not believe the issues they had identified were directly related to their gender or sexual identity (Equality South West 2012).

Mental health

Despite similar levels of social support and quality of physical health, gay men and lesbians report more psychological distress than heterosexuals (King 2003).

Depression is twice as likely and anxiety 1.5 times more likely in lesbian, gay and bisexual individuals than in heterosexual individuals (King 2008).

Lifetime prevalence of deliberate self-harm is higher in lesbian and bisexual women, than heterosexual women (King 2008). Nationally, rates of reported self-harm are higher amongst bisexual people than gay men and lesbians (Guasp 2012), and higher amongst lesbian, gay and bisexual disabled people compared to lesbian, gay and bisexual people who are not disabled (Guasp 2012).

Both lifetime prevalence of suicidal ideation and suicidal attempts in lesbian, gay and bisexual people are twice as high as in heterosexual people (King 2008).

High levels of social isolation have also been reported among lesbian, gay and bisexual people.

Sexual health

Devon is defined as an area of low HIV prevalence (in all transmission groups) with a prevalence of <2 per 1,000 population (crude rate 0.69 per 1,000 population). Men who have sex with men remain the group most frequently affected by HIV infection, with a prevalence of 47 per 1,000 population (2012), with an estimated 18% of these unaware of their infection. High levels of transmission and an increase in testing have resulted in new diagnoses among men who have sex with men continuing to rise. People living with HIV can expect a near normal life expectancy and better clinical outcomes if diagnosed promptly. Late diagnosis is the most important clinical predictor of morbidity and mortality among those living with HIV infection.

Less than half of lesbian and bisexual women have reported being tested for sexually transmitted infections, but over half of those who have been tested have been diagnosed with an infection. Human Papillomavirus (HPV) is becoming increasing prevalent in men who have sex with men and can be a causal factor in anal and genital cancers. HPV vaccination is currently only available to younger females, although the Joint Committee on Vaccination and Immunisation is investigating extending the vaccination programme nationally to men who have sex with men attending sexual health clinics.

Other issues

Risk factors such as smoking and alcohol and substance misuse are more common in the lesbian, gay and bisexual population than in the heterosexual population, with alcohol dependence is more than twice as likely and drug dependence almost three times as likely.

There is some evidence there are high levels of homelessness among lesbian, gay and bisexual young people.

Further Information

- The Intercom Trust http://www.intercomtrust.org.uk/
- Devon Lesbian, Gay, Bisexual and Transgender Health Needs Assessment 2014 http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/09/Devon-LGBT-Health-Needs-Assessment-2014.pdf
- Healthwatch Devon 'Made of Rainbows' film, which features young people from Devon talking about their experiences of coming out as lesbian, gay, bisexual or transgender: http://www.healthwatchdevon.co.uk/made-of-rainbows-film2/

4.06 Gender

Overall 51.4% of Devon's population are female, a proportion that increases with age reaching 71.0% in those aged 90 and over.

Health, Care and Wellbeing Needs

Health outcomes are generally better for females than for males, with lower levels of ill-health and longer life expectancy. The following differences between males and females are taken from the Devon Health and Wellbeing Outcomes Report and the Devon Public Health Outcomes Report:

- Males in Devon spend one year less in good health than females, which is much smaller than the 3.7 year gap in life expectancy.
- Life expectancy gap – greater males (5.2 years) than females (3.3 years)
- Males are much more likely to be killed or seriously injured on Devon roads than females
- Hospital admissions for self-harm in 10 to 24 year olds three times higher in females than males and this gap has widened in recent years
- Conversely, suicide rates are three times higher and more variable for men, and are lower and more stable for women
- Female social care users in Devon more satisfied with their social situation than male social care users.
- Dementia prevalence rates higher in females, which when combined with linger life expectancy means females with dementia out number males by more than two to one
- Mortality rates from cancer 20% higher in males than females in England
- In Devon, mortality rates from cardiovascular disease 2.5 times higher in males than females
- Hospital admission rates in 0 to 14 year olds are much higher in males than females
- Levels of excess weight higher in boys than girls in 4/5 and 10/11 year olds
- Participation in physical activity higher in males than females
- Smoking higher in males than females, although rates have been slower to fall in females, especially those living in areas with higher levels of deprivation
- Alcohol admission rates higher for males than females
- Mortality rates from preventable causes tend to be higher in males than females
- Older single men are particularly at risk from social isolation
- Single parent households, particularly where headed by a female, are more likely to experience economic poverty.

Domestic violence is more common in females, with 7.3% of women and 5.0% of men having been a victim of domestic abuse in the previous year and 31.0% of women and 17.8% of men at some point since the age of 16 (British Crime Survey).

Further Information

- Fawcett Devon http://www.fawcettdevon.org.uk/index.php
- World Health Organisation: Gender, equity and human rights http://www.who.int/gender-equity-rights/en/

4.07 Gender Reassignment

In 2010 it was estimated nationally the number of gender variant people presenting for treatment was around 12,500. Of these, around 7,500 have undergone transition. The median age for treatment for gender variation is 42 years. There is no precise number of the trans population in Devon. However, the Gender Identity Research and Education Society has published estimates (www.gires.org.uk/prevalence.php) suggesting that 1% of the population were gender nonconforming to some degree (which would equate to 7,600 in Devon), with around 0.02% having undergone gender reassignment (which would equate to 150 in Devon) and around 0.004% likely to start treatment in the next year (which would equate to 30 in Devon).

Health, Care and Wellbeing Needs

Mental wellbeing

Trans people are more likely than others to experience mental distress, social isolation and social exclusion.

Discrimination can be one of the main issues that can impact on the mental health of trans people, with approximately three quarters having experience some form of harassment in public.

A lack of understanding within families, the workplace or society as a whole can impact on self-esteem, resulting in social isolation and exclusion.

The largest ever UK survey of trans people (n=889), The Trans Mental Health Study (McNeil 2012), found extremely high levels of previous or current self-reported depression (88%), stress (80%) and anxiety (75%) in trans people (McNeil 2012). The survey focused on how the process of transitioning (social and/or medical) impacts mental health and wellbeing. It should be noted the survey did not include the wider transgender population who were not undergoing permanent social or medical transition. The transgender population is also more likely to be affected by social isolation and depression.

Further Information

Information and useful links are available from NHS Choices and the Exeter Specialist Gender Identity Clinic's website.

4.08 Pregnancy and Maternity

Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Health, Care and Wellbeing Needs

Pregnancy is a normal physiological process, but it increases specific susceptibilities and risks.

For most women, pregnancy and having a baby, is a happy and positive experience, but for some women they may experience considerable discomfort, ill-health and complications. All women need some information and support during pregnancy and postnatally, but some require additional support.

There are strong associations between the health of mothers and their socioeconomic circumstances, as well as the health of their baby.

Mental health

It is estimated up to 1 in 7 mothers will experience a mental health problem during pregnancy or postnatally. Antenatal maternal stress and poor maternal health are more prevalent in more disadvantaged socioeconomic groups and have been found to impact on foetal development, with maternal depression contributing to low birth weight.

Domestic violence

One in four women experience domestic abuse or violence at some point during their lives. This may be physical, sexual, emotional or psychological abuse. 30% of this abuse starts in pregnancy and existing abuse may get worse during pregnancy or after giving birth.

In addition to the impact on the woman, domestic abuse during pregnancy puts her unborn child at risk by increasing the risk of miscarriage, infection, premature birth and injury or death to the baby.

Dental health

Some women get swollen and sore gums during pregnancy as the hormonal changes during pregnancy make your gums more vulnerable to plaque, leading to inflammation and bleeding.

Discrimination

Women with complex social problems, including mental health problems, report discrimination and judgemental behaviour from healthcare staff, which impacts on their ongoing engagement with services.

Breastfeeding

Breastfeeding rates vary considerably across Devon at all stages of feeding. For example, initiation of breastfeeding varies from 66.3% in Mid Devon to 83.3% in the South Hams. Breastfeeding rates tend to be higher in black and minority ethnic groups, in older mothers, and in less deprived areas.

Further Information

- Northern, Eastern and Western Devon Children, young people and maternity services http://www.newdevonccg.nhs.uk/your-ccg/children-young-people-and-maternity/100082
- Devon and Cornwall Maternity Strategy http://www.newdevonccg.nhs.uk/permanent-link/?rid=102488
- Devon and Cornwall Maternity Strategy Appendix http://www.newdevonccg.nhs.uk/permanent-link/?rid=102487

5. Economy

This section provides an overview of employment, income, skills and benefits. Devon has a culture of enterprise and resourcefulness. However average wages and productivity are low and given the variation across Devon, skills shortages present a barrier to growth in some parts of the county.

5.01 Devon Economic Assessment

The Devon economic assessment is informed by a wealth of evidence, much of which is presented on the Devonomics website http://www.devonomics.info/. This includes data from ONS, analysis of Devon's performance in relation to productivity, baseline economic projections for Devon and the districts, analysis of social, technological, environment, economic and political trends and drivers, analysis of self-employment in Devon, challenges and opportunities linked to the transition to a low carbon economy and in-depth economic profiles for each of Devon's eight local authority districts.

The Devon Economic Assessment http://www.devonomics.info/sites/default/files/documents/Devon%20LEA%20-%20Final%20-%20May%202012.pdf in 2012 provided the following summary. Overall, in 2009 the value of Devon's economy, measured in terms of Gross Value Added at current basic prices, was just over £12bn. To put this in to context of other similar rural authorities, the Devon economy is about 50% bigger than that of Somerset, but smaller than that of Norfolk. In 2010, the county was home to over 30,000 active enterprises. The Devon economy accounted for almost 300,000 employee jobs and almost 60,000 residents were self-employed.

In economic terms, the diversity of Devon should be considered. Within Devon there is only the one city of Exeter, which has a significant impact on the character of the Devon economy as a whole. When the hinterland of Exeter is included, Exeter is home to approaching 20% of the Devon's resident population. To the North, South, East and West of Exeter, Devon is overwhelmingly rural. Exeter and the towns along the A38 corridor and the route of the Great Western Railway are relatively well connected. However, there are significant areas of the county which are remote from major centres of population and economic activity. Rurality and access to key economic markets is an important issue from Devon's economy.

The Devon economy needs to be considered alongside the adjacent areas of Torbay and Plymouth. Torbay is an urban area which faces some important economic issues with a long standing dependency on seasonal tourism. Torbay currently experiences net out-commuting to neighbouring districts in Devon. Longer term interventions to address issues in Torbay are underway, including the construction of the South Devon Link Road, support for sectors such as the electronics industry and significant investment in the new South Devon College. Plymouth is a large city, with a population more than twice that of Exeter, that has long been dependent on the Naval Base which has an uncertain future. Plymouth is also seeking to change and to reposition itself as a vibrant waterfront city.

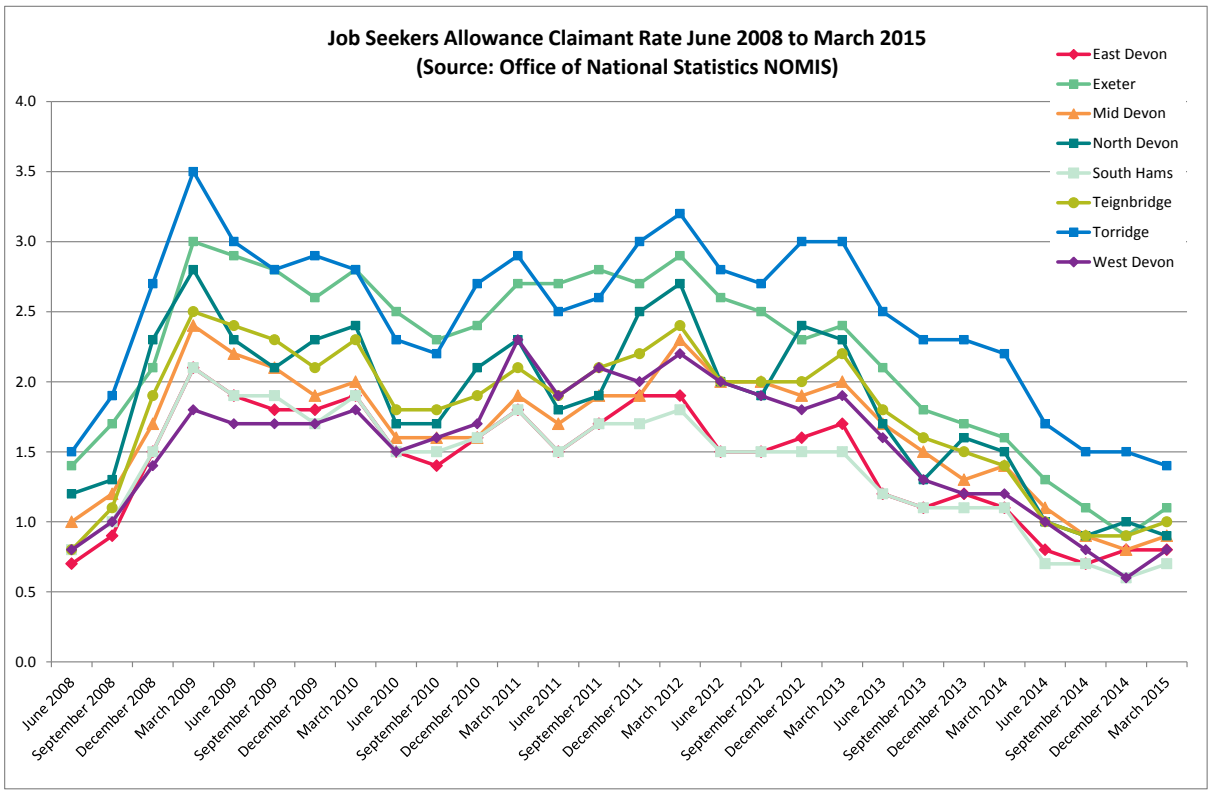
The following critical issues were highlighted in the 2012 Devon Economic Assessment:

1. Devon's economy is performing poorly in terms of productivity
2. Devon has a relatively skilled workforce, however this masks significant differences at a district level
3. Earnings are lower than average in most of Devon and link to housing affordability and relative poverty
4. Devon has an opportunity to better exploit the assets it has for high value economic growth
5. Devon's towns and rural communities in more peripheral areas are falling behind
6. Devon's population is ageing rapidly
7. Devon's resilience to face environment changes is being challenged.

5.02 Employment

The claimant count in Devon, although lower overall, has followed the same pattern as nationally. From a low point in June 2008 through to June 2009, Job Seekers Allowance claimants across the whole of the UK increased by 87%. In the South West rates increased by 130% over the year. In Devon the increase was 131%. Figure 5.1 shows the trend in Job Seekers Allowance claimants by local authority from February 2008 to March 2015. It shows unemployment had remained above the pre 2008 level and varied considerably by local authority with Torridge in particular showing a higher rate than the South West overall, however in the last 6 months rates have returned to similar levels as 2008. The overall claimant count rate for Devon in March 2015 was 0.9%, and was higher for males (1.2%), than females (0.7%).

Figure 5.1, Job seekers allowance claimant rate by local authority

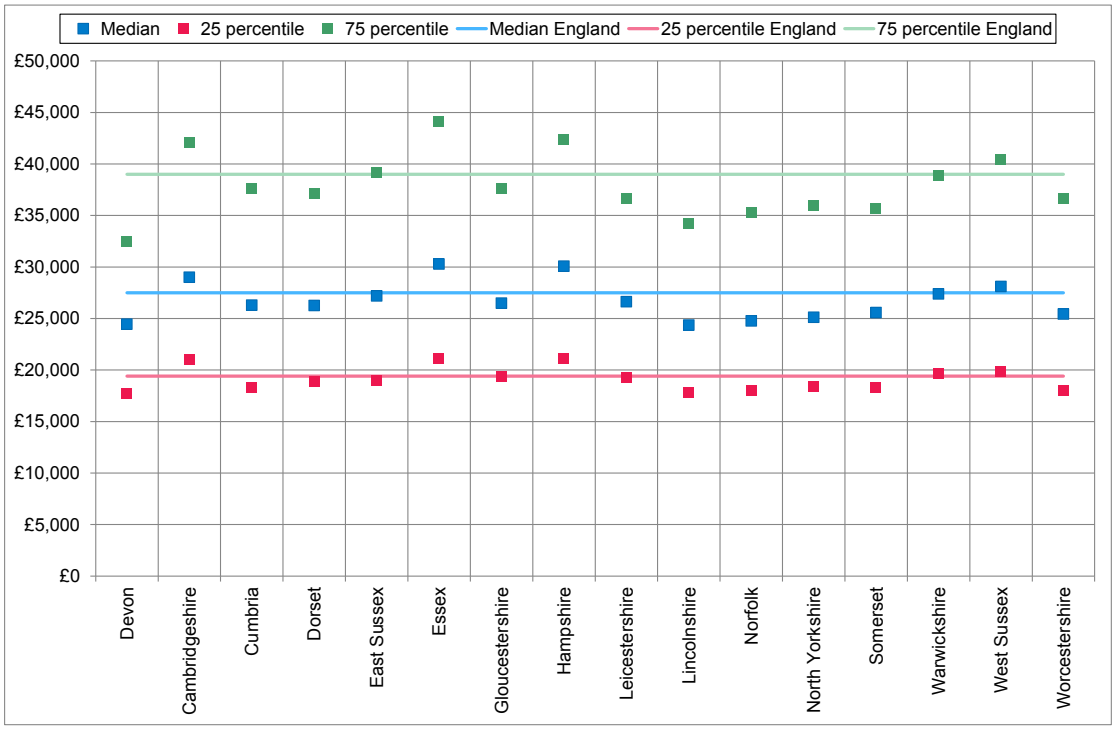


5.03 Income

Levels of income in Devon are lower than the national average. Figure 5.2 displays average full-time annual pay in Devon compared to similar local authorities and the England average. The blue dots show the average (median), the red dots the 25th percentile (the point at which one quarter of full-time workers earn less than, and the green dots the 75th percentile (the point at which one quarter of full-time workers earn more than). This reveals average full-time annual pay in Devon (£24,452) is less than the national level (£27,500), and similar local authorities. Whilst the lower pay 25th percentile point is lower than the national level (£17,736 compared to £19,403), more notable is how much lower the higher pay 75th percentile point in Devon (£32,498), than the national average (£39,000) and similar local authorities, such as Essex (£44,095), Hampshire (£42,370) and Cambridgeshire (£42,022). This pattern contributes to the high cost of living in the county. Figure 5.3 shows that although employment rates are relatively high in most areas of Devon, wages are low with median wage levels in Mid Devon, North Devon and Torridge in the lowest 10% across Great Britain.

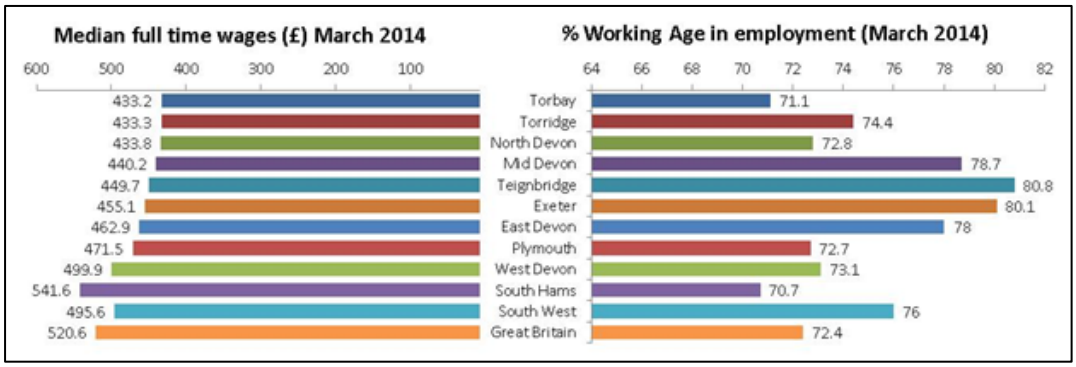
Notable differences are also seen between average male and female annual earnings. In 2014 average pay for male full-time workers (£26,085) was more than £5,000 per annum higher than female full-time workers (£20,856). When the average for all workers is considered the difference between male workers (£24,571) and female workers (£14,500) is more than £10,000 per annum, on account of a larger proportion of women working part-time.

Figure 5.2, Full-Time Annual Earnings per annum, average and range, Devon Local Authority Comparison Group, 2014



Source: Annual Survey of Hours and Earnings, Office for National Statistics, 2015

Figure 5.3 Median wages and proportions in employment, Devon, 2014

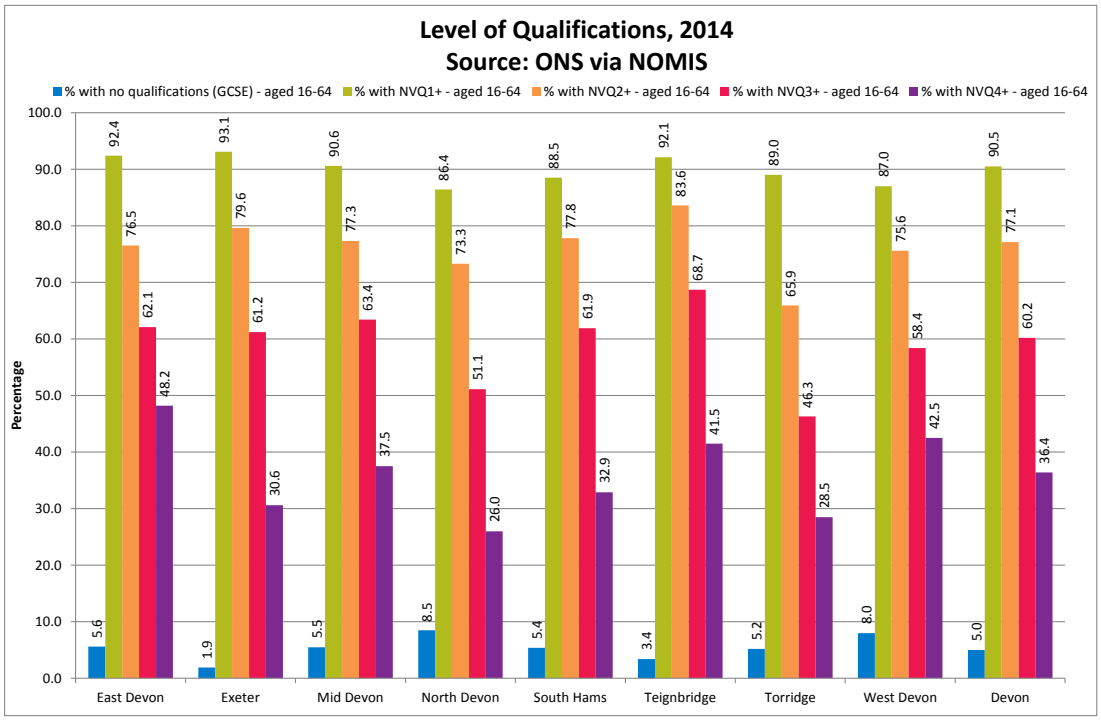


Source: Annual Survey of Hours and Earnings, Office for National Statistics, 2015

5.04 Skills and Qualifications

Figure 5.4 shows the level of qualifications by local authority across Devon in 2014. The local authorities with the highest proportion of people with no qualifications were in North Devon and West Devon and the lowest in Exeter. East Devon, West Devon and Teignbridge have the highest proportion of NVQ4+ (equivalent to HND or degree and above). West Devon has an interesting population mix of high proportions with high qualifications, and high proportions with no qualifications, due to a mix of service and agricultural work within the district and relatively high levels of professionals commuting to work in Exeter and Plymouth.

Figure 5.4, Level of Qualifications by Devon Local Authority District, 2014

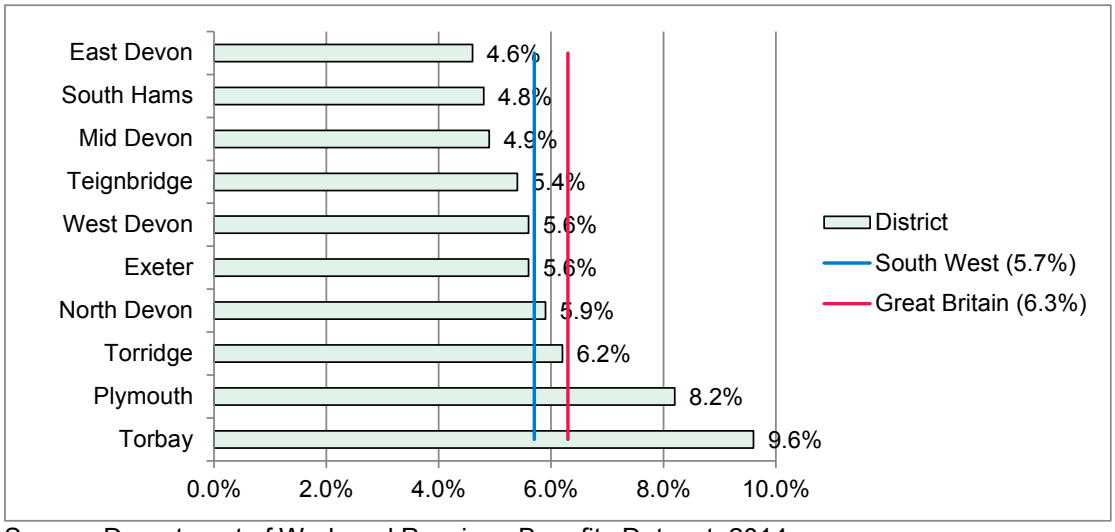


Source: Labour Force Survey, Office for National Statistics, 2014

5.05 Health and Wellbeing Benefits

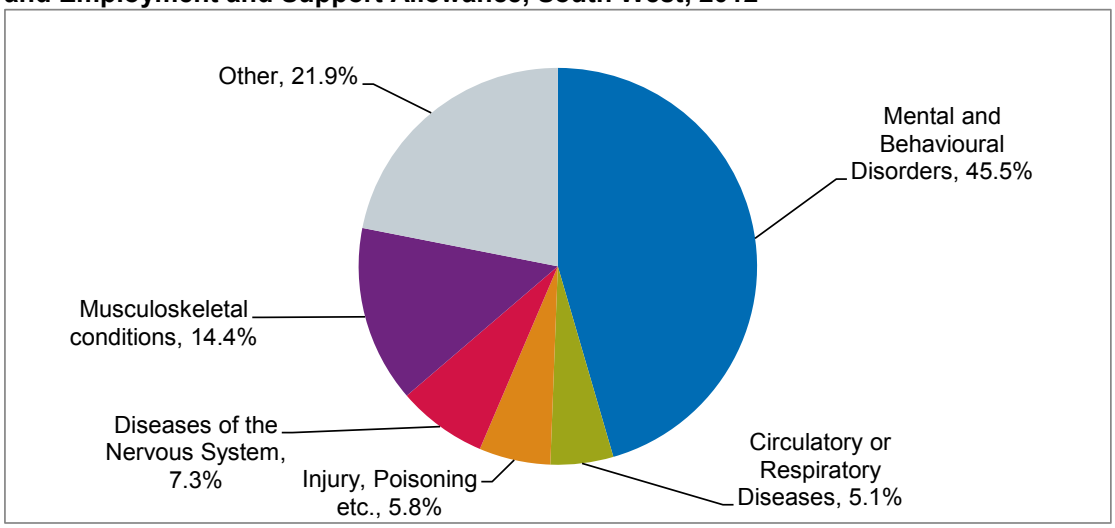
Figure 5.5 shows the proportions of people claiming health related benefits. These figures cover only those people who successfully claimed benefits and not all those who applied. There is variation across Devon with the highest proportions of claimants being seen in North Devon and Torridge. Mental and behavioural disorders are the most frequent conditions for claiming of disability benefits and account for half of all claims. Figure 5.6 shows a breakdown of the conditions of claimants across Devon compared to the South West and Great Britain. These figures cover only those people who successfully claimed benefits, Changes in benefit

Figure 5.5, Percentage of working-age population claiming Employment and Support Allowance (ESA) or Incapacity Benefit by Devon Local Authority, August 2014



Source: Department of Work and Pensions Benefits Dataset, 2014

Figure 5.6, Conditions leading to claim of Invalidity Benefit, Severe Disability Benefit and Employment and Support Allowance, South West, 2012



Source: Department of Work and Pensions Benefits Dataset, 2012

5.06 Benefits and Welfare Reform

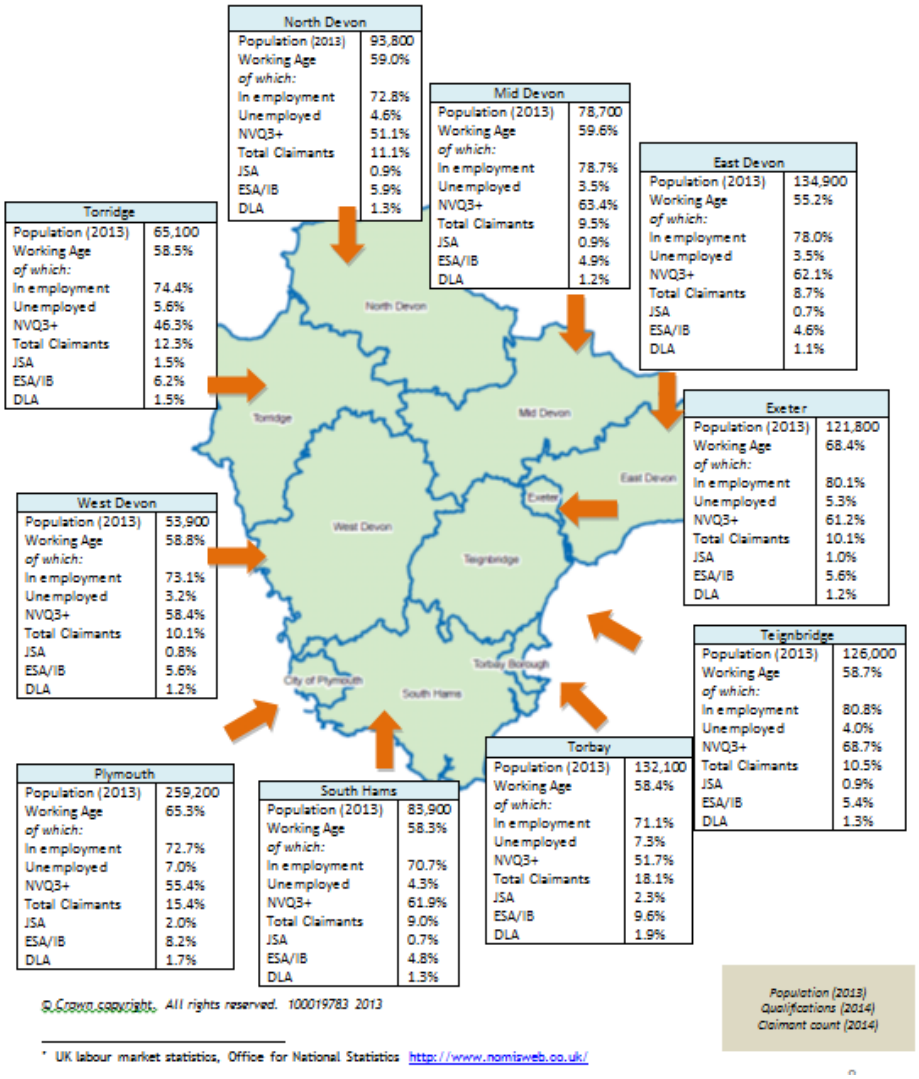
The Government's programme of welfare reform represents perhaps the biggest change to the welfare state since its establishment. The Social Security Bill had risen to £164.7 billion by 2009-2010, and was at that point identified by the Government as unsustainable. It rose further to £200 billion in 2011/12, a rise of 22% in real terms since 2005/06, equivalent to a rise of 2% of GDP. The Institute of Fiscal Studies predicts without on-going reforms to curb increases in public spending, non-interest spending will increase by 5.2% between 2016/17 and 2061/62, while revenues increase by less than 1% (http://www.ifs.org.uk/fiscalFacts/taxTables).

The Welfare Reform and Advisory Group produced a substantial report at the end of 2013 looking at the impact of reforms on Devon. The headline impacts identified in this report are striking. On the most conservative estimate, the reforms will take £258m out of the Devon economy in 2015/16 (https://new.devon.gov.uk/devonsp/welfare-reform). 159,000 working age households will be affected, with 61% of the losses falling on households in which someone is in employment. These losses will average around £1,600 per household, but ill and disabled people face greater losses.

The report identifies substantial opportunities to be opened up. The reforms provide a focus for local action to promote jobs and employability, to support people to gain financial, digital and employment skills, and to help thousands of people whose circumstances have been affected by the changes in the welfare system to secure a better future.

Figure 5.7 shows a breakdown of various benefits by local authority. This shows the variation across the county, with the highest levels of all benefits in the eight Devon districts being claimed in Torridge.

Figure 5.7 Devon economic activity summary



Source: UK Labour Market Statistics, Office for National Statistics, 2014

5.06 Food Poverty

Food poverty was defined by the Department of Health in 2005 as 'the inability to afford or have reasonable access to food which provides a healthy diet'. On average, foods high in salt, sugar and fat are cheaper to buy than healthier foods. Poor diet and obesity are leading risk factors for non-communicable diseases including cardiovascular disease and cancer.

Food poverty is a complex issue that has become more visible with the recent rise in emergency food providers. Food bank use is an inadequate indicator of need, because many households only ask for emergency food help as a last resort. There are 30 food banks and 20 other emergency food providers in Devon, including soup kitchens, and day centres. The Trussell Trust run 10 food banks and the others are independent. The Trussell Trust provided three days' emergency food to 67,858 adults and 38,434 children in the South West in 2014-15. In 2014, Exeter Food Bank provided food to 4,783 people, including 1,072 children. These figures refer to the number of individual food parcels distributed and therefore include some 'repeat' users. During a six month period in 2014, repeat users accounted for over a third (36%) of total activity. Nationally food bank usage has increased over recent years, with the Trussell Trust reporting the numbers given three days' emergency food from their food

banks nationally had increased from 346,992 in 2012-13, to 913,138 in 2013-14 and 1,084,604 in 2014-15.

Table 5.1, Primary referral causes to Trussell Trust food banks, 2014-15

Referral cause	Percentage
Benefit Delays	29.7%
Low Income	22.3%
Benefit Changes	13.8%
Other	11.7%
Debt	7.2%
Homeless	4.6%
Unemployed	4.4%
Sickness	2.5%
Domestic Violence	1.5%
Delayed Wages	1.1%
Child Holiday Meals	0.8%
Refused Short-Term Benefit Advances	0.7%

Source: Trussell Trust, 2015

A number of issues have been highlighted in relation to food poverty. These include:

- Increased food, fuel and housing costs
- The impact of welfare reform, including benefit delays and sanctions
- In-work poverty; low-paid, insecure jobs and zero-hours contracts
- The challenges of school holidays, including the absence of free schools meals and added childcare costs
- Impact of rurality including cost of transport.

Box 1, Food Poverty, Perceptions and Experiences
Overview

The following quotes are from interviews with clients and staff at Exeter Food Bank. This study was submitted to the All-Party Parliamentary Enquiry on Food Poverty and Hunger, 2014. Further in-depth research on rural food poverty in Devon is underway.

> *"I am a single person, aged 21, living at Exeter YMCA. I have had a job since April but they can't guarantee my hours as I am on a zero hour contract. Due to a lack of hours at work, I had only been paid a little and had to pay for rent and travel. I don't have any money to buy food."*
>
> *"On 30th May 2013, we spoke to a single mum at Foodbank who came with her 8 year old daughter. She had gradually fallen into debt because has had to pay for childcare expenses in school holiday time in order to keep her own fulltime, minimum wage job. She said they'd be better off on benefits, but wanted to work."*

Source(s)
McIvor, L. and Williams, A. *Emergency Food Aid in Exeter: Findings from Exeter Foodbank.* Submitted to the All-Party Parliamentary Inquiry on Food Poverty and Hunger, July 2014.
http://www.academia.edu/8112668/Emergency_food_aid_in_Exeter_Findings_from_Exeter_Foodbank

6. Community and Environment

6.01 Devon Strategic Assessment

The Devon Strategic Assessment http://www.devon.gov.uk/devon-strategic-assessment.pdf is a technical report describing crime and community safety issues for Devon and also looks at changes and patterns over time. The latest report was produced in 2014 and an update is currently being planned with potentially new priorities being identified. The new report will align closely with the Joint Strategic Needs Assessment and will include information linking mental and offending behaviour, crime and drug use and hospital data around assaults and alcohol use.

6.02 Crime and Community Safety

Figure 6.1 provides an overview of areas of community safety across Devon. It shows the overall trend in reported crimes and incidents, as well as a comparison of Devon with a group of other community safety partnerships with similar geography and demographics to Devon. The information is taken from the Devon Strategic Assessment technical report http://www.devon.gov.uk/devon_strategic_assessment_2013.14technical_report_2014.pdf and further detail on different types of crime can be found in the assessment and also overlaps with different sections of this Devon JSNA overview. Overall there has been a reduction in crime across Devon, although there is variation between different crimes. There has been an increase in arson, domestic abuse, violence against a person, other thefts, shoplifting and hate crime. There has been a reduction in anti-social behaviour, criminal damage, vehicle crime, non-dwelling burglary, dwelling burglary, sexual offences and robbery. No change has been seen in drug offences or in the number of people killed or seriously injured in road traffic accidents.

Figure 6.1 Overview of community safety in Devon

Recorded crimes & incidents	Direction of travel	Number of crimes 2013/14	Number of crimes 2012/13	Change since 2012/13 %	Comparison 'Most Similar family'	Trend 'most similar family'
All crime	↓	31,335	32,680	-4.1%	■	▲
Anti-social behaviour	↓	14,995	17,568	-14.6%	No data available	No data available
Road traffic casualties (KSI)*	→	308	309	-0.3%	No data available	No data available
Arson	↑	224	186	20.4%	■	▲
Domestic Abuse (total incidents)	↑	10,487	9,262	13.2%	No data available	No data available
Criminal damage	↓	5,287	5,801	-8.9%	■	▲
Violence against a person	↑	7,369	7,048	4.6%	■	▲
Other Theft and handling of stolen goods	↑	8,524	8,230	3.6%	■	▲
Vehicle crime	↓	2,255	2,391	-5.7%	■	▲
Shoplifting	↑	3,101	2,674	16.0%	■	▲
Non-dwelling burglary	↓	1,820	2,127	-14.4%	■	▲
Drug offences	→	1,410	1,513	-6.8%	■	▲
Dwelling burglary	↓	1,127	1,207	-6.6%	■	▲
Sexual offences	↓	555	733	-24.3%	■	▲
Hate crime	↑	342	323	5.9%		
Robbery	↓	103	133	-22.6%	■	▲

Source: Devon Strategic Assessment Technical Report, 2014

6.03 Environment

Devon's natural environment is incredible and varied, from Dartmoor and Exmoor to the more than 300 miles of stunning coastline. The Devon environment is important in that it provides us with food, fuel, pollination, flood control, great recreational and business opportunities, even a natural health service. The environment is an asset which cannot be taken for granted. It underpins life in Devon.

However, our native wildlife species and habitats are under pressure, with only 36% of Sites of Special Scientific Interest and 32% of rivers classed as being in good condition. The connections between Devon's communities, economies and environment need to be strengthened and need to ensure the assets of the natural environment are properly valued and therefore safeguarded into the future. To enable this, Natural Devon, the Devon Local Nature Partnership (http://www.naturaldevon.org.uk/) was established in 2012. Its three main aims are to protect and improve Devon's natural environment, to grow Devon's green economy and to reconnect Devon's people with nature. To achieve these aims, seven interconnected priority themes have been identified. These are naturally healthy, green connections, outdoor learning, farming with nature, wood for good, resilient wetlands and sustainable seas.

A more detailed overview of the Local Nature Partnerships priorities can be found here: http://www.naturaldevon.org.uk/priorities-test/

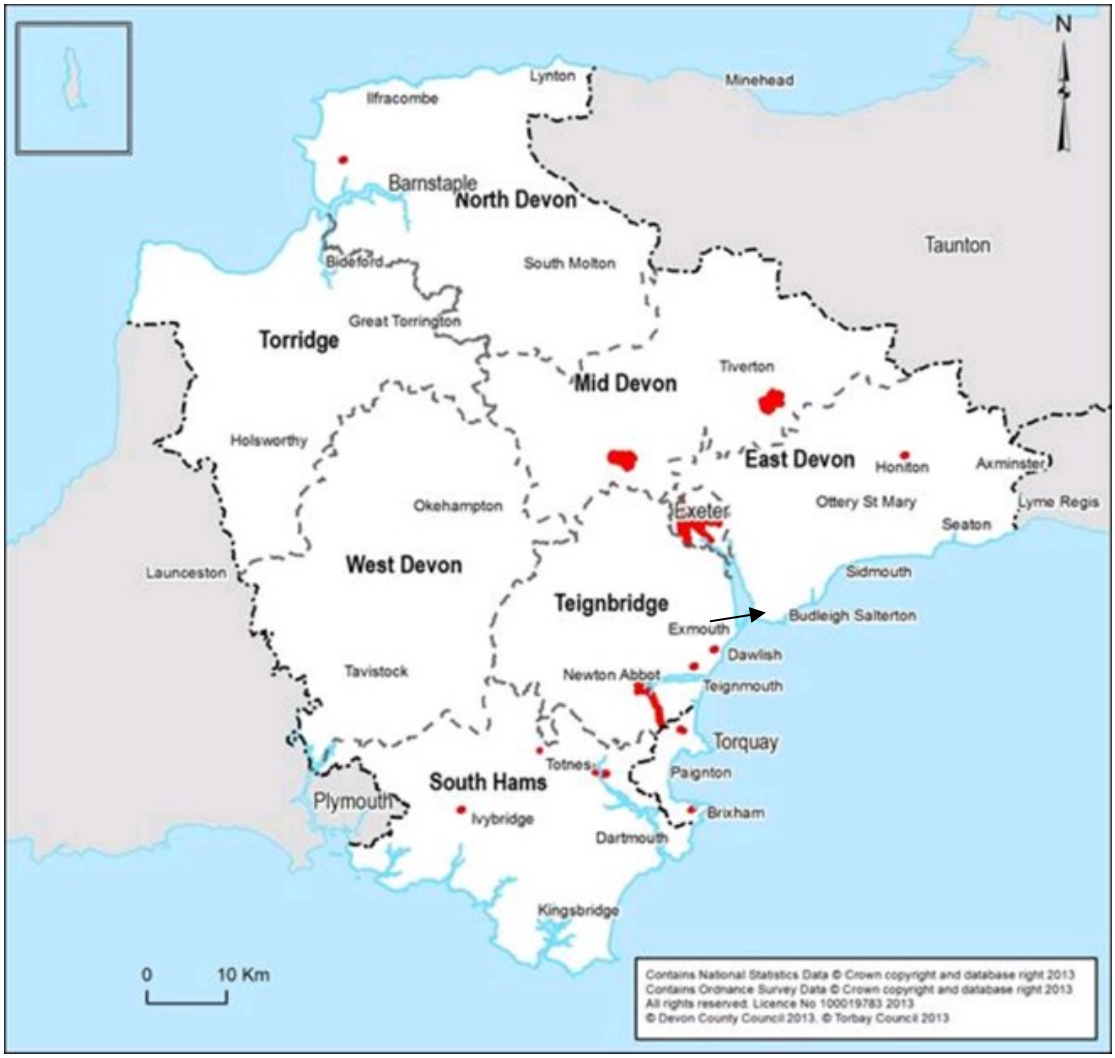
The partnership has released a State of the Environment report for Devon and Torbay, which describes the current condition of the environment around 13 separate themes. The report is also available on the Natural Devon website, and can be accessed here: http://www.naturaldevon.org.uk/state-of-environment/

Nationally an Environment and Health Atlas is available for England and Wales which shows the distribution of disease risk and agents relating to environment impacts on health. This includes information relating to climate, particular health conditions and environmental hazards at a small area level for the entire country: http://www.envhealthatlas.co.uk/homepage/index.html

Air Quality

Poor air quality negatively affects human respiratory and cardiovascular systems and is strongly linked to asthma and mortality. In the short-term, high pollution episodes, perhaps associated with heat waves for example, can contribute to the premature death of people who are more vulnerable to daily changes in levels of air pollutants. Objectives are set for nine main air pollutants within Defra's Air Quality Strategy, and where these objectives are not met, the local authority must declare an Air Quality Management Area (AQMA). There are 12 AQMAs in Devon shown in the map in figure 6.2. All areas are designated as AQMAs for excessive levels of Nitrogen dioxide which is a pollutant from road traffic which can cause increased vulnerability to respiratory infection and may cause infection of the lungs. The Crediton AQMA is also designated for excessive levels of particulate matter below 10 microns in diameter (PM10) which is predominantly emitted from diesel engines without particulate filters. The proportion of mortality attributable to particulate air pollution in Devon is 3.7% which is below the South West average of 4.4% and England average of 5.4%.

Figure 6.2 Devon Air Quality Management Areas

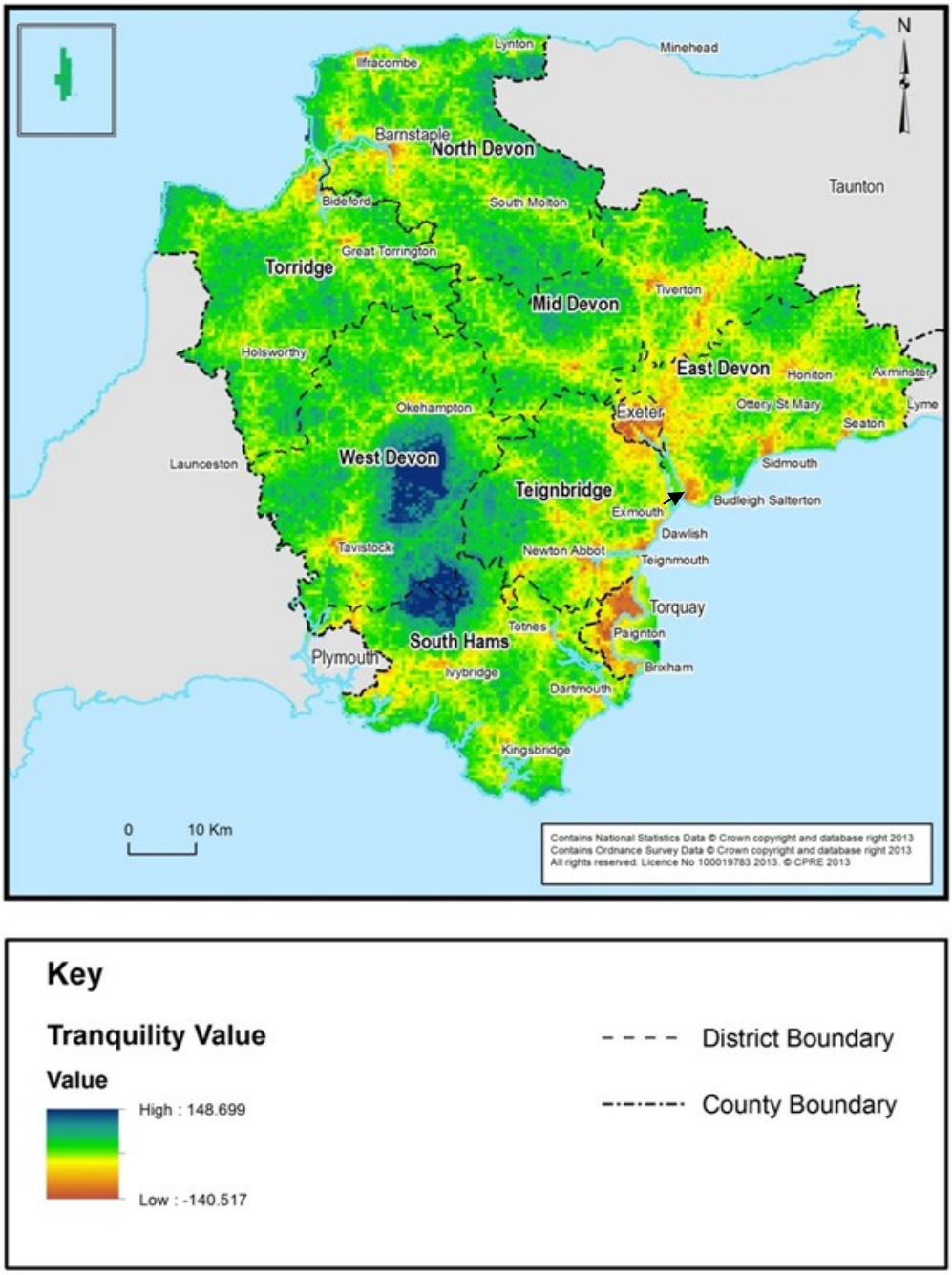


Source: State of the Environment, 2014 – Devon Local Nature Partnership

Tranquillity

An area's tranquillity is determined by the levels of noise and visual intrusion from major infrastructure such as motorways, A roads, urban areas and airports and defined by the Campaign to Protect Rural England. An increase in areas disturbed by noise and visual intrusion has been seen with the greatest increase being seen between the early 1960s and 1990s, during which a 154% increase in land area affected by noise and visual intrusion. Over this time, Devon became more urbanised, the M5 motorway was constructed and the A38, A380 and A30 roads were dualled. Figure 6.3 maps the tranquillity levels in 2007, showing the sparsely populated areas of central Devon as the most tranquil and the lowest levels following the major roads and urban settlements in Devon.

Figure 6.3 Map of tranquillity across Devon



Source: State of the Environment, 2014 – Devon Local Nature Partnership

6.04 Social Isolation and Connectedness

Older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility and income.

Within the Annual Population Survey carried out by the Office of National Statistics, information is collected around wellbeing. One element of this looks at the extent to which people feel the things they do in their life are worthwhile. A scale from 0-10 is used, where 0 is ‘not at all worthwhile’ and 10 is ‘completely worthwhile’. In 2013-14 across Devon overall the score is 7.78, and by local authority the scores range between 7.46 in Torridge and 7.97 in East Devon. A score of between 7 and 8 on the scale is considered high and therefore feelings of life being worthwhile are higher across Devon compared to the national profile.

The Adult Social Care Survey in England reports on the proportion of adult social care users and carers who report having as much social contact as they would like. In 2013-14 across Devon, the 47.5% of adult social care users and 42.6% of adult carers reported they had as much social contact as they would like. These proportions are statistically similar to the national average.

Devon County Council are currently using a range of data and undertaking modelling to produce an overall likelihood of isolation. This is being looked at by a very low geographical level to enable small pockets of potential isolation to be identified.

Statistics on internet use in the UK in 2015 (http://visual.ons.gov.uk/internet-use/) reveal that whilst usage is increasing, 10% of males, and 13% of females have never used the internet. This increases with age, with 61% of those aged 75 and over having never used the internet. Regular use of the internet in Devon increased from 84% in 2013 to 86% in 2015.

6.05 Community Resilience

Community resilience refers to the ability of communities to support one another by engaging and participating with community organisations. In Devon it is estimated there are 31,255 formal volunteers, based on records help by Devon Voluntary Action (DeVA). These estimates do not include informal volunteering, including babysitting and checking and helping neighbours. This contribution not only helps the organisation but also helps the individual. Volunteering can support successful transition into employment through developing skills, confidence, self-esteem, motivation to work, office skills and IT capability (Devon Voluntary Action (DeVA) Third Sector Overview of Devon, May 2014). These volunteers also have an economic impact on society. If each volunteer provides just 2 hours a week, this leads to a £39 million annual contribution in Devon. In the 2011 Devon Community Needs Survey (www.devon.gov.uk/hearmetoo201203.pdf) a significant proportion of people indicated that they did not know what to do in the event of a major emergency (30% of males and 48% of females).

6.06 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.

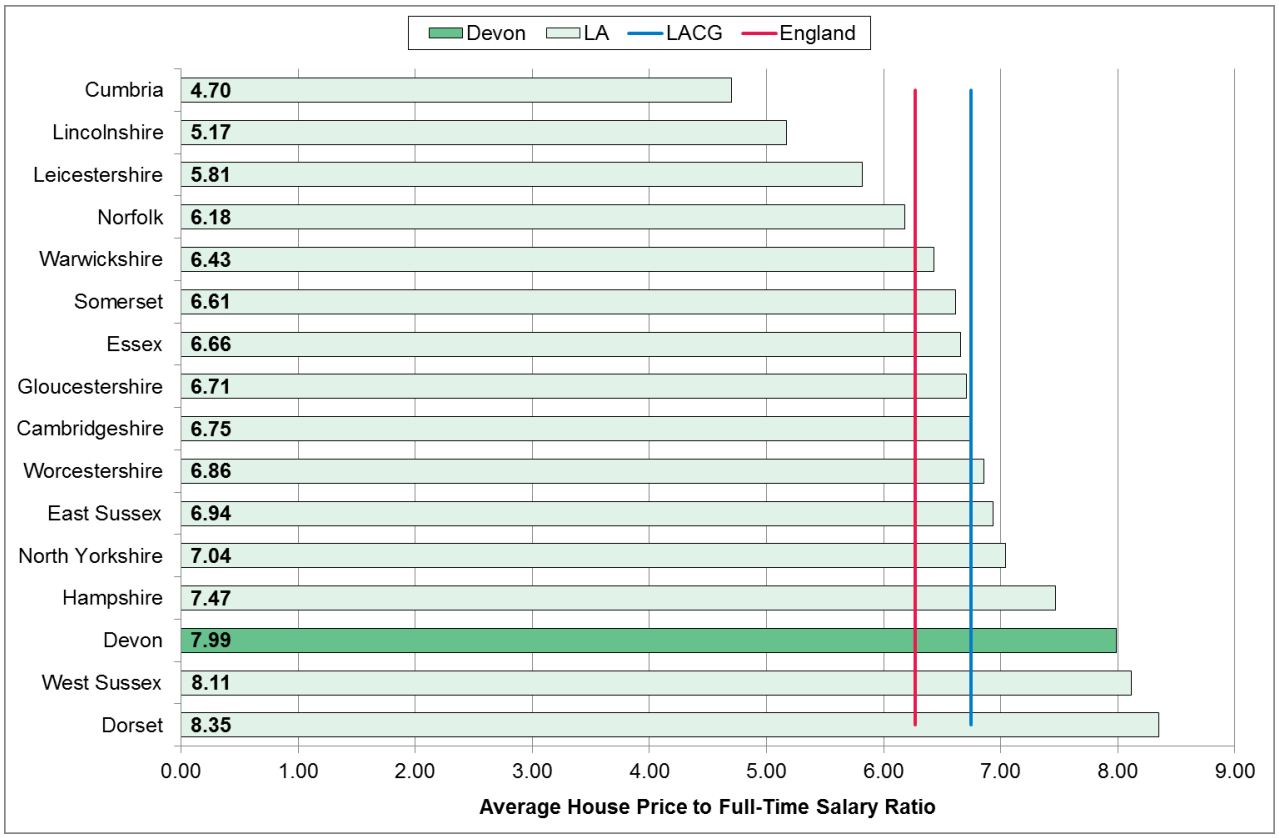
In relation to the links between housing and health inequalities it is useful to look at the housing tenure of vulnerable groups and the condition of that housing. Data shows in Devon vulnerable households account for just under a fifth of the population living in private rented housing. In the South 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 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 6.4 shows affordability ratios across Devon are higher than the national average. The ratios vary from district to district and in 2014 the highest ratio was in South Hams and the lowest in Exeter.

Figure 6.4, Average House Price to Full-Time Earnings Ratio, Devon Local Authority Comparator Group, 2014



Source: Department for Communities and Local Government, 2014

6.07 Homelessness

Homelessness and, in particular, rough sleeping is often viewed as a problem which only exists in large cities. However, there are 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.

Rough sleepers represent the smallest proportion of those who are homeless or in housing need and represent the most acute need. The latest rough sleeper count (November 2014) identified 73 individuals sleeping rough across Devon compared to 46 during the same period in 2013. 26% of these people were aged over 50 and 7% were under 25.

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 few years has seen an increase in rough sleeping nationally, partly because the evaluation method was changed by the government in this period.

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 everyday life.

Public Health have been working in partnership with key stakeholders to better coordinate a range of services for people with complex needs using the MEAM (Making Every Adult Matter) Approach. MEAM is a national coalition of Drugscope, Homeless Link, MIND and CLINKS who are giving time and sharing best practice to assist Devon to develop more inclusive services. A pilot cohort was selected in Exeter and the project developed in 2014 and 2015.

6.08 Rurality and Accessibility

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 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.

Access to broadband internet services can also be challenging in rural areas. A project is currently underway across Devon and Somerset to extend coverage to rural areas and details about availability and coverage can be found here:
www.connectingdevonandsomerset.co.uk

Box 2, Transport to Health Services, Perceptions and Experiences

One in five people said the transport they use is either not convenient, or prompt or affordable. Nearly two thirds of respondents did not know it was possible to get help with travel costs, or did not know how to make a claim.

Patient Transport Service drivers are widely praised for goodwill and courtesy. The Single Point of Contact (SPOC) scheme is seen as a model of good practice. But punctuality is a problem, and one provider in particular has been the cause of numerous complaints.

> *"They manage to undertake a very patient/people focus task which is highly improbable, yet make it all look and feel very professional and relaxed. I have nothing but high praise for the entire team."*

Bus services feature long journeys, complicated timetables and lack of connections. Early morning appointments are difficult to get to by bus, journeys are long, and evening appointments are hard to get home from. People with bus passes may not be able to use them on early buses.

> *"If one travels before 9.30 Monday-Friday one cannot use their bus pass, often the bus times do not tie in and one often misses the connections."*

Travelling distance matters. The further away a service, the harder it is to get there if you are reliant on public transport, and the harder it is for friends and relatives to visit or offer practical support.

> *"Hospitals do not consider distance and time taken to get to appointments, often early morning when no bus is available."*

Parking is difficult for some car drivers, with inadequacy of spaces, and long walking distances from car park to building. But the Park and Ride scheme for the Royal Devon and Exeter hospital was praised for convenience and accessibility.

> *"Not everyone for example receives benefits, so hospital car parking fees on top of travelling costs can be very expensive, for cancer patients."*

Cost is a concern - particularly when bus users have to go by taxi instead. The possibility, in some cases, to reclaim travel costs, is not well known.

> *"Not everyone for example receives benefits, so hospital car parking fees on top of travelling costs can be very expensive, for cancer patients."*

Source
Healthwatch Devon, 'Transport to Health Services' Report, October 2014
http://www.healthwatchdevon.co.uk/wp-content/uploads/2014/12/Transport-to-Health-Services-final-051214.pdf

7. Socio-Economic Deprivation

The term socio-economic deprivation refers to the lack of material benefits considered to be basic necessities in a society. In England, the Indices of Deprivation is a measure of local levels of deprivation taking into account income, employment, health, education, access to housing and services, education, the indoor and outdoor living environment and crime. When interpreting these statistics it is vital to note not every person in a highly deprived area will themselves be deprived, and equally some deprived people will be living in the least deprived areas. This is particularly important to note in a county like Devon, where the pattern of deprivation is very dispersed with isolated pockets of deprivation rather than large swathes.

7.01 Indices of Deprivation

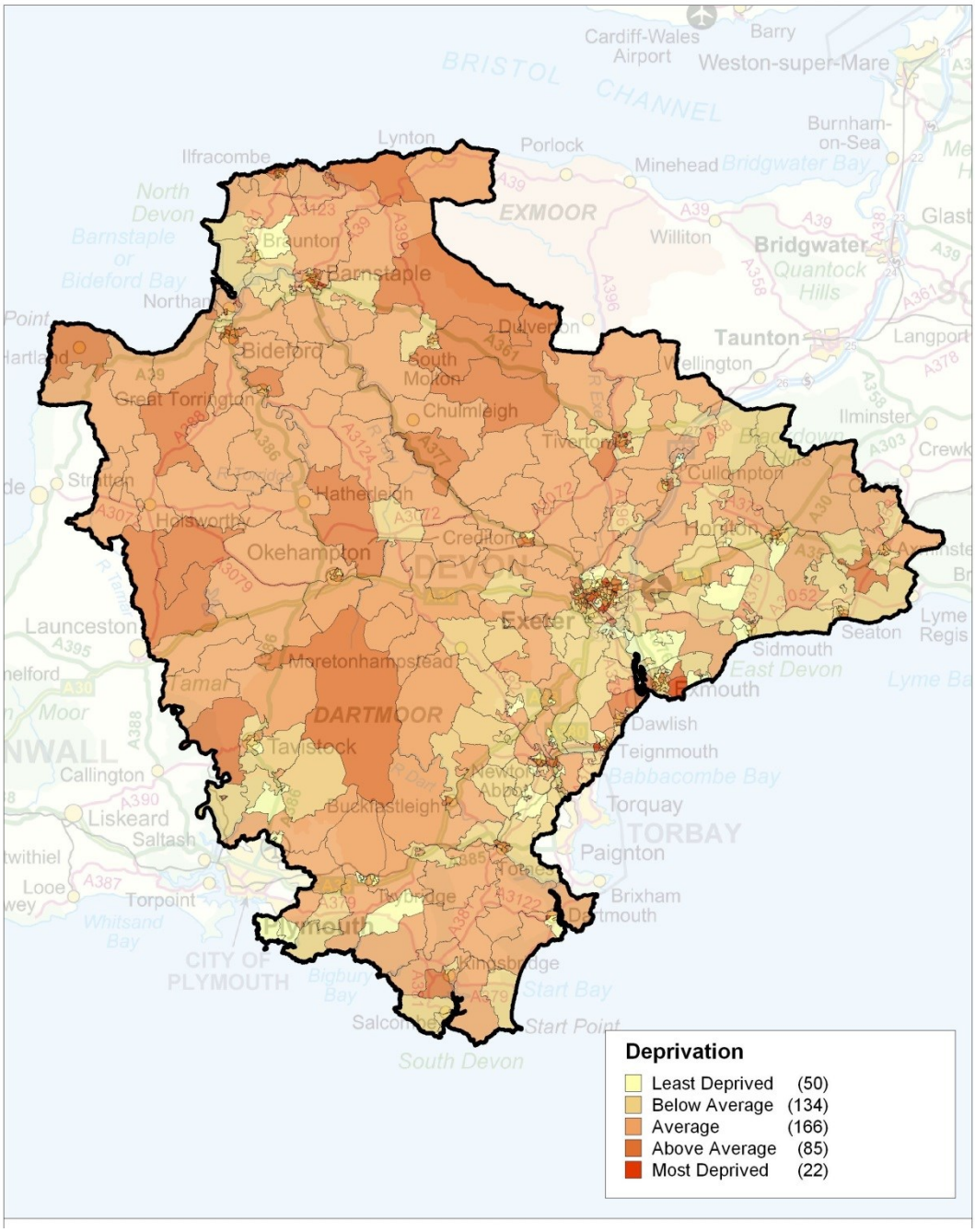
The latest version of the Index of Multiple Deprivation for 2010 was published in March 2011, with the next version due later in 2015. Figure 7.1 shows Index of Multiple Deprivation 2010 figures by Lower Super Output Area (LSOA), which are small areas of similar size created by the Office for National Statistics). This suggests 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. 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. Figure 7.2 compares average deprivation scores for urban and rural areas in the district areas in Devon. Whilst 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 7.3 shows the percentage of the Devon population in each national indices of deprivation quintile for the overall index, the individual domains, and the supplementary income deprivation indices for children and older people. This reveals there are typically fewer areas at the extremes, with lower proportions in the most deprived or least deprived quintiles for the overall index of multiple deprivation (IMD), the income, employment, health, education domains, and the income measures for children and older people, with most areas being in the below average or average groups. Relatively low levels or crime, road traffic accidents and generally good air quality mean the majority of areas in Devon are in the least deprived quintile nationally for the crime and outdoor environment domains. This is largely reversed in the barriers domain (accessibility and affordability of housing, and distance from local services) with 32.5% of the Devon population in the most deprived group nationally, and the indoor environment domain (houses failing to meet the decent homes standard or without central heating), with 47.3% of the Devon population in the most deprived group nationally.

The local areas in the most deprived 20% nationally are listed in more detail below, with links out to detailed community baseline profiles for the areas:

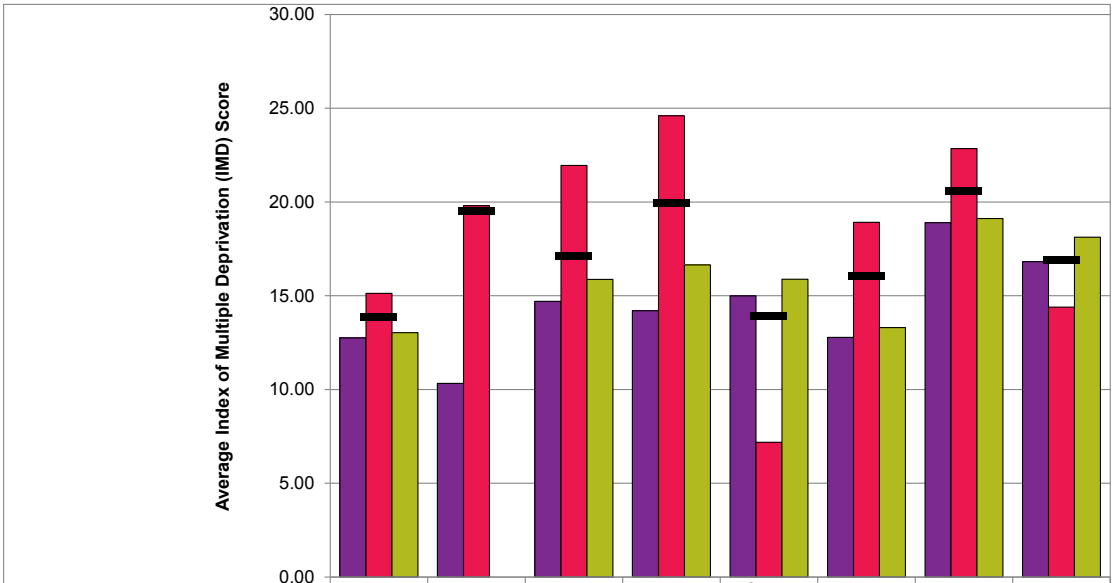
1. Exeter Central – two LSOAs, Profiles 1 2
2. Ilfracombe Central – three LSOAs, Profiles 1 2 3
3. Exeter Wonford, Whipton and Beacon Heath – seven LSOAs, Profiles 1 2 3 4 5 6 7
4. Barnstaple Central– one LSOA, Profile
5. Barnstaple Forches and Whiddon Down– two LSOAs, Profiles 1 2
6. Bideford Central– one LSOA, Profile
7. Teignmouth West – one LSOA, Profile
8. Newton Abbot Buckland – one LSOA, Profile
9. Exmouth Littleham – one LSOA, Profile
10. Dartmouth Townstal – one LSOA, Profile
11. Tiverton Queensway / Beech Road – one LSOA, Profile
12. Dawlish Strand, Seafront and High Street – one LSOA, Profile

Figure 7.1, 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

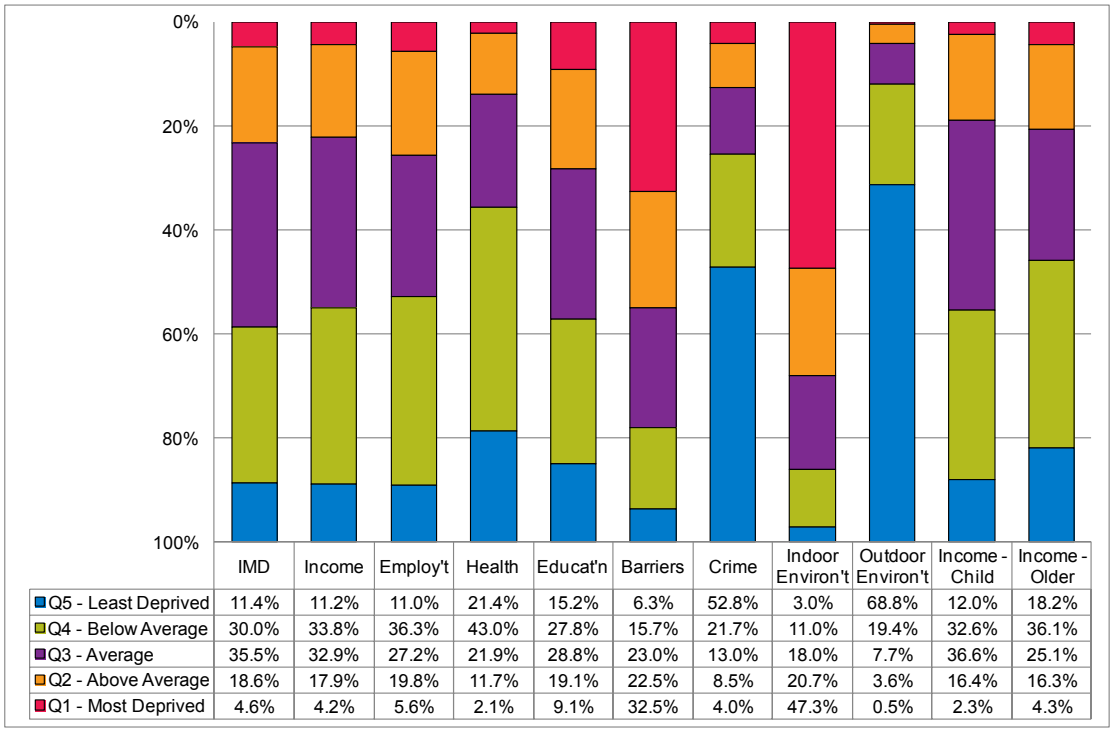
Figure 7.2, Index of Multiple Deprivation, 2010 by Devon district and rurality



	East Devon	Exeter	Mid Devon	North Devon	South Hams	Teign-bridge	Torridge	West Devon
Town and Fringe	12.75	10.32	14.70	14.21	14.99	12.78	18.90	16.82
Urban > 10K	15.13	19.80	21.95	24.60	7.18	18.92	22.85	14.39
Village Hamlet & Isolated Dwellings	13.03		15.88	16.65	15.88	13.30	19.12	18.12
Overall	13.87	19.50	17.14	19.96	13.91	16.05	20.59	16.89

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

Figure 7.3, Percentage of Devon Population in each Indices of Deprivation Quintile by Domain, 2010



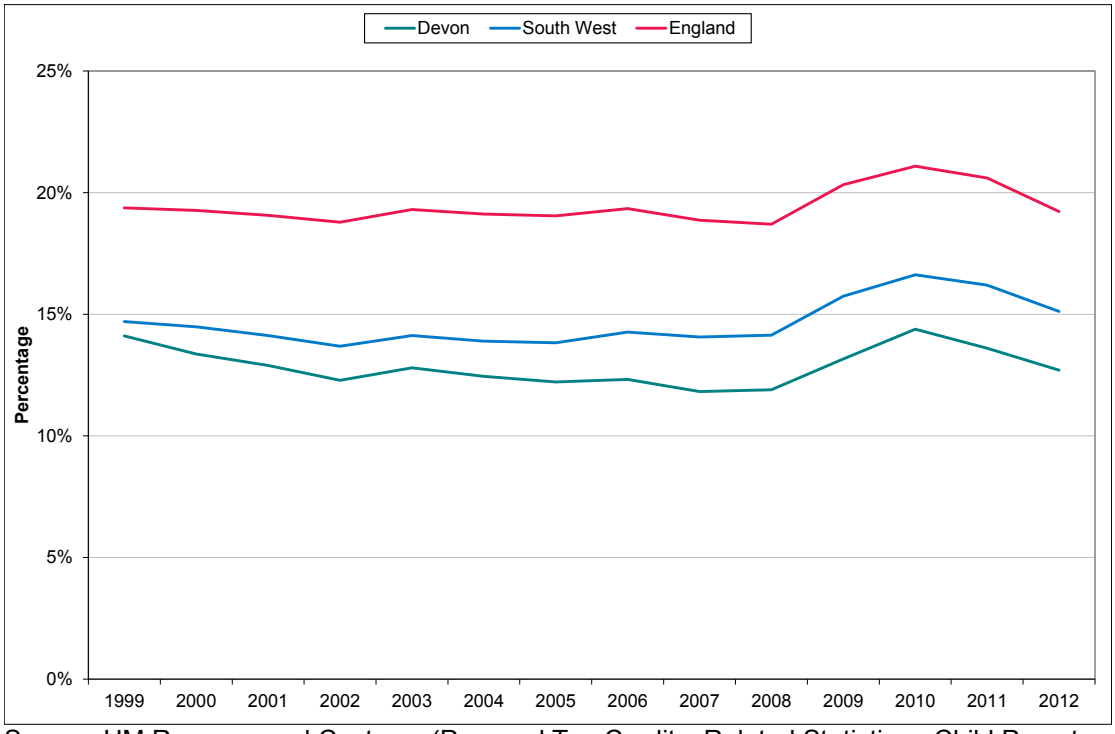
	IMD	Income	Employ't	Health	Educat'n	Barriers	Crime	Indoor Environ't	Outdoor Environ't	Income - Child	Income - Older
Q5 - Least Deprived	11.4%	11.2%	11.0%	21.4%	15.2%	6.3%	52.8%	3.0%	68.8%	12.0%	18.2%
Q4 - Below Average	30.0%	33.8%	36.3%	43.0%	27.8%	15.7%	21.7%	11.0%	19.4%	32.6%	36.1%
Q3 - Average	35.5%	32.9%	27.2%	21.9%	28.8%	23.0%	13.0%	18.0%	7.7%	36.6%	25.1%
Q2 - Above Average	18.6%	17.9%	19.8%	11.7%	19.1%	22.5%	8.5%	20.7%	3.6%	16.4%	16.3%
Q1 - Most Deprived	4.6%	4.2%	5.6%	2.1%	9.1%	32.5%	4.0%	47.3%	0.5%	2.3%	4.3%

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

7.02 Trends in Child Poverty

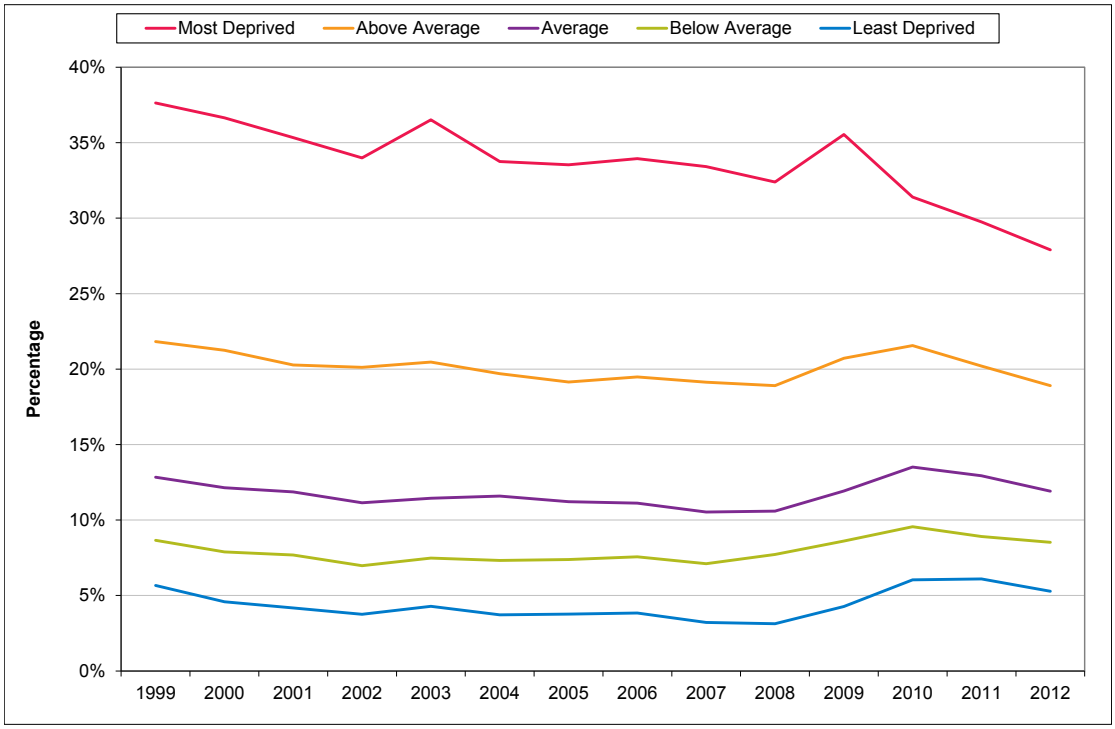
The percentage of children living in households which are dependent on benefits or tax credits is a measure within the Devon Health and Wellbeing Board Outcomes Report and the Devon Public Health Outcomes Report. 16,760 children (13.6%) in Devon live in households dependent on benefits or tax credits, compared with 16.2% in the South West and 20.6% nationally. Child poverty rates in Devon fell between 1999 and 2008 and have dropped further from the South West average over time. Rates increased in 2009 and 2010 before falling slightly in 2011. Rates at a district level range from 10.6% in East Devon to 16.8% in Torridge. Rates in the most deprived areas are five times those in the least. Considerable variation exists across Devon communities. Rates of child poverty are higher in younger families due to higher benefit claimant rates and lower incomes in persons in their 20s and 30s. Single parent households, particularly where headed by a female, are also more likely to experience economic poverty, as are children of disabled parents. There are no significant variations by ethnic group in Devon.

Figure 7.4, Percentage of children aged under 16 living in households dependent on benefits or tax credits, 1999 to 2012



Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics), 2014

Figure 7.5, Percentage of children aged under 16 living in households dependent on benefits or tax credits, 1999 to 2012

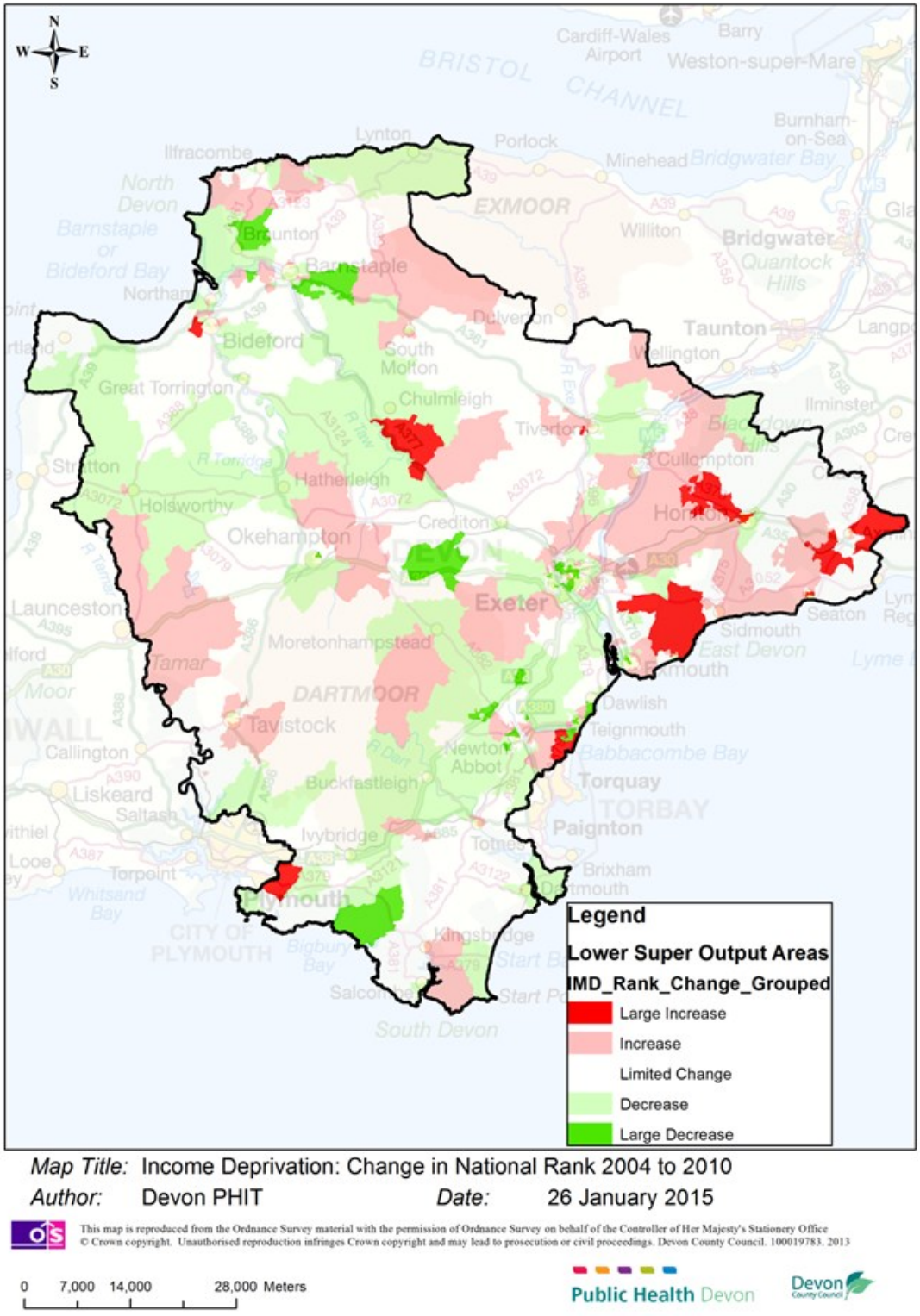


Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics), 2014

7.03 Local Change in Deprivation

The pattern of deprivation by Devon area is not static and changes over time. The following map shows areas which have since larger relative increases in levels of deprivation as determined by their rank nationally (red shading), and areas with larger relative decreases in deprivation (green shading). Increases were seen in areas of East Devon, with increases elsewhere in the county seen in predominantly rural areas. Decreases were seen in central parts of Exeter, with the largest decreases outside of Exeter seen in towns in parts of Teignbridge (Newton Abbot, Dawlish, Teignmouth and Chudleigh) as well as in parts of North Devon.

Figure 7.6, Map of Devon showing change in socio-economic deprivation, 2004-2010



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

8. Starting Well: Children, Young People and Families

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.

8.01 Early Help: prevention in childhood

Early Help describes the range of support that can be offered in response to the emerging needs of children, young people and families. When a child's needs increase, more than one service may be required to meet their needs. 'Early Help' is the name given to the way services work together, in a coordinated way, to support the child, young person and their family. If we do this well, fewer children will need to be supported by statutory services, such as children's social care. The Devon Threshold Tool and Devon Assessment Framework (DAF) allow professionals, whichever organization they work for, to assess the needs of a child, young person or family and involve partner organisations or support services and enable the process of providing or accessing support services can begin. Support, advice and guidance to assist practitioners involved with early help activity in Devon is available through the Early Help Coordination Centre (EHCC). Support and advice are available around completion of the DAF, contacting agencies and identifying lead professionals and signposting professionals and families to local services and support. Early help advisors, based in locality areas provide support in completing high quality assessments, with clear, positive outcomes for children, young people and their families.

Devon Early Help Strategy: www.devonsafeguardingchildren.org/parents-carers/early-help

Box 3, Young People and Community Health Services, Perceptions and Experiences

In May 2014, the Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) started a major review of community health and care services. Healthwatch Devon undertook a survey of young people in Budleigh Salterton, which has a predominantly older population profile, to gain insights into what younger people thought about community health services in the area. A total of 281 young people from Budleigh Salterton took part in the engagement, through an online survey, and focus groups and interviews at different locations.

Key findings include:

- The top three health and care issues highlighted by young people were sexual health, mental health and smoking
- Young people want frank and open discussions, but health professionals can seem inaccessible and unfriendly
- Young people want better awareness of mental health issues including self-harm
- Young people with special needs often feel excluded from places and activities

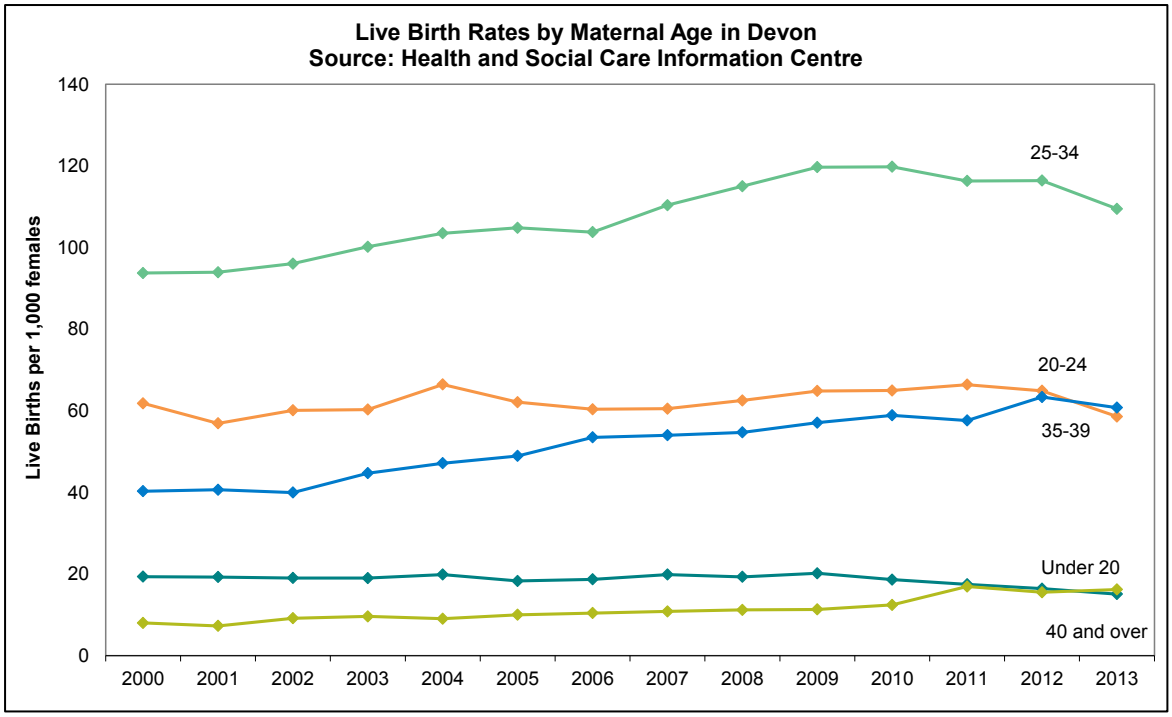
Healthwatch Devon concluded that future community wellbeing hubs could be of value and relevance to young people if they provided advice and resources about a range of mental health conditions, including depression, anxiety, self-harm and eating disorders, alongside the provision of social space for the whole community.

Source
Healthwatch Devon, 'Young people speak out on community health services' Report, 2014
http://www.healthwatchdevon.co.uk/young-people-speak-community-health-services

8.02 Fertility and Birth

There are over 7,000 births per annum in Devon. Since 2001 a gradual increase has been seen in the numbers of babies being born, with numbers dropping slightly in 2013. Figure 8.1 below shows the rates of births by age group over time and shows increasing rates of births to mothers aged 35 and above and decreasing rates in those aged under 35. The rate of births to mothers aged 40 is now just above the rate in under 20 year olds which is showing a gradual decrease.

Figure 8.1 Live births per 1,000 females by maternal age, Devon, 1997 to 2013

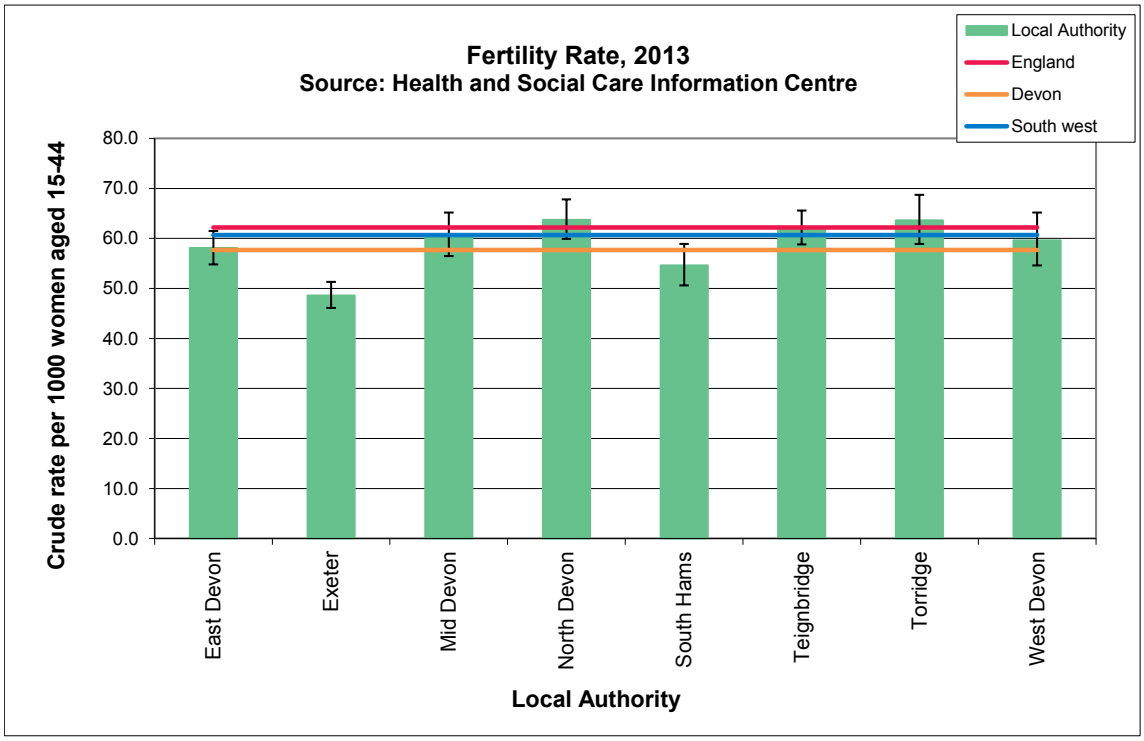


Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

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. In Devon, the rate (1.83) is slightly below the national and regional averages of 1.85 and 1.86 respectively. This rate varies significantly across Devon, ranging from 1.51 in Exeter up to 2.06 in Torridge.

The birth rate varies cross Devon and figure 8.2 shows Exeter has a statistically significantly lower rate than the Devon, regional and national averages. North Devon, Teignbridge and Torridge all have birth rates significantly above the Devon average but similar to the regional and national rates.

Figure 8.2 Birth rates by local authority, 2013

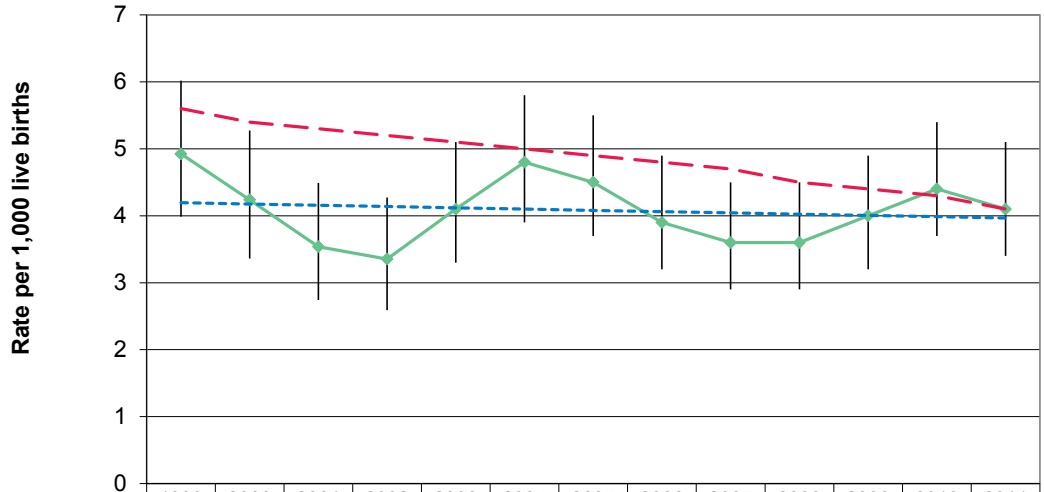


Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

8.03 Infant Mortality

Infant mortality is the death of a child less than one year of age. Figure 8.3 below illustrates how rates of infant mortality have changed in Devon since 1999-2001. Three year rolling averages are used because of the low numbers. Although the rates have fluctuated over time, the overall Devon trend is decreasing. This decrease is however at a slower pace than in England and Wales overall.

Figure 8.3 Infant mortality rates (per 1,000 live births) in Devon for three-year periods between 1999 and 2013



	1999 - 2001	2000 - 2002	2001 - 2003	2002 - 2004	2003 - 2005	2004 - 2006	2005 - 2007	2006 - 2008	2007 - 2009	2008 - 2010	2009 - 2011	2010 - 2012	2011 - 2013
Devon annual deaths	32	27	22	22	27	32	31	28	26	26	30	33	31
Devon annual rate	4.9	4.2	3.5	3.4	4.1	4.8	4.5	3.9	3.6	3.6	4.0	4.4	4.1
England and Wales rate	5.6	5.4	5.3	5.2	5.1	5.0	4.9	4.8	4.7	4.5	4.4	4.3	4.1
Devon rate trend	4.2	4.2	4.2	4.1	4.1	4.1	4.1	4.1	4.0	4.0	4.0	4.0	4.0

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

8.04 Life Expectancy at Birth

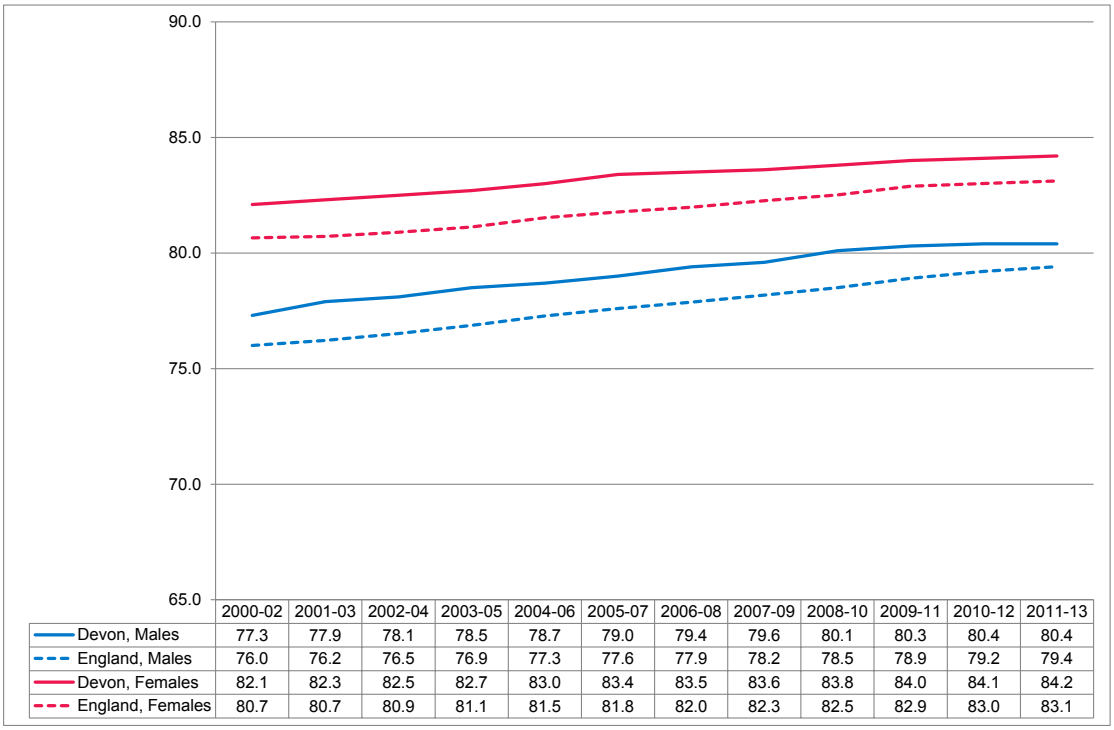
Life expectancy is the average period that a person can expect to live. Table 8.1 sets out the current average life expectancy in Devon, with males living 80.4 years and females living 84.2 years on average, a difference of 3.8 years. Figure 8.4 shows the trend in male and female life expectancy, highlighting that life expectancy has increased over recent years, and that life expectancy in Devon has been consistently above the England average.

Table 8.1, Average Life Expectancy at Birth in Years, Devon Local Authorities, 2011-13

	Males		Females	
Area	Average Life Expectancy	95% Confidence Interval	Average Life Expectancy	95% Confidence Interval
East Devon	81.1	(80.5 to 81.7)	84.3	(83.8 to 84.9)
Exeter	79.8	(79.2 to 80.3)	83.9	(83.3 to 84.6)
Mid Devon	80.9	(80.1 to 81.7)	85.6	(85.0 to 86.2)
North Devon	79.7	(78.9 to 80.4)	83.2	(82.6 to 83.8)
South Hams	81.1	(80.4 to 81.8)	85.3	(84.7 to 85.9)
Teignbridge	80.1	(79.5 to 80.6)	84.2	(83.7 to 84.8)
Torridge	80.5	(79.8 to 81.3)	82.5	(81.7 to 83.3)
West Devon	79.4	(78.4 to 80.4)	84.8	(84.2 to 85.3)
Devon	80.4	(80.2 to 80.7)	84.2	(84.0 to 84.4)
South West	80.1	(80.0 to 80.2)	83.8	(83.8 to 83.9)
England	79.4	(79.4 to 79.4)	83.1	(83.1 to 83.2)

Source: Health and Social Care Information Centre, Compendium of Population Health Indicators, 2015

Figure 8.4, Trend in Average Life Expectancy in Years in Devon and England, 2000-02 to 2011-13



	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13
Devon, Males	77.3	77.9	78.1	78.5	78.7	79.0	79.4	79.6	80.1	80.3	80.4	80.4
England, Males	76.0	76.2	76.5	76.9	77.3	77.6	77.9	78.2	78.5	78.9	79.2	79.4
Devon, Females	82.1	82.3	82.5	82.7	83.0	83.4	83.5	83.6	83.8	84.0	84.1	84.2
England, Females	80.7	80.7	80.9	81.1	81.5	81.8	82.0	82.3	82.5	82.9	83.0	83.1

Source: Health and Social Care Information Centre, Compendium of Population Health Indicators, 2015

Substantial differences in average life expectancy exist within Devon, with shorter life expectancy seen in more deprived areas and areas with a high concentration of care homes. The shortest life expectancy at ward level in Devon is in Ilfracombe Central (74.6 years) which is 15 years less than the life expectancy in Newton Poppleford and Harpford in East Devon (89.6 years). Life expectancy is also significantly lower in certain groups including gypsies and travellers, the homeless and persons with moderate or severe learning disabilities.

Table 8.2, Overall, shortest and longest average life expectancy in years (LE) at birth by ward, Devon local authority districts, 2009 to 2013.

District	Overall LE	Shortest LE		Longest LE		Gap (years)
		Ward Name	LE	Name	LE	
East Devon	82.8	Exmouth Littleham	80.0	Newton Poppleford and Harpford	89.6	9.6
Exeter	81.8	Newtown	77.4	Topsham	85.9	8.5
Mid Devon	83.0	Cullompton North	79.6	Upper Culm	85.9	6.3
North Devon	81.5	Ilfracombe Central	74.6	Chittlehampton	87.7	13.1
South Hams	82.9	Totnes Bridgetown	79.0	Marldon	86.7	7.7
Teignbridge	82.1	Newton Abbot: College	78.8	Kerswell-with-Combe	86.1	7.3
Torridge	81.8	Kenwith	79.6	Three Moors	89.2	9.6
West Devon	82.1	Okehampton West	79.7	Milton Ford	86.1	6.4
Devon	**82.3**	**Ilfracombe Central**	**74.6**	**Newton Poppleford and Harpford**	**89.6**	**15.0**

Source: Primary Care Mortality Database 2014 and Office for National Statistics Mid-Year Population Estimates

8.05 Smoking in Pregnancy

In Devon, around one in eight women smoke in pregnancy (12.2%). This is similar to the national rate of 12% and below the south west rate of 13%. The impact of smoking in pregnancy is significant. 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. Smoking at delivery varies by age with younger mothers in their teens and twenties more likely to smoke than mothers in their thirties and forties. Highest smoking rates are in the deprived populations and are the leading factor in increased health inequalities amongst babies. In Devon, rates in most deprived areas are almost five times higher than those in the least deprived areas, at 25.7% compared to 5.4%.

8.06 Breastfeeding

Breastfeeding rates in Devon overall compare well to the national average. There is however variation across Devon at all stages of feeding. Initiation of breastfeeding varies from 66.3% in Mid Devon to 83.3% in South Hams. At primary birth visit, which typically occurs around 10 to 14 days after birth, there is a drop off of 17% across Devon – ranging from 20% in Teignbridge to just fewer than 10% in North Devon and Torridge. Breastfeeding at 6-8 weeks ranges from 43% in Mid Devon to 57% in South Hams with a drop off again ranging from 15% to 4% from primary birth visit. Breastfeeding rates tend to be higher in black and minority ethnic groups, in older mothers, and in less deprived areas.

Table 8.3, Breastfeeding at birth, primary birth visit and 6-8 weeks by local authorities, 2013

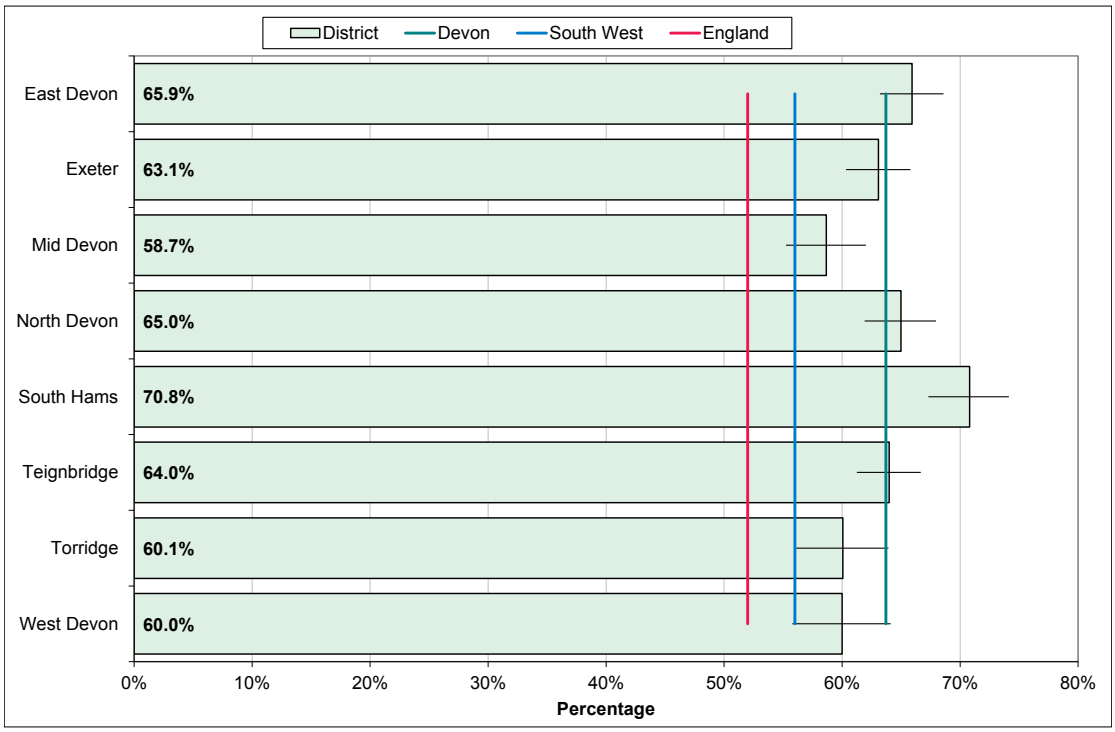
Local Authority	Breastfeeding initiation	Breastfeeding at primary birth visit	Breastfeeding at six to eight weeks
East Devon	71.7%	60.8%	49.8%
Exeter	72.1%	57.2%	53.3%
Mid Devon	66.3%	55.4%	43.8%
North Devon	75.0%	65.0%	54.4%
South Hams	83.3%	63.6%	57.3%
Teignbridge	78.9%	58.1%	48.0%
Torridge	74.0%	64.1%	49.3%
West Devon	80.0%	63.6%	56.7%
Devon	77.8%	60.3%	51.1%

Source: Devon child health information systems and local maternity datasets

8.07 Education

The Early Years Foundation Stage (EYFS) Profile collects data on the development of children aged five, based on teacher assessments of individual children. These are reported annually to the Department for Education. In Devon, the proportion of children achieving the expected level of development through the EYFS was 67% which is above the South West average of 61% and the national average of 58%. There is however variation between districts with 58.7% in Mid Devon and 70.8% in South Hams. The results record various areas of development, including communication, physical development, personal, social and emotional development, literacy, mathematics, understanding the world and expressive arts, designing and making. Devon results in all areas are higher than nationally and in the South West (Source: Department for Education).

Figure 8.5, Early Years Foundation Stage Profile 2013-14, Overall Development Scores



Source: Department for Education, 2014

Level 4 is the recommended level of achievement at Key Stage Two (year six, aged 10 to 11). Pupils in Devon have consistently achieved a higher proportion of level 4 and level 5 than nationally and have also increased year on year. There is however still a difference in achievement between girls and boys, with higher proportions of girls achieving both level 4 and 5 than boys.

Table 8.4, Key stage 2 attainment in reading, writing and mathematics

	Percentage achieving level 4 or above								
	2012			2013			2014		
	All	Boy	Girls	All	Boy	Girls	All	Boy	Girls
Devon	78%	75%	81%	77%	73%	82%	81%	78%	84%
South West	75%	71%	79%	76%	72%	80%	79%	76%	82%
England	75%	71%	79%	75%	72%	79%	79%	76%	82%
	Percentage achieving level 5 or above								
	2012			2013			2014		
	All	Boys	Girls	All	Boys	Girls	All	Boys	Girls
Devon	22%	19%	26%	23%	20%	28%	26%	22%	30%
South West	21%	17%	24%	22%	18%	25%	23%	20%	26%
England	20%	17%	23%	21%	18%	25%	24%	20%	27%

Source: Department for Education, 2014

Achievement data for 5 or more GCSEs or equivalent had shown an upward trend nationally and although achievement levels were slightly lower in Devon, the trend was increasing. In 2013/14 there have been major reforms that have had an impact on the performance measures and this can be seen in the data in table 8.5 below for 2013/14. There were some changes in relation to vocational qualifications in relation to what is included, the point scores they count for and how many count towards performance measures. There were also changes to how early entries counted within performance measures and the results show clearly these changes have reduced the percentage with five or more GCSE or equivalent. It is therefore no possible to compare the results from 2013/14 in a trend over time. Further changes to the curriculum are expected and so data is included for this year, but further changes are likely in the future.

Table 8.5, Trends in pupils attaining five or more GCSEs at grades A* to C, Devon, 2005-06 to 2013-14

Area	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Devon	58.0%	57.3%	63.5%	65.9%	68.7%	73.8%	77.9%	78.0%	67.4%
South West	58.2%	59.5%	63.6%	67.9%	72.7%	76.8%	79.8%	79.8%	65.8%
England	59.0%	61.4%	65.3%	70.0%	75.4%	79.6%	81.9%	81.8%	63.2%

Source: Department for Education, 2014

8.08 Youth Offending and Crime

Young People as Perpetrators of Crime

The level of offending by children and young people is relatively low in Devon, 411 young people were recorded as offenders in 2013-14 committing a total of 719 offences. The total number of young people aged 10 to 17 years who offended in Devon has fallen by 56% between 2010 and 2013 and the overall number of offences committed has fallen by 60% within the same period. According to the Devon Youth Offending Service, the highest number of offences committed in 2013 was violence against the person (24%), theft & handling (20%), criminal damage (12%) and drugs offences (12%).

Children and young people in contact with the youth justice system have higher unmet health and wellbeing needs than other children of their age. They have often missed out on early attention to health needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting might be linked to parental poverty, substance misuse and mental health problems. The overwhelming majority of children and young people in contact with the Youth Justice Service remain in the community throughout that contact, but a small number are remanded or sentenced to custody. The health and well-being needs of children and young people in custody tend to be particularly severe.

For the purposes of the Safeguarding it is important to understand the vulnerabilities of the perpetrators of crimes rather than the offences that have been committed. The following tables show the number of offenders that have been in care, or have had a child protection plan.

Table 8.6, Looked after status of youth offenders in Devon, 2013-14

Looked after child status	Accommodated by Voluntary Agreement	Subject to Care Order	On the Child Protection register
Currently	35	18	5
Previously	19	5	31
Never	105	136	123
Total	159	159	159

Source: Devon Youth Offending Team, ASSETS completed 2013-14

Over half of the children and young people assessed by the Youth Offending Team (YOT) in 2013-14 had experienced intensive social care input into their families. This is likely to indicate high levels of need within that population.

The vulnerability level reflects the risk of harm-to-self relating to that young person. It is clear from the data that a significant minority of YOT clients are quite vulnerable and will need support to stay safe.

Table 8.7, Vulnerability of youth offenders (2013-14)

Vulnerability Level	Number of Young People	%
None	5	3%
Low	90	57%
Medium	47	30%
High	17	11%
Total	159	100%

Source: Devon Youth Offending Team, ASSETS completed 2013-14

Young people as victims of crime

According to the Crime Survey for England and Wales, children and young people are more likely to be victims of crime than any other age group and only 13% of young victims report incidents to the police.

Children and young people can be victims in relation to any offence. For example, as victims they may be abused sexually or physically by adults or, much more commonly, they may be assaulted by other children or have their possessions damaged or stolen. They may also be witnesses in cases involving other children or adults for offences from common assault to homicide. In the domestic setting they may witness violence against a close family member.

Children can be affected by crime even if they are not themselves victims or witnesses. A child may be seriously affected by, for example, domestic violence, even if not present in the same room where the offence is committed.

Both serious and low-level persistent crime can have devastating effects on children and young people, and is related to self-harm or suicide attempts, unemployment or truancy, low attainment and social isolation.

These effects often last into adulthood with a corresponding emotional and financial cost to children, families, communities and the wider society.

The more traumatic the offence for the child (being a victim of or a witness to violence or sexual abuse are the most obvious examples), the more likely it is criminal proceedings may re-traumatise and cause further emotional damage to the child. Yet the most serious cases are usually the ones that will, on the facts, require a prosecution in the public interest, both to secure justice but also to provide protection for the child and the public at large.

According to Devon and Cornwall Police in 2013-2014 over 1,824 children aged under 18 were victims of crime in Devon (this does not represent all child victims as it only covers the first victim in any crime, many crimes have multiple victims). The most common crimes for males to experience where ‘violence with injury’ followed by ‘violence without injury’ and ‘other theft’ where as females were most likely to experience ‘violence without injury’ followed by ‘violence with injury’, the third most common crime was ‘other sexual offences’. Young people in Devon are far more likely to be victims of contact crime and far less likely to be victims of property crime than older age groups. As a proportion of reported crime females under 18 are the most likely to experience rape and other sexual offences than other age groups.

8.09 Accidents and Unintentional Injuries

Attendance statistics for accident and emergency departments provide an indication of both accidental and deliberate harm affecting young people and the magnitude of particular risk factors. Table 8.8 shows overall numbers by gender and category for Devon, highlight there were over 65,000 attendances for persons aged 0 to 19 in 2013-14. The pattern varies markedly by gender, with males much more likely to attend as a result of assault, a sports injury, and to a lesser extent a road traffic accident. Females are more likely to attend as a result of self-harm.

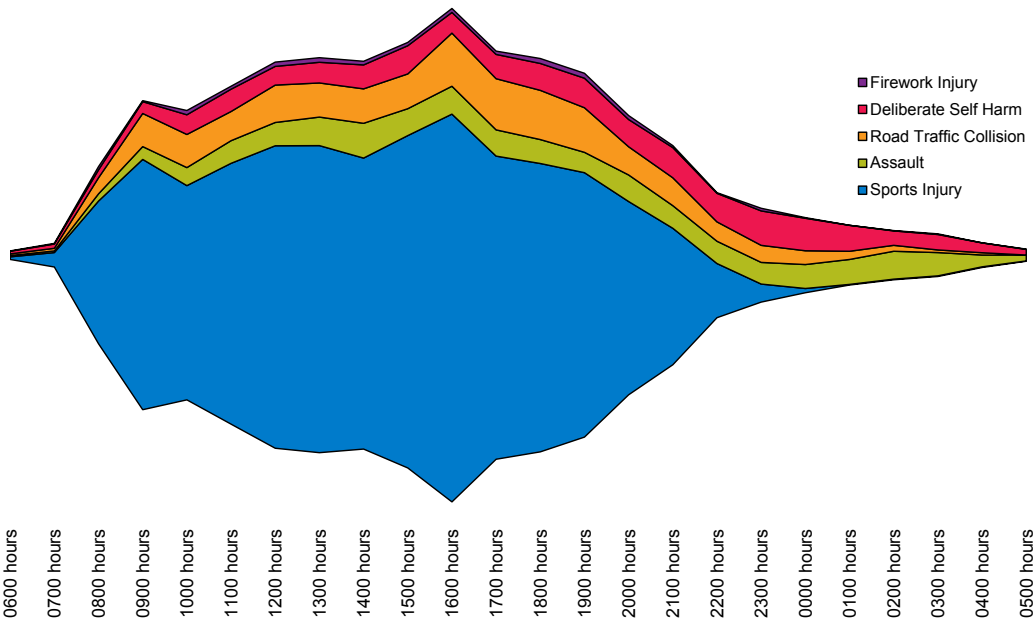
Table 8.8, Accident and Emergency Attendances in Devon by gender and category, persons aged 0 to 19, Devon, 2013-14

Patient Group	Males	Females	Total
Road Traffic Collision	276	207	483
Assault	274	111	385
Deliberate Self-Harm	139	409	548
Sports Injury	2,769	963	3,732
Firework Injury	28	14	42
Other Accident	18,121	14,866	32,987
Other	10,628	10,452	21,080
Unknown	3,449	2,958	6,407
Grand Total	35,684	29,980	65,664

Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

Figure 8.6 displays the pattern by time of attendances by time of day for selected patient groups for 2011-12 to 2013-14. This highlights attendances due to sports injury are highest during the daytime peaking at 4pm. Road traffic collision attendances peak in the late afternoon. Attendance rates for deliberate self-harm increase through the day and peak between 11pm and 1am. Attendance rates for assault are highest from 12 noon to 4pm and peak again in the early hours.

Figure 8.6, Accident and Emergency / Minor Injury Unit Attendances in Devon for Selected Patient Groups and Hour, 2011-12 to 2013-14

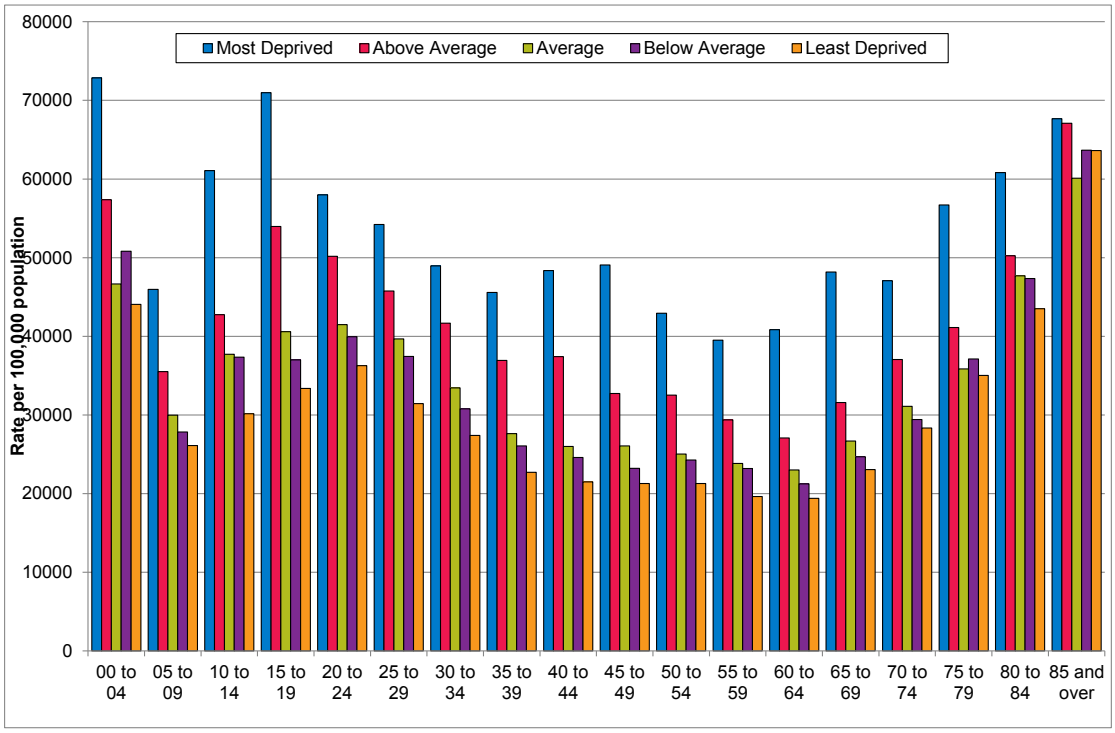


Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

The figure below shows age-specific attendance rates for Devon by deprivation, highlighting attendances are particularly frequent for children, with the peak ages being 0 to 4, and 15 to

19. Attendances are also more likely in more deprived areas at all ages, highlighting the impacts of both social deprivation and age on attendance rates.

Figure 8.7, Accident and Emergency Attendances per 100,000 population by Age and Deprivation, Devon, 2013-14

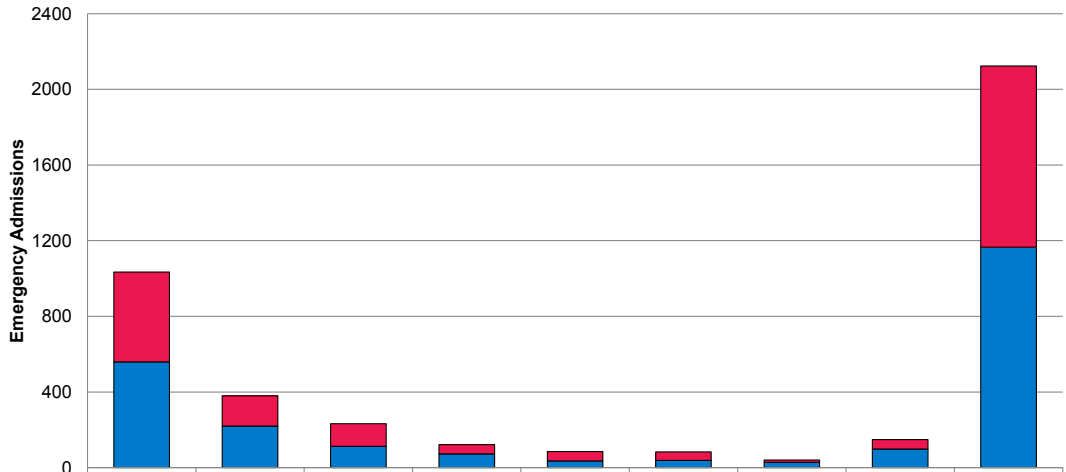


Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

Unintentional injury is the leading cause of death amongst young people aged one to 14 years and causes more children to be admitted to hospital each year than any other reason. The Preventing Unintentional Injuries to Children and Young People in Devon Strategy highlighted some important issues and challenges (http://www.devonhealthandwellbeing.org.uk/health-and-wellbeing/lifestyles/unintentional-injuries/).

More up-to-date figures on emergency admissions from accidental causes for under-fives are included below. This highlights falls, exposure to inanimate objects and accidental poisoning are the leading causes of accidental injury.

Figure 8.8, Emergency Hospital Admissions from accidental causes in under-fives, Devon, 2008 to 2012



	Falls	Exposure to inanimate mechanical forces*	Accidental poisoning	Contact with heat and hot substances	Exposure to animate mechanical forces (e.g. animal bites)	Transport Accidents	Threats to breathing / drowning	Other accidents	Total
Persons	1034	380	232	122	85	83	40	148	2124
Female	475	160	119	49	49	45	12	49	958
Male	559	220	113	73	36	38	28	99	1166

* includes accidentally being struck by objects, crushing, contact with tools / machinery, glass or sharp objects, explosions, and exposure to noise

Source: Secondary Uses Service, Inpatient Commissioning Dataset, 2014

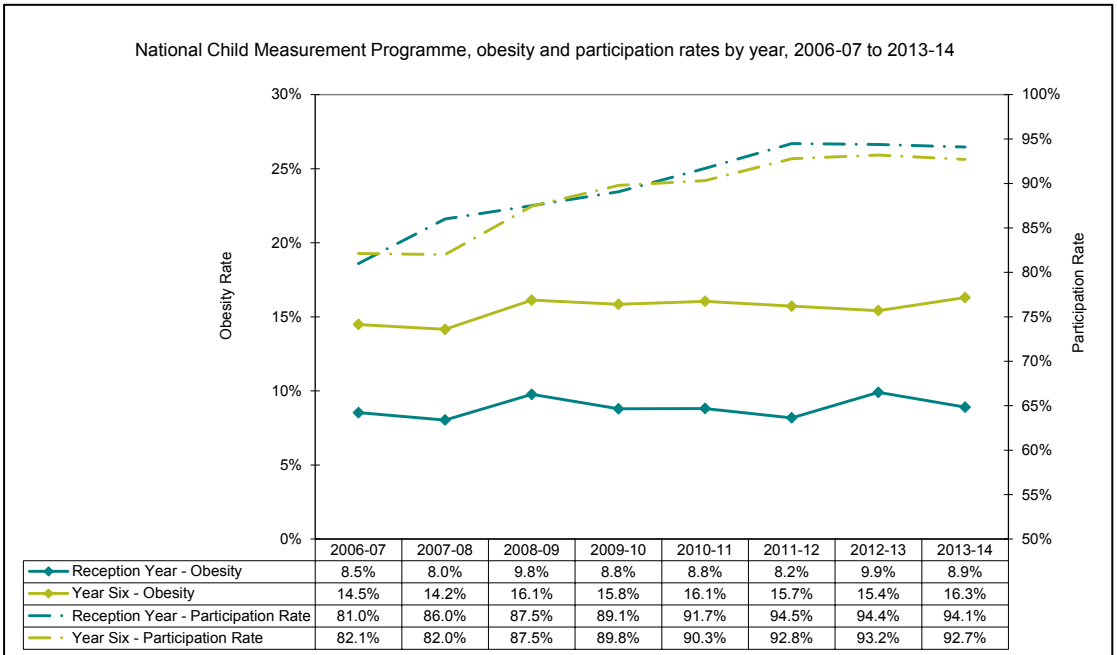
8.10 Healthy Weight

The UK is experiencing an epidemic of obesity affecting both adults and children. The Health Survey for England found among boys and girls aged two to 15, the proportion of children who were classified as obese increased from 11.7% in 1995 to 16.0% in 2010, peaking at 18.9% in 2004.

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem.

The national childhood measurement programme (NCMP) records height and weight in children in both Reception year (aged 4/5) and in Year 6 (aged 10/11). Figure 8.9 below shows the trend in obesity for Devon and also shows the increasing participation in the NCMP programme. Although there is fluctuation, rates of obesity are relatively stable in both reception and year six.

Figure 8.9, Obesity Rates in 4/5 and 10/11 year olds in Devon



	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Reception Year - Obesity	8.5%	8.0%	9.8%	8.8%	8.8%	8.2%	9.9%	8.9%
Year Six - Obesity	14.5%	14.2%	16.1%	15.8%	16.1%	15.7%	15.4%	16.3%
Reception Year - Participation Rate	81.0%	86.0%	87.5%	89.1%	91.7%	94.5%	94.4%	94.1%
Year Six - Participation Rate	82.1%	82.0%	87.5%	89.8%	90.3%	92.8%	93.2%	92.7%

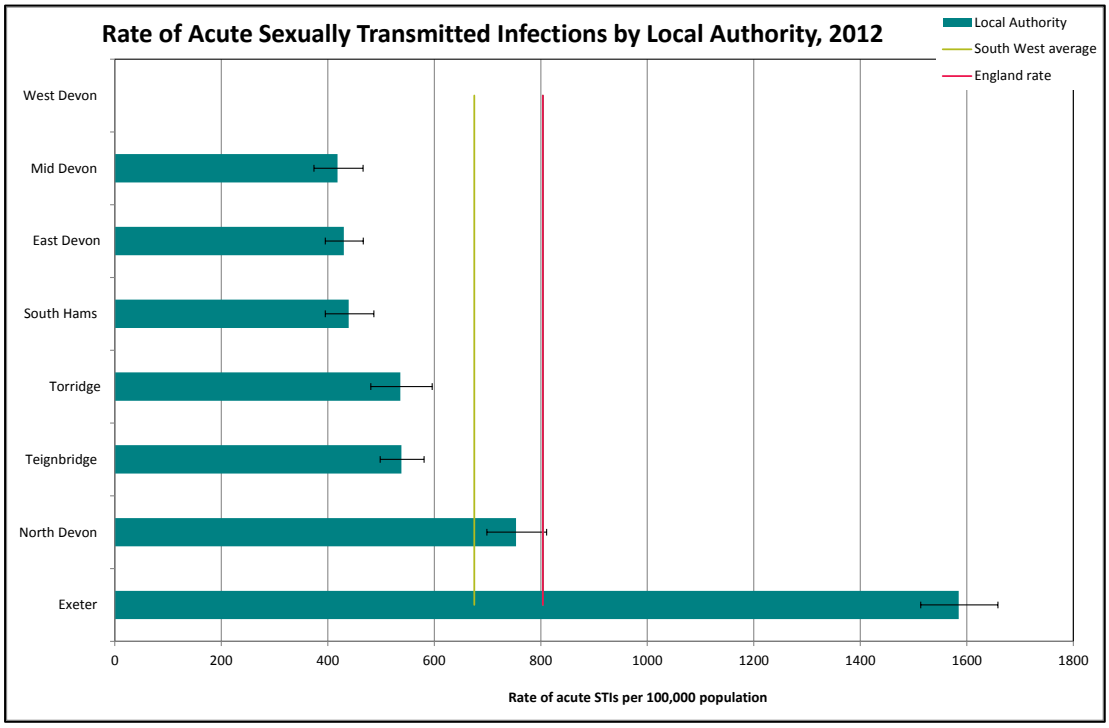
Source: National Child Measurement Programme, 2014

8.11 Sexual Health and Teenage Conceptions

Devon County Council is now the commissioner of most sexual health services in Devon, with the exception of HIV services, Sexual Assault Referral Centres and primary care contraception services which are the responsibility of NHS England and terminations of pregnancy which are commissioned by Clinical Commissioning Groups. The complexity of these commissioning arrangements is addressed through the Sexual Health Alliance which works to ensure sexual health outcomes improve, especially as they are an area where considerable health inequalities exist.

Figure 8.10 below shows rates of acute sexually transmitted infections in Devon were lower than both the South West and England rates. There are large variations between the local authorities with Exeter having a statistically significantly higher rate of infections than nationally. Rates in all local authorities apart from North Devon and Exeter were significantly lower than the regional rate. The main genitourinary medicine clinics are in Exeter, North Devon and Torbay and access and accessibility may have an impact on those diagnosed. Services have been redesigned to enable integrated contraception and sexual health clinics to be offered in many of the towns across Devon at times convenient to the needs of both the young and young adult populations which will make accessibility easier. There are signs these clinics are being well used and so, although an increase in rates may be seen initially, this will have a positive impact on inequalities across Devon.

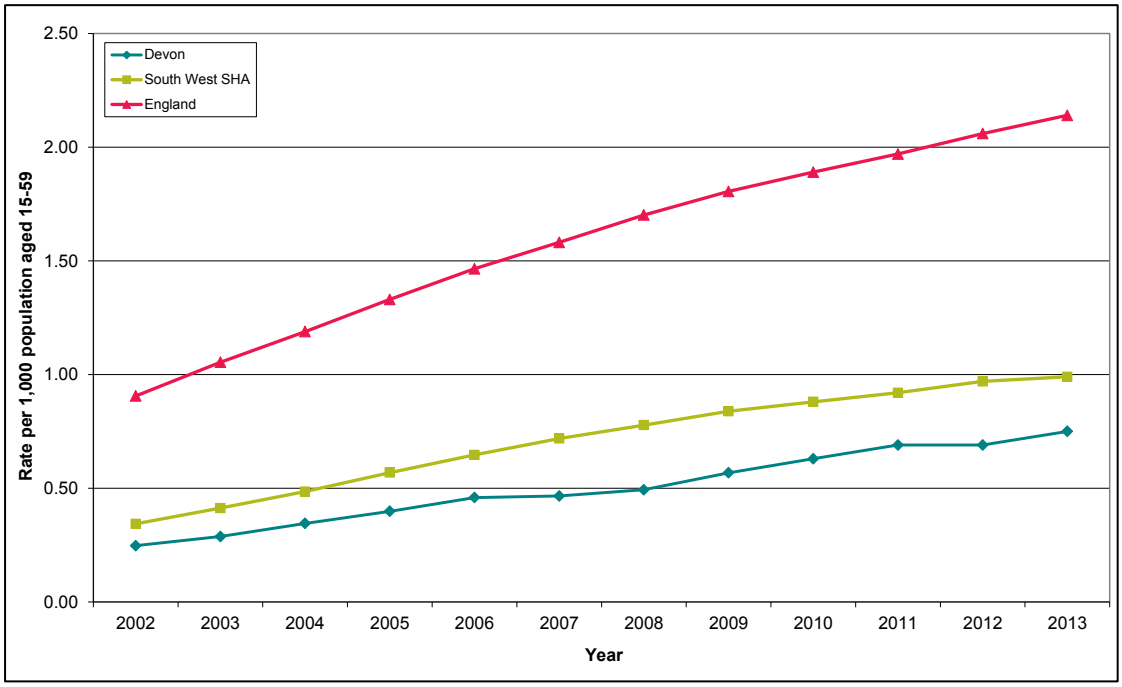
Figure 8.10, Rates of acute sexually transmitted infections diagnoses per 100,000 population, by local authority, 2012



Source: Public Health England, 2014

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 showed an increase in HIV cases, peaking in 2005 and has since decreased. The numbers vary across the United Kingdom and Devon has a lower rate than the South West and England average. Figure 8.11 shows the prevalence of HIV in Devon, the South West and England. The Devon prevalence is considerably lower than nationally, although there is an evident upward trend, highlighting that life expectancy for people with HIV has increased substantially in recent years so more people are living with the condition. Prevalence varies across local authorities with South Hams having the lowest prevalence (0.53 per 1,000 aged 15 to 59) and Exeter having the highest (1.21 per 1,000 aged 15 to 59).

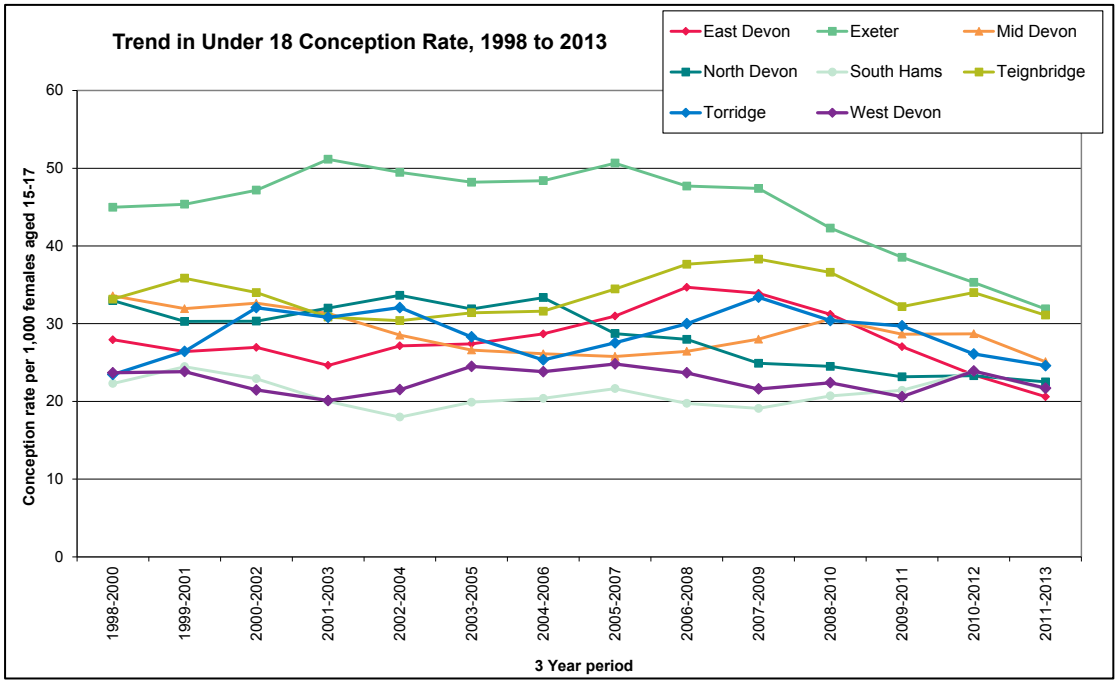
Figure 8.11, Prevalence of HIV Infection, rate per 1,000 population aged 15 to 59, 2002-2013



Source: Public Health England, 2014

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. Figure 8.12 shows teenage conception rates by District Council for Devon, highlighting that although the highest rates are seen in Exeter, the rates have shown considerable decrease. Year-on-year fluctuations are seen, which are mainly due to the low number of conceptions involved at a district level, but overall rates are showing a strong downward trend, a pattern that is also seen nationally.

Figure 8.12 Under-18 conception rates per 1,000 15 to 17 year-old females for District Councils in Devon



Source: Office for National Statistics, 2015

8.12 Not in Education, Employment or Training (NEETs)

2014-15 is the second year of implementation of the Government's legislation to raise the participation age of young people in education or training (RPA). Young people in the current year 12 (and below) are required to remain in full-time education or work based training until their 18th birthday.

The impact of this change is visible in both national and local statistics. Nationally, in the period Oct-Dec 2014, the 16-18 NEET rate was 7%. This is 0.6% lower the Oct-Dec figure for 2013 and the lowest at this point in the year since comparable data began. (Source: DfE NEET Quarterly Brief Oct-Dec 2014).

Locally the downward trend is even greater. For the period Oct-Dec 2014 the 16-18 NEET rate was 4.2%, This is 1.2% lower than the 2013 figure of 5.4%. (Source: Careers South West Quarterly Data reports)

The vast majority of young people chose to participate in full time education, at either school or FE college in their post 16 phase. However for the period Oct-Dec 2014, 9.3% of the young people in the year 12-14 age range were in either apprenticeship or a job with accredited training. A further 9.5% were employed but with no accredited training being delivered to them. Work is still an attractive option for a significant number of young people and the challenge is to prepare them well for the world of work (achievement of maths and English qualifications is critical) and make better paid, fully accredited training available to them via the apprenticeships programme.

8.13 Mental Health and Wellbeing in Childhood

Mental health and emotional well-being describes how we think, feel and relate to ourselves and others and how we interpret the world around us. Having good mental health affects our capacity to manage, communicate, and form and sustain relationships. It also affects our ability to cope with change and major life events.

Most people will come into contact with mental health issues during their lifetime, and one in four will have personal experience of a mental health problem. The invisibility of mental illness means many do not receive the support and treatment that could help them.

The Mental Health Foundation has highlighted some of the common mental health problems in childhood:

- **Depression** affects more children and young people today than in the last few decades, but it is still more common in adults. Teenagers are more likely to experience depression than young children.
- **Self-harm** is a very common problem among young people. Some people find it helps them manage intense emotional pain if they harm themselves, through cutting or burning, for example. They may not wish to take their own life.
- Children and young people with **generalised anxiety disorder** (GAD) become extremely worried. Very young children or children starting or moving school may have separation anxiety.
- **Post-traumatic stress disorder** can follow physical or sexual abuse, witnessing something extremely frightening of traumatising, being the victim of violence or severe bullying or surviving a disaster.
- Children who are consistently **overactive** ('hyperactive'), behave impulsively and have difficulty paying attention may have Attention Deficit Hyperactivity Disorder (ADHD) Many more boys than girls are affected, but the cause of ADHD isn't fully understood.
- **Eating disorders** usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development.

Nationally there has been an increased prevalence of mental ill health in children and young people, with only a small proportion with mental health problems in contact with mental health services. Around one in 10 children in Devon have a mental health disorder.

The table below show the number of school-age children estimated to have a mental health condition by local authority district.

Table 8.9, Estimated number of school-age children (aged 5 to 16) with a mental health disorder, 2013

Local Authority	Total
East Devon	1,538
Exeter	1,398
Mid Devon	1,041
North Devon	1,185
South Hams	1,006
Teignbridge	1,521
Torridge	772
West Devon	672
Devon Total	9,133

Source: Association for Young People's Health: Key Data on Adolescence 2013

Tier four specialist inpatient and day-patient care are for children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community mental health services. According to the CAMHS Annual Report to the Devon Safeguarding Children's Board, between 15 and 25 young people from Devon will be in inpatient care at any one time.

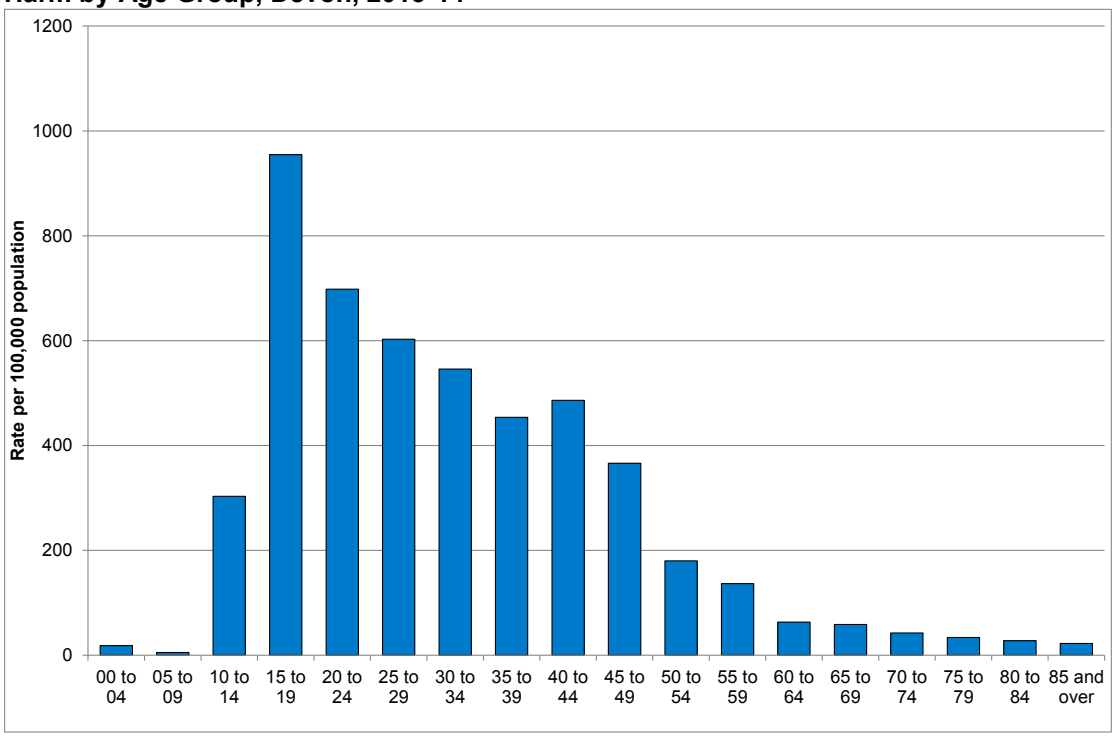
The range and nature of risk behaviour from young people at tier four is broad and can include self-harm, suicide, physical consequences of low weight, absconding, aggression, sexualised behaviour, fire-setting, and safeguarding concerns. All of these can represent a risk to the young person and may represent a risk to other patients. These risks and behaviours are harder to manage if the young person is placed on a paediatric ward instead of in a specialist Children and Adolescent Mental Health Services (CAMHS) bed.

There has been an increase within Devon of young people admitted to paediatric wards and to tier four units. Devon does not have specialist mental health beds in county (the nearest being in Plymouth, though the young people may be placed at a much greater distance if a more local bed is not available) meaning the majority of South West admissions have been to paediatric a ward on which staff may not have the specialist skills to support a mental health crisis. This means young people in crisis are being placed at great distances from their family and support networks and family members are unable to participate in supportive therapy.

Self-Harm

Self-harm amongst younger people is one of the most direct forms of impairment to health or development. It includes overdoses (self-poisoning) and self-mutilation, such as cutting, burning, and scalding. Self-harm can also be indicative of other underlying safeguarding issues, such as those outlined in the protection from maltreatment sub-section. Reliable figures on the prevalence of self-harming are difficult to obtain, although work by the Social Care Institute for Excellence, suggest around 1% of children with a mental health problem self-harm (http://www.scie.org.uk/publications/briefings/briefing16/). In Devon, 139 males and 409 females aged 0 to 19 attending accident and emergency departments as a consequence of self-harm in 2013/14. Attendance rates peak in the 15 to 19 age group as illustrated in the chart below.

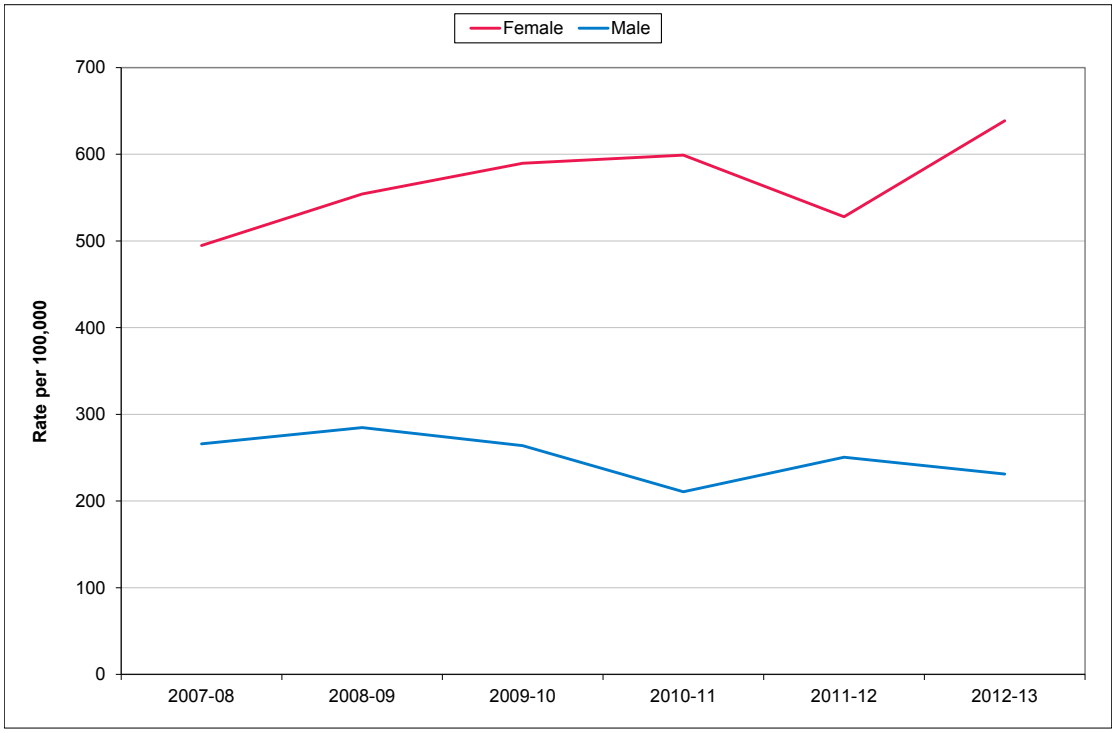
Figure 8.13, Accident and Emergency and Minor Injury Unit Attendance Rates for Self-Harm by Age Group, Devon, 2013-14



Source: Secondary Uses Service, Accident and Emergency Commissioning Dataset, 2014

The Child Health and Maternity Service (CHIMAT) monitor self-harm admissions in the 10 to 24 age group. There were 548 hospital admissions for self-harm in persons aged 10 to 24 in Devon in 2012-13. The rate per 100,000 in Devon was 419.5, which is below the South West rate (442.5), but above the local authority comparator group (388.8) and England (346.3) rates. Admission rates increased from 376.6 in 2007-08 to 419.5 in 2012-13. Within the 10 to 24 age group admission rates were highest in those aged 15 to 19 (625.4). Admission rates also are higher in more deprived areas, with a rate of 1034.0 in the most deprived areas compared with 308.6 in the least deprived areas in 2012-13. Within Devon rates were highest in North Devon, and lowest in the South Hams and Torridge. Rates of hospital admission for self-harm are three times higher in females than males and the gap has widened in recent years as illustrated in figure 8.14 below.

Figure 8.14, Hospital Admissions for Self-Harm by Year and Sex, Rate per 100,000 population, Persons aged 10 to 24, Devon



Source: Secondary Uses Service, Inpatient Commissioning Dataset, 2014

Eating Disorders

Eating disorders usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as Anorexia Nervosa and Bulimia Nervosa can have serious consequences for their physical health and development. Table 8.10 highlights around 122 persons aged between 11 and 15 have an eating disorder. Around 15 new cases of Anorexia Nervosa and 17 new cases of Bulimia Nervosa are expected in Devon each year.

Table 8.10, Estimated Incidence and Prevalence of Eating Disorders in Devon, 2013

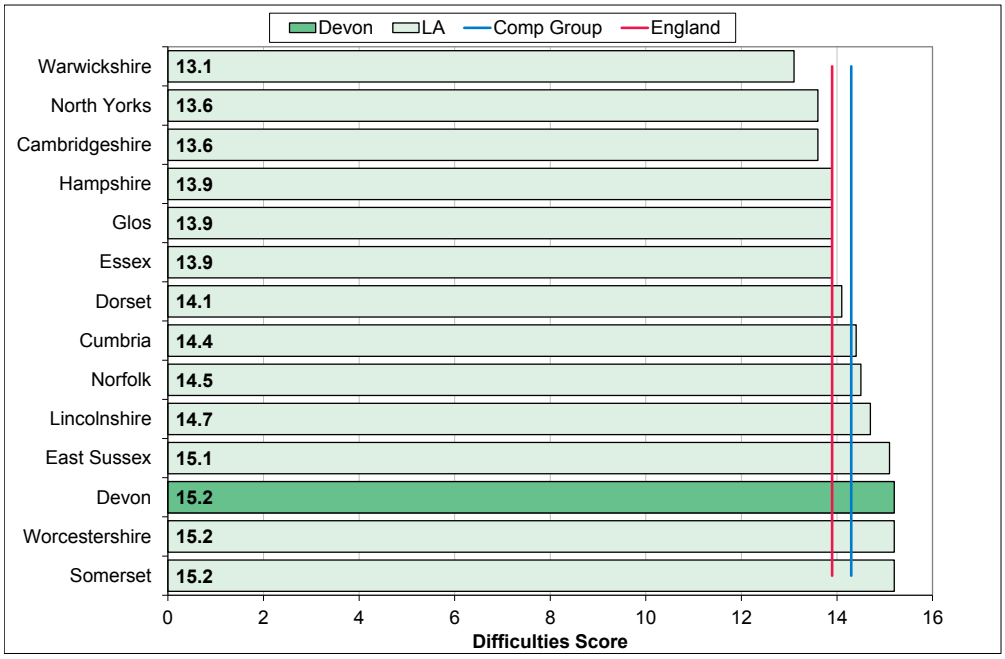
Condition	Rate	Numbers Affected in Devon
New cases of Anorexia Nervosa per year, aged 10 to 19	17.5 per 100,000	15
New cases of Bulimia Nervosa per year, aged 10 to 19	20.5 per 100,000	17
Persons with any eating disorders, aged 11 to 15	300 per 100,000	122

Source: Early Onset Eating Disorders, BPSU 2007 and LHO Mental Health of Adolescents 2000

Emotional Wellbeing of Looked After Children

The difficulties score is collected through a strengths and difficulties questionnaire, with higher scores (on a scale of 0 to 40) highlighting greater difficulties. The average difficulty score in Devon was 15.2 compared which is higher than the South West (14.8), local authority comparator group (14.3) and England (13.8) averages. The average score has decreased since 2011-12 level and the gap to the regional and national average scores has lowered. Difficulties score tends to increase with age with teenagers having higher difficulties scores. The older age profile of children in care in Devon may well influence the higher average scores observed.

Figure 8.15, Average of total difficulties score for all looked after children aged between four and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31 March, Devon Local Authority Comparator Group, 2014



Source: Public Health Outcomes Tool, 2015

8.14 Child Sexual Exploitation

Sexual exploitation of children and young people under eighteen involves exploitative relationships, violence, coercion and intimidation being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability. Perpetrators of child sexual exploitation are found in all parts of the country and across ethnic groups.

Reliable estimates of the prevalence of child sexual exploitation are also difficult to find. It is rarely identified and victims do not disclose for various reasons including fear of the perpetrator, shame and fear they will not be believed. Some young people are not even aware they are experiencing abuse as the perpetrator has manipulated them into believing they are in a loving relationship. The majority of child victims of sexual exploitation are girls and the average age of victims, of any gender, is 15.

The REACH team in Devon is tasked with working with children who are being sexually exploited (except those in care, who are supported by their existing social worker but the REACH team offer input). The team supported 96 young people in Devon in the first 6 months of 2014 who had been victims of child sexual exploitation.

On the 7th Jan 2014 Devon had 448 children in care aged 10 and over, 62 (13.84%) of these children were recorded by Devon and Cornwall Police as victims of child sexual exploitation. There is a strong link between young people going missing, 54 of the 62 (87%) young people in care linked to child sexual exploitation have missing episodes recorded by the police.

Sexually exploited young people have a range of vulnerabilities which may be associated with physical and mental health problems. Some vulnerabilities contribute to the exploitation, others arise from it. These include mental health problems, self-harm and suicide attempts, injuries from physical violence, sexual health problems, pregnancy, terminations and drug and

alcohol misuse. In particular, children who go missing frequently are not attending school, and those who live in care are over represented among sexual exploitation victims.

8.15 Female Genital Mutilation

Female Genital Mutilation/Cutting involves partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is regarded as a form of abuse and a grave violation of the human rights of girls and women to life and their right to health. This is a crime in the UK even if the person is taken overseas for the mutilation. It is also sometimes known as female circumcision or 'sunna'.

The procedure is traditionally carried out by an older woman with no medical training. The procedure can have significant long and short term health implications (including immediate fatal haemorrhaging, severe pain and shock, urine retention, infections, sexual dysfunction and complications in pregnancy and child birth). In addition to these health consequences, there are considerable psycho-sexual, psychological and social consequences of FGM.

The number of women and girls in Devon who are victims of, or at risk of, female genital mutilation is unknown. The health and social care information centre has introduced reporting for FGM from acute hospital providers from September 2014. The first monthly report identified 1,746 women and girls in England who had been victims of FGM and had used acute hospital services during that month (for any medical condition not limited conditions relating to FGM).

A UNICEF report highlights prevalence rates by country (http://www.unicef.org/cbsc/files/UNICEF_FGM_report_July_2013_Hi_res.pdf), revealing that the practice is concentrated in the 30 countries in Western and Eastern Africa and parts of the Middle East. The highest rates by country are seem in Somalia (98%), Guinea (96%), and Egypt (91%)

8.16 Safeguarding Children

Safeguarding Children was 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 children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes."
> (Working Together to Safeguard Children, 2015)

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/wp-content/uploads/2015/03/Devon-Safeguarding-Children-JSNA-2014-15.pdf

Ofsted carried out an inspection of Devon County Council's arrangements for safeguarding children earlier this year (2015) and the findings are available here: http://reports.ofsted.gov.uk/local-authorities/devon.

There was a rapid rise in demand for children's social care assessments after the previous Ofsted inspection. During 2013/14 there were 8,717 Children In Need referrals, of which 162 (2%) resulted in no further action. This represents a 54% increase in referrals from 2012/13 (5,648 referrals).
As at 31st March 2014 there were 5,741 Children in Need in Devon , an increase of 23.5% from the previous year (4,648 children) , this number includes Children in Care and Children with a Child Protection Plan. Provisional reporting for the 2014/15 financial year indicates this trend has stabilised and the number of children in need is starting to fall.

As at 31st March 2014 there were 600 Children with a Child Protection Plan in Devon, a significant increase (34.5%) from 446 children the previous year, which was in turn an increase from 404 children at 31st March 2012. Child Protection Plan numbers have therefore risen by 48.5% over two years. Provisional reporting for the 2014/15 financial year indicates this trend has stabilised and the number of children subject to a child protection plan is starting to fall.

8.17 Domestic Violence and Abuse

Domestic violence is the abuse of one partner within an intimate or family relationship. It is the repeated, random and habitual use of intimidation to control a partner. The abuse can be physical, emotional, psychological, financial or sexual. Domestic violence and abuse affects a large number of people, with an estimated 7.1% of women and 4.4% of men aged 16 to 59 had been a victim of domestic abuse past year according to the Crime Survey for England and Wales (CSEW) for 2012-13, with 30.0% of women and 16.3% of men have been victims at some point since the age of 16. If that prevalence rate is applied to all of those aged 16 and over in Devon that would equate to 23,400 women and 13,400 men experiencing domestic violence in the past 12 months, and 98,800 women and 49,700 men experiencing domestic violence since the age of 16.

The costs of domestic violence and sexual abuse are extensive to the public purse. In Devon, Home Office research estimates that domestic violence costs the statutory agencies over £70 million (Walby S. The cost of domestic violence, 2009): http://www.lancs.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc.

Exposure to domestic violence represents a serious risk to both adults and children. The Children and Adoption Act 2002 broadened the definition of significant harm to include 'any impairment of the child's health or development as a result of witnessing the ill-treatment of another person such as domestic violence'. As well as the impact on adults, national research by the NSPCC (http://www.nspcc.org.uk/inform/research/findings/child_abuse_neglect_research_PDF_wdf84181.pdf) has found nearly a quarter young people witnessed at least one type of domestic violence during childhood. The research found

- 12.0% of under 11s, 17.5% of 11–17s and 23.7% of 18–24s had been exposed to domestic violence between adults in their homes during childhood.
- 3.2% of the under 11s and 2.5% of the 11–17s reported exposure to domestic violence in the past year.

According to the national Confidential Inquiry into Maternal and Child Health in 2007, nearly three quarters of children with a child protection plan live in households where domestic abuse occurs. 624 Devon children and young people were subject to a child protection plan in March 2014 (up from 446 in March 2013). In 2013-14 domestic violence was the most common risk factor identified during social care initial assessments. In sample of 101 plans in March 2010 65% of children with a child protection plan either were at the time, or had previously lived in a household, experiencing domestic violence.

The Police record data on the number of children and young people who were present at reported domestic abuse incidents. Children were at around 40% of domestic abuse incidents although there is variation over time and across the districts. The majority of incidents will not be recorded here as they have not been reported to the police.

Table 8.11, Number of reported domestic violence and abuse incidents (last 5 years)

Devon	2009-10	2010-11	2011-12	2012-13	2013-14
Domestic Violence Incidents	9,151	8,798	8,957	9,236	10,334
Domestic Violence Crimes	2,352	2,415	2,728	2,994	3,457
Number of incidents with Children and Young People Present	4,259	3,418	3,649	3,584	3,737
% incidents with Children and Young People present	47%	39%	41%	39%	36%

Source: Devon and Cornwall Police 'Crimed' Domestic Violence Incidents Data record on CIS with Mo Code DV1

Devon specialist domestic violence services supported 226 children and young people in 2012-13 a large increase from 165 clients in 2011-12. 154 children and young people spent time living in a refuge in 2012-13. 73% of the children in the refuge were under the age of 7. Their reporting shows 96% of children had been exposed to domestic abuse with 54% having been direct victims of abuse themselves. Between April and October 2014 the parents of 807 children and young people from 389 families received support from Devon domestic violence and abuse support services (SPLITZ).

In 2013 805 cases, assessed to be at very high risk, were taken to Multi Agency Risk Assessment Conferences (MARACs) in Devon compared to 621 in 2012. 27% of these were repeat attendances. There were 1,009 children and young people associated with these cases in 2013.

The impact of domestic violence and abuse on an individual child will vary according to the child's resilience and the strengths and weaknesses of their particular circumstances. On both a national and local level (four out of the last seven serious case reviews in Devon found domestic violence as a contributory factor) there is evidence serious injury or death can occur as a consequence of domestic violence. Children and young people will be distressed by living with domestic violence and may show a range of mental and physical symptoms. In younger children they may show developmental regression including bed wetting or temper tantrums. They may also become anxious and complain of stomach-aches. Older children react differently with boys much more outwardly distressed such as being more aggressive and disobedient, increasing likelihood of risk taking behaviours in adolescence including school truancy and start to use alcohol or drugs. Girls are more likely to internalise issues by withdrawing from social contact and become anxious or depressed. They are more likely to have an eating disorder, or to self-harm. Children of all ages with these problems often do badly at school. They may also get symptoms of posttraumatic stress disorder, for example have nightmares and flashbacks, and be easily startled.

In the longer term children who have witnessed violence are more likely to be either abusers or victims themselves echoing the behaviour which was normalised within their household. The repetition of violence is not a forgone conclusion but even for those who break the cycle, children from violent families often grow up feeling anxious and depressed, and find it difficult to get on with other people.

9. Living Well: Adults

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. There are around 452,500 people aged between 16 and 64 in Devon, of which around 8,900 are supported in social care (2013-14 RAP return). This section aims to bring as many topics together as possible and if necessary identify the part of adulthood where they are particularly relevant. There is a specific focus on prevention, the risk factors most strongly associated with poor health outcomes, and long-term conditions.

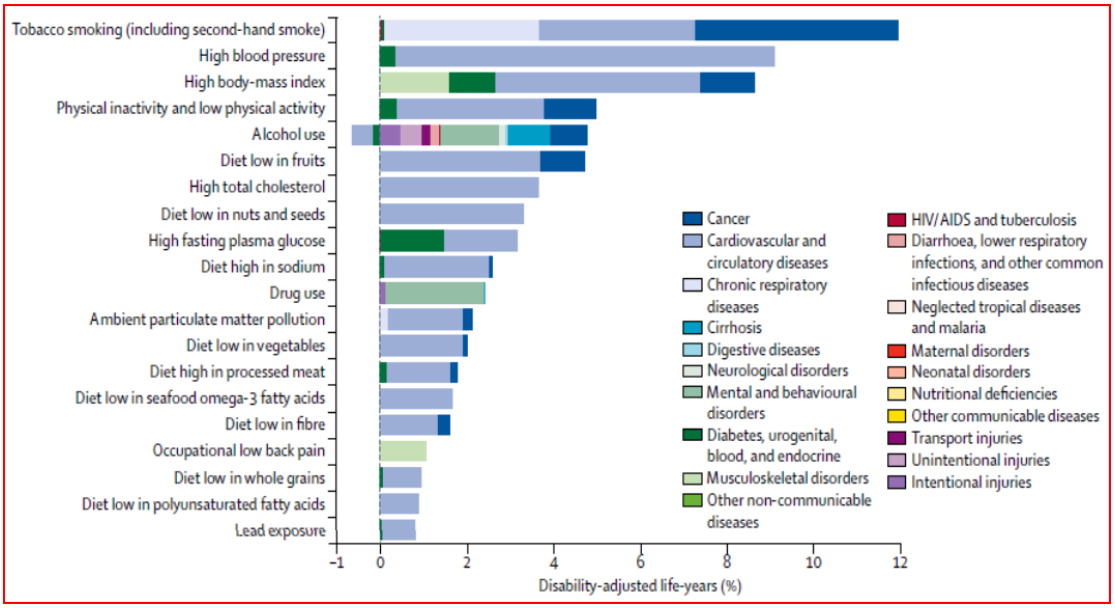
9.01 Commissioning for Prevention

The NHS and Public Health England publication 'A Call to Action: Commissioning for Prevention' was launched in 2013 and provides a case for prevention and framework for local action. It was used as a basis to develop an information paper on commissioning for prevention in adults with a synthesis of national policy and strategies and consideration of the local need in Devon. The intention of the paper was to inform local clinical commissioning groups, the local authority and wider stakeholders when developing commissioning strategies and plans relating to prevention.

Traditionally, health and care services are developed with individual treatment and care pathways but increasingly the system will have to adapt to increasing complexity of need. Prevention is important to manage increasing demand and to respond to the changing disease patterns. Due to financial pressures it is also essential to prevent, reduce and delay demand for services.

The greatest risk factors contributing to deaths from the major killers are largely preventable. Figure 9.1 shows although smoking prevalence is reducing it remains a major contributor. High blood pressure is also significant and provides an example of where preventive action on an individual level needs to be coupled with early diagnosis through programmes such as the Health Check programme. This chapter is themed around these risk factors.

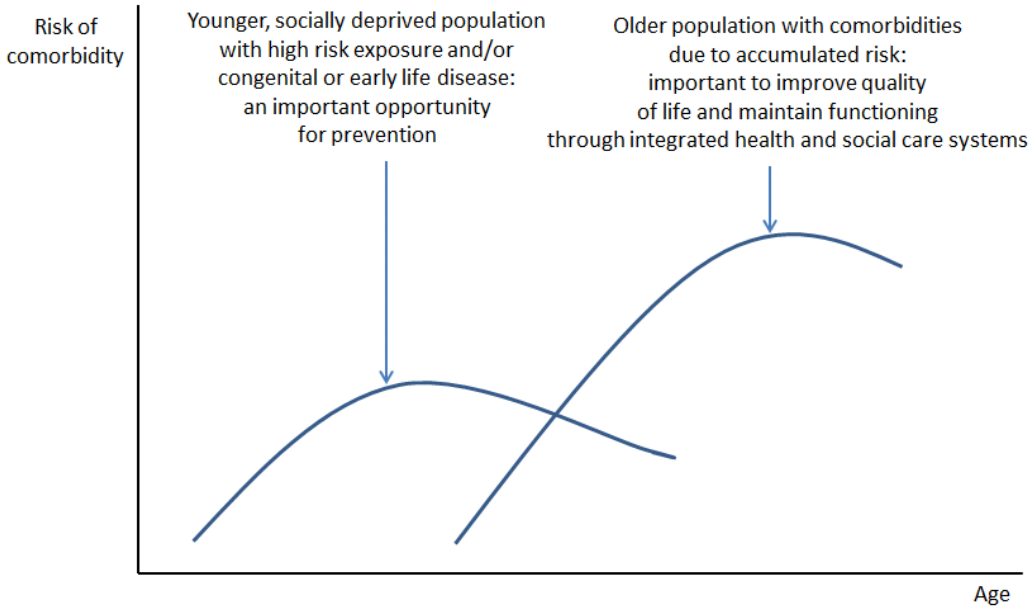
Figure 9.1, Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of disability-adjusted life-years



Source: Living Well for Longer. National Support for Local Action to Reduce Premature Avoidable Mortality. Department of Health. 2014.

Long-term conditions are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multi-morbidity, which as life expectancy increases mean more people are living longer with a complex mix of health problems. Figure 9.2 demonstrates the main population at risk of comorbidities and further demonstrates the need to address risk at an earlier stage for certain areas and groups. Mental health conditions, social isolation and loneliness further exacerbate complex health problems and have a detrimental effect on quality of life, life expectancy and health outcomes.

Figure 9.2, Illustrative diagram of two key populations at risk of comorbidities across the life course

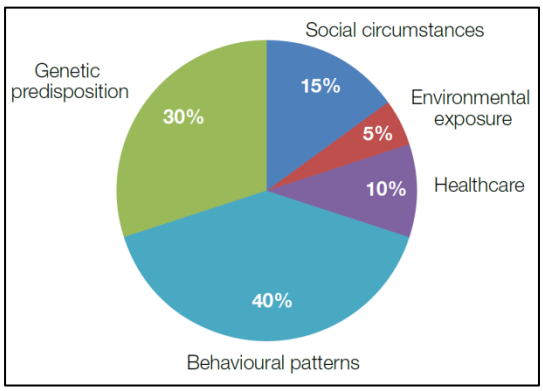


Source: Living Well for Longer. National Support for Local Action to Reduce Premature Avoidable Mortality. Department of Health. April 2014.

9.02 Premature Mortality

There are a range of factors that contribute to premature death as shown in figure 9.3. Behavioural patterns are important and a leading cause but the confounding social circumstances are significant. Interestingly healthcare is less significant but it is essential healthcare is accessed when appropriate and necessary to do so including access for immunisation and screening programmes.

Figure 9.3, Factors contributing to premature death in England

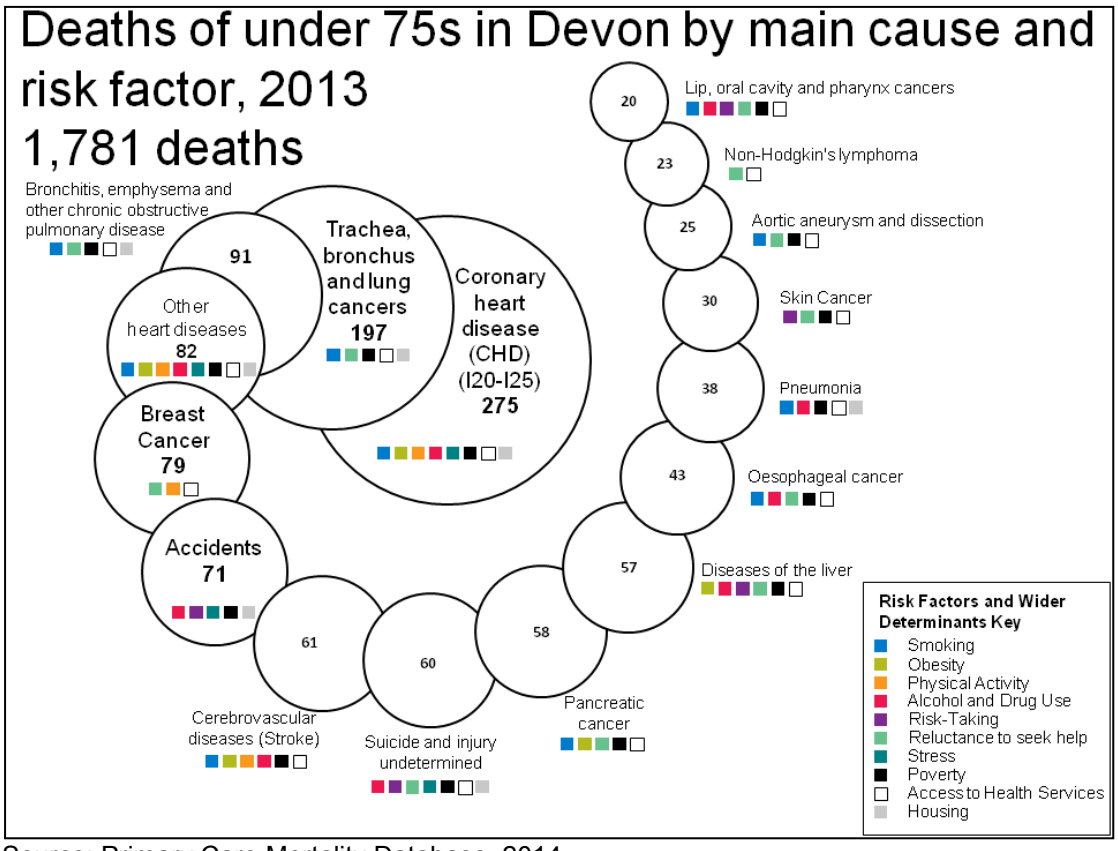


Source: 'Evidence into action: opportunities to protect and improve the nation's health', Public Health England. October 2014

The following figure looks at the underlying causes of death for people aged under 75 in Devon during 2013 with coloured dots to illustrate the wider risk factors associated with these conditions. There were 1,781 deaths under the age of 75 in 2013, of which the largest underlying causes were heart diseases, lung cancer, respiratory conditions, breast cancer and accidents. The following observations can be made about risk factors:

- **Poverty** – Health inequalities are apparent for virtually all causes of death, with people living in poverty more likely to die younger
- **Access to Health Services** – Timely and appropriate access to health services can be a major factor in premature death
- **Housing** – Housing conditions are associated with premature death and are a particular factor when it comes to respiratory conditions and accidents
- **Smoking** – Smoking is the behaviour with the strongest association with premature death, particular in relation to heart disease, lung cancer and respiratory conditions
- **Obesity and Physical Activity**– Obesity and Physical activity are risk factors for premature death, particularly in relation to heart disease and stroke
- **Alcohol and Drug Use** – Substance misuse increases the likelihood of premature death, both from health conditions, and due to accidents or suicide
- **Risk Taking** – Risky sexual behaviours, dangerous driving, and failing to protect yourself in the sun, can increase the likelihood of premature death
- **Reluctance to Seek Help** – A reluctance to seek help from health professionals can lead to later detection of disease and a greater likelihood of ill health and death
- **Stress** – Stress is a risk factor associated with both physical and mental conditions.

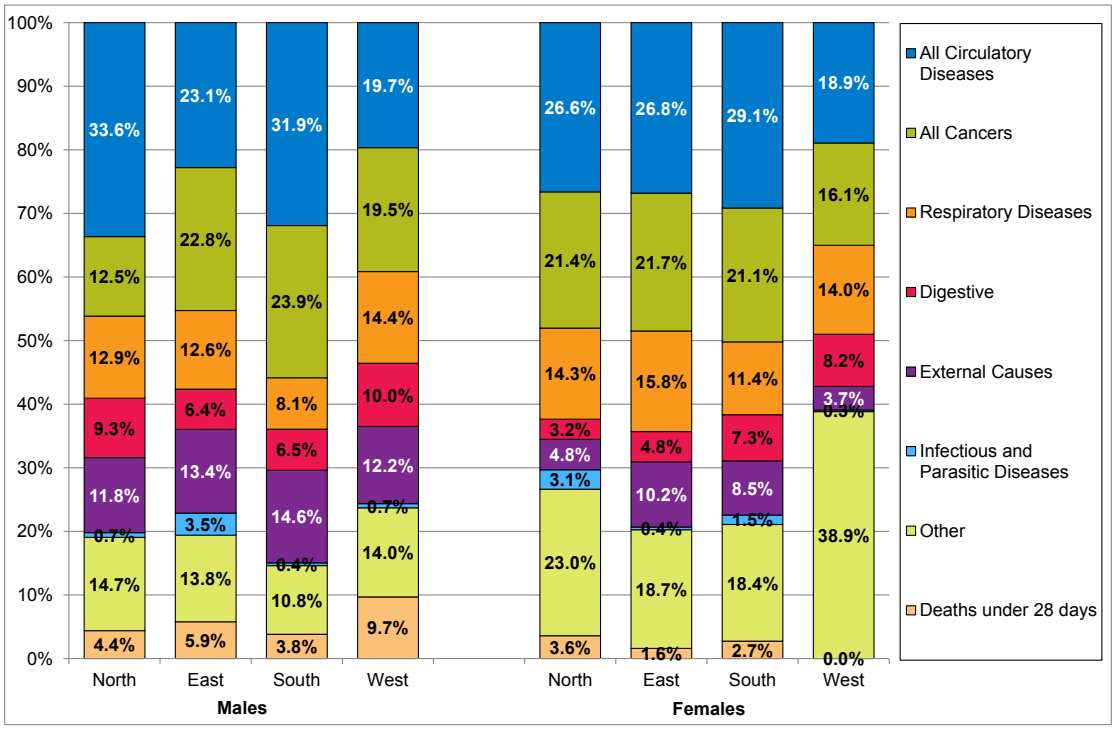
Figure 9.4, Deaths of under 75s in Devon by main cause and associated risk factors, 2013



Source: Primary Care Mortality Database, 2014

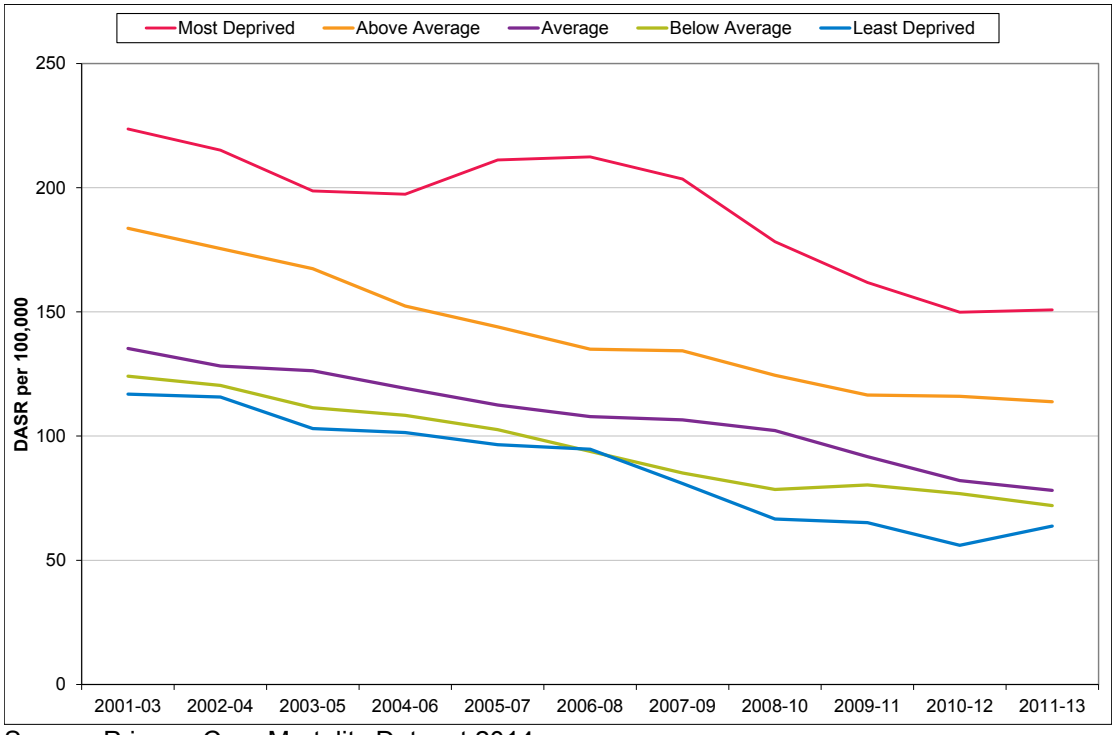
As noted above, poverty is a major factor in premature mortality. On average there is a 5.2 year gap in male life expectancy and a 3.3 year gap in female life expectancy between the most and least deprived communities in Devon. Figure 9.5 highlights the conditions contributing to this gap by area. Whilst mortality rates from preventable conditions have fallen, the gap still persists between areas of the county as shown in figure 9.6.

Figure 9.5, Conditions contributing to the life expectancy gap by area, Devon, 2013



Source: Primary Care Mortality Database, 2014

Figure 9.6, Mortality rates from conditions considered amenable to healthcare by Index of Multiple Deprivation quintile, Devon, 2001-03 to 2011-13

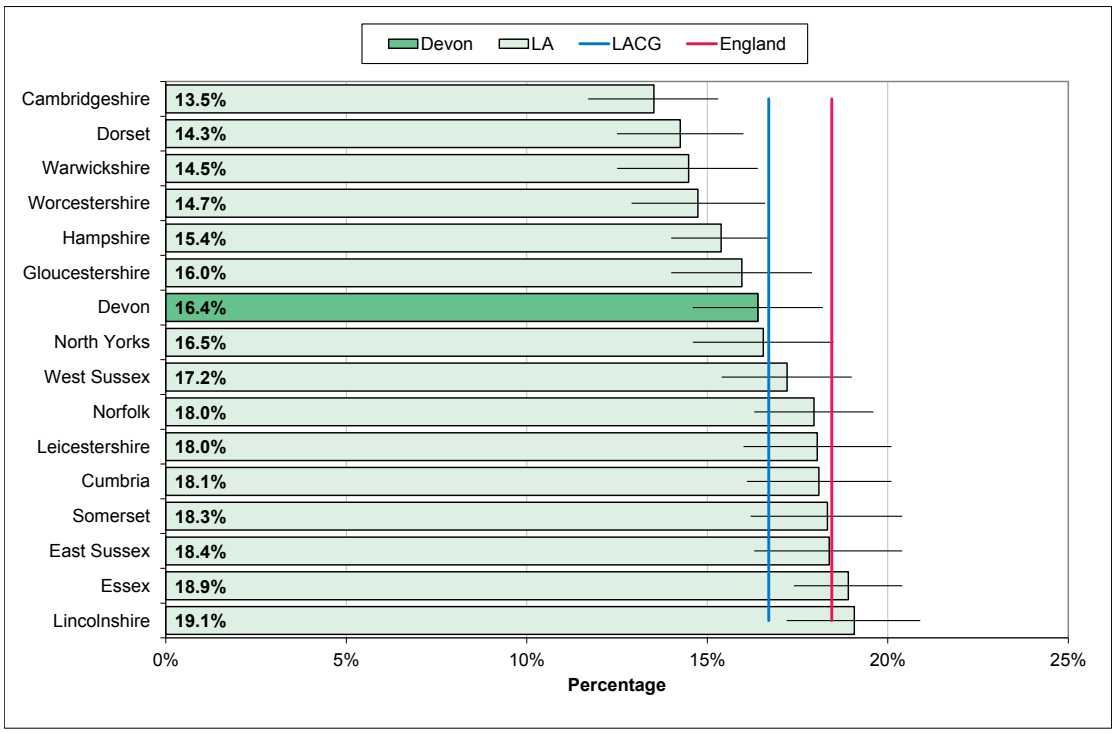


Source: Primary Care Mortality Dataset 2014

9.03 Smoking

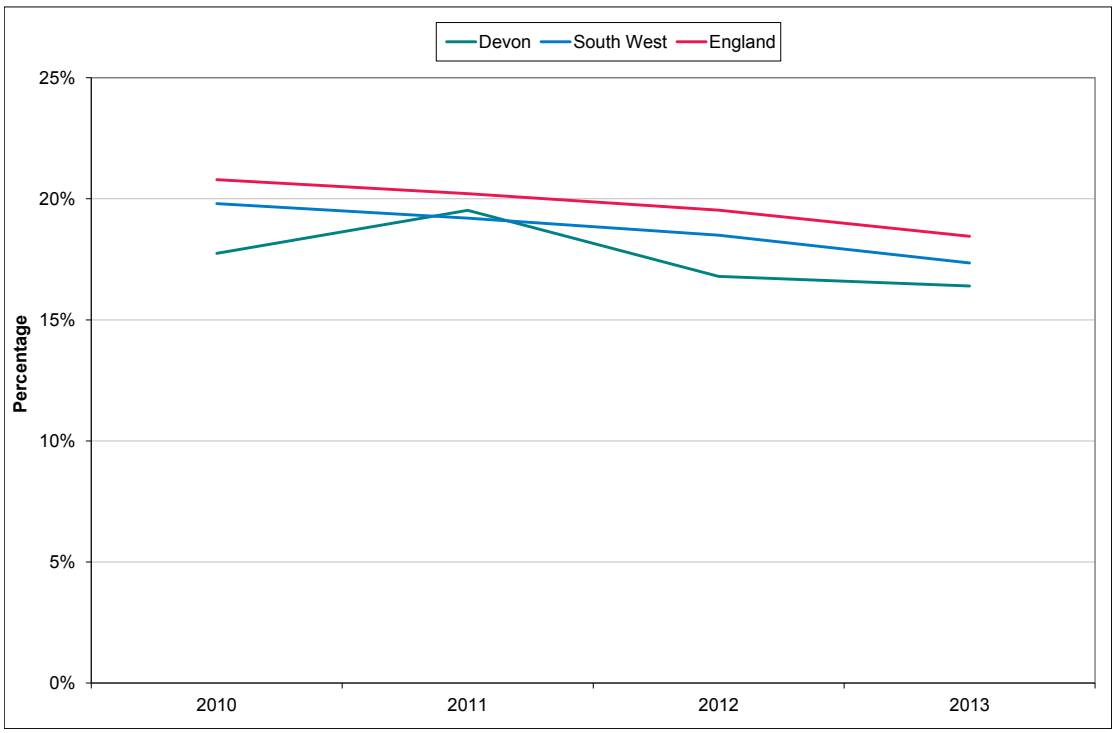
The latest figures from the Integrated Household Survey suggest 16.4% of the adult population in Devon smoke as illustrated in figure 9.7. This is below the South West (17.3%), local authority comparator group (16.7%) and England rate (18.4%). As shown in figure 9.8, smoking rates have fallen in recent years.

Figure 9.7, Adult Smoking Rate (%), Devon Local Authority Comparator Group, 2013



Source: Office for National Statistics Integrated Household Survey, 2014

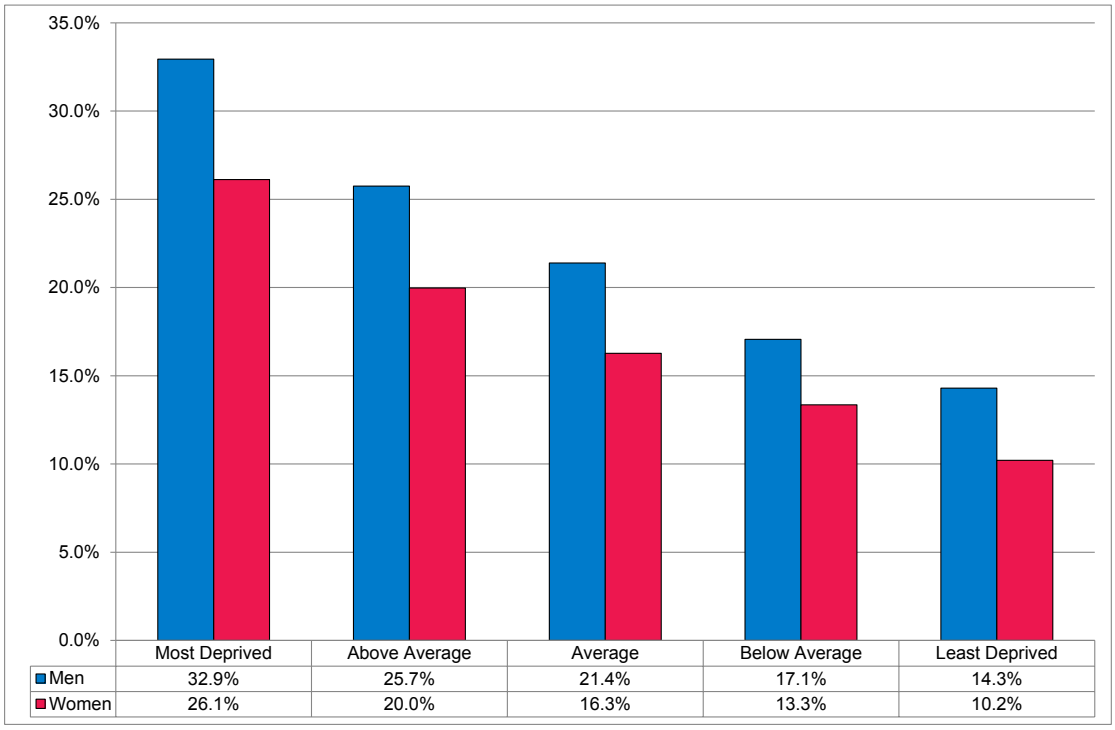
Figure 9.8, Trend in Adult Smoking Rate (%), Devon, 2010 to 2013



Source: Office for National Statistics Integrated Household Survey, 2014

Smoking rates are higher in more deprived areas and are higher in males than females, as illustrated in figure 9.9. This contributes to higher levels of smoking in routine and manual occupational groups (24.6% in Devon), although as seen in figure 9.10 the gap has decreased over the last few years. Figure 9.11 reveals the pattern of smoking prevalence across the county, with higher rates in Exeter, North Devon, and parts of Teignbridge

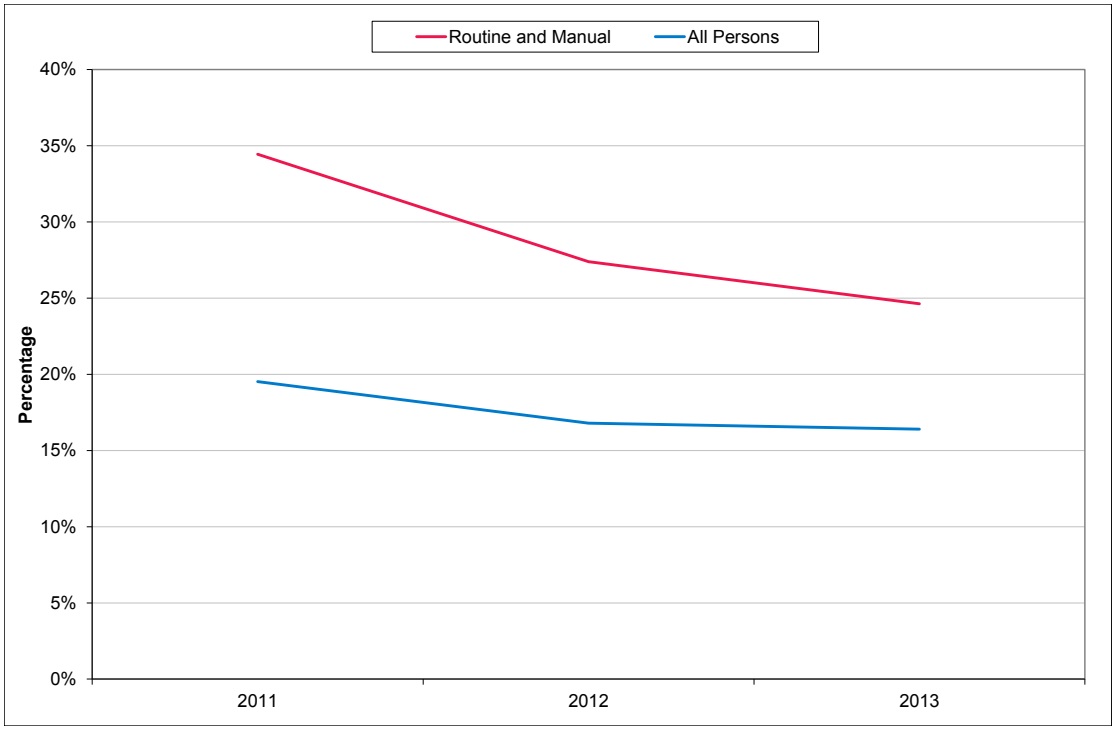
Figure 9.9, Adult Smoking Prevalence by Deprivation, England, 2012



	Most Deprived	Above Average	Average	Below Average	Least Deprived
Men	32.9%	25.7%	21.4%	17.1%	14.3%
Women	26.1%	20.0%	16.3%	13.3%	10.2%

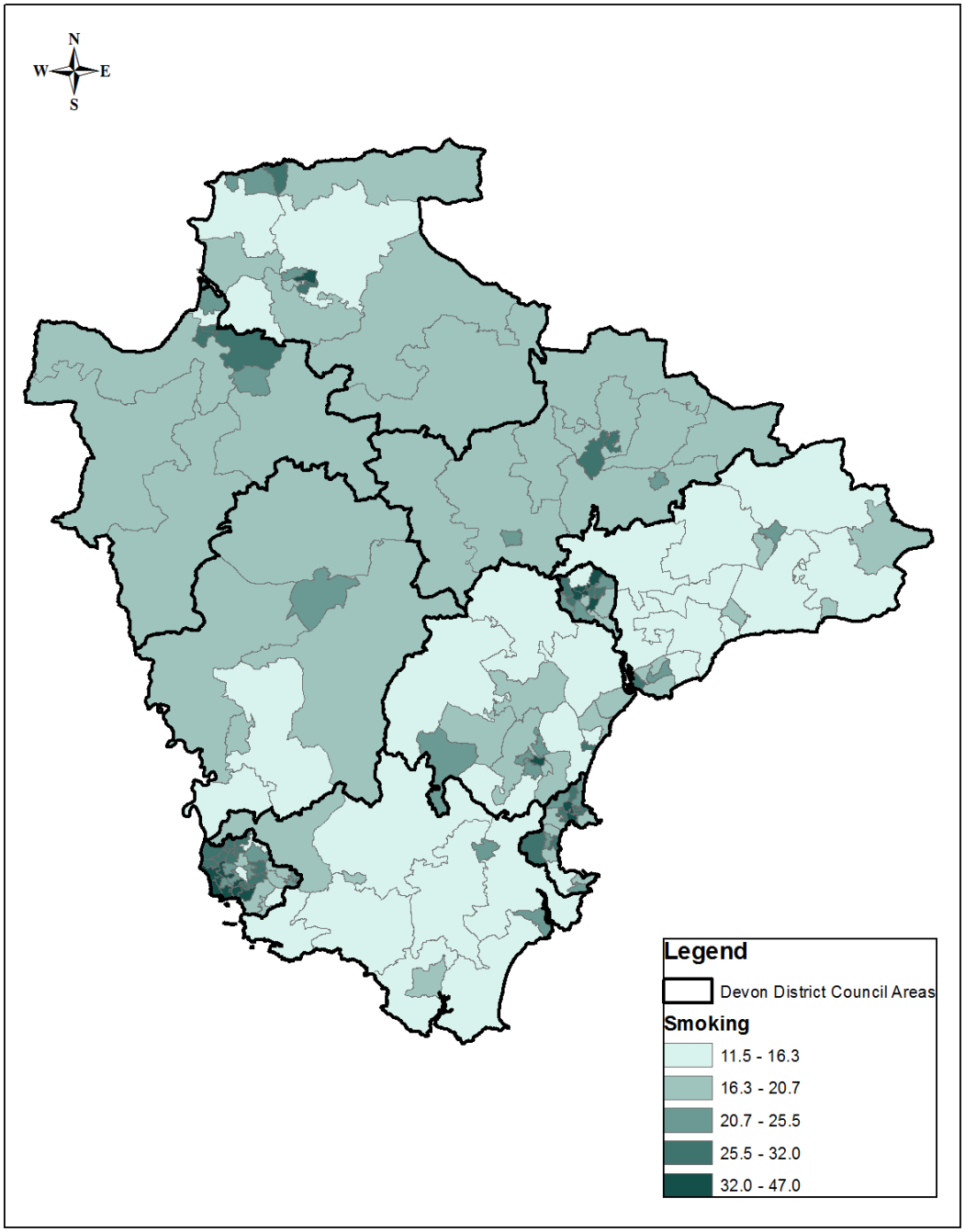
Source: Office for National Statistics General Lifestyle Survey, 2012

Figure 9.10, Trend in Adult Smoking Rate (%), Routine and Manual occupations and overall rate, Devon, 2011 to 2013



Source: Office for National Statistics Integrated Household Survey, 2014

Figure 9.11, Map of Smoking Prevalence by Middle Layer Super Output Area in Devon, 2003 to 2005



Source: Office for National Statistics Synthetic Estimates of Health Behaviours

9.04 High Blood Pressure (Hypertension)

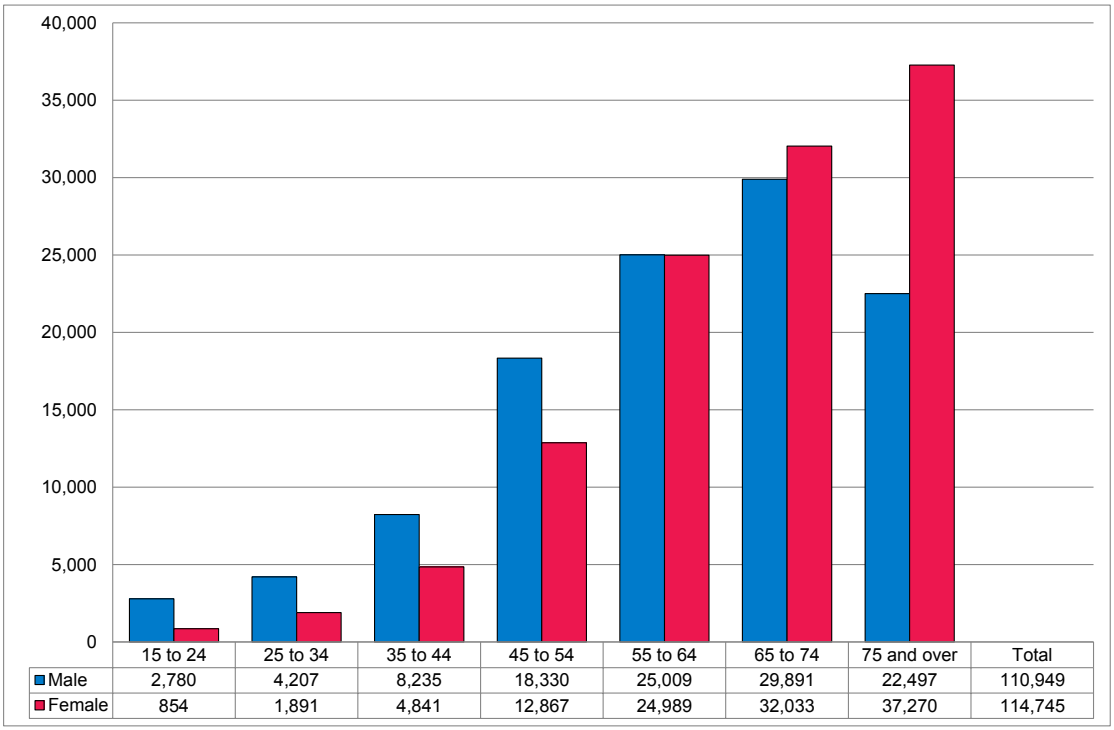
High blood pressure or hypertension is thought to affect over 225,000 people in Devon. Prevalence increases with age as illustrated in table 9.1 and figure 9.12, and whilst rates are higher in males below the age of 65, they are higher in females above the age of 75. An important factor in hypertension is detection, as according to the Devon long-term conditions health needs assessment only around 53.4% of people in Devon expected to have hypertension were on the GP disease register for hypertension in 2015. This has increased in recent years, and the NHS health checks programme will play a major role in increasing early detection and ensuring effective treatment of hypertension.

Table 9.1, Estimated Hypertension Prevalence by Age and Sex, England

Age Group	Male (%)	Female (%)
15 to 24	6%	2%
25 to 34	11%	5%
35 to 44	20%	11%
45 to 54	35%	23%
55 to 64	51%	47%
65 to 74	64%	64%
75 and over	64%	75%

Source: Faculty of Public Health Hypertension Ready Reckoner

Figure 9.12, Estimated number of people with hypertension in Devon, 2013



	15 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75 and over	Total
Male	2,780	4,207	8,235	18,330	25,009	29,891	22,497	110,949
Female	854	1,891	4,841	12,867	24,989	32,033	37,270	114,745

Source: Faculty of Public Health Hypertension Ready Reckoner and ONS Mid-Year Population Estimate, 2013

9.05 Weight

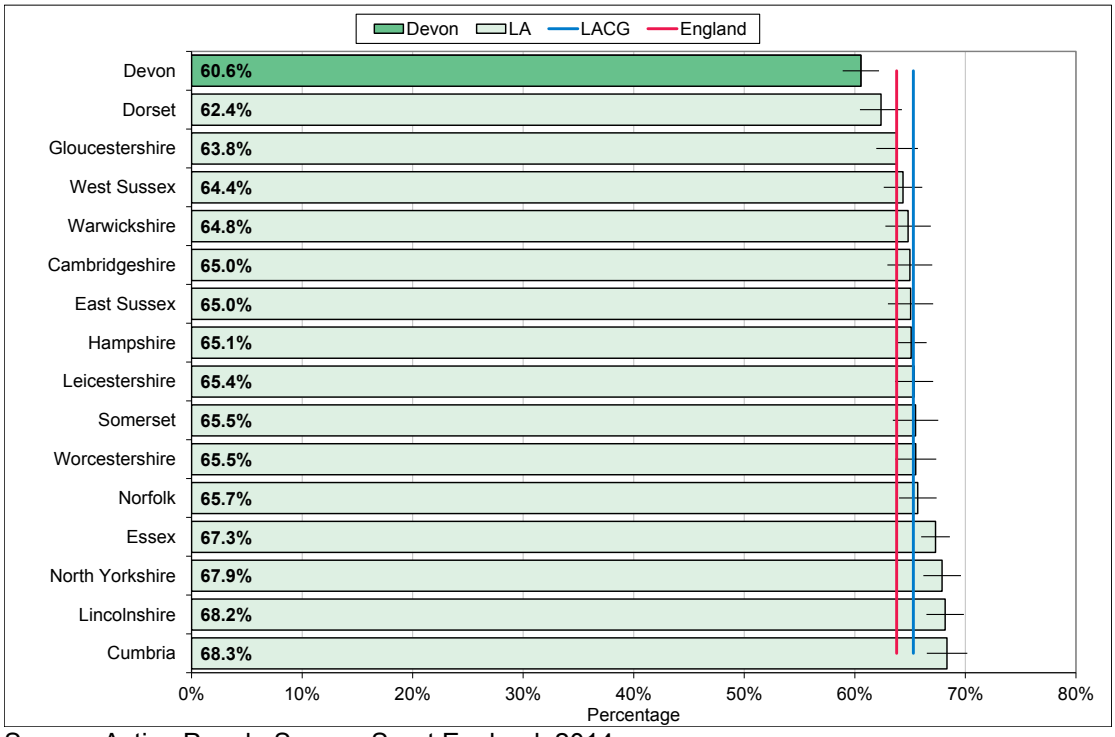
Body Mass Index (BMI) is an approximate measure of whether someone is overweight or underweight, calculated by dividing their weight in kilograms by the square of their height in metres. Four broad categories are used; if a person's BMI is less than 18.5 they are classed as underweight; if a person's BMI is between 18.5 and 25 they are classed as healthy weight; if a person's BMI is between 25 and 30 they are classed as overweight; and if a person's BMI is 30 or above they are classed as obese. A combined category for those with a BMI of over 25 is used within the Public Health Outcomes Framework, known as excess weight. Obesity and excess weight is associated with higher risk of illness and premature death, particularly in relation to heart and circulatory diseases, whilst being underweight can be associated with musculoskeletal problems, a weakened immune system and fatigue. Table 9.2 provides an estimate of the adult population in Devon in these categories. Nationally according to the health survey for England obesity among from 15% in 1993 to 26% in 2010, with higher rates seen in adults aged between 45 and 74. Figure 9.13 highlights the proportion of the population in the excess weight category compared to similar local authorities nationally. This reveals Devon has a significantly lower proportion of the adult population in the excess weight category compared to the local authority comparator group and England.

Table 9.2, Weight status among adults in Devon, 2012

Weight Category	Estimated rate and 95% confidence interval (in brackets)	Estimated number and range based on 95% confidence interval (in brackets)
Underweight (BMI < 18.5)	0.9% (0.6% to 1.3%)	5,600 (3,900 to 7,900)
Healthy Weight (BMI 18.5-25)	38.6% (36.9% to 40.2%)	242,700 (232,400 to 253,100)
Overweight (BMI 25-30)	38.9% (37.3% to 40.6%)	245,100 (234,700 to 255,400)
Obese (BMI 30+)	21.6% (20.2 to 23.0%)	136,100 (127,300 to 144,800)
Excess Weight (BMI 25+)	60.6% (58.9% to 62.2%)	381,100 (370,800 to 391,500)

Source: Active People Survey, Sport England, 2014

Figure 9.13, Percentage of Adults classified as overweight or obese (BMI 25 or greater), Devon Local Authority Comparator Group, 2012

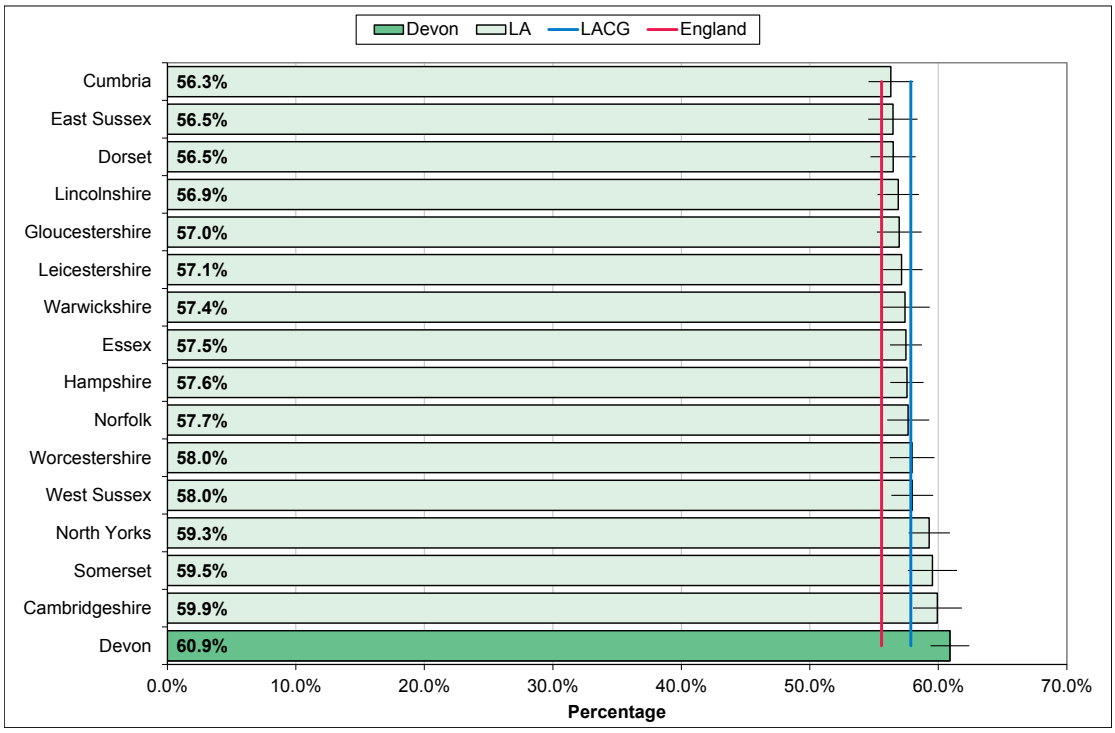


Source: Active People Survey, Sport England, 2014

9.06 Physical Activity

Regular physical activity is one of the most important things individuals can do for their health. It can help control weight, and reduce the risk of heart disease, stroke, diabetes and other conditions. Exercise is also beneficial in terms of mental health and wellbeing, and can reduce the likelihood of premature death. Figure 9.14 highlights 60.9% of adults in Devon were physically active for at least 150 minutes per week in 2013. This was significantly above the local authority comparator group (57.9%) and national (55.6%) rates. Levels of physical activity increased from 59.5% in 2012 to 60.9% in 2013. According to local level estimates based on analyses from the Active People Survey, the lowest levels of sports participation were seen in parts of Tiverton, Barnstaple, Newton abbot, Teignmouth, Bideford, and the Wonford and Whipton areas of Exeter. Table 9.3 shows levels of physical inactivity (less than 30 minutes of moderate physical activity per week) by age and sex in England. This highlights levels of inactivity are generally higher in women and increase with age.

Figure 9.14, Percentage of adults achieving at least 150 minutes of moderate physical activity per week, Devon Local Authority Comparator Group, 2013



Source: Active People Survey, Sport England, 2014

Table 9.3, Levels of physical inactivity (less than 30 minutes of moderate physical activity per week) among adults by age and sex in England, 2012

Age	Men	Women
16 to 24	8%	22%
25 to 34	11%	19%
35 to 44	14%	16%
45 to 54	18%	21%
55 to 64	26%	27%
65 to 74	27%	27%
75 and over	46%	65%
Total	19%	26%

Source: Health Survey for England, 2013

9.07 Alcohol Use

The number of premises and clubs licensed to sell or supply alcohol by the licensing authorities in Devon are shown in tables 9.4 and 9.5, respectively, with the highest levels seen in North Devon (106 premises per 100,000 population).

Table 9.4, Number of premise licences permitted to sell or supply alcohol by licensable activity, 31st March 2014

District	On-sale/supply alcohol only	Off-sale alcohol only	On- and off-sale/supply alcohol	Licenses with late night refreshment	Total	Rate per 10,000 population over 18
East Devon	115	121	284	**257**	777	70
Exeter	66	109	208	232	615	61
Mid Devon	53	64	144	124	385	62
North Devon	**121**	**122**	**343**	217	**803**	**106**
South Hams	114	95	216	129	554	81
Teignbridge	93	114	249	188	644	63
Torridge	51	51	157	76	335	63
West Devon	54	47	138	100	339	77
Devon	**667**	**723**	**1,739**	**1,323**	**4452**	**72**

Source: Devon Local Authority Districts, 2015

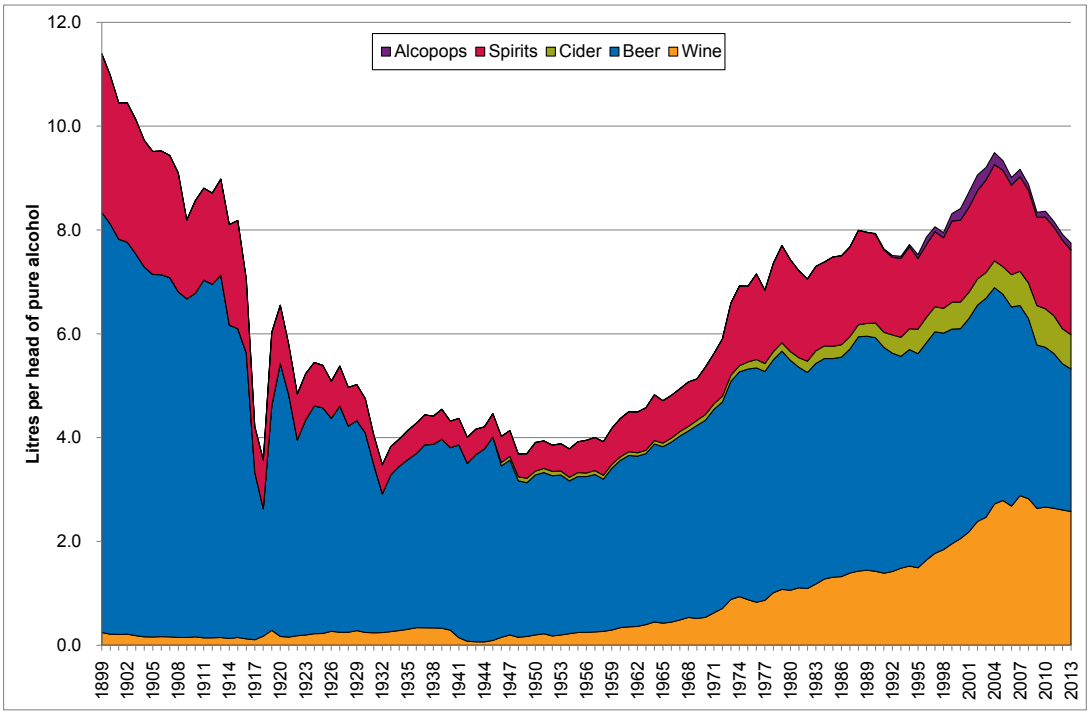
Table 9.5, Number of club premises certificates permitted to sell or supply alcohol by licensable activity, 31st March 2014

District	On-sale/supply alcohol only	On- and off-sale/supply alcohol	Total	Rate per 10,000 population over 18
East Devon	22	35	57	5
Exeter	8	20	28	3
Mid Devon	10	36	46	**7**
North Devon	4	34	38	5
South Hams	7	**37**	44	6
Teignbridge	**52**	10	**62**	6
Torridge	25	5	30	6
West Devon	3	24	27	6
Devon	**131**	**201**	**332**	**5**

Source: Devon Local Authority Districts, 2015

Figure 9.15 displays average alcohol consumption by type in the United Kingdom between 1899 and 2013. Great increases in alcohol consumption were seen between the 1960s and 1990s, with increasing consumption of wine, spirits and cider and decreasing consumption of beer. Average consumption peaked in 2004 and has been decreasing ever since.

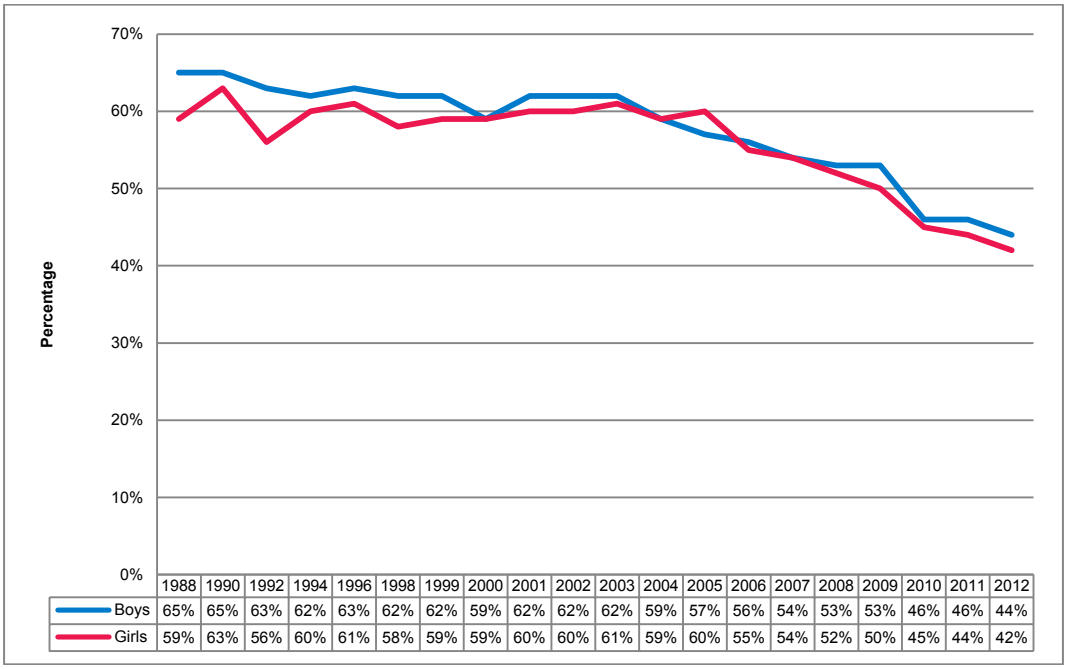
Figure 9.15, Litres of pure alcohol consumed per person per year by type, United Kingdom, 1899 to 2013



Source: British Beer and Pub Association, 2014

This pattern is being driven by a reduction in the number of young people drinking alcohol, which has fallen nationally from over 60% in 1988 to below 45% in 2012 as illustrated in figure 9.16.

Figure 9.16, Proportion of pupils at age 15 in England who had ever had an alcoholic drink (1988-2012)

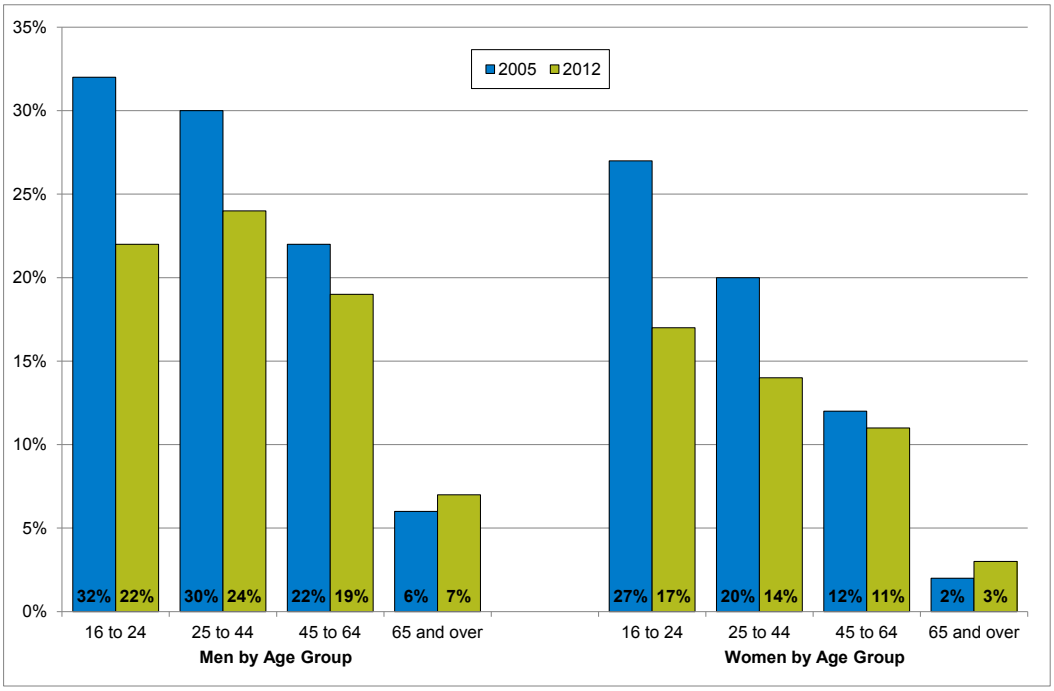


	1988	1990	1992	1994	1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Boys	65%	65%	63%	62%	63%	62%	62%	59%	62%	62%	62%	59%	57%	56%	54%	53%	53%	46%	46%	44%
Girls	59%	63%	56%	60%	61%	58%	59%	59%	60%	60%	61%	59%	60%	55%	54%	52%	50%	45%	44%	42%

Source: Smoking, Drinking and Drug Use among young people in England in 2012. Health and Social Care Information Centre, 2013

Figure 9.17 reveals the proportion of people binge drinking (men who have consumed more than eight units of alcohol and women more than six units at least once in the past week) has also reduced. This is in all age groups, except those aged 65 years and over, with the greatest reductions seen in the 16 to 24 age group.

Figure 9.17, Binge drinking in men and women by age group, UK, 2005 to 2012



Source: Office for National Statistics Opinions and Lifestyle Survey, 2012

Two related measures of alcohol-related hospital admissions exist. The first is a narrow definition, used in the Public Health Outcomes Framework, which covers admissions where the primary diagnosis was alcohol-related or where there was an alcohol-related external cause including accidents, self-harm and intentional injury. The broad definition also includes admissions where secondary diagnoses were alcohol-related, which captures a wider range of chronic health conditions where alcohol is a contributory factor. The further analyses in this report use the broad definition of alcohol-related hospital admission to better represent the overall impact on alcohol use.

There were around 17,500 admissions to hospital due to alcohol-related conditions in Devon in 2013-14, at a cost of around £30 million. North Devon and Torridge have the highest alcohol-related hospital admission rates, as shown in table 9.6. However, there is considerable variation within local authority districts, with the highest rate within small local areas in Devon (lower super output areas) around 13 times higher than the lowest.

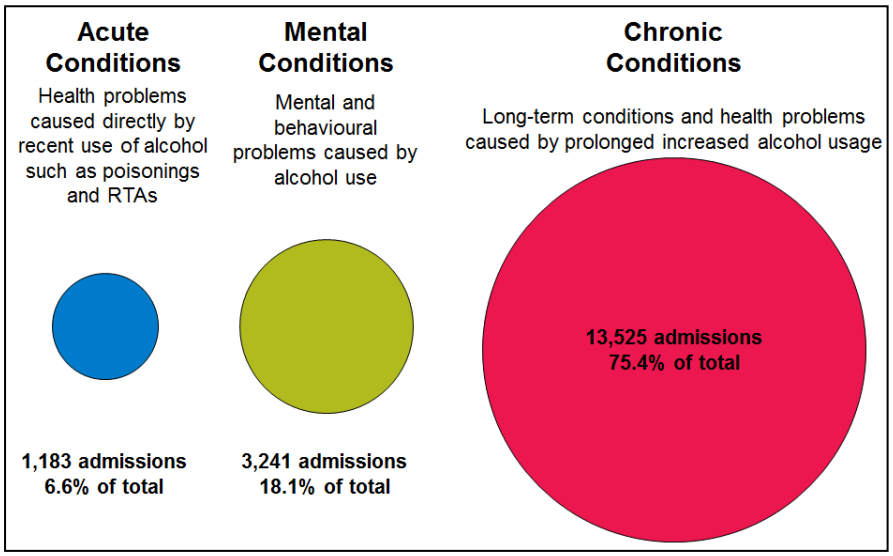
Table 9.6, Overall, highest and lowest alcohol-related admission rates by Devon local authority district, 2011-12 to 2013-14, direct-age standardised rate (DASR) per 100,000

District	DASR per 100,000	Area with highest rate		Area with lowest rate	
		Name	DASR	Name	DASR
East Devon	1277.1	Honiton King Street area	2537.9	Uplyme and Axmouth area	465.3
Exeter	1683.6	Longbrook Street area	3963.0	Matford Lane and St Leonards road	654.5
Mid Devon	1234.7	Tiverton: The Avenue area	2135.1	Clayhanger and surrounding areas	634.5
North Devon	2064.2	Barnstaple Town Centre	6061.3	Woolacombe and surrounding areas	1136.6
South Hams	1568.2	Ivybridge Central	2965.8	Dittisham and surrounding areas	971.8
Teignbridge	1569.3	Newton Abbot: Windsor Avenue, Buckland	3247.3	Combeinteignhead and surrounding areas	740.8
Torridge	1950.5	South East Bideford	4465.8	Clawton and surrounding areas	1006.4
West Devon	1512.3	Tavistock East	2979.2	Beaworthy and surrounding areas	849.5
Devon	**1582.5**	**Barnstaple Town Centre**	**6061.3**	**Uplyme and Axmouth area**	**465.3**

Source: Secondary Uses Service, Commissioning Dataset (Inpatient), 2014

Chronic long-term conditions make up the largest group of alcohol-related hospital admissions accounting for 13,061 admissions (74.6%), with mental illness the next biggest group (3,256 admissions, 18.6%), and acute conditions the smallest group (1,187 admissions, 6.8%), as shown in figure 9.18.

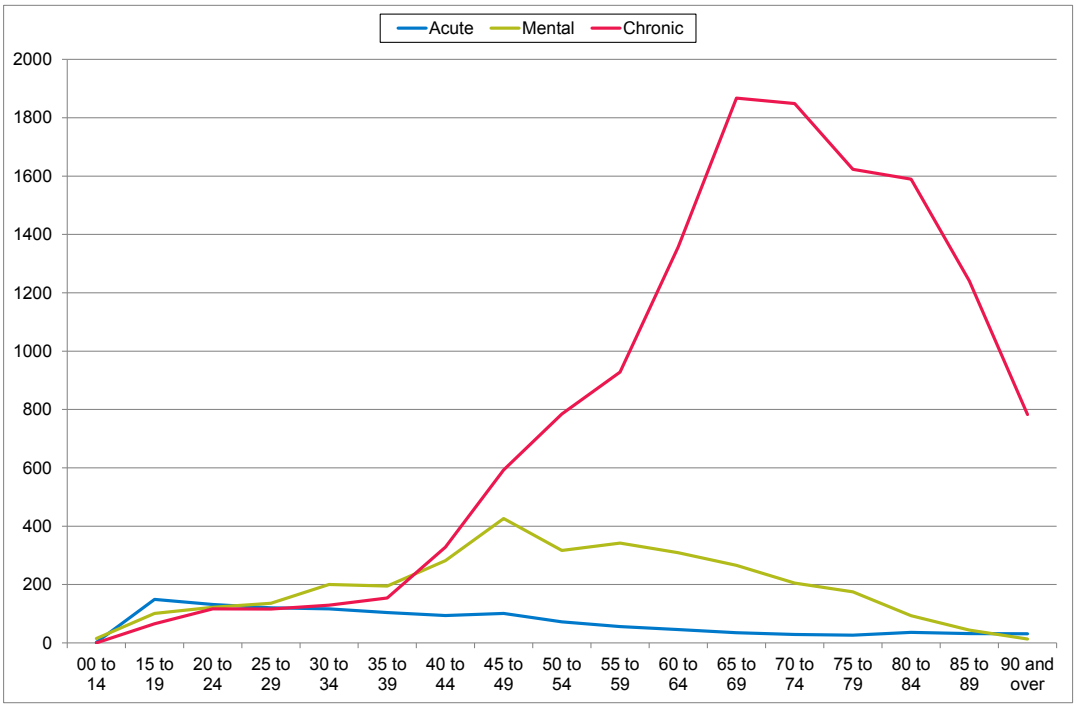
Figure 9.18, Number of alcohol-related admissions by condition type



Source: Secondary Uses Service, Commissioning Dataset (Inpatient), 2014

Acute risks to health, such as injury and poisoning occur more frequently in younger age groups, with admissions for alcohol-related mental health conditions peaking in the 40s, 50s and 60s, and chronic long-term health conditions increasing in later life (figure 9.19). The ageing population in Devon will lead to considerable growth in both chronic and mental conditions.

Figure 9.17, Alcohol-related hospital admissions by age and type, 2013-14



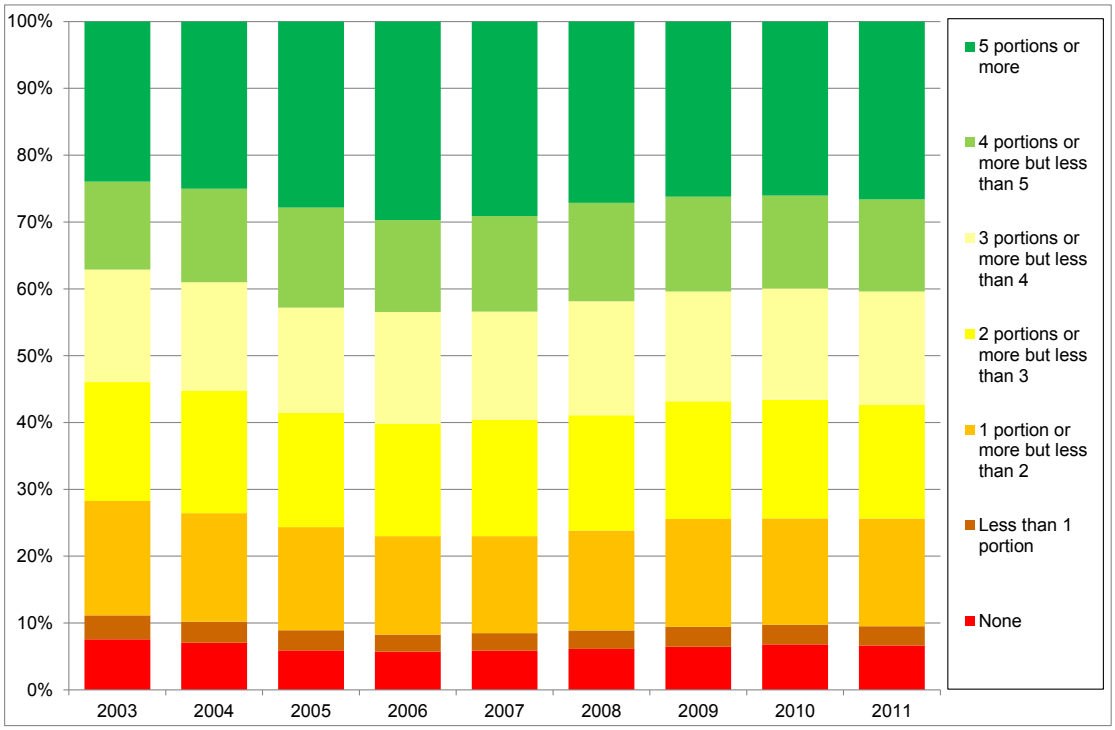
Source: Secondary Uses Service, Commissioning Dataset (Inpatient), 2014

Adults living in affluent areas consume more alcohol. The 2011 General Lifestyle Survey households on higher incomes are more likely to have drunk alcohol in the last week and to have done so on five or more days. However, adverse effects of alcohol disproportionally affect those living in areas with higher deprivation, with people living in the most deprived areas are around two and a half times more likely to be admitted for an alcohol-related condition or die from an alcohol-related cause than those in the least deprived areas.

9.08 Diet

Diet has a significant impact on health and is particularly associated with heart disease. Food with high fat, sugar and salt contents can raise blood pressure and cholesterol, whereas a more balanced diet with fruit and vegetables, protein, unsaturated fat, carbohydrates and lower levels of salt, sugar and saturated fat is likely to improve health. Figure 9.18 highlights only a quarter of the population in the UK consume five or more portions of fruit and vegetables per day.

Figure 9.18, Number of portions of fruit and vegetables consumed per day by adults in the UK, 2003 to 2011



Source: Health Survey for England, 2011

9.09 Cholesterol

Cholesterol is a fatty substance known as a lipid and is vital for the normal functioning of the body. It is mainly made by the liver but can also be found in some foods. Cholesterol is carried in your blood by proteins, and when the two combine they are called lipoproteins. There are harmful and protective lipoproteins known as LDL and HDL, or 'bad' and 'good' cholesterol.

- Low-density lipoprotein (LDL): LDL carries cholesterol from your liver to the cells that need it. If there is too much cholesterol for the cells to use, it can build up in the artery walls, leading to disease of the arteries. For this reason, LDL cholesterol is known as "bad cholesterol".
- High-density lipoprotein (HDL): HDL carries cholesterol away from the cells and back to the liver, where it is either broken down or passed out of the body as a waste product. For this reason, it is referred to as "good cholesterol" and higher levels are better.

High cholesterol itself does not cause any symptoms, but it increases the risk of serious health conditions, increasing the risk of a heart attack or stroke. Causes include having an unhealthy diet high in saturated fat, smoking, having diabetes or high blood pressure and having a family history of stroke or heart disease. Approximately six out of every 10 adults (around 380,000 people in Devon) have raised Cholesterol, and healthy adults should aim for total cholesterol of 5mmol/l or less and LDL-Cholesterol of 3mmol/l or less. Reducing the populations LDL-Cholesterol by 1mmol/l has the potential to reduce CHD by 19%.

9.10 Drug Use

The British Crime Survey examines the extent and trends in illicit drug use among a nationally representative sample of 16 to 59 year olds resident in households in England and Wale. The following headline figures are taken from the 2013-14 Survey for England and Wales:

- Around 1 in 11 (8.8%) adults aged 16 to 59 had taken an illicit drug in the last year. However, this proportion more than doubled when looking at the age subgroup of 16 to 24 year-olds (18.9%).
- Levels of last year drug use in 2013/14 were higher than in 2012 to 2013. In 2012 to 2013, 8.1% of 16 to 59 year-olds and 16.2% of 16 to 24 year-olds had taken an illicit drug in the last year. However, these figures were both lower than in 1996.
- Cocaine, ecstasy, LSD and ketamine use increased between 2012 to 2013 and 2013 to 2014. However there were no statistically significant decreases in last year drug use of any individual drug types among 16 to 59 year olds between 2012 to 20 13 and 2013 to 2014.
- Around one-third of adults had taken drugs at some point during their lifetime. Of 16 to 59 year olds, 35.6% had reported ever using drugs.

Figure 9.19 looks at longer term trends in drug use from the survey highlighting that whilst the use of certain drugs and drug use overall has fallen, the use of Powder Cocaine and Methadone has increased.

Figure 9.19, Overall national trends in drug use for ages 16-24 and 16-59 between 1996 and 2011-12 (British Crime Survey 2013-14 data)

Drug	16-24	16-59
Powder Cocaine	▲	▲
Crack cocaine	●	●
Heroin	●	●
Methadone	●	▲
Tranquilisers	●	●
Anabolic steroids	●	●
Ecstasy	▼	●
LSD	▼	▼
Magic mushrooms	▼	▼
Amphetamines	▼	▼
Cannabis	▼	▼
Amyl nitrate	▼	▼
Overall Class A drug use	▼	●
Overall stimulant use	▼	▼
Overall drug use	▼	▼

Key
▲ Statistically higher
● No statistical change
▼ Statistically lower

Source: British Crime Survey

Problematic drug users (PDU's) classified as those using opiates and crack cocaine, place a disproportionately large burden on the substance misuse treatment services. A prevalence estimate for opiate and crack users (OCU) released by the National Treatment Agency estimated that in 2009-10, 6.18 people per 1000 aged 18 to 64 in Devon were opiate and crack users. This was lower, but not statistically different to the South West rate (8.95 per 1,000) and national rate (9.24 per 1,000) and equated to an estimated 2887 users.

Combining prevalence estimates from the British Crime Survey for age, gender, ONS classification and deprivation with Devon population data enables prevalence estimates to be created locally. Using this methodology, the prevalence estimates for Devon for the 16-24 and 16-59 year age groups and gender are shown in tables 9.7 and 9.8.

Table 9.7, Modelled prevalence estimates of substance misuse (in the last 12 months) in Devon for 16-24 year olds

Drug Type		Number			Percent		
		Males	Females	Persons	Males	Females	Persons
Class A	Powder Cocaine	2,101	920	3,021	4.96%	2.21%	3.60%
	Ecstasy	1,707	765	2,472	4.03%	1.84%	2.95%
	Hallucinogens	990	384	1,374	2.34%	0.92%	1.64%
Class A/B	Amphetamines	1,137	670	1,807	2.68%	1.61%	2.15%
Class B	Cannabis	8,812	4,026	12,839	20.81%	9.68%	15.30%
	Mephedrone	2,444	940	3,384	5.77%	2.26%	4.03%
Class C	Ketamine	807	429	1,237	1.91%	1.03%	1.47%
Not classified	Amyl nitrite	1,395	423	1,818	3.29%	1.02%	2.17%
Any Class A drug		3,193	1,328	4,521	7.54%	3.19%	5.39%
Any stimulant drug		3,634	1,586	5,220	8.58%	3.81%	6.22%
Any drug		10,460	4,871	15,331	24.70%	11.72%	18.27%

Source: 2011-12 British Crime Survey (now CSEW) and Exeter System population data

Table 9.8, Modelled prevalence estimates of substance misuse (in the last 12 months) in Devon for 16-59 year olds

Drug Type		Number			Percent		
		Males	Females	Persons	Males	Females	Persons
Class A	Powder Cocaine	4,625	2,040	6,665	2.23%	0.97%	1.59%
	Ecstasy	2,902	1,305	4,207	1.40%	0.62%	1.01%
	Hallucinogens	1,486	579	2,066	0.72%	0.27%	0.49%
Class A/B	Amphetamines	2,186	1,301	3,487	1.05%	0.62%	0.83%
Class B	Cannabis	16,490	7,647	24,137	7.95%	3.62%	5.77%
	Mephedrone	3,560	1,379	4,939	1.72%	0.65%	1.18%
Class C	Ketamine	1,146	609	1,755	0.55%	0.29%	0.42%
Not classified	Amyl nitrite	2,627	807	3,434	1.27%	0.38%	0.82%
Any Class A drug		6,513	2,731	9,244	3.14%	1.29%	2.21%
Any stimulant drug		7,588	3,345	10,933	3.66%	1.58%	2.61%
Any drug		21,202	10,027	31,229	10.22%	4.75%	7.46%

Source: 2011-12 British Crime Survey (now CSEW) and Exeter System population data

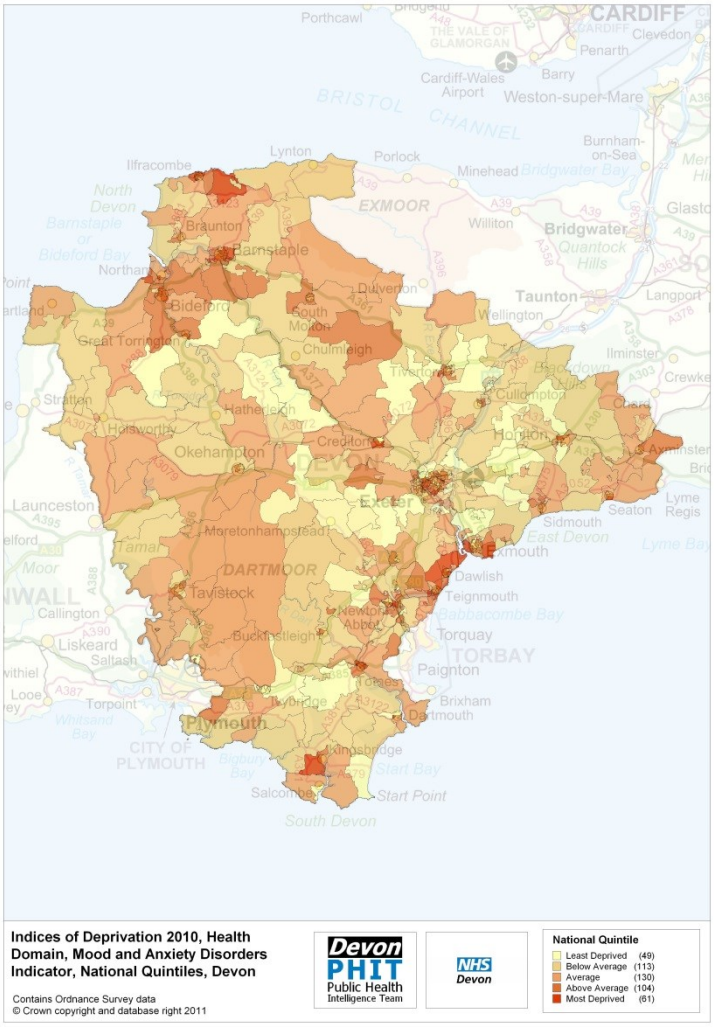
The use of new psychoactive substance (formerly known as 'legal highs') is increasing. These are defined by the UK government as 'a narcotic or psychotropic substance newly available in the UK [and mostly but not exclusively synthetic] which may pose a public health threat comparable to drugs controlled under the Misuse of Drugs Act 1971.' New psychoactive substances were covered in the Devon Strategic Assessment 2013-14 (http://www.devon.gov.uk/devon_strategic_assessment_2013.14technical_report_2014.pdf), which emphasised the point the term 'legal' is particularly misleading as many of these substances are quickly made illegal.

The Strategic Assessment also highlights that the Devon Drug and Alcohol Action Team (DAAT) is working with colleagues from a range of organisations including treatment providers, Young People's services, Police, Community Safety and Trading Standards across Devon to monitor the emerging issue of NPS. The work aims to explore the nature, extent and impact of these substances and to consider ways of working together to develop a coordinated approach. Since April 2013 the Drug Treatment Monitoring System database has required treatment providers to collect data of NPS use from everyone entering substance misuse treatment and it is hoped that this will become available from 2015-2016. Other agencies are likewise now collecting data more consistently yet it is still difficult to gain a clear picture of NPS use across the County. All Community Safety Partnerships are linked into the Devon group looking at this new topic area to ensure they are up to speed with current trends and concerns as anecdotally these substances are implicated in anti-social behaviour locally.

9.11 Mental Health and Wellbeing in Adulthood

Around one person in six adults in England had at least one common psychiatric disorder with women more likely to experience common psychiatric problems than men, and the peak ages being between 25 and 54 for men, and 16 to 34, and 45 to 54 for women. Only around a quarter of those with a common mental health condition were receiving treatment for their condition. Psychotic disorders, such as schizophrenia and affective disorder, are also more common in younger age groups, with the peak age being 35 to 44 for both men and women. (Psychiatric Morbidity Survey of Adults, 2007, http://www.ic.nhs.uk/pubs/psychiatricmorbidity07). Within Devon, 33,700 persons were registered with depression at their GP practice, and 5,800 persons were registered with a serious mental illness (Quality and Outcomes Framework, 2013). The anxiety and mood disorders indicator from the Indices of Deprivation 2010 shown in figure 9.19 below highlight the pattern of mental health needs across the population, highlighting particular concentrations in Exeter, Exmouth, Teignmouth, Dawlish, Newton Abbot, Totnes, Ilfracombe, Bideford and Barnstaple. Poor parental mental health can have a detrimental effect on the health and development of children, leading to an increased risk of mental health problems for the children themselves. The prevalence and age distribution of common mental health problems highlight the need for a family focus in adult mental health services, and also the need to increase access to treatment.

Figure 9.19, Indices of Deprivation 2010, Mood and Anxiety Disorders Indicator, Devon areas in national context



Source: Indices of Deprivation, 2010

There are four self-reported wellbeing measures in the Public Health Outcomes Framework, relating to how satisfied people are with their life, how worthwhile they think the things they do in their life, how happy they are, and whether they feel anxious or not.

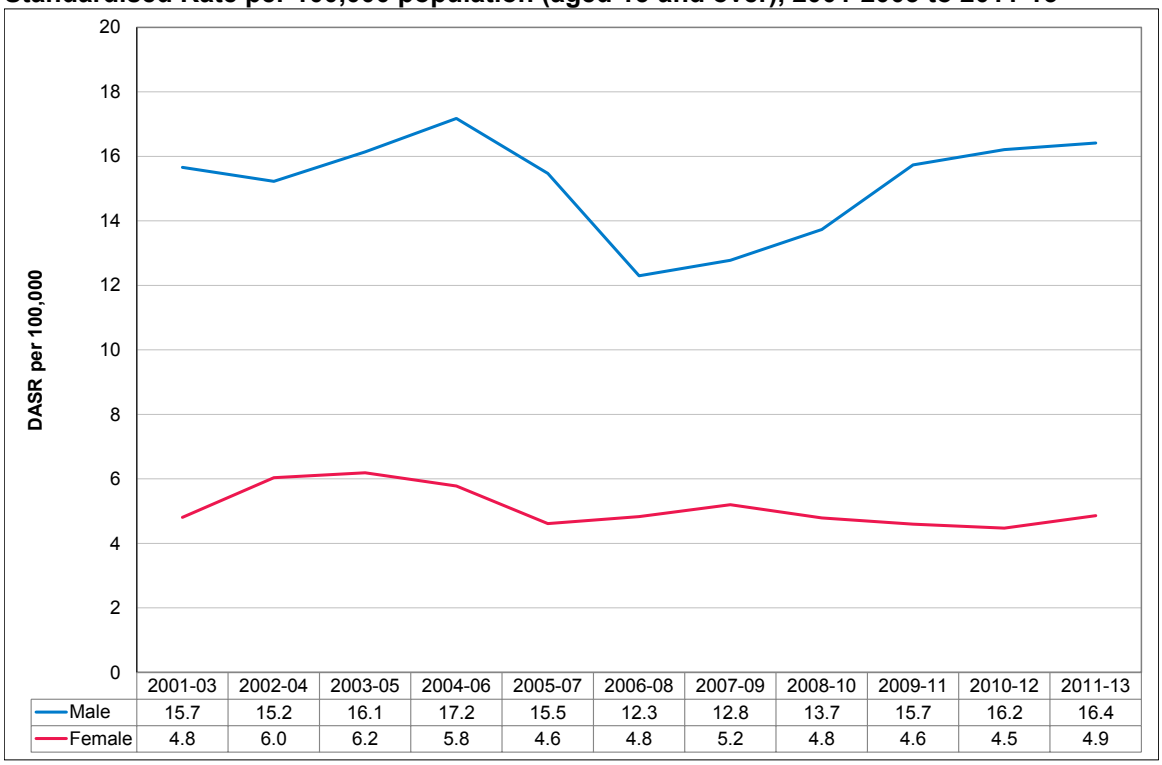
Table 9.9, Self-Reported wellbeing measures in Devon compared with the South West and England, 2013-14

Measure	Devon	South West	England
Low satisfaction score	4.9%	5.3%	5.6%
Low worthwhile score	*	4.4%	4.2%
Low happiness score	8.5%	9.7%	9.7%
High anxiety score	18.1%	19.3%	20.0%

Source: Office for National Statistics Integrated Household Survey, 2014
* not available for Devon

Around 65 deaths per annum are registered as suicide or injury undetermined (open verdict), with a direct age standardised rate of 10.4 per 100,000. This was above the South West (10.1), local authority comparator group (9.5) and England (8.8) rates. Figure 9.20 highlights difference by sex, which tend to be low and stable for females and higher and more variable in males. Suicide rates are highest for people in the 40s and 50s and are relatively low for persons in their teens and 20s.

Figure 9.20, Deaths from Suicide or Injury Undetermined by Sex, Direct Age Standardised Rate per 100,000 population (aged 15 and over), 2001-2003 to 2011-13



	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13
Male	15.7	15.2	16.1	17.2	15.5	12.3	12.8	13.7	15.7	16.2	16.4
Female	4.8	6.0	6.2	5.8	4.6	4.8	5.2	4.8	4.6	4.5	4.9

Source: Primary Care Mortality Dataset, 2014

9.13 Long-Term Conditions

According to the Department of Health, long-term conditions are 'those conditions that cannot, at present be cured but which can be controlled by medication and other therapies'.

A long-term conditions health needs assessment was undertaken in 2014-15 which looked in detail at the eight long-term conditions. A brief overview of these conditions and how many people are affected in Devon is supplied below.

Coronary Heart Disease (CHD)

Coronary Heart Disease (CHD) is when coronary arteries (the arteries that supply the heart muscle with oxygen-rich blood) become narrowed by a gradual build-up of fatty material within their walls. 29,932 people were on a GP disease register for the condition in Devon in 2015. The expected number of people with the condition is 43,759, suggesting that around 68% of the people who are likely to have the condition are on the GP disease register.

Heart Failure

Heart failure is a condition caused by the heart failing to pump enough blood around the body at the right pressure. It usually occurs because the heart muscle has become too weak or stiff to work properly. 6,364 people were on a GP disease register for the condition in Devon in 2015. The expected number of people with the condition is 13,286, suggesting around 48% of the people who are likely to have the condition are on the GP disease register.

Stroke

This definition includes stroke, a serious medical condition where one part of the brain is damaged by a lack of blood supply or bleeding into the brain from a burst blood vessel, and transient ischaemic attack (TIA), a temporary fall in the blood supply to one part of the brain, resulting in brief symptoms similar to stroke. 17,756 people were on a GP disease register for the condition in Devon in 2015. The expected number of people with the condition is 19,154, suggesting around 93% of the people who are likely to have the condition are on the GP disease register.

Chronic Kidney Disease (CKD)

Chronic Kidney Disease (CKD) is a long-term condition where the kidneys do not work effectively. 31,055 people aged 18 and over were on a GP disease register for the condition in Devon in 2015. The expected number of people with the condition is 73,114, suggesting around 42% of the people who are likely to have the condition are on the GP disease register.

Diabetes

Diabetes is a condition where the amount of glucose in blood is too high because the body cannot use it properly because the pancreas doesn't produce any insulin, or not enough insulin, to help glucose enter your body's cells, or the insulin that is produced does not work properly (known as insulin resistance). 41,114 people aged 17 and over were on a GP disease register for the condition in Devon in 2015. The expected number of people with the condition is 53,733, suggesting around 77% of the people who are likely to have the condition are on the GP disease register.

Asthma

Asthma is a common long-term condition that can cause coughing, wheezing, chest tightness and breathlessness. The condition is marked by attacks of spasm in the bronchi of the lungs, causing difficulty in breathing. It is usually connected to allergic reaction or other forms of hypersensitivity. 50,592 people are on a GP disease register for the condition in Devon. The expected number of people with the condition is 71,853, suggesting around 70% of the people who are likely to have the condition are on the GP disease register.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing, primarily due to the narrowing of their airways, this is called airflow obstruction. 14,542 people are on a GP disease register for the condition in Devon. The expected number of people with the condition is 21,405, suggesting around 68% of the people who are likely to have the condition are on the GP disease register.

Epilepsy

Epilepsy is a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain. 5,397 people aged 18 and over were on a GP disease register for the condition in Devon in 2015. The expected number of people with the condition is 7,394, suggesting around 73% of the people who are likely to have the condition are on the GP disease register.

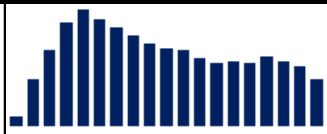
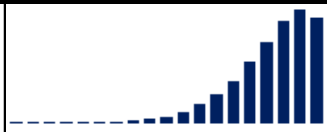
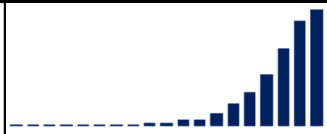
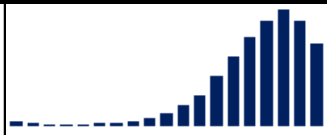
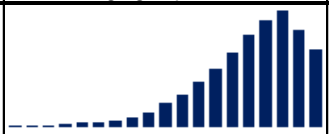
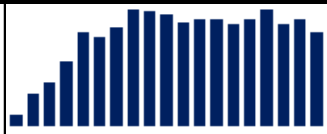
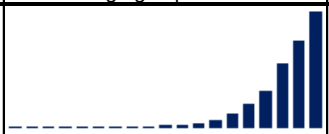
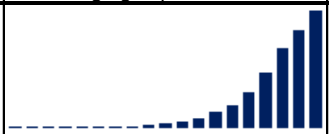
Age, Sex and Inequality Summaries

The above summary uses information from the GP registers and estimates of prevalence from national studies to provide a profile of long-term conditions in Devon. The following analysis uses data from a project in Somerset, to provide further information about the pattern and costs of long-term conditions across the health and social care system. The South West Academic Health Service Network launched the Symphony project in Somerset, which joins up health and social care data so usage and cost of services across the whole system can be analysed. The project is expected to be extended to cover Devon in due course, but the existing Somerset data can still deliver some useful insights for our local population. This can be done by applying the patterns seen by age, sex and social characteristics in Somerset to our local populations to estimate what we might expect to see in Devon.

Figure 9.21 provides an overview of each of our selected conditions from the Somerset Symphony project, applied by age, sex and deprivation to the Devon population. The column 'estimated treated prevalence' as the Symphony project captured the numbers recorded with disease either in primary care, secondary care or elsewhere in the health and social care system. The subsequent charts for each condition show the profile by sex, age and deprivation. Most conditions are more likely in males than females, in older age groups, and in more deprived areas. The following patterns are seen:

- For the pattern by sex, only Asthma has higher prevalence in females. The conditions where male rates are particularly higher are CHD (86% higher), CKD (52% higher) and Heart Failure (51% higher).
- The pattern by age, highlights an increasing pattern with age, with much lower likelihood of having the condition in younger age groups for cardiovascular diseases (CHD, Stroke and Heart Failure), along with CKD. A similar pattern is seen for COPD and diabetes but the peak in earlier in old age (80 to 84) and prevalence rates drop of more quickly for older age groups. Asthma peaks at an earlier age (20 to 24), whilst Epilepsy prevalence is much more even across adult age groups.
- For all conditions prevalence rates are higher in more deprived areas. The greatest differences are seen for COPD (134% higher), Epilepsy (81% higher) and Diabetes (78% higher).

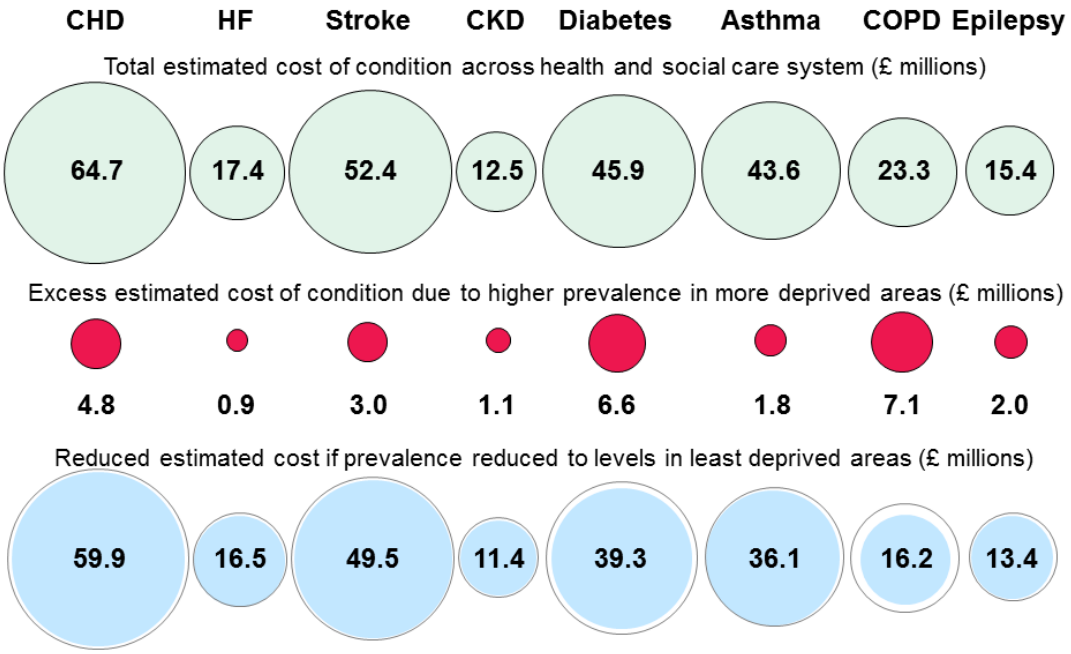
Figure 9.21, Estimated number treated for selected long-term conditions in Devon, with summary breakdowns by age, sex and deprivation, 2013-14 (Somerset Symphony data applied to wider Devon, Plymouth and Torbay population profile)

Condition	Estimated Treated Prevalence	Sex Persons / Male / Female	Age Younger ---------- Older	Deprivation Most Deprived ----- Least Deprived
Asthma	NEW Devon = 92,000 SD&T CCG = 28,500 Devon CC = 77,600 Plymouth = 28,800 Torbay = 14,100	 Female rates 10% higher	 Peak age group is 20 to 24	 Most deprived areas 15% higher
CHD	NEW Devon = 35,300 SD&T CCG = 13,000 Devon CC = 32,500 Plymouth = 9,300 Torbay = 6,600	 Male rates 86% higher	 Peak age group is 85 to 89	 Most deprived areas 50% higher
CKD	NEW Devon = 3,900 SD&T CCG = 1,500 Devon CC = 3,600 Plymouth = 1,000 Torbay = 800	 Male rates 52% higher	 Peak age group is 90 and over	 Most deprived areas 74% higher
COPD	NEW Devon = 16,300 SD&T CCG = 6,200 Devon CC = 14,500 Plymouth = 4,600 Torbay = 3,300	 Male rates 30% higher	 Peak age group is 80 to 84	 Most deprived areas 134% higher
Diabetes	NEW Devon = 43,000 SD&T CCG = 15,800 Devon CC = 38,500 Plymouth = 12,000 Torbay = 8,200	 Male rates 44% higher	 Peak age group is 80 to 84	 Most deprived areas 78% higher
Epilepsy	NEW Devon = 11,200 SD&T CCG = 3,700 Devon CC = 9,300 Plymouth = 3,600 Torbay = 2,000	 Male rates 14% higher	 Peak age group is 35 to 39	 Most deprived areas 81% higher
Heart Failure	NEW Devon = 7,100 SD&T CCG = 2,700 Devon CC = 6,600 Plymouth = 1,800 Torbay = 1,300	 Male rates 51% higher	 Peak age group is 90 and over	 Most deprived areas 44% higher
Stroke	NEW Devon = 20,500 SD&T CCG = 7,600 Devon CC = 18,900 Plymouth = 5,300 Torbay = 3,900	 Male rates 26% higher	 Peak age group is 90 and over	 Most deprived areas 47% higher

Source: South West Academic Health Science Network, Symphony Project Data for Somerset modelled by age, sex and deprivation for the Devon population, 2014

Figure 9.22 looks at the estimated overall health and social care costs of selected long-term conditions (green circles) in the Devon County Council area, and how much of this cost can be attributed to the higher prevalence of these conditions in more deprived areas (red circles). This helps us quantify the cost of health inequalities, and also highlight the conditions with the greatest variation and potential for reduction through a focus on prevention (blue circles). This analysis used unit costs for the conditions by service and age were taken from the Symphony Project and then applied to the estimated treated prevalence by age figures. The conditions with the highest overall costs are CHD (£64.7m), Stroke (£52.4m), Diabetes (£45.9m), and Asthma (£43.6m). The highest levels of excess cost due to higher prevalence in more deprived areas were COPD (£7.1m), In terms of percentage share, the greatest potential savings through prevention and reducing prevalence in more deprived areas is seen for COPD, Diabetes and CHD. This is illustrated by COPD costs, which are estimated to total around £23.3 million in Devon, but if all areas had the same prevalence as the least deprived areas, then the cost would be around £7.1 million lower at around £16.2 million. These figures may also be an underestimate as average cost for all persons by service and age is used, and the service costs for those living in more deprived areas is likely to be greater.

Figure 9.22, Estimated Health and Social Care System-Wide Cost including overall, health inequality related and opportunity costs for selected long-term conditions, Devon County Council, 2014



Source: South West Academic Health Science Network, Symphony Project Data for Somerset modelled by age, sex and deprivation for the Devon population, 2014

Table 9.10 reveals the number of hospital admissions where the primary diagnosis was for one of the selected long-term conditions locally. The greatest volumes of hospital admissions were seen for COPD (around 4,000 admissions), Stroke (around 2,100 admissions) and COPD (around 1,650 admissions).

Table 9.10, Number of hospital admission for selected long-term conditions (primary diagnosis only), for CCGs, NEW Devon localities and upper tier / unitary local authorities in Devon, Plymouth and Torbay, 2013-14

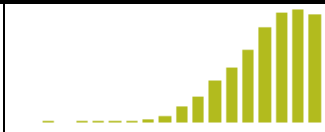
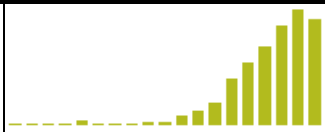
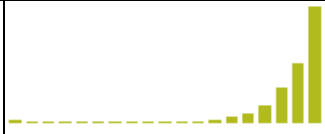
Condition	Admission Type	South Devon & Torbay CCG	NEW Devon CCG	Eastern Locality	Northern Locality	Western Locality	Devon County Council	Plymouth City Council	Torbay Council
Asthma	Elective	14	183	6	167	10	184	7	*
	Emergency	302	783	347	181	255	702	208	172
	Other	*	*	*	*	*	6	*	*
CHD	Elective	451	1994	797	544	653	1770	465	201
	Emergency	773	2309	902	505	902	1983	666	426
	Other	41	245	56	165	24	248	15	24
CKD	Elective	118	323	172	55	96	301	71	62
	Emergency	28	96	32	17	47	76	28	17
	Other	*	7	*	*	*	11	*	*
COPD	Elective	36	214	72	23	119	129	104	16
	Emergency	627	1693	679	325	689	1413	572	340
	Other	78	68	23	25	20	112	6	28
Diabetes	Elective	15	65	27	13	25	56	18	6
	Emergency	217	615	229	74	312	446	279	112
	Other	13	25	*	15	*	30	*	*
Epilepsy	Elective	31	144	33	27	84	106	58	9
	Emergency	202	605	183	135	287	468	217	115
	Other	20	13	*	*	*	21	*	10
Heart Failure	Elective	23	120	63	34	23	115	14	14
	Emergency	400	841	316	179	346	785	258	194
	Other	74	82	35	30	17	108	8	42
Stroke	Elective	44	112	47	18	47	100	32	23
	Emergency	626	1621	665	403	553	1531	404	306
	Other	252	486	191	150	145	519	106	103

Source: Secondary Uses Services, Commissioning Dataset, Inpatient Table, 2015
The admission type 'Other' includes transfers
* indicates less than six admissions

Figure 9.23 shows the pattern of hospital admissions in the wider Devon area by age, sex and deprivation. The following patterns are seen:

- For the pattern by sex, only Asthma has higher prevalence in females. The conditions where male rates are particularly higher are CHD (181% higher).
- The pattern by age, generally highlights an increasing pattern with age, different patterns are Asthma and Epilepsy which both have younger peaks, and Diabetes which has a secondary peak for children aged 5 to 19.
- For all conditions admissions rates are higher in more deprived areas, which is particularly marked for COPD (299% higher) and Diabetes (222% higher). A stronger relationship with deprivation is seen for admissions compared to treated prevalence, highlighting the greater likelihood of ill health and complications in these groups.

Figure 9.23, Direct age standardised rate per 100,000 of hospital admissions (primary diagnosis only) for selected long-term conditions in Devon, Plymouth and Torbay, with summary breakdowns by age, sex and deprivation, 2011-12 to 2013-14

Condition	Direct Age Standardised Rate per 100,000	Sex Persons / Male / Female	Age Younger ---------- Older	Deprivation Most Deprived ----- Least Deprived
Asthma	All Persons = 126.5 Males = 102.0 Females = 149.6 Most Deprived = 159.6 Least Deprived = 91.1	 Female rates 47% higher	 Peak age group is 01 to 04	 Most deprived areas 75% higher
CHD	All Persons = 325.4 Males = 492.0 Females = 175.0 Most Deprived = 440.0 Least Deprived = 265.9	 Male rates 181% higher	 Peak age group is 80 to 84	 Most deprived areas 65% higher
CKD	All Persons = 37.9 Males = 49.9 Females = 28.1 Most Deprived = 50.3 Least Deprived = 20.1	 Male rates 78% higher	 Peak age group is 85 and over	 Most deprived areas 150% higher
COPD	All Persons = 143.0 Males = 154.1 Females = 134.9 Most Deprived = 322.4 Least Deprived = 81.1	 Male rates 14% higher	 Peak age group is 80 to 84	 Most deprived areas 299% higher
Diabetes	All Persons = 74.5 Males = 76.8 Females = 73.9 Most Deprived = 147.3 Least Deprived = 45.7	 Male rates 4% higher	 Peak age group is 80 to 84	 Most deprived areas 222% higher
Epilepsy	All Persons = 85.2 Males = 89.8 Females = 80.9 Most Deprived = 128.2 Least Deprived = 80.4	 Male rates 11% higher	 Peak age group is 00 to 00	 Most deprived areas 59% higher
Heart Failure	All Persons = 61.7 Males = 81.0 Females = 45.8 Most Deprived = 94.6 Least Deprived = 48.7	 Male rates 77% higher	 Peak age group is 85 and over	 Most deprived areas 94% higher
Stroke	All Persons = 141.6 Males = 165.1 Females = 120.2 Most Deprived = 183.1 Least Deprived = 113.9	 Male rates 37% higher	 Peak age group is 85 and over	 Most deprived areas 61% higher

Source: Secondary Uses Services, Commissioning Dataset, Inpatient Table, 2015

Box 4, Long-Term Conditions, Perceptions and Experiences

Healthwatch Devon undertook a survey of people living with long-term conditions in the county, which yielded 566 responses. The majority (63%) considered the care and support they received was good or excellent.

> *"…a good combination of day-to-day care from GP practice, with well-defined routes to more specialist care as and when I need it."*

Around two thirds were involved in decisions about their care, had enough information to manage their health, felt information provided was clear, had confidence in taking care of their own health or felt they had control over their care most of the time.

> *"I am listened to when I have a problem with the existing regime of medication, but there is no systematic, regular review."*

However, just under a fifth of respondents (18%) considered the care they received to be poor or very poor. Communication between mental and physical health services was highlighted as a particular area for concern, and concerns were also expressed about the sharing of information between health and social care services.

> *"The support varies between average and poor. Both my carer and myself feel isolated at times in seeking information and support."*
>
> *"More continuity would be good."*
>
> *"Agencies do not seem to liaise with each other over my varying health problems, or keeping my family informed."*

Two out of three respondents did not have a personal care plan, of which 95% had not talked it over with a professional. People highlighted communication, treating people as equal partners in their care, and holistic care were particularly important.

> *"You are helped at first and then left to your own devices."*
>
> "Look at all aspects of my health and have a holistic plan where all health professionals involved work together."

Source
Healthwatch Devon, 'People Living with Long Term Conditions' Report, December 2014
http://www.healthwatchdevon.co.uk/long-term-conditions/

9.14 Cancer

There are over 5,000 new cases of cancer diagnosed each year in Devon, with around 2,400 deaths due to the condition, representing around just under a third of all deaths. According to the Quality and Outcomes Framework, more than 30,000 are living with a diagnosis of cancer in Devon, Plymouth and Torbay. Figure 9.24 summarises the incidence and mortality figures for different types of cancer in Devon compared to the South West and England, and the trend over time. This reveals whilst the incidence of cancer has increased, due largely to longer life expectancy and improved detection, mortality rates have fallen due to improvements in treatment and long-term care, with many more people living with cancer. The pattern varies by type of cancer, with relatively high levels of malignant melanoma (skin cancer) in the county, and lower levels of lung cancer.

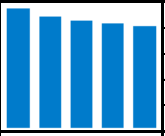
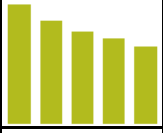
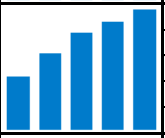
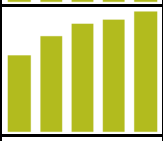
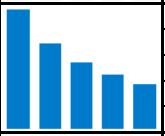
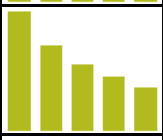
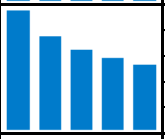
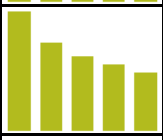
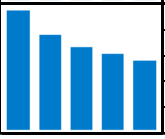
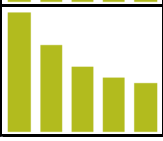
Figure 9.24, New cases (incidence) and deaths (mortality) from selected cancer types, Devon

Type	Measure	Devon PA	Devon rate	South West	England	Comparison	Trend
All Cancers	Incidence, all ages	5,078	594.6	598.2	586.3		
	Incidence, under 75	3,063	414.3	418.0	407.7		-
	Mortality, all ages	2,390	264.5	264.8	279.3		
	Mortality, under 75	994	130.9	134.3	144.4		
Malignant Melanoma	Incidence, all ages	296	36.3	31.2	22.8		
	Incidence, under 75	211	29.7	25.1	18.4		-
	Mortality, all ages	41	4.7	4.8	3.9		
	Mortality, under 75	24	3.2	3.1	2.5		
Lung Cancer	Incidence, all ages	504	57.7	64.2	76.0		
	Incidence, under 75	268	35.4	40.1	47.0		-
	Mortality, all ages	425	47.4	49.7	60.2		
	Mortality, under 75	210	27.2	29.0	34.3		
Colorectal Cancer	Incidence, all ages	708	80.9	80.7	77.2		
	Incidence, under 75	375	49.7	50.9	48.5		-
	Mortality, all ages	252	27.3	28.3	28.8		
	Mortality, under 75	81	10.7	12.5	13.4		
Stomach Cancer	Incidence, all ages	84	9.6	10.8	12.4		
	Incidence, under 75	43	5.8	6.1	6.7		-
	Mortality, all ages	54	6.1	6.6	8.1		
	Mortality, under 75	22	3.0	2.9	3.7		
Prostate Cancer	Incidence, all ages	746	190.5	188.1	174.1		
	Incidence, under 75	438	118.2	119.8	113.9		-
	Mortality, all ages	207	55.5	51.3	49.1		
	Mortality, under 75	48	12.9	12.0	11.7		
Breast Cancer	Incidence, all ages	757	170.2	171.7	163.6		
	Incidence, under 75	548	145.3	146.0	139.1		-
	Mortality, all ages	175	35.4	35.6	36.2		
	Mortality, under 75	83	21.5	21.7	22.6		
Cervical Cancer	Incidence, all ages	35	9.4	10.3	9.2		
	Incidence, under 75	29	9.2	10.2	9.0		-
	Mortality, all ages	11	2.6	2.9	2.8		
	Mortality, under 75	7	2.1	2.4	2.2		

Source: Compendium of Population Health Indicators, Health and Social Care Information Centre, 2015
Incidence = 2010-2012, trend = 1995 to 2012, Mortality = 2011-13, trend = 1995 to 2013

The following figure shows the pattern of cancer incidence and mortality in England by area deprivation using the 2010 Indices of Deprivation. This reveals that for all cancers incidence rates are 18% higher in more deprived areas compared with the least deprived, and mortality rates 53% higher. Considerable variation is seen by cancer type, with a clear relationship between certain cancer types and higher deprivation (lung cancer, stomach cancer and cervical cancer in particular), and some exhibiting a relationship with lower deprivation, such as malignant melanoma. What is clear throughout is health inequalities are always greater in mortality than in incidence rates, highlighting not only is the risk of being diagnosed with cancer is generally greater in more deprived areas, the likelihood of dying for those diagnosed is also higher.

Figure 9.25, Direct Age Standardised Incidence and Mortality rates per 100,000 population for selected cancers by deprivation, England, 2006-10 (incidence) and 2007-11 (mortality)

Type	Deprivation	Incidence Rate	Incidence Chart	Mortality Rate	Mortality Chart	Summary
All Cancers	Most Deprived	432.1		216.4		Incidence rates are up to 18% higher in deprived areas. Mortality rates are up to 53% higher in deprived areas.
	Above Average	401.9		186.4		
	Average	385.8		166.2		
	Below Average	376.0		154.1		
	Least Deprived	366.3		141.1		
Malignant Melanoma	Most Deprived	9.2		1.9		Incidence rates are up to 55% lower in deprived areas Mortality rates are up to 37% lower in deprived areas
	Above Average	13.2		2.4		
	Average	16.7		2.7		
	Below Average	18.6		2.8		
	Least Deprived	20.6		3.0		
Lung Cancer	Most Deprived	78.6		63.9		Incidence rates are up to 167% higher in deprived areas. Mortality rates are up to 172% higher in deprived areas.
	Above Average	56.6		46.1		
	Average	44.0		35.4		
	Below Average	35.7		28.7		
	Least Deprived	29.4		23.5		
Colorectal Cancer	Most Deprived	47.2		18.4		Incidence rates are up to 8% higher in deprived areas. Mortality rates are up to 22% higher in deprived areas.
	Above Average	46.0		17.1		
	Average	45.4		16.3		
	Below Average	44.6		15.6		
	Least Deprived	43.9		15.1		
Stomach Cancer	Most Deprived	12.0		7.8		Incidence rates are up to 85% higher in deprived areas. Mortality rates are up to 105% higher in deprived areas.
	Above Average	9.4		5.8		
	Average	8.0		4.9		
	Below Average	7.2		4.3		
	Least Deprived	6.5		3.8		
Prostate Cancer	Most Deprived	94.1		24.0		Incidence rates are up to 17% lower in deprived areas Mortality rates are up to 3% higher in deprived areas.
	Above Average	99.5		24.3		
	Average	103.2		24.4		
	Below Average	109.4		24.5		
	Least Deprived	113.3		23.2		
Breast Cancer	Most Deprived	59.9		14.3		Incidence rates are up to 13% lower in deprived areas Mortality rates are up to 8% higher in deprived areas.
	Above Average	64.0		14.1		
	Average	66.4		14.0		
	Below Average	67.8		13.5		
	Least Deprived	68.7		13.2		
Cervical Cancer	Most Deprived	11.9		3.7		Incidence rates are up to 72% higher in deprived areas. Mortality rates are up to 147% higher in deprived areas.
	Above Average	9.5		2.7		
	Average	8.2		2.0		
	Below Average	7.6		1.7		
	Least Deprived	6.9		1.5		

Source: Cancer by Deprivation in England 1996 - 2011, National Cancer Intelligence Network, 2014

Early Detection

Early detection of cancer greatly improves the chances of survival. The NHS Cervical Screening Programme screens more than three million women each year. Cancer Research UK estimates the programme saves more than 4,500 lives in England every year. Screening is used to detect abnormal cells on the cervix. Cervical cancer is one of the few preventable cancers, because screening picks up pre-cancerous changes. Early detection and treatment can prevent up to 75% of cervical cancers. Table 9.11 gives screening coverage by local authority of residence for March 2014. This highlights coverage rates for breast cancer and cervical cancer screening for women in Devon are above the national average.

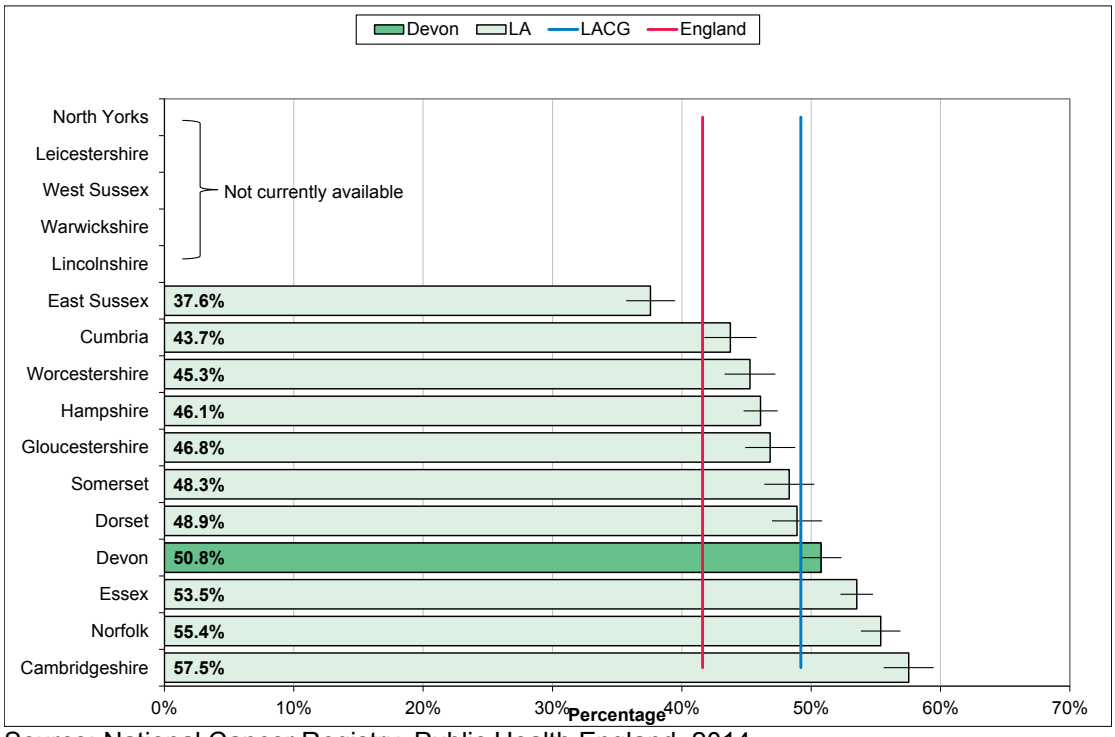
Table 9.11, Percentage of eligible women screen adequately, March 2014

Screening Type	Devon	South West	England
Breast cancer, aged 53 to 70	79.1%	78.9%	75.9%
Cervical cancer, aged 25 to 64 years	77.5%	76.2%	74.2%

Source: Health and Social Care Information Centre (Open Exeter), 2014

In 2012, 50.8% of diagnoses for selected cancers were diagnosed at an early stage (one or two). This is above the South West (47.8%), local authority comparator group (49.2%) and England (41.6%) rates. Within Devon the highest rates were seen in North Devon (58.0%) and Teignbridge (56.5%). These are experimental statistics, with poor data quality in some areas meaning data are not available. Differences between areas may relate to better coding and data quality, as well as earlier diagnosis.

Figure 9.26, Proportion of invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin, diagnosed at stage 1 or 2



Source: National Cancer Registry, Public Health England, 2014

9.15 Multi-Morbidity

Multi-morbidity is defined as the co-occurrence of two or more chronic medical conditions in one person. Long-term disorders are the main challenge facing health-care systems worldwide, but health systems are largely configured for individual diseases rather than multi-morbidity. A Scottish study by Barnett et al in 2012 (Barnett K, Mercer ST, Norbury M et al (2012) Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet 380: 37-43) considered the distribution of multi-morbidity, and of comorbidity of physical and mental health disorders, in relation to age and socioeconomic deprivation. Existing approaches focusing on patients with only one disease dominate most medical education, clinical research, and hospital care, but increasingly need to be complemented by support for the work of generalists, mainly but not exclusively in primary care, providing continuity, coordination, and above all a personal approach for people with multi-morbidity. This approach is most needed in socioeconomically deprived areas, where multi-morbidity happens earlier, is more common, and more frequently includes physical–mental health comorbidity. The paper concluded that the most deprived areas experienced multi-morbidity 10 -15 years earlier.

Table 9.12 presents estimates numbers and percentages of the population in Devon with certain number of long-term conditions. This highlights that over a third of the population are estimated to have one long-term condition (36.68%), around a seventh are likely to have two or more conditions (14.37%), and around one in 170 people are likely to have five or more long-term conditions. Figure 9.27 shows the pattern of people with different numbers of long-term conditions by age. This reveals that with increasing age some individuals may have increasing comorbidities, which will impact on emergency admissions. The peak age for multi-morbidity is 85 to 89, which highlights that those surviving into their nineties and beyond are likely to have fewer long-term conditions.

When deprivation is considered a different pattern emerges. Figures 9.28 and 9.29 display the percentage of the population with certain numbers of co-morbidities in the population in general and in those admitted to hospital in an emergency. Individuals living in the most deprived areas are typically around 10 to 15 years ahead in terms of the state of their health and this is even wider for certain age groups. For example, for emergency admissions 20.65% had five or more comorbidities in the 40-44 age group in the most deprived areas, which is actually higher than the 20.36% for the 55-59 age group in the least deprived areas. Similarly for the general population 3.11% of 40-44 year olds in the most deprived areas had three or more long-term conditions compared to 3.22% of 55-59 years olds in the least deprived areas. Whilst the divergence also begins at age 20, the factors influencing it begin much earlier as described in chapter 8. When you look at 85 to 89, 90 to 94 and 95 and over, the percentage with five or more comorbidities actually drops. There are two possible reasons; firstly in a very elderly group some comorbidities may be ignored or overlooked as health professionals focus on the ‘clear and present danger’, secondly those surviving to a very old age may actually be likely to have less long-term conditions, it is probably a mix of the two. It is also interesting to note that differences between areas based on social deprivation start falling at after the age of 90 and do not exist after the age of 95.

Figure 9.30 highlights the increased likelihood of having other long term conditions when someone has a selected long term condition. For each long term condition area the relative risk ratio indicates how many times more likely people are to have another long term condition compared to the reference group (those without the long term condition). It also highlights the relationship between physical and mental health, with the likelihood of serious mental illness (SMI) and depression also increasing when long-term conditions are present. So, for example, with Asthma you are almost four times more likely to have COPD than if you didn’t have asthma and 1.6 times more likely to have depression. Whilst some of the co-morbidities illustrated here are unsurprising others are less well known or expected. Some clusters of multiple long term conditions are more likely than others. For example, someone with Heart Failure is seven times more likely to have chronic kidney disease, five times more likely to have CHD, and four times more likely to have a serious mental illness than someone who doesn’t have heart failure. Equally someone with Chronic Kidney Disease is almost seven times more likely to have heart failure but also almost 4 times more likely to have CHD, over

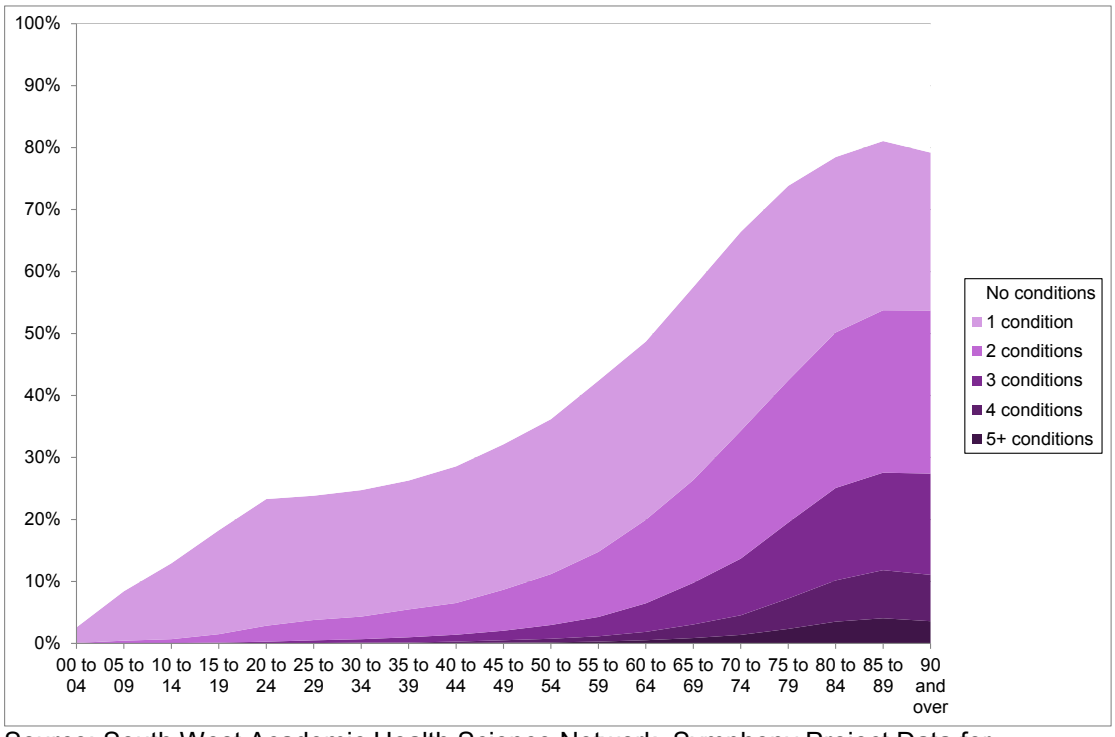
3.5 times more likely to have diabetes and 3.3 times more likely to have a serious mental illness and hypertension compared to someone who does not have CKD. Someone with diabetes is almost three times more likely to have CKD, 2.4 times more likely to have heart failure and 2.3 times more likely to have hyperthyroidism than someone without diabetes.

Table 9.12, Estimated number of long-term conditions in Devon, 2013-14

Number of long-term conditions	Number	Percentage
No Conditions	479,968	63.32%
1 Condition	169,195	22.32%
2 Conditions	67,837	8.95%
3 Conditions	26,959	3.56%
4 Conditions	9,738	1.28%
5 Conditions	3,141	0.41%
6 Conditions	951	0.13%
7 Condition	216	0.03%
8 or more Conditions	46	0.01%
Total	758,052	100.00%

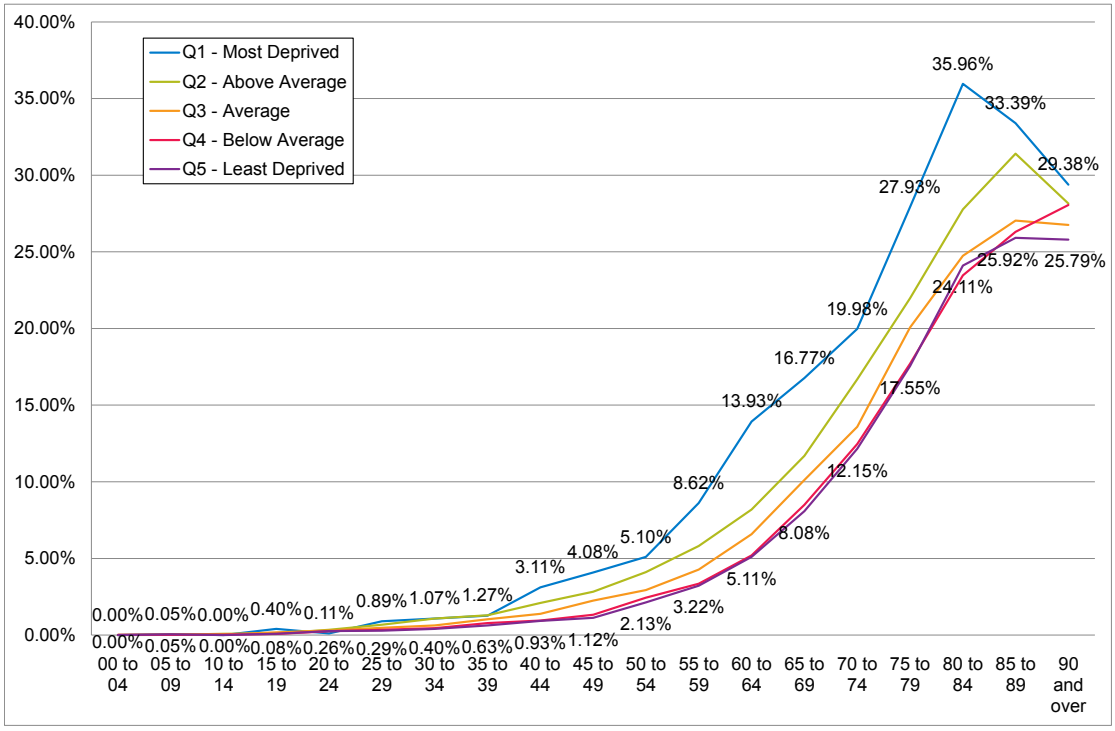
Source: South West Academic Health Science Network, Symphony Project Data for Somerset modelled by age, sex and deprivation for the Devon population, 2014

Figure 9.27, Estimated percentage of population with selected long-term conditions by age group in Devon, 2013-14



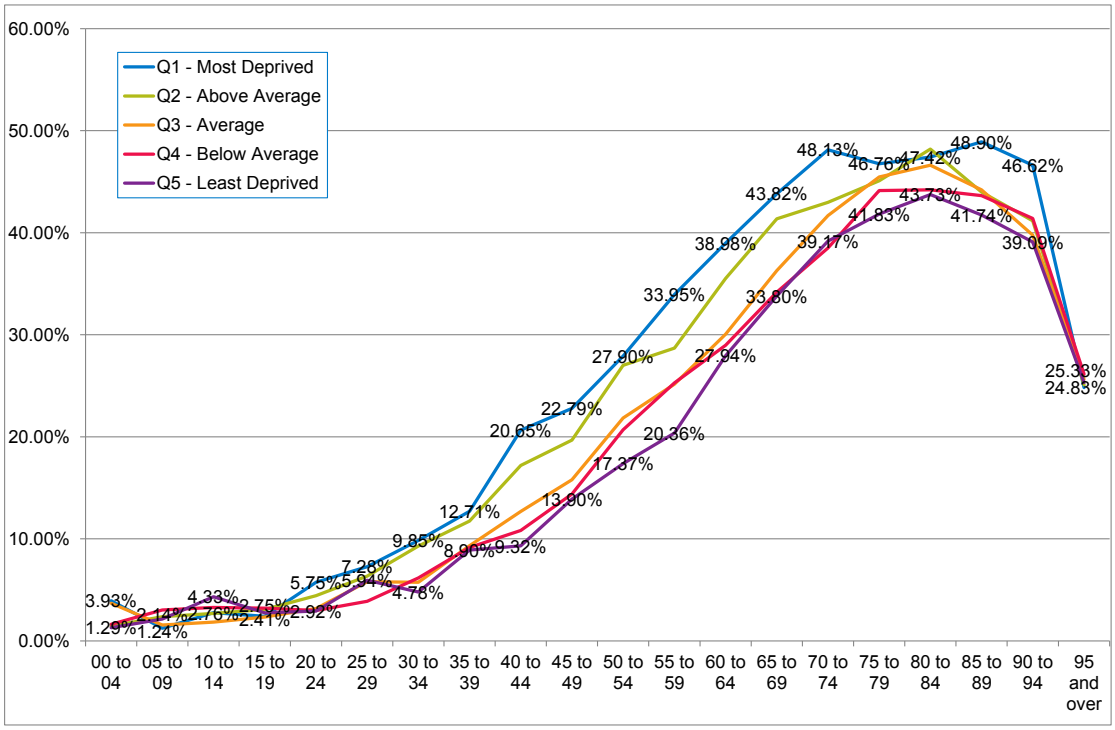
Source: South West Academic Health Science Network, Symphony Project Data for Somerset modelled by age, sex and deprivation for the Devon population, 2014

Figure 9.28, Percentage with three or more selected long-term conditions by Index of Multiple Deprivation National Quintile and Age (Somerset Symphony data applied to Devon resident population)



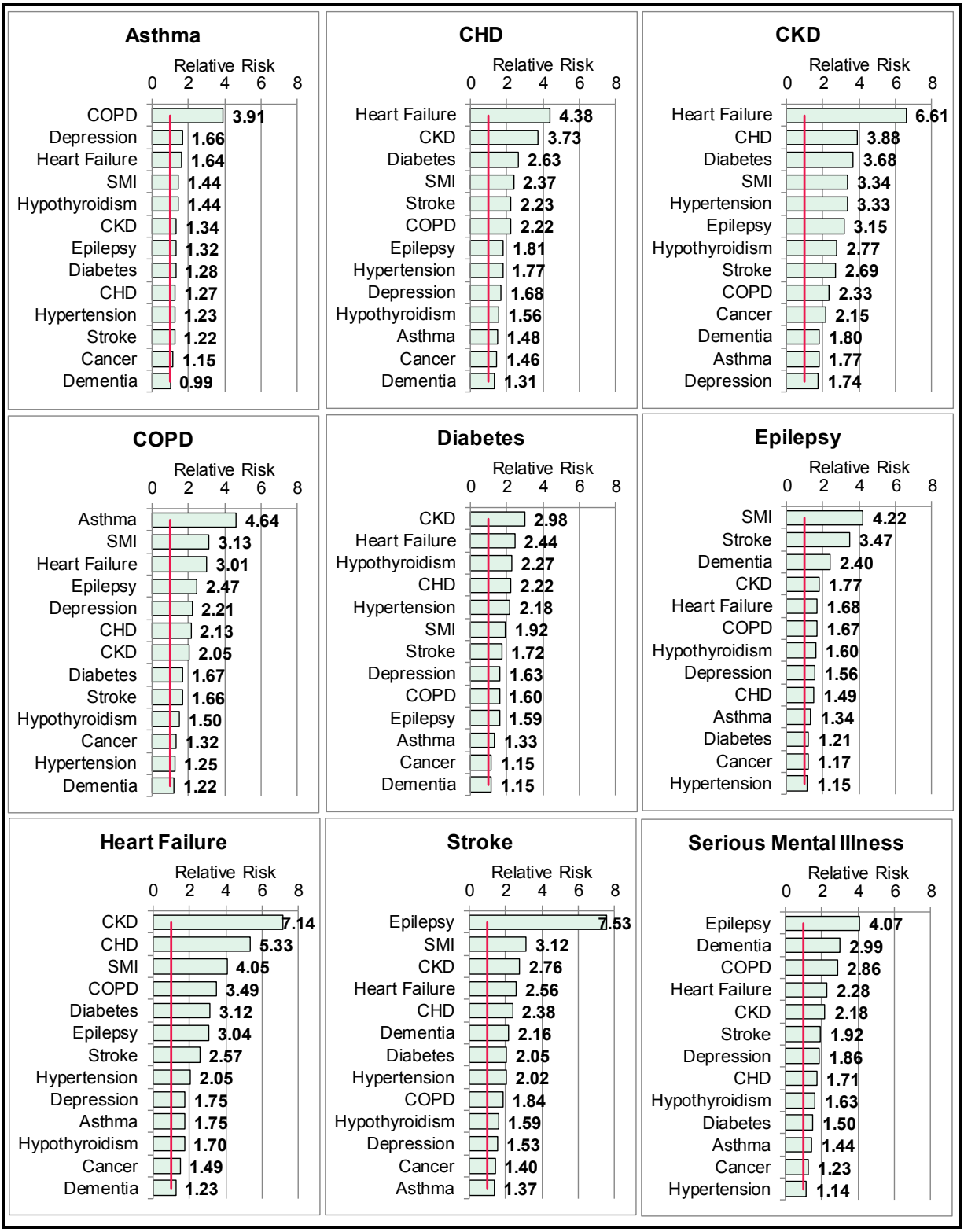
Source: South West Academic Health Science Network, Symphony Project Data for Somerset modelled by age, sex and deprivation for the Devon population, 2014

Figure 9.29, Percentage of emergency admissions with five or more co-morbidities by age and area deprivation, Devon, 2013-14



Source: Secondary Uses Services, Inpatient Dataset, 2014

Figure 9.30, Relative risk ratios showing the increased likelihood of being treated for other conditions for persons with select long-term conditions or serious mental illness, 2013-14 (Somerset Symphony data applied to Devon population), red line shows relative risk of 1 (same likelihood)



Source: South West Academic Health Science Network, Symphony Project Data for Somerset modelled by age, sex and deprivation for the Devon population, 2014
SMI = Serious Mental Illness

10. Ageing Well: Older People

The following section aims to identify topics that are of particular concern to older people. As identified in chapter four, Devon is expected to experience the greatest population growth in the older age groups. There are around 181,600 people aged between 65 and over in Devon, of which around 15,600 are supported in social care (2013-14 RAP return).

10.01 Prevention in Older Age

The focus of prevention in older age groups is around healthy active ageing and supporting independence so older people area able to enjoy long and healthy lives, feeling safe at home and connected to their community.

Healthy ageing is associated with being physically active, not smoking, eating healthily, maintaining a healthy weight and drinking alcohol sensibly. Therefore, changing these common behavioural risk factors during adult life, not only reduces the risk of non-communicable disease (such as heart disease or stroke), but also helps prevent dementia, disability and frailty.

In January 2014, NHS England published Safe, compassionate care for frail older people using an integrated care pathway: http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf.

Their pathway contains nine stages, each containing evidence-based examples taken from the Silver Book: http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf, and the King's Fund's Making our health and care systems fit for an ageing population http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population. The nine stages are:

1. Healthy active ageing and supporting independence
2. Living well with simple or stable long-term conditions
3. Living well with complex comorbidities, dementia and frailty
4. Rapid support close to home in a crisis
5. Good acute hospital care when (and only when) needed
6. Good discharge planning and post-discharge support
7. Good rehabilitation and re-ablement after acute illness or injury
8. High quality nursing and residential care for those who truly need it
9. Choice, control and support towards the end-of-life

Further to this, the National Institute for Clinical Excellence (NICE) have recently published draft guidance on mid-life approaches to the prevention of dementia, disability and frailty entitled 'Disability, dementia and frailty in later life - mid-life approaches to prevention': https://www.nice.org.uk/guidance/indevelopment/GID-PHG64/consultation

This guidance emphasises changes to these behavioural risk factors during adult life will reduce the risk of dementia, disability and frailty in later life. The NHS Health Check programme provides one mechanism to do this. Individual behaviour change approaches such as this are likely to be more cost effective and less likely to widen health inequalities when combined with population-based approaches.

Box 5, Non-Urgent Care, Perceptions and Experiences

In 2014 Healthwatch Devon ran a survey on non-urgent care which received over 500 responses. The survey was focused on access to primary care services, in response to national findings from Healthwatch England highlighting that some people were resorting to using urgent care services, such as accident and emergency departments due to difficulties in accessing primary care.

The majority of respondents found it easy to make an appointment with their GP.

> "I feel my GP surgery is very good. I am always able to get an appointment if I need one, on the same day. The staff are friendly and helpful and the surgery is located in the same building as a pharmacy, which is very useful"

Around a quarter had some difficulty.

> "Trying to get an appointment to see someone is like getting blood from a stone…when you ring at 8.30am everyone else is ringing at the same time"

Concerns and issues highlighted included:

- Rigid appointment booking systems
- Not being able to get through to make an appointment on the telephone
- Not being able to see the GP of choice on the day
- Long waiting times to see a named GP
- Staff attitude and communication, particularly within reception
- If people are not able to make an appointment with their GP, the majority of those surveyed would visit their local pharmacy, slightly more than a fifth would call 111 and a further fifth would 'do nothing'
- A quarter of those surveyed were unsure about the range of services available to them if they required non urgent medical treatment or advice
- Walk-In Centres were praised by many people as being a useful resource, with several suggesting that there should be more places where people can walk in and be seen by a medical professional without the need to book an appointment
- Responses suggest that more information needs to be made available to the public to explain the 111 Service
- Many people were unsure what 'non-urgent' means and those surveyed suggested that people need more information and advice to help people understand when it is necessary to go to A&E, or when another service would be more appropriate.

Source
Healthwatch Devon, 'Speaking out on non-urgent care' Report, August 2014
http://www.healthwatchdevon.co.uk/non-urgent-care

10.02 Life Expectancy at Age 65

As with life expectancy at birth, variations also exist across Devon for life expectancy at the age 65, which highlights how many years, on average, someone reaching the age of 65 can expect to live. Table 10.1 sets out the current average life expectancy at age 65 in Devon, with males living 18.7 years and females living 21.1 years on average, a difference of 2.4 years. Figure 10.1 shows the trend in male and female life expectancy at age 65, highlighting that life expectancy has increased over recent years, and that life expectancy at age 65 in Devon has been consistently above the England average.

Table 10.1, Average Life Expectancy at Age 65, Devon Local Authorities, 2011-13

Area	Males		Females	
	Average Life Expectancy	95% Confidence Interval	Average Life Expectancy	95% Confidence Interval
East Devon	20.0	(19.7 to 20.3)	22.1	(21.8 to 22.4)
Exeter	18.5	(18.1 to 18.9)	22.2	(21.8 to 22.6)
Mid Devon	19.9	(19.5 to 20.4)	23.0	(22.5 to 23.4)
North Devon	19.2	(18.8 to 19.6)	21.3	(20.9 to 21.6)
South Hams	20.0	(19.6 to 20.4)	22.5	(22.1 to 22.9)
Teignbridge	19.0	(18.7 to 19.3)	22.1	(21.8 to 22.5)
Torridge	19.0	(18.6 to 19.5)	21.2	(20.8 to 21.7)
West Devon	19.2	(18.7 to 19.7)	21.8	(21.3 to 22.2)
Devon	19.4	(19.3 to 19.6)	22.0	(21.9 to 22.2)
South West	19.2	(19.1 to 19.3)	21.7	(21.6 to 21.7)
England	18.7	(18.7 to 18.7)	21.1	(21.1 to 21.2)

Source: Health and Social Care Information Centre, Compendium of Population Health Indicators, 2015

Figure 10.1, Trend in Average Life Expectancy at Age 65 in Years in Devon and England, 2000-02 to 2011-13

	2000-02	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13
Devon, Males	17.1	17.3	17.5	17.7	18.1	18.4	18.7	19.0	19.1	19.4	19.3	19.4
England, Males	16.1	16.3	16.5	16.8	17.1	17.4	17.6	17.9	18.1	18.4	18.6	18.7
Devon, Females	20.3	20.4	20.5	20.7	21.1	21.4	21.5	21.5	21.7	21.9	22.0	22.0
England, Females	19.2	19.3	19.4	19.6	19.9	20.1	20.3	20.5	20.7	21.1	21.1	21.1

Source: Health and Social Care Information Centre, Compendium of Population Health Indicators, 2015

Differences in average life expectancy exist within Devon, with shorter life expectancy seen in more deprived areas and areas with a high concentration of care homes. This is highlighted by the fact that average life expectancy at the age of 65 in the most deprived areas of Devon is 18.4 years compared to 21.8 years in the least deprived areas, a difference of 3.4 years.

10.03 Frailty

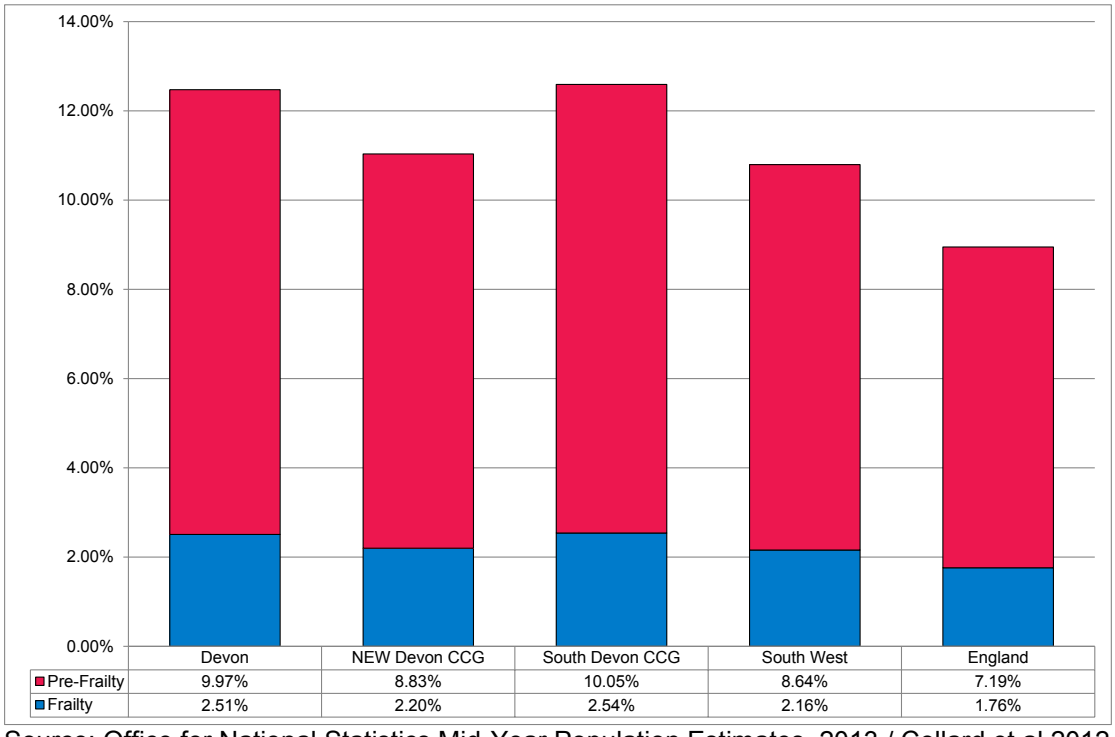
Frailty is not an inevitable consequence of ageing. Many people live to an advanced age while maintaining physical and cognitive function, functional independence and a full and active life, with ill health and disability compressed into a relatively short period before death. However, in a proportion of people, the normal gradual age-related decline in multiple body systems is accelerated, resulting in limited functional reserve, so that even a relatively minor illness or event has a substantial impact on health. This increased vulnerability is termed frailty.

An increased risk of adverse health outcomes can be predicted by early identification of frailty, and adverse outcomes prevented by appropriate multidisciplinary interventions. Frailty in older people negatively impacts on their quality of life and causes ill-health and premature mortality. Older people who are frail have an increased risk of falls, disability, long-term care and death.

Using a methodology developed by Collard et al in 2012 (Collard et al, 2012. Prevalence of frailty in community-dwelling older persons: A systematic review. J Am Geriatr Soc; 60: pp1487-92), it is estimated that approximately 11% of over 65 year olds are frail, defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed and weak grip strength. About 42% of over 65 year olds have one or two of these symptoms and are categorised as pre-frail.

This equates to 2.51% (19,001 people) of the Devon population who are frail and 9.97% (75,546 people) who are pre-frail as shown in figure 10.2 and table 10.2 below.

Figure 10.2, Estimated percentage of total population who are frail or pre-frail and aged 65 and over



	Devon	NEW Devon CCG	South Devon CCG	South West	England
Pre-Frailty	9.97%	8.83%	10.05%	8.64%	7.19%
Frailty	2.51%	2.20%	2.54%	2.16%	1.76%

Source: Office for National Statistics Mid-Year Population Estimates, 2013 / Collard et al 2012

Table 10.2, Older People Frail Estimates, Devon, 2013

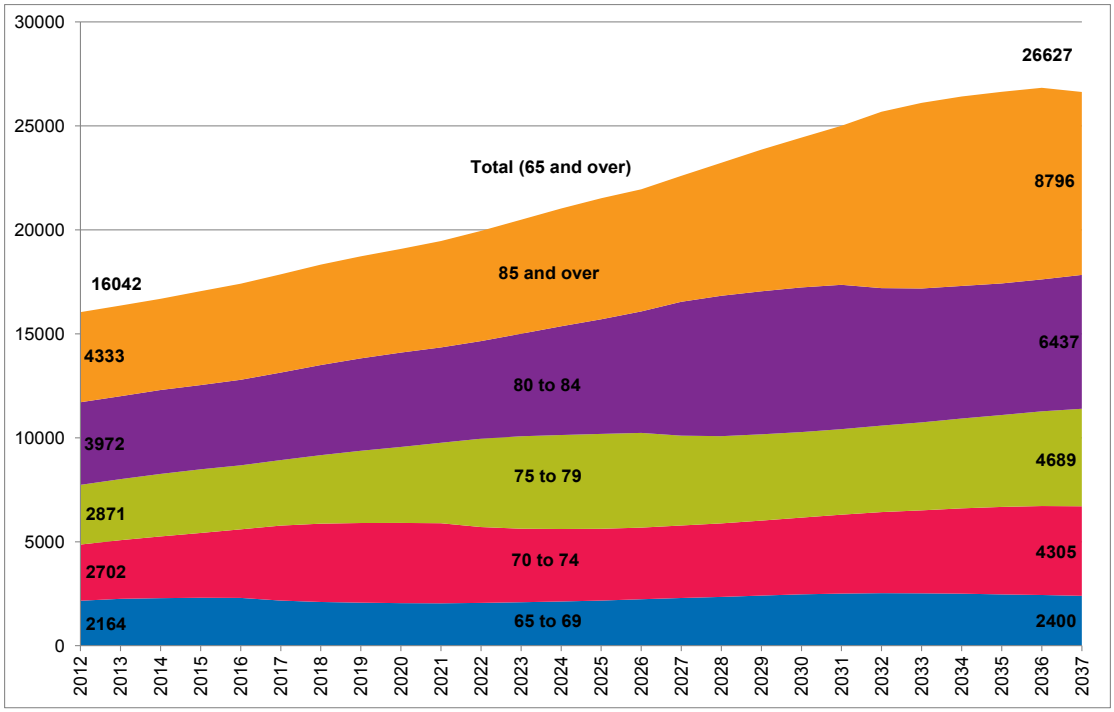
Age Group	Reported Frailty Rate	Reported Pre-Frailty Rate	Population	Estimated Frailty	Estimated Pre-Frailty
65 and over	-	41.6%	181,600	19,001	75,546
65 to 69	4.0%	-	56,422	2,257	-
70 to 74	7.0%	-	40,334	2,823	-
75 to 79	9.0%	-	32,639	2,938	-
80 to 84	15.7%	-	25,408	3,989	-
85 and over	26.1%	-	26,797	6,994	-

Source: Office for National Statistics Mid-Year Population Estimates, 2013 / Collard et al 2012

As these estimates focus on older people over 65 years of age with either frailty or pre-frailty, it is important to note that these are likely to be underestimates, as a proportion of the under 65 year old population will meet the criteria for frailty and pre-frailty.

Figure 10.3 reveals how the number of older people who are frail is predicted to rise over the next 25 years, increasing from 16,042 in 2012 to 26,627 in 2037.

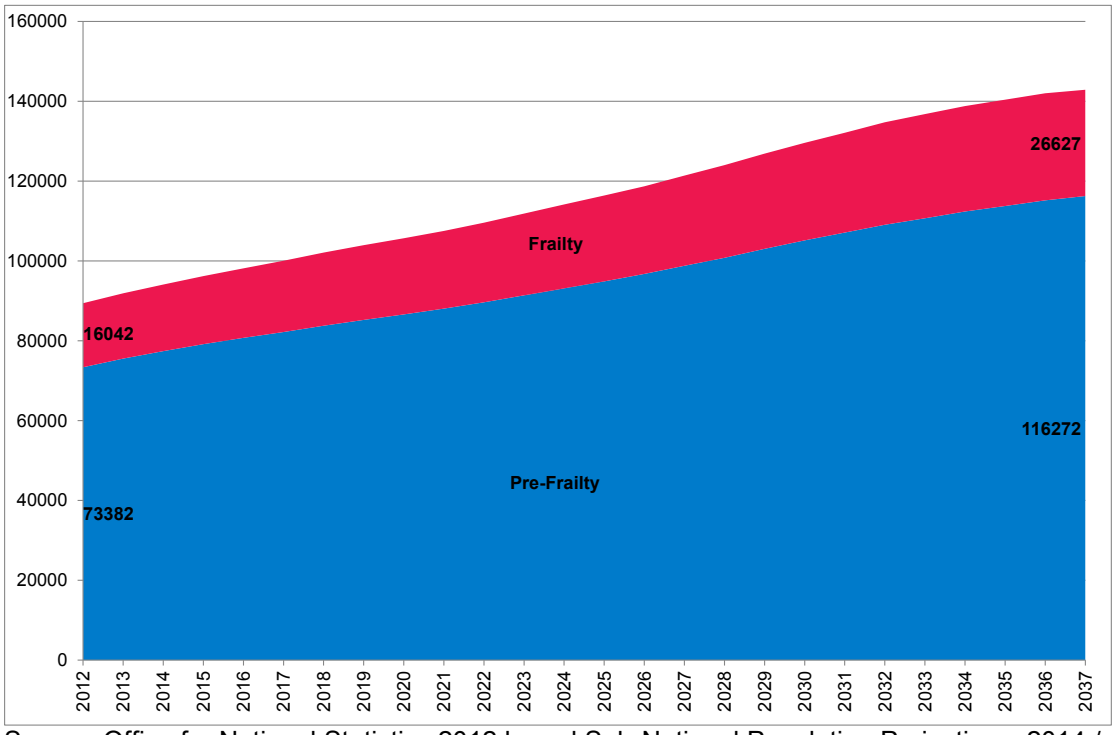
Figure 10.3, Frailty Projections by Age Group, Devon, 2012 to 2037



Source: Office for National Statistics 2012 based Sub-National Population Projections, 2014 / Collard et al 2012

As illustrated in figure 10.4, it is predicted that by 2037 there will be 26,627 older people who are frail and 116,272 who are pre-frail.

Figure 10.4, Frailty and Pre-Frailty Projections, Devon, 2012 to 2037



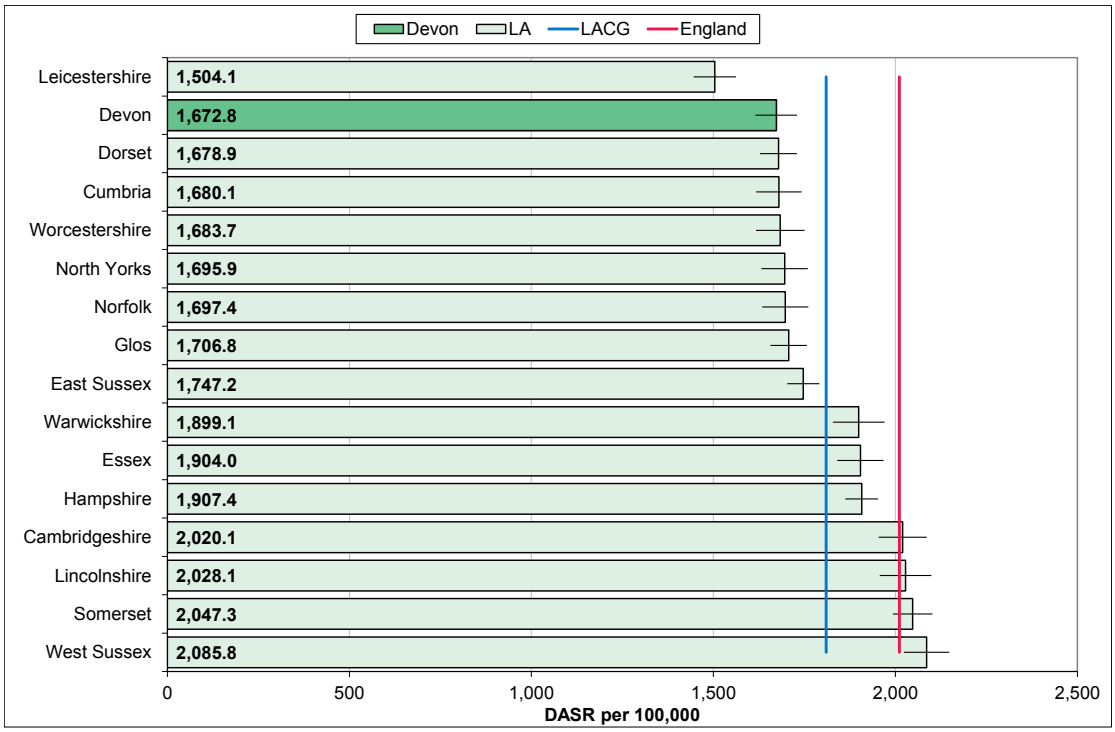
Source: Office for National Statistics 2012 based Sub-National Population Projections, 2014 / Collard et al 2012

10.04 Falls

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

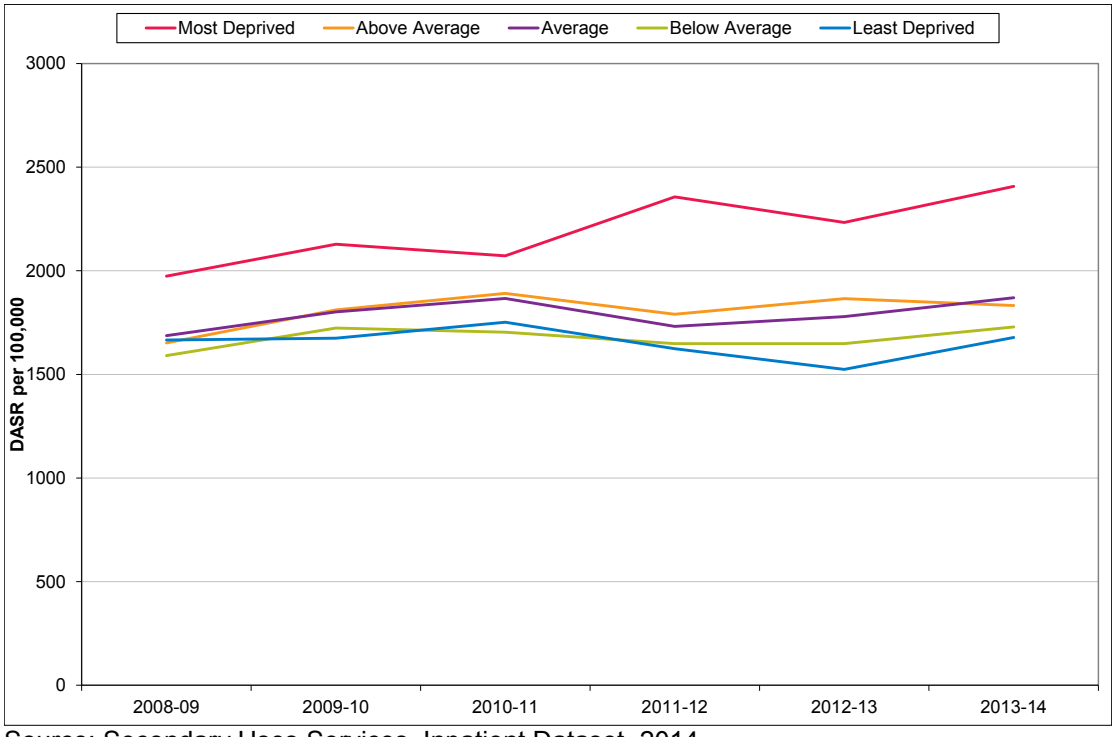
There were 3,259 emergency hospital admissions due to falls in 2012-13 in Devon for people aged 65 and over. The age standardised rate per 100,000 was 1672.8 in Devon, which is below the South West (1875.6), local authority comparator group (1809.9) and England (2011.0) rates. The rate in Devon is the second lowest in the South West and the second lowest in Devon's local authority group, as illustrated in figure 10.5. Within Devon rates were significantly lower in Mid Devon (1363.2). Rates have fallen on 2010-11 levels (1737.6). Age standardised admission rates have remained consistently higher in the most deprived deprivation quintile. Whilst the gap narrowed in 2012-13, the rate in the most deprived areas (2233.1) was still 47% higher than the least deprived areas (1523.9) as shown in figure 10.6. Rates increase sharply with age with an age-specific rate of 484.2 for persons aged 65 to 69, compared with 6146.8 for those aged 85 and over.

Figure 10.5, Emergency admission following an accidental fall for persons aged 65 and over, direct age standardised rate per 100,000, Devon Local Authority Comparator Group, 2012-13



Source: Public Health Outcomes Framework, 2015

Figure 10.6, Trend in emergency admission following an accidental fall by Index of Multiple Deprivation national quintile, direct age standardised rate per 100,000, Devon, 2008-09 to 2013-14

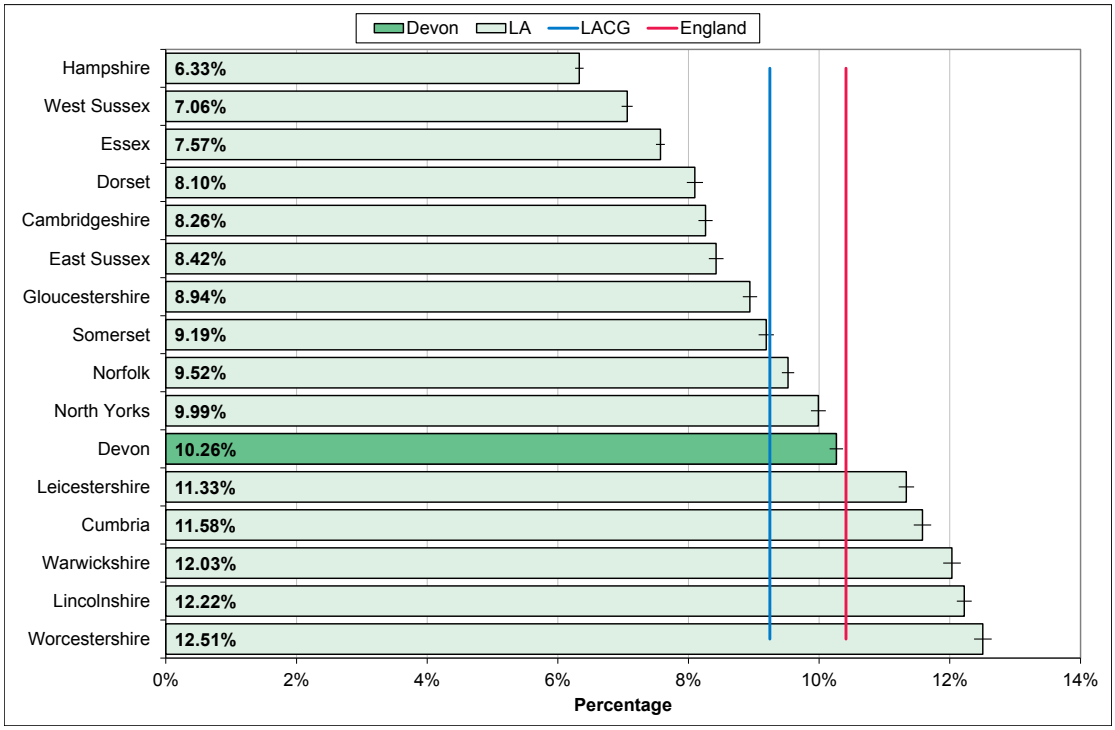


Source: Secondary Uses Services, Inpatient Dataset, 2014

10.05 Fuel Poverty

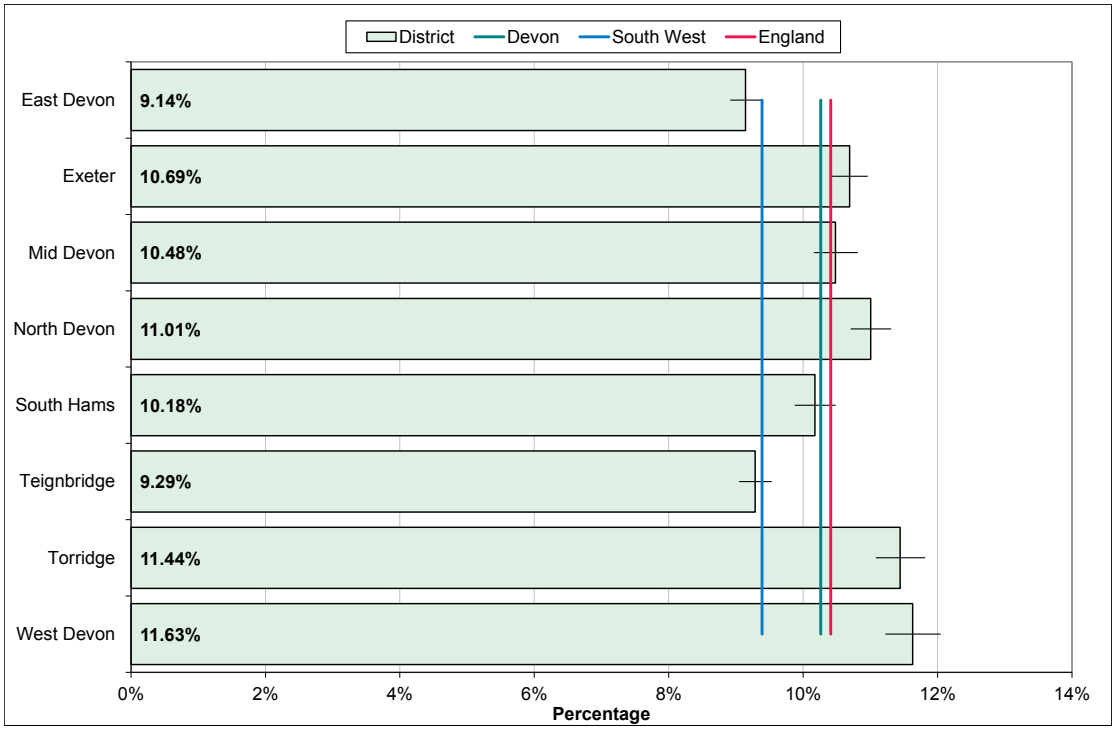
Just over one in 10 households in Devon are in fuel poverty (10.26%), which is above the South West (9.39%) and local authority comparator group (9.24%) rates but below the England (10.41%) rates. The relationship with similar local authorities is shown in figure 10.7. Within Devon the highest levels of fuel poverty were seen in West Devon (11.63%) and the lowest were seen in East Devon (9.14%) as revealed in figure 10.8. Levels of fuel poverty increased between 2011 and 2012 in Devon but fell in many other areas of the country. Fuel poverty in more common in groups with lower household incomes including pensioners, persons on benefits, and working families with below average earnings. The low wage economy, particularly in North and West Devon and higher living costs contribute to levels of fuel poverty locally.

Figure 10.7, Percentage of households that experience fuel poverty based on the 'Low income, high cost' methodology, Devon Local Authority Comparator Group, 2012



Source: Department of Energy and Climate Change (DECC), 2014

Figure 10.8, Percentage of households that experience fuel poverty based on the 'Low income, high cost' methodology, Devon Local Authority Districts, 2012



Source: Department of Energy and Climate Change (DECC), 2014

10.06 Carers

The table below shows the number of people providing unpaid care in the county according to the 2011 Census, which reveals over 84,000 carers and over 18,000 providing unpaid care for 50 hours or more per week.

Table 10.3, Carers in Devon and hours of care provided: 2011 Census

Provides unpaid care: Total	**84,492**
Provides 1 to 19 hours unpaid care a week	56,249
Provides 20 to 49 hours unpaid care a week	9,831
Provides 50 or more hours unpaid care a week	18,412

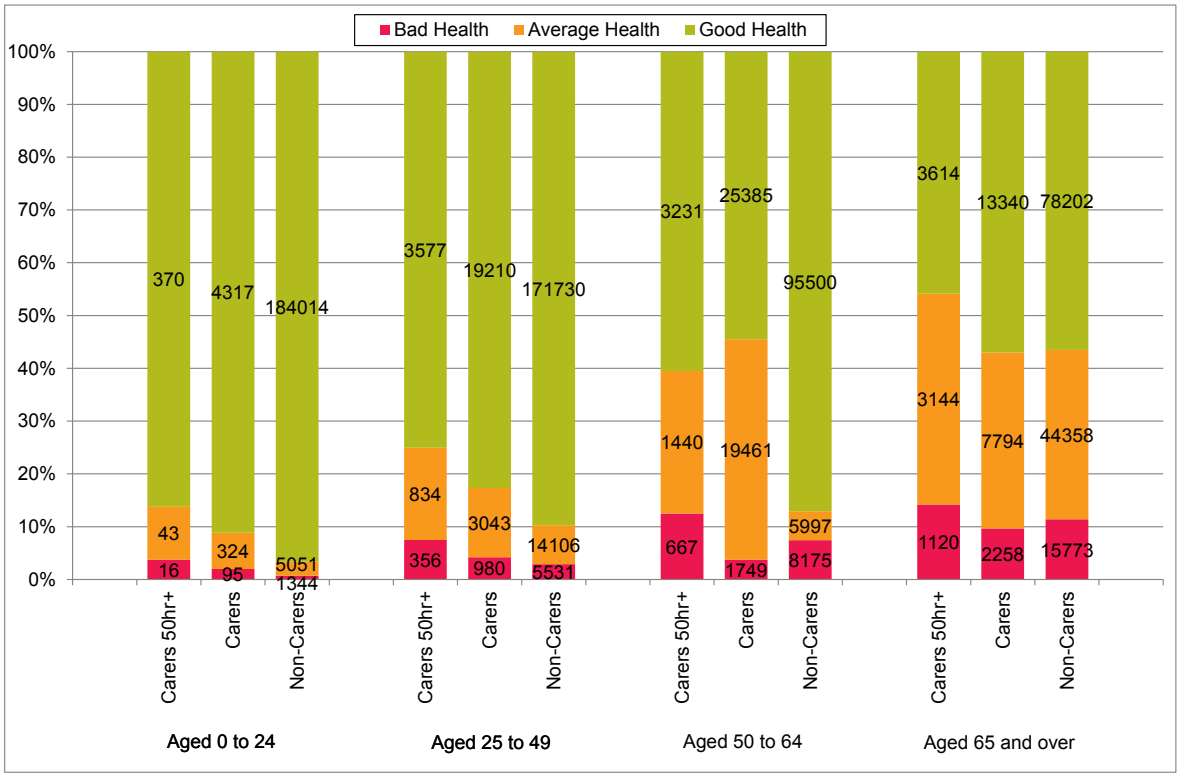
Source: 2011 Census, Office for National Statistics

While recognising the particular needs of young carers and for preventive action the 2010 Carers Needs Assessment recommended carer support should be particularly targeted at carers who are:

- Caring for more than 50hrs per week
- Over the age of 65
- Caring for someone with a deteriorating physical condition or mental health problems
- Making the transition from caring for a child in transition to adulthood
- Caring for someone at the end of their life

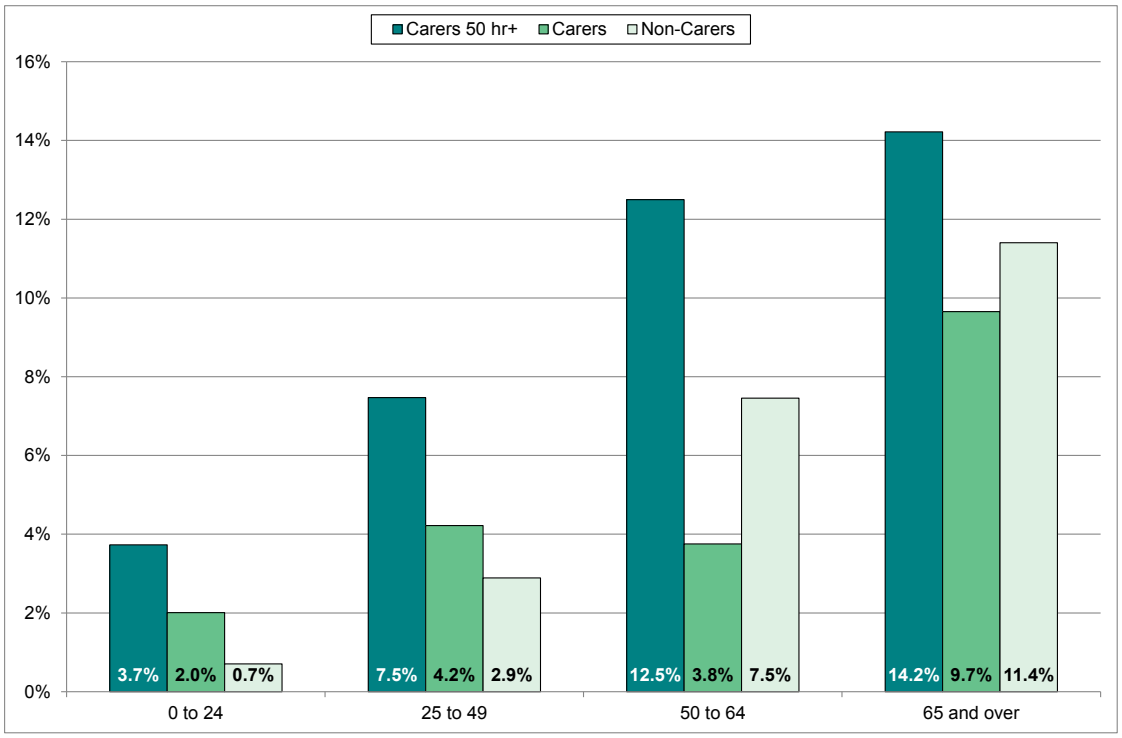
Carers tend to be in poorer health than non-carers, and higher levels of unpaid care are associated with particularly poor general health. Figures 10.9 and 10.10 provide a breakdown of health by age for non-carers, carers, and those who provide unpaid care for 50 hours or more from the 2011 census. The health of young carers and persons aged 25 to 49 is notably worse than non-carers. Levels of good health are significantly higher in non-carers in the 50 to 64 age group, and for persons aged 65 and over whilst the general health of carers and non-carers is similar, for those providing unpaid care for 50 hours or more general health is notably worse.

Figure 10.9, Self-Reported Health by Unpaid Care Provision and Age in Devon, 2011 Census



Source: 2011 Census, Office for National Statistics

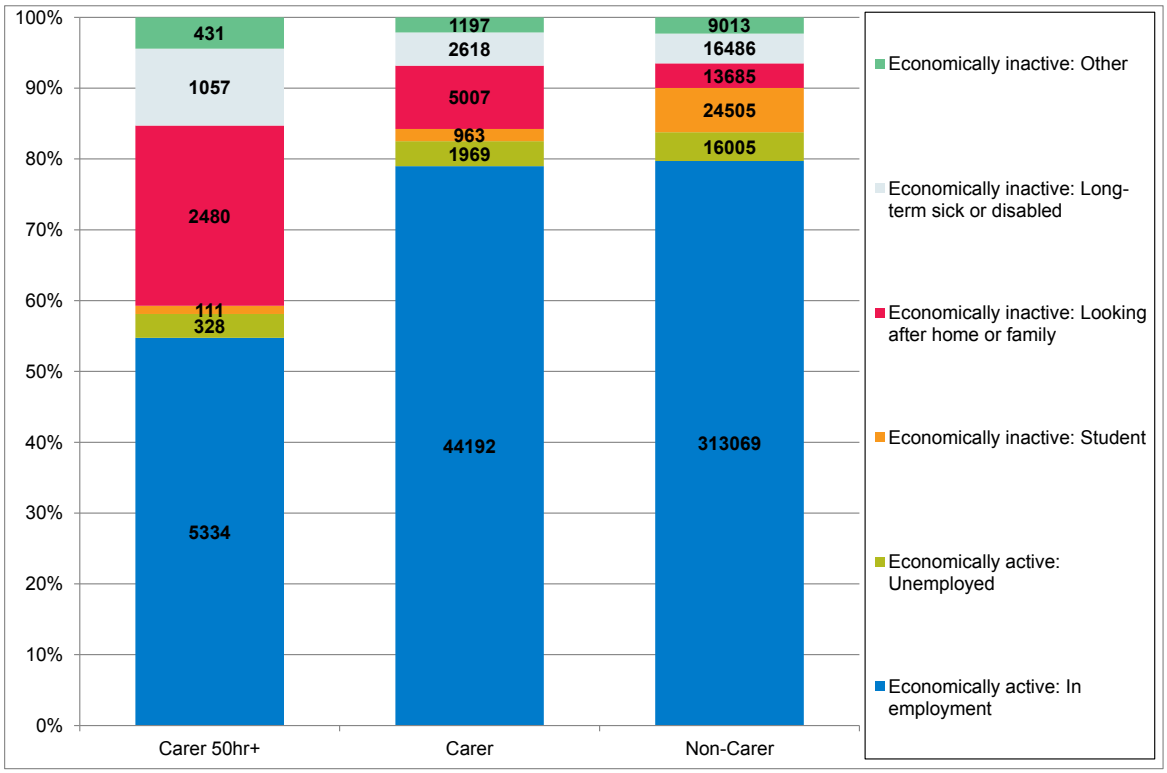
Figure 10.10, Percentage in Bad Health by Unpaid Care Provision and Age in Devon, 2011 Census



Source: 2011 Census, Office for National Statistics

Levels of economic activity are also much lower in persons who provide unpaid care. Figure 10.11 reveals non-carers have higher employment levels, whilst unpaid carers are more likely to be long-term sick or disabled, or defined as 'looking after family or home'.

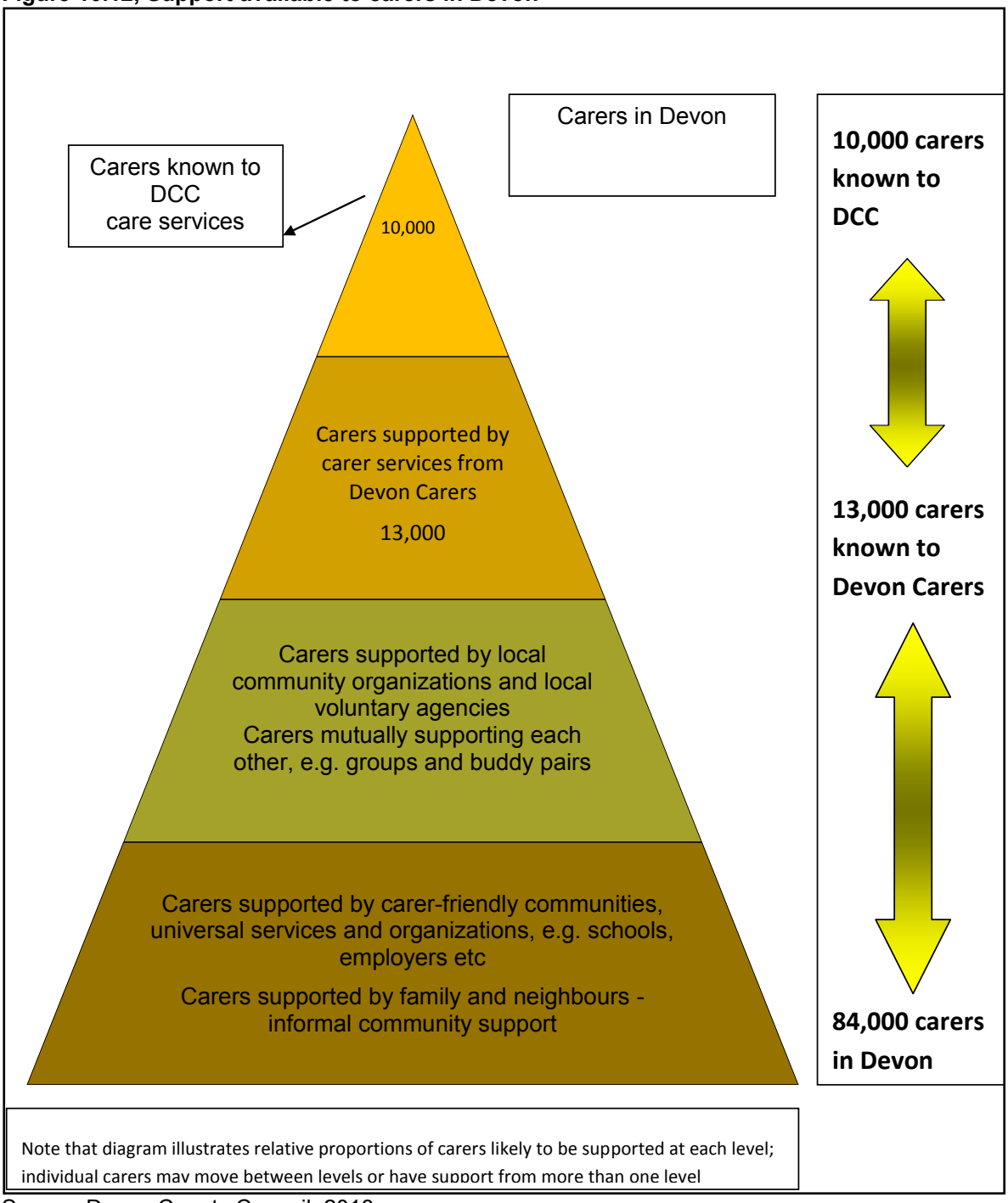
Figure 10.11, Economic Activity by Unpaid Care Provisions in Devon (16+), 2011 Census (excluding retirees)



Source: 2011 Census, Office for National Statistics

Figure 10.12 reveals levels of support available to carers in Devon. This reveals whilst a fairly small proportion of all carers have sought or are receiving support from Devon County Council or Devon Carers, with most being supported either through informal community and familial support, voluntary agencies and non-specialist services.

Figure 10.12, Support available to carers in Devon



Source: Devon County Council, 2013

10.07 Visual Impairment

Visual impairment occurs when a person has sight loss that cannot be fully corrected by wearing glasses or contact lenses. The term covers a number of conditions, including Glaucoma, Macular Degeneration and Cataracts, along with more general problems of low vision, which can be associated with the ageing process.

Definitions for common eye conditions are provided below:

- **Glaucoma** – a condition of increased pressure within the eyeball, causing gradual loss of sight.
- **Age-Related Macular Degeneration (AMD)** – an eye condition and a leading cause of vision loss among people age 50 and older. It causes damage to the macula, a small spot near the centre of the retina and the part of the eye needed for sharp, central vision, which lets us see objects that are straight ahead.
- **Cataracts** – a condition in which the lens of the eye becomes progressively opaque, resulting in blurred vision

The likelihood of having eye health conditions increases with age, and the older age profile in Devon contributes to higher prevalence rates locally. The most common condition is cataracts, which affect around 23,100 people in Devon or just over 3% of the total population. Around 18,600 people are defined as having impaired vision (poor visual acuity and/or reduced field of vision); of which around 2,900 are severely impaired where a person is so impaired they cannot do any work for which eyesight is essential. Population ageing and growth have a major impact on the prevalence of these conditions in the population, and their rate of increase, with an increase of around 11 to 14% in visual impairment and associated conditions expected in Devon over the next five years.

Table 10.4, Prevalence of Eye Health Conditions, Devon, 2015 to 2035

District	2015	2020	2025	2030	2035
Glaucoma	9,626 (1.26%)	10,671 (1.36%)	11,812 (1.46%)	13,156 (1.58%)	14,130 (1.66%)
Age-Related Macular Degeneration (AMD)	9,666 (1.27%)	10,858 (1.38%)	12,520 (1.55%)	14,563 (1.75%)	15,973 (1.88%)
Cataracts	23,121 (3.03%)	25,955 (3.30%)	28,914 (3.57%)	32,383 (3.89%)	35,026 (4.13%)
Impaired Vision	18,586 (2.43%)	21,024 (2.67%)	24,433 (3.02%)	28,697 (3.45%)	32,299 (3.80%)
slight impairment	*15,682 (2.05%)*	*17,721 (2.25%)*	*20,527 (2.53%)*	*23,972 (2.88%)*	*26,927 (3.17%)*
severe impairment	*2,904 (0.38%)*	*3,304 (0.42%)*	*3,906 (0.48%)*	*4,725 (0.57%)*	*5,373 (0.63%)*

Source: Moorfields Eye Hospital (prevalence) and ONS Sub-National Population Projections, 2014 (population)

Prevalence rates for visual impairment and associated conditions vary by local authority in Devon, with the lowest percentage prevalence in areas with a younger age profile, such as Exeter and Torridge, and the highest rates seen in East Devon and Teignbridge. Table 10.5 sets out current estimated prevalence for Glaucoma, Age Related Macular Degeneration, Cataracts and Impaired Vision by local authority district.

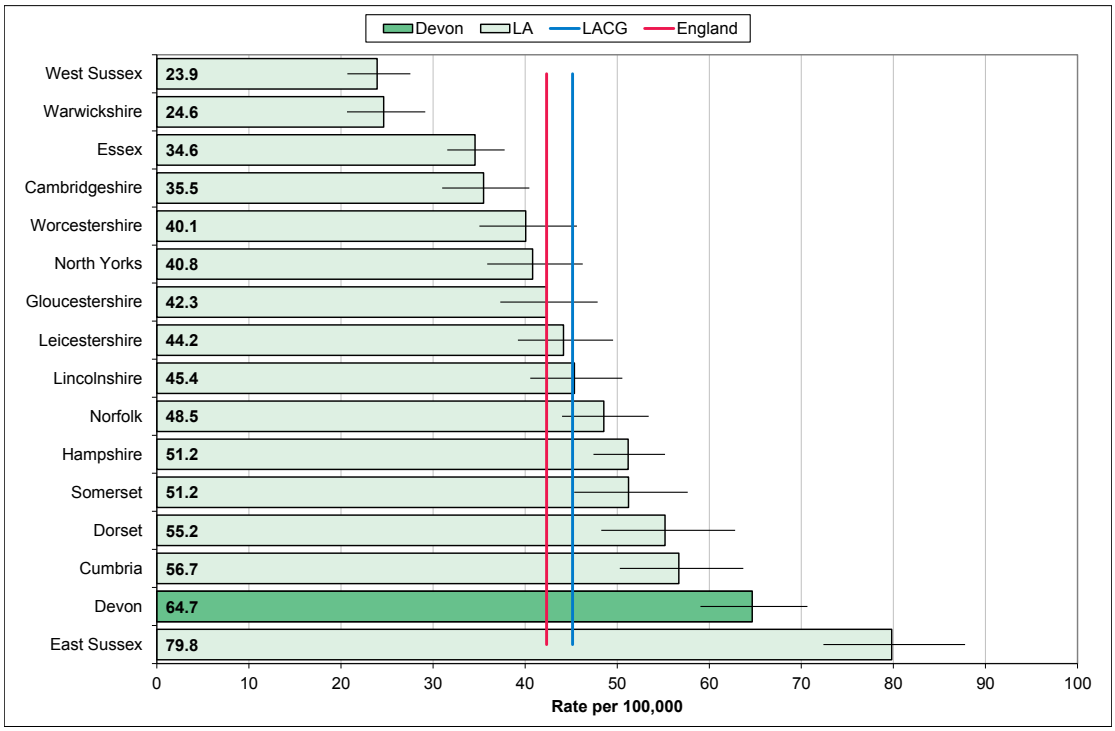
Table 10.5, Number and proportion of people with selected eye conditions by Local Authority District, 2015

District	Glaucoma	AMD	Cataracts	Impaired Vision		
				All	Slight	Severe
East Devon	2,064 (1.52%)	2,201 (1.62%)	5,048 (3.71%)	4,267 (3.14%)	3,586 (2.64%)	681 (0.50%)
Exeter	1,096 (0.91%)	1,106 (0.91%)	2,564 (2.12%)	2,124 (1.75%)	1,789 (1.48%)	335 (0.28%)
Mid Devon	1,096 (0.91%)	1,106 (0.91%)	2,564 (2.12%)	2,124 (1.75%)	1,789 (1.48%)	335 (0.28%)
North Devon	932 (1.17%)	901 (1.13%)	2,217 (2.78%)	1,733 (2.17%)	1,465 (1.84%)	267 (0.33%)
South Hams	1,178 (1.24%)	1,169 (1.23%)	2,826 (2.98%)	2,241 (2.36%)	1,893 (2.00%)	349 (0.37%)
Teignbridge	1,117 (1.33%)	1,093 (1.30%)	2,682 (3.19%)	2,076 (2.47%)	1,757 (2.09%)	319 (0.38%)
Torridge	1,665 (1.31%)	1,678 (1.32%)	4,001 (3.16%)	3,235 (2.55%)	2,728 (2.15%)	507 (0.40%)
West Devon	851 (1.28%)	820 (1.24%)	2,045 (3.08%)	1,563 (2.36%)	1,325 (2.00%)	238 (0.36%)
Devon	9,626 (1.26%)	9,666 (1.27%)	23,121 (3.03%)	18,586 (2.43%)	15,682 (2.05%)	2904 (0.38%)

Source: Moorfields Eye Hospital (prevalence) and ONS Sub-National Population Projections, 2014 (population)

Sight loss certifications per 100,000 population are measured in the Public Health Outcomes Framework, revealing higher levels of sight loss certifications than the national and comparator group rates in Devon.

Figure 10.13, Sight Loss Registrations per 100,000 population, Devon local authority comparator group, 2012-13



Source: Public Health England Knowledge and Intelligence Team (West Midlands) from data provided by Moorfields Eye Hospital and Office for National Statistics

Three further indicators appear in the Public Health Outcomes Framework relate to the three main eye diseases, which can result in blindness or partial sight if not diagnosed and treated in time. These are age related macular degeneration (AMD), glaucoma and diabetic retinopathy. These indicators relate to sight loss registrations as a result of these three conditions in particular age groups. Table 10.6 highlights higher levels of registrations in Devon for these conditions compared with England. The counts include sight loss due to these conditions as the main cause or if no main cause as a contributory cause, which could result in individuals being counted again under other conditions if more than one contributory cause. Certification is voluntary so true rates may be higher than this analysis shows. As such it is unclear whether differences are due to incidence or data collection levels, so it is not possible to conclude if these differences are due to greater risk in Devon or improved detection and recording. Incidence may vary due to the risk of sight loss being influenced by health inequalities, including ethnic, deprivation and age profiles of the local population. There are also geographic variations in data collection; in some instances completion of additional examinations required to complete the certification are incentivised. Due to this data collection levels may reflect non-completion of certification rather than just low incidence. These limitations relate to all four eye health measures in the Public Health Outcomes Framework. An Eye Health Needs Assessment is currently underway in Devon and will be completed during 2015-16, which will explore these issues in much greater detail.

Table 10.6, Sight Loss Registrations per 100,000 population for selected preventable eye conditions and age groups, 2012-13

Condition	Devon	England
AMD, aged 65 and over	154.7	123.1
Glaucoma, aged 40 and over	18.1	12.5
Diabetic Retinopathy, aged 12 and over	5.6	3.5

Source: Public Health England Knowledge and Intelligence Team (West Midlands) from data provided by Moorfields Eye Hospital and Office for National Statistics

10.08 Mental Health in Older Age

Older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility and income. Loneliness has been described as an unwelcome feeling of lack or loss of companionship, marked by a discrepancy between the contact people have and what they desire (http://www.jrf.org.uk/sites/files/jrf/loneliness-neighbourhoods-engagement-full.pdf). Estimates suggest that around 20% of those aged 65 and over experience mild loneliness with a further 8-10% experiencing intense loneliness, which would equate to around 36,400 older people experiencing mild loneliness in Devon, and a further 14,500 to 18,200 experiencing intense loneliness (http://campaigntoendloneliness.org/toolkit/wp-content/uploads/Statistics.pdf).

According to the English Longitudinal Study of Ageing (ELSA) people aged 80 and older were the most vulnerable to loneliness, with women more likely to report feeling lonely than men. There is a socio-economic gradient to loneliness with higher levels in more deprived areas. Whilst wealth is an important determinant of life satisfaction, its effect declines over the age of 75. Contact with children generally reduces loneliness, although having children but not feeling close to any of them is associated with higher rates of loneliness than being childless. People without friends report the highest rates of loneliness. (http://www.elsa-project.ac.uk/reportWave2 - see chapter 10)

Cacioppo and Patrick (Loneliness: Human Nature and the Need for Social Connection, 2008) highlighted five ways in which severe loneliness can adversely affect health:

- Increasing self-destructive habits (overeating, smoking, excessive alcohol use etc.)
- Increasing stress levels
- Self-imposed isolation and failure to seek emotional support
- The effect on immune and cardiovascular systems and
- Difficulty in sleeping, negative impact on metabolic, neural and hormonal regulations

The most common mental health conditions in older people are depression and dementia. Depression affects proportionately 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.

10.09 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 stronger population growth in the older age groups. Dementia prevalence rates are higher in females. This, coupled with longer life expectancy, means females with dementia outnumber males by more than two to one. Prevalence rates for dementia increase rapidly with age, with one in 1400 affected under the age of 65, compared with more than one in five in those aged 85 and over.

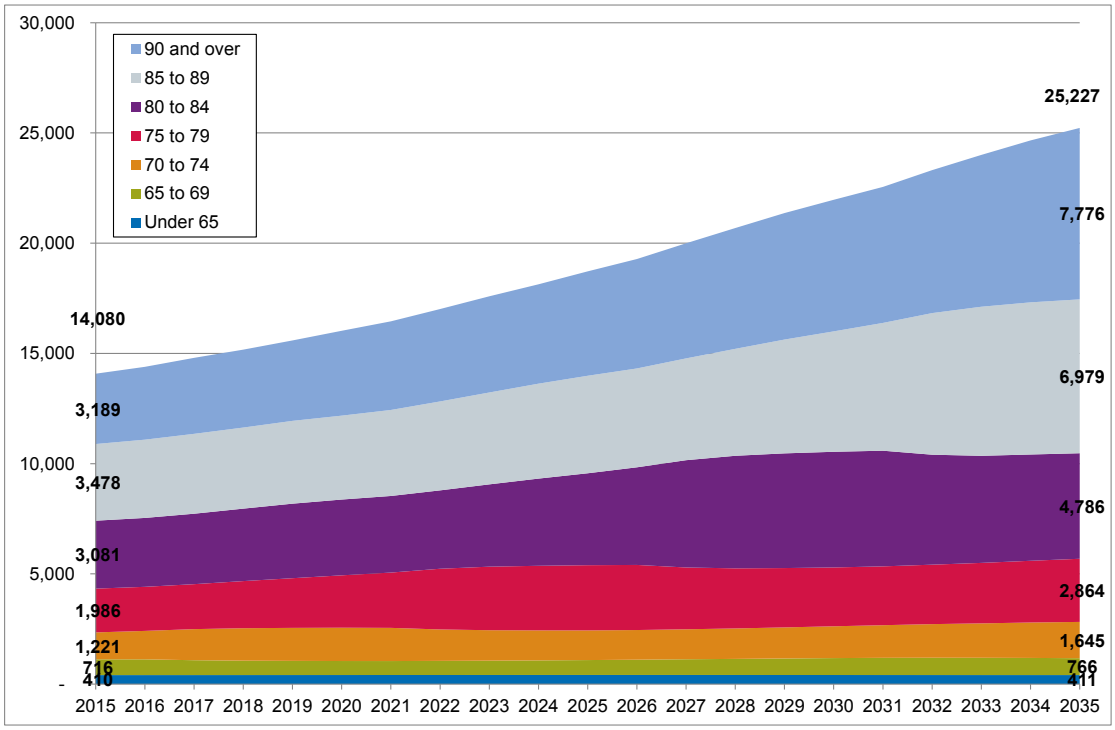
Table 10.7 shows the projected number of people with dementia between 2015 and 2035 by Devon local authority district. This highlights that around 14,080 people living in Devon are estimated to have dementia in 2015, representing 1.84% of the population, which is set to rise to 25,227 by 2035, when it will affect around 2.97% of the population. Districts with an older age profile such as East Devon have a higher percentage of the population living with dementia. Figure 10.14 provides an age breakdown for the dementia projections for Devon, highlighting the impact by age group. This shows that the biggest shifts over the next 20 years will be in the 90 and over age group.

Table 10.7, Projected number and percentage of total population with dementia by Devon local authority district, 2015 to 2035

District	2015	2020	2025	2030	2035
East Devon	3257 (2.39%)	3619 (2.58%)	4128 (2.85%)	4839 (3.25%)	5516 (3.62%)
Exeter	1629 (1.34%)	1809 (1.46%)	2045 (1.61%)	2336 (1.79%)	2628 (1.98%)
Mid Devon	1629 (1.34%)	1809 (1.46%)	2045 (1.61%)	2336 (1.79%)	2628 (1.98%)
North Devon	1311 (1.64%)	1496 (1.81%)	1796 (2.11%)	2109 (2.42%)	2414 (2.71%)
South Hams	1696 (1.79%)	1954 (2.01%)	2302 (2.32%)	2715 (2.67%)	3071 (2.97%)
Teignbridge	1549 (1.84%)	1737 (2.03%)	2080 (2.39%)	2447 (2.76%)	2806 (3.14%)
Torridge	2446 (1.93%)	2747 (2.11%)	3238 (2.41%)	3810 (2.77%)	4383 (3.12%)
West Devon	1174 (1.77%)	1381 (1.99%)	1661 (2.3%)	1979 (2.65%)	2292 (2.99%)
Devon	14080 (1.84%)	16026 (2.04%)	18721 (2.31%)	21967 (2.64%)	25227 (2.97%)

Source: ONS Sub-National Population Projections, 2014 and Dementia UK Prevalence Estimates, 2007

Figure 10.14, Projected number with dementia by age group and year, Devon, 2015 to 2035



Source: ONS Sub-National Population Projections, 2014 and Dementia UK Prevalence Estimates, 2007

Table 10.8 displays the 10 Devon wards with the highest expected dementia prevalence in 2013. This reveals that the top five wards for dementia prevalence in Devon are in East Devon, with the highest rate seen in the Sidmouth Town ward (4.55%).

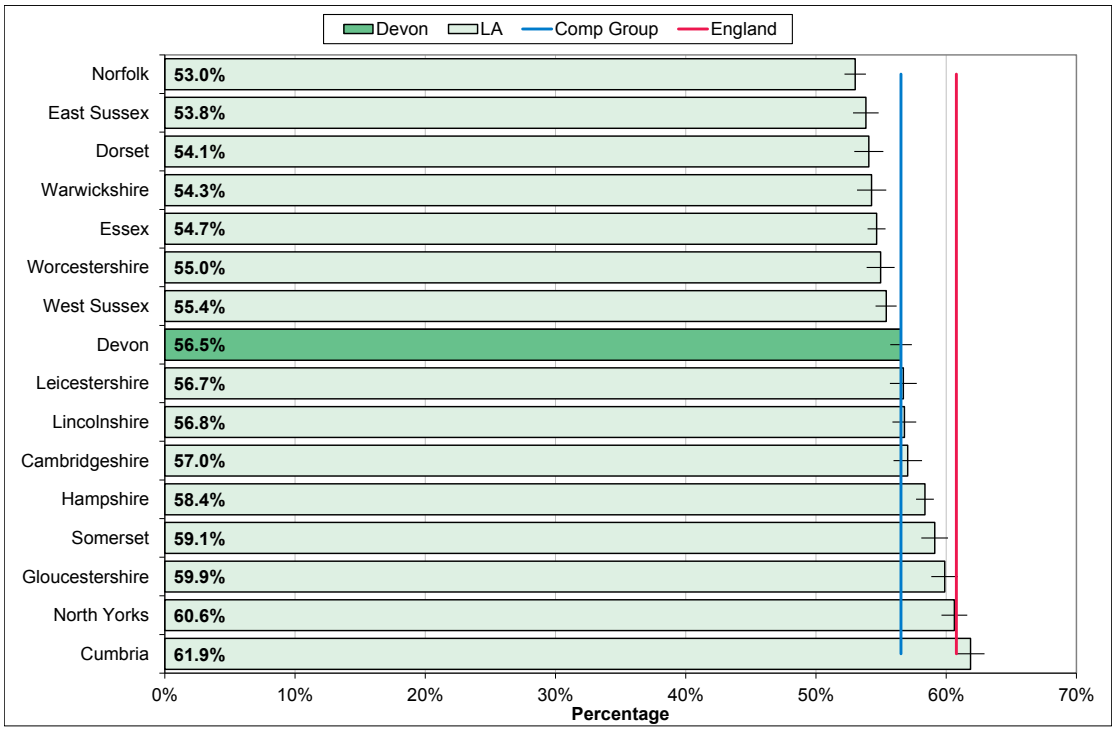
Table 10.8, Top 10 Devon Wards for Expected Prevalence of Dementia, 2013

Ward	District	Estimated number with dementia	Population	Estimated % with dementia
Sidmouth Town	East Devon	236	5,195	4.55%
Seaton	East Devon	261	7,177	3.64%
Exmouth Littleham	East Devon	263	7,250	3.63%
Budleigh	East Devon	210	5,903	3.56%
Sidmouth Rural	East Devon	70	2,176	3.20%
Teignmouth East	Teignbridge	149	4,939	3.02%
Bishopsteignton	Teignbridge	79	2,623	3.00%
Kingsbridge East	South Hams	62	2,052	3.00%
Sidmouth Sidford	East Devon	188	6,629	2.84%
Orchard Hill	Torridge	48	1,700	2.83%

Source: ONS Mid-Year Population Estimates, 2014 and Dementia UK Prevalence Estimates, 2007

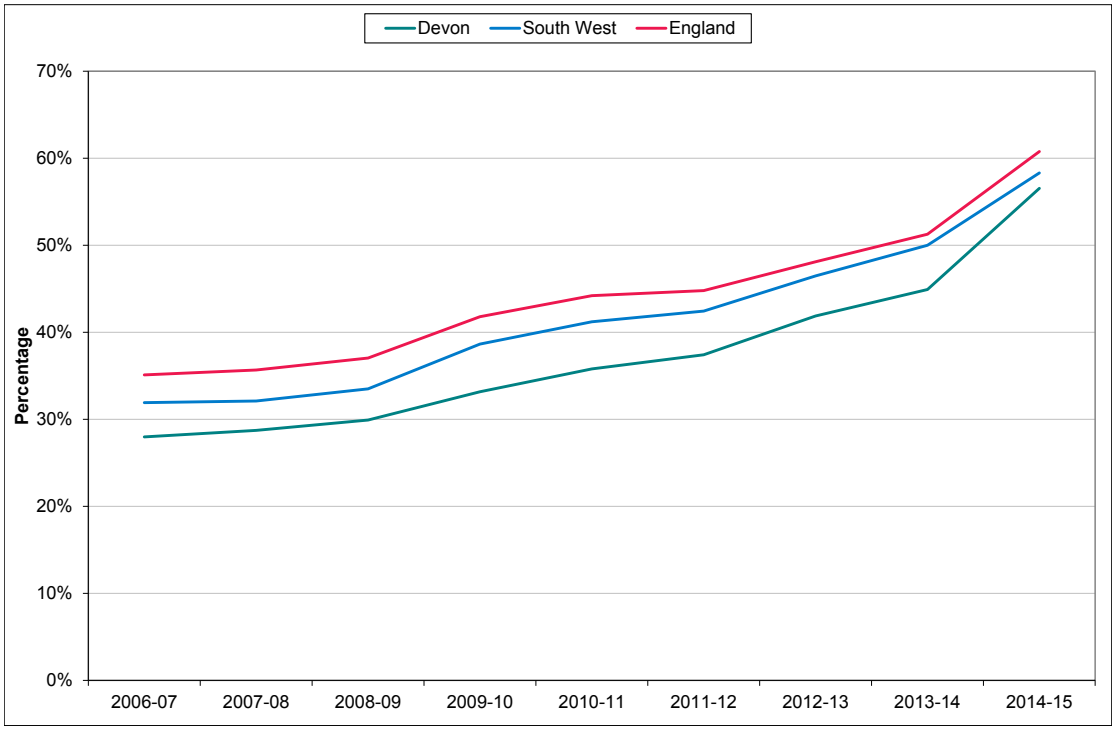
In March 2015, 7,838 people registered with Devon GPs were on a GP register for dementia, compared with an expected prevalence of 13,864, a diagnosis rate of 56.5%. This is in line with Devon's local authority comparator group (56.5%) as illustrated in figure 10.15, and below the South West (58.3%) and England (60.8%) rates. Figure 10.16 reveals that diagnosis rates have improved in recent years, increasing from 28.0% in 2006-07, narrowing the gap on the rates seen regionally and nationally. At a town level, the highest rates in Devon are seen in Teignmouth (70.0%) and the lowest diagnosis rates are seen in Moretonhampstead (41.6%) and Tiverton (44.7%). There are no significant differences in Devon based on area deprivation.

Figure 10.15, Dementia Diagnosis Rate (% of those expected to have dementia who are on the GP disease register), Devon Local Authority Comparator Group, March 2015



Source: Dementia Prevalence Calculator, Primary Care Data Tool, 2015

Figure 10.16, Trend in the Dementia Diagnosis Rate (% of those expected to have dementia who are on the GP disease register), Devon, South West and England



Source: Dementia Prevalence Calculator, Primary Care Data Tool, 2015

11. Conclusion

The main health and wellbeing challenges in Devon are:

- An ageing population which is also growing faster than the national average increasing future demand for health and care services
- Increasing financial pressures affecting local authorities, Clinical Commissioning Groups and other agencies requiring changes to traditional patterns of service provision to ensure health and care services remain affordable
- A sparse and predominantly rural population, creating additional challenges around access to health and care services and the need for sophisticated models of home-based care, outreach and work to reduce social isolation. The effective utilisation of local resources, voluntary / community organisations and community assets will be critical
- Patterns of deprivation marked by isolated pockets and hidden need within communities and higher levels of rural deprivation, with groups experiencing health inequalities likely to be geographically dispersed. This creates additional challenges when addressing health inequalities and targeting services to those most in need
- A configuration of local authority and health organisations more complex than most other counties, with two-tier local authorities, and Clinical Commissioning Groups crossing local authority boundaries. This creates extra challenges in terms of the continuity of services, planning and effective partnership working
- Average earnings below the national average and house prices and cost of living above the national average which contribute to a number of issues including food poverty, housing-related health conditions, homelessness, mental health and wellbeing, and fuel poverty
- The need for a focus on prevention at all stages of the life course aimed at improving health in later life for all, as well as narrowing the 10 to 15 year gap in health status between those living in the most and least deprived areas. This will be critical to addressing the demographic and financial pressures that local organisations are facing
- The need for a focus on mental health and wellbeing throughout the life course with a particular emphasis on areas where outcomes are comparatively poor, and an understanding of the relationship between mental and physical health
- Changing patterns of health-related behaviours including smoking, excess weight, physical activity, diet, alcohol and drug use and ensuring that the planning of services addresses changing patterns of behaviour and demand
- The growing number of people with long-term conditions, sensory impairment, frailty, dementia, cancer and other health problems. This requires a particular focus on those living with multiple health conditions, as traditionally health systems have been largely configured for individual diseases rather than multi-morbidity
- The Devon population is diverse in its needs and inequality can take many forms, resulting in differing health and care needs to which health and care commissioners need to respond.