

Joint Strategic Needs Assessment Devon Overview 2013

Understanding the Different Needs Across the Life Course in Devon



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1 INTRODUCTION

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

(www.devonhealthandwellbeing.org.uk)

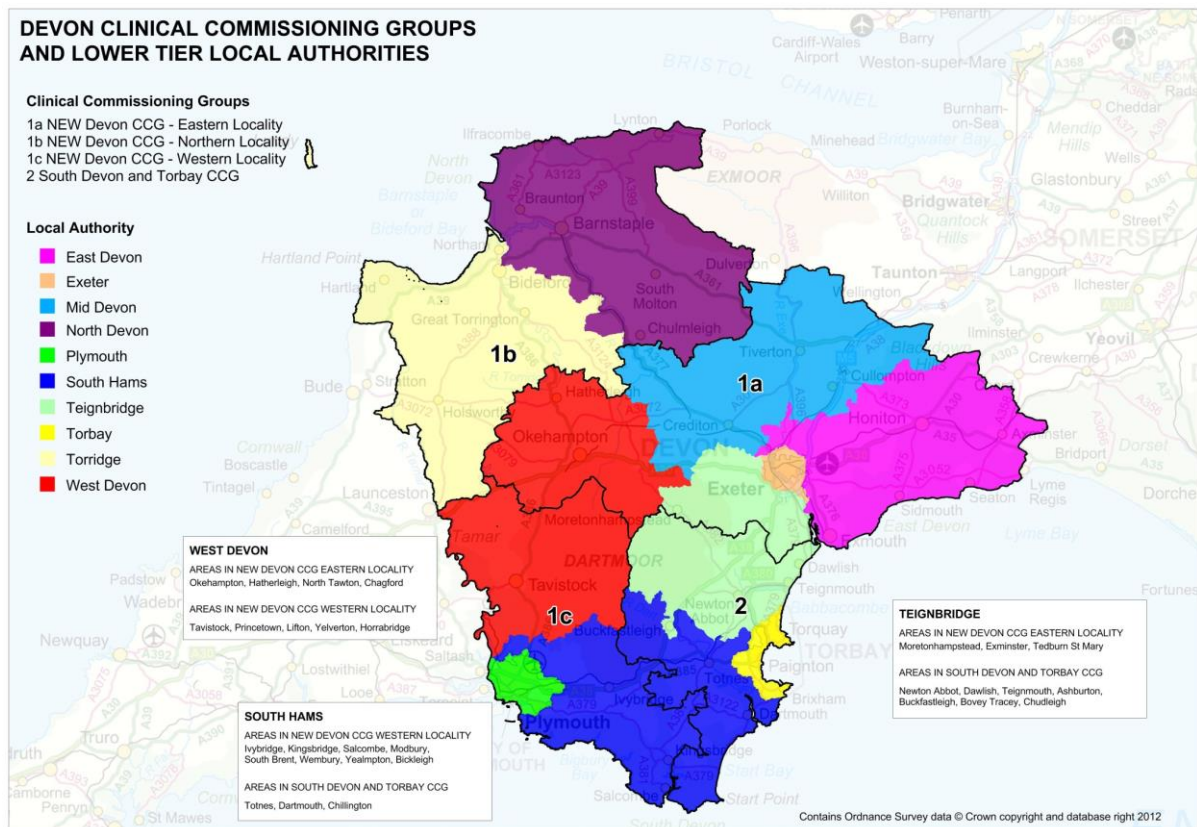
The life course approach

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

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

From April 2013, the responsibility for public health, who lead on coordinating the Devon Joint Strategic Needs Assessment has been transferred from the NHS to Devon County Council. The close relationship with the NHS continues through the 'core offer' of public health support from Devon County Council to the two clinical commissioning groups which include the Devon County Council area: Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group. The map below in figure 1.1 shows the new boundaries graphically.

Figure 1.1 Map of local authority and clinical commissioning group boundaries



Outcomes frameworks

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

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

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

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

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

Devon County Council Public Health Intelligence Team provide a detailed report on public health outcomes in Devon, which is available here:

<http://www.devonhealthandwellbeing.org.uk/jsna/performance/phof/>

The Devon Joint Health and Wellbeing Strategy (<http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/downloads/2013/09/Joint-Health-and-Wellbeing-Strategy-2013-update-Final-19-09-13.pdf>) sets out the priorities for the Devon Health and Wellbeing Board, with the aim of improving health in Devon and promoting health equality. The update of the Joint Health and Wellbeing Strategy 2013-16 identified four priority areas, including a focus on families, healthy lifestyle choices, good health and wellbeing in older age and strong and supportive communities. The Health and Wellbeing Outcomes Report is themed around these four areas. It sets out the indicator types used and the analyses include: comparisons of Devon with other upper tier and unitary local authorities in the South West and in the local authority comparator group, local breakdowns by local authority district and Clinical Commissioning Groups (CCGs) and their localities, trend information and the pattern of local health inequalities for the measure. Each individual outcome indicator report also includes a second page detailing technical specifications for the indicator. The regularly updated full report and individual indicator reports can be found here: <http://www.devonhealthandwellbeing.org.uk/jsna/health-and-wellbeing-outcomes-report/>

Protected Characteristics

The Equality Act 2010 identified nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The act requires that people are treated equally in terms of treatment by public and private services and employment regardless of these characteristics.

In terms of 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 general health, and to ensure that groups have equitable access to health services in relation to the needs that they exhibit.

Table 1.1 summarises risk factors associated with the NHS Health Checks programme for the nine protected characteristics from the Equality Act 2010. Health checks are aimed at those aged 40-74 and are designed to help prevent heart disease, stroke, diabetes, kidney disease and dementia. Monitoring the pattern of service usage by different groups will help ensure that issues relating to protected characteristics are addressed.

Table 1.1: NHS Health Checks Risk Factors by Protected Characteristic, Persons aged 40 to 74, Devon

| Protected Characteristic | Overview | Devon Population (aged 40 to 74) | |
|--------------------------|--|--|--------|
| Age | Behavioural risk factors (smoking, alcohol usage, mental illness etc.) highest in younger age groups within the cohort (40-49). Resultant health-related factors (high BP, cholesterol etc.) increase with age. High immigration in Devon at retirement age influences local patterns. | 40-44 | 49,200 |
| | | 45-49 | 55,200 |
| | | 50-54 | 52,500 |
| | | 55-59 | 49,400 |
| | | 60-64 | 54,200 |
| | | 65-69 | 54,100 |
| | | 70-74 | 38,600 |
| Disability | People with a learning disability are more likely to experience ill-health and die prematurely and use of screening and health services in this | PANSI/POPPI estimate for any learning disability is 7,900. 2011 Census figure for persons with a long-term | |

| | | |
|------------------------------|---|---|
| | population are known to be low. People with disabilities are more likely to smoke, have a poor diet and limited physical activity, and a higher prevalence of diabetes and heart disease. | health problem or disability that limits activities a lot is 27,500. |
| Gender | Behavioural risk factors and resulting health problems are usually more common in males. | Female 182,600 Male 170,500 |
| Gender Reassignment | No definitive evidence around the distribution of risk factors and resultant health problems associated with gender reassignment. | Estimate < 100 |
| Marriage & Civil Partnership | No definitive evidence around the distribution of risk factors and resultant health problems associated with marital status. | Married 233,600 Civil 900 Single 39,200 Sep 9,600 Div'd 52,100 Widow 16,900 |
| Pregnancy & Maternity | While most older mothers have a healthy pregnancy and birth, there is an increased risk of developing on-going health conditions such as diabetes and high blood pressure. | 350 Births P.A. for females aged 40 and over |
| Race | The pattern of risk factors and the likelihood of developing health conditions vary by ethnic group. Smoking rates are particularly high in Black Caribbean and Bangladeshi men. Heart disease risk is highest in Bangladeshi and Pakistani groups, stroke risk is higher in Black Caribbean groups and type 2 diabetes is highest in Black Caribbean and Indian men. | White British 341,200 White Other 7,500 Mixed 1,400 Asian 2,000 Black 500 Other 500 |
| Religion & Belief | No definitive evidence around the distribution of risk factors and resultant health problems associated with religion and belief. | Christian 353,100 Buddhist 1,500 Hindu 200 Jewish 400 Muslim 600 Other 2,800 None 78,500 Not Stated 29,400 |
| Sexual Orientation | Some evidence around higher levels of smoking prevalence for lesbians, gays and bisexuals, but no definitive evidence around the distribution of other risk factors and resultant health problems associated with sexual orientation. | LGB Population Estimate 3,800 |

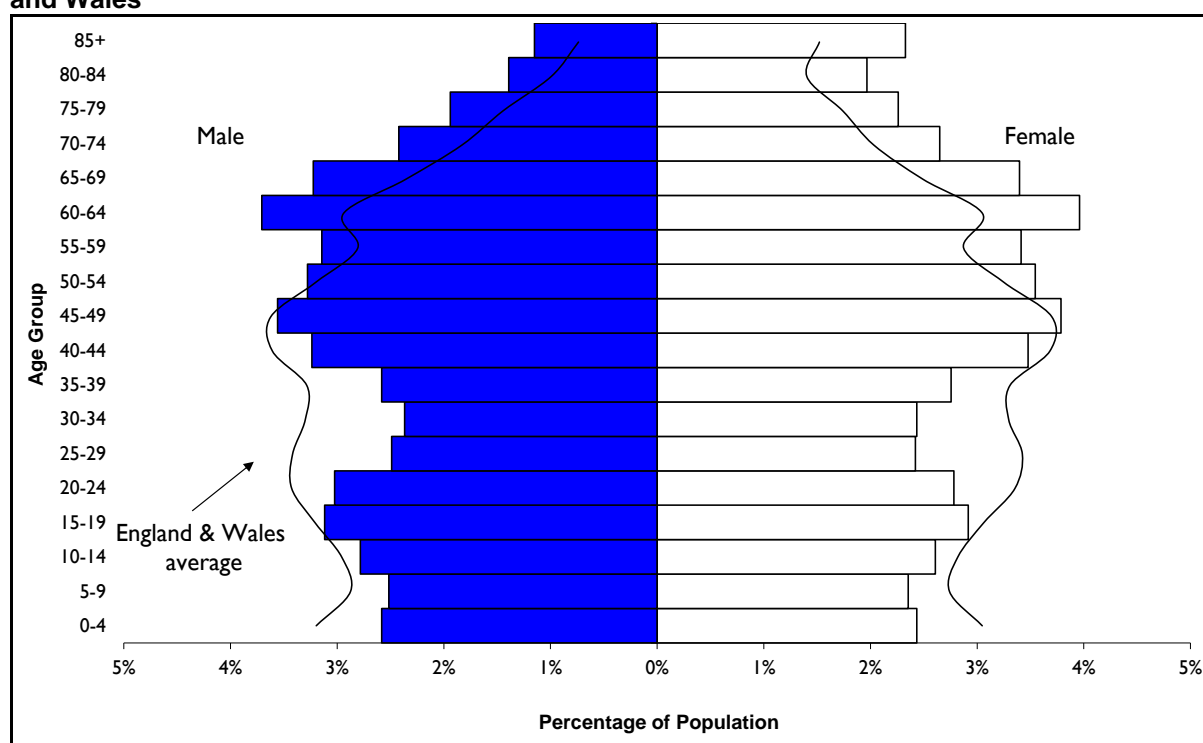
2 DEMOGRAPHICS

Population

Devon has an older population profile than nationally, particularly in those aged 55 years of age and above, reflecting significant in-migration in this age group, and those aged 85 years and over, reflecting an ageing population and longer life expectancy (Figure 2.1). The proportions of those aged 20 to 39 and those under 10 years are below the national average, particularly in those aged 25 to 39 where there is significant out-migration from Devon. This overall pattern is even more marked in areas of East Devon and South Hams, whilst the population in Exeter is 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 we know that older age groups are the highest users of these services.

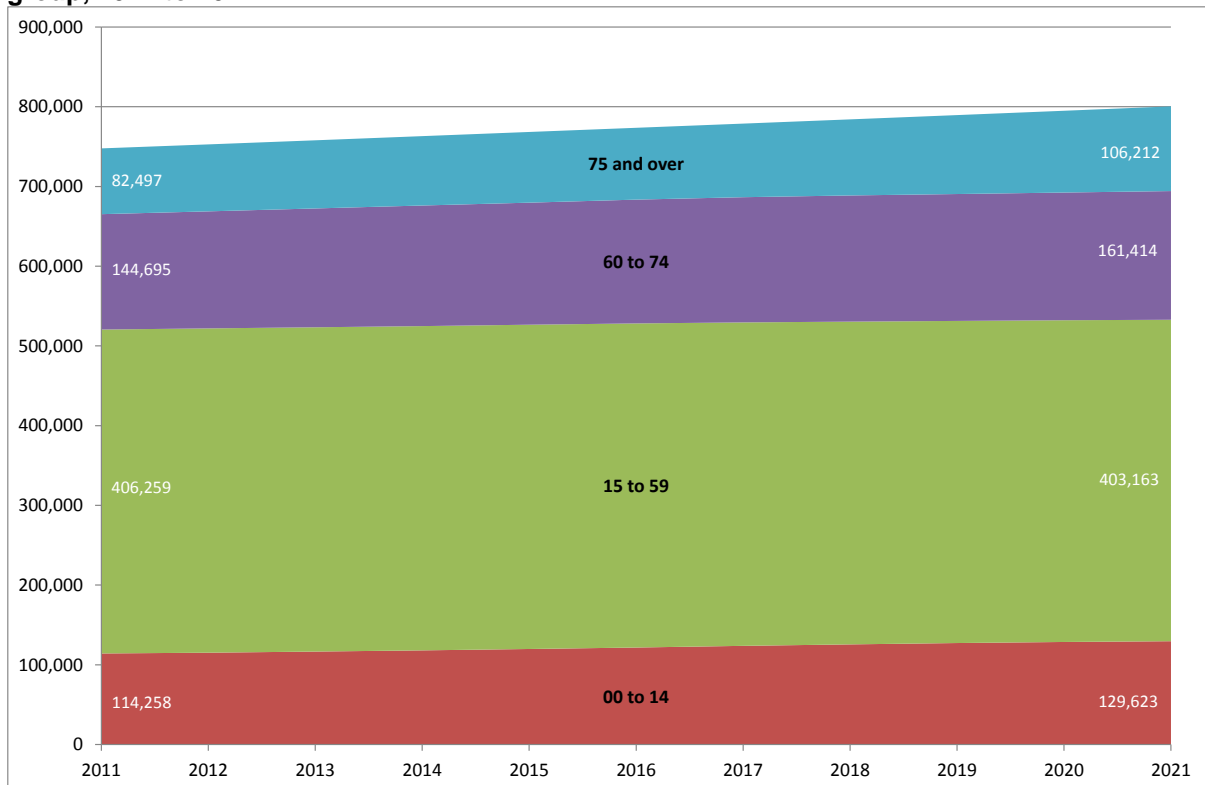
Figures 2.2 and 2.3 show the projected change in the number of people in Devon over the decade from 2011 to 2021. While there is relatively little change in the under-60 age groups, the major change occurs in the population over 60 years, both in numbers and as a proportion of the whole.

Figure 2.1: Structure of the Devon mid-year 2012 population in Devon compared with England and Wales



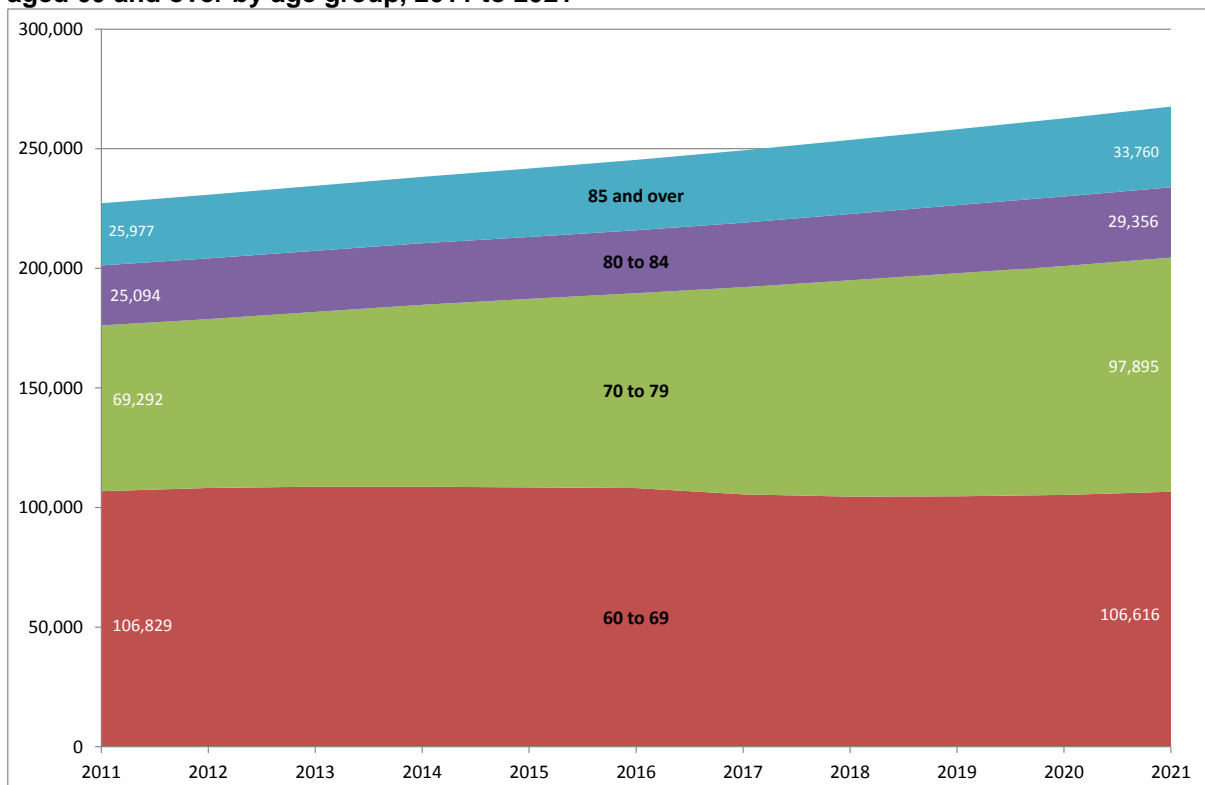
Source: Mid-Year Population Estimates 2012, Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 2.2: The projected demographic change in the population structure of Devon, by age group, 2011 to 2021



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

Figure 2.3: The projected demographic change in the population structure of Devon, persons aged 60 and over by age group, 2011 to 2021

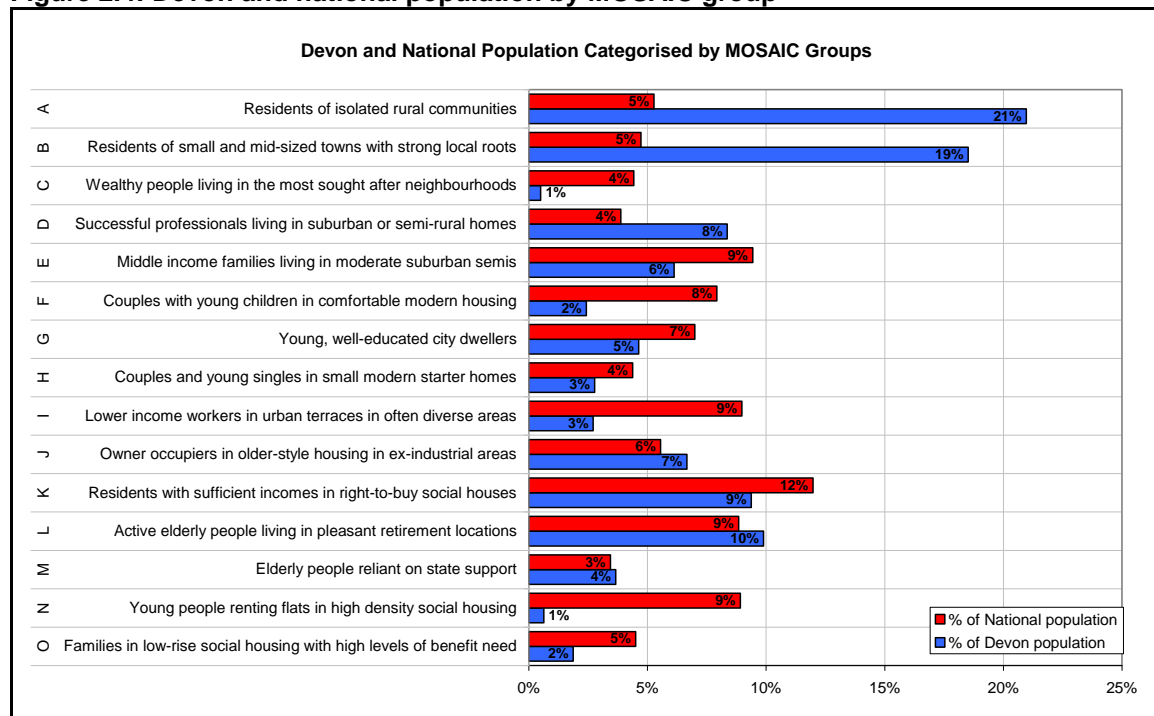


Source: Sub-national population projections, Office for National Statistics licensed under the Open Government Licence v.1.0

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

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

Figure 2.4: Devon and national population by MOSAIC group



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

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

Ethnicity and Migration

Devon's ethnic make-up is very different from England. Overall in England, almost 80% of people are White British, with the next highest proportion of people being Asian or Asian British (including Chinese) at almost 8%. The Devon population consists of almost 95% White British with the next highest percentage being 'White Other including Gypsy and Traveller' ethnic groups at 2.2%. Although still less diverse than nationally, Exeter is the local authority with the greatest variation in ethnic origin across Devon. Exeter has 88.3% of people identifying as White British compared to 94.9% in Devon overall, 4.3% White other compared to 2.2% and 3.9% Asian/Asian British compared to 1.2%.

Table 2.1: Percentage of population by ethnic group and Devon district, 2011

| Area | White British | White: Irish | White: Other White (including Gypsy or Traveller) | Mixed/ multiple ethnic groups | Asian/Asian British (including Chinese) | Black/ African/ Caribbean/ Black British | Other ethnic group |
|----------------|---------------|--------------|---|-------------------------------|---|--|--------------------|
| | % | % | % | % | % | % | % |
| East Devon | 96.2 | 0.4 | 1.8 | 0.7 | 0.7 | 0.1 | 0.1 |
| Exeter | 88.3 | 0.5 | 4.2 | 1.6 | 3.9 | 0.6 | 0.8 |
| Mid Devon | 95.9 | 0.4 | 2.4 | 0.6 | 0.6 | 0.1 | 0.1 |
| North Devon | 95.9 | 0.3 | 1.7 | 0.8 | 0.9 | 0.2 | 0.2 |
| South Hams | 95.8 | 0.4 | 2.1 | 0.8 | 0.6 | 0.1 | 0.1 |
| Teignbridge | 96.2 | 0.4 | 1.8 | 0.7 | 0.7 | 0.1 | 0.1 |
| Torridge | 97.1 | 0.3 | 1.3 | 0.7 | 0.4 | 0.1 | 0.1 |
| West Devon | 96.4 | 0.4 | 1.6 | 0.8 | 0.6 | 0.1 | 0.1 |
| Devon | 94.9 | 0.4 | 2.2 | 0.9 | 1.2 | 0.2 | 0.2 |
| England | 79.8 | 1.0 | 4.7 | 2.3 | 7.8 | 3.5 | 1.0 |

Source: Office for National Statistics licensed under the Open Government Licence v.1.0 via NOMIS March 2013

Devon Economy

The Devon County Council Strategic Plan highlights the role that enterprise can play in helping us achieve the goal of ensuring Devon is strong, healthy and prosperous and is the place we all want it to be. The challenge is to promote strong and sustainable growth in Devon – a task made harder given the current challenges faces in the UK and world economy. The Devon County Council Strategy for Growth which was published in May 2013, highlights that the County Council has a strong role to play as an employer, a purchaser of goods and services and through the implementation of strategies to guide future development.

Nationally there are many factors impacting on the economy. Firstly, the on-going financial crisis which has lead to the perceived reluctance of banks to lend to businesses. This clearly effects economic growth as many businesses cannot invest or grow without borrowing. Secondly, the continuing Eurozone crisis has implications on both trade and investment. The third factor affecting the economy is the increasing price of commodities, and there is currently no suggestion that this will change. These three factors have particular implications for the economy in Devon. Structurally, Devon is dominated by small and micro enterprises that tend to rely on debt to grow, and therefore the banks reluctance lend is challenging with regards to them growing. The county has an extensive geography with vast rural areas which are great distances from main population centres. The mean high energy and particularly fuel prices are more problematic to an area such as Devon that in other less rural areas. As a result of these factors, the mean poor national economic performance is biting harder for Devon businesses and communities than in some areas.

The Devon Strategy for Growth gives a summary of the Devon. 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 Norfolk¹.

In 2010, the county was home to over 30,000 active enterprises². The Devon economy accounted for almost 300,000 employee jobs³ and almost 60,000 residents were self-employed⁴.

¹ ONS Regional Accounts (as at 14 December 2011)

² ONS IDBR (Business Demography 2010)

³ ONS ABI Employee Analysis, 2008

In economic terms, the diversity of Devon needs to be understood. 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 to Devon 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.

When considering how the national economic position is impacting on Devon, and drawing on the evidence within the Local Economic Assessment, seven of the most important critical issues of barriers to growth are identified below and these are the basis of the rationale behind the strategy:

Critical issue 1: Devon's economy is performing poorly in terms of productivity.

Critical issue 2: Devon has a relatively skilled workforce however this masks significant differences at a District level.

Critical issue 3: Earnings are lower than average in most of Devon and link to housing affordability and relative poverty.

Critical issue 4: Devon has an opportunity to better exploit the assets it has for high value economic growth.

Critical issue 5: Devon's towns and rural communities in more peripheral areas are falling behind.

Critical issue 6: Devon's population is ageing rapidly.

Critical issue 7: Devon's resilience to face environmental changes is being challenged.

The Strategy of Growth provides an assessment of Devon's economy and emphasised some of the challenges that really must be addressed. In shaping Devon's economic future these challenges need to be addressed and creative solutions developed. The surrounding imperative is all the more pressing given the challenging national economic backdrop outlined. Devon needs, as far as possible, to steer its own economic destiny and to do so in a manner that creates sustainable opportunities, particularly for its talented young people and graduates.

The Strategy for Growth aims to tackle these issues and by doing this secure the following strategic outcomes:

- A more productive economy
- A higher wage economy
- Employment opportunities for all and a workforce with the right skills for the future
- A well connected county
- A thriving business economy

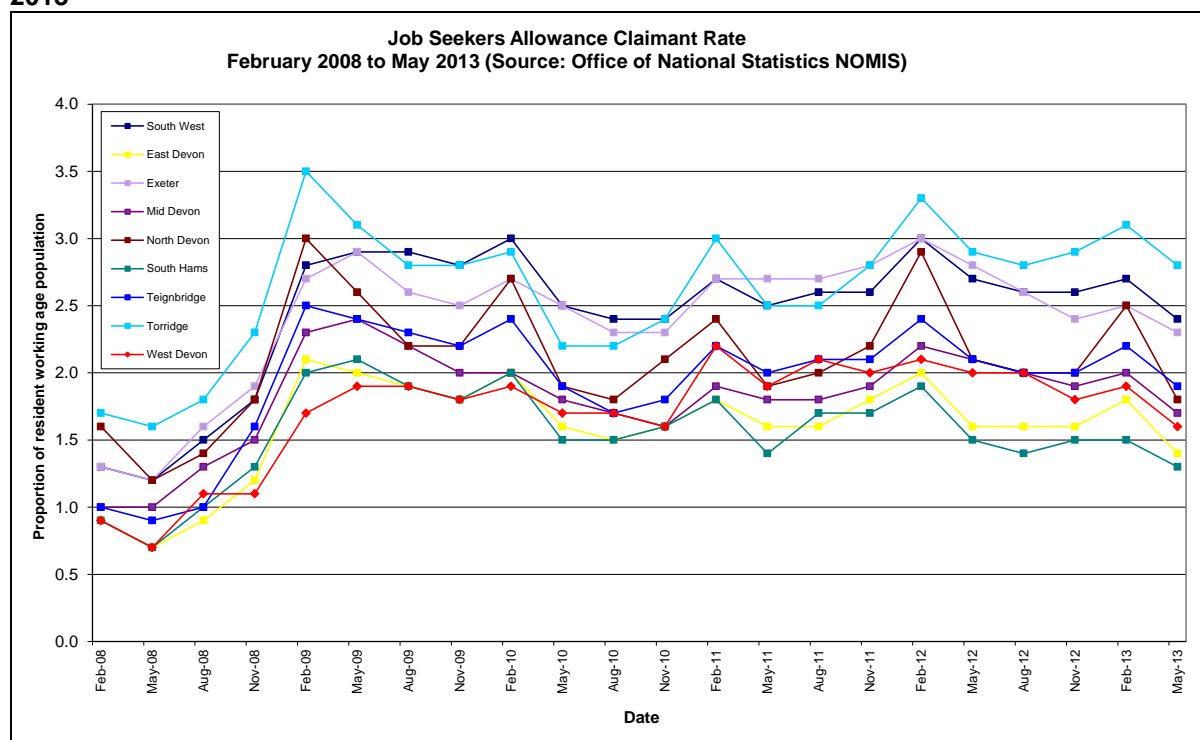
⁴ ONS Annual Population Survey

Delivering the Strategy for Growth requires a partnership approach both within the council and with our external partners. A separate action plan has been developed that brings together existing and new projects. The Action Plan is not intended to be an exhaustive list of all activities that are focused on delivering economic growth in Devon. Rather it is a selection of key actions across the council that have the potential to deliver the greatest impact. Other projects and programmes mentioned in the strategy will also deliver economic growth.

Job Seekers Allowance Claimants

The claimant count in Devon increased faster than the national rate. 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 2.5 below shows the trend in Job Seekers Allowance claimants by local authority from February 2008 to May 2013. It shows unemployment has remained above the pre 2008 level and varies considerably by local authority with Torridge in particular showing a higher rate than the South West overall. Changes at a local level can have a major impact as well, with a number of business closures in Okehampton contributing to the West Devon claimant rate moving from one of the lowest to one of the highest in the county.

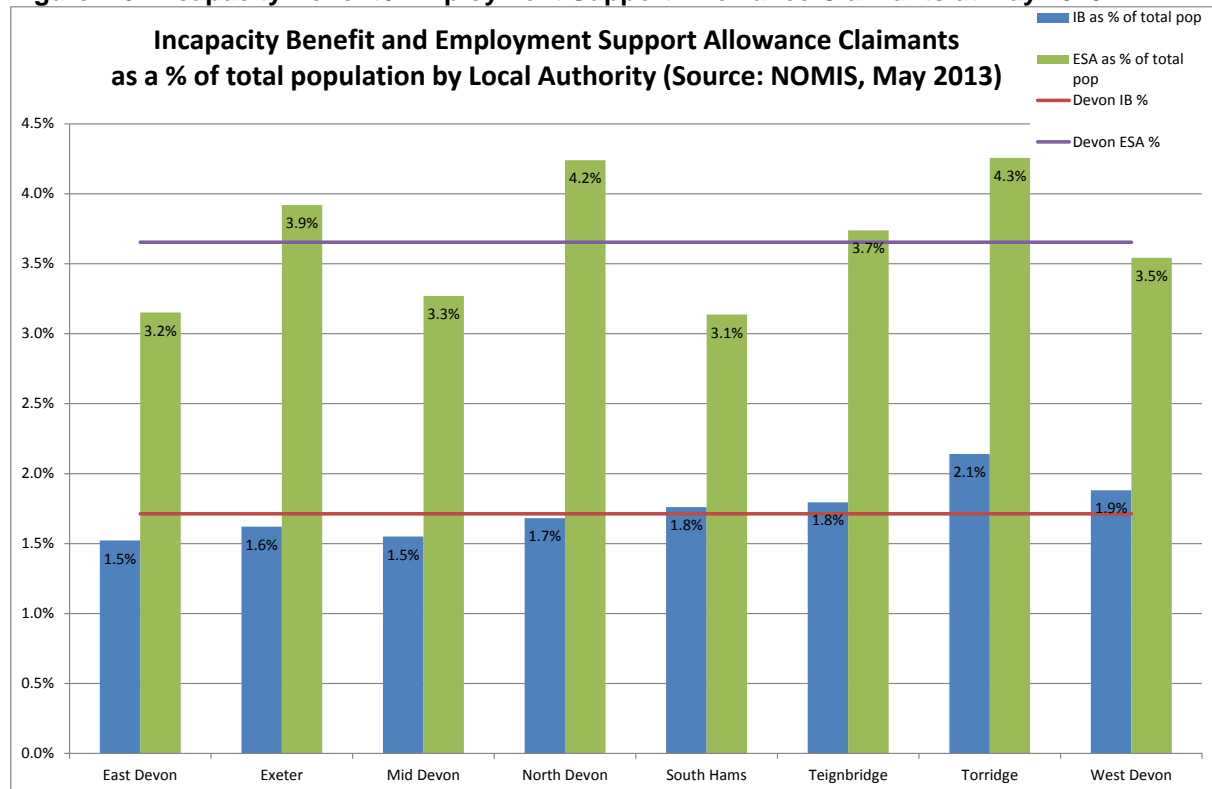
Figure 2.5: Job Seekers Allowance Claimant Rates by Devon District, February 2008 – May 2013



Incapacity Benefit and Employment Support Allowance Claimants

The association between rates of illness and certain population characteristics, notably poverty, unemployment and social isolation, is well established. Previously Incapacity Benefit was claimed by people who were unable to work due to ill health. This has now been replaced for new claimants, and people who were previously claiming Incapacity Benefit slowly migrated, across to Employment Support Allowance. The graph below shows the proportions of the population who were still claiming Incapacity Benefit and those that were claiming Employment Support Allowance. The highest rates of Employment Support Allowance claimants were seen in the North Devon and Torridge Local Authorities.

Figure 2.6: Incapacity Benefit / Employment Support Allowance Claimants at May 2013

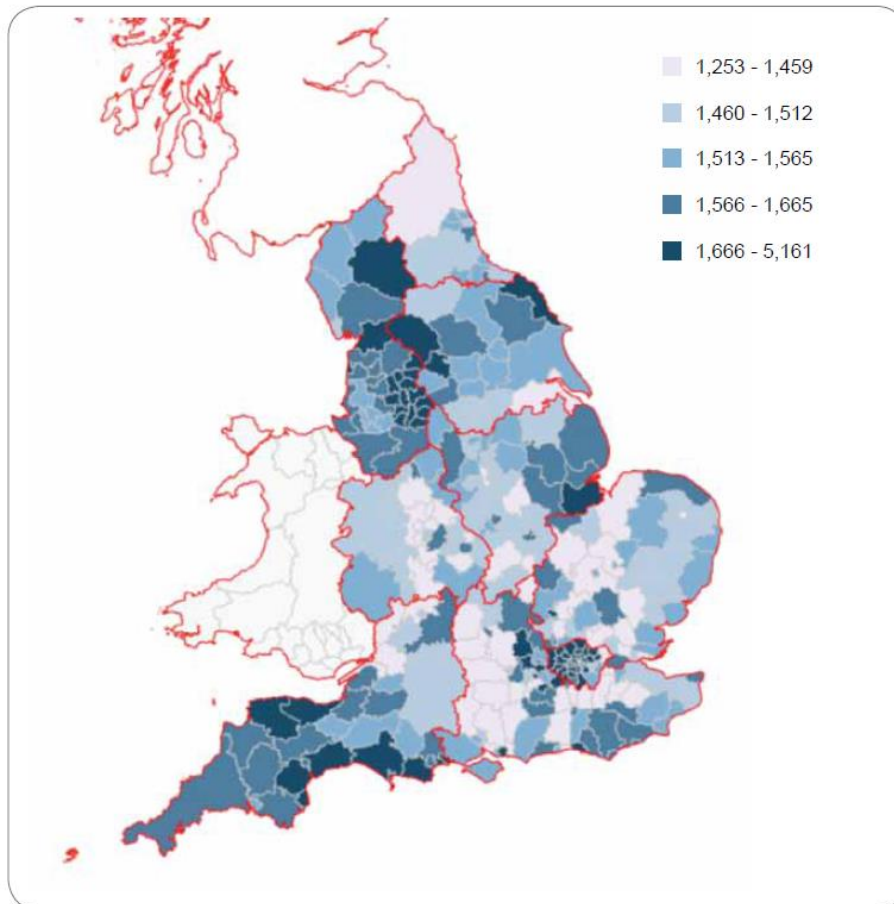


Welfare Reform

The government's welfare reforms are considered to be the most fundamental changes to the benefits system in a generation. The Local Government Association commissioned some research to be carried out by The Centre for Economic and Social Inclusion to describe the cumulative impact of all of the major benefit reforms announced since the coalition government came in to office in May 2010. The research uses the governments most recent or final estimate of the fiscal impact by local authority. The overall analysis looks at the impacts for the £11.8 million in savings projected savings by 2015/16 by local authority.

The research estimated that as a result of the reforms, the income of households claiming benefit will be, on average, £1,615 a year or £31 a week lower in 2015/16. Across the country the average impact per claimant is relatively similar and this is explained by the different impacts of the higher proportions of people being out of work in the northern half of the country balanced by the higher house prices in the southern half of the country. London is an exception to this as high job related benefit claimants combined with high housing costs, combine to give larger impacts per household with average claimant household incomes lower by £1,965 per year. Figure 2.7 shows the average loss per claimant household from all welfare reforms on a map of England by local authority. It is broken in to quintiles across the country and North Devon, Teignbridge and East Devon are highlighted as being in the highest quintile.

Figure 2.7: Map of English local authorities' average loss per claimant household from all welfare reforms excluding universal credit (£ per year in 2015/16)

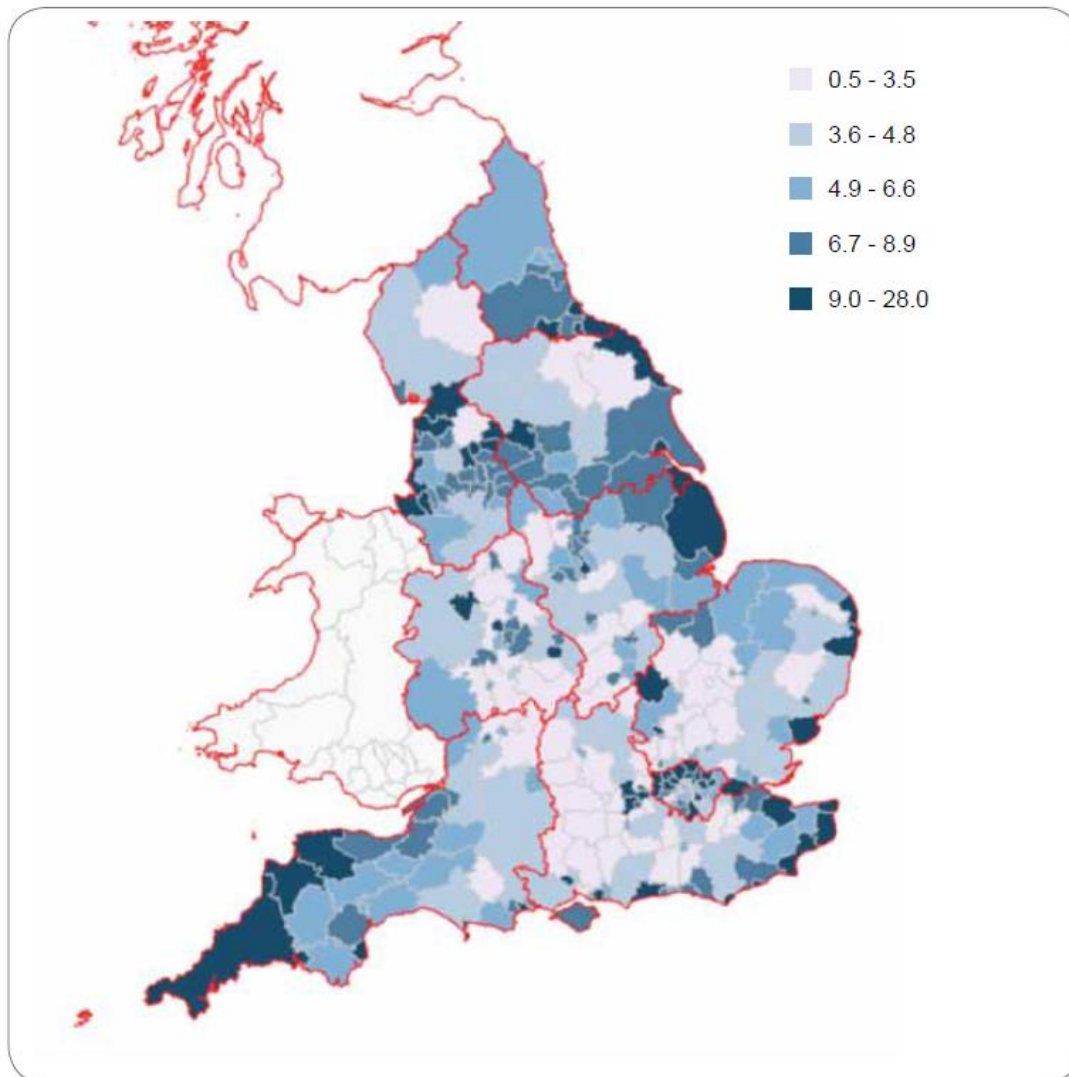


The report highlights the ten per cent of local authorities with the largest average losses per claimant households. These are predominantly in areas of London and the South East where losses from reforms to housing benefit for private renters are having the largest impact. None of the Devon local authorities feature in this 10 per cent and the only one in the South West is West Somerset.

It is estimated that around 59 per cent of all projected welfare reform savings fall on households where someone works. The analysis highlighted that the reductions for working households were greater than the reductions in households where no one works in 314 of the 325 local authorities in England. Mid Devon, South Hams, East Devon and North Devon local authorities all feature in the ten per cent experiencing greater reductions in working households.

The government has reformed the Local Housing Allowance system for households renting in the private sector. It has reduced maximum rent payable from the median rent to the thirtieth percentile of average rents in that rental market area, introduced a weekly cap for the amount of Local Housing Allowance that be paid based on household size and for claimants under 35 there is a limited entitlement to a lower "shared accommodation rate". Figure 2.8 shows the proportions of households impacted by these changes and it shows that coastal towns are adversely affected and this is reflected in Devon with North Devon and Torridge both showing high proportions of households effected.

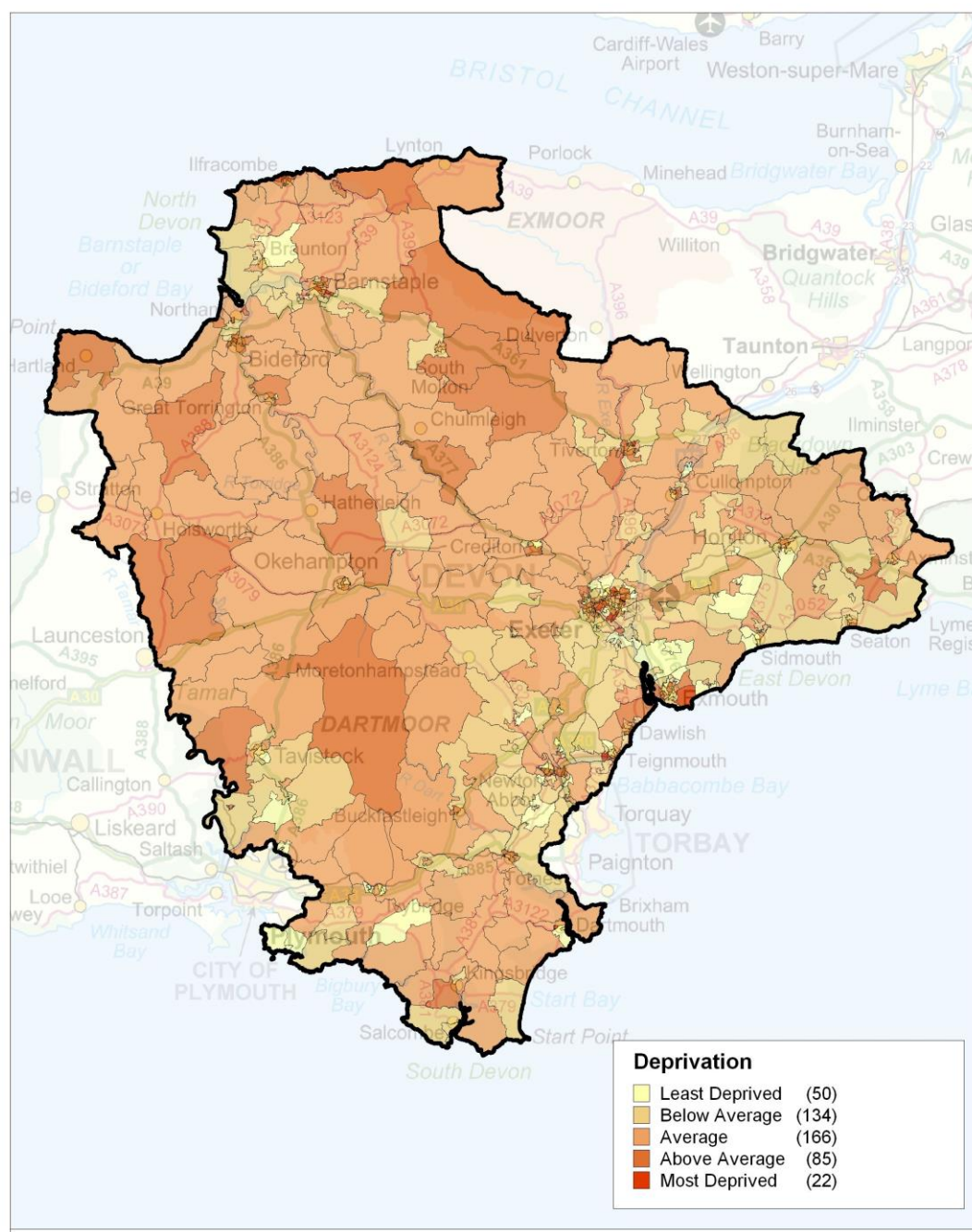
Figure 2.8: Map of proportion of households impacted by changes to Housing Benefit Local Housing Allowance (percentage, 2013)



Deprivation

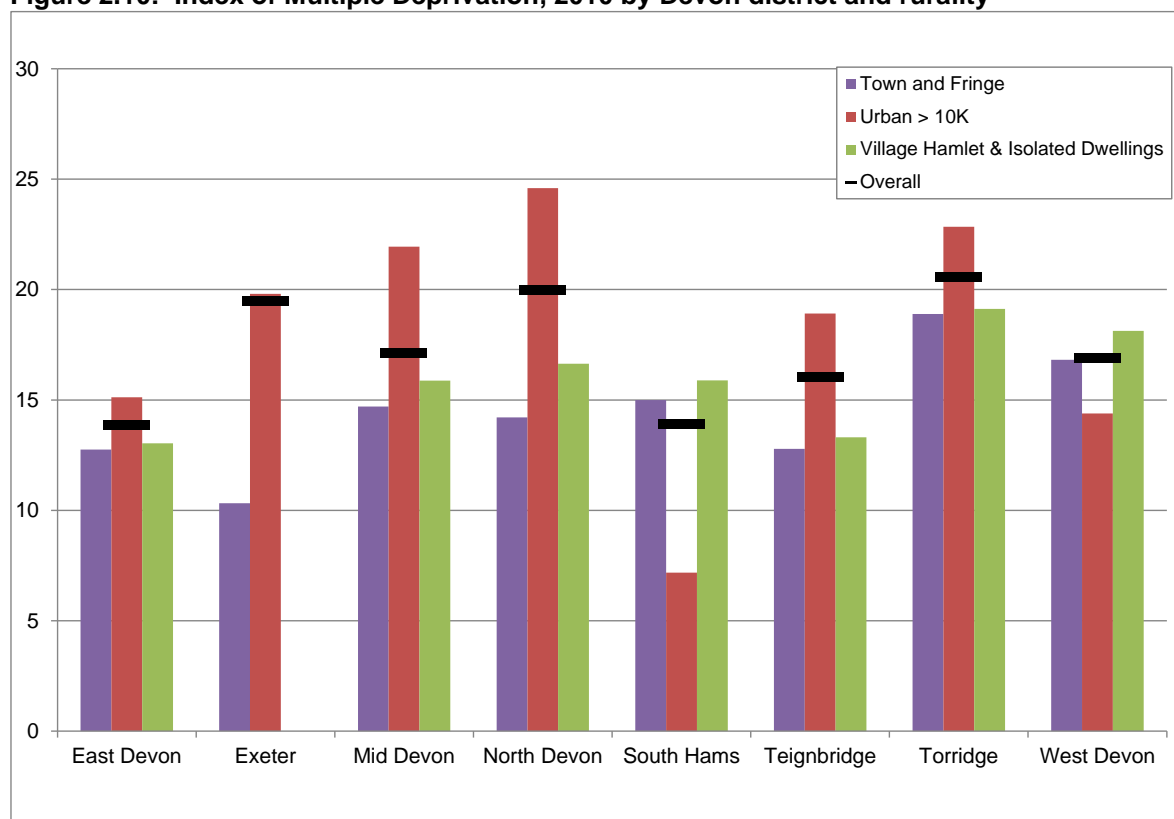
An updated version of the Index of Multiple Deprivation for 2010 was published in March 2011. Figure 2.9 shows Index of Multiple Deprivation 2010 figures by Lower Super Output Area (small areas of similar size created by the Office for National Statistics). This suggests that just below 5% of the Devon population live in the most deprived national quintile (one-fifth). These areas include parts of Exeter, Ilfracombe, Barnstaple, Bideford, Dawlish, Dartmouth, Teignmouth, Newton Abbot and Tiverton. Just over 10% of the Devon population were in the least deprived quintile. While overall levels of deprivation across Devon are lower than the national average, there are issues in relation to rural and urban deprivation which seem to affect Devon differently than is experienced elsewhere. With Devon being a largely rural county this is an important difference to be explored. 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 2.10 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 2.9: Map of Devon showing Lower Super Output Areas according to Index of Multiple Deprivation, 2010



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

Figure 2.10: Index of Multiple Deprivation, 2010 by Devon district and rurality



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

Rurality

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

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

3 CHILDREN AND YOUNG PEOPLE – *GETTING THE BEST START*

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

Trends in Birth Rates

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

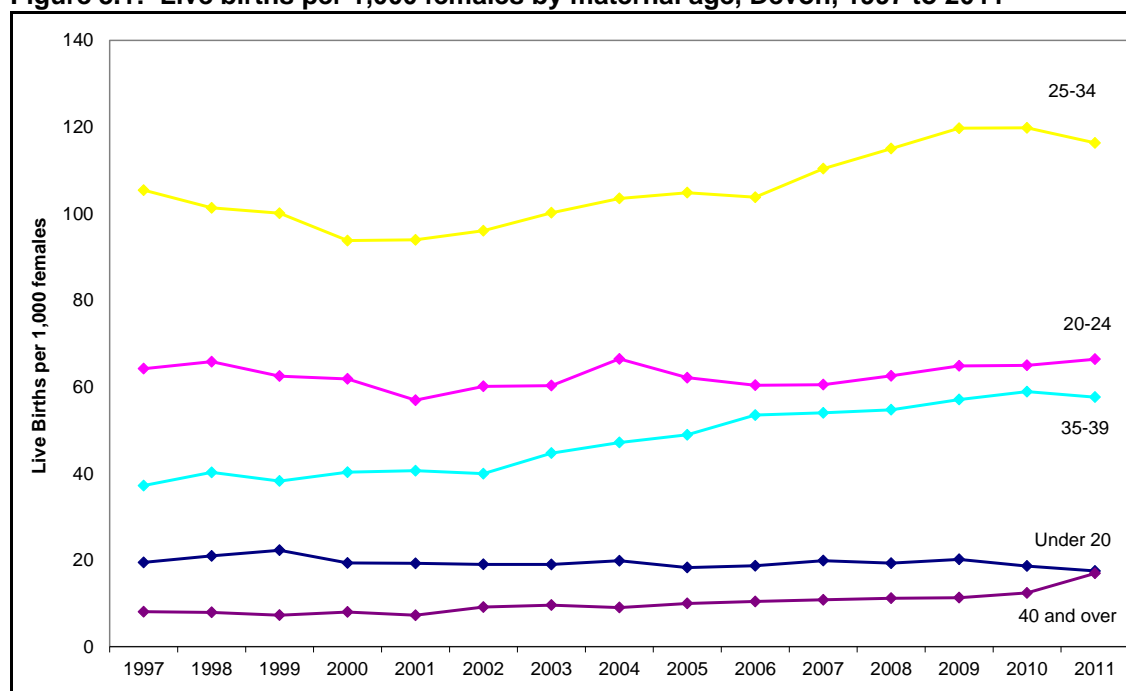
Total period fertility rates look at the mean average number of births per woman if they are to pass through childbearing years conforming to fertility rates by age of a given year. Within the European Union in 2008, the United Kingdom had a higher than average rate of 1.96 compared with 1.60. In Devon,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

Table 3.1: Total births by maternal age, Devon, 1997 to 2011

| Year | Under 20 | 20-24 | 25-34 | 35-39 | 40+ | Total |
|-------------|-----------------|--------------|--------------|--------------|------------|--------------|
| 1997 | 370 | 1,130 | 4,480 | 852 | 180 | 7,012 |
| 1998 | 411 | 1,112 | 4,296 | 946 | 180 | 6,945 |
| 1999 | 441 | 1,012 | 4,133 | 918 | 167 | 6,671 |
| 2000 | 383 | 1,014 | 3,816 | 991 | 189 | 6,393 |
| 2001 | 385 | 939 | 3,711 | 1,016 | 176 | 6,227 |
| 2002 | 384 | 1,004 | 3,621 | 1,019 | 226 | 6,254 |
| 2003 | 395 | 1,019 | 3,657 | 1,140 | 244 | 6,455 |
| 2004 | 423 | 1,143 | 3,664 | 1,202 | 237 | 6,669 |
| 2005 | 406 | 1,118 | 3,669 | 1,233 | 267 | 6,693 |
| 2006 | 417 | 1,141 | 3,622 | 1,337 | 285 | 6,802 |
| 2007 | 449 | 1,186 | 3,808 | 1,323 | 301 | 7,067 |
| 2008 | 442 | 1,232 | 3,876 | 1,313 | 309 | 7,172 |
| 2009 | 456 | 1,271 | 4,022 | 1,307 | 310 | 7,366 |
| 2010 | 420 | 1,293 | 4,049 | 1,278 | 333 | 7,372 |
| 2011 | 381 | 1,381 | 4,222 | 1,187 | 349 | 7,520 |
| 2012 | 353 | 1,369 | 4,297 | 1,258 | 308 | 7,585 |

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

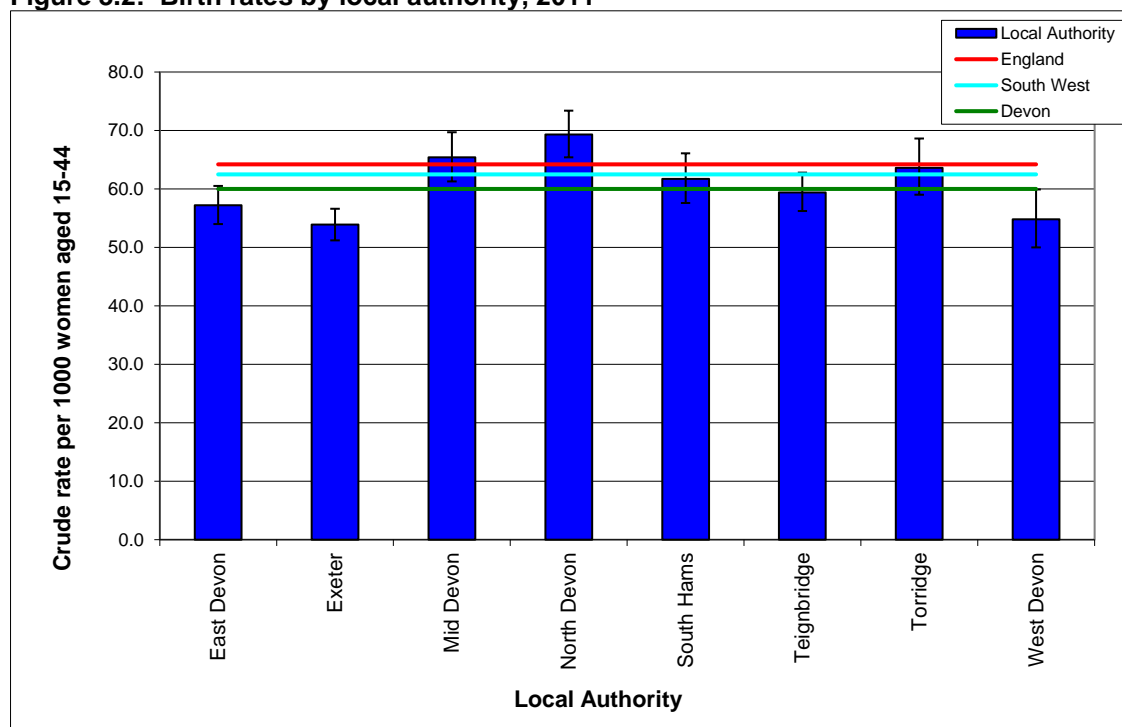
Figure 3.1: Live births per 1,000 females by maternal age, Devon, 1997 to 2011



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

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

Figure 3.2: Birth rates by local authority, 2011

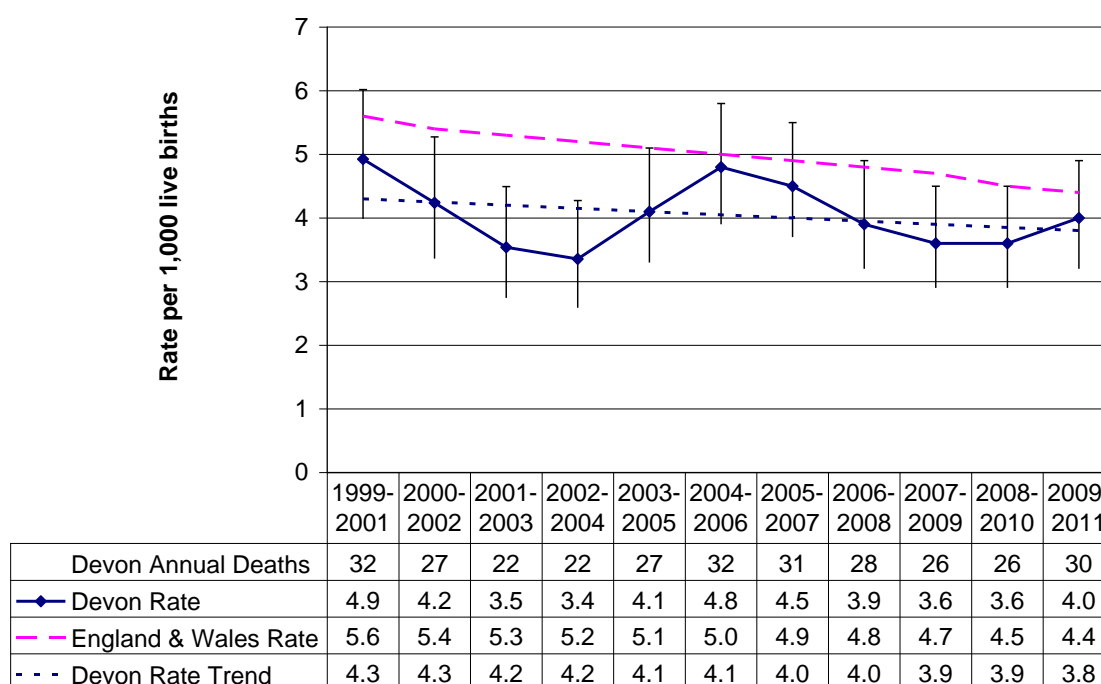


Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Infant Mortality

Figure 3.3 below illustrates how the rates have changed in Devon since 1999-2001. Three year rolling averages are used because of the low numbers. While the infant mortality rate was significantly lower than the England and Wales rate from the period 2000-02 to 2004-06, this difference is no longer present; although the Devon trend is still decreasing, it is doing so at a slower rate than for England and Wales. This suggests that more could be done locally to prevent infant deaths.

Figure 3.3: Infant mortality rates (per 1,000 live births) in Devon for three-year periods between 1999 and 2011



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

Smoking in Pregnancy

In Devon around 1 in 10 women smoke in pregnancy (9.9%). Although this is better than the national average of 13.2%, the impact is startling. Smoking during pregnancy is estimated to contribute to 40% of all infant deaths, by increasing the risk of cot death, risk of premature birth and poorer lung function than babies born to non-smoking mothers. Children born to mothers who smoke are also more likely to become smokers themselves later in life. 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%.

Breastfeeding

Breastfeeding initiation rates had increased between 2005 and 2010 from 76% to 81% nationally. (UK Infant Feeding Survey 2010).

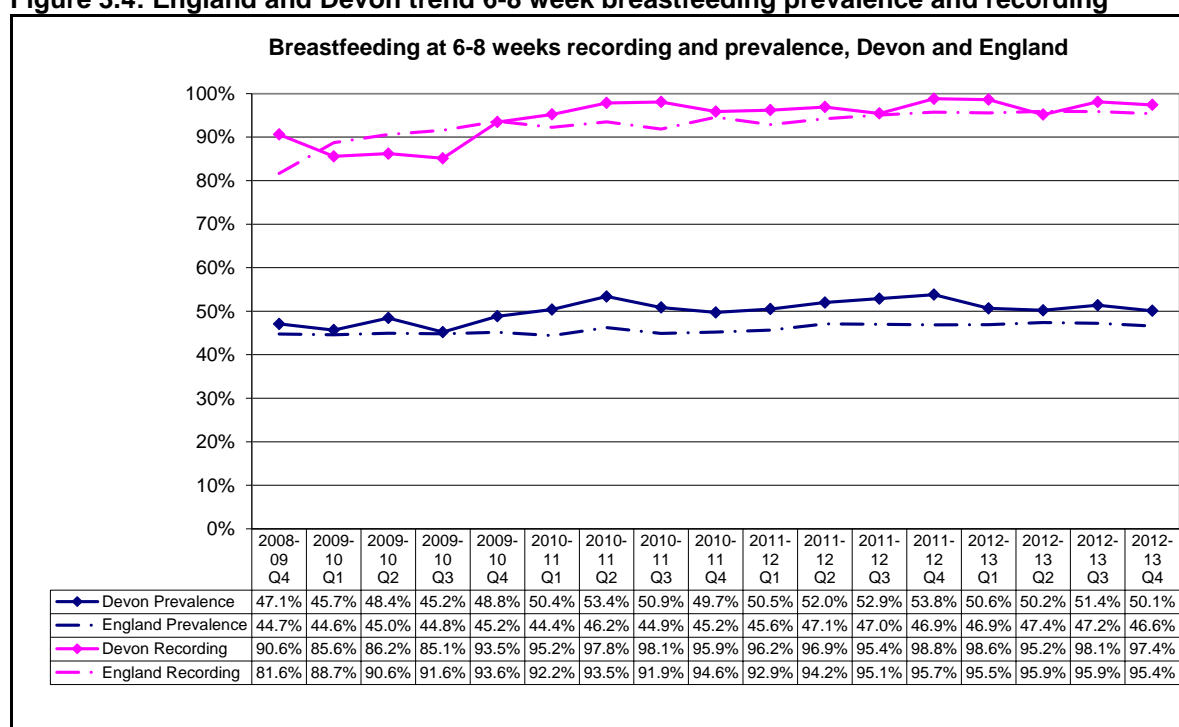
The World Health Organization (WHO) recommends that infants are fed exclusively on breast milk until the age of six months and then breastfed alongside food for as long as the mother and baby are happy. Evidence shows that as well as providing all the energy and nutrients that the child needs in its first few months of life, breast milk promotes sensory and cognitive development. It leads to slower, healthier weight gain, reducing the chance

of later obesity. It provides greater protection from infectious and chronic disease. Babies breastfed for a minimum of six months are less likely to experience colic, constipation, vomiting, diarrhea, chest infections and thrush. Breastfeeding has also been shown to reduce the risk of ovarian and breast cancer in mothers (Department of Health, 2011). Nationally, only 1% of babies are exclusively breastfed at 6 months and 34% combined breastfeeding and other milk or food, showing that most mothers do not follow this advice. Across Devon at the end of quarter 4 2012-13 78% of mothers initiated breastfeeding at birth, compared to 74% in England overall. The proportion of mothers still exclusively breastfeeding in Devon by the time of the primary birth visit, at between 10-14 days, is considerably lower at 49%. By 6-8 weeks the proportion of mothers exclusively breastfeeding their babies had dropped to 40%.

The proportions of mothers either exclusively breastfeeding or mix feeding at 6-8 weeks is monitored by the Department of Health quarterly. Figure 3.4 below shows the trend in both recording of feeding method and prevalence of breastfeeding and mixed feeding across Devon. In quarter 4 in 2012-13 50.1% of mothers were breastfeeding. Devon had a slightly higher rate of breast and mix feeding at 6-8 weeks than both the South West and England average.

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

Figure 3.4: England and Devon trend 6-8 week breastfeeding prevalence and recording

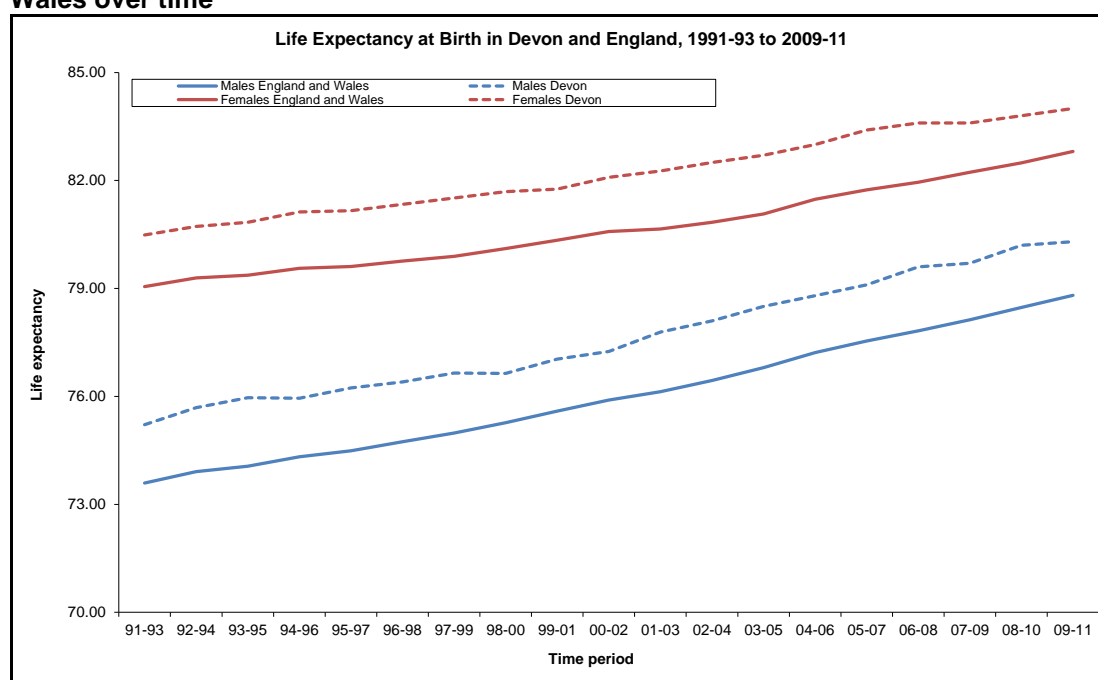


Source: Health and Social Care Information Centre

Life Expectancy at Birth

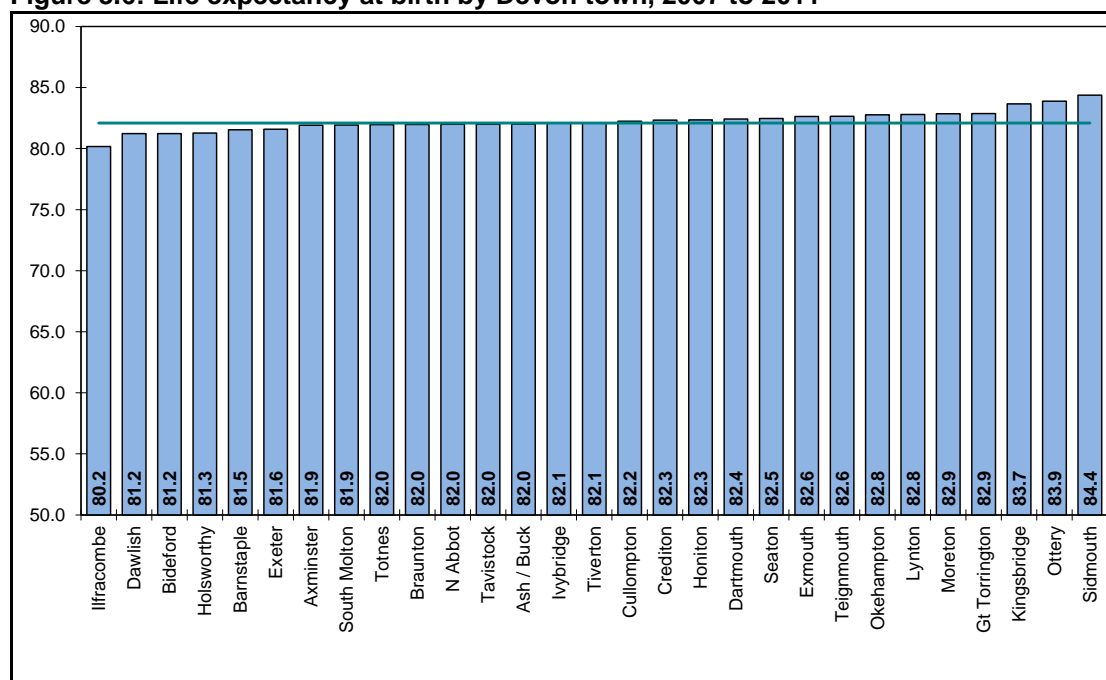
Life expectancy in Devon is above the national average, standing at 80.2 years for males and 84.0 for females compared with 78.81 and 82.81 nationally. Figure 3.5 highlights increasing average life expectancy from 1991-93 through to 2009-11. Whilst Devon has longer life expectancy overall, there are some significant differences on a local level. Figure 3.6 shows overall life expectancy by locality and town in Devon for 2007-11, highlighting shorter life expectancy in Northern Devon. Even greater differences are seen at ward level, as illustrated in Figure 3.7, which reveals a 12.1 year gap between the shortest life expectancy (Ilfracombe Central at 75.5) and the longest (Three Moors at 87.6). There are also major differences within districts, such as the 9.7 year gap in North Devon (Ilfracombe Central at 75.5 to Marwood at 85.2), the 9.4 year gap in Torridge (Tamarside at 78.2 to Three Moors at 87.6) and the 9 year gap in South Hams (Charterlands at 77.5 to Ivybridge Woodlands at 86.5). Table 3.2 shows the life expectancy gap by different geographies across Devon. This clearly identifies the variation among smaller areas in Devon, with the life expectancy gap varying from 0.8 years between NHS Devon localities, and up to 16.3 years by lower super output areas in Devon.

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



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

Figure 3.6: Life expectancy at birth by Devon town, 2007 to 2011



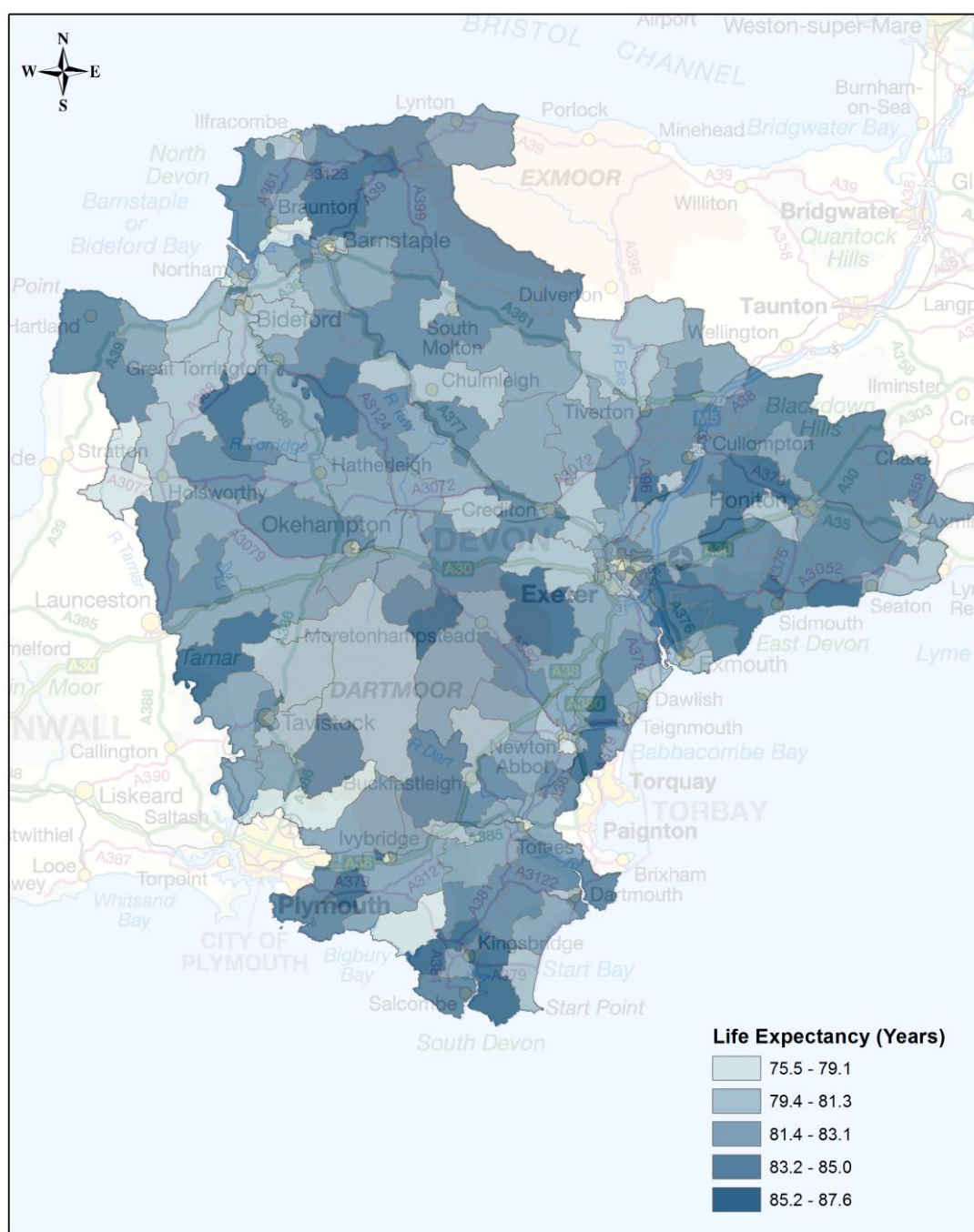
Source: Public Health Mortality Files, Office for National Statistics, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Table 3.2: Life expectancy at birth by different Devon geographies, 2007-11

| Area Type | Number of Areas | Longest Average Life Expectancy | Life LE | Shortest Average Life Expectancy | Life LE | Gap (Years) |
|--------------------------------|-----------------|---------------------------------|---------|----------------------------------|---------|-------------|
| | | Area | | Area | | |
| Lower Layer Super Output Area | 457 | Sidmouth (Woolbrook area) | 90.0 | Exeter (Longbrook Street area) | 73.7 | 16.3 |
| Ward | 201 | Three Moors | 87.6 | Ilfracombe Central | 75.5 | 12.1 |
| Middle Layer Super Output Area | 107 | North Sidmouth | 86.7 | Exeter (St James area) | 77.1 | 9.6 |
| Electoral Division | 62 | Exeter St Loyes & Topsham | 85.1 | Exeter St David's & St James | 77.9 | 7.2 |
| Devon Town | 29 | Sidmouth | 84.4 | Ilfracombe | 80.2 | 4.2 |
| National Deprivation Quintile | 5 | Least Deprived | 83.9 | Most Deprived | 78.0 | 5.9 |
| Local Authority District | 8 | East Devon | 82.9 | Exeter | 81.4 | 1.5 |
| Devon County Council Locality | 3 | Eastern | 82.3 | Northern | 81.5 | 0.8 |

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

Figure 3.7: Life expectancy at birth by Devon electoral ward, 2007 to 2011



Public Health Devon

Public Health Intelligence Team

Devon
County Council

Map Title: Life Expectancy by Ward, Devon, 2007-11

Date: 10 April 2013

Author: Devon Public Health Intelligence Team

0 7,000 14,000 28,000 Meters



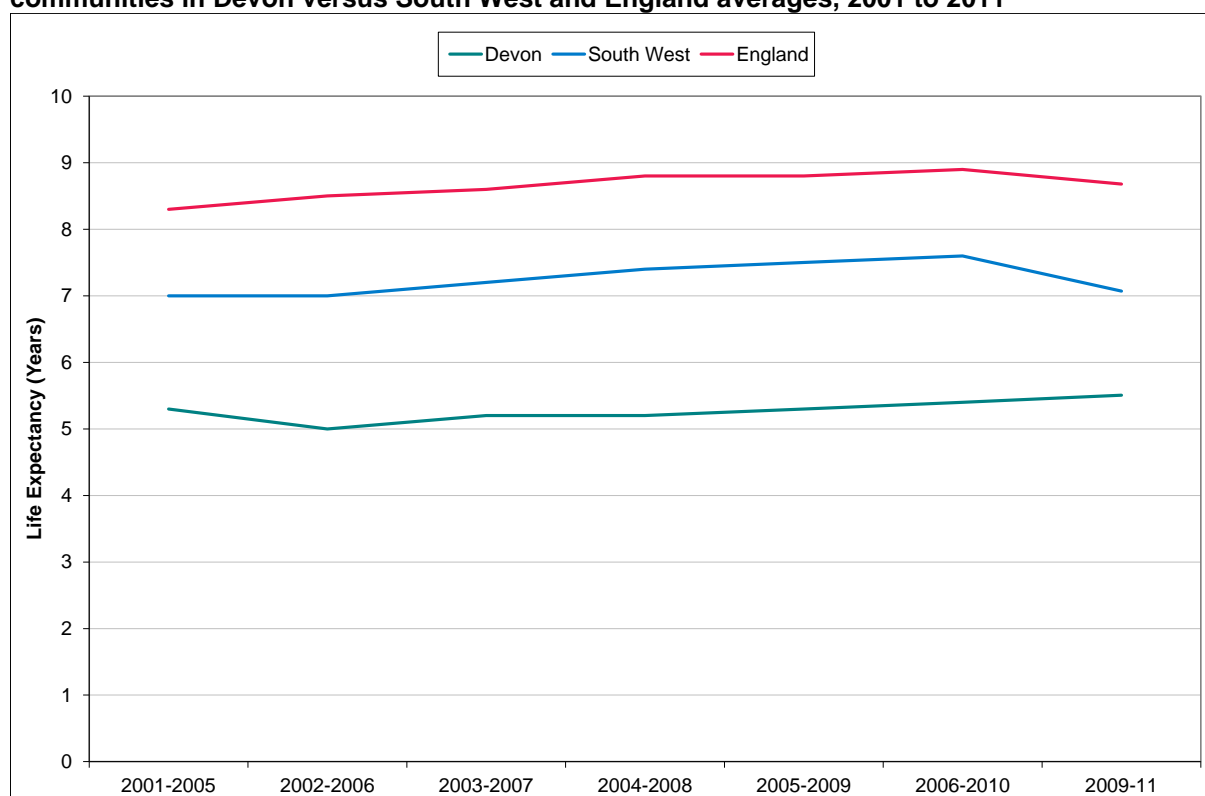
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Slope Index of Inequalities

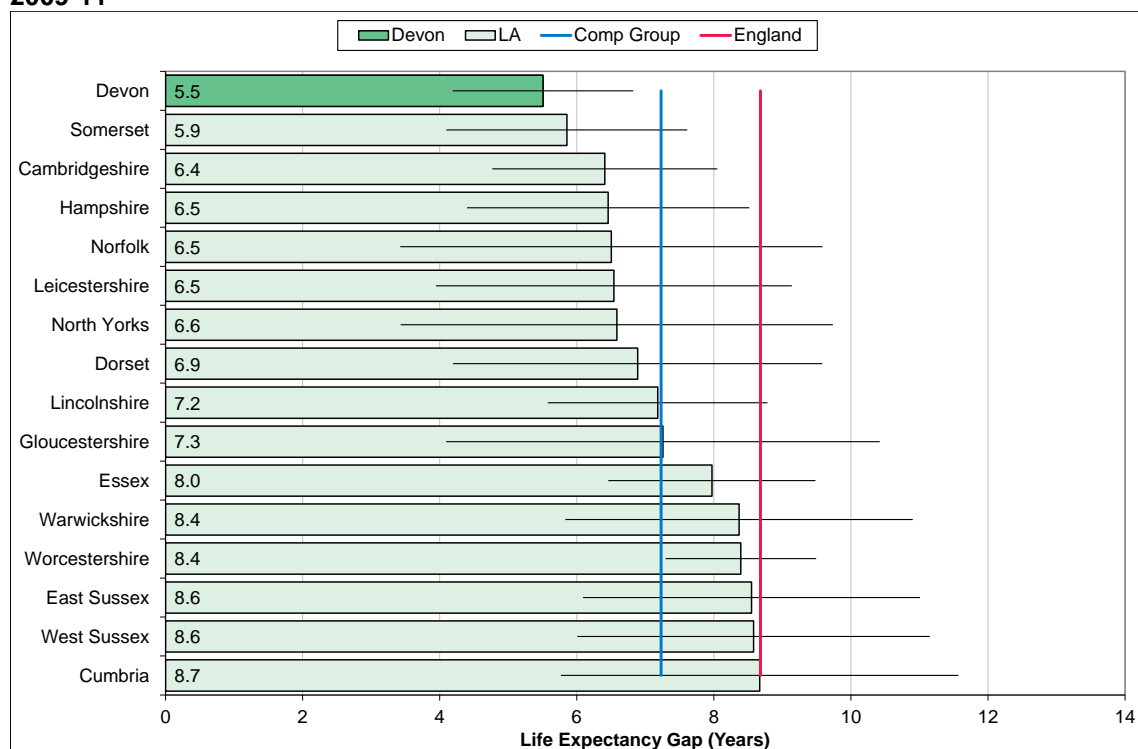
The Slope Index of Inequality is a national indicator which compares life expectancy in the most and least deprived communities an area's population to produce the 'gap' in life expectancy in years. Figure 3.8 compares the life expectancy gap for males in Devon, Plymouth and Torbay with the South West and England figures, revealing a significantly smaller gap in Devon. The gap decreased slightly in Devon in 2009-11. Figure 3.9 shows the male life expectancy gap for similar upper tier/unitary local authorities, illustrating that the Devon gap (in green) is the smallest in the local authority comparator group. Figures 3.10 and 3.11 present the same analysis for females. Devon has a smaller gap in female life expectancy than nationally or regionally, although the gap increased slightly in 2009-11. Devon has the second smallest gap in the local authority comparator group for females. One important element to note with this analysis is that Devon has very few areas which are either very deprived or very prosperous, and therefore does not contain the stark social inequalities seen in other areas across the country. Therefore, in Devon, the small gap in life expectancy shown by this analysis is not a true representation of the levels of social inequality experienced across the county.

Figure 3.8: Gap in male life expectancy (years) between most and least deprived communities in Devon versus South West and England averages, 2001 to 2011



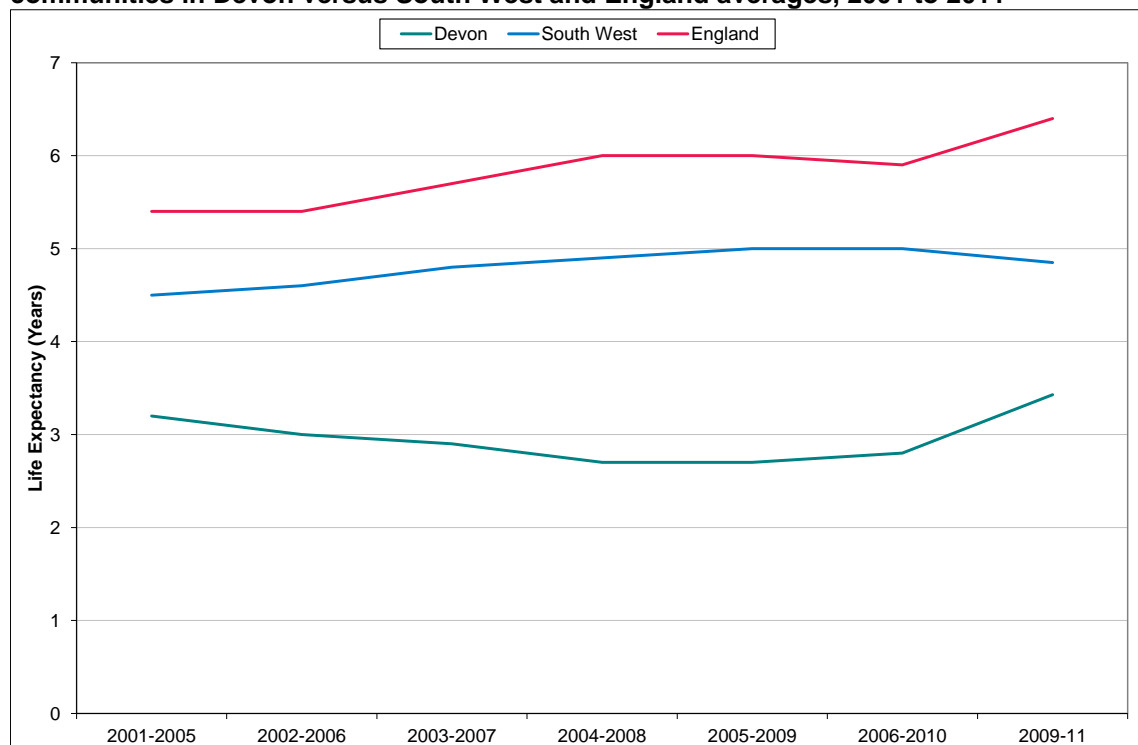
Source: Slope Index of Inequalities, Association of Public Health Observatories. Public Health Mortality Files, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0; and Indices of Deprivation 2010

Figure 3.9: Gap in average male life expectancy (years) between most and least deprived communities by upper tier/unitary local authority, Devon Local Authority Comparator Group, 2009-11



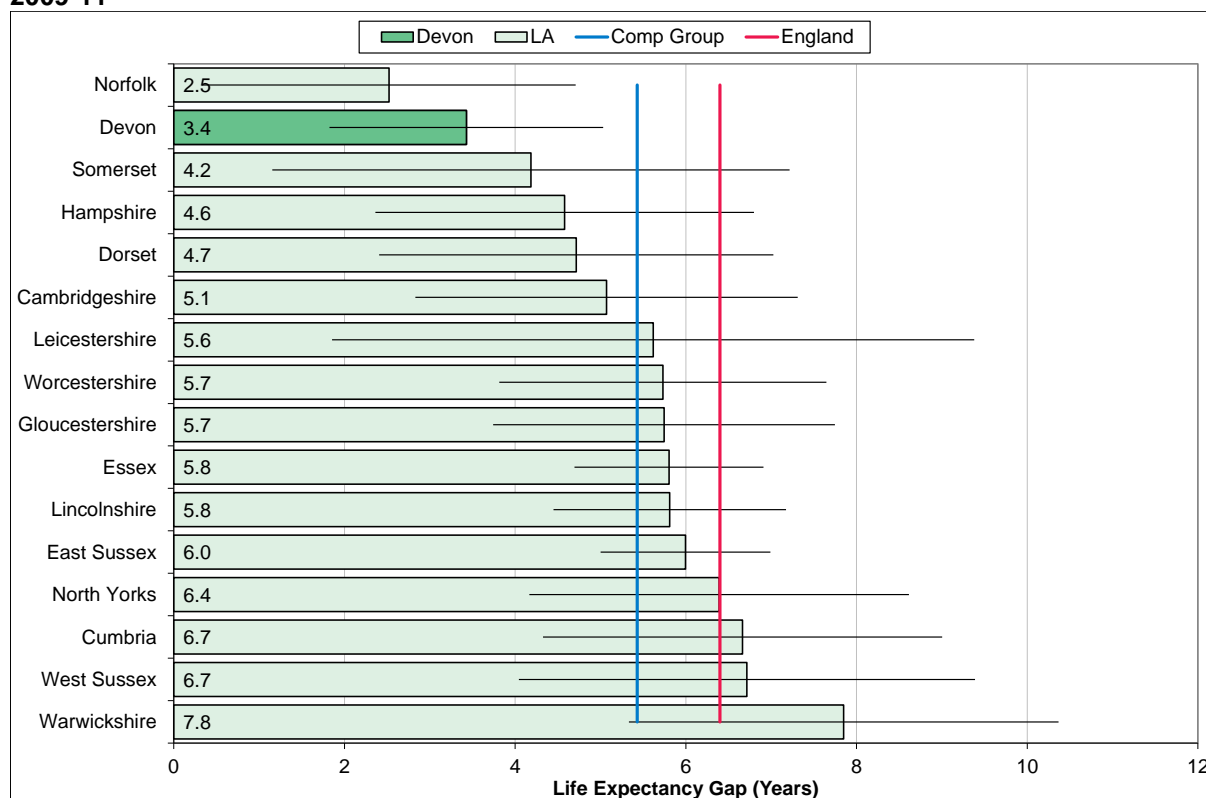
Source: Slope Index of Inequalities, Association of Public Health Observatories. Public Health Mortality Files, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0; and Indices of Deprivation 2010

Figure 3.10: Gap in female life expectancy (years) between most and least deprived communities in Devon versus South West and England averages, 2001 to 2011



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

Figure 3.11: Gap in average female life expectancy (years) between most and least deprived communities by upper tier/unitary local authority, Devon Local Authority Comparator Group, 2009-11



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

Ethnicity in school children

In January 2013 there were 5,614 pupils from a minority ethnic background in Devon schools. This represents 6.5% of the total school population. Over 45 schools now have more than 10% of their roll recorded as Black and Minority Ethnic (BME). However, in contrast, there are still a few schools with no BME pupils. There is variation across the county, with Exeter having the highest proportion of pupils from minority ethnic backgrounds at 12.7%. The largest numbers are White Eastern European (928), White Western European (632) and White Asian (556) .

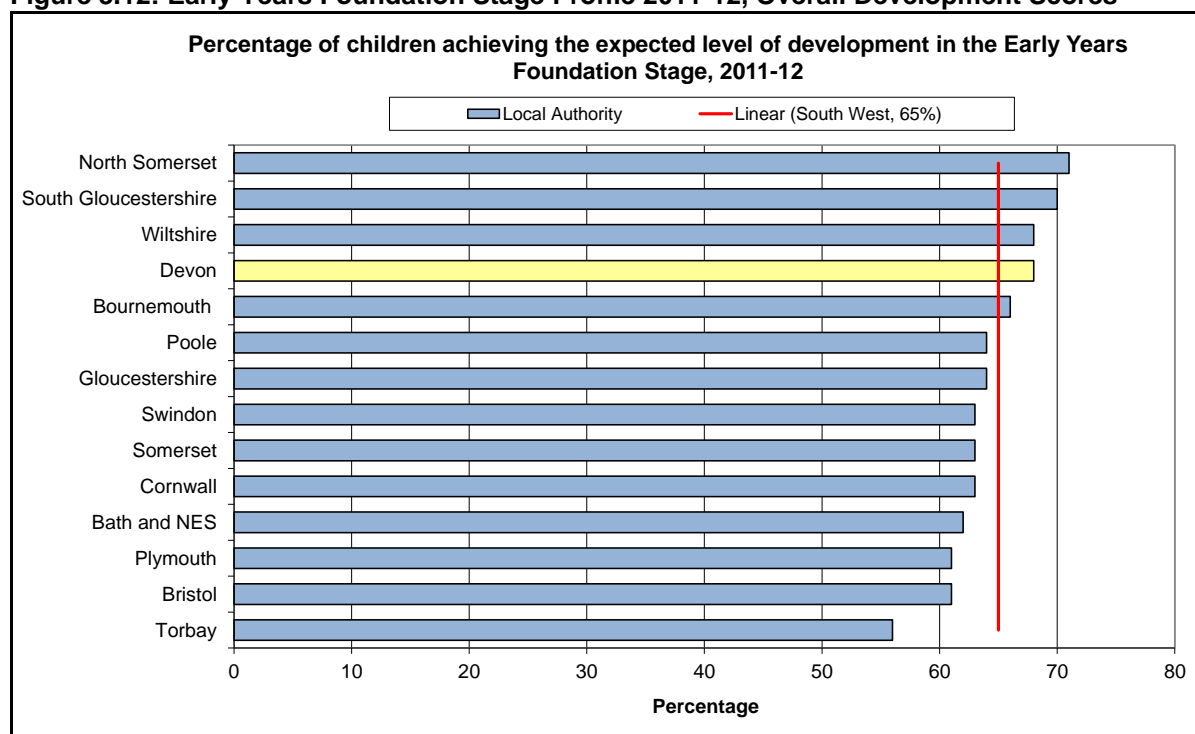
Children with English as an Additional Language

In January 2013 there were 2,607 pupils speaking English as an additional language in Devon schools. This represents 2.8% of the total school population. There are around 100 different languages spoken by children and young people in Devon schools, the largest minority languages in 2011 being Polish (430) and Arabic (146).

Education

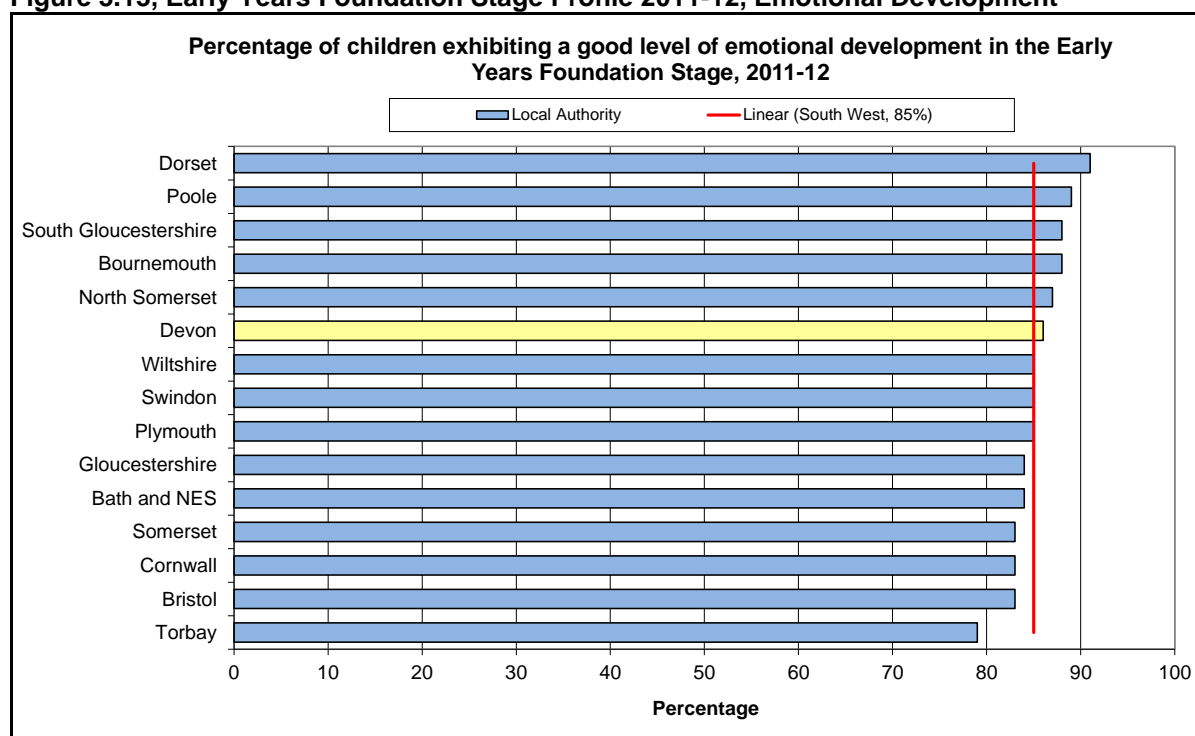
The Early Years Foundation Stage (EYFS) Profile collects data on the development of children aged five, based on teacher assessments of individual children. These are reported annually to the Department for Education. In Devon, the proportion of children achieving the expected level of development through the EYFS was 68% which is above the South West average of 65% and the national average of 64%. The results record various areas of development, including emotional development. The results for 2011-12 indicate 85% of children nationally and in the South West had a score indicating good emotional well-being; this figure was slightly higher in Devon at 86%.

Figure 3.12: Early Years Foundation Stage Profile 2011-12, Overall Development Scores



Source: Department for Education

Figure 3.13, Early Years Foundation Stage Profile 2011-12, Emotional Development



Source: Department for Education

Key Stage 4 results improved again in 2012 (58.5% gaining 5 A*-C including English and Maths), showing an improvement of nearly 4% on 2010. Girls are still outperforming boys with 64.5% to 53% gaining five A*-C (inc. E&M).

Youth Offending

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

Devon Youth Offending Service is an effective example of integrated multi agency team-working in both its statutory court and supervision work, its pre-court work and is one of only a few Youth Offending Services nationally that still manages and delivers its own early intervention services, Youth Inclusion & Support Programme, which work to prevent offending behaviour.

The level of offending by children and young people is relatively low in Devon 550 young people offended in 2012/13 committing a total of 961 offences.

The total number of young people aged 10-17 years who offended in Devon has fallen by 41% between 2010 and 2012 and the overall number of offences committed has fallen by 46% within the same period.

The highest number of offences committed in 2012 was violence against the person (25%), theft & handling (19%), criminal damage (11%) and drugs offences (11%).

Whilst we continue to see significant reductions in both the total number of young people on youth offending caseloads and the number of first time entrants into the criminal justice system we are seeing proportionately more of the cases being complex in nature, with multiple needs e.g.

- known behavioural conditions
- complex Speech, Language & Communication Needs (SLCN)
- Children in Care
- children with assessed vulnerability and/or risk of harm levels

In 2012/13, 30% of young people were assessed as having medium to high levels of vulnerability (i.e. 84) and only 21% are assessed as having no vulnerability risk. 22% of young people (i.e. 60) were assessed as being at risk of causing harm to others.

Accidents and Unintentional Injuries

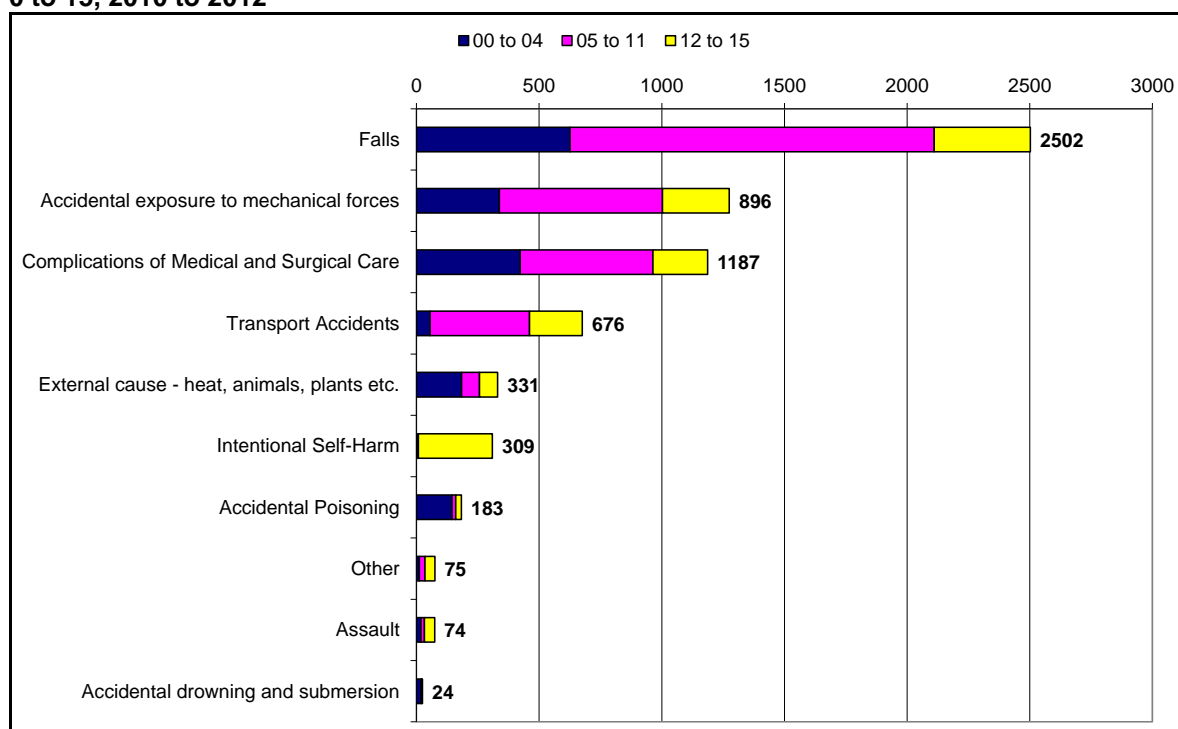
Accidents and unintentional injuries are the leading cause of death among young people between 1 and 14 years of age and cause more children to be admitted to hospital each year than any other reason. Falls are also a major cause of disability and the leading cause of death resulting from injury in people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

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

There were a total of 184 accidental deaths in Devon in 2010, with 32 relating to land transport accidents and 152 to other causes. Deaths from land transport accidents are higher in younger age groups. Breakdowns of hospital admissions due to injuries from external causes by age are presented in Figures 3.14 and 3.15. This highlights that falls are by far the largest cause of admissions in all age groups.

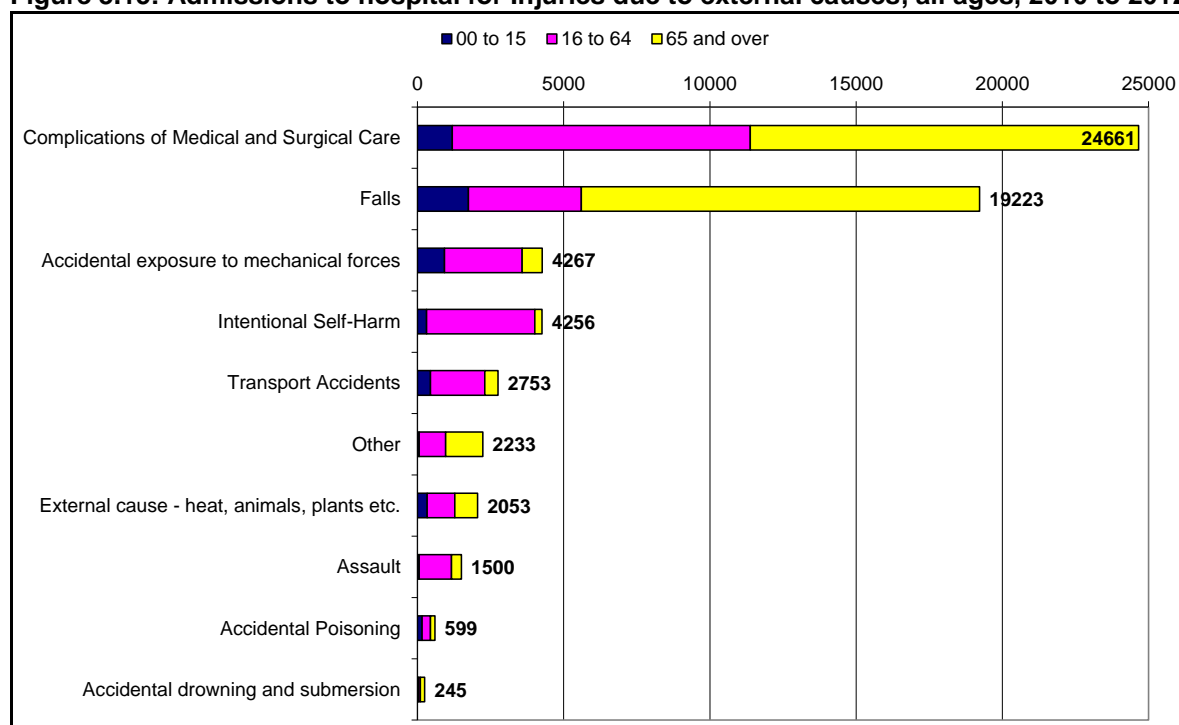
Falls prevention is identified as a top priority area within the Devon Prevention Strategy: Promoting Independence and Wellbeing for Adults, 2011 – 13 (2010) which builds on work undertaken over recent years within NHS Devon to identify older people at a higher risk of falling to be supported through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

Figure 3.14: Admissions to hospital for Injuries due to external causes by age, persons aged 0 to 15, 2010 to 2012



Source: Secondary Uses Service, Commissioning Dataset, National Health Service, Crown Copyright 2013

Figure 3.15: Admissions to hospital for Injuries due to external causes, all ages, 2010 to 2012



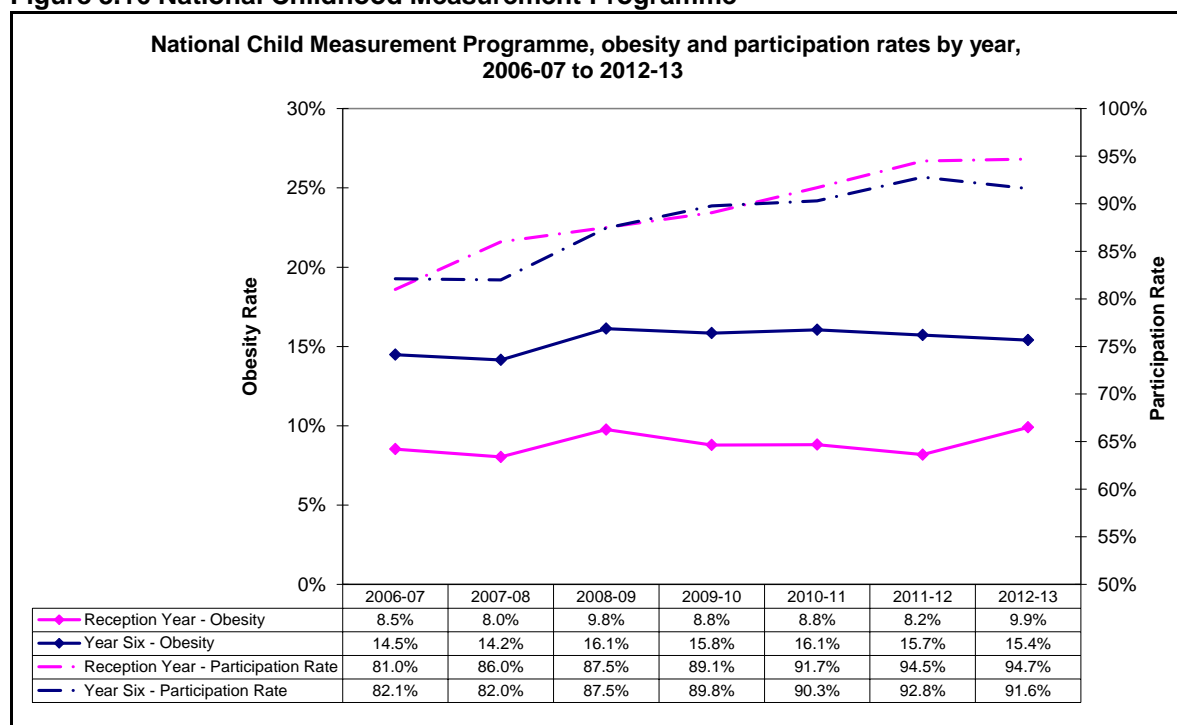
Source: Secondary Uses Service, Commissioning Dataset, National Health Service, Crown Copyright 2013

There were a total of 1,616 emergency admissions (0 to 15yrs) following an accident for the period 2010-12, and a total of 65,562 Accident and Emergency cases for the same age group within the same time period. It is estimated that approximately half of the accident and emergency cases for this age group is as a result of unintentional injuries. In 2009, NHS Devon published the 'Preventing unintentional injuries in children and young people in Devon strategy'. A multi-agency steering group has been established to take forward the recommendations from this strategy. As part of this, a Devon mapping exercise has been completed to identify all current interventions for preventing unintentional injuries. The steering group has also identified areas for improvement.

Obesity

The National Childhood Measurement Programme which weighs and measures children at school entry in reception year and at the end of primary school in Year six is now in its eighth year. The graph below shows the trend shown in Devon over the past six years. The participation is now over 90% in both year groups and obesity has remained relatively stable. The latest nationally published data is for 2012/13 and shows Devon to be above the England average (9.3%) obesity prevalence rates at 9.9% in Reception year and below the national average (19.9%) at 15.4% in Year 6.

Figure 3.16 National Childhood Measurement Programme



Source: Health and Social Care Information Centre

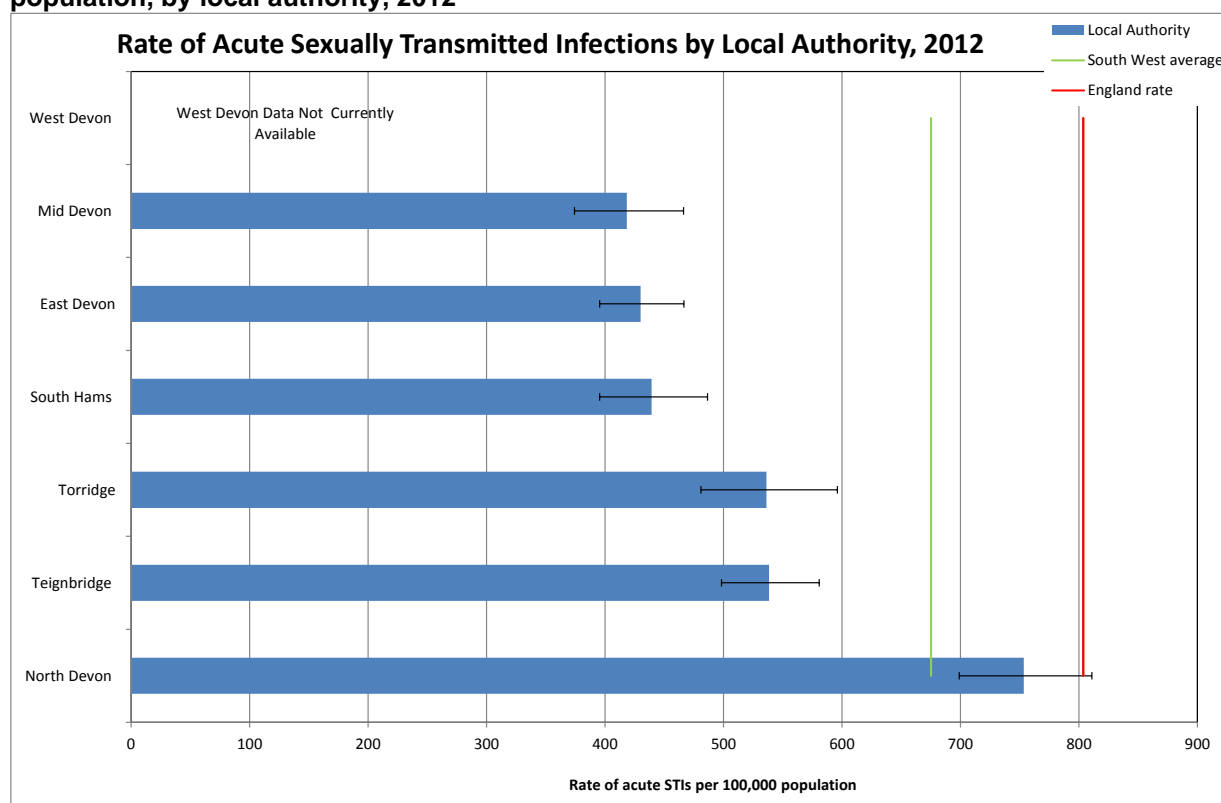
Sexual Health and Teenage Pregnancy

The commissioning of sexual health services has changed in the reorganisation of healthcare services since April 2013. 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 should be addressed through the development of a new sexual health partnership to ensure that sexual health outcomes improve, as they are an area where health inequality exists.

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

Figure 3.17 below shows that rates of acute sexually transmitted infections in Devon were lower than both the South West and England average 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 statistically 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 early signs that 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.

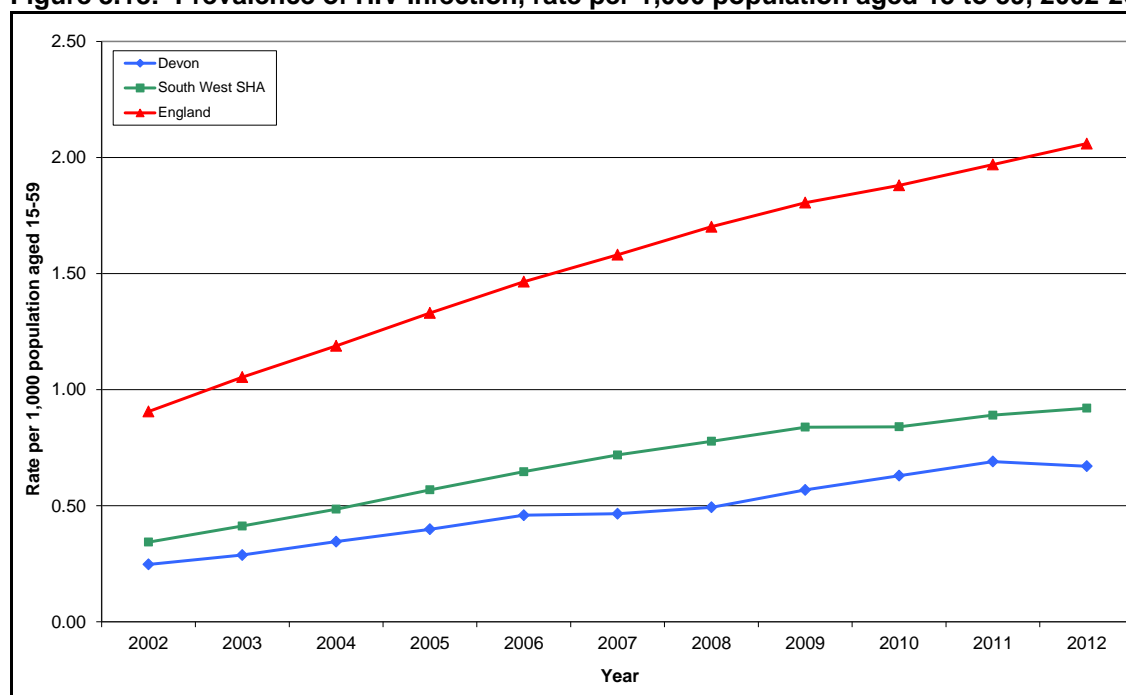
Figure 3.17: Rates of acute sexually transmitted infections diagnoses per 100,000 population, by local authority, 2012



Source: Public Health England, Local Authority Health Profiles

HIV (Human Immunodeficiency Virus) remains one of the most serious communicable diseases in the United Kingdom, associated with morbidity, mortality and high numbers of years of life lost. There are high costs associated with both treatment and care. In the United Kingdom, health protection data shows an increase in HIV cases, peaking in 2005 and has since begun to decrease. The numbers vary across the United Kingdom and Devon has a lower rate than the South West and England average. Figure 3.18 shows the prevalence of HIV in Devon, the South West and England. The Devon prevalence is considerably lower than nationally, and in the latest year, after a steady increase, the rate has shown a decrease. Prevalence varies across local authorities with South Hams having the lowest prevalence (0.48 per 1,000 aged 15 to 59) and Exeter having the highest (1.17 per 1,000 aged 15 to 59).

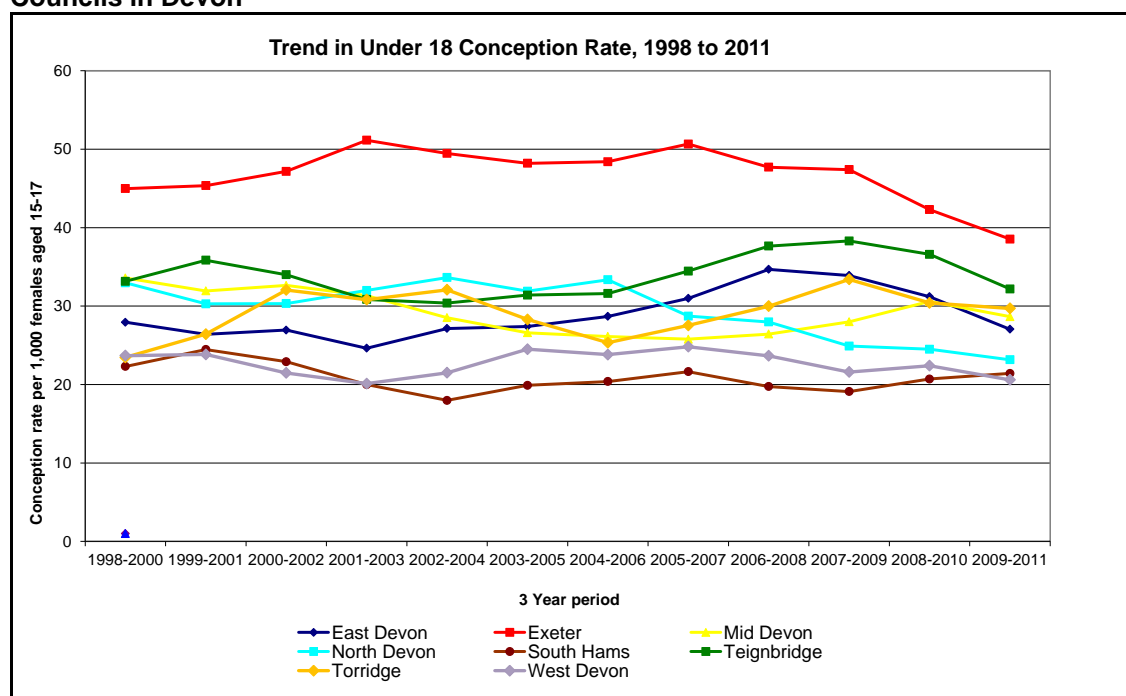
Figure 3.18: Prevalence of HIV Infection, rate per 1,000 population aged 15 to 59, 2002-2012



Source: Public Health England

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 3.19 shows teenage conception rates by District Council for Devon, highlighting that the highest rates are seen in Exeter. 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 beginning to show a good downward trend. Mid Devon and South Hams both have generally lower rates but need to be monitored as have shown slight increases over the past few years.

Figure 3.19: Under-18 conception rates per 1,000 15 to 17 year-old females for District Councils in Devon



Source: Office of National Statistics

NEETS, Education and Learning

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

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

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 that children are growing up in circumstances consistent with the provision of safe and effective care, and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.” (Working Together to Safeguard Children, 2010)

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

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

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

<http://www.devonhealthandwellbeing.org.uk/health-andwellbeing/groups/safeguarding/children/>

Ofsted carried out an inspection of Devon County Council's arrangements for safeguarding children earlier this year (2013) and found the overall effectiveness of Devon's arrangements to be inadequate. In response to this a Children's Safeguarding Improvement Board has been established led by an independent chair. The board oversees the Child Protection Improvement Plan and monitors its impact and effectiveness. The Ofsted Delivery Improvement Group has been established which is responsible for the delivery of the Improvement Plan and its three workstreams of Quality Assurance, Quality of Practice and Early Help.

There has been a rapid rise in demand for children's social care assessments. Prior to the Ofsted inspection earlier in the year there were in the region of 400 initial assessments started each month, post Ofsted this has increased to over 700. At the end of March 2013 there were 297 open assessments (329 in March 2012), by the end of September 2013 there were 2155 open assessments.

There were 604 children with a child protection plan in September 2013, up from 446 in March 2013 and 404 in March 2012. There were 686 children in care in September 2013, compared to 693 in March 2013 and 711 in March 2012. There were 7,187 children in need in September 2013, compared to 4,648 in March 2013.⁵

The number of people receiving Tier 2 social care (Early Help) support has declined, from 426 cases held in March 2013 to only 114 in September 2013⁶.

Safeguarding and Complex and Multiple Needs

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

A Devon study in 2010 of 101 young people with a Child Protection Plan found that 99% were living in families with multiple and complex needs. With respect to the needs and risk factors in the young people's parents:

- 33% of young people were affected by both domestic violence and parental mental health issues
- 27% of young people had parents offending and parents with substance misuse

⁵ DfE Children in Need data collections 2012, 2013

⁶ Devon County Council Children's Social Work Volume and Activity Data Senior Management Team Monthly Report, September 2013

- 20% of young people had both poor housing (inc. homelessness, threat of eviction, unsafe/overcrowded housing) and domestic violence.

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

Troubled Families

National policy recognises that multiple needs within families can compound and exacerbate their difficulties and subsequent cost to services. The Troubled Families Programme is a key plank in the government's approach to social justice and to reducing public sector costs. It intends to turn around the lives of 120,000 'Troubled Families', which equates to an estimate of 1370 in Devon, who have multi risk factors by the end of the Coalition term of office. It focuses on those families where:

- no adult in the family is working
- children are not in school
- family members are involved in crime and anti-social behaviour
- there is 'high cost' to the system

Within Devon there is a long tradition of seasonal or under employment. This contributes to the cycle of deprivation or poverty in disadvantaged communities but is often not reflected in National policy as that tends to focus on those completely out of work. Attributing the national criteria to the need profile in Devon has been challenging as a result. Negotiations with the Department of Communities and Local Government who are charged with overseeing the programme has led to the following criteria for risk categories in Devon being developed:

1. Youth Crime and Anti-social Behaviour (mandated)
Under 18 in the household that has offended in the last 12 months OR A member of the household has received a second letter from a Community Safety Partnership in last 12 months regarding ASB (or equivalent status as assessed by a Provider of social housing) 1817 individuals within 1315 families identified in Devon cumulatively (July 2013)
2. Education (mandated)
Child in household has been subject or permanent or 3 year fixed term exclusions in last school year OR at any point in the last school year child in household has been in receipt of DPLS service after previous exclusion OR child missing education in household that is currently subject to EWO referral OR under 17 in household had a unauthorised absence rate of >15% in last school year. 1711 individuals within 1453 families identified in Devon cumulatively (July 2013).
3. An adult in the household is currently in receipt of 'out of work' benefits: 1211 individuals within 853 families cumulatively (July 2013).

4. Child at Risk (local discretion) Child in household has social care classification 'In Need' (including child Protection Plan, Children in Care) OR In the last year there has been at least one repeat referral to the Multi Agency Safeguarding Hub (MASH) regarding the child in a household 4649 individuals identified in Devon (July 2013).

Households where at least three of these risk categories exist are classified as 'troubled' but local authorities and partners have some flexibility in including families who have two out of three of the characteristics of a 'Troubled Family' and other more locally identified needs and who would benefit from a different service response

Transition

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

4 ADULTS – *GETTING THE BALANCE RIGHT*

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

Housing

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

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

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

Health inequalities are related to the shortage of new homes and the affordability of housing in general. Affordability can lead to poor mental health; over six million households state that they are suffering from stress and depression due to their housing costs, whilst 14% of households live in houses that are too small for them. The ratio of house prices to earnings is one measure of how affordable it is to buy a property. The higher the ratio, the less affordable it is for households to get onto the property ladder. Figure 4.1 shows affordability ratios across Devon are higher than the national average. The ratios vary from district to district and in 2012 the highest ratio was in South Hams and the lowest in Exeter.

Figure 4.1: House Prices to Earnings Ratio, 2000-2012, Source: Department for Communities and Local Government



Homeless

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. In July 2013 a Health Audit was carried out to understand the health needs of the homeless population in Totnes, South Devon and the barriers that there were to accessing services. This was in response to 3 deaths among people with a history of rough sleeping. 25 people completed the survey and a report will be available In January 2014.

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. The evaluation method has been changed by the current government; arguably this combined with the economic downturn has seen numbers of rough sleepers rise.

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 will be selected in Exeter and the project developed in 2014.

A Homelessness Prevention Needs Assessment was completed by Devon County Council in 2013 and included the following diagram which illustrated Devon's housing defined homelessness needs data by severity.

Figure 4.2: Housing authority homelessness need in Devon by severity

| Rationale for severity of need | Description and volumes* of Devon's housing defined homelessness vulnerability | | | | | | |
|--|--|---|--|---|--|--|--|
| <ul style="list-style-type: none"> This section of the community could not be said to have a definable or quantifiable need | People (each year) with any kind of homelessness related needs, including those people that do not approach (non-engaged) housing advice for help Total number = unknown, but probably less than 8000 | | | | | | |
| <ul style="list-style-type: none"> A low level of need could be said to exist for 89% of this group. Some within this group (11%) are likely to have a more significant need. | <table border="1"> <tr> <td>People approaching housing advice for assistance Total number during 2012 = 7818</td><td></td></tr> <tr> <td>People that Housing Advice has been able to resolve things for, through preventative advice and actions = 2815</td><td></td></tr> <tr> <td>Homelessness applications = 883</td><td></td></tr> </table> | People approaching housing advice for assistance Total number during 2012 = 7818 | | People that Housing Advice has been able to resolve things for, through preventative advice and actions = 2815 | | Homelessness applications = 883 | |
| People approaching housing advice for assistance Total number during 2012 = 7818 | | | | | | | |
| People that Housing Advice has been able to resolve things for, through preventative advice and actions = 2815 | | | | | | | |
| Homelessness applications = 883 | | | | | | | |
| <ul style="list-style-type: none"> Many people in this group could be said to have a significant need, and some may have an urgent need | <table border="1"> <tr> <td>Homeless acceptances = 297</td><td></td></tr> <tr> <td>Temporary accommodation = 255</td><td></td></tr> <tr> <td>Hospital delayed discharges = 165</td><td></td></tr> </table> | Homeless acceptances = 297 | | Temporary accommodation = 255 | | Hospital delayed discharges = 165 | |
| Homeless acceptances = 297 | | | | | | | |
| Temporary accommodation = 255 | | | | | | | |
| Hospital delayed discharges = 165 | | | | | | | |
| <ul style="list-style-type: none"> Most people in this group could be said to a significant and urgent need | <table border="1"> <tr> <td>Rough sleepers = 66 (streetcount) Or 112, (survey)</td><td></td></tr> </table> | Rough sleepers = 66 (streetcount) Or 112 , (survey) | | | | | |
| Rough sleepers = 66 (streetcount) Or 112 , (survey) | | | | | | | |

During 2013 the impact of homelessness upon Health has been highlighted by studies into the pressures upon hospital beds and A&E waiting times. Devon put in a successful bid for Health 'Homeless Hospital Discharge Fund' resources. Aside from the potential for the bid itself to change and improve hospital discharge pathways, the bid preparation represented a unique Devon-wide study of the way that homelessness needs can combine with health needs to create a more complex need for commissioners to respond to. The bid suggests that within Devon & Torbay over three years (2010/11 – 2012/13):

- The number of Inpatients discharged as 'NFA' (No fixed abode) was 377, consisting of 275 unique individuals.
- The number of 'NFA' A&E attendances was 2,990, consisting of 1,306 unique clients.
- The five most frequent individuals were admitted to hospital 59 times.
- The five most frequent individuals attended A&E 240 times.

The consultation for the bid revealed that NHS stakeholders were confident that many more homeless clients than just those captured in the above figures were not currently identified or recorded.

Migrants

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

The 2011 Census recorded country of birth of all usual residents in the UK. The table below shows a breakdown of the area of countries of birth of Devon local authority residents. The census showed that Exeter had the highest proportion of residents born outside of the UK, with the highest proportion in Devon from both other EU countries and other non EU countries, with Mid Devon having the second highest proportion of residents from other EU countries and South Hams having the second highest proportion from other countries.

Table 4.1: - Country of Birth by Local Authority

| Country of Birth | Devon | | East Devon | | Exeter | | Mid Devon | | North Devon | | South Hams | | Teignbridge | | Torridge | | West Devon | |
|--|---------|------|------------|------|---------|------|-----------|------|-------------|------|------------|------|-------------|------|----------|------|------------|------|
| United Kingdom | 703,841 | 94.3 | 125,924 | 95.1 | 104,759 | 88.9 | 73,931 | 95.1 | 89,481 | 95.5 | 78,662 | 94.6 | 118,429 | 95.3 | 61,648 | 96.6 | 51,007 | 95.2 |
| Ireland | 2,668 | 0.4 | 515 | 0.4 | 469 | 0.4 | 251 | 0.3 | 307 | 0.3 | 317 | 0.4 | 445 | 0.4 | 177 | 0.3 | 187 | 0.3 |
| Other EU | 15,307 | 2.1 | 2,311 | 1.7 | 4,276 | 3.6 | 1,698 | 2.2 | 1,665 | 1.8 | 1,576 | 1.9 | 2,082 | 1.7 | 799 | 1.3 | 900 | 1.7 |
| Other EU: Member countries in March 2001 | 8,328 | 1.1 | 1,396 | 1.1 | 2,015 | 1.7 | 716 | 0.9 | 914 | 1.0 | 1,076 | 1.3 | 1,216 | 1.0 | 476 | 0.7 | 519 | 1.0 |
| Other EU: Accession countries April 2001 to March 2011 | 6,979 | 0.9 | 915 | 0.7 | 2,261 | 1.9 | 982 | 1.3 | 751 | 0.8 | 500 | 0.6 | 866 | 0.7 | 323 | 0.5 | 381 | 0.7 |
| Other countries | 24,583 | 3.3 | 3,707 | 2.8 | 8,269 | 7.0 | 1,870 | 2.4 | 2,214 | 2.4 | 2,585 | 3.1 | 3,264 | 2.6 | 1,215 | 1.9 | 1,459 | 2.7 |

Source: 2011 Census

Table 4.2 shows the proportion of households where all people have English as the main language, those where not all have English as a main language but at least one does and those households where no people have English a main language. Exeter has the highest proportion of households with no people speaking English a main language.

Table 4.2: English as a main language in households

| | All people aged 16 and over in household have English as a main language | | At least one but not all people aged 16 and over in household have English as a main language | | No people in household have English as a main language | |
|-------------|--|------|---|-----|--|-----|
| | Number | % | Number | % | Number | % |
| Devon | 314,218 | 97.4 | 4,282 | 1.3 | 3,747 | 1.2 |
| East Devon | 58,023 | 98.2 | 598 | 1.0 | 386 | 0.7 |
| Exeter | 45,774 | 93.0 | 1,491 | 3.0 | 1,816 | 3.7 |
| Mid Devon | 32,036 | 97.8 | 337 | 1.0 | 360 | 1.1 |
| North Devon | 39,202 | 98.0 | 391 | 1.0 | 367 | 0.9 |
| South Hams | 36,178 | 98.2 | 455 | 1.2 | 187 | 0.5 |
| Teignbridge | 53,039 | 98.2 | 566 | 1.0 | 352 | 0.7 |
| Torridge | 27,612 | 98.7 | 211 | 0.8 | 154 | 0.6 |
| West Devon | 22,354 | 98.4 | 233 | 1.0 | 125 | 0.6 |

Source: 2011 Census

Gypsies and Travellers

Table 4.3 highlights that 554 people, or 0.07% of the Devon population identified themselves as Gypsies or Irish Travellers in the 2011 Devon. Within Devon, the highest percentage was seen in Mid Devon.

Table 4.3: Number and percentage of Gypsies and Irish Travellers in Devon, 2011 Census

| Area | Number | Percentage |
|-------------|--------|------------|
| East Devon | 90 | 0.07% |
| Exeter | 93 | 0.08% |
| Mid Devon | 88 | 0.11% |
| North Devon | 45 | 0.05% |
| South Hams | 45 | 0.05% |
| Teignbridge | 118 | 0.09% |
| Torridge | 54 | 0.08% |
| West Devon | 21 | 0.04% |
| Devon | 554 | 0.07% |
| South West | 5,631 | 0.11% |
| England | 54,895 | 0.10% |

'The Health Status of Gypsies and Travellers in England', a report to the Department of Health produced by the University of Sheffield in 2004, found that:

- Health problems amongst Gypsy Travellers are between two and five times more common than the settled community
- Gypsy Travellers are more likely to be anxious, have breathing problems (including asthma and bronchitis) and chest pain. They are also more likely to suffer from miscarriages, still births, the death of young babies and older children.
- Gypsy Traveller women are twice as likely to be anxious than Gypsy Traveller men.

The report also looks at the use of health services and Gypsies and Travellers attitudes, beliefs and experiences of health and the health service. In it, Gypsies and Travellers talk about their experience of:

- Discrimination and bad communication with, and ignorance about, Gypsies and Travellers within the healthcare system. The report recognises the value of doctors and health workers who understand Gypsy and Traveller culture.
- Traveller attitudes to health, including a traditional belief in relying on yourself or family, suspicion of health services, and the belief that treatment will not be effective.
- The effect of the lack of access to education and decent accommodation has on Gypsy and Traveller Health

The report makes key recommendations aimed at improving Gypsy and Traveller health, and is intended to be a useful tool for the community to improve its access to the healthcare system. The report also identifies ways in which the health service can improve service delivery to the Gypsy and Traveller community:

- Improving access to health services
- Partnership between Gypsy and Travellers and health worker
- Employing specialist Gypsy and Traveller health workers
- Training of health service staff to fight ignorance and prejudice
- The need for Gypsies and Travellers to identify in ethnic monitoring
- Increasing GP registration

A detailed Health Needs Assessment was conducted in Devon in 2009 and is available here: <http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/07/Health-Needs-Assessment-of-Gypsies-and-travellers-2009.pdf>

Crime

The following section has been compiled using information on crime taken from the Devon Strategic Assessment 2013-14. The strategic assessment is prepared by assessing 40 crime and disorder issues using a Strategic Threat and Risk Assessment tool (STRA). It considers each area in relation to the scale and frequency of impact on communities, whether it is a priority for the public, the cost to agencies and the wider community, and how well the area performs compared to the rest of the UK.

Across Devon, crime overall showed a reduction from 2011-12 to 2012-13 of 5.5%, which although this is a lower rate than similar local authorities, the trend shows other similar authorities have made a greater reduction between the time points. There is variation across Devon with Exeter experiencing higher rates than the other three community safety partnership areas of East and Mid Devon, Northern Devon and South and Dartmoor.

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

There has been a reduction in anti social behaviour across the county between 2011-12 and 2012-13 of 22%, similarly the rate of arson has dropped by 21.5%. Vehicle crime has shown a reduction of 14% and criminal damage has also reduced by 10%.

There have been small increases in violence against the person (2.9%), and also in domestic abuse has increased by 2.7%. Robbery has increased by 9% across the county and road traffic casualties have increased by 19.5%.

Crime is strongly clustered in the larger urban centres and this is influenced by a range of factors, including concentration of shops, car parks and public spaces, the evening and night time economy and the regular influx of transient population for work, education, leisure and tourism.

Across Devon, the assessment tool has highlighted a number of priorities and the Devon Strategic Assessment highlights the plan to address these. The areas identified are:

- Domestic, family and sexual violence and abuse,
- Alcohol, violence and the night time economy
- Anti-social behaviour
- Reoffending
- Additional risks – Understanding of hate crime and hidden harm

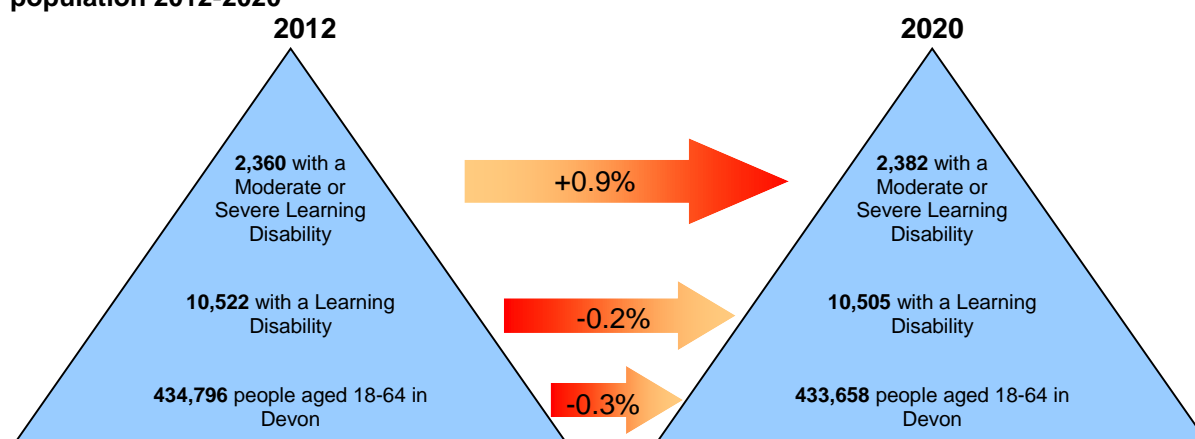
Learning Disabilities

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

10,522 people in Devon aged 18-64 are predicted to have a learning disability (baseline estimate). Based on population projections, this number is expected to remain relatively stable with a reduction of 0.2% at 10,505 by 2020 (*Source: CSED www.pansi.org.uk version 7.0. Crown copyright 2012*). Most of these people have mild learning disabilities and are getting on with their lives in society without particular statutory support. However some of them may still be excluded from having equal access to universal services due to an inability to understand information provided or to respond as expected. This is further complicated by other people's prejudices or unintended institutional prejudice. The Public Health England Learning Disabilities profile for Devon shows the rate for those aged 18-64 with a learning disability known to Local Authorities is 4.81 per 1,000 for 2012. This is higher than the England average of 4.27 per 1,000. Adults aged 18-64 with a learning disability using day services is higher in Devon (527.3) compared to 347.2 for England (per 1,000 people of those known to the local authority as having a learning disability). The number receiving community services is similar to England (738.72 compared to 749.71)⁷.

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

Figure 4.3: Predicted increase in numbers of people with Learning Disabilities in the population 2012-2020



Source: CSED www.pansi.org.uk version 7.0 and ONS interim 2011-based subnational population projections. Crown Copyright Reserved 2012

Valuing People Now (2009) identifies five key areas to focus on to make a real difference to people's lives: personalisation (increasing choice and control); how people spend their time (including paid work and leisure); better health (with full and equal access to NHS services); access to housing (particularly tenancies and home ownership); making sure that change happens (with more effective Partnership Boards). There are currently four

⁷ : <http://www.improvinghealthandlives.org.uk/profiles/index.php?view=E10000008>

key strategic priorities taken from this list that are being addressed by the Devon Learning Disability Health and Social Care Partnership and Partnership Board over the next year; these are better health, employment, housing and hate/mate Crime.

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

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

The Health and Wellbeing Board will be considering learning disability as a topic via a theme paper that will be produced and discussed at a Health and Wellbeing Board meeting in January 2014.

Smoking

Current smoking rates in England based on the Office of National Statistics Integrated Household Survey are 20% generally and 34.4% for routine and manual groups. For Devon the most recent estimated smoking rate is 20.2% in the overall population which is slightly higher than in England, the South West (19.2%) and the local authority comparator group (19.0%). It is also an increase on the last two previous prevalence estimates for Devon, although the difference is not statistically significant due to a relatively small sample.

Although the smoking prevalence in Devon is marginally higher than England, the rate of smoking related deaths is statistically significantly lower than in England.

Alcohol

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

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

There were around 17,500 admissions to hospital due to alcohol-related conditions in Devon in 2012-13, at a cost of around £30 million. Table 4.4 provides a breakdown of alcohol-related admission rates in Devon, highlighting higher admission rates in North Devon and Torridge. Within local authority districts, considerable variation is seen, with the highest rate within small local areas in Devon (Lower Super Output Areas) around 12 times higher than the lowest.

Table 4.4: Overall, Highest and Lowest Alcohol-Related Admission Rates by Devon Local Authority District, 2010-11 to 2012-13, Direct-Age Standardised Rate per 100,000

| District | DASR per 100,000 | Area with highest rate | | Area with lowest rate | |
|-------------|------------------|--|--------|-------------------------------------|--------|
| | | Name | DASR | Name | DASR |
| East Devon | 1257.7 | Honiton King Street area | 2628.9 | Uplyme and Axmouth area | 439.7 |
| Exeter | 1629.6 | Longbrook Street area | 3762.7 | Matford Lane and St Leonards Road | 749.5 |
| Mid Devon | 1177.4 | Tiverton: The Avenue area | 2085.1 | Clayhanger and surrounding areas | 551.6 |
| North Devon | 1940.2 | Barnstaple Town Centre | 5244.1 | Woolacombe and surrounding areas | 1098.1 |
| South Hams | 1495.3 | Kingsbridge West | 2573.3 | Dartmouth Warfleet and surroundings | 840.6 |
| Teignbridge | 1512.8 | Newton Abbot: Windsor Avenue, Buckland | 2881.0 | Widcombe-in-the-moor area | 621.3 |
| Torridge | 1854.2 | South East Bideford | 3751.7 | Clawton and surrounding areas | 929.9 |
| West Devon | 1463.5 | Tavistock East | 2173.0 | Beaworthy and surrounding areas | 851.4 |
| Devon | 1520.9 | Barnstaple Town Centre | 5244.1 | Uplyme and Axmouth area | 439.7 |

There is a strong relationship between alcohol-related admissions and levels of deprivation. Figure 4.4 reveals that people living in the most deprived areas are around two and a half times more likely to be admitted for an alcohol-related condition than those in the least deprived areas.

Figure 4.4, Alcohol-Related Admission Rates by National Deprivation Quintile, Devon, 2010-11 to 2012-13, Direct Age Standardised Rate per 100,000

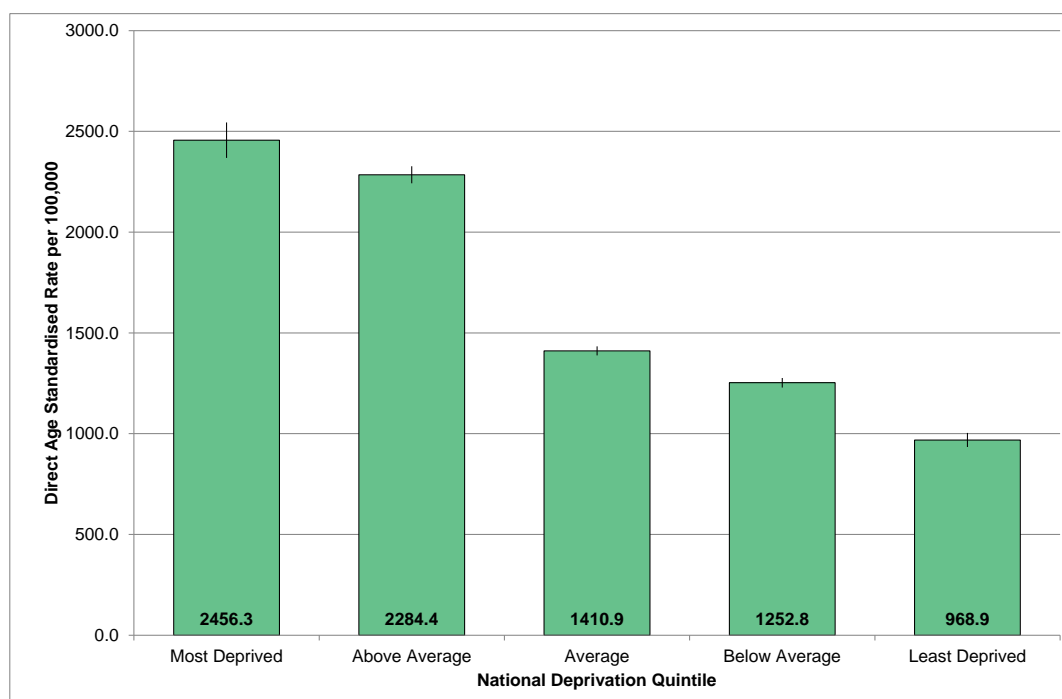
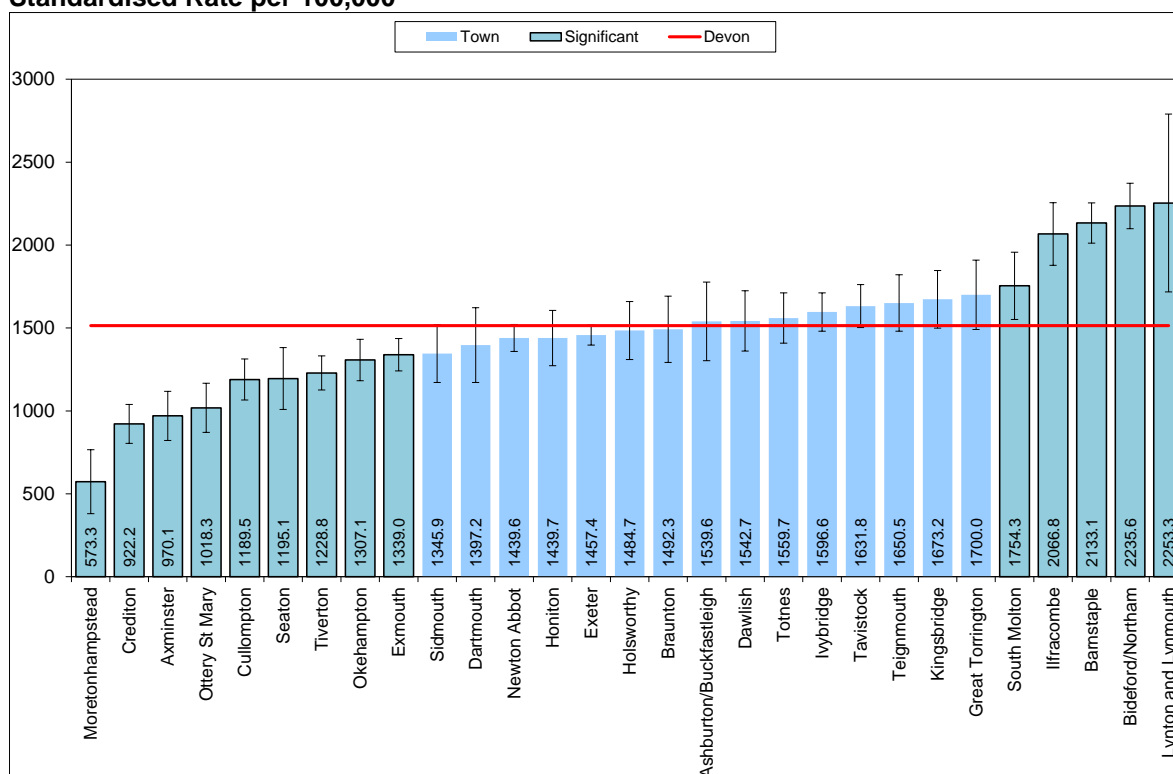


Figure 4.5 provides a breakdown by settlement within Devon, which encompasses the town and surrounding rural areas. This reveals significantly higher rates of alcohol related admissions in Ilfracombe, Bideford, Barnstaple, South Molton and Lynton and Lynmouth.

Figure 4.5: Alcohol-Related Admission Rates by Devon Town, 2008 to 2012, Direct Age Standardised Rate per 100,000



The pattern of alcohol consumption and the related health risks vary significantly by age. This is illustrated by the pattern of alcohol-related admissions by type and age shown in figure 4.6 below. Acute risks to health, such as accidents 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. The ageing population will lead to considerable growth in both chronic and mental conditions.

Figure 4.6: Percentage Share of Alcohol-Related Admissions by Age and Admission Type, Devon, 2012-13

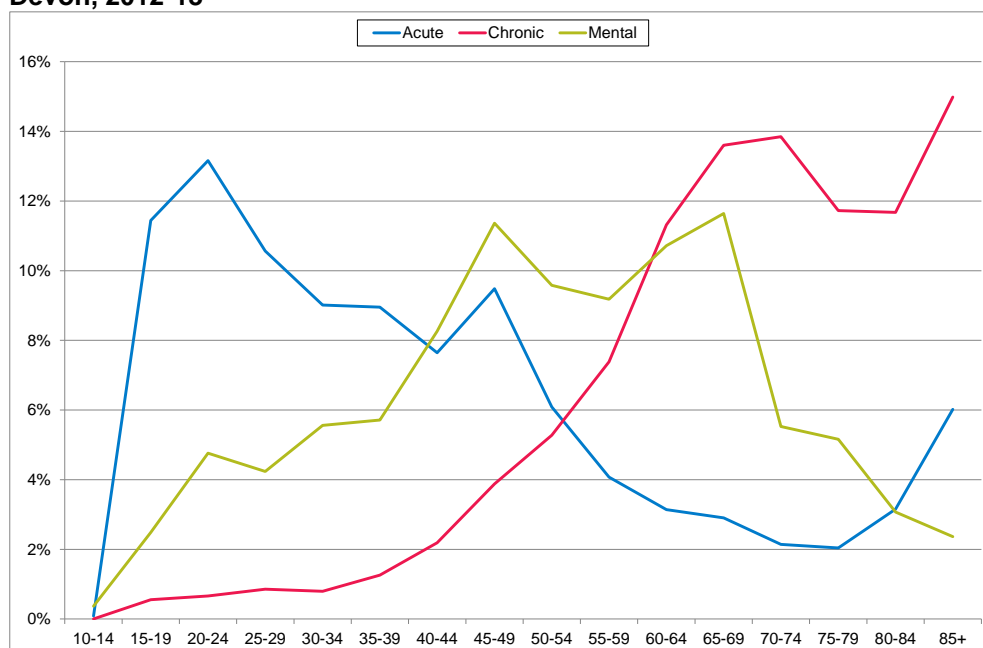


Table 4.5 summarises the total number of admissions type and alcohol related condition in Devon during 2012-13. This highlights that chronic long-term conditions make up the largest group accounting for 13,061 admissions (74.6% of total). Mental conditions are the next biggest group (3,256 admissions, 18.6% of total), and acute conditions are the smallest group (1,187 admissions, 6.8% of total). This illustrates that in terms of the impact on health service usage and cost, conditions caused by long-term excessive use of alcohol are much more significant than acute conditions relating to recent use of alcohol.

Table 4.5: Total Alcohol-Related Admissions by Cause, Devon, 2012-13

| Type | Alcohol-Related Condition | Admissions |
|--------------------------------|--|------------|
| Acute | Ethanol poisoning | 352 |
| | Fall injuries | 272 |
| | Intentional self-harm/Event of undetermined intent | 264 |
| | Spontaneous abortion | 110 |
| | Assault | 74 |
| | Road traffic accidents (driver/rider) | 50 |
| | Other Acute Conditions | 66 |
| Acute Total | | 1,187 |
| Chronic | Hypertensive diseases | 5,480 |
| | Cardiac arrhythmias | 4,414 |
| | Epilepsy and Status epilepticus | 1,189 |
| | Alcoholic liver disease | 467 |
| | Malignant neoplasm of breast | 320 |
| | Liver Cirrhosis | 290 |
| | Malignant neoplasm of lip, oral cavity and pharynx | 225 |
| | Malignant neoplasm of oesophagus | 141 |
| | Psoriasis | 104 |
| | Oesophageal varices | 101 |
| | Acute or chronic pancreatitis | 58 |
| | Malignant neoplasm of rectum | 46 |
| | Haemorrhagic stroke | 43 |
| | Malignant neoplasm of colon | 42 |
| | Malignant neoplasm of larynx | 30 |
| | Other Chronic Conditions | 112 |
| Chronic Total | | 13,061 |
| Mental | Mental and behavioural disorders due to use of alcohol | 3,256 |
| Mental Total | | 3,256 |
| All Alcohol-Related Admissions | | 17,505 |

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

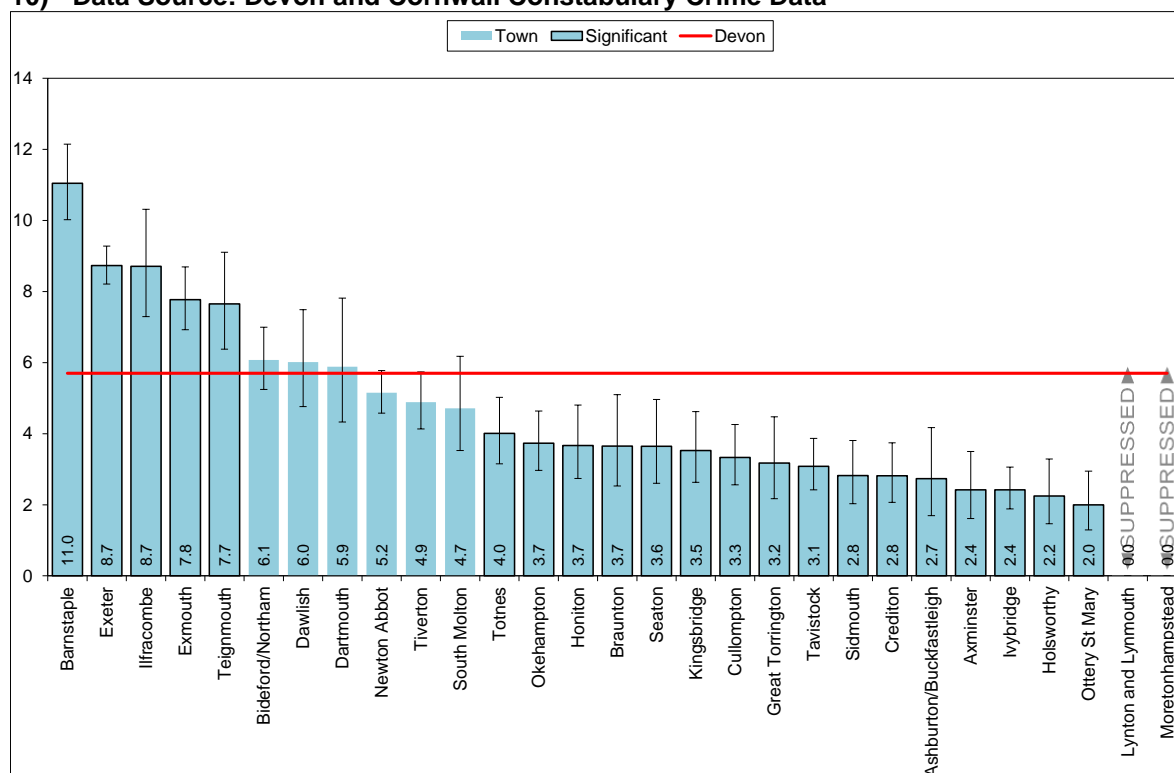
A full needs assessment has been completed looking at substance misuse was published earlier in 2013 and can be found here http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/08/Substance-Misuse-Health-Needs-Assessment_Final.pdf

Alcohol Related Crime

Alcohol can be linked to a wide range of criminal offences and has become a concern to the public over the years as the number of alcohol related crimes has been perceived to increase. In Devon there is variation across the county in the rates of alcohol related crime

seen. The graph below shows that in 2008-09 to 2009-10 the highest rates of alcohol related violent crimes were seen in the larger urban areas of Barnstaple and Exeter and also larger seaside towns of Ilfracombe, Exmouth and Teignmouth.

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



Domestic Violence

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

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

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

It is estimated in the Crime Survey for England and Wales (2011-12) that 7.3% women and 5% of men have been a victim of domestic abuse in the past year, whilst 31% of women and 17.8% of men have been victims at some point since the age of 16. If these prevalence rates are applied to the Devon population (aged 16 and above), that equates to

23,741 women and 14,971 men experiencing domestic violence in the past 12 months and 100,817 women and 53,296 men experiencing domestic violence since the age of 16.

In 2012-13 670 high risk cases were taken to Multi Agency Risk Assessment Conferences (MARACs) in Devon compared to 729 in 2010-11. 25% of these were repeat attendances. There were 832 children and young people associated with these cases. Children were present at 39% of the 8,915 domestic violence incidents attended by the police in Devon in 2012-13.

An estimated 3.0% of women and 0.3% of men according to the Crime Survey for England and Wales (2011-12) have been a victim of sexual assault, including attempts, in the past year, whilst 19.6% of women and 2.7% of men have been victims at some point since the age of 16. In Devon during 2012-13 there were 608 sexual violence offences reported to the police, of which 253 were rape and 355 sexual assaults. Of these, 39% of victims were under 17 years of age, 73% under 25 years of age and around 2.5% were aged over 60.

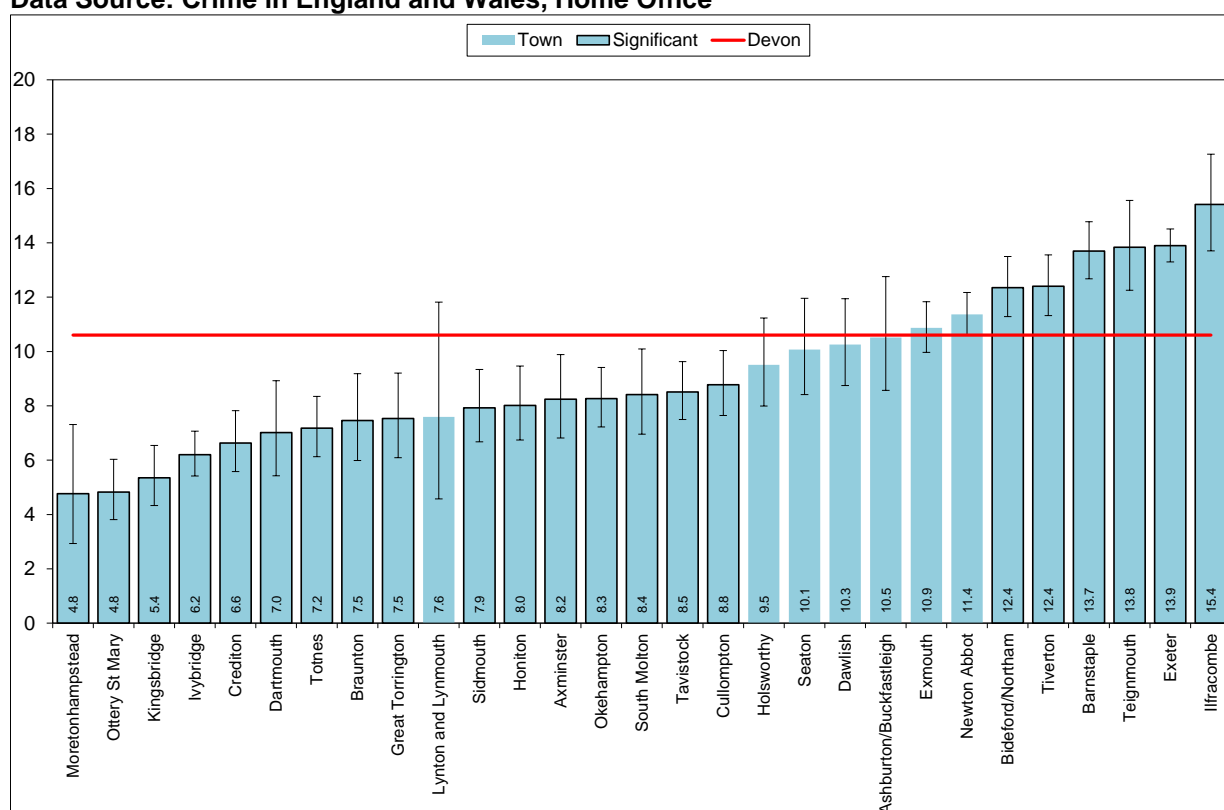
In a national study it was reported that 16% of children aged under 16 experience sexual abuse during childhood. There are currently 125,000 children aged under 16 living in Devon and therefore 16% would represent 20,000 children. The actual number of perpetrators of domestic abuse and the number of sex abusers/offenders living in Devon is not known. Devon and Cornwall Probation service were managing 1,011 adults under Multi-Agency Public Protection Arrangements (MPPA) relating to DSVAs, 504 domestic violence offenders and 507 sex offenders (August 2013).

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 million⁸.

The graph below shows the rates of reported cases of domestic violence by Devon town in 2012-13. It shows the highest rates of reported cases were in Ilfracombe, Exeter, Teignmouth, Barnstaple, Tiverton and Bideford/Northam. The rates varied greatly across the county from 15.4 per 1,000 in Ilfracombe to 4.8 per 1,000 in Moretonhampstead.

⁸ Walby S. The cost of domestic violence; update 2009. Lancaster, Lancaster University;2009
http://www.lancs.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc (accessed 03 August 2010)
calculated for local authorities by Trust for London and the Henry Smith Charity

Figure 4.8: Number of domestic violence cases per 1000 population aged 18+ (2012-13) - Data Source: Crime in England and Wales, Home Office



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

Obesity

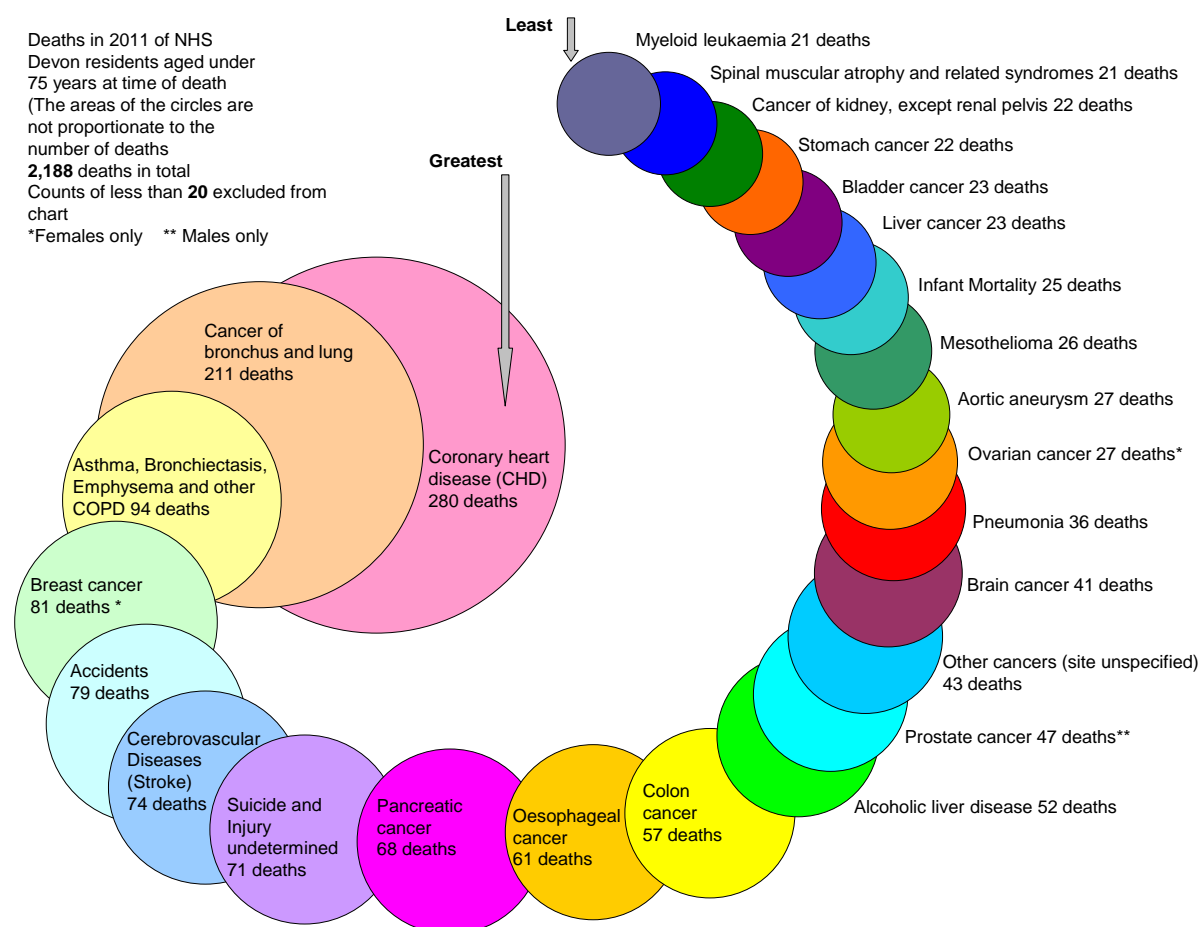
Obesity is a major public health issue across the UK with rates of obesity increasing over the past 20 years. The most recent data from the Health Survey for England relates to 2011 and show that 24% of men and 26% of females nationally are obese. When the proportions of people who are overweight are considered, this proportion rises to 61.3% which is nearly two thirds of the adult population. Risk factors associated with obesity include high blood pressure, high cholesterol, cardiovascular disease, type 2 diabetes and some cancers which explains why both nationally and locally reducing obesity is a priority for public health.

Disease and Mortality

The latest available mortality data is for 2012 and during that year there were 8,588 deaths in total in Devon, of which 2,236 were below the age of 75. Figure 4.9 displays the commonest causes of death in those aged under 75, with coronary heart disease (CHD)

accounting for 280 deaths, followed by lung cancers with 211 deaths and asthma, bronchiectasis, Emphysema and other COPD accounting for 94 deaths.

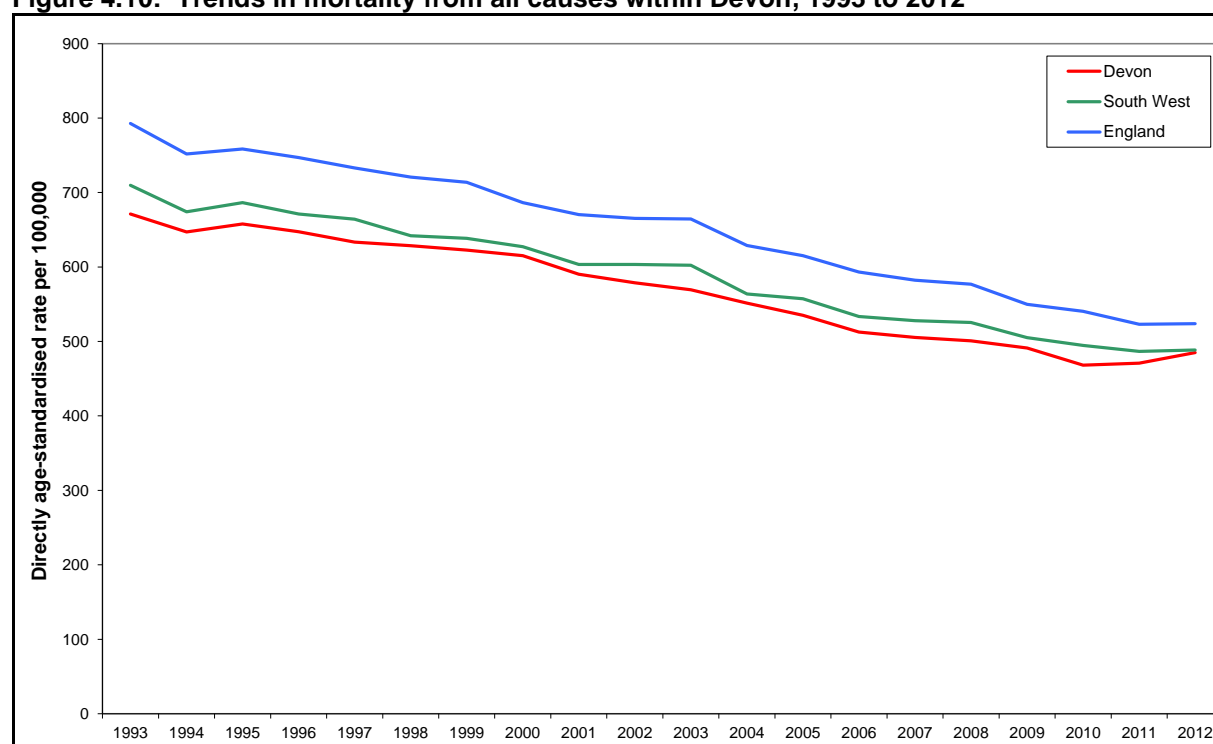
Figure 4.9: Deaths from selected causes under the age of 75 years



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

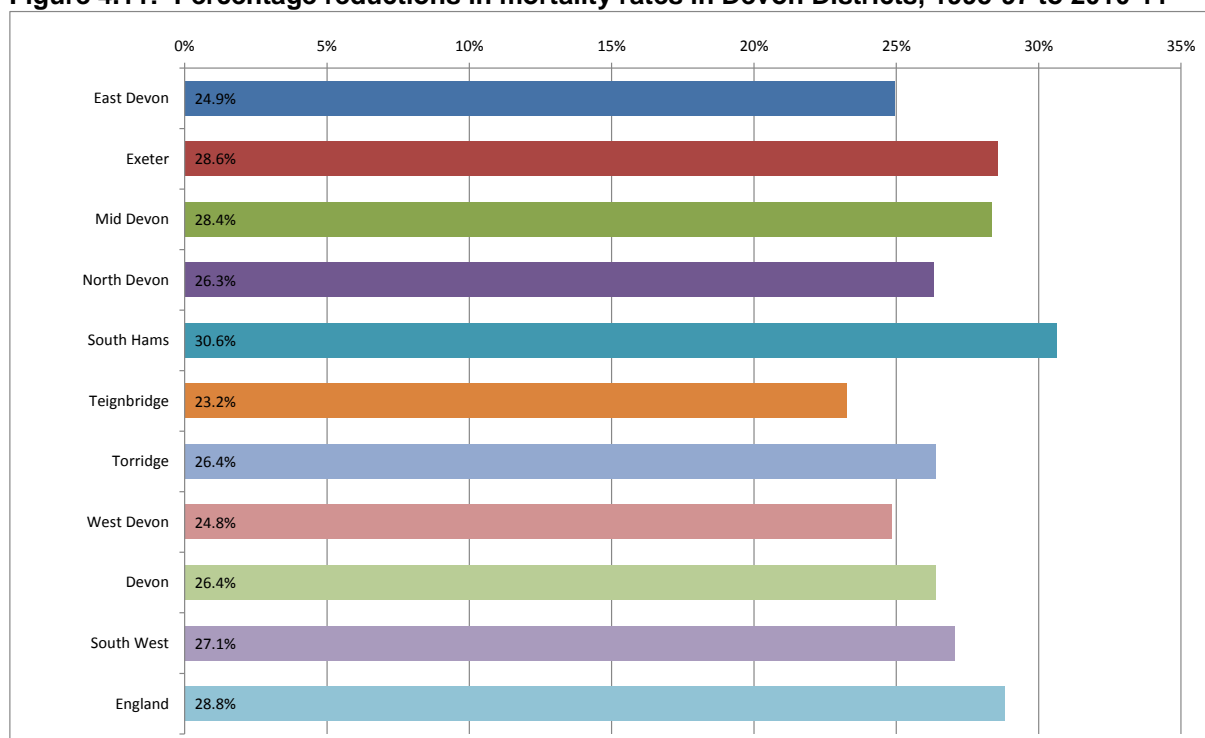
Figure 4.10 presents trends in overall mortality rates between 1993 and 2012, highlighting that mortality rates have fallen significantly over recent years. Devon rates have stayed consistently below South West and national rates with only the latest year showing a slight increase. The reduction in mortality varies across the county and Figure 4.11 presents the reduction in mortality by Devon local authority districts between 1995 and 1997 and 2010 to 2012. Overall Devon saw a 26.4% reduction in mortality rates, with the highest decrease seen in South Hams (30.6%). While mortality rates have fallen, there are notable differences between rates for males and females. Figure 4.12 highlights that whilst mortality rates are much higher for males, they have shown a greater reduction over recent years. Specific areas where the reduction in mortality has been much greater for males include heart disease and chronic obstructive pulmonary disease (COPD), which are closely associated to lifestyle factors such as smoking.

Figure 4.10: Trends in mortality from all causes within Devon, 1993 to 2012



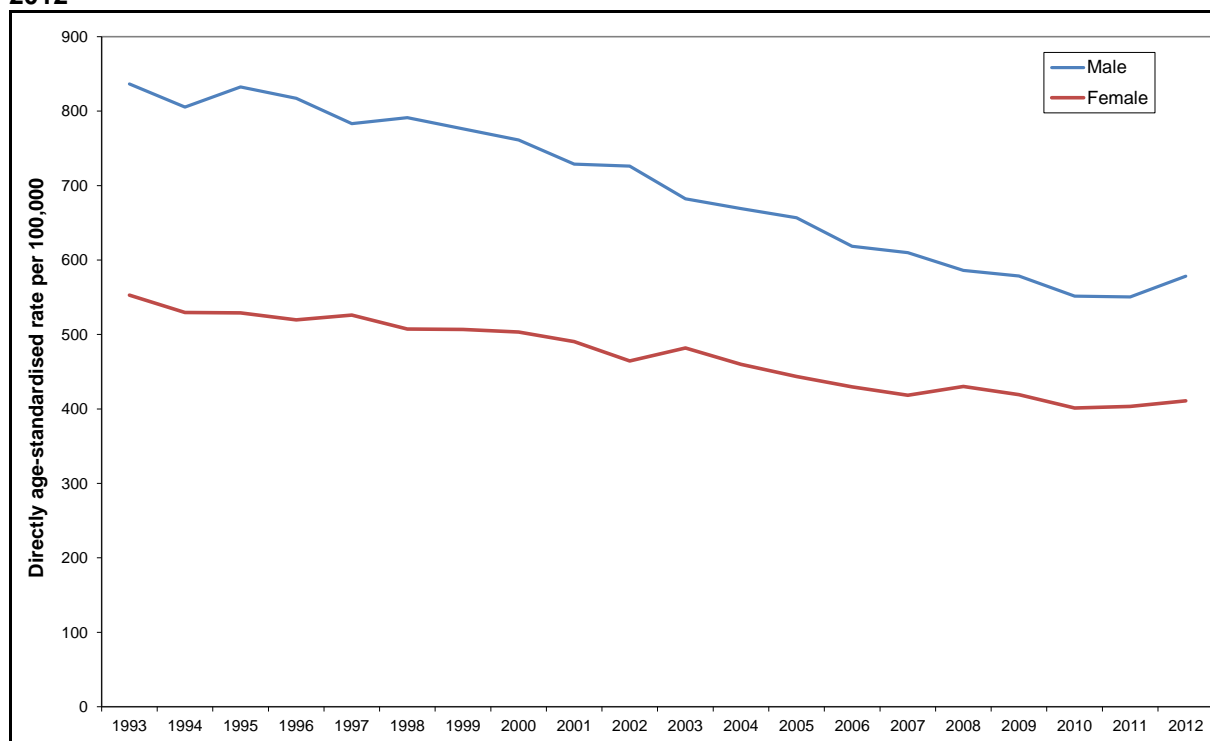
Source: National Compendium of Clinical Indicators, Adapted from data from the Office for National Statistics licensed under the Open Government Licence v.1.0

Figure 4.11: Percentage reductions in mortality rates in Devon Districts, 1995-97 to 2010-11



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

Figure 4.12: Trends in mortality from all causes for males and females within Devon, 1993 to 2012



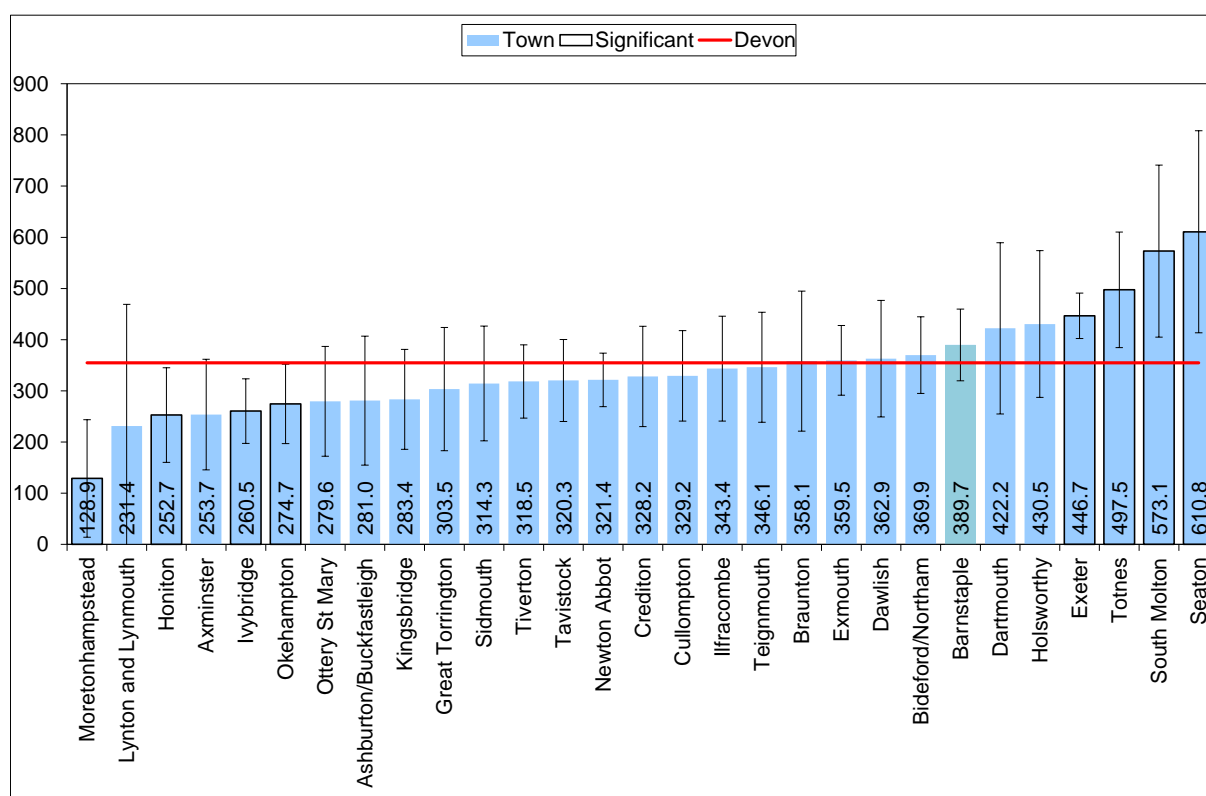
Source: National Compendium of Clinical Indicators, Crown Copyright 2009

Physical Disability

In Devon, during 2012, it is predicted 36,433 people aged 18-64 had a moderate physical disability. It is predicted that this number will increase by 1.7% (to 37,055) by 2020. 11,196 people aged 18 to 64 were estimated to have a severe physical disability and over half (54%) of those were aged 55-64. It is predicted that the number with severe physical disability will increase by 2.6% to 11,500 by 2020. (Data Source: CSED www.pansi.org.uk version 7.0. Crown copyright 2012)

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

Figure 4.13: Number of people with physical disabilities aged 18-64 receiving an assessment per 1000 population aged 18-64 (2012-13) - Data Source: CareFirst (Referrals, Assessments & Packages of Care Statutory Return 2012-13).



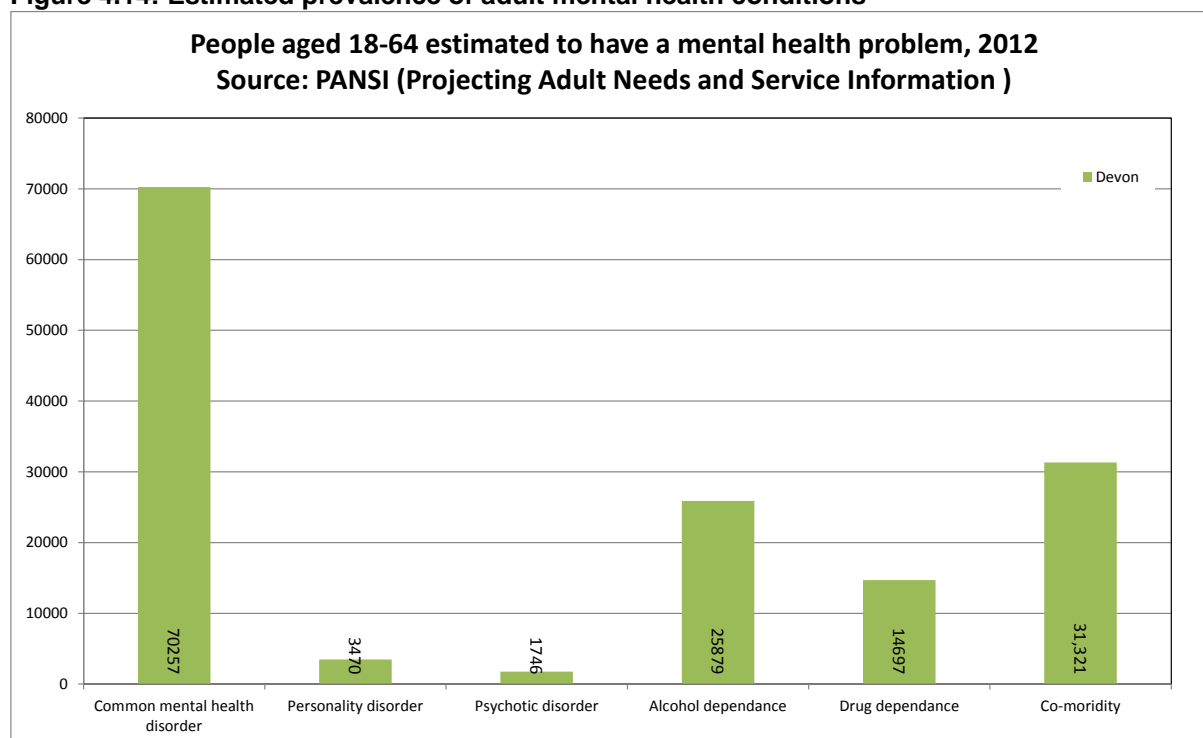
Mental Health

In 2013 a Mental Health and Wellbeing Health Needs Assessment was produced to support the commissioning of mental health and wellbeing services. Ensuring good mental health within the population throughout the life course is about more than just the absence of mental disorder, and is a major contributor to wellbeing within the population.

The full needs assessment and a summary report can be found here <http://www.devonhealthandwellbeing.org.uk/library/needs-assessments/> but the following section gives a few headline figures and some updated graphs from the needs assessment and also the recommendations that came out of the report.

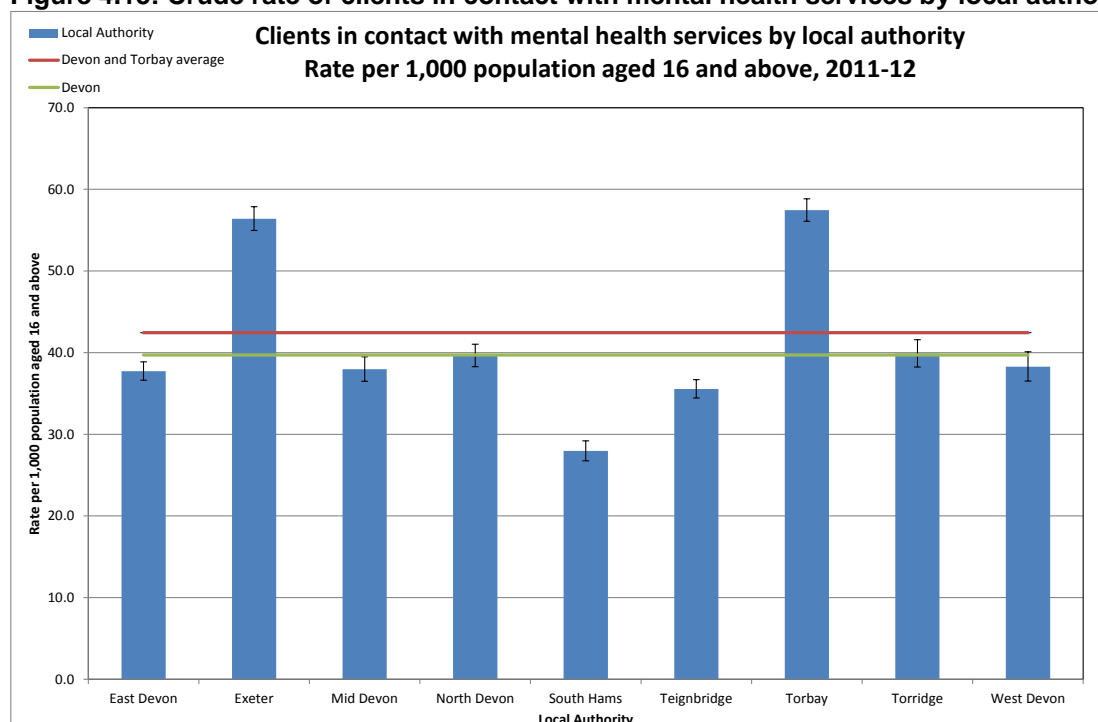
The graph in figure 4.14 below shows estimated prevalence of various mental health conditions. It is based on the result of the Adult Psychiatric Morbidity Survey which is applied to the local populations. This shows the greatest burden were the more common mental health conditions, followed by alcohol and drug dependence. It also shows that a large proportion of people suffer from multiple psychiatric disorders.

Figure 4.14: Estimated prevalence of adult mental health conditions



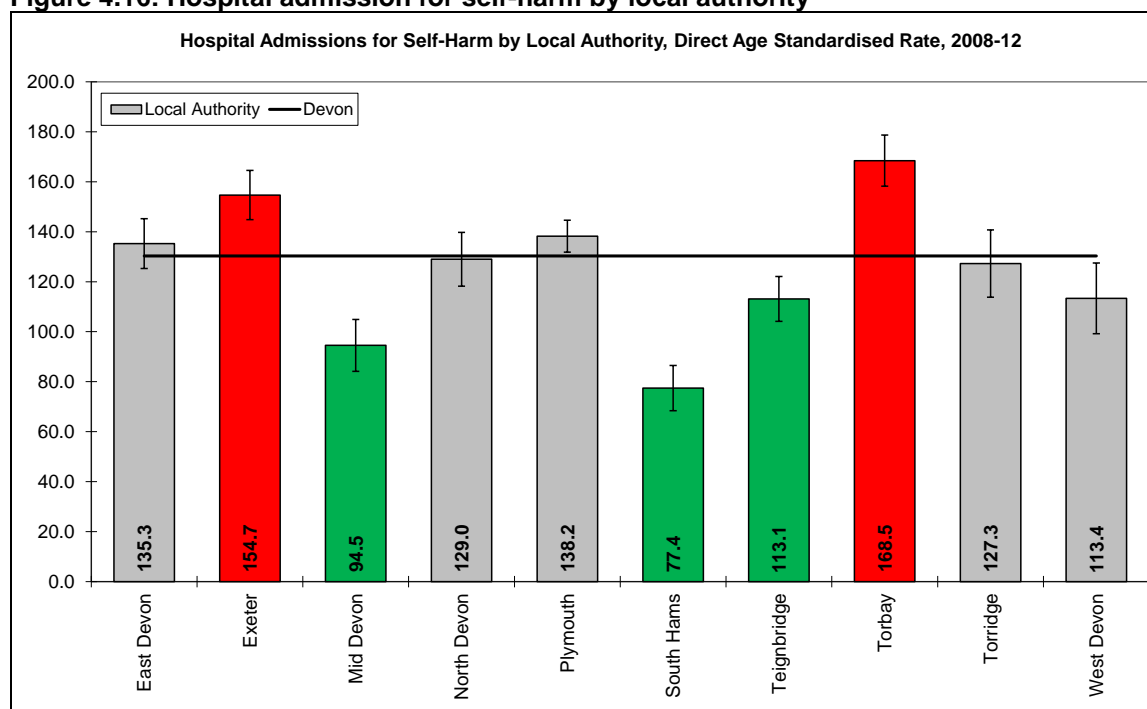
Data from Devon Partnership trust is shown below in Figure 4.15 which highlights the rates of clients in contact with mental health services by local authority. There is variation between local authorities with Torbay and Exeter showing the highest rates. Rates in East Devon, South Hams and Teignbridge are statistically significantly lower than the Devon average compared to the rates in other parts of Devon.

Figure 4.15: Crude rate of clients in contact with mental health services by local authority



Self-harm amongst younger people is one of the most direct forms of impairment to health or development. It can be linked to other mental health conditions or can be a reaction to or seen as a way of coping with distressing events. Some self-harm events may not be serious enough to need an A&E attendance; some may be more serious and require a hospital admission. Figure 16 below shows directly age standardised hospital admission rates for self-harm by local authority. The graph shows the rates are statistically significantly higher in Exeter and also in Torbay. Mid Devon, South Hams and Teignbridge all have statistically significantly lower rates of admissions.

Figure 4.16: Hospital admission for self-harm by local authority



Source: Secondary Uses Service Commissioning dataset

There were many areas of the report where information highlighted needs but the following recommendations were identified as reflecting areas which have been highlighted as requiring further direction or analysis where work is not currently already being undertaken.

1 As part of the planned CAMHS service review by the Partnership Directorate later this year, service activity recording and data quality are reviewed with plans for improvement agreed where necessary.

2 Carry out further analysis of self-harm activity data to gain a better understanding of the variation shown to inform future service provision.

3 Review current service provision for eating disorders and agree an appropriate care pathway based on the latest NICE guidance.

4 Engage with Healthwatch Devon to agree any further consultation and service user engagement in relation to mental health needs and services to build on the work begun by LINK Devon.

5 Improve access to prescribing data by age group via the primary care data warehouse to support life course analysis.

6 Review existing local suicide prevention strategies and consider the opportunity to refresh, in the light of the national strategy, on a peninsula wide basis to ensure an alignment of objectives and promote consistent preventive action.

7 Commissioners to undertake an improved audit and mapping exercise of the access to both commissioned mental health services and wider community based mental health support services to inform future commissioning.

Circulatory Disease (including heart disease and stroke)

In 2012, there were 455 circulatory deaths in under 75s, with an direct age standardised rate of 44.9 per 100,000 for 2010-12. The Devon rate in 2010-12 was below the South West (49.0) and England (58.6) rates. Within the county, rates are highest in Exeter and Northern Devon. Mortality rates by year have fallen from 122.6 per 100,000 in 1993 to 42.9 in 2012. Whilst rates have fallen more quickly in areas of above average deprivation, the gap persisted for those in the most deprived areas. Mortality from circulatory disease increases rapidly with age, with the highest mortality rates in under 75s in the 65 to 74 age group, and very few deaths in persons aged under 40. In Devon mortality rates are 2.5 times higher in males than females. In terms of ethnicity, the British Heart Foundation highlight that whilst risks did not vary considerably by ethnic group for females, white males were at higher risk.

Figure 4.17: Mortality from Circulatory Diseases in Under 75s, Direct Age Standardised rate per 100,000 population, Local Authority Comparator Group, 2010 to 2012

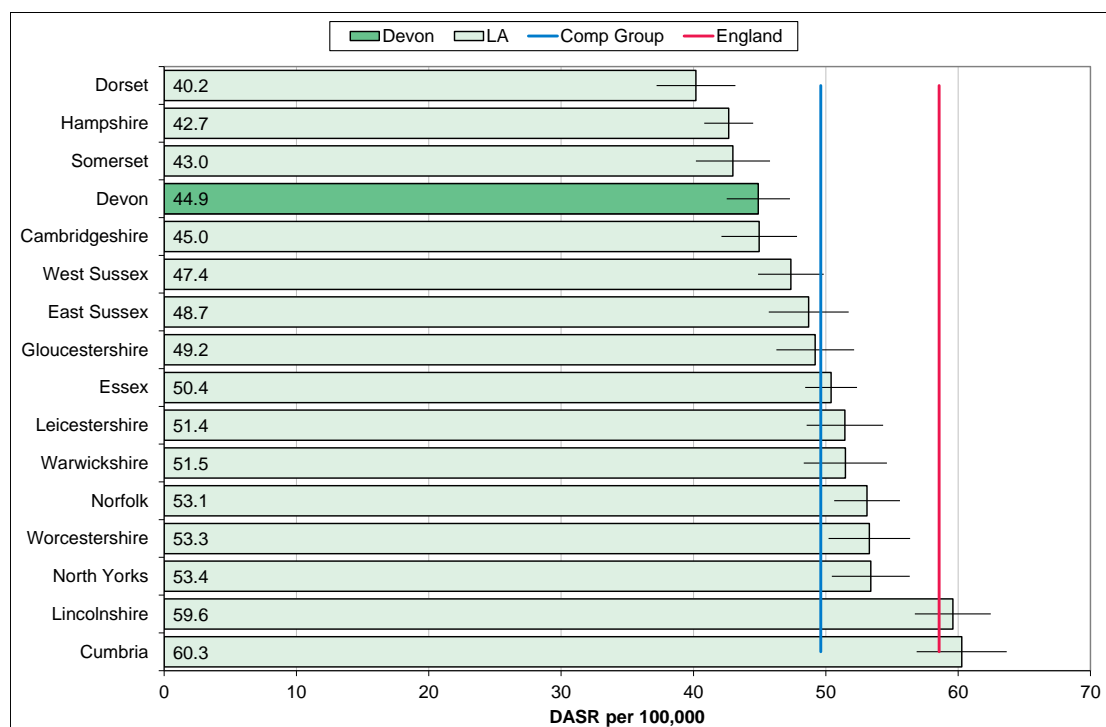
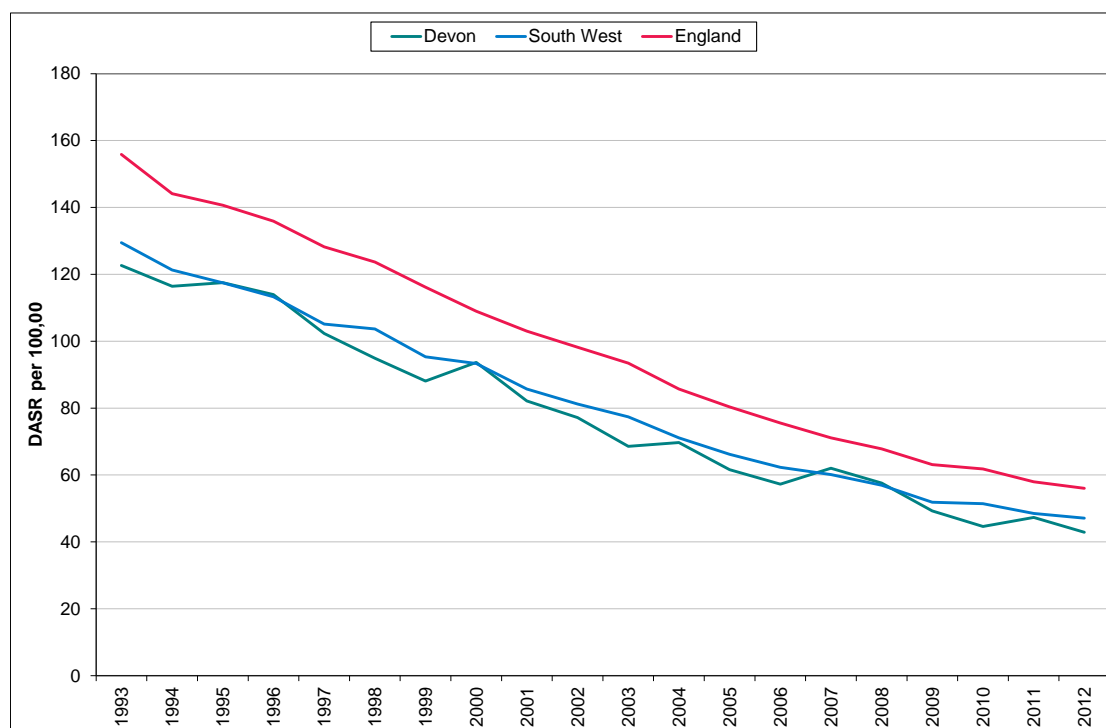


Figure 4.18: Mortality from Circulatory Diseases in Under 75s, Direct Age Standardised rate per 100,000 population, Annual Trend for Devon, South West and England, 1993 to 2012

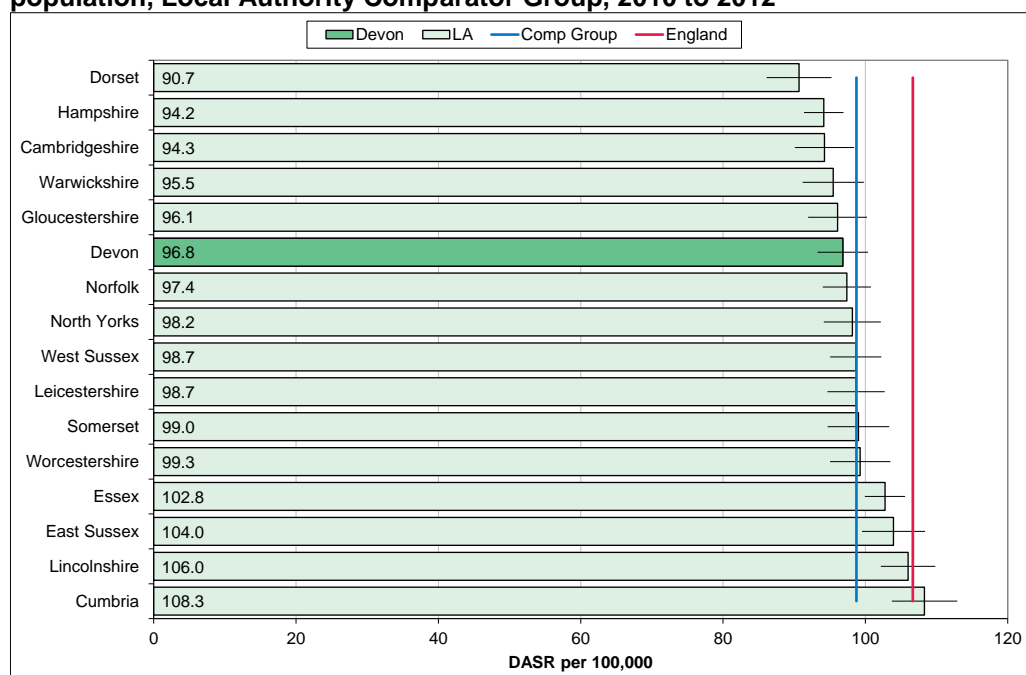


Cancer

In 2012, there were 1,058 deaths due to cancer in under 75s, with a direct age standardised rate of 96.8 per 100,000 for 2010-12. The Devon rate in 2010-12 was below the South West (100.0) and England (106.7) rates. Within the county, rates are highest in Exeter (110.2).

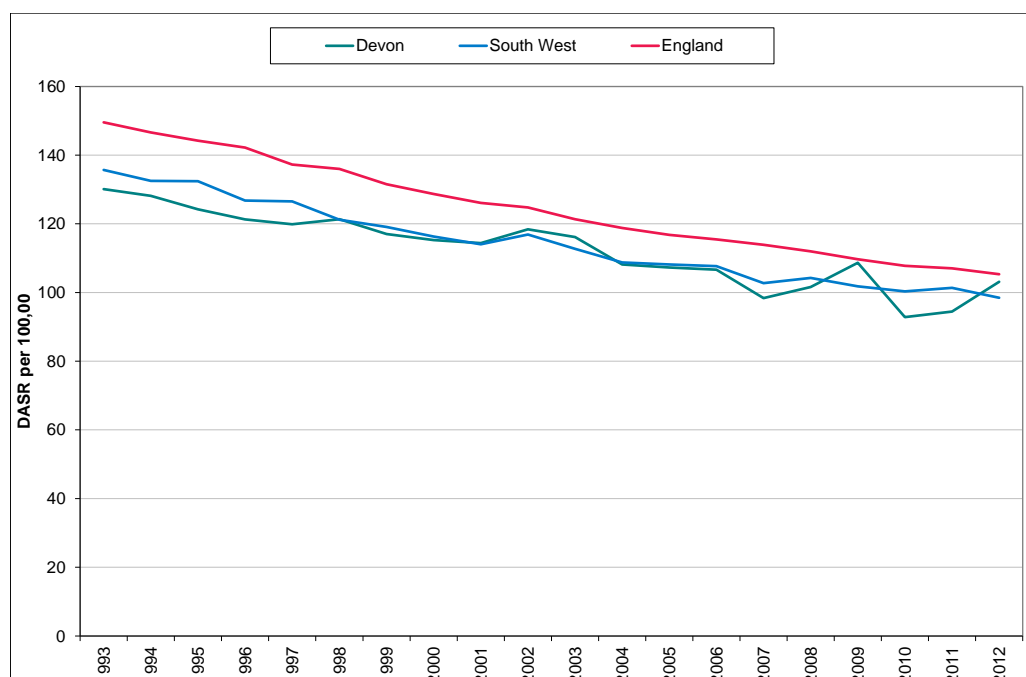
Mortality rates by year have fallen from 130.1 per 100,000 in 1993 to 103.1 in 2012. Mortality rates are higher in more deprived areas, although the health inequality gap has decreased over the last 10 years. Mortality from cancer increases rapidly with age, with the highest mortality rates in under 75s in the 65 to 74 age group. Mortality rates from cancer are around 20% higher in males than females in England. In terms of ethnicity, Cancer Research UK suggests higher mortality rates in white groups, although survival rates for breast cancer are lower in Asian and Black ethnic groups.

Figure 4.19: Mortality from Cancer in Under 75s, Direct Age Standardised rate per 100,000 population, Local Authority Comparator Group, 2010 to 2012



Source: ONS Mortality files via Health and Social Care Information Centre

Figure 4.20: Mortality from Cancer in Under 75s, Direct Age Standardised rate per 100,000 population, Annual Trend for Devon, South West and England, 1993 to 2012



Source: ONS Mortality files via Health and Social Care Information Centre

Offender Health

Offenders and also ex offenders are more likely than the general population to have acute health needs. They often have particular needs around substance misuse and mental health, and also social care needs. Dealing with these problems can be difficult within prisons and particularly the transition of care outside of prison for ex offenders. A detailed Prison Health Needs Assessment has been completed for Devon in 2012 and looks in more detail at the difficulties facing healthcare in prisons. Partnership work to address these needs is important to reduce both reoffending and health inequalities.

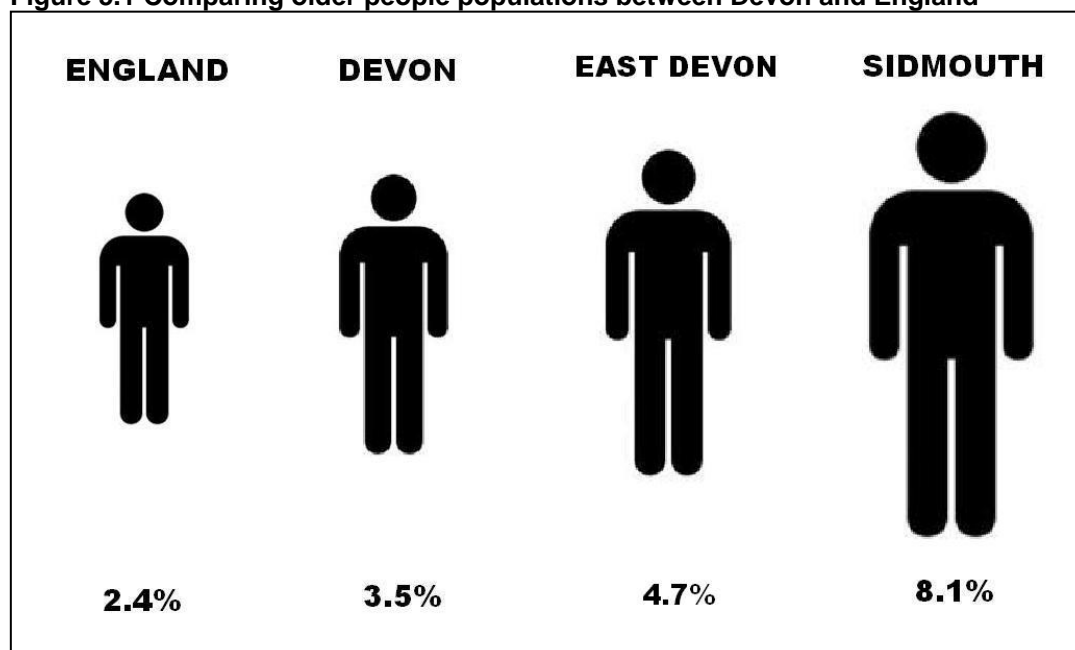
A recent development is the Liaison and Diversion scheme which has experienced mental health workers based in the four Police Custody suites in Devon, Torbay and Plymouth. The Bradley Report in 2009 stated that people with mental health problems were over-represented in the prison population and more could be done to intervene earlier in their criminal justice “journey”. The scheme aims to identify those individuals who have been in contact with local mental health services either in the past or presently, in order to give up to date information on their mental health to the police, magistrates or judges. This will in turn allow for more appropriate sentences to be handed down.

5 OLDER PEOPLE - *AGING WELL*

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

Figure 5.1 illustrates the proportion of people aged 85 and over in Devon compared with England. It will be 2027 before the proportion of older age groups in England resembles the current picture in Devon, 2035 before England resembles the oldest local authority (East Devon) and 2076 before England resembles the oldest town (Sidmouth).

Figure 5.1 Comparing older people populations between Devon and England

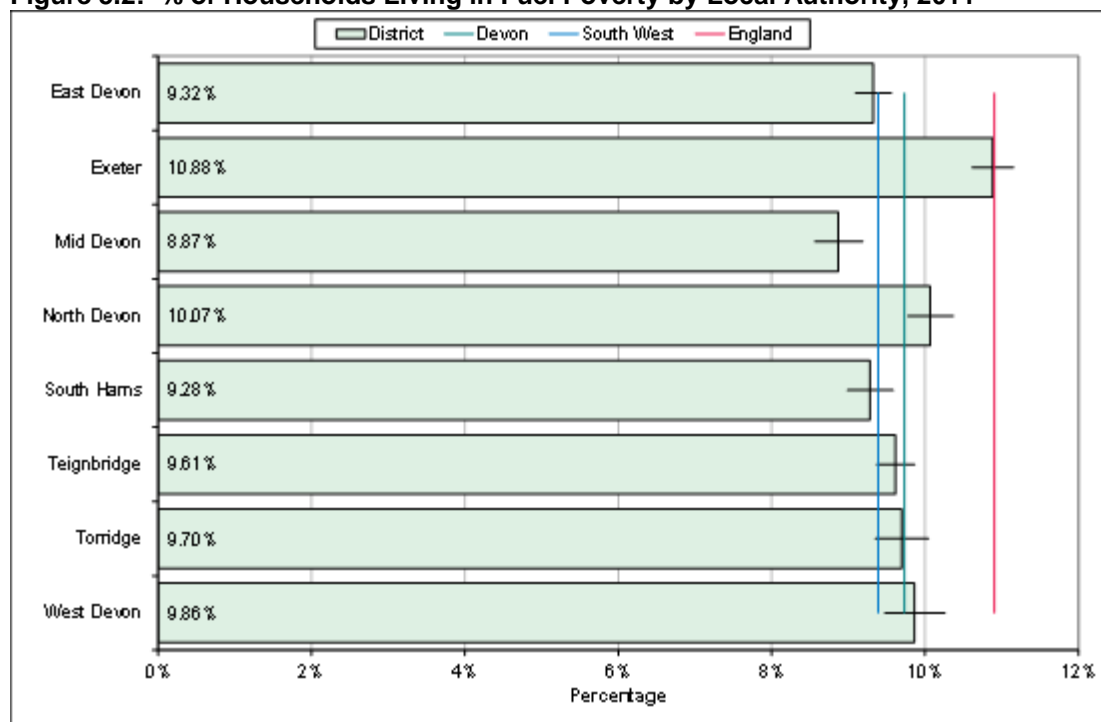


The topics identified will help to establish priorities for older people in Devon; however some topics and priorities identified in the adult section will also be relevant to older people.

Fuel Poverty

Fuel poverty in Devon is just below the England average, with one in ten households classed as fuel poor in the county. In recent years there has been a focus from central government to reduce fuel poverty by making grants available, however increasing fuel prices has meant that numbers in fuel poverty continue to rise. Fuel poverty is more prevalent in groups with low household incomes, including pensioners, people on benefits and working families with below average incomes. As shown below, just under one in ten people in Devon live in fuel poverty (9.73%), which is above the South West average (9.39%), but below the local authority comparator group (10.05%) and England (10.90%) rates. Within Devon the highest levels of fuel poverty were seen in Exeter (10.88%) and the lowest were seen in Mid Devon (8.87%).

Figure 5.2: % of Households Living in Fuel Poverty by Local Authority, 2011



Source: Department of Energy and Climate Change, 2011

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 5.1 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 |

While recognising the particular needs of young carers and for preventive action the 2010 Carers Needs Assessment recommended that 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 with 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 5.3 and 5.4 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 5.3 Self-Reported Health by Unpaid Care Provision and Age in Devon, 2011 Census

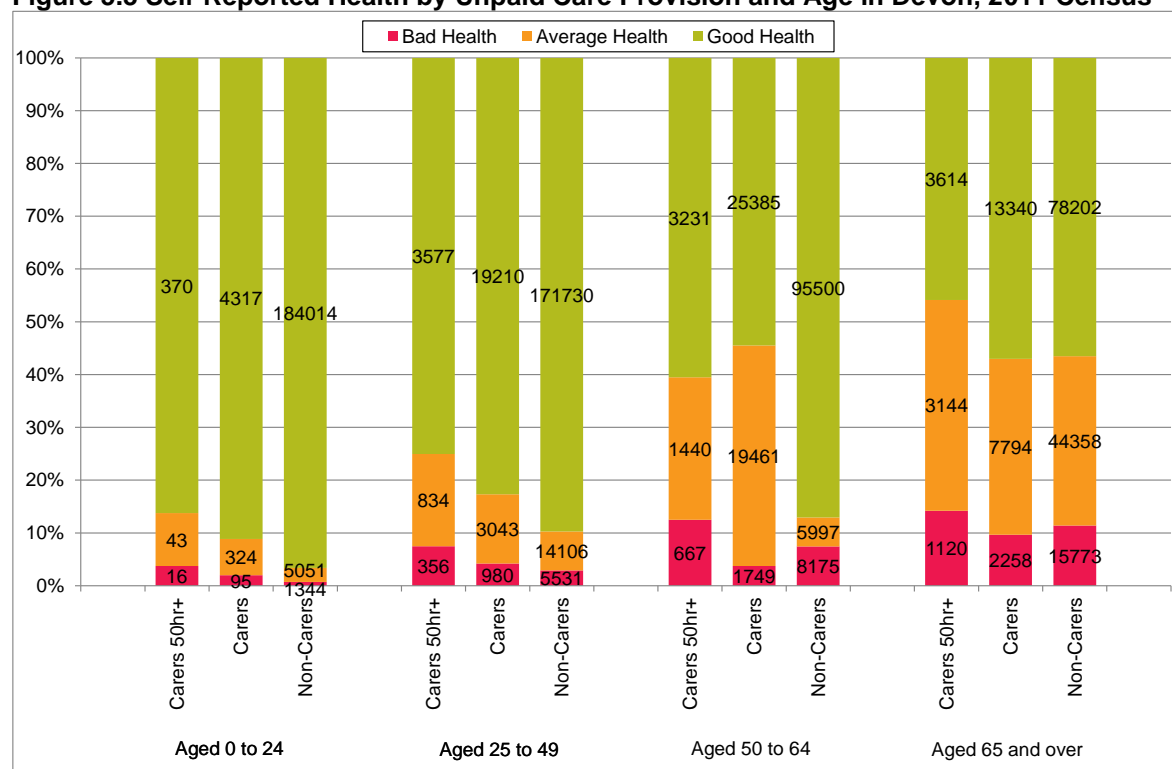
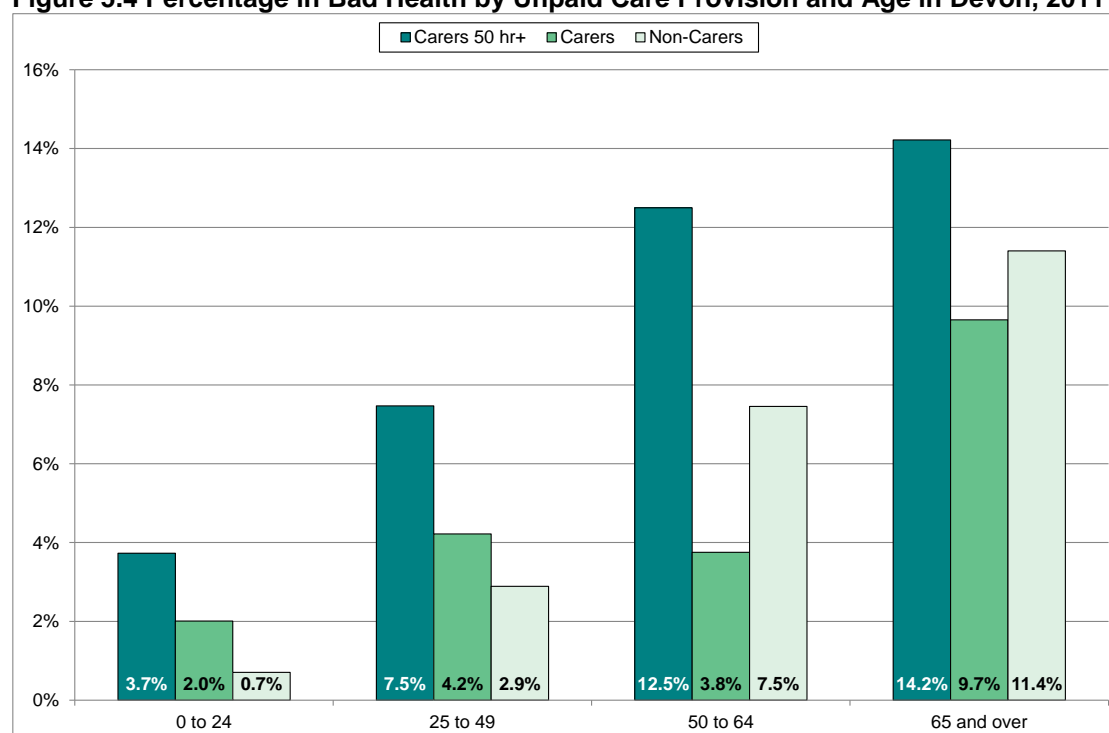


Figure 5.4 Percentage in Bad Health by Unpaid Care Provision and Age in Devon, 2011 Census



Levels of economic activity are also much lower in persons who provide unpaid care. Figure 5.5 reveals that 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 5.5 Economic Activity by Unpaid Care Provisions in Devon (16+), 2011 Census (excluding retirees)

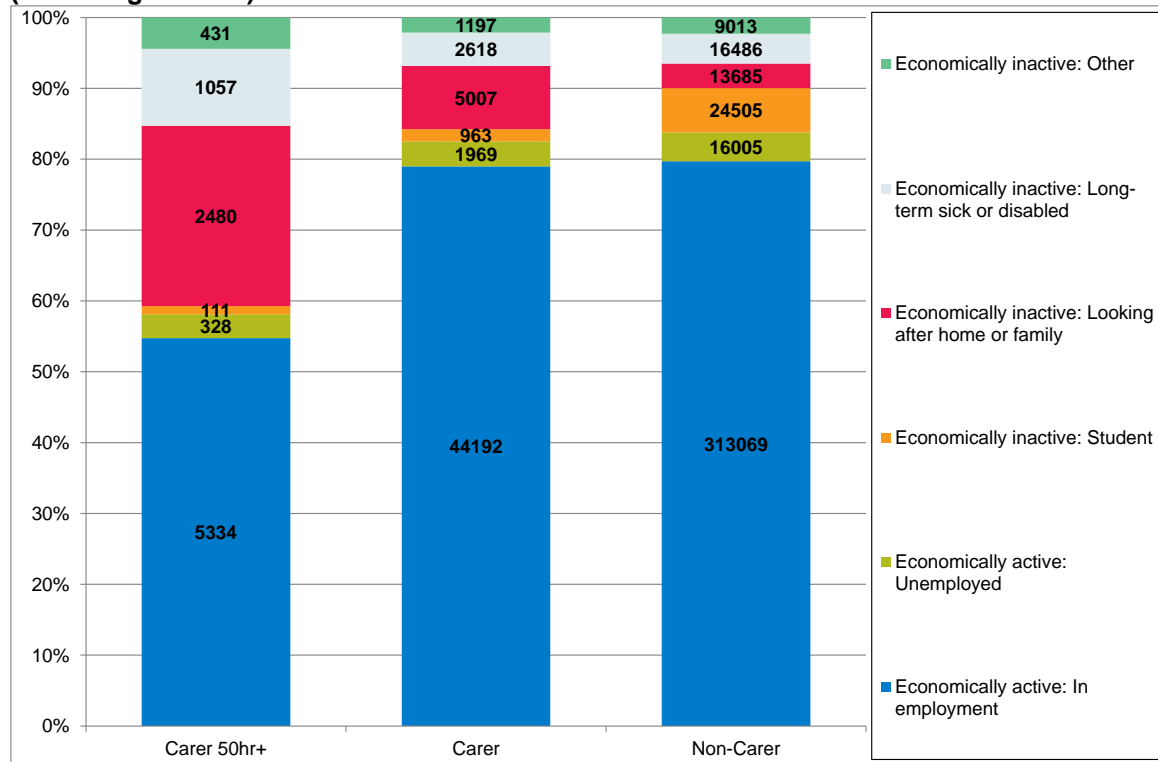
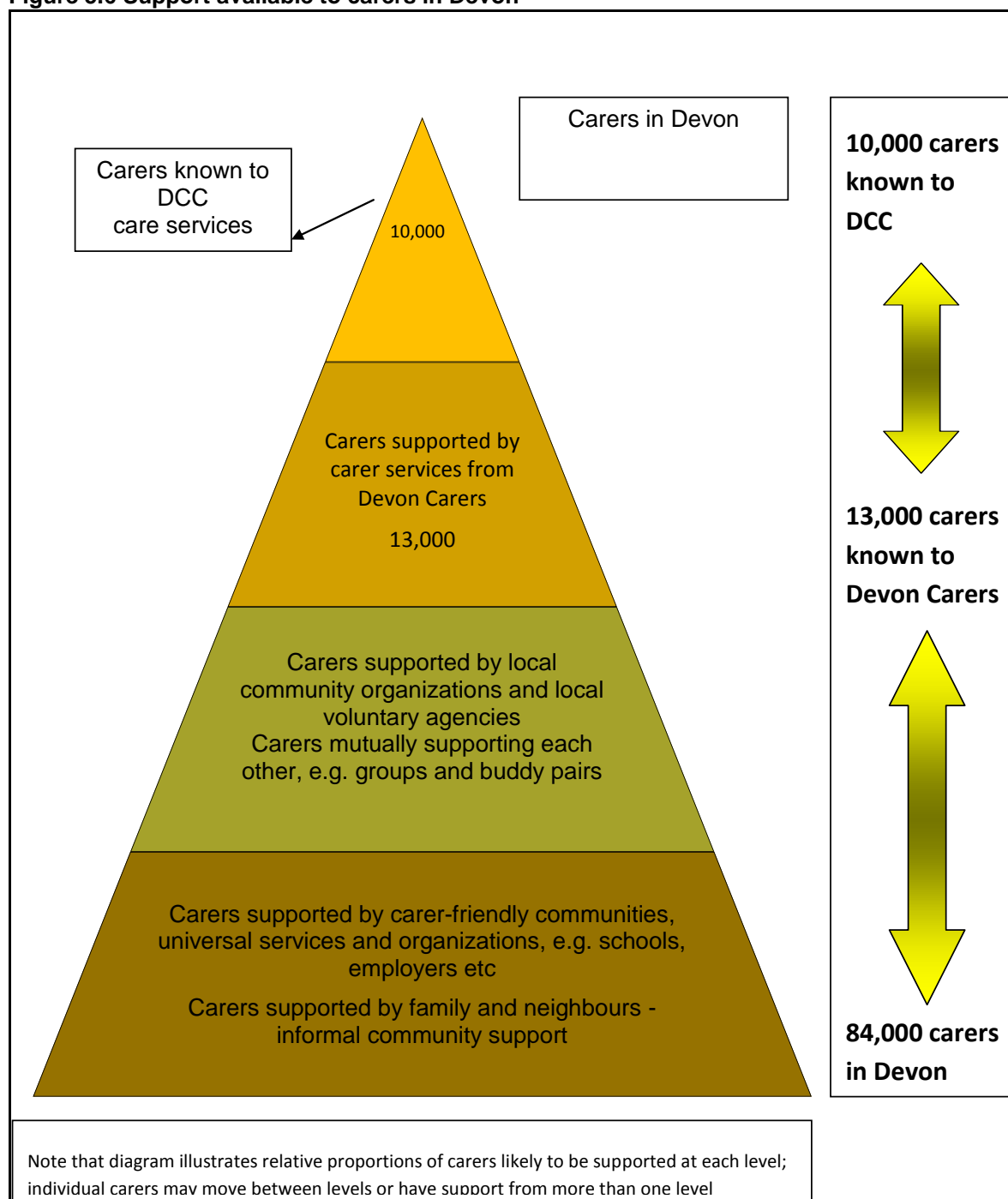


Figure 5.6 reveals levels of support available to carers in Devon. This reveals that whilst a fairly small proportion of all carers have sought or are receiving support from Devon County Council or Devon Carers, with most being supported either through informal community and familial support, voluntary agencies and non-specialist services.

Figure 5.6 Support available to carers in Devon

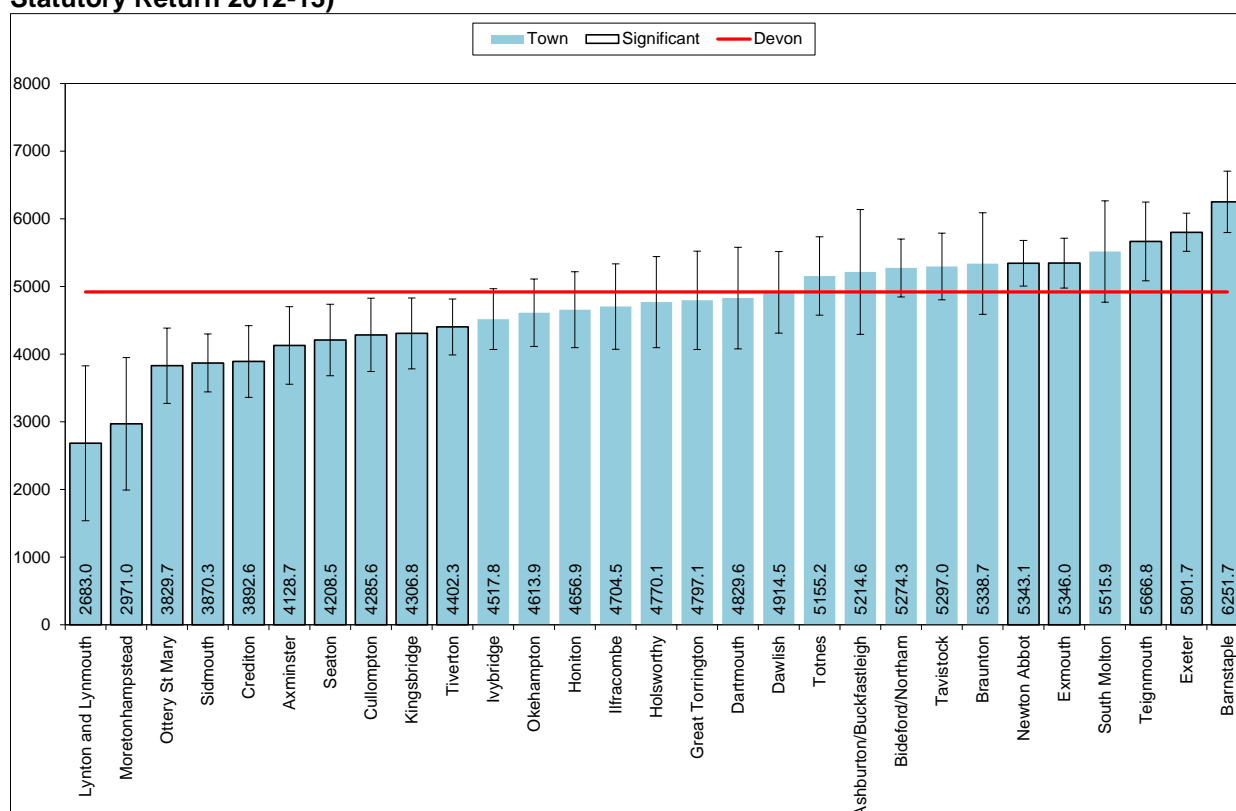


Older people aged 65 and above with mental health conditions

The most common mental health problems in older people are depression and dementia. Depression affects proportionately more older people than any other demographic group, because older people face more events and situations that may trigger depression: physical illness, debilitating physical conditions, bereavement, poverty and isolation. The majority of people who have depression make a full recovery after appropriate treatment, and older people are just as responsive to treatment as younger people. Communities and support services can help older people address some of the causes of depression such as social isolation, financial problems, or difficulties with their accommodation.

Older people with dementia usually continue to live at home with support, but may benefit from specialist accommodation, including extra care housing.

Figure 5.7: Proportion of over 65 population receiving assessments during the year per 100,000 population (2012-13)- Data Source: CareFirst (Referrals, Assessments & Packages of Care Statutory Return 2012-13)



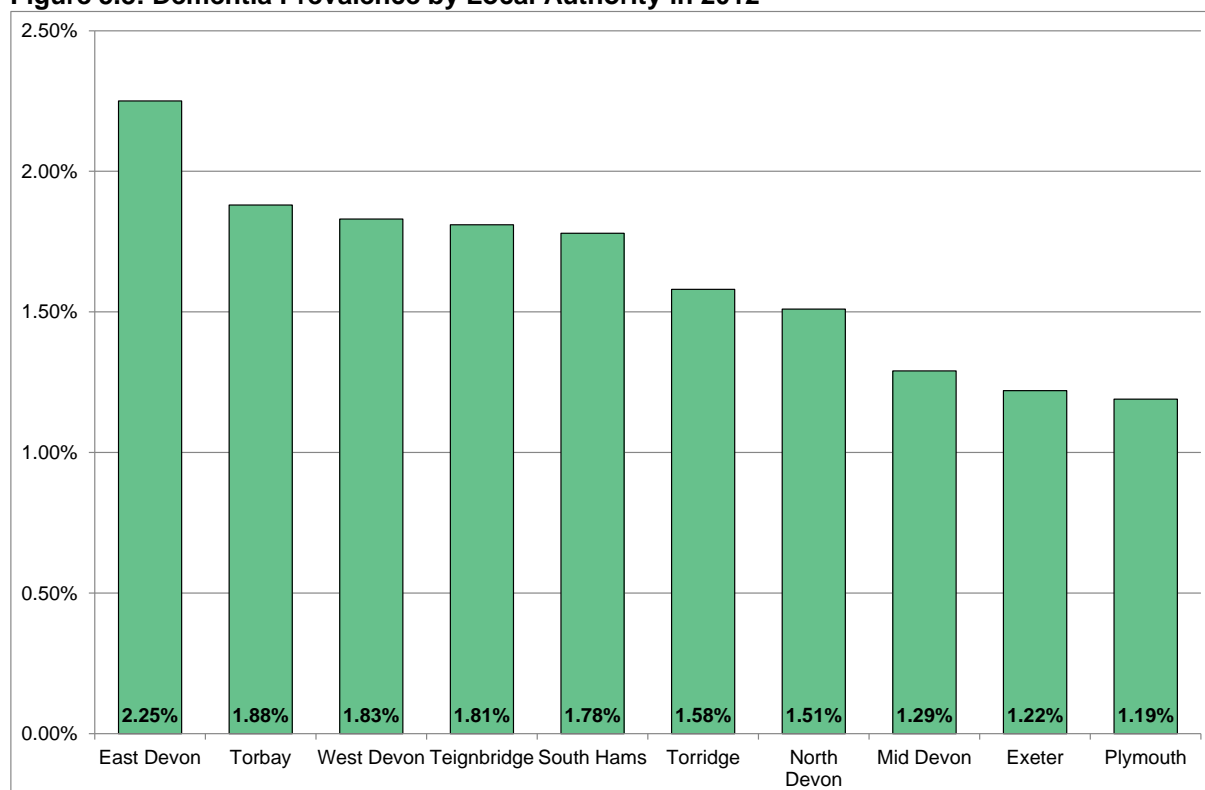
Dementia

Although Dementia is a common condition in older people, managing it can be hard for both the sufferer and family and friends around them. Although it can affect people at a younger age it predominantly affects people aged over 65. Devon has an older than average population and is also showing population growth in the older age groups.

Devon has recently published a high level dementia strategy which is underpinned by local action plans. It covers all types of dementia – a term which describes a set of symptoms that include loss of memory, mood changes and problems with communication and reasoning. The most common types are Alzheimer's disease and vascular dementia.

Figure 5.8 shows the expected dementia prevalence by local authority in 2012. This data is not age adjusted; however the highest prevalence is expected in East Devon.

Figure 5.8: Dementia Prevalence by Local Authority in 2012



Source: Devon Public Health Intelligence Team, 2013

Since the National Dementia Strategy was published in 2009, significant progress has been made in improving services and outcomes for people with dementia and their carers, but this strategy will help ensure services improve further.

In 2011-12, 4,848 people in Devon were on a GP register for dementia, compared with an expected prevalence of 13,075, this is a diagnosis rate of 37.1%. This is the third lowest ratio in the South West, and is below the South West (42.6%) and England (45.0%) rates. Diagnosis rates have improved in recent years, increasing from 28.0% in 2006-07, however national ratios have increased at the same rate. The highest rates in Devon are seen in Teignbridge (42.8%) and Torridge (41.4%). There are no significant differences in Devon based on area deprivation. 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.

The strategy sets out what has been achieved regarding dementia care and services, a care pathway for living well with dementia and the next steps. It also highlights the input of the findings of a Dementia Needs Assessment which is due to be published shortly.

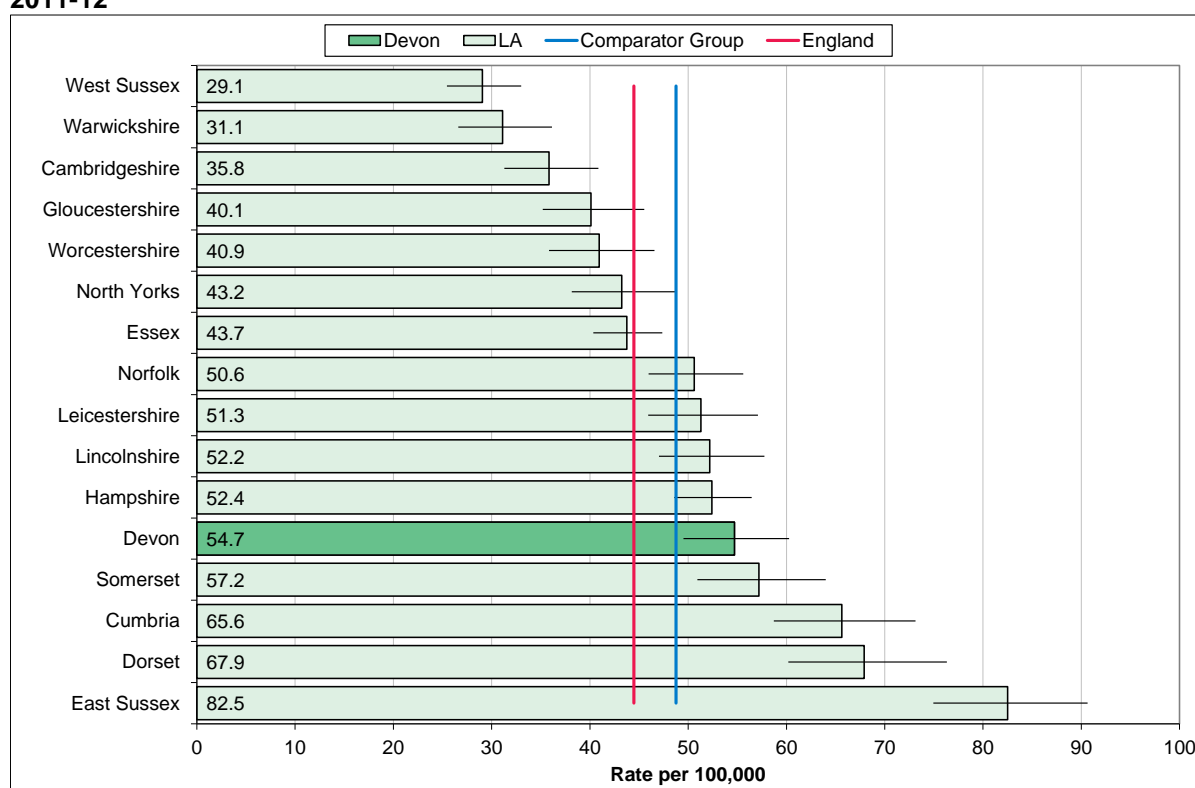
Visual Impairment

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 or more general problems of low vision, which can be associated with the ageing process.

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. This is largely influenced by the older age profile in Devon, with higher proportions of older people contributing to higher prevalence rates.

Figure 5.9: Sight Loss Registrations per 100,000 population by comparator local authority, 2011-12



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 22,400 people in Devon or just under 3% of the total population. Around 18,000 people are defined as having impaired vision (poor visual acuity and/or reduced field of vision), of which around 2,800 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 20% in visual impairment and associated conditions expected in Devon over the next eight years. The 'Facing Blindness Alone' report was published by the RNIB in 2013, highlighted that despite increasing prevalence there was a 43% decline in the number of blind and partially sighted people in England receiving local authority support, with a larger 67% drop in Devon.

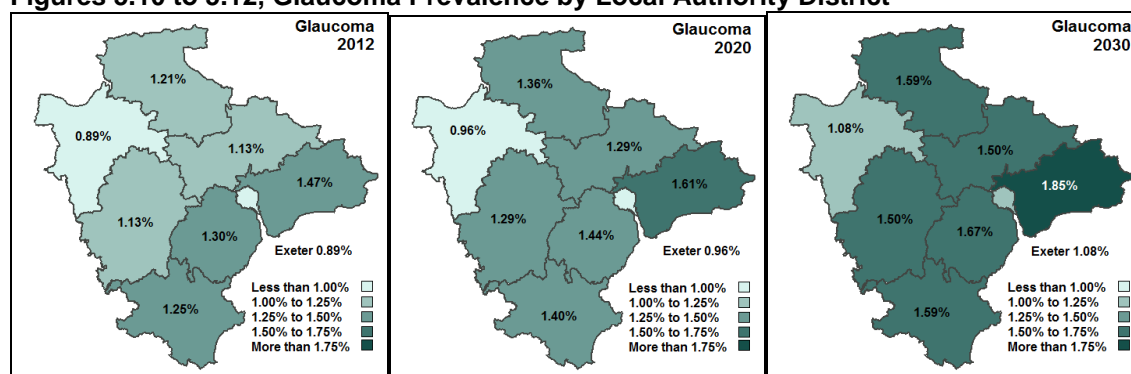
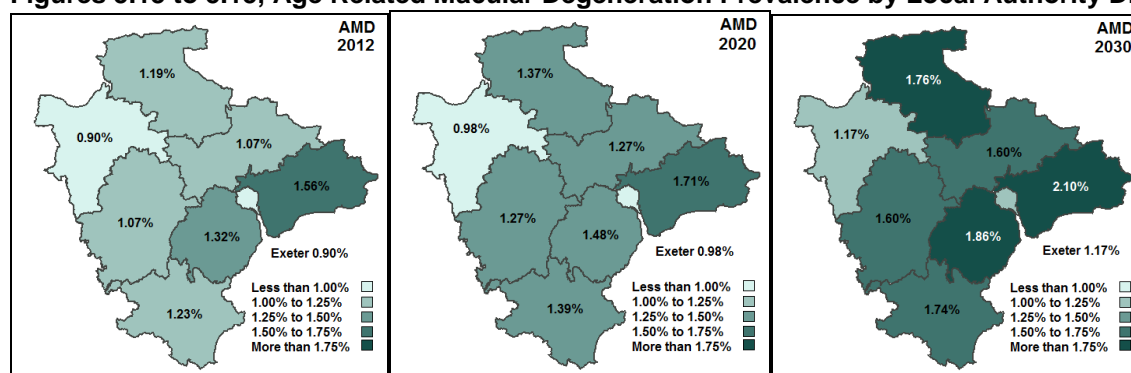
Table 5.2, Prevalence of Eye Health Conditions, 2012

| Condition | 2012 n | 2012 % | 2020 n | Change 2012 to 2020 |
|--|--------|--------|--------|---------------------|
| Glaucoma | 9,400 | 1.22% | 11,100 | +1,700 (+18.6%) |
| Age-Related Macular Degeneration (AMD) | 9,400 | 1.22% | 11,300 | +1,900 (+20.4%) |
| Cataracts | 22,400 | 2.91% | 27,000 | +4,600 (+20.6%) |
| Impaired Vision | 18,000 | 2.34% | 25,800 | +4,000 (+22.4%) |
| <i>slight impairment</i> | 15,200 | 1.97% | 18,500 | +3,400 (+22.2%) |
| <i>severe impairment</i> | 2,800 | 0.37% | 3,500 | 700 (+23.5%) |

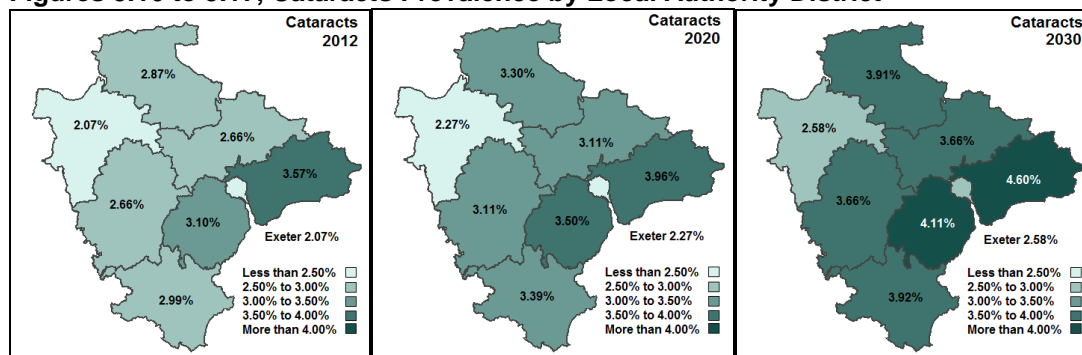
*numbers rounded to nearest hundred

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. Figures 5.10 to 5.26 highlights current and predicted future prevalence rates for Glaucoma, Age Related Macular Degeneration, Cataracts and Impaired Vision, highlighting significant increases in prevalence across all areas over the next two decades. These figures are summarised in tables 5.3 and 5.4.

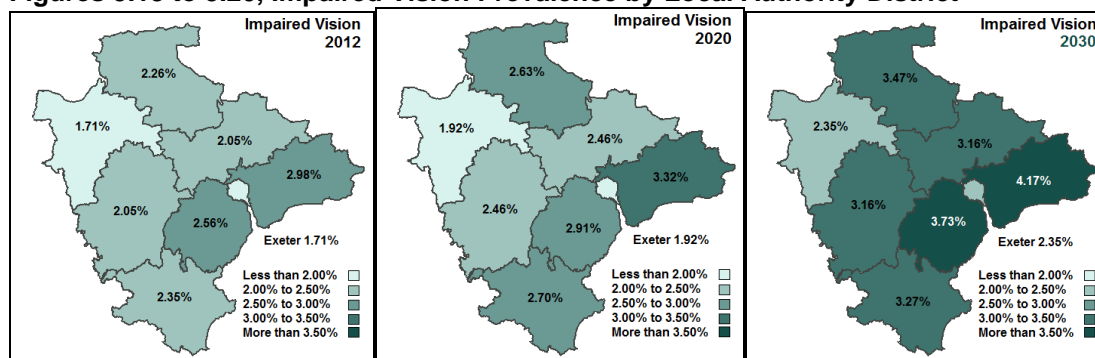
Prevalence Projections by Local Authority District, 2012 to 2030

Figures 5.10 to 5.12, Glaucoma Prevalence by Local Authority District**Figures 5.13 to 5.15, Age Related Macular Degeneration Prevalence by Local Authority District**

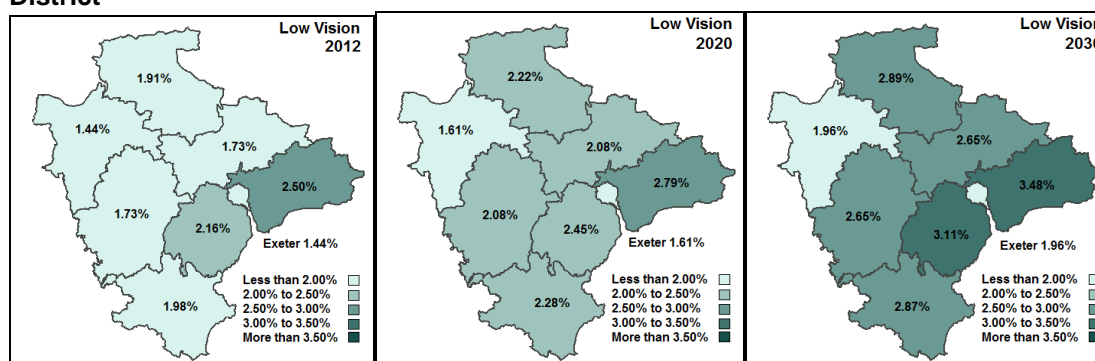
Figures 5.16 to 5.17, Cataracts Prevalence by Local Authority District



Figures 5.18 to 5.20, Impaired Vision Prevalence by Local Authority District



Figures 5.21 to 5.23, Low Vision (slight visual impairment) Prevalence by Local Authority District



Figures 5.24 to 5.26, Severe Visual Impairment Prevalence by Local Authority District

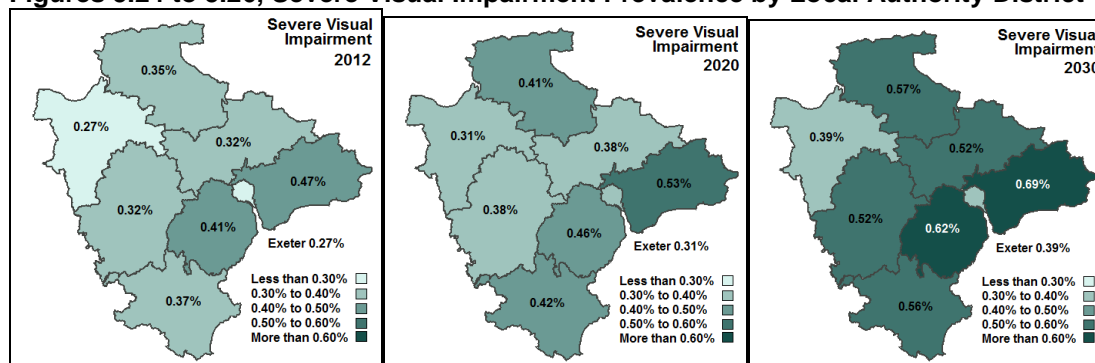


Table 5.3, Number of people with selected Eye Health Conditions by Local Authority District, 2012

| District | Glaucoma | AMD | Cataracts | Impaired Vision | | |
|-------------|----------|-------|-----------|-----------------|------------|--------|
| | | | | All | Low Vision | Severe |
| East Devon | 2,023 | 2,145 | 4,919 | 4,102 | 3,448 | 653 |
| Exeter | 1,085 | 1,099 | 2,537 | 2,093 | 1,763 | 331 |
| Mid Devon | 884 | 841 | 2,085 | 1,607 | 1,360 | 249 |
| North Devon | 1,125 | 1,110 | 2,681 | 2,106 | 1,781 | 326 |
| South Hams | 1,064 | 1,041 | 2,536 | 1,995 | 1,685 | 310 |
| Teignbridge | 1,682 | 1,713 | 4,022 | 3,323 | 2,798 | 525 |
| Torridge | 1,085 | 1,099 | 2,537 | 2,093 | 1,763 | 331 |
| West Devon | 884 | 841 | 2,085 | 1,607 | 1,360 | 249 |
| Devon | 9,383 | 9,424 | 22,400 | 17,987 | 15,181 | 2,814 |

Table 5.4, Proportion of people with selected Eye Health Conditions by Local Authority District, 2012

| District | Glaucoma | AMD | Cataracts | Impaired Vision | | |
|-------------|----------|-------|-----------|-----------------|------------|--------|
| | | | | All | Low Vision | Severe |
| East Devon | 1.47% | 1.56% | 3.57% | 2.98% | 2.50% | 0.47% |
| Exeter | 0.89% | 0.90% | 2.07% | 1.71% | 1.44% | 0.27% |
| Mid Devon | 1.13% | 1.07% | 2.66% | 2.05% | 1.73% | 0.32% |
| North Devon | 1.21% | 1.19% | 2.87% | 2.26% | 1.91% | 0.35% |
| South Hams | 1.25% | 1.23% | 2.99% | 2.35% | 1.98% | 0.37% |
| Teignbridge | 1.30% | 1.32% | 3.10% | 2.56% | 2.16% | 0.41% |
| Torridge | 0.89% | 0.90% | 2.07% | 1.71% | 1.44% | 0.27% |
| West Devon | 1.13% | 1.07% | 2.66% | 2.05% | 1.73% | 0.32% |
| Devon | 1.22% | 1.22% | 2.91% | 2.34% | 1.97% | 0.37% |

A detailed Health Needs Assessment on visual impairment will be published in 2014.

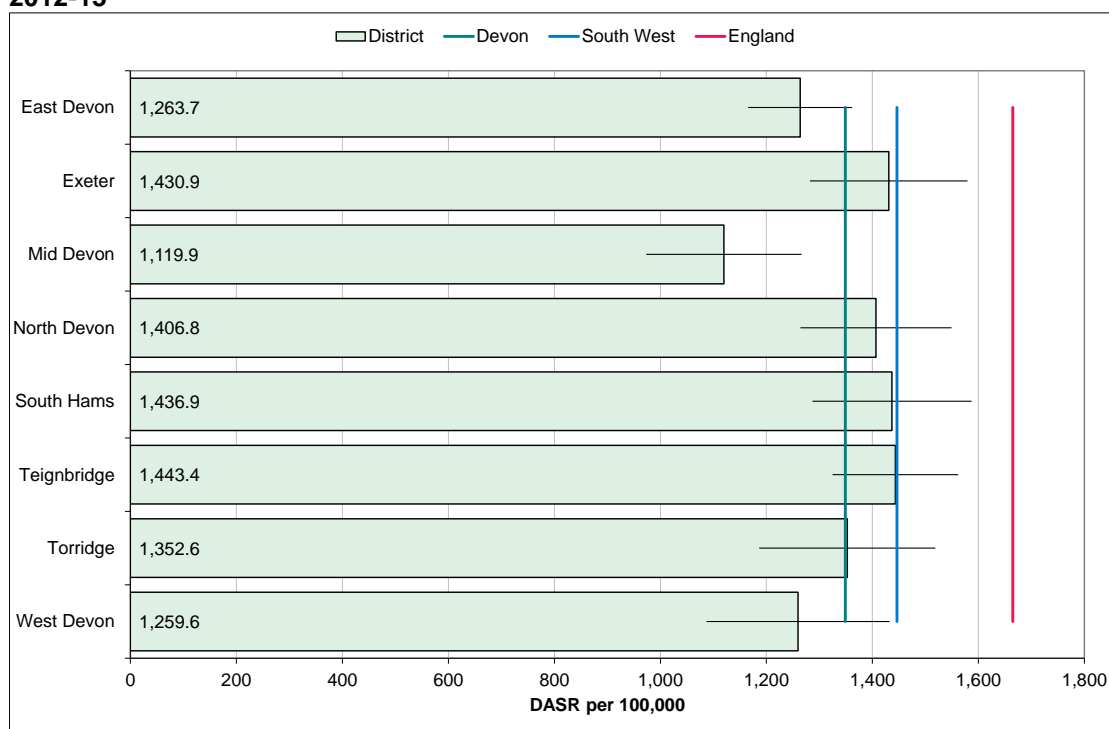
Falls

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

In 2012-13 there were 3,260 admissions due to falls in Devon for people aged 65 and over. The age standardised rate of admissions per 100,000 population was 1,348.9 which is below the South West (1446.5), the local authority comparator group (1419.1) and England (1664.8) rates. Although rates have increased between 2007-08 and 2010-11 they have stabilised in recent years. Devon had the second lowest rate in the South West and as figure 5.6 shows there was variation across the local authorities within Devon, Mid Devon had a significantly lower rate.

Rates vary by deprivation across Devon and age standardised admission rates have remained consistently higher in the most deprived deprivation quintile. Although the gap narrowed in 2012-13, the rate in the most deprived areas (1703.2) was still 47% higher than the least deprived areas (1161.2). As people age the rates increase sharply with an age specific rate of 477.1 for persons aged 65-69, compared with 6165.7 for those aged 85 and above.

Figure 5.27: Emergency admissions rates for injuries due to falls in people aged 65 and over, 2012-13



Source: Hospital Episode Statistics, Health and Social Care Information Centre