Torbay Strategic Partnership
Teaming up for today's tomorrow

Wednesday, 20 June 2012

A meeting of the **Shadow Health and Wellbeing Board** will be held on **Thursday, 5 July 2012**, commencing at **3.00 pm**
The meeting will be held in the Anna Dart Lecture Centre, Horizon Centre, Torbay Hospital

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# Agenda

**1.** **Election of Chairman/woman**
To elect a Chairman/woman for the Municipal Year 2012/13.

**2.** **Apologies and Changes in Membership**
To receive any apologies, including notifications of any changes to the membership of the Board.

**3.** **Election of Vice-Chairman/Woman**
To elect a Vice-Chairman/woman for the Municipal Year 2012/13.

**4.** **Minutes** (Pages 1 - 5)
To confirm as a correct record the Minutes of the meeting of the Board held on 15 March 2012.

**5.** **Matters Arising from the Minutes** (Pages 6 - 9)
To consider any matters arising from the Minutes of the meeting of the Board held on 15 March 2012.

1. **Update on Torbay Pharmaceutical Needs Assessment – Sue Taylor/Debbie Stark**
   Arising from Board Meeting on 15 March 2012, an update on the agreed actions in respect of the Torbay Pharmaceutical Needs Assessment.
2. **Notes from Away day – Siobhan Grady**
   -Agreement of way forward

**6.** **PART ONE: Providers perspective on Draft Heath & Wellbeing Strategy - Paula Vasco-Knight, Anthony Farnsworth, Iain Tulley** (Pages 10 - 27)
Debate with key providers.

**7.** **Clinical Commissioning Groups Draft Strategy Presentation - Dr Dave Barratt, Simon Tapley, Jo Turl**
Debate with key providers.

**8.** **Joint Strategic Needs Assessment - Debbie Stark, Doug Haines** (Pages 28 - 77)
Arising from the Board Meeting on 15 March 2012, an update on the development of the Joint Strategic Needs Assessment.

**9. PART TWO: Standard Items/Update**

- Children & YP Services
- Adults & SP
- Public Health
- CCG/Health
- Healthwatch Update

**10. Date of Next Meeting**

The date of the next meeting will be held on 20 September 2012.

**Members of the Partnership**

| | |
|---|---|
| Councillor Chris Lewis | Torbay Council |
| Councillor Christine Scouler | Torbay Council |
| Councillor Mike Morey | Torbay Council |
| Councillor Bobbie Davies | Torbay Council |
| Debbie Stark | Director of Public Health |
| Richard Williams | Director of Children's Services |
| Caroline Taylor | Deputy Chief Executive Torbay Council |
| Anne Mattock | Link |
| Sam Barrell | Baywide GP Commissioning Consortium |
| Kevin Muckian | Devon Local Pharmaceutical Committee |

# Minutes of the Shadow Health and Wellbeing Board

**15 March 2012**

**-: Present :-**

**Members of the Partnership:**

| | |
|---|---|
| Councillor Christine Scouler | Torbay Council |
| Councillor Bobbie Davies | Torbay Council |
| Debbie Stark | Director of Public Health |
| Richard Williams | Children's Trust |
| Anne Mattock | Link |
| Dr Charlie Daniels (In place of Sam Barrell) | Baywide GP Commissioning Consortia |
| Sue Taylor (In place of Kevin Muckian) | Devon Local Pharmaceutical Committee |

**Also present:**
Teresa Buckley, Molly Holmes (Sanctuary Housing Group), Helen Duff, Julia Melluish, Sean Westlake (Eat That Frog), Councillor Nicole Amil, Tracey Cabache (Torbay Council), Siobhan Grady (Torbay Care Trust) and Doug Haines (Torbay Care NHS Trust)

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## 19. Tour of Sarsons Pharmacy

Prior to the meeting Members of the Board received a tour of Sarsons Pharmacy to help them gain an understanding of the work carried out by the Pharmacy, particulary in relation to community and preventative services.

## 20. Apologies and Changes in Membership

Apologies for absence were received from Board Members: Councillor Morey and Carolone Taylor (Torbay Council), Anthony Farnsworth (Torbay Care Trust), Sam Barrell (Baywide GP Commissioning Consortium – who was represented by Charlie Daniels), Kevin Muckian (Devon Local Pharmaceutical Committee – who was represented by Sue Taylor); and Observers: Liam McGrath (CVA Torbay – who was represented by Julia Melluish and Sean Westlake), Councillor Hernandez and Fran Mason (Torbay Council).

## 21. Minutes

The Minutes of the meeting of the Shadow Health and Wellbeing Board held on 20 October 2011 were confirmed as a correct record and signed by the Chairman.

## 22. Matters Arising from the Minutes

Arising from Minute 16, it was agreed that the Board would received an update on the actions in respect of the Torbay Pharmaceutical Needs Assessment at their next meeting.

**Action:**

Teresa Buckley to add item to the agenda for the next meeting.

## 23. Part 1 - Key Strategic Issues - Refreshed Joint Strategic Needs Assessment (JSNA)

Members took part in a workshop session to look at the emerging Joint Strategic Needs Assessment (JSNA) having regard to the four life course groups of: starting well; developing well; living and working well; and aging well.

**Action:**

Debbie Stark to collate the results of the workshop session and provide an update on the JSNA at the next meeting.

## 24. Part 2 - Key Changes/Issues for Agreement

### 24.1 The New Youth Offer/Positive for Youth

Richard Williams presented a paper which provided an update on changes to services for young people following the publication of the Government's policy for young people aged between 13-19 'Positive for Youth'. Previously there had been no statutory framework for youth offer and the Ofsted Inspection Framework had been used to drive performance. However the Government was in the process of making it statutory to provide youth services and ensure that local Councils and partners actively involve young people in development of local services to ensure they meet their needs.

Torbay already has a good voice for youth through the successful Youth Parliament; is working closely with parents looking at developing support around teenage parenting; is working closely with the community and voluntary sector; looking at earlier support to help prevent bad behaviour; and has released £150,000 previously used to employ youth workers to the voluntary sector within Torbay to deliver services for young people.

It was noted that the Council was currently going through the tendering process for a youth contract which would also include employment issues and NEETS (not in employment, education, training or school).

### 24.2 Young People and Families Partnership Commissioning Group

Siobhan Grady outlined the submitted paper on the proposed merger of the Young Person Substance Misuse and Joint Commissioning Group and Housing Strategy Group (which is focussed on young people) and the new reporting arrangements.

**Agreed:**

(i) the Health and Well Being Board agreed to the decision for accountability for children's substance misuse commissioning to be undertaken through a merged commissioning delivery group (i.e. the Children, Families and Young Persons Planning Commissioning Group) reporting to the Supporting People Commissioning Board which in turn reports to the Health and Well Being Board;

(ii) the Supporting People Commissioning Board to extend it's scope taking a broader remit to include children substance misuse issues;

(iii) the revised Terms of Reference set out in Appendix 1 to the submitted report were approved. This includes name of group, Chair, membership and representation, agenda planning and process for performance management;

(iv) the proposed new arrangements and first meeting to be held May 2012; and

(v) the new arrangements to be monitored for nine months in order to make any further recommendations for further merger and streamlining of commissioning and planning groups and scope and remit to Supporting People Commissioning Board.

## 25. Part 3 - Commissioning Services and Updates

### 25.1 Children's

**Children and Young Peoples Plan (CYPP)** – Richard Williams provided a brief update on the direction of travel in respect of the CYPP. Teenage pregnancy, school attendance and achievement were heading in the right direction, although child poverty was increasing.

**Action:**

Richard Williams to provide a report to a future meeting on monitoring and changes to the CYPP.

**Community Budgets** – Richard Williams outlined the submitted paper on community budgets, which had been rebranded as 'improving outcomes for troubled families. Torbay has been told that it has approximately 365 troubled families using the following areas for selection (although local analysis would suggest this figure would be nearer to 500):

- Families with children below minimum acceptable school attendance levels (likely to be below 85%);
- Families with offending histories (exact criteria unknown, likely to be conviction in previous 12 months); and
- Families claiming out of work benefits.

It was noted that Torbay had been allocated £75,000 to employ a co-ordinator for this work. This function is currently being carried out by existing members of staff in order to utilize the funding to support the service. There was an expectation that 60% of the cost

for this work would be funded by local authorities and partners within existing resources with 40% being funded by the Government for successful achievement of improvement. It is not yet know how success will be measured, however, most of the work is the same as we are already doing with our partners.

A Multi Agency Troubled Families Steering Group will be established by mid April to agree how the first cohort of families will be engaged and to continue to develop and monitor the approach over the three year period.

**25.2 Adults and Supporting People**

Siobhan Grady outlined the submitted paper on the proposed extension of the Terms of Reference of the Supporting People Commissioning Body to include commissioning of adult social care to ensure appropriate governance arrangements are in place following the appointment of the Director of Adult Social Services (DASS) within Torbay Council and the widened remit for the Torbay Care Trust provider arm to cover southern Devon.

**Agreed:**

The Shadow Health and Wellbeing Board endorsed the decision of Supporting People Commissioning Body on 16 February to extend the Memorandum of Understanding and Terms of Reference for the Supporting People Commissioning Body to include accountability for adult social care commissioning in Torbay. A Summary of the commissioning decisions will be provided at future Health and Wellbeing Board meetings.

**25.3 Clinical Commissioning Group**

Charlie Daniels provided an update in respect of the Clinical Commissioning Group. He advised that it had been agreed to merge Torbay's Baywide Clinical Commissioning Group with South Devon's Clinical Commissioning Group as it was too small on its own. A new South Devon and Torbay Clinical Commissioning Group will be established which covers 38 GP practices and 290,000 patients and is coterminous with the boundary of the South Devon Healthcare Trust. A Joint Board with Torbay and South Devon will be establishing a shadow Board which will be operational from October 2012.

**26. Public Health**

Debbie Stark provided an update on the public health transition which was due to take effect from April 2013. The transition is going well in Torbay due to existing arrangements although there are still issues to be resolved around finance. The Government is not clear on how the arrangements with the NHS will work with the changes and are working with Public Health England and the Clinical Commissioning Groups.

**26.1 Healthwatch Implementation Programme**

Tracey Cabache outlined the submitted paper which provided an update in respect of Healthwatch. The Government published a 20 page summary report on 2 March 2012 which outlined the key changes. The new target date for operation has changed from October 2012 to April 2013 with Local Involvement Networks (LINks) continuing to function until April 2013. The implementation will no longer be staggered and

Healthwatch England will be established in October 2012 so that it is up and running before the local Healthwatch.

It was noted that it is possible to grant aid the Healthwatch funding to an existing LINks provided that evidence can be shown that they have a 'unique capacity' to deliver the Healthwatch function. The Council has asked for national guidance in respect of this. In the meantime the existing LINks is registering as a corporate entity.

**Agreed:**

(i) the Shadow Health and Wellbeing Board supported the development and procurement of Healthwatch Torbay as outlined in the submitted report;

(ii) the Health and Wellbeing Board to consider the recommendations for the establishment of local Healthwatch in Torbay at their July 2012 meeting.

**Action:**

Tracey Cabache to email a copy of the summary report to Teresa Buckley for circulation to the Board.

Members were encouraged to attend the Pathfinder Stakeholder event at the Riviera International Conference Centre on Thursday, 22 March 2012.

**27. 'Measure Up' 2012 - 14: Torbay's Interagency Carers Strategy**

The Board noted the submitted report 'Measure Up' 2012 -14: Torbay's Integrated Carers Strategy which was approved by the Board under the ten day rule on 6 March 2012.

**28. Date of Future Meetings**

Future meetings of the Health and Wellbeing Board will be rotated around our partners venues or held at the Town Hall, Torquay at 3.00 p.m. and have been scheduled for:

- Thursday,17 May 2012;
- Thursday, 5 July 2012;
- Thursday, 20 September 2012;
- Thursday, 22 November 2012;
- Thursday, 17 January 2013; and
- Thursday, 21 March 2013.

Chairman

**Health and Wellbeing Board**

**Strategic Planning Awayday Outputs: Thursday 3 May 2012**

Present: Councillor Chris Lewis, Councillor Mike Morey (morning only), Councillor Bobbie Davies, Debbie Stark (Director of Public Health), Siobhan Grady (Public Health), Dr Sam Barrell (Clinical Co-Chair, South Devon and Torbay Clinical Commissioning Group), Caroline Taylor (Deputy Chief Executive, Torbay Council), Anne Mattock (LiNK representative), Sue Taylor (Devon Local Pharmaceutical Committee), Richard Williams (Director, Childrens' Trust). Facilitator: Louise Hardy (Head of Organisation Development, South Devon and Torbay CCG)

**Overview of the day**

Members met and spent some time discussing their desired outputs from the day. These included:

- Some tangible direction for self and Board for the future
- Improved working relationships, fostering of a partnership ethos and a better feeling of 'team'. Learning to trust one another
- Working through, and agreeing priorities for work
- Seeing the scale of change in a system context
- Wanting to retain focus on what we know is important (eg, Children and Families)
- Understanding our stakeholders and knowing how to engage them
- Ensuring outcomes

**Team Profiles**

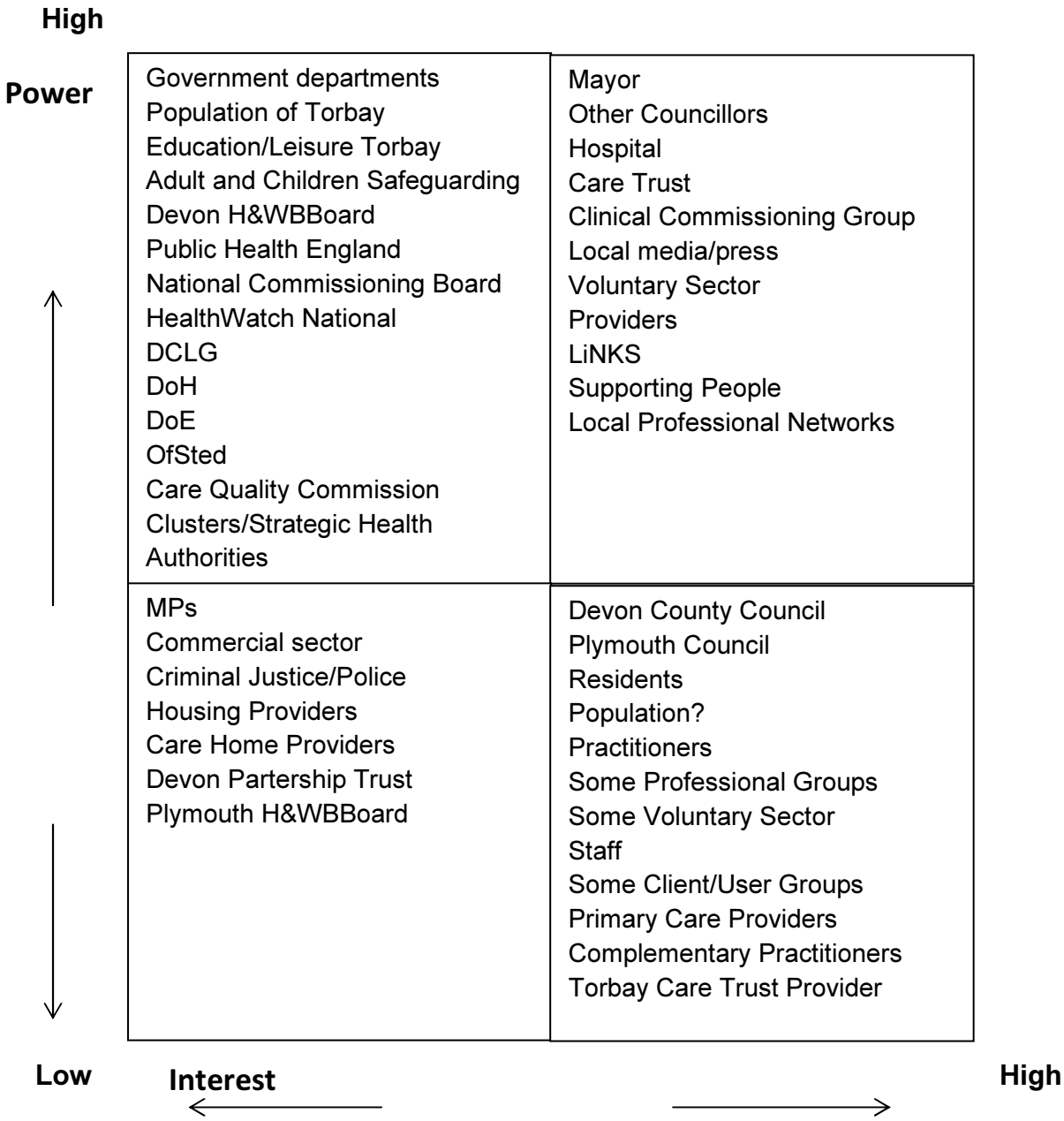
The members spent some time working together on their individual personality profiles, learning that they favour different modes of approach to team working. The group displays a good balance of fiery red energy (competitive, dynamic, strong-willed, directional and purposeful), earth green energy (caring, encouraging, sharing, patient and relaxed), sunshine yellow energy (sociable, dynamic, demonstrative, enthusiastic, persuasive). Somewhat lacking in the group is the presence of cool blue energy (cautious, precise, deliberate, questioning and formal), and this may need attention as the Board works through problems and issues during business as usual.

**Team Vision**

The group agreed that their vision for service needed to focus on facilitation of outcomes (rather than active delivery through their own limited resources). They likened this to a glass musical box: one in which the cogs were stakeholders (the CCG, the third sector, childrens' services etc), the key was the Health and Wellbeing Board and the glass surround would represent transparency in all their dealings.

**Stakeholder Analysis**

The group generated a large and diverse list of stakeholders with whom they recognised they would need to build communications relationships at various levels. The output of an analysis of this list demonstrated the following:




The grid shows where stakeholders are currently placed – but the group discussed the need to communicate and work with certain stakeholders in order to move them from one box to another. For example:

- Housing providers: working with them to move them from low to high interest status
- Torbay Hospital – ditto the above

- The media would need careful management to ensure they remained engaged and supportive
- Police and the criminal justice system could be worked with to ensure that they had high interest but also high power (particularly where certain workstreams are concerned

**Setting strategy**

Using a strategic planning model, the group looked at the key influencers on policy and strategy for the next three years. These include:

- Political drivers: current Mayor's own preferences and leadership, national legislation, national and local elections – need to remain engaged and adaptive
- Economic drivers – poor economic climate, significant areas of deprivation, welfare reform, climate of recession, payment by results, upward pressures, budgetary cuts
- Social drivers – welfare reforms, the Big Society, families (troubled), elderly care, issues re. children, the third sector
- Technological drivers – self-care solutions ('Looking Local'), sharing of information, lack of IT cohesion?

The group spent some time thinking about existing thematic workstreams and the priorities for Torbay in the future. What is vital now, what can we achieve and how can we plan to engage key stakeholders in achieving it?

**Strategic Direction: next five years**

Consensus was reached over the following known priorities:

| **Area for focus** | **Rationale** |
|---|---|
| Children and troubled families | Significant problem in Torbay, as benchmarked nationally. Root of future good health and wellbeing if tackled early. Breaking the cycle of future problems. Politically desirable, and potentially achievable if efforts are focused |
| Elderly care | Significant high elderly population in Torbay. Issues of isolation, malnourishment, frailty, low self-esteem, poverty, housing/care home/residential home problems, warmth. |
| Mental health | High drug use, environment problems, family issues (see Children above), divorce, low wealth, lack of jobs, physical factors (such as sickness and disability) |
| Obesity | Still a problem, but good progress being made locally |
| Dementia | Growing problem – to be tackled with 'Elderly' (see above)? |
| Alcohol/drug abuse | Known issues – some good progress locally |

The group agreed that many of the issues identified above are interlinked. For example – drug/alcohol use contributes to troubled family problems, and thus children are affected.

They also agreed that a focus on children/troubled families would yield significant improvements in other areas (for example – mental health).

The size and complexity of this list of priorities led the group to consider engaging with one, prime strategy for the next three years, which will be communicated to stakeholders through a planned Forum event. This will be Children and Troubled Families. The following strategic aims were agreed:

- To achieve joint commissioning (health, social care, public health – all focused on children) within three years
- To achieve joint front-line delivery within three years
- To achieve a reduction in: those on child protection register, enhanced educational attainment, improvement in current key indicators, narrowing of the inequality gap and – remaining within budget

The following immediate actions were agreed:

| **Action** | **Timescale/Action Owner** |
|---|---|
| Design and hold a forum event for stakeholders at which strategic plan is discussed and actions agreed | Event in September (Caroline Taylor to action, along with other Service Directors) |
| Officer support group need | Now (Richard Williams to action) |
| Health and Wellbeing Board agenda redesign: to outline new intentions and launch | Councillor Chris Lewis to action for September Board |
| Refresh JSNA in the light of these strategic intentions, and consult | By September (Debbie Stark to action) |
| Ensure local people are communicated to, with and are involved in order to attain successful outcomes | Forum event – plus ongoing communications/involvement |
| | |

# HEALTH AND WELL BEING PLAN

## 2012 – 2014

**(A Framework for Design to Delivery)**

**January 2012**

## CONTENTS

# 1. FORWARD

Chair of Health and Well Being Board

A plan that will enable communities to reduce inequalities and experience good health and well-being throughout life needs to take account of the wider determinants and mirror the cross government framework.

This plan provides the framework for action promoting prevention, early intervention and targeted support.

Has been developed with three underlying principles:

1. ***First and Most focus attention and effort to address the health and wellbeing inequalities that exist between communities within the Bay.***
2. ***Early Intervention to improve overall outcomes and ultimately reduce cost with a focus on Prevention rather Treatment.***
3. ***Integrated and joint systems approach to planning, commissioning and delivery at a local level***

# 2. POLICY CONTEXT

2.1 The Coalition Government has set out major reform within the Local Government and National Health Service. A vast number of literature has been published; equity and excellence: liberating the NHS[1], healthy live healthy people[2], no health without mental health[3] and the health and social care bill 2011.[4] These papers set the backdrop for change, including a new Public Health System which will focus on improving the health of the poorest fastest and transformational change to the way that services are commissioned and increasing local democratic legitimacy.

2.2 The health and social care bill makes proposals to strengthen the partnership working across health and local authorities, underpinned by local democracy. This will see the establishment of Health and Well Being Boards providing the opportunity for a more integrated approach at a local level to deliver better health and wellbeing outcomes, better quality of care and better value.

**2.3 HEALTH AND WELL BEING BOARDS**

The Government proposals have set out the proposed role and function of the Health and Well Being Board:

- To assess the needs of the local population and lead the statutory joint strategic needs assessment.
    - Including the undertaking of the Pharmaceutical Needs Assessment.
- To promote integration and partnership working between the health, social care, public health and other local services.
- Promote collaboration on local commissioning plans, including supporting joint commissioning and pooled budget arrangements where each party so wishes.
- To undertake a scrutiny role in relation to major service changes and priorities.

Membership of the health and well-being board, outside a core membership list, will be discretionary at a local level. The core membership, as proposed in liberating the NHS: legislative framework and next steps[6], include GP consortia, the director of adult social services, the director of children's services, the director of public health, an elected member and a local health watch. Locally Torbay has established it's board with membership as follows:

| | | |
|---|---|---|
| Cllr Chris Lewis | Torbay Council | (Chair) |
| Cllr Christine Scouler | Torbay Council | |
| Cllr Mike Morey | Torbay Council | |
| Cllr Bobbie Davies | Torbay Council | |
| Anthony Farnsworth | Torbay Care Trust | |
| Debbie Stark | Director of Public Health | (Vice Chair) |
| Richard Williams | Torbay Council | |
| Caroline Taylor | Deputy Chief Executive Torbay Council | |
| Clare Tanner | Torbay Council | |
| Anne Mattock | Link | |
| Dr Sam Barrell | Baywide GP Commissioning Consortium | |
| Kevin Muckian | Devon Local Pharmaceutical Committee | |

The new Health and Wellbeing Board will be the local forum for discussion (and decision making) of Torbay strategies to prevent ill health and maximise effective, integrated

treatment. Based on an available evidence base such as NICE and on what matters most to local people.

## 3. BUILDING A SUSTAINABLE H&WB PLAN

3.1 This Health and Wellbeing Plan is based around an integrated approach which reflects the collective responsibility of communities, the local authority and partners in improving and protecting health. As well as promoting the personal responsibility for one's own health and self management. Health and well being objectives have been set based on needs identified from within the Joint Strategic Needs Assessment (JSNA); priorities identified from people in the community ('what matters the most'); priorities identified from development of other strategies. Under the direction of the Health and Wellbeing Board we can jointly create opportunities by maximising resources and minimising duplication.

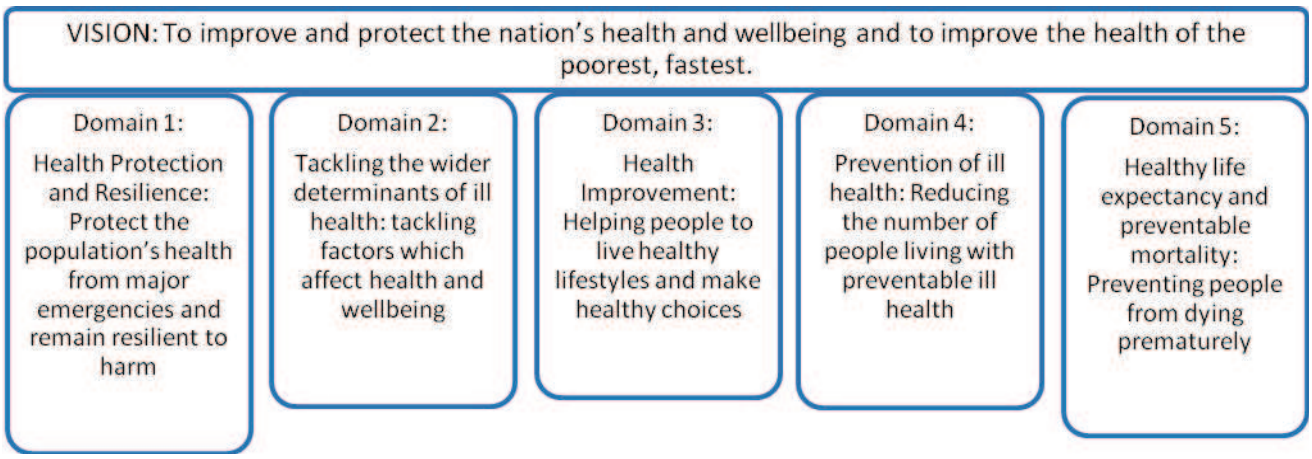
3.2 Physical and psychological health and wellbeing is an essential foundation for a prosperous and flourishing society. [(13)] It enables individual and families to contribute fully to their communities, and underpins higher levels of motivation, aspiration and achievement. It improves the efficiency and productivity of the labour force – critical to ensuring economic recovery. Poor health and wellbeing also costs a great deal through medical and social care costs, reduced productivity in the workplace, increased incapacity benefits, and many other calls on public services and community support. Our most deprived communities experience the poorest health and wellbeing, so systematically targeted approaches on the geographical areas and population groups at greatest need is crucial in reducing inequalities. This is why we have set an underlying principle of, **'First and Most Approach.'**

3.3 The White paper 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' sets out the future for public health. It adopts a life course framework for tackling the wider social determinants of health and provides a framework for action promoting prevention, early intervention and targeted support. This is why we have set an underlying principle of, **Early Intervention to improve overall outcomes and ultimately reduce cost with a focus on *Prevention rather treatment.***

3.4 Putting public health responsibilities firmly back to local government with a stated ring fenced budget to ensure that local government and local communities are central to improve health and wellbeing of their populations and tackling inequalities

3.5 A new Outcomes Framework for public health at national and local levels is proposed. It will be evidence driven, taking account of the different needs of different communities and supportive of delivering health and well being strategies. Figure 2 illustrates the proposed Public Health Outcomes Framework which is set out across five domains

**Figure 2: Public Health Outcomes Framework**




3.6 The Health and Social Care Outcomes and Accountability Framework (Figure 3) plays a significant role in shaping the priorities for the local population together with evidence from the joint strategic needs assessment.

**Figure 3. Health & Social Care Outcomes and Accountability Framework**

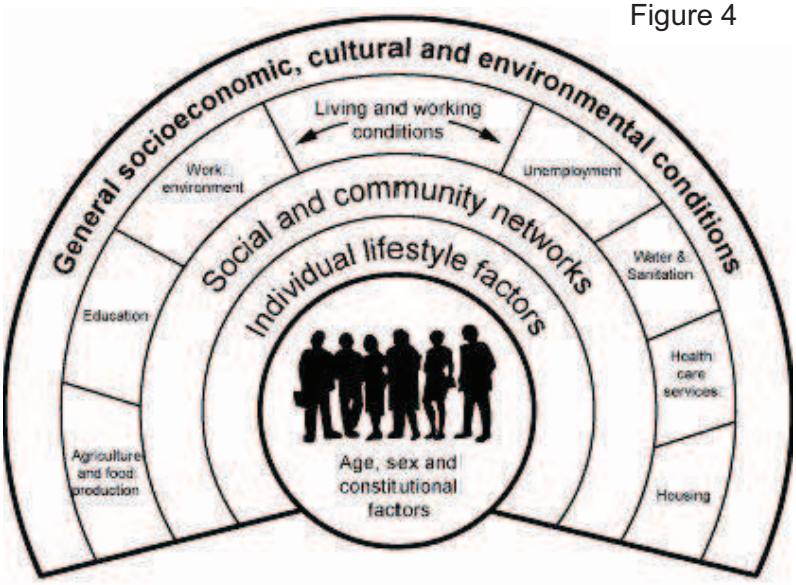

3.7 Torbay Care Trust in partnership with the Council is a national leader in the transformation of community based health and social care services targeting prevention and greater integration of services. In addition to working collaboratively with business and the voluntary sector we have set the underlying principle for, **'Integrated and Joint System Approaches.'**

3.8 The level of spend already within the Bay is considered a shrinking purse. Combined NHS (£254m), Adult social Care, Public Health and Children services (£27.8m plus £71.3m Dedicated Schools Grant) provides a basis on which to plan and commission less not more. (Please note that this does not include housing support). Already impact of Government grant cuts and flat cash / no growth has begun to impact the increasing challenge will be how to manage the pressures from demographic changes, financial cost of advancements in technology, drugs and increasing expectation and levels of need from our residents particularly those with long term conditions.

3.9 The health and wellbeing plan forms part of the Torbay Policy Framework and sits under the Community Plan which has recently been refreshed to deliver against a shared vision for 'Health, Prosperous and Happy Communities.'

3.10 It is clear that there is significant co dependency on organisations working together in order to impact on improvements in health and well being and the role that housing; employment; leisure and environment plays in contributing to this as is illustrated by the Dahlgren and Whitehead's model below. Good health is affected by the wider determinant such as housing, environmental conditions, but also impact on an individual's ability to work or take part in society.

Figure 4



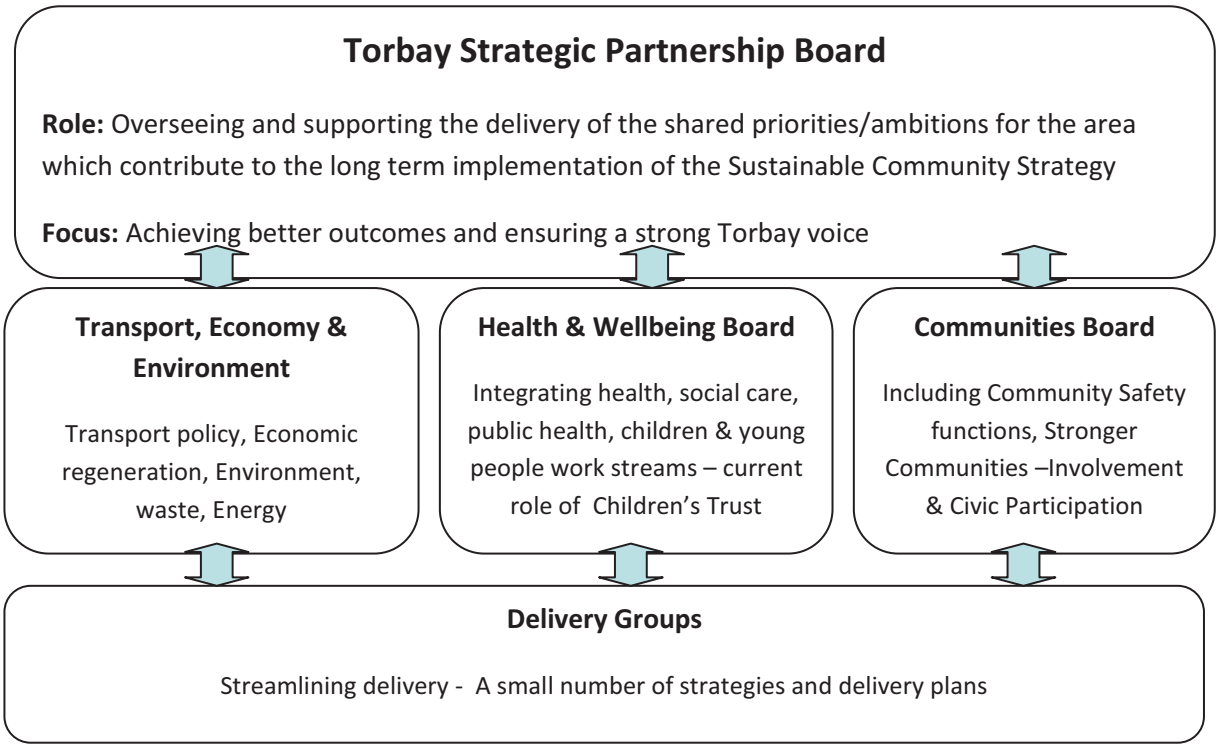

Source: Dahlgren & Whitehead 1991.

3.11 Therefore it is crucial that the links are made between this H&WB Plan and other strategies and influencing plans such as, Torbay Council's Core Strategy, Economic Development Strategy, Homelessness Strategy, Housing and Culture Strategies, Children & Young Peoples Plan, Active Aging, 'Measure Up' Torbay's Interagency Carers strategy, Local Transport Plan, as well as the NHS Commissioning and Operating Plan. In addition to the strong connectivity between the work programmes and priorities of the Transport, Economy and Environment Board and Communities Board.

An example of this is...The Core Strategy makes a commitment for: *Healthy Bay – all new development should contribute towards creating healthy and sustainable communities and neighbourhoods through the provision of well located, and designed, housing, employment and social facilities, including those for sport, recreation, play and open space, in attractive, accessible, safe, secure sustainable environments which benefit people's psychical and mental health and well-being. Green infrastructure policies promoting walking and cycling and the accessibility of goods and services are supported along with leisure and recreational spaces. Health impact assessments will be completed to check and understand any health implications and measure impact on local environment and community.*

3.12 The following strategic governance architecture outlines where the Health and Well Being board will sit alongside the other two strategic delivery boards under the umbrella board of the Torbay Strategic Partnership.

Figure 5:




3.13 The following set of core underlying principles are proposed to underpin the Health & Well Being Plan:

1. ***First and Most: focus attention and effort to address the health and wellbeing inequalities that exist between communities within the Bay.***
2. ***Early Intervention: Prevention rather treatment***
3. ***Integrated and joint systems approach to planning, commissioning and delivery at a local level.***

3.14 Given the scale of the challenge set before us in addressing the inequalities that exist across the Bay the support to communities to help build a sustainable health and well being system will require transformation and challenge to the way of thinking and expectations. For example.

| | | | | |
|---|---|---|---|---|
| From | Health and social care as institution led services | | To | Health and social care as part of the community |
| From | Curative and fixing medical care | | To | Early intervention and preventative care |
| From | Sickness | | To | Health and well being |
| From | Sustainability as an add on | | To | Integration in culture, practice and training |
| From | Nobody's business | | To | Everyone's business |
| From | Single indicators and out of date measurements | | To | Multiple score card information with Outcomes |

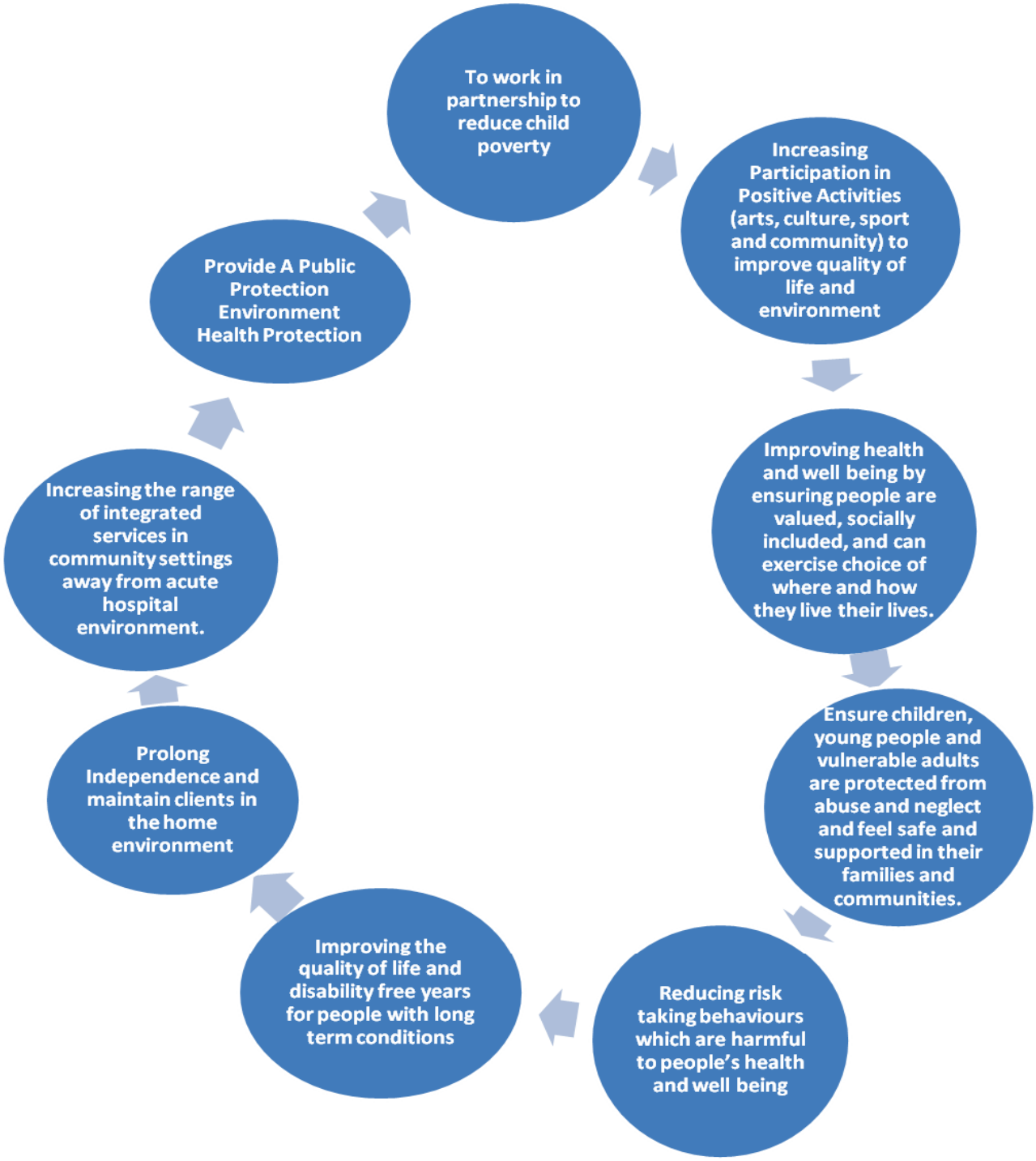
Source: Route Map for Sustainable Health

3.15 Therefore, investment in early intervention and prevention is considered paramount and all sectors must work more closely together to provide appropriate care. This means housing, education, support to early years and community networks should provide a fully integrated health and well being system. Key government investment in coming

years will see the health visiting capacity in Torbay doubling in recognition of the impact across the life course of a healthy start for children and locally joint planning of hospital discharge to ensure appropriate housing is accessible preventing homelessness;

3.16 A key success factor in changing mind set and shifting behaviour will be for Torbay organisations and businesses working with communities to deliver on what matters most to them and can be delivered through multi disciplinary locality working.

## 4. PRIORITY AREAS



**ONE: To Work In Partnership To Reduce The Effects Of Child Poverty**

- Recruitment of additional qualified health visitors over the next 3 years to support a whole family targeted approach within communities.
- Provide peer support breastfeeding programme which will include practical support and follow up and information.
- Children centre community hubs provide parenting support to ensure improved child development and school readiness
- Promote social action in the community, that will encourage people to come together in their neighbourhoods to support each other
- Working with the Community and Voluntary sector to identify those at most risk of disadvantage and not receiving the support they need

**TWO: Increasing Participation In Positive Activities (arts, culture, sport and community) To Improve Quality of Life and Environment**

- Promote use of green gyms and natural environment in addressing increasing obesity levels
- Commission and Promote arts, culture and leisure opportunities and events to improve mental well being and quality of life
- Work with libraries, museums, leisure centres to improve access to health information and support services

**THREE: Improving Health And Well Being By Ensuring People Are Valued, Socially Included, And Can Exercise Choice Of Where And How They Live Their Lives**

- Tackle the difficulties people have accessing affordable housing, particularly young disabled adults wanting to leave home and those with poor mental and emotional health
- Support and manage choice in the Care Home market
- Promote health and well being through sustainable design, energy efficiency, affordable warmth, the reduction of risk of accidents in the home, green space and provide space for play

**FOUR: Ensuring Children, Young People And Vulnerable Adults Are Protected From Abuse And Neglect And Feel Safe And Supported In Their Families And Communities**

- Redesign support services for children and parents/carers in relation to Safeguarding system and processes
- Identify and support unpaid Carers of all ages to support them in their caring role and in maintaining their own health and well being.
- Supporting the ongoing multi agency work around the “Keeping safe” packs developed with people who have a learning disability.

**FIVE: Reducing Risk Taking Behaviours Which Are Harmful To People's Health And Well Being**

- Provide support and resources to schools to create healthy learning environments where children and staff can learn, thrive and achieve.
- Developing and improve opportunities for recovery capital for people with drug and alcohol issues and maintain timely safe and effective access to treatment.
- Review and commission sexual health services which are accessible and offer choice and are delivered by qualified practitioners offering a wider range of contraception; information and testing of STIs and HIV.
- Target stop smoking advice and support to routine/ manual 35+yrs as part of Torbay Well@work 2012 with larger employers as well as specific focus on supporting mothers who are pregnant to stop smoking
- Develop primary care based clinical infrastructure with a particular focus on preventative measures and diagnostics
- Develop specific programme to address inequalities in health behaviours amongst young women in Torbay.

**SIX: Improving The Quality Of Life And Disability Free Years For People With Long Term Conditions**

- Focus on chronic disease management and case management to improve the patient experience and outcomes
- Improve access to psychological therapies and Dementia services
- Support the use of annual health checks for people who have a learning disability within primary care to promote early diagnosis treatment and prevention of long term conditions.

**SEVEN: Prolong Independence And Maintain Clients In The Home Environment**

- Agreed quality assurance framework which monitors provider contracts including client held budgets
- Further develop self care support systems through implementation of telehealth, telecare, personal budgets, assistive technology, advice and information
- Deliver the key aims of 'Measure Up', the interagency Carers strategy
- Work with an expanded market of new specialist providers who have specific skills to support people who have a range of needs in their homes and in their community.

**EIGHT: Increasing The Range Of Integrated Services In Community Settings Away From Acute Hospital Environment**

- Review effective use and resource to secure improvement in the acute and community hospital capital
- Increase range of integrated services being delivered and provided in primary care and community which will reduce emergency admissions, ambulance care and alternatives to follow ups.
- Offer alternative clinical management pathways to acute services referral following primary care led assessment.

**NINE: Provide A Public Protection Environment Health Protection**

- Work with Public Health England and the wider NHS to plan, prepare and be able to respond to a range of disruptive challenges – such as terrorism, infectious disease outbreaks, chemical, biological, radiological and nuclear incidents, and the health impacts of climate change – in a co-ordinated and effective way both nationally and locally.

## 5. MEASUREMENT

5.1 The following measurements have been derived from previous National Indicators and proposed set of public health indicators which are still to be confirmed. Please note that those with ** will be the responsibility of either the Transport, Economy & Environment Board or Community Board however the Health and Well being board will need to have oversight due to the nature of co- dependency.

- Children in poverty
- Housing overcrowding rates
- Proportion of people with mental illness and or disability6 in settled accommodation
- Employment of people with long-term conditions **
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- Killed and seriously injured casualties on England's roads **
- Prevalence of healthy weight in 4-5 and 10-11 year olds
- Prevalence of healthy weight in adults
- Smoking prevalence in adults (over 18)
- Rate of hospital admissions per 100,000 for alcohol related harm
- Percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)
- Hospital admissions caused by unintentional and deliberate injuries to 5-18 year olds
- Number leaving drug treatment free of drug(s) of dependence
- Under 18 conception rate
- Rate of dental caries in children aged 5 years (decayed, missing or filled teeth)
- Self reported wellbeing
- Hospital admissions caused by unintentional and deliberate injuries to under 5 year olds.
- Rate of hospital admissions as a result of self-harm
- Incidence of low-birth weight of term babies
- Breastfeeding initiation and prevalence at 6-8 weeks after birth
- Prevalence of recorded diabetes
- Work sickness absence rate **
- Screening uptake (of national screening programmes)
- Chlamydia diagnosis rates per 100,000 young adults aged 15-24
- Proportion of persons presenting with HIV at a late stage of infection
- Child development at 2 - 2.5 years
- Maternal smoking prevalence (including during pregnancy)
- Smoking rate of people with serious mental illness
- Emergency readmissions to hospitals within 28 days of discharge
- Health-related quality of life for older people
- Acute admissions as a result of falls or fall injuries for over 65s
- Take up of the NHS Health Check programme by those eligible
- Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed
- Infant mortality rate
- Suicide rate
- Mortality rate from communicable diseases
- Mortality rate from all cardiovascular disease (including heart disease and stroke) in persons less than 75 years of age
- Mortality rate from cancer in persons less than 75 years of age
- Mortality rate from Chronic Liver Disease in persons less than 75 years of age
- Mortality rate from chronic respiratory diseases in persons less than 75 years of age*
- Mortality rate of people with mental illness*
- Excess seasonal mortality
- Number of carers on GP registers

[1] Fair Society, healthy Lives. The Marmot Review. University College London, Feb 2010.

## 6. THE CHALLENGES SET BEFORE US

This section sets out the social challenges faced by Torbay's resident population, those living within Torbay. It is important to identify that there are also challenges, with a shrinking public purse, for the commissioning of services to meet the local populations need.

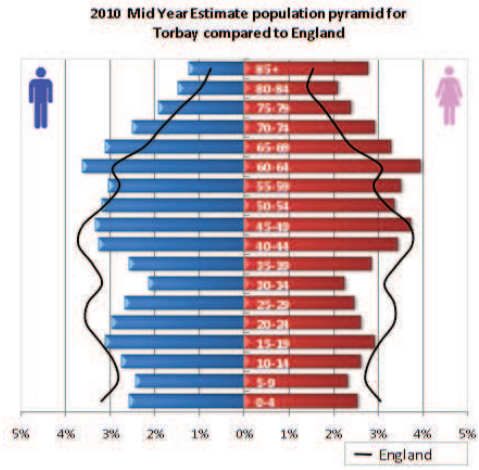
The challenges set out below are structured around the life course journey, with broad age related themes along the journey being presented as the framework. This is supplemented with an additional overarching life course section that pulls challenges that don't naturally fit with a specific age category.

The challenges set out below have been taken from a number of strategies and key documents that identify the issues facing Torbay today, including the Community Plan, the Core Strategy and the children's and young people's plan. The evidence to support the perception of the challenges has been taken from Torbay's Joint Strategic Needs Assessment.

**Life course:**

- Demographics
- Inequalities
    - Social deprivation
    - Life expectancy
    - All age all-cause mortality
    - Disability free life expectancy

**Demography**:
Torbay's position as a seaside community continues to prove popular as a retirement destination. This popularity is illustrated in the following population pyramid, where Torbay's population structure is shown with the solid bars, compared to the England structure with the line. Torbay's population structure is very much dominated by the higher proportion of older people and the noticeably lower proportion of younger adults aged 20 to 39.



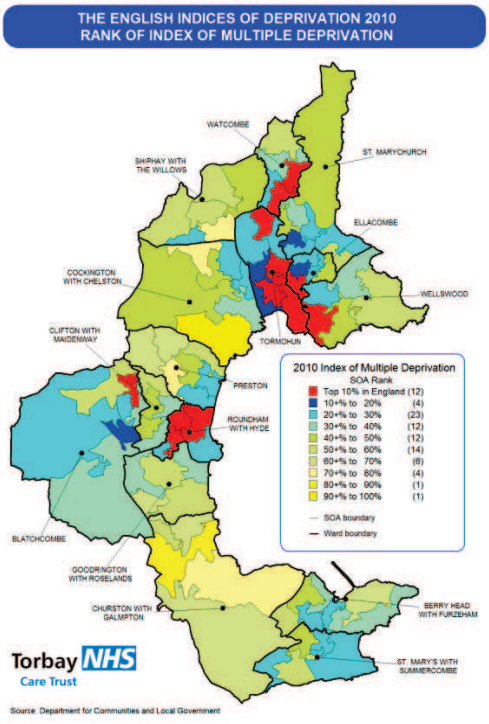

Torbay has a noticeably higher average age when compared to the national average. In 2010, Torbay's average age is estimated to be 4.7 years older than the national; this difference is expected to grow to just over 5 years by 2020.

As Torbay's population ages, the proportionate workforce within the bay to support the retirement age population is expected to decrease. This means that for every person of retirement age, there are expected to be fewer people of working age. In 2010, there are 2.1 working age people in Torbay for every person of retirement age; this is expected to decrease to 1.7 people of working age per person of retirement age by 2020. This is noticeably lower than the national average.

Despite Torbay's position as a seaside community, there are pockets of severe deprivation. These pockets, shown in red in the below map, have a direct link with communities with poorer educational attainment, poorer socio-economic status, lower earnings and the lowest life expectancy.

Levels of modelled socio economic deprivation for Torbay have deteriorated over the last 10 years. From just outside the top quartile most deprived local authorities in 2001 and 2004 to well within the top quartile most deprived in 2007, this trend of worsening deprivation has continued with the updated 2010 Index of multiple deprivation published in March 2011. Torbay ranked as the most deprived local authority in the South West region, and within the top 20% (quintile) most for the rank of average score.

There is an overwhelming amount of evidence that links economic prosperity and population socio economic outcomes, evidenced recently in the Marmot review[1].



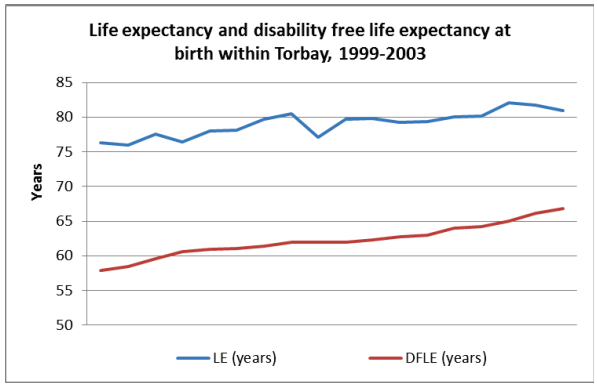

Health problems appear to arise less from the infectious diseases of previous times but more from diseases caused by behavioural and environmental factors. People are being treated more effectively than ever before but to fully benefit from longer life, people need to take advantage also of the opportunities provided for staying well for longer.

A strong link also exists between environmental factors such as poor housing and unemployment and certain lifestyles or behaviours which lead to health inequalities, for example, smoking, alcohol and obesity.

Levels of mortality in Torbay are in line with national mortality rates, but higher than regional rates. With around 670 males, and 480 females dying from all causes per 100,000, (this is a standardised rate per 100,000, and takes account of age.)

Life expectancy in Torbay is in line with national estimates, at around 78 years for males, and 82 years for females. However, within Torbay there is noticeable variation, for example, males in Tormohun having a life expectancy of 74.5 years compared to Churston with Galmpton having a life expectancy of 82.4 years.

Along with the variation in life expectancy at birth in Torbay, there is also a variation in disability free life expectancy. In Torbay, communities with the lowest life expectancy also experience the lowest number of disability free life expectancy. On average, these communities experience shorter lives; however the gap between life expectancy and disability life expectancy is widest in the more deprived communities.




Torbay has high levels of deprivation in a number of wards, a high proportion of people claiming job seekers' allowance, some poor educational attainment by certain groups of young people and pockets of child poverty. Turning these factors around poses some challenging decisions for the Consortium working in partnership with TCT and other key stakeholders.

There are also warning signs of a number of "risk-taking behaviours" that will have a negative impact on health and well-being in the future.

We know that tobacco use, physical inactivity, excess alcohol consumption and poor diet – are the biggest behavioural contributors to preventable disease. These 'top four' are responsible for 42% of deaths from leading causes and approximately 31% of all disability adjusted life years *World Health Organization, The European Health Report, 2005). Tackling behavioural risk factors through health promotion is often seen as an issue among younger, predominantly healthier people, however, behavioural factors are also major risk factors in the onset and relapse of, and premature mortality from, **long-term**

**conditions** such as diabetes, cardiac disease and respiratory disease, and for increase disability from musculoskeletal conditions and mental ill health.
There is also strong evidence that reducing behavioural risk factors in older people significantly increase both quality and length of life, irrespective of any pre-existing long term condition. 'No Health without Mental Health ' (DH, 2011) Government strategy provides focus and evidence that improving mental health and wellbeing significantly reduces physical (as well as psychological) ill health.
Over a quarter of the population is still smoking, a fifth of all adults are obese and there are increasing high levels of alcohol misuse plus estimated numbers of problematic drug users living in Torbay in excess of 1000. There is evidence of poor sexual health choices, including teenage conceptions and high abortion rates.

**Obesity** among primary school age children with 8.9% of reception children and 17.4% of year 6 children classed as being obese in 2009. In addition to an estimated 25% of adults locally as being obese. (Health Surveys for England 2003 to 2005)

**Smoking.** 18.3% of adults smoking in Torbay (2010) compared to national figure of 21.4%. Over 80% of all smokers start the habit before the age of 18yrs.
Levels of smoking among women during pregnancy is of particular concern with Torbay having the eight highest rate in country for smoking on delivery.

**Teenage Pregnancy rate (2009)** 55.3 per 1,000 high for a population size of Torbay in comparison to other areas. **Abortion rate (2010)** Torbay 23.6 per 1,000 compared to England 17.5. **Sexually Transmitted Infection r**ates in diagnosis for Herpes and Warts has increased by 9% between 2009 and 2010. There is also a continuing rise in numbers of individuals seen for **HIV** related care. Nationally there has been a 6% increase compared to 2009. Although actual numbers are low the prevalence rate per 1,000 population (15-59yrs) has increased by 28% from 2009 to 2010 in Torbay

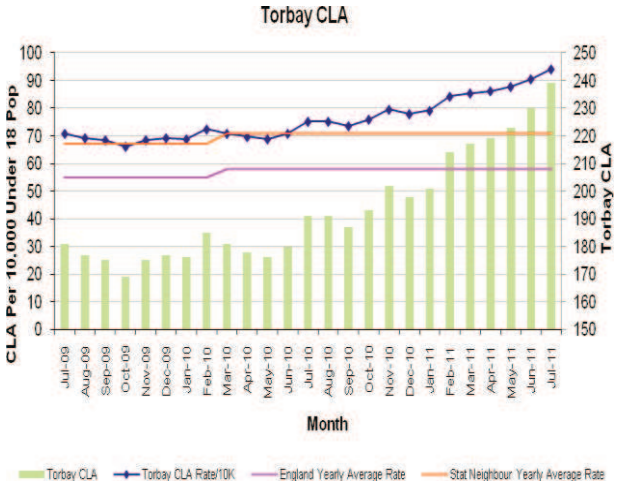
While overall hospital admission rates are below expected levels there are some conditions where this is not the case, namely admissions for alcohol-related liver disease (twice expected levels), emergency admissions for injuries and poisonings and admissions for teeth extractions due to dental caries (decay) in children. Torbay experiences more mental health admissions than would be expected and the Bay has a high suicide rate.

**Children, Young People and Families**
We know that Children's health and well being is determined by a complex interaction of social, economic, psychological and family factors. Child poverty remains a key issue and therefore it is essential that organisations work in partnership together to meet the needs of children and families; raise standards; lift children from poverty and improve health and well being. We know from the Marmot[i] review that investing in early years is crucial to breaking the cycle of inequalities and reducing the gap between the least and most advantaged. A disproprotionate focus on achieving specific outcomes within the educational sytem would be ineffective if support is not given in the early developmental years.
Whilst **Childhood Immunisation** rates have improved year on year, in 2011 we saw a measles outbreak in an area surrounding Torbay. There is evidence that immunisation uptake among infants is poorest in the most deprived area and that interventions undertaken are more likely to be taken up by more affluent areas therefore widening the gap. In particular the issue in Torbay is with the low 2nd dose of MMR.

**Breastfeeding** (initiation & 6 to 8 weeks)

- Torbay performs
- The consequence is that

There are rising numbers of children on a **Child Protection and Looked After** by the care system. At the end of July 2011 there were 239 children looked after (a rate of 94.0 per 10,000 under 18 population). This is the highest number for several years.
The England rate at 31st March 2010 was 58 and the statistical neighbour rate was 71.
Graph below shows the rate over the last 2 years.




We know that young carers are more likely to experience poor mental health; more likely to smoke, drinking and substance misuse; more at risk of having a teenage pregnancy; more likely to not be in education or employment or training and achieve lower attainment grades at school leaving age.

**Adult Age Population**
We know that the number of adults living with long term conditions is increasing. A shift with clear focus on prevention and self management rather than treatment is needed to address this growing concern and dependency. Many interventions that cost less and are most cost-effective increase disability-free life expectancy, yet are not routinely implemented. For example, increasing physical activity improves mental health and wellbeing, reduces rates of heart disease and cancer, reduces the likelihood of developing diabetes in those at risk, reduces deterioration and improves mobility, quality of life and life expectancy.

**Unpaid Carers**
We know that 1 in 7 of the adult population have substantial caring roles and that the impact of this on their physical and mental health can be significant and that the risk in breakdown of their own health will also impact on the people they care for. Carers experience health inequalities which require particular attention.

Mortality from all **Cancers** all age (2007-2009) Torbay - Directly age-standardised rates (DSR) 167.55 compared to England DSR 171.68. Screening programmes are an important route to identify disease early on and enable access to treatments.
Torbay DSR for the following cancers are higher than the England rates*
**Breast Cancer** 30.17 (*26.08)
**Prostate Cancer** 26.23 (*24.18)
**Cervical Cancer** 3.03 (*2.27)

Poor **Mental Health** is both a contributor to and a consequence of wider health inequalities. At any one time, just over 30% of working-age women and 17% of working age men are affected by depression or anxiety. Mental illness begins early; 10% of children have a diagnosable mental health condition and 50% of lifetime mental illness is present by the age of 14.

All age **Suicide** rate (for the period of 2007-2009) 7.87 in comparison to England rate 5.76.

**Alcohol**
Men are significantly more likely to binge drink than women - highest level of binge drinking is seen in 18-24 year olds.
High rates of alcohol related admissions 1986 per 100,000 population. Over the period 2007-2009 mortality from **chronic liver disease including cirrhosis** in Torbay was 75.

**Drug Misuse** – (estimated problematic drug misuse data due 29.10.11)

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# 2012/13 Joint Strategic Needs Assessment for Torbay

## *The narrative; a life course understanding of the health and social care needs in Torbay*

DRAFT COPY

i-Bay Intelligence Torbay 'working in partnership'

## Glossary

| | |
|---|---|
| APHO | Association of Public Health Observatories |
| ASC | Adult Social Care |
| BME | Black Minority Ethnic |
| CHD | Coronary Heart Disease |
| COPD | Chronic Obstructive Pulmonary Disease |
| CYPP | Children and Young Peoples Plan |
| DFLE | Disability Free Life expectancy |
| DH | Department of Health |
| DSR | Directly Standardised Rate |
| GCSE | General Certificate of Secondary Education |
| GP | General Practitioner |
| GVA | Gross Value Added |
| HPV | Human Papillomavirus |
| IC | Information Centre |
| JSNA | Joint Strategic Needs Assessment |
| LD | Learning Disability |
| LE | Life Expectancy |
| LSP | Local Strategic Partnership |
| MMR | Mumps Measles and Rubella |
| NCHOD | National Centre for Health Outcomes Development |
| NEPHO | North East Public Health Observatory |
| NHS | National Health Service |
| ONS | Office for National Statistics |
| POPPI | Projecting Older People Population Information |
| SAR | Standardised Admission Ratio |
| SNPP | Sub National Population Projections |
| SP | Supporting People |
| SWPHO | South West Public Health Observatory |

# CONTENTS

# FOREWORD

**Councillor Chris Lewis,**

**Chair of the Shadow Health & Wellbeing Board**

Health and Wellbeing boards are at the heart of the Government's plans to transform health and social care and achieve better population health and wellbeing. Their collective focus will be to improve services for the whole community so that individuals and communities are able to live healthier lives, and have a better experience of the health and care system.

Torbay's Health and Wellbeing board is expected to become statutory from April 2013. The board will have an on-going responsibility to prepare the Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy. These will allow for jointly agreed and locally determined priorities on which to base commissioning plans within the reformed health and social care system going forward.

This refreshed JSNA for 2012/13 sets out the current health and social needs of our local population. It has been compiled by the partners of the Intelligence Network for Torbay, *i-Bay,* with contributions from members of the Shadow Health and Wellbeing Board.

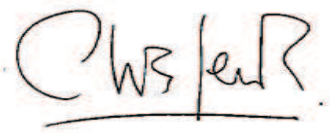
This JSNA will be used to revise Torbay's Health and Wellbeing Strategy. The strategy will provide the agreed collective action to address the identified priorities and underpin commissioning plans for 2013/14.

Health and Wellbeing boards will have a duty to encourage integrated working of commissioners and providers in order to improve the health and wellbeing of the local population, reduce inequalities, and increase the quality and experience of services for the local population. It could also be a great benefit to the taxpayer with the opportunity for efficient use of shared resources.

Within this JSNA, we have considered the needs of Torbay's local population at different stages of life. I would like us to consider the case and opportunities for integrated services for each of those different stages of life for our population.

# FOREWORD

I would like us to work together to make a real difference to the inequalities and needs within our local population and the most vulnerable. To do this, we have to recognise that no one single organisation, be they statutory or voluntary, can do this alone. A shared sense of priorities, supported by this robust evidence base, will help us work together to focus on the key issues that matter locally.



Chris Lewis

**Debbie Stark,**

**Director of Public Health for Torbay**

This JSNA for 2012/13 is the fourth in a series for Torbay and comes at a time of great change for the NHS. The commissioning of healthcare will transfer from Primary Care Trusts and be undertaken by GP-led Clinical Commissioning Groups and the national commissioning board. Functions for public health will be returning to Local Government from April 2013.

National guidance has been considered in the production of the 2012/13 JSNA and in particular, the questions Health and Wellbeing board members should be asking in order to support their focus on local priorities:

- What are the outcomes for our population?
- What does our population and place look like?
- So what does that mean the population needs now and in the future?

This JSNA offers answers to the above and defines a set of priorities for collective action. The emerging advice from the Department of Health is that action against priorities will only be effective if it is focused on a small number of key issues. The guidance is clear that this should include an assessment of opportunities for integration. How to achieve congruent action against the priorities will be set out in the Health and Wellbeing strategy and from there in commissioning plans for individual and multi-agency action.

Health and Wellbeing boards will be expected to consider national outcomes frameworks for the NHS, adult social care and public health. We have taken the indicators for each of these outcomes frameworks and assigned them to appropriate life course or life stage group in this assessment. Data have been grouped, where possible and assessed to identify priorities for Torbay on the basis of: Torbay's relative position against the national picture; national priorities; public perception and financial implications.

Within each life course group we have tried to provide a narrative of the Torbay position which also incorporates current actions, future implications and the impact of wider issues being considered by other boards. Members of the Shadow Health and Wellbeing board have been able to provide some of the assessment of emerging priorities through meetings of the board.

One of the early decisions of the Shadow Health and Wellbeing board was to include issues for children alongside the national expectations for healthcare, adult social care and public health. This reflects an understanding of the levels of child poverty and safeguarding concerns for our local population highlighted in the Children and Young Peoples plan (CYPP).

There is a national expectation that the Health and Wellbeing board will look at opportunities for integration between services. In Torbay, we already have a well- known integrated care provision for the elderly with joint health and social care teams operating in five zones across the Bay (now 10 across Torbay and South Devon). There is evidence that suggests this integrated model for the elderly has shown many benefits, with Torbay having the lowest non-elective length of hospital stay in the South West, the lowest number of occupied bed days for repeat patients aged over 75 in the country (more than 2 admissions) and the lowest rate of hospital deaths in England.

Currently, services for children in Torbay are in intervention with the Department for Education. Outcomes for Torbay's children and young people are not as good as we would like in the Bay. There are an increasing number of children being looked after in the Bay, increasing numbers in need, and relatively high levels of troubled families. The health and wellbeing board have an opportunity to bring agencies together to improve the outcomes for our younger and vulnerable people

Summary of priorities from this JSNA:

- Integration of services for children, public health and safer communities on a locality basis
- Continued focus on inequalities, both for this board and others
- Management of long term conditions
- Alcohol and teenage pregnancy

Finally, this JSNA has been prepared for the Torbay Health and Wellbeing board and has considered the needs of the population within the local authority boundary only at this time. As the Clinical Commissioning group is now expected to cover a wider area, incorporating South Devon, a second iteration of this document will be prepared to reflect those wider population needs in conjunction with Devon Public Health colleagues.

Debbie Stark

**Inequalities**

***The cost of inequalities in illness in Torbay is estimated to be in the region of £75 to £80 million***. There are pockets of severe deprivation in Torbay, with around 15% (21,000) of the population living in areas in the top 10% most deprived in England (2010). In relative terms, Torbay's position has worsened over time, in 2004 there were some 6,000 residents living in the top 10% most deprived and in 2007 some 15,500.

Within Torbay there are pronounced and significant inequalities. For example, life expectancy is significantly higher in the least deprived communities, and preventable mortality, such as from diseases attributed to smoking, is highest in the most deprived communities. Disability free life expectancy is highest amongst those in the least deprived communities. However those in the more deprived communities tend to experience disabilities at a younger age and live with the disability for a longer period.

There are clear inequalities within the wider determinants of health. It can also be observed that areas with the greatest levels of deprivation show higher rates of recorded domestic abuse, higher rates of teenage pregnancy, higher rates of alcohol related admissions to hospital and housing in the poorest condition.

Reducing inequalities is a matter of moral fairness and financial sense. Consideration should be given to collective action to reduce inequalities in Torbay.

**Children**

***Children in Torbay experience significant inequalities***. Children born in the more deprived communities, on average, are born into areas with the challenges of poverty, lower levels of attainment, and increased exposure to risk taking behaviours, such as being born to a smoker. Reducing smoking in pregnancy in Torbay will benefit the unborn child; it will improve the child's chance of not becoming a smoker, and reduce their risk of developing chronic long term conditions later in life.

Torbay's children have high rates of hospital admissions for unintentional and deliberate injuries. Injuries have been linked to long term health issues relating to the injury, and also mental health related issues due to the experience.

The rates of children looked after by the local authority in Torbay, the rate of children in need and the rate of children subject to child protection plans are amongst the highest in England.

The proportion of looked after children taken into care has fallen dramatically between 2008 and 2011. Torbay could be considered an outlier for the high proportion of children in need due to the child's disability or illness, and family in acute stress.

Troubled families in Torbay are estimated to cost in the region of £27 million. The Government has identified a troubled family as one that has serious problems and causes serious problems. In every troubled family there are a range of factors including parents not working, mental health problems, children not in school, the family causing crime and anti-social behaviour and costing local services a lot of time and money routinely responding to these problems.

Disadvantage starts at birth and accumulates throughout life [1]. Consideration should be given to collective action to improve children's chances for a healthy life in Torbay.

**Aging population**

Torbay has a higher proportion of older people in the population compared with the national average. This higher proportion is ***expected to increase over the coming years***. An aged population places increased pressures on both health and social care.

On our current trajectory, and assuming todays prices, we may expect the over 85 population to cost the NHS in Torbay (secondary care) over £1m more in 2020 compared to today, based on demographic change alone. Up from around £7.3m in 2012 to £8.5m in 2020.

Life expectancy at 65 is generally higher for residents in Torbay than compared to England. With males estimated to live for a further 18.9 years and females 21.4 years. This compares to 17.7 years and 20.3 years respectively for males and females in England. Locally, life expectancy at 75 in Torbay shows significant variation by deprivation quintile. Those living in the most deprived 20% in Torbay can expect to live, on average, significantly less than residents in the least deprived 20% in Torbay.

Consideration should be given to the increased demand anticipated as Torbay's population ages.

"*Reducing health inequalities is a matter of fairness and social justice*"

Sir Michael Marmot, Fair Society, Healthy Lives (2010) [1]

**Introduction**

This report is the ***2012 Joint Strategic Needs Assessment (JSNA) report for Torbay***. It provides a ***narrative overview*** on the needs of the local population through a ***life course framework.***

This report is themed around a life course approach using the outcomes frameworks for Adult Social Care [2], the NHS [3] and Public Health [4]. A life course approach is where the population needs are considered from the different perspectives along the path of life. For example, the needs of babies and those in their early years will be significantly different from those entering adulthood or entering retirement. Undertaking a life course approach allows understanding of community needs for different age groups now, and also enables suggestions for what future population needs may look like.

Inequalities are evident across the life course, from ***children being born in more deprived areas expected to experience shorter life expectancy***; to working age persons with lower or no qualifications; to premature mortality. Is it fair that children born in different areas experience such different life outcomes? As Sir Michael Marmot argues, "Reducing inequalities is a matter of fairness and social justice" [1].

In order to begin to reduce inequalities, an understanding of the complex web of issues is required. There is evidence to suggest that ***disadvantage starts before birth and accumulates throughout life*** [1]. To reduce inequalities across the life course, it is important to reduce the early disadvantage and reduce poorer outcomes from pregnancy and birth and during childhood.

JSNAs analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas [5]. JSNA will be the means by which local leaders work together to understand and agree the needs of the local population [6]. JSNAs, along with health and wellbeing strategies will enable commissioners to plan and commission more effective and integrated services to meet the needs of Torbay's population [6], in particular for the most vulnerable and for groups with the worst health outcomes, and reduce the overall inequality that exists within Torbay.

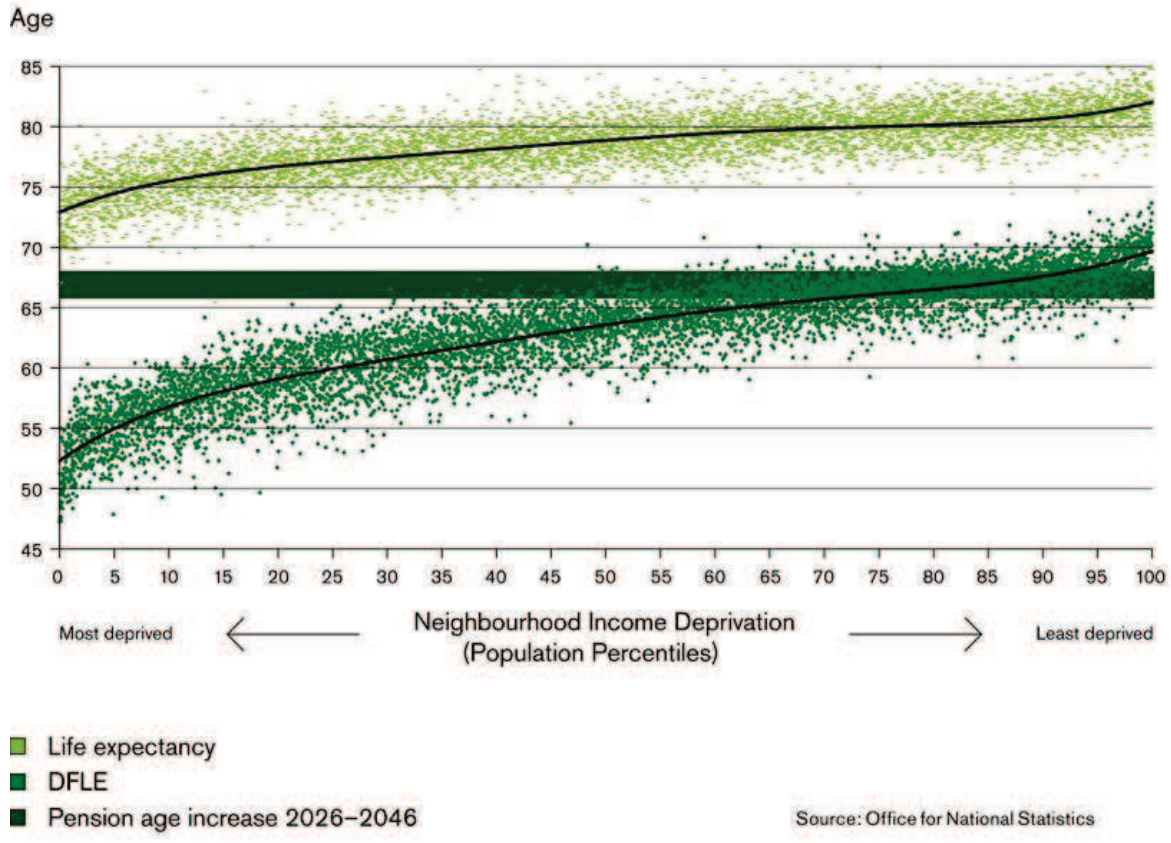
**Health inequalities**

Health inequalities are when different people experience different outcomes. For example, higher rates of people dying prematurely in one community compared to another community. There is a well evidenced relationship between poorer communities, in terms of income, and poorer health outcomes such as life expectancy [1].

Whilst ***people in our more deprived communities die earlier*** than those in the least deprived, they also ***tend to live longer with poorer health***. Nationally, there is a gap of 17 years in the more deprived communities between disability free life expectancy and life expectancy (left hand side of figure 1); this gap is 18 years in Torbay. The gap is smaller at the less deprived end of the spectrum, right hand side of figure 1 [1]; 13 years nationally and 14 years in Torbay.

Therefore, on average, the more deprived populations in Torbay can expect to live 18 years with a disability compared to those in the least deprived, and still expect to die around 7 years earlier.

Figure 1: life expectancy and disability free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999-2003 [1].



**Why tackle health inequalities?**

Reducing inequalities in health does not require a separate health agenda, but action across the whole of society [1]. The coalition government set out, within their programme for government, that they will investigate ways of improving access to preventative healthcare for those in disadvantaged areas to help tackle health inequalities [7]. A stronger policy directive is given within the NHS [8] and Public Health [9] white papers. ***Tackling health inequalities*** in health care is identified within the Health and Social Care Bill [10] as a ***cross cutting theme***.

Reducing inequalities is not only a matter of social fairness, but also economic sense. Inequalities in the population have a significant impact on public sector expenditure, with the tax payer ***disproportionately spending more in areas of greatest need***. Removing, or significantly reducing inequalities would be to the benefit of society in general.

Figure 1 shows that people in our more deprived communities live for longer with a disability. This population needs to access care for a relatively longer period of time before their mortality. Reducing the gap between disability free life expectancy and life expectancy would result in significant financial savings in the public purse [1]. At a national level, it is estimated that the cost of inequality in illness accounts for productivity losses of around £32 billion per year [1]. Proportionately, more locally, in ***Torbay this could represent a cost of inequality in illness of around £75 to £80 million per year***. That would include lost taxes, higher welfare payments and NHS healthcare costs. The Torbay figure presented is based on a national population spend per head being applied to Torbay's population; it has not been adjusted for deprivation, age or gender.

**What does it mean for Torbay?**

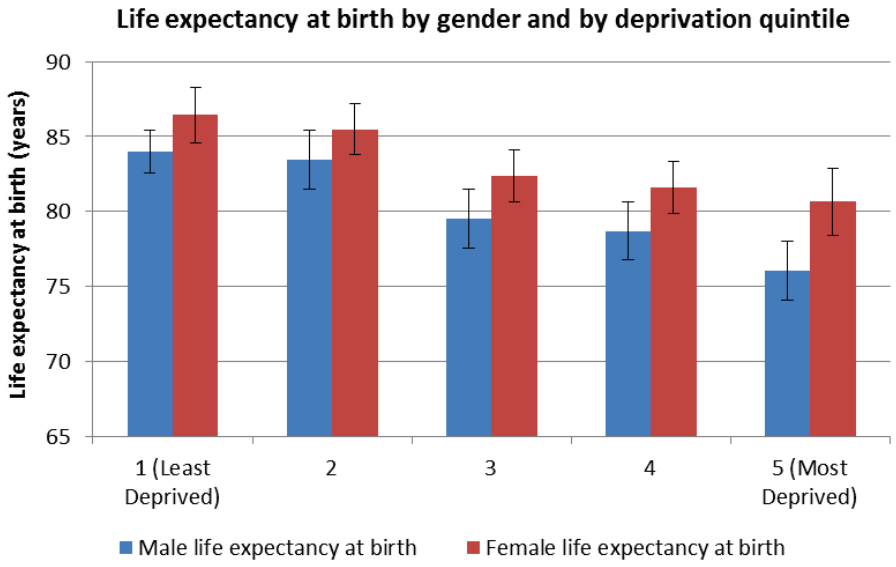
Within Torbay the more deprived (lower income) communities live, on average, between around 6 to 8 years less than those in the less deprived communities. This gap in life expectancy is most pronounced for males in Torbay. Life expectancy at birth for those born between 2008 and 2010 is around 83.1 years for males born in Churston-with-Galmpton, this compares to 75.4 years for males born in Tormohun. For females, this is around 85.4 years for those born in Goodrington-with-Roselands and 79.8 years for those born in Tormohun.

There is a statistically significant difference for life expectancy at birth between communities in Torbay. This difference, or gap in life expectancy, is present for both males and females. Whilst females in Torbay live longer than males, the gap between genders is widest in the most

deprived communities. In the most deprived quintile, the gap between males and females is 4.5 years. This difference, shown in figure 2, is very noticeable, and shows a clear gradient of life expectancy.

The deprivation quintile used below is the local quintile of the 2010 Index of Multiple Deprivation. It groups the population into quintiles, or blocks of 20%. For example those living in the 20% least deprived areas and the 20% most deprived.

Figure 2: 2008/10 Life expectancy at birth by local 2010 Index of Multiple Deprivation quintile in Torbay




Health inequalities are multi-faceted, with complex relationships between individuals and areas. Understanding these relationships is important in attempting to reduce the overall picture of inequalities that exist in Torbay.

The relationship between health inequalities and wider social inequalities, such as poverty, lifestyle choices and housing, is also well evidenced [1]. In Torbay, our more deprived communities not only experience premature mortality and shorter life expectancy, but also have higher rates of emergency admissions to hospital, higher smoking in pregnancy rates and higher rates of violent crime.

**Wider determinants of health**

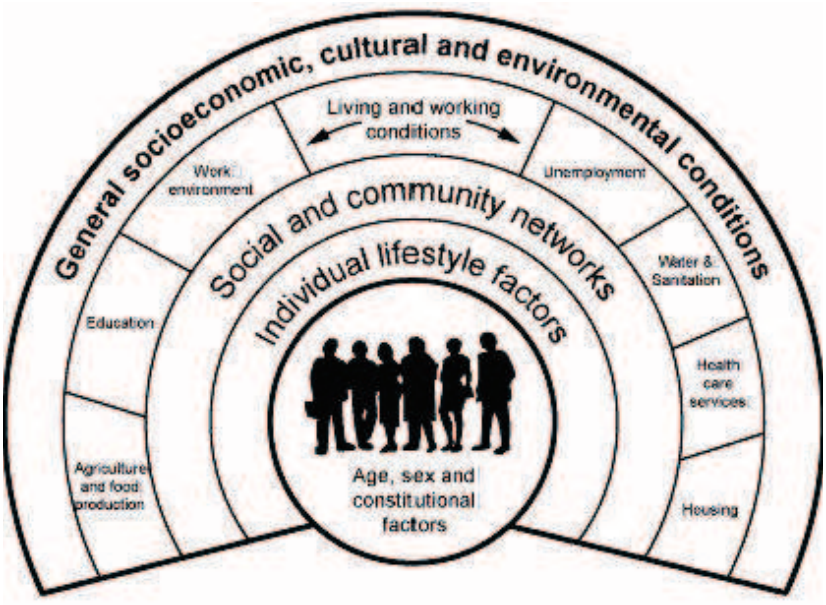
Some of our individual determinants are fixed, such as our birth dates, our gender at birth and our genetic makeup. All of which influence our individual health. However, there are other factors

that we can try to control or influence. These other factors are influences such as the environment in which we live, our ability to work and the lifestyle choices we make. Figure 3 illustrates the main influences on health. These influences could be thought of as a series of layers, one on top of the other [11].

The layers presented in figure 3 include;

- individual lifestyle factors such as smoking habits, diet and physical activity have the potential to promote or damage health;
- social and community network interactions with friends, relatives and mutual support within a community can sustain people's health;
- wider influences on health include living and working conditions, food supplies, access to essential goods and services, and the overall economic, cultural and environmental conditions prevalent in society as a whole.

Figure 3: Wider determinants of health [11]




It will be through influencing these layers, across the life course, that we can collectively try to reduce the inequalities in Torbay.

**What is life course?**

The public health strategy for England, Healthy Lives, Healthy People [9] proposed a partnership approach through life in response to Fair Society, Healthy Lives, the Marmot Review [1]. This

suggests an approach to address the wider factors that affect people at different stages and key transition points in their lives [9].

***A life course approach is about understanding exposures in childhood, adolescence and early adult life and how they influence the risk of disease and socio economic position in later life*** [12]. Understanding the influence of risk in this way may help prevent future generations experiencing some of the illnesses of today.

Structuring JSNA around a life course framework allows consideration of different population needs based on their collective journey through life in Torbay. The following life course headings represent different chapters within this JSNA document.

**Starting well** is about understanding the needs of the population from pregnancy, birth and for the first few years of life. This includes understanding the anticipated need for maternity services, health visiting services and early year's services.

**Developing well** is about understanding the needs of the population between the ages of 5 and 17. This includes understanding the anticipated needs for schools and the developing health of this age group.

**Living and working well** is about understanding the needs of adults from 18 years of age. This includes understanding the lifestyles and health outcomes experienced by this group.

**Ageing well** is about understanding the needs of those from around 45 years and over. It is about reducing and preventing long term conditions, promoting active aging and tackling inequalities.

There are also three further chapters. The first presents a demographic overview of Torbay's population, the second examines the experiences and safety across the life course for services accessed by Torbay residents. The final additional chapter presents a series of maps and an overview of service statistics in Torbay.

**What are outcome frameworks?**

Outcome frameworks are mechanisms to understand how people's lives are affected by different events. They provide a performance framework that allows comparison between areas. The health related outcomes frameworks included within this JSNA are the Adult Social Care [2], the NHS [3] and Public Health [4] frameworks. Each framework contains a selection of specific

outcomes that, hopefully, can be improved for both individuals and the wider population as a whole. The three outcome frameworks became operational from April 2012. At this stage not all of the aspirational outcome measures have been constructed. Therefore there are several gaps in this JSNA; the final chapter (future intentions) lists indicators which will be presented in a future edition of the JSNA.

The Local Government and Public Involvement in Health Act (2007) [17] requires Primary Care Trusts (PCTs) and Local Authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community.

From April 2013, Local Authorities and Clinical Commissioning Groups will have equal and explicit obligations to prepare JSNA; this will be under the governance of the health and well-being board [14].

The ***purpose of JSNA*** is to provide an ***objective view*** of the ***health and wellbeing*** needs of the population. JSNA identifies "the big picture" in terms of the health and wellbeing needs and inequalities of a local population. It provides an evidence base for commissioners to commission services, according to the needs of the population.

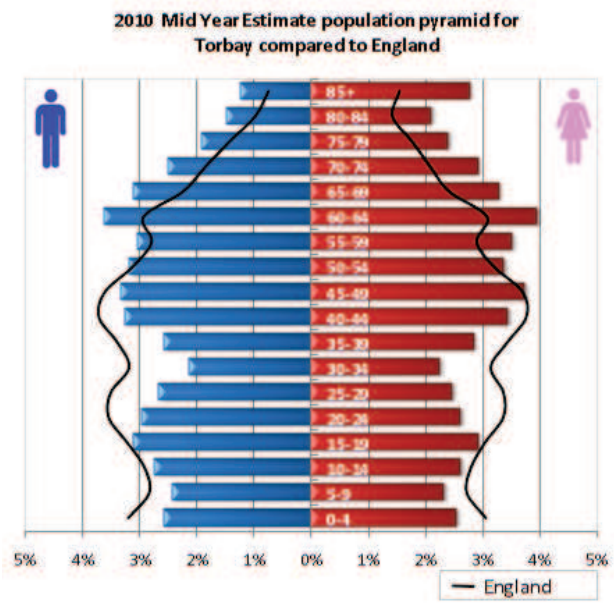
A JSNA is not a needs assessment of an individual, but a ***strategic overview*** of the local community need – either geographically such as local authority / ward or specific groups such as younger or older people or people from black and minority ethnic communities.

In Torbay, JSNA has evolved from an NHS / Local Authority centric assessment to a Local Strategic Partnership (LSP) assessment of population need. Incorporating information from LSP members not only benefited the wider LSP members, but also recognised the wider determinants of health [11]. Torbay's approach to JSNA continues to recognise the importance that all organisations (statutory, voluntary and community) have in improving the health and wellbeing of Torbay's population

Further discussion on JSNA in Torbay is provided towards the end of this report (JSNA in Torbay). This includes outlining the JSNA structure and frequency for delivery.

Torbay's position as a seaside community continues to prove popular as a retirement destination. This popularity is illustrated in the following population pyramid (figure 4), where Torbay's population structure is shown with the solid bars and compared to the England structure (line). Torbay's population structure is very much dominated by the higher proportion of older people and the noticeably lower proportion of younger adults aged 20 to 39.

Figure 4: 2010 population structure for Torbay compared to England




As we would expect from an older population, Torbay has a noticeably ***higher 'average age'*** when compared to the national average. In 2010 Torbay's average age is estimated to be 4.7 years older than the national average, this difference is expected to grow to around 5 years by 2020.

| **Table 1: Average Age (years)** ONS 2012 SNPP | **2012** | **2015** | **2020** |
|---|---|---|---|
| **England** | 39.6 | 39.8 | 40.3 |
| **South West** | 41.8 | 42.2 | 42.9 |
| **Torbay** | 44.6 | 44.9 | 45.7 |

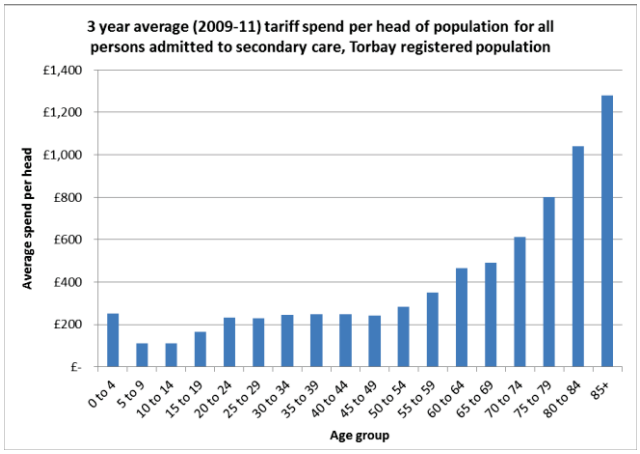
As Torbay's population ages, the potential workforce within the bay to support the retirement age population is expected to decrease.

In 2010, there were 2.1 working age people in Torbay for every person of retirement age; this is expected to decrease to around 1.7 people of working age per person of retirement age by 2020.

As we age, our complex health needs increase, and we require increased levels of help and support. At present, ***our over 85 year old population cost around 10 times*** that of our population aged 5 to 9 or 10 to 14 for all hospital admissions; elective and non-elective. Overall, our older population tend to cost the most per head with regards to hospital care.

On our current trajectory, and assuming todays prices, we may expect the over 85 population to cost the hospital over £1m more in 2020 compared to today, based on demographic change alone. Up from around £7.3m in 2012 to £8.5m in 2020.

Figure 5: Average cost per head by age for hospital admissions, 2009-11.




Whilst older people do cost more per head, a life course approach to understanding the needs of the population now and in the future would aim to reduce this burden on the public purse by influencing the risks associated with the burden of disease.

### Ethnicity

Torbay's BME (Black & Minority Ethnic) population has increased in recent years. The BME population includes all but the White British population.

| Table 2: BME Pop[n] | 2007 (%) | 2008 (%) | 2009 (%) | 2009 (count) |
|---|---|---|---|---|
| England | 16.3 | 16.8 | 17.2 | |
| South West | 8.5 | 9.0 | 9.5 | |
| Torbay | 7.0 | 7.5 | 7.8 | 10,500 |

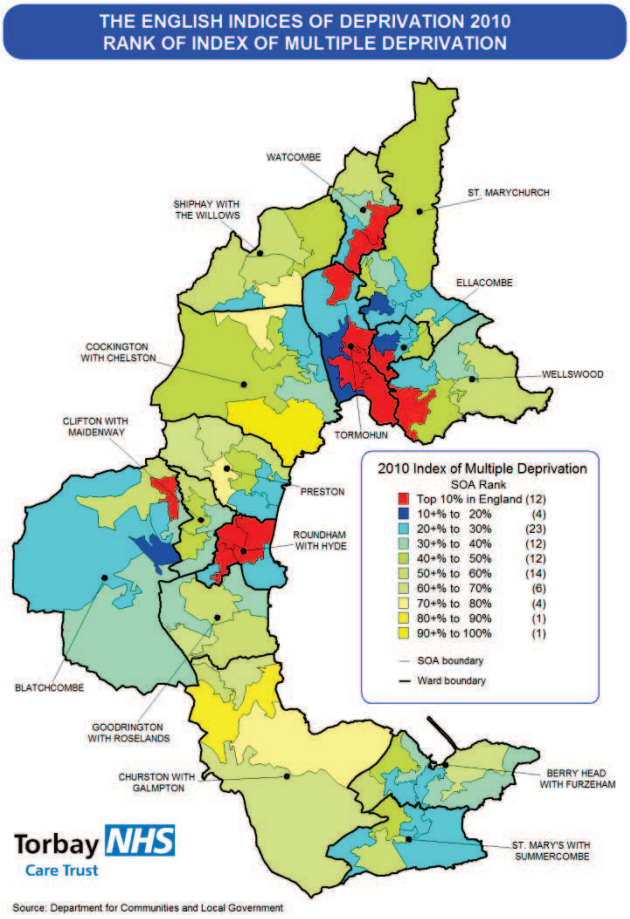
### Deprivation

There are ***pockets of severe deprivation*** and inequalities within Torbay. These pockets tend to be communities that experience poorer outcomes such as poorer educational attainment, poorer socioeconomic status, lower earnings and the lowest life expectancy.

There is an overwhelming amount of evidence that links economic prosperity and the populations socio economic outcomes, evidenced recently in the Marmot review [1].

Torbay is within the top 20% most deprived local authority areas in England for the rank of average score and the rank of local concentration; and most deprived local authority in the South West for rank of average score. Torbay's relative position within the national model of deprivation has worsened in recent years.

Map 1: 2010 Index of Multiple Deprivation



*"Give every child the best start in life"*

Sir Michael Marmot, Fair Society, Healthy Lives (2010) [1]

## Introduction

Starting well is about understanding the needs of the population from pregnancy, birth and for the first few years of life. This includes understanding the anticipated need for maternity services, health visiting services and early years.

## Overview

| Table 3: Population Overview | England | South West | Torbay |
|---|---|---|---|
| **Total 0 to 4 population.** (2010), ONS | - | - | 7,000 |
| **% of total population aged 0 to 4,** (2010) ONS | 6.2% | 5.5% | 5.2% |
| **Live Births,** (2010) ONS | - | - | 1,402 |

The total number of residents aged 0 to 4 in Torbay is expected to increase. It is estimated that there will be around 7,500 in 2015; accounting for around 5.5% of the total population.

## Maternity

There has been a noticeable ***increase in the number of live births*** to women in Torbay, from an average of around 1,300 per year to over 1,400 per year. The general fertility rate is the number of live births per 1,000 women aged 15 to 44; in Torbay this has risen from 56.9 in 2006 to 64.0 in 2010.

Whilst the ***fertility rate has increased*** in Torbay, the overall rate is slightly lower than the England average. However, the standardised fertility ratio, the observed live births as a proportion of expected, is higher. This suggests that Torbay experienced 5% higher rate of births than we would expect.

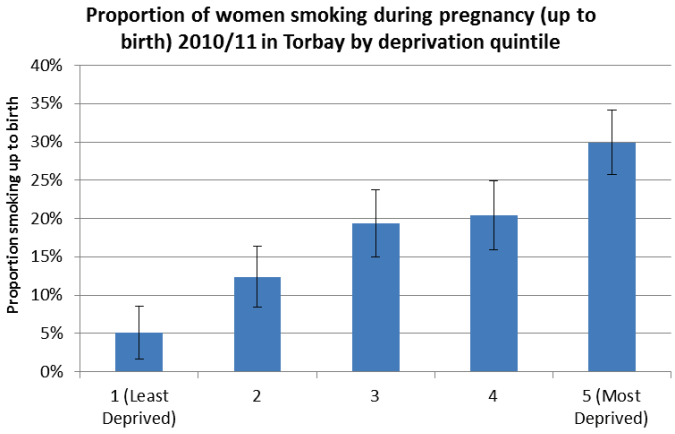
| Table 4: Maternity Overview | England | South West | Torbay |
|---|---|---|---|
| **Standardised Fertility Ratio** (2010), ONS | 100 | 100 | 105 |
| **General Fertility Rate.** Per 1,000 women aged 15 to 44 (2010), ONS | 65.4 | 62.3 | 64.0 |
| **Perinatal Mortality Rate.** Per 1,000 live births (2010), ONS | 7.4 | 5.9 | 9.9* |
| **Infant Mortality Rate.** Deaths under a year per 1,000 live births (2010), ONS | 4.3 | 3.2 | 6.4* |
| **Under weight babies.** Proportion of live births under 2500 grams (2010), ONS | 7.0% | 6.1% | 8.1% |
| **Smoking in Pregnancy.** Proportion of women smoking up to birth (2010), DH | 13.6% | 13.6% | 21.8% |
| **Breastfeeding Initiation.** Proportion of women initiating breastfeeding at birth (2010), DH | 73.3% | 76.8% | 68.6% |
| **Breastfeeding at 6 to 8 weeks.** Proportion of women breastfeeding at 6 to 8 week check (2010), DH | 45.2% | 47.7% | 35.7% |

* rate calculated from small numbers

Torbay experiences ***relatively high levels of smoking during pregnancy***. Smoking during pregnancy has been linked to increased risk of cot death, being born prematurely, having poorer lung function and having organs that are smaller than babies born to non-smoking mothers. Children born to mothers that smoke are also more likely to smoke themselves in later years.

There is a strong relationship between smoking in pregnancy and deprivation. Around a third of all pregnancies from Torbay's most deprived 20% (quintile) smoke during pregnancy; this is significantly higher than other areas in Torbay.

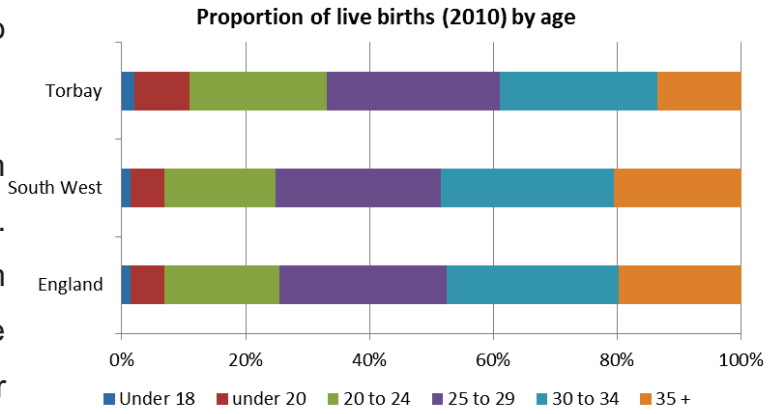
Figure 6: smoking in pregnancy by deprivation quintile




Reducing smoking in pregnancy in Torbay will benefit the un-born child; it will improve the child's chance of not becoming a smoker, and reduce their risk of developing chronic long term conditions later in life.

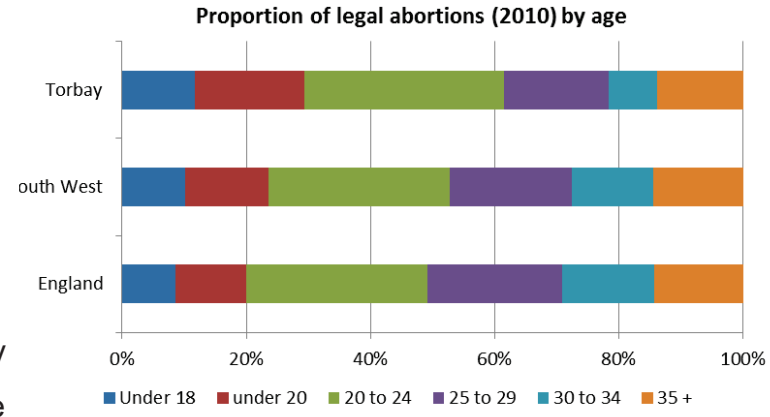
Women in Torbay tend to be, on average, younger when having babies. With a slightly higher proportion aged under 20, and a lower proportion aged over 35.

Figure 7: The proportion of live births by age group




Women accessing termination services in 2010 were, on average, slightly younger than the national equivalent, with around a quarter aged under 20.

Figure 8: the proportion of terminations by age group




**Protection & Development**

Levels of vaccine coverage are generally higher in Torbay than the national average.

| Table 5: Vaccination Overview (2010/11) IC | England | Torbay |
|---|---|---|
| **Percentage immunised by their 1st birthday** | | |
| Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) % | 94.2 | 97.6 |
| MenC % | 93.4 | 97.3 |
| Pneumococcal Disease (PCV) % | 93.6 | 97.2 |
| **Percentage immunised by their 2nd birthday** | | |
| Diphtheria, Tetanus, Polio, Pertussis Hib,(DTaP/IPV/Hib) % | 96.0 | 97.7 |
| MMR % | 89.1 | 90.6 |
| MenC % | 94.8 | 97.5 |
| Hib/MenC % | 91.6 | 93.2 |
| Pneumococcal Conjugate Vaccine (PCV) % | 89.3 | 91.6 |
| **Percentage immunised by their 5th birthday** | | |
| Diphtheria, Tetanus, Polio (Primary) %, | 94.7 | 96.8 |
| Hib (Primary) % | 94.2 | 96.9 |
| Diphtheria, Tetanus, Polio, Pertussis (Booster) %, | 85.9 | 87.0 |
| MMR first dose,% | 91.9 | 90.9 |
| MMR first and second dose, % | 84.2 | 83.3 |

Levels of ***tooth decay*** in 5 year olds in Torbay are similar to the national perspective, although they are slightly higher than the regional average. In Torbay the mean number of decayed, missing or filled teeth in 5 year olds (2007/08) was 1.12 compared to 1.11 for England.

Achievement of at least 78 points across the ***early year's foundation stage***, a readiness for school indicator, shows Torbay children to be making positive progress in recent years. Increasing from 46% in 2009 to 57% in 2011, however this is below the national average.

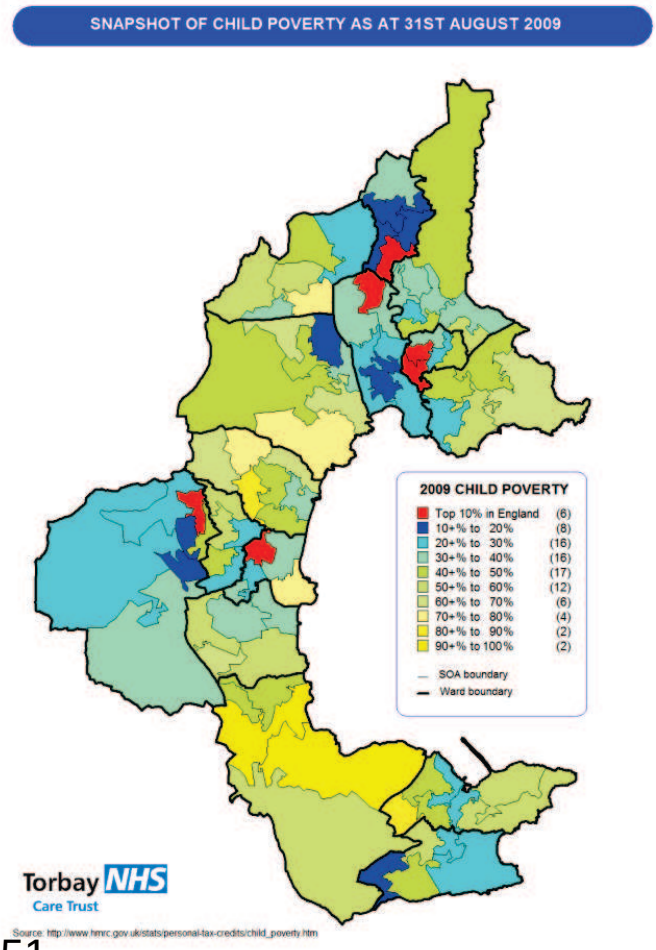
**Wider determinants**

***Child poverty*** is defined as the proportion of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income. It is not a measure of absolute poverty, but a measure of relative poverty within England.

The consequences of child poverty are wide ranging and long lasting. ***Children from low income families are less likely to achieve at school and more likely to experience ill health.*** The society costs of child poverty have been estimated to be somewhere between £10 and £20 billion a year [18]. This includes the service provision and benefit payments.

Torbay shows higher than national levels of child poverty, with around 23.7% of children living in families considered to be in poverty. This places Torbay just inside the top quartile areas with the highest levels of child poverty, the England average is 21.4% (2009).

Map 2: Areas of relative child poverty



*"Enable all children, young people and adults to maximise their capabilities and have control over their lives"*

Sir Michael Marmot, Fair Society, Healthy Lives (2010) [1]

## Introduction

Developing well is about understanding the needs of the population between the ages of 5 and 17. This includes understanding the anticipated needs for schools and colleges and the developing health of this age group.

## Overview

| Table 6: Population Overview | England | South West | Torbay |
|---|---|---|---|
| **Total 5 to 17 population.** (2010), ONS | - | - | 18,400 |
| **% of total population aged 5 to 17.** (2010) ONS | 14.9% | 14.5% | 13.7% |
| **Under 15 mortality rate per 100,000.** (2008-10 pooled), NCHOD | 45.45 | 38.00 | 56.83 |

The 5 to 14 population is expected to remain relatively static over the forthcoming couple of years. However it is expected to increase by 1,500 by 2020. The 15 to 19 age group is estimated to decrease over the coming years, from 7,400 now to 7,000 in 2015 and 6,600 in 2020.

Mortality in the under 15s in Torbay is higher than the regional and national levels. Further analysis is recommended to understand the issue. It should be stressed that the numbers are relatively small and the rate is not significantly different to the national or regional rates.

## Preventing future illness

***Childhood obesity*** has been linked with poorer health outcomes for children, such as asthma, diabetes, psychological ill health and cardiovascular risk factors. There is also evidence to suggest that obesity in childhood extends to poorer health outcomes in adulthood. This is through persistence of obesity, cardiovascular risk factors and premature mortality.

Children in Torbay are, on average, less obese than the national average. However, there has been an increase in the proportion of children considered as overweight in the Bay, the increase is not significantly different.

Figure 9: Proportion of children - obese

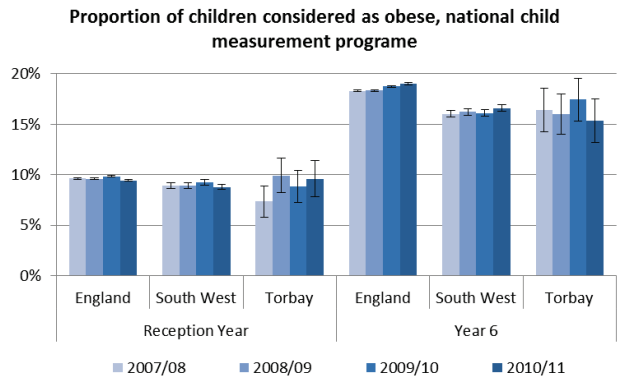
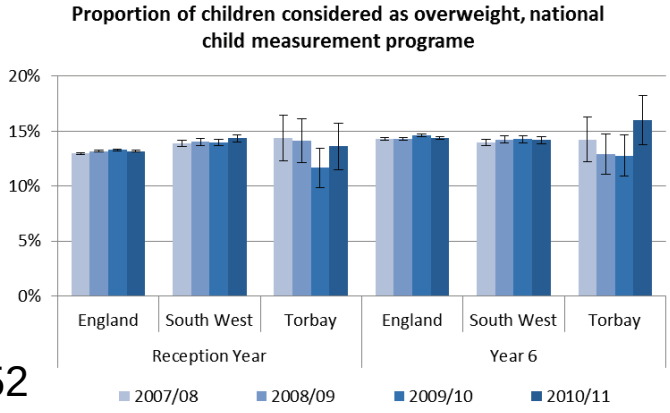



Figure 10: Proportion of children - overweight



The ***HPV (human papillomavirus) vaccination*** programme is an important step towards preventing cervical cancer. In Torbay the school year 8 (12 to 13 year olds) completing the course of three doses is slightly higher than the regional and national averages, at 77.9% (2009/10, DH).

**Special Educational Needs (SEN)**

The number of pupils with a statement of Special Educational Need (SEN) maintained by Torbay Council decreased by 8% between 2007 and 2011. The decrease was from 890 to 815, nationally the proportion fell by 3%.

Torbay experiences a higher than average proportion of pupils with a statement of SEN, at 3.9% of pupils in Torbay schools. This is higher than the national average and the highest in the region.

There are a noticeably lower proportion of both primary and secondary age children with moderate learning disabilities in Torbay. Behavioural, emotional and social difficulties could be considered an outlier in the primary age population, 26.3% in Torbay, compared to 18.6% for England. The proportion at secondary school age is in line with the national average for that population, in 2011.

**Treatment**

Hospital admissions for under 18s for ***unintentional and deliberate injuries*** have been linked to longer term health issues including being related to the injury and also mental health related to the experience.

The rates of hospital admissions caused by unintentional and deliberate injuries in the under 18s for Torbay has been fluctuating over recent years. The latest official data for Torbay shows the rate to be around 139 per 10,000, equivalent to 355 admissions, (2009/10, swpho), this is significantly higher than the national average of 123 per 10,000.

The rate of emergency admissions for children with **lower respiratory tract infections** shows a pattern of seasonality, with highest rates over the winter period. Rates in Torbay are similar to the national rates in the summer months but noticeably lower in the winter months.

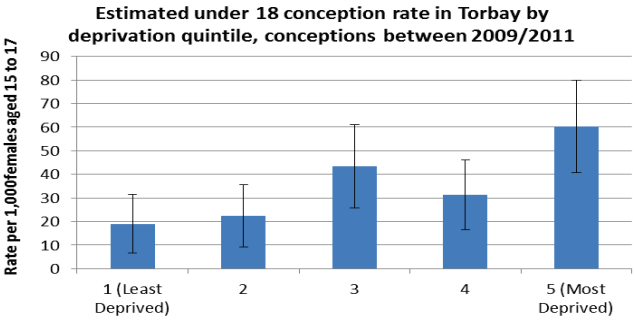
Rates of Unplanned ***hospitalisation for asthma, diabetes and epilepsy*** in under 19s for the final 6 months in 2010/11 were particularly high in Torbay, at 136.7 per 100,000. This is higher than the England average of around 93 per 100,000 for the same period.

**Sexual Health**

Diagnoses rates for ***chlamydia*** in Torbay amongst the 15 to 24 year olds, are amongst the highest in the region. Latest figures show the rate to be some 3,115 per 100,000 being diagnosed with chlamydia in the bay, the rate nationally is just under 2,000 per 100,000 (1,963). This could be that Torbay sexual health services are effectively targeting the population at risk, or perhaps that the underlying levels of chlamydia are higher in Torbay.

Torbay experiences relatively high rates of ***teenage pregnancy***, but relatively small numbers. Within Torbay there is a difference in rates between the least and most deprived communities. With higher rates in Torbay's more deprived communities. Rates in the most deprived quintile (top 20%) are significantly higher than the 2 least deprived quintiles.

Figure 11: Teenage conceptions by deprivation quintile in Torbay




**Wider determinants**

The level of ***pupil absence*** in Torbay is relatively high. Higher than both the national and regional averages. What could be of concern are the particularly high levels of authorised absence and the persistent absentees. With 5.84 pupil half days missed in Torbay due to authorised absences, compared to 5 nationally, and 5.15 regionally. 3.2% of enrolments were identified as persistent absentees in all schools in 2009/10 in Torbay, compared to 2.9% nationally and 2.6% regionally.

The percentage of pupils achieving 5 or more grade A* to C GCSEs in Torbay is slightly higher, at 80.9% than the regional, 76.8% and national 80.7% averages. However, the per cent achieving 5 or more grade A* to C in English and Mathematics is lower, at 57.2% in Torbay compared to 58.4% nationally and 57.9% regionally.

Around 4.2% of 16 to 18 years olds in Torbay were not in education, employment or training (***NEET***) in 2010. This is significantly lower than the national average of 6%.

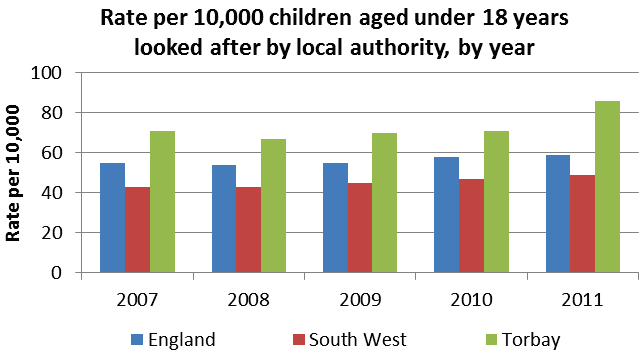
**Young carers**

Many disabled and ill adults are forced to rely on their children for support and wellbeing and as a result their children become young carers. National estimates suggest between 6% and 12% of school age children are caring for a parent. In Torbay, this suggests that between 1,000 and 2,000 children and young people would be young carers.

**Children looked after**

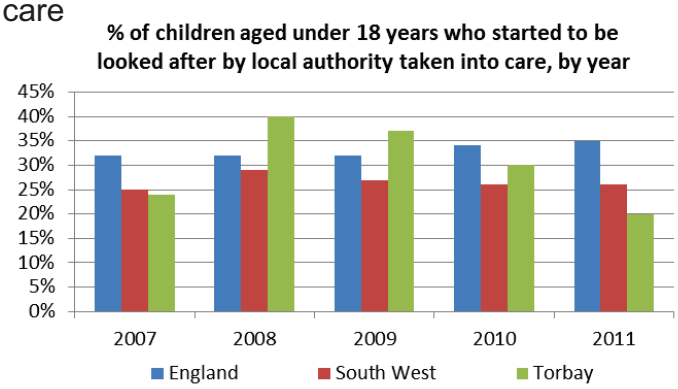
The rate per 10,000 children looked after by the local authority has increased in recent years (shown in figure 12). The rate was relatively stable in Torbay; however the rate for 2011 showed a noticeable increase. 86 per 10,000 children aged under 18 were looked after by the local authority at the 31st March 2011. This was the highest rate in the region, and higher than the recent average.

Figure 12: Rate of children looked after



The proportion of children taken into care fell noticeably in 2011 in Torbay, from a high of 40% in 2008 to 20% in 2011.

Figure 13: Percentage of children taken into care




## Children in need

The rate per 10,000 children, under 18s, in need in Torbay is amongst the highest in England. The number of children in need at 31st March 2011 was 1,490, equivalent to a rate of around 586.8 per 10,000. The regional rate was 330, and for England 346.2.

The primary need at initial assessment for children in need shows lower levels of abuse or neglect in Torbay. However, needs relating to child's disability or illness and family in acute stress are noticeably higher.

| Table 7: Children in need | Abuse or neglect | Child's disability or illness | Family in acute stress |
|---|---|---|---|
| England | 44.01% | 11.66% | 9.99% |
| Torbay | 33.60% | 21.79% | 16.11% |

The rate of children who were subject to a ***child protection plan*** at the 31st March 2011 in Torbay was amongst the highest in England, with a rate of some 86.6 per 10,000. The regional rate was 33.9, and for England the rate was 38.7 per 10,000.

## Troubled families

In 2011, there were estimated to be around 365 'troubled families' in Torbay [15]. The Government has identified a troubled family as one that has serious problems and causes serious problems. In every troubled family there are a range of factors including parents not working, mental health problems, children not in school, the family causing crime and anti-social behaviour and costing local services a lot of time and money in responding to these problems.

The perceived level of 'troubled families' in Torbay is equivalent to a rate of around 235 per 10,000 families. This compares to an England average of 178 per 10,000 families. This places Torbay within the top 25% highest upper tier local authority areas rates.

It is estimated that troubled families cost an average of £75,000 each [15]. Therefore, within Torbay it is estimated that troubled families cost in the region of £27 million

## Youth Offending

The number of first time entrants to the youth justice system has been relatively stable over the past 3 years, at approximately 30 per quarter and 120-130 per year. This is lower than the preceding years. There were 109 first time entrants aged 10 to 17 in 2010/11, with a rate of 916 per 100,000, this compares to a national rate of 787 per 100,000.

*"Ensure a healthy standard of living for all"*

Sir Michael Marmot, Fair Society, Healthy Lives (2010) [1]

## Introduction

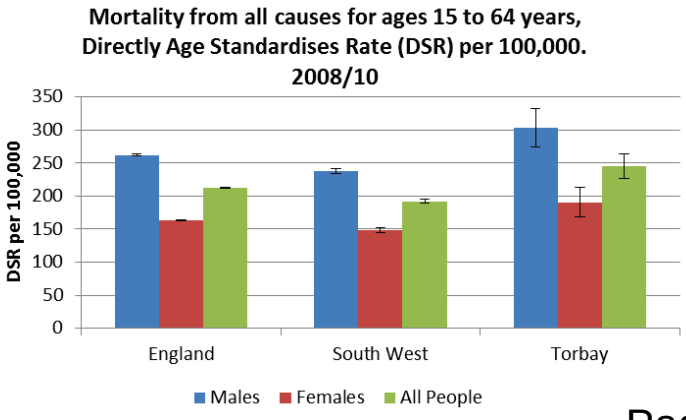
Living and working well is about understanding the needs of adults from 18 years of age. This includes understanding the lifestyles and health outcomes experienced by this group.

## Overview

| Table 8: Population Overview | England | South West | Torbay |
|---|---|---|---|
| **Total 18+ population.** (2010), ONS | - | - | 108,900 |
| **% of total population aged 18+.** (2010) ONS | 14.9% | 14.5% | 13.7% |
| **15 to 64 mortality rate per 100,000** (2008-10 pooled), NCHOD | 212.17 | 192.35 | 245.56 |

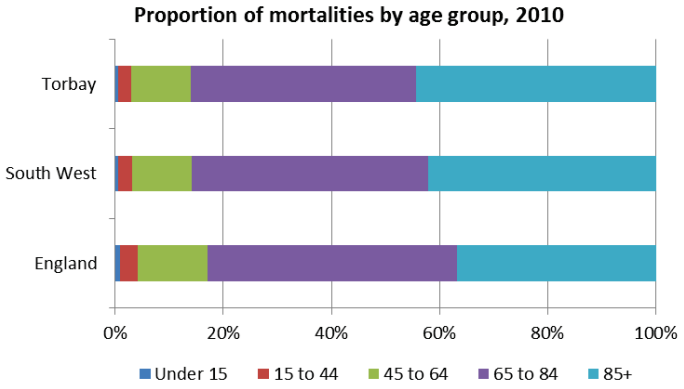
***Mortality*** within the ***15 to 64*** year age group during 2008/10 was ***significantly higher*** than the national average. On average in Torbay, around 250 people in this age group die a year, around 150 males and 100 females. A greater break down of rates for the three years of 2008/10 is shown below.

Figure 14: 15 to 64 DSR mortality




Whilst there are higher rates of mortality in the 15 to 64 age group, just under 90% of mortalities in Torbay are for those aged 65 and over.

Figure 15: Mortality by age group




The number of persons aged 18 and over is expected to remain relatively static between 2012 and 2015. Population projections suggest that the over 18 population will be around 110,000 in 2015.

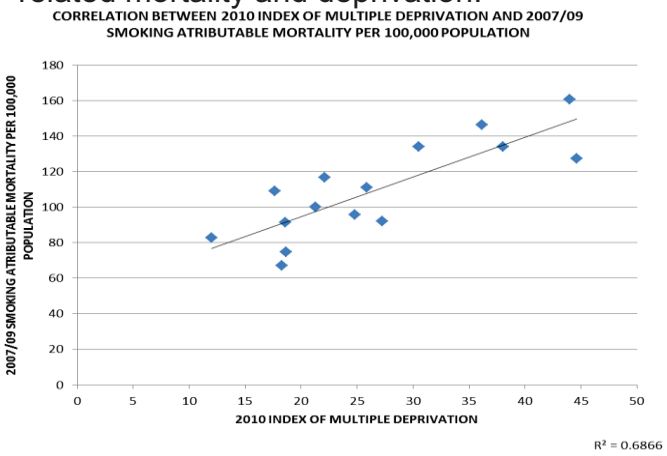
## Preventing morbidity / mortality

An individual's life style has a great influence over their health outcomes. There is plenty of evidence that identifies a causal relationship between smoking and lung cancer and other respiratory related diseases. Effective health promotion programmes to reduce smoking prevalence have the potential to improve the health outcomes within communities in Torbay.

The evidence around ***smoking prevalence*** in Torbay is mixed. There are some estimates that suggest the levels of smoking in Torbay are less than the national averages, with around 1 in 5 estimated as being smokers. However, the levels of smoking in pregnancy could suggest expected smoking prevalence to be relatively high.

There is a strong relationship in Torbay between smoking related mortality and deprivation. The highest levels of smoking related mortality were identified in Roundham with Hyde (an electoral ward in Paignton), with a directly age standardised rate of around 160 per 100,000.

Figure 16: Correlation between smoking related mortality and deprivation.




There are estimates that suggest just under a quarter of all NHS costs are smoking related. At a local level this could potentially be somewhere in the region of £50-60 million [19].

The incidence of ***Tuberculosis*** (TB) in Torbay is low but has increased in recent years. In 2009 there were 14 cases, an incidence of 10.4 /100,000 compared with 14.9/100,000 in the UK. The increase has been amongst the local population; the majority are working people and several have a high alcohol intake. TB can be prevented and is treatable. Increased awareness of the symptoms is important for the public and health professionals. TB typically causes a prolonged cough, weight loss and night sweats.

Further lifestyle factors influence health, such as ***diet and physical activity***. These can affect health now, and also in the future. If a population was to continue to eat poorly, and not undertake physical activity, they are potentially storing up a financial and health burden in years to come.

Synthetic (modelled) estimates suggest Torbay's population not significantly different to the national average. Torbay shows less ***binge drinking***, less ***smoking*** and less ***obesity***. However, these are synthetic estimates and are quite dated.

| Table 9: Healthy Lifestyle Behaviours | England | South West | Torbay |
|---|---|---|---|
| **Binge Drinking** (2003-05)% of 16+, ONS | 17.6% | 15.1% | 15.2% |
| **Obesity** (2003-05)% of 16+, ONS | 23.8% | 23.3% | 23.5% |
| **Smoking** (2003-05)% of 16+, ONS | 23.3% | 21.0% | 21.7% |
| **Vegetable consumption** (2003-05)% of 16+, ONS | 26.7% | 26.2% | 25.3% |

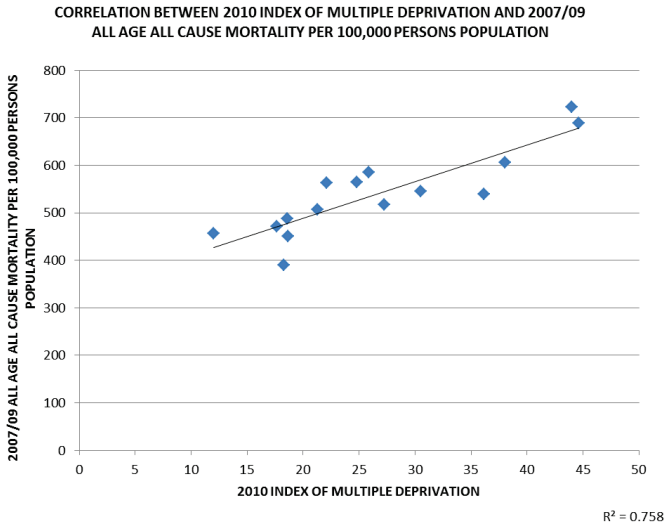
Estimates from the active people survey suggest that Torbay's over 16 population is less active than the national average. It is estimated that the health costs of physical inactivity are in the region of £2.4million in Torbay, this equates to around £1.7million per 100,000; compared to a national cost of £1.5million per 100,000 [16].

The rate of ***road injuries and mortalities*** in Torbay is significantly lower than the national average, at 25.4 per 100,000 population, compared to 48.1 per 100,000 for England.

### Mortality

Rates of all age all-cause mortality in the total population show a relationship with social inequality. Areas of highest deprivation experience highest rates of mortality, even after adjusting for age.

Figure 17: Correlation between deprivation and all age all-cause mortality




The rate of ***premature mortality*** in Torbay, all age all-cause mortality for those aged under 75, has decreased over time. However the overall decrease has not been as noticeable as the regional and national decreases.

| Table 10: Mortality | England | South West | Torbay |
|---|---|---|---|
| **Causes considered amenable to health care (DSR persons <75)** (2008-10 pooled), NCHOD | 92.14 Per 100,000 | 78.53 Per 100,000 | 91.96 Per 100,000 |
| **Causes considered amenable to health care (SMR persons)** (2008-10 pooled), NCHOD | 100 | 85 | 94 |
| **Years of life lost due to mortality from all causes, <75s crude rate** (2008-10 pooled), NCHOD | 444.2 Per 10,000 | 425.3 Per 10,000 | 542.3 Per 10,000 |
| **Suicide, DSR <75s** (2008-10 pooled), NCHOD | 5.85 Per 100,000 | 6.79 Per 100,000 | 6.30 Per 100,000 |

***Flu vaccinations*** for individuals at risk aged under 65 have been increasing steadily in Torbay. However, the uptake rate for 2009/10, at 47.4% was amongst the lowest in the region, and lower than the 51.6% for England.

### Hospital admissions

Managing health through preventative agendas and primary care would reduce the burden on hospital admissions. Whilst admissions could be reduced, in most cases it would not prevent an individual requiring treatment, it may simply delay it.

The rates of ***unplanned hospitalisation*** for chronic ambulatory care sensitive conditions are noticeably higher in Torbay than the

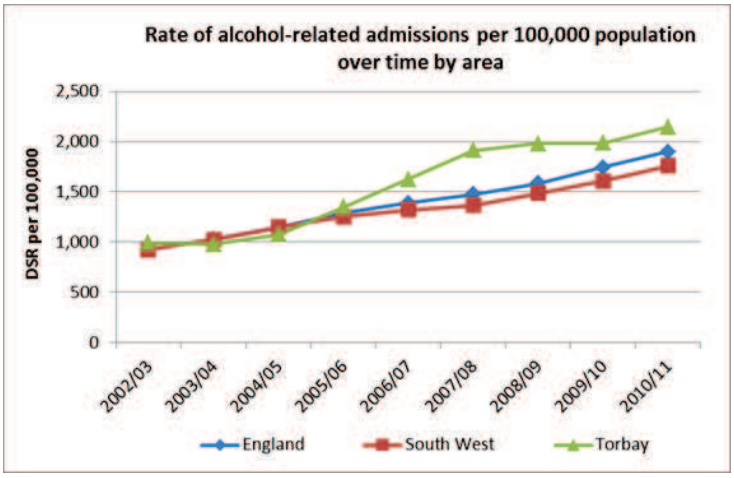
England average. Rates in Torbay varied over a range of 254 to 322 per 100,000 in Torbay during 2010/11.

The standardised rate per 100,000 emergency admissions for acute conditions that should not usually require hospital admission is similar in Torbay to the national average, at around 258 per 100,000 (Q4 2010/11)

Torbay has a significantly higher rate of hospital admissions as a result of **self-harm**. The rate in 2009/10 for Torbay was some 341 per 100,000 compared to 198 for England. The rate of 341 for Torbay represents some 393 admissions in that financial year.

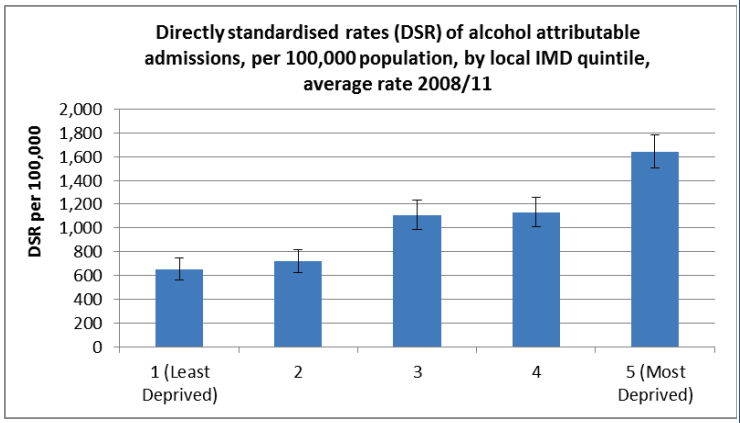
***Alcohol related admission to hospital*** for Torbay has increased in recent years. However whilst the rate of increase has slowed, the rates for Torbay are still higher than the national and regional average.

Figure 18: Alcohol related hospital admissions




There is a clear social gradient for alcohol related admissions in Torbay. Areas of greatest deprivation have the highest rates of admission for alcohol (after adjusting for age).

Figure 19: Social gradient for alcohol related hospital admissions




Torbay has a slightly lower proportion of adults successfully completing treatment for ***drug misuse***, 14% locally verses 15% nationally. However the local service is arguably more effective than the national average with a lower proportion re-entering the treatment services.

### Ill health and long term conditions

The ***prevalence of diabetes*** in Torbay is estimated to be around 9% or around 10,500, this is higher than the national average of 7.9%. Given Torbay's older demographic we would expect a higher prevalence. However, there may be a hidden level of need within the population as there are only 7,487 patients identified by GP practices with diabetes.

All persons known to practices eligible for screening for ***diabetic retinopathy*** are reported as being offered. Of those, 87% receive the screening in Torbay; this is higher than the 80% nationally.

The proportion of persons presenting with HIV at a late stage of infection is slightly higher in Torbay than the national average, however the difference is not significantly different.

**Screening**

Uptake of screening in Torbay is slightly better than the national average for Breast, and similar for cervical.

***Breast screening***; the proportion of women aged 53-70 years who have been screened within three years was 79.3% in 2010 and 78.7% in 2011. However, these are higher than the national averages of 76.9% and 77.2% respectively.

***Cervical screening***; There has been a gradual decline in uptake in recent years. However preliminary figures for 2011/12 suggest a small improvement. In 2010/11 uptake was higher in Torbay's 25 to 49 year old population than in England, but lower in the 50-64 year age-group.

| Table 11: Cervical screening 2010/11 | Torbay | England |
|---|---|---|
| 25 to 49 years (screened every 3.5 years) | 75.0% | 73.7% |
| 50 to 64 years (screened every 5 years) | 76.6% | 78.0% |

The results for 99% of those being screened for cervical cancer are available within 2 weeks in Torbay (compared with 83%. in England).

**Mental health**

In Torbay, 7.9% of those aged 18 to 69 who were receiving secondary mental health services or were on a care programme and had their employment status recorded as employed. Whilst this is in line with the national average, there is however variation by local area and is as high as 20% in some areas (2009/10).

Around half, (45%), of those claiming ***incapacity benefits*** in Torbay are claiming for ***'mental and behavioural disorders'***. This proportion is similar to both the national and regional averages.

Torbay has experienced high rates of suicide over time; however recent figures suggest that Torbay is no longer an outlier. As shown in table 10, Torbay's most recent suicide rates is higher than the national, but lower than the regional averages.

**Learning Disabilities**

Estimates suggest that there are higher rates of learning disability (LD) in Torbay than the national average. Torbay is within the top quintile with a rate of 5.8 per 1,000 reported to have a learning disability.

However, within Torbay there are estimated to be some 2,000 persons with a learning disability who are not known to services.

The percentage of adults with learning disabilities in settled accommodation has increased in Torbay, from 34.6% (08/09) to 55.4% (09/10). However, the percentage in settled accommodation in Torbay has not increased by as much as in other areas.

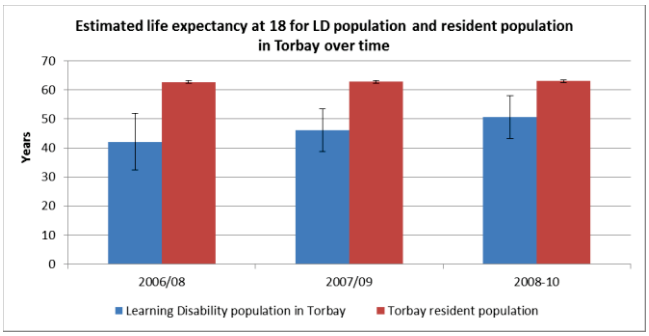
The percentage of adults with learning disabilities who are known to Adult Social Services in settled accommodation at the time of their assessment or latest review is lower in Torbay at 55.7%, compared to 60.6% nationally.

Torbay is amongst the lowest in the country for the percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities in paid employment at the time of their assessment or latest review. In Torbay this is half that of the national average, at 3.1% compared to 6.4%.

Local estimates show there to be a gap in life expectancy for persons with a learning disability compared to the wider population (those with an LD were included in the wider population analysis). Life expectancy at 18 has risen from 42 years to 50 years for persons with an LD in a relatively short space of time, 2006/08 to 2008/10.

The increasing ***life expectancy of people with learning disability*** in Torbay could in part be due to some 87% of known persons with a learning disability receiving a health check in 2010/11. This was the highest proportion in England.

Figure 20: estimated life expectancy at 18 for persons with a learning disability




**Supporting People**

Supporting People (SP) services support people to live independent lives. Services include supported housing, sheltered housing, supported lodgings, a woman's refuge and community outreach support. In promoting the independence of vulnerable people SP services make a major contribution to early intervention and prevention: reducing hospital admissions, ambulance call outs, use of mental health services, crime, homelessness and residential care.

In 2010/11 around 1,000 adults entered supporting people services, a 9% increase on the previous year. The 4 most common primary needs of people entering services in

2010/11 were domestic abuse, (ex) offending, poor mental health and homelessness.

In 2010/11 the proportion of 18-24 year olds entering supporting people services was less (20%) than the South West (25%) and England (27%). However the proportion of clients aged over 45 is higher in Torbay at 27% compared to 20% in the South West and England. This reflects the older population in Torbay. Almost half (46%) of clients entering services in Torbay were female, slightly lower than England where there was a 50% split between men and women entering services.

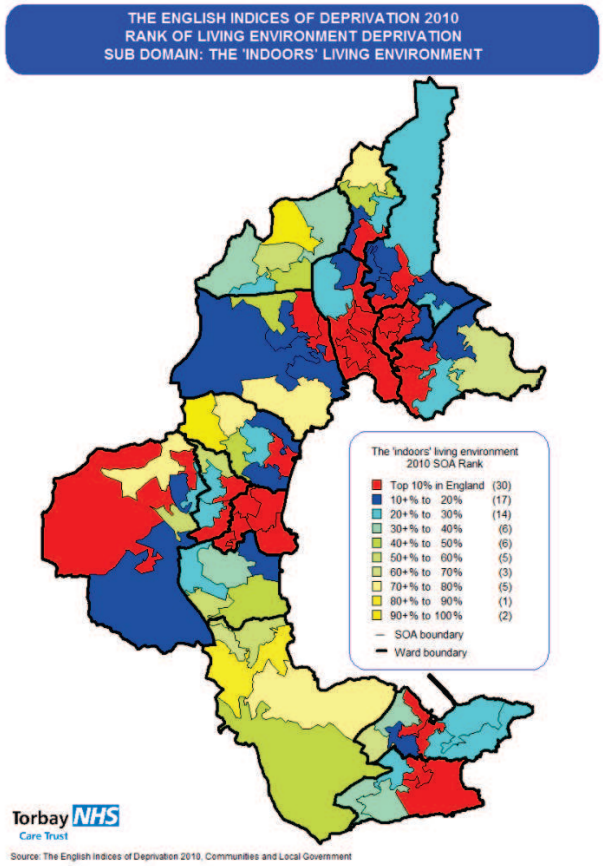
**The living environment**

There is evidence to suggest that bad ***housing conditions constitutes a 'risk to health'*** [1]. Those without a home are expected to experience negative health outcomes. In Torbay there is a homeless population. The numbers accepted as being homeless and in priority need in Torbay was just less than 1 per 1,000 households, compared to 2 per 1,000 in England (2010/11).

The condition of Torbay's dwelling stock could be described as worse than the national average. Over half of the areas in Torbay are in the top 20% (quintile) most deprived for housing in poor conditions in England – shown in map 3.

Torbay has a relatively low social housing stock. Figures for April 2011 suggest the social housing stock in Torbay to be 7.9%, compared to 18% nationally and 13.6% regionally.

Map 3: The indoor living environment



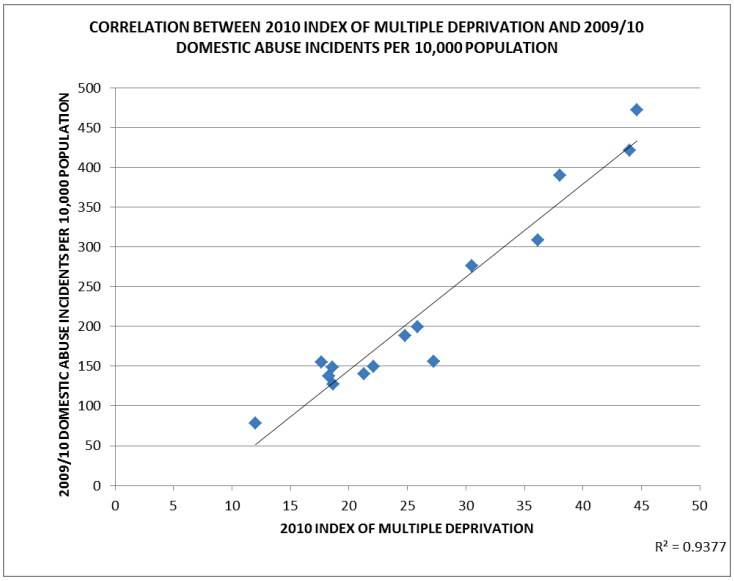

**Wider determinants**

***Domestic abuse*** is estimated to cost the state £3.1 billion for the criminal justice system, the health system, social services, social housing and legal aid bills to support victims of domestic abuse [20]. Lost economic output is estimated at £2.7 billion, over half of which is borne by employers. The cost in terms of pain, suffering and loss

of employment, housing or health amounts to an enormous £17 billion

In Torbay, there is evidence of a relationship between the rates of recorded domestic abuse and socioeconomic deprivation, where higher rates can be observed in our more deprived communities.

Figure 21: Correlation between deprivation and recorded domestic abuse



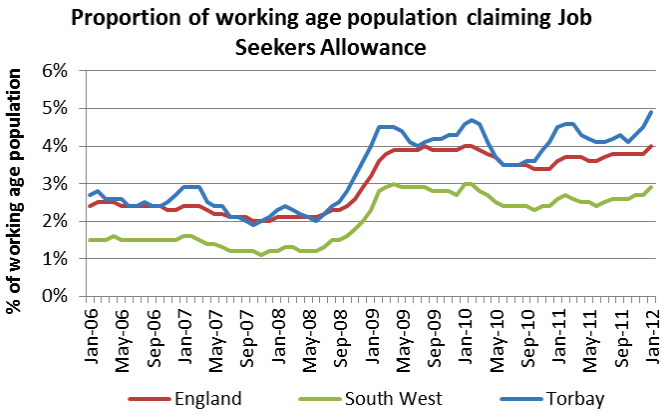

Domestic abuse is a form of violent crime. The wider picture of recorded violent crime in Torbay is showing a gradual decrease in the numbers.

**Economy and employment**

Being in good employment is protective of health [1]. ***Torbay's economic worth*** per head, as measured by gross value added (GVA) is amongst the lowest in England. Torbay's structural economic weaknesses could suggest that Torbay has been more acutely affected by the 2008 recession than elsewhere. Torbay experienced a near 8% reduction in GVA between 2008 and 2009, the third highest reduction (at current prices) in England.

The ***job seekers allowance*** claimant rate in Torbay is at its highest rate this millennium, at 4.9% of the working age population. This is the highest rate in the region and higher than the national average.

Figure 22: job seekers allowance claimants




Understanding the employment patterns of different communities within the population is complex. Enabling all to engage with good employment has been identified by Marmot as being protective for health.

*"Strengthen the role and impact of ill-health prevention"*

Sir Michael Marmot, Fair Society, Healthy Lives (2010) [1]

## Introduction

Ageing well is about understanding the needs of those from around 45 years and over. It is about reducing and preventing long term conditions, promoting active aging and tackling inequalities.

## Overview

| Table 12: Population Overview | England | South West | Torbay |
|---|---|---|---|
| **Total population aged 45+.** (2010), ONS | - | - | 69,200 |
| **% of total population aged 45+.** (2010) ONS | 41.8% | 46.3% | 51.5% |
| **64 to 74 mortality rate per 100,000.** (2008-10 pooled), NCHOD | 1,675 Per 100,000 | 1,444 Per 100,000 | 1,421 Per 100,000 |

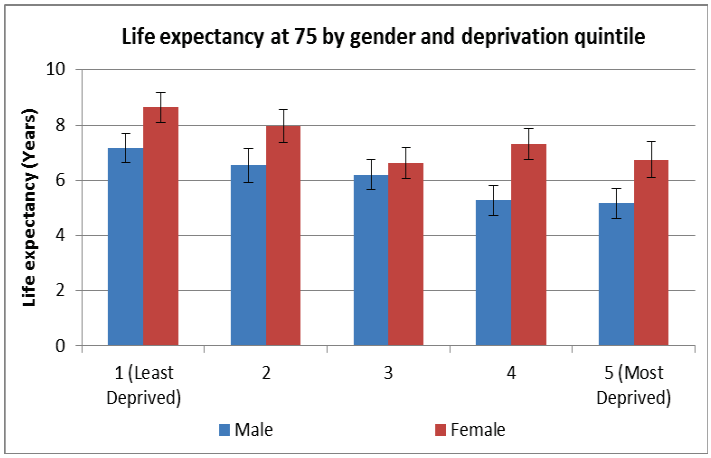
The over 45 population in Torbay is expected to grow by around 4.5% over the next few years. Population projections estimate that this population will grow to around 72,500 by 2015. This is estimated to be a slower rate of growth compared to the England average of around 7.5%.

## Life expectancy

Life expectancy for those aged 65 is generally higher for residents in Torbay than compared to the England average. With males estimated to live around 18.9 years and females 21.4 years. This compares to 17.7 years and 20.3 years respectively for the average male and female in England.

Locally, life expectancy for those aged 75 in Torbay shows significant variation by deprivation quintile. Those living in the most deprived 20% in Torbay can expect significantly lower life expectancy on average, than residents in the least deprived 20% in Torbay. There are also significant differences by gender.

Figure 23: Life expectancy at 75 years




## Premature mortality

Premature mortality rates for the 65 to 74 year old group in 2008/10 (table 11) show Torbay to be similar to both the England and regional averages. Whilst the overall rate for Torbay is lower, the difference is not significant.

One disease where Torbay demonstrates significantly higher rates of ***premature mortality*** is ***chronic liver disease***, including cirrhosis. 67 individual mortalities were due to this disease between 2008 and 2010; or around 22 per year.

| Table 13: Premature mortality rate <75 | England | South West | Torbay |
|---|---|---|---|
| **Circulatory diseases.** (2008-10 pooled), NCHOD | 67.3 Per 100,000 | 55.6 Per 100,000 | 65.7 Per 100,000 |
| **All cancers.** (2008-10 pooled), NCHOD | 110.1 Per 100,000 | 101.9 Per 100,000 | 108.2 Per 100,000 |
| **Chronic liver disease including cirrhosis.** (2008-10 pooled), NCHOD | 10.0 Per 100,000 | 8.3 Per 100,000 | 14.4 Per 100,000 |
| **Respiratory disease** (2009) NCHOD | 24.2 Per 100,000 | 19.1 Per 100,000 | 18.4 Per 100,000 |

Premature mortality from other diseases such as cancers, circulatory and respiratory is similar in Torbay to the wider England average; they are not significantly different.

***Excess winter mortality*** is potentially amenable to effective intervention. This excess death is greatest in both relative and absolute terms in elderly people and for certain disease groups.

Excess winter mortality rates fluctuate in Torbay. The most recent data, 2006/09, suggest that Torbay's rate is lower than the regional and national averages. However, Torbay's rate in 2004/07 and 2005/08 was noticeably higher than the regional and national averages.

**Hospital admissions**

***Elective hospital admissions*** (non-emergency), admissions where patients are booked in, are lower than expected for the Torbay population, with a standardised admission ratio (SAR) less than 100, generally within the 80's. A SAR of 100 suggests an admission rate as expected, less than 100 suggests an admission rate lower than expected and over 100 suggests a higher than expected rate.

Elective admissions are highest for cancers (neoplasms), musculoskeletal and digestive related diseases or disorders. There is a significantly higher than expected number of elective admissions for cancer treatments as well as injuries and poisonings. These also include on-going treatments for diseases such as cancers, and also attendances at fracture clinics.

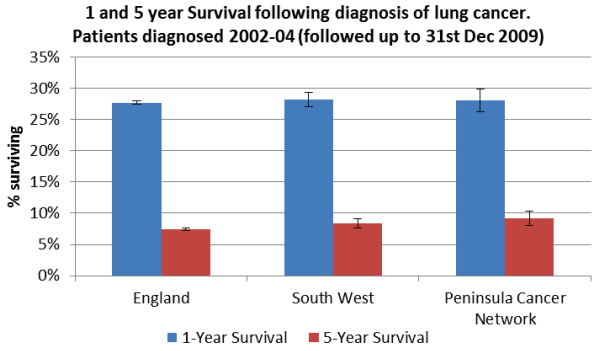
***Non elective admissions***, or emergency admissions, admissions that are unpredictable, are highest in the over 65's for circulatory, injuries & poisonings, respiratory and digestive related diseases or disorders. Emergency admissions for injuries & poisonings are significantly higher than we would expect for Torbay's population. Emergency admissions for fracture of the neck of femur (hip) represent the highest

number of emergency admissions within the injuries and poisonings chapter with a SAR of 121 for 2009/12.

### Cancer survival

Cancer survival rates in Torbay are similar to the regional and national rates. Survival rates for ***lung cancer*** are perhaps the worst, with around 3 out 4 people diagnosed not surviving a year. Fewer than 9 out of 10 people diagnosed with lung cancer survive more than 5 years. There is a lack of information on diagnosis by stage of cancer at diagnosis.

Figure 24: 1 and 5 year lung cancer survival




Survival rates for ***breast cancer*** are better, with more than 8 out of 10 surviving for 5 years or more. Early diagnosis is key to increasing survival.

| Table 14: Survival following diagnosis of: | | England | South West | Peninsula (Devon & Cornwall) |
|---|---|---|---|---|
| **Colon cancer** IC, 2002-04 | Number | 50,145 | 6,401 | 2,193 |
| | 1-Year Survival | 68.8% | 71.8% | 71.0% |
| | 5-Year Survival | 50.1% | 53.5% | 49.4% |
| **Breast cancer** IC, 2002-04 | Number | 103,100 | 12,156 | 4,042 |
| | 1-Year Survival | 94.8% | 94.9% | 95.2% |
| | 5-Year Survival | 82.3% | 83.0% | 82.5% |

### Long term conditions

Long term conditions are conditions that, at present, cannot be cured but can be controlled through treatment and behaviour. These include conditions such as heart disease, diabetes and mental health problems.

People with long term conditions are the most frequent users of healthcare services. Those with long term conditions account for 29 percent of the population, but use 50 percent of all GP appointments and 70 percent of all inpatient bed days [21].

Long term conditions fall more heavily on the poorest in society: compared to social class I, people in social class V have 60 percent higher prevalence of long term conditions and 60 percent higher severity of conditions [21]. Half of people aged over 60 in England have a long term condition [21].

With an ageing population and the growth of health harming behaviours such as physical inactivity, unhealthy eating and harmful alcohol consumption, we would expect the prevalence of long term conditions to rise.

The number of people with comorbidities is expected to rise by a third in the next ten years [21].

With Torbay's aged population, it is not a surprise to observe that Torbay experiences higher prevalence's of long term conditions.

Current prevalence estimates for ***COPD*** in Torbay suggest that Torbay has a slightly lower prevalence in the 65 and over age group.

| Table 15: Chronic Obstructive Pulmonary Disease<br>APHO, 2011 | Aged 16+ | Aged 65 to 74 | Aged 75+ |
|---|---|---|---|
| **England** | 3.6% | 8.3% | 8.9% |
| **South West** | 3.4% | 7.1% | 7.7% |
| **Torbay** | 4.2% | 8.0% | 8.3% |

Estimates suggest that almost 1 in 4 of the over 75 population have ***CHD***.

| Table 16: Coronary Heart Disease<br>APHO, 2011 | Aged 16+ | Aged 65 to 74 | Aged 75+ |
|---|---|---|---|
| **England** | 5.8% | 16.1% | 21.9% |
| **South West** | 6.3% | 15.4% | 21.0% |
| **Torbay** | 8.2% | 17.6% | 23.7% |

Levels of ***dementia*** in Torbay are expected to decrease slightly over coming years, however overall numbers are expected to increase.

| Table 17: Dementia (Aged 65+)<br>NEPHO, 2009 | England | Torbay | |
|---|---|---|---|
| | | % | Count |
| **2010** | 7.1% | 7.7% | 2,570 |
| **2015** | 6.9% | 7.3% | 2,750 |
| **2020** | 7.2% | 7.6% | 3,140 |

The proportion of the over 16 population with ***diabetes*** is currently higher in Torbay than the England average. Torbay is also estimated to experience a higher proportion in the coming years.

| Table 18: Diabetes<br>APHO, 2010 | 2012 | 2015 | 2020 |
|---|---|---|---|
| **England** | 7.6% | 8.0% | 8.5% |
| **South West** | 7.6% | 7.9% | 8.4% |
| **Torbay** | 8.7% | 9.1% | 9.7% |

Current levels of ***hypertension*** (high blood pressure) are noticeably higher in the 16+ population in Torbay. As this population ages, we may notice increased levels in the aged population.

| Table 19: Hypertension<br>APHO, 2011 | Aged 16+ | Aged 65 to 74 | Aged 75+ |
|---|---|---|---|
| **England** | 30.5% | 64.8% | 71.3% |
| **South West** | 32.7% | 64.2% | 70.9% |
| **Torbay** | 37.0% | 65.9% | 72.4% |

### General health

The proportion of people aged 65+ predicted to have a moderate or severe ***visual impairment*** is higher in Torbay than England.

| Table 20: Visual impairment<br>POPPI | 2011 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| **England** | 8.8% | 8.8% | 8.9% | 9.2% |
| **Torbay** | 9.1% | 9.1% | 9.4% | 9.8% |

The proportion of the population aged 65 and over predicted to have a moderate or severe ***hearing impairment*** is higher in Torbay than England.

| Table 21: Hearing impairment<br>POPPI | 2011 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| **England** | 42.8% | 42.4% | 43.6% | 45.9% |
| **Torbay** | 45.0% | 45.0% | 46.7% | 50.0% |

The proportion of the population aged 65 and over unable to manage at least one activity on their own is slightly higher in Torbay than the England average.

| Table 22: Mobility POPPI | 2011 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| England | 18.6% | 18.4% | 19.0% | 19.6% |
| Torbay | 19.9% | 19.8% | 20.5% | 21.6% |

The proportion of the population aged 65 and over predicted to have a ***bladder problem*** at least once a week is higher in Torbay.

| Table 23: Continence POPPI | 2011 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| England | 16.4% | 16.4% | 16.6% | 16.8% |
| Torbay | 17.0% | 17.1% | 17.3% | 17.9% |

## Carers

The number of carers in the UK is increasing as the population ages and people with disabilities and serious illnesses live longer and are more likely to live at home. This means that community-based care will rely increasingly on the participation of family and community members as carers.

Carers are at risk from health problems varying from stress-related conditions to injury caused by lifting. There are currently around 1,700 people claiming carers allowance in Torbay, or around 127 per 10,000 population, compared to 95 per 10,000 in England and 80 per 10,000 in the South West region.

## Living status

An estimated 12,400 persons aged 65 and over ***live alone*** in Torbay; this is around 38% of this age group. This is estimated to increase to around 18,600 by 2020.

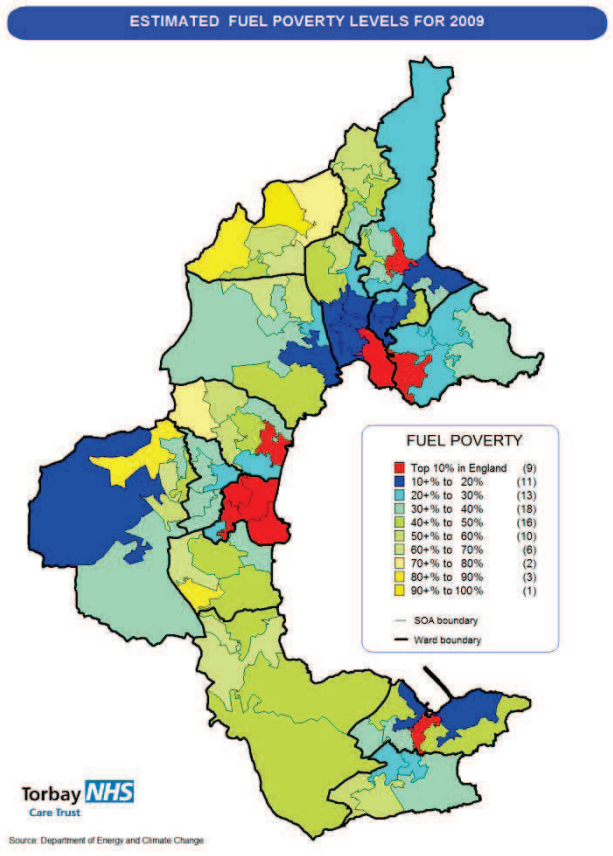
There are estimated to be around 2,000 people aged 65 and over living in a care home with or without nursing in Torbay, this is expected to increase to around 2,500 by 2020.

## Poverty

A household is said to be in ***fuel poverty*** if it needs to spend more than 10% of its income on fuel to maintain a satisfactory heating regime.

The national evidence suggests that those most fuel poor are single people aged 60 or over, with some 38.5% being fuel poor.

Map 4: Relative fuel poverty in Torbay



**Introduction**

Experience and safety is about understanding the needs from the perspective of those using the services.

**Service experience**

The patient experience of the GP surgery in Torbay is generally a positive one. Overall the levels of satisfaction with patients are better than average. With 92% stating their overall experience with the GP surgery as being good or very good, compared to 88% for England.

Similar to the in hours GP surgery experience, the patient experience with out of hours GP services is good. With 80% stating the experience as good or very good, compared to 71% for England.

Patient experience with dental health is also positive in Torbay. 94% were successful in getting an NHS dental appointment, with 87% getting an appointment with a practice they'd been to before. This compares to 92% and 84% respectively for the England average.

Patient experience with outpatients could be described as about the same as other NHS trusts in England. Torbay scored better where the patients felt that they were involved in the decisions about their care.

Overall, women's experience of maternity services in Torbay could be described as about the same as other NHS trusts in England. Torbay scored better for experiences around the labour and birth, including pain relief during birth.

Patient experience of community mental health services was unfortunately considered worse than the wider average.

**Satisfaction**

The overall level of satisfaction for access to GP practices in Torbay is in line with the national average. Around 95% of patients reported being able to obtain a convenient appointment, however there are still around 5% that found the appointment inconvenient. Torbay patients found the overall experience of making an appointment better than the England average, with 84% stating that their experience of making an appointment was fairly or very good, compared to 79% for England.

**Safety – Healthcare associated infections**

***Clostridium difficile*** (c-diff) infection is the most important cause of hospital-acquired diarrhoea. The number of cases has increased in Torbay, from 54 in 2010/11 to 73 in 2011/12. However there has been a regional increase, and improved testing.

There were no ***MRSA*** bacteraemia cases recorded in Torbay during 2011/12, with only 2 in 2010/11 and 1 so far in 2012/13 the numbers are very small.

## GP locations

There are 19 practices in Torbay serving a registered population of around 145,000.

The average practice population in Torbay is around 7,600. This is slightly higher than the England average of around 6,900 per practice.

| Table 24: GP registered patients | Number of GP practices | Average list size |
|---|---|---|
| Brixham | 3 | 7,100 |
| Paignton | 8 | 6,500 |
| Torquay | 8 | 9,100 |
| Torbay | 19 | 7,600 |

Map 5: GP practice locations in Torbay


## Pharmacy locations

There are 39 pharmacies in Torbay, serving a residential population of around 134,000.

There are, on average, 3,400 residents in Torbay per pharmacy. In England, the average is around 4,900 persons per pharmacy.

| Table 25: population per pharmacy | Number of Pharmacies | Average resident population per pharmacy |
|---|---|---|
| Brixham | 6 | 2,900 |
| Paignton | 12 | 4,200 |
| Torquay | 21 | 3,200 |
| Torbay | 39 | 3,400 |

Map 6: Pharmacy locations in Torbay

Within Torbay, three pharmacies provide 100 hour opening coverage. This includes opening outside of regular 9 to 5, including evenings and weekends. Enhanced services plug a gap in essential services or deliver higher than specified standards, with the aim of helping reduce demand on secondary care. Locally in Torbay, these additional enhanced services are offered out of different pharmacy locations within the bay. Enhanced services include:

- Supervised consumption – offered out of half Torbay pharmacies and is where the pharmacist supervise the ingestion of the patients medicine
- Emergency hormone contraception – females presenting with 72 hours of unprotected sex, offered to out of 75% of pharmacies
- Stop smoking services – offered out of a third of pharmacies in Torbay
- Chlamydia screening – self testing chlamydia kits free to 15 to 24 year olds, available at a quarter of Torbay's pharmacies.

**Optometrist locations**

There are 15 Opticians in Torbay.

Map 7: Optician locations in Torbay


**Dental locations**

There are 22 Dentists in Torbay.

Map 8: Dental locations in Torbay

Within Torbay, JSNA forms the central evidence base. Positioning JSNA as the central evidence base provides a consistent story of need across partner organisations and removes duplication of effort. There are a number of local assessments used by other local public sector organisations to inform service planning and commissioning strategies. Alignment of these under the JSNA should provide the consistent story across the area.


In Torbay, a local intelligence network was established in 2008 to deliver the 2008 JSNA, i-bay. Whilst JSNA has been led by Public Health, it has been greatly supported by the wider intelligence network. Delivering JSNA in the future will be through the wider intelligence network on behalf of the Torbay Health and Wellbeing board.

JSNA in Torbay is structured into three levels. The three levels provide different degrees of understanding of Torbay's population. This JSNA document is constructed through a narrative understanding of need in Torbay. It is then supported by a set of profiles and a wider data repository.

**Structure for Torbay JSNA**

***1) The narrative; a life course understanding of need in Torbay (annual)***

**2) Summary profiles for areas and settings within Torbay (and Southern Devon?) (annual)**

**3) Data repository providing information by area and / or setting (on going)**

Aspirations for the future of JSNA in Torbay include inclusion of currently unavailable outcome framework indicators. A complete set of outcomes will be used to support Clinical Pathway Groups set their priorities. It will also facilitate opportunities to stretch clinical pathways into other areas, such as the housing conditions.

# FUTURE INTENTION

It is the intention that the following lists of indicators are included in future JSNA.

These indicators are missing due to a lack of data, an incomplete definition or local collection needs to be established.

Each indicator in the below lists is accompanied with the outcome framework and reference number.

**Starting Well**

- New-born physical examination including blood spot and hearing screening (PH – 2.21)
- Admission of full-term babies to neonatal care (NHS – 5.5)
- Child development at 2 to $2^{1/2}$ years (PH – 2.5)

**Developing Well**

- Emotional well-being of looked after children (PH – 2.8)
- Smoking prevalence – 15 year olds (PH – 2.9 )
- BCG vaccination coverage (1 to 16 year olds) (PH – 3.3)
- Incidence of harm to children due to 'failure to monitor' (NHS – 5.6 )

**Living and Working Well**

- Social connectedness (PH – 1.18)
- People in prison who have mental illness or significant mental illness (PH – 1.7)
- Emergency re-admissions within 28 days of discharge from hospital (NHS – 3b)
- An indicator on recovery from injuries and trauma (NHS – 3.3)
- Proportion of patients who successfully complete treatment for tuberculosis (PH – 3.5)
- Helping people to recover from episodes of ill health or following injury (NHS – 3)
- Proportion of stroke patients reporting an improvement in activity / lifestyle on the modified Rankin scale at 6 months (NHS – 3.4)
- The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days (NHS – 3.5)
- The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days (NHS – 3.5)
- Self –reported well-being (PH – 2.23)
- HIV coverage – the proportion of pregnant women eligible (PH – 2.21)
- Syphilis, hepatitis B and susceptibility to rubella uptake. (PH – 2.21)
- Pregnant women eligible for antenatal sick cell (PH – 2.21)
- The percentage of the population affected by noise (PH – 1.14)
- The proportion of the population exposed to transport noise (PH – 1.14)
- Proportion assessed for substance dependence issues when entering prison (PH – 2.16)
- Percentage of people using green space for exercise / health reasons (PH – 1.16)

- Air pollution (PH – 3.1)
- Gap between the employment rate for those with a long term condition / mental illness / learning difficulty and the overall employment rate (PH – 1.8)
- Proportion of adults in contact with secondary mental health services living independently, with or without support (ASC – 1h)

**Aging Well**

- Mortality from communicable diseases (PH – 4.8)
- Potential years of life lost from causes considered amenable to health care (NHS – 1a)
- Excess under 75 mortality in adults with serious mental illness (PH – 4.9)
- Permanent admissions to residential and nursing care homes per 100,000 population (ASC – 2a)
- Delayed transfers of care from hospital, and those which are still attributable to adults social care per 100,000 (ASC – 2c)
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services (ASC – 2b)
- The proportion of people who use services who have control over their daily life (ASC-1b)
- Proportion of people using social care who receive self-directed support, and those receiving direct payments (ASC – 1c)
- Carer reported quality of life (ASC – 1d)
- Health related quality of life for people with long term conditions (NHS – 2)
- Proportion of people feeling supported to manage their condition (NHS – 2.1)
- Improved quality of life for those with dementia (NHS – 2.6)
- Social care quality of life (ASC – 1a)

**Experiences and Safety**

- Ensuring that people have a positive experience of care (NHS – 4)
- Patient experience of hospital care (NHS – 4b)
- Survey of bereaved carers (NHS – 4.6)
- Patient safety incident reporting (NHS – 5a)
- Severity of harm (NHS – 5b)
- An indicator on children and young people's experience of healthcare (NHS – 4.8)
- Patient reported outcome measures for elective procedures (NHS – 3.1)
- Overall satisfaction of people who use services with their care and support (ASC – 3a)
- Overall satisfaction of carers with social services (ASC – 3b)
- Treating and caring for people in a safe environment and protecting them from avoidable harm (NHS – 5)
- Agreed inter agency plans for responding to public health incidents (PH – 3.7)
- The proportion of carers who report that they have been included or consulted in discussion about the person they care for (ASC – 3c)

- The proportion of people who use services and carers who find it easy to find information about services (ASC – 3d)
- The proportion of people who use services who feel safe (ASC – 4a)
- The proportion of people who use services who say that those services have made them feel safe and secure (ASC – 4b)
- Incidence of hospital-related venous thromboembolism (NHS – 5.1)
- Incidence of healthcare associated MRSA infection (NHS – 5.2)
- Incidence of healthcare associated C. difficile infection (NHS 5.2)
- Incidence of newly-acquired category 3 and 4 pressure ulcers (NHS – 5.3)
- Incidence of medication errors causing serious harm (NHS – 5.4)

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