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.

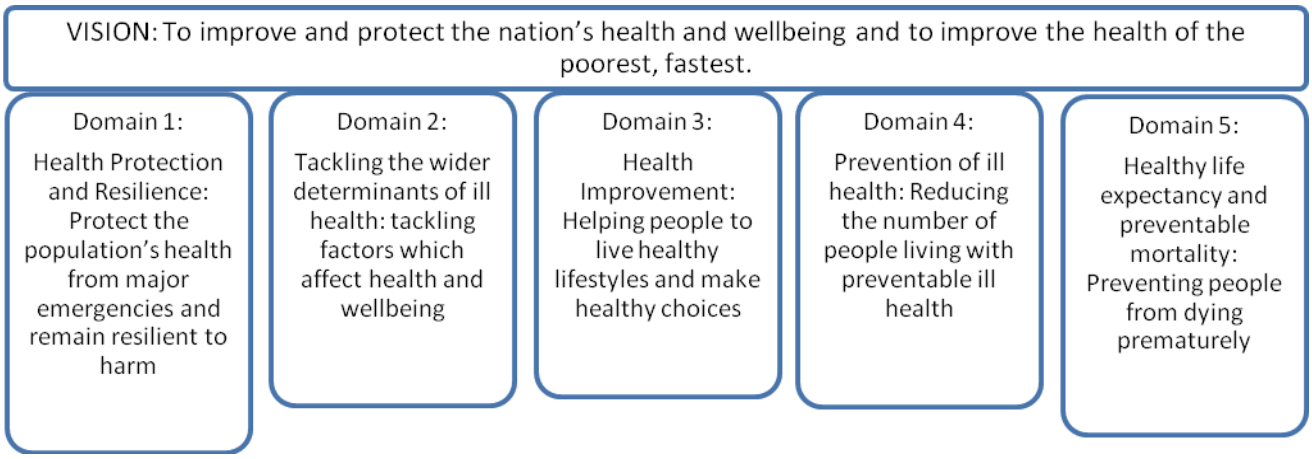
3.2 Physical and psychological health and wellbeing is an essential foundation for a prosperous and flourishing society. [(13)] It enables individual and families to contribute fully to their communities, and underpins higher levels of motivation, aspiration and achievement. It improves the efficiency 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

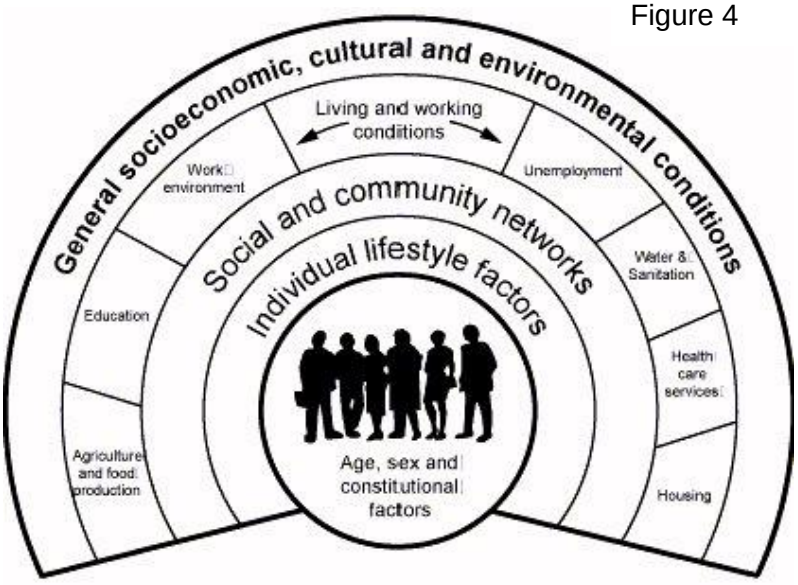
3.7 Torbay Care Trust in partnership with the Council is a national leader in the transformation of community based health and social care services targeting prevention and greater integration of services. In addition to working collaboratively with business and the voluntary sector we have set the underlying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



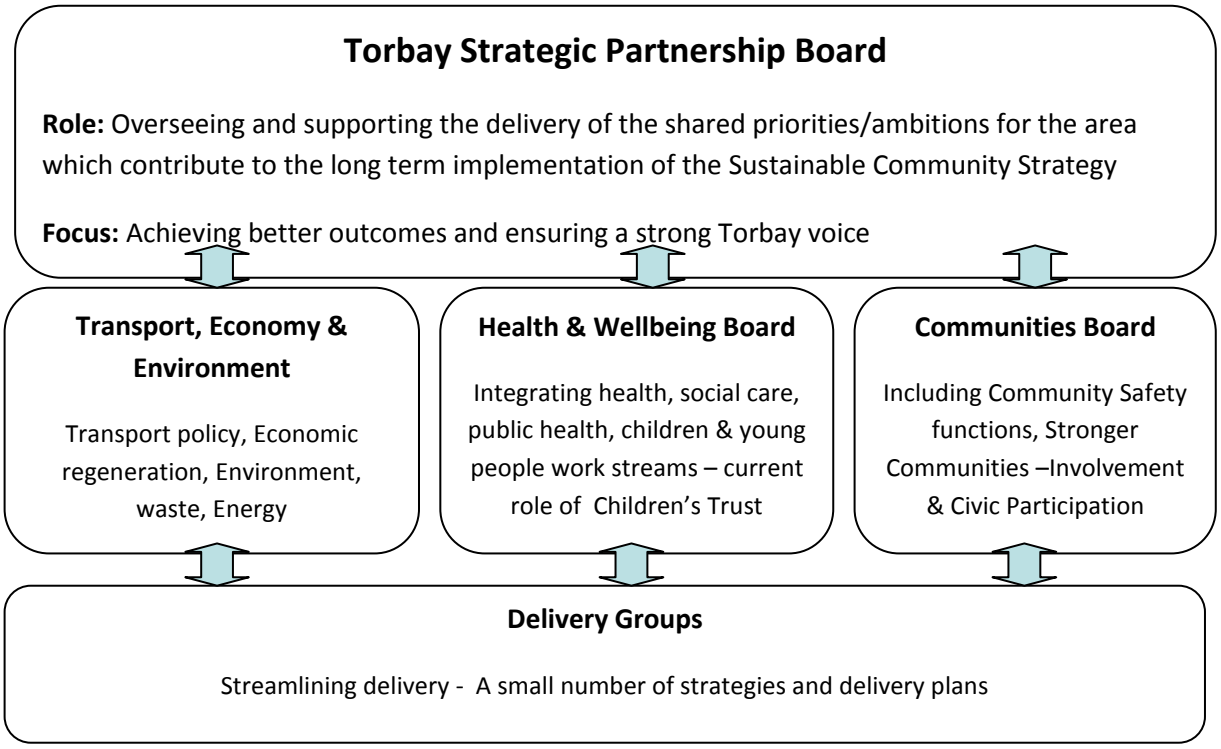
Source: Dahlgren & Whitehead 1991.

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

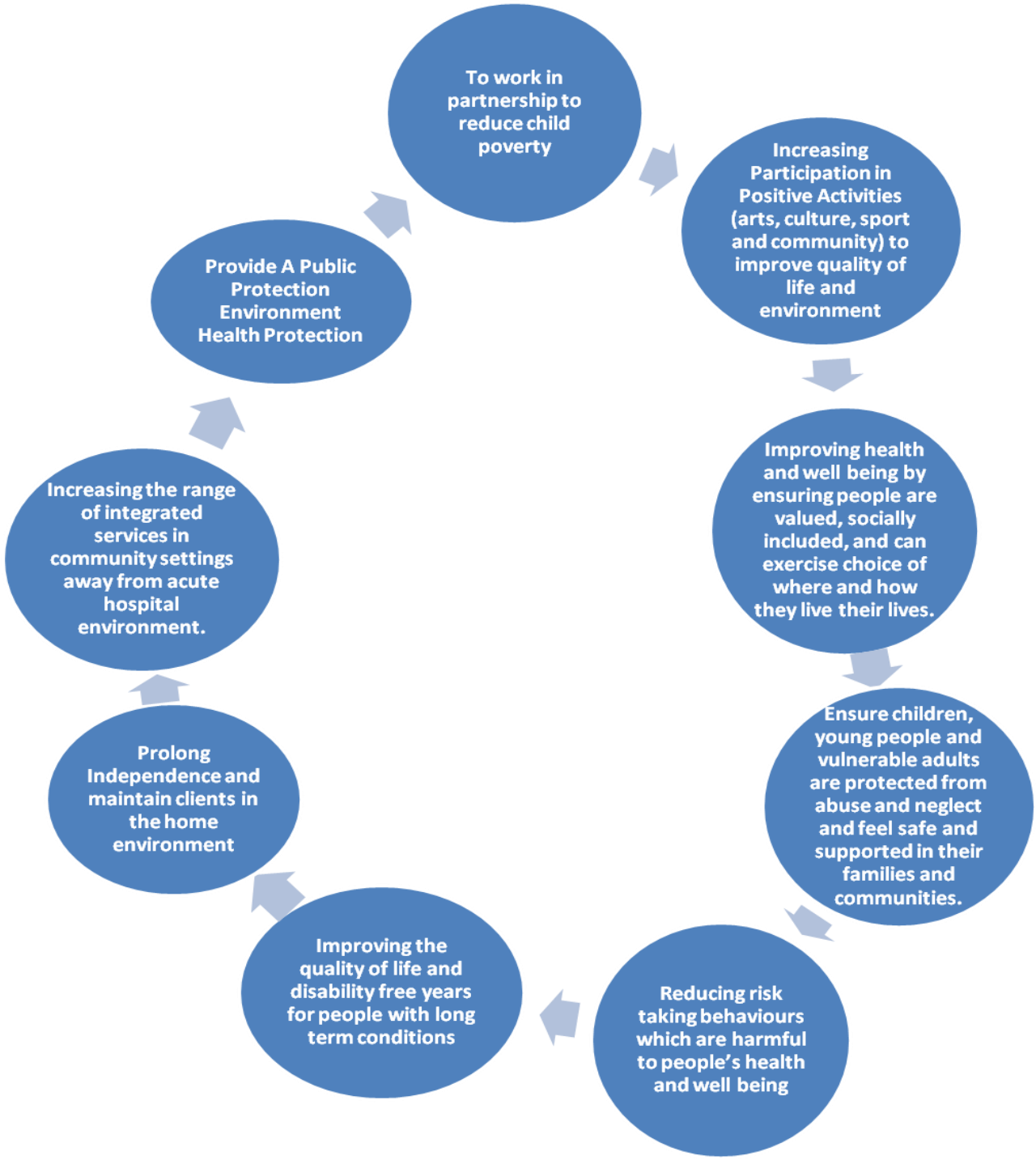
Source: Route Map for Sustainable Health

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.

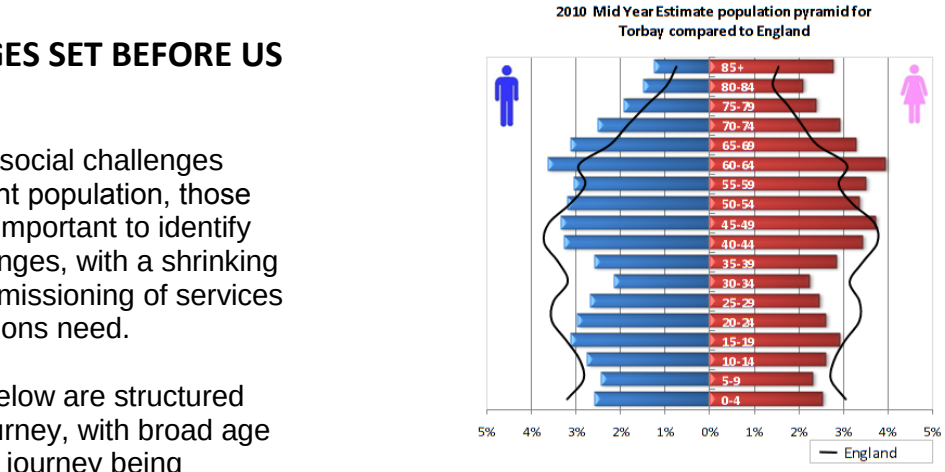
The challenges set out below are structured around the life course journey, with broad age related themes along the journey being presented as the framework. This is supplemented with an additional overarching life course section that pulls challenges that don't naturally fit with a specific age category.

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.



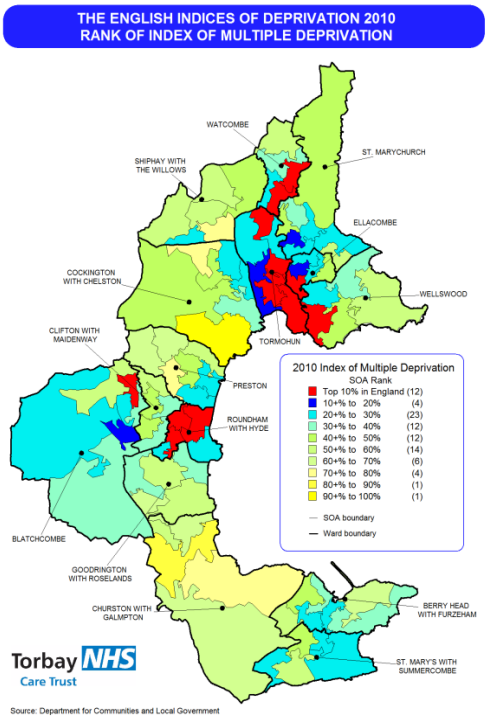
Torbay has a noticeably higher average age when compared to the national average. In 2010, Torbay's average age is estimated to be 4.7 years older than the national; this difference is expected to grow to just over 5 years by 2020.

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].



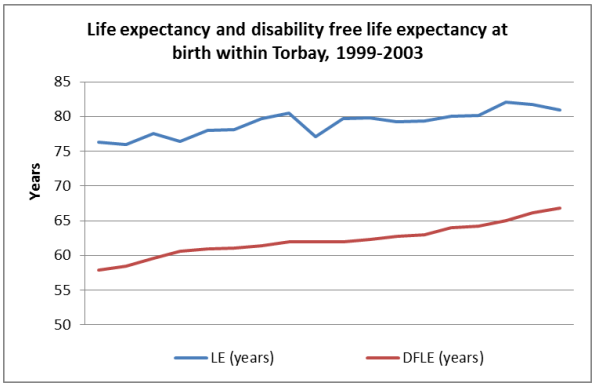
Health problems appear to arise less from the infectious diseases of previous times but more from diseases caused by behavioural and environmental factors. People are being treated more effectively than ever before but to fully benefit from longer life, people need to take advantage also of the opportunities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

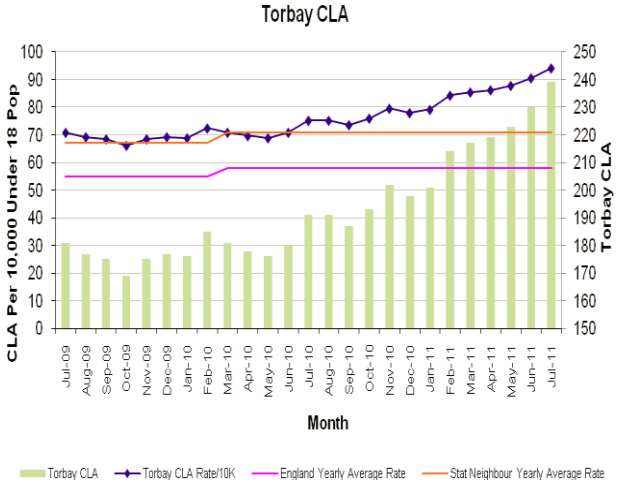
While overall hospital admission rates are below expected levels there are some conditions where this is not the case, namely admissions for alcohol-related liver disease (twice expected levels), emergency admissions for injuries and poisonings and admissions for teeth extractions due to dental caries (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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