Devon County Council

Annual Public Health Report 2012-13

Summary

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Annual Public Health Report 2012-13 Summary Introduction

This year's Annual Report seeks to answer the question: "How well have we done over the last six years in improving the health of people in Devon, and what should we hope to achieve over the next six years?"

This Annual Public Health Report for 2012-13 concludes the period when public health responsibilities sat with the NHS Primary Care Trust in Devon.

Changes brought into effect from 1 April 2013 now place the responsibility for local public health with Devon County Council (DCC), giving it new statutory responsibilities for public health, health improvement and health protection and its own Director of Public Health.

Last year's Report looked back over 60 years of public health in Devon, most of it when public health was a local authority responsibility.

The close working relationship with the NHS continues through the 'core offer' of healthcare public health support from DCC to the county's two clinical commissioning groups (CCGs): Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG.

This year's report looks back over the previous six years. As well as providing an independent commentary on the health of the people of Devon, the five previous annual reports were based around particular themes, as follows:

- 2007-08: Tackling inequalities in health
- 2008-09: The health of children and young people
- 2009-10: Mental health
- 2010-11: The health of older people
- 2011-12: 60 years of public health in Devon

These documents can all be found on the Devon Health and Wellbeing website:

http://www.devonhealthandwellbeing.org.uk/aphr

Or search: Devon annual public health reports

Annual Public Health Report 2012-13 Summary Executive Summary

There are 40 recommendations at the end of this summary and the full report: 25 arise from this annual analysis of the health of the population of Devon, making reference to the best evidence available today. The remaining 15 recommendations come from previous annual reports. All the recommendations set out an ambitious programme of work to improve health and promote health equality in Devon.

While people in Devon continue to benefit from long life expectancy and low mortality rates, these overall rates disguise significant variations in health. Now that local authorities, NHS clinical commissioning groups and NHS England all have a statutory duty to reduce health inequality, commissioners must take these inequalities into account when producing their commissioning plans and be able to demonstrate an impact year on year.

THOSE AREAS OF HEALTH AND WELLBEING WHERE THE GREATEST IMPACT CAN BE MADE ON HEALTH INEQUALITY ARE:

1. Reducing smoking
2. Increasing the proportion of the population at a healthy weight
3. Detecting and treating diseases earlier, such as heart disease, high blood pressure, diabetes and cancers
4. Targeting preventive interventions at those vulnerable groups with the worst health, including those who may be at risk of domestic or sexual violence and abuse
5. Investing in the health and wellbeing of all children and young people
6. Improving mental health and emotional wellbeing, and preventing loneliness
7. Increasing income levels and employment, and reducing poverty
8. Improving the quality and warmth of housing
9. Reducing misuse of substances, including alcohol and drugs
10. Helping people in their neighbourhoods to live healthier and happier lives.

Annual Public Health Report 2012-13 Summary
Health decision-making bodies

The NHS reforms set out in the Health and Social Care Act 2012 heralded a new era for healthcare provision in England and a number of different organisations make up the new healthcare system.

THE JOINT STRATEGIC NEEDS ASSESSMENT, THE JOINT HEALTH AND WELLBEING STRATEGY AND THE HEALTH AND WELLBEING BOARD

The passage of the Health and Social Care Act 2012 required local authorities (upper-tier and unitary) to establish statutory health and wellbeing boards. Devon's Shadow Health and Wellbeing Board started work in 2012 and produced the first Joint Health and Wellbeing Strategy in September 2012.

An annual cycle now exists of refreshing the Joint Strategic Needs Assessment, developing a Joint Health and Wellbeing Strategy (in partnership with local people and organisations), consulting on those strategic priorities, and ensuring that they are reflected in the plans of commissioners, generating tangible improvements in health and wellbeing outcomes.

In Devon, the Public Health team has developed a stand-alone website where all of the information about the Board, its members, its meetings and supporting papers can be found, as well as the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. The website can be found at:

http://www.devonhealthandwellbeing.org.uk

Or search: Health and Wellbeing Board

Detailed work has been completed on topic pages and local health and wellbeing profiles which are there to inform local planning. There are also reports on specific health indicators which allow us to measure our progress.

NEW NHS STRUCTURES AND ORGANISATIONAL RESPONSIBILITIES

The NHS reforms set out in the Health and Social Care Act 2012 have been implemented over 2012-13 with the abolition of strategic health authorities (SHAs), primary care trusts (PCTs) and the Health Protection Agency, among others.

There is no direct replacement for these bodies and the NHS commissioning functions, which were largely carried out by PCTs over the last decade and by the SHAs before them, are now divided between NHS England, NHS clinical commissioning groups (CCGs), and local authorities (through the new Public Health grant to them from Public Health England).

There is some complexity with this, as for some services several commissioners will be involved in a pathway of care (for example, weight management, where the local authority in question will be responsible for prevention, the CCG for hospital services, and NHS England for obesity (bariatric) surgery).

The Department of Health recently published a guide to the different organisations that make up the new healthcare system. This document will be updated annually and can be found at the following link:

http://www.gov.uk/government/publications/guide-to-the-healthcare-system-in-england

Or search: England's healthcare system guide

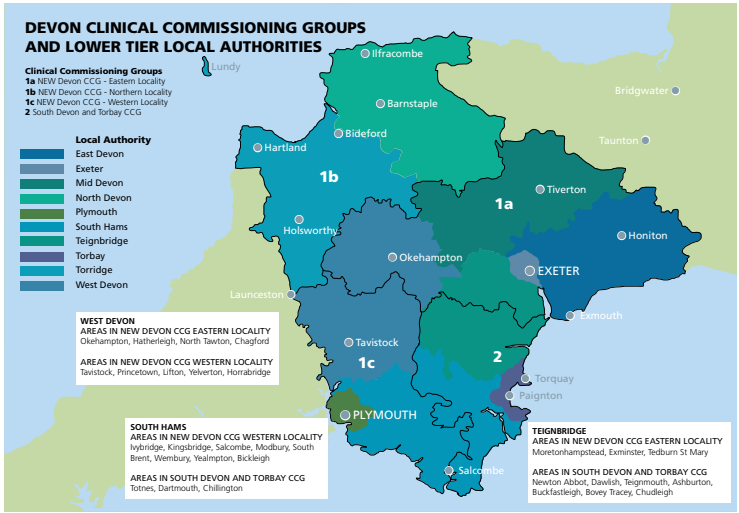
Annual Public Health Report 2012-13 Summary
A profile of health in Devon

Demographics (age and gender), ethnicity, life expectancy, birth statistics, causes of death and health inequality must all be considered if we are to gain a true picture of the county's health.

Demographics: Devon has a higher proportion than the national average of people aged 55 and over. This has a marked effect on the use of health and social care services as we know that older age groups are the highest users of these services. The impact of the ageing population as well as the inward migration of people retiring to Devon is also having a significant effect on the differing age structure of some of our local communities. The resident population is growing at twice the national average. While modest population growth is expected in those aged under 60, population growth is set to be greatest in older age groups, ranging from a 28% increase in those aged 60 to 69 over the next 25 years to a 233% increase in those aged 90 and above.

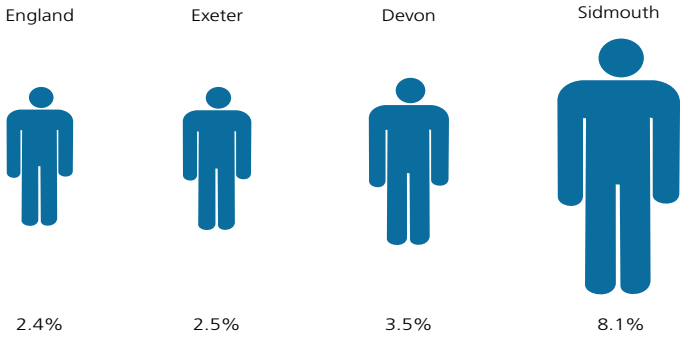
When considered by locality, the population profiles of the four main locality areas covered by NEW Devon CCG and South Devon and Torbay CCG are very different.

CCG AREAS COVERING THE LOCAL AUTHORITIES OF DEVON, PLYMOUTH AND TORBAY



SOURCE: ORDNANCE SURVEY DATA, © CROWN COPYRIGHT AND DATABASE RIGHT 2012

THE PROPORTION OF PEOPLE AGED 85 AND OVER IN DEVON COMPARED WITH ENGLAND



SOURCE: SECONDARY USES SERVICE POPULATION EXTRACT, NATIONAL HEALTH SERVICE, 2012

The Western locality is very similar to the national profile, with a larger proportion of persons aged 20 to 24 due to the University of Plymouth. The Eastern locality has an older age profile, and lower proportions of those aged 25 to 39, and there is a larger proportion of 20 to 24 year olds, mostly due to Exeter University. Northern Devon also has an ageing population, with a particularly large proportion of those around retirement age (60 to 69 years) and noticeably lower proportions in the 20 to 39 age group, highlighting the greater impact of inward and outward migration in Northern Devon.

Ethnicity: Devon's ethnic make-up is very different from England. Overall in England, almost 80% of people are White British, with the next highest proportion of people being Asian or Asian British (including Chinese) at almost 8%. The Devon population consists of almost 95% White British, with the next highest percentage being 'White Other including Gypsy and Traveller' ethnic groups at 2.2%.

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A profile of health in Devon

Life expectancy: Overall, the health experience of Devonians is very good; few places have better overall life expectancy, it is rising steadily for both men and women and local services are of good quality.

However, when we look below the surface at the three main locality areas, Northern, Eastern and Western, there is considerable variation. There is striking variation between the different town and locality profiles. This variation exposes an inequality in health experience that is closely linked to premature death rates.

The life expectancy gap between the most and least deprived 10% of the population is increasing in the Western locality and decreasing in the Eastern locality. This is partly because the Western locality has greater social divisions, with a higher level of very deprived and very prosperous neighbourhoods; the gap has effectively widened because health has not improved so quickly for the most deprived members. It should be noted that for Northern, Eastern and Western (NEW) Devon CCG as a whole, while the life expectancy gap is relatively stable for males, it is increasing for females – making the health of women in West Devon a priority for the Western locality.

Birth statistics: Infant mortality is measured when a baby dies before their first birthday. It is a good indicator of the healthiness of the environment which the baby is born into – which is why we have seen huge reductions in infant mortality in this country over the last two centuries as the standard of living has improved and fewer children have been born into poverty. It is therefore also an indicator of inequality in health, with poorer or disadvantaged groups having higher infant mortality rates. As the actual numbers of deaths are very small, the death of an infant is unusual nowadays and therefore Local Safeguarding Children Boards and Child Death Overview Panels are important contributors to the intelligence about untoward deaths and what may be done to prevent avoidable deaths at such a young age.

While the infant mortality rate was significantly lower than the England and Wales rate from the period 2000-02 to 2004-06, this difference is no longer present; although the Devon trend is still decreasing, it is doing so at a slower rate than for England and Wales. This suggests that more could be done locally to prevent infant deaths.

Live births have been increasing over recent years, an increase of almost 21% in the last ten years. This has implications for maternity and community services, as well as for schools and early-years provision. The most striking recent change is the increase in the rate of births in women over the age of 40.

Teenage pregnancy is another indicator of deprivation and the latest statistics tell us that there has been considerable improvement in the relative position of Exeter to the other districts. Devon's overall teenage pregnancy rate is the lowest it has been since 1998.

Causes of death: The prevention of premature death is the key to achieving greater equality in life expectancy. An analysis of causes of premature death shows coronary heart disease as the top cause of premature death in Devon, followed by cancers, chronic obstructive pulmonary disease (COPD), accidents, strokes and suicide. Many of these deaths at such a young age could be prevented – smoking is the direct cause of many of these premature deaths and this explains why smoking is a major contributor to health inequality.

One of the most obvious inequalities in health is that which exists between men and women. Men's mortality rates are higher than women's but the improvement over time is faster. This suggests that more could be done to improve the health of women, particularly in the earlier recognition and treatment of circulatory disease (high blood pressure, heart disease) and preventing cancer – increases in lung cancer being largely preventable by not exposing the lungs to tobacco smoke.

Since the very first Annual Public Health Report in 2008, we have been tracking progress against the then Labour Government's 'Our Healthier Nation' targets published in 1998, to be achieved by 2010. At the time of publication 15 years ago, these targets seemed very daunting and we have been tracking them each year. The intention was to save 15,000 lives each year by improving the general health of the population by focusing on four main target areas:

- Heart disease and strokes
- Cancers
- Accidents
- Mental health

We now have the final position on these targets for circulatory disease, cancers, accidents and suicide. While the target for circulatory diseases and cancers has been exceeded, death rates for accidents nationally and locally have stayed relatively steady with little evidence of change.

Although the target has been achieved for mental health, as measured by suicide/injury undetermined, the overall reduction has been at a slower rate than for England – again suggesting that more could be done.

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Annual Public Health Report 2012-13 Summary
Health inequality

"Health in our country has generally improved over the years. But far too many people are still falling ill more often and dying sooner than they should. Poor people are ill more often and die sooner, and that's the greatest inequality of them all: the inequality between the living and the dead."

Rt Hon Frank Dobson MP,
Secretary of State for Health, 1998

Health inequality is closely related to socio-economic deprivation. Deprivation varies across Devon, and although Devon is not commonly perceived as a deprived area, because it has relatively small pockets of urban deprivation compared with cities in the South West like Plymouth and Bristol, further analysis reveals relatively high levels of rural deprivation. Devon has higher levels of rural deprivation than the national average and lower levels of urban deprivation. Issues include social isolation, a low wage economy, high housing and living costs and greater distance from services. Areas of North Devon and West Devon are most severely affected.

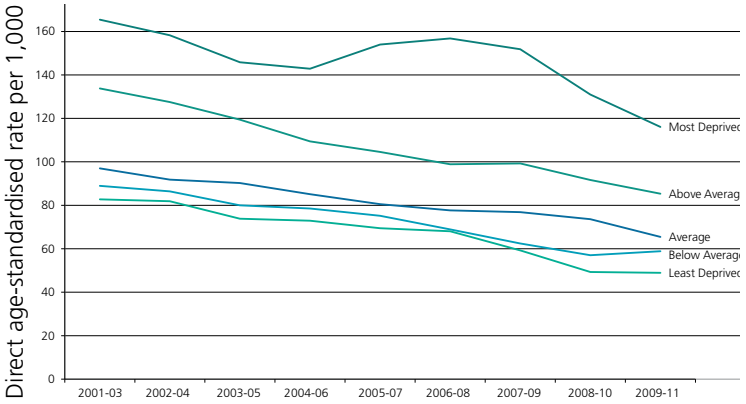
In terms of the gap between the least deprived and the most deprived in Devon, we had seen a stable gap following a fall in the period 2001-05 to 2002-06. This was in contrast to the national trend, and seen across the South West as a whole. In the period 2005-09 to 2006-10, there has been an increase in the male life expectancy gap which suggests that inequality has increased – a trend seen in England and the South West too. It should be noted that Devon still compares well with other parts of England, where the life expectancy gap for men is over three times that of Devon's.

For women, the change in the downward trend is more marked, although a similar position in relation to the rest of England is seen.

This is particularly important because the new commissioning organisations (local authorities, NHS England and clinical commissioning groups) all now have a statutory duty to reduce inequalities in health. The information available to us in relation to the gap in average life expectancy between the most deprived 10% in Devon versus the South West and England suggests that far more attention needs to be paid to tackling health inequality – increasing the health of the poorest much faster. Far more progress is needed in Devon's most deprived groups relative to the least deprived.

This is even more striking when we look at the changes in death rates from causes which can be influenced by healthcare, which shows the opposite of what is needed to tackle health inequality – in effect, Devon's healthcare services successfully improving the health of the most affluent much faster than that of the poorest – although this situation has improved since 2006-08, which suggests that NHS Devon (Devon Primary Care Trust) and its healthcare providers had much greater success than the predecessor NHS organisations. This trend sets the ambition for the future and is an indicator which we will be monitoring in future public health reports.

MORTALITY RATES FROM CAUSES CONSIDERED AMENABLE TO HEALTHCARE BY NATIONAL DEPRIVATION QUINTILE, DEVON, 2001-03 TO 2009-11



SOURCE: PUBLIC HEALTH MORTALITY FILES, ADAPTED FROM DATA FROM THE OFFICE FOR NATIONAL STATISTICS LICENSED UNDER THE OPEN GOVERNMENT LICENCE V.1.0; AND INDICES OF DEPRIVATION 2010, © CROWN COPYRIGHT 2011

Annual Public Health Report 2012-13 Summary
Health equality

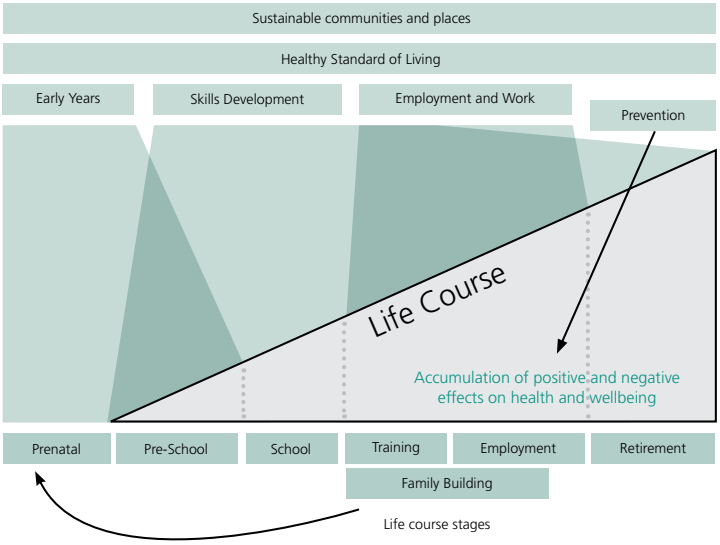
"It has been heartbreaking to see so many children's lives and potential wasted, all the more so for knowing that this could have been prevented by small investments in the early years of those lives. Getting this wrong has impacts way beyond the individual and family concerned: every taxpayer pays the cost of low educational achievement, poor work aspirations, drink and drug misuse, teenage pregnancy, criminality and unfulfilled lifetimes on benefits. But it is not just about money... it is about social disruption, fractured lives, broken families and sheer human waste."

Graham Allen MP, January 2011

A lifecourse approach: Professor Michael Marmot's review of health inequalities (Marmot, 2010) restated the importance of considering how people's circumstances contribute to their health and wellbeing over their whole life. The final report, 'Fair Society, Healthy Lives', was published in February 2010, and concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

A LIFECOURSE APPROACH TO HEALTH AND WELLBEING



SOURCE: MARMOT, M. (2010). 'FAIR SOCIETY, HEALTHY LIVES – THE REPORT OF THE MARMOT REVIEW'

Giving every child the best start in life means optimising health and wellbeing from pre-conception through transition to adulthood. In January 2012, the then Secretary of State for Health, the Rt Hon Andrew Lansley MP, established the Children and Young People's Health Outcomes Forum composed of individuals with a wide range of expertise and a shared commitment to improving the health of children and young people.

The Forum published a report in July 2012 which highlighted the number of poor health outcomes for our children, some of which were due to failures of care, and the fact that there is substantial and unexplained variation in many aspects of children's healthcare. As with adults, the United Kingdom compares unfavourably with many other countries in Europe for outcomes where improvements could be expected through better prevention and treatment (Wolfe *et al*, 2011). The Forum also noted wide differences in health outcomes relating to social gradient, resulting in health inequalities. One of the recommendations which is also to be found in the most recent Annual Report on Safeguarding Children for NHS Devon (NHS Devon, 2012), is to listen to the voice of the child in improving outcomes when commissioning services or developing strategies.

As well as the qualitative information which comes from children and young people, we lack good-quality information about lifestyles. The government has welcomed the Forum's request for the systematic collection of information, which we believe is critical to planning and evaluating public health and community interventions.

Given the importance of creating an environment where health and wellbeing flourishes, school provides a place where healthy behaviours can be modelled and reinforced, with children taking their healthy attitudes and

behaviours out of school and into their families and communities. Delivering the Food for Life Partnership and looking at the role of the school nurse are examples of work in this area which is intended to help us achieve the best health outcomes in schools.

Vulnerable populations: Vulnerability can be defined as not having the usual protection against developing ill-health – or being more susceptible to developing poor health. Children, older people, people with a learning disability, physical disability or mental health problems, substance misusers, travelling populations, homeless people or those in poor housing, people from minority ethnic groups, people in care settings or children in care – all of these have particular characteristics which make them susceptible to poorer health.

The vulnerability may extend beyond the individual to the family, where family circumstances, such as having a drug misuser or an alcoholic living in a domestic setting, or domestic or sexual abuse taking place, can create vulnerability in the children. It is important to consider the family circumstances when health or social care professionals come into contact with adults who have health or social issues.

Socio-economic deprivation leading to poverty can create vulnerability, among children or adults and older people, which is one of the reasons why public health analysis always considers the pattern of socio-economic deprivation in relation to health. Clustering of causes of vulnerability such as poverty, substance misuse, domestic violence, perhaps leading to criminality, creates a downward spiral of health and wellbeing which early intervention champions, such as MP Graham Allen, feel may be best tackled by prevention rather than cure, and much more cost-effectively for society.

Generic health improvement or commissioning policies will be unlikely to meet the needs of these groups, unless they recognise how vulnerability impacts on access to services. There are many examples of interventions such as screening or treatment programmes where the middle class or affluent sectors are well served by them, whereas poorer, more vulnerable people miss out. Dr Julian Tudor Hart's theory of the 'inverse care law' postulated that those with the greatest need for healthcare were the least likely to receive it, and that the quality of care was also inversely related to need (Hart, 1971). Sir Ian Kennedy's report on children's healthcare in 2010 (Kennedy, 2010) concluded that the health system has a poor track record in relation to children, a finding which was supported by the Children and Young People's Health Outcomes Forum. In relation to older people, the enquiry into the hundreds of avoidable deaths at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 shows how serious ignoring the needs of vulnerable people can be (Francis, 2013).

Health and Wellbeing Boards (see page 4 of this Summary) must by law consider the impact of their strategies on protected characteristics (such as gender, ethnicity and disability) as part of their public sector equality duty.

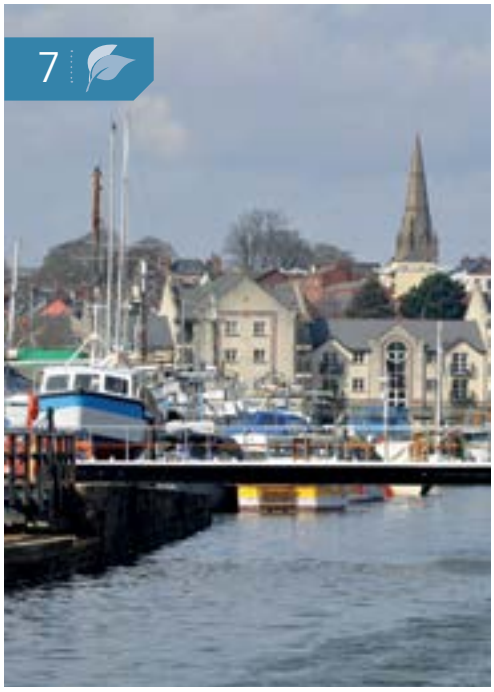
Safeguarding children and adults: Devon has carried out two in-depth joint strategic needs assessments of children and young people. These highly-focused pieces of work have highlighted the importance of risk factors such as substance misuse, mental health and domestic and sexual violence and abuse, in the safety and wellbeing of children and young people and vulnerable adults. Both reports contain recommendations which are being implemented by the respective statutory Safeguarding Boards. The link between assessing need and the business of the Safeguarding Boards is an important one. The reports and their implementation plans can be found at:

http://devonsafeguarding.org

Or search: JSNA of children and young people Devon

REFERENCES

See page 49 of the full Annual Public Health Report 2012-13. This is available on the Devon Health and Wellbeing website.



Annual Public Health Report 2012-13 Summary
Improving health: determinants of health

Social and economic determinants of health are as important as health improvement or healthcare interventions in people's health and wellbeing.

Poverty: There is a direct relationship between poverty and health. Associations include unemployment, poor housing, poor educational achievement, and lifestylefactors such as exposure to smoking and a poor-quality diet.

For children, poverty is particularly damaging and we have seen child poverty increase over the last 30 years. The Joseph Rowntree Foundation estimates that in 1968 in this country one in ten children lived in poverty, but by 1995 this had risen to one in three. In 2010-11 the number of children in poverty was estimated at 2.3 million. The impact of the recession and welfare reform will mean that the proportion of children and families living in absolute poverty will increase (Brewer and Joyce, 2010). Over the last ten years, the financial situation of people in England has changed, with the poor becoming much worse off (Cribb *et al*, 2012) and this will impact both on their health and their use of health and social care services.

Educational attainment: Higher educational attainment leads to a better chance of employment and less likelihood of poverty. There is a close relationship between low educational attainment and risk-taking behaviours, some resulting in lifelong impacts such as teenage pregnancy. Aspiration is thought to be a major factor in educational achievement, with research suggesting that parental involvement in shaping children's aspirations is the factor most likely to lead to improvement (Carter-Wall and Whitfield, 2012).

Economic activity and employment: Wealth and health have always been intimately related. Extensive research carried out by Richard Wilkinson (Professor Emeritus of Social Epidemiology at the University of Nottingham at the time of witing), has continued to demonstrate the direct relationship between economic status and health. Author of the bestselling book *The Spirit Level* (Wilkinson and Pickett, 2009), he explores the importance of the differences between us in society (including the relationship between income differences) and health. In a TED Talk, you can listen to Richard Wilkinson describing the relationship between economic inequality and health, showing what happens when rich and poor are too far apart: there are effects on health, life expectancy and measures of social capital, such as trust.

https://www.ted.com/talks/richard_wilkinson.html

Or search: Richard Wilkinson: How economic inequality harms societies

While this can be seen as a national political issue, income inequality is something that all employers can consider.

Promoting health in the workplace is a way of improving the productivity of the workforce. In Devon, workforce productivity has been chosen as a priority by the Heart of the South West Local Enterprise Partnership. Some rural parts of Devon, such as Torridge District Council, have real challenges in terms of wage levels and employment opportunities. Some areas in Devon, such as Teignbridge, have been actively working with local businesses on providing support to help employees stop smoking. There are other benefits to be gained from a broader approach to health and wellbeing at work, and this is an approach that should be adopted given the new public health responsibility of local authorities for promoting workplace health.

Socilal isolation and loneliness: Loneliness is associated with poor physical and mental health. It is the quality of social interaction rather than the quantity that appears to be important (Hole, 2012). An important piece of research (Holt-Lunstad *et al*, 2010) analysed the data from

Annual Public Health Report 2012-13 Summary
Improving health: determinants of health

148 separate research studies to explore how social relationships impacted on the mortality risk. They found a 50% greater likelihood of survival for people with stronger social relationships compared with those who had weaker relationships. This highly significant finding suggests that combating loneliness, through projects such as 'Connected Communities', may be as good for people's health as conventional health improvement interventions.

Housing: Poor housing is a contributory factor to poor health. Cold, damp houses create health problems, some of which are reflected in excess seasonal mortality (excess deaths in winter from pneumonia or heart disease, for example). Last year's Annual Public Health Report (2011-12) showed how significantly housing and living conditions had improved over the last 60 years. Nevertheless, the quantity and condition of housing and the link to preventable injury and illness needs to be recognised as a continuing public health issue. Devon has already undertaken detailed needs assessments to explore the impact of homelessness on health, which is profound.

We also know the health risks of houses in multiple occupation, where the house is shared by more than one household and common areas (for example, kitchens and bathrooms) are shared. These properties are often in poorer condition than normal residential properties and residents have an increased risk of health hazards such as fires and accidents. Social housing is increasingly provided by housing associations, which have a role in improving health and wellbeing through specific initiatives including the prevention of loneliness.

Environment: The environment in which we live affects health through direct contact with pollutants (such as noise, traffic exhaust fumes, radon gas) and indirectly through the access to things that promote health and wellbeing such as opportunities for recreational and sporting activities.

Devon's natural heritage (coast and countryside) provides an unparallelled opportunity for improving health and wellbeing, as explored in a recent report, 'Natural Solutions' by the New Economics Foundation (2012). The emergence of the Devon Local Nature Partnership, a new statutory partnership for promoting the local natural environment, provides a forum for exploring the impact of the environment on health.

The natural environment includes landscape, wildlife, water, urban green space and links to work on climate change, sustainability and risks such as flooding and coastal erosion. The State of the Environment report, which provides the basis for its strategy, should be linked to the work of the Devon Health and Wellbeing Board and the health benefits of developing the natural environment.

Sustainable communities: In the context of a public health report, environmental justice may be defined as the right to a healthy environment. A report in 2008 by the Faculty of Public Health noted that:

"Poor quality environments and ill-health are found disproportionately amongst the disadvantaged in society, and contribute to health inequalities. Disadvantaged communities are more exposed to hazards, such as pollution and poor air quality, and will often lack access to safe green spaces. Factory emissions, high traffic levels and consequent respiratory problems are more prevalent in disadvantaged areas. Environmental problems impact most heavily on the most vulnerable."

(FACULTY OF PUBLIC HEALTH, 2008)

As well as the current impacts of the environment on health, the World Health Organisation and World Meteorological Organisation have assessed the impact of climate change on health in the 2012 report 'Atlas of Health and Climate', a summary of which can be found at:

http://undertheweather.eu/

For full report search: Atlas of Health and Climate 2012

The Department of Health recommended the use of a common solution to multiple problems and called this a 'syndemic' – so interventions to combat the epidemic of obesity through reduced car use also reduces carbon emissions; reducing meat intake for a healthier diet also reduces methane production by cattle farmed for meat production. Fewer resources are consumed by producing a kilogram of grain compared with producing a kilogram of meat.

When considering sustainability, we seek to meet the needs of our current populations without compromising the needs of future generations (Watts, 2009). Longer-term planning is the key to this, and one of the reasons why the Joint Strategic Needs Assessment must consider changing population needs in their widest sense.

REFERENCES

See page 69 of the full Annual Public Health Report 2012-13. This is available on the Devon Health and Wellbeing website.

Annual Public Health Report 2012-13 Summary Improving health: lifestyle and public health interventions

Breastfeeding: Breastfeeding confers long-term benefits on the baby, and provides a healthy start to life. Thanks to a national drive to collect information on breastfeeding, we are able to monitor women's breastfeeding status in Devon at six to eight weeks after the birth. Levels of recording and breastfeeding prevalence have tended to stay above the national average in Devon but this has flattened off over the last two years and we need to do more to ensure that maternity units, midwives, health visitors and GPs are working with local voluntary sector assist organisations and peer supporters to support as many women who wish to breastfeed as possible.

Smoking cessation: In Devon, smoking has been a top priority for the last five years, because it comes out as the best way of tackling health inequality. Smoking accounts for half the difference in life expectancy between the richest and poorest parts of our society. It is the most powerful lever we have to tackle the health inequalities gap. In relation to keeping our children safe, and the future likelihood of poor health and health inequality, smoking is a decision of childhood – 84% of smokers start smoking at age 19 or under.

Devon's Smokefree strategy has an overall vision of reducing prevalence by 1% a year from 18.1% to 15% by the end of 2015. Underlying this vision are seven supporting priorities:

1. Reduce health inequalities caused by smoking
2. Reduce illicit tobacco in the community
3. Protect children and young people from smoking
4. Reduce smoking in pregnancy
5. Normalise a smokefree lifestyle
6. Support smokers to quit
7. Carry out marketing and communication programmes.

The cost of smoking to society in Devon (including smoking-related lost productivity, absenteeism, litter cleaning, house fires), and to the NHS, is estimated to be £191.3 million. Reducing smoking prevalence will have clear benefits for Devon's economy, boosting the disposable income of the poorest people in the population.

Healthy weight: Results from the 2011-12 National Child Measurement Programme indicate that recording levels have continued to improve, and levels of childhood obesity have dropped. Levels of obesity in year six are slightly above the local targets for 2011-12, but all other targets have been successfully achieved. We have recorded falling levels of obesity in reception year over the last few years, and a reduction on the 2010-11 level in year six, with strong, consistent improvements in participation rates. The prevalence of childhood obesity was lowest in East Devon, the South Hams and Northern Devon. Greater variation was seen in obesity levels in year six, with the highest rates in Mid Devon, Teignbridge and West Devon. Participation in this programme enables children to access the appropriate professional advice and support as well as providing a mechanism for us to support physical activity and healthy eating programmes within those local learning communities with the greatest need.

Alcohol: Excessive alcohol consumption is associated with high blood pressure, obesity and liver damage, as well as a loss of control resulting in an increase in violence and accidents, including adomestic and sexual violence and abuse. Alcohol consumption is often associated with suicide attempts. Identification of alcohol as a health priority in 2007 led to considerable investment in prevention and treatment services by the NHS in Devon, with a consequent slowing down of alcohol-related admissions to hospital. Admission rates in Devon are well below average and among the lowest in the South West.

Annual Public Health Report 2012-13 Summary
Improving health: lifestyle and public health interventions

Cancer prevention: Premature deaths – those under the age of 75 years – from cancers of the lung, breast, pancreas, colon, oesophagus and prostate – can be reduced by lifestyle changes and avoidance of risk factors. Over the last three years several high-profile campaigns have been run in Devon to encourage people to seek treatment early and new screening programmes have been introduced. Cancer registration rates have increased over the last six years, mainly due to improved detection.

While for most cancers Devon's local trend does not vary from the national trend, registrations for skin cancer show how Devon varies from the national trend, with a striking increase in incidence. Given that much skin cancer is preventable therough the protection of the skin from excessive sunlight, this remains a local priority.

Lung cancer is the second commonest cause of death in people under the age of 75. Like skin cancer, much lung cancer is preventable as its main cause is smoking. While Devon's rates are lower than England's, the registration rates reflect the trend in diagnosis, as smoking rates in the population have decreased, but also reflect the lack of any screening test for lung cancer. Recent national and local campaigns have therefore focused on prevention and trying to encourage people with persistent coughs or blood in their sputum to see their GP earlier rather than later.

Although our trend data shows a reduction in premature mortality, there is some suggestion that the reduction locally has not been as great as the national reductions. We should seek to avoid people becoming unwell earlier in their lives and therefore living with the burden of illness for longer. As some populations are more likely to develop disease earlier, particularly those people living in areas which are socio-economically deprived, who are less likely to seek help if they do become ill, we need to ensure that they do not experience the 'double disadvantage' of worse healthcare as well. Health equity audits are a way of answering this question, and social marketing tools can help to influence health-seeking behaviours.

Mental health: Emotional health and wellbeing are as important as physical health. Financial pressures on young people and families increase at a time of recession – and we have seen an increasing trend in suicides of young men nationally and locally. Local authority public health responsibilities include suicide prevention – and, despite much good work being done, a change in patterns means a review is required.

The increase in dementia associated with an ageing population presents Devon with a different type of mental health challenge. We are facing a huge increase in future numbers which health and social care commissioners will need to plan for. This impacts on carers as well, who are a vital part of the support system for people living with dementia.

According to the first Subjective Well-being Annual Population Survey (2012), Devon has very high 'happiness' scores. A map showing how Devon compares with the rest of the United Kingdom can be found at:

http://www.neighbourhood.statistics.gov.uk/HTML-Docs/dvc34/Well-being_map.html

Or search: Wellbeing estimates map

Nevertheless there are still opportunities to improve wider mental health – so we are developing a public mental health strategy, to see what the most effective interventions are to prevent loneliness and improve social interactions.

Sexual health: New diagnoses of STIs have risen steadily in England over the last ten years. In Devon we have seen increasing sexually transmitted infections, including HIV, but a reduction in teenage pregnancy rates. Chlamydia is the commonest sexually transmitted infection as we now have increased detection due to the National Chlamydia Screening Programme.

Devon County Council is now the commissioner of sexual health services (except for HIV services, Sexual Assault Referral Centres and primary care contraceptive services, which are the responsibility of NHS England, and terminations of pregnancy which are commissioned by CCGs). The complexity of the commissioning arrangements should be addressed through the development of a new a sexual health partnership to ensure that outcomes improve in this area where health inequality exists.

Accident prevention: Of all the 'Our Healthier Nation' mortality trends, death rates due to accidental injury have increased, unlike the others which have all decreased. Deaths due to falls are the main issue, and Devon has recently published an updated 'Falls and Bone Health' strategy. As this is an area where prevention works, be it through developing better balance for older people through promoting physical activity, or by reducing road deaths and injury by reducing speed limits, this is an area where more detailed work is required to look at how best to target interventions. The challenge is to develop approaches which do not make people too risk averse to physical activity, encouraging games, sport and activities which will improve health and wellbeing.

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Protecting health

Communicable diseases: Public Health England is now responsible for monitoring and responding to communicable diseases. Over the last five years, diseases preventable by immunisation have increased, notably measles, mumps, pertussis (whooping cough) and hepatitis.

Healthcare associated infections: Over the period 2007-13 there has been a striking reduction in diagnoses of MRSA (Meticillin Resistant Staphylococcus Aureus) as a result of continued focus by the NHS on the screening and treatment (decolonisation) of patients. Numbers are now so low that it is unusual to see a case in Devon. The focus has shifted to Clostridium difficile. Broad-spectrum antibiotics are usually the cause, as they alter the balance between the healthy gut bacteria and C. diff. Every year there is a campaign to increase antibiotic awareness, to reduce unnecessary prescribing of antibiotics, which is the cause of increasing antibiotic resistance, but also to reduce the occurrence of C. diff.

It is recommended that social marketing techniques are used to devise a local campaign with the aim of reducing unnecessary antibiotic prescribing and reducing the expectation of antibiotics being prescribed by the public.

Emergency planning: New arrangements are in place from April 2013 where NHS England takes over the responsibility for emergency planning, preparedness and response (EPRR) from primary care trusts. Previously the Devon Public Health team led the PCT's responsibilities for planning for and responding to major incidents.

The Director of Public Health is now responsible for exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health, and a responsibility for ensuring that plans are in place to protect the health of their local population, whether from communicable disease threats or major incidents. The working relationship between the local partners is effected through the Local Health Resilience Partnership which is a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies and offers a coordinated point of contact.

Immunisation: Since 2007, immunisation uptake rates have increased steadily and the latest results suggest that Devon is doing well against targets. Despite this, MMR uptake rates at age five are below the average South West rate. Much effort has been expended in those areas where MMR uptake is low, such as South Devon. A small outbreak of measles occurred in North Devon in early 2013 due to lower protection levels in the community. At the time of writing there is a major catch-up immunisation campaign underway for those young people aged 10-16 whose parents were less likely to have had their children immunised 10 years ago.

Screening programmes: There is an extensive range of national screening programmes, with new programmes being introduced over the last five years such as Abdominal Aortic Aneurysm (AAA) screening and bowel cancer screening. The well-established cervical cancer and breast cancer screening programmes have a target to reach 80% of the eligible population by 2013 and services in Devon show good progress towards this target. A health equity audit of programmes should establish variation in local uptake and make recommendations on improving this, while every opportunity should be taken to promote the benefits of immunisation, including the new programmes being introduced in 2013, namely shingles immunisation, influenza immunisation for children, rotavirus immunisation for children, and Meningitis C immunisation for older children.

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5 Health equality in Devon

R 5.1 A high-quality lifestyle survey of young people should be commissioned to provide a baseline for health and wellbeing improvement in Devon.

R 5.2 Devon County Council, working with all schools, should commission evidence-based interventions to improve children and young people's health, for example healthy eating and physical activity programmes.

R 5.3 Evidence should be sought that the school nursing service, commissioned by Devon County Council from April 2013, is improving young people's health and wellbeing.

R5.4 The Health and Wellbeing Board and Local Authority Scrutiny Committee should use health equity audits to review how well the needs of the most vulnerable (or those with protected characteristics) are being met.

R5.5 The updated Joint Strategic Needs Assessments for Children and Adult Safeguarding should describe how successfully improvements are being made in children's and adults' health, wellbeing and safety.

R5.6 Detailed needs assessments should be considered for all vulnerable groups to help target resources to improve their health and wellbeing.

R5.7 All NHS commissioning plans must provide details about how they will fulfil their statutory duty to reduce health inequality, so that it is explicit how they will improve the health of the poorest in Devon even faster.

6 Improving health

R6.1 Social and economic determinants of health are as important as health improvement or healthcare interventions in people's health and wellbeing. Local authorities and strategic partnerships, such as the Local Enterprise Partnership, should include the health impact of local economic and social strategies.

R6.2 Public health should review seasonal mortality rates in Devon and produce recommendations on reducing excess deaths.

R 6.3 Devon County Council should continue to work with Devon's housing officers and housing associations to promote good housing and good health.

R 6.4 Employers should be supported and encouraged to promote health in the workplace through a healthy workplace accrediation scheme, to promote workforce productivity, developed in collaboration with the Local Enterprise Partnership.

R 6.5 The State of the Environment report should include links to health and wellbeing.

R 6.6 Commissioners should ensure that maternity units, midwives, GPs, health visitors and Children's Centres are working with local voluntary-sector support organisations and peer supporters to support as many women who wish to breastfeed as possible.

R 6.7 Tobacco control and smoking cessation initiatives are central to tackling health inequality, protecting the health of the worst off, and protecting our young people. This should continue to be a top priority for Devon County Council and the Devon Health and Wellbeing Board.

R 6.8 Alcohol misuse should be reduced, and this should be a priority for the criminal justice system as well as health.

R 6.9 Consideration should be given to commissioning an adult lifestyle survey to provide detailed baseline information on health behaviours and health status in Devon which is not currently available.

R 6.10 The Devon Accident Prevention Strategy should be reviewed to help target public health interventions with the aim of reducing the upward trend in mortality.

R 6.11 A Devon sexual health partnership should be established to ensure we continue to work on improving sexual health outcomes and reducing sexual health inequality.

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R 6.12 A new suicide prevention strategy should be prepared for Devon, reflecting the new commissioning responsibilities.

R 6.13 Social marketing programmes should target those areas where health can be improved fastest.

R 6.14 A public mental health strategy should be developed to reflect the new local authority responsibility for public mental health.

7 Protecting health

R 7.1 Every opportunity should be taken to promote the benefits of immunisation, including the new programmes being introduced in 2013, namely shingles immunisation, influenza immunisation for children, rotavirus immunisation for children, and Meningitis C immunisation for older children.

R 7.2 A social marketing campaign should be developed with the aim of reducing the expectation of, and prescribing of, unnecessary antibiotics to combat antimicrobial resistance and help further reduce cases of Clostridium difficile.

R 7.3 The Devon Health and Wellbeing Board should establish a Health Protection Subcommittee which provides the governance for assurance on all health protection matters, including communicable diseases, healthcare associated infections, screening and immunisation programmes and emergency preparedness, planning and response (EPRR).

R 7.4 A health equity audit of screening programmes should establish variation in uptake of local screening programmes and make recommendations on improving uptake.

8 Recommendations from previous annual public health reports

R 8.1 A health equity audit should be undertaken of the availability of high-quality care before pregnancy, with all women being able to access advice, information, support and the antenatal screening they require.

R 8.2 Immunisation uptake rates should be scrutinised for evidence of increasing uptake.

R 8.3 Review Public Health Nursing caseload audit and include in refresh of Joint Strategic Needs Assessment for Safeguarding Children.

R 8.4 An audit to be undertaken of prevalence of obesity in pregnant women and success of interventions.

R 8.5 A health equity audit to be undertaken of access by people with learning disabilities to public health promotion programmes such as weight management, physical activity and screening programmes.

R 8.6 Devon Health and Wellbeing Board to ensure safeguarding children and families remains a high priority in the Joint Health and Wellbeing Strategy.

R 8.7 Audit of swimming pool managers and premises alongside analysis of reports of outbreaks of diarrhoea associated with pool use.

R 8.8 Commissioners to audit whether improved access to psychological therapies is improving mental health outcomes and reducing the prescribing of medication.

R 8.9 Commissioners to seek assurance that care home provision is of high quality, linked with community mental health teams and that they comply with the requirements for prescribing anti-psychotic medication.

R 8.10 Health equity audit to be undertaken of falls.

R 8.11 Health equity audit to establish what the most effective interventions should be to improve the health of the most deprived groups, to target health inequality.

R 8.12 Health equity audit of health of older people's access to health improvement opportunities and healthcare services.

R 8.13 Social marketing programmes to be aligned to R8.10, R8.11 and R8.12.

R 8.14 Health Inequalities Intervention Tool methodology to be used analyse other conditions, for example, diabetes, bone health and cardiovascular disease.

R 8.15 Health equity audits to be published on Devon Health and Wellbeing website.

If you would like this summary in a different format such as large print or Braille, please contact:

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The full Annual Public Health Report 2012-13 and previous Devon Annual Public Health Reports can also be found at:
www.devonhealthandwellbeing.org.uk/aphr

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