Democratic and Members Support
Chief Executive's Department

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#healthyplym

HEALTH AND WELLBEING BOARD

Thursday 20 November 2014
10 am
Warspite Room, Council House

Members:
Councillor Sue McDonald (Chair)
Councillors Ian Tuffin and Dr John Mahony.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative, NHS England Devon Cornwall and the Isles of Scilly representative.

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

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Tracey Lee
Chief Executive

HEALTH AND WELLBEING BOARD

PART I (PUBLIC COMMITTEE)

1. APOLOGIES

To receive apologies for non-attendance by Health and Wellbeing Board Members.

2. DECLARATIONS OF INTEREST

The Board will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business, which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. MINUTES **(Pages 1 - 8)**

To confirm the minutes of the meeting held on the 4 September 2014.

5. CORRESPONDENCE

The Board to note the following correspondence.

5.1. Mental Health Crisis Care Concordat **(Pages 9 - 12)**

5.2. Tobacco Pledge **(Pages 13 - 14)**

6. HEALTHWATCH

The Board to receive a presentation from Healthwatch.

7. GOVERNANCE AND MEMBERSHIP **(Pages 15 - 24)**

The Board to note the governance and membership of the Children and Young People's Partnership.

8. 4-4-54 **(Pages 25 - 48)**

The Board to receive a report on 4-4-54.

9. PLYMOUTH REPORT **(Pages 49 - 196)**

The Board to receive the Plymouth Report.

10. WELLBEING SURVEY (Pages 197 - 204)

The Board to receive the Wellbeing Survey.

11. PHARMACEUTICAL NEEDS ASSESSMENT

The Board to receive an update on the Pharmaceutical Needs Assessment.

12. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

Nil.

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Health and Wellbeing Board

Thursday 4 September 2014

PRESENT:

Councillor McDonald, in the Chair.
Kelechi Nnoaham – Director of Public Health, Vice Chair for this meeting.

Ian Ansell – Office of the Police and Crime Commissioner, Kevin Baber – Plymouth NHS Hospitals Trust, David Bearman - Devon Local Pharmaceutical Committee, C/Supt Andy Boulting - Devon and Cornwall Police, Carole Burgoyne - Plymouth City Council, Peter Edwards - Healthwatch, Amanda Fisk - NHS England Devon Cornwall and the Isles of Scilly, Tony Fuqua - Voluntary and Community Sector, Councillor Dr. Mahony, Steve Waite - Plymouth Community Healthcare and Val Woodward – Voluntary and Community Sector.

Apologies for absence: Veryan Barneby – Voluntary and Community Sector, Jerry Clough - NEW Devon CCG, Dr Paul Hardy - NEW Devon CCG, Dr Richard Stephenson - University of Plymouth, Councillor Tuffin and Clive Turner – Plymouth Community Homes.

Also in attendance: Craig McArdle – Plymouth City Council, Dave Spencer – NEW Devon CCG, Ross Jago – Plymouth City Council, Julie Frier – Public Health, Laura Juett – Public Health , Sarah Ogilvie – Public Health and Amelia Boulter – Plymouth City Council.

The meeting started at 10.00 am and finished at 12.40 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

12. DECLARATIONS OF INTEREST

There were no declarations of interest made.

13. CHAIR'S URGENT BUSINESS

The Chair reported that 6,000 questionnaires were sent to randomly selected people across the city as part of a jointly funded venture between Plymouth City Council and Public Health England. The aim of the questionnaire was to gain a picture of the city's wellbeing and lifestyle and would form a baseline for Public Health and the Plymouth Plan. The Board would be provided with a report at the November meeting.

14. MINUTES

Agreed that the minutes of the meeting of 12 June 2014 were confirmed.

15. **CORRESPONDENCE**

(a) DIGITAL FUND BID/TECHNOLOGY FUND

The Board noted the Digital Fund Bid. A further update would be provided at a future meeting.

(b) FAIRNESS COMMISSION

The Board noted the letter to Dame Suzi Leather on the Fairness Commission Report. A small working group as agreed at the last Board meeting would look at the recommendations and form a response.

16. **PHARMACEUTICAL NEEDS ASSESSMENT**

David Bearman, Devon Local Pharmaceutical Committee provided the Board with an update on the process they were adopting in relation to the pharmaceutical needs assessment. It was reported that –

(a) it was a statutory duty of the Health and Wellbeing Board to be aware of the legal duty to publish a Pharmaceutical Needs Assessment by 1 April 2015;

(b) they had taken a collaborative approach working together with Plymouth, Devon, Torbay and Cornwall to devise a structured assessment across these areas;

(c) a draft document would be consulted on from 10 November 2014 to 9 January 2015 with the final version to the Board in February 2015 for sign off.

In response to questions raised, it was reported that voluntary and community groups would be consulted with and that Board members had a responsibility to take this back to their organisations and community groups for that wider consultation and feedback their views.

The following comments were made by Board members –

(d) this was a useful tool to be fed into Education SW to develop the workforce and to inform workforce issues;

(e) that a further recommendation be put forward to look at the delivery of pharmaceutical needs of people within a domiciliary setting.

Agreed that the Health and Wellbeing Board -

1. Note the statutory duty to produce a pharmaceutical needs assessment by 1 April 2015.

2. Endorse the approach to produce the Pharmaceutical Needs Assessment (PNA) for Plymouth to receive progress reports and be consulted on the final draft on the 20 November 2014 with final sign off by the Health and Wellbeing Board at the meeting of 5 February 2015.

3. Look at the delivery of pharmaceutical needs of people within a domiciliary setting.

17. CHALLENGED HEALTH ECONOMIES AND STRATEGIC PRIORITIES

Ben Chilcott, NEW Devon CCG provided the Board with an update on Local NHS Futures (previously Financially Challenged Health Economy). It was reported that there would be 9 work streams with a strategic group to oversee the work. The work of groups would be discussed at the Programme Board meeting on 22 September 2014. All partner organisations to contribute financially or provide people. This Board would be provided with regular updates.

The Board made the following comments -

(a) this was not just about the clinical commissioning group but about retaining overview, support and scrutiny as this moves forward and would be helpful to receive regular updates to this board;

(b) we are all actively involved in the work streams and for those colleagues not actively engaged perhaps at the next meeting a simple overview should be provided to ensure that everyone makes a contribution;

(c) workstream to include projects on prevention and not just a focus on the acute end but embedding prevention.

Agreed that –

1. the Health and Wellbeing Board welcomes the breadth of this paper and requests that the work stream includes a strong emphasis on prevention.

2. the Health and Wellbeing Board to receive further updates and request that the Caring Plymouth Panel undertake scrutiny on this.

18. **BETTER CARE FUND**

Craig McArdle, Plymouth City Council, Dave Spencer and Ben Chilcott, NEW Devon CCG provided the Board with an update on the Better Care Fund (BCF). It was reported that –

(a) nationally it was felt that the original BCF would not change the balance of care in those communities. We were asked to complete a more detailed template and have more engagement with partners and acute providers working to tight timescale to submit the completed template by 19 September 2014;

(b) the Plymouth BCF was identified as area that would benefit from additional support;

(c) the BCF was only part of the bigger system and important to note this. This vision had driven our activity and as a result set up the Integrated Health and Wellbeing Programme as agreed by the Clinical Commissioning Group (CCG) and Plymouth City Council;

(d) there were a few changes to the metrics since we last presented in March. A change to non-elective admissions with a target set nationally at 3.5% and looking to keep the dementia metric.

In response to questions raised, it was reported that -

(e) the BCF was a proportion of the wider system change and by understanding the BCF would help us understand the changes, the scope and the focus on the prevention. The Board needs to understand the challenges and benefits that the BCF would bring;

(f) the non-elective metric to achieve 3.5% reduction represents a significant challenge to the system. This was a very challenging metric;

(g) the Plymouth Hospital NHS Trust were looking at 3 BCF templates, Plymouth, Devon and Cornwall. There was a need to understand the pace and make sure if we are aligning schemes that we back he tight ones;

(h) they were honest with the temperature check and the additional support had given them the capacity for wider planning. They were using intelligence and advice at the heart of the process which allowed them to focus on areas of weakness and to identify the cohorts that would benefit from the changes.

(i) a focus on being a Dementia Friendly City was important.

Agreed that -

1. authority is delegated to the Health and Wellbeing Board to sign off the paper via the Assistant Director of Joint Commissioning and Adult Social Care in consultation with the Chair of the Health and Wellbeing Board and the Director of Public Health when the final template is available.

2. the Health and Wellbeing Board commend the Better Care Fund to Cabinet in November.

19. **ALCOHOL PLAN UPDATE**

Laura Juett, Senior Public Health Manager provided the Board with an update on the Strategic Alcohol Plan for Plymouth 2013 – 2018. It was reported that –

(a) the dashboard sits alongside the plans and describes the scale of the issue, benchmarks the position, demonstrate progress over time and highlights the on-going challenges;

(b) alcohol related hospital admissions in Plymouth were higher than the national average. In 2012/13 saw the first drop in hospital admissions since 2008;

(c) the 2014 Wellbeing Survey would provide a baseline in reported levels of alcohol consumption to gain a better understanding on how much people were drinking;

(d) Devon and Cornwall Police were working to improve the recording and reporting of alcohol related offences. In early 2015 they would be providing trend data and breakdown by neighbourhood;

(e) that children affected by parental alcohol misuse was difficult to record and more intelligence was needed. The Health Visitor Caseload Survey undertaken every 2 years records a series of health needs from families across the city with children under the age of 5 years should gather more intelligence;

(f) the detailed implementation plan shows areas of progress and challenges in the following areas :
- Prevent;
- Protect;
- Treat;
- Enforce and control.

In response to questions raised, it was reported that -

(g) they hadn't set specific measures but were looking at an overall reduction in alcohol consumption across the city;

(h) the voluntary and community sector (vcs) were involved in a series of initiatives in delivering the Strategic Alcohol Plan such as 'the reduction of full strength alcohol campaign' led by the Shekinah Mission and Harbour Drug and Alcohol Services working in partnership with the local authority. Treatment services delivered by the vcs were very much a core part of the successful delivery of the plan;

(i) the licensing policy was amended to make much better use of control measures for licensed premises and they were working with the responsible authorities to respond to licensing applications and reviews;

(j) the Evening and Night Time Economy (ENTE) forms part of the enforce and control aspect. They were working with the Business Improvement Districts (BID) areas to create safer environments, ensuring people do not enter a BID area drunk and working with premises to ensure they do not serve alcohol to people that were drunk and how we get the balance for a vibrant economy for ENTE with licenced premises acting responsibly;

(k) the Chair would continue to have regular meeting with the Chair of the Growth Board. The Growth Board Chair supports the aims of the Health and Wellbeing Board and wants people to go out and enjoy the city safely;

(l) mental health was covered within treatment services that deliver services for dual diagnosis. Further development of the Alcohol Liaison Service would see those people with dual diagnosis and builds the capacity and links between the hospital and community based mental health services;

(m) the dashboard was developed to give an indication of the position on the overall objectives set and the implementation plan provides a sense of whose involved with the plan. The Alcohol Programme Board chaired by the Director of Public Health has a number of partners across the city sitting on the board;

(n) the Strategic Alcohol Plan was not the responsibility Public Health but the responsibility of this Board. Public Health co-ordinates the delivery of the plan and this board agreed to this and wanted to provide the assurance that different partners were engaged with the delivery;

A discussion took place on whether this Board had the delegated authority to approve the financial requirements as set in the recommendations. The Board were asked to think about its role and remit to make resolutions in both human and fiscal investment to meet the strategic aims. The Board then agreed to slightly amend recommendation 2.

Agreed that –

1. Health and Wellbeing Board members consider the proposed dashboard as the annual performance framework for the Strategic Alcohol Plan for Plymouth 2013 – 2018. Specifically the Board is asked to –

    - financially support further editions of the Wellbeing Survey to measure consumption levels;

    - support the development of the proposed police flagging system to record alcohol related violence;
    - support further development of the alcohol related anti-social behaviour indicator;
    - consider inclusion of number of child protection cases where parental alcohol misuse is a factor as an additional indicator.

2. The Health and Wellbeing Board supports a sustainable hospital alcohol liaison service, as stated in the previously agreed Strategic Alcohol Plan for Plymouth.

20. **HEALTHY WEIGHT PLAN**

Sarah Ogilvie, Specialist Registrar in Public Health provided the Board with an update on Plymouth's Healthy Lives for Healthy Weight Action Plan (draft). It was reported that the aim of the action plan was to enable all Plymouth citizens to achieve and maintain healthy lives for healthy weight. To achieve this, the action plan has 4 strategic aims:

- to build a strategic, sustainable and city-wide approach to promoting healthy lives for healthy weight;
- to create and develop active, health promoting environments where we live, play, learn and work;
- to give all children the best start and support the achievement of healthy lives for healthy weight in their families and communities;
- to ensure effective prevention, identification, early intervention and management of obesity in children and adults.

In response to questions raised, it was reported that the action plan was still very much in a draft format. They were in the process of developing a framework looking at how they work with a wide range of community groups.

Agreed that the Health and Wellbeing Board -

1. Note progress and support further development of the Action Plan and fit with the Health and Wellbeing Board's Strategic Priority 2 ('Healthy Weight').

2. Are asked to provide feedback on the plan regarding significant omissions or suggested edits.

3. Receive a final draft of the Healthy Weight Plan for the Board to review at a future meeting.

21. CLINICAL COMMISSIONING GROUP - QUALITY PREMIUM

Dave Spencer, NEW Devon CCG provided the Board with a report on the Quality Premium. It was reported that the Quality Premium was intended to reward clinical commissioning groups for achieving improvements in particular outcomes and reducing inequalities. A discussion took place on whether the quality premium could be achieved because of the challenged health economy and may warrant further scrutiny.

Agreed that –

1. The Health and Wellbeing Board are requested to support the recommendation to use the dementia diagnosis rate as the local metric for NEW Devon CCG.

2. The Health and Wellbeing Board are requested to support the improvement trajectories as set out in Section 2 of the report.

22. WORK PROGRAMME

The Board noted the work programme.

23. EXEMPT BUSINESS

There were no items of exempt business.

Department of Health | Home Office

From Rt Hon Norman Lamb MP
Minister of State for Care and Support
Department of Health
Richmond House
79 Whitehall
London SW1A 2NA

Rt Hon Mike Penning MP
Minister of State for Policing & Criminal Justice, Home Office
Home Office
2 Marsham St
London SW1P 4DF
Home Office

27 AUG 2014

To: Chairs of Health and Wellbeing Boards

MENTAL HEALTH CRISIS CARE CONCORDAT: Making change happen in your area

We are writing to make sure that leaders in every area recognise that they are expected to sign up to local declarations, demonstrating how they will implement the standards in the Crisis Care Concordat locally.

In February this year, the Department of Health and Home Office published the mental health Crisis Care Concordat. This sets out the standards that people experiencing a mental health crisis should expect of the public services that respond to their needs. It is available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

The Concordat is a joint agreement, written and agreed by over 20 national signatory organisations, including NHS England, the Home Office, the Association of Chief Police Officers, the LGA and ADASS, and the medical Royal Colleges.

Collaborative working

We are writing to describe the range of opportunities for Health and Wellbeing Boards to access support to develop a mental health concordat for their local communities, and to urge you to get involved in this work. These crisis responses typically involve the police, social services, mental health services and emergency care. The Concordat is about improving the way these services work together, to make sure that people in crisis get the care they need in the appropriate place.

Use of police cells

You will be aware that in around a third of the cases in which police officers detain people they believe to be in a mental health crisis, these people end up being taken to police custody, despite committing no crime. Last year, this happened nearly 8,000 times. The Concordat includes a commitment to halve the numbers who end up in police cells in this financial year, and to end the practice of placing under 18s in police cells.

National commitment

The Concordat is about the national commitment and action required to improve this situation. But we know that this is not enough on its own. This is why the Concordat states that all local areas should produce their own Local Crisis Declarations by December this year, because meaningful action and change happens on the ground, and every area is different and requires unique approaches and solutions to bring about the improvements we all want to see in place.

Mandate

All of this follows the refreshed Mandate from the Government to NHS England, which includes a new requirement for the NHS that "every community has plans to ensure no one in mental health crisis will be turned away from health services".

Local leadership

Because local leadership is such a vital part of this work, we are asking that you each consider the role your own Health and Wellbeing Board can make in helping partners come together to make these Declarations in your areas.

Mind: there to help with local Crisis Declarations

The Department of Health has contracted Mind, the mental health charity, to help support you in this work. They have produced a Concordat website at http://www.crisiscareconcordat.org.uk/ which contains a map that will display progress on ensuring every local area has a Declaration in place. There are also templates available on the website for Declarations, and information on what these should contain and which organisational partners should sign up to them.

Mind and the Department of Health are both available to provide advice and support in your areas, and are running a series of regional events. To find out more about this, please contact the team at crisiscareconcordat@mind.org.uk.

Of course, we know that many areas have already made a strong start on this work, and we certainly look forward to hearing about more examples of local engagement and success. The NHS has already set the requirement, in its guidance *Operational resilience and capacity planning for 2014/15*, for Declarations to be in place. This document is available at:

http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

Yours sincerely,

Rt Hon Norman Lamb MP

Rt Hon Mike Penning MP

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NHS Statement of Support for Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people; two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

We welcome the:

- Commitment from local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Opportunity to support partnership working with local government as part of delivering local tobacco control in line with NICE guidance;
- Endorsement of this statement by central government, Public Health England, NHS England and others.

We, ..., commit from the date ..... to:

- Continue to actively support work at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco;
- Work with our partners and local communities to address the causes and impacts of tobacco use, according to NICE guidance on smoking and tobacco control;
- Play our role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
- Protect our work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities; and
- Participate in local and regional networks for support.

Signatories

Local NHS leader

Chair of the Health and Wellbeing Board

Director of Public Health

Endorsed by

Jane Ellison, Public Health Minister, Department of Health

Duncan Selbie, Chief Executive, Public Health England

Simon Stevens, Chief Executive, NHS England

Sir Richard Thompson, President, Royal College of Physicians

Dr Hilary Cass, President, Royal College of Paediatrics and Child Health

Dr Janet Atherton, President, Association of Directors of Public Health

Professor John Ashton CBE, President, UK Faculty of Public Health

David Behan, Chief Executive, Care Quality Commission

Baroness Hollins, Chair, BMA Board of Science

Dr Maureen Baker, Chair, Royal College of General Practitioners

Department of Health | Public Health England | Association of Directors of Public Health | Faculty of Public Health | NHS England | Royal College of Physicians | BMA | Care Quality Commission | Royal College of General Practitioners | RCPCH Royal College of Paediatrics and Child Health

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PLYMOUTH CITY COUNCIL

Subject:	Governance and Membership
Committee:	Health and Wellbeing Board
Date:	20 November 2014
Cabinet Member:	Councillor Sue McDonald (Chair)
CMT Member:	Kelechi Nnoaham, Director of Public Health
Author:	Ross Jago, Lead Officer
Contact details:	ross.jago@plymouth.gov.uk
Ref:	N/A
Key Decision:	No
Part:	I

Purpose of the report:

This report provides for the establishment of the Children and Young People's Partnership as a sub-committee of the Health and Wellbeing Board, the establishment of a working protocol between the this Board, the Children and Young People's partnership and the Plymouth Safeguarding Children Board, makes recommendations for provisional meetings of this Board to be added to the calendar and proposes a new member for the Board to represent the voice of the child.

The Brilliant Co-operative Council Corporate Plan 2013/14 -2016/17:

The recommendations will support the corporate plan values of Fair, Democratic, Partners and Responsible by ensuring that the voice of the child is represented within the formal decision making process through the addition of a member to the Board and the establishment of the Children and Young People's Partnership as a sub-committee of the Health and Wellbeing Board; ensuring that the Health and Wellbeing Board has sufficient time to consider business fully in the interest of the citizen; and by clarifying the working relationship between key partners in the safeguarding of children and young people from harm.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

None identified, any requirements identified will be met through existing resources.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

The terms of reference for both the health and wellbeing board and the children and young people partnership make specific commitments to addressing issues quality and wellbeing.

Equality and Diversity:

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:

That the Board agree –

1. the working protocol between the Health and Wellbeing Board, Children and Young People's Partnership and the Plymouth Safeguarding Children Board;
2. the establishment of the Children and Young People's Partnership as a sub-committee of the Health and Wellbeing Board;
3. to appoint the Assistant Director for Education, Learner and Family Support as chair of the Children and Young People's Partnership and as a member of the Health and Wellbeing Board;
4. the addition of two provisional board meetings to the business meeting calendar.

Alternative options considered and rejected:

The status quo was considered but rejected as following changes in the make-up of the cabinet and subsequent changes to the board the voice of the child required at the board required strengthening. The number of Board meetings does not allow for adequate consideration of business.

Published work / information:

Health and Wellbeing Board Terms of Reference
Health and Social Care Act 2012
Local Government Act 1972
Local Safeguarding Children Boards Regulations 2006
Working Together Guidance 2013 (Chapter 3)

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Sign off:

Fin		Leg		Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member N/A													
Has the Cabinet Member(s) agreed the content of the report? Yes													

PLYMOUTH CHILDREN AND YOUNG PEOPLES' PARTNERSHIP

Terms of Reference

1. FUNCTIONS

The Plymouth Children and Young People's Partnership is established as a sub-committee of the Health and Wellbeing Board under section 102 of the Local Government Act 1972 to advise the Board on any matters relating to the discharge of their functions and represent the voice of the child.

2. RESPONSIBILITIES OF HEALTH AND WELLBEING BOARD

2.1 The Plymouth Children and Young People's Partnership will oversee delivery of services for children and young people in the city and will champion children and families' needs on a broader citywide platform. Delivery of services will be driven within organisations and through delivery partnerships. The Plymouth Children and Young People's Partnership will -

- Create and develop an agreed vision and priorities that will promote partnership working along cooperative principles and link to other strategic boards
- Create clear lines of accountability between the partnership and sub groups (some virtual) that will provide robust support to deliver the priorities and present peer challenge.
- Oversee delivery of services for children and young people and through the Health and Wellbeing Board will ensure that partnerships in the city maintain an appropriate focus on children and young people and deliver excellent services for them.
- Champion the voice of children and young people and parents in service design and everything we promote.
- Provide leadership and accountability for the outcomes for children, young people and their families.
- Promote safeguarding as an overarching principle of delivery of all services to children and young people and respond to any issues raised from independent partnerships such as Plymouth Safeguarding Children's Board.

3. GENERAL

Membership

3.1 The Plymouth Children and Young People's Partnership will be comprised of:-

- The Cabinet Member for Children, Young People and Public Health
- Health and Wellbeing Board Lead Member for Children Young People (Chair)
- One representative of Plymouth Hospitals NHS Trust
- One representative of Plymouth Community Healthcare
- One representative of the NEW Devon Clinical Commissioning Group
- One representative of the Devon and Cornwall Police
- One representative of the Voluntary and Community sector
- One representative of Headteachers
- One representative of Further Education
- One parent representative

- One representative of Public Health

3.2 Reflecting the co-operative approach to engage with customers and other stakeholders over the city's key priorities, the Partnership will co-opt additional partners which it considers are most likely to be able to work together to deliver their vision.

3.3 The Partnership will act in accordance with the council constitution.

Meetings

3.4 The Plymouth Children and Young People's Partnership will meet four times per year which will be reviewed after 12 months. The date, time and venue of meetings will be fixed in advance by the Partnership and an annual schedule of meetings will be agreed by council. Additional meetings may be convened at the request of the Chair.

Voting

3.5 In principle, decisions and recommendations will be reached by consensus. In exceptional circumstances and where decisions cannot be reached by a consensus of opinion and/or there is a need to provide absolute clarity on the will of the partnership to the Board, voting will take place and decisions will be agreed by a simple majority of all members.

Where there are equal votes the Chair of the meeting will have the casting vote.

Declaration of Interests

3.6 Members of the Plymouth Children and Young People's Partnership will promote and support high standards of conduct and as such will be subject to the council's code of conduct. Members of the Board must, before the end of 28 days beginning with the day on which they become a member of the Board, notify the authority's monitoring officer of any disclosable pecuniary interests. Notification of changes to declared interests must be made to the authority's monitoring officer within 28 days of the change taking effect.

Quorum

3.7 A quorum of one third of all members will apply for meetings of the Plymouth Children and Young People's Partnership.

Access to Information/ Freedom of Information

3.8 Plymouth Children and Young People's Partnership meetings will be regarded as a sub-committee of the Health and Wellbeing Board for Access to Information Act purposes and meetings will be open to the press/public. Freedom of Information Act provisions shall apply to all business.

Papers

3.9 The agenda and supporting papers will be in a standard format and circulated at least five clear working days in advance of meetings. The minutes of recommendations made will be kept and circulated to partner organisations as soon as possible and will be published on the city council web site.

WORKING TOGETHER PROTOCOL

Plymouth Safeguarding Children Board, Health and Wellbeing Board and Plymouth Children and Young Peoples' Partnership

PROTOCOL FOR THE INTERFACE BETWEEN PLYMOUTH SAFEGUARDING CHILDREN BOARD, CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP AND HEALTH AND WELLBEING BOARD

This protocol sets out the distinct roles and responsibilities of the Plymouth Safeguarding Children Board (PSCB), Children and Young People's Partnership (CYPP), the Health and Wellbeing Board and the inter-relationships between them, in terms of safeguarding and well-being. It also sets out the means by which we will aim to secure effective co-ordination and coherence between the bodies.

Safeguarding is everyone's business. As such, all key strategic plans whether they are formulated by individuals, or by partnership forums, should include safeguarding as a cross-cutting theme.

1 Communication and Engagement between the Boards

1.1 To ensure an effective working relationship between partnerships, these bodies will, through shared membership and invited representation, –

- have an on-going and direct relationship, communicating regularly;
- work together to ensure action taken by one body does not duplicate that taken by another;
- work together to ensure that there are no strategic or operational gaps in policies, protocols, services or practice;
- develop a clear approach to understanding the effectiveness of current services and identifying priorities for change, including where services need to be improved, reshaped or developed;
- ensure the voices of children and young people inform plans.

2 Shared Membership and Invited Observers

2.1 The Assistant Director for Education, Learner and Family Support will Chair the Children and Young People's Partnership as a sub-committee of the Health and Wellbeing Board and will represent the partnership at the Board. This member also has a seat at the Plymouth Safeguarding Children Board.

2.2 The Cabinet Member for Children, Young People and Public Health Chairs the Health and Wellbeing Board, is a member of the Children and Young Peoples' Partnership and an observer member of the Plymouth Safeguarding Children Board. The Chair of the Plymouth Safeguarding Children's Board will be an invited observer at the Children and Young People's Partnership.

3 Arrangements to manage the interface between the Boards

3.1 In order to secure the relationship set out above:

- the CYPP will ensure that issues raised in the PSCB Annual Report, regarding the effectiveness of safeguarding arrangements, are responded to as part of the CYPP's

contribution to the Health & Wellbeing Board Strategy;

- the CYPP will consult the PSCB on strategies, polices and services, which affect how children and young people are safeguarded;
- the CYPP will agree annually with the PSCB what performance information it needs to report to the PSCB in order for the PSCB to be able to quality assure service provision and practice ;
- in undertaking its Learning and Improvement function, the PSCB will inform the CYPP and its agencies of issues coming to the PSCB's attention, in relation to the effectiveness of agencies, individually and collectively, in meeting the safeguarding needs of children and young people;
- the PSCB will present its annual report to the CYPP and the CYPP lead member will raise issues when required at the Health and Wellbeing Board;
- the PSCB will inform the CYPP of its priorities identified from the PSCB's Business Plan;
- the Director of People, Independent Chair of the PSCB and the Chair of the CYPP will liaise closely with regards to the effective operation of both bodies.

4 PLYMOUTH SAFEGUARDING CHILDREN BOARD

4.1 The core functions of the PSCB are set out in the Local Safeguarding Children Boards Regulations 2006 and the Working Together Guidance 2013 (Chapter 3). In all their activities PSCBs should take account of the need to promote equality of opportunity and to meet the diverse needs of children. Under this section the specific functions include:

Policies and Procedures

4.2 The PSCB has a specific role in relation to the development and implementation of policies and procedures. In that regard the PSCB shall develop policies and procedures for safeguarding and promoting the welfare of children and young people in the area of the authority, including policies and procedures in relation to:

- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- training of persons who work with children or in services affecting the safety and welfare of children;
- recruitment of supervision person who work with children;
- investigation of allegations concerning persons who work with children;
- safety and welfare of children who are privately fostered;
- cooperating with neighbouring children's services authorities and their Board Partners.

Communication and Raising Awareness

4.3 Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can be done and encouraging them to do so.

Monitoring and Evaluation

4.4 The PSCB will monitor and evaluate the effectiveness of what is done by the authority and their Board Partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve.

Planning

4.5 Participating in the planning of services for children in the area of the authority.

Child Deaths

4.6 Since 1 April 2008 all Safeguarding Boards have regulatory functions relating to child deaths. In order to carry out those functions the PSCB shall collect and analyse information about the deaths of all children in the area with a view to identifying

- Any matters of concern affecting the safety and welfare of the children in the area, including any case giving rise to the need for a serious case review; and
- Any general public health or safety concerns arising from the deaths of children.
- Develop and implement procedures to ensure there is a co-ordinated response by
- Plymouth, the Board partners and other relevant persons, to an unexpected death of a child.
- Participate within the Peninsula Child Death Overview Panel arrangements.

Serious Case Review

4.7 The PSCB shall undertake reviews of serious cases where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected and there is a cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child, and will advise the authority and Board partners on any lessons that can be learned.

Other Activities

4.8 The LSCB, where appropriate, may determine to promote individual initiatives with partner organisations, for example in relation to child sexual exploitation, e-safety, domestic violence or bullying.

4.9 PSCB's do not commission or deliver front line services though they may provide training. While PSCB's do not have the power to direct other organisations, they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding (In addition the PSCB shall make appropriate arrangements at a strategic management level to involve others in its work as needed.

5 HEALTH AND WELLBEING BOARD

5.1 The purpose of the Board is to promote the health and wellbeing of all citizens in the City of Plymouth. The Board has three principles of working cooperatively which are to:

- Work together with all city partners and with those we serve to take joint ownership of the sustainability agenda.
- Ensure systems and processes will be developed and used to make the best use of limited resources, every time.
- Ensure partners move resources – both fiscal and human to the prevention and health and wellbeing agenda.

5.2 The Board will identify and develop a shared understanding of the needs and priorities of local communities in Plymouth through the development of the Plymouth Joint Strategic Needs Assessment (JSNA). Specifically, the Board will ensure that:

- A Joint Health and Wellbeing Strategy for Plymouth is prepared and published to ensure that the needs identified in the JSNA are delivered in a planned, coordinated and measurable way.
- The Plymouth JSNA is based on the best evidence and data available so that it is fit for purpose and reflects the needs of local people, users and stakeholders.
- The JSNA drives the development of the Joint Plymouth Health and Wellbeing Strategy

and influences other key plans and strategies across the city.
- Oversee the preparation of the Plymouth Pharmaceutical Needs Assessment (PNA) and ensure that it is based on the best evidence and data available.
- Plymouth City Council, NEW Devon Clinical Commissioning Groups and NHS Commissioning Board Area Teams demonstrate how the JSNA has driven commissioning decisions.

5.3 The Board will:

- Develop an agreed set of strategic priorities to focus both collective effort and resources across the city.
- Seek assurance that commissioners plans are in place to deliver the Board's strategic priorities and outcomes.
- Review the commissioning plans for healthcare, social care and public health to ensure that they have due regard to the Joint Plymouth Health and Wellbeing Strategy and take appropriate action if they do not.
- Ensure that appropriate structures and arrangements are in place to ensure the effective engagement and influence of local people and stakeholders.
- Represent Plymouth in relation to health and wellbeing issues across the sub regional and at national level.
- Work closely with Healthwatch to ensure the patient voice is at the heart of the health and wellbeing strategy and add local intelligence to areas of work of the board through Healthwatch engagement work and partnership with local groups.
- Retain a strategic overview of the work of commissioners in the city.
- Support joint commissioning of NHS, social care and public health services and identify those service areas in Plymouth where additional improvements in joint commissioning could achieve the Board's priority outcomes.
- Recommend the development of aligned or pooled budgets and encourage partners to share or integrate services where this would lead to efficiencies and improved service delivery.

6 CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP

6.1 The Children's Partnership is a sub-committee of the Health and Wellbeing Board and will oversee the delivery of current Children and Young People's Plan and related priorities established in the Plymouth Plan.

6.2 The Children's Partnership will oversee delivery of services for children and young people in the city and will champion children and families' needs on a broader citywide platform. Delivery of services will be driven within organisations and through delivery partnerships. The partnership will act as a forum for ideas - for developing strategic relationships between members, pooling collective knowledge, and joint problem solving. The format of meetings will encourage creativity among members and will offer an arena for peer challenge.

Terms of Reference

6.3
- Create and develop an agreed vision and priorities that will promote partnership working along cooperative principles and link to other strategic boards
- Create clear lines of accountability between the partnership and sub groups (some virtual) that will provide robust support to deliver the priorities and present peer challenge.
- Oversee delivery of services for children and young people and through the Health and Wellbeing Board will ensure that partnerships in the city maintain an appropriate focus

on children and young people and deliver excellent services for them.

- Champion the voice of children and young people and parents in service design and everything we promote.
- Provide leadership and accountability for the outcomes for children, young people and their families.
- Promote safeguarding as an overarching principle of delivery of all services to children and young people and respond to any issues raised from independent partnerships such as Plymouth Safeguarding Children's Board.

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HEALTH AND WELLBEING BOARD

20 November 2014

PLYMOUTH CITY COUNCIL

1. Context and Purpose

1.1 Public health is defined as the art and science of promoting health, prolonging life and preventing disease through the organised effort of society.

1.2 In January 2014, the following recommendation was agreed at a Budget Scrutiny meeting, 'an action plan addressing the revised approach to health inequalities across the city is brought to the Caring Scrutiny Panel within six months by the incoming Director of Public Health.'

1.3 With the help of my colleagues in Public Health, I have produced this paper partly in response to that recommendation but crucially in recognition that there is opportunity to define and agree a coherent approach to addressing health inequalities in the city by organising and directing society's effort to promote health, prolong life and prevent disease.

1.4 The framework and action plan will be presented to the Caring Plymouth Panel on 11 December 2014.

1.5 Plymouth City Council as part of its new public health function is seen as a leader for the local public health system and is expected to lead on setting a coherent city-wide strategy for public health in Plymouth. Accordingly, I have made explicit the relationship between the 4-4-54 action plan and the Council's Corporate Plan in Table 2 and figure 12. However, my overriding purpose in the 4-4-54 framework is to reduce health inequalities in Plymouth by building a Plymouth City Health and Wellbeing Collaborative with multiple participating organisations and one or more sponsors. Along with my colleagues in Public Health, I will champion this initiative, lead the development and delivery of the action plan with internal and external partners and provide strategic advice and technical support to partners.

1.6 In addition to developing the workplan detailed in appendix 1, I have chosen to focus activity in year one on working with employers and businesses in the city. In doing so, I believe that not only will the health and wellbeing of the working population in the city be improved, but also that considerable economic benefits will become evident. The focus in the second year of the programme will be on schools and educational settings within the city.

1.7 Since developing the original 4-4-54 Framework, I have had discussions with the Council's Communications Leads to determine whether the 10-year campaign should retain the 4-4-54 name, or whether it should be known by a different title. The view of the communications experts was that the individual 4-4-54 elements were somewhat negative as they focussed on unhealthy behaviours, diseases, and death.

1.8 On that basis an alternative name for the 10-year campaign has been chosen. The campaign will be known as 'Thrive Plymouth.' Thrive is much more positive and can be defined as doing well, 'prospering, being successful and flourishing. The focus is therefore on 'Positive choices for better health in a growing city.'

1.9 The following sections retain the references to the individual 4-4-54 elements in order to explain the development of the framework.

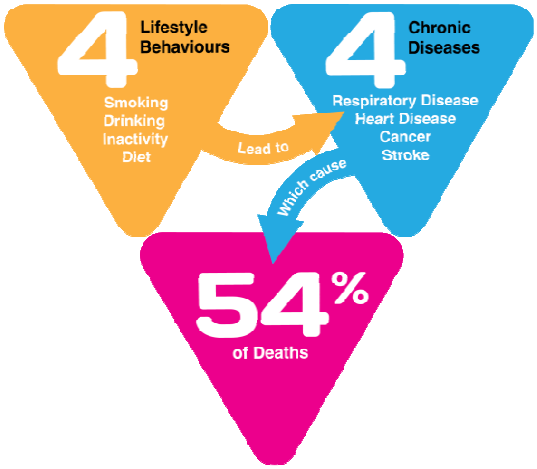
2. Background

2.1 The 4-4-54 framework which I outline in this paper is based on the original work of the Oxford Health Alliance (OxHA). The OxHA came up with the concept of 3four50 in response to global concerns about chronic diseases. This construct reflects the observation that there are three risk factors to health that together contribute to four chronic diseases which, in turn, contribute to more than 50% of preventable deaths worldwide. This focus on chronic diseases is appropriate as they are now the major cause of death and disability worldwide, having surpassed infectious diseases and injuries.

2.2 Based on the work of the OxHA and implementation of the approach in the City of San Diego, U.S.A, the Council's Public Health Intelligence Team has undertaken a detailed Plymouth-specific analysis of the local data to inform the development of a relevant version of this construct and approach to chronic disease reduction for Plymouth as a means of addressing health inequalities in the city.

2.3 The relevant framework for Plymouth will be known as 4-4-54 and within it will sit an action plan to tackle health inequalities across Plymouth by building a new Plymouth Health and Wellbeing Collaborative of multiple partner organisations in the city. In summary, poor diet, lack of physical activity, tobacco use and excess alcohol consumption are risk factors for coronary heart disease, stroke, cancers and respiratory problems which together contribute to 54% of deaths in Plymouth. Changing these four behaviours would help prevent these four diseases and reduce the number of deaths due to those chronic diseases. I have shown this in Figure 1.

Figure 1: 4-4-54 Plymouth



3. The relationship between health behaviours and health inequalities

3.1 People's lifestyles (whether they smoke, how much they drink, what they eat, and whether they are physically active) affect their health and wellbeing. Each of these lifestyle risk factors is unequally distributed in the population. The overall proportion of the English population that engages in three or four of these unhealthy behaviours has declined significantly, from around 33% of the population in 2003, to 25% in 2008. However these reductions have been unequal as they have been seen mainly among those in higher socio-economic and educational groups. Furthermore, the gap between these groups in terms of how common these behaviours are has widened in recent years; people with no qualifications were more than five times as likely as those

with higher education to engage in all four poor behaviours in 2008, compared with only three times as likely in 2003. So although the health of the overall population has improved as a result of the decline in these behaviours between 2003 and 2008, the poorest and those with least education have benefitted least, leading to widening inequalities and avoidable pressure on health and social care services.

4. What are the four behaviours?

4.1 Smoking

4.1.1 Smoking is one of the leading causes of death and illness in the UK. It accounts for 40-60% of the life expectancy gap between men and women in England. Every year around 100,000 people die from smoking, with many more deaths caused by smoking-related illnesses. Smoking increases the risk of developing more than 50 serious health conditions. Some conditions may be fatal and others can cause irreversible long-term damage to health. Smoking consequently accounts indirectly for the growing burden on both the health and social care service.

4.1.2 About 9 out of every 10 cases of lung cancer have been caused by smoking, which also causes cancer in many other parts of the body, including the mouth, lips, throat, voice box (larynx), oesophagus (the tube between the mouth and stomach), bladder, kidney, liver, stomach, and pancreas.

4.1.3 Smoking damages the heart and blood circulation, increasing the risk of developing conditions such as cardiovascular disease (which includes coronary heart disease, stroke and peripheral vascular disease). Smoking also damages the lungs, leading to conditions such as chronic bronchitis (inflammation of the main airways in the lungs), emphysema (damage to the small airways in the lungs), and pneumonia (infection in the lungs). Smoking can also worsen or prolong the symptoms of respiratory conditions such as asthma, or respiratory tract infections such as the common cold.

4.1.4 In men, smoking can cause impotence because it limits the blood supply to the penis through the sclerosing (thickening, narrowing) effects it produces on blood vessels. It can also affect the fertility of both men and women, making it more difficult to have children.

4.1.5 Smoking during pregnancy puts the unborn baby's, as well as the mother's, health at risk. Smoking during pregnancy increases the risk of complications such as miscarriage, premature (early) birth, a low birth weight baby and stillbirth.

4.2 Alcohol misuse

4.2.1 Alcohol is a powerful chemical that can have a wide range of adverse effects on almost every part of the body, including the brain, bones and heart. Alcohol misuse and its associated risks can have both short-term and long-term effects. According to the Longevity Science Advisory Panel, alcohol misuse accounts for about 20% of the gap in life expectancy between men and women in England.

4.2.2 Some of the risks associated with alcohol misuse include:

- Accidents and injury (more than one in 10 visits to the Derriford accident and emergency department are due to alcohol-related illnesses)
- Violence and antisocial behaviour (each year in England over 1.2 million violent incidents are linked to alcohol misuse; in Plymouth the number is likely to be in excess of 5,000)
- Unsafe sex (this can lead to unplanned pregnancies and sexually transmitted infections)

- Loss of personal possessions (many people lose personal possessions, such as their wallet or mobile phone, when they are drunk)
- Unplanned time off work or college (putting an individual's job or education at risk)

4.2.3 Alcohol poisoning occurs when excessive amounts of alcohol start to interfere with the body's automatic functions such as breathing, heart rate, and gag reflex (which prevents choking). Alcohol poisoning can cause a person to fall into a coma and could lead to their death.

4.2.4 Drinking hazardous amounts of alcohol for many years will eventually take its toll on many of the body's organs and may cause organ damage. Organs known to be damaged by long-term alcohol misuse include the brain and nervous system, heart, liver and pancreas. Heavy drinking can also increase blood pressure and blood cholesterol levels, both of which are major risk factors for heart attacks and strokes. Long-term alcohol misuse can weaken the immune system, increasing vulnerability to serious infections. It can also weaken bones, placing an individual at greater risk of fracturing or breaking them. There are many long-term health risks associated with alcohol misuse. They include high blood pressure, stroke, pancreatitis, liver disease, liver cancer, mouth cancer, head and neck cancer, breast cancer, bowel cancer, depression, dementia, sexual problems, such as impotence or premature ejaculation and infertility.

4.2.5 As well as having a significant impact on health, alcohol misuse can also have long-term social implications. For example, it can lead to family break-up and divorce, domestic abuse, unemployment, homelessness and financial problems.

4.3 Lack of physical activity

4.3.1 Many people take no physical activity during a typical week. Physical inactivity is the most common risk factor for heart disease in the UK with seven out of 10 women and six out of 10 men not active enough to achieve health benefits. It is estimated that in the UK, about 36% of deaths from heart disease in men and 38% of deaths from heart disease in women are related to lack of physical activity, compared to only 19% of heart disease deaths being related to smoking. Physical activity is one of the best preventative medicines. It halves the risk of developing heart disease and could avert 9% of deaths from coronary heart disease if people who are currently physically inactive or have a low level of physical activity increased their activity to a moderate level.

4.3.2 Physical activity plays an important part in preventing heart disease by helping to lower high blood pressure which in turn reduces the risk of having a stroke (particularly the more dangerous ones involving bleeding in the brain). It also increases the HDL-cholesterol level (the good cholesterol) in the blood, reduces weight if you are overweight and helps to maintain it, controls blood sugar (glucose), reduces the chance of developing diabetes, prevents blood clotting and lowers the risk of osteoporosis.

4.3.3 Just getting moving everyday can also help people feel more energetic, feel better about themselves, relieve stress, reduce feelings of anxiety and depression, and relax.

4.4 Poor diet

4.4.1 The Department of Health recognises food poverty as 'the inability to afford, or to have access to, food to make up a healthy diet.' Tackling food poverty is recognised as key to achieving government targets on reducing inequalities. Those who are most likely to experience food poverty are people living on low incomes or who are unemployed, households with dependent children, older people, people with disabilities, and members of black and minority ethnic communities.

4.4.2 A poor diet is characterised by excessive intakes of saturated fat, salt or sugar, and an insufficient consumption of fruit and vegetables, and dietary fibre. Inequalities in people's diets can result in inequalities in people's health. People on low incomes eat more processed foods which are much higher in saturated fats and salt. They also eat a smaller variety of foods. This is related to economies of scale and fear of potential waste. People living on state benefits eat less fruit and vegetables, less fish and less high-fibre breakfast cereals. People in the UK living in households without an earner consume more total calories, and considerably more fat, salt and non-milk extrinsic sugars than those living in households with one or more earners. Socioeconomic differences account for 5,000 deaths a year in men aged less than 65 years of age. In all age groups, people living on a low income have higher rates of diet-related diseases than other people. There are differences in diet-related disease in different ethnic groups. For example, stroke mortality rates are around 50% higher in South Asian and black Caribbean men and women than in the general population.

4.4.3 Poor diet is a major health risk. It contributes to almost 50% of coronary heart disease deaths, 33% of all cancer deaths, increased falls and fractures in older people, low birthweight births, increased childhood morbidity and mortality and increased dental caries in children. There is also growing evidence to support the link between poor diets and anti-social behaviour.

4.4.4 A relevant aspect of poor diet related to early years is infant breastfeeding. Breastfeeding has been suggested as a potential protective factor against weight gain in childhood and this is important because overweight children and adolescents are at risk of becoming overweight adults. In Plymouth the breastfeeding initiation rate was 70.3% in 2013. However, this ranged from 43.1% in Barne Barton to 89.9% in the Greenbank & University neighbourhood (a more than two-fold difference). By the time of the 6-8 week check only 36.6% of Plymouth children were still being breastfed in 2013, ranging from 13.6% in Barne Barton to 63.1% in Peverell & Hartley (a more than four-fold difference).

4.4.5 We can secure significant health benefits at both the population and individual level in Plymouth by enabling a shift towards the recommended balanced diet and achievement of targets for breastfeeding initiation and maintenance at 6-8 weeks. For example, lowering cholesterol levels by just 10% in the UK would prevent approximately 25,000 deaths every year.

5. What are the four chronic diseases?

5.1 Cancer

5.1.1 Cancer is a group of conditions where cells in a specific part of the body grow and reproduce uncontrollably. Although cells in different parts of the body may look and work differently, most repair and reproduce themselves in the same way. Normally, cells divide in an orderly and controlled way but if for some reason the process gets out of control, the cells carry on dividing and develop into a lump called a tumour (swelling). Tumours are either benign (slow growth, non-spreading) or malignant (rapidly growing and spreading). In a benign tumour, the cells do not spread to other parts of the body. However, they may carry on growing at the original site, and may cause a problem by pressing on surrounding organs. In a malignant tumour, the cancer cells have the ability to spread beyond the original area of the body. If the tumour is left untreated, it may spread into surrounding tissue. Sometimes cells break away from the original (primary) cancer. They may then spread to other organs in the body through the bloodstream or lymphatic system.

5.2 Heart disease

5.2.1 Coronary heart disease (CHD), is the leading cause of deaths in the UK, causing around 82,000 deaths each year. About one in five men and one in eight women die from the disease. There are an estimated three million people living with the condition in the UK and two million people affected by angina (the most common symptom of CHD). CHD generally affects more men than women, but from the age of 50 the chances of developing CHD are similar for men and women. The main symptoms of CHD are angina (chest pain related to reduced oxygen supply to the heart muscle but not associated with death of the heart muscle) and a heart attack (death of the heart muscle). Over time, CHD can weaken the heart muscle and lead to heart failure (in which the heart can't pump enough blood to meet the body's needs) and arrhythmias (problems with the rate or rhythm of the heartbeat).

5.2.2 CHD is the term that describes what happens when the heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries. Over time, the walls of the arteries can become furred up with fatty deposits. This process is known as atherosclerosis and the fatty deposits are called atheroma. Atherosclerosis can be caused by lifestyle habits and other conditions, such as smoking, high cholesterol, high blood pressure (hypertension) and diabetes.

5.3 Stroke

5.3.1 A stroke occurs when the blood supply to part of the brain is cut off. Strokes are a medical emergency and prompt treatment is essential because the sooner a person receives treatment, the less damage is likely to happen. Like all organs, the brain needs the oxygen and nutrients provided by blood to function properly. If the supply of blood is restricted or stopped, brain cells begin to die. This can lead to brain damage and possibly death. There are two main causes of strokes (1) ischaemic - the blood supply is stopped due to a blood clot (accounting for over 80% of all cases) and (2) haemorrhagic - a weakened blood vessel supplying the brain bursts and causes brain damage. There is also a related condition known as a transient ischaemic attack (TIA), where the supply of blood to the brain is temporarily interrupted, causing a 'mini-stroke'. TIAs should be treated seriously as they are often a warning sign that a stroke is coming.

5.3.2 Every year over 150,000 people in England have a stroke and it is the third largest cause of death, after heart disease and cancer. The brain damage caused by strokes means that they are the largest cause of adult disability in the UK. People over 65 years of age are most at risk from having strokes, although 25% of strokes occur in people who are under 65. It is also possible for children to have strokes. People of South Asian, African or Caribbean descent are at a higher risk of strokes; this is partly because of a higher prevalence of diabetes and heart disease, which are two conditions that can cause strokes. Smoking, being overweight, lack of exercise and a poor diet are also risk factors for stroke. Also, conditions that affect the circulation of the blood, such as high blood pressure, high cholesterol, atrial fibrillation (an irregular heartbeat) and diabetes, increase the risk of having a stroke.

5.4 Respiratory disease

5.4.1 Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing, primarily due to the narrowing of their airways, this is called airflow obstruction. The main cause of COPD is smoking. The likelihood of developing COPD increases the more a person smokes and the longer they've been smoking. This is because smoking irritates and inflames the lungs, which results in scarring. Over many years, the inflammation leads to permanent changes in the lungs. The walls of the airways thicken and more mucus is produced. Damage to the delicate walls of the air sacs in the lungs causes emphysema

and the lungs lose their normal elasticity. The smaller airways also become scarred and narrowed. These changes cause the symptoms of breathlessness, cough and phlegm associated with COPD. Some cases of COPD are caused by fumes, dust, air pollution and genetic disorders, but these are rarer.

5.4.2 COPD is one of the most common respiratory diseases in the UK. It usually affects people over the age of 35, although most people are not diagnosed until they are in their fifties. It is thought there are over three million people living with the disease in the UK, of which only about 900,000 have been diagnosed. This is because many people who develop symptoms of COPD do not get medical help and some dismiss their symptoms as a 'smoker's cough'. COPD affects more men than women, although rates in women are increasing.

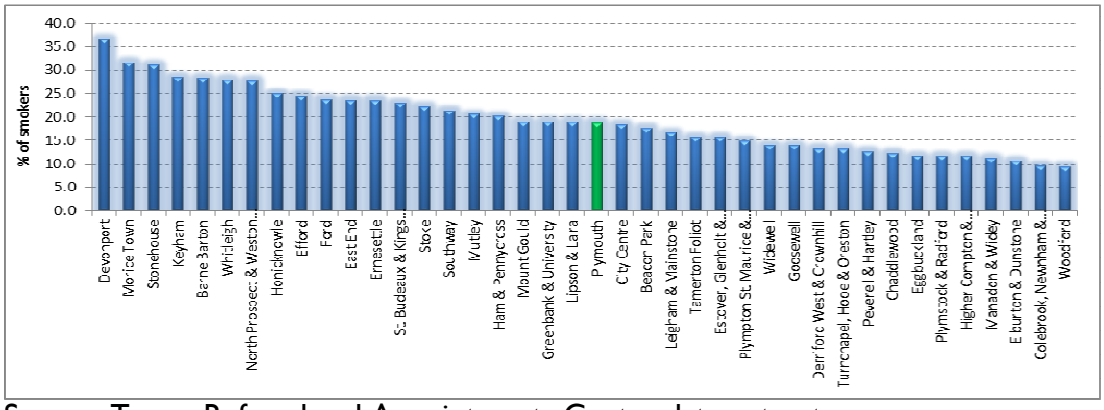
6. What are the 4-4-54 patterns of behaviour in Plymouth's neighbourhoods?

6.1 In this section, I present neighbourhood-based information. This is made possible as the numbers of 'events' (e.g. adults smoking) are sufficiently large and the data is sufficiently robust. This is not the case with mortality data from the four chronic diseases presented in a subsequent section. In other words, as the number of deaths is much smaller than the number of people engaging in a particular behaviour, this information is best presented on a larger geographic basis (e.g. electoral wards or the city as a whole).

6.2 Information relating to two of the specific behaviours (smoking and alcohol consumption) is presented below. As neighbourhood-based information on diet and exercise is not currently available, I present information on the neighbourhood distribution of 'excess weight' as a proxy measure to indicate the likely distribution of levels of poor diet and exercise at neighbourhood level in Plymouth.

6.3 I will address the lack of data on each of the four behaviours at sub-city level through the Wellbeing Survey which the Council's Public Health Team has commissioned with support from Public Health England. As well as collecting information on patterns of wellbeing at electoral ward level across the city, this survey will record information on smoking, diet, exercise and alcohol consumption. I will use the intelligence from this survey to inform the development of the 4-4-54 programme in Plymouth.

Figure 2 - Adult smokers by neighbourhood (%), 2012/13

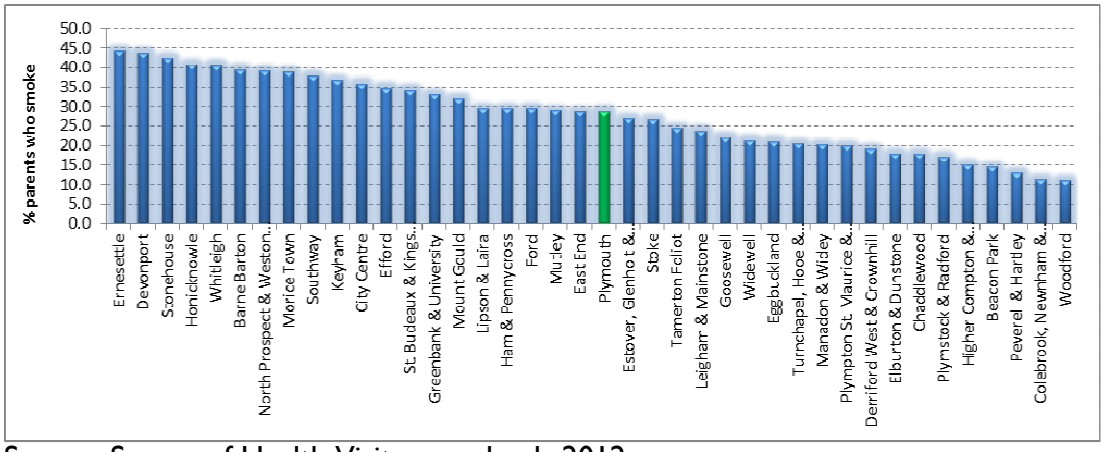


Source: Tamar Referral and Appointments Centre data extract

6.4 In 2012/13 the percentage of smokers in Plymouth was 18.9%. The percentage of smokers by neighbourhood ranged from 9.4% in Woodford to 36.7% in Devonport (an almost four-fold difference). It's worth noting that this data is based on the smoking status of adults who were

referred to hospital (for any condition) as opposed to the population as a whole and as such should be considered as a proxy measure of smoking in the Plymouth population as a whole.

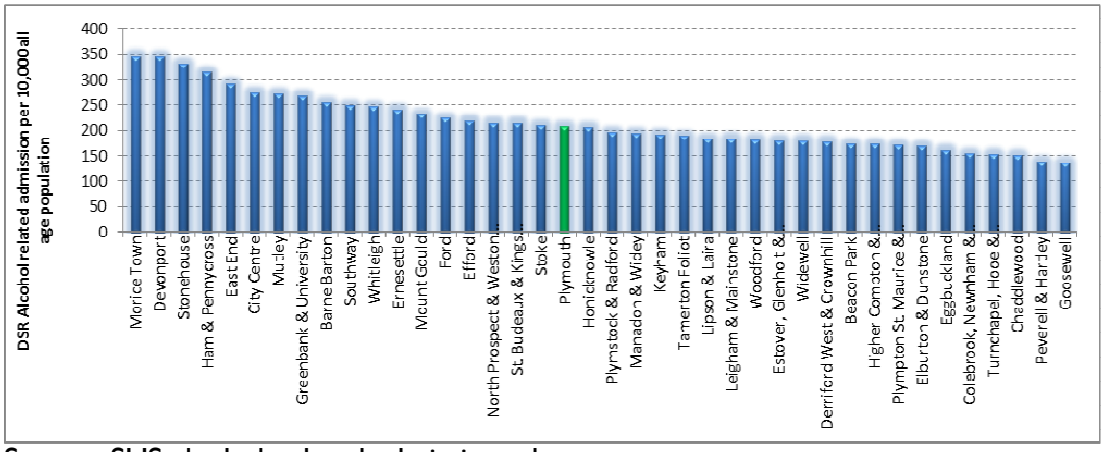
Figure 3 - Percentage of families with parents who smoke, according the Plymouth Health Visitor Caseload Survey



Source: Survey of Health Visitor caseloads 2012

6.5 In 2012/13 the percentage of families where 'one or more parents smoke' was 28.8%. This ranged from 11.2% in Woodford to 44.4% in Ernesettle (an almost four-fold difference).

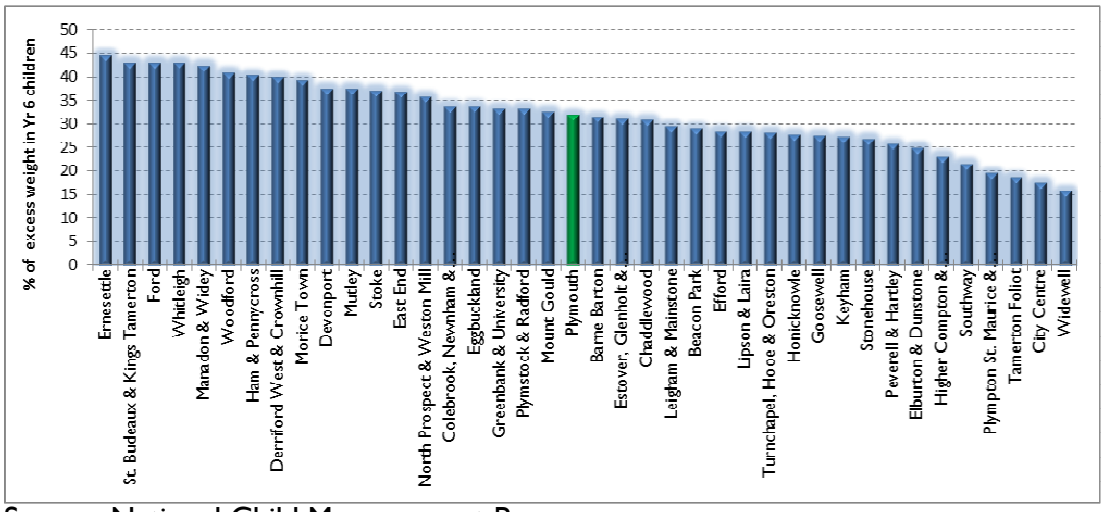
Figure 4 - Alcohol-related hospital admissions (directly age-standardised) per 10,000 all-age population by neighbourhood, 2012/13



Source: SUS alcohol-related admissions data

6.6 In 2012/13 the rate of alcohol-related hospital admissions in Plymouth was 209.7 per 10,000 all-age population. This ranged from 137.7 per 10,000 in Goosewell to 346.5 per 10,000 in Morice Town (a more than two-fold difference).

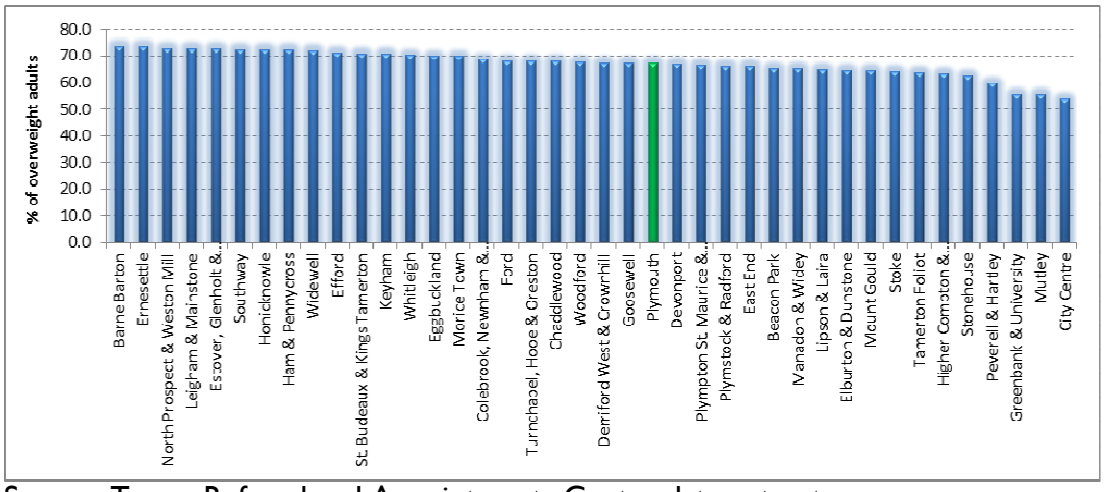
Figure 5 - Excess weight in Year 6 children by neighbourhood (%), 2012/13



Source: National Child Measurement Programme

6.7 In 2012/13 the percentage of Year 6 children with excess weight in Plymouth was 32.1%. The percentage of Year 6 children with excess weight by neighbourhood ranged from 16.0% in Widewell to 44.6% in Ernesettle (a more than two-fold difference).

Figure 6 - Excess weight in adults by neighbourhood (%), 2012/13



Source: Tamar Referral and Appointments Centre data extract

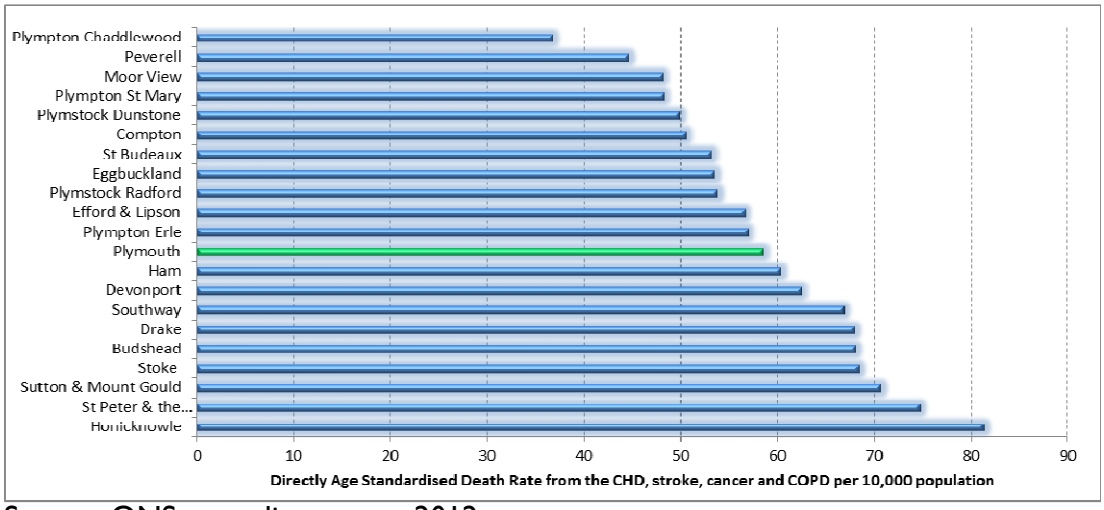
6.8 In 2012/13 the percentage of adults with excess weight (i.e. classified as overweight or obese according to their Body Mass Index) in Plymouth was 67.4%. The percentage of adults with excess weight by neighbourhood ranged from 54.3% in City Centre to 73.8% in Barne Barton (a difference of nearly 20 percentage points). This data is based on the body mass index of people who were referred to hospital (for any condition) as opposed to the population as a whole and as such should be considered as a proxy measure of overweight in the Plymouth population as a whole.

6.9 The information I have presented in Figures 2 to 6 highlights the clustering of behaviour patterns in certain areas of the city.

7. What are the 4-4-54 variations in mortality rates within Plymouth?

7.1 In this section, I present electoral ward-based mortality rates for the four chronic diseases (combined) to highlight the variation that exists across the city. The rates are age-standardised to remove the variation in rates that would be found as a result of the areas having populations with different age structures.

Figure 7 - Mortality rate for CHD, stroke, cancer, and COPD combined per 10,000 all-age population by Plymouth electoral ward, 2012



Source: ONS mortality extract 2012

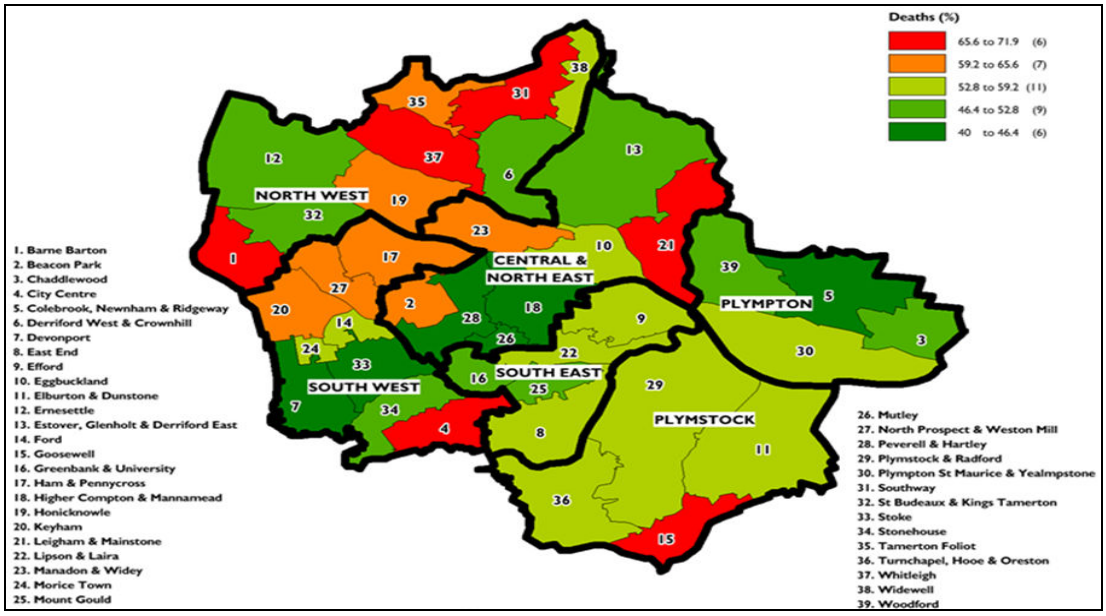
7.2 In 2012 the mortality rate for CHD, stroke, cancer and COPD combined in Plymouth was 58.5 per 10,000 all-age population. The rate by ward ranged from 36.7 per 10,000 in Plympton Chaddlewood to 81.2 per 10,000 in Honicknowle (a more than two-fold difference).

8. What are the 4-4-54 proportions of deaths in Plymouth?

8.1 In this section the percentages of total deaths due to the four chronic diseases are shown in maps of Plymouth's neighbourhoods (Figure 8) and electoral wards (Figure 9).

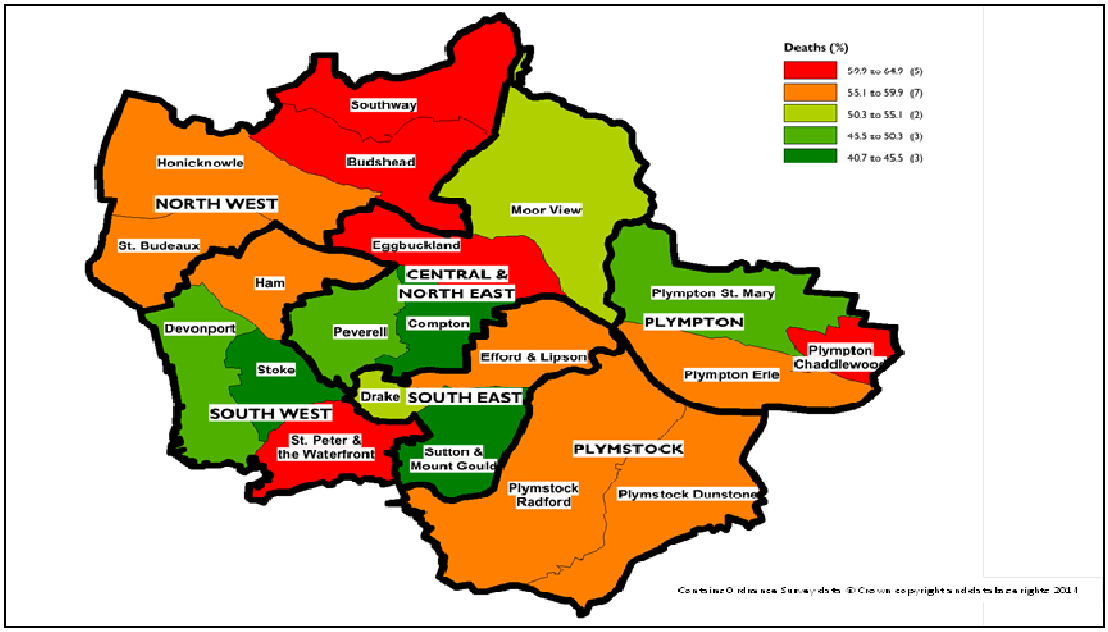
8.2 In 2012 there were a total of 2,453 deaths in Plymouth. Of these 1,324 (54%) were from the four chronic diseases (cancer 715, CHD 307, stroke 152, COPD 150 deaths).

Figure 8 - Deaths from CHD, stroke, cancer and COPD combined (% of all deaths) by neighbourhood, 2012



8.3 The percentage of deaths from CHD, stroke, cancer and COPD combined (as a percentage of all deaths) by neighbourhood ranged from 40.0% in both Mutley and Peverell & Hartley to 71.9% in Goosewell (a difference of more than 30 percentage points). As shown on the map in Figure 8, although there are neighbourhoods with high values (red) scattered across the city, there are considerable concentrations in the North West and South West of the city.

Figure 9 - Deaths from CHD, stroke, cancer and COPD combined (% of all deaths) by electoral ward, 2012



8.4 The percentage of deaths from stroke, CHD, COPD and cancer combined (as a percentage of all deaths) by ward ranged from 40.7% in Stoke to 64.9% in Plympton Chaddlewood (a difference of almost 25 percentage points). Analysis of information on an electoral ward basis often hides the inequalities that exist when the same information is considered at a smaller geographic level. Further electoral ward-based information is shown in Appendix 2.

9. The framework setting out the 4-4-54 approach to addressing health inequalities

9.1 The 4-4-54 approach to addressing health inequalities in Plymouth can be summarised by the framework shown in Table 1. At the heart of the framework is the unifying focus (4-4-54). This is preceded by the recently agreed ODPH vision statement. The principles underlying 4-4-54 are also listed and highlight that it will be long-term, collaborative, inclusive, fair, flexible, integrated, and evidence-based.

Table 1 - Framework setting out the 4-4-54 approach to addressing health inequalities

ODPH vision statement	Supporting the development of healthy and happy communities in Plymouth by using social networks, increasing investment in public health and putting health and wellbeing at the heart of everything we and our partners do
Message	Four behaviours (individually or in combination) increase the risk for four chronic diseases that together cause more than 54% of all deaths in Plymouth
Unifying focus	4-4-54 Plymouth
Objective	To reduce health inequalities in Plymouth by building a Plymouth City Health & Wellbeing Collaborative with multiple participating organisations and one or more sponsors
Principles	1. **Long-term**: 10 year plan to improve health and wellbeing and reduce health inequalities.
	2. **Collaborative**: Work with all partners across the city to realise a shared agenda.
	3. **Inclusive**: Something for everyone (all ages, all abilities, households and institutional settings, homeless, marginalised and vulnerable residents).
	4. **Fair**: Focusing on preventable deaths will help reduce health inequalities across the life course.
	5. **Flexible**: Encourage variety and wide range of options.
	6. **Integrated**: Prevention is linked to early detection and effective treatment of chronic diseases.
	7. **Evidence based**: Drawing on what works elsewhere and assessing work done in Plymouth.

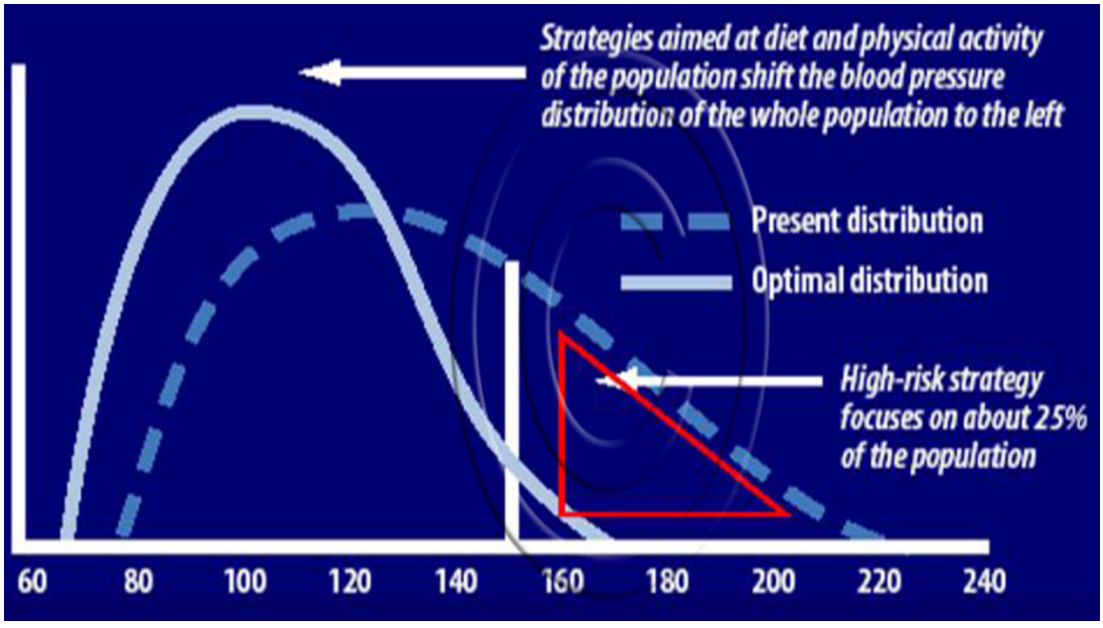
10. The three approaches underpinning the framework

10.1 The population prevention approach

10.1.2 The population prevention approach is a public health oriented approach which consists of shifting the population distribution of a condition (usually a risk factor for a disease) in order to prevent a higher number of cases of the disease. The fundamental concept is that a large number of people at low risk (of developing a disease) may give rise to more cases of the disease than the small number who are at high risk. For example, if there are a lot of 30 year olds with low risk, but a few 50 year olds with high risk, then more cases will occur in the 30 year old cohort, simply because there are more of them. The advantages of this approach are that there is a large potential to change the distribution of a risk factor in a whole population, and that because changes are happening to whole populations, individuals will not have to struggle to change their behaviours in the face of peer-pressure. Although some see disadvantages in the fact that large changes will be seen at a population level while only small changes will be apparent at an individual level, I don't view it that way. Instead, I reckon it's an opportunity to say to Plymouth people – 'you only need to make a little change to help make a big difference in Plymouth'.

10.1.2 The more traditional 'high-risk' approach to prevention is where medical professionals identify people with a condition (e.g. high blood pressure) and prescribe medication to prevent it developing into cardiovascular disease or other hypertension-related diseases. The advantages are that the subjects are likely to be motivated to take the medication and the intervention will be tailored to the individual. The disadvantages are that any fixes may be temporary because the cause is often not identified.

Figure 10 – The population approach applied to the blood pressure distribution in a population



10.1.3 Importantly, the prevalence of adverse risk factors such as smoking, poor diet, lack of physical activity and excess alcohol consumption is higher in areas characterised by higher levels of disadvantage. Appealing to individual willpower to change in these communities leads to a disproportionate amount of effort for small returns. Partly this is because the financial and non-financial cost of personal lifestyle change in these communities is comparatively high (and is starting from a base of poverty and living in deprived environments). So, although the overall success of individual approaches can be impressive, they may mask serious inequalities in health and make them prone to widen.

10.1.4 However, many current interventions are dependent on the individual. They include smoking cessation, vaccination uptake, various forms of screening, uptake of rehabilitation for drug misuse, and reduction in teenage pregnancies. These interventions depend on people accepting preventive and treatment services or taking preventive action themselves. A more strategic population prevention approach is exemplified by mass public health campaigns. This is best undertaken at scale and is the difference between (for example) smoking cessation and tobacco control, using fluoride toothpaste and fluoridating water, traffic calming as well as speed limits, and compulsory immunisation before school entry compared with individual parental choice in presenting their child. Once the population approach is taken, the balance of risk and benefit changes.

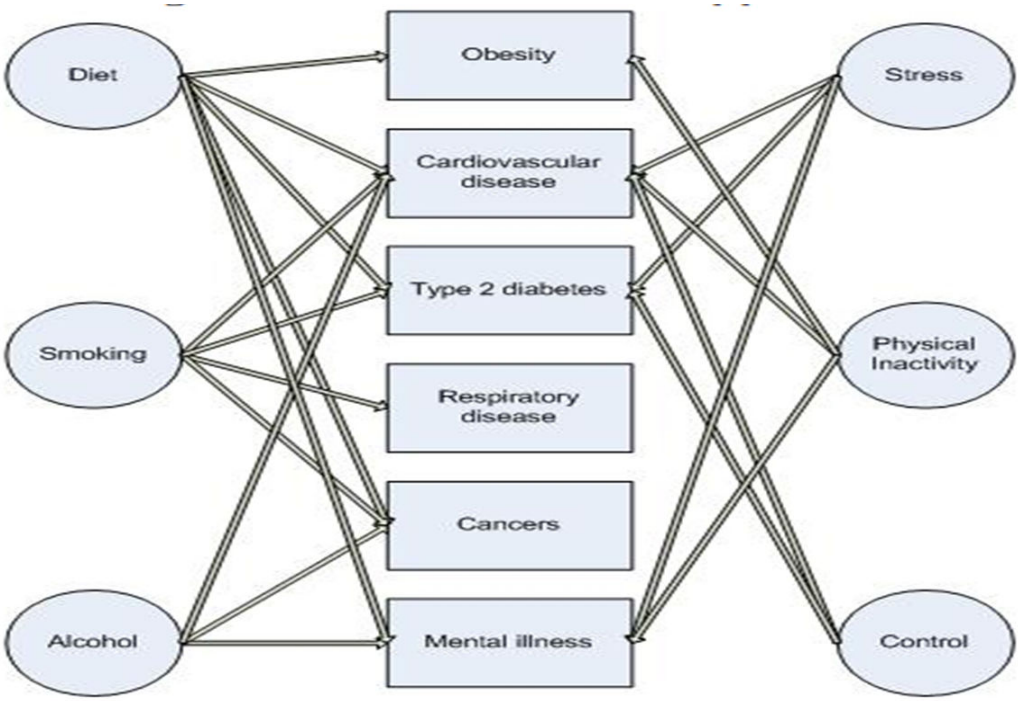
10.2 The common risk factor approach

10.2.1 The risk factors for poor health are often shared by groups or populations. For example, a smoker is likely to drink more alcohol, have a worse diet and take less exercise than a non-smoker. This clustering of risk factors occurs in individuals and groups, particularly those at the lower levels of the social gradient. This highlights the potential of having more integrated interventions aimed at improving health behaviour and engaging communities, rather than parallel interventions for different issues such as smoking, diet, physical activity and alcohol.

10.2.2 A number of chronic diseases have risk factors in common and many risk factors are relevant to more than one chronic disease. The common risk factor approach therefore based on an integrated model that aims to address a small number of risk factors that may have a major impact on a large number of diseases. The approach is considered to have greater efficiency than interventions aimed at disease specific approaches.

10.2.3 A major criticism of preventive and educational programmes has been the narrow and isolated approach adopted. This uncoordinated approach can at best lead to a duplication of effort, but often results in conflicting and contradictory messages being delivered to the public. The common risk factor approach recognises that chronic non-communicable diseases such as heart disease, stroke, cancers, and respiratory problems share a set of common risk conditions and factors.

Figure 11 – The common risk factor approach



10.2.4 The key concept of the common risk factor approach is that by directing action on these common risks and their underlying social determinants, improvements in a range of chronic conditions will be achieved more efficiently and with greater effectiveness. The common risk factor approach provides a rationale for partnership working. A wide range of national and local health initiatives exists, which provide an ideal opportunity to integrate health actions.

10.3 The behaviour change approach (changing the context in which people make choices)

10.3.1 Despite the overwhelming amount of information on the negative effects of smoking, poor diet, lack of physical activity and excess alcohol consumption, all these health risks remain prevalent. Most people know how to improve their health, and many want to do it. Yet, despite good intentions, change is hard to achieve. Research shows that having information and a desire to change is often insufficient. This disconnect between knowing what needs to be done and actually doing it is known as the intention behaviour gap. There are six major factors that undermine healthy intentions.

- We are wired to favour impulsive choices
- We are too busy to make clear headed decisions
- We have limited willpower
- We live for today
- We are influenced by our environment
- We tend to go with the flow

Changing the context in which people make choices can help to achieve better outcomes for the population as a whole either by complementing established policy tools or by suggesting more innovative interventions.

"One of the most important discoveries of behavioural economics is how little our behaviour is influenced by our intentions, and how much it is influenced by context." (Zoë Chance, Yale University)

11. Structure of the 10-year action plan supporting the 4-4-54 framework to addressing health inequalities

11.1 The action plan that will support the delivery of 4-4-54 in Plymouth will be based on the four individual themes that have been brought together to form the ODPH vision. Activities against each of these individual themes will be considered in the short, medium and longer term. These themes and the structure of the 4-4-54 supporting action plan are outlined in Table 2.

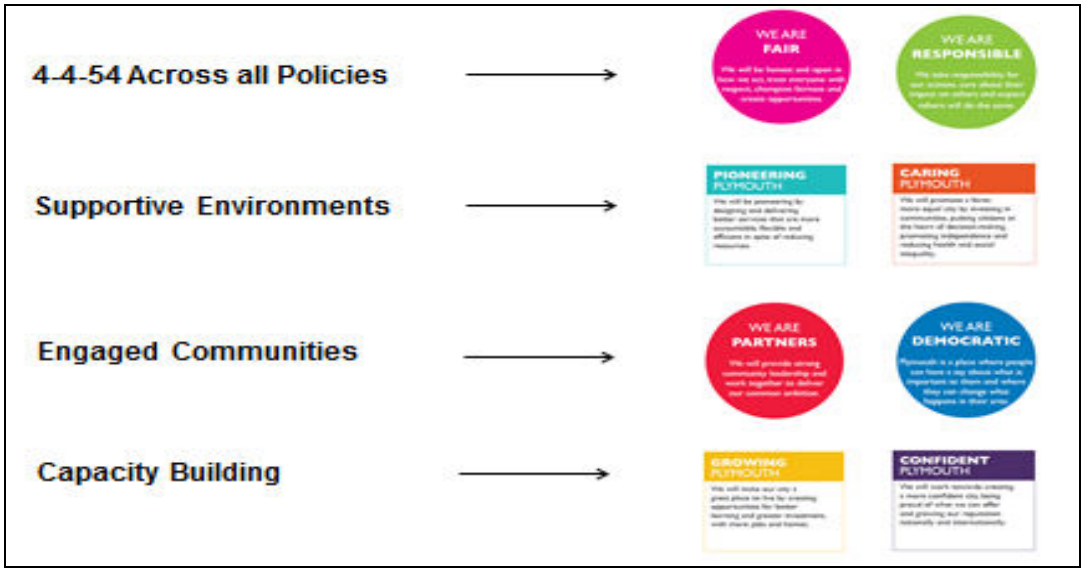
Table 2 - Themes and structure of the 4-4-54 supporting action plan

		Timeframe (years)		
		0-3	**4-6**	**7-10**
Theme 1	**4-4-54 across policies**			
Corporate Plan objectives	Pioneering (objective 1)			
Theme 2	**Supportive environments**			
Corporate Plan values	Fair (value 3)			
Theme 3	**Engaged communities**			
Corporate Plan values	Partners (value 4)			
Theme 4	**Capacity building**			
Corporate Plan objectives	Confident (objective 4)			

11.2 A completed summary version of this action plan covering the first three years of the programme can be found in Appendix 1. This action plan will be developed in the coming months as a result of dialogue with multi-agency partners across the city.

11.3 The links between the four individual themes and the values and objectives laid out in the Council's Corporate Plan are shown in figure 12.

Figure 12 – The relationship between 4-4-54 and the Corporate Plan



12. Summary

12.1 Most people are aware that health status is influenced by many factors including genetics, social circumstances, environmental exposures, health care, and behavioural patterns. What might be less obvious is that behavioural patterns have the single greatest influence on personal and population health. The behavioural patterns that limit health are socio-economically patterned, tending to cluster in poorer populations in our city.

12.2 There is scope to employ effective ways to support and enable people in lower socio-economic groups and those with the least education to improve their health-related behaviours. This requires collaborative, city-wide effort and a more holistic approach to policy and practice that addresses lifestyles of multiple rather than individual unhealthy behaviours.

12.3 I believe we can secure tangible gains in the health and wellbeing of Plymouth residents by linking behaviour change more closely to inequalities policy and focusing more directly on improving the health of the poorest fastest. This is the ethos behind the 4-4-54 approach to addressing health inequalities in Plymouth.

13. Acknowledgments

13.1 I introduced this concept which was originally developed by the Oxford Health Alliance. Robert Nelder and Moira Maconachie did background research, developed the narrative and wrote the early drafts. Simon Hoad and Sarah Macleod developed the analyses and some of the narrative. I did a final review of the draft with minor editing of the analyses and the text.

Dr. Kelechi Nnoaham
Director of Public Health
Plymouth City Council

Appendix 1: Summary 4-4-54 action plan for years 0-3

Theme 1	4-4-54 across policies	Planned actions	Date	Comment
(1)	4-4-54 adopted by the Council	Action Plan and 4-4-54 approach presented to Caring Scrutiny Panel	2014	As requested by Budget Scrutiny meeting (January 2014)
(2)	4-4 -54 Plymouth	DPH annual report 2014/15 to focus on 4-4-54	2015	Examples from across the Council included in report. DPH public health annual report and subsequent reports for years 2 and 3 will be based on this framework and action plan
(3)	Build a collaborative of multiple organisations in the city in a Health & Wellbeing Collaborative	Map partners in relevant settings Design and deliver (with Corporate Comms) a social marketing concept to raise awareness of Plymouth 4-4-54 Plan an event to formally launch Plymouth 4-4-54 Draw up a Plymouth 4-4-54 Concordat to which Participating members of the collaborative will be invited to sign up	October 2014 to February 2015	
(4)	Prevention linked to early detection and effective treatment	Influence the CCG's Strategic Plan	New	Will be achieved through engagement with CCG both as part of core offer and through visible leadership achieved by engagement of ODPH with the CCG at both Western locality and NEW Devon
(5)	Prevention linked to improving access to services	Influence the CCG's Strategic Plan	New	Will be achieved through engagement with CCG on the Challenged Health Economy programme
(6)	4 -4-54 monitored and evaluated for impact	Included in the Public Health Team's workplan	2014 onwards	Included in remit of relevant area of Public Health Team following re-alignment of responsibilities

Theme 2	Supportive environments	Planned actions	Date	Comment
(1)	Enable wider access to healthy foods and local produce	Links with 'Food Plymouth' and 'Plymouth Food Charter'	Ongoing	Links already established via the Public protection service and the PCH Livewell Team New work stream created in ODPH to co-ordinate efforts in the City around food poverty, nutrition and healthy diets in liaison with colleagues in City of Service initiative
(2)	Enable wider access to leisure facilities for residents of all ages and abilities	Through reviews of existing commissioned activity and implementation of recommendations of the sport and physical activity needs assessment	Ongoing	Existing commissioned activity focusses on priority groups and in priority areas. The recommendations of the sport and physical activity needs assessment will be considered by a partnership group.
(3)	Enable wider access to active transport routes	Ongoing support of 'Plymotion' work with the Council's Transport Planning Team	Ongoing	New business partnering arrangements between Public Health and other council team will enable this work to continue.
(4)	Enable responsible sale and use of alcohol	Enable safe drinking environments and restrict availability of super-strength alcohol	2014 onwards	The Public Health Team currently co-ordinates the delivery of the Strategic Alcohol Plan
(5)	Enable healthier workplaces and routes into employment	The Business Health Network is currently commissioned through the PCH Livewell team. In addition, the Council is establishing an internal employee health and wellbeing programme.	2014 onwards	The new programme of work within the Council (led jointly by ODPH and HR) will focus on mental health, diet, exercise and smoking
(6)	Routes into employment	Commission the PCH Livewell Team to deliver a programme of work to enable people with mental health conditions to access to meaningful occupations	New	This is a new initiative for the Public Health Team working in partnership with the PCH Livewell team

Theme 3	Engaged communities	Planned actions	Date	Comment
(1)	Working with communities	To work with the Council's Homes and Communities Team to develop a plan for working with communities.	New	This is a priority for both Public Health and Homes and Communities. Therefore this work will be taken forward jointly
(2)	Enable civic leadership	Establish a small grant scheme for Councillors to enable identified health and wellbeing priorities in their wards to be addressed	New	This scheme is part of a larger programme of work with Councillors that the Public Health Team will be engaged in in 2014/15 and 2015/16
(3)	Enable active living in neighbourhood areas	Through reviews of existing commissioned activity that focusses on both priority neighbourhoods and client groups.	Ongoing	Future developments will include a commissioned service that includes activity for the elderly
(4)	Enable healthy choices in neighbourhoods areas	Working with elected members and partnership groups to determine the barriers to unhealthy choices	New	This scheme is part of a larger programme of work with Councillors that the Public Health Team will be engaged in in 2014/15 and 2015/16
(5)	Provide accessible services for all residents	Working with the People Directorate, develop a commissioning plan for people with complex needs and multiple vulnerabilities	New	Joint programme of work across the ODPH and People directorates to inform commissioning of services from 2016
(6)	Encourage residents to take up screening programmes	Existing public health commissioned activity carried out by the PCH Livewell Team	Ongoing	This work in ongoing
(7)	Encouraging residents to seek early diagnosis	Existing public health commissioned activity carried out by the PCH Livewell Team.	Ongoing	This work is ongoing
(8)	Engaging the resource of medical students from Plymouth University to deliver targeted behavioural change outreach in Devonport in liaison with Public Health and Primary Care	To develop a proposal for setting up a primary care-public health collaborative for Devonport (which I have titled Devonport TORCh*) in collaboration with Richard Ayres at the	July 2014	This work could be possibly sponsored but would involve collaboration with the University of Plymouth, Plymouth Community Healthcare and ODPH

		Cumberland Centre		
Theme 4	**Capacity building**	**Planned actions**	**Date**	**Comment**
(1)	Increase capacity for delivery of this approach	Build the case through evidence of effect – include a thorough economic analysis for Plymouth Build a local suite of evidence of interventions that have been known to work	From Sept 2014	
(2)	Collaborate and encourage joint working	Business partnering arrangement to be established following re-alignment of Public Health Team's responsibilities	New	This will enable the Public Health Team to have a more effective impact across the Council as a whole.
(3)	Encourage evidence-based interventions	Access guidance documents from LGA, NICE, DH, PHE and ensure they are shared as appropriate across the Council	Ongoing	This work is ongoing
(4)	Share knowledge and information	Ensure that data, information and intelligence is available when required and in the appropriate format. This includes making key publications available to partners via the Council website	Ongoing	This work is ongoing
(5)	Work with local media	Work with the Plymouth Herald and partners to ensure that key health and wellbeing improvement-related messages are communicated to the population via the 'I Love Life' campaign (ensure the programme is evaluated)	2014/15	Other partners involved in this campaign include Plymouth Community Healthcare, Plymouth Community Homes and Marjons
(6)	Monitor and evaluate progress	Included in the Public Health Team's workplan	2014 onwards	Included in remit of relevant area of Public Health Team following re-alignment of responsibilities.
(7)	ODPH commissioned services (link 4-4-54)	Review existing public health commissioned	New	Once adopted, there may need to be a shift of focus in

		activity carried out by the PCH Livewell Team to ensure links are made to the 4-4-54 priorities		in commissioned activity to align with 4-4-54

Appendix 2: Numbers and percentages of deaths due to stroke, CHD, COPD, and cancer, by ward, 2012

Plymouth wards	2012 deaths (persons)	Stroke deaths	CHD deaths	COPD deaths	Cancer deaths	Total number of 4-4-54 deaths	% of all deaths from 4-4-54
Budshead	123	6	18	12	40	76	61.8
Compton	147	10	20	7	26	63	42.9
Devonport	115	4	8	11	33	56	48.7
Drake	61	1	9	7	15	32	52.5
Efford & Lipson	95	5	13	8	29	55	57.9
Eggbuckland	124	9	11	3	53	76	61.3
Ham	122	4	17	13	39	73	59.8
Honicknowle	184	10	25	15	55	105	57.1
Moor View	109	3	20	1	35	59	54.1
Peverell	122	8	14	4	30	56	45.9
Plympton Chaddlewood	37	1	7	5	11	24	64.9
Plympton Erle	107	10	11	9	34	64	59.8
Plympton St Mary	163	16	15	7	37	75	46.0
Plymstock Dunstone	138	16	14	7	44	81	58.7
Plymstock Radford	145	9	14	8	51	82	56.6
Southway	120	10	18	4	41	73	60.8
St Budeaux	101	5	16	9	30	60	59.4
St Peter & the Waterfront	158	9	26	13	47	95	60.1
Stoke	167	11	17	7	33	68	40.7
Sutton & Mount Gould	115	5	14	0	32	51	44.3
Plymouth	**2,453**	**152**	**307**	**150**	**715**	**1,324**	**54.0**

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THE PLYMOUTH REPORT 2014

Author: Public Health Team, Plymouth City Council

Date: November 2014

This profile is produced as part of Plymouth's Joint Strategic Needs Assessment.

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Contents

Note:
Throughout the document footnotes specify the title of the source or extract. Please see the references section at the end of each chapter for full details of references. Website addresses are provided if available.

1. POPULATION

Knowing how many people live within the city and the characteristics of them is critical to ensuring that:

- Local services such as transport, housing, schools, and hospitals can be provided where they are needed.
- Individuals, businesses, local authorities, and government can plan properly for the future.

It is also a key component for how central and local government allocate public funding each year.

1.1 Current population

Plymouth currently has a population of 259,200 (Office of National Statistics (ONS) 2013 mid-year population estimates), making it the 15th largest city (by population) in the country.[1]

1.2 Age and gender

The city has the third lowest percentage of people 75 years and over (7.8%), and the middle ranking percentage of children and young people under-18 (19.8%) of the 16 SW county and unitary authorities (2012).[1]

Due to an estimated 30-35,000 students residing in the city, the percentage of 18-24 year olds (13.2%) is higher than that found regionally (8.8%) and nationally (9.2%).[1]

The proportion of the working-age (16-64 year old) population (65.3%) is higher than that regionally (61.7%) and nationally (63.5%).[1]

Plymouth has the fourth highest percentage of working age people of the 16 SW county and unitary authorities (65.3%).[1] Only Bristol (68.0%), Bournemouth (66.2%) and Swindon (65.4%) have higher.

Overall 50.4% of Plymouth's population are female; this reflects the national figure of 50.7%.[1]

[1] Population estimates mid-2013

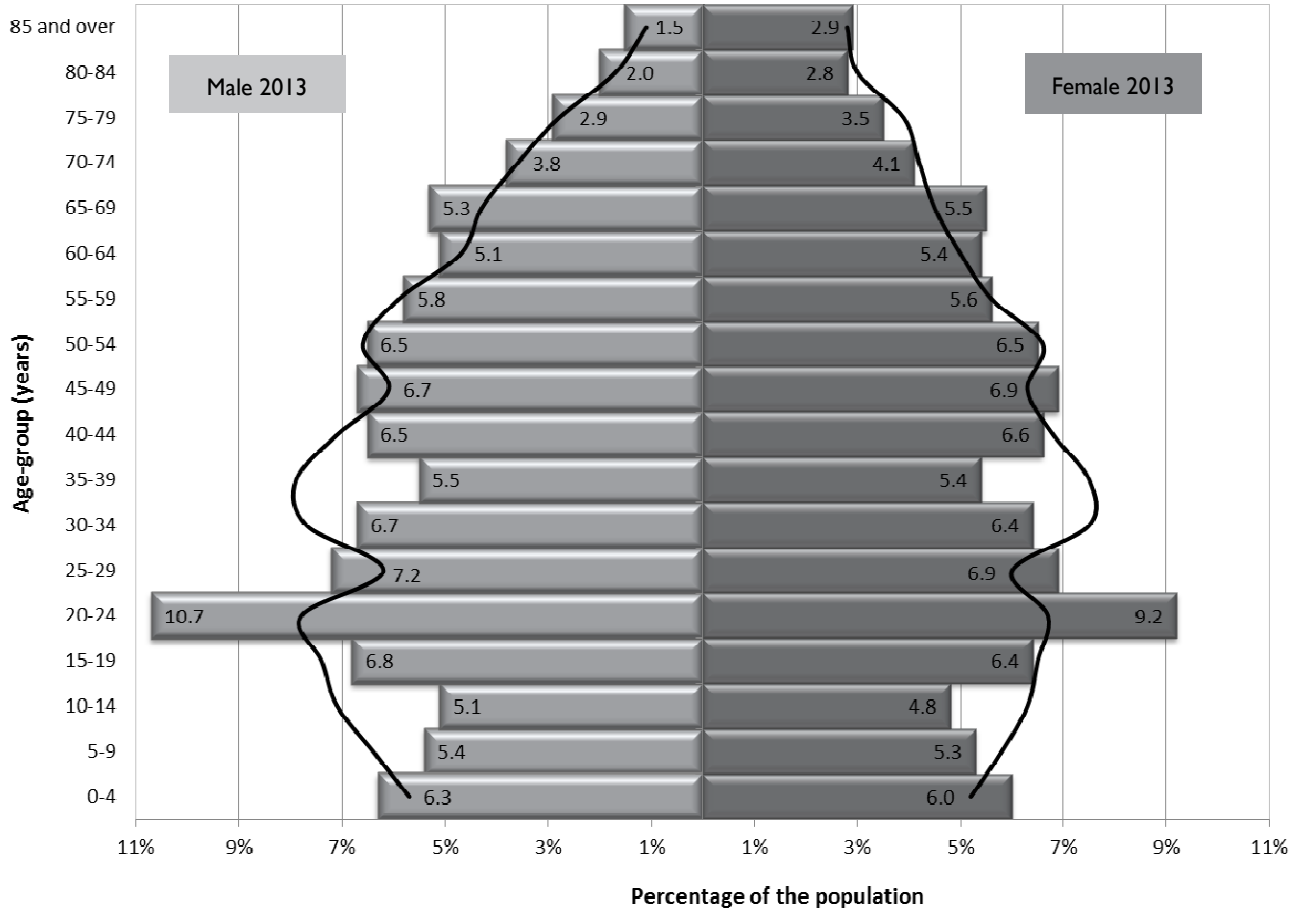
1.3 Population change since 2001

There were 3,418 live births in 2012 (the latest published small area statistics). Areas with high numbers of births include Honicknowle (165), Stonehouse (150), and Devonport (143) - some of the most deprived neighbourhoods of the city.[2]

The number of births has increased annually from 2,547 in 2001, except in 2011 when the number was the same as 2010 (3,280 births in each year).[2]

Plymouth's population is estimated at 259,200, an increase of 18,200 (7.6%) since 2001. This is below the growth rate in England (8.9%).

Figure 1: Plymouth population pyramid 2001to 2013



The black line depicts 2001 male and female populations
Source: ONS 2001 (revised) and 2013 mid-year population estimates (rounded figures)

[2] Public Health Birth Extracts, 2001-2012

Key changes in population numbers since 2001 (Table 1):

- Between 2001 and 2013 there have been increases in the number of: very young children (0-4) by 21.4 %; 20-24 year olds by 48.3%; and 25-29 year olds by 23.7%.
- With respect to the 20-24 age group growth in part has occurred as a result of the Plymouth University expansion over the last 10 years. Once graduated however, the majority of this group leave the city and do not stay to work or start businesses.
- People aged 65 years and over account for 17.2% of Plymouth's total population. This is equal to that found nationally (17.2%).
- There has been shrinkage in the young working-age 30-39 year olds of 17.9%.

Table 1: Population change in Plymouth 2001 to 2013 (rounded figures)

Age (years)	Number of persons 2013	Change in numbers from 2001	% change
0-4	15,900	2,800	21.4
5-9	13,900	-700	-4.8
10-14	12,900	-3,200	-19.9
15-19	17,100	400	2.4
20-24	25,800	8,400	48.3
25-29	18,300	3,500	23.7
30-34	17,000	-1,300	-7.1
35-39	14,200	-4,300	-23.2
40-44	16,800	0	0.0
45-49	17,600	2,700	18.1
50-54	16,800	800	5.0
55-59	14,700	900	6.5
60-64	13,700	2,100	18.1
65-69	14,100	3,600	34.3
70-74	10,100	700	7.5
75-79	8,400	300	3.7
80-84	6,200	500	8.8
85 and over	5,700	900	18.8
Total	259,200	18,200	7.6

Source: ONS 2001 and 2013 mid-year population estimates

By 2031 ONS projects the 65 years and over age group will grow by 35.3% and will account for 21.9% of Plymouth's total population. An aging population will put pressure on Plymouth's public services, supported housing and adult social care in particular.[3]

[3] ONS Subnational Population Projections, Interim 2011-based

ONS projects the total population of Plymouth to reach 275,200 by 2031.[3] This trajectory would not result in Plymouth reaching its target of 300,000 residents by 2031.

Figure 2: Projected population change in Plymouth, 2013 to 2031 (rounded figures)

Age (years)	Number of persons 2031	Change in numbers from 2013	% change
0-4	15,500	-400	-2.5
5-9	15,100	1,200	8.6
10-14	15,200	2,300	17.8
15-19	18,700	1,600	9.4
20-24	28,300	2,500	9.7
25-29	17,800	-500	-2.7
30-34	16,400	-600	-3.5
35-39	16,000	1,800	12.7
40-44	15,100	-1,700	-10.1
45-49	14,600	-3,000	-17.1
50-54	13,300	3,500	20.8
55-59	13,500	-1,200	-8.2
60-64	15,500	1,800	13.1
65-69	15,300	1,200	8.5
70-74	13,400	3,300	32.7
75-79	10,600	2,200	26.2
80-84	10,000	3,800	61.3
85 and over	10,900	5,200	91.2
Total	275,200	23,000	8.9

Source: ONS subnational population projections, interim 2012-based

Population change occurs as a result of two factors:

- 'natural change', the difference between the number of births and the number of deaths,
- 'net migration', the difference between the number of people migrating into an area and the number migrating out of the area.

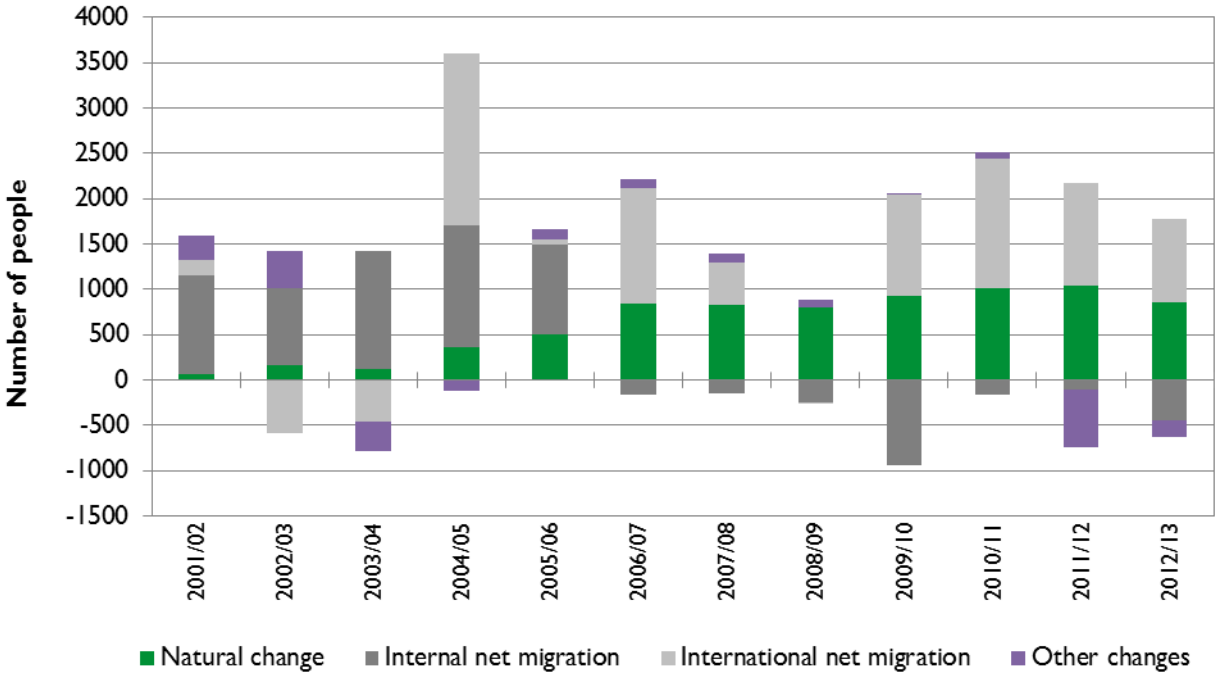
These components combined affect whether the population increases or decreases over the course of a year.

In Plymouth live births are increasing whilst deaths are decreasing resulting in an increase in the population due to natural change (Figure 3). From 2001 to 2013 Plymouth's population increased by 7,500 people due to natural change alone. This accounts for 15.4% of all change in Plymouth over that time.

Since 2006/07 internal net migration has resulted in a net loss of individuals out of the city. In 2004/05 inward international migration increased considerably indicating that migration was led

by the 2004 Accession Countries entry into the European Union. The sharp reduction of international migration in 2008/09 is likely a result of the national recession in 2008.

Figure 3: Plymouth population components of change, 2001/02 to 2012/13



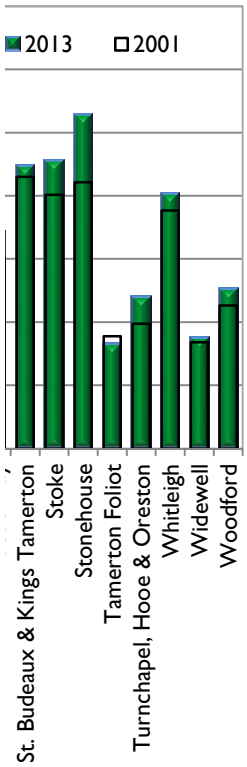
Other changes consist of the prison population, armed forces population, and asylum seekers
Source: Provided by Policy, Performance and Partnerships Team, Plymouth City Council

Live births can be analysed according to the birth place of the mother. In Plymouth, births to both UK and non-UK born mothers are increasing in number. The proportion of births to non-UK born mothers has increased from 6.4% in 2001 to a peak of 12.8% in 2013.

1.4 Population by neighbourhood

Until 2010 the ONS had not produced official population statistics at LSOA level making it impossible to estimate population at small geographies such as neighbourhoods. There are however many administrative sources that capture population data such as the GP register. This data has been used for a number of years to calculate numbers of residents at various sub-city geographies using postcode data. Figure 4 details the change in population using the GP register from 2001 and 2013.

Figure 4: Plymouth GP population register by neighbourhood, 2001 to 2013



Greenbank and University has seen the biggest population growth over the last 13 years. This change is predominantly attributable to the increases in student population throughout this time. Other neighbourhoods seeing high increases in population include Stonehouse and City Centre.

Higher Compton and Mannamead has seen the biggest reduction in population over the same time period. Other neighbourhoods showing noticeable decreases include Leigham and Mainstone and North Prospect and Weston Mill. The latter neighbourhood is currently undergoing a major regeneration project which began in 2009. This has seen a large number of residents move out of the area whilst work is completed.

1.5 Children, younger people, and older people

Key facts:

- In 2013 17.4% of the population were under-16.[4]
- Honicknowle, Whitleigh, Stonehouse, and Devonport had the largest numbers of children aged 0-4 years.[4]
- Children and young people (CYP) under-18 account for 18.5% of the population.[4]
- 16.8% of people in Plymouth are aged 65 years and older.[4]
- 7.6% are 75 years and over and 2.2% are 85 years and over.[4]
- The over 75's age-group is predicted to rise from 20,400 in 2013 to 33,000 in 2031.[5]

Table 2: Neighbourhoods with the highest number/percent of young people aged 0-15 years, 2013

Neighbourhood	Number
Honicknowle	2,131
Peverell & Hartley	1,724
St Budeaux & Kings Tamerton	1,709
Chaddlewood	1,688
Efford	1,649
Neighbourhood average	1,193

Neighbourhood	Percent (%)
Barne Barton	28.0
Widewell	23.0
Tamerton Foliot	22.2
Devonport	22.1
North Prospect & Weston Mill	21.9
City average	17.4

Source: Public Health Team, Plymouth City Council [6]

Table 3: Neighbourhoods with the lowest number/percent of young people aged 0-15 years, 2013

Neighbourhood	Number
Mutley	370
City Centre	566
Morice Town	616
Greenbank & University	678
Tamerton Foliot	728
Neighbourhood average	1,193

Neighbourhood	Percent (%)
Greenbank & University	5.4
City Centre	7.9
Mutley	10.0
Mount Gould	13.2
Stoke	14.2
City average	17.4

Source: Public Health Team, Plymouth City Council [6]

[4] 2013 ONS mid-year population estimates analysis, 2014
[5] 2012-based subnational population projections, 2014
[6] GP population register (2013) analysis, 2014

Figure 5: 2013 population estimates for 0-4 year olds, by neighbourhood

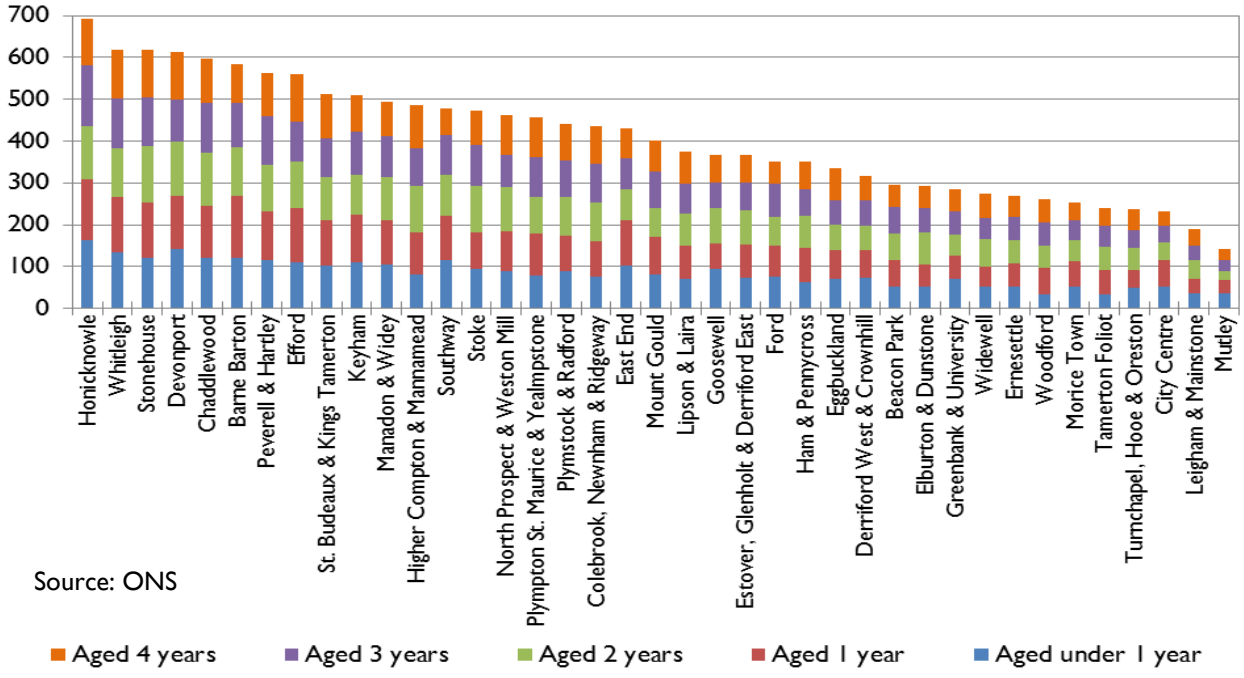


Table 4: Neighbourhoods with the highest number/percent of people aged 65 and over, 2013

Neighbourhood	Number
Elburton & Dunstone	2,488
Colebrook, Newnham & Ridgeway	2,128
Plymstock & Radford	1,991
Plympton St Maurice & Yealmpstone	1,981
Higher Compton & Mannamead	1,936
Neighbourhood average	1,151

Neighbourhood	Percent (%)
Elburton & Dunstone	32.2
Colebrook, Newnham & Ridgeway	25.3
Plymstock & Radford	25.1
Turnchapel, Hooe & Oreston	23.0
Leigham & Mainstone	22.6
City average	16.8

Source: Public Health Team, Plymouth City Council [6]

Table 5: Neighbourhoods with the lowest number/percent of people aged 65 and over, 2013

Neighbourhood	Number
Morice Town	332
Mutley	385
Barne Barton	432
Tamerton Foliot	577
Keyham	617

Neighbourhood	Percent (%)
Greenbank & University	5.7
Barne Barton	8.0
East End	10.2
Lipson & Laira	10.2
Morice Town	10.4

Neighbourhood average	1,151	City average	16.8

Source: Public Health Team, Plymouth City Council [6]

1.6 Ethnicity, race, and language

There is relatively little ethnic diversity in Plymouth. According to the 2011 Census 92.9% of Plymouth's population considered themselves White British.[7] This is significantly higher than the England average (79.8%).

7.1% considered themselves Black and Minority Ethnic (BME) with White Other (2.7%), Chinese (0.5%) and Other Asian (0.5%) the most common ethnic groups.[7] Plymouth has lower percentages of residents within each ethnic group compared with the national average. Despite the small numbers Plymouth has a rapidly rising BME population which has more than doubled from 7,906 individuals since the 2001 census.[8]

Table 6: Ethnic groups in Plymouth, 2011

	Ethnicity	Plymouth count	Plymouth %	England (%)
White	English/Welsh/Scottish/Northern Irish/British	238,263	92.9	79.8
	Irish	1,105	0.4	1.0
	Gypsy or Irish traveller	153	0.1	0.1
	Other White background	6,988	2.7	4.6
Mixed	White and Black Caribbean	904	0.4	0.8
	White and Black African	523	0.2	0.3
	White and Asian	1,028	0.4	0.6
	Other Mixed background	832	0.3	0.5
Asian	Indian	875	0.3	2.6
	Pakistani	202	0.1	2.1
	Bangladeshi	359	0.1	0.8
	Chinese	1,251	0.5	0.7
	Other Asian background	1,219	0.5	1.5
Black	African	1,106	0.4	1.8
	Caribbean	343	0.1	1.1
	Other Black background	229	0.1	0.5
Other	Arab	399	0.2	0.4
	Any other ethnic group	605	0.2	0.6
Total		256,384		

[7] 2011 Census: ethnic group, Dec 2012.
[8] 2001 Census: ethnic group

Source: 2011 Census [7]

The two neighbourhoods with the highest BME populations are Stonehouse (11.1%) and Greenbank and University (10.0%). Elburton and Dunstone had the lowest percentage (1.2%).[9]

Table 7: Ethnicity of Plymouth school children (5 to 18 years), 2012

	Ethnicity	Number of pupils	School population (%)
White	White British	33,646	91.7
	White Irish	41	0.1
	Gypsy/Roma	19	0.1
	Traveller of Irish heritage	6	<0.1
	Other White background	1,123	3.1
Mixed	White & Black Caribbean	185	0.5
	White & Black African	117	0.2
	White & Asian	204	0.6
	Other Mixed background	196	0.5
Asian	Indian	92	0.3
	Pakistani	29	0.1
	Bangladeshi	103	0.3
	Chinese	150	0.4
	Other Asian background	75	0.2
Black	African	226	0.6
	Caribbean	31	0.1
	Other Black background	30	0.1
Other	Any other ethnic group	438	1.2
Grand total		36,711	100.0

Those cases where ethnicity data was not obtained or the participant refused to answer are not included.
Source: School Census 2012.[10]

Schools are required to report on the ethnicity of their attending children see
Table 7. Four neighbourhoods have a schoolchild BME population of 20% or more. They are City Centre (38.0%), Greenbank and University (32.3%), Stonehouse (29.9%) and East End (23.4%).[10] There are 1,867 school children (5 years and over) that speak English as an additional language.[10] Nearly 100 different languages are spoken by children in the city. Polish and Arabic are the most common, spoken by 385 (1.0%) and 143 (0.4%) children respectively.[10] The variety of languages spoken by the population presents a challenge for front-line services.

[9] 2011 Census: Ethnic group
[10] School Census data 2012: ethnicity and language data

1.7 Religion and belief

Data for 2011 unless otherwise stated.

- Christianity is the most common religion in Plymouth.
- 32.9% of the Plymouth population stated they had no religion.[11]
- Those following Hinduism, Buddhism, Judaism or Sikhism combined totalled less than 1.0%.[11]
- 0.5% of the population had a current religion, such as Paganism or Spiritualism, which was not one of the six main religions listed below.[11]

Christianity

- 58.1% (148,917 people).[11]
- Decreased from 73.6% (177,068 people) since 2001.[12]

Islamism

- 0.8% (2,078 people).[11]
- Increased from 0.4% (885 people) since 2001.[12]

Buddhism

- 0.3% (881 people).[11]
- Increased from 0.2% (470 people) since 2001.[12]

Hinduism

- 0.2% (567 people).[11]
- Increased from 0.1% (212 people) since 2001.[12]

Judaism

- 0.1% (168 people).[11]
- Remained at 0.1% (181 people) since 2001.[12]

Sikhism

- <0.1% (89 people).[11]
- Remained at <0.1% (56 people) since 2001.[12]

[11] 2011 Census: religion
[12] 2001 Census: population by religion

1.8 Marriage and civil partnerships

Data for 2011 unless stated otherwise.

- Of those aged 16 and over 90,765 (42.9%) people are married.[13]
- There were 21 Civil Partnership Formations in Plymouth in 2010, 24 in 2011, and 30 in 2012.[14]
- 5,190 (2.5%) of people in Plymouth are separated and still either legally married or legally in a same-sex civil partnership.[13]

1.9 Gender reassignment and sexual orientation

In 2010 it was estimated nationally that the number of gender variant people presenting for treatment was around 12,500. Of these, around 7,500 have undergone transition.[15]

The median age for treatment for gender variation is 42 years.

The Laurels Gender Identity and Sexual Medicine Service in Exeter is the only gender identity clinic in the South West.

There is no precise number of the trans population in Plymouth.

There is also no precise local data on numbers of Lesbian, Gay and Bi-sexual (LGB) people in Plymouth but it is nationally estimated at 5.0% to 7.0%. This would mean that approximately 13,300 people aged 16 years and over in Plymouth are LGB.

1.10 Travellers and Gypsies

Plymouth has established Gypsy and Traveller communities. Evidence shows that these communities live shorter lives than settled ones and are less likely to use established preventative or early treatment health services.

Typically the city gets 20 to 25 unauthorised Traveller and Gypsy encampments a year. In 2010, this rose to over 40.[16]

In 2012 there were 13 Gypsy and Traveller families (comprising 14 adults and 22 children) at The Ride (Plymstock), Plymouth's only official site.[17]

It has been identified that a further 40 permanent pitches and 15 transit pitches are required in Plymouth.[16]

[13] 2011 Census: marital and civil partnership status (local authorities)
[14] Local management statistics, Dec 2012.
[15] Number of Gender Variant People in the UK - update 2011
[16] Gypsy and traveller sites in Plymouth, 2011
[17] Data provided by the Homes and Communities Department, Plymouth City Council, Dec 2012.

1.11 Migration

Of the 521 non-UK born short-term residents (intending to stay between 3 and 12 months) in Plymouth over the age of 16 recorded by the 2011 Census 15.5% (81 individuals) were in employment.[18]

Estimates using the International Passenger Survey (mid-2011) suggest that of the 326 individuals satisfying the United Nations definition of a short-term migrant roughly one third (112) were arriving for employment.[19]

Table 8: Residency terms of England and Plymouth residents, 2011

			Resident in the UK for…					
	Born in the UK		less than 2 years		2-10 years		10 years or more	
	Number	%	Number	%	Number	%	Number	%
England	45,675,317	86.2	928,025	1.8	2,692,174	5.1	3,716,940	7.0
Plymouth	238,177	92.9	2,628	1.0	7,340	2.9	8,239	3.2

Source: 2011 Census

The 2011 Census recorded a residency pattern in Plymouth that mirrored that seen nationally. There is an increasing proportion of non-UK born individuals that have been resident from less than two years to 10 years or more.

1.12 Asylum seekers

Plymouth has been a dispersal area for asylum seekers since 2000. There are approximately 350 asylum seekers in Plymouth. Most are supported by the UK Border Agency but a few (mainly those under-18 when claiming asylum) are assisted by the Council.[20]

[18] 2011 Census: economic activity
[19] Inflows by local authority by main reason for migration, mid-2008 to mid-2011
[20] Asylum seekers in Plymouth

1.13 References

References are listed in alphabetical order by footnote name. The corresponding footnote number(s) is(are) also displayed. Links to online documents/tools/sources are included if available.

8	2001 Census: ethnic group http://data.gov.uk/dataset/ethnic_group_2001_census
12	2001 Census: population by religion, ONS http://neighbourhood.statistics.gov.uk/dissemination/viewFullDataset.do?instanceSelection=048&productId=95&$ph=60_61_62&datasetInstanceId=48&startColumn=1&numberOfColumns=10&containerAreaId=276708
18	2011 Census: economic activity (non-UK born short-term residents), Table: AP1601EW, local authorities in England and Wales http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-301981
7, 9	2011 Census: ethnic group, local authorities in England and Wales, Table: KS201E, Dec 2012. http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/rpt-ethnicity.html http://www.nomisweb.co.uk/census/2011/ks201ew
11	2011 Census: religion, local authorities in England and Wales, Table: KS209EW ONS http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262
13	2011 Census: marital and civil partnership status (local authorities), Table: KS103EW ONS. http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262
5	2012-based subnational population projections for local authorities in England http://ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Projections#tab-data-tables
4	2013 ONS mid-year population estimates analysis, Public Health Team, Plymouth City Council, 2014
20	Asylum seekers in Plymouth http://www.plymouth.gov.uk/homepage/communityandliving/socialinclusion/asylumseekers.htm
17	Data provided by the Homes and Communities Department, Plymouth City Council, Dec 2012.
6	GP population register (2013) analysis, Public Health Team, Plymouth City Council, 2014
16	Gypsy and traveller sites in Plymouth, http://www.plymouth.gov.uk/gypsytraveller_cabinet_report.pdf
19	Inflows by local authority by main reason for migration, mid-2008 to mid-2011. http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-294361

3	Interim 2011-based subnational population projections, persons by single year of age for local authorities in England http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Sub-national+Population+Projections
14	Local management statistics provided by the Democracy and Governance Unit, Plymouth City Council, Dec 2012
15	Number of Gender Variant People in the UK - Update 2011 http://www.gires.org.uk/assets/Research-Assets/Prevalence2011.pdf
1	Population estimates mid-2012 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-310118
2	Public Health birth extracts, 2001-2012, Public Health Team, Plymouth City Council
11	School Census data 2012: ethnicity and language data provided by Policy, Performance & Partnerships Department, Plymouth City Council, Jan 2013.

2. DEPRIVATION, CHILD POVERTY, AND LOCAL COMMUNITY

2.1 Deprivation

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. Deprivation measures attempt to identify communities where the need for healthcare is greater, material resources are fewer and as such the capacity to cope with the consequences of ill-health are less. People are therefore deprived if there is inadequate education, inferior housing, unemployment, insufficient income, poor health, and low opportunities for enjoyment. A deprived area is conventionally understood to be a place in which people tend to be relatively poor and are relatively likely to suffer from misfortunes such as ill-health.

The English Indices of Deprivation 2010 use 38 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2010 (IMD 2010). This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA) in England. The IMD 2010 can be used to rank every LSOA in England according to their relative level of deprivation.

When analysing IMD data it is important to bear in mind the following:

- It is not an absolute measure of deprivation
- Not all people living in deprived areas are deprived and vice versa
- It cannot be compared over time because an area's score is affected by the scores of every other area; so it is impossible to tell whether a change in score is a real change in the deprivation level of an area, or whether it is due to the scores of other areas going up or down.

Using the population weighted average combined scores for the Lower Super Output Area scores in a local authority district, Plymouth is ranked 72 out of 326 (1 most deprived; 326 least deprived). This places Plymouth just above the bottom 20% of local authorities in England. In comparison Salford was ranked 18, Bristol 79, and Newcastle-upon-Tyne 150.

Out of 32,482 LSOAs in England Plymouth has two LSOAs in the 4% most deprived, two in the 3% most deprived, two in the 2% most deprived and one in the 1% most deprived LSOAs in the country (see Figure 6).

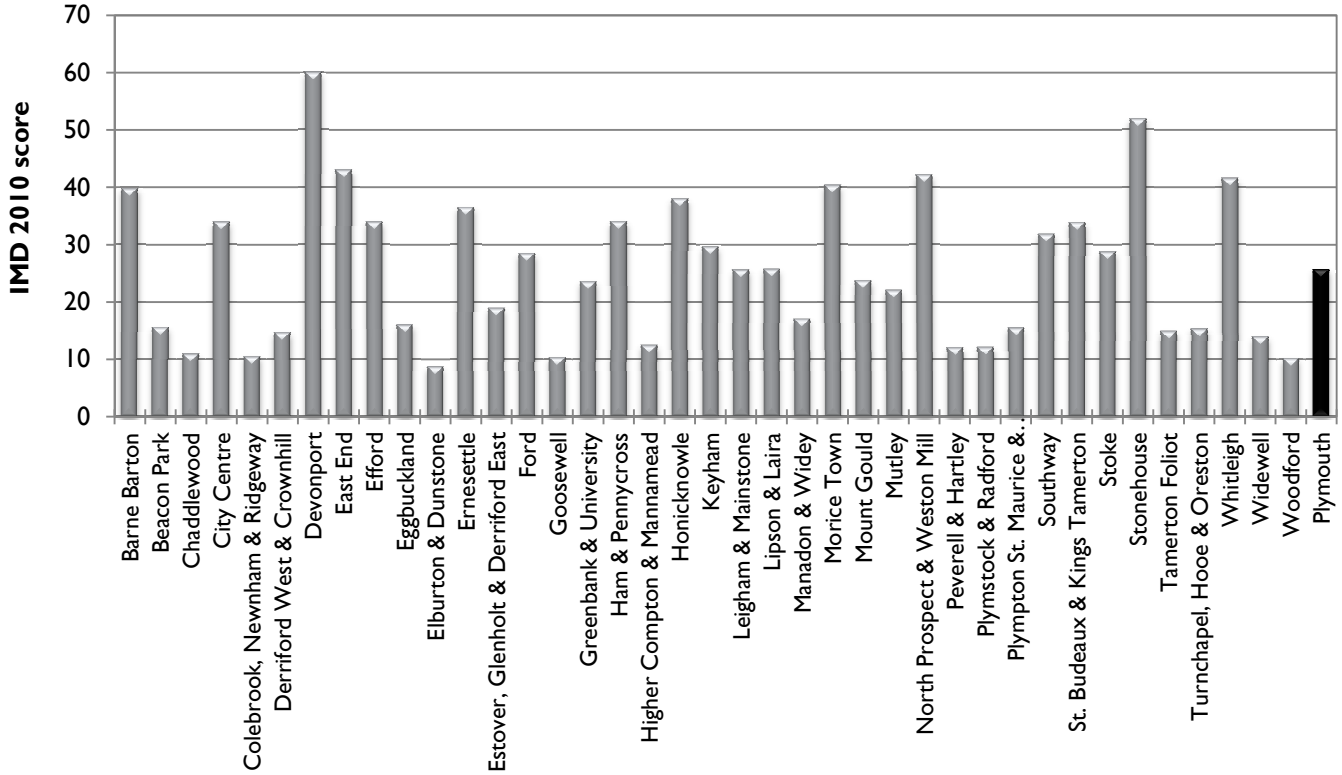
The Department for Communities and Local Government is currently updating the indices of deprivation, including the Index of Multiple Deprivation (IMD) and is due for publication in summer 2015.

Figure 6: Plymouth's most deprived Lower Super Output Area (LSOA)

Source: Index of Multiple Deprivation, 2010
Digital mapping solutions from Dotted Eyes Crown copyright 2013 License number 100019918

LSOA E01015155 (029C) is located in the Stonehouse neighbourhood (St Peter and the Waterfront ward) and is the most deprived LSOA in Plymouth. It is the 319th most deprived LSOA in England.

Figure 7: Index of Multiple Deprivation 2010 score by neighbourhood



Source: Public Health Team, Plymouth City Council using Index of Multiple Deprivation, 2010 data

Table 9: The top five most and least deprived neighbourhoods in Plymouth

Most deprived neighbourhoods	Rank	Least deprived neighbourhoods	Rank
Devonport	1	Chaddlewood	35
Stonehouse	2	Colebrook, Newnham, & Ridgeway	36
East End	3	Goosewell	37
North Prospect & Weston Mill	4	Woodford	38
Whitleigh	5	Elburton & Dunstone	39

Source: Index of Multiple Deprivation, 2010

Figure 7 and Table 9 highlight that Devonport is Plymouth's most deprived neighbourhood. The most deprived neighbourhoods listed contain some of the most deprived LSOAs in the country. Many of these neighbourhoods are identified throughout this document in relation to poorer health, lower educational attainment, limited access to goods and services, and inferior housing.

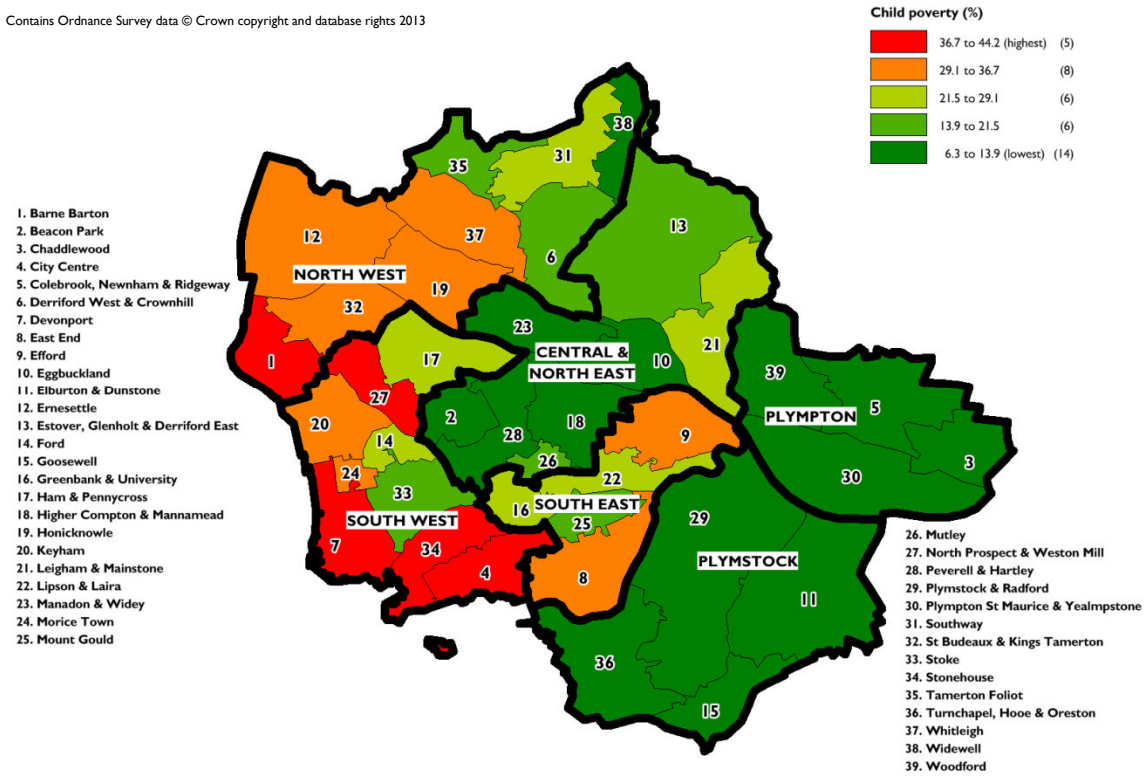
2.2 Child poverty

The Children in Low-Income Families Local Measure shows the proportion of children living in families in receipt of out-of-work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60 per cent of UK median income. This measure provides a proxy for low-income child poverty as set out in the Child Poverty Act 2010 and enable analysis at a local level.

Plymouth has an estimated 11,335 children living in poverty (of which 10,140 are under-16). This equates to 21.6% compared to 20.1% nationally.[21]

Nearly 70% of children in poverty (7,660) live in lone parent families, whilst 41% live in families with three or more children.[21]

Figure 8: All-age child poverty by neighbourhood (%), 2011



Source: HMRC, 2011

Figure 8 illustrates the distribution of child poverty across Plymouth. High levels are concentrated in the western side of the city. Child poverty ranges from 6.3% in Peverell and Hartley to 44.2 % in Devonport (44.2%). At smaller LSOA level there are pockets of deprivation in the city where around 50% of the resident children are living in poverty. These areas are based in the neighbourhoods of Devonport, City Centre, and North Prospect and Weston Mill.

[21] Children in low income families local measure, as at 31 Aug 2011

2.3 Participation in, and influence of, decision-making

In the 2014 European parliamentary elections 37.6% of Plymouth residents voted[22] - a turnout slightly higher than the UK average of 34.2%.[23] The turnout for the city council elections in the same year was 37.3%.[22]

Only 18.8% of those surveyed as part of Listening Plymouth in 2012 felt they could influence decisions affecting their local area. This was a decrease of 5.1 percentage points since the previous Place Survey in 2009.[24]

Voluntary Neighbourhood Liaison Officers host 'Have Your Say' meetings in many of the neighbourhoods each year. Around 10 community members attend each meeting. The five neighbourhoods with the highest deprivation scores also have Neighbourhood Managers and Wardens who co-ordinate a number of activities to enhance community engagement and cohesion.[25]

2.4 Community cohesion

Measures of community cohesion show that Plymouth performs badly compared to other cities. This may be due to the city's rapidly changing demographics, particularly in terms of ethnicity, coupled with high levels of unemployment caused in part by the shift away from the city's manufacturing base.[25]

According to the 2012 Listening Plymouth Survey 52% of residents outlined that people from different ethnic backgrounds get on well with one another in their local are whilst 58% very or fairly strongly felt that they belonged to their local area.[24]

2.5 Voluntary and community sector

Plymouth City Council has identified 800 Voluntary and Community (VCS) groups and organisations in the city although anticipates that the number is much higher. The VCS in Plymouth benefits from around £20 million per year in grants and subsidies.[25]

2.6 Social enterprise and cooperatives

Plymouth is recognised as having a high proportion of social enterprises compared to other cities. There are a number of bodies offering support to social enterprises in Plymouth including Plymouth University and the Plymouth Social Enterprise Network.[25]

Cooperatives have been a part of the city's identity for many years. The move of Plymouth City Council to become a 'cooperative council' reflects this and the desire to make the city fairer and more democratic.[25]

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[22] Percentage turnout at elections within Plymouth from 1966 to 2014
[23] European parliament election turnout 1979-2014
[24] Listening Plymouth: a view from you household survey report, 2012
[25] Plymouth Plan Sustainability Appraisal Scoping Report, 2013

2.7 References

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21	Children in low income families local measure as at 31 Aug 2011 https://www.gov.uk/government/publications/personal-tax-credits-children-in-low-income-families-local-measure
23	European parliament election turnout 1979-2014 http://www.ukpolitical.info/european-parliament-election-turnout.htm
24	Listening Plymouth: a view from you household survey report, Marketing Means on behalf of Plymouth City Council, 2012
22	Percentage turnout at elections within Plymouth from 1966 to 2014 http://www.plymouth.gov.uk/homepage/councilanddemocracy/elections/percentageturnouts.htm
25	Plymouth Plan Sustainability Appraisal Scoping Report, 2013 http://www.plymouth.gov.uk/sa_scoping_report_for_plymouth_plan.pdf

3. LEARNING AND EDUCATION

Plymouth is an aspiring city and the presence of a highly educated population is of great importance. The general level of educational attainment is an important determinant factor in public-health wellbeing.

A total of £13.6 million has been invested as parts of basic need work since 2011 which has resulted in 1,546 extra school places in Plymouth. An additional £8.4 million has been allocated recently by Government through targeted capital funding to build a new two-form entry primary school and to expand three further primary schools from 2015.[26]

3.1 School standards

Table 10: Change in Ofsted ratings between 2009 and 2014 for Plymouth schools

Ofsted rating	Primary schools		Secondary schools	
	2009 (%)	2014 (%)	2009 (%)	2014 (%)
Outstanding	18	12	25	13
Good	44	69	63	63
Satisfactory	35	15	13	19
Inadequate	3	3	0	6

Source: Ofsted[27]

The percentage of primary schools achieving a Good or Outstanding rating has risen from 62% in 2009 to 81% in 2014. Plymouth's current value is slightly better than the England average (80%) and the city performs better than nine of ten other similar local authorities; only Torbay's value (86%) is better.

Good or Outstanding ratings in Plymouth's secondary schools has decreased from 88% in 2009 to 76% in 2014. This is still better than the England average (71%) and only Torbay (83%) and Telford and Wrekin (85%) of the ten similar local authorities had higher 2014 values.

3.2 Special Educational Needs

Table 11: Percentage of pupils with Special Education Needs (SEN), 2014

Area	Primary schools		Secondary schools	
	With statements	Without statements	With statements	Without statements
Plymouth	1.9	15.8	2.7	16.5
England	1.4	15.2	1.9	15.9

Source: Department for Education[28]

[26] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[27] Overall effectiveness; how good is the school
[28] Special educational needs in England: January 2014

Nationally the percentage of primary pupils with statemented Special Educational Needs was 1.4% in 2014 compared to 1.9% in Plymouth. Both areas have shown a decrease from 2005 from 1.6% and 2.1% respectively. Nationally the percentage without statements was 15.2% in 2014 compared to 15.8% in Plymouth. Again both areas have shown a decrease since 2005 from 16.5% and 18.9% respectively.

The percentage of secondary pupils with statemented Special Educational Needs in England was 1.9% in 2014, down from 2.3 per cent in 2005. Plymouth's value of 2.7 was a slight increase on the 2.5% seen in 2005. The percentage of pupils without statements was 15.9% nationally compared to 16.5% in Plymouth. Both areas have shown an increase since 2005 from 14.3% and 11.3% respectively.

3.3 Absence

Table 12: Overall absence, 2012/13

	Primary (%)	Secondary (%)	Special (%)	Total (%)
Plymouth	5.0	5.9	8.6	5.5
England	4.7	5.8	9.7	5.2

Source: Department for Education[29]

Compared to England absence in Plymouth schools is slightly higher overall. Absence in secondary schools is the most similar nationally and locally, whilst absence in special schools is one percentage point lower in Plymouth than England.

3.4 Permanent exclusions

Table 13: Permanent exclusions in Primary, Secondary, and Special Schools, 2012/13

	Number of exclusions	Percentage of the school population (%)
Plymouth	< 5	x
England	4,630	0.06

x = *data has not been calculated due to low numbers in the numerator that could have allowed for potential identification of individuals.*

Source: Department for Education[30]

The proportion of the school population in England permanently excluded from school was 0.06%. Plymouth had less than five permanent exclusions in 2012/13 resulting in the data being suppressed to comply with data protection.

[29] Pupil absence in schools in England: 2012/13

[30] Permanent and fixed period exclusion in England: 2012/13

3.5 Educational attainment and inequalities

Within Plymouth there are clear educational attainment gaps at all levels, from the Early Years Foundation Stage (EYFS) through to Key Stage 4 and post-16 qualifications. It is also clear from the statistics that the gap in attainment between the rich and poor widens as a child moves through the education system i.e. the gap in attainment is wider at Key Stage 4 compared to both Key Stage 2 and the EYFS.

3.5.1 Early Years Foundation Stage

Early Years Foundation Stage (EYFS) refers to the education between the ages of 0 and 5 years. 2013 was the first year of new EYFS assessments with the key measure being the percentage of children who achieve a good level of development.

Children are defined as having reached a good level of development at the end of the EYFS if they have achieved at least the expected level in:

- early learning goals in the prime areas of personal, social and emotional development; physical development; and communication and language
- early learning goals in the specific areas of mathematics and literacy.

In 2014 60% of children nationally achieved a good level of development at foundation stage with the figure being slightly lower in Plymouth at 58%. This represents a 1% increase from the previous year.[31]

The gap in Foundation Stage Profile achievement (the inequality gap measure) between the lowest achieving quintile of children and the median (middle) child's score in England has fallen from 36.6% to 33.9%. There is a current achievement gap within Plymouth of 34 percentage points. The gap is a slight increase from the previous year (up from 33.1%).[31]

3.5.2 Primary years (Key Stage 2)

Key Stage 2 refers to the education between the ages of 7 and 11 years. Table 14 provides a comparison between Plymouth and England using 2013/14 attainment data for pupils who have made expected progress (defined as progressing two attainment levels) between Key Stage 1 and 2 in reading, writing, and maths and the percentage of pupils achieving Level 4 or above in reading, writing, and maths.

Table 14: Key Stage 2 attainment, 2013/14

Area	Pupils making expected progress in …			Pupils achieving Level 4 or above in …		
	… reading (%)	… writing (%)	… maths (%)	… reading (%)	… writing (%)	… maths (%)
Plymouth	90	90	88	87	81	83
England	91	93	89	89	85	86

Source: Plymouth City Council [32]

[31] Early Years foundation stage profile results 2013/14 – data provided by Policy, Performance, and Partnership Team, Plymouth City Council

Plymouth pupils compare reasonably well with the national average, but have slightly lower values for each of the measures tabled.

Table 15: Highest and lowest achieving neighbourhoods at Key Stage 2, 2012/13

Neighbourhoods with lowest percentage of pupils achieving Level 4 or above in reading, writing, and maths (%)		Neighbourhoods with highest percentage of pupils achieving Level 4 or above in reading, writing, and maths (%)	
Whitleigh	41.5	Higher Compton & Mannamead	90.1
Stonehouse	52.9	Manadon & Widey	89.2
Barne Barton	55.4	Tamerton Foliot	87.9
Honicknowle	56.3	Turnchapel, Hooe & Oreston	87.8
Greenbank & University	59.3	Colebrook, Newnham & Ridgeway	87.3

Source: Plymouth City Council [33]

Table 15 demonstrates the attainment gap between neighbourhoods at Key Stage 2. The gap between the highest performing neighbourhood of Higher Compton & Mannamead (90.1%) and the lowest performing neighbourhood of Whitleigh (41.5%) is 48.6 percentage points.

3.5.3 Secondary years (Key Stage 4)

Key Stage 4 refers to the education between the ages of 14 and 16 years. Table 16 below benchmarks the attainment at Key Stage 4 of Plymouth's pupils compared to England 2012/13.

Table 16: Percentage of pupils getting five or more A*-C GCSE grades, 2012/13

	Five or more A*-C grades (%)	Five or more A*-C grades incl. Maths and English (%)
Plymouth	85.9	60.8
England	81.8	59.2

Source: Department for Education[34]

More children in Plymouth are achieving five or more A*-C grades at GCSE level (85.9%) than their national counterparts (60.8%) when all subjects are taken into account. Plymouth (60.8%) remains marginally above the national average (59.2%) when including Maths and English.

Attainment levels in Plymouth have been improving for a number of years. The percentage of children achieving five A*-C's across all subjects in 2012/13 has risen from 59.8% in 2005/06. A rise has also been seen in attainment including Maths and English, from 42.5% in 2005/06 to 60.8% in 2012/13.[34]

[32] Assessment of Key Stage 2 2013/14 - data provided by Policy, Performance, and Partnership Team, Plymouth City Council
[33] Area profile data, Plymouth City Council, 2014
[34] GCSE and equivalent results in England, 2012/13

Table 17: Highest and lowest achieving neighbourhoods at Key Stage 4, 2012/13

Neighbourhoods with lowest percentage of pupils achieving five or more A*-C grades at GCSE (incl. English and Maths) (%)		Neighbourhoods with highest percentage of pupils achieving five or more A*-C grades at GCSE (incl. English and Maths) (%)	
City Centre	33.3	Higher Compton & Mannamead	84.2
Stonehouse	35.5	Peverell & Hartley	79.6
Efford	36.4	Elburton & Dunstone	78.5
North Prospect & Weston Mill	38.0	Beacon Park	76.5
Whitleigh	43.5	Turnchapel, Hooe, & Oreston	75.0

Source: Plymouth City Council [35]

As seen in Table 15 there are significant inequalities in attainment at GSCE level across the neighbourhoods. The gap between the highest achieving neighbourhood of Higher Compton and Mannamead (84.2%) and the lowest achieving City Centre (33.3%) is 50.9 percentage points. The neighbourhoods associated with lower levels of deprivation have the highest attainment levels whereas those with the lowest levels of attainment are among the most deprived.

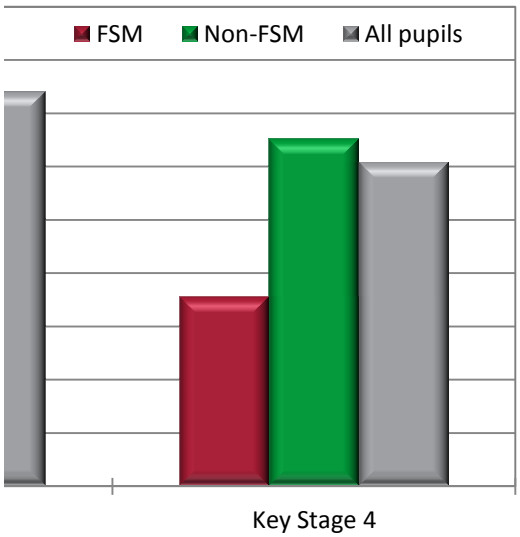
3.5.4 Free school meals

Using free school meals as a proxy for poverty it is clear that those children from deprived areas are disadvantaged in relation to attainment. There is a clear attainment gap between those eligible for free school meals (FSM) and those not.

In 2012/13, the attainment gap at Key Stage 2 between those eligible for FSM and those not was 21 percentage points which, although considerable, actually represents the fourth smallest gap within the South West. The attainment gap at Key Stage 4 was 30%. The proportion of children not eligible for FSM who attained at least five A*-C GCSE's including Maths and English is nearly double that for those who are eligible.

[35] Area profile data, Plymouth City Council, 2014

Figure 9: Key Stage 2* and Key Stage 4** attainment in Plymouth by free school meal eligibility



* Pupils achieving Level 4 or above in reading, writing, and maths
** Pupils achieving five or more GCSEs at Grade A*-C including English and Mathematics
Source: Department for Education[36, 37]

Table 18: Key Stage 2* and Key Stage 4** attainment by pupils eligible for Free School Meals, 2012/13

	Key Stage 2 (%)	Key Stage 4 (%)
Plymouth	57	35.5
South West	56	32.2
England	60	38.1

Source: Department for Education[36, 37]

Table 18 compares the attainment of pupils in Plymouth who are eligible for free school meals against their regional and national counterparts for achievement of Level 4 or above at Key Stage 2 and achievement of five or more A*-C's (including Maths and English) at Key Stage 4.

The data shows that:

- The proportion of pupils eligible for FSM in Plymouth achieving Level 4 or above (57%) at Key Stage 2 is lower than both the South West average (56%) and the England average (60%).
- The proportion of pupils eligible for FSM in Plymouth achieving five or more GCSE grades A*-C (35.5%) is higher than the South West average of 32.2% but lower than the England average of 38.1%.

[36] National curriculum assessments at key stage 2, 2012 to 2013
[37] GCSE and equivalent attainment by pupil characteristics, 2012 to 2013

Table 19: Highest and lowest achieving neighbourhoods at Key Stage 2 for pupils with FSM eligibility, 2012/13

Neighbourhoods with lowest percentage of pupils achieving Level 4 or above in reading, writing, and maths (%)		Neighbourhoods with highest percentage of pupils achieving Level 4 or above in reading, writing, and maths (%)	
Honicknowle	27.9	Colebrook, Newnham, & Ridgeway	100.0
North Prospect & Weston Mill	45.8	Morice Town	85.7
Keyham	47.8	Tamerton Foliot	83.3
Barne Barton	51.9	Estover, Glenholt & Derriford East	77.8
Ham & Pennycross	52.6	East End	75.0

14 neighbourhoods have data suppressed
Source: Area Profile data[38]

Table 19 demonstrates the considerable attainment gap at Key Stage 2 for pupils eligible for FSMs between neighbourhoods. The gap between the highest performing neighbourhood of Colebrook, Newnham, and Ridgeway (90.1%) and the lowest performing neighbourhood of Honicknowle (41.5%) is 72.1 percentage points.

3.6 Entry to higher education

Department for Education data (Table 20) shows that there are fewer Plymouth pupils going into Higher Education Institutions (HEI) than the England average. In addition, in 2010/11 only 10% of Plymouth pupils went on to study at a Russell Group University (including Oxford and Cambridge), this is below the England average of 15%.

There are stark differences in the percentage of pupils going into HEI when you compare schools within Plymouth. Devonport High School for Boys and Devonport High School for Girls had the highest percentage of pupils going into HEI (73% and 72% respectively). This compares to just 9% from Marine Academy Plymouth), a school that serves communities that fall within some of Plymouth's most deprived areas.

Pupils in Plymouth who attend schools that serve more deprived areas are also less likely to go on to attend Russell group universities. Table 20 also shows that 27% and 29% of pupils go on to these universities from Devonport High School for Boys and Girls respectively. This compares to 0% of pupils from schools such as Marine Academy, All Saints Academy, and Tor Bridge High.

[38] Area profile data, 2014

Table 20: Percentage of pupils going into all UK Higher Education Institutions (HEI) and Russell Group Universities by state-funded school, 2011/12

School/College	All UK HEI (%)	Russell Group (%)	Activity not captured (%)
Plymouth	56	10	8
England	62	15	11
Coombe Dean School	54	6	4
Devonport High School for Boys	73	27	13
Devonport High School for Girls	72	29	10
Eggbuckland Community College	48	x	x
Hele's School	56	4	8
Lipson Community College	61	x	x
Marine Academy Plymouth	9	0	x
Notre Dame RC School	43	4	7
Plymouth High School for Girls	66	11	11
Plymstock School	62	14	8
Ridgeway School	39	x	10
Sir John Hunt Community Sports College	x	x	x
St Boniface's RC College	60	6	6
Stoke Damerel Community College	51	4	11
The All Saints Church of England Academy	44	0	5
Tor Bridge High	56	0	8

"x" data has not been included due to low numbers in the numerator or denominator that could have allowed for potential identification of individuals.
Source: Department for Education[39]

3.7 Further and higher education sector

Plymouth has a high-quality further and higher education sector which makes a substantial contribution to teaching, learning, research, and the local economy – achieving recognition regionally, nationally, and internationally. The sector includes the University of Plymouth, one of the largest in the UK with over 30,000 students, The University of St Mark and St John, Plymouth College of Art, the Peninsula Schools of Medicine and Dentistry, and Plymouth City College. The further and higher education sector in Plymouth is large and is set to grow.

3.8 Not in Education, Employment, or Training (NEET)

Measuring the number of young people classed as Not in Education, Employment, or Training (NEET) is a priority indicator for the city and can be a good measure for levels of youth unemployment and of post-16 education attendance. Plymouth's data is more accurate than a

[39] Destination of KS4 and KS5 pupils: 2011 to 2012

lot of other councils in that the activity of only 1.4% of post-16s was unknown in 2013/14. This compares to the national average of 6.9%.[40]

At the end of March 2014 in Plymouth there were an estimated 7.4% of young people in academic years 12-14 not in education, employment or training.[40] This is one of the higher figures seen national and compares poorly to the national average of 5.3%.[40] As this is the first year of the new methodology previous data is not comparable.

As with other measures of unemployment, there is a strong link between where levels of NEET are highest and levels of deprivation are correspondingly high. It is worth mentioning that many people who would fall into the NEET category will be subject to multiple needs and the reason for them being in this category will be beyond just educational attainment.

Plymouth is widely acknowledged as one of the most successful providers of apprenticeships nationally. Work-based learning, in the form of apprenticeships, at the end of March 2014 stood at 7.5%, nearly three percentage points higher than the national average.[40]

[40] Not in Education, employment, or training - data provided by the Policy Performance and Partnership Team, Plymouth City Council

3.9 References

References are listed in alphabetical order by footnote description. The corresponding footnote number(s) is(are) also displayed. Links to online documents/tools/sources are included if available.

33, 35, 38	Area profiles, Plymouth City Council, 2014 http://www.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/areaprofiles.htm
32	Assessment of Key Stage 2 2014 - data provided by Policy, Performance, and Partnership Team, Plymouth City Council, October 2014.
39	Destination of KS4 and KS5 pupils: 2011 to 2012 https://www.gov.uk/government/publications/destinations-of-key-stage-4-and-key-stage-5-pupils-2011-to-2012
31	Early years foundation stage profile results 2013/14. Data provided by the Policy, Performance, and Partnership Team, Plymouth City Council, October 2014
37	GCSE and equivalent attainment by pupil characteristics https://www.gov.uk/government/publications/gcse-and-equivalent-attainment-by-pupil-characteristics-2012-to-2013
34	GCSE and equivalent results in England, 2012 to 2013 (revised) https://www.gov.uk/government/publications/gcse-and-equivalent-results-in-england-2012-to-2013-revised
36	National curriculum assessments at key stage 2: 2012 to 2013 https://www.gov.uk/government/publications/national-curriculum-assessments-at-key-stage-2-2012-to-2013
40	Not in Education, Employment or Training. Data provided by the Policy, Performance, and Partnership Team, Plymouth City Council, October 2014
27	Overall effectiveness; how good is the school, Ofsted Data View Tool. http://dataview.ofsted.gov.uk
30	Permanent and fixed period exclusion in England: 2011 to 2012 https://www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2012-to-2013
26	Plymouth Plan Sustainability Appraisal Scoping Report, Plymouth City Council, 2013 http://www.plymouth.gov.uk/sa_scoping_report_for_plymouth_plan.pdf
29	Pupil absence in schools in England: 2012 to 2013 https://www.gov.uk/government/publications/pupil-absence-in-schools-in-england-2012-to-2013
28	Special educational needs in England: January 2014 https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2014

4. HEALTH, WELLBEING, AND CARE

4.1 Health inequalities from the cradle to the grave

4.1.1 Life expectancy

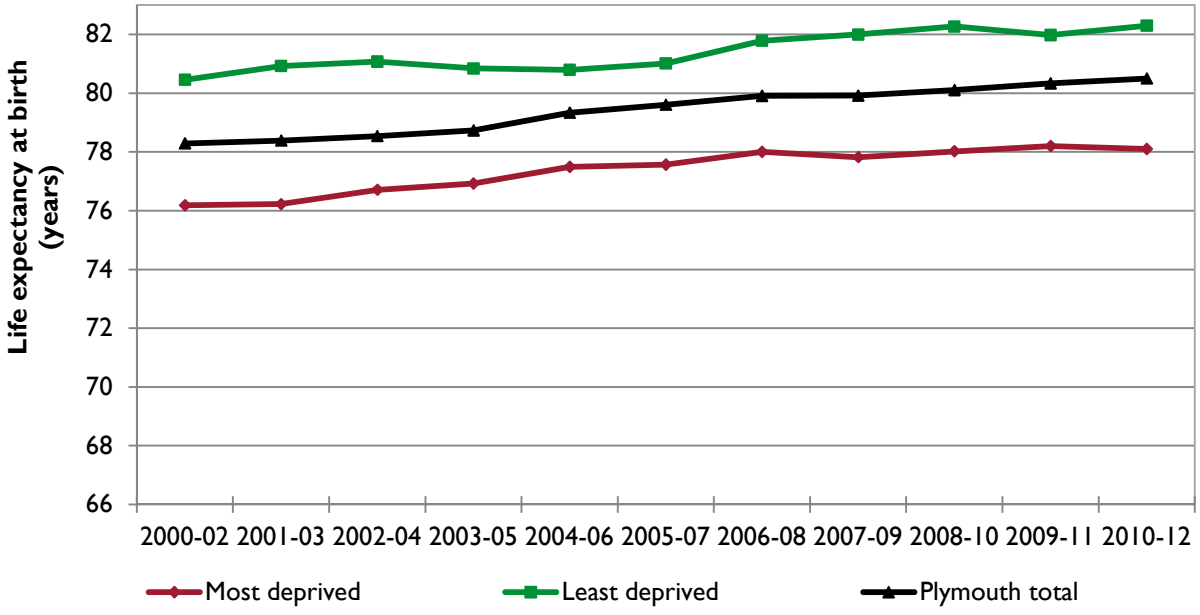
Since 2000-02 life expectancy has improved for both males and females in the city (from 75.5 to 78.3 years and from 80.4 to 82.1 years respectively).

Male life expectancy has consistently been below the England average. The latest 2010-12 data reveals male life expectancy in Plymouth is currently 0.9 years lower than the England average.

During the two three-year periods of 2004-06 and 2005-07 female life expectancy in Plymouth was slightly higher than the England value. The Plymouth value has plateaued around 82 years since 2006-08 whilst the England average has continued to rise. This has resulted in the latest 2010-12 Plymouth figure being 0.9 years lower than the England average.

Note: *The information detailed above was sourced from the NHS Information Centre for Health and Social Care and is not available at sub-city level. The information presented in* Figure 10 *and* Figure 11 *has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.*

Figure 10: Trends in life expectancy at birth in the most and least deprived neighbourhood groups



Source: Public Health Team, Plymouth City Council

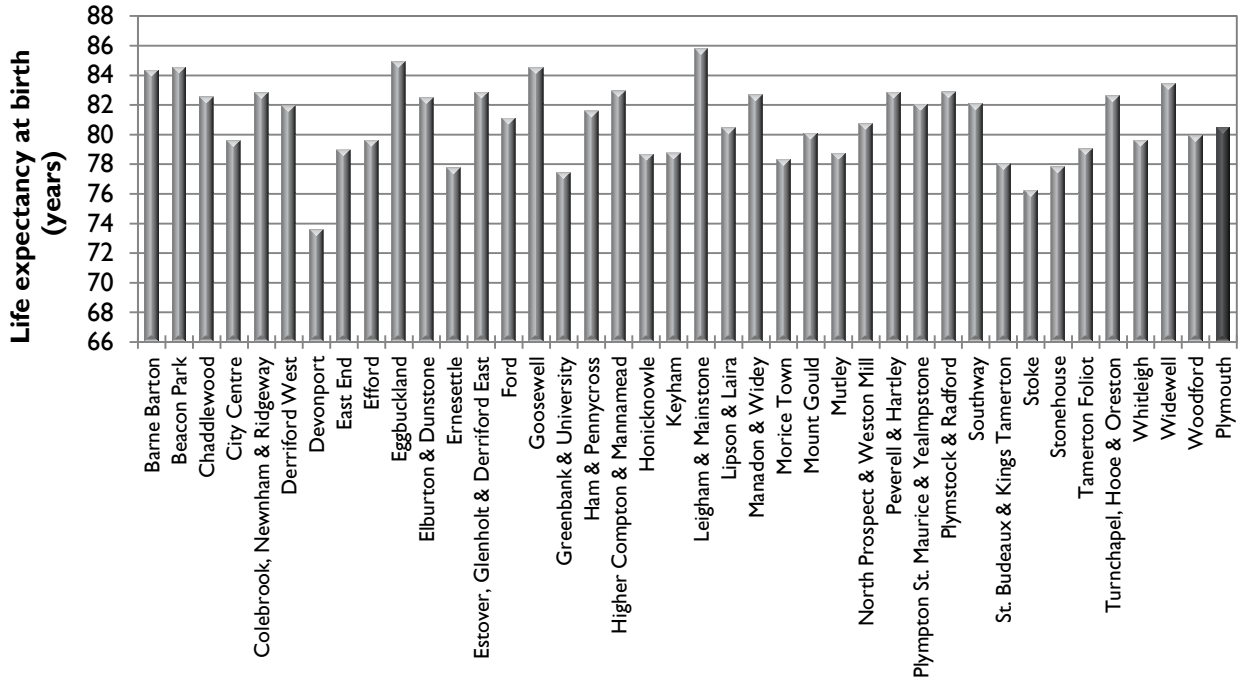
As seen in Figure 10 life expectancy at birth (for males and females combined) has increased from 78.3 years in 2000-02 to 80.5 years in 20010-12.

In the least deprived neighbourhood group the rates mirror the pattern found across the city as a whole, albeit they are higher.

In the most deprived neighbourhood group the rates mirror the pattern found across the city as a whole, albeit they are lower.

The gap between the most and least deprived neighbourhood groups has decreased very slightly from 4.3 years in 2000-02 to 4.2 years in 2009-11. There have however been fluctuations in the gap over this period.

Figure 11: Life expectancy by neighbourhood, 2010-12



Source: Public Health Team, Plymouth City Council

The Leigham and Mainstone neighbourhood had the highest overall life expectancy in 2010-12 (85.8 years). This compares with Devonport where life expectancy was 73.6 years in the same period (Figure 11). On this basis the gap in life expectancy between the neighbourhoods with the highest and lowest life expectancy in 2010-12 is 12.2 years.

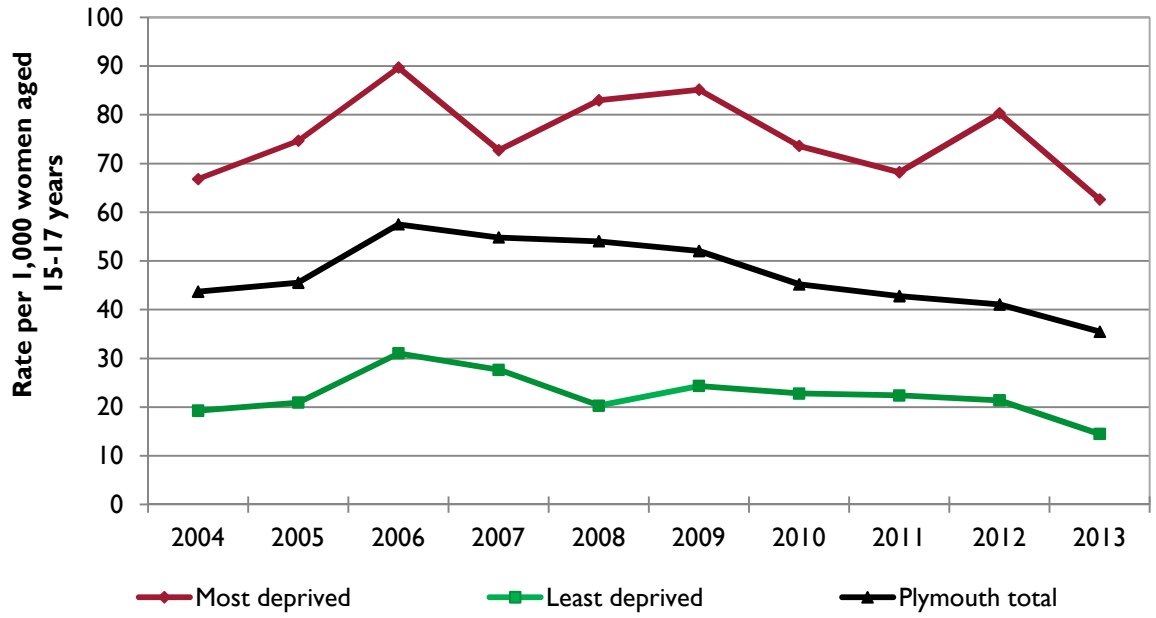
4.1.2 Teenage pregnancy

Since 2010 the rates of teenage pregnancy per 1,000 females aged 15-17 years have decreased both nationally (from 34.2 to 27.7) and locally (44.1 to 39.5). Plymouth rates have consistently been higher than the England average.

Between 2010 and 2011 the Plymouth rate plateaued at just above 44 per 1,000 whilst the England average continued to fall. This has resulted in the latest 2012 Plymouth value being 11.8 conceptions per1,000 higher than the England average.

Note: The information detailed above was sourced from the NHS Information Centre for Health and Social Care and is not available at sub-city level. The information presented in Figure 12 and Figure 13 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.

Figure 12: Trends in under-18 conception rates in the most and least deprived neighbourhood groups



Source: Public Health Team, Plymouth City Council

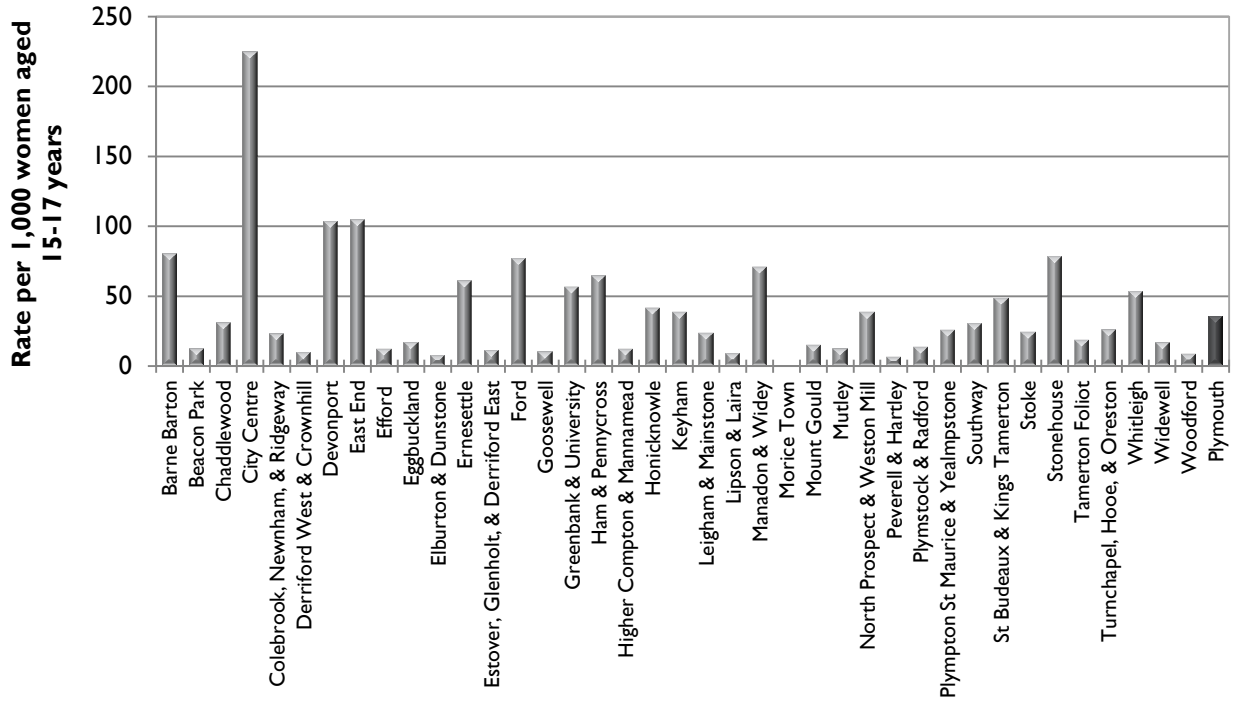
As seen in Figure 12, since 2004, the city-wide rate of teenage pregnancy has been in the range of approximately 35 per 1,000 to 58 per1,000. Since a peak in 2006 of 57.5 per 1,000, the rate has fallen year on year to the latest (2013) rate of 35.5 per 1,000.

In the least deprived neighbourhood group rates have followed a similar pattern. After a peak in 2006 of 31.0 per 1,000 there has been an overall rate decrease in the following years. The 2013 rate was 14.5 per 1,000.

There was also a peak in the conception rate (89.7 per 1,000) in the most deprived neighbourhood group in 2006. Since then rates have been more variable. The latest 2013 value of 62.6 per 1,000 is a decrease of approximately 18 conceptions per 1,000 on the previous year.

There was over a four-fold variation in rates of teenage pregnancy between the least deprived and most deprived neighbourhood groups in 2013.

Figure 13: Teenage pregnancy by neighbourhood, 2013



Source: Public Health Team, Plymouth City Council

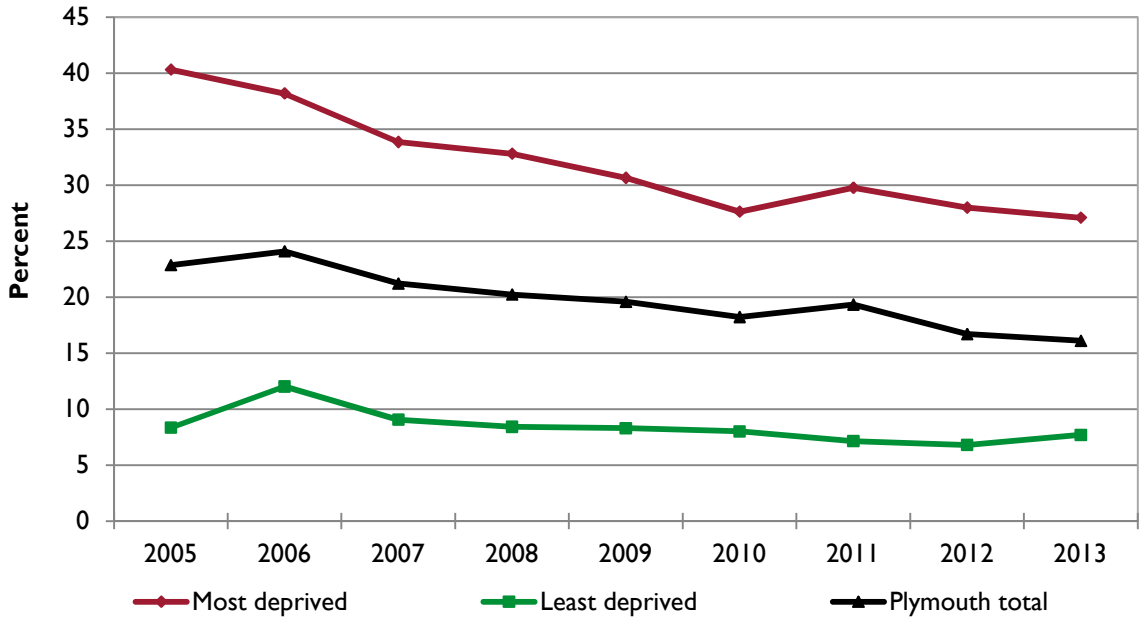
Figure 13 shows that in 2013 the highest rate of teenage conceptions was in City Centre (224.5 per 1,000). This compares with Morice Town where there were no teenage pregnancies in the same time period. Other neighbourhoods with high rates include Devonport, East End, and Stonehouse.

4.1.3 Smoking in pregnancy

Since 2010/11 the percentage of women smoking during pregnancy has remained relatively constant both locally (18%) and nationally (13%).

Note: The information detailed above was sourced from the Public Health Outcomes Framework Data Tool and is not available at sub-city level. The information presented in Figures 15 and 16 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.

Figure 14: Trends in smoking in pregnancy in the most and least deprived neighbourhood groups (%)



Source: Public Health Team, Plymouth City Council

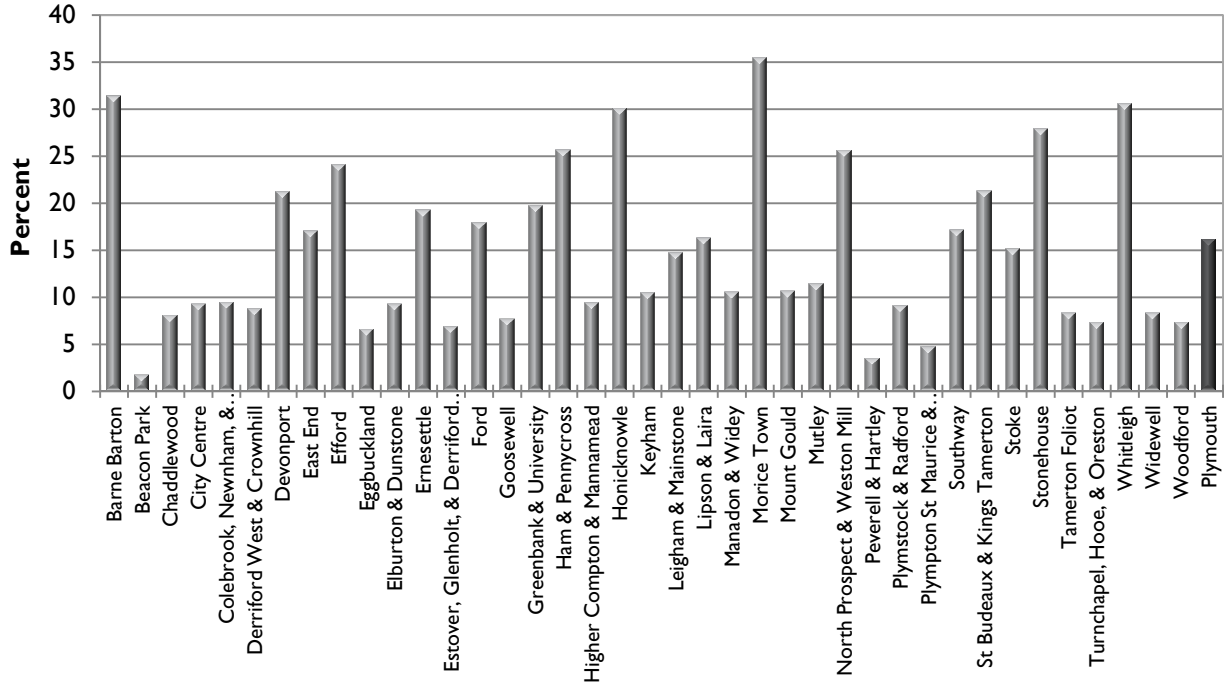
Since 2006 the percentage of women who smoke during pregnancy has fallen overall, albeit there was a slight increase in 2011 (Figure 14).

In the least deprived neighbourhood group the percentage of women smoking in pregnancy has continued to fall over the same time period. There was no increase in 2011; however the 2013 value of 7.7% is a 0.9 percentage point increase from the previous year.

In the most deprived neighbourhood group there has been a reduction in the percentage of women smoking during pregnancy from 40.3% in 2005 to 27.1% in 2013. An increase of 2.2 percentage points occurred in 2011 but values are once again on the decrease. These changes are mirrored in the overall city-wide figure.

There was an approximate four-fold difference in the percentage of women smoking during pregnancy between the most and least deprived groups (27.1% and 7.7% respectively) in 2013.

Figure 15: Smoking in pregnancy by neighbourhood, 2013



Source: Public Health Team, Plymouth City Council

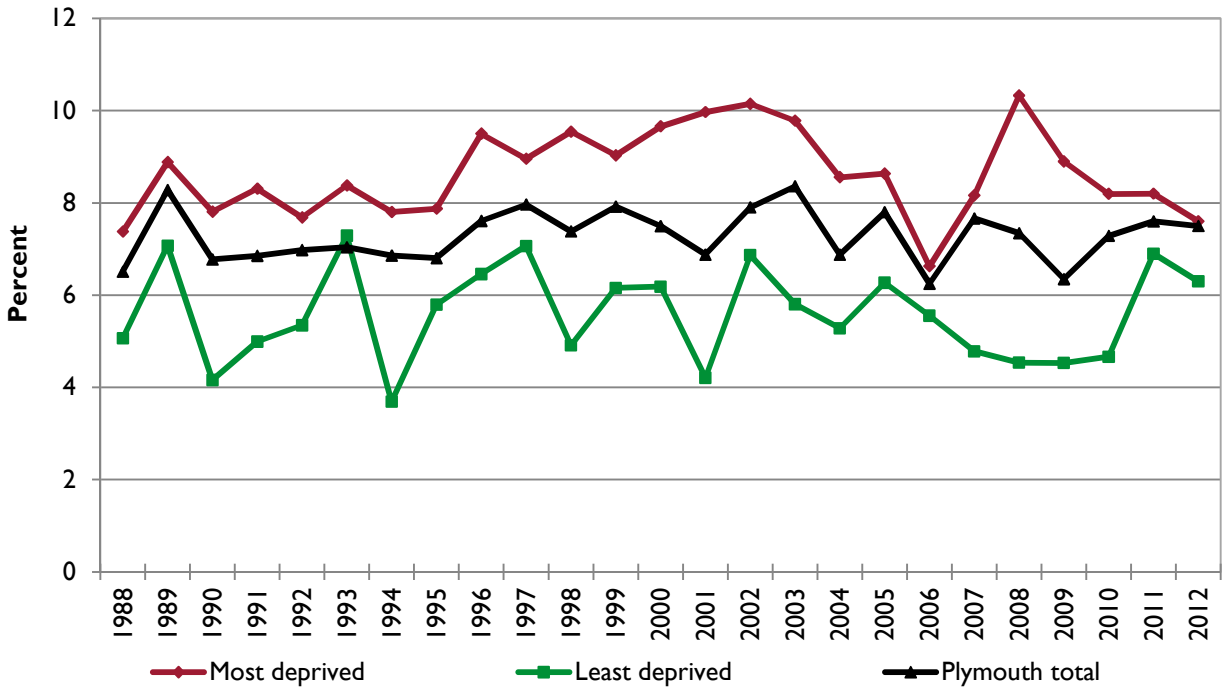
As shown in Figure 15, in 2012 the highest rate of smoking in pregnancy was seen in Morice Town (35.4%) compared to only 1.7% in Beacon Park. This is a greater than 20-fold variation. Other neighbourhoods with high values include Barne Barton (31.4%), Whitleigh (30.6%), and Honicknowle (30.1%).

4.1.4 Low birthweight births

Since 2010 the percentage of low birthweight births (birthweights under 2,500g) has remained between 7.3% and 7.5% both in the city and nationally. The latest 2012 data shows the Plymouth value (7.4%) to be 0.1 percentage point higher than the national average (7.3%).

Note: The information presented above was sourced from the NHS Information Centre for Health and Social Care and is not available at sub-city level. The information presented in Figure 16 and Figure 17 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.

Figure 16: Trends in low birthweight births (<2,500 grams) in the most and least deprived neighbourhood groups



Source: Public Health Team, Plymouth City Council

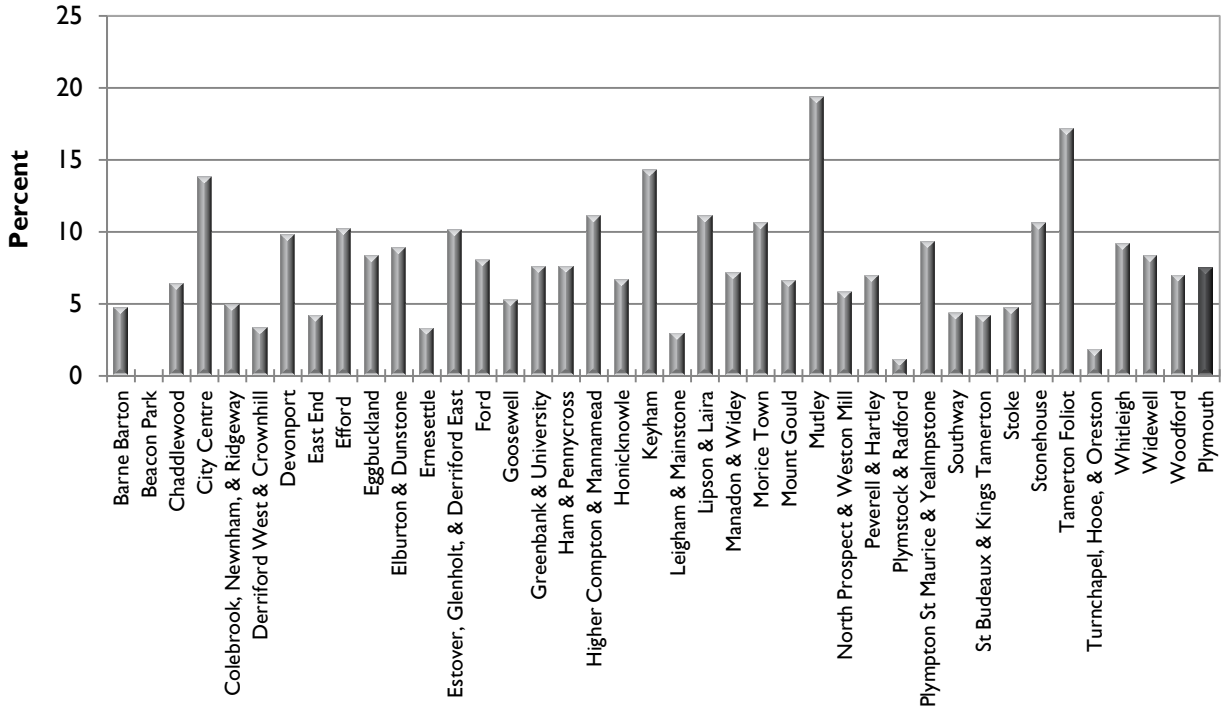
Since 1998 the percentage of low birthweight births has remained relatively static, fluctuating at around 6-8.5% (Figure 16).

In the least deprived neighbourhood group the percentage shows a more pronounced cyclical pattern. Peaks are often followed by a sharp decline, after which the percentages then increase for a couple of years and so on. The latest 2013 value is 6.3%.

In the most deprived neighbourhood group there was an increase in the percentage of birthweights under 2,500g from 7.4% in 1988 to a peak of 10.3% in 2008. Since then the percentage has dropped to 7.6% and is now only 0.1 percentage points higher than the city average.

The gap between the most and least deprived groups has decreased from 2.3 percentage points in 1998 to 1.3 percentage points in 2013.

Figure 17: Low birthweight births (<2,500g) by neighbourhood, 2012



Source: Public Health Team, Plymouth City Council

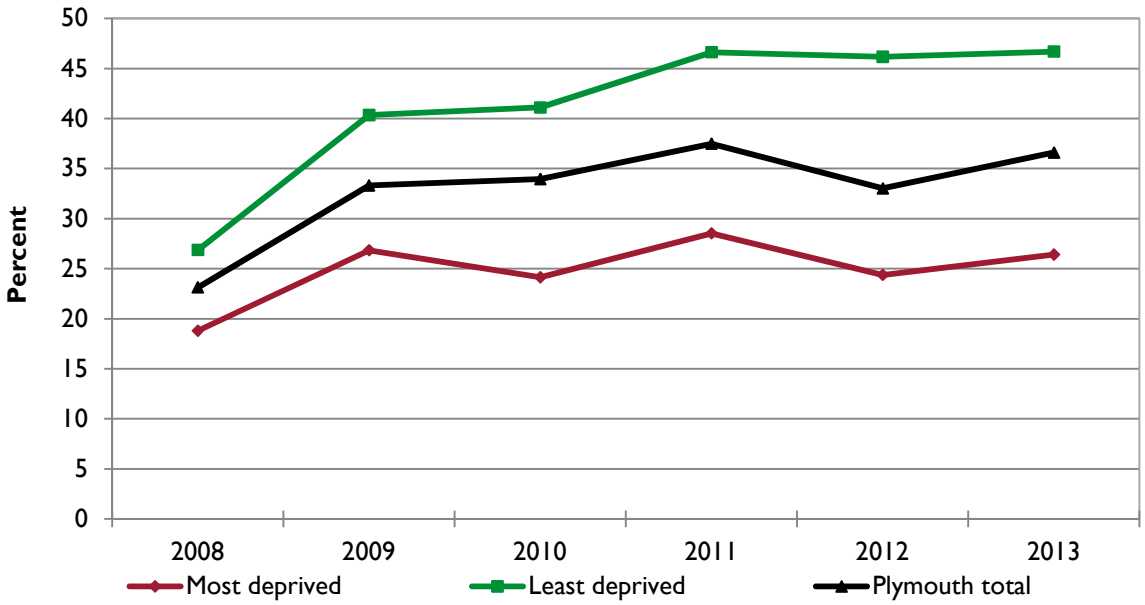
The Mutley neighbourhood had the highest rate of low birth weight births in 2012 (19.4%). This compares with Beacon Park where there were no birthweights less than 2,500g (Figure 17).

4.1.5 Breastfeeding at 6-8 weeks

Since the first quarter of 2010/11 the percentage of children being breastfed at 6-8 weeks has increased nationally (44.4% to 46.6%) and in Plymouth (30.3% to 35.3%). The gap between the values has decreased from 14.1 to 11.3 percentage points.

Note: The information presented above was sourced from the Department of Health Quarterly Breastfeeding Statistics and is not available at sub-city level. The information presented in Figure 18 and Figure 19 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.

Figure 18: Trends in breastfeeding at 6-8 weeks in the most and least deprived neighbourhood groups



Source: Public Health Team, Plymouth City Council

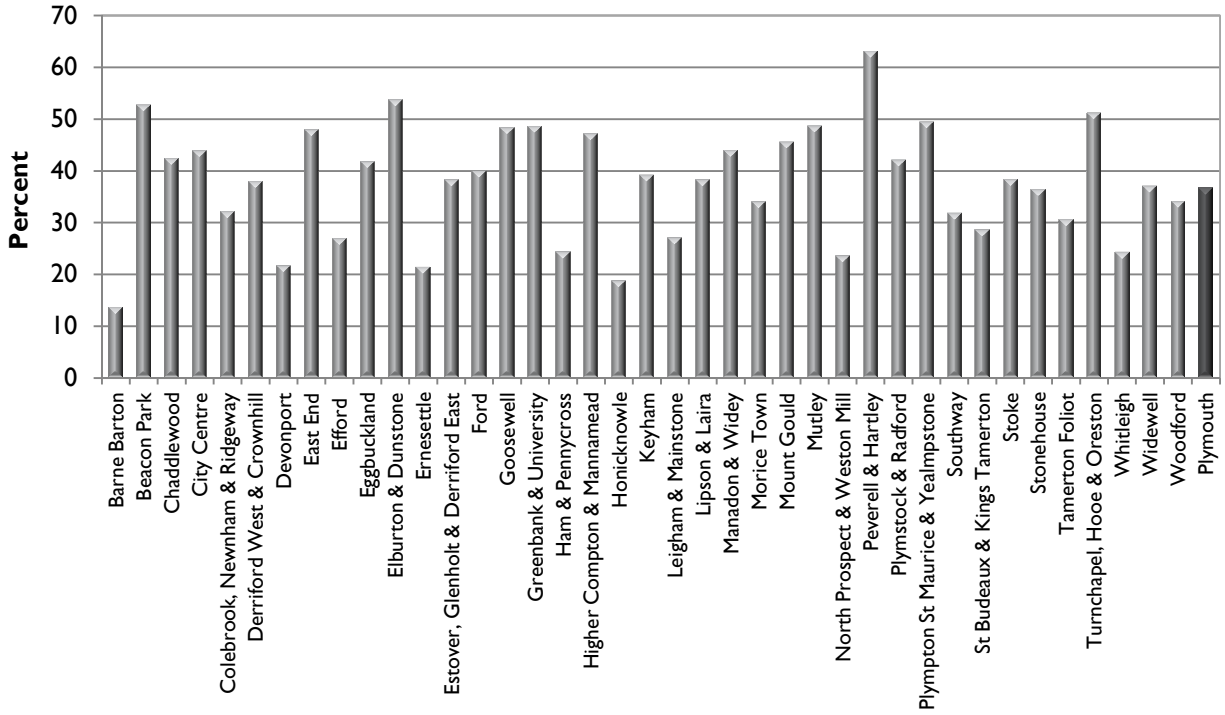
In 2008, 23.1% of women in Plymouth were breastfeeding at 6-8 weeks. Since then, the city-wide average has increased to 36.6% in 2013 (Figure 18).

In the least deprived neighbourhood group the percentage has increased from 26.9% to 46.7%.

In the most deprived neighbourhood group the percentage has increased from 18.8% to 26.4%.

Despite percentages increasing in both the most and least deprived neighbourhood groups from 2008 to 2013, the gap between them has grown from 8.1 percentage points in 2008 to 20.3 percentage points in 2013.

Figure 19: Breastfeeding at 6-8 weeks by neighbourhood, 2013



Source: Public Health Team, Plymouth City Council

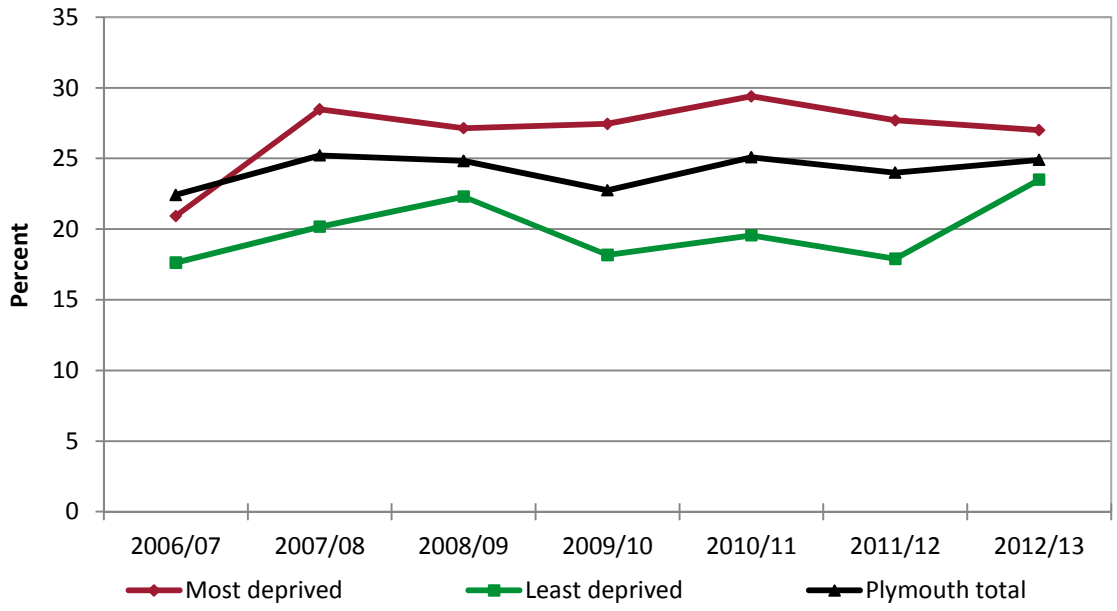
As seen in Figure 19 the Barne Barton neighbourhood had the lowest rate of breastfeeding at 6-8 weeks in 2013 (13.6%). This compares with Peverell and Hartley where 63.1% of children were breastfed in the same period.

4.1.6 Excess weight (children in Year R)

The percentage of Year R children of excess weight (those overweight or obese) in England has remained virtually constant since 2006/07. Plymouth's figure has been more variable but has shown a general increasing trend from 22.5% in 2006/07 to 24.7% in 2012/13. The gap between the city and national figures is now 2.5 percentage points.

Note: The information presented above was sourced from the NHS Information Centre National Child Measurement Programme (NCMP) reports and is not available at sub-city level. The information presented in Figure 20 and Figure 21 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.

Figure 20: Trends in excess weight (overweight and obese combined, BMI ≥85th centile) in children in Year R in the most and least deprived neighbourhood groups



Source: Public Health Team, Plymouth City Council

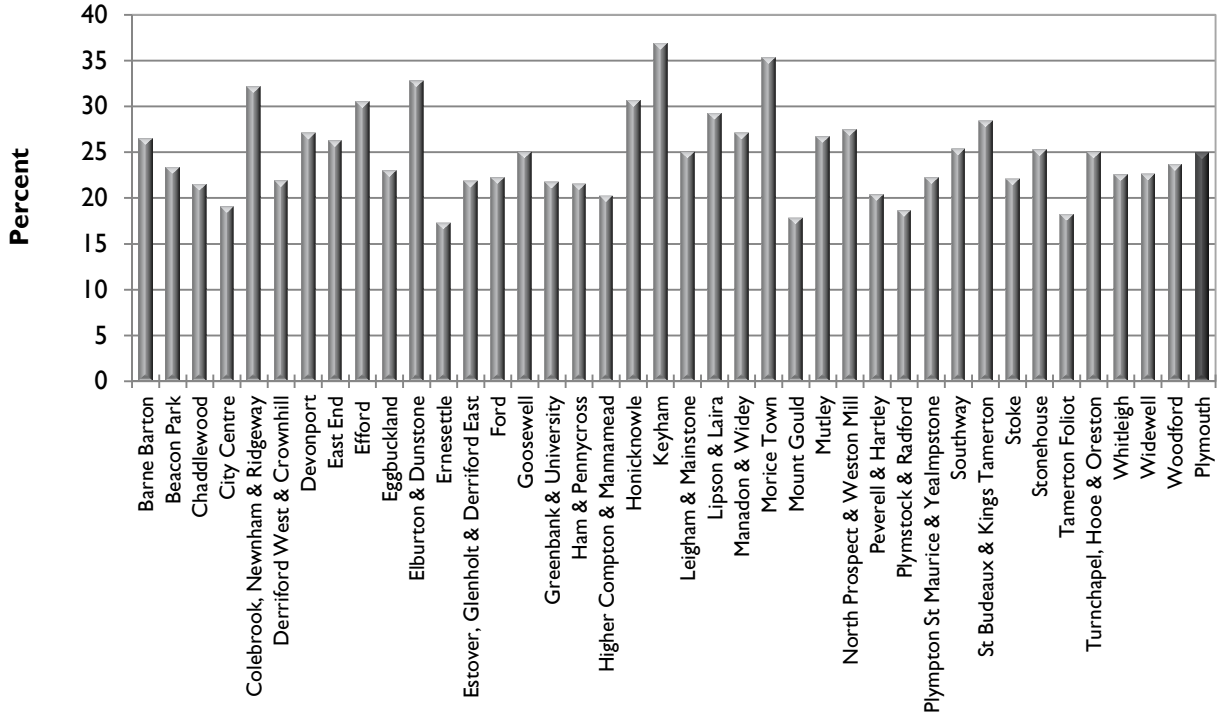
Figure 20 highlights that the percentage of overweight and obese children in Year R has increased from 22.4% in 2006/07 to 24.9% in 2012/13.

In the least deprived neighbourhood group the percentage has increased from 17.6% to 23.5%. Since 2008/09 pattern has mirrored that seen in Plymouth as a whole, albeit the values are lower.

In the most deprived neighbourhood group the percentage has increased from 20.9% to 27.0%. Since 2007/08 the value has remained around 27.0 to 29.0%. The percentage has been falling since 2010/1.

The gap between the most and least deprived neighbourhoods has been variable over the last seven years. Overall the gap has increased from 3.3 percentage points in 2006/07 to 3.5 percentage points in 2012/13.

Figure 21: Excess weight (overweight and obese combined, BMI ≥85th centile) in children in Year R classes by neighbourhood, 2012/13



Source: Public Health Team, Plymouth City Council

In 2012/13 the Keyham neighbourhood had the highest percentage of Year R childhood overweight/obesity (36.8%) as seen in Figure 21. The lowest value was seen in Ernesettle (17.2%).

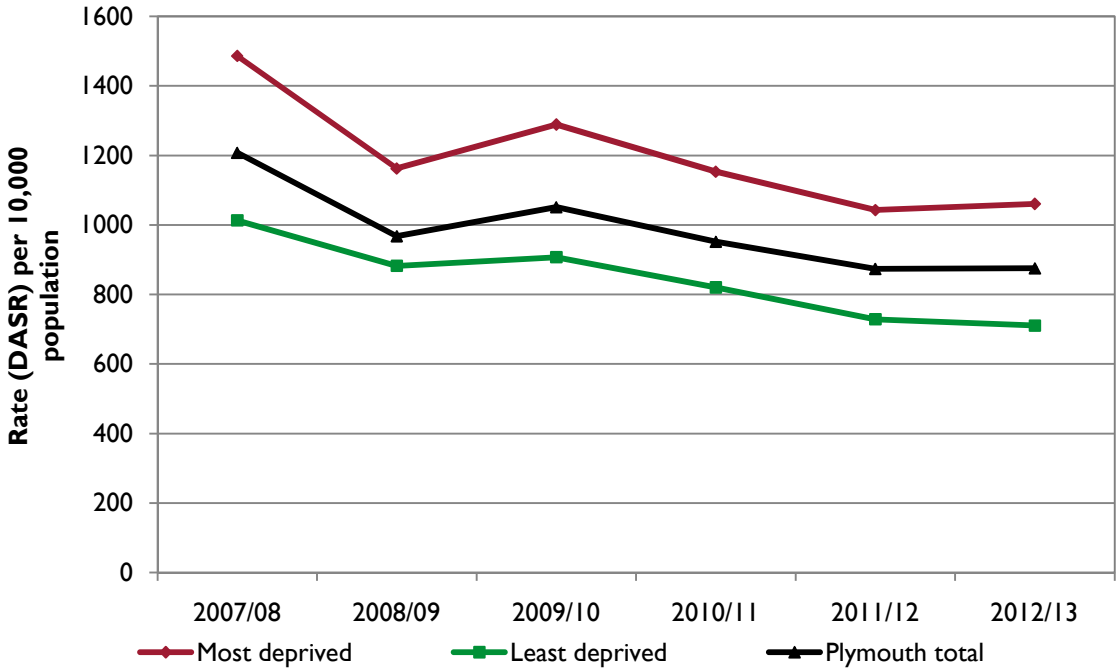
4.1.7 Emergency hospital admissions

Since 2002/03 the rate of emergency hospital admissions has increased from 7,675 to 8,988 per 100,000 population in England. In contrast, after a peak in 2003/04 the Plymouth value has considerably decreased over the same time period, from 7,381 to 4,237 per 100,000.

The gap between the city and the national average has widened from 294 per 100,000 in 2002/03 to 4,751 per 100,000 in 2010/11.

Note: The information presented above was sourced from the NHS Information Centre and is not available at sub-city level. The information presented in Figure 22 *and* Figure 23 *has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.*

Figure 22: Trends in emergency hospital admissions (excluding planned) in the most and least deprived neighbourhood groups



DASR = directly age-standardised rate
Source: Public Health Team, Plymouth City Council

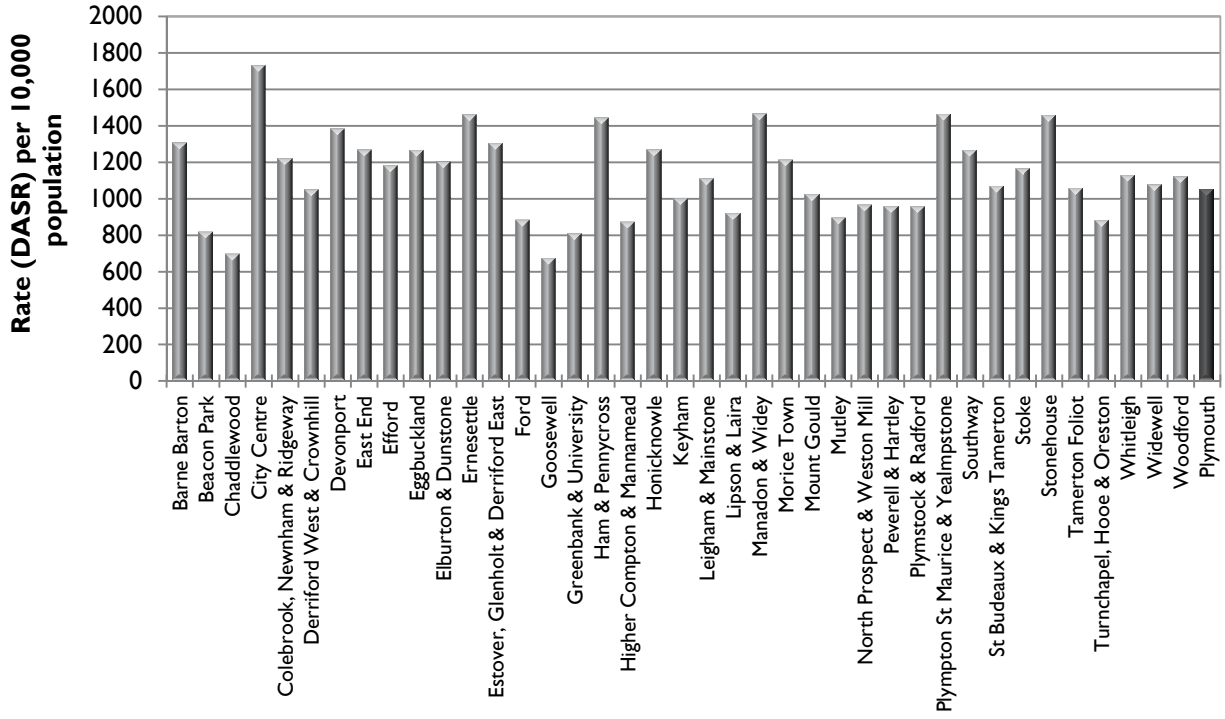
Since 2007/08 the rate of emergency hospital admissions has decreased from 1,208 per 10,000 to 875 in 2012/13 (Figure 22).

In the least deprived neighbourhood group the rates mirror the pattern found across the city as a whole, albeit they are lower.

In the most deprived neighbourhood group the rates mirror the pattern found across the city as a whole, albeit they are higher.

The gap between the most and least deprived neighbourhood groups has decreased from 473.2 per 10,000 in 2007/08 to 350.6 per10,000 in 2012/13.

Figure 23: Emergency hospital admissions by neighbourhood, 2012/13



DASR = directly age-standardised rate (using ESP 2013)
Source: Public Health Team, Plymouth City Council

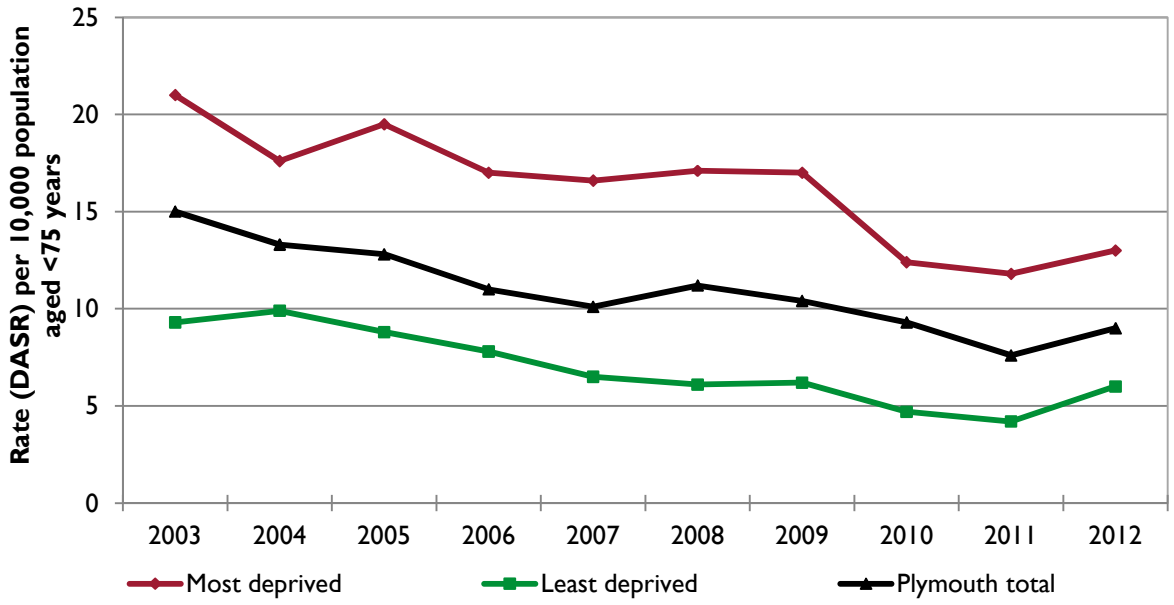
The City Centre neighbourhood had the highest rate of emergency hospital admissions in 2012/13 (1,730 per 10,000). This compares with Goosewell where the rate was 673 per 10,000 in the same time period (Figure 23).

4.1.8 Circulatory disease mortality (in under-75s)

Since 1993 the rates of circulatory disease mortality in persons aged less than 75 years have decreased from 155.8 to 56.0 per 100,000 in England and 178.2 to 65.4 per 100,000 in Plymouth. The gap between the city and the national average has narrowed from 22.4 per 100,000 in 1993 to 9.4 per 100,000 in 2012.

Note: The information presented above was sourced from the NHS Information Centre and is not available at sub-city level. The information presented in Figure 24 and Figure 25 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.

Figure 24: Trends in circulatory disease mortality (in under-75s) in the most and least deprived neighbourhood groups



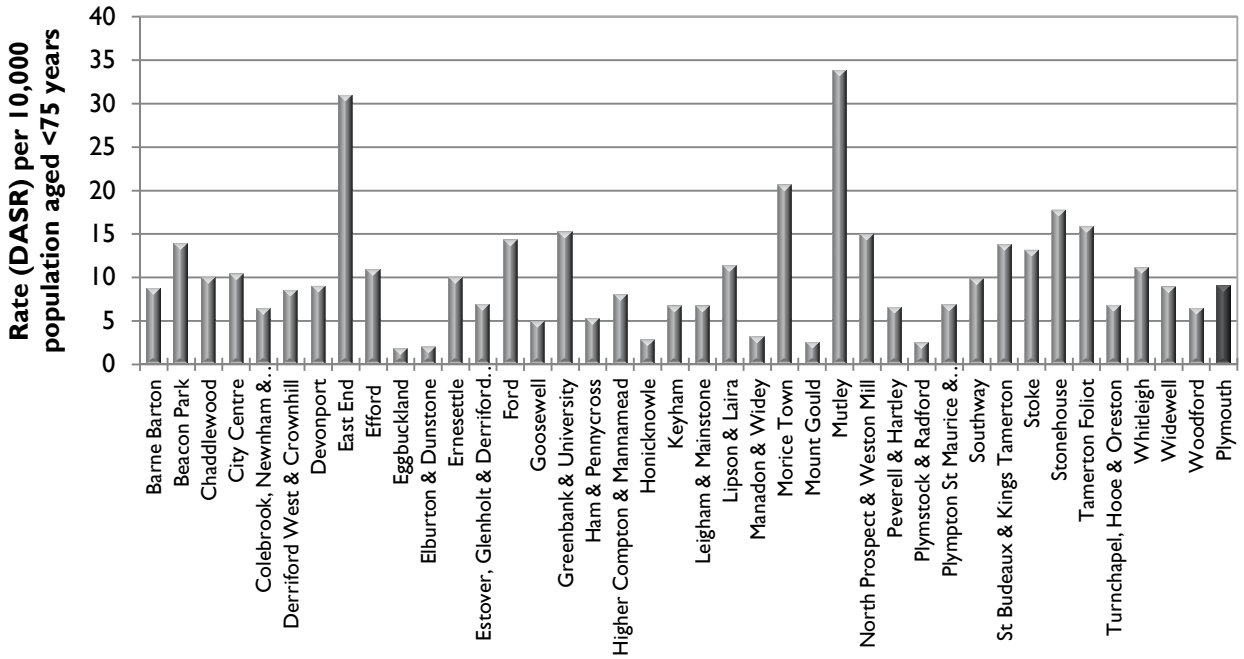
DASR = directly age-standardised rate (using ESP 2013)
Source: Public Health Team, Plymouth City Council

Since 2003 the rate of circulatory disease mortality in persons aged less than 75 years has decreased overall from 15.0 per 10,000 in 2003 to 9.0 per 10,000 in 2012 (Figure 24). The latest figure is an increase from the lowest rate (7.6 per 10,000) seen in 2011.

In the least deprived neighbourhood group the rate decreased steadily until 2011. In the most deprived neighbourhood group, although the rate has fallen overall, there have been periods of increase, before larger reductions in 2010 and 2011. In both groups the latest 2012 figures have increased in line with the city overall.

The gap between the most and least deprived groups has also decreased slightly from 2003 to 2012. The gap is now 7.0 per 10,000 compared to 11.7 per 10,000 in 2003.

Figure 25: Circulatory disease mortality (in under-75s) by neighbourhood, 2012



Source: Public Health Team, Plymouth City Council (using ESP 2013)

The Mutley neighbourhood had the highest rate of circulatory disease mortality in under-75s in 2012 (33.8 per 10,000). This compares with Eggbuckland where there the rate of circulatory disease death was 1.8 per 10,000 population in the same time period (Figure 25).

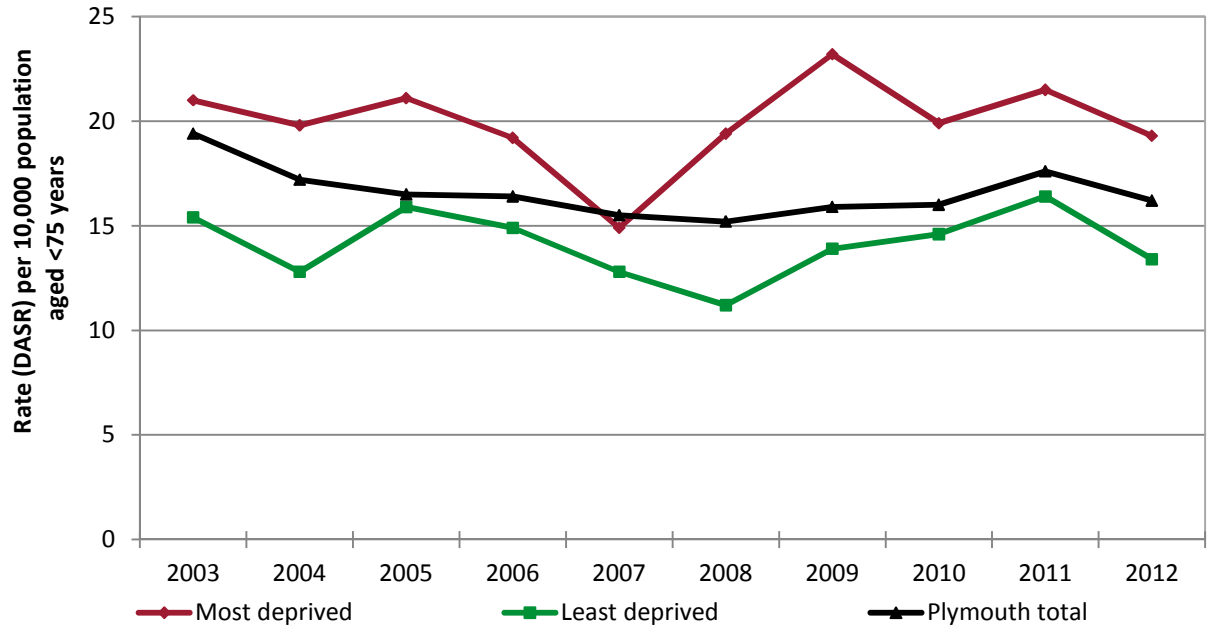
4.1.9 Cancer mortality (in under-75s)

Mortality rates from all cancers in persons aged less than 75 years in England have steadily decreased since 1993 (from 149.6 to 105.3 per 100,000).

Plymouth's values have been more erratic. After decreasing for a few years from a peak in 1994 of 155.1 per 100,000 the rate has cyclically risen and fallen. The overall trend since 1993 has been a decrease to 118.8 per 100,000 in 2012. The gap between the national and city value has fluctuated since 1993. The difference between the two is currently 13.4 per 100,000.

Note: *The information presented above was sourced from the NHS Information Centre and is not available at sub-city level. The information presented in Figure 26and Figure 27 has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.*

Figure 26: Trends in cancer mortality (<75s) in the most and least deprived neighbourhood groups



DASR = directly age-standardised rate (using ESP 2013)
Source: Public Health Team, Plymouth City Council

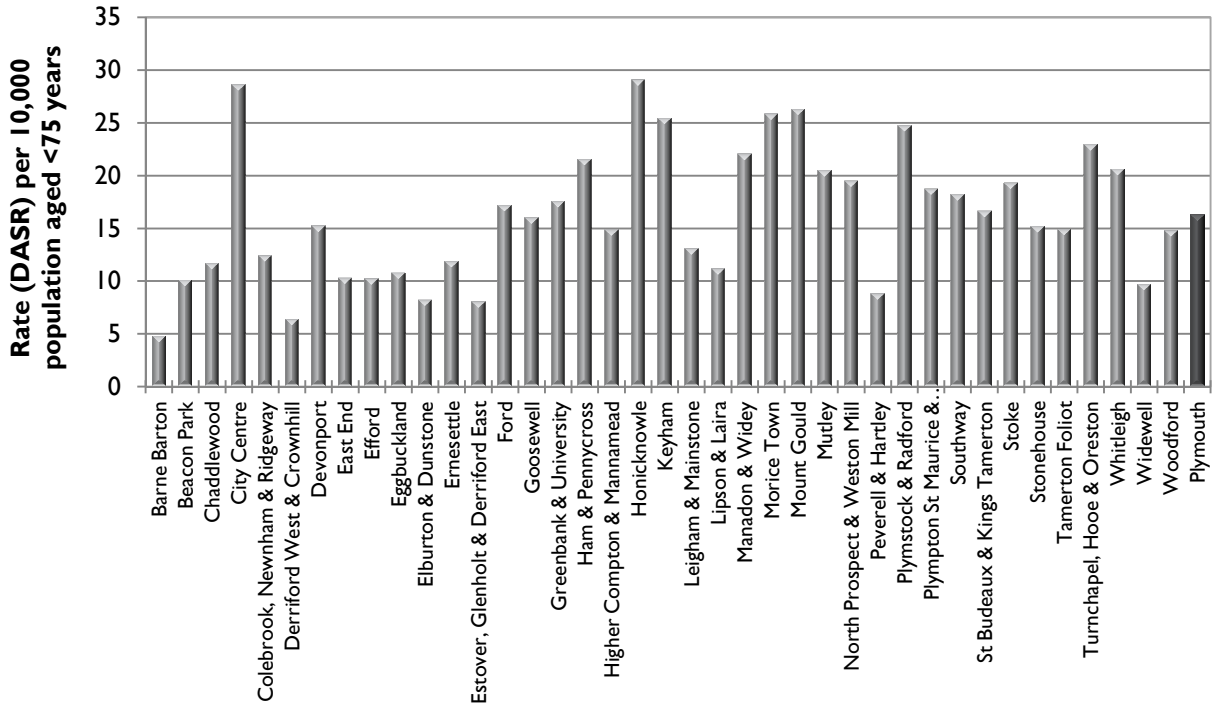
Mortality rates from all cancers in persons aged less than 75 years in Plymouth have remained relatively stable since 2003 at 15-20 per 10,000 population, as can be seen in Figure 26. The highest value was 19.4 per 10,000 in 2003; the lowest was 15.2 per 10,000 in 2008.

Rates in the least deprived neighbourhood group are below the Plymouth average. Although rates in this deprivation group fell steadily from 2005 to 2008, they increased year-on-year from 2008 to 2011. The latest 2012 figure has dropped again to 13.4 per 10,000 under-75 population.

Apart from in 2007, rates in the most deprived neighbourhood group are above the Plymouth average. After an overall reduction from 2003 to 2007, rates increased to 2009. The latest 2012 figure has dropped again to 19.3 per 10,000.

The gap between the most deprived and least deprived neighbourhood groups has fluctuated since 2003. The difference between the two is currently 5.9 per 10,000.

Figure 27: Cancer mortality (in under-75s) by neighbourhood, 2012



Source: Public Health Team, Plymouth City Council (using ESP 2013)

In 2012 the City Centre neighbourhood had the highest rate of cancer mortality in under-75s (28.6 per 10,000). This compares with Barne Barton where the rate was 4.8 per 10,000 (Figure 27).

4.1.10 All-age all-cause mortality

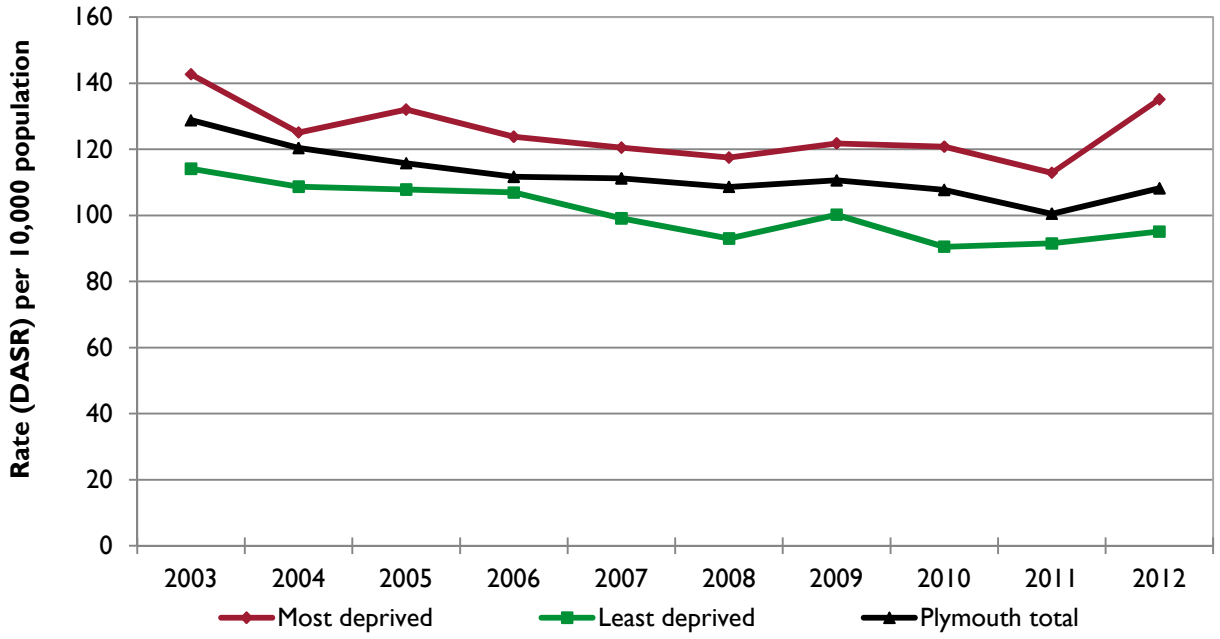
Since 1993 rates of all-age all-cause mortality have fallen for males, females, and persons in both Plymouth and England as a whole.

Despite this fall, rates of male all-age all-cause mortality in Plymouth have consistently been higher than England as a whole. The latest 2012 figure for Plymouth is 690.9 per 1,000 compared to 614.3 for England.

Rates for female all-age all-cause mortality have generally been similar to the England average. However, the latest 2012 figure (499.9 per 100,000) is higher than the England average (447.7 per 100,000).

Note: *The information presented above was sourced from the NHS Information Centre and is not available at sub-city level. The information presented in* Figure 28 *and* Figure 29 *has been calculated by Plymouth's Public Health Team using information from local sources and as such can be made available at sub-city level. For this reason the time periods stated and the Plymouth values might differ across the information.*

Figure 28: Trends in all-age, all-cause mortality in the most and least deprived neighbourhood groups



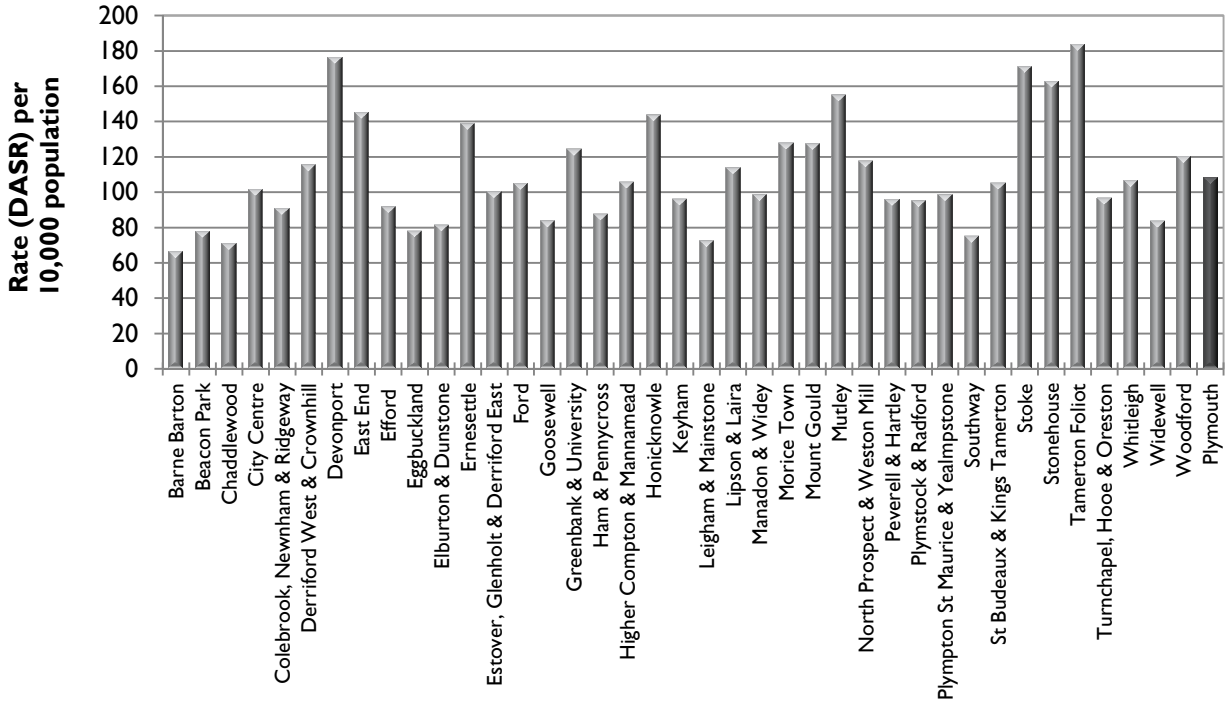
DASR = directly age-standardised rate
Source: Public Health Team, Plymouth City Council (using ESP 2013)

Since 2003 rates of all-age all-cause mortality have decreased from 128.38 per 10,000 to 108.2 per 10,000 in 2012 (Figure 28).

In the least deprived neighbourhood group the rates mirror the pattern found across the city as a whole albeit that they are lower. In the most deprived neighbourhood group the rates mirror the pattern found across the city as a whole albeit that they are higher.

Since 2001 the gap between the most and least deprived groups has widened. The gap in 2012 is now 40.0 per 10,000 compared to 28.6 per 10,000 in 2001.

Figure 29: All-age, all-cause mortality by neighbourhood, 2012



Source: Public Health Team, Plymouth City Council (using ESP 2013)

The Tamerton Foliot neighbourhood had the highest rate of all-age, all-cause mortality in 2012 (183.5 per 10,000). This compares with Barne Barton where the rate was 66.3 per 1,000 (

Figure 29).

4.2 Health of families with young children (Health Visitor Survey 2012)

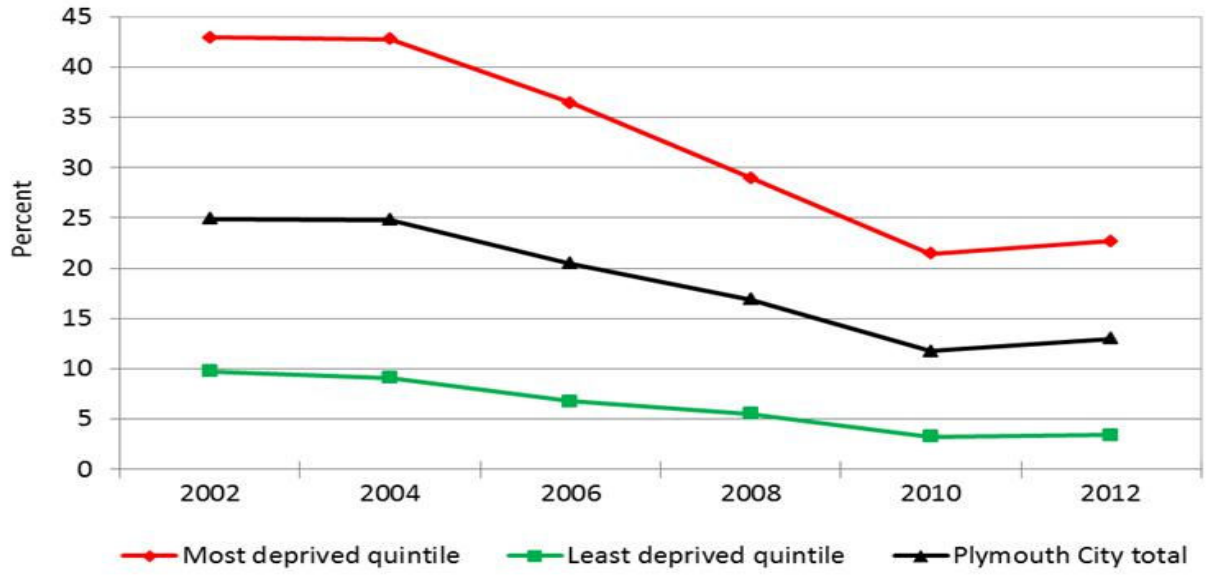
The following analysis is of data that has come from the bi-annual survey of health visitors' caseloads offering us an insight into health, family issues and benefits reliance all from the same source. The survey reports across a range of different areas including; vulnerable families, smoking prevalence amongst parents, families on low income and dependent on benefits, one parent families, where major wage earner is unemployed, violence in the family, depression and mental illness amongst parents, child protection issues, parenting problems and social isolation.

*Note: *For reasons of confidentiality, data is not presented for some neighbourhoods in Figure 30 to Figure 40 where the percentage value is based on less than five occurrences.*

4.2.1 Vulnerable families

Note: This data comes from the bi-annual survey of health visitors' caseloads. A family is classified as vulnerable if they experience four or more of the original 26 health factors which have been collected since the survey process began. This classification of vulnerability is unique to the Plymouth Health Visitor caseload survey and as such there is no national comparison data.

Figure 30: Trends in vulnerable families in the most and least deprived neighbourhood groups



Source: Public Health Team, Plymouth City Council

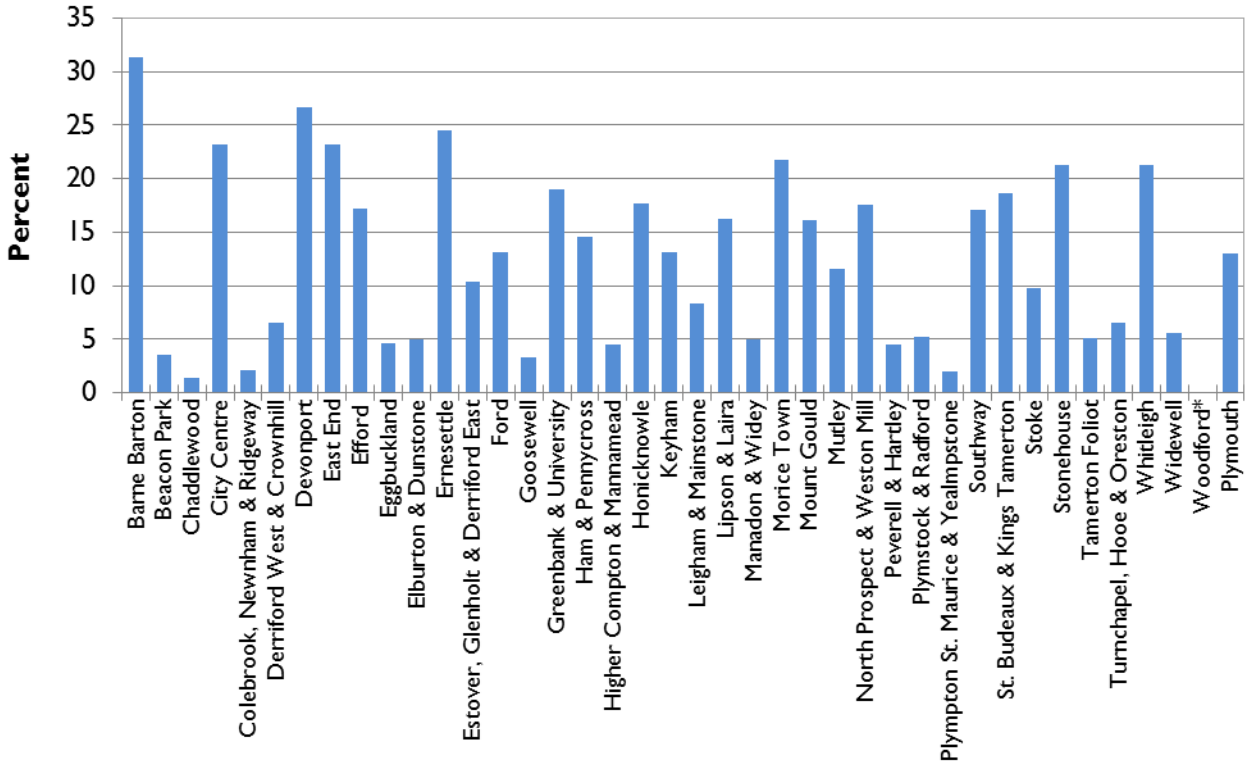
Since 2002 the percentage of vulnerable families has decreased from 24.9% to 13.0% in 2012. There has been a very slight increase from 2010 to 2012, as shown in Figure 30.

In the least deprived neighbourhood group the percentage has decreased from 9.8% to 3.4%. In the most deprived neighbourhood group the percentage has decreased from 42.9% to 22.7%. The slight increase from 2010 to 2012 is evident in this group.

Over the last eight years, the percentage of vulnerable families have decreased across the city as a whole and in the both the most and least deprived neighbourhood groups.

The gap between the most and least deprived neighbourhoods groups has decreased from 33.1 percentage points in 2002 to 19.3 percentage points in 2012. However, there is an approximately seven-fold difference in the percentage of vulnerable families between the most and least deprived groups (22.7% and 3.4% respectively) in 2012.

Figure 31: Vulnerable families by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

According to the survey of health visitor caseloads the Barne Barton neighbourhood had the highest rate of vulnerable families in 2012 (31.3%). This compares with Woodford where the rate was 0.9% (Figure 32).

4.2.2 One or more parent(s) smoke

Table 21 shows that compared to the city average of 28.8%, the South West locality had the highest percentage of families where 'one or more parent(s) smoke' (36.6%) and the Plympton locality had the lowest percentage (15.2%). There was also a more than two fold difference in the percentage of families where 'one or more parent(s) smoke' by deprivation group in 2012.

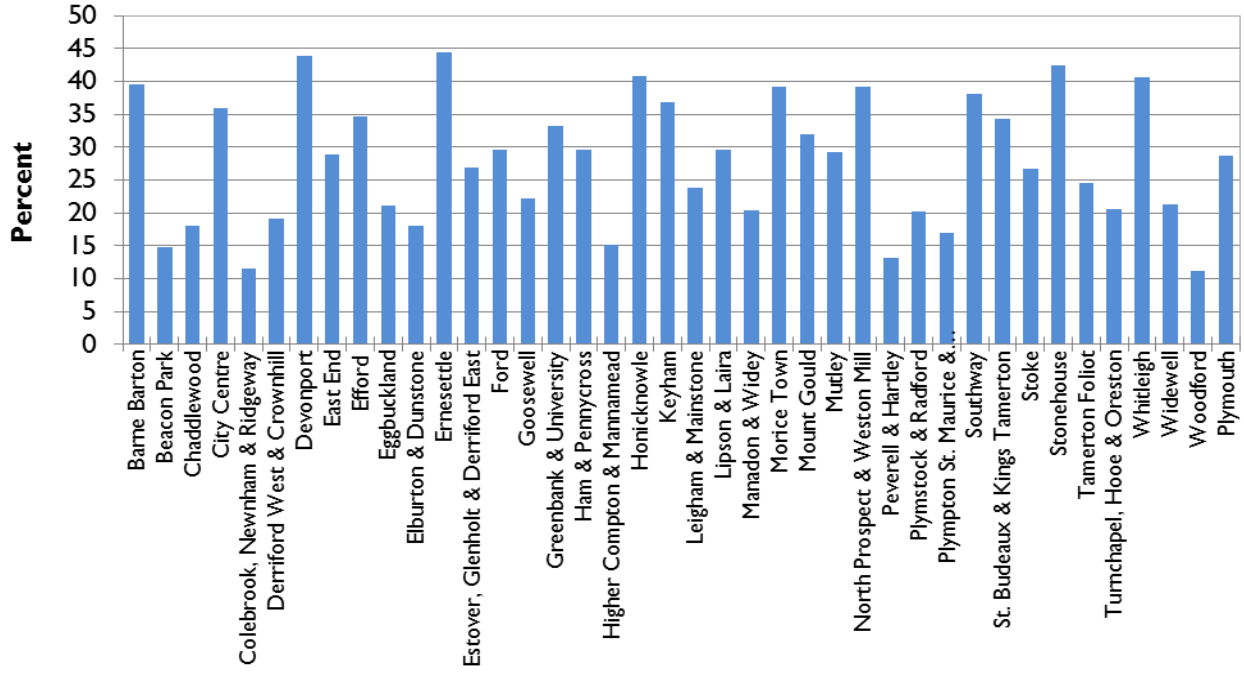
Table 21: Families where 'one or more parent(s) smoke' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	467	19.3 (+/- 1.5)
North West	1,125	35.1 (+/- 1.6)
Plympton	220	15.2 (+/- 1.8)
Plymstock	207	20.3 (+/- 2.4)
South East	539	31.9 (+/-2.2)
South West	1,200	36.6 (+/-1.6)
Plymouth	**3,758**	**28.8 (+/- 0.8)**
Most deprived	1,375	39.9 (+/- 1.6)
Least deprived	450	16.1 (+/- 1.3)

Source: Public Health, Plymouth City Council

Figure 32 shows that the Ernesettle neighbourhood had the highest percentage of families where 'one or more parent(s) smoke' in 2012 (44.4%). This compares with Woodford where the value was 11.2% in the same period.

Figure 32: Families where 'one or more parent(s) smoke' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.3 Low income, dependent on benefits

Table 22 shows that compared to the city average of 20.7%, the North West locality had the highest percentage of families which were 'low income, dependent on benefits' (28.6%) and the Plympton locality had the lowest percentage (2.6%). There was also an almost seven-fold difference in the percentage of families which were 'low income, dependent on benefits' in 2012 by deprivation group in 2012.

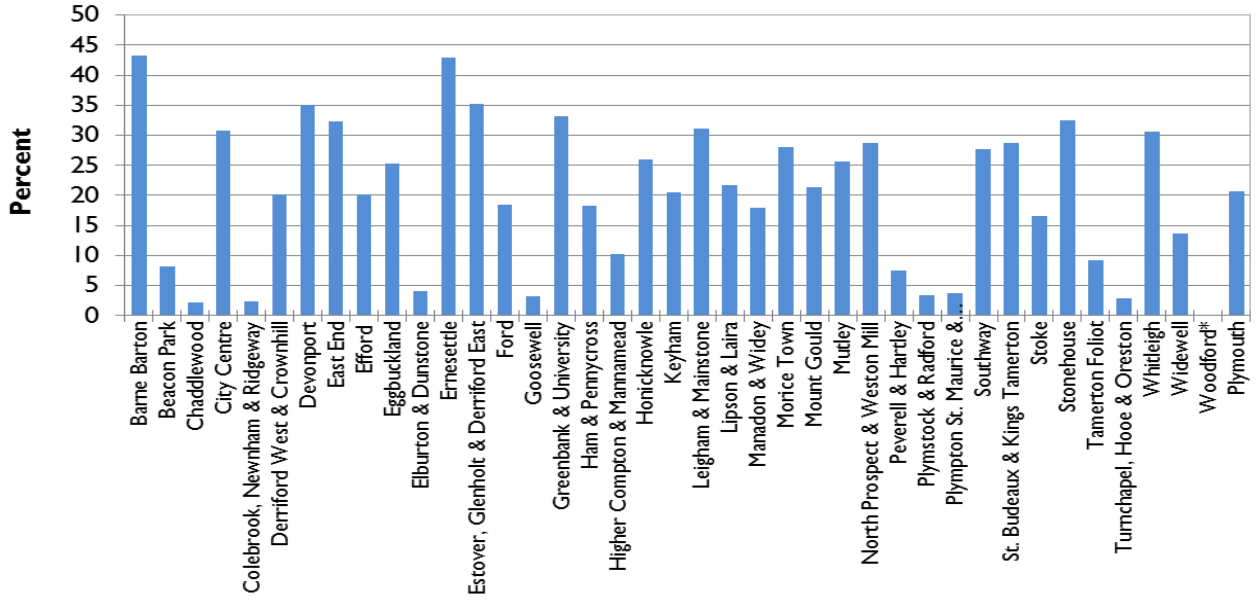
Table 22: Families which were 'low income, dependent on benefits' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	445	18.4 (+/- 1.5)
North West	914	28.6 (+/- 1.5)
Plympton	38	2.6 (+/- 0.7)
Plymstock	35	3.4 (+/- 1.0)
South East	422	24.9 (+/- 2.0)
South West	853	26.0 (+/- 1.5)
Plymouth	**2,707**	**20.7 (+/- 0.7)**
Most deprived	1,120	32.5 (+/-1.5)
Least deprived	130	4.7 (+/- 0.7)

Source: Public Health Team, Plymouth City Council

Figure 33 shows that the Barne Barton neighbourhood had the highest percentage of families which were 'low income, dependent on benefits' in 2012 (43.2%). This compares with Chaddlewood where the value was 2.2% in the same period.

Figure 33: Families which were 'low income, dependent on benefits' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.4 One parent families

Table 23 shows that compared to the city average of 12.4%, the South West locality had the highest percentage of 'one parent families' (16.1%) and the Plympton locality had the lowest percentage (4.5%). There was also more than three-fold difference in the percentage of 'one parent families' by deprivation group in 2012.

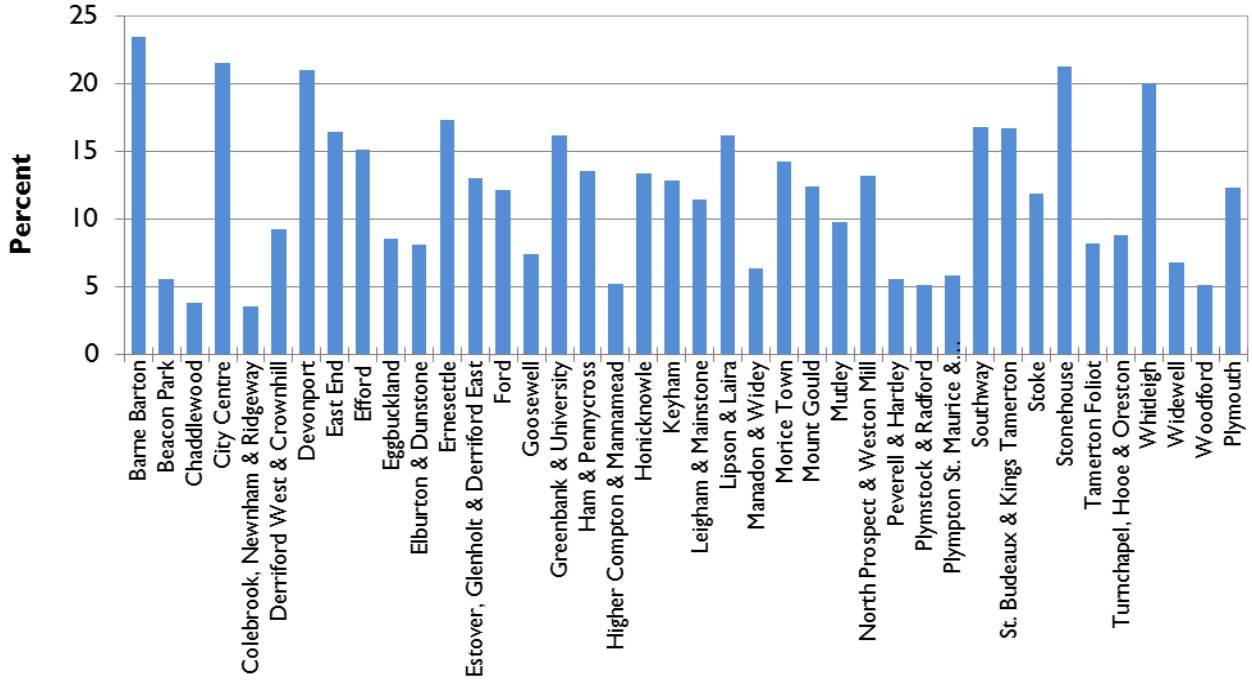
Table 23: 'One parent families' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	186	7.7 (+/- 1.0)
North West	508	15.9 (+/- 1.2)
Plympton	65	4.5 (+/- 1.0)
Plymstock	71	6.9 (+/- 1.4)
South East	257	15.2 (+/- 1.6)
South West	527	16.1 (+/- 1.2)
Plymouth	**1,614**	**12.4 (+/- 0.6)**
Most deprived	634	18.4 (+/-1.3)
Least deprived	146	5.2 (+/- 0.8)

Source: Public Health Team, Plymouth City Council

Figure 34 shows that the Barne Barton neighbourhood had the highest percentage of 'one parent families' in 2012 (23.4 %). This compares with Colebrook, Newnham, & Ridgeway where the value was 3.6% in the same period.

Figure 34: 'One parent families' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.5 Major wage earner is unemployed

Table 24 shows that compared to the city average of 14.8%, the South West locality had the highest percentage of families where the 'major wage earner is unemployed' (21.3%) and the Plympton locality had the lowest percentage (1.3%). There was also a more than nine-fold difference in the percentage of families where the 'major wage earner is unemployed' by deprivation group in 2012.

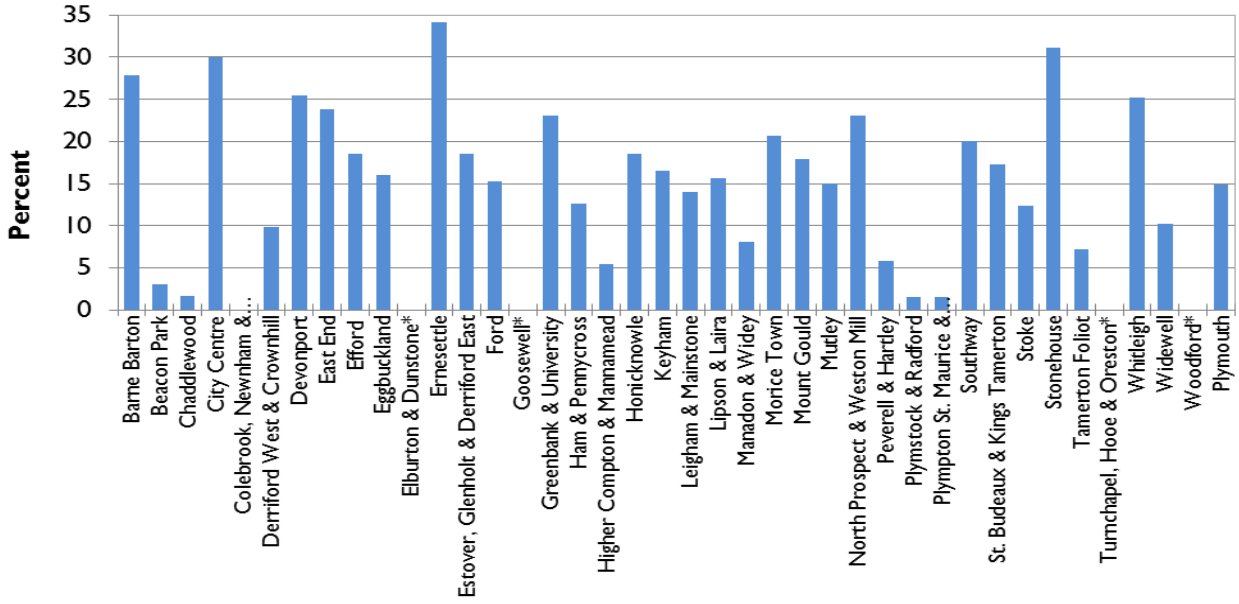
Table 24: Families where the 'major wage earner is unemployed' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	240	9.9 (+/- 1.1)
North West	635	19.8 (+/- 1.3)
Plympton	19	1.3 (+/- 0.5)
Plymstock	15	1.5 (+/- 0.6)
South East	330	19.5 (+/- 1.8)
South West	698	21.3 (+/- 1.4)
Plymouth	**1,937**	**14.8 (+/- 0.6)**
Most deprived	860	25.0 (+/- 1.4)
Least deprived	74	2.7 (+/- 0.5)

Source: Public Health Team, Plymouth City Council

Figure 35 shows that the Ernesettle neighbourhood had the highest percentage of families where the 'major wage earner is unemployed' in 2012 (34.2%). This compares with Plympton St Maurice & Yealmpstone where the value was 1.5% in the same period.

Figure 35: Families where the 'major wage earner is unemployed' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.6 Violence in the family

Table 25 shows that compared to the city average of 9.7%, the North West locality had the highest percentage of families experiencing 'violence in the family' (14.7%) and the Plympton locality had the lowest percentages (2.1%). There was also a nearly five-fold difference in the percentage of families experiencing 'violence in the family' by deprivation group in 2012.

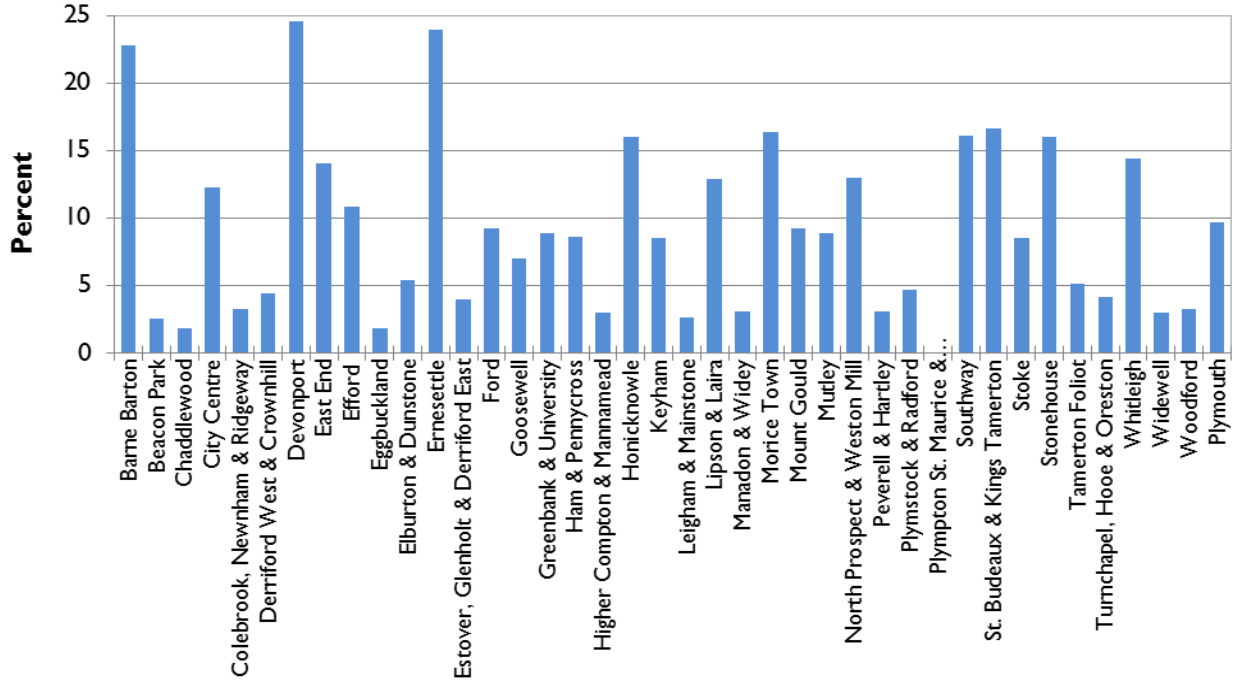
Table 25: Families experiencing 'violence in the family' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	78	3.2 (+/- 0.6)
North West	472	14.7 (+/- 1.2)
Plympton	31	2.1 (+/- 0.6)
Plymstock	54	5.3 (+/- 1.2)
South East	190	11.2 (+/- 1.4)
South West	444	13.5 (+/- 1.1)
Plymouth	**1,296**	**9.7 (+/-0.5)**
Most deprived	601	17.4 (+/- 1.2)
Least deprived	101	3.6 (+/- 0.6)

Source: Public Health Team, Plymouth City Council

Figure 36 shows that the Devonport neighbourhood had the highest percentage of families experiencing 'violence in the family' in 2012 (24.6%). This compares with the Chaddlewood and Eggbuckland neighbourhoods where the values were 1.8% in the same period.

Figure 36: Families experiencing 'violence in the family' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.7 Depressed/mentally ill parents

Table 26 shows that compared to the city average of 9.9%, the Plymstock locality had the highest percentage of 'depressed/mentally ill parents' (14.0%) and the Plympton locality had the lowest percentage (2.6%). There was also more than two-fold difference in the percentage of 'depressed/mentally ill parents' by deprivation group in 2012.

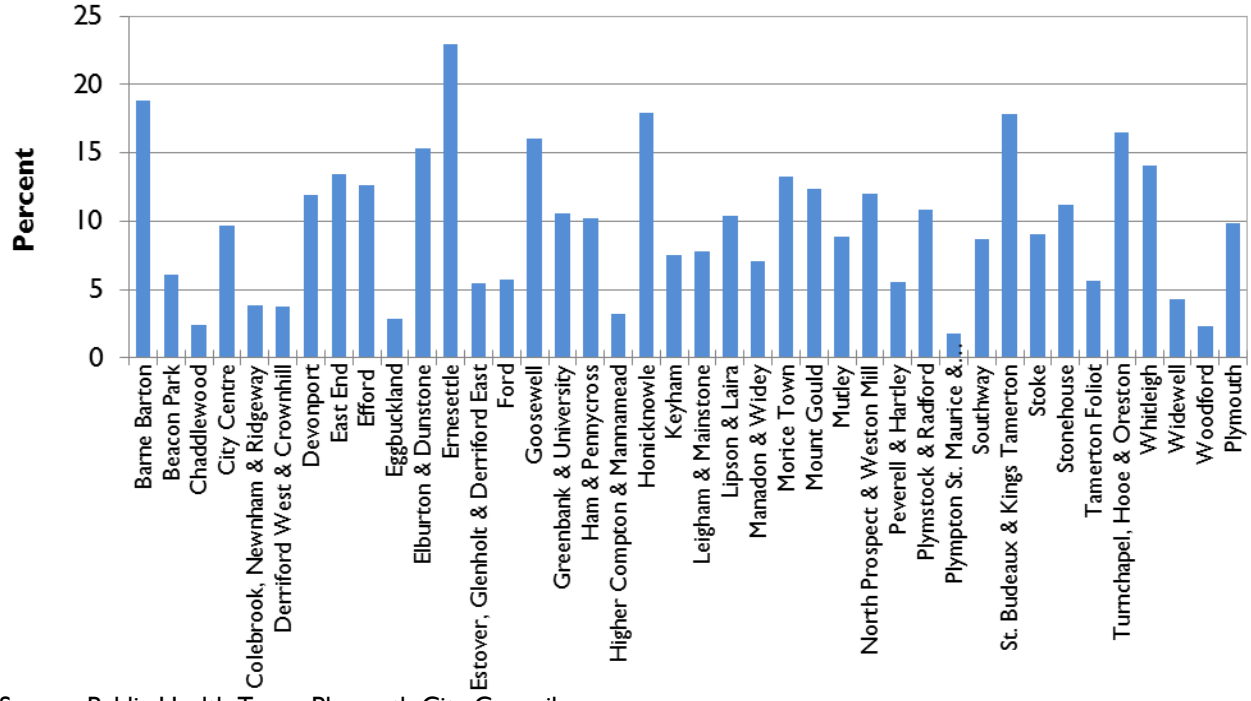
Table 26: 'Depressed/mentally ill parents' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	133	5.5 (+/- 0.8)
North West	442	13.8 (+/- 1.2)
Plympton	37	2.6 (+/- 0.7)
Plymstock	143	14.0 (+/- 2.0)
South East	203	12.0 (+/- 1.5)
South West	333	10.1 (+/- 1.0)
Plymouth	**1,291**	**9.9 (+/- 0.5)**
Most deprived	488	14.2 (+/- 1.1)
Least deprived	185	6.6 (+/- 0.9)

Source: Public Health Team, Plymouth City Council

Figure 37 shows that the Ernesettle neighbourhood had the highest percentage of 'depressed/mentally ill parents' in 2012 (23.0%). This compares with Plympton St Maurice & Yealmpstone where the value was 1.8% in the same period.

Figure 37: Depressed/mentally ill parents by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.8 Child protection issues

Table 27 shows that compared to the city average of 2.3%, the South West locality had the highest percentage of families with 'child protection issues' (3.6%) and the Plymstock locality had the lowest percentage (<0.5%). There was also a more than six-fold difference in the percentage of families with 'child protection issues' by deprivation group in 2012.

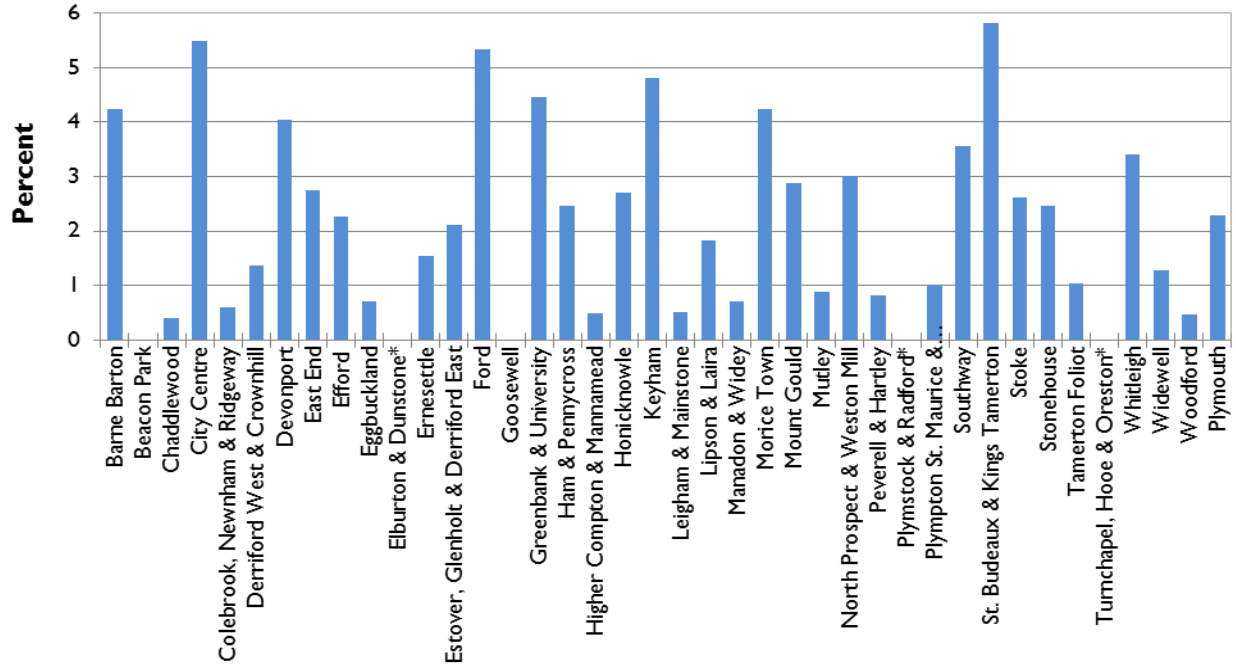
Table 27: Families with 'child protection issues' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	20	0.8 (+/- 0.3)
North West	103	3.2 (+/- 0.6)
Plympton	<10	<0.7 (+/- N/A)
Plymstock	<10	<0.7 (+/- N/A)
South East	46	2.7 (+/- 0.7)
South West	119	3.6 (+/- 0.6)
Plymouth	**300**	**2.3 (+/- 0.2)**
Most deprived	114	3.3 (+/- 0.5)
Least deprived	13	0.5 (+/- 0.2)

Source: Public Health Team, Plymouth City Council

Figure 38 shows that the St Budeaux & Kings Tamerton neighbourhood had the highest percentage of families with 'child protection issues' in 2012 (5.8%). This compares with the Goosewell and Beacon Park neighbourhoods where the values were 0.0% in the same period.

Figure 38: Families with 'child protection issues' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.9 Parenting problems

Table 28 shows that compared to the city average of 5.5%, the North West locality had the highest percentage of families with 'parenting problems' (9.9%) and the Plympton locality had the lowest percentage (0.6%). There was also a six-fold difference in the percentage of families with 'parenting problems' by deprivation group in 2012.

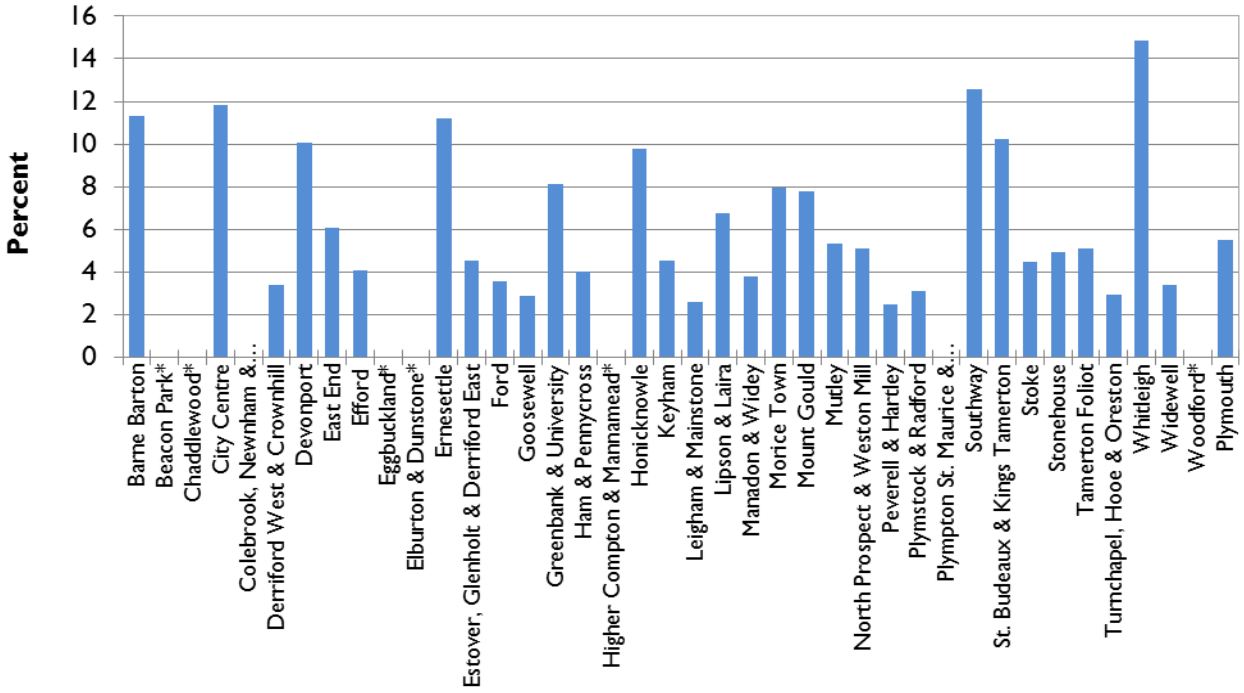
Table 28: Families with 'parenting problems' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	62	2.6 (+/- 0.6)
North West	317	9.9 (+/- 1.0)
Plympton	9	0.6 (+/- 0.3)
Plymstock	25	2.4 (+/- 0.8)
South East	107	6.3 (+/- 1.1)
South West	200	6.1 (+/- 0.8)
Plymouth	**720**	**5.5 (+/- 0.4)**
Most deprived	310	9.0 (+/- 0.9)
Least deprived	41	1.5 (+/- 0.4)

Source: Public Health Team, Plymouth City Council

Figure 39 shows that the Whitleigh neighbourhood had the highest percentage of families with 'parenting problems' in 2012 (14.8%). This compares with Peverell & Hartley where the value was 2.5% in the same period.

Figure 39: Families with 'parenting problems' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.2.10 Social isolation

Table 29 shows that compared to the city average of 4.7%, the Plymstock locality had the highest percentage of families experiencing 'social isolation' (8.8%) and the Plympton locality had the lowest percentage (0.5%). There was also a two-fold difference in the percentage of families experiencing 'social isolation' by deprivation group in 2012.

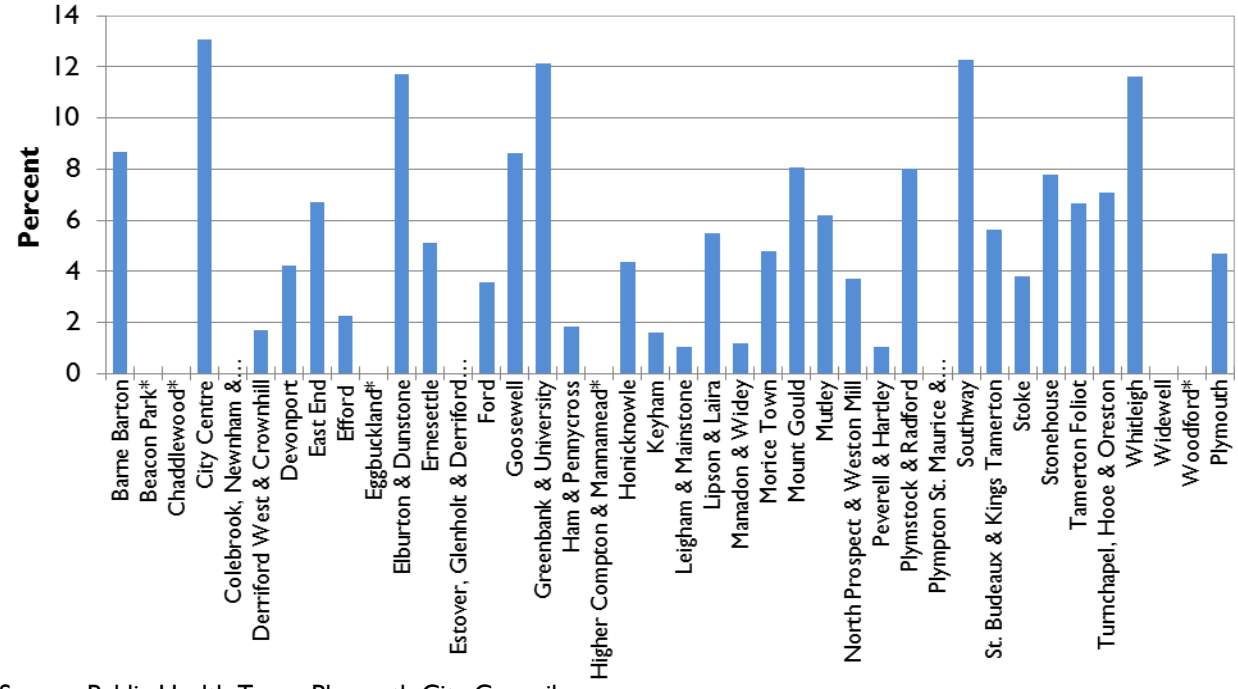
Table 29: Families experiencing 'social isolation' by locality and deprivation group, 2012

Locality/IMD 2010 group	Number	Percent
Central/North East	31	1.3 (+/- 0.4)
North West	220	6.9 (+/- 0.8)
Plympton	7	0.5 (+/- 0.2)
Plymstock	90	8.8 (+/- 1.6)
South East	108	6.4 (+/- 1.1)
South West	156	4.8 (+/- 0.7)
Plymouth	**612**	**4.7 (+/- 0.3)**
Most deprived	231	6.7 (+/- 0.8)
Least deprived	93	3.3 (+/- 0.6)

Source: Public Health Team, Plymouth City Council

Figure 40 shows that the City Centre neighbourhood had the highest percentage of families experiencing social isolation in 2012 (13.1%). This compares with Woodford where the value was 0.0% in the same period.

Figure 40: Families experiencing 'social isolation' by neighbourhood, 2012 (%)



Source: Public Health Team, Plymouth City Council

4.3 Ophthalmic public health data for Plymouth

All information is taken from Ophthalmic Public Health Statistics for Plymouth (original data sources available from the document).[41]

Nationally 68% of adults aged 16 and over wear spectacles or contact lenses, the estimate in Plymouth of adults needing sight correction aids is therefore around 114,200.

There are 17 optician practices across Plymouth and all are equipped to carry out full eye examinations. With adequate commissioning they are able to monitor and/or co-manage patients with long term eye conditions. The cost of providing premises, consulting rooms, equipment and staff is borne by the practice. Diabetic Retinal Screening is currently provided in some optician practices across Plymouth.

According to NHS sight test statistics, 63,557 individuals in Plymouth had an NHS Sight test in 2012/13. Uptake was 24% in the 0-16 year age-group and 41% in those aged 60 years and over. Plymouth is low in its overall uptake of eye tests compared with other areas across England.

The Public Health Outcomes Framework has four indicators relating to eye health (Table 30). With the exception of glaucoma-related sight loss Plymouth's values are not significantly different to England.

Table 30: Public Health Outcomes Framework eye-health indicators

Indicator (rate per 100,000 population)	England value	Plymouth value
Rate of sight loss in those aged 65 and over	110.5	123.8
Rate of sight loss due to glaucoma in those aged 40 and over	12.8	6.5
Rate of sight loss due to diabetic eye disease in those aged 12 and over	3.8	4.5
Rate of sight loss certifications	44.5	39.0

There are an estimated 7,530 people living with sight loss in Plymouth 910 of which are living with severe sight loss (blindness). By 2020 the number of people living with sight loss in Plymouth is projected to increase to 8,670 and severe sight loss to 1,080

Diabetic retinopathy is a common complication of diabetes. It occurs when high blood sugar levels damage the retina. Left untreated it can cause blindness. In Plymouth there are approximately 15,798 diabetic patients. The uptake of Diabetic Retinal Screening in Plymouth is 77.6% of the diabetic patients compared to 81% nationally. Approximately 40% of the diabetic population go on to develop diabetic retinopathy.

[41] Ophthalmic public health statistics for Plymouth

Table 31: Estimated prevalence of ophthalmic conditions in Plymouth

Condition	Prevalence (number)	Prevalence (%)
Glaucoma	3,695	1.4
Dry age-related macular degeneration (dAMD)	6,517	2.5
Wet age-related macular degeneration (wAMD)	4,593	1.8
Cataract	11,290	4.4
Diabetic retinopathy	6,400	40.0 (of diabetic patients)

Based on 2011 Census population; dry AMD is a risk factor for wet AMD

The link between smoking and increased risk of sight loss has shown to potentially double the risk of wet age-related macular degeneration and increase the risk of cataract and diabetic retinopathy.

There is also growing evidence of the impact of impaired vision on falls. Almost half (47 per cent) of all falls in the visually impaired population were directly attributable to the visual impairment. It was estimated that of the 2.35 million accidental falls requiring hospital treatment in the UK in 1999 189,000 (8%) occurred in individuals with visual impairment and 89,500 (3.8 per cent) can be attributed to the visual impairment itself.

4.4 Census results 2011: general health and limiting long-term illness

The census provides detailed information on housing and population which allows central and local government, health authorities and many other organisations to target their resources more effectively and to plan housing, education, health, and transport services for the future.

The latest census took place on Sunday 27 March 2011, a decade after the previous census.

There were 56 questions on the 2011 Census questionnaire: 14 about the household in general and the accommodation and 42 for each member of the household. For those living in Wales there was an extra question about the Welsh language. Questions about household members were based on topics including work, health, national identity, passports held, ethnic background, education, language, religion, and marital status.

There were two questions related to health and disability:
(1) How is your health in general?
(2) Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

The general health question was a self-assessment of a person's general state of health. People were asked to assess whether their health was (1) very good; (2) good: (3) fair; (4) bad; or (5) very bad. This assessment was not based on a person's health over any specified period of time.

Studies show strong links between how people view their health and the actual state of their health. The answers to this question can provide a picture of people's health and how it is related to various factors such as age, labour market position, and educational attainment. Information from this question will also be used by local authorities to identify and tackle areas of deprivation. General health status information can be used as a proxy indicator of poverty and can be combined with other census variables census to build up a picture of an area's deprivation.

The disability-related question was a self-assessment of an individual's long-term health conditions, including problems that are related to old age, if present. People were asked to assess whether their daily activities were (1) limited a lot; (2) limited a little; or (3) not limited at all by such a health problem.

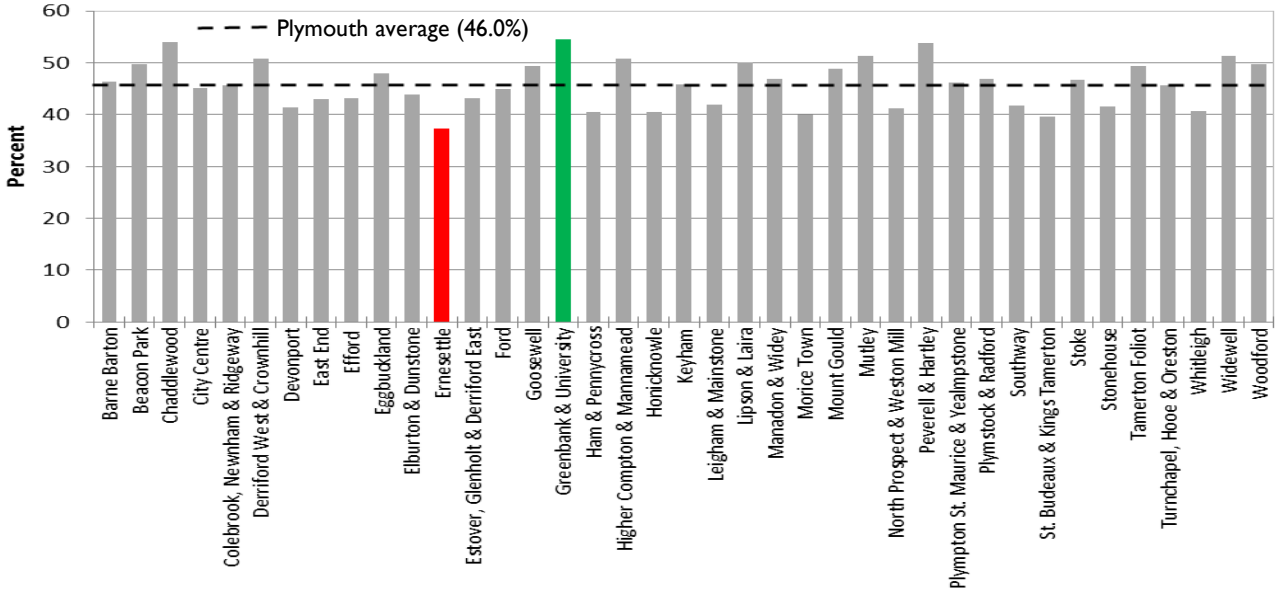
The following analysis corresponds to the census results for both questions related to health and disability for those people resident in Plymouth.

4.4.1 General points

- In 2011, 46.0% of Plymouth residents reported their general health as 'very good'; this increased to 79.5% when also including those who reported their health as 'good'.
- In England 81.4% of people reported their general health as either 'very good' or 'good'
- Plymouth's combined value is therefore nearly two percentage points lower than the national average.
- Of the 161 LSOAs in Plymouth the LSOA with the lowest percentage of residents reporting 'very good' health was in the Ernesettle neighbourhood. This neighbourhood is part of the North West locality and is in the 'upper middle deprived' neighbourhood group.
- Of the 161 LSOAs in Plymouth the LSOA with the highest percentage of residents reporting 'very good' health was in the Chaddlewood neighbourhood. This neighbourhood is part of the Plympton locality and is in the 'least deprived' neighbourhood group.
- Of the 161 LSOAs in Plymouth the LSOA with the lowest percentage of residents reporting 'very bad' health was in the Chaddlewood neighbourhood. This neighbourhood is part of the Plympton locality and is in the 'least deprived' neighbourhood group.
- Of the 161 LSOAs in Plymouth the LSOA with the highest percentage of residents reporting 'very bad' health was in the Stonehouse neighbourhood. This neighbourhood is part of the South West locality and is in the 'most deprived' neighbourhood group.
- In 2011, 10.0% of Plymouth residents reported their day-to-day activities as 'limited a lot'; this increased to 20.4% when also including those who reported 'limited a little'.
- In England 17.6% of people reported their day-to-day activities as either 'limited a lot' or 'limited a little'.
- Plymouth's combined value is therefore nearly three percentage points higher than the national average.
- Of the 161 LSOAs in Plymouth the LSOA with the highest percentage (21.3%) of residents reporting day-to-day activities as 'limited a lot' was in the Stonehouse neighbourhood. This neighbourhood is part of the South West locality and is in the 'most deprived' neighbourhood group.
- Of the 161 LSOAs in Plymouth the LSOA with the lowest percentage (3.5%) of residents reporting day-to-day activities 'limited a lot' was in the Greenbank and University neighbourhood. This neighbourhood is part of the South East locality and is in the 'middle' neighbourhood group.
- Of the 161 LSOAs in Plymouth the LSOA with the highest percentage of residents reporting 'day-to-day activities 'not limited' was in the Greenbank and University neighbourhood. This neighbourhood is part of the South East locality and is in the 'middle' neighbourhood group.
- Of the 161 LSOAs in Plymouth the LSOA with the lowest percentage of residents reporting day-to-day activities 'not limited' was in the Plympton St Maurice and Yealmpstone neighbourhood. This neighbourhood is part of the Plympton locality and is in the 'lower middle' neighbourhood group

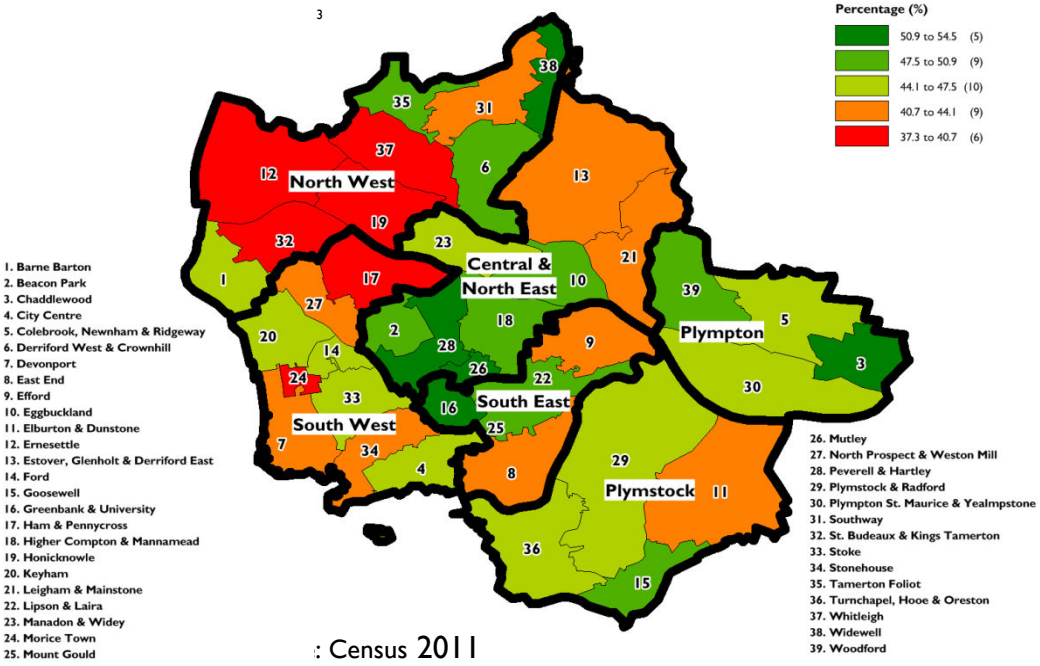
4.4.2 Analysis by neighbourhood

Figure 41: General health self-reported as 'very good' by neighbourhood, 2011 (%)



The Greenbank & University neighbourhood had the highest percentage of residents in 2011 self-reporting their health as 'very good' (54.5%). This compares with Ernesettle where the value was 37.3%. Of the 39 neighbourhoods just under half (19 of 39) had levels of 'very good' health above that of the Plymouth average of 46.0%.

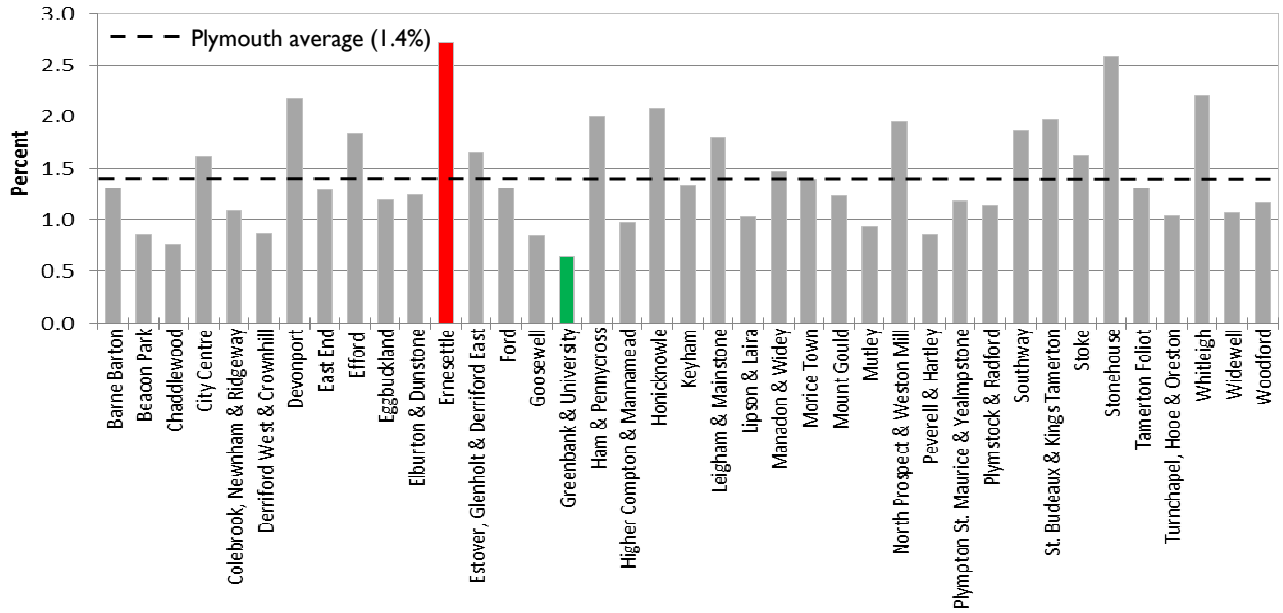
Figure 42: General health self-reported as 'very good' by neighbourhood, 2011 (%)



: Census 2011

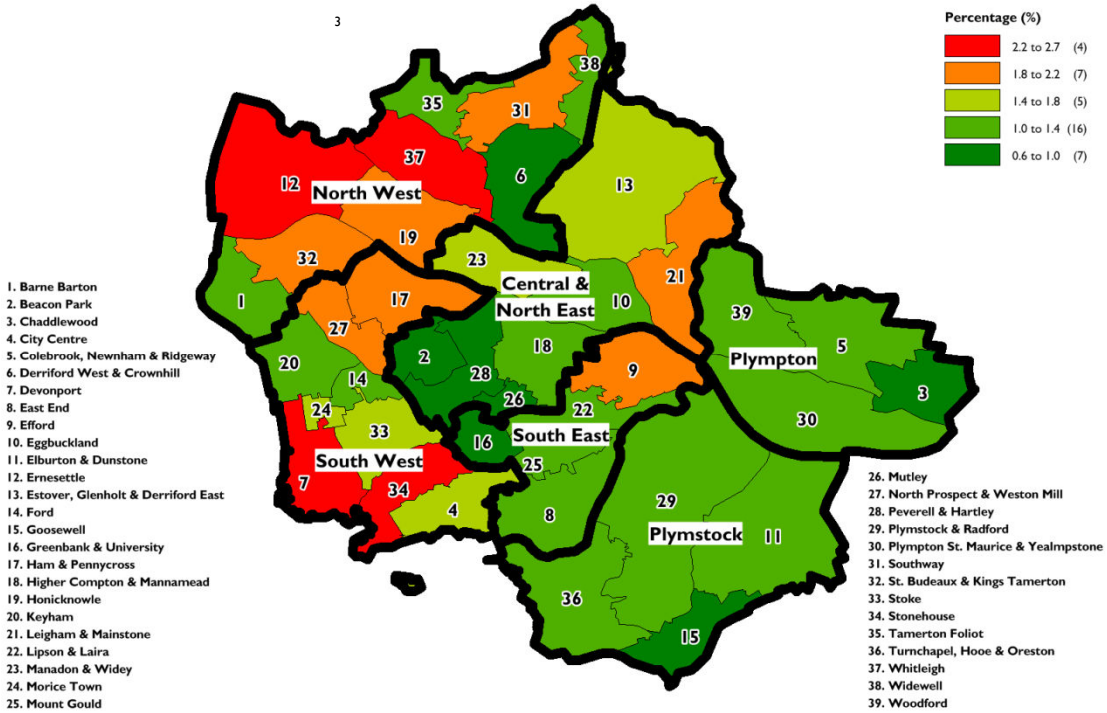
High levels of 'very good' health were concentrated mainly in neighbourhoods in the middle of the city.

Figure 43: General health self-reported as 'very bad' by neighbourhood, 2011 (%)



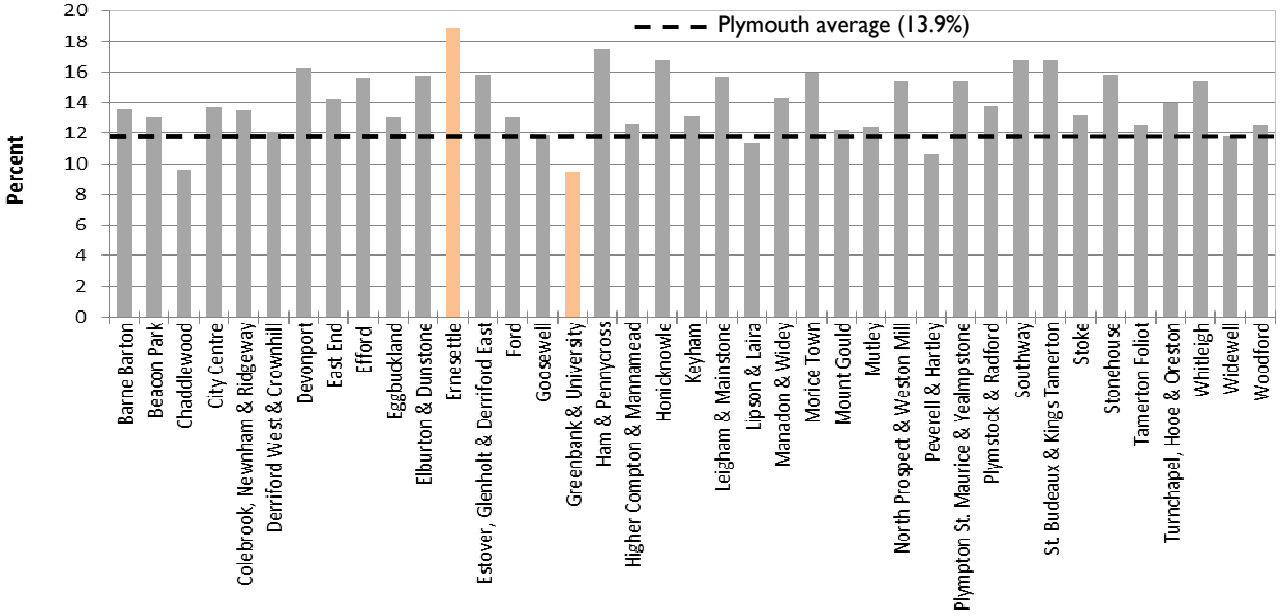
The Ernesettle neighbourhood had the highest percentage of residents in 2011 self-reporting their health as 'very bad' (2.7%). This compares with Greenbank & University where the value was 0.6%. Of the 39 neighbourhoods nearly half (15 of 39) had levels of 'very bad' health above that of the Plymouth average of 1.4%

Figure 44: General health self-reported as 'very bad' by neighbourhood, 2011 (%)



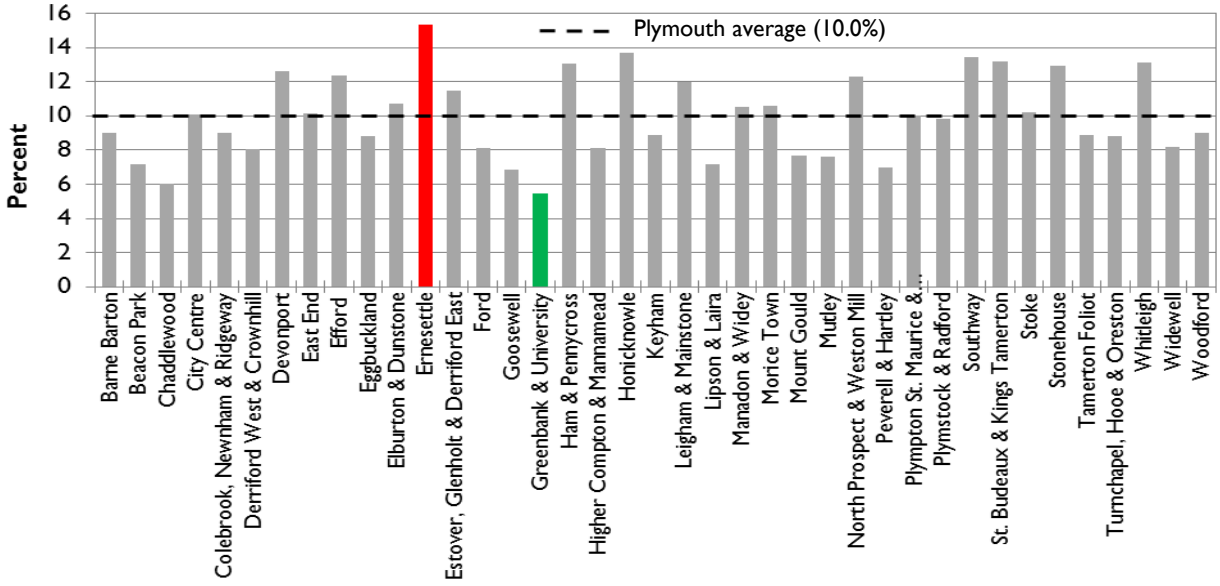
High percentages of 'very bad' health were seen in neighbourhoods to the north and west of the city.

Figure 45: General health self-reported as 'fair' by neighbourhood (%), 2011



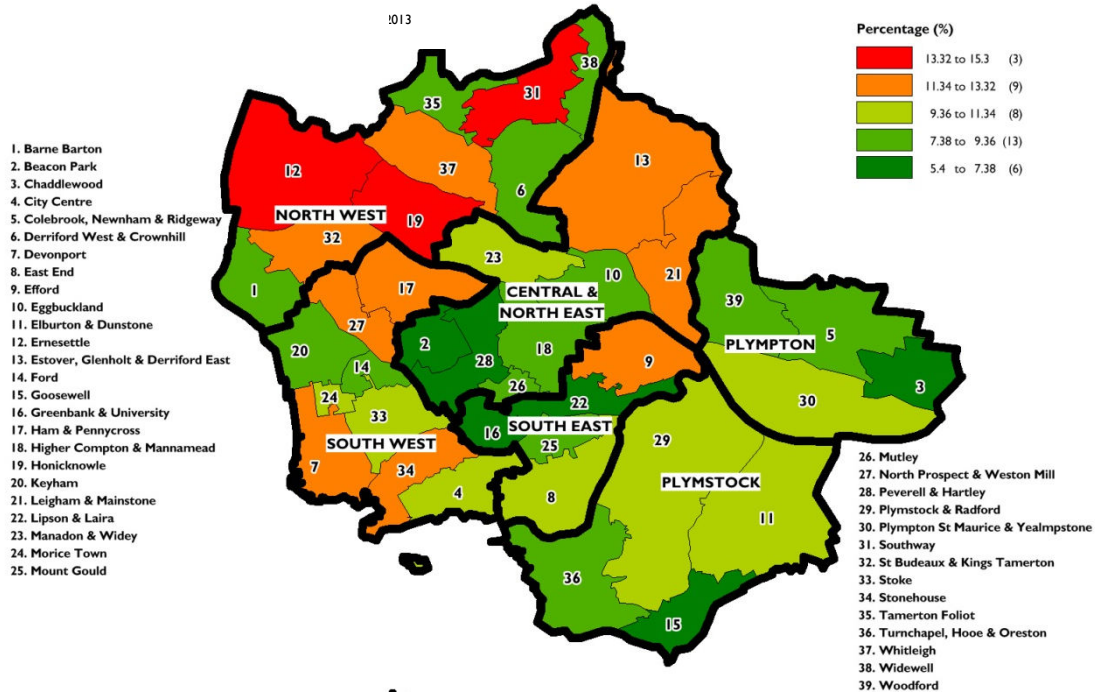
Levels of 'fair' health ranged from 18.9% in Ernesettle to 9.5% in Greenbank & University.

Figure 46: Day to day activities self-reported as 'limited a lot' by neighbourhood (%), 2011



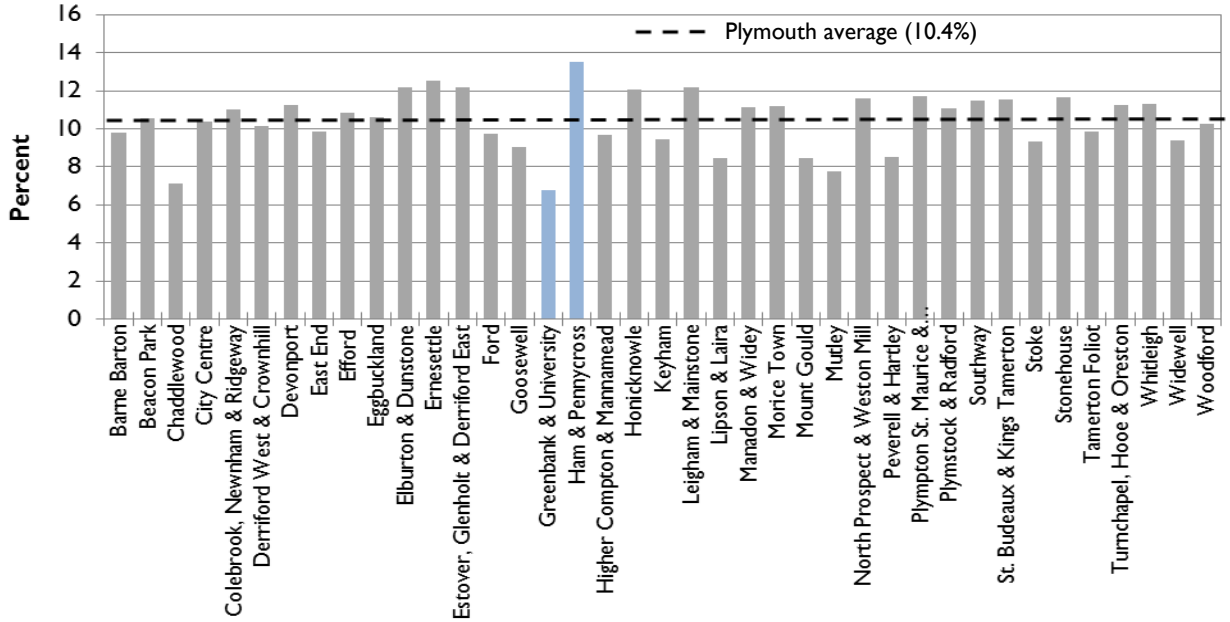
The Ernesettle neighbourhood had the highest percentage of residents in 2011 self-reporting their day-to-day activities as 'limited a lot' (15.3%). This compares with Greenbank and University where the value was 5.4%. Of the 39 neighbourhoods just under half (18/39) had levels above that of the Plymouth average of 10.0%.

Figure 47: Day-to-day activities self-reported as 'limited a lot' by neighbourhood (%), 2011



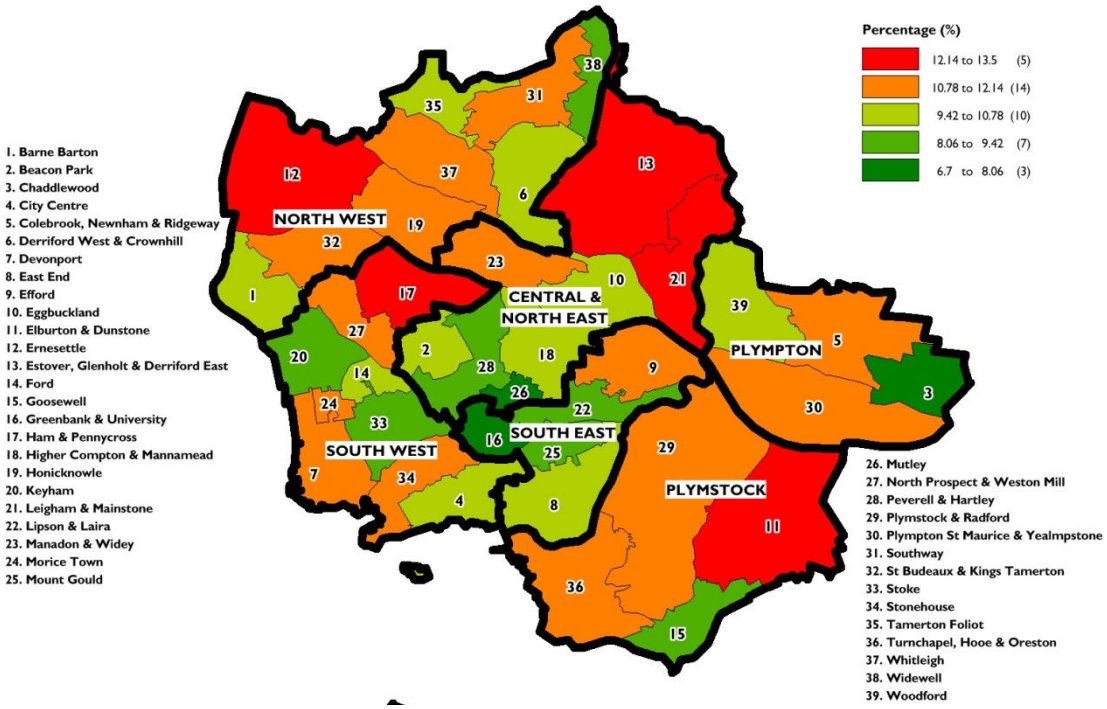
High levels of reported day-to-day activities 'limited a lot' were concentrated mainly in neighbourhoods to the north of the city.

Figure 48: Day-to-day activities self-reported as 'limited a little' by neighbourhood (%), 2011



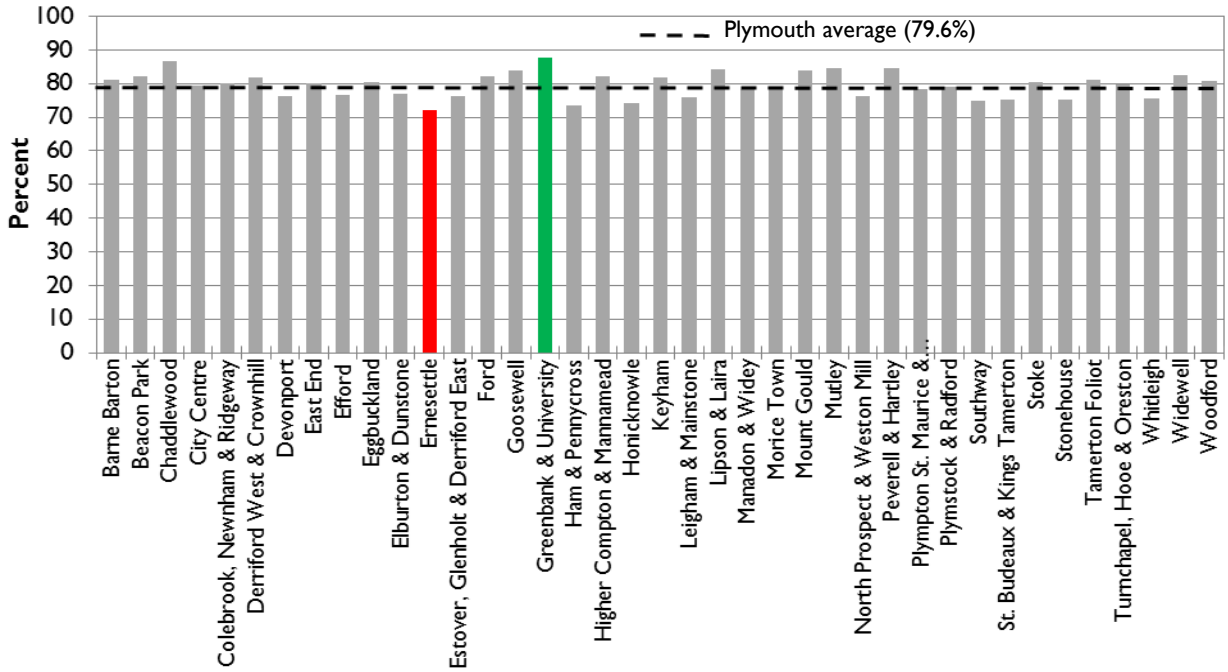
The Ham and Pennycross neighbourhood had the highest percentage of residents in 2011 self-reporting their day-to-day activities 'limited a little' (13.5%). This compares with Greenbank & University where the value was 6.7%. Of the 39 neighbourhoods over half (21/39) had levels of above that of the Plymouth average of 10.4%.

Figure 49: Day-to-day activities self-reported as 'limited a little' by neighbourhood (%), 2011



High levels of reported day-to-day activities 'limited a little' were seen in neighbourhoods scattered across the city.

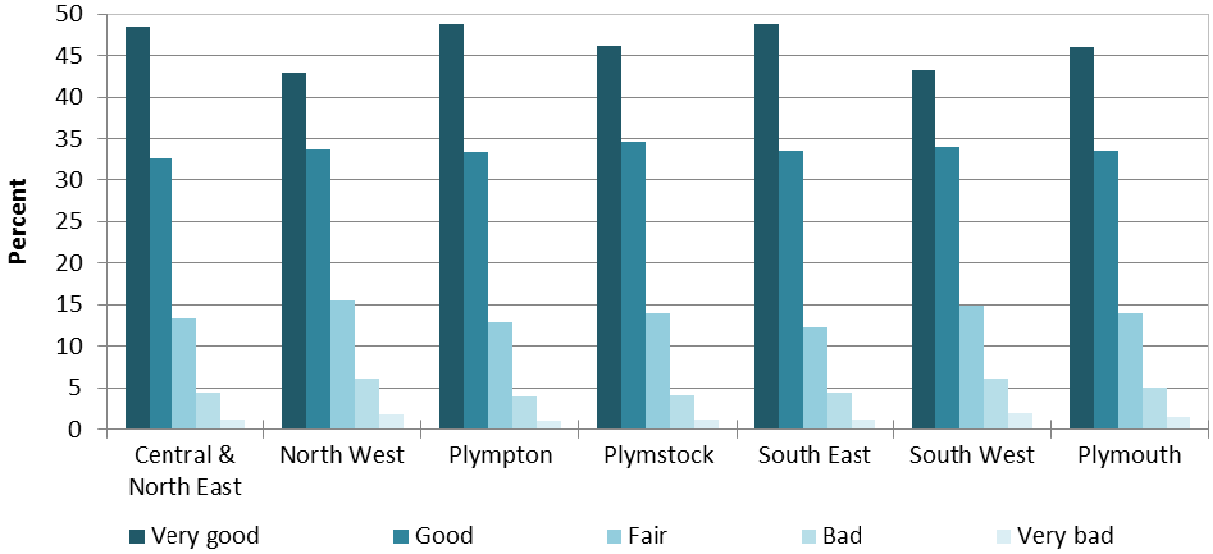
Figure 50: Day-to-day activates self-reported as 'not limited' by neighbourhood (%), 2011



Levels of day-to-day activities 'not limited' ranged from 72.2% in Ernesettle to 87.8% in Greenbank & University.

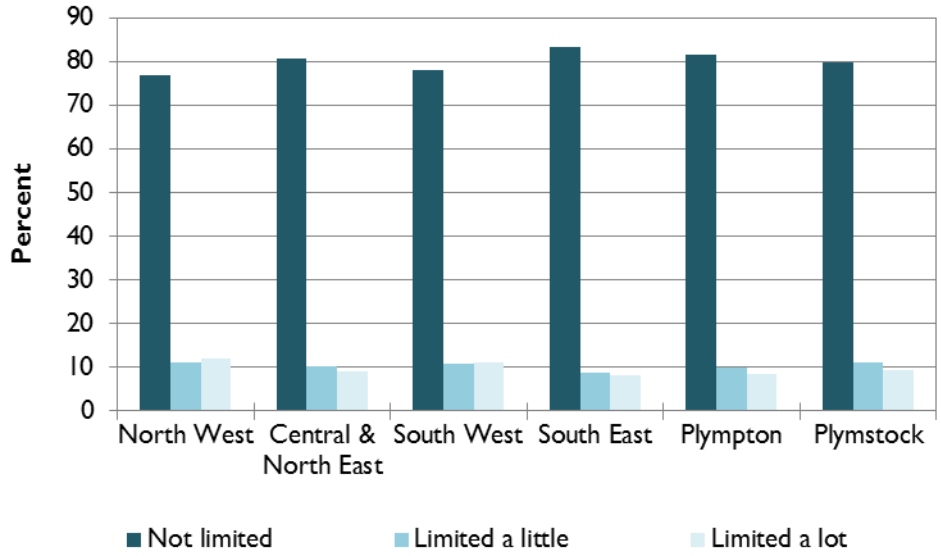
4.4.3 Analysis by locality

Figure 51: Self-reported general health by locality (%), 2011



Compared to the city average of 46.0%, the Plympton locality had the highest percentage of 'very good' self-reported health (48.8%) and the North West locality had the lowest percentage (43%). Compared to the city average of 1.4%, the South West locality had the highest percentage of 'very bad' self-reported health (1.9%) and the Plympton locality had the lowest percentage (1.0%).

Figure 52:Self-reported day-to-day activity limitation by locality (%), 2011

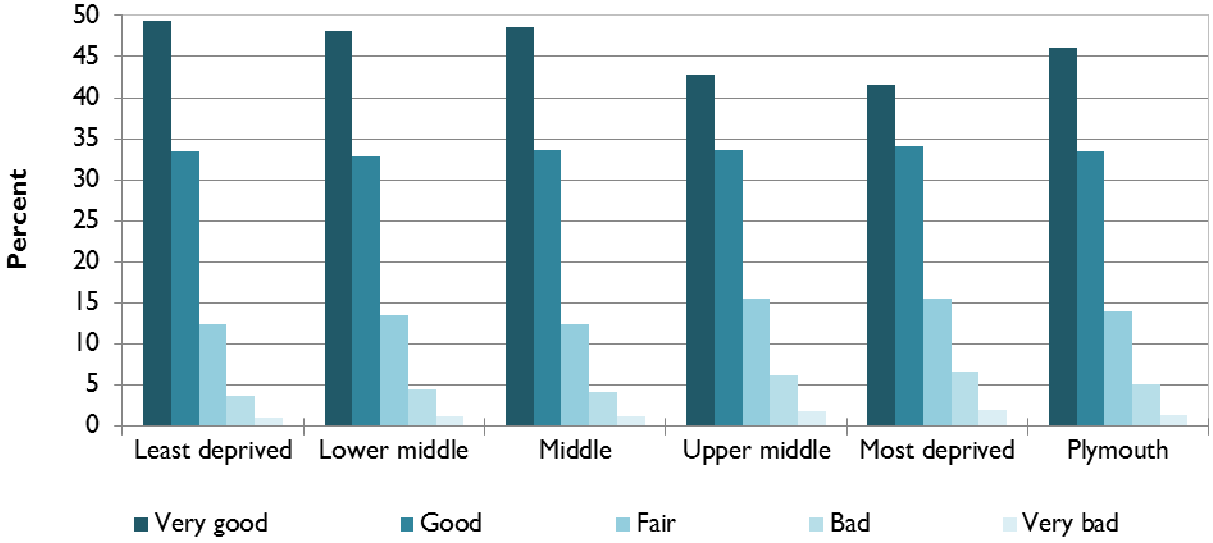


Compared to the city average of 79.6%, the South East locality had the highest percentage of self-reported day-to-day activities 'not limited' (83.2%) and the North West locality had the lowest percentage (76.8%).

Compared to the city average of 10.0%, the North West locality had the highest percentage of self-reported day-to-day activities 'limited a lot' (12.0%) and the South East locality had the lowest percentage (8.2%).

4.4.4 Analysis by deprivation group

Figure 53: Self-reported general health by deprivation group (%), 2011

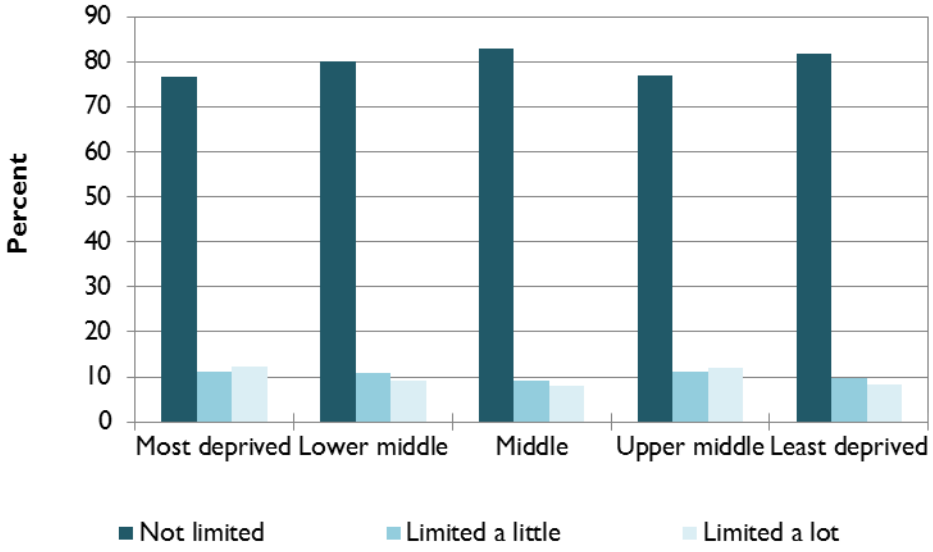


There is an overall decreasing gradient of self-reported 'very good' health as deprivation levels increase across the city. In the least deprived neighbourhood group 49.4% stated 'very good' health compared to only 41.6% in the most deprived group.

Levels of 'bad' and 'very bad' health showed the converse relationship i.e. an increase in proportions as deprivation increases. In the least deprived neighbourhood group 1.0% stated 'very bad' health. This doubled to 2.0% in the most deprived group.

Levels of 'good' health were similar across each deprivation group and similar to the Plymouth average of 33.5%.

Figure 54: Self-reported day-to-day activity limitation by deprivation group (%), 2011



Compared to the city average of 79.6% the middle neighbourhood group had the highest percentage stating their day-to-day activities were 'not limited' (82.8%) whilst the lowest value was seen in the most deprived group (76.6%).

Compared to the city average of 10.0% the most deprived neighbourhood group had the highest percentage stating their day-to-day activities were 'limited a lot' (12.2%) whilst the lowest value was seen in the middle neighbourhood group (8.1%).

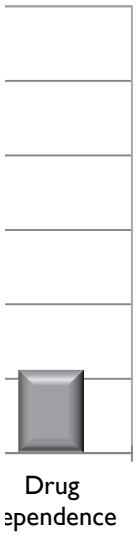
It should be noted that the upper middle neighbourhood group had the second highest values for 'limited a lot' and 'limited a little', 12.0% and 11.0% respectively, and the second lowest value (77.0%) for 'not limited'.

4.5 Estimated prevalence of mental health problems in Plymouth

4.5.1 Background

The estimates in this section are from PANSI[42] (Projecting Adult Need and Service Information) and POPPI[43] (Projecting Older People Population Information), both provided by the Institute for Public Care. The estimates are modelled from responses to the Adult Psychiatric Morbidity Survey[44] (APMS) which took place in 2007. These calculated prevalence rates have then been applied to the ONS population projections for the 18-64 year old population in Plymouth. Where these estimates are significantly different from those in the locally produced 2009 Mental Health Atlas[45] this has been highlighted. Numbers have not been given for Plymouth's comparator cities as these are numbers rather than rates; and as the cities are of different sizes comparison is not as meaningful.

Figure 55: Estimated 2014 prevalence of mental health problems in 18-64 year olds in Plymouth



Source: PANSI[42]

Figure 55 demonstrates that common mental health problems, including depression, anxiety and obsessive-compulsive disorder, constitute the greatest proportion of the mental health burden in Plymouth. Drug and alcohol dependence; as well as psychiatric co-morbidity are also very significant. However, the need for services is not necessarily proportionate to the numbers; for example a person with a psychosis may require repeated episodes of inpatient care and greater input from specialist services than a person suffering from a mild depressive illness.

[42] Projecting Adult Needs and Services Information
[43] Projecting Older Peoples Population Information (POPPI)
[44] Adult psychiatric morbidity in England, 2007
[45] Atlas of adult mental health and related information within Plymouth, 2009

4.5.2 Common mental disorders

Common mental disorders (CMDs) are defined as conditions causing emotional distress and interference with functioning, but where the person recognises that they are unwell (has insight) and retains cognitive abilities such as memory. This category includes different types of depression, anxiety, and obsessive-compulsive disorder.

PANSI estimates nearly 26,300 people aged 18-64 years suffer from a common mental disorder in Plymouth in 2014 (based on APMS figures of 19.7% of women and 12.5% of men suffering from at least one of these disorders).

This figure is lower than the figure of 36,729 predicted in the 2009 Mental Health Atlas. The figures in the atlas are for the year 2000 and encompass a wider age range (16-74 year olds). In addition they are based on a tool which takes population characteristics into account, which PANSI does not.

Over the next seven years the number of cases of CMDs is predicted by PANSI to not change significantly; increasing to just over 25,670 18-64 year olds in 2030.

4.5.3 Estimated numbers with specific common mental health problems

In 2008, the North East Public Health Observatory (NEPHO; now the Knowledge and Intelligence Team Northern and Yorkshire) produced figures estimating the number of sufferers from CMD. These estimates were based mainly on the findings from the National Psychiatric Morbidity Survey carried out in the year 2000, with some adjustment for population characteristics. The purpose of these estimates was to inform planning for the Improving Access to Psychological Therapies (IAPT) programme.[46]

The estimated rates, as applied to the estimated 2012 Plymouth population aged 16-74 years, are displayed in Table 32. The term 'neurotic disorders' is used to cover common mental health problems such as anxiety and depressive disorders.

The Adult Psychiatric Morbidity Survey 2007 as used by PANSI and POPPI estimated that, of the 18-64 year old population, 12.5% of males and 19.7% of females would have a common mental disorder (around 26,000 people). Table 32 estimates that over 38,000 would have a neurotic disorder. The latter figure may be higher due to adjustment for population characteristics – it also covers those aged 16-18 and 65-74 years.

Not all sufferers of a mental health problem will need a treatment intervention. The 2007 APMS survey found that only 50% of adults with a Clinical Interview Schedule – Revised (CIS-R) score (a ratings scale for CMD) indicating neurotic symptoms had symptoms of a level of severity likely to require treatment. If this is applied to the 16-74 year old Plymouth population, it is possible that nearly 20,000 people in Plymouth are likely to suffer with a 'neurotic disorder' which requires treatment. Many of these may already be receiving treatment whilst others may not want it.

[46] Estimating the prevalence of common mental health problems

Table 32: Estimated prevalence of neurotic disorders in Plymouth residents aged 16-74 years (using mid-2012 ONS population estimates)

Disorder	Rate per 1,000 population (16-74 years)	Estimated number of cases	Estimated number of a severity needing treatment
Any neurotic disorder	201.2	38,786	19,393
All phobias	22.8	4,395	2,198
Depressive episode	15.8	3,046	1,523
Generalised anxiety disorder	49.0	9,446	4,723
Mixed anxiety & depression	115.3	22,227	11,114
Obsessive compulsive disorder	10.6	2,043	1,022
Panic disorder	7.6	1,465	733

Source: NEPHO and ODPH

4.5.4 Personality disorders

Personality disorders are longstanding problematic personality features which cause a person to have difficulty functioning in addition to making and sustaining relationships. There are various types of personality disorders but two are particularly important in terms of need for health and other services:

(1) Borderline personality disorder is significant because this condition involves high levels of emotional instability, self-harm, and suicide. In 2014 more than 730 people in Plymouth aged 18-64 years are predicted to have borderline personality disorder.[47]

(2) Antisocial personality disorder, characterised by an aggressive and irresponsible pattern of behaviour, also has a wider impact on society as it is linked with crime and violence. In 2012 almost 580 people aged 18-64 years in Plymouth are estimated to have antisocial personality disorder.[47]

4.5.5 Psychosis

Psychosis is a term for disturbance of perception, thought, and insight. For example, people may experience hallucinations, or distorted sensations such as hearing things, that are not there in external reality. These experiences may be frightening and distressing. A lack of insight means that sufferers may not recognise that they are unwell or that they could benefit from treatment. Psychotic symptoms occur in illnesses such as schizophrenia, and can also accompany mood disorders such as bipolar affective disorder. In 2014 over 650 people aged 18-64 in Plymouth are estimated to have some type of psychotic disorder.[47]

4.5.6 Psychiatric co-morbidity

It is quite common for people to meet the diagnostic criteria for two or more mental health problems and suffer from psychiatric comorbidity. This is an important issue as it is associated with greater disease severity, longer illness duration, greater functional disability, and an

[47] Projecting Adult Needs and Services Information

increased use of health services. Over 11,500 people in Plymouth aged 18-64 years are estimated to have more than one mental health problem.[47]

4.5.7 Dementia

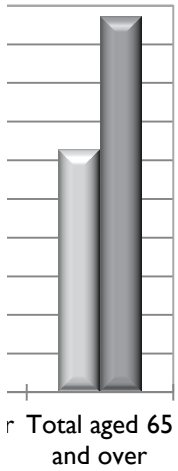
Dementia is a syndrome or collection of progressive symptoms which are due to a decline in the functioning of the brain. Symptoms of dementia include memory loss, and problems with thinking, language, judgement, and understanding. Personality and behavioural changes and mood disturbances such as depression may also occur. There are various types of dementia, two of the most common being Alzheimer's disease and vascular dementia.

Dementia becomes more common with age and is rare under the age of 65. The proportion of people with dementia doubles for every five year increase in age, until around one third of people over 95 have dementia.

With an ageing society, dementia is becoming steadily more common and more significant – the emotional, social, and financial costs to the person, family, community, and wider society are considerable. Understanding the local situation is very important to providing early diagnosis and appropriate support to people and their carers. Figures taken from PANSI and POPPI state that:

- Approximately 60 people aged 30-64 years in Plymouth are estimated to have early-onset dementia in 2014.[48]
- Over 3,130 over-65s are predicted to suffer with the dementia in 2014.[49]
- The number of cases of dementia in the over-65s is projected to increase over time, reaching around 4,850 by 2030.[49]

Figure 56: Plymouth population projections for dementia cases by age group



Source: POPPI

[48] Projecting Adult Needs and Services Information
[49] Projecting Older Peoples Population Information (POPPI)

These estimates use prevalence rates applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.

4.5.8 Other mental health disorders

In this section national estimates have been applied to the local population (mid-2012 ONS population estimate) to give an approximate indication of the likely scale of need of some of the mental health disorders not covered by PANSI and POPPI.

- Bipolar affective disorder

Bipolar affective disorder is a 'cyclical mood disorder' where abnormally elevated mood (known as mania or hypomania) and/or irritability alternates with a depressive state. There can sometimes be psychotic symptoms. The first episode usually occurs before the age of 30, with a peak in onset occurring between the ages of 15 and 19 years of age.[50]

The lifetime prevalence of bipolar disorder is approximately 1.0%; affecting around one in one hundred people over their lifetime.[50] The annual incidence is around 3.7 per 100,000.[51] In a city the size of Plymouth we would therefore expect in the region of 10 new cases a year.

- Schizophrenia

Schizophrenia is a severe and enduring psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts, affect and behaviour. Individuals who develop schizophrenia will each have their own unique combination of symptoms and experiences, the precise pattern of which will be influenced by their particular circumstance.

The incidence of new cases is around 11 per 100,000 people per year and is the most common form of psychotic disorder.[52] The lifetime prevalence is in the region of 4-14 per 1,000, i.e. from 0.4-1.4%.[52] Prevalence of the disorder varies with age, but applying these figures to the Plymouth population aged 18 years and over would give a number in the range of 830 to 2,900 people.

- Eating disorders

Eating disorders include anorexia nervosa, bulimia, and Eating Disorders Not Otherwise Specified (EDNOS). Anorexia is characterised by a preoccupation with low body weight, and food restriction which can be severe and even fatal. The main features of bulimia are recurrent binge eating teamed with compensatory behaviours such as purging. There are many people with disordered eating who may not meet the criteria for these illnesses but may have an EDNOS.

In the Adult Psychiatric Morbidity Survey (2007) 6.4% of adults screened positive for a possible eating disorder in the previous year. Of those who screened positive 1.6% also reported that their feelings about food had a significant negative impact on their life.[53]

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[50] Bipolar disorder. The management of bipolar disorder in adults, children and adolescents, in primary and secondary care, 2006

[51] Systematic review of the incidence and prevalence of schizophrenia and other psychoses in England, 2012

[52] Schizophrenia: The NICE guideline on core interventions in the treatment and management of schizophrenia in adults in primary and secondary care, 2010

[53] Adult psychiatric morbidity in England, 2007: Results of a household survey, 2008

Annual incidence estimates for anorexia are in the region of 19 new cases per 100,000 women, and 2 per 100,000 men. The prevalence of bulimia amongst young women has been estimated at between 0.5-1.0% whilst the numbers suffering with EDNOS is less well known.[54]

Given these figures we might expect in the region of 25 new cases of anorexia per year in women in Plymouth, and 4 new cases per year in men. The more common prevalence of bulimia suggests at any one time there may be around 650-1300 young women with the condition.

- Adult Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is most common is children and young people. The symptoms include impulsivity, hyperactivity, and inattention. These symptoms will persist into adulthood in up to half of cases. Services for adults with this condition have historically been poor or non-existent.

Using the Adult Self-Report Scale (ASRS) 8.2% of the adult population in England screened positive for ADHD characteristics in the Adult Psychiatric Morbidity Survey.[53] NICE estimates that 1.8% of men and 0.4% of women aged 18 years and older will have adult ADHD.[55] In Plymouth, this would suggest around 1,830 men and 420 women are likely to have the condition.

4.6 Self-harm

Self-harm can include self-poisoning and other injuries such as cutting or burning. It can be associated with disorders such as depression or borderline personality disorder, or can be a reaction to distressing events. Self-harm may not occur with suicidal intent, but may be a means of release or of coping with difficulties such as relationship breakdown.

When looking at hospital stays for self-harm as a proxy of the prevalence, it is worth bearing in mind that this measure only looks at events severe enough to warrant an admission to hospital. It is likely this is only the tip of the iceberg in relation to the health and well-being burden of self-harm. Whilst not all cases of self-harm will present to services, the number of A & E attendances can paint a picture of the prevalence of this problem. The following information is from Plymouth Hospitals NHS Trust for 2012/2013:

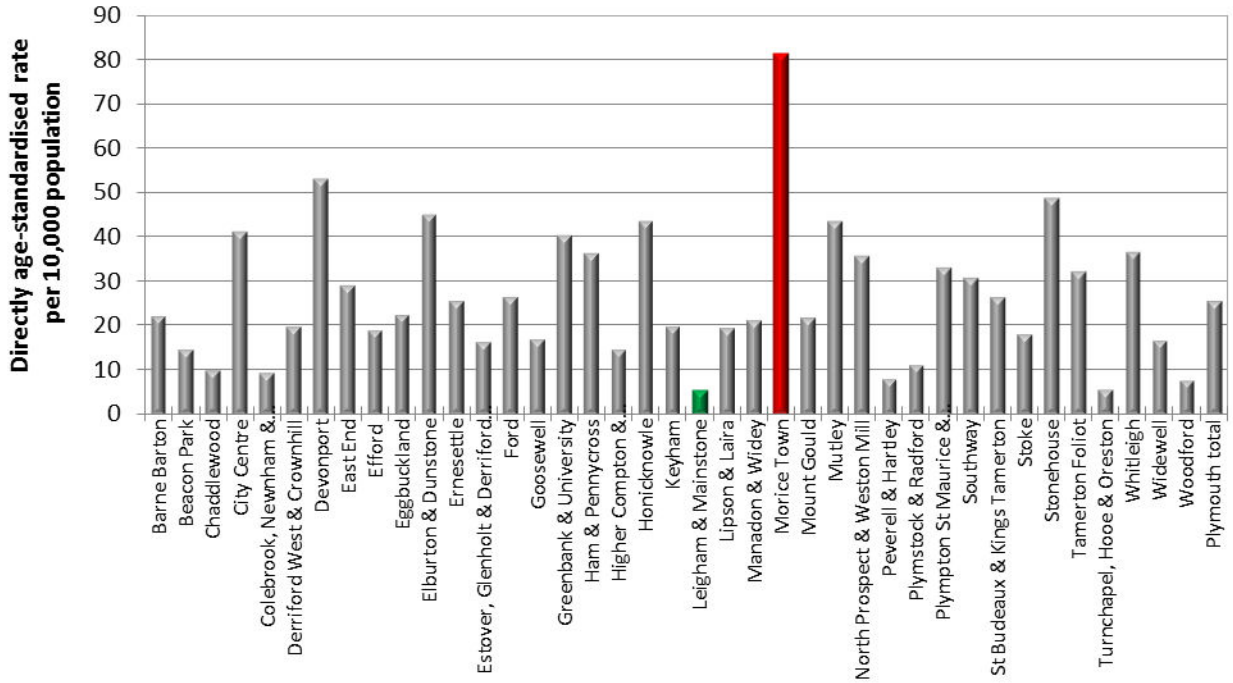
- There were 687 'deliberate self-harm' coded attendances at A & E from a total of 510 individuals.
- The attendance rate had decreased slightly to 25.6 per 10,000 compared to 28.7 attendances per 10,000 in 2010/11.

[54] Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders, 2004

[55] Attention deficit hyperactivity disorder costing report, 2008.

- On a neighbourhood basis the rate ranged from 5.5 per 10,000 in Leigham and Mainstone to 81.4 per 10,000 in Morice Town (Figure 57). Other neighbourhoods with high rates include Devonport and Stonehouse.
- The rate for female A&E attendances was 33.3 per 10,000 whilst for males it was 18.0 per 10,000.
- Neighbourhood rates ranged from 0.0 per 10,000 in Elburton and Dunstone to 108.1 per 10,000 in Morice Town for males; and from 3.7 per 10,000 in Turnchapel, Hooe, and Oreston to 94.4 per 10,000 in Elburton and Dunstone for females. Interestingly the highest female rate is seen in a neighbourhood that is one of the least deprived in the city.
- The age-group most likely to present were the 15-29 year olds. However since 2010/11 there has been a marked decrease in the numbers of attendances of both males and females of this age.
- Over three times as many self-harm A & E attenders came from the most deprived group of neighbourhoods than the least deprived group.
- The majority of those who had self-harmed attended only once during the year. However there were 64 individuals who attended more than once and collectively accounted for 123 attendances.
- There were 633 admissions to Derriford with a self-harm or self-poisoning coded diagnosis from a total of 478 individuals.
- The admission rate had increased slightly to 24.2 per 10,000 compared to 23.8 attendances per 10,000 in 2010/11.
- On a neighbourhood basis the rate ranged from 4.8 per 10,000 in Turnchapel, Hooe, and Oreston to 63.4 per 10,000 in Morice Town (Figure 57).
- The rate for female admissions was 32.4 per 10,000 whilst for males it was 16.0 per 10,000.
- Neighbourhood rates ranged from 0.0 per 10,000 in Goosewell to 65.3 per 10,000 in Morice Town for males; and for females from 3.7 per 10,000 in Turnchapel, Hooe, and Oreston to 79.7 per 10,000 in the City Centre.
- The age-group most likely to present were the 15-29 year olds.
- Over four times as many self-harm A & E attenders came from the most deprived group of neighbourhoods than the least deprived group.
- There were 72 individuals who were admitted more than once and collectively accounted for 106 admissions.

Figure 57: Rate of attendances at A & E for self-harm by neighbourhood 2011/2012



Source: SUS; analysis Public Health Team, Plymouth City Council

4.7 Mental Health Services

Data in this section is taken from the Adult Mental Health data refresh 2013.[56]
There were 5,758 referrals of Plymouth residents to the Improving Access to Psychological Therapies (IAPT) system during 2011-2012. Not all of these referrals engaged with the system.

Key points:

- Almost 30% of referrals to the IAPT system came from the South West locality.
- On a neighbourhood basis Stonehouse had the largest percentage of referrals (5.5%), Leigham & Mainstone and Widewell had the lowest percentage (1.0%).
- Neighbourhoods with the highest proportions of referrals not engaged were Stonehouse (6.5%), Stoke (5.2%), Mount Gould (4.5%) and Greenbank & University (4.5%).
- Of the total referrals to the IAPT system over 63% were females and almost 30% were aged 20 to 29 years.

Of the 6,715 individuals in contact with Plymouth Community Healthcare's mental health service in 2012/2013 (from the Mental Health Minimum Dataset):

- 30% came from the South West locality.

[56] Adult Mental Health data refresh, 2013

- The majority were female (54.2%).
- Just over 16% were aged 35 to 44 years.
- There were over 100,000 contacts with the service; the greatest proportion (37,381; 37.3%) were with the Adult Community Mental Health Team.
- The South West locality had the highest rate of emergency mental health admissions to Plymouth Hospitals NHS Trust; 18.6 per 10,000 all ages (122 admissions) compared to the Plymouth average of 11.8 per 10,000 (378 admissions).

4.8 Suicide and injury of undetermined intent

Where suicide is mentioned in this section it refers to both suicide and deaths from injury of undetermined intent.
Suicide – a coroner at inquest has concluded the person intentionally too their own life.
Injury of undetermined intent – a coroner at inquest reaches an open or narrative verdict because the intention of the person is uncertain.

Data in this section is taken from the 2010-12 Summary Plymouth Suicide Audit unless stated otherwise.[57]

Many factors have been identified as being associated with suicide. Men are more likely to commit suicide than women, and young men are most likely to die from this cause. The highest rates of suicide occur amongst people in the lowest social classes. Most people who commit suicide are not in contact with mental health services at the time; only approximately 25% are in current contact[58].

Other risk groups for suicide include:[58]

- People in the lowest social class.
- People who have self-harmed.
- People with histories of childhood sexual abuse or recent adverse life events (bereavement, separation, and divorce).
- People who abuse alcohol and/or drugs.
- People who are socially isolated or live alone.

Between 2001-03 and 2010-12 the number of deaths in each three-year period from suicide in Plymouth has varied from 66 to 83 (average per year of 25). In England it has varied between 12,679 and 15,444.[59]

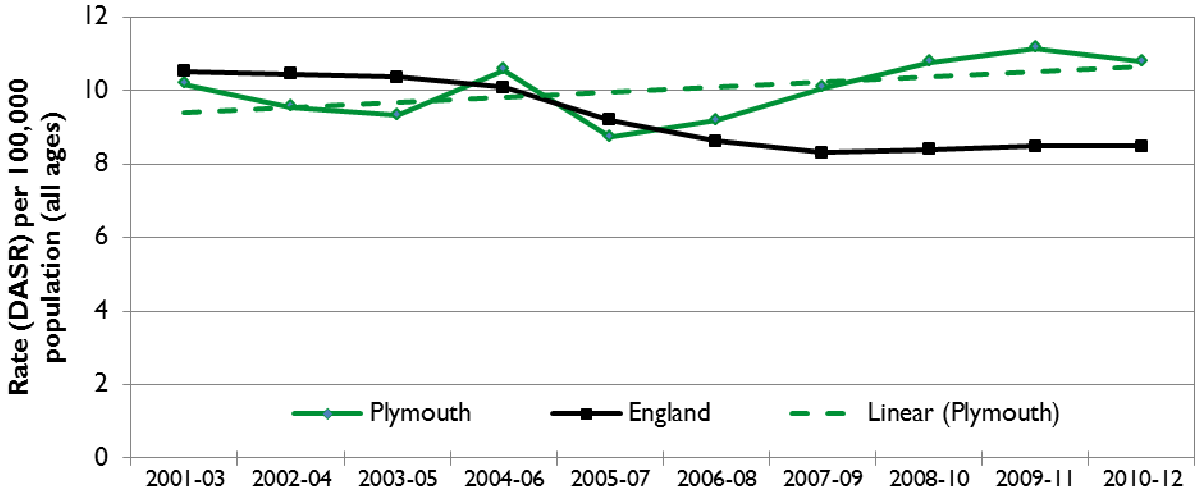
[57] Plymouth Suicide Audit Summary, 2010-12
[58] Suicide Prevention Strategy and Action Plan. 2008.
[59] Public Health Outcomes Framework Indicator 4.10 – suicide rate trend, 18 Aug 2014

There were 80 deaths from suicide in Plymouth residents aged 15 years and over in the latest 2010-12 time period (23 in 2010; 24 in 2011; and 33 in 2012). Deaths by suicide are registered only after an inquest has taken place, therefore not all of these deaths will have occurred during these three years.

Key gender, age, and place of death details for 2010-12:

- Three times as many men than women died by suicide, 63 and 17 respectively.
- Ages of individuals ranged from 17 to 93 years.
- More than half (55%; corresponding to 44 individuals) of all deaths occurred between the ages of 40 and 64 years
- The majority of people (65%; corresponding to 52 individuals) died in their own home.
- Death by suicide is an issue across the city. All six localities had at least once resident die by suicide.
- On a neighbourhood basis the City Centre and Stoke neighbourhoods had the highest number of suicide deaths (six per neighbourhood).

Figure 58: Trends in mortality from suicide in England and Plymouth, 2001 to 2012

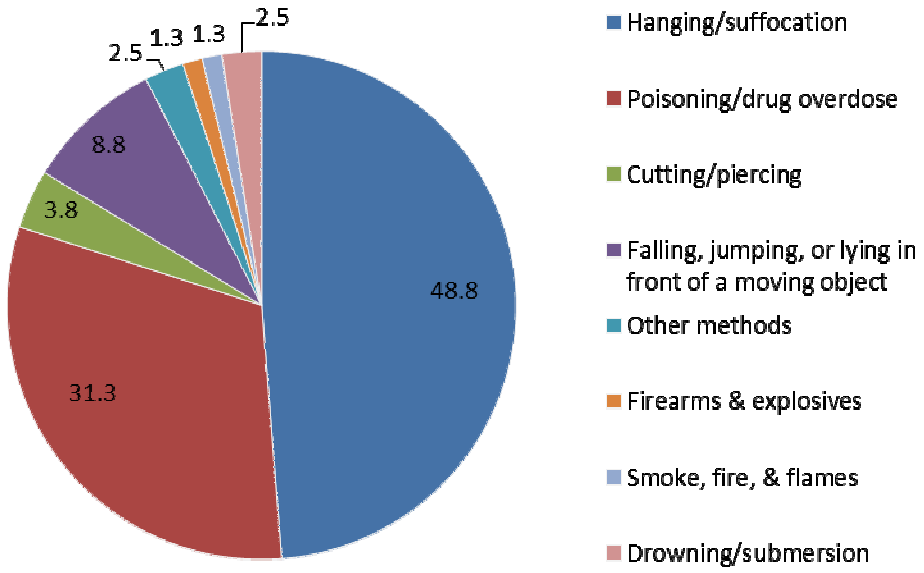


Source: Public Health Outcomes Framework[59]

Since 2006-08 the rate of suicide deaths per 100,000 population in Plymouth has been consistently higher than the rate in England (Figure 58). The gap between Plymouth and the national average has been widening

The overall linear trend for Plymouth (dotted line) is of an increasing rate of suicides since 2001-03.

Figure 59: Suicide deaths by cause 2010-2012 (%)



As shown in Figure 59 from 2010 to 2012, the most common method of suicide in Plymouth was 'hanging/suffocation' (48.8%). This is 17.5 percentage points higher than the next most common method 'poisoning/drug overdose' (31.3%).

Hanging/suffocation was the method of choice for men (57.1%; corresponding to 36 individuals), whilst the most common method for female suicide was poisoning/drug overdose.

4.9 Children's social care

Children's social care caseloads are increasing year on year.

4.9.1 Children in care (looked after children)

- There were a total of 370 looked after children in Plymouth (as of 31 March 2013; rounded to nearest five). This corresponds to a rate of 73 per 10,000 children aged under 18 years. The England rate was 60 per 10,000.[60]
- The gender split was 55% male to 45% female. 23% were under 5yrs old, 53% were aged 5-16yrs and 24% were over 16.[60]
- Of the 140 children who started to be looked after in 2012/13 50 (37%) were taken into care.[60]

[60] Children looked after in England (including adoption), Dec 2013,

4.9.2 Children-in-need

- There were a total of 3,214 children starting a children-in-need episode (referred and subsequently assessed to be in need of social care) in Plymouth throughout 2012/13.[61] This is an increase of 355 children on 2,859 recorded in the previous year.
- In 2012/13 the rate of children-in-need of 630.0 per 10,000 children was the highest in the South West and nearly double that of the national rate (332.2).[61]

4.9.3 Child protection

- There were a total of 413 children who became the subject of a child protection plan in Plymouth throughout 2012/13.[61] This is an increase of 28 children on the 385 recorded in the previous year.
- Compared to the national average of 37.9 per 10,000 children, the rate of children becoming a subject of a child protection plan in Plymouth was 58.8 per 10,000 (2012/13).[61]

4.10 Adult Social Care

In 2012/134 there were 697 permanent admissions to care homes per 100,000 persons aged 65 and over in Plymouth. A value close to the South West (680.8) and England (697.2) rates[62]

Projecting Older Peoples Population Information (POPPI) projects an increase in demand in care home places in Plymouth. The total population aged 65 and over living in care homes with or without nursing is predicted to rise from 1,524 in 2014 to 2,408 in 2030.[63] This increase in provision will need to be met through an increase in bed capacity unless alternative models of care are developed.

Clients in receipt of packages of care (including community-based services, residential care, and nursing care) during 2012/13 totalled 354 per 10,000 over 18 population, an increase from 278 per 10,000 in 2011/12. This ranged from 145 per 10,000 in Chaddlewood to 588 per 10,000 in Stoke.[64]

The real challenge facing the city arises as the population changes. For example it is expected that those aged over 65 years with a limiting long-term illness will rise from 21,682 in 2013 to 24,061 in 2020, while those in this age group with dementia are predicted to rise from 3,107 to 3,667.[65] At the same time there will be an increase of around 6,000 people aged 0-14 years.[66] Therefore, unsurprisingly, it is predicted that spending on social care will pass 45% of Plymouth City Council's budget by 2019/20.[67]

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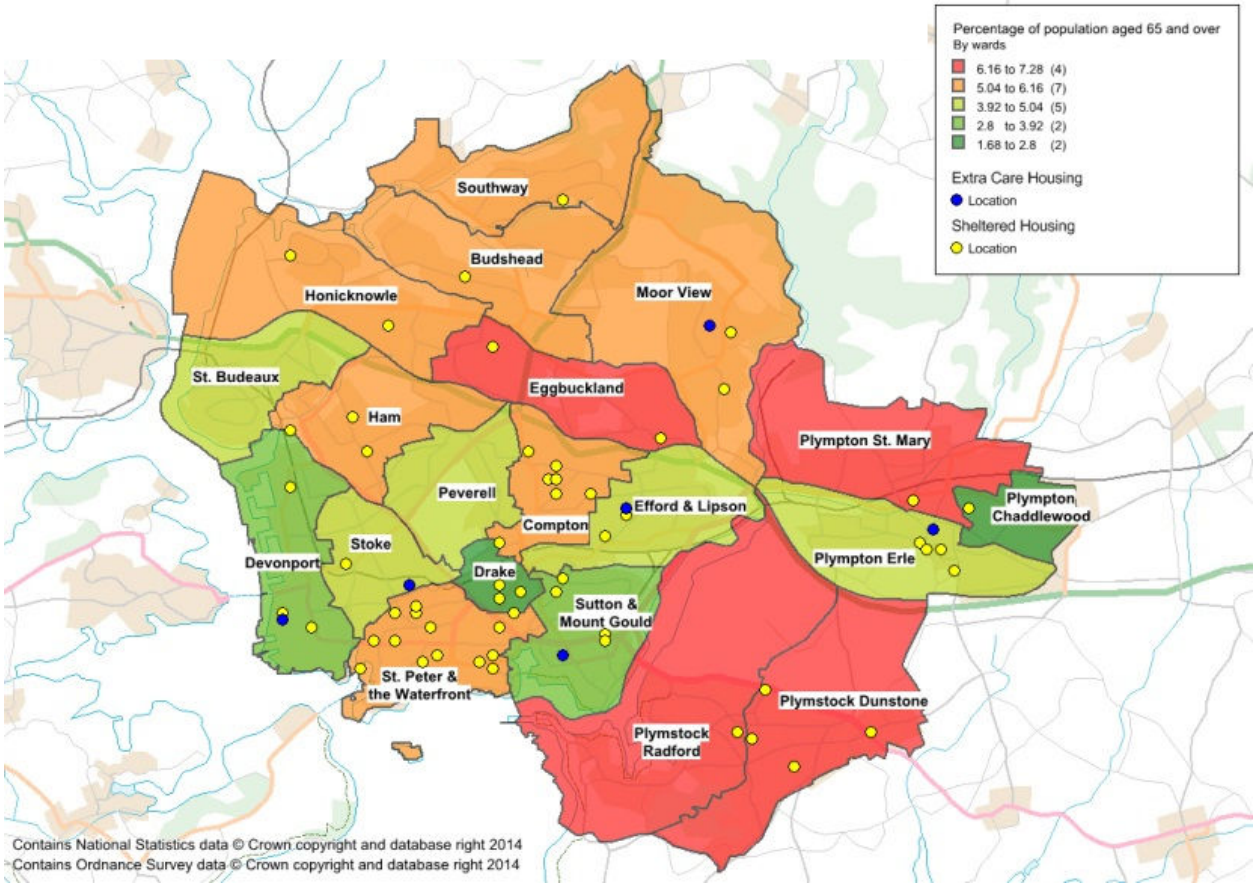
[61] Characteristics of children in need in England:2012 to 2013, Jul 2014
[62] Care home residents in Devon, Plymouth, and Torbay – a health needs assessment, 2014
[63] Projecting Older Peoples Population Information (POPPI)
[64] Area profiles, 2014,
[65] Projecting Older People Population Information
[66] Subnational population projections, 2012
[67] Plymouth Interim Report, 2012

Extra care housing is housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home. Extra care housing can be run by housing associations and charities, local authorities or private sector providers. Plymouth currently has 274 flats across six extra care schemes for older adults. The recommended number for the 75 and over population of Plymouth is 500, a shortfall of 226 units. As at April 2014 there were 41 active cases on the housing list waiting for active care accommodation.[68]

Sheltered housing schemes are self-contained, purpose built complexes generally owned, run and maintained as social housing by a local authority or housing association. There will be: a site manager who lives onsite or offsite; provision of 24-hour emergency help; and often communal areas such as a lounge, laundry room, and garden. Enhanced sheltered housing (extra-care/assisted living schemes) are also self-contained, allowing more independence than living in a care home, but provide a domiciliary care service and personal care element alongside the site manager. Meals are usually provided in a communal dining room.

Figure 60: Extra care and sheltered housing schemes in Plymouth, as at April 2014



Source: Taken from 'Review of sheltered housing demand', Plymouth City Council

[68] Review of extra care demand, 2014

The distribution of the 61 extra care and sheltered housing schemes, provided by 23 providers, across the Plymouth wards is shown in Figure 60. St Peter and the Waterfront had the highest number (16; 26%). In 2012 Plymouth had 1,685 sheltered housing units and no provision of enhanced sheltered housing. The recommended number for Plymouth according to the 75 years and over population was 2,538 sheltered, a shortfall of 853 units, and 406 enhanced sheltered, a shortfall of all 406 units. Under a normal growth scenario it is predicted that Plymouth will need 3,713 sheltered housing units and 594 enhanced units in 2030.[69]

The minimum total annual cost of £2,157,099 for care and support delivered through sheltered accommodation schemes in Plymouth includes around: £1.5 million for long-term services (domiciliary care, supported living etc.); £569,000 for sheltered housing block contracts, and £15,000 for low-level floating support.[69]

4.11 Autistic Spectrum Disorder

There is a lack of up-to-date data on the levels of autistic spectrum disorder (ASD) in and across Plymouth. Ideally an autism needs assessment is required to fully realise the levels of autism in the city and identify: the profile of need in the population; evidence of effective interventions; current provision of services; and recommendations for future commissioning.

The prevalence of ASD was found to be 1.0% of the adult population in England, using the threshold of a score of 10 on the Autism Diagnostic Observation Schedule to indicate a positive case. The rate among men (1.8%) was higher than that among women (0.2%). The prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have autistic spectrum disorder to 2030. Of the 18-64 year old population the 2014 estimated figure for individuals with autistic spectrum disorder was 1,651. The vast majority (90.2%) are male. The number is not expected to have changed much by 2030 with a prediction of 1,472.[70]

4.12 Provision of unpaid care

In the England and Wales, there are around 5.4 million people providing unpaid care for an ill, frail or disabled family member or friend. Using data from the 2011 Census revealed there were 27,247 of these carers in Plymouth. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours.[71]

Across the Plymouth neighbourhoods the total number of carers ranged from 212 in Mutley to 1,133 in Honicknowle. The same two neighbourhoods respectively had the lowest and highest numbers of individuals providing 50 hours or more care.[71]

[69] Review of sheltered housing demand, 2014
[70] Projecting Adult Needs and Services Information
[71] 2011 Census Table QS301EW provision of unpaid care

Table 33: Provision of unpaid care in Plymouth and percentage of the total population

Hours of unpaid care/week	Plymouth		South West		England	
	Number	%	Number	%	Number	%
1 to 19	15,624	6.1	376,909	7.1	3,452,636	6.5
20 to 49	4,057	1.6	68,164	1.3	721,143	1.4
50 or more	7,566	3.0	125,225	2.4	1,256,237	2.4
Total	27,247	-	570,298	-	5,430,016	-

Source: 2011 Census, ONS

4.14 Substance misuse

Alcohol dependence is a syndrome where a person has difficulties controlling their drinking. It includes features such as a strong desire to drink, persisting in drinking despite the problems that it creates, and physical withdrawal symptoms. Drug misuse has been defined as the use of a substance for purposes not consistent with legal or medical guidelines. In a small proportion of drug users, this may lead to dependence, a cluster of behavioural, cognitive, and physiological phenomena, such as a sense of need or dependence, impaired capacity to control substance-taking behaviour, and persistent use despite evidence of harm.

Both drug and alcohol dependencies are significant not just for personal health consequences, but for wider services too. In 2014 nearly 10,000 people in Plymouth aged 18-64 years, of which 7,204 are male, are predicted to be alcohol dependent; whilst over 5,500 are estimated to be dependent on drugs.[72] Substance misuse is closely linked with poor mental health. Firstly, intoxication, harmful use, withdrawal, and dependence can all trigger or exacerbate mental health problems, even if these problems don't constitute a psychiatric diagnosis. Secondly, mental health problems can lead to drugs and alcohol misuse. Co-existing mental health and substance misuse problems are known as 'dual diagnosis', and are very common, estimated to affect between 30% and 70% of those presenting to health and social care services.[73] The social, family and economic impact of these is highly significant.

[72] Projecting Adult Needs and Services Information

[73] The relationship between dual diagnosis: substance misuse and dealing with mental health issues, 2009

4.15 References

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5. HOUSING

New and existing good quality housing in thriving communities is essential to achieving Plymouth's aspirations to grow to over 300,000 population. It is fundamental to ensure that provision is made for an appropriate mix of housing accommodation that addresses housing need.[74]

5.1 Housing stock

There are over 114,000 dwellings in Plymouth with most of the city's housing stock in the private sector. Plymouth has lower than average levels of home ownership but greater amounts of private rented housing. As of the 2011 Census Plymouth's homes comprised:

- Owner occupied 64,998 dwellings (Plymouth 59.5%; England 64.2%)
- Privately rented 21,095 dwellings (Plymouth 20.2%; England 16.8%)
- Social housing 22,026 dwellings (Plymouth 19.3%; England 17.7%)
- Living rent-free 1,188 dwellings (Plymouth 1.1%; England 1.3%)

In 2010 social housing stock amounting to 15,500 properties were transferred to Plymouth Community Homes (PCH) which now operates as a Housing Association managing almost three quarters of Plymouth's social housing. Plymouth Community Homes has received grant funding in order to improve the quality of these homes.[75]

Approximately 660 private sector dwellings have stood empty for over six months. The city's construction sector has been affected by the recession. House construction rates have fallen from a peak of 1,429 in 2006/07 to 557 in 2010/11, of which 60% were affordable. Work has started on a further 777 dwellings whilst 3,884 homes have planning permission but work is yet to start.[75]

The city's housing growth target is challenging however there is still a high level of need for good quality accommodation.[75]

5.2 Housing standards and conditions

Families living in poor housing are more likely to suffer from a range of health problems including poorer mental health and cognitive development as well as respiratory and stomach problems. Those growing up in the poorest households are more likely to suffer enduring physical and mental health problems in adulthood and have increased risk of severe, long-term and life-limiting illness. Children in these households are more likely than their more affluent peers to have difficulty in sleeping, studying, or playing at home which can affect their health, their school lives and their social participation.[76]

[74] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[75] Plymouth Interim Report, 2012
[76] Plymouth Fairness Commission: an initial presentation of evidence, 2013

There is also strong evidence that poor housing conditions are associated with educational under-achievement, with children in better quality homes gaining greater numbers of GCSEs, 'A' levels and degrees, and therefore having greater earning power.[77]

Plymouth's private sector stock is older than the national average with a far higher proportion of medium/large terraced houses (31% compared with 19% nationally). Around 50% of private rented stock is pre-1919 (compared with 40% nationally) and predominates in inner-central neighbourhoods with older, terraced housing.[77]

The age, condition, and tenure of the city's housing stock presents a number of challenges that need to be addressed, particularly with regard to the impact of poor housing on health and child poverty. The CPC Private Sector Housing Stock Conditions Report 2010 highlighted the scale of poor housing across the city.

Key statistics from the report with regard to housing quality include:[77]

- There are 25,500 private sector dwellings occupied by vulnerable residents (in receipt of qualifying benefits).
- There are 29,930 (33.3%) 'non-decent' private sector dwellings, of which 9,500 dwellings are occupied by vulnerable residents.
- There are 18,800 (20.9%) private sector dwellings have Category 1 health and safety hazards including 'excess cold', 'poor thermal comfort', 'trip and fall hazards' and 'disrepair'.
- Of the 29,930 'non-decent' private sector dwellings, the estimated investment repair cost to achieve decent homes is £170 million.
- There are an estimated 6,000 private Houses in Multiple Occupation (HMO) across the city, of which around 750 are licensable.

The most common Category 1 Hazard failure across the private sector, contributing to the poor health and well-being of residents and generating significant NHS and care costs, is 'excess cold' followed by 'falls on stairs' and 'falls on the level'.[77]

HMO properties are often poorly managed which in turn increases the risk of accidents and ill-health. By their nature these properties cater for the bottom end of the market i.e. those most vulnerable, often due to combinations of age, infirmity, and health problems. There is often an increased risk of exposure to exploitation by landlords.[78]

Housing conditions in Plymouth are worst in the private rented sector, as illustrated in Table 34. Of the city's private rented dwellings 37.2 % were non-decent in 2010/11 – the worst across all tenures.

[77] Plymouth Fairness Commission: an initial presentation of evidence, 2013
[78] Plymouth Interim Report, 2012

Table 34: Housing conditions in Plymouth, 2010/11

Tenure	Non decent (%)	Category 1 hazard (%)	Disrepair (%)	Thermal comfort (%)	Fuel poverty (%)
Owner occupied	32.0	19.3	8.5	13.0	12.9
Privately rented	37.2	26.1	19.0	20.1	18.4
Social housing	24.8	11.5	4.4	10.2	13.5

Source: Plymouth City Council [79]

There is an urgent need to improve housing conditions across the private sector, but notably in private rented housing, as there are: [79]

- 8,208 'non-decent' private rented dwellings
- 5,758 private rented dwellings with Category 1 Hazards
- 4,192 private rented dwellings with disrepair (Decent Homes Standard)
- 4,435 private rented dwellings failing thermal comfort (Decent Homes Standard)
- 4,060 private rented dwellings in fuel poverty

There is a clear link in Plymouth between the areas of worst housing condition and the areas of high deprivation and greatest health inequalities. The poorest condition stock is largely found in the west and inner central parts of the city, where most of the pre-1919 properties and former council housing are found, which closely matches the areas of highest deprivation.

"Money spent on dealing with poor housing is money invested in health – when local authorities act to improve housing conditions, there is a resulting financial benefit to the health sector".[80] Using the BRE Trust's 'Real Cost of Housing' (2010) costing analysis, it has been estimated that Category 1 health and safety 'hazards' in homes nationally are costing the NHS in excess of £600 million annually whilst in Plymouth they cost the NHS in excess of £3 million annually.[81]

5.3 Poor housing and child poverty

Plymouth has a higher rate of child poverty than the national average with 22.4% of children under-16 living in poverty – equivalent to 10,140 children.[82]

The Social Care Institute for Excellence (2005) highlights the following messages:[83]

- More than one million children live in housing in England that is considered unfit to live in or sub-standard

[79] Plymouth Fairness Commission: an initial presentation of evidence, 2013
[80] Linking housing conditions and health: a report of a pilot study into the health benefits of housing interventions,2010
[81] Housing and Health: the impact of poor housing on health, 2012
[82] Plymouth Health Profile 2014
[83] Social Care Institute for Excellence, 2005

- The research indicates an association between homes with visible damp or mould and the prevalence of respiratory problems or asthma among children
- Poor quality housing can have an adverse effect on children's psychological well-being
- Interventions such as installing or improving heating systems has been found to be effective in alleviating the potentially adverse effects of damp on the health on children

5.4 Overcrowding

There are high levels of overcrowding in Plymouth. Of the 9,671 households currently registered for social housing through Devon Home Choice (DHC) 1,951 (20%) lack one bedroom and 190 (2%) lack two bedrooms. Those that are more overcrowded (i.e. lacking two or more bedrooms) are a higher priority for housing but if they're large families they're less likely to access social housing because larger, three-bed and bigger, properties are rarely advertised through DHC.[84]

Families with children living in overcrowded housing will have no or insufficient space to do their homework, limiting their ability to thrive and/or to attain the standards they might otherwise have reached.

5.5 Affordability of housing

Despite Plymouth having relatively cheap house prices (compared to the rest of the housing market and most of the South West), many households are unable to afford their own home. The city's average house price was £129,931 in June 2014; considerably lower than the South West and England and Wales averages of £180,880 and £172,011[85]

In general, a house price to earnings ratio below 3.5 is best as this is an accepted responsible level of borrowing (3.5 times the person's or family's income). As the ratio increases it gets riskier for mortgage providers to lend so they are likely to require larger deposits, creating a barrier to first time buyers. In addition, despite low interest rates, mortgages remain difficult to obtain as is the ability to build up a deposit is, for some, impossible.

Full-time median annual earnings for Plymouth residents in 2013 were £23,600 compared to £26,900 for the UK.[86] This results in the average house costing over five and a half times the median earnings. An income of £29,829 (with a 10% deposit) is required to be able to either purchase a lower quartile house costing £116,000 or afford the average market rent for a two bed property in Plymouth.[87]

Since 1997 house affordability (the ratio of lower quartile house prices to lower quartile earnings) has varied from 3.2 in 1998 to 7.3 in 2007. It is currently 5.6. [88]

[84] Plymouth Interim Report, 2012
[85] House Price Index, Jun 2014
[86] Labour Market Profile, 2013
[87] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[88] Ratio of lower quartile earnings to lower quartile house prices, 2013

5.6 Homelessness and temporary accommodation

There are a number of worrying national trends in homelessness/rough sleeping and helping people to access accommodation, many of which are amplified in Plymouth. Plymouth had higher levels of homelessness than both the regional or national average during the period 2010/11 (see Table 35).[89]

Table 35: Rate of homelessness per 1,000 population, 2010/11

	Homelessness rate
Plymouth	0.65
South West	0.35
England	0.48

Source: Plymouth Fairness Commission[89]

In addition, many more people are homeless than those reflected in the official statistics. There are particular concerns in Plymouth with regards to those who are 'single non-priority' homeless at risk of rough sleeping or 'sofa surfing', and who access the city's supported housing provision.[89]

Despite the Council tackling homelessness since 2002, achieving year-on-year reductions in rough sleeping and homelessness and meeting the government's target of halving temporary accommodation uptake by 2010 homelessness is now on the rise.[90] Current levels showing a 15% increase since 2009/10.[91]

The city's hostels accommodate an average of 183 single homeless people/rough sleepers at any one time. These are often people who suffer enduring or multiple health inequalities and experience barriers to accessing both primary and secondary health services – particularly in relation to addressing mental health needs.[91]

On average, 49 homeless families are bringing up their children in temporary accommodation and an average of 87 children are in this situation at any one time. There has also been an increase in the use of bed and breakfasts as an emergency measure.[90]

Shelter highlight that children living in temporary accommodation are almost twice as likely to suffer poor health compared to other children and nearly a third more likely to suffer from respiratory problems such as asthma and bronchitis.[92] It is also well recognised that the prolonged and transient nature of life in temporary accommodation makes it harder to safeguard vulnerable children and has an effect on school work, emotional and psychological well-being, and social relationships.

[89] Plymouth Fairness Commission: an initial presentation of evidence, 2013
[90] Plymouth Interim Report, 2012
[91] Housing and Health: the impact of poor housing on health, 2012
[92] Against the odds: an investigation comparing the lives of children on either side of Britain's housing divide, 2006

The most common trigger for homelessness is family conflict. This is often driven by underlying issues including drug and alcohol misuse, poor physical and mental health, behavioural problems, a lack of education and skills, and offending behaviour. There are three critical environmental factors that make these triggers more likely to result in homelessness: [93]

(1) An economic downturn leading to higher levels of unemployment and lower income.

(2) Housing supply not keeping pace with demand.

(3) Major welfare and social policy reforms affecting accessibility and affordability of housing.

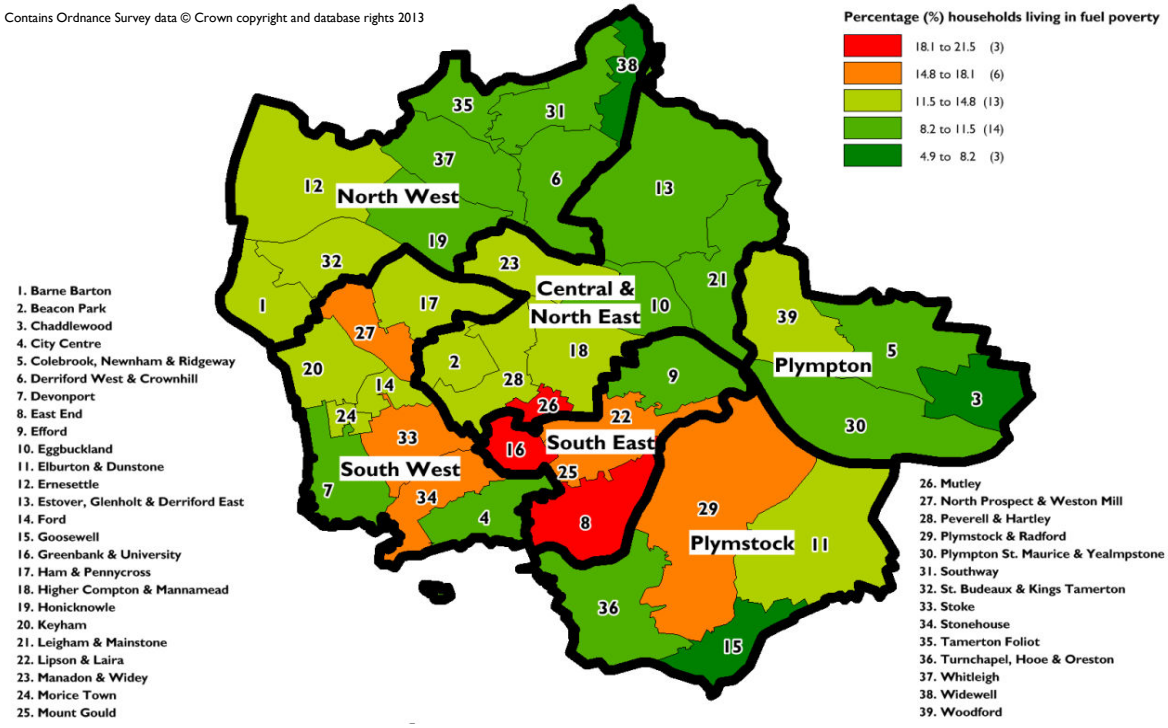
Homelessness is likely to rise further in the current challenging economic and housing market environment. For example, changes to Housing Benefit payments may result in families struggling to afford their existing private rented homes – with a consequent impact on the levels of homelessness.[93]

5.7 Fuel poverty

The latest Department of Energy and Climate Change figures identify that 13,712 (12.8%) households in Plymouth were living in fuel poverty in 2011.[94] Occupiers are considered to be in fuel poverty if more than 10% of their net household income would need to be spent on heating and hot water to give an adequate provision of warmth and hot water. With increasing fuel prices and static or diminishing incomes, it is likely that the number of people in fuel poverty will have risen further since 2011. Fuel poverty impacts particularly on older people with no central heating, children in low income families, disabled people and people with longstanding medical conditions and can lead to excess winter deaths and respiratory diseases. Figure 61 displays the distribution of fuel poor households the city and shows significantly higher percentages in neighbourhoods containing high levels of private rented properties.

[93] Housing Choices Delivery Plan, 2012-17
[94] Sub-regional fuel poverty statistics, 2011

Figure 61: Percentage of households living in fuel poverty by neighbourhood, 2011



Source: Sub-regional fuel poverty statistics[95]

Table 36: Top and bottom five neighbourhoods for households living in fuel poverty, 2011 (%)

Neighbourhoods with highest levels of households living in fuel poverty (%)		Neighbourhoods with lowest levels of households living in fuel poverty (%)	
Greenbank & University	21.5	Chaddlewood	4.9
Mutley	20.1	Goosewell	7.2
East End	18.1	Widewell	7.8
Mount Gould	16.6	Leigham & Mainstone	8.9
Stoke	16.5	Estover, Glenholt & Derriford East	9.0

Source: Sub-regional fuel poverty statistics[95]

5.8 Housing-related benefits

- In May 2014 25,060 people were recipients of Housing Benefit - corresponding to around one in eight people aged 18 years and over.[96]
- Council Tax Benefit was claimed by 27,920 people in February 2013.[97]

[95] Sub-regional fuel poverty statistics, 2011
[96] Housing benefit claimants, May 2014
[97] Housing benefit and council tax benefit summary statistics, Feb 2013

5.9 Housing and disability

There is a growing waiting list for 'major adaptations' which enable disabled people and their families to live independently in their own homes and help to contain increases in care costs for the NHS and care services.[98]

There are 1,262 people requiring an accessible home (with no more than three steps) registered for social housing through Devon Home Choice (13% of the register).[98]

Over 3,700 people currently registered for social housing through Devon Home Choice state that their health and welfare is compromised by their current accommodation.[98]

The city has a growing and ageing population, with a projected 23% increase in those aged 75 and over by 2021. The provision of extra care housing, supported accommodation, and lifetime homes will remain a priority to meet identified and projected need and encourage independent living.[99]

5.10 Housing growth and renewal

Plymouth has a clear vision for growth with a current target of 33,000 new homes by 2031. The city has a very good track record of delivery: £1.7 billion of development approved by the Planning Committee since January 2009; 1,269 new affordable homes, and 342 empty private sector homes brought back into use. There is a substantial estate renewal programme underway in North Prospect (the biggest in the South West) and major regeneration projects underway in Devonport and Mutley.[99]

5.11 Affordable housing

The demand for housing that is affordable far outstrips supply. The number of households on the housing register now stands at over 10,000 with over 3,000 identified as having a high priority need for housing. The housing register has seen a rise the number of people on a high priority banding (Band B) awarded when the client has been assessed as housebound, or they are suffering high levels of isolation, or their independent living is at risk. This has been mainly due to the changes in the register in a reaction to the bedroom tax to create opportunities for people to downsize. However there are limited suitable properties available to meet the need.[99]

5.12 Housing demand and challenges

Although the city has achieved a lot in terms of developments like the East End Village concept and is currently regenerating the Devonport and North Prospect areas there still remains a number of serious housing problems. There are, for instance, over 12,000 households on the housing register, with over a quarter identified as 'high priority'.[100]

[98] Housing and health: the impact of poor housing on health, 2013
[99] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[100] Plymouth Interim Report, 2012

There is insufficient social housing to meet demand. As with other areas of disadvantage the problem is particularly evident around the western edges of the city.[100]

The housing market is failing many households. Housing affordability problems, rigid lending criteria, restricted mortgage availability, and higher deposits are making it harder for first time buyers to get onto the housing ladder. There remains a shortage of affordable housing to rent and buy to meet the city's increasing housing needs and to support economic growth. Waiting lists are growing; identified housing needs far exceed the supply of housing options.[100]

The budget for new affordable homes nationally has been reduced from £8.4 billion in 2011 to £4.5 billion in 2014. Reduced public expenditure will impact on the Council's ability to deliver new affordable.[101]

In addition Private Sector Renewal funding ceased from April 2011 restricting the amount of funding available for things such as; removal of category 1 hazards; improving energy efficiency; work on empty homes; and home adaptations. This makes the support of older people to sustain independence at home rather than accessing costly care solutions even more difficult.[101]

5.13 Future developments

As at July 2013 there were 4,238 dwellings with planning permission yet to start across 83 sites in Plymouth. The city's 5-year housing plan is anticipated to yield around 5,780 new dwellings between 2013 and 2018. The city therefore has considerable potential for future residential development despite the impact of the recession.[102]

The 'Get Plymouth Building' programme aims to accelerate housing delivery particularly of greener and more affordable homes. It aims to deliver over 2,000 homes and more than 800 local jobs in construction and supply chain roles within the next two to three years by taking an innovative approach to housing and planning.[102]

[101] Housing and Health: the impact of poor housing on health, 2012
[102] Plymouth Plan Sustainability Appraisal Scoping Report, 2013

5.14 References

References are listed in alphabetical order by footnote name. The corresponding footnote number(s) is(are) also displayed. Links to online documents/tools/sources are included if available.

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6. ECONOMY, INCOME, AND EMPLOYMENT

6.1 Local economic status

Plymouth is the second largest city in the South West region with a resident population of 258,000 and a further 100,000 across its travel-to-work area (TTWA).[103]

The city plays a significant economic role in its sub-region contributing Gross Value Added (GVA; a measure of the value of all goods and services generated through economic activity) of £4.5 billion in 2012; around 17% of the combined output of the Heart of the South West (Plymouth, Torbay, Devon, and Somerset) and Cornwall Local Enterprise Partnership areas. It provides central healthcare, cultural and leisure facilities; business, financial and retail services; and transport hubs.

In the period 2003-2007 the number of jobs in Plymouth TTWA increased at a rate in line with the ambitious Local Economic Strategy target (1,800 per annum); the largest gains being in public administration, education, and health. The recession ended this progress in the short-term, with job numbers falling faster than nationally and returning to 2003 levels.[103]

Plymouth's economy continues to recover from the recession of 2008/09 against a challenging and unstable economic environment – though the rate of unemployment is falling it remains high (particularly for youth and long-term) and incomes continue to be squeezed in real life terms.[103]

The public sector was an important source of wealth creation in the run up to the recession but this is unlikely to continue. Further growth will need to be driven by the private sector with a rebalancing of economic activity from domestic consumption to investment and exports.[103]

The Plymouth Local Economic Strategy identified Plymouth as a fragile economy highlighting the need to improve its economic performance by becoming more competitive and diversifying its economic base. It called for a more supportive culture for its business community and intellectual property, and more opportunities for current small and medium sized companies to flourish. It proposed a number of interventions to improve its connectivity with other core cities and regional urban centres in Devon and Cornwall.[103]

The LES recognised a number of key assets on which to build, most notably an outstanding natural waterfront setting and an exciting physical vision for the city centre (the Mackay vision). These assets together with a growing education infrastructure and established specialisms in advanced manufacturing, medicinal sciences, arts and creative industries, sustainability and environmental sciences, and marine sciences were viewed as providing a good platform to achieve the city's vision.[103]

[103] Plymouth Plan Sustainability Appraisal Scoping Report, 2013

6.2 Output & productivity

Gross Value Added (GVA) per head, a proxy measure for productivity, is one of the key performance measures around the growth agenda for the city. In 2012, Plymouth's economy was worth £4.5 billion in GVA terms, equating to £17,579 per head of its resident population. Against other UK urban areas, Plymouth's economic productivity is comparable to York (£4.3 billion), Portsmouth (£4.5 billion) and Hull (£4.6 billion).[104]

For a city of its size and importance Plymouth continues to perform poorly in economic terms, signified by persistently low rates of productivity Accounting for relative population size, the rankings confirm that Plymouth lags some way behind the national average in terms of GVA per head; productivity stands at 81.1% of the national average (see Table 37). Of the large urban areas listed, only Sunderland recorded a lower value.

Table 37: GVA and GVA per head, 2012*

Area	GVA (£million)	GVA per head		GVA % change	
		£	UK = 100	2010 to 11	2011 to 12
Swindon	5,765	27,200	125.5	2.3	-2.9
Bristol, City of	11,740	27,148	125.3	-3.1	1.6
Nottingham	8,258	26,748	123.4	1.1	5.2
Leeds	18,767	24,770	114.3	3.9	-0.4
Derby	6,023	24,039	110.9	4.8	2.9
UK	1,383,082	21,674	100.0	2.5	1.6
Portsmouth	4,471	21,617	99.7	-7.6	5.7
York	4,305	21,526	99.3	2.6	3.2
Liverpool	9,991	21,272	98.1	0.6	2.5
Bournemouth and Poole	6,887	20,537	94.8	2.3	3.8
Birmingham	21,191	19,523	90.1	2.3	0.2
Southampton	4,656	19,446	89.7	0.1	1.2
South West	101,576	19,023	87.8	0.0	1.2
Sheffield	10,264	18,415	85.0	-0.3	2.3
Hull	4,641	18,045	83.3	1.2	4.7
PLYMOUTH	4,536	17,579	81.1	4.9	3.1
Sunderland	4,682	16,978	78.3	-0.3	1.2
Devon CC	12,394	16,456	75.9	-3.7	-1.0
Somerset	8,727	16,314	75.3	3.2	0.3
Torbay	1,720	13,080	60.3	5.2	-0.7
Cornwall and Isles of Scilly	7,042	13,036	60.1	-3.0	-0.3

Source: Regional Gross Value Added[104] *provisional

[104] Regional Gross Value Added (Income Approach), 2013

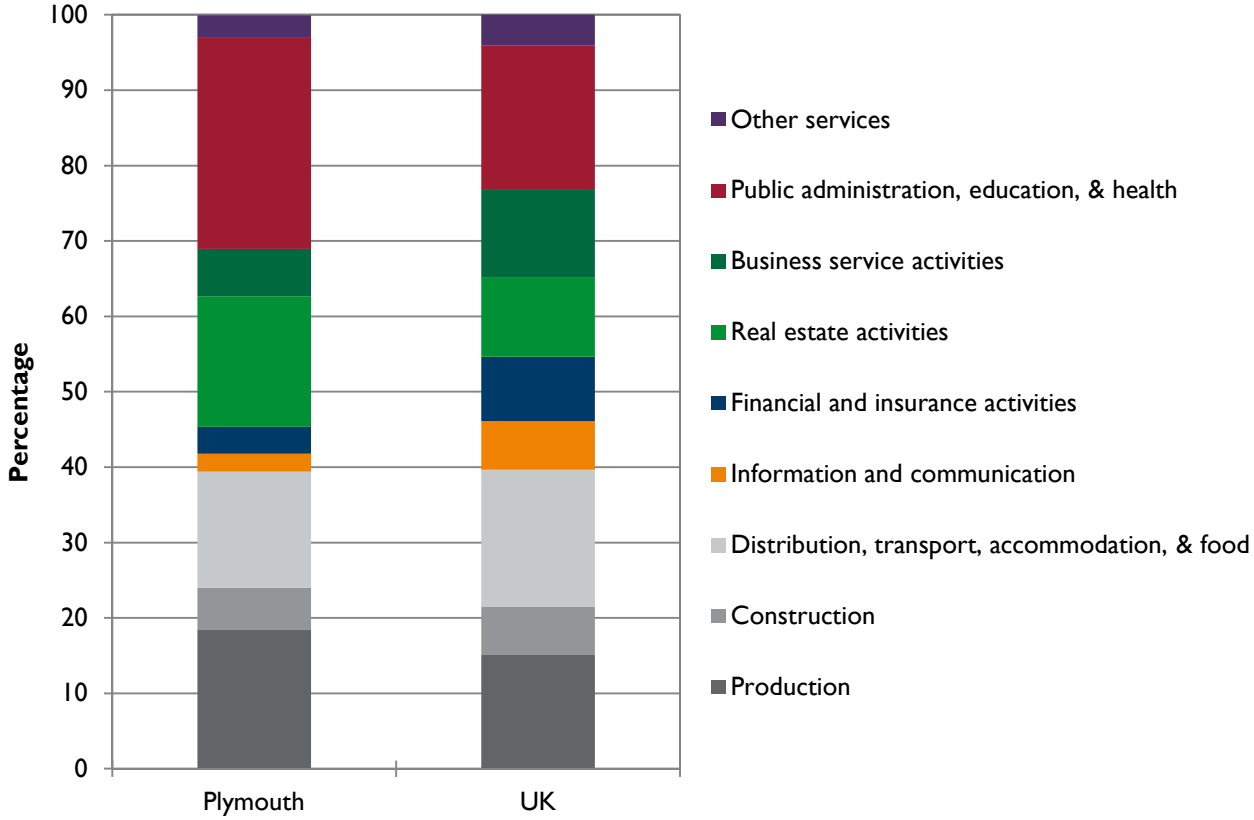
The 2006 Local Economic Strategy included an aspirational target to eliminate the GVA per head gap between Plymouth and the UK average by 2016. Over this time the city has seen this gap widen rather than narrow; The per-head figure attributes output to the entire resident population and is therefore distorted by economic inactivity and commuting patterns.

The long-term decline in the city's relative labour productivity can be attributed to a number of factors: low capital stock to labour ratios; relatively low employment in high value sectors; low engagement with international trade; relatively low skill levels; high levels of part-time working; peripherality; high rates of economic inactivity; and a high percentage of low value occupations.

6.3 Output by industry

The city's public administration, education and health sector was worth £1.2 billion in GVA in 2011; 28.1% of the total industry output compared to a corresponding 19.0% for the UK overall. Other sectors in which Plymouth exhibits output specialisation include production (18.4% vs.15.1%) and real estate activities (17.3% vs. 10.6%). Business services and financial and insurance activities, sectors which tend to be 'high-value', contributed a smaller proportion of output than the UK average (together 9.9% vs. 20.3%).

Figure 62: GVA by broad industry, Plymouth and UK, 2011



Source: ONS

6.4 Skills and learning

High skill levels are a modern requirement for economic growth. Although seeing some improvement in recent years Plymouth remains below the national average and other comparator cities for the proportion of its workforce qualified to degree level or equivalent. Given the city's large student population this suggests that high-end skills are not necessarily being retained in the local economy. This leaves the city less well placed than others to attract new technology and knowledge-intensive varieties of investment.[105]

The employment of individuals across the skills range is fundamental to long-term competitiveness.[105]

Plymouth is a significant hub for the far South West, having an economic influence beyond its administrative boundaries. A key priority for the city's economy is to ensure the growth of its main economic centres, in particular the City Centre and Derriford.[105]

6.5 Sustainable growth

Sustainable economic growth requires a high degree of participation from within local communities. Plymouth's economic development needs to be supported by measures to address socio-environmental causes of worklessness and the barriers to employment including disengaged young people, low skill levels, or a mismatch between skills and demand.[105]

Plymouth has an ambitious growth agenda to create 42,500 jobs by 2026 from the 2003 base line. Prior to the recession the city was making good progress with its jobs target with an increase in 7,000 jobs between 2004 and 2006. However, the impact of the recession has been to see this figure revert to one of no net increase in jobs. In terms of future forecasts, modelling undertaken by Oxford Economics projects increases in the private services and construction sectors, but these will be offset by losses in manufacturing and public services, with a net effect of little, if any, job gain by 2030.[106]

6.6 Earnings

The median gross weekly wage for full-time workers in Plymouth in 2013 was £454 compared to South West and UK averages of £485 and £518 respectively (note UK average heavily influenced by higher earnings in London). The city's wages increased by <0.1% between 2012 and 2013 compared to the SW increase of 1.6% and the UK of 1.9%.[107]

Overall, the city remains a relatively low-wage economy reflecting a collection of economic factors which lower labour productivity e.g. low-level skills, industrial composition, and location peripherality.

[105] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[106] Plymouth Interim Report, 2012
[107] Labour Market Profile,2013/14

6.7 Business and enterprise

Enterprise is a key driver of productivity. New entrants to the market place increase competitive pressure and create a necessary level of business mix to stimulate growth.[103]

In 2012 the city has amongst the lowest rates of business density (62/64) and start-ups (56/64) in the country.[108] More positively, research shows that Plymouth ranked in the top 50 local authorities in terms of proportion of "business champions". These are defined as young, small, rapidly growing companies with directors that show entrepreneurial skill, appetite for business risk and international activity.[109]

There were 5,940 active enterprises in the city in 2012, a density of 279 per 10,000 resident population compared to a UK average of 477 per 10,000.[110] Plymouth's low business density masks the fact that it has a comparatively large number of bigger businesses.

The city recorded just 33.4 business start-ups per 10,000 resident adults in 2012 (a total of 710) compared to 55.3 per 10,000 for England overall. Table 38 shows that the rate of business births fell between 2007 and 2009 in line with national trends. The last three years have seen a year-on-year increase.[110]

Table 38: Density of business births per 10,000 resident adults (16 years and over)

	2007	2008	2009	2010	2011	2012
Plymouth	38.6	33.1	29.0	26.2	32.4	33.4
England	59.4	56.3	49.4	48.6	54.0	55.3

Source: Business Demography[110] and ONS 2012 mid-year population estimates

According to data from Duport, there were a record 1,156 new companies formed in Plymouth during 2013. This was more than any other year in the history of the city and a 10.2% increase on 2012; growth higher than the 7.6% seen nationally.[111] This more up-to-date data (drawn from Companies House) gives an important insight into the creation of all businesses including those that fall below the VAT threshold and are therefore excluded from the performance indicator 'business births'. There is an important role to play to harness this potential to enable these businesses to grow and thus move into the 'business births'/VAT statistics.

There were 715 companies that dissolved in Plymouth in 2013, an increase of 23.7% on the 578 in 2012 and the largest number since the 793 dissolutions in 2009.

[108] Centre for Cities: Plymouth Summary, 2014
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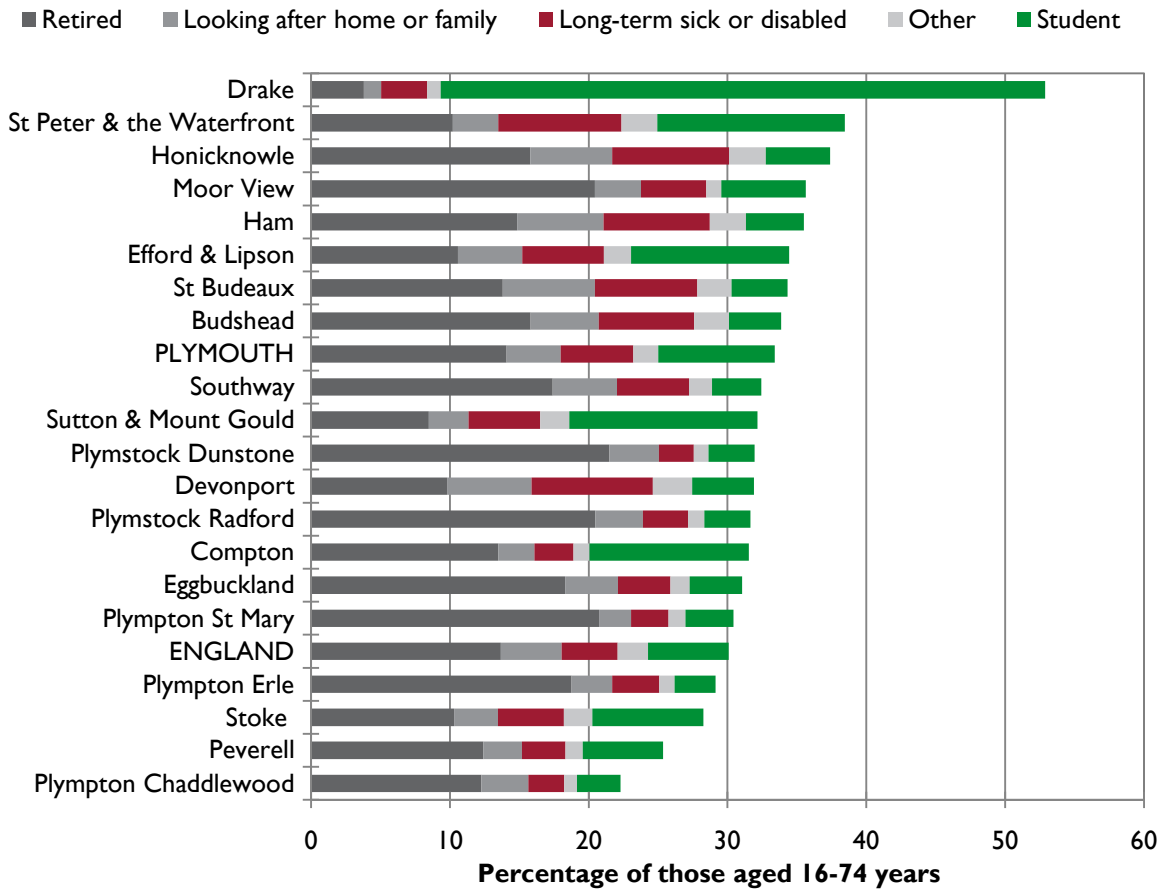
[111] Duport Annual Business Confidence Report, 2013

6.8 Economic activity and inactivity

The 'economically active' proportion of the population comprises the employed and the unemployed actively seeking work: effectively those closest to the labour market and ready to take up employment. Economic inactivity describes a situation in which a person is looking for work but not available to start within two weeks, as well as anyone not looking for work, or unable to work e.g. retired, looking after home/family, permanently sick or disabled. Inactivity may be a result of both push and pull factors – it is important to remember that it may be a completely rational choice not to work.

According to the 2011 Census there were 127,742 economically active residents in Plymouth. This equated to 66.6% of the resident population aged 16-74, above the corresponding national average of 69.9%. Conversely, the city's inactivity rate was 33.4% against a national value of 30.1%.

Figure 63: Economic inactivity by reason, 2011



Source: 2011 Census Economic activity[112]

Figure 63 shows that the majority of wards in the city (16 out of 20) recorded economic inactivity rates above the national average. The reasons for economic inactivity vary considerably across wards for example the significant student population in Drake ward heavily

[112] 2011 Census Economic activity

skews the figure. The presence of students, unlike other reasons, is not a sign of 'economic stress' in a particular area, although it could mask this. The city has a large proportion of individuals who are inactive due to long-term sickness or disability. The wards of St Peter and the Waterfront (8.9%), Devonport (8.7%), and Honicknowle (8.4%) all had percentages which were more than double the national average (4.0%).

6.9 Employment

In 2012, there were 105,100 employees in the city – 80,800 of these (around 77%) were classed as private sector with the remaining 30,700 public sector. Plymouth's private sector share was below the GB average of 79.8%.

Table 39 shows the change in the total number of employees in the city's public and private sectors since 2009. Between 2009 and 2010 there was a sharp decline in employee numbers. However, between 2010 and 2011 the city's workforce showed an upturn which continued into 2012. This was largely attributable to a strong increase in private sector jobs which was more than enough to compensate for the 1,700 lost in the public sector.

The proportion of jobs in Plymouth that are part-time has increased from 36.5% in 2009 to 37.5% in 2012.

Table 39: Plymouth employee numbers by sector and full-time/part-time status, 2009-2012

		2009	2010	2011	2012*	Change 2011 to 2012	
						Number	%
Private sector	Full-time	49,600	46,600	47,400	50,100	2,700	5.7
	Part-time	28,200	27,400	29,200	30,700	1,500	5.1
	Sub-total	77,900	73,900	76,700	80,800	4,100	5.3
Public sector	Full-time	16,600	17,000	15,600	15,600	0	0
	Part-time	9,900	9,900	10,300	8,700	-1,600	-15.5
	Sub-total	26,500	26,900	25,900	24,200	-1,700	-6.6
All employees	Full-time	66,300	63,600	63,000	65,600	2,600	4.1
	Part-time	38,100	37,300	39,600	39,400	-200	-0.5
	Total	104,400	100,800	102,600	105,100	2,500	2.4

Source: Business Register and Employment Survey[113] *provisional data *NB Figures may not tally due to rounding*

Self-employment has increased from 7.6% of those in employment in 2010 to 10.8% in 2012, possibly a useful 'bridging tool' keeping people engaged in the labour market. Part-time working has also seen an increase from 26.6% up 2009 to 31.3 in in 2011, which compares to the current national average of 25.7%. This figure is likely to include people who actually want to work full-time.[114]

[113] Business Register and Employment Survey, 2012
[114] Plymouth Interim Report, 2012

6.10 Employment Support Allowance and Incapacity Benefits

The city continues to have high proportions claiming Employment and Support Allowance (Table 40) and Incapacity Benefits or Severe Disablement Allowance (Table 41). As at February 2014 there were 10,415 people in Plymouth claiming Employment and Support Allowance (ESA) and 3,210 claiming Incapacity Benefits or Severe Disablement Allowance.

Values for both vary across the city with a nearly six-fold difference between the highest and lowest neighbourhood values for ESA and over a seven-fold difference for incapacity benefits.

The highest percentages of claimants are from some of the most deprived neighbourhoods including: Devonport, Stonehouse, Ernesettle, Whitleigh, and Morice Town.

Table 40: Employment and Support Allowance (ESA) claimants as a percentage of the 16-64 year neighbourhood population, February 2014

Neighbourhoods with highest percentage of ESA claimants (%)		Neighbourhoods with lowest percentage of ESA claimants (%)	
Stonehouse	14.9	Elburton & Dunstone	2.8
Devonport	13.7	Higher Compton & Mannamead	2.7
Morice Town	12.7	Chaddlewood	2.7
Barne Barton	10.3	Peverell & Hartley	2.7
Ernesettle	10.2	Goosewell	2.6

Source: Neighbourhood Statistics,[115] neighbourhood data aggregated from rounded LSOA
Percentages calculated using ONS 2012 mid-year population estimates

Table 41: Incapacity Benefit or Severe Disablement Allowance claimants as a percentage of the 16-64 year neighbourhood population, February 2014

Neighbourhoods with highest percentage of Incapacity/Disablement benefit claimants (%)		Neighbourhoods with lowest percentage of Incapacity/Disablement benefit claimants (%)	
Ernesettle	3.6	Lipson and Laira	0.9
Whitleigh	3.4	Woodford	0.9
Devonport	3.4	Widewell	0.7
Morice Town	3.1	Goosewell	0.7
Stonehouse	3.1	Chaddlewood	0.5

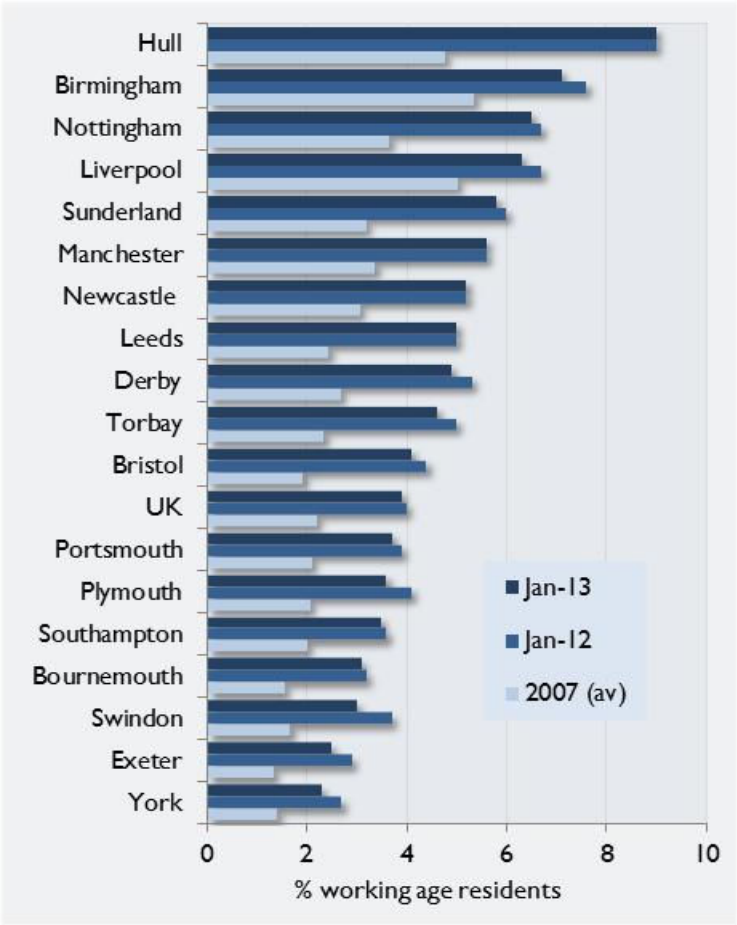
Source: Neighbourhood Statistics[115] neighbourhood data aggregated from rounded LSOA
Percentages calculated using ONS 2012 mid-year population estimates

[115] Neighbourhood Statistics

6.11 Job Seekers Allowance claimant count

On the headline measure of local unemployment – the JSA claimant rate – the city saw noticeable improvements in 2012, with the rate falling from around 4.1% in January 2012 to 3.6% in January 2013. The city's rate continues to compare favourably with other UK cities (see Figure 64).[116]

Figure 64: Percentage JSA claimants for various UK cities, 2012 to 2013



Source: ONS (figure taken from Plymouth's Economic Review[116])

Figure 64 places Plymouth alongside other major urban areas across the UK: in this context, it has fared much better, certainly in comparison to other major cities outside the South West region. Of the 18 cities analysed, Plymouth saw the eighth smallest percentage point rate increase (comparing January 2012 with the 2007 average of 2.7%) and the joint second largest decline in rate between January 2012 and 2013.

[116] Plymouth's Economic Review Issue 3, 2013

Amongst its geographical neighbours, unemployment in Plymouth is comparatively high: Cornwall (3.2%), Devon (2.2%) and Somerset (2.2%) all recorded rates comfortably below the city's rate, reflecting a long-term disparity between urban and rural labour markets.

6.12 Job Seekers Allowance claimants by neighbourhood and ward

Whilst the percentage of claimants across the city is slightly below the national average (2.6% and 2.8% respectively), some neighbourhoods have more than five times the amount of others.

As at February 2014 there were 4,465 people in Plymouth claiming Job Seekers Allowance (aggregated from rounded LSOA level data). The highest percentages of JSA claimants are situated on the western side of the city covering deprived neighbourhoods such as Stonehouse and Devonport, Stonehouse.

Table 42: JSA claimants as a percentage of the 16-64 year neighbourhood population, February 2014

Neighbourhoods with highest percentage of JSA claimants (%)		**Neighbourhoods with lowest percentage of JSA claimants* (%)**	
Stonehouse	6.4	Woodford	1.0
Devonport	6.0	Eggbuckland	1.1
Morice Town	5.3	Chaddlewood	1.1
Barne Barton	5.0	Goosewell	1.2
East End	5.0	Widewell	1.2

Source: Neighbourhood Statistics [117] neighbourhood data aggregated from rounded LSOA

Table 43 shows that the number of claimants fell across all wards of the city between January 2013 and 2014.

Wards concentrated largely in the 'western arc' of the city continue to experience unemployment rates well above the city average: St Peter & the Waterfront and Devonport together contributed a quarter of the total claimant count. Generally, wards ranked above the city average for unemployment also recorded a greater proportion of long term-claimants suggesting this issue has greater significance in areas of high joblessness and deprivation. The link was less clear for 16-24 year old claimants.

In February 2014 youth unemployment (ages 16-24 years) accounted for 30.6% of all JSA claimants in the city.

[117] Neighbourhood Statistics

Table 43: Unemployment claimants by ward, February 2013-2014

	Feb 2014 16-64 number	Change since 2013	Feb 2014 16-64 * (%)	Change in % since 2013	Proportion of those unemployed in Feb 2014	
					16-24 years * (%)	1 year + (%)**
St Peter & the Waterfront	610	-185	5.3	-1.6	23.8	30.3
Devonport	500	-225	4.5	-2.0	27.0	32.0
Sutton & Mount Gould	400	-135	3.7	-1.3	23.8	30.0
Stoke	335	-140	3.5	-1.4	28.4	23.9
St Budeaux	315	-120	3.7	-1.4	38.1	27.0
Efford & Lipson	285	-115	2.9	-1.2	31.6	22.8
Honicknowle	280	-100	3.2	-1.2	41.1	28.6
Ham	270	-105	3.3	-1.3	37.0	31.5
PLYMOUTH	4,465	-1,600	2.6	-0.9	30.6	25.6
Budshead	205	-75	2.5	-0.9	31.7	29.3
Drake	185	-75	2.0	-0.8	24.3	27.0
Compton	170	-50	2.0	-0.6	20.6	14.7
Southway	150	-85	1.9	-1.1	33.3	23.3
Peverell	130	-35	1.5	-0.4	30.8	19.2
Moor View	115	-50	1.5	-0.7	30.4	21.7
Eggbuckland	105	-20	1.3	-0.2	28.6	14.3
Plymstock Radford	105	-20	1.5	-0.3	28.6	9.5
Plympton St Mary	90	-20	1.2	-0.3	55.6	5.6
Plymstock Dunstone	85	-10	1.2	-0.1	47.1	17.6
Plympton Erle	70	-15	1.3	-0.3	35.7	21.4
Plympton Chaddlewood	60	-20	1.1	-0.4	41.7	8.3

Source: Neighbourhood Statistics[118] ** Nomis

* using ward-based 2012 mid-year population estimates, ONS (rounded to nearest five)

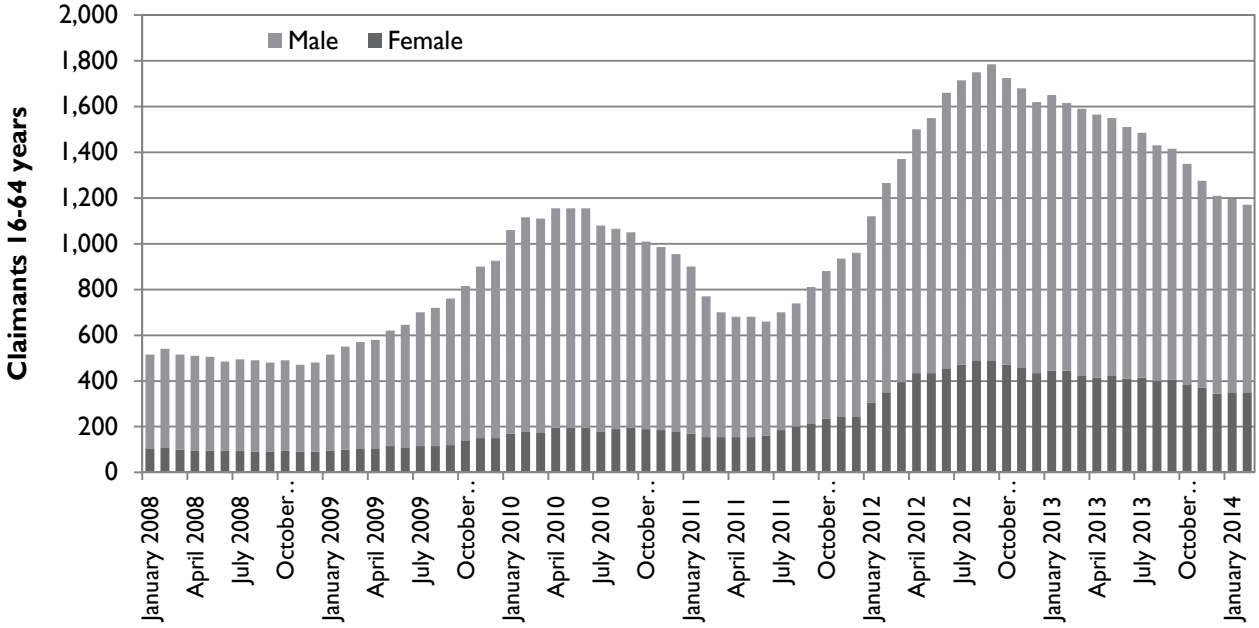
Ward data aggregated from rounded LSOA level data

[118] Neighbourhood Statistics

6.13 Trend in long-term unemployment claimants

Since mid-2011, the number of long-term claimants (claiming for over 12 months) has risen dramatically, reaching a peak of 1,785 (28% of all claimants) in September 2012. Of note is the significant proportion of long-term claimants that are male; 70% of the February 2014 long-term claimant total (see Figure 65).

Figure 65: Quarterly long-term JSA claimants by gender, Feb 2008 to Feb 2014



Source: JSA claimants time-series[119]
Data aggregated from rounded LSOA data

6.14 The real level of unemployment

A deeper analysis of the city's labour market reveals a high degree of 'hidden unemployment', capturing individuals seeking work but not claiming JSA, and those diverted onto incapacity benefits. In 2012 Plymouth's real level of unemployment was estimated at 9.8% of the working age residents, around 17,000 individuals. [120]

Furthermore, 'under-employment' is comparatively high in Plymouth, reflecting the rise in part-time working and too few suitable full-time job opportunities being created.

[119] JSA claimants time-series
[120] Plymouth's Economic Review Issue 3, 2013

6.15 Under-employment

Under-employed workers are those people aged over-16, in employment and wishing to work more hours, either in their current job, in a replacement job or in an additional job. Under-employment provides a valuable insight into the health of the labour market and the quality of jobs being created. Furthermore, the process of 'hysteresis' is equally relevant, when an individual is not fully utilising their unique skill-set and reaching their productive potential.

Between October 2010 and September 2011, there were 16,000 under-employed people in Plymouth, equating to 13.6% of the workforce. This was the second highest rate of England's NUTS3 regions behind Brighton & Hove (Nomenclature of territorial units for statistics is a hierarchical system for dividing up the economic territory of the EU). The proportion of those in employment working part-time started to increase at the end of 2009, stabilising at a new elevated rate of around 31% in 2012. These data corroborate with the findings that the bulk of new jobs created since 2008 have been part-time. Whilst this is positive in the short-run – keeping individuals engaged in economic activity in a tough economic climate – high rates of part-time employment can be damaging to long-run labour productivity and competitiveness.[120]

6.16 Occupational structure

Compared to nationally, Plymouth has a smaller proportion of 'high-level' occupations (occupations (1) to (3)) and concurrently a larger proportion of 'low-level' occupations (occupations (7) to (9) in Table 44). This relative 'skew' towards lower-level occupations is reflected in the city's lower than average wages and labour productivity.

Table 44: Employment by occupation (proportion of those employed), 2013/14

	Plymouth (%)	England (%)
(1) Managers, directors and senior officials	9.4	10.2
(2) Professional occupations	16.3	19.9
(3) Associate professional and technical occupations	13.6	14.1
(4) Administrative and secretarial occupations	10.8	10.7
(5) Skilled trades occupations	12.1	10.5
(6) Caring, leisure and other service occupations	11.6	9.1
(7) Sales and customer service occupations	8.3	7.9
(8) Process, plant and machine operatives	6.3	6.2
(9) Elementary occupations	10.7	10.7

Source: Labour Market Profile[121]

This pattern varies across the city's neighbourhoods. Table 45 shows the proportion of occupations classed as higher managerial and professional occupations (a different set of categories to those shown in Table 44) across the five neighbourhoods with the highest and lowest values. Plymouth's value was 11.3%, nearly five percentage points lower than the national average of 16.1%.

[121] Labour Market Profile, 2013/14

Table 45: Top and bottom five neighbourhoods for proportion (of all 16-74 year olds employed) working in 'higher managerial and professional' occupations, 2011 (%)

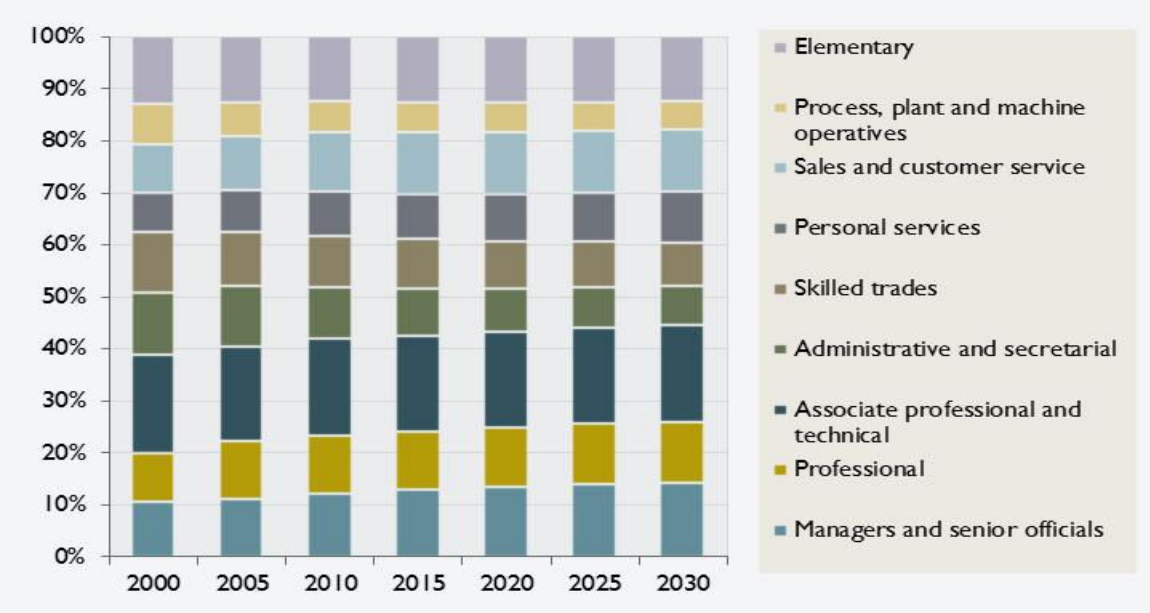
Neighbourhoods with highest proportion of higher managerial and professional' occupations (%)		Neighbourhoods with lowest proportion of higher managerial and professional' occupations (%)	
Peverell and Hartley	20.5	Barne Barton	4.9
Derriford West and Crownhill	18.8	Devonport	5.1
Higher Compton and Mannamead	18.7	Ernesettle	5.2
City Centre	18.1	Honicknowle	5.5
Elburton and Dunstone	17.1	Southway	6.1

Source: 2011 Census National Statistics Socio-economic status[122] neighbourhood data aggregated from LSOA

6.17 Occupational change

Forecasts from Oxford Economics suggest that Plymouth's labour market is expected to see a continued increase in the proportion of higher level occupations over the next 10-20 years in line with that expected nationally. Between 2010 and 2030, 'managers, directors, and senior officials', 'professional' and 'associate professional and technical' occupations will see the largest net increase (over 4,000 combined) with their shares of the labour force continuing to grow – see Figure 66. This trend is not strictly linear however, and the forecasts suggest there will be a large increase in the number of 'sales and customer service' and 'personal services' occupations – the latter reflecting an ageing demographic and new markets associated with health and social care for the elderly.[123]

Figure 66: Change in Plymouth's occupational structure, 2000 to 2030



Source: Oxford Economics, (figure taken from Plymouth's Economic Review[123])

[122] 2011 Census National Statistics socio-economic status
[123] Plymouth's Economic Review Issue 3 2013

The occupations set to see the largest declines are 'administrative and secretarial' (-2,400), 'skilled trades' (-1,400), and 'process, plant and machinery' occupations (-500).

These changes reflect a gradual shrinkage of middle-level occupations (through technological change) and growth at either end of the spectrum: this has been described as the 'hourglass effect'[124]. One of the implications of these trends is the increase in competition for low-level occupations as those with intermediate skills are effectively 'bumped down'. This issue could potentially be alleviated by a targeted up-skilling of the workforce to ensure that individuals are equipped to take up the managerial and senior roles as they are generated.[123]

6.18 Skills and qualifications

Skills are important drivers of productivity, both directly in terms of adding to individual performance and, indirectly, by enabling individuals to adopt a more flexible and adaptable approach to work which may facilitate the development of innovative ideas and practices. A skilled workforce helps to drive growth and attract new investment. Plymouth has some world-class infrastructure and skills particularly around the Naval Base and Dockyard and within the marine sector. Skill levels have been consistently rising in recent years; for instance 29.4% of Plymouth residents aged 16-64 years had a qualification at Level 4 or above in 2013, an increase from 18.8% in 2004.[125]

Whereas the city compares well with regional and national averages at the lower end of the skills range it does not do so well at the higher end. Plymouth has less people without a qualification (6.1%) than nationally (9.3%). At Level 1 and above the city's 88.7% success rate is better than that nationally (84.4%). At Level 3 and above the figures are 57.0% and 55.8% for Plymouth and England respectively. The local value of 29.4% for Level 4 and above contrasts with the 35.2% for the country.[126]

There is a significant dispersion of skill levels across the city as seen in Figure 67. Seven neighbourhoods including Peverell & Hartley and Higher Compton & Mannamead had a higher than (national) average percentage of residents with Level 4+ qualifications reflecting the concentration of high-level occupations highlighted earlier in Table 45. Similarly, the 'bottom five' wards for high-level occupations also have low levels of Level 4+ qualifications and high levels of individuals with no qualifications.

Note:

Level 1 qualifications: 1-4 O levels/CSEs/GSCEs (any grades), NVQ level 1, Foundation GNVQ

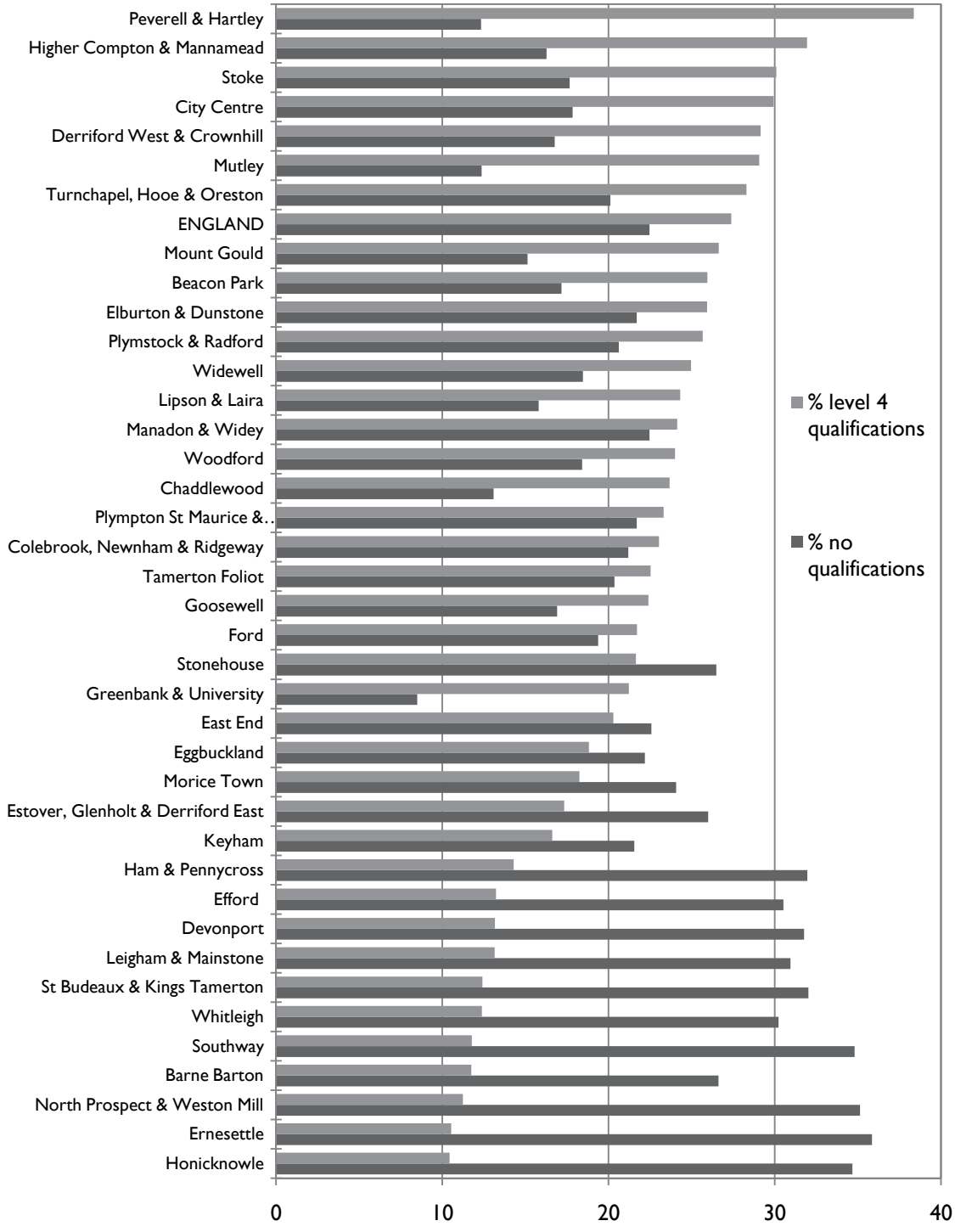
Level 2 qualifications: 5+ O Level (passes)/CSEs (grade 1)/GCSEs (grades A-C), School Certificate,1 A Level/ 2-3 AS Levels/VCEs, NVQ level 2, Intermediate GNVQ, City and Guilds Craft, BTEC First/General Diploma, RSA Diploma apprenticeship*

Level 3 qualifications: 2+ A Levels/VCEs, 4+ AS Levels, Higher School Certificate, Progression/Advanced Diploma, NVQ Level 3, Advanced GNVQ, City and Guilds Advanced Craft, ONC, OND BTEC National, RSA Advanced Diploma

Level 4+ qualifications: Degree, Higher Degree, NVQ Level 4-5, HNC, HND, RSA Higher Diploma, BTEC Higher Level, Foundation degree, Professional qualifications (e.g. teaching, nursing)

[124] SKOPE Issues Paper 26 2011
[125] Qualifications time-series
[126] Labour Market Profile 2013/14

Figure 67: Percentage residents aged 16 years and over with 'level 4+' and 'no qualifications' by neighbourhood, 2011



Source: 2011 Census Highest level of qualification[127]

[127] 2011 Census Highest level of qualification

6.18 References

References are listed in alphabetical order by footnote name. The corresponding footnote number(s) is(are) also displayed. Links to online documents/tools/sources are included if available.

112	2011 Census Economic activity Table: QS601EW http://www.nomisweb.co.uk/census/2011/qs601ew
127	2011 Census, Highest level of qualification Table: QS501EW http://www.nomisweb.co.uk/census/2011/qs501ew
122	2011 Census, National Statistics socio-economic status classification Table: QS607EW http://www.nomisweb.co.uk/census/2011/qs607ew
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119	JSA claimants time-series, Nomis, ONS https://www.nomisweb.co.uk/reports/lmp/la/1946157352/subreports/jsa_time_series/report.aspx?
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104	Regional Gross Value Added (Income Approach), ONS, December 2013 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-317145
124	SKOPE Issues Paper 26: Implications of polarisation for UK policymakers, 2011 http://www.academia.edu/756725/Implications_of_polarisation_for_UK_policymakers

7. CRIME

The Crime and Disorder Strategic Assessment 2014/15 outlines four key priority themes for each local authority across the Peninsula. These are:

- Domestic/family abuse and Sexual abuse
- Anti-social behaviour
- Re-offending
- Alcohol, violence and the night-time economy

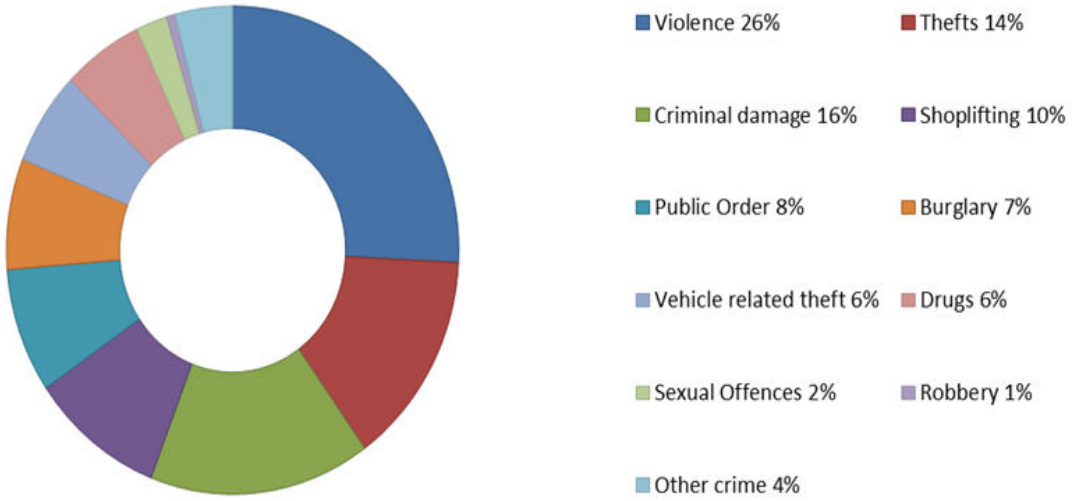
7.1 Overall crime levels

The total crime rate recorded by Devon and Cornwall Police was 73.2 per 1,000 population (2013/14).[128] This is an increase of 3% (571 more crimes) from 2012/13.[128]

The long-term overall crime trend is a reducing one despite the increase recorded in 2013/14. As a guise there were 21,175 crimes recorded in 2009/10 compared to 18,980 in 2013/14 (a reduction of 2,195 or 10%).[128]

Violence (including violence against a person, possession of weapons, and homicide), theft, and criminal damage accounted for more than 50% of the crimes (see Figure 68).[128]

Figure 68: All crimes by type, 2013/14



7.2 Anti-social behaviour

Incidents of anti-social behaviour recorded by Devon and Cornwall Police were 39.9 per 1,000 Plymouth residents (2013/14). This is an increase of less than 1% (+8 incidents) from 2012/13.[128]

In 2013/14 anti-social behaviour was dominated by three types: rowdy/inconsiderate behaviour (5,923 incidents; 57% of all incidents); rowdy/nuisance neighbours (1,760; 17%); and vehicle nuisance (722; 7%).[128]

[128] Strategic Assessment (Crime and Disorder) 2014/15

After a number of years of significant reductions in the overall level of Anti-Social Behaviour (ASB) it would appear that Plymouth has reached its base level of ASB and further reductions will unlikely be significant.

7.3 Hate crime

Plymouth has an indicator, which focuses on hate crimes, incidents and, the satisfaction of victims. In 2013/14 there were 603 incidents reported which achieved target. Incidents relate to racist, disablist, homophobic, transphobic or faith incidents. The satisfaction rate with how the issues were dealt with among victims was 89%, maintaining the good performance of 2012/13.

We have worked proactively over the last 12 months to make it easier for people to report hate crimes and incidents. We currently have 15 third party reporting centres in Plymouth and are looking to develop more over the next 12 months. We have also delivered hate and mate crime/incident training to key organisations in the city including Plymouth Community Homes where we worked in partnership with Devon and Cornwall Police to deliver training to over 50 people. In addition, we worked with diverse community members to develop a series of posters that promote Plymouth as a Welcoming City and advises people how to report.[129]

7.4 Domestic violence/abuse

Defined by HM Government as 'any incident of threatening behaviour, violence, or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

In 2013/14 there were 6,947 Domestic Abuse incidents recorded in Plymouth which is a 13% (+794) increase on numbers recorded in 2012/13. This increase could representative of the work undertaken by the partnership in trying to improve under-reporting in the city. There were however some technical factors in that the definition of domestic abuse widened to include 16 and 17 year olds and inclusion of coercive behaviour and change to DASH Risk Assessment Policy, therefore a rise was expected.[129]

Violent crime continues to dominate when domestic abuse crimes are split by type, violence with injury represented 37.2% of all DA crimes (when non-crime domestics are excluded) and violence without injury 37.4%. This proportion is significantly higher than the next most common crimes of Criminal Damage (9.4%) and Public Order offences (7%).[129]

3,238 incidents recorded by the Police are flagged as having a repeat victim (victim to a incident within the preceding 12 months). This equates to over 50% of all recorded DA incidents and crimes. This is an increase on the proportion of repeat victims in 2012/13 when repeat victims equated to 48% of the total.[129]

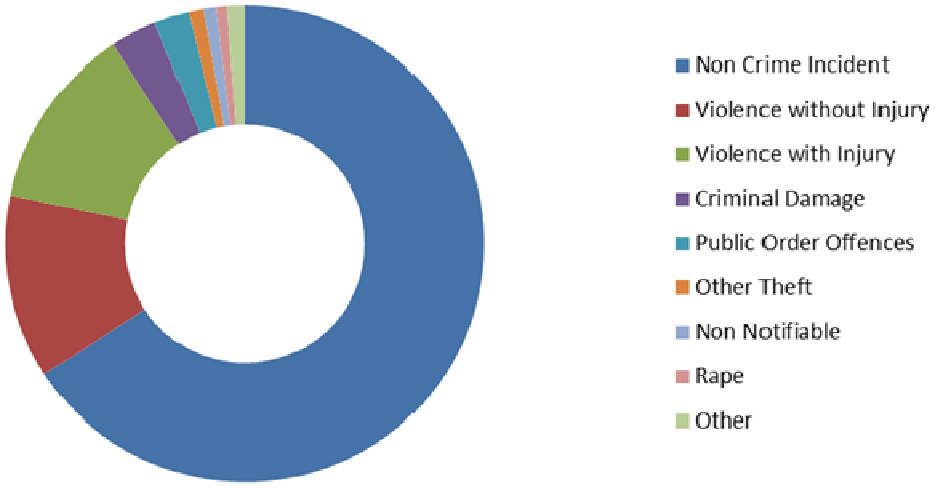
[129] Strategic Assessment (Crime and Disorder) 2014/15

Analysis was carried out on incidents/ crimes to ascertain victim numbers, as incidents were analysed it means that individuals may have appeared more than once. Victim details were recorded for 6,939 incidents.[130]

- 3 out of 4 victims were female
- 1 out of 4 victims were male
- 18 to 25 were peak ages for DA crimes (28%)
- Nearly half of victims were aged 30 or under
- 80% were aged under 40 or under
- 3% of victims were aged 60 or over

There is little change from previous years in relation to the geographical distribution of incidents with neighbourhoods with the highest rates of DA remaining consistent. Therefore the link between higher rates of DA and deprivation remains with some of Plymouth's most deprived neighbourhoods having the highest DA rates. Neighbourhoods for example like Stonehouse, Devonport and Barne Barton.[130]

Figure 69: Domestic abuse crimes by type, 2013/14



7.5 Sexual violence

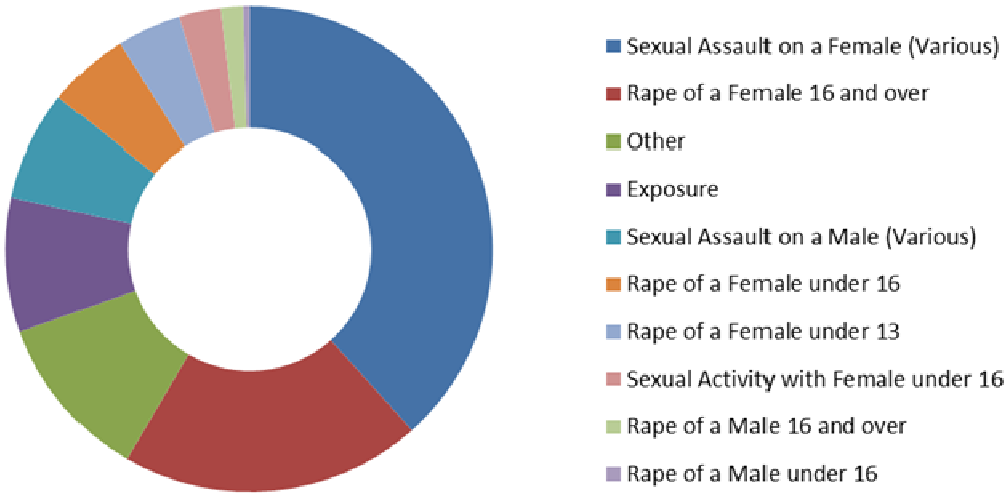
In 2013/14 there was an increase in the numbers of sexual offences recorded; this is the second consecutive year that levels have risen.[130]

Last year saw 157 rapes recorded which was an increase of three crimes on the previous year. It is however the levels of other sexual offences that increased by more, 2013/14 saw the number of 'other sexual offences' rise from 273 to 312 (an increase of 39 crimes).[130]

[130] Strategic Assessment (Crime and Disorder) 2014/15

It is well known that this crime type, together with domestic abuse, will be under reported to the Police and therefore the true number of incidents will be higher than that recorded. The Police and Crime Commissioner's plan outlines as a priority the requirement to increase the public's confidence in reporting sexual offences. Any activity around this is likely to result in increased crime numbers.[131]

Figure 70: Sexual violence by type, 2013/14



7.6 Acquisitive crime

Acquisitive crime includes lower level theft offences such as shoplifting and theft from the person.

2013/14 saw large increases in levels of acquisitive crime, such as non-dwelling burglary, theft offences and shoplifting. These increases bought about concern resulting in for example an action plan to reduce shoplifting.[131]

To date in 2013/14 the impact on performance has been positive with the level of crimes lower than for the same period in 2012/13.[131]

At the end of July levels of 'other' theft offences have reduced by 2% (-44), non-dwelling burglary by 1% (-6) and shoplifting by 1% (-19). Theft from the person has reduced the most with levels being 24% lower than the same period in 2012/13 (-83).[131]

[131] Strategic Assessment (Crime and Disorder) 2014/15

7.7 Serious acquisitive crime

Serious acquisitive crime is defined as domestic burglary (residence), theft of a motor vehicle, theft from a motor vehicle, and robbery (people and business).

For a sustained period serious acquisitive crime has been reducing, both in Plymouth and across the Devon and Cornwall Police force area. Table 46 illustrates the change in levels of burglary, vehicle related theft and robbery.[131]

Table 46: Change in serious acquisitive crime levels

Crime type	2012/13	2013/14	Change in number	Change in percentage (%)
Burglary dwelling	777	757	-20	-3
Theft – vehicle offences	1,414	1,179	-235	-17
Personal robbery	114	104	-10	-9
Business robbery	18	9	-9	-50

Source: Strategic Assessment (Crime and Disorder) 2014/15

Levels of serious acquisitive crime will continue to be monitored so any dips in performance can be responded to appropriately.

7.8 Violence with/without injury

In 2013/14 violence increased across the board, with increases in both violence with injury and violence without injury. There was also an increase in the number of violence with injury crimes when domestic abuse related crimes were excluded. [132]

Violence with injury increased in 2013/14 by 1% with 26 more crimes recorded than in 2012/13, although the longer term trend has been relatively steady. However, at the end of August 2014 levels are showing a further increase with 94 more crimes recorded, an 8% increase compared to the same period in 2013/14.[132]

The biggest increases have been seen in the numbers of violence without injury, In 2013/14 numbers increased by 289 crimes, equating to a 14% rise. The long term trend is one of continued increases in this crime type, at the end of August 2014 violence without injury has increased by 224 crimes, equating to a 24% increase.[132]

Analysis has identified that the increases have been felt across the city with a number of neighbourhoods recording increases. 27 neighbourhoods recorded an increase in violence without injury, and 18 recording an increase of 10 or more crimes. Devonport neighbourhood recorded the biggest increase (+53 crimes), other neighbourhoods recording large increases were East End (+28), Stonehouse (+22) and Derriford West.[132]

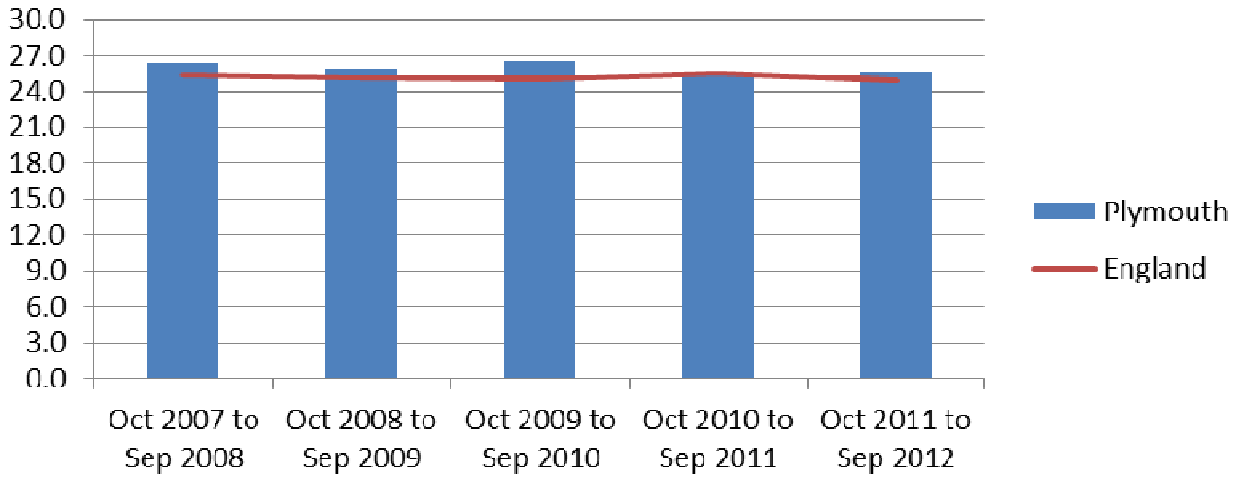
[132] Strategic Assessment (Crime and Disorder) 2014/15

7.10 Re-offending

Adult

The latest proven reoffending statistics provides data for adults up to the end of September 2012 on the numbers of offenders, rates of re-offending, and the average number of offences committed by a re-offender.

Figure 71: Proven adult re-offending rates



Source: Strategic Assessment (Crime and Disorder) 2014/15

The trend in proven re-offending rates is steady as outlined in Figure 71; the reoffending rate in the 12 months to the end of September 2012 in Plymouth was 25.7%, a very small increase on the previous year (25.6%). Re-offending rates in Plymouth are in line with the national figure. The national trend has also relatively static over the five-year period.[133]

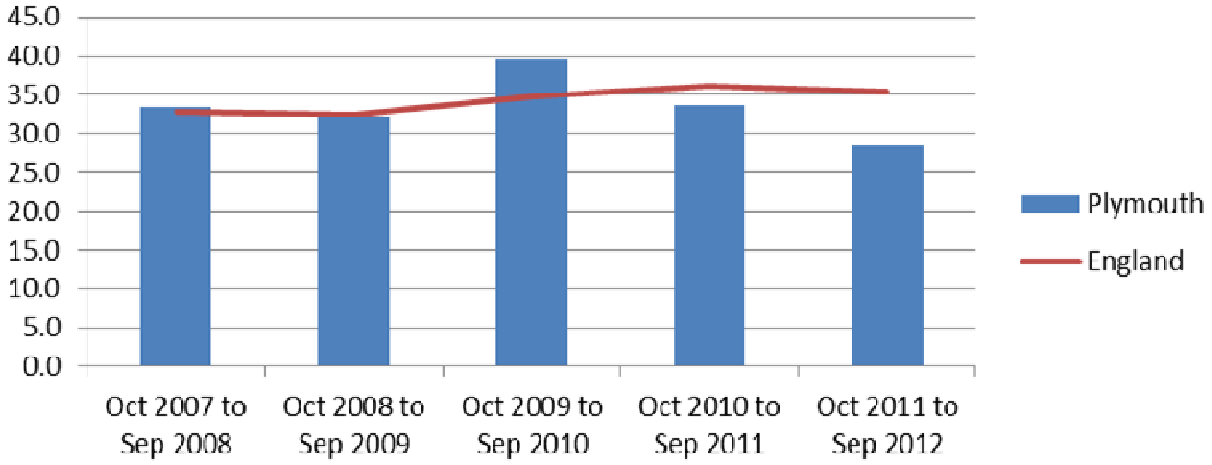
Youth

The latest national re-offending rates for juveniles provides data up to September 2012.

Figure **72** illustrates juvenile re-offending rates since 2008 and highlights a reduction in re-offending rates between October 2011and September 2012. The most recent figures for Plymouth shows re-offending rates at 28.3% against a national figure of 35.4%. Plymouth has been below the national rate for juvenile re-offending for the past two years.133

[133] Strategic Assessment (Crime and Disorder) 2014/15

Figure 72: Proven youth re-offending rates



Source: Strategic Assessment (Crime and Disorder) 2014/15

Local data shows that the number of young people offending in Plymouth is falling, in 2013/14 there were 1,540 in the youth offending cohort which compares to 2,123 the previous year (a reduction of 583 offenders).[134]

2013/14 also saw a drop in the numbers of first time entrants into the youth offending system, 111 first-time entrants last year compares to 140 in 2012/13 and 188 in 2011/12. It should be noted however that this figure is subject to change and will likely rise once recording issues are resolved.

[134] Plymouth City Council Youth Offending Team

7.13 References

References are listed in alphabetical order by footnote name. The corresponding footnote number(s) is(are) also displayed. Links to online documents/tools/sources are included if available.

134	Plymouth Youth Offending Partnership Board Report Apr-Sept 2013/14, Youth Offending Team, Plymouth City Council as stated in the Strategic Assessment (Crime and Disorder) 2014/15
128, 129, 130, 131, 132, 133	Strategic Assessment (Crime and Disorder) 2014/15, Plymouth Community Safety Partnership, 2014 http://www.plymouth.gov.uk/plymouthpartnershipstrategicassessment.pdf

8. TRANSPORT AND PHYSICAL ACCESS TO SERVICES

Transport is key to providing better links between and within communities. Transport needs to address inequalities in the city. Particularly with regards to connecting people in more deprived parts of the city to areas with more opportunities. It is important to improve access to community amenities, leisure facilities, and the natural environment by increasing availability of attractive routes for walking and cycling and access to public transport.

8.1 Accessibility

Plymouth is a major hub on the main routes from London & the rest of the UK (and Europe) to Cornwall. These routes include the A38 Devon Expressway, the main rail links, and the commercial port. The city's future prosperity depends, in part, on the continual improvement of these vital links. It is also important, both socially and economically, to improve the city's links with its surrounding hinterland. Significant numbers travel into Plymouth from the surrounding towns for work, shopping, entertainment, healthcare, and education.[135]

8.2 Road travel and buses

The main transport infrastructure in Plymouth, as in other UK cities, is based on its roads. However, the A38 creates something of a north-south split in the city, making cycle and foot travel across it more challenging. The bounding of the city on three sides by water also constrains the options for non-vehicle transport, although it creates opportunities for growth in local water-based tourism.[135]

An area of great concern within Plymouth is the accessibility of the key employment areas of Belliver, Estover, and Langage. Those residents living in the most deprived parts of the city will find the journey takes more than 30 minutes and often requires a change of bus to reach these areas. Those who are employed in shift work with early morning starts or late night finishes are also more disadvantaged as bus services are fewer and less frequent between these times. Some larger employers, such as EE, provide subsidies to bus operators to run services as part of their staff travel plan. Other key employment areas of the City Centre and Derriford are much better served by public buses.

Overall 68.8% of residents surveyed were satisfied with the bus services in Plymouth, an improvement from 63.8% in 2012.[136]

More affluent neighbourhoods are identified as not being well served by public transport; this is in contrast to the more deprived areas. During the daytime few people in deprived areas will find themselves more than a 400 metre walk from a bus stop with a frequent service and certainly no more than 800 metres.[137]

[135] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[136] National Highways and Transport Network Public Satisfaction Survey, 2013
[137] Plymouth Fairness Commission: an initial presentation of evidence, 2013

8.3 Traffic

In comparison to many other towns and cities of similar size Plymouth is relatively free of congestion, other than at peak periods on critical sections of the northern and eastern corridors. Area wide traffic has fluctuated in recent years, reaching a peak in 2006 of 741 million vehicle miles within the Plymouth area. The 2013 value decreased to 702 million vehicle miles.[138] Traffic speeds as well as traffic volume have an impact on quality of life, particularly in residential areas. In 2012 49% of cars and vans exceeded the 30mph speed limit on urban roads in the UK, whilst no specific data is available for Plymouth there are no factors which would cause driver behaviour to be different in this city.[139]

8.4 Rail travel

Rail also plays a role in the urban public transport network. In addition to the main railway station, there are five inner-city stations, which provide a modest level of commuter services for travellers living in South Devon, East Cornwall, and the Tamar Valley. There is a trend of consistently high passenger growth on all railway lines in the South West peninsula over the past decade; 2012 saw many lines with around 10% growth. Around two million people travel through Plymouth's main station however usage from local stations, such as Devonport, is much lower, probably due to the low frequency of train services and the much better offer presented by the local bus services.[139]

The far South West suffers from longer journey times than most other areas of the country which are a similar distance from London. The fastest journey time by rail between Plymouth and London is three hours. A three-hour journey is recognised as the limit to doing 'return travel in a day'.[140]

Evidence produced by the Universities of Bath and UWE (*Meeting the Productivity Challenge, 2005*) found that connectivity improvements to major conurbations, but in particular London, can unleash significant economic growth. The report found that productivity decreases by 6% for every 100 minutes of journey time from London. Analysis undertaken for Plymouth City Council in 2011 found that the benefits of speeding up just the Plymouth to London services to an average time of 2h45m could add £94m per year to the UK economy by 2026.[141]

8.5 Walking and rights of way

Plymouth has an extensive and important network of public rights of way. They are a valuable part of the city's history and a central recreational resource. Public rights of way are also important because they offer users the choice of sustainable travel options such as walking or cycling.

The South West Coastal Path is a national trail which runs from Minehead in Somerset to Poole Harbour in Dorset. The path is 630 miles (1,014 km) long, making it the longest

[138] Traffic by local authority: Table TRA 8902
[139] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[140] Plymouth Interim Report, 2012
[141] The South West Spine report, 2013

continuous walking route in the country. It is an internationally important recreational walking route and an excellent attraction for tourists. There are 10 miles (16 km) of coastal path in Plymouth running between Admiral's Hard in Stonehouse to Jennycliff in Plymstock. This section is known as Plymouth's Waterfront Walkway. A written guide to accompany the walk reveals many facts about Plymouth's history and heritage.[142]

8.6 Cycling

Plymouth adopted the Strategic Cycle Network (SCN) in 2011. It was developed by Council officers working closely with the Cycle Touring Club, the University of Plymouth, Plymouth Cycle Forum, and Velo Club Plymouth. It is a city plan detailing the network of routes, cycle paths, and lanes creating a focus for biking travel. Cycling has increased in Plymouth by 40% since 2008.[143] This could be in part due to the successful provision of improved facilities for cyclists and public awareness campaigns designed to encourage and enable trips to be made by bike. These campaigns include: adult cycle training, 'Sky Ride', and 'Bike It Plus'.[144]

Of those surveyed in the National Highways and Transport Survey (2013) 55.6% were satisfied with the provision of cycle routes, lanes and facilities across the city.[145]

The following information was provided in 2014 by Plymouth City Council's Smarter Choices Manager.

'Sky Ride Plymouth'

Over the past three year Plymouth City Council has been part of Sky Ride, the national programme to increase cycling. Locally this has included:

- Traffic-free mass participation events encouraging occasional cyclists to join in annual rides in safe environments with friends and family. The event in 2014 attracted nearly 4,000 participants.
- Weekly guided rides encouraging cyclists of all abilities to cycle more. 35 local rides are being delivered in 2014/15.
- Informal social cycling allowing cyclists to sustain and develop their participation by joining with others at mutually convenient times and places.
- 'Breeze rides' led by women for women.

Adult cycle training

In partnership with the Cyclists' Touring Club (CTC), the national cycling charity, free cycle training is available to anyone aged 16 and over who lives, works, or studies in Plymouth. The training offers the skills and competencies required to use bikes as a sustainable and active alternative transport mode. To date 252 training sessions have been delivered and feedback has been very good.

[142] The South West Coast Path walking guide, 2012
[143] Plymouth Plan Sustainability Appraisal Scoping Report, 2013
[144] Plymotion Cycling
[145] National Highways and Transport Network Public Satisfaction Survey, 2013

'Bike links'
This scheme provides access to education, training, and employment for individuals suffering from social exclusion where there is an identified transport need. Individuals meeting the criteria and attending cycle training are allocated a bike, a healthier and better value solution than providing taxis to activities.

'Bikeability'
The 21st century 'cycling proficiency' is designed to give the next generation the skills and confidence to ride on today's roads. Successful funding bids to the Department for Transport has meant training in Plymouth Schools is at an all-time high. Over 3,500 training places from beginners to advanced levels are expected to be delivered in 2014/15.

'Bike It Plus'
Delivered in partnership between Sustrans and Plymouth City Council this scheme aims to increase the number of children, parents, and staff cycling, scooting, or walking to school using many of the new and improved routes. A particular focus is on areas that suffer from health inequalities. Bike It Plus started in September 2012 and initial year-one results have been promising:

- Regular cycling to school has more than doubled from 3.6% to 7.6%.
- Regular skating and scooting to school has tripled from 6.2% to 19.9%.
- Pupils being driven to school three times a week or more have decreased from 29.8% to 26.4%.

8.7 Workforce travel

Only 7.0% of people work from home, a slight increase on 2001 figures. The average for the South West is 13.1%, and for England and Wales 6.9%. Plymouth is quite self-contained, with 78% of people living and working in the city. However, 12,800 commute in from outside of Plymouth each day; 46% from Devon and 14% from Cornwall. 11% of the workforce travel to work by bus, which is high relative to the South West (4.6%) and England and Wales (7.2%) whilst 14.1% walk to work, 2.6% commute by bicycle, and 61.3% by car or van.[143]

8.8 Plymotion Personalised Travel Plans

People's travelling habits often stems from habit. The Plymotion Personalised Travel Plan (PTP)[146] programme provides information about all transport choices allowing individuals to rethink how they travel and make sure they are making the wisest choice. PTP achieves reduced car use and associated congestion, environmental and road safety benefits, increased physical activity, increased revenue for public transport providers and local businesses, as well as improving the resilience of neighbourhoods through better connected communities.
The residential PTP programme "Plymotion on Your Doorstep"[147] will engage with 60,000 properties, 55% of the city's households, over a three-year period.

[146] Plymotion Personalised Travel Plan
[147] Plymotion on Your Doorstep

An independent assessment of the programme has reported that *'The overwhelming view of the programme was positive. [Respondents] commented on the professionalism of the travel advisors and the level of services that were already available (that people often didn't know about). It is clear from the data that PTP has developed into much more than simply a sustainable transport project for addressing congestion in the rush hour – it is a community-based social engagement, addressing a wide range issues including social exclusion, accessibility, transport, health and wellbeing for all trips and for all people regardless of demographics. As such it should be viewed and valued in a much wider context than simply influencing day-to-day travel choices.'*[148]

Table 47: Participation in "Plymotion on Your Doorstep"

	Phase one 2012	Phase two 2013	Total
Number of properties visited	5,849	23,017	28,866
Number of conversations had	1,112	4,123	5,235
Number of conversations (%) with engaged properties	52%	60%	58%

Of the households where someone was home when the team called 58% participated in the programme.

The results from surveys completed before (2012) and after (2013) the programme suggests Plymotion on Your Doorstep is helping to increase awareness and use of sustainable transport. There was:

- 3% more people walking more frequently or much more frequently in the PTP compared to the comparison community following delivery.
- A 33% increase in those cycling at least several times a week in the PTP community post-delivery.
- A 50% increase in people using the Plymouth Cycle Network in the PTP community post-delivery.

Comparison communities are selected because they have similarities in public transport provision, local highway networks, and distance on foot to the city centre. These areas are good comparisons for how peoples travel habits in the PTP community may have changed if the Plymotion on Your Doorstep had not been delivered, as per Department for Transport recommendations.

[148] Independent report, Peter Brett Associates

Table 48: Percentage of people strongly agreeing to statements regarding sustainable transport

	2012	2013	Gain/ loss	2012	2013	Gain/ loss	2012	2013	Gain/ loss
Walking is…	**'an easy way to get around' (%)**			**'a good way to improve your health' (%)**			**'a practical choice for getting around' (%)**		
PTP community	17	34	+17	49	55	+6	12	27	+15
Comparison community	18	22	+4	58	48	-10	15	18	+3
Cycling is…	**'an easy way to get around' (%)**			**'a good way to improve your health' (%)**			**'a practical choice for getting around' (%)**		
PTP community	9	19	+10	37	39	+2	9	16	+7
Comparison community	11	13	+2	42	34	-8	12	13	+1
Public transport…	**'is a practical transport option'**			**'can be used to easily access work'**			**'can be used to easily access education'**		
PTP community	6	19	+13	7	15	+8	7	15	+8
Comparison community	21	30	+9	18	16	-2	16	18	+2

Results also suggest that public perception, access to, and acceptance of walking, cycling and public transport facilities in the city as a viable travel choice is increasing. Some positive impacts of the programme on peoples travel:

- "We used the map to walk with my 9 year old son to Central Park as we didn't realise how close it was."
- "[I've] been walking more now that I know the routes."
- Since the visit my son-in-law, who used to drive to work, has found a cycle path and he now cycles."

8.9 Air travel

Plymouth City Airport ceased to operate on 24th December 2011, following a Non-Viability Notice being served by Sutton Harbour Holdings. The Council continues to consider that the long term future of the airport site is an issue of such strategic importance to the city, the sub region and the region.[149]

8.10 Water travel

Plymouth ferry port has daily passenger and freight services to Roscoff in France and regular sailings to Santander in Spain. There is a domestic vehicle ferry link to Torpoint in Cornwall, served by three chain-driven vessels and three passenger ferry links between Mount Edgcumbe and Stonehouse, Royal William Yard and The Barbican, and The Barbican and Mount Batten.

[149] Plymouth Plan Sustainability Appraisal Scoping Report, 2013

There is also a significant commercial port, handling a range of bulk commodities, including oil and china clay. In 2012 the Port of Plymouth handled around 2.3 million tonnes of freight. Plymouth has also become the base for a growing number of pleasure boats and marina-based craft. [150]

8.11 Road safety

The number of 'slight' (non-serious) road casualties in Plymouth reduced from 1,072 incidents in 2000 to 766 in 2013, a reduction of 29%. Similarly, the number of serious and fatal incidents reduced from 97 in 2000 to 64 in 2013, a reduction of 34%. However, there was a spike in 2011 when the total reached 74 serious or fatal incidents, 14 of which were children. The number of child casualties dropped to two in 2012, the best figure recorded to date.[150]

8.12 Air quality

The air quality in Plymouth is generally good, however, there are some isolated areas within the city that experience higher levels of pollution due to traffic. In 2013 70% of those surveyed felt they were not very well informed (35%) or not informed at all (35%) about local air quality.

Where air quality standards are not met Air Quality Management Areas (AQMAs) are declared and an Air Quality Action Plan, which sets out how the pollution will be addressed within the AQMA, is produced. Plymouth has two existing Air Quality Management Areas (AQMAs) caused by excess nitrogen dioxide levels - Mutley Plain and Exeter Street. Three more areas of elevated nitrogen dioxide have been identified; Molesworth Road and Devonport Road junction, Tavistock Road and Crownhill Road junction, and Royal Parade.[151]

The Council is currently deciding how to determine the boundary of the AQMA. They could decide to declare three new separate AQMAs in addition to the existing two, or propose one AQMA which links the two existing areas and the three proposed areas together by the main interlinking roads through the city.A single AQMA will benefit the Council by enabling it to manage the areas with one encompassing action plan and report to Defra on one AQMA instead of five. This is an approach used by other local authorities and is a sensible option when there is a single underlying cause of pollution such as road traffic. Taking a citywide approach will prevent individual traffic improvements schemes having knock-on effects in other areas.

8.13 Access to public services

Plymouth Plan Area Assessments (PPAAs) will replace the previous Sustainable Neighbourhood Assessments[152] that were prepared to inform the Local Development Framework Core Strategy and Area Action Plans. They will form an evidence base for the Plymouth Plan and be used to shape Area Visions. The aim of these documents (draft versions of which are available online[153]) is to provide an overview of the current situation in a particular Plymouth Plan Area

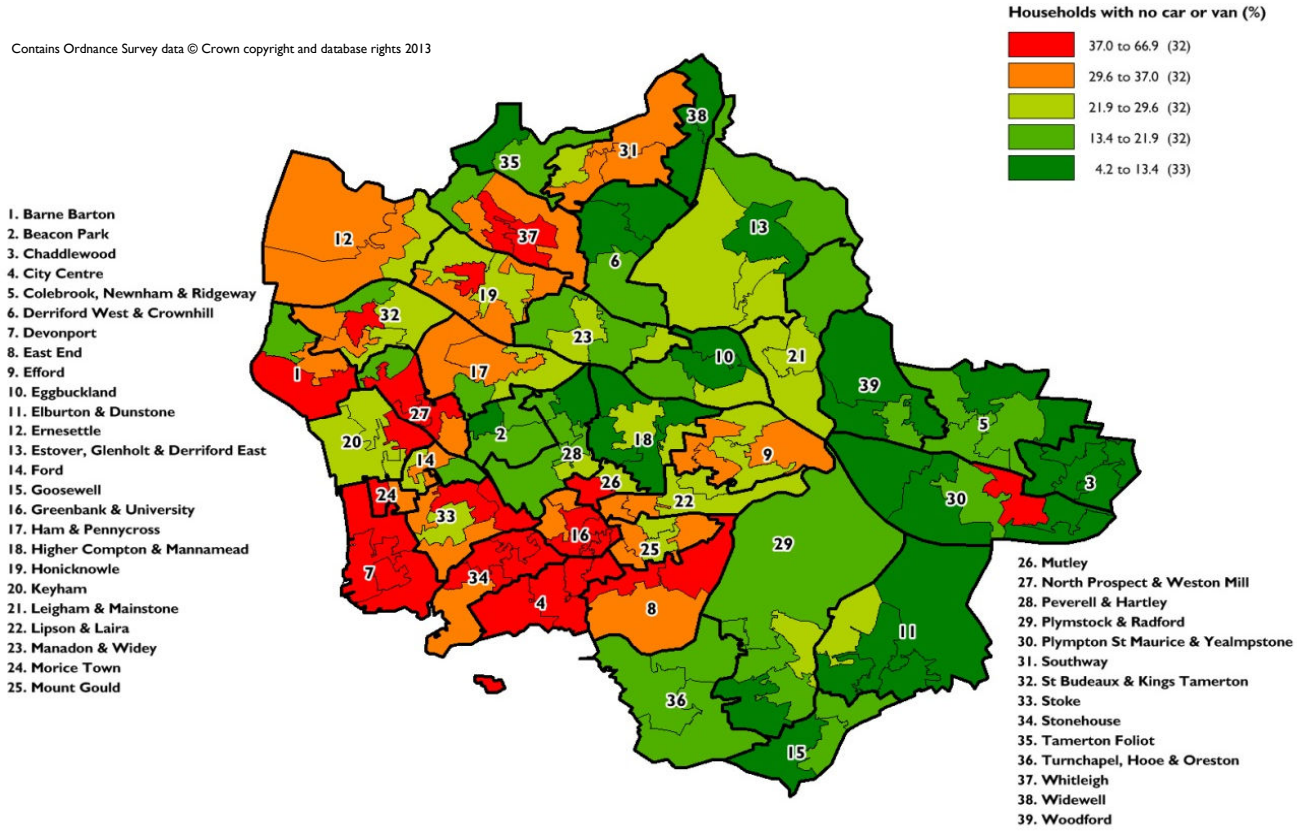
[150] Personal communication, Street Services Research and Data Officer, Plymouth City Council, 2014
[151] Air Quality Management Area declaration, 2014
[152] Sustainable Neighbourhood assessments, 2007
[153] Plymouth Plan Area assessments, 2014

in terms of social, economic, and environmental characteristics, based upon factual evidence sources such as the 2011 Census and Experian Mosaic data.

8.14 Access to a car or van

Using 2011 Census data the map in Figure 73 identifies the percentage of households who do not have access to a car or van. The data shows us that LSOAs in Devonport, Stonehouse, City Centre, Barne Barton, North Prospect & Weston Mill, and Whitleigh amongst others have the highest percentages of households without access to a vehicle. The lack of access to a vehicle will impact the ability of residents to move around the city and reinforces the importance of sustainable transport.

Figure 73: Percentage of households with no access to a car or van by Lower Super Output Area



Source: Census 2011, ONS

8.15 Dial-A-Ride Community Transport

Dial-A-Ride, a partnership between Plymouth City Council, Citybus, and the local transport charity Access Plymouth, plays a key role in providing access to services and reducing social exclusion for elderly and disabled residents.

The door-to-door, citywide, anywhere to anywhere service was shortlisted for the Transport Team/Partnership of the Year category of the 2014 National Transport Awards.[154]

As well as being a functional provision to meet the transport needs of the residents has helped enhance the lives of customers. Reasonable fares, personal door-to-door service with regular drivers, and the opportunity for conversation are all reasons the service has become both a success and a lifeline for city residents whose lives are made more difficult through disability or age-related mobility issues.

The service commenced city-wide in October 2013 with a fleet of five minibuses. From 784 trips in the first month to 1,007 trips in March 2014 the service has already seen a 28% increase in use. State of the art scheduling software creates the most efficient pick-up runs reducing fuel use and journey times whilst enhanced publicity has led to greater public awareness.

The public, private, and charity sector partners are working together to:

- Expand the fleet with newer, more accessible vehicles.
- Extend operational hours.
- Continue delivery of a targeted promotional campaign to ensure those that would benefit the most know about the service.

[154] Transport Times National Transport Awards nomination, 2014

8.16 References

References are listed in alphabetical order by footnote name. The corresponding footnote number(s) is(are) also displayed. Links to online documents/tools/sources are included if available.

151	Air quality management area declaration, Plymouth City Council, 2014 http://modgov/documents/s56951/Air%20Quality%20Management%20Area%20Declaration.pdf
148	Independent report as part of the quality assurance programme for Plymotion on Your Doorstep, Peter Brett Associates on behalf of Plymouth City Council
136, 145	National Highways and Transport Network Public Satisfaction Survey, 2013 http://nhtsurvey.econtrack.co.uk/Content.aspx?6313
150	Personal communication, Street Services Research and Data Officer, Plymouth City Council, October 2014
144	Plymotion Cycling, Plymouth City Council http://www.plymouth.gov.uk/plymotioncycling
147	Plymotion on Your Doorstep, Plymouth City Council http://www.plymouth.gov.uk/plymotiononyourdoorstep
146	Plymotion Personalised Travel Plan, Plymouth City Council http://www.plymouth.gov.uk/plymotion
137	Plymouth Fairness Commission: an initial presentation of evidence, 2013 http://www.plymouth.gov.uk/plymouth_fairness_commission_introductory_analysis.pdf
140	Plymouth Interim Report, 2012, Plymouth City Council http://www.plymouth.gov.uk/jsnaplymouthinterimreport.pdf
153	Plymouth Plan Area assessments, 2014 http://www.plymouth.gov.uk/homepage/environmentandplanning/planning/planningpolicy/ldf/plymouthplan/ppareaassessments.htm
135, 139, 143, 149	Plymouth Plan Sustainability Appraisal scoping report, 2013, Plymouth City Council http://www.plymouth.gov.uk/sa_scoping_report_for_plymouth_plan.pdf
142	South West Coast Path walking guide www.plymouth.gov.uk/swcp
135	South West Spine report: the case for greater investment across the South West Peninsula Rail Network, Feb 2013 http://www.plymouth.gov.uk/the_south_west_spine.pdf

152	Sustainable Neighbourhood assessments, Plymouth City Council http://www.plymouth.gov.uk/homepage/environmentandplanning/planning/planningpolicy/ldf/ldfbackgroundreports/brsustainableneighbourhoodassessments.htm
138	Traffic by local authority: Table TRA 8902, Department for Transport https://www.gov.uk/government/statistical-data-sets/tra89-traffic-by-local-authority
154	Transport Times National Transport Awards 2014 nomination for Transport Team/Partnership of the Year category Provided by Public Transport Manager, Plymouth City Council, Oct 2014

Appendix A: Public Health England data and knowledge gateway

The data and knowledge gateway is a single point of access to all nationally produced Public Health England data profiles, tools, and other high quality resources. It can be accessed via the link: http://datagateway.phe.org.uk/index.html. The resources cover a range of public health areas including:

- specific health conditions – such as cancer, mental health, cardiovascular disease
- lifestyle risk factors – such as smoking, alcohol, and obesity
- wider determinants of health – such as environment, housing, and deprivation
- health protection

Specific profiles (with direct links) include:

- Diabetes community health profiles (CCG), 2012/13
  http://www.yhpho.org.uk/diabetescommunityhealthprofiles/default.aspx
- Cardiovascular disease local authority profiles, 2013
  http://www.sepho.org.uk/NationalCVD/docs/00HG_CVD%20Profile.pdf
- Child and maternity profiles 2014 (child health/breastfeeding/early years/ healthy schools)
  http://www.chimat.org.uk/profiles
- Community mental health profiles, 2012/13
  http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp
- End of life care profiles (local authority and CCG),
  http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/
- General health profile for Plymouth 2013
  http://fingertips.phe.org.uk/profile/health-profiles/data
- Learning disabilities profiles, 2013
  http://www.improvinghealthandlives.org.uk/profiles/index.php?pdf=E06000026
- Local alcohol profiles for England (LAPE), 2012
  http://www.lape.org.uk/index.html
- Local tobacco control profiles, 2014
  http://www.tobaccoprofiles.info/
- National Child Measurement Programme (NCMP) Local authority profiles, 2012/13
  http://fingertips.phe.org.uk/profile/national-child-measurement-programme
- Neurology profiles, 2012/13
  http://fingertips.phe.org.uk/profile-group/mental-health/profile/neurology
- Sexual and reproductive health profiles, 2012/13
  http://fingertips.phe.org.uk/profile/sexualhealth

Many of these links take you to interactive tools that then require one or more steps to select the geography required. Often the option to download the PDF is then available.

Appendix B: Other locally produced Plymouth Joint Strategic Needs Assessment profiles and reports

- 2011 Census profiles
  http://www.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/census2011profiles.htm
- Area profiles, 2014
  http://www.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/areaprofiles.htm
- Alcohol needs assessment, 2011
  http://www.plymouth.gov.uk/jsnaalcoholneedsassessment.pdf
- Child poverty needs assessment, 2011
  http://www.plymouth.gov.uk/jsnaplymouth_childpovertyneedsassessment.pdf
- Devon CCG Health and Wellbeing profile, 2014
  http://www.plymouth.gov.uk/devon_ccg_health_and_wellbeing_profile.pdf
- Life expectancy in Plymouth, 2001-03 to 2010-12
  http://www.plymouth.gov.uk/jsnalifeexpectancyreport.pdf
- National Child Measurement Programme Report 2012 to 2013
  http://www.plymouth.gov.uk/plymouths_national_child_measurement_programme.pdf
- Ophthalmic public health statistics for Plymouth, 2014
  http://www.plymouth.gov.uk/ophthalmic_public_health_factsheet_for_plymouth.pdf
- Plymouth Fairness Commission: an initial presentation of evidence, 2013
  http://www.plymouth.gov.uk/jsnafairnesscommissionpresentationofevidence.pdf
- Plymouth Interim Report, 2012
  http://www.plymouth.gov.uk/jsnaplymouthinterimreport.pdf
- Plymouth neighbourhoods and localities, 2012
  http://www.plymouth.gov.uk/jsnaplymouthneighbourhoods.pdf
- Prevalence of smoking, obesity, and high blood pressure in Plymouth, 2010/11 to 2012/13
  http://www.plymouth.gov.uk/smoking_obesity_high_blood_pressure_in_plymouth.pdf
- Survey of health visitor caseloads, 2002 to 2014
  http://www.plymouth.gov.uk/healthvisitorsurveyreport.pdf

Plymouth City Council Wellbeing Survey

Your reference number: 2409 /

Help for completing the Plymouth City Council Wellbeing Survey

- On 1st April 2013, responsibility for Public Health in Plymouth transferred from the NHS to the City Council. Part of that responsibility includes working to improve the health and wellbeing of Plymouth residents whilst at the same time reducing inequalities.
- This survey will play an important role as it will enable us to get a picture of personal wellbeing, community wellbeing and lifestyle behaviours in Plymouth. Using this information we will be able to more effectively target our resources on the basis of need. By repeating this survey in future years we will be able to see if levels of wellbeing in the city have improved and if the inequalities have reduced.
- You have been randomly selected to take part in this survey along with other residents across the city. Please be assured that all responses are strictly confidential and you will not be identified in the results.
- **If you do not return this survey then you may be sent a reminder letter.** If you do not wish to receive a reminder then please send back your completed/uncompleted survey in the envelope provided.
- PLEASE COMPLETE THE SURVEY BY Friday 3rd October 2014 and return using the enclosed FREEPOST envelope (please note that surveys received after this date will not be accepted).
- Local independent research agency Marketing Means is administering this survey. If you have any queries about the survey please call Freephone 0800 849 4019. For council related queries please call 01752 66800
- The survey should be completed by someone living in the house who is aged 18 or over
- If you would like this document in another format or language please telephone 0800 849 4019.

To complete this survey online

- Go to **www.marketingmeans.co.uk/OnlineSurveys/fs-PlymouthWell.aspx** and enter the password
- You will only be able to complete the survey once

Personal wellbeing

1. Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each <u>over the last 2 weeks?</u>

Please tick one box per line

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	☐	☐	☐	☐	☐
I've been feeling useful	☐	☐	☐	☐	☐
I've been feeling relaxed	☐	☐	☐	☐	☐
I've been feeling interested in other people	☐	☐	☐	☐	☐
I've had energy to spare	☐	☐	☐	☐	☐
I've been dealing with problems well	☐	☐	☐	☐	☐
I've been thinking clearly	☐	☐	☐	☐	☐
I've been feeling good about myself	☐	☐	☐	☐	☐
I've been feeling close to other people	☐	☐	☐	☐	☐
I've been feeling confident	☐	☐	☐	☐	☐
I've been able to make up my own mind about things	☐	☐	☐	☐	☐
I've been feeling loved	☐	☐	☐	☐	☐
I've been interested in new things	☐	☐	☐	☐	☐
I've been feeling cheerful	☐	☐	☐	☐	☐

2. Overall how satisfied are you with your life nowadays, on a scale of 0 to 10? Please tick one box only

0 (not at all satisfied)	1	2	3	4	5	6	7	8	9	10 (completely satisfied)
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. Overall to what extent do you feel the things you do in life are worthwhile, on a scale of 0 to 10?

Please tick one box only

0 (not at all worthwhile)	1	2	3	4	5	6	7	8	9	10 (completely worthwhile)
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. Overall how happy did you feel yesterday, on a scale of 0 to 10? Please tick one box only

0 (not at all happy)	1	2	3	4	5	6	7	8	9	10 (completely happy)
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Overall how anxious did you feel yesterday, on a scale of 0 to 10? Please tick one box only

0 (not at all anxious)	1	2	3	4	5	6	7	8	9	10 (completely anxious)
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Community wellbeing

6. Overall, how satisfied or dissatisfied are you with Plymouth as a place to live?
Please tick one box only

Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Don't know
☐	☐	☐	☐	☐	☐

7. Overall, how satisfied or dissatisfied are you with your local area as a place to live?
Please tick one box only

Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Don't know
☐	☐	☐	☐	☐	☐

8. How strongly do you feel you belong to your local area? Please tick one box only

Very strongly	Fairly strongly	Not very strongly	Not at all strongly	Don't know
☐	☐	☐	☐	☐

9. To what extent do you agree or disagree that your local area is a place where people from different backgrounds get on well together? By getting on well together, we mean treating each other with respect. Please tick one box only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

10. How safe or unsafe do you feel when outside in your local area? Please tick one box per line

	Very safe	Fairly safe	Neither safe nor unsafe	Fairly unsafe	Very unsafe	Don't know
After dark	☐	☐	☐	☐	☐	☐
During the day	☐	☐	☐	☐	☐	☐

11. To what extent do you agree or disagree that you can influence decisions affecting your local area? Please tick one box only

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Lifestyles - Physical Activity

The following questions ask you about your **levels of physical activity**. By physical activity, we mean any activity that results in **expenditure of calories and a raised heart rate**. This includes:

- **Everyday activities** (e.g. housework, gardening, DIY)
- **Active recreation** (e.g. walking, cycling, dancing)
- **Sport** (e.g. swimming, exercise and fitness training, competitive activities).

12. How many times have you participated in 30 minutes of moderate intensity physical activity in the past 7 days? (moderate intensity exercise is when you should experience a raised heart rate) Please tick one box only

None	Once	Twice	Three times	Four times	Five or more times
☐	☐	☐	☐	☐	☐

13. Would you like to be more physically active? Please tick one box only

Yes ☐ No ☐

14. What stops you from becoming more physically active? Please tick all that apply

- ☐ Lack of time
- ☐ Lack of childcare
- ☐ Lack of money
- ☐ Lack of transport
- ☐ Lack of motivation
- ☐ Personal safety concerns
- ☐ Limited opportunities for participation (not aware of opportunities, can't access etc)
- ☐ Unable to access facilities
- ☐ Body image concerns
- ☐ Clothing and equipment (expensive)
- ☐ Lack of self-confidence
- ☐ Social and cultural barriers
- ☐ Attitudes and prejudices (e.g. about sexuality, disability, ethnicity)
- ☐ Physical/health barriers (morbidly obese, disability, illness etc
- ☐ Other (please explain)

.....

Lifestyles - Diet

15. On average how many portions of FRUIT do you eat a day? (examples include a handful of grapes, an orange, a glass of fruit juice, a handful of dried fruits)) Please tick one box only

None	1	2	3	4	5	More than 5
☐	☐	☐	☐	☐	☐	☐

16. On average how many portions of VEGETABLES do you eat a day? (examples include 3 heaped tablespoons of carrots, a side salad, two spears of broccoli) Please tick one box only

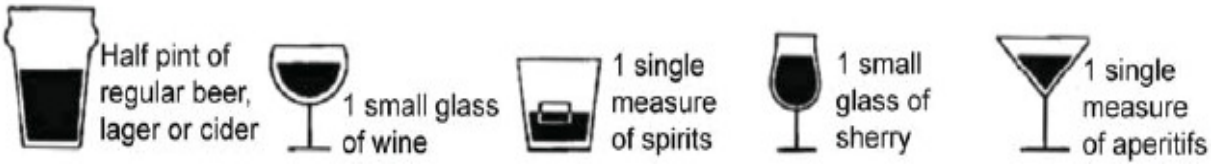
None	1	2	3	4	5	More than 5
☐	☐	☐	☐	☐	☐	☐

Lifestyles - Alcohol

17. How often do you have a drink containing alcohol? Please tick one box only

- ☐ Never **Go to Q20**
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4+ times a week

This is one unit of alcohol...



...and each of these is more than one unit

18. How many units of alcohol do you drink on a typical day when you are drinking?

Please tick one box only

1-2	3-4	5-6	7-9	10+
☐	☐	☐	☐	☐

19. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? Please tick one box only

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
☐	☐	☐	☐	☐

Lifestyles - Smoking

20. Do you smoke cigarettes, cigars or other tobacoo products at all nowadays?

Yes ☐ **Go to Q21** No ☐ **Go to Q22**

21. How many cigarettes/cigars (tobacco products) do you smoke each day?

Up to 10	10-20	21-30	31-40	More than 40
☐	☐	☐	☐	☐

22. Do you currently use e-cigarettes? Please tick one box only

Yes ☐ **Go to Q23** No ☐ **Go to Q24**

23. Which statement best describes you? Please tick one box only

- ☐ I use e-cigarettes often (more than once a week)
- ☐ I use e-cigarettes sometimes (more than once a month)
- ☐ I have tried e-cigarettes once or twice

About you

Please complete these questions, which will help us to see if there are differences between the views of different residents. All the information you give will be kept completely confidential.

24. Gender - are you? Please tick one box only

Male	Female	Transgender	Prefer not to say
☐	☐	☐	☐

25. What was your age on your last birthday (in years)? Please write in

_____ years

26. Do you consider yourself a disabled person? Please tick one box only

Yes	No	Prefer not to say
☐	☐	☐

27. What is the occupation of the chief wage earner in your household? Please tick one box only

- ☐ Higher managerial/professional/ administrative e.g. established doctor, board director in large organisation (200+ employees) top level civil servant/public service employee.
- ☐ Intermediate managerial/professional/administrative e.g. newly qualified (under 3 years) doctor, solicitor, board director of small organisation, middle manager in large organisation, principal officer in civil service/local government.
- ☐ Supervisory or clerical/junior managerial/professional/administrative e.g. office worker, student doctor, foreman with 25+ employees, salesperson.
- ☐ Skilled manual worker e.g. skilled bricklayer, carpenter, plumber, painter, bus/ambulance driver, HGV Driver, AA patrolman, pub/bar worker.
- ☐ Semi or unskilled manual work e.g. manual workers, all apprentices in skilled trades, caretaker, park-keeper, non-HGV driver, shop assistant.
- ☐ Unclassified something else

28. Please tell us your ethnicity. Please tick one box only

☐ White British	☐ Black or Black British
☐ White Irish	☐ Asian or Asian British
☐ White Gypsy or Traveller	☐ Chinese
☐ Any other White background	☐ Any other ethnic group - please state
☐ Mixed background	.....

Thank you for completing the Survey.

Please return your survey by 3rd October 2014 in the Freepost envelope provided.

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