

THE PLYMOUTH REPORT

Health & Wellbeing Board, 26 January 2017



1. INTRODUCTION

1.1 The Plymouth Report is a high level report that aims to provide readers with a single strategic analysis of the key issues for the city - one version of the truth to enable sound, intelligent decision making and inform strategic priority setting. It has been developed in close collaboration with the Plymouth Plan process.

1.2 Developed as part of the Council's Intelligent Organisation programme, the Plymouth Report will enable, for the first time, all relevant data sets to be analysed in conjunction with each other and will be fed by a range of monitoring reports, strategic needs assessments, evidence base updates that include relevant forecasts. Specifically, the Plymouth Report will meet the locally defined requirements of the Joint Strategic Needs Assessment (JSNA) as well as act as the Annual Monitoring Report (AMR) for the Planning Authority.

1.3 On a more practical note, the report will give Officers across the city easy access to a consistent narrative about needs, along with headline data for the Council and city – this is particularly useful when working on single issue needs assessments, commissioning plans, awards submissions, bids, briefing papers, press statements, etc.

1.4 The Plymouth Report is intended as an interactive, web based document, with links to the more detailed needs assessment or source data if required. It will use infographics to present headline data, and case studies to illustrate notable examples of where strategic interventions are addressing need.

1.5 The Plymouth Report will be updated annually - horizon scanning will also enable an annual programme of 'deep dives' to give a more detailed analysis of some of the bigger challenges facing the city or where significant intelligence gaps have been identified.

2. OVERVIEW OF THE PLYMOUTH REPORT

2.1 Where possible, the Plymouth Report follows the themed approach used in the Plymouth Plan (see below). There are however some exceptions to this based on the inherent differences between needs focused and strategic planning documents. The final report will allow progress on the delivery of the objectives and outcomes of the Plymouth Plan to be examined alongside the identification of new issues and new ways of dealing with existing challenges.

2.2 A brief overview of each section can be seen overleaf (Table 1). Please note that the location of some content may change to ensure readability and flow of analysis across sections.

Table 1 – Overview of contents

Section 1: Introduction / Executive Summary	Plymouth overview, strategic context, overview of each section.
Section 2: Living Plymouth	Population, neighbourhoods, resident insight, deprivation, poverty, environment, transport, housing, crime & community safety, education & schools.
Section 3: Healthy Plymouth	Life expectancy, mental health, dementia, life conditions, geography of health, chronic conditions, mortality, vulnerable groups.
Section 4: Growing Plymouth	City region, economy, economic sectors, employment and skills, worklessness, infrastructure and investment, land use.
Section 5: International Plymouth	Community cohesion, welcoming city, visitor economy, culture and heritage.
Section 6: Conclusions: Challenges & Ambitions	Key issues, questions and challenges, gaps in knowledge/data, alignment between city needs and Plymouth Plan outcomes (positive, neutral, gaps).

3. TIMELINE

3.1 Overseen by the Director of Public Health and prepared by a cross council team of Analysts, the Plymouth Report is still under development. A working draft of the full document is expected at the end of February 2017.

3.2 While the Healthy Plymouth section is being presented to the Health and Wellbeing Board meeting at its meeting on the 26th January (included in the next section), it is proposed that the full Plymouth Report document be brought back to the Board when it next meets. This will enable a broader discussion of the key issues, questions and challenges that arise from the full analysis.

3.3 Where possible, inter dependencies with other sections are highlighted and addressed within this iteration of the Healthy section.

4. HEALTHY PLYMOUTH

4.1 Overview

Overall the health and wellbeing of the Plymouth population is mixed compared with the England average. Of the 31 indicators presented in the 2016 Public Health England Health Profile¹, Plymouth has 13 that were significantly worse ('red') compared to England. These include adult smoking prevalence, life expectancy, under 75 deaths from cancer and cardiovascular disease, and under 18 conceptions.

The health and wellbeing of children in Plymouth is also mixed compared to the England average according to the 2016 Public Health England 'Child Health Profile'.² Whilst there are some clear successes such as mothers smoking at time of delivery, vaccine uptake, and A&E attendances in 0-4 year olds, Plymouth compares negatively to England for 12 of the 32 indicators including breastfeeding, and hospital admissions due to alcohol-specific conditions, injuries, and self-harm.

The following section highlights some of the key health and wellbeing issues in the city and outlines some of the innovative work going on to address them.

4.2 Life expectancy

From 2001-03 to 2012-14 life expectancy in Plymouth has improved by 2.8 years for males (to 78.5 years) and 2.1 years for females (to 82.5 years). Over this time male life expectancy has been consistently below the England average and the gap in male life expectancy between Plymouth and England has widened. Female life expectancy has, on occasions, been slightly higher than the England average. However, the life expectancy of females in Plymouth is currently lower than the England average. The gap in female life expectancy between Plymouth and England has also widened since 2001-03.³

Life expectancy varies across the city; from 86.5 years in the Plympton Chaddlewood ward to 76.4 years in Drake. Figure 1 highlights that wards just a few miles apart can have life expectancy value varying by years. Travelling the seven miles west from Plympton Chaddlewood, or south from Southway, each mile closer to St Peter and the Waterfront represents over one year of life expectancy lost.

In terms of inequalities, the life expectancy gap between those living in the most deprived areas and those in the least deprived areas remains significant; life expectancy in the most deprived areas of Plymouth (at 78.4 years) is 4.4 years lower than in some of the least deprived areas.³

¹ Health Profile 2016: Plymouth, Public Health England, 06 Sep 2016

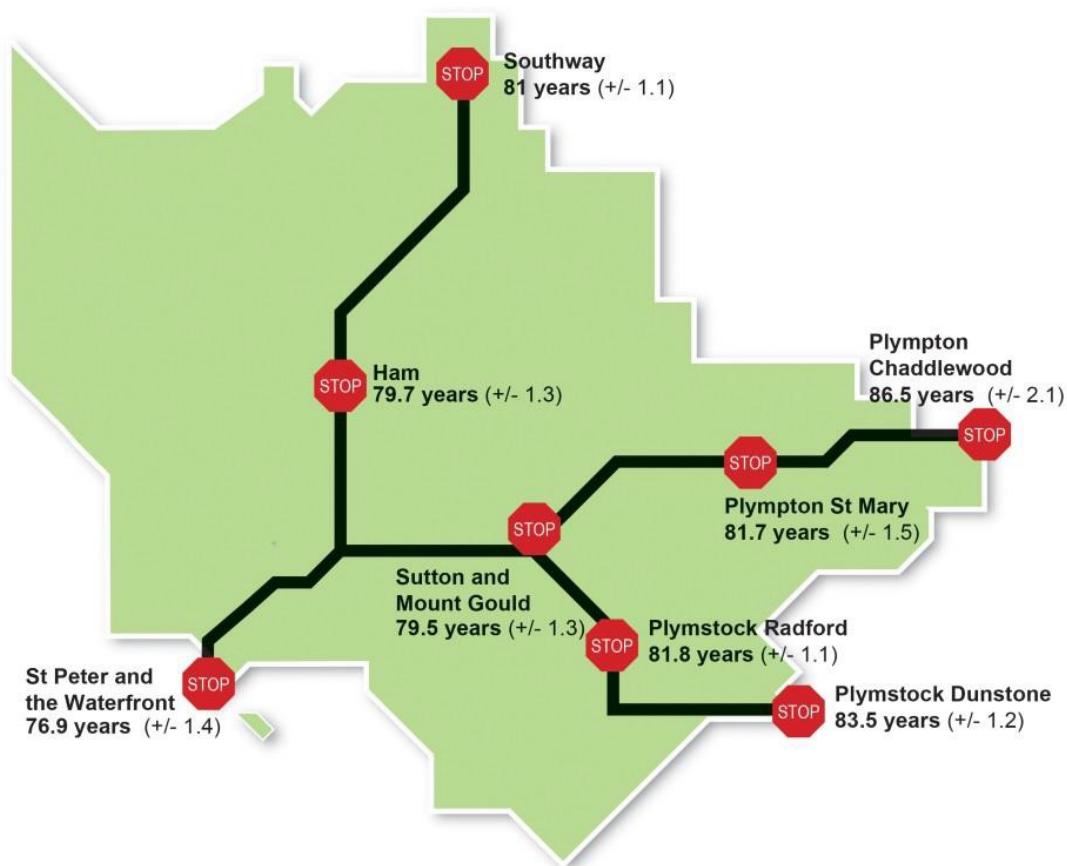
² Child Health Profile: Plymouth, Public Health England, 15 Mar 2016

³ Life expectancy in Plymouth 2001-03 to 2012-14, Public Health, Plymouth City Council, Mar 2016

Using the Public Health England 'Segment Tool'⁴ it is possible to understand the broad causes of death which contribute most to the gap in life expectancy between Plymouth and England. For men these are cancer (34.5%), circulatory disease (17.9%), and external causes including deaths from injury, poisoning, and suicide (17.4%); and for women these are circulatory disease (33.5%), mental and behavioural factors including dementia and Alzheimer's disease (15.3%), and cancer (14.1%).

Healthy life expectancy in Plymouth (the average number of years a person can expect to live in good health) was significantly lower than the England average for both males and females in 2012-14.⁵ Males in Plymouth had a healthy life expectancy of 59.0 years whilst females had a healthy life expectancy of 59.5 years. Unlike life expectancy, healthy life expectancy in Plymouth shows little difference between genders.

Figure 1: Plymouth's life expectancy bus route by electoral ward, 2012-14



However, due to the differences in overall life expectancy men in Plymouth can expect to live on average the last 19.5 years of their lives in poor health whilst for women it's their last 23.0 years.

⁴ <https://fingertips.phe.org.uk/profile/segment>

⁵ Healthy life expectancy and life expectancy at birth by upper tier local authority: England, Office for National Statistics, 10 Mar 2016

Continued efforts will need to be made to improve life expectancy and healthy life expectancy in Plymouth, and close the gap between the most and least deprived areas of the city.

4.3 Mental health

Poor mental health is the largest cause of disability in the UK.⁶ It's also closely connected with other issues, including poor physical health and problems in other areas like relationships, education, and work prospects. Almost three in every five people with mental health conditions are currently unable to work, despite evidence showing employment can be a crucial part of treatment. It has been estimated that mental health problems in England cost over £100 billion a year.⁷ Over recent years, mental health services in England have received additional investment and undergone significant reform, but demand for mental health services has been rising, and there is still significant unmet need.

The Plymouth mental health needs assessment⁸ highlights a number of factors which may promote good mental health and wellbeing and protect against developing mental health problems. These include employment, education, physical activity, green space access, and community cohesion. It also highlights a number of risk factors which increase the likelihood of experiencing poor mental health and wellbeing. These include poor quality housing, deprivation and inequality, unemployment, crime, poor physical health, and drugs and alcohol misuse. The breadth of these factors highlights how interconnected mental health is with physical health, environment, and behavioural choices.

In 2015 there were over 26,200 people in Plymouth estimated to be suffering from common mental health problems including depression, anxiety, and obsessive compulsive disorder.⁹ It is also quite common for people to meet the diagnostic criteria for two or more mental health problems and suffer from psychiatric co-morbidity. This is an important issue as it is associated with greater disease severity, longer illness duration, more functional disability, and an increased use of health services. Over 11,700 Plymouth residents aged 18-64 years in 2015 were estimated to have more than one mental health problem; a figure that is projected to decrease to around 11,500 by 2030.⁹

The number of referrals to the Child and Adolescent Mental Health Services (CAMHS) in Plymouth in 2015/16 was 1,207. This is a 10% increase from the 1,099 referrals reported in 2014/15.¹⁰ Mental health service providers report that they have noticed not only an increase in the number of referrals but also an increase in the complexity of children and young people's needs and issues requiring attention.¹¹

Over the last three years hospital admissions of young people (aged 10-24 years) for self-harm has increased in both Plymouth (425.5 per 100,000 population to 473.6 per 100,000)

⁶ Department of Health. 2010 to 2015 government policy: mental health service reform, 08 May 2015

⁷ Economic and social costs of mental health problems, Centre for Mental Health, Oct 2010

⁸ Adult Mental Health Needs Assessment for Plymouth, Public Health, Plymouth City Council, Mar 2012

⁹ Mental health problems predictions, Projecting Adult Needs and Service Information, 2014

¹⁰ Livewell Southwest, November 2016

¹¹ Children and young people, a single view of need/ demand, 2016

and England (346.3 per 100,000 to 398.8 per 100,000). The latest 2014/15 data is significantly higher in Plymouth than England.¹²

In response to the 'Emotional Wellbeing and Mental Health Strategy 2009-14' and the 'Early Intervention and Prevention Strategy', there have been a number of developments to better target the services in this system. This includes a range of brief interventions in schools. For example, a co-commissioned system of support for vulnerable children and young people began in September 2016 in 26 of Plymouth's secondary and special schools. A redesign of CAMHS has enabled specialist staff to be based in these schools for half a day a week. In addition, to ensure a more holistic population-based system, The 'Healthy Child Quality Mark' (a development tool which gives schools a framework to plan, deliver, and measure healthier behaviour change) has also been developed to improve schools' offer in respect to emotional wellbeing and mental health education, sex and relationship education, and promotion of healthy lifestyles.¹¹

4.4 Dementia

In 2014, 3,134 people over the age of 65 were estimated to be living with dementia. By 2030 it is expected that this number will have risen to 4,855.¹³ Understanding the local situation is very important to providing early diagnosis and appropriate support to people and their carers. Plymouth City Council, working alongside the Plymouth Dementia Action Alliance, is continuing to deliver its commitment to being a Dementia Friendly City. In November 2016 this was recognised when Plymouth won the Dementia Friendly Community category at the Alzheimer's Society's national awards in London.

4.5 Life conditions

There are higher levels of long-term health problems or disability, and lower levels of reported 'good' or 'very good' health in Plymouth compared to England. According to the 2011 Census, 10.0% of Plymouth residents reported having a long-term health problem or disability that limits their day-to-day activities a lot and has lasted, or is expected to last, at least 12 months. The England value was 8.3%. The 2011 Census also reported fewer Plymouth residents thought their health was 'good' or 'very good', compared to England.¹⁴

Over the past five years the percentage of people reporting that they have a low 'self-reported life satisfaction' has been falling nationally, from 6.5% in 2011/12 to 4.6% in 2015/16. Within Plymouth the results have been inconsistent, ranging from a high of 5.8% in 2014/15 to a low of 4.2% in 2015/16.¹⁵ Although the current figure (4.2%) is a move in the right direction it is difficult to predict whether this better performance will be maintained given the previous trend.

¹² Child Health Profiles, Public Health, 2016

¹³ People aged 65 and over predicted to have dementia, by age and gender, projected to 2030, Projecting Older People Population Information System, 2014

¹⁴ 2011 Census table QS303EW (long-term health problem or disability), Office for National Statistics, 30 Jan 2013

¹⁵ Headline estimates of personal well-being, Office for National Statistics, 27 September 2016

4.5.1 OBESITY

Results from the 'National Child Measurement Programme' (NCMP) 2015/16 show that by the time they start primary school around one in four children living in Plymouth are either overweight or obese, and by the time they leave this has increased to over three in ten.¹⁶

Compared to Plymouth, fewer children in England are overweight or obese when starting primary school, but more fall into this category by the time they leave. This suggests that the environment in Plymouth may be more 'obesogenic' for pre-school children, but less obesogenic for those of primary school age when compared to England.

As a result of more sedentary lifestyles and increased availability and affordability of high calorie food the prevalence of obesity among adults has grown considerably over the past few decades. Survey data for Plymouth 2013-15 shows that 62.4% of adults aged 16 are classified as overweight or obese, a value similar to the 64.8% seen for England.¹⁷

4.5.2 CHILDREN'S DENTAL HEALTH

Whilst the overall level of dental disease in Plymouth is similar to the national average this figure masks oral health inequalities across the city and a small number of people bear the greatest burden of disease in the city. These groups include children living in material and social deprivation and at risk groups such as older people, people living with a disability, or those in long term institutional care.

Dental decay remains a significant problem for many children in Plymouth. There are large differences in the extent of decay experienced by children depending on where they live; those from more deprived areas often suffering from a higher burden of disease. In Plymouth, 848 children (aged one to 16 years) had teeth removed under general anaesthetic (GA) in 2015/16. On an electoral ward basis the rate of dental extractions ranged from 56.2 per 10,000 children aged 0-16 years in the Plympton Chaddlewood ward to 292.0 per 10,000 in the Honicknowle ward (this represents over a five-fold difference) whilst the rate was over three times higher in children from the most deprived areas of the city (261.5 per 10,000) compared to the least deprived (85.1 per 10,000).¹⁸

One of the four priorities in Plymouth's 'Child Poverty Action Plan 2016-19'¹⁹ commits to improve the dental health of children aged under-16 and reducing the number of children having teeth removed. Delivery of the plan's outcomes will be achieved by priority activities including an accessible targeted fluoride varnish scheme and oral health promotion initiatives. These key activities will complement citywide efforts to tackle child

¹⁶ National Child Measurement Programme England 2015/16, NHS digital, 03 Nov 2016

¹⁷ Active People Survey: percentage adults classified as overweight or obese 2013-15, Public Health Outcomes Framework indicator 2.12, Nov 2016

¹⁸ Dental extractions under general anaesthetic in Plymouth Children 2015/16, Public Health, Plymouth City Council, 26 Jul 2016

¹⁹ Plan for Child Poverty, 2016-19, Plymouth City Council, 2016

<http://modgov/documents/s74516/Child%20Poverty%20Action%20Plan%20FINAL%200092016.pdf>

poverty, as outlined in the 'Plymouth Plan' and will be achieved by coordinated partnership working, with an emphasis on shared and joined up service provision that relies on targeting and sharing skills and capacity when and where required.

4.6 Geography of health: lifestyle behaviours

Four lifestyle behaviours (poor diet, inactivity, lack of exercise, tobacco use, and excess alcohol consumption) are risk factors for four diseases (coronary heart disease, stroke, cancers, and respiratory problems) which together account for 54% of deaths in Plymouth.²⁰ These behaviours remain highest in the areas where people are most deprived. It is these behaviours and chronic diseases that form the basis of the Thrive Plymouth (for more detail see section 3.10).

4.6.1 DIET

In a health-related behaviour survey of secondary school pupils in Plymouth, 16% reported eating five or more portions of fruit and vegetables on the day prior to the survey in both 2013/14, and when the survey was repeated in 2015/16.²¹

Plymouth has a similar proportion of adults eating the recommended '5-a-day' (51.4%) compared to England (52.3%).²²

In order to support healthy eating and improve access to good food the 'Plymouth Plan' states a responsibility to promote access to food growing opportunities, ensure healthy catering choices at facilities and events across the city, and protect the food environment within 400m of providers of secondary education. A key achievement of this policy has been the refusal of planning applications for hot food takeaways within close proximity to secondary schools. A future opportunity will be to encourage other types of local shops to improve the healthiness of their food offer.

4.6.2 PHYSICAL ACTIVITY/INACTIVITY

In 2015 56.2% of adults in Plymouth were classed as physically active, a figure similar to the England average of 57.0%.²³ Results from a health related behaviour survey carried out by the Schools Health and Education Unit in secondary schools across the city reported that 67.3% of the pupils surveyed 'exercised enough to breathe harder and faster on at least three days in the week' in 2015/16 (an increase from 66.0% in 2014/15).²¹

²⁰ Positive choices for better health in a growing city: director of public health annual report 2014/15, Public Health, Plymouth City Council, Jul 2015

²¹ Health Related Behaviour Survey: Plymouth secondary schools 2014 and 2016, Public Health, Plymouth City Council, Nov 2016

²² Active People Survey: proportion of the adult population meeting the recommended '5-a-day' on a usual day, Public Health Outcomes Framework indicator 2.11i, 2015

²³ Active People Survey: percentage of inactive adults 2015, Public Health Outcomes Framework indicator 2.13ii, Nov 2016.

In a response to the issues around physical activity, the 'Plymouth Plan' outlines the commitment to improve sporting facilities in the city. A 'Plan for Sport' is being created that will bring together activities across a wide range of council departments including; Sports Development, Commissioning, Economic Development, Events, and the Green Infrastructure teams. Key achievements to date include the adoption of the 'Plan for Playing Pitches' and the drafting of the 'Sports and Leisure Facilities Plan'.²⁴

4.6.3 SMOKING

The rate of smoking in Plymouth has fallen in recent years however it remains higher than the England average. Currently 20.6% of the adult population of Plymouth smokes compared to the England average of 16.9%.

Rates are higher among specific groups of people such as those who live in more deprived areas. The rates of smoking in wards in Plymouth range from 4.1% to 37.1%. Generally the more deprived wards have a higher rate of smoking and a higher rate of children who report that they have tried smoking. This is important because smoking is a fundamental cause of ill health and the principle reason for the difference in life expectancy within the city.²⁵

Fundamental drivers behind the prevalence of smoking relate to supply and demand. These include: access, price, age of uptake, peer influence, and support to stop smoking. In order to further address prevalence and reduce inequalities in smoking rates amongst Plymouth's population there is a need for local focus and action to tackle the fundamental determining factors and prioritise specific groups of people. This will help contribute to the 'Plymouth Plan' priority to encourage a smoke-free Plymouth.²⁵

4.6.4 ALCOHOL AND DRUG MISUSE

Alcohol and drug (illegal and prescribed) dependence are significant issues for Plymouth. They are commonly associated with mental health problems, homelessness, and offending, and have negative impacts on families and children. In 2015 over 5,500 people in the city aged 18-64 were estimated to be dependent on drugs; and nearly 10,000 were predicted to be alcohol dependent.²⁶ This has significant consequences and costs for the city in terms of individual health and wellbeing, family breakdown, and social cohesion.

The number of alcohol related hospital admissions provides a measure of the burden of health harms and the impact of alcohol related disease and injury. The number of admissions in Plymouth has risen significantly over recent years. In 2014/15 there were

²⁴ Sports Development Team, Plymouth City Council, 2016

²⁵ Tobacco Control Needs Assessment for Plymouth 2017, Public Health team, Plymouth City Council, in development

²⁶ Drug/alcohol predictions, Projecting Adult Needs and Services Information, 2014

over 5,600 admissions which is significantly higher than the England average.²⁷ Rates of alcohol related hospital admissions are higher in more deprived areas.

Under 18 admissions for an alcohol specific condition has been on a downward trajectory both locally and nationally since 2007. Although the number of admissions has reduced, Plymouth continues to have a significantly higher rate (53.9 per 100,000 population) than England (36.6 per 100,000).²⁷

As alcohol use impacts across a wide range of policy and service priorities a robust partnership approach is essential to reducing harm. 'Promote Responsibility, Minimise Harm, A Strategic Alcohol Plan for Plymouth 2013-18'²⁸ defines a partnership approach to addressing alcohol in the city. It focuses on changing attitudes to alcohol, managing supply, identifying need earlier, and ensuring evidence based interventions are available where necessary.

Commissioners across Plymouth are working to develop a whole system approach for re-commissioning mental health, homelessness, drug and alcohol treatment services and some offender services. This is focused on providing integrated responses across the system and ensuring that people's needs can be met wherever they access services. This will make a step change in how services for people with drug and alcohol dependency and complex needs are provided in Plymouth and will achieve cost efficiencies for key organisations in the city.

4.7 Chronic diseases

The following data is not available at local authority level. Instead they are available at Clinical Commissioning Group (CCG) level. Plymouth sits within the Western locality of the NHS Northern, Eastern, and Western (NEW) Devon CCG.

4.7.1 CORONARY HEART DISEASE

Since 2012/13 the prevalence of coronary heart disease in England has remained between 3.2-3.3%. The prevalence in NEW Devon CCG has been consistently higher than England. The current prevalence of 3.9% is significantly higher than England.²⁹

4.7.2 STROKE

Since 2012/13 the prevalence of stroke in England has remained static at 1.7%. The prevalence in NEW Devon CCG has been consistently higher than England and has increased by 0.1% annually. The current prevalence of 2.2% is significantly higher than England.

²⁷ Local Alcohol Profiles for England 2016: Plymouth, Public Health England, 06 Sep 2016

²⁸ Strategic Alcohol Plan for Plymouth 2013-18, Public Health, Plymouth City Council, Jul 2013

²⁹ PHE Cardiovascular Disease Profiles <https://fingertips.phe.org.uk/profile/cardiovascular>

4.7.3 CANCERS

Since 2012/13 the prevalence of cancer England has increased in England. The prevalence in NEW Devon CCG has also increased and consistently been higher than England. The current prevalence of 2.9% is significantly higher than England (2.4%)

4.7.4 RESPIRATORY DISEASE

Since 2005/06 the prevalence of Chronic Obstructive Pulmonary Disease has increased in England.³⁰ The prevalence in NEW Devon CCG has been consistently higher than England since 2010/11 and has increased at a greater rate. The current prevalence of 2.0% is significantly higher than England (1.8%).

4.8 Mortality

Since 1995 rates of all-age all-cause mortality have fallen for males, females, and hence 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 the England average, whilst rates for female all-age all-cause mortality have generally been similar to England.³¹ The rate in Plymouth in 2012-14 was 102.8 per 1,000. This compares with 94.9 per 1,000 for England.³² Rates across Plymouth vary from a low of 58.8 per 1,000 in the Plympton Chaddlewood ward to a high of 129.5 per 1,000 in the Drake ward.³³

In 2012-14 the all-age, all-cause mortality rate in those aged under the age of 75 years (i.e. considered to be premature mortality) in Plymouth was 37.6 per 1,000 under-75 population.³⁴ This varied across the city, with more deprived areas having rates nearly twice as high as the least deprived areas.

Plymouth has higher mortality rates than England for three of the four Thrive Plymouth chronic diseases (cancers, coronary heart disease, and respiratory disease) that account for the majority of deaths in Plymouth³⁵ (see section 3.10). Rates of death for all four diseases are higher in the more deprived areas of the city.³⁶

Combining the four causes of death locally results in a 2012-14 mortality rate of 55.1 per 10,000 all-age population. Rates by ward vary from a low of 31.1 per 10,000 in the Plympton Chaddlewood ward to a high of 76.4 per 10,000 in the St Peter and the Waterfront ward.

³⁰ PHE Inhale Profiles <https://fingertips.phe.org.uk/profile/inhale>

³¹ Mortality from all causes: directly standardised rate, all ages, annual trend, MFP, NHS Digital, Dec 2015

³² Mortality from all causes: directly standardised rate, all ages, 3-year average, MFP, NHS Digital, Dec 2015

³³ Public Health, Plymouth City Council, Oct 2015

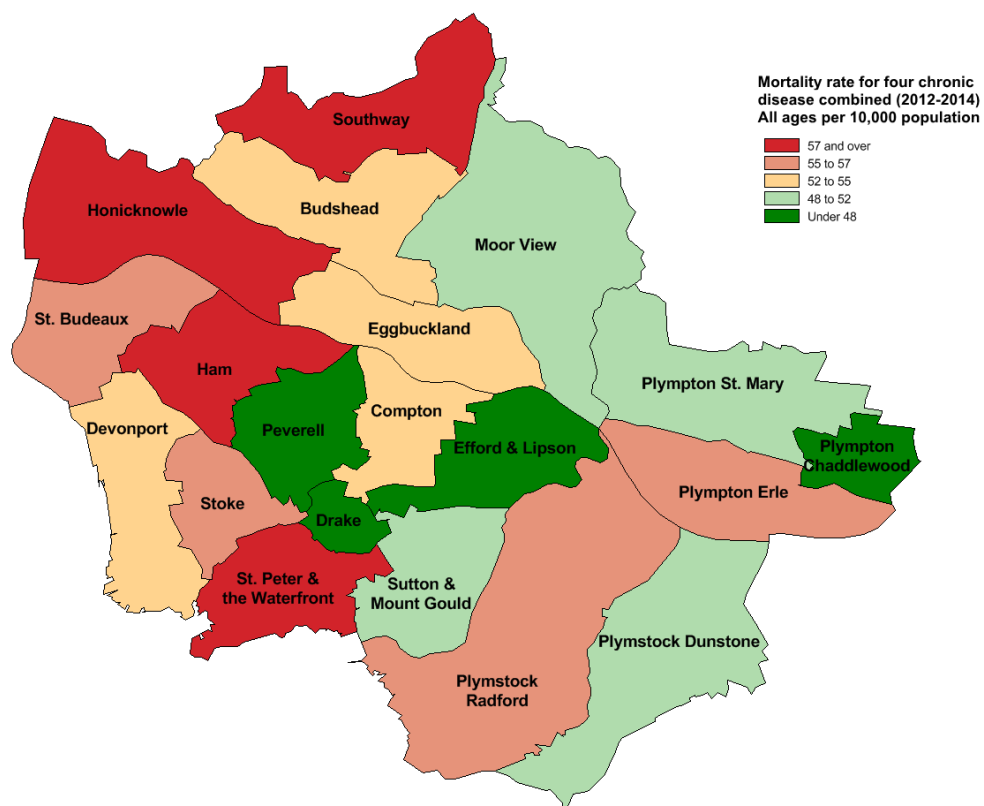
³⁴ Mortality from all causes: directly standardised rate, <75 years, 3-year average, MFP, NHS Digital, Dec 2015

³⁵ Mortality from coronary heart disease/stroke/cancer/: directly standardised rates, all ages, 3-year average, MFP, NHS Digital, Dec 2015

³⁶ Public Health, Plymouth City Council, Aug 2016

Again this varied with deprivation, with the more deprived areas of the city having higher rates than the lesser deprived areas.

Figure 2: All-age mortality rate for cancer, heart disease, respiratory disease, and stroke combined, 2012-14



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3.9 Vulnerable groups

3.9.1 CHILDREN IN CARE

Nationally it is known that achieving positive outcomes for children in care is a challenge. Department for Education, Centre for Social Justice data tells us:

- 12% of looked-after children gained five or more A* to C GCSE's including English and maths in 2014 compared to 53.4% of all children.
- Nearly 6% of looked-after children aged between 10 and 17 were convicted of an offence or subject to a final warning or reprimand in 2014.
- 20% of young homeless people were previously looked-after children.
- 24% of the adult prison population have been in care.
- 70% of sex workers have been in care.

Narrowing the gap in educational achievement between looked-after children and the rest of the school population locally and nationally is a priority and there has been some progress on this in recent years. 2016 attainment results for Key Stage 2 show

that Plymouth's pupils' attainment in achieving the expected standards in Reading, Writing and Maths is either on par with, or better than, pupils nationally, regionally and those within our statistical neighbour group. Additionally, the gap between the attainment of disadvantaged children and all other pupils in Plymouth is smaller than the gap nationally, regionally, and amongst our statistical neighbours. Attainment results for Key Stage 4 are released in January. All results will be analysed and key findings reported when available.

For the last three years the number of children and young people in care has ranged between 380 and 400, remaining relatively stable compared to the national trend.

In 2015/16, 205 children and young people (115 males, 90 females) came into the care of the local authority. Of these, 80 were aged 0-4 years, 35 were aged 5-9 years, and 80 were aged of 10-17 years.

Young people who enter into care later in life often struggle to settle into a placement and form new attachments to carers or staff. It is critical that a range of placements are available to meet need, with carers and staff able to provide a robust and resilient response to children and young people. Carers and staff need to be skilled in understanding the manifestations of trauma – both from a history of abuse and the process of removal from family members.³⁷

Placement stability and permanence processes are vitally important in securing stable homes for looked-after children; a team approach with clear planning is required for each child. All permanence options need to be considered as part of the process to secure the most appropriate long term option for the child or young person.³⁷

4.9.2 FAMILIES WITH MULTIPLE AND COMPLEX NEEDS / SAFEGUARDING CHILDREN

In Plymouth the main problems facing families with children subject to a child protection plan are domestic abuse, unsafe parenting, at sexual risk from an adult, parental mental health problems, parental alcohol misuse, or parental drug misuse.

Ofsted's report 'In the child's time: professional responses to neglect' (2014), highlighted an inconsistency in the quality of professional responses to neglect. Where children were not making positive progress, a common feature was lack of parental engagement. The Targeted Family Support Service in Plymouth has a well-developed approach to parental non-compliance aimed at diverting families from the statutory intervention. However there is still a need to review how to address parental engagement across the system of early help services to prevent the need for child protection referrals.³⁷

The Corporate Safeguarding Improvement Plan identifies a number of areas where the Plymouth Safeguarding Children's Board (PSCB) want to focus its activity. These include:

- reducing the number of repeat referrals and child protection plans
- reducing the number of children subject to child protection plans

³⁷ Children and young people, a single view of need/ demand, 2016

The Board is taking a number of steps to improve the quality of supervision, care planning and assessments, and developing and embedding an enhanced, systems-based approach to quality assurance. It is also taking the lead on the multi-agency work being undertaken to try to better understand and tackle Child Sexual Exploitation.³⁷

4.9.3 ENHANCED AND SPECIALIST CARE

The focus of commissioning is on the provision of Individual Patient Placements (IPPs), care home support, and end of life support. Enhanced and specialist services are needed by people when other interventions have not achieved their outcomes and their health care needs cannot be met or provided elsewhere. Often referrals originate from another health care organisation. In 2015/16 the identified spend on services within scope of the 'Enhanced and Specialised Care Strategy' was £29.30 million*.

An ageing population will mean increased prevalence of dementia, other long-term conditions, and multiple comorbidities. The complexity of need of people living in care homes is increasing. This will mean care home provision will need to be better at supporting people with complex needs, particularly dementia and mental ill-health.

(* N.B. Highly specialised healthcare services in hospital are commissioned by NHS England on behalf of the local population – an additional budget in excess of £130m)

4.9.4 CARERS

In 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, there were 27,247 of these carers in Plymouth. This was a 13% increase on number identified in the 2001 Census. The majority (57.3%) provided 1-19 hours of care per week but nearly 30% (7,566 individuals) were committing over 50 hours. Challenges around Plymouth's ageing population and an increased complexity of need will put increasing pressure on unpaid carers. Currently, only 24% (approximately) of carers in Plymouth are registered with the local carers support service.³⁸

Under the 'Care Act' (2015) all adult carers became entitled to a full carer's assessment. Within Plymouth there has been a substantial increase in the numbers of carer's assessments undertaken. Between April 2016 and the end of September 2016 564 carer's assessments have been undertaken by either Livewell Southwest or the Plymouth Guild Carer's hub, this is compared to just 150 during the same period in 2015/16. The number of completed carer's assessments is on track to more than double in 2016/17. This increase is seen as a real positive for carers in the city and an attempt to improve the performance against national outcome indicators in relation to carer quality of life and the level to which they feel consulted on care provision.

³⁸ Children and young people, a single view of need/ demand, 2016

4.9.5 YOUNG CARERS

Young carers are the children and young people who take on the responsibility of caring for a family member, most often a parent or sibling, who has a condition such as a disability, illness, mental health condition or a drug and/or alcohol problem. The approximate total number of children and young people aged 18 years and younger in Plymouth is 56,155. Using the national estimate, that 1.5 per cent of young people are carers, it suggests there are at least 840 children and young people with caring responsibilities in the city. There are approximately only 200 young carers under the age of 18 known to Plymouth City Council, therefore there could be around 640 young carers unknown to the local authority.³⁸

4.9.6 COMMUNITY-BASED CARE

Plymouth's rising population (described in section one of this report) is likely to put increasing pressure on community-based provision within the definition outlined in the 'Community-based care commissioning strategy'. One of the most significant factors that will impact on further demand for community services is the growing number of older people in Plymouth.³⁹ It is estimated that Plymouth's population will increase by over 16,000 by 2030. The largest increase will be seen in 75+ year olds (54.6%).⁴⁰

Community-based care delivers targeted services for people who need support in the community to maintain independence or those who may be at risk in the future of losing their independence. The services support people with multiple care and support needs, people requiring urgent care, and people with long-term needs who require ongoing personalised support. The 'Community-based Care Needs Assessment' undertaken in 2016 provides an extensive overview of community based care needs and demand.

4.9.6.1 People with multiple care and support needs

Local information, combined with national modelling, indicates that adults experience complex needs (relating to homelessness, substance misuse, offending, and mental health) at different levels. Within Plymouth the 'Community-based Care Needs Assessment' identifies that there are;

- in excess of 25,000 people with a hazardous drinking need, and in excess of 6,000 people with a harmful drinking need⁴¹
- more than 1,000 households prevented from becoming homeless in 2015/16⁴²
- around 5,600 people with a drugs need⁴³

³⁹ Community-based Care Commissioning Strategy, 2016

⁴⁰ Office of National Statistics Population Projections

⁴¹ Alcohol needs assessment, 2011

⁴² Community Connections Department

⁴³ Substance misuse atlas

- in excess of 26,000 people with a common mental health disorder need⁴⁴ and 4,500 people with depression and severe depression need⁴⁵

Analysis of the above has identified that;

- There is a core group of approximately 270 individuals requiring intense support for a number of issues at the same time.
- There are approximately 3,000 people that are not in immediate crisis but could shift into core without intervention.
- There are approximately 5,000 people who have complex needs but are stable and engaging with support.

4.9.6.2 People requiring urgent care

These people may need services such as rapid response home care, mental health support services, reablement and/or community equipment.

The 'Community-based Care Needs Assessment' reports that the number of emergency admissions to hospital is expected to rise by around 1.1% per year. However, due to the ageing population it is expected that the total number of emergency bed days will increase by around 1.6% per year. It is also known that the prevalence of long-term conditions is rising, which will place an additional demand pressure on the urgent care system.⁴⁶

There has already been an increase in the number of domiciliary hours commissioned by Plymouth City Council and Northern, Eastern and Western Devon Clinical Commissioning Group. A 12.5% increase in hours was reported in 2014/15⁴⁷

4.9.6.3 People with long-term needs who require ongoing personalised support

In 2014, a total of 12,041 people over the age of 65 were predicted to have a long-term limiting illness where their day-to-day activities were limited a lot (self-definition as per the 2011 Census). Between 2014 and 2030, it is expected that the number of people aged over 65 with a limiting long-term illness will rise from 12,042 to 16,538.⁴⁸ Reasons for requiring long-term support include; sensory impairment, dementia, frailty, mental health issues, and learning disabilities.

⁴⁴ Projecting Adult Needs and Service Information System

⁴⁵ Projecting Older People Population System

⁴⁶ Community-based Care Needs Assessment, 2016

⁴⁷ Community-based Care Commissioning Strategy, 2016

⁴⁸ Projecting Older People Population Information

4.9.7 Residential and nursing care

There were in excess of 1,000 clients in long-term residential care in 2015/16. Although numbers are stable (1,092 in 2014/15) the average annual cost of a long term residential care package has risen, from £31,530 at 2015/16 year end to £34,419 as at the end of November 2016.

The numbers in long-term nursing care are increasing. In 2015/16 192 clients accessed long term nursing care. Between April and November 2016 that number was 209 so numbers for 2016/17 will be higher. The average annual cost of a long-term nursing care package has also increased, from £27,764 at 2015/16 year end to £31,659 as at the end of November 2016.

The increase in the cost of residential and nursing care placements (including short-term placements) is a concern. An action plan is currently in place with Livewell Southwest (the provider) to try and mitigate the financial pressures.

The quality of residential and nursing care provision in Plymouth remains high. The percentage of homes that are rated by the Care Quality Commission as 'good' or 'outstanding' is higher than the England average. The most recent adult social care client survey also showed that 70% of people in receipt of long-term social care were either 'satisfied' or 'very satisfied' with the care they receive. This is also above the national average.

4.9.8 Safeguarding adults

The [Adult Safeguarding Health needs assessment](#) provides an in-depth analysis in relation to the people in Plymouth who are in need of safeguarding (i.e. in need of care and support who also, due to these needs, may be unable to protect themselves, and therefore must be protected from the risk of or actual abuse).

In 2015/16 there were 1,731 safeguarding concerns reported. This number is likely to increase again in 2016/17 due to the continued efforts to raise awareness and tackle potential under-reporting. Based on the reported incidents, those most at risk of needing safeguarding are older people in receipt of physical support and who are resident in a care home setting or who live in their own home. However, ongoing analysis has also identified a cohort of people who are the subject of a disproportionately low number of safeguarding alerts. These are people who are in receipt of their social care support via a direct payment meaning less is known about their circumstances and they are subject to much less social care supervision.

The Adult Safeguarding Board remains on target to deliver against its strategic plan. Safeguarding information and the facility for online referral for professionals and members of the public are also now more prominent on the new Plymouth City Council website. Across the safeguarding network, partnership work on the modern slavery agenda continues and representatives from a variety of agencies and sectors recently undertook training to raise awareness of signs and processes. Whilst the recent modern slavery referral mechanism review pilot is due to end for evaluation at the end of March 2017, the Home Office thanked Plymouth for its participation.

4.10 Example 1: 'Thrive Plymouth'

In January 2014, at a Plymouth City Council Budget Scrutiny meeting, the following recommendation was agreed:

'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.'

Thrive Plymouth was developed in response to this recommendation and is a 10-year programme to improve health and wellbeing and reduce health inequalities in Plymouth. It is being led by the Office of the Director of Public Health, Plymouth City Council. Thrive Plymouth is based on the local 4-4-54 construct, i.e. that four behaviours (poor diet, lack of exercise, tobacco use and excess alcohol consumption) are risk factors for four diseases (coronary heart disease, stroke, cancers and respiratory problems) which together account for 54% of deaths in Plymouth (i.e. 4-4-54). Changing these four behaviours would help prevent these diseases and reduce the number of deaths due to these chronic diseases.

Thrive Plymouth is based on the following three approaches:

(1) Population prevention

Population prevention is about the whole population making positive changes, big or small, to their lifestyle choices. This is because lots of people with a small risk of getting a disease can cause as much ill health as a small number of people with a large risk. So everyone making even a small change will help Plymouth Thrive.

(2) Common risk factors

Common risk factors are based on the fact that one unhealthy behaviour can be the basis of many diseases, and several of these unhealthy behaviours tend to cluster in individuals in less affluent groups. Focusing on these common risks and how they cluster is more efficient and effective.

(3) Changing the context of choice

Context of choice acknowledges that despite an understanding of what is unhealthy, and good intentions to be healthier, change is hard to achieve. This is because we all make choices in settings we often don't control, where the healthy choice can be harder than the unhealthy choice is the easy choice

An electoral ward performance dashboard has been developed to monitor change in 20 relevant indicators and is updated as new data becomes available.

In addition to an on-going focus on the four behaviours, Thrive Plymouth also has a specific focus every year. In year one the focus was workplace health and wellbeing. In year two the focus was on schools. The focus for year three (from November 2016) is on localising Public Health England's 'One You' campaign.

4.11 Example 2: Integrated health and wellbeing: 'One System, One Budget'

Public sector organisations across the country are facing unprecedented challenges and pressures due to changes in demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth, and Devon as a whole, face a particular financial challenge because of the local demography, the historic pattern of provision, and pockets of deprivation and entrenched health inequalities.

On the 1st April 2015 Plymouth City Council (PCC) and the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) pooled their wellbeing, health and social care budgets and formed an integrated commissioning function. The primary driver of this was to streamline service delivery and provision with the aim of improving outcomes for individuals and providing value for money.

Four integrated commissioning strategies were developed to drive activity across the wellbeing, health and social care systems. The strategies describe the current picture and the integrated commissioning response across the health and wellbeing 'system' in Plymouth, specifically covering:

- Wellbeing
- Children and young people
- Community
- Enhanced and specialist

APPENDIX A: PUBLIC HEALTH ENGLAND DATA AND ANALYSIS TOOLS

A single point of access to all nationally produced Public Health England data profiles and tools, and other high quality resources can be accessed via the link: <https://www.gov.uk/guidance/phe-data-and-analysis-tools>.

The resources cover a range of public health topics including:

- specific health conditions – such as cancer, mental health, cardiovascular disease, and diabetes
- lifestyle risk factors – such as smoking, alcohol, and obesity
- wider determinants of health – such as environment, housing, and deprivation
- health protection

The interactive tools require one or more steps to select the desired geography. Often the option to download a PDF is then available.

APPENDIX B: OTHER USEFUL RESOURCES

- Director of Public Health annual report 2014/15
http://web.plymouth.gov.uk/public_health_annual_report.pdf
- Director of Public Health annual report 2015/16
http://web.plymouth.gov.uk/public_health_annual_report1516.pdf
- Integrated commissioning strategy needs assessments: 'Wellbeing', 'Children & Young People', 'Enhanced & Specialised Care', and 'Community-based Care'
<http://web.plymouth.gov.uk/homepage/socialcareandhealth/hscintegrationstrategies.htm>
- Thrive Plymouth
<http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/thrive.htm>

APPENDIX C: LINKS TO LOCALLY PRODUCED PLYMOUTH JOINT STRATEGIC NEEDS ASSESSMENT PROFILES AND REPORTS

- 2011 Census profiles
<http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/census2011profiles.htm>
- Area profiles, 2014
<http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna/areaprofiles.htm>
- Alcohol harm mapping: Plymouth neighbourhood profiles 2016
http://web.plymouth.gov.uk/alcohol_harm_mapping_neighbourhood_profiles.pdf
- Health related behaviour survey analysis: secondary education providers in Plymouth 2014
http://web.plymouth.gov.uk/healthrelatedbehavioursurvey_plymouthgeographies_finalv1.0_-_secure.pdf
- Index of Multiple Deprivation (IMD) 2015: Plymouth summary analysis
http://web.plymouth.gov.uk/index_of_multiple_depravation.pdf
- Life expectancy in Plymouth, 2001-03 to 2012-14
<http://web.plymouth.gov.uk/jsnalifeexpectancyreport.pdf>
- Mental health review 2014 (Pledge 90)
http://web.plymouth.gov.uk/pledge_90_mental_health_review.pdf
- National Child Measurement Programme Report 2014/15
http://web.plymouth.gov.uk/plymouths_national_child_measurement_programme.pdf
- Physical activity needs assessment for Plymouth 2015 to 2018
http://web.plymouth.gov.uk/physical_activity_needs_assessment_2015_to_2018.pdf
- Prevalence of smoking, obesity, and high blood pressure in Plymouth, 2010/11 to 2012/13
http://web.plymouth.gov.uk/smoking_obesity_high_blood_pressure_in_plymouth.pdf
- Survey of health visitor caseloads, 2002 to 2016
http://web.plymouth.gov.uk/healthvisitorsurveyreport_2016_final_v1.0_-_secure.pdf

The full list can be found here:

<http://web.plymouth.gov.uk/homepage/socialcareandhealth/publichealth/healthandwellbeingboard/jsna.htm>