



Public Health Devon



Exeter Overview

Simon Chant

1st February 2018



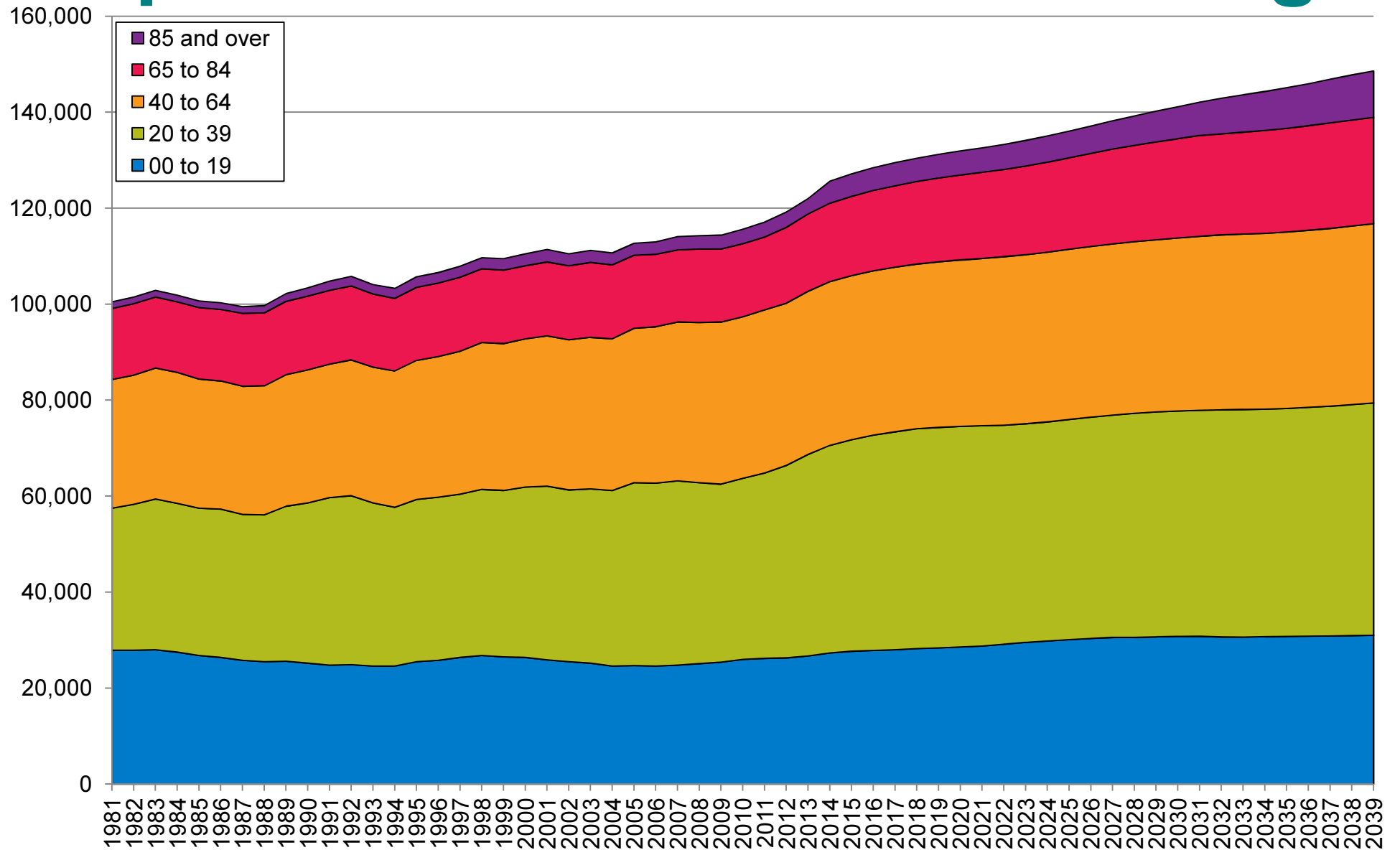
Public Health Devon



Sources

- JSNA overview
www.devonhealthandwellbeing.org.uk/jsna/overview
- JSNA profiles
www.devonhealthandwellbeing.org.uk/profiles
- Annual Public Health Reports
www.devonhealthandwellbeing.org.uk/aphr
- Local Health Outcomes Reports
www.devonhealthandwellbeing.org.uk/jsna
- National Public Health Profiles
<https://fingertips.phe.org.uk/profile/health-profiles>

Population Structure and Change



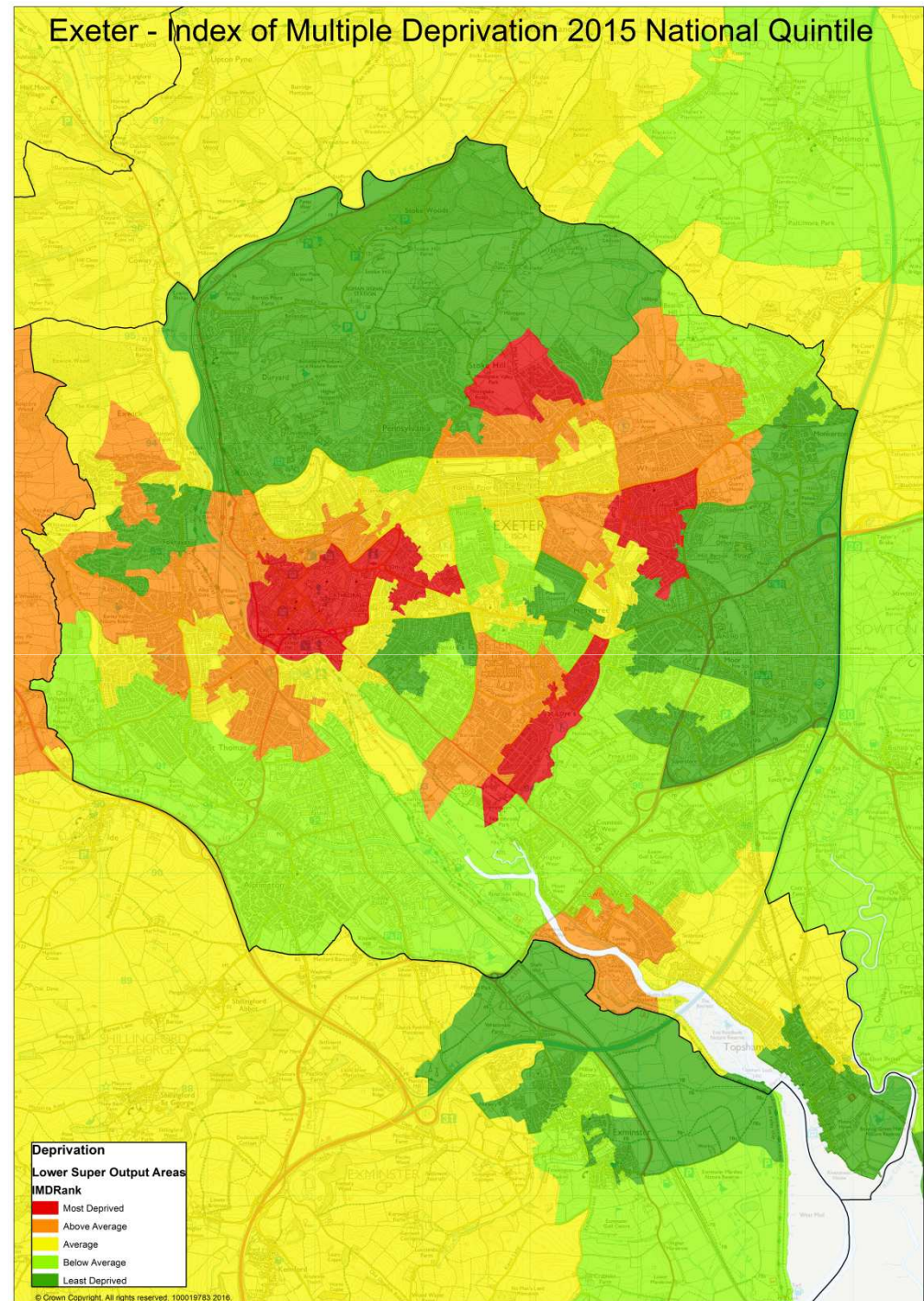
Indicators with worse outcomes than England average

- Rough sleeping
- Alcohol-specific admissions in under 18s
- Hospital stays for self-harm
- New sexually transmitted infections
- Social contentedness
- Fuel poverty

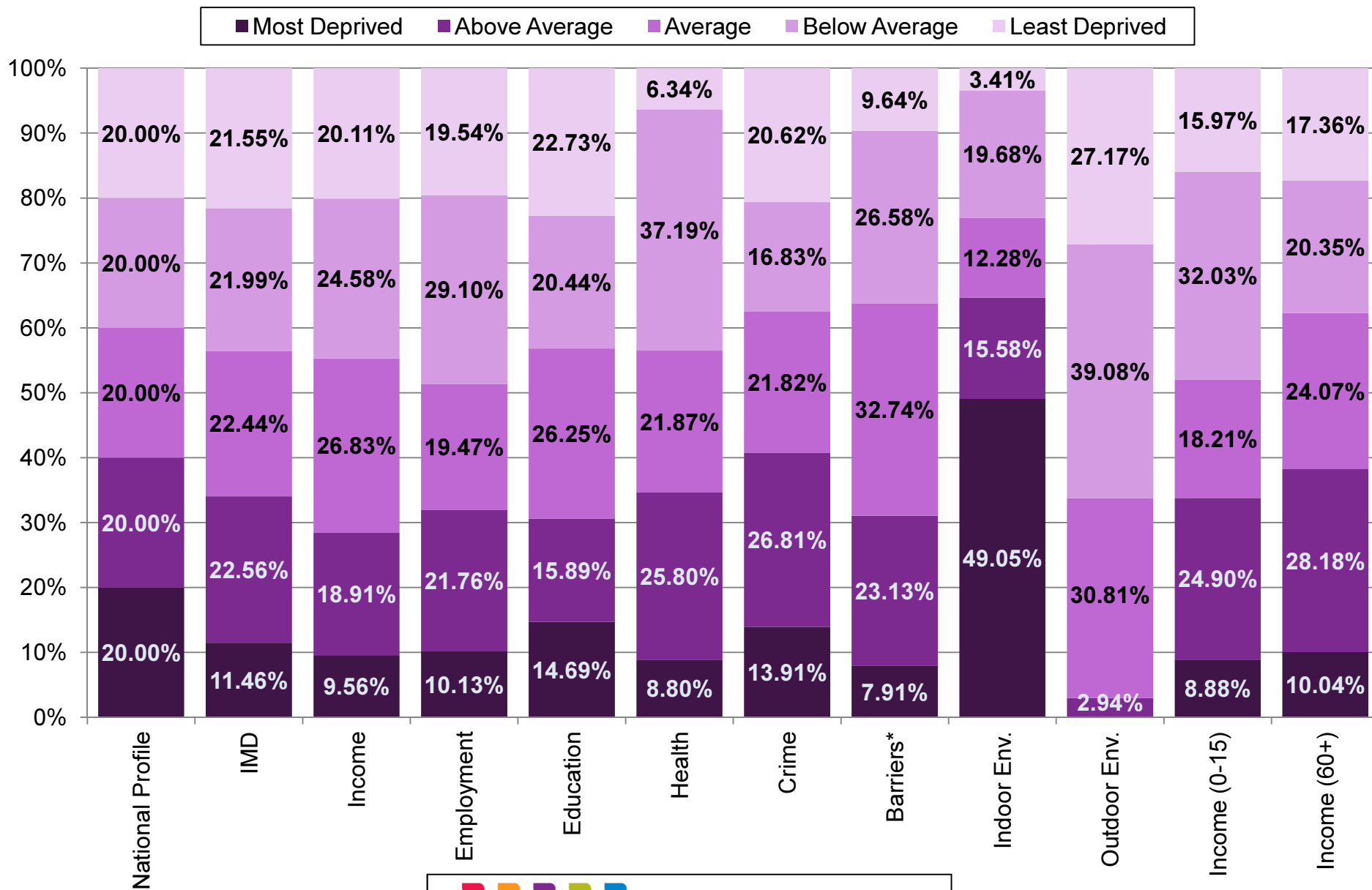
Index of Multiple Deprivation

Areas in the most deprived 20% nationally included the city centre and parts of Wonford, Whipton and Beacon Heath.

Above average levels are also seen in Countess Wear, parts of Pinhoe, St Thomas and Exwick.



Deprivation Profile by Domain



* Barriers to housing and services domain, covers access to services and housing affordability

Deprivation and Health

- Behaviours like smoking and alcohol use are more common in deprived areas
- People in the most deprived areas live five to 10 years less than those in the least deprived
- People in the most deprived areas tend to experience chronic ill-health 10 to 15 years earlier than the least deprived and spend more years in poor health
- Mental health and deprivation closely linked

The health inequalities gap



Area: Collins Road, Pennsylvania
Average Life Expectancy: 89.5 years
Population: 1,432
Largest age group: 30 to 34
Fuel Poverty: 10.3%



Area: Mount Pleasant
Average Life Expectancy: 72.0 years
Population: 1,722
Largest age group: 20 to 24
Fuel Poverty: 34.3%



Public Health Devon



Health-related behaviours

Health-Related Behaviour	Age group at greatest risk	Trend in Children	Trend in adults aged 16 to 64	Trend in Older People
Excessive Alcohol Use	25 to 44	Improving	Stable	Worsening
Smoking	25 to 34	Improving	Improving	Improving
Illegal Drug Use	16 to 24	Improving	Improving	Improving
Fruit and Vegetable consumption	16 to 24	Stable	Stable	Stable
Physical activity	75 and over	Improving	Improving	Improving
Obesity	55 to 64	Stable	Worsening	Worsening



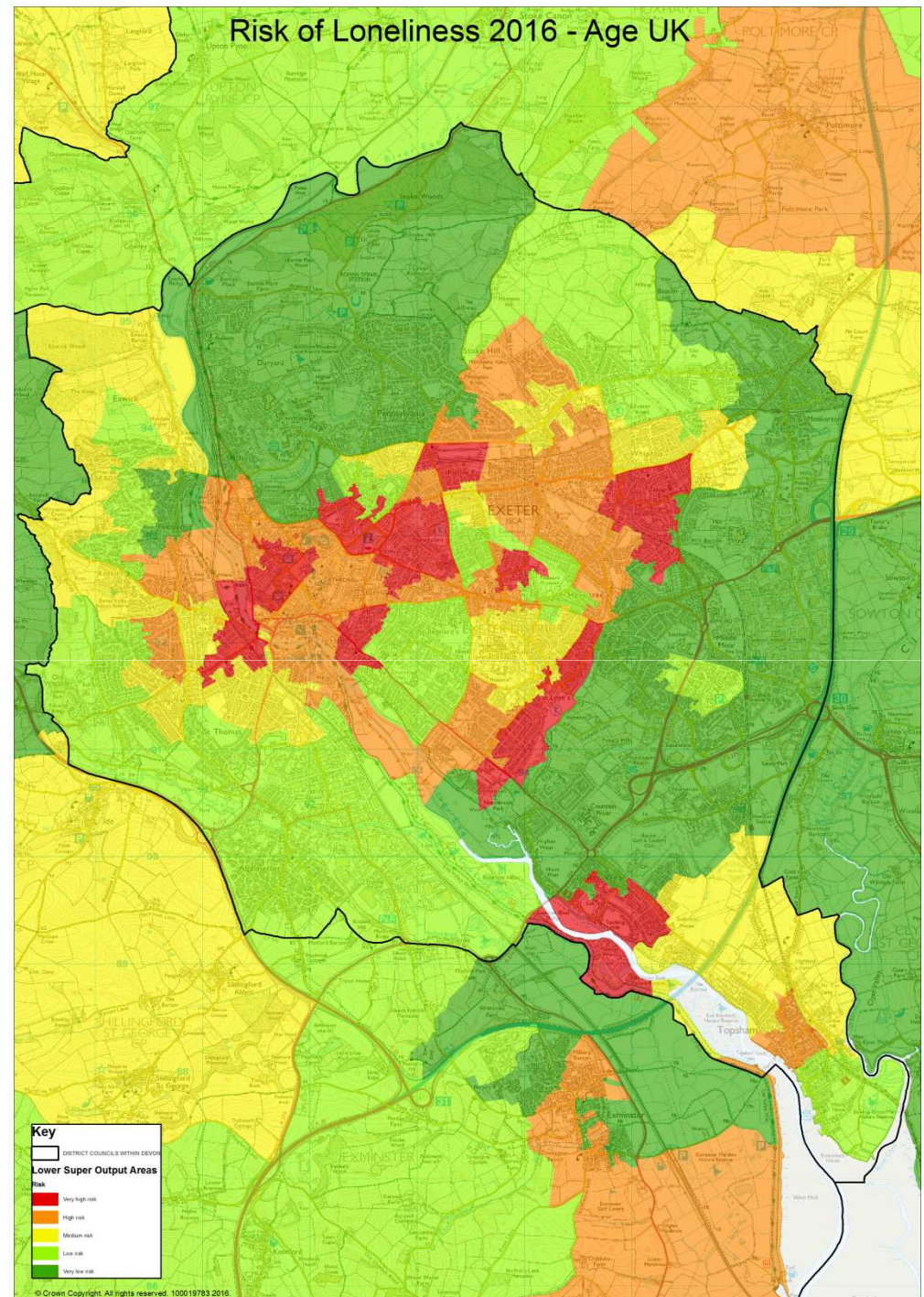
Loneliness

- Loneliness exists across the population but is most common in older age groups, in people living in deprived areas and in minority groups
- A range of personal, familial and social factors can trigger or exacerbate loneliness
- Loneliness has a detrimental effect on physical and mental health
- Social networks can play a pivotal role in reducing loneliness

Risk of Loneliness

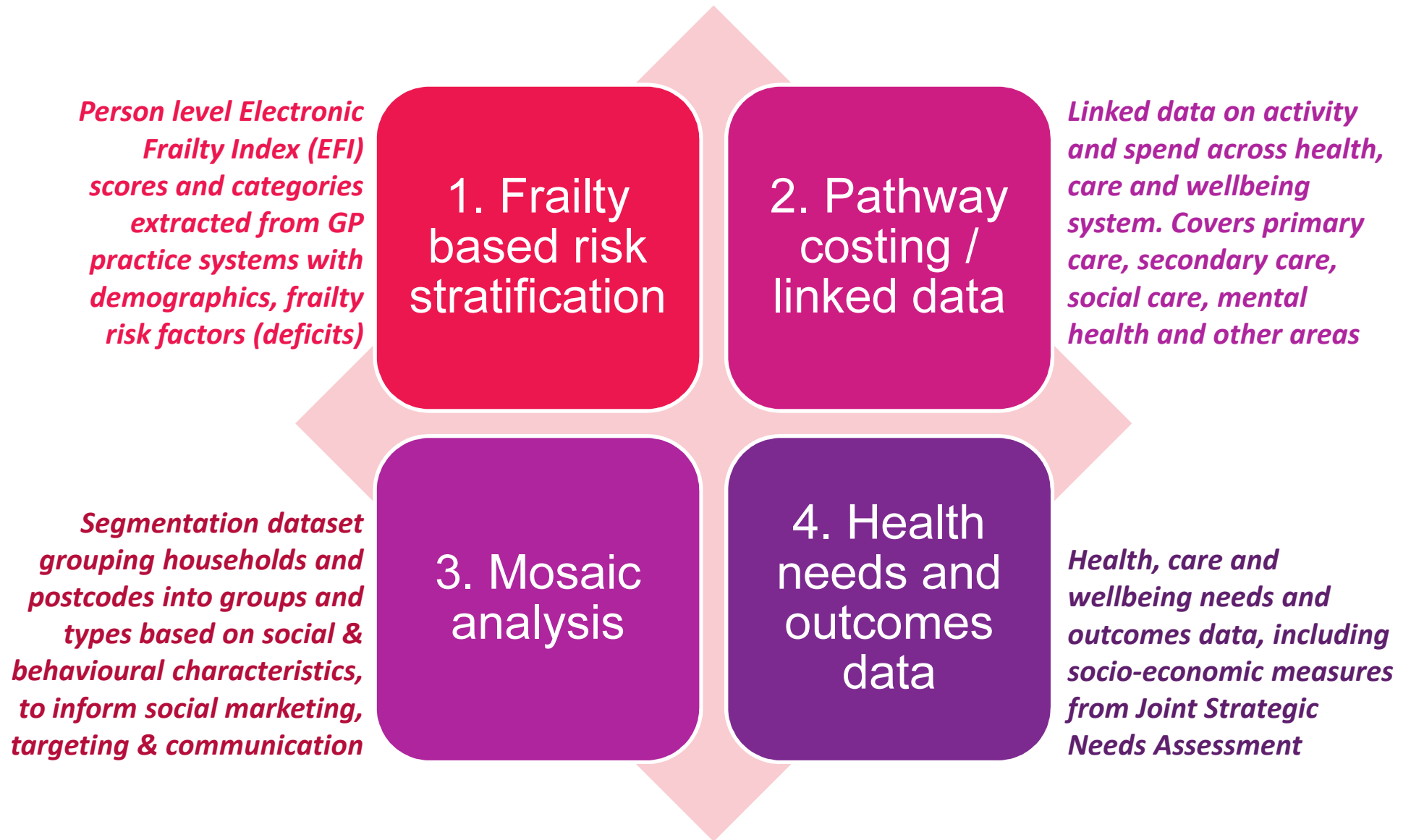
Areas of the city with a very high risk of loneliness include areas around the city centre, Mount Pleasant, Heavitree, Beacon Health, Wonford, Whipton and Countess Wear.

Further risk factors include deprivation, household size/type, and health status

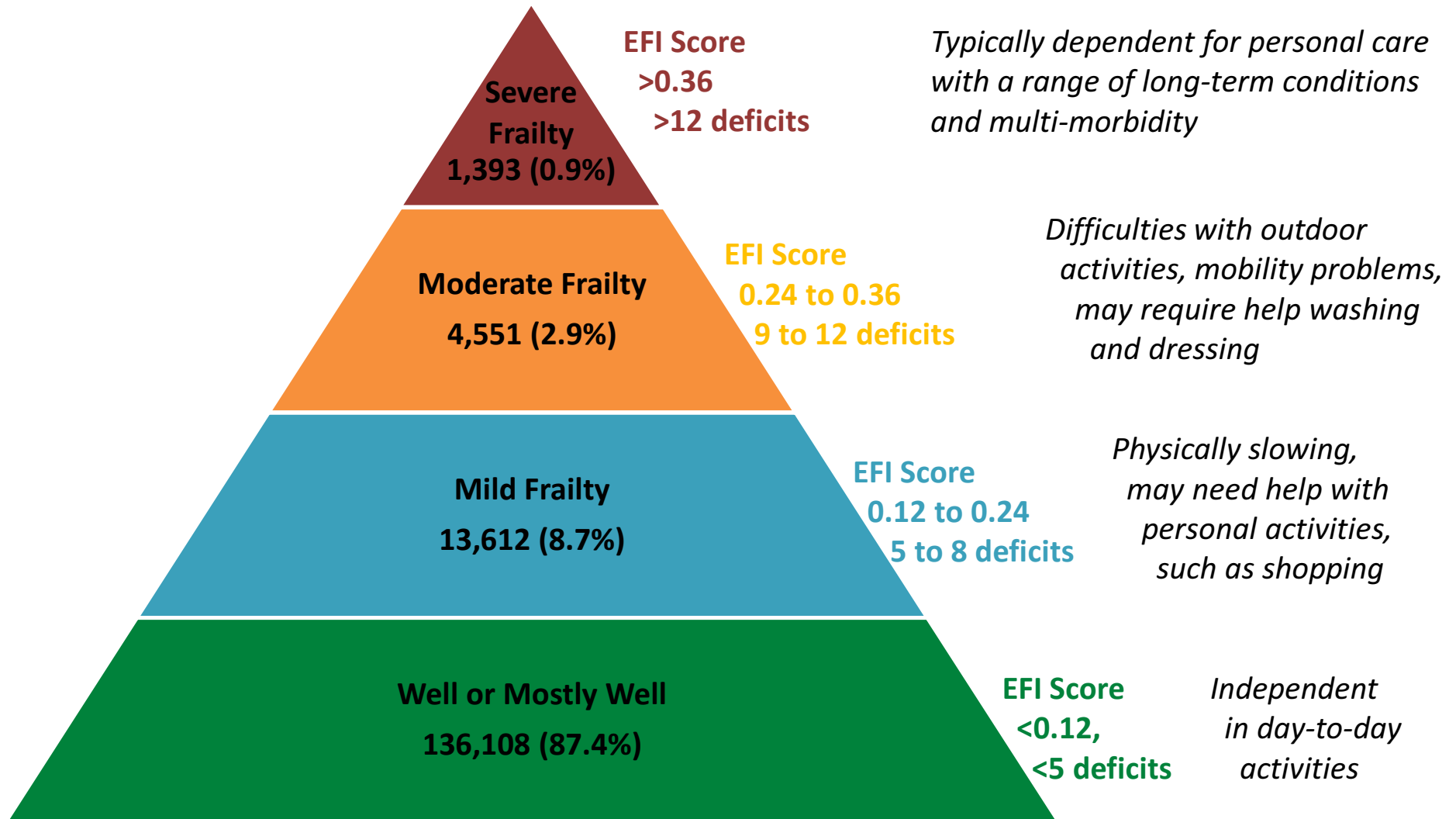


Integrated Care Exeter Risk Stratification Model

The Model



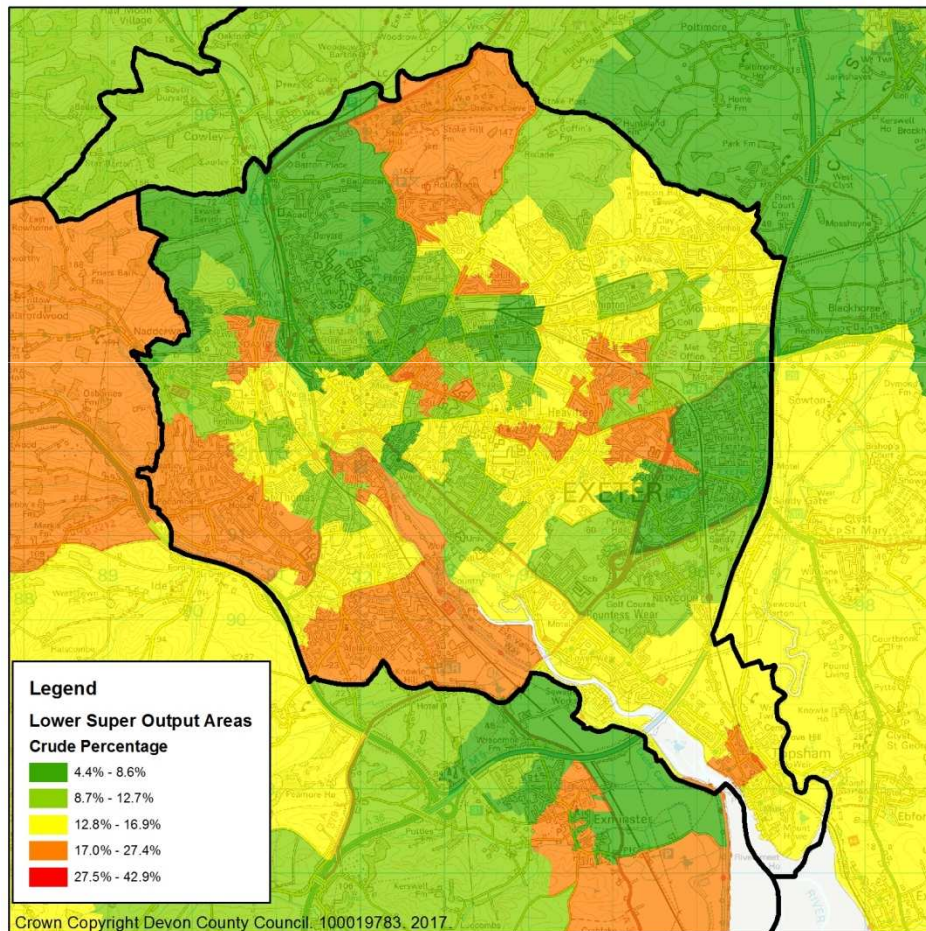
Frailty Profile



Frailty Maps

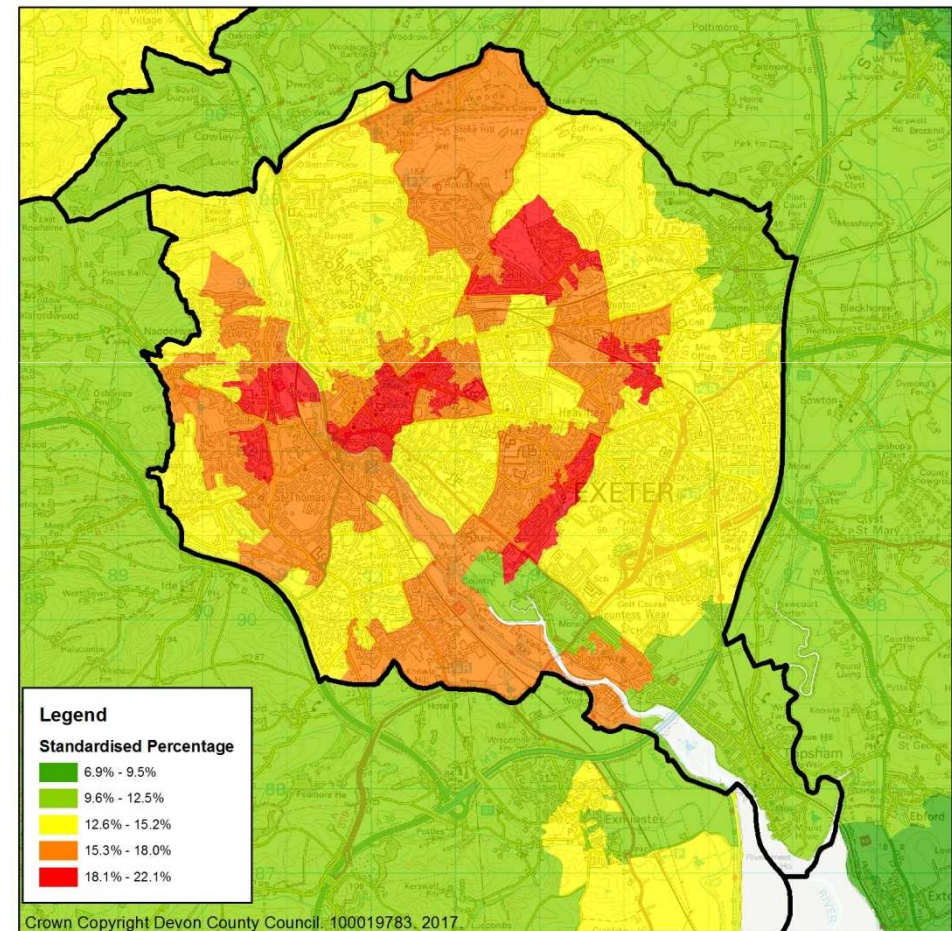
Crude Percentage

Highlights the overall percentage of population in any frailty category. Influenced by age, the location of care homes and deprivation.



Standardised Percentage

This rate is adjusted by age to reveal areas where the onset of frailty is earlier. Influenced by deprivation and proximity to services.



Main findings from ICE

1. Frailty is age-related but not inevitable
2. Considerable window of opportunity available through early detection
3. Deprivation and housing type a major predictor of frailty
4. Frailty is the strongest predictor of current and future activity and cost
5. Linked datasets have considerable potential

Next steps for risk stratification

- Publication/further analysis of Exeter work
- Space Syntax work: urban form and health
- Devon wide roll-out of linked data risk stratification model. Plan focused on:
 - Raising awareness across local system
 - Agreeing and establishing IG arrangements
 - Establishing data infrastructure and data flows
 - Establishing reporting arrangements
 - Establishing place-based and strategic applications of model

How can this model be used?

- At individual level, for prevention and early intervention due to detection at early stage
- At community level, to inform community development, targeting and service planning
- To understand system interdependencies
- To test, monitor, evaluate and adapt specific interventions to achieve cost savings
- More efficient/effective use of local intelligence
- Inform/underpin funding bids e.g. Sport England

Sport England Local Delivery Pilots

**NEW APPROACH
TO DELIVERING
PHYSICAL ACTIVITY LOCALLY**



LOCATIONS:

- RURAL PLACES
- SMALL TOWNS
- COASTAL COMMUNITIES
- BIG CITIES

£100 MILLION
of National Lottery money across 12 local pilots

113 APPLICATIONS

19 PROPOSALS SHORTLISTED

12 PLACES SELECTED

Location	Population
REDCAR & CLEVELAND AND MIDDLESBROUGH	274,800
PENNINE LANCASHIRE	532,500
BRADFORD	132,800
WITHERNEA	6,000
CALDERDALE	208,400
DONCASTER	304,800
GREATER MANCHESTER	2,756,200
BIRMINGHAM AND SOLIHULL	471,400
ESSEX	1,443,200
HACKNEY	269,000
SOUTHALL	71,200
GREATER EXETER	139,200

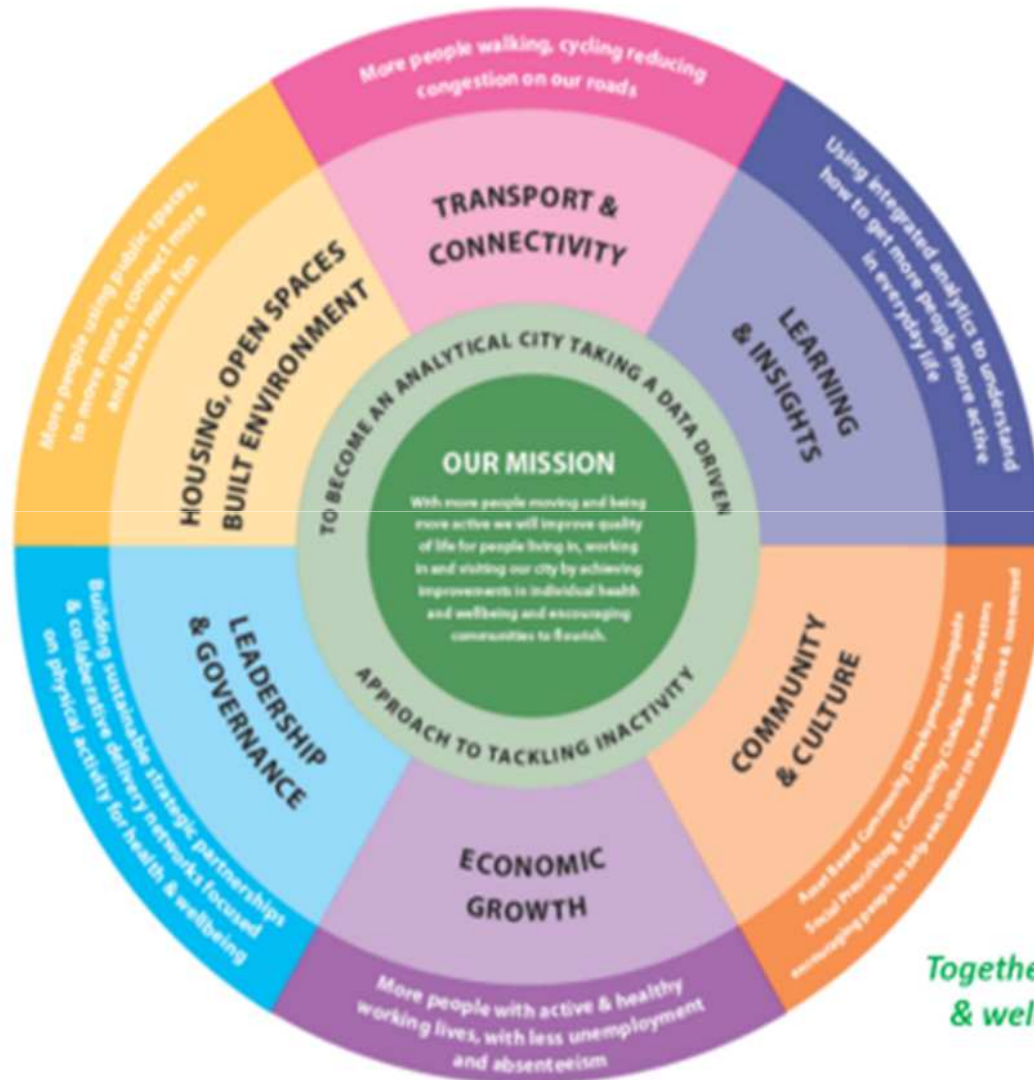
REACHING:

- PEOPLE FROM SOME ETHNIC MINORITIES
- DISABLED PEOPLE
- OLDER PEOPLE
- WOMEN
- PEOPLE ON LOWER INCOMES
- FAMILIES

**FOR HEALTHIER, happier communities
AND TO DISCOVER a blueprint for tackling inactivity locally**

➔ sportengland.org/localpilots

Exeter & Cranbrook



Tackling inactivity is key to helping address the challenges of *inclusive growth*

Our vision is that Exeter & Cranbrook are pioneering places for leading an active lifestyle, with Exeter the most active city in England and Cranbrook a model of best practice for families being active together.

Together we will achieve improvements in individual health & wellbeing and support new & existing communities to flourish

Exeter & Cranbrook OUTCOMES

- ***We will encourage 10,000 of our least active residents to lead regular active lifestyles***

BY.....

- Narrowing stubborn health inequality by encouraging those least likely to take part in activity to lead active lifestyles
- Improved inclusivity and sense of community connectivity and belonging,
- A reduction in congestion and improved air quality influenced by more people walking and cycling
- An embedded analytical approach, using integrated data to inform decisions and share learning.

Using integrated analytics to understand how to get more people more active in everyday life

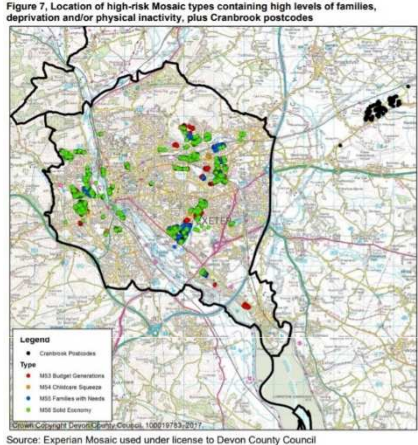
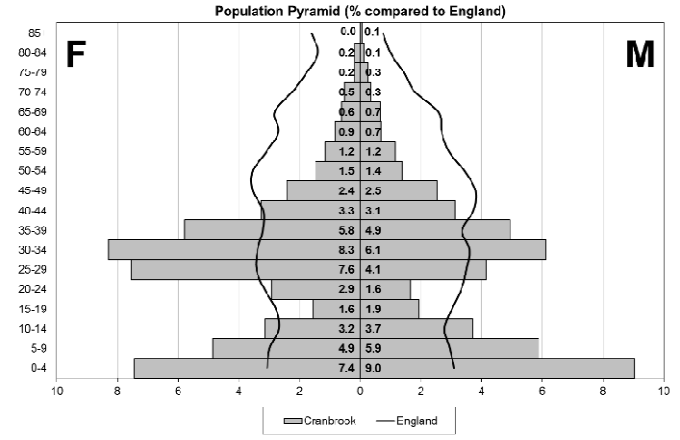
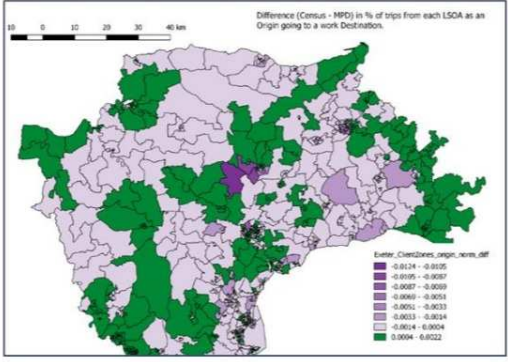
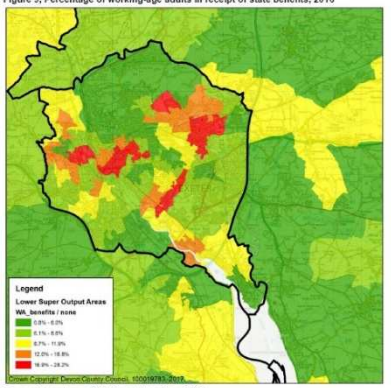
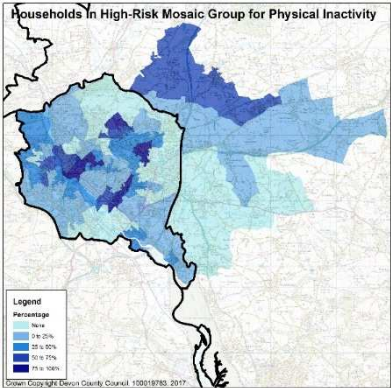
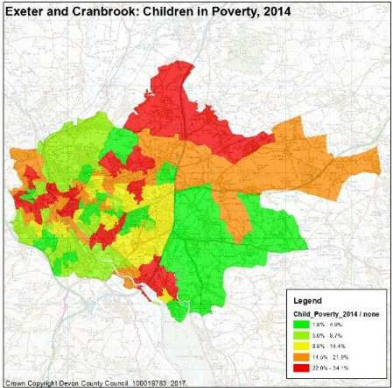


Figure 5: Identification of Walking and Cycling Potential



ANALYSIS: HEATMAPS

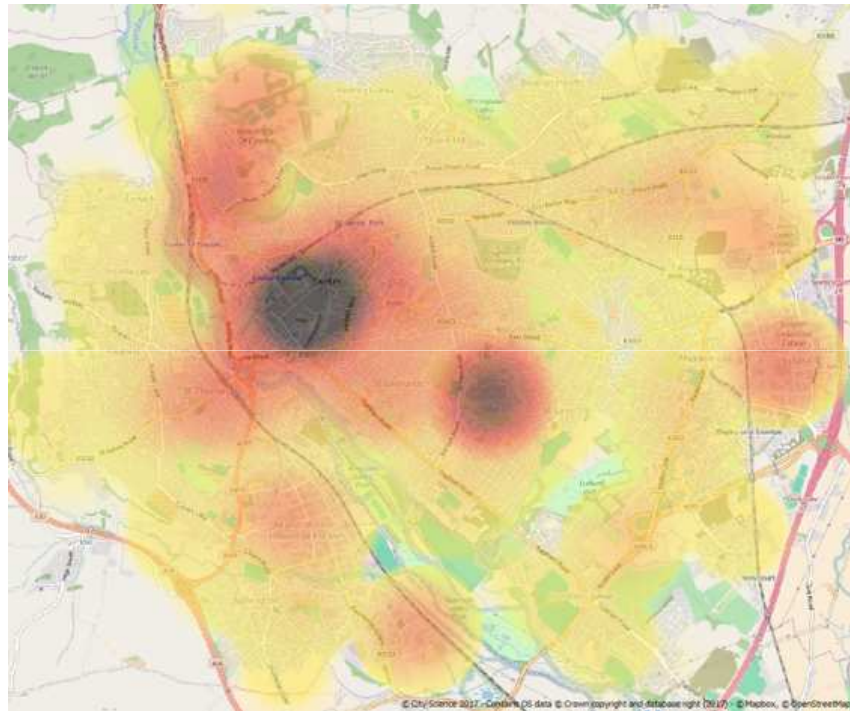


Figure 7: Walk Destinations

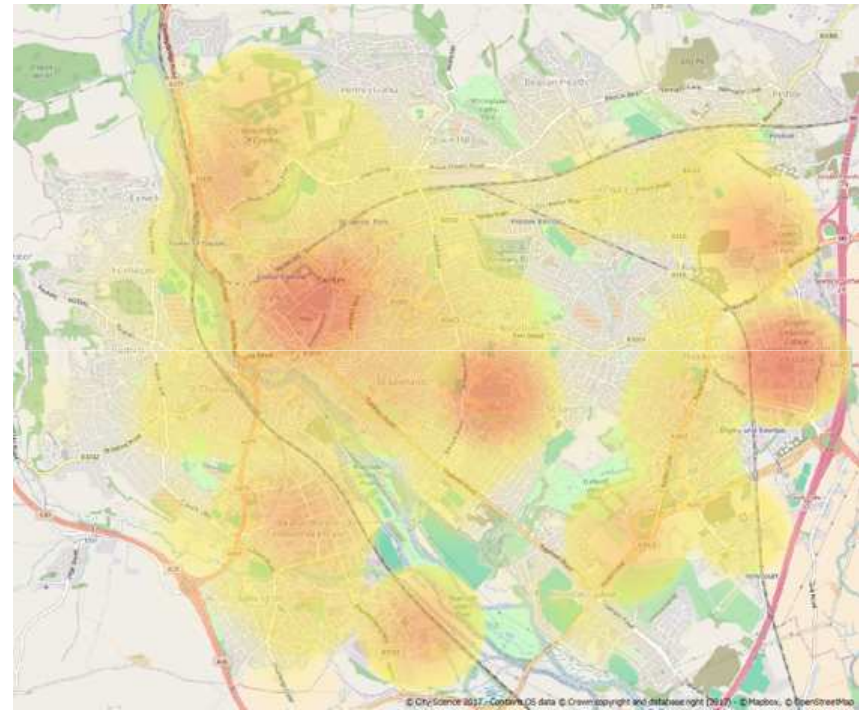


Figure 8: Cycle Destinations

Exeter & Cranbrook AUDIENCES

Our data has informed those populations in Exeter & Cranbrook we wish to target whom are the least active, and can provide the biggest impact for health outcomes:

- Working age adults on low incomes
- Pre-frail individuals, adults at risk of early onset of frailty
- Low Income Families in Exeter and Cranbrook
- People living within a 10 mile radius of Exeter who regularly commute to the city

WHAT NEXT?

- Use data and intelligence to stimulate further conversations with stakeholders, communities and residents to generate local insight to tackle inactivity
- Make informed decisions about where & when to target resource
- Work with partners to develop an evaluation and feedback framework that enables us to test at pace and scale
- Share our learning across key networks e.g. Sport England Local Delivery Pilots, NHS Healthy Towns

QUESTIONS FOR DISCUSSION

- What, if anything, was a surprise or unexpected in the health overview?
- Is information like this helpful to you in your role as Councillor? If so, how do you think you might be able to use it?
- What areas should the ESB focus on for 2018 and why?