Island Strategic Partnership

Joint Strategic Needs Assessment (JSNA) 2009

Evidence Paper

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Introduction

The JSNA is an overview of current and future health and wellbeing needs of Isle of Wight residents. It forms the foundation for commissioning health and social care services that best meet residents needs and reduces inequalities. There is a statutory responsibility to produce a JSNA, not as a one-off but continually updated to inform the various planning cycles.

The requirement for JSNA was created in the Local Government and Public Investment in Health Act (section 116) and described in the draft statutory guidance Creating Strong, Safe and Prosperous Communities,

Community engagement is an essential element of JSNA – engaging with communities includes understanding whether services have delivered what was expected and whether service users have had their needs met. There is also a key link to Local Area Agreements and informing Sustainable Community Strategies.

There needs to be stakeholder involvement in undertaking JSNA.

Directors of Public Health, Adult and Community Services and Children and Young People's Services must now undertake regular strategic needs assessment of the health and well-being status of the population of the IW.

Background and Context

The first Joint Strategic Needs Assessment for the IW was produced in October 2008 and consisted of several interrelated documents. These are:

- The Isle of Wight Public Health Annual Report 2008
- The 'Health of the Isle of Wight' Public Health Information Compendium 2007
- The Dr Foster 'Trailblazer' report 'Isle of Wight JSNA Analysis'
- The Isle of Wight Council Housing Strategy 2007 - 2012
- The Leisure-Net Leisure Needs Analysis report
- The IW Council's Children and Young People's Plan Year 2 Review
- The IW Council's Children's Services Directorate Service Plan 2008/2009

This 2009 JSNA references the 2008 JSNA and identifies the information gaps and updates and revises conclusions to be drawn from both the 2008 JSNA and data (mainly the 'JSNA core dataset') compiled for 2009.

1. The Population of the Isle of Wight

1.1 Demographics

1.1.1 The 2001 resident population of the Isle of Wight was 132,731 with a 48:52 male/female split. This represented 1.7% of the population of the SE region. Mid-year estimates (MYEs) published by the Office for National Statistics indicate a population of 139,482 in 2007 – a 5.1% growth on 2001. The projected population of the IW for 2009 is 142,500.

1.2 The Island's population is not ethnically diverse with only 1,763 persons of non-white background recorded by the Census. This represents 1.3% of the population as against 4.9% for the SE and 8.7% across England and Wales. The ethnic minority population is mainly concentrated in Ryde and within the prison population in Parkhurst ward.

1.2 Population Change

1.2.1 The Island's population grew by 6.6% in the 1980s (1981 – 1991) with a slightly lower rate of growth in the 1990s of 5.6%, although total population actually fell between 1990 – 1993 by 1.1%. Since 1998 the population has grown consistently, at a rate of 1.3% per annum.

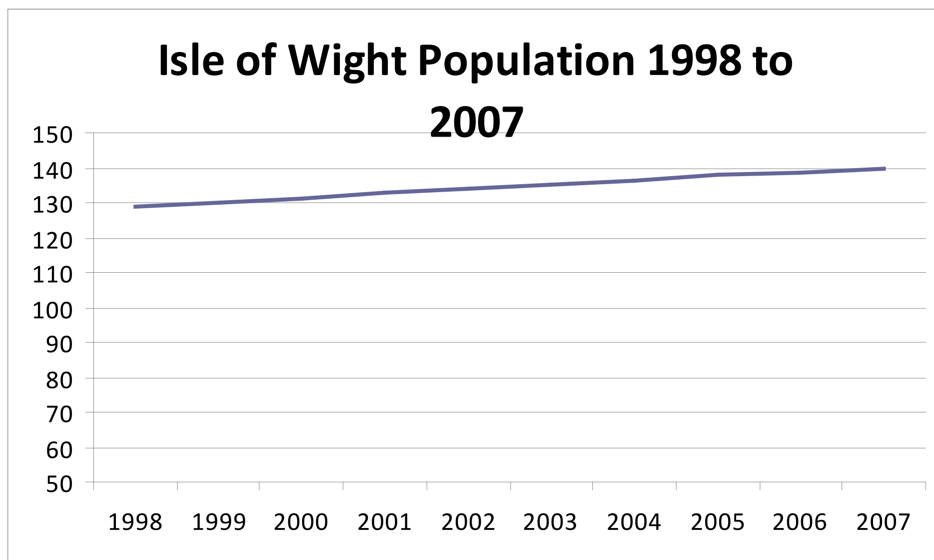


Figure 1.2.1 : Isle of Wight Population (Ref 10008)

1.2.2 Population growth on the Island has largely been driven by in-migration, in the main from other parts of the UK. Indeed as, shown in figure 1.2.2. below, natural change (the result of subtracting deaths from births) has consistently been negative, i.e. deaths have exceeded births by an average of 600 over the past decade

1.2.3 Overall, the Island's population has grown over the last decade by 9.6% between 1999 and 2009 which is above regional (5.2%) and national (4.1%) growth rates. This rate of growth is slowing when compared with 1995 – 2005 when the growth rate was 10.9%.

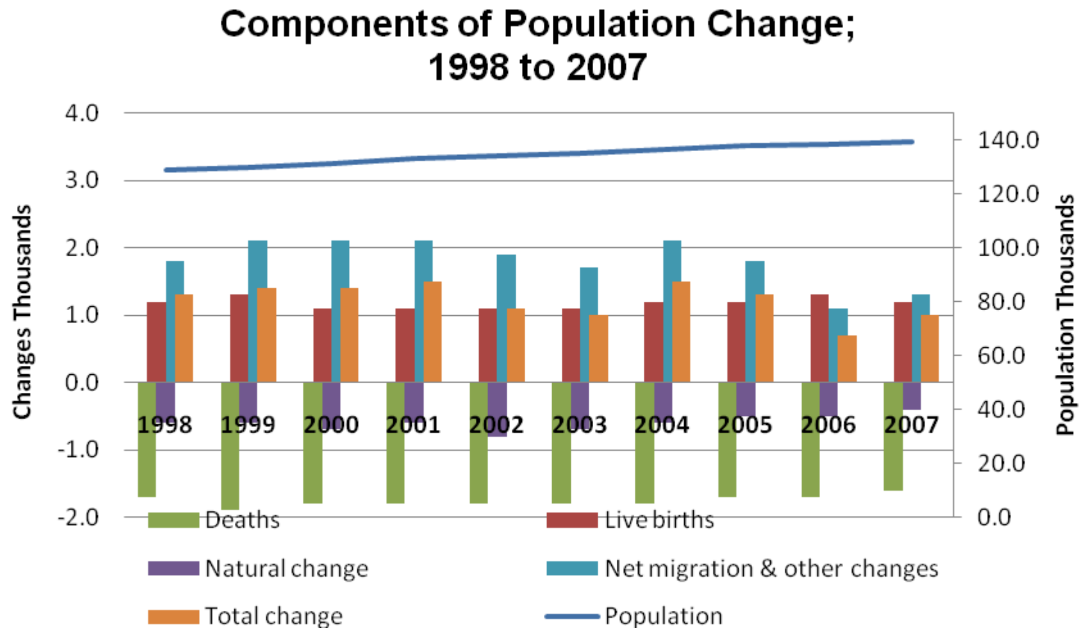


Figure 1.2.2 : Population Growth on the IW. (Ref 10007)

1.3 Age Structure

1.3.1 The Island has an older population structure than average with an above average proportion of the population in the 55+ cohorts compared to the regional profile and a below average proportion in each cohort below this. There is a particularly low proportion aged between 20 – 34.

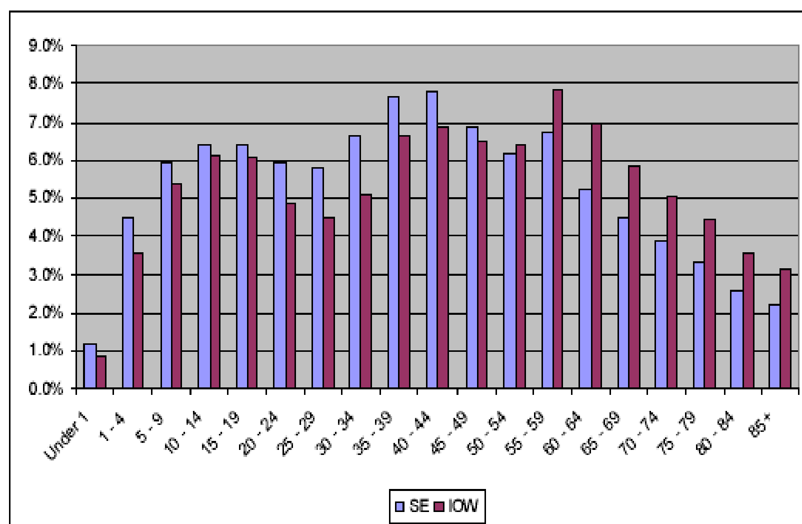


Figure 1.3.1 : Age structure of the IW Population (Ref A)

1.3.2 An alternative pyramid graph of population of the IW in 2009 (figure 1.3.2 below) also shows an above national average population for all ages above 50, and a significant variance in the age bands 20 to 39. Between 20 and 30 marginally more females than males appear to be pursuing education and employment on the mainland. From age 40 onwards females make a greater than male contribution to each age group.

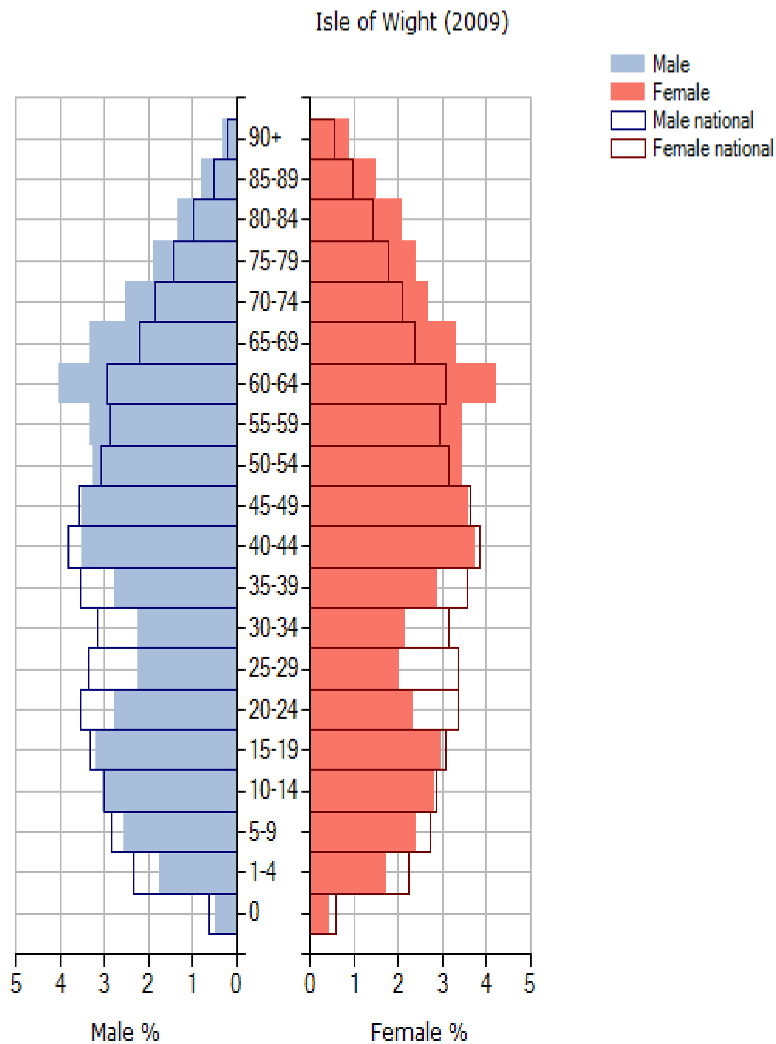


Figure 1.3.2 : Age structure of the IW compared to the national structure (Ref 10004)

1.3.3 A working-age population (15 – 59/64) of 76,800 represents 54.8% of the Island's total population. This compares with 60.1% across the South East region. More than 1 in 5 of the Island's population is aged over 65.

Age Band	0 - 14	15 - 64	65+
Isle of Wight	15.9%	61.8%	22.1%
South East	18.0%	65.4%	16.6%
England and Wales	18.0%	66.0%	16.1%

1.3.4 Population growth over the past 10 years was mainly seen in the working-age population. Between 1995 – 2005 the school-age population grew by 3%, the working-age population by 16% and the retirement age population by 6%. This can be related to strong growth in employment. As a result, the working-age population increased in proportion at the expense of the populations of school and retirement age. .

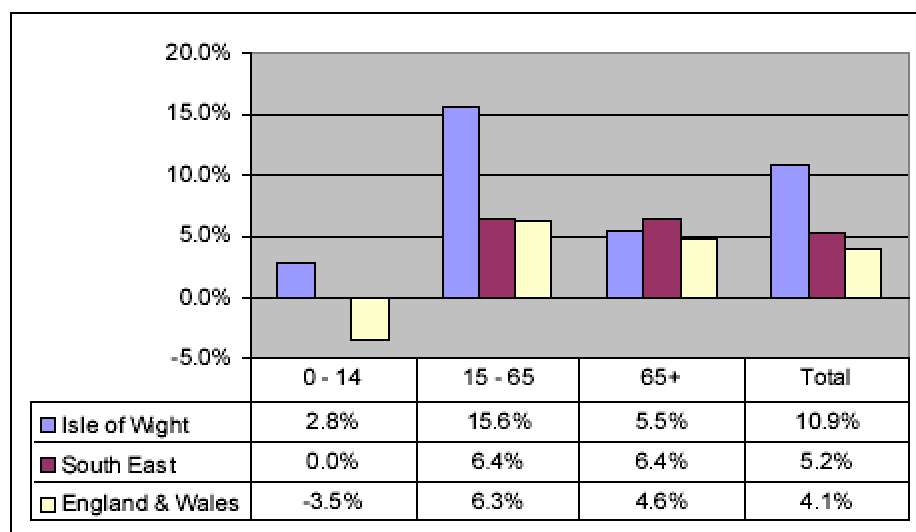


Figure 1.3.3 : Changes in population composition on the IW (Ref A)

1.3.5 Subsequently – between 2002 and 2007 (figure 1.3.4) the proportional growth in working age population reached a plateau and declined slightly in 2007 whilst growing in absolute terms by 2,900. Proportionately the child cohort is declining both absolutely and proportionally – by 600, -1.2% – respectively. Whilst the pensioner population maintains its upward growth increasing over the five years covered in the table by 1.3% as a proportion of the total population or 3,200 people.

Population by Age Bands 2002 to 2007 as a percentage of Total Population							
	All ages	Children 0-15		Working Age16-64M/59F		Pensioners 65M/60F and over	
	n/1000	n/1000	%	n/1000	%	n/1000	%
2002	134.1	24.1	18.0%	75.9	56.6%	34.0	25.4%
2003	135.1	24.0	17.8%	76.6	56.7%	34.5	25.5%
2004	136.5	24.1	17.7%	77.4	56.7%	35.1	25.7%
2005	137.9	23.9	17.3%	78.2	56.7%	35.8	26.0%
2006	138.5	23.8	17.2%	78.5	56.7%	36.2	26.1%
2007	139.5	23.5	16.8%	78.8	56.5%	37.2	26.7%

Figure 1.3.4 : Population cohort change (ONS mid year estimates)

1.4 Future Population

1.4.1 To assess future population we have drawn upon two sources – national trend-based population projections, and an economic-led projection developed by Experian Business Strategies (2006).

1.4.2 In 2006 the Office for National Statistics (ONS) published sub-national trend-based population projections. These project births, deaths and migration based upon observed age-specific trends over the previous five years (2000 – 2004). They do not take account of policy changes or economic performance, but provide a consistent baseline nationally.

1.4.3 the IW population is projected to grow 22% between 2009 and 2031, faster than in England or the South East

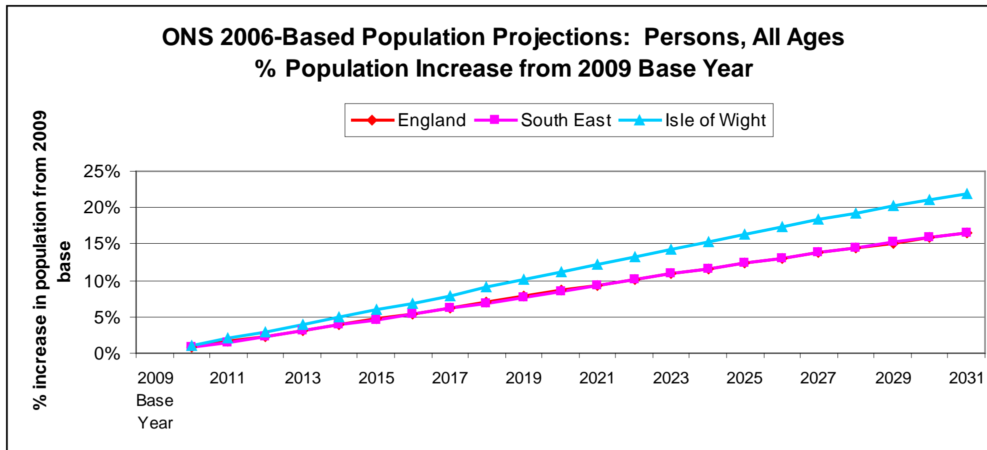


Figure 1.4.1 : ONS Population Projections (Ref G)

1.5 Population Growth by Age Cohort

1.5.1 As the figure below indicates, over the next decade the 45-54 and 65-74 cohorts are expected to increase significantly as a proportion of the total population. The corollary of this is decline in the population aged under 20 and between 35-44. The population in their 20s, which is key to new household formation, is expected to remain relatively consistent as a proportion of the total population.

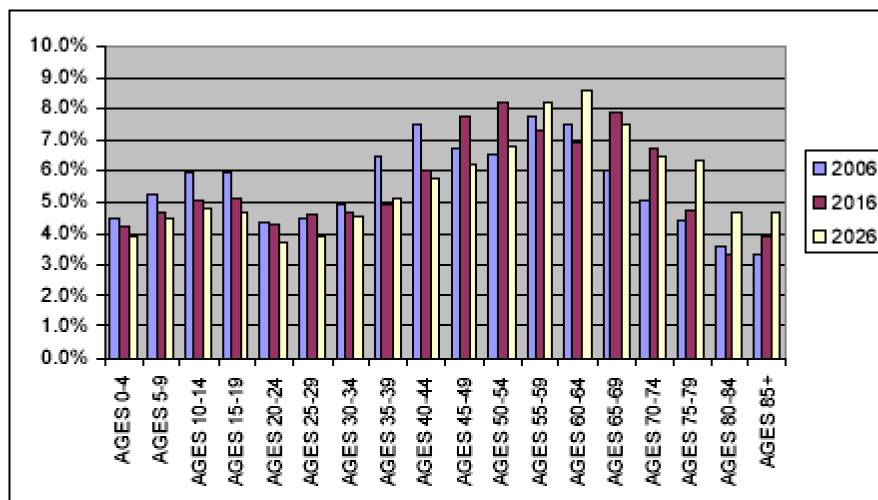


Figure 1.5.1: Projected Population by Age Cohort (Ref A)

1.5.2 In the subsequent decade, from 2006-26, the projections indicate contraction in proportion of the population in all age groups under 50, with strong growth in the population aged 55- 64 and over 75.

1.5.3 The 65 plus population is expected to grow significantly in the decade 2009-2019, illustrated in the graph below: please see section 6.1 where this is covered in more detail

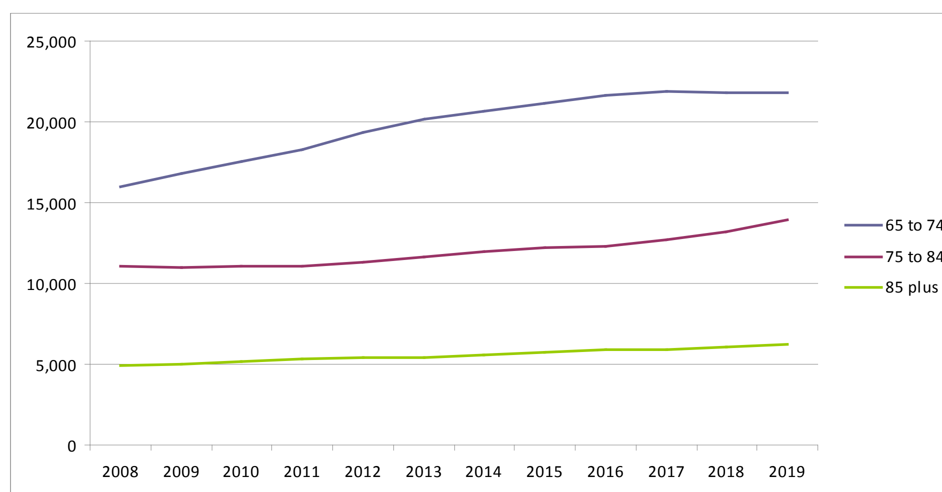


Figure 1.5.2 : 65 plus Population Projection 2008 to 2019 (Ref 10003)

1.6 Household Characteristics

1.6.1 According to the 2001 Census the Isle of Wight contained 57,519 households, with an household size of 2.31. This was below regional (2.48) and national (2.40) levels. The Housing Strategy Statistical Appendix (HSSA) returns, based upon completions and council tax records, indicate 64,816 households live on the Island in 2006.

1.6.2 The Island saw a 10.2% increase in households between 1991 – 2001 (Figure 4.11) – a more significant growth than across the region or country.

	1991 Households	2001 Households	% Increase
Isle of Wight	51652	57,519	10.2%
South East	2,985,444	3,287,488	9.2%
England/Wales	19,997,655	21,660,475	7.7%

1.6.3 DCLG publishes annual household estimates, with the latest available for 2006. Figure 1.6.1 plots household growth predictions 1981 - 2006. It indicates that growth on the Island has broadly tracked the regional picture over the longer-term; Figure 1.6.4 indicates that the greater growth since 2001 will be sustained, indeed the gap may well widen.

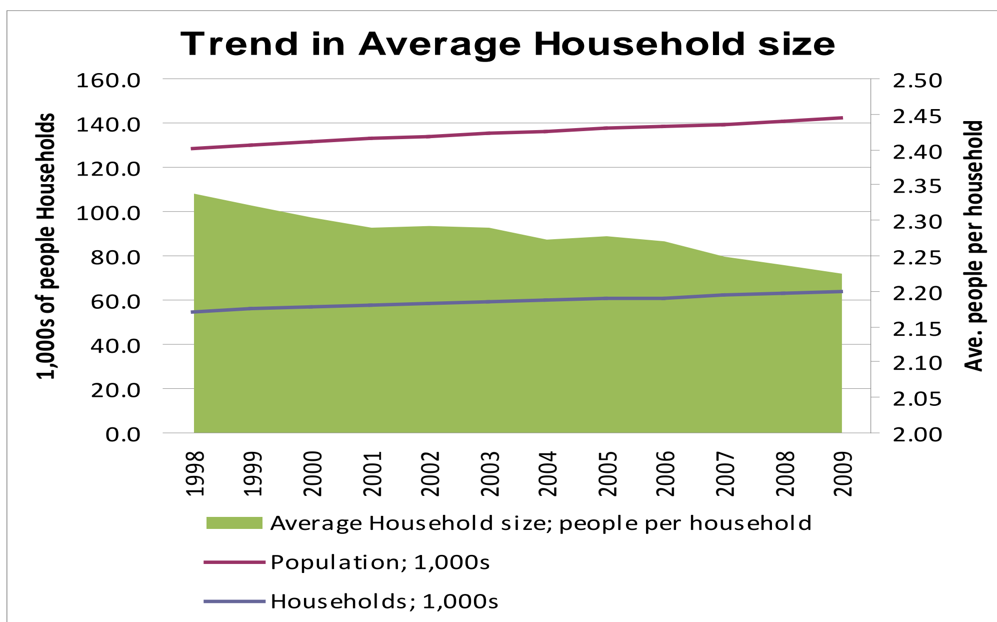


Figure 1.6.1 : Trend in average household sizes *Data sourced from ONS (population) and DCLA (household count), uses both estimated and projected data from these sources. Household formation is occurring faster than population growth, so whilst both are increasing the average size of families is in a slow decline*

1.6.4 Household sizes are falling as a result of broader demographic trends – people are living longer, are marrying and having children later, and the divorce rate is increasing. This is helping to stimulate housing demand and means that even in areas where the population is static; there is demand for additional housing.

1.6.5 The Census provides a profile of household composition. It indicates a higher proportion of pensioner households on the Island, and lower proportion of family households with dependent children compared to the South East and England and Wales profiles. The level of one person households is marginally above the national average and notably (2.8%) above the GOSE average.

	Isle of Wight	South East	England & Wales
All Households	57519	3287489	21660475
One Person Households	31.38	28.51	30.02
Couple No Dependents	38.96	37.86	36.06
Households with Dependents	26.00	29.19	29.49
Other Households	3.67	4.43	4.42
Pensioner Households	31.52	24.56	23.81

Figure 1.6.2 : Household Composition, total population and household types expressed as percentages of the total

1.6.6 Trend based household projections published by the DCLG indicate household growth of 16% over the next decade compared to 11% across the region and 10% nationally. This compares to 13.2% household growth on the Island over the previous decade (1994 – 04). Total households are projected to increase from 63,000 in 2006 to 79,000 in 2021.

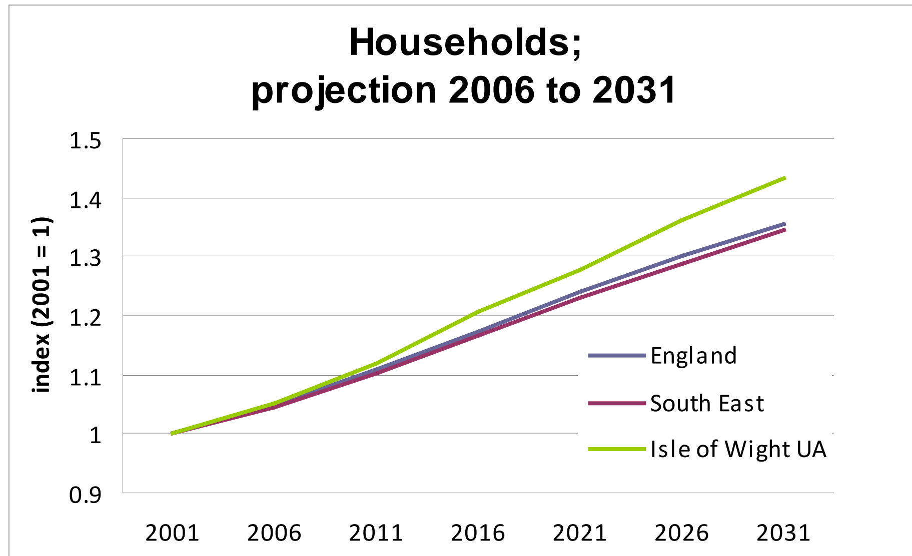


Figure 1.6.4 : Households; Projection 2006 – 2031 (Ref 10601)

1.7 Key Messages

The Island's population has grown strongly, at a rate of 1.3 per cent per annum since 1998, driven by in-migration. Growth is strongest in the 40+ age groups, and especially in the 65+ age groups and the post-war 'baby boomers' move into this age range.
Continued strong population growth of 11 per cent is expected over the next decade, according to both trend-based and economic-led projections. Household projections indicate growth of 16 per cent to 2016 reflecting growth in the population and continuing trends towards smaller households.
The Island has an older population structure than average with a high proportion in each cohort over 55. A low proportion of the population is aged 20 to 34. Related to this, there is an above average proportion of pensioner households and lower proportions of resident families with children. Average household size is therefore below regional and national benchmarks.
If sustained, the absolute decline in child numbers will present in the medium-term over capacity problems for education, and longer-term challenges retaining and replenishing the labour force.

2. Social and Environmental Context

2.1 Deprivation

2.1.1 The South East region has the lowest proportion of population living in the UK's most deprived areas. However the Isle of Wight falls within the 40% most deprived local authorities in England, ranked 134th from 354, according to the 2007 Indecies of Multiple Deprivation (IMD2007). It is within the most deprived quartile of local authorities in the South East region. From the 354 local authorities nationally, the Island is ranked 101st for Income deprivation and 108th for Employment deprivation.

2.1.2 The IMD2007 uses a range of indicators to assess the existence of multiple deprivation at a local level, categorising deprivation for LSOAs. The Isle of Wight contains 89 LSOAs, none of which are in the most deprived 10% of areas nationally but six of which are in the 10 – 20% most deprived covering parts of Ryde, Newport and Ventnor (Figure 2.1).

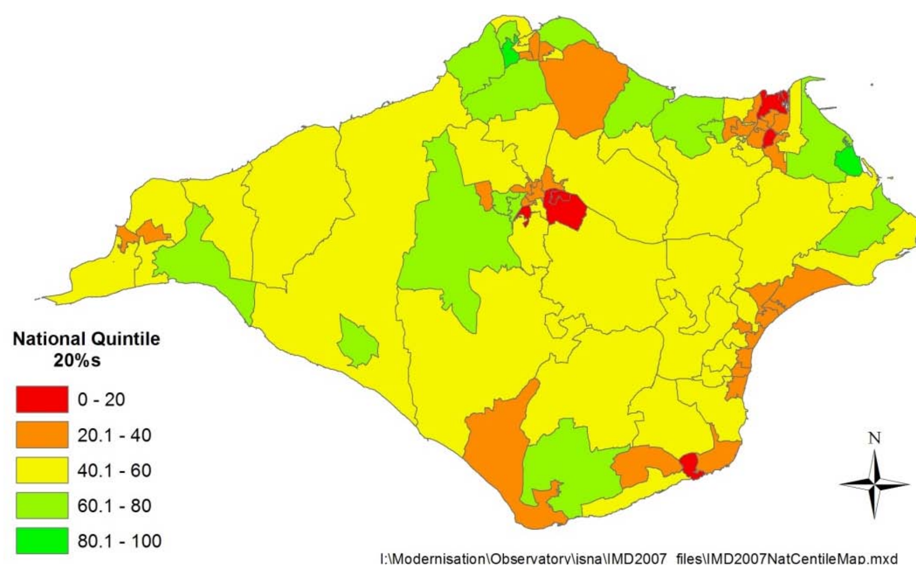


Figure 2.1 1: Indices of Multiple Deprivation 2007 (Ref 11305)

2.1.3 Deprivation on the Island is particularly noted in: Income, Employment and Education and Skills domains together with Barriers to Housing and Services, and the Living Environment. Crime and Disorder, and Health and Disability make a relatively small contribution to overall deprivation on the Island.

2.1.4 Whilst Employment, Living Environment and Income Deprivation are greatest in extent, deprivation is most severe in terms of Barriers to Housing and Services (with 8 LSOAs in the top 10%) and the Living Environment (5 SOAs in the top 10%). These represent severe concentrations of physical deprivation.

2.1.5 An analysis of deprivation by individual domain reveals:

- Deprivation at the 20 – 40% level is concentrated in the main urban areas – Parts of Ryde, SE Newport, East Ventnor. Parts of Newport, Sandown, East and West Cowes, West Ventnor; and Niton and Chale is the rural area that falls within the 20 – 40% most deprived areas
- Housing deprivation is focused in the more rural parts of the Island, with parts of Rural West Wight and Rural South Wight, Ventnor West, the Parkhurst area and Yarmouth/Norton falling in the 20% most deprived areas
- Income and Employment deprivation are most severe in the main urban, (particularly coastal urban,) areas of Ryde, Sandown/Shanklin, SE Newport, East Cowes/Osborne and Ventnor. This is most extensive in Ryde and the Bay Area.

- Poor living environments (most deprived 20%) are concentrated in parts of the urban areas of Ryde, SE Newport, and Central Cowes (East and West), Sandown/Shankin and Ventnor.
- No parts of the Island fall within the most deprived 20% areas against the Crime and Disorder, or Health and Disability domains. Parts of Freshwater/Afton, SE Newport, Sandown/Shankin and Ryde are within the 30-40% most deprived for the Crime domain. Parts of Ryde, Newport, Freshwater, Osbourne, Sandown/Shanklin and Ventnor are within the 20 – 40% most health deprived areas with the greatest concentration of SOAs in Newport and Ryde.

2.1.6 Figure 2.1 summarises the deprivation position island-wide. Underlying the multiple index, the individual indices indicate that 40% of the Island's LSOAs are in 30% most Employment deprived, 35% are in the 30% most Income deprived, and 35% are in the 30% worst living environments nationally.

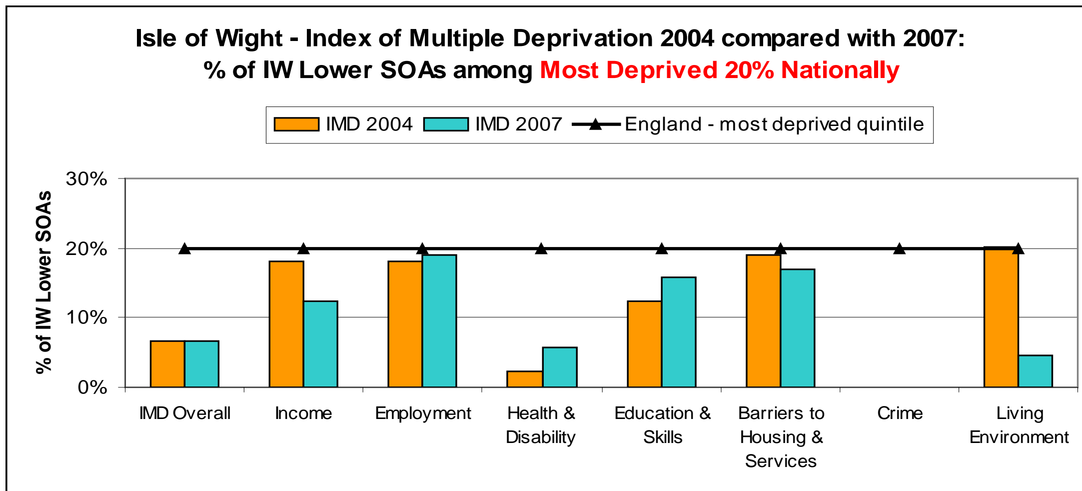


Figure 2.1.2 : Deprivation : IMD 2004 and 2007 by lower super output area : % of IW lower SOAs in most deprived 20% nationally. (Ref G)

2.1.7 Proportionately fewer IW lower super output areas are among the 20% most deprived areas in England, with no change overall between 2004 – 2007.

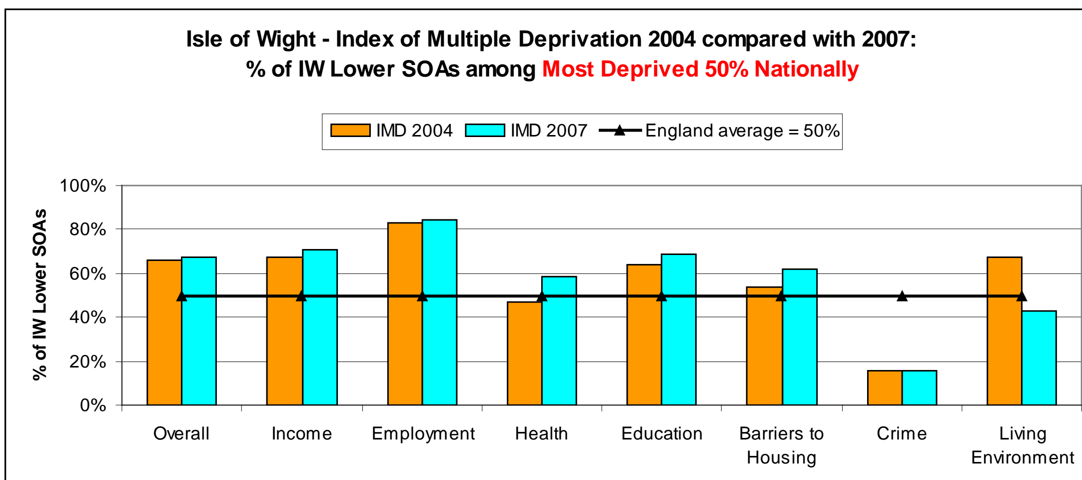


Figure 2.1.3: Deprivation : IMD 2004 and 2007 by lower super output area : % of IW lower super output areas in most deprived 50% nationally (Ref G)

2.1.8 Proportionately more IW super output areas are more deprived than the England average, with a slight increase overall between 2004 – 2007

2.1.9 There is a range of research which demonstrates a clear link between socio-economic factors and health. The 1998 Independent Inquiry into Inequalities in Health report concluded that: "the weight of scientific evidence supports a socio-economic explanation of health inequalities. This traces the roots of ill health to such determinants as income, education and employment as well as material environment and lifestyle".

2.1.10 The 2009 Department of Health 'Health Profile 2009: Isle of Wight' Island indicate that it performs significantly worse than the England average against: GCSE attainment, violent crime, smoking in pregnancy, physically active children and incapacity benefits for mental illness. It performs significantly better than average in relation to statutory homelessness, breast feeding initiation, teenage pregnancy, adult smokers, over 65's 'not in good health' hospital stays for alcohol related harm, drug misuse, male and female life expectancy, infant deaths, deaths from smoking, and early deaths from cancer.

2.1.11 GDHI (Gross Domestic Household Income) is a composite measure that includes un-earned income; benefits, share dividends, interest, rents etc., as well as wages. Consequentially the (declared) income of the comparatively wealthy will tend to skew the figures upwards. The Island by this measure is third from the bottom in figure 2.1.4 comparing us to the rest of the LAs in the GOSE (Government Office South East) area, and significantly below the national average (Indexed on the graph at 100).

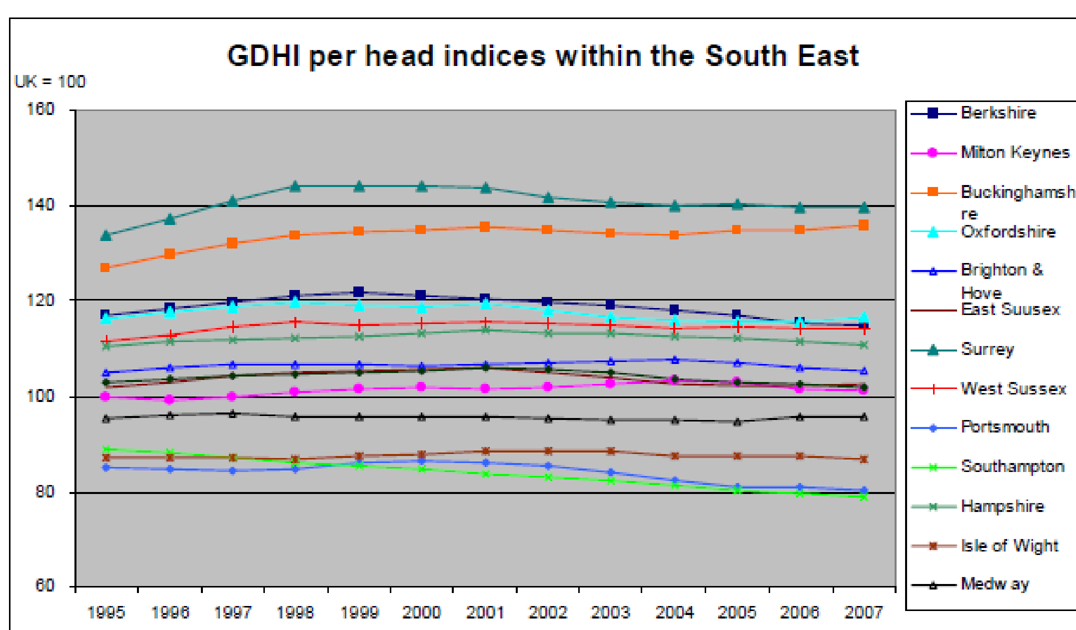


Figure 2.1.4 : GDHI Indices per head indices within the South East (Ref G)

2.2 Life Expectancy

2.2.1 Life expectancy on the Isle of Wight is higher than the England average and rising steadily. In 2003 it stood at 81.8 years for women and 77.4 years for men, in each case about one percentage point above the England average. However there are noticeable spatial differentials: life expectancy in the lowest fifth of Isle of Wight wards is 77.1 years, 5.1 years less than those in the highest fifth. See also section 3.1 to 3.3.

2.3 Unemployment

2.3.1. Due to the recession between April 2008 and April 2009 the JSA (Job Seekers Allowance) figures doubled from 1579 to 3224; further growth in unemployment can be expected. Prior to this, between 2000 and August 2008 the Islands employment had improved both absolutely and relative to the regional trends

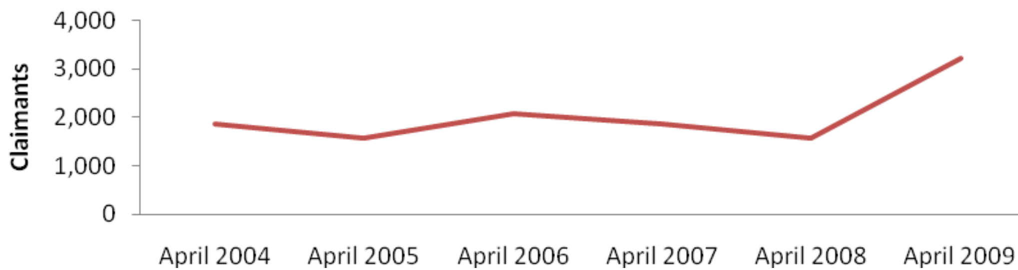


Figure 2:3.1 : Overall Employment Rate (working age)(%) 2007-08 (Ref 001401)

Unemployment (JSA) Claimants July 2008 - July 2009 in English Seaside Locations

Parliamentary area (seaside town)	July 2008 (number)	July 2008 (rate)	July 2009 (number)	July 2009 (rate)	Annual rate growth	Annual per cent growth
Bournemouth East	852	1.7	1,960	4	2.3	130
Weston-Super-Mare	973	1.6	2,164	3.5	1.9	122
South Dorset (Weymouth)	656	1.2	1,398	2.6	1.4	113
Isle of Wight	**1,417**	**1.8**	**2,995**	**3.8**	**2**	**111**
Bridgwater (Minehead)	894	1.6	1,875	3.3	1.7	110
Bognor Regis & Littlehampton	958	1.9	1,942	3.9	2	103
North Cornwall (Newquay)	861	1.3	1,707	2.5	1.2	98
North Devon (Ilfracombe)	694	1.2	1,294	2.3	1.1	86
Bexhill and Battle	755	1.6	1,405	3	1.4	86
Southport	1,114	2.2	2,042	3.9	1.7	83
Rochford & Southend East	1,849	3.3	3,323	5.9	2.6	80
United Kingdom	0.8 M	2.3	1.6 M	4.2	1.9	81

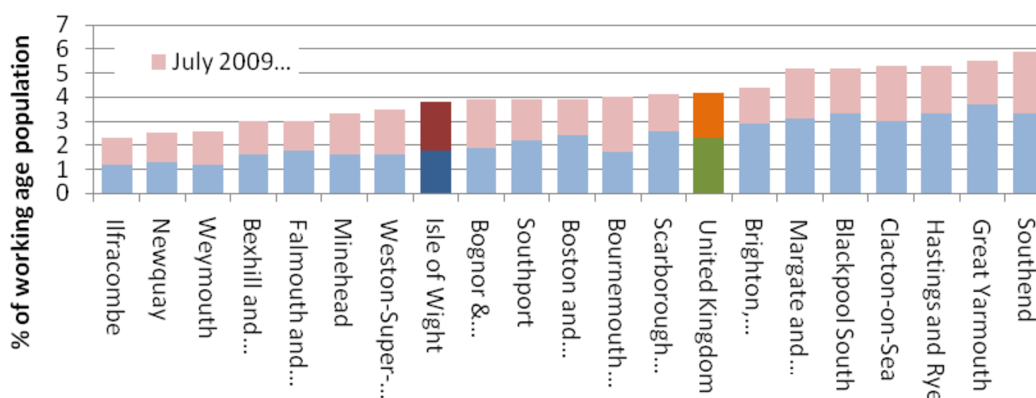


Figure 2.3.2: JSA Claimant growth July 2008 – July 2009, ONS unemployment statistics – not seasonally adjusted. (Ref 01404 and TUC)

2.3.2 Unemployment as measured by JSA claimants has risen over the year by 111%, from 1.8% (July 2008) to 3.8% (July 2009) of the working age population. The Island remains slightly below the national average of 4.2%, but growth in unemployment was 30% higher over the year.

2.3.3 Working age benefit claimants describes the group of people between 16 and 65 male and 16 and 59 females whom are claiming any sort of benefit – not just the 'out of work' benefits. These 'out of work' benefits are; Job seekers allowance, Incapacity benefits, Lone parents and 'Other benefits'. Of these the jobseekers figures are most volatile and are subject to both acute shocks such as the recession, and structural change in the nature of employment as may be the medium to long term consequence of the recession, or the long term move from manufacturing to a more service (saliently on the Island, tourism and care provision) and financial services focused economy.

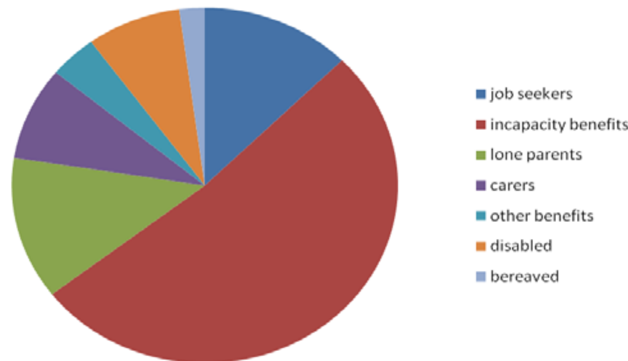


Figure 2.3.3 : Working age benefit claimants

2.3.4 Currently incapacity benefits claimants are the largest, and arguably, quite the most static group. Prior to the recession the reduction of this group's size was the focus of government initiatives to encourage them into employment. The not out of work benefits; carers allowance, disabled living allowance and bereaved (widows) are designed to assist people with their lives despite adverse circumstances.

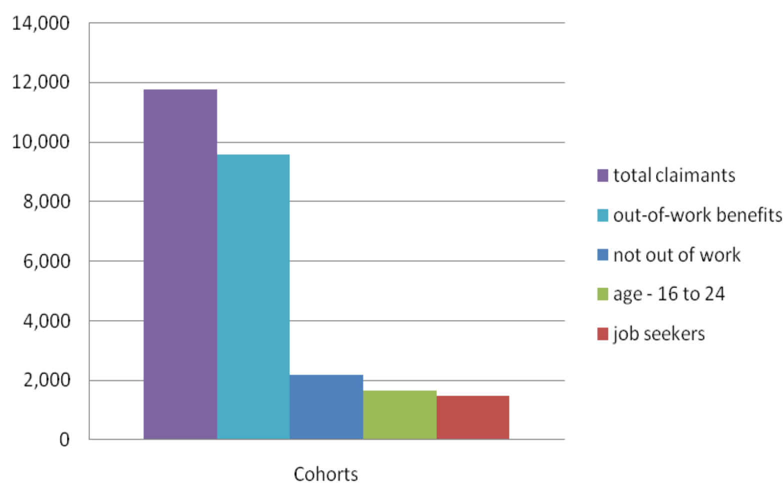


Figure 2.3.4 Working age people on benefits

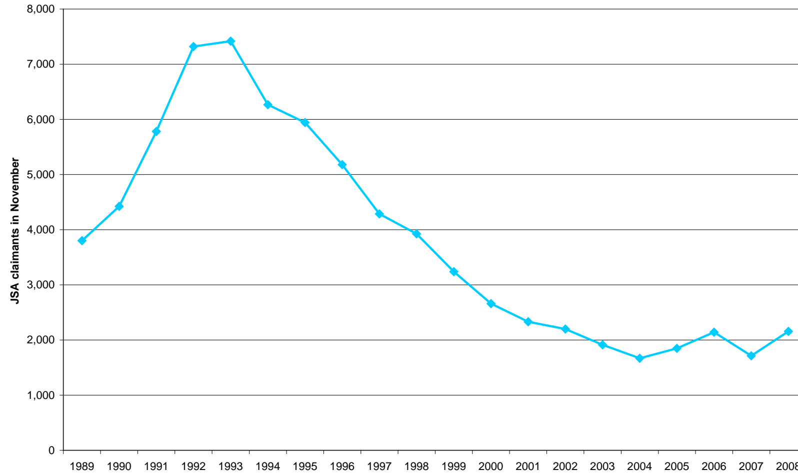


Figure 2.3.5 : Economics : Job seeker's Allowance: trends in November claimants as a guide to future trends

2.3.5 IW unemployment is starting to increase but while there was high unemployment during the last recession ion 1991-93 it started from a higher level compared with the current situation. The IW's current unemployment rate is close to the UK rate, whereas it was comparatively higher in the 1990's

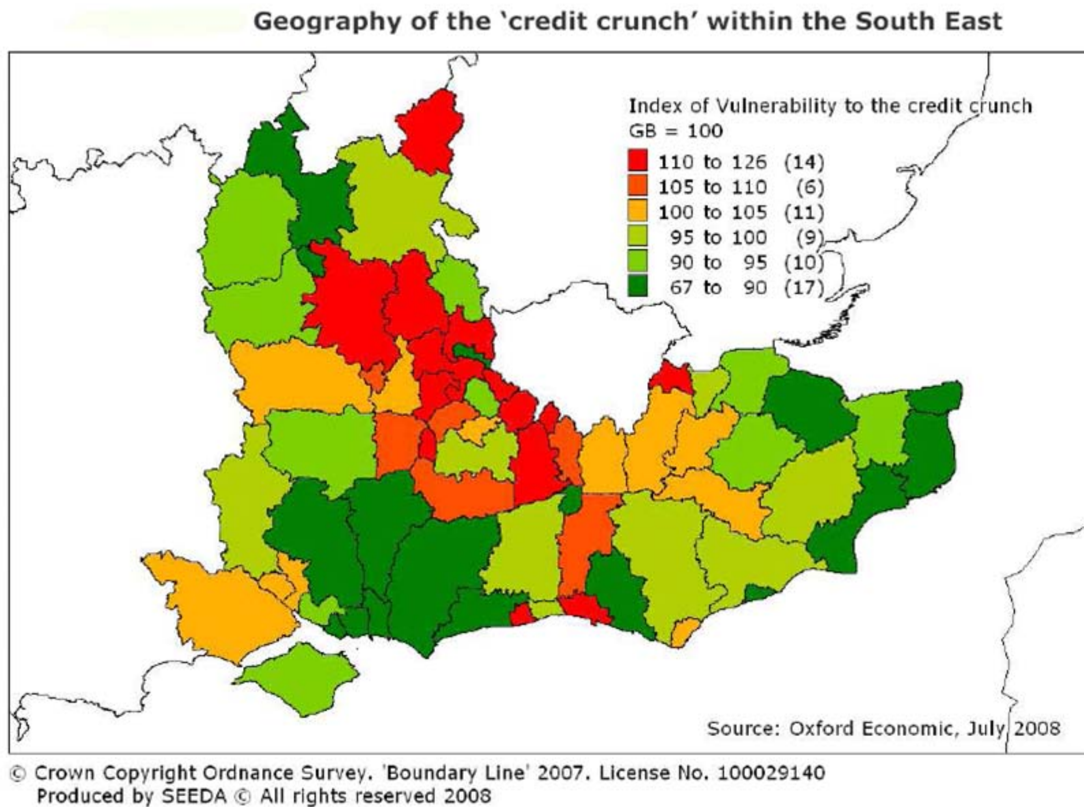


Figure 2.3.6 **:** Economics : Geography of the 'Credit Crunch' within the South East (Ref G)

2.3.6 An Oxford Economics index of vulnerability to the credit crunch shows that the IW is among Local Authorities considered less vulnerable compared to others within the South East. The sectors considered most vulnerable are mainly financial/business services, construction and consumer related industries.

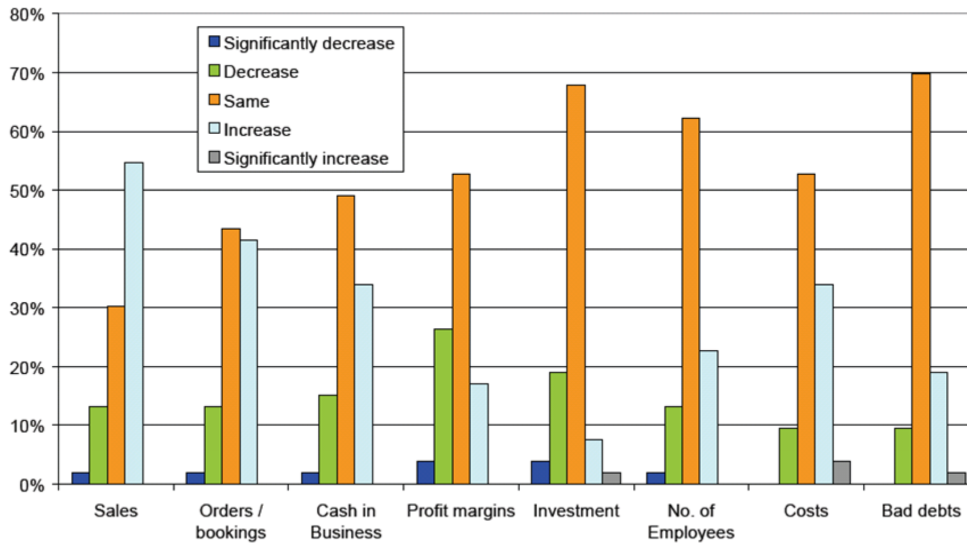


Figure 2.3.7 : Economics : Business expectations for the next six months (Ref G)

2.3.7 In a survey of IW businesses in April 09, while most businesses reported a decline in performance since January, participants were still optimistic that performance would stay the same or improve over the next six months.

2.4 Key Messages

2.4.1 The Island is in the most deprived quarter of local authorities in the South East region. Deprivation is particularly shown in low incomes, education and skill levels, barriers to housing and services, and living environment. It is concentrated in the main urban areas, although deprivation in the Barriers to Housing and Services domain are more severe in rural areas.

2.4.2 JSA (Job seekers allowance) claims doubled between April '08 to April '09 and further consequences of the recession e.g. the reduction in Vesta's workforce may be expected. As the JSA is regarded as being difficult to claim, this will be an understatement of the full impact of the recession. The industrial structure of the Island will serve to mute the initial impact of the recession, in the short to medium term.

3. Burden of Ill Health

3.1 Mortality

3.1.1 Figure 3.1.1 below compares the IW's mortality rate over time with England and the South East, for Persons, All Ages. The IW rate has fallen over this period and is lower (better) than England's and similar to the South East's.

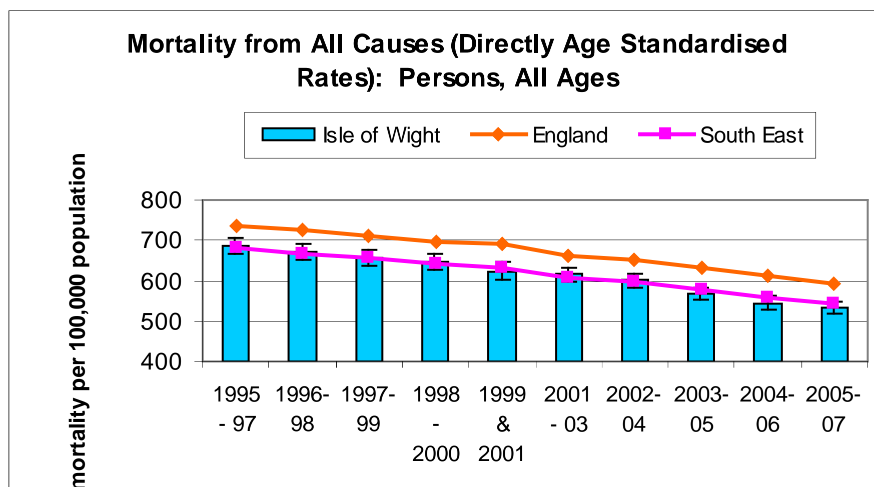


Figure 3.1.1: All-Age, All Cause Mortality Rates : Deaths per 100,000 Age Standardised Population (Ref 03201)

3.1 2 This indicator provides another way of showing performance against the national Public Service Agreement target to increase average Life Expectancy at Birth, being based on the same data about deaths. In order to improve performance against this indicator, lives will need to be prolonged across the age range.

3.1.3 Figure 3.1.2 below compares the IW mortality rates for Males and Females. Both rates have fallen over the period shown. The Male rate has fallen proportionately more than the Female rate, but from a higher starting point, and remains significantly higher than the Female rate.

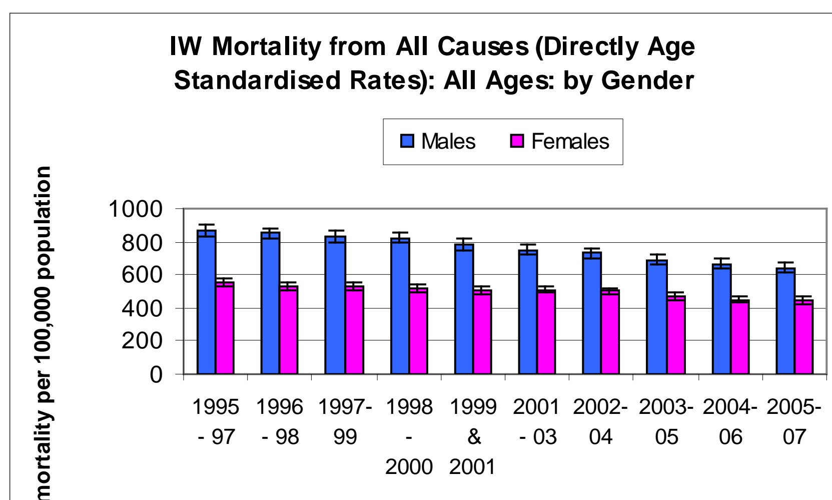


Figure 3.1.2: IW Mortality from All Causes by Age: By Gender (Ref 03201)

3.2 Infant Mortality

3.2.1 The infant mortality rate is a key government Public Service Agreement target, in particular in relation to narrowing the inequalities in mortality rates between geographical areas and specific occupational groups with the worst and best mortality rates.

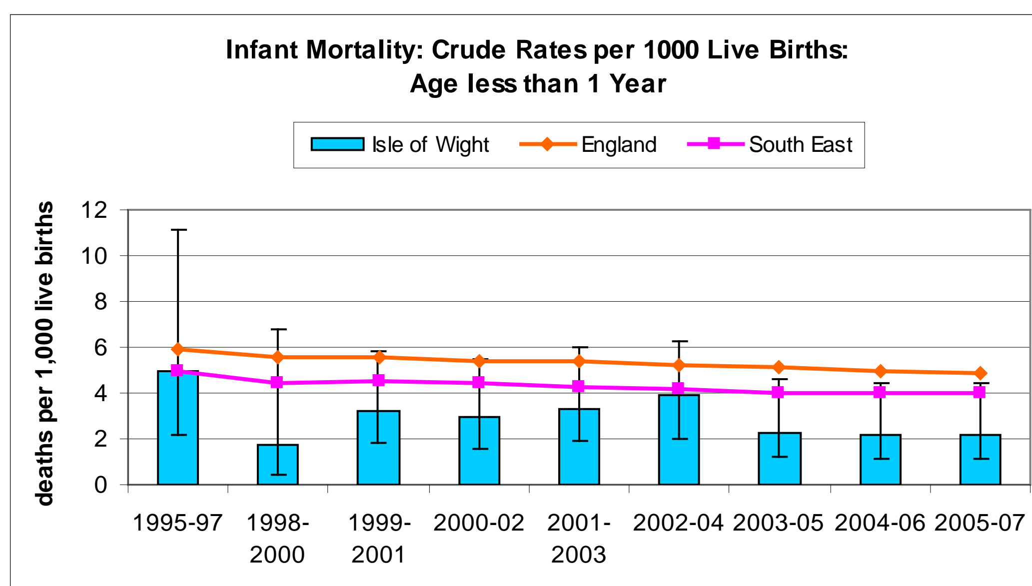


Figure 3.2.1 Infant Mortality : Crude rates per 1000 Live Berths (Ref 03301)

3.2.2 Figure 3.2.1 compares the Isle of Wight mortality rate for infants aged under 1 year with the rates for England and the South East. In the IW over the period shown there have been on average 4 deaths a year of infants in this age group. Over this period the IW rate has fallen and is now lower than England's and similar to the South East's.

3.2.3 IW mortality rates among infants aged under 28 days and under 7 days are not shown because of the very small numbers of deaths involved. Since 1997 there have been on average 3 deaths a year of infants aged under 28 days, of which on average 2 deaths a year were of infants aged under 7 days.

3.3 Life Expectancy

3.3.1 Life Expectancy is a key proxy indicator for the general health of an area. There is a government Public Service Agreement target to increase life expectancy at birth for men and women by the year 2010, and to narrow inequalities in Life Expectancy between geographical areas and specific occupational groups.

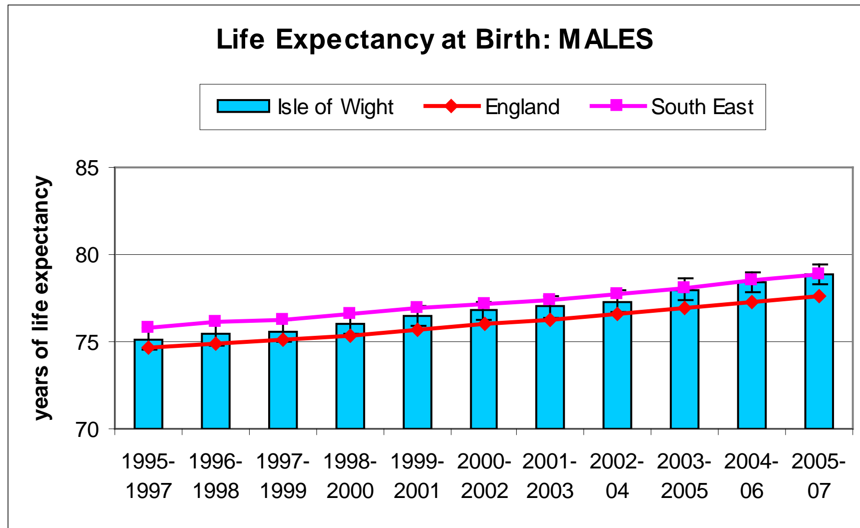


Figure 3.3.1 : Life expectancy at Birth : Males (Ref 03401)

3.3.2 The chart 3.3.1 above compares Isle of Wight Life Expectancy among Males over time with that for England and the South East. IW Male Life Expectancy has increased steadily over the period shown. It is slightly higher than in England and similar to the South East.

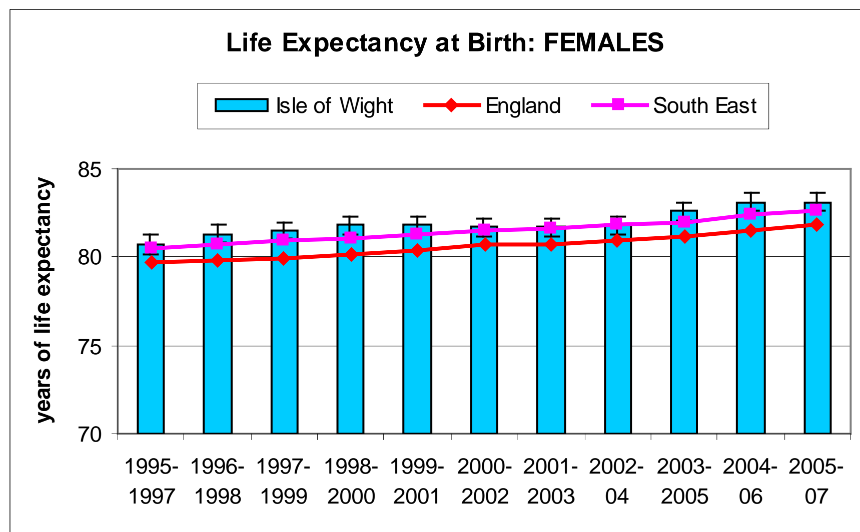


Figure 3.3.2 : Life expectancy at Birth : Females (Ref 03401)

3.3.3 Figure 3.3.2 compares Isle of Wight Life Expectancy among Females over time with that for England and the South East. IW Female Life Expectancy has increased steadily over the period shown, although the increase halted in the most recent period shown. It is slightly higher than in England and similar to the South East.

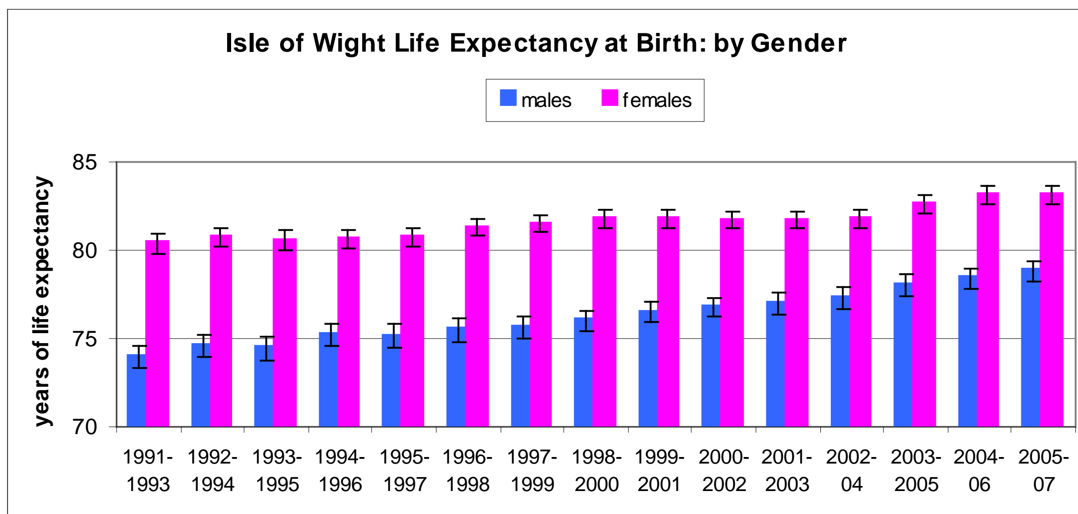


Figure 3.3.3 : Isle of Wight Life Expectancy at Birth : by Gender (Ref 03401)

3.3.4 Figure 3.3.3 compares Isle of Wight Life Expectancy among Males and Females. Life Expectancy is higher among Females than among Males, reflecting the national and regional pattern. Over the period shown it has increased faster among Males than Females.

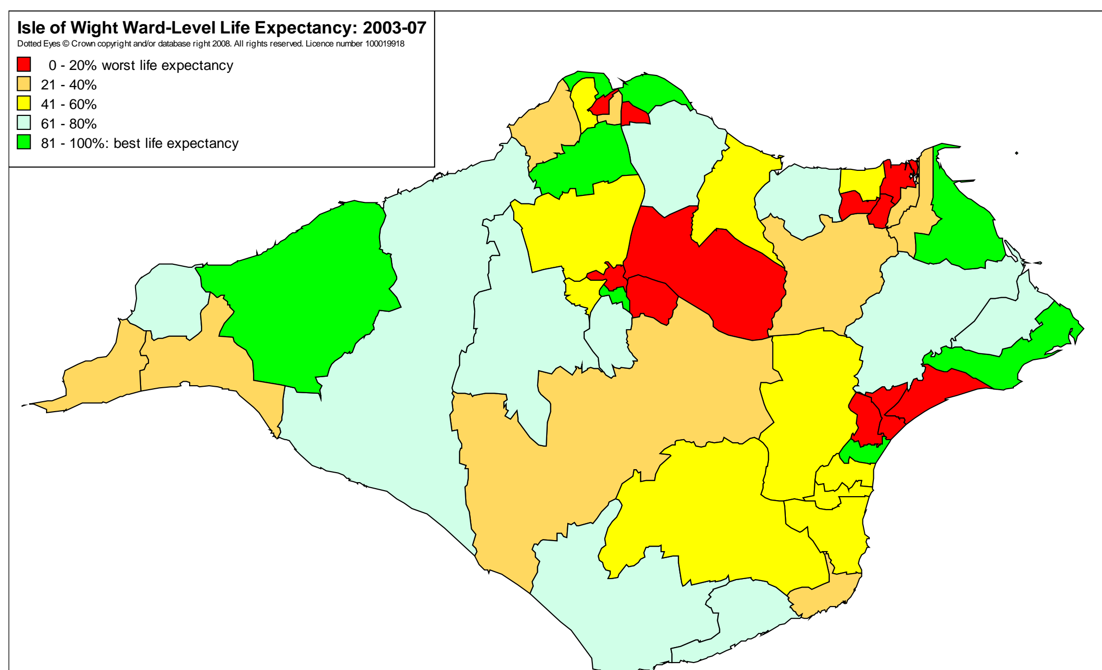


Figure 3.3.4: Life Expectancy at Birth by Ward: 2003 - 07 Pooled Data - Mapped by Ward Quintiles (Ref 03402)

3.3.5 Using 5 years of data, the confidence intervals of the data shown on the map in figure 3.3.4 overlap so that, statistically, most ward-level life expectancies might not be significantly different from each other or from the Island average life expectancy. Taking into account this caveat, the key point to note is that the 'gap' between the wards with the lowest (worst) and highest (best) life expectancies is 9.7 years

3.4 Healthy Life expectancy at age 65

3.4.1 Nationally, while Life Expectancy is increasing, Healthy Life Expectancy (the number of years spent in good or fairly good health) is not increasing at the same rate. An increase in

Healthy Life Expectancy would indicate that older people were living longer and healthier lives.

3.4.2 This indicator will be measured at Local Authority level by the Census, held every 10 years, in which people will be asked how they assess their health. In between censuses the national General Household Survey will be used to measure national trends.

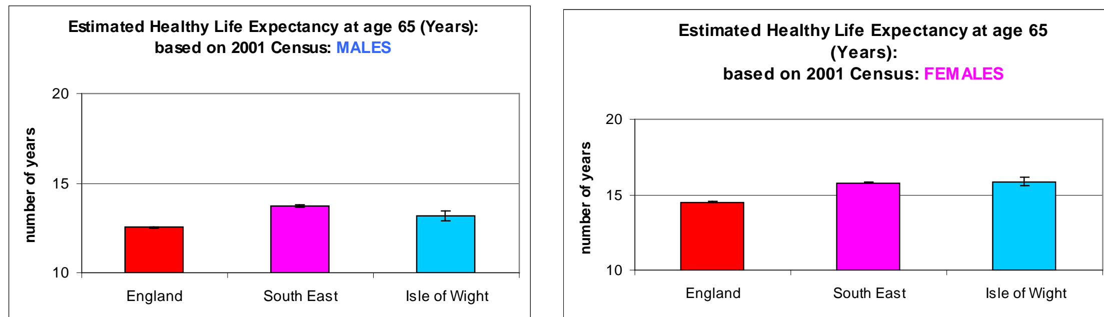


Figure 3.4.1 : Estimated Healthy Life Expectancy at age 65 years (Ref 03801)

3.4.3 Figure 3.4.1, shown separately for Males and Females, is based on 2001 Census data about self-assessed health, and compares the Isle of Wight's Healthy Life Expectancy for Males and Females with that in England and the South East. In both cases IW Healthy Life Expectancy is better than England's. Compared with the South East, IW Healthy Life Expectancy among females was similar and among males is slightly worse.

3.5 Main Causes of Death

3.5.1 All deaths are 'coded' to a specific cause of death using the standard International Classification of Disease (ICD) codes. This classification is divided into 21 Chapters, which are further broken down into Blocks.

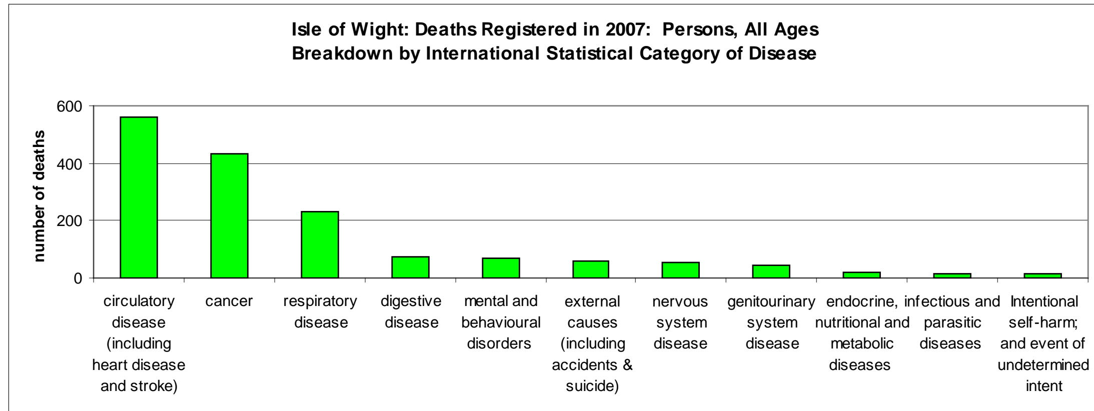


Figure 3.5.1 : Main Causes of Death (Ref 03501)

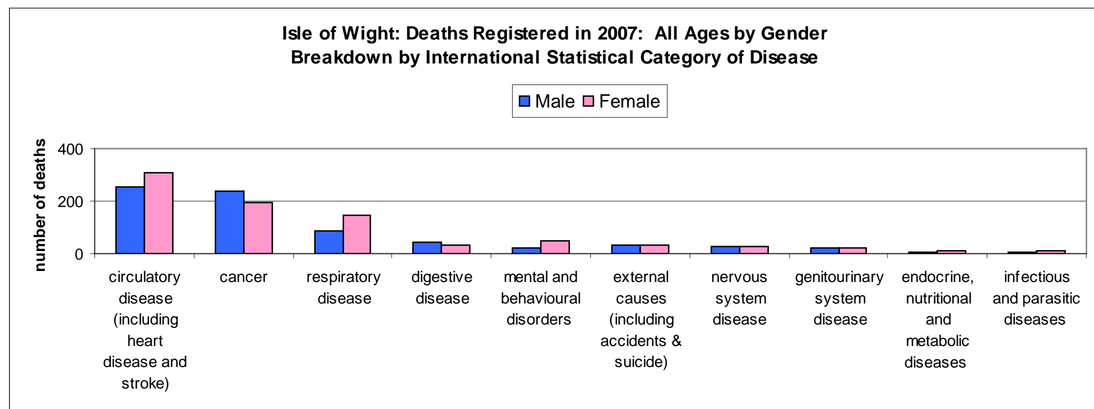


Figure 3.5.2 : Main Causes of Death, by Gender (Ref 03501)

3.5.2 The data and charts above use data on deaths of IW residents registered in 2007 (the most recent data available) to show a breakdown by gender of their cause of death by ICD chapter. All numbers under 5 are withheld in line with Office for National Statistics guidance. The charts display this data for Persons and by Gender. The data shows clearly that the 3 main causes of death, by broad category, are Circulatory Disease (including heart disease and stroke), Cancer and Respiratory Disease.

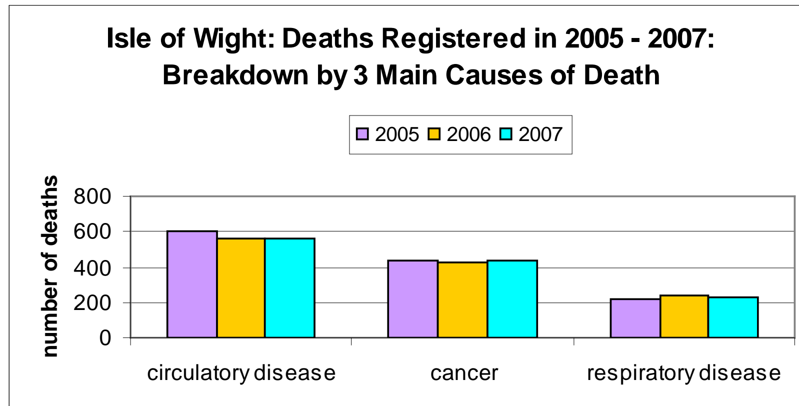


Figure 3.5.3 : Deaths registered in 2005 – 2008 : Breakdown by 3 main Causes of Death (Ref 03501)

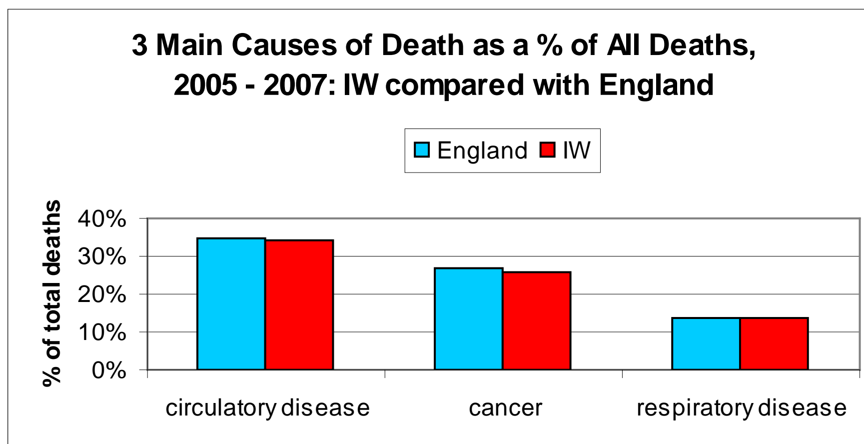
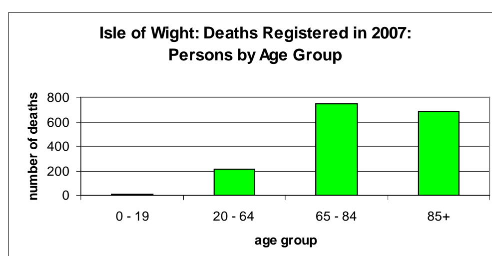


Figure 3.5.4 : 3 Main Causes of Death as a % of all Deaths (Ref 03501)

3.5.4 The charts above show:

- For the IW, the 3 main causes of death by number over time, and their sub-total as a % of total deaths. This shows that, on average, 75% of deaths are from one of these 3 main causes.
- For the IW compared with England, for the years 2005-07 combined, the % of all deaths attributed to each of these 3 causes. This shows clearly that the cause of death pattern is almost identical.



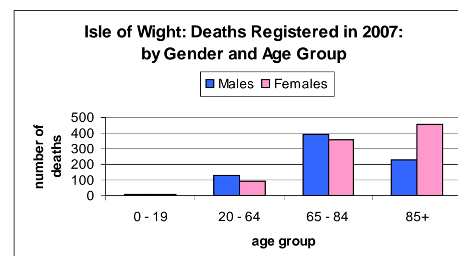


Figure 3.5.5 : Isle of Wight Deaths Registered in 2007, by Age and Gender (Ref 03502)

3.5.5 The data above presents data about deaths of IW residents which were registered in 2007 , as an example of the profile of IW deaths by age and gender. More males than females die overall in the younger age groups; and more females die in the 85+ age group, reflecting their longer life expectancy.

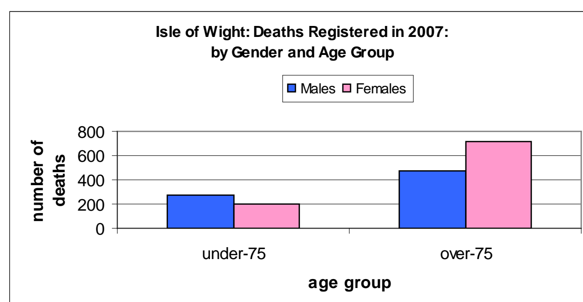


Figure 3.5.6 : Isle of Wight Deaths Registered in 2007 by Gender and Age Group (Ref 03502)

3.5.6 The charts above shows deaths among age groups under-75 and over-75, 75 being the age below which death is regarded as 'premature'. This data shows that:

- 29% of deaths in 2007 were 'premature'.
- More males than females died 'prematurely'.

3.6 Mortality from Causes Amenable to Healthcare

3.6.1 The purpose of measuring this indicator is to help reduce deaths from causes considered amenable to health care, including preventing disease onset as well as treating disease. 3 indicators are measured.

1. Mortality from causes of death where there is evidence that they are amenable to healthcare interventions.
2. Mortality from causes of death considered amenable to health care (shown below).
3. Mortality from causes of death other than those considered amenable to health care.

3.6.2 The difference between 'amenable' and 'non-amenable' causes in their trends over time may provide evidence of the increasing (or decreasing) effectiveness of health care,

This includes a range of causes of death: a very selective list includes some cancers, some respiratory disease, whooping cough, epilepsy, appendicitis and measles. The age groups for which deaths are included vary: for the major causes of cancer and respiratory disease, only deaths in the age group 0 - 74 are counted as amenable to healthcare.

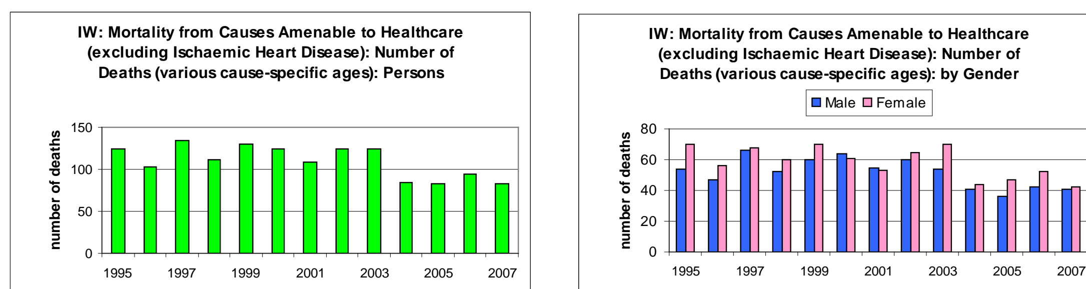


Figure 3.6.1 : Mortality from Causes Amenable to Healthcare (Ref 03902)

3.6.3 The charts above show numbers of deaths of IW residents in this category. Key points:

- Annual numbers have fallen over the period shown, but the fall is less steep for this indicator compared for the one in which heart disease included. This probably reflects the faster rate of reduction in mortality from heart disease compared with cancer, one of the other main causes of premature death included in this indicator (see separate indicators for cancer and circulatory disease).
- Deaths in this category are more evenly split among males and females, though numbers among males are slightly higher. Numbers for both have fallen at a similar trajectory over the period shown.

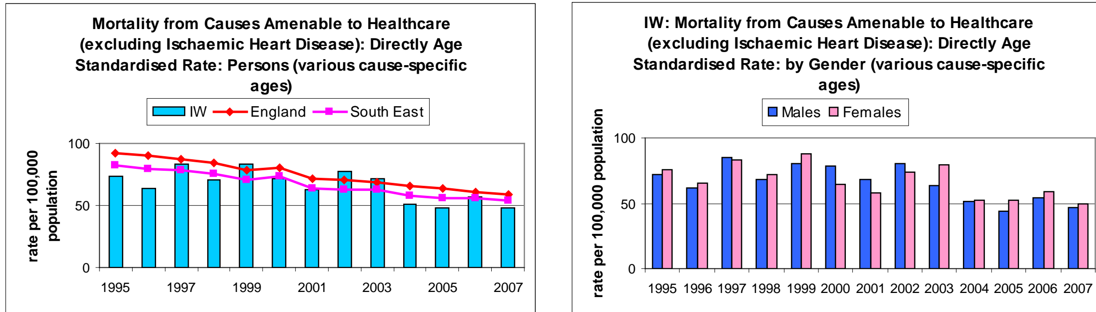


Figure 3.6.2 : Mortality from Causes Amenable to healthcare : Directly Age Standardised Rate (Ref 03901)

3.6.4 The data and charts, below, show mortality rates per 100,000 population, comparing the IW with England and the South East. Key points:

- IW mortality rates among Persons have fallen steadily over the period shown and are slightly lower than in England and the South East.
- IW rates among males and females have been similar over this period and both have fallen at a similar rate.

3.6.6 *Mortality from Causes of Death NOT Amenable to Healthcare* The difference between 'amenable' and 'non-amenable' causes in their trends over time may provide evidence of the increasing (or decreasing) effectiveness of health care,

3.6.7 This includes deaths of people aged 0-74 years from causes other than those considered amenable to health care - i.e. excluding deaths from causes included in indicators (1) and (2) above.

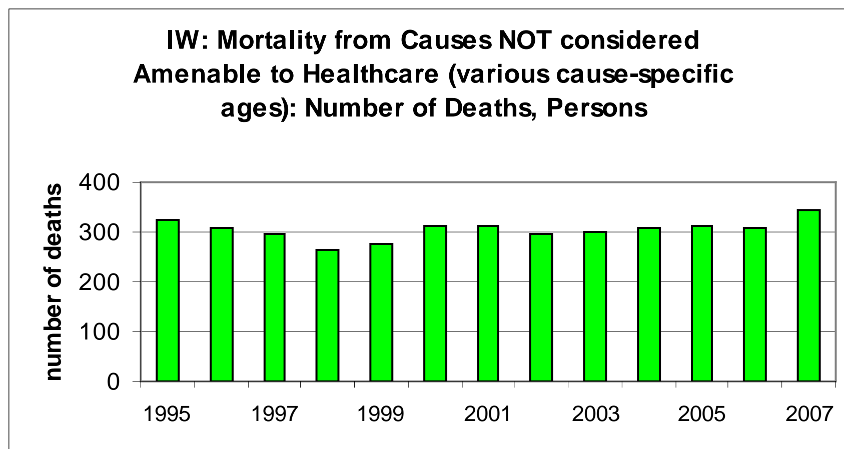


Figure 3.6.3 : Mortality from Causes NOT amenable to Healthcare (Ref 03902)

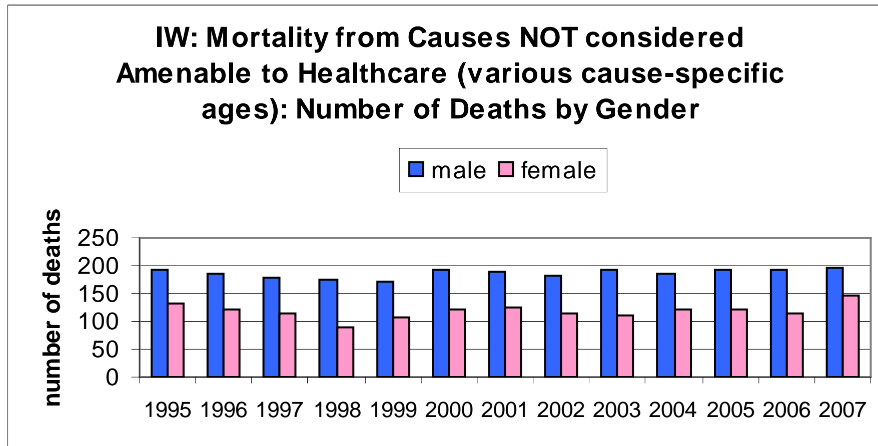


Figure 3.6.4 : Mortality from Causes NOT amenable to Healthcare, by Gender (Ref 03902)

3.6.8 The charts above show numbers of deaths of IW residents in this category. Key points:

- Annual numbers have increased slightly over the period shown, but this should be contrasted with the steeper decrease in deaths whose cause is amenable to healthcare.
- There have been consistently more deaths among males and females, with numbers for both following a similar slightly increasing trajectory over the period shown.

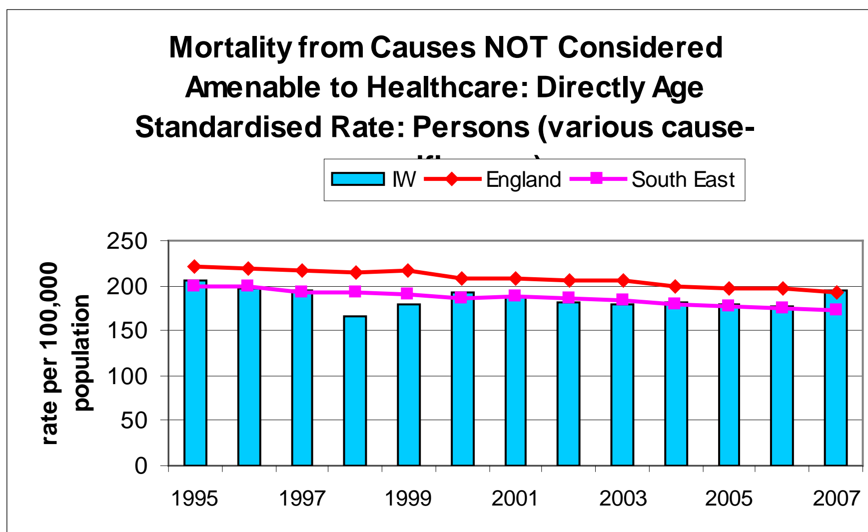


Figure 3.6.5 : Mortality from causes NOT considered amenable to Healthcare : Directly age-standardised rate (various cause specific ages) (Ref 03902)

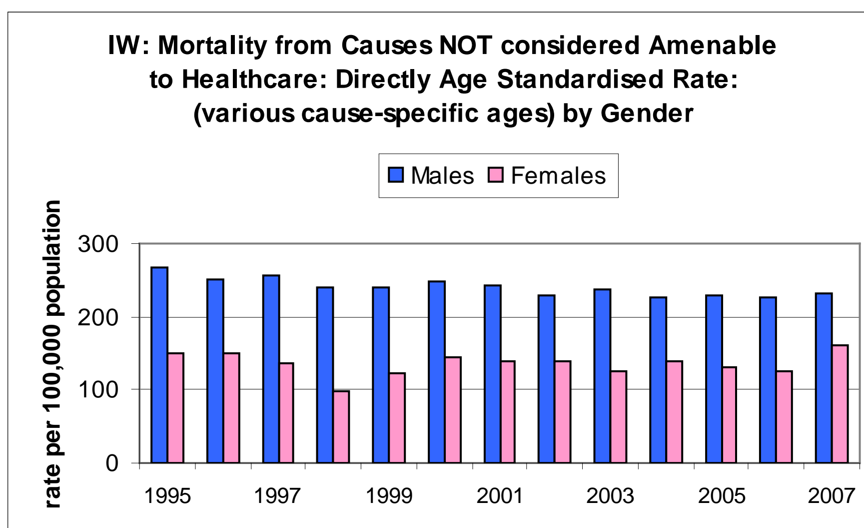


Figure 3.6.6 : Mortality from causes NOT considered amenable to Healthcare : Directly age standardised rate (various cause specific ages)(by Gender) (Ref 03902)

3.6.9 The charts above show mortality rates per 100,000 population, comparing the IW with England and the South East. Key points:

- IW mortality rates among Persons have fallen slightly over the period shown and are similar to those in England and the South East.
- IW rates were higher among males than among females over this period. The trajectory for males has been slightly downwards, and for females has been stable.

3.7 Deaths attributable to Smoking

3.7.1 Smoking is the UK's single greatest cause of preventable illness and premature death, and accounts for a significant proportion of the inequality in mortality rates between geographical areas and socio-economic groups. Smoking causes a wide range of illnesses including various cancers (of which lung cancer is the most significant), respiratory diseases and heart disease.

3.7.2 Deaths from smoking among persons aged 35+ have been estimated through a calculation which combines: attributing a certain percentage of deaths from specific causes to which smoking is known to contribute, such as specific cancers and cardiovascular disease, and national smoking prevalence.

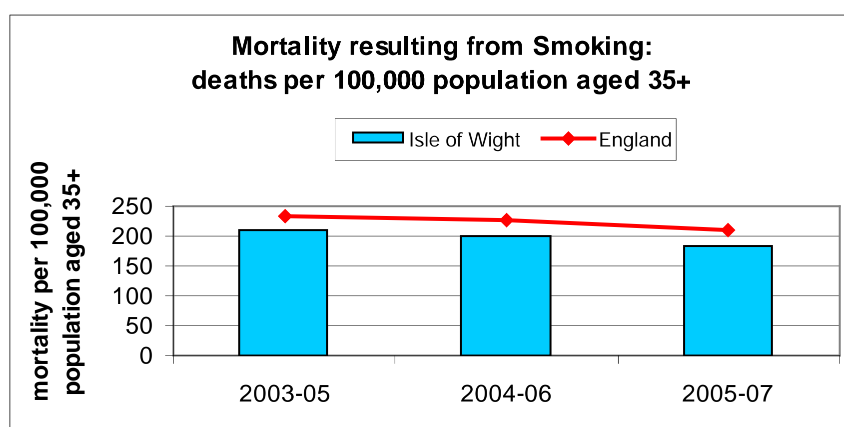


Figure 3.7.1: Mortality resulting from Smoking (Ref 04001)

3.7.3 Figure 3.7.1 above compares estimated rates of mortality resulting from smoking for the Isle of Wight compared with England. For the period shown, the IW's estimated rates have been lower than England's, and rates for both have fallen.

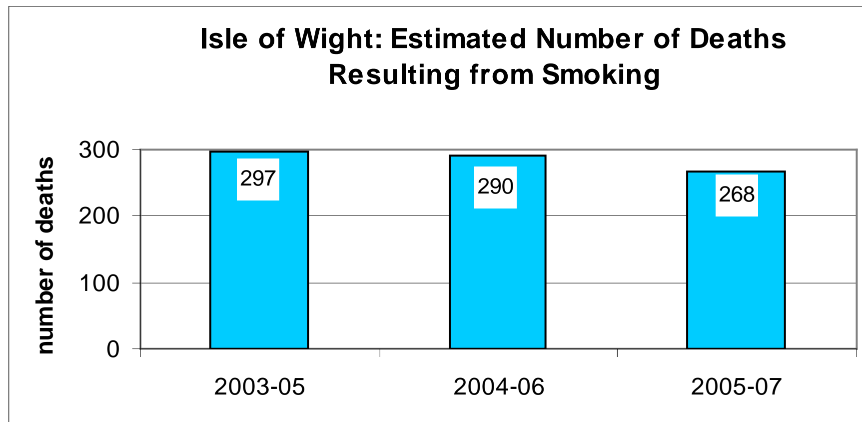
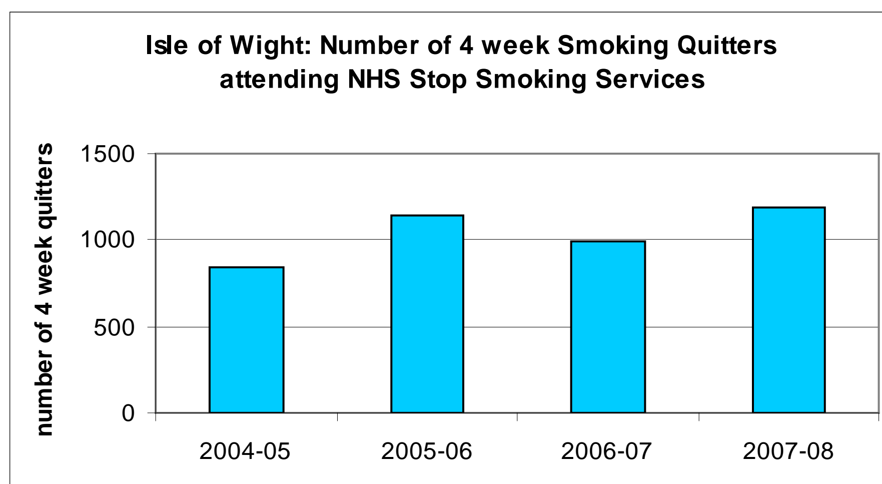


Figure 3.7.2 : Estimated Deaths from Smoking (Ref 04001)

3.7.4 Figure 3.7.2 above shows the estimated number of deaths of IW residents resulting from smoking. On average nearly 100 deaths of IW residents a year are attributed to smoking. Smoking is the UK's single greatest cause of preventable illness and early death, causing a wide range of illnesses including various cancers (of which lung cancer is the most significant), respiratory diseases and heart disease. The data below represents smokers who quit smoking with the help of NHS Stop Smoking services and remain quit after 4 weeks. Isle of Wight NHS Stop Smoking Services include Island Quitters, GP Practices and Pharmacies.

Figure 3.7.3 : Isle of Wight : Number of 4 week Smoking Quitters attending NHS Stop Smoking Service (Ref 02001)



3.7.5 Figure 3.7.3 shows the number of IW 4 week smoking quitters over the last 4 complete years. (Ref 02001)

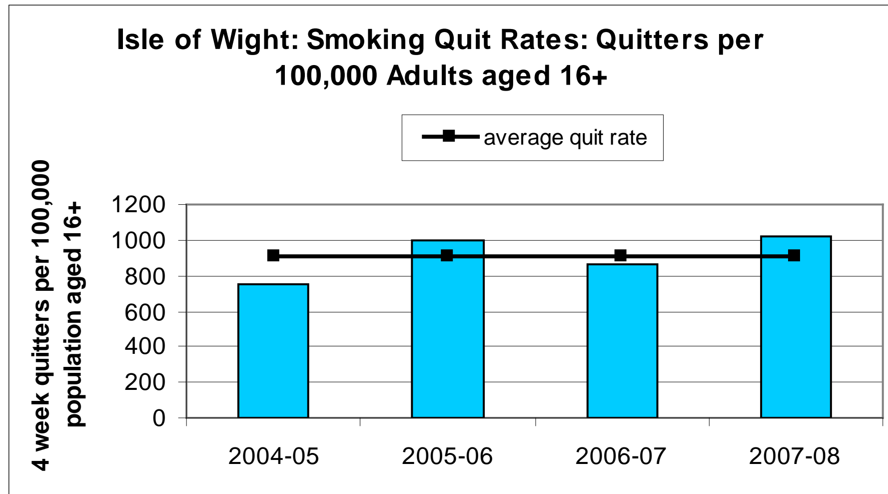


Figure 3.7.4 : Isle of Wight : Smoking Quit Rates : Quitters per 100,000 Adults aged 16+ (Ref 02001)

3.7.6 Figure 3.7.4 shows the rate of week smoking quitters per 100,000 population aged 16+ over the last 4 years.

3.8 Diabetes

3.8.1 It is known that official data on mortality under-records the role of diabetes, since not all deaths to which diabetes has contributed will show diabetes as the primary cause of death. Yorkshire & Humber Public Health Observatory has produced estimates of the number of deaths attributable to diabetes, using a methodology developed by the World Health Organisation.

Figure 3.8.1 Estimated % of all deaths attributable to Diabetes/ Number of deaths cased by Diabetes (Ref 04201)

3.8.2 The chart above left compares the IW's estimated % of deaths in the 20 – 79 age group attributable to mortality in 2005 with that in England. The IW rate is close to the England average and in the mid-range of PCTs. The range across all PCTs was 9.25% to 17%, with higher rates found in areas with a lower proportion of the population aged 40+, substantial populations aged over 40 years from Asian and Black ethnic groups, and relatively high levels of deprivation.

3.8.3 The chart above right compares IW deaths in 2005 in the 20 - 79 age group whose cause was recorded as diabetes with the YHPHO estimated figure. Only 10 deaths in this age group were recorded as being caused by diabetes, compared with 82 attributed to diabetes by this model. The gap between the 2 figures shows the large number of deaths (72) estimated as being attributable to diabetes but not recorded as such.

3.8.4 Diabetes is a chronic and progressive disease comprising a group of disorders characterised by a raised blood glucose level. Poorly-controlled diabetes significantly increases the risk of heart attacks, stroke, blindness, kidney failure and amputation.

3.8.5 Yorkshire Public Health Observatory has developed a model to estimate and project the prevalence of diabetes in a population, recognising that GP Practice diabetes prevalence data recorded through the Quality Outcomes Framework does not provide a complete picture of the prevalence of diabetes. This model uses diabetes prevalence data taken from a number of UK studies and applies it to individual Local Authorities, taking account of the age, sex and ethnicity breakdown of their population, and of local deprivation.

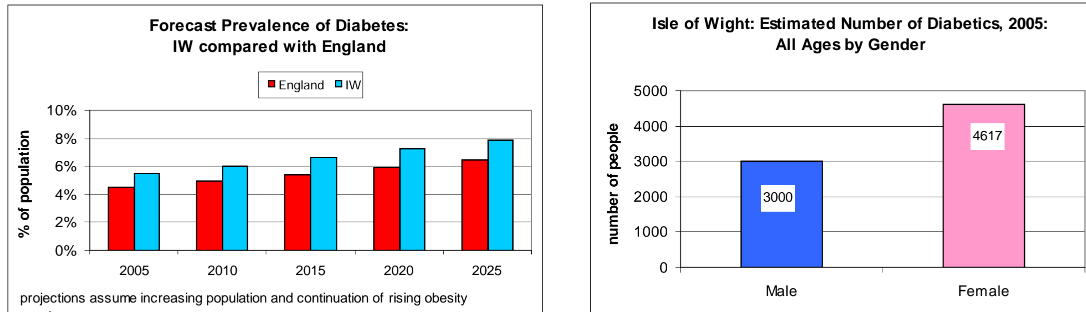


Figure 3.8.2 : Forecast Prevalence of Diabetes : IW compared with England (Ref 04101)

3.8.6 Figure 3.8.2, (left) compares the current and projected prevalence of diabetes on the Isle of Wight compared with England up to 2025. The estimates take account of projected population growth by age and gender and assume a continued rise in obesity. The IW's older age profile is the main reason for its higher projected prevalence compared with England. Figure 3.6.2 (right) shows the 2005 estimated numbers for the Isle of Wight broken down by gender, with higher numbers among females reflecting their greater proportion in the older population in which prevalence is higher.

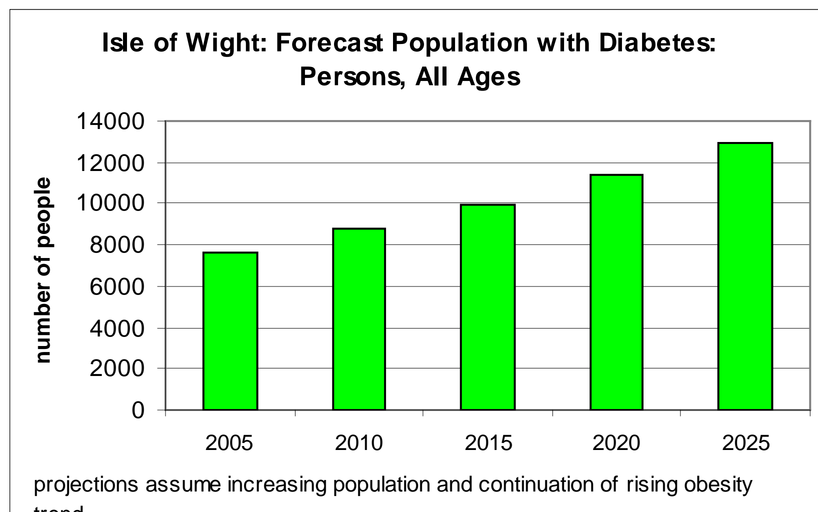
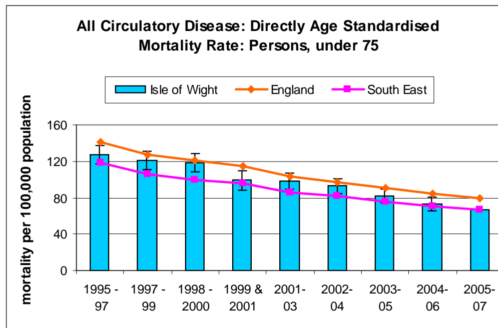


Figure 3.8.3 Isle of Wight : Forecast population with Diabetes (Ref 04101)

3.8.7 Figure 3.8.3 shows projected numbers of Isle of Wight diabetics by age. By 2025 it is projected that over 12,000 IW residents will be diabetic.

3.9 Circulatory Diseases

3.9.1 Circulatory or Cardiovascular disease refers to all diseases of the heart and circulation, including coronary heart disease (angina and heart attack), and stroke. It is the most common cause of death in the UK and on the Isle of Wight, accounting for 34% of deaths of IW residents in 2007. Key risk factors for cardiovascular disease include obesity and smoking.



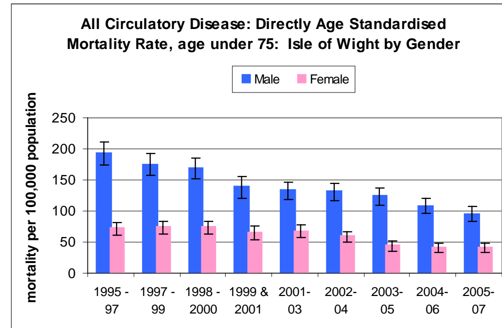


Figure 3.9.1 : All Circulatory Disease : Directly Age Standardised Mortality Rate : Persons under 75 and by Gender (Ref 04301)

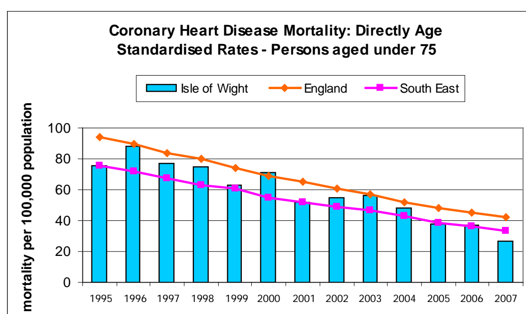
3.9.2 The IW PCT has a target to reduce mortality among people aged under 75 (the age group in which death is considered 'premature') by 40% from a 1995-97 baseline by 2010. The IW has already met this target, with the mortality rate falling by 47% between 1995-97 and 2005-07, in line with the national and regional trends. Figure 3.7.1 shows this trend. The IW's most recent available rate is lower (better) than England's rate and the difference is statistically significant. The IW's rate has been worse than the South East's rate over most of the period shown, but is now similar.

3.9.3 Although this mortality rate has improved, there are significant inequalities on the IW in terms of:

- Gender: males continue to have a statistically significantly higher (worse) mortality rate than females, as shown in the second chart below, although mortality among males has fallen faster than among females over this period.
- Geography: there is considerable geographical variation in mortality on the IW – see separate pages.

3.10 Coronary Heart Disease – Mortality

3.10.1 Coronary Heart Disease (CHD) is one of the 2 major types of Circulatory Disease (see separate indicator), Stroke being the other. CHD causes nearly 50% of all deaths from Circulatory Disease, both among people of all ages and in the under-75 age group. Reducing CHD deaths in people aged under 75 would therefore support the aim of reducing circulatory disease mortality rates in that age group.



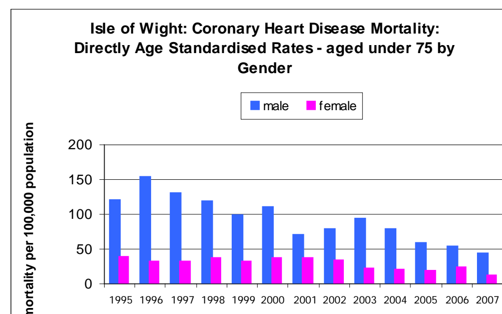


Figure 3.10.1 Coronary Heart Disease Mortality : Persons aged under 75 and by Gender (Ref 04401)

3.10.2 Figure 3.10.1 compares the IW mortality rate since the 1995 baseline with England and the South East. The IW's rate has fallen steadily over this period and is lower than both. The chart above, right shows mortality rates by gender for the Isle of Wight over this period. The rate for Males has fallen more steeply than for Females over this period, from a much higher baseline, but remains higher.

3.11 Coronary Heart Disease – Hospital Admission Rates

3.11.1 The rate of emergency hospital admissions for Acute Myocardial Infarction, or heart attack, is used a proxy for the incidence (rate of new cases) of Coronary Heart Disease. The National Service Framework for Coronary Heart Disease included among its standards reducing heart disease in a population and reducing the risk of dying among people who do experience heart attacks.

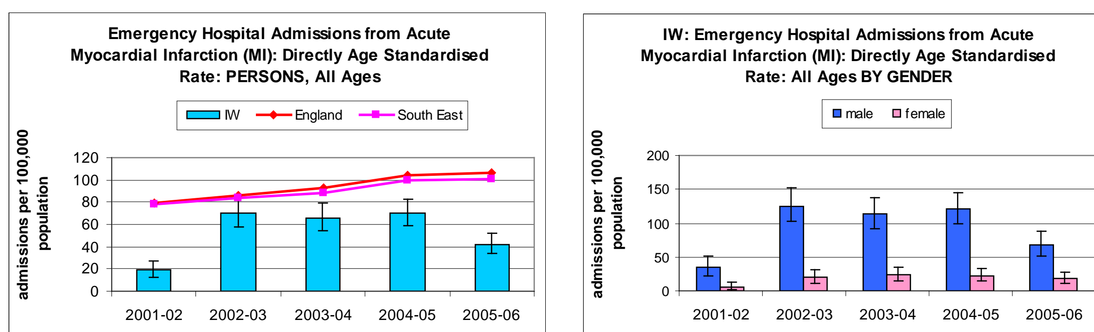


Figure 3.11.1 Emergency Hospital Admissions from Acute Myocardial Infarction (Ref 04601)

3.11.2 Figure 3.11.1 (left) compares the Isle of Wight admission rate for Persons with the rates for England and the South East. At the start of the period shown IW rates were slightly higher than both, but IW rates have fallen over this period and are now similar. Figure 3.9.1 (right) compares IW rates among males and females. The rate among males is significantly higher than the rate among females, reflecting the national pattern. Both rates have fallen over the period shown, with the male rate falling more steeply from a higher baseline.

3.12 Cardiac Revascularisation

3.12.1 The symptoms of Coronary Heart Disease are usually caused either by the gradual narrowing of the arteries supplying the heart (coronary arteries) or by the sudden/rapid obstruction of coronary arteries following the formation of a blood clot. These symptoms can be relieved and risk of death reduced by a process of Cardiac Revascularisation, whereby blood flow through blocked coronary arteries is restored. The two most widely used techniques are Coronary Artery Bypass Surgery (CABG) and Percutaneous Transluminal Coronary Angioplasty (PTCA).

3.12.2 The National Service Framework for Coronary Heart Disease noted that rates of revascularisation in the UK were low and that there were inequalities in access between different groups in the population. It aimed to increase overall revascularisation rates.

3.12.3 Figure 3.10.1 below compares the IW rate of admissions for revascularisation with those for England and the South East. The IW's rate has been significantly lower than both over most of the period shown, and fell back in 2005-06, the most recent period available. This could reflect a lower level of need or a lower level of provision irrespective of need. However, over this period, some heart surgery carried out for IW residents in private hospitals was not correctly coded to the Isle of Wight PCT, and these lower figures could still reflect that issue.

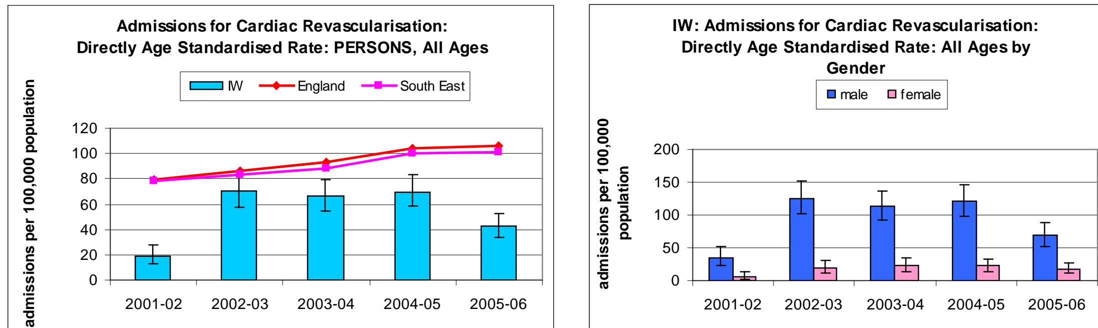


Figure 3.12.1 : Admissions for Cardiac Revascularisation : Directly Age Standardised Rates : Persons, all ages, and all ages, by Gender. (Ref 04701)

3.12.4 Figure 3.12.1 compares IW rates for males and females over this period. The rate for males has been significantly higher than for females over this period.

3.13 Stroke – Mortality

3.13.1 Stroke is one of the 2 major types of Circulatory Disease, Coronary Heart Disease being the other (see separate indicators). In 2007 Stroke caused 20% of deaths of IW residents from Circulatory Disease in the under-75 age group (compared with 28% of deaths from Circulatory Disease among people of all ages). Reducing Stroke deaths in people aged under 75 would therefore contribute to the aim of reducing circulatory disease mortality rates in that age group.

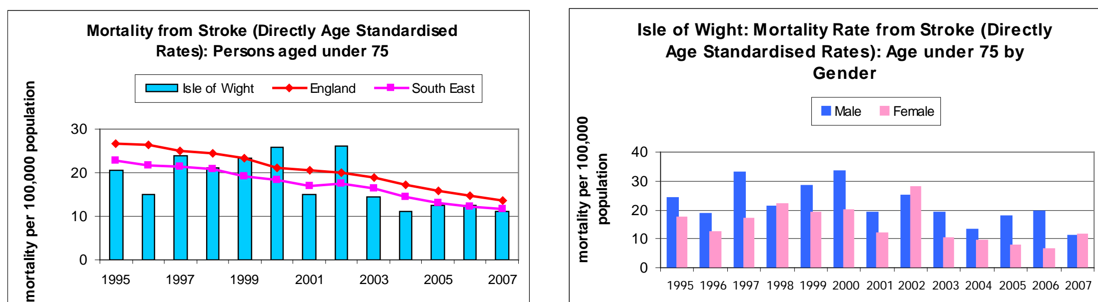


Figure 3.13.1 Mortality from Stroke (Ref 04801)

3.13.2 Figure 3.13.1 (left) compares the Isle of Wight mortality rate from stroke in the under 75 age group with that in England and the South East. The IW rate has fallen by 46% since 1995 and is slightly lower than in both England and the South East. Figure 3.11.1 (right) compares IW mortality rates from stroke among males and females aged under 75. Although mortality among males has been higher than among females over this period, the difference is less pronounced than for Coronary Heart Disease.

3.14 Stroke – Hospital admission rates for Stroke

3.14.1 The rate of emergency hospital admissions for Stroke is used a proxy for the incidence (rate of new cases) of Stroke.

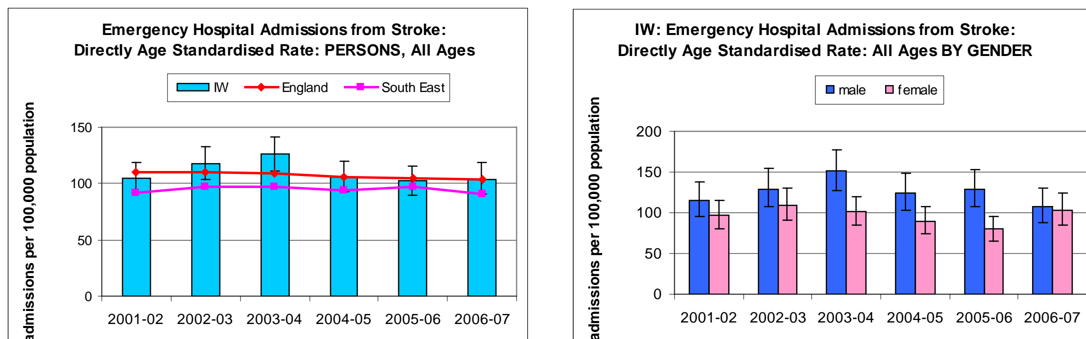


Figure 3.14.1 Emergency Hospital Admissions from Stroke (Ref 04901)

3.14.2 Figure 3.14.1 (left) compares the Isle of Wight admission rate for Persons with the rates for England and the South East. The IW rate has been relatively stable over the period shown. In the most recent period available it was similar to England's rate and higher than the South-East's, but the IW rate's confidence intervals overlapped with both of those rates so the differences might not be statistically significant. Figure 3.12.1 (right) compares IW rates among males and females. Both rates have been relatively stable over the period shown. In the most recent period available they were very similar to each other.

3.15 Cancer

3.15.1 Cancer is one of the biggest killers in the UK. Approximately 26% of deaths among IW residents are caused by cancer, similar to the national picture.

3.15.2 The IW PCT has a target to reduce premature mortality from cancer, among people aged under 75 (the age group in which death is considered 'premature') by 20% from a 1995-97 baseline by 2010. In 2007 45% of deaths of IW residents aged under 75 were from cancer.

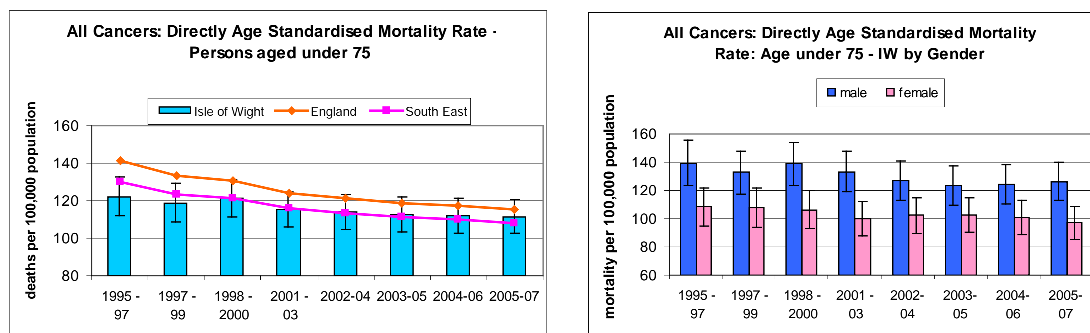


Figure 3.15.1 All Cancers : Directly age standardised mortality rate and by Gender (Ref 05001)

3.15.3 Figure 3.15.1 (left) shows the trend against this target. The IW's mortality rate is currently slightly lower than England's rate and slightly higher than the South East's but both those rates are within the IW rate's confidence interval range and so the differences might not be statistically significant. The IW's rate has fallen by 9% since the 1995-97 baseline, a smaller decrease than in England and the South-East, though from a lower baseline, and it will be challenging to achieve the 2010 target. Figure 3.13.1 (right) compares the IW rates for males and females. The female rate has fallen slightly faster than the male rate since the 1995-97 baseline. The male rate is currently higher than the female rate and the difference is likely to be statistically significant.

3.16 Cancer Registrations

3.16.1 The IW PCT has a target to reduce mortality from cancer among people aged under 75 (the age group in which death is considered 'premature') by 20% from the 1995-97 baseline by 2010. In order to do this it will be necessary to reduce the number of new cases

of cancer contracted by people aged under-75, and to prolong their lives if they do develop cancer.

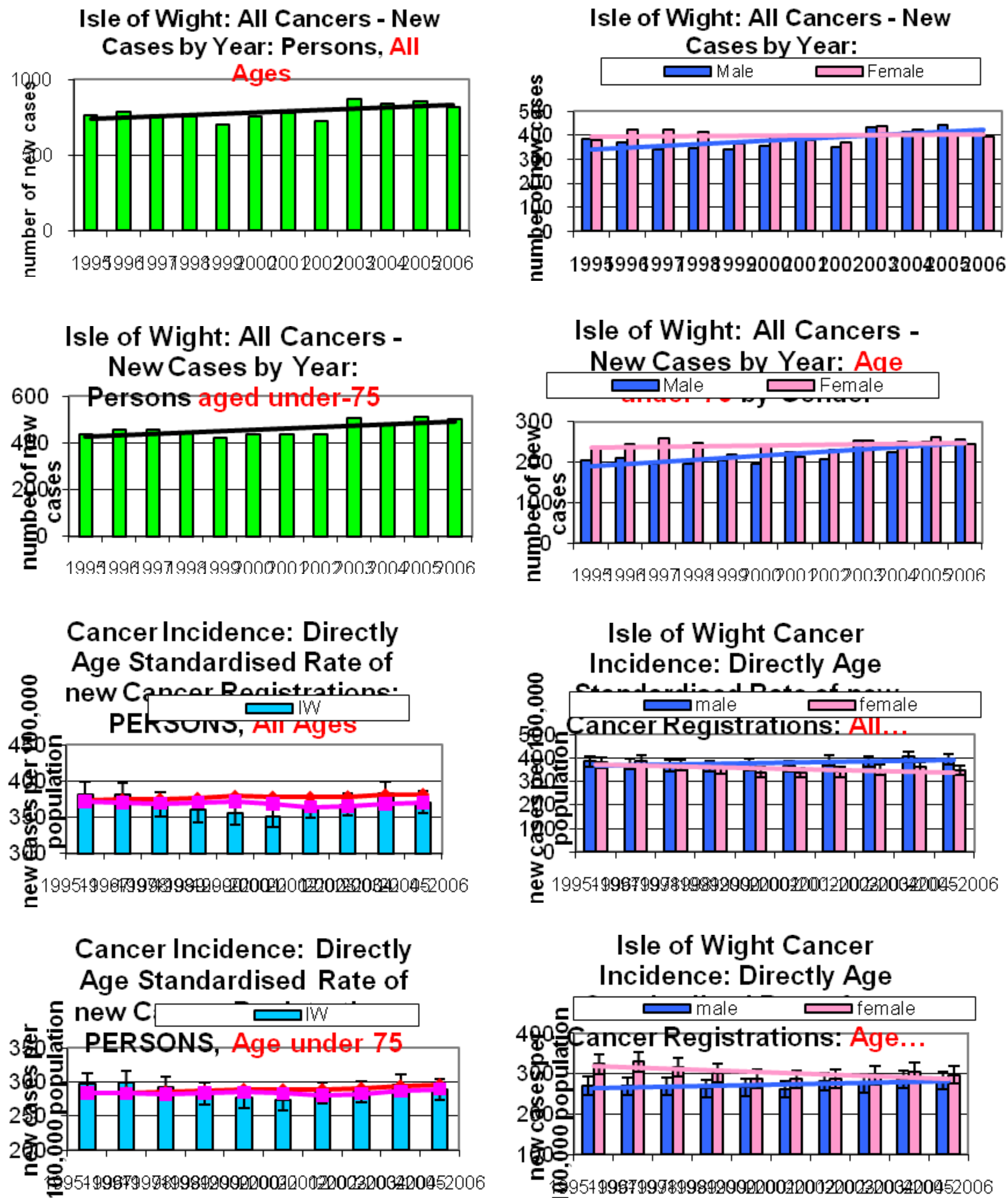


Figure 3.16.1 Number and Incidence of new cancer registrations; all Ages, and under 75 by year (Ref 05101)

3.16.2 Key points on the data tabulated above are shown below. The data above shows, for people of All Ages and in the Under-75 age group, numbers of new cases; incidence (rates of new cases) per 100,000 population, comparing the Isle of Wight with England and the South-East; and comparing Males and Females on the Island. Data is shown for the period 1995 - 2006 (the most recent year available).

3.16.3 Number of New Cancer Cases

- The number of new cancer cases among people of **All Ages** on the Island each year has risen, from 762 cases in 1995 to 817 in 2006. This is mostly accounted for by the

Island's increasing population over this period, with a greater proportional increase among older age groups.

- The number of new cancer cases among people aged **Under-75** has also risen over this period, from 436 cases in 1995 to 501 in 2006. The proportion of new cases in the under-75 age group has increased from 57% to 61%.
- In both age groups, Males and Females experience similar numbers of new cancer cases, distributed among different cancers (see subsequent sections).

3.16.4 Directly Age Standardised Rate of New Cancer Cases per 100,000 Population

- Statistically, the most recent (2004-06) IW rates for Males and Females are similar, in both the All Ages and Under-75 age groups, and the IW rates for Persons are similar to England and the South-East.
- Since 1995 there has been a slight upward trend in the IW rate for **Males**, both for All Ages and the Under-75 age group. A contributor to this has been the increase in the number and rate of **Prostate Cancer** cases.
- Since 1995 there has been a slight downward trend in the IW rate for **Females** for All Ages and the Under-75 age group. Notwithstanding this trend, there has been a slight upward trend in the rate of **Lung Cancer** cases among females.

3.16.5 Data about the incidence of the most significant cancers in terms of the number and rate of new cases is shown separately by following this link to cancer registrations These cancers are Breast Cancer; Lung Cancer; Prostate Cancer and Colorectal Cancer

3.17 Modelled Chronic Obstructive Pulmonary Disorder (COPD)

3.17.1 Chronic Obstructive Pulmonary Disorder (COPD) is a disease of the lungs whereby inflammation develops and airflow becomes progressively obstructed, causing coughing and breathlessness. It is caused predominantly by smoking, but occupational exposure to harmful substances can also contribute. It is more commonly seen after the age of 35. Many people with COPD experience several years of ill health and poor quality of life before they die.
The Association of Public Health Observatories has commissioned a model to estimate and project the prevalence of COPD in the population, recognising that GP Practice COPD prevalence data recorded through the Quality Outcomes Framework (QOF, see separate file) does not provide a complete picture of this. This model uses national COPD prevalence data from the Health Survey for England and applies it to individual Local Authorities, taking account of the age, sex, ethnicity and estimated smoking status of their population, and the rurality and deprivation of their area.

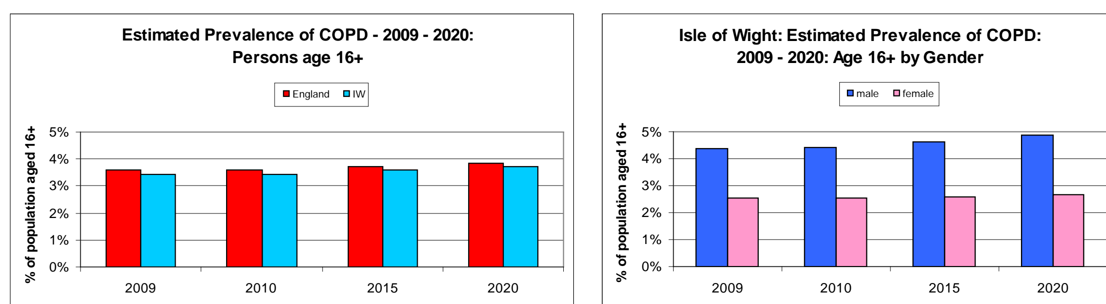


Figure 3.17.1. Estimated Prevalence of COPD (Ref 05301)

3.17.2 Figure 3.17.1 (left) shows current estimated and projected COPD prevalence up to 2020, comparing the IW with England. This shows that the projections are very similar. Figure 3.17.1 (right) shows the Isle of Wight current estimate and projections by gender. Estimated prevalence is higher among males, reflecting their higher smoking prevalence.

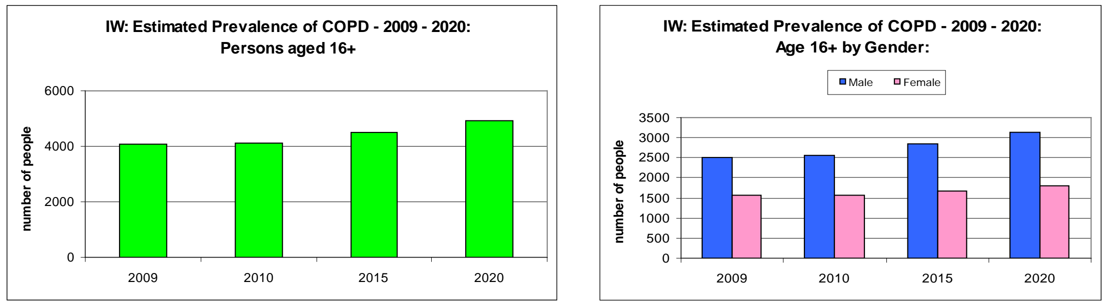


Figure 3.17.2 IW Estimated prevalence of COPD (Ref 05301)

3.17.3 Figure 3.17.2 (left) shows, for the Isle of Wight, the estimated and projected number of people with COPD. The current estimate is just over 4,000 people; by 2020 the figure will be nearly 5,000 people, an increase of 21%. Figure 3.17.2 (right) shows this breakdown by gender. By 2020 it is projected over 3,000 IW males will have COPD.

3.18 GP recorded COPD

3.18.1 The QOF is the Quality and Outcomes Framework, a voluntary annual reward and incentive programme for all GP surgeries in England which is part of GP contracts. QOF includes a number of 'disease registers', which count patients recorded by GP Practices as having specific 'diseases', of which COPD is one. COPD Registers record patients who have COPD in order to offer ongoing care to them to ensure that their condition is managed. In QOF terms, higher numbers and % of people recorded would be seen as a good thing, as this means that more people in the population with the condition are being identified and offered treatment.

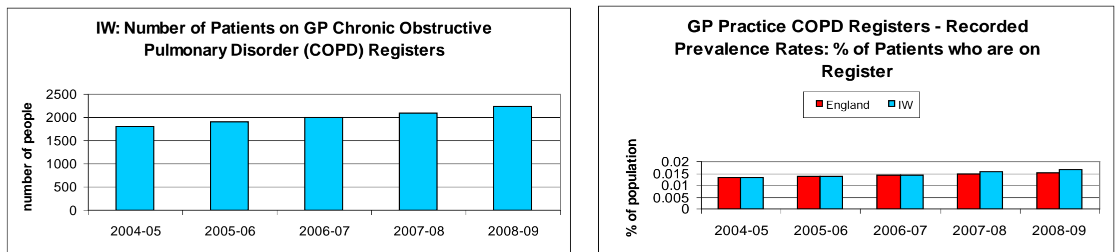


Figure 3.18.1 Number of patients on GP COPD registers/Recorded Prevalence rates (Ref 05301)

3.18.2 Figure 3.18.1 (left), shows the number of people recorded on IW GP COPD registers over time, with a clear upward trend. Figure 3.18.1 (right), compares the % of the GP Practice population recorded on COPD registers in the IW and England. There has been an upward trend in recorded prevalence for both, with the IW's recorded prevalence now slightly higher.

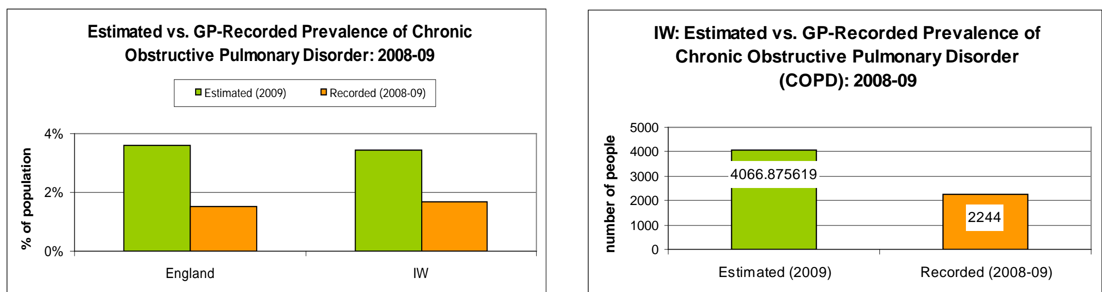


Figure 3.18.2 Estimated v. GP recorded prevalence (Ref 05301)

3.18.3 Figure 3.18.2 (left), compares the estimated vs. recorded COPD prevalence for England and the IW. The IW has a higher % of recorded prevalence, but a slightly lower % of estimated prevalence than England, and so the IW 'gap' is smaller than for England. Figure

3.18.2 (right) compares the IW's estimated vs. recorded COPD prevalence in terms of number of people. The gap represents an estimated 1,800 people with undiagnosed COPD.

3.19 COPD Mortality

3.19.1 Respiratory disease includes bronchitis, emphysema, pneumonia, asthma, and influenza, some of which are included in the umbrella category of Chronic Obstructive Pulmonary Disease (COPD). Respiratory disease is the 3rd most common cause of death in the UK and in the IW, accounting for 232 or 14% of all deaths among IW residents in 2007. Of those 237 deaths, 80% were caused either by pneumonia, or by bronchitis, emphysema and other COPD. Mortality from respiratory disease occurs mainly among older people; 81% of deaths in 2007 were of people aged 75+.

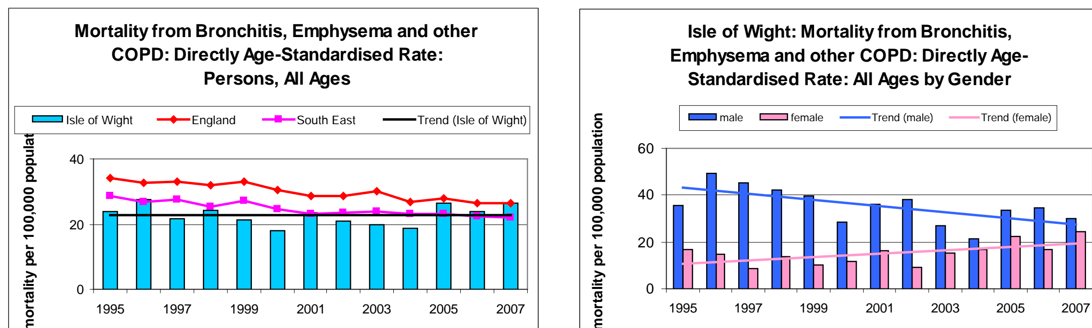


Figure 3.19.1 Mortality – COPD (Ref 05201)

3.19.2 (see Figure 3.19.1) Mortality from Bronchitis, Emphysema and other Chronic Obstructive Pulmonary Disorder (COPD) - This cause accounted for 36% of all deaths from respiratory disease in 2007. 70% of these deaths were of people aged 75+. Between 1995 - 2007 the trend in the IW mortality rate for people of All Ages has been flat. The most recent, 2007, rate was similar to that for England and the South-East. Over this period the IW rate among males has shown a downward trend and the rate among females has shown a slight upward trend, though the IW rate remains higher among males compared with females.

3.20 Mortality from Pneumonia

3.20.1 This cause accounted for 44% of all deaths from respiratory disease in 2007; 94% of these deaths were of people aged 75+.

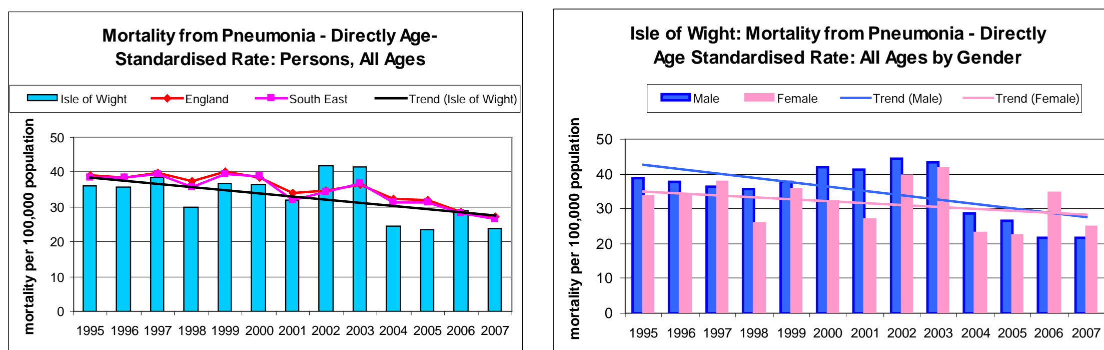


Figure 3.20.1 Mortality from Pneumonia (Ref 05201)

3.20.2 (See figure 3.20.1) Between 1995 - 2007 there was a downward trend in the IW mortality rate for people of All Ages. The most recent, 2007, rate was slightly lower than for England and the South-East. Over this period the IW rates for both males and females have both shown a downward trend and they are now similar to each other.

3.21 Sexually Transmitted Infections

3.21.1 Risk-taking sexual behaviour, which is increasing across the population, can result in poor sexual health, with potential consequences including Sexually Transmitted Infections (STIs). Nationally, between 1998 - 2007, there was an increase of 63% in new diagnoses of STIs. The national Health Protection Agency (HPA) has stated that this national upward trend is probably due to a combination of factors, including increases in unprotected sexual intercourse, increased awareness of chlamydia through population-level campaigns, and the increased availability of diagnostic services.

3.21.2 This upward trend in new diagnoses of STIs has also been seen on the Isle of Wight. Some IW rates of new diagnoses (per 100,000 population) are higher than the equivalent national rates - see subsequent datasets. However this reflects rates of diagnosis of STIs, and not necessarily the prevalence of STIs in the population, and indicates that people with infections are being identified and treated. Case detection has also increased since the implementation of the National Chlamydia Screening programme began on the IW during 2007.

3.21.3 The Island's Genito-Urinary Medicine (GUM) service is located within the Sexual Health Service at St. Mary's Hospital. They conduct the majority of routine STI tests on the Island, excluding the National Chlamydia Screening Programme (see separate dataset). Only GUM data is 'counted' in the HPA's analysis of new diagnoses of STIs, locally and nationally. All IW data shown here is from the GUM Clinic's reporting to the HPA.

3.21.4 The 5 main STIs diagnosed in the UK since 2003 are chlamydia, gonorrhoea, genital warts, herpes and syphilis. (Data on syphilis is not shown above because of the small numbers involved, as already mentioned).

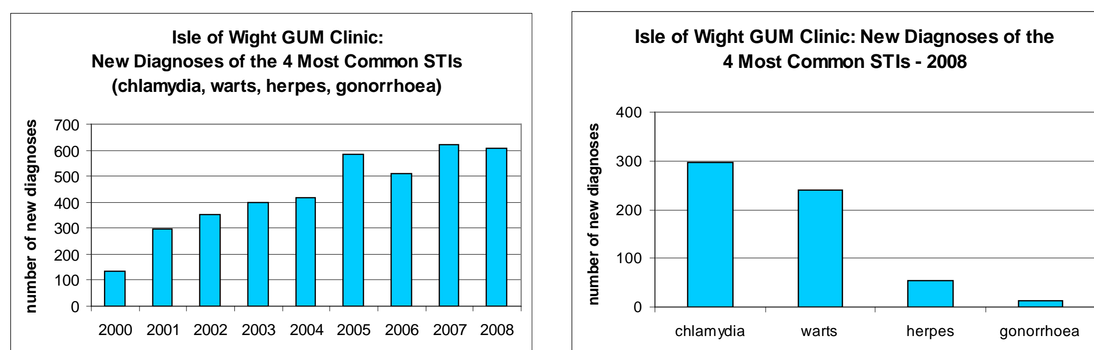


Figure 3.21.1 New diagnoses of the 4 most common STI's (Ref 05501)

3.21.5 Figure 3.21.1 (left) shows the annual number of new diagnoses made at the GUM clinic of 4 of these STIs (excluding syphilis) combined, between 2000 – 2008: 3,922 in total. Although numbers have fallen in some years, the trend over the period shown has been upwards, reflecting the national trend. Figure 3.21.1 (right) shows new diagnoses in 2008 by STI. Chlamydia was the most common STI diagnosed in 2008, representing 50% of new diagnoses, and further data is shown separately. New diagnoses of Gonorrhoea are much less common compared with chlamydia, nationally and locally, but gonorrhoea is considered a more appropriate proxy to provide a reliable indicator of the general state of unsafe sexual behaviour and sexual health. Further gonorrhoea data is shown separately.

3.22 Chlamydia

3.22.1 Chlamydia is the STI most commonly diagnosed nationally and locally: it represented 31% of all new STI diagnoses in UK GUM clinics in 2007. Untreated chlamydia can initially be symptom-free, but can lead to serious complications in women, including infertility and ectopic pregnancy, as well as complications in men. As the available information was about the behaviour of under 25's, further discussion can be found by in section 5.10 below.

3.23 Gonorrhoea

3.23.1 Gonorrhoea is the second most common bacterial STI in the UK, after chlamydia. New diagnoses of gonorrhoea are much less common compared with chlamydia, nationally and locally. However gonorrhoea, which is usually symptomatic, is considered a more appropriate proxy to provide a reliable indicator of the general state of unsafe sexual behaviour and sexual health. If untreated it can lead to chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy and infertility in women.

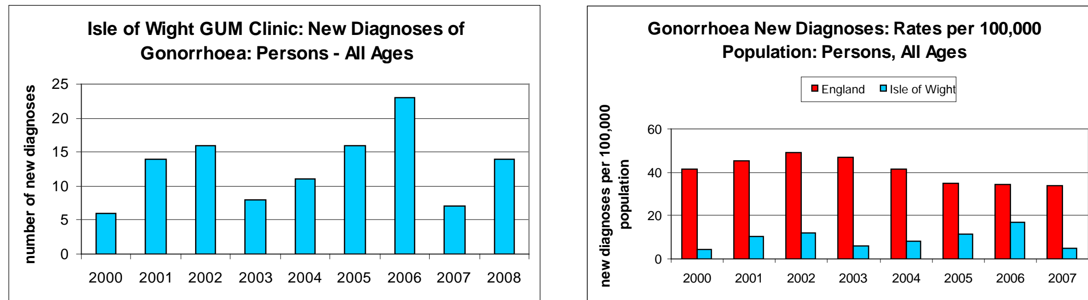


Figure 3.23.1 Isle of Wight GUM Clinic – New diagnoses and rates per 10,000 population (Ref 05502)

3.23.2 Figure 3.23.1 (left), show the number of new gonorrhoea diagnoses by year between 2000 - 2008 for Persons, All Ages. The year-on-year numbers are relatively small and follow a pattern similar to the national figures in that, over this period:

- 75% of IW diagnoses were of Males, 25% were of Females.
- 51% of IW diagnoses were in the 15-24 group, a lower % than for diagnoses of chlamydia (75%).

3.23.3 Figure 3.23.1 (right), show the rate of new diagnoses per 100,000 population for All Ages, comparing the IW with England. This data shows that the IW rate has been consistently lower than for England. It should be noted that:

- the IW rates are based on relatively small numbers of cases each year, which fluctuate year on year;
- these are rates of new diagnosis, and not prevalence rates.

NB: no local area rates are available from the HPA, so IW rates have been calculated locally.

3.24 HIV/AIDS – Diagnosed Prevalence

3.24.1 HIV stands for Human Immunodeficiency Virus. According to the national Health Protection Agency (HPA), "HIV continues to be one of the most important communicable diseases in the UK". People with HIV usually have no symptoms for a prolonged period of time, while the virus acts slowly to weaken the body's immune system. Nationally, 28% of people with HIV are unaware of their infection. HIV can in time lead to AIDS (Acquired Immune Deficiency Syndrome). HIV can be found in blood, semen, vaginal fluids and breast milk.

3.24.2 HIV prevalence is defined as the proportion of people in a population who are infected with HIV. The Survey of Prevalent HIV Infections Diagnosed (SOPHID) is an annual survey which collects reports of individuals living with HIV who have been in contact with the NHS. It is therefore a good measure of the annual prevalence of HIV in the population, although as noted above, some people who are infected have not yet been diagnosed.

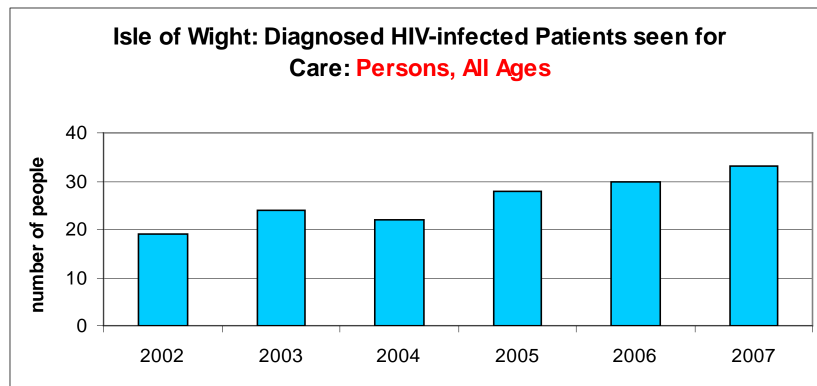


Figure 3.24.1 Isle of Wight : Diagnosed HIV-infected Patients seen for care (Ref 05601)

3.24.3 Figure 3.24.1 above shows the number of Isle of Wight residents who received HIV-related treatment or care, though not necessarily on the IW itself, by year for the period 2002 – 2007. NB: there will be significant overlap of patients across the 6 years shown, with the same patients counted in each year during which they received care. While numbers have risen over the period shown, this could be because more people are being screened and diagnosed, and not necessarily because the prevalence in the population is increasing.

3.24.4 HIV crude prevalence rate: this is defined as the number of individuals accessing HIV care per 1,000 population (aged 15-59 years). In 2007 the Isle of Wight's rate was 0.33 cases per 1000 population, among the quintile of Local Authorities with the lowest rates in England.

3.24.5 HIV incidence is the number of new cases diagnosed each year. Incidence data for Local Authorities or Primary Care Trusts cannot be published because annual numbers are small and publication risks identifying individuals.

3.25 People Killed or seriously injured on roads

3.25.1 The IW Council is committed to reducing the number of road casualties in line with the Road Casualty Reduction 2010 Targets. These targets are:

- to reduce the annual number of road accident casualties of All Ages who are Killed or Seriously Injured (KSI) by 40% from the baseline (1994-1998 average).
- to reduce the annual number of road accident casualties aged under 16 who are KSI by 50% from the baseline (1994-1998 average).

3.25.2 In actual numbers the 2010 targets for the annual number of KSI casualties are:

- All Ages: 73
- Aged under-16: 8

3.25.3 The Local Transport Plan (LTP2) and Local Area Agreement (LAA2) reflect these targets but use a rolling three year average (due to low annual numbers).

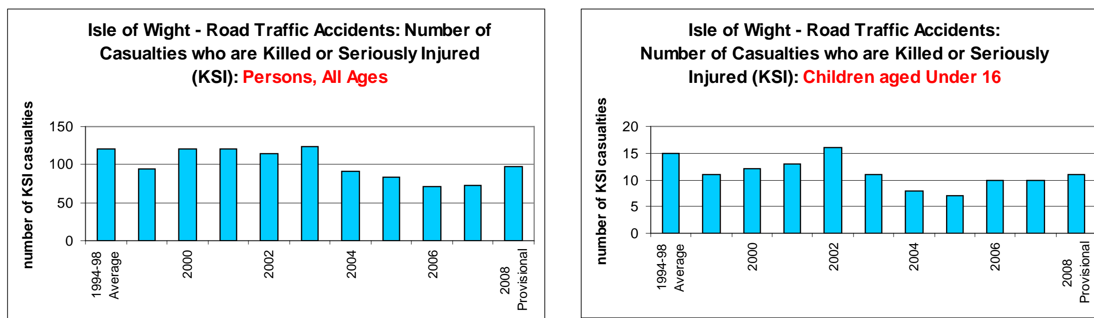


Figure 3.25.1 Isle of Wight – Road Traffic Accidents : Number of casualties who are killed or seriously injured (Ref 06401)

3.25.4 Up to 2008 the IW was exceeding both targets, as demonstrated in the graphs above, however 2008 showed an approximate 30% increase in the number of KSI casualties. Using a rolling three year average, the overall KSI target is still being met. While the under-16 target is not being met, it must be considered that this target involves very small numbers and one incident can easily alter the whole picture. Early indications for 2009 are that the figures are returning to 2007 levels.

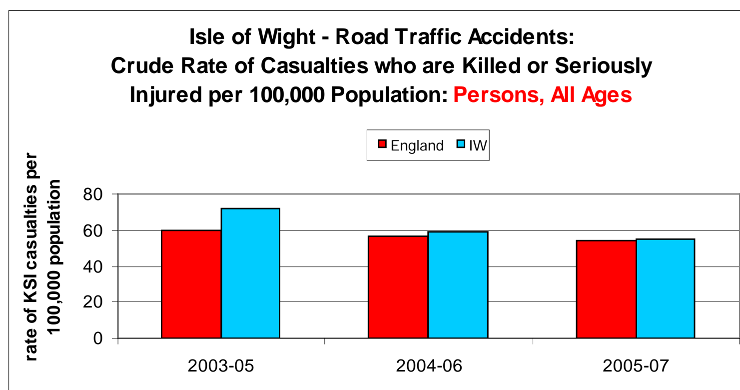


Figure 3.25.2 Isle of Wight – Road Traffic Accidents : Number of casualties who are killed or seriously injured per 100,000 population (Ref 06401)

3.25.5 The rate of KSI casualties per 100 000 population is also declining and is approaching the national average, as shown in the chart immediately above.

3.26 Admissions for Hip Replacements

3.26.1 This indicator is included to monitor the provision of, and level of access to, operative procedures such as hip operations. These are known to benefit people in terms of improved mobility and pain relief to people with hip joint problems, though not everyone who could benefit from surgery will necessarily access it. This data compares admission numbers and rates among the **under-75 and 75+ age groups**

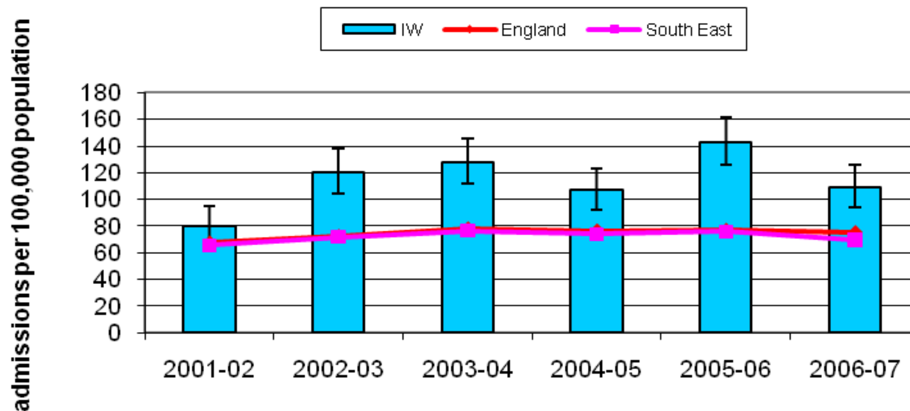


Figure 3.26.1 Hospital admissions for Hip Operations, under 75; Trends IW, GOSE, England (Ref 06702)

3.26.2 In the under-75 age group, the IW admission rate increased over this period, compared with stable rates in England and the South East, and was statistically significantly higher than those rates for most of that period.

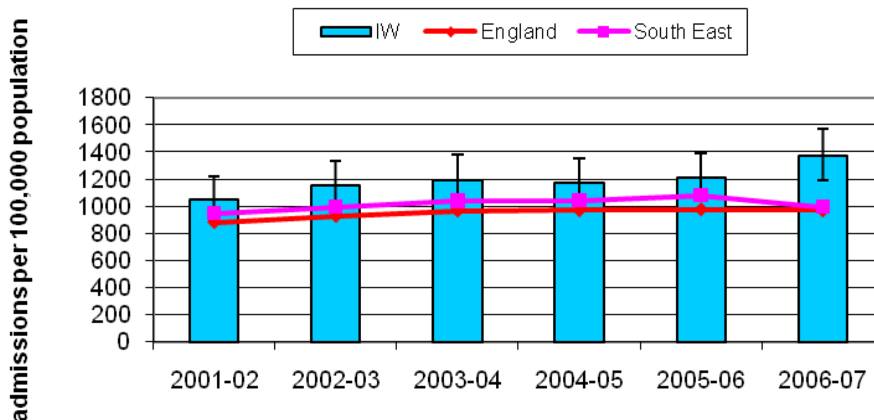


Figure 3.26.2 Hospital admissions for Hip Operations, 75+; Trends IW, GOSE, England (Ref 06702)

3.26.3 In the 75+ age group, the IW rate increased over this period, again compared with relatively stable rates in England and the South East. The IW rate was higher than those rates for the whole period, but was statistically significantly higher only in 2006-07, the most recent data available

3.27 Admissions for Knee Replacements

3.27.1 This indicator is included to monitor the provision of, and level of access to, operative procedures such as knee operations. These are known to benefit people in terms of improved mobility and pain relief to people with knee joint problems, though not everyone who could benefit from surgery will necessarily access it. This data compares admission numbers and rates among the under-75 and 75+ age groups

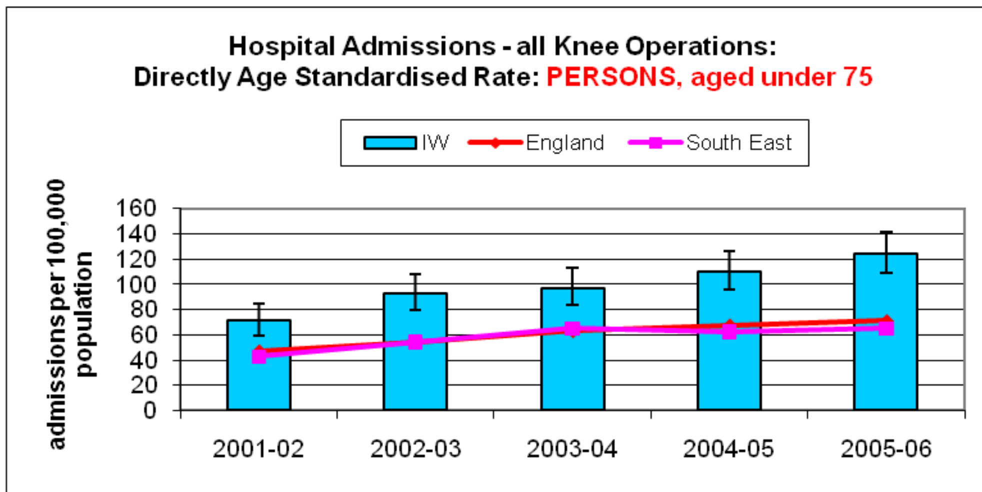


Figure 3.27.1 Hospital admissions for Knee Operations, under 75; Trends IW, GOSE, England (Ref 06701)

3.27.2 In the under-75 age group, the IW admission rate increased over this period, faster compared with England and the South East, whose rates also increased. The IW rate was statistically significantly higher than those rates for all of that period.

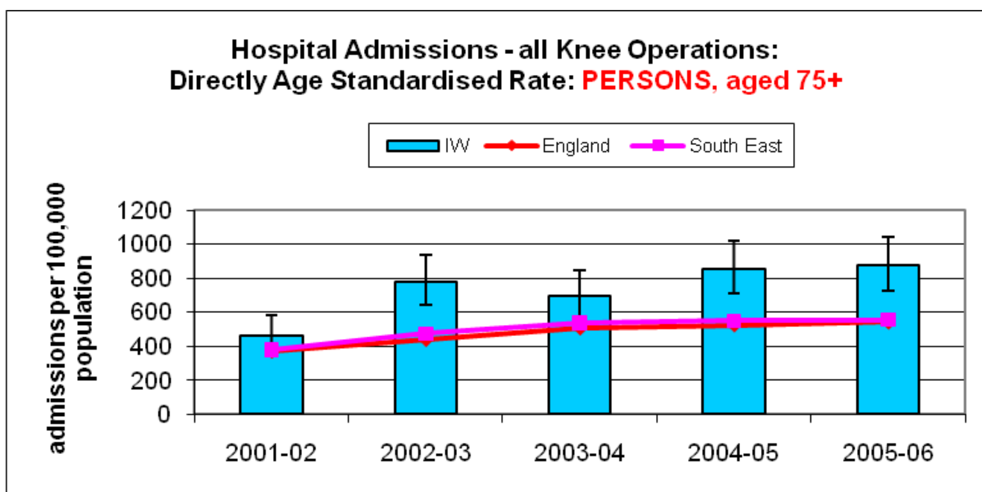
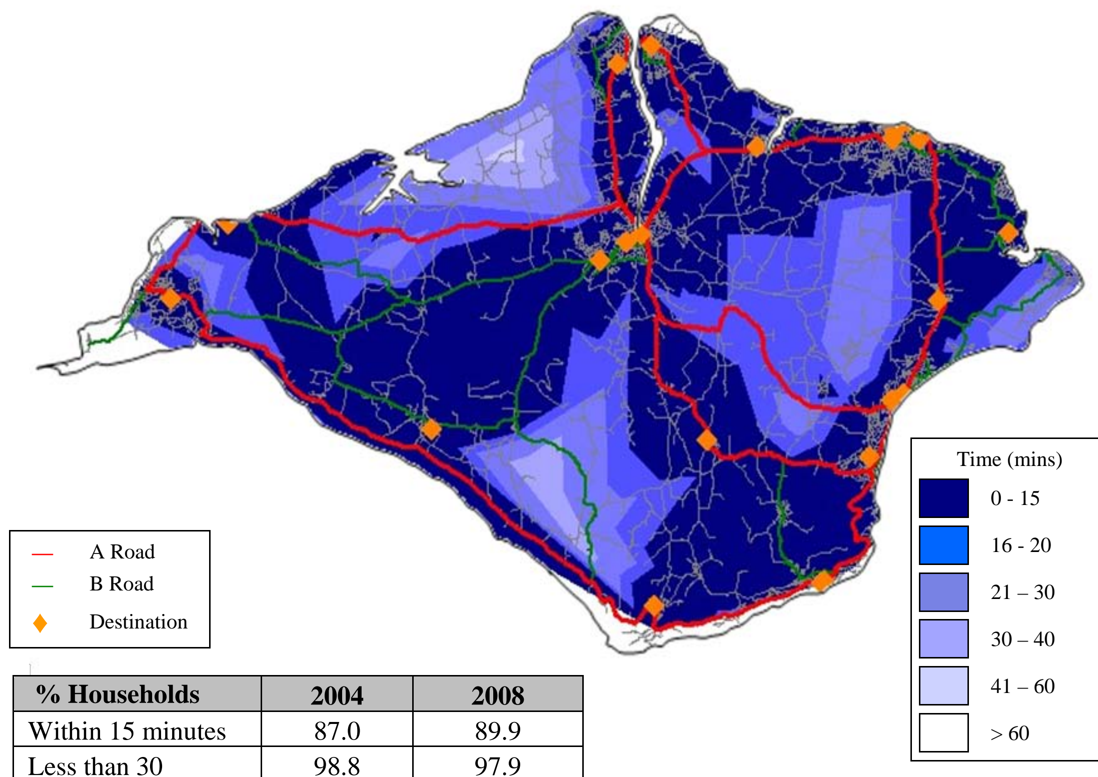


Figure 3.27.2 Hospital admissions for Knee Operations, 75+; Trends IW, GOSE, England (Ref 06701)

3.27.3 .In the 75+ age group, the IW rate increased over this period, again faster compared with England and the South East, whose rates also increased. The IW rate was statistically significantly higher than those rates for most of the period. More data on this indicator can be found on the Information Observatory/JSNA website at Reference 06701.

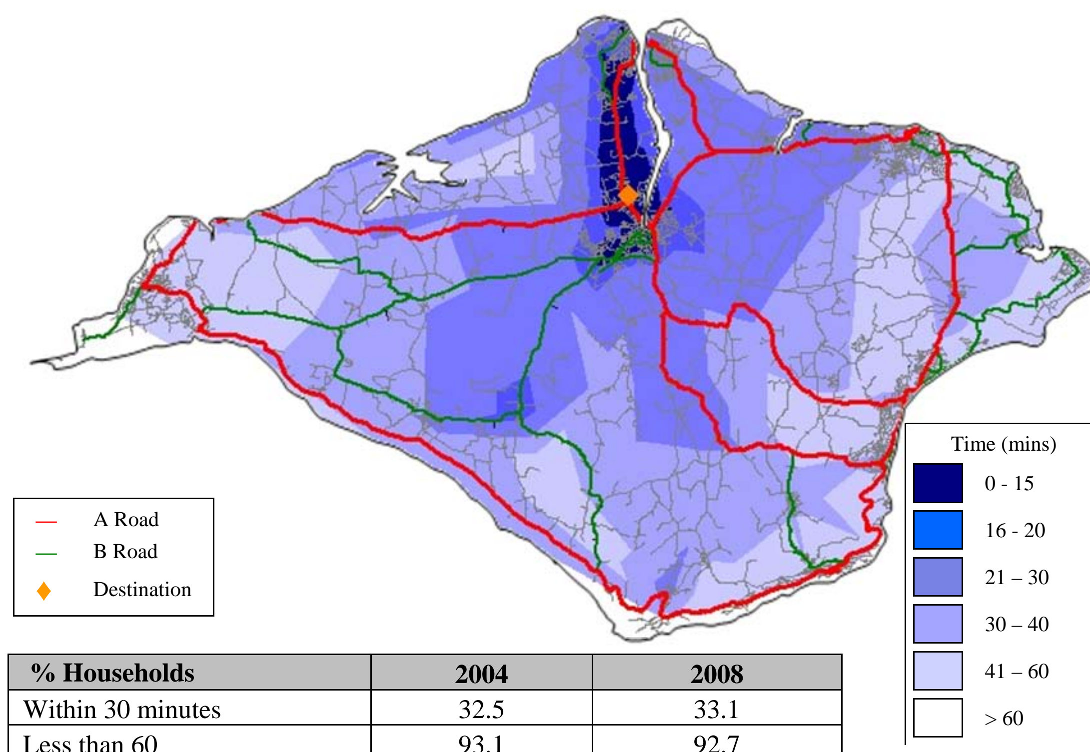
3.28 Access to Medical Services



% Households	2004	2008
Within 15 minutes	87.0	89.9
Less than 30	98.8	97.9

Figure 3.28.1; Access to GP Surgeries by Public Transport and Walking - indicates the fastest possible public transport based journeys from doorstep to the nearest GP surgeries during 07:00 to 09:00 on a weekday.

3.28.1 GP Coverage: Figure 3.28.1 demonstrates that GP surgeries are seemingly supplying good coverage to the major concentrations of population. Increased proportions (2.9%) of households are within 15 mins of a GP surgery when 2008 is compared to 2004, over the same time period a 1.1% drop in the 'within 30 minutes' coverage occurred. These changes reflect the progressive concentration of the population and building of accommodation.



% Households	2004	2008
Within 30 minutes	32.5	33.1
Less than 60	93.1	92.7

Figure 3.28.2; Access to St Mary's Hospital by Public Transport Walking and Cycling: indicates the fastest possible public transport based journeys from doorstep to St Mary's Hospital during 07:00 to 09:00 on a weekday.

3.28.2 Travel time to St Mary's Hospital, between 2004 and 2008 these have improved at the 30 mins or less level by 0.6%, and worsened 0.4% at the less than 60 minutes level. Approximately 7% of Island residents dependant on public transport face a journey of at least 1 hour to reach St Mary's Hospital.

Isle of Wight Residents: Hospital Admissions by Method of Admission: 2008-09			
Admission Method	**Number of Admissions**	**% of Total**	**Examples**
Emergency	11,501	39%	pneumonia, heart attacks, head injuries
Elective	14,938	51%	cataract procedures, cancer treatments
Non Emergency, Non Elective	2,766	9%	childbirth and related
Total	**29,205**	**100%**	

Figure 3.28.2 Admissions to Hospital 2008-09; count and classification (Ref 03601)

3.28.3 Hospital Admissions: A breakdown by top 10 causes for each of the categories of risk may be had on the Information Observatory/JSNA website at Reference 03601.

3.28.4 Dental Services: Primary Care Trusts (PCTs) have responsibility for commissioning primary care dental services to meet the needs of their local populations. They carry this out by contracting with local dental providers for an agreed annual level of dental services. The NHS services are delivered through independent contractors and salaried dentists. PCTs are required to improve patient access to NHS dental services and ensure year-on-year improvements in the numbers of patients accessing such services

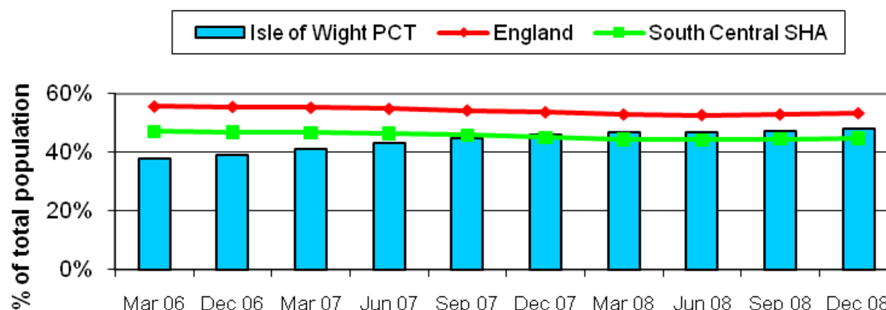
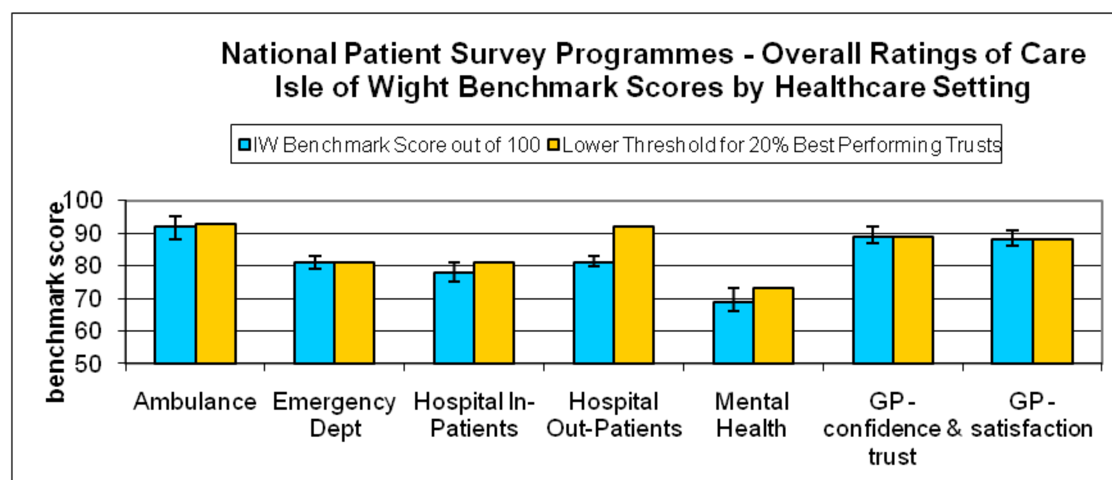


Figure 3.28.3 Total patients seen (Adults + Children) by NHS Primary Care Dental Services as a percentage of the Total Population in the previous 24 months ending at the specified dates (Ref 08301)

3.28.5 The data and chart, in Figure 3.28.3 show the % of the total population who have been seen by NHS primary care dental services within the previous 2 years, comparing the IW with England and South Central Strategic Health Authority over time. This shows that the IW's % increased from 38% to 48% over this period, and the Island's gap with England and the SHA has narrowed, although both are still higher

3.29 Patient Satisfaction with Care

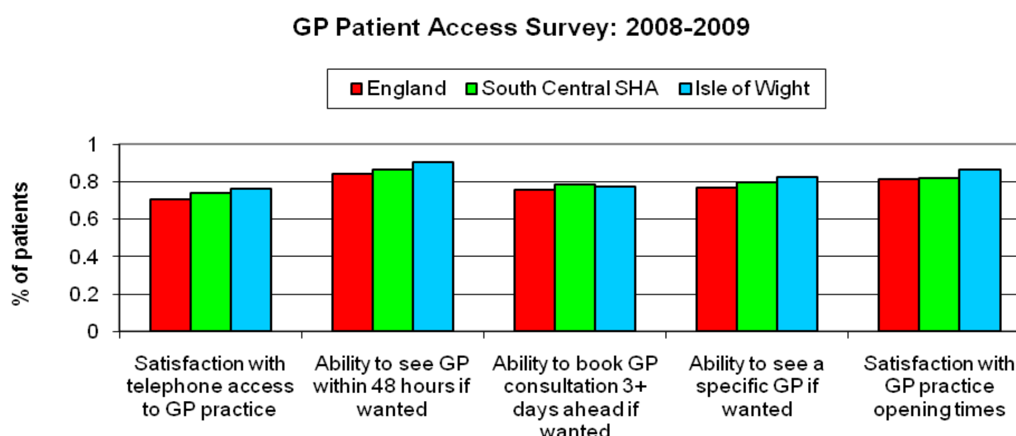
3.29.1 Satisfaction with access to primary care (e.g. GP Practice services) is a Public Service Agreement priority for the Department of Health. If someone is satisfied with access to primary care, they are more likely to be able to access primary care when and where they need it. This is, in turn, likely to lead to better overall health outcomes.



Survey Year	Service	IW Benchmark Score out of 100	Lower Threshold for 20% Best Performing Trusts
2008	Ambulance	92	93
2008	Emergency Dept	81	81
2008	Hospital In-Patients	78	81
2004-05	Hospital Out-Patients	81	92
2008	Mental Health	69	73
2008	GP - confidence & trust	89	89
2008	GP - satisfaction	88	88

Figure 3.29.1 Isle of Wight: National Patients Survey Programme Findings - Overall Satisfaction with Care (Ref 09501)

3.29.2 The Island score is the same as or statistically similar to the threshold score for 4 out of the 6 settings - this means that the Island score is among or close to the top 20% nationally. The IW is lower than the threshold score for 2 settings, Mental Health and Out-Patients Department, though it should be noted that the most recent Out-Patients survey is from 2004-05.



2008-09 Survey Findings	England	South Central SHA	Isle of Wight
Satisfaction with telephone access to GP practice	70%	74%	76%
Ability to see GP within 48 hours if wanted	84%	87%	91%
Ability to book GP consultation 3+ days ahead if wanted	76%	79%	77%
Ability to see a specific GP if wanted	77%	80%	82%
Satisfaction with GP practice opening times	82%	82%	86%

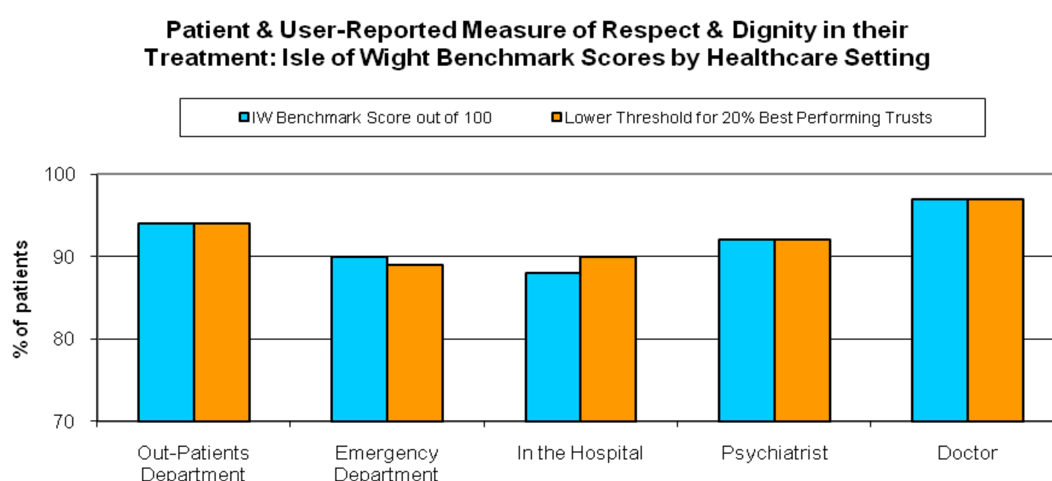
Figure 3.29.2 Patient Satisfaction with Access to Primary Care (GP) Services: 2008-09 Survey Findings (Ref 09701)

3.29.3 The data and chart show findings for the 2008-09 survey, comparing the IW with England and South Central SHA. The IW performed better on 4 out of the 5 measures of

access compared with England and South Central. Comparisons with previous years are not shown as the questionnaire wording changed in 2008-09, so that any changes over time could be attributed to the change in question wording, rather than representing real change.

3.30 User Reported Respect and Dignity

3.30.1 The Department of Health has introduced a new indicator which measures whether patients and users of healthcare services perceive that they have been treated with respect and dignity. This is measured by a rolling programme of patient surveys in different healthcare settings using standardised instruments and methodologies. The survey programme is designed so that each provider conducts at least one patient/user survey per year, although the precise setting/service may vary. Each survey contains a question that asks recent users whether they were treated with respect and dignity by different members of staff and/or during their treatment/care episode. It is planned in the future to integrate findings from social care surveys which address the same issue.



Date of Last Survey	Healthcare Setting	IW Benchmark Score out of 100	Lower Threshold for 20% Best Performing Trusts
2004-05	Out-Patients Department	94	94
2008	Emergency Department	90	89
2008	In the Hospital	88	90
2008	Psychiatrist	92	92
2007-08	GP	97	97

Figure 3.30.1 User-reported measure of respect & dignity in their treatment: IW benchmark scores from most recent Patient Surveys (Ref 09801)

3.30.2 The data and chart above figure 3.30.1show the findings from the most recent surveys in specific healthcare settings. PCT results are calculated by converting responses to particular questions into scores out of 100. Directly comparable England scores are not available, and so IW scores are compared with the threshold score for comparable healthcare settings in the top 20% nationally. The Island score is the same as or better than that threshold score on 4 measures - this means that the Island score is among the top 20% nationally

4. Lifestyles and Health

4.1 Smoking - Prevalence

4.1.1 Smoking is the UK's single greatest cause of preventable illness and early death, causing a wide range of illnesses including various cancers (of which lung cancer is the most significant), respiratory diseases and heart disease.

4.1.2 Information from the Health Survey for England has been used by the Office for National Statistics to measure the % of adults (aged 16+) in England who smoke, and to estimate smoking prevalence at Local Authority level based on local demographic and social characteristics.

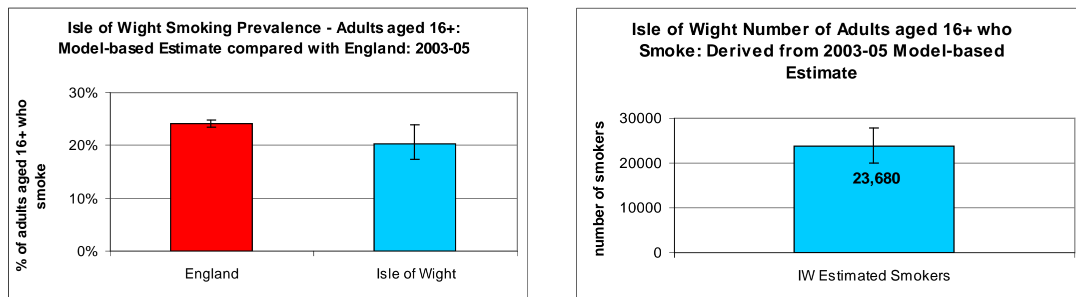


Figure 4.1.1 : Isle of Wight smoking prevalence, Adults aged 16+ (Ref 01901)

4.1.3 Figure 4.1.1 (left) shows that the IW's estimated adult smoking prevalence (among persons aged 16+) is 20.4%, lower than England's. The respective confidence intervals overlap so the difference might not be statistically significantly different. Figure 4.1.1 (right) applies the IW's smoking prevalence estimate to the Island's population aged 16+ (2007 estimate) to estimate the number of current adult smokers on the Island. There are an estimated 23,680 smokers, but the confidence interval range means that the true figure could be between 20,000 and 27,800.

4.2 Smoking in Pregnancy

4.2.1 Smoking in pregnancy is an important public health issue because of its health risks to both pregnant women and their babies. Smoking is associated with low birthweight, subsequent infant illness and even mortality.

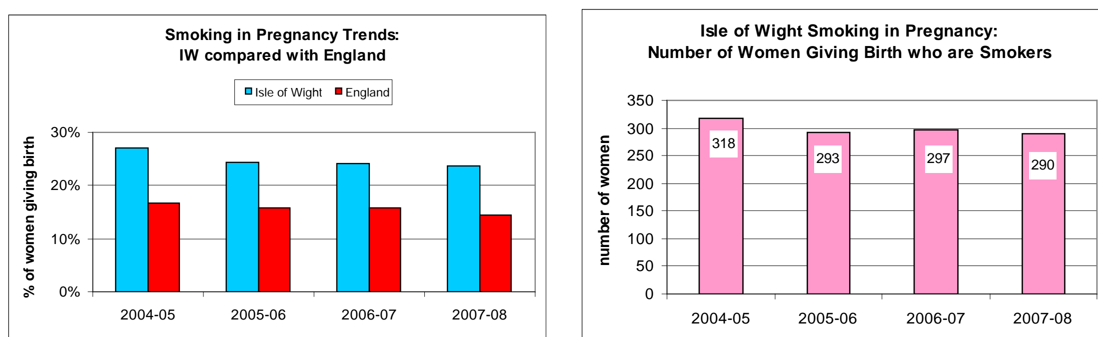


Figure 4.2.1 : Smoking in pregnancy Trends (Ref 01901)

4.2.2 Figure 4.2.1 (left) compares the IW with England over the last 4 years. Over this period the IW's rate has consistently been much higher than England's, although the IW rate has improved slightly. Figure 4.2.2 (right), shows, for this same 4 year period, the number of women giving birth who were recorded as current smokers. There were on average 300 women each year, and hence approximately 300 babies born to mothers who smoked.

4.2.3 Increasing the recording of GP Practice patients' smoking status has been a target for Primary Care Trusts, and GPs continue to report on patients' smoking status as recorded within the preceding 15 months, although directly comparable national data is not available as this indicator is not part of the Quality Outcomes Framework. As with QOF, higher numbers and % of people recorded would be seen as a good thing, as this means that more people in the population who smoke are being identified, and can potentially be offered support to quit.

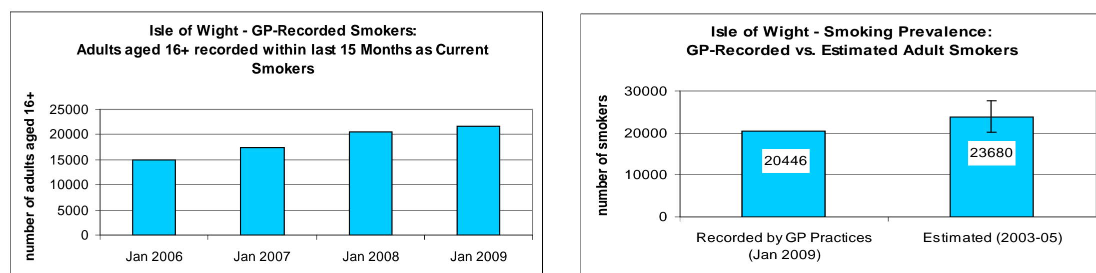


Figure 4.2.2 : GP recorded smoking prevalence (Ref 01901)

4.2.4 Figure 4.2.2 (left), shows the trends in the number of current smokers aged 16+ recorded by Isle of Wight GPs over time. Recording has increased steadily. Figure 4.2.2 (right) compares for the Isle of Wight the number of GP - recorded smokers with the estimated number of smokers. 86% of estimated smokers are recorded as such by their GP Practices, a very high proportion of the estimated total. The confidence interval range for estimated smokers means that the true % of smokers recorded could be between 74% and 100%.

4.2.5 Smoking is the UK's single greatest cause of preventable illness and early death, causing a wide range of illnesses including various cancers (of which lung cancer is the most significant), respiratory diseases and heart disease.

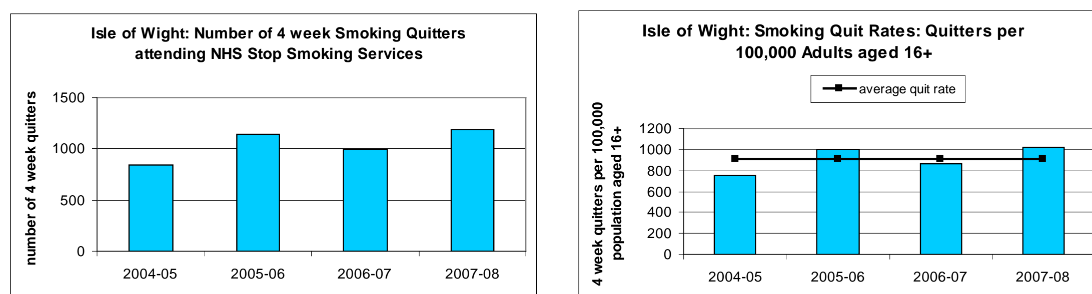


Figure 4.2.3 : Smoking quit rates (Ref 02001)

4.2.6 The data above represents smokers who quit smoking with the help of NHS Stop Smoking services and remain quit after 4 weeks. Isle of Wight NHS Stop Smoking Services include Island Quitters, GP Practices and Pharmacies. Figure 4.2.3 (left) shows the number of IW 4 week smoking quitters over the last 4 complete years. Figure 4.2.3 (right) shows the rate of week smoking quitters per 100,000 population aged 16+ over the last 4 years.

4.3 Smoking – modelled and/or recorded eating behaviour

4.3.1 Consuming recommended amounts of fruit and vegetables is a key aspect of a healthy diet. Consuming at least five portions of fruit and vegetables a day can reduce the risk from heart disease, stroke and cancer by up to 20% (Choosing Health: Fact Sheet on Diet and Nutrition' (Department of Health, 2006)).

4.3.2 National Consumption of Fruit and Vegetables is measured by the Health Survey for England (HSfE), which surveys a statistically representative sample of the population to measure lifestyle issues such as this at national and regional level. However the HSfE sample is too small reliably to determine consumption at Local Authority level. Local Consumption of Fruit and Vegetables is therefore estimated through Office for National

Statistics model-based estimates for Local Authority districts. These estimates are based on HSfE data and applied to each Local Authority's local demographic & social characteristics.

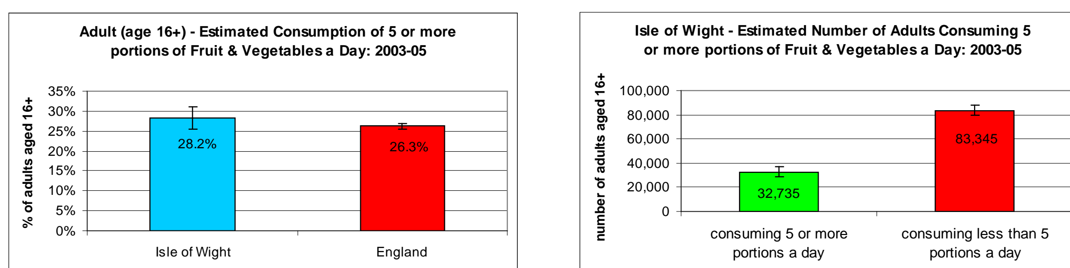


Figure 4.3.1 Estimated consumption of 5 or more portions of vegetables a day (Ref 02101)

4.3.3 Figure 4.3.1 above use both sets of information to enable us to compare adult fruit and vegetable consumption on the IW with the national situation. Figure 4.3.1 (left) compares the estimated % of adults (aged 16+) on the IW who eat 5 portions of fruit and vegetables a day, compared with the actual measures for England. It shows that the estimated % on the IW is slightly higher than in England, but that the IW confidence intervals overlap with those for England, so that the difference might not be statistically significantly.

4.3.4 Figure 4.3.1 (right), shows the estimated number of adults on the IW who consume at least or less than 5 portions a day, calculated by applying the estimated consumption prevalence and its 'confidence intervals' to the population aged 16+. The figures show that:

- Between 28,400 and 37,000 adults consume 5 or more portions a day.
- Between 78,000 and 86,600 adults consume less than 5 portions a day.

4.4 Physical Activity

4.4.1 The Chief Medical Officer recommends that: "for general health, a total of at least 30 minutes a day of moderate intensity physical activity on 5 or more days of the week reduces the risk of premature death from cardio-vascular disease and some cancers, significantly reduces the risk of type 2 diabetes, and can also improve psychological well-being". The Framework for Sport in England has defined sport's "larger contribution" to the overall 5 days a week physical activity target as 30 minutes of moderate intensity sport and active recreation on at least 3 days a week (12 days out of the previous 28 days). This '3 days a week' target has been incorporated into National Indicator 8.

4.4.2 Sport England has commissioned the Active People Survey, which measures adult participation in sport and active recreation for all Local Authorities England. Two rounds have been conducted: Active People 1 (2005-06) and Active People 2 (2007-08). Results for performance against National Indicator 8 are shown here.

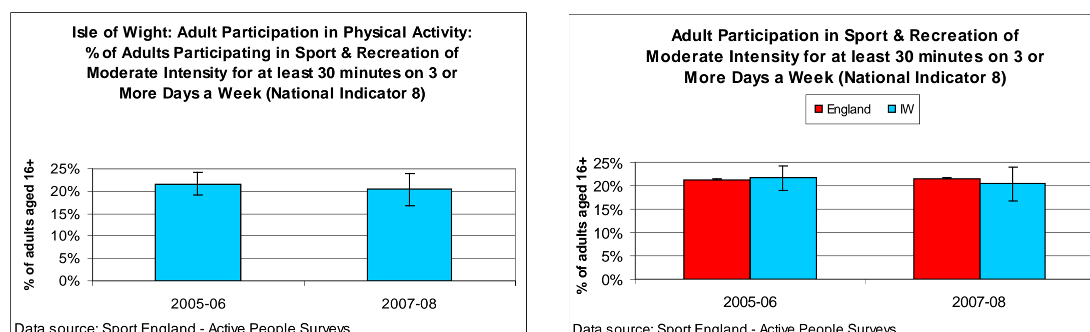


Figure 4.4.1 Physical Activity (Ref 02501)

4.4.3 Figure 4.5.1 (left) compares the Isle of Wight's results in the 2 survey periods. Participation fell slightly in the Active People 2 survey, but the change is not statistically significant. Figure 4.5.1 (right) compares the IW's results with England in the 2 surveys. The IW's participation rate is slightly higher than England's in survey 1 and slightly lower in survey 2, but the confidence intervals overlap and the differences might not be statistically significant.

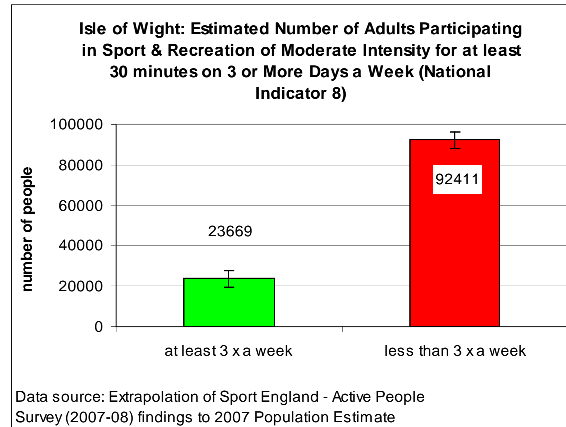


Figure 4.4.2 Adults participation in sport and recreation (Ref 02501)

4.4.4 Figure 4.4.2 extrapolates the IW's data from survey 2 to estimate the number of adults aged 16+ who undertake at least / less than 3 sessions of sport and active recreation weekly. This shows that an estimated 90,000+ adults undertake less than 3 sessions a week.

4.5 Hypertension

4.5.1 Hypertension refers to blood pressure persistently raised above a designated threshold – NICE recommends the threshold as 140/90mmHg or above. Hypertension damages arteries and organs and is a major contributory factor to cardio-vascular diseases including coronary heart disease and stroke. NICE states that monitoring for persistently raised blood pressure is one aspect of cardio-vascular risk management.

4.5.2 The Department of Health has commissioned a model to estimate and project the prevalence of hypertension in the population, recognising that GP Practice hypertension prevalence data recorded through the Quality Outcomes Framework (QOF, see separate file) does not provide a complete picture of the prevalence of hypertension in the population. This model uses national hypertension prevalence data from the Health Survey for England and applies it to individual Local Authorities, taking account of the age, sex and ethnicity breakdown of their population, and of local deprivation.

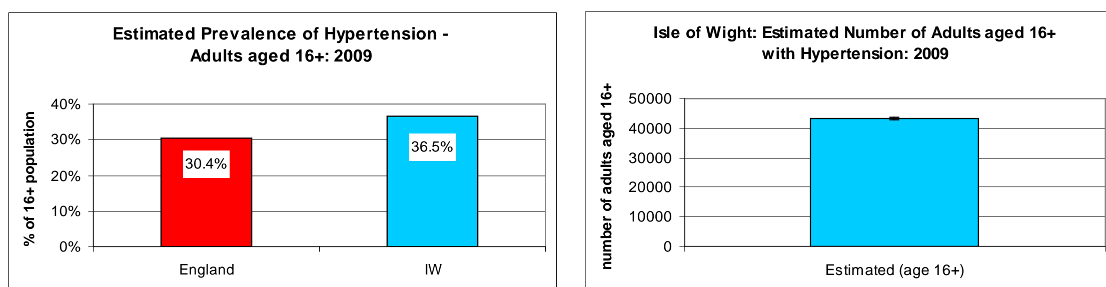


Figure 4.5.1 Estimated prevalence of hypertension (Ref 02801)

4.5.3 Figure 4.5.1 (left) compares the estimated prevalence of hypertension on the IW with that in England. Since the risk of hypertension increases with age and the IW has a proportionately larger % of older people in its population, the IW's estimated rate is

significantly higher than England's and in the highest 5% of Local Authorities in England. Figure 4.6.1 (right) applies this prevalence data to the population to show the estimated number of IW residents with hypertension, of whom there are over 43,000.

5 Children and Young People

5.1 Children and Young People; population

5.1.1 The population of the Isle of Wight is growing at a faster rate than the rest of the south east and the UK, with working age population levels comparatively low. The Island's population has relatively high numbers of retirees, an ageing population and a significant number of people not in education, employment or training. In total we have approximately 140,000 residents; the total amount of children aged 18 and under on the Island is 27,790.

5.1.2 Between 2002 and 2007 (See section 1.3), the population of children aged 0 to 15 has declined both absolutely (from 24,100 to 23,500) and proportionally (from 18.0% to 16.8%), ONS population estimates. In the decade prior to 2005 the school age population had grown by 2.8%.

5.2 Key aims of the Isle of Wight Children's Trust – 2009 to 2012

- Improve emotional and physical health and wellbeing of all children and young people on the Isle of Wight
- Strengthen interagency communication to promote the safety and wellbeing of all children and young people on the Isle of Wight
- Enable all children and young people on the Isle of Wight to achieve their full potential through a range of outcomes (personal/social/physical/emotional/academic)
- Encourage all children and young people participating in positive activities to develop personal and social skills, promote wellbeing and reduce behaviour that puts them at risk
- Engage all children and young people in meaningful employment, education and training.

5.3 Be Healthy

5.3.1 Aim: Improve emotional and physical health and wellbeing of all children and young people on the Isle of Wight

5.3.2 To achieve this we will:

• discourage smoking, alcohol and substance misuse among young people;
• provide access to information, advice, guidance and support for healthy life choices and lifestyles;
• provide a comprehensive child and adolescent mental health service with an increase of accessibility of user friendly services;
• encourage opportunities for involvement in physical activities.

5.3.3 Children and young people told us that:

The recent TellUs3 survey found that the vast majority (58 per cent) of children consider themselves to be quite healthy while 29 per cent consider themselves to be very healthy. But while the overall picture was positive, some concerns also emerged. These related to drinking and low self-esteem/body image.

5.3.4 National Indicator 50 (Emotional Health of Children) rationalises that the quality of relationships young people enjoy is a key risk factor for their emotional well-being. Figure X shows the four question items from the TellUs 3 survey which examine the quality of children's relationships with peers, parents and other adults.

5.3.5 In the Isle of Wight survey (taken across 3 year groups in 25 schools), the percentage of children responding "true" to each question was 1% lower than the national average indicating similar responses to those made by comparable children in other Local Authorities

in England. Perhaps of most concern is the 17% of children responding who felt they could not talk to mum or dad when "worried about something". This is 2% higher than the national average - the biggest gap across the 16 possible responses.

	Isle of Wight %	National %
TellUs 3 Survey question 2j: For each of the following sections please tick the option that best describes you. (Tick one option for each section)		
I have one or more good friends		
True	94	95
Neither true nor not true	2	3
Not true	3	2
Don't know	0	1
When I'm worried about something I can talk to my mum or dad		
True	65	66
Neither true nor not true	17	16
Not true	17	15
Don't know	2	3
When I'm worried about something I can talk to my friends		
True	70	71
Neither true nor not true	18	17
Not true	10	10
Don't know	2	3
When I'm worried about something I can talk to an adult other than my mum or dad		
True	51	52
Neither true nor not true	21	20
Not true	24	23
Don't know	4	5

Figure 5.3.1 : TellUs 3 question 2j - National Indicator 50

5.3.6 Other consultation activity highlighted:

- the need for the promotion of healthy lifestyles;
- the need for more information for young people and their parents/carers about healthy eating and taking exercise;
- the importance of improved access to help with emotional and mental health issues, especially at school and in the areas where they live.

5.3.7 Where more work is needed:

- *Continue to improve the emotional wellbeing and mental health of children and young people, with more services around prevention.*
- *Obesity levels continue to be a concern.*
- *There is a continuing decrease in substance misuse, but concern remains that this should improve further.*
- *Immunisation uptake rates remain low.*
- *Teenage conceptions remain significantly above target and more work needs to be done to support young people in their sexual behaviour and their understanding of the consequences around risk taking.*
- *Improve breast feeding education*
- *Improve dental health*

5.4: Children's Mental Health

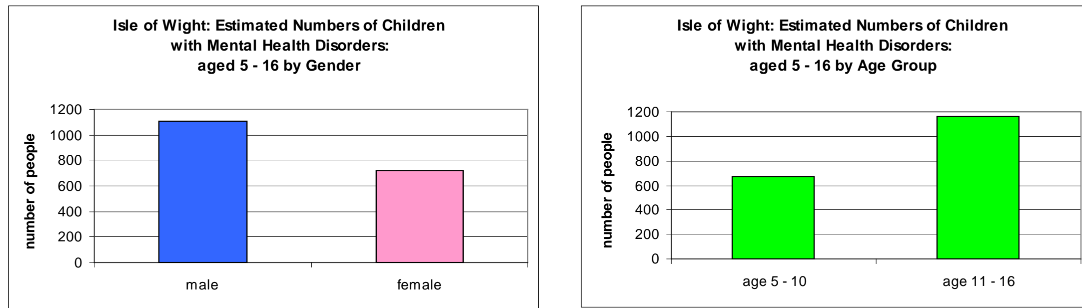


Figure 5.4.1 : Isle of Wight : est. numbers of children with mental health disorders (Ref 06201)

5.4.1 Figure 5.35.2 shows the estimated number of IW children aged 5 - 16 with mental health disorders, including anxiety and depression, conduct disorders and hyperactivity. The total exceeds 1,800 children, of whom 61% are male and 39% female, with numbers higher among older children. Nationally there is evidence that children and young people in the poorest households are three times more likely to experience mental health problems than those in more affluent households. These estimates do not reflect actual numbers of children known to relevant services, the degree of difference between the indicator and the actual service delivery constitutes an evidence gap.

5.4.2: The term CAMHS (Child and Adolescent Mental Health Services) describes mental health services for young people. According to the National Service Framework (NSF) NSF, the term is used in two different ways.

- As a broad concept embracing all services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies.
- Specialist CAMHS delivered by specialist staff for young people with more severe, complex or persistent disorders – this latter usage is the topic of the following .

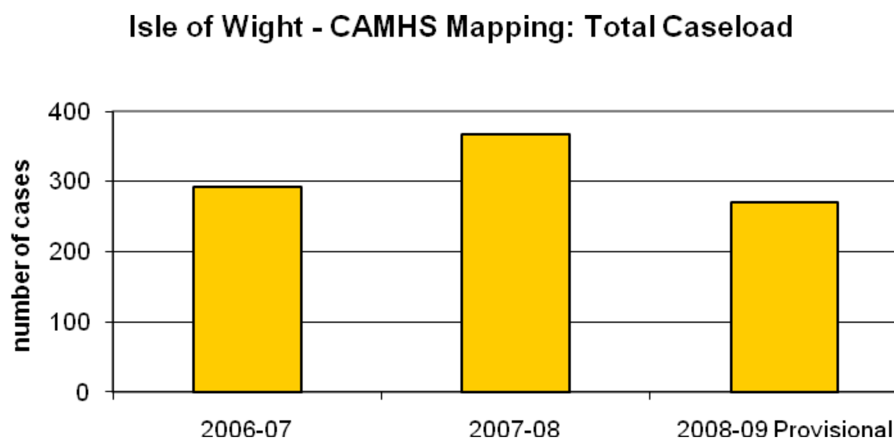


Figure 5.4.2: CAMHS Caseload 2006 to 2009 (ref 12901)

5.4.3: CAMHS Mapping is an annual data collection and reporting system which creates an annual snapshot of local service provision and investment, and provides trend data as annual data accumulates. The total caseload and number of new cases increased significantly in 2007-08 but fell again in 2008-09. It is not clear why this was and it is possible that it reflects an inconsistency in local data collection and recording for the mapping exercise.

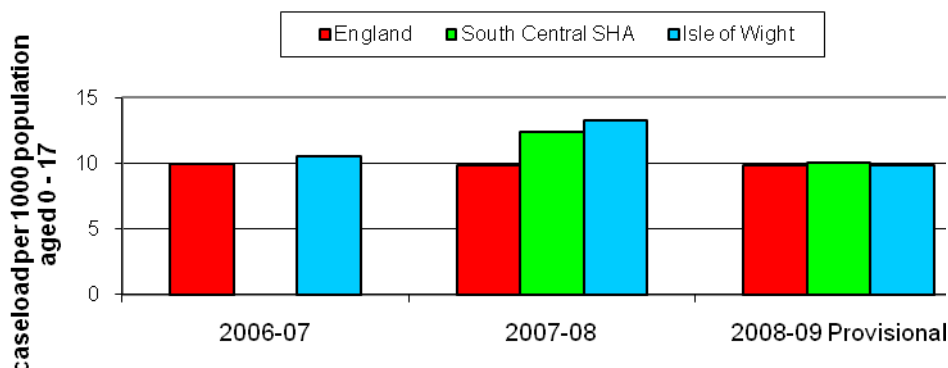


Figure 5.4.3: CAMHS Caseload 2006 to 2009 (ref 12901)

5.4.4: In 2008-09, compared with England and South Central Strategic Health Authority, the IW had a similar caseload rate (number of cases per 1000 population aged 0 - 17). The IW rate was higher than both in 2007-08 but based on the higher number of cases mentioned above.

CAMHS Primary Presenting Problem, by Year			
	2006-07	2007-08	2008-09 provisional
Hyperkinetic disorders/ problems	10	50	40
Emotional disorders/ problems	108	223	136
Conduct disorders/ problems	16	75	45
Eating disorders/ problems	6	24	20
Psychotic disorders/ problems	6	15	15
Deliberate self harm	11	61	41
Substance abuse	2	22	20
Habit disorders/ problems	4	23	19
Autistic spectrum disorders/ problems	8	41	41
Developmental disorders/ problems	7	43	18
Other	6	48	16
Not Possible to Define	3		
More than one Disorder	120		
Total cases with Presenting Problem identified	307	625	411

Figure 5.4.4: CAMHS Presenting Problems; 2006 to 2009 (ref 12901)

5.4.5: The IW % breakdown of primary presenting problems (figure 5.4.4) in 2008-09 is similar to that in England and South Central SHA, where emotional disorders also comprise the largest single group of presenting problems. The IW has slightly higher percentages of deliberate self-harm, and of habit and autistic spectrum disorders

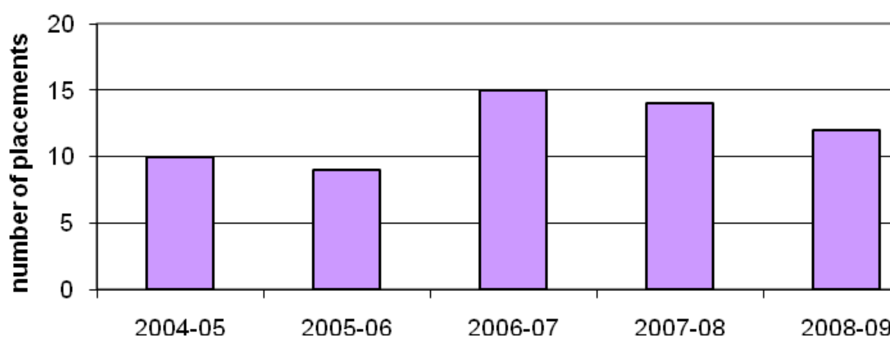


Figure 5.4.5: CAMHS Placements (ref 12901)

5.4.6 CAMHS Placement activity

- 28 young people received specialist in-patient treatments over this period, all off the Island.
- In terms of placements per year, there were 60 placements supported over the last five years, an average of 15 each year. (This figure of 60 counts each young person in each year in which they were placed).
- Over this 5 year period, 43% of young people were placed for 1 year or less; 32% for 1 - 2 years; and 25% for 2 - 5 years.

5.5 Obesity in school age children

5.5.1 The National Child Measurement Programme (NCMP) weighs and measures children in Reception (4 -5 years) and Year 6 (aged 10 – 11 years) to gather population-level data to allow analysis of trends in growth patterns and obesity; assess overweight and obese levels in order to inform local planning and delivery of services for children; and be a vehicle for engaging with children and families about healthy lifestyles and weight issues. The measurement process is overseen by trained healthcare professionals in schools; data is collected and checked by Primary Care Trusts (PCTs) and submitted to the NCMP. 2 years' worth of measurement data (2006-07 and 2007-08) are now available for the Isle of Wight.

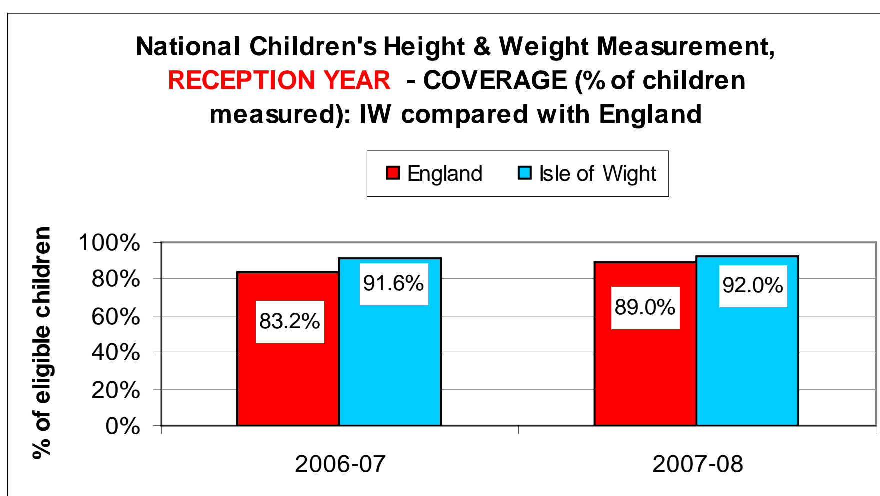


Figure 5.5.1: Island and National Children's Height and Weight Measurement – Reception Year; 2006 to 2008. (Ref 03001)

5.5.2 Figure 5.5.1 shows the % of Reception children measured (coverage) compared with England for both years in which children on the Island have been measured. The IW has had a higher coverage rate of Reception Year children in both years.

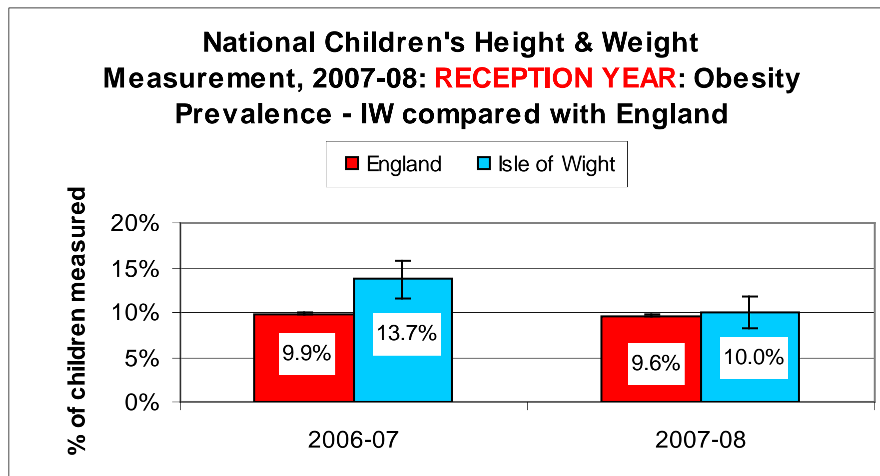


Figure 5.5.2: National children's Height and Weight Measurement – Obesity prevalence (Ref 03101)

5.5.3 Figure 5.40.2 compares the IW's measured Reception Year obesity prevalence with England's in both years in which children on the Island have been measured. In 2006-07 the IW's prevalence was significantly higher than England's and among the highest in the country. In 2007-08 the IW's prevalence fell and was closer to the England average. The IW's confidence intervals for these 2 periods overlap and so the difference between these 2 periods is unlikely to be statistically significant. With the relatively small size of the Island's year groups (e.g. there were 1,194 Reception Year children eligible for measurement in 2007-08), the prevalence will naturally vary from year to year.

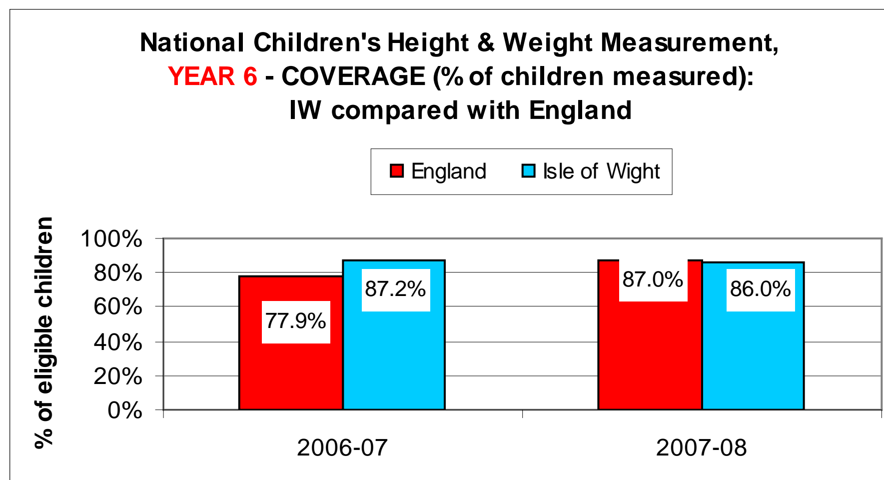


Figure 5.5.3: National Children's Height and Weight Measurement, Year 6 Coverage (% of children measured) : IW compared with England (Ref 03101)

5.5.4 Figure 5.5.3 shows the % of Year 6 children measured (coverage) compared with England for both years in which children on the Island have been measured. The IW had a higher coverage rate of Year 6 children in 2006-07 but a slightly lower rate in 2007-08.

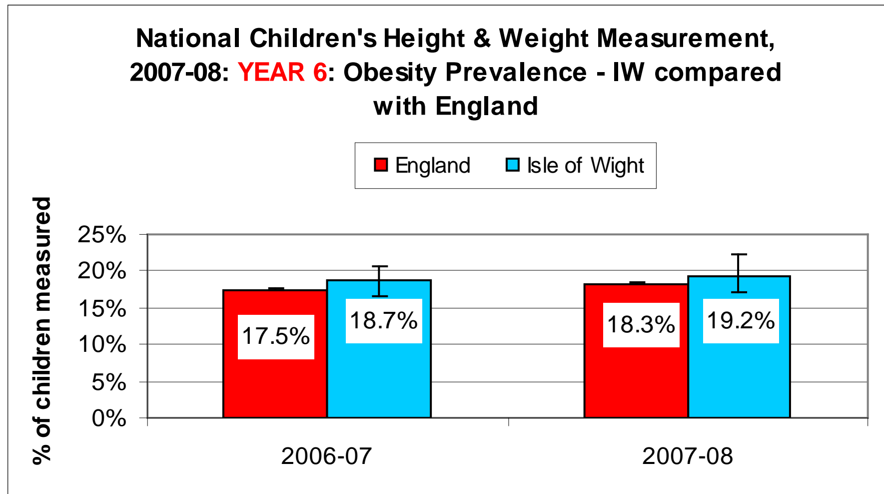


Figure 5.5.4 : National Children's Height and Weight Measurement, 2007-8 Year 6 Obesity prevalence - IW compared with England (Ref 03101)

5.5.5 Figure 5.5.4 compares the IW's measured Year 6 obesity prevalence with England's in both years in which children on the Island have been measured. The IW's rate increased slightly over the 2 years, but the confidence intervals for the 2 periods overlap and the increase might not be statistically significant. In both years the IW's rate has been higher than England's, but the confidence intervals overlapped and the difference might not be statistically significant. With the relatively small size of the Island's year groups (e.g. there were 1,505 Year 6 children eligible for measurement in 2007-08), the prevalence will naturally vary from year to year.

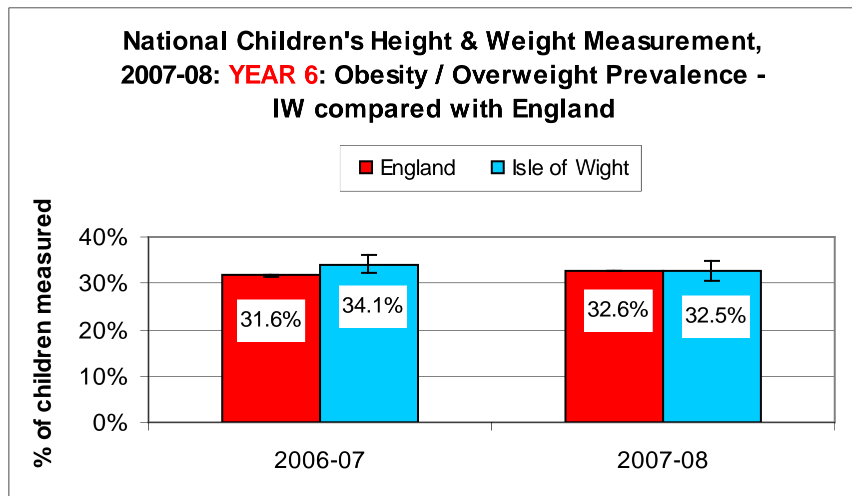


Figure 5.5.6 : National Children's Height and Weight Measurement, 2007-8 Year 6 Obesity /Overweight prevalence - IW compared with England (Ref 03101)

5.5.6 Figure 5.40.5 compares the IW's measured Year 6 prevalence of obesity / overweight with England's in both years in which children on the Island have been measured. In 2006-07, the IW's prevalence was higher than England's and the difference was statistically significant. In 2007-08 the IW's prevalence fell and was closer to the England average. The IW's confidence intervals for these 2 periods overlap and so the difference between these 2 periods might not be statistically significant.

5.6 Substance Abuse amongst Children

5.6.1 Problem Drug Users 15 to 24 are the responsibility of a number of agencies on the Island; Medical, Youth Offending Team, Education and Charitable. Much of the information for these services is co-ordinated by the National Treatment Agency, rendering a joined-up local view difficult to obtain.

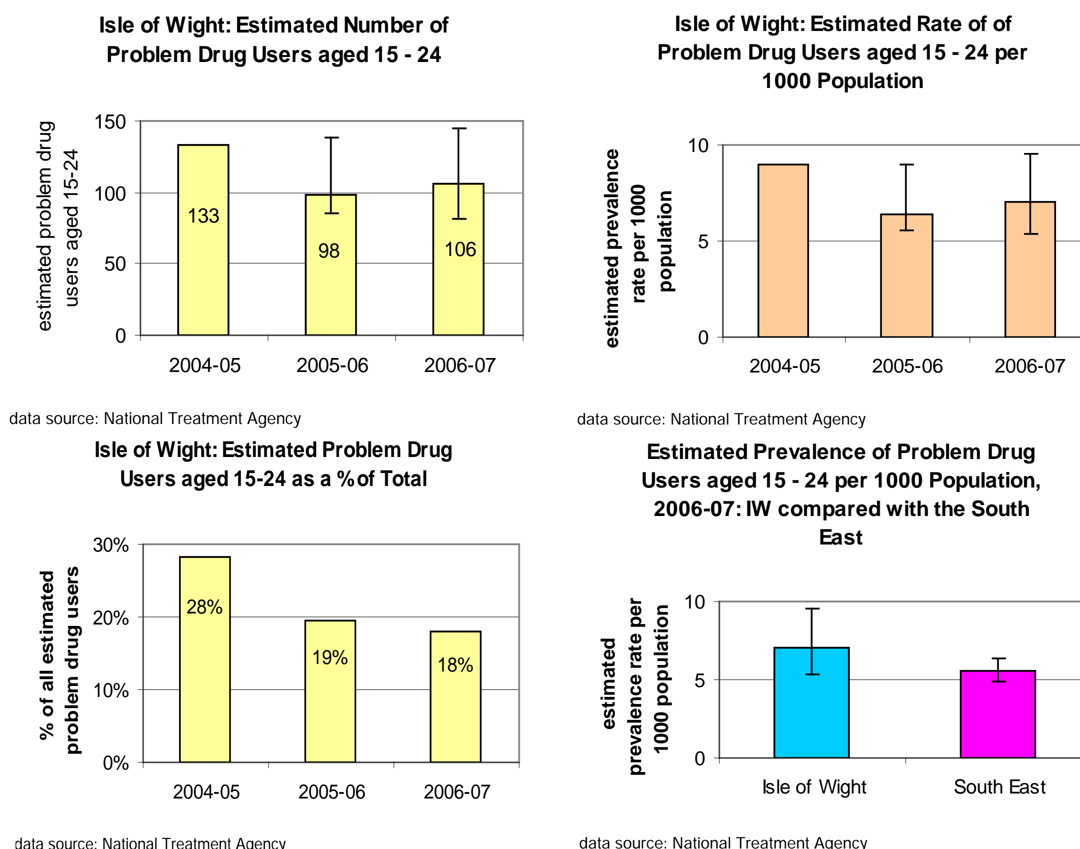


Figure 5.6.1: Problem Drug Users aged 15 to 24

5.6.2 The available information (Figure 5.6.1) is ambiguous in that overlapping confidence intervals cast doubt on their statistical significance. They appear to indicate that the Island has 1.5 more of these children per 1,000 (7.0) than is the case in the South East as a whole (5.5). They are diminishing as a percentage of all age problem drug users.

5.7 Alcohol specific Hospital Admissions among Under 18s

5.7.1 The North West Public Health Observatory (NWPHO), the lead public health observatory in England for alcohol misuse, has published nationally comparative data by Local Authority for 'persons aged under 18 admitted to hospital due to alcohol specific conditions - crude rate per 100,000 population.' This data (shown below figure 5.7.1) has demonstrated that the Isle of Wight's admission rate on this indicator has consistently been very significantly higher than the England and regional average, and one of the highest Local Authority rates in England. This data informed the adoption of a local target (NI70a) in the Island's Local Area Agreement (LAA) to reduce the rate of alcohol-specific admissions among young people. The NWPHO target definition has informed the local definition of NI70a. This target is not directly comparable with the NWPHO indicator, which counts each person admitted only once, however many times they are admitted, whereas the Island target counts each admission, including repeat admissions by the same person.

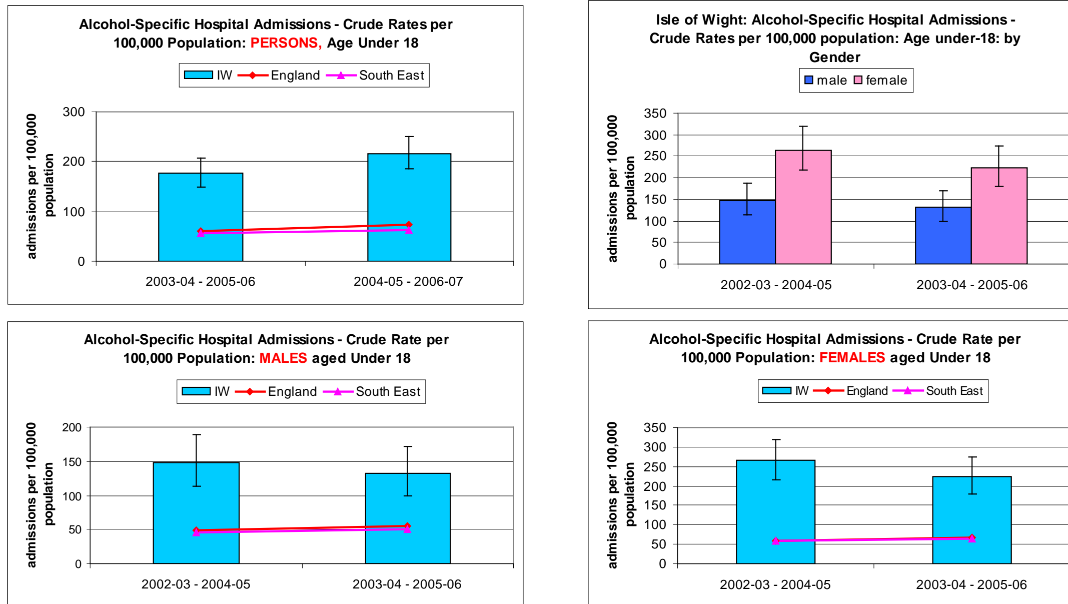


Figure 5.7.1 : Alcohol specific hospital admissions (Ref D, 02302)

5.7.2 Figure 5.7.1 shows NWPHO data for the Isle of Wight. Because the number of admissions each year at Local Authority level is relatively small, NWPHO pools (combines) data for 3 year periods to increase the robustness and meaningfulness of the rate calculations. Data for all available years is shown, though the periods for which data by Gender is available are not identical to the periods for which data by Persons is available.

The data shown includes:

- number of admissions by gender and for persons
- average number of admissions each year
- comparative crude rates of admission per 100,000 population aged under-18, by gender where available.

The key points are that, over the period shown:

- There were on average 55 admissions of under-18 IW residents each year for alcohol-specific conditions (excluding repeat admissions).
- The IW admission rates for Persons, Males and Females were consistently very significantly higher than the England and South-East regional averages, and among the worst of all Local Authorities in England.
- The IW admission rate was consistently higher among Females than among Males, reflecting the national and regional pattern.

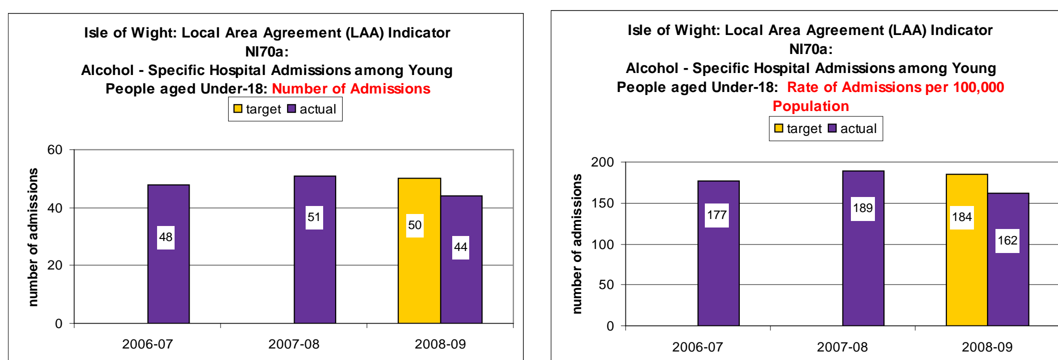


Figure 5.7.2: Isle of Wight LAA Indicator NI70a : Alcohol specific hospital admissions among Young people aged Under-18 (Ref D, 02302)

5.7.3 Figure 5.7.2 shows IW data by quarter for the year 2008-09 for the NI70a target, the first year in which this target was in operation. The data shows that there were 44 alcohol specific admissions of under-18s over the whole year, including repeat admissions. This means that performance exceeded the targets set both for 2008-09 and for 2009-10. However, the small number of admissions involved means that this reduction could have happened by chance and might not be the start of a true downward trend.

5.7.4 We still do not have a clear understanding of why the Isle of Wight alcohol-specific hospital admission rate among under-18s has been so high compared with the national and regional average. Contributory factors could include:

- problem alcohol use among young people in the community
- hospital admission policies and decision-making around the admission of young people who present at A&E having consumed excess alcohol.

Work is continuing to address this issue, including specifically through the appointment of a Specialist Alcohol Nurse in the A&E Department. It is hoped that the lower number of admissions in 2008-09 could be the start of a downward trend but it is not yet clear whether this will be the case.

5.8 Under-18 Conceptions

5.8.1 Teenage conceptions matter because the babies of teenage mothers are more likely to suffer from poor health; and because teenage mothers are more likely to leave education early and become trapped in poverty. There is a national target to reduce the under -18 teenage conception rate, from the 1998 baseline, by 50% by 2010. Each Local Authority has an individual target - the Isle of Wight's is to reduce its Under-18 conception rate by 45% from the 1998 baseline by 2010.

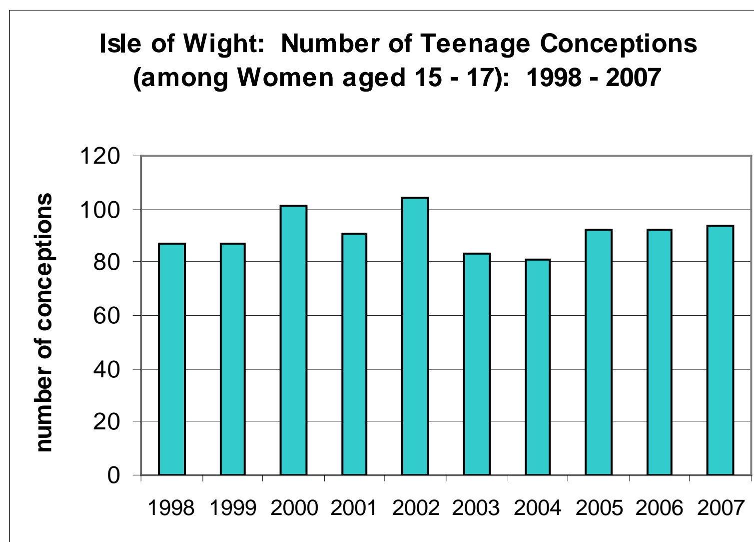


Figure 5. 8.1 : Isle of Wight: Number of Teenage Conceptions (among Women aged 15 : 17): 1998 – 2007 (Ref 02601)

5.8.2 Figure 5.38.1 shows the number of conceptions to Isle of Wight resident females aged under 18 by year since 1998. There have been on average 91 such conceptions a year over this period.

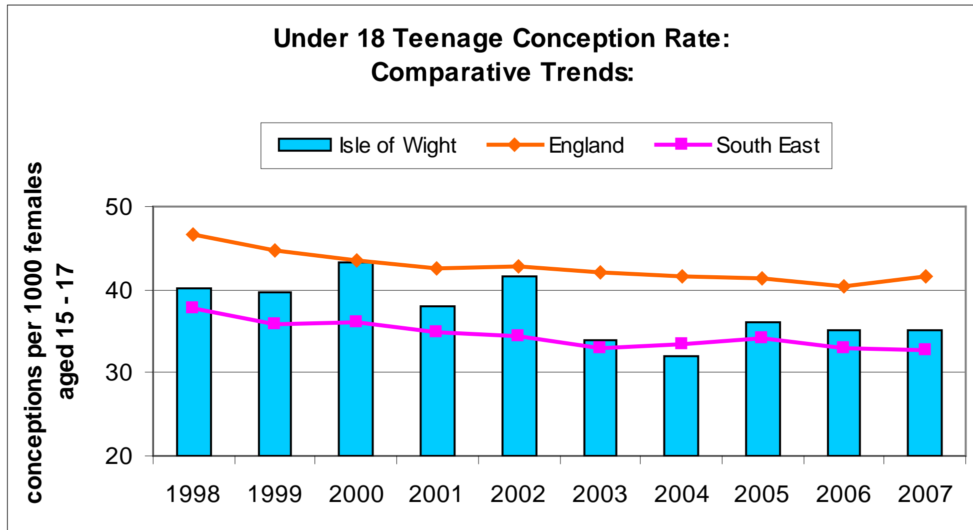


Figure 5.8.2 : Isle of Wight Under 18 Teenage Conception Rate : Comparative trends (Ref 02601)

5.8.3 Figure 5.8.2 shows the IW's conception rate compared with England and the South East over this period. The IW's rate is lower than England's and slightly higher than the South East's. However it increased slightly in 2007 and has now fallen by 12.4% over this period; achievement of the 45% reduction target will be challenging.

5.9 Under-16 Conceptions

5.9.1 While the national and Local Authority targets are to reduce the under -18 teenage conception rate, conceptions among females aged under-16 are also specifically monitored.

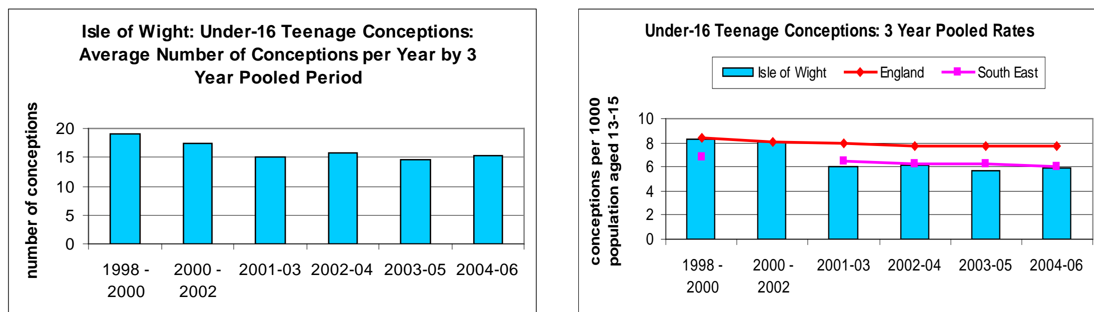


Figure 5.9.1 Under – 16 teenage conceptions (Ref 02701)

5.9.2 Figure 5.9.1 (left) shows the number of conceptions to Isle of Wight resident females aged under 16 by year since 1998. There have been on average 16 such conceptions a year over this period. Figure 5.9.1 (right) shows the IW's conception rate compared with England and the South East over this period. The IW's rate is lower than in both England and the South East and has been relatively unchanged since 2001-03.

5.10 Chlamydia

5.10.1 There is evidence of a high prevalence of chlamydia among young people, with up to 10% testing positive. The National Chlamydia Screening Programme (NCSP) offers opportunistic screening for chlamydia, with the aim of detecting asymptomatic infection in sexually active males and females aged under 25 who would not otherwise access or be offered a chlamydia test. The NCSP is offered in a range of community settings.

5.10.2 The NCSP started on the Island in 2007-08, when 3.3% of the age group 15 - 24 were screened. The 2008-09 target has been to screen 17% of the age group 15 - 24, or 2,632 people. Screenings which are conducted within the GUM clinic are not counted in this data (see separate dataset). Once the NCSP is established, it will be used to measure the prevalence of chlamydia in the 15 - 24 population; however this is not planned for 2009-10 when the % of people screened will remain as the indicator.

5.10.3 Data for quarters 1 - 3 2008-09 is shown above (Q4 data has not yet been validated) and IW performance is compared with that for England and South Central Strategic Health Authority (SHA).

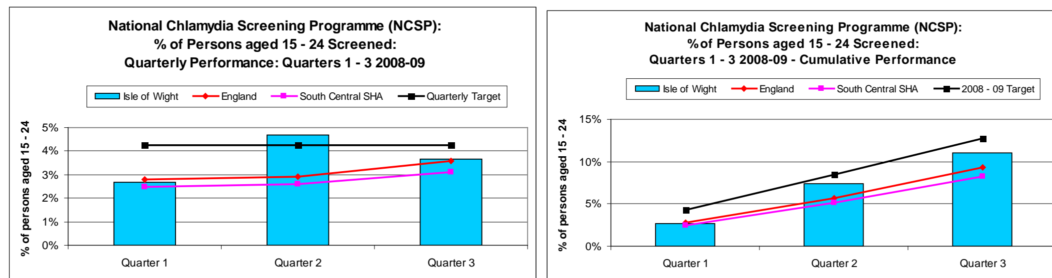


Figure 5.10.1: National Chlamydia Screening Programme (Ref 05801)

5.10.4 Figure 5.10.1 (left) shows performance by quarter compared with the quarterly target. The IW has performed well compared with England and South Central SHA, but has been below target in 2 out of the 3 quarters. Figure 5.10.1 (right) shows cumulative performance over the year to date compared with the annual target. The IW's cumulative performance was similar to or better than that in England and South Central SHA in each quarter, but was below the cumulative target in each quarter. Provisional Quarter 4 data suggests that the IW will just miss the full 2008-09 target of 17%.

5.11 Prevalence of Breast Feeding

5.11.1 There is evidence that breast-feeding has positive health benefits for both mother and baby in the short-term and longer-term (beyond the period of breast-feeding). The longer the duration of breast-feeding, the greater the health benefits. While breast-feeding initiation rates have been improving nationally, only 50% of mothers who initiated breast-feeding were still doing so at 6 weeks. This indicator has therefore replaced the breast-feeding initiation indicator previously measured.

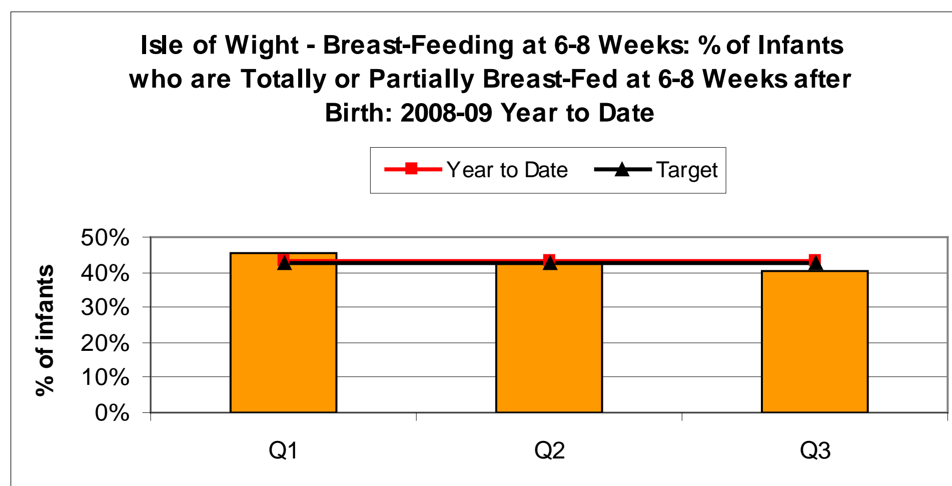


Figure 5.11.1 : Isle of Wight, Breast feeding at 6 – 8 weeks (Ref 02201)

5.11.2 Figure 5.11.1 shows IW performance by quarter during the first year of this indicator. 100% of infants due a 6-8 week health check have had their breast-feeding status recorded at that time. In terms of the % of infants being completely or partially breast-fed, performance has been steady over the year and is on target.

5.11.2 No comparative data is available for England or the South East because not enough other PCTs have achieved sufficiently high recording of infants' breast-feeding status at 6 - 8 weeks.

5.13 Dental Health

5.13.1 Poor dental (or oral) health among children is important in its own right, as a cause of pain and poor health, but can also reflect poor diet.

5.13.2 There are two main indicators of dental health:

- dmft score: this is the average number of decayed, missing or filled teeth (dmft),
- the % of dmft scores that are greater than 0: i.e. the % of children with decayed, missing or filled teeth.

The National Oral Health Strategy (1994) incorporated targets for these indicators. Those for 5 year old children were:

- to reduce the average dmft score to 1 (per child);
- to reduce the % of children with any decayed, missing or filled teeth to 30%.

The most recent national Oral Health Plan for England, 'Choosing Better Oral Health' (2005) contained no national targets and the ones above are no longer in place.

5.13.3 The Dental Health of 5 year old children has been measured in alternate years through national surveys conducted within the NHS under the auspices of the British Association for the Study of Community Dentistry (BASCD) Dental Epidemiology Programme. Results are available for Primary Care Trust areas up to 2005-06.

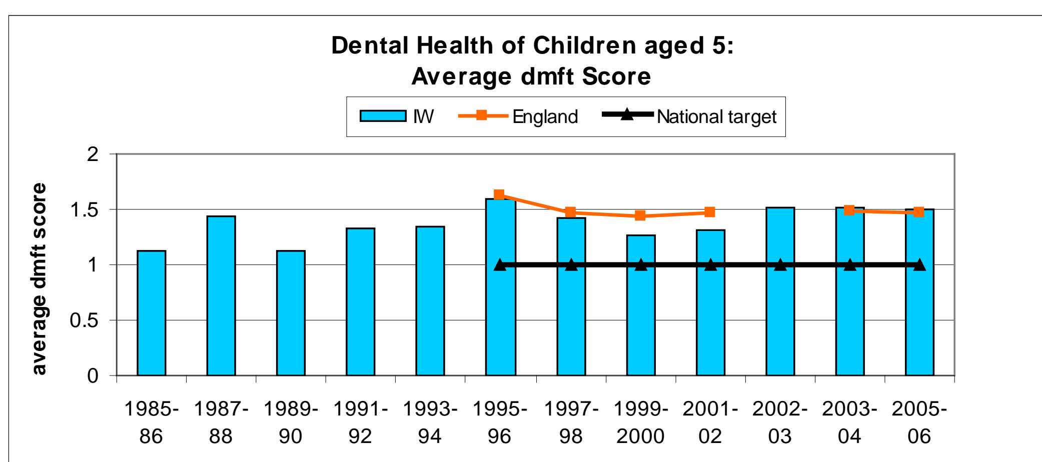


Figure 5.13.1 Dental Health of Children aged 5 – Average dmft score (Ref 05901)

5.13.4 Figure 5.13.1 shows dmft trend data for the 5 year old age group, comparing the IW with England. This shows that the increase in dmft on the Island after 1999-2000 was halted, but was not reversed. The most recent data available, for 2005-06, showed that the Island dmft score was very similar to the England average, but was well above the previous national target.

5.14 Stay Safe

5.14.1 Aim : To strengthen inter-agency communication to promote the safety and wellbeing of all children and young people on the Isle of Wight

To achieve this we will:

- reduce crime and anti-social behaviour in and out of school;
- diminish the numbers of children and young people experiencing significant harm;
- provide access to information, guidance and support to help all parents, carers and families
support children and young people achieve their potential
- promote safeguarding.

5.14.2 Children and young people told us that:

Some 34 per cent of children said they had been bullied at least once a year with 29 per cent of children reporting that the school does not deal with bullying very well. Twenty-three per cent say they don't feel safe on public transport. (Tellus3 Survey 2008) Other consultation activity revealed issues and some potential solutions:

- Fear of bullying. Bullying of children and young people with disabilities has been raised as an issue. Peer led approaches were perceived as the best way to make progress. There was a general feeling that talking to the teacher was not necessarily the best way forward and suggested that peer mentoring could help with bullying.
- Feeling unsafe – especially around parks, in localities and on public transport**.**

5.14.3 Only 3% of the Isle of Wight child population are in receipt of targeted services, and of those about 40% are either in care or subject to a child protection plan. Reducing referrals from adult services seem to correlate with lower numbers of recognised young carers than are expected for our population size.

5.15 Hospital admissions – injuries to children

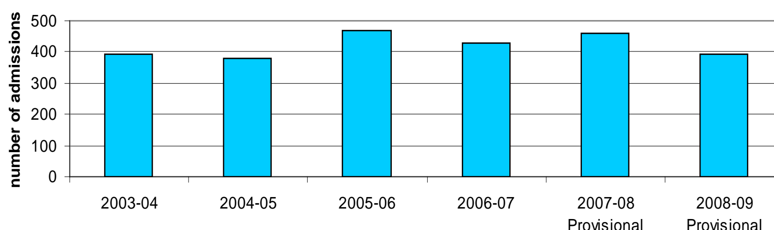
5.15.1 The Government's Public Service Agreement 13 is to "Improve children and young people's safety", on the basis that harm to children can have a fundamental impact during their childhood and lasting effects into adult life. Accidents are the leading cause of injury to children and disproportionately affect children from less affluent socio-economic groups. Injuries caused by accidents and deliberate harm, including those injuries that present at hospital as accidents but which may in fact be caused deliberately, are an important indicator of the effectiveness of local agencies in working to prevent accidental and deliberate harm to children.

5.15.2 Hospital admissions caused by injury can be 'coded' as caused by:

- 'Unintentional' Injury: includes accidental causes of harm, such as traffic accidents, falls, accidental contact with tools, machinery, etc, burns and scalds, etc.
- 'Deliberate' Injury: includes different kinds of assault.

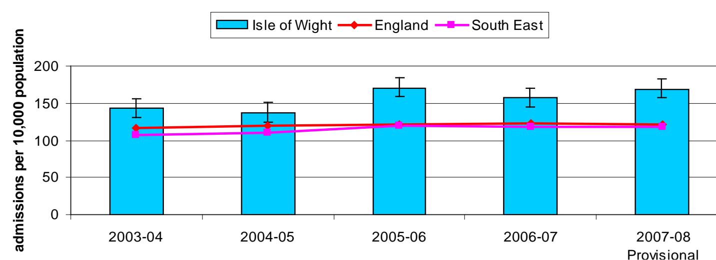
5.15.3 This indicator is among potential targets for Primary Care Trusts and Local Authorities and the Department of Health has published comparative data for the period 2003-04 - 2007-08, including numbers of admissions and rates of admission per 10,000 population. Data has not yet been published for 2008-09 but provisional local data is shown above. (NB: the 2007-08 IW data shown above is based on local data since the nationally published data is believed to under-count IW admissions).

VSC29 / NI 70: Emergency Admissions caused by Injuries among Children aged Under 18: Number of Admissions



07-08 & 2008-09 numbers based on local data. The nationally published 2007-08 figure is believed to under-count IW admissions.

VSC29 / NI 70: Emergency Admissions caused by Injuries among Children aged Under 18: Rate of Admissions per 10,000 Population



2007-08 IW rate is based on local data: the nationally published figure is believed to under-count IW admissions.

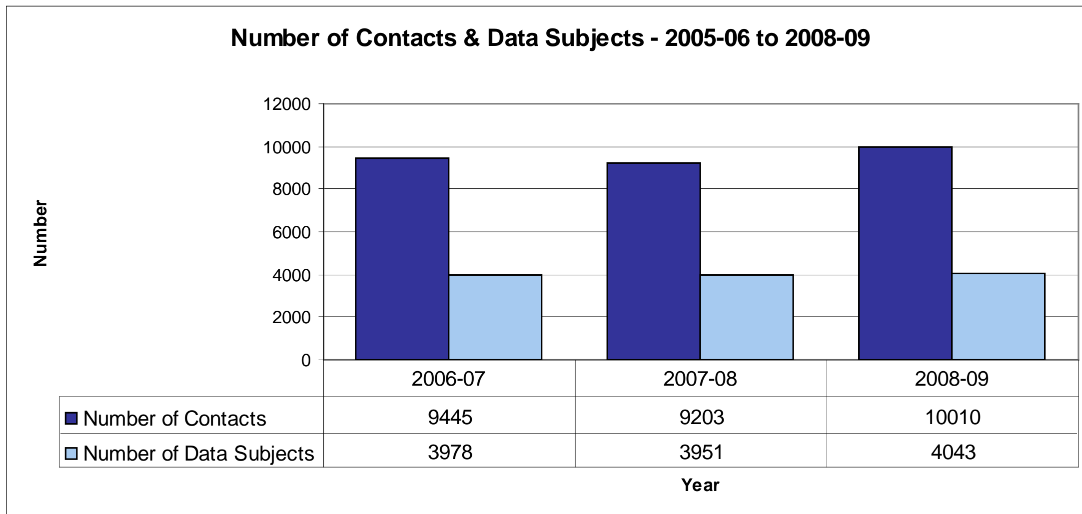
Figure 5.15.1 : NI 70 : Emergency admissions caused by Injuries to Children aged under 18 (Ref 06601)

5.15.4 The charts above show that:

- Among IW residents aged under 18, there were on average over 400 emergency hospital admissions for injuries annually in the years shown.
- The IW rate was higher (worse) than the England and South East rates in each year for which comparative data is available. In each of the 3 years between 2005-06 - 2007-08, the difference was statistically significant.
- The IW rate has been among the highest (worst) compared with other PCTs in England. In 2005-06 the IW was in the worst 4% of PCTs and in 2006-07 in the worst 15%.

5.16 Contacts into Targeted Services

5.16.1 Figure 5.16.1 shows that the number of contacts into children's targeted services over the last three years have shown a slight upward trend. There has been a significant drop in internal teams within the local authority making contact and an increase in police contacts and contacts from schools. 37% of contacts come from the police.

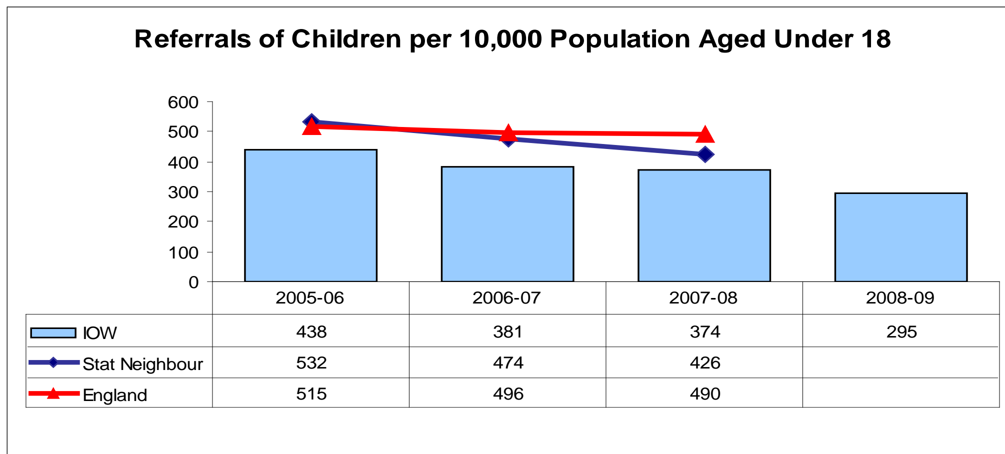


	2006-07	2007-08	2008-09
Number of Contacts	9445	9203	10010
Number of Data Subjects	3978	3951	4043

Figure 5.16.1 : Number of contacts and Data Subjects 2005-06 to 2008-09 (Ref F)

5.16.2 Those contacts that move into a referral have reduced year on year. Referrals of children to Councils are important as a measure of local concerns about children's welfare. A referral is defined as a request for services to be provided by social care services.

5.16.3 As services change, work more closely together etc, the counts of referrals may change reflecting changes in gate keeping arrangements. Children's social care services vary in their definition of what constitutes a referral, which makes comparisons difficult.



	2005-06	2006-07	2007-08	2008-09
IOW	438	381	374	295
Stat Neighbour	532	474	426	
England	515	496	490	

Figure 5.16.2 : Referrals of children per 10,000 population aged under 18 (Ref F)

5.16.4 Referral rates need to be considered alongside repeat referrals, referrals leading to initial assessments.

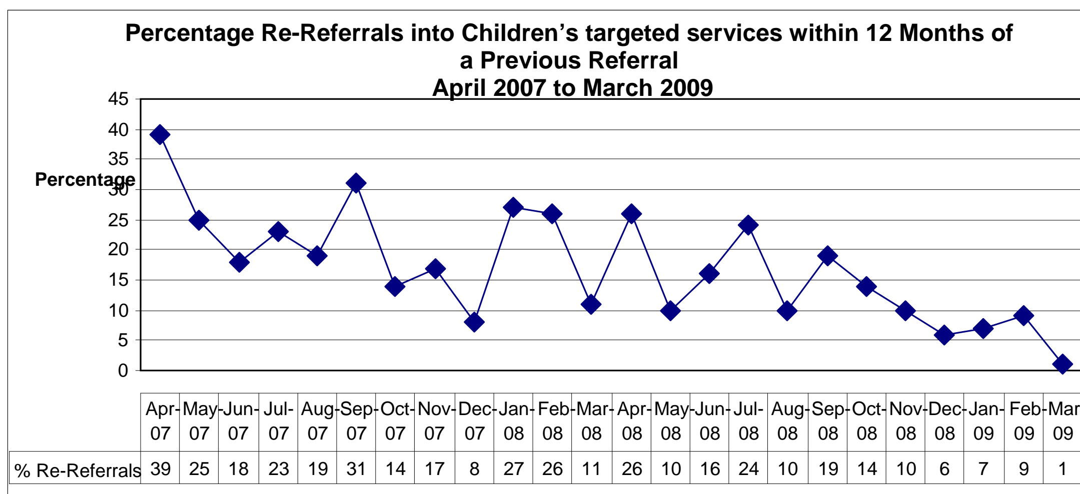


Figure 5.16.3 : Percentage Re-referrals into Children's targeted services within 12 months of a previous referral, April 2007 to March 2009 (Ref F)

5.16.5 Repeat referrals are showing a downward trend in line with overall reduced referrals. Performance for 07/08 was generally in line with national and statistical neighbours as can be seen from Figure 5.16.3

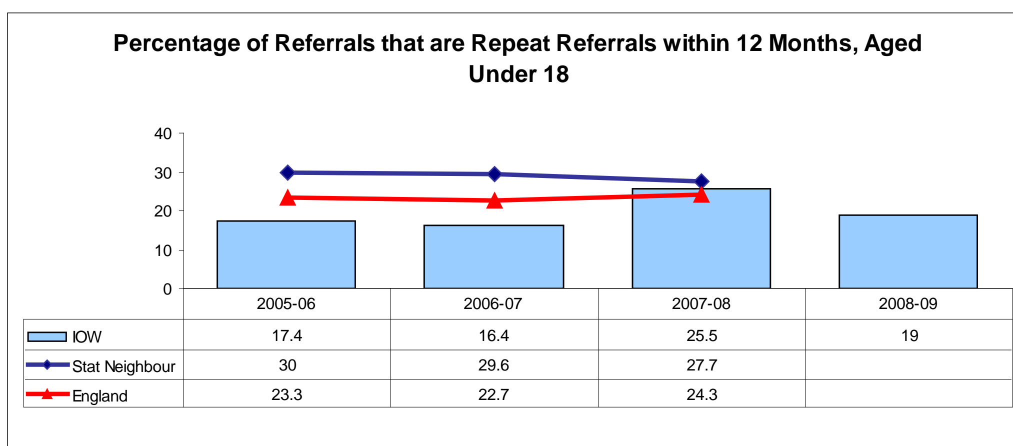


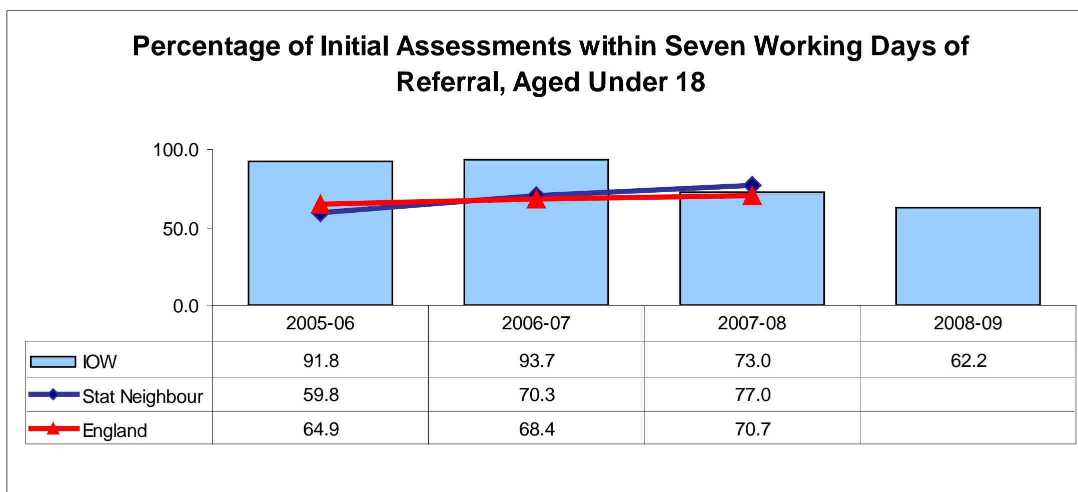
Figure 5.16.4: Percentage of referrals that are repeat referrals within 12 months, aged under 18 (Ref F)

5.17 Initial Assessments

5.17.1 An initial assessment is defined as a brief assessment of any child who has been referred to social care services with a request that a service be provided. An initial assessment starts at the point of referral to social care services, or when new information on an open case indicates that an initial assessment should be repeated.

5.17.2 The expected timescale for an initial assessment to be completed is a maximum of 7 working days. Good performance is typified by higher percentages.

5.17.3 Initial assessments are an important indicator of how quickly services can respond when a child is thought to be at risk of harm. As assessments involve a range of local agencies, this indicator also shows how well multi-agency working arrangements are established.



	2005-06	2006-07	2007-08	2008-09
IOW	91.8	93.7	73.0	62.2
Stat Neighbour	59.8	70.3	77.0	
England	64.9	68.4	70.7	

Figure 5.17.1 : Percentage of initial assessments within seven working days of referral, aged under 18 (Ref F)

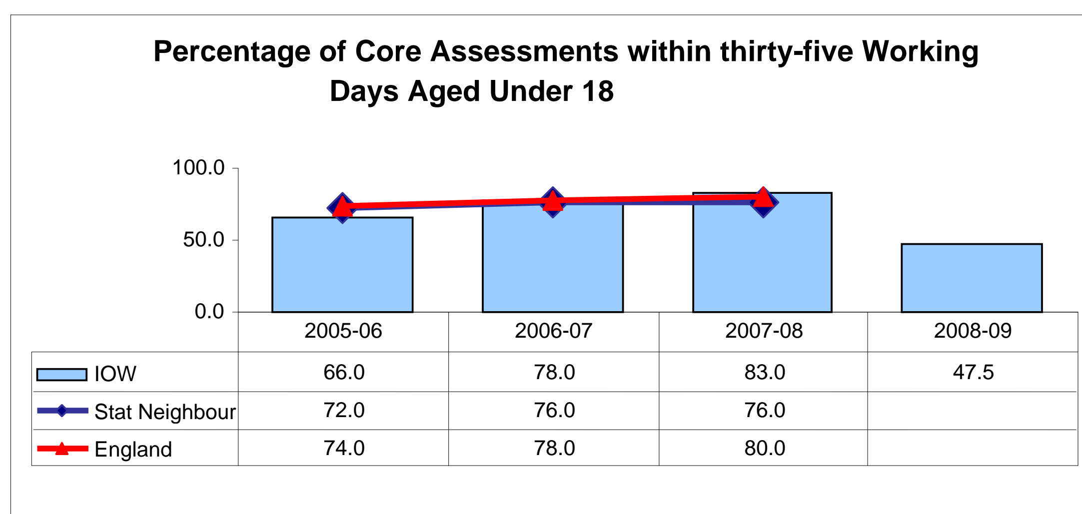
5.17.4 As shown in figure 5.17.1 the last four year trend shows a dip in performance for initial assessments completed on time on the Isle of Wight. In 07/08, we were performing better than the England average, but worse than the statistical neighbour average.

5.18 Core Assessments

5.18.1 Core assessments are in-depth assessments of a child/ren and their family. They are also the means by which child protection enquiries (Section 47 enquiries) are undertaken following a strategy discussion.

5.18.2 Core assessments should be completed within 35 working days. It is important that Local Authorities should investigate and address concerns in a timely and efficient manner and that those in receipt of an assessment have a clear idea of how quickly this should be completed.

5.18.3 Successful meeting of the timescales can also indicate effective joint working where multi-agency assessment is required.

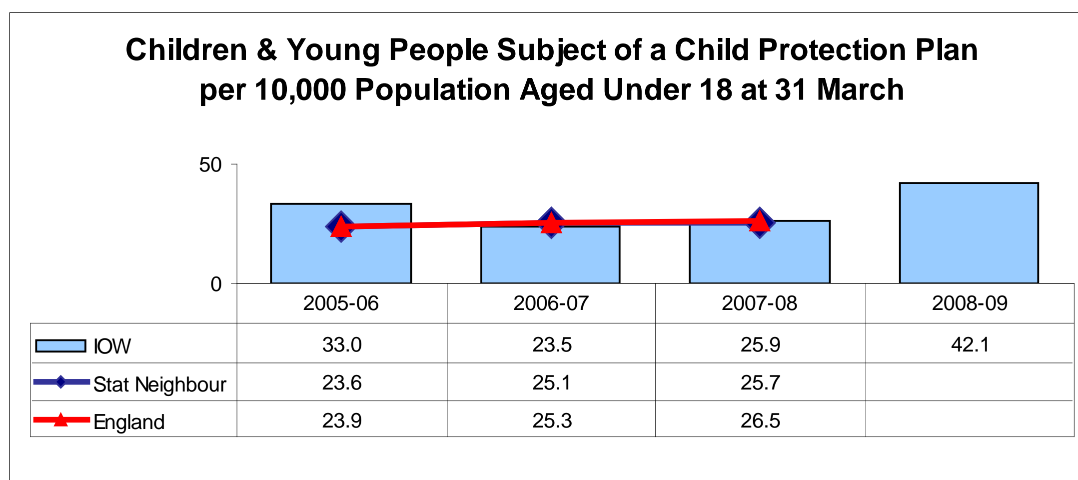


	2005-06	2006-07	2007-08	2008-09
IOW	66.0	78.0	83.0	47.5
Stat Neighbour	72.0	76.0	76.0	
England	74.0	78.0	80.0	

Figure 5.18.1 : Percentage of core assessments within seven working days of referral aged under 18 (Ref F)

5.18.4 Figure 5.18.1 shows that Performance for core assessments completed on time has been good or very good since 06, when compared with both England average and statistical neighbours until 08/09, when there has been a significant drop in performance. There has also been a drop in the ratio of core assessments completed per 10,000 cases, therefore volume of assessments is not a reason for this drop in performance. Implementation of a new electronic recording system (ICS) has partially impacted on performance in this area.

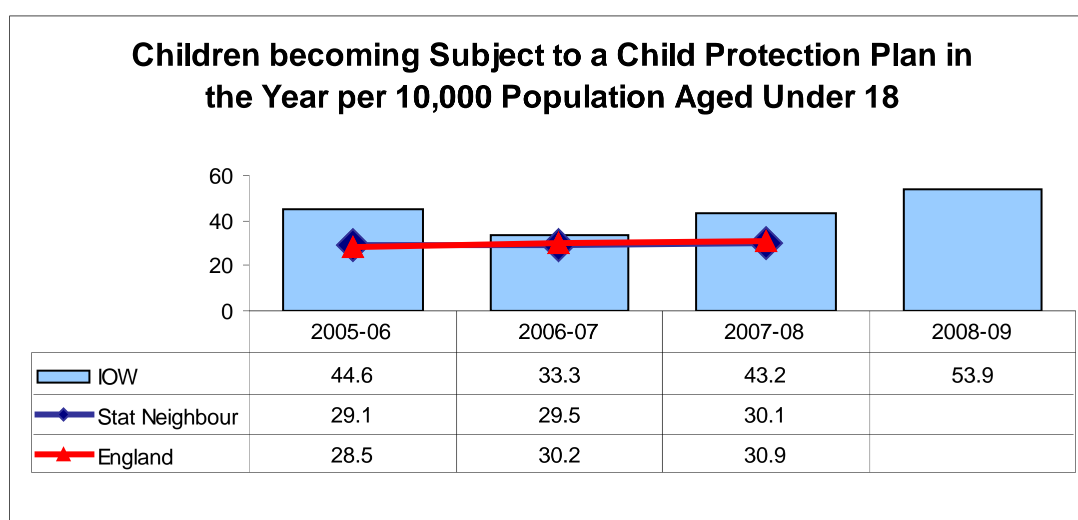
5.19 Numbers of Children subject to Child Protection Plans



	2005-06	2006-07	2007-08	2008-09
IOW	33.0	23.5	25.9	42.1
Stat Neighbour	23.6	25.1	25.7	
England	23.9	25.3	26.5	

Figure 5.19.1 : Children and Young People subject to a Child Protection Plan per 10,000 population aged under 18 at 31 March (Ref F)

5.19.1 This indicator tries to establish whether appropriate thresholds are being used in the cases where children are at risk of suffering significant harm. A high rate may indicate threshold is set too low, a low rate may indicate threshold set too high. There has been a significant increase in the number of children subject to a child protection plan for the Isle of Wight. From information obtained this appears to be a national trend.



	2005-06	2006-07	2007-08	2008-09
IOW	44.6	33.3	43.2	53.9
Stat Neighbour	29.1	29.5	30.1	
England	28.5	30.2	30.9	

Figure 5.19.2 : Children becoming subject to a Child Protection Plan in the year per 10,000 population aged under 18 (Ref F)

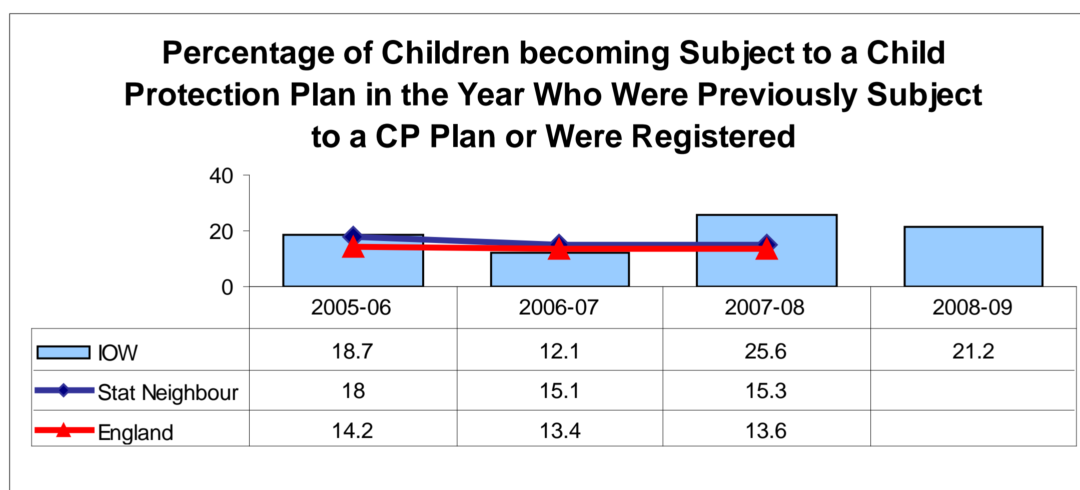
5.19.2 We have largely been in line with the national picture and with our statistical neighbours for those children still subject to a plan at the end of each reporting year. However, when we look at the numbers of children who have a child protection plan during the year and then are "de-registered", there is significant variance with national and statistical

neighbours. There has also been a dramatic increase in children subject to child protection plans in 08/09 which may have been a response to media pressure around child protection services. Current indications are that this is reducing again.

5.20 Percentage of Children subject to a Child Protection Plan for a second or subsequent time

5.20.1 This indicator is a proxy for the level and quality of service a child receives. Its purpose is to monitor whether children's social care services devise and implement a child protection plan which leads to lasting improvement in a child's safety and wellbeing.

5.20.2 The child protection plan is a multi-agency plan formulated by children's social care to ensure that children at risk of harm are protected by developing a coordinated multi-agency approach.



	2005-06	2006-07	2007-08	2008-09
IOW	18.7	12.1	25.6	21.2
Stat Neighbour	18	15.1	15.3	
England	14.2	13.4	13.6	

Figure 5.20.1 : Percentage of children becoming subject to a Child Protection Plan in the year who were previously subject to a CP Plan or were registered (Ref F)

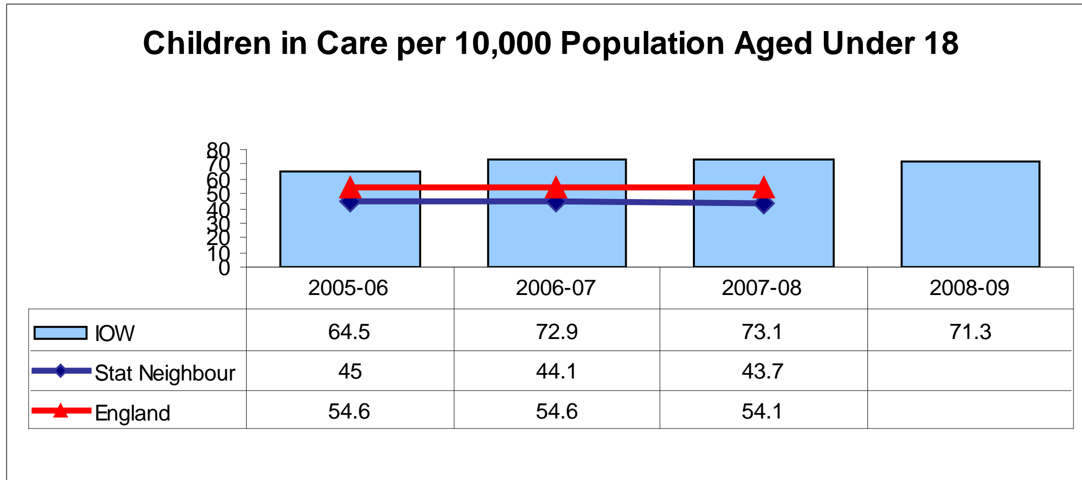
5.20.3 Some subsequent plans are essential in responding to adverse changes in circumstances, but high levels of subsequent plans may suggest that the professionals responsible for the child's welfare are not intervening effectively enough to bring about the required changes in the child's circumstances. Low levels of subsequent plans may mean that Local Authority is not submitting some children to a child protection plan who are in need.

5.20.4 Good performance is between 10% and 15%. This indicator is viewed alongside durations for child protection plans and reviews of child protection cases.

5.20.5 Due to the low numbers in this cohort small numbers disproportionately affect the percentage outturn and lead to some volatility. Performance has swung between very low to very high and has reduced slightly at the end of March 09.

5.21 Numbers of Children in Care

5.21.1 This is an indicator intended to provide some context for all indicators relating to children in care and give an indication of thresholds for children in care. The detail about where children are cared for is significant to consider at the same time, i.e., those placed with parents, relatives and friends.



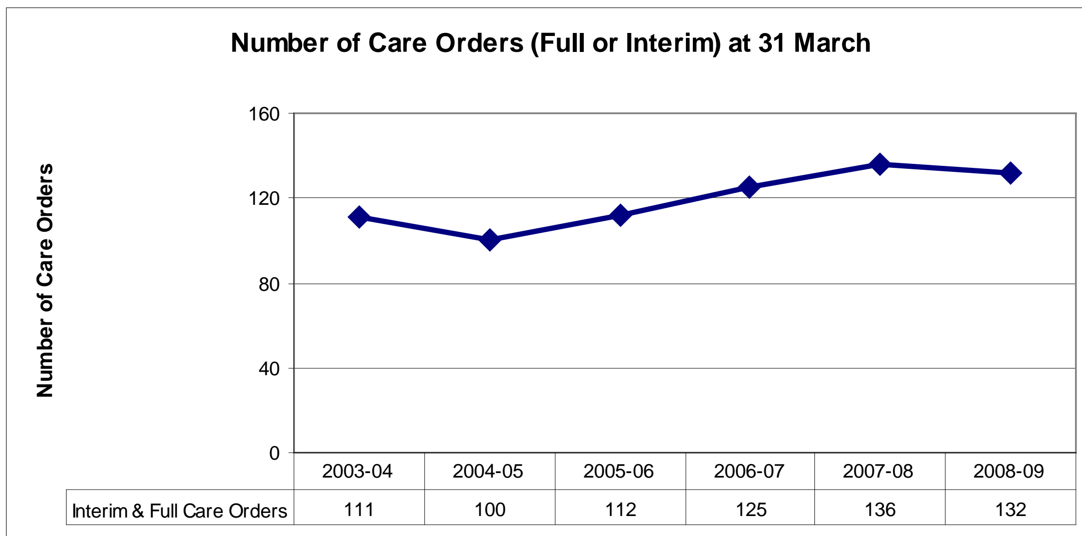
	2005-06	2006-07	2007-08	2008-09
IOW	64.5	72.9	73.1	71.3
Stat Neighbour	45	44.1	43.7	
England	54.6	54.6	54.1	

Figure 5.21.1 : Children in care per 10,000 population aged under 18 (Ref F)

5.21.2 There are no good or bad figures for this indicator, but if numbers are significantly lower than other comparator Local Authorities, it may indicate thresholds for becoming looked after, are leaving some children inadequately protected. If numbers are significantly higher, it may suggest ineffective gate keeping, or delays in care plans being progressed.

5.21.3 It is also important to note that high numbers can also suggest that young people are not being forced to leave care prematurely, which is an indication of a responsible Local Authority.

5.21.4 Numbers of children in care have consistently been higher than both the national average and our statistical neighbours, showing a considerable increase for 07/08.



	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Interim & Full Care Orders	111	100	112	125	136	132

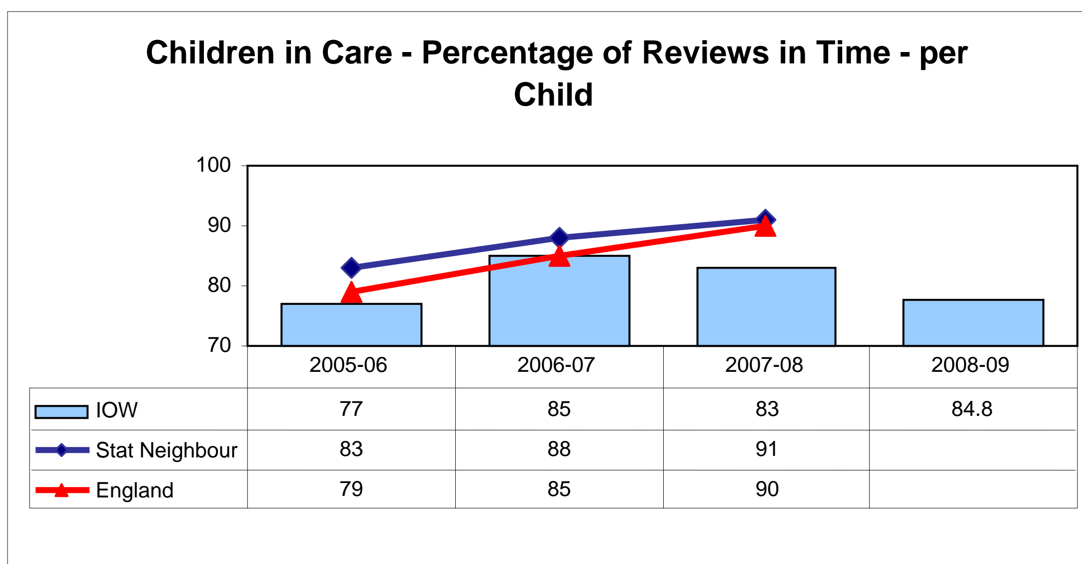
Figure 5.21.2 : Number of care orders (Full or Interim) at 31st March (Ref F)

5.21.5 There has also been a considerable increase in the involuntary episodes of care, i.e., those where a Court Order is required, rather than parental agreement. The majority of children in care are looked after because they have been abused or neglected.

5.21.6 There is no marked increase in the 16-17 year old age group in the last 4 years, and a fairly even split now between girls and boys, showing a slight increase in girls coming into the care system.

5.21.7 More children and young people are cared for by Local Authority foster carers, and a considerable number are placed with parents/relatives.

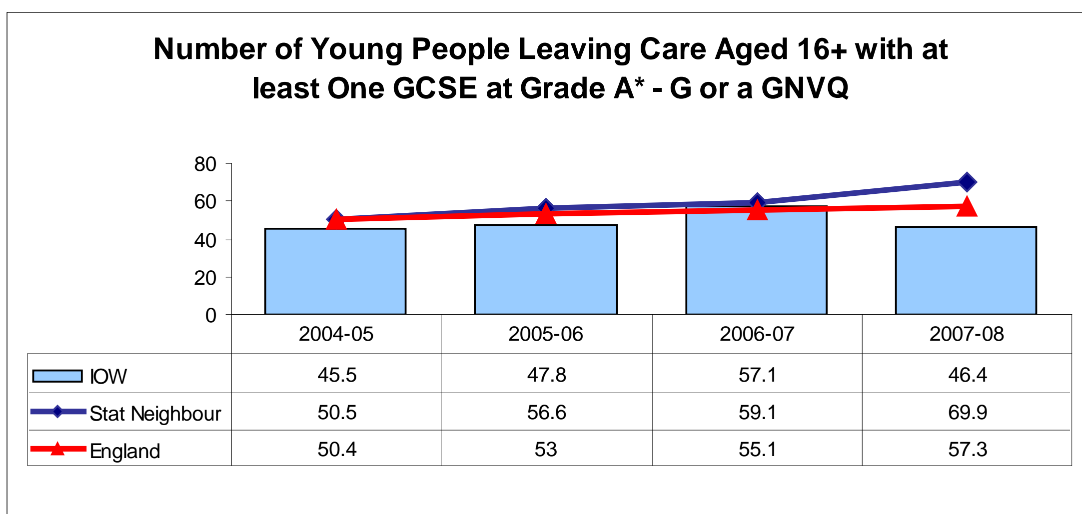
5.21.8 There are no children under 10 years of age in a residential placement. 4.5% of our children in care are BME which is a higher representation than in the general population.



	2005-06	2006-07	2007-08	2008-09
IOW	77	85	83	84.8
Stat Neighbour	83	88	91	
England	79	85	90	

Figure 5.21.3 : Children in care percentage of reviews in time – per child (Ref F) (unvalidated data for 08/09)

5.21.9 The increase in numbers of children in care has an associated impact on other indicators such as undertaking the statutory reviews on time, only 82% on time in 07/08.



	2004-05	2005-06	2006-07	2007-08
IOW	45.5	47.8	57.1	46.4
Stat Neighbour	50.5	56.6	59.1	69.9
England	50.4	53	55.1	57.3

Figure 5.21.4 : Number of young people leaving care aged 16+ with at least a GCSE at grade A-G* or a GNVQ (Ref F)

5.21.10 The percentage of children in care with at least 1 GCSE at grade A – G is less than the national average and our statistical neighbours, and there appears to be an associated poor attendance rate, with more of our children in care missing at least 25 days of education, than is the case in other areas.

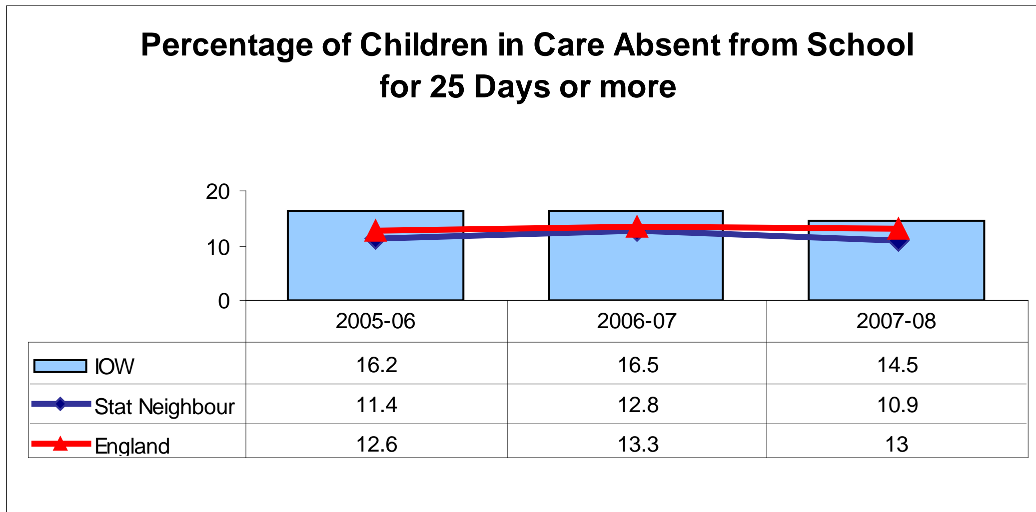


Figure 5.21.5 : Percentage of children in Care absent from School for 25 days or more (Ref F)

5.21.7 This is a measure of how effective the Local Authority is as a corporate parent. Access to school is a key factor in improving the stability of their lives. Continuous attendance will lead to improving educational achievement.

5.22 Stability of Placement

5.22.1 Stability of placement is associated with better outcomes for children in care. Some placement changes are planned in children's best interests, but often placements breakdown because they are not sufficiently well matched to a child's needs, or they are not of sufficient quality; or well supported.

5.22.2 Placement breakdowns have a significant impact on children's wellbeing and their friendships, as well as disrupting education and continuity of access to other services. This indicator shows those children who were living in the same placement for at least 2 years, or are placed for adoption (aged under 16 years and looked after for 2½ years or more).

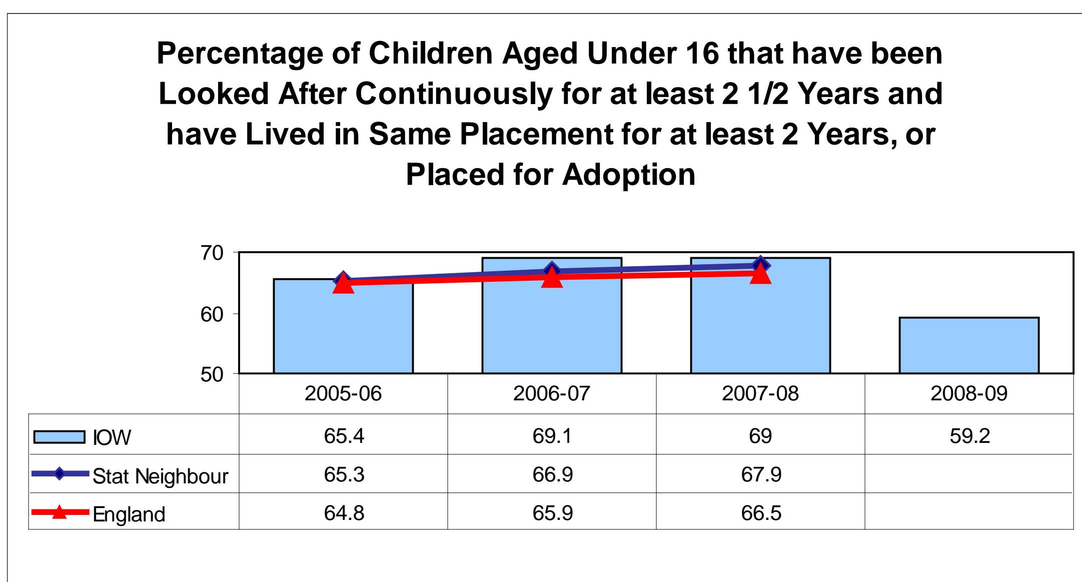


Figure 5.22.1 : Percentage of children aged under 16 that have been Looked After **continuously for at least 2 ½ years and have lived in same placement for at least 2 years or placed for Adoption (Ref F)**

5.22.3 Performance has been slightly above national and statistical neighbour level for the past 2 years, but has shown a significant dip this year.

5.23 Young Carers

The 2001 census identified 175,000 young carers in the UK, which was 0.30% of the UK population. This figure is widely disputed as being too low. On the Isle of Wight, 88 young carers represent just 0.06% of the current population. Using the UK-wide percentage figure from the 2001 census, we would expect to find at least 400 young carers currently on the Isle of Wight

5.23.1 Young carers face challenges in managing their responsibilities while securing good outcomes for themselves.

5.23.2 At the end of March 09, 80 children/young people were recognised as young carers and receiving support from a commissioned service.

Young People Currently Registered with the Young Carers Program (YCP)

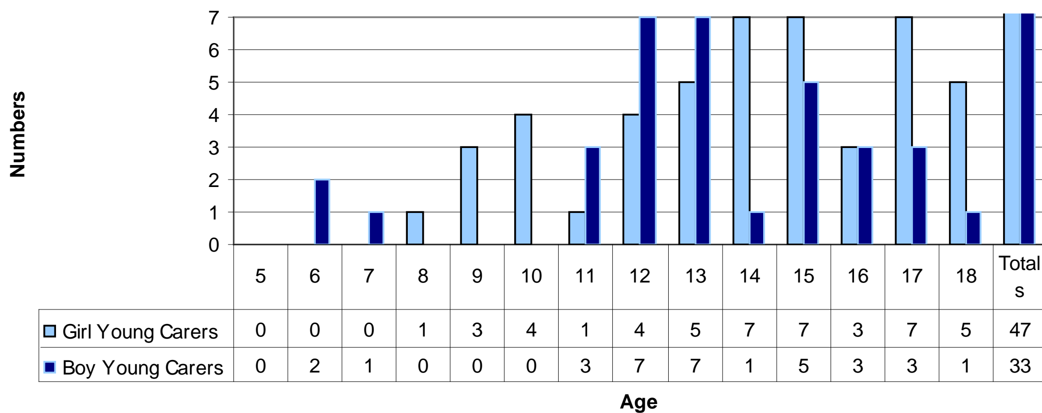


Figure 5.23.1 : Young People currently registered with the CYP (Ref F)

5.23.3 There are more girls (47) than boys (33) and an age range between 6 and 18 years. The most common ages being 13 and 15 (12 in each age group) and 12 and 17 (11 in each age group).

5.23.4 The majority of the children and young people (37) live in lone parent families and are caring for their mother because of physical disability or mental health issues.

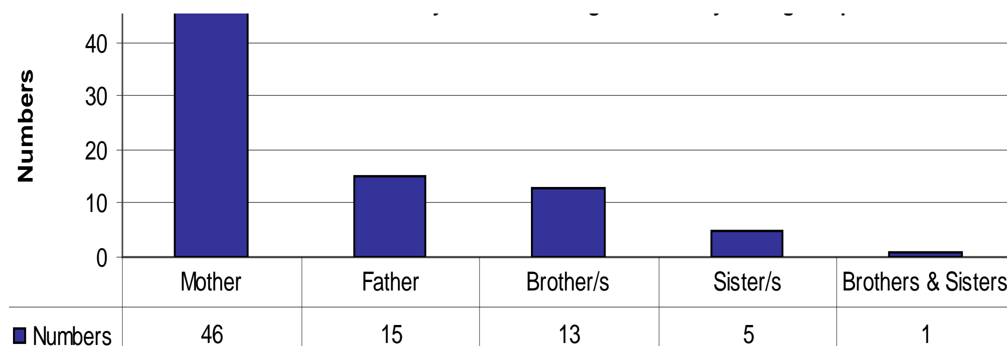


Figure 5.23.2 : Breakdown of Family Member being cared for by young people (Ref F)

5.23.5 There appears to be a very low percentage of recognised young carers who are caring for parents with alcohol/substance misuse issues, even though there are an estimated 20,000 adults who binge drink. Further investigation will be needed to identify if that is because they are invisible to the statutory services.

5.23.6 8% are from BME backgrounds which is much greater than the ratio in the general population, though small numbers are disproportionate. We need to work closely with schools to identify patterns of absence and lateness that may be linked to caring responsibilities.

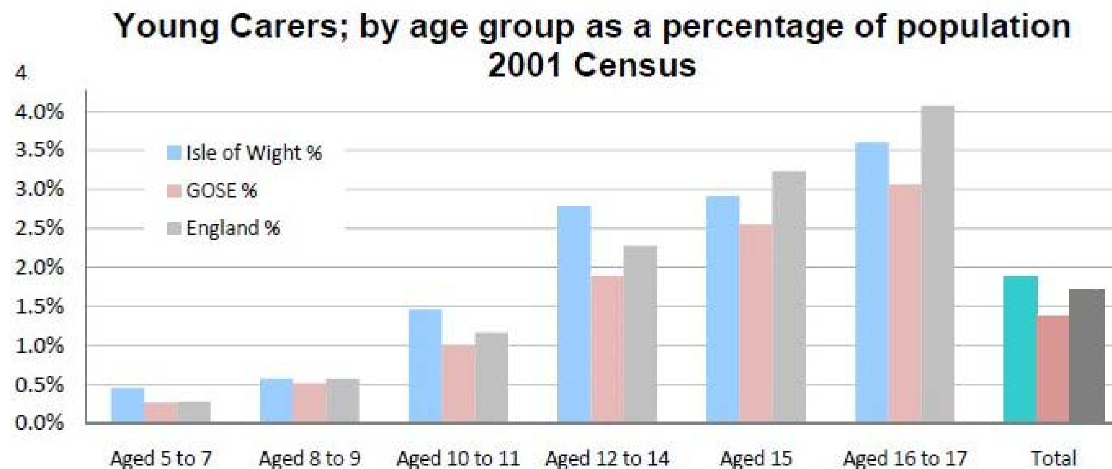
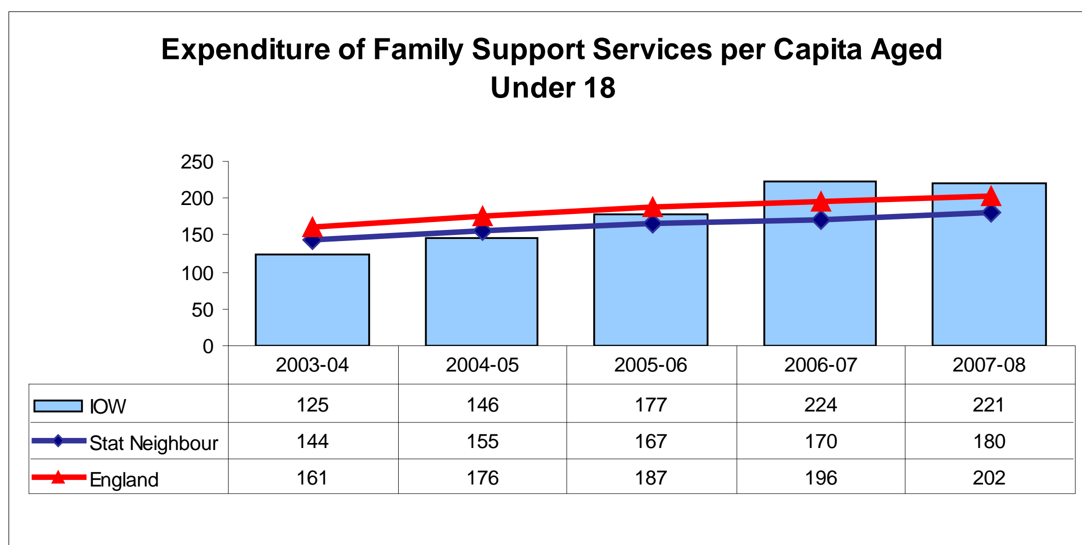


Figure 5.23.3 : Young carers; by age group as a percentage of population, 2001 census (Ref 08002)

5.24 Average Gross Weekly Expenditure Per Looked After Child

5.24.1 The cost of services is an important aspect of efficient delivery of services. If quality and children's needs are adequately met, a lower cost is generally held to be more efficient.



	2003-04	2004-05	2005-06	2006-07	2007-08
IOW	125	146	177	224	221
Stat Neighbour	144	155	167	170	180
England	161	176	187	196	202

Figure 5.20.1 : Expenditure of Family Support Services per Capita Aged Under 18 (Ref F)

5.24.2 This indicator can be improved by commissioning foster care and residential care at lower unit costs and more importantly by shifting the pattern of care away from residential to foster care.

5.24.3 Approximately a quarter of children's services budget [£5,305,989 from a budget of £20,000,000] is spent on 79 of the most vulnerable children, which equates to .3% of the child population

5.25 Domestic Abuse

5.25.1 Approximately 50% of children subject to child protection plans are living with domestic abuse.

5.25.2 The increase in police contacts into targeted services is mainly linked to an increased awareness and identification of the risks linked to domestic abuse.

Further information on this can be found at the following Link

5.26 Disabled Children

5.26.1 The Isle of Wight is slightly lower than the national average and statistical neighbours, and is in line with the national average for new statements, and for the percentage of children with new statements placed in mainstream school.

5.26.2 Disabled children are more likely to experience abuse and to feel isolated from and unsafe in their communities. National research has shown that disabled children are far more likely to live in poverty. The educational attainment is unacceptably lower than their peers.

5.26.3 There are approximately 1,600 disabled children on the Isle of Wight and about 1,600 other children with identified educational needs. There about 3 times as many boys as girls, comparable with the national picture.

5.26.4 The majority of children with statements of educational need are supported in mainstream schools, with approximately 237 attending special schools. Of this figure, 198 Children with statements attend Island maintained special schools, which is a raise of 14% on 2007-08.

5.26.5 Fixed term and permanent exclusions for this vulnerable group are much lower than the national average.

5.26.6 40 young people receive short term breaks overnight from Beaulieu House and there are about 50 children who receive day care/sessional support. There are also 23 young people have such specific needs they require specialist provision which is only available on the mainland. This is an acknowledged area of need.

5.27 Enjoy and Achieve

5.27.1 Aim: To enable all children and young people on the Isle of Wight to achieve their full potential through a range of outcomes (personal/social/physical/emotional/academic)

To achieve this we will:

- support those with special educational needs, those who are looked after, those from ethnic minority communities and those with a disability;
- encourage attendance and the enjoyment of school or alternative provision;
- support children, young people and their families while reorganising the schools into a two tier system.
- narrow the gap between Isle of Wight standards and those nationally.

5.27.2 Children and young people told us that:

An overwhelming 85 per cent of pupils called for more fun and interesting lessons at school and 43 per cent requested quieter and better behaved classes (Tellus3 Survey 2008)

Other consultation activity revealed issues related to:

- more things to do and places to go – places to make friends and be safe;
- more and better facilities at evenings and weekend;
- more activities where everyone can join in;
- youth clubs open more often and longer;
- transport – access to free transport where appropriate, particularly safe transport to make access to activities after school easier.

5.27 Foundation Stage Profile

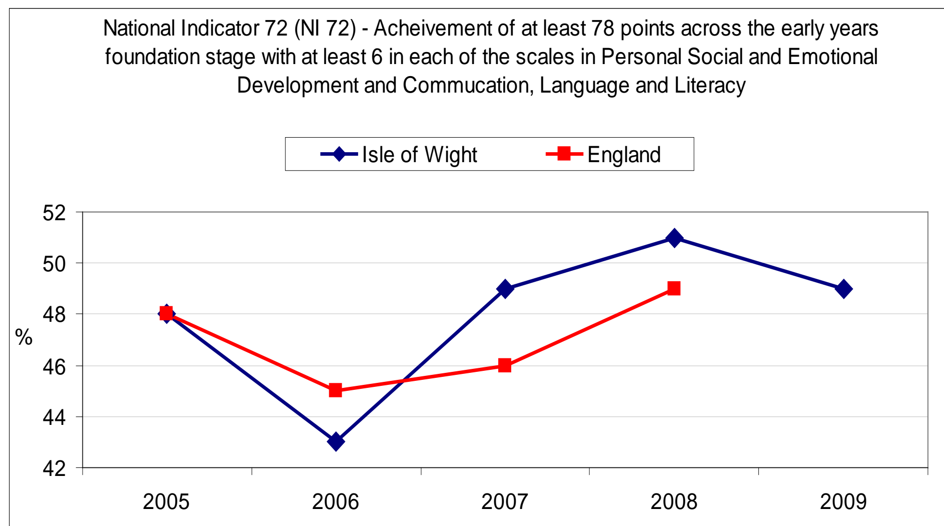


Figure 5.27.1 Foundation Stage profile : National Indicator 72 (Ref E)

5.27.1 The Foundation Stage Profile (FSP) is an assessment of children's achievement at the end of the academic year in which they turn 5. Figure 5.11.1 shows the Isle of Wight's performance against National Indicator 72, which looks at a child's combined achievement in key areas of the FSP.

5.27.2 Isle of Wight performance improved by three percentage points overall between 2005 and 2008 (despite a drop of 5% in 2006), putting us above the national average. However, provisional 2009 data shows a drop of 2 percentage points from 2008. At the time of writing 2009 England results are not known, but any improvement will see us fall below the national average once again.

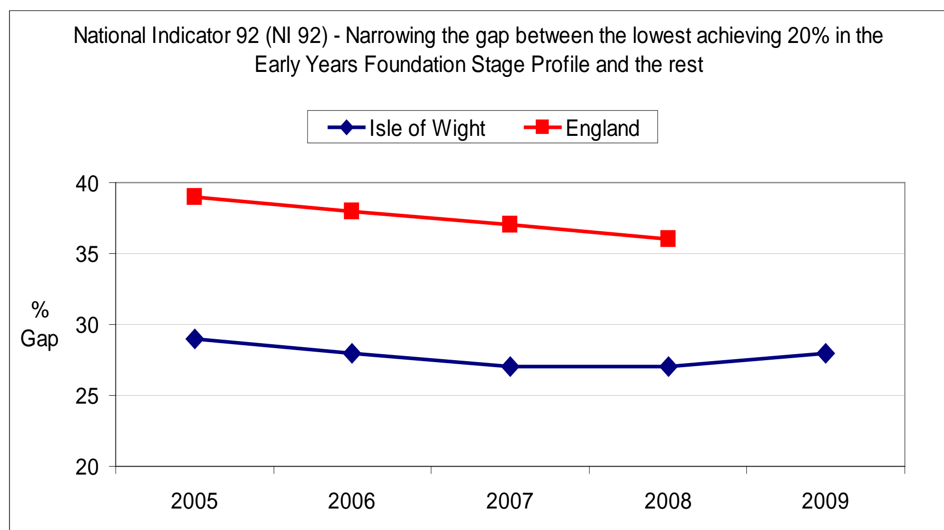


Figure 5.27.2 Foundation Stage profile : National Indicator 92 (Ref E)

5.27.3 Figure 5.11.2 relates to National Indicator 92, which puts focus on narrowing the gap in achievement of the lowest performing 20% and the rest in the Foundation Stage Profile. The aim is to ensure that all children regardless of background are able to reach their potential. The Isle of Wight's percentage gap was consistently 10 points narrower than the national average between 2005 and 2007, representing excellent performance. However, provisional 2009 figures show the Island gap widening by 1%, meaning an overall narrowing of only one percentage point across the five year period (2005 and 2009).

Overall, comparison with the England average is very favourable.

5.28 Key Stage 2 (Age 11) and Key Stage 4 (GCSE) Attainment

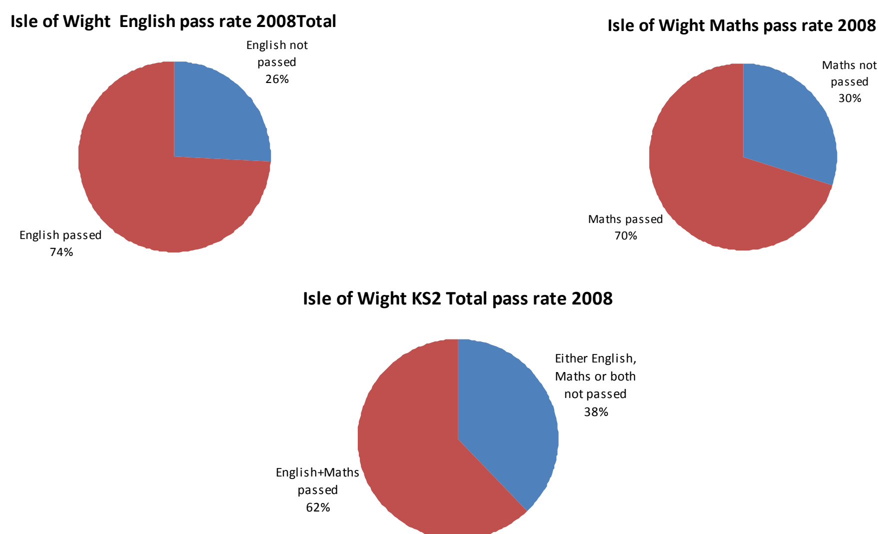


Figure 5.28.1 : Educational attainment KS2 (Ref 11901)

5.28.1 Mathematical attainment at KS2 is 4% lower than English attainment. For a ward by ward analysis please see http://www.eco-island.org.uk/information_observatory/jsna2/jsna_2009_11900.aspx

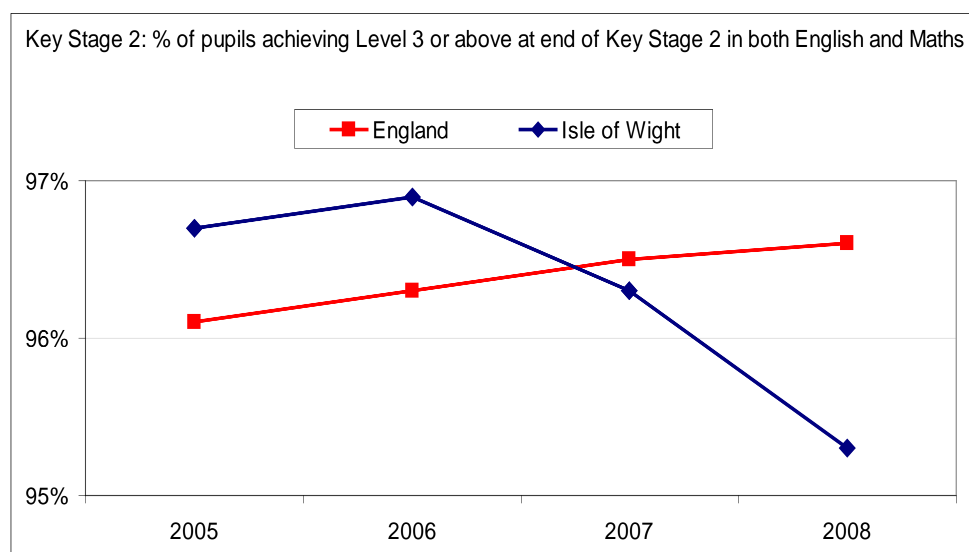


Figure 5.28.1 : Key Stage 2 : Percentage of pupils achieving level 3 or above (Ref E)

5.28.2 Figure 5.28.1 shows the percentage of children at the end of Key Stage 2 who have achieved level 3 or above in English and Maths. The expected level of attainment at the end of the Key Stage is level 4. Whilst the England percentage has been increasing year on year since 2005, the Isle of Wight percentage fell in both 2007 and 2008 leaving the Island 1.3 percentage points below the national average.

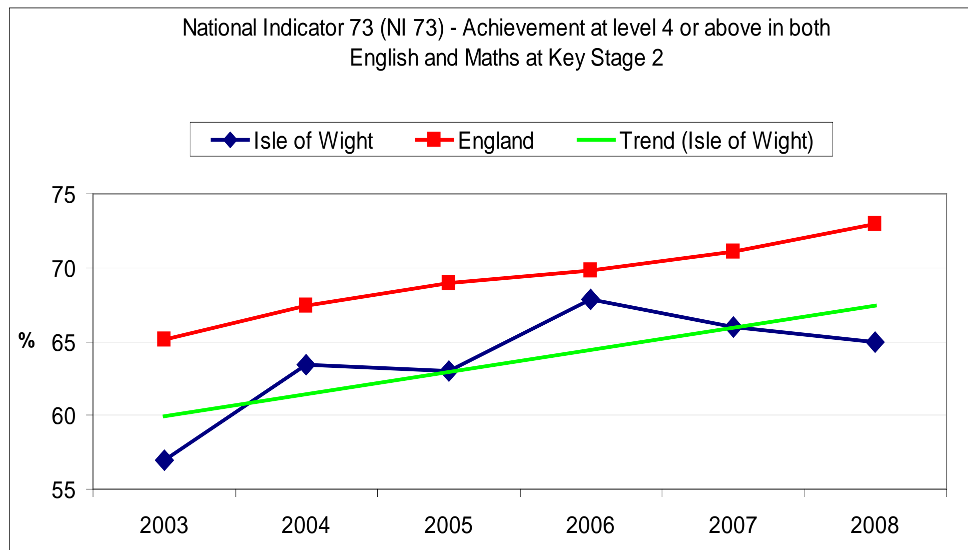


Figure 5.28.2 : National Indicator 73 – Achievement at level 4 or above (Ref E)

5.28.3 Figure 5.28.2 shows that from 2003 through to 2008, the Isle of Wight has remained below the national average for achievement at level 4 or above in both English and Maths at Key Stage 2. Whilst the gap narrowed to just two percentage points in 2006, the following two years have seen a downward trend forming, resulting in a gap of eight percentage points in 2008. However, despite the recent dip in performance, the Isle of Wight average improved by 8% between 2003 and 2008 - the same percentage point rise as the England average. The linear trend across the 6 academic years remains positive.

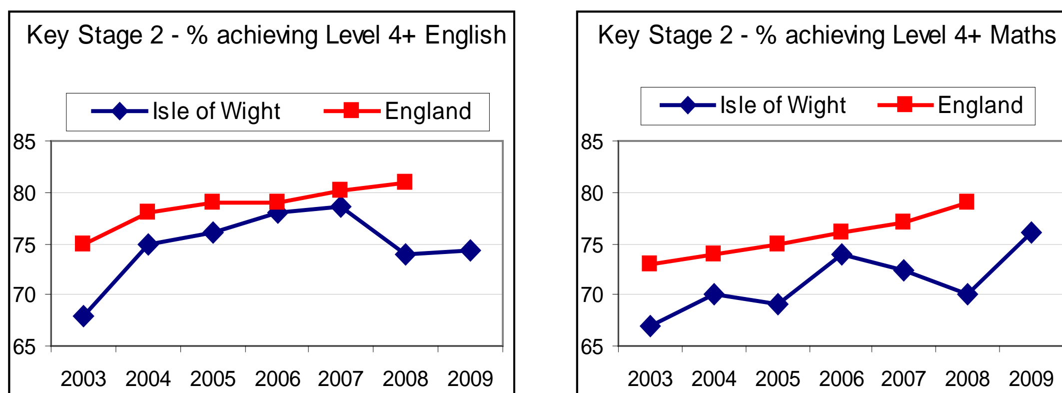


Figure 5.28.3 : Key Stage 2 performance - % achieving expected level (Ref E)

5.28.4 Since 2004 the Isle of Wight has been below the national average for 2 levels of progression between Key Stage 1 and Key Stage 2 in both English and in maths. Provisional 2009 results indicate that we will once again be below the national in both subjects, despite hugely improved performance in maths (see figure 5.28.3 above). This is indicative of the Island's excellent performance at Key Stage 1 and poor performance at Key Stage 2. For example, in 2008 the Isle of Wight ranked 3rd out of 150 local authorities for the percentage of children achieving the expected level in maths at Key Stage 1. At Key Stage 2 in the same year, the Isle of Wight was ranked 150th out of 150.

5.28.5 2008 Key Stage 2 performance for Looked After Children (LAC) was below the national average in both English and mathematics, although the Island's small LAC cohort

sizes should be taken into consideration when looking at percentage outcomes. 2 of 6 LAC (33.3%) achieved level 4 or above in English, and the same percentage achieved level 4 or above in maths. These figures were below the 2008 national averages (46% and 44% respectively). Provisional results for 2009 indicate that maths performance remained at 33.3% (3 of 9 children) whilst the English percentage dropped to 22.2% (2 of 9 children).

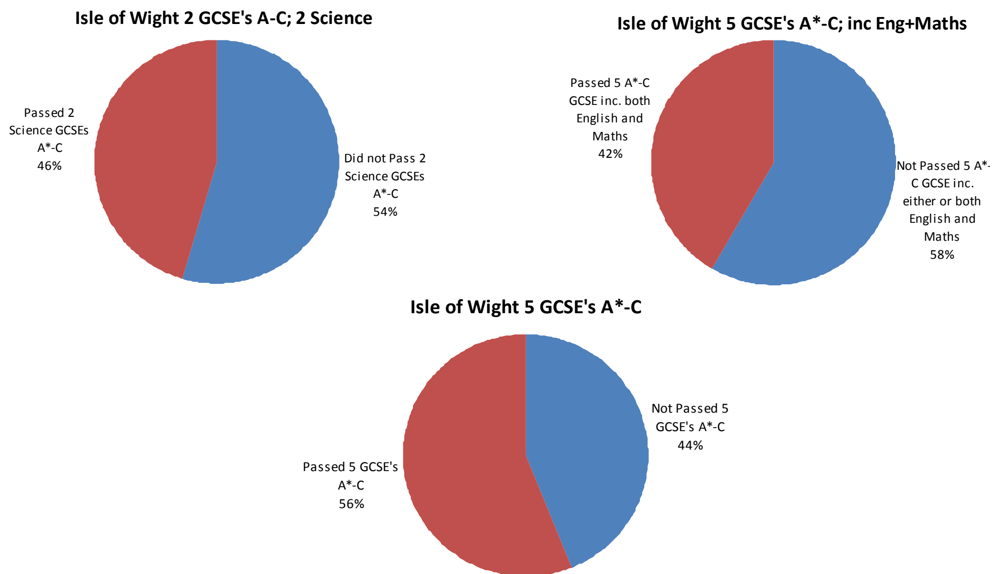


Figure 5.28.4 : KS4 GCSE results 2008 (Ref 12001)

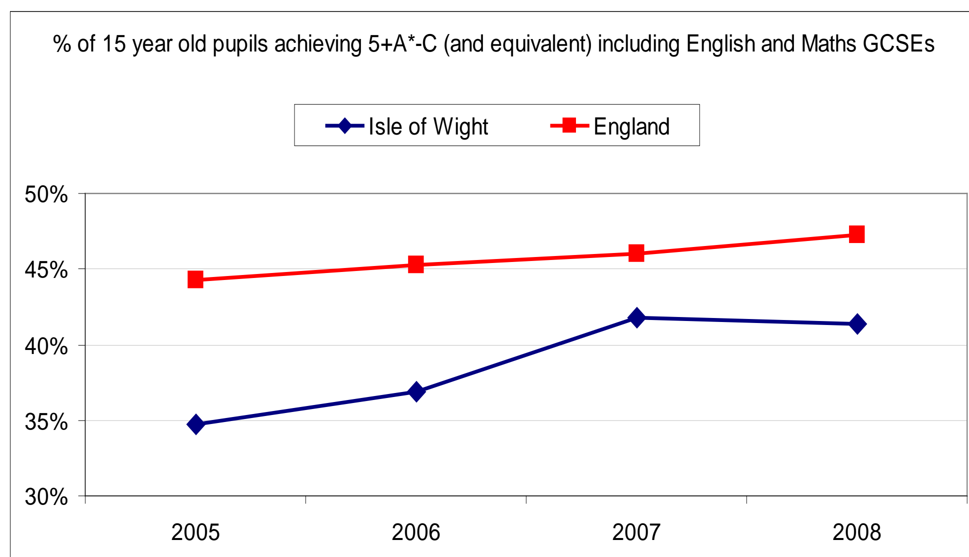


Figure 5.28.5 : Percentage of 15 year old pupils achieving 5 +A*-C and equivalent including English and Maths GCSEs (Ref E)

5.28.6 Figure 5.28.5 shows a four year trend for GCSE performance locally and nationally. Isle of Wight achievement has been below the England average for this entire period and whilst the gap narrowed to 4.2% in 2007 there was no improvement in Island performance in 2008, resulting in the gap widening to 5.9%. By 2012, the Government wants to see no schools where less than 30% of pupils achieve 5+ A*-C GCSE grades (and equivalent) including English and Maths. The Isle of Wight currently meets this target.

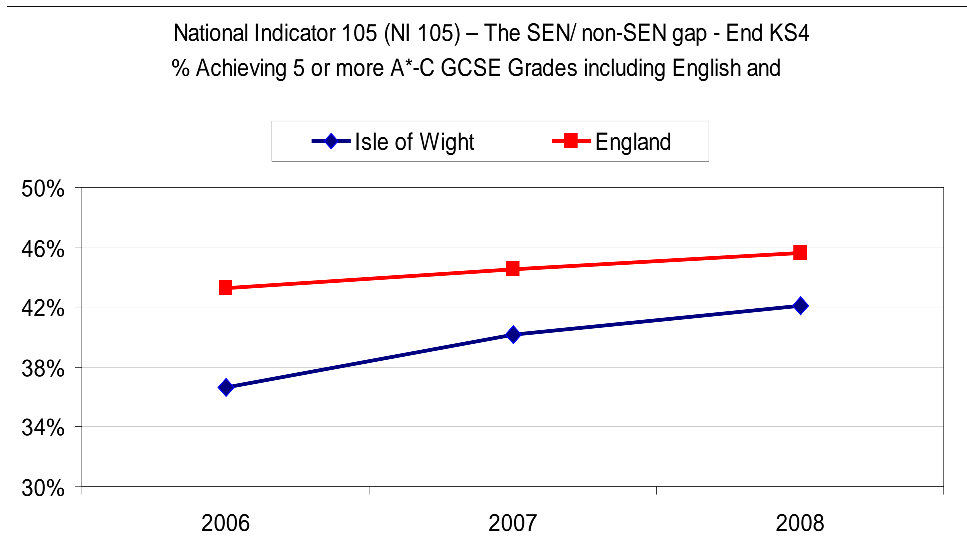


Figure 5.28.6 : National Indicator 105 (NI 105) – the SEN/non-SEN gap – End KS4 (Ref E)

5.28.7 Figure 5.25.6 compares the Key Stage 4 performance of children with special educational needs (SEN) with those who have not been identified as having SEN. This national indicator is intended to encourage improvement in the attainment of children with SEN. With lower percentage gaps indicating better performance, figure 5.1.9 shows that the Isle of Wight has been performing better than the England average since 2006. However, the Island's SEN/non-SEN gap has widened in that period, from 36.6% in 2006 to 42.1% in 2008.

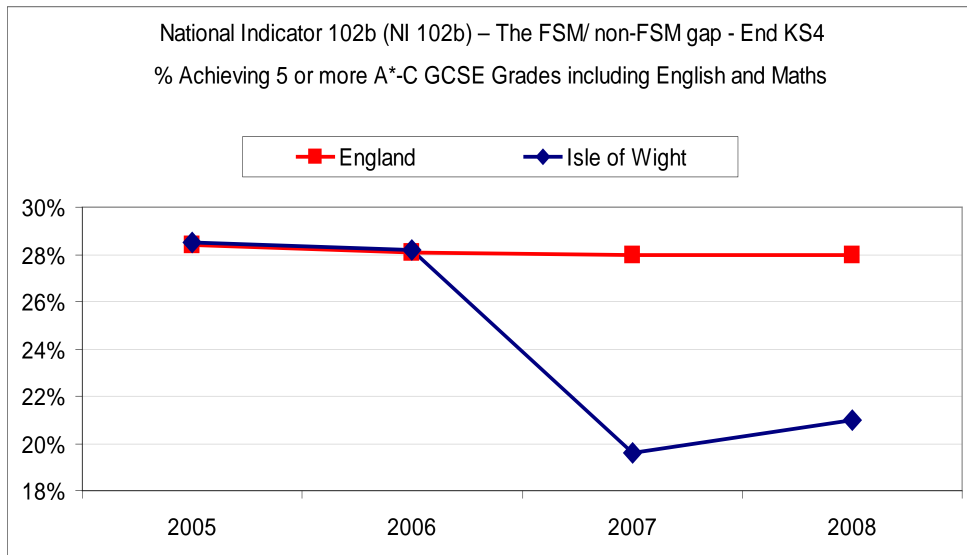


Figure 5.28.7 : National Indicator 102b – the FSM – non-FSM gap – End KS4 (Ref E)

5.28.8 Figure 5.25.7 shows the achievement gap between pupils eligible for free school meals (FSM) and their peers at Key Stage 4. FSM "eligibility" refers to those pupils who have a current, validated claim for free school meals with the Local Authority. The rationale for this national indicator is to narrow the gap in achievement between children from disadvantaged backgrounds and their peers.

5.28.9 Whilst the England average FSM/non-FSM gap has remained relatively consistent at around 28%, the Isle of Wight has seen considerable improvement in narrowing the gap since 2007. Although the Island's gap widened by 1.4% in 2008, it is still 7 percentage points narrower than the national average and is the narrowest in the South East region.

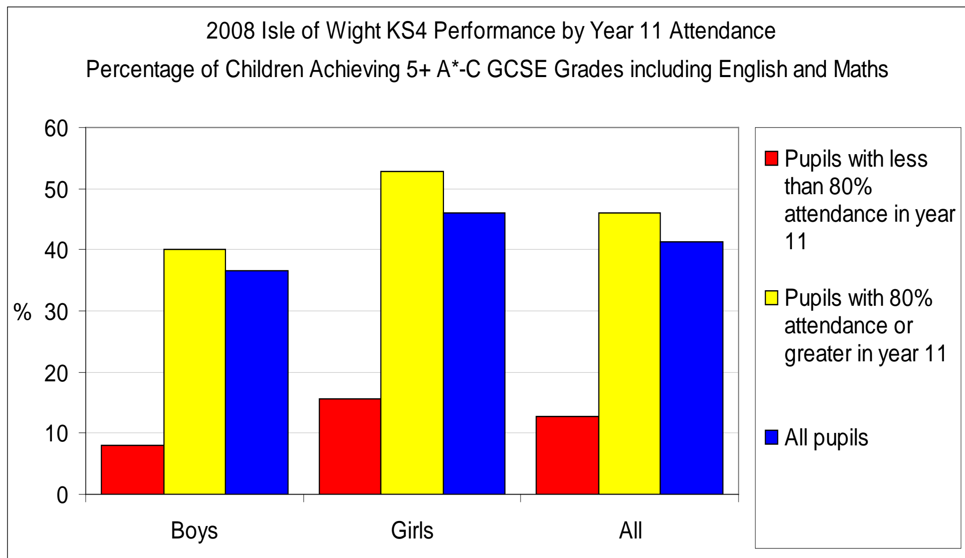
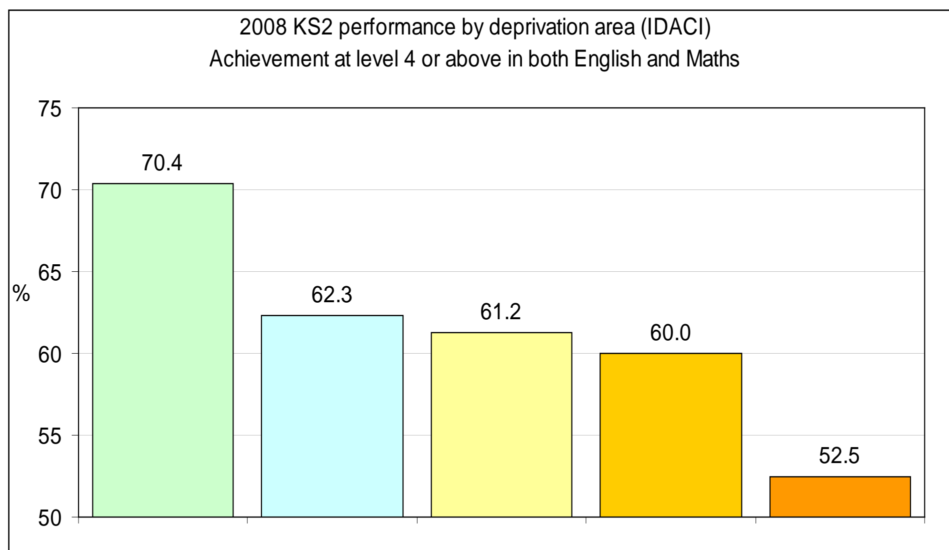


Figure 5.28.8 : 2008 Isle of Wight KS4 Performance by year 11 Attendance (Ref E)

5.28.13 Figure 5.28.8 shows the Key Stage 4 performance of pupils who were persistently absent during year 11 compared to the performance of the rest of the cohort. Persistent absenteeism is defined as attending less than 80% of available half days.

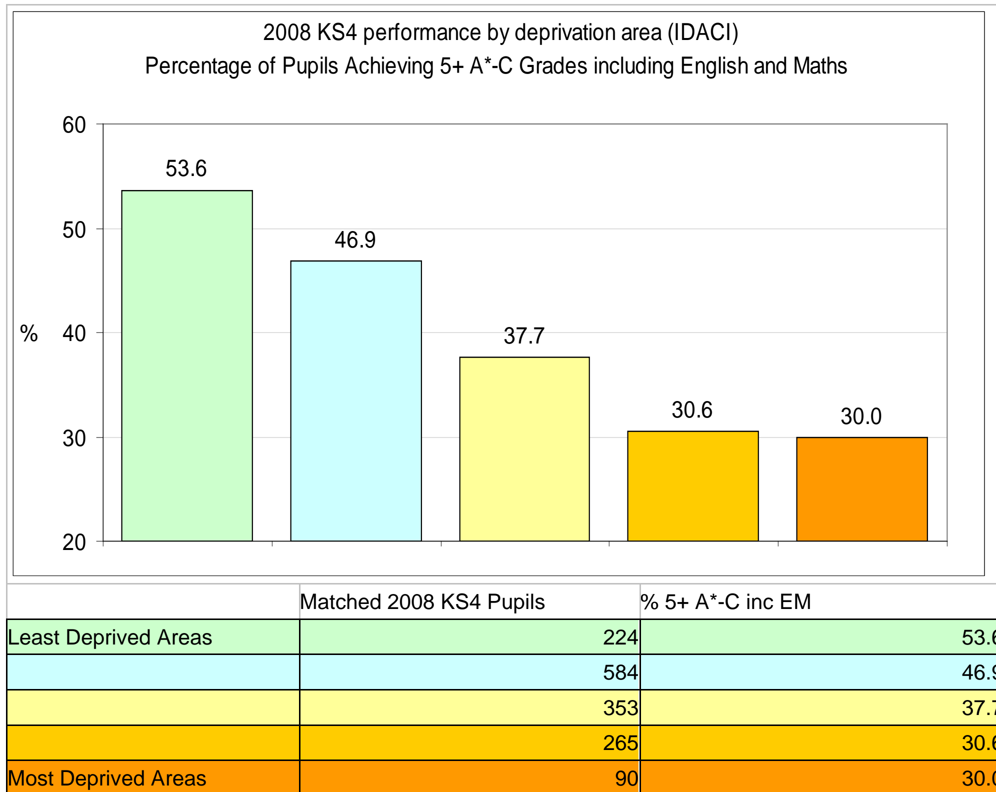
5.28.14 14.6% of Island pupils at the end of Key Stage 4 in 2008 were classified as persistently absent during year 11. Of those pupils, only 12.7% achieved 5 or more A*-C GCSE Grades (or equivalent) including English and Maths, which is 33.4 percentage points below the achievement of pupils whose attendance was 80% or greater.

5.29 IDACI Deprivation Vs Attainment



	Matched 2008 KS2 Pupils	% 4+ English and Maths
Least Deprived Areas	223	70.4
	573	62.3
	369	61.2
	250	60.0
Most Deprived Areas	80	52.5

Figure 5.29.1 : 2008 KS2 performance by deprivation area (IDACI) (Ref E)



	Matched 2008 KS4 Pupils	% 5+ A*-C inc EM
Least Deprived Areas	224	53.6
	584	46.9
	353	37.7
	265	30.6
Most Deprived Areas	90	30.0

Figure 5.29.2 : 2008 KS 4 performance by deprivation area (IDACI) (Ref E)

5.29.1 Figures 5.29.1 and 5.29.2 examine the relative Key Stage 2 and Key Stage 4 performance of pupils living in the least/most deprived areas on the Isle of Wight. The levels of deprivation are based on the 2007 Income Deprivation Affecting Children Index (IDACI). This analysis looks at the IDACI score of each of the 89 Lower Super Output Areas on the Isle of Wight and derives 5 deprivation bands based on a standard deviation model.

5.29.2 Whilst there are fewer children living in the most deprived areas of the Island, their average performance at Key Stage 2 (2008) was almost 18 percentage points worse than their peers living in the least deprived areas. The disparity is even more evident at Key Stage 4 where the gap is over 23%. At both Key Stages there is a downward trend, with lower percentages of children achieving the expected levels as the deprivation level increases.

5.30 Exclusions

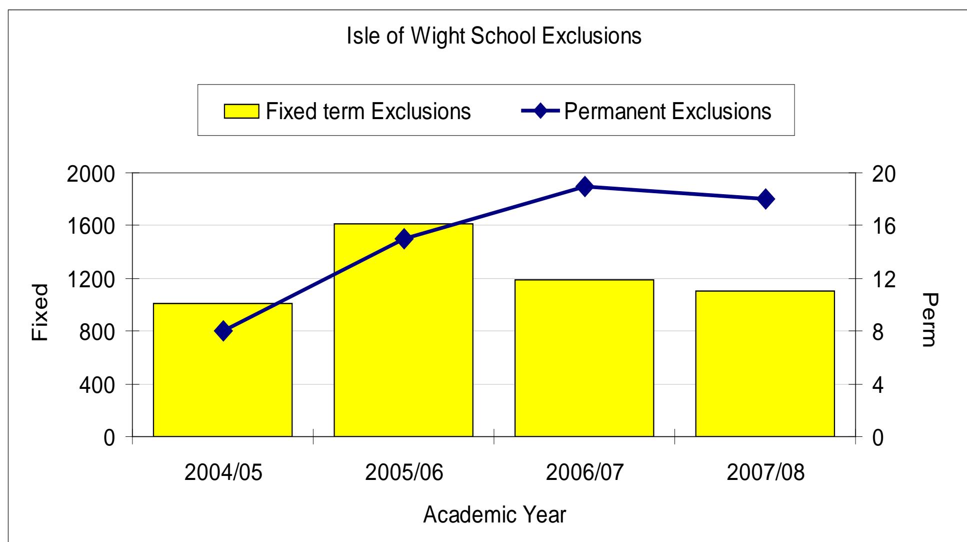


Figure 5.30.1 : Isle of Wight School Exclusions (Ref E)

5.30.1 Figure 5.30.1 shows the numbers of school exclusions on the Isle of Wight over the past four academic years. There has been an upward trend for permanent exclusions (levelling out in 2007/08) whilst fixed term exclusions have been decreasing year on year since 2005/06. There were 1101 fixed term exclusions in 2007/08 which represents a 32% reduction over two years.

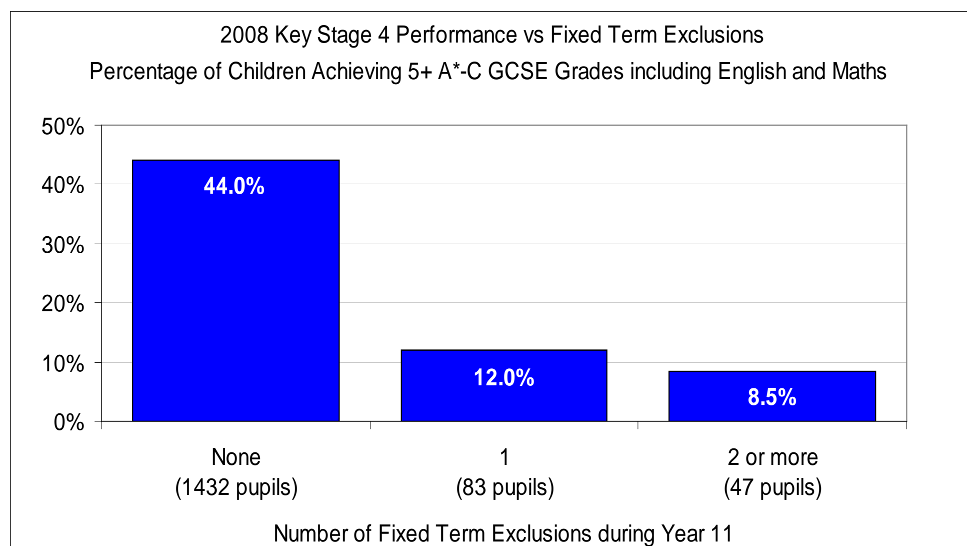


Figure 5.30.2 : 2008 Key Stage 4 Performance vs Fixed Term Exclusions (Ref E)

5.30.2 Figure 5.30.2 shows the comparable performance at Key Stage 4 of pupils with one or more fixed term exclusion and those with no exclusions. 130 pupils received one or more fixed term exclusion during year 11 (academic year 2007/08) and of those pupils only 10.8% went on to achieve 5 or more A*-C GCSE Grades (or equivalent) including English and Maths. This is a full 33 percentage points below the achievement of pupils with no exclusions. It is clear that the imperative is to improve behaviour and prevent exclusion.

5.31 Post 16 Education and Training

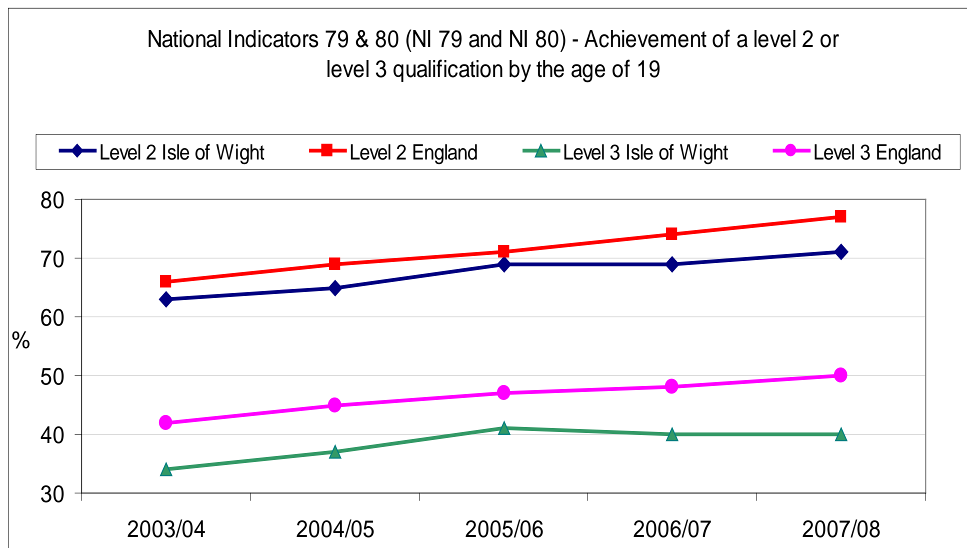


Figure 5.31.1: Achievement at Qualification Levels 2 and 3 by age 19

5.31.1 Figure 5.31.1 shows Island achievement of a level 2 or level 3 qualification by the age of 19. Level 2 qualifications provide an important platform for employability and further learning, whilst level 3 qualifications allow access to Higher Education and highly skilled employment.

5.31.2 The Isle of Wight has enjoyed rising trends at both level 2 (8% over 5 years) and level 3 (6%) but remains below the national average for both. In addition, since 2005/06 the gap between local and national performance has widened by 4% for both measures, highlighting the need to increase participation and engagement post-16.

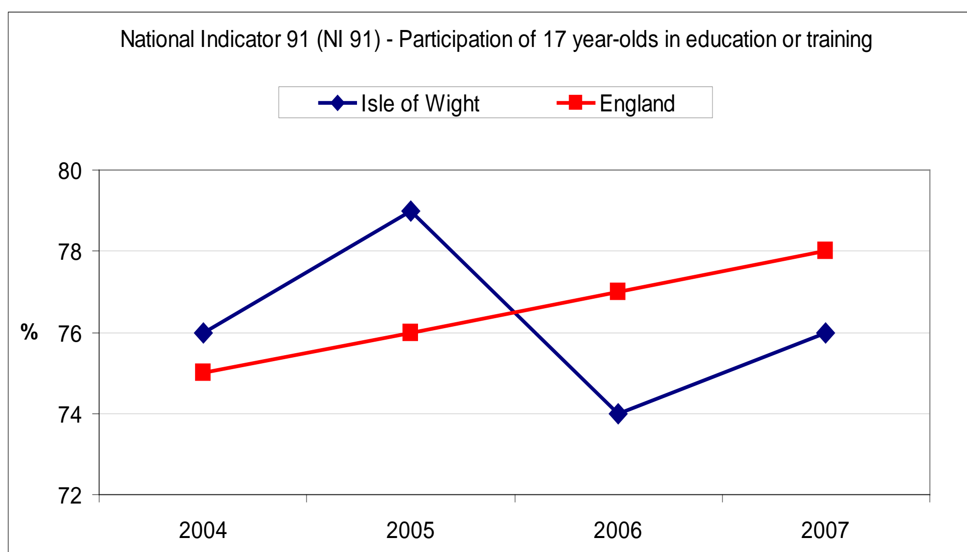


Figure 5.31.2 : Participation of 17 year olds in Education or Training

5.31.3 Figure 5.28.2 shows the numbers of young people at academic age 17 who participate in education or work based learning (National Indicator 91). The long term national ambition is to have 90% of 17 year olds participating by 2015.

5.31.4 The latest validated performance has the Isle of Wight at 76% in 2007. Despite fluctuation of 5% across the period, this shows no improvement from 2004 and has the Island below the national average. The England average has risen by one percent year on year

since 2004. Validated 2008 performance will not be available until 2010, but provisional figures are positive and suggest the Island may exceed 80%.

5.32 Special Educational Needs

5.32.1 Less than 2% of the population of children on the Isle of Wight have a statement of SEN. Though 18% of the child population on the Island have SEN which has been identified and addressed by the child's school

Pupils with SEN by type of school attended

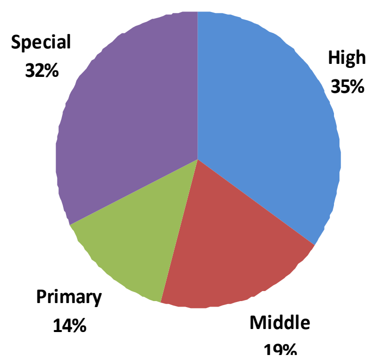


Figure 5.32.1 : Pupils with SEN by type of school attending (Ref 12101)

5.32.2 Disproportionately more high school children are subject to having been identified as having a SEN than appear to be the case for primary and middle school children. Exploring the differences apparent in the application of 'statementing' across these school types may repay dividends by earlier identification and remediation

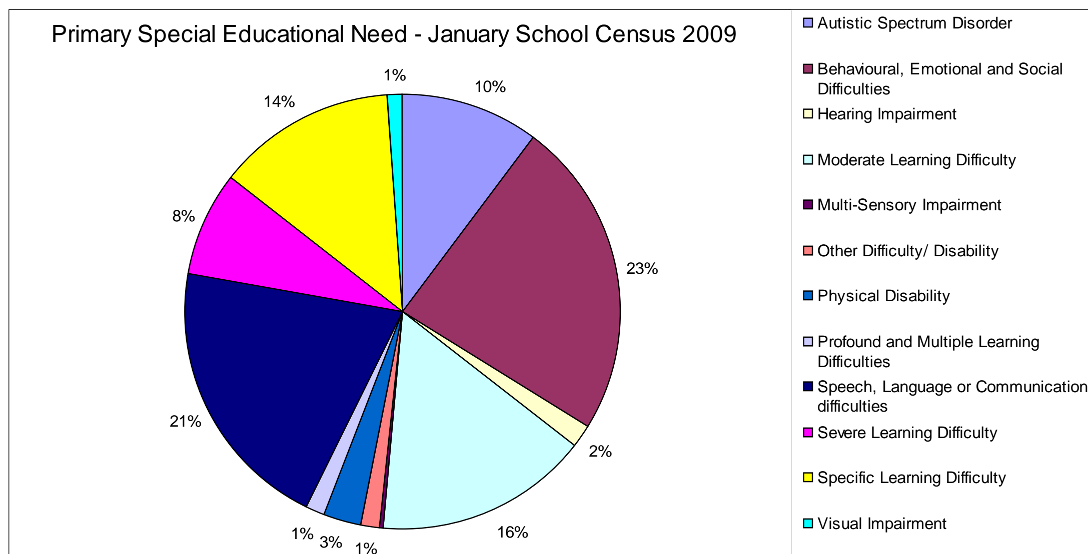


Figure 5.32.2 : Primary Special Educational Need

5.32.3 Figure 5.29.2 shows a breakdown of the type of primary Special Educational Need on the Isle of Wight, as at the January 2009 School Census. The school census covers all children at Local Authority maintained schools aged 4 to 18. Behavioural, Emotional and Social difficulties affect the most children (23%) followed by Speech, Language and Communication difficulties (21%). Physical, Visual and Hearing disabilities combined make up 6% of the total.

5.33 Ethnicity and Language

Ethnicity by Age <20's - as % of Population

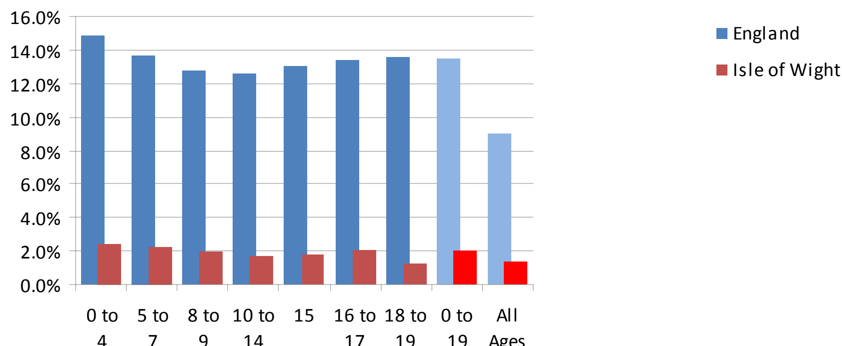
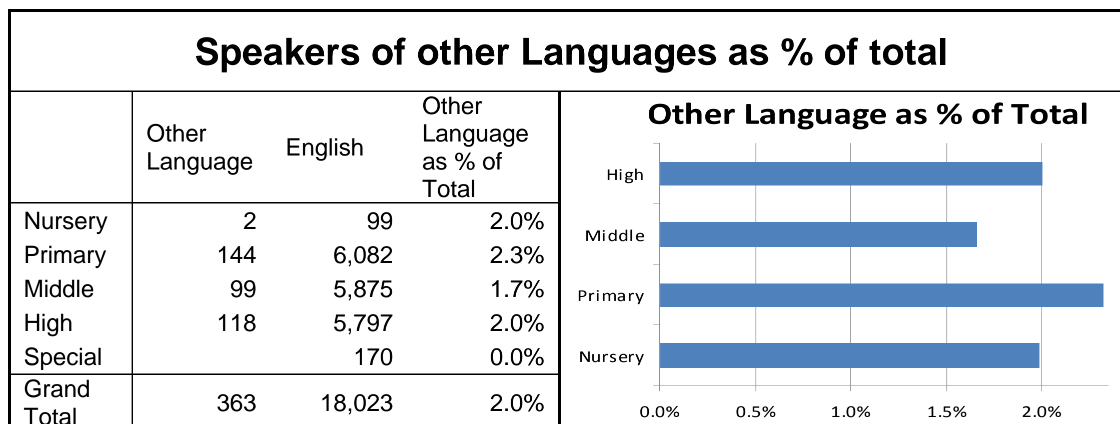


Figure 5.33.1 : Ethnicity in school population. (Ref 13002)

5.33.1 The 0 to 19 ethnic minority population (Figure 5.33.1) is significantly higher than the all-age ethnic population. It is worth noting that this cohort is likely to grow further given that the 0 to 4 and 5 to 7 sub-cohorts are over the 2% level implying that natural growth is being sustained in this population whereas there is slight diminution in the overall child population.

Speakers of other Languages as % of total



	Other Language	English	Other Language as % of Total
Nursery	2	99	2.0%
Primary	144	6,082	2.3%
Middle	99	5,875	1.7%
High	118	5,797	2.0%
Special		170	0.0%
Grand Total	363	18,023	2.0%

Figure 5.33.2 : English as a 2nd Language (Ref 13101)

5.33.2 Figure 5.33.2 suggests demand for remedial English and English as a second language provision is to grow; as demand at the nursery and primary level is strong.

5.34 Surplus School Places

5.34.1 This indicator shows the percentage of primary schools with 25% or more surplus places.

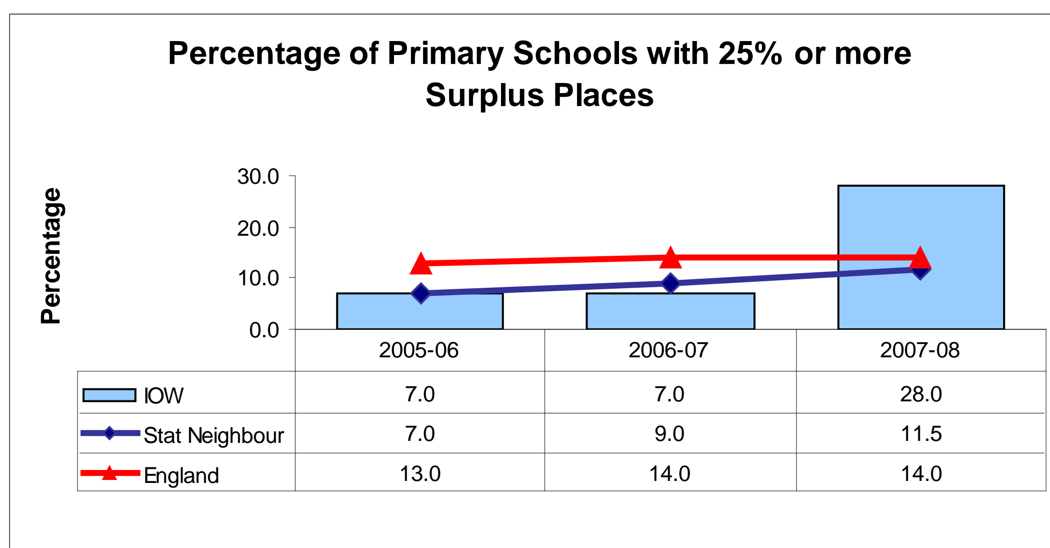


Figure 5.34.1 : Percentage of Primary Schools with 25% or more Surplus Places (Ref F)

5.35 Childminding Inspections

5.35.1 Between September 2008 and July 2009, 29 Childminders were inspected of these 25% were judged to be outstanding, 48% good, 17% satisfactory and 10% inadequate. In the same period 20 early years settings have been inspected of these 35% were judged to be outstanding, 45% good and 20% satisfactory. Twenty-four Schools were also inspected during this period and 8% were judged to be outstanding, 75% good and 17% satisfactory.

5.36 Make a Positive Contribution

Aim: Encourage all children and young people participating in positive activities to develop personal and social skills, promote wellbeing and reduce behaviour that puts them at risk

5.36.1 To achieve this we will:

- celebrate the successes and achievements of children and young people;
- involve children and young people in decisions about how services are planned, delivered and reviewed;
- provide opportunities for children and young people to be active members of their local communities;
- promote intergenerational understanding to increase the feeling of being safe in communities.

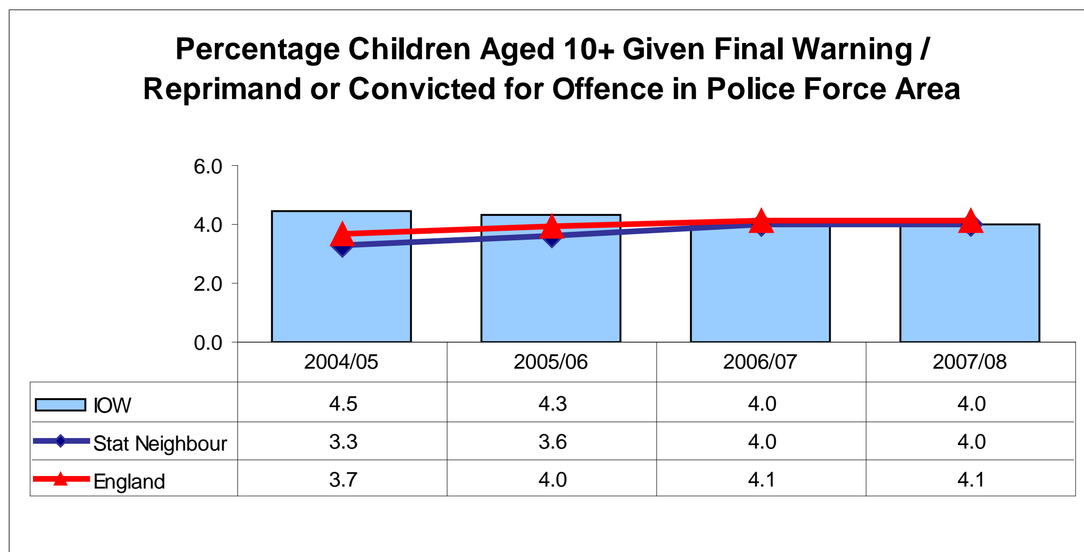
5.36.2 Children and young people in the Tellus 3 survey told us that:

- involvement in their local community is important to children and young people. However
- 37 per cent of children and young people felt that their views and decisions about the local area were not listened to, although
- 24 per cent reported their views about the local area to a school council.
- 51 per cent have asked for better activities for children and young people

Other consultation activity confirmed that young people wanted to be listened to – “adults need to show they are listening by doing what they say they will and listening more often”.

5.37 Young Offenders

5.37.1 In 2007/08, there were 257 first time entrants to the criminal justice system on the Isle of Wight. A first time offender is a young person receiving a reprimand, final warning or Court Order for the first time. The target is to reduce year on year by identifying children and young people at risk of offending.

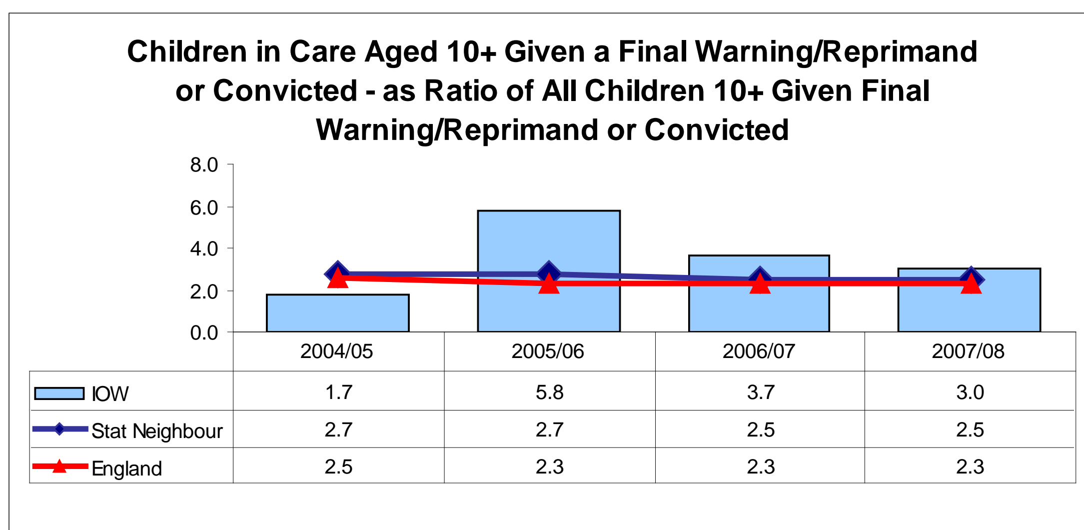


	2004/05	2005/06	2006/07	2007/08
IOW	4.5	4.3	4.0	4.0
Stat Neighbour	3.3	3.6	4.0	4.0
England	3.7	4.0	4.1	4.1

Figure 5.37.1 : Percentage children aged 10+ given Final Warning / Reprimand or convicted for offence in Police Force area (Ref F)

5.37.2 The Isle of Wight have exceeded their target in reducing first time offending overall, there was a decrease from 529 to 489 of young people coming into the criminal justice system, suggesting partnership working has produced significant results.

5.37.3 More young women are entering the youth justice system for the first time. Analysis of the type of crime has shown that theft offences have increased more on the Isle of Wight than in the other Wessex teams. Criminal damage has remained consistent and violence against the person offences has reduced. Peak age of offending is 15 years, and about a quarter of young offenders are aged 10 -13 years.



	2004/05	2005/06	2006/07	2007/08
IOW	1.7	5.8	3.7	3.0
Stat Neighbour	2.7	2.7	2.5	2.5
England	2.5	2.3	2.3	2.3

Figure 5.37.1: Children in Care aged 10+ given a Final Warning / Reprimand or convicted as ratio of all children 10+ given Final Warning / Reprimand or convicted (Ref F)

5.37.4 Slightly higher numbers of children in care received final warnings/reprimands and convictions than our statistical neighbours/national average in 07/08.

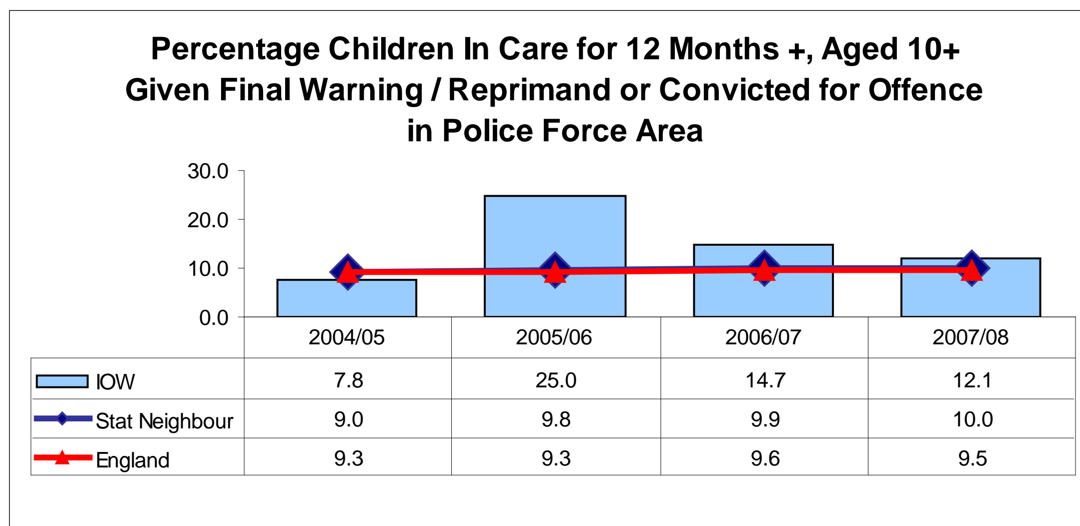


Figure 5.37.2: Percentage Children in Care for 12 months+, aged 10+, given Final Warning / Reprimand or convicted for offence in Police Force Area (Ref F)

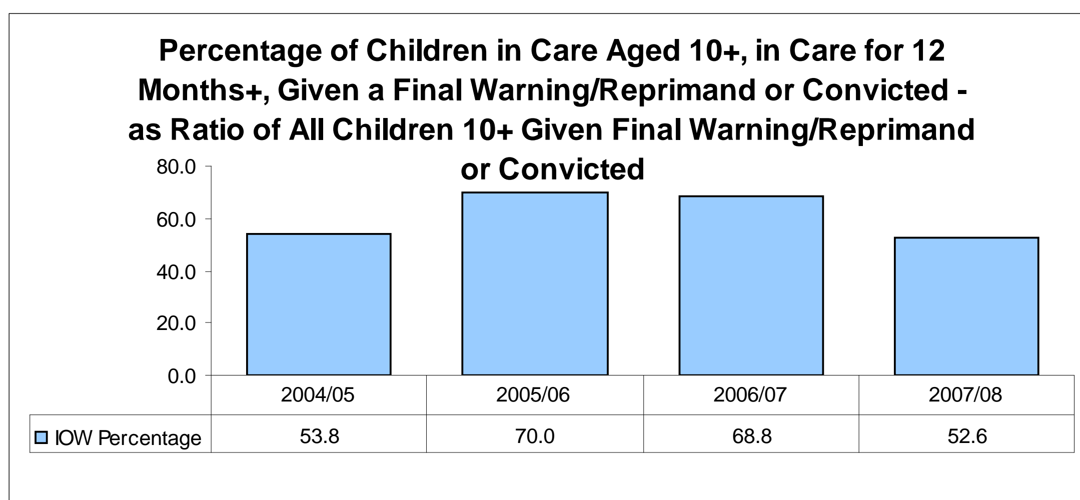


Figure 5.37.3: Percentage of children in Care aged 10+, in care for 12 months + given a Final Warning / Reprimand or Convicted – as ratio of all children 10+ given Final Warning / Reprimand or Convicted (Ref F)

5.37.5 Offending is a measure of the quality of care and support children receive once in care. Caution should be exercised though in the interpretation of this indicator, because of the low numbers which can disproportionately affect the end figure.

Where more work is needed:

- Although there has been a significant reduction in the numbers of young people entering the youth justice system and a corresponding reduction in repeat offending we must keep a focus on prevention to continue this decline.

- There is a perceived unease among residents including children and young people about crime, especially on public transport.
- Children and young people continue to be seen as a problem in their communities rather than to be involved in the solutions.

5.38. Extra Curricular Life

5.38.1 Children and young people have prioritised more things to do and places to go in the current children and young people's plan 2006 to 2009 drawn from an analysis of 8,000 individual consultations carried out between 2004 and 2006. The priority for more positive activities remains in the new 2009 to 2012 plan. Youth services, social services and Connexions were the three most mentioned services young people who were asked said they had had contact with. The findings from the recent survey of 35 young people from across the Island accessed through mobile outreach identified young people who reported that there was nothing to do, that they were not aware of what is available, that they wanted more services to be accessible through their local centre / community and for informal comfortable café places to go equipped with computers, modern décor and furnishings with lots of activities on.

5.38.2 The findings from the TellUs2 survey report that over the previous 7 days, Island children and young people reported that they spent approximately the same many days on at least 30 minutes doing sports or other active things. They reported that there were fewer barriers that prevented them from accessing existing positive activities such as availability of information. Thirty one percent of young people reported that the activities and things to do were good enough compared to a national average of 26% with 69% reporting they wanted more/better things to do compared to 74% nationally. Ten per cent more young people reported that they were listened to a great deal/fair amount than compared nationally.

5.38.3 The current spend by the Isle of Wight Council on the Youth Service excluding other sources of funding is £71 per young person compared to our statistical neighbours average of £52 per young person. Yet in 2007/2008 only 16% of young people in the 13-19 age group regularly used the service.

5.39 Achieve Wellbeing

Aim: Engage all children and young people in meaningful employment, education and training

To achieve this we will:

- reduce the number of children and young people living in poverty;
- provide access to information, advice, guidance and support to make and follow choices in education, employment and training;
- positively promote training, learning and employment;
- engage effectively with employers to maximise economic wellbeing on the Isle of Wight.

5.39.1 Children and young people told us that:

When asked about their future 54 per cent of Island children said they have ambitions to go to university when they leave school (Tellus3 Survey 2008), which is in line with the national average. Forty-six per cent of year 8 and 10 pupils say they want more or better information and advice when planning their future. Forty-five per cent of children and young people felt that better parks and play areas would make the Island a better place to live.

5.39.2 From other consultation activity:

- Young people identified that for those of them not in education, employment or training post 16 was a key area for improvement.
- A key concern was for them to be able to get better qualifications and better jobs.
- More work experience and support to identify relevant experience were cited as ways of helping young people make positive choices for their future.

- Better information and advice was requested to help inform choices.

5.40 Child Poverty

5.40.1 Almost 20 per cent of our children live in poverty. Poverty is one of the most significant barriers to achievement and well being in children and young people. This is one of our local area agreements and we want to reduce it to 16.5 per cent, which is challenging in the current climate.

- Child Poverty is measured as the proportion of children who live in families in receipt of out of work benefits
- On the Island the percentage of children in poverty currently stands at 19.7% which is the same as the national figure (approximately 4,500 children)
- The Islands poverty percentage has steadily fallen between 2004 and 2007our latest data is 19.7% of the under 16 population
- Child Poverty is one of the most significant barriers to achievement and wellbeing in Children & Young People
- Infant mortality is highest for lower socio-economic groups in society (*Neighbourhood Statistics*)
- Low Birth Weights, children who are poor are also at greater risk of being born small (*Neighbourhood Statistics*)
- Poverty leads to poorer health outcomes and it has an impact on Life Expectancy (*Neighbourhood Statistics*)
- The statistics show that areas with high levels of child poverty are also likely to have low proportions of teenage conceptions resulting in abortion (*Office for National Statistics and Teenage Pregnancy Unit (Feb 08))*
- Poverty increases the chances of a teenage women becoming a parent and the impact that this may well have on the mother and on her child in terms of later income and social conditions (*Office for National Statistics and Teenage Pregnancy Unit (Feb 08)*
- Poor children are more likely to have an unauthorised absence from school than richer children (*Neighbourhood Statistics*)
- Poor children typically do worse in schools and do not stay on as long (*Dcfs)*

5.40.2 National Indicator 116 measures Child Poverty the definition is “the proportion of children who live in families in receipt of out of work benefits” Figure 5.40.1 shows the latest data from 2007 and compares it with our statistical neighbours.

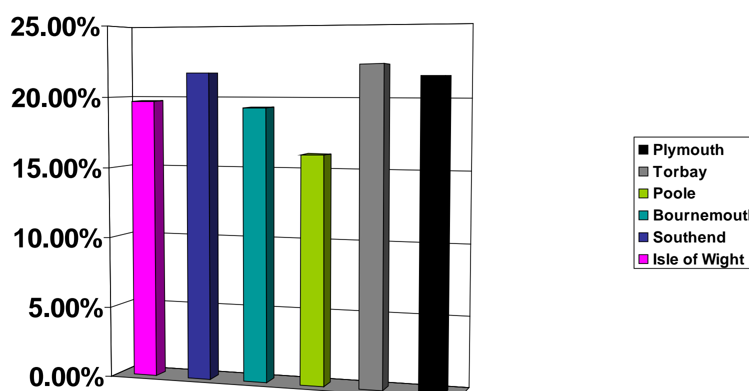


Figure 5.40.1 : Child Poverty – Isle of Wight Statistical neighbours 2007 (Ref C)

5.40.3 Figure 5.40.2 shows the Isle of Wight’s poverty figures since 2004 and our target percentage for 2010/11 of 16.5%, in the light of the recession and the increase in JSA figures since 2007 it may be anticipated that these targets are optimistic.

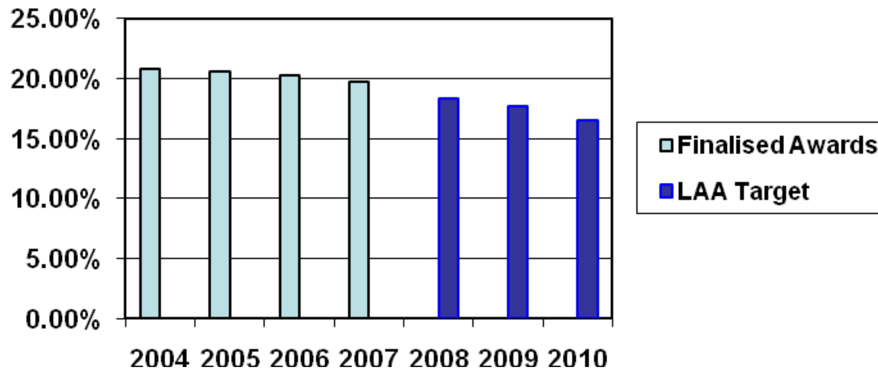


Figure 5.40.2 : NI 116 Proportion of Children in Poverty (Ref C)

5.40.4 National Indicator 118 Take up of formal childcare by low-income working families, is another measure linked to Child Poverty, the definition is "The number of working families benefiting from the childcare element of Working Tax Credit (WTC) as a percentage of the number of working families receiving more than the families element of Child Tax Credit (CTC)". Figure 5.40.3 shows the latest data from 2006/07 and compares it with our statistical neighbours. This figure has steadily been increasing from 13.4% in 2004/05 to 15.5% in 2006/07, this is the upward trajectory we are looking for.

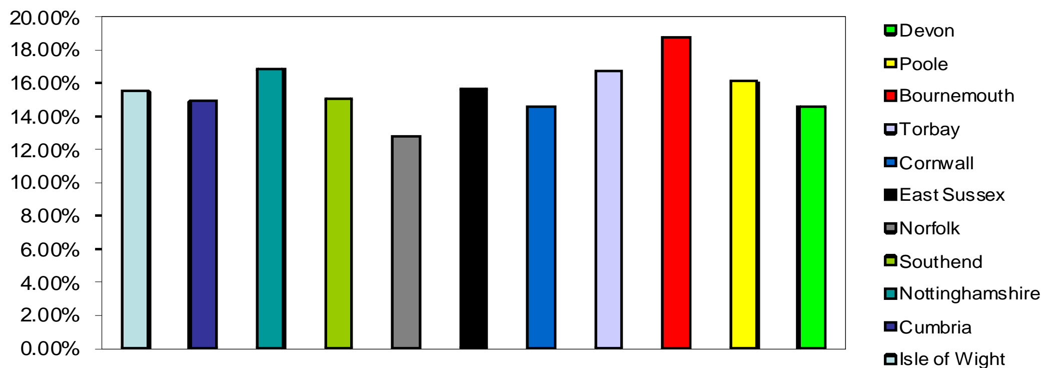


Figure 5.40.3 NI 118 Take up of formal childcare by low-income working families (%) (ref SS e-mail 23/06/09)

5.40.5 The introduction of the 0-2 year old pilot will help as focus on the most deprived families and in turn improve the take up of formal childcare

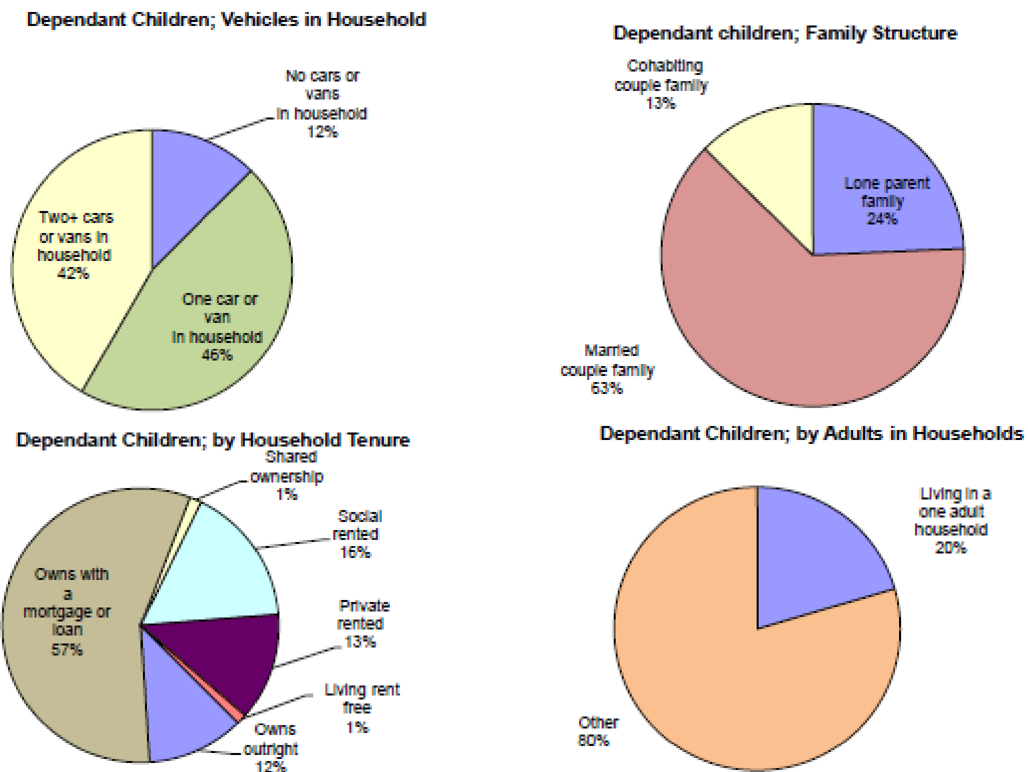


Figure 5.40.4 : Dependent children families by household vehicles, family structure, household tenure and adults in household (Ref 00203)

5.40.6 (see Figure 5.40.4) One eighth of dependent children live in families that are dependent on public transport. This situation will be especially acute amongst those families living in the more rural parts of the island. A quarter of children live in lone parent families and a third live in families outside of normal matrimonial family structures. The high levels of family homes subject to a mortgage or loan in the current economic climate are to some degree or another at risk of homelessness if the sustained growth in unemployment continues.

Households (HHs) Total, with Dependant Children, by Overcrowding and Parental Type; Census 2001

		Isle of Wight	GOSE	England
Total HHs		57,520	3,287,489	20,451,427
All Households with Dependent Children	All Married couple HHs	8,456	623,643	3,591,335
	All Cohabiting couple HHs	1,872	101,454	661,073
	All Lone parent HHs	3,516	171,549	1,311,974
	Other HHs	1,118	62,647	458,369
	Total HH's with Dependent Children	14,962	959,293	6,022,751
	HHs with Children as % of Total HHs	26.0%	29.2%	29.4%
Overcrowded by Family types with Dependent Children	Married couple HH's	389	30,462	253,124
	Married couple HH's as % of all Married Couple HH's	4.6%	4.9%	7.0%
	Cohabiting HH's	152	8,407	56,614
	Cohabiting HH's as % of all Cohabiting HH's	8.1%	8.3%	8.6%
	Lone parent	343	19,750	181,050
	Lone parent HH's as % of all Lone Parent HH's	9.8%	11.5%	13.8%
	Other HH's	165	14,532	140,779
	Other HH's as % of all Other HH's	14.8%	23.2%	30.7%
	total overcrowded	1,049	73,151	631,567
	Total overcrowded as % of total HHs with children	7.0%	7.6%	10.5%

< IW Average (7%) Overcrowded HH's with Dependent Children

> IW Average (7%) and < National Average (10.5%) Overcrowded HH's households with Dependent Children

> National Average (10.5%) Overcrowded Households containing Dependent Children

Figure 5.40.5 : Households with dependent children by overcrowding and parental type (Ref 00301)

5.40.7 The prevalence of overcrowded dependent children households that occur on the Island are 3% lower than national or GOSE levels. (Figure 5.4.5). A significant difference from national prevalences of overcrowding occurs with lone parent and other households. Both sets of household arrangements are significantly less subject to overcrowding proportionately to the national and GOSE levels.

5.40.8 Child Well-Being Index : - Housing : Children spend a great deal of their lives at home. Therefore the house that they live in can have a profound impact on their well-being. Four indicators have been selected to represent the housing circumstances of children and, as a result of preliminary analysis, they are represented in two sub-domains.

5.40.9 The Indicators:

- *Access to housing:*
- *Overcrowding: occupancy rating*. Source: Census table CAS053.
- *Shared accommodation: people living in shared dwellings, aged 0 to 15 as a proportion of all children 0-15 in each LSOA*. Source: Census tableCAS054
- *Homelessness:*
- *concealed families containing dependent children as a proportion of all families with dependent children*. Source: Census table CAS011

For the overcrowding indictor, the counts of households comprising couples, lone parents, and other types of household containing dependent children living in accommodation with at least one room too few is summed across the tenures and expressed as a proportion of all households to give a rate of 'overcrowded' households containing dependent children.

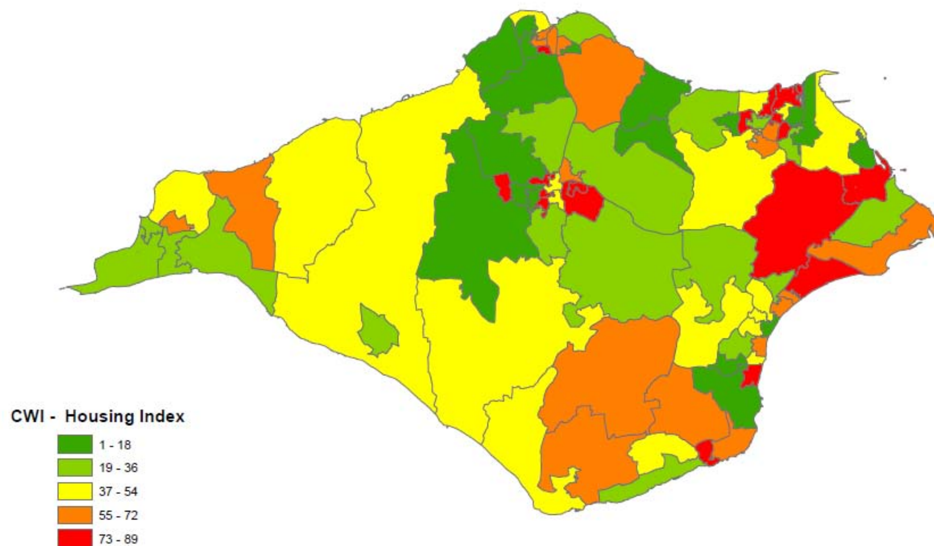
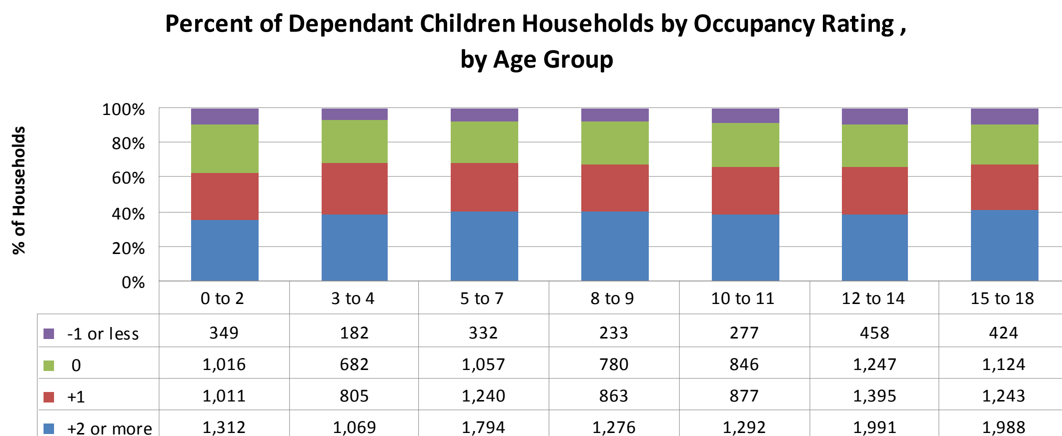


Figure 5.40.6: Child well-being index : Access to Housing by lower super output areas : Quintiles (Ref 00303)

5.40.10 The quintiles shown are local to the Island on the map, and show in the red and orange areas where there are issues to address, mainly in terms of occupancy and tenure rather than household condition



	0 to 2	3 to 4	5 to 7	8 to 9	10 to 11	12 to 14	15 to 18
-1 or less	349	182	332	233	277	458	424
0	1,016	682	1,057	780	846	1,247	1,124
+1	1,011	805	1,240	863	877	1,395	1,243
+2 or more	1,312	1,069	1,794	1,276	1,292	1,991	1,988

Figure 5.40.7 : Percent of Dependent Children Households by Occupancy Rating (Overcrowding) (Ref 00102)

5.40.11 A dependent child is a person in a household aged 0 to 15 (whether or not in a family) or a person aged 16 to 18 who is a full time student in a family with parent(s). Occupancy rating provides a measure by rooms of under occupancy and overcrowding, e.g. a value of -1 implies that there is one room too few and that there is overcrowding in the household.

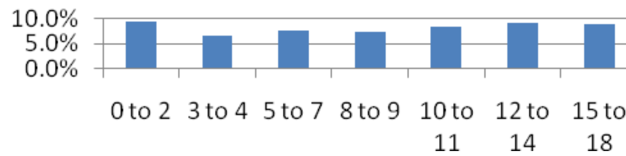


Figure 5.40.8 : Children living in overcrowded accommodation by Age Group

5.40.12 The age group 0 to 2 (9.5%) are more likely to be living in households that suffer from overcrowding by this measure. Other age groups that are particularly overcrowded are the 12 to 18 years groups, overcrowding at this age may have a negative impact on educational attainment.

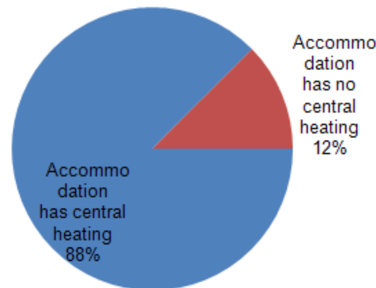


Figure 5.40.9 : Children in centrally heated accommodation (Ref 00702)

5.40.13 Nearly an eighth of the Islands children (ONS Census 2001) lived in homes without central heating.

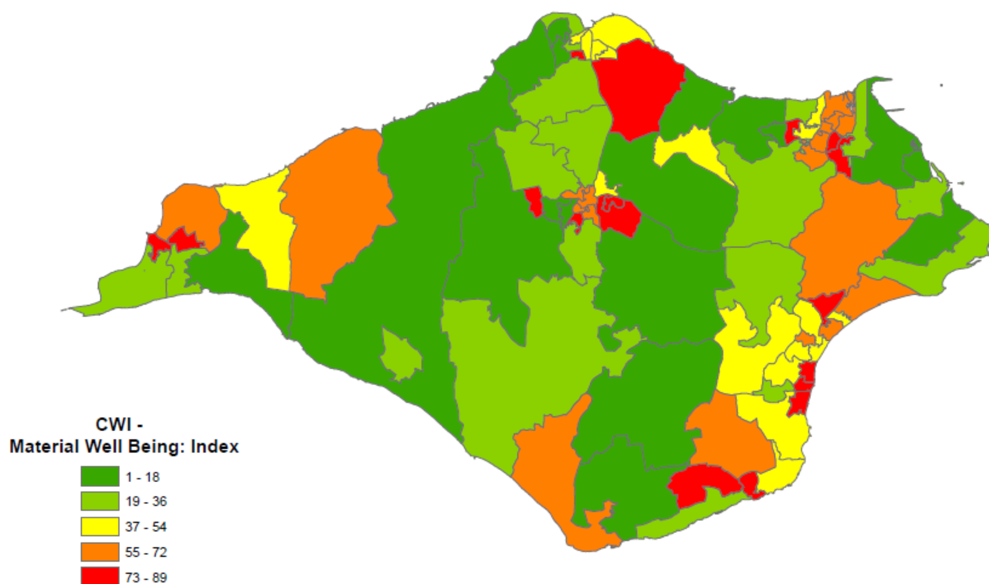


Figure 5.40.11 : Child well being – Material well being : Lower super output areas : Quintiles (Ref 00104)

5.40.14 This map (Figure 5.40.11) illustrates the proportion of children experiencing income deprivation in small areas.

5.35.15 **The Indicators**

- *Children aged 0-15 in households claiming Income Support* (Source: DWP, 2005)
- *Children aged 0-15 in households claiming Income-Based Job Seekers' Allowance* (Source: DWP, 2005)
- *Children aged 0-15 in households claiming Pension Credit (Guarantee)* (Source: DWP, 2005)
- *Children aged 0-15 in households claiming Working Tax or Child Tax Credit whose equivalised household income (excluding housing benefits) is below 60 per cent of the median before housing costs* (Source: HMRC, 2005)
- *Children aged 0-15 in households claiming Child Tax Credit (who are not eligible for Income Support, Income-Based Job Seeker's Allowance, Pension Credit or Working Tax Credit) whose equivalised income (excluding housing benefits) is below 60 per cent of the median before housing costs* (Source: HMRC, 2005).

The material well-being index is a comprehensive, non-overlapping count of children living in households in receipt of both in-work and out-of-work means-tested benefits. The **numerator** is a simple sum of children aged 0-15 living in low-income households while the **denominato**r is total number of children aged 0-15. Thus, the domain score for each LSOA in the CWI is the proportion of its 0-15 year old children who are living in low income households.

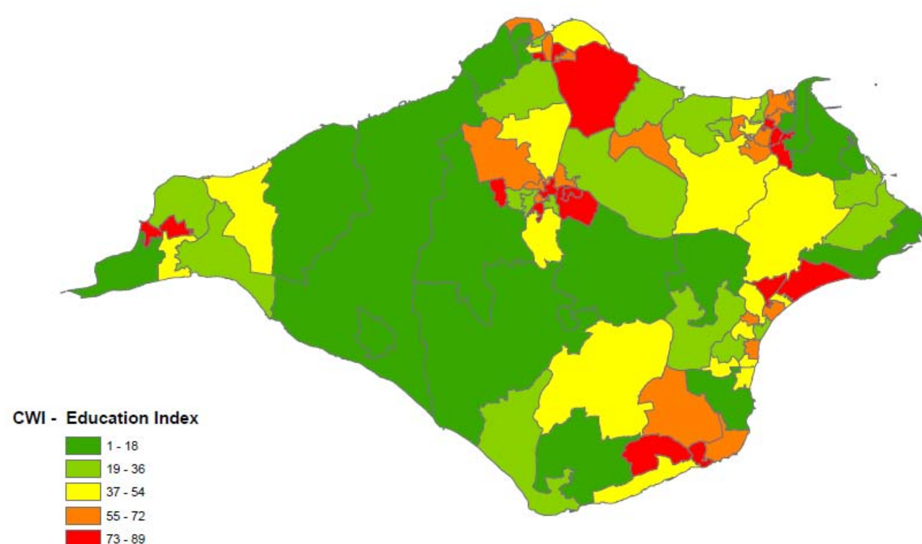


Figure 5.40.12 : Child Well being Index – Education – lower super output areas : Quintiles (Ref 12502)

5.40.16 The Education Domain includes a variety of education outcomes including attainment, school attendance and destinations at age 16.

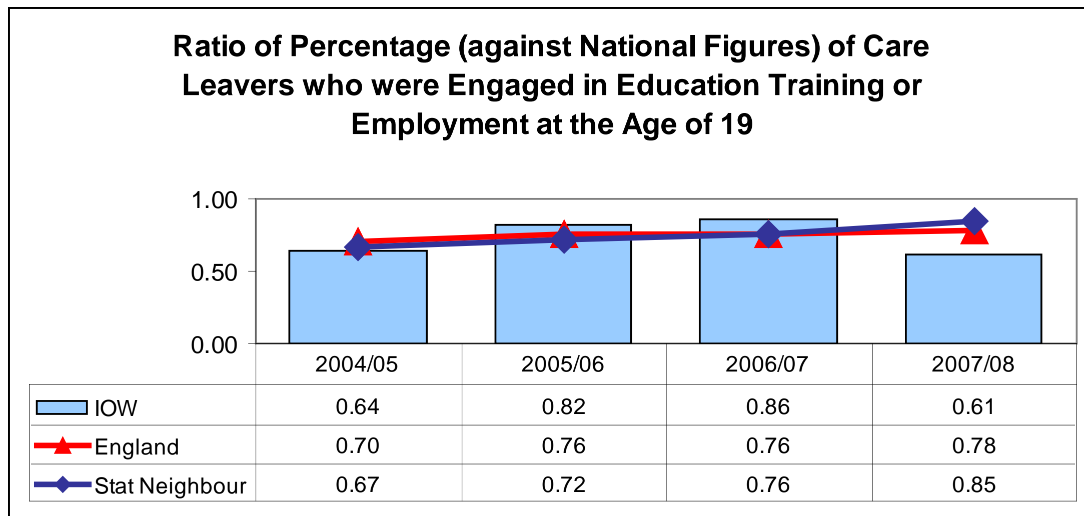
5.40.17 **The Indicators:**

- *Two year rolling average points score at Key Stage 2 derived from test score.* Source: PLASC (2004-2005), NPD (2004-2005)
- *Two year rolling average points score at Key Stage 3 derived from test score.* Source: PLASC (2004-2005), NPD (2004-2005)
- *Two year rolling average capped (best of 8 GCSE and/or equivalent vocational qualifications) points score at Key Stage 4.* Source: PLASC (2004-2005), NPD (2004-2005)
- *Secondary school absence rate* – based on two year average of school level absence rates
- allocated to local area using PLASC. Source: PLASC and DfES absence rate data (2004-2005)

- *Proportion of children not staying on in school or non-advanced further education or training beyond*
- *the age of 16*, average of 2004 and 2005. Source: Child Benefit (2002-2005)
- *Proportion of those aged under-21 not entering higher education (4 year average, 2002-2005).* Source: Universities and Colleges Admission Service (UCAS), Higher Education Statistics Agency (HESA).

5.41 Not in Education Employment or Training (NEET)

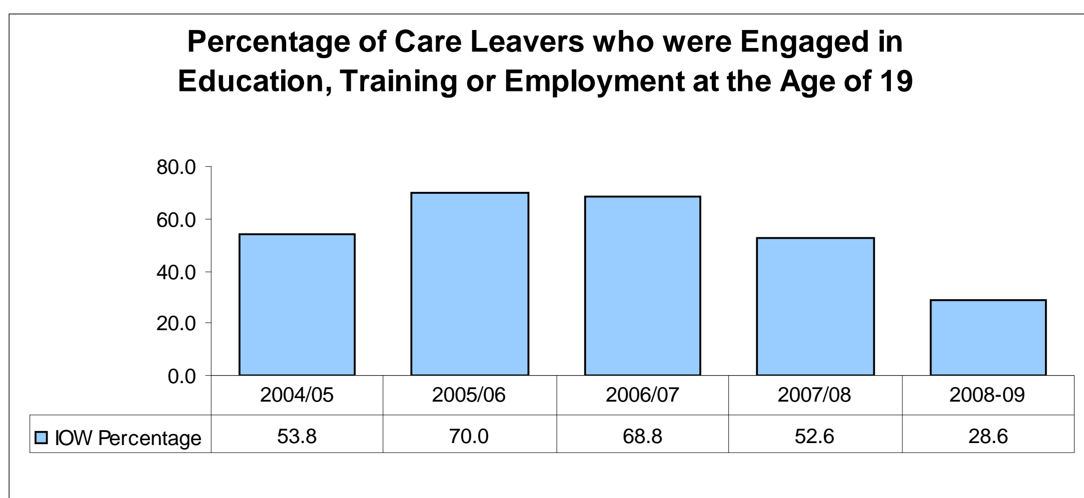
5.41.1 Non-participation in education, employment or training between the ages of 16 – 18 years is a major predictor of later unemployment, low income, depression, involvement in crime and poor mental health.



	2004/05	2005/06	2006/07	2007/08
IOW	0.64	0.82	0.86	0.61
England	0.70	0.76	0.76	0.78
Stat Neighbour	0.67	0.72	0.76	0.85

Figure 5.41.1 : Ratio of percentage against national figures of Care Leavers who were engaged in Education Training of Employment at the age of 19 (Ref F)

5.41.2 There has been a significant fall in the number of care leavers in education, training or employment at age 19 in 2008-09



	2004/05	2005/06	2006/07	2007/08	2008-09
IOW Percentage	53.8	70.0	68.8	52.6	28.6

Figure 5.41.2 : Percentage of care leavers who were engaged in Education, Training or Employment at the age of 19 (Ref F)

5.41.3 Young people who were looked after up to aged 16 and engaged in education, training or employment at aged 19 years as a ratio against the local population was lower

than national and statistical neighbour average and has dropped significantly in 08/09 though the outrun has yet to be validated.

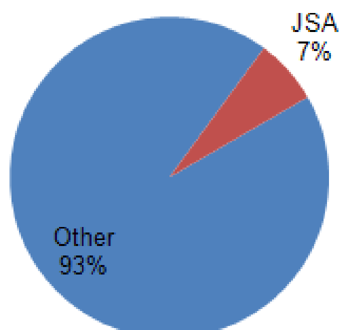


Figure 5.41.3: Job Seeker's Allowance claimants August 2008 as a percentage of under 19's (Ref 01403)

5.41.4 Figure 5.41.3 is indicative only as the JSA is perceived to be a difficult benefit to claim for people in this age group that are living with their parents, and therefore understates the levels of unemployment in this cohort.

5.42 Childcare Sufficiency Assessment

5.42.1 The island is generally more deprived than elsewhere in the south east. Out of the council's 48 wards, 15 are in the 20% most deprived nationally and the unemployment level was 3.8% compared to the national average of 3.3%, as shown below.

Isle of Wight unemployment levels – April 2009	
Category	% Unemployed
Male	5.0
Female	2.1
Overall	3.8
UK Average	3.3

5.42.2 Childcare on the Island has seen a rapid development over the last 5 years. This has been in response to:

- Local demand from parents
- Childcare providers wishing to extended their services
- Government agenda to raise children out of poverty - through the Neighbourhood Nursery Initiative and Children's Centres
- Extended Services agenda

5.42.3 Early Years Childcare provision on the IoW is in the main provided by the private, voluntary and independent sector (PVI sector). The rural nature of the island means that childcare is quite vulnerable to sustainability issues.

Childcare Provision by Ward					
Ward	Childminder 0-8yrs	Nursery 0-2yrs	Preschool 2-4 yrs	After school clubs 5+yrs	Crèche
Newport	17	6	14	10	
Sandown/Shanklin	19	3	10	7	2
Cowes	20	2	7	2	
Ryde	26	4	14	8	
West Wight	3	3	5	1	
Ventnor	10	1	7	2	

All nursery provision operates within a pre-school provision.

5.42.4 Full time childcare fees for after school clubs and holiday provisions are typical to the average cost in England. Cost of nursery and preschool care are £39 - £79 per week cheaper than the average cost in the South East region.

- Full time childcare fees for one child aged 0-3 years equate to a quarter of the average household income (Working Tax Credits not applied).
- Out of school club fees for children aged 5+ years in the term time equates to one tenth of average household income.
- The average weekly benefit in the childcare element of Working Tax Credits is £32.16. This equates to approximately 25% of childcare fees for full time 0-3yr childcare and 47% of full time 3-4 yr childcare when claiming the full entitlement of NEG.

5.42.5 Nearly 50% of preschools are registered as management committee structure with charity status. The voluntary groups struggle to maintain committee numbers and require additional support in business management. There were 2 changes of legal status during 2006 and 2007 from the voluntary to the private sector and 2 groups considering change. In the last 2 years the local authority has built a programme of business support specifically to enable childcare providers to have the skills to operate as sustainable and viable businesses.

5.43 Extended Services in and around Schools

5.43.1 Many schools are already seeing the benefits of offering extended services in order to meet the needs of the Later Years Provision. The core offer for Extended Services consists of

- A varied range of activities, including study support, sport and music clubs, combined with childcare in primary schools
- Parenting and family support
- Swift and easy access to targeted, and specialist, services
- Community access to facilities, including adult and family learning, ICT and sports grounds

5.43.2 By schools meeting the core offer, families and children and young people are more supported to achieve their potential. These services are based on consultation and shaped to meet the needs of pupils, parents and the community; this core offer ensures that there is a minimum of services and activities for families. Services will not necessarily be provided on the school site or by teachers.

Schools have access/provide access to out of school clubs and activities:

	Primary Schools – 46 in total	Middle Schools – 14 in total	High Schools – 5 in total
Breakfast club	29	5	4
After school club	7	0	0
Holiday club	23	1	1
After school activities i.e. music, art clubs	20	16	5

5.44 Number of Childcare vacant places

5.44.1 Vacancy data shows that 20% of places are vacant across the island of which 33% are 2-3 year places and 61% are 3-4 year places suggesting there are additional barriers to accessing childcare. Wards have vacancy rates ranging from 18% in Newport, 29% - 30% in Ventnor and Ryde wards. However, vacancy analysis is misleading as there are only 4 vacancies in the Ventnor wards.

5.44.2 The West Wight wards have the third highest vacancy rate of just under a quarter of places vacant and the lowest take up of places provided in respect of the free entitlement. West Wight has the lowest number of providers on the island. This could possibly suggest barriers are greater in these areas.

5.44.3 Shanklin/Sandown and Cowes wards show insufficiency of full and part time places and have a vacancy rate at the lower end of the range suggesting more places are required. The most significant vacancy ratings are in the Ryde and Ventnor areas where over a quarter of places provided are vacant; the highest vacancy rate across the island. This would suggest supply exceeds demand in these areas for children from age 2 years.

5.44.4 As of November 2007 there were 110 vacant childminder places.

5.44.5 *Further research would need to establish the difference between vacancies and a lack of provision and how this relates to different localities across the Island.*

5.45 Local Demand for Childcare Provision Places

We know that:

5.45.1 Nurseries (0-2 years) There is a 91% take up of nursery and preschool places for children aged 0-2 years. Results show insufficient full time places provided for under 2's island wide, if every child accessed childcare.

- A proportionately small percentage of parents/carers returning questionnaires (13%) use nursery childcare compared to informal care at 29%.
- Most parents can stay at home for longer due to new employments laws surrounding maternity entitlements.
- Parents have indicated they would prefer their children to be older before accessing childcare
- In some areas where large housing estates have had a stable population for over 20 years the families have grown up and moved away. Many childcare groups in these areas have dropped the age range to take children under 2 years to accommodate the decline.

5.45.2 Nurseries/Preschools (2-4 years)

- There is a 79% take up for children aged 2 – 4 years.
- Birth rate statistics show a 2.7% increase in birth rate in 2003 and a 7% increase in 2004 impacting heavily on the number of children aged 3-4 years in 2007.
- There is less than one child per place for 3-4 year old children suggesting sufficient places provided.

- There are sufficient part time places for children aged 2-3 years and insufficient full time places
- Many parents are beginning to access part time places for their child at the age of 2 for social reasons
- Many of them opting for 2 or 3 half day sessions a week for children aged 2 - 3.
- Many parents feel that 2 or 3 sessions are sufficient for their child's needs and their own childcare needs.

5.45.3 Childminders (0-8 years)
- There was a 77% take up of places provided by childminders for ages 0-8yrs.
- Data suggests there is no take up for children aged 3-4 years.
- There are currently only 2 childminders accredited to provide childcare in respect of the free entitlement.
- Numbers of registered childminders have increased in 2007
- Survey results show an increased demand for childminding as the second highest requirement type at 17% of parents and 9% actually use childminders.
- Parents indicate a lack of childminders and the need for more joined up services

Total take up of childminder places

Age	Take up
0-2	38%
2-3	4%
3-4	0%
5+	36%

5.45.4 Out of school clubs (5+yrs)
- Overall take up level of 72.5% of places provided in out of school clubs.
- The take up of ranges from 61% to 100% in some areas.
- 1% is taken up by children with special education needs.
- There has been a drop in holiday provisions
- The greatest demand overall is for out of school care where 26% of respondents demand childcare after school or at weekends

5.45.5 13% of parents indicate that they use formal childcare and 29% use family or informal childcare. This would indicate that parents prefer to use own family or friends.

5.45.6 The number of free entitlement places required

We know that:

Summer Term 2006 hours	Hours per week (average)	Place @ 12.5 hours	Take up of places 3-4 years**	Proportion of NEG claims to places	
Cowes	4.,372.0	3,282.3	263	330	80%
Newport	59,392.3	4,828.6	386	546	71%
Ryde	55,327.0	4,498.1	360	472	76%
Sandown/Shanklin	44,233.0	3,596.2	288	334	86%
Ventnor	19,650.0	1,957.6	128	148	86%
West Wight	18,602.5	1,512.4	121	258	47%
Total	237,576.8	19,315.2	1545		

** Registered number of children (take up) am + pm

5.45.7 The average number of part time places claimed each week in respect of the free entitlement equates to 74% of total places provided for 3-4 year olds.
- The take up of the free entitlement varies in each part of the Island.
- There were 1,677 children accessing the free entitlement at the time of the study.
- Many parents access 2.5 hours per week in the first few weeks of registration increasing to full entitlement either during or from their first term.

- Providers will book places up to 12.5 hours to accommodate parents as they increase hours.
- Parents may not be able to have their preferred choice of hours as this depends on occupancy levels
- The survey illustrated 78% or parents would be willing to pay for additional hours outside of the free entitlement.
- Parents would like more flexibility and would prefer not to set hours for the 3-4 year children.
- Providers are challenged in providing the entitlement on a needs basis due occupancy levels and room planning.

Further research would need to qualify why there are differences in uptake across the IoW and the potential impact of increased free entitlement to uptake of places.

5.45.8 The requirements for specialist childcare for disabled children and those with special educational needs

We know that:

- The take up of childcare is low between 3% - 8%.
- Questionnaire results
  - 7% of parents require childcare
  - 5% identified SEN as a barrier to access
- Discussions with parents indicate
  - A need for special provisions specifically for their children
  - A need for more trained staff
  - More one to one childcare
  - Trust is an issue
  - Transport to and from clubs is needed

Further research would need to extract what type of childcare is required, when is it required and where would it take place and how it relates to the range of needs.

The full assessment can be found at *http://eduwight.iow.gov.uk/the_lea/early_years/images/RefreshCSA2009.pdf*

5.46 Living Environment

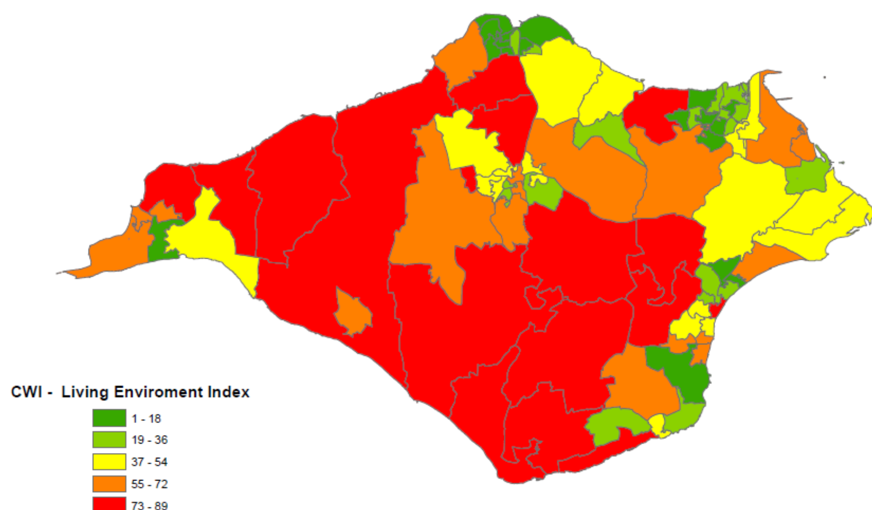


Figure 5.46.1: Child well being index : living environment lower super output areas : quintiles (Ref 12601)

5.46.1 Although initially alarming the environmental indices shown in Figure 5.41.1 captures aspects of the environment that affect children's physical wellbeing (health, exercise and safe, independent mobility). Indicators of the potential of the natural environment to provide children with play spaces that enhance their personal, cognitive and social development are incorporated.

5.46.2 The Indicators:
Environmental quality

- Air quality: *combined air quality indicator. Source:* Geography Department at Staffordshire University
- The natural environment: *percentage of green space and woodland*
- *The number of bird species.* Source: European Environment Agency's CORINE Land Cover (CLC) database; British Trust for Ornithology bird breeding atlas
- Road safety: *severity-weighted accidents per 1000 children aged under-16.* Source: Department for Transport.

Environmental access

- Availability of opportunities for sports and leisure: *average number of different types of sports and leisure facility within walking distance for children aged 11 to 16* Source: Ordnance Survey Points of Interest
- Distance to school: *average road distances to primary and secondary schools for children aged 4 to 10 years and 11 to 16 years*. Source: PLASC (2005) and Edubase (2005).

6 Adult and Community Services 65+

6.1 Pensioner Demographics

6.1.1 The Isle of Wight has the 2nd highest proportion of 65+ in its population for upper tier local authorities (22nd of 434 for Districts and Unitaries) in the UK. Amongst the 85+ population figures the Island has the third highest population amongst upper tier local authorities (18th of the 434 Districts and Unitaries) in the UK.

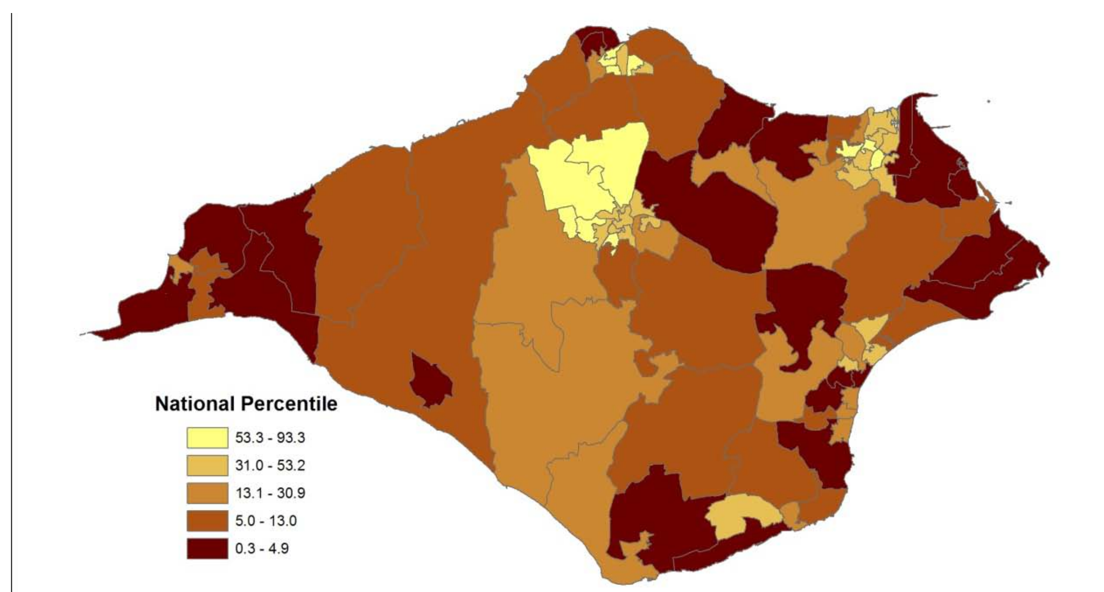


Figure 6.1.1 Pensioners (Male 65+, Female 60+) in Lower Super Output Areas (LSOA's) by National Percentile (low figure = high population). ONS 2007 Mid Year Estimates

6.1.2 Pensioners as a percentage of the population; 10% (9) of the Island's 89 LSOA's fall into the top 1% of national LSOA's by this measure – and 20% (22) fall in the top 5% e.g. the dark brown areas in figure. 6.1.1. The highest proportions of pension age people are noticeably in rural and seaside areas, very low proportions in Cowes, Newport and Ryde. Figure 6.1.2 demonstrates by table and graph the degree of skew in the frequency distribution. In an 'average' population the columns would be of roughly equal height and there would be three more columns to the right.

National Percentiles of Pensioners as a Proportion of the Population: by I.o.W. Lower Super-Output Areas

National Percentile	LSOAs
<=1%	9
1.1% to 4.9%	13
5% to 9.9%	13
10% to 19.9%	15
20% to 39.9%	15
40% to 59.9%	16
60% to 93.3%	8
Grand Total	89

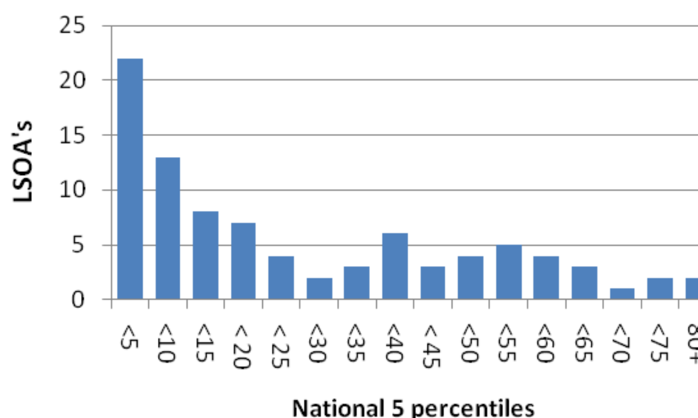


Figure 6.1.2 National Percentiles of Pensioners as a Proportion of the Population: by I.o.W. Lower Super-Output Areas. ONS 2007 Mid Year Estimates. 10011

6.1.3 85 plus population: this cohort - and their distribution – is of especial interest as they are 21 times more likely (than the 65 to 74 cohort) to need assistance with the business of living due to increasing fragility and vulnerability. That assistance is supplied by; carers, the voluntary, private and public sectors or a combination. The actual numbers of 85+ by ward are explored in Figure 6.1.3. If compared with figure 6.1.1. it may be seen that this cohort are less likely to be living in rural situations and are concentrated in seaside locations.

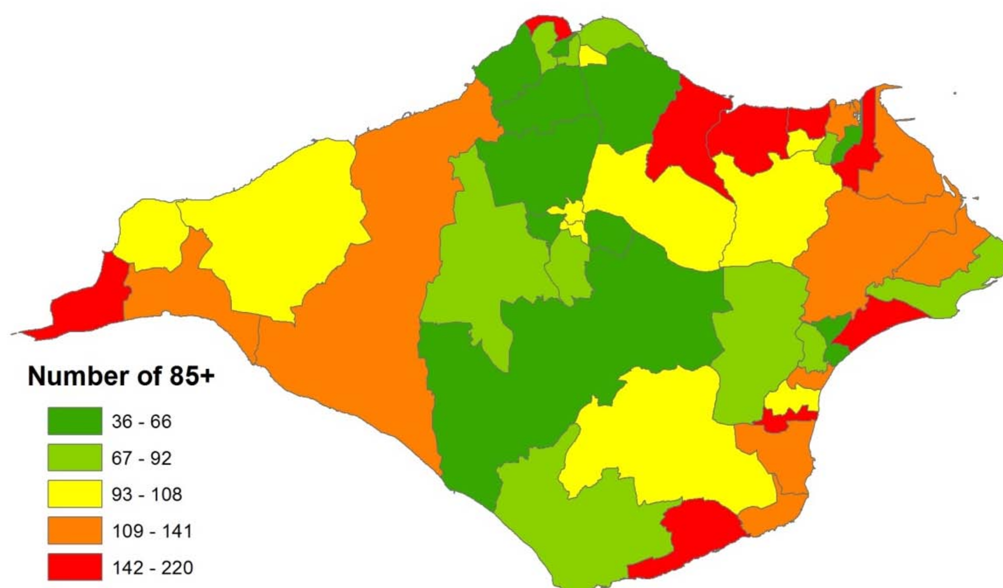


Figure 6.1.3: Number of 85+ by Ward. ONS 2007 Mid Year Estimate

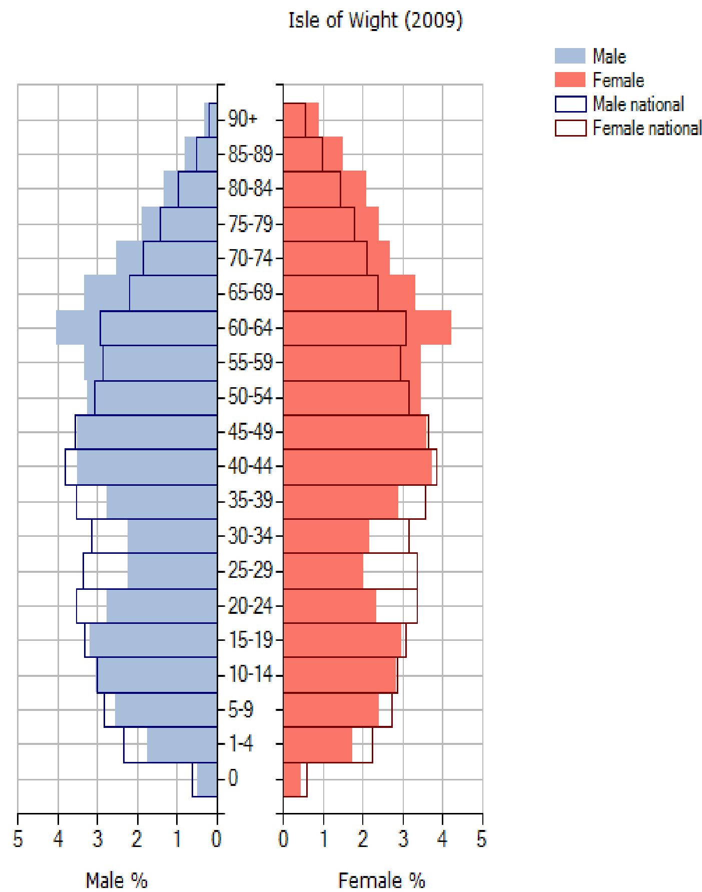


Figure 6.1.4: Population Pyramid for 2009 from ONS 2006 Population Projections.

6.1.4 Confirmation of the extent of the imbalance in the Islands population can be seen in fig 6.1. 4:- from 50 onwards each age cohort consistantly exceeds the national profile. The reduced proportion of working age people also has implications for the delivery of services to the elderly.

6.1.5 Between 2002 and 2007 the pensioner population maintained its upward growth increasing over the five years covered in figure 6.1.5 by 1.3% as a proportion of the total population or 3,200 people.

Population by Age Bands 2002 to 2007 as a percentage of Total Population			
	All ages	Pensioners 65M/60F and over	
	n/1000	n/1000	%
2002	134.1	34.0	25.4%
2003	135.1	34.5	25.5%
2004	136.5	35.1	25.7%
2005	137.9	35.8	26.0%
2006	138.5	36.2	26.1%
2007	139.5	37.2	26.7%

Figure 6.1.5 : Population cohort change (ONS mid year estimates)

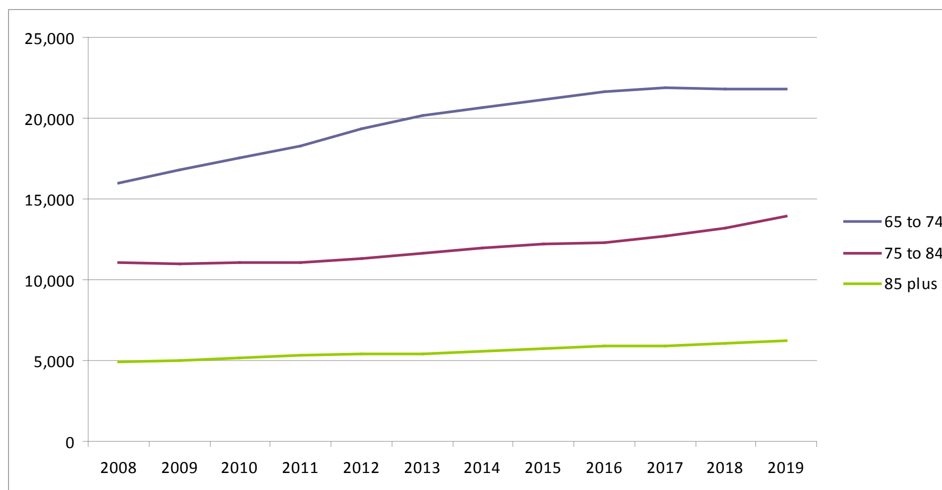
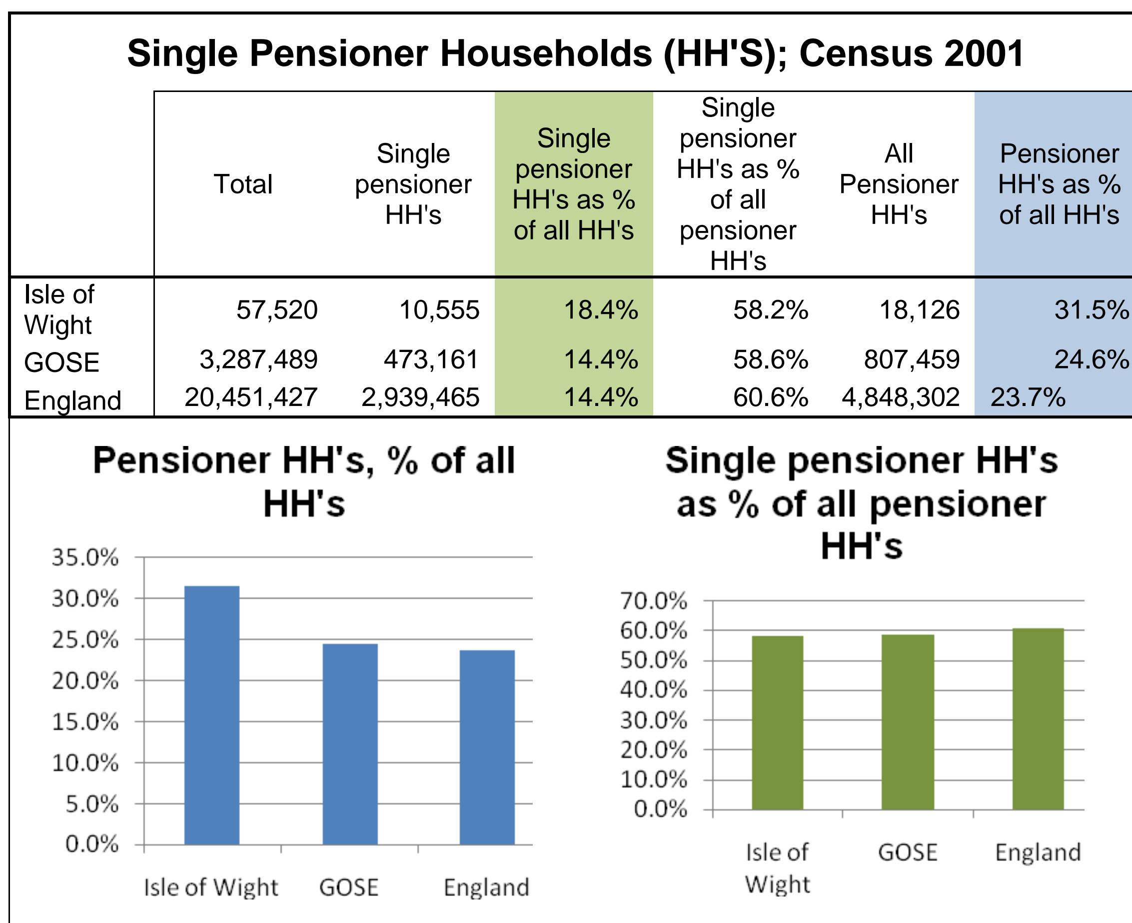


Figure 6.1.6: 65 plus Population Projection 2008 to 2019 (Ref 10003)

6.1.6 The 65 plus population is expected to grow significantly in the decade 2009-2019, illustrated in Figure 6.1.6. This growth will be sustained across all three of the cohorts, but the most dramatic rise will be seen in the 65 to 74 cohort. The impact of the post war baby-boom can be clearly seen in the steep climb of this cohort through to 2016, and the steepened growth of the 75 to 84 cohort post 2017. The volume of people entering the 65+ cohort will tend to drive down the average age of the 'elderly' for the next decade. This is the first generation to benefit from an entire lifetime spent in the care of the NHS, they represent an unknown quantity in terms of longevity, quality of health and expectations.

6.1. 7 Single Pensioner Households: The Island has a significantly (7.8%) larger proportion of pensioner households as a proportion of the total number of households (31.5%) when compared to the national proportion (23.7%). To a lesser extent (4.0%) single pensioner households as a proportion of all households are also a significantly larger proportion of total households (18.4%) versa the national proportion (14.4%) - in numerical terms this is 2,270 more single pensioner households than would be expected for a similar sized area elsewhere nationally. The single pensioner proportion of all pensioner households (58.2%) is marginally lower than the national proportion (60.6%), suggesting either that pensioner's partners are surviving longer here than the national average, or that the pensioners that move here are more likely to have a partner.


Single Pensioner Households (HH'S); Census 2001

	Total	Single pensioner HH's	Single pensioner HH's as % of all HH's	Single pensioner HH's as % of all pensioner HH's	All Pensioner HH's	Pensioner HH's as % of all HH's
Isle of Wight	57,520	10,555	18.4%	58.2%	18,126	31.5%
GOSE	3,287,489	473,161	14.4%	58.6%	807,459	24.6%
England	20,451,427	2,939,465	14.4%	60.6%	4,848,302	23.7%

Figure 6.1.7: Single Pensioner Households; ONS Census 2001 (Ref 00601)

6.1.8 Single pensioners generate additional demand for social services, as there are more risks; of social isolation, exclusion, depression and poorer chances of survival from illness and accident. These risks originate in the absence of a live in carer and can be considerably reduced if the individual has family or friends living close by, or if they are living in a sheltered housing scheme. Failing this there will be more willingness to consider them for residential care, especially on discharge from hospital.

6.2 Pensioner Housing

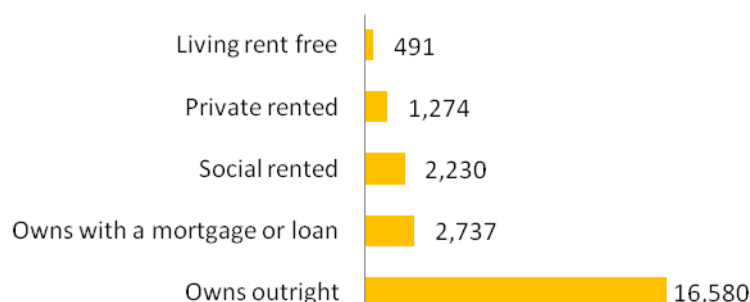
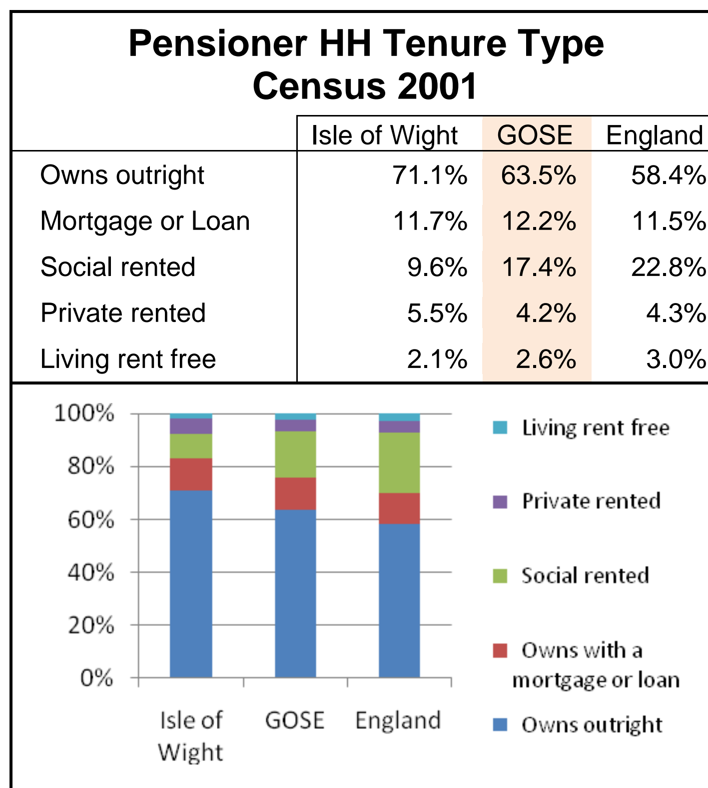


Figure 6.2.1: Pensioner Household (HH's) Tenure: ONS census 2001 (Ref 00602)

6.2.1 There are high levels of home ownership (12.5% higher than the national average) amongst the Islands pensioners, and a correspondingly low use of socially rented housing (13.2% lower than national average). This impacts on the national funding provided for social care in that reductions are made on the assumption that people will be able to pay for their own care with the proceeds from the sale of their properties.



Pensioner HH Tenure Type Census 2001

	Isle of Wight	GOSE	England
Owns outright	71.1%	63.5%	58.4%
Mortgage or Loan	11.7%	12.2%	11.5%
Social rented	9.6%	17.4%	22.8%
Private rented	5.5%	4.2%	4.3%
Living rent free	2.1%	2.6%	3.0%

Figure 6.2.2: Pensioner Tenure

Pensioner Households (HH's) by Heating: Census 2001

	Households with at least one Pensioner	Age in years								1 or more pensioners with 1 non-pensioner	1 or more pensioners with 2 non-pensioners
		Lone males			Lone females			2 or more people, all pensioners			
		65 to 74	75 to 84	85 and over	60 to 74	75 to 84	85 and over	All under 75	Any aged 75 and over		
Central Heating											
Accommodation has have central heating	19,816	785	696	283	3,042	2,692	1,168	3,464	3,291	3,257	1,138
Accommodation does not have central heating	3,499	214	212	75	581	553	254	341	477	586	206

Figure 6.2.3: Pensioner Households with heating (Ref 00701)

6.2.2 15% of pensioner households on the Island (in 2001) could not offer accepted levels of thermal comfort, i.e. central heating. This broadly indicative measure is deficient as a comprehensive measure as;

- It does not take into account the ability of people living on pensions that are in many cases steadily depreciating in value to pay for fuel, especially now that the price of fuel has become unpredictably volatile.
- Nor indeed does it offer information on the thermal efficiency of the properties concerned, poorly insulated centrally heated properties could well prove a burden.
- Finally there are alternative heating arrangements which offer acceptable heating solutions.

Pensioner Households (HH's) by Vehicle Availability: Census 2001

	Households with at least one Pensioner	Age in years								1 or more pensioners with 1 non-pensioner	1 or more pensioners with 2 non-pensioners
		Lone males			Lone females			2 or more people, all pensioners			
		65 to 74	75 to 84	85 and over	60 to 74	75 to 84	85 and over	All under 75	Any aged 75 and over		
Car or Van Availability											
No car or van in household	8,708	364	402	220	1,948	2,353	1,252	384	1,062	617	106
One car or van in household	11,309	589	486	134	1,623	864	163	2,641	2,353	2,029	427
Two or more cars or vans in household	3,298	46	20	4	52	28	7	780	353	1,197	811

* Car or van availability includes any company car or van if available for private use.

Figure 6.2.4 : Pensioner Households by Vehicle availability; ONS 2001 Census (Ref 00801)

6.2.3 In 2001 37% of pensioner households did not have access to a car or van, this rises to 88% for single females aged 85+, and to 61% for single males 85+. Amongst households with 2 or more pensioners with any aged 75+ the figure stands at 28%

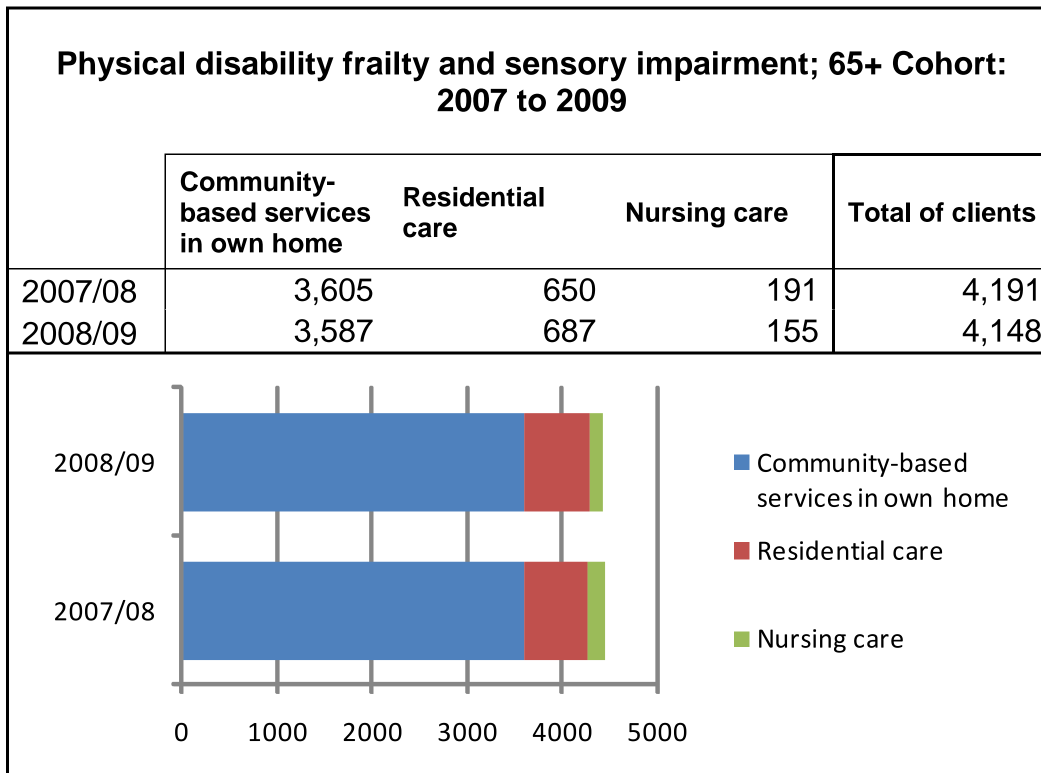
6.3 Pensioner Client Groups

On the whole the differentiation between client groups amongst the elderly was blurred historically (prior to 2005) by the practice of counting (and funding) everyone over the age of 65+ as 'elderly'. The process of resolving this is still ongoing, driven in part by

- the survival of growing numbers of learning disabilities clients
- the emergence of community mental health teams, and a specific need to identify people living with dementia

Consequentially complete surety about the applicability of these broad categories on an individual basis is not possible, and confidence in their application statistically is qualified.

6.4 Physical Disability and Frailty 65+


Physical disability frailty and sensory impairment; 65+ Cohort: 2007 to 2009

	Community-based services in own home	Residential care	Nursing care	Total of clients
2007/08	3,605	650	191	4,191
2008/09	3,587	687	155	4,148

Figure 6.4.1: Physical Disability Clients 65+; RAP P1 annual returns, clients provided with services during relevant year (Ref 06809)

6.4.1 The largest single category of client that adult social services deal with the Physical Disability category represents 11% of the 65+ population on the Island. Residential and nursing care account for 2.3% (842) of this 11%, the other 8.7% (3,587) receive services in the wider community. This category has been (is?) widely used as a catch all default for all the ills of advanced age, in particular 'frailty', a term which has no medical basis, and is liable to include clients whose conditions include the psychological with the physiological.

6.4.2 Community based services will be dealt with in more detail below, but given client choice, funding constraints and eligibility criteria, it is worth noting here that these services are favoured over residential and nursing care. Residential care is frequently a long term service; a permanent move for the client from a domestic setting to institutional care, but within these figures at any one time there is a considerable respite element. It is rather less common for nursing care to be long term as much of what is supplied is palliative care.

Physical Disability Clients 65+ - Services; 31st March 2008 and 2009.

	65 to 74		75 plus	
	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009
Home Care	109	114	1067	1163
Day Care	32	33	370	348
Meals	39	43	546	456
Short term residential not respite	13	16	255	254
Direct Payments	11	15	98	78
Professional Support	74	68	249	279
Equipment & Adaptations	77	67	290	352
Other	46	42	321	255
Total of Clients	275	279	1922	1980

Figure 6.4.2: Figures taken from the RAP P2s annual return, and were current as of the 31st March in the respective years. As clients may have multiple services the total clients line counts clients, not services delivered

6.4.3 Figure: 6.4.2 is a snapshot at the end of the year of the clients currently receiving community services (2,259 at 31/03/2009). Clients ceasing during the year equal 1,328 (subtracting from the total in figure: 6.2.1.1. 3,587; 01/04/2008 to 31/03/2009) to give an estimated turnover rate of 37% p.a.

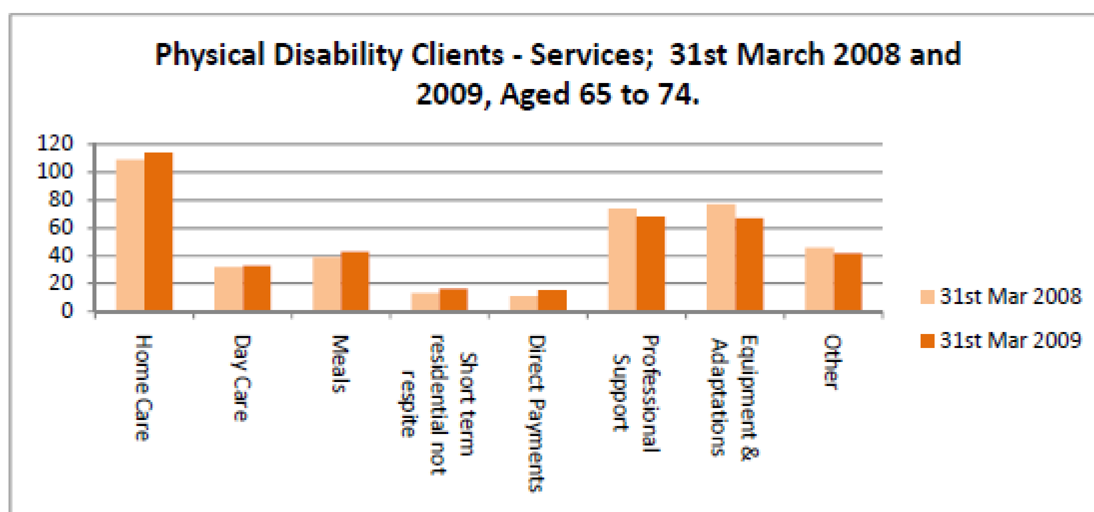


Figure 6.4.3: Physical Disability Clients – Services : 65 to 74 (Ref 06902)

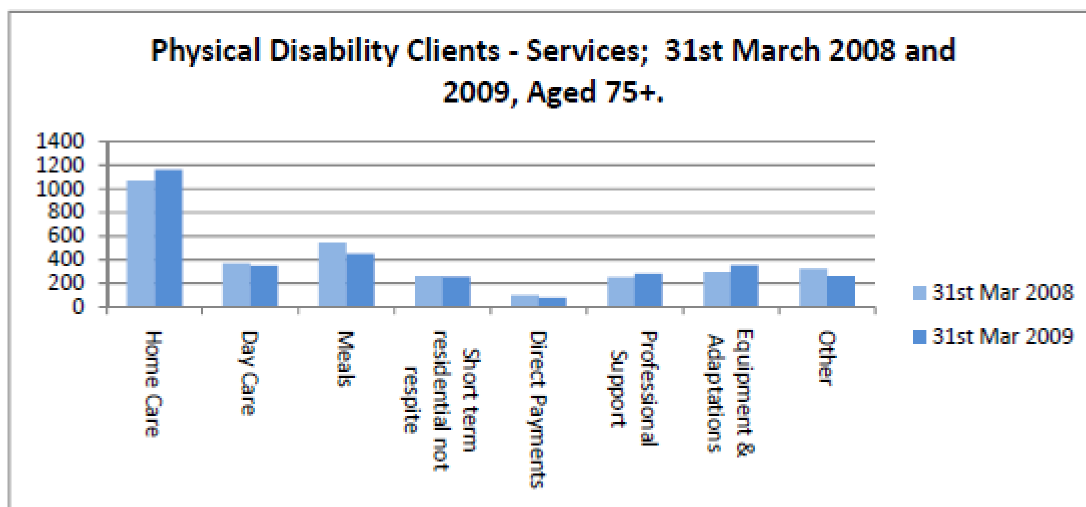


Figure 6.4.4: Physical Disability Clients – Services : 75+ (Ref 06902)

6.4.4 For both age cohorts the uptake of direct payments is disappointing given the high levels of home care, some improvement in the 65 to 74 cohort year on year. A sustained intervention to encourage uptake of personalised budgets is underway and significant improvement in these figures is to be expected.

Proportionately low levels of OT support 17.8% for the 75+ group when compared to 24% for the 65 to 74 group. Also for professional support 14.1% - 75+ as compared to 24.4% for the 65 to 74's

6.5 Pensioner Hearing Impairment

Hearing Impairment; by Reason Registered and by Age Group					
	0 to 17	18 to 64	65+	No Age	Sum:
Community Support Requested		2			2
Deaf Without Speech		2	1		3
Deaf With Speech		12	7		19
Enviro. Equip. Request	7	98	497	12	614
Hard of Hearing Without Speech		1			1
Hard of Hearing With Speech	3	68	496	11	578
Info.on Deaf/Blind Requested			2		2
No Case Information (Not on Register)	1	4	11		16
Other		23	56		79
SW Support Requested		2	1		3
No Reason Given		8	75	7	90
Sum:	11	220	1,146	30	1,407

Figure 6.5.1: Hearing Impairment by reason registered and age group (Ref 06802)

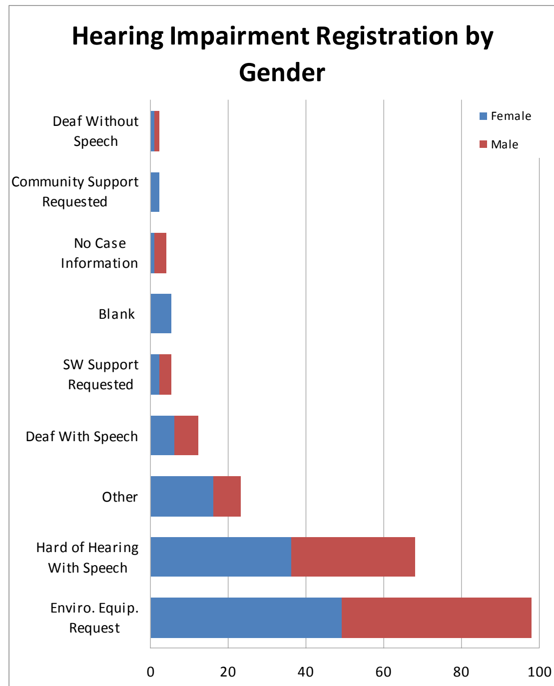


Figure 6.5.2: Hearing Impairment Registration by Gender (Ref 06802)

6.6 Visual Impairment 65+

Figure 6.6.1: Visual Impairment : Register status by Gender and age group (Ref 06807)

Visual Impairment: Register Status by Gender and Age Group

		Registered Blind	Registered Partially Sighted	Other Status	Total
Female	0 to 19	4	4	1	**9**
	20 to 39	17	5	1	**23**
	40 to 59	26	20	2	**48**
	60 to 79	40	56	7	**103**
	80+	142	176	32	**350**
	Age Missing			1	**1**
	Total	**229**	**261**	**44**	**534**
Male	0 to 19	2	12	3	**17**
	20 to 39	11	6	2	**19**
	40 to 59	30	32	6	**68**
	60 to 79	51	41	6	**98**
	80+	52	83	7	**142**
	Age Missing		1		**1**
	Total	**146**	**175**	**24**	**345**
Grand Total		**375**	**437**	**68**	**880**

Figure 6.6.2 : Visual Impairment : Register status by Gender and age group (Ref 06807)

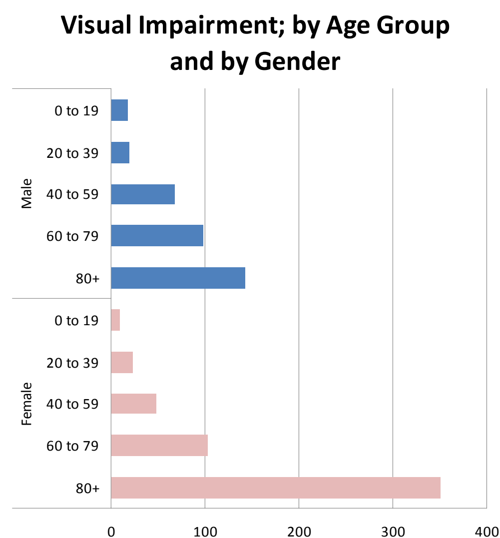


Figure 6.6.3 : Visual Impairment by age group and gender (Ref 06807)

6.6.4 Registration is a voluntary option and considerable numbers of clients opt not to be registered. People appear on the Visual Impairment register when they accept services that are funded by Social Services regardless of their registration status. Registration is for life and or until leaving the Island. The Visual Impairment register is maintained on Swift by the Blind Society/RNIB in the course of their work and for the above reasons is indicative rather than a complete count of the visually impaired.

Visual Impairment by Dysfunction by Age Group

	0 to 19	20 to 39	40 to 59	60 to 79	80+	Age Missing	Sum:
Albanism	1			1			**2**
Choroidal Sclerosis					2		**2**
Multiple Sclerosis			1	1			**2**
Keritities			1	2	1		**4**
Diabetic Maculopathy			1	3	2		**6**
Trauma	1	1	2	1	2		**7**
Detached Retina			3	3	2		**8**
Hereditary Retinal Dystrophy	1	1	4	5	2		**13**
Haemianopia		1	4	5	4		**14**
Cataracts			5	4	8		**17**
Nystagmus	7	5	5	4	2		**23**
Myopia	1	1	4	11	8		**25**
Diabetic Retinopathy		1	5	15	8		**29**
Optic Atrophy	1	5	12	12	7		**37**
Retinitis Pigmentosa		3	10	18	9		**40**
Glaucoma	2	3	5	14	34	1	**59**
Not Specified	12	17	47	55	64		**195**
Macular Degeneration		5	6	47	338	1	**397**
Sum:	**26**	**43**	**115**	**201**	**493**	**2**	**880**

Figure 6.6.4: Visual Impairment by dysfunction by age group (Ref 06807)

Visually Impaired; by Lives Alone by Registration Status

	Other	Registered Blind	Registered Partially Sighted	Total
Lives with others	85	329	456	870
Lives alone	26	43	37	106
Sum:	111	372	493	976

Figure 6.6.5: Visually impaired by lives alone by registration status (Ref 06807)

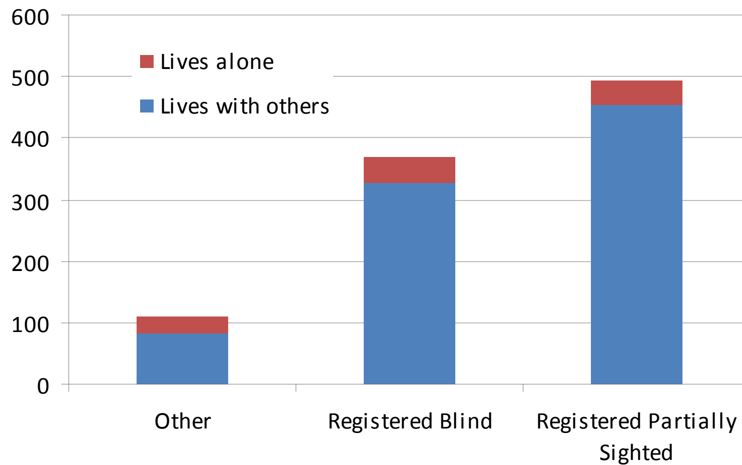


Figure 6.6.3 : Visually impaired/lives alone/lives with others (Ref 06807)

6.7 Mental Health 65+ : Dementia

6.7.1 According to the 'Dementia UK' report produced for the Alzheimer's Society:

"The term 'dementia' is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer's disease, the most common type of dementia. It is thought that many factors, including age, genetic background, medical history and lifestyle, can combine to lead to the onset of dementia. Dementia is a progressive condition whose symptoms become more severe over time. It can affect people of any age, but is most common in older people."

6.7.2 The Dementia UK report used a methodology known as the Expert Delphi Consensus to produce the best possible estimates of the prevalence of dementia, using currently available research data. Prevalence was then estimated for Local Authority areas by gender and age, and forecast forward to the year 2021. The data below shows these estimates for the Isle of Wight.

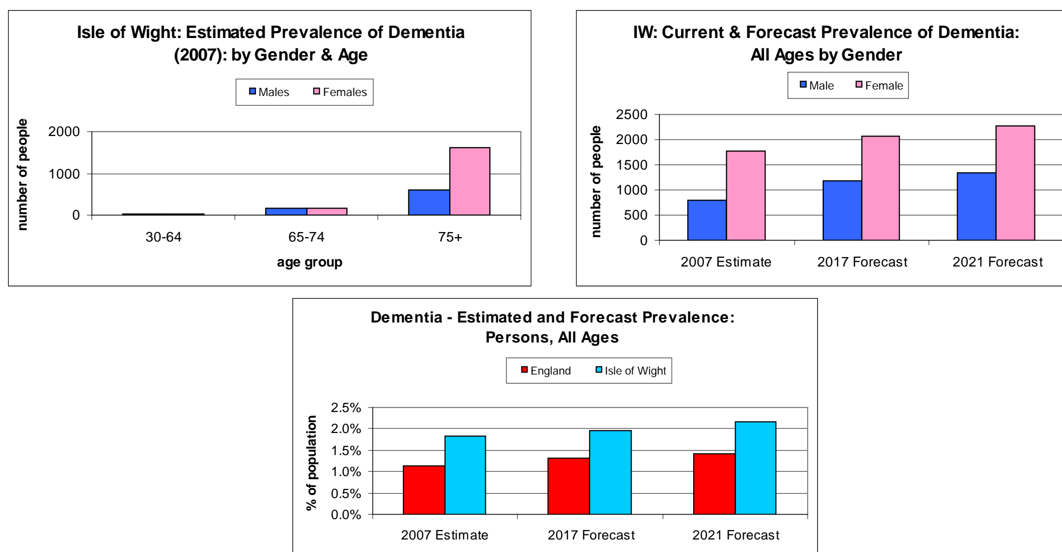


Figure 6.7.1: Estimated and Forecast Prevalence of Dementia (Ref 06002)

6.7.3 Figure 6.7.1 shows the estimated and forecast numbers of Isle of Wight residents with dementia.

- In 2007 there were an estimated 2,577 IW residents with dementia, predominantly aged 75+. Nearly 70% were women, but prevalence is only slightly higher among women and their higher numbers reflect the fact that there are more women in this older age group.
- By 2021 it is forecast that there will be 3,620 IW residents with dementia, an increase of 40% on the 2007 estimate.

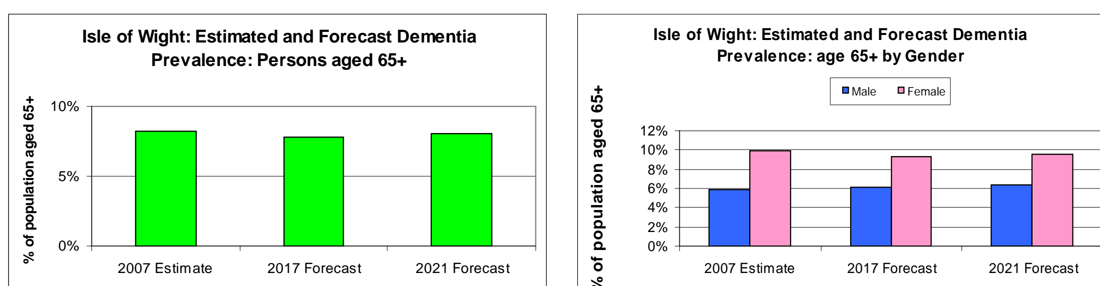


Figure 6.7.2 Estimated and Forecast Dementia Prevalence : Persons aged 56+ (Ref 06002)

6.7.4 Figure 6.7.2 above shows the estimated and forecast prevalence of dementia on the Isle of Wight, compared with England, and comparing the age groups All Ages and age 65+.

The IW prevalence of dementia in the All Ages group is higher than in England and is the 4th highest of all Local Authorities (2007 estimate). This is in line with the 'Dementia UK' report comment that prevalence is higher in rural and coastal local authorities and those with larger proportions of older inhabitants and a higher relative density of residential and nursing care settings.
It is estimated that approximately 8% of people aged 65+ have dementia.
The forecasts of prevalence up to 2021, for both the All Ages and the 65+ age groups, remain relatively stable. The additional numbers of people with dementia arise from the growing and ageing population.

6.7.5 The QOF is the Quality and Outcomes Framework, a voluntary annual reward and incentive programme for all GP surgeries in England which is part of GP contracts. QOF includes a number of 'disease registers', which count patients recorded by GP Practices as having specific conditions, of which dementia is one. Dementia Registers record patients who have dementia in order to offer ongoing care to them. In QOF terms, higher numbers and % of people recorded would be seen as a good thing, as this means that more people in the population with the condition are being identified and offered treatment.

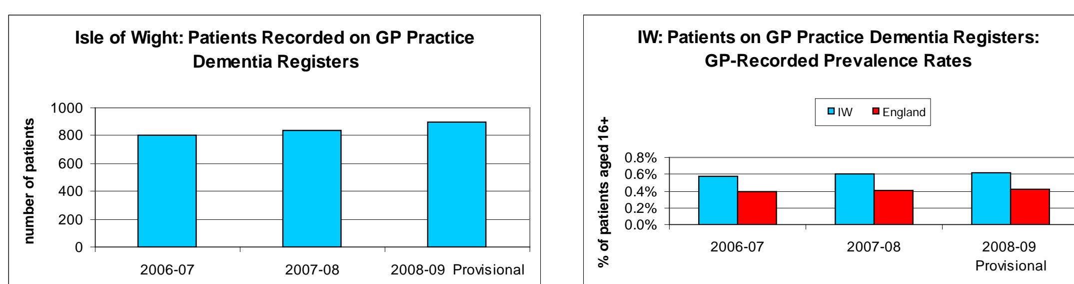


Figure 6.7.3 Isle of Wight Patients on GP Dementia Registers (Ref 06002)

6.7.6 Figure 6.7.3 (left) shows the number of people recorded on IW GP dementia registers over time, with an upward trend showing. Figure 6.7.3 (right) compares the % of the GP Practice population recorded on dementia registers in the IW and England. Recorded prevalence has remained stable in both England and the IW, but the IW's recorded prevalence has been consistently higher.

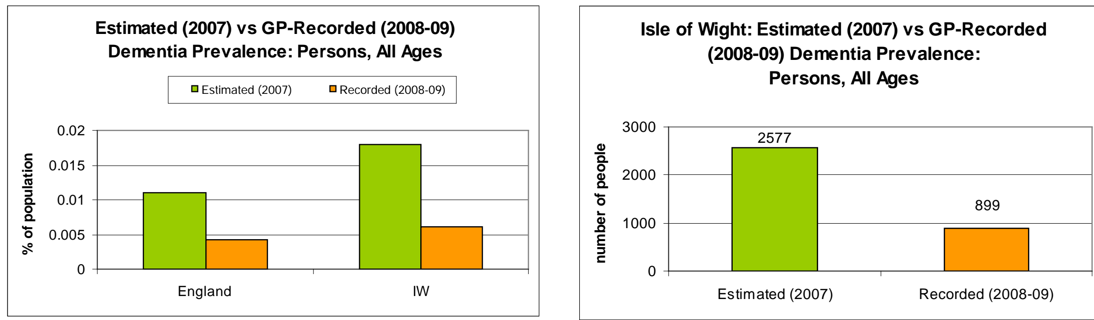


Figure 6.7.4 Estimated v GP recorded Dementia Prevalence (Ref 06002)

6.7.7 Figure 6.7.4 (left) compares the estimated vs recorded dementia prevalence for England and the IW. Although the IW has a higher % of recorded prevalence, it also has a higher % of estimated prevalence than England, and so the 'gap' is bigger. Figure 6.7.4 (right) compares the IW's estimated vs recorded dementia prevalence in terms of number of people. The gap represents an estimated 1,600 people with undiagnosed dementia.

People living with Dementia Known to Social Services				
		previous clients	current clients	Total
Female	under 50	4	1	5
	50 to 64	3	8	11
	65 to 69	3	14	17
	70 to 74	8	27	35
	75 to 79	26	41	67
	80 to 84	37	95	132
	85 plus	102	164	266
Female Total		183	350	533
Male	under 50	4	2	6
	50 to 64	2	11	13
	65 to 69	5	13	18
	70 to 74	11	20	31
	75 to 79	12	33	45
	80 to 84	11	56	67
	85 plus	36	58	94
Male Total		81	193	274
Grand Total		269	544	813

Figure 6.7.5: Dementia Clients known to Social Services.

6.7.8 Female clients represent fractionally more than 65% of all known clients. Clients, even those with a quite severe degree of dementia may cease to remain clients if their means are such as to allow them to pay for their own care.

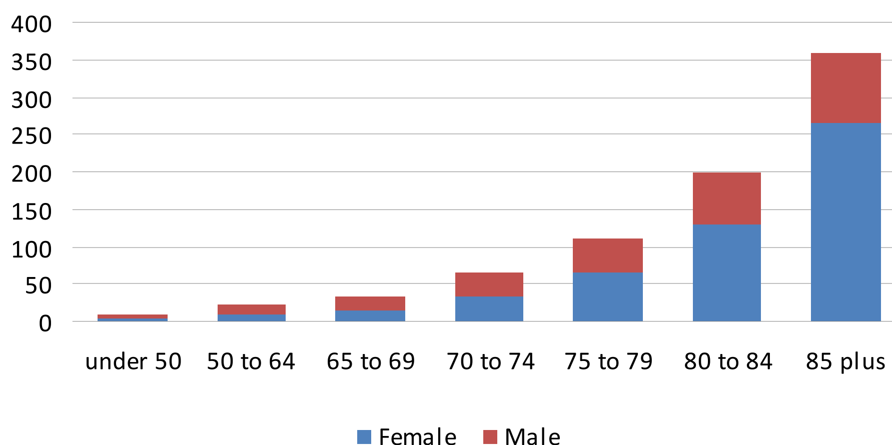


Figure 6.7.6: People living with dementia by age and gender (Ref 07301)

6.7.9 Clients were counted from Social Services data on the basis of their attributed main client category or from having had dementia specific services.

Known and Expected People living with dementia: 2009

		Known	Predicted	Variance
Female	65 to 69	17	38	55.3%
	70 to 74	35	81.6	57.1%
	75 to 79	67	195	65.6%
	80 to 84	132	282.6	53.3%
	85 plus	266	321.3	17.2%
Female Total		533	918.5	42.0%
Male	65 to 69	18	53.8	66.5%
	70 to 74	31	83.7	63.0%
	75 to 79	45	96.9	53.6%
	80 to 84	67	116.6	42.5%
	85 plus	94	90.1	-4.3%
Male Total		274	441.1	37.9%
Grand Total		813	1359.5	40.2%

Figure 6.7.7: Known and expected People living with dementia : 2009 (Ref 07301)

6.7.10 (Figure 6.7.7) : Predicted figures are taken and applied as prevalence rates by age group. Swift data is influenced by eligibility criteria and may be expected to reflect severity of condition over the course of the illness. The result is a broad convergence between the predicted and known figures as the population ages. This supports applying the predictions pro-rata to the current known figures.

Dementia Services by Type of Care; Projection to 2014						
			Community Care		Residential Care	
		% Change 2009 to 2014	2009	2014	2009	2014
Female	65 to 69	17.9%	11	13	3	4
	70 to 74	5.9%	20	21	7	7
	75 to 79	-3.3%	25	24	16	15
	80 to 84	8.8%	52	57	45	49
	85 plus	8.8%	75	82	98	107
Female Total		6.4%	183	195	169	180
Male	65 to 69	19.0%	11	13	3	4
	70 to 74	22.2%	13	16	8	10
	75 to 79	15.8%	24	28	10	12
	80 to 84	18.7%	37	44	21	25
	85 plus	18.6%	38	45	22	26
Male Total		18.7%	123	146	64	76
Grand Total		10.4%	306	338	233	257
Weekly rate per person £'s		11.7%	£107	£120	£418	£467
Cost Projection £,000's			£1,708	£2,108	£5,067	£6,252

Figure 6.7.8 : Dementia Services by type of care : Projection to 2014 (Ref 07301)

6.7.11 The figures in 6.3.1.41 as projections/prevalence rate calculations are indicative. Cost projections using PSSEX1 2008 unit costs for residential and nursing care (2.4 adjusted) £409 and for Home Care (2.26) £105; prices uplifted by 2.25% p.a. (11.7% 2009-2014) to reflect inflationary pressure.

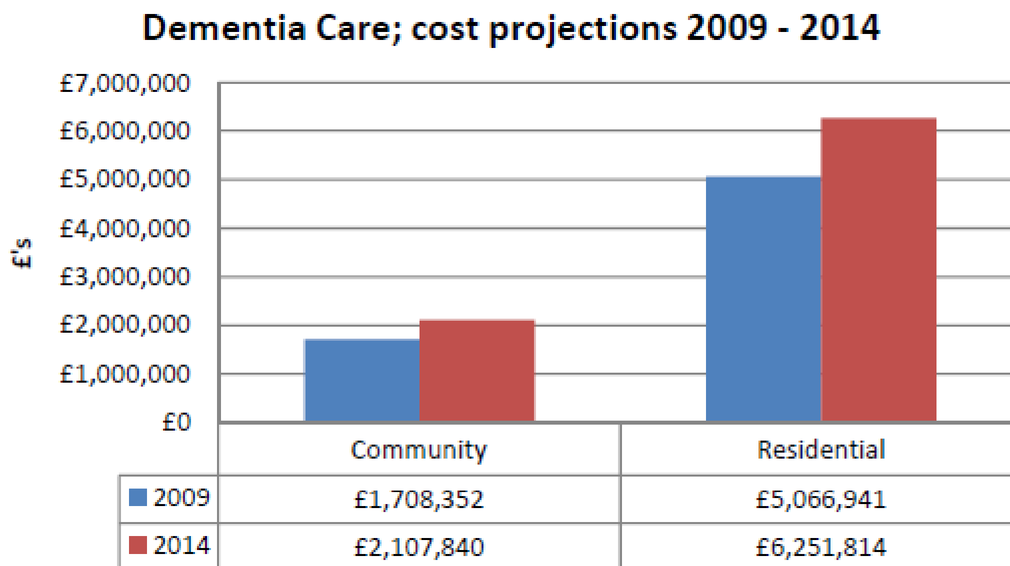


Figure 6.7.9: Dementia care: cost projections 2009 – 2014 (Ref 07301)

Predicted Dementia 2007 to 2014, by Gender and Age Cohort (65+)										
		2007	2008	2009	2010	2011	2012	2013	2014	% Change 2009 to 2014
Males	65-69	49.5	50.9	53.8	56.7	56.7	58.2	61.1	64	19.0%
	70-74	83.7	83.7	83.7	86.8	86.8	89.9	96.1	102.3	22.2%
	75-79	96.9	96.9	96.9	102	102	107.1	107.1	112.2	15.8%
	80-84	109.3	109.3	116.6	123.9	123.9	131.1	131.1	138.4	18.7%
	85 and over	84.4	84.4	90.1	95.7	95.7	101.3	101.3	106.9	18.6%
	Male Total	423.8	425.2	441.1	465.1	465.1	487.6	496.7	523.8	18.7%
Females	65-69	36	37	38	38.9	38.9	40.9	42.8	44.8	17.9%
	70-74	84	84	81.6	81.6	81.6	81.6	84	86.4	5.9%
	75-79	195	195	195	188.5	188.5	188.5	188.5	188.5	-3.3%
	80-84	274.3	282.6	282.6	290.9	299.3	299.3	299.3	307.6	8.8%
	85 and over	311.9	321.3	321.3	330.8	340.2	340.2	340.2	349.7	8.8%
	Female Total	901.2	919.9	918.5	930.7	948.5	950.5	954.8	977	6.4%
Total population		1325	1345.1	1359.5	1395.8	1413.6	1438.1	1451.5	1500.8	10.4%

Figure 6.7.10: Predicted Dementia 2007 to 2014 by gender and age cohort (65+) (Ref 07301)

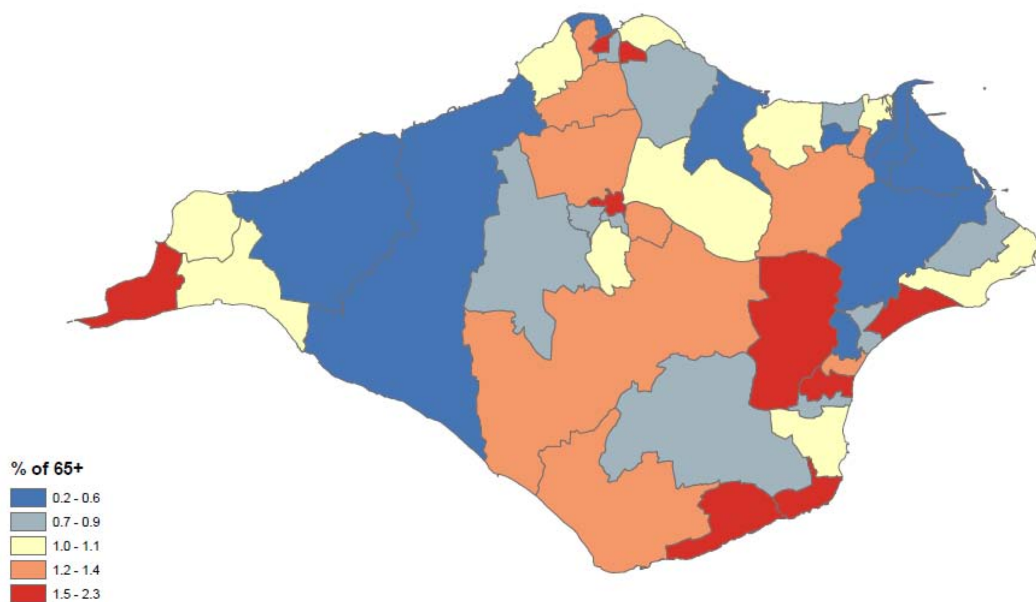


Figure 6.7.11: Community Care Dementia clients as %age of 65+ population (Ref 07303)

6.7.12 The clients in figure 6.7.11 are identified as having Dementia and as having their care delivered in the community. Clients known to be supported in residential care by IWC are excluded from this count. The population count is taken from the 2001 census.

6.8 General Mental Health 65+

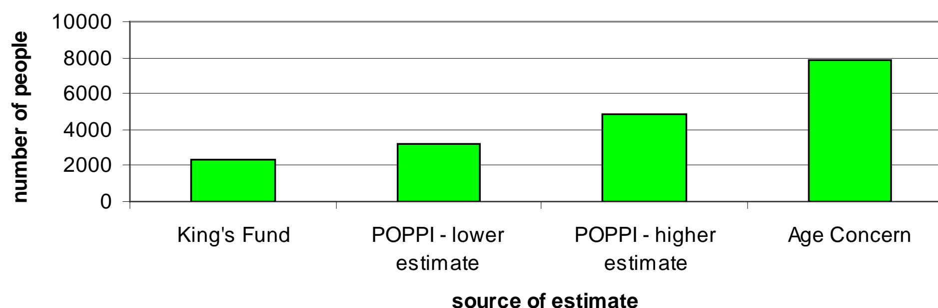


Figure 6.8.1 Isle of Wight : Mental Health problems among Older People : Estimated number of Persons aged 65+ with Depression and/or Anxiety (Ref 06202)

6.8.1 While national surveys have measured the prevalence of mental health problems in the population aged 5 - 74 there is no equivalent survey data on mental health problems among people aged 75+. Though there are estimates derived from a range of small studies, findings will vary depending on the definitions of mental health problems used, the methods used to identify people with mental health problems and the population studied. There is therefore no definitive estimate of the prevalence of mental health problems among older people.

6.8.2 In order to estimate the number of older people with mental health problems on the Isle of Wight, the prevalence estimates used in a number of national reports and data sources have been extrapolated to the IW population (2007 Estimate) to produce a range of estimates (Figure 3.28.1). For this purpose older people were defined as those aged 65+. The estimates are for the prevalence of depression and / or anxiety and do not include conditions such as dementia, for which see separate datasets.

6.8.3 The reports and data sources used are as follows:

- King's Fund (2008) 'Paying the Price: the Cost of Mental Health Care in England to 2026': draws on GP data about diagnosed depression and anxiety, adjusted to take account of survey data for people aged 16 - 74.
- Projecting Older People Population Information System (POPPI): uses an estimate of depression in older people taken from a specific study.
- Age Concern (2007) 'Improving Services and Support for Older People with Mental Health Problems': draws on a literature review which draws together various studies into the prevalence of mental health problems in the older population.

6.8.4 The lowest estimate, from the King's Fund, is based to a significant extent on GP-diagnosed depression and anxiety, which would not include people who had not attended their GP or been diagnosed with these conditions. The highest estimate, from the Age Concern report, sets out to estimate the true prevalence of depression and anxiety in the population, and would include people whose condition is undiagnosed and potentially unknown to service providers.

Mental Health; 65+ Cohort: 2007 to 2009				
	Community-based services in own home	Residential care	Nursing care	Total of clients
2007/08	390	176	44	563
2008/09	558	184	26	712

Figure 6.8.2: Clients with Mental Health problems open to Social Services – includes dementia (Ref 07304)

6.8.5 There is a considerable gap between the most conservative of the estimates (Kings fund 2,000) in figure 6.8.1 and the current Social Service Clients count for the 65 plus of 712. This is an identified information gap which will require more work to resolve.

Mental Health Clients - Services; 31st March 2008 and 2009.						
	18 to 64		65 to 74		75 plus	
	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009
Home Care	18	16	29	29	94	108
Day Care	46	51	28	26	58	75
Meals	2	2	13	9	33	32
Short term residential not respite	4	3	6	4	26	24
Direct Payments	5	5	3	5	6	7
Professional Support	219	374	57	107	42	97
Equipment & Adaptations	8	11	8	13	16	28
Other	10	11	10	4	24	25
Total of Clients	297	456	115	168	181	258

Figures taken from the RAP P2s annual return, and were current as of the 31st March in the respective years. As clients may have multiple services the total clients line counts clients, not services delivered.

Figure 6.8.3: Clients with Mental Health problems open to Social Services for care in the community (Ref 07304)

6.9 Learning Disability 65+

Learning Disability; 65+ Cohort: 2007 to 2009				
	Community based services in own home	Residential Care	Nursing Care	Total of Clients
2007/08	34	28	1	52
2008/09	32	27	2	48

Figure 6.9.1 : Learning Disability – 65+ cohort, 2007 to 2009 (Ref 07001)

6.9.1 Figure 6.9.1 Figures taken from the RAP p1 return which counts the entire number of clients provided with services during the relevant year. Significant growth in the number of these clients over recent decades as improved medical care for their conditions have improved their survival.

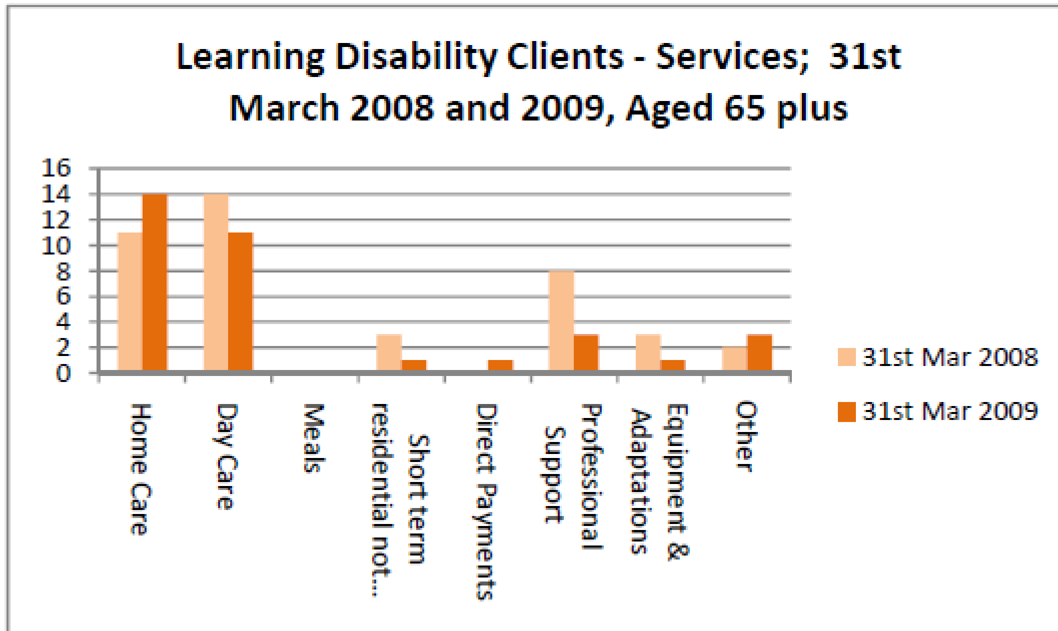


Figure 6.9.2 : Learning Disability Clients – Services : aged 65 (Ref 07101)

6.10 Vulnerable People 65+

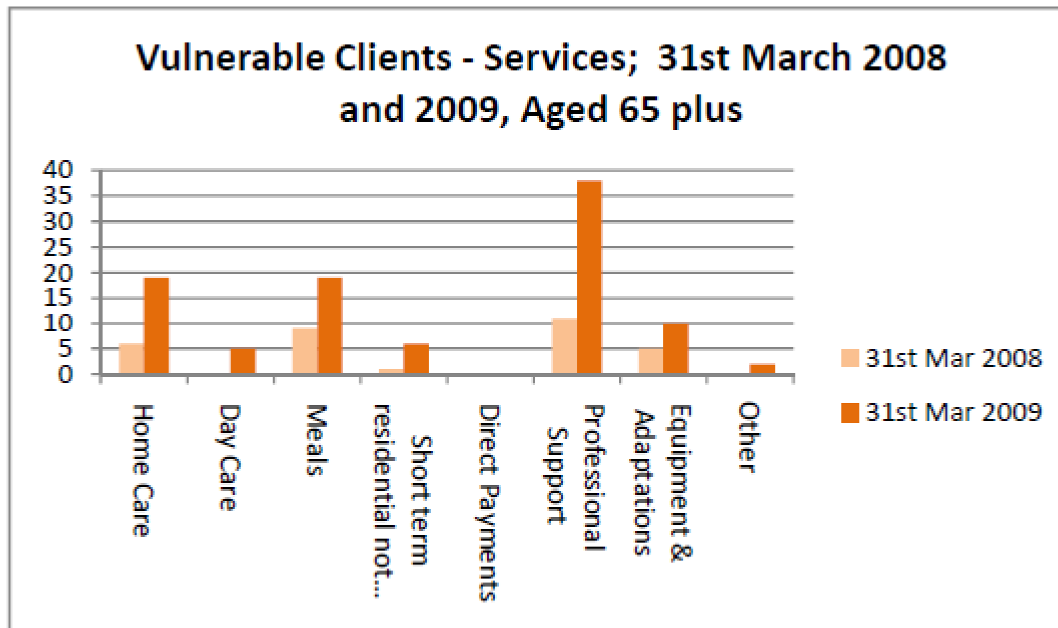


Figure 6.10.1: Vulnerable Clients : Services : Age 65+ (Ref 07701)

6.11 Voluntary Sector Provision

6.11.1 Age Concern provide a range of services on the Island in terms of advice and support, and reach people whom may otherwise be reluctant to use public sector services.

Age Concern Clients; September 2009 by LSOA

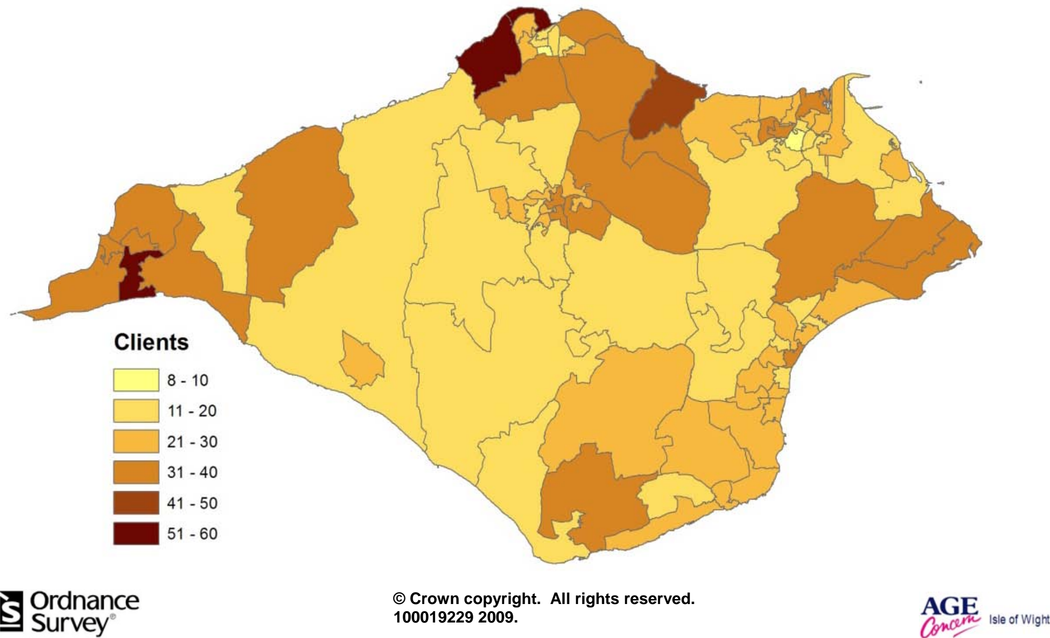


Figure 6.11.1: Age Concern client distribution

6.11.2 The take up of some services appears lower this year because some services have been at capacity and they have had to close waiting lists to new clients until lists are cleared. This may be due to availability of adequate project co-ordinator time (most of their service co-ordinators are part-time) or ability to attract volunteers for certain roles. This could be improved with further resources

Age Concern Service Take-up by Month

	2008										2009									Total
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Other				9	9		2	5	4	3	9	3	6	4	4	2	2		3	65
Home Safe					5	2		1	3	1	13	6		1	2	16	13	15	4	82
Shopping					11	5	72	8	5	14	9	15	12	5	9	10	3	6	1	185
Active Networks Support		2	1	8	2	2	84	31			44	21	8	4	1	5	6	5	5	229
Befriending				1	10	16	105	11	17	18	22	15	15	5	8	15	17	8	4	287
Advocacy			1	1	52	30	38	11	34	5	39	17	15	22	16	10	22	10	3	326
Information and Advice		1	3	5	181	62	53	65	77	78	116	89	100	79	51	35	34	19	17	1065
Welfare Benefits	1		1	3	220	48	62	71	68	48	95	87	87	52	46	61	16	66	47	1079
Grand Total	1	3	6	27	490	165	416	203	208	167	347	253	243	172	137	154	113	129	84	3318

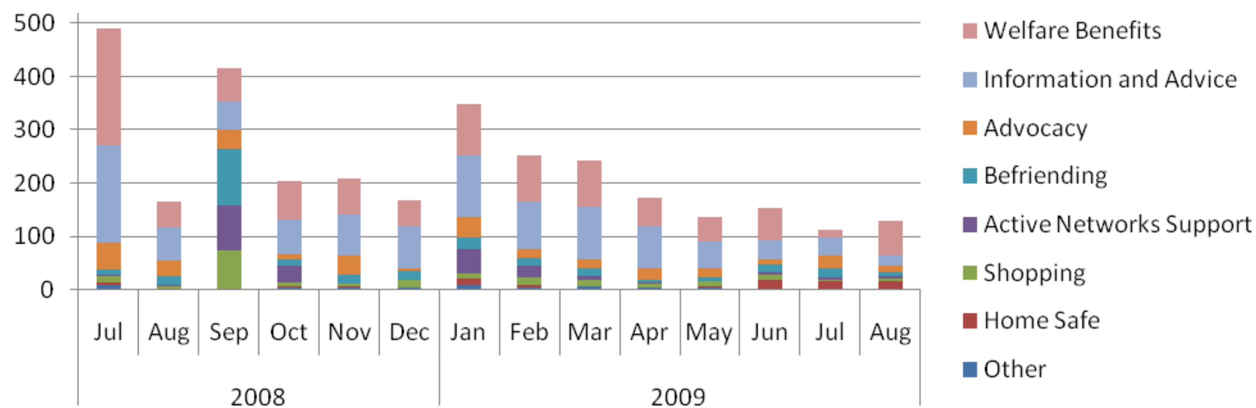


Figure 6.11.2: Age Concern Activities by month delivered

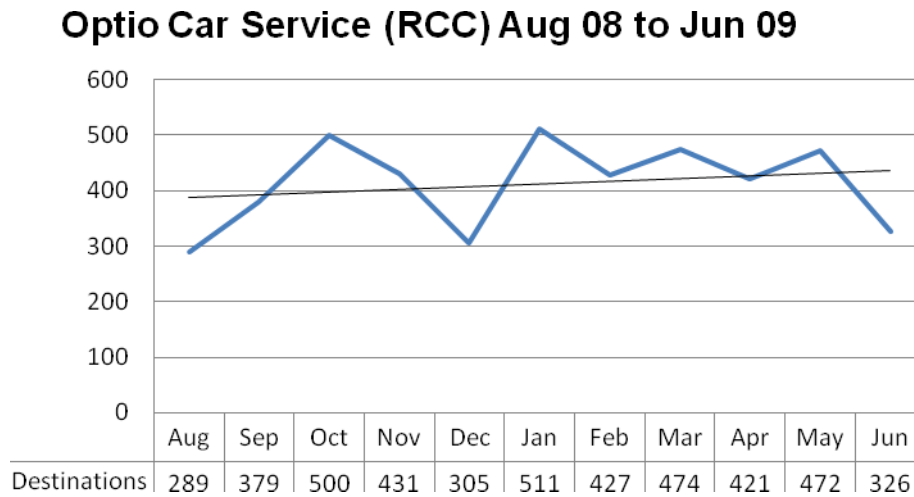
6.11.3 The data base is relatively new and some data quality issues are currently being resolved, Age Concern is confident that the general trends represented here are accurate. Further work using this data to profile these clients has been identified as an information gap for attention during 2010.

6.11.4 Rural Community Council – Optio Car Service

Optio Car Trips Aug 2008 to Jun 2009 by Destination												
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Clinics	16	19	10	14	6	6	10	23	10	16	8	138
Day Care	32	61	83	41	38	66	24	45	62	22	12	486
Dentist	3	8	23	13	4	9	8	10	18	10	10	116
Ferry-Mainland	2	2	3	3	4	8	12	3	1	5	1	44
GP's	44	58	96	74	65	110	89	97	60	75	55	823
Memory Clinic	25	34	52	49	27	50	46	51	48	72	39	493
Other non-specific	42	29	5	7	3	2		3	2	2	2	97
Residential Home	32	24	20	10	12	36	21	26	20	44	29	274
Shops etc.,	25	53	52	73	58	87	90	95	96	103	65	797
St Mary's Hospital	68	91	156	147	88	137	127	121	104	123	105	1,267
Grand Total	289	379	500	431	305	511	427	474	421	472	326	4,535

Figure 6.11.3: Optio Car Service by month and destination

6.11.5 The above data set demonstrates a clear requirement for this service in terms of getting people to medical and social care facilities 3,641 round trips over the period, or over 80.3% of the recorded activity.



Note the data for December reflects the two week holiday period

Figure 6.11.4: Optio Car Service by month and trend.

6.11.6 A steadily increasing upwards trend suggests that there is a continuing need for a door to door transport service especially to meet the needs of the more vulnerable in rural areas.

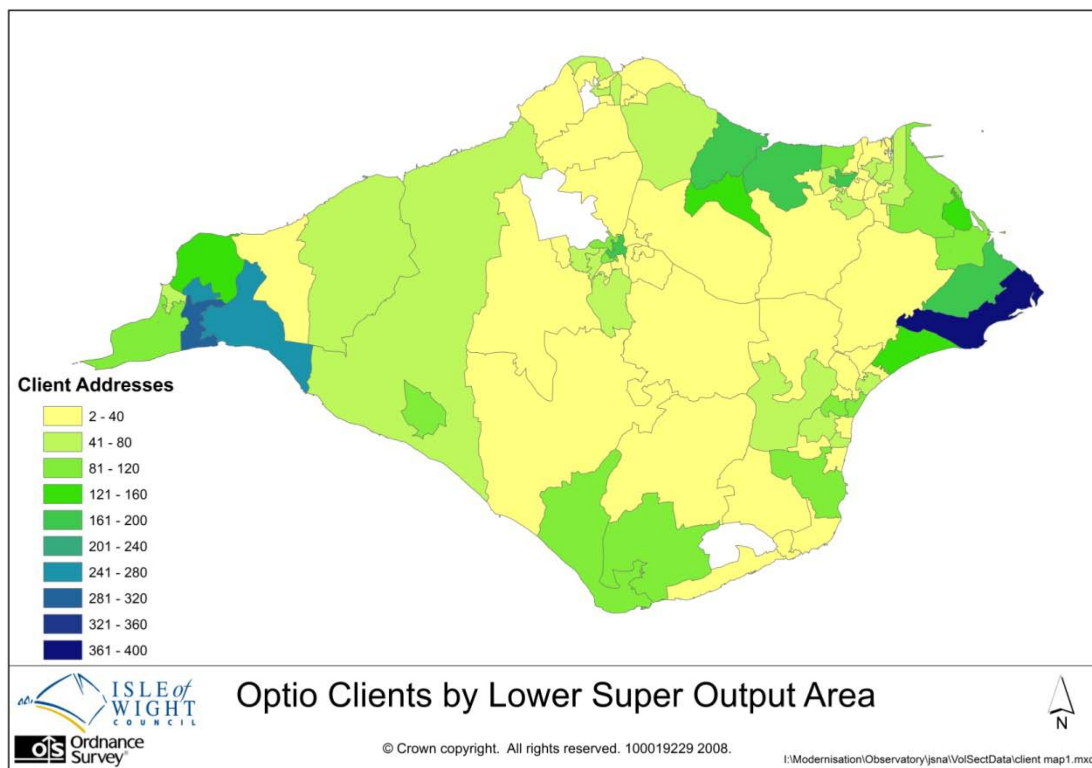


Figure 6.11.5: Distribution of Optio clients byy LSOA

6.11.7 The breakdown of data from the Optio scheme indicates the importance of voluntary sector transport provision in helping older people to access essential services. There is a clear concentration of need in rural areas of the Island. It should be noted concentration of uptake is also likely to be affected by some degree by driver availability."

6.11.8 Isle of Wight Society for the Blind - 2008/09 Activity

6.11.9 New referrals – 522 - this includes:

- CVI registrations arising from referrals received from St Mary's Hospital
- Support and advice
- Braille and communications
- Benefits and grant advice
- Equipment & aids
- Training and mobility support
- Independent living skills
- Low vision aids

6.11.10 Home visits – 1,021

6.11.11 Social activities – 4,104; - this includes:

- Handicrafts
- Swimming
- A number of condition-specific self-support groups
- Strollers & Striders
- Holidays

6.11.12 Other services:

- Weekly talking newspaper distributed to 250 people
- Library service of Braille, large print and audio books provides an average of 60 – 70 items per week

6.11.13 Also please see the following link

7 Adult and Community Services 18 to 64

7.1 Working Age Population

7.1.1 A working-age population (15 – 59/64) of 76,800 represents 54.8% of the Island's total population. This compares with 60.1% across the South East region. More than 1 in 5 of the Island's population is aged over 65.

Age Band	0 - 14	15 - 64	65+
Isle of Wight	15.9%	61.8%	22.1%
South East	18.0%	65.4%	16.6%
England and Wales	18.0%	66.0%	16.1%

7.1.2 Population growth over the past 10 years was mainly seen in the working-age population. Between 1995 – 2005 the school-age population grew by 3%, the working-age population by 16% and the retirement age population by 6%. This can be related to strong growth in employment. As a result, the working-age population increased in proportion at the expense of the populations of school and retirement age. .

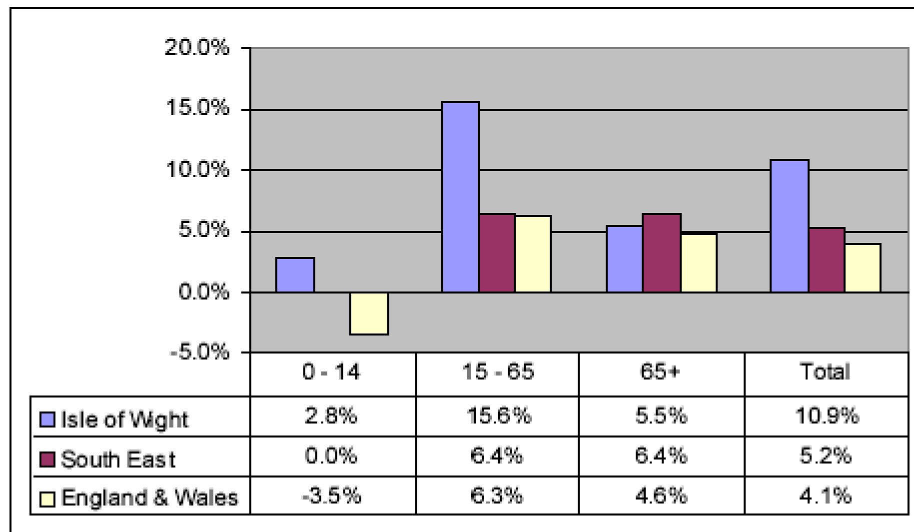


Figure 7.1.1 : Changes in population composition on the IW (Ref A)

7.1.3 Subsequently – between 2002 and 2007 (figure 7.1.2) the proportional growth in working age population reached a plateau and declined slightly in 2007 whilst growing in absolute terms by 2,900. Proportionately the child cohort is declining both absolutely and proportionally – by 600, -1.2% – respectively. Whilst the pensioner population maintains its upward growth increasing over the five years covered in the table by 1.3% as a proportion of the total population or 3,200 people.

Population by Age Bands 2002 to 2007 as a percentage of Total Population							
	All ages	Children 0-15		Working Age16-64M/59F		Pensioners 65M/60F and over	
	n/1000	n/1000	%	n/1000	%	n/1000	%
2002	134.1	24.1	18.0%	75.9	56.6%	34.0	25.4%
2003	135.1	24.0	17.8%	76.6	56.7%	34.5	25.5%
2004	136.5	24.1	17.7%	77.4	56.7%	35.1	25.7%
2005	137.9	23.9	17.3%	78.2	56.7%	35.8	26.0%
2006	138.5	23.8	17.2%	78.5	56.7%	36.2	26.1%
2007	139.5	23.5	16.8%	78.8	56.5%	37.2	26.7%

Figure 7.1.2: Population cohort change (ONS mid year estimates)

Benefit Claimants - Working Age Clients, by Wards: August 2008	total claimants		job seekers		incapacity benefits		lone parents		carers		Other benefits		disabled		bereaved		age - 18 to 24		out-of-work benefits	
	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %	Count	Rate %
Ashey	230	12.90	35	2.00	110	6.20	25	1.40	25	1.40	5	0.30	20	1.10	10	0.60	35	2.00	175	9.80
Bembridge North	55	6.70	5	0.60	20	2.40	5	0.60	5	0.60	5	0.60	10	1.20	5	0.60	5	0.60	35	4.30
Bembridge South	105	10.40	15	1.50	50	5.00	10	1.00	10	1.00	5	0.50	10	1.00	5	0.50	10	1.00	80	7.90
Binstead	145	8.10	15	0.80	70	3.90	10	0.60	20	1.10	5	0.30	20	1.10	5	0.30	15	0.80	100	5.60
Brading and St Helens	240	12.70	40	2.10	110	5.80	35	1.80	15	0.80	10	0.50	20	1.10	10	0.50	30	1.60	195	10.30
Brighstone and Calbourne	145	10.40	10	0.70	85	6.10	10	0.70	15	1.10	5	0.40	15	1.10	5	0.40	5	0.40	110	7.90
Carisbrooke East	205	10.40	25	1.30	105	5.40	25	1.30	20	1.00	5	0.30	20	1.00	5	0.30	40	2.00	160	8.20
Carisbrooke West	225	12.60	20	1.10	110	6.20	40	2.20	25	1.40	10	0.60	15	0.80	5	0.30	40	2.20	180	10.10
Central Rural	155	9.70	15	0.90	85	5.30	10	0.60	20	1.20	5	0.30	15	0.90	5	0.30	10	0.60	115	7.20
Chale, Niton and Whitwell	215	14.30	30	2.00	125	8.30	15	1.00	25	1.70	5	0.30	10	0.70	5	0.30	25	1.70	175	11.60
Cowes Castle East	120	9.50	25	2.00	65	5.10	10	0.80	5	0.40	5	0.40	10	0.80	0	-	15	1.20	105	8.30
Cowes Castle West	100	7.10	10	0.70	50	3.50	10	0.70	20	1.40	0	-	5	0.40	5	0.40	15	1.10	70	5.00
Cowes Central	200	10.90	20	1.10	110	6.00	25	1.40	15	0.80	10	0.50	20	1.10	0	-	20	1.10	165	9.00
Cowes Medina	235	13.90	40	2.40	115	6.80	30	1.80	20	1.20	10	0.60	20	1.20	0	-	45	2.70	195	11.60
East Cowes North	140	12.90	10	0.90	80	7.40	20	1.80	10	0.90	5	0.50	10	0.90	5	0.50	15	1.40	115	10.60
East Cowes South	285	13.90	30	1.50	140	6.80	45	2.20	25	1.20	15	0.70	20	1.00	10	0.50	35	1.70	230	11.20
Fairlee	245	14.40	45	2.70	125	7.40	20	1.20	20	1.20	15	0.90	15	0.90	5	0.30	55	3.20	205	12.10
Freshwater Afton	185	12.40	15	1.00	110	7.40	15	1.00	20	1.30	5	0.30	15	1.00	5	0.30	10	0.70	145	9.70
Freshwater Norton	230	17.50	15	1.10	120	9.10	35	2.70	25	1.90	10	0.80	20	1.50	5	0.40	25	1.90	180	13.70
Gurnard	95	9.90	5	0.50	50	5.20	5	0.50	10	1.00	5	0.50	15	1.60	5	0.50	10	1.00	65	6.70
Lake North	300	18.20	40	2.40	150	9.10	35	2.10	35	2.10	10	0.60	20	1.20	10	0.60	45	2.70	235	14.30
Lake South	155	14.70	10	0.90	85	8.10	10	0.90	25	2.40	5	0.50	20	1.90	0	-	15	1.40	110	10.40
Mount Joy	295	18.50	30	1.90	160	10.00	35	2.20	25	1.60	10	0.60	35	2.20	0	-	45	2.80	235	14.70
Newchurch	165	11.20	10	0.70	85	5.80	20	1.40	20	1.40	5	0.30	15	1.00	10	0.70	10	0.70	120	8.10
Newport North	335	21.20	35	2.20	175	11.10	60	3.80	25	1.60	10	0.60	25	1.60	5	0.30	60	3.80	280	17.70
Newport South	335	19.30	50	2.90	170	9.80	60	3.50	25	1.40	5	0.30	20	1.20	5	0.30	70	4.00	285	16.40
Northwood	140	11.60	10	0.80	75	6.20	15	1.20	15	1.20	5	0.40	20	1.70	0	-	20	1.70	105	8.70
Osborne	260	22.00	30	2.50	135	11.40	35	3.00	30	2.50	10	0.80	15	1.30	5	0.40	35	3.00	210	17.70
Pan	360	22.50	30	1.90	200	12.50	55	3.40	30	1.90	10	0.60	30	1.90	5	0.30	65	4.10	295	18.40
Parkhurst	235	7.00	20	0.60	125	3.70	25	0.70	25	0.70	5	0.10	25	0.70	10	0.30	40	1.20	175	5.20
Ryde North East	480	23.30	105	5.10	235	11.40	60	2.90	25	1.20	30	1.50	20	1.00	5	0.20	90	4.40	430	20.80
Ryde North West	325	18.20	50	2.80	195	10.90	35	2.00	5	0.30	15	0.80	15	0.80	10	0.60	40	2.20	295	16.60
Ryde South East	395	19.30	65	3.20	185	9.00	70	3.40	25	1.20	15	0.70	35	1.70	0	-	75	3.70	335	16.40
Ryde South West	325	18.80	35	2.00	160	9.30	60	3.50	25	1.40	5	0.30	30	1.70	10	0.60	50	2.90	260	15.10
Sandown North	325	18.10	45	2.50	170	9.50	45	2.50	15	0.80	15	0.80	25	1.40	10	0.60	45	2.50	275	15.30
Sandown South	475	21.10	65	2.90	225	10.00	75	3.30	40	1.80	30	1.30	35	1.60	5	0.20	70	3.10	395	17.60
Seaview and Nettlestone	115	7.80	15	1.00	60	4.10	5	0.30	15	1.00	5	0.30	10	0.70	5	0.30	5	0.30	85	5.70
Shalfleet and Yarmouth	150	11.30	10	0.80	85	6.40	10	0.80	20	1.50	10	0.80	10	0.80	5	0.40	5	0.40	115	8.70
Shanklin Central	320	18.20	55	3.10	165	9.40	45	2.60	15	0.90	10	0.60	25	1.40	5	0.30	50	2.90	275	15.70
Shanklin North	300	19.50	40	2.60	160	10.40	35	2.30	25	1.60	15	1.00	20	1.30	5	0.30	40	2.60	250	16.20
Shanklin South	330	18.10	40	2.20	195	10.70	35	1.90	15	0.80	20	1.10	20	1.10	5	0.30	40	2.20	290	15.90
St Johns East	280	18.80	45	3.00	145	9.70	40	2.70	20	1.30	10	0.70	15	1.00	5	0.30	40	2.70	240	16.10
St Johns West	445	24.50	70	3.90	210	11.60	95	5.20	30	1.70	15	0.80	20	1.10	5	0.30	80	4.40	390	21.50
Totland	215	13.80	15	1.00	115	7.40	25	1.60	20	1.30	15	1.00	20	1.30	5	0.30	20	1.30	170	10.90
Ventnor East	385	21.50	45	2.50	225	12.60	45	2.50	20	1.10	20	1.10	30	1.70	0	-	45	2.50	335	18.70
Ventnor West	290	17.80	25	1.50	145	8.90	40	2.50	35	2.10	10	0.60	25	1.50	10	0.60	35	2.10	220	13.50
Wootton	230	12.20	30	1.60	120	6.40	25	1.30	20	1.10	5	0.30	25	1.30	5	0.30	25	1.30	180	9.50
Wroxall and Godshill	250	13.20	35	1.80	125	6.60	30	1.60	25	1.30	10	0.50	20	1.10	5	0.30	30	1.60	200	10.60
Column Total	11,770	16.0	1,480	1.8	6,115	7.8	1,625	1.8	1,000	1.3	470	0.6	830	1.2	260	0.3	1,850	2.1	8,680	12.2

	total claimants	job seekers	incapacity benefits	lone parents	carers	Other benefits	disabled	bereaved	age - 18 to 24	out-of-work benefits
1st Quintile	10.4	0.9	5.6	0.8	0.9	0.3	0.9	0.2	1.0	8.1
2nd Quintile	12.9	1.5	6.6	1.4	1.2	0.5	1.1	0.3	1.6	10.3
3rd Quintile	17.6	2.0	8.9	2.1	1.3	0.6	1.2	0.3	2.2	13.5
4th Quintile	19.1	2.6	10.0	2.7	1.6	0.8	1.6	0.5	2.9	16.3
5th Quintile	24.5	5.1	12.6	5.2	2.5	1.5	2.2	0.7	4.4	21.5

Figure 7.1.3 : Benefit claimants – Working age clients by Ward (Ref 01002)

7.2 Physical Disability 18-64

7.2.1 We have greater aspirations around younger clients with a disability. In line with the transformation agenda we are seeking to offer individuals and their carers Personal Budgets to purchase the care and support they require to lead fully inclusive lives within the community. We are working with third sector providers to develop opportunities across the island. In addition working with housing, culture and leisure, and health to improve the health and wellbeing of people with disabilities on the island and ensure they are enabled to access generic services.

7.2.2 We ensure that Service User Surveys are used regularly and there are specific areas within the contract auditing processes that ensure service user views are heard and acted upon.

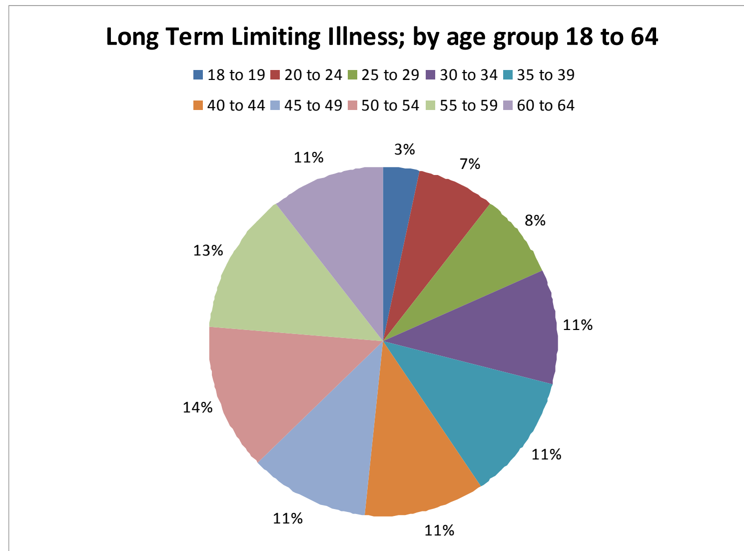


Figure 7.2.1: Long term limiting Illness by age group 18 to 46 (Ref 06803)

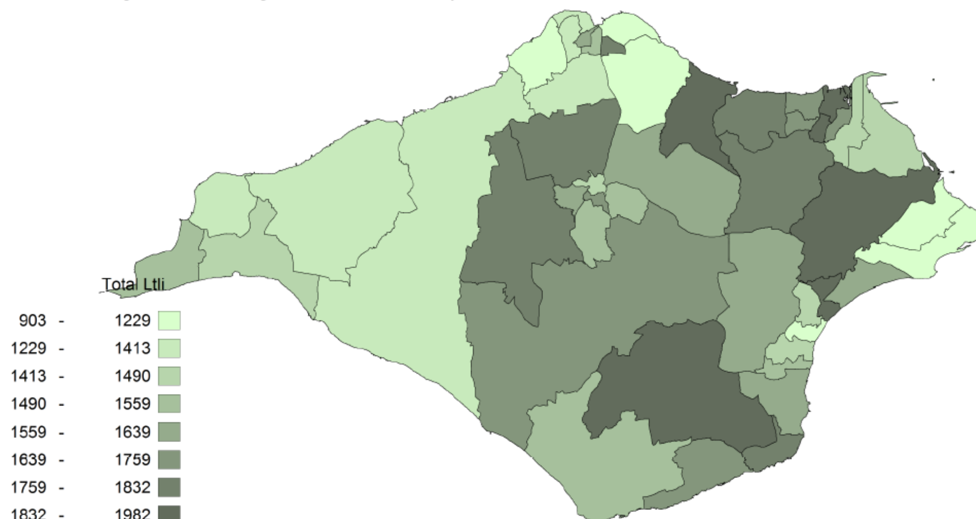


Figure 7.2.2: Long term limiting illness, 18 to 64, by ward (Ref 06804)

7.2.3 Long term limiting illness is measured by a census question, and does not constitute a medical opinion; being the respondents own subjective assessment of their condition.

People aged 18-64 predicted to have a moderate or serious physical disability, projected to 2025					
	2008	2010	2015	2020	2025
Total population aged 18-64 predicted to have a moderate physical disability	6,988	7,050	7,144	7,475	7,708
Total population aged 18-64 predicted to have a serious physical disability	2,192	2,202	2,205	2,335	2,442
Total population aged 18-64 predicted to have a moderate or serious physical disability	9,180	9,252	9,349	9,810	10,150

Figure 7.2.3: People predicted to have a moderate or serious physical injury (Ref 06801)

7.2.4 This table is based on the prevalence data for moderate and serious disability by age and sex included in the Health Survey for England, 2001. The prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have a moderate or serious physical disability to 2025.

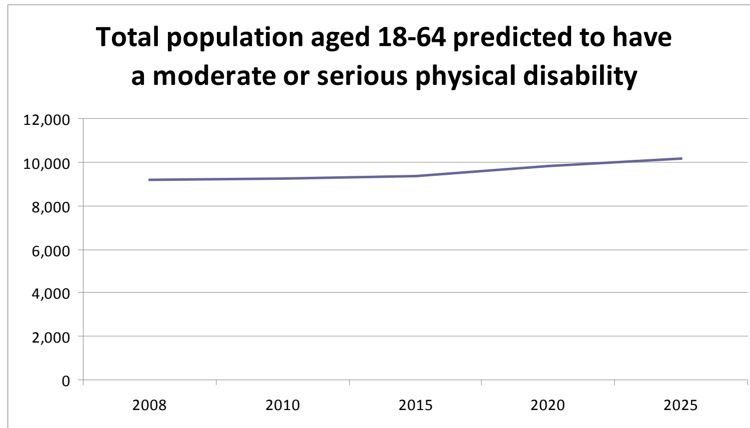


Figure 7.2.4 : Total population aged 18-64 predicted to have a moderate or serious physical disability (Ref 06801)

7.2.5 from figures 7.2.3 and 7.2.4, it may be seen that overall numbers of the disabled are expected to increase by 10.6% between 2008 and 2025

7.2.6 Many disabled do not require a continuing input from public services to meet their personal care needs. These include:

- getting in and out of bed,
- getting in and out of a chair,
- dressing,
- washing,
- feeding and
- use of the toilet.

A moderate care disability means the task can be performed with some difficulty, a severe personal care disability means that the task requires someone else to help.

People aged 18-64 in cohorts predicted to have a moderate or serious personal care disability, projected to 2025					
	2008	**2010**	**2015**	**2020**	**2025**
Total population aged 18-64 predicted to have a serious personal care disability	771	780	789	825	853
Total population aged 18-64 predicted to have a moderate or serious personal care disability	4,345	4,376	4,414	4,654	4,829

Figure 7.2.5 : People aged 18 – 64 predicted to have a personal care disability (Ref 06801)

7.2.7 Table 7.2.5 is based on the prevalence data on adults with physical disabilities requiring personal care by age and sex in the Health Survey for England, 2001. The prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have a moderate or serious physical disability and requiring personal care to 2025..

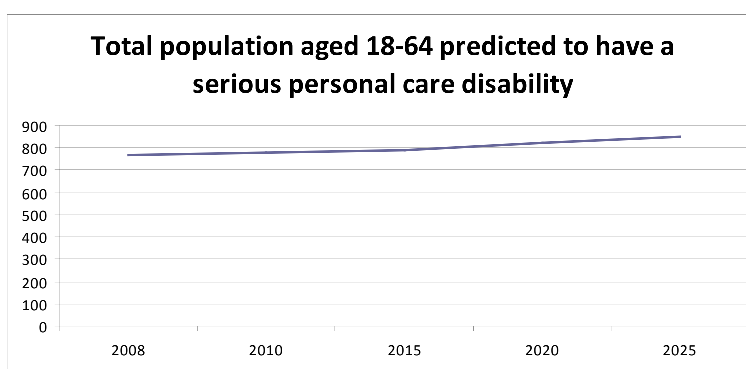


Figure 7.2.6 : Total population aged 18 – 64 predicted to have a serious personal care disability (Ref 06801)

7.2.8 From figures 7.2.5 and 7.2.6 people in this age group with a serious physical disability are projected to rise by 10.6% over the period to 2025. These are the people most likely to meet current eligibility criteria for social services care or support.

7.2.9 People with a degree of disability that requires personal care needs are a sub group of a larger group where the disability is such that they cannot enter employment. Many of these will be getting support in the form of benefits, and will be looking to use public provision of housing centred support, leisure facilities and various forms of medical services.

People by age and gender cohorts predicted to have a physical disability and be permanently unable to work; projected to 2025

	2008	2010	2015	2020	2025
Total males 18-64 predicted to have a physical disability and be permanently unable to work	2,457	2,481	2,505	2,628	2,738
Total females 18-64 predicted to have a physical disability and be permanently unable to work	1,439	1,456	1,546	1,624	1,621
Total 18-64 predicted to be permanently unable to work	3,896	3,937	4,051	4,252	4,359

Figure 7.2.7: People by age and gender cohorts predicted to have a physical disability and be permanently unable to work (Ref 06801)

7.2.10 Figure 7.2.7 is based on the prevalence data on disabled people permanently unable to work presented in the Health Survey for England, 2001. The survey has prevalence data available in the table 'Economic Activity, By Disability Status, Age and Sex' on disabled people permanently unable to work by age and gender. The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to be permanently unable to work due to a physical disability, projected to 2025.

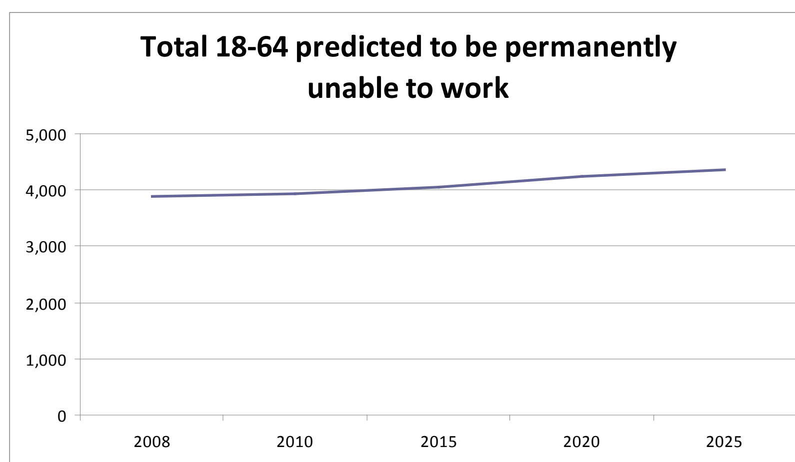


Figure 7.2.8: Total 18-64 predicted to be permanently unable to work. (Ref 06801)

7.2.11 From figures 7.2.7 and 7.2.8 it can be seen that over the period to 2025 the numbers projected to be unable to work by reason of physical disability on the Island are to rise by 11.2%.

People aged 18-64 with a physical or sensory disability, helped to live at home, and those supported by social care in care homes, projected to 2025					
	2008	2010	2015	2020	2025
People aged 18-64 with a physical or sensory disability helped to live at home	367	370	376	386	395
People aged 18-64 with a physical or sensory disability in residential and nursing care during the year, purchased or provided by the CSSR	25	26	26	27	27

Figure 7.2.9 : People aged 18-64 with a physical or sensory disability helped to live at home, and those supported by social care in care homes, projected to 2025 (Ref 06801)

7.2.12 Values in figure 7.1.1.15 are taken from two sources.

- Helped to live at home' is taken from the Social Services CSCI / National Statistics, reference Ao/C29. The rates per 1000 have been applied to ONS population projections of the 18-64 population to estimate the numbers helped to live at home with 2006/07 performance levels. 'Supported by social care in care homes' is taken from Community Care Statistics 2006-07.
- The 2006-07 RAP figures have been applied to ONS 2006 mid-year population estimates of the 18-64 population, to give estimates of the numbers of people with a physical or sensory disability in supported residential and nursing care during the year, with 2006/07 performance levels

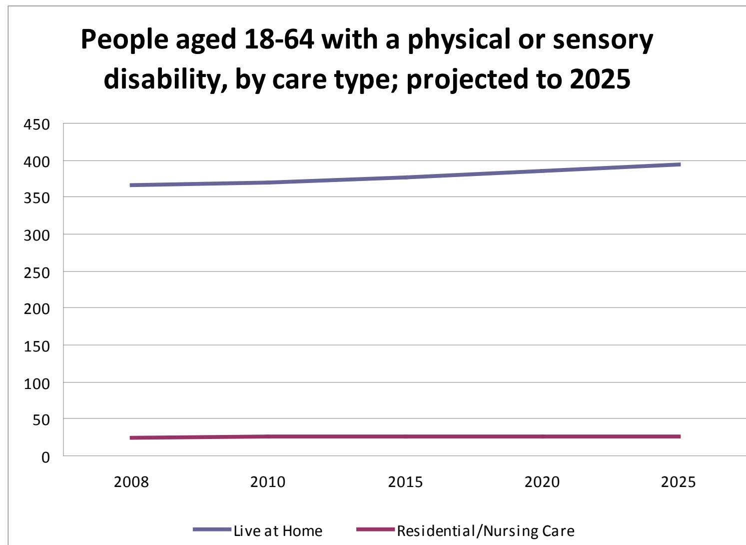


Figure 7.2.10 : People aged 18-64 with a physical or sensory disability, by care type; projected to 2025 (Ref 06801)

7.2.13 from figures 7.2.9 and 7.2.10 people in this client group receiving social services support will rise by 7.6% over the period 2008 to 2025.

Physical Disability Clients by Type of Care and 10 year age bands

	18-28	29-38	39-48	49-58	59-64	Grand Total
Home Care	6	5	15	34	41	101
Phone Services	4	7	14	22	17	64
Direct Payment	4	6	10	14	12	46
Residential/Nursing	1	1	4	8	5	19
Day Services		2	2	6	8	18
Respite			2	4	6	12
Long Term - Day Care				1	1	2
Short Term - Meals				1	1	2
Grand Total	15	21	47	90	91	264

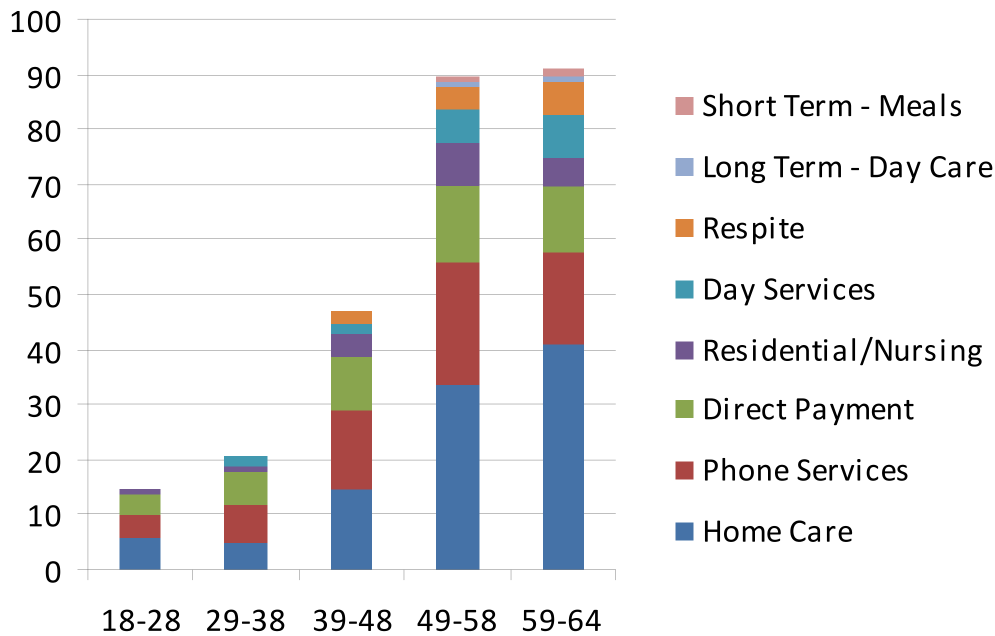


Figure 7.2.11: Physical Disability Clients by type of direct service received and 10 year age bands (Ref 06805)

7.2.14 Data in figure 7.2.11 is restricted to the care directly provided or purchased, and excludes social worker and OT input. It demonstrates a direct link with age for both the volume and type of care delivered.

Physical disability frailty and sensory impairment; 18 to 64 Cohort: 2007 to 2009				
	Community based services in own home	Residential Care	Nursing Care	Total of Clients
2007/08	589	16	7	608
2008/09	551	17	7	569

Figure 7.2.12 : Physical Disability Frailty and sensory impairment 2007 to 2009 (Ref 06809)

Physical Disability Clients - Services; 31st March 2008 and 2009.						
	18 to 64		65 to 74		75 plus	
	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009
Home Care	128	117	109	114	1067	1163
Day Care	26	25	32	33	370	348
Meals	19	19	39	43	546	456
Short term residential not respite	3	6	13	16	255	254
Direct Payments	49	47	11	15	98	78
Professional Support	132	113	74	68	249	279
Equipment & Adaptations	89	80	77	67	290	352
Other	78	81	46	42	321	255
Total of Clients	392	353	275	279	1922	1980

Figures taken from the RAP P2s annual return, and were current as of the 31st March in the respective years.
As clients may have multiple services the total clients line counts clients, not services delivered.

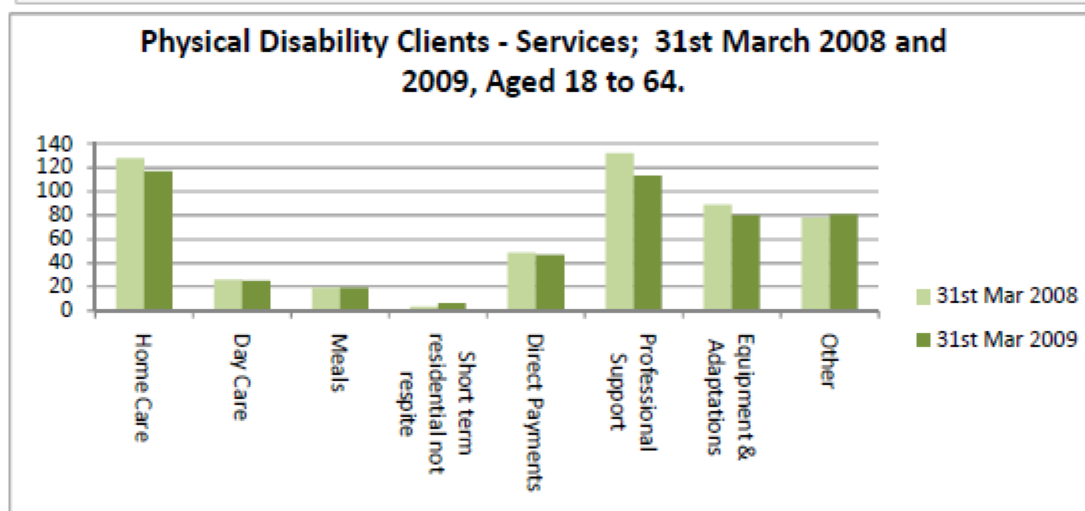


Figure 7.2.13 : Physical Disability Clients services (Ref 06902)

7.3 Visual Impairment

People predicted to have a serious visual impairment, projected to 2025					
	2008	2010	2015	2020	2025
Total population aged 18-64 predicted to have a serious visual impairment	53	53	54	56	57

Figure 7.3.1 : People in age cohorts predicted to have a serious visual impairment (Ref 06801)

7.3.1 This table (figure 7.1.2.25) is based on the prevalence of visual impairment in the UK. A review of the literature by Tate, Smeeth, Evans, Fletcher, Owen and Rudnicka, The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a serious visual impairment and require help with daily activities projected to 2025.

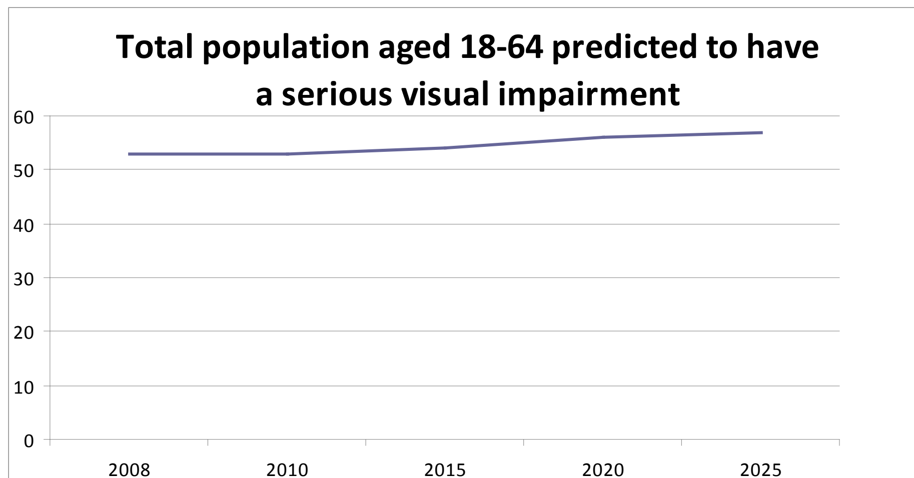


Figure 7.3.2 : Total population aged 18-64 predicted to have a serious visual impairment (Ref 06801)

7.3.2. Further information on this client group may be found at sections 6.11.8 and 6.6

7.4 Mental Health 18 to 64

7.4.1 Suicide

7.4.1 It is difficult to measure mental health at a community or Local Authority level, and to compare meaningfully one area with another. Population surveys are expensive to conduct and repeat. While there are reliable methods of diagnosing severe mental health problems, less severe symptoms are harder to classify. In 1999 the Government therefore adopted the suicide rate as a 'proxy' or representative target for mental health. The reasons for this were the availability of reliable data, and the fact that policies to promote good mental health should also lead to a reduction in suicides.

7.4.2 There is a national Public Service Agreement target to reduce by 20% the rate of mortality from 'suicide and injury of undetermined intent', from the 1995-97 baseline by 2010. Mortality from suicide and injury undetermined includes deaths where a Coroner holds an inquest (a legal inquiry into the medical cause and circumstances of a death); and where the verdict is suicide or some cases of an open verdict (where there is insufficient evidence for any other verdict). All PCT areas are expected to reduce their mortality rates over this period, although there are no specific targets at PCT level.

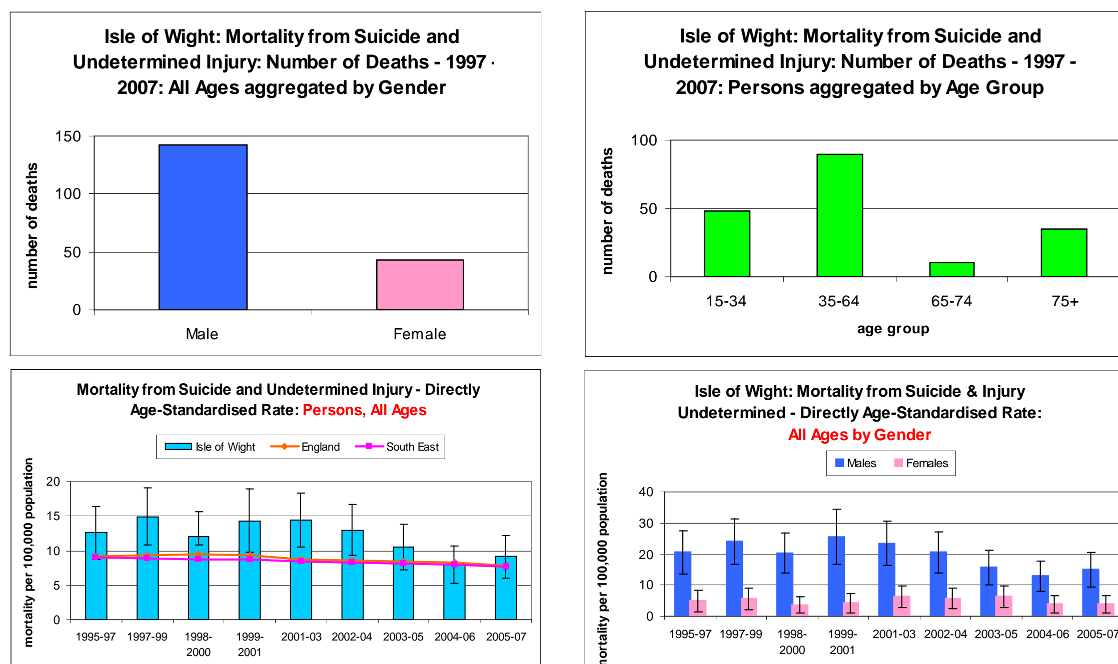


Figure 7.4.1 Isle of Wight: Mortality from Suicide and Undetermined Injury (Ref 06101)

7.4.3 The graphs above show the number of deaths of IW residents from suicide and injury undetermined by year. Since 1995:

- there have on average been 16 deaths of IW residents each year;
- 77% of people who died were Male, 23% were Female;
- 50% of deaths were among people aged 35 - 64, with 19% of deaths among people aged 75+.
- The age profile of Male and Female deaths was similar, but with a slightly higher proportion of male deaths aged 35-64 and a slightly higher proportion of female deaths aged 75+.

7.5 Mental Health indices and Prevalence Rates

7.5.1 Measurement of mental health in the population has tended to focus on mental ill health rather than mental health and well-being, which is more difficult to measure. According to the most recent national surveys of mental ill health, at any one time:

- 16.4% (1 in 6) of adults aged 16-74 living in private households have a mental health problem (ONS Psychiatric Morbidity Survey, 2000).
- 80% of those people are experiencing anxiety and/or depression.
- 9.6% of children aged 5 – 16 have a diagnosable mental health disorder (ONS Survey 'Mental Health of Children & Young People in Great Britain, 2004').

These survey findings have been applied to the most recent (2007) estimates of the IW population.

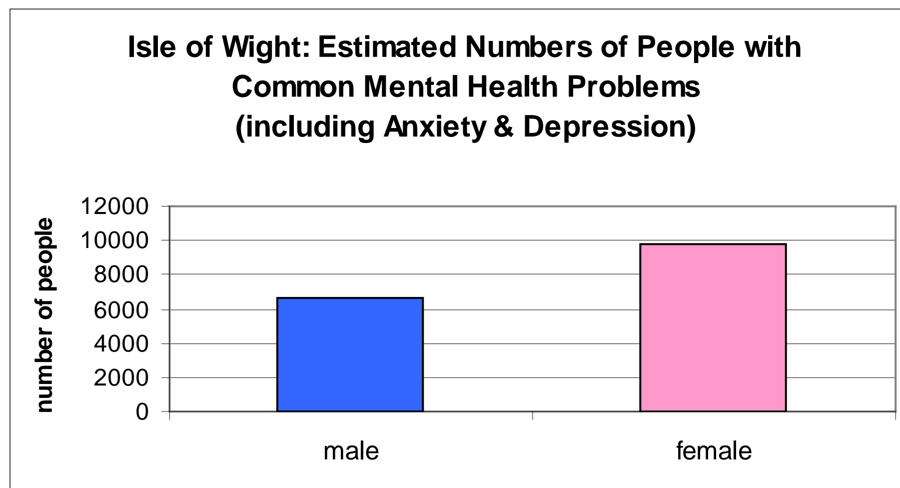


Figure 7.5.1 Isle of Wight : Estimated Numbers of people with common Mental Health problems (Ref 06201)

7.5.2 Figure 7.2.1 shows the estimated number of IW adult residents aged 16 - 74 with common mental health problems, including depression and anxiety, at any one time. The total exceeds 16,000 people, of whom 60% are female and 40% male.

7.5.3 Some of these people will be experiencing short-term problems, and will recover on their own, with non-medical support, or with only short-term medical intervention. However it is important to note that specific groups of people are at higher risk of mental health problems, and could be disproportionately represented in the figures shown above. These groups include people who are unemployed; who have been victims of abuse or domestic violence; who sleep rough; from some black and minority ethnic groups; in prison; with drug or alcohol problems; and with physical illnesses.

7.5.4 The activity explored below in figure 7.5.2 is representative only of the activity of the social services element in the CMHT's; this constitutes a significant information gap which requires early redress.

Mental Health Clients - Services; 31st March 2008 and 2009.	18 to 64		65 to 74		75 plus	
	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009
Home Care	18	16	29	29	94	108
Day Care	46	51	28	26	58	75
Meals	2	2	13	9	33	32
Short term residential not respite	4	3	6	4	26	24
Direct Payments	5	5	3	5	6	7
Professional Support	219	374	57	107	42	97
Equipment & Adaptations	8	11	8	13	16	28
Other	10	11	10	4	24	25
Total of Clients	297	456	115	168	181	258

Figures taken from the RAP P2s annual return, and were current as of the 31st March in the respective years. As clients may have multiple services the total clients line counts clients, not services delivered.

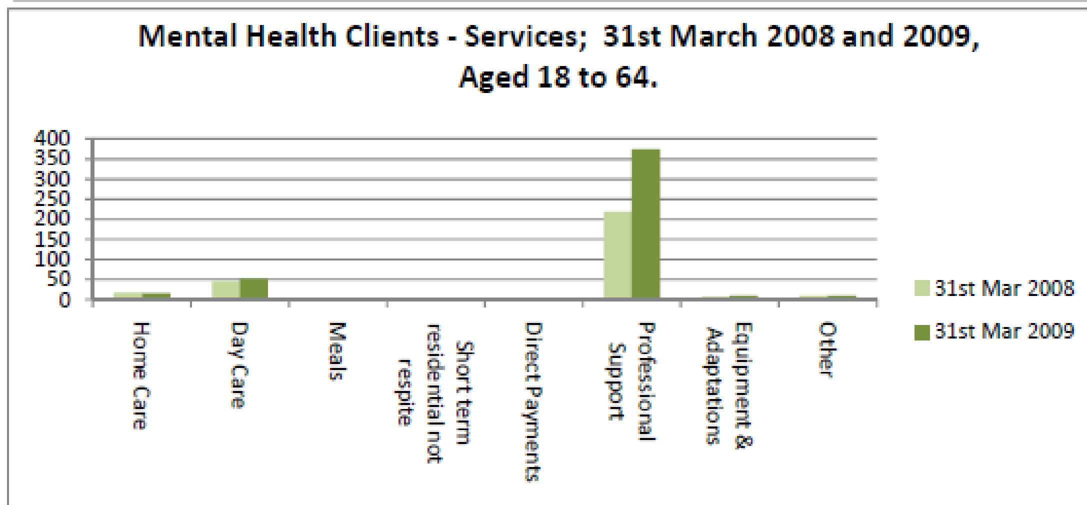


Figure 7.5.2 : Mental Health Clients – Services (Ref 07304)

7.6 Learning Disabilities

7.6.1 There are 458 service users who have learning difficulties. The largest call on services for this cohort is within day care services with 293 accessing these services. The numbers of LD service users 18-64 supported to live at home will increase over next few years with the Joint health and social care strategy to help people to move to independent living.

Learning Disability; 18 to 64 Cohort: 2007 to 2009				
	Community based services in own home	**Residential Care**	**Nursing Care**	**Total of Clients**
2007/08	459	162	2	503
2008/09	473	156	2	507

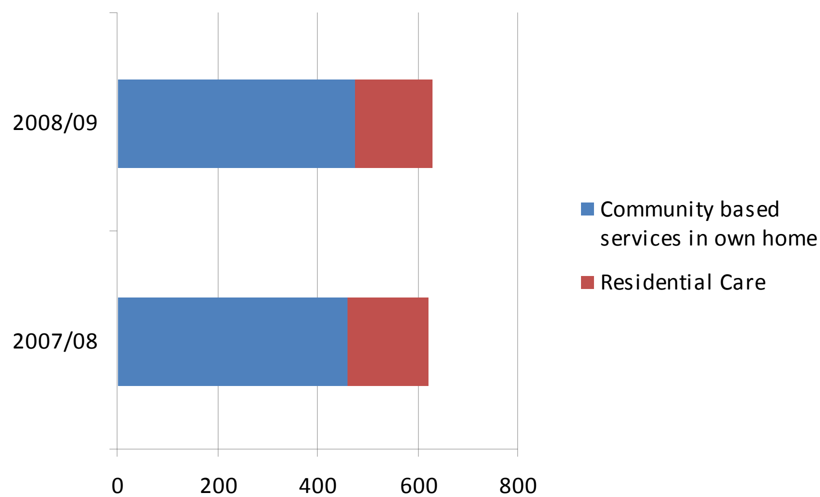


Figure 7.6.1 : Learning Disability – 18 to 64 cohort 2007 to 2009 (Ref 07001)

7.6.2 The figures in 7.6.1 are for the whole years worth of clients, and includes clients (49 during 08-09) whose cases where opened and closed during the year.

Learning Disability Clients - Services; 31st March 2008 and 2009.				
	18 to 64		65+	
	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009
Home Care	97	116	11	14
Day Care	275	293	14	11
Meals	4	2	0	0
Short term residential not respite	1	6	3	1
Direct Payments	31	45	0	1
Professional Support	108	94	8	3
Equipment & Adaptations	4	7	3	1
Other	12	11	2	3
Total of Clients	433	458	32	28

Figures taken from the RAP P2s annual return, and were current as of the 31st March in the respective years.
As clients may have multiple services the total clients line counts clients, not services delivered.
Due to low numbers the 65+ cohort has been amalgamated.

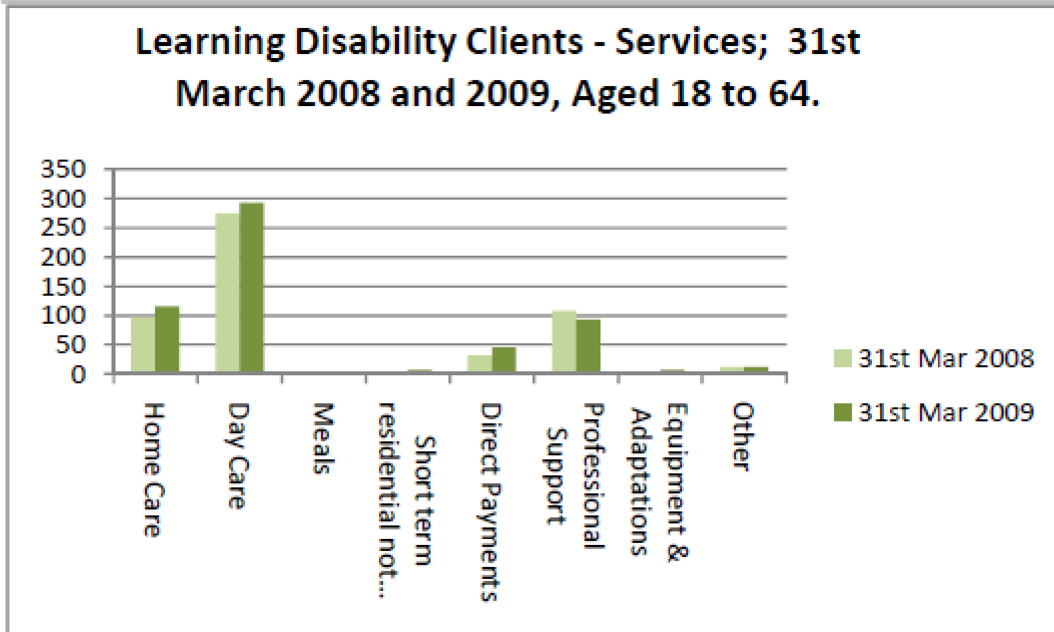


Figure 7.6.2 : Learning Disability Clients – Services (Ref 07101)

7.7 Substance Abuse

Data is presented in this section for drug misuse.

7.7.1 Drug Misuse[1]

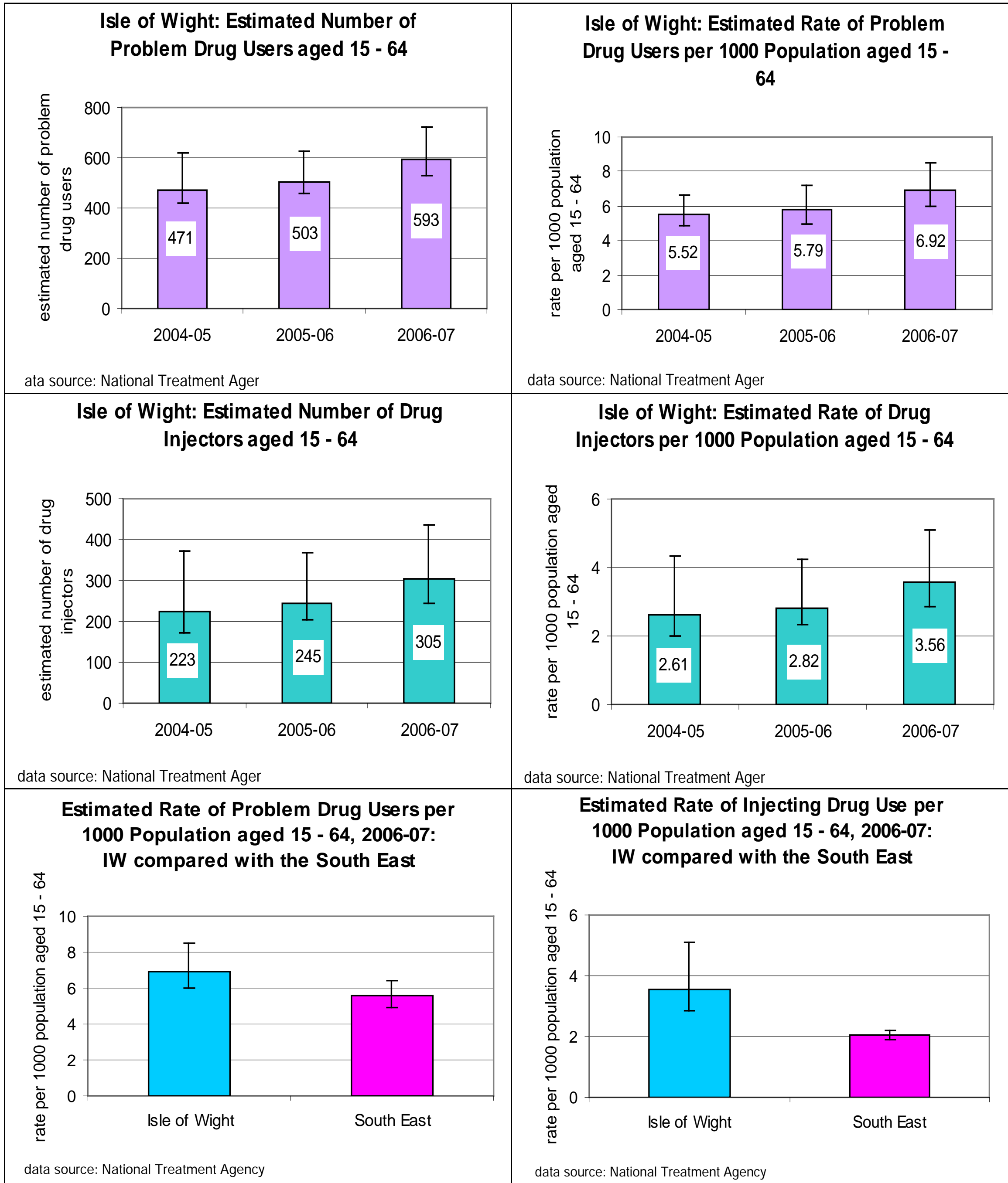


Figure 7.4.1.1; Drug Abuse between 2004 and 2007 (ref 07402)

[1] I:\Modernisation\Observatory\jsna\Substance Misuse\Needs Assessment data for YPSM TP 2009

7.7.1 The most recent available data (from 2006-07) on 'problem drug use' (use of opiates and / or crack cocaine) estimates an Island population of 593 "problem drug users" (PDUs) aged between 15 – 64. The confidence interval range indicates that the true number could be between 515 and 727. Although this shows an increase on the 2005-06 estimate of 503 PDUs, the difference between the two estimates is not statistically significant. The IW rate of PDUs per 1000 population aged 15 – 64 for 2006-07 is not statistically significantly different from the South East's rate.

7.7.2 By July 2008 services have approximately 65% of these PDUs (383) in effective treatment in the adult services. This increases to 82% if you include all drug misuse (487) not taking into consideration young people under the age of 18years. Young People services had by October 2008, 76 people in treatment.

7.7.3 In 2006-07 the estimated number of injecting drug users aged 15 – 64 was 305, with the confidence interval range indicating that the true value could be between 244 and 437. This shows an increase on the 2005-06 estimate of 245, but the difference between the two estimates is not statistically significant. However the IW rate of injecting drug users per 1000 population aged 15 – 64 for 2006-07 is higher than the South East's rate and the difference is statistically significant.

7.7.4 Drug Misuse - Summary

- Overall people in effective treatment are a high proportion of the treatment population
- The percentage of women in effective treatment remains similar to previous years with 29% women
- The percentage of BME population in effective treatment remains similar with a low level of 2%, the percentage is higher in known to treatment figures to 8%.
- For young people the percentage has decreased in effective treatment and known to treatment the same at 27%
- The figure for estimated 'not known to treatment' has over doubled to a figure of 226. This is perhaps an indication of the changes in prevalence data although we realise there is more work required to understand this figure.

7.7.5 Substance Misuse – Illegal Drugs – Control Measures

- **Bronze Action Visits:** Visits are made to nominals believed to be involved criminality linked to the use or supply of drugs. These actions, raised on the basis of intelligence received by the OCU (Operational Control Unit) are co-ordinating with the treatment providers on the Isle of Wight which allows Officers to offer fast-track referrals to a treatment programme; appointments are offered the same or next day.
- **Operation Augustus:** A Partnership funded Operation, AUGUSTUS, has run for several years on the Isle of Wight, targeting the supply, dealing and use of Class A drugs. Police and joint agency Operations are planned under the umbrella of AUGUSTUS and given their own Operational names.
- **Festival and Bestival:** Operation KENNEDY was the OCU's music-festival search operation at the Isle of Wight Festival 2008, compiled through a selection of tactics from the Force menu of Tactical Options for the disruption of drugs supply at Festival events. The OCU adopted a similar approach to the Isle of Wight Bestival 2008 event within Operation Fairoak.
    - At the 2008 Isle of Wight Festival, there were a total of 781 drugs searches carried out, resulting in 512 persons in possession or admitting to recent drug use. Cannabis warnings were issued to 161 individuals, and 66 people were arrested for drug offences, including 11 Possession with Intent to Supply offences. The total value of drugs seized was £77350.00.
    - At the 2008 Bestival, which was subject to severe weather conditions, there were a total of 586 drugs searches, resulting in 372 persons in possession or admitting

to recent drug use. Cannabis warnings were issues to 91 individuals, and 53 people were arrested for drug offences including 18 for possession with intent to supply. The total value of drugs seized was £104,695.10.

- **Operation SHERIDAN:** Ownership if this has been passed to the Dog Support Unit and continues to target the transport of drugs to the Isle of Wight from the mainland by ferry. This Operation provided public reassurance and disrupted the supply of drugs to the Island through increasing the received risk to suppliers, dealers and mules.
- **HM Prisons:** Operation REGINA addresses the issue of drug supply into HM Prisons Albany, Camp Hill and Parkhurst[2]. Working in partnership with Prison Staff and Police Prison Liaision Officers, this Operation has been presented to the strategic group of Government Office for the South East and is being recommended for best practice to ACPO. Several UK forces have or plan to adopt the approach developed on the Isle of Wight.
- **Early Drug Intervention Initiative (EDII) Drug Awareness Programme:** Over 5000 parents, pupils and school staff have received drug awareness training through this programme to date. Delivery to pupils will be passed to Connexions in 2009/10, with parent and staff education sessions provided by the OCU Drugs Intelligence Officer in partnership with Cranstoun Drug Treatment Service and RESULT.

7.7.6 Drug Action Team (DAT)

- [3] The PCT is now passing on data in relation to the supervised consumption and pharmacy needle exchange services. However, there are three key areas for continuing improvement for 2009/10: TOPs completions, Blood Bourne Viruses services delivery and recording and shared care services.
- Ongoing work has been undertaken to increase tier one service awareness and joint working with rapid access to services.
- The areas where there is a need to work more closely with are housing, housing related support, education and employment. However, some progress has been made especially by the tier 2 / DIP service.
- The tier three prescribing service has continued to work well with people requiring specialist prescribing and been focussed on workforce development over the past year.
- Tier 4 services have had an increase in referrals, although mostly for alcohol related problems. The 3rd sector provider for the Tier 4 capital project withdrew from the project early in 2008 and it has been difficult to progress.
- The Pharmacy services have worked well with the DAT with a training event on Needle Exchange for pharmacy staff delivered in November 2008. The RESULT Secret Shopper on Needle Exchange has been shared with pharmacies and they will be undertaking a follow up exercise in 2009.
- The most recent available data (from 2006-07) on ‘problem drug use’ (use of opiates and / or crack cocaine) estimates an Island population of 593 “problem drug users” (PDUs) aged between 15 – 64. The confidence interval range indicates that the true number could be between 515 and 727. Although this shows an increase on the 2005-06 estimate of 503 PDUs, the difference between the two estimates is not statistically significant. The IW rate of PDUs per 1000 population aged 15 – 64 for 2006-07 is not statistically significantly different from the South East’s rate.
- By July 2008 services have approximately 65% of these PDUs (383) in effective treatment in the adult services. This increases to 82% if you include all drug misuse (487) not taking into consideration young people under the age of 18years. Young People services had by October 2008, 76 people in treatment.

[2] Operation Regina III, PROACTIVE & REACTIVE OPTIONS, PC Nathan LUCY

[3] Adult drug treatment plan 2009/103

- In 2006-07 the estimated number of injecting drug users aged 15 – 64 was 305, with the confidence interval range indicating that the true value could be between 244 and 437. This shows an increase on the 2005-06 estimate of 245, but the difference between the two estimates is not statistically significant. However the IW rate of injecting drug users per 1000 population aged 15 – 64 for 2006-07 is higher than the South East's rate and the difference is statistically significant.

7.7.7 Partnership key treatment priorities:

- Improved clinical governance of drug treatment services;
- Achieving numbers into treatment target with a 3% increase from baseline provided at end of March 2009.
- Achieving 12 week retention target of 85%
- Achieving BBV screen and testing targets, all people accessing a new treatment journey will be offered a Hep B vaccination and screening for Hep B/C/HIV
- Achieving DIP Compact Targets 60% of adults with whom initial contact is made who are not already on the caseload, to be assessed by the CJIT/ 85% of adults assessed as needing a further intervention to have a care plan drawn up and agreed and 95% of adults taken onto the caseload to engage in treatment. Numbers seen for assessment from 1st April 2008 – 31st March 2009 set at 40.
- Achieving Care Plan targets of 95%
- Achieving Shared Care Targets as defined in part 2 of the ATP 2009/10
- Developing Move On accommodation in 2009/10
- Developing IDTS in Camp Hill Prison with prison healthcare and PCT.
- Improved health outcomes as part of the public health agenda, including addressing harm around BBV;s, alcohol, mental health, health eating and exercise.

7.7.8 Get Sorted

Get sorted delivered around 32 Drug and Alcohol Awareness sessions during 2008/2009. The sessions reached around 2146 individuals from a multitude of backgrounds and age groups. Approximately 50% of those receiving sessions were Year 7 – Year 10 school children, with a further 40% being made up of students, teachers and professionals and the remaining 10% being split over such groups as Nurses, Parent groups and smaller community groups.

On discharge 94% of young people reported being an active participant in their care plan and 100% reported having received appropriate drug and alcohol information.

In addition to young people in treatment Get Sorted have offered harm reduction advice in 1:1 sessions for in excess of 50 young people.

Get Sorted participate in special events such as:

- Wight 2B Heard;
- Awareness Day at the Hospital for staff;
- Question of Crime; Crime Stoppers;
- Road shows at Thompson House and Clatterford Centre;
- Band Night – a community partnership project in Church Litten Park.

7.7.9 Drug Intervention Programme (DIP) – Hidden Harm

[4]In 2003 the Inquiry by the Advisory Council on the Misuse of Drugs published its report '*Hidden Harm – Responding to the needs of children of problem drug users.* Whist data is not easily obtainable locally the inquiry highlight six key messages in relation to Hidden Harm:-

[4] http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm

- We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user.
- Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.
- Reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
- Effective treatment of the parent can have major benefits for the child.
- By working together, services can take many practical steps to protect and improve the health and well-being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

7.7.10. Current Picture

In 2008/09, a total of 57 Class A Possession with Intent to Supply offences were detected, resulting from 111 investigations into Class A drug supply, with further Class B and C offences also detected from these investigations[5].

The total number of persons arrested in relation to drugs offences on the Isle of Wight in 2008/09 was 960, an increase of 13% (852)[6].

In 2008/09, there was a 4% (53) reduction in total number of drug seizures on the Isle of Wight in 2008/09 to 1149. This reduction is attributed to the commitment of resources to other Force and OCU priorities in the final quarter of 2008/09[7].

The total street value of drugs seized in 2008/09 was £436,976.20.

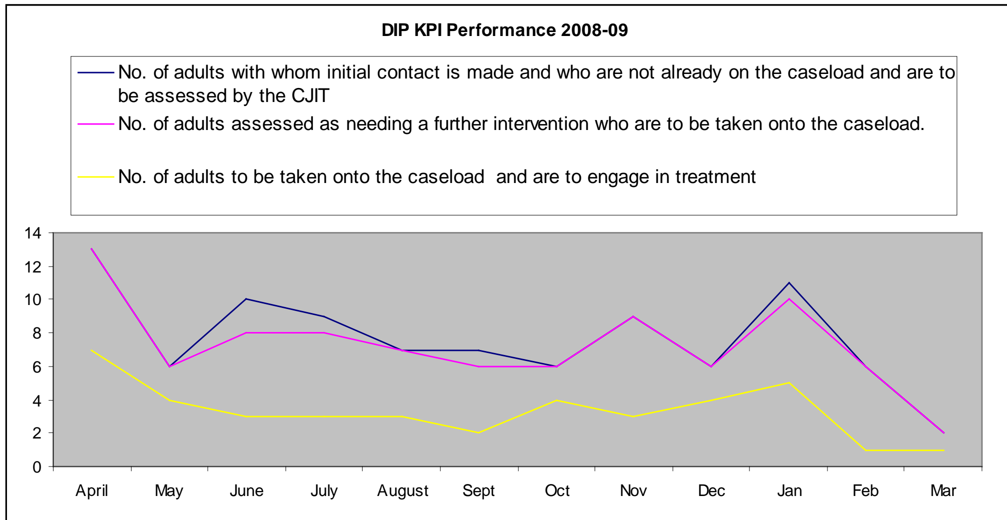
DAT treatment data In 2008/09 shows that the out-turn on Problem Drug Users's in treatment was a 3.4% increase on the previous year (baseline = 370). Retention of 98% in effective treatment (12 weeks or more) at 98% compares with a DAT target of 85%, so performed above target. The Outcomes at 49% of planned exits is in top quartile within South East. BBV figures through Providers was low, however the pilot scheme with a group of IW Pharmacies offering tests for Hep B and Hep C, and Hep B injections; are showing very positive results – 100 tests undertaken in 3 months; 56 injections completed; 12 positive Hep C tests. Clientele is mixture of those in treatment and those not known to treatment

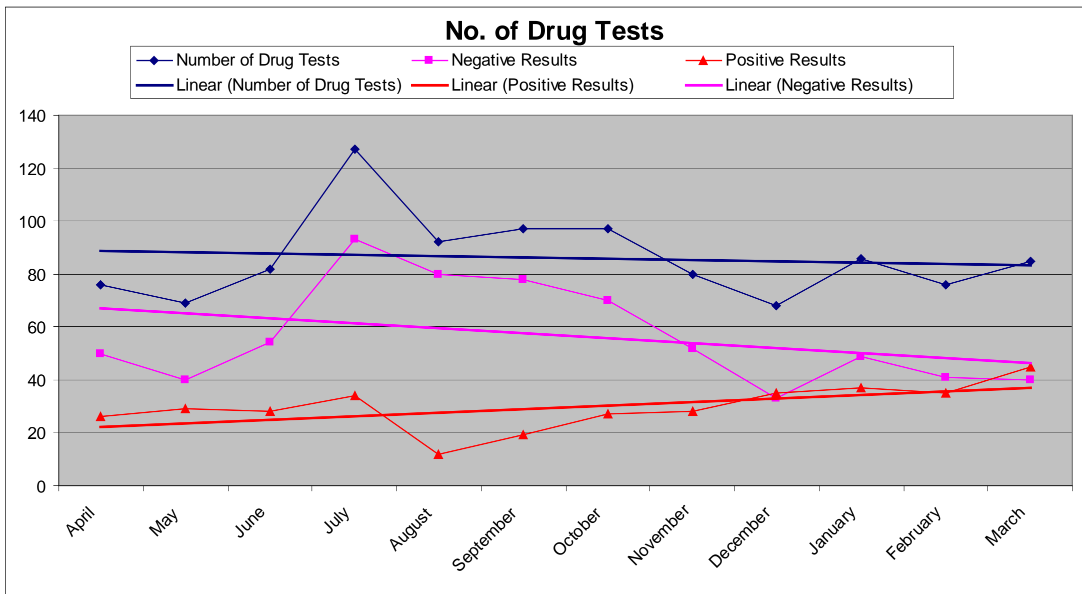
DIP (Drugs Intervention Programme) is monitored by the Home Office using the following KPI's:

- % of adults with whom initial contact (as defined in the DIR guidance) is made and who are not already on the caseload , to be assessed by the CJIT.
- % of adults assessed as needing a further intervention, to be taken onto the caseload.
- % of adults to be taken onto the caseload to engage in treatment.

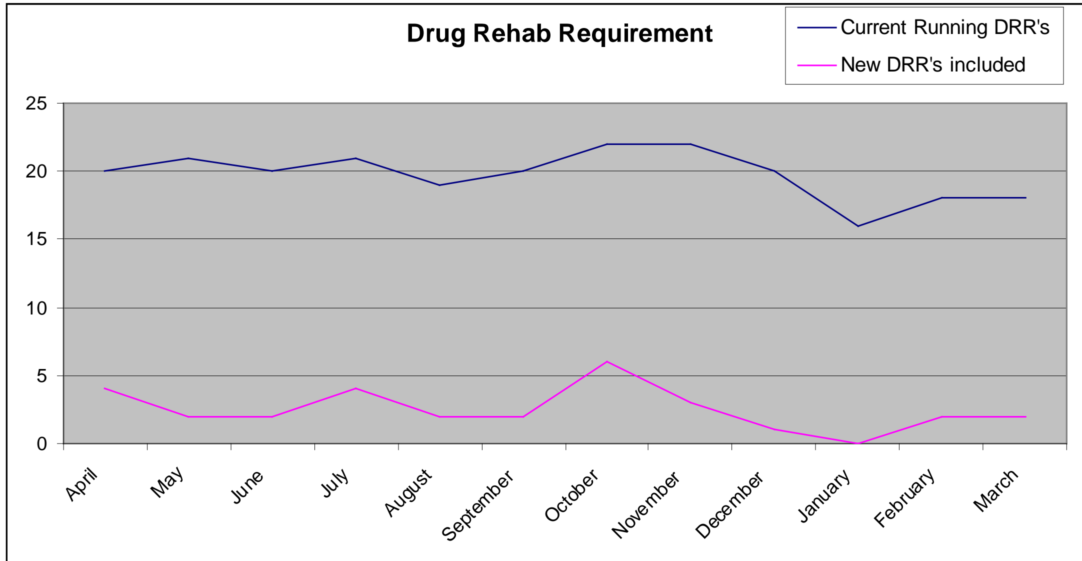
Over the 12 month period leading up to March 31st 2009 DIP has consistently performed above target. Due to such low figures (this was only where 1 person each month was not taken onto the caseload) there were occasions in June, July, September 2008 where performance was within 5% above target. Specifically in relation to % of adults assessed as needing a further intervention, to be taken onto the caseload. [8]This could be the fact that some individuals move straight into local remand (prison), which means that they automatically get a DIR and avoid being taken onto the caseload.

[5] Operation Augustus Final Report for 2008/09
[6] ibid
[7] ibid
[8] Commentary on stats, Amanda Brown (Cranstoun)

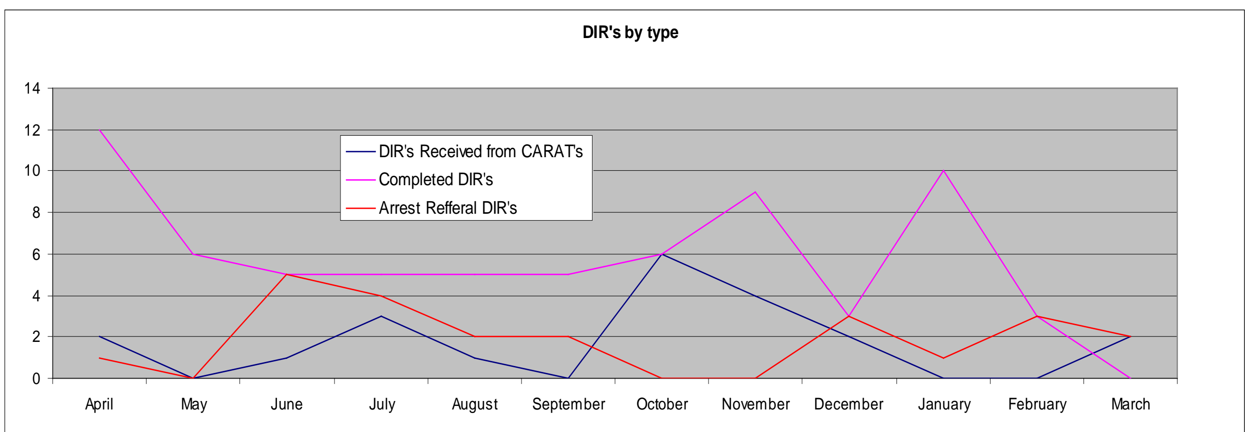




Tests are carried out on individuals with Drug Rehab Requirement orders, and individuals can have as many as 8 tests a month to see whether they are clean. Over the 12 month period there were 1035 drug tests, 66% (680) of the results proved to be negative with the remaining 34% being positive. There are around 15-20 individuals a month receiving tests and due to the those leaving and entering DRR's at differing times it's difficult to distinguish particular trends.



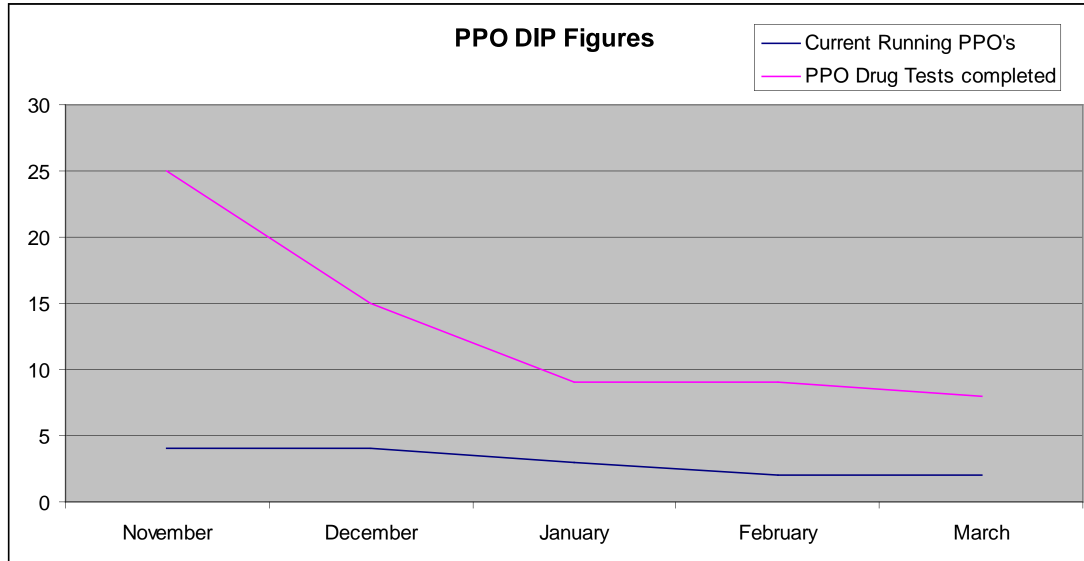
New Drug Rehab Requirement's (DRR's) are relatively low for the year with a noticeable peak of 6 in October and then a steady drop to there being no requirements in January. This is also reflected in the Current Running DRR's where a similar drop in January was recorded.



In the 12 months leading up to March 09 there were:

- 21 DIR's received from CARAT's (Counselling, Assessment, Referral, Advice and Thoroughcare)
- 69 completed DIR's
- 23 Arrest referral DIR's

The number of completed DIR's over the year has dropped throughout the year from 12 cases in April08 down to no DIR's being completed in March09.



PPO data is absent for the most part, with data only starting to be collected in November 08. Figures for Current running PPO's are generally low and DIP don't have a say in the control of PPO testing as these cases are selected by the Police and Probation team.

7.7.11 Public Perception

Public perception is influenced by increases in police activity and high profile operations. Safer Neighbourhood Teams form an integral part of operation planning in order to provide reassurance to local communities when there is high profile police activity in the area.

There has been a significant decrease in the proportion of residents who consider drug use and sale is a problem on the Island. In 2007, 31% of residents thought that drug use was a problem, which reduced to 24% in 2008. In 2007, 27% of Island residents thought that people dealing drugs was a problem, reducing to 21% in 2008[9].

Emerging Issues

The use of ketamine and steroids is increasing on the Isle of Wight, and the growing use of steroids in HMP Camp Hill is of note[10].

7.8 Alcohol harm

7.8.1 This indicator measures the rate of alcohol-related hospital admissions - taking into account conditions which are either wholly or partly attributable to alcohol misuse. Admissions are included in proportion to the role that alcohol is estimated to have played in causing them; these proportions are known as 'attributable fractions'. So for example:

- 100% of admissions for alcoholic liver disease, mental & behavioural disorders due to alcohol and alcoholic poisoning are counted.
- Lower percentages of admissions for some cancers, some heart conditions and stroke, accidents and assaults are counted.

[9] Isle of Wight Council Residents Survey 2008 Executive Summary, July 2008
[10] Operation Augustus Final Report for 2008/09

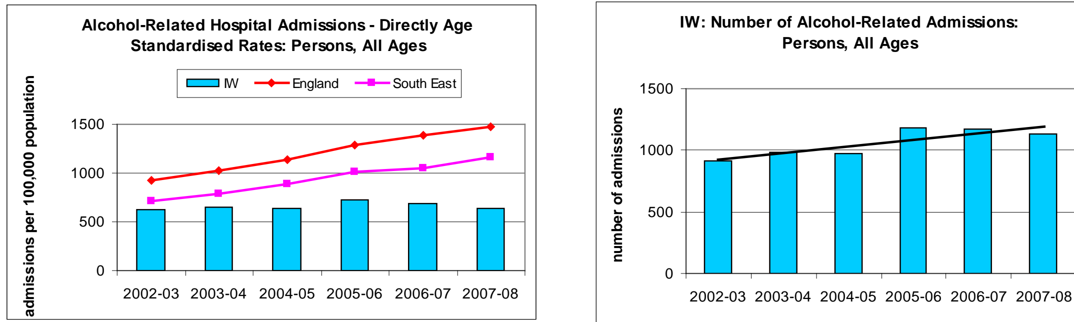


Figure 7.8.1 : Alcohol related hospital admissions (Ref 02301)

7.8.2 Figure 7.8.1 (left) compares the IW's rate of admissions with the comparable rates for England and the South East since 2002-03. The IW's rate has seen a gradual increase over this period, but the most recent year's data shows that the England and South East rates are much higher, having experienced a steeper increase in rates over the same period. Figure 7.4.2.1 (right) shows the number of admissions of IW residents by year since 2002-03. There is a steadily increasing trend in the number of admissions.

7.8.3 Alcohol – Binge Drinking

7.8.4 The Government defines binge-drinking as people drinking over double the daily recommended levels – more than 8 units of alcohol (men) or 6 units of alcohol (women) on their heaviest drinking day during the previous week.

7.8.5 Information from the Health Survey for England has been used by the Office for National Statistics to measure the % of adults (aged 16+) who are binge-drinkers in England, and to estimate binge-drinking prevalence at Local Authority level based on local demographic and social characteristics.

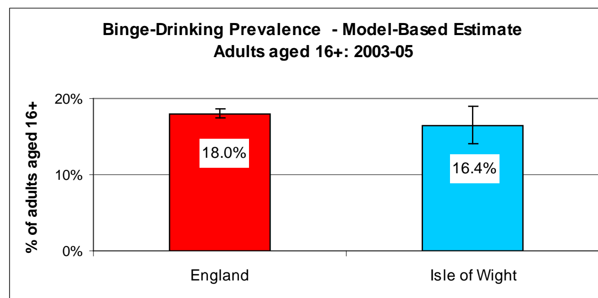


Figure 7.8.2: Binge Drinking Prevalence – Model Based Estimate, Adults aged 16+ (Ref 02401)

7.8.6 Figure 7.8.2 above compares the estimated % of binge-drinking on the IW with the equivalent % for England. The IW's estimated rate is slightly lower than England's, but the confidence intervals overlap with those of England, implying that there may be no statistically significant difference between them.

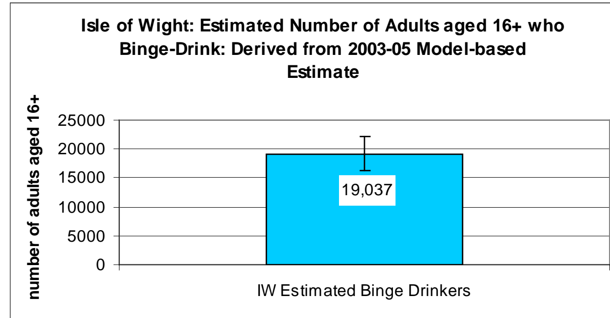


Figure 7.8.3 : Isle of Wight : Estimated Number of Adults aged 16+ who Binge Drink : Derived from 2003-05 Model Based Estimate (Ref 02401)

7.8.4 Figure 7.8.3 illustrates the estimated % of IW residents aged 16+ who are binge-drinkers has been applied to the IW population aged 16+ to estimate the number of binge-drinkers on the IW. It is estimated that there are between 16,000 – 22,000 IW residents aged 16+ who binge-drink.

7.9 Vulnerable People 18 to 64

Vulnerable People; 18 to 64 Cohort: 2007 to 2009

	Community based services in own home	Residential Care	Nursing Care	Total of Clients
2007/08	69	0	0	70
2008/09	56	0	0	56

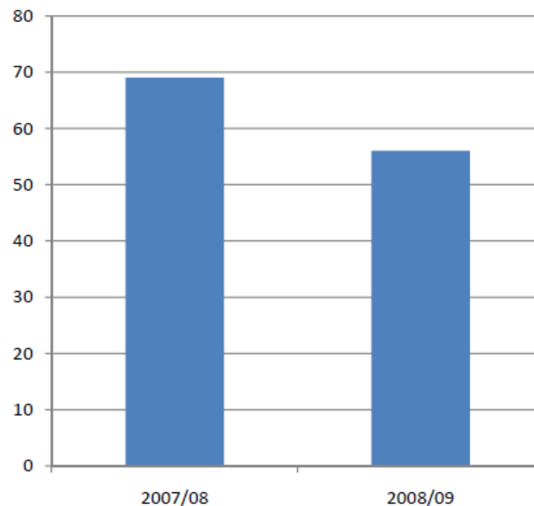


Figure 7.9.1 Vulnerable People 18 to 64 cohort 2007 to 2009 (Ref 07601)

7.9.1 A fluid category from social work practice these clients are significantly short term, of the 56 whom are represented for 2008/09 in figure 7.9.1, 33 (59%) remained open on the 31st March 2009.

Vulnerable Clients - Services; 31st March 2008 and 2009	18 to 64		65 plus	
	31st Mar 2008	31st Mar 2009	31st Mar 2008	31st Mar 2009
Home Care	0	3	6	19
Day Care	0	0	0	5
Meals	0	0	9	19
Short term residential not respite	0	1	1	6
Direct Payments	1	1	0	0
Professional Support	14	22	11	38
Equipment & Adaptations	2	4	5	10
Other	0	2	0	2
Total of Clients	17	33	29	81

Figures taken from the RAP P2s annual return, and were current as of the 31st March in the respective years.
As clients may have multiple services the total clients line counts clients, not services delivered.
Due to low numbers the 65 plus cohort has been amalgamated.

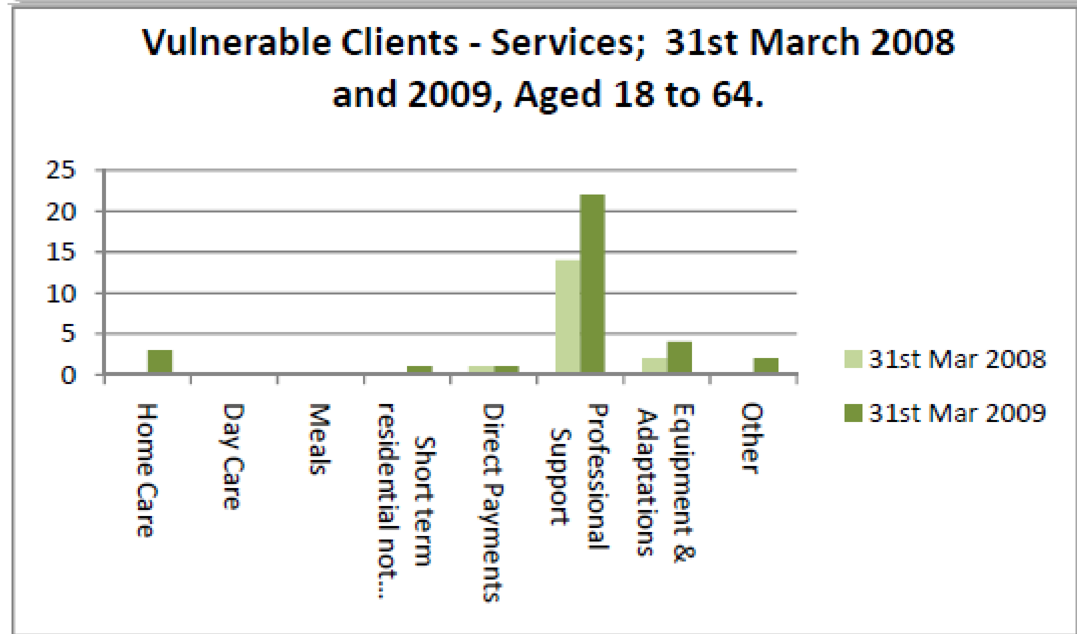


Figure 7.9.2: Vulnerable Clients – Services : Age 18 to 64 (Ref 07701)

7.10 Domestic Abuse

The shared Association of Chief Police Officers (ACPO), Crown Prosecution Service (CPS) and government definition of domestic violence is:

'*any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality*.'
(family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.)

On the Isle of Wight, the CDRP (Crime and Disorder Reduction Partnership) has established a Domestic Abuse Forum which has responsibility for coordination and managing the delivery of services to support those affected by domestic abuse, although it has not met since September 2008.

7.10.1 Multi-Agency Risk Assessment Conferences (MARAC)

The Multi-agency Risk Assessment Conference (MARAC) process has become an established method of managing very high risk domestic abuse victims. Chaired by the Public Protection Inspector of the OCU, the MARAC raises actions to a range of agencies in order to manage the risk to victims. The Isle of Wight was independently inspected and congratulated by the charity "co-ordinated action for domestic abuse" (CAADA) for *"….a very effective MARAC which follows the CAADA Model.*[11]"

7.10.2 Rehabilitation Programmes

The Integrated Domestic Abuse Programme has been fully implemented, led by Probation, although it is reported that numbers are low[12]. In July 2009 there was one programme running for the Island, with a cohort of 8 offenders. The Isle of Wight Women's Refuge also ran a Men for Change Programme, which has suffered from poor take up since implementation due to it's voluntary nature and has now been withdrawn.

7.10.3 Freedom Programme

[13]Isle of Wight Women's Refuge runs a freedom programme for victims of domestic abuse. The programme is a 12 week, two hour a week rolling group work programme for women who have experience of an unequal relationship. Women can self refer and there are crèche facilities available provided by Children's Services however there are only spaces for 4 children despite around 18 women attending the programme each week. The programme is run by staff from the Refuge.

The aims of the programme are:

- To help women to understand the beliefs held by abusive men and in doing so, recognise which of these beliefs they have shared.
- To illustrate the effects of domestic violence on children.
- To assist women to recognise potential future abusers.

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[11] MARAC 2nd Stage Feedback Report for Isle of Wight - CAADA
[12] Partnership Plan 2008-2011, Isle of Wight CDRP, Progress Report – April 2009
[13] Draft Domestic Abuse Strategic Review, author Kim Brown, September 2009

- To help women gain self-esteem and the confidence to improve the quality of their lives.
- To provide women with information that will enable women to protect themselves and their children

7.10.4 Directory

A directory of services for victims of domestic abuse has been produced by the Domestic Abuse Forum.

7.10.5 Police Domestic Abuse Team

Alongside the MARAC, the Police OCU Domestic Abuse Team provide a victim-focused approach for all victims of domestic abuse. Those victims that fall outside the MARAC process are offered multi-agency support, co-ordinated by this team, as a result of the close working relationship that the MARAC process has garnered. Within the Police OCU, a Public Protection Investigation Unit has been established and has taken responsibility for the investigation of a number of Domestic Abuse incidents where their involvement has had a positive impact.

7.10.6 Hampton Trust LINX Programme

The Hampton Trust offers a range of programmes aimed at addressing domestic abuse. Currently they only deliver one programme on the island.

The LINX programme works with young people aged 10 – 18 years who have committed a violent offence or who are showing escalating signs of violence. Global research consistently shows that 80 – 90% of young people who exhibit violent behaviour have experience of domestic abuse in their own families.

LINX consists of a 12 week group based interactive programme and is based on experiential learning theory. It is aimed at facilitating the young person in building empathy.

The LINX Coordinator commences work in September and will be based at the Youth Offending Team.

The island LINX programme will be closely monitored and an evaluation of the programme will be undertaken by Dr Rosie Meek of the University of Southampton. The Trust is running the same programme in Hampshire, Devon, and Gloucestershire whereby the lessons learned in each county and the outcomes for young people will be measured across all areas.

7.10.7 Safeguarding Adults

The role and function of Safeguarding Vulnerable Adults in relation to domestic abuse is evolving. This is a joint policy between the local authority and health. Around 50 referrals per month are received of which the majority relates to physical or financial abuse. The definition and criteria for making an assessment of domestic abuse are being further developed.

Over the last seven months 12 cases were defined as domestic abuse.

7.10.8 Safeguarding Children

The strategic body overseeing safeguarding is the multi agency Local Safeguarding Children Board. Government funded research into child protection practices in relation to domestic abuse shows that domestic abuse is recognised in around 73% of safeguarding cases. In only 5% of those cases are services for domestic abuse routinely involved. In the planning stage the involvement of domestic abuse services was evident in 8% of plans. This may be in part to the

violent partner having left, responsibility for addressing violence seen to lie solely with the police, or a lack of domestic abuse services to refer to. Despite social work case files showing that domestic abuse rarely exists in isolation with many families experiencing a combination of domestic violence, parental substance misuse (drugs and alcohol) , mental illness, and learning disability, it was noted there was very little collaboration between services serving these different needs (Cleaver et al 2006).

In 2007/08 it was noted that around 50% of children on the Child Protection Register on the island were victims of domestic abuse.

7.10.9 Housing Related Support - Supporting People

Anyone made homeless through domestic abuse is entitled to apply to any council for assistance.

Supporting People provides financial assistance for housing support in relation to securing accommodation, benefits advice, liaison with the police and encouraging education and employment.

Concerns about risk management have been expressed on the island by stakeholders with regards to closure of Refuges in other localities in order to provide generic services. The island is in a unique position due to its geographical structure which needs to be taken into account.

One of the challenges on the island is to facilitate move on from the Refuge for families. Some of the issues within this is obtaining references which all private letting agents require, and the funding required to re-house a family on the mainland. Find a Home scheme is utilised and there is regular liaison between the Refuge and the Accommodation Officer. All clients receive a Housing Options interview.

7.10.10 Support - Independent Domestic Abuse Advocate (IDVA) - Refuge Outreach Service

The role of the IDVA is a pivotal component of both the Specialist Domestic Violence Court (SDVC) model and the Multi-Agency Risk Assessment Conference (MARAC). IDVA involvement with victims of domestic violence has been shown to decrease victimisation, increase notification of children at risk and reduce the number of victims unwilling to support a prosecution. Victims are more likely to participate in the criminal justice system if they are assisted by advocates.

The Isle of Wight Local Authority, via the Crime and Disorder Partnership, currently funds 18 hours a week for an Independent Domestic Abuse Advocate (IDVA) through the Refuge (15k). The Refuge has to apply for the funding year on year and there is no guarantee this will continue.

The Isle of Wight CDRP funds one 0.5. WTE IDVA post and worked with 260 victims. Southampton has 4 full time permanent IDVA posts and during the same period worked with 360 victims. To further contextualize IDVA provision on the island, Portsmouth has 9 such posts, and Hampshire has 2 posts however they are currently reviewing their provision for IDVA's to increase capacity in relation to demand.

7.10.11 Sanctuary Scheme

A multi-agency Sanctuary Scheme, coordinated by the Isle of Wight Council Housing Department and supported by Police, Fire, various council departments, registered social Landlords, Health and other key agencies was established in 2007/08, as part of the homelessness prevention strategy, in order to support victims of domestic abuse to remain in their homes. This working arrangement was funded through the Local Public Service Arrangement (LPSA) grant. Future funding has not been secured, and the project is running in the 2009/10 year without a financial plan or budget.

7.10.12 Operation Pemberton

Operation Pemberton was repeated during the Christmas and New Year period 2008/09, delivered through CDRP funding. This targeted campaign was originally delivered in 2007/08 in response to a Hampshire Constabulary force wide problem profile[14], and its aim was to improve responses to Domestic Abuse calls by providing a dedicated police response during peak times. The Operation ensured that Police patrols were briefed and equipped, and that the Prison, Interview and Intelligence Team (PIIT) was assisted in dealing with domestic abuse cases and that assistance was available to relocate victims and families in emergency cases. The operation also included radio interviews and raising awareness through the media.

7.10.13 Specialist Domestic Abuse Courts

The Island has implemented a Specialist Domestic Abuse Court in April 2009, following the establishment of a multi agency steering group, comprising Police, Courts, Crown Prosecution Service, Probation, Isle of Wight Council and other key agencies. Initial reports are encouraging with plans to apply for accreditation in the next round of applications and to measure impact in line with the Criminal Justice System Public Service Agreements of:

- Bring more perpetrators to justice
- Improve support, safety and satisfaction of victims
- Increase confidence in the CJS

7.10.14 Domestic Abuse detection training

The Refuge and the Child and Family Healthcare Services currently combine to provide training on the island. One example of good practice on the island is the Dog wardens undergoing training in the Common Assessment Framework. The links between animal abuse and domestic abuse, as well as child abuse, are well recorded and this innovation helps build on that research evidence to ensure risks can be identified.

7.10.15 Current Picture

Overall, there was a slight increase in Domestic Crime in 2008/09 compared with the previous year, rising by 3% to 639 offences. The two most frequently recorded domestic offences are common assault and Actual Bodily Harm offences. Common Assault reduced by 19% (43) to 176 offences in 2008/09 compared with 2007/08, whereas ABH offences increased by 14% (29) to 229 in the same period.

The proportion of Domestic Abuse offences which are Actual Bodily Harm Offences has been increasing, from 39% in 2007/08, to 45% in 2008/09, and in April and May 2009, the proportion of Domestic Abuse which inflicted ABH injuries was 55%[15].

There is inconsistency in the recording of domestic crime and incidents which is sometimes at variance with the ACPO definition of Domestic Abuse. Based on the figures available, domestic crime and incidents have fluctuated greatly over the last three years. Domestic crime rose 12% between the 2006/7 period and the 2007/8 period, followed by a reduction of 2% the following year. Domestic non-crime incidents increased 24% between the 2007/08 period and the following year[16]. Male victims account for 19% of all victims of domestic abuse.

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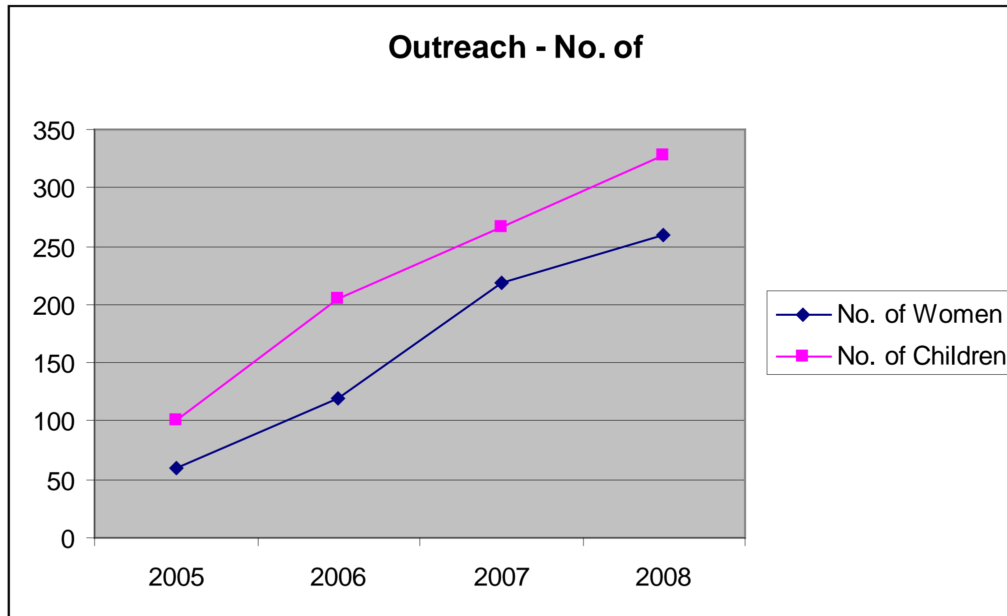
[14] Violence Offences During Christmas and New Year 2006/07, Force Intelligence Bureau

[15] Crime Pattern Analysis, Actual Bodily Harm Offences, Isle of Wight, Created: June 2009, Analyst: Rachel Brown

[16] Crime Pattern Analysis, Domestic Crime and Incidents on the Isle of Wight, Date of report: March 2009

In 2008 there were 4 domestic murders across Hampshire and the IOW. It is estimated that each murder costs in the region of one million pounds to services to bring the perpetrator to justice. This does not include costs for imprisonment.

7.10.16 Women's Refuge



260 Women and 328 children were referred to the outreach programme between January 08 - December 08. 58% of women were referred to the refuge by the Police, 13% of their own accord, 8% were referred by the local authority via Social Services /Housing with the remaining 21% by various other means.

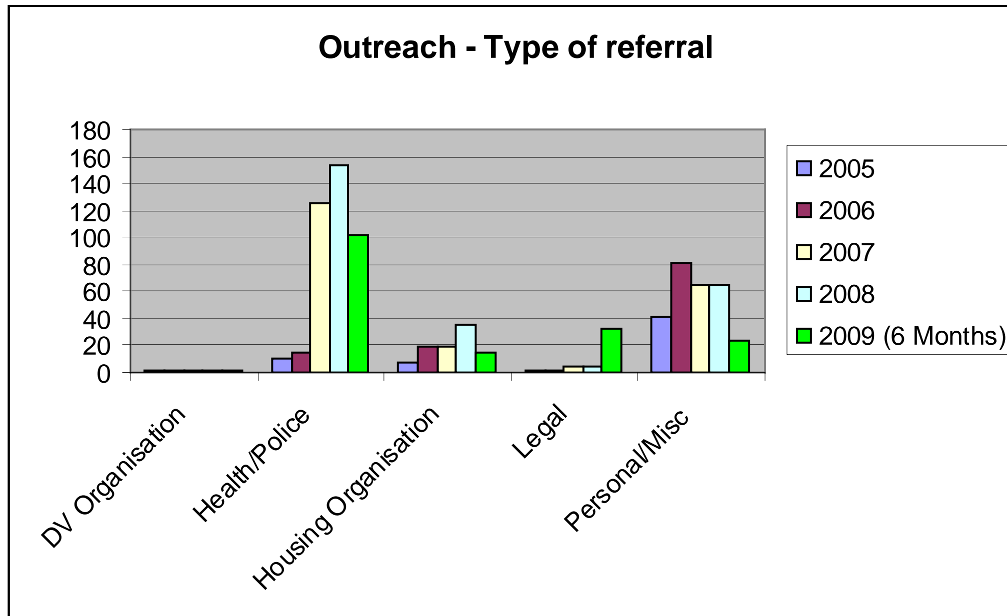
[17]Demand for refuge places remains fairly constant however the numbers of women being accommodated by the refuge has reduced due to the increased difficulties in accessing suitable accommodation for them to move on to. The emphasis is now on them finding private rented accommodation with the assistance of the rent deposit scheme. This presents difficulties for the following reasons:

- Landlords not prepared to accept housing benefit
- Finding one month rent in advance
- Credit checking creates link to address fled
- No guarantors or cash available for admin fees etc.

All too often now families remain in the refuge for much longer than necessary due to difficulties with move on. This of course denies access to the refuge to those in urgent need.

The increase in outreach cases in 2005-2006 reflects an increased capacity in our staff team. The outreach project started in 2002 with just one worker. This number has steadily increased and we now have 5.5fte outreach workers. Other increases are in all likelihood attributable to greater awareness of our services and the introduction of the police AD232 Risk assessment and the advent of the MARAC.

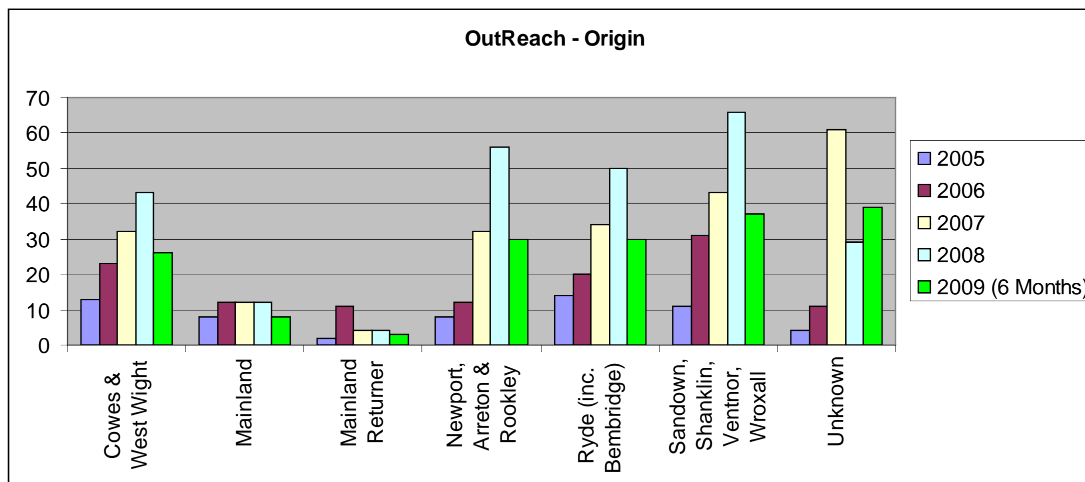
[17] Commentary via email from Fiona Gwinnet, Islands Women's Refuge Chief Executive Sept 2009



The figure for Self referrals almost doubled in 2005 – 2006 (7-15) and then dropped by around 66% in 2006 -2007 (15 – 5). This seems to reflect the fact that fewer women were accommodated overall, due to difficulties in accessing suitable move on accommodation.

Under Health/Police, Police referrals are showing an upward trend, this is with only 6 months worth of data, which points towards a likely rise again by the end of the year with figures higher than that on previous years. This could possibly be attributed to greater detection rates of Domestic Violence through a programme of awareness training. Very few referrals were made via Domestic Violence Organisations nor would many be expected. Referrals from other organisations are almost always related only to the need for Refuge accommodation, and are from organisations on the mainland assisting women in fleeing. The small number of outreach referrals are women signposted to local services by the national helpline.

Outreach was not required for 28% of women, support ended by mutual agreement for 13% of the women and 10% were unable to be contacted following referral with the remaining 20% split between other destinations.



25% of referrals came in from Sandown, Shanklin, Ventnor and Wroxall. 22% of referrals came in from Newport, Arreton and Rookley. 19% of referrals came in from Ryde (inc. Bembridge). 17% came from Cowes and West Wight with the remaining 17% split between Mainland and unknown addresses.

OutReach figures are showing an increase of around 10 new cases a year from the Cowes and West Wight area, 2009 figures are already showing to be over half on last years figure with a likely trend towards the end of year figure being higher than 2008. House Mainland cases are dropping year on year and this may be attributed to refuges closing all over the country due to changes in funding and a shift to emphasis on generic services. The steep increase in cases coming in from the Newport areas, Ryde areas, Sandown, Shanklin, Ventnor and Wroxall can be attributed to greater recording of origin and the significant drop in Unknowns (30) reflect this trend. There is a steady rise across all area's of the island with the only noticeable rise being in Unknown's in 2009 with only 6 months worth of data already performing higher than 2008. This can be attributed to overstretch of team combined with lack of geographical location on original referral.

29% of women referrals were aged between 26-40 years of age. 20% were over 40 and 18% were aged up to 25 years with the remaining 32% unknown.

Children being referred to the Womens Refuge ranged in age with 20% aged between 9-15, 19% were aged up to 4 years of age, 14% were aged between 4-8 years of age with the remaining 47% either being over 15 or unknown.

Where a health problem was attributed to a referral 8% were linked to Alcohol and a partner, 7% were attached to Depression, 5% were linked to mental health and another 5% were linked to Alcohol and self with the remaining split between a number of other problems.

7.10.17 Predictions for next period

The deteriorating economic climate has led to redundancy and financial instability for Isle of Wight families. There is a higher risk of domestic violence in lower income households[18], and it can be expected that the level of Domestic Abuse will continue to increase.

[18] Domestic Violence: Findings from a new British Crime Survey self-completion questionnaire, Catriona Mirrlees-Black

7.11 Carers

7.11.1 We have approximately 1200 open carers registered within Swift. We recognise the importance of carers in the delivery of services and their invaluable contribution to helping people to stay in their own homes. We have developed an action plan for carers that will lead to improved services and information for carers on the Island.

7.11.2 We have developed a Carers' Strategy, jointly with partners from the PCT, third sector and carers themselves. Following a carers' survey on the Island and in line with the national strategy, we have set key priorities for carers locally. The strategy will ensure the views and needs of carers remain the focus of future commissioning decisions. We will be developing personal budgets for carers and will be expanding direct and support services to carers eg: therapies and carers weekend.

7.12 General performance

7.12.1 We recognise that the performance for both the timeliness of assessments undertaken and delivery of care packages, alongside the reviewing of those packages is below that of comparator local authorities.

7.12.2 We are addressing this in a number of ways:

- Targeted management action from the Director and Head of service to ensure that all employees are aware of the necessity to ensure assessments and reviews of care are undertaken promptly to ensure services are delivered and maintained which are effective for the service user and keep pace with their needs.
- Additional training and workshop availability for staff to undertake case work with Swift trainers on hand to assist with recording problems.
- Management reporting to team and senior management highlighting areas for improvement and case loads that require attention.

NI 132: Timeliness of social care assessment (all adults) (%)			
Latest Actual Value	Previous Actual Value		
70.25	78.43		
National Minimum	National Maximum	National Average	Performance Against National Average (%)
51.11	97.73	79.38	-11.50
Regional Minimum	Regional Maximum	Regional Average	Performance Against Regional Average (%)
61.08	94.98	77.43	-9.27

Figure 7.12.1 : National Indicator 132 : Timeliness of social care assessment (all adults, f/y 2007-08) (Ref 07801)

NI 133: Timeliness of social care packages following assessment (%)			
Latest Actual Value	Previous Actual Value		
92.58	94.40		
National Minimum	National Maximum	National Average	Performance Against National Average (%)
77.78	99.60	90.93	1.81
Regional Minimum	Regional Maximum	Regional Average	Performance Against Regional Average (%)
83.03	97.98	91.16	1.56

NI 136: People supported to live independently through social services (all adults) (Number)			
Latest Actual Value	Previous Actual Value		
3228.82	3062.67		
National Minimum	National Maximum	National Average	Performance Against National Average (%)
1531.47	7148.81	3233.62	-0.15
Regional Minimum	Regional Maximum	Regional Average	Performance Against Regional Average (%)
2528.62	5468.18	3941.25	-18.08

Figure 7.12.2 (left) Timeliness of social care packages following assessment (%)(f/y 2007-08) (ref 07802) and (right) Figure 7.12.2 : National Indicator 136 : People supported to live independently through social services (f/y 2008-09) (Ref 07901)

NI 135: Carers receiving needs assessment or review and a specific carer's service or advice and information (%)			
Latest Actual Value	Previous Actual Value		
19.18	11.99		
National Minimum	National Maximum	National Average	Performance Against National Average (%)
5.74	64.19	21.32	-10.04
Regional Minimum	Regional Maximum	Regional Average	Performance Against Regional Average (%)
8.40	53.87	22.85	-16.05

Figure 7.12.3 National Indicator 135 : Carers receiving needs assessment or review and a specific carer's service or advice and information (%) (Ref 08001)

NI 130: Social Care clients receiving Self Directed Support per 100000 population (Number)			
Latest Actual Value	Previous Actual Value		
193.61	179.09		
National Minimum	National Maximum	National Average	Performance Against National Average (%)
65.80	1438.66	176.44	9.74
Regional Minimum	Regional Maximum	Regional Average	Performance Against Regional Average (%)
108.99	1438.66	242.10	-20.03

NI 124: People with a long-term condition supported to be independent and in control of their condition (%)			
Latest Actual Value	Previous Actual Value Not Available		
86.71			
National Minimum	National Maximum	National Average	Performance Against National Average (%)
58.14	86.71	74.48	16.41
Regional Minimum	Regional Maximum	Regional Average	Performance Against Regional Average (%)
69.75	86.71	78.59	10.33

Figure 7.7.4 : NI 130 : Social care clients receiving self directed support per 100000 population (ref 08101) (left) and Figure 7.7.4 (right) : NI 124 : People with a long-term condition supported to be independent and in control of their condition (%) (right) (Ref 09101)

8 Housing Need

8.1 Housing Services Overview

8.1.1 Changes in demographics and family composition reflect the need to provide housing choices to ensure the right mix of good quality, affordable housing across all tenures on the Isle of Wight. It is also a priority to ensure residents are able to access suitable housing according to need.and provide a good choice of accommodation that meets their changing needs, whether they rent or purchase.

8.1.2 Particular issues of need are related to tackling homelessness; ensuring housing supply; ensuring quality and decent standards; provision of adaptations enabling people to say in their homes; and provision of housing related support for vulnerable people to enable them to maintain their tenancies and independence. .

8.1.3 Particular client groups are :

- homeless people and people at risk of becoming homeless
- young people, including first time buyers
- people needing social rented housing
- people who want to part-own in shared ownership arrangements
- people who want to rent good quality, reasonably priced accommodation
- vulnerable or people who need care and support
- people who need affordable housing in rural areas
- people who need specialised or adapted housing:- including older persons, people with disabilities, Gypsies and Travelers

8.1.4 Housing and Community Support's aims fall into the following categories:

- Housing Needs:
  - tackle homelessness
  - improve the standard of temporary accommodation
  - provide a homeless hostel for those in crisis need
  - provide a rent deposit scheme to assist residents to access private rented accommodation
  - increase private rented accommodation and choice for other housing on the Island
  - offer people on the Island housing register realistic choices
- Supporting People
  - provide support services to enable people to sustain tenancies
- Housing Enabling
  - ensure the right mix of housing is delivered to fulfil identified need
  - ensure that all new houses built on the Island should contribute to affordable housing policies
  - assist first time buyers to access the housing market and provide affordable housing across all tenures
  - bring empty housing back into use
  - enable new affordable housing for rural areas on the Island
  - provide ' lifetime homes' which can be easily adapted as peoples needs change ,
  - work with developers to provide specialised housing for older and vulnerable residents
  - support the needs of large families on the Island

- Housing Renewal
    - enable older and vulnerable residents to stay in their own homes where applicable with providing Disabled Facilities Grants for adaptations.
    - supporting the provision of a Handyperson service
    - improve the standard of private rented accommodation
    - work to ensure that Houses of Multiple Occupation meet decent home and safety standards and are licensed where applicable.
    - provide Discretionary Repair Grants to remove hazards in private rented (and private owned housing for those who qualify)
    - work to ensure that grants for improved heating and insulation in private homes are provided to eligible applicants

8.2 Regional Context

8.2.1 The Isle of Wight is designated both a Priority Area for Economic Regeneration (PAER) and a Rural Priority Area within Regional Planning Guidance 9 (RGP9). We are also identified as one of nine priority regeneration areas in the SE Regional Economic Strategy (RES) and are listed as a sub-region within the RES Action Plan. These indicators of priority status are also reflected within the Regional Housing Strategy (RHS), reflecting the level of deprivation and social exclusion that exists on the Island.

8.2.2 In summary the Regional Housing Board's priorities for funding are:

- maintaining a strong focus on the delivery of affordable housing
- maintaining a commitment to providing funding for improvements to ensure Decent Homes
- maintaining focus on investment in urban areas
- emphasis on providing the right type of housing
- support for programmes that assist key workers
- investment in pump priming innovative delivery mechanisms, such as Brownfield Land Assembly Trust, to unlock housing potential
- to maintain a commitment to invest in accommodation for Gypsies and Travellers

8.2.3 For more details on the Regional Housing Strategy and priorities please see the following web link : www.southeast-ra.gov.uk/rhb

8.3 Island Housing Needs - new housing provision options

8.3.1 Between September 2006 and June 2007 the Isle of Wight Council commissioned research to find out the level of need for housing and affordable housing on the Isle of Wight. This research was used to compare provision against need and identified a very high need for housing to be delivered over the next five years with a demand of 1595 extra housing units per year.

8.3.2 Regional targets are for the island to provide 520 units per year of which at least 180 should be affordable housing units. This figure includes new-build, conversions of existing property and also bringing existing long term empty properties back into use.

The following sections show the headline demands for housing on the Island identified in the 2006 Housing Needs Survey (HNS):

Island Housing Stock

Household Sizes	% of total	Current provision	Actual need	Need in 5 years
1 bed	15%	9600	9773	10457
2 beds	37%	24320	26728	28598
3 beds	41%	26240	28549	30551
4 beds	5%	3200	3296	3526
4+ beds	2%	1280	1331	2262

(Actual need HNS2006. 5yr need 13% new households in-migration every 10 years (Housing Market Assessment 2006)

Figure 8.3.1: Current Stock and Projections

Social Rented Housing

Household Sizes	% of total	Current provision	Actual need*	Need in 5yrs*
1 bed	33%	2152	3698	4728
2 beds	32%	2097	3742	4786
3 beds	32%	2075	3719	4757
4 beds	3%	109	250	307
4+ beds	0.04%	5	36	46

**Actual need: Number of people currently in social rented housing plus the total on the register less the proportion of those on the register who already live in social rented housing.*
**Need in five years: Newly forming households times the number of HNS respondents who indicated a wish for moving into social rented housing plus actual need*

Figure 8.3.2: Social Rented Housing, Current Stock and Projections

Homebuy - Shared Ownership (SO) & Low Cost Starter homes (LCHO)

Current provision	Actual number wanting SO or LCHO
117	3,007

12% of total HNS respondents indicated wish for shared ownership or low cost housing. 80% of new first time buyers cannot afford to buy.
The Gross annual income of £48,242 needed for a 95% mortgage (average wage £17464) this makes a house price to income ratio of 10.2 needed to purchase at the average IOW price of £177,735 (lower quartile average £121,875)
Source National housing federation SE Housing Time bomb Sept 06
Average wage: ASHE 2005

Figure 8.3.3: Low cost or Shared Ownership homes, Current Stock and Projections

Market Rented Housing

Household Sizes	% of total	Current provision	Actual need	Need in 5ys
1 bed	33	1838	2003	2143
2 beds	32	2477	2600	2782
3 beds	32	1191	1212	1297
4 beds plus	3	445	445	476

Actual need HNS2006:- no respondents indicated a need. 5yr worked out need taking into consideration new households in-migration 7%

Figure 8.3.4: Market Registered Housing, Current Stock and Projections

Intermediate Rented Housing

Household Sizes	Current provision	Actual need	Need in 5ys
1 bed	0	67	70
2 beds	0	66	69
3 beds	0	66	69
4 beds plus	0	-	-

Actual need HNS2006:- number of respondents indicated a want to rent but cannot afford, as proportion of available rented housing

Figure 8.3.5: Intermediate Rented Housing, Current Stock and Projections

Older Persons Sheltered and Extra Care

Type of provision	Current provision	Actual need	Need in 5 years
Sheltered housing (Housing Associations and other providers)	882	1430	1575
Extra Care Sheltered	24	33	160
Private leasehold	282	284	884

Research undertaken by Housing Services in 2007 into need for sheltered housing, this was mapped against future household growth

Figure 8.3.6: Older Persons Sheltered and Extra Care, Current Stock and Projections

8.4 Housing Enabling

8.4.1 Housing Enabling ensures that policies are developed to ensure delivery of the right type and size of housing to meet local need. This includes:

1. Setting the strategic direction for delivering a balanced housing market including all tenure types
2. Enabling the provision of all forms of housing, including affordable housing and housing for vulnerable groups,
3. Liaising with Registered Providers and developers of market housing to deliver quality housing .
4. Ensuring that new housing projects provide the right mix of housing including on- site affordable housing in new developments where appropriate, or , if , not negotiating the mount payable by developers for the provision of affordable housing elsewhere (S106 payments)
5. distributing housing capital grants to social housing providers .
6. Undertaking housing needs and housing condition assessments
7. Undertaking development viability assessments
8. Enabling the provision of rural affordable housing
9. Dealing with Empty Properties to support economic and social regeneration
10. Trying to deliver enough housing on the Island to meet social and demographic challenges.

8.4.3 The current local area agreement target is to deliver a three year target (up to March 2011) of 548 affordable housing units. Housing Services is an enabler of this target which is delivered through negotiation with external providers to bring forward development on the Island.

8.4.4 In addition to the delivery of general needs, affordable housing the section is also responsible for ensuring that delivery is maintained on services for vulnerable groups, such as older people, those with learning disabilities, mental health issues, rough sleepers and provision for gypsies and travellers.

8.5 Gypsies and Travellers

8.5.1 Gypsies and Travellers are at a greater risk of homelessness that the rest of the population and less likely to be well linked into available health and education services.

8.5.2 The July 2005 Caravan Count found only two unauthorised encampments on the Island, with the previous two counts identifying none. However, Local staff and community representatives suggest that this is inaccurate and that there could be over 80 households living in encampments on the Island.

8.5.3 There is currently no provision at all on the island for Gypsies and Travellers. Under the terms of Section 225 of the Housing Act 2004 a Statutory Duty was placed on all Local Authorities to undertake an assessment of the Housing Needs of Gypsies, Travellers and Travelling Showpersons. (GTAA). This was carried out in 2007 and identified a need for at least an additional 24 new authorised site pitches to be made available between 2006 – 2011 to deal with the backlog of demand existing on the Isle of Wight. This provision figure was amended to a requirement for 27 pitches under the requirements of the South East Plan (which has deadline of 2016 for the delivery of pitches).

8.6 Homelessness and Housing Options

8.6.1 The Housing Act 1996 consolidated various pieces of homelessness legislation. In summary, it places a duty on local authorities to provide housing to those people who are homeless through no fault of their own and who are considered by the local authority to be in a priority need category as defined by legislation. Those in priority need include families with dependent children or whose household includes a pregnant woman and people who are vulnerable due to illness, disability or other special reasons. The main duty is to take reasonable steps to prevent the loss of existing accommodation and to secure new accommodation if this is not possible. If the applicant is not in priority need or is homeless intentionally; the duty is restricted solely to the provision of advice and assistance.

8.6.2 The Homelessness Act 2002 made some significant amendments. In particular it extended the priority need categories to include all 16 and 17 year olds, 18-21 year olds who are leaving local authority care, people who are considered vulnerable as a result of abuse or threats of abuse, or as a result of spending time in the armed forces, serving a prison sentence or who have a care background. Allied to the above is the Children (Leaving Care) Act 2000. This placed a new duty on Social Service departments, particularly with regard to what were described as "eligible" or "relevant" children (children who are 16 or 17 years old and are either currently being looked after by the local authority or who have left care) and former "relevant" children (those aged 18 – 21 who have left care). The duties include the provision of accommodation and financial support for care leavers until they are 18 and the provision of help and support for all care leavers until they are at least 21.

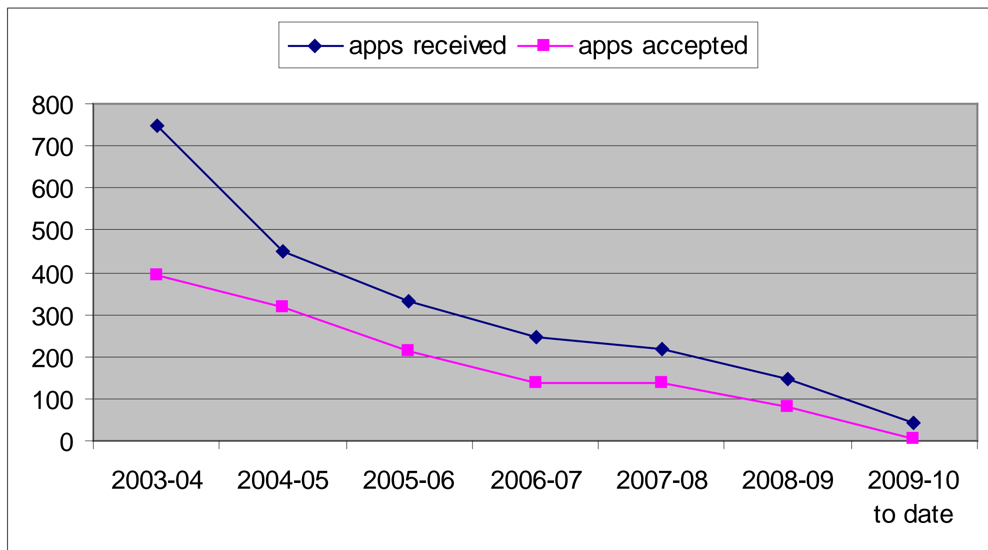


Figure 8.6.1: Homelessness Applications, received and accepted.

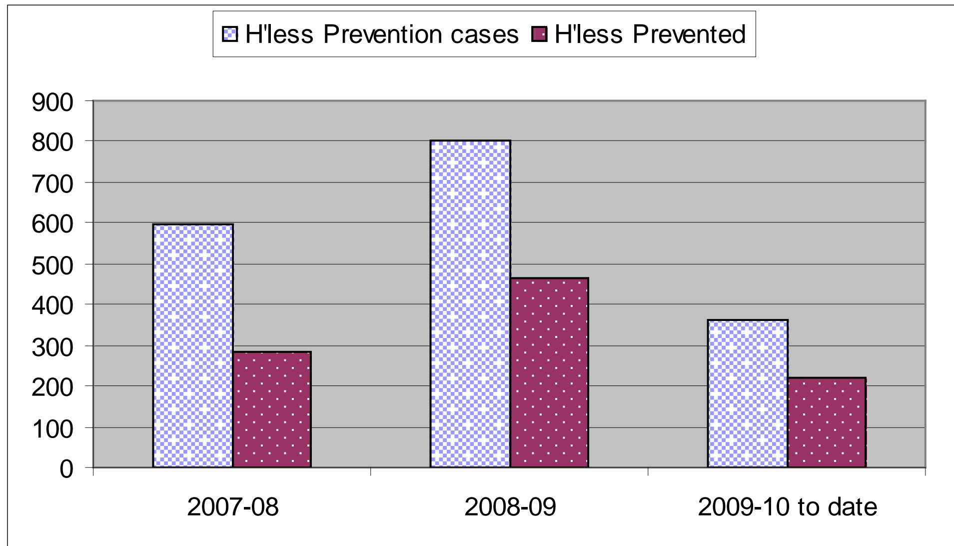


Figure 8.6.2: Homelessness prevention

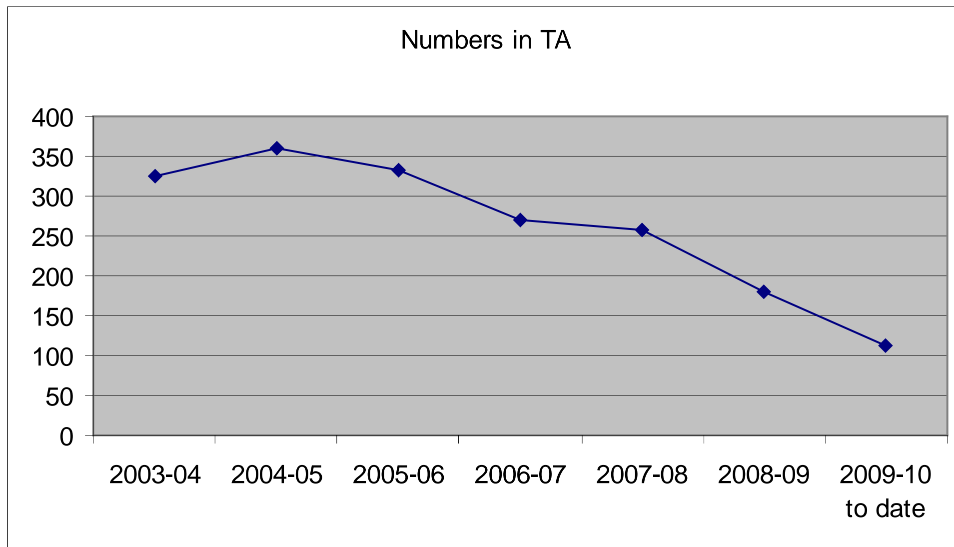


Figure 8.6.3: Households in temporary accommodation

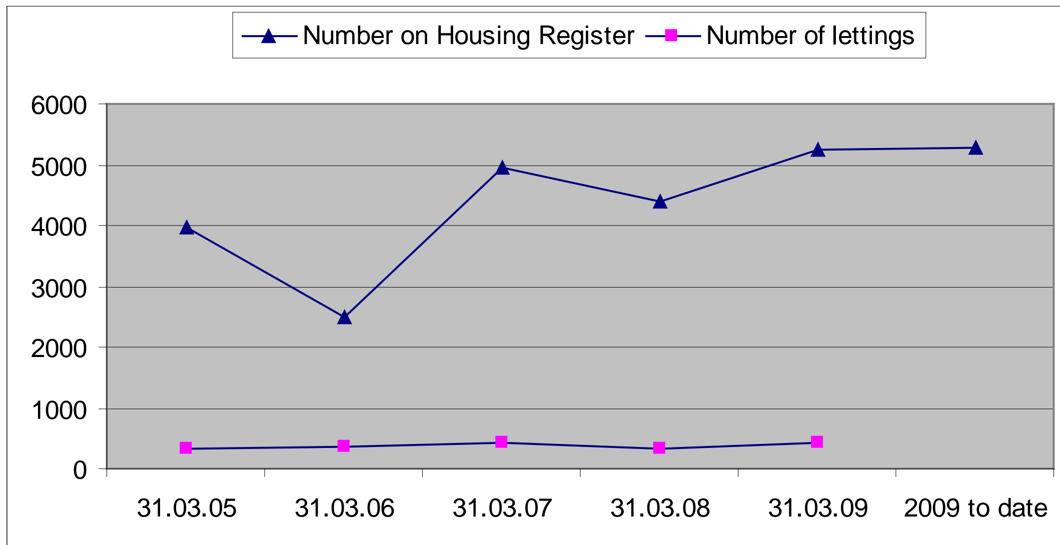


Figure 8.6.4: Movement on and off of the Housing Register

8.6.3 During the last five years, the number of households registered with the local authority for housing has risen significantly. This could be attributed to the fact that the average house price on the Isle of Wight has risen by just over 30% during the same period.

8.6.4 In 2003, the Isle of Wight Council and its partner Registered Providers (RP), formed the common housing register with a target of 80% of lettings to be made from the register, the remainder being used for existing RP tenants wishing to transfer to another property. Over the past five years, average lettings from the common housing register have remained stable at around 345 per year, however, in 2007/08 the number of lettings dropped slightly.

8.6.5 It is not possible to show whether people on the housing register are in urgent housing need or are currently living in unsuitable, overcrowded or temporary accommodation; as anyone can register on the list for social rented accommodation. Many people register wishing to move to an area of their choice where they currently cannot access affordable housing (especially in rural areas). In practice, social rented housing is offered to those in most housing need with the most 'points' (points being allocated according to the need).

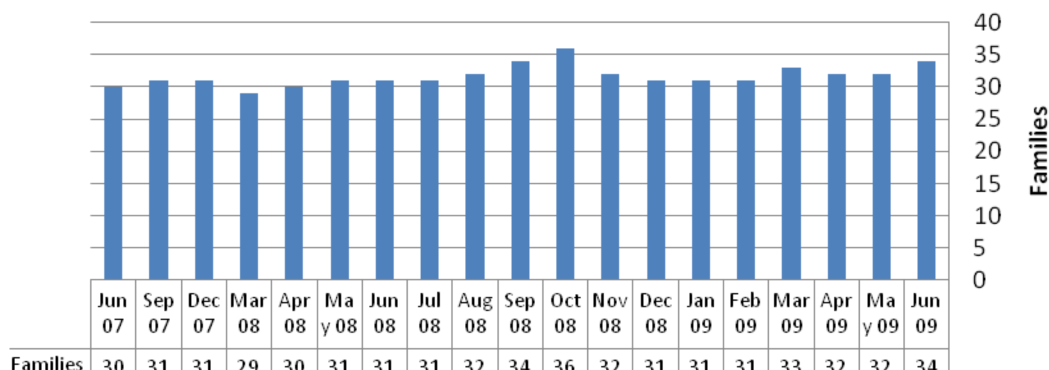


Figure 8.6.5: Large Families on the Housing register

8.6.6 The situation is the same for the relatively few large families on the register requiring housing of 4 bedrooms or over. The reason for the demand is that of supply as fewer social units of 4+ beds are built than of smaller units (these being in greater demand).

8.6.7 The low turnaround of lets through the common housing register and the seasonal nature of the private rented sector have impacted on the homeless service. Many households are unable to access the accommodation they desire and therefore see homelessness as a shortcut into more settled long term accommodation. The recent economic downturn has mitigated the problem slightly as more private rented accommodation has become available and this has enabled more success in homeless prevention and options work. This has reduced both the homelessness figures and those in temporary accommodation coupled with introduction of a ‘Find a home scheme’, and the introduction of a rent deposit scheme.

8.6.8 It is believed that the current operation of the register does not provide applicants with the choice that is expected from allocation policies today. By moving to a ‘choice based’ lettings scheme, the register will become more open, transparent and empower applicants to take more control over their housing options.

8.7 Housing Renewal

8.7.1 Enforcement of housing conditions is a fundamental requirement in achieving the government’s Decent Home standard. Combined with assistance, much work is still needed to reach this challenging target for the Island residents. We use a variety of statutory instruments to assess conditions and undertake enforcement action; typically the Housing Acts 2004 and 1985, and the Environmental Protection Act 1990.

8.7.2 The Housing Act 2004 completely changed the way housing enforcement is undertaken. Until June 2006 the dwelling ‘condition’ factors for the decent home standard were based around ‘unfitness’. The updated document “A Decent Home: The definition and guidance for implementation: June 2006 Update” reviewed progress made and restated targets, but also clarified various issues. These issues included a significant change in the way non decent homes were measured; i.e. the replacement of the Fitness Standard by the Housing Health and Safety Rating System (HHSRS) as the means of assessing minimum standards of housing. This is one of the four components of the Decent Homes Standard. This was an important change, as nationally around 900,000 dwellings failed the fitness standard at the end of 2006 whereas 4.8

million contained a Category 1 Hazard under the Rating system,. The most common Category 1 hazard was excess cold which contributed towards over 20,000 excess winter deaths per annum[19]. The impact of this change was greater in the private sector than the social sector due to the Category 1 hazards of excess cold and falls being more prevalent in the older private sector stock.

8.7.3 At the national level, the updated definition of decent homes incorporating the Rating system results in 57% of vulnerable households being decent in 2006 (compared to 68% using the previous definition incorporating the fitness standard)[20].

8.7.4 Housing stock that would fail the Decent Homes standard if it was shown to be deficient in the first **four** areas identified below in the Category 1 Rating System Hazards

- Inadequate thermal comfort
- Disrepair
- Non modern facilities and services
- Vulnerable households[21] in decent homes
- Vulnerable households in non decent homes
- Dwellings with a SAP less than 35[22]
- Fuel poverty

8.7.5 HHSRS can assess the risk of up to 29 different hazards in and around the home. Failures under the HHSRS can result in enforcement action and If significant hazards that are discovered the Authority has a duty on to take action.

8.7.6 The Authority receives requests for adaptations and regarding housing condition problems from many sources; such as vulnerable tenants, occupational health workers, social services , Council members, owner-occupiers, concerned members of the public, police and fire officers.

Enquiries over the years have increased dramatically as seen in the graph below.

[19] Excess winter deaths in England for 2001/2002 were 25,790. The lowest figure since 2001 was for 2003/4 at 21,930 and the highest was in 2004/5 at 29,740. The most recent figures for 2005/6 are 24,200. The often quoted 40,000 per annum figure was exceeded in 1996/7 (44,850), 1988/9 (44,010) and 1999/2000 (45,650). *Excess winter deaths* by age group, Government Office Region and country of usual residence, England and Wales, 1991/1992-2004/2005 and 2005/2006***
http://www.statistics.gov.uk/StatBase/ssdataset.asp?vlnk=7089&More=Y

[20] English House Condition Survey 2006 Headline Report: Decent homes and Decent places. CLG 2008
http://www.communities.gov.uk/publications/housing/2006headlinereport

[21] Vulnerable household is where someone receives at least one means-tested benefit

[22] SAP is the UK Government's standard methodology for home energy cost ratings. SAP ratings allow comparisons of energy efficiency to be made, and can show the likely improvements to a dwelling in terms of energy use.

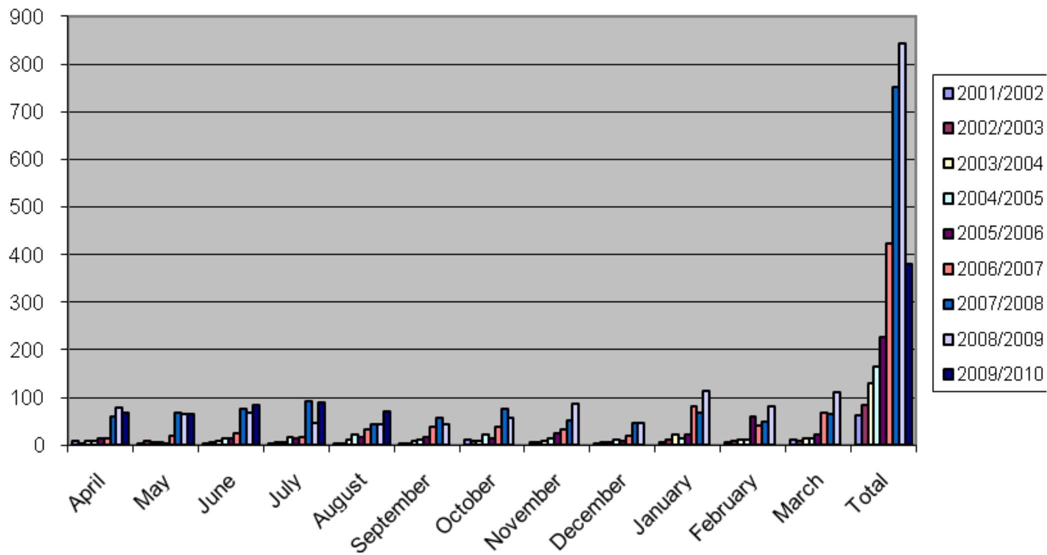


Figure 8.7.1: Housing Complaints

8.7.8 Houses in Multiple Occupation (HMO) are commonly thought just to be hostels, or bedsit type accommodation, however, the Housing Act 2004 brought a variety of other premises within the definition, including shared houses, some converted buildings and a variety of blocks of self-contained flats. It estimated the Island has up to 369 HMO's.

8.8.9 HMO's are of particular significance because it is much more likely that occupants will be seriously injured by fire, and suffer increased risks from the sharing of amenities and poor management of the premises.

8.8.10 Drainage nuisance enforcement; Drains or sewers require maintenance at some point, and when the people responsible fail to undertake this a nuisance often occurs. The resolution of these matters falls upon the Housing Renewal section. Historically the control and enforcement of adequate sanitation (together with clean water) has had the most significant public health impact on morbidity and mortality of any measure.

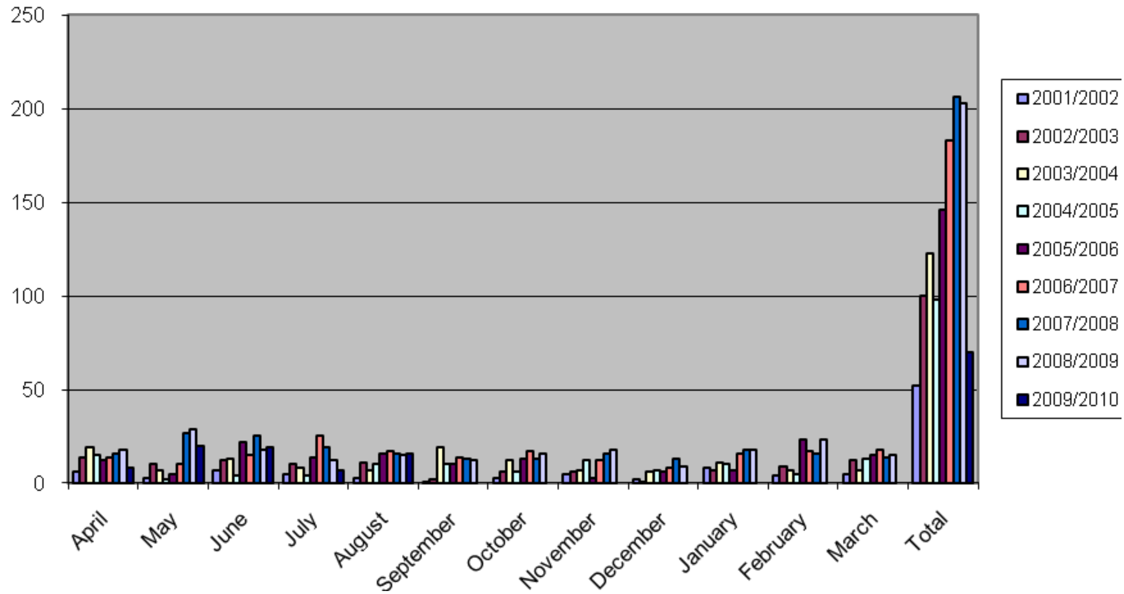


Figure 8.8.2: Drainage Complaints

8.8.11 Mandatory Disabled Facilities Grants; this function is part of the wider government agenda to assist elderly and disabled people to live satisfactorily within their own homes. Adaptations for people come in many forms, and it is the major adaptations that fall under the Housing Renewal Section's responsibilities. Typically we receive 16 new referrals a month, and the demand for resources outstrips the finance available. The types of work undertaken assist disabled applicants with bathing and W/C's, access in and around the home, cooking facilities, health and safety of the disabled occupant, provision of/or access to a bedroom and a variety of fixed lifting equipment.

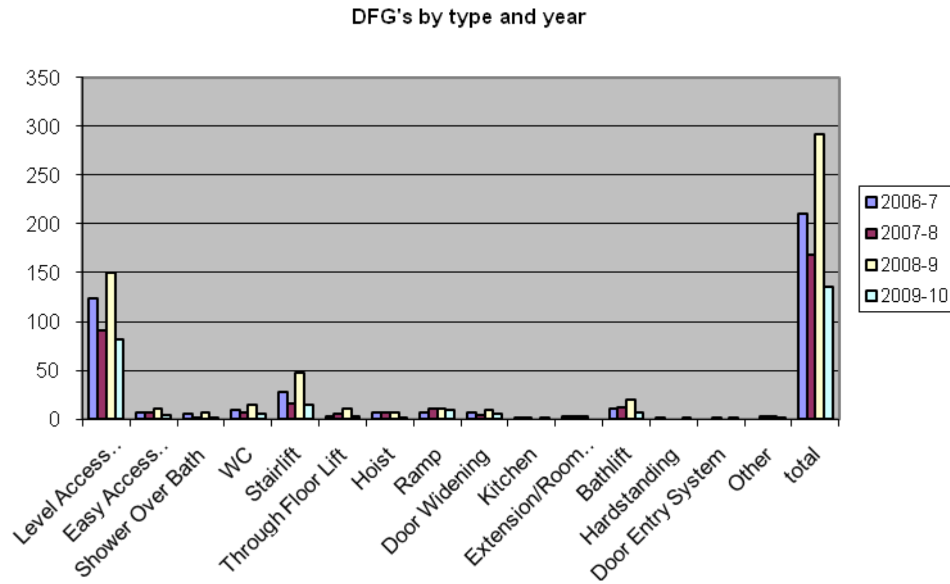


Figure 8.8.3: Disabled Facilities Grants:

8.8.12 Discretionary Repair Grants are for private sector owners and landlords of vulnerable people, and a general option for disabled adaptations assistance for any applicant with an interest in the property concerned. Notwithstanding the disabled assistance element, the main reason for grant assistance is to resolve serious hazards that are present, and to make homes decent to live in, assisting in the strategy of the Housing Section.t he majority of customers are vulnerable people,

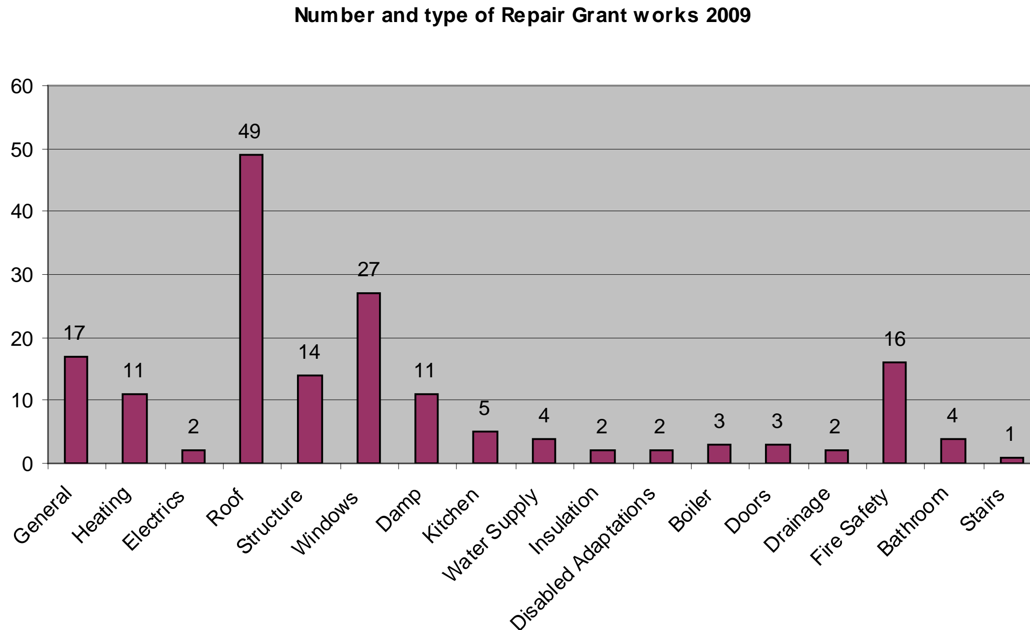


Figure 8.8.4: Discretionary Repair Grants

8.9 Stock condition survey

8.9.1 Social rented housing is regulated in terms of standards, and by far the largest majority of houses that would fail the decent homes standard are in the private sector. The island has a large proportion of private housing and, combined with the lower than average income rates seem for Island residents represents therefore a potentially high level of poor house condition

8.9.2 Typically levels of failure in private sector homes would be measured by commissioning a stock condition survey (SCS) in which several thousand homes would be canvassed to ascertain levels of repairs and thermal efficiency. The drawback with this approach is cost, and al reluctance by private owners to supply the information, resulting in poor response rate and accuracy. The Building Research Establishment (BRE) has developed a stock modelling tool to estimate levels of house condition, combining local and national data.

8.9.3 Therefore in 2008 the Isle of Wight council commissioned BRE to carry out a modelling exercise to provides estimates of local private sector housing conditions within the Isle of Wight and build on the previous 2002 SCS.

8.9.4 Results were mapped to show ‘hot spots’ of need. This enables resources to be targeted more accurately.

Figure 8.9.1: Non decent homes by Ward 2008

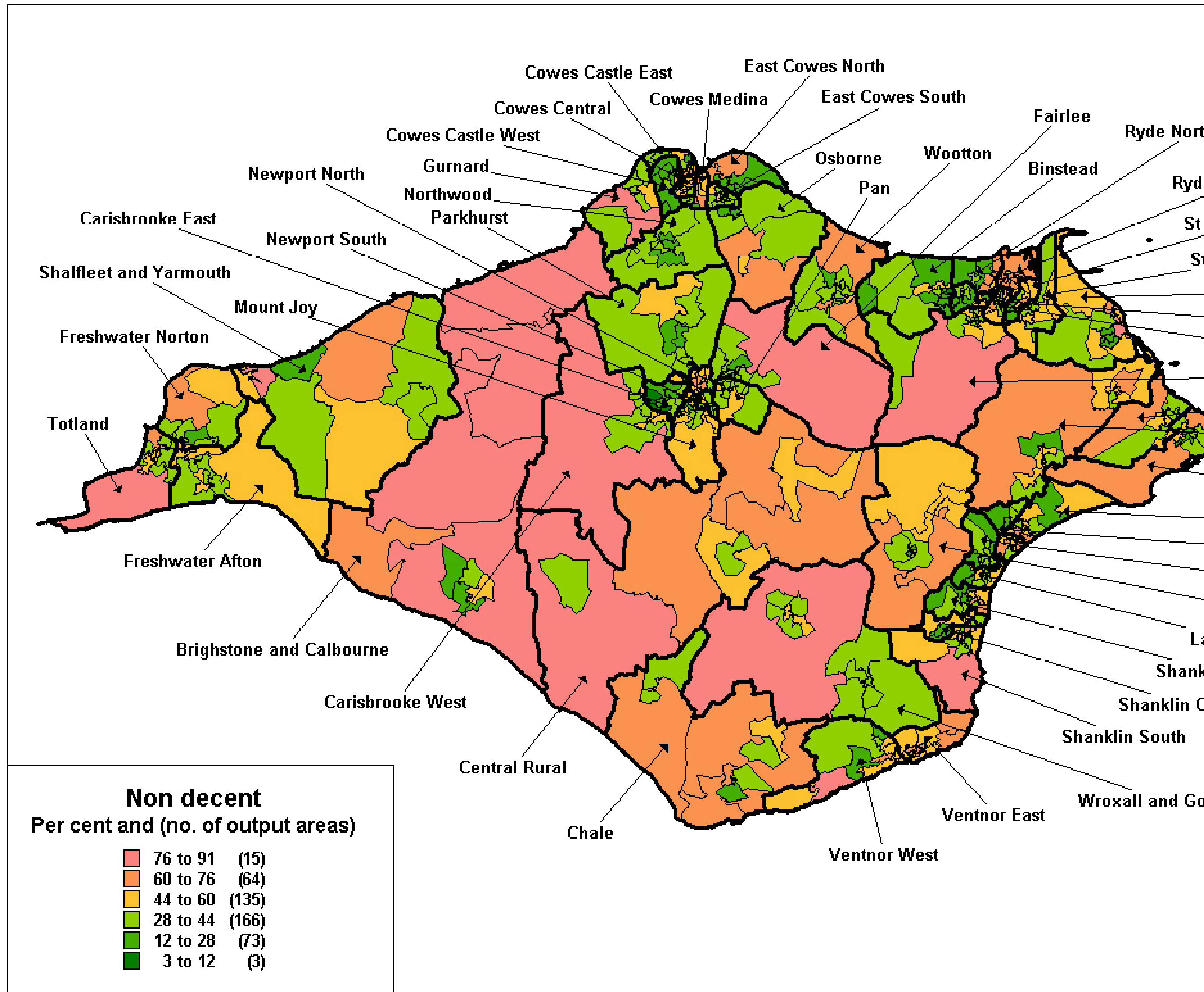


Figure 8.9.2: Percentage of private sector dwellings failing the Decent Homes standard due to inadequate thermal comfort

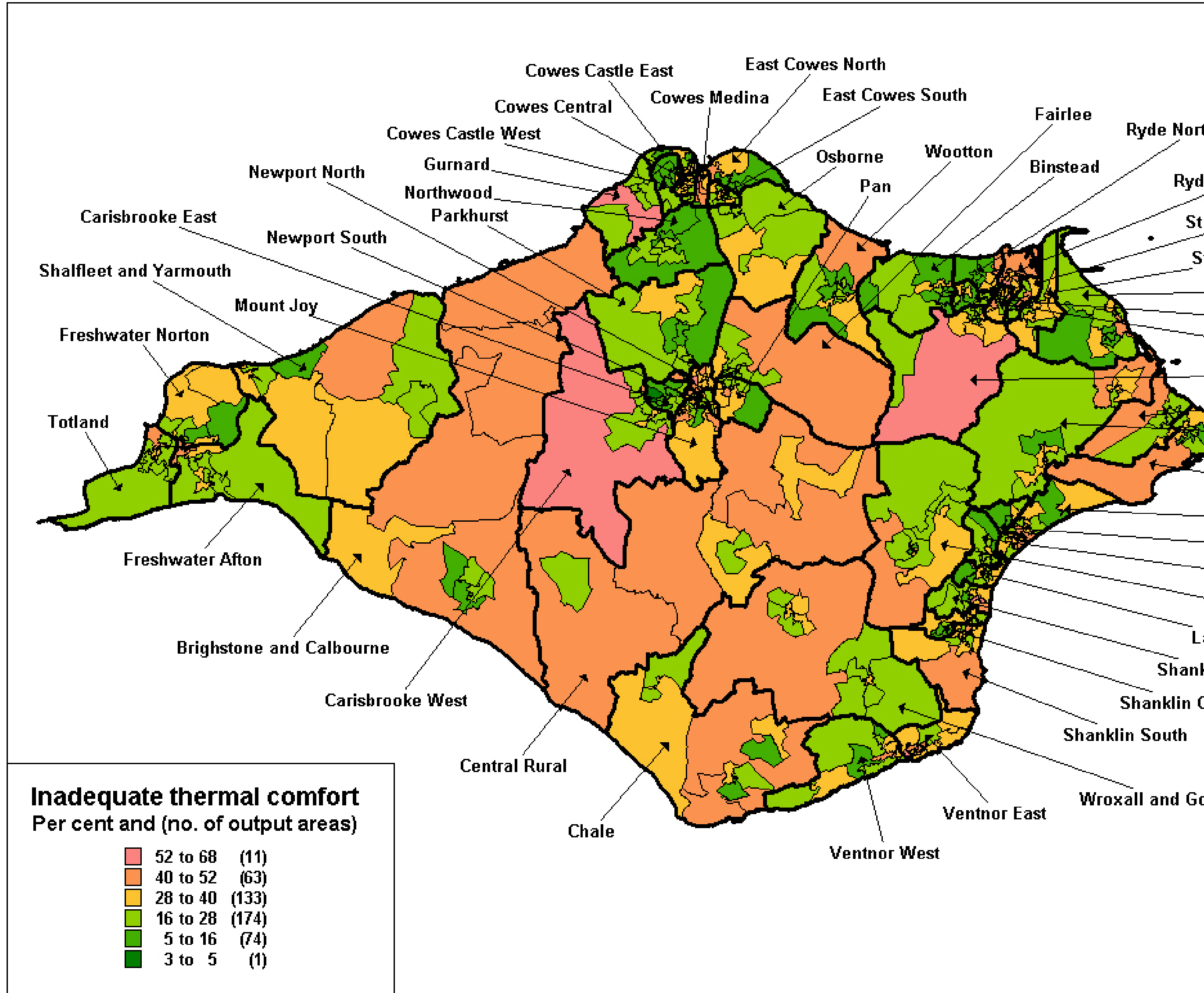


Figure 8.9.3: % of private sector dwellings failing the Decent Homes standard due to the presence of a Category 1 Rating System Hazard

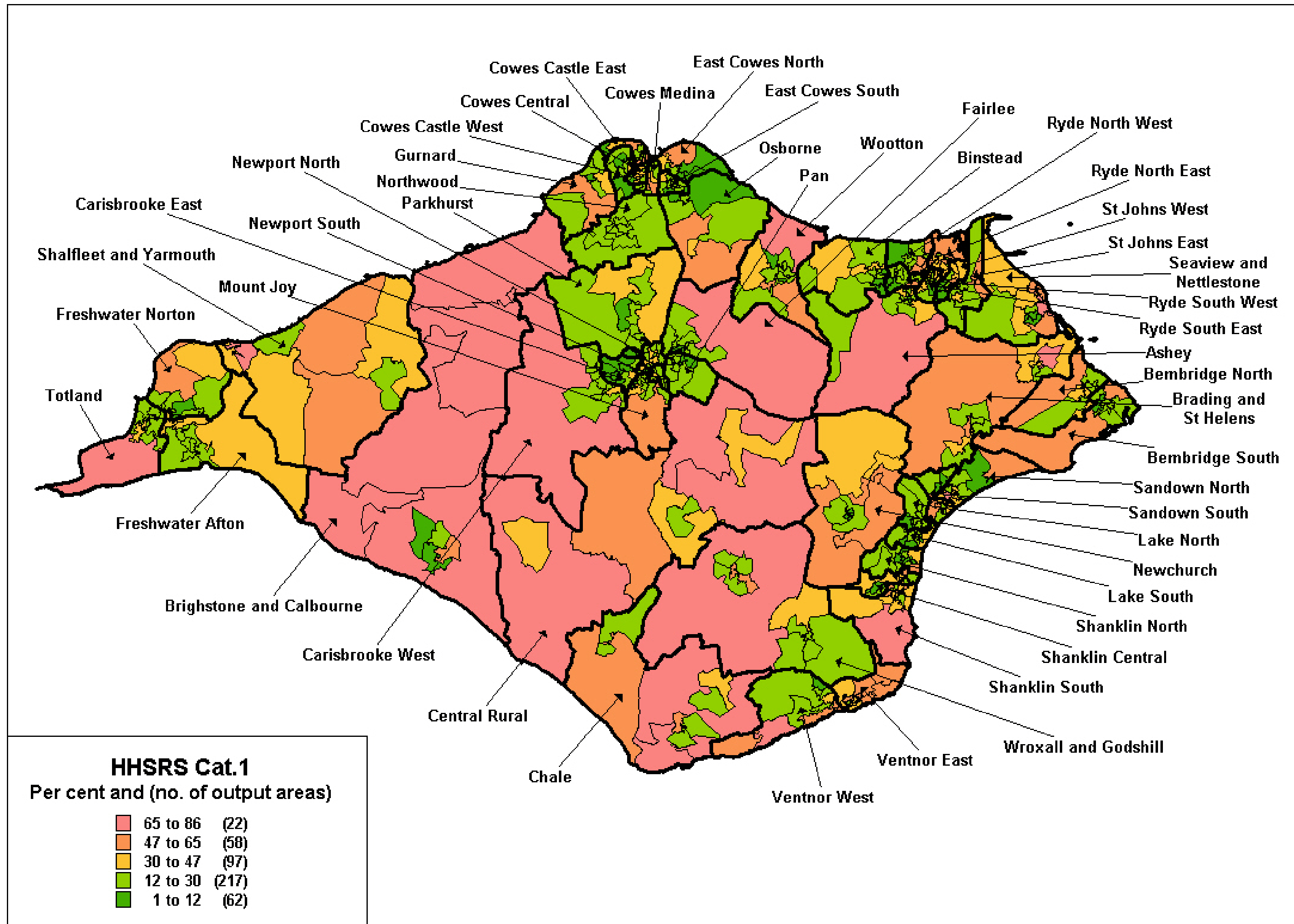


Figure 8.9.4: % of private sector dwellings failing the Decent Homes standard due to disrepair

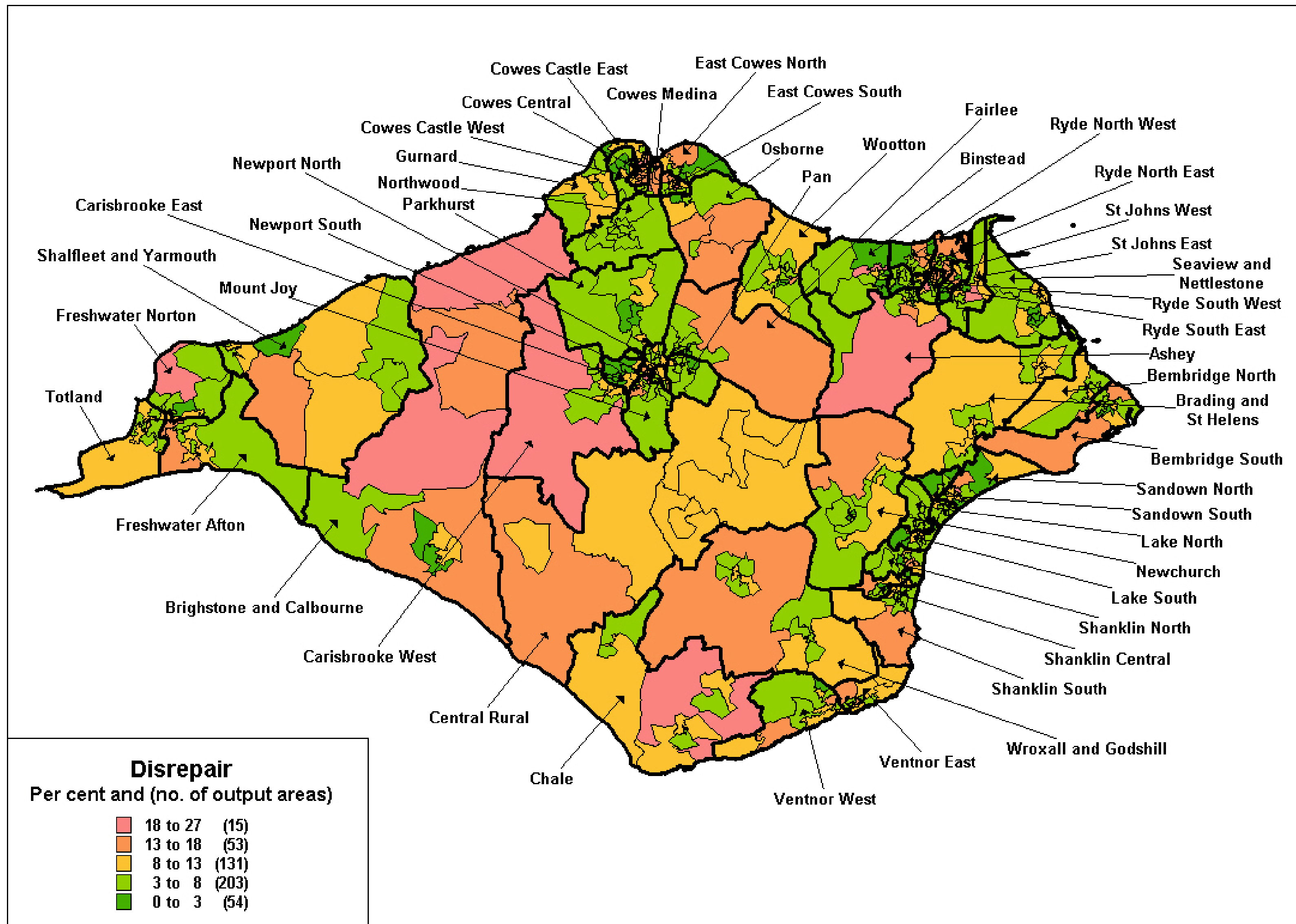


Figure 8.9.5: Percentage of private sector vulnerable households

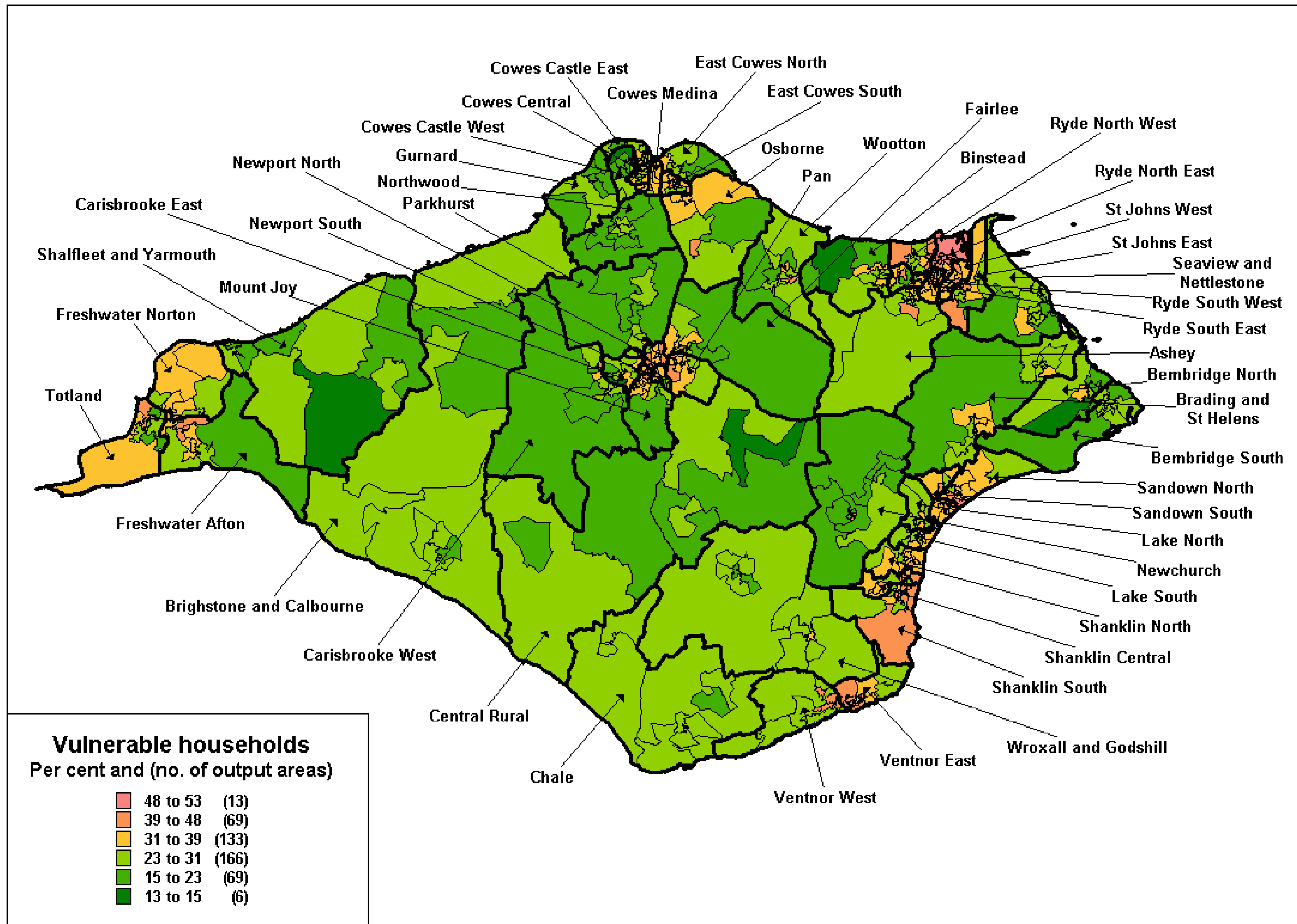


Figure 8.9.6: Percentage of private sector dwellings failing the Decent Homes standard due to non modern facilities and services

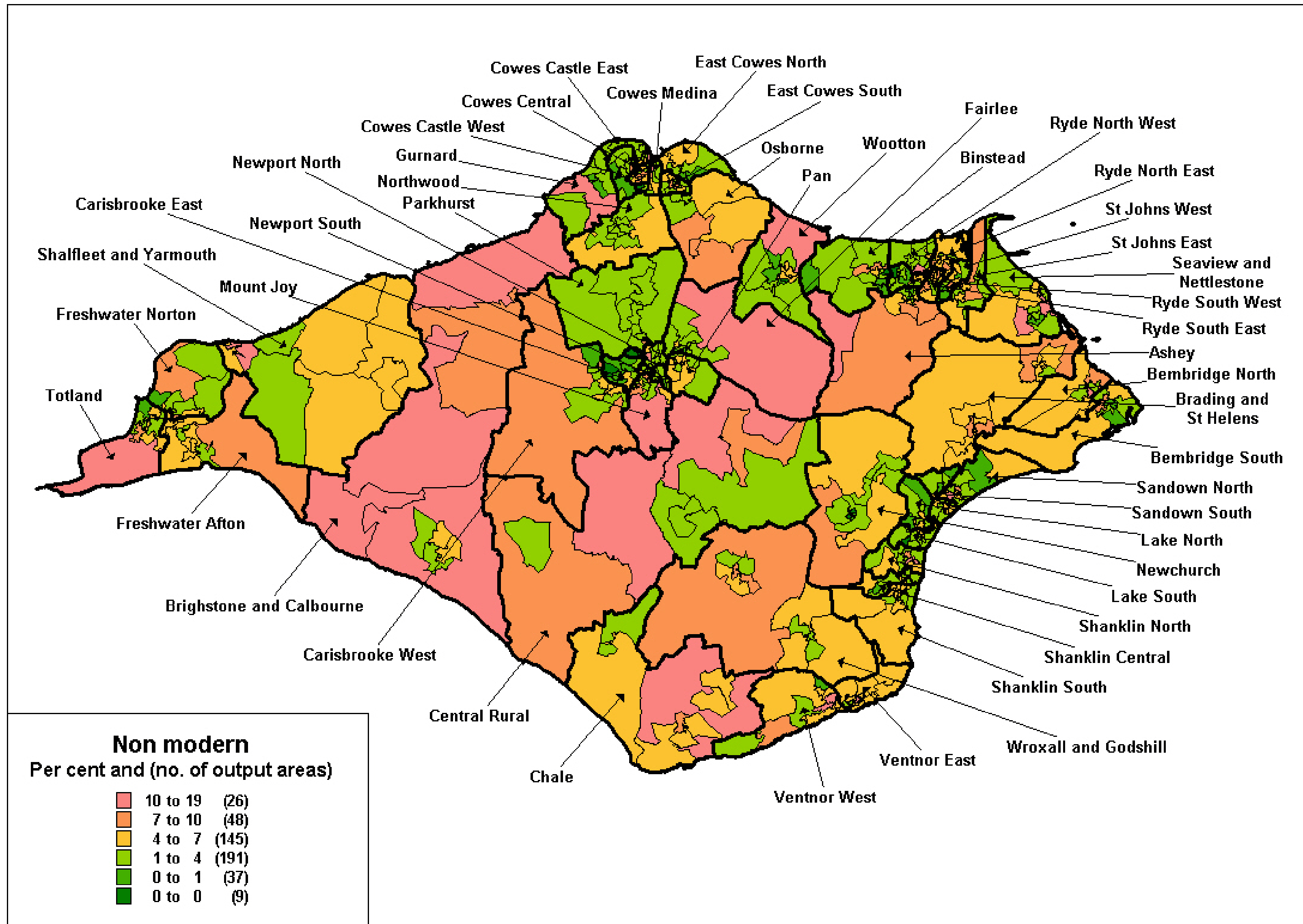
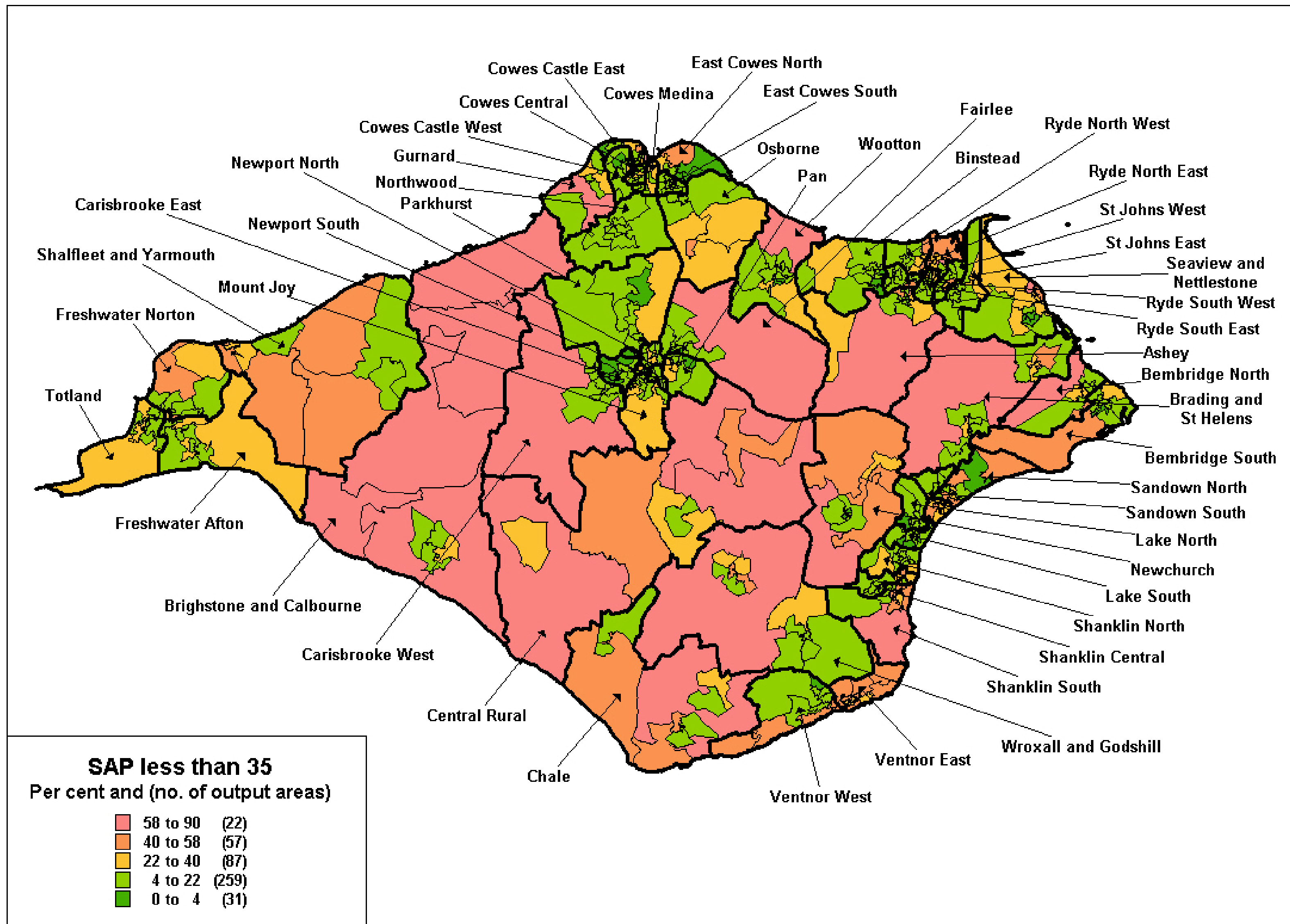


Figure 8.9.7: Percentage of private sector dwellings with a SAP rating less than 35



8.10 Supporting People

8.10.1 The Supporting People programme was introduced on 1 April 2003, with the aim of providing housing related support to a range of vulnerable people, in order to improve their quality of life and support them to live independently. Supporting People currently funds housing-related support services to around 1.2 million vulnerable people across the country to enable them to live more independently in the community and to provide them a better quality of life.

8.10.2 The programme is tailored to local needs and includes housing-related support to prevent problems that can lead to hospitalisation, institutional care or homelessness. It also can help to protect tenancies and aims to assist the transition to independent living for those leaving an institutionalised environment.

8.10.3 In 2007 the Department of Communities and Local Government (CLG) published 'Independence and Opportunity' its national strategy for Supporting People. In the strategy the Government states that it 'is committed to making sure that every citizen has the opportunity to live a fulfilled, active and independent life'.

8.10.4 The Isle of Wight Council is the administering authority for Supporting People on the Island. The programme is administered by the Supporting People team who are employees of the Isle of Wight Council.

8.10.5 The Commissioning Body comprises of representatives from the Primary Care Trust, Hampshire and Isle of Wight Probation and the Isle of Wight Council. The three partners have an equal vote.

8.10.6 Currently, 1,819 people receive housing –related support services . The support itself is predominantly either accommodation-based such as homeless hostels or floating support which is available to people in their own homes. Currently, the programme funds services for the following groups:

- people with alcohol problems/substance misuse
- women at risk of domestic abuse
- homeless families
- people with learning disabilities
- people with mental health problems
- ex offenders or people at risk of offending
- older people with support needs or mental health problems
- people with physical or sensory disabilities
- homeless single people with support needs
- teenage parents with support needs
- young people who are at risk, have support needs or who are leaving care

8.10.7 It is important that vulnerable people receive help and support to live independently. The Supporting People programme contributes to this by ensuring that individuals;

- Have the life skills they need to live independently
- Are given support in gaining and maintaining settled accommodation
- Are given help to identify training and job opportunities
- Are able to access necessary utility services
- Are given the help they need to ensure that their existing accommodation continues to meet their accessibility and/or safety needs

8.10.8 During 2008 there were a number of national decisions, which affect the programme locally. At the start of year the Communities and Local Government Department (CLG) announced the Supporting People Distribution Formula, which will result, for the next six years, in

a 5% year on year reduction in the programme grant to the Island. In November 2008, the CLG announced the future arrangements for the grant conditions and removal of the grant ring-fence This is likely to have a significant impact on the delivery of the programme locally.

8.10.9 There will be opportunities created for some of the clients and services via personalisation and self directed support. There is therefore a need to work on the personalisation agenda with all stakeholders to ensure commissioning plans don't restrict choices for clients in the future.

Supporting People Clients, by Type of Client, by Service Type

	Accommodation based Service	Accommodation based with floating support	Floating support	Total Clients
Offenders or People at risk of Offending			22	22
People with a Physical or Sensory Disability	10		56	66
People with Alcohol Problems	16			16
People with Drug Problems	3		64	67
People with Learning Disabilities	27	4	65	96
People with Mental Health Problems	112	4	263	322
Single Homeless with Support Needs	23	22	146	191
Women at Risk of Domestic Violence		1	63	64
Homeless Families with Support Needs	2	22	60	84
Teenage Parents		4	15	19
Young People at Risk	57	8	24	86
Young People Leaving Care			17	17
Older people with support needs	578	2	230	769
Total	828	67	1025	1819

Figure 8.10.1: Supporting People Clients by Service Type

Supporting People Clients by Client Group, by Service Type

	Accommodation Based Service	Accommodation based with floating support	Floating support	Total Clients
Families, Children and Young People Services	59	34	116	206
Adult Services	191	31	679	844
Services specific for the 65+	578	2	230	769

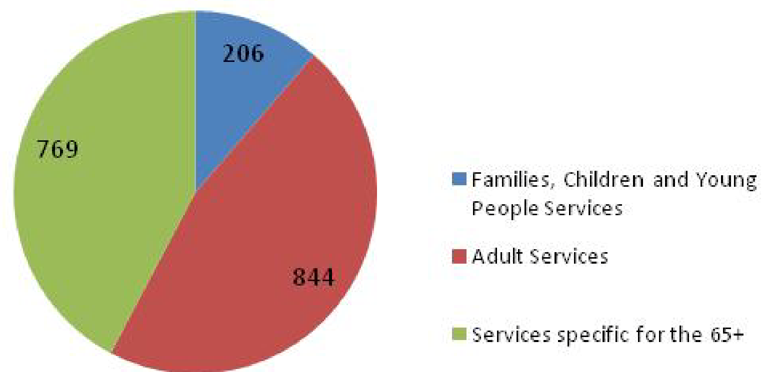


Figure 8.10.2: Supporting People Client Groups

Floating Support Clients, (Supporting People) by Client Type and Provider Sector					
	Housing Associations	Private Sector	Public (Council) Sector	Voluntary Sector	Total
Offenders or People at risk of Offending	20			2	22
People with a Physical or Sensory Disability				56	56
People with Drug Problems				64	64
People with Learning Disabilities	43	22			65
People with Mental Health Problems	233			30	263
Single Homeless with Support Needs	44	102			146
Women at Risk of Domestic Violence				63	63
Homeless Families with Support Needs	13			47	60
Teenage Parents	15				15
Young People at Risk	10			14	24
Young People Leaving Care			17		17
Older people with support needs	147	81	2		230
Total	525	205	19	276	1025
capacity	448	200	17	280	945
Under (-n) or Over Capacity	77	5	2	-4	80

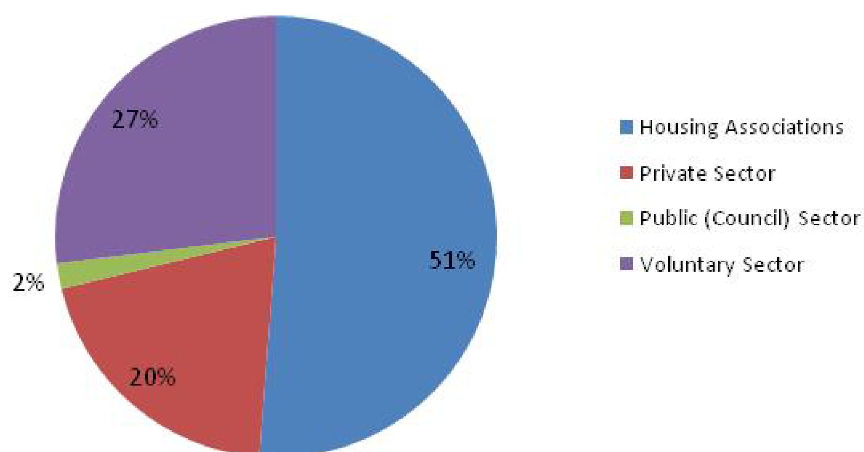


Figure 8.10.3: Floating Support by Client type and Provider Sector

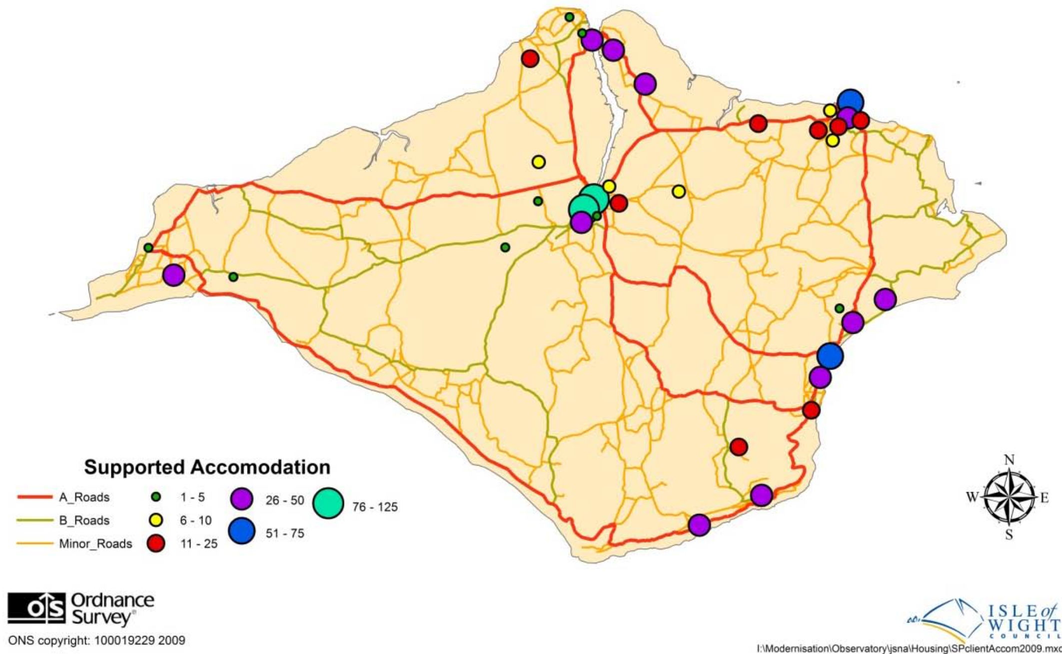


Figure 8.10.4: Location of Supporting People residents by Super Output level

8.10.10 The map identifies Supported Housing provision across the Island (including Sheltered Housing). In the majority of cases, the properties are managed by Registered Social Landlords who also provide the support; The remainder of the properties are managed by registered charities and the private sector and again support is provided by the landlord. The primary purpose on “non - sheltered” supported accommodation is to prepare vulnerable clients to move on to more independent accommodation in the private and social housing sector. Whilst the map would seem to indicate gaps in provision in rural areas, this is offset by the extensive use of community based floating support services. These services deliver support to around 1000 vulnerable clients every week.

8.10.11 Needs analysis for future services: in 2007 a needs analysis exercise was carried out. This and using population projections shows the following estimates of needs through till 2015:

Isle of Wight; Supportive Housing Needs and Projection			
Client Group	**Calculated extra units required 2007**	**Calculated extra units required 2010**	**Calculated extra units required 2015**
Older people with support needs	889	1026	1164
Refugees and asylum seekers	4	4	5
Frail elderly	709	764	819
People with Learning Disabilities	837	850	861
People with Alcohol problems	57	58	59
Mentally disordered offenders	22	23	23
Gypsy and Traveller (Families)	23	24	24
People with Mental Health Problems	222	229	236
Homeless Families with support needs	56	58	59
Women at risk of domestic violence	59	61	62
People with HIV/ AIDS	48	49	49
Rough Sleeper	1	1	1
Young people leaving care	1	2	2
Teenage Parents	-6	-16	-16
Offenders or at risk of offending	1	2	2
People with Physical or sensory disability	117	120	123
People with Drug problems	218	218	222
Young people at risk	61	65	64
Single homeless with support	9	7	9

8.10.12 Within this some specific needs gaps have been identified. A selection of these related to a sample of client groups are discussed below.

8.10.13 It is also important to recognise that many clients have cross-cutting needs and so could be in more than one category as assessed in the model above . I.e. someone could be a substance abuser *and* have a mental health problem, or have physical *and* learning disability needs. This means that services need to be individually tailored depending on need (as indeed they are).

8.10.14 People with Learning Disabilities (LD); are the highest client group in terms of the gap between current provision and projected needs. Current Provision figures show that less than 10% of people identified as being in potential need currently access Supporting People services. This is possibly because levels of LD vary significantly in severity. Many people with LD live with their families and may not come to the attention of support services until their families , can no longer cope. This is a potential issue for the island given the demographics of ageing population. Also, not all who are identified with the condition may need support.

8.10.15 However, an alternative projection estimate based on historic and current service levels (below) still indicates an increasing need.

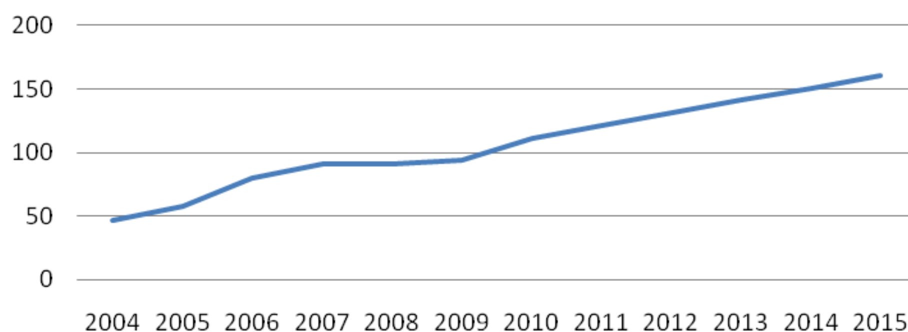


Figure 8.10.: LD supported housing demand

8.10.16 People with Drug and Alcohol problems; a lack of settled housing and support has been identified as a key barrier to delivery of intervention programmes. The 2007 Needs analysis identified that many people who are substance misusing are unable to access the services that they need until they have completed a detox programme. Substance abusers without housing entering treatment find it difficult to sustain and those leaving drug treatment without suitable housing and support are more likely to relapse.

8.10.17 People with Mental Health issues; one in six members of the working -age population experience mental health problems at any given time. The majority of these are living in rented accommodation with a high proportion living alone. Move on accommodation is often difficult to obtain for those in accommodation based support services and this 'bed-blocking' leads to services being inaccessible to those that need them.

8.10.18 Older People; as people become older they are more likely to need support and this need will increase as they age. Access to the majority of sheltered housing services is not controlled by eligibility criteria based on *support* needs, but primarily on an applicant's *housing* needs.

Some Island Registered Social Landlords (RSL's) do have allocation processes for certain properties based on some levels of support need; but increasingly housing need is the predominate factor in determining eligibility.

8.10.19 From the recent round of service reviews undertaken by the Supporting People team it was noted that a number of people in sheltered accommodation have no need for a support service at this time, although they may require this in the future. It was also seen that some clients required more support than was currently able to be offered by the warden at the schemes. As of 3 August 2009 there are a total of 481 households waiting for sheltered accommodation on the Island Housing Register[23]. Suicide rates show that Older people are also disproportionably shown to have potential mental health problems.

8.10.20 People with a physical/sensory disability; some people with a physical or sensory disability would be unable to live in the community independently without housing related support.Projections indicate that numbers of people with a physical or sensory disability will rise over the next 15 years on a local and national level.

8.10.21 Gypsies and Travellers; currently there are no specific Supporting People services for gypsies and travellers on the Island. And no specific Gypsies and travellers site (this issue has been discussed previously in this paper)

[23] Source: Island Housing Register

Appendices

Appendix A - The Core JSNA Dataset

Index	**Domain:**	**Sub-domain**	**Sub-sub-domain**	**Indicator (bold = National Indicator or Vital Sign)**	**General Population**	**Children & Young People**	**Older People**
1	**Social & Environmental Context**	Poverty	Poverty	**Proportion of children in poverty (NI 116)**		x	
2	**Social & Environmental Context**	Living arrangements	Living arrangements	Housing tenure	x	X	
3	**Social & Environmental Context**	Living arrangements	Living arrangements	Overcrowding	x	X	x
4	**Social & Environmental Context**	Living arrangements	Living arrangements	**Adults with learning disabilities in settled accommodation (NI 145 and Vital Sign VSC05)**	x		
5	**Social & Environmental Context**	Living arrangements	Living arrangements	**Adults in contact with secondary mental health services in settled accommodation (NI 149 and Vital Sign VSC06)**	x		
6	**Social & Environmental Context**	Living arrangements	Living arrangements	Living alone			x
7	**Social & Environmental Context**	Living arrangements	Living arrangements	Central heating		X	x
8	**Social & Environmental Context**	Living arrangements	Transport	Access to car or van etc	x		
9	**Social & Environmental Context**	Economic	Employment	**Overall employment rate (NI 151)**	x		
10	**Social & Environmental Context**	Economic	Employment	Working age people on out-of-work benefits (NI 152)	x	X	
11	**Social & Environmental Context**	Economic	Employment	**Working age people claiming out-of-work benefits in the worst performing neighbourhoods (NI 153)**	x	X	
12	**Social & Environmental Context**	Economic	Employment	**Adults with learning disabilities in employment (NI 146 and Vital Sign VSC07)**	x		
13	**Social & Environmental Context**	Economic	Employment	**Adults in contact with secondary mental health services in employment (NI 150 and Vital Sign VSC08)**	x		
14	**Social & Environmental Context**	Economic	Employment	Unemployment rate	x	X	
15	**Social & Environmental Context**	Economic	Employment	Claimant count	x		
16	**Social & Environmental Context**	Economic	Other	Average incomes	x	X	

Index	Domain:	Sub-domain	Sub-sub-domain	Indicator (bold = National Indicator or Vital Sign)	General Population	Children & Young People	Older People
17	**Social & Environmental Context**	Environment	Isolation	Access to services	x		
18	**Social & Environmental Context**	Voice	Satisfaction	**Satisfaction of people over 65 with home and neighbourhood (NI 138)**			x
19	**Lifestyle & Risk Factors**	Behaviour	Smoking	Modelled and/or recorded smoking prevalence	x		
20	**Lifestyle & Risk Factors**	Behaviour	Smoking	**Quit rates (NI 123 and Vital Sign VSB05)**	x	X	
21	**Lifestyle & Risk Factors**	Behaviour	Eating habits	Modelled and/or recorded eating behaviour	x		
22	**Lifestyle & Risk Factors**	Behaviour	Eating habits	**Prevalence of breastfeeding at 6-8 weeks from birth (NI 53 and Vital Sign VSB11)**		x	
23	**Lifestyle & Risk Factors**	Behaviour	Alcohol	**Alcohol-harm related hospital admission rates (NI 39 and Vital Sign VSC26)**	x	X	
24	**Lifestyle & Risk Factors**	Behaviour	Alcohol	Modelled and/or recorded drinking behaviour	x		
25	**Lifestyle & Risk Factors**	Behaviour	Physical activity	Participation in sport and active recreation	x	X	
26	**Lifestyle & Risk Factors**	Behaviour	Teenage pregnancy	**Under 18 conceptions (NI 112 and Vital Sign VSB08)**		x	
27	**Lifestyle & Risk Factors**	Behaviour	Teenage pregnancy	Under 16 conceptions		x	
28	**Lifestyle & Risk Factors**	Other	Hyper-tension	Modelled and/or recorded hypertension	x		
29	**Lifestyle & Risk Factors**	Other	Obesity	Modelled and/or recorded obesity (adult)	x		x
30	**Lifestyle & Risk Factors**	Other	Obesity	**Obesity among primary school age children in Reception Year (NI 55 & Vital Sign VSB09)**		x	
31	**Lifestyle & Risk Factors**	Other	Obesity	**Obesity among primary school age children in Year 6 (NI 56 & Vital Sign VSB09)**		x	
32	Burden of Ill Health	Misc	All Causes	**All-Age All-Cause Mortality (NI 120 and Vital Sign VSB01)**	x		
33	Burden of Ill Health	Misc	All Causes	Infant mortality		X	
34	Burden of Ill Health	Misc	All Causes	Life expectancy	x		
35	Burden of Ill Health	Misc	All Causes	Main causes of death	x		
36	Burden of Ill Health	Misc	All Causes	Hospital admissions – top 10 causes	x		
37	Burden of Ill Health	Misc	All Causes	**Self-reported measure of overall health and wellbeing (NI 119)**	x	x	
38	Burden of Ill Health	Misc	All Causes	**Healthy life expectancy at age 65 (NI 137 and Vital Sign VSC25)**			
39	Burden of Ill Health	Misc	Causes considered amenable to healthcare	**Mortality rate from causes considered amenable to healthcare (Vital Sign VSC30)**	x		

Index	Domain:	Sub-domain	Sub-sub-domain	Indicator (bold = National Indicator or Vital Sign)	General Population	Children & Young People	Older People
40	Burden of Ill Health	Misc	Due to smoking	Deaths attributable to smoking	x		
41	Burden of Ill Health	Diabetes	General	Modelled v. recorded prevalence	x		
42	Burden of Ill Health	Diabetes	General	Estimated excess deaths among people with diabetes	x		
43	Burden of Ill Health	Circulatory	General	**Mortality rate from all circulatory diseases under 75 (NI 121 and Vital Sign VSB02)**	x		
44	Burden of Ill Health	Circulatory	Coronary heart disease	Mortality	x		
45	Burden of Ill Health	Circulatory	Coronary heart disease	Modelled v. recorded prevalence	x		
46	Burden of Ill Health	Circulatory	Coronary heart disease	Hospital admission rate for MI (proxy for incidence)	x		
47	Burden of Ill Health	Circulatory	Circulatory	Admissions for cardiac revascularisation	x		
48	Burden of Ill Health	Circulatory	Stroke	Mortality	x		
49	Burden of Ill Health	Circulatory	Stroke	Hospital admission rate for stroke (proxy for incidence)	x		
50	Burden of Ill Health	Cancer	General	**Mortality rate from all cancers under age 75 (NI 122 and Vital Sign VSB03)**	x		
51	Burden of Ill Health	Cancer	By site	Cancer registrations	x		
52	Burden of Ill Health	Respiratory	COPD	COPD mortality	x		
53	Burden of Ill Health	Respiratory	COPD	COPD modelled v. recorded prevalence	x		
54	Burden of Ill Health	Infectious	TB	TB notifications	x		
55	Burden of Ill Health	Infectious	STIs & HIV	KC60 GUM STI data, particularly gonorrhoea	x		
56	Burden of Ill Health	Infectious	STIs & HIV	New diagnoses of HIV/Aids	x		
57	Burden of Ill Health	Infectious	STIs & HIV	Late diagnoses of HIV/Aids	x		
58	Burden of Ill Health		STIs & HIV	**Uptake of Chlamydia screening in under-25s (NI 113 and Vital Sign VSB13)**		x	
59	Burden of Ill Health	Dental health	Decay	% dmft in 5-year olds		x	
60	Burden of Ill Health	Mental health	Dementia	Prevalence of dementia			x
61	Burden of Ill Health	Mental health	Suicide	**Suicide and injury of undetermined intent mortality rate (Vital Sign VSB04)**	x		
62	Burden of Ill Health	Mental health	Mental illness	Mental illness needs indices and prevalence rates	x		
63	Burden of Ill Health	Trauma	Falls	Hospital admissions for fractured proximal femur (proxy for incidence)			x
64	Burden of Ill Health	Trauma	Road accidents	People killed or seriously injured on roads	x		
65	Burden of Ill Health	Trauma	Injuries	**Children killed or seriously injured on roads (NI 48)**		x	

Index	Domain:	Sub-domain	Sub-sub-domain	Indicator (bold = National Indicator or Vital Sign)	General Population	Children & Young People	Older People
66	Burden of Ill Health	Trauma	Injuries	**Hospital admissions caused by unintentional and deliberate injuries to children and young people (NI 70 and Vital Sign VSC29)**		x	
67	Burden of Ill Health	Musculo-skeletal	Arthritis	Admissions for hip and knee replacement			x
68	Services	Social Care	Physical disability, frailty and sensory impairment	1. Number of clients	x	X	x
69	Services	Social Care	Physical disability, frailty and sensory impairment	2. Number receiving services in community	x	X	x
70	Services	Social Care	Learning disability	1. Number of clients	x	X	x
71	Services	Social Care	Learning disability	2. Number receiving services in community	x	X	x
72	Services	Social Care	Mental health	1. Number of clients	x	X	x
73	Services	Social Care	Mental health	2. Number receiving services in community	x	X	x
74	Services	Social Care	Substance misuse	1. Number of clients	x	X	x
75	Services	Social Care	Substance misuse	2. Number receiving services in community	x	X	x
76	Services	Social Care	Vulnerable people	1. Number of clients	x	X	x
77	Services	Social Care	Vulnerable people	2. Number receiving services in community	x	X	x
78	Services	Social Care	Standard of service	**Timeliness of social care assessment (NI 132 and Vital Sign VSC12) and packages (NI 133 and Vital Sign VSC13)**	x	X	
79	Services	Social Care	Standard of service	**People supported to live independently through social services (NI 136 and Vital Sign VSC03)**	x	x	
80	Services	Social Care	Standard of service	**Carers receiving needs assessment or review and a specific carer's service, or advice and information (NI 135)**	x		
81	Services	Social Care	Standard of service	**Adults and older people receiving direct payments and/or individual budgets per 100,000 population aged 18 and over (Vital Sign VSC17, NI 130)**	x	X	
82	Services	Health services	Maternity	**Early access for women to maternity services (NI 126, Vital Sign VSB06)**	x		
83	Services	Health services	Dental health	**Number of people accessing NHS dentistry (Vital Sign VSB18)**	x	X	
84	Services	Health services	Preventative / screening	Uptake rates for flu jab	x		

Index	Domain:	Sub-domain	Sub-sub-domain	Indicator (bold = National Indicator or Vital Sign)	General Population	Children & Young People	Older People
85	Services	Health services	Preventative / screening	**Proportion of children who complete immunisation by recommended ages (Vital Sign VSB10)**		x	
86	Services	Health services	Preventative / screening	**Proportion of women aged 47-49 and 71-73 offered screening for breast cancer (Vital Sign VSA09)**	x		
87	Services	Health services	Sexual health	Offer of an appointment at a GUM service within 48 hours	x	x	
88	Services	Health services	Sexual health	Long acting reversible contraception methods	x		
89	Services	Health services	Sexual health	Access to NHS funded abortions before 10 weeks gestation	x	x	
90	Services	Health services	Mental health	**Proportion of people with depression and/or anxiety disorders who are offered psychological therapies (Vital Sign VSC02)**	x		
91	Services	Health services	Long-term conditions	**Proportion of people with long-term conditions supported to be independent and in control of their condition (NI 124, Vital Sign VSC11)**	x		
92	Services	Voice	User perspective on social care	**The extent to which older people receive the support they need to live independently at home (NI 139)**			x
93	Services	Voice	User perspective on social care	**User reported measure of respect and dignity in their treatment (NI 128 and Vital Sign VSC32)**	x		
94	Services	Voice	User perspective on social care	**Self-reported experience of social care users (NI 127)**	x		
95	Services	Voice	User perspective on health care	National Patients Survey Programme findings for local institutions	x		
96	Services	Voice	Parental perspective on care	**Parental experience of services for disabled children (NI 54, Vital Sign VSC33)**		x	
97	Services	Voice	User perspective on health care	**Patient experience of access to primary care (Vital Sign VSA06)**	x		
98	Services	Voice	User perspective on health care	**User reported measure of respect and dignity in their treatment (NI 128 and Vital Sign VSC32)**	x		
100	Demography	Population numbers		Estimated and projected population by age-band and gender	x	x	
102	Demography	Births		Current births	x		

Index	Domain:	Sub-domain	Sub-sub-domain	Indicator (bold = National Indicator or Vital Sign)	General Population	Children & Young People	Older People
103	Demography	Ethnicity		Estimated population by ethnic group	x		
105	Demography	Disability		Estimated number of disabled people, overall and/or by impairment group	x		
107	Demography	Religion		Estimated population by religious group	x		
108	Demography	Migrant population		Estimated population by migrant status	x		
110	Demography	Local area		Number of households	x		
111	Demography	Local area		Breakdown of area into constituent communities/neighbourhoods			
113	Demography	Local area		Deprivation band			
115	Demography	Local area		ONS classification			
116	Demography	Local area		Social marketing categories			
118	Demography	Local area		Urban / rural classification			
119	Child Specific	Education	Results	KS2 attainment		x	
120	Child Specific	Education	Results	KS4 attainment		x	
121	Child Specific	Education	SEN	SEN		x	
122	Child Specific	Education	exclusions	exclusions		x	
123	Child Specific	Protection	DA	DA reported and recorded		x	
124	Child Specific	Protection	referral	referral		x	
125	Child Specific	Education	Results	CWIattainment		x	
126	Child Specific	Environment	Environment	CWI environment		x	
127	Child Specific	Environment	Environment	crime		x	
128	Child Specific	health	health	CWI health		x	

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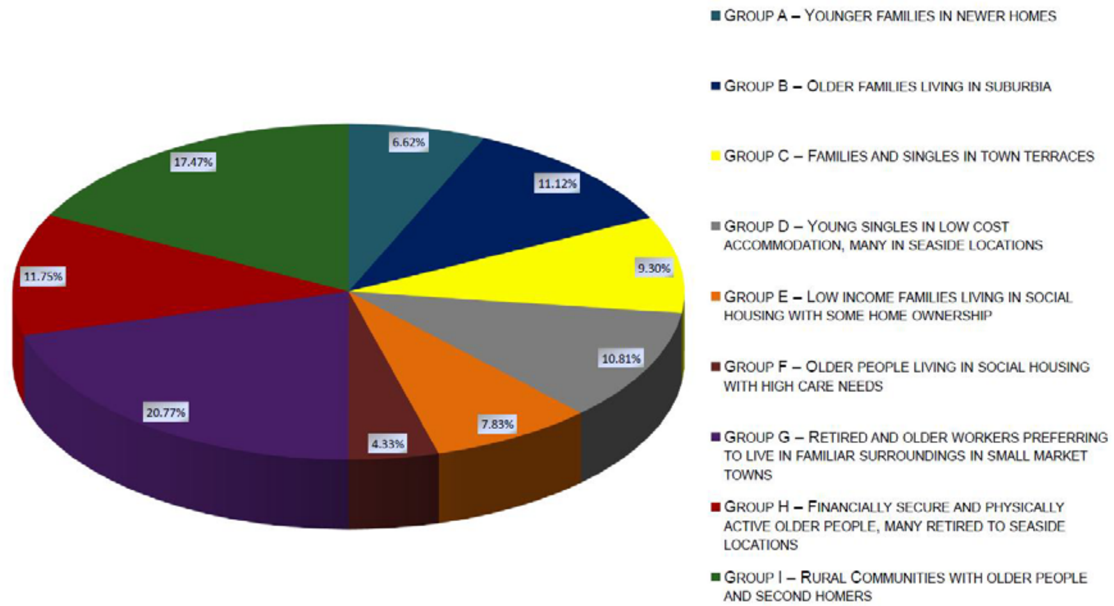
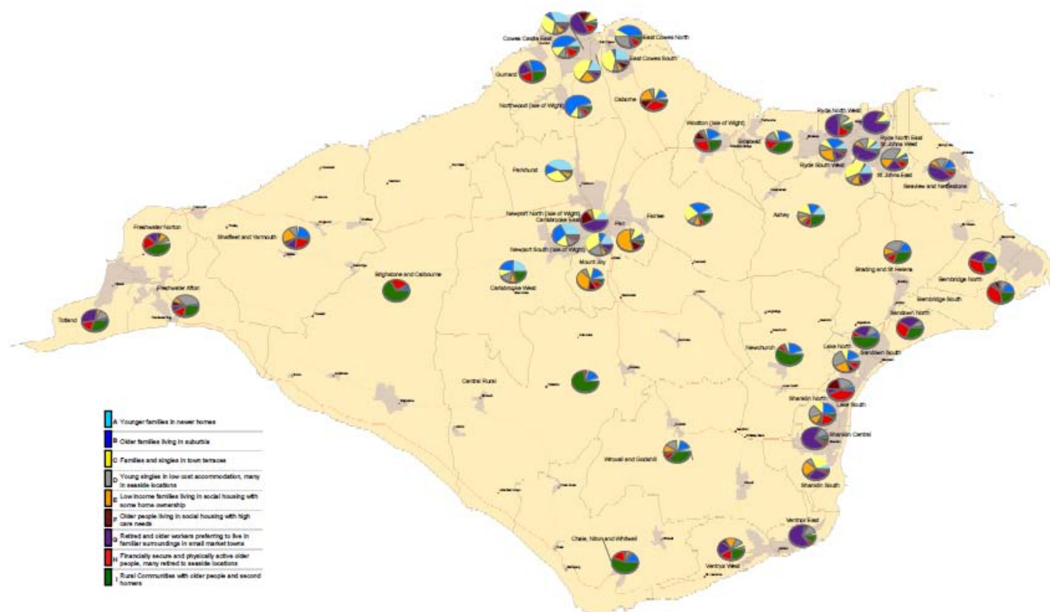
Appendix B - Mosaic classifications of the IW



The relative proportions of Mosaic groups represented by the population of the IW, in 2008



Ward map of the IW showing relative representation of Mosaic groups.

Mosaic Group A Key Features :

- Young couples
- Children at middle/secondary school
- Middle incomes
- Low unemployment
- Good prospects
- Modern homes
- Internet
- High borrowing
- Good health

Group A is found in the modern suburbs of mortgaged owner-occupiers which are affordable to middle incomes. These are mostly younger age groups who are married. They are now raising children in post war family houses, often in areas of the country with rapidly growing populations. General health levels are good, there are some gym members but also some with inactive lifestyles which does not yet affect their health. Group A has a strong requirement for credit, needing to finance two cars, a mortgage on a new house, and consumer durables such as living room furniture and kitchen appliances. With steady incomes and often with two parents working these debts are usually affordable. They are basic rate tax payers, tend not to require the support of the state, and are likely to pay their council tax bills. This group regards their neighbourhood as an area that they enjoy living in and fear of crime is less than the national average. Where an offence does occur there is a general level of satisfaction with the police response. Whilst this Group shows concern for the environment, it is not particularly prepared to do anything of significance about it. This Group's dependence on the car means they are very likely to have high vehicle emissions, but the relatively modern nature of properties means that they have higher levels of insulation and more efficient heating and lighting than older properties.

Mosaic Group B Key Features :

Married couples
Older / grown up children
Older working ages
Self reliant
Suburban homes
Some Small businesses
Plan for retirement
Good place to live
Healthy lifestyles

Group B comprises people who have successfully established themselves and their families in comfortable homes in mature suburbs. Children are becoming more independent, and with more time on their hands, people can relax and focus on activities that they find intrinsically rewarding. They generally have a good diet, are not heavy smokers and do not tend to drink to excess. This group is financially comfortable, with many having share investments and property values are generally high in relation to the outstanding mortgage. Loans are rarely needed and credit cards are used merely as a convenient payment method. There is little reliance on the state for support, and incidence of non-payment of taxes is low. In general these people feel that their neighbourhood is a good place to live, that neighbours help each other, and that problems linked to anti-social behaviour occur less often here than in many other parts of the island. Attitudes to police performance are not normally negative. Some are concerned about the environment and are prepared to spend more on environmentally friendly products, and are occasional contributors to environmental charities. However, their energy inefficiency at home and car usage is likely to have an adverse effect on their carbon footprint.

Mosaic Group C Key Features :

Young adults
Working class families
Family close by
Middle incomes
Semi-detached/terraced houses
Small towns
Some unhealthy lifestyles
Close knit communities
Working family tax credit

Group C is comprised of people whose lives are mostly played out within the confines of close knit communities. Living mostly in older houses in small towns, most of these people own their homes and hold down responsible jobs. Community norms rather than individual material ambitions shape the pattern of most residents' consumption. There is a tendency towards a bad diet and smoking, and apart from a small minority they are unlikely to lead active lifestyles. Money has traditionally been hard to come by, so there is some reliance on state benefits. However, they have evolved a culture of economy and thrift and a reluctance to borrow beyond their means, so they are more likely than many to pay bills such as their council tax. The proportion claiming the state pension is below the national norm, reflecting that the majority are of working age. Few people expect to have more than a basic state pension in old age. This group has varying experiences of crime. While the communities of more expensive housing view their neighbourhoods as a good place to live, the communities with lower value housing not only experience above average instances of crime but also have a corresponding high fear of crime. This varied experience is also replicated in the perception of the police and their performance. Environmental attitudes are also mixed but typically households have access to none or one small car, and do average annual mileage, so vehicle CO emissions are relatively low.

Mosaic Group D Key Features :

Young single adults
Some divorcees
Few children
Well informed
Low incomes
Liberal values
High unemployment
Income Support
Bad place to live

Group D contains young unattached people who live in small flats above shops or in the less prestigious side streets bordering centres of small market towns and declining seaside resorts. These people are fairly ambivalent to health issues, and their diet is neither particularly good nor particularly bad. Smoking and drinking is part of the lives of many, with high incidence of medical problems relating to drug and alcohol abuse and to mental health. There is a diverse mix of people living in these areas. Over half do not pay tax, yet slightly above the national average pay the higher rate tax, possibly reflective of divorcees renting accommodation while they turn their lives around. Savings and investments are rare, and there is heavy reliance across the board on the state for financial assistance. The transient nature of these areas mean that non-payment of bills such as council tax is an issue. These town centre neighbourhoods are not seen as pleasant, and most people tend to keep to themselves. There is evidence of anti social behaviour as would be expected in town centres. Most types of crime are reasonably prevalent, and repeat victimisation is not uncommon. These people have little concern for the environment, and insufficient money to contribute even if they did. Perhaps their greatest contribution is the low

level of car ownership and low annual mileages, & home energy consumption is also likely to be low.

Mosaic Group E Key Features :

Working class couples
Mostly poorly educated
Council estates
Small towns
Some exercised Right to Buy
Self reliant and capable
Poor diet
Heavy smokers
Heavy viewers of TV

Group E live in terraced/semi-detached council housing, although some tenants have exercised their right to buy. The majority of these adults have few, if any, qualifications and their children are only likely to achieve at best moderate academic success. Tastes are mass market and they buy mainstream brands that focus on price rather than range or service. These people do not tend to have a good diet, take insufficient exercise and are heavy smokers. Teenage pregnancies are also found within this group. Group E generally earn reasonable incomes, although a slightly higher proportion than nationally are on Income Support. For other kinds of state benefit, take-up rates are close to the norm. Income is more likely to be spent on the mortgage and household bills than go towards savings and investments. In these neighbourhoods, crime generally occurs immediately outside the home, reflecting that anti-social behaviour is a big concern. On the whole, this group are dissatisfied with police efforts and do not show particular concern for the environment, with few contributing financially to environmental concerns. The fact that they do not tend to be high contributors to vehicle emissions is more a reflection of finances and lifestyle, rather than consideration for the environment.

Mosaic Group F Key Features :

Older people
Low incomes
Some seaside locations
Pension Credit
Some small bungalows
Some sheltered homes
TV popular
Bingo, dominoes, cards
HES emergencies

Group F consists of elderly people who are mostly reliant on state benefits and live in purpose built housing. Some live in old people's homes or sheltered accommodation, while others live in small bungalows, set within larger council estates. Most of this group spend money only on the basic necessities of life. The health issues of this group reflect the age of the population, with above average hospital admission rates for many conditions, such as influenza and pneumonia and age-adjusted emergency admission rates over four times the national average. They have few, if any, savings or investments and low incomes. Low levels of income result in a general reliance on the state, with many qualifying for Pension Credits in particular. The relatively low rates of defaults on council tax payment is partly to do with the attitudes of an elderly population, but also reflecting that a significant proportion are not actually liable for council tax. These neighbourhoods are generally viewed as areas where neighbours help each other. They see less of the anti-social and criminal problems than any of the other poorer groups. These people are environmentally friendly in that few drive cars and are frugal when it comes to spending on heating and cooking. However, this low environmental impact is due to circumstance not attitude, as many do not believe the hype about environmental issues.

Mosaic Group G Key Features :

Many Retired Couples
Active Lifestyles
Mid/High Incomes
Older working age
Good diet
Traditional values
Health checks
Social networks
Good place to live

Group G consists mostly of older people, who own their homes and who cater for the needs of day trippers and holiday makers. On retirement, many have moved to the seaside or the countryside to live among people similar to themselves. Most have quite active lifestyles, tend to eat a good diet and whilst they have health problems typical of their older profile, after adjusting for age, their hospital admissions are only marginally higher than average. Throughout their working lives, these elderly people have amassed sufficient investments to provide for a comfortable retirement. However, there is a significant minority that struggle to get by, and require Pension Credits for support. Overall there is little take-up of any benefit other than the state pension, as few have personal pensions, reflecting that this method of long term investment was not commonplace during their early working years. These neighbourhoods are peaceful and quiet. Crime and anti-social behaviour are not at all commonplace. If Group G does become a victim of crime then it is more likely to happen when they are away from home. Problems that do occur are typically small scale, and are more likely to be in the entertainment centres than in the nearby residential areas. This group are from the age and the background that breeds respect for and trust in the police, and the low amounts of crime do nothing to shake those beliefs.

Mosaic Group H Key Features :

Pensioners
Relocated on retirement
Own their homes
Index linked pensions
Significant capital
Active
Good health and diet
HES emergencies
Prefer face-to-face service

Group H consists mostly of pensioners who own their homes and who have some source of income beyond the basic state pension. Many have, on retirement, moved to the seaside or the countryside to live among people similar to themselves. Most have quite active lifestyles, tend to eat a good diet, and whilst they drink alcohol regularly it is rarely to excess. However, the proportion of heavy smokers is only marginally less than the national average. These are people who value the security that comes from insurance, and the security afforded by credit cards over cash. They invest their savings in ways that maximise their current revenue, minimise tax and protect long-term capital values. Overall there is little take-up of any benefit other than the state pension, as few have personal pensions, reflecting that this method of long term investment was not commonplace during their early working years. This Group does not experience high levels of crime, and in general is not living in fear of crime. Their views of the police appear to reflect old fashioned values of trust; whilst they may not be satisfied with actions taken by the police over specific incidents, they remain very satisfied with the police in general. Many show concern for the environment, and are prepared to make financial contributions. However, there is a significant minority that believes that environmental issues are overplayed. Cars tend to be small, only one per household, and annual mileage is usually below average.

Mosaic Group I Key Features :

Wealthy professionals
Older detached houses
Coastal/semi-rural
Areas of natural beauty
Good diet and health
Drink alcohol daily
Country pursuits
Gentle relaxed pace
Quality of life

Group I are communities set in areas of high landscape value which, on account of their accessibility to towns, attract wealthy urban commuters. They live on the outskirts of small towns or attractive villages, where bed and breakfasts and other agro-tourism enterprises provide important sources of seasonal income. Most are well educated, and overall they enjoy reasonable health. They have an active lifestyle, and whilst they may drink alcohol on a daily basis, it is not to excess. In general, those of working age are in work earning a reasonable rather than a high income. They rarely require additional support from the state. Similarly, those who have retired will take the state pension, but most do not need additional Pension Credits. They will have earned sufficient during their working lives to put some aside for the future, with a preference for national savings schemes rather than shares or investment products. These are areas where social capital is high and where crime, and the fear of crime, are both very low. There is little antisocial behaviour and opinions of the police are high. These people, despite claiming to be very concerned for the environment, follow lifestyles that are quite damaging, with high car ownership and inefficient energy usage at home. Instead of materially changing their lifestyle they will seek to make amends via financial contributions.

Appendix C - References and links

Ref A : GVA Grimley Report on Housing on the IW (2007)
I:\Modernisation\Observatory\jsna\Housing\HMA Final (19-04-07)
Ref B : Needs Assessment data for YPSM TP 2009/10
I:\Modernisation\Observatory\jsna\Substance Misuse\Needs Assessment data for YPSM TP 2009
Ref C : Data supplied by Quality Assurance and Information Team, Directorate of Children & Young People
Ref D : I:\Modernisation\Observatory\jsna\burdenillhealth\children's alcohol-specific admissions.xls. See also (Ref 02302)
Ref E : I:\Modernisation\Observatory\jsna\Childrens data requests\jsna data pack.xls. See also (ref 13201)
Ref F : I:\Modernisation\Observatory\jsna\Childrens data requests\Joint Strategic Needs Assessment 1 7 09_v1
Ref G : Microsoft powerpoint presentation by Debbie Sagar for JSNA Director's meeting 9.7.2009
Other references are to datasets on the Information Observatory JSNA 2009 website at
http://www.eco-island.org.uk/information_observatory/jsna2/jsna_2009.aspx