Date: 26 August 2010
Contact name: 01395 517525
Contact number: Rachel Perram
E-mail: rperram@eastdevon.gov.uk

To: Members of the Communities Overview and Scrutiny Committee (Councillors: Helen Parr (Chairman), Darryl Nicholas (Vice Chairman), Peter Burrows, Vivien Duval-Steer, Roger Giles, Marion Olive, Philip Skinner, Pauline Stott, Graham Troman, Mark Williamson)

Portfolio Holders
Other Members of the Council for information
Chief Executive; Corporate Directors
Phil Taylor
Lucy O'Loughlin

East Devon District Council
Knowle
Sidmouth
Devon
EX10 8HL

DX 48705 Sidmouth

Tel: 01395 516551
Fax: 01395 517507

www.eastdevon.gov.uk

Meeting of the Communities Overview and Scrutiny Committee

Wednesday 8 September 2010 – 6.30pm. Council Chamber, Knowle, Sidmouth

Members of the public are welcome to attend this meeting.

- **A period of 15 minutes has been provided at the beginning of the meeting to allow members of the public to raise questions.**
- **In addition, the public may speak on items listed on the agenda. After a report has been introduced, the Chairman (Leader of the Council) will ask if any member of the public wishes to speak and/or ask questions.**
- **All individual contributions will be limited to a period of 3 minutes – where there is an interest group of objectors or supporters, a spokesperson should be appointed to speak on behalf of group.**
- **The public is advised that the Chairman has the right and discretion to control questions to avoid disruption, repetition and to make best use of the meeting time.**

A hearing loop system will be in operation in the Council Chamber.

AGENDA

Page/s

1. **Public question time** – standard agenda item (15 minutes)
   Members of the public are invited to put questions to the Committee through the Chairman.

   Councillors also have the opportunity to ask questions of the Chairman and/or Portfolio Holders during this time slot whilst giving priority at this part of the agenda to members of the public.

2. To confirm the minutes of the meeting of the Communities Overview and Scrutiny Committee held on 30 June 2010. 4 - 9

3. To receive any apologies for absence.

4. To receive any declarations of interests relating to items on the agenda.

5. To consider any items which, in the opinion of the Chairman, should be dealt with as matters of urgency because of special circumstances.

(Note: such circumstances need to be clearly identified in the minutes; Councillors please notify the Chief Executive in advance of the meeting if you wish to raise a matter under this item. The Chief Executive will then consult with the Chairman).

6. To agree any items to be dealt with after the public (including the press) have been excluded. There are no items that the officers recommend should be dealt with in this way.

7. **a) Health** 10 - 37
Members to note the supporting information included in the Agenda papers and to hear from the local GP consortia on possible changes in health priorities and service delivery. Feedback is invited from Members.

b) Childhood and Adolescent Obesity
This item was requested by a Member – further statistical data for East Devon can be found in Annex 1.

8. **Joint Engagement Strategy to involve the people of Devon**
Members to note that this strategy document will be distributed via the Knowledge newsletter and available on the Council's Members website for information.

9. **Forward Plan 2010/11** 38
Members to agree items for consideration at future meetings of the Communities Overview and Scrutiny Committee.

10. **Community Group Preparation**
Members to discuss this forthcoming agenda item for October 2010 and to agree topics for scrutiny.

Members remember!

Members remember!

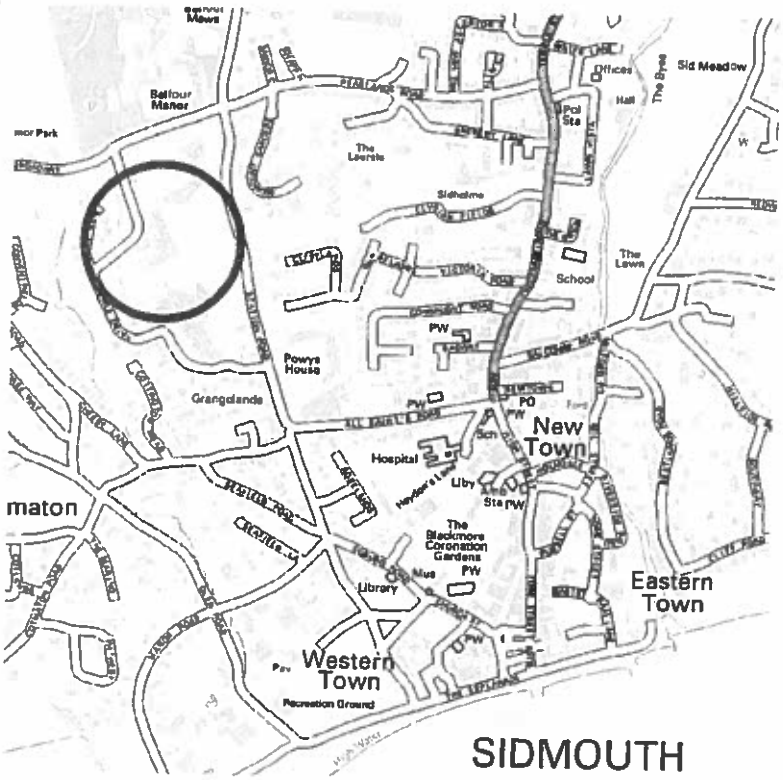
- You must declare the nature of any personal or prejudicial interests in an item whenever it becomes apparent that you have an interest in the business being considered.
- Where you have a personal interest because the business relates to or is likely to affect a body of which you are a member or manager as an EDDC nominee or appointee, then you need only disclose that interest when (and if) you speak on the item. The same rule applies if you have a personal interest in relation to a body exercising functions of a public nature.
- Make sure you say the reason for your interest as this has to be included in the minutes.
- If your interest is prejudicial you must leave the room unless
  a) you have obtained a dispensation from the Council's Standards Committee or
  b) where Para 12(2) of the member Code of Conduct applies. [Para 12(2) allows a Member with a prejudicial interest to stay for the purpose of making representations, answering questions or giving evidence relating to the busines but only to the extent the public are allowed the same rights. If you do remain for these purpos , you must not exercise decision-making functions or seek to improperly influence the decisio , you must leave the meeting room once you have made your representation, answered questi s or given evidence.]
- The Code states that any member of the Execut e Board or other decision-making committee or joint committee or sub-committee attending Overv w and Scrutiny committees has a prejudicial interest in any business where that member was a m mber of the committee at the relevant time **and** present when the decision was made or other acti n was taken (whether or not implemented). Members with prejudicial interests should declare them nd are allowed to remain in the meeting for the limited purposes set out in the Code para 12(2) – se last paragraph.
- You also need to declare when you are subject to t party whip before the matter is discussed.

Suggestions for questioning during an Overview and Scrutiny meeting

Below are some prompts which may help you to form your own questions to ask at an Overview and Scrutiny meeting. Your questioning technique is crucial in creating an atmosphere conducive to open answers. Avoid excessive interrogation and treat those being questioned with courtesy and respect; however don't be afraid to ask supplementary questions if you feel that you haven't been given a clear answer.

- **IS IT REQUIRED?** (do we have this, does it make sense to tackle it, do we really need it).
- **IS IT SYSTEMS THINKING?** (is it evidence based and designed around the customer demands)
- **IS THE INTENTION CLEAR?** (what are we actually trying to achieve)
- **ANY REAL OUTCOMES?** (are we actually, and measurably, achieving things for our customers).
- **WHAT IS THE COST?** (both time and money)
- **DOES IT COMPLY?** (have we checked that it meets our obligations, the law, any formal guidance, and any Council policy or resolutions).
- **OTHERS DO WHAT?** (how do other organisations tackle this, best practice)
- **EFFECTIVE AND EFFICIENT?** (how do we know we're doing things well, in a timely fashion, and at "best value")
- **WHAT IS THE RISK?** (any areas of risk for the Council)
- **ANYONE LOSE OUT?** (are there sections of the community who might be disadvantaged by this approach, or be less able to take advantage, than others)
- **DOES IT LINK?** (have we linked this to other, similar, pieces of work within or outside the Council)

Getting to the Meeting – for the benefit of visitors



The entrance to the Council Offices is located on Station Road, Sidmouth. **Parking** is limited during normal working hours but normally easily available for evening meetings.

The following **bus service** stops outside the Council Offices on Station Road:
From Exmouth, Budleigh, Otterton and Newton Poppleford – 157

The following buses all terminate at the Triangle in Sidmouth. From the Triangle, walk up Station Road until you reach the Council Offices (approximately ½ mile).
From Exeter – 52A, 52B
From Honiton – 52B
From Seaton – 52A
From Ottery St Mary – 379, 387

Please check your local timetable for times.

The Committee Suite has a separate entrance to the main building, located at the end of the visitor and Councillor car park. The rooms are at ground level and easily accessible; there is also a toilet for disabled users.

Visitors please note that the doors to the civic suite (meeting rooms) will be opened ¼ hour before the start time of the meeting. Councillors are reminded to bring their key fobs if they wish to access the area prior to that time.

For a copy of this agenda in large print, please contact the Democratic Services Team on 01395 517546

EAST DEVON DISTRICT COUNCIL

Minutes of a Meeting of the Communities Overview and Scrutiny Committee held at Knowle, Sidmouth on Wednesday 30 June 2010

Present: Councillors:

Helen Parr (Chairman)
Darryl Nicholas (Vice Chairman)
Peter Burrows
Vivien Duval-Steer
Pauline Stott
Graham Troman
Mark Williamson

Officers:
Jamie Buckley – Engagement and Funding Officer
Bob Darbourne – Communications and Improvement Manager
Peter Jeffs – Corporate Director
Anderson Jones – Diversity Officer
Rachel Perram – Democratic Services Officer

Also Present: Councillors:

Graham Brown
David Cox
Jill Elson
Frances Newth

Martin Wood, Assistant Director – Communities, SSDC

Apologies: Councillors:

Marion Olive
Philip Skinner

The meeting started at 6.32pm and ended at 8.17pm.

*1 **Public question time**

There were no questions from members of the public.

*2 **Introductions and Welcome**

The Chairman welcomed Martin Wood, Assistant Director – Communities for South Somerset District Council to the meeting and thanked him for attending to give the Council an insight into South Somerset's approach to community engagement.

*3 **Minutes**

The minutes of the meeting of the Communities Overview and Scrutiny Committee held on 10 March 2010 were confirmed and signed as a true record.

*4 **2010 Equalities Assessment**

Vivien Duval-Steer, Equalities Champion, gave Members an introduction to the Council's progress towards the submission of an Equality Impact Assessment. Anderson Jones,

2010 Equalities Assessment (cont'd)

the council's Diversity Officer was asked to come to the Committee to present a brief outline as to how far the Council had progressed in achieving the work required for the assessment in September 2010. In the short time that Anderson had worked at EDDC, significant progress had been made in meeting the work required by the 'Equality Framework for Local Government' (EFLG)

Members of the Committee were circulated with papers giving further information on the EFLG and then received an interesting presentation from Anderson Jones, Diversity Officer, who outlined the Government's requirements for the Equalities Impact Assessment from the Council, as well as giving an update on the progress to date.

Members heard that there were 3 levels of achievement classification – developing (low), achieving (medium) and excellent (high). It was anticipated that EDDC would manage to reach 'Achieving' status for the first assessment and would aim for 'Excellent' in the future.

Members heard that a great deal of work had been carried out to highlight 'hate crime' in East Devon, with the district council being the lead Council in Devon.

In response to the Diversity Officer's presentation, Members noted that the Council had made real progress, through the Development Management Committee, with the provision of traveller sites in East Devon in order to meet Government targets.

Members of the Committee were advised that the Council would be required to complete a self-assessment and cite robust examples of where EDDC and its Members had made provision for residents with a variety of needs.

RESOLVED

1 that Members be emailed and asked to provide examples of where they have engaged with residents or communities that could have been at risk of inequality, discrimination, social exclusion or disadvantage.

5 **Place survey – Residents Influencing Decisions**

Jamie Buckley, Engagement and Funding Officer, advised Members that it seemed unlikely that the newly elected Government would commission further Place Surveys with local Councils. However it was vital that EDDC pursue improvements in the Council's relationship with its residents. The Council received a very poor result on the percentage of residents who could influence local decisions in the 2008 Place Survey and the score was low when compared with other neighbouring councils in Devon and Dorset.

Martin Woods, Assistant Director, Communities, South Somerset District Council gave Members of the Committee an interesting insight into SSDC's approach to the way in which they engaged with their community, with specific examples of close working with Parish and Town Councils in the district.

SSDC had still not achieved a particularly high score on the Place Survey question, but did have an increasingly good reputation for their community engagement work. The Council's target had been to 'get under the skin' of the community and this had largely been achieved by close working with Town and Parish Councils – with a focus on 'place shaping' and 'localism'. SSDC was similar to EDDC in that there were large rural areas.

Place survey – Residents Influencing Decisions (cont'd)

There were some 121 parish councils in their district and the council wanted to make sure that they were engaged with the district council and felt involved in decision making. SSDC serviced these with four area committees – and believed this enabled the council to reach out into the community much more effectively.
Area committee and local planning meetings helped this process and SSDC carried out a great deal of work to aid local projects such as street enhancement, play areas and community safety improvements. Every elected member was allocated to an area committee.

SSDC noticed that, despite improved communications, there was a large number of residents that did not attend meetings. The council had examined this issue and decided to allocate annual funds for each area in the district. This money was allocated according to public consensus with a proposal and voting process undertaken to ensure that the process was democratic and met residents' needs and aspirations. The Council had received extremely positive feedback from residents, with between 80-90% of those attending stating that this process was working for their communities. This also gave benefits in that residents gained greater understanding of how the council allocated funds, as well as comprehending how complex some projects were and how some, however desirable, might not be achievable within resources available at District Council level.

Members heard that Parish and Town councils were encouraged to attend area committee meetings. Workshops were held with these councils in all 4 areas 1-2 times per year. Councils were encouraged to bring forward issues and topics for discussion – to which SSDC officers and experts attended to provide feedback or further information. If, for example, planning issues were raised, these would be addressed and an explanation of policies and procedures given at the meetings.

SSDC worked hard with Town and Parishes to improve communication on planning matters as these were often the most contentious issues for residents. For example, in the case of a possible recommendation for refusal of permission, Ward Members as well as Town and Parish Councils would be notified and the Town and Parish Councils being invited to make representations at the planning committee meeting. A scheme of delegation ensured that where Parishes disagreed with the planning officers recommendation there was the opportunity to bring the item to committee with the agreement of the Chair. Following the committee meetings, Planning Officers wrote to parishes explaining planning reasons for decisions made.

SSDC also worked closely with young people and youth partners, holding democracy days each year.

The Chairman thanked Martin for his very informative talk and invited Members to discuss the Place Survey further.

A request was made for examples of the allocation of the £40,000 funds to communities by SSDC, with the following given:

Community Safety in a Churchyard – despite CCTV being positioned in a local churchyard, there was still a high crime rate at night, which was not detected by the cameras in the dark. Infra-red cameras had been installed which led to several arrests and a drastic reduction in crime in the area.

Countryside Parks – The Council and other outside bodies worked together to improve the cleanliness of parks at the weekend. These parks were popular, but not serviced by Street Scene over weekend periods. More support was requested, and funding sought to ensure that these parks were enjoyable spaces to use all the time.

Place survey – Residents Influencing Decisions (cont'd)

Young People – several rural communities noted that there were no facilities for young people. Parish councils helped contribute money from their precepts to pay for a Youth Worker who helped to inspire young people and provide entertainment and a place to go and meet.

Litter Problem Areas – Street Scene had worked with residents to carry out community litter picks – which helped residents to have more pride in their surroundings. Where problem areas existed for litter or unkempt space, Street Scene had provided costed solutions to provide clean ups. The Council often worked with such groups, such as the Scouts and local schools, to improve engagement of young people.

Street Football – Some areas had little provision for activities such as football. SSDC worked with agencies to close off car parks at night and provide mobile floodlights and engaged with local young people to play sport and have fun. Local football clubs had also engaged with the residents in such activities.

SSDC ensured that feedback was sought following such events and to ensure that projects delivered an appropriate and desirable outcome for local communities.

Members heard that Exmouth had worked to bring together community pressure groups, resulting in the formation of a Joint Liaison Panel. This had seen great success. Exmouth Town Council had a similar project to that of SSDC in that it set aside money for worthy projects in the town. It was understood that EDDC had decided to move away from area committees due to the expense involved and the officers needed to service this system.

Members felt that the supply of information on planning matters was extremely important to many members of the public and interested parties. It was noted that a number of other district councils posted a link on their home page to further information on forthcoming planning meetings and/or major planning applications.

Members were interested to note SSDC's policy with regard informing Town and Parish Councils of planning decisions. Some concerns were raised over the resources needed to implement this system at EDDC.

Members of the Committee agreed that there would always be controversial planning applications, but that the Council should look at proactive ways to improve relationships with Councils and residents alike. One way of doing this would be to provide detailed information on planning decisions and policy to support the decision making process. Members heard that developers were encouraged to be involved in community engagement and consultation on large projects in South Somerset. This helped the community to understand the planning process and improved relations with residents, resulting in greater comprehension of the processes involved in planning applications.

On the matter of communication with residents, Members heard that a scheme of 'contact cards' had been successful in Littleham, Exmouth. Residents had received cards with details of their local Ward Members, as well as providing information on other bodies, such as the Police, the District Council and service providers. These were well received and a useful point of reference for residents.

The Chairman thanked Martin Woods for agreeing to come along to the meeting and for sharing the interesting and successful work that South Somerset had undertaken to improve community engagement in their district.

Place survey – Residents Influencing Decisions (cont'd)

RECOMMENDED: that the Committee recommends to the Executive Board actions that would bring about improvements in residents' perceptions that they can influence decisions in their locality, namely;

1 In Planning Matters more information be given to local people and Parish and Town Councils on how Planning works, explaining how people can get involved and to what level, including:

a) A structured interview between the media and the Head of Planning and Development Manager be given.

b) Publicise the Local Development Framework further, showing its importance as this is the stage where people really can have some influence.

c) Publicise all future Planning Policy consultations much more widely and make them more inclusive as this is where the public and Town and Parish Councils can make a difference.

d) Publicise the Planning Committee and Planning Process leaflets widely and send to all Town and Parish Councils.

e) Make the online 'Planning Guide to Objectors' easier to find on the website and promote it.

f) Publish a link on the homepage of the EDDC website to planning information for Development Management meetings, so that information is readily accessible to all.

g) Have a dedicated conclusion section on Planning reports written in Plain English detailing Planning Officers' comments, planning policies and procedures on objections.

h) Explore the possibility of better alerting Ward Members, Parish and Town Councils with "contrary decisions" on planning applications. This might detail in Plain English decisions made and the planning reasons for the decision.

2 that for Councillors the following potential areas for improvement be considered:

a) Members raise their profile in their wards to help address the concerns of local people, who say that they do not know who their Councillor is or how to contact them. That the Council adopt personalised 'Contact cards' for distribution to residents and include - relevant information on Ward Members, outside body contacts and so on.

b) Members attend community or Council organised events to meet and engage with local people, such as Countryside's Wet and Wild Weekend.

c) Members share good practice examples of where they have been able to address issues raised by their constituents and where they have actively sought and acted on feedback. This information to be made freely available to Members possibly through the dedicated 'Members Section' of the EDDC website.

*6 **Forward Plan 2010/11**

Chairman, Cllr Helen Parr asked Members for their comments and feedback for the proposed plan for the next 12 months for the Communities Overview and Scrutiny Committee. Members of the Committee were asked whether they had additional items for consideration, which could be added to the plan.

RESOLVED

1 that the 'Street Pastors' who operate in Exmouth be invited to a future meeting to explain their work to the Committee.

2 that the meeting on 20 October 2010 include other Community Groups (not funded by EDDC) who would like to explain their work to the Committee

3 that the Committee consider proposals for a programme of engagement projects with residents of East Devon – with reference made to successes at SSDC and Exmouth Town Council.

Chairman ..... Date .....

Health Issues – Background papers

- Annex 1
  Recent Health Profile explaining areas of good and less good health for East Devon (including data on childhood obesity)

- Annex 2
  Slides from the Chief Executive of NHS Devon explaining recent changes for the NHS from the NHS White Paper and possible impacts for East Devon residents.

- Annex 3
  Summary paper for Members of scrutiny recommendations around NHS white paper (Equality and Excellence).

- Annex 4
  Notes from the Chief Executive of NHS Devon responding to specific health questions by the LSP, relating to East Devon.

- Annex 5
  First part of new Rural Health & Wellbeing Strategy for Devon. A document led by NHS Devon with multi-agency input.

- Annex 6
  Brief summary of proposed East Devon Health Improvement and Tackling Health Inequalities Plan. A document led by NHS Devon with some multi-agency input but further work still to do.

- Annex 7
  Main body of East Devon District Council's Health and Health Equality Policy adopted in 2009.

PJ/smep
Aug 10

East Devon

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info

Based on Ordnance Survey material. © Crown Copyright. All rights reserved. DH 100020290 2010. Other map data © Collins Bartholomew.

Population 132,700

Mid-2008 population estimate

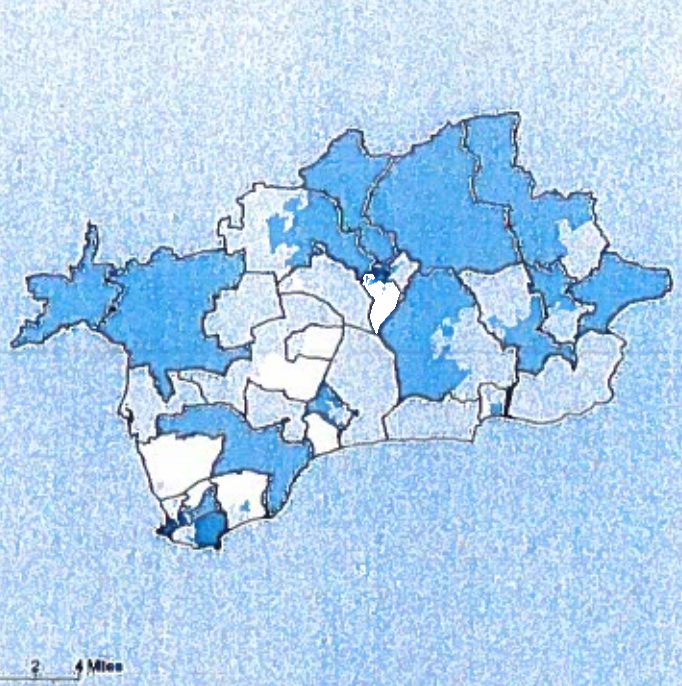
Source: National Statistics website: www.statistics.gov.uk

East Devon at a glance

- The health of people in East Devon is generally better than England as a whole. However, the rate of malignant melanoma skin cancer is worse, with 28 new cases of skin cancer in East Devon each year.
- East Devon has low deprivation levels compared to England as a whole. The rates of children living in poverty, homelessness and violent crime are all better than the England averages.
- The rate of early death from heart disease and stroke has fallen over the last 10 years and remains lower than the England average.
- The percentages of children in Reception year classified as obese, children spending at least 3 hours per week on school sports and rates of teenage pregnancy are all better than the England averages. The breastfeeding initiation rate is also better than average.
- The rate of people claiming incapacity benefits for mental illness is better than the England average. The rate of hospital stays for alcohol related harm is also better than the average, although there were still over 2,400 admissions for alcohol related harm in 2008/09.
- In East Devon emotional health, teenage conceptions, CVD prevention, smoking, healthy weight, alcohol and falls have been identified as local public health priorities to be addressed through partnership working.
- For further information see the Annual Public Health Report at www.devonpct.nhs.uk and the Joint Strategic Needs Assessment at www.devon.gov.uk

a national view

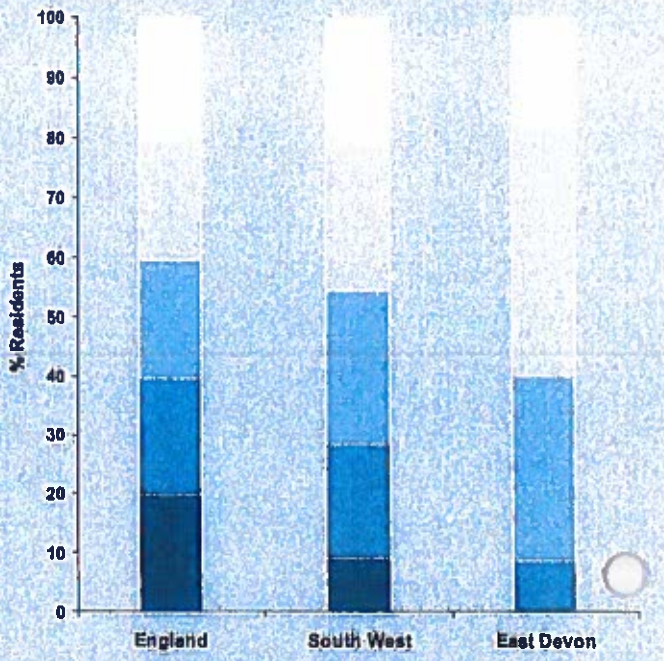
This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



Based on Ordnance Survey Material. © Crown Copyright. All rights reserved. DH 100020290. 2010.

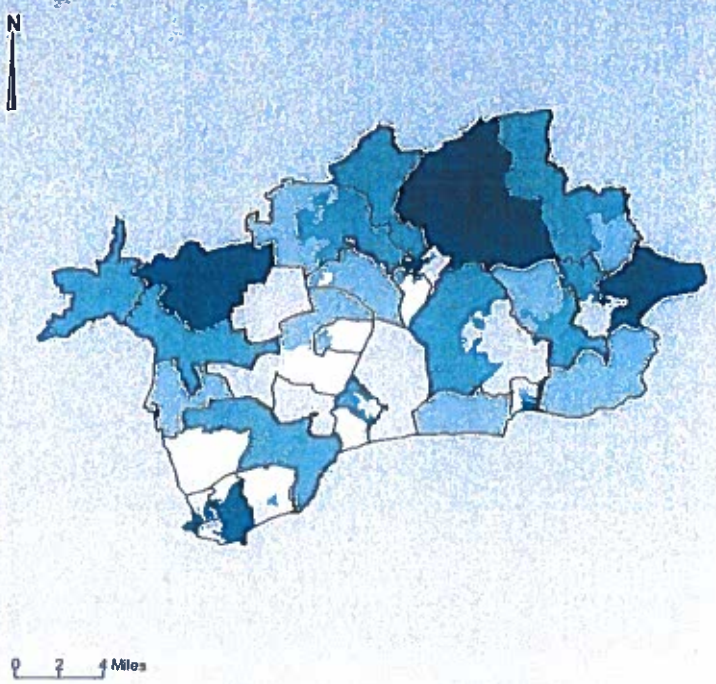
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



Health inequalities: a local view

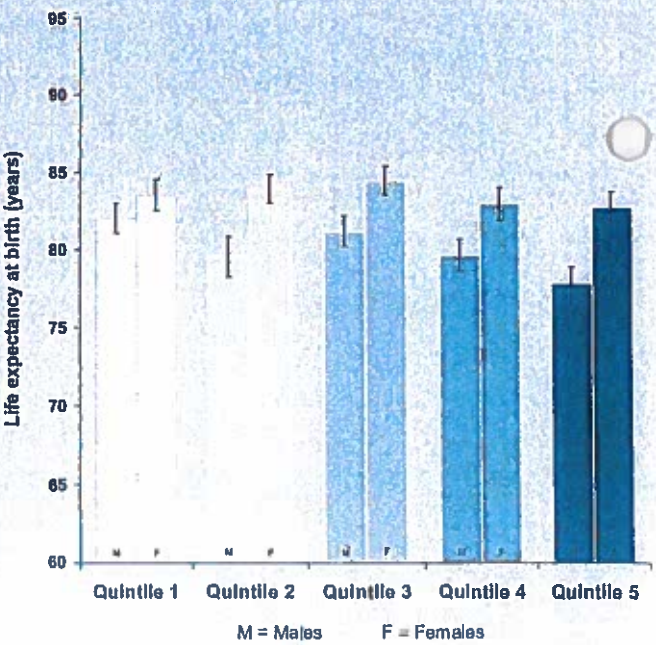
This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Based on Ordnance Survey Material. © Crown Copyright. All rights reserved. DH 100020290. 2010.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.



95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

East Devon - updated 28 July 2010

© Crown Copyright 2010

Changes over time

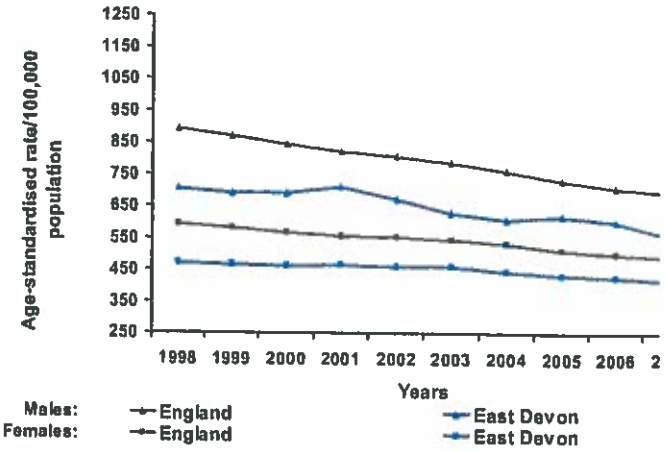
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

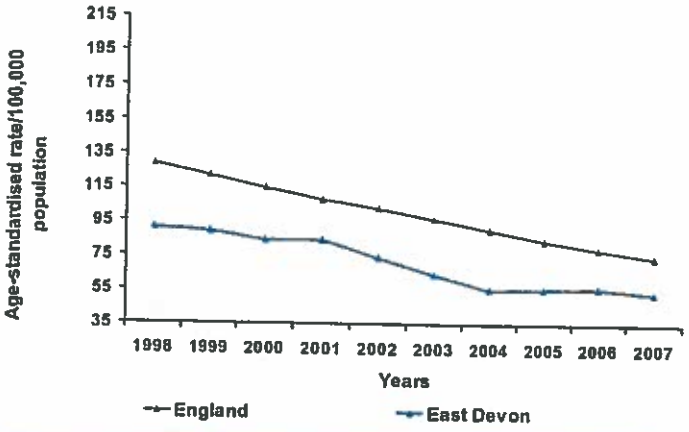
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

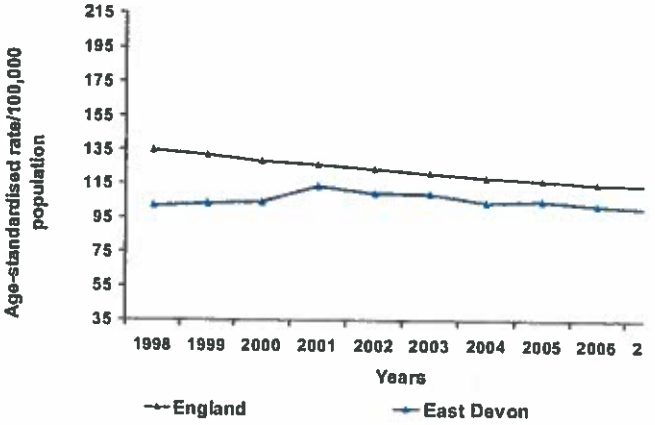
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

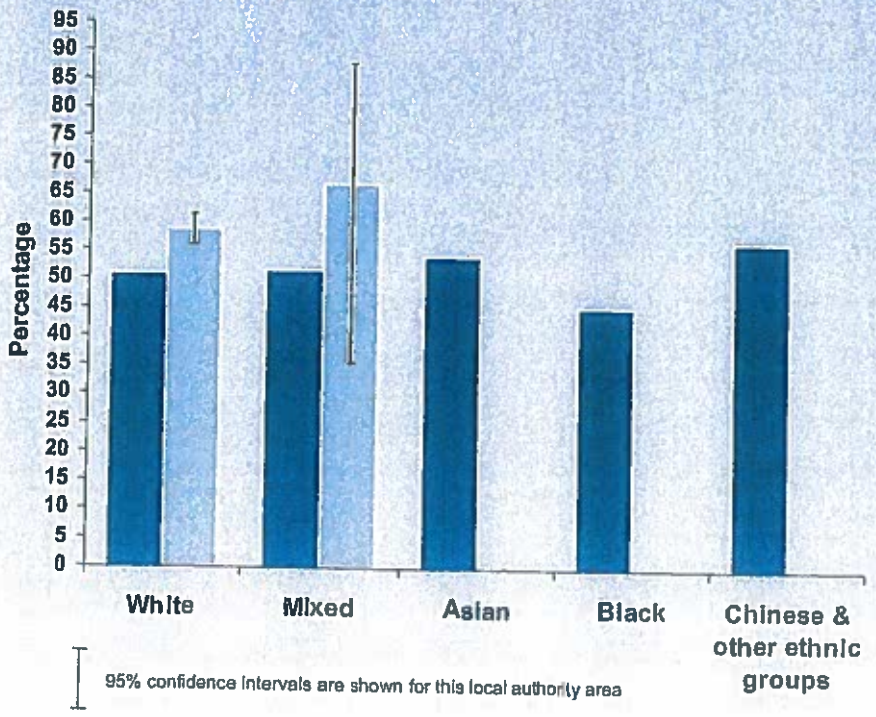


Trend 3:
Early death rates from cancer



Health inequalities: ethnicity

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C gra Including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
East Devon

Ethnic Groups	% pupils achieved grades	No. of pup achieve grades
White	58.7	792
Mixed	66.7	6
Asian		
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presente in order to prevent counts of small numbers bein calculated from values for other ethnic groups or areas.

© Crown Copyright 2010

Health summary for East Devon

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

+ In the South East Region this represents the Strategic Health Authority aver

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	0	0.0	19.9	89.2		0.(
	2	Children in poverty	2717	13.0	22.4	66.5		6.(
	3	Statutory homelessness	78	1.34	2.48	9.84		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	807	58.6	50.9	32.1		76.
	5	Violent crime	1164	6.8	16.4	36.6		4.(
	6	Carbon emissions	812	6.1	6.8	14.4		4.'
Children's and young people's health	7	Smoking in pregnancy	127	13.0	14.6	33.5		3.(
	8	Breast feeding initiation	745	76.7	72.5	39.7		92.
	9	Physically active children	8316	53.5	49.6	24.6		79.
	10	Obese children	72	6.8	9.6	14.7		4.
	11	Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.
	12	Teenage pregnancy (under 18)	79	34.8	40.9	74.8		14.
Adults' health and lifestyle	13	Adults who smoke	n/a	16.1	22.2	35.2		10.
	14	Binge drinking adults	n/a	17.0	20.1	33.2		4.
	15	Healthy eating adults	n/a	33.6	28.7	18.3		48
	16	Physically active adults	n/a	15.2	11.2	5.4		16
	17	Obese adults	n/a	21.0	24.2	32.8		13
Disease and poor health	18	Incidence of malignant melanoma	28	19.3	12.6	27.3		3.
	19	Incapacity benefits for mental illness	1400	20.0	27.6	58.5		9.
	20	Hospital stays for alcohol related harm	2433	1250	1580	2860		78
	21	Drug misuse						
	22	People diagnosed with diabetes	5469	4.12	4.30	6.72		2.(
	23	New cases of tuberculosis	2	2	15	110		(
	24	Hip fracture in over-65s	225	404.7	479.2	643.5		27:
Life expectancy and causes of death	25	Excess winter deaths	84	14.7	15.6	26.3		2.
	26	Life expectancy - male	n/a	80.6	77.9	73.6		84
	27	Life expectancy - female	n/a	83.6	82.0	78.8		88
	28	Infant deaths	4	4.16	4.84	8.67		1.(
	29	Deaths from smoking	222	129.6	206.8	360.3		11(
	30	Early deaths: heart disease & stroke	104	53.7	74.8	125.0		40
	31	Early deaths: cancer	192	100.9	114.0	164.3		7(
	32	Road injuries and deaths	42	31.7	51.3	167.0		14

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude r per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end us CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating brea feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of sch children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Und conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-20 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % a 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 200 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problems Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 1 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org

You may use this profile for non-commercial purposes as long as you acknowledge where the information came from by printing 'Source: APHO and Departm Health. © Crown Copyright 2010'.

© Crown Copyright 2(

NHS Devon

East Devon District Council
Local Strategic Partnership

Thursday 15 July 2010

An update presentation by
Ann James, Chief Executive NHS Devon

Respect, Quality, Effectiveness, Openness, Improvement

THE NHS CONSTITUTION

NHS Devon

The National Agenda – the key messages

- The White Paper published on Monday 12 July
- Budget Statement – June 2010

NHS Devon

- Areas for priority working
- How NHS Devon wants to work with local communities
- Developing our joint working and local framework
  - Prevention
  - Primary Care
  - Community Services

Prevention

NHS Devon

Advocating Public Health agenda

- Strategic Partnership Infrastructure
  - Devon Strategic Partnership Delivery Board
  - Healthier and Stronger Communities Partnership
- Heads of Health Improvement – Locality Working
- Joint Strategic Needs Assessment into Strategy
- Stakeholder engagement in Strategy
  - e.g. physical activity strategy (Local Transport Plan; Health impact assessments in growth points; housing developments; local community sport and physical activity networks)
  - Infrastructure planning for new communities / LDF development
  - Memory Cafes to support people with dementia and their carers and to reduce carer stress, social isolation and identify problems early

Primary Care

NHS Devon

Meeting patients needs – specific to locations

- Branch Surgeries within villages and smaller towns

Balance ease of access for patients to clinicians able to make available high standard services

- General Practice in East Devon configured to achieve this balance and react to the population's future needs

Working with GPs to improve mental health services

- Locality Commissioning
- Wellbeing and Access Teams
- Increased funding for IAPT (from 750k to £3.3m)
- Care pathway and service improvements
- Older People's Mental Health support

Community Services

NHS Devon

Integrated health and social care in Devon

- Working in Partnership

Community services

- Support people in their own homes

Community Hospitals to manage and host a range of services

- manage and host a range of services, potentially from different providers
- consider the services mix and quality countywide to achieve maximum health impact and value for taxpayer's money
- respond to new treatment approaches and changing health needs (based on JSNA)
- rising numbers of older people with long term conditions
- shift from bed based approach to new models of care

NHS Devon

Summary and any questions

cfps the centre for public scrutiny
better scrutiny for better government

The Centre for Public Scrutiny
Equity and Excellence – NHS White Paper Summary

Introduction

A link to the Health White Paper 'Equity and Excellence' and supporting documentation, published on 12 July 2010, is:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

The White Paper is published in the context of the Coalition Agreement, but some aspects of the Agreement do not appear in the White Paper (for example elected people on PCT Boards). This summary is not a critique of every proposal – it is intended to identify 5 key themes that will be of interest to councillors, especially those serving on overview and scrutiny committees. Comments on the White Paper are invited before 5 October 2010 and a series of consultation papers about aspects of the proposals are promised before a Health Bill is published in the Autumn.

Implementation of some White Paper proposals may be influenced by the Spending Review expected from the Treasury in October 2010 and the Localism and Decentralisation Bill expected from CLG in December 2010. For example, what the Bill says about the governance arrangements for councils and what the Review says about placed-based budgets.

Changing the structure of the NHS

Familiar organisations will disappear – for example Primary Care Trusts and Strategic Health Authorities. New organisations will emerge either nationally or locally – for example around 500 local General Practice Commissioning Consortia, the national NHS Commissioning Board and Healthwatch (locally and nationally). The Care Quality Commission will be the 'quality regulator' and Monitor will be the 'economic regulator'.

Changing the culture of the NHS

The culture of the NHS will change. Instead of measuring progress through 'processes', progress will be judged against 'service quality and outcomes'. Frontline clinicians and patients will be in the driving seat rather than remote performance managers.

Patients and public at the heart

Patients and the public will be empowered through transparency of information about service quality and outcomes, shared decision-making with clinicians about their treatment and care and choice about who will provide their treatment and care. Local Healthwatch will have a strong voice and will have a strong relationship with councils. Patient and public involvement will be a duty for commissioners.

Commissioning

Perhaps the most significant shift in structure and culture is the creation of around 500 GP commissioning consortia that will decide local priorities for buying healthcare within a framework established by the NHS Commissioning Board. The Commissioning Board will be responsible for some regional and national specialised services.

New roles for councils

The health improvement role of PCTs will transfer to local councils. Councils will be given new roles, through Health and Well-being Boards, to:

- Join up healthcare, social care and health improvement
- Promote integration and partnership
- Lead on assessing local needs
- Build partnerships for service change and priorities

Because councillors will make sure these things happen, the statutory 'health scrutiny' powers for councillors to get information and responses from NHS bodies will not be required.

Conclusion

- there are roles for councils and for councillors in the new arrangements
- tackling challenges to people's health remains a key focus
- councillors need to keep asking questions about issues that matter to local people
- there are opportunities to link together transparency, involvement and accountability at local and national level

10 questions that Councillors might want to ask

How will councillors influence:

- the local transition to the new arrangements?
- appropriate outcome measures for commissioners and providers?
- how well GP Commissioners evaluate whether the services they commission meet local needs and change services that don't meet needs?
- the effectiveness of Health and Well-being Boards as co-ordinators of healthcare, social care and health improvement?
- the NHS Commissioning Board, especially around regional and specialist services?
- the development and support of an effective local Healthwatch?
- the relationship between councils and the Care Quality Commission and between local Healthwatch and national Healthwatch?
- the experience of patients and carers and the quality and safety of services?
- the influence local people have to develop options for changes to services?
- the process for assessing service reconfigurations?

Briefing paper for East Devon District Council Local Strategic Partnership Meeting
Thursday 15 July 9:15am, Sidmouth

PREVENTION

Q. Are there any models of good practice, and what is your commitment to the preventative agenda?

A. Our commitment to the preventative agenda is through the strategic partnership infra-structure. We are aiming to make an impact in terms of outcomes through public policy. We use the LAA infrastructure/DSP framework to promote the health improvement agenda, alongside our work around healthcare and treatment.

We have strong involvement in partnership working. Structures are two way - bottom up from localities to county level partnerships. Health and wellbeing groups, local children's trusts, community physical activity and sports partnerships, and community safety partnerships at locality level link into county-wide theme groups and ultimately the Devon Strategic Partnership. Health and wellbeing groups are the local process to maintain 2 way communication around the tackling health inequalities and health improvement agenda.

Memory Cafes for people experiencing memory problems or dementia and their carers are now in place or have an imminent start date in each of the market coastal towns in East Devon. These offer very local preventative support to reduce carer stress, reduce social isolation and identify problems early so that they can be dealt with in a timely manner. DPT CPNs attend each of these to offer professional advice and support. Start up funding has been provided by DCC.

Q. How are you working with other agencies (including district councils) to generate better health and wellbeing?

A. Strategies are developed with the involvement of a wide range of stakeholders, which identify the wider determinants and benefits from healthier public policy to improve health. For example, the physical activity strategy emphasises the public health impact of increased walking and cycling. We therefore link into the development of the Local Transport Plan to ensure opportunities for walking and cycling are maximised through this process. We work with district partners to undertake health impact assessments in growth points, to ensure such opportunities are maximised within new housing developments. We work within the local community sport and physical activity networks to join resources and align activities to maximise impact within the community, ensuring new developments- such as the Active Villages programme, support the needs of the least active, most vulnerable citizens. Our work in this regard has been recognised and applauded by the Department of Health and Strategic Health Authority peer Review process.

Working with DCC and District Councils in terms of their infrastructure planning for new communities and LDF development to ensure a joint service delivery / and co location service model and better up stream working.

A regional government email has recently been recognised. DCC and Devon PCT joint infrastructure planning was commended as fundamental to building in health (and especially Joint Needs Assessment) into emergency core strategies and new development proposals

Q. How are you advocating for the public health agenda across the County?

A. I (Ann James) chair the DSP Delivery Board and Virginia Pearson chairs the Healthier and Stronger Communities Partnership

Heads of Health Improvement work within localities- offering a key officer role-, linking into partnerships, joining up and aligning resources, influencing the development of local priorities and policy, ensuring strategies focus on evidence based approaches, using implementation plans and reporting mechanisms to evidence impact.

PRIMARY CARE

Q. In the north there is an example where GPs go out to the Villages once a week. Is there a reason why this should not happen in East Devon?

A. Within Devon there are some Practices that operate branch surgeries within villages and smaller towns. In addition there are some examples of specific identified need where local GPs have decided that the best way to meet patients needs is to visit specific locations, for example a large nursing home, on a scheduled basis rather than patients visiting the Practice. However in both cases it is usual that the full range of services now provided by GPs and their team would not be available under such arrangements. Clearly as commissioners of healthcare it is important that the Trust balances ease of access for patients to clinicians with the ability to make available as full a range of services provided to a high standard as is possible. Within East Devon we feel that General Practice is configured in such a way that it is well placed to continue to achieve this balance and to be able to react to the future needs of the population.

Q. What are you doing about improving mental health services?

A. **Working with GPS**

NHS Devon now has a locality commissioning structure that enables regular planning and performance tasks to be delivered involving practice based commissioners.

Wellbeing and Access Teams provide access to a wider range of mental health services, e.g. for common mental health problems through to psychosis and self harm. GP's have fast access to these teams, which also respond to self referrals.

Improving Access to Psychological Therapies (IAPT) is being underpinned by an increase in funding in Devon from around 750K at the beginning of 2009 to a minimum of £3.3m in 2010-11. The funds are being used to train a workforce in the most modern evidence based interventions. These are mostly based in cognitive behaviour therapy and aimed at maximising people's own resources and resilience. The service will be fully staffed by the end of 2011.

By the end of this financial year, improvement in care pathways will reduce the period to assessment for both people who use mental health services and carers to a maximum of 4 weeks.

NHS Devon recognises the importance of considering people's needs in the round, including people's physical and emotional needs. Services are being improved at the RD&E in both A&E and on the wards through the provision of a mental health liaison service. This will cover self harm as well as the mental health needs of older people.

Local specialist eating disorder services have improved our ability to respond to the needs of people within Devon. A similar approach is being taken with specialist personality disorder services. These involve both DPT and an independent provider and include a new hospital facility located a short distance from East Devon (in Crediton).

A new service for the provision of assessment, diagnosis and treatment for adults with autistic spectrum conditions (and Attention Deficit and Hyperactivity Disorder) has been commissioned by NHS Devon and DCC and will be operational within the next 4 months. The design of a community support service (for ASC and ADHD) will also take place over the next 6 months and include people with ASC and their family supporters.

In relation to OPMH we are developing community services to support people better at home and reduce reliance on hospital admissions where these are inappropriate. See memory cafe info above. Crisis resolution services previously only available to people under 65 will now encompass older people and rapid response services are being developed to ensure people with dementia have support to remain at home

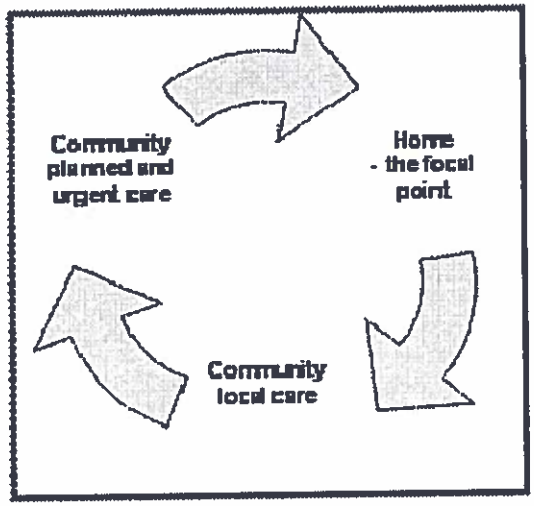
COMMUNITY SERVICES

Q. What do you see for the future of community hospitals?

A. Community service that support people in their own homes, and access to community hospitals and other local services, will play an important role in the future health and integrated health and social care in Devon. NHS Devon has previously stated in The Way Ahead, the value of community hospitals and the opportunity to make the most of these assets.

The vision described is that community hospitals will manage and host a range of services, potentially from different providers, to deliver the most comprehensive care possible across Devon. This will mean carefully considering the services mix and quality that will be needed across the county to achieve maximum health impact and value for taxpayer's money.

To get this right we need to be prepared to shift our thinking about the possibilities of community hospitals of the future.



Q. Services – what do you see for the future of community hospitals and how will you tackle the large growth in population but constrained hospital sizes?

A. The remit of community hospitals will change as we respond to new treatment approaches and changing health needs. Our annual Joint Strategic Needs Assessment gives a detailed analysis of the population health need and we are also linking with District Councils Local Development Frameworks to ensure we have a longer term understanding of plans and proposals for the area. We therefore have very sound planning information. Our knowledge of population growth means we must start now to future proof our services.

Lengths of stay in hospital are shorter overall and there are procedures such as blood transfusion, which in the past mainly took place in hospital and now increasingly take place in people's own homes. There are new approaches - some we are now testing locally such as virtual wards and early supported discharge that will help people return home earlier with the right support. Changes to the population with the rising numbers of older people and increased long term conditions mean that learning from other areas in relation to national and international practice will be important.

There are local variations the way hospitals are presently used, and through best practice implementation for care pathways, admissions, length of stay and other factors, our emphasis will shift from the more traditional bed based approaches to models of care that enhance services and improve experiences of care.

Now is the time for us to move from the strategy and make the step towards bringing Devon's community hospitals to the forefront of future models of care. We will be working with GP's providers and communities to take this next step.

Rural Health and Wellbeing Strategy for Devon 2010-2013

[INSERT IMAGE OF RURAL DEVON AS BACKGROUND]
[DSP LOGO AT TOP]

Contents

Rural Health and Wellbeing Strategy for Devon
Foreword

Living in a rural area of Devon can be a very positive experience for people's health and wellbeing. At the same time some people, groups and communities can face particular issues that make achieving or maintaining good health and wellbeing more difficult. This first **"Rural Health and Wellbeing Strategy for Devon 2010-2013"** starts to explore the story and highlight actions that will help improve the health of all people in rural areas, particularly those with greatest need.

The Strategy has been developed following extensive dialogue and discussion with a wide range of individuals and organisations. It builds on the work of the Devon Rural Network and identifies a number of common themes; access to services, the need for more integrated services and the promotion of community cohesion and engagement. Focusing on a people perspective, its scope covers both the wider determinants of health such as housing, employment and transport, plus lifestyle factors including physical activity, sexual health and alcohol misuse. With the challenging financial situation facing everyone in the next few years, we must work together to achieve the best for our rural communities.

An implementation plan will be produced by September 2010 setting out how partners will deliver each recommendation. The Healthier and Stronger Communities Partnership reporting to the Devon Strategic Partnership will monitor progress in implementing the Strategy. It will be subject to an annual review which will take into account the views of local people and any new local or national policies.

I look forward to working with you on this Strategy.

Dr Virginia Pearson
Joint Executive Director of Public Health
NHS Devon and Devon County Council

1. Introduction

Who is the Strategy for?

1.1 The Rural Health and Wellbeing Strategy is for **all partner organisations** which can impact on the health and wellbeing of local people (defined in its widest sense) and in particular those individuals and/or organisations who have key responsibilities in relation to any specific recommendations. Overall, the Strategy is for all organisations aligned to the Devon Strategic Partnership.

1.2 This Strategy will be accompanied by a detailed **implementation plan** that identifies who is best placed to lead the implementation of each recommendation, other supporting partners, timescales and available resources. The Strategy should inform priority actions within any local health improvement plan produced by District Level Local Strategic Partnership Health and Wellbeing Groups.

2. The vision

2.1 This Strategy sets out Devon's vision to improve the overall health, wellbeing and quality of life of **all people** living in rural areas, with a focus on reducing inequalities in health and reducing inequities in health and social care provision.

2.2 The main objectives are to:

- gain a better understanding of the needs of people of all ages living in rural areas in Devon;
- consider possible barriers to, and opportunities for, health improvement;
- build the resilience of Devon's rural communities;
- utilise the potential of local people and local infrastructure to provide innovative solutions to the challenges faced by people living in rural areas;
- develop and/or redesign services to meet the needs of rural communities.

3. Background

Health, wellbeing and rurality

3.1 The World Health Organization defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[1] The Ottawa Charter for Health Promotion[2] outlined that in order to reach this state, "an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment". In this context, health is seen as "a resource for everyday life, not the objective of living". It is also viewed as a "positive concept emphasising social and personal resources, as well as physical capacities".

3.2 In the rural context, evidence suggests that people living in rural areas typically enjoy better health and wellbeing than their urban counterparts,[3] often appearing to score better on standard measures of health such as life expectancy and infant mortality. Many rural communities also offer well-developed community resources, strong social networks and healthy environments for leisure, education and enterprise.[4] However, the widely recognised benefits of rural life have led to the concept of the "rural idyll".[3] This stereotype ignores the real challenges faced by many people living in rural areas, including:

- deprivation (including pockets of hidden deprivation);
- a growing ageing population;
- small, sparsely distributed populations;
- changing population patterns, including outward migration of young people;
- social isolation and social exclusion;
- lack of affordable housing and fuel poverty;
- poor infrastructure, access issues and a lack of health and related services;
- a shrinking skilled workforce;
- specific health needs associated with some population subgroups.

In particular, people experiencing deprivation often live alongside the affluent and car ownership is viewed as a necessity rather than a luxury. This means that the needs of some people living in rural areas can remain hidden to service providers.

[1] The World Health Organization (1948) - WHO definition of health - http://www.who.int/about/definition/en/print.html.
[2] The World Health Organization (1986) - Ottawa Charter for Health Promotion - http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.
[3] Mind (2009) – Rural issues in mental health - http://www.mind.org.uk/help/people_groups_and_communities/rural_issues_in_mental_health.
[4] The Carnegie Commission for Rural Community Development – A Charter for Rural Communities - http://rural.carnegieuktrust.org.uk/files/rural/A%20Charter%20for%20Rural%20Communities.pdf.

3.3 According to the Ottawa Charter for Health Promotion,[2] the promotion of health and wellbeing is "not just the responsibility of the health sector". Dahlgren and Whitehead's model[5] (Figure 1) provides a useful framework for considering many of the wider determinants of health and wellbeing, as well as helping to engender partnership working. This model underpins Devon's Rural Health and Wellbeing Strategy, particularly as the issues identified (see Section 8) generally fall under the broad category of "living and working conditions". Barton and Grant[6] have since added additional layers to this model. This extended version has been included below as it proves useful in highlighting the impact of both the natural environment (e.g. access to green space) and the built environment (e.g. the availability of public infrastructure and facilities) on rural health and wellbeing (Figure 2).

Figure 1. The **wider determinants of health (Dahlgren and Whitehead 1991)[5]**

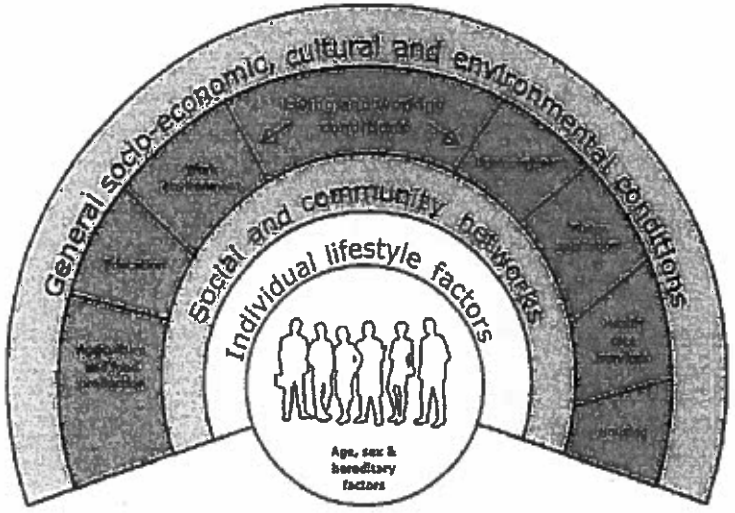
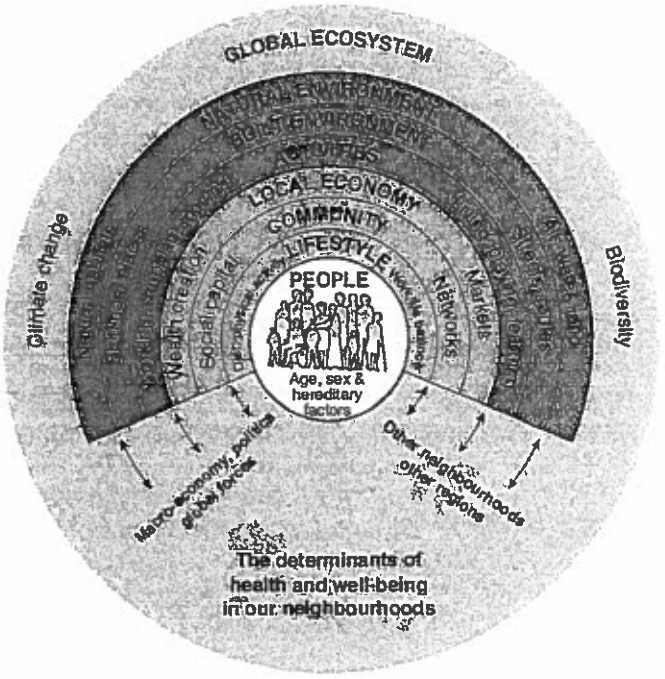


Figure 2. A health map (Barton and Grant 2006)[6]



[5] Dahlgren, G. and Whitehead, M. (1991) - Policies and strategies to promote social equity in health - http://www.framtidsstudier.se/filebank/files/20080109$110739$fil$mZ8UVQv2wQFShMRF6cuT.pdf.

[6] Barton, H. and Grant, M. (2006). A health map for the local human habitat. The Journal of the Royal Society for the Promotion of Health; 126: 252-253.

4. The national context and local approach

The Government's vision of sustainable rural communities in which economic, social and environmental issues are taken into account is at the heart of Devon's Strategy for Rural Health and Wellbeing. The importance of promoting citizen engagement and community involvement in local decision-making and the benefits that this can bring to health is emphasised. In particular, the New Performance Framework from the Improvement and Development Agency (see page 43) has had an important impact on rural communities and the ways in which service providers engage with them.

In relation to health outcomes, the Institute of Rural Health published a rural proofing guide for Primary Care Organisations in 2005 (page 42). Whilst this is useful in helping to identify gaps in service delivery and service provision, Devon's Strategy takes a **people-based** approach to rural issues, as well as acknowledging many of the **wider determinants** of health and wellbeing (Figures 1 and 2, page 7).

There are a number of other national strategies and initiatives that have direct relevance to rural health and wellbeing (see Appendix 2, page 42 for details). Devon's Strategy also relates closely to the **2010 Marmot Review "Fair Society, Healthy Lives"** which outlines an evidence-based Strategy for reducing health inequalities, with focus on addressing the wider determinants of health.

It is important that the Joint Strategic Needs Assessment reflects rural health and wellbeing issues to inform the commissioning cycles of individual organisations and various partnerships.

There are also a number of local policies and initiatives with positive implications for rural communities in Devon (see Appendix 3 page 45 for more details). Key local strategies, frameworks and reports are:

Sustainable Community Strategy for Devon (2008-18) – http://www.devonsp.org.uk/scs/home.html. The **Local Area Agreement (2008-2011)** priorities express this Strategy (http://www.devonsp.org.uk/sustainablecommunitystrategy/outcomes/devonlaa0811.pdf).

NHS Devon's and Devon County Council's joint vision and plans for health and social care (2010-2015) – "The Way Ahead – Five Years of Improvement" - http://www.devon.gov.uk/the_way_ahead_for_board.pdf.

The Devon Rural Strategy (2007) produced by the Devon Strategic Partnership's Rural Task Group - http://www.devon.gov.uk/drnruralstrategyactionplan.pdf.

Rural Access to Health Task Group Report (March 2010) – http://www.devon.gov.uk/index/councildemocracy/decision_making/cma/cma_report.htm?cmadoc=report_cx1036.html.

Community-led and accessibility planning (see Appendix 3, page 45)

Devon County Council's Local Transport Plan (2006-2011) - http://www.devon.gov.uk/ltp-ch1-2006.pdf.

Local agencies and organisations with a rural focus are listed in Appendix 3.

5. Commissioning challenges

5.1 In order to achieve the vision outlined in Section 2, a number of commissioning challenges need to be addressed. Commissioners of services in Devon need to:

- undertake rural proofing of local policies and initiatives to ensure that "rural need" is addressed appropriately (the Devon Rural Proofing Self Assessment Tool will be available during 2010);
- engage rural communities effectively and recognise distinctive needs;
- acknowledge the difficulty of achieving equity of access to services and include the issues of travel within dispersed communities;
- develop local resources by building on or adding value to already established local services;
- build on existing links with the voluntary and community sector, acknowledging their role in supporting the needs of the rural communities and recognising their potential for delivering innovative service solutions;
- involve people living in Devon's rural communities in developing services to address need.

5.2 In terms of the Health and Social Care agenda, it will be important that the implementation of NHS Devon's and Devon County Council's joint plans for health and social care 2010-2015 (The Way Ahead: Five Years of Improvement) take rural issues into account. The current priorities outlined in Devon's Local Area Agreement 2008-2011 take account of a number of rural issues; whilst Devon's Children and Young People's Plan 2008-2011 can make explicit actions which address the impact of rural issues on children, young people and their families. The Rural Health and Wellbeing Strategy also relates closely to **World Class Commissioning** competencies and objectives, particularly regarding reducing health inequalities and increasing live expectancy.

6. Delivering the Strategy

6.1 The accountability for the Strategy will be held by the Devon Healthier and Stronger Communities Partnership (HSCP), working specifically with the Stronger Communities and Health Improvement Group (SCHIG) which will oversee the implementation of the various recommendations and report on subsequent progress through the production of an annual report.

6.2 The nature of many of the issues is complex and will require links to be made across various organisations at a local level. To this end, it is anticipated that actions reflecting the recommendations will be made explicit within the local health improvement plans and other relevant plans linking into Local Strategic Partnership Sustainable Community Strategies.

6.3 This Strategy will be accompanied by a **separate implementation plan** that specifies who is best placed to lead the implementation of each recommendation outlined in Section 8, including resources, timescales and how success will be measured by September 2010.

East Devon Health Improvement and Tackling Health Inequalities Plan

The action plan is a mechanism for monitoring and prioritising health and well-being issues across East Devon

Two priority areas for targeted action have been identified for 2010/11:

- Emotional Health and Wellbeing
- Teenage conceptions and young peoples sexual health

Public Health priorities also include:

- Physical activity, Healthy eating and Healthy weight
- Alcohol
- Smoking

Promoting emotional health and preventing suicide are a priority for East Devon, with 17656 people seeking support for a mental health problem in 2008. Reversing the rising trend of teenage conceptions is also a local priority. Data over the last decade indicate a 24.6% rise in teen conception rates since 1998. Rates in East Devon are now higher than the Devon average. Lifestyle factors are key to improving health and reducing health inequalities. A reduction in Coronary Heart Disease (CHD) in the most deprived communities could make the greatest impact on reducing health inequalities across East Devon. Cardio-vascular disease prevention programmes need to address the recognised risk-factors of smoking, poor diet and physical inactivity.

Other areas for action include:

- Prevention of falls
- Prevention of childhood injuries

Addressing the wider determinants of health is essential for health improvement and reducing health inequalities.

East Devon District Council
Health, and Health Equality Policy

Reviewed
New policy created January 2009

Policy Approval
-

Reasons for introducing the Policy
PCT changes aligned their organisations to County Council and Unitary areas so the previous East Devon relationships have changed. There is strong pressure from Government (reflected in IDeA and CAA working) for Councils to take their public health leadership role seriously. This policy sets out where the District Council will be involved in health issues as part of its core business, and how it supports the corporate priorities. The Local Area Agreement for Devon includes health and health equality work.

Policy Statement
The policy explains how the Council is already a significant local player in health of its local communities and establishes how it will continue in this role in a way which will not overlap or conflict with the roles of other organisations but will still seek to achieve the best for East Devon and ensure that health equalities are maintained.

Terms Explained
Usually when we use the word 'health' we usually immediately think about the opposite.... illness... but of course 'health' covers more than that.

The World Health Organisation regards health as a 'complete state of physical, mental and social wellbeing' not just an absence of illness. So we need to think wider than the medical issues of just tackling illness, disability and injury. In order for people to be, and to stay, physically, mentally and socially healthy we also need to consider the environment in which they spend their lives, and the social support and influences around them.
If we recognise that health is not just about doctors we see that much of the work of a District Council is in fact about protecting peoples' good health.

How will we go about it?
The role of a district Council very much complements the health efforts of the clinical professions. However:

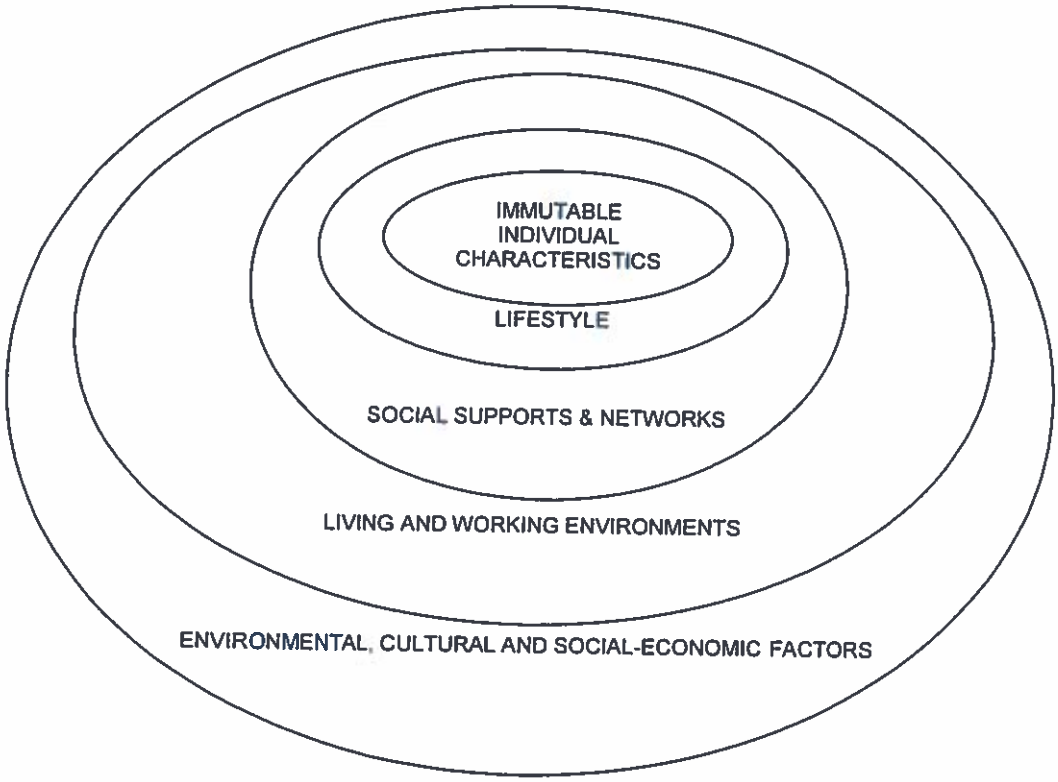
1. Whereas the NHS (National Health Service) mostly think of patients and illness, we mostly think about ways of keeping people well
2. Whereas the NHS look principally at the health of individuals we tend to look at the health of communities
3. Whereas the NHS think about the health issues of existing patients we are starting to plan for the health, and health facilities, of future generations
4. Local Authorities provide an opportunity for democratic input to health issues
5. We have a regulatory dimension for health, enforcing various health related laws
6. We may be less science, and evidence focussed, and more responsive to people's feelings about things than the NHS

7. We have a much wider brief than the NHS

If we consider the bare essentials for a healthy life ....food, water, shelter (housing) and air:... a District Council has an input to good quality of all of these. Furthermore a District Council does have a direct role in control of disease and injury (food poisoning, pest and dog control, work related illness, refuse collection and other services), and control of stressors (for instance noise, crime, low income, and nuisance), as well as providing for an active and creative lifestyle and fulfilling occupation. Thus our roles affect everything from basic safety from injury to opportunities to improve feelings of self worth.

A famous diagram (Dahlgren and Whitehead) is at Fig. 1. It shows the whole range of elements that go into making a person or a community healthy, and the majority are aspects a District Council has an input into.

Figure 1 – Health Factors



From the diagram we can see the relevance of social and mental factors in health and wellbeing and also the potential links to many areas of Council activity. One of the key aspects of health activity is "Health Equality". This is ensuring that not only does the overall health of a population or community increase but that this increase is spread equally through the community. There can be a risk that certain groups (typically more affluent groups) improve but others do not – thus widening the health 'gap'. For this reason there is an important link between health and equal opportunities work.

Within the Council this also means that the impact of our health work also needs to at least fall equally on <u>all</u> parts of our community, preferably that those with least good health receive more benefit (positive action). This links Health Equalities to our other Equal Opportunities work.

We have an 'Environmental Health and Health Equalities' Service which should bring particular focus to this aspect.

What do we already do?

As suggested above many of the everyday activities and initiatives of a District Council are directly linked with health and this should be no surprise as, at its beginnings, local government was fundamentally a health organisation, long before the NHS was born. Sanitation, waste collection, control of nuisances, control of housing conditions, and even management of hospitals and doctors were at the heart of local authorities a century ago.

At Appendix 1 is a list of the current main inputs by the many different parts of EDDC to the health, and healthy lifestyles of people resident in our District (including many of our staff and Members).

Much of the regulation that exists to control illness, disease, and injury has been vested in local authorities. Local Authorities have also been given a legal 'power of wellbeing' which is the authority to do things and spend money for the wellbeing of their local people.

How does 'health link to the corporate priorities?

1. Affordable Homes – shelter is a health requirement
2. Thriving economy – working environmental freedom from money worries improve health
3. Safe, clean and green environment – these support basic public health and freedom from stress
4. Recycling – this is part of healthy and sustainable waste management which is about basic public health
5. Children and Young People – the health and wellbeing of this sector can sometimes be overlooked
6. Excellent service for customers – our services are predominantly health related (see Appendix 1) and health equalities should be a guiding principle
7. An inspirational Council – a broader perspective on communities and their health is an integral part of this priority. We also apply 'good health' principles for our staff and Members.

In the Appendix is a service by service breakdown of the activities of the Council in meeting the corporate priorities.

What is health like in East Devon?

We are fortunate in East Devon to be living in one of the most healthy districts in the country, considering the age profile of our population. However we should not be complacent. The 'average' figures behind this general statement hide a complex mass of variability. At Appendix 2 is a brief comparison of the local health situation. We do have areas of relative deprivation within the district but even the "non-deprived" areas contain households with deprivation problems.

Whilst we have a large resident population we also have some responsibility towards the health of those who visit East Devon, including thousands of holidaymakers.

Specific Policy Areas

What more, if anything, should we be tackling to improve local people's health?

As well as the Council's corporate priorities the East Devon Sustainable Community Plan, the developing LDF (Local Development Framework), and the Devon Local Area Agreement all contain targets and actions to help promote local health. These are in Appendix 3

As an employer we have many hundreds of staff, and contractors, (most of whom live locally) for whom we can ensure we provide healthy, and health promoting, workplaces. In broad terms our strategy for Health should be to complement the work of other agencies and to continue to develop our role in the following aspects:

1. Work with health partners in delivering the locally relevant parts of the Local Area Agreement.
2. Maintain links with PCT, GP consortia and other health groups providing Council representation on these groups when requested and appropriate.
3. Advocate for East Devon's local health issues to other partners and agencies.
4. Advocate for the health needs of rural populations (especially access issues) with partners and other agencies.
5. Scrutinise the changing local and national health needs, and the priorities and activities of other health providers (including changes to the level of service). Develop the Health Equalities aspect of the Environmental Health & Health Equalities Service and maintain regional and national links through their Corporate Director.
6. Promote social and environmental health issues to local communities and continue Council actions to do this. Use our in-house publicity to assist in information provision.
7. Promote positive mental health both within the Council and in our communities
8. Exercise our range of regulatory functions for public health.
9. Make direct provision for health, and healthy activity, when this complements (but does not duplicate or override) the role of other agencies, and where it is permitted by budgets and priorities.
10. Assess the health impact of major new developments, and ensure that the wider aspects of health are recognised in the Local Development Framework and policy.
11. Assist in consultation (with other agencies) to establish the wider health priorities of our local communities and (working alongside our Equalities and Diversity activity) seek to better ensure Health Equalities across all parts of our community.
12. Seeking better resourcing for health improvement.

Outcomes

The outcome of this policy is that EDDC as a community leader continues to make a difference to the overall health and wellbeing of East Devon but in a way which narrows gaps and which complements and stimulates activity by other health related agencies.

Who is responsible for delivery?

This area of policy falls to the Communities Portfolio holder and the relevant Corporate Director. The various service and Member roles are as set out in Appendix 1.

Performance Monitoring

This will primarily be through our monitoring of Local Area Agreement activity.

Policy Consultation

All services.

Policy Review

To be reviewed by the relevant Corporate Director in December 2010.

Related Policies and Strategies

Human Resources Policy
Equality Policy

Environmental \Health Policies
Waste Policies
Housing Policies
Planning Policies and many others

Communities Overview and Scrutiny
Proposed Forward Plan 2010/11

Month	Topic	Lead
20 October 2010	**Community Groups in East Devon** Members to receive a presentation from Groups funded by EDDC **Update from Member Champion for Equality** Members to receive an update following the Equalities Assessment in September 2010	
12 January 2011	**Affordable Housing** **Review of Home Safeguard Charges** – Review effect of changes introduced. **Presentation from Member Champion for Culture**	
16 February 2011	**Exmouth Street Pastors** Members to hear of the work of this group **Community Engagement** Members to hear of successful community engagement projects (such as Exmouth model) **Children and Young Peoples' Facilities** Continued debate	

Suggestions for Future topics:

- Parish Plans
- Presentations from Member Champions – what work is being done for communities and how can the Council assist further?:
    - Post Offices Champion
    - Community Safety Champion
    - Sustainability Champion

East Devon

updated 28 July 2010

This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info

Based on Ordnance Survey material. © Crown Copyright. All rights reserved. DH 100020290 2010. Other map data © Collins Bartholomew.

Population 132,700

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

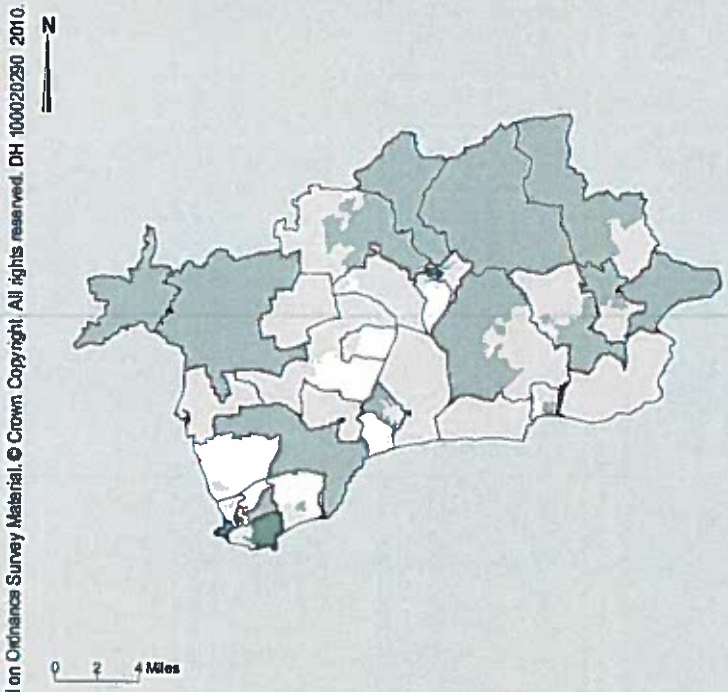
East Devon at a glance

- The health of people in East Devon is generally better than England as a whole. However, the rate of malignant melanoma skin cancer is worse, with 28 new cases of skin cancer in East Devon each year.
- East Devon has low deprivation levels compared to England as a whole. The rates of children living in poverty, homelessness and violent crime are all better than the England averages.
- The rate of early death from heart disease and stroke has fallen over the last 10 years and remains lower than the England average.
- The percentages of children in Reception year classified as obese, children spending at least 3 hours per week on school sports and rates of teenage pregnancy are all better than the England averages. The breastfeeding initiation rate is also better than average.
- The rate of people claiming incapacity benefits for mental illness is better than the England average. The rate of hospital stays for alcohol related harm is also better than the average, although there were still over 2,400 admissions for alcohol related harm in 2008/09.
- In East Devon emotional health, teenage conceptions, CVD prevention, smoking, healthy weight, alcohol and falls have been identified as local public health priorities to be addressed through partnership working.
- For further information see the Annual Public Health Report at www.devonpct.nhs.uk and the Joint Strategic Needs Assessment at www.devon.gov.uk

© Crown Copyright 2010

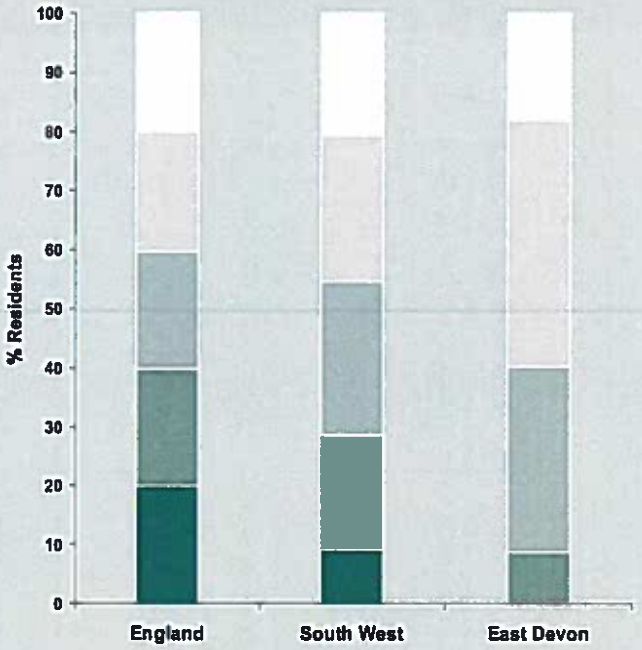
Deprivation: a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.



Based on Ordnance Survey Material. © Crown Copyright. All rights reserved. DH 100020290 2010.

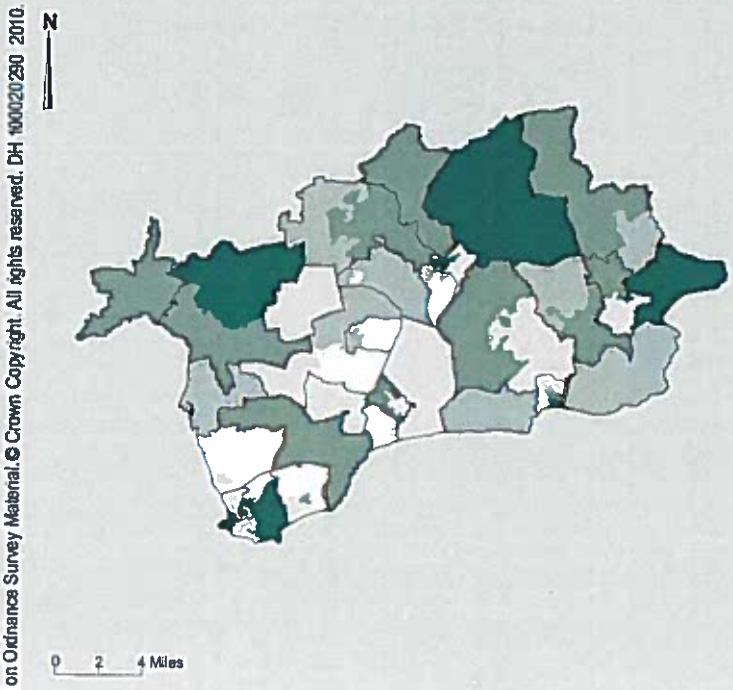
This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

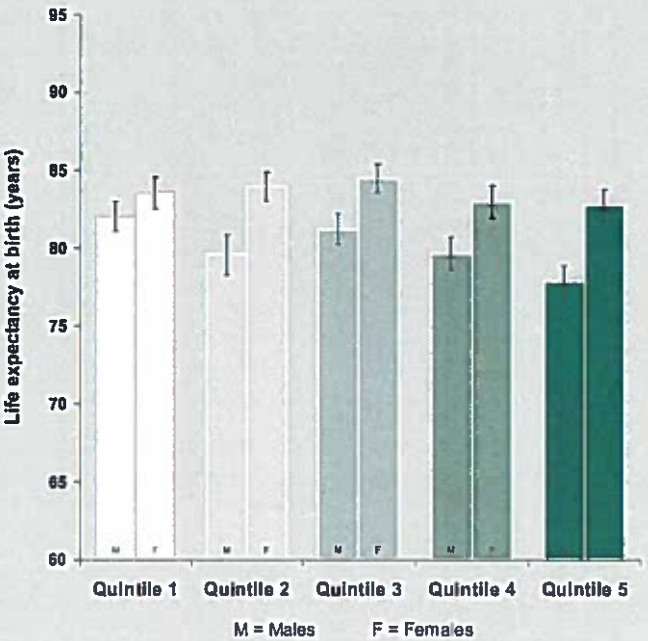
Health inequalities: a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Based on Ordnance Survey Material. © Crown Copyright. All rights reserved. DH 100020290 2010.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.



95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

www.healthprofiles.info

© Crown Copyright 2010

Health inequalities: changes over time

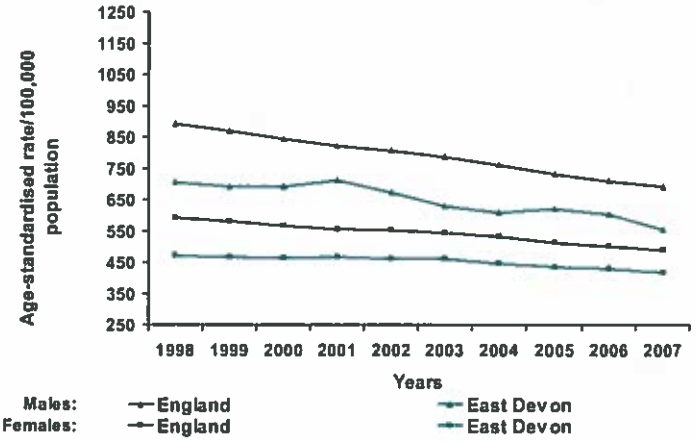
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

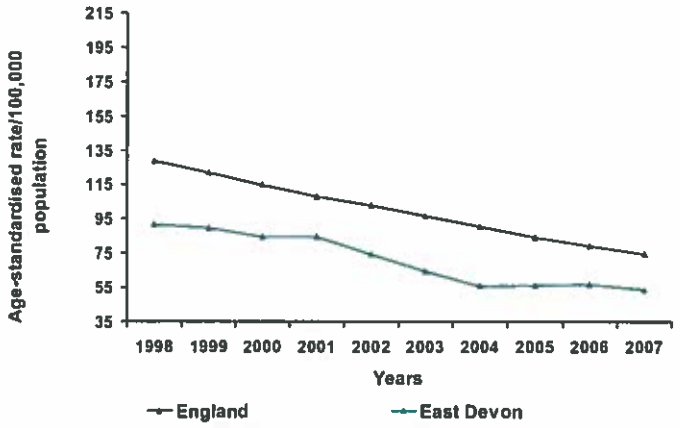
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

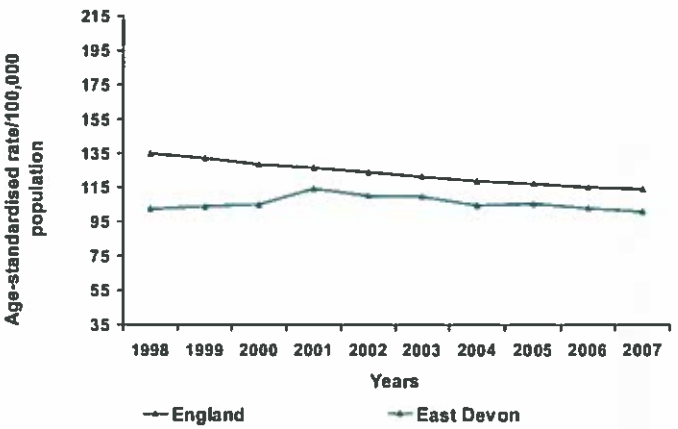
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

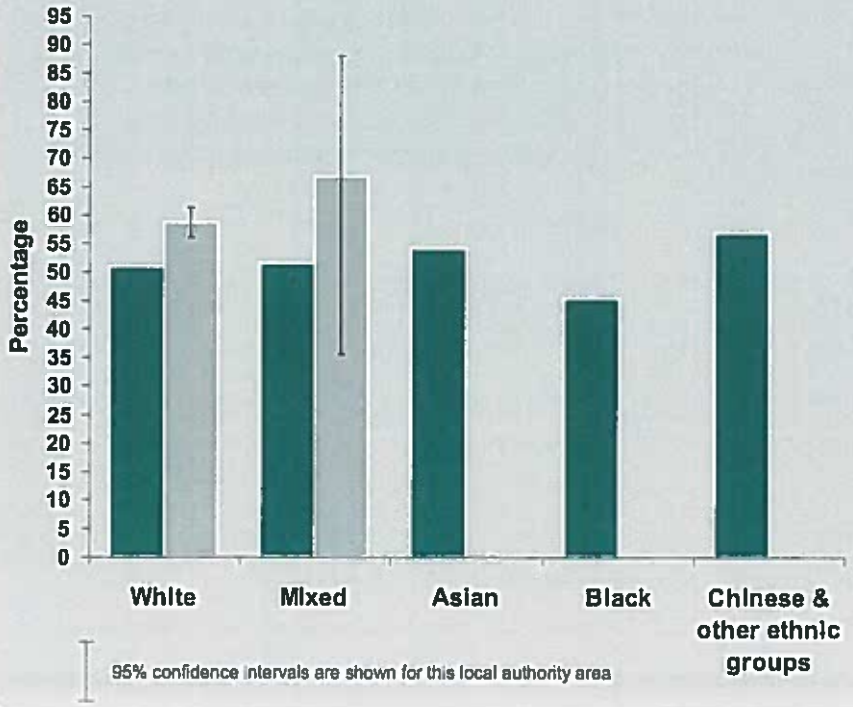


Trend 3:
Early death rates from cancer



Health inequalities: ethnicity

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.



England
East Devon

Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	58.7	792
Mixed	66.7	6
Asian		
Black		
Chinese/other		

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

© Crown Copyright 2010

Health summary for East Devon

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

+ In the South East Region this represents the Strategic Health Authority average

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	0	0.0	19.9	89.2		0.0
	2	Children in poverty	2717	13.0	22.4	66.5		6.0
	3	Statutory homelessness	78	1.34	2.48	9.84		0.00
	4	GCSE achieved (5A*-C inc. Eng & Maths)	807	58.5	50.9	32.1		76.1
	5	Violent crime	1164	8.8	16.4	36.6		4.8
	6	Carbon emissions	812	6.1	6.8	14.4		4.1
Children's and young people's health	7	Smoking in pregnancy	127	13.0	14.6	33.5		3.8
	8	Breast feeding initiation	745	76.7	72.5	39.7		92.7
	9	Physically active children	8316	53.5	49.6	24.6		7[illegible]
	10	Obese children	72	6.8	9.6	14.7		4.7
	11	Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.2
	12	Teenage pregnancy (under 18)	79	34.8	40.9	74.8		14.9
Adults' health and lifestyle	13	Adults who smoke	n/a	16.1	22.2	35.2		10.2
	14	Binge drinking adults	n/a	17.0	20.1	33.2		4.6
	15	Healthy eating adults	n/a	33.6	28.7	18.3		48.1
	16	Physically active adults	n/a	15.2	11.2	5.4		16.6
	17	Obese adults	n/a	21.0	24.2	32.8		13.2
Disease and poor health	18	Incidence of malignant melanoma	28	19.3	12.6	27.3		3.7
	19	Incapacity benefits for mental illness	1400	20.0	27.6	58.5		9.0
	20	Hospital stays for alcohol related harm	2433	1250	1580	2860		784
	21	Drug misuse						
	22	People diagnosed with diabetes	5469	4.12	4.30	6.72		2.69
	23	New cases of tuberculosis	2	2	15	110		0
	24	Hip fracture in over-65s	225	404.7	479.2	643.5		273.6
Life expectancy and causes of death	25	Excess winter deaths	84	14.7	15.6	26.3		2.3
	26	Life expectancy - male	n/a	80.6	77.9	73.6		84.3
	27	Life expectancy - female	n/a	83.6	82.0	78.8		8[illegible]
	28	Infant deaths	4	4.16	4.84	8.67		1.08
	29	Deaths from smoking	222	129.6	206.8	360.3		118.7
	30	Early deaths: heart disease & stroke	104	53.7	74.8	125.0		40.1
	31	Early deaths: cancer	192	100.9	114.0	164.3		70.5
	32	Road injuries and deaths	42	31.7	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

You may use this profile for non-commercial purposes as long as you acknowledge where the information came from by printing 'Source: APHO and Department of Health. © Crown Copyright 2010'.