PUBLIC
Author: Mandy Chambers Agenda Item No.7 (a)

DERBYSHIRE COUNTY COUNCIL

CABINET

2 June 2014

Report of the Director of Public Health

LOCALITY PUBLIC HEALTH PLANS (Health and Communities)

1. Purpose of the report

To approve Public Health Locality Plans as endorsed by Local Area Committees.

2. Information and Analysis

2.1. At the meeting of Cabinet held on 3 December 2013 the Public Health Locality Programme was approved and totals £989,301. Each district locality was allocated a formula based budget to address issues to improve health and address health inequalities at a local level.

2.2. Local Area Committees have overseen the development of the Locality Public Health Plans which have been drawn together with partners, including Local Strategic Partnerships (LSPs), district and borough councils, and the voluntary and community sector.

2.3. Each Plan has been developed using local data and information in order to identify needs and priorities which are relevant to the area. The priorities and actions in each plan focus activity to address health improvement and health inequalities and will direct the Locality Public Health investment in each area.

2.4. Local Area Committees have endorsed the Plan for their respective areas. The detailed plans are available on the council website identified as Appendices 1 – 8 and will be made available to all Members in their respective group rooms. Hard copies will be available on request.

2.5. Local Area Committees will receive annual reports to monitor the delivery of priorities, actions and investment. This will enable Members to have a key role in influencing the annual review and refresh of their Public Health Locality Plans.

2.6 Local Area Committees have supported this approach and will receive reports to agree the investment and monitor outcomes. Where LSP locality health partnerships are established it is proposed that these are used to deploy the locality investment to meet the outcomes

established in the Plan. All monies must be used to tackle health inequalities and health improvement and will be deployed in accordance with the County Council's financial regulations.

2.7 If LSP locality health partnerships are not available, Public Health staff will work with Local Area Committees, and other local partners, to deploy the locality investment to meet the outcomes established in the Plan, in accordance with the County Council's financial regulations.

3. Other considerations:

In preparing this report the relevance of the following factors has been considered: financial, legal, prevention of crime and disorder, equality of opportunity, human resources, environmental, health, and property and transport considerations.

4. Background papers:

Cabinet Report 3 December 2013 – Public Health Locality Programme and Reports to Local Area Committees.
All eight Locality Plans are available on the Derbyshire County Council website.

5. Key Decision:

No

6. Call-in:

Is it required that call-in be waived for any decision on this report?
No

7. OFFICER'S RECOMMENDATIONS

(1) That the Public Health Locality Plans endorsed by Local Area Committees, be approved;

(2) That the deployment of resources be agreed as set out in the report;

(3) That investment and monitoring reports be submitted to Local Area Committees.

Elaine Michel
Director of Public Health

Appendices 1 - 8

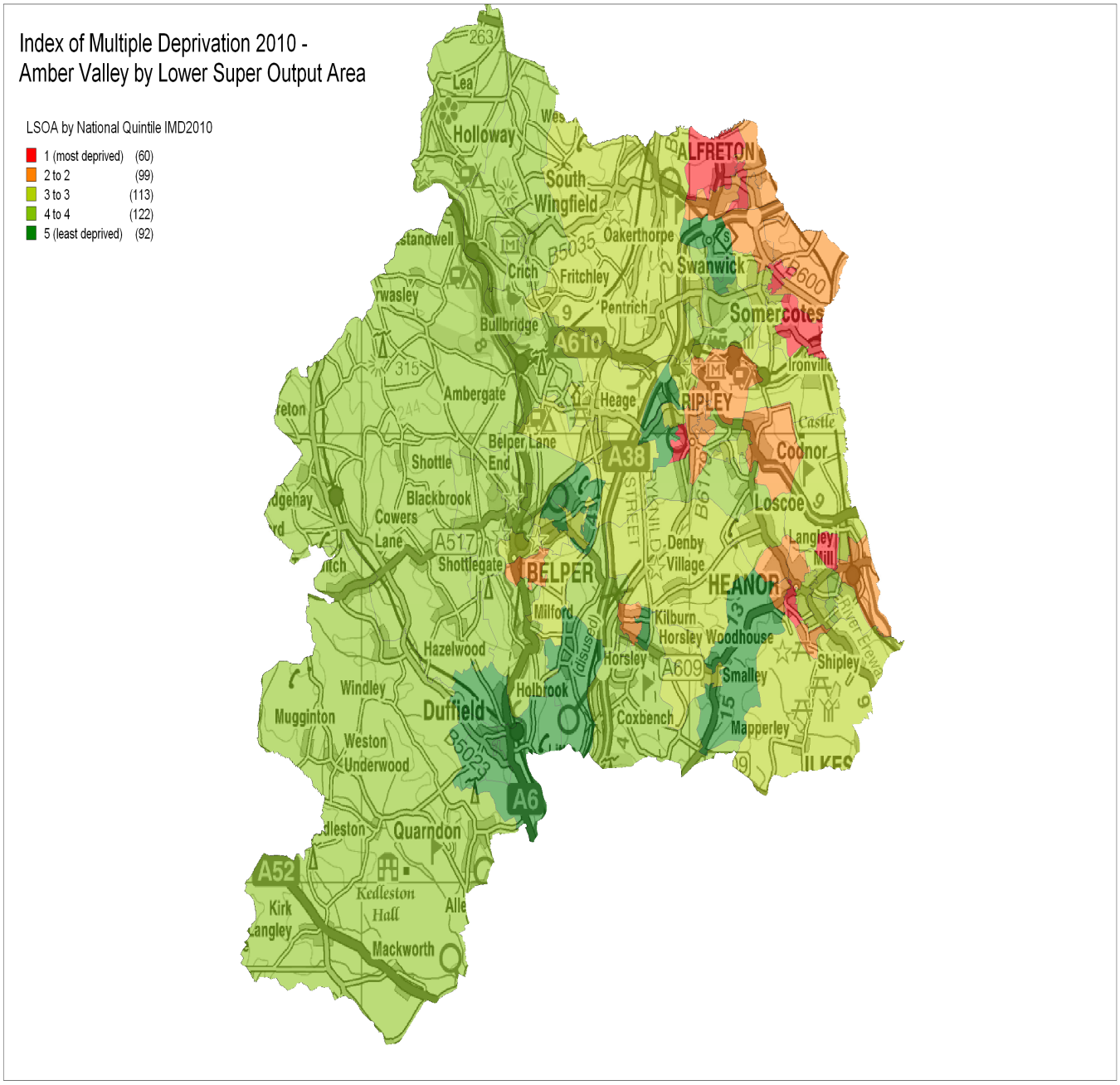
Locality Public Health Plans

	Locality	Allocation	Plan approved by Local Area Committee
Appendix 1	Amber Valley	£132,802	4 March 2014
Appendix 2	Bolsover	£265,588	5 March 2014
Appendix 3	Chesterfield	£123,860	11 February 2014
Appendix 4	Derbyshire Dales	£51,488	12 March 2014
Appendix 5	Erewash	£129,255	18 March 2014
Appendix 6	High Peak	£99,912	17 March 2014
Appendix 7	NE Derbyshire	£94,113	25 March 2014
Appendix 8	South Derbyshire	£92,283	2 April 2014

APPENDIX 1 **Controlled**

Amber Valley Locality Health Plan

2014 – 16



Summary of Amber Valley Priorities 2014-2016

These priorities have been developed as a result of a great deal of work by many partners, and are our shared commitment to health improvement and reducing health inequalities in Amber Valley.
They have been developed through consultation with Partners and the Community. This Locality Health Plan has been informed by a wealth of information including building on the experiences of partners, the community profile tools, JSNA, partners' experience and residents' feedback.
This Plan identifies the shared priorities and ambitions for the borough between key agencies from the public, private and voluntary sector who seek to improve the quality of life experienced in Amber Valley.

Building Healthy Communities	**40% Funding**
Lifestyle is closely linked to deprivation and disadvantage and we need to firstly support local people to make healthier lifestyle choices by addressing the wider determinants of health like employment, education, housing, and the environment	To achieve this we will work in partnership to…. • Support a stronger voluntary and community sector • Improve access to telecare for funded clients with low and moderate care and support needs • Develop a number of joint initiatives to address social isolation within individuals' homes and communities, including specific interventions for those suffering from Dementia.
Improving Access to Preventative Healthcare	**20% Funding**
Improving health outcomes for the people of Amber Valley requires a focus on the early identification of people at risk of requiring preventative healthcare to allow them to remain independent and self-manage their conditions. This means implementing clinical and lifestyle interventions for those individuals and communities with a higher risk of developing disease.	To achieve this we will work in partnership to…. • Work with general practices to proactively identify those at high risk • Form Community support teams • Ensure that all partners are aware of the services associated with helping people to stay in their own homes
Promoting Healthy Lifestyles	**40% Funding**
A healthy lifestyle can help to reduce the risk of ill health and early death from major diseases such as, cancer, heart disease, stroke, respiratory illness and diabetes.	To achieve this we will work in partnership to…. • Support people to live healthy and active lifestyles • Reduce health inequalities targeting priority locations • Support ageing well and independent living of the most vulnerable • Commission services to support young people to achieve their full potential

Vision: Our vision is for a 'healthier Amber Valley' where residents feel confident and supported to choose a healthy lifestyle and stay healthy.

Aim: The Amber Valley Locality Health Partnership will provide a coordinated, innovative and evidence based approach to health improvement and reducing health inequalities in the Amber Valley District by:

- Responding to health need and setting priorities within Amber Valley as outlined in the County Council's Health and Wellbeing Strategy, the Borough Council's Corporate Improvement plan, the County and Local Joint Strategic Needs Assessments (JSNA) and other relevant health need assessment data.
- Acting as the central coordinating body for health improvement projects planning, implementation and evaluation across the Amber Valley District.
- Promoting partnership working throughout the district and encouraging understanding of the different agencies roles and responsibilities.
- Planning, implementing and evaluating a 'health/locality action plan'. The health action plan will aim to improve the health of Amber Valley by identifying local priorities and health inequalities. The health action plan will 'add value' rather than replace the operational and delivery plans of the individual organisations.
- Ensuring that the focus of partnership activity in the Borough is aimed at addressing three key priority areas :
  1. Building Healthy Communities
  2. Promoting Healthy Lifestyles
  3. Improving Access to Preventative Healthcare

Building Healthy Communities

The next section indicates how a healthy lifestyle can help to reduce the risk of ill health and early death from developing major diseases such as cancer, heart disease, stroke, respiratory illness and diabetes. Lifestyle is closely linked to deprivation and disadvantage and we need to firstly support local people to make healthier lifestyle choices by addressing the wider determinants of health like employment, education, housing, and the environment. It is important to strengthen local communities by addressing social issues like binge drinking and drug use. We also need to ensure that we take care of older and more vulnerable members of society.

Promoting Healthy Lifestyles

People in the United Kingdom can now expect to live longer than ever before, but people living in and the most disadvantaged areas have markedly lower life expectancy than those living in the most affluent areas. A healthy lifestyle can help to reduce the risk of ill health and early death from major diseases

such as, cancer, heart disease, stroke, respiratory illness and diabetes. Lifestyle is closely linked to deprivation and disadvantage and we need to look at how we can support local people to make healthier lifestyle choices.

Improving Access to Preventive Health Care

Improving health outcomes for the people of Amber Valley requires a focus on implementing clinical and lifestyle interventions for those individuals and communities with a higher risk of developing disease. Major priorities are to scale up the identification, medical treatment and lifestyle interventions for those at risk of the 'major killers', cardiovascular disease (CVD - heart disease and stroke), cancer and respiratory disease, and to ensure good uptake of preventative health interventions such as the CVD Health Checks. Although the CCG has a key role in delivering effective medical interventions, the local authority, other partners and individuals play an important role in making sure these approaches work, and ensuring people can access services. It is particularly important for vulnerable groups such as socially isolated older people, people with mental health problems and people with disabilities.

Amber Valley Borough:

- Amber Valley is the third largest district in the East Midlands and the largest district authority population in Derbyshire with approximately 122,309 residents.
- Amber Valley is a mixture of affluent rural communities in the western parishes to more urban communities in the east. The eastern areas include the market towns of Alfreton, Heanor and Ripley with villages and parishes from Somercotes and Swanwick to Waingroves and Codnor. Belper sits in the centre of the Borough. The western part of the Borough is formed by affluent rural parish and village communities including Duffield, Holloway, Lea and Quarndon.
- There is a similar age profile to the county – more older people, particularly females, and fewer younger people, especially aged 16 to 24
- Overall the population has increased by 5.0% or 5,835 compared to Derbyshire (4.8%) and England (7.9%) between 2001 and 2011 and is estimated to increase by around 17.2% by 2035
- The ethnic minority population is 4,321 or 3.5% - slightly lower than average for Derbyshire at 4.2%
- 24,809 (20%) people over 16 have a long term limiting illness or disability
- Amber Valley's population comprises 49.1% males and 50.9% females (2008) 18.1% of Amber Valley's population is aged 0-15, 60.7% is aged 16 plus (2008) and 21.2% is of retirement age.

(Census 2011)

Health of Amber Valley Residents

The health of people in Amber Valley is varied compared with the England average. Deprivation is lower than average, however about 3,900 children live in poverty. Life expectancy for both men and women is similar to the England average. Life expectancy is 6.4 years lower for men and 6.2 years lower for women in the most deprived areas of Amber Valley than in the least deprived areas. Over the last 10

years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen. In Year 6, 17.5% of children are classified as obese. Levels of breast feeding and smoking in pregnancy are worse than the England average. An estimated 19.8% of adults smoke and 25.1% are obese. The rate of sexually transmitted infections is better than the England average. The rate of excess winter deaths is worse than average. The rates of statutory homelessness, violent crime, long term unemployment and drug misuse are better than average.
Priorities include increasing the levels of physical activity and reducing obesity; reducing smoking, particularly in pregnancy; and increasing independence into old age. For more information, see *www.derbyshire.gov.uk or http://observatory.derbyshire.gov.uk*[1]
The most deprived wards of Amber Valley are within, Alfreton, Langley Mill, Aldercar, Somercotes and Ironville and Riddings. In order to improve the health of the poorest fastest and reduce inequalities interventions to improve health should initially be focussed within these areas. The most deprived wards are highlighted on the cover map.

It is important to note that any health promotion interventions aimed at improving health need to target those from the lower socio economic groups. If they do not, they run the risk of actually widening the health inequalities gap. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism (The Marmot Review, 2010)

Proposed Locality budget allocation for 14/15; £165,351

[1] http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=A*

MAPPING OF EXISTING SERVICE PROVISION AGAINST PRIORITIES

H&WBB PRIORITIES [2]	JSNA PRIORITIES FOR THE AREA [3]	PARTNER KEY PRIORITIES	DCC INEQUALITIES STRATEGY [4]	PH COUNTYWIDE PROGRAMMES	ADDITIONAL LOCAL DELIVERY	
Improve health and wellbeing in the early years	• To increase breastfeeding at 6-8 weeks • To reduce inappropriate A&E attendances by children • To reduce the number of fixed term school exclusions • To reduce the rate of under 18 teenage conceptions • Children's behaviour pathway work	Improve emotional health and wellbeing through development of a clear behaviour pathway.	Reduce and mitigate child poverty	Family Nurse Partnership (Ripplez)	Blend youth project AV Homestart Children's Centres CAYA funded projects (NEET) Sporting Futures Princes Trust	Drop In DV support The Bears
Promote Healthy lifestyles	• To increase physical activity • To reduce obesity • To reduce alcohol consumption	Women and girls (all ages). Older people (physical activity and isolation). Age 14-25 years		Healthy Lifestyle Hub Village Games Walking for Health Jog Derbyshire Return to Sport Health Trainers DCHS Health Promotion service Health Checks County wide drug and alcohol services Sexual health services Smoking cessation services School Health Promotion Service	Sports Clubs Private gyms Slimmer's Clubs Groundwork activity School Sport Partnerships leisure Services Derbyshire Sport DCC Adult Education DCC Countryside Services AVBC Sports Development Sporting Futures (including Doorstep Clubs) Derby County in the Community DC Leisure Belper Leisure Centre OzBox Private individuals delivering locally.	Woodland Trusts Boxing Club Zumba – private fitness classes Outdoor Gyms Alcohol Advice Service

[2] http://www.hardwickccg.nhs.uk/website/X24712/files/Health_and_Wellbeing_Strategy_2012-15.pdf
[3] http://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/GeoProfiles/JSNAGeoProfile_2012_AmberValley.pdf#view=Fit
[4] http://www.derbyshire.gov.uk/images/Agenda%20item%2010%20-Development%20of%20Derbyshire%20Health%20Inequalities%20Strategy_tcm44-235079.pdf

Improve mental and emotional health	• To increase the number of adults in adults in contact with secondary mental health services in settled accommodation • To increase numbers of volunteers (community development / sustainable services)	Fuel Poverty Dementia CVS- increase voluntary activity, support volunteers Decent Homes	Increase financial inclusion Supporting employment for vulnerable groups	CAB in primary care CAB in children's centre Credit union investment County wide affordable warmth programme Health Promotion Service (Children and Young People)	Amber Trust Green Health Stroke clubs DASG DDCIL Mediquip Sight support Belper Depression group Warden led activity Family support worker Voluntary opportunities throughout Amber Valley within statutory and third sector organisations	
Promote the independence of people with long term conditions and their carers.	• To increase the take up of the NHS Health Check programme by those eligible • To reduce the rate of emergency readmission within 30 days of discharge from hospital • To fund rising demand for housing adaptations to support independent living and those that are living with a long-term condition.	Improved, better integrated community services provide more care in the community in order to reduce the number of people in hospital Expand telecare service Work with partners to assist with hospital discharge Integrated aids and adaptation service		Befriending support Telehealth service for people with heart failure Living with long term conditions programme Diabetes and you programme	Home from Hospital Youth service Red Cross Community Support Teams. Pulmonary Rehabilitation.	
Improve the health and wellbeing of older people	• To reduce the number of excess winter deaths • To provide sufficient numbers of suitable homes in the right location to meet future needs and support appropriate independent living into later life	Reduce falls Reduce social isolation	Affordable warmth	Strictly No Falling Social enterprise footcare services	Phone Buddy Age UK services Lunch & social groups U3A over 50 forums Comm Transport	Telecare/ telelink Hearing Help Help at home Befriending

ACTION PLAN TO SHAPE DELIVERY 2014-2016

Overarching Priority	Specific Aim	Outcome	Current Provision	Gaps / At Risk	Actions	Lead Organisation	Measure
Building Healthy Communities	Ensure that individuals experiencing mental ill health are supported to enable them to live independently, well and in settled accommodation.	Increase in the number of adults in contact with secondary mental health services who are in settled accommodation	Referrals from Future Homescape Limited (FHL)to other support agencies Amber Trust lease 40 properties from landlords to provide support service to individuals experiencing mental ill health	Sufficient availability of support (access and timescales) for those with low to moderate needs Funding at risk for low level support which will reduce the preventative work FHL and other providers can do to ensure tenancy sustainment	Consider the impact of any withdrawal of existing funding which supports people with mental health issues from remaining independent in their home.	(DCC Public health)	

	Ensure that there are adequate suitable homes in the right location to meet future needs and support appropriate independent living into later life.	Increase in the number of lifetimes homes within the borough Number of referrals through the housing options service who are rehoused or provided with support to remain in their own home. Assistive Technology	2014/15 Delivery of 10 x 2 bedroomed lifetime home bungalows in Heanor FHL develop all HCA grant funded properties to code 3 that Inc. some lifetime home features Housing Options Service for Older People FHL Housing related support visiting service for tenants and private households FHL provide a range of tailored assistive technology packages that are tenure neutral	S106 developments do not inc lifetime home requirements Planning do not specify lifetime requirement Lifetime homes and wheelchair new build very expensive – gap in funding This service is at risk of funding cuts from DCC Access difficult for funded persons to telecare who do not have a care package. Provision of suitable accommodation for older owner occupiers and assistance to maintain existing properties.	Utilise the strength of the partnership to lobby for lifelong homes / older people's homes on proposed developments Improve access to telecare for funded clients with low and moderate care and support needs Wider promotion of Home improvement agency and Handyvan services	(AVBC) Dave Arkle (Futures Homescape) Jo Prior	

	Ensure that the benefits of volunteering are actively promoted and that Amber Valley is seen as having a vibrant and responsive volunteering community capacity.	Increase in the number of volunteers operating across the borough especially those who come from the most deprived wards of the borough. Increase in the variety of volunteering opportunities . Increase in positive relationships between sources of volunteers including patients, young people and the voluntary organisations within the area.	FHL staff volunteer and provide opportunities for tenants to volunteer Promotion to FHL private sector leasing tenants to signpost in to training, volunteering and work opportunities. Volunteering opportunities provided within Village Games, Sporting Futures and AV School Sports Partnership.	At risk due to loss or reduction in funding from DCC	More co-ordination amongst partners to promote volunteering and to measure voluntary activity	(CVS) Lynn Alison	
	Ensuring that access to opportunities to reduce social isolation is widely publicised and easy for people to achieve without support from statutory services.	Reduction in the number of people who report being socially isolated Address social isolation for young carers	Social Isolation is reviewed as part of support plans completed with clients by FHL's staff Memory Lane reminiscence sessions delivered FHL is upgrading community centres to be dementia friendly. These are available	Gaps centre on assisting individuals to attend activities, go out or become involved. Transport to enable access is a key issue for many	Develop a number of joint initiatives to address social isolation within individuals' homes and communities, including specific interventions for those suffering from Dementia. Update to lunch clubs and social activity directory. Review transport /access	(Adult Care) Dominic Sullivan (Public Health) Jayne Needham	

			for other agencies and groups to book. Older people's activity sessions currently taking place in Belper and in Codnor.		arrangements and improve where funding /reconfiguration allows		
	Care homes supported to ensure that residents especially those with dementia receive appropriate care and support to remain mobile and active within their care home.	Reduction in number of emergency admissions for care home residents within Amber valley	Strictly No Falling Primary falls prevention programme (SNF)	Limited Chair based exercise in care homes	Support for Care Home residents to access evidence based falls prevention exercise Commission additional services to improve outcomes and care received via SNF Access the outcomes from the DCC 'IMPACT' project and determine future opportunities.	(Adult Care) Dominic Sullivan (Public Health) Jayne Needham	
	Ensure that strategies are in place at a local level to engage residents with income maximisation	All eligible benefits are claimed	CAB	Knowledge of services and entitlements	Promotion campaign at a local level Promote CAB in SureStart centres	CAB	Number of clients supported

Overarching Priority area	Specific Aim	Outcome	Current Provision	Gaps / At risk	Actions	Lead organisation or individual	Measure
Promoting Healthy Lifestyles	To provide environments and opportunities which ensure that women are supported to initiate and continue to breastfeed their babies	Increasing rates of breastfeeding especially in the most deprived areas of the borough after 6 to 8 weeks.	Support being offered within a Children's Centre setting. Champions identified within each setting Nursery nutrition training You're Welcome: making services young people friendly Young Inspectors Sporting Futures		Questionnaire to identify why women stop breast feeding Consideration of findings and initiation of activity to respond to increase rates of breast feeding adherence	(CVS) Lynn Alison (CAYA) Dave Bond	Target for Amber Valley - 46% 2014/2015 Quantitative: Reach of numbers trained. Learners self-evaluation of impact on knowledge, skills and confidence to deliver. Qualitative: Feedback from questionnaires and/or focus groups with both staff and children/young people
	Provide evidence based	Reduction in the rates of	Work underway with	Funding to cease	Commission evidence	(CAYA)	2014/2015

	interventions which promote self-esteem and raise aspirations amongst young people in order to ensure they achieve their full potential	inappropriate A&E attendances by children Reduction in the number of fixed term exclusions Reduction in the rate of under 18 teenage conceptions	those deemed at risk. Multi agency teams working within School with identified people. (Risk of NEET indicators – RONIs). R Time training Circle Time training Building Steps to Resilience training Promoting Good Mental Health training Peer buddy/listener training Raising awareness of e-safety Quality relationship and sex education training Young Inspectors Teenage Pregnancy sub group of the Locality Planning and Commissioning Partnership (LPCP) Group in place with clear operational action plan. C-Card operational across Amber Valley	31/3/14 Information about sexual health needs to be more widely available and accessible Potential gaps in delivery of C-Card in Crich	based services to support young people to achieve their full potential Work closely with secondary schools to support this agenda	Dave Bond	targets to be confirmed Current performance Primary (25) Secondary (211) Increase in the Into Learning post 16 (Jan 2014) 93.7% Reduction of 5% over 3yr from 2011/2013 data. Quantitative: Reach of numbers trained. Learners self-evaluation of impact on knowledge, skills and confidence to deliver. Qualitative: Feedback from questionnaires

			FHL Family Support Officer Sporting Futures				and/or focus groups with both staff and children/young people Number of accredited qualifications gained by young people
	To improve the rates of participation in physical activity opportunities for all ages within the borough by ensuring that barriers of affordability, access and motivation are reduced or removed	Increasing rates of participation levels for physical activity in all age groups especially in the most deprived wards of the borough	FHL Otago and CBE Physical Literacy training for KS1 Midday Supervisor training Community Sports Trust (Village Games and Jog Derbyshire) Aurora (Walking for Health) AV School Sports Partnership DC Leisure Belper Leisure Centre DCC Adult Education DCC Countryside Services Sporting Futures Derby County in the Community Sports Clubs	At risk due to reduced or lost funding for NSCs from DCC No/little activity in place :- Need to increase Community development worker capacity in these communities to increase participation by individuals from key communities. Activities for 0-5yrs and family participation activities	Utilise the partnership to ensure the integration of services being procured by Derbyshire County Council's new 'Wellbeing Service' Develop a number of joint evidence based initiatives to address specific lifestyle health related issues; e.g. WAVE (Women in Amber Valley Energised) LEAF (Leisure, Exercise Activity and Friends)IMPACT (Improving Physical Activity in Targeted areas) Expand SNF Provision	(AVBC) Kirk Monk (Derbyshire Sport) Margaret Blount	Quantitative: Reach of numbers trained. Learners self-evaluation of impact on knowledge, skills and confidence to deliver. Qualitative: Feedback from questionnaires and/or focus groups with both staff and children/young people

			Private gyms Private individuals delivering in village halls etc. AVISPA	Need to increase training and awareness of existing physical activity services amongst key staff and residents	Doorstep Clubs (in Aldercar and new clubs established) Training/awareness raising sessions for key staff on benefits of PA and how to find out what is available.		Active People Public Health outcomes % of 16+ doing more than 150 mins moderate intensity PA PW in bouts of 10 mins of more % of 16+ doing less than 30 mins moderate intensity PA pew week in bouts of 10 mins of more % of 16+ who are members of a club.
	To impact upon the rates of obesity amongst adults by ensuring that evidence based support is available to help them to achieve long term behaviour changes in eating and physical activity.	Levelling off or reduction in the rate of adult obesity especially in the most deprived wards in the borough.	Number of Health and Wellbeing events delivered by FHL targeting older people in deprived wards Referrals to Health Trainers from NSCs Skills for Life – Cooking on a budget sessions for FHL tenants and homeless	Community development in targeted wards Behaviour change initiatives.	Utilise the partnership to explore and actively source external funding to deliver additional / enhance existing projects to promote / increase healthy lifestyles in those areas which have the greatest need	(AVBC) Kirk Monk	PHOF

			Healthy Lifestyle HUB				
	Promote the benefits of safe levels of alcohol consumption especially amongst the older population and teenagers	Levelling off or reduction in the rate of alcohol consumption especially in the most deprived wards in the borough.	Alcohol – engaging parents and encouraging change Making the links – alcohol, relationships and sex Amber Valley Vibe Project (AVBC/SF). Licensing policies	Availability of training to assist NSCs to identify and discuss issues with older people	Utilise the partnership to explore and actively source external funding to deliver additional / enhance existing projects to promote / increase healthy lifestyles. Develop links between care co-ordinators in GP surgeries and other agencies	(DCC)	Quantitative: Reach of numbers trained. Learners' self-evaluation of impact on knowledge, skills and confidence to deliver. Qualitative: Feedback from questionnaires and/or focus groups with both staff and children/young people
	Engagement with primary care and with local people to ensure that those who entitled to receive an NHS health check can attend.	Increase in the rate of uptake of NHS health checks especially in those practices which service populations in the most deprived wards.		Number of practices meeting health check targets Number of referrals to the HUB Access to and availability of Health checks in community settings.	Develop links between care co-ordinators in GP surgeries and other agencies to promote and increase access Possibility of referral officers being trained up to deliver official NHS health checks in the community settings and	(SDCCG) Andy Mott (Public Health)	PHOF

					with remit to refer to other programmes.		
Overarching Priority area	**Specific aim**	**Outcome**	**Current Provision**	**Gaps / At risk**	**Actions**	**Lead organisation or individual**	**Measure**
Improving Access to preventative healthcare	Ensure that responsive services are available within the community to ensure that where possible people are supported to remain out of hospital or be discharged sooner	Reduction in the rate of emergency readmissions within 30 days of discharge from hospital	Home from Hospital volunteering Install assistive technology and offer housing related support visiting service available regardless of tenure NSCs undertake falls assessments and complete direct referrals to Falls Clinic – 90+ referrals over last 3yrs Falls Recovery Service delivered by FHL NSCs to anyone with a lifeline Priority within Allocations Policy for	Ability of voluntary & third sector to engage with new support teams/co-ordinators Costs of Home from Hospital volunteering Lack of formal and consistent structure so all relevant agencies know that someone is being discharged Reablement/ intensive support funding no longer available from Adult Care to resettle anyone discharged	Formation of Community Support Teams Recruitment of Care Co-ordinators/Matrons Closer links with Social Service teams Better links with mental health services Closer links with voluntary and third sector Review the existing services within Amber valley which support this agenda and work in partnership to close any gaps.	(SDCCG) Andy Mott	

			rehousing Derventio have a post within hospitals to ensure people are not discharged with nowhere to go (homeless)	Interim accommodation to assist discharge			
	Ensure the effective provision of services which ensure a range options is available to support individuals who would benefit from adaptions within their home to enable them to remain independently	Assessment of the demand for housing adaptations which support independent living	Mediquip / Handy Van network Assessments for minor adaptations to FHL properties undertaken by NSCs Minor adaptations for works up to £1000 Signpost tenants to Call Derbyshire for DFG works Housing Prevention Forum	Use of volunteers for DIY tasks Disabled Facility Grant funding at risk Ongoing training needed for staff in all partner agencies re process and options available FHL have to remove some adaptations on empty properties due to no demand	Ensure that all partners are aware of the services associated with helping people to stay in their own homes or move to more suitable homes and are promoting these to residents. These include: Home options Adaptations Handy van RemPod Neighbourhood support co-ordinators Lifeline / Tele coordinators	(AVBC) Dave Arkle	
	Ensure that support is available to all people who are at risk of experiencing ill health as a result of living in cold and damp housing conditions which enables them to improve their	Levelling off or reduction in number of excess winter deaths Levelling off or reduction in number of people living in fuel poverty	Promotion of warm homes via Help at Home client base FHL Money Advice Service Erewash Credit union	Affordability Advice re proper use of heating systems Capped metres (no gas)	Through the strength of the partnership promote existing / identify new opportunities to maximise / generate additional revenue to improve energy efficiency in	(AVBC) Dave Arkle (Public health) Jayne	

	housing conditions or increase their ability to heat their home		Older Persons advice service Referrals to AVBC re owner occupiers in poor properties and referrals to HIA FHL advice leaflets Annual upgrade heating programme Door/window programmes Energy efficiency works	Use of card metres (expensive) Use of inappropriate devices e.g. unvented dryers, gas heaters	homes. Working with general practices to proactively identify those at high risk Co-ordinated plan to tackle excess winter deaths	Needham	
	Improve quality of life and reduce hospital admissions for people with long-term respiratory disease				Improve outcomes for people with Chronic Obstructive Pulmonary Disease. Develop and fund evidence-based Pulmonary Rehabilitation scheme in AVSD	(SDCCG) Andy Mott	

Appendix One

VISION
To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest.
Outcome measures
Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life. Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System
***** Indicator shared with the NHS Outcomes Framework.
** Complementary to indicators in the NHS Outcomes Framework
+ Indicator shared with the Adult Social Care Outcomes Framework
++ Complementary to indicators in the Adult Social Care Outcomes Framework
Indicators in italics are placeholders, pending development or identification

Public Health Outcomes Framework 2013-2016
At a glance

1 Improving the wider determinants of health	2 Health Improvement	3 Health protection	4 Healthcare public health and preventing premature mortality
Objective	**Objective**	**Objective**	**Objective**
Improvements against wider factors which affect health and wellbeing and health inequalities	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	The population's health is protected from major incidents and other threats, whilst reducing health inequalities.	Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.
Indicators	**Indicators**	**Indicators**	**Indicators**
1.1 Children in poverty 1.2 School Readiness 1.3 Pupil absence 1.4 First time entrants to the youth justice system 1.5 16-18 year olds not in education, employment or training 1.6 Adults with a learning disability / in contact with secondary mental health services, who live in stable and appropriate accommodation+ (*ASCOF 1G and 1H)* 1.7 People in prison who have a mental illness or a significant mental illness. 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services * *(i-NHSOF 2.2) ++ (ii ASCOF 1E) ** (iii NHSOF 2.5) ++ (iii-ASCOF 1F)* 1.9 Sickness absence rate 1.10 Killed and seriously injured casualties on England's roads. 1.11 Domestic abuse 1.12 Violent crime (including sexual violence) 1.13 Re-offending levels 1.14 The percentage of the population affected by noise 1.15 Statutory homelessness 1.16 Utilisation of outdoor space for exercise / health reasons 1.17 Fuel poverty 1.18 Social isolation + *(ASCOF 1I)* 1.19 Older people's perception of community safety ++ *(ASCOF 4A)*	2.1 Low birth weight of term babies 2.2 Breastfeeding 2.3 Smoking status at time of delivery 2.4 Under 18 conceptions 2.5 Child development at 2-21/2 years 2.6 Excess weight in 4-5 and 10-11 year olds 2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years 2.8 Emotional well-being of looked after children *2.9 Smoking prevalence – 15 year olds (Placeholder)* *2.10* Self-harm *2.11* Diet *2.12* Excess weight in adults *2.13* Proportion of physically active and inactive adults *2.14* Smoking prevalence – adults (over 18s) *2.15* Successful completion of drug treatment *2.16* People entering prison with substance dependence issues who are previously not known to community treatment *2.17* Recorded diabetes *2.18* Alcohol-related admissions to hospital *2.19* Cancer diagnosed at stage 1 and 2 *2.20* Cancer screening coverage *2.21* Access to non-cancer screening programmes *2.22* Take up of the NHS Health Check programme – by those eligible *2.23* Self-reported well-being *2.24* Injuries due to falls in people aged 65 and over	2.1 Fraction of mortality attributable to particulate air pollution 2.2 Chlamydia diagnoses (15-24 year olds) 2.3 Population vaccination coverage 2.4 People presenting with HIV at a late stage of infection 2.5 Treatment completion for TB 2.6 Public sector organisations with board approved sustainable development management plan 2.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies	4.1 Infant mortality* *(NHSOF 1.6i)* 4.2 Tooth decay in children aged 5 4.3 Mortality rate from causes considered preventable ** *(NHSOF 1a)* 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)* 4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)* 4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)* 4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)* 4.8 Mortality rate from communicable diseases 4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5)* 4.10 Suicide rate 4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)* 4.12 Preventable sight loss 4.13 Health-related quality of life for older people 4.14 Hip fractures in people aged 65 and over 4.15 Excess winter deaths 4.16 Estimated diagnosis rate for people with dementia* *(NHSOF 2.6i)*

Appendix Two; the following programmes or initiatives cover all localities in Derbyshire in 2014

STARTING AND DEVELOPING WELL

- Vision screening
- Breastfeeding support
- School breakfast clubs
- **5/60** -Healthy eating, physical activity and obesity prevention programme
- Citizen's advice in Children's Centre's
- School Nursing service
- Young people's sexual health service
- Young peoples' drug and alcohol services

LIVING AND WORKING WELL

- Tobacco Control including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Health referral scheme
- Walking for health groups
- Health trainers programme
- Make every contact count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Living with long term conditions programme
- Diabetes education

HEALTH INEQUALITIES

- Citizen advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support
- Support for welfare assessment

AGEING WELL

- Health Checks for over 40's
- Fall s prevention programme Inc. transport
- Social isolation initiative
- Foot care programme

Appendix Three

Derbyshire County Council Priorities

Young people

We will ensure high quality early years provision and affordable childcare, first class schools, special educational needs and disability services; youth services and careers advice

Economy, Jobs and Transport

We will help businesses set up and thrive in Derbyshire and make sure people have the right skills and training they need to work and earn a decent living. We will invest in the road, bus and rail network to enable people to travel to work and leisure

Derbyshire Communities

'Improve the quality of life for Derbyshire people. We will work with communities to identify and tackle the problems you face a better deal for those with disabilities and tackle health inequalities. We will support cultural, sports and community events celebrating the vibrancy and beauty of our county

Older People

Listen to older people, carers and families and use their views to shape better services and support

Appendix Four

Community Resilience

A priority theme from the Councils, public health and the CCG and which has the potential to support the most vulnerable groups of people in the community is the concept of community resilience . A number of national strategies - *A vision for adult social care: capable communities and active citizens; Health Lives - Healthy people (Public Health White Paper which aim to promote independence, empower local communities to improve health and wellbeing and reduce inequalities*

Community development is a core of a public health approach to address health inequalities
Community development is a process of getting communities involved in decisions that affect them; - identifying needs, planning, development and the management of services
Community development is about building active and sustainable communities based on fairness mutual respect participation equality and co-operation i.e. increasing social capital

The programme targets disadvantaged communities with poor or unknown outcomes and identifies what is important to them and their wellbeing ideally a programme should be developed in partnership with local primary care services including the independent sector.

Appendix Five

Derbyshire Health Inequalities Strategy[5]

• Use data from the Joint Strategic Needs Assessment to describe the range and extent of health inequalities in Derbyshire that affect socially disadvantaged areas and sub-groups of the population

• Target a small number of key strategic priorities to address inequalities focusing on the wider determinants of health inequality, the main lifestyle issue affecting inequalities, and equitable access to a key healthcare intervention.

• Ensure delivery of the agreed HWS life-course priority areas contributes to reducing health inequalities in Derbyshire.

• Identify indicators to use to measure progress (including process, output and outcome measures) and an overarching strategic health inequalities goal to provide focus and direction.

There is already a wealth of established collaborative activity contributing to tackling health inequalities, including public health locality working to address inequalities at local level. However, it is essential to increase our efforts in specific areas with the greatest potential to impact on inequalities.

Wider determinants of health

The Marmot review proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The most important wider determinant of health and the one that impacts most on health inequalities is poverty. Poverty impacts on all aspects of social and economic disadvantage of individuals and communities, and tackling income inequality has become even more challenging as a result of the economic downturn and the recent welfare reforms. Proposed themes are:-

• Tackling childhood poverty

• Increasing access to affordable warmth with a specific focus on vulnerable groups

• Creating opportunities for financial inclusion and building skills for financial management

• Supporting people with health problems to get back to work and supporting the development of workplaces as a healthy setting

Lifestyle risk factors

Health inequalities are affected by differences in the prevalence of key lifestyle risk factors between areas associated with levels of disadvantage. Levels of smoking, physical inactivity, alcohol harm and

[5] DERBYSHIRE HEALTH AND WELLBEING BOARD, November 2013 Development of a Derbyshire Health Inequalities Strategy

obesity are all more prevalent among the most disadvantaged neighbourhoods of Derbyshire. Taking into account the relatively weak collective action on smoking locally compared to other lifestyle factors and the good level of confidence in being able to do more, the lifestyle factor with the greatest potential to impact on inequalities in premature mortality and ill health is smoking. While stop smoking services have been shown to successfully recruit smokers from disadvantaged areas, these individuals have lower success in quitting than those in more affluent groups because of factors such as lack of social support, higher nicotine dependency and challenging life circumstances. It is proposed that we should work collaboratively to change social norms around smoking.

Access to and outcomes from preventive health interventions

Ensuring equitable access to effective preventive health interventions contributes to reducing health inequalities by ensuring those most at risk of poor health outcomes receive timely and effective prevention and treatment interventions. The majority of the gap in life expectancy between disadvantaged and more affluent areas is due to premature deaths from cardiovascular disease, cancer and respiratory disease, much of which can be addressed by early prevention. The priority is to agree a programme of health equity audits with key partners. Equity audits help to address inequitable access to and benefit from services and can be used to check progress against the range of HWS priorities.

A HEALTHY BOLSOVER
- Locality Public Health Plan -
Building, Promoting & Supporting the Health and Wellbeing of Local People
2014-2017

Introduction

This Locality Public Health plan sets out the priorities and actions for improving the health of people in the Bolsover District, providing a focus for local delivery of the national Public Health Outcomes Framework (PHOF).
The most up to date Bolsover Community Health Profile 2010 **http://www.apho.org.uk/resource/view.aspx?RID=126997**
shows that, over the last few years, good progress has been made in tackling health inequalities, particularly in terms of addressing some of the wider economic issues which affect health and wellbeing. However, activity needs be sustained in order to continue moving in the right direction and further reduce the health inequalities within the district, as well as those apparent when comparing Bolsover with other parts of Derbyshire and England.

Local Priorities & Partnership Working

Partnership working is critical to achieving improvements in health and well-being at a local level. Working together to identify priorities which are important to partners, and have relevance to their own plans and strategies, encourages ownership of the action plan.
For over a decade Bolsover Health and Well-being Partnership, part of the wider Bolsover Partnership (LSP) has been pivotal to the planning and delivery of public health programmes across the district. Adopting a multi- agency approach has meant that a wide range of organisations and community groups from across the district have contributed to identifying needs, sharing good practice and securing funding for the benefit of health & wellbeing. It has also presented opportunities for developing innovative work to support the delivery of Public Health outcomes at a local level e.g. Bolsover Wellness, HEET Events, School Health Champions, Raising Aspirations
Moving forward, the Local Area Committee for Bolsover, led by Derbyshire County Council, will be actively involved in agreeing public health priorities and plans, which will strengthen partnership working for public health across the locality.

Identifying Local Needs & Priorities

This plan has been produced using local information collated from a variety of sources, as well as local health profile data information has been gathered locally through a number of community forums, including Bolsover Voluntary Sector Health & Wellbeing Forum held in September 2013. A summary of some of the cross cutting themes/priorities drawn from a number of agencies/plans can be found in the appendices

Engaging partners across all sectors means that Healthy Bolsover reflects the priorities identified in the strategies and plans of partners organisations, these include; Bolsover Community Strategy **http://www.lsp.bolsover.gov.uk/index.php**, A Fairer Deal for Derbyshire **http://www.derbyshire.gov.uk/council/policies_plans/council_plan** Derbyshire Health & Wellbeing Strategy **and** Hardwick **http://www.hardwickccg.nhs.uk/** and North Derbyshire Clinical Commissioning Groups **http://www.northderbyshireccg.nhs.uk/**

This inclusive approach to identifying local needs and priorities is an essential/important part of agreeing an action plan which is meaningful to local people and organisations delivering services to the area.

Furthermore, it creates opportunities for linking up across neighbouring areas, sharing actions and avoiding duplication, for example, Financial Inclusion Strategy, Food Poverty Strategy and action plan of the Children's & Younger Adults Partnership for Bolsover/North East. Other strategic developments currently in development or revised will be reflected in more detail as part of an annual review, for example, Bolsover District Councils' Growth Strategy; others include; Bolsover Sports and Facilities Strategy, Bolsover Arts and Cultural Development Strategy, Bolsover/NED Corporate Strategy.

From the local information examined the following issues stand out for Bolsover District

- **Lower life expectancy that those living in England**
- **Higher levels of premature death from cancers, heart disease and stroke**
- **Higher than average levels of income deprivation, child poverty and lower GCSE attainment**
- **High youth unemployment**
- **Significant impact of the Welfare Reforms agenda, increased fuel and food poverty.**
- **Higher than national average levels of obesity and physical inactivity**

Funding & Resources

The current economic climate does mean that resources are limited and will be for the foreseeable future. It is therefore imperative that effective partnership working continues to ensure that duplication is reduced and resources that are available can be maximised. Bolsover's allocation from Derbyshire County Public Health will remain static and some of the investment identified within the plan is from current budget levels. Any additional funding that can be sourced from other partners within the locality will be used to enhance existing programmes and projects.

Priorities & Action Plan: 2014-2015

The action plan priorities are divided into 3 sections for easy reference; however, in some cases an activity or action actions may appear in more than one section because the issue cuts across more than one priority area.

- **Building Healthy Communities**
- **Promoting Healthy Lifestyles**
- **Supporting Effective Health and Social Care**

Each section identifies the expected outcomes and monitoring.

PRIORITY: BUILDING HEALTHY COMMUNITIES

Objectives	Activity or Action	Outcome	Funding Allocation required (£)	Monitoring success/evaluation
1. Reducing Poverty with a focus on Child Poverty (incorporating Financial Inclusion, Food & Fuel Poverty)	• Support co-ordination of Bolsover Fighting Poverty Forum (recently merged Financial Inclusion & Food Poverty Forums) and implement associated strategies	To develop a more co-ordinated approach to tackling root causes of poverty in Bolsover District	£14000 committed	SLA Performance targets
	• Identify opportunities to link with the delivery of the Work and Skills Plan to support people into training, education and employment	Increase opportunities for economic growth in the district and improve education training and employment for vulnerable communities.	Funds proposed through Bolsover Partnership H&WB Fund(Help to Work)	Unemployment data IMD data – employment Local impact data Evaluation reports and consultation
	• Support/develop training of Contact Centre staff on e.g. mental health awareness, to address short and long term impact of welfare reforms on local communities.	Develop more positive relationships and wider understanding for clients with mental health needs in relation to welfare reform	Funds proposed through Bolsover Partnership H&WB Fund(tbc)	
	• Support the development and expansion of Food banks across Bolsover District	Reduce stigma and increase awareness & accessibility of food banks, community gardens, bulk buying and veg box schemes.	Some committed funds from County PH allocation for food banks	Health profile data Local impact data Trussell Trust Data
	• Fuel Poverty/ Affordable Warmth (also see Older/Vulnerable communities)	Reduce numbers of people living in fuel poverty	£20000 committed through PH SLA	SLA Performance targets
	• Support the expansion of the Budget Buddies Scheme across Bolsover District to support people with budgeting and money management support	Increased awareness of budgeting to reduce numbers of people at risk of financial exclusion.	Funds proposed through Bolsover Partnership H&WB Fund(tbc)	Local impact data SLA Performance targets
	• Maintain support for the expansion of Bolsover	Increased support for children	Bolsover	Youth employment data

	Raising Aspirations Project; improving school attainment &youth employment.	and young people to achieve their potential	Partnership funded	Annual monitoring report from Connexions DCC
2. Reducing Binge Drinking and associated crime and anti-social behaviour	• Support the development of a community cohesion programme in Shirebrook • Support the Raising Aspirations programme for young people in Bolsover District e.g. Namibia project, Development of the RAiSE project • Continued support for the Extreme Wheels programme to provide diversionary activities for young people	Reduction in existing community and racial tensions in targeted areas of the district. Improve confidence and aspiration of young people aged 11-17 across the district Contribute to a reduction in anti-social behaviour across the district and improve physical activity among hard to reach young people	Funds proposed through Partnership H&WB Fund(tbc) £5000 – fundraising committed to Namibia £1050 – training SLA Funded until March 2015 via Bolsover Wellness	Health profile data Crime data Local project Evaluation, reports and consultation Health profile data Crime data
3. Promoting Healthy Families includes, parenting, teenage pregnancy, breastfeeding	• Support the 'troubled families' agenda to address parenting and the early years • To explore opportunities for a home visiting befriending service for parents of children under 5 in the locality • Engage with DCCs 'Community Budget' to support the ethnographic approach to researching needs of 'thriving families' • Co-ordinate the HEET (Health Education Employment and Training) programme across the district to ensure health support and information is available. • Support and develop county and local Breastfeeding initiatives	Reduce the number of troubled families in Bolsover District Improving parenting skills for the under 5s Improve commissioning and reduce duplication of services Raise awareness and aspirations of local health, education, training and employment opportunities for young people and communities Increase breastfeeding figures across Bolsover district	Committed PH funding £2500 (£500 per school)	Health profile data Local impact data Local impact data Health profile data Local impact data Evaluation reports and consultation Health profile data Local impact data

4. Supporting Older People and Promoting Healthy Ageing	• Roll out the provision of the over 50s Health Information Point with a view to expanding across the district • Contribute to reducing hospital admissions agenda lead by Bolsover CCG Liaison Group including initiatives that reduce slips trips and falls across the district. • Maintain District based Fuel Poverty/ Affordable Warmth referral service • Support the development of a local website providing information to reduce fuel & food poverty, and improve debt management support and services to the public. • Explore opportunities to invest in the development of and access to entry level walks for older people and vulnerable groups e.g. Community Transport, W4H forum • Undertake a health needs assessment with local Residential Care homes for Older people	Increased engagement and information about health services for Older people To develop a more co-ordinated approach to reducing hospital admissions Reduce numbers of slips, trips and falls Improved access to fuel poverty advice and support. Improve awareness of a range of services and information to reduce fuel poverty for older people Increase access and opportunities for physical activity among older people Increase opportunities for promoting health and wellbeing in care homes	PH Funding to support development lead by BHNT £11,000 £3000 (tbc 2014/15)	Health profile data Local impact data Evaluation reports and consultation Quarterly monitoring data from Environmental Health
5. Supporting Vulnerable People	• Continue links with programmes that specifically support vulnerable people and disadvantaged groups e.g. disability dynamics • Support the co-ordination delivery of the Work and Skills Plan to support people with disabilities into Training, Education and Employment support • Involve local disabled people within the decision	Increase the number of programmes supporting vulnerable people across the district Increase opportunities for economic growth in the district and improve education training and employment for vulnerable communities. Increase awareness of disability	Funds proposed through Bolsover Partnership H&WB Fund(Help to Work)	Health profile data Local impact data Evaluation reports and consultation Unemployment data IMD data – employment Local impact data Evaluation reports and

	making process of the council • Explore opportunities for supporting Armed Forces Task group	issues across the council Increase wellbeing and support for veterans and Armed Forces in Bolsover District		consultation Local impact data Evaluation reports and consultation
6. Strengthening Mental Health and Wellbeing	• Support/develop training on mental health awareness, for Contact Centre and front line staff, local community and voluntary sector to address short and long term impact of welfare reforms on local communities.	Develop more positive relationships and wider understanding for clients/communities experiencing mental health issues in relation to welfare reform	Funds proposed through Bolsover Partnership H&WB Fund(Help to Work)	Health profile data Local impact data Evaluation reports and consultation
	• Improve access to Training, education and employment through the delivery of the Work and Skills Plan to improve mental wellbeing	Increase opportunities for economic growth in the district Improved Mental Wellbeing	Funds proposed through Bolsover Partnership H&WB Fund(Help to Work)	Unemployment data IMD data – employment Local impact data Evaluation reports and consultation
	• Explore opportunities for piloting a mental health support worker role for staff working within Bolsover and North East District Council	Extend support for district council staff in working with people with mental health issues		
	• Support the development of the Community and Voluntary Sector Health and Wellbeing Forum	Ensure health and well-being is addressed positively within local organisations and communities to promote mental wellbeing and support the social inclusion agenda		Local impact data Evaluation reports and consultation
	• Support the promotion, development and expansion of Bolsover Befriending Service	Reduce social inclusion for older and vulnerable people	Funds proposed through Bolsover Partnership H&WB Fund(Help to Work)	Local impact data Evaluation reports and consultation

PRIORITY: PROMOTING HEALTHY LIFESTYLES

Key Objectives	Activity or Action	Outcome	Funding Allocation required (£)	Monitoring success/evaluation
1.Increasing Physical Activity	• Enhance County Wellbeing model though the provision of Bolsover Wellness	Increased physical activity and access to tailored services for local people	Part of Bolsover Wellness service spec	Health profile data Local impact data
	• Add value to the County Walking for Health programme by developing a Bolsover W4H Forum to promote entry level walks to Older People and vulnerable groups	Develop new groups to increase physical activity among older people, contributing to the slips trips and falls agenda	£3000 (tbc 2014/15)	Monthly monitoring data & Annual Report
	• Increasing access to Entry Level Walking groups through Community transport provision in the north and south of the district	Increase access to physical activity for older and vulnerable groups	(as above tbc 2014/15)	Evaluation reports and consultation
	• Develop and pilot Community and Employment Health Checks programme across Bolsover and North East District Councils	Increase uptake of NHS Health Check programme in a community/workplace setting	£24000 Committed through Bolsover Partnership and DCC PH	Health Profile data Pilot evaluation and Health Check data
	• Develop a Pilot project with young women through Extreme Wheels BMX 'DIVAS' project	Increase physical activity among young women aged 10-17yrs	Sessions committed through Bolsover Wellness C&YP programme	Pilot evaluation reports
2.Reducing Obesity and Promoting Healthier Weight	• Promote the County Wellbeing Approach to Obesity and weight management and wellbeing through Bolsover Wellness	Increase access to local services to support a reduction levels of Obesity across Bolsover District	DCC Funded County Programme	Health profile data Local impact data
	• Pilot the Healthy Weight Programme for 11-	Improve consistency and	£30000 (tbc)	Evaluation reports and

	17yrs across Bolsover & NED in partnership with LCPCYP • Develop and pilot Community and Employment Health Checks programme across Bolsover and North East District Councils	partnership win addressing healthy weight for young people Increase uptake of NHS Health Check programme	Bolsover Partnership £24000 Committed through Bolsover Partnership and DCC PH	performance monitoring Pilot evaluation and HC data
3.Reducing Smoking and its effects	• Promote the County Wellbeing Approach to smoking, tobacco control and wellbeing • Develop and pilot Community and Employment Health Checks programme across Bolsover and North East District Councils	Increase access to local services to support a reduction in prevalence of smoking across the district Increase uptake of NHS Health Check programme	DCC Funded County Programme £24000 Committed (partnership & DCC PH)	Health profile data Local impact data Evaluation reports and consultation Pilot evaluation and HC data
4.Improve Healthy Lifestyles for Young People	• Develop and evaluate the pilot of the School Health Champion project in Shirebrook Academy • Roll out the School Health Champion model to other secondary schools across Bolsover in 2014/15 • Provide the Healthy Ipad to local secondary schools supported by CAB and local partners • Support the Teen Healthsmart programme for North Derbyshire to enhance school nursing support for local secondary schools • Maintain and support delivery of Physical Activity & Sports Development programmes for Children & Young People, and the families, including 5/60; Junior Gym; Breakfast Gym, Street games & Street Sports plus, Village Games	Improve Confidence, Skills and information around healthy lifestyles Increase access to health and wellbeing information and support for young people Increase availability of healthy lifestyles activities using innovative approaches with young people	£1000 to Shirebrook Academy (2013/14) £1000 per school set up costs (tbc) £5555 committed to school nursing £48,000 (part of Bolsover Wellness service spec)	Health profile data Local impact data Evaluation reports and consultation Evaluation reports and consultation Quarterly monitoring & Annual Report

5.Promoting Positive Mental Well-being and Reducing Social Isolation	• Promote the County Wellbeing Service to address needs of individuals in Bolsover with complex issues	Reduce Inequalities for those most vulnerable individuals	DCC Funded County Programme	Health profile data Local impact data
	• Support/develop training of Contact Centre Staff and community and voluntary sector on e.g. mental health awareness, to address short and long term impact of welfare reforms on local communities.	Develop more positive relationships and wider understanding for clients and communities with mental health issues		Evaluation reports and consultation
	• Support development of the Health and Wellbeing Forum lead by CVP in April 2014	Ensure local organisations and communities promote mental wellbeing and support the social inclusion agenda		Evaluation reports and consultation
	• Explore opportunities for piloting a mental health support worker role for staff working within Bolsover and North East District Council	Extend support for district council staff and Community voluntary sector in working with people with mental health issues	Funds proposed Bolsover Partnership Health Development Fund	Local impact data Evaluation reports and consultation
	• Add value to the Walking for Health programme to support wellbeing and reduce social isolation	Reduce social isolation and and improved mental and physical wellbeing	PH Funds £3000 tbc	SLA Performance targets
	• Support the development of a Peer Support Programme through CVP	Reduce social isolation and improved mental and physical wellbeing	Funds proposed through Bolsover Partnership H&WB Fund(Help to Work)	Local impact data Evaluation reports
	• Support wellbeing at work as part of Health Champion approach within Bolsover and North East District Councils	Improve wellbeing and support in the workplace (Strategic Alliance)		Employee Surveys Local impact data Health check uptake data

PRIORITY: SUPPORTING ACCESS TO EFFECTIVE HEALTH & SOCIAL CARE

Key Objectives	Activity or Action	Outcome	Funding Allocation required (£)	Monitoring success/evaluation
1.Improve identification and treatment of those at risk of CVD	• Develop and pilot Community and Employment Health Checks programme across Bolsover and North East District Councils • Work with CVS partners to enable the development of a Peer Support Programme to signpost and help people to access service provision	Increased uptake of NHS Health Check programme Increased uptake of Health and social care service provision	£24000 Committed through partnership and PH ageing well team	Health profile data Local impact data Health check data Local impact reports Evaluation reports and consultation
2.Improve uptake of cancer screening	• Support local and county Cancer Screening initiatives, especially targeting vulnerable people	Increase uptake of cancer screening and health checks		Health profile data Local impact data Evaluation reports and consultation
3.Support the Integrated Care Agenda to reduce hospital admissions	• Contribute to reducing hospital admissions agenda lead by Bolsover CCG Liaison Group including initiatives that reduce slips trips and falls across the district • Maintain District based Fuel Poverty/ Affordable Warmth referral service (also see Older/Vulnerable communities)	Contribute to a reduction in hospital admissions caused by slips trips and falls across Bolsover District Reduce numbers of people living in Fuel Poverty	£11,000 (as above)	Health profile data Local impact data Evaluation reports and consultation
4.Extend local links with Clinical Commissioning Groups (CCGs) for preventative healthcare	• Support the CCG liaison group to strengthen partnership working and joint commissioning of services	Increase joint working for more effective and efficient service provision		Health Profile Data Local impact data Evaluation reports and consultation
5.Improve	• Support wellbeing at work as part of 'Change	Improve wellbeing and support in		Local impact data

Workplace Health & Social Care	Motivators' Health Champion approach within Bolsover and North East District Councils • MECC – support the County roll out of 'Making Every Contact Count' for organisations across the district	the workplace Increase numbers of professionals and volunteers who are MECC trained across the county	DCC Funded County Programme	Local Impact data

The following programmes or initiatives cover all localities in Derbyshire in 2014

STARTING AND DEVELOPING WELL

- Vision screening
- Breastfeeding support
- School breakfast clubs
- **5/60** -Healthy eating, physical activity and obesity prevention programme
- Citizen's advice in Children's Centre's
- School Nursing service
- Young people's sexual health service
- Young peoples' drug and alcohol services

LIVING AND WORKING WELL

- Tobacco Control including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Health referral scheme
- Walking for health groups
- Health trainers programme
- Make every contact count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Living with long term conditions programme
- Diabetes education

HEALTH INEQUALITIES

- Citizen advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support

AGEING WELL

- Health Checks for over 40's
- Fall s prevention programme inc transport
- Social isolation initiative
- Foot care programme

Appendix 2

Sustainable Community Strategy - A Healthy Bolsover: Links with Bolsover District Council, Partners and Clinical Comissioning Groups (CCG) and Gap Analysis

* Due to be refreshed

BDC Corporate Aims *

SOCIAL INCLUSION: Promoting fairness, equality and lifelong learning

REGENERATION: Developing healthy, prosperous and sustainable communities

HEALTHY BOLSOVER

	North Derbyshire					Hardwick					
Building Healthy Communities											
Reducing Child Poverty (Inc Food Poverty, Financial Exclusion & Fuel Poverty)		■									
Reducing Binge Drinking and associated crime and anti-social behaviour		■	■				■				
Promoting Healthy Families (includes parenting, teenage pregnancy, breastfeeding)		■	■		■						
Supporting Older People and Promoting Healthy Ageing	■	■	■	■		■	■	■	■	■	■
Supporting Vulnerable People		■	■			■					
Strengthening Mental Health and Wellbeing	■	■	■				■				
Promote Healthier Lifestyles											
Increasing Physical Activity		■		■				■	■		
Reducing Obesity and Promoting Healthier Weight		■			■			■	■		
Reducing Smoking and its effects		■		■				■		■	■
Improve Healthy Lifestyles for Young People		■			■		■				
Promoting Positive Mental Well-being and Reducing Social Isolation		■					■				
Support Effective Health and Social Care											
Improve identification and treatment of those at risk of Cardio Vasculor Disease		■		■		■					■
Improve uptake of cancer screening		■				■		■			
Support the Integrated Care Agenda to reduce hospital admissions		■				■					
Extend local links with Clinical Commissioning Groups (CCGs) for preventative healthcare		■									

Links to BDC Service Areas

	Joint Leisure Services	Joint Environmental Health	Joint Street Services	BDC Housing	BDC Youth Council	BDC CEO Partnership	BDC Contact Centres	BDC Planning/Development Control	BDC Domestic Abuse Worker	BDC Housing
Building Healthy Communities										
Reducing Child Poverty (Inc Food Poverty, Financial Exclusion & Fuel Poverty)	■	■								
Reducing Binge Drinking and associated crime and anti-social behaviour							■	■	■	
Promoting Healthy Families (includes parenting, teenage pregnancy, breastfeeding)	■									
Supporting Older People and Promoting Healthy Ageing	■	■	■				■	■		■
Supporting Vulnerable People	■	■	■			■	■		■	■
Strengthening Mental Health and Wellbeing	■		■	■		■			■	■
Promote Healthier Lifestyles										
Increasing Physical Activity	■							■		
Reducing Obesity and Promoting Healthier Weight	■									
Reducing Smoking and its effects							■			
Improve Healthy Lifestyles for Young People	■				■					
Promoting Positive Mental Well-being and Reducing Social Isolation	■			■		■	■		■	■
Support Effective Health and Social Care										
Improve identification and treatment of those at risk of Cardio Vasculor Disease	■							■		■
Improve uptake of cancer screening										
Support the Integrated Care Agenda to reduce hospital admissions										
Extend local links with Clinical Commissioning Groups (CCGs) for preventative healthcare	■	■	■						■	

Partners

	DCC-Adult Care	DCC	MAT	Bolsover and NE CSP	Rykneld Homes	Bolsover Countryside Partnership	P3 Charity Housing Options	NEDCAB	RELEASE	DCHS	CVP	SNAP	Ashgate Hospice	Chesterfield Community Farm	Junction Arts	Chesterfield Royal -School Health	ND CCG	Clowne and District Community Transport	Steps to Change	Rhubarb Farm	Older Peoples Forum
Building Healthy Communities																					
Reducing Child Poverty (Inc Food Poverty, Financial Exclusion & Fuel Poverty)	■	■	■	■		■	■	■	■		■	■		■	■	■				■	
Reducing Binge Drinking and associated crime and anti-social behaviour	■		■							■	■	■									
Promoting Healthy Families (includes parenting, teenage pregnancy, breastfeeding)	■		■		■	■	■	■	■	■	■	■	■		■		■	■			■
Supporting Older People and Promoting Healthy Ageing	■		■		■	■	■	■	■	■	■		■	■	■		■	■		■	■
Supporting Vulnerable People	■		■		■	■	■	■	■	■	■	■	■	■	■		■	■		■	■
Strengthening Mental Health and Wellbeing	■		■		■	■	■	■	■		■	■	■	■	■			■		■	■
Promote Healthier Lifestyles																					
Increasing Physical Activity		■				■					■	■		■	■	■		■		■	
Reducing Obesity and Promoting Healthier Weight	■		■								■	■		■		■	■			■	
Reducing Smoking and its effects										■	■									■	
Improve Healthy Lifestyles for Young People	■	■						■			■	■				■				■	
Promoting Positive Mental Well-being and Reducing Social Isolation	■							■			■	■		■	■	■		■	■	■	■
Support Effective Health and Social Care																					
Improve identification and treatment of those at risk of Cardio Vasculor Disease	■				■							■									■
Improve uptake of cancer screening								■			■										
Support the Integrated Care Agenda to reduce hospital admissions																					
Extend local links with Clinical Commissioning Groups (CCGs) for preventative healthcare																					

Link to CCG Aims

North Derbyshire					Hardwick					
Dementia	Integrated Working	Patient/ Stakeholder Focus	Long Term Conditions	Childhood Obesity	Integrated care for patients with long term conditions	Mental Health	Cancer	Diabetes	Heart Failure	Respiratory Disease

Derbyshire Heath and Wellbeing Board

Chesterfield Locality Public Health Plan

Chesterfield is the largest settlement in the county of Derbyshire. It is a relatively compact and mainly urban area. Chesterfield is a major centre of employment (over 48,000 people work in the Borough) and attracts almost 20,000 in-bound commuters on a daily basis.

The Borough of Chesterfield has an estimated population of over 100,000; just over 94% of whom are White British and just under 6% are from other ethnic groups. The population of the Borough will have risen to over 112,000 by 2033.

The Borough is relatively deprived, ranking 91st out of 326 English local authority areas in the 2010 English Index of Multiple Deprivation (1 is the most deprived). Some 17 of the 68 Lower Super Output Areas in Chesterfield fall within the top 20% of most deprived areas in England.

The locality plan has two key aims:

1. To continue with the delivery of and support for the implementation of county-wide public health programmes at a locality level. Specific details of these programmes are not included in this plan.

2. To identify and implement locality-specific interventions which address the priority needs within the Chesterfield Borough area.

The plan will incorporate:

- the development of the Chesterfield contribution to the Healthy Communities approach and a health and wellbeing partnership to support the implementation of the priorities and support future production of locality plans. The membership of the partnership will comprise of representatives of statutory and voluntary organisations.

- the setting up of a small grants scheme (£10,000) to enable local groups to apply for support. The scheme will be administered by North Derbyshire Voluntary Action (NDVA)

Identifying need

The process of identifying needs involved discussions with partner agencies as well as a review of relevant documents and local data. This included the Derbyshire Health and Wellbeing strategy and related Health Inequalities strategy, the North Derbyshire Clinical Commissioning Group's Chesterfield Locality Plan, The Joint Strategic Needs assessment profile of Chesterfield, Chesterfield Borough Council's State of the Borough report, Public Health England's area profiles and the Public Health programme priorities. Common themes and priorities that emerged were:

1. Poverty and financial inclusion
2. Healthy lifestyles
3. Mental health and wellbeing
4. Older people

The 2010 Index of Multiple Deprivation indicated that 5 of Chesterfield's 68 LSOAs fell in the 10% most deprived in England and a further 12 fall within the 20% most deprived in England. Some of the actions identified in this plan will be borough-wide initiatives others will be targeted at the areas where identified need is greatest and where we can make the biggest difference as indicated in the following table

Ward	**Area (LSOA)**	**Ward**	**Area (LSOA)**
Rother	Birdholme Central Birdholme North	Hollingwood and Inkersall	Duckmanton
Loundsley Green	Loundsley Green East	Hasland	Hasland North East
Middlecroft and Poolsbrook	Poolsbrook Middlecroft East Middlecroft central	Holmebrook	Brampton South
Ward	**Area (LSOA)**	**Ward**	**Area (LSOA)**
Barrrow Hill and Old Whittington	Barrow Hill	St Leonard's	Town Centre
Old Whittington	Old Whittington East	Moor	Newbold Moor
St Helen's	Stonegravels South	Lowgates and Woodthorpe	Staveley Central Mastin Moor
Dunston	Dunston South East		

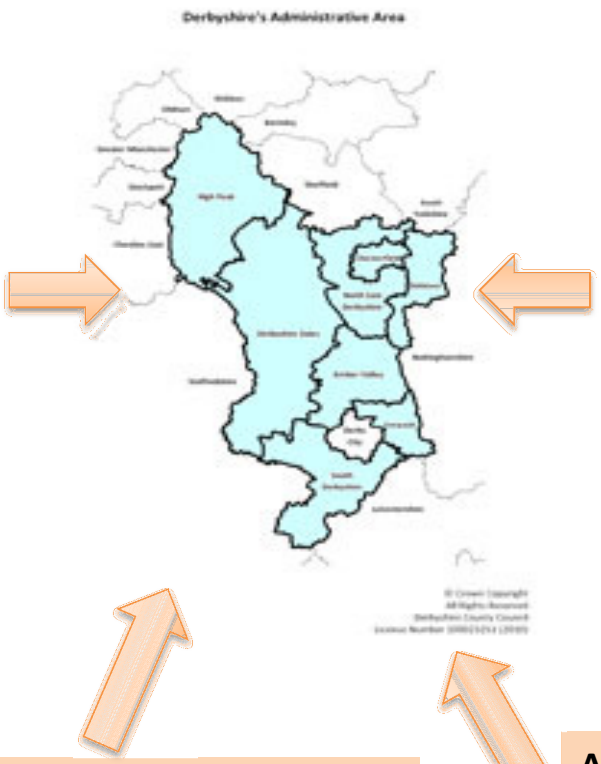
Locality plan – overview of public health and partner's priorities

High level priorities: Derbyshire Health & wellbeing strategy 2012-2015 (currently under review)				
Improve health & wellbeing in early years	Promote healthy lifestyles	Improve emotional and mental health and wellbeing	Promote the independence of people living with long term conditions and their carers	Improve health and wellbeing of older people
North Clinical Commissioning Group	**Chesterfield Borough Council**	**Health Watch**	**Derbyshire County Council**	**Public Health**
- Mental health - Dementia - Integrated care - Emergency admissions - Breast screening uptake - Flu vaccinations uptake	- Housing - Environment - Poverty - Lifestyle	- Carers - Mental health - Parents - Children and young people - Older people	- Support school breakfast clubs and older people's luncheon clubs - Run a 'quids in' campaign - Invest in community based advice services and DCCs welfare rights service - Promote credit unions tackle loan sharks and help families to manage their budget.	- Tackling childhood poverty - Increasing access to affordable warmth with a specific focus on vulnerable groups - Creating opportunities for financial inclusion and building skills for financial management - Supporting people with health problems to get back to work and supporting the development of workplaces as healthy settings

The following programmes or initiatives cover all localities in Derbyshire in 2014

STARTING AND DEVELOPING WELL

- (Health Visiting*)
- Breastfeeding support
- Children and Young People's Health Promotion
- National Child Measurement Programme
- HENRY (Health Exercise and Nutrition for the Really Young)
- School breakfast clubs
- Five60 (Healthy eating, physical activity and obesity prevention)
- Citizen's advice in Children's Centre's
- School Nursing service
- Young people's sexual health service
- Young peoples' drug and alcohol services



LIVING AND WORKING WELL

- Tobacco Control including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Health referral scheme
- Walking for health groups
- Health Trainers programme
- Make Every Contact Count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Living with long term conditions programme
- Diabetes education

HEALTH INEQUALITIES

- Citizen advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support
- Support for welfare assessment

AGEING WELL

- Health Checks for over 40's
- Fall s prevention programme inc transport
- Social isolation initiative
- Foot care programme

Chesterfield locality public health priorities

1. Poverty and financial inclusion Current county and locality priorities include: Increasing access to affordable warmth; tackling childhood poverty and creating opportunities for financial inclusion and building skills for financial management.				
Activity	**Actions**	**Timescales**	**Resources**	**Monitoring**
Roll-out of the financial inclusion project trialled in Poolsbrook	Evaluation of the Poolsbrook initiative Amend programme as appropriate Agree target areas Agree timescales	Aim to cover priority areas during 2014 - 2015	Input from partner agencies including CBC Housing	Report to be produced to include: - numbers engaged - type of support required - outcome of contact
Financial Inclusion training for key workers	Programme for key workers in statutory and voluntary sectors will be commissioned and delivered across the borough Further discussion with possible providers is required	Programme to commence in autumn	£3,000	Will be agreed during the development of the programme
Maximising your money campaign	Agree programme with Derbyshire Unemployed Workers Centre to target priority areas	Programme to commence in April 2013	£12,000 to provide intervention for all priority areas	DUWC to produce interim and final report on numbers accessing the service and referrals/signposting to other agencies
Support for the Credit Union's Junior Saver scheme	Liaise with Credit Union and agree numbers to be reached in target areas		£5 per pupil (awaiting confirmation of final sum from Credit union)	Credit Union has mechanisms to monitor the scheme

2. Mental health and wellbeing

Many aspects of mental health and wellbeing are integral to all of the locality work. There are some areas where specific issues require more detailed interventions.

The Starting and Developing Well team are working with Children and Young People to develop a programme to support emotional wellbeing which will be supported at a local level by the Locality Planning and Commissioning Partnerships.

Activity	Actions	Timescales	Resources	Monitoring
Develop a programme with NED team to address issues relating to self-harm.	Develop a plan based on the Manchester model based in Accident and Emergency unit Contribute to the employment of a worker	To be agreed with NED team	£4,000 in Year 1 £12,500 in Year 2	To be agreed
Mental health awareness training	Currently in discussion with the Mental Health Commissioning Team Programme to be agreed	Programme agreed by end April 2014	£6,000	Number of courses and participants Each course to be evaluated
Chesterfield Football Community Trust Mental health project	Work with Sport Activity Manager and Physical Health & Wellbeing Lead for Mental Health to develop outline plan	Draft produced March 2014 Timescales to be agreed with the group		CFC Community trust

3. Healthy lifestyles The locality team will continue to promote and support the Integrated lifestyle approach and the work of Active Chesterfield				
Activity	**Actions**	**Timescales**	**Resources**	**Monitoring**
Rollout of the Making Every Contact Count programme / health champions	Discussions with key partners Agree which staff will be trained Produce training programme	This will be a rolling programme over the time frame of the plan CBC Housing staff to be trained as health Champions by autumn 2014		Number of partners participating and staff involved Reports on progress and numbers of contacts
Focussed work with BME communities on specific health issues	Areas for consideration: • Community champions • MECC • Diabetes • CHD • Mental health	Programme to be developed during first half of 2014	£15,000	
Healthy eating and Cooking skills 1) Work with Locality Planning and Commissioning Partnership 2) Extension of the cooking skills programme to be provided through the responsibility Deal	1) Support the Locality Planning and Commissioning Partnership's healthy weight initiative (due to commence in Holme Hall in February) 2) Develop a programme of cooking skills session across targeted areas and identified groups.	Programme to be rolled-out across the target areas at agreed intervals	£15,000 for both programmes	Activity will be monitored by the Partnership Monitoring to be agreed with providers
Extension of the Community organisers initiative with Loundsley Green Community Trust	Meet with LGCT to discuss if this is a feasible area for support			
Increase the participation rates in physical activity for all ages	Target activities at inactive communities following consultations and developing appropriate interventions	Consultation to take place in first half of 2014.		KPIs collected for each project/activity Annual Active People Participation indicators

4. Older people County-wide priorities that will be supported at local level are; falls prevention; social isolation and affordable warmth				
Activity	**Actions**	**Timescales**	**Resources**	**Monitoring**
Commissions a programme of volunteering to support older people	Liaise with Volunteer Centre Develop network of older people's health champions linked to other priority area e.g. financial inclusion and healthy lifestyles	Programme to be agreed by summer 2014	£10,000	
Future development of the HAPPI project with Volunteer Centre	Review of current programme Revise and agree programme for future delivery across CBC and NEDDC	Programme to be reviewed Spring 2104	£7,000	
Commission programme of arts and health activity to support mental health and wellbeing of older people in care homes	Joint work with NE Derbyshire locality currently being scoped	To be agreed	£5,000	
Purchase and distribution of Winter Warmth packs	Discuss with NDVA and agree process	To be distributed Autumn 2014	£2,500	

DERBYSHIRE DALES
Locality Public Health Plan

Introduction

This is the first Locality Public Health Plan for Derbyshire Dales and sets out the priorities and actions for improving the health of people in the district, providing a focus for local delivery of the national Public Health Outcomes Framework (PHOF). The Local Area Committee will be actively involved in agreeing public health priorities and plans, which will strengthen partnership working for public health

Partnership Working

Partnership working is critical to achieving improvements in health and well-being at a local level. Working together to identify priorities which are important to partners, and have relevance to their own plans and strategies, encourages ownership of the action plan. Adopting a multi- agency approach means that a wide range of organisations and community groups from across the district will contribute to identifying needs, sharing good practice and securing funding which will benefit health & wellbeing. It also presents opportunities for developing innovative work to support the delivery of Public Health Outcomes at a local level. .

This first version of the plan has been developed in consultation with Derbyshire Dales District Council and initial communication with North Derbyshire Clinical Commissioning Group and Derbyshire Dales CVS. Further consultation will continue and association will be made with South Derbyshire Clinical Commissioning Group, Peak District Partnership and local forums to develop the plan further.

Demographics

Derbyshire Dales is a district council area in the North West of Derbyshire. It is a large, rural area spreading across 306 square miles. The main towns and populations are Matlock 10,500, Ashbourne 7,500, Wirksworth 5,500 and Bakewell 4,500 along with over 100 villages.

In the 2011 census the population of Derbyshire Dales was 71,116 and is made up of approximately 51% females and 49% males. The average age of people in Derbyshire Dales is 45. 22.4% of the population are over the age of 65

Identifying Local Needs and Priorities

Along with local information from partners to date, local health profile data information has been collated. From the local information examined the following issues stand out for further exploration:

- Access to housing and services
- The rate of road injuries and deaths
- Significant over 65 popluation
- Uptake of flu vaccination
- Fuel poverty
- Higher risk drinking
- Unpaid care provision
- One lower layer super output areas (LSOA) in Matlock falls within the 20% most deprived in England.
- Activity and exercise

Some of these issuse are being addressed by partners and/or the current public health programmes which run accross the whole county (fig.1).

Fig 1 Programmes or initiatives are available in all localities in Derbyshire in 2014

STARTING AND DEVELOPING WELL

- (Health Visiting*)
- Breastfeeding support
- Children and Young People's Health Promotion
- National Child Measurement Programme
- HENRY (Health Exercise and Nutrition for the Really Young)
- School breakfast clubs
- Five60 (Healthy eating, physical activity and obesity prevention)
- Citizen's advice in Children's Centre's
- School Nursing service
- Young people's sexual health service
- Young people's drug and alcohol services

LIVING AND WORKING WELL

- Tobacco Control including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Health referral scheme
- Walking for health groups
- Health Trainers programme
- Make Every Contact Count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Living with long term conditions programme
- Diabetes education
- Heart of Derbyshire

HEALTH INEQUALITIES

- Citizen advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support
- Support for welfare assessment

AGEING WELL

- Health Checks for over 40's
- Falls prevention programme inc transport
- Social isolation initiative
- Foot care programme

The Priorities

Fuel poverty & Housing

Definition

A household is said to be in fuel poverty if:
They have required fuel costs that are above average (the national median level)
Where they to spend that amount they would be left with a residual income below the official poverty line

Why is this issue within Derbyshire Dales?

- 7,483 people (24.4%) of Derbyshire Dales households are living in fuel poverty.
- Larger, older housing stock is harder to make energy efficient and more expensive to heat
- High property prices and low average incomes lead to unaffordable housing

Action

- Promote awareness of affordable warmth projects and improve energy efficiency of homes.
- Work with partners to identify those most vulnerable and assist them with accessing improvements, reducing fuel costs through relevant schemes.
- Support local initiatives for reducing homelessness, supporting vulnerable households and reducing debt
- Explore and evaluate current home safety equipment schemes (adult and children)

Access to healthcare / leisure / support services

Definition

'Geographical Barriers' which relate to the physical proximity of shops, GP surgeries, schools, post offices and 'Wider Barriers' which relate to access to housing e.g. affordability, homelessness and overcrowding.

Why is it an issue for Derbyshire Dales?

The Local Area Profile domain Barriers to Housing and Services indicates that of the 16 highest ranking LSOAs in Derbyshire 11 are within Derbyshire Dales. This is likely to reflect the high house prices and long distances to travel to key services in rural parts of the district. Easy and affordable access to health care and other services can have a significant impact on people's lives. Public transport that is not available or reliable and/or expensive may mean that people do not access the help that they need early enough or access

preventative measures such as flu vaccinations etc. Shopping may be done at more expensive shops and there may not be easy access to affordable healthy food. Although volunteer transport schemes are available in some areas people may not be aware of them. Children's services to support with parenting capacity are also difficult to access for young families in some areas.

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Action

- Increase awareness of voluntary and community transport schemes and develop effective signposting via CVS; also develop new local services
- Review evidence and previous studies to understand the extent and impact of isolation and deprivation in the District and put in place services that meet the needs of isolated rural populations.

Unpaid care

Definition

The provision of unpaid care to a friend or relative who otherwise could not manage without this help, this could be due to illness, disability, a mental health problem or an addiction

Why is this issue for Derbyshire Dales?

9,003 (12.7%) residents provide unpaid care in the district. This may be indicative of the older and ageing population.
Taking on a caring role can mean poverty, isolation, ill health and depression. Many carers also work outside of the home and try to juggle jobs with their responsibilities. Carers may not know what help is available to them and what support they can access including financial support, information and breaks which are vital in helping them manage the impact of caring.

Action

- Work with partners to identify carers and signpost to support available.
- Consider opportunities for support provision that is accessible to carers in rural areas.

Physical Inactivity

Definition

Number of adults achieving less than 3 x 30 minutes of physical activity per week

Why is it an issue for Derbyshire Dales?

Over 40% of adults in the district do no activity. 27% of adults take part in sport once or twice a week (Sport England 2012)
The health cost of inactivity within Derbyshire Dales is £1.2 million per year (DH 2007)

Action

- Further analysis of data to explore level of activity.
- Continue contribution of funding for sports development officer to increase physical activity take up across Derbyshire Dales.
- Continue contribute to funding the Walking for Health programme to develop new health walks throughout the District
- Work with partners to increase awareness of the benefits of physical activity for themselves and those people they are working with.
- Promote awareness of the exercise referral scheme and Healthy Hearts Clubs
- Support the development of cycle rides and planned expansion of routes
- Support targeting of areas where level of inactivity are greatest.

Higher risk drinking

Definition

The regular drinking of more than the recommended daily alcohol intake causes risk to health. Men should not drink more than 3-4 units per day, women 2-3 units per day. There should be at least 2 alcohol free days per week. The higher risk category is more than 50 units per week for men and more than 35 units per week for women.

Why is it an issue for Derbyshire Dales?

Of those who drink alcohol 28.2% drink at levels that could harm their health. People living in higher income households and those in the least deprived areas were more likely to drink above the threshold for risk of harm.

Action

- Identification of target group and subsequent intervention to reduce alcohol harm
- Work with community safety team and partners to develop a substance use delivery plan

Road deaths and serious injury

Why is this issue for Derbyshire Dales?

The numbers of road injuries and deaths within Derbyshire Dales are significantly worse than the England average.

Regularly visiting motorcyclists are represented in these numbers

Action
Support the plans of all partners to reduce the number of road injuries and deaths

Older population

Definition
Over 65 years of age

Why is this issue for Derbyshire Dales?
Life expectancy is higher than average, men likely to live until 83 and women to 86 on average.
Older people make up over 20% of the population, higher than the England average, and this is expected to grow over the next 20 years at a higher rate than elsewhere to 33%.

Actions
- Work with North Derbyshire CCG to contribute to the frail and elderly plan to support the older population's health within Derbyshire Dales
- Establish working with Southern Derbyshire CCG on similar priority plans
- Develop small grants scheme for local initiatives that relate to older people's health and well-being.
- Support partner plans for increasing uptake of influenza vaccination

Most deprived areas

Definition
Super output areas are units of geography used in the UK for statistical analysis. They are developed and released by Neighbourhood Statistics. LSOAs are the Lower layer indicating the most deprived areas.

Why is this issue for Derbyshire Dales?
The minimum population for a LSOA is 1,000. Populations less than this are linked with adjoining areas. This may mean that small pockets of deprivation are not highlighted.

Actions

- Identify most deprived areas in consultation with partners using additional data sources
- Develop small grants scheme for local initiatives that relate to health and well-being in identified deprived areas.
- Support community development projects in the areas most deprived.
- Promote current public health programmes e.g. food banks

Budget

Existing budget £38,475
Additional budget £13,013
Total budget £51,488

Plan

To identify use of funds in consultation with partners to include:

- Contribution to post of Sports Development Officer £6,200
- Contribution towards the Walking for Health Project £8,200
- Small grant fund to meet identified health needs of elderly, access to services and support for the most deprived communities £5-10,000
- Contribution to agricultural chaplaincy £1,500
- Contribution to homelessness support worker £5,000
- Contribution to Next Steps (help to access walks) £1,000
- Contribution to Practical Support Project (for elderly/isolated) £5-10,000
- Work with partners to prioritise use of remaining budget

The Action Plan

PRIORITY	INTERVENTION	PUBLIC HEALTH OUTCOME/INDICATORS	OBJECTIVE
Fuel Poverty / Housing	Promote awareness of affordable warmth and improve energy efficiency of homes. Work with partners to identify those most vulnerable and assist them with accessing improvements, reducing fuel costs through relevant schemes. Support local initiatives for reducing	Improving the wider determinants of health • Statutory homelessness • Fuel poverty • Social isolation • Children in poverty	Improvements against the wider factors that affect health and wellbeing and health inequalities

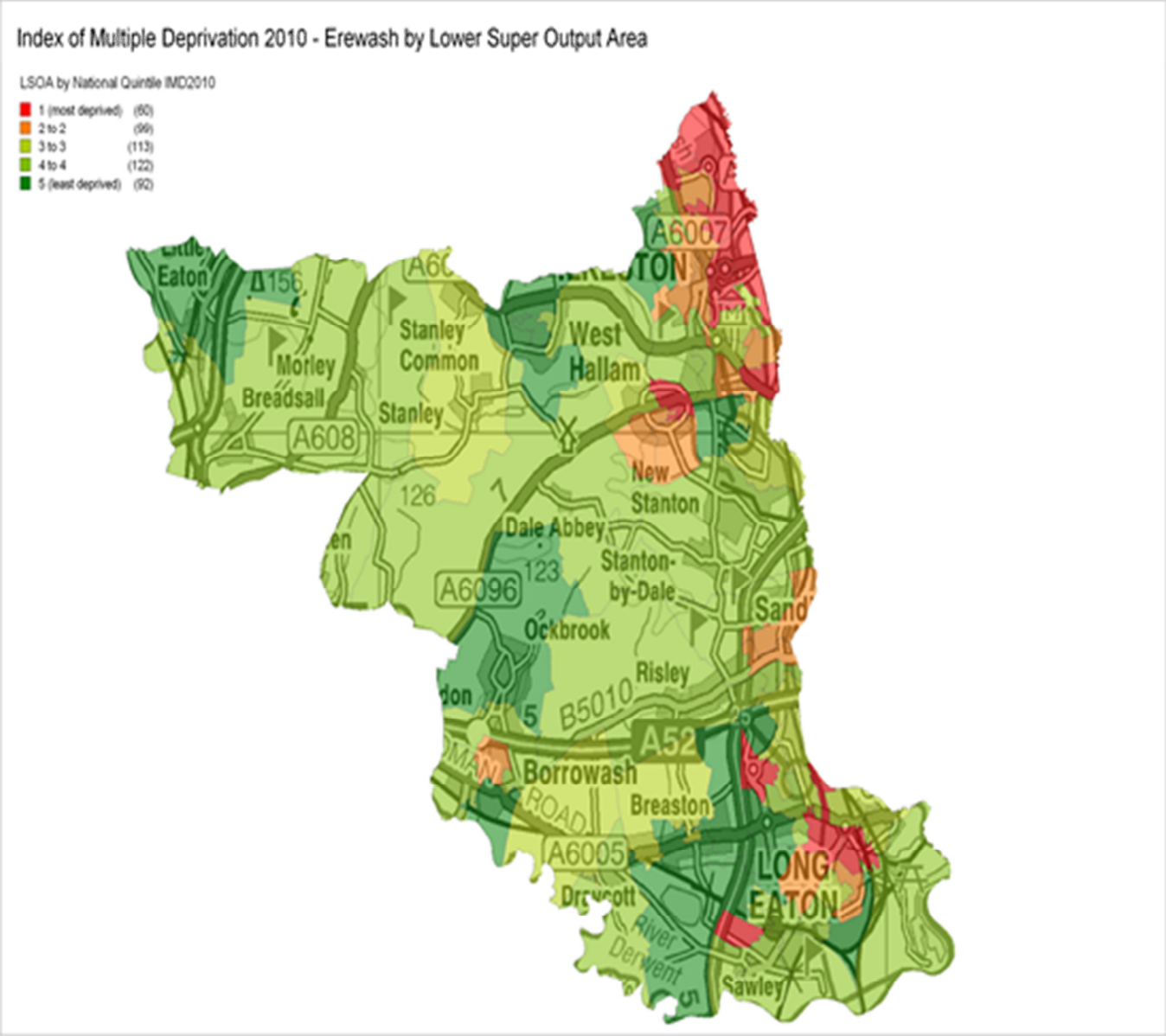
	homelessness, supporting vulnerable households and reducing debt Explore and evaluate current home safety equipment schemes (adult and children)		
Access to services	Increase awareness of voluntary and community transport schemes and develop effective signposting via CVS Review evidence and previous studies to understand the extent and impact of rurality in the District put in place services that meet the needs of isolated rural populations.	Health Improvement • Cancer screening coverage • Access to non-cancer screening programmes • Take up of NHS Health Check programme	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
Unpaid carers	Work with partners to identify carers and signpost to support available. Consider opportunities for support provision that is accessible to carer's in rural areas.	Health Improvement • Self-reported wellbeing Improving the wider determinants of health • Social isolation	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities Improvements against wider factors that affect health and wellbeing and health inequalities
Physical activity	Further analysis of data to explore levels of activity. Continue contribution of funding for sports development officer to increase physical activity take up across Derbyshire Dales. Continue contribute to funding the Walking for Health programme to develop new health walks throughout the District Work with partners to increase awareness of the benefits of physical activity for themselves and those people they are working with. Promote awareness of the exercise referral scheme and Healthy Hearts Clubs	Health Improvement • Proportion of physically active and inactive adults Improving the wider determinants of health • Utilisation of green space for exercise/health reasons	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities Improvements against wider factors that affect health and wellbeing and health inequalities

Higher risk drinking	Identification of target group and subsequent intervention to reduce alcohol harm Work with community safety team and partners to develop a substance use delivery plan	Health Improvement • Alcohol related admissions to hospital • Mortality from liver disease	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
Older people	Work with North Derbyshire CCG to contribute to the frail and elderly plan to support the older population's health within Derbyshire Dales Establish working with Southern Derbyshire CCG on similar priority plans Develop small grants scheme for local initiatives that relate to older people's health and well-being	Healthcare public health and preventing premature mortality • Health related quality of life for older people • Hip fractures in people aged over 65yrs • Estimate diagnosis rate for people with dementia	Reduced number of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.
Deprived areas	Identify most deprived areas in consultation with partners using additional data sources Develop small grants scheme for local initiatives that relate to health and well-being in identified deprived areas. Support community development projects in the areas most deprived. Promote current public health programmes e.g. food banks	Improving the wider determinants of health • Statutory homelessness • Fuel poverty • Social isolation • Children in poverty	Improvements against the wider factors that affect health and wellbeing and health inequalities

APPENDIX 5 CONTROLLED

Erewash Locality Health Plan

2014 – 16



Summary of Erewash Priorities 2014-2016

These priorities have been developed as a result of a great deal of work by many partners, and are our shared commitment to health improvement and reducing health inequalities in Erewash.

They have been developed through consultation with Partners and the Community and are taken from the Erewash Sustainable Community Strategy 2014/2024. This Locality Health Plan has been informed by a wealth of information including building on the experiences of partners, the community profile tools, partners' experience and residents' feedback.

This Plan identifies the shared priorities and ambitions for the borough between key agencies from the public, private and voluntary sector who seek to improve the quality of life experienced in Erewash.

Economic Wellbeing	**10% Funding**
We aim to….. Provide the places and conditions that attract businesses and encourages their development, to ensure that Erewash benefits as the economy recovers from the recession.	To achieve this we will work in partnership to…. • Support a stronger voluntary and community sector • Support future development of transport links to support the local economy
Employment and Skills	**30% Funding**
We aim to….. Ensure people have the skills, abilities, attitudes and behaviours to find work, stay in work and get better work.	To achieve this we will work in partnership to…. • Develop skills to improve employability • Support young people to be employment ready
Health and Wellbeing	**40% Funding**
We aim to….. Help people to live healthy and active lifestyles from an early age, make healthy choices and reduce health inequalities	To achieve this we will work in partnership to…. • Support people to live healthy and active lifestyles • Reduce health inequalities targeting priority locations • Support ageing well and independent living of the most vulnerable • Support increased participation and raise the aspirations of our communities
Safer Communities	**20% Funding**
We aim to ….. Work together to improve neighbourhoods and make Erewash even safer	To achieve this we will work in partnership to…. • Prioritise support towards the most vulnerable and their families • Prioritise those areas with the highest rates of crime and anti-social behaviour

Vision: Our vision is for a 'healthier Erewash' where all residents feel confident and supported to choose a healthy lifestyle and stay healthy.

Aim: The Erewash Health Partnership will provide a coordinated, innovative and evidence based approach to health improvement and reducing health inequalities in Erewash by:

- Responding to health need and setting priorities within Erewash as outlined in the County Council's Priorities ; Health and Wellbeing Strategy, Erewash Borough Council's Corporate Plan, The Erewash Sustainable Communities Strategy and the County and Local Joint Strategic Needs Assessments (JSNA)

- Acting as the central co-ordinating body for Health Improvement projects planning, implementation and evaluation across Erewash.

- Promote Partnership working throughout the district, and encourage an understanding of the different agencies roles and responsibilities through the LSP.

- The health action plan will contribute to the health of Erewash by identifying local priorities and health inequalities. The health action plan will 'add value' rather than replace the operational and delivery plans of the individual organisations.

- Ensuring that the focus of partnership activity in the Borough is aimed at addressing four key priority areas :

1. Employment and Skills
2. Health and Wellbeing
3. Safer Communities
4. Economic Wellbeing

<u>Erewash Borough:</u>

Erewash is located in the East Midlands region of England, lying between the cities of Derby and Nottingham. The two main towns, Ilkeston and Long Eaton and the rural parish areas each comprise one third of the Borough's population. Historically, the economy in Erewash was built upon coal mining, iron working, textiles and railways.
Manufacturing still accounts for more than 30 per cent of jobs in the area. While many of the traditional industries have declined, new employment growth has occurred in engineering, furniture making,

packaging, electronics and distribution. The area is well served by the M1 motorway and is close to East Midlands Airport.

- 112,249 people live in Erewash.
- Slightly younger age profile than the county overall with more people aged 0-4 years and 16-44 years
- A population increase of 1.8% (1,982 people) compared to Derbyshire (4.8%) and England (7.9%) between 2001 and 2011
- 4.8% of people from an ethnic minority background, slightly higher than Derbyshire (4.2%) but much lower than the England average (20.2%). This has increased over time, with the greatest increase in Petersham.
- By 2020 21% of the population (22,000) will be over 65, an increase of 17% from 2013
- By 2020 3% (3,500) will be over 85, an increase of 33% from 2013[1]

Health of Erewash

The health of people in Erewash is varied compared with the England average. Deprivation is lower than average, however about 3,900 children live in poverty. Life expectancy for men is higher than the England average. Life expectancy is 6.5 years lower for men in the most deprived areas of Erewash than in the least deprived areas.
Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is similar to the England average. In Year 6, 19.6% of children are classified as obese. The estimated level of adult obesity is worse than the Derbyshire and England average.
GCSE attainment, breast feeding and smoking in pregnancy are worse than the England average.
The rate of sexually transmitted infections is better than the England average.
The rates of violent crime and long term unemployment are worse than average.
The rates of statutory homelessness and drug misuse are better than average. [2]

The most deprived wards of Erewash are within Ilkeston North, Cotmanhay, Kirk Hallam, Ilkeston and Long Eaton Central. Therefore the investment will be targeted in the most deprived areas in order to improve the health of the poorest fastest. The most deprived wards are highlighted on the cover map.

It is important to note that any health promotion interventions aimed at improving health need to target those from the lower socio economic groups. If they do not, they run the risk of actually widening the health inequalities gap. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism (The Marmot Review, 2010).

[1] http://nhserewash.com/wp-content/uploads/2013/10/Our-2020-Vision-2.pdf
[2] http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50413

MAPPING OF EXISTING SERVICE PROVISION AGAINST PRIORITIES

H&WBB PRIORITIES [3]	JSNA PRIORITIES FOR THE AREA[4]	PARTNER KEY PRIORITIES	DCC INEQUALITIES STRATEGY [5]	PH COUNTYWIDE PROGRAMMES	ADDITIONAL LOCAL DELIVERY	
Improve health and wellbeing in the early years	• To increase the number of mothers continuing to breastfeed at 6-8 weeks • To increase childhood vaccination coverage • To reduce the number of children in workless households • To reduce the number of children requiring free school meals • To reduce absence due to illness in primary schools • To reduce the number of fixed term exclusions from schools • To reduce the number of Children in Need • To reduce the number of children in care • To reduce the number of children requiring a Child Protection Plan	Employment - Engaging with Young people with meaningful activities training, apprenticeships etc.	Reduce and mitigate child poverty	County wide affordable warmth programme	Children's Centres CAYA funded projects (NEET) Sporting Futures Princes Trust PACE Drama Crew Health Toolkit EVA CVS support for groups working with CAYA Inc. DCC Passport training delivery	Drop In Community budgets (Thriving Families) work in Cotmanhay – all key local partners
Promote Healthy lifestyles	• To reduce the prevalence of obesity • To Increase Physical Activity Levels	To ensure that the population can access independently or through their general practice a range of lifestyle support services		Healthy Lifestyle Hub Village Games Health Trainers Health Promotion service Health Checks County wide drug and alcohol	School sports leisure Services Sports Clubs Private gyms Slimmer's Clubs Groundwork activity	Woodland Trusts Boxing Club Zumba – private fitness classes Outdoor Gyms Alcohol Advice Service EVA CVS support for sector groups.

[3] http://www.hardwickccg.nhs.uk/website/X24712/files/Health_and_Wellbeing_Strategy_2012-15.pdf
[4] http://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/GeoProfiles/JSNAGeoProfile_2012_Erewash.pdf#view=Fit
[5] http://www.derbyshire.gov.uk/images/Agenda%20item%2010%20-Development%20of%20Derbyshire%20Health%20Inequalities%20Strategy_tcm44-235079.pdf

		Target the inactive Family activities		services Sexual health services Smoking cessation services NHS Health checks		EVA CVS increasing volunteering opportunities
Improve mental and emotional health	• To increase the proportion of adults in contact with secondary mental health services in employment • To reduce the number of first time entrants to the Youth Justice system • To reduce violent crime, including sexual violence	Young people's mental health	Increase financial inclusion Supporting employment for vulnerable groups	CAB in primary care CAB in children's centre Credit union investment	EVA CVS support for sector groups. EVA CVS increasing volunteering opportunities EVA CVS hosting Trident & Relate services.	
Promote the independence of people with long term conditions and their carers	• To reduce A&E attendances • To improve the patient experience of primary care, especially GP services	Improved, better integrated community services in order to reduce the number of people in hospital		Befriending support Telehealth service for people with heart failure Living with long term conditions programme Diabetes and u programme	Youth service Red Cross Community Support Teams. Pulmonary Rehabilitation. EVA CVS support for sector groups EVA CVS increasing volunteering opportunities. Direct service delivery – shopping (DCC contract), befriending, social car scheme, Welcome Home from hospital, Patient support when Carer hospitalised.	
Improve the health and wellbeing of older people	• To reduce emergency readmissions within 30 days of discharge from hospital • To reduce excess winter deaths	Reduce social isolation Vulnerable Groups Winter Warmth Long Term Conditions including falls Fuel Poverty Dementia	Affordable warmth	Strictly No Falling Social enterprise footcare services	Phone Buddy Age UK services Lunch & social groups U3A over 50 forums Comm Transport EVA CVS Hosting Tea Dances & various groups Inc. U3A. Survival packs	Telecare/ telelink Hearing Help Befriending CCE Dinners 4 U Arts at the Heart EVA CVS support for sector groups. Fuel switching – Peoples Power CIC. EVA CVS Health & Social Care S Derbys partner/provider.

		To discuss with CCG / practices the appointment of a Voluntary Sector Co-ordinator to support practices in identifying vulnerable people and ensure they are linked with appropriate services.				EVA CVS increasing volunteering opportunities Erewash CTA

Locality budget allocation from 1st April 2014; £129,254

ACTION PLAN TO SHAPE DELIVERY 2014-2016

Overarching Priority Area	Specific Aim	Outcome	Current Provision	Gaps / At Risk	Actions	Lead Organisation or individual	Measure
Economic Wellbeing	Support a stronger voluntary and community sector	Increase in the number of volunteers operating across the borough especially those who come from the most deprived wards of the borough Increase in the variety of volunteering opportunities Increase in positive relationships between sources of volunteers including patients, young people and the voluntary organisations within the area.	EVA CVS CCE	County and CCG level funding cuts will significantly impact on the voluntary and community sector	Assess the impact of funding cuts on the voluntary and community sector to identify areas for priority action and support	Pete Edwards (Erewash VA CVS) Bren Davies (CCE)	No of registered volunteers and where they are from. No of volunteering opportunities
	Support future development of transport links	Vibrant local economy	Ilkeston Railway station development	Active Travel opportunities	Support the development of sustainable travel options within the borough	DCC/EBC	Erewash CTA EVA CVS social car scheme and Wheels to Work

Overarching Priority Area	Specific Aim	Outcome	Current Provision	Gaps / At Risk	Actions	Lead Organisation or individual	Measure
Employment and Skills	Ensure that individuals experiencing mental ill health are supported to enable them to work	Increase in the number of adults in contact with secondary mental health services who are in settled Employment					
	Develop Skills to Improve employability	More people entering the workplace Few people claiming Job Seekers Reduce the number of children in workless households		Limited number of work experience opportunities	Develop and deliver a Work Experience Programme	(Job Centre Plus)	Number of opportunities placed
	Support Young people to be employment ready	More young people equipped to enter the work place Fewer young people claiming Job Seekers allowance			Support the Development of the National Citizen Service Project	(Derby College)	Numbers completing the scheme

Overarching Priority Area	Specific Aim	Outcome	Current Provision	Gaps / At Risk	Actions	Lead Organisation or individual	Measure
Health and Wellbeing	To provide environments and opportunities which ensure that women are supported to initiate and continue to breastfeed their babies	Increasing rates of breastfeeding especially in the most deprived areas of the borough at 6 to 8 weeks.					
	Provide evidence based interventions which promote self-esteem and raise aspirations amongst young people in order to ensure they achieve their full potential	Reduction in the rates of inappropriate A&E attendances by children Reduction in the number of fixed term exclusions Reduction in the rate of under 18 teenage conceptions			Commission services to support young people to achieve their full potential Improve prevention and early intervention (a consistent approach) e.g. good practice in Derby City where a Mental Health Nurse provides outreach support following discharge from hospital for self-harm/attempted suicide. Increase understanding of the safe use of Social Media and consequences of unsafe use (including how to report concerns).	Rosie Kightley (DCC MAT)	

					Increased availability of specialist support.		
	To improve the rates of participation in physical activity opportunities for all ages within the borough by ensuring that barriers of affordability, access and motivation are reduced or removed	Increasing rates of participation levels for physical activity in all age groups especially in the most deprived wards of the borough Increase participation rates for those with physical and learning disabilities	Healthy Lifestyle Hub Village Games Health Trainers DCHS Health Promotion service Health Checks Leisure Services	Family activity Target areas and inactive populations Active Travel Opportunities for disabled clients	Utilise the strength of the Alliance to maximise on the services being procured by Derbyshire County Council's new 'Wellbeing Service' and to ensure that all services are integrated. Develop a number of joint initiatives to address specific lifestyle health related issues: Such as Marketing campaign Family activities Active Travel Target workplaces	Tim Spencer (EBC) Andy Raynor (DCC)	Active people survey
	To impact upon the rates of obesity amongst adults by ensuring that evidence based support is available to adults to help them to achieve long term behaviour changes in eating and physical activity.	Levelling off or reduction in the rate of adult obesity especially in the most deprived wards in the borough.	Healthy Lifestyle Hub Village Games Health Trainers DCHS Health Promotion service Health Checks Smoking cessation services	Targeted healthy eating projects Family activities	Utilise the Alliance to explore and actively source external funding to deliver additional / enhance existing projects to promote / increase healthy lifestyles.	Tim Spencer (EBC) Andy Raynor (DCC)	PHOF
	Engagement with primary care and with local communities to ensure that those who entitled to receive	Increase in the rate of uptake of NHS health checks especially in those practices which service populations in the most deprived	Health Checks Care Coordinators	Number of practices meeting health check targets Number of referrals	Develop links between care co-ordinators in GP surgeries and other agencies to promote and	(CCG) (DCC)	PHOF Number of health checks completed in

	an NHS health check are supported to attend and referred to the HUB services	wards. Increase referrals to the HUB		to the HUB Community health checks	increase access Develop Community health checks options		Erewash
	Care homes supported to ensure that residents especially those with dementia receive appropriate care and support to remain mobile and active within their care home to reduce falls	Reduction in number of emergency admissions and falls for care home residents within Erewash	Strictly No Falling	Provision of evidence based falls exercises within the care home setting	Looking to commission additional services to improve outcomes and care received via SNF	Andy Raynor (DCC)	Care home audit
	Ensuring that access to opportunities to reduce social isolation is widely publicised and easy for people to achieve without support from statutory services.	Reduction in the number of people who report being socially isolated	Trusted befriender network	Buddying and group provision	Develop a number of joint initiatives to address social isolation within communities, including specific interventions for those suffering from Dementia.	(DCC Public Health) (DCC Adult Care)	PHOF
	Ensure that responsive services are available within the community to ensure that where possible people are supported to remain out of hospital or be discharged sooner	Reduction in the rate of emergency readmissions within 30 days of discharge from hospital			Formation of Community Support Teams Recruitment of Care Co-ordinators/Matrons Closer links with Social Service teams Better links with mental	(CCG)	

					health services. Closer links with voluntary and third sector		
		To increase childhood vaccination coverage To reduce absence due to illness in primary schools					
		To reduce the number of Children in Need To reduce the number of children in care To reduce the number of children requiring a Child Protection Plan					

Overarching Priority Area	Specific Aim	Outcome	Current Provision	Gaps / At Risk	Action	Lead organisation or individual	Measure
Safer Communities	Promote the benefits of safe levels of alcohol consumption especially amongst the older population and teenagers	Levelling off or reduction in the rate of alcohol consumption especially in the most deprived wards in the borough.			Utilise the partnership to explore and actively source external funding to deliver additional / enhance existing projects to promote / increase healthy lifestyles.	(DCC)	
		To reduce the number of first time entrants to the Youth Justice system				(DCC)	
		To reduce violent crime, including sexual violence				(DCC)	

Appendix One

The following programmes or initiatives cover all localities in Derbyshire in 2014

STARTING AND DEVELOPING WELL

- Vision screening
- Breastfeeding support
- School breakfast clubs
- **5/60** -Healthy eating, physical activity and obesity prevention programme
- Citizen's advice in Children's Centre's
- School Nursing service
- Young people's sexual health service
- Young peoples' drug and alcohol services

LIVING AND WORKING WELL

- Tobacco Control including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Health referral scheme
- Walking for health groups
- Health trainers programme
- Make every contact count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Living with long term conditions programme
- Diabetes education

HEALTH INEQUALITIES

- Citizen advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support
- Support for welfare assessment

AGEING WELL

- Health Checks for over 40's
- Fall s prevention programme Inc. transport
- Social isolation initiative
- Foot care programme

Appendix Tv

Public Health Outcomes Framework 2013-2016

At a glance

VISION
To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest.
Outcome measures
Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life. Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System
***** Indicator shared with the NHS Outcomes Framework.
** Complementary to indicators in the NHS Outcomes Framework
+ Indicator shared with the Adult Social Care Outcomes Framework
++ Complementary to indicators in the Adult Social Care Outcomes Framework
Indicators in italics are placeholders, pending development or identification

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in poverty
1.2 School Readiness
1.3 Pupil absence
1.4 First time entrants to the youth justice system
1.5 16-18 year olds not in education, employment or training
1.6 Adults with a learning disability / in contact with secondary mental health services, who live in stable and appropriate accommodation+ (*ASCOF 1G and 1H)*
1.7 People in prison who have a mental illness or a significant mental illness.
1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services * *(i-NHSOF 2.2)* *++ (ii ASCOF 1E) ** (iii NHSOF 2.5) ++ (iii-ASCOF 1F)*
1.9 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads.
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Re-offending levels
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation + *(ASCOF 1I)*
1.19 Older people's perception of community safety *++ (ASCOF 4A)*

2 Health Improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies
2.2 Breastfeeding
2.3 Smoking status at time of delivery
2.4 Under 18 conceptions
2.5 Child development at 2-21/2 years
2.6 Excess weight in 4-5 and 10-11 year olds
2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8 Emotional well-being of looked after children
2.9 Smoking prevalence – 15 year olds (Placeholder)
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Successful completion of drug treatment
2.16 People entering prison with substance dependence issues who are previously not known to community treatment
2.17 Recorded diabetes
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2
2.20 Cancer screening coverage
2.21 Access to non-cancer screening programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities.

Indicators

2.1 Fraction of mortality attributable to particulate air pollution
2.2 Chlamydia diagnoses (15-24 year olds)
2.3 Population vaccination coverage
2.4 People presenting with HIV at a late stage of infection
2.5 Treatment completion for TB
2.6 Public sector organisations with board approved sustainable development management plan
2.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.

Indicators

4.1 Infant mortality* *(NHSOF 1.6i)*
4.2 Tooth decay in children aged 5
4.3 Mortality rate from causes considered preventable ** *(NHSOF 1a)*
4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)*
4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
4.8 Mortality rate from communicable diseases
4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5)*
4.10 Suicide rate
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia* *(NHSOF 2.6i)*

Appendix Three

Erewash CCG Strategic Priorities

1 - Improving the Quality of Primary Care

- More services available in GP practices across 7 days
- Patients are consistently happy with the services they receive
- Better access to services in the community

2 - Improving the Mental Health of the population and Dementia services

- Less people will need to be admitted to hospital
- There will be more choices for care and treatment closer to home
- There will be more support for people with mental health
- conditions and learning disabilities across 7 days

3 - Providing the best start in life: Improving outcomes for Children

- Children's services will be “joined-up” with a team organised around the needs of the child – health, education, voluntary sector etc.
- School nursing will play a key part in ensuring children have healthy lifestyles
- Children will have more access to emotional well-being programmes to help with mental health and behavioural issues

4 – Reducing inequalities across the CCG population

- Less patients will be admitted to hospital in an unplanned way
- More “easy access” clinics will be available to help stop people being admitted to hospital when they could be cared for elsewhere
- There will be less people with alcohol related liver disease
- More people will be routinely screened for cancer and appropriate treatments started earlier

5 - Integration of Care Focusing on older and frail people

- More people will be able to stay at home and live independent lives
- Health care, social care and voluntary sector agencies will work around the person as a team

6 - Supporting People with Long Term Conditions

- More people will take responsibility for their own health focusing on
- prevention
- New ways of helping people manage their condition will be available health coaching, technology solutions
- More services will be available in the community

7 - Improving End of Life Care

- More people will be given the choice of dying in their preferred place of care with the necessary support
- More community care packages will be available to help keep people in their own home, where they choose

Appendix Four

Derbyshire County Council Priorities

Young people

We will ensure high quality early years provision and affordable childcare, first class schools, special educational needs and disability services; youth services and careers advice

Economy, Jobs and Transport

We will help businesses set up and thrive in Derbyshire and make sure people have the right skills and training they need to work and earn a decent living. We will invest in the road, bus and rail network to enable people to travel to work and leisure

Derbyshire Communities

'Improve the quality of life for Derbyshire people. We will work with communities to identify and tackle the problems you face a better deal for those with disabilities and tackle health inequalities. We will support cultural, sports and community events celebrating the vibrancy and beauty of our county

Older People

We will continue to work closely with our health partners and the community and voluntary sector to identify the most effective ways of supporting older people to live independently, safely and well, for as long as possible. We'll ensure older people are always treated with dignity and respect and are listened to, using their views to better shape services.

Appendix Five

Community Resilience

A priority theme from the Councils, ,public health and the CCG and which has the potential to support the most vulnerable groups of people in the community is the concept of community resilience . A number of national strategies - *A vision for adult social care: capable communities and active citizens; Health Lives - Healthy people (Public Health White Paper which aim to promote independence, empower local communities to improve health and wellbeing and reduce inequalities*

Community development is a core of a public health approach to address health inequalities

Community development is a process of getting communities involved in decisions that affect them; - identifying needs, planning, development and the management of services
Community development is about building active and sustainable communities based on fairness mutual respect participation equality and co-operation i.e. increasing social capital

The programme targets disadvantaged communities with poor or unknown outcomes and identifies what is important to them and their wellbeing Ideally a programme should be developed in partnership with local primary care services including the independent sector .

Appendix Six

Derbyshire Health Inequalities Strategy[6]

• Use data from the Joint Strategic Needs Assessment to describe the range and extent of health inequalities in Derbyshire that affect socially disadvantaged areas and sub-groups of the population
• Target a small number of key strategic priorities to address inequalities focusing on the wider determinants of health inequality, the main lifestyle issue affecting inequalities, and equitable access to a key healthcare intervention.
• Ensure delivery of the agreed HWS life-course priority areas contributes to reducing health inequalities in Derbyshire.
• Identify indicators to use to measure progress (including process, output and outcome measures) and an overarching strategic health inequalities goal to provide focus and direction.

There is already a wealth of established collaborative activity contributing to tackling health inequalities, including public health locality working to address inequalities at local level. However, it is essential to increase our efforts in specific areas with the greatest potential to impact on inequalities.

Wider determinants of health

The Marmot review proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The most important wider determinant of health and the one that impacts most on health inequalities is poverty. Poverty impacts on all aspects of social and economic disadvantage of individuals and communities, and tackling income inequality has become even more challenging as a result of the economic downturn and the recent welfare reforms. Proposed themes are:-

• Tackling childhood poverty
• Increasing access to affordable warmth with a specific focus on vulnerable groups
• Creating opportunities for financial inclusion and building skills for financial management
• Supporting people with health problems to get back to work and supporting the development of workplaces as a healthy setting

Lifestyle risk factors

Health inequalities are affected by differences in the prevalence of key lifestyle risk factors between areas associated with levels of disadvantage. Levels of smoking, physical inactivity, alcohol harm and obesity are all more prevalent among the most disadvantaged neighbourhoods of Derbyshire. Taking into account the relatively weak collective action on smoking locally compared to other lifestyle factors and the good level of confidence in being able to do more, the lifestyle factor with the greatest potential to impact on inequalities in premature mortality and ill health is smoking. While stop smoking services have been shown to successfully recruit smokers from disadvantaged areas, these individuals have lower success in quitting than those in more affluent groups because of factors such as lack of social

[6] DERBYSHIRE HEALTH AND WELLBEING BOARD, November 2013 Development of a Derbyshire Health Inequalities Strategy

support, higher nicotine dependency and challenging life circumstances. It is proposed that we should work collaboratively to change social norms around smoking.

Access to and outcomes from preventive health interventions

Ensuring equitable access to effective preventive health interventions contributes to reducing health inequalities by ensuring those most at risk of poor health outcomes receive timely and effective prevention and treatment interventions. The majority of the gap in life expectancy between disadvantaged and more affluent areas is due to premature deaths from cardiovascular disease, cancer and respiratory disease, much of which can be addressed by early prevention. The priority is to agree a programme of health equity audits with key partners. Equity audits help to address inequitable access to and benefit from services and can be used to check progress against the range of HWS priorities.

Appendix Seven

Consultation

The broad priorities outlined in this plan are taken from the Erewash Sustainable Community Strategy, which can be accessed here.
http://littleeatonparishcouncil.com/Sustainable%20Community%20Strategy%202014-2024%20for%20consultation.pdf
Many Erewash partners were involved in the development of these priorities. Including CVS and Community Concern Erewash along with other voluntary and statutory agencies.

Consultation on these priorities has also been carried out with local residents.

Other partners from CAYA, Adult Care and Derbyshire Sport have also been consulted with.

It is envisaged that the physical activity and much of the health element of this plan will be delivered in conjunction with the Erewash Sport Health and Physical Activity Alliance which is an independent group of partner agencies.

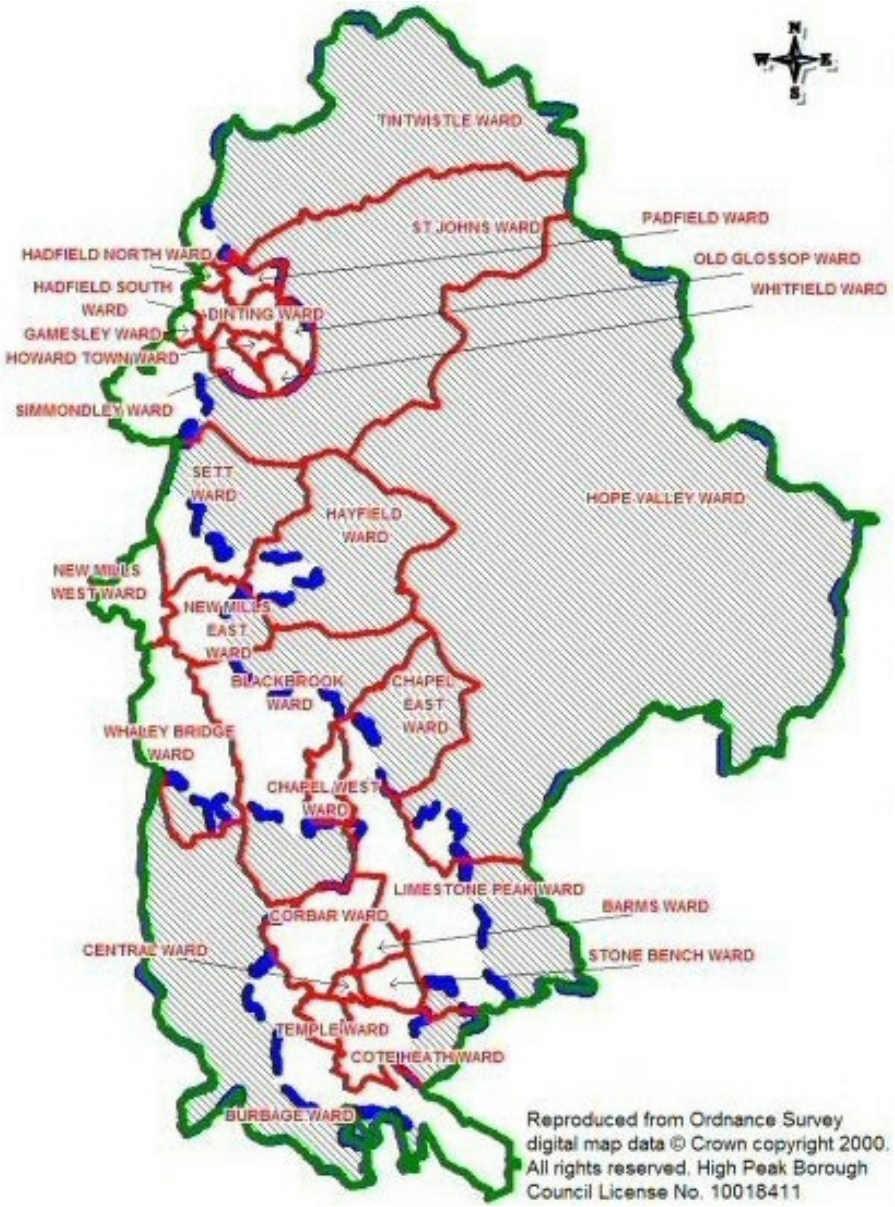
It is important to note that these are purposely broad high level priorities that will accommodate many opportunities to impact upon the Public health Outcomes framework, Joint Strategic Needs Assessment and improve the health of Erewash residents.

It will be expected that any projects that are delivered as a result of this plan will be developed in conjunction with the communities which they aim to serve, in line with the public health ethos of community development.

HIGH PEAK PUBLIC HEALTH LOCALITY PLAN

Demographic profile

The High Peak is a Borough Council area in the North of Derbyshire. It has a population of about 91,000 distributed across 208 square miles. The largest town is Glossop (population 33,000) and the second largest is Buxton (population 25,000).



Key statistics

1. Two lower super output areas (LSOA) in Glossop (Gamesley and Hadfield North) fall within the 10% most deprived in England and are the third and fourth most deprived LSOAs in Derbyshire (IMD 2010)

2. Male life expectancy in these areas is 69 and 73 compared with 78 for both Derbyshire and England (ONS). For females the figures are 72 and 78 respectively compared with 82 for both Derbyshire and England.

3. ONS figures for Jobseekers allowance claimants (Nov 2013) show that Gamesley in Glossop has the highest level in Derbyshire with a rate of 6.6%. Whitfield ranked 15th worst (4.3%). The comparable figures for High Peak are 2.1% Derbyshire 2.1% and England 2.9%.

4. In the High Peak, a higher percentage of Jobseekers allowance claimants are long term unemployed (over 12 months) compared to county or national rates (34.5% in High Peak equating to 430 people compared to 31.8% in Derbyshire and 31.2% England).

5. The rates of people on Employment Support Allowance and Incapacity Benefits in High Peak at 5.1% are below the Derbyshire (6.1%) and English (5.9%) rates but these mask specific areas where ESA rates are much higher. This includes Gamesley (13%); Whitfield (12.4%) and Hadfield North

(9.5%). It is also worth noting that although the rate of ESA is lower, the actual number of people who are on ESA in wards such as Stone Bench, Howard Town and New Mills East are the same or higher than in Gamesley - and there are 50% more people on this benefit in the relatively affluent ward of Whaley Bridge than in Barms.

6. There are 125 NEETs (not in education, employment or training) young people aged 16-18 years in the High Peak (38 Buxton; 31 Central towns; 53 Glossop and 3 in Hope Valley).This represents 4.3% of overall cohort and compares to Derbyshire average of 5.12%. However, 15.9% of 16-18 year olds current status is unknown. (561 people) compared to a Derbyshire average of 10.8% and in Glossop the rate of unknowns is 26%. There is a particularly high number of 'lapsed' unknowns in Glossop (whereby young people who have left their original destination and it has not yet been discovered if they are in alternative EET or have become NEET) which could be a result of poor careers guidance for post 16 choice.

7. The numbers for teenage parents (16-18) including those who were pregnant were: Buxton 23; Central area 10; and Glossop 30. Historically the number of 16-18 years who were teenage parents and NEET were twice as high in Glossop than Buxton or Derbyshire averages. (i.e. teenage parents in Glossop were more likely to remain workless than in other locations)

8. There were 345 18-24 year olds on JSA benefits in December 2014. This is a significant reduction from 635 in March 2012, but is still approximately 100 people above the pre-recession level. Of these, 35% (121 people) are on the Work Programme for longer term unemployed – normally 9 months JSA beneficiary for young people - which is delivered in the High Peak by DNCC (70 attached to Buxton and 51 to Glossop).

PRIORITIES

Derbyshire County Council Health and Wellbeing Priorities	Derbyshire County Council health inequalities strategy	Derbyshire County Council	Public Health Priorities in High Peak
1. Improve health and wellbeing in the early years 2. Promote healthy lifestyles 3. Improve mental and emotional health 4. Improve the health and wellbeing of older people 5. Promote the independence	1) Reduce and mitigate child poverty 2) Increase financial inclusion 3) Affordable warmth 4) Supporting employment for vulnerable groups	- Support sbclubs and older people's luncheon clubs - Run a 'quids in' campaign - Invest in community based advice services and DCCs welfare rights service - Promote credit unions tackle loan sharks and	**Philosophy:** Work upstream to address the social determinants of health **Issues:** Reduce poverty including child, food & fuel poverty Promote mental wellbeing Reduce alcohol misuse in young people Increase breastfeeding rates Reduce smoking in pregnancy Increase physical activity

of people with long term conditions and their carers		help families to manage their budgets	**Priority areas** Glossop; Gamesley; Hadfield North; Whitfield; Stonebench; New Mills East; Buxton Central **Priority group** Young people (13-25)

Partner Organisation Priorities

Peak District Partnership	High Peak Borough Council	North Derbyshire CCG 2013/14	Tameside and Glossop CCG 2013/14	Health Watch
• Affordable, decent homes • High-wage and high-skills jobs • Older People • Supporting future generations	• Good quality , affordable homes • Local employ-ment /training • Accessible services • Leisure provision	Integrated mental health services • Integrated care for complex needs • Long term conditions • Development of young people • Urgent care	• Supporting children and families • Improving lifestyles • Mental health • Long term conditions • Planned care and cancer • Urgent care • End of life services	• Carers • Mental health • Parents • Children and young people • Older people

ACTION PLAN

PRIORITY	INTERVENTION/PROJECT	EVIDENCE	OUTCOMES
Poverty	Wealth health & wellbeing project. An outreach approach in neighbourhoods with high levels of rent arrears. Takes 5 key services to these neighbourhoods to reduce poverty in an holistic way.	Outcomes from intervention in Tameside, Glossop & Fairfield	3 programmes/year 180 families helped each year
Poverty	Employment support to Wealth, Health and Wellbeing project Pilot Raising Aspirations project from Bolsover	Impact of unemployment on health Raising aspirations Bolsover	Employment advisor attendance at W, H WB events Number of people advised about employment or training Pilot of Raising Aspirations
Poverty	Credit union development. Proposal	Research on impact of CUs in	1 FTE development worker

	to fund a full time worker to increase membership of the credit union across the High Peak.	poor communities	500 new credit union members a year in High Peak
All	HPBC officer	Outcomes from past 6 years: Public health key priority for HPBC HPBC Policy influenced PDP policy influenced	Key tasks – • Support/link H&WB sub group, Credit Union, PDP, Home Start • Manage PH small grant fund • Operate safety referral scheme • Local project support – WH&WB, Healthy Communities (pilot), 5 Ways2WB, LAEP (Affordable Warmth).
Glossop	Health needs assessment	Glossop is new to Derbyshire Public Health so a HNA will be undertaken to provide a baseline of assets and needs	HNA complete by end July 2014 Action plan developed by October 2014 Actions built into locality plan from April 2015.
Poverty Young people	Young people's homelessness prevention project. Run by Adullam Homes, working with young people to prevent homelessness and house the people who are homeless. Also provides lifeskills support	Outcomes from project since 2008	Contribution to 1 FTE post
All	Small grants fund taking an empowerment approach to health improvement, e.g. • Bowling Club Recruitment Scheme through Well Fit • Pit Stop Breakfast Club	Empowerment & social capital building	Measure against fund criteria
Physical activity Mental health	Health walks Pedal project Complements county-wide physical activity programmes.	There is a strong evidence base for the impact of regular physical activity on physical and mental health.	Number of walks/events Numbers of participants

Mental health	Care Farm project. Places people with mental health issues with local farms to reduce isolation, develop confidence, lifeskills and experience. Supports local farms.	Research from Holland; pilot in High Peak	Number of clients Case studies of impact
Mental health	Agricultural chaplaincy. Outreach social and technical support to local farmers delivered by an ex-farmer and chaplain.	Outcomes from existing project	Number of clients Case studies of impact
Young people Reducing alcohol harm	Be safe project. Outreach to young people at risk of harm due to excessive alcohol consumption in target areas of High Peak.	Outcomes from Be Safe Literature review	
Increase breastfeeding rates	Support county-wide programme through locality team.	Lots on effectiveness of peer support	Breast feeding rates trend
Reduce smoking in pregnancy	Financial incentive scheme – support county-wide programme roll out from October 2014.	Cochrane Review Pilot in Chesterfield	Smoking at delivery rates

Extract from the Pilot of the Wealth Health & Wellbeing in Gamesley February 2013:

Feedback from Citizens Advice Worker:
"I was surprised how much we at CAB could offer and it is very interesting because most of the clients it seems would not have approached us for help if it were not for us "going to them". I guess this does show the true value of the day and in terms of outcomes the results were fantastic. Considering that this was a small corner of Gamesley this was very impressive and it just goes to show how many people need some help in accessing available services even when you already offer them on their doorstep."

Key findings:

- 1 household with multiple debts of more than £10,000
- 1 household with multiple debts of £2,600
- 6 households with an increase in entitlements to sum of £10,500
-

Feedback from an Individual supported on the delivery day:
"I was close to a nervous breakdown until I had the service of CAB which was brought to my house. I was being told that I needed to move into a bungalow and give up my house of 30 years. I have suicidal thoughts and trouble controlling myself, my son has to stay with me about

once a month for 2 or 3 nights. I would have killed myself in that bungalow. Through CAB I learned that I was only 6 month off the exemption of the bedroom tax due to my age of 61 and I kept my house. Also due to my ill health was able to get £100 per week more money and I am also going back to see them 1 year on to sort out my bus pass. Without this service I would be dead".

RESOURCES

STAFF

Public health principal (0.2 FTE)
Partnership and Communities Officer (HPBC; 0.4 FTE)
Community health development lead (0.6 FTE)
Community health development worker (0.6 FTE)

BUDGET

Intervention	2014/15	Match funding	2015/16	2016/17
Wealth health & wellbeing	15,000			
Employment support to Wealth, Health and Wellbeing project	15,000			
Credit union	13,000			
HPBC officer	13,000			
Young people's homelessness prevention	10,000			
Small grants fund	10,000			
Health walks	8,000			
Care Farm project	5,000			
Agricultural chaplaincy	3,000			
Glossop action plan from HNA	0			
Be safe (young people & preventing alcohol harm)	8,000			
TOTAL	100,000		100,000	100,000

DATA SOURCES

JSNA: http://observatory.derbyshire.gov.uk/IAS/jsna/ Local Health - http://www.localhealth.org.uk/#v=map4;l=en
Health Profiles: http://www.apho.org.uk/resource/view.aspx?RID=50215&REGION=50153&SPEAR=
Derbyshire Observatory geo-profiles: http://observatory.derbyshire.gov.uk/IAS/healthandwellbeing/healthprofiles/geoprofiles.aspx

North East Derbyshire Locality Public Health Plan 2014 -15

Demographic profile

The district of North East Derbyshire covers an area of approximately 100 square miles, and has a population total of 99,100 inhabitants which is variously distributed between urban and rural locations. Some of the larger settlements in the district include the parishes of, Dronfield (all usual population 21,261), Killamarsh (9,445), Eckington (11,855), Clay Cross (9,222), North Wingfield (6,505) and Wingerworth (6,533). http://www.nomisweb.co.uk/census/2011/ks101ew [accessed 03/03/14]

The locality plan has two key aims:

1. To continue with the delivery of and support for the implementation of county-wide public health programmes at a locality level. Specific details of these programmes are not included in this plan but there is a diagram of Public Health life course commissioning priorities in Appendix 1 on the final page.

2. To identify and implement locality-specific interventions which address the priority needs within the North East Derbyshire area.

Key statistics:

The English Indices of Deprivation 2010 (DCC, 2011) indicates there are one or more Lower Super Output Areas (LSOAs) within North East Derbyshire that fall in the top 20% nationally in the overall Index of Multiple Deprivation (IMD). The LSOAs are located in 6 geographical Wards. Some of the Wards also feature by single indicator in the top 10%, nationally.

WARDS (IMD top 20%)	
• Holmewood & Heath	• Clay Cross North
• North Wingfield Central	• Clay Cross South
• Grassmoor	• Shirland

SINGLE INDICATOR	WARD (IMD top 10%)
Employment	1. Holmewood & Heath 2. North Wingfield Central 3. Clay Cross North 4. Shirland
Health & disability	Holmewood & Heath
Education skills & training	All 6 Wards

Further information on key health and wellbeing indicators can be accessed on the Derbyshire Observatory geo-profiles web page http://observatory.derbyshire.gov.uk/IAS/healthandwellbeing/healthprofiles/geoprofiles.aspx

Or the Department for Communities and Local Government website via the following link: http://www.communities.gov.uk/publications/corporate/statistics/indices2010?view=Standard

High level priorities: Derbyshire Health & wellbeing strategy 2012-2015 (currently under review)		
• improve health & wellbeing in early years	• promote healthy lifestyles	• improve emotional and mental health
• promote the independence of people living with long term conditions and their carers	• improve health and wellbeing of older people	

Partner Organisations: Vision and Goals				
NEDDC	**Hardwick CCG 2013/14**	**North CCG 2013/14**	**Health Watch**	**DCC**
• reduce health inequalities • improve people's quality of life through healthy living and reduced deprivation • support vulnerable and disadvantaged people • improve accessibility to services through local transport schemes	• Integrated care for patients with long term conditions • Heart failure • Respiratory disease • Mental health • Cancer • Diabetes	• Dementia • Integrated working • Patient/stakeholder focus • Long term focus • Long term conditions • Childhood obesity	• Carers • Mental health • Parents • Children and young people • Older people	- support school breakfast clubs and older people's luncheon clubs - run a 'quids in' campaign - invest in community based advice services and DCCs welfare rights service - promote credit unions tackle loan sharks and help families to manage their budgets **Public Health** - Tackling childhood poverty - Increasing access to affordable warmth with a specific focus on vulnerable groups - Creating opportunities for financial inclusion and building skills for financial management - Supporting people with health problems to get back to work and supporting the development of workplaces as a healthy setting **Public Health North East** - reduce smoking in pregnancy - reduce killed and seriously injured casualties on the road - reduce levels of self-harm through promoting mental health and wellbeing

Priority	Intervention or Action	Evidence	Outcome	Monitoring	Budget 2014/15
Encourage more people of all ages and abilities to become more active, more often through the means of Physical activity opportunities.	Deliver bespoke activities for residents based in the priority areas listed.	Current barriers surrounding participation, cost, transport, current Active PeopS 7 results.	District of fitter, happier healthier residents with physical activity opportunities available on the doorstep.	Attendances to new initiatives 16+ achieving 30 minutes once a week 16+ achieving 3x30.	
Reduce poverty and its effects on health and wellbeing.	Child Hood Poverty – introduce junior saving account for primary school children in the 6 identified areas as a pilot to encourage young people to save.	Research on impact of Credit Union junior saving scheme with in primary schools	To encourage a community culture of saving	Extent of take up of the junior saving scheme within primary schools	8,000
	Increase the delivery of cooking skills workshops within the community. Link this with the setting up of Food Banks in community settings.	Previous cooking skills workshops delivered by Children's Centres within North East Derbyshire	Develop a programme of cooking skills session across targeted areas	Extent of uptake	10,000
	Invest in community development work in target areas.	Targeted interventional work in a geographical area and community neighbourhoods	To engage local people in efforts to reduce poverty and health inequalities	Meeting the agreed objectives	25,000

Supporting the delivery of local Affordable Warmth and Fuel Poverty interventions at county-wide level	Funding allocated to District Council Fuel Poverty advice service, which provides support and onward referral to vulnerable families and older people	Work developed through the strategic alliance with Bolsover District Council	Fuel poverty advice service, which provides support and onward referral to vulnerable families and older people	Monitoring information from Environmental Health Department annual monitoring figures submitted	11,000
	Contribute to a Winter Warm Programme for children under 5s, vulnerable and older people	Cold weather mortality rates baseline	Deliver the Winter Warmth Programme Autumn 2014	Mortality rates	4,000
Reduce Worklessness and its effects on health and wellbeing	Continue the current work delivered by North East Derbyshire District Council in supporting people back to work	Providing one to one support for residents North East Derbyshire residence unemployed or facing redundancy	Outcomes from project since 2007	Quarterly monitoring submitted by North East Derbyshire District Council	4,500
Reduce the risk of homelessness and its effects on health and well-being	Continue supporting the current work delivered by North East Derbyshire District Council to deliver interventions for homeless and vulnerable people	Providing support to people to prevent homelessness and support in finding accommodation and moving on in a planned way	Outcomes from project since 2010	The end of financial year report on Homelessness Prevention	4,000
Reduce hospital admissions for self-harm related incidents	Develop a programme with Chesterfield Public Health team to tackle the issue of self-harm affecting younger adults.	Develop the self-harm model that operates in Manchester A&E and contribute to employment of worker joint with Chesterfield Public Health team	To further investigate the issue around self – harm.	Admissions figures from hospital A&E data.	5,000 in 1st Year 12,500 in 2nd year

Promote health and wellbeing amongst older people • focussing on reducing social isolation	Review the work being delivered to tackle social isolation of vulnerable older people and develop a plan for strengthening the interventions available	HHAPI project (Healthy Homes and Personal Independence)	Review project and agree future delivery across North East Derbyshire and Chesterfield	Outcomes of the review	7,000
• age related mental health issues including dementia	Joint work with Chesterfield locality Public Health team, promoting arts based activities within care homes to improve mental wellbeing, including dementia and age related mental health issues	Arts impact report 2013	Improving physical and mental wellbeing	Increased delivery of arts based activities within the care homes	5,000
Increase local capacity to address health & wellbeing issues at neighbourhood/community level	Maintain Grant Scheme to support local initiatives promoting health and wellbeing	The impact or success an initiative in a local community, or neighbourhood.	The number of local initiatives awarded with a small grant.	Measure against funding criteria	9,000
Promote health and wellbeing through community engagement and help to reduce social isolation	To continue with the roll out of the Micro Time-bank initiative in the North East and Chesterfield locality areas with Chesterfield Time Bank.	Case studies from current Time banking model	To promote community engagement and improve mental health and wellbeing	Measure through community engagement	Previously funded
Address health inequalities in relation to teenage pregnancy	Review data to identify any difference in the rates of teenage pregnancy across the Locality. Explore the need for localised interventions which could enhance and support the Countywide programmes addressing teenage pregnancy and sexual health.	Teenage pregnancy data for North East Derbyshire.	To reduce difference in teenage pregnancy rates between wards in North East Derbyshire	Annual teenage pregnancy data	Not known at this stage

The following programmes or initiatives cover all localities in Derbyshire in 2014

STARTING AND DEVELOPING WELL

- (Health Visiting*)
- Breastfeeding support
- Children and Young People's Health Promotion
- National Child Measurement Programme
- HENRY (Health Exercise and Nutrition for the Really Young)
- School breakfast clubs
- Five60 (Healthy eating, physical activity and obesity prevention)
- Citizen's advice in Children's Centre's
- School Nursing service
- Young people's sexual health service
- Young peoples' drug and alcohol services

LIVING AND WORKING WELL

- Tobacco Control including illicit and illegal tobacco
- Smoking cessation
- Weight management
- Health referral scheme
- Walking for health groups
- Health Trainers programme
- Make Every Contact Count (MECC)
- Sexual health services
- Drug and alcohol services – tier 2 and 3
- Family and carer support for drug users
- Living with long term conditions programme
- Diabetes education

HEALTH INEQUALITIES

- Citizen advice in GP surgeries
- Credit Union development
- Affordable warmth programme
- Food bank support
- Support for welfare assessment

AGEING WELL

- Health Checks for over 40's
- Falls prevention programme inc. transport
- Social isolation initiative
- Foot care programme

The South Derbyshire Health and Wellbeing Plan 2013 - 16

1. Vision and Aim

A healthier and more active lifestyle across all communities.
(c. Our Sustainable Community Strategy for South Derbyshire 2009-2029)

The South Derbyshire Plan aims to improve the health and wellbeing of local people, with specific focus on people who are at risk of and/or living with significant health inequalities compared to the district as a whole.

2. Objectives

The Plan will continue to develop:

- strong collaborative working through partnership working, match-funding, shared capacity to deliver, joint ownership of key local outcomes
- local strategic outcomes to measure health improvement. Local outcomes will contribute and align to the priorities and indicators within wider strategies including:
    - Derbyshire Health and Wellbeing Strategy
    - Strategic priorities across partner organisations delivering locally
    - national Public Health Outcome Indicators (Appendix 1 Overview of PHOF indicators)
- opportunities to redirect current resources to better meet identified need – a shared outcomes approach
- cross-agency utilisation of staff capacity to ensure an identified health and wellbeing focus eg. staff working within a community development role to meet the varying needs of communities most in need, staff supported through Making Every Contact Count (MECC)
- cross-working with county-level services, including additional county-wide Public Health commissioned services (Appendix 2) to ensure targeting to communities living with highest health inequality
- specific focus to reduce health inequalities within South Derbyshire through the principles outlined above and through additional Pubic Health resource
    - Public Health staff capacity and the joint post (*Health Partnership Manager*) with South Derbyshire District Council
    - New allocated financial resource 2013/15
- Maximisation of budgets to ensure efficiency and SMART outcomes across locality programmes

- planning against identified local health need, consultation with local people and local organisations and underpinned by robust evidence base
- performance monitoring to determine effectiveness
- working in liaison with the South Derbyshire Local Area Committee (LAC) who maintain an advisory role on decision-making and plan development
- locality planning through the South Derbyshire Partnership structure (Appendix 3 South Derbyshire Partnership) :
    - Health and Wellbeing Group develop and act upon the plan
    - South Derbyshire Partnership Board ratify decisions and hold accountability for the locality plan
- opportunities to develop innovative solutions to health issues identified locally

3. **Health Need in South Derbyshire**

South Derbyshire is the fastest growing district in the county with a projected 30.6% growth rate upto 2035, compared to 16.2% for the whole of Derbyshire and has a current population of almost 94,915 (*Census 2011, ONS*). This projected growth rate is almost double that of some other local authority second tier districts and covers both urban and rural areas. The growth crosses both younger and older age bands with increases in the under 20s, 25-44 age group particularly and the 75-84, 85+ age group. The projected growth in housing is forecast at 38% compared to 24% for Derbyshire as a whole (2008 – 2033).
Over 6% of the population are not White British, a rate exceeding Derbyshire and there are higher variations in some communities within district. This demographic is higher than Derbyshire and it is important to recognise needs specific to different race and culture.

Health in South Derbyshire is similar and/or better to England averages.
Health successes include:

- Over the last ten years the rates of death from all causes and rates of early deaths from heart disease and stroke and from cancer have all improved and are close to the England average
- Life expectancy in the district is similar to Derbyshire and England averages
- Deprivation levels are low and the proportion of children living in poverty is lower than the average for England as is free school meal eligibility
- Percentage of those economically active/ available to work is the highest in Derbyshire; long term unemployment is the lowest compared to Derbyshire
- Rate of adults educated to degree level is better than Derbyshire

- Rates of incapacity benefits for mental illness, new cases of tuberculosis and hospital stays for alcohol related harm are all better than the England average.

JSNA 2012/13 health data

However some communities are living with poorer health outcomes compared to others in the district. Challenges to health indicate a level of inequality within some communities across the district. These need specific focus in the locality plan, with identified solutions to address them and support the improvement of health and reduction of inequalities for residents.

Challenges to health include**:**

- Life expectancy is 9.8yrs lower for men and 5.8yrs lower for women in the most deprived areas than in the least deprived areas
- Some smaller communities within the urban areas around Swadlincote fall within the 10-20% most deprived areas nationally
- The need to promote mental wellbeing (JSNA 2013)

Health inequality in Children and Young People:

- a higher drop-off rate/ breastfeeding from initiation to 6-8 weeks compared to England
- above England rates of smoking in pregnancy
- 17.9% of y.6 children are obese similar to England
- Childhood (5-18yrs) inpatient admission rates for asthma significantly higher than Derbyshire (2010/11)
- Above England emergency admissions (under 18s) for accidents
- Lower education attainment is low (5 A* - C grades/GCSE level incl. Maths and English) (2011/12) –rate of 49% achieving compared to Derbyshire 57%

Health inequality in Adults:

- Above England rate of hospital admission for COPD (GP Practice Profiles 2011)
- Above Derbyshire rate of emergency readmissions within 30 days of discharge from hospital and higher rate of admissions for acute conditions that should not usually require hospital admission
- Above Derbyshire rate for acute hospital admissions due to a fall or falls injuries for over 65s
- Lower uptake of cervical screening compared to Derbyshire *although higher than England*
- Lower uptake of the NHS Healthcheck compared to Derbyshire

- Lower uptake of flu vaccination in under 65s compared to Derbyshire rate
- Poorest use of libraries within Derbyshire (out of all LAs) (may reflect access issues/ or use across borders)
- Greatest travel times to GP surgeries compared to other districts in Derbyshire

Data is collated for a variety of sources including: JSNA 2012/13 health priorities, ONS 2011 data

Health inequalities across smaller communities within South Derbyshire

Significant health inequality exists between rural and urban areas *(compared to Derbyshire rates),* with most inequality focussed in urban areas around Swadlincote. Newhall and Stanton ward includes a lower super output area (LSOA) ranked in the top 10-20% most deprived in England (*Source: Department for Communities and Local Government, Indices of Deprivation 2010)*. This ranking of deprivation has shown a worsening trend since 2007.

Indicator measures specific to the urban core areas around Swadlincote, compared to the district as a whole indicate

- poorer health amongst young people including emotional and mental wellbeing
- poorer health amongst adults including:
    - Higher % of people where the daily routine is limited by illhealth or disability
    - Lower life expectancy
    - Higher early death/ circulatory disease/ cancer
    - No qualifications
    - Higher proportion of lone parent families
    - Poor mental wellbeing

c. **Area Summary Quilt 2013**

http://observatory.derbyshire.gov.uk/IAS/Custom/Resources/Area%20Profile%202013%20Quilt%20Rank%20DCC%20v4.01.pdf

Local consultation *(online process and through formal meetings)* identified the following inequalities:

- Health in the workplace – stress and muscular skeletal injury
- Mental wellbeing children, young people and adults
- Homelessness within under 18s
- Emotional wellbeing under 18s
- Quality of housing in the private rented sector

4. **Priorities**

Derbyshire County Council Health and Wellbeing Priorities	**Derbyshire County Council health inequalities strategy**	**South Derbyshire Health and Wellbeing three key Priorities**
1. Improve health and wellbeing in the early years	1. Reduce and mitigate child poverty	**1. Reducing health inequalities within families and young people living in the urban core around Swadlincote**
2. Promote healthy lifestyles	2. Increase financial inclusion	**2. Supporting health of older people in their own home**
3. Improve mental and emotional health	3. Affordable warmth	**3 Supporting individuals and families living in rural areas experiencing health inequality (rural isolation, deprivation)**
4 Improve the health and wellbeing of older people	4. Supporting employment for vulnerable groups	
5 Promote the independence of people with long term conditions and their carers		

The Health and Wellbeing action plan for South Derbyshire reflects the Vision, Aim, Objectives and Health needs local to South Derbyshire. The Plan includes the three key priorities as detailed above. The additional Public Health resource (2013/15) will support the reduction of local health inequalities through addressing these **three key priorities**.

Two key Priorities	**We will……..**	**Suggested proportion of new Public Locality Public Health money (%)**

Reducing health inequalities within families and young people living in the urban core around Swadlincote	Focus collaborative working across urban core areas to support: Improvements <u>to all failing measures</u> indicating health inequality compared to other parts of the district and including *Reduction in crime and antisocial behaviour.* *Reduced school absenteeism.* *Reduced under 18s conceptions* *Reducing selfharm* *Improving emotional and mental wellbeing* *Increased level of adults with basic skills* Work in partnership to promote and improve • Financial management in families • Mental and emotional wellbeing across young people and families • Community resilience and "sense of community" across identified inequality areas	75%
Supporting health of older people in their own home	• Work with organisations including the voluntary sector, general practice and adult social care to identify older people at risk in their own home • Ensure services that enable older people to stay in their own home are fully known to organisations, older people and carers • Ensure pathways into services (both clinical and lifestyle) are known to organisations, older people and carers • Develop a community support referral scheme to address social isolation and promote strong emotional and mental wellbeing amongst carers and older people in their own homes	20%

Supporting individuals and families living in rural areas experiencing health inequality (rural isolation, deprivation)	• Work with organisations to ensure pathways into support services are visible, accessible and supportive for individuals and families living in rural communities • Develop targeted activity to minimise the harmful effects for individuals and families due to social isolation, deprivation and poor access to services	5%

Additional Public Health Staff resource and the Health Partnership Manager (joint post between SDDC/ Public Health) will lead and support the delivery of the plan outcomes.

The Local Structure to develop and achieve the three priorities outlined above:

The three priorities for South Derbyshire have been decided against analysis of local need, local intelligence, consultation across stakeholders and in liaison with the South Derbyshire Local area Committee (SD LAC). The plan acknowledges the discussion and agreement at the SD LAC meetings (October 2013; January 15th 2014) and the issues raised including that the plan address "hidden" health inequality across the district and in particular within more rural communities. The SD LAC will act as a reference group for the continued development of the plan to meet the priorities.

Development and monitoring of actions within the plan will be the responsibility of the Health and Wellbeing Group with ratification through the South Derbyshire Partnership Board. Commissioning decisions and performance monitoring will be through the South Derbyshire Partnership Board.

This Health and Wellbeing Plan will seek to work closely across all other local organisations with a role in the promotion of health improvement. It aims to ensure its strategic priorities are aligned across other local plans eg. the South Derbyshire Physical Activity Plan, the Children's and Young People's commissioning Plan. This model will ensure collaborative and efficient working and maximisation of positive health outcomes for local residents.

4.1 **Partner Organisation Priorities**

South Derbyshire Partnership	South Derbyshire District Council 13/14	South Derbyshire CCG 2013/14	South Derbyshire CVS
• Healthier communities • Safer communities • Vibrant communities; a sense of community • Sustainable development; affordable housing, employment • Children and young people	Sustainable growth and opportunity • Economic and employment • Recycling • Sustainable planning Safe and secure • Housing – decent and affordable to address local need • Safer communities Lifestyle choices • Community based recreational And cultural provision to promote healthier lifestyles • Supporting communities to reduce environmental impact Value for money • Financial resilience • Reduce costs NOT services • String leadership and governance • Improved customer experience	• Older people and people with long term conditions • Mental Health • Urgent care • Primary care • Children's health • locality focus* • Quality • Finance • Patient and public engagement • CCG development • Provider relationships *SD Local: • Frail older people's services/ Oakland • Intermediate care/ Oakland • Urgent Care – A&E attendance • Care Pathway implementation – Dementia case finding; Dementia Management; A&E improvement pathway – falls risk. • Carpal Tunnel pathway; paediatric behavioural pathway; Choose and book	• Support for individuals in need of help • Support for voluntary and community groups • Promoting and supporting volunteering

5. **Health and Wellbeing action Plan 2013-16 across the life course**

Derbyshire Health and Wellbeing Priorities	**South Derbyshire Priorities (JSNA)**	**Outcomes (SMART)**	**ACTION**	**Who? (lead agency and partners)**	**RAG/ Progress rating**
STARTING WELL/ DEVELOPING WELL					
Improve health and wellbeing in the early years *and children and young people*	Maintain rates of breastfeeding from initiation to 6/8 weeks	% increase in awards in areas of inequality	SD Welcome Here Award Support county services through locality team	SDDC Welcome Here award Children's centres	
	Reduce emergency admissions accidents under 18s	Family engagement	RoSPA programme	Partners Children's centres CAYA	
	Reduce smoking in pregnancy	Decrease in smoking rates during pregnancy	Support Integrated Lifestyles Services through locality team	SDP partners CAYA	
	Decrease in school absenteeism Improve Education attainment (GCSE 49% attainments compared to county 57%)/ GCSE	No of inspire events Case study information from young participants	Facilitate regular interventions "Inspire" through schools, colleges	EM Airport; SDP partners; local business Schools and colleges	
	Decrease in under 18 conceptions Decrease in under 18	Improved access to services	Facilitate county services through locality team –	SDP partners CAYA	

	alcohol admissions to hospital		review working across organisations; pathways		
	Promote emotional wellbeing across under 18s	Improved access to services for young people and families with emotional and behavioural needs	Locality team to support county development of Pathway supporting emotional wellbeing and SD CCG paediatric behavioural pathway development	Public Health CAYA SD CCG schools	
DEVELOPING WELL/ LIVING WELL/ WORKING WELL					
Promote healthy lifestyles and Promote mental health and emotional wellbeing	Reduce childhood obesity Reduce adult obesity Improve physical health of people living with mental illhealth and/or disability	Increase in PA measure No of family interventions/% in urban core No of participants living with mental illhealth and/or disability	Family physical activity interventions; outdoor gym/ urban park interventions; use of www.healthiersouthderbyshire.org facilitate county services through locality team – support to Five/60 in urban core	SDDC DCC (PA funding – *16yrs +sedentary*) Leisure Private business GAIF National Forest Primary Care Schools Integrated Lifestyle Service	

	Reduce health inequalities amongst young people and families in Swadlincote areas (incl. Newhall and Stanton)	No of people consulted Findings report	Public participatory needs appraisal project , consult and engage people within identified need areas (IMD 2010)	SD CVS Organisations/ frontline staff specific to urban areas Local people	
		% increase in participants % from LSOA most deprived communities	Financial inclusion project - support development of Money Spider Credit Union	MoneySpider Credit Union SDP partners	
		No of participants No achieving work	Facilitate an intervention, supporting people into work; aspiring vulnerable parents and carers	SDP; CAYA Local business DCC Family learning SD CVS	
		No of participants % Increase in access to services	Flourish project – self empowerment for local people	SD CVS Local people and volunteers SDP partners	
		No of participants	Family intervention project – infrastructure to support positive parenting development	SDP partners	

	Increase uptake of NHS healthcheck	% increase in NHS Healthcheck uptake % uptake from LSOA postcode areas/ highest deprivation	Facilitate county service through supporting referral pathways, promoting local support information/ signposting and use of targeted model ie. Body MOTs	Primary Care/ CCG Integrated Lifestyles Service SDDC SD CVS Partners	
	Promote mental health and wellbeing	No of positive promotions/ mental health	Healthier South Derbyshire Information project Workplace health intervention	SDDC Voluntary organisations Adult Care CAYA Derbyshire Mental Health FT Library service SDDC Env Health Local businesses	
AGEING WELL					
Improve the health and wellbeing of older people Promote the independence of people with long	Reduce rate of hospital admissions due to a fall over 65s **Improve health of older people including mental and emotional**	No of referrals Uptake of additional services	Community support referral project; Interventions/ elders – dance, active in age;	SD Locality/ CCG General practices CVS/ voluntary organisations SDP partners Older people	

term conditions and their carers	**wellbeing** Improve flu vaccination uptake		Support to county services Physical activity opportunities for older people – support to county falls prevention; dance	DCC (PA funding/16+ sedentary pop)	

6.**New Public Health Investment**

Additional Public Health resource is allocated to South Derbyshire as follows. Funding is directed to support interventions and development specific to the identified two key priorities (section 4).

	Current position	**Proposed annual additional resource**	**Total annual allocation 2014/15**	**Part year additional funding 2013/14**
South Derbyshire	£51,300 Senior Public Health Manager (WTE0.2) Health Partnership Manager	£40,983 Public Health Manager (WTE0.4) *Maintain* Health Partnership Manager	£92,283 Public Health Manager (WTE0.4) Health Partnership Manager* Senior Public Health Manager (WTE0.2)	£10,245

- *Match funding for this post is included within the PH allocation*

REFERENCES

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http://observatory.derbyshire.gov.uk/IAS/Custom/Resources/Area%20Profile%202013%20Quilt%20Rank%20DCC%20v4.01.pdf

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http://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/GeoProfiles/JSNAGeoProfile_2012_SouthDerbyshire.pdf#view=Fit

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http://www.south-derbys.gov.uk/Images/Sustainable%20Community%20Strategy%20for%20web_tcm21-112771.pdf

Mary Hague
Derbyshire County Council Public Health
March 2014

Appendix 1. Public Health Outcomes Framework 2013-16 – Derbyshire performance
http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/pat/6/ati/102/page/0/par/E12000004/are/E10000007

Appendix 2 Derbyshire Public Health commissioned services

PH commissioned services county.zip

Appendix 3 South Derbyshire Partnership – organisation

APPENDIX 3 SDP - Dec 2013.zip