Health and Wellbeing in Exeter

A Joint Health and Wellbeing Strategy for 2013-2016

Exeter City Council

Public Health Devon

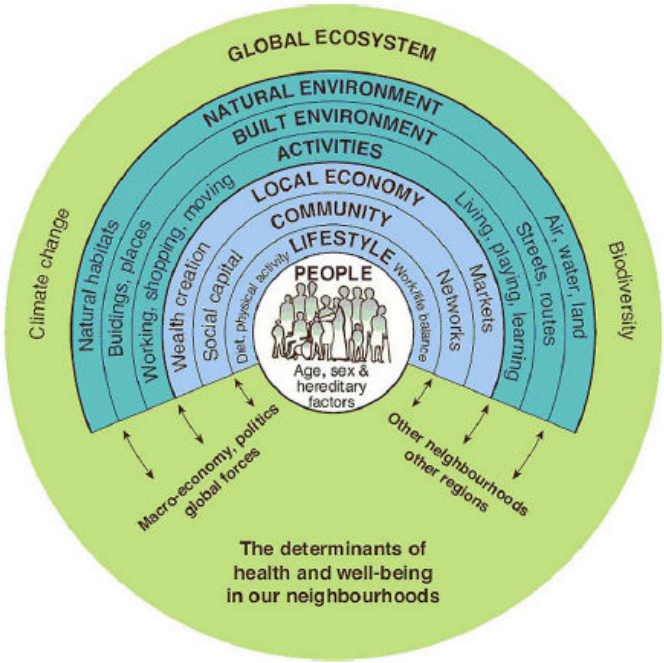
Devon County Council

Introduction

Health and wellbeing Boards have been set up at upper tier local authority level as a statutory duty laid out in the Health and Social Care Act 2012. The Devon board includes a range of partners from county and district councils, GP clinical commissioning groups, the national commissioning board and patient and carer, service user and older people representation. They aim to deliver improvements in the health and wellbeing of the local population. Working together they must produce a joint health and wellbeing strategy (JHWS), explaining the health and wellbeing priorities set to tackle the needs identified in the Joint Strategic Needs Assessment (JSNA). The strategy is not about trying to address everything at once but about prioritising issues that can be addressed by joint action and make a real impact on people's lives, particularly in relation to promoting the equity to reduce health inequalities.

A large number of factors influence the health and wellbeing of individuals. These range from lifestyle factors such as smoking and physical activity to social determinants such as education, housing, employment, and crime as well as the environment in which we live, the housing conditions, the roads we use and the accessibility of public and active transport. Health inequalities exist with in Devon and Exeter and vulnerable individuals, groups and communities experience worse health outcomes than others and may need more help and support to become healthier. In addressing these issues it is helpful to think of health and wellbeing in the widest sense with many influencing factors. The health map below illustrates the determinants of health and wellbeing in our neighbourhoods.

Figure 1: A Health Map
© Barton and Grant 2010
(based on Whitehead and Dahlgren.1991)



To address these wider determinants of health and wellbeing effectively action needs to be at a local level empowering individuals and local communities to take responsibility to influence these areas when they can with the right support. Exeter has decided to form its own health and wellbeing board with members from local GP clinical commissioning group, business, police, public health, city and county councillors and officers and the voluntary sector to help facilitate delivery of appropriate priorities at a very local level.

Promoting Health Equality

The Exeter health and wellbeing strategy has been guided by the same set of principles used by the Devon health and wellbeing board in the development of their strategy. These are:

- focus on improving health and wellbeing for individuals and communities
- ensure services are efficient and effective
- promote healthy lifestyles and identify illness and the need for support at an early stage
- support joint working where it makes sense to do so
- use evidence of what works, informed by people's views, to guide its work
- enable improvements and progress to be measured

The Health and social care act 2012 placed a duty on upper tier local authorities to work to improve the health of their populations and this is being delivered through the Devon Health and wellbeing board and its partners.

To deliver improvements to health and wellbeing in Devon and Exeter overall progress will be monitored against two national high level public health outcomes:

- Increased life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities including differences between and within local authorities

Exeter includes some of the most deprived areas in Devon at ward and lower super output area with nine LSOAs ranking in the 20% most deprived nationally using indices of multiple deprivation (IMD) scores.

Life expectancy is also markedly different for some communities of people or 'Protected Characteristic' groups who are represented in the Exeter population. Some protected characteristic groups such as those with complex needs and homeless populations have a considerably lower life expectancy than the population as a whole.

The gap between the health of the best off and the worst off has narrowed, but the health of the worst off needs to improve faster for health equality to be achieved.

In light of this the Exeter Health and Wellbeing Board has chosen improving the health of the most disadvantaged as one of its priorities.

Sources of Evidence

The Devon Public Health Annual Report 2012 -13 outlines that the areas of health and wellbeing where the greatest impact can be made on health inequality as:

1. Reducing smoking
2. Increase the proportion of the population at a healthy weight
3. Detecting and treating diseases earlier such as heart disease, high blood pressure diabetes and cancers
4. Targeting preventative interventions at those vulnerable groups with the worse health, including those who may be at risk of domestic or sexual violence and abuse
5. Investing in the health and wellbeing of all children and young people
6. Improving mental health and emotional wellbeing and preventing loneliness
7. Increasing income levels and employment, and reducing poverty
8. Improving the quality and warmth of housing
9. Reducing misuse of substances including alcohol and drugs
10. Helping people in their neighbourhoods to live healthier and happier lives

Knowledge about the needs of Exeter residents is available through the Joint Strategic Needs Assessment (JSNA) and Exeter Locality Public Health Plan. Some data is available by trend as well as the current year so we are able to build up a picture of how the health and wellbeing of residents has changed over time and compares to Devon, the Southwest and England averages.

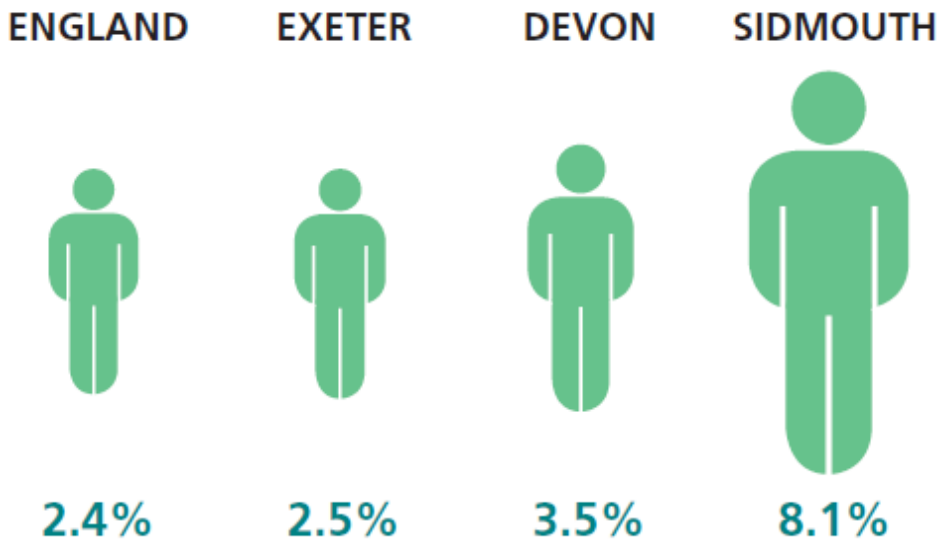
Exeter within the Devon Context

The Joint Strategic Needs Assessment for Devon provides a detailed picture of health and wellbeing for the Devon population and is available on the web www.devonhealthandwellbeing.org.uk/jsna

The Devon Health and Wellbeing pages provide further information in the Joint Strategic Needs Assessments (JSNA) for the Eastern locality and The Exeter City Council area as well as Exeter GP practice profiles and the Exeter Locality Public Health Plan. Link: Devon Health and Wellbeing Pages -JSNA

Devon is a largely rural county with an older population profile than England especially those 60-64 years of age, reflecting significant in-migration in these age groups and those aged 85 and over reflecting an ageing population and longer life expectancy. Exeter's population profile varies from that of the Devon average with a much higher proportion of people in the younger age brackets. The University means the population age profile during term time differs significantly to that of the full time resident population.

Figure 2: Scaled comparison of the 85 and over population in Devon, Exeter and England, 2012



The Devon economy relies on agriculture, tourism and the public sector employees of these sectors make up more of the Devon workforce than nationally. High levels of economic activity and employment rates often mask the low productivity and low average wages.

In the context of Devon, Exeter has a higher proportion of individuals with academic qualifications and skills at all levels with a high level of employment in professional, managerial and skilled occupations. It also has a high proportion of the traditional working age population (16 to 64) that are in or are looking for work. This rate would be higher were it not for the large proportion of students living in the city.

Strong population growth, a low wage economy and the image of the South West as a desirable place to live have greatly increased the demand for, and cost of housing in Devon. House prices are above the national average, rents are above the national average, and particularly high in Exeter. Levels of rough sleeping in the South West are higher than any other region outside London (Communities and Local Government, 2011). This has implications for health with poor housing precipitating a range of physical and mental conditions.

The Exeter Overview

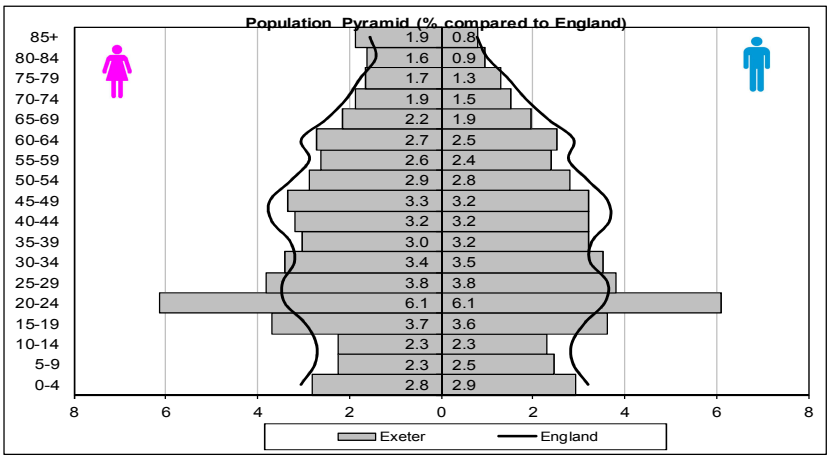
Demographics

Exeter city area has a population of 122,770 (June 2010). This breaks down to 62504 females and 60266 males.

Figure 3: Exeter population pyramid compared to Devon (June 2010) Data source: Patient and Practitioner Services Agency.

Population Pyramid - Exeter Population - 2011

The table and population pyramid below show the population broken down by age and sex for the area against England. The age and gender of your population can have a significant impact on their health and social care needs.



Age Group	Female	Male
0-4	3281	3426
5-9	2644	2879
10-14	2635	2703
15-19	4315	4255
20-24	7171	7144
25-29	4478	4467
30-34	3980	4129
35-39	3530	3763
40-44	3744	3760
45-49	3917	3771
50-54	3370	3295
55-59	3083	2806
60-64	3190	2960
65-69	2525	2278
70-74	2196	1798
75-79	1937	1511
80-84	1889	1110
85+	2190	933
Total	**60075**	**56988**

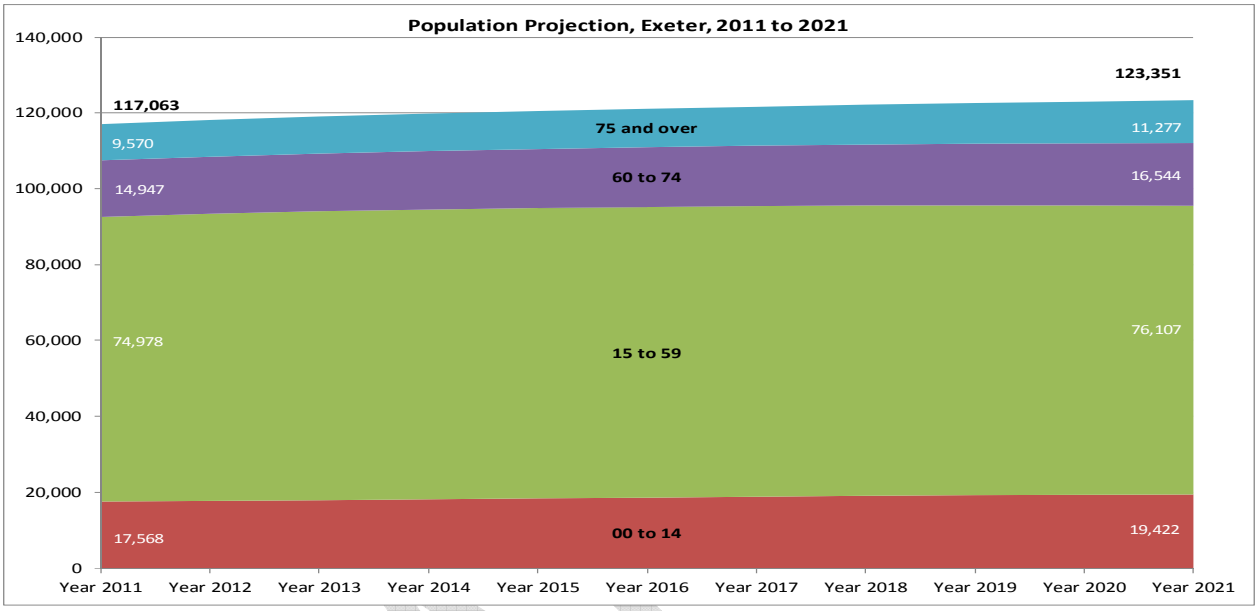
Exeter has a much higher proportion of people in the younger age brackets, particularly 20-24, compared to the England average. This is reflects the university student population, the employment opportunities provided by the city and the fact that areas of higher deprivation also tend to have higher proportion of their population in the younger age brackets.

This is not the same for all electoral divisions, with some wards such as Alphington and Cowick, Heavitree and Whipton Barton, and Topsham and St Lloyds having a higher proportion of the population over 85 than the England Average.

Population Growth

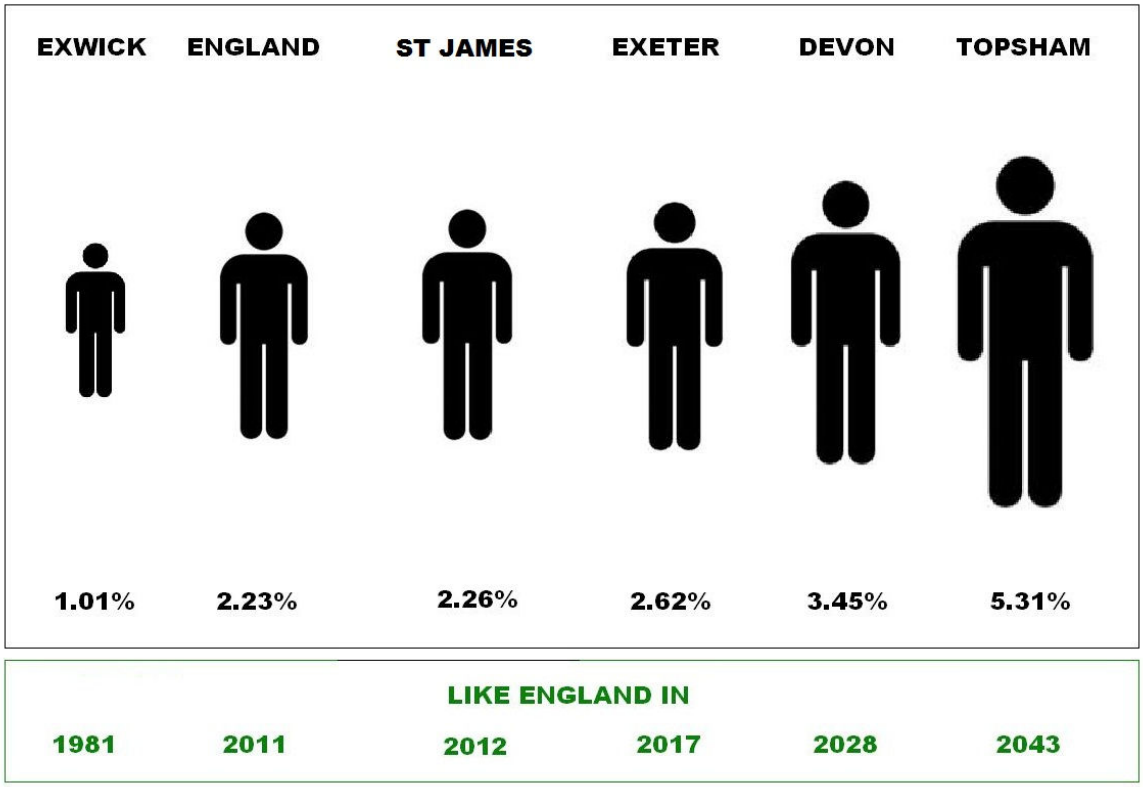
The population of Exeter is predicted to increase by 15833 people between 2011 and 2026, a rise of 12.6%

Figure 4: Exeter population projection by age group. Data source: Jan 2010 DCC population projections



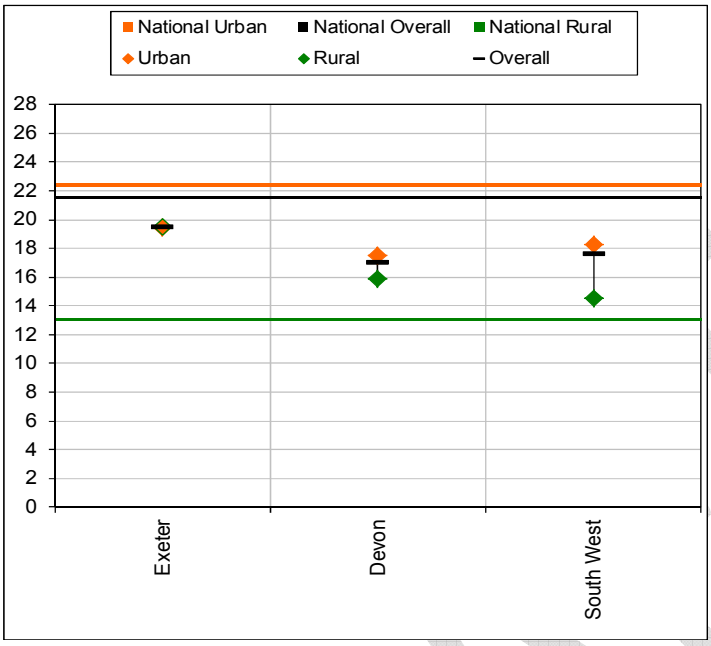
Ageing Population

The Exeter 85+ population is currently 2.62% which is slightly ahead of England which will be like Exeter in 2017. The figure below demonstrates the differences.



Deprivation

Exeter has higher levels of urban deprivation than both Devon and the South West as you would expect.



The trend in deprivation over time follows the South West and England rate and shows an increase in deprivation in terms of income and employment following the economic downturn in recent years.

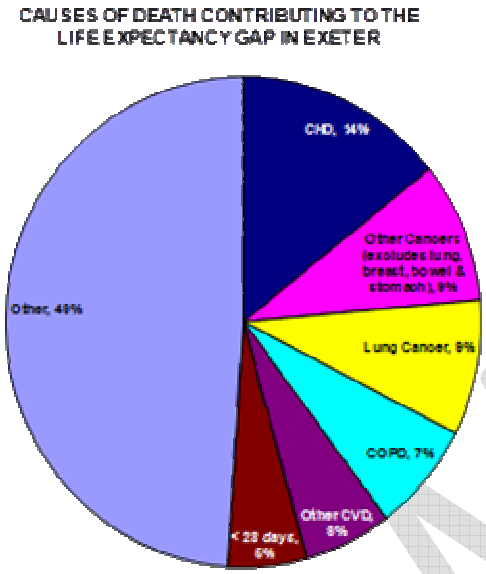
Health Inequalities

Average life expectancy for the Exeter locality is 82.6 years; this is higher than the Devon average of 82 and the national average of 80.2 yrs. However there are marked differences between the least and most deprived areas in the city at lower super output area (LSOA) representing a gap of 16.8 years for Exeter.

The biggest impact in reducing health inequalities in the Eastern locality of NEW Devon clinical commissioning group would be made by focusing on interventions which will impact most on the top five conditions contributing to the gap in life expectancy. These are coronary heart disease, other cancers, road traffic accidents, chronic obstructive pulmonary disorder and lung cancer.

For the Exeter City area the difference in life expectancy between the most and least deprived quintile could be most greatly impacted by action on circulatory disease, cancer and respiratory disease. Smoking prevalence in the city is higher than the Devon average with areas of higher deprivation and high concentration of routine and manual workers, such as St David's, Newtown & St James **,** Mincinglake, Pinhoe, Whipton Barton and Priory demonstrating prevalence rates of up to **25% compared to the Devon Average of 18.5%.**

Figure 5: Causes of Death contributing to the life expectancy gap in Exeter and interventions to narrow the gap between the most and least deprived communities 2010



How can we narrow the gap?

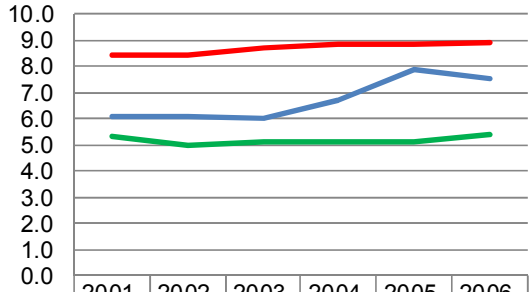
- Address the root causes of health inequalities (housing, work, poverty etc.)
- Stop Smoking clinics and tobacco control
- Early detection of cancer (screening and public awareness)
- Health Checks
- Prescribing of statins and anti-hypertensives
- Healthy eating and physical activity
- Reducing harm from alcohol
- Improving mental health and wellbeing

Gap in Life Expectancy

There is a gap of 16.8 years between the Lower Super Output Area with the longest life expectancy (Wilton Way, Lower Hill Barton Road and Honiton Road area; 90.4 years) and the shortest (Priory Road area in Polsloe; 73.6 years).

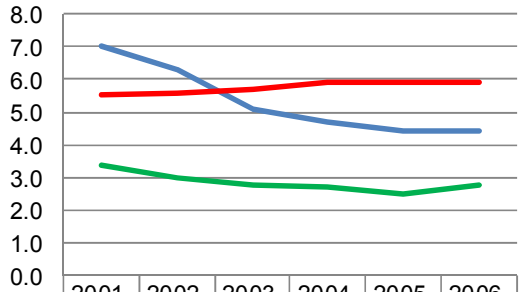
The following chart shows the gap in life expectancy between the most deprived 10% of Exeter's population and the least deprived 10%

Male Gap in Life Expectancy (Years)



	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10
Exeter	6.1	6.1	6.0	6.7	7.9	7.5
Devon	5.3	5.0	5.1	5.1	5.1	5.4
England	8.4	8.4	8.7	8.8	8.8	8.9

Female Gap in Life Expectancy (Years)



	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10
Exeter	7.0	6.3	5.1	4.7	4.4	4.4
Devon	3.4	3.0	2.8	2.7	2.5	2.8
England	5.5	5.6	5.7	5.9	5.9	5.9

The Health and Wellbeing of Exeter

Exeter is doing well in many areas of health and wellbeing:

- It has the lowest rate of severe road injury and deaths in Devon.
- The uptake rate of childhood immunisations is higher than in the rest of Devon.
- The rate of fuel poverty is the lowest in Devon at 13%, although there are still pockets of high levels in the city's most deprived areas.
- Only 21.7% of the Adult population are obese, the lowest figure in Devon, however this will still impact on the long-term health outcomes of the population

However other areas are of concern:

- Exeter has the highest age standardised rate for alcohol admissions in the Eastern Locality and remains higher than the Devon average
- Smoking prevalence is 21.4%, higher than both the England and Devon average
- It has the 4th highest rate of malignant melanoma in Devon
- Sexually Transmitted Infection rates and Teenage Conception rates are high in Exeter compared to the rest of Devon
- Hospital stays for self-harm are higher than the Devon rate
- The Directly Age Standardised Rate of falls is statistically higher than the Devon average
- In 2012 Only 12.7% of adults were active enough to receive health benefits – one of the lowest in Devon
- The percentage of children recorded as obese in year 6 remains consistently above the Devon average

Health and Wellbeing Priorities

The health and wellbeing priorities for the city have been chosen in relation to the evidenced need but within the context of the Devon Health and Wellbeing Strategy and priorities. The Devon Health and Wellbeing Strategy outlines four priorities based on strategic themes with a number of areas of work under them some of which will take place within Exeter:

- Priority one: A focus on families;
- Priority two: Health lifestyle choices;
- Priority three: Independence in older age and
- Priority four: Social capital and building communities.

The Exeter Health and wellbeing priorities have been chosen by the Exeter Health and Wellbeing Board to provide a number of evidenced based priorities which are a challenge to resolve and span organisational responsibilities. The Joint Strategic Needs Assessment, Exeter Public Health Locality Plan and Exeter Health Profile provide evidence for priorities as presented in the previous section.

Some areas of health and wellbeing are highlighted as being significantly worse than the England rate and of concern for Exeter such as; acute sexually transmitted infections, incidence of malignant melanoma, hospital stays for self-harm, Alcohol specific hospital stays for under 18 and violent crime. These areas are currently tackled either through other partnerships such as the community safety partnership or well served by the commissioning of comprehensive services through partner organisations. In deciding on its priorities the Exeter Health and wellbeing board was not only concerned with the evidence highlighting the extent of the health and wellbeing issues but in particular those that would benefit most from a co-ordinated approach with input from a range of partners.

Four priorities were decided upon for development of co-ordinated actions:

- Priority One - Increasing Physical Activity
- Priority Two - Reducing Alcohol misuse
- Priority Three - Reducing Falls and Cold Homes
- Priority Four - Health of the Most Disadvantaged

A number of key health and wellbeing issues will also continue to be monitored by the board and the priorities will be reviewed in the light of evidence and progress on an annual basis. For example smoking prevalence, sexually transmitted infection rates, teenage conception rates, hospital admissions for self-harm incidence of malignant melanomas may merit greater attention in the future.

Priority One: Increasing Physical activity levels

Why is it an issue?

Low levels of physical activity and increasing levels of obesity in adults and children are associated with increased risk of ill health and developing long term conditions with increasing health and social care costs. Work to promote healthier lifestyles can improve healthy life expectancy.

What is the position in Exeter?

Population estimates are available for adult obesity and the latest figures show that over 21.7% of the adult population in Exeter are obese whilst this is the lowest level in Devon it will still have an impact on long-term health outcomes.

Exeter is higher than the England Average for participation in physical activity. 2011 data indicates physical activity levels for adults in Exeter were at 12%. However this translates into 88% of the adult population in Exeter not being active enough to receive physical or mental health benefits.

2012 data indicates more favourable physical activity levels, with Exeter falling significantly above the England Average. This is because the measure takes into account active travel, house work and accumulative hours of activity taken in shorter bursts. However this type of activity does not translate into the intensity of activity needed to provide physical health benefits.

A significant proportion of the Exeter population are not doing enough physical activity to receive physical or mental health benefits.

What is the evidence of effective interventions?

Physical activity helps people maintain full and independent lives, improves social cohesion, and can help reduce falls, osteoporosis and the demand on health and social care services. There is strong evidence for the health benefits that people can gain from participating in regular moderately intense physical activity:

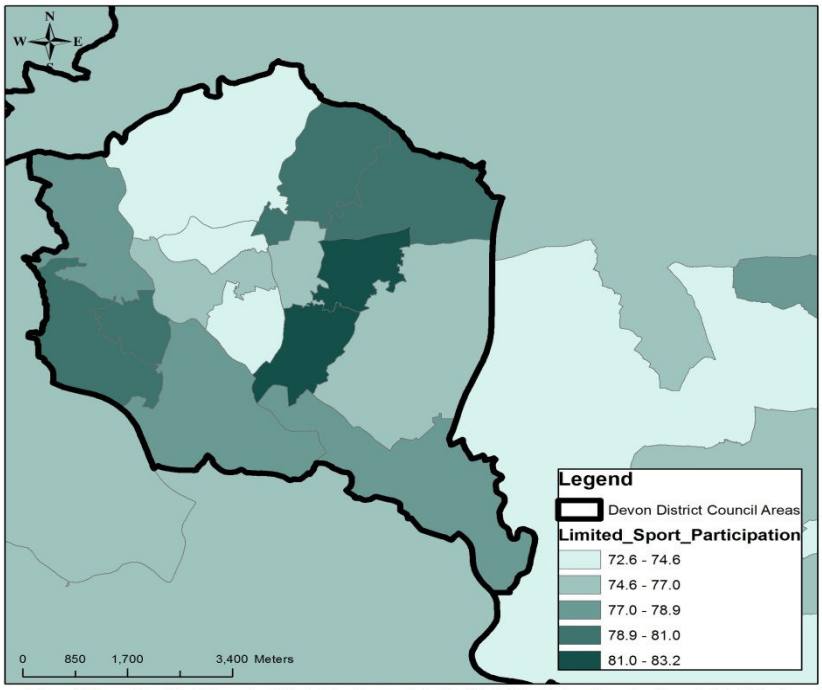
> *"Regular physical activity can reduce the risk of many chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions. Even relatively small increases in physical activity are associated with some protection against chronic diseases and an improved quality of life."*

Whilst there is also likely to be wider social, environmental and economic benefits:

> *These benefits can deliver cost savings for health and social care services. However, the benefits of physical activity extend further to improved productivity in the workplace, reduced congestion and*

pollution through active travel, and healthy development of children and young people.
(Department of Health 2011)

Children from lower socio economic groups and some black and ethnic minority groups do less sport and exercise than those form higher socio-economic groups. In Exeter the MSOAs of highest deprivation using Indices of Multiple Deprivation also have the highest levels of adults not doing enough physical activity to receive any health benefits (adults not participating in 3x30 minutes of physical activity per week).



Map Title: Health Checks Risk Factors: Adults Not Participating in Sport (3x30min p/w)
Author: Devon PHIT *Date:* 09 October 2013

Our focus for priority one is:

Making Exeter one of the most active cities in the South West by 2018

- Increasing active travel
- Enhancing communications to promote the Get Active Devon physical activity mapping tool
- Increasing accessibility and use of parks and open spaces for physical activity
- Maximising physical activity opportunities Exeter population

Priority Two: Reduction in Alcohol misuse

Why is it an issue?

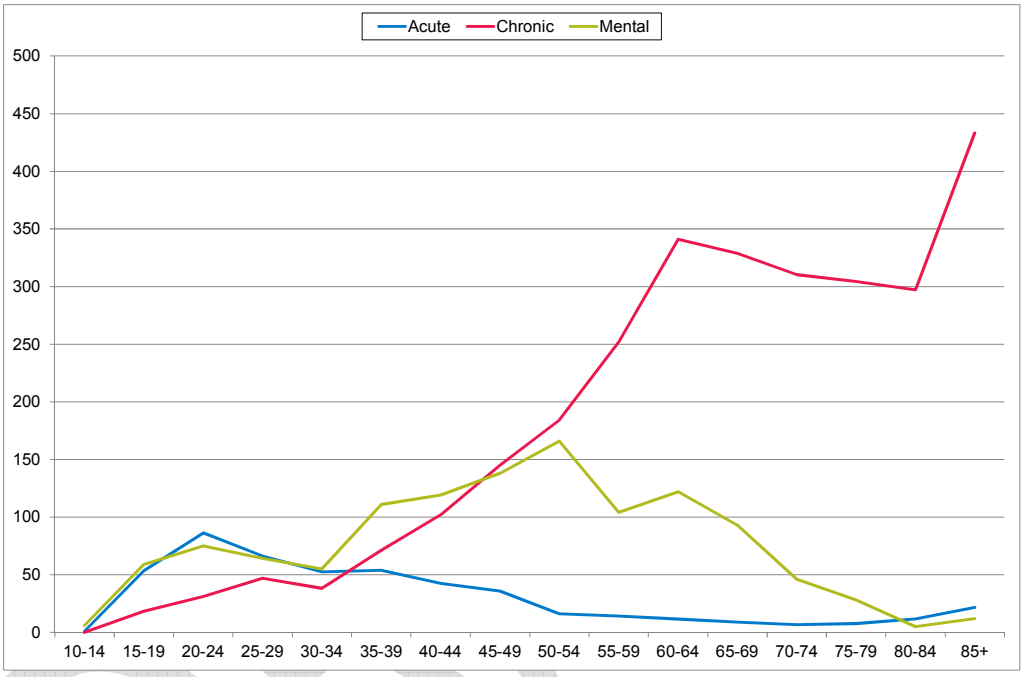
Alcohol misuse in Devon and Exeter contributes to increased hospital admissions, early mortality, crime and disorder, domestic violence and health and social inequalities.

What is the position in Exeter?

There is currently an estimated 24.6% of the Exeter 16+ population at increased risk of harm from alcohol due to regularly drinking more than recommended limits. The Devon population estimate is 23.8% (APHO, 2012 Health Profiles).

The increase in alcohol related hospital admissions is now below the South West and England rate this is particularly so in Exeter which may be impacted by improved access to alcohol treatment. Chronic disease conditions are more evident in older age and acute attendances in the younger age group. Mental health alcohol related admissions are more evident in the 40-60 age groups.

Figure 6: Exeter Alcohol-Related Admissions by Age-Group and Type, 2010 to 2012 (number of admissions)



Alcohol related hospital admissions are falling in Devon against the national trend. Devon's national rank is continuing to fall and currently remains one of the lowest rates in England. Exeter however has the highest Directly Age Standardised Rate in the Eastern locality of NEW Devon CCG and remains above the Devon average. Exeter has both the most Medium Super Output Areas (MSOAs) with a statistically higher admission rate and the highest estimated prevalence of increasing and higher risk drinking in Devon. People living in the most deprived areas are almost four times more likely to be admitted to hospital for alcohol specific conditions than those in the least deprived areas. The Lower Super Output Areas (LSOAs) of Longbrook Street, City Centre, Sidwell Street, Exwick Cemetery area and Heavitree Fore Street, have the highest alcohol related admission rates in the city.

What is the evidence of effective interventions?

The alcohol treatment model commissioned in Devon by the Drug Alcohol Action Team (DAAT) is evidence-based and has resulted in a reduction in the increasing rate of alcohol-related hospital admissions. There is evidence of the effectiveness of peer-led recovery and the model is being piloted in Devon and will include working with families in need of targeted support.

There is evidence of the effectiveness of brief interventions in a range of settings including primary care and community-based settings. In Devon there is a focus on working with individuals at risk of further hospital admissions through hospital liaison nurses and community outreach staff, this model has a current focus in North and South Devon but the possibility of an Exeter scheme is being explored. There is some evidence to support the use of targeted night-time economy work to reduce alcohol related admissions.

Our focus for priority two is:

The extent of alcohol harm and its effect on health

- Keep a watching brief on the work of the Community Safety Partnership under alcohol, violence and the night time economy theme.
- Examine the way that the Licensing Policy and linked discretionary schemes can be used progressively to reduce harm.
- Support development of project plan for an alcohol liaison nurse service at RD&E Wonford.

Priority Three: Reducing Falls and Cold Homes

Why is it an issue?

The risk of an accidental fall increase rapidly with age, and higher levels are evident in people living alone, people with existing medial conditions and people living in more deprived areas. Older housing stock compounds the risk as highlighted by the inclusion of four falls hazards in the Housing Health and Safety Rating System inspection criteria.

Cold homes are a health risk with cold believed to be the main explanation for the extra 'winter deaths' occurring each year between December and March (Marmott 2010). Cold homes also increase the risk of falls through a loss of balance and the increased trip hazards created by extra blankets and huddling around one heater in a room. A lack of heating in a home through poor insulation, fuel poverty or poor housing stock will therefore contribute to falls and schemes such as the warm home schemes can provide some solutions.

What is the position in Exeter?

In Devon the number of people aged 65 and over suffering at least one fall in the last 12 months is predicted to increase from 46,700 in 2011 to 74,500 in 2030. Around 7,000 hospital admissions relate to accidental falls in Devon, costing the NHS over £18 million per year, and contributing to increased social care costs and reduced mobility.

In Exeter the ageing population will have an impact on the number of falls, the crude rate of falls is relatively lower than Devon but the direct age standardised rate is statistically significantly higher than Devon.

Households in fuel poverty in Exeter is at 13% one of the lowest rates in Devon. However this masks pockets of much higher rates in the areas of higher deprivation with in the city.

"We think each person lifted out of fuel poverty will save the health service about £250 a year. Data suggests there are 20% more deaths in Oldham in winter than in summer because of extra respiratory illnesses and heart problems [linked to cold homes]. If you get a cold winter and people cannot heat their homes, you get more people turning up in A&E and suffering." (Allan Higgins, Director of Public Health Oldham, 2013).

What is the evidence of effective interventions?

Falls prevention involves interventions intended to reduce falls and fall-related harm. Evidence identifies four main objectives:

- improving patient outcomes and improved efficiency of care after hip fractures
- responding to a first fracture and preventing the second
- early intervention to restore independence
- preventing frailty, promoting bone health and reducing accidents.

The work of the Health and wellbeing board can have most impact on the fourth objective.

Post-menopausal women with a previous or new fracture are a priority group. These women make up only 14% of the population of older women but account for 50% of hip fractures. Falls hazards can be mitigated through inspection and improvement of housing stock.

"Home modification in the absence of other intervention approaches may be effective for persons with a history of falling but is likely to be most effective when integrated into a multi-faceted intervention program that also focuses on education, exercise and nutritional status." (Department of Health 2009).

Evidenced based actions include widespread and accessible evidence-based exercise programmes and targeted use of validated home safety assessments. (Department of Health 2009).

Our focus for priority three is:

- Join up and maximise opportunities for health and local authority partners in the safe and warm home referral pathways to widen access and improve delivery
- Work progressively with other partners such as energy providers to lever in funding for warmer homes
- Link with physical activity priority one in increasing accessibility to evidence based exercise programmes to improve balance and strength across the city

Priority Four: Health of the most disadvantaged

Why is it an issue?

Those in more deprived areas have significantly poorer health outcomes than those living in more affluent areas. Those with multiple disadvantages such as the homeless, those in custody of probation services, those with multiple morbidities such as drug, alcohol and mental health issues have particularly poor health outcomes and cost the health, social care and criminal justice services huge sums of money yearly. Services used by these individuals can often be disjointed and difficult to navigate for individuals with chaotic lifestyles.

Life expectancy in these groups is considerably lower for example the average life expectancy for the Clock Tower Surgery population is 62 years, which is almost 20 years lower than average life expectancy across Devon and over 25 years lower than the communities in Devon with the longest life expectancy (NHS Devon 2011).

What is the position in Exeter?

Average life expectancy for the Exeter locality is 82.6 years; this is higher than the Devon average of 82 and the national average of 80.2 yrs. However there are marked differences between the least and most deprived areas in the city at lower super output area (LSOA) representing a gap of 16.8 years for Exeter. There is a gap of 16.8 years between the LSOA with the longest life expectancy (Gallows Bridge area, 90.4 years) and the shortest (Priory Road area in Polsloe, 73.6 years).

Exeter is a conduit for many specialist services for mental health, drug and alcohol and criminal justice. Consequently there are considerably more individuals living in the Exeter area with complex needs compared to the rest of Devon (NHS Devon 2011; NHS Devon 2012; Public Health Devon 2013).

Exeter has one of the highest rates of clients in contact with mental health services as a rate of the overall population aged 16+ in Devon. This is second only to Torbay and statistically significantly higher than the Devon average.

From mosaic profiling the G33 type – Transient singles, poorly supported by family and neighbours are over represented within the service users (opiate and cocaine users in treatment) population, 10 times more than in the population of Devon as a whole. This G33 type represents more than 50% of the Exeter St David's Ward.

Exeter has the highest count of rough sleepers compared to other areas in Devon, excluding Torbay or Plymouth (NHS Devon 2011). The report 'Reaching Out: An Action Plan on Social Exclusion' states:

"*Among the homeless population there are a group with complex needs who are not benefiting from services because their lives and engagement with services are too chaotic. These adults continue to face poor outcomes in the form of offending, long-term mental and physical health problems, poor family relationships, continuing substance misuse, worklessness and deprivation."* HM Government (September 2006)

What is the evidence of effective interventions?

For the Exeter area the difference in life expectancy between the most and least deprived quintile could be most greatly impacted by action on circulatory disease, cancer and respiratory disease. Smoking prevalence in the city is higher than the Devon average with areas of higher deprivation and high concentration of routine and manual workers, such as St David's, Newtown & St James , Mincinglake, Pinhoe, Whipton Barton and Priory demonstrating prevalence rates of up to 25% compared to the Devon Average of 18.5%.

Nationally several different approaches to working with people with complex and multiple needs have been developed and piloted one Making Every Adult Matter (MEAM) is being adopted in Exeter. This approach will try to engage frontline staff and users in changing the way services work to support individuals.

Our focus for priority four is:

- educing smoking prevalence
- upport the MEAM approach and the Engage HUB project within Exeter
- ink to CSP anti-social behaviour priority action plan/ Needle find work

Measuring progress / Monitoring

The health and wellbeing board members want to make sure that the work undertaken in response to the strategy is making a difference and impacts on the local priorities chosen. The outcomes of importance to Exeter have been isolated from a range of existing measures and will be used to track measurable improvements in health and wellbeing.

Some of the outcomes will relate to areas of interest to the Exeter Health and Wellbeing Board and will be monitored as a 'watching brief' on progress. Others which are indicative of progress being made on the key priorities identified in this strategy will be of greater interest and will be closely monitored using more detailed outcome reporting.

An action plan will be developed to effect the health priorities identified by the Board, and reviewed and updated annually by the Board to ensure priorities are current and work is progressing in the right directions.

References

Department of Health (2009) Falls and Fractures: Effective interventions in health and social care,

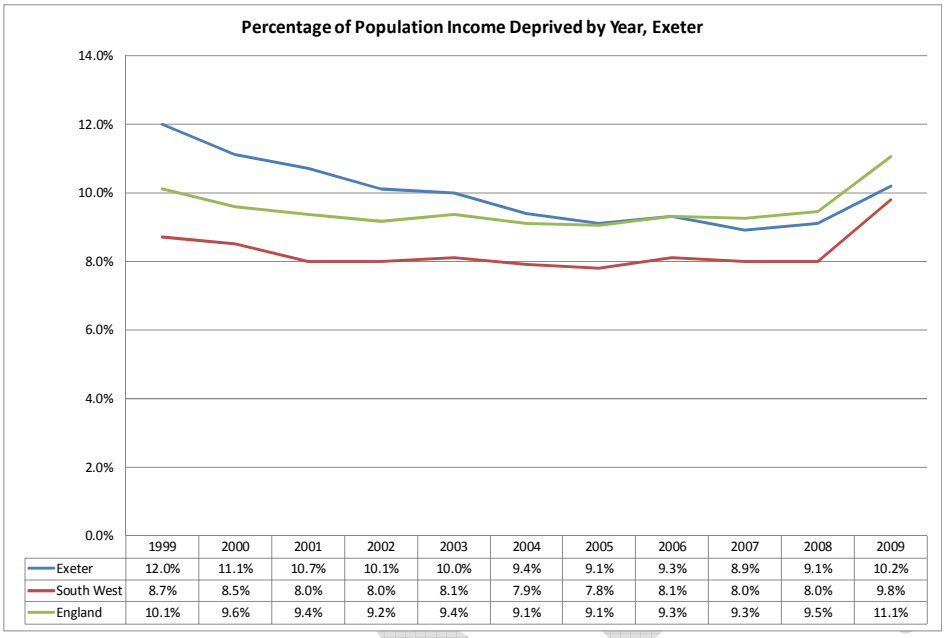
NHS Devon (2011); Devon Homelessness Health Needs Assessment
http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/07/Homelessness-Health-Needs-Assessment-2011.pdf

NHS Devon (2012); Substance Misuse Health Needs Assessment.
http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2011/08/Substance-Misuse-Health-Needs-Assessment_Final.pdf

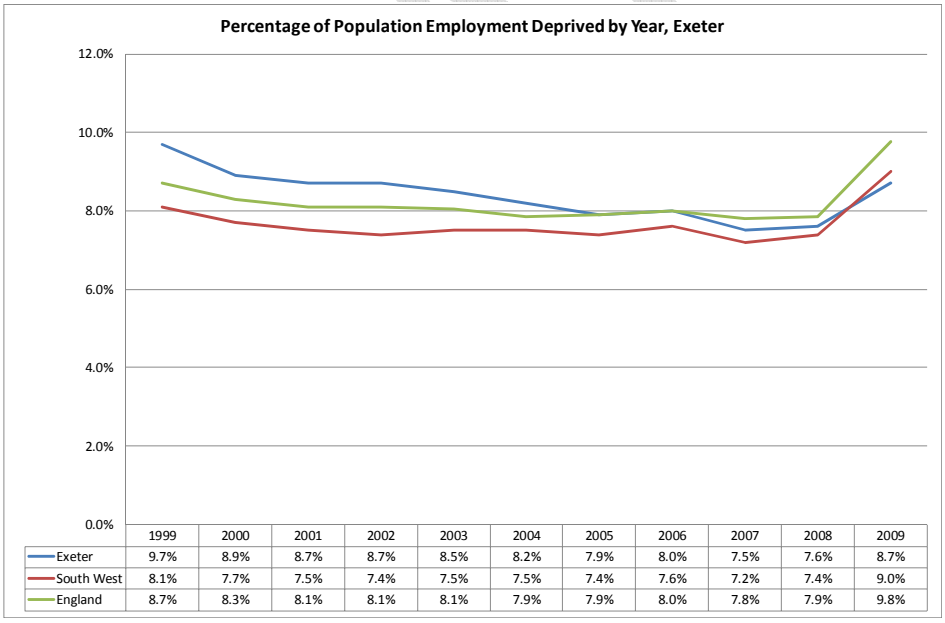
Public Health Devon (2013); Mental Health and Wellbeing Health Needs Assessment
http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/downloads/2013/09/Mental-health-needs-assessment-2013.pdf

Homelesslink (2011) Better together: Preventing reoffending and homelessness
www.homeless.org.uk/criminaljustice project

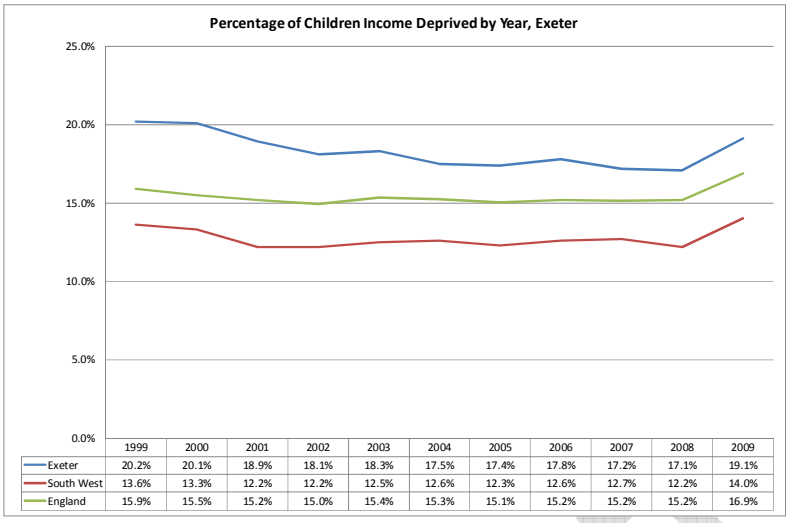
Appendix 1



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Exeter	12.0%	11.1%	10.7%	10.1%	10.0%	9.4%	9.1%	9.3%	8.9%	9.1%	10.2%
South West	8.7%	8.5%	8.0%	8.0%	8.1%	7.9%	7.8%	8.1%	8.0%	8.0%	9.8%
England	10.1%	9.6%	9.4%	9.2%	9.4%	9.1%	9.1%	9.3%	9.3%	9.5%	11.1%



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Exeter	9.7%	8.9%	8.7%	8.7%	8.5%	8.2%	7.9%	8.0%	7.5%	7.6%	8.7%
South West	8.1%	7.7%	7.5%	7.4%	7.5%	7.5%	7.4%	7.6%	7.2%	7.4%	9.0%
England	8.7%	8.3%	8.1%	8.1%	8.1%	7.9%	7.9%	8.0%	7.8%	7.9%	9.8%



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Exeter	20.2%	20.1%	18.9%	18.1%	18.3%	17.5%	17.4%	17.8%	17.2%	17.1%	19.1%
South West	13.6%	13.3%	12.2%	12.2%	12.5%	12.6%	12.3%	12.6%	12.7%	12.2%	14.0%
England	15.9%	15.5%	15.2%	15.0%	15.4%	15.3%	15.1%	15.2%	15.2%	15.2%	16.9%