Essex Health and Wellbeing Board

14:00	**Thursday, 21 November 2013**	**Council Chamber, Uttlesford District Council Offices, London Road, Saffron Walden, Essex CB11 4ER**,

Quorum:
One quarter of membership and will include:

- At least one Essex County Council elected Member
- At least one Clinical Commissioning Group Representative
- Essex County Council *either* Director of Adults Services, Director for Children's Services or Director for Public Health

Membership:

Councillor David Finch	Essex County Council (Chairman)
Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Jacqui Foile	Voluntary Sector
Councillor John Galley	Essex District Councils
Dr Rob Gerlis	West Essex CCG
Dr Mike Gogarty	Essex County Council
Dr Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
David Marchant	Essex District Councils
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG
Peter Tempest	Essex County Council
Co-opted Members:	
Nick Alston	Essex Police & Crime Commissioner
Simon Hart	Independent Chair ESCB & ESAB

For information about the meeting please ask for:
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Essex County Council and Committees Information

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Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Apologies and Substitution Notices** The Committee Officer to report receipt (if any)	
2	**Minutes of meeting held on 18 September 2013**	**7 - 16**
3	**Declarations of Interest** To note any declarations of interest to be made by Members	
4	**Questions to the Chairman from Members of the Public** The Chairman to respond to any questions relevant to the business of the Panel from members of the public, notice of which has been given in advance	
5	**Who Will Care? Next Steps**	**17 - 40**
6	**West Essex 10yr plan** To receive a joint presentation by Clare Norris, West Essex CCG and Chris Martin, Essex County Council	**41 - 84**
7	**Colchester Hospital University NHS Foundation Trust** To receive an oral update from the North East CCG	
8	**Break**	
9	**Joint Strategic Needs Assessment (JSNA) Update** To receive a report by Dave Hill, Executive Director for People, Essex County Council on the updated JSNA	**85 - 172**
10	**Joint Health and Wellbeing Strategy (JHWBS) refresh** To receive a report by Dave Hill, Executive Director for People (Children and Adults), Essex County Council to sign off the refreshed JHWBS	**173 - 202**
11	**Integration Update** To receive an update from Dave Hill, Director for People, Essex County Council and includes timelines for the integrated plans and the integrated transformation fund.	**203 - 208**

12 **Draft Voluntary Sector Strategy - for consultation** **209 - 236**
To receive a report for information only

13 **Date of Next Meeting**
To note that the next meeting will be held on 14 January at 2pm in the Council Chamber at Rochford District Council Offices, South Street, Rochford, SS4 1BW

14 **Urgent Business**
To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.

15 **Urgent Exempt Business**
To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

MINUTES OF A MEETING OF THE ESSEX HEALTH AND WELLBEING BOARD HELD AT BASILDON AND BRENTWOOD CLINICAL COMMISSIONING GROUP, PHOENIX COURT. BASILDON ON WEDNESDAY 18 SEPTEMBER 2013

Present:

Members

Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Nick Alston, Co-opted Member	Essex Police & Crime Commissioner
Dr Kamal Bishai (Vice Dr Rob Gerlis)	West Essex CCG
Councillor Terry Cutmore	Rochford District Council
Councillor Dick Madden (Vice Cllr David Finch)	Essex County Council (Chairman)
Dr Mike Gogarty	Essex County Council
Dr Kevin McKenny(Vice Sunil Gupta)	Castle Point and Rochford CCG
Dr Bryan Spencer	Mid Essex CCG
Simon Hart, Co-opted Member	Independent Chair ESCB and ESAB
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
David Marchant	Castle Point District Council
Nicola Beach (vice Ian Davidson)	Braintree District Council
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG (Vice-Chairman)
Peter Tempest	Essex County Council
Councillor John Galley	Chelmsford District Council
Jacqui Foyle	Community & Voluntary Sector

Officers

Tom Abell	Basildon & Brentwood CCG
Roger Bullen	Essex County Council
Ann Coldicott	Essex County Council
Shane Gordon	North East Essex CCG
Clare Hardy	Essex County Council
Barbara Herts	Essex County Council
Paul Probert	Essex County Council
Miles Smith	Essex County Council

1. Apologies and Substitutions

Apologies were received from:

Ian Davidson with Nicola Beach as his substitute	Braintree District Council
Dr Rob Gerlis with Dr Kamal Bishai as his substitute	West Essex CCG
Dr Sunil Gupta with Kevin McKenny as his substitute	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell with Dr	Mid Essex CCG

Bryan Spencer as her deputy Councillor David Finch with Councillor Dick Madden as his deputy	Essex County Council (Chairman)

2. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 16 July 2013 were approved as a correct record and signed by the Chairman subject to the following correction: Councillor John Galley should have been listed in the Apologies section and not as an officer in attendance.

Matters Arising:

The Board were advised that

- The draft Memorandum of Understanding was still the subject of discussion
- pursuant to Minute 10 the Winterborne View Stocktake had duly been signed off.

3. Declarations of Interest

Item 6 - Who Will Care? Commission Report

Mike Adams and Dr Gary Sweeney declared an Interest in this item as they along with Sir Thomas Hughes-Hallet were members of the Who Will Care Commission.

Item 8 - Urgent Care Plans

Nick Alston declared an interest in this item as he is a Non-Executive Director of Broomfield Hospital.

4. Questions to the Chairman from Members of the Public

Mr Ali asked a question relating to a statement which implied that the public belief was that GP's were over funded. He was advised that the future funding for GP's was still being looked at along with other views raised regarding GP funding.

5. Integration Programme Update

The Board considered a report HWB/012/13 by Dave Hill, Executive Director for People (Adults and Children), which provided an update on the Integration Programme including recent policy announcements, progress on the pioneer submission, planning for the integration transformation fund and an update on the task and finish groups.

The report provided an opportunity for Health & Wellbeing Board members to comment on the progress being made and agree next steps.

Dave Hill advised that the governance task and finish group set up at the last meeting had met once, they were now awaiting further guidance from central government and would report back on their findings at the next meeting. He advised that work on data and information mapping was on going and a meeting of the task and finish group dealing with this matter would take place soon.

He advised that NHS England had issued a call to action "The NHS belongs to the People" and we should all work together to support this debate.

Dave Hill also updated the Board on the progress to date regarding Pioneer Status. He advised that the formal interview had taken place earlier in the day which he had attended along with other members of the Board. He advised that the presentation had gone well. He also advised that successful applicants will not be advised until the end of October and there will be a formal launch on 5 November. He went on to say that 111 submissions were made, and 26 had been interviewed and approximately 10 would be successful. Southend Council had also been one of the applicants interviewed.

During the discussion on this item the following comments were made:

- Dr Bryan Spencer stated he believed the theory was there it just had to be turned into action;

- Councillor John Aldridge advised that he felt there was still a need to see what the gain is for partner organisations rather than advice for Central Government;

- Joanna Killian responded to a question regarding the Integrated Transformation Fund, a matter which had not yet been reported to the Board, regarding performance related funding. She advised that it was intended that payments would be made in two instalments and would relate to performance and not automatically paid. She went on to advise she would know more detail after a meeting scheduled to take place on 30 September.

Resolved:

1. That the Health and Wellbeing Board supports the NHS England call to action 'the NHS belongs to the people' and encourages partners to use their stakeholder and citizen networks to support this debate, be agreed;

2. That the Health and Wellbeing Board Business Management Group lead on developing the process for the Integrated Transformation Fund plan alongside the Integrated Plan process and report back to the November Health and Wellbeing Board meeting, be agreed; and

3. That the Health and Wellbeing Board use a workshop at one of its meetings to explore governance models, to support integrated commissioning conversations at a local level, be agreed.

6. The Health and Wellbeing Board's Proposal to Agree a Response to the Who Will Care? Commission Report

The Board received a report HWB/013/13 by Dave Hill which suggested a process for members to enable them to undertake a review and to prepare a formal and collective response to the recommendations that the Commission had made in the report published on Thursday 12 September 2013.

The Board once again welcomed Sir Thomas Hughes-Hallet to the Board meeting. Sir Thomas thanked the Board for the support he had received. The Board confirmed their agreement tot Dr Gary Sweeney continuing to Chair the meeting even though he had declared an interest in this item as a member of the Who Will Care commission.

Dave Hill urged the Board having gained momentum whilst the commission was in operation to remain determined that the outcomes should if possible be implemented and not lost. He tabled some analysis of the recommendation which indicated which could be easily introduced as quick wins, which would need more work before implementation and which were aspirational or required substantial work.

Dave Hill referred specifically to recommendation 5 – Leadership and the need to move on this quickly as a priority. He was also concerned thatthere should not be duplication of roles. He referred specifically to the recommendation regarding a new forum to assist, aid and advise. He believed there were already groups within CCG's and county wide who undertook the task. Dave Hill suggested that he, Andrew Pike and Sir Thomas bring together a provider forum to replace any similar bodies in existence. The forum would be a formal sub-group of the Health and Wellbeing Board and would make recommendations to the Board.

During the discussion on this item the following comments were made:

- Dr Shane Gordon stated that he thoroughly commended the report. He believed it would be a good preparation to the Call for Action. However, he asked if it is legally achieveable? Other members acknowledged his comment and that there were barriers to be overcome. Sir Thomas gave as an example the recommendation 5.3.1 One pot of money alongside one set of outcomes. He clarified this recommendation by explaining he actually meant that all parties should state up front the amount available to them in order to agree one outcome;

- Reference was made to the prolification of groups. Dave Hill advised that he did not intend to duplicate any CCG groups. Sir Thomas agreed and added that any new groups would need to add value. He had already had

an interest from large companies who might be useful partners namely Nestle and Glaxo Smyth Kline.

- Dr Kamal Bishai urged that the strategic be separated from the operational recommendations and that all be set achievable timescales. Sir Thomas agreed and added it would be a shame if the actions were not evaluated as work progresses.

- Sir Thomas stated that he was disappointed that he had not had time to include discharges from hospital in his project. He also commented that he believed Learning Disabilities had also felt like an untackled service. He also stated that he believed some organisations needed managerial support and not cash to make them more useful to the whole county and not just pockets of the community.

Resolved:

That the Board:

i. acknowledges receipt of the "Who Will Care?" Commission's final report, thanks Sir Thomas Hughes-Hallett (Chairman) and all members of the Commission for the time and effort that they have put into their role, be agreed;

ii. give the BMG approval to deal with the quick wins straight away, to bring back the nice but need work recommendations and give further consideration to those that would give a a longer term gain but are more difficult to achieve, be agreed;

iii. note that the newly formed group will put together Terms of Reference and membership. He gave an understanding that the sub-group would not interfere with the CCG groups, but would look into the logistics of possibly ending any groups where there was significant overlap, be agreed

iv. requests that all members should share the Commission's Report with their own organisations in order to determine what actions partner organisations will be taking in response to the Commission's recommendations; be agreed.

v. provides guidance for member organisations regarding their initial assessment of the recommendations, be agreed; and

vi. agrees to consider the accumulated responses from all partner organisations at the next meeting on 21 November 2013 and agrees a consolidated response and action plan, prepared by the Business Management Group, that represents the formal response from the Health and Wellbeing Board to the "Who Will Care?" Commission, be noted.

7. The Children and Young People and Families Plan 2013/2016

The Board considered a report HWB/014/13 by Barbara Herts, Director of Integrated Commissioning and Vulnerable People, which was jointly presented by Barbara Herts, Roger Bullen and Councillor Dick Madden seeking endorsement from the Board regarding the Children, Young People and Families Partnership Plan (CYPFPP) which set the broad interagency agenda for Children's Services and which will influence the future commissioning intentions, priorities and approach within ECC's emerging People Commissioning Strategy (Children, Young People and Families).

The Essex Children, Young People and Families Partnership Plan for 2013-2016 had been developed at a time of significant change both at a National and County Level. The document took account of the increasing emphasis on commissioning for children's services within Essex alongside reconfiguration within the NHS, transfer of Public Health responsibilities to the Local Authority and significant restructure within ECC.

The plan was essential in setting the direction of travel for Children's Services across Essex and maintaining progress through a commitment to partnership planning and exploring opportunities to integrate commissioning.

The plan sets out 10 priority themes, agreed by partners, which provide strategic direction to inform commissioning. Partners have agreed to work within a set of principles including the principle to 'eliminate unlawful discrimination, advance equality of opportunity and foster positive relations between those who share a protected characteristic and those who do not.

During the discussion on this item the following comments were made:

- Councillor Terry Cutmore stated that he was pleased that young carers were mentioned;

- Nick Alston advised that he was pleased that the Board were still overseeing the production of a Plan even though there is no longer a Statutory responsibility to have one. He went on to say he believed that more work was required regarding domestic abuse;

- Dr Bryan Spencer urged that there should be specific mention of 0-2 year olds instead of 0-5;

- Mike Adams commented that such plans need to capture comments from children who act as unpaid carers.

Barbara Herts agreed to review the priorities with the CCG's.

Resolved:

That the report be noted and the Children, Young People and Families Partnership Plan be endorsed as being in alignment with the Essex Joint Health and Wellbeing Strategy.

8. Urgent Care Plans

The Board considered a report HWB/015/13 by Andrew Pike, Essex Area Director – NHS England which provided an overview of the Urgent Care Plans being developed by each of the Clinical Commissioning Groups in Essex.

The Board noted that after a very difficult winter in 2012/13, the NHS had required all Clinical Commissioning Groups to put in place urgent care plans. The purpose of the plan was to ensure the delivery of a safe urgent care system for 2013/14 and to ensure the delivery of the 4 hour waiting time target within Accident & Emergency Departments. This was a key measure both of specific patient quality for treatment within A&E departments, but also as an indicator of the broader health of the health and social care urgent care system. Urgent Care Plans would be signed off by CCG Boards in September and October of this year.
The Board received an oral update from each individual CCG regarding the specific action they had each taken.

Councillor Terry Cutmore asked about the Out of Hours Service. He was advised that the new 111 Service had been a success in the south of the County compared to other areas.

Resolved:

That:

1) The Health and Wellbeing Board note the update and overview of the Urgent Care Plan development;

2) the establishment of Urgent Care Boards in each CCG, which senior officers of the County Council attend, be noted;

3) Clinical Commissioning Groups and Social Care colleagues evidence and update on delivery of the A&E target and urgent care resilience over this coming winter and for this to be reflected in the development of integrated plans for 2014/15, be agreed; and

4) the decisions made by the Department of Health in respect of allocation of winter monies for this year and receipt of winter monies by the West Essex, Mid Essex and Basildon & Brentwood Health systems, be noted.

9. Update on Keogh Action Plans

The Board received presentation from Tom Abel and Dr Shane Gordon regarding the outcome and response to the Keogh Review at Basildon and

Thurrock University Hospital and Colchester Hospital University Foundation Trust respectively.

During the discussion on this item the following was discussed:

- Simon Hart commented on the numerous levels of scrutiny which Basildon and Colchester have to deal with. He was concerned about how scrutiny is set up rather than what scrutiny was taking place. He believed work could be undertaken to streamline scrutiny by topic and reduce the number of scrutiny inspections. Tom Abel agreed to discuss further with Simon.

- Dr Bryan Spencer asked about the out of hours services. Officers confirmed that the weekend and out of hours services had been more vulnerable.

- Nick Alston stated that a lot of work has already been undertaken but more work was needed across all trusts to get things right.

- Mike Adams commented on the Frances Review – the need to get from a have to do to a want to do is imperitive to success.

- Andrew Pike advised that Quality of Delivery was likely to be the topic of a report to a future meeting.

Resolved:

That the presentations and comments be noted.

10. Economic Sustainability of West Essex and Mid Essex Health Systems

The Board received an oral report by Andrew Pike, NHS England flagging up an area for future discussion regarding work which will be required in order to help the most financially challenged areas of the County, Mid and West. Andrew advised that their economic sustainability was an issue as they needed to find 40 million across both areas. He advised that even though there was a clear financial plan in place the Trusts could not continue to have that level of bail out

Dr Bryan Spencer advised that there was a Board meeting scheduled to take place on 19 September and that the Trusts may need to look further to seek a solution.

Resolved:

That that the above be noted.

11. Safeguarding Board Annual Reports 2012/13

The Board considered a report HWB/018/13 by Simon Hart advising of the publication of the annual reports from The Essex Safeguarding Adults Board

(ESAB) and The Essex Safeguarding Children Board (ESCB). The Board were asked to note the reports for information.

12. Date of next meeting

The Board noted that its next ordinary meeting is scheduled to take place on Thursday 21 November at 2pm at a venue tba. The Board also noted that a stakeholder conference would take place on Tuesday 5 November 2013.

Chairman
21 November 2013

Essex County Council

Report to: Health & Wellbeing Board **Report of: Dave Hill**	**Reference number HWB/018/13**
Date of meeting: 21st November 2013 **Date of report: 6th November 2013**	**County Divisions affected by the decision: All divisions**
'Who Will Care?' Commission: next steps	
Report by: Dave Hill, Executive Director People, Essex County Council, & Andrew Pike, NHS England **Enquiries to: Clare Hardy, Head of Commissioning: Vulnerable People, ECC**	

1. Purpose of report

1.1. To set out the next steps on the recommendations from the 'Who Will Care?' Commission report.

2. Recommendations

2.1. Agree to request that the CCG and ECC officers developing the Integrated Plans consider the recommendations around Understanding and Prevention and include appropriate activity within the Integrated Plans.

2.2. Agree to establish a HWB Advisory Group to have oversight and co-ordination of the 'Who Will Care?' recommendations. The Group will ensure we have costed recommendations for the end of January 2014 and will focus on taking forward recommendation 3 around the community, as set out in the table at 3.9.

2.3. Agree to establish a Data Reform task and finish group to identify our data needs, address local barriers and submit evidence to support the national work on enabling data sharing as set out in section 4 of the table at 3.9.

2.4. Agree to support the development of the Care Partnership concept as set out in section 5 of the table at 3.9.

3. Background and proposal

3.1. The “Who Will Care?” Commission was set up in January 2013 and was tasked with seeking some practical solutions to the challenges presented by the county’s growing ageing population and the complex care needs of these residents in the future.

3.2. Sir Thomas Hughes-Hallett, the Chairman of the Commission, published the Commission’s report on the 12th September having engaged with numerous stakeholders including the HWB. The HWB at its meeting on the 18th September acknowledged the report and thanked the commission for its work. The meeting sought views from partners, remitting the Business Management Group (BMG) to consolidate the views and prepare a formal response for the HWB to consider at this meeting. The meeting also agreed that the BMG could deal with any quick wins and that work on a Care Partnership approach should commence.

3.3. Following the HWB on the 18th September a letter went out to all partners inviting feedback. The BMG considered the feedback on the 30th October and a number of discussions have been held with Sir Thomas Hughes-Hallett, including discussions with central government who are interested in our work.

3.4. 20 responses were received from a range of partners including; local authorities, CCGs, Healthwatch, providers and a good representation from community groups and carers groups in particular. There is a good deal of support for the recommendations with some words of caution around capacity and resource to deliver the work. Some concern was also raised around the level at which activity should take place and in particular concerns about the importance of the voluntary sector to be rooted in communities and how that aligns to an Essex wide approach. A copy of the responses is attached at 9.3.

3.5. The breadth of Commission’s recommendation is significant and requires further analysis to explore all the possibilities and co-ordinate activity. It is proposed that we establish a HWB Advisory Group that would lead on co-ordinating the ‘Who Will Care?’ activity and will develop a fully costed implementation plan by the end of January 2014. The group’s initial focus would be to take forward recommendation 3 on the community elements. Sir Thomas Hughes-Hallett has kindly agreed to continue working with us on this.

3.6 The recommendations around prevention are a key part of the work that in currently going on in each CCG locality around refreshing the integrated commissioning plans for 2015/16-2016/17 and the 5 year strategic plans. Work is also going on in each locality around the Big Care debate which links to the recommendations around understanding. Healthwatch Essex are also undertaking significant engagement programmes and testing out the recommendations with patients/ services users. All this work will feed into the Integrated Plans which will be coming to the HWB in January and March.

3.7. On data and technology we are combining a previous discussion at the HWB to set up a task and finish group with these recommendations and a single high-

level task and finish will look at removing barriers locally but also feeding into central government work on a Data Bill on the national support we need to address any challenges.

3.8. Work is continuing on the leadership elements to establish a Care Partnership model and ensure we avoid duplication with other County arrangements, the precise model requires further exploration and we will report back to the HWB in due course. On the 'Thorny issues'; the hospital discharge work is already being picked up through the Integrated Plans and the Learning Disabilities work is being taken forward as part of the integrated commissioning work on 'Enabling Independence'.

3.9. A summary of all the discussions on next steps is set out in the table:

Possible Solution	**Suggested Activity**	**Leads**
Co-ordination	Establish a HWB Advisory Group. This group would have an oversight role across the Who Will Care recommendations developing a fully costed implementation plan by end January 2014. The HWB Advisory group is considering options for co-ordinating activity under each work stream. The initial focus of the group will be on recommendation 3. It is proposed that the group is chaired by Sir Thomas Hughes-Hallett and should include Dr Gary Sweeney (deputy chair), Bob Reitemeier, Cllr John Aldridge, a District Council elected member, Joanna Killian, Dr Sunil Gupta, Andrew Gardner, Andrew Pike, James Anderson, an Essex Acute Trust representative, and Dave Hill. The group will meet monthly and report to the Business Management Group, which is chaired by Dave Hill who will report progress back to the HWB. GlaxoSmithKline have also offered support us on taking the programme forward and we are exploring with them what this approach will look like.	Sir Thomas Hughes-Hallett,
1. Understanding	Joint work is already taking place in each CCG locality on the Big Care debate, further consideration and work on this will be picked up through the integrated plans developed by the CCGs and the ECC Integrated Commissioning Directors which are due to come through the HWB in Jan/March. The Council will also work with	CCG Accountable Officers and ECC Integrated Commissioning Directors working with Healthwatch and partners in

	Healthwatch to consider countywide elements.	each locality.
2. Prevention	This work is at the heart of our integration programme and the proposals are being considered through the Integrated Plan process in each locality. The Integrated Plans are due to come through the HWB in Jan-March.	CCG Accountable Officers and ECC Integrated Commissioning Directors working with other partners in each locality.
3. Community	The HWB Advisory Group which provides the overall co-ordination will specifically focus on recommendation 3. The group will aim to strengthen the voluntary sector and harness its support and commitment to achieve the changes set out within the recommendation. The group will meet monthly and report to the HWB Business Management Group, who will report progress back to the HWB. The development of the group is linking in with the Community Budget work on Strengthening Communities and will also be able to report into the Essex Partnership Board on wider opportunities.	Sir Thomas Hughes-Hallett
4. Data & Technology	It is proposed that a Data Reform task and finish group be established to consider Essex's whole system data requirements. The group will look to identify what data we need to share, for what purpose and to whom and will work to address local barriers at both a macro and individual level. It will also use this to develop an evidence base to inform public sector data sharing enabling powers in the Government's Communications Data Bill. It is proposed that the group will be Chaired by Cllr David Finch, and will include; representatives from Essex Fire, Essex Police/ PCC, NHS England, CCGs, ECC Children's Services, ECC commissioning as well as some technical and legal input. The group will report back to the HWB, coordinated via the HWB Business Management Group. The Anglia Ruskin Health Partnership and have offered support in this area which the task and finish group will be keen to explore.	Cllr David Finch as Chair supported by Chris Martin, Integrated Commissioning Director, ECC
5. Leadership	The HWB on the 18th September agreed to progress the concept of a Care Partnership but there was concern to ensure we avoid duplication	Dave Hill and Andrew Pike

	with other groups. Discussions have been taking place to bring together a number of existing forums to create a new Partnership including the Anglia Ruskin Health Partnership and the NHS England Systems Group into this. Work is continuing on the most appropriate model to facilitate this and the Partnership would feed in directly to the HWB as well as the NHS England Area Team or to the Advisory Group on matters relating to the WWC recommendations.	

A copy of all the summary responses received by the HWB is attached as an Appendix.

4. Policy context

4.1. The "Who Will Care?" Commission recommendations are in alignment with the Joint Health & Wellbeing Strategy (JHWBS). The recommendations specifically addresses the following priorities and cross cutting themes:

Priorities:
Living and working well: residents make better lifestyle choices and have better opportunities needed to enjoy a healthy life;
Ageing well: older people remain as independent for as long as possible;

Cross Cutting Themes:
Tackling inequalities and the wider determinants of health and wellbeing;
Transforming services: developing the health and social care system;
Empowering local communities and community assets;
Prevention and effective intervention.

4.2. The recommendations from the Commission also have direct relevance to the whole system leadership role of the Board and the challenge of integrating health and social care commissioning.

5. Financial Implications

5.1. There are no additional resources available to support the implementation of the recommendations contained within ECC Medium Term Resource Strategy. When the actions required to achieve the recommendations are known and have been costed in January 2014 all partners will need to consider how to fund these.

5.2. There is an expectation that the recommendations and proposals for funding will be covered in the Integrated Plans.

6. Legal Implications

6.1 There are no direct legal implications arising on the recommendations set out in paragraphs 1.1, 1.2 and 1.4 of this report at this stage. However, as detailed proposals emerge these will need to be reviewed in the context of the Council's powers and duties including those relating to the development of integrated commissioning with CCGs. Any issues that emerge will be identified in future reports.

6.2 The Data Reform task and finish group may identify what they regard as inappropriate statutory restrictions on the management of data which have the effect of inhibiting good practice in the development of integrated commissioning. These will be the subject of a detailed report to the Board.

7. Staffing and other resource implications

7.1. Staffing resource is required to engage in and support the Advisory Group, the task and finish group and the Care Partnership this will come from existing resources.

7.2. The activity identified within the Integrated Plans will need to be fully resourced and work is taking place between the CCG Accountable Officers and the ECC Integrated Commissioning Directors to ensure the plans are fully resourced.

8. Equality and Diversity implications

8.1. It is not appropriate to carry out an EIA on the whole of the recommendations, actions to take forward individual actions around services will require an EIA and the Integrated Plans will be subject to an EIA process.

9. Background papers

9.1. More information including the final report from the "Who Will Care?" Commission can be downloaded from their website: http://www.essexpartnershipportal.org/pages/index.php?page=who-will-care

9.2. A copy of the HWB letter sent to partners requesting feedback.

	Who Will Care Commission: Prioritising analysis		Total	Essex Carers Network	Basildon Borough Council	Essex County Council	Mid Essex CCG - Simon Griffiths/ James Bullion	SEPT	Voluntary Sector Training	Action for Family Carers	Supporting Carers & Families together	Healthwatch	ACE
		Timescale											
1	**Understanding**												
	Agree a new understanding between the public sector and the people of Essex			Essex Carers Network: We believe that the ECN can be the conduit between public services and families of people with a learning disability; we know that historically people may distrust the public sector and be more likely to trust their peers. As a network we feel we are well placed to help build bridges and engender trust. Patients as partners; this is a concept we fully support but people need to be empowered and supported to be effective partners and this must be at all levels from a strategic to ground level.	The Basildon Health Partnership is already looking to develop this as part of its Commissioning Framework, potential outcomes of which will touch upon public participation, including conducting research (using CACI) on what is the best way of outreaching to local residents on health related issues. How can Basildon Borough Council (BBC) support ECC in this regard? As a suggestion, BBC can share data with partners for a greater understanding of the health needs at a local level. A further review could be done by ECC that identifies the IT aspirations of residents and whether IT could be used more to promote future health messages as part of this solution. The report refers to welcoming new players and provides incentives for greater participation by corporate employers. (This is a great opportunity to join this up to Education, Employment & Skills Partnership that is currently in operation) The BIG LOCAL project in Pitsea has been in operation for the last 18 months. Community Champions have been determined by the local community to		We welcome this, and it fits with NHS plans on A Call to Action. We believe the emphasis should be equal between services needing to change, and personal behaviours to support more preventative approaches.	This is an important aim as it has the real chance of shifting demand down and encouraging people and communities to be more self sufficient.	A laudable solution but consideration needs to be made for vulnerable individuals who are less able to take ultimate responsibility for their care. The recommendations (satnav, trip adviser and driving lessons) are interesting approaches. Some of the information already exists although it may not be joined up. Mapping exercises always raise a concern for me in that the resources to undertake the exercise can exceed the resources to deliver the services – and the "geography" being mapped can change almost overnight.		A culture shift is required, moving from state provision to self provision of care and responsibility is a huge challenge and one not helped as it seems to become embroiled in political posturing i.e debates relating to means testing older people and those deemed vulnerable who may also be financially secure arguably in the need to save so much money this is a necessary debate to have to ensure money is best utilised? Agree wholeheartedly agree the services available should be easier to access services.		We have a large community volunteer base are are also implementing a Volunteering Strategy, which will enable ACE's staff to volunteer out into their community. We have discussed the need to acknowledge, celebrate and reward these volunteers.
1.1.1	Campaign to create a new contract with the people of Essex	ongoing	7			Priority: The Council also sees the importance of developing an on-going campaign to promote a new 'contract' with the people of Essex. This communication strategy could help to manage citizen's expectations of which services are available to them as individuals, including those available in advance of a crisis rather than at a critical time. This must align with changes due to be implemented from April 2015 under the Care Bill and therefore needs to work alongside a national campaign, possibly through the LGA. Such a campaign cannot simply be a County Council one. The Health and Wellbeing Board will need to play a role in determining the key objectives for the campaign.	We would see ourselves working with the County Council and District level Councils through the health and well-being board and would see this culminating in a high level document which complimented statutory plans not which does not replace them. Linkage to' Call to Action' with possible exploration of 'core offer'.						
1.1.2	GPs begin to make greater use of social prescriptions, helping us deal with issues beyond the physical	Autumn 2013	14			Priority: We agree that providing GPs with the tools to provide support outside of physical treatments could encourage people to self-manage their health needs, for example by making greater use of social prescriptions. Colchester CVS has begun to direct patients to beneficial activities, such as exercise facilities and social clubs. This scheme may be extended across the county once GPs are informed about relevant partner organisations and their services. Essex Libraries are already facilitating a book prescription scheme.	We welcome this and see a role for promoting this approach with primary and secondary care, working in partnership for example with the Council's library services. Public health to invest in this area and develop proposals with CCG leads. Involve District Councils and voluntary sector						
1.1.3	Voluntary sector begins to review how it does business, grounded in principle that our wellbeing is our responsibility	Winter 2013	11			We agree that the voluntary sector needs to review how it supports people in Essex by applying the principle that our wellbeing is our responsibility. We support that the current group of voluntary sector leaders could be used as an official forum to map additional services for 'whole-person' care. Essex County Council is clear as part of our commission strategy that the VCS needs to compete with other sectors, and demonstrate best value and outcomes, and that this may require some restructuring and consolidation of the VCS sector. Our VCS commissioning strategy encourages collaboration between voluntary sector organisations.	We would support the County Council leading a collaborative piece of work with a view to improving support to VCS groups, but with the epectation that this is the reprioritisation of existing resources and not necessarily new resources. Already commenced in Mid Essex. Voluntary sector events established. Keen to support the development and funding priorities for voluntary care. Significant investment in carers already in place	The army of volunteers is good but will require considerable cordiantion and likely seed funding. Who will undertake this role?					
1.2.1	Launch the Citizens' Guide to Care in Essex	Spring 2014	7			Priority: We support the development of a Citizen's Guide to Care in Essex that explains how different aspects of care can be accessed through the state, other organisations and ourselves as individuals. This must align with changes due to be implemented from April 2015 under the Care Bill. It is imperative that any guide is concise, easy to follow and user-focused. It needs input from ECC, health partners, care providers and Healthwatch.	We would see this as a positive development, and feel that the Health and Well-being board should oversee this. CCG keen to work with health to disseminate the information through services such as SPoR, 111, etc. Keen to establish a coordinated approach to directory and access to services					This is a recommendation not specifically linked to Healthwatch Essex, but HWE would be extremely well-placed to commission/produce such an (independent) guide. This would complement HWE's work in providing information and signposting support for Essex citizens, and HWE could take the lead on this recommendation.	
1.2.2	Extension of coaching, training and helplines to support self-management	Spring 2014	10	Essex Carers Network: We support the introduction of coaching and training to support people to take control of their health and wellbeing and would like to ask that the health and wellbeing board advocate the use of experts by experience in the delivery of this. Some of our members have completed the partners in policymaking course (http://www.in-control.org.uk/whatwe-do/partners-in-policymaking.aspx) and have found it very useful in solving the many challenges that life brings them as family carers. It would be great if other families could benefit from this kind of empowering training.		see 1.1.2	We support the principle here, in partnership with colleagues in Public Health.	Sept has some examples of good self management programmes developing with MAPP and our recovery college and we would welcome more focus on initiatives like these. We think reference should be made to personal health and social care budgets as part of the delivery plan for achieving this goal also.					
1.2.3	Introduce a scheme supporting and celebrating carers and those who self-manage	By mid-2014	8	Essex Carers Network: Support acknowledgment and celebration of carers; it is not celebration that we as carers wish to see; we welcome acknowledgment of the role that we play in supporting our family members but most importantly as carers we want to be supported to enable us to continue in our caring role. The carers strategy 'carers at the heart of the 21st century families and communities' was launched in 2008. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136492/carers_at_the_heart_of_21_century_families.pdf). In Essex family carers still do not know what the local offer is for carers, 5 years is too long to wait for an Essex response to the national strategy. It is essential that the mechanics are in place to support carers and we would like to work with Essex County Council and the Clinical commissioning groups to make it right. The voice of the family carer needs to be heard to ensure that the lived experience is influencing the services that are developed to support carers, this is not happening effectively at the moment and again we would like to work with you to get it right.		We agree that carers and those who self-manage are to be supported, celebrated and rewarded and should come to represent an emerging social norm. This requires new behaviours beyond the County Council as well as within. Coaching and training appears the primary means of encouraging people to care for themselves and their families. This requires a clear strategy of how such training may be provided and funded.	We welcome this and see the County Council's carers strategy and the coordinating point for this. Schemes already exist keen to review integration opportunities and ensuring sustainability in light of optimising existing resources. Close working with voluntary sector essential and support for carers should be embedded in all services.		Action for Family Carers welcomes the call for a 'new approach in Essex to the support, acknowledgement, celebration, recognition and reward for informal and unpaid carers and patients who self-manage'. We are committed to this ambition and we are prepared and well-placed to take a leadership role on every aspect. Unpaid Carers are perhaps the best example of individuals and families taking responsibility for their own care. We need to ensure that they are in a position – both financially and in terms of their own health and wellbeing – to continue doing so. Action for Family Carers supports the concept of such people 'becoming key members of the care team'. We describe this as a 'triangle of care' consisting of the patient/cared-for, the clinician/social care worker and the Carer.	Unpaid carers should be celebrated and valued as they save the state huge amounts of money, but mainly go unseen and not supported or recognised (particulalry true for young carers). Unpaid carers need to be able to access support easily in their locality to ensure they receive support to stay well, hopefully this will serve to reduce the issues raised in Recommendation 2.		

1.2.4	Health TripAdvisor Essex launched by Healthwatch Essex	By end of 2014	10			We see the benefit of Healthwatch developing a Trip Advisor-style guide in print, online and across other media to share the strengths and weaknesses of care services in Essex. Clearly this market-like approach is for Healthwatch to decide whether to take forward.	We see the benefit of this and would see the ultimate responsibility and decision being made by Healthwatch					This is something HWE could support, and also potentially resource, should we be funded by ECC to take on additional information and signposting responsibilities from 2014-15. We have concerns as to whether there is an audience for a 'magazine' format, but would welcome the chance to provide more consumer-related information direct to citizens. The prospect of a 'Trip Advisor' website has potential to glean voice and lived experience, but statutory (and other) stakeholders have expressed concern about the medium. There is also risk of duplication, as exiting websites such as NHS Choices, PEBL, and Macmillan provide similar services. HWE is currently engaging with service users and the public about their needs for information across health and social care – this empirical work can inform the next steps.	
1.3.1	Government changes tax policy to no longer penalise those who save for their disabled children's future	2015					N/A						

Tendring District Council	North East Essex CCG	B&B CCG	Essex Cares	North East Essex Health Forum	Voluntary Sector Responses from Healthwatch Engagement
TDC supports the concept of ownership by communities for their and others health & well-being. The provision of up to date information and advice through a variety of media is an element to achieving this and TDC would be interested in developing seamless, easy to navigate systems of information with partners. TDC also supports the concept of a process whereby the experience of public, service users, carers etc. is used to drive up standards and improve service quality. There is some concern that the report does not recognise that some population groups will require extra support to access information and advice. These messages will also need to be marketed to public sectors partners. We would like to see a requirement to develop working partnerships between providers built into commissioning contracts.	Individuals are the ones who know most about their own care needs and play a key role in keeping themselves, their families and friends healthy and independent. We are strongly supportive of the principle of empowering people to be active community members. Commissioners and providers alike need to listen to patients' and carers' stories, which are a rich source of information and ideas. This needs to be triangulated with data and hard evidence about which services provide high quality care and outcomes. Commissioning must be based on evidence as well as patient experience. The Report focuses on existing types of provision – we need to move beyond this to look at how services can be provided in new and innovative ways to meet changing needs. For example, moving away from over-specialising towards staff who can care for individuals with complex health needs, drawing on specialist advice when needed.	Promotion of self-care in collaboration with CVS (they are members of our PCRG forum) Mental Health VSO contracts moving to PHBs in 18 months. Increasing over-the-counter medications to support self care. NHSE to support promotion of pharmacies as alternatvies to hospital/GP Services. ECC strategy is to reduce individual's reliance on social care.			
The statement regarding agreeing an understanding between the public sector and people of Essex appears to simplify the diverse nature of both areas. The public sector comprises of a vast array of different bodies, even the very number of local authorities in the county poses its own difficulties. Similarly the population of Essex is extremely diverse across the range from the outer parts of London through to rural areas such as Tendring or Uttlesford.			We are in contact with a very large number of Essex residents and believe that we can have a key role in brokering a new contract. We are experts in the provision of enablement services and are currently developing models of wellbeing, prevention and early intervention that are aimed at keeping people well and helping them to maintain independence.		
			We currently run day and home based opportunities for both Older People and those with Learning Disabilities and this experience would be valuable in meeting the needs outline in social prescriptions. We are committed to the prevention of ill health and hospital admissions and recognise the role that maintaining good mental health plays in this. We currently have formal referral systems in place from GPs and these could be further developed to meet the need of social prescriptions. We recognise that we do not currently provide a full range of services that might be covered by social prescription but are keen to look at where service can appropriately be developed.		
TDC is keen to support the development of the voluntary sector, but it is unclear in this section how this might happen.	There is a great opportunity to empower voluntary organisations to get on with what they do so well. There are so many community resources out there – both health and social care need to work much more closely with these groups that know their local communities.		We work with several voluntary organisations and would be keen to further develop our relationships to support the delivery of this recommendation.		A partnership approach which recognises that both statutory and voluntary sectors need to change is required here. There is a need for greater, meaningful market development of the VCS.
	We support the idea of enabling and supporting people to care for themselves and the production of guides and magazines about the services available.		This is a major piece of work that would benefit from involvement across a range of expertise and skills. Essex Cares would be interested in supporting this work.	A "Citizen's Guide" would be very helpful in showing the range of services available and who is responsible for what. The community and voluntary sectors have an important role to play but it would be useful to cite some existing successful partnerships projects from around the country.	
	Training of staff and health champions needs to be a co-design with service users – otherwise it continues to be a model imposed from above, rather than the true engagement we want.		We would like to take a lead part in this area. Through our day and home based opportunities we already offer a range of support to meet the prevention agenda for this category of customer. We are in the process of modernising our day centre offering and are moving to 'Wellbeing hubs' whose concept is to provide varying levels of support and interaction for those both living well and with a low level of need to help maintain their health and independence.		
TDC is keen to contribute to supporting carers to help them maintain their caring role and manage their own health and wellbeing. However, rather than the reward and celebration of carers, TDC would like to see real support in place. It is disappointing that the Joint Carers Commissioning Strategy developed last year has not been taken forward as this was informed by what carers said their real needs were and offered opportunities for joint commissioning of information and support services.			We support the ethos of this recommendation and our current services already have a clear focus on supporting carers. Our Enablement Plus services can demonstrate our success in supporting people who can self-manage and we would be interested in working with others to develop a scheme.	Carers want recognition, respect, dignity, choice and a life outside of caring. Whilst good practice should be promoted and celebrated, practical support is more valuable than "Carer of the Year" type awards, which do little to reach out to those isolated by the most intensive caring situations. The use of the word "reward" also needs some clarification.	

			We support the ethos of this recommendation and would be interested in working with others to develop this initiative.		

	Who Will Care Commission: Prioritising analysis		Total	Essex Carers Network	Basildon Borough Council	Essex County Council	Mid Essex CCG - Simon Griffiths/ James Bullion	Uttlesford District Council & Voluntary Sector Board	SEPT	Voluntary Sector Training	St Lukes Hospice	Action for Family Carers	Supporting Carers & Families together
		Timescale											
2	**Prevention**												
	Prevent unnescessary crises in care			Essex Carers Network: This is something that we support; our families need to be supported to plan with their family member who has a learning disability so that when a crisis occurs the plan becomes active. We are in the process of working with colleagues within the local authority looking at this specific issue in particular relating it to our older carers who still have their family member living at home with them.	Keeping people in their communities – own homes, local care homes etc. Basildon has a large housing stock and a number of supported housing schemes. Both ECC and BBC need to establish what data sharing protocols are currently in place to understand the health and social care needs of individuals that we serve. This will help to understand the preventative work that is currently ongoing within the Borough and to avoid duplication. Encourage collaborative working to prevent people entering the "last resort" of the care system – e.g. Accident & Emergency (A&E) within this solution. Ongoing investigative work relating to A&E admissions is currently taking place between Basildon and Brentwood Clinical Commissioning Group (CCG) and Basildon Borough Council. This needs to be linked to the aspirations of this solution to help reduce the demands on Basildon Hospital.		.		The five statements are strong and to deliver them will require urgent and high level planning across agencies with supporting focus on the capacity and capability of organisations to work together in difficult times. We would suggest the focus of work should be on those with complex and Long term conditions and in particular people with long term mental health problems, drug and alcohol problems and obesity as targeted work with them will reduce demand on crisis services and significantly improve their quality of life. Again an important high impact change but we feel a significant and quick step to community 24 hours services and some pre GP services where individuals and communities resolve health issues themselves will see a shift from crisis and inpatient acute care. Also what will you offer in terms of behaviour change and communication with the public using Nudge theory maybe useful here? a	It is absolutely vital to refocus resources on prevention rather than responding to crises. The recognition of the roles for the VCS (wellness workers and volunteers at long term condition centres) are to be applauded but recognition is also needed that there are costs involved in these roles and activities. Recruiting supporting and developing volunteers mean that volunteers whist invaluable are not a free resource. These costs should be seen as investment. (Each £1 investment in a volunteering programme yielded an average return of between £3.38 and £10.46 (Teasdale 2008) as quoted in Kings Fund report on Volunteering in health and Care.	Our Hospice at Home team effectively manage the discharge processes from hospital for these who wish to be cared for at home. The service also provides an integrated Health and Social Care approach to provide additional support to those requiring care at home. The Hospice has significant experience of education and training to health care professionals, patients and carers. Our work for Essex Council staff has been highly commended. Training and support is also provided to volunteers to cover the range of complex roles they perform with the Hospice and across the community	Action for Family Carers supports the change in focus to 'supporting individuals earlier – preventing crises in care, improving independent living'.	Concerned that volunteers may be replacing paid staff - how is consistency maintained as volunteers will leave if they have internal relationship difficulties or personal priorities, accountability is also a potential issue. Consistency is very important for those using services at a time when they feel most vulnerable due to ill health or the challenges of older age.
2.1.1	Begin identifying the 20% of Essex residents most in need of care and support	Autumn 2013	11			Priority:	In Mid Essex we think this is essential and see the work between health, social care and housing on the frail older people services as our key way of achieving this. ECC and partners need to habitually share information about people and co-locate responses through primary care. Significant priority for Mid Essex. Work in hand with risk stratification tool to predict those within health that are reflected within this category. There is potential to look at the overlap with the social care detail to further enhance targeted support once IG barriers resolved. Interim work will be to look at what can be achieved in the meantime. Primary care are already using a scoring methodology to look at patients with a social care need also holding MDTs involving GPs, Community Matrons and social workers at practice level. This includes schemes such as the Medical Response Vehicle schemes and HIgh Impact team for Care						
2.1.2	Ensure intensive initial support is in place for those considered most in need of care and support	Winter 2013	12			Priority: We agree this is a priority for action. We see the importance of identifying those who are most in need of care and support, and wish to develop a simple yet thorough way of calculating this. A current source of insight that the Council is developing is the Mosaic geo-demographic database, which indicates the types of household that are most likely to benefit from early action. We are combining this with data on loneliness and social isolation that are associated with a higher demand for care to identify where people may need extra home-based interventions to avoid residential care.	We welcome the emphasis here and would support the approach, and see this as joint action by the CCG and County Council Commissioners. Frailty pathway and reablement agenda (physical and mental health) commissioning in conjunction with 2.1.2						
2.1.3	Promotion of online communities to help those in need	Winter 2013	7	Essex Carers Network: Online communities: we would like to suggest that when looking at this kind of thing you look at multi me (http://www.multime.com) a networking tool that can help people to "communicate and plan their lives. It is based on the idea of people telling their story through the use of multimedia and getting involved in each others' project planning, in a safe and supportive online environment" Some of us have used multi me for our family members and it has worked well for them.		We support the promotion of online communities to encourage people to support one another to live independently and combat loneliness. We would need to find an accessible online location for new forums that includes links or signposts to relevant supportive organisations. This could be supported by a separate body, such as Healthwatch Essex.	We would see this as primarily the lead for Voluntary Sector groups but support the idea to ensure sustainability.						
2.2.1	Commissioning of new services for those most in need of care and support underway	In 2014	11			see 2.1.2	Shared CCG and ECC lead. This will be a mixture of new service and changing the current balance of services. In Mid we are suggesting a Steering Group to promote joint commissioning. This relates to the various schemes that the CCG has initiated for physical and mental healh extedned to Districts and Voluntary sector						
2.2.2	First nurse-led and volunteer-supported Long Term Conditions Centre opens	Spring 2014	9		Essex is to support the evolution of Long Term Condition Centres. These will be nurse led and staffed partly by trained volunteers. BBC could support this initiative by using local community facilities (in the same way we are at the moment re the provision of Sexual Health services) that reduces costs to the CCG and could be strategically linked to local need informed by data we have in Basildon.	We see the benefit of nurse-led and volunteer-supported Long Term Conditions Centre that focus on the responsibility of the individual for their health. Staff must be trained on how to educate patients and carers as well as care for their health needs.	CCG is currently looking at care of Long term conditions and the workforde requirements associated with this as well as community cohesion opportunities	There are, of course, limits to district councils' involvement in some of these solutions although in Uttlesford we work very closely with our Leisure Centre provider and have a shared Community Health post. The officer delivers a number of classes to support specific health issues such as COPD, cardiac rehabilitation, diet and exercise sessions for those with neurological conditions and we are just embarking on an exercise rehabilitation programme for people			Therapeutic Support groups are provided to combat loneliness and to deal with complex psychological and social needs. We are able to provide facilities within a number of sites to provide long term condition support. Our new Day Hospice facilities have been designed specifically to enable increased input and development of this area		

2.2.3	Introduce a care record owned by Essex residents not public agencies and designed to allow for advanced planning and improved support	Spring 2014	8			The County Council supports the creation of a patient record that belongs to the individual. It is important that the record is accessible to relevant professionals, easy to understand and allows for early planning with care partners.	We would suggest looking at the prospects for information exchange and improving coordination through an information partnership under the auspices of the Pioneer initiative (if Essex are successful).					We welcome the suggested individually-owned record as a means of ensuring improved communication and information sharing. This is less straightforward where, for example, an individual does not have mental capacity to make decisions regarding their own care. Action for Family Carers can contribute to addressing such issues as this.	
2.3.1	Across Essex, every person needing care and support has the choice to appoint their own co-ordinator or wellness worker	In 2015	8	Essex Carers Network: We would like to encourage the exploration of systems already around which use the "coordinator / wellness worker" approach. This way of working can only encourage and enhance the practice of person centred working which is essential. An example of this which works well for our families is the early support model (http://www.ncb.org.uk/earlysupport) used with families of disabled children and young people soon after diagnosis which advocates the team around the child and identifying a key worker to coordinate the work. Another well documented system is that of brokerage: http://www.ndti.org.uk/uploads/files/TheWWH_of_brokers.pdf this document talks about the use of independent support brokers in relation to social care. We have families within the network who have experience of brokerage and we would be happy to		We would like to give persons requiring care the opportunity to appoint their own co-ordinator, although we would target this at those most in need of support as above for recommendation 8. Communities and the voluntary-sector should be encouraged to fill this role and to take an individualised, non-disease based approach that endeavours to support people outside of hospital. Opportunities to use personal budgets could be investigated through this initiative.	We support the general notion of coordination but would like to see what guidance emerges through the forthcoming Operational Framework and integration guidance.				We can and do play a key role in helping Carers and those they care for to plan in advance for their future care – a crucial element of the work we do which makes a real contribution to reducing the future demand on health and social care, e.g. by avoiding unnecessary hospital admissions for people with dementia. Our workers would be well-placed to act as coordinators/wellness workers where this is the individual choice made.	

ACE	Tendring District Council	B&B CCG	Essex Cares
We have establisehd teams who provide services for patients with long term conditions and so we would be interested in the development of Long Term Condition Centres.	TDC supports the concept of early intervention and prevention and particularly supporting people to manage their long term conditions. There appears to be a growing consensus of the importance of prevention as the best use of resources however already this area is suffering in terms of resourcing for example via removal of funding for the GP referral scheme and reduction in spend for Supporting People. There is some concern that whilst schemes to support people with long term conditions in Tendring has been developing well, for example Virtual Wards, some long term conditions are given a lower priority. Through our own Local Health and Wellbeing Board a focus has been placed on mental health.	SPOR, PCATC, and other unplanned care admission avoidance schemes. Developing integrated commissioning schemes for frail elderly.	Essex Cares would be best placed to lead and facilitate this recommendation on behalf of partners across the sector for the people of Essex. Through the reablement work that we undertake across Essex, and the newer Rapid Response contracts in Mid and West Essex we are engaged in working with many of those residents already receiving care and support. We are keen to further develop our services into the preventative and supportive role for this highest risk section of society. We would be keen to coordinate the development of a means of identifying the 20% most at need of care and support.
			Essex Cares would be best placed to lead and facilitate this recommendation on behalf of partners across the sector for the people of Essex. Through the reablement work that we undertake across Essex, and the newer Rapid Response contracts in Mid and West Essex we are engaged in working with many of those residents already receiving care and support. We are keen to further develop our services into the preventative and supportive role for this highest risk section of society. We would be keen to coordinate the development of a means of identifying the 20% most at need of care and support.
			We would like to take a lead part in this area. Whilst we currently support people referred to us, as well as those referring themselves, with various options of support, we are very keen to proactively seek out and work with people in an early intervention and prevention approach. We are committed to this ethos - to both maintain health and independence and to reduce the burden on the health and care industries
			We support the ethos of this recommendation and would be interested in working with others to develop this initiative.
			We would like to work with commissioners and take a lead in developing the specifications for the new services needed. We are in a unique position working across all of Essex to suggest new opportunities/services that can maintain health, slow the loss of independence and reduce the burden on both the health and social care services, by the delivery of joined up integrated working practices across the spectrum. Our current work enables us to be able to make significant contributions to the design of cost effective care services that would slow the flow of people into the health and social care sector. We have the organisational and service infrastructure in place that allows for us to deliver new services swiftly and effectively across Essex.
			We would like to contribute in this area. We support all initiatives that move towards redesigning routine care to provide a personalised approach for people with long term conditions (LTC). We see a role for local services being commissioned to support those with LTCs to live well in the community, and we would offer an expert resource in the delivery of such initiatives and would like to be part of this service design.

			We would like to take a lead part in this area. It is clear that many people receiving our services are confused by the plethora of providers they meet on their pathways. Client held records have worked well in maternity services nationally for many years, in common with adult care this service also crosses all sections of the community but this does work. We believe that client held records that enabled true control and planning by the client in partnership with agencies, and alongside good continuity of care and carer, are essential. We would like to work with the many partners in operation across Essex on developing this record. We believe that there can be not only better control and care for the individual, but savings by reducing the duplication of services there can be increased choice and improved standard of quality.
			We would like to take a part in this area. We see this as a key development in enabling residents of Essex to take control of their health. We would like to be a part of the discussions on this and to take an active part in providing a solution.

	Who Will Care Commission: Prioritising analysis		Total	Essex Carers Network	Basildon Borough Council	Essex County Council	Andrew Pike & Dave Hill work with THH	Mid Essex CCG - Simon Griffiths/ James Bullion	Uttlesford District Council & Voluntary Sector Board	SEPT	Voluntary Sector Training	St Lukes Hospice	Action for Family Carers
		Timescale											
3	**Community**												
	Mobilise community resources			We firmly believe we are a community resource and we want to be part of the solution to ensure resources are used appropriately to support the health and wellbeing of the people of Essex.	This solution has already been developed in the Borough. Projects include the Vange REVAMP, Pitsea BIG LOCAL, Craylands and Highcliffe Troubled Families, all of which involve community engagement that support ongoing health related initiatives. BBC Community Development Officers (CDO) mobilise community resources for these projects and their contacts could be used to help move this solution further forward e.g. Voluntary Sector.		i. That an advisory group be established to take forward recommendation 3. The overarching aim of the group would be to: - Strengthen the voluntary sector and harness its support and commitment to implement recommendation 3; ii. The group would be chaired by Sir Thomas Hughes-Hallett and will comprise: - Gary Sweeney (Deputy Chair) - Bob Reitemeier - Andrew Gardner - Andrew Pike - A Medical Director from an Essex hospital iii. The Group would meet monthly and have joint meeting with the Anglia Ruskin Health Partnership and Essex NHS Commissioning Board on a bi-monthly basis to provide an update of progress and seek advice. iv. The Advisory group would report progress to the Health and Well	In this section we would warmly welcome participating in a partnership with the County Council, Districts, Parish Council and community sector. We believe that this work is best done locally, but perhaps suppported by a County overview to spread ideas. We would liike to see the County Council focus its work on Strenthening Communities in to this area of work.	The Uttlesford Voluntary Sector Board considered the 5 high impact solutions recommended in some detail recently. The Board concluded that to a degree the agencies' work already has an impact on delivering some of these aspirations but that the detail is not necessarily known about by the CCG or Social Care. The local voluntary sector in Uttlesford is a strong community support service and it is important under the future ECC commissioning approach that these organisations are not overlooked in favour of larger county wide service providers.		VST welcomes the recognition that communities and individuals are already active in contributing to the prevention of health and social care needs and in particular the help recommended for local voluntary schemes – seed funding, training and information on best practice. VST already seeks to support the training needs for local schemes and would welcome endorsement and support to extend this for the smallest volunteer led groups who can find even the heavily subsidised charge that VST makes for training, beyond their resources.		Action for Family Carers has long been seeking to ensure access to high quality support for unpaid carers across Essex. Currently there is a postcode lottery – a large variation in the range of services available as well as the quality. Action for Family Carers is the only Carers Trust Carers Centre in Essex, and holds the Carers Trust Quality Award. We are the only organisation providing hospital-based carer support services and transition support for Young Adult Carers, and one of only two providing school-based support for Young Carers. We are piloting the 'whole family approach' to working with Young Carers, and also work in partnership with Macmillan to provide support for Adult Carers around end of life care. We are in a position, through partnership where appropriate, to develop a model for supporting Carers across the county. Through this we could secure: - a locally based voluntary sector pan-Essex solution - increased use of volunteers (both
3.1.1	Implement community schemes, drawing on local knowledge and appetite - bolstered where appropriate	Ongoing	8	The report talks about help for schemes providing support and care; we feel the very first aspect of support comes from good information and appropriate signposting. This is a role that we aim to undertake for our families and wish to continue to do so. It would be useful if there was a community road map which illustrated what resources are out there in the community, we know there is some good stuff going on but not everyone knows about it. This road map would also need to be quality checked by people who will be using the resources identified on the road map. This is something which local user groups could be involved in.		We support the implementation of community schemes which provide support and care on a voluntary basis, drawing on local knowledge and appetite. Our VCS Strategy supports this, making it clear for instance, that piloting innovative ideas with grant funding is within the gift of a commissioner. Our proposed Community Resilience Fund is an example of how we could fund such schemes.			The District Council and the Voluntary Sector Board concluded that it is essential that agencies compile a paper identifying the areas of work that directly contribute towards the solutions that highlight voluntary sector involvement. This information would then demonstrate where the gaps are and where further work would need to be undertaken if the solutions are to be fully implemented in Uttlesford. If the Essex Health & Wellbeing Board resolves to adopt the recommendations in the "Who Will Care" report then we believe this local information will assist the Board in implementing the high impact solutions.			Our current Information Resource Centre provides support to patients and carers at all stages of their illness and addresses the needs of the worried well. The centre is nurse led and staffed by volunteers who also sign post to other agencies and organisations	As a local Essex charity in contact with over 5000 unpaid Carers, Action for Family Carers can contribute to the 'local approach and local understanding of grass-roots needs'.
3.1.2	Consortia of organisations encouraged to collaborate and jointly bid for services	Winter 2013	8			We believe that there are already sufficient community organisations in place across Essex to help those in need of immediate help and that there is no need for a new Essex-wide organisation. As part of our Whole Essex Community Budgets Strengthening Communities work, we have piloted Community Builders schemes in five areas in the County, developing local assets including community groups to make a real difference to neighbourhoods. Another of our projects is looking at boosting volunteering across Essex. The Essex Community Foundation also does a lot to sustain our communities, investing and distributing funds to worthwhile community causes.							
3.1.3	Large employers commit to promoting volunteering and community activity to their staff	Winter 2013	10		Employers to support staff volunteering – Staff volunteering is currently evolving in Basildon. An example of a project that has been completed is the clearing of water courses in Wat Tyler Country Park to promote physical exercise. This helped joining up the efforts of BBC staff and the Voluntary Sector.	We agree that employers should commit to promoting volunteering and community activity among their staff and believe that the public sector should lead by example. This is why we already have policies in place to encourage employee volunteering. While we would also welcome similar policies in the private sector, we recognise that this is a matter for the private sector, many of whom already have effective corporate responsibility policies.				This is highly commendable but we think will be resource intensive initially. We though are keen to work with partners to develop more staff volunteering and at an early stage with our own staff of developing a volunteering for staff policy. We think the voluntary and independent sector could play a key role here and would welcome a focus for them on this.			Action for Family Carers could not do what it does without the support of volunteers. We therefore welcome encouragement for employers to support staff volunteering.
3.2.1	Move toward 3-5 year contracts for services commissioned by public agencies	Spring 2014	9	The report talks about poor procurement undermining commissioners aspirations; the use of people who use services and family carers can bring a unique perspective to the procurement process and we would encourage this, remembering that people will need support and training to undertake this.	Contracts of more than 12 months need to be included as an action within the Basildon Health Partnership Commissioning Framework. This will ensure the commissioning ambitions of the Health and Social Care aspects are joined up across both partnerships.	We welcome moving towards 3 – 5 year contracts for services commissioned by public agencies. This is a stated target within ECC's VCS commissioning strategy and is something we consider to be good practice for commissioners. We also agree that consortia of providers should be encouraged to collaborate and jointly bid for services. ECC's commercial function will actively encourage this. Our VCS Strategy also refers to this, expecting that the VCS will engage in consortia where appropriate.							Action for Family Carers supports the recommendation that longer-term contracts are agreed and that consortia of providers should be encouraged where this leads to 'integration of services and better value'. As the only Carers Trust Carers Centre in Essex and the largest provider in the county we are in a position to lead such a consortium of carer support organisations. We would positively welcome the opportunity to work with commissioners and providers to achieve this to ensure a local community-based solution.
3.2.2	Create village / town / community groups to care for groups of households	Spring 2014	8					CCG is keen to enable further community cohesion across existing for a					
3.2.3	1000 individuals each look out for 600 households	End 2014	Follows on from 3.2.2										
3.2.4	Inaugural 'vibrant communities' awards for Essex neighbourhoods	End 2014	10			This links in with our VCS Strategy and we agree with it in principle. Careful thought would need to be given to how the scheme would work and whether it can add value and contribute towards continual improvement and innovation. If it is not done properly, the scheme risks being patronising and ineffective. We think this should be taken forward by the Essex Community Fund with Healthwatch.						
3.3.1	1500 individuals each look out for 600 households	End 2015											

Supporting Carers & Families together	Healthwatch	ACE	Tendring District Council	B&B CCG	Essex Cares	North East Essex Health Forum	Voluntary Sector Responses from Healthwatch Engagement
I am very excited by the possibilities the report has raised and the challenges offers the voluntary sector a chance to shine.		As well as the large volunteer base outlined in the first solution, as a social enterprise, if we make a surplus at the end of each financial year, we are able to use a percentage to support local community groups and organisations. We could potentially help with one-off funding (providing that our Social Impact Plan criteria is met) and also use staff skills to provide/advice/support.	TDC supports the concept of building community capacity and is currently part of the Essex Community Builders pilot. TDC recognises that communities are different and that whilst some areas have vibrant communities, others are non-existent. We would like to see approaches to support communities that may be more deprived or isolated.	As item 1 , continue to support VSOs. Service specificatiosn to ensure providers deliver person centred-care. Review our pilot schemes to either mainstream or cease. Where mainstreamed, make it easier for alternative providers to join the market and give contracts of up to 3 years.		Help for local schemes and an award scheme for the most vibrant communities seem good and straightforward ideas. The suggestion for longer contracts also seems sensible on the face of it. Employers supporting staff volunteering is also good. However, the proposal to create an Essex-wide body embracing paid staff and volunteers, is of concern – it would introduce another layer of bureaucracy and cut across existing structures. Finally, the voluntary sector should not be seen as care on the cheap but as an equal partner.	This would be welcomed either through appropriate and proportionate grants or contracts, or through philanthropic or in-kind support. More grass-roots activity can be stimulated if support is in the right place, to make better use of volunteers and community assets.
					We would like to take part in this area. Recognising that much of the focus of this recommendation is on voluntary organisations, we believe there is also a role for us as a care provider to engage further with the communities in which we operate and to develop relationships for the good of all.		
					We would like to take a part in this area. Currently we are developing relationships with the public sector, private and volunteer organisations with the aim of us collaboratively delivering services. We would be keen to work on system wide solutions to the issues of collaboration.		This is recognised, although VCS organisations would like to see evidence that consortia approaches would be welcomed by statutory funders. The Essex Alliance could look at this agenda.
					We would like to take a part in this area. Whilst we do currently have policies in place to support volunteering, and have volunteers working within the organisation, we are open to reviewing these to support greater engagement with large employers.		Models for this are evident across the County and could be easily promoted.
Agree new contracts with a range of providers across all sectors need to have some longevity as the current one year scenario is destructive and create insecurity for organisations to maintain staff levels, not a good use of public money to continually be recruiting and training new people. Public agencies also need to be much more prescribed in the 'outcomes' they require contractors to achieve, combined with much better communicated lead in times for the commissioning processes. Currently the situation going forward with public agencies is very unclear with no clear timeline communicated particulalry to voluntary sector organisations who receive 'Grant Funding'.			TDC fully supports the use of longer term contracts and the concept of consortia of providers to deliver integrated care. However, we are concerned that large scale contracts, and the way they are currently procured, disadvantage smaller, valuable voluntary sector providers. TDC would wish to work with partners to develop commissioning systems that enable a wide range of providers to innovate and compete.		ECL see this as an important recommendation. As a major provider of care we would support commissioners introducing more stability into the market with the provision of longer contracts.		This could be picked up as part of the VCS Strategy, but would require action on the part of statutory authorities.
			We do not support the concept of every household having an individual or team charged with identifying early any difficulty. This does not fit with a model of individual autonomy and self-help and best use of resources. We would prefer this resource to be targeted at people most in need		We would like to take a part in this area. We welcome this recommendation that supports individuals taking more responsibility for themselves.		This could be picked up as part of the VCS Strategy, but would require action on the part of statutory authorities.
					We would like to take a part in this area. We welcome this recommendation that supports individuals taking more responsibility for themselves.		
	This is something HWE could support, as well-run award schemes (such as Colchester's 'Celebrating Volunteering' Awards) can really raise the positive profile of volunteering. However, it is not clear whether HWE is the right body to promote this, but done in partnership, this could be a good step forward.				We would like to take a part in this area. We welcome this recommendation that supports individuals taking more responsibility for themselves.		This proposal received some support, but needs focus and to avoid duplication of existing, successful schemes.
					We would like to take a part in this area. We welcome this recommendation that supports individuals taking more responsibility for themselves.		This notion is based on a Columbian model advanced by a Canadian academic, Professor Jadad. Members of the BMG attended a workshop on the proposal – at the time of writing, I am awaiting detailed feedback from attendees.

	Who Will Care Commission: Prioritising analysis		Total	Essex Carers Network	Basildon Borough Council	Essex County Council	Andrew Pike & Dave Hill work with THH	Mid Essex CCG - Simon Griffiths/ James Bullion	Anglia Ruskin Health Partnership	SEPT	Voluntary Sector Training	Action for Family Carers	Supporting Carers & Families together
		Timescale											
4	**Data and Technology**												
	Use data and technology to the advantage of the people of Essex			We welcome the use of technology to support people to maintain health and keep well, as long as it is not used as a way to covertly reduce support that is necessary and already in place. We know that some of our families are wary of telecare and we would welcome the opportunity to find out more about telecare and share it with our families in a positive way.	Governance relationships need to be reviewed that support data sharing and protocols developed to make this process easier and help better target the needs of individuals in the Borough. Basildon very much support the process of both upper/lower tier authorities working with housing associations to create a housing strategy using assertive technology. However this is very ambitious approach given the number of authorities potentially affected. Further clarification needs to be determined on what this means for Basildon given we are an authority with a substantial amount of social housing stock.		vi. It is also proposed that a separate Data group be established to consider Essex's whole system data sharing requirements. This group will consist of specialist staff from across the appropriate range of public sector bodies in Essex with the task of identifying what data needs to be shared with whom and why with the purpose of providing an evidence base to inform public sector data sharing enabling powers in the Government's draft Communications Data Bill. vii. Both groups will be provided with project management support to ensure they work to an agreed schedule of deliverables within a pre-determined timescale.	We strongly agree that technology can make a significant impact of care and health.					
4.1.1	Begin development of Essex-wide data strategy	Autumn 2013	11			We are already driving for the creation of an Essex-wide data strategy and believe patient-owned records should be the default across Essex. We would like to agree a preferred patient care system with the CCGs and will agree data standards between social care records and health records. We also support moving from separate organisation ICT and information governance strategies to convergent ones where our services touch each other so as to prevent artificial blockers to sharing services, systems and data tautology.		We see the importance of coordinating data and look forwards to working with partners on this.		We agree that one pragmatic approach to data sharing across agencies is long overdue SEPT has been using a data sharing portal with Thurrock council with great success and would be happy to share that across Essex.			
4.1.2	Agree telehealth and telecare sites	Spring 2014	10			We support this in principle but recognise that further research would need to be undertaken regarding costs and outcomes and identifying a meaningful population. We have also been actively involved in developing telecare in Essex for several years, particularly following a pledge on telecare by ECC in 2009-10 where we piloted it with the over 80s in Essex for a year.		We acknowledge the value that telehealth and telecare can play as part of a wider package of support, but we do think that further commissioning review of the evidence has to be undertaken as part of this work, so that developments can be made.	we think we can help with the "fourth solution" around telehealth and telecare. Within our partnership, which includes providers of health and social care, the county council, and Anglia Ruskin University, we have broad base of relevant expertise. For example, the Anglia Ruskin MedTech campus is developing an "Assisted Living Observatory" to showcase and support the implementation of new technologies, including in remote monitoring. We are also supporting the sharing of knowledge and good practice across the county, and on the 30th October we are hosting an "Industry Seminar" where Invicta Telecare will be sharing their latest national and international experience in remote care. Furthermore, we are already collaborating across our partnership on assistive technology. We are in the final stages of developing	Meanwhile a real push for the public sector to catch up with the public with things like trip adviser for care and telehealth and telecare is overdue.		Action for Family Carers can support the proposed telehealth and telecare trial by ensuring there is involvement of and support for the role of unpaid Carers as 'expert partners' in the care of the person they look after.	
4.2.1	Housing strategy supporting assisted technologies in place across Essex	End 2014	8			We support the creation of a housing strategy supporting assistive technologies in Essex but, as a non-housing authority, recognise that this is predominantly a matter for the borough, city, district and unitary councils and housing associations to take forward. We will therefore table the matter with the leaders and chief executives of these councils. We also have a Housing for People with Additional Needs Strategy and have recently identified Capital grant for specialist housing, which will require assisted technologies to be in place in any funded development. It is also our policy to actively seek opportunities to maximise assisted technologies in new build and existing housing developments.		We would encourage this as part of wider work with the County and Districts on housing strategy.					
4.3.1	Implement and assess progress at telehealth and telecare sites whilst lobbying for improved connectivity across Essex	Throughout 2015						We acknowledge the value that telehealth and telecare can play as part of a wider package of support, but we do think that further commissioning review of the evidence has to be undertaken as part of this work, so that developments can be made.					
4.3.2	Patient-owned records are the default across Essex	2016									Again absolutely vital to maximise benefits of technology but also to make sure that this does not exclude individuals or groups without access or facility with technological approaches.		Person held records may help to tackle the barrier of data sharing and holding personal data electronically for ease of access by a number of services that may be working with an individual or family. Positive reporting of this working well by service users to the masses is required as the media has historically reported very negatively in relation to electronically held personal data.
4.3.3	If appropriate, roll out telehealth and telecare across Essex	Early 2016						We acknowledge the value that telehealth and telecare can play as part of a wider package of support, but we do think that further commissioning review of the evidence has to be undertaken as part of this work, so that developments can be made.					

ACE	Tendring District Council	North East Essex CCG	B&B CCG	Essex Cares	North East Essex Health Forum
We would welcome the opportunity to work with the Borough, City and District and Unitary councils and housing associations to create a housing strategy, as this will impact on health and wellbeing.	TDC is keen to support the development of data systems and technology and are keen to build on their data sharing work from the EssexFamilies pilot.	Whilst the internet is a great resource, we must remember that significant numbers of people do not have online access. This must be remembered when talking about people owning their own health records. In addition, the creation of online communities can be useful, but only if they are linked into real community support and not just offered in isolation to other support offers.	Telecare/telehealth/assistive technology in some of our plans, New patient held record for COPD.		The essential point is ownership of the health record by the individual. The inclusion of housing in health and social care needs to be pursued if independent living is to become really meaningful. It must be remembered that a significant number of people don't have access to the internet – this has an impact on engagement as well as on their ability to benefit fully from telehealth and telecare.
		Data sharing, with proper protocols, is vital for good care planning, for ensuring patient safety and for avoiding people having to repeat the same information many times over to different staff. It is paramount that a practical solution is found that allows proper access whilst complying with data regulations. The barriers posed by current legislation (Data Protection Act) and policy (Caldicott guidelines, revised 2013) are significant and a robust and lawful mechanism must be implemented to achieve these aims.		We would like to take a part in this area. At ECL we have implemented electronic systems that support the management of the care work we do. We are working on a companywide IT strategy and would welcome the opportunity to develop unified systems with partners	
		Whilst technology needs to be harnessed to support people's wellbeing and independence, we must take note of evidence around telehealth and also recognise, as mentioned above, that not everyone has online access.		We would like to take a lead part in this area. As current providers of Telecare in Essex we would be keen to see this developed to reach its potential. We are the first responders in one area of Essex and this could be developed across the whole county. Our experience is positive but we would welcome the opportunity to participate in further trials and evaluations.	
				We would like to contribute in this area. With both our Assisted Technology Service and Telecare we work with colleagues in the housing sector but recognise that there is much to be gained from better working with residents and housing. We are already in conversation with housing providers in the county regarding equipment services for example.	
				We would like to take a lead part in this area. As current providers of Telecare in Essex we would be keen to see this developed to reach its potential. We are the first responders in one area of Essex and this could be developed across the whole county. Our experience is positive but we would welcome the opportunity to participate in further trials and evaluations.	
				We would like to take a part in this area. At ECL we have implemented electronic systems that support the management of the care work we do. We are working on a companywide IT strategy and would welcome the opportunity to develop unified systems with partners	
		There is now a considerable body of evidence regarding successful and unsuccessful management of frailty and long-term conditions. We must be mindful of this when choosing which interventions and services to commission. Many attractive-sounding opportunities such as "telecare" and polyclinics ("long-term conditions centres") have not proven effective when subject to critical evaluation.		We would like to take a lead part in this area. As current providers of Telecare in Essex we would be keen to see this developed to reach its potential. We are the first responders in one area of Essex and this could be developed across the whole county. Our experience is positive but we would welcome the opportunity to participate in further trials and evaluations.	

	Who Will Care Commission: Prioritising analysis		Total	Essex Carers Network	Essex County Council	Mid Essex CCG - Simon Griffiths/ James Bullion	SEPT	Voluntary Sector Training	Braintree District Council	Action for Family Carers	Supporting Carers & Families together	Healthwatch	ACE
		Timescale											
5	**Leadership**												
	Ensure clear leadership, vision and accountability						We would suggest this in fact needs to be high impact number one here. We welcome the Essex Care Partnership concept of providers and commissioners working together on this but would not want to see duplication with the statutory health and well being board. Would it be possible instead to invite providers to join the health and well being board and do the work from there? The leaders can and should work together to build trust and competence to work across organisational silos and see integration of care around the individual and the reshaping of the providers and commissioning patterns to support this as their primary goal here.	The suggestions and approach are absolutely needed. The leadership and vision need to be followed through with actions that are understood and followed throughout the "partnership". In "flexing the workforce" the paid and unpaid staff in the VCS need to be taken into account.					W e would welcome the opportunity to be a member of the Essex Care Partnership. We have experience and knowledge of hospital discharge and learning disabilities and would like to be involved in creating new solutions.
5.1.1	A Care Partnership/Health Executive is created, that develops a common approach to care and begins work on the core health and social care challenges	In Autumn 2013	11	This solution suggests "a care partnership with an independent chair governed by the health and wellbeing boards and operating across Essex to bring together key partners from the public, private and voluntary sectors" the ECN welcomes this and would like to ask that users of services and family carers are included on this board. We often hear that we are represented by a third party but to us as families the only people who can represent us are people who have direct experience. We must stress though that people who use services and family carers who become part of this partnership or other initiatives should be supported and offered training to take on such a role. As a network we strongly believe that as family carers we must be involved at the onset of planning, too often in the past we have been told this is what we are going to do. Increasingly now we are being involved right at the beginning at a strategic level which is where we want to be, we feel we are very well placed to be able to influence commissioning and development of services. We hope that this way of working continues and people of Essex can feel they have a role to play in developing good services in their county.	Priority: We are fully committed to greater partnership working and recognise that the Health and Wellbeing Board have agreed to look into this recommendation. It is important that any Care Partnership complements rather than confuses the governance arrangements in Essex and that any such partnership adds value and works towards goals and strategies set by the Health and Wellbeing Board, rather than work independently.	We support greater integrated leaderhip and partnership working. The Health and Wellbeing Board have agreed to look into this recommendation. It is important that any Care Partnership compliments rather than confuses the governance arrangements in Essex and that any such partnership adds value and works towards goals and strategies set by the Health and Wellbeing Board, rather than work independently			Braintree Health & Wellbeing Panel to be a sensible mechanism to develop further collabortive working on this agenda in the Braintree District.	Action for Family Carers can contribute to the proposed Essex care partnership of commissioners and providers and the creation of a 'county-wide strategy' focused on integration, earlier identification and intervention. We have a clear vision concerning future support for Carers across Essex based on best practice locally and through evidence gathered by Carers Trust nationally.			
5.1.2	Business leaders begin mentoring health leaders in Essex - part of the development of a trusting leadership team	By Winter 2013	8	Investment in the leadership team is discussed we believe that people who use services and family carers should also be invested in to encourage them to be leaders which will lead to empowered groups of people willing to work with you in a solution focussed way to support the health and wellbeing of everyone in Essex. The report talks about "a culture of compassion, acknowledgement, value, learning, sharing and improvement . . . learning from others to achieve" this is how we strive to work within the ECN and we would welcome the opportunity to work with others leading by example to encourage this way of working.	This is very important, which is why we have already begun investing in the leadership team and building trust with partners in Essex. For instance, we held an Accelerated Design Event for Essex health and social care integration partners in June. We also recognise the value of mentoring but believe it would be most beneficial when carried out on an as-and-when-required basis. Partners could also look to the private sector for examples of best practice.								
5.1.3	Integration plans agreed	In Jan 2014	15			Steering group established. ToR being established			The Council recognises that integration means that all authorities and agencies need to work effectively toegther, and pledge to develop, with partners the methods and mechanisms to achieve the aims set out in the Commisison's report. It supports a local apprach to health and social care as documentmented in the report. BDC has constructive relationships with ME CCG and NHS ENgland and supports the Urgent Care Plan, Primary Care Strategy and the ME Integrated Plan.		A real intention to work collaboratively will also require a real intention to pool funding and expertise. Integrated services are the buzz phrase of the moment, but how will empire builders be encouraged to move from gatekeeper of budgets to sharer? This has been a key issue for service users being pulled from one provider to another due to this protection of budgets and 'its somebody else's problem or responsibility' which is very distressing for the individual or family on the receiving end of this culture.		
5.1.4	Permission to innovate' granted	Early 2014	10										
5.2.1	Begin measuring success	In Sep 2014	8			Will need further definition for us going forward ie 5.3.1							
5.2.2	Integration of provision begins - an ongoing drive to make services less complicated	Throughout 2014				Integration							
5.2.3	Decommissioning of non-core services alongside commissioning of new activity	Throughout 2014			While we agree with the spirit of this recommendation, we believe we need to take a pragmatic rather than dogmatic and arbitrary approach to this. The focus of commissioning activity needs to be on securing better outcomes within increasingly confined budgets, as well as looking for opportunities to remove duplication and de-commission services that are not making the best contribution towards outcomes.	Mid Essex Dilemma outside of frailty in light of resource allocation						This is entirely consistent with HWE's current strategy, and so can be supported.	
5.2.4	Those providing services are incentivised to work better together	Throughout 2014 and ongoing			We recognise how essential this is and have been working hard with the CCGs to better integrate our services. We have restructured our own internal organisation and appointed Integrated Commissioning directors aligned to each CCG. We have also created a single People Commissioning function under one accountable owner, ending the distinction between adults and children.								
5.2.5	Clear progress and improvement in the Health Executive's areas of focus	By January 2015			We agree with this recommendation and believe that the Health and Wellbeing Board and partners in Essex need to continue to put momentum behind work that is already underway. An Accelerated Design Event with partners in Essex recognised that if we are to make progress we need to prioritise key areas of activity and Older People/ Frailty and Learning Disabilities emerged as the key priority areas for accelerated focus.								
5.2.6	A culture of measurement, comparison, learning and improvement is in place	2015											

5.3.1	One pot of money alongside one set of outcomes	By Apr 2015	12		We agree with the concept of aligning budgets behind outcomes but do not think a single pot of money is necessarily the only effective way of delivering identified outcomes. This could equally be managed by aligning budgets around common outcomes and we are currently working towards such arrangements through our integrated plans with the CCGs.	We agree with the notion of aligning, pooling or delegating specific budgets around common outcomes but do not think a single pot of money should be looked at mechanistically as it is not necessarily the only effective way of delivering identified outcomes. This could equally be managed by aligning budgets around common outcomes and we are currently working towards such arrangements through our integrated plans with the CCGs. We suggest a pragmatic but ambitious approach going wider than government minimums and expect to work intensively with the Couunty Council on this over the next 6-9 months.							
5.3.2	A common, collaborative leadership across the Essex health economy	Winter 2015										HWE recognise the key role to be played by partnership boards in the future, and would welcome the opportunity to place patient and service user voice and lived experience at the heart of strategic decision making. It is vital that solutions to challenges facing health and social care are generated in a co-productive capacity. That said, any new partnership arrangements, such as the proposed 'Care Partnership', have to be fit for purpose and not produce a new layer of bureaucracy.	
5.3.3	Cradle to grave coordinated and convenient care is the norm in Essex	2016		Navigating the system: we are glad to see the report acknowledge that this is difficult, the ECN wants to work with their family carers to empower them. Information for our carers is fragmented; mainstream carer groups and organisations often have very few if any carers attending who care for a family member with a learning disability we need to be a conduit for our carers. The report talks about services being based increasingly on professionals working with people to develop individual services: this is where brokerage as mentioned above would be very useful. People who use services and family carers are ideal people to become brokers and support and empower others to develop person centred individual services.		AFFORDABLE							

Tendring District Council	North East Essex CCG	B&B CCG	Essex Cares	North East Essex Health Forum
TDC would like to see this section considered more broadly and perhaps more bravely. The current structure of public services in Essex should be fundamentally reviewed. We would want to see a partnership that seriously tackles the issues highlighted above, effecting real change and new approaches to commissioning and delivery. There also needs to be consideration to the tension between resourcing early intervention and prevention work and reactive acute services as this is missing from the report. The concept of the Community Budgets (and family solutions in particular) is a concept which should be adopted in taking this report forward. It needs to look at how to invest up front and reduce demand which will lead to better outcomes for less cost.		Integrated commissioning. In turn this may also pave the way for new health care trusts. Integrated provision - using the System Group to encourage providers to work closely together. Plus to consider provider incentives? We also propose to decommission services as they are replaced by improved ones. Potentially an area that CCGs cannot tackle in isolation.		We are very wary of the creation of a new Essex Partnership outside of existing arrangements. However, we can see the value of ensuring that all partners work together on core areas that pose significant care challenges, especially if this brings together health and housing provision.
			We would like to take a part in this area. It is evident that in the churn created by the introduction of new structures in Health in 2013 not all existing organisations in care and the 3rd sector have yet got a voice/been heard. Any move that enables better representation and the development of a unified approach to core challenges is welcome and we offer our support to developing this. We would welcome the opportunity to bring our expertise to such forum in the future.	
			We would like to take a part in this area. We believe that all leaders, in Health, care and voluntary organisation would benefit from mentoring and support. We are accredited under the Integrated Leadership Programme and committed to strengthening leadership.	
			We are keen to contribute to integration plans, but as providers not commissioners we do need to be assured that our contributions will be valued and that we will not be compromised by participation and sharing of commercial data.	
			We see ourselves as offering part of the solution to make this happen.	
			We see ourselves as offering part of the solution to make this happen.	
			We see ourselves as offering part of the solution to make this happen.	
TDC does not support the notion that where a new service is commissioned another service should be decommissioned. This is too simplistic and comes across as a sound bite. Commissioning should be based on need, when a new need is identified this does not automatically mean that a cut should occur in another area. The decommissioning of a service needs to be more considered.	Some services are amenable to commissioning uniformly across Essex. However, the local populations within Essex are very diverse and need careful attention to meet their unique circumstances. CCGs are well placed to for a focus for this. In addition key stakeholders such as Pharmacy, Community Services, Voluntary / Charitable organisations and GPs are tightly bound to local communities and will require a more locally engaging approach to successful transform their services to meet the aspirations in the report.		ECL totally supports this vision.	
			ECL totally supports this vision.	
			ECL totally supports this vision.	
			ECL totally supports this vision.	

	We recognise the potential of joint decision making and the purchasing power offered by commissioning jointly between health and social care. However, we remain focussed on the seamless services we desire for our population rather than the intricacies of formal pooling of budgets. We believe that we can achieve all the benefits of collaborative working without the delay and complexity of creating either an intermediate governance arrangement or a formal pooling of budgets. Instead, we suggest that jointly agreed specifications and gainshare / riskshare agreements will be far quicker to implement and far less costly to amend.		We would like to take a lead part in this area. We are clear that for this to be a seamless service offering care and support in an integrated way, then unified funding is key to this success.	
			We see ourselves as offering part of the solution to make this happen.	
			ECL totally supports this vision.	

	Who Will Care Commission: Prioritising analysis		Total	Essex Carers Network	Basildon Borough Council	Essex County Council	Mid Essex CCG - Simon Griffiths/ James Bullion	Uttlesford District Council & Voluntary Sector Board	SEPT	Voluntary Sector Training	Braintree District Council	Action for Family Carers	Supporting Carers & Families together
		Timescale											
6	**Thorny issues**												
6.1	Appropriate hspital discharge			In relation to discharge of someone with a learning disability we know that the learning disability liaison nurses placed in each of the hospitals in Essex work hard to get this right, however we also would like it acknowledged that these nurses are very stretched in their role which is much more detailed than hospital admission and discharge.	I'm already working with Tom Abell (CCG) and Ian Wake (ECC Consultant – Public Health) on this and will have data that could be used to help this review.							Action for Family Carers can contribute directly and knowledgeably to addressing this issue. We provide hospital-based carer support (at Broomfield Hospital, funded by Mid Essex CCG). There is great demand for this service yet it is the only such service in Essex. We are addressing issues in the system, working on policy as well as working at the front end to create a model which can be replicated across other hospitals. There is a major issue with communication and information sharing between clinicians and patients and carers, as well as the ongoing issue with delayed transfers of care due to poor integration of health and social care services. We are able to manage the transition between services, providing a single point of contact for Carers.	Hospital discharge seems to be a bit of a lottery from the feedback my organisation receives from carers. It is either good or awful - from the same hospital! this really is an area for a single process to be implemented to ensure people are not falling between the gaps and ending up back in hospital immediately. Definitely an area to develop with service users from the good and bad ends of experience.
6.2	Learning Disabilities			The report asks whether services for people with a learning disability and their families is optimal given the large financial investment. The confidential inquiry into the premature deaths of people with a learning disability (http://www.bristol.ac.uk/cipold/fullfinalreport.pdf) showed that men with learning disabilities die on average, 13 years sooner than men in the general population, and women with learning disabilities die 20 years sooner than women in the general population. This indicates there is work to be done regarding effective use of resources to bring about positive life experiences, health and wellbeing for people with a learning disability. As a network the ECN want to be fully involved in looking at the current situation in Essex and the potential solutions; as some very good friends with learning disabilities say "nothing about us without us!"	The above problem areas would be discussed as part of the new Care Partnership.							Action for Family Carers works directly with Carers of people with learning disabilities and will support efforts to ensure that future support better addresses their situation and needs.	We should be treating all patients with dignity and respect regardless of their ability, race, culture, age, sexuality or religion and ensuring they do not feel undermined or marginalised by their experiences, life is difficult already, it does not require professionals to compound the situation. Again those with learning disabilities accessing services need to be the shapers of future services. The Stay Safe Group will be a fantastic asset in helping to achieve improvements and efficiencies.
	Other			The report says that services must meet the needs of the people not the preconceptions of those who draft current tenders for services; this builds on our belief that user groups including the ECN must be involved at a strategic level to support those who commission services and work with providers to ensure they are fit for purpose and effective; don't tell us what we need ask us! • The report talks about a focus on community activity and preventative work, we welcome this and want to continue to be part of this, it is important to remember that the voluntary and third sector groups and networks who are already trying to do this and want to continue and do more will need to be given the resources to enable them to do this. We believe that people can make good decisions about their health and wellbeing if they have access to good information when they need it. We feel as a network we can support our families to navigate the system.		We support this and recognise that it is the present direction of travel. This is why, with health colleagues and the Anglia Ruskin Health Partnership, we have already begun to develop a leadership programme for the next level of health and social care senior managers. The programme will include the rotation of managers between health and social care teams.	Mid Essex CCG welcomes the report and in particular thinks there are 3 priority responses: (i) a new level of public expectations through local dialogue with people (in line with the call to action) to faciliate preventative self action and minimise immediate and future costs (ii) integration of commissioning and services between health, social care and housing as this underpins much of the work, and (iii) freedom for innovative service models which target and prioritise need but which underpin universal services.	We would very much like to put this paper to the Essex Health & Wellbeing Board for consideration and as the Board is meeting in Uttlesford on the 21 November we will endeavour to provide a paper prior to that date.	We welcome the aspiration that the public services should be bolder, better coordinated, easier to access and more convenient and flexible to use. We also welcome the intention to shift money away from hospital care and to community, mental health and support at home. We are hesitant about the aspirational nature of some of the aims not that they are not worthy but we wonder how Essex leaders will be able to impact on the pressure outside of our control. In particular national reductions in funding for the NHS and local government and the need for councils to cap council tax spending locally.	VST welcomes the Report's recognition of the current and potential roles for the VCS and communities and for highlighting specific actions to support these roles. VST would welcome the opportunity to deliver the required training topics to support volunteer and voluntary and community sector engagement across health and social care.	Keen to play their part and work with us on all 5 high impact solutions. Role of Districts in healthy lifestyles with BDC having many leisure facilities including new multi-use leisure facilitiy in Witham opening summer 2014. New leisure providr is extending wellbeing clasess outside of current facilities into rural areas.		

North East Essex CCG	North East Essex Health Forum
A clear delivery plan is needed to ensure all Essex residents can play their part. Residents should be involved in drawing up the engagement plan. Finally, we would like to note that we understand people's concerns about access to primary care and the importance of this in managing their own care. We recognise that lifestyles have changed and that models of care need to adapt. However, we would also like the issue of understaffing in primary care to be acknowledged: an issue that particularly affects Tendring.	- See ageing as a creative enterprise - Move care from the medical to the social sector - Reconciling self-care and mutual-care. - Avoid institutional dominance. - Maintain autonomy, security and safety. - Political participation. - Accountability and empowerment. - Equity within free health care and self-funded. - The importance of mental activity. - Social contact and strengthening relationships. - Against inward looking organizations. - Against ageism and negative stereotyping. - Against limited choice. - Foster life-long-learning.

Essex Health and Wellbeing Board	**HWB/19/13**
Date: 21 November 2013	

A vision for the West Essex health and care system

Report by Clare Morris, Chief Officer, West Essex CCG

Enquiries to Clare Morris

The format for the information to be covered in a report is set out below.

Purpose of report and Decision Areas and Recommendations	To provide the Board with an overview of the key elements of the emerging vision for health and care commissioning and services in West Essex. West Essex remains one of the most financially challenged economies in the region. The vision sets the scene for the forthcoming business planning round and for integrated commissioning discussions between the CCG and Essex County Council. The Board is asked to consider how the plans fit with the wider Essex Health and Wellbeing Strategy.
Background and context.	This is the first major piece of strategic planning work undertaken in West Essex jointly by health and social care since the implementation of the NHS reforms in April this year. A full programme of public engagement was undertaken as part of the process and to inform the direction of travel. This was a joint process between health and social care and commissioners and providers. There is strong alignment between the West Essex vision and the findings of the 'Who Will Care' commission. West Essex intends to implement the findings of the commission that fit well and enhance local plans. There is strong interest in community mobilisation and good emerging local system governance arrangements to support this. The vision is a 10 year view in order to ensure long range enablers such as IT and estates can be addressed. The first wave of exemplar schemes and implementation plans for 2014/15 will be set out in the West Essex Integrated

	Plan for approval by the Health and Wellbeing Board in March 2014.
Options/Proposals	n/a
Equality and Diversity	An EIA will be undertaken as part of the integrated plan process.
Background Papers	The fuller document is available on the CCG website: http://www.westessexccg.nhs.uk/Document%20Library/board-papers.htm

My health
My future
My say
Your healthcare over the next ten years

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My health, My future, My say

A vision for the west Essex health and care system

2014 - 2024

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My future
My say
Your healthcare over the next ten years

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West Essex
Clinical Commissioning Group

The challenge we set ourselves

Set a vision that will:

- Put our patients at the centre - quality and outcomes
- Determine and deliver the future model of the health and care system in west Essex
- Underpin plans that will secure both financial and clinical sustainability for this local system and a phased programme of implementation from April 2014.

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Why the vision?

- 65 years ago - The NHS was founded to treat people when they are ill
- Now- evolved to prevent people becoming ill, treat those already ill, prevent health and wellbeing getting worse
- Context of population growth, inequalities and reduced resources
- What our patients are telling us
- = Health and care services and professionals need to work differently with us

Population Growth	By 2024 National	By 2024 WE
0-19 years	10.26%	14.92% (10.7k)
20- 74 years	4.82%	8.1% (15.8k)
75 years plus	36.86%	36.6% (8.9k)
Total	8.7%	12.1% (35.5k)

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Balancing the financial challenge, improved care and provider sustainability

- Continue to deliver the same to meet demand = £87 million debt
- Focus on value to patients – can we spend money differently?
- 55% of NHS money spent on hospital care- need to spend less

	2013/14	2014/15	2015/16	2016/17	2017/18
Transformation/ QIPP	£20.000m	£10.089m	£13.604m	£9.941m	£8.353m
	5.2%	3.2%	4.4%	3.2%	2.7%

But:

- Acute hospital - less income
- Need to change
- Need whole system approach

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Our underlying principles

1. **Quality first -** Patient safety, clinical effectiveness, improved clinical outcomes and care for people as people
2. **Significantly shifting the point of care -** right care is provided at the right time and in the right place
3. **Integration** between health and social care as a key enabler for delivery
4. **Connected transition of care** and support between professionals and organisations
5. Provision built around and **responsive to the different needs** of our communities and localities
6. Maximise **productivity and efficiency** where appropriate
7. Allow individuals to **take responsibility for their own health and retain independence** where appropriate.

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Success will depend on

- Pursuing integration
- An enlarged primary care sector
- Mobilising our communities
- Partnership and collaboration
- Key enablers - Information systems, workforce, contracting

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Your healthcare over the next ten years

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What has been the process?

- *My Health, My Future, My Say* campaign
- Clinical leadership- clinical models
- System governance

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Outcome of communications and engagement

August and September 2013




Wendy Smith, Independent Communications Adviser

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We reached out

- Forums and meetings
- Special interest groups
- Online survey
- Open workshops in each locality
- Focus groups – patients, carers, vol. sector, staff
- Pop-up stalls in markets and shopping centres
- Leaflets and questionnaires in libraries, sports centres as well as the usual distribution

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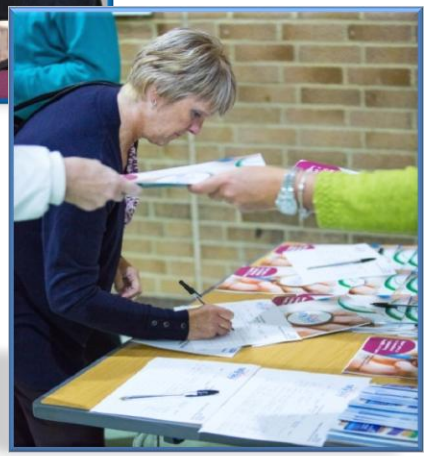
Who responded?

- Voluntary sector
- Frontline staff
- Patient and public representatives
- Local authorities and councillors
- People with learning disabilities
- Young people – Harlow Youth Council
- Ethnic minorities – Integration Support Services
- Over 580 people took part in our survey



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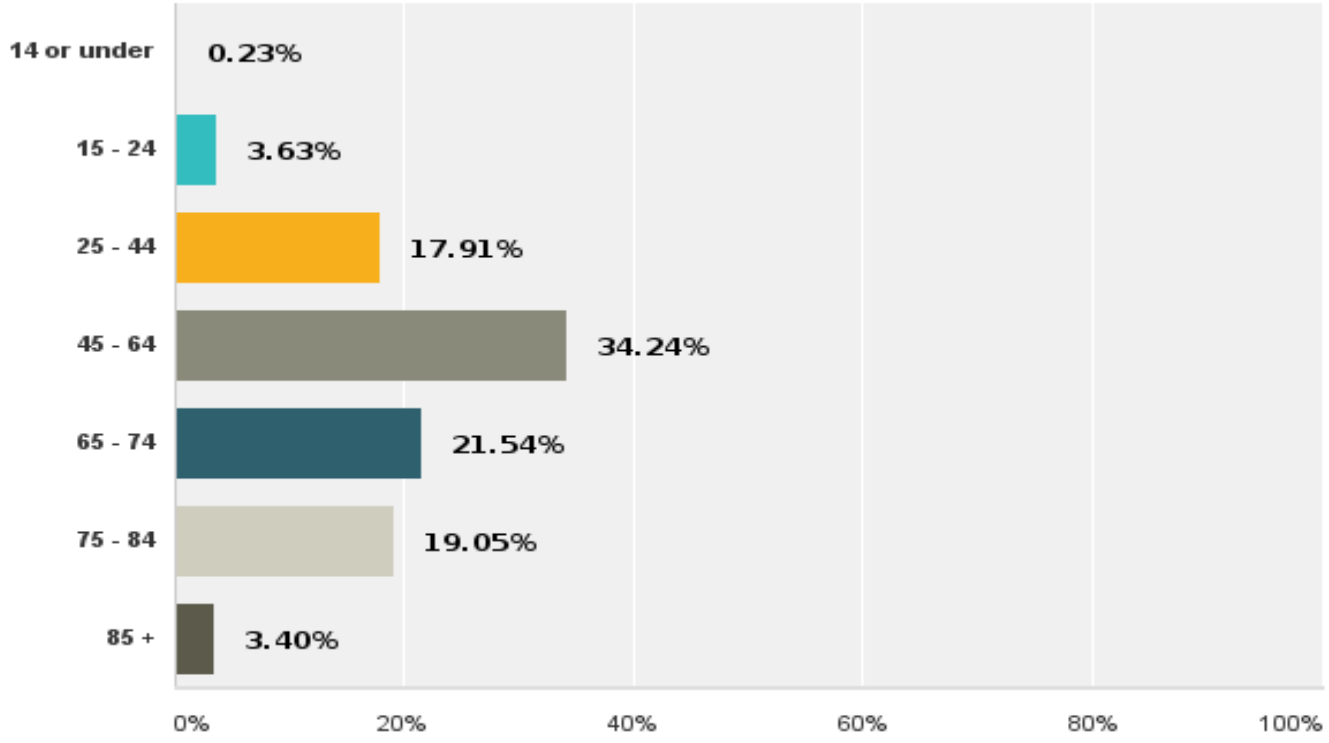
Q10 About you: Please select your age group from the list below

Answered: 441 Skipped: 101



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GPs at the centre, but we can be part of it

1. People should take more responsibility, give us the tools
2. Prevention – and person-centred
3. Care for people as people
4. Minor problems are important
5. Single points of contact – also to support GPs
6. Integrated care – and transferable skills
7. Financial contribution

Keep our NHS public!

My health
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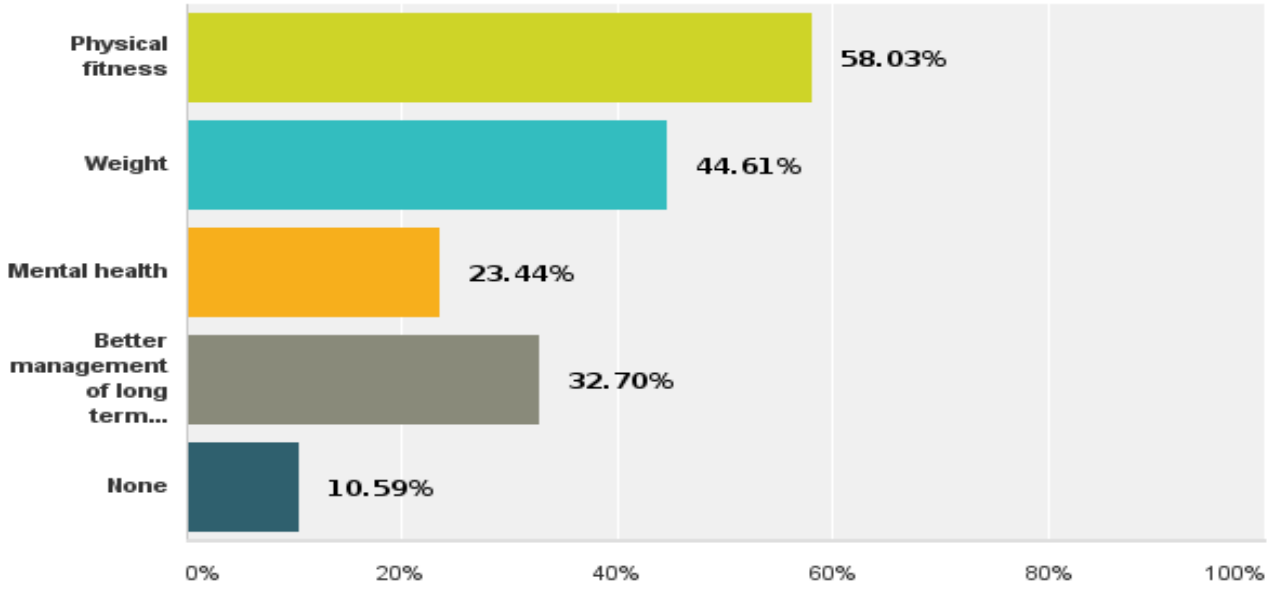
Personal responsibility

Q1 Over the next ten years: What aspects of your health would you like to improve?

Answered: 529 Skipped: 28



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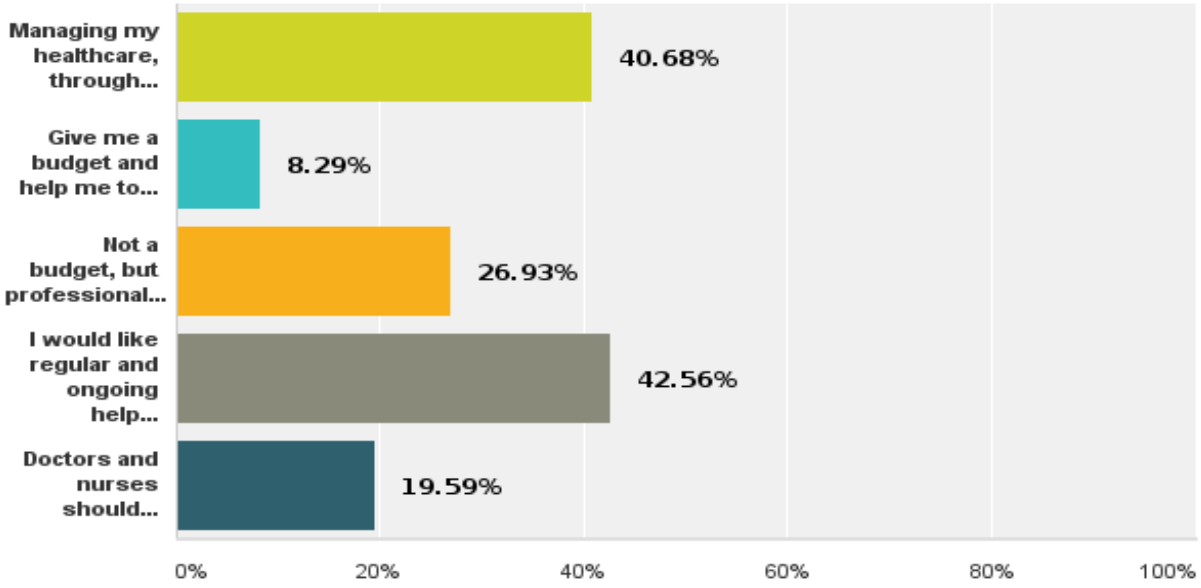
Personal responsibility

Q5 What best describes the way you would want to manage your healthcare in ten years' time? (please tick)

Answered: 531 Skipped: 26



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Prevention – and person-centred

Care for people as people

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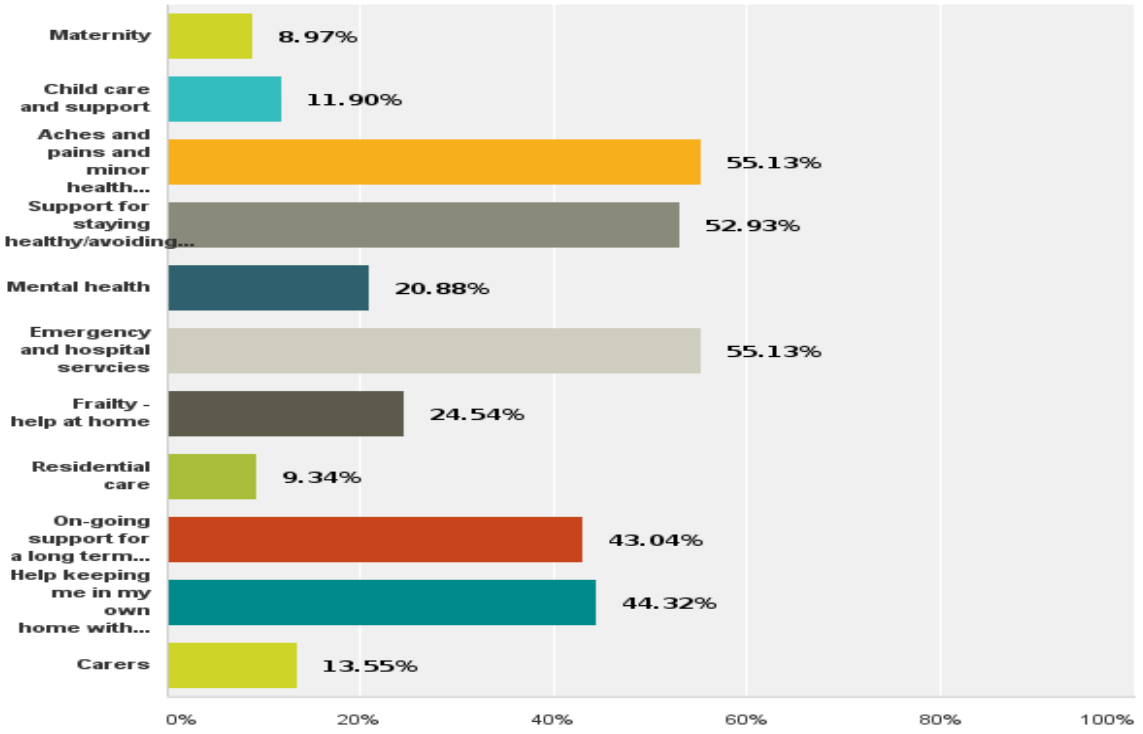
Minor problems are important

Q4 Please can you list what you think your priorities might be over the next ten years from the following services. Please tick the five that are most important to you.

Answered: 546 Skipped: 11



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Single points of contact – also to support GPs

Integrated care – and transferable skills

Eg Areas highlighted for improvement

Main points from feedback	%
Access, mainly to GP services	41
Courtesy, dignity, respect	19
Integration / communication between services	6
GPs as personal gateway	4
Staff training	4
Help for older people	4
Wellbeing	2
General standards	2
Access, mainly to GP services	1
Mistakes	1

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Financial contribution

- Payment for low priority procedures
- Payment schemes eg for meals in hospitals
- Fines for missing appointments
- Contributions for treatment of self-inflicted problems eg drunkenness
- Health tourism

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Person-centred care

Group	Key points
Patients and public	• Taking responsibility – change culture of dependency
Carers	• Support for carers • Listen to patients and carers
Vol. sector	• Person first – doing “with” not “to” • Holistic approach • In control of your own recovery – fully informed • Single point of contact
Professionals	• Services tailored to needs, meaningful to family • Listen, agree, review • Choices and goal setting

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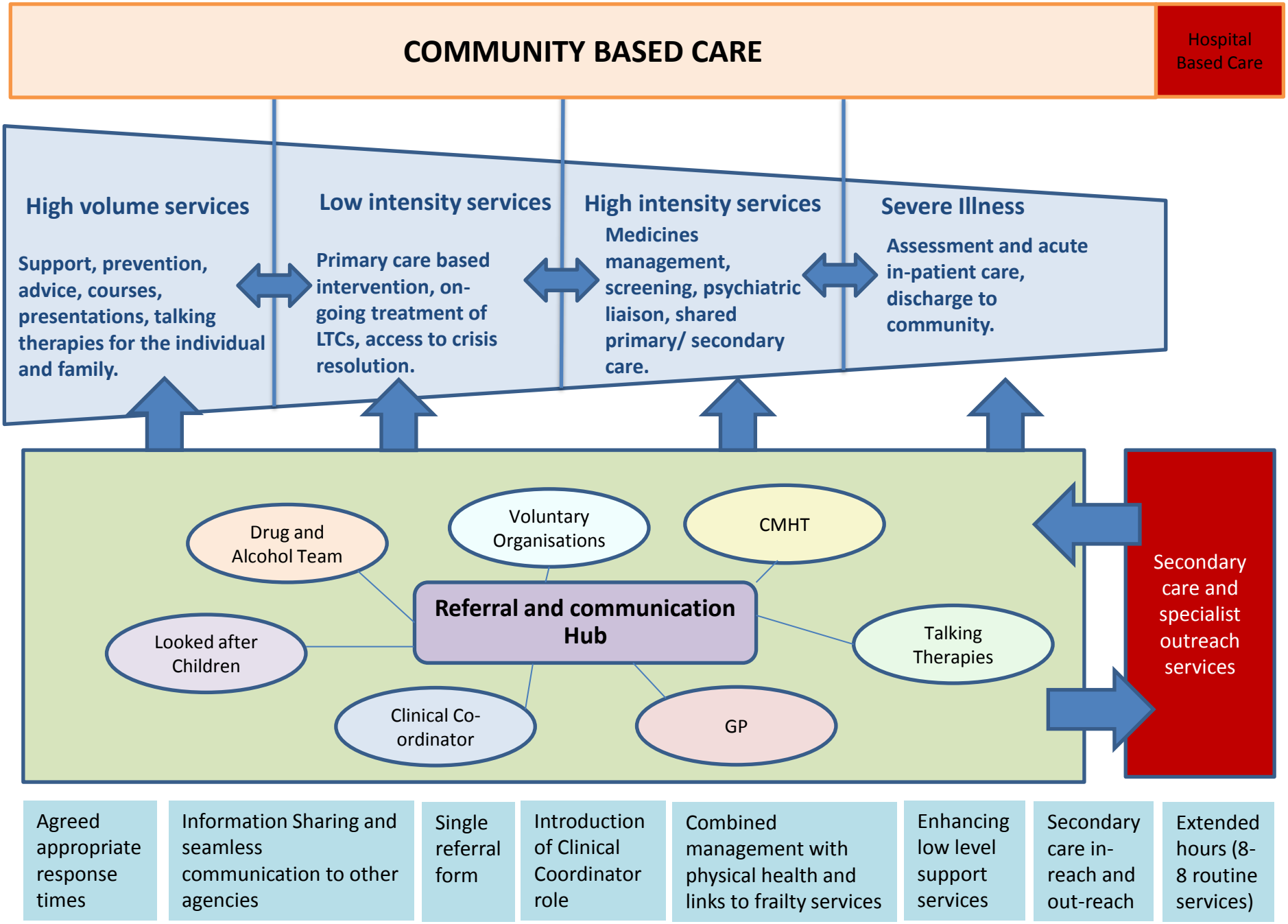
What our professionals told us

- Co-morbidities
- Investment in prevention
- Supporting self care
- Connected care
- Focus on carers
- Building resilience in communities
- Best practice in data, technology
- Incentives and levers
- Culture
- System planned by clinician
- System organised/no barriers

1. Frailty
2. ACSC
3. Children's
4. Maternity
5. Mental Health

Adult Mental Health



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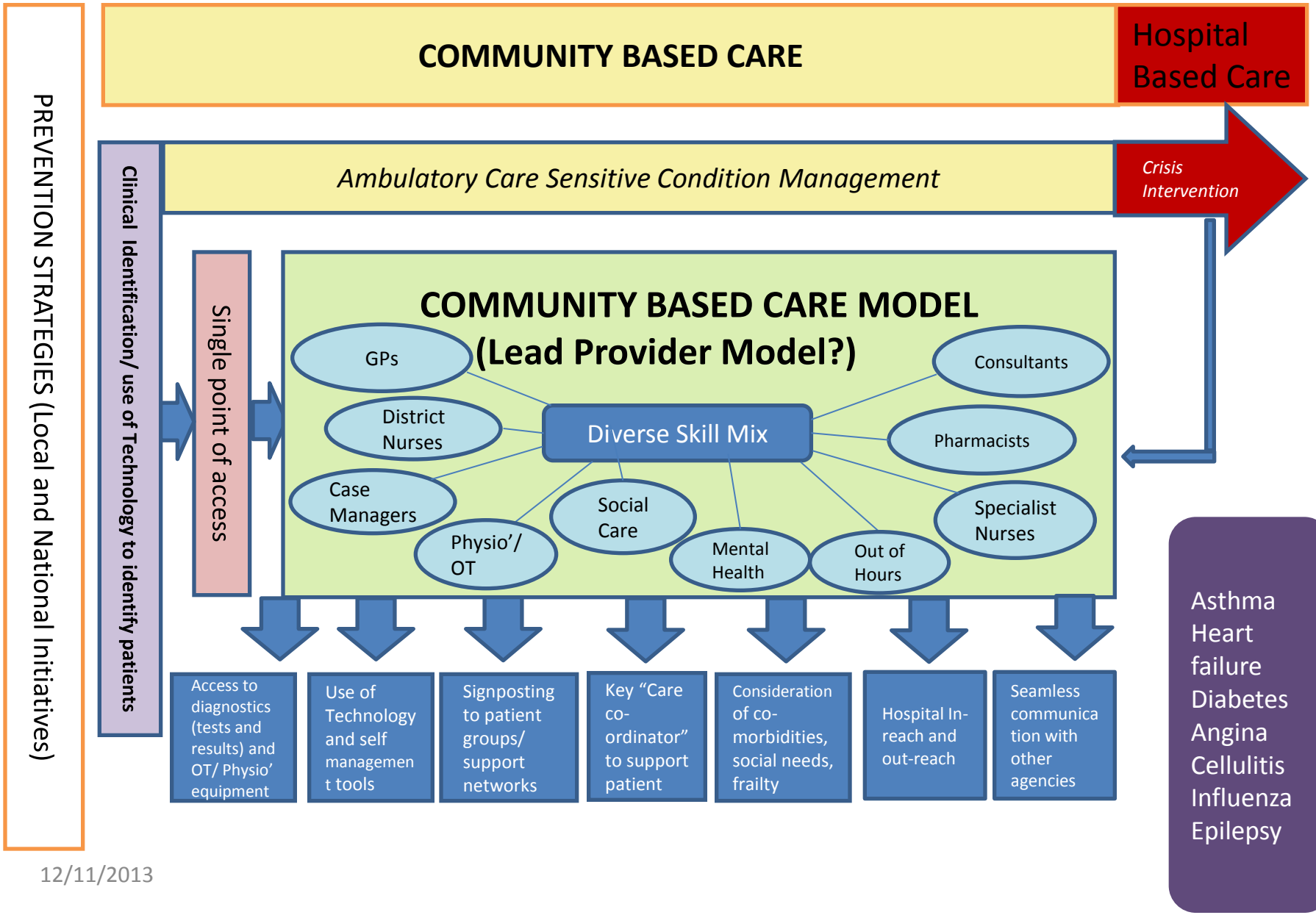
Adults living with mental illness

What improvements will mean for patients

- better prevention of mental ill health
- quicker responses to early signs of mental ill-health
- more people with mental ill health living independently (with support) at home or in the community
- better co-ordination of social and mental health needs, including housing and welfare
- better physical health for those with mental ill-health
- better responses to crisis and acute episodes of mental ill-health, resulting in shorter acute stays and fewer readmissions
- better support for the carers and families of those with mental ill health.

Emerging model: Ambulatory Care Sensitive Conditions Model



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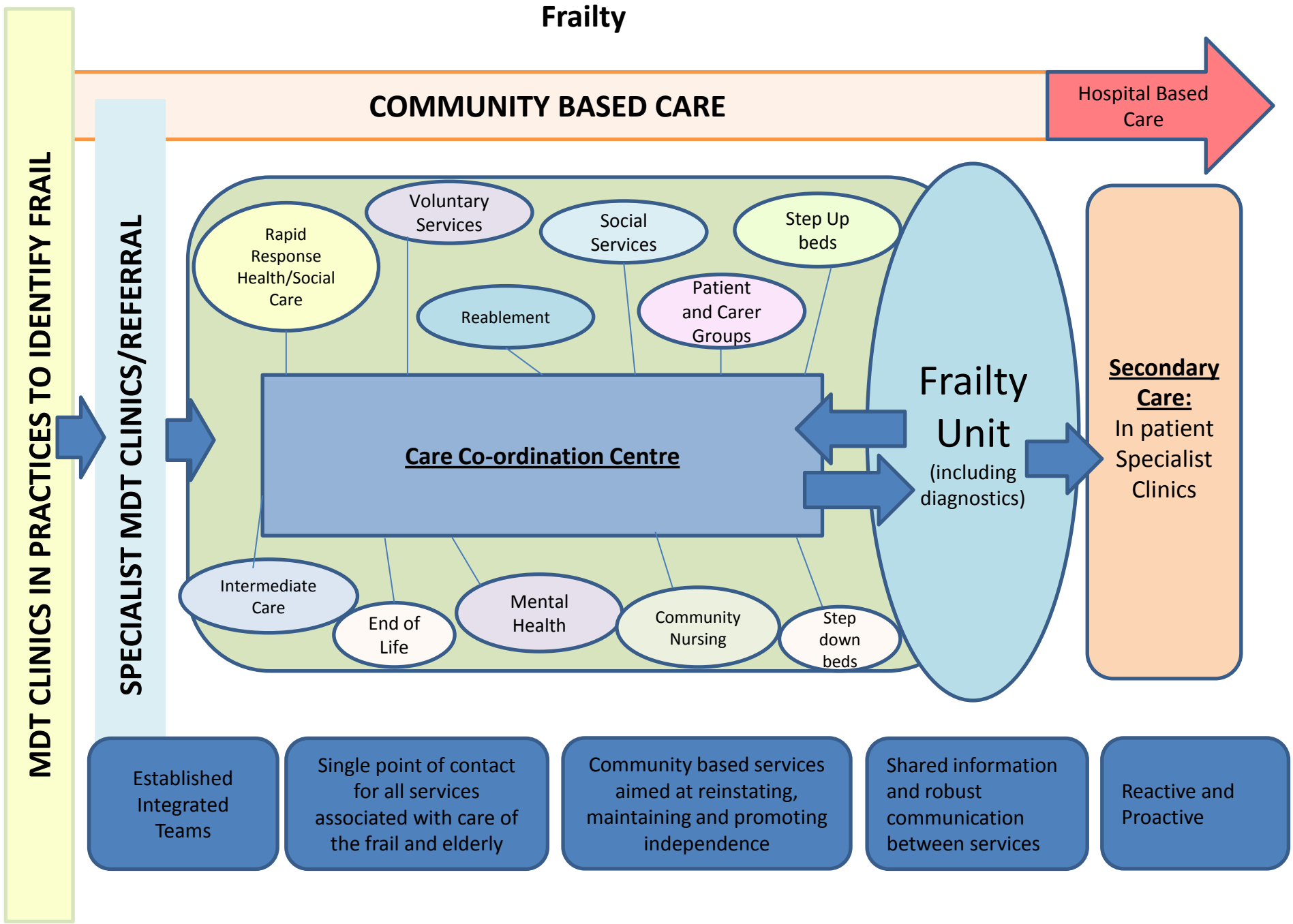
Living with long term illness and chronic conditions

What improvements will mean for patients

- better prevention of ill health
- quicker responses to early signs of ill-health
- people with ASCS conditions living independently (with support) for longer at home or in the community
- better responses to crisis and acute episodes of ill health, resulting in shorter acute stays and fewer readmissions
- better support for the carers and families of those with ACS conditions


Frailty
COMMUNITY BASED CARE
Hospital Based Care
MDT CLINICS IN PRACTICES TO IDENTIFY FRAIL
SPECIALIST MDT CLINICS/REFERRAL
Rapid Response Health/Social Care
Voluntary Services
Social Services
Step Up beds
Reablement
Patient and Carer Groups
Care Co-ordination Centre
Intermediate Care
End of Life
Mental Health
Community Nursing
Step down beds
Frailty Unit
(including diagnostics)
Secondary Care:
In patient Specialist Clinics
Established Integrated Teams
Single point of contact for all services associated with care of the frail and elderly
Community based services aimed at reinstating, maintaining and promoting independence
Shared information and robust communication between services
Reactive and Proactive

My health
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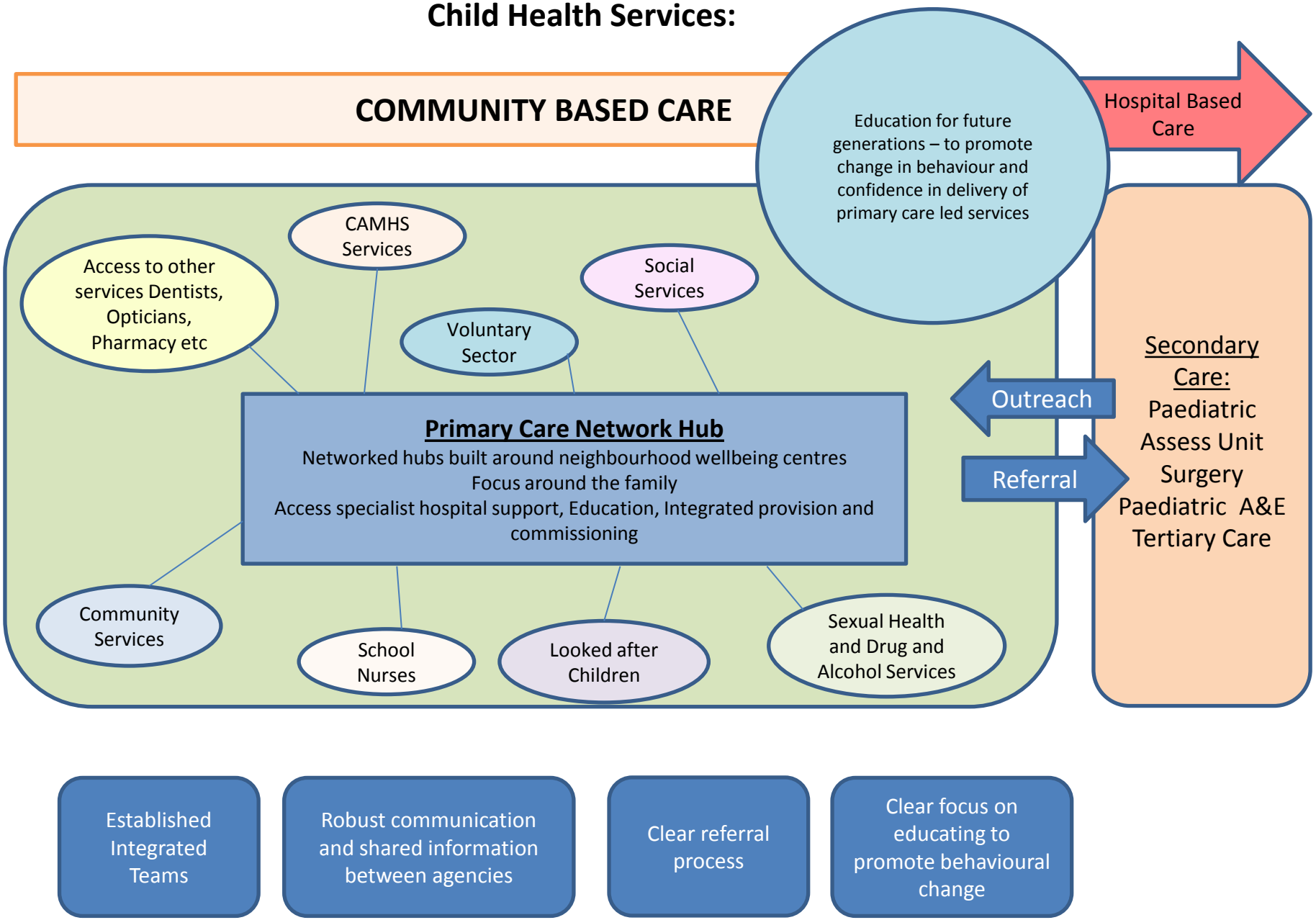
Frail and older people

What improvements will mean for patients

- improved quality of life and independence for the frail and vulnerable
- better prevention of ill health
- quicker responses to early signs of ill-health
- better responses to crisis and acute episodes of ill health, resulting in shorter acute stays and fewer readmissions
- better support for the carers and families of the frail and vulnerable

Child Health Services:



Established Integrated Teams

Robust communication and shared information between agencies

Clear referral process

Clear focus on educating to promote behavioural change

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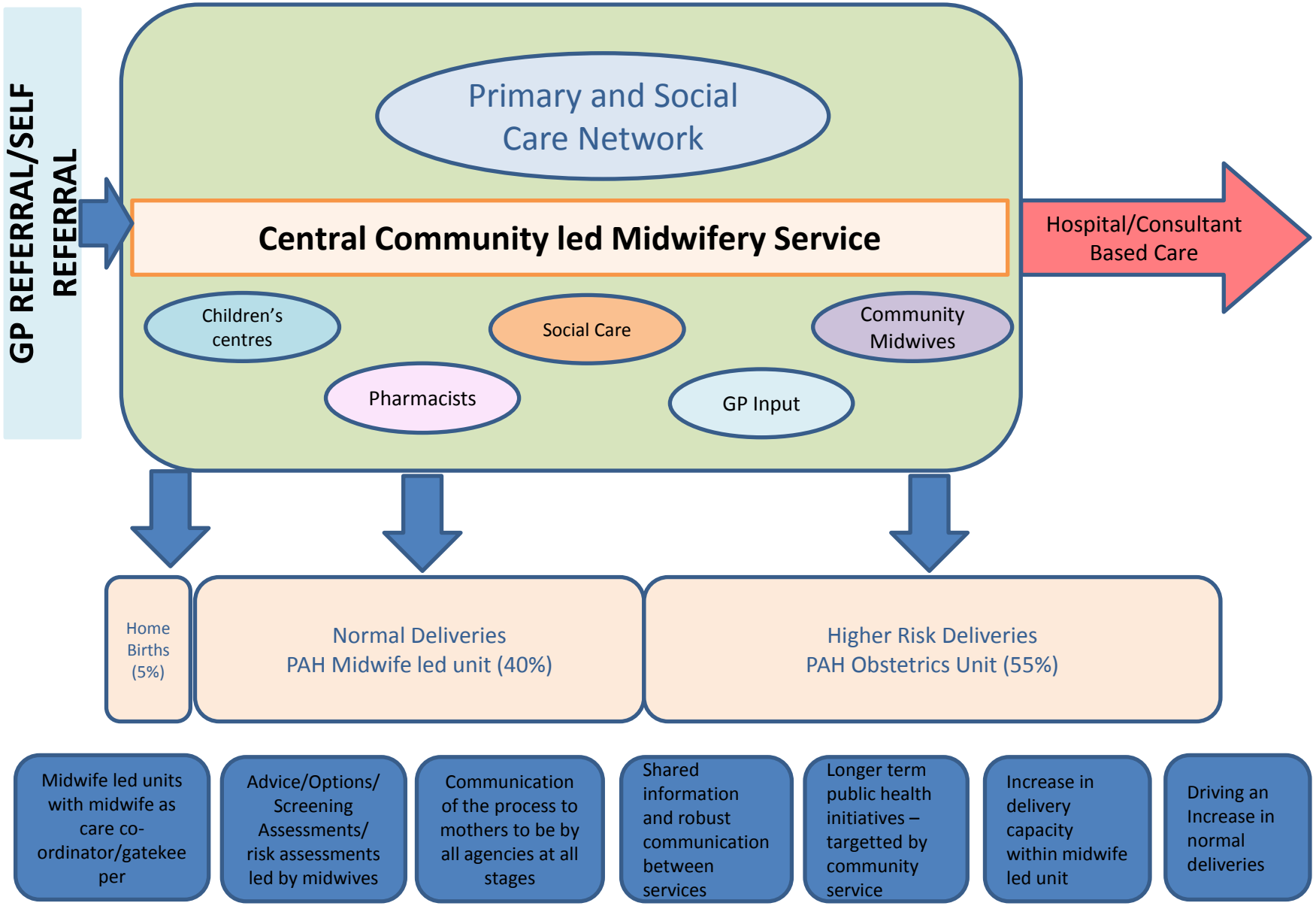
Children

What improvements will mean for patients

- better protection of vulnerable children and those at risk.
- quicker responses to early indicators of risk
- better management of low level illness and long-term conditions in non-hospital settings
- better responses to crisis and acute episodes of poor health, resulting in shorter acute stays and fewer readmissions
- better support for the carers and families of children with poor health

Maternity


GP REFERRAL/SELF REFERRAL
Primary and Social Care Network
Central Community led Midwifery Service
Hospital/Consultant Based Care
Children's centres
Social Care
Community Midwives
Pharmacists
GP Input
Home Births (5%)
Normal Deliveries
PAH Midwife led unit (40%)
Higher Risk Deliveries
PAH Obstetrics Unit (55%)
Midwife led units with midwife as care co-ordinator/gatekeeper
Advice/Options/ Screening Assessments/ risk assessments led by midwives
Communication of the process to mothers to be by all agencies at all stages
Shared information and robust communication between services
Longer term public health initiatives – targetted by community service
Increase in delivery capacity within midwife led unit
Driving an Increase in normal deliveries

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Maternity

What improvements will mean for patients

- More comprehensive uptake of prenatal care services
- More patient choice in place of birth
- Fewer complicated pregnancies as a result of improved prenatal care
- Higher patient satisfaction in the delivery of birth plans in accordance with patient wishes.

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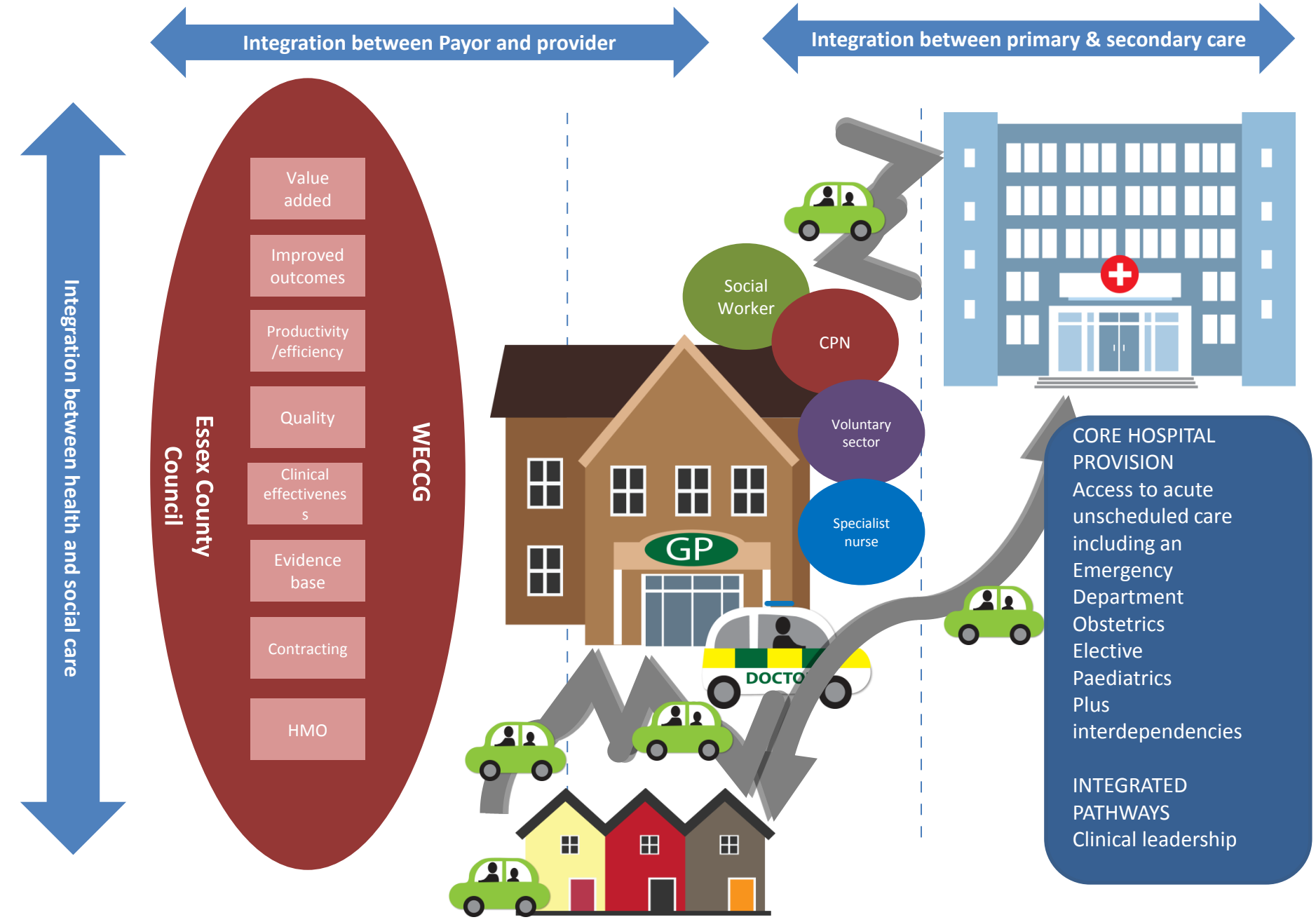
Common themes how services are provided

- Significant shift of point of care to out of hospital setting
- Community/primary care hubs
- Integrated community provision (primary care, social care, community, voluntary sector)
- Primary care led pathways/Consultant led pathways
- Care co-ordinators / Gatekeepers
- Extended routine provision
- Outreach from secondary care/In-reach to secondary care
- Preventing crisis- access in times of crisis

The system as a whole



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What we expect for primary care

Vision:

- Integrated with other providers, providing a seamless service to patients.
- High quality and accessible, offering a wider range of services across the week from a number of healthcare facilities.
- Practices working together to provide efficient services, sharing skills as appropriate.
- The coordinator of the healthcare system from a patient's perspective.

Opportunities:

- Lead responsibility to invest current resources
- Keeping care local
- Direct influence over provision
- Better patient outcomes
- Career progression
- Recruitment and retention
- Estate and environment
- Expansion and/or security
- Financial sustainability

But…..

- Requires collaboration between practices – need for scale
- Requires primary care leadership
- Stronger business models… systematic processes and governance
- Need for pace

My health
My future
My say
Your healthcare over the next ten years

NHS

What we expect from our local acute hospital

CORE HOSPITAL PROVISION

- Access to acute unscheduled care including an Emergency Department
- Obstetrics
- Elective
- Paediatrics
- Plus interdependencies

OPPORTUNITIES - TRANSFORMATION

Primary Care & Secondary Care Integration…

- Unscheduled care in the community/frailty
- Management of Long term conditions/ Ambulatory Care Sensitive Conditions
- Workforce development
- Maternity

Market share…

- Elective repatriation
- Pathways review
- Maternity

Creating Capacity….

- Frailty (Scope - 15% non elective activity)
- Hospital without walls
- ACSC
- Social care integration (re-ablement)

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

Integration

Brings together organisations:

- Deliver consistent and coordinated care
- Higher quality care
- Improve efficiency also control costs

Essex County Council

Levels of integration:

- Between primary care secondary care
- Between health and social care
- Between payer and provider

NHS
West Essex
Clinical Commissioning Group

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

Mobilising our communities

Voluntary sector and volunteering

- Gathering intelligence
- Delivering services
- Navigation of services
- Innovating
- Part of an integrated system

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

Turning the vision into reality

The enablers:

- Transforming commissioning - for outcomes , value added, lead provider model
- Technology- integrated systems, apps
- Workforce- development
- Estate- utilisation
- Provider development and contestability- choice
- Working with local people - new era

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

Next steps -Business Planning for 2014/15

CCG Board approved Vision for West Essex System

System wide agreed vision and principles

Business Plans 2014/15 – Demonstrators

Approved by CCG Board

System governance

Programme mobilisation

Preparations for implementation

Transformation implementation 14/15

October | November | December | January | February | March

Busness Initation Documents- 2014/15 Demonstrators

System Wide Agreement

System governance

System clinical leadership

CCG Integrated Plan

Commence

Financial Framework including capacity plans

14/15 Agreed with local providers

CCG Financial Plans Approved

Board approved 2014/15 budgets

CCG integrated Plan Approved

CCG Board & Health & Wellbeing Board

Contract negotiations

Budget setting

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

What will we see from April

As a starter:

- Integrated provision - frailty, diabetes, respiratory plus
- New commissioning models- Lead provider/outcome based
- Integrated commissioning- Older people, LD, Children's
- Increased local provision low acuity mental health
- Mobilising communities- voluntary sector development
- Mobilising primary care- extended provision, collaboration
- Implementing plans for system sustainability – clinical, financial and capacity
- CCG Organisational development- fit to deliver

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

What will this all mean for our patients

- Supported independent living
- Prevention of crisis- access and response to crisis when needed
- Co-ordinated care
- Connected care across organisations
- Avoiding and shortening hospital stays
- Local and extended access to range of services
- Support for carers, families and vulnerable
- Community support networks

My health
My future
My say
Your healthcare over the next ten years

NHS
West Essex
Clinical Commissioning Group

My health, My future, My say

A vision for the west Essex health and care system

2014 - 2024

Essex County Council

Report to Health & Wellbeing Board Report of Executive Director (People)	**Reference number HWB/020/13**
Date of meeting 21 November 2013 **Date of report** 1 November 2013	**County Divisions affected by the report** All
JOINT STRATEGIC NEEDS ASSESSMENT – COUNTYWIDE VIEW 2013	
Report by Executive Director (People)	
Enquiries to Duncan Wood (Insight & Analysis Adviser) or Loretta Sollars (Head of Insight & Analysis)	

1. Purpose of report

1.1. The purpose of this report is to advise the Board of the refreshment for 2013 of the countywide view of the Joint Strategic Needs Assessment.

1.2. In particular, the Board is asked to note the Key Issues identified on page N of the attached countywide JSNA.

2. Recommendations

2.1 Approve the attached countywide JSNA overview for publication.

3. Background and proposal

3.1 There are three types of strategic JSNA report in Essex:

- A countywide overview
- 12 city, borough or district overviews
- 5 clinical commissioning group overviews

3.2 All three reports are being refreshed in 2013.

3.3 A major review of evidence took place in 2012 for the countywide overview that informed the creation of the new Joint Health & Wellbeing Strategy.

3.4 For 2013, that evidence is simply being updated. Formally, the attached JSNA countywide overview report follows very similar lines to last year's overview. However, one important structural change is the incorporation of 'voice data', ie, evidence of public and service users' experiences and opinions, into each chapter. This is part of a move to making such evidence fundamental to identifying issues, rather than merely illustrative.

3.5 The work of Healthwatch Essex and the County Council's social care user groups, as well as survey evidence of the views of the general public, has been drawn on in the writing of this overview.

3.6 The next major rewriting of the countywide JSNA will occur in time to shape the creation of a new three-yearly Strategy.

4. Policy context

4.1 The JSNA in its various forms – as the three types of strategic report or overview discussed above, or as special topic reports – should underpin the commissioning intentions of local government and the local NHS in Essex.

5. Financial Implications

5.1 There are no direct financial implications from this report.

6. Legal Implications

6.1 There are no direct legal implications from this report.

7. Staffing and other resource implications

7.1 There are no direct staffing or resource implications from this report.

8. Equality and Diversity implications

8.1 A core purpose of the JSNA is to explore inequalities in health and other circumstances and to review evidence of what works in reducing these

inequalities. These inequalities may be defined geographically, socio-economically or in terms of protected characteristics, though data may not always be available in respect of every characteristic. Every effort will be made to break data down to support analysis of inequalities.

9. Background papers

9.1 Existing JSNA reports can be seen on Essex Insight: http://www.essexinsight.org.uk/grouppage.aspx?groupid=19

Essex Joint Strategic Needs Assessment – Countywide Report 2013

Executive Summary

Essex Population and Health Determinants

The population of Essex is close to 1.74 million (including Southend and Thurrock) with Colchester Town and Chelmsford city [1]being the largest urban areas. The older population is expected to grow to 28% by 2033, with a 15% reduction in the working age group. Currently 10.5% of the population are from ethnic backgrounds (9.2% for Essex) and 30% of travelling families in the county live on unauthorised sites. Essex has some of the most affluent and some of the most deprived areas in the country, with further pockets of disadvantaged communities that are hard to identify.

Employment opportunity, mental health and educational achievement have a strong association. Although the Essex unemployment rate is lower than the national rate, there is a nearly threefold variation between districts (from 13.2% to 4.6%). The working age population is ageing and the level of adult qualifications is low. The number of young people in Essex not in education, employment or training (NEET) is higher than national and regional averages but has reduced slightly over the last year. Young people from more disadvantaged communities are at a higher risk of becoming NEET.

Effective and efficient transport can support people in having good access to services and is essential to local economic prosperity but must be at a reasonable cost, in reasonable time and with reasonable ease. There should be clear strategy for promoting walking and cycling as well as good road safety measures.

Crime and community safety continue to be highlighted as a priority by the residents of Essex. The issues of domestic abuse, violence and burglary link closely with other issues related to criminality such as drug and alcohol misuse and anti -social behaviour.

Decent, affordable and appropriate housing is increasingly needed to meet the current and longer term needs of the people of Essex, especially with the rise in older residents, people with a disability and other vulnerable groups. Poor housing conditions, including heating deprivation, is a local concern in our disadvantaged communities. Welfare reform also has serious consequences for housing which need to be monitored.

In regards to environmental issues, Essex is doing well in waste management and in implementing measures to keep air pollution low, but with increasing housing development, making these improvements sustainable will prove a challenge. Essex is also highly dependent on non renewable energy.

Essex has a number of poverty related issues, especially in Harlow where the level of house ownership is very low and the level of benefit claimants is high. Building strong social capital can help reduce childhood poverty, which in turn will provide the right opportunities for young people and the community to flourish.

Community cohesion cannot be maintained without balancing the need for targeted and universal interventions and explicitly addressing the socioeconomic wellbeing of communities, including engaging with young people, enabling social inclusion for marginalised groups and instilling a sense of localism.

Health, Community Wellbeing and Inequalities

Although the trend in life expectancy is upward, there is a 3.5 year gap between males and females across Essex, with more inequalities in disadvantaged communities. There is a 17% difference in people's perception of their quality of life between the best and worst districts in Essex.

There is a decreasing trend in cancers across Essex but we have geographical and gender differences. Survival rate is dependent on early diagnosis as well as good prevention programmes.

There is a decreasing trend in cardiovascular diseases (CVD) across Essex but we have geographical and gender differences. With an ageing population, and early identification of CVD including current undiagnosed cases, the prevalence is likely to be much higher.

Although mortality for respiratory diseases such as Asthma and Chronic Obstructive Pulmonary Disease (COPD) is on the decline, the level of morbidity can be reduced with good policy measures and prevention work especially around smoking.

The mortality and morbidity rates for conditions related to liver disease are increasing, especially among younger people, primarily due to the excessive consumption of alcohol.

The prevalence of diabetes is likely to rise over coming years, especially with better ascertainment and poor lifestyle choices.

The level of accidental mortality and intended deaths is relatively high in Essex, with the home and roads being the most common sites.

Largely preventable accidental falls continue to have a significant impact on quality of life and independent living as well as a significant contribution financially.

With a growing ageing population, good falls prevention work can contribute to low levels of morbidity and mortality. A number of districts in Essex have levels of excess seasonal deaths, which could be caused by fuel poverty, exceptional warm weather, poor safety at home and the severity of flu outbreaks.

After a gradual increase in mortality rates from communicable diseases there has been a reduction across Essex, possibly as a result of better surveillance and increase in immunisation rates.

Over 150000 Essex residents are expected to be living with a mental health illness, with almost 50% of them having developed this condition in their early teens. The prevalence of dementia, which increases rapidly with age and , is projected to increase by 38% by 2021 which will have a significant impact on public services.

There is a rising rate in obesity with a corresponding high level of physical inactivity in Essex, with fewer women taking part in physical activity and resulting in high public services costs. Some districts in Essex have higher than national obesity rates and there is a 11.7% difference between the higher and lower

prevalence districts rate. The projected annual increase in obesity rate is 2% in adults and 0.5% in children.

Even though we predict a 1% annual reduction in smoking prevalence, there will be an increasing concentration of smokers in our younger population and in lower income groups.

Although Essex has a lower proportion of people consuming higher levels of alcohol, many young people are engaging in harmful drinking and we continue to see a rise in alcohol related hospital admissions. Evidence also suggests an increase in people consuming high levels of alcohol at home. This is fuelled by the low cost and accessibility of alcohol, especially to young people.

Drug misuse contributes to the associated health and crime burden in Essex with nearly 4600 known opiate and crack users and an increase in young people (under 18 years) accessing treatment.

There is a wide variation between districts in the level of poor sexual health practices as well as high service usage (eg terminations) especially related to teenage pregnancy.

There are some early signs of success with interventions to reduce health inequalities, particularly in reducing the impact of child poverty and targeted lifestyle interventions around childhood obesity and teenage pregnancy rates. But much remains to be done including improving joint working, ensuring appropriate measures of performance outcomes and rolling out more evidence based interventions.

A major task for Healthwatch Essex will be to drive that integration by presenting a view of the lived experience of users of health, social care and other related services, so that services can become seamless and better oriented to meeting people's needs.

In regards to population protection across Essex, a number of key agencies collaborate effectively to ensure that the population is protected from the consequences of major incidents. The public health system provides adequate surveillance of infectious diseases as well as nationally accredited and monitored screening and immunisation programmes.

Children, Young People and Families

Early & Effective support for Children

Every child should have the opportunity to reach their full potential and children are best supported to grow and achieve within their own families. ECC are working hard to develop flexible services which are responsive to children's and families' needs and provide the right level of intervention at the right time. Universal services seek, together with parents and families , to meet the needs of children and young people. A co-ordinated, multi-disciplinary is best, especially for children with more intense needs.

Maternal and Infant Health and Wellbeing

The health of children in Essex is generally better than or similar to the England average. Although the proportion of babies born with a low birth weight and infant mortality rates are relatively low, poor lifestyle choices, including smoking in pregnancy, alcohol misuse and poor diet are still a public health concern.

Rates of breastfeeding, which has numerous benefits, are comparatively low in most areas of Essex, especially in more deprived areas and among younger mothers. Good support and advice can help improve parenting skills, ensure adequate level of income support, promote healthier choices and give children a better future.

Although the childhood immunisation rates are improving and in some cases are higher than England , the uptake for Mumps, Measles and Rubella (MMR) vaccination remains lower than the required level to achieve population protection.

Early Years development

Early Education is important for later health and economic wellbeing. Supporting children and parents in children's centres can help reduce later inequalities; it is therefore encouraging that uptake is higher in the some of the more deprived areas of Essex. However generally speaking uptake is still low at around 64% of children under 5.

Family Environment

Poor family environment can have a significant impact on good outcomes for children. Research has suggested that a number of factors such as mental health, behaviour and youth offending etc. are influenced by the quality of the parent-child relationship and by improving this relationship it has a positive impact on outcomes for the child, the family as a whole and society (e.g. the social, health and economic costs of unemployment and poor health). Concerns about finances, lack of employment, the risk of eviction and homelessness alongside families with complex / multiple needs increases the risk of poor outcomes for children.

Educational achievement

Attainment across Essex has improved significantly at each key stage, however there is a significant disparity across Essex in educational achievements at GCSE level. Areas with low educational attainment tend to have more young people who are NEET and higher levels of teenage pregnancies. Attainment for children in care has improved but is still below that of their peers.

Lifestyle Issues

We need to improve health education to ensure that the poor lifestyle choices we experience across Essex can be improved. Young people have easy access to alcohol and smoke from a younger age. Risk taking behaviours, possibly fuelled by alcohol misuse, can lead to high levels of Sexually Transmitted Infections (STIs), crime and violence, risk to personal safety as well as poor mental health, some of which will continue into adulthood.

Although lower than the national average childhood obesity continues to pose a challenge and continues to rise across the county. More can be done to improve diet and increase physical activity.

Child and Adolescent Mental Health and Wellbeing

Mental health and emotional wellbeing depend both on environmental factors and the mental resilience built up throughout the years of early life and into adulthood. It is crucial that children and young people are supported more in this area.

Children with Disabilities

There is a rising population of children with disabilities nationally, with two main elements: a growing number of children with profound learning disabilities and/or multiple complex health needs; and a growing number of children with autistic spectrum disorders, some of whom have very challenging behaviour.

Young Carers

It is important that agencies collaborate to ensure young carers are identified early, provided with adequate support to maximise their health and wellbeing, ensuring that they do not miss out on their life opportunities.

Crime and Young People

A number of risk factors can contribute to the likelihood of young people (10 to 17 years) becoming known to the local police and entering the youth justice system. These range from; poor family relationships, poor educational attainment, absenteeism or exclusion from school, associating with offending or risk-taking peers, drugs or alcohol use, mental health issues, accommodation in a high crime area or temporary accommodation / homelessness, poor communication or comprehension skills, anti-social attitudes or behaviour and thinking skill issues including impulsivity, risk taking and lack of victim empathy. Children who are in care or looked after are over-represented in the youth justice system.

In Essex[2] (2012/2013) there are 3,569 offences where a young person aged 10-17 years old has been suspected as having committed the offence; a rate of 26.2 offences per 1000 10-17 year old population[3]. The Youth Offending Service (YOS) caseload was 1220 young people in 2010/11, with the number of first time entrants continuing to fall in Essex in 2012.

Children at Risk and Safeguarding Issues

Although of rare occurrence, the abuse and neglect of children is intolerable. Safeguarding is everyone's responsibility, parents, relatives, the public and staff. All staff who, during the course of their employment, have direct or indirect contact with children, or who have access to information about them, have a responsibility to safeguard and promote their welfare. Furthermore, children in care also need to receive better support to ensure they can maximise their potential.

Many of the issues highlighted in this document, such as social deprivation, parenting history, poor education, parental mental health, drug and/or alcohol misuse, can all impact on child neglect and abuse. The Essex Drug and Alcohol Partnership (EDAP) estimates there are 5,240 families in the county with four or more vulnerabilities, with a greater concentration of these families in deprived areas.

Adults and Vulnerable Groups

Working Age Population

The current economic climate has created trends that will have a negative effect upon health. Unemployment rates, benefits claims and debt are increasing accompanied by concerns about the high level of fuel poverty. The impact of poor health or disability on a person's likelihood of finding and keeping a job are significant.

Predicted demographic change, increased survival rates, reduced mortality rates, improved diagnostic techniques and improved health care will lead to an increase in the number of people with learning disabilities. At present the highest rates of people with a learning disability can be found in Tendring, Colchester and Braintree where the historical long stay hospitals were located.

There are currently 814 specialist housing units to support adults with Learning disabilities in Essex. This is an increase on the previous year of 803 specialist housing units, which was a shortfall of 186 compared with the estimated requirement of 989 units. Braintree, Chelmsford and Colchester show the greatest deficits.

During 2011/12 approximately 3900 people, a 5% increase compared with the previous year, received support from the reablement service, which aims to support people to regain skills with a view to reducing longer term care.

The rate of adults with physical disabilities who are supported in Essex in terms of receiving either community or residential/nursing home care has seen an increase year on year since 2006/07 and is now at a rate that is higher than that of the East of England.

Almost 10% of our residents provide informal care to relatives, friends or neighbours. Research suggests that the economic value of the contribution made by carers in Essex is £2.4 billion per year which is £45.4 million per week. Over half of the people providing unpaid care are people aged over 50. The physical impairment planning group and older peoples planning group have reiterated the need to help carers maintain their caring role while preserving their health and wellbeing.

It is estimated that 90500 older people with social care needs live in Essex that is 35% of the older population over 65 years. There is a projected 22.8% increase in older people with care needs over the next five years which is higher than the anticipated 19.2% increase for England.

Generally the 2012/13 ASC surveys suggest that people are experiencing decent services and are able to live reasonable lives. However, key areas for improvement include better signposting to existing sources of information, advice and support and improved standards following the assessment process.

During 2012/13, the ECC Customer Liaison Service, covering feedback about Adult Social Care services, handled 568 complaints and 581 representations were handled from Councillors and MPs. The team also recorded just under 200 compliments.

It is estimated that the number of people over 65 years living on their own will have increased by around 17% by 2020. Loneliness can damage both physical and mental health and can be further exacerbated by lack of transport and poor mobility.

Falls are a major cause of illness and disability amongst those over 65 years and one in three experiences one or more falls in a year. Falls can result in a loss of independence and may impact on both physical and mental health. The prevalence of falls almost doubles in the visually impaired and highly increases the risk of losing independence.

Engagement with planning groups has further highlighted the need to improve awareness and accessibility of information and services. Visual impairment and deaf or hard of hearing awareness training is also a key priority for all front line staff, in all service areas

As previously mentioned excess seasonal deaths are an important public health concern which sees an increase in mortality among older people. These deaths mostly occur during winter but also during heat waves. The uptake of flu immunization needs to be kept at a high level to ensure better protection for the vulnerable population.

The population in Essex aged over 75 years is expected to increase significantly over the next 20 years and if the need for supported housing units follows this trend it is estimated there will be a potential deficit of over 11384 units by 2020 and 22000 units by 2030.

Key Issues

Social and Economic Factors

Population Growth

By 2031, Essex will have to absorb an extra 324,000 residents. By 2031, the number of people over 85 years in Essex will more than double, from about 31,000 to 77,000. These extra years of life will often involve poor health, dementia or disability. The number of people with learning disabilities may also continue to grow with further advances in medical technology. These factors will have an impact on housing needs, including specialised housing, as well as on health and social care.

Deprivation

A wide range of problems, from poor health to crime to low educational attainment are associated with deprivation or low income. Deprivation even reduces the ability to die of a terminal illness in one's own home rather than in hospital. Children from the lowest social class are five times more likely to die in road accidents than those from the highest. Effective targeting of action to tackle clusters of issues for deprived communities will be important.

Educational Attainment

Given its relative level of affluence all areas of Essex suffer comparatively poor educational attainment measured by the Index of Multiple Deprivation (IMD) domain and by the new Marmot measure of educational development at age 5. This represents a key challenge for partners if the children we serve are to enjoy the same relative level of affluence and health as their parents.

Impact of Economic Downturn

UK Gross Domestic Product (GDP) is 2.5% points below its 2008 peak. The economy is now growing but this is not yet true of real disposable income. Less secure part time jobs with low real income can be a source of stress affecting health and wellbeing. The impact of these changes is more likely to be felt by women and young people in particular. Long term investment in skills would help to counteract this.

Stresses on Family Life

About 5% of primary and 9% of secondary pupils in Essex – about 16,000 people - have poor emotional wellbeing. This can affect their social and emotional development and educational attainment. Children and young people say that their safety, especially from bullying, is their biggest concern. The percentage of children in poverty in Essex is lower than in England but is rising more rapidly especially in Tendring. Being a carer can adversely affect the wellbeing of both children and adults.

Stresses on Communities

'Sense of belonging' and of 'people getting on well together' as measured by surveys are high in Essex. However, communities can be disrupted by high house prices forcing younger people to move. Commuting long distances to work is common in Essex. Crime is generally low but people say that keeping it low is important. Some minority groups, such as those by ethnicity, sexuality and disability, experience prejudice or hate crime.

Life Expectancy Gap

Life expectancy is 7.3 years lower for men and 4.9 years lower for women in the most deprived areas of Essex than in the least deprived areas. Circulatory diseases are the most common cause of death, followed by cancer. Life expectancy is shaped by social and economic factors, mediated through individual behaviours.

Behavioural Factors

Smoking

This is the single biggest cause of preventable illness and early death. Braintree, Tendring and Basildon have the highest prevalence. Overall in Essex it is estimated that 25.1% of the 20% most deprived communities smoke compared to only 17.5% in the remaining 80% of the population. The prevalence is estimated to be as high as 33.6% in the most deprived communities of Tendring. Younger men and women in routine and manual groups as well as teenagers are most likely to smoke.

Diet and Exercise

Some 28.9% of people in Essex are obese. This is higher than both the East of England (24.3%) and the national average (25.8%). Out of the districts/boroughs, the estimates suggest that Harlow (31.1%), Castle Point (27.3%) and Braintree (26.7%) have the highest prevalence. Breastfeeding can reduce obesity in later life but only West Essex has an initiation rate higher than the national average. A good diet can reduce risks of several illnesses. Over the last 25 years there has been a big drop in physical activity as part of daily routines but a small rise in it for leisure.

Alcohol

In 2011/12 binge drinking was highest in West (19.6%) and Mid Essex (20.5 %). North East Essex (18.7%), South East Essex (18.8%) and South West Essex (18.9%) all had rates similar to the East of England (18.3%). This behaviour increases the risk of CVD, cirrhosis, poor mental health, unemployment, accidental injury and death. Factors which can trigger hazardous drinking amongst adults include bereavement, mental stress, physical ill health, loneliness, isolation and loss.

Safeguarding

Domestic abuse impacts on both adults and children, with women most likely to be the victims. In 2010 it was estimated that over 35,000 females aged 16 to 59 years may have been the victim of domestic abuse. Estimates also suggest that there are 57,902 children in Essex with at least one parent abusing alcohol, 7,300 children with at least one parent who is a dependent drug user, 46,636 children with at least one parent with a mental health problem and 26,200 children experiencing parental domestic abuse. Most of the children looked after by ECC have parents with two or more of these vulnerabilities.

Immunisation

Inaccurate media reporting around the effect of some immunisation programmes had a negative impact on uptake for MMR and the flu jab over recent years. With some innovative campaigns, we have seen an improvement in uptake with MMR vaccination alone showing a 5 to 6% increase in recent years. It will be important to sustain this and to encourage more people to have the flu jab.

Services

Access to Services

Physical access to services depends on transport. This is a high priority for residents. Lack of transport can be an important factor in social isolation, which can have impacts on both health and the need for social care. Service user groups have identified that better information and advice is needed to help people manage their needs and to access services efficiently when they need to.

Satisfaction with Services

Generally, the 2012/13 surveys suggest that people are experiencing decent services and are able to live reasonable lives. However, key areas for improvement include better signposting to existing sources of information, advice and support; and improved standards of follow-up after social care assessments.

Integrating Health and Social Care Systems

Health conditions are major drivers of the demand for social care and appropriate housing and social care can help to prevent acute health episodes. Citizens recognise the issues and want a single approach to their care. Failure to integrate the systems eg through delayed discharges from hospital or poor reablement can be wasteful of public resources. Better predictive risk modelling can help to prevent people's needs from escalating unnecessarily in both the health and social care systems.

Balance between Community and Secondary Services

A major challenge will be to meet people's needs in the community through universal public services; community based social care and primary health care. This can prevent escalation of need through psychological dependency on care systems and is usually preferred by citizens as a better outcome. It is also usually a more effective use of scarce public resources.

1. Essex Population and Health Determinants

Understanding local demographics and the wider determinants of health provides a sound basis on which to improve quality of life, raise aspirations and secure better health outcomes.

1.1 Population of Essex

Profile

Essex has a population[4] of 1.41 million residing in its twelve District/Borough/City Council areas. Some of our public services serve Greater Essex which also includes the two unitary authorities of Southend-on-Sea (pop. 174,800) and Thurrock (pop. 159,500), making the total population 1.74 million. Basildon (176,500) and Colchester (176,000) have the largest population and Brentwood (74,000) and Maldon (61,900) the smallest. Chelmsford and Colchester are the biggest urban areas in Essex.

In comparison with the population of England, Essex has a similar proportion of children (19% of 0 to 15 years) but more older aged people (19% are over 65 years compared with and England value 17%). There are fewer 16 to 64 year olds (62% vs. 64%), which may reflect the migration outwards, primarily as people seek work elsewhere. Tendring and Castle Point have a difference in population structure, 16% of the population in Tendring are under 16yrs and 17% in Castle Point; 27% of the population in Tendring are over 65 years and 23% in Castle Point.

Southend-on-Sea is the most densely populated[5] unitary area (4,187 people per km2) In terms of districts in Essex, Harlow (2,707 people per km2), Castle Point (1,957) and Basildon (1,604) are most densely populated. Conversely, Braintree (243), Maldon (173) and Uttlesford (127) are the least. Areas with high population density are most likely to have pockets of high deprivation and poor housing.

Projections

Between 2008 and 2033 the population projection[6] for Essex is expected to show a decrease in the working age group (from 60% to 55%) and an increasing older population (21% increasing to 28%). Significant differences at district level is expected for Maldon with the largest decrease in children (3%) and second largest decrease in working age adults (8%) after Castle Point (9%). In terms of older people, both these areas will also see the largest increase with an 11% increase in Maldon and 10% in Castle Point.

In the future it is predicted that the balance between those of working age and the 'dependent' population is likely to shift, changing the proportion of economically active people in relation to the proportion supported by the state. The increase in the older age group will not only impact on all public services (explored further in this document), but will also mean an increasing demand on care home places, more unpaid carers and the need for better community networking to support independent living.

Ethnicity and Sexual Orientation

People from differing ethnic groupings (including travelling families) and those who are not heterosexuals are at greater risk of discrimination and social exclusion, which can lead to poor health and social care outcomes. National reports [7] suggest that they are less likely to be considered to provide adoption and less likely to seek support from statutory agencies.

The 2011 Census tell us that Essex is home to 181,300 residents from BME groups (including Irish, Gypsy or Irish Traveller and other white). There are 116,600 residents from ethnic groups other than white

and 64,700 from white minority groups. The BME groups made up 10.5% of Essex residents (9.2% in Essex County Council area), which is less than the England average (20.2%).

Essex has become more diverse with the areas closest to London and the largest towns having the highest concentrations of people from BME groups. In Essex the highest proportions reside in Epping Forest (16.1%) and Harlow (14.8%) compared to the lowest in Rochford (4.2%) and Maldon (4.2%).

According to the 2011 census[1], the highest concentration of ethnic minorities (including white other, irish and traveller) is in the young population, specifically people aged 0 to 24 and 25 to 49 (both 7%).

It is becoming more customary for gypsy and travelling families to live in more formal style of housing. Of people living in caravans, most are on authorised public or private sites and around 20% are on unauthorised sites. Whilst the trend in unauthorised encampments and trespass has diminished over recent times, the trend in unauthorised developments (permanent fixtures) has been increasing. In Essex (2011), there were 1142 caravans, of which 30% were not on authorised sites.

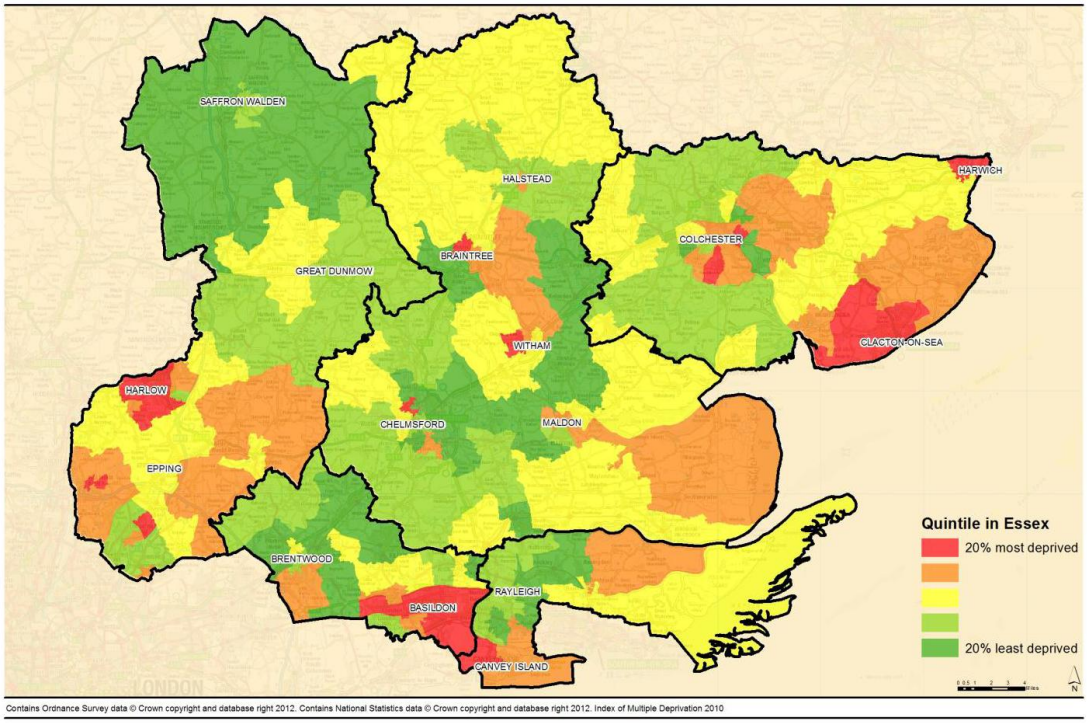
1.2 Deprivation and Wider Impact on Population

Although quality of life for most Essex residents is good, some areas of Essex are very deprived. An area located in Golf Green ward in Tendring (in Jaywick), has been identified as the most deprived small area in England. Essex has some of the most affluent and some of the most deprived areas in the country. The least deprived areas are in Uttlesford, Brentwood and Chelmsford. The most deprived areas in Essex tend to be more focused in and around the larger towns, in condensed pockets (hot spots) and these are most common in Tendring and Basildon.

Many of the most deprived areas also experience the lowest levels of life expectancy, poor educational achievements, higher levels of teenage pregnancy, poor housing (including fuel poverty) and generally higher levels of social and health care needs. There is a high eligibility level for free school meals in the more deprived areas, which is a proxy measure for childhood poverty. Many children from these disadvantaged communities tend to experience poor parenting support, have poor aspirations and end up generally bereft of essential life skills. Children's centres have been set up in the areas of most need to help redress these inequalities and improve life opportunities.

[1] Nomis based on 2011 census actual

Deprivation in Essex



1.3 Employment and Aspirations

GDP

Last year, GDP was estimated to be about four percentage points below what it would have been on pre-recession growth trends. GDP is estimated to have been flat between 2011 and 2012[8], and latest figures suggest that it is still 2.5% below the 2008 peak.[9]

Given issues around the scale of both public and private debt, consequent falls in the level of aggregate demand, and liquidity problems in the financial sector, many commentators expect a long period of low growth ahead. However growth of GDP in the third quarter of 0.8% seems to suggest that UK's economy is beginning to recover.[2]

Labour Market

Recent national analysis of labour market conditions[10] indicates that from May to July 2013 employment rate for those aged from 16 to 64 was 71.6%, up 0.2 percentage points from February to April 2013 and up 0.4 from a year earlier.

Output is estimated to have expanded by 0.6% in Q2, and a similar increase is expected in Q3. Employment growth has eased from unusually strong rates. Productivity remains some 8% below its pre-crisis level. A margin of slack remains in the economy, both within companies and particularly within the labour market.

Full time and permanent jobs reduced in number and the number of part time and temporary jobs rose correspondingly. More recently, the labour market has shown only a modest recovery, with

[2] http://news.sky.com/story/1159517/uk-economy-gdp-growth-accelerates-to-0-8-percent_original source ONS October 2013

employment rising by less than in previous recoveries from recession. The labour market has also adjusted to the recession through slower earnings growth.

Earnings continue to rise slowly with a 1.1% rise (including bonuses) over May to July 2013 when compared to the same period in the previous year. The Bank of England's inflation forecasts for the next three years, based on market interest rate expectations, show a probability of Consumer Pricing Index (CPI) inflation remaining above 2%. The Bank of England Committee's best collective judgement is that the average probability of inflation 18 to 24 months ahead being at or above the 2.5% knockout is less than 50% [11] These changes in the structure of the labour market if they persist over a period of sluggish economic growth may create some stresses for households in Essex in terms of lower earnings and job instability. The Consumer Prices Index (CPI) grew by 2.7% in the year to August 2013, down from 2.8% in July. The largest contributions to the fall in the rate came from the transport (particularly motor fuels and air transport) and clothing sectors. These were partially offset by an upward contribution from furniture, household equipment & maintenance.

Unemployment Level

Unemployment is strongly correlated with health and wellbeing. Educational qualifications, both as part of secondary education and adult learning, are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources that have an impact on health and health inequalities.

Unemployment rates have risen sharply since the end of 2008 as the UK economy has gone into recession. The rate in Essex[12] (7.3%) is above the average for the Eastern region (6.6%), but was below the UK average (7.8%) as of March 2013.

Within Essex 72.9% of the working age population are employed, this is higher than the national average of 70.9 % but lower than the regional average of 74.5%. Unemployment rate varies across the county with the highest rates in Harlow 13.2% (up on 2011) and Tendring (13.9%). Lowest unemployment rates are seen in Epping Forest (4.6%) and Rochford (4.8%). Unemployment has risen in Castle Point (from 4.1% 2011 to 9.2% in 2013) and Colchester (from 4.8% in 2011 to 6.9% in 2013).

In 2011, there was an increase of 0.2% over 2 years, across ECC (0.5%) in the working age resident population (aged 16 to 64) claiming job seekers allowance for over 12 months; this was similar to the national increase. In 2013 this has reduced by 0.1%. Latest figures suggest that the number of 16 to 64 year olds claiming job seekers overall has fallen to 2.6%, which is 0.8% lower than it was in February 2010 (which is the highest since the 2008 recession). In September 2011, the number of male (3.7%) Job Seekers Allowance (JSA) claimants was much higher than female (2.3%).

Employment has a high weighting (22.5%) in the computation of the deprivation score. People with little and/or no qualifications are less likely to find jobs or earn a decent income and have poorer health related outcomes.

Qualifications and Skills

The workforce in Essex tends to be slightly older than the average for England and older people tend to have fewer qualifications. Essex is also a net exporter of 16 to 24 year olds who are more likely to hold qualifications.

As a result, skills in Essex[13] tend to be lower than elsewhere, with the percentage with higher skills levels (NVQ4+) being much lower than the national average (28.1% and 34.4% retrospectively). Those with no qualifications present the biggest concern and at a district level, in 2012 Harlow (15.9%) and Tendring (15.4%) have the highest proportions of people without qualifications and these are also the more deprived districts in the county. Conversely, Harlow also has the second biggest proportion of people with NVQ 4+ (34.7% vs. Essex 28.1%) and Colchester the biggest (37.5%).

Prior to the recent recession, the number of young people not in education, employment or training (NEET) in Essex was comparatively low, but this number has risen since the start of the credit crunch. The percentage of 16 to 18 years olds in Essex who were NEET[14] fell to 5.7% in 2012/13, from 6.4% a year earlier, which is now very close to the average for the East of England and England, but is slightly higher than the statistical neighbour average of 5.4%. Basildon (7.5%), Harlow (7.1%) and Tendring (6.7%) have the highest proportions of NEET young people.

Mental Health and Employment

In 2009, Essex had 10.1% adults who were receiving secondary mental health services and known to be in employment at the time of their most recent assessment, formal review or multi disciplinary care planning meeting, this was higher than the England average (7.9%) and an increase on 2008 (6.3%). Current data (July 2013) suggests this has risen to 15.9% (national 7.7%)

National Institute of Clinical Excellence (NICE) guidance supports the provision of Increasing Access to Psychological Therapies (IAPT) services, to help those with mental health problems get back into work and these are now operating across a number of areas in Essex.

Migration and Welfare reform

The advent of economic migration, associated with the expansion of the European Union, has led to significant inward migration into Essex; especially as Harwich Port provide an easier gateway into the county. A cumulative total of 15430 migrants registered to work in Greater Essex between May 2004 and December 2009. Anecdotal evidence suggests that many of these migrant workers suffer from poor living conditions and lack the knowledge and support required to ensure they remain safe and well.

A recent strategic housing Market Assessment report by the DCA shows in and out migration is biggest in Colchester, this is also evident in the mid 2012 population estimates.

Colchester has seen the biggest net international migration, followed by Chelmsford and Epping Forest. Colchester has also seen the biggest increase of in migration (an increase of 19%), whereas Chelmsford has seen a small decrease (-1%). [15]

As well as within county migration there is a risk that welfare reforms could increase migration from London which could impact on front line services. Early findings from the welfare reform working group suggest that this is not currently evident but there is still a risk. This risk will continue to be monitored by the welfare reform working group.

Since reforms were introduced there was a concern that migration from London would increase due to housing benefit cap, and we should continue to monitor the situation.

1.4 Access to Services and Transport

Access to services, regardless of the purpose (eg to work, hospital, educational establishment, recreational activities), is closely linked to transportation. The chosen modes of travel (walking, cycling or motorised) can vary according to people's means (can they afford a car or bus fare), their personal mobility (are they able to walk or cycle) and the availability of public or alternative transport. It is also important to note that lack of transport may not always be a factor in addressing inequity in access to services, as issues such as homelessness and lack of information also have an effect.

Impact on Community Health and Wellbeing

With motorised transport comes the challenge of traffic congestion, pollution, accidents and physical inactivity. People have become more dependent on the use of private cars for their journeys, including short ones, instead of walking or cycling to their chosen destination, thus contributing to a reduction in physical activity.

This over dependence has increased the volume of traffic in the UK over the last ten years by 6.2%. Provisional estimates for the second quarter of 2013 show that traffic volumes increased on all road types when compared to the same quarter in 2012. However, traffic volumes were still lower than in 2007, before the downward trend began.[3] In Essex, the same pattern is seen with traffic volume rising over the last year[4] but reaming lower than 2007. Increased traffic volume causes long delays and impacts on air quality with an increase in carbon dioxide emissions, which can have a detrimental effect on people who have respiratory problems.

Generally if you are young and in a good state of health, moderate air pollution levels are unlikely to have any serious short term effects. However, elevated levels and/or long term exposure to air pollution can lead to more serious symptoms and conditions affecting human health. This mainly affects the respiratory and inflammatory systems, but can also lead to more serious conditions such as heart disease and cancer. People with lung or heart conditions may be more susceptible to the effects of air pollution.[16]

Children from the lowest social classes are five times more likely to die in road accidents than those from the highest social class. More than 1 in 4 of child pedestrian/cyclist casualties happen in the 10% most deprived wards[17]. Good accident prevention work must be sustained if we are to reassure parents and encourage young people to walk and cycle more regularly.

Utilisation and Satisfaction with Public Transport

In the National highways and transportation survey (2012) an average of 59.11 out of 100 was the score Essex residents gave when asked how satisfied they were with bus services overall and 57.57 out of 100 was the average score Essex residents gave when asked how satisfied they were with the frequency of buses. These average scores rank Essex more than 10 points away from the best national score.

Another survey asked to passengers at the point of use[18] found that 79% of Essex Residents were satisfied with the bus services they had used. This was slightly lower than Residents in Kent (84%).

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226935/road-traffic-estimates-quarter-2-2013.pdf

[4] http://www.dft.gov.uk/traffic-counts/area.php?region=East+of+England&la=Essex

The older peoples planning group have suggested that issues surrounding improving accessibility, service, and take-up of public transport throughout the county and ways it could be improved should be investigated further.

1.5 Crime and Community Safety

Crime Rates

Crime is associated with social disorganisation, dysfunctional communities, deprivation and inequalities. In addition to the human and emotional costs, crime has a direct impact on housing, employment and health. Recent Essex Place surveys have highlighted crime as an area that requires high priority despite continued increased in crime detection rates and a reduction in criminality. Drug and alcohol related crime, anti social behaviour (including damage to property), violence against the person and domestic violence are the key areas where the intervention is needed to protect the population and property. There is also a high inter relationship between these elements of crime and disorder.

The latest Crime Survey for England (2012/13) shows that there has been a 9% decrease in crime compared with last years British Crime survey (2011/12). This latest estimate is the lowest since the survey began in 1981 and is now less than half its peak level in 1995. In Essex overall crime has reduced by 5% but burglary (2%) and domestic burglary (12%) have increased.[19]

The overall level of police recorded crime decreased by 7% in the year ending March 2013 compared with the previous year. For Essex the 2012/13 police force area statistics show that total recorded crime in Essex was 100,144.

Hate Crime

The term 'hate crime' covers crimes that are driven by hostility or personal hatred because of race, religion, sexuality or disability. Nationally, the number of such crimes referred by the police to the Crown Prosecution Service (CPS) for decision rose from 14133 in 2006/07 to 15519 in 2010/11, ie, by nearly 10%. In 2011/12, the number of hate crime cases referred to the CPS by the police for decision fell by 5.0% to 14,781 from 15,519 the previous year. This is the first year that the number of referrals has fallen since 2006/07[20]. In the Essex CPS area in 2011/12 there were 277 prosecutions, of which 88.1% were successful (1% increase from previous year). Of these prosecutions, 238 involved race or religious hatred, 28 homophobic or transphobic hatred, and 11 hatred of people with disabilities.

Crimes against Older People

The CPS collects data on crimes which are targeted at or take advantage of older people or involve abuse of trust or hostility towards them. Nationally, the number of such cases referred to the CPS doubled to 2,987 between 2008/09 and 2011/12. In the Essex CPS area in 2011/12, there were 75 such prosecutions, which was higher than previous year (54), however fewer led to a conviction (79% compared to 91% in the previous year).

Fear of Crime

A standard perception measure of the fear of crime is feeling safe after dark. The percentage of people feeling safe after dark in Essex increased significantly between the 2008 Place Survey and the 2010 Tracker 9 Survey, from 56% to 65%. Results from Tracker 10 in 2012 indicate that the percentage feeling safe after dark dropped down to 58%, this has remained fairly consistent in Tracker 11 at 59%.

Tracker 11 shows that people in Uttlesford (75%) and Maldon (68%) feel the safest outdoors after dark, followed by residents in Chelmsford and Colchester (65% in both cases). However, residents are less likely to feel safe after dark in Castle Point (49%), Basildon (48%), and particularly in Harlow (where 37% feel safe). This is similar to Tracker 9, except for Colchester which previously fell below the average. Figures for Maldon are also starkly different, although still above the average.

Additionally, analysis of tracker 9 showed that there was a relationship between fear of crime and actual crime, suggesting that people are aware of the levels of crime in their area. At smaller geographical areas however, there was more variance with some areas showing high fear and high crime rates whilst people in other areas had fairly high crime rates but had fairly low fear of crime.

Drug and Alcohol Related Criminality

There is a strong link between drug and alcohol use and the level of crime, in particular where violence and anti social behaviour are involved but it also correlates with a high level of burglaries and is associated with increased incidents of domestic abuse. Nationally, the impact of alcohol misuse alone, on health, crime and society, is estimated to cost nearly £20bn a year. In Essex this would approximately represent £432 million. Harlow (10.5/1000) had the highest alcohol related crime rate in 2010/11, with Basildon (7.2) and Epping Forest (7.1) also above the regional average (6.2). Rochford (2.7/1000 ranked 10th lowest nationally), Maldon (3.6) and Uttlesford (4.2) were the districts with the lowest recorded alcohol related crime rates.

Domestic Abuse

Domestic abuse impacts on both adults and children, and makes up one fifth of all police incidents (29,000)[21]. Around half of these are repeat police incidents, with women most likely to be the victims. It is difficult to determine actual victims of domestic abuse but in 2010 it was estimated that over 35000 females aged 16 to 59 years may have been the victim of domestic abuse with a further 11000 victims of sexual assault in Essex.

Domestic abuse has a detrimental effect on Health and it is estimated that the financial impact of these incidents on the NHS in Essex is £20 million[22].

A violence against women and girls (VAWG) policy was published in 2012 which has set in motion proposals to standardise and rationalise national operating practices. For VAWG this involved addressing charging procedures across VAWG; ensuring domestic violence was a central part of the standard operating practice for magistrates' courts and rolling out Rape and Serious Sexual Offence Units across all Areas in 2013-14. The majority (86%) of crimes grouped under VAWG for performance management purposes are domestic violence with rape at 4.5% and sexual offences, excluding rape, at 9.5%. Overall, VAWG makes up approximately 10% of the CPS workload. In 2012/13 the proportion of successful prosecutions rose to 74.1%, delivering the highest VAWG conviction rates ever. In Essex the number of successful domestic abuse prosecutions has risen to 81.7% in 2012/13, which is higher than the East of England (80.7%).[23]

Analysis of Essex Police data (covering November 2010 to April 2012) showed that 5 of the 26 murders in Essex were attributable to domestic abuse. 29.6% of violence against the person over the same period was also attributable to domestic abuse.

Recent analysis showed that 21% of incidents are witnessed by a child, the same analysis estimated that 18% of these children were known to social care. It is estimated that around one in four children who have witnessed domestic violence suffer from post traumatic stress and have serious social and behavioural problems including school absenteeism, ill health, bullying, anti-social behaviour, drug and alcohol misuse, self-harm and psychosocial impacts (and are 2.5 times more likely to have these problems than children from non-violent backgrounds).[24]

Incidents and Crime involving Young People

One of the indicators in recent years has looked at 'first time' young people who have engaged in criminal activities. Changes in policing policies and better crime detection rates seem to have deterred youths from committing crimes as there has been a 50% reduction over the last 10 years in England and Wales of first and further offences resulting in a reprimand, warning or conviction committed by those aged 10 to 17 years. Within Essex, there has been a 32% decrease in the rate of youths receiving their first reprimand, warning or conviction over the same time period. The 2012 data indicates that Essex (570 per 100,000) has a similar rate to England (537) of first time entrants into the youth justice system. With continued prevention work, young people can be channelled to more meaningful activities and learning to develop their civic skills.

Preventing young people from becoming offenders and promoting a value based society (eg civil responsibilities) can help improve community health and wellbeing through better educational attainment (enhancing aspirations), improved employability and a reduction in crime against the person and property.

1.6 Poverty and Social Class

All the evidence suggests that social class inequalities persist throughout life and post retirement. Life expectancy is 7.3 years lower for men and 4.9 years lower for women in the most deprived areas of Essex than in the least deprived areas.[25]

Other than occupation, a number of proxy indicators can indicate the level of poverty including housing tenure, income deprivation index, entitlement to free school meal, take-up of means-tested benefits and level of fuel poverty.

Home Ownership

Tracker surveys have shown that a higher proportion of Essex residents (75% in 2011[26], 76% in 2013[27]) own their own homes compared to the England average (69%), although commuting patterns into London is also suggesting that Essex's residents are benefitting from higher salaries. Castle Point (89.6%) and Rochford (90.1%) have the highest proportion of households owning their accommodation while Harlow (63.1%) has the lowest. Basildon (11596) has the highest number of local authority dwellings and Braintree (17%) the highest proportion of registered social landlord stock, also known as housing association.

Childhood Poverty

Despite the relative affluence of Essex, 17.1% of children (around 52,500) live in poverty[28]. This proportion is lower than East of England (17.3%) and England (19.6%). In Harlow (23%), Basildon (24%) and Tendring (26%) a quarter of all children are in poverty, the highest proportions in the county. In Tendring's Rush Green and Golf Green wards, the majority of children (over 50%) are estimated to be in poverty. Wards[29] with high levels of child poverty often have high proportions of families where the

youngest child is aged 0-4 years and families with 3 or more children and higher proportions of their youngest child being under the age of five.

Additionally, there has been a significant increase in the number of pupils assessed as eligible for Free School Meals over the last 7 years[30]. This is likely to be the result of both increased financial hardship and increased awareness of eligibility. FSM eligibility is particularly high in known areas of deprivation however large increases have been seen in Brentwood, Braintree and Uttlesford.

Evidence suggests that socially disadvantaged groups suffer poorer physical health and lower life expectancy than the more advantaged, have higher incidence and prevalence of acute and chronic illness, and are more likely to smoke and have a poor diet. Children from poorer backgrounds suffer higher rates of accidental injury, infections, failure to thrive, general ill health, anaemia, dental caries and teenage pregnancy. In addition, poorer families are less likely to have access to, and make appropriate use of, health services than those from more advantaged circumstances, and they are less likely to benefit from health promotion services and advice. Collaborative intensive support for families and children with the most need can prevent a decline in their quality of life.[31]

Although the educational attainment of children living in poverty is improving (as it is nationally), there remains a significant gap between the performance of children receiving free school meals and those who do not. On average, pupils receiving free school meals have lower attainment than pupils who do not at each key stage. The gap in attainment at GCSE in those children achieving 5+ A*- C grades in 2012[32] was especially pronounced in Brentwood (35%), Epping Forest (34%), Uttlesford (31%) and Chelmsford (30%). Where local interventions can raise young people's aspirations, this can lead to improvement in educational attainment, reduction in 'planned' teenage pregnancy and better job prospects.

Low Income and Poor Housing

Low income and the rising cost of heating can contribute to high levels of fuel poverty. A recent report by the ONS showed that the proportion of household income accounted for by essentials rose from 19.9% in 2003 to 27.3% a decade later.[33] And a recent report by the Childrens society (2013) showed that over half of all children in the UK who say they are in poverty are living in homes that are too cold and a quarter live in damp or mould-ridden conditions, a new The Children's Society report today reveals.[34]

The consequences of fuel poverty include cold and damp homes, reduced quality of life, poor health and debt. People with existing health problems and living in poorly heated dwellings are more likely to need health interventions and suffer from health complications and even death. People already struggling financially may find themselves in even more serious debt problems if they cannot pay their fuel bills and even resort to borrowing money from unscrupulous lenders. It may also lead to a move into temporary accommodation, which is mostly preventable.

Low income families cannot readily afford childcare, which makes it difficult for them to penetrate the job market or develop their skills. The evidence also points to a lack of information and/or support to parents, especially lone parents, in accessing their full benefit entitlement.

1.7 Housing and Environment

Over recent years, central government plans have brought about significant housing development in Essex. As population growth and housing development accelerate, the need for inward investment and local job growth will intensify.

House prices in the East of England fell by 0.3% over the year to December 2011 although over England as a whole they rose by 0.5%. Most commentators expected prices to level out over the next twelve months, however the average house price has increased by 1.3% over the last year (12/13) bringing the average house price in England and Wales to £164,654. In the East there has been an increase of 0.9%, but Essex has only seen an increase of 0.4% making average house prices at £189,033, which is marginally higher than our comparator neighbour of Kent (184,249) which has seen an annual increase of 1.3%.[35] High house prices can have a detrimental effect on the sustainability of communities, leading to increased levels of homelessness and forcing people on low income to seek housing in poorer condition to facilitate their access to work. Developing affordable housing for first time buyers and low income families will continue to be critical for both urban and rural communities.

It is also hoped that the housing provision requirement will cater for the increasing number of people who are becoming homeless, those who are victims of domestic abuse, the increase in migrant workers and those who have become teenage parents. However early anecdotal evidence from the welfare reform working group suggests that there is lack of appropriate housing stock to deal with the issue of social housing under occupancy.

Ageing Population and Supported Living

The growth in the number of older people and the increasing levels of disability, together with shifts in national and local policy towards independence and choice, will impact on the availability of adequate housing.

For the majority of older people, staying in their own home, being cared for by members of their family and dying in their own home are their preferred options. Despite home ownership being fairly high in Essex[36], many cannot afford to adapt their home or keep it in good repair,[37] therefore making this preference difficult to achieve.

We will need to make better use of technology, develop a wider range of supported housing options and give people greater control over the support they receive. Existing planning guidance places an obligation on local developers to provide new houses that meet the Lifetime Homes Standard policy for Essex

Fuel Poverty

Fuel poverty occurs when a household needs to spend more than 10% of its income on fuel to maintain satisfactory heating and other energy services. The consequences of fuel poverty include cold and damp homes, reduced quality of life, poor health and debt. Fuel poverty is particularly an issue in rural areas, for instance the north of Uttlesford and Braintree districts and the east of Rochford and Maldon. This is generally because homes in these areas are detached and may offer poor heat insulation, meaning high heating costs.

Waste Management and Recycling

90.8% of Essex's residents indicated in the 2010 tracker survey, that they already recycle as much as possible. The districts where this is highest are Braintree (96.1%), Castle Point (94%) and Harlow

(92.9%). The following three areas have rates below 88%, Colchester (87.3%), Maldon (87.5%) and Chelmsford (87.9%). Better education and continued work around raising awareness, especially among children and young people, will provide Essex with a better outlook on recycling.

Carbon Footprint

Although Essex has a relatively low carbon footprint, road transport emissions are high due to the M11 and M25 passing through Uttlesford, Epping Forest and Brentwood. In 2011 Essex produced 6.1 tones of CO2 per person, falling from 7.4 in 2005. Uttlesford produced the highest amount of carbon dioxide per person in the district (10.2) Castlepoint (4.1) and Rochford (4.4) had the lowest levels. With almost 99% of the energy consumption in Essex coming from unsustainable source, realising opportunities in environmental technology are seen as key to improving both the local economy and the environment. [38]

Air Quality

Air quality is measured on a scale where the national average is 1 and areas are given a score against that scale, with lower scores being better than high scores. In Essex, air quality is best in Maldon (1.02), Uttlesford (1.02) and Tendring (1.04) and worst in Basildon (1.29), Epping Forest (1.26) and Castle Point (1.25). All areas in Essex had scores above the national average. Pollution measured includes nitrogen dioxide, sulphur dioxide, particles and benzene. Poor levels of air quality can have a direct detrimental effect on health, exacerbating existing health conditions but with good local surveillance and management, this can be minimised.

1.8 Community Cohesion

Analysis of community cohesion data 'people getting on well together' in 2007 highlighted how important a driver this is for residents overall satisfaction with their local area. In 2013 Communities in Harlow (68.2%) Tendring (73.7%) and Braintree (74.6%) were the least cohesive; Harlow and Braintree were also among those who reported the least 'sense of belonging,' with Basildon as the second lowest. Conversely Tendring was one of the highest (73.8) to report a sense of belonging along with Rochford (75.6%) and Maldon (78%). Maldon (83%) and Rochford (84.4%) were also among the highest in terms of cohesion.

Attitudes to community cohesion also differ according to how residents rate the local area and local services. Compared with the Essex average of 78%, residents are more likely to think that their area is cohesive if they themselves are satisfied with the area (84%) or the County Council (85%).[39]

Across Essex, the trend since the summer of 2007 in 'people getting on well together' has been slightly more positive. The Place survey (2008) reported that more people in Essex (79.9%) believed that 'people got on well together', which was higher than both East of England (78.2%) and England (76.4%). Tracker 11 (2013) showed that across the county, those in Rochford most often agree that people of different backgrounds get on well (84%), but this figure is considerably lower in Harlow (68%).

Socioeconomic wellbeing, the labour market, immigration, housing policy and the economy, all play a significant role in defining the interaction in a given community which can promote community participation (eg in crime prevention or volunteering), life ambitions (eg seek education and civic responsibilities) and promoting equality (eg race relations, access to services).

1.9 Recommendations to the Health and Wellbeing Board

Population

. Continue with the development of strategies aimed at preparing Essex to cope with the growing ageing population and people with disability, all of which will have significant impact on infrastructure (eg housing needs) and services (eg care needs).

Deprivation and Wider Determinants

. Focus on tackling health inequalities with identified priority groups and families in areas with high levels of deprivation.

. Through the continued development of the Children's Centres, we must ensure all children get a good start in life.

Employment and Aspirations

. Concerted effort is required to improve the workforce competencies (qualification and skills) and promote the creation of jobs in Essex. Consideration should be given to the creation of apprenticeships and volunteering schemes to support the overall strategy.

. Ensure integration of work around benefit take-up, unemployment and health and wellbeing promotion (eg mental health intervention), which can also support a reduction in NEET.

Access to Services and Transport

. Engaging with relevant groups, including young people and parents is essential to address specific transport barriers, support change in travel behaviour and improve travel information.

. Strategy needs to ensure physical activity is embedded in policy (eg Transport Planning), encouraging walking and cycling and promoting road safety.

. Consider the challenges faced by hard to reach groups, eg homeless people, in accessing services that can improve their health and wellbeing.

Poverty and Social Class

. Active collaboration between agencies can help create social capital in the most deprived communities, by developing strong social networks, civic engagement and volunteering.

. Engaging people in the planning and design of the built environment to generate a sense of belonging, especially for young people, with further extension of the 'early years' programme.

Housing and Environment

. Agencies should work in collaboration to ensure that people live in decent, affordable houses and promote the development of a housing stock fit for purpose in supporting independent living.

. It is important to shift the focus of housing related support towards early recognition of issues, prevention and intervention in order to reduce the need for more costly longer term services.

. Essex needs to implement measures aimed at improving environmental factors, such as reduction in waste, air pollution, increase sustainable development and reduce its dependency on non-renewable energy.

Community Cohesion

. Ensure policies actively promote community engagement and participation and promote equality.

2. Health, Community Wellbeing and Inequalities

Measures of population mortality and morbidity are indicative of the health care needs and the overall disease burden on the population. The burden of ill health can be reduced and life expectancy can be improved by reducing the population's risk (behavioural or inherited), by earlier detection of disease and through more effective interventions to reduce health-related inequalities.

2.1 Life Expectancy and Quality of Life

Causes of Reduced Life Expectancy

Data on years of life lost show that for males the main causes of premature death are coronary heart disease, lung cancer and stroke and for females it is breast cancer, lung cancer and coronary heart disease.

Trends in Life Expectancy

In Essex, the trend in life expectancy for both males and females is upward, with male life expectancy currently at 79.9 years and at 83.4 years for women (at birth 2009-2011). Life expectancy is 7.3 years lower for men and 4.9 years lower for women in the most deprived areas of Essex than in the least deprived areas.[40]

At a district level, males in Harlow (77.9), Tendring (78.1) and Basildon (79.5) have the lowest life expectancy. Those men living in Rochford (81.0), Uttlesford (81.4) and Brentwood (82.0) have the highest life expectancy; this is a gap of 4.1 years between males in Harlow and Brentwood which is an increase on last year (2.7 years).

For women, Harlow (82.3), Tendring (82.4) and Basildon (83.1) have the lowest life expectancy with women in Chelmsford (84.3), Brentwood (84.5) and Uttlesford (85.0) having the longest life expectancy, a gap of 2.7 years between the highest and lowest districts.

Quality of Life

The overarching quality of life measure used within the UK is the percentage of people who feel satisfied with their local area overall. This quality of life measure is influenced by a number of factors, including community cohesion, feeling of safety, and a high satisfaction score indicates a cohesive and functioning community.

In 2013, the districts with the lowest satisfaction are Basildon (74.5%), Harlow (69.1%), and Castle Point (76%). Basildon and Harlow are also two of the most deprived districts in Essex with lower life expectancy. The four districts with the highest satisfaction are Rochford (86.4) Uttlesford (87.7%) Chelmsford (87.9%) and Maldon (91.2%). These are among the least deprived districts in Essex with higher life expectancy.

Satisfaction rating in Essex saw a small upward trend between 2006 and 2010 (rising from 80% to 85% overall) but in 2012 and 2013 this has fallen and is currently at 80.7%. In 2008, Essex's (85.5%) satisfaction rating was above that of the East of England (83.3%) and England (79.7%), however national data is no longer collected meaning national comparisons cannot be made for current data.

2.2 Mortality and Trends

Across Essex, overall mortality rates have steadily improved over the last ten years (from 662 per 100,000 to 491 in 2009). Current data (2010) indicates Essex is 35th (out of 150) nationally with a

premature mortality rate of 238 per 100,000 residents aged 75 years and under. Circulatory diseases remain the most common cause of death followed by cancer.

During 2007/09, the infant mortality rate in Essex (3.9 per 1000 live births) was lower than England (4.7). This has decreased to 3.5 per 1000, which remains below the national average of 4.3. Data for 2010 by district shows that Brentwood (1.3) continues to have the lowest rate, followed by Thurrock (2.5). Castle Point has moved from one of the lowest (2.1 in 2007/09) to the highest in 2010 (5.7), with Southend on sea (5.0), Braintree (4.9) and Uttlesford (4.4) close behind. All other districts (including Colchester, which was the highest) had rates lower than England.

Cancer

Despite a downward trend, cancer remains a major contributor to mortality and health inequalities, with high NHS treatment costs. It is estimated that 21% of the gap between the national average life expectancy and the areas with the lowest life expectancy is attributable to cancer mortality. Total number of cancer related deaths was 10965 (2008/10) in the ECC area.

While there have been marked reductions in cancer mortality rates across Essex, from 133.2 per 100,000 (1995/97) to 103.3 (2009/11), these have been far less than these seen in heart disease. Higher mortality rates from Cancer are associated with deprivation, with Harlow (142.8) and Tendring (129.9) (both significantly different from England) having the highest rates. Brentwood (89.3), Uttlesford (98.2), Rochford (105.4) and Chelmsford (107.9) have the lowest mortality rates from cancer, which are significantly lower than England.

Across Essex, the highest mortality rates (2008/10) are in cancers associated with the lungs (22 per 100,000), colo-rectal area, (9.29) breast (26.5) and the prostate (25.08). The lung cancer rate in men (43.2) is nearly twice that of women (26.36). Early detection of these conditions through national screening programmes as well as prevention programmes (eg smoking cessation) including Human Papillomavirus (HPV) vaccination, are key to a reduction in associated morbidity and mortality.

Moreover, despite most people's wish to die at home, there is a wide variance in the proportion who can experience this across Essex. Cancer patients living in Uttlesford (38.9%) and Rochford (34.9%) are more likely to die at home while those least likely reside in Maldon (21.0%) and Harlow (23.5%).

There is also an indication that user experience in Mid Essex is poor, as nearly a third of the indicators included in the national cancer patient experience programme are in the lowest 20% of trusts nationally. The reasons for this are worth further investigation.[41]

Cardiovascular Diseases

CVD describes the group of diseases that includes coronary heart disease and stroke. Essex's all age mortality rate (151.44 per 100,000) is much lower than England (167.13) though Braintree (159.14), Basildon (164.43) Harlow (164.98) and Epping Forest (170.71) have rates higher than the East of England (156.98). CVD is the second biggest cause of premature mortality in Essex (2814 deaths in the under 75 age group, 2007/09), despite a steady annual decrease, and is strongly associated with inequalities in health. Total number of CVD related deaths was 12451 in 2007/09, this fell slightly in the following year to 12328 (2008/10).

Broad public health and healthcare interventions to address heart disease have contributed to a significant reduction in associated mortality in Essex from 121.6 per 100,000 (1995/97) to 51.8

(2008/10). Higher mortality rates are associated with deprivation with Harlow (57.0), Tendring, (55.9) and Basildon (54.6) all recording higher mortality rates.[42]

The older peoples planning group have called for an investigation into early supported discharge for stroke survivors in Essex in terms of cost effectiveness and health benefits.

Respiratory Diseases
COPD is the collective term for a range of conditions (including bronchitis and emphysema) that result in long term damage to the lungs and they are largely preventable through reduction in smoking. Levels of COPD deaths (people under 75 years) reduced marginally across Essex from 10.01 per 100,000 in 2003/05 to 9.07 in 2008/10. Harlow reduced from 21.73 per 100,000 in 2007/09 to 14.81 in 2008/10 but continued to have the highest rate in Essex. Basildon (13.44), Tendring (11.42) and Maldon (10.70) also had higher rates. Rochford (5.53) and Chelmsford (6.40) had the lowest mortality rates in 2008/10.

Liver Disease
There has been a marginal increase in mortality rates (people under 75years) from liver disease since 2004/06 across most of Essex (the latter had increased from 6.33 per 100,000 to 6.97 per 100,000 over 2008/10). Total number of deaths in the under 75 population was 310 during 2008/10 in the ECC area, nearly two thirds of this were men (193).

Colchester (10.18 per 100,000) and Tendring (9.64) had the largest rate in 2008/10, although Basildon (8.47) also had a high mortality rate in 2008/10, Uttlesford (4.34), Rochford (5.21) and Braintree (5.27) had the lowest mortality rates in 2008/10. Colchester was the only district with a rate higher than England (9.99)

Diabetes
Diabetes is a chronic and progressive disease that is associated with an increased risk of certain complications including heart disease and chronic kidney disease. At least two thirds of Type 2 diabetes (almost 90% of all diabetes) is preventable and the condition has a significant impact, 10 years on life expectancy.

In England 14968 people died of diabetes during 2008/10 (all ages), in people under 75, diabetes accounted for 4195 deaths (a rate of 2.49 per 100,000). In Essex the rate was 2.42. Tendring (4.16), Maldon (2.77), Colchester (2.97) and Castle point (2.62) were all above this rate.

Diabetes is much more common in some ethnic minority groups, especially the south Asian population and lower socioeconomic groups. Around 5% of total NHS spend (and up to 10% of hospital inpatient spend) is used for the care of people with diabetes.

Chronic Kidney Disease (Renal Failure)
Chronic kidney disease (CKD) is often caused by diabetes or by high blood pressure (hypertension). Since 2007 the number of deaths from chronic renal failure in people of all ages has reduced from 45 deaths in 2007 to 29 deaths in 2010. Between 2007/09, Essex saw 23 deaths from chronic renal failure in people under 75, in 2008/10 there were 20 deaths. Numbers are too small at district level for any meaningful comparison. With smoking being a key risk factor, it is likely that the high prevalence of this condition persists in the more deprived communities.

Accidents and Suicides

Accidental injury is one of the main causes of death for children aged 1 to 15 years and is closely linked to deprivation. Home remains the most common site for accidents, particularly for young children and older people, followed by the road. In Essex there were 2987 hospital admissions amongst people aged 0 to 17 years with accidental injuries in 2009/10.

Road traffic accidents resulted in 759 people being seriously injured or killed on the Essex roads in 2011, which is a slight decrease on the previous year (797). The highest rate per 100,000 of the population was in Uttlesford (75.0), followed by Epping Forest (66.5). The lowest rates were in Basildon (28.0) and Maldon (28.8) Alcohol and/or use of illegal substances are often linked to accidents, especially road traffic accidents amongst young adults (16 to 29 year olds).

Falls can result in a loss of independence and can also lead to complications and death. In Essex, there were 144 deaths from accidental falls in 2008/10. All the local districts/boroughs had rates lower than England (2.96 per 100,000) except Brentwood (3.20). Harlow (0.48) and Rochford (0.77) had the lowest rates.

During 2007/09, the mortality rate from suicides in Essex (4.3 per 100,000) was lower than England (5.7). District data for 2008/10 shows that South-end (10.98), Harlow (10.08) and Uttlesford had the highest rates, which were all above the England rate (7.92).-All other districts/boroughs had rates lower than England.

Mortality from serious mental illness is often linked with unintentional (eg substance misuse, communicable diseases and infections) and intentional injuries (suicide). We do not have definitive estimates for our local population and it is not possible to extrapolate from existing information on the level of suicides, the proportion who had a serious mental health condition.

Excess Seasonal Mortality

Excess seasonal death is an important public health concern which sees an increase in mortality among people with cardiovascular diseases, respiratory diseases and amongst older people, mostly during winter but also during heat waves.

Links between poor quality housing, fuel poverty and health are widely recognised. Lower/higher temperatures, peoples lowered resistance to illnesses (due to disease), safety in the home and the incidence and intensity of influenza outbreaks, all contribute to a higher mortality rate during winter.

Over 2008/11 Colchester (27.2) had a significantly higher rate of excess winter deaths than England (19.1). Castle Point (25.0), Uttlesford (23.7), Rochford (21.9), Chelmsford (21.6), Thurrock (21.0) and Basildon (20.9) also had rates higher than England but these differences were not statistically significant. Harlow (15.9) and Brentwood (16.6) had the lowest rates.

Communicable Diseases

Because the number of deaths is small, we can only draw conclusions with caution. Over 2008/10 there were 281 deaths caused by infectious and parasitic disease (4.05 deaths per 100,000). This was lower than the rate for England (6.56). Similarly all districts of Essex, except Harlow (7.99) had rates lower than England over 2008/10. Basildon(2.69) and-Maldon (2.93) had the lowest mortality rates There was a slight increase in mortality rates for Essex in 2006 and 2007 but the rate has since fallen over 2008/10 . This reduction is possibly as a result of better surveillance and increase in immunisation rates.

2.3 Disease Burden – Prevalence and Hospitalisation

Essex has similar levels of disease prevalence, on the GP disease registers to the average for England; except for hypertension (higher by 1.1%), depression (lower by 2.3%), kidney disease (higher by 0.2%) and thyroid problems (higher by 0.8%), Asthma, Heart Failure and Atrial Fibrillation (all higher by 0.1%), Stroke, Mental Health and Obesity (lower by 0.1%). Early identification of at risk patients and better management of chronic/long-term conditions will enhance and improve quality of life, increase life expectancy and reduce costs by preventing hospital admissions.

Long-term condition and chronic illness (formerly referred to as Limiting Long Term Illness) include conditions that people have to live with over a period of time such as stroke, COPD, diabetes, heart disease and dementia. Additionally, physical and sensory impairments as well as learning difficulties can affect people's ability to carry out day to day activities, so causing disability, dependency and/or a reduced capacity to learn.

Cancer Incidence and Prevalence

There are more than 200 types of cancer but breast (most common cancer in women), lung, skin, bowel (colon) and prostate (most common cancer in men) accounted for most new cases (incidence). Risk factors for lung and bowel cancers in men are strongly linked to lower income. However, the opposite is true with breast, prostate and skin cancers, being more common in higher income groups[43] .

Each year in Essex, there are approximately 1100 new cases of breast cancer, 50 cases of cervical cancer, 800 cases of lung cancer, 950 cases of prostate cancer and 900 cases of colorectal cancer. Colorectal cancer incidence has been increasing and this may be due to the implementation of the national bowel cancer screening campaign which has enabled earlier detection.

In 2011/12 the prevalence of all cancers in England was 1.77%, the regional prevalence was slightly higher at 1.87%. Locally Thurrock had the lowest prevalence at 1.39% (or Basildon and Brentwood CCG (1.73%) if administrative Essex) with North East Essex having the highest with 2.03%, although this may be reflective of the large older population that is resident here.

Survival rates are improving but this can be improved further with early diagnosis and management of cancer patients. With over 31,966 people on the GP cancer registers across Essex (QOF 2011/12), it is also important to ensure good provision of end of life care.

A substantial proportion of cancers could be avoided through a combination of reducing smoking rates (lung cancer is increasing amongst women due an increase in smoking), improving diet and increasing physical activity. People also underestimate the risk of skin cancer and the dangers of excessive sun or sun bed exposure.

Cardiovascular Diseases

North East Essex has a higher prevalence and associated ill health from CVD than other areas in Essex. The prevalence of hypertension in all the Essex CCG areas bar Mid Essex are higher than the England average (13.6%), the highest being Castle Point and rochford with 16.7%. It is estimated that around 25% of the Essex population have an undiagnosed CVD condition that will culminate in poorer health outcomes.

A number of chronic illnesses associated with CVD can prevent people from retaining employment and claim incapacity benefit due to the severity of their illness and/or poor management of their condition.

It is also recognised that with an ageing population, Essex will have more people with CVD on the GPs disease registers with increased demand on health and social care services in years to come.

Lifestyle behaviours such as smoking, obesity and physical inactivity, all contribute to increased risks of CVD. Tackling these risk factors from an earlier age will reduce demand on services and increase life expectancy. This is discussed in more details in section 2.4 below.

The prevalence of stroke is high in some areas of Essex, (North East Essex 1.9% vs England 1.7%), which is particularly linked with age and higher deprivation. With the growth in an ageing population and poor lifestyle choices, we will continue to face a challenge in reducing the incidence of stroke and in providing adequate rehabilitation for stroke sufferers. There are 30,048 people on the stroke registers across Essex, and in 2011/12 there were just under 2,000 hospital admissions across Essex for this condition.

Diabetes

Diabetes is one of the biggest health challenges facing people living in the UK (prevalence is nearly 4%). By 2030 up to 1 in 10 of the population will have the condition with obesity, age and ethnicity being key risk factors. The poor management of diabetes can lead to serious complications including heart disease, stroke, blindness, kidney disease and amputations which in turn lead to disability and earlier death.

Across Essex, some 81,786 people are on GP diabetic registers, a prevalence of 5.7%. Many diabetic people are overweight and have poor diets and can improve their condition by becoming more physically active and making healthier dietary choices.

Over the last 3 years, Essex has seen a year on year increase in the number of emergency admissions related to diabetic ketoacidosis from 328 in 2007/08 to 394 in 2011/12. In terms of diabetic emergency admissions (2011/12) in those aged under 19 years, only South East Essex (88 per 100,000) had admission rates higher than the regional average (68).

Chronic Kidney Disease

Although seen as a serious condition, CKD if identified and managed well can be prevented from causing further renal damage. People with CKD are at increased risk of heart attack or stroke, especially if they smoke or are overweight and people from some ethnic groups are at higher risk of developing CKD. People with these co-morbidities and ethnic backgrounds, are more likely to progress to the severe form of end stage renal disease.

Across Essex, there are over 63,780 people on the chronic kidney disease registers a local prevalence of 4.5%, this is compared to a national prevalence of 4.3%. At a CCG level prevalence is highest in North East Essex (5.8%) and lowest in West Essex (3.5%).

Respiratory Diseases

COPD is the collective term for a range of conditions (including bronchitis and emphysema) that result in long term damage to the lungs. The estimated prevalence of COPD in England is 4.7%. However, only a proportion of those with COPD are on the local GP registers, with the highest prevalence in North East Essex (2.1%) and lowest in Mid Essex (1.3%). In total there are 30,126 people on GP registers across Essex. Overall prevalence is projected to continue falling especially as we continue to see a reduction in smoking prevalence.

Across Essex (2010/11), approximately 11% of patients on the COPD registers are admitted to hospital as an emergency admission related to their condition, this compares to 12% in England and 11% across the East of England.

Asthma is a more common condition than COPD and affects many children as well as adults. Triggers for asthma attacks can be very different for each person, with cigarette smoke, housing conditions, allergies (eg to pet hair) and air quality the most common triggers. Children whose parents smoke are 50% more likely to develop asthma and women who smoke during pregnancy are at risk of giving birth to babies with low birth weight, who are at increased risk of developing asthma.

The asthma prevalence across Essex (6.0%) is higher than England's (5.9%). Essex has 107,600 people diagnosed and on the GP registers for asthma. Although many patients have mild to moderate levels of asthma, in some the effects of asthma can be severe resulting in hospitalisation. Essex Asthma admission rates in those under 19 years, were highest in North East Essex (145 per 100,000) in 2011/12 and were similar to the regional (140) average. South East Essex had the lowest rate (95).

In 2011/12 the rate of emergency admissions for children with lower respiratory tract infections in Essex (240 per 100,000), was lower than both the regional (321) and national (388) rates. At a district/borough level, there is a threefold difference between the lowest district of Castle Point (116) and the highest of Tendring (379).

Liver Disease

Regular drinking above recommended daily limits increases the risk of a wide range of health problems including liver damage, such as cirrhosis and liver cancer. There is an increasing trend for people who are regular social drinkers to become dependent drinkers. The availability of cheaply priced alcohol, especially through supermarkets, is contributing to this growing concern.

Hospital admissions related to alcohol are seeing a year on year increase both at a national level (average yearly increase of 9%) and at a regional level (average yearly increase of 10%). The same is also true at a local level and all districts/boroughs in Essex, have a yearly average increase in hospital admissions ranging from 4% in Brentwood to 14% in Harlow.

37.7% of people in Essex reported binge drinking in 2010. This was slightly higher than the national average (35.1%). In 2011/12 binge drinking was highest in West (19.6%) and Mid Essex (20.5 %). North East Essex (18.7%), South East Essex (18.8%) and South West Essex (18.9%) all had rates similar to the East of England (18.3%).

Substance misuse and domestic violence often co-exist. Alcohol abuse and dependence amongst perpetrators is up to 7 times higher than the general population. Women experiencing domestic abuse are up to 15 times more likely to have alcohol dependence and nine times more likely to have a drug problem.

Nationally, the impact of alcohol misuse alone, on health, crime and society, is estimated to cost nearly £20bn a year, which roughly equates to 432 million in Essex. Harlow (10.5/1000) had the highest alcohol related crime rate in 2010/11, with Basildon (7.2) and Epping Forest (7.1) also above the regional average (6.2). Rochford (2.7/1000 ranked 10th lowest nationally), Maldon (3.6) and Uttlesford (4.2) were the districts with the lowest recorded alcohol related crime rates.

Mental Health

Mental illness is common with one in six adults afflicted at any one time and for half of these people, the problem will last longer than a year, which suggests that almost 150000 people across Essex are experiencing long term mental illness. Furthermore, over half of all adults with mental illness will have developed their conditions by the time they were 14 years old.

Mental health issues include a wide range of disorders that can impact on everyday living, including anxiety and depression, eating disorders and dementia and are a common cause of short term and long term impairment to health and wellbeing. In 2013, Essex had 7,290 people claiming incapacity benefit / severe disablement for a mental health related disorder, which is a decrease on previous years. Colchester (49%) had the highest proportion and Castle Point (33%) the lowest proportion of all incapacity claimants with a mental health illness.

The association between rates of mental illness and certain population characteristics, notably poverty, unemployment and social isolation is well established. Mental ill health can and does affect anyone (in childhood, working age, older age) and impacts on society as a whole.

Recent data (2012/13) shows that of those who are receiving secondary mental health services and are in receipt of the care programme approach (CPA) programme, only between 8.7% (South Essex) and 16.8% (North Essex) are in employment. Nationally 7.9% of those with mental illness were in employment.

Dementia accounts for more years of disability than any other condition, including stroke, cardiovascular disease and cancer. Cases of dementia are expected to double by 2030 and increase rapidly with age. There are nearly 9,325 people on GP registers with dementia across Essex. The variation in GP registers across Essex is between 0.4% and 0.6%. By 2021, the projected increase in prevalence is expected to reach 38% in the total UK population.

In a recent report on dementia care in Mid Essex, carers of people with dementia raised concerns over the co-ordination of care, there was also some concern about the understanding that health and social care staff had of their burden. Support from local voluntary groups, such as Alzheimers Society and Action for Family Carers were an essential lifeline. Excellent and innovative pockets of care in Essex were highlighted, including the “My Home Life Essex” programme which focuses on creating a positive culture in care homes by engaging with residents on an emotional level, not just a practical one. Other examples include creative dementia rehabilitation programmes, communal singing, and “Dementia Adventure” holidays. [44]

During 2010/11 over 4,000 people were admitted in Essex for inpatient care with NHS Mental Health Services. Rates of access to all NHS Mental Health Services across Essex varied from a high of 3,766 per 100,000 people in South East Essex down to 2,606/100,000 in North East Essex, against a national average of 2,789.

Over 30,000 children aged 5-16 across Essex (10%) are estimated[45] to have a diagnosable mental health disorder while the number of pupils (aged 8-16) with poor emotional wellbeing is estimated[46] at nearly 16,000 (9%). Prevalence rates are higher amongst boys than girls and amongst 11 to 15 year olds when compared to younger children. Mental health difficulties are particularly prevalent among young prisoners, homeless young adults and children in care/care leavers, plus children living in poverty,

children who are bullied, those with substance misuse problems, teenage mothers and children whose parents have mental health issues or substance misuse . Poor mental health in childhood affects educational attainment, social skills and physical health. It also increases the likelihood of smoking, alcohol and drug use. There are also wider consequences for later in life as it increases the risk of poorer physical health, unemployment, reduced earnings and criminal activity.

Satisfaction with Primary Care and Hospital Services
The latest GP patient survey (2012/13) indicated that across Essex 59% of people felt there was support from local services to manage their long term health conditions. This was in line with the national average (59%). At a CCG level, Southend (42%) (or if Admin Essex then Mid Essex (60.3%) had the lowest level of support indicated and North East Essex the highest with 65.4%.

The Hospital Inpatient Survey 2012 places all the Essex hospitals "about the same" as other Trusts for overall views and experiences, the results ranged from 4.8 out of 10 for The Princess Alexandra Hospital in Harlow to 5.3/10 for the Colchester Hospital.

2.4 Lifestyle Behaviours

Physical and Recreational Activities
Physical activity can contribute significantly to people's general physical health and wellbeing, reducing the risk of premature death from heart attacks, stroke and diabetes and improves mental health, reduces the risk of falls and protecting people from becoming overweight and obese. Over the last 25 years there has been a significant reduction in physical activity as a part of daily routines, and a small increase in the proportion of people taking physical activity for leisure in the UK. The total cost of physical inactivity for Essex PCTs in 2007 was £22.6m (£7m/100,000)10. The cost in North East Essex (£2m) and West Essex (£1.54m) were above the national average of £1.5m/100,000.

In terms of mortality, morbidity and quality of life, the Chief Medical Officer estimated in 2012 that the cost of inactivity in England to be £8.2 billion annually.

According to the most recent Active Peoples Survey data (2012/13) 57.4% of the Essex population do at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more. This is significantly better than the England average (56.0%).

The Proportion of adults participating in recommended levels of physical activity[47] in Essex (10.9%) is lower than England (11.2%), however the proportion of people in Uttlesford (14.8%), Maldon (13.0%), Rochford (12.1%), Epping Forest (12.0%) and Colchester (11.5%) that participate in recommended levels are all above the England Average.

35% of primary pupils in Essex[48] say that they have exercised to the right intensity five or more times in the last week, but just 22% of secondary pupils say this, with both proportions being slightly lower than in 2012 and lower than the national average. Boys are more likely to be exercising frequently than girls and the percentage of pupils exercising five times or more per week decreases as they get older, from 35% in Year 4 to 27% in Year 7 and 16% in Year 11. This year there were no districts with a significantly different percentage of pupils who exercise five times or more. While 84% of primary pupils enjoy physical activities at school, fewer secondary pupils (71%) say the same, with a similar pattern for how much pupils enjoy physical activities outside of school.

Across the districts/boroughs, policy makers have driven the need to ensure the allocation of green space within new developments as part of the Local Development Plans. The provision of green space including parks, playgrounds, allotments, is an essential part of the socio-environmental fabric to help promote moderate and recreational physical activity.

It is still encouraging that around half of secondary pupils[49] usually walk to school with a third travelling to school by car/van and a third taking the bus. Less encouraging is that just 7% of primary and 3% of secondary pupils cycle to school in Essex. However, in Essex, more people cycled at least once for approximately 30 minutes at moderate intensity per week, males 12.8% (an increase of 2.6%) and females 6.9% (an increase of 1.2%), over 3 years up to 2008/09. It should be noted that areas with the highest level of deprivation, such as Tendring and Harlow, have seen no or very little increase. Generally more men are taking up cycling than women, especially in Colchester (19.6%), Braintree (15.9%) and Maldon (15.7%).

The ability to keep active and independent depends greatly on mobility. Mobility can be seriously limited as a consequence of age, by the effects of falls and physical inactivity. In Essex, more falls leading to a hospital admissions were recorded in Castle Point (1578 per 100,000) and Epping Forest (1504) whilst Tendring (978) and Colchester (1004) had the lowest rates.

Work sickness absence is a significant cost to the UK economy in terms or working days lost. Although the key causes of sickness absence relate to mental health problems and alcohol related sickness, the promotion of physical activity in this setting will improve health and wellbeing as well as workplace productivity.

Diet and Obesity

Diet and nutrition are key contributors to the prevention of chronic ill health and to some extent social exclusion. The challenge of tackling obesity (increasing in prevalence) and associated chronic diseases means looking at this issue before the child is born right through to old age. A diet that includes a good range (5 a day campaign) of fruits and vegetables, can contribute to reducing the risk of CVD, obesity and some cancers.

According to 2008/10 data on obesity prevalence, 28.9% of people in Essex are obese. This is higher than both the East of England (24.3%) and the national average (25.8%). Out of the districts/boroughs, the estimates suggest that Harlow (31.1%), Castle Point (27.3%) and Braintree (26.7%) have the highest prevalence. The lowest prevalence areas are Brentwood (19.4%), Uttlesford (21.7%) and Epping Forest (22.4%).

In 2010/11, the Quality and Outcomes Framework (QOF) data indicates there are 146586 identified obese adults registered with general practices in Essex, however only around a third of the total GP registered population have had their BMI measured, an indication that many people are going undiagnosed.

According to Public health indicator 2.06, the prevalence of obesity amongst children overall in Essex in 2011/12 was 20.6% for Reception Year (children aged 4 to 5 years) and 31.9% for Year 6 (aged 10 to 11 years), both below the national averages of 22.6% and 33.9% retrospectively.

However, the 2011 NCMP lifestyle statistics data (LB0I 11.9) indicates that this is much lower. In reception year (children aged 4 to 5 years) obesity for England is 9.4%. Maldon (11.0%), Tendring

(10.9%), Chelmsford (10.7%) and Harlow (10.4%) were all above this rate. The NCMP data also shows that 17.3% of year 6 children in Essex were Obese[50], which was significantly better than the England average (19.2). Harlow (20.8) and Castle point (20.4) had the highest proportion of children classified as obese but this was not significantly different from England. We now have several years of data but there are no clear trends in prevalence at local level.

Encouraging breastfeeding can reduce the risk of obesity in later life. In 2011/12 Epping Forest, Harlow and Uttlesford had the highest initiation rates (all 77.6%) but this was only significantly better than England (74.8) in Harlow and Epping Forest. Basildon (70.1%) and Brentwood (70.1%) had the lowest rates, both of which were worse than England. The rate in Essex (74.3) overall was not significantly different from England.

The data recording for the prevalence of breastfeeding at 6 to 8 weeks following birth has been problematic and is still being developed and improved, this has led to data quality and reporting issues for a number of PCTs. Over the past two years the North East Essex PCT has experienced 6 to 8 week breastfeeding prevalence proportions of around 40%.

Smoking and Tobacco Control

Smoking is the UK's single greatest cause of preventable illness and early death. Nationally, the prevalence of cigarette smoking in the adult population was estimated at 20% in 2011/12[51] Data from the 2011/12 Integrated Household Survey, indicates that Essex (18.7%) has a smoking prevalence lower than both regional (19.6%) and national (20%) estimates.

Overall in Essex it is estimated that 25.1% of the 20% most deprived communities smoke compared to only 17.5% in the remaining 80% of the population[52]. The prevalence is estimated to be as high as 33.6% in the most deprived communities of Tendring. Younger men and women in routine and manual groups as well as teenagers are most likely to smoke. The smoking prevalence is estimated to be 26.9% in Essex overall.

According to the 2012 SHEU survey[53] 81% of all secondary pupils in Essex say that they have never smoked and just 3.3% say they smoke regularly or every day, a figure that has fallen in the last seven years. There is very little difference in smoking behaviours by gender but there is a significant difference by age as while 97.5% of Year 7 pupils have never smoked, this proportion falls to just 54.5% of those in Year 12.

Smoking in pregnancy is associated with poor pregnancy outcomes, and exposure of infants to second hand smoke is associated with death in infancy. Smoking is more common in more deprived women. The variation in smoking habits in pregnancy between socioeconomic groups accounts for about one third of the difference in stillbirth rates and infant mortality rates. In 2011/12, Essex (13.1%) had a similar rate of smoking in pregnancy to England (13.3%) and the East of England (13.3%). Tendring and Colchester had rates significantly higher than England (both 17.0). Chelmsford, Braintree and Maldon all had a rate (9.7) significantly lower than the England average.

Excessive Alcohol Consumption

2008/09 estimates suggested that adults in Essex were taking part in increasing and higher risk drinking. In 2011/12 binge drinking was highest in West (19.6%) and Mid Essex (20.5 %). North East Essex (18.7%), South East Essex (18.8%) and South West Essex (18.9%) all had rates similar to the East of England

(18.3%). This behaviour increases the risk of CVD, cirrhosis, poor mental health, unemployment, accidental injury and death. Factors which can trigger hazardous drinking amongst adults include bereavement, mental stress, physical ill health, loneliness, isolation and loss.

Women who regularly drink more than 6 units of alcohol a day (or more than 35 units a week) and men who regularly drink more than 8 units a day (or 50 units a week) are at the highest risk of alcohol related harm. Women who drink heavily during pregnancy put their baby at risk and consequential disorders can lead to lifelong intellectual and behavioural problems for the child.

In Essex with people aged over 15 years, 18.6% reported engaging in hazardous drinking and 4.5% in harmful drinking, – this is higher in the south of the County at 4.9% (2009/10). The data also suggests that there are over 34000 (3.6%) dependant drinkers across Essex.

10% of all secondary pupils in Essex[54] say that they have been drunk at least once in the last four weeks: 4% once, 3% twice and 2% three times or more. This percentage has fallen significantly in the last five years. There is no difference between genders but the percentage of those being drunk increases significantly with age, from just 1% of Year 7 pupils to 32% of Year 12 pupils.

This increase in alcohol abuse coincides with an increase in hospital admissions due alcohol related harm over the last few years. In 2010/11 Harlow (2380 per 100,000) remained the only district in Essex to have a rate significantly higher than England (1895 per 100,000). All other areas in Essex had rates significantly lower than England (1515 per 100,000). The lowest rates were in Brentwood (1163) Colchester (1309) and Braintree (1362).

There has also been an increase in alcoholic liver disease which does not usually cause any symptoms until the liver has been extensively damaged. There has been a marginal increase in mortality rates (people under 75years) from liver disease since 2004/06 across most of Essex (the latter had increased from 6.33 per 100,000 to 6.97 per 100,000 over 2008/10). Total number of deaths in the under 75 population was 310 during 2008/10) in the ECC area, nearly two thirds of this were men (193).

Alcohol misuse can also contribute to an increase in criminal behaviour. Harlow (10.5 per 1000) had the highest alcohol related crime rate in 2010/11, with Basildon (7.2) and Epping Forest (7.1) also above the regional average (6.2). Rochford (2.7 per 1000 was ranked 10th lowest nationally), Maldon (3.6) and Uttlesford (4.2) were the districts with the lowest recorded alcohol related crime rates. It is also important to take note of the effect of alcohol abuse on families, with the risk of domestic abuse. Intoxication also increases the risk of accidental injuries, including road traffic incidents.

Early identification and referral of people with a drinking problem is important if we are to slow down these gradual increases in morbidity, especially as it is estimated that only 5.6% of these people access an alcohol treatment programme annually.

Drug Misuse

People with drug misuse problems are more likely to live in and be from more deprived communities and are likely to concentrate (especially for illicit substance users) in conurbations (eg Clacton, Basildon) where drugs and the means to pay for them are more readily available.

They are also more likely to be experiencing a range of health and social care related issues and will be linked to a number of services such as Mental Health, Primary Care and other non medical service

provision and are frequently also known to criminal justice services due to offending behaviour often associated with this client group.

The Problem Drug Use (PDU) now defined as Opiate and Crack Users (OCU) prevalence estimate for Essex was 4668 people in 2009/10, this estimate fell in 2010/11 to 4556 people[55]. Latest figures from the local data in 2012/13 show that treatment for PDU is highest in Basildon (OCUs 418, others 132) and Colchester (OCUs 370, others 104), whilst Maldon (OCUs 40; others 25) and Uttlesford (OCUs 59; others 25) had the lowest proportion of users in treatment. This is fairly consistent with the previous year end data.

For many young people drug and alcohol use is a part of growing up, but for a small proportion of young people experimental and recreational use becomes problematic. 9% of all secondary pupils in Essex[56] say that they have ever taken drugs, with boys being slightly more likely to say this and with age having a significant impact on behaviour: while 3% of Year 7 pupils say they have taken drugs, this rises to 23% of Year 12 pupils. 39% of pupils who have taken drugs also say that they have been drunk three times or more in the last month, while 55% of those who have been drunk three times or more in the last month have ever taken drugs.

Recent trends show that those under 18 years accessing structured treatment has remained the same between 2011/12 to 2012/13, 287 and 298 respectively. The decline between 2010/11 to 2011/12 was due to a recalculation in the methodology to the raw data itself. Essex saw an increase of 62% over 2008/09 to 2010/11 in those under 18 years accessing structured treatment for substance misuse, (from 218 to 353 retrospectively.) The profile of these clients has remained very similar to previous years although towards the end of 2012/13 we have seen an increase in the number of clients entering treatment for drugs such as Mephedrone and other Novel Psychoactive Substances which is replicated in the national data.

Sexual Health

Unprotected sex can lead to STIs, unwanted pregnancy and preventable terminations. The health and social consequences associated with contracting STIs, such as HIV, are enormous to the individual, their relatives and the health economy. HIV sufferers can feel excluded and people are often so worried about stigmatisation that they avoid checking whether they may have accidentally contracted a STI following unprotected sex.

50% of people diagnosed with HIV in England are diagnosed late; this figure increases to 55.9% in Essex. Basildon is an outlier with a significantly higher proportion of those with HIV diagnosed late compared to the national average (72.5%)

There is a major need in the HIV positive population in Black African women living in the second most deprived areas of Harlow, aged 35 to 44. The prevalence of diagnosed HIV in Harlow exceeds the threshold of 2 per 1000, and general testing of the population for HIV is recommended by NICE, BHIVA and other national organisations. [57]

More females than males under 20 are diagnosed with STIs although there are more males in this age group.

There are high prevalence levels of the 5 key sexually transmitted infections (chlamydia, gonorrhoea, syphilis, HIV and all acute STIs) in the areas of Harlow and Basildon compared to the rest of Essex. This is suggestive of the need to better engage with the more disadvantaged communities in developing and improving access to sexual health services.

Good contraceptive services can keep the demand for terminations low and reduce the risk of teenage pregnancy. Based on information gathered through the Chlamydia screening programme, it is evident that poor sexual health practices prevails in the younger age groups (people under 25 years), across Essex. Just 36% of all secondary pupils in Essex[58] say that lessons on sex and relationships are useful, and the proportion saying this falls significantly from Year 10 onwards. Half of pupils say they would know where to go for advice and/or support on sexual health, although the percentage saying they know where to go increases from 42% in Year 7 to 60% in Year 12.

A study by Healthwatch Essex[59] found that some young people access advice about sexual health on the internet but that this is not always a reliable source. This risk is particularly relevant when considering young people aged 16-25 who are not connected to a school or employment. There are also gaps in sex education for disabled people and for young people with special needs.

There is a strong association between teenage conception rates, low educational attainment, low aspirations, and poor employment prospects at 16 to 18 years. Teenage parents often have poor parenting skills and end up living in 'poverty'. Under 18 conception rates have been steadily declining in England, the East of England and Essex, with rates in Essex (28.3 per 1000) being higher than the East of England (26.2 per 1000) but lower than England (30.7 per 1000) in general . The under 18 conception rate (15-17 year olds) in Essex declined from 36.9 per 1000 GP registered female population in 1998 to 28.3 per 1000 in 2011. The highest rates are in Harlow, Tendring and Basildon with only Harlow (Harlow, 40.6/1000) having a rate higher than England and the East of England.

2.5 Interventions to Reduce Health Inequalities

Tackling health inequalities has been on the local agenda, following a plethora of government policies introduced since 2003, culminating in Essex's publication of its Health Inequalities Strategy in 2009. There are some signs of progress (reported in this section) but much remains to be done including improving joint working, ensuring appropriate measures of performance/progress, and rolling out more evidence based interventions that would help achieve the QIPP (Quality, Improvement, Prevention and Productivity) agenda.

In April 2013, LINks was superseded by Healthwatch Essex which is a new 'consumer champion' for health and social care services. Healthwatch Essex has a seat on the Health and Wellbeing Board whose function is to integrate health and social care locally. A major task for Healthwatch Essex will be to drive integration by presenting a view of the lived experience of users of health, social care and other related services, so that services can become seamless and better oriented to meeting people's needs.

Issues currently being investigated by Healthwatch include the experience of unpaid carers and understanding people's information and signposting needs. The organisation is also considering investigations into the experience of hospital discharge (which is one of the issues raised by the Who Will Care Commission) and the higher ratio of population to GPs in Essex in comparison with other localities.

Early Years and Children

Pre-birth to five are considered key developmental years for a child's health and wellbeing habits and foundations. Parental and in particular maternal characteristics and behaviour during pre-conception, the antenatal period and post birth play key roles in the child's development alongside the general wider determinants of health such as family income, access to health care interventions such as immunisations and access to early education. Our local emphasis on early years' interventions is

consistent with the life course approach to tackling inequalities. More targeted services in children's centres have been established, and centres are also focusing on reducing the impact of child poverty.

The main presenting issues for families seen by children's centres in Essex[60] include: poor or inadequate parenting; adult mental health and emotional issues; the impact on children of domestic abuse or parental substance misuse; finding employment; advice/support on benefits and debt management; child behaviour issues; and parental isolation or poor self-esteem. The most common reasons for referrals for targeted support include supporting families with: basic parenting skills, including play; managing challenging behaviour in children; understanding the impact of domestic abuse; emotional and social development; and accessing community services/building support networks.

Nearly 54,000 children under five are currently registered with children's centres in Essex[61], representing 64% of all children under five, although the percentage varies, with the lowest proportion in Uttlesford (48%) and the highest in Harlow (75%) and Tendring (74%). 33% of children under five who are registered with a children's centre have attended an event during a three month period.

Research evidence[62] shows the majority of parents using children's centres in Essex appear to be satisfied with them and the help/advice/service they have received there, and although they generally feel catered for, they would appreciate some additional services. 68% of children's centres inspected were rated by Ofsted as good or outstanding under 'Overall Effectiveness', while none were rated as inadequate. The needs of most families can be met through what is currently on offer at centres, although some gaps in services have been identified. For many, though, the issues are deep-rooted from cycles of poor parenting and counselling could support parents if it were to be made available.

Targeted lifestyle interventions have also been introduced with early indications of some success. These include tackling childhood obesity (eg the Mind, Exercise, Nutrition, Do It! (MEND) scheme), teenage pregnancy (eg access to free contraception and emergency hormonal contraception) and improving educational attainment for children being looked after. There has also been an improvement in the proportion of children being breastfed at 6 to 8 weeks, following the roll out of peer led support programmes.

Early Identification

A number of national screening and assessment programmes are in place to support the early identification of health and social care needs. In the past 2 to 3 years a number of new schemes have been implemented across Essex which will specifically target risk factors associated with health inequalities. Some of these include Health Checks and the introduction of the alcohol Identification and Brief Advice (IBA) scheme.

All PCTs/CCGs in Essex have now introduced a local Health Check programme, primarily through GP services. This programme will help identify people at risk of conditions, such as diabetes and CVD but will also help identify those who need to be encouraged to lead a healthier lifestyle. In areas, where uptake to the checks has been low, especially with hard to reach groups, external providers have been commissioned. A senior health check scheme is also being piloted in North East Essex to identified patients at higher risk of health related complications.

A more comprehensive alcohol pathway is being developed across Essex to ensure that we can identify people who are dependent drinkers as well as consuming harmful levels of alcohol and signpost them to

services to help them. The IBA scheme in primary care has been rolled out across Essex, with additional liaison nurses based in acute hospitals to provide timely assessment of people at risk of alcohol abuse.

Community Based Interventions
Implementing broad lifestyle interventions aimed at supporting people to make healthier choices is paramount in tackling the gap in health inequalities. In Essex there are innovative and evidence based schemes aimed at tackling obesity, drug and alcohol misuse and a comprehensive smoking cessation service operates across the county. There are also plans in place targeting the health and wellbeing of vulnerable groups, such as travelling families, people with learning disabilities, prisoners and people who are homeless.

Targeted social marketing is used to improve health and social wellbeing and reduce stigma (eg promoting the uptake of Chlamydia screening is helping to de-stigmatise perceptions about STIs). The use of marketing has helped improve flu and MMR immunisation rates. There is also an Essex wide website, via Facebook, to promote health and wellbeing and to signpost young people to relevant services.

Improving Disease Management in Primary Care
The introduction of the Quality Outcomes Framework in primary care is intended to help improve the quality of primary care services and improve the care of people with chronic conditions. In some areas of Essex, additional Local Enhanced Services have been introduced to help identify and treat people at higher risk of complications.

2.6 Population Protection

Infectious Diseases
A number of well established national public health strategies are in place for the surveillance, prevention and control of infectious diseases. Currently of particular interest in infectious disease control, are the threat of pandemics (Influenza - Swine Flu and Bird Flu), hospital acquired infections (such as MRSA), the increase in Blood Borne diseases (such as Hepatitis B/C and HIV) and the increase of certain infections (for example, Tuberculosis and Measles).

Preventing the spread of these diseases is of paramount importance as the outcome of contracting many of them may shorten life. The surveillance work undertaken by the Health Protection team can help to reduce the risk and consequences of potential serious outbreaks.

A number of immunisation programmes are in place to ensure that the population acquire a good level of immunity from childhood into older age. Inaccurate media reporting around the effect of some of these programmes had a negative impact on the uptake of MMR and the flu jab over recent years. With some innovative and evidence based public health interventions, we are seeing an improvement in uptake with MMR vaccination alone showing a 5 to 6% increase over the past 2 years. In 2011/12 Essex had a rate similar to England for 1 dose at 2 years old (91.2%) a rate lower than England for 1 dose at 5 years old (91.1%) but a rate higher than England for 2 doses at 5 years old (86.7%)

In 2012/13 MRSA infection rates in England were 1.7 per 100,000, this is the lowest since April 2009; Basildon and Brentwood (3.1) had a rate above this. The other CCGs in Essex had rates similar to this, except for North East Essex which was much lower (0.6) .

Over April 2009 to March 2012 *C. Difficile* infection rates fell in Mid Essex, North East Essex and South East Essex. However, Latest figures up to March 2013 show that Mid and West have continued to fall but other CCG areas have risen. For example, the rate in Basildon and Brentwood increased from 17.2 per 100,000 to 20.3. The current rates are however (West Essex = 18.6, North east = 21.4, Mid= 20.4, Castlepoint and Rochford = 23.8, Basildon and Brentwood =20.3) all below the national rate (27.3 per 100,000).

The rolling out of targeted specialist services, Hepatitis B/C vaccination (eg drug users) and the Needle and Syringe Programme, is helping to prevent the spread of Blood Borne Viruses.

Other Major Incidents
Agencies continue to collaborate to ensure that Essex is fully prepared for the effects of flooding as some of the county is within high risk flood zones.

The Essex Resilience forum has a comprehensive strategy to help deal with other major incidents such as the risk of terrorism, outbreak of a pandemic flu and large scale incidents.

2.7 Recommendations to the Health and Wellbeing Board

Life Expectancy and Quality of Life

. Need to ensure that a strategy is in place to reduce inequalities in life expectancy and that there is a collaborative undertaking to tackle the wider determinants of life, implement targeted interventions where necessary and engage with local communities to improve overall quality of life.

Cancers

. Ensure regular campaigns for the public to be aware of risks and also symptoms that can indicate cancer and know when to seek medical advice.

. Ensure increasing numbers of people are attending national cancer screening programmes and that patients are diagnosed without unnecessary delay.

. Effective strategies to reduce risk factors, tobacco consumption, alcohol misuse, unhealthy diets, obesity and excessive sun/sun-bed exposure.

Cardiovascular Diseases

. Need to ensure a robust strategy to improve prevention, provide better management of patients and provide effective evidence-based interventions.

. Prevention strategy needs to focus on inequalities associated with lifestyle risk factors and personal responsibility for health (eg physical inactivity).

Respiratory Diseases

. Collaborative working to improve housing conditions for people with asthma.

. Ensure stop smoking programmes target people with asthma and COPD and those with children.

. Early identification and better management of people with respiratory illnesses in primary care.

Liver Disease

. More concerted support for the development of work around earlier identification and support for alcohol misuse within primary care, hospitals and other settings.

. Develop a systematic alcohol strategy, with a focus on preventing alcohol abuse amongst young people.

Diabetes

. Prevention strategy needs to be tailored and focus on inequalities associated with lifestyle risk factors and personal responsibility for health (eg physical inactivity).

. Early identification and optimal management are paramount to enable good diabetes control and avoid unnecessary complications.

Chronic Kidney Disease

. More CKD care, including renal replacement therapy, should take place closer to home, especially for those patients requiring end of life care.

. Early identification and better management of people with CKD in primary care.

Accidents and Suicides

. Continue to develop a more co-ordinated safety enforcement, promotion and education programme across key agencies, especially with children (eg home safety equipment), young people (eg through PSHE) and older people (eg home minor adaptations).

. Strategy to improve the population's mental wellbeing should address the broader factors affecting mental health which could lead to suicidal intent (eg people in debt, being bullied or prisoners).

Excess Seasonal Mortality

. Improve referral system for high risks residents and assessments using the Common Assessment Framework (CAF) which can include identification of at-risk residents.

. Effective falls prevention programme with community-based support services, effective public health interventions (eg fuel poverty payment) and better management of chronic conditions.

Mental Health

. Work with partners to ensure focus on positive emotional and social wellbeing across services and implement/ rollout initiatives for children and families (eg parenting programmes) as well as carers, especially those supporting people who have dementia.

. Develop a strategy to improve the population's mental wellbeing whilst addressing the broader factors affecting mental health and not just treating mental ill-health.

. Focus on earlier diagnosis of dementia, improving the provision of intermediate care and rehabilitation and increasing the range of accommodation choices for people with dementia with good quality residential and nursing care places.

. Consistent signposting to opportunities for support in the wider factors such as support to maintain/seek employment (eg skills development, volunteering) and managing income and debt (eg to minimise accommodation issues).

Physical and Recreational Activities

. Strategy to ensure physical activity is embedded in policy (eg Planning, Sports Development) with a need to protect green space for formal and informal active recreation.

. Sustainable and tailored support for the individual (eg Health Trainers) and families (eg MEND) through setting-based interventions (eg workplaces, schools).

Diet and Obesity

. Better identification and referral of people at risk of being overweight is required at primary care (GP) level and in schools, with more effective community based prevention and support programmes.

. Continue to develop new initiatives and embrace new approaches to improve breastfeeding rates.

Smoking Prevalence

. As a major cause of ill health and mortality, strategy must tackle prevention among young people, increase smoking cessation services in areas of high prevalence and ensure robust tobacco control measures are in place and enforced.

Alcohol Misuse

. Co-ordinated approach to focus on problem drinkers, where domestic violence is a known risk with support for perpetrators and victims.

. Investment in alcohol misuse prevention (including setting-based) and treatment services needs to increase to improve access to detoxification programmes. Early identification and referral of problem drinkers can further impact on morbidity.

. Strategy must also focus on the health and social impact of alcohol misuse among young people.

Drug Misuse

. Increase the penetration rate to ensure drug users are engaged in effective drug treatment and supported to live independently.

. Life course approach to prevention to tackle societal adversity by implementing comprehensive intervention programmes in adolescence and early adulthood and restricting supply.

Sexual Health

. Ensure sexual health services are configured to provide an effective prevention programme, a broad range of contraception and promote STI screening (esp. Chlamydia) in core services.

. Strategy should also focus on the link between alcohol misuse, sexuality and personal safety.

Interventions to Reduce Health Inequalities

. Strategy should embrace the wider social and economic determinants of health, including skills, jobs and good neighbourhoods in which families can thrive. A shared focus by public sector agencies on children is an investment in the future of our communities. Community based interventions to promote healthier lifestyle choices will also help reduce inequalities.

Population Protection

. Strategy should continue to promote immunisation and vigilance against outbreaks of infectious diseases.

3. Children, Young People and Families

3.1 Early and effective support for children, young people and their families

Every child should have the opportunity to reach their full potential and children are best supported to grow and achieve within their own families. ECC are working hard to develop flexible services which are responsive to children's and families' needs and provide the right level of intervention at the right time. This supports a shift of focus away from managing short-term crises and towards effective intervention and support for children and young people and their families at an earlier stage.

All children and young people receive universal services, such as maternity services at birth; health visiting and children's centre in early years; school and youth services for older children. Universal services seek, together with parents and families, to meet all the needs of children and young people so that they are happy and healthy and able to learn and develop securely. However, some children, either because of their own additional needs or because of less advantageous circumstances need extra help to be healthy and safe and to achieve their potential. Children with additional needs are best supported by those who already work with them, such as children's centres or schools, organising additional support with local partners as needed.

For those children whose needs are intensive, a co-ordinated multi-disciplinary approach is usually best, in which a lead professional works closely with the child and family to ensure they receive all the support they require. Children, young people and their families[63] want to be: treated with dignity and not judged or stigmatised; listened to and their opinions respected; given choices and involved in making decisions.

Essex has recently implemented a new Family Solutions service with teams across the county working with families who have multiple vulnerabilities by supporting and challenging families to identify their own solutions and move forwards towards their goals.

It is our belief that most children and young people do best when they are supported to live safely at home. We are therefore committed to preventing children from entering the care system through our in-house Divisionally-Based Intervention Teams (D-BIT), Multi-Systemic Family Therapy service, and continuing our commitment to High Level Family Support offering crisis intervention and support 24/7 to families in difficulties, including families where a child or young person has a disability.

Children and young people and their parents receiving support from the D-bit wanted the support to continue, either through more targeted or specialised support, or to have support available on hand when families need it, such as through telephone support or drop in facilities. All members of the family appeared to want to be able to talk to someone when they feel they need help, with many wanting to remain in contact with their current workers. [64]

Some children's needs are so great that statutory and /or specialist intervention is required to keep them safe or to ensure their continued development. Examples of specialist services are Children's Social Care, Child and Adolescent Mental Health Service (CAMHS) Tier 3 and 4 or Youth Offending Service.

3.2 Maternal and Infant Health and Wellbeing

There is widespread consensus that the early years in a child's life (aged 0 to 5 and especially the first 24 months) have a strong impact on future health, attainment and social/emotional development. The factors that affect children's health generally are social disadvantage, poverty and poor access to education and other services. Socially disadvantaged groups suffer poorer physical health and lower life expectancy than the more advantaged, have higher incidence and prevalence of acute and chronic illness, and are more likely to smoke and have a poor diet. Children from poorer backgrounds suffer higher rates of accidental injury, infections, failure to thrive, general ill health, anaemia, dental cavities and teenage pregnancy. In addition, poorer families are less likely to have access to and make appropriate use of health services than those from more advantaged circumstances and they are less likely to benefit from health promotion services and advice.

The majority of women are judged to be at low risk of developing complications during pregnancy or childbirth, with around 20 to 25% at higher risk. These risks may also include factors such as smoking, diet and substance misuse all of which can contribute to low birth weight and infant mortality. These factors are more prevalent amongst younger pregnant women, especially teenagers. There are an estimated 1,180 young mothers under 20 in Essex[65]. Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health and have lower rates of economic activity in adult life. The health risks to the children of teenage parents include a much higher infant mortality rate (60% higher than older mothers). Teenage mothers are more likely to smoke during pregnancy and are less likely to breastfeed.

To minimise other risks to both mothers and the unborn children, a number of antenatal screening programmes have been introduced and it is crucial that expectant mothers are provided with expert guidance to take up these tests.

In Essex County in 2011, there were 16330 live births (62.60 per 1000 females aged 15-44yrs) to women aged 11 to 49 years. This is below the national average (64.2) and the regional average (65.0). The highest birth rate in Essex was in Harlow (74.9) and the lowest in Castle Point (54.8).

Low birth weight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life. In Essex 6.7% of live and still births were under 2500 grams in weight in 2011, which was lower that England (7.4%) and the East of England (6.9%). Tendring (8.9%) had the highest proportion of low birth weight babies in Essex and Chelmsford (5.1%) had the lowest.

The infant mortality rate (under 1 year) is a useful indicator of the overall health of a population. There are significant differences in infant mortality rates between different population groups. Whilst neonatal deaths (within 28 days of birth) are particularly associated with the circumstances of pregnancy/ childbirth, post-neonatal deaths are more associated with parental circumstances.

During 2007/09, the infant mortality rate in Essex (3.9 per 1000 live births) was lower than England (4.7). This has decreased to 3.5 per 1000, which remains below the national average of 4.3.

Breastfeeding is an important part of maternal and child health and provides the best start in life for a new born child as well as offering many benefits for mothers. Breastfeeding has an essential role to play in improving the public's health and reducing health inequalities; by preventing disease in both the short

and long term, for mother and child. It also supports the development of an intimate and affectionate bond between mother and child.

Children who are not breastfed are at increased risk of a number of poor health outcomes. Breastfeeding protects babies from infections including gastroenteritis and urinary tract infection and childhood diseases, including juvenile-onset insulin-dependent diabetes mellitus and respiratory disease. Breastfeeding can also positively influence maternal health and can protect women against certain forms of cancer, including breast cancer and epithelial ovarian, thereby reducing the burden of ill health on women.

In 2011/12 Epping Forest, Harlow and Uttlesford had the highest initiation rates (all 77.6%) but this was only significantly better than England (74.8) in Harlow and Epping Forest. Basildon (70.1%) and Brentwood (70.1%) had the lowest rates, both of which were worse than England. The rate in Essex (74.3) overall was not significantly different from England.

The data recording for the prevalence of breastfeeding at 6 to 8 weeks following birth has been problematic and is still being developed and improved, this has led to data quality and reporting issues for a number of PCTs. However, over the past two years the North East Essex PCT has experienced 6 to 8 week breastfeeding prevalence proportions of around 40%.

The provision of immunisations programmes is aimed at reducing the risks associated with communicable diseases (such as measles, mumps, rubella, flu and polio) all of which are diseases with serious complications. The childhood immunisation programme targets children under the age of 5 years. With some innovative and evidence based public health interventions, we are seeing an improvement in uptake with MMR vaccination alone showing a 5 to 6% increase over the past 2 years. In 2011/12 Essex had a rate similar to England for 1 dose at 2 years old (91.2%) a rate lower than England for 1 dose at 5 years old (91.1%) but a rate higher than England for 2 doses at 5 years old (86.7%).

Good parenting skills can contribute significantly to improved outcomes in later life for all children. Supporting parents to make healthier choices, provide a safe learning environment (including discipline) and have aspirations will prevent poor outcomes (eg criminality, poor lifestyle choices) in life.

A recent survey[66] of maternity services highlighted some areas of concern, including lack of information about new mothers' emotional health (21%), about their physical health (17%) and about infant feeding (13%). Hospital level patient ratings across Essex were poor (between 5.8 to 6.5 out of 10) in comparison to the rest of England. Only 74% of patients felt they were involved in decisions about their care and only 63% reported being treated with 'kindness' and understanding in hospital after birth.

3.3 Early years development

Supporting children and parents during a child's early years of development is key for children's health and wellbeing. Educational attainment is influenced by both the quality of education children receive and their family's socioeconomic circumstances. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources and has an impact on health and health inequalities. The factors associated with low achievement are eligibility for free school meals, levels of unemployment single parent households, having parents with low educational qualifications and being persistent truants.

The needs of most families can be met through what is currently on offer at children's centres, through signposting and through referring on. Nearly 54,000 children under five are currently registered with children's centres in Essex, representing 64% of all children under five. However, the percentage of children registered varies, with the lowest proportion in Uttlesford and the highest in Harlow and Tendring. 33% of children under five who are registered with a children's centre have attended an event during a three month period but this again varies by district, with the highest proportions in Harlow and Tendring and the lowest in Brentwood. The highest rates of average daily attendances are also in Tendring and Harlow, while Colchester and Castle Point are above the county average rates as well, but Uttlesford, Maldon and Brentwood all have below average attendance rates.

Research evidence show the majority of parents using children's centres in Essex appear to be satisfied with them and the help/advice/service they have received there. 68% of children's centres inspected in Essex were rated by Ofsted as good or outstanding under 'Overall Effectiveness', while none were rated as inadequate.

A recent needs assessment of children centre services has revealed a number of gaps in the service and difficulties in obtaining services. For example, a lack of childcare/crèche provision for parents to attend services; uncertainty around the referral criteria and thresholds for other agencies; Long delays in accessing specialist support, or a lack of support, from agencies providing services such as counselling, mental health or SEN support; Joint antenatal and breastfeeding support/advice; Transition to pre-school/nursery settings and schools.[67]

3.4 Family environment and impact on outcomes for children

Poor family environment can have a significant impact on good outcomes for children. Research[68] has suggested that a number of factors such as mental health, behaviour and youth offending etc. are influenced by the quality of the parent-child relationship and by improving this relationship it has a positive impact on outcomes for the child, the family as a whole and society (e.g. the social, health and economic costs of unemployment and poor health). Concerns about finances, lack of employment, the risk of eviction and homelessness alongside families with complex / multiple needs increases the risk of poor outcomes for children.

In Essex there is a growing population of families with younger children and lone parents. The child and young people population is expected to increase by 10% by 2021. An increase will occur across all districts but will be greatest in Colchester. Findings from the Essex Residents' Survey (2013) suggest in comparison with all respondents, people with children in the household are more likely to be concerned about financial issues. In Essex, there are approximately 19,600 families that have dependent children but where no one aged 16 or older in the household is in employment[69]. Supporting parents to reduce their costs and increase their income is therefore important in improving both the family environment and longer-term improved outcomes for children.

Housing and homelessness

There are four groups of children and young people who are at particular risk of poor outcomes resulting from homelessness: those aged 16 to 17 years who are homeless or at risk of homelessness;

care leavers aged 18 to 21 years; children of families living in temporary accommodation; and children of families who have been, or are at risk of being, found intentionally homeless by a housing authority. People with children are the biggest priority need identified in applicants eligible for assistance and unintentionally homeless. Additionally there has been a large increase in applicants from lone parents. Over a quarter of all applicants lost their last settled accommodation due to the termination of assured short hold tenancy or accommodation tied to a job which is no longer available.

A total of 1,117 households were accepted as homeless by Essex district councils (excluding Colchester)[70] in the 12 months ending 30/9/2012, up from 1,023 a year earlier. Of these, 799 households had dependent children or a pregnant female within them. Children's social care carries out 500 to 600 joint assessment interviews with housing departments each year, but this is not the full number across the county. In addition there are just under 300 children in care aged 16 or 17 who will require housing support as they leave care and around 400 18-19 year olds known to the Leaving and Aftercare Team[71], many of whom will have housing needs.

Homelessness can significantly increase child vulnerability and care leavers may go into bed and breakfast accommodation increasing their risk of outside influences. Those from disadvantaged backgrounds or who have experienced trauma are at increased risk of homelessness. The main 'trigger' for youth homelessness[72] is the breakdown of family relationships, often compounded by difficulties at school (for 16/17 year olds), overcrowding at home, mental health problems, substance abuse and crime. Up to half of single homeless youths have experienced being looked after. Children who have been excluded from school are 90 times more likely to end up living on the streets than those who stay on and pass exams. Young homeless people often do not get the help they need from local authorities or formal support services but instead get by in hidden homelessness situations such as rough sleeping and squatting. They are more likely to sleep in dangerous places, travel longer distances and have mental health, drug and alcohol problems.

Since 2009, there has been a year on year increase in the number of housing benefit claimants with children[73]; both single claimants (25%) and couples (63%). Basildon, Colchester and Tendring are all areas with high levels of housing benefit claimants that are likely to attract additional families seeking affordable housing.

Welfare reforms are likely to have a greater impact on areas with higher concentrations of benefit claimants and particularly social housing estates and low income areas. This impact will be two fold both in terms of the impact on existing families but also on families migrating to the area seeking affordable housing. Estimates by the Essex Welfare Reform group suggest 1,000 existing households with children are likely to be affected by the benefit cap; 150 families will see reductions in excess of £600 per month and an estimated 14,200 claimants will be affected by social sector under occupancy and reductions in housing benefit. Disabled children may lose up to £28 per week and reassessment for adult Disability Living Allowance is likely to see a reduction in eligible claimants and young people being found fit for work. This may impact on 'Not in Employment, Education or Training' figures.

Families with multiple needs

Living in a family with multiple needs or a particularly disadvantaged household increases the risk that children in the family will also have a number of different needs[74] and experience difficulty reaching their full potential. This could include; mental health issues, drug and alcohol misuse, poor health, additional educational needs, persistence absences from school leading to poor educational attainment and employability issues, behavioural problems, youth offending and anti-social behaviour and risk of eviction or homelessness.

In the past interventions to support families with complex needs have been reactive, often single agency, single issue responses without input from the family. The Whole Essex Community Budget project aims to support families with multi-agency family teams providing intensive intervention with a view to reducing duplication, providing a whole family solution and reducing costs, thereby helping to: reduce drug and alcohol misuse, unemployment, poor health, crime and family conflict; help support people into employment; and improve community participation, reducing the need for some services e.g. social care. As at 31/3/2013 the service had worked with 293 of 480 families identified and since September 2013 there have been eight multi-disciplinary family teams in place and working intensively with families who have multiple vulnerabilities to move forwards towards their goals.

The term 'Toxic Trio' has been used to describe the issues of domestic violence, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people. Analysis was carried out to identify where children may be at increased risk of harm as a result of living in a household where both substance misuse and domestic violence are both present and hot-spots were found in Basildon, Harlow, Central Colchester, Central Chelmsford, Witham, Braintree and Jaywick/Harwich[75]. A further refinement of this analysis should be possible if/when adult mental health service data becomes available.

3.5 Educational attainment and aspiration

Attainment across Essex has improved significantly at each key stage, and although it is still below the national average for Foundation Stage, it now equals national averages at Key Stage 2. Essex now matches or betters the England average in most Key Stage 4 (GCSE) measures, although the percentage achieving 5+A*-C GCSEs in 2012 (58.9% including English and Maths) was slightly lower than the England figure. The percentage of students achieving 2 or more passes (of A Level equivalent) at Level 3 qualifications was also above the national average.

This means 40% of pupils did not achieve the expected score at Foundation Stage and a fifth of pupils did not achieve the expected Level 4 in both English and Math at Key Stage 2. 41% of pupils did not achieve the target five A*-C grades at GCSE (including English and Maths) and 6% did not achieve 2 or more passes at A level. However, there is wide variation across Essex with pupils in Basildon, Harlow and Tendring performing below the county average at all stages and those in Braintree, Castle Point and Maldon performing below the Essex average for some stages.

Poor attendance is a strong predictor of poor attainment. Several initiatives are aimed at improving attendance, directly or indirectly through increasing general engagement/ enjoyment. Persistent secondary school absence has fallen to 7.7% in 2011/12, slightly higher than with the national figure.

While Essex has made significant improvements in the expected outcomes for children and young people in care over the last few years, it is still below that of their peers. There is also a significant gap in attainment levels between boys and girls (as there is nationally), between pupils having free school meals and those who do not, and between pupils with special needs and all pupils. The picture amongst the BME community is mixed, with some communities outperforming the Essex average.

Assessment of children with special educational needs (SEN) is a national requirement. If a child's needs cannot be met through an agreed plan (eg Statement, School Action Plus), ECC may consider the need for a statutory assessment and if appropriate a multi-disciplinary assessment will be made. Most children with SEN require support with behavioural, emotional and social development and cognitive skills. The percentage of Statemented pupils in Essex achieving expected levels was above the England average at Foundation Stage and Key Stage 4 but below at Key Stage 2 in 2012, but significantly fewer pupils with special needs achieve the expected level of attainment at each key stage. Young people with statements of SEN are considerably more likely to move into positive outcomes than those on School Action Plus and more likely to do so than those on School Action.

Young People Not in Employment, Education or Training

National statistics show that young people who are not in employment, education or training (NEET), are more likely to have parents with qualifications below 'A' Levels, parents who are in routine or lower supervisory jobs and have been eligible for free school meals. 27% of persistent truants and 11% of occasional truants are NEET, compared to 5% of young people who have not truanted. 36% of young people with no reported qualifications and 28% with lower grades at GCSE are NEET, compared to 2% who have received 5 or more A*-C grades at GCSE. Young people who report risky behaviours in Year 9 (such as smoking cigarettes or cannabis, vandalism, graffiti and shop lifting) are twice as likely to end up NEET after Year 11.

The percentage of 16 to 18 year olds in Essex who were NEET fell to 5.7% in 2012/13 from 6.4% a year earlier, which is now very close to average for the East of England and England but is slightly higher than the statistical neighbour average of 5.4%. Basildon (7.5%), Harlow (7.1%) and Tendring (6.7%) have the highest proportions of NEET young people. ECC has developed a model (ACHIEVE), based on known historical data, that illustrates how risk factors interact and will help secondary schools to predict the vulnerability of current individual secondary school pupils. This information will be used in the context of the "Raising the Participation Age" agenda, to start discussion on how qualitative (e.g. family) issues can be identified early – especially for pupils already at greater risk.

3.6 Lifestyle Issues

Many of the risk factors associated with the key causes of ill health and mortality are lifestyle based. These include alcohol and drug misuse, smoking, poor diet, physical inactivity and poor sexual health practices.

The consumption of alcohol by young people is a growing area of concern. It causes a wide range of problems including increased risk of injury, accidents, risk taking behaviour, cognitive problems and a long term risk to health. Under the influence of alcohol, young people are more likely to indulge in unprotected sex (which can lead to unwanted pregnancies and contracting STIs) and may also be subject to unwanted sexual advances or abuse/rape. Adolescent binge drinking is a risk behaviour associated with significant later adversity and social exclusion[76]. By the time the teenage binge drinkers reach 30 they are 60% more likely to be an alcoholic, nearly twice as likely to have a criminal conviction, 40% more likely to use illegal drugs, 40% more likely to suffer mental health problems and 60% more likely to

be homeless. They are also 40% more likely to have suffered accidents, almost four times as likely to have been excluded from school and 30% more likely to have gained no qualifications.

The Chlamydia diagnostic rate in people aged 15 to 24 in Essex (1526.7) is worse than England (2124.6). In 2011, Brentwood (1046.7 per 100,000) and Braintree (1263.9 per 100,000) had lower rates, whilst screening services in Harlow (2130.4), Colchester (1955.5) and Tendring (1692.7) detected higher rates. It is likely the levels were as much influenced by service availability as by levels of actual disease. Despite the access to free condoms across Essex and the apparent reduction in teenage pregnancy, the 'safe sex' message may still be falling on deaf ears and made worse by alcohol fuelled risk taking behaviours.

There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence.

Pupils who have had a Police warning and those with poor emotional wellbeing are significantly more likely to say that they smoke/drink regularly, have been drunk at least once in the last month or have taken drugs than their peers[77].

The issue of overweight children continues to pose a challenge with a gradual rise in obesity rate across the county. Childhood obesity is a complex public health issue that is a growing threat to children's health. Being overweight or obese increases the risk of a wide range of diseases and illnesses, including coronary heart disease and stroke, type 2 diabetes, high blood pressure, metabolic syndrome, osteoarthritis and cancer. Obesity reduces life expectancy on average by 11 years. Although, Essex has lower rates of obesity in children compared with the national average, more can be done to improve diet and increase physical activity with a view to reduce morbidity and premature mortality. Children who are overweight can also succumb to mental health issues, through low self esteem, bullying and a general lack of motivation. These in turn can impact negatively on their future aspirations and contribute to more chronic mental health conditions.

3.7 Child and Adolescent Mental Health and Wellbeing

In evidence collected as part of the national 'Good childhood Inquiry'[78] positive wellbeing for children was held to depend on good relationships, especially within the family; on a sense of purpose and achievement; on freedom and autonomy; and on a positive sense of self. Support for parents, valuing all the professions charged with the care of children, and the role of schools, were all felt to be important. Young people highlighted the importance of being free from stress, pressure and worry. Some children and young people explicitly linked pressure to school, the influence of peers, bullying, family expectations and their looks.

Primary pupils report a higher level of overall wellbeing[79] than secondary pupils, with an index score (out of 20) of 14.1 compared to 13.1. This is lower than the scores seen in the 2011 and 2012 surveys and below or in the bottom range of the mean scores from the national Children's Society survey of young people, where the mean scores tend to be between 14 and 16 out of 20 depending on the age group surveyed. (This equates to a score of between 70 and 80 out of 100, which is very much in line with surveys of the wellbeing of adults which have tended to find mean overall life satisfaction scores for adults in the region of 75 out of 100.) Mirroring the national findings, the level of wellbeing is stable during primary years but declines for secondary pupils as they get older and secondary school girls are less happy with life as a whole. Primary pupils in Castle Point appear to have higher wellbeing scores

than pupils in other districts, while secondary pupils in Maldon appear to have slightly higher average scores and secondary pupils in Chelmsford appear to have lower scores than average.

The issues of most concern for young people in Essex[80] are bullying and substance misuse, followed by crime/feeling safe and exam stress and jobs. 10% of primary and 6% of secondary pupils[81] say they feel afraid to go to school because of bullying either 'very often' or 'often', similar to national levels. The percentage of pupils saying they are afraid to go to school because of bullying at least sometimes declines with age, from 52% of Year 4 pupils to 24% of Year 7 pupils and 11% of Year 12 pupils. The percentage of primary pupils saying that they feel afraid to go to school because of bullying has shown a continuous decline over the last seven years but the percentage for secondary pupils rose by 2% in 2011 before falling slightly again in the following two years.

Young people's emotional health and wellbeing is important, both for the impact that it has on their present quality of life and also for the implications it has for their future social and emotional development, academic experience and achievement. National research highlights that good emotional and mental health is fundamental to the quality of life and productivity of individuals, families, communities and nations. Positive mental health is associated with enhanced psychosocial functioning; improved learning; increased participation in community life; reduced risk-taking behaviour; improved physical health; reduced mortality and reduced health inequality. Poor emotional wellbeing and mental health can lead to negative outcomes for children, including educational failure, family disruption, poverty, disability and offending. These often lead to poor outcomes in adulthood, such as low earnings, lower employment levels and relationship problems which can also affect the next generation.

The 2013 SHEU survey identified that 5% of all primary and 9% of all secondary pupils have poor emotional wellbeing[82], which is very similar to the 2012 survey data. There is little difference between genders at primary school, but secondary girls are ten percentage points more likely than boys to have poor emotional wellbeing and the proportion of all pupils with poor emotional wellbeing shows a steady increase with age, from 6% in Year 4 to 14% in Year 11. The survey responses have been used to estimate that the number of pupils (aged 8-16) with poor emotional wellbeing in Essex is nearly 16,000. Pupils who are bullied very often are between three and five times more likely to have poor emotional wellbeing than their peers, and this gap has been evident over the last three years. Secondary school young carers are also significantly more likely to have poor emotional wellbeing, while LGBT young people and those not living with their parents also appear to be more likely to have poor emotional wellbeing. Pupils with poor emotional wellbeing have significantly less positive views about their lives than all pupils.

The national evidence highlights the interplay between good parenting, education achievement and lifestyle choices. While we have a wealth of local information to focus our interventions there is a lack of robust data on the prevalence of mental health issues in children and young people as well as a clear understanding of complex needs. However, in Essex, it is estimated that 10% of children aged 5 to 19 years have a diagnosable mental health condition[83] (equating to 25,000 children in Essex) and a further 10% have an emotional or behavioural problem requiring targeted support. These children have a wide range of conditions including clinically significant conduct disorders, self harm, depression, hyperactivity and less common disorders such autistic disorders and eating disorders. Many young people suffer from

multiple problems such as bullying and learning difficulties. Prevalence rates are higher among boys than girls and amongst those aged 11 to 15 years compared to younger children. Mental health difficulties are particularly prevalent among young prisoners, homeless young adults and young adults leaving care. Over half of adults with a mental illness will have begun to develop this by the time they were aged 14 years.

During 2012/13, just over 3,400 young people received Tier 2 direct intervention services from ECC provided services or Mind, plus consultation/advice was provided by staff for a further 3,000 children. Around 4,500 young people received Tier 3 interventions during the same period, which equates to 75% of expected numbers according to ChiMat estimates. However, there are substantial difficulties in gaining a basic understanding of the numbers using CAMHS services across Essex. This has made it difficult to identify the characteristics of service users but initial data[84] shows that the main reason for referral to Tier 2 services was conduct disorders, followed by stress/anxiety, attachment problems and anger management problems while the main reasons for young people being referred to Tier 3 services were emotional disorders, anxiety/stress and depression.

Accidental Injuries

Accidental injury is one of the main causes of death for children aged 1 to 15 years and is closely linked to deprivation. Home remains the most common site for accidents, particularly for young children, followed by the road.

Essex (98.4 per 10000) has a lower emergency hospital admission rate caused by self harm (deliberate) than the East of England (113.80) to people aged 0 to 18 years. Unintentional injures are highest in Chelmsford (119.04) Colchester (114.36) and Braintree (112.24) . Rochford and Castlepoint had the lowest rates in Essex.

The need for more support for schools in dealing with pupils' emotional wellbeing and mental health difficulties has been identified as a key priority[85] since schools may well be the one stable factor in a child's life and education staff are the professional group with most contact with children who already have, or are developing, mental health difficulties. Also necessary is a greater focus on family work and earlier intervention, both at an early stage of a child or young person developing mental health problems and a focus on 0-5 years olds with parents who themselves have mental health disorders, learning disabilities, are teenage parents or are affected by domestic violence.

3.8 Children with Disabilities

There is a rising population of children with disabilities nationally, with two main elements: a growing number of children with profound learning disabilities and/or multiple complex health needs; and a growing number of children with autistic spectrum disorders, some of whom have very challenging behaviour.

Families of disabled children commonly experience exclusion from ordinary child and family activities, as well as some mainstream and community services, including education, healthcare, leisure activities, transport and housing. Families with disabled children often face high levels of day to day stress and many have high levels of unmet need for support services, which can lead to higher levels of stress and ill health than those experienced by other parents. In particular, families of children with learning disabilities show greater levels of unmet need than those with children who are not disabled. Lowering stress levels in families is important for the wellbeing of the whole family and is also likely to reduce the

number of children who require residential placements or who are looked after. Disabled children and their families face challenging times in coping with their physical and/or learning disability, which can increase the risk of experiencing further ill health, unless we gear up universal services and provide additional specialist services to support them. Their needs are unique to them, often complex, and change over time.

It is difficult to establish the exact number of children with special needs who are known to children's services in Essex since the information is held in separate Health, Social Care and Schools databases that are not linked up.

SENCAN estimates[86] that there are around 4,000 children with severe disabilities aged 0-19 in Essex, but only 1,200 receive a service from social care. There are just under 6,000 school pupils in Essex who have a Statement of Educational Needs[87], accounting for 3.2% of the total pupil population, and the SENCAN pre-school teams have just under 1,000 children aged under 5 on their database[88]. The proportion has gradually risen from 2.7% in 2008, in contrast to the proportion in England which has remained static over the last four years. Just under 600 pupils with a Statement have a physical or sensory impairment, around 850 have behavioural and emotional support needs (BESD) and around 750 have speech and language communication needs. Around 900 have autistic spectrum disorders and just under 2,800 have learning disabilities.

It is important to ensure that the educational and skills development needs of children and young people living with a disability are carefully considered, to ensure that they can integrate better and have similar opportunities to others with no disabilities.

Young people with disability often do not access health and social care services readily and we need to better understand why this is the case. For epilepsy admissions in those under 19 years North East Essex had the highest rate (81 per 100,000) in the County, although this was more in line with regional admission rates (78), West Essex had the lowest rate of admission (51). Better management of this condition can minimise the need for hospital admissions.

3.9 Young Carers

Another area of concern in Essex is the issue of young carers. Caring can be a positive experience, helping to foster maturity and independence and strengthen family ties. However, extensive or inappropriate caring can be damaging, constraining young people's time and contributing to poor outcomes. 27% of all young carers of secondary school age are experiencing some educational problems. Many miss school and fail to attain any educational qualifications. This, combined with ongoing caring responsibilities, serves to exclude some young carers from the labour market.

Substantial numbers of young carers report stress, anxiety, low self-esteem and depression and many report feeling isolated from their peers. They also feel that they lack the time and opportunity to socialise and can also be reluctant to do so. Young carers also report bullying and anxiety about bullying. Young carers are often reluctant to disclose their situation to practitioners or other young people.

There are an estimated 13,500 young carers aged 11-18 in Essex who provide care every day to someone, with around 9,000 providing more than one hour of care per day. Although this figure is lower than the 2011 Census data of just over 9,000 carers aged 24 or under in Essex, the Census figure is likely to be an underestimate, given this was dependent on the person completing the questionnaire recognising the caring role of the child or young person. Just over 1,000 young people are supported by

young carer groups across the county[89] which is less than 10%. All young carers[90] are significantly more likely to receive free school meals and have special needs and are more likely to be bullied very often, to have had a Police warning and to have poor emotional wellbeing. Secondary young carers are more likely to live with a single parent (and so less likely to live with both parents).

A recent Carers' Needs Assessment[91] in North East Essex estimated that this group made up 2.4% of the carer's population. Nationally it is estimated that of the young carers known to support services, 66% care for parents/step parents (especially in one parent families) while 31% care for their siblings. Notably, 12% of young carers are caring for more than one person. Most of the care provided is in the form of emotional support, domestic support (eg cooking, ironing and general support (eg administering medicines, assisting with mobility, etc), with a relatively small group (18%) involved in providing intimate care (ie washing, dressing, toileting). Young carers in Essex[92] feel that schools should be better at supporting them and being flexible while GPs need to improve their services, including listening to them more and understanding that they have additional responsibilities and needs. They also want to be consulted as carers and listened to by other professionals, including housing, health professionals and social workers - both for them and their cared for.

3.10 Crime and Young People

A number of risk factors can contribute to the likelihood of young people (10 to 17 years) becoming known to the local police and entering the youth justice system. These range from; poor family relationships, poor educational attainment, absenteeism or exclusion from school, associating with offending or risk-taking peers, drugs or alcohol use, mental health issues, accommodation in a high crime area or temporary accommodation / homelessness, poor communication or comprehension skills, anti-social attitudes or behaviour and thinking skill issues including impulsivity, risk taking and lack of victim empathy. Children who are in care or looked after are over-represented in the youth justice system.

Research[93] suggests that young people who offend have greater health needs than young people in the general population and that access to services tends to be during crisis periods rather than for prevention purposes or resolving health complaints as they occur. These health implications tend to be more severe at the point of receiving a referral order or YRO and worse still when a young person is sentenced to custody. Early intervention and access to mainstream services is seen as important and specialist services should not be necessary if accessed in time[94]. Emphasis should not only be around eliminating or reducing these health concerns but also ensuring wellbeing. Whilst contact with the YOS tends to be for short periods of time, young people who offend often exhibit behaviours and have contact with other statutory authorities e.g. schools and social care who also are also able to help improve outcomes for young people.

There are a number of areas of health concerns which are more prevalent in young people who offend including physical and mental health and substance misuse. Self-harming is more prevalent in young people in custody than in the general population. Approximately a fifth of young people in custody had tried to harm themselves (compared to 7% of the general population), and around a tenth had tried to commit suicide at some point in their lives.[95]

83% of a sample (n=302) of young people interviewed in custody and 90% of questionnaire respondents (n=232) reported having smoked prior to custody.[96] Of the interviewees, 29% felt that their offence was related to drinking and 38% that their offence was related to drugs.

The Essex Police Force are able to give a number of different sanctions to young people; informal sanctions such as community resolution, pre-court sanctions such as Youth cautions and Youth conditional cautions or charge the young person where they will be asked to attend court for sentencing or trial. These options are aimed at helping lower level first time offenders to divert from entering the formal youth justice system. Since April 2013 as a result of the LASPO Act 2012 there is increased flexibility in sentencing where in the past there was a progression from informal, to pre-court to court outcomes it is now possible for young people who have previously gone to court to be given an informal or pre-court disposal if appropriate. Additionally young people kept in secure accommodation will now be considered 'Looked after' and for cost to be solely the responsibility of the local authority. This change has been implemented to encourage local authorities to reduce the number of young people in secure accommodation particularly in terms of remand awaiting trial, who often may not receive a custodial sentence and to only use for the most serious offences.

In Essex[97] (2012/2013) there are 3,569 offences where a young person aged 10-17 years old has been suspected as having committed the offence; a rate of 26.2 offences per 1000 10-17 year old population[98]. Including 18 year olds this is an additional 924 offences or 29.3 per 1000 10-18 year old population. This includes young people who are in the youth justice system awaiting an outcome which could include being found not guilty at trial and those that have received a sanction. Highest levels of offences are occurring in the North East quadrant[99] (40.1 offences per 1000 10-17 year old population) and Violence against the person and Theft & Handling are the biggest volume crimes where young people have been identified as suspects. Males are over-represented in the YJS and are more likely to be given an in court sanction compared with females who are more likely to receive a pre-court sanction; the difference in this data is statistically significant. There are statistically significant differences in terms of males and females and the mean age which they commit certain offence types (e.g. Criminal damage and Violence against the person). Some outcomes are dependent on the type of offence and age is also a factor. Both of these may be impacted by the number of previous convictions, the type of outcome previously given and seriousness of the offence. Additionally, White British young people commit offences at a statistically significant younger age than those that are BME.

The Youth Offending Service caseload was 1220 young people in 2010/11, of whom 78% were males and 93% were White. 23% were 14 or under at the time of referral, 22% were 15, 23% were 16 and 31% were 17 or 18 years. The 2012 data indicates that the number of first time entrants to the youth justice system in Essex (570 per 100,000) was similar to England (537).

3.11 Children at Risk and Safeguarding Issues

Although of rare occurrence, the abuse and neglect of children is intolerable. Safeguarding is everyone's responsibility, parents, relatives, the public and staff. All staff who, during the course of their employment, have direct or indirect contact with children, or who have access to information about them, have a responsibility to safeguard and promote their welfare. Furthermore, children in care also need to receive better support to ensure they can maximise their potential.

Many of the issues highlighted in this document, such as social deprivation, parenting history, poor education, parental mental health, drug and/or alcohol misuse, can all impact on child neglect and abuse. The Essex Drug and Alcohol Partnership (EDAP) estimates there are 5,240 families in the county with four or more vulnerabilities, with a greater concentration of these families in deprived areas. Children in families displaying 'chaotic life styles' are at high risk of being or becoming children in need or looked after and often such families have been receiving attention from a range of social care and other organisations. EDAP estimates that there are 57,902 children in Essex with at least one parent abusing alcohol, 7,300 children with at least one parent who is a dependent drug user, 46,636 children with at least one parent with a mental health problem and 26,200 children experiencing parental domestic abuse. Most of the children looked after by ECC have parents with two or more of these vulnerabilities.

Domestic abuse is a common risk factor leading to children being taken into care and becoming subject to a child protection plan (CPP). Conservative estimates indicate that 30% of children living with domestic violence are themselves physically abused by the perpetrator and also use domestic violence against their mothers. Other studies estimate that up to 66% of children suffer direct abuse when living with domestic violence.

Domestic abuse[100] may be so embedded in the daily life of some families that it may not be recognised as domestic abuse and this could be a barrier in seeking help. Information about the impact of domestic abuse on children is largely centred on their emotional wellbeing and development and rarely their experiences. Interventions may assist female victims and their relationship with the perpetrator but often children are not included, may not be given the opportunity to express how they feel or their relationship with their father may not be incorporated in interventions.

A recent NSPCC national study[101] of 6,195 children and young people showed that in the past 12 months at least 3% of both the under 11 year olds and the 11 to 17 year olds, and 12% of the 18 to 24 year olds had witnessed at least one type of domestic abuse incident. Additionally, 12% of under 11 year olds, 18% of 11 to 17 year olds and 25% of 18 to 24 year olds had said that they had witnessed at least one type of domestic abuse incident during their childhood. Also, 4% of under 11 year olds and 11 to 17 year olds and 6% of 18 to 24 year olds had seen one parent kick, choke or beat up the other parent.

In Essex (2012/13), there were an estimated 5,800[102] domestic abuse offences where children were present in households (although they may not have been in the same room). This is 28% of all domestic abuse offences and an increase of 6% on the previous year. The Community Budget Project in Essex[103] has a number of different strands of which reducing domestic abuse is one of them. The aim is to improve multi-agency working, reducing duplication, improving efficiency and providing improved intelligence to disrupt the activities of perpetrators through management and intervention and support victims and families. Research conducted for Community Budgets project (Nov 2013) suggested that there was a small but statistically significant increase in the risk to the parent identified by the DASH model when the incident was witnessed by a child.

Children known to Children's Social Care

Research by the NSPCC[104] has found that there is a substantial minority of children and young people who are severely maltreated and experiencing abuse at home, in school and in the community, from adults and from peers. Over half of the 4,800 children identified as children in need in Essex had the primary reason[105] of abuse or neglect at initial assessment, 22% had a primary reason of the child's

disability/illness and 21% were due to parenting/family issues. Nearly half of the 570 children with a Child Protection Plan had an initial category of abuse[106] as neglect, 24% had emotional abuse as the initial category and 20% had multiple categories.

In 2012-2013, there were 50,583 contacts to Children's Social Care from a wide range of different sources and statutory organisations, professional bodies and family. The top three sources of contacts are the Police (46% of all contacts), Family (8%) and School (8%). Contacts are most frequently made as a result of concern for the child (52%) and as a result of a domestic abuse incident report (36% of all contacts).

The top three main outcomes following contacts are; no further action accounting for 43% of all contacts, provision of information or advice being provided (23%) and contact progressed to a referral (20%). The contacts made by the Police account for high levels of contacts leading to no further action (79%) whilst only 11% lead to a referral and are likely due to the high levels of domestic abuse incidents where children do not reach the threshold for Social care. There are higher proportions of contacts progressing to referral for contacts from family members (25%) and for Schools (49%) these are also coupled with lower proportions of NFA contacts (11% and 8% respectively).

Children in need

As at July 2013 there were 6,364 open Children's Social Care cases[107] (including Children Looked After and those on a Child Protection Plan) in Essex and 4,624 of these are Children in Need. Disability is a key factor among Children in Need representing 25% (1,136) of the cohort (smaller proportions of children with a disability exist in the general population).

A child can be identified as requiring social care support services from before birth (representing 2% of all Children in Need) to age 24, if in full-time education. Boys and children that are BME, particularly those of dual or multiple heritages, are over-represented in the CiN cohort. Additionally, 2% of CiN, are children who have entered the UK as refugees, asylum seekers or have leave to remain in the UK.

The most frequent category of need for CiN is abuse or neglect (58% of the cohort), followed by disability (19%), family dysfunction (9%) and family in acute stress (7%). Disabled children are known to be at greater risk of abuse and neglect[108] and there has been little research investigating how well child protection services respond to disabled children's needs[109].

Child Protection[110]

Essex saw a fall in the number of S47 enquiries completed as at the end of March 2013 to 55 per 10,000 under 18's. This rate is below that for England and our statistical neighbours and comparable to that seen in 2009 and 2010, before the impact of the 'Baby P' case and the Essex improvement notice. Over the past 2 years there has also been a sharp drop in the rate of children on a child protection plan from a peak (30 per 10,000) in 2010-11 to just 19 per 10,000 under 18's in 2012-13 (547 children). Whilst the sharp drop in the proportion of children subject to a child protection plan raises valid questions in relation to the current effectiveness of safeguarding procedures in Essex, a lowering of the rate is not necessarily a cause for concern. Child Protection Coordinators now provide additional scrutiny and expertise, to develop services that could be used as an alternative to a child protection plan. In addition, a Strengths Based Approach to child protection conferencing has been rolled out across the county. Anecdotally it is thought that practitioners are now more likely to manage the child's needs

under a Children in Need rather than a Child Protection plan however, data on the impact of this approach is still being gathered.

By far, the most frequent reason for a child protection plan continues to be neglect (54% of plans) followed by emotional abuse (28%), physical abuse (9%), sexual abuse (5%). Three percent of plans have a category of 'multiple abuse'.

Three quarters of children on a child protection plan are under the age of 10 years. Children of dual or multiple heritage are over represented and children of White other ethnicity (including Irish, Gypsy-Roma, Traveller, Eastern European) and Black African ethnicity are underrepresented. These differences may suggest the incidence or reporting detection of child abuse and neglect is lower or higher in some ethnic groups than others. There is also the possibility that the ethnicity of the child and parents may be impacting upon referral practices and child protection decision-making.

During 2012-13, 83 children were transferred into Essex from other local authorities while subject to a child protection plan and 69% continued on a child protection plan following their transfer-in CP conference. The remaining 31% of children continued receiving services as a Child in Need. The welfare benefit changes will undoubtedly have an impact on the numbers of children transferring in from other Local Authorities, and their originating Authorities and presenting needs need to be monitored. However, over 2012-13, there were no discernible trends in the geographical origins of transfer-in conferences; but given the changes to benefits, clearly migration from London is a key concern for the future.

Children in Care

After a significant increase between 2009 and 2011, the number of children in care as at 31st March 2013 fell to 1,260 or 42 per 10,000 under 18 year's population. This fall is contrary to trends seen nationally and for the local authority's Statistical Neighbour group and has been achieved by a variety of factors: improvements in preventative work; refocusing social work practice on relationship-based social work; the age profile of the current cohort of children in care; more children exiting the care system through Special Guardianship Orders and more timely adoption; effective senior management involvement in case management at resource panels; and the establishment of the D-Bit service, which provides intensive support to families to prevent admissions to care.

There is higher proportion of 10-15 and 16-17 year olds in care in Essex, compared to the national average. This is a reflection of the higher number of entries into the care system in previous years and it is anticipated that the age profile will become more closely aligned to the national profile, as those children become older and exit the care system. As seen in other local authorities, boys and children of black and minority ethnicity are over represented in the children in care cohort.

National research shows that children in care are seven times more likely than their peers in the wider population to suffer from mental health problems and also seven times more likely to misuse alcohol or drugs. 20% have a statement of special educational need (compared with 3% of the general population). Young people who were looked after at one point are twice as likely to become teenage parents: 17% of young women leaving care are pregnant or already mothers while 50% of looked after girls are pregnant within two years of leaving care. Young people in care are over represented in the youth justice system (9% are cautioned for, or convicted of, an offence, three times higher than other young people) while about a quarter of adults in prison were looked after as a child. Between a quarter and a third of rough

sleepers were looked after at one point in their lives. It is therefore vital that children in care or with a CPP have their needs adequately assessed to ensure the best placement (including fostering) and to provide stability. This would ensure the best outcome for them as well as represent better value for ECC.

In Essex, most children in care are placed in directly provided placements and increasing numbers of children enjoy more stable placements with fewer children experiencing three or more moves within the year. In 2012-13, 68.7% of children in care have been in the same placement for two years but a small proportion (9.2%) of children in care had three or more placements. Stability of placement has been shown to impact positively on young people's experience and children in longer term placement have positive perceptions about where they live, their social worker and their school. They are also positive about their family and friends contact arrangements and understand their long-term plan. As a priority for 2013-14, work is being carried out to develop permanence plans for children in care early.

Children and young people's happiness appears to vary considerably depending on where they are placed within the county, with children in care in South (83%) significantly more likely to 'really like' their placement compared to those in West (73%). Gaps in happiness are also evident depending on the type of placement the child or young person is in, with those living in residential or hostel provision (51%) or independently living or no longer in care (53%) being significantly less likely to be happy compared to their peers living in foster care (83%) or kinship care (89%).[111]

In 2012-13, 330 children (27%) were placed more than 20 miles from home although just over half of these were placed within county. The distance travelled and time taken to see family and friends can affect the young person's experience of contact and although the majority of children tell us that contact with family and friends is important and going well, most would like to have more frequent and increased time spent in contact. Early indicators suggest improvements are being made this year, however, given that a number of children have been in care for a long period, it will take some time for improvements to impact. A small percentage of children (2.5% or 42 children) were placed over 100 miles from home and over half of these children were in residential homes best suitable for their needs or in long-term kinship fostering placements. All long distance fostering placements are being reviewed and we are taking the opportunity to covert some children's status to Special Guardian ship Orders (SGO).

To help improve the health of children in care, ECC works in partnership with health service colleagues and health assessments for children in care are arranged by Looked After Children's Nurses, located in the health service. Work began during 2012/13 to improve the coverage of the looked after children's nursing services to improve health outcomes further. From the health assessment a healthcare plan is drawn up, which forms an integral part of the child's overall care plan. The outcomes for each child are monitored at the child's statutory review by the Independent Reviewing Officer and noted in the review report.

The percentage of children in care with up to date health (87%) and dental (86%) checks is above that seen nationally and for statistical neighbours. The percentage of children with up to date immunisations increased considerably from 49% in 2011-12 to 88% in 2012-12. The majority of children (88%) and young people (89%) reported in their review consultation that they feel healthy and well most of the time.

The local authority's Achievement Service, supports social workers and schools to develop and maintain good quality support to children in care. This includes its work with the authority's partners, Welfare Call, to monitor and address pupil absence. Each child in care must also have a Personal Education Plan (PEP), drawn up by the social worker in consultation with the child, parents, carers and the school. This plan also forms part of the child's care plan. The plans seek to identify how the child will be supported in education both in school and by the carers and social work service. It addresses issues such as attendance, support for educational activities in and out of school and support to address areas of weakness.

Essex has improved the attendance rate of children in care considerably (95.8% compared to 95.3% nationally) and the proportion of children in care categorised as persistent absentees (5.7%) has improved considerably over the past four years and is below that seen nationally. It is difficult to make a comparison with all children because of the way in which attendance data is collected but there appears to have been a positive attitude fostered towards attendance amongst children in care. Similarly the attainment of children in care has improved in Essex since 2011. Attainment at Key Stage 3 improved by 10% with 57% attaining level 4 in both maths and English, and attainment at GCSE improved by 4.3% so that 17.1% obtained 5 A*-C grade GCSEs in 2012. Despite this, attainment of children in care remains substantially below that of their peers at every key stage and increases with age, in all areas.

Most children in care in Essex[112] feel healthy and well most of the time and most feel they have an adult to talk to when they have a problem, although those in foster placements and kinship care are more likely to feel this than those in residential/school provision, independent living or no longer in care. The majority feel safe in their school/college and where they live and the percentage of children in care who say they have been bullied in school is similar to that of the total school population. Most say that their education is going well and only a few that it is going badly. 60% say that they get help at school/college from a member of staff who is there especially to help children in care (lower than the national average). Up to a third of young people say that they need more help with school/college.

Feedback on the support received from social workers and the assessment were mixed, key themes included listening to the child and access and clarity of the information and the support on offer to both the Child and the family. There were also some concerns raised over the frequency of changes in social workers and the consideration of how much attention should be given to family versus child needs. Feedback on specialist services, such as family group conferences and Multi Agency Allocations Groups are still in development.[56]

Care leavers

Children in care usually remain looked after until their 18th birthday. In planning to leave care, young people need to be given information and advice, as well as practical and financial support to make the transition into independent living. They should be provided with suitable and safe accommodation and supported into education, training or employment.

Care leavers in discussion groups in 2013[113] highlighted a number of things as being essential in order to live independently. These included finance, having emotional wellbeing and health, keeping in contact with family and friends, and having stability.

The number of young people aged 16 and over leaving care in Essex has risen by 79% from 140 in 2008 to 250 in 2013. Those aged 16+ made up 42% of leavers in 2013 and 76% of these were aged 18 at the time of leaving care, 12% were aged 16 and 12% were aged 17.

Nationally, the proportion of care leavers not in employment, education or training has fluctuated from 33% (2010-11) to 37% (2011/12) and back down again to 34% (2012/13) and the proportion of young people in education has remained at around 35% for the last three years. However, in Essex has been a 21% reduction in Care Leavers in education, employment and training and the number of Care Leavers NEET continued to rise from 32% in 2010/11 to 45% in 2011/12 and to 50% in 2012/13. Despite the a high proportion of young people leaving care at the age of 18 as recommended there has been a shift away from education but the number in training and employment has also gone down. The incidence of NEET is higher for girls than for boys and just over half of this is down to parenthood (there has been an increase in the incidence of teenage pregnancy within this cohort).

Whilst based on analysis of small numbers, it is not surprising that the data suggests a link between single periods of care with stable placements and the likelihood of being in education training or employment. Similarly, young people in fostering placements are more likely to be in education at the age of 19 than those in other types of accommodation; however this has reduced over the last two years and contributed to the increase in NEET.

The number of 19 year old care leavers has increased again from 148 in 2012/13 to 184 in 2013/14 and the number of 19 year olds will drop to 146 in 2014/15 but increase to 163 in 2015/16. It has been recognised that data for 19 year old care leavers needs to be up to date in order to monitor how they are doing and this year data will also be collected on care leavers at the ages of 20 and 21.

There is already a commitment to reinvest in the Leaving & Aftercare service, both to address capacity and improve outcomes. The Leaving & Aftercare Review, set up to review the organisation and delivery of this part of the service, is addressing these key issues, too.

Young people using the Leaving & Aftercare service report positively on the support they receive, including that provided by the Benefits Advisor and mental health specialist attached to the service. Research amongst care leavers and foster carers in 2013[4] found a clear difference in young people's views by age, with the 13-15 year olds being generally positive about their experience of being in care and the support they are receiving, but fewer of those aged 16 and over being positive about the Leaving and Aftercare Service.

Children missing from care

The arrangements for supporting children missing from care have been refreshed and the Children Missing from Care and Home Partnership, which involves representatives from Essex Police, Children's Social Care and other partner agencies, was set up in March 2013 to provide a strategic approach to safeguarding children who run away from care or home. Missing children episodes are now being consistently recorded and monitored and between Jan and Jun 2013 there have been 472 episodes of which 459 were recorded as found within the same monthly reporting period. Developing support for children missing from care has been identified as a priority and access to independent interviews are

now accessible to all children missing from care on their return.

Child Sexual Exploitation (CSE)

Child sexual exploitation is a form of abuse where a young person receives something, such as money, food and clothing, drugs or alcohol, or attention in exchange for taking part in a sexual act. It is largely hidden and the true scale is unknown. A study conducted by the Children's Commissioner[114] suggests that there are at least 16,000 young people at high risk of sexual exploitation during any one year. The nature of and pathways into CSE are varied involving both face-to-face contact and electronically via the internet or mobile phone, and affects both young males and females. Young people may be unaware that they are being exploited and may feel that they are in a genuine relationship or friendship with their abuser. Children's Social Care are currently carrying out research with young people in Essex to explore their understanding of sexual exploitation and related topics, and their experience of how sex and relationship education in school deals with such topics.

The Essex Children's Safeguarding Board (ESCB), a multi-agency team including Essex Police, Social Care services, and Voluntary organisations chairs a CSE Strategic group which aims to raise awareness of child sexual exploitation with young people, parents, local businesses and practitioners. This is with a view to identify and support victims of child sexual exploitation and to identify and prosecute perpetrators. Other activities include putting in place support pathways and training practitioners on how to identify children at risk.

3.12 Recommendations to the Health and Wellbeing Board

MATERNAL and INFANT HEALTH

. Implement a life course perspective to health promotion, independent living, disease prevention and good parenting to address disparities in maternal, infant and child health.

. Develop preconception health initiatives, aimed at improving the health of a woman before she becomes pregnant and supporting young and vulnerable mothers-to-be.

. Need to improve hospital care in maternity services in relation to the provision of information, patient engagement and satisfaction.

. Need to ensure that there is a high uptake of the national childhood immunisation programmes across the County to ensure maximum protection for the population.

EARLY DEVELOPMENT

- Need to improve attainment at Foundation stage and ensure children are ready for school

FAMILY ENVIRONMENT

- Need to ensure that families in difficulty are offered help at the earliest opportunity and that the help offered prevents family problems escalating into more serious ones and enhances families' capacity to resolve their own problems.

– Monitor the impacts of welfare reforms to ensure children and families do not experience increased levels of disadvantage and inequality.

- Provide opportunities for reskilling and up-skilling throughout residents' working lives

EDUCATION and NEET

. Action to reduce the disparities in educational achievement at an early stage will support efforts to reduce health inequalities, by improving individual's employment prospects as well as their ability to make informed healthy choices.

- Work with partners to maximise the number of young people who are in Employment, Education or Training

MENTAL HEALTH and BULLYING

. There is a need for early identification and intervention in regards to children's mental health and emotional wellbeing, including improved access to Tiers 1 and 2 as well as specialist services.

. High quality, jointly commissioned children's mental health services are not only a safeguard for children and families but also a cost-effective investment over the medium to long term.

. The Essex strategy must place a significant emphasis on prevention including better health promotion for children and young people, as well as supporting people who are already suffering from mental health issues.

CHILDREN WITH DISABILITIES

. A more detailed needs assessment is required to ensure we can better plan for the level and types of services so that people with disabilities and their families feel better supported.

. Children's Services and the NHS need to work to support parents whose have children with learning disabilities to improve their health and wellbeing.

. Provision of personalised and integrated care to encompass better management of health conditions (eg epilepsy), minimise crisis management and delayed transfer of care.

ACCIDENTAL INJURIES

. Need to ensure effective risk-reduction strategies, including training for front-line staff, and prevention schemes (including development of parenting skills) are in place. Community and setting-based interventions are most effective.

YOUNG CARER'S HEALTH

. Strategy to improve young carer's assessment process, adopting a person-centred approach to addressing the needs of young carers.

CRIME and YOUNG PEOPLE

. It is important to recognise the correlational link between vulnerability on young people, substance misuse and offending and adopt corresponding interventions to reduce misuse of drug and alcohol.

. There is a need to reduce the level of NEETs, exclusions from school and have effective actions in place to tackle truancy in a bid to avert young people entering the Youth Justice system.

CHILDREN AT RISK and SAFEGUARDING

. Develop joint commissioning strategy enabling Children's and Adult services, along with partner agencies, to co-ordinate their work to ensure that the family as a whole is supported to achieve the best possible outcomes for children at risk.

. Co-ordinated services to focus on working with perpetrators of domestic violence and children who are victims.

-Strengthening Families in order to keep children and young people living at home and prevent them from entering the care system where it is safe and appropriate to do so. Develop the market of providers of specialist placements so that children and young people in care are able to have their needs met in locally available placements.

Improve outcomes for Care leavers

-Promote the involvement of CYP in making a positive contribution to their community and decisions affecting their own lives.

4 Adults and Vulnerable groups

4.1 Working Age Population

While generally an area of prosperity, some parts of Essex have high unemployment rates and higher levels of deprivation. Being employed plays a key role in mental and physical wellbeing. However, jobs that are insecure, low paid and that fail to protect employees from stress and danger can contribute to ill health. The number of people likely to become unemployed in coming months will rise, with more people aged over 60 years and who are unlikely to work again.

Work and Health

The impact of poor health or disability on a person's likelihood of finding and keeping a job is significant. Prevalence estimates suggest that in Essex, about 162000 people of working age have a disability of some sort. Nationally only 46% of people with a disability are in work compared to 76% of those without a disability this would equate to 66700 people being unemployed in Essex. This effect can be mitigated by educational qualifications.[115] Recent labour market statistics (2013) suggest that 52% of all people with a long term health problem or disability are in employment, which is a 0.7% increase on the previous year.

Essex Adult Community Learning Service provides a CV writing course to improve employability. Additionally, Essex Cares is providing employment opportunities for adults with a learning disability and, at March 2013, had 339 such adults in employment. The mental health trusts supported 727 services users in 2012-13 into education and employment and greatly exceeded their target of 455.

Conversely, nationally, it is estimated that 1 in 5 adults have health conditions caused by or made worse by work. In 2011/12 the East of England saw over 950 thousand working days lost either to injury or illness. Nationally, the biggest causes of work related ill health in 2010/11 were:

• Mental ill health caused half of all sickness absence. Local data shows that the proportion of incapacity benefits claimants ranges from 11% in Uttlesford up to 32% in Tendring (2008)

• Musculo skeletal problems caused about a third of all working days lost in England in 2010/11 but in the Eastern region this figure was higher at about 40%. Regional figures suggest that in 2011/12 there were 43000 cases (1420 per 100,000), which is a decrease on the previous year (54000 cases). However, this rate was not significantly lower than the national rate (1500 per 100,000)

Some of these cases would have been acquired as a direct result of work related stress and/or injury.

Disability

Disability is an important issue for public health for a number of reasons. First, with more effective health promotion measures, a reduction in the proportion of people who develop disability can be achieved by addressing the underlying causes. Secondly, adequate treatment and rehabilitation directed at restoring function in people who are already ill or injured can minimise disability. Thirdly, disabled people have special needs and require personalised, tailored care.

Supported Housing

There are currently 814 specialist housing units to support adults with Learning disabilities in Essex and approximately 32% are self contained units with the remainder shared units. In 2010-11 it was estimated that the requirement for units is 989 which is a shortfall of 186 units across Essex. Braintree (-54), Chelmsford (-42) and Colchester (-41) are showing the greatest deficits. The demand for specialist housing units is expected to increase as young people move from children's to adult services and move away from their family home.

In order to obtain social care provision, people are assessed against the 'Fair Access to Care' (FACS) criteria. FACS is a national eligibility framework that classifies a person's needs as either low, moderate, substantial or critical. In Essex, the council funds services for people who are assessed as having 'Critical

or Substantial' needs. As at 31st March 2013 approximately 25500 adults in Essex were being provided with ECC-funded social care support, a quarter of which (6180) were residential services and the remaining 19300 people were given access to community services to support their needs. 79% (4862) of all residential services were provided to adults over the age of 65 compared with 52% (10053) of all community services. Although a lack of suitable housing for people with a physical impairment can lead to admissions into residential care, adults with mental health (3700 non-resi) or physical impairments (2800 non-resi) were more likely to receive community based services than residential services, helping people to maintain their independence for longer.

During 2010/11 approximately 3900 people, a 5% increase compared with previous year, received support from the reablement service, which aims to support people to regain skills with a view to the risk of reducing longer term care. Of those people that received support 81% left the reablement service and either received packages of support in line with their new level of need or went onto self care.

4.2 Learning Disabilities

As of 2012, there were estimated to be 20424 adults, aged 18-64, across Essex with a learning disability, which is 2.4% of the adult population. 16.5% are estimated to have a moderate learning disability and 6% a severe or complex learning disability. Predicted demographic change, increased survival rates, reduced mortality rates, improved diagnostic techniques and improved health care will lead to an increase in the number with learning disabilities. Estimates suggest that the number of adults with a moderate or severe learning disability could increase by 5.4% by 2020. Additionally, longer life expectancies will mean that support will be required for a longer period of time and may need to support more complex needs.

The highest rates of people with a learning disability can be found in Tendring, Colchester and Braintree, where former long stay hospitals were located. People have since moved out of these into the local community. 36% of adults with a moderate or severe learning disability are living at home with a parent. One third of known unpaid carers for learning disability service users funded by ECC are over the age of 65; this equates to around 800 carers. These people are at risk of needing intensive support from social care in the future.

According to the 2012/13 Adult Social Care Outcomes Framework (ASCOF) indicator there were 4650 adults with learning disabilities known to adult social services in employment in Essex, Southend and Thurrock, an average rate of 7.9, which is above the rate in England (7.2). Of these Southend on sea had the highest rate (9.9) when compared to Essex (8.5) and Thurrock (5.2).

National findings from the 2012/13 Adult Social Care survey indicate that a higher percentage of these service users are satisfied overall and are very happy with the way staff treat them. They give higher ratings for the majority of other questions about services and their lives also.

4.3 Physical and Sensory Impairment

Physical disability has far reaching implications not only for a person's own circumstances in terms of healthy living but, depending on the level of disability; there are implications in terms of health and social care resources. Across Essex, there are estimated to be just over 67500 people of working age with a moderate disability which is estimated to rise to just over 71250 by 2020. In terms of serious physical disability it is estimated that we have 20250 people as at 2012 with this figure expected to rise to over 21500 by 2020. 47% of adults with moderate or serious physical disabilities require personal

care assistance which includes getting in and out of bed or a chair, dressing, washing, feeding or use of a toilet.

Mobility and Falls

The ability to keep active and independent depends greatly on mobility. Mobility can be seriously limited as a consequence of age and by the effects of falls which may lead to fractured neck of femur. Falls are a major cause of illness and disability amongst those aged 65 years and over and one in three experiences one or more falls in a year. Falls can result in a loss of independence and may impact on both physical and mental health.

In 2011/12 the number of injuries due to falls in people aged 65 and over in Essex was 1527 per 100,000, the number of falls was lower than England (1665), this was true for older people in all age bands.

Almost two million people in the UK are living with sight loss (vision less than 6/12). By 2020 this number is predicted to increase by 22%. It will double to four million people by the year 2050. These increases are mainly due to the demographics of the population and eye health will be particularly subject to this because over 80% of sight loss occurs in people over 60 years. Visual impairment is another serious debilitating condition that can have implications for a person's health and ability to stay independent. Visual impairments and sight loss can double the likelihood of falls and thus greatly increase the chances of someone losing their independence. Sight loss is associated with age due to conditions such as macular degeneration (MD), cataract and refractive error. It is estimated that the cost to the NHS of falls associated with sight loss is at least £25.1 million per annum [116].

It is estimated that currently across Essex there are approximately 550 adults with a serious visual impairment, however in those over 65 years this figure is estimated to be over 23500. By 2020, it is estimated that there will be over 28500 people with a visual impairment. The estimated numbers of people with a hearing impairment are also significant, in Essex it is estimated that circa 150000 people have impairment with this figure rising to over 178000 by 2020.

The rate of adults with physical disabilities who are supported in Essex in terms of receiving either community or residential/nursing home care increased after 2006/07 (580 per 100,000) and peaked in 2010-11 (675 per 100,000). It is now at a rate (550 per 100,000) that is higher than that for the East of England overall (460) but has lower in each of the last 2 years. The highest rates locally can be found in Colchester, Basildon and Tendring.

ECC engages with a number of planning groups which focus on sensory and physical impairments and other issues of relevance to older people and vulnerable groups[117]. These groups have outlined a number of actions to help improve awareness and accessibility of information and services, for example the updating of the 'what next?' booklet for deaf and hard of hearing people and the introduction of hospital translation and interpretation policies. Visual impairment and deaf or hard of hearing awareness training is also a key priority for all front line staff, in all service areas, including health, education, social care and transport and should include those who work on reception desks in county and district councils.

The need for improvement in information was noted in the 2010/11 ASC surveys and again in the 2012/13 survey with only 52.6% of people in Essex finding information very or fairly easy to find, which was consistent to the national trend (55.7%).

4.4 Adult social care services

The County Council's transformation programme has moved into its second phase and this is affecting the design and delivery of services for customers. The initial point of contact for customers who need social care services, the Customer Service Centre, is in the process of redesign the offer when people first approach Essex County Council for advice or support. This involves developing the channels for people to most easily contact the Council and get the information and support they need. The Customer Service Centre has already delivered improvements and is in the process of moving to a Client Relationship Manager (CRM) system which will better allow the organisation to manage a customers' journey from initial contact. The Council has undertaken a significant review and audit of Personal Budgets to ensure that service users understand their responsibilities and that people's needs are correctly met in the most effective and efficient way.

Staff who undertake assessments and reviews continue to be monitored on an annual basis through a quality assurance process to ensure they meet the standards agreed in partnership with service users and local citizens. The comprehensive workforce programme is delivered to ensure workers are kept up to date with best practice and where qualified supported to maintain their professional registration HCPC. Social Workers in their first year of practice are enrolled on the assessed year in employment programme. The guidance available to staff is updated to reflect the local / national policies and practice guidelines.

Generally the 2012/13 surveys suggest that people are experiencing decent services and are able to live reasonable lives. However, key areas for improvement include better signposting to existing sources of information, advice and support (market research in Essex suggests that most people would not think to contact the Council and that they tend to rely on their acquaintances and neighbours or ring their GP for advice); and improved standards following the assessment process.

A high proportion (87%) of respondents report that they have a good quality of life, which is similar to previous years and around half (54.5%) say that the way they are helped and treated makes them think and feel better about themselves. 74.4% have as much social contact as they want with people they like and 60.5% are able to spend enough of their time doing things they value or enjoy. However, over two thirds (69%) of respondents said they had difficulty or could not get to all the places in their local area that they wanted or did not go out (72.7%).

With regards to safeguarding vulnerable adults, the majority (93.2%) of respondents reported feeling safe. 82% said the care and support they had helped them to feel safe. The majority of respondents (93.6%) also felt clean and presentable.

58.5% of service users were satisfied (extremely, very or happy for LD) with care and support services in Essex, this was higher in Thurrock (59.6%) and in Southend (61.9%), satisfaction was also higher for the 18-64 population in both Essex (66.8) and Southend (65.9). [118]

Complaints

During 2012/13, the ECC Customer Liaison Service, covering feedback about Adult Social Care services, handled 568 complaints which is 1% of the total number of reviews and assessment completed by Social Work staff during the year. In addition 581 representations were handled from Councillors and MPs. This appears to show a substantial increase from 2011/12 but this is as a result of all enquiries, whether initial or further contact, being recorded on the system by the central customer service team. The team also recorded just under 200 compliments, mainly about customers experience of the support received from adult Social Workers. The main theme of customers' complaints were financial charging (62) and assessment needs / conduct of staff jointly (47). Service improvements have included fast track handling of customer feedback; a change in the process for managing financial assessments / charging; practice development in staff awareness of the impact of the quality of their communication with service users' and improvements to the handling of blue badge applications.

4.5 Carers

Over 10% of our residents provide informal care to relatives, friends or neighbours, i.e. 145900 according to the 2011 census. Carers are people looking after or giving help or support to family members, friends, neighbours or others because of long term physical or mental ill health or disability, or problems related to old age. It is estimated that 66% of people are providing unpaid care for less than 19 hours per week. 12% are estimated to be providing between 20 to 49 hours and 22% are providing 50 or more hours a week. These people are likely to be providing help and support with domestic and personal care tasks.

Research suggests that the economic value of the contribution made by carers in Essex is £2.4 billion per year which is £45.4 million per week.[119]

Two thirds of adult carers are economically active but are more likely to be in part time employment. 50480 carers are likely to be economically inactive. Carers are more likely to describe their health as not good or fairly good compared to non carers.

There are an estimated 13,500 young carers aged 11-18 in Essex who provide care every day to someone, with around 9,000 providing more than one hour of care per day. A recent Carers' Needs Assessment in North East Essex estimated that this group made up 2.4% of the carer's population.

Older Carers

Over half of the people providing unpaid care are aged over 50, which is of particular concern as they are more likely to be suffering from ill health themselves. It is estimated that 83850 people aged 50 years and older (1 in 6 people) provided unpaid care for others in Essex (2010). It is estimated that two thirds of people with dementia are looked after by unpaid carers.

Approximately one third receive no support from either social services or the voluntary sector and only 36% are not satisfied with the support they get. In future fewer people of working age will be available to care for and support older people; the 2008 sub national population projections suggest that Braintree will see the biggest decrease in this ratio from just over 3:1 to under 2:1 over the next 25 years.

Essex assessed or reviewed 11009 carers needs during 2012-13, of which 1988 received a carers assessment in their own right. 40% of these assessments were for older carers aged 65 years and over. A

carers assessment aims to help a carer access support, which can help them to carry on with their caring role or help them to take a break from caring. Only 36.1% of carers in Essex (not including Thurrock and South-end) said they were very or extremely satisfied when asked how satisfied they were with social services. A higher percentage were satisfied in Thurrock (45.4) and South-end (43.8). In Essex (excluding South-end and Thurrock) higher rates of satisfaction were also found when asking Older Carers (51.1%).[120]

Similarly carers should be consulted when the person they care for has an assessment (ASCOF 3C). Carers in Essex generally agreed that this was the case (68.2%) but there was higher agreement from carers in Thurrock(79.9%) and South-end (75%).

The physical impairment planning group and older peoples planning group have reiterated the need to help carers maintain their caring role while preserving their health and wellbeing and have reiterated the need to identify; the kind of support unpaid carers need; how well are they supported by public and voluntary agencies and what support for carers would help to prevent avoidable admissions to hospital or residential care.

National research has highlighted the need to support carers and has shown that breaks from caring (through respite and carer's breaks), assistive technology, advocacy, manual handling, training [121] and flexible working[122] can help carers to carry out their caring role. This evidence also shows that interventions work better when they are targeted at the carer and help to address specific groups of carers, such as carers of dementia. They also delay admission into residential care. However, further analysis is needed on how effective this support is in preventing carers from acquiring their own impairments and health problems due to caring.

4.6 Older People

Social Care Needs and Social Capital
It is estimated that 90500 older people with social care needs live in Essex ,defined as people who are having difficulty with or unable to perform personal care or domestic tasks without help. This is 35% of the older population aged 65 years and over, which is in line with the England estimate of 34.9%. There is a projected 22.8% increase in older people with care needs over the period 2012-2020, which is higher than the anticipated increase in England (19.2%).

Harlow (37%), Basildon (35.5%) and Castle Point (34%) have the highest percentage of the older population with social care needs and Brentwood (27%), Uttlesford (28%) and Chelmsford (29%) have the lowest proportion. Harlow and Basildon also have the fewest number of charitable organisations who provide local support. There is an indication that local investments (eg grants to voluntary sector) to encourage grass-root community activity, are contributing to the building of valuable social capital which in turn may reduce social isolation and improve community networking. There are estimated to be 61750 older people in Essex with care needs that are either unsupported or privately funded. 66% of these people have either low or moderate needs.

The living circumstances of older people and people with mental health issues affect both opportunities for social interaction and the need for additional support from formal and informal services. It is estimated that the number of people aged 65 years and over living on their own will have increased by

around 17% by 2020. Loneliness can damage both physical and mental health and can be further exacerbated by lack of transport and poor mobility.

It is established from research that a range of such health issues can arise from loneliness and social isolation. Although not necessarily effects of the aging process, loneliness and social isolation can be exacerbated by life events associated with older people such as leaving work, health decline and bereavement. To counteract these issues good local environments and social networks can help to protect older people.

Locating the lonely and socially isolated is key to successfully implementing and developing effective interventions. A model using modelling techniques involving Mosaic Customer Profiling has indicated locations of 15,297 households where there could be a potential "high risk" of isolation with a further 12,973 households at "above average risk" of isolation. [123]

Identifying ways of preventing social isolation in the elderly was identified as a priority for the older peoples planning group. In line with other planning groups, information and advice is a priority for a whole range of services. It is essential therefore that information considers the needs of those most at risk of social isolation due to their pre-existing or acquired disabilities. A number of other priorities were identified by the older peoples planning group which have specific relevance to the quality and accessibility of social care; including: access to reablement and assistive technology; ability of care homes to meet individual needs, continuity of care and the evaluation of dementia services across Essex.

As of February 2013, there were 362990 people in Essex (including Southend and Thurrock) of pensionable age, 109930 (30%) receiving state pension plus at least one other state benefit. These are people who are more likely to require support from statutory services. The proportion is similar in Essex when compared to England (31%).

Areas where there is a higher proportion of the population receiving more than one benefit include Harlow (36%), Tendring (36%) and Thurrock (35%) South-end on sea (34%) and Basildon (34%). Areas where there is a lower proportion include the more affluent areas of Uttlesford (24%), Brentwood (24%) and Chelmsford (24%)[124].

Mental Health

Mental health and dementia account for more years of disability than any other condition, including stroke, cardiovascular disease and cancer. Cases of dementia are expected to double by 2030 and increase rapidly with age. There are nearly 8700 people on GP registers with dementia across Essex. By 2021, the projected increase in prevalence is expected to reach 38%[125].

The older peoples planning group have highlighted the need to evaluate the current dementia services in Essex in order to assess whether they are meeting the needs of those living with dementia and those who care for them.

Excess Seasonal Deaths and Flu Immunisation

Excess seasonal deaths are an important public health concern which sees an increase in mortality among people with cardiovascular diseases, from respiratory diseases and amongst older people, mostly during winter but also during heat waves[126]. Links between poor quality housing, fuel poverty and health are widely recognized. Lower/ higher temperatures, people's lowered resistance to illnesses (due to

disease), safety in the home and the incidence and intensity of influenza outbreaks, all contribute to a higher mortality rate during winter.

Over 2008/11 Colchester (27.2) had a significantly higher rate of excess winter deaths than England (19.1). Castle Point (25.0), Uttlesford (23.7), Rochford (21.9), Chelmsford (21.6), Thurrock (21.0) and Basildon (20.9) also had rates higher than England but these differences were not statistically significant. Harlow (15.9) and Brentwood (16.6) had the lowest rates.

People aged over 65 years and those who are at risk (eg due to chronic illness) are eligible to an annual flu jab. The 2012/13 target for immunisation in those aged 65 was 75%, which is higher than the previous years level of 70%. None of the PCTs achieved this target 72.5% mid essex 71.8% north east, 69.1% southeast Essex, 72.6 (southwest Essex) 70.7%(west Essex). With new strains of viruses emerging and the risk of a flu pandemic, the uptake of flu immunisation must be kept at a high level to ensure protection for our population. [127]

End of Life Care

Across Essex, end of life care programmes are in place to support people to enable them to make decisions about their palliative care packages and preferred place of death. The majority of deaths occur in hospital but the vast majority of people would choose to die at home in their own surroundings. End of life care aims to support these people and to increase the proportion of people that are able to fulfill this wish. Data from 2008/10 showed that 20% of Essex deaths were at home, with local authority figures ranging from almost 24% in Uttlesford down to 18% in both Brentwood and Epping Forest.

Nursing and Residential Care

As people are living longer and the proportion of older people increases, the use of residential and nursing homes will become more vital as there will be fewer younger relatives to support and look after older people in their own homes and the demand for live in care and support is likely to increase over the next decade. Despite the significant increase in older people with care needs this has not been matched by increased use of registered care, as people are being cared for via alternatives in the community. The rate of adults (65+) in permanent nursing care in Essex in 2012-13 was 365 per 100,000, significantly lower than both the regional (535) and national rate (900). However in terms of adults in permanent residential care in Essex (2450 per 100,000), the rates are currently higher than both the regional (2035) rates and the national level (1880). However, for Essex, both nursing and residential care rates dropped from 2011-12.

Loneliness increases the risk of dementia (which in turn is likely to lead to more use of residential care) by up to 50% and there is a concern that the socially isolated are therefore more likely to enter residential or nursing care early.

Special Housing Needs

It is estimated that there should be 22236 specialist housing units available to the over 75 population in Essex whilst 15612 were currently provided as at 2012. This is a shortfall of 6624 units. It is estimated that Tendring (1794), Colchester (1096) and Castle Point (1088) have the largest deficits in terms of supported housing requirements. The over 75 years population in Essex is expected to increase significantly over the next 20 years and if the need for supported housing units follows this trend, it is estimated to increase to 26996 units in 2020 with a potential deficit of over 11384 units.

4.7 Vulnerable Adults

The older population in Essex is increasing faster than the UK average and presents one of our most significant challenges. The likelihood of developing a chronic disease or long term condition increases with age and, as our population ages, levels of disability will increase sharply. Patterns of disability are also being affected as more premature babies survive and more children with complex and multiple disabilities live on into adulthood. However, the changes are not expected to occur uniformly across Essex and there are already considerable differences.

People who are predisposed to suffer from chronic ill health, unable to work, homeless, who are in the older age group and those adults who rely on people to care for them are at high risk of neglect, isolation and poor health. As people age, the frequency of ill health and disability increases.

As of May 2011, in Essex there were 43500 people receiving employment and support allowance or incapacity benefit (of working age) and over 57000 people receiving disability living allowance. There are 37475 people of working age in Essex, who are permanently sick or disabled.

Another group of vulnerable people are those who are made homeless, as of Dec 2009, there were 903 households in Essex that were in temporary accommodation and of these 67% of households included either had dependent children or a pregnant woman. In 2011/12 there were 980 households in temporary accommodation (a rate of 1.7 per 1000). In Southend there were a further 34 households. The rates in Essex and South-end were below the England rate (2.3 per 1000). It is still imperative that those households that have become homeless and have dependent children recover a sense of stability as the outcomes for these children in later life can be very much shaped by childhood experiences and their living environment.

It is also important to understand the changing demographics of families with older parents at risk of needing social care support. Further research and modelling is required to gain a better understanding of these demographics.

There has been a decrease in the number of people from BME groups who accessed social care in 2012-13 compared with the previous years' data. The proportion of BME people assessed is less than the overall percentage of BME groups in the wider population and the situation will continue to be monitored.

Travelling Families

Travelling families have low life expectancy, are unaware of or are unwilling to access statutory services and therefore tend to have poorer health outcomes. There are 11 permanent sites across Essex for the gypsy and traveler community, however at the last caravan count there were several unauthorised encampments across Essex. There are currently in place a range of services available to the gypsy and traveller community including both adult and child education services and local health services; however it has long been recognised that engagement with these communities is challenging and more work is needed to promote better health and social care outcomes.

In April 2013, LINks was superseded by Healthwatch Essex which is a new 'consumer champion' for health and social care services. One role of Healthwatch is to reach out into local communities so that it hears and adequately represents a wide range of experiences to both health and social care

commissioners. It is hoped that engagement with local communities will help to tackle some of the inequalities experienced by these minorities and other sections of the community.

4.8 Recommendations to the Health and Wellbeing Board

WORK and HEALTH

. Develop and implement an effective workplace health and wellbeing programme based on the recommendations of the Boorman review, starting with the whole of the public sector, which can lead by example.

ACCOMMODATION and WELLBEING

. Develop joint commissioning strategy for health and social care that promotes healthy living, independence and quality of life.

. Need to ensure that there is adequate provision of care homes/supported accommodation and better support for carers.

PHYSICAL and SENSORY IMPAIRMENT

. Need to ensure that individuals with physical and sensory impairment are receiving adequate level of support from health and social services, including community-based services and welfare support. The aim should be to enable disabled people to be fully integrated within society.

CARERS HEALTH

. Develop an integrated commissioning strategy to improve the carer's assessment process, adopting a person centred approach, including respite care and emergency support.

MENTAL HEALTH and DEMENTIA

. Age, injury to the brain and vascular diseases are the main risk factors to tackle in addressing dementia. Early identification can help improve quality of life.

. There is a need for early identification and intervention of mental health conditions and improved access to specialist services.

EXCESS SEASONAL MORTALITY

. Clear identification of vulnerable groups for targeted interventions (eg reducing fuel poverty, increasing flu jabs) is key to the prevention of excess seasonal mortality.

SOCIAL CAPITAL

. Support the development of the minimum infrastructure necessary to build social capital, working with the Third Sector and communities.

VULNERABLE ADULTS

. Safeguarding Adults strategy to support early intervention, reablement, information/support and promote healthy lifestyles for vulnerable groups.

TRAVELLING FAMILIES

. Better engagement with this population group is required to understand the health and social care needs. This will necessitate multi-agency working in addressing the negative effects both of adverse social experiences and attitudinal barriers to health and wellbeing.

Glossary

ASCOF

Adult Social Care Outcomes Framework

BME

Black and Minority Ethnic groups

CAMHS

Children and Adolescent Mental Health Services

CHD

Coronary Heart Disease

CKD

Chronic Kidney Disease

CLA

Children Looked After

COPD

Chronic Obstructive Pulmonary Disease

CPA

Care Programme Approach

CPI

Consumer Pricing Index

CPP

Child Protection Plan

CPS

Crown Prosecution Service

CVD

Cardio Vascular Disease

DNR

Do Not Resuscitate

ECC

Essex County Council

EDAAT

Essex Drug and Alcohol Action Team

EDAP

Essex Drug and Alcohol Partnership

E-PAG

Essex Patient Advisory Group

FACS

Fair Access to Care

GDP

Gross Domestic Product

HPA

Health Protection Agency

HPV

Human Papillomavirus

IAPT

Increasing Access to Psychological Therapies

IBA

Identification and Brief Advice on alcohol

IMD

Index of Multiple Deprivation

JSA

Job Seeker's Allowance

JSNA

Joint Strategic Needs Assessment

LINks

Local Involvement Networks

MEND

Mind, Exercise, Nutrition, Do it

MMR

Mumps, Measles and Rubella vaccine

MRSA

Methicillin-resistant Staphylococcus aureus

NEET

Not in Education, Employment or Training

NICE

National Institute of Clinical Excellence

NVQ

National Vocational Qualification

OCU

Opiate and Crack Users

OIL

Options for Independent Living

ONS

Office of National Statistics

PCT

Primary Care Trust

PDU

Problem Drug Users

QIPP

Quality, Innovation, Productivity and Prevention

QOF

Quality and Outcomes Framework

SEN

Special Educational Needs

SENCAN

Special Educational Needs and Children with Additional Needs

SHEU

School Health Education Unit

STI

Sexually Transmitted Infections

VAT

Value Added Tax

YEA

Young Essex Assembly

YJS

Youth Justice Service

YOS

Youth Offending Service

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[127] Seasonal flu vaccine uptake (GP) 2012/13

Essex County Council

Report to: Health & Wellbeing Board **Report of:** Dave Hill	**Reference number HWB/021/13**
Date of meeting: 21 November 2013	**County Divisions affected by the decision:** all county/ all divisions
Title of report: 2013 Annual refresh of the Joint Health and Wellbeing Strategy	
Report by: Richard Puleston, Director of Policy, Strategy & Communications, ECC **Enquiries to** Loretta Sollars: loretta.sollars@essex.gov.uk	

1. Purpose of report

1.1. To conduct the 1st annual refresh of the Joint Health and Wellbeing Strategy by taking account of changes in the Joint Strategic Needs Assessment (JSNA) and national policy since the strategy's publication in March 2013.

1.2. To set the baseline figures for the key performance indicators associated with each of the three priorities in the strategy (as agreed in the strategy's evaluation framework signed off by the HWB in May 2013).

1.3. To agree on the areas for focus within each of the three priorities and five cross cutting themes during 2014/15. These will guide the development of integrated commissioning plans of the CCGs with ECC.

2. Recommendations

2.1. Agree the changes that have been made to the Joint Health and Wellbeing Strategy as identified in the 2013 Refresh document.

2.2. Agree to amend the fifth cross cutting theme so that it is extended to "Safeguarding and quality".

2.3. Agree to incorporate the recommendations from the “Who Will Care?” Commission report that have been accepted by the Board (agenda item 5), as additional areas of focus in the Strategy Refresh.

2.4. Agree the areas for focus for each of the three priorities and five cross cutting themes so that they can guide the development of integrated commissioning plans of the CCGs with ECC for 2014/15.

3. Background and proposal

3.1 The HWB agreed the first health and wellbeing strategy for Essex at its inaugural meeting in March 2013. The vision of the strategy is:

By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.

3.2 The lifetime of the strategy is 2013 – 2018 and it is scheduled to be refreshed annually. The refresh takes into account changes in the Joint Strategic Needs Assessment (which is also reviewed on an annual basis) and other external influences on the health and wellbeing of residents in Essex such as changes in national policy.

3.3 The changes that have been made to the strategy for 2013 are:

i. incorporating the progress that has been made (and the future plans to continue at pace), with the integration of health and social care, into the whole document;
ii. the most recent data from the JSNA;
iii. a renewed evaluation framework for the strategy (as approved at the Health and Wellbeing Board in May 2013);
iv. performance “score cards” for each of the three priorities, which will act as a baseline to track progress in future years;
v. a clearer focus for each of the priorities and cross cutting themes for the year ahead (2014/15).

3.4 Members are asked to consider and debate the proposed changes to the strategy and may wish to address the following questions:

i. Should the fifth cross cutting theme be extended to include quality issues?
ii. Do the areas for focus for 2014/15 reflect changes in the JSNA?
iii. Should the recommendations from the “Who Will Care?” Commission report that the Board has accepted, be incorporated into the strategy as additional areas of focus in 2014/15 and beyond?
iv. Are members confident that they will be able to incorporate the areas for focus into their commissioning plans for 2014/15?

3.5 Following acceptance of this Strategy refresh, the next steps are:

i. ECC and the CCGs will be asked to incorporate the areas for focus into their commissioning plans for 2014/15;
ii. The priority scorecards will be disaggregated to establish baseline figures at CCG and district level, to assist with more localised planning and review purposes.

4. Policy context

4.1. The document under consideration is the refresh of the Joint Health and Wellbeing Strategy.

4.2. The document, and the Joint Strategic Needs Assessment that is summarised in it, outlines the evidence base for other strategies and documents. One such strategy is the Children and Young Peoples Plan and the Sufficiency Statement. This is based on the evidence base of the JSNA.

5. Financial Implications

5.1. At this stage it is not possible to quantify the financial implications of the commissioning plans that will result from the refreshed strategy. The intent is that partners will draw up commissioning plans by February 2014 that are aligned with the 2014/15 areas of focus within their own financial regulations and commitments. These plans will be brought back through the Board in early 2014 and appropriate approvals secured at that point in time.

5.2. Our current financial plans do not assume any further financial provision at this point, however the commissioning plans will be developed and may seek re prioritisation from within existing resources.

6. Legal Implications

6.1. The recommendations are consistent with the Board's statutory terms of reference and that there are no additional legal implications.

7. Staffing and other resource implications

7.1. Partners will draw up commissioning plans that are aligned with the 2014/15 areas of focus and for which they can provide sufficient staffing/other resource capacity. Partners will comply with employment legislation and other relevant council policies.

8. Equality and Diversity implications

8.1. An Equality Impact Assessment was carried out with the development of the Strategy. A review of this assessment will be made following the development of the commissioning plans for 2014/15, which will assess the actual proposed impact of the Strategy for 2014/15.

8.2. The cross cutting theme "Addressing the social determinants of health and reducing health inequalities" specifically addresses the equality and diversity

implications. The areas for focus in 2014/15 will result in positive action to reduce health inequalities.

9. Background papers

9.1. Joint Health and Wellbeing Strategy Annual Refresh 2013

9.2. Children and Young Peoples' Plan

9.3. Windscreen of Needs Mosaic Analysis

2013 to 2018

Essex Health & Wellbeing Board

Joint Health & Wellbeing Strategy for Essex

1st Annual Refresh v.5 06/11/2013

Contents

1. The vision

This is the first Health and Wellbeing Strategy for Essex. The Essex Health and Wellbeing Board brings together key partners to improve health and wellbeing through the development and implementation of a Health and Wellbeing Strategy for the communities of Essex.

The World Health Organisation (WHO) defines health as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity". We have used this definition to develop our strategy.

This strategy sets out how the partners will work together to improve health and wellbeing over the next five years in Essex. The key priorities are based on evidence from the Joint Strategic Needs Assessment (JSNA), and an extensive consultation process throughout the county.

It is fully recognised that Essex has different communities with significant socio-economic/health diversity; wide variances in baselines for health and wellbeing; and that any strategy must be driven by, and be relevant to, the needs and priorities within those communities.

The vision for better health and wellbeing in Essex

By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.

To pursue the vision, the Essex Health and Wellbeing Board will:

- promote a shift from acute services to the prevention of ill health, to primary health care, and to community-based provision;
- support investment in early intervention and the prevention of risks to health and wellbeing to deliver long-term improvements in overall health and wellbeing;
- support individuals in exercising personal choice and control, and influence over the commissioning of relevant services;
- enable local communities to influence and direct local priorities for better health and wellbeing strengthening their resilience and using community assets to reduce demand;
- promote integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way where it is beneficial to do so;

- ensure resources are allocated consistent with the needs within and between the communities in Essex; and

- support individuals in making informed lifestyle choices and promoting the importance of individuals taking responsibility for their own health and wellbeing.

The strategy has a five-year life span, from 2013 – 2018. This document embodies the 1st Annual Refresh, signed off by the Health and Wellbeing Board in November 2013. The updates that have been incorporated include:

- incorporating the progress that has been made and the future plans to continue at pace, with the integration of health and social care, into the whole document;

- the most recent data from the JSNA;

- a renewed evaluation framework for the strategy (as approved at the Health and Wellbeing Board in May 2013);

- performance "score cards" for each of the three priorities, which will act as a baseline to track progress in future years;

- a clearer focus for each of the priorities and cross cutting themes for the year ahead (2014/15).

These changes are shown in olive green text.

2. Setting the priorities

This strategy has been developed by looking at the data and information on health and wellbeing in Essex to pin-point what the key challenges and areas for focus should be, and also an extensive programme of consultation and engagement with stakeholders and residents seeking their views on the areas that need prioritising.

The Joint Strategic Needs Assessment (JSNA)

This is the main source of evidence and related information on the health and wellbeing of the population of Essex; the wider determinants of health; and the quality of life in the county. It has been used to identify the key areas that need addressing in this strategy to make the greatest improvements in health and wellbeing. The JSNA is the fundamental basis for choosing our priorities.

Consultation on the key health and wellbeing challenges facing Essex

In addition to the evidence in the JSNA this strategy has been influenced by a wide-ranging consultation programme undertaken between May and August 2012. There have been 4 elements to the consultation and engagement process supporting the strategy's development.

1. Circulation of a draft strategy with consultation questions to key stakeholders;
2. An on-line survey open to partners and the public that resulted in nearly 750 responses;
3. Consultation events across the county involving general briefings and discussion as well a detailed exercises looking at potential priorities;
4. A health and wellbeing conference and stakeholder forum on the 18 July 2012.

From August 2012 – September 2013, other consultation and engagement activity has taken place on a range of topics. These are summarised on the Essex Insight website.

JSNA: Summary of the headline health and wellbeing issues in Essex

Essex Population and Health Determinants

The **population** of Essex is close to 1.74 million (including Southend and Thurrock) with Colchester Town and Chelmsford city being the largest urban areas. The older population is expected to grow to 28% by 2033, with a 15% reduction in the working age group. Currently 10.5% of the population are from ethnic backgrounds (9.2% for Essex) and 30% of travelling families in the county live on unauthorised sites. Essex has some of the most affluent and some of the most **deprived areas** in the country, with further pockets of disadvantaged communities that are hard to identify.

Employment opportunity, mental health and **educational achievement** have a strong association. Although the Essex unemployment rate is lower than the national rate, there is a nearly threefold variation between districts (from 13.2% to 4.6%). The working age population is ageing and the level of adult qualifications is low. The number of young people in Essex not in

education, employment or training (**NEET**) is higher than national and regional averages but has reduced slightly over the last year. Young people from more disadvantaged communities are at a higher risk of becoming NEET.

Effective and efficient transport can support people in having good access to services and is essential to local economic prosperity but must be at a reasonable cost, in reasonable time and with reasonable ease. There should be clear strategy for promoting walking and cycling as well as good road safety measures.

Crime and community safety continue to be highlighted as a priority by the residents of Essex. The issues of domestic abuse, violence and burglary link closely with other issues related to criminality such as drug and alcohol misuse and anti -social behaviour.

Decent, affordable and appropriate **housing** is increasingly needed to meet the current and longer term needs of the people of Essex, especially with the rise in older residents, people with a disability and other vulnerable groups. Poor housing conditions, including heating deprivation, is a local concern in our disadvantaged communities. Welfare reform also has serious consequences for housing which need to be monitored.

In regards to environmental issues, Essex is doing well in **waste management** and in implementing measures to keep air pollution low, but with increasing housing development, making these improvements sustainable will prove a challenge. Essex is also highly dependent on non-renewable energy.

Essex has a number of **poverty related issues**, especially in Harlow where the level of house ownership is very low and the level of benefit claimants is high. Building strong social capital can help reduce childhood poverty, which in turn will provide the right opportunities for young people and the community to flourish.

Community cohesion cannot be maintained without balancing the need for targeted and universal interventions and explicitly addressing the socioeconomic wellbeing of communities, including engaging with young people, enabling social inclusion for marginalised groups and instilling a sense of localism.

Health, Community Wellbeing and Inequalities

Although the trend in life expectancy is upward, there is a 3.5 year gap between males and females across Essex, with more inequalities in disadvantaged communities. There is a 17% difference in people's perception of their quality of life between the best and worst districts in Essex.

There is a decreasing trend in **cancers** across Essex but we have geographical and gender differences. Survival rate is dependent on early diagnosis as well as good prevention programmes. There is a decreasing trend in **cardiovascular diseases (CVD)** across Essex but we have geographical and gender differences. With an ageing population, and early identification of CVD including current undiagnosed cases, the prevalence is likely to be much higher.

Although mortality for **respiratory diseases** such as Asthma and Chronic Obstructive Pulmonary Disease (COPD) is on the decline, the level of morbidity can be reduced with good policy measures and prevention work especially around smoking.

The mortality and morbidity rates for conditions related to **liver disease** are increasing, especially among younger people, primarily due to the excessive consumption of alcohol.
The prevalence of diabetes is likely to rise over coming years, especially with better ascertainment and poor lifestyle choices.

The level of **accidental mortality and intended deaths** is relatively high in Essex, with the home and roads being the most common sites.

Largely preventable **accidental falls** continue to have a significant impact on quality of life and independent living as well as a significant contribution financially.

With a growing ageing population, good falls prevention work can contribute to low levels of morbidity and mortality. A number of districts in Essex have levels of **excess seasonal deaths**, which could be caused by fuel poverty, exceptional warm weather, poor safety at home and the severity of flu outbreaks.

After a gradual increase in mortality rates from **communicable diseases** there has been a reduction across Essex, possibly as a result of better surveillance and increase in immunisation rates.

Over 150,000 Essex residents are expected to be living with a **mental health illness**, with almost 50% of them having developed this condition in their early teens. The prevalence of **dementia**, which increases rapidly with age, is projected to increase by 38% by 2021 which will have a significant impact on public services.

There is a rising rate in obesity with a corresponding high level of physical inactivity in Essex, with fewer women taking part in **physical activity** and resulting in high public services costs. Some districts in Essex have higher than national obesity rates and there is an 11.7% difference between the higher and lower prevalence districts rate. The projected annual increase in obesity rate is 2% in adults and 0.5% in children.

Even though we predict a 1% annual reduction in **smoking prevalence**, there will be an increasing concentration of smokers in our younger population and in lower income groups.
Although Essex has a lower proportion of people consuming higher levels of alcohol, many young people are engaging in harmful drinking and we continue to see a rise in alcohol related hospital admissions. Evidence also suggests an increase in people consuming high levels of alcohol at home. This is fuelled by the low cost and accessibility of alcohol, especially to young people.

Drug misuse contributes to the associated health and crime burden in Essex with nearly 4600 known opiate and crack users and an increase in young people (under 18 years) accessing treatment.

There is a wide variation between districts in the level of poor **sexual health** practices as well as high service usage (eg terminations) especially related to teenage pregnancy.

There are some early signs of success with **interventions to reduce health inequalities**, particularly in reducing the impact of child poverty and targeted lifestyle interventions around childhood obesity and teenage pregnancy rates. But much remains to be done including improving joint working, ensuring appropriate measures of performance outcomes and rolling out more evidence based interventions.

A major task for the Pathfinder Healthwatch Essex will be to drive that integration by presenting the single view of health, social care and other related services that the public and service users have.

In regards to population protection across Essex, a number of key agencies collaborate effectively to ensure that the population is protected from the consequences of **major incidents**. The public health system provides adequate surveillance of infectious diseases as well as nationally accredited and monitored screening and immunisation programmes.

Children, Young People and Families

The health of children in Essex is generally better than or similar to the England average. Although the proportion of babies born with a low **birth weight and infant mortality** rates are relatively low, poor lifestyle choices, including smoking in pregnancy, alcohol misuse and poor diet are still a public health concern.

Rates of **breastfeeding**, which has numerous benefits, are comparatively low in most areas of Essex, especially in more deprived areas and among younger mothers. Good support and advice can help improve parenting skills, ensure adequate level of income support, promote healthier choices and give children a better future.

Although the childhood **immunisation** rates are improving and in some cases are higher than England, the uptake for Mumps, Measles and Rubella (MMR) vaccination remains lower than the required level to achieve population protection.

Poor **family environment** can have a significant impact on good outcomes for children. Research has suggested that a number of factors such as mental health, behaviour and youth offending etc. are influenced by the quality of the parent-child relationship and by improving this relationship it has a positive impact on outcomes for the child, the family as a whole and society (e.g. the social, health and economic costs of unemployment and poor health). Concerns about finances, lack of employment, the risk of eviction and homelessness alongside families with complex / multiple needs increases the risk of poor outcomes for children.

Attainment across Essex has improved significantly at each key stage, however there is a significant disparity across Essex in **educational achievements** at GCSE level. Areas with low educational attainment tend to have more young people who are NEET and higher levels of teenage pregnancies. Attainment for children in care has improved but is still below that of their peers.

We need to improve health education to ensure that the poor **lifestyle choices** we experience across Essex can be improved. Young people have easy access to alcohol and smoke from a younger age. Risk taking behaviours, possibly fuelled by alcohol misuse, can lead to high levels of Sexually Transmitted Infections (STIs), crime and violence, risk to personal safety as well as poor mental health, some of which will continue into adulthood.

Although lower than the national average **childhood obesity** continues to pose a challenge and continues to rise across the county. More can be done to improve diet and increase physical activity.

Mental health and emotional wellbeing depend both on environmental factors and the mental resilience built up throughout the years of early life and into adulthood. It is crucial that children and young people are supported more in this area.

There is a rising population of **children with disabilities** nationally, with two main elements: a growing number of children with profound learning disabilities and/or multiple complex health needs; and a growing number of children with autistic spectrum disorders, some of whom have very challenging behaviour.

It is important that agencies collaborate to ensure **young carers** are identified early, provided with adequate support to maximise their health and wellbeing, ensuring that they do not miss out on their life opportunities.

A number of risk factors can contribute to the likelihood of young people (10 to 17 years) becoming known to the local police and entering the **youth justice system**. These range from; poor family relationships, poor educational attainment, absenteeism or exclusion from school, associating with offending or risk-taking peers, drugs or alcohol use, mental health issues, accommodation in a high crime area or temporary accommodation / homelessness, poor communication or comprehension skills, anti-social attitudes or behaviour and thinking skill issues including impulsivity, risk taking and lack of victim empathy. Children who are in care or looked after are over-represented in the youth justice system.

In Essex (2012/2013) there are 3,569 offences where a young person aged 10-17 years old has been suspected as having committed the offence; a rate of 26.2 offences per 1000 10-17 year old population . The Youth Offending Service (YOS) caseload was 1220 young people in 2010/11, with the number of first time entrants continuing to fall in Essex in 2012.

Although of rare occurrence, the abuse and neglect of children is intolerable. **Safeguarding** is everyone's responsibility, parents, relatives, the public and staff. All staff who, during the course of their employment, have direct or indirect contact with children, or who have access to information about them, have a responsibility to safeguard and promote their welfare. Furthermore, children in care also need to receive better support to ensure they can maximise their potential.

Social deprivation, parenting history, poor education, parental mental health, drug and/or alcohol misuse, are issues that can all impact on **child neglect and abuse**. The Essex Drug and

Alcohol Partnership (EDAP) estimates there are 5,240 families in the county with four or more vulnerabilities, with a greater concentration of these families in deprived areas.

Adults and Vulnerable Groups

The current economic climate has created trends that will have a negative effect upon health. **Unemployment** rates, benefits claims and debt are increasing accompanied by concerns about the high level of fuel poverty. The impact of poor health or disability on a person's likelihood of finding and keeping a job are significant.

Predicted demographic change, increased survival rates, reduced mortality rates, improved diagnostic techniques and improved health care will lead to an increase in the number of people with **learning disabilities**. At present the highest rates of people with a learning disability can be found in Tendring, Colchester and Braintree where the historical long stay hospitals were located.

There are currently 814 **specialist housing** units to support adults with Learning disabilities in Essex. This is an increase on the previous year of 803 specialist housing units, which was a shortfall of 186 compared with the estimated requirement of 989 units. Braintree, Chelmsford and Colchester show the greatest deficits.

During 2011/12 approximately 3900 people, a 5% increase compared with the previous year, received support from the **re-ablement service**, which aims to support people to regain skills with a view to reducing longer term care.

The rate of adults with **physical disabilities** who are supported in Essex in terms of receiving either community or residential/nursing home care has seen an increase year on year since 2006/07 and is now at a rate that is higher than that of the East of England.

Almost 10% of our residents provide informal care to relatives, friends or neighbours. Research suggests that the economic value of the contribution made by **carers** in Essex is £2.4 billion per year which is £45.4 million per week. Over half of the people providing unpaid care are people aged over 50. The physical impairment planning group and older peoples planning group have reiterated the need to help carers maintain their caring role while preserving their health and wellbeing.

It is estimated that 90,500 **older people** with social care needs live in Essex that is 35% of the older population over 65 years. There is a projected 22.8% increase in older people with care needs over the next five years which is higher than the anticipated 19.2% increase for England.

Generally the 2012/13 ASC surveys suggest that people are experiencing decent services and are able to live reasonable lives. However, key areas for improvement include better **signposting** to existing sources of information, advice and support and improved standards following the assessment process.

During 2012/13, the ECC Customer Liaison Service, covering feedback about Adult Social Care services, handled 568 complaints and 581 representations were handled from Councillors and MPs. The team also recorded just under 200 compliments.

It is estimated that the number of people over 65 years living on their own will have increased by around 17% by 2020. **Loneliness** can damage both physical and mental health and can be further exacerbated by lack of transport and poor mobility.

Falls are a major cause of illness and disability amongst those over 65 years and one in three experiences one or more falls in a year. Falls can result in a loss of independence and may impact on both physical and mental health. The prevalence of falls almost doubles in the visually impaired and highly increases the risk of losing independence.

Engagement with planning groups has further highlighted the need to improve awareness and accessibility of information and services. **Visual impairment and deaf or hard of hearing** awareness training is also a key priority for all front line staff, in all service area.

As previously mentioned excess **seasonal deaths** are an important public health concern which sees an increase in mortality among older people. These deaths mostly occur during winter but also during heat waves. The uptake of flu immunisation needs to be kept at a high level to ensure better protection for the vulnerable population.

The population in Essex **aged over 75 years** is expected to increase significantly over the next 20 years and if the need for supported housing units follows this trend it is estimated there will be a potential deficit of over 11,384 units by 2020 and 22,000 units by 2030.

Summary of the headline health and wellbeing issues affecting local communities in Essex

Basildon has particular challenges related to high levels of deprivation. It has the highest level of teenage pregnancy in the county, equal lowest level of breastfeeding, and the lowest adult physical activity rates. It has the second highest rate of deaths due to smoking. It also has the lowest life expectancy rate for women in Essex.

Braintree has the second lowest life expectancy rate for women in Essex, and a high level of hip fractures in those aged 65 or older. GCSE attainment in Braintree is poor compared to most parts of Essex. The number of obese adults is also relatively high.

Brentwood has the equal lowest level of breast feeding in Essex; it also has a very low level of physical activity among adults. Brentwood has the highest level of excess winter deaths in Essex, and one of the highest levels of road injuries and deaths.

Castle Point has high levels of children with tooth decay and one of the lowest levels of adults who eat healthily, and the highest number of obese adults in Essex. It also has one of the highest levels of hospital stays for alcohol-related harm.

Chelmsford has a low level of physically active children and high levels of adults with increasing and higher risk drinking. It has the highest level of hospital stays for self-harm in Essex, and a high level of excess winter deaths.

Colchester has a high level of statutory homelessness; it also has the equal highest level of smoking while pregnant.

Epping Forest has the highest level of obese children in Essex (age 10-11) and the highest level of road injuries and deaths in Essex.

Harlow has the highest level of homelessness in Essex, and the lowest level of educational attainment. Harlow also has the highest level of violent crime and long-term unemployment in Essex. It has the highest number of adults who smoke, the highest number of hip fractures in those aged 65 or older, and the lowest level of physically active adults. It also has the highest rate of hospital stays for alcohol-related harm, drug misuse, new cases of TB, smoking-related deaths, and early deaths: heart disease, stroke, and cancer.

Maldon has relatively high levels of tooth decay among children, the second highest incidence of hospital stays for self-harm, low life expectancy for men, and relatively high incidence of road injuries and deaths.

Rochford has the second highest level of increasing and higher risk drinking, and a relatively high level of hospital stays due to alcohol-related harm.

Tendring has the second highest overall level of deprivation and the highest proportion of children in poverty. It has the equal highest incidence of smoking in pregnancy, and the lowest level of physical activity among children. It has one of the lowest rates of physical activity among adults, the highest level of people diagnosed with diabetes, and the equal lowest life expectancy for men. It has the second highest rate of smoking-related deaths, and one of the highest early death rates for heart disease and strokes.

Uttlesford has the second highest rate of physically inactive children and the highest rate of increasing and higher risk drinking. It has the second highest number of road injuries and deaths.

3. The priorities

There are a wide range of issues that we want to tackle to improve health and wellbeing in Essex. In order to be clear about our priorities we have combined the findings of the JSNA with feedback from stakeholders and the public. Our approach to health and wellbeing takes the perspective of the "whole life course": improving the outcomes for Essex's residents by focusing on prevention and better outcomes for every individual and family throughout their lives, and at the end of life – encompassing investment in palliative care. This strategy reflects the Marmot Review findings that action is needed across the social determinants of health. This means we have an over-riding strategic framework; specific priorities and areas for action; and wider cross cutting themes where action will occur to underpin the strategy. In this 2013 refresh document, the areas for focus have been updated and rationalised in order to present health and social care partners with a clearer steer for the delivery of integrated commissioning plans for the 2014/13 financial year.

The over-arching framework for better health and wellbeing in Essex

Starting well
Developing well
Living well
Working well
Ageing well

Starting and developing well: ensuring every child in Essex has the best start in life.

Recent External Influences

The government has increased the provision of free pre school education places. The extensive revision of the assessment and support arrangements for children with Special Educational Needs (SEN) which includes the introduction of a single education health and care assessment and plan for all children with SEN aged 0-25 is aligned with the moves in Essex to integrate health and care services and will be welcomed by children, young people, their parents and carers.

Areas for focus during 2014/15

- Improve pre-school support, in particular for the 0-2 age group
- Integrate the 0-5 years and 5-19 years Healthy Child Programmes
- Improve educational achievement

- Work with schools to identify children at greatest risk of becoming NEETs (not in education, employment or training) and provide early intervention support to lower their risk profile.
- Deliver the Family Solutions project.
- Integrate services so the transition from children's to adult services is more effective.
- Meet the requirements of the Children and Families Bill to prepare a local offer to deliver Education, Health and Care Plans for children and young people.

Areas for focus extending across the full lifetime of the strategy:

- Reduce teenage pregnancies and increase breast feeding rates.
- Increase immunisation take-up, particularly MMR.
- Improve pre-school and educational achievement.
- Improve outcomes for children with special educational needs.
- Reduce risk-taking behaviours.
- Design new interventions to focus on families with complex needs.
- Integrate services so the transition from children's to adult services is more effective.
- Reduce childhood obesity levels by increasing physical activity, improving diet, and delivering more effective education in health and health-related matters

Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life.

Recent External Influences

The impact from the introduction of welfare reforms is being monitored by partners, though a clear and decisive picture is still to emerge. As part of their approach to revitalising the economy, the government is providing stimuli to the housing market. The impact of these various initiatives on Essex in terms of the buoyancy of the housing market, and whether any growth is meeting the identified demand, is yet to be fully understood. The transfer of public health responsibilities from Primary Care Trusts to Essex County Council has resulted in a greater incorporation of public health issues into the Council's mainstream activities. There is strong partnership working emerging with the Police and Crime Commissioner on interventions aimed at reducing drug and alcohol misuse which can often result in criminal behaviour.

Areas for focus during 2014/15

- Reduce alcohol misuse and reduce smoking.
- Ensure sufficient affordable housing is available to meet the needs identified.
- Ensure sufficient supported and adapted housing is available.
- Reduce the harm caused by substance misuse.
- Increase physical activity and improve diet across all age groups.

Areas for focus extending across the full lifetime of the strategy:

- Increase physical activity and improve diet across all age groups.
- Reduce alcohol misuse and reduce smoking.
- Increase opportunities for training, apprenticeships, employment and skills.
- Ensure sufficient affordable housing is available to meet the needs identified.
- Ensure sufficient supported and adapted housing is available.
- Reduce the harm caused by substance misuse.
- Increase employment and other opportunities for people suffering from mental illness.

Ageing well: ensuring that older people remain as independent for as long as possible.

Recent External Influences

In Spring 2013, the government published the Care Bill. This is a significant piece of legislation that from 2015 onwards will transform the way in which social care is delivered and funded. The headline changes of the introduction of a cap on the total amount that people will have to pay for their own care and the right to deferred payments are just two of the many major changes that will take effect. The Bill which contains a number of new powers and duties for local authorities is passing through parliament during 2013. The regulations that will spell out in detail the full implications and enable local authorities to start to plan for implementation will not be published until Spring 2014.

The government is due to publish a plan to support vulnerable older people with a focus on a small number of key initiatives to enable older people to live more independent lives, including the nomination of a single named contact as the coordinator for all health and care.

The Health and Wellbeing Board received the final report from the "Who Will Care?" Commission led by Sir Tom Hughes Hallett. This inquiry reported 5 high impact solutions to prevent a health and social care crisis in Essex. The Health and Wellbeing Board will agree their response to the Report at their November meeting.

Areas for focus during 2014/15

- Develop and integrated pathway for elderly care to prevent and reduce the harm from falls.
- Extend the provision of re-ablement services across the county.
- Extend partnerships with the community and voluntary sector to provide community-based information and support services.

Areas for focus extending across the full lifetime of the strategy:

- Innovation and improvements to end of life care.
- Improve and develop services to respond to the rising prevalence of dementia.
- Developing integrated pathways for elderly care encompassing provision but also prevention, reducing falls, and ensuring independence is maintained for longer.
- Enabling residents to maintain or regain their independence for as long as possible via technology and equipment, supporting carers, and re-ablement services.
- Developing of community-based information and support services encompassing voluntary organisations, volunteering and more provision in primary care settings.
- Extending support for carers and responding to growing numbers of older people experiencing loneliness.

Cross cutting themes that underpin the priorities

Tackling health inequalities and the wider determinants of health and wellbeing

There are wide differences between the health and wellbeing of different groups of people and between different parts of Essex. Residents in the most deprived parts of Essex tend to experience poorer health and have a lower life expectancy. There are parts of Essex that have high levels of deprivation and Jaywick is the most deprived area. In addition, some groups experience a much poorer quality of life across all the wider determinants of ill-health. These groups include travellers, homeless people, and victims of domestic abuse. The overall focus of this strategy is to reduce health inequalities and tackle the wider determinants of health so life expectancy is increased and inequalities between areas and groups reduced.

Areas for focus during 2014/15

- Develop improved profiling and identification of vulnerable groups in each of the priorities and target specific interventions in order to close the health inequality gaps that exist.

Transforming services: developing the health and social care system

One of the main purposes of HWBs is to ensure that there is a better coordination between health and social care services in order to deliver better services to patients and service users. At the start of 2013, Essex County Council worked with each of the CCGs to produce integrated commissioning plans that in themselves were based on the JSNA and broadly reflected the priorities in this strategy. These have been further developed throughout the year and in June 2013 an accelerated design event saw the leaders of the health and wellbeing system coming together to ratchet up the progress of integrating health and social care. In the same month the government announced that health and social care provision by all local authorities must be integrated by 2018.

Areas for focus during 2014/15

This cross cutting theme has an overarching priority above all others. Without success in the integration of health and social care and the associated health and wellbeing system transformation that it will bring with it, the implementation of this Health and Wellbeing Strategy will only comprise a partial attempt.

- Continue the work to establish a full integration programme with overall leadership provided through the Health and Wellbeing Board and operational management through the Board's Business Management Group.

- Begin the implementation of whole scale transformation of primary care in line with NHS England Essex Area Team's Primary Care Strategy which will be published in April 2014.

Empowering local communities and community assets

To meet our vision the approach to improving health and wellbeing in Essex is underpinned by engaging with local communities so that children, young people, and families have the opportunity to have their say. HealthWatch will be supported to take an active role in the Essex

Health and Wellbeing Board, enabling it to effectively represent the views of patients and service users. The Essex Health and Wellbeing Board is working with local decision-makers and commissioners to ensure that it understands local communities' needs and aspirations, and that there is a clear understanding of how community assets can be used to improve health and wellbeing at a community or neighbourhood level.

To understand the most effective ways to improve the health and wellbeing of communities in Essex there is a need to develop an understanding of the strengths each community has that can be built on and focus support around this so that at the local level we can support and foster active citizens able to shape their own life and those of their friends, family and neighbours. The transformation of primary and community services in Essex will be supported by a fundamental change in the way services are commissioned and delivered. As well as integrated commissioning arrangements, a much greater emphasis will be placed on local communities – supporting investment in local activity and networks so that community assets are identified and developed.

Through the Community Budget programme, the Strengthening Communities Strand has established pilot projects in Harlow, Braintree, Tendring and Southend (in Southend unitary authority) that aim to create and build upon strong, resilient communities of active citizens who are willing and able to take responsibility for their own wellbeing, and work together to find local solutions for local problems.

Areas for focus during 2014/15

- Review the progress of the Community Builders pilots to assess their viability for extending county-wide.

Prevention and effective interventions

The Essex Health and Wellbeing Board will drive the changes needed to improve health and social care services in the county. Much more will be done to enable local residents and communities to develop their own capacity for self-care. For example, by supporting social enterprises, and developing more community-based services.

A key theme of the "Who Will Care?" Commission's report was concerned with emphasising that a new contract is required with the citizens of Essex, whereby they take a greater responsibility for their own health and wellbeing and take a much more proactive role in being a part of an empowered local community that helps itself to support older and more vulnerable people.

The priorities for investment must be chosen on the basis that interventions that delay or avoid the use of services offer the best use of resources and the best outcomes for residents and their families. Services will be re-designed so they start with individual needs plotted through

the whole life course from childhood to old age. For example, we can improve the quality of services for disabled children as they move into adulthood by creating an "all-age" service.

Areas for focus during 2014/15

- Improve identification and management of long term conditions

  Enable Essex residents to access and maximise uptake of national screening programmes in order to identify disease early and improve chances of survival
- Establish care pathways to deliver better coordinated and more effective health and care services that ensure that preventive interventions are made early enough to avoid/delay more costly and significant treatments

Safeguarding

Safeguarding has not been out of the news in the last year with a series of high profile inquiries into child deaths, investigations linked to Jimmy Saville and the conviction of child sexual exploitation groups. This issue maintains high levels of public and regulatory interest. The recent publication of Ofsted's new inspection regime for children in need of help and protection will have implications for the content of the JSNA.

On a connected matter, following the publication of the Francis Report into the causes of the Mid Staffs Hospital failures in care and performance, Sir Bruce Keogh led a review into 14 hospitals that had been identified with outlying mortality statistics. This included Basildon & Thurrock University Hospital Foundation Trust and Colchester Hospital University Foundation Trust. These investigations resulted in Basildon Hospital being placed under special measures on 19 September 2013. Quality Surveillance Groups have been established across the country with a remit to carry out operational oversight regarding quality issues.

Areas for focus during 2014/15

- The scope of this cross cutting theme is extended to consider safeguarding **and quality** issues

4. Measuring success

The Evaluation Framework:
A process and the parameters for evaluation of the strategy

Background

The requirements of an Evaluation Framework for this strategy are that:

- if the framework acts as a distraction or complicates systems and processes already in place, then it will have failed;
- overall progress on the JHWBS should be measured with a limited set of indicators for each priority;
- the performance indicators would be selected from the national outcomes frameworks for the NHS, Adult Social Care and Public Health;
- evaluation of the strategy should be both quantitative and qualitative in form;
- the HWB will schedule in-depth reviews of each priority and cross cutting theme in its 4 meetings throughout the summer/autumn of each year in time to feed into the corporate planning cycle for the following year and the annual review of the strategy;
- Clinical Commissioning Groups (CCGs) and NHS England proposed that progress on the elements of the Integrated Commissioning Plans that contribute to the JHWBS should be assessed at 6 months during their regular progress reporting sessions with NHS England;
- Reporting to the HWB from these 6 month assessments should be on an exception (good and poor) basis.

Strategy Evaluation Process

April – November:

1. **Progress Reports**
   For each priority and cross cutting theme, the JSNA Planning Group will prepare a progress report. This report will include quantitative and qualitative elements. Healthwatch Essex will contribute towards the collection of the qualitative elements so that it represents the views of Essex residents. The report will consider the topic in the context of the whole Health and Wellbeing System. For the priorities, the latest data on each of the performance indicators will be included.

2. **In-depth Review(s)**
   An in-depth review will be conducted for each of the priorities and cross cutting themes. The aim of these reviews is to consider the progress report and for partners from across the Essex health and wellbeing system to contribute to a debate of the key issues and to make recommendations to the HWB on changes to the strategy.

3. **HWB Review**
   The HWB is scheduled to consider these in-depth reviews at its meetings throughout the summer/autumn period. Although the progress report and in-depth reviews will have taken into account each topic by looking at the impact on the whole Health and Wellbeing system, the HWB will, by virtue of their role as system leaders, be particularly focused on these aspects of the reviews. The conclusions of the HWB will be recorded and used to inform the following commissioning planning cycle and the annual review of the strategy.

The documentation for stages 1-3 (above) will be posted on the HWB website and opened for public comment and input. The effectiveness of the HWB's stakeholder networks will be crucial

in ensuring that partners are aware of and participate in this engagement opportunity. Proactive steps will be taken to encourage responses from community groups that the Equality Impact Assessment has identified as being underrepresented in previous consultation activity.

Stages 1-3 will then feed into the annual review of the strategy and the annual commissioning planning cycle (and in particular the integrated commissioning plans of CCGs and ECC):

November – December:

4. **Strategy Review**

   The following will be used to conduct an annual review of the strategy:

   - JSNA priority and cross cutting theme Progress Reports;
   - Key issues identified through the in-depth and HWB Reviews;
   - The conclusions of other strategic discussions that have been held by the Board throughout the year (eg Francis report);
   - Integrated Plans Summary Progress Reports (see below);
   - Feedback received from partners and responses to website publications of reports;
   - Other consultation events including any wider Stakeholder Conferences that have been held throughout the year.

   The annual review will be conducted by the HWB in November/December of each year. This will enable any changes to be incorporated into the following year's commissioning planning. It is expected that in the first year of the strategy, the review will be more substantial because partners will have a greater understanding of the direction being taken by the implementation of the integrated commissioning plans, and baseline figures will be available for the priority indicators.

October – March:

5. **Commissioning Planning Cycle**

   Our ambition is to incorporate progress reviews of the strategy through 2 of the quarterly checkpoints in the CCG Assurance Framework that NHS England and the CCGs will be conducting: in the Autumn as a mid-year review and in the spring as an end of year review. Further work is required to agree how to achieve this, ensuring that an equal assessment of ECC activity to deliver the integrated plans is embedded into these meetings and that there is sufficient assessment of the social care activities that are the sole responsibility of ECC. Support will be given to the CCGs by the HWB secretariat to carry out a self-assessment that will cover the delivery of the strategy priorities and cross cutting themes in order to identify topics for inclusion as "exceptional" (good and poor) issues.

   Following all of these review meetings, the BMG will agree a summary progress report that will be presented to the HWB. The autumn report will feed into the strategy's annual review and the start of the following year's commissioning planning activity. The spring report will feed into the sign-off of the Annual Commissioning Plans.

5. Priorities Scorecard

This section sets out the baseline data for each of the three priority areas: Children, Adults and Older Persons. Data sources are not published consistently for all areas, but where available, data has been presented for Essex, alongside a Comparator Neighbour, Eastern Region and England as a whole. There are contextual descriptions for each of the indicators on the Scorecard, however below, there is an overview of each of the priority areas as they currently stand.

Children: In nine out of the 18 indicators chosen to measure the impact of the Health & Wellbeing Strategy in the Children and Young People's priority area, Essex has matched or been better than the National average. Of the remaining nine indicators, four have yet to be fully developed, two do not have nationally comparable data and in only three areas Essex is fairing worse. Where data exists for Essex and our chosen comparator area, Essex is doing better in five out of the ten indicators chosen, which shows there is room for improvement.

Adults: Out of the 18 indicators in this section, only one data source: a nationally consistent count of housing adaptation - is yet to be published. Overall, Essex is doing better than other areas on healthy lifestyle indicators such as smoking, moderate drinking and exercise, along with good health check services offered and accessed. However, among those who need to access Health & Social Care Services, there is more of a mixed picture of success. For example although Essex compares well for offering stable accommodation for people with Learning Disability or Mental Health conditions, however, they are more likely to be unemployed when compared to other areas.

Older Persons: As in the case with data for Children, the data for Older Persons is not as consistently published for all areas – although more data is available for England as a whole. On data that is published for Essex and other areas, a mixed picture emerges. While there are lower rates of admission to residential and nursing homes, the rate of hip fractures is higher in Essex than all other areas. For other indicators such as Excess Winter Deaths, or a sufficient degree of social interaction, Essex is comparable to the England average.

Priority			Starting and developing well: ensuring every child in Essex has the best start in life							
				Baseline data						
Reference	Frequency	Polarity	Measure	Essex	England (Average)	Regional	Comparator Neighbour	Period	Context
Reduce childhood obesity levels by increasing physical activity, improving diet, and delivering more effective education in health and health related matters									
PH 2.6i	A	▼	Percentage of children aged 4-5 classified as overweight or obese	20.6%	22.6%	n/a	21.7%	2011/12	Essex has a lower % of overweight or obese children (4-5yrs) than the England average and comparator area.
PH 2.6ii	A	▼	Percentage of children aged 10-11 classified as overweight or obese	31.9%	33.9%	n/a	32.7%	2011/12	Essex has a lower % of overweight or obese children (10-11yrs) than the England average and compararto area.
Reducing smoking, drug and alcohol misuse									
SHEU survey	A	▼	Secondary school pupils who say they smoke reguarly	9.9%	n/a	n/a	n/a	2013	No national, regional or comparator area data available as not all areas take part in the SHEU survey.
SHEU survey	A	▼	Percentage of secondary school pupils who say they have been drunk at least once in the last 4 weeks	4%	n/a	n/a	n/a	2013	No national, regional or comparator area data available as not all areas take part in the SHEU survey.
Improving Mental Health									
PH 2.07i	A	▼	Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years per 10,000 resident population	111.3	118.2	n/a	111.0	2011/12	Essex has a lower rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 than the National rate, and on par with the comparator area.
Increase immunisation take-up particularly MMR									
PH 3.03x	A	▲	MMR vaccination coverage - % of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday	91.1%	92.9%	n/a	95.1%	2011/12	Essex has a lower % of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday than the National average and comparator area.
Improve outcomes for children with special eductional needs									
		▼	Pupil absence in C&YP with mental health problems						Indicator not yet developed
SFR42/2013	A	▲	Educational achievement of children with SEN - Pupils achieving 5+ A*- C grades at GCSE and equivalent including English and Mathematics at the end of Key Stage 4 - Pupils with a statement of SEN	11.1%	8.4%	8.2%	8.4%	2012	Essex have a higher % of Pupils with a Statement of SEN achieving 5+ A*- C grades at GCSE and equivalent including English and Mathematics at the end of Key Stage 4 than the National, Regional and Comparator area average.
Improve preschool and educational achievement									
27b / SFR37/2013	A	▲	School readiness - Percentage of Year 1 children meeting the expected standard in the phonics screening check	67%	69%	67%	68%	2012/13	The Essex % of Year 1 children meeting the expected standard in the phonics screening check is equal to the regional average and just slightly below the National and comparator area average.
SFR42/2013	A	▲	Percentage of children (incl. SEN Children in Care and those eligible for free school meals) achieving 5+ A*-C GCSE or equivalent (incl. English and Maths)	58.9%	59.0%	58.2%	61.2%	2012	Essex have a near equal % of children (incl. SEN Children in Care and those eligible for free school meals) achieving 5+ A*-C GCSE or equivalent (incl. English and Maths) as the National and Regional averages and a slightly lower % compared to our comparator area.
SFR43/2013	A	▲	Percentage of children achieving a good level of development in Early Years Foundation Stage - A pupil achieving at least the expected level in the Early Learning Goals (ELGs) within the three prime areas of learning and within literacy and numeracy is classed as having "a good level of development"	53%	52%	52%	63%	2012/13	Essex have a slightly higher % of children achieving a good level of development in Early Years Foundation Stage compared with the National and Regional average, but are 10% lower compared to our comparator area.
Working with families with complex needs to ensure better outcomes for children									
	A	▼	Total average difficulties score for all looked after children aged between 4 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months at 31 March	13.5	13.8	13.1	15.9	2012	A higher score on the SDQ indicates more emotional difficulties. Essex score better than the National and comparator area average, but worse than the Regional average.
	A	▼	Domestic Abuse						Indicator not yet developed
	A	▼	Incidence of harm to C&YP due to failure to monitor (NRLS)						Indicator not yet developed
Reduce teenage pregnancies and increase breast feeding rates									
PH 2.4	A	▼	Rate of conceptions per 1,000 females aged 15-17	28.3	31.7	n/a	31.0	2011	The Essex rate of conceptions in 15-17 year olds is lower than the National and comparator area average.
PH 2.2ii	Qtr	▲	Breastfeeding prevalence at 6-8 weeks after birth	43.8%	47.2%	n/a	n/a	2011/12	Essex has a lower % prevalance breastfeeding at 6-8 weeks after birth than the National average.
Integrate services so the transistion from children's to adult services is more effective									
	A	▲	C&YP continue to receive the care they need following transfer from paediatric services						Indicator not yet developed
Reduce risk-taking behaviours									
Q7.3	A	▼	Juvenile first time entrants to the criminal justice system as a rate per 100,000 population	690	595	n/a	602	2012	The Essex (police force area) rate of juvenile first time entrants to the criminal justice system as a rate per 100,000 population is higher than the England/Wales and comparator area and has been improving at a slower rate.

Key		
	▲	The higher the figure the better
	▼	The lower the figure the better

Priority	Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life.

				Baseline data					Current
Reference	Frequency	Polarity	Measure	Essex	England (Average)	Regional	Comparator Neighbour	Period	Context
Increase physical activity and improve diet across all age groups.									
PH 2.12	A	▼	Proportion of adults classified as overweight or obese.	24.2%	24.2%	23.6%	26.3%	2006-08	Essex has same as England average but higher than East Region, but lower than Comparator Neighbour.
PH 2.13	A	▲	Proportion fo adults achieving at least 150 minutes of physical activity/week.	57.4%	56.0%	57.1%	57.2%	2012-13	Essex has the highest rate when compared to other areas.
PH 2.11	A	▲	Comparison with national dietary targets and guidelines.	29.6%	28.7%	30.3%	27.3%	2006-08	Essex has a higher figure than the English average but lower then Eastern Region as a whole.
Reduce alcohol misuse and reduce smoking.									
PH 2.14	Q	▼	Prevalence of smoking among persons aged 18 years and older.	18.7%	20.0%	19.6%	20.1%	2011-12	Smoking lowest in Essex as compared to Comparator Neighbour, Region or England.
PH 4.07i	A	▼	Age-standardised rate of mortality from respiratory diseases in persons less than 75 years per 100,000 population.	18.3%	23.4%		22.4%	2009-11	Essex has the lowest rate when compared to other areas. No regional data exists from Public Health England.
PH 4.06i	A	▼	Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population.	10.9%	14.4%		11.5%	2009-11	Essex has the lowest rate when compared to other areas. No regional data exists from Public Health England.
PH 2.18	A	▼	Alcohol related admissions to hospital.	31.3%	61.8%	34.7%	54.9%	2007-10	Essex has significantly lower rate when compared to England.
Reduce the harm caused by substance misuse.									
PH 2.15i	M	▲	Number of drug users that left drug treatment successfully who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment.	10.1%	8.6%		14.6%	2011	Only 1 in 10 people stay off drugs in Essex, which is less successful than Comparator Neighbour area, but better than Eastern Region as a whole.
Increase employment and other opportunities for people suffering from mental illness.									
NHS 2.5	Q	▲	Employment of people with mental illness / learning difficulty.	30.7%	32.4%	38.1%	33.6%	Q1 2013	Essex needs to improve its rate of employing people with MH conditions or LD, at 30.7% is the lowest compared to all other areas.
PH 1.06ii	Q	▲	% of adults receiving secondary mental health services known to be in settled accommodation.	79.1%	66.8%		68.4%	2010-11	Essex has the highest success rate of housing people with MH conditions.
NHS 1.5	A	▼	Excess under 75 mortality rate in adults with serious mental illness (per 100,000 population).	898.1	921.2		829.3	2010-11	Although Essex has a lower mortality rate among adults with a mental illness compared to England as a whole, it could do better, when compared to Comparator Neighbour which has a significantly lower figure.
Responding to long term conditions and chronic illness.									
NHS 2.1	BiA	▲	Proportion of people feeling supported to manage their condition.	69.0%	69.3%	70.3%	69.9%	2012-13	All areas are comparable on people who feel supported to manage their conditions.
NHS 2.2	Q	▲	Employment of people with long-term conditions.	11.2%	11.8%	10.3%	13.2%	2013 Q1	Although slightly higher than Eastern Regional average, Essex needs to increase its employment of people with LTC.
PH 4.04i	Q	▼	Age-standardised rate of mortality from all cardiovascular disease (including heart disease (including heart disease and stroke). Cases per 100,000	51.8%	60.9%	53.9%	58.0%	2009-11	Essex is managing its patients with CVD well, with lower rates of mortality when compared to other areas.
PH 2.22i	Q	▲	Percentage of eligible population aged 40-74 offered an NHS Check in financial year.	24.8%	16.5%		14.9%	2012-13	Essex offers 1 in 4 people aged 40-74 a health check which is significantly higher than other areas.
Ensure sufficient affordable housing to meet the needs identified.									
LBOI 1.9	A	▼	Affordable housing (ratio of average house price to average annual gross full time pay by place of residence.)	8.83	8.53		8.76	2010	The ratio of house prices to earning is higher in Essex, meaning affordable housing is more difficult to come by when compared to England as a whole.
Ensure sufficient support and adapted housing is available.									
									Data not published.
Increase opportunities for training, apprenticeships, employment and skills.									
PH 1.5	A	▼	Percentage of 16 to 18 year olds not in education, employment or training.	5.7%	5.8%		6.4%	2012	Essex has a lower rate of 16-18 year olds not in education, employment or training, comparable to England as a whole.

Key		
	▲	The higher the figure the better
	▼	The lower the figure the better

Priority	Ageing well: ensuring that older people remain as independent for as long as possible.

				Baseline data					Current
Reference	Frequency	Polarity	Measure	Essex	England (Average)	Regional	Comparator Neighbour	Period	Context
Increasing levels of physical activity and participarion in sport and improving nutrition.									
									No data published by age groups, therefore no data for Older Persons.
Reducing smoking and drug and alcohol misuse.									
									No data published by age groups, therefore no data for Older Persons.
Improve and develop services to respond to the rising prevalence of dementia.									
NHS 2.6i	A	▼	Estimated diagnosis rate for people with Dementia.		46.0%			2011-12	Figures are published for England only at 46.0% in the financial year 2011-12.
NHS OF Indicator 2	A	▲	Health-related quality of life for people with long-term conditions.					2012-13	Figures are published for PCTs, Districts, Regions and England only. No data at County level.
Responding to long term conditions and chronic illness.									
PH 2.22i	A	▲	Percentage of eligible population offered a Senior NHS Health Check in the financial year.						No data published by age groups, therefore no data for Older Persons.
Developing integrated pathways for elderly care encompassing provision but also prevention, reducing falls and ensuring independence is maintained for longer.									
PH 4.14	A	▼	Hip fractures in people aged 65 and over (per 100,000) people.	471.1	457.2	449.5	469.0	2011-12	The number of hip fractures in Essex is higher than all other areas. Preventive measures could benefit.
ASC 2A	A	▼	Permanent admission to residential and nursing care homes (per 100,000) people	610.0	708.8	617.2	818.7	2012-13	Essex has a low rate of admission into residential and nursing homes.
Enabling residents to maintain or regain their independence for as long as possible via technology and equipment, supporting carers and reablement services.									
NHS 3.5ii	A	▲	Proportion of patients recovering to their previous levels of mobility ability.		47.3%			2012	Figures are published for England only at 47.3% in 2012.
NHS 3.6i	A	▲	Proportion of older people who are still at home 91 days after discharge from hospital into reablement services.						Data to be published as part of ASCOF - not yet available.
Developing of community based information and support services encompassing voluntary organisations, volunteering and more provision in primary care settings.									
PH 4.15	A	▼	Excess winter deaths.	20.6%	19.1%	18.9%	20.8%	2008-11	Although marginally higher than England or the Region as a whole, Essex's rate of Excess Winter Deaths in in line with other areas.
PH 1.18	A	▲	Proportion of people who use services and their carers who reported that they had as much social contact as they woud like.	42.1%	42.3%		37.5%	2011-12	OP in Essex report about the same as national rates of social integration.
Providing better end of life care.									
NHS 4.6	A	▲	Bereaved carer's view on the qualitty of care in the last 3 months of life.					2012	Figures published for England only (April 2012). The survey asked: "Overall, and taking all services into account, how would you rate his/her care in the last three months of life?". The results are: Outstanding (12.6%), Excellent (31.2%), Good (33.5%), Fair (13.6%) and Poor (9.1%).

Key		
	▲	The higher the figure the better
	▼	The lower the figure the better

Essex County Council

Report to: Health & Wellbeing Board **Report of: Dave Hill**	**Reference number:** **HWB/022/13**
Date of meeting: 21st November 2013 **Date of report: 31st October 2013**	**County Divisions affected by the decision: All divisions**
Title of report: Integration update	
Report by Dave Hill, Executive Director People, Essex County Council **Enquiries to Clare Hardy, Head of Vulnerable People, Essex County Council**	

1. Purpose of report

1.1. To update members on the progress of our health and social care integration work and the Pioneer submission made by the Health & Wellbeing Board.

1.2. To update members on the Integration Transformation Fund and the role for the Health & Wellbeing Board

1.3. To set out the timeline for the Integration Transformation Fund and Integrated Plans

2. Recommendations

2.1. Agree the timeline for the Integration Transformation Fund and Integrated Plans including an additional HWB meeting for February to sign off the Integration Transformation Fund plan.

Background and proposal

3.1 Integration Programme and Pioneer

3.1.1 In June the Health & Wellbeing Board (HWB) agreed to submit a proposal to the Department of Health (DH), for their Health and Social Care Integration Pioneer Programme. The DH received 111 applications and 26 areas were shortlisted of which Essex was one. An representation from Essex presented to the judging panel in September and on the 30th October we were informed that our submission was the most ambitious of all the submissions received but further planning and development as to how it would be delivered was required to enable it to be a Pioneer. Although we were not accepted in this round we were encourage to continue to work on our Integration Programme and consider resubmitting in a future round for the Pioneer programme. The HWB will need to consider its position on this at a later date.

3.2 Integration Transformation Fund

3.2.1 At the September HWB we noted the recent announcement by the government of the Integration Transformation Fund (ITF). On the 17th October the LGA and NHS England issued guidance to support the development of the ITF plans.

3.2.2 The ITF is based on each HWB area and is a catalyst to improve services and value for money through creating a pooled budget across health and social care. The guidance notes that the opportunity of the ITF is to create a shared plan for the totality of health and social care activity and expenditure that will have benefits beyond the effective use of the mandated pooled fund. HWBs are encouraged to extend the scope of the plan and pooled budgets.

3.2.3 Although the ITF does not fully come into being until April 2015 we are required to produce a 2 year plan covering the Social Care Sustainability Transfer from Health in 2014/15 and the full ITF in 2015/16. This is because the ITF in 2015/16 will include a 'pay-for-performance' element based upon producing a 2 year plan by April 2014 and performance in 2014/15. The ITF also fits in with the 2 year plans that CCGs are currently producing and the 5 year strategies that will come to the HWB in the New Year.

3.2.4 The ITF pooled budget brings together NHS and Local Government resources that are already committed to existing core activity, including the Disabled Facilities Grant from District Councils. Council's and CCGs will have to redirect funds from activities into shared programme that delivers better outcomes for individuals. This calls for a new shared approach to delivering services and requires Councils and CCGs to work together through their HWB. The ITF fund from 2015/16 will be put into pooled budgets under joint governance between CCGs and local authorities and we are awaiting further detail on how this will work.

3.2.5 The ITF from 2015/16 requires local areas to meet six national conditions:

- Plans to be agreed jointly;
- Protection for social care services (not spending);

- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessment and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impacts of changes in the acute sector.

3.2.6 The ITF requires some ministerial decisions and legislative changes. We are also expecting a notification for each HWB of its share of the pooled fund for 2014/15 and 2015/6. The HWB is then required to agree the 2 year ITF plan covering 2014/15 & 2015/16. In the first year the HWB needs to ensure that the funding is used to:

- *'support adult social care services, which also has a health benefit*';
- that discussions have taken place between the HWB CCGs and local authorities on how the funding should be spent;
- that the plan has regard to the Joint Strategic Needs Assessment (JSNA);
- that the funding transfer makes a positive difference to social care services.

For the 2015/16 funds it is suggested that the HWB will need to agree:

- the aggregate ambition set for the fund;
- ensure the national conditions set out at 3.2.5 are met;
- that providers have been engaged/ manage the transition;
- a joint risk register.

A draft template has been produced for each HWB to use and should be used by CCGs and local authorities to develop the plan. The template needs to be agreed and submitted by the HWB by the 15th February 2014.

3.2.7 Work has already commenced through the BMG and in each locality on the ITF plan. We will need to explore some of the ministerial announcements and legislative change as they emerge and in particular we have already agreed that the governance task and finish group will look at any governance implications. Local areas will work to ensure Districts and providers are engaged in the process.

3.2.8 To enable the HWB to meet the deadline of the 15th February for submission of this plan we do need to put in place an extra meeting of the HWB specifically to agree the plan. We are looking to do this for either the 12th or 13th February. A full timeline for the ITF is set out in appendix a for agreement by the HWB.

3.3 Integrated Plan timelines

3.3.1 A statutory duty of the HWB is to agree the Commissioning plans of the CCGs. Last year the HWB agreed 5 Integrated Plans one for each CCG and a 6th county wide plan that included the Council's contributions to each of the CCG commissioning plans. This year the intention is to produce just 5 integrated plans and to have the County Council's contributions embedded in each plan. The high level ambitions of these plans will come to the January HWB meeting, with the

full plans coming to the HWB meeting on the 27th March at which the HWB needs to ensure alignment with the Joint Health & Wellbeing Strategy (JHWBS). The timeline for this integrated plan process is set out in appendix a alongside the integrated plan for agreement by the HWB. Further guidance may be issued on this and we will adapt as required.

3. Policy context

3.1. This paper set out the processes for the Integrated Plans and Integrated Transformation Fund both of which need to be in alignment with the Essex JSNA and the Essex JHWBS.

4. Financial Implications

4.1. There are no assumptions being made that the ITF is providing 'new funding' to meet existing burdens – therefore closing existing or known affordability gaps. The assumption is that the new fund will be accompanied by new responsibilities.

4.2. The expected level of the fund for Essex is circa £89m for 2014/15 onwards.

5. Legal Implications

5.1 S. 75 of the National Health Service Act 2006, and regulations made thereunder, provides authority for the Council and clinical commissioning groups to agree arrangements for the pooling of funds and the discharge of functions by one of the constituent bodies on behalf of the other where such arrangements are likely to lead to improvement in the way in which those functions are exercised.

5.2 Developing arrangements of this type comes within the Board's duty to encourage integrated provision. However formal approval of such arrangements remains the responsibility of the Council's executive and the CCGs involved. It is understood that the Department of Health are reviewing the powers of Health and Wellbeing Boards in this respect and the Board will be advised of any proposed changes.

6. Staffing and other resource implications

6.1. The only direct staffing implications of this paper are those required by the CCGs and local authorities to develop the Integration Transformation Fund plan and the Integrated Plans. Both of these plans are requirements of those organisations.

7. Equality and Diversity implications

7.1. This paper sets out planning processes for our Integrated Plans and Integration Transformation Fund plans. These documents will need to go through the appropriate Equality and Diversity Impact Assessments and should be in line with the JSNA and JHWBS.

8. Background papers

8.1. Letter from DH on the Pioneer programme.

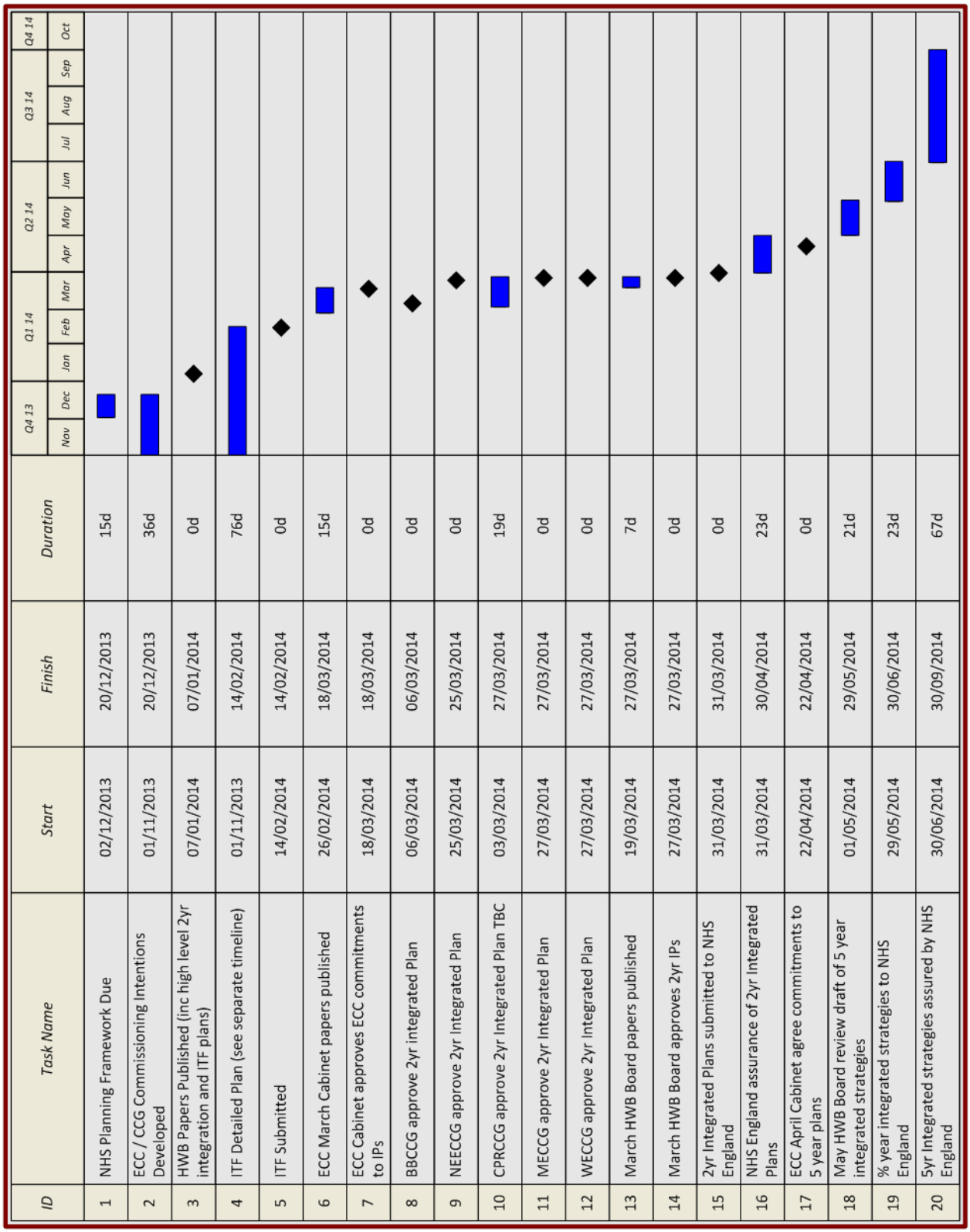
8.2. ‘Next steps on implementing the Integration Transformation Fund’ letter from the LGA and NHS England to the Chair of the HWB.

8.3. Integration Transformation Fund template.

8.4. Appendix A Integrated Plan and Integration Transformation Fund plan timeline.

Appendix A

Health & Social Care Integrated Plan & Integration Transformation Fund 2014/15 timeline



ID	Task Name	Start	Finish	Duration
1	NHS Planning Framework Due	02/12/2013	20/12/2013	15d
2	ECC / CCG Commissioning Intentions Developed	01/11/2013	20/12/2013	36d
3	HWB Papers Published (inc high level 2yr integration and ITF plans)	07/01/2014	07/01/2014	0d
4	ITF Detailed Plan (see separate timeline)	01/11/2013	14/02/2014	76d
5	ITF Submitted	14/02/2014	14/02/2014	0d
6	ECC March Cabinet papers published	26/02/2014	18/03/2014	15d
7	ECC Cabinet approves ECC commitments to IPs	18/03/2014	18/03/2014	0d
8	BBCCG approve 2yr integrated Plan	06/03/2014	06/03/2014	0d
9	NEECCG approve 2yr Integrated Plan	25/03/2014	25/03/2014	0d
10	CPRCCG approve 2yr Integrated Plan TBC	03/03/2014	27/03/2014	19d
11	MECCG approve 2yr Integrated Plan	27/03/2014	27/03/2014	0d
12	WECCG approve 2yr Integrated Plan	27/03/2014	27/03/2014	0d
13	March HWB Board papers published	19/03/2014	27/03/2014	7d
14	March HWB Board approves 2yr IPs	27/03/2014	27/03/2014	0d
15	2yr Integrated Plans submitted to NHS England	31/03/2014	31/03/2014	0d
16	NHS England assurance of 2yr Integrated Plans	31/03/2014	30/04/2014	23d
17	ECC April Cabinet agree commitments to 5 year plans	22/04/2014	22/04/2014	0d
18	May HWB Board review draft of 5 year integrated strategies	01/05/2014	29/05/2014	21d
19	% year integrated strategies to NHS England	29/05/2014	30/06/2014	23d
20	5yr Integrated strategies assured by NHS England	30/06/2014	30/09/2014	67d

Essex County Council

Report to: Health & Wellbeing Board **Report of Dave Hill**	**Reference number HWB/023/13**
Date of meeting: 21st November 2013 **Date of report**: **1st November 2013**	**County Divisions affected by the decision:** All Divisions
Title of report: Essex VCS Commissioning Strategy	
Report by Dave Hill, Director of People, Essex County Council **Enquiries to**: Greg Myddelton, Senior Policy & Strategy Manager, Essex County Council	

1. Purpose of report

1.1. To inform the Health & Wellbeing Board of the public consultation underway to inform the development of the Essex VCS commissioning strategy.

1.2. To provide an opportunity for members of the Board to respond to the consultation and disseminate the message to their networks to ensure strategy is informed by the full range of stakeholders.

2. Recommendations

2.1. For the Board to publicise the Strategy consultation process within their organisations and wider networks.

2.2. For Board members to consider the approval and governance processes required for public sector partners to formally adopt the strategy following the consultation period, and to consider developing individual action plans to deliver the objectives of the strategy.

3. Background and proposal

3.1. The need for a Voluntary Sector commissioning strategy was identified as part of the consultation activity for the Strengthening Communities Whole Essex Community Budget project. Members of the Essex VCS highlighted issues faced as a result of multiple engagement, and funding / commissioning processes across the public sector, observing that a consistent approach would save considerable time, effort and resources. This strategy is a direct result of that consultation activity.

3.2. The purpose of the strategy is to provide a consistent and clear approach to commissioning the VCS in Essex. It is a high-level strategic document that sits alongside the Essex, Southend and Thurrock Compacts and states some commitments and expectations of both sectors. It acknowledges the current financial challenges and resulting structural and organisational changes and articulates what a new relationship between the statutory and voluntary sector may look like. The strategy acknowledges the value of the VCS and attempts to create conditions that support the strengthening of local communities to respond to challenges themselves and to reduce the impact on public sector services at a time of increasing demographic pressures and reduced funding.

3.3. In developing this strategy, the WECB Strengthening Communities Team have engaged extensively; holding a stakeholder conference event, establishing a task and finish team, examining existing national best practice, meeting individual groups from both the public and voluntary sectors and finally publishing the draft strategy for public consultation to allow all stakeholders to share their views.

3.4. In line with Compact guidance, and to allow as many stakeholders as possible to contribute to the consultation, the document will be publically available via Essex Insight from 31st October 2013 until 31st January 2014. Following the conclusion of the consultation process, public-sector partners will be expected to formally adopt the strategy and develop individual action plans to deliver the objectives within the strategy. The strategy will be reviewed annually to ensure it remain fit for purpose and to reflect changing circumstances.

4. Policy context

4.1. The VCS in Essex play a significant part in designing and providing services, supporting residents, patients and families. Improving the ability of the VCS to become involved in the commissioning process will improve services, reduce duplication, and deliver better value for money. The strategy sits alongside existing organisational policies and the Essex Compact, it references Social Value, which will form an element of partners' procurement strategy and also references the work of Sir Thomas Hughes Hallett's "Who Will Care?" Commission.

5. Financial Implications

5.1. This is a high-level strategic document and does not contain any direct financial implications. It does discuss the need for future funding to be evidence-based and outcomes focused and for the need to explore alternative funding arrangements where possible and make use of economies of scale via the development of consortia and sharing best practice.

6. Legal Implications

6.1 This report has no direct legal implications. Individual commissioning decisions will continue to be taken in the context of the public procurement regime.

7. Staffing and other resource implications

7.1. The strategy should have no direct effect on resources.

8. Equality and Diversity implications

8.1. The strategy has no direct implications.

9. Background papers

9.1. Latest draft version of the strategy

Essex Voluntary and Community Sector (VCS) Commissioning Strategy 2013-2016

Our Vision

To establish a transparent and consistent strategic framework that supports the development of resilient communities and enables the VCS to thrive. Delivered by building strong and effective working relationships between the public sector and the VCS in Essex; helping to achieve common goals and develop sustainability.

In Partnership:

List and logos of all partners signed up

Contents

Note: “Essex” in this document, unless otherwise specified means the area of Essex County Council, Southend-on-Sea Borough Council and Thurrock Council.

Version Control

Number	Date	Author	Comment
Version 0.5	March 2013	Greg Myddelton	Draft following internal stakeholder consultation
Version 0.6	16.07.13	Greg Myddelton	Further amendments
Version 0.7	18.07.13	Suzanna-Yong Lee	Edit of chapter structures and Stakeholder workshop conference notes added
Version 0.8	19.07.13	Greg Myddelton	Edited to First Draft
Version 0.9	30.08.13	Greg Myddelton	Amended for consultation
Version 0.10	30.10.13	Greg Myddelton	Final amendment for consultation

1. Purpose

This strategy aims to develop a framework to create and support the enabling conditions for stronger, more resilient communities in Essex. It will seek to enable sustainable community-led activity and support a different relationship between public, private, voluntary and community sectors; a relationship that focuses on the citizen and family rather than organisations, promotes early-intervention to prevent longer-term issues, and seeks to ensure value for money for public services by improving co-ordination between agencies.

In addition, the strategy is needed:

- to establish a consistent, multi-agency approach to VCS commissioning and support;
- to clarify how the future VCS commissioning landscape will operate with better co-ordination between commissioners;
- to devolve control and power to communities so that they can make use of all public assets to achieve the vision
- to support the development of community capacity, whilst recognising the need for continued support for evidenced core VCS services;
- to understand the implications of organisational change upon the VCS ie more joined-up approach to commissioning, both internally and externally;
- to supporting innovation within the VCS;
- to ensure that commissioning the VCS is transparent, fair and COMPACT compliant;
- to ensure alignment between external finance levered-in by the VCS and the desired outcomes of public sector VCS funding;
- to influence organisational strategies and action plans that impact on procurement, commissioning and engagement between the sectors;
- as a high-level plan, intended to inform relations between public sector and VCS, not a prescriptive check-list for interaction;
- to achieve strategic relationships. It is not intended to be an operational plan for local implementation.

This Strategy has been developed and informed by national best practice and guidance including the CLG Best Value Statutory Guidance, the Public Services (Social Value) Act, and the Public Services Equality Duty guidance.

2. Audience

The strategy is intended for use by those within the public sector and those in the voluntary and community sector, for instance:

- Commissioners and funders of public sector services;
- Voluntary and community sector organisations;
- Partners agencies across Essex that engage between public and voluntary sectors;
- Organisations providing capacity building, development and support to the voluntary and community sector;
- Local business organisations and groups;

- Elected Councillors and politicians.

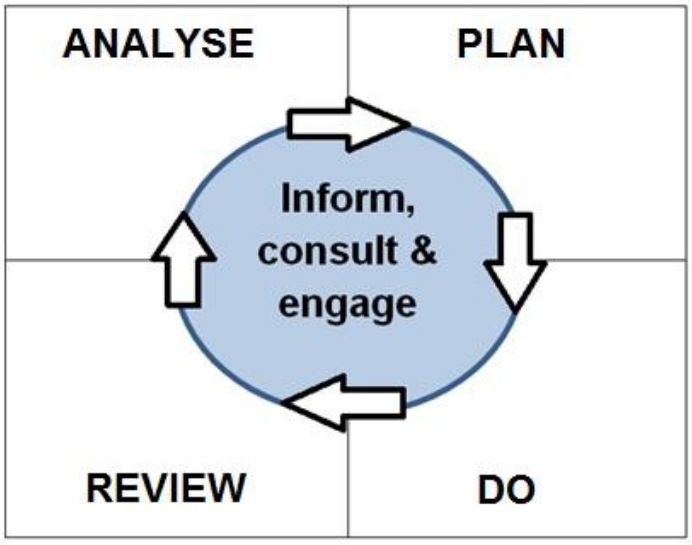
In addition, it is acknowledged that the VCS tend to operate at a local level, and have access to information, experience, relationships and networks that larger organisations (working with a larger number of clients across larger geographic areas) cannot obtain. Working with the VCS can provide a link to service users and their families, and communities that are often the most vulnerable and hard to reach.

3. Priorities

The objectives of this strategy are to:

a) Bring coherence and clarity to the commissioning of the VCS.
b) Ensure that the Essex VCS is able to comment on and influence public sector strategies, in order to develop more reliable and robust policies and strategies that better reflect community needs.
c) Continue to improve the relationship between the public sector and the VCS across Essex in managing and using resources to achieve a strong and prosperous VCS that contributes to the delivery of good public services across the County.
d) Create mechanisms to build capacity and capability into the sector which create a sustainable VCS that is equipped to meet future challenges.
e) Ensure a fair and equitable commissioning framework that reflects competing priorities.
f) Ensure transparency and accessibility of data covering information about our relationship with the VCS.

The National Audit Office outlines the key principles for effective commissioning (see Appendix A for details). It is important to ensure that our relationship with the VCS is focused on the delivery of outcomes which are priorities for our local communities and have been informed by robust intelligence, careful planning, smart commissioning with associated evaluation and outcomes specified. The following chart captures the key components:



4. The Essex VCS

There are an estimated 10,000 voluntary and community groups working across the county of Essex. The sector is extremely diverse in size, scope and function with the term encompassing national, regional and local charities, faith groups, community organisations focusing on a particular area, social enterprises, co-operatives, mutuals and infrastructure / umbrella organisations. They can be geographic, special interest, single purpose or a combination. This rich variety gives the sector a perspective that is different from statutory organisations and enables it to take on a variety of roles and functions. Functions vary accordingly and include grant making, umbrella or resource provision, direct service provision, and campaign and advocacy organisations. These functions are not mutually exclusive. The sector includes groups that are managed and run entirely by volunteers, or large organisations that employ paid staff and a continuum of a mixed range of these two.

The VCS in Essex contributes to many of the same outcomes as public sector partners and VCS organisations represent, or provide services for, many of the same people. This strategy acknowledges the work that VCS organisations in Essex are involved in, and recognises that in many cases this work is undertaken without interaction or interference with the statutory sector. Whilst this document focuses on the new relationship that is developing as a result of a broad move towards commissioning by many in the public sector it also looks to provide the conditions that allow the whole of the voluntary and community sector in Essex to thrive.

5. Approach & Context

This commissioning strategy is informed by a number of key developments; including an independent review of Essex VCS engagement in 2011, local COMPACTs, the report from the “Who Will Care?” independent commission led by Sir Thomas Hughes Hallett, reviews such as Winterbourne, Keogh and Francis that resulted from service failures and significant stakeholder consultation. It is also written in the context of a challenging financial climate when organisations within the statutory and public sectors are being asked to do more with fewer resources. This, compounded by the complexity inherent in our large and two-tier county, means there are risks that threaten the vibrancy of our VCS and the value that it brings to our local communities. We know that these challenges and opportunities can be tackled far more effectively in partnership.

Appendix B contains further information about the context within which this strategy has been formed, and the implications of current and future developments within the public and voluntary sectors.

6. Commissioning

a) The importance of commissioning

Organisations across the public sector are increasingly shifting the way that they operate to become 'commissioning-led organisations' – but what does this mean and what impact does it have upon how they work with the voluntary and community sector? There are many models of commissioning however at the core of them all is a process that goes beyond simply procuring goods and services. For the purposes of this strategy, commissioning is defined as:

> *"the process of identifying needs within the population and developing policy direction/service models, and the market, to meet those needs in the most appropriate and cost-effective way".*

Breaking this down further commissioning can be understood as an on-going process divided into four broad activities.

(i) quantify service-user/patient/family groups needs and for general population in an area;
(ii) align, convene and plan resources to meet needs;
(iii) secure or promote an appropriate solution, and then;
(iv) evaluate the impact and learning from the process.

b) Impact upon the VCS

Commissioning is outcome focussed, with the needs of service users and their carers and families at its core and not the needs of service providers. It sets out a framework for deciding how best to deploy resources strategically in order to achieve objectives, making best use of the strengths of the statutory, voluntary and private sectors. However it is recognised that service providers have a full part to play in developing innovation and co-commissioning, particularly where they are closer to the end user and may have a dual role in advocacy and service provision.

We recognise that engaging the VCS, in particular the local sector, in the commissioning process, harnesses direct advantages such as effective, customer-focussed services, but also provides opportunities to achieve wider local social and economic objectives such as higher levels of volunteering, increasing local employment and improved local skills, and a greater sense of community ownership of local issues.

There is also an acknowledgement that some VCS organisations, especially very small ones, continue to experience significant barriers to engagement in the process. In order to remove these barriers the public sector has a responsibility to support capacity building within the VCS and ensure that the infrastructure that supports small organisations is fit for purpose?

c) Current practices

Traditionally, Essex public sector organisations have played an important role in grant-giving to the local VCS for a whole range of purposes. The shift to becoming commissioning-led organisations means that the amount of grant funding available, and the purpose of these grants, has and will continue to change. Grants will remain

a key part of the public sector's funding mix, becoming one of the tools available to commissioners.
However, they will be increasingly used for targeted purposes which:

- Test new ideas over a specific time period to develop innovative solutions to meet the needs of customers.
- Invest and build capacity in the sector so that it is 'business ready'. This will enable the sector to meaningfully engage in all or parts of the commissioning cycle. This could include the development and support of commercial skills.
- Builds social capital including community engagement and increasing volunteers.

Grants will not be used to fund the outsourcing of public services to the VCS. Where services are externalised it must follow a full and appropriate commissioning process including procurement where necessary. Alongside grant-giving and the wider commissioning process, we will continue to support and seek new opportunities to work with the VCS in creative ways.

7. Evolving Relationship with VCS

VCS organisations vary in size and scope, and it is recognised that the challenges facing large multi-million pound charities are very different from those facing small community groups relying entirely on voluntary effort. Organisations also have very different and often mixed missions, with some working alongside public agencies to deliver public services, some operating in the market to generate surpluses to invest in social causes, and some providing advocacy or campaigning to challenge vested interests or seats of power.

Sector boundaries have always been blurred; but there is a concern these have become more complex as a result of recent developments in policy and practice. Support from government and contract funding to deliver public services take organisations towards the state; and commercial trading and social investment take them towards the market. These developments have led to concerns about mission drift – some VCS organisations losing their charitable or community origins and becoming more like semi-independent state agents. There are also concerns about pressures put on organisations to place business planning and financial sustainability above social values - losing their core identity and distinctiveness in the process. In his report "*Independence under threat: The voluntary sector in 2013*", Sir Roger Singleton states:

> *"The voluntary sector is increasingly being treated in funding, contracting and regulatory arrangements as interchangeable with the private or public sectors, potentially a mere arm of the state, a delivery agent or subcontractor without an independent voice,"*

None of these concerns are new, and they have always been a feature of the VCS landscape. But the effects are real and pose real challenges to voluntary organisations and the sector more generally. Others may find that they are 'left behind' if they are unable to access large public contracts or take on substantial social investment. This may lead to organisational change; but it will not threaten the sector more generally.

The 2012 IPPR report; "*Taken for granted? The needs of small voluntary and community organisations in a big society era*" stated that a key role for government is

to ensure that there is funding available to support organisations though the on-going transition towards outcome based commissioning. This does not necessarily mean government (local or national) should be the provider of such funding and finance, but it does have a key role to play in developing markets, sending signals about what needs to happen and creating the context for a thriving sector. For small organisations with limited capacity, navigating the range of funding and finance options available and identifying which are the most promising for a given organisation and project can be difficult and time consuming. This is as much a challenge as the absence of funding. The organisations that support small VCS organisations – such as councils for voluntary service – have a key role to play.

This strategy acknowledges the work of the 'Who Will Care?' Independent Commission into future health and social care challenges led by Sir Thomas Hughes Hallett. Specifically, the report calls for "a revolution for the voluntary sector where it reviews, revises and regroups leading to an exciting new offering, supporting us to take ownership of our own care". One of the 5 high-impact solutions to prevent a future crisis in health and social care proposed by the report is to develop a new approach to supporting communities and people. The report states that "voluntarism can and should play a greater role" and "local understanding of grass-roots needs can deliver best care, best support, best value and greater independence for each of us".

In addition, the 'Who Will Care?' report calls upon commissioners to agree longer-term contracts; one year for pilot projects, but three to five years for services that are proven and essential, subject to annual appraisal of performance. The report also encourages commissioners to favour consortia of providers to encourage integration of services and better value.

This strategy acknowledges and welcomes the emerging 'Essex VCS Alliance' partnership as a new body with which the statutory sector can work for the mutual benefit of both sectors and the people of Essex. This proposed organisation brings together a broad cross section of voluntary and community organisations that would facilitate communication, increase partnership working and provide representation from the combined services and geographical areas within the Alliance. The Alliance is not intended to replace local structures that already exist but would seek to work with them, acknowledging the diversity that exists in communities throughout Essex, Southend-on-Sea and Thurrock.

8. Legal Duties

In recent years, the coalition government's emphasis on social enterprises places social value at the heart of how communities' needs should be met. Alongside the need to align various existing statues, new regulations and guidance such as the Public Services (Social Value) Act 2012 and Best Value Statutory Guidance set the legal framework to achieve this change. All relevant legal duties and guidance can be found in Appendix C.

9. Delivering the Strategy

This strategy seeks to provide a framework for the future relationship between the public sector and VCS and is intended to be a high-level, strategic document. There are a number of actions within the document, but the bulk of actions will be identified and adopted by individual organisations' action plans or multi-organisational joint commissioning plans that sit underneath this strategy.

It is anticipated that actions will focus on;

- Improving communication between sectors
- The length and size of contracts. Research has highlighted that this is one of the VCS's main concerns as the 'clumping' together of services for commissioning to achieve efficiencies sometimes has the impact of pushing small and medium sized VCSs out of the market.
- The role and structure of infrastructure organisations
- Community Connectors (which links to the wider WECB Strengthening Communities work-stream)
- The increasing importance of capacity-building within VCS, including the role of infrastructure organisations in relation to funding and optimising awareness of new funding streams
- Work to understand and develop alternative delivery vehicles

The public sector in Essex will enable the objectives of this strategy to be met by:

1. Communicating and committing to deliver our strategic intent. This would see public sector agencies:
    - Comply with the Essex Compact;
    - Be honest and open about the challenges that lie ahead and where possible find solutions collaboratively with the VCS; and
    - Be open and transparent with information and proactively share where possible such as upcoming procurement and funding opportunities.

2. Having constructive relationships with organisations whether they receive public funds or not:
    - Valuing and respecting the Voluntary Sector for what it has to offer;
    - Engaging in dialogue and partnerships where it is mutually beneficial to do so and being clear about the nature of any partnership;
    - Being honest about the financial context within which we are operating;
    - Recognising that the local public sector has a role to play in encouraging a market where local organisations (or consortia of local organisations) have the opportunity and incentive to deliver services;
    - Encouraging VCS organisations to work together where it would be beneficial to do so; and
    - Strengthening links with elected Members.

10. Evaluating the Strategy / Measures of Success

As per the deliverables of this strategy, success should be measured against individual action plans but some generic success measures may include;

- The VCS feel more included in the commissioning process and able to be involved on an equal footing
- An increase in involvement and engagement of the VCS in public sector commissioning
- Capacity building within the sector, increasing the sustainability of the VCS

11. Further Reading

- Essex Compact including the Funding and Procurement Code of Practice
- Southend-on-Sea Compact
- Thurrock Joint Compact
- Essex County Council – Supplying the Council

There is also a range of national guidance and material on this subject which may be of help including:

- Association of Chief Executives of Voluntary Organisations – Procurement and Commissioning Guidance and Support
- Communities and Local Government, Making it easier for civil society to work with the state.

building-social-value in the NHS.pdf

12. Glossary of Key Terms

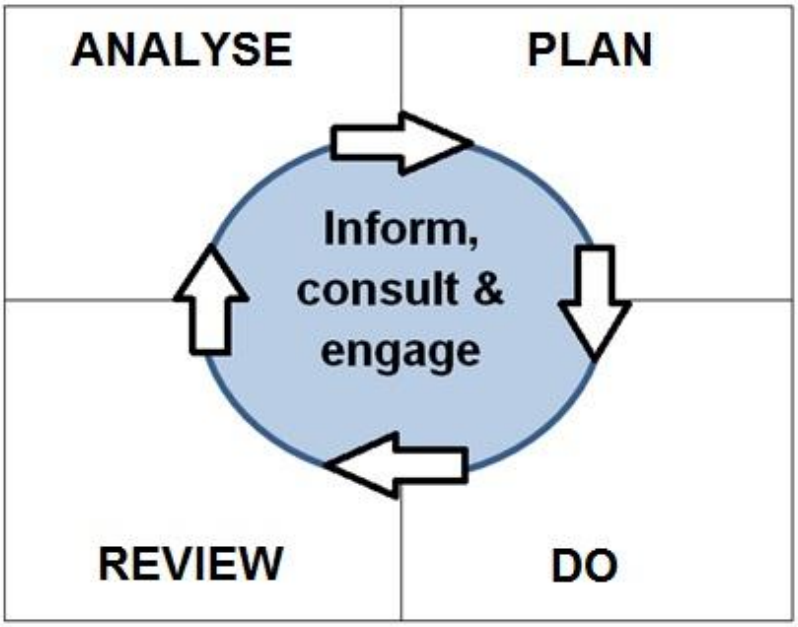
Commissioning	Commissioning is the process of identifying needs within the population and developing policy direction/service models and the market to meet those needs in the most appropriate and cost-effective way.
Contracts	A contract is a formal, legally enforceable agreement with another party by which each party commits to deliver something in return for something else - usually a service in return for payment.
Grants	A grant is an award of money given by an organisation (usually a public sector organisation or a grant-giving trust) to another organisation (usually a voluntary or community sector organisation) to support its work. The grant may partially or wholly support the work of the recipient organisation, or may be tied to a particular purpose such as running a project or delivering a service.
Joint Commissioning	This is when two or more organisations work together and pool their resources to co-ordinate and implement a common strategy for commissioning services. An example of this could be the health and social care commissioning a place to meet a child's holistic needs.
Outcomes	The benefits or other effects that are realised as a result of services and activities provided by an organisation. Outcomes can be defined in advance of a project and measured to demonstrate the success of the activity.
Procurement	Procurement is a specific part of the commissioning cycle. It focuses on the process of buying services or goods from initial advertising though to appropriate contract or grant arrangements. The rules and process will be dependent upon the value and nature of the contract. Further details about each organisations approach to procurement can be found on the Organisations' Website
Payment by Results	A mechanism to incentivising providers to ensure that the services they offer support positive outcomes.
Social Value	Under the Public Services (Social Value) Act 2012, all public bodies in England and Wales are required to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area. This means that whilst value for money will be secured this will be considered alongside other benefits. Social value asks e question: 'If £1 is spent on the delivery of services, can that same £1 be used, to also produce a wider benefit to the community?'

Appendix A: Principles of Good Commissioning

The National Audit Office outlines eight key principles for effective commissioning[1]:

i. Understanding the needs of users and other communities by ensuring that, alongside other consultees, you engage with the third sector organisations, as advocates, to access their specialist knowledge;
ii. Consulting potential provider organisations, including those from the third sector and local experts, well in advance of commissioning new services, working with them to set priority outcomes for that service;
iii. Putting outcomes for users at the heart of the strategic planning process;
iv. Mapping the fullest practical range of providers with a view to understanding the contribution that could make to delivering those outcomes;
v. Considering investing in the capacity of the provider base, particularly those working with hard-to-reach groups;
vi. Ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers, including considering sub-contracting and consortia building, where appropriate;
vii. Seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs.

The following diagram illustrates the commissioning cycle. Further details about our commitments as part of this process and those that we would expect to see from the voluntary and community sector are set out later in this document.



[1] Source: National Audit Office; http://www.nao.org.uk/successful-commissioning/successful-commissioning-home/general-principles/principles-of-good-commissioning/

Expectations and commitments of the commissioning process:

Analyse

Engagement with service users and their support structures such as family and carers is more likely to result in appropriate and effective services, ensuring that they meet the requirements of communities that are supposed to benefit.

The VCS holds a wealth of local knowledge and can play a key role in engaging with service users and representing their views. Voluntary and community sector organisations across Essex can provide a valuable link to service users and communities that are often the most vulnerable and hard to reach.

Not all voluntary and community sector organisations in Essex receive public funding or would wish to directly deliver services on behalf of public services. However, we recognise that they have an important role to play in shaping and reviewing policies by representing the views of users and communities.

To maximise the benefits of a commissioning-based approach, in working with Essex VCS organisations, the public sector will:

- Ensure that commissioning at all levels is informed by an assessment of local knowledge and the local community,
- Be transparent and provide clear mechanisms for the VCS to contribute their knowledge,
- Build in meaningful and specific consultation with providers at early stages, within a framework that does not create conflicts of interest,
- Where appropriate involve local VCS organisations in undertaking research or advocacy to access socially excluded groups, encourage stakeholder involvement and communicate the findings, and
- Consider the resource implications for the voluntary and community sector of gathering and sharing this knowledge and expect that this will be built into the cost of tenders for contracts.

In return, there would be an expectation that Essex voluntary and community sector organisations will:

- Encourage and capture user feedback in ways that are readily accessible with commissioners,
- Gather and share evidence where a need is not being met,
- Seek-out opportunities to engage with the public sector in order to provide local information and get involved in service design,
- Be prepared to adapt and change their provision to meet local needs where these are identified,
- Gather and share information where there is duplication of service delivery across multiple organisations, with a view to reducing such duplication.

Plan

During this stage, work takes place to identify current providers and design how the need will be met.

This stage allows commissioners to secure the most appropriate provider to deliver those outcomes identified during the assessing need stage.

Involvement with the voluntary and community sector at this stage can help facilitate a culture of trust and partnership with the public sector and enables the sharing of knowledge and experience in planning services.

A broad pool of suppliers which includes a thriving VCS will mean greater opportunity to find the right provider and achieve the right service at the right price.

In some instances commissioners will need to consider whether the market is ready to support the service outcomes identified and work may be necessary to develop the market offer.

To maximise the benefits of a commissioning-based approach, in working with Essex voluntary and community sector organisations, the public sector will:

- Find out the number, size, and capabilities of current and potential service providers. Commissioners should consider whether this could be supplemented by information held by local infrastructure organisations.
- Work with the local VCS infrastructure bodies to address gaps in the VCS ability to take part in the commissioning of services. Consider the use of other creative ways in which to build VCS capacity and capability, including training, skills exchanges and other initiatives that may require grant-funding.
- Look at the geographical level at which we are shaping services and always consider the need to look local versus countywide,
- Communicate future commissioning plans to enable suppliers, including the VCS, to forecast and plan capacity effectively,
- Listen to, and usefully interpret, what the VCS are saying to get the right services for users and achieve best value.
- Consider using an advisory panel to inform this process. This may involve specialists from the VCS. However care must be taken not to give any potential contractors a competitive advantage.
- Consider using a third sector organisation with specialist knowledge to act as a consultant in designing services,
- Will consider is this is a suitable area for grant funding.

In return, there would be an expectation that Essex voluntary and community sector organisations will:

- Share good practice and respond to need, be flexible and in touch with different communities to lobby for user interests,
- Explore mechanisms in which the VCS can work together (including through infrastructure organisations) to facilitate contact with potential providers,

- Offer creative and innovative opportunities for the public sector to re-design, improve and achieve better outcomes in relation to the design and delivery of services.

Do

Having identified the need for service development and understood the capacity of the market, commissioners will need to design the service.
Choosing the most appropriate provider to deliver the required outcomes is vital. It will mean that individuals and local communities receive the most appropriate services with the greatest impact. During this stage they will take account of factors including:

- ❖ Funding availability and sustainability
- ❖ Good practice and policy guidance
- ❖ Learning from pilot/pathfinder experience
- ❖ Service user experience and aspirations
- ❖ Clarity of desired outcomes.

Increasingly services will be driven by the personalisation agenda, leaving individual service users/customers to specify the nature of the service they require. Particular services such as early intervention/prevention services may not be subject to personalisation.

To maximise the benefits of a commissioning-based approach, in working with Essex voluntary and community sector organisations, the public sector will:

- Ensure that all information relating to the process, including application forms are clear and accessible,
- Ensure that the solution will be to a good quality, within budget and will achieve the best outcomes.
- Consider the wider social, economic and environmental implications of design alongside costs, in line with the Social Value Act.

In return, there would be an expectation that Essex voluntary and community sector organisations will:

- Be proactive in signing-up to the relevant information and support networks to find out more about potential funding opportunities,
- Read the specification or funding criteria carefully, know the deadlines, evaluation criteria and information required,
- Ensure that any proposals put forward including costings are clear and realistic,
- Consider working with other voluntary or community sector bodies to form consortia and collectively submit applications, if that would make you a better fit to deliver the requirements,
- Consider the legal responsibilities and liabilities of managing a contract,
- If unsuccessful , request feedback on tender or grant applications submitted

Review

Having designed and secured the service to meet the initial need identified it is crucial to have a programme of evaluation - considering what is being done against what was planned. This will include the quality of the services being provided and the outcomes that this service is resulting in. Being aware of the initial needs identified and whether or not these have changed is also key.

Actively encouraging the involvement of service users and providers can provide valuable insight

To maximise the benefits of a commissioning-based approach, in working with Essex voluntary and community sector organisations, the public sector will:

- Build and finance effective evaluation mechanisms into the design stage of the commissioning process, based upon the original required outcomes,
- Involve the VCS where appropriate in determining the best ways to evaluate the services being commissioned,
- Set out clear and proportionate performance management and reporting arrangements, which are not onerous but provide robust accountability,
- Provide opportunities for the VCS to feel able to review and challenge the commissioning process set out by Essex public sector organisations,
- Ensure procurement is accessible to the VCS and consider how practices will impact upon smaller organisations,
- Carry out post tender evaluations that include analysis of VCS involvement in the commissioning process and use this as necessary to improve the process in the future.

In return, there would be an expectation that Essex voluntary and community sector organisations will:

- Have appropriate monitoring and information gathering mechanisms in place that can meet the requirements of the contract,
- Provide representation on appropriate forums where there are opportunities to review and challenge commissioning processes.

Share experiences and knowledge of the process with other VCS to build capacity and capability into the sector.

Appendix B: Approach & Context further information

This commissioning strategy builds on an independent 2011 review of VCS engagement and development of the various Compacts in Essex. The on-going legacy is incorporated in the Strengthening Communities strand of the Whole Essex Community Budget (WECB) pilot. It is important that this strategy acknowledges the new and emerging commissioning structures such as integrated commissioning between health, social care and other partners.

a) **COMPACT**: All the Compacts in Essex set out clear principles and rules for a fair and fruitful relationship between the voluntary and statutory sector across Essex. A central principle of these Compacts is that in the development and delivery of public policy and delivery of services, statutory organisations and the voluntary and community sector have distinct but complementary roles. Three qualities unite the voluntary and community sector and are used to define the VCS for the purposes of this strategy:

   (i) Independence from government; this is an important part of the history and culture of the sector;
   (ii) 'Value driven'; this means the sector is motivated by the desire to achieve social goals rather than the desire to distribute profit, and
   (iii) Not for profit; any surpluses generated in the pursuit of goals are reinvested.

   This strategy promotes the principles articulated in the Compacts of promoting equality of opportunity and aims to ensure a fair and transparent association with VCS organisations based upon inclusiveness and equality. A principle from the strategy is for the adoption of Compact principles to become everyday good practice for the statutory sector.

   As this strategy has developed a common question has been "what is the difference between this strategy and the Compact?" A brief explanation of the difference is set-out in Appendix D.

b) **Whole Essex Community Budget (WECB):** At the commencement of the Strengthening Communities WECB work-stream, workshops were held with VCS partners to establish what the key issues were. The development of a refreshed VCS strategy was a direct output of those sessions. As the strategy began to develop a stakeholder workshop was organised to allow partners within the statutory and voluntary sectors to provide their input into the strategy document and the refresh process.

c) **Community and Social Enterprise:** Over the past few years there has been substantial growth in social business with community interests, and this strategy seeks to ensure that such approaches are promoted alongside the more established VCS organisations.

Increasingly, the role of public sector organisations is changing from that of service provider, supporting residents and service users directly, to a commissioner of services, provided by a variety of delivery organisations such as private companies, charities, social enterprises, local authority trading companies, co-operatives and community groups. The public sector in Essex is taking steps to become more flexible and responsive to the needs of residents and communities and to introduce

new ways of putting people in touch with solutions and local providers. One way this is being progressed is through the WECB programme, which is based upon public sector organisations working in partnership to improve their effectiveness and efficiency in order to be able to accommodate increasing demands as budgets are reduced.

The activities and outcomes of the VCS contribute to, and complement, many of those of the public sector; by acting as providers of information, by being providers of services directly, by acting as advocates for individuals and groups, and by raising funds for these purposes. It is recognised that there is the potential for significant mutual benefit from closer working between sectors, for instance closer working with the VCS would mean the public sector would benefit from enhanced social capital, a thriving marketplace of potential suppliers, and a more efficient process of delivering improved services. For the VCS it could mean influence over the design of services and providing information that ultimately improves services to their clients. Guidance such as the Essex Safeguarding Children's Board's *Effective Support Windscreen* emphasises the importance of co-ordination of activity between partners for the benefit of children and their families. This approach is supported by the findings of the "Who Will Care?" report published by the independent commission led by Sir Thomas Hughes Hallett, which encourages commissioners to spend money on people, not organisations, observing that commissioners are not achieving best value if they do not jointly-commission services.

The public sector and VCS are operating in an increasingly challenging economic climate where organisations are undergoing significant change in terms of their structure and available financial resource. This, compounded by the complexity inherent in our large and two-tier county, means there are risks that threaten the vibrancy of our VCS and the value that it brings to our local communities. We know that these challenges and opportunities can be tackled far more effectively in partnership.

There are a number of implications of the current economic climate and the move to a more commissioning-led approach from the public sector, most notably;

- VCS organisations (infrastructure support groups, advocacy groups, and service providers) are increasingly facing financial pressures that could lead to closure or the rationalisation of their services, just as public sector services are also having to restructure their own service provision and develop new ways of working;
- This coincides with growing societal needs in terms of socio-economic and health-related problems associated with disadvantaged communities and aging populations;
- A move towards outcomes-based commissioning, and recognition of the benefits of prevention and early intervention activity rather than reactive solutions that are often more costly and less effective.
- There is a need for individuals and communities to become more self-reliant, providing support for one another rather than relying solely on state funding.
- Joint commissioning arrangements are being explored as the traditional boundaries within, and between, organisations are challenged, with public services playing an enabling role; helping people to do more for themselves and others.

Although the current high level of public debt and shrinking public sector budgets are creating unprecedented issues, it must also be recognised that even before the global economic crisis and comprehensive spending review, there was greater scrutiny and demand for accountability of the public sector to ensure value for money was prioritised.

In order to improve the efficacy of public sector spend, a number of challenges have been identified that could be addressed by this strategy;

- Improvements could be made in the public sector's communication with the VCS, particularly via infrastructure organisations who have the potential to assist the public sector in identifying opportunities and challenges as they emerge.
- A more consistent, proportionate and joined-up approach to commissioning processes from the public sector to reduce bureaucracy, which would be especially beneficial for small and medium-sized enterprises.
- Clarification around the role of grants in the commissioning process; it is recognised that grants can provide a useful tool for commissioners who wish to support organisations whose work contributes to shared outcomes, or to commission new or innovative approaches. This is outlined effectively in the LGiU briefing Open Public Services which observes that grants could be used to support core funding of organisations whose objectives align with those being commissioned[2]
- The public sector needs to ensure that procurement procedures take account of social value, in line with the 2012 Public Services (Social Value) Act, and recognise that this may offer more opportunities for VCS organisations to engage in public sector outcomes-based commissioning activity compared to simple best-value procurement exercises. For example, the NHS report "*Building social value in the NHS*", suggests a wider aim of public sector commissioning to maximise social value as well as financial savings and efficiency. The NHS regards social value as currency that exists within communities and engaging with them.

This strategy is also written in the context of recent reports that have emerged as a result of failings within the health and care sector; findings from the Keogh review, Winterbourne review and Francis report have been considered in the formulation of this strategy and will continue to influence policies and practices within the public sector in the future. The impact upon the relationship between the public sector and the VCS is an acknowledgement of the importance of the advocacy role that VCS organisations often play in representing the voice of the citizen and ensuring that the views of patients and their families are not ignored. These reports also support the involvement of VCS organisations in the commissioning process to review and, where appropriate, re-design and improve services.

[2] Open Public Services – Experiences from the Voluntary Sector, Mark Upton, November 2012 (http://content.govdelivery.com/attachments/UKLGIU/2012/11/13/file_attachments/174934/Open%2BPublic%2BServices%2B-%2Bexperiences%2Bfrom%2Bthe%2Bvoluntary%2Bsector.pdf)

Appendix C: Legal Duties and Guidance:

a) **Public Services (Social Value) Act 2012**: On 31 January 2013, the new Public Services (Social Value) Act 2012 (SVA) came into force, its purpose being to enable the improvement of the economic, social and environmental wellbeing of the local area. The SVA is applicable to all services over the Official Journal of the European Community (OJEU) threshold, and removes the Local Government Act's exclusions to enable social value criteria to be considered for awarding Service Contracts & Frameworks governed by the Procurement Regulations. Previously the Local Government Act excluded non-commercial considerations when awarding contracts. The SVA states that use of economic, social and environmental criteria must be 'relevant and proportionate'. It also requires public sector bodies, before commencing a procurement, to consider:

   (i) how what is proposed to be procured might improve the economic, social and environmental well-being of the local area, and

   (ii) how, in conducting the process of procurement, the public sector body might act with a view to securing that improvement.

   Consider must also be given as to whether any consultation with relevant stakeholders is required to deal with (a) and (b). Although public sector bodies must consider social value prior to commencing a procurement exercise, they may also decide to consider it at different stages of the procurement exercise.

b) **Early Market Engagement Activities:** Early market engagement activities are used to engage with the supply market pre-procurement to test and stimulate the market and to give the supply base an opportunity to inform requirements. These activities allow Authorities greater flexibility in discussing key areas of forthcoming requirements, as the activities take place outside of a competitive tendering exercise, which is governed by the scope of the OJEU Notice and rules on supplier engagement. Examples of early market engagement activities can include:

   (i) Market Sounding: a process of assessing the reaction of the market to a proposed requirement and procurement approach, and can assist subsequent procurement processes in being more focused and efficient. The activity focuses on suppliers as a whole, rather than individual suppliers. There is no defined process for market sounding, but it is vital to ensure that the process remains open and that the suppliers involved are treated with fairness and equality.

   (ii) Market Creation & Development: where there is a lack of interest in the supply market (due to scale, geographical or organisational scope) , or if you have a novel requirement this may be the most appropriate process. Early engagement with the potential supply market is essential, giving them an opportunity to shape the requirement.

   (iii) Prior Indicative Notice (PIN**):** This is a good method of alerting the market to a forthcoming procurement exercise. Suppliers will have the chance to respond to the PIN by expressing an interest in bidding for the contract, and supplier feedback can be sought to inform the specification.

(iv) Soft Market Testing: this can take the form of a workshop and/or questionnaire which can focus on specific areas and includes a representative selection of key suppliers within a particular market.

(v) Supplier Conferences: this activity is an opportunity to stimulate supplier interest in a requirement and offer possible networking opportunities for SME's, other potential supply chain members, and major suppliers. Attendees should be asked for feedback during the event and/or written feedback after the event. It is important that a Supplier Conference event is a two way process, involving the participating suppliers and not solely an exercise in informing the supplier market of the forthcoming procurement exercise.

c) **Public Procurement Legislation:** Public Procurement Legislation sets out the procedures & practices to which central and local government, as well as other public bodies, must adhere to when carrying out their procurement practices. It is designed to ensure that contracts are awarded fairly, transparently and without discrimination, and that all potential bidders are treated equally. The rules for tendering must be adhered to when the contract in question is not excluded from the rules and the estimated value is above the relevant threshold. Failure to comply with the legislation could expose the public body to unnecessary risk, a potential legal challenge, reputational damage and the failure to deliver services.

d) **Best Value Statutory Guidance:** Under the Duty of Best Value, authorities should consider overall value, including economic, environmental and social value, when reviewing service provision. To achieve the right balance – and before deciding how to fulfil their Best Value Duty – authorities are under a Duty to Consult representatives of a wide range of local persons. Authorities must consult representatives of council tax payers, those who use or are likely to use services provided by the authority, and those appearing to the authority to have an interest in any area within which the authority carries out functions. Authorities should include local voluntary and community organisations and small businesses in such consultation. This should apply at all stages of the commissioning cycle, including when considering the decommissioning of services. Authorities should be responsive to the benefits and needs of voluntary and community sector organisations of all sizes (honouring the commitments set out in Local Compacts) and small businesses.

e) **The Public Sector Equality Duty (PSED):** The Equality Act 2010 replaced the previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with it. It also strengthened the law in important ways, to help tackle discrimination and inequality. The majority of the Act came into force on 1 October 2010. A key measure of the Act is the public sector Equality Duty, which came into force on 5 April 2011. The new Equality Duty supports good decision-making by encouraging public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and

services that are efficient and effective. It also applies to marriage and civil partnership, but only in respect of the requirement to have due regard to the need to eliminate discrimination. The new Equality Duty is designed to reduce bureaucracy while ensuring public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all.

Appendix D: How this strategy relates to the Compact

Compact

The Compacts in Essex represent voluntary agreements which aim to underpin and support joint working between the statutory sector and the VCS in working together fairly and productively to improve the well-being of people living and working in Essex. Compacts set out principles and standards for transparent and fair relationships between agencies and provide a framework for effective working relations.

VCS commissioning strategy

This strategy sets out a joint vision for how the public sector and VCS will collectively move forward towards a new relationship. It is a shared vision to accommodate joint outcomes such as sustainable communities, services shaped around residents and value for money for the public sector.

The strategy has been developed in partnership and through consultation with local stakeholders and has been guided by the principles of the Compacts in Essex. This process is illustrated in the graphic below: