ANNUAL REPORT

OF THE

DIRECTOR OF PUBLIC HEALTH

2014

southend onsea
BOROUGH COUNCIL

Contents

Foreword

I am pleased to present my second Annual Public Health Report for Southend-on-Sea Borough Council. This year my report focuses on the key health issues at either end of the age spectrum – the very start of life and older people.

There is overwhelming evidence that what happens in childhood has a huge impact on health in later life. The foundations for good health, well-being and life chances are laid in early childhood, starting even before birth.

Infancy and childhood is a key period during which the interplay of a child's genetics with their family and community experiences and environmental factors can support or harm their development and life expectations. This in turn determines educational achievement and income, which themselves have a direct impact on health.

In seeking to achieve sustainable improvements in health and well-being, it is essential that we invest time, energy and resources in the early years of life – this will yield returns in the future.

Southend-on-Sea has a higher proportion of people aged 65 years and over compared to the England average, and this is expected to grow sharply in the coming years.

As with the early years of life, the health and well-being of older people is influenced by an interplay of the determinants of health – such as poverty and housing, genetic factors and lifestyle behaviours. This makes it vitally important for agencies to work together to ensure that older people have active, independent and fulfilling lives for as long as possible.

To achieve this we need to have a positive approach to ageing, whilst recognising that at times people will need extra help and support, particularly in their later years. There needs to be a key focus on prevention and helping people to make healthy lifestyle choices throughout the life course and during older age.

In such times of austerity, it is vitally important that we spend our collective resources wisely. Protecting the health of older people through immunisation, the prevention of falls and fractures and managing long term conditions well in the community, will help to achieve better outcomes and individual experience, as well as realising savings.

I hope that you find my report interesting and I would welcome your feedback, comments and suggestions.

Dr Andrea Atherton
Director of Public Health

Executive Summary

The 2014 Director of Public Health Annual Report for Southend-on-Sea focuses on the key health and wellbeing issues at either end of the age spectrum – the very start of life and for those people aged 65 years and over.

The demographic profile of Southend-on-Sea is changing. Currently children and young people under the age of 20 years make up 23.8% of the total population. The 2011 Census found that 8.9% of the local population were from a black, Asian and minority ethnic group (BAME); however, the latest annual pupil census established that 20.5% of school aged children in Southend-on-Sea are from a BAME group. Although this proportion is lower than the England average (26.7%) it may have implications for service planning in the future.

The foundations of good health, well-being and life chances are laid at the very start of life, in pregnancy and in early childhood. There is a complex interplay of genetics, family and community experiences and environmental factors which can either support or harm a child's physical and emotional development. Investing in prevention and early intervention in these early years will have a profound effect on children's lives and bring about significant health improvements.

The number of babies born in an area with a low birth weight, (babies weighing less than 2500g) is a good indicator of the overall health of the population and women of child bearing age in particular. The rates of low birth weight babies and the infant mortality rate in Southend-on-Sea, are similar to the England average and other local authorities with similar population characteristics and levels of disadvantage. However, children growing up in Southend-on-Sea experience greater disadvantage than the England average, with 23.5% of children in Southend-on-Sea living in poverty compared to 20.6% of children in England.

The Council has prioritised action to address the issue of childhood disadvantage and has worked in partnership to develop a long term vision and strategy. Southend-on-Sea and its partners were successful in a submission to the BIG Lottery Fund's Fulfilling Lives: A Better Start. A partnership led by the Pre-school Learning Alliance was awarded £40m to invest over the next ten years to improve outcomes in pregnancy and childhood. The funding is focused on six specific wards but the learning and interventions will benefit all families with young children across the borough.

Giving every child the best start in life is a key priority for reducing health inequalities. This starts pre-conception and during pregnancy. It is important to encourage and support women to make healthier lifestyle choices and maximise their health before and during pregnancy. In Southend-on-Sea, over 90% of women book for antenatal care before the twelfth week of their pregnancy. Early antenatal booking enables women to participate in antenatal screening programmes and have appropriate care plans.

Advice and support on healthy lifestyles during pregnancy is provided by midwives, General practitioners and community pharmacists. Additional arrangements have been made to enable women to access Healthy Start vitamins in a number of the Council's Children's Centres.

Prevention and early intervention public health services are delivered through the evidence based Healthy Child Programme (HCP) which provides screening, immunisation, health and development reviews from early pregnancy, through the early weeks of life and throughout childhood. The HCP is led and coordinated by Health Visitors and Family Nurses for children from birth up to 5 years old and by School Nurses for children aged between 5-19 years old. From October 2015, the Council will become responsible for the commissioning of the 0-5 Healthy Child Programme, including the Family Nurse Partnership which is an intensive preventive home visiting programme for first-time young parents.

There is clear evidence that breast feeding has positive health benefits for the mother and baby in both the short term and long term. Whilst breast feeding initiation in Southend (73%) is similar to the England average (73.9%), breast feeding prevalence at 6-8 weeks (36.7%) is significantly lower than the national average (47.2%). Local initiatives to improve breast feeding include specialist Infant Feeding Advisors in the hospital and community, achievement of UNICEF Baby Friendly joint Hospital and Community Stage 2 award and a specific website with links to national and local support for breast feeding.

Local Children's Centres actively engage with community and hospital health services to support breast feeding mothers. The Council's Early Years Team is working closely with the Public Health Department to achieve UNICEF Baby Friendly accreditation for local Children's Centres.

Sensitive and responsive parenting and good parent-child relationships have a wide range of positive benefits. These include reducing the risk of mental health problems, helping to protect children from adverse effects of stress and poverty and positive impacts on educational achievement, antisocial behaviour and crime.

The Council has a Parenting and Family Support strategy and a strong universal offer for parenting through the Healthy Child Programme and the network of Children's Centre.

The number of older people in Southend-on-Sea is expected to grow sharply in the coming years. The proportion of people aged 65 and over currently living in Southend-on-Sea is higher than the average for England (18.7% compared to 17.3% respectively). There are significant implications for health and social care services, associated with managing issues arising from an increasing ageing population. Southend-on-Sea has the 6th highest level of older people living in poverty in the East of England, and disadvantage in older people is significantly higher than the England average. Life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived.

Addressing the issues impacting on older people is a complex undertaking. A wide range of factors, including quality of housing and fuel poverty can greatly affect the health of older people. Older people living in cold homes are at greater risk from heart disease and stroke and have reduced resistance to respiratory infections and can suffer poor mental health. Locally a number of initiatives are in place to address these issues. In addition to national Government grant schemes for heating systems and boilers, improvements in home insulation for vulnerable households and winter fuel payments, the Council also provides assistance to tackle fuel poverty in the form

of Council Tax benefits and funding to install energy condensing boilers and loft insulation in properties occupied by vulnerable tenants or homeowners. The Council has been working with the voluntary sector and local housing charities to implement a 'Warm and Well' project. This aims to reduce the impact of cold weather on the health and wellbeing of local people and particularly older people and other vulnerable groups.

Local action on fuel poverty is believed to have contributed to the downward trend and reduction in excess winter deaths that has been evidenced in Southend-on-Sea from 2007 to 2013.

Healthy lifestyle choices during the ages of 40-60 years can have a marked impact on health in later years. It is never too late to make lifestyle changes and older people, particularly those with long term chronic health conditions, need to be supported to address negative lifestyle behaviours. For example, helping people to stop smoking is a public health priority. Stopping smoking results in health benefits for the individual at any age.

There are well evidenced benefits associated with being physically active, however, fewer than 20% of men and women aged 65-74 achieve the recommended levels of 30 minutes of physical activity five times per week. Diet also affects key aspects of health in old age. The proportion of people who are overweight or obese tends to increase with age. Being obese is not the only issue for older people. Research suggests 1 in 10 of people aged over 65 are malnourished or at risk of malnutrition.

Older people often consume alcohol above recommended levels. Excessive alcohol consumption can have a significant impact on the physical and mental health of older people, increasing risks related to injurious falls and also clinical conditions including vascular dementia. The NHS Health Check programme for people aged 40-74 now incorporates questions on alcohol intake.

Dementia is one of the major health and social care issues of our time. Currently around 815,827 people in the UK have dementia and this number is set to increase by 40% in the next 12 years. It is more common in people aged over 65 and prevalence roughly doubles from this age onwards. In Southend currently less than half (40.78%) of the estimated number of people with dementia have received a formal diagnosis. Early detection allows for more effective planning of treatment and appropriate support for the person and their family.

Southend-on-Sea Borough Council has developed a comprehensive Southend specific dementia implementation plan linked to the Southend, Essex and Thurrock Dementia Strategy. In addition, the roll out of the dementia friends initiative and a Southend Dementia Action Alliance will help to facilitate earlier diagnosis and support from local services.

The prioritisation of the management of long term conditions, such as coronary heart disease, chronic obstructive pulmonary disease and diabetes is a major issue for Southend-on-Sea. Long term conditions are more prevalent in older people. Most long term conditions are multifactorial, however, there is a strong link between unhealthy lifestyle behaviours and some of the most prevalent and disabling long term conditions. Care planning is a key feature of national and local policy for people

with long term conditions. A named health professional works collaboratively with the person and agrees a personalised package of care for their condition(s).

Southend-on-Sea is a Year of Care early implementer and an Integrated Health and Social Care Pioneer site. This means the Council and its partners can explore ambitious and innovative approaches to deliver person centred, coordinated care and support.

A key approach to encouraging and helping people adopt healthier lifestyles is through 'Making Every Contact Count' (MECC). This is a project that uses the everyday contact people have with frontline staff, to deliver brief lifestyle interventions and signpost them to services that can help them modify their behaviour and manage any existing long term condition better. Southend Adult Community College has been commissioned to provide training on MECC, to frontline staff across public, private and third sector organisations.

Falls and fall-related injuries are a common and serious problem for older people. It is estimated that 9,185 local people aged 65 years and over will have experienced a fall in the last 12 months. Of these falls, 2.8% will have been an injurious fall resulting in a fracture or soft tissue damage that requires treatment. There were 224 hip fractures in people aged 65 and over in Southend-on-Sea during 2012/13. The local falls prevention programme includes a Community Falls Service, a Postural Stability Instructor Programme, re-ablement services and a Fracture Liaison Service.

In the 2011 Census, 6.5 million people in the UK identified themselves as carers, compared with 5.8 million people in 2001. Carers are vital to the wellbeing and independence of thousands of people, with many carers providing more than 50 hours of unpaid support per week. The demands of being a carer can have a negative impact on their quality of life, including their ability to work, their finances and their physical and mental health. The Council and local voluntary sector provide a range of services to support carers with their caring responsibilities.

Flu vaccination is a safe and effective way to protect older people and reduce avoidable illness, hospitalisation and excess seasonal deaths. Only 66% of people aged 65 and over living in Southend-on-Sea received flu vaccine in 2013, which is below the England average (73.2%) and below the World Health Organisation target of 75%.

Summary of Recommendations

- Commissioners to prioritise training for healthcare professionals to continue to offer pre-conceptual advice and promote early antenatal booking
- Frontline staff working with women of child bearing age to continue to promote the importance of healthy lifestyles during pregnancy
- Undertake an audit of uptake of Healthy Start to inform the decision on where further distribution centres should be located within Southend-on-Sea
- Commission a specialised weight management service for maternal obesity
- Offer training to support staff in the early identification of perinatal mental health issues
- Undertake a review of how services promote and support breastfeeding
- Refresh and strengthen the Southend-on-Sea Child Poverty Strategy in line with the new Government Strategy
- Expand early education and learning programmes for vulnerable and disadvantaged two year olds
- Raise awareness of frontline health and social care staff of the importance of wider determinants on the health of older people, to facilitate early intervention and referral to appropriate services for help and support in claiming welfare and housing benefits
- Raise awareness of the link between poor housing and poor health so that older people are referred to appropriate housing services in Southend-on-Sea
- Promote partnership working on the identification of hazards within the homes of older people
- Undertake an annual 'Keep Warm Keep Well' social marketing campaign to inform individuals, families and carers on how to protect themselves from the cold
- Build the capacity and capability of staff in the NHS and partner agencies to provide brief interventions to tackle smoking and alcohol misuse as well as to promote healthy eating and physical activity
- Promote lifestyle intervention and risk reduction for adults aged 40-64 years to reduce long term conditions and dementia
- There should be a review of the future plans for older people's housing needs in Southend-on-Sea to identify alternatives to residential accommodation particularly for older people with a mild to moderate dementia diagnosis
- An overarching falls prevention strategy should be developed that

includes factors related to wider determinants such as housing, environmental hazards as well as other local strategies that impact on older adults

- All front-line staff who are routinely in contact with older people (such as sheltered housing and care home staff, GP practice staff, fire service, community transport, library staff and pharmacists) should receive update training on falls risk assessment and referral pathways to local services

- Southend-on-Sea Borough Council should work closely with NHS England Essex Local Area Team, Public Health England, GPs, community pharmacists and Southend Clinical Commissioning Group to promote flu vaccination to at risk groups, targeting those areas that have lower uptake rates

- The Southend Health and Well-being Board should receive an Annual Report from the Essex Local Health Resilience Partnership to provide assurance to the Council on local health sector emergency preparedness

- NHS England needs to provide comprehensive and timely information on the uptake of screening and immunisation programmes to the Council to enable more effective monitoring of this aspect of health protection

- To continue to support carers to access the services offered by statutory and voluntary organisations

- To look into support required by carers from Black, Asian and Minority Ethnic Groups and Lesbian, Gay, Bisexual and Transgender communities

- Work with Southend Clinical Commissioning Group, third sector organisations and carers to create an integrated carers pathway

- Work should be undertaken with Southend Clinical Commissioning Group to look at carer support within GP practices

- Work should be undertaken with Southend Clinical Commissioning Group to jointly re-commission carer support services

Chapter 1 Profile of Children and Young People in Southend-on-Sea

1.0 Introduction

This chapter focuses on the demography and health status of children and young people in Southend-on-Sea, chapters 2-4 provide information on the national and local initiatives to improve their health.

The public health white paper 'Healthy Lives, Healthy People' (2010) emphasised the importance of giving all children the best possible start to life and clearly outlined that disadvantage before birth and during children's earliest years can have life-long, negative effects on health.

The early years (0-5 years) are where high-quality public services and programmes can have the greatest impact on the future health and well-being of children.

2.0 Current Population

Children and young people under the age of 20 years make up 23.8% of the population of Southend-on-Sea, which is similar to that for the East of England and England as a whole.

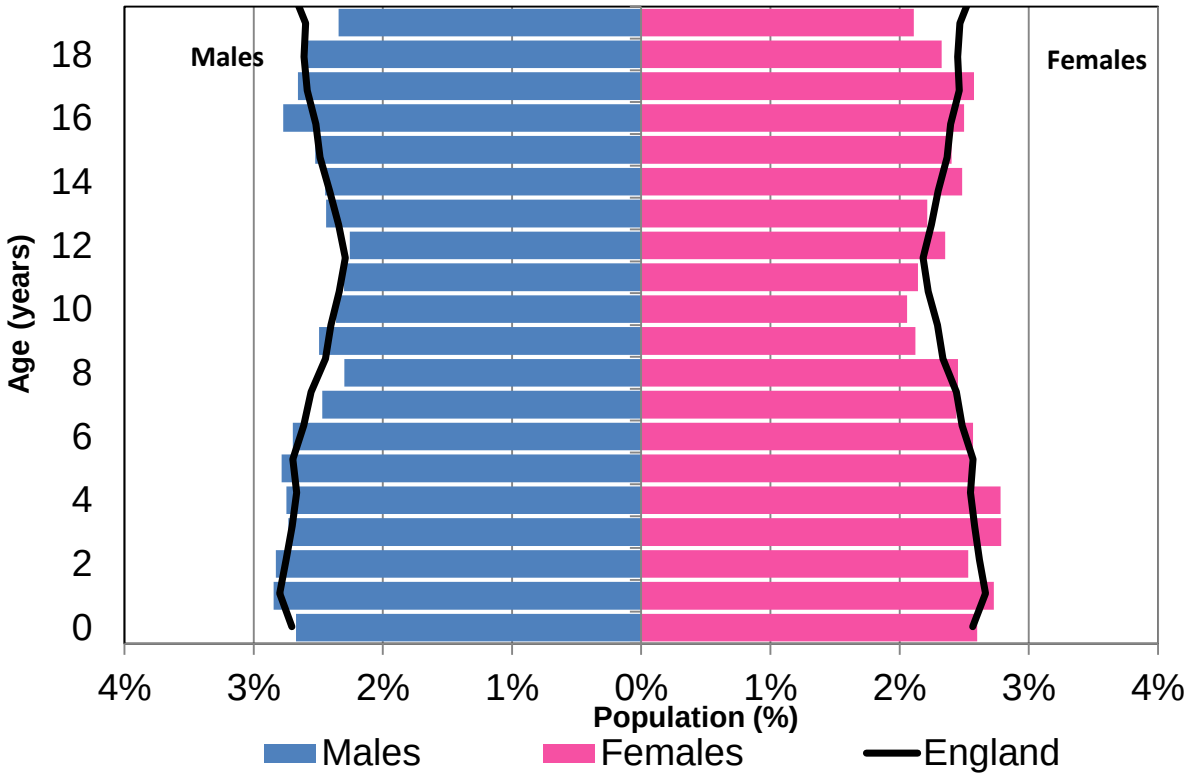
Since 2009, Southend-on-Sea has seen a gradual increase in the numbers of children and young people within its population (Table 1). Figure 1 shows the distribution of the population of 0-19 year olds (as a proportion of the total population) in Southend-on-Sea compared to England.

Table 1. Children Aged 0-19 by Ward in Southend-on-Sea, 2009-2013

	0-19 Years Old				
Ward Name	**2009**	**2010**	**2011**	**2012**	**2013**
Belfairs	1,810	1,767	1,814	1,849	1,877
Blenheim Park	2,538	2,484	2,608	2,567	2,614
Chalkwell	1,794	1,821	1,894	1,870	1,962
Eastwood Park	1,959	1,945	1,939	1,903	1,910
Kursaal	2,479	2,526	2,866	2,946	2,974
Leigh	2,074	2,126	2,326	2,368	2,401
Milton	1,690	1,724	2,070	2,102	2,112
Prittlewell	2,196	2,203	2,352	2,402	2,431
Shoeburyness	2,814	2,745	2,921	2,925	2,958
Southchurch	2,479	2,483	2,427	2,456	2,481
St Laurence	2,209	2,225	2,189	2,159	2,162
St. Luke's	2,871	2,901	3,019	3,073	3,042
Thorpe	1,774	1,765	1,945	1,883	1,797
Victoria	2,493	2,612	2,897	2,988	3,059
West Leigh	2,132	2,125	2,169	2,177	2,172
West Shoebury	2,706	2,660	2,858	2,823	2,840
Westborough	3,165	3,105	3,056	3,078	2,996
Total	**38,974**	**39,183**	**39,217**	**41,350**	**41,788**

Source: ONS

Figure 1: Population of Southend-on-Sea, Ages 0-19 years (2013)



Data Source: ONS 2011 Census: mid-year estimates for 2013

3.0 Ethnicity

Evidence suggests that individuals from black, Asian and minority ethnic (BAME) groups are disproportionately affected by health problems. The latest Census has identified that the population of Southend-on-Sea is becoming more diverse, with 8.9% from a BAME group in 2011 (Table 2) compared to 4.2% in 2001. The pupil annual census for 2013 highlights that there is even greater diversity in school aged children, with 20.5% from a BAME group. This is slightly higher than East of England (19.7%), but significantly lower than the England average (26.7%) Table 3 shows the number of children with English as an additional language by ward in Southend-on-Sea.

Table 2. Ethnicity Profile of Southend-on-Sea, Population by Ward (2011)

Ward	White	Mixed	Asian/ Asian British	Black / Black British	Other ethnicity
Belfairs	93.8%	0.8%	2.6%	2.2%	0.6%
Blenheim Park	92.5%	1.4%	4.1%	1.6%	0.4%
Chalkwell	86.7%	2.0%	5.0%	5.9%	0.4%
Eastwood Park	94.6%	0.4%	2.4%	1.6%	0.9%
Kursaal	87.0%	2.4%	4.4%	5.4%	0.9%
Leigh	95.3%	1.1%	2.5%	0.5%	0.6%
Milton	80.1%	3.1%	8.4%	6.6%	1.8%
Prittlewell	83.8%	1.1%	10.3%	3.7%	1.1%
Shoeburyness	93.6%	1.1%	1.9%	2.6%	0.8%
Southchurch	88.5%	1.3%	6.2%	3.3%	0.6%
St Laurence	90.3%	0.9%	4.9%	3.4%	0.4%
St Luke's	89.7%	1.6%	3.1%	4.3%	1.3%
Thorpe	92.7%	1.1%	3.7%	1.9%	0.7%
Victoria	80.1%	1.8%	10.7%	6.7%	0.7%
West Leigh	97.2%	0.7%	1.6%	0.4%	0.0%
West Shoebury	90.8%	1.5%	3.5%	3.4%	0.8%
Westborough	80.9%	1.7%	11.3%	4.8%	1.2%
Southend	89.1%	1.4%	5.2%	3.5%	0.8%
National	**80.6%**	**1.7%**	**10.7%**	**5.5%**	**1.5%**

Data Source: ONS

Table 3. Children with English as an Additional Language (EAL)

Ward	% EAL Children in Ward 2013
Belfairs	4.1%
Blenheim Park	7.0%
Chalkwell	11.2%
Eastwood Park	2.7%
Kursaal	18.1%
Leigh	3.7%
Milton	31.1%
Prittlewell	17.1%
Shoeburyness	4.9%
Southchurch	11.7%
St Laurence	10.7%
St Luke’s	10.6%
Thorpe	4.7%
Victoria	28.7%
West Leigh	2.4%
West Shoebury	6.7%
Westborough	22.1%
Southend	**11.9%**

Data Source: Southend-on-Sea Borough Council

4.0 Poverty

Poverty in childhood has profound effects on the health of children, and the impact on their health continues throughout their life. There are a number of definitions of child poverty but a common definition is:

"A child in poverty lives in a family with resources that are far lower than the average, with the result that that they don't fully participate in society."

DWP Child Poverty Strategy 2007

There are also a number of different indicators of poverty. The primary measure used is provided by HM Revenue and Customs. This indicator is "the proportion of children aged less than 16 years living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of median income" (1).

The calculations are made before housing costs and do not take account of the impact of higher local housing costs.

The level of child poverty in Southend-on-Sea (23.5%) is worse than the England average (20.6%) and the regional average (16.7%) (2).

Table 4 provides estimated child poverty levels in 2012 by ward. There is considerable variation across the borough, with 7% in West Leigh contrasting with 39% in Kursaal Ward. It is important to consider that as this data is based on numbers receiving benefits/credits it may not present the complete picture, as not everyone entitled will actually have made a claim.

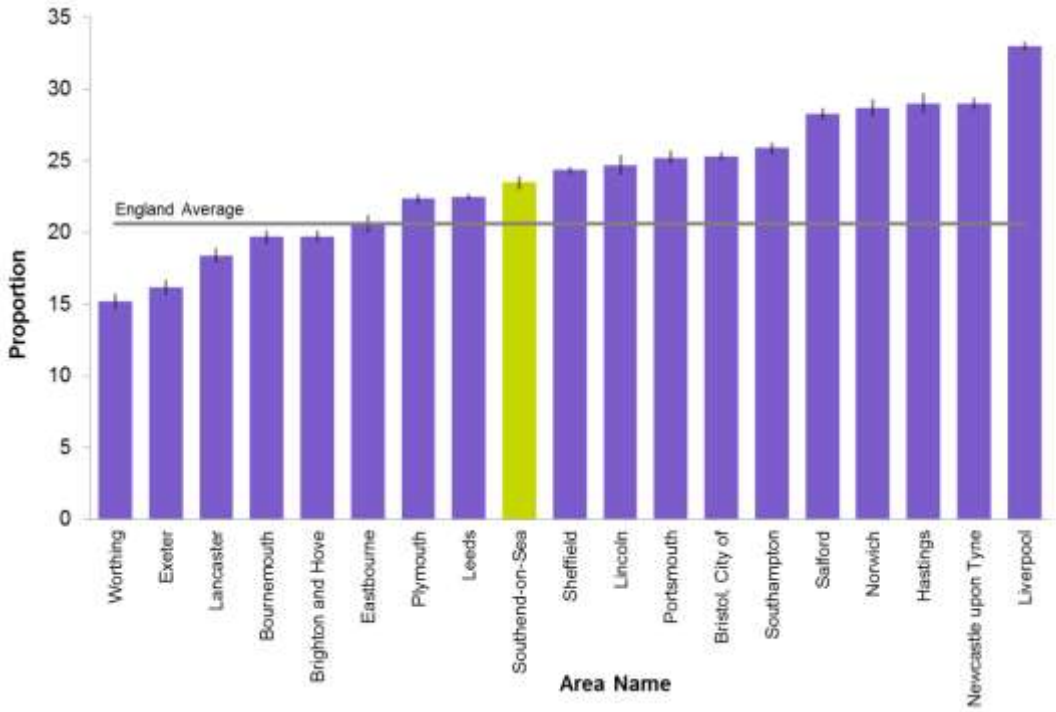
Table 4. Children Living in Poverty by Ward (Estimates - 2012)

Ward name	Estimate of Children in Poverty 2012	
	Number	Percentage
Belfairs	280	17%
Blenheim Park	569	24%
Chalkwell	230	13%
Eastwood Park	226	12%
Kursaal	1026	39%
Leigh	222	11%
Milton	546	30%
Prittlewell	348	16%
Shoeburyness	766	29%
Southchurch	699	30%
St Laurence	467	23%
St. Luke's	747	26%
Thorpe	206	11%
Victoria	941	36%
West Leigh	132	7%
West Shoebury	701	26%
Westborough	732	26%

Data Source: END Child Poverty action group

Figure 2 shows the percentage of children living in poverty in Southend-on-Sea compared to its ONS comparator group and national average in 2011.
The impact of this is explored further in chapter 4.

Figure 2: Children Living in Poverty in Southend-on-Sea, Compared with ONS Comparator Group, 2011



Data Source: PHE Fingertips

5.0 Births

In 2012, there were 2,345 live births registered to mothers resident in Southend-on-Sea. Four hundred and twenty seven (20.2%) babies were born to mothers aged 35 years and over, with 29 (1.4%) babies born to mothers under the age of 19 years.

5.1 Fertility Rate

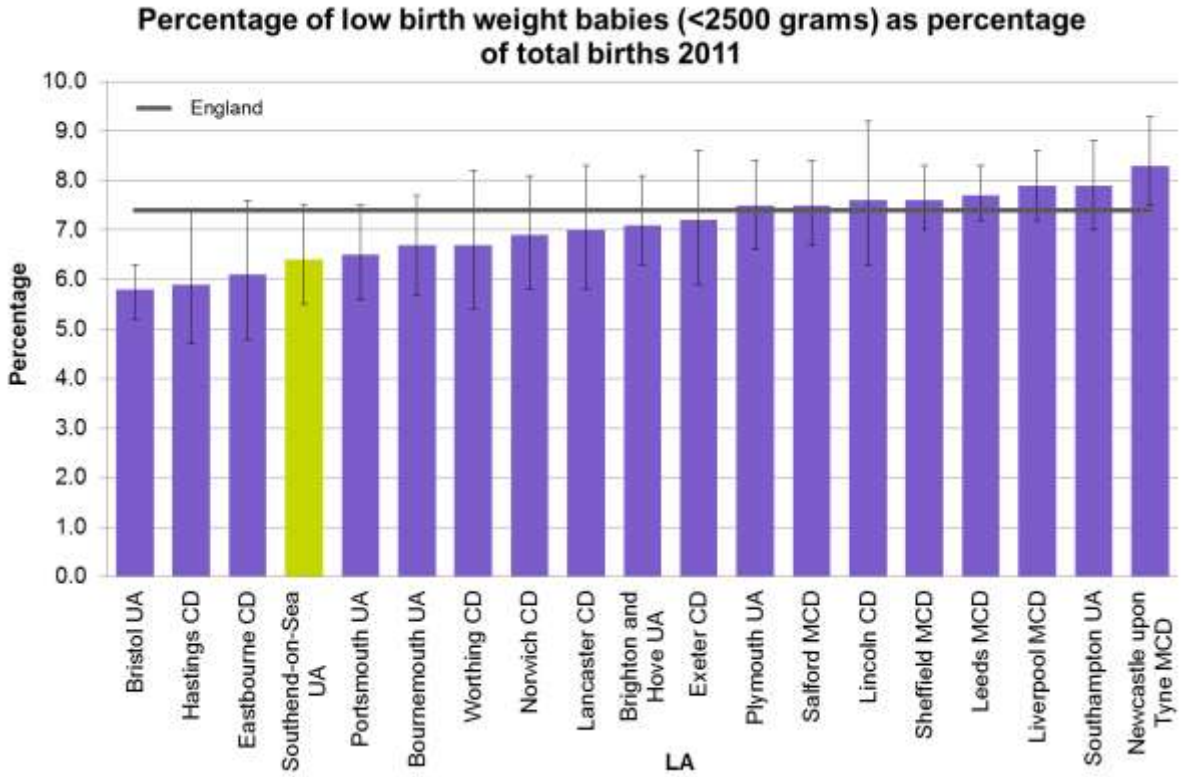
The general fertility rate expresses the number of births per 1,000 women in the population of childbearing age (by convention taken as those aged 15-44 years). A number of factors influence fertility including contraceptive availability, level of affluence and the fact that more women are working. In 2013, the general fertility rate in Southend-on-Sea was 66.3 per 1,000 women aged 15-44 years.

5.2 Low Birth Weight

Low birth weight babies are defined as those babies born weighing less than 2,500 grams. They have a higher risk of infant mortality and have poorer health outcomes. Factors associated with low birth weight include:- multiple pregnancy, maternal country of birth, poor maternal health and nutrition, deprivation/poverty and mother smoking and/or drinking alcohol during pregnancy. Teenage mothers are at greater risk of having a low birth weight baby.

In 2011, 146 babies with a low birth weight were born in Southend-on-Sea, 6.4% of all births (live and stillbirths). The rates of low birth weight in the Southend-on-Sea area are similar to those in our ONS comparator group and England (Figure 3).

Figure 3: Percentage of Low Birth Weight Babies, in Southend-on-Sea, Compared with ONS Comparator Group, 2011

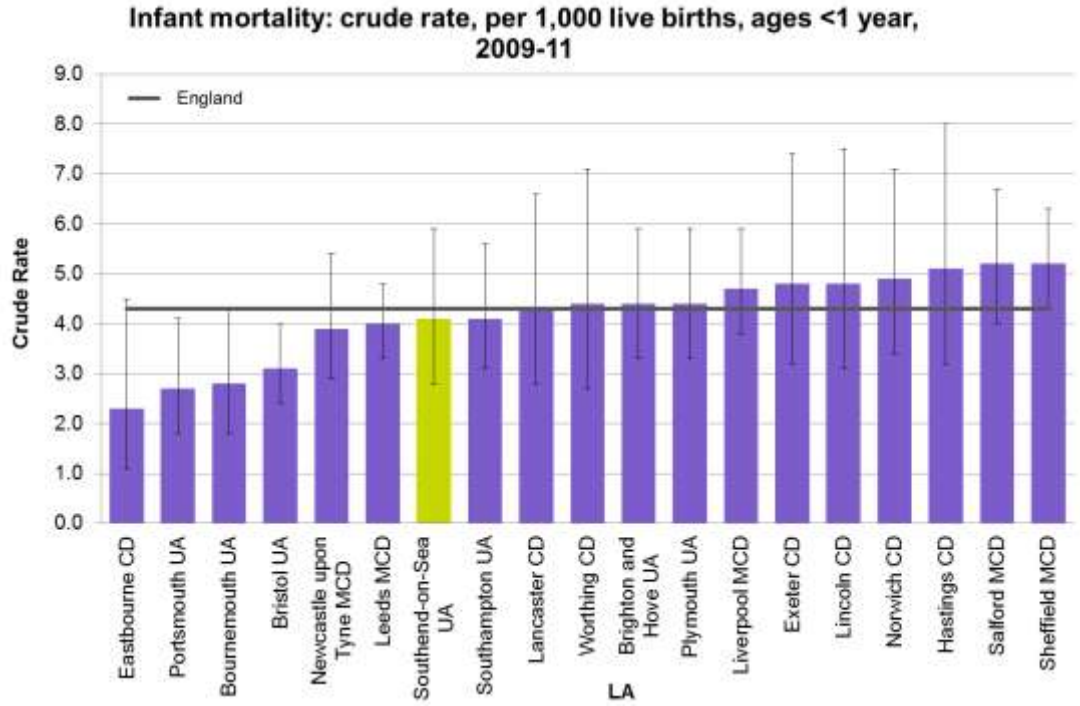


Data Source: NCHOD

5.3 Infant Mortality Rate

Infant mortality is the term used to describe a death between birth and exactly one year of age. A lower infant mortality rate (the number of deaths between birth and one year old per 1,000 live births) is a good indicator of the health of the population and, in particular, maternal health. It is also considered an indicator of progress towards addressing inequalities. Figure 4 compares the infant mortality rate in Southend-on-Sea from 2009-11 with its ONS comparator group.

Figure 4: Infant Mortality Rate in Southend-on-Sea compared with ONS Comparator Group, 2009-2011



Data Source: NCHOD

5.4 Perinatal Mortality

Perinatal mortality relates to stillbirths and deaths in babies less than 7 days old. The perinatal mortality rates tend to be higher than infant mortality rates because many babies born with very serious health problems may be born alive but unable to survive beyond a few days. Table 5 shows that the perinatal mortality rate in Southend-on-Sea is the lowest rate of its comparator group, but it is not significantly different to the national rate.

Table 5. Perinatal mortality rate in Southend-on-Sea compared with Children & Young People Comparator Groups 2009-11

	Denominator Number of total births	Numerator Number of perinatal deaths	Rate per 1,000 total births	95% CI	
				RateLL	RateUL
ENGLAND	2056797	15439	7.5	7.4	7.6
Bournemouth UA	6816	40	5.9	4.3	8.0
East Sussex CC	16026	99	6.2	5.1	7.5
Isle of Wight UA	3874	24	6.2	4.2	9.2
Kent CC	52600	363	6.9	6.2	7.6
Medway Towns UA	10666	66	6.2	4.9	7.9
Portsmouth UA	8113	48	5.9	4.5	7.8
Sefton MCD	8545	51	6.0	4.5	7.8
Southend-on-Sea UA	6820	39	5.7	4.2	7.8
Swindon UA	8796	56	6.4	4.9	8.3
Telford and Wrekin UA	6770	44	6.5	4.8	8.7
Torbay UA	4346	39	9.0	6.6	12.3

Data Source: NCHOD

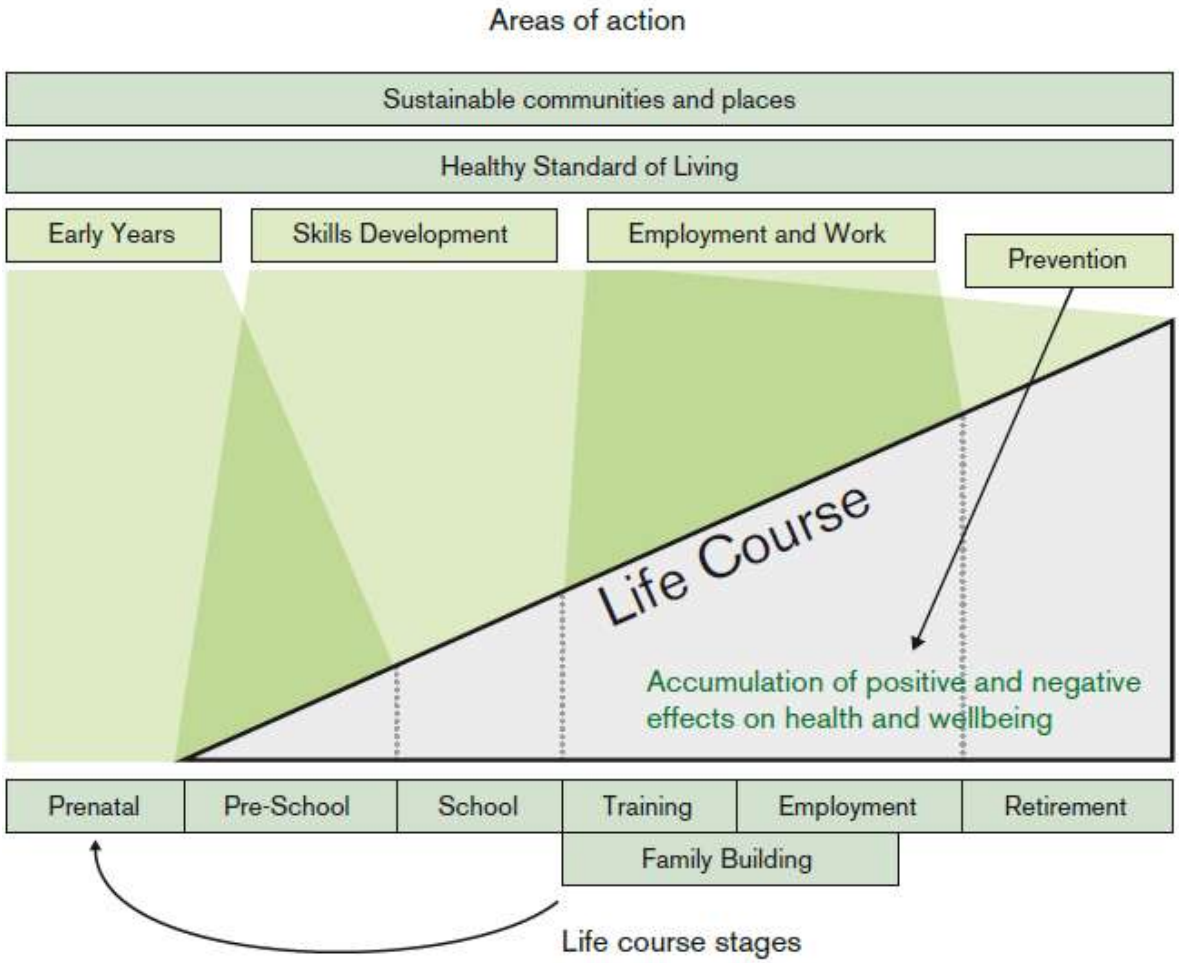
Chapter 2 Starting Well – An Introduction

1.0 Background

The transfer of public health to local authorities has provided a greater opportunity to work with different Council departments and to begin to influence the many factors, known as wider determinants, that impact on health such as education, transport, housing, leisure and employment. In Southend-on-Sea for the 0-4 years age group in particular, there has been close partnership working with the Early Years Team and with staff and parents in local Children's Centres and Nurseries.

There is a strong and compelling evidence base for the 'life course approach', a developmental health model which clearly shows that a person's future life outcomes are dependent on the accumulation of positive and negative experiences from conception to old age (Figure 1). A person's life course trajectory can be improved by identifying risk and protective factors at different stages and taking action to reduce risk and promote health and wellbeing. There is increasing evidence that the early part of the life course appears to be the most crucial and that the foundations of good health, well-being and life chances are laid at the start of life, in pregnancy and early childhood (0-4 years).

Figure 1: Action across the Life Course



Source: 'Fair Society, Healthy Lives' Marmot Review 2010

> ***"What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status."***
>
> 'Fair Society, Healthy Lives' Marmot Review 2010 (1)

As the understanding of fetal and child development, neuroscience, genetics and health and disease has improved, the critical importance of the experiences and learning in early life has become clearer. This is supported by a strong evidence base of 'what works' for prevention and early intervention to support health, growth and development and so improve public health outcomes in the population.

There is a much greater understanding of the factors which increase vulnerability and those which increase resilience in very young children and their families, and recognition of how environment interacts with genetics. Children may be genetically predisposed to resilience or to vulnerability, but the impact depends on a complex interplay of family and community experiences and environmental factors, which can support or harm their development.

Risk factors in pregnancy and early childhood include: maternal smoking, maternal alcohol or substance misuse, poor diet, maternal age, maternal obesity, poverty, maternal stress, domestic abuse.

Protective factors in pregnancy and early childhood include: good maternal diet with appropriate supplements i.e. folic acid and vitamin D, early booking and good antenatal care, smoke free environment, strong attachment, attuned and responsive parenting.

2.0 Investing in Early Years

The financial climate, the decrease in public sector funding and the requirement to 'do more with less' requires the Council and its partners to give careful consideration to the programmes and services they invest in.

From health, education and economics there are a number of key national reports emphasising the need for much greater support for young children and their families through the most important part of their development, namely, during the period of pregnancy to five years old. These reports also stress the importance of rebalancing resource allocation to invest in prevention and early intervention to improve health and education outcomes and to reduce inequalities.

They propose greater investment early in the life course, recognising:

- it is more difficult to intervene at a later stage of the life course
- the monetary costs associated with remedial action or treatment for those with poor health and/or low attainment, are high and will continue to increase.

There is also an emphasis on funding programmes that have been proven to be effective, are well-designed and are delivered with fidelity and to scale.

This 'better start' approach is detailed in:

- the Marmot Review into health inequalities [1]
- the two Graham Allen independent reports into early intervention[2][3]
- the Frank Field Independent Review on Poverty and Life Chances [4]
- the WAVE Trust Report *Conception to 2 years: The Age of Opportunity* [5]
- the Kennedy Review [6]
- the recent Chief Medical Officer (CMO) Annual Report [7] and
- the work of economist James Heckman on early years and return on investment [8]

The CMO's recent Annual Report, "*Our Children Deserve Better: Prevention Pays"*, set out the human and economic case for prevention, and stressed that spending on the early years of life should be seen as an investment which will yield returns in future. The report noted that:

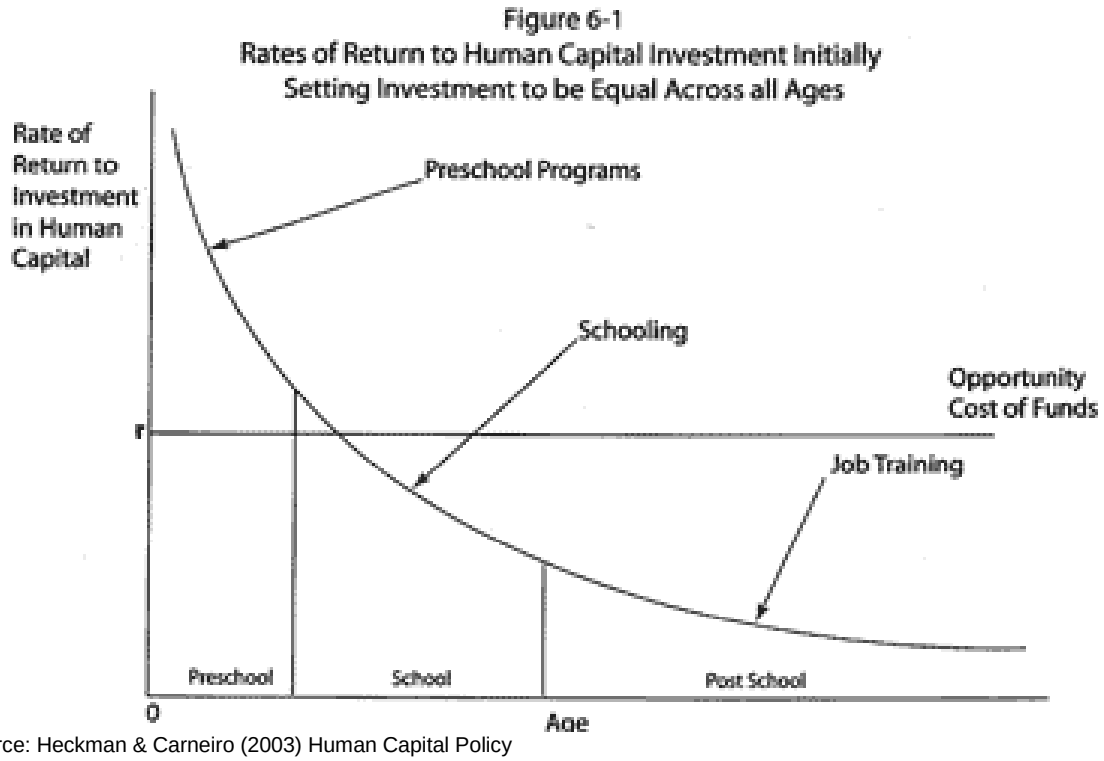
> ***"In many areas of child health, small shifts in focus towards prevention would have a profound impact on children's lives while also saving money. These financial gains are major in the long term, but even in the short term they represent significant health improvements and cashable savings."***

The report advised that there is a wide range of evidence-based practice already available which, if properly implemented, would make a real difference to children's lives and children's futures, and cited 5 key areas where there was expert guidance from NICE:

- Support for breastfeeding (PH11 Maternal and child nutrition)
- Promoting smoking cessation for pregnant women and pre-conception (PH26 quitting smoking in pregnancy and following childbirth)
- Developing and implementing accident prevention strategies targeting home safety and road traffic injuries (PH29, 30, 31 on prevention of unintentional injuries in under-15s)
- Taking steps to tackle the obesogenic environments faced by many children and young people, and in particular using schools as a central place to promote healthy living (e.g. PH8 Physical activity and the environment)
- Providing proportionate universal parenting support that ensures adequate evidence based provision which does not stigmatise, and school based approaches to well-being (e.g. CG158 Antisocial behaviour and conduct disorders in children and young people and NICE briefing on social and emotional well-being)

There is also evidence that investment in early years brings a higher rate of return than in older children and adults [8]. This is set out in Figure 2.

Figure 2: Rates of Return to Human Capital Investment



Source: Heckman & Carneiro (2003) Human Capital Policy

3.0 Fulfilling Lives: A Better Start

The approach and focus on prevention and early intervention in pregnancy and early years was developed in detail for Southend-on-Sea in a successful submission to the BIG Lottery Fund's Fulfilling Lives: A Better Start. This partnership, led by Pre-school Learning Alliance, was awarded £40m to invest over the next ten years to improve outcomes in pregnancy and early childhood, with the overall aim being to improve communication and language, social and emotional development, and diet and nutrition. The funding will be focused on six target wards: Kursaal, Victoria, Westborough, Milton, Shoeburyness and West Shoebury – but the learning and interventions will benefit all families with young children across the borough.

Chapter 3 Starting Well: Pre-conception and Pregnancy

1.0 Introduction

The Marmot Review set out the priorities for reducing inequalities in health across England. The report highlighted the importance of 'giving every child the best start in life' and the effect that this has on the health of the population [(1)].

During pregnancy and infancy the developing baby is vulnerable because of the rapid growth taking place. Healthy mothers tend to have healthy babies, so high quality care, support and health promotion during pregnancy make crucially important contributions to the health of the mother. Giving the child "the best possible start" before birth will improve their health and life chances across the whole life course.

Pre-conception and during pregnancy are important times when women have increased contact with services and there is potential to intervene and help them make healthy choices. The promotion of healthy lifestyle behaviours to women of child bearing age and pregnant women is therefore particularly important.

Adverse influences in pregnancy and in the first years of life can affect the developing fetus. This can increase vulnerability to mental and physical health problems, both in childhood and into adulthood [(2)]. For example, evidence suggests that low birth weight increases the risk of coronary heart disease and the related disorders of stroke, diabetes and hypertension in later life [(3)(4)].

Exposure to exceptionally stressful experiences (referred to as 'toxic stress') in the fetus or child leads to changes in areas of the brain that are essential for learning and memory, and alters the child's long term stress response. [(5)] This can have direct and lasting impact on a child's development and their future physical and mental health [(1)].

Children who are exposed to toxic stress have heightened stress response systems that are easily triggered by low level stress in later childhood and have difficulty in 'dampening down' their stress response. These children are more likely to experience emotional and behavioural difficulties and do less well at school [(6)].

The most common risk factors for toxic stress in the fetal period and early childhood are adverse events such as neglect, abuse, parental substance abuse, maternal depression, exposure to violence and growing up in poverty [(7)]. The main protective factor is a consistent, positive and loving relationship with a parent or caregiver, as the baby's brain develops in response to early relationships and experiences.

2.0 Maternity Services

2.1 The National Picture

The number of births in England has increased by almost a quarter over the last ten years. The rate of increase is now slowing, but it still continues to rise.

The proportion of high risk and complex pregnancies is growing due to the increase in risk factors such as maternal obesity, higher maternal age, and increased multiple

births. There is also an increase in the number of women with pre-existing medical conditions that impact on pregnancy e.g. diabetes. There are more assisted deliveries with almost one in 4 women delivering by caesarean section and a further one in 10 with forceps or ventouse deliveries.

The national policy context on improving and developing maternity services is detailed in a number of key documents:

- Pregnancy , Birth and Beyond (DH 2011)
- Midwifery 2020, Delivering Expectations (DH 2010)
- Towards Better Births (2008)
- Standards for Maternity Care (RCOG 2008)
- Safe Births: Everybody's Business (Kings Fund 2008)

The key themes from these documents focus on:

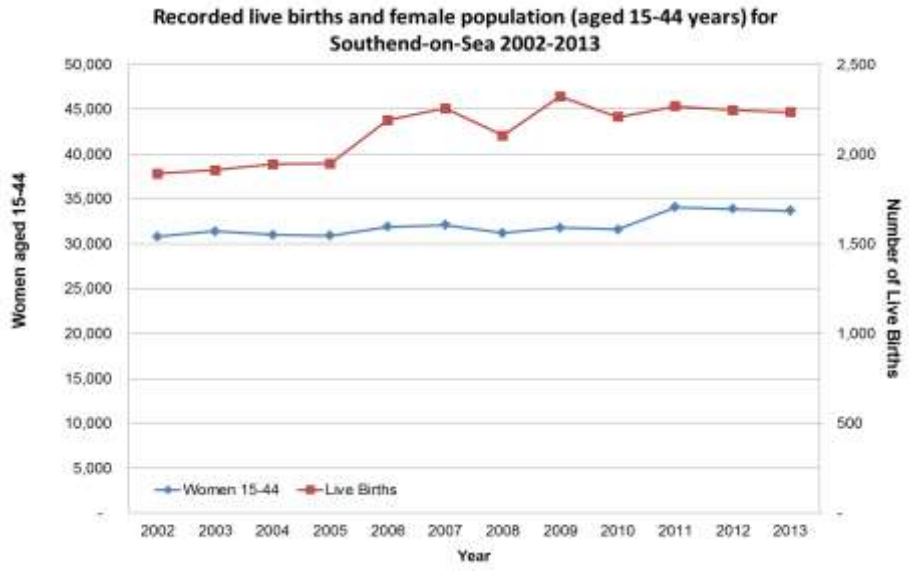
- **CHOICE** in how to access antenatal and maternity care and in place of birth (where practical and safe)
- **CONTINUITY** of care so women know and trust their midwives
- **SAFETY** and well-being of the pregnant woman and her baby

2.2 The Local Picture

Maternity services care for women once they become pregnant until transfer to the Health Visiting Services (usually 10-14 days after birth). Maternity Services in Southend-on-Sea are provided by Southend University Hospital NHS Foundation Trust. The services work in partnership with primary care, community and voluntary services and Children's Centres to achieve the best outcomes for babies and their families.

In Southend-on-Sea the numbers of births are remaining fairly static (Figure 1). In 2012, there were 2345 live births.

Figure 1: Number of Live Births and Female Population (15-44yrs) for Southend-on-Sea 2002-2013



Source: ONS

2.3 Pre-conception and Antenatal Period

2.3.1 Preparing for pregnancy

Maternal health and health behaviours such as alcohol use, diet, physical activity, drug use and in particular smoking, have a significant influence on fetal development. Maternal obesity carries risk for both the fetus and the mother herself [8], as does maternal depression and some other mental illnesses [9].

To improve child health, prevention needs to start early in pregnancy, or if possible before conception. It is important to encourage and support women to make healthier lifestyle choices and maximise their health before and during pregnancy. For example dietary supplementation of folic acid is recommended before conception and up to 12 weeks of pregnancy to reduce the risk of having a baby with neural tube defects such as spina bifida.

Locally pre-conception advice and checks are delivered by GPs, midwives and the specialist contraceptive and sexual health services (CASH).

2.3.2 Antenatal Booking

NICE guidance on antenatal care recommends that women should have access to maternity services for a full health and social care assessment of needs, risks and choices. This should be as early as possible in the pregnancy to ensure that women are able to participate in antenatal screening programmes and have appropriate care plans [10].

Late booking and poor attendance for antenatal care are associated with poorer outcomes for both mother and baby. There is evidence that those women at highest risk of poor pregnancy outcomes (e.g. women under 20, victims of domestic abuse, women with mental illness) are less likely to 'book' and attend for care [8].

The Healthy Child Programme [11] was developed to set out a universal preventive service to support a healthy pregnancy. The booking assessment in early pregnancy is the starting point for the Healthy Child Programme.

There is a national target of 90% of eligible women to book by 12 weeks 6 days. In Southend-on-Sea, maternity services have introduced an electronic Pregnancy Booking Line which can be accessed by women directly by telephone or e-mail. This has markedly improved early antenatal booking and currently over 90% of women book before the twelfth week of pregnancy.

2.3.3 Specialist Midwives

Good work has been done in Southend-on-Sea to improve access to services and to provide support for women who have risk factors, such as those who are socially vulnerable or who have medical conditions e.g. diabetes.

Southend University Hospital NHS Foundation Trust has appointed specialist midwives to give targeted support for the most vulnerable women. There is also a named safeguarding midwife and a clear pathway linking midwifery to local safeguarding arrangements.

2.3.4 Antenatal Education

Antenatal education provides important information for pregnant women and their partners [12]. A recent review of parents' experiences of antenatal education noted considerable variation in the type and content [13]. A local study supported by Warwick University echoed this finding [14]. The NHS has recently produced a resource pack 'Preparation for Birth and Beyond' which supports the community delivery of high quality antenatal education.

Antenatal education has been highlighted as one of the key work streams for Southend: A Better Start and local parents have identified the need for the inclusion of fathers in these sessions.

2.3.5 Antenatal Screening

Screening is a process of using tests to identify apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk of any complications arising from the disease or condition.

Population screening programmes start in pregnancy to detect infections, inherited conditions and physical problems which may affect the health of the mother and child if not identified early in the antenatal or neonatal period.

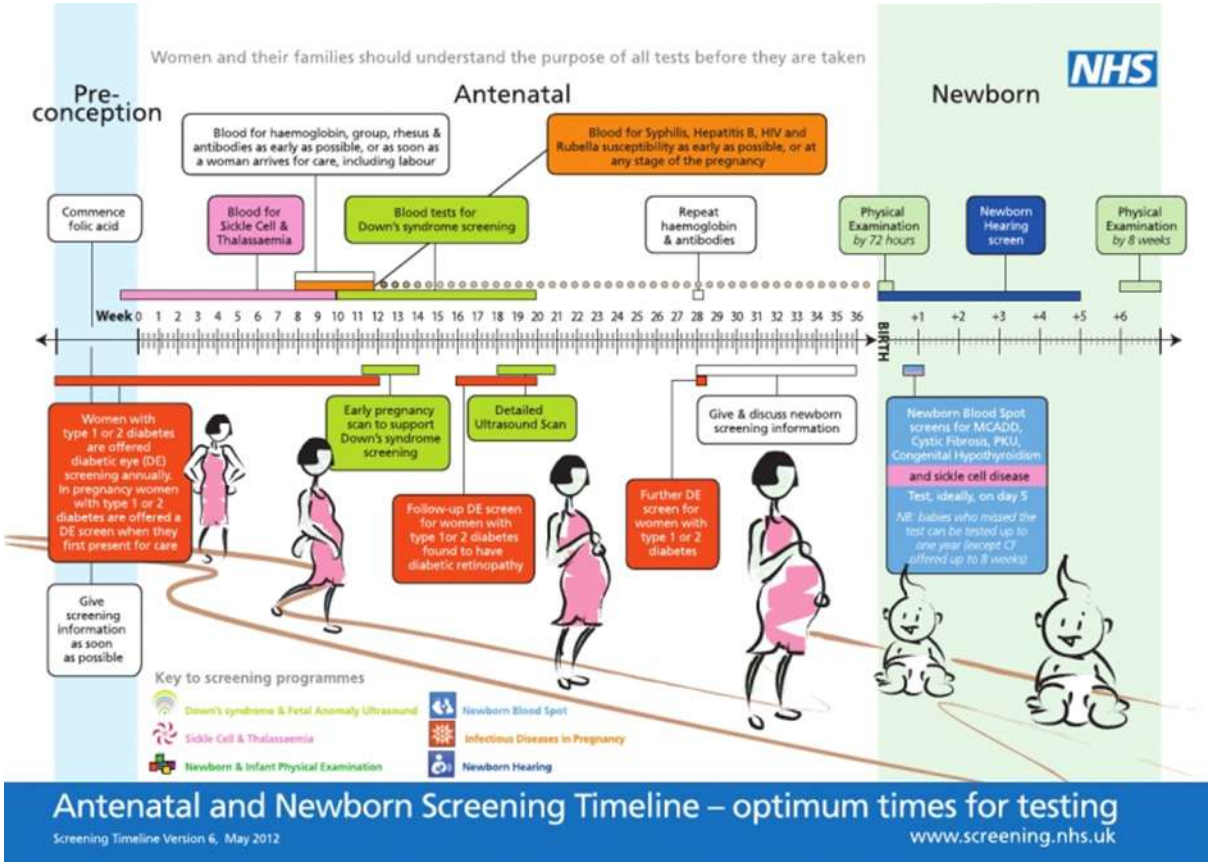
There are currently three antenatal screening programmes:

- sickle cell and thalassaemia to detect inherited conditions which affect red blood cells
- infectious diseases in pregnancy to assess whether a woman has HIV, hepatitis B or syphilis and to check susceptibility to rubella. These conditions can be transferred from mother to child
- Down's syndrome and fetal anomaly screening to identify the risk of a child having Down's syndrome or other inherited conditions

Figure 2 shows the optimal times for the antenatal and new-born screening timeline

There are also three screening programmes for new-borns which are detailed in chapter 4.

Figure 2: Antenatal and New-born Screening Programme Timeline



Source: NHS National Screening Programmes

2.3.6 Female Genital Mutilation (FGM)

FGM refers to procedures that intentionally alter or cause injury to female genital organs for non-medical reasons. The practice is illegal in the UK. It is unnecessary and causes significant emotional, psychological and physical effects such as chronic pain, sexual difficulties and complications in pregnancy and childbirth [(15)].

From September 2014, it is now mandatory for health professionals to record the presence of FGM whenever it is identified through delivery of NHS healthcare [(16)]. This information will be published from October 2014 as an official statistic.

3.0 Pregnancy

3.1 Smoking

Smoking in pregnancy is the single most important modifiable risk factor in pregnancy and is estimated that about one-third of all perinatal deaths (stillbirths and infant deaths) in the UK are caused by maternal smoking [(17)].

As part of The Tobacco Control Plan for England (2011), the Government has a national ambition to reduce rates of smoking throughout pregnancy to 11% or less by 2015 [(18)].This is very important to prevent damaging effects on the growth and development of the baby and the health of the mother.

Pregnant smokers have more complications during their pregnancy and labour, including increased risk of miscarriage. Their infants are at risk of congenital defects, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy [17] [20].There is a direct link between the amount of tobacco smoked, and the amount of harm to babies [21].

It is difficult to get accurate statistics on smoking during pregnancy. Maternity services record smoking status of women at the antenatal booking appointment and at time of delivery. Studies suggest that this data is an underestimate of the extent of smoking in pregnancy as women have a tendency to under report smoking in pregnancy [19]. Teenage mothers and women in lower socioeconomic groups are more likely to smoke during pregnancy [20]. In Southend-on-Sea the percentage of mothers known to be smoking at time of delivery was 11.5% in 2012/13, which is lower than the England average of 12.7% [21].

The Southend Specialist Stop Smoking Service works closely with the local maternity unit to ensure all staff understand the importance of raising the issue of smoking and to ensure best recommended practice is implemented [22]. Midwives locally validate smoking status by measuring the levels of carbon monoxide in all pregnant women at the booking visit. Pregnant women who smoke are given brief advice and are then referred for intensive stop smoking support.

Stop smoking support is offered to pregnant women (and their partners) in the community from a range of specialist advisors, including those in GP practices and community pharmacy.

3.2 Alcohol

Alcohol crosses the placenta to the fetus and can potentially damage the developing organs. The risks depend on the amount of alcohol consumed and the stage of pregnancy. Binge drinking and regular excessive drinking are particularly harmful [22].

Drinking alcohol in the first 3 months of pregnancy is linked to miscarriage, some birth abnormalities, increased risk of premature labour and low birthweight. Drinking in the later stages of pregnancy is associated with learning and behavioural disorders [23].

Drinking heavily (> 6 units per day) throughout pregnancy can lead to serious, but preventable, conditions called fetal alcohol spectrum disorders (FASD), which are the most common, non-genetic cause of learning disability[24][25]. Estimates suggest that the prevalence is at least 10 per 1000, or 1% of all live births [26].

Symptoms of fetal alcohol spectrum disorders include distinct facial abnormalities, low birth weight, learning and behavioural difficulties, poor attention span and memory deficits.

Current guidance is that women who are pregnant or trying to conceive should avoid alcohol altogether during the first 3 months of pregnancy. If they do choose to drink, they should not drink more than 1 to 2 units, once or twice per week. Women should be advised not to get drunk or to binge drink (drinking more than 7.5 UK units of alcohol on a single occasion) while pregnant [27]. These guidelines are currently under review.

There is no local data on prevalence of alcohol consumption in pregnancy; however this is a key area of work due to the potential risk of FASD. Alcohol consumption is assessed and recorded by midwives during the antenatal booking appointment and brief advice is given. Women recorded as drinking at harmful levels are referred to a specialist midwife and to alcohol treatment services as appropriate.

3.3 Diet

A healthy diet is particularly important in the pre-conceptual period and during pregnancy. In addition to a healthy and varied diet, pregnant women are advised to take appropriately formulated vitamin and iron supplements during pregnancy. These include folic acid and vitamin D, as well as iron supplements if required.

Under the national Healthy Start scheme, vouchers are provided to low income mothers and pregnant women under the age of 18, to spend on fresh milk, fresh and frozen fruit and vegetables. They also get free vitamin supplements.

Until recently free Healthy Start vitamins were mainly distributed through NHS clinics and Health Centres. The Public Health Department are keen to increase access and uptake of these vitamins and have now set up distribution points in some local Children's Centres.

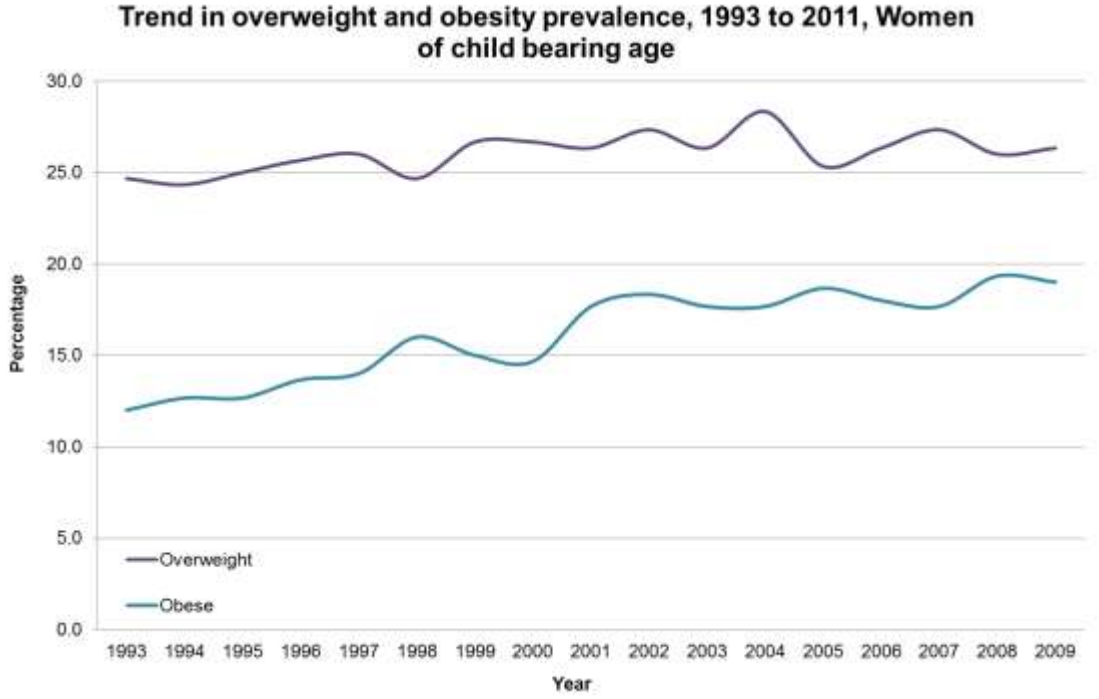
3.4 Maternal Obesity

Maternal obesity is associated with greater health risks for both mother and baby. Obesity increases the risk of pregnancy complications such as gestational diabetes, pre-eclampsia, miscarriage and maternal death [(28)].

Women who are obese in pregnancy are also more likely to require specialist facilities and care, and to have medical interventions such as caesarean and medical induction of labour.

National statistics for the prevalence of maternal obesity are not collected routinely in the UK, but trend data from the Health Survey for England (HSE) show an increase in the prevalence of obesity amongst women of childbearing age (Figure 3).

Figure 3: Trend in prevalence of overweight and obesity (BMI > 30) in women of child bearing age during the period 1993-2011



Source: Health Survey for England

Work is now taking place to set up a care pathway for very overweight women. This will help with the difficult challenge of achieving and maintaining a healthy weight in pregnancy.

3.5 Immunisation

A number of vaccinations have recently been introduced to protect pregnant women and their unborn babies against certain infectious diseases.

3.5.1 Pertussis (Whooping Cough)

Following a rise in whooping cough cases among young babies in England pertussis vaccination has been offered to pregnant women since September 2012. This vaccine is offered between 28 and 38 weeks of pregnancy to increase maternal antibodies which pass across the placenta to the unborn infant and provide protection during the early weeks of life.

In a recent study babies born to women vaccinated at least a week before delivery, had a 91% reduction in the risk of pertussis disease in their first weeks of life when compared with babies whose mothers had not been vaccinated.

Uptake of the pertussis vaccine in pregnant women varies across the year and is approximately 60%. All pregnant women should continue to be given the opportunity to be vaccinated, by using every contact to remind them of the importance of vaccination and by sign-posting them to general practice. All babies should continue to receive their primary vaccinations, scheduled at 2, 3 and 4 months, in a timely manner.

In June 2014, the Joint Committee on Vaccination and Immunisation (JCVI) advised that the maternal pertussis vaccination programme should be continued for at least the next five years.

3.5.2 Influenza

In 2010, pregnancy was added as a clinical risk category for routine influenza immunisation as there is good evidence that pregnant women have a higher chance of developing complications if they get flu, particularly in the later stages of pregnancy.

3.6 Maternal Mental Health

The term 'perinatal mental illness' refers to mental illness during pregnancy and up to one year after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. Examples of perinatal mental illness include antenatal depression, postnatal depression, maternal obsessive compulsive disorder, postpartum psychosis and post-traumatic stress disorder (PTSD). These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment.

Significant mental health problems at this time causes distress, and can seriously interfere with the adjustment to motherhood and the care of the new-born baby as well as existing children.

Around 12% of women develop a perinatal mental illness. Early identification, support and treatment can prevent the onset and escalation of maternal mental illness and limit the impact on the family to improve the well-being, health and achievement of the child [(29)].

Risk factors associated with increased risk of perinatal mental illnesses include history or family history of mental illness, maternal anxiety or depression, being a lone parent, low levels of social support, teenage parenthood, early emotional trauma/childhood abuse and unwanted pregnancy [(29)].

Southend-on-Sea has a Perinatal Emotional Well-being Service which provides support, advice and guidance to pregnant women and mothers. However there is no specialist clinical network and there is limited access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding as recommended by NICE guidance [(30)].

3.7 Intensive Support for Young Mothers

Teenage mothers are more likely than others to experience poor outcomes from pregnancy. An important development in Southend-on-Sea is the introduction of the Family Nurse Partnership programme (FNP). This is a preventative home visiting programme which works with vulnerable first-time young mothers (aged 19 or under) and fathers, to help them understand their baby. Specially trained nurses visit the family regularly from early pregnancy until the child is two years of age.

The nurse works with the parents and the wider family to help make changes to their behaviour and increase their parenting capacity. Outcomes from FNP include

improved health in pregnancy, more women breastfeeding, and increased child immunisation rates, reductions in child abuse and neglect, improved education and job prospects for mothers.

Southend-on-Sea has been fortunate to be a first wave site for FNP and also took part in the randomised control trial which reported in 2013.

4.0 Recommendations

- Commissioners to prioritise training for healthcare professionals to continue to offer pre-conceptual advice and promote early antenatal booking

- Frontline staff working with women of child bearing age to continue to promote the importance of healthy lifestyles during pregnancy

- Increase uptake of the Healthy Start Scheme through expansion of distribution points throughout the community

- Commission a specialised weight management service for maternal obesity

- Offer training to support staff in the early identification of perinatal mental health issues

Chapter 4 Infancy and Early Childhood

A healthy pregnancy, positive but authoritative parenting, high-quality childcare, a positive approach to learning at home and an improvement in parents' qualifications together, can transform children's life chances and trump class background and parental income. A child growing up in a family with these attributes, even if the family is poor, has every chance of succeeding in life.

Frank Field
The Foundation Years

1.0 Introduction

The health and wellbeing of children in the early years of life has significant impact on their long term health outcomes and indeed on their social, educational and economic outcomes as well. The provision of services to young children is key to reducing health inequalities across the whole population.

There is now a considerable evidence base showing that the period from conception to a child's second birthday is a crucial phase of human development when the foundations of a child's future physical, mental and emotional health are established [(1) (2)]. This period is key for brain development; and the positive experiences or adverse events a child has in these early days lead to structural changes in the brain which can have lifelong ramifications. A cross-party manifesto published in 2013, *The 1001 Critical Days,* called for a proactive, supportive and preventive approach by services during this period [(3)].

Factors that encourage positive development after a child has been born include: sensitive and responsive parenting, healthy diet and nutrition and an environment rich in spoken language to facilitate language acquisition.

There is a wide and varied workforce supporting families and young children across the first 1001 days and beyond to the start of primary school. Professionals working with children in these first five years need to be involved in promoting and encouraging children's health and development, as good health and educational attainment are important determinants of a child's life chances.

The two main statutory frameworks which guide provision for these 'early' or 'foundation' years are: the Healthy Child Programme and the Early Years Foundation Stage (EYFS) [(4) (5)]. In addition the reforms of the Children Act 2014, brought in new statutory duties and responsibilities for integration of the educational, health and social care provision for children and young people with Special Educational Needs and Disability (SEND)[(6) (7)]. The SEND code of practice sets out the requirements for all providers working with children to make effective provision and improve long-term outcomes for children.

1.1 Health inequalities

The link between socioeconomic disadvantage and poor health is well documented. This is particularly relevant for Southend as there are more children living in poverty compared to the national average.

1.2 Success for All Children Partnership

In Southend-on-Sea partnership working is well-established. The main strategic group for children's services is the Success for All Children Partnership which brings together agencies and organisations to work together to improve outcomes for children and their families.

Partners work together to make sure that all children and families who live in Southend-on-Sea can take advantage of the current opportunities and help them to create more opportunities for themselves in the future. The group and the wider children's workforce support children and families by:

- Helping them to raise their aspirations and achievement
- Ensuring they have the opportunities they need to be included
- Facilitating their participation in decision-making that affects their lives
- Providing them with excellent services to action excellent outcomes

2.0 Child Poverty

Children growing up in poverty face many barriers that impact on them achieving their full potential. However, resilient parents or carers with good coping skills can offset some of the impact of financial and material disadvantage.

Outcomes for children growing up in lower income households are significantly worse than those in more affluent households. Children raised in poverty:

- are more likely to have a mother with poor health behaviours and to be born with a low birth weight
- have poorer general health than their peers
- have more attendances at Accident and Emergency departments and more hospital admissions
- have a higher incidence of respiratory infections and asthma
- are 13 times more likely to die from unintentional injury
- are 37 times more likely to die as a result of exposure to fire, flames or smoke
- are more likely to have preschool conduct and behaviour problems
- are more likely to be in the lowest 20% of educational achievement [(8)(9)]

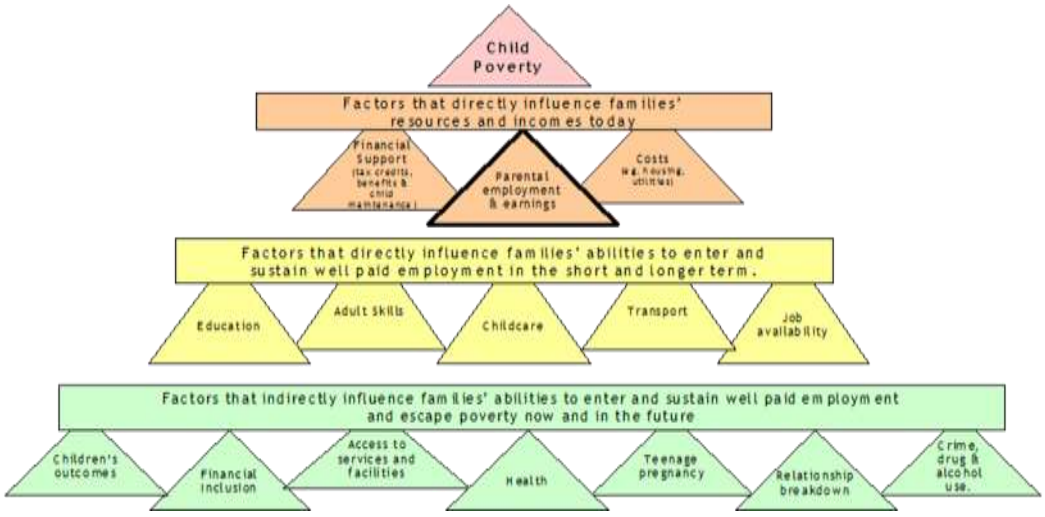
The Marmot Review on health inequalities referred to a 'social gradient' in health meaning that the lower a person's social status, the worse his or her health [(10)]. The strategy recommended by the Marmot Review to reduce the steepness of this social gradient and address health inequalities was referred to as 'proportionate universalism'. The review team advised that there should be actions that are universal to improve health throughout society 'but with a scale and intensity that is proportionate to the disadvantage' [(10)]. This means making services available to everyone, with additional services for those with greater need. The delivery of the Healthy Child programme and services in Children's Centres take this approach.

The measure of poverty used in this chapter and as a health indicator in the Public Health Outcomes Framework is *relative* rather than *absolute* poverty i.e. it reports on children who are worse off than the majority of children rather than children who do not have basic needs like food and shelter. Child poverty is defined as "the proportion of children aged less than 16 years living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of median income [(11)]. The calculations are made before housing costs so do not take account of the impact of higher local housing costs.

The Child Health Profile for Southend-on-Sea 2014 highlights that there are more children living in poverty compared to the national average and this impacts on a range of health outcomes [(12)]. There are also clear links with educational outcomes and employment prospects, as poor health acts as a barrier to education and work. The impact on child development and attainment is apparent at a very early age and by age 2, children from the poorest families are already showing lower attainment than those from more affluent families and this gap widens as children continue through the education system [(13)].

The Child Poverty Pyramid (Figure 1) developed by the national Child Poverty Unit gives a visual model showing the key factors that directly and indirectly contribute to child poverty. It shows how complex and interrelated the factors are and highlights the need for an integrated approach to tackling child poverty.

Figure 1: Child Poverty Pyramid



Source: Child Poverty Unit

There is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults, so reducing the numbers of children who experience poverty should also improve these adult health outcomes and increase healthy life expectancy.

In tackling child poverty the particular impact of poor housing and fuel poverty needs to be considered. The *Health Impacts of Cold Homes and Fuel Poverty* report noted the particular effects of cold homes on child health:

- reduced weight gain in infants
- asthma in young children
- impeded ability to learn in older children
- mental health problems in adolescents
- increased incidence of colds and flu [14]

2.1 The National Picture

In March 2010 the Child Poverty Act (CPA) established a duty to 'minimise socioeconomic disadvantage' [15]. In 2011 the coalition Government published a national child poverty strategy which outlined an approach to tackling the causes of poverty [16]. In June 2014, the government published its second Child Poverty Strategy for the period 2014-2017[17]. This sets out measures to tackle the root causes of poverty by:

- supporting families into work and increasing their earnings
- improving living standards, and
- raising educational achievement for children

Over the last 15 years the UK has gone from having one of the highest rates of child poverty in the developed world to the EU average. The latest child poverty figures show that in the UK for 2011/12, 2.3 million children (17%) lived in households with substantially lower than average income.

One strategy to address the health and education inequalities resulting from poverty is to provide high-quality childcare. This can make a difference directly, by improving child development and attainment, and indirectly by enabling mothers to work [18].

Since 2010, all three and four year olds have been entitled to 15 hours a week of funded early years education. This helps all children, while narrowing the gap in outcomes between poor children and the more affluent.

In September 2014, this provision was extended to two year olds from families on low income. Around 260,000 children per year (40% of all two year olds) from the most disadvantaged families will be eligible to benefit.

The Government is also introducing an Early Years Premium in 2015-16 to ensure children from the most disadvantaged backgrounds get the best start in life with high-quality pre-school provision.

2.2 The Local Picture

Southend has a number of initiatives to reduce and mitigate the effects of child poverty. These include:

- a Child Poverty Strategy and implementation group. This strategy is currently being reviewed and refreshed in line with the 2014-17 national strategy.
- corporate strategies and external funding which promote prosperity and economic regeneration e.g. City Deal, MedTech, Coastal Communities Fund
- increasing aspirations and providing adult education, skills and training including family learning courses and adult apprenticeships
- advice to maximise the uptake of benefits

- Essential Living Fund
- support for people living in poor housing, a Homelessness Prevention Strategy and driving up standards in the private rented sector
- Healthy Start vouchers, breakfast clubs and free fruit and vegetables for children aged 4-6 years
- access to high quality affordable childcare
- implementing ‘two-year old’ funding
- support to schools to improve educational achievement
- support from employment services
- local employers offering flexible working and becoming accredited Living Wage employers

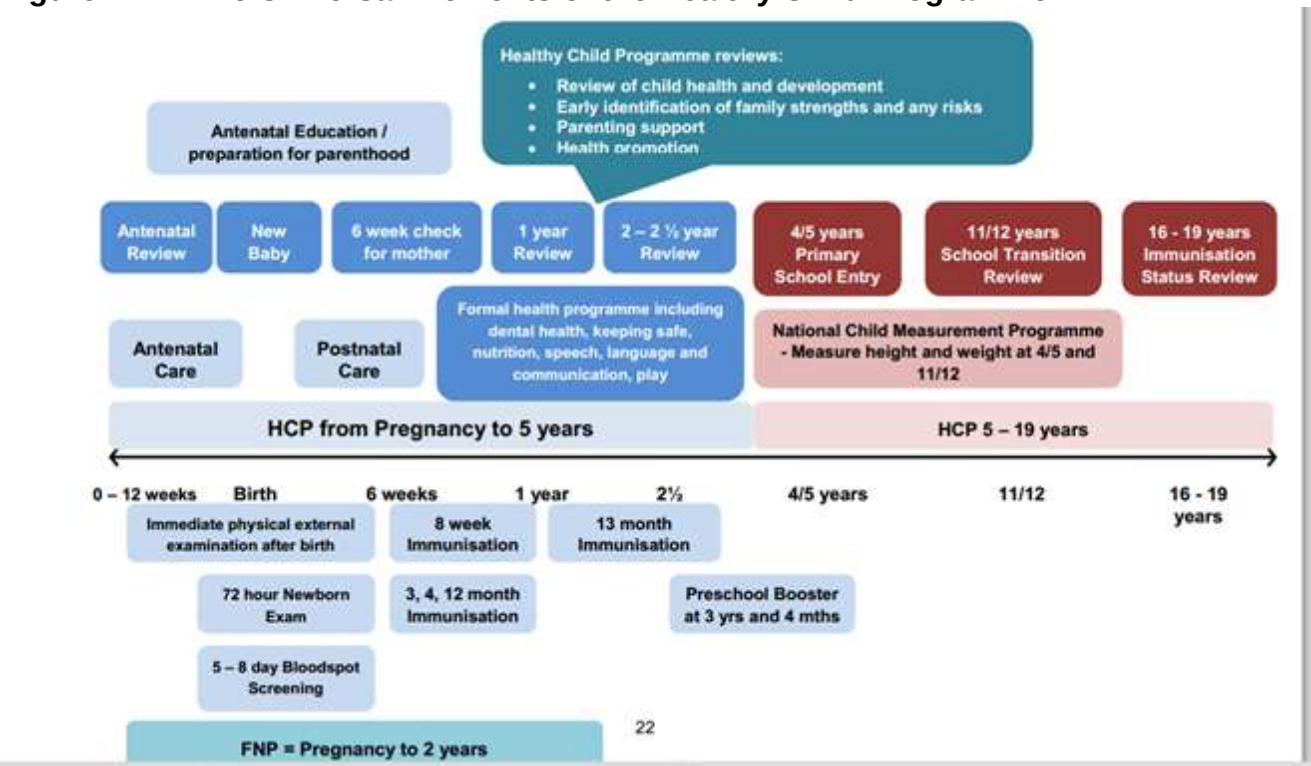
3.0 The Healthy Child Programme

Prevention and early intervention public health services are delivered through the evidence-based Healthy Child Programme (HCP), which provides screening, immunisation, health and development reviews from early pregnancy, through the early weeks of life and throughout childhood.

The HCP recognises the roles of a variety of professionals in promoting and health well-being and is aimed at the full range of practitioners in children’s services.

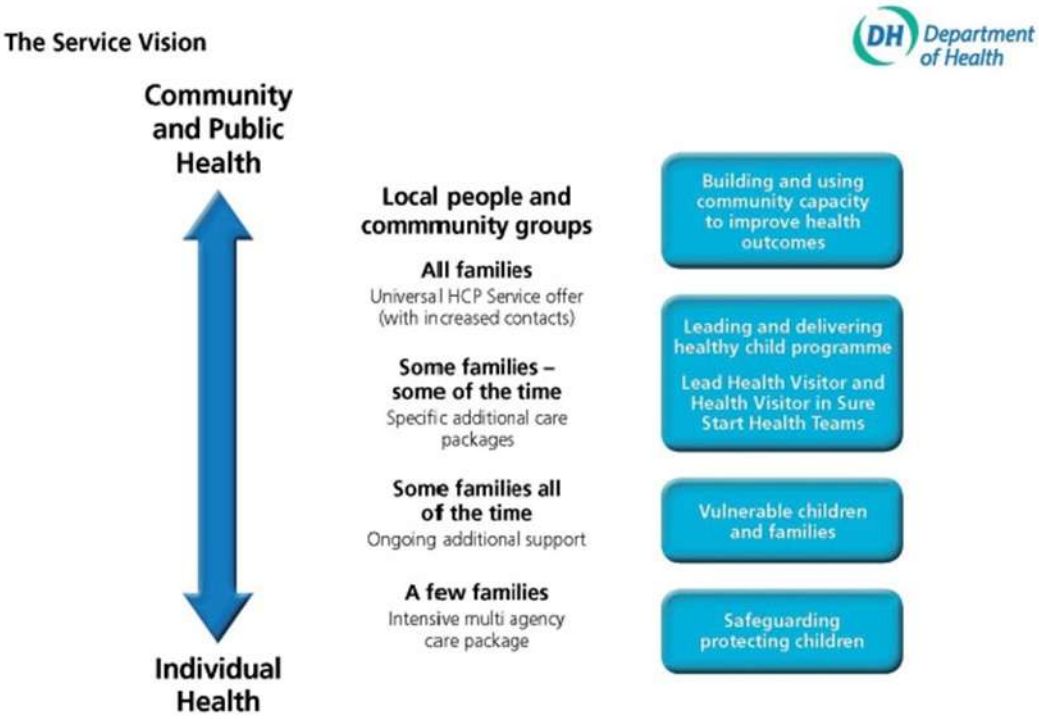
The programme is led and coordinated by children’s public health nursing services: the lead professionals for HCP from birth to age 5 are Health Visitors and Family Nurses and for children aged between 5-19 years, School Nurses. These public health nurses are registered children’s or general nurses or midwives who have undertaken specialist training in family and community health. The nurses work with families and other practitioners to provide support, guidance and early intervention on health issues and developmental problems at key stages of the life course: pre-conception, antenatal, postnatal, infancy, preschool, school age and adolescence. The HCP has been developed to give a continuum of support; those with greatest need receiving intensive support; and those with lower levels of need a ‘lighter touch’. This is termed ‘progressive universalism’.

Figure 2: The Universal Elements of the Healthy Child Programme



The universal elements of the HCP are offered to all children and families (Figure 2).The public health nurses then identify when any additional support is needed for the child or family and provide this or refer appropriately. Figure 3 explains this tiered model for the Health Visiting Service.

Figure 3: The Health Visiting Service



Source :DH

3.1 The National Picture

Health Visitor numbers have been falling for about 20 years, but more rapidly since 2004: 10,137 in 2004, 8860 in 2009, and 8017 in 2010. This has restricted their ability to effectively deliver the Healthy Child Programme, as there are not enough health visitors to offer all families the support they need.

An important national development in child public health provision was the reform of health visiting set out in the *Health Visitor Implementation Plan 2011-2015: A Call to Action* [(19)]. This outlines the Government's intention to recruit an extra 4,200 health visitors by 2015, which is an increase of almost 50% on 2011 numbers.

A similar review and refocus was undertaken for school nursing. School nurses are the lead professionals for the HCP 5-19 years, and their role includes assessment of children's health, health promotion advice and advice on health conditions and child protection.

In 2012, the Government published its vision for maximising the contribution of school nursing to public health, *Getting it Right for Children and Young People* [(20)]. This set out a similar service model to health visiting i.e. progressive universalism. There was also a strong emphasis on the school nurse role in safeguarding.

The Government also made a commitment to roll out the Family Nurse Partnership (FNP) an evidence-based, intensive preventive home visiting programme for vulnerable, first-time young parents that begins in early pregnancy and ends when the child reaches age two years [(21)]. FNP has three aims: to improve pregnancy outcomes, to improve child health and development, to improve parents' economic self-sufficiency.

3.2 The Local Picture

This HCP is at present commissioned by NHS England for 0-5 years, and by Public Health in Southend-on-Sea Borough Council for 5-19 years. The shift in commissioning responsibility for 0-5 public health from NHS England Essex Area Team to the Southend-on-Sea Public Health Department in October 2015 creates an opportunity to ensure more integrated working between maternity, health visiting, school nursing, mental health services, and early years staff, and offer a comprehensive package of support to young children and families.

Mothers whose children may be at greater risk of poor outcomes will be offered intensive health visiting support by the introduction of the MECSH (Maternal and Early Childhood Sustained Home Visiting) programme [(22)].

4.0 Breastfeeding

Breast milk is the best form of nutrition for infants. There is clear evidence that breastfeeding has positive health benefits for the mother and the baby in both the short and long term. The Department of Health recommends exclusive breastfeeding for the first six months of an infant's life, with breastfeeding continuing after this age along with solid food [(23)].

Breastfed babies have:

- reduced risk of gastroenteritis (diarrhea and vomiting)
- fewer chest and ear infections which may require hospitalisation
- less chance of becoming overweight and developing diabetes
- less chance of developing eczema
- fewer urinary tract infections [23]

Breastfeeding also supports the development of good attachment, assisting in the formation of a close and affectionate bond between mother and child [24].

Breastfeeding can also positively influence maternal health. It assists maternal recovery from childbirth and return to pre-pregnancy body weight. It can protect women against certain forms of cancer, including pre-menopausal breast cancer and ovarian cancer [25].

4.1 The National Picture

Improving breastfeeding rates are essential to reduce health inequalities. Despite the benefits outlined above, breastfeeding rates in England remain among the lowest in Europe.

Data on breastfeeding initiation and breastfeeding prevalence at 6-8 weeks are collected nationally by the NHS. Data is also collected by the NHS Information Centre in an Infant Feeding Survey every 5 years. The Infant Feeding Survey undertaken in 2010 reported a rise in breastfeeding initiation in England, but noted that many mothers did not continue for the recommended period of 6 months. Breastfeeding prevalence fell by 12% between birth and one week with a further drop of 14% by 6-8 weeks.

Low breastfeeding rates lead to an increased incidence of illness which has a significant cost to the health service. A recent report commissioned by UNICEF found a modest increase in rates could save at least £40 million pounds annually, reducing hospital admissions, GP consultations, childhood obesity and cases of Sudden Infant Death Syndrome [26].

NICE recommends attainment of UNICEF Baby Friendly Initiative (BFI) full accreditation. BFI employs best practice in supporting mothers to breastfeed. NICE also recommends the use of lay peer supporters as an effective measure to sustain breastfeeding. Women who know about the health benefits of breastfeeding are more likely to start breastfeeding so it is essential that in the antenatal period the health benefits of breastfeeding are discussed and explained to all women.

Initiation and continuation rates for breastfeeding are lowest amongst families from lower socio-economic groups, those with low educational achievement and teenage mothers, who are half as likely as older mothers to initiate breastfeeding. Lower rates in these groups result in poorer health outcomes for the mother and child, adding to inequalities in health and continuing the cycle of deprivation [27]. Many young mothers lack access to key sources of information and advice including antenatal classes, peer support programmes, friends, family and other support networks.

4.2 Local picture

In Southend-on-Sea in 2012-13 breastfeeding initiation was 73.0%, similar to the England average (73.9%). Breastfeeding prevalence at 6-8 weeks was 36.7% significantly lower than the national average (47.2%).

Locally breastfeeding prevalence is also recorded at 10 days when care is transferred from community midwives to health visitors, as there is evidence that this is when many women stop.

There are a number of initiatives in Southend-on-Sea to support breastfeeding:

- Both hospital and community providers have specialist Infant Feeding Advisors, who coordinate staff training and continuing professional development and to ensure support for breastfeeding mothers
- Southend University Hospital NHS Foundation Trust and South Essex Partnership NHS Foundation Trust have been implementing the Baby Friendly Initiative and achieved the joint Hospital and Community Stage 2 award in July 2014
- Community services have developed a website with links to national and local support, www.breastfeeding.see.nhs.uk;
- A research project, in conjunction with Warwick University, has been completed and provides intelligence on local women's attitudes to breastfeeding and the support required

Local children's centres have already actively engaged with community and hospital health services to support breastfeeding mothers. The UNICEF Baby Friendly Initiative has now introduced a specific set of standards for children's centres, so it is anticipated that they can further expand their role to provide greater support for breastfeeding and very early years development [28]. The Early Years Team is working with Public Health to begin the process of formal accreditation for our local Children's Centres.

5.0 Improving Parenting and the Home Environment

> ***"We have found overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life. It is family background, parental education, good parenting and the opportunities for learning and development in those crucial years that together matter more to children than money, in determining whether their potential is realised in adult life."***
>
> Frank Field, Independent Report on Poverty and Life Chances

There is increasing evidence that the quality of the relationship between parent and child is an important life-course determinant of children's emotional and social development and of mental and physical health in adulthood.

Evidence has shown that sensitive and responsive parenting and good parent-child relationships:

- reduce the risk of mental health problems in children, adolescents and adults
- reduce the risk of children adopting unhealthy behaviour

- are the basis of successful future relationships
- help protect children from the adverse effects of stress and poverty
- impacts on educational achievement, emotional control and empathy, anti-social behaviour, crime and violence [8]

The aspects of the parent-child relationship which are important for health outcomes are also those which influence outcomes in education, anti-social behaviour and crime. In addition positive parental engagement in learning can have a major impact on educational attainment and life chances.

5.1 The National Picture

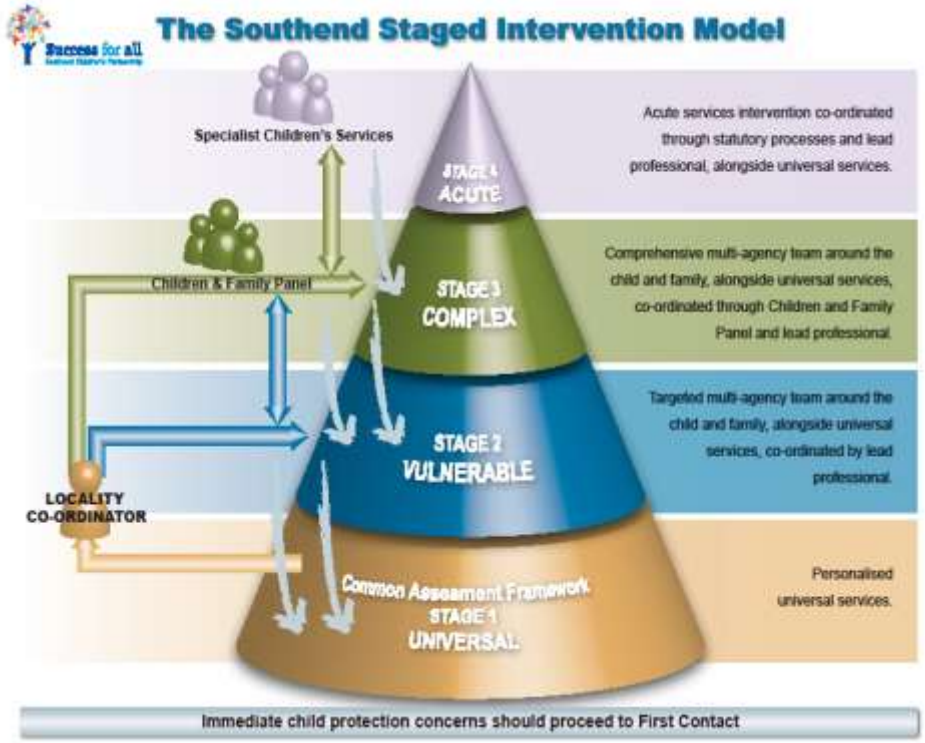
The importance of optimal parenting has been widely recognised by policy makers nationally. Supporting parents, building their skills, confidence and resilience is also seen as important across a number of sectors.

Many of the policies which are developed to improve parenting also address factors which affect parents' ability to bring up their children i.e. poverty, poor education, social exclusion, unemployment, and poor housing. There is, however, an increasing role for evidence-based parenting programmes. These can be prevention based e.g. Family Nurse Partnership which is a targeted prevention programme for children at risk of poor outcomes or as an intervention e.g. Incredible Years, aimed at children who have early behaviour problems.

5.2 Local initiatives

Southend-on-Sea has a Parenting and Family Support strategy which details the provision of parenting support within the Southend staged model of support (Figure 4).

Figure 4: The Southend Stage Model of Intervention



Locally there is a wide range of support for parents, including:

- Healthy Child Programme
- Family Nurse Partnership
- Teenage Pregnancy Support
- Parenting programmes - Incredible Years, Delta Parenting Programme, Mellow Babies
- Parent and child play and activity sessions
- Support for speech and language development
- Respite sessions

Southend has a strong universal offer for parenting through the Healthy Child Programme. In addition a network of Children's Centres offers a wide range of additional support services for young children and their families.

6. Recommendations

- Undertake an audit of uptake of Healthy Start to inform the decision on where further distribution centres should be located within Southend-on-Sea

- Undertake a review of how services promote and support breastfeeding

- Refresh and strengthen the Child Poverty Strategy in line with the new Government Strategy

- Expand early education and learning programmes for vulnerable and disadvantaged two year olds

Chapter 5 A Profile of Older People in Southend

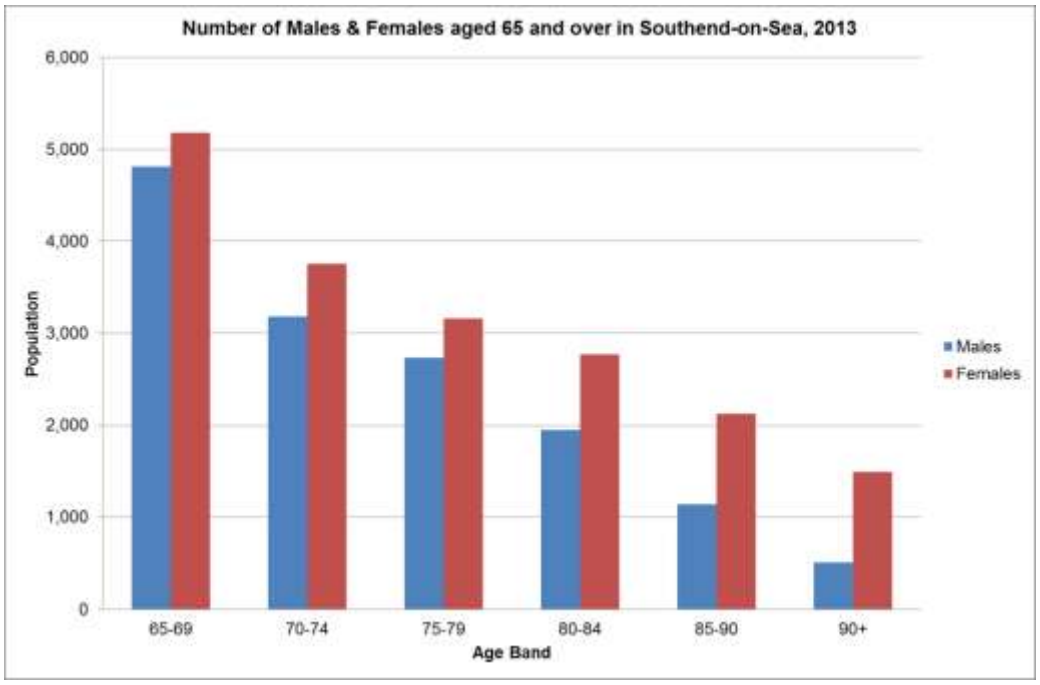
1.0 Introduction

Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person. This definition has been adopted for the purpose of this report. However, it is recognised that this age cut off point is arbitrary and cannot reliably predict a person's health and level of function.

2.0 Current Population

In 2013, there were 32,816 people aged 65 and over in Southend-on-Sea. Figure 1 shows the breakdown of the population aged 65 years and over:

Figure 1: Southend-on-Sea Population Aged 65 and Over

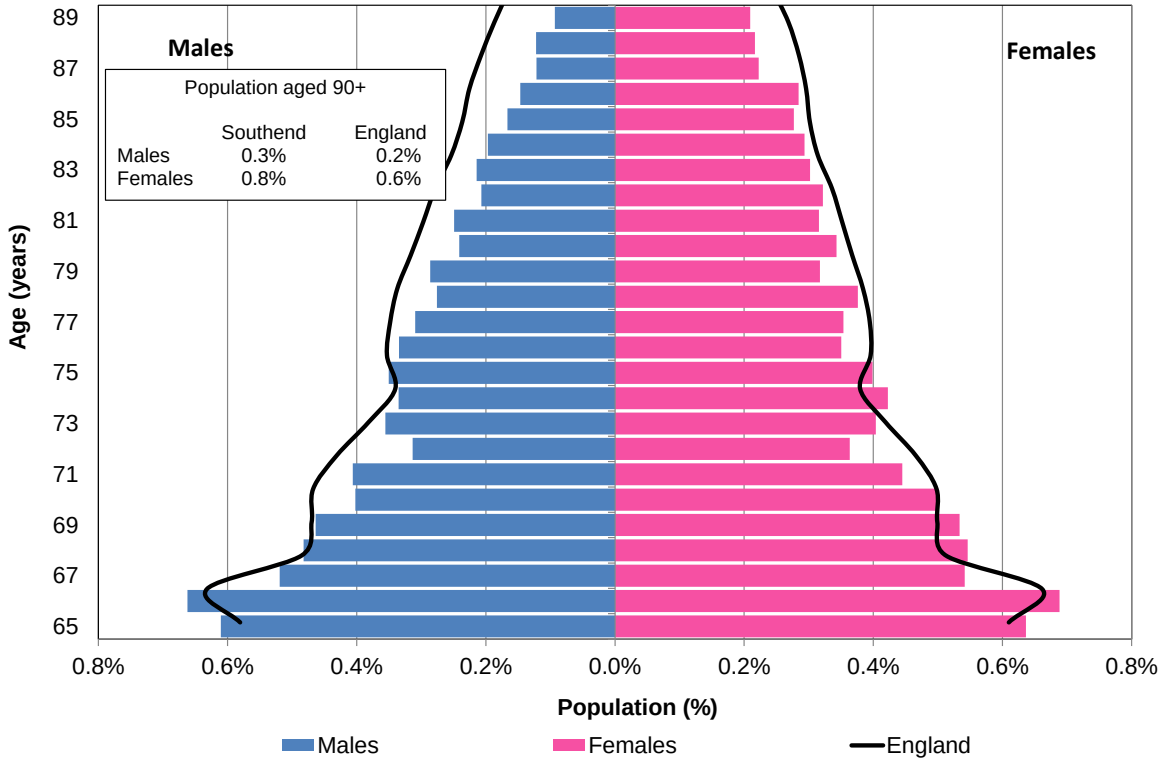


Data Source: POPPI

The 65 and over age group represents 18.7% of the total population of Southend-on-Sea which is higher than the national average of 17.3%.

Of the population aged 65 and over in Southend-on-Sea, 56.3% are women and by the ages of 85 and over this figure has increased to 68.7%. Figure 2 shows the population distribution of males and females aged 65 and over, by individual ages as a proportion of the total population.

Figure 2: Population Structure of People Aged 65 and Over in Southend-on-Sea



Data Source: ONS – Mid Year Estimates 2013

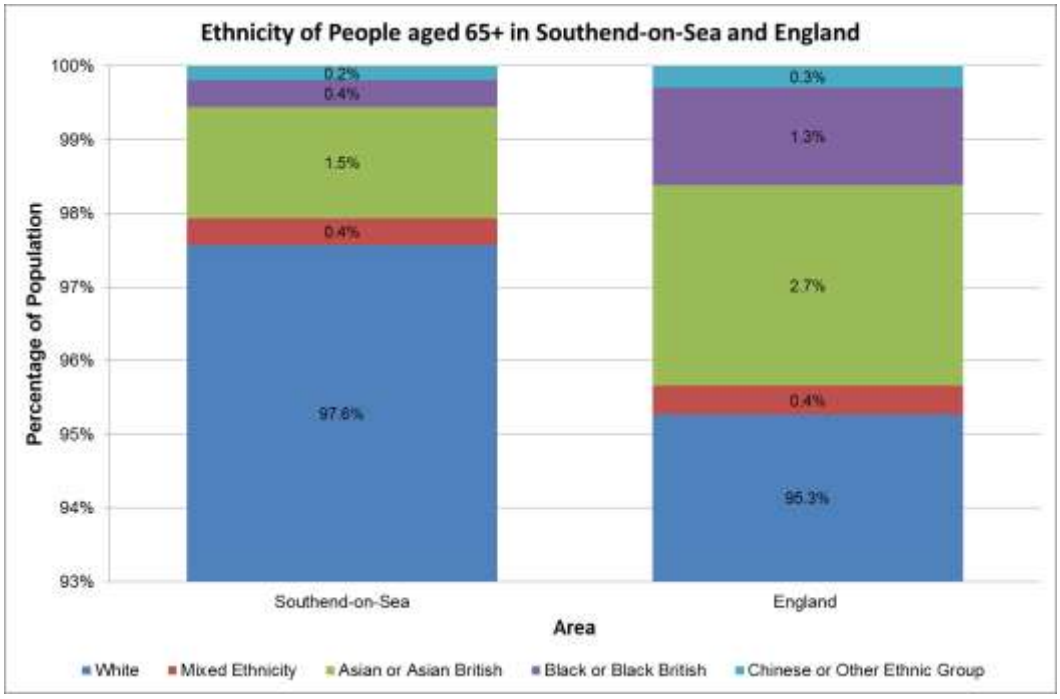
3.0 Ethnicity

Figure 3 shows the proportion of people aged 65 years and over in each ethnic group in Southend-on-Sea. Of the total population of Southend-on-Sea, 10.9% are in a black, Asian and minority ethnic (BAME) group; only 3.4% of the population aged 65 and over are in a BAME group. However, as ethnic diversity in younger age groups in Southend-on-Sea has increased over the last decade, the proportion of older people from a BAME group in Southend-on-Sea is set to increase.

Local health and social care services should recognise the greater prevalence of some illnesses among specific groups of people, for example increased rates of hypertension and stroke among African-Caribbeans and diabetes among South Asians. This will become increasingly significant as these populations continue to age.

It is important to maintain an accurate picture of the ethnic diversity of the area to ensure that service provision is culturally sensitive and appropriate to the needs of the local residents.

Figure 3: Ethnicity Profile of Southend-on-Sea Population Aged 65 and Over

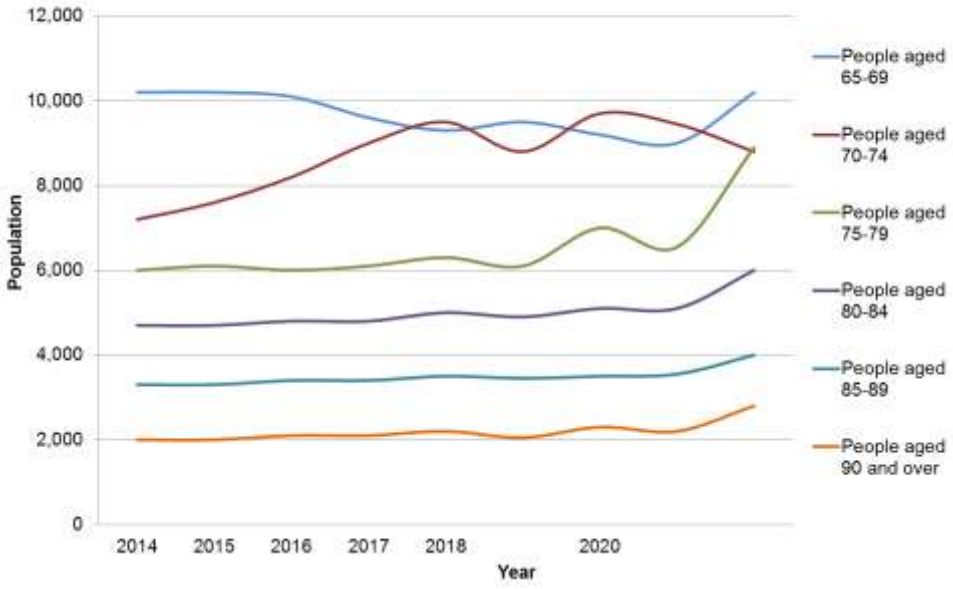


Data Source: POPPI

4.0 Population Change

The overall number of older people in Southend-on-Sea is expected to grow sharply in the coming years; with a particularly large increase in the numbers of people aged 75-79 of 40% (Figure 4).

Figure 4: Population of Southend-on-Sea Aged 65 and Over, Projected to 2020



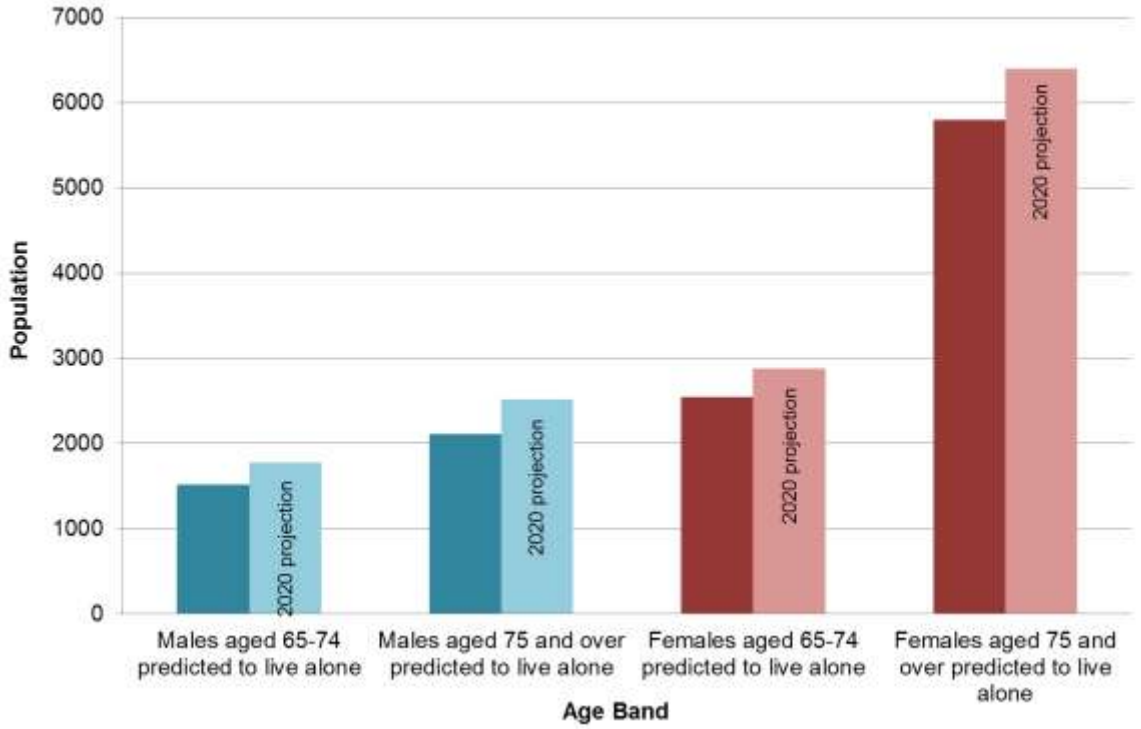
Data Source: POPPI

5.0 Living Circumstances

The living circumstances of older people affect both opportunities for social interaction and the need for additional support from formal and informal services.

Figure 5 shows a significant proportion of those aged 75 years and over live alone. 61% of those living alone are women.

Figure 5: People Aged 65 and Over Living Alone, Projected to 2020



Data Source: POPPI

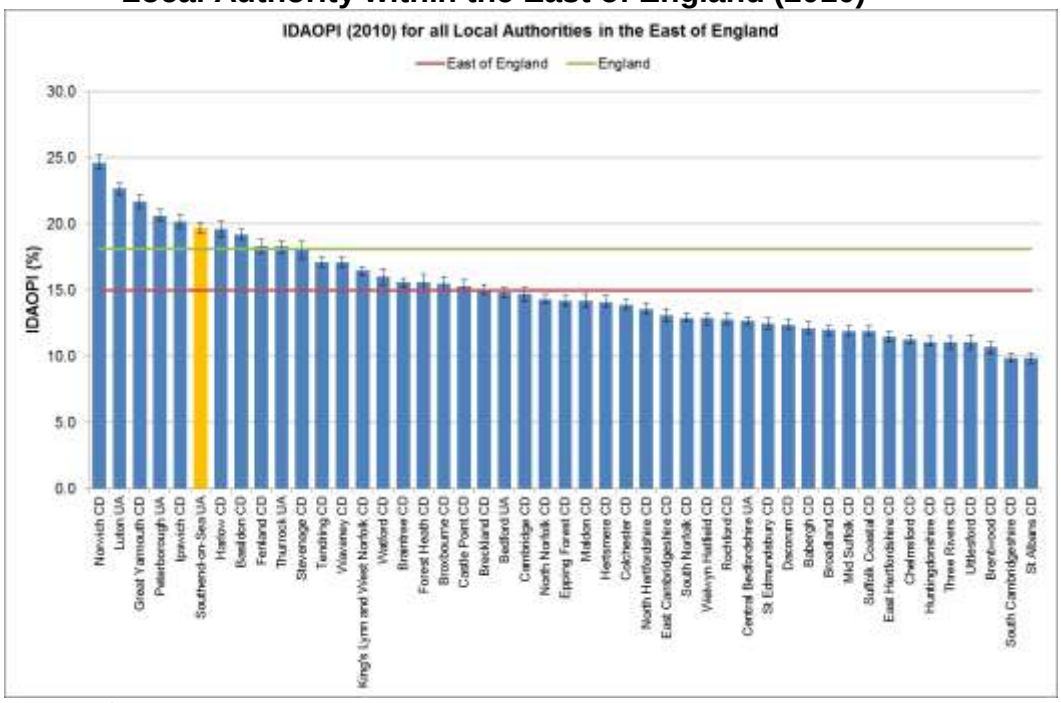
Evidence suggests that older people who live alone are more likely to report fair or poor health, social isolation and difficulties in the basic activities of daily living, lower mood and lower levels of physical activity [(1)] which has implications for the potential level of support that may be required from external agencies.

6.0 Poverty

A useful measure of older people living in poverty is the Income Deprivation Affecting Older People Index (IDAOPI). The score for this Index gives the proportion of adults age 60 or over living in income deprived households (i.e. someone in the family is claiming Income Support or income based Jobseeker's Allowance or Pension Credit [Guarantee]).

At a local authority level there are significant differences between levels of income deprivation in older people, with Southend-on-Sea having the 6th highest level within the East of England (Figure 6), significantly higher than the England average.

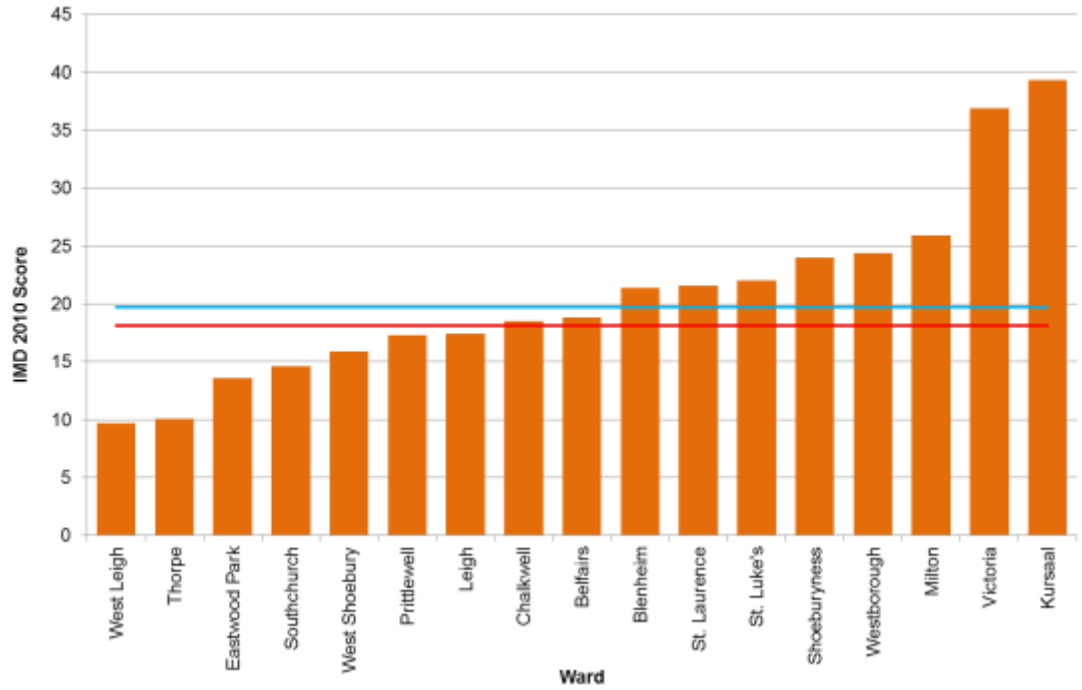
Figure 6: Income Deprivation Affecting Older People Index (IDAOPI) by Local Authority within the East of England (2010)



Data Source: APHO

There are 2 wards in Southend-on-Sea, Victoria and Kursaal that have double the England average of older people living in poverty (Figure 7). Nearly one fifth of Lower Super Output Area (LSOAs) in Southend-on-Sea are in the top quintile of LSOAs in England with the highest proportion of older people living in poverty.

Figure 7: Income Deprivation Affecting Older People Index (IDAOPI), Southend-on-Sea Wards, 2010

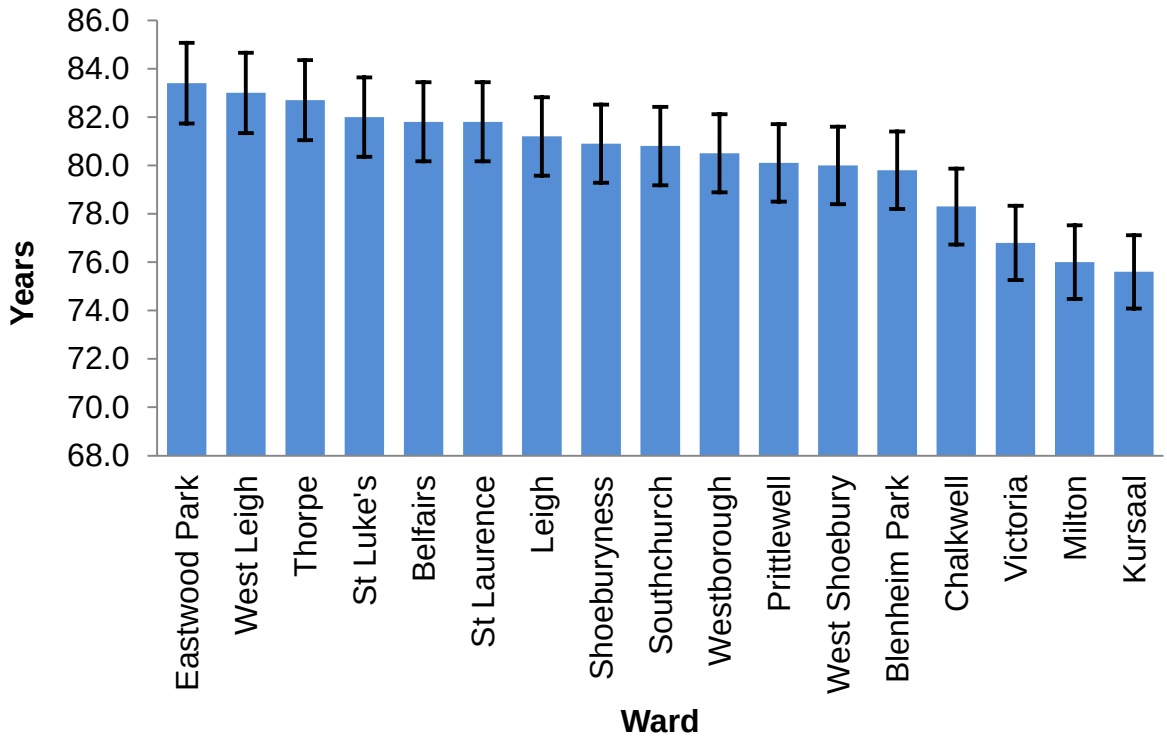


Data Source: APHO

7.0 Life Expectancy

Life expectancy is a measure indicating the number of additional years that a person can expect to live having reached a particular age. It is an alternative summary indicator of the mortality experience of a population. Figure 8 shows the life expectancy by ward within Southend-on-Sea. Most recent published data highlights that life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas.

Figure 8: Southend-on-Sea Life Expectancy by Ward, all persons, 2008-10



Data Source: PHE

Chapter 6 Ageing Well – An Overview

1.0 Introduction

Population ageing is an important public health issue and a priority for action at national and local government level.

From a biological perspective, ageing is commonly defined in terms of what it does to vitality and prospects for further survival. Healthy ageing may be considered as 'the promotion of healthy living and the prevention and management of illness and disability associated with ageing' [(1)].

There is a common perception of ageing as something which affects only older people, and those approaching old age. However, ageing begins at birth, with an increase in the rate of ageing beginning at puberty. Once a person attains adulthood, the annual risk of dying approximately doubles with every 8 additional years that pass [(2)].

The ageing process itself is caused by a gradual build-up of subtle faults in the cells and organs of our bodies, with genes influencing cellular repair. However, evidence suggests that genetic factors only account for 25% of human longevity and much can be gained from targeting the non-genetic factors that impact on the ageing process such as nutrition, lifestyle and the environmental factors such as poverty, housing, transport and employment, often referred to as the wider determinants of health.

Figure 1 shows the interrelationship of all the issues that impact on the health and well-being of a population.

Figure 1: The Health Map

The complexity of this interplay between all the determinants of the health and well-being of the population makes it vitally important for agencies to work collectively to ensure that older people have active, independent and fulfilling lives for as long as possible.

2. Healthy Ageing - Determinants of Health

2.1 Poverty

The current difficult financial climate and increasing costs have become a key issue for many older people. Having an adequate income is essential if older people are to maintain an appropriate standard of living to maintain their health and well-being. This includes basic needs such as having a warm home, eating properly and having opportunities to engage in leisure and social activities. The extent of income deprivation in older people in Southend-on-Sea has been highlighted in Chapter 5.

There is a proven link between poorer health outcomes and low income. People on a low income are more likely to have a shorter life expectancy as well as suffer from chronic conditions that affect their health and well-being and which may also reduce life expectancy [(3)].

Whilst there needs to be a stronger emphasis on planning for old age at an earlier stage to enable people to have greater control over their lives, action is also required to assist those older people who currently live on a low income.

2.1.1 Local Action

Advice and information services are provided by the Southend Citizens Advice Bureau. Residents can access this service to obtain practical help and advice, including financial and debt relief services, housing advice, and benefits advice. These services help increase incomes in low income households and contribute to increased standards of living.

There is a need to ensure that older people hear about and access support services at the earliest opportunity and receive help to claim welfare and housing benefits to which they are entitled. Frontline health and social care staff and third sector organisations such as Age Concern Southend and South East Essex Advocacy for Older People play an important role in identifying and signposting older people in the community to the appropriate services.

2.2 Housing

There is a wealth of evidence linking housing and health [(4)]. Those aspects of housing that are known to impact on health are likely to affect older people to a greater extent as they spend more time at home and may be unable to afford heating or on-going repairs.

Health problems may be caused by a number of hazards within the home:

- Excessive cold:

Older people living in cold homes are at a greater risk from heart disease and stroke, reduced resistance to respiratory infections and poor mental health. They are also at

risk from hypothermia. Cold housing can also cause an exacerbation of arthritic symptoms. This then impacts on strength and dexterity, which both decrease as temperatures drop, increasing the risk of falls and other non-intentional injuries [5]. The particular issue of fuel poverty is considered in the next section.

- Damp and mould growth:

Key factors contributing towards damp and mould include cold housing due to poor construction, along with poor ventilation and inefficient heating within homes. Those living in damp and/or mouldy homes are more likely to experience health problems such as respiratory infection, allergic rhinitis and asthma [4]. Damp conditions can also aggravate existing respiratory conditions such as bronchitis.

- Quality of housing

Poor housing conditions including poor lighting, unsafe stairs or lack of stair handrails, electrical hazards and disrepair can all increase the risk of accidents and injuries within the home, with older people being particularly at risk. The majority of injuries to people aged 75 and older occur at home. The annual cost to the UK Government from falls in those aged 60+ is £1 billion with the average cost of a single hip fracture estimated at £30,000. This is five times the average cost of a major housing adaptation (£6,000) and 100 times the cost of fitting hand and grab rails to prevent falls [6].

Good quality housing can protect and promote health. The health and well-being of older people can be improved by:

- Adequate heating and ventilation
- Basic safety checks and minor repairs
- Adaptation of existing homes to facilitate independent living at home

2.2.1 Local Action

There are a number of actions that can be undertaken to promote better health and help to ensure that older people are able to maintain their independence within their own homes.

- Development of more homes that can be flexible to the changing needs of older people e.g. sheltered housing or extra care housing which provide additional support whilst enabling people to maintain their independence within their own home.

- South Essex Homes manages the Council's housing stock. There are 22 sheltered housing properties in Southend-on-Sea which allow people to live independently in their own property, with the support of a sheltered housing officer. Four of the properties provide extra care to meet the needs of older people and help them to stay in their own homes for as long as possible.

- The use of telecare can help to increase independence and safety and decrease carer stress. One example being the Southend Careline service, a home alarm system that is available to provide help in an emergency 24 hours a day for those who may be more vulnerable.

- Work in partnership to increase the numbers of adaptations to existing homes

  Papworth Trust Home Solutions offer specialist advice and support to repair, improve or adapt the homes of disabled and older people. Equipment Services at Southend–on-Sea Borough Council provide equipment, support and advice to help people live as independently as possible in their own home.

2.3 Fuel Poverty

Older people are particularly susceptible to the adverse health implications of fuel poverty. They often have to heat their homes for longer but are unable to do so due to low incomes.

There is now a new legal framework and indicator to monitor fuel poverty in England.

Households are considered to be fuel poor if:

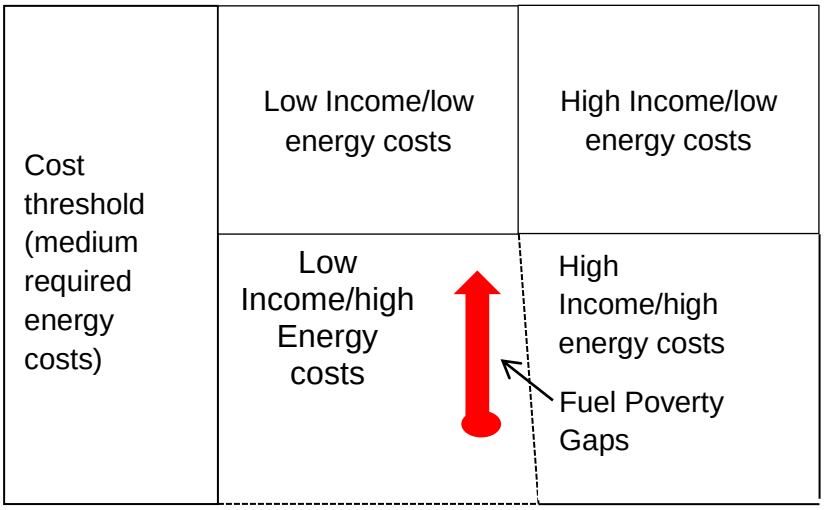
- they have required fuel costs that are above average (the national median level)

- were they to spend that amount, they would be left with a residual income below the official poverty line.

Under this indicator there are around 2.4 million households and 1.14 million older people in England living in fuel poverty [(7)].

Figure 1 provides an overview of the relationship between fuel poverty and household income.

Figure 1: Correlation between Household Income and Fuel Poverty



Source: Department for Energy and Climate 2013

In terms of fuel poverty, many older people fall within the low income/high energy cost quadrant set out in Figure 1.

The proportion of households which are fuel poor has fallen between 2003 and 2012. However, the average fuel poverty gap increased as a result of rising fuel prices [(8)].

Evidence has found older people on low incomes are reluctant to turn on heating, or to heat their homes for long enough to a level sufficient to maintain health and well-being.

The health implications of living in cold homes have been described earlier. To reduce their risk of adverse events during cold periods, the guidance is that older people should heat their homes to at least 18°C, and having temperatures above this threshold may be beneficial for health. Maintaining this temperature overnight is also recommended [(9)].

The Government has developed and promoted a number of schemes to address the issue of cold homes. These include:

- Grants and programmes to replace/renew boilers and heating systems and improve home insulation within vulnerable households
- Winter fuel payments to vulnerable households during cold spells to offset the cost of fuel bills

2.3.1 Local Action on Tackling Fuel Poverty

The Council directly assists through Council Tax benefit to nearly 6,500 pensioners. The Council has invested significant effort and resources to support people to better deal with housing related issues.

The Council also provides funding to install energy efficient condensing boilers into properties occupied by vulnerable tenants or homeowners and subsidises loft insulation.

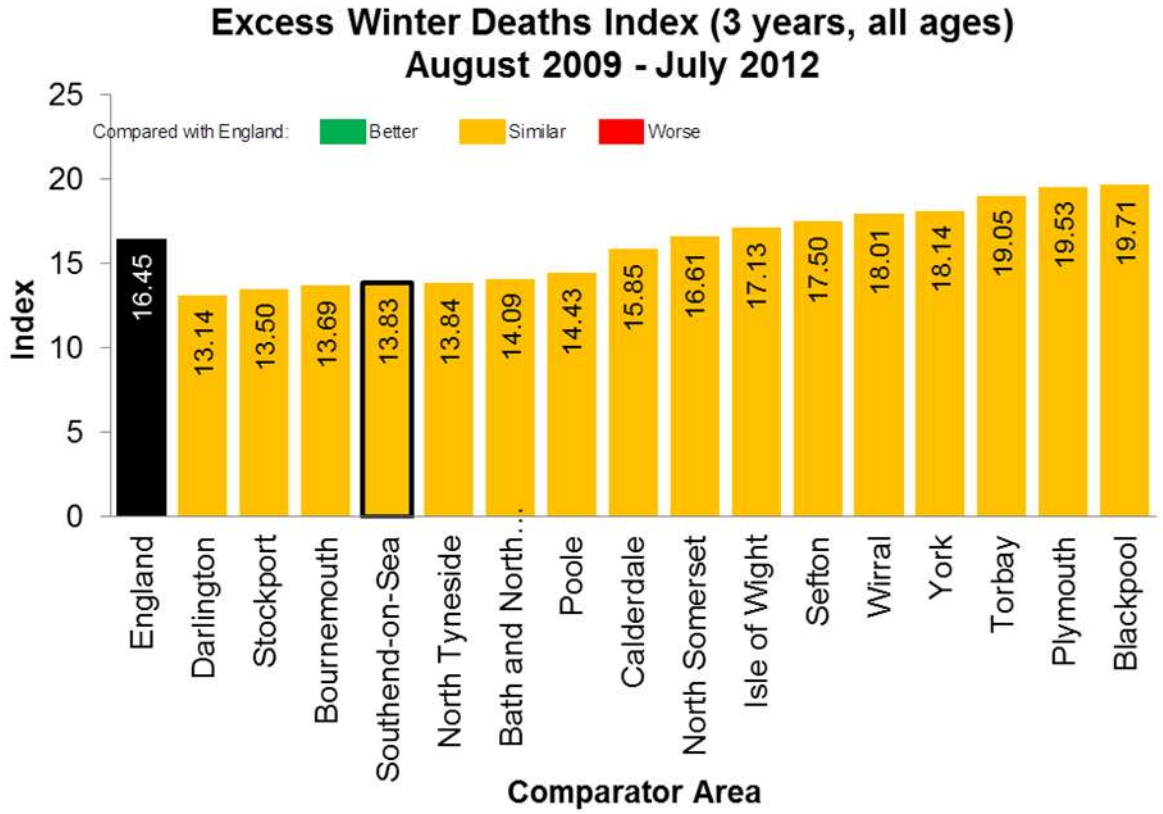
2.3.2 Excess Winter Deaths

Excess Winter Deaths (EWD) are defined as the difference between the number of extra deaths that occur in the winter months (December-March) compared to the average number of deaths in non-winter months (August-November and April-July).

In the winter of 2012/13, there were 31,000 'excess winter deaths' (EWD) in England and Wales, the majority of which occurred in people aged 65 and over [(10)]. The majority of deaths were from complications associated with cardiovascular disease (40%) and respiratory infections (33%).

In 2012, there were 80 more deaths in Southend-on-Sea (people of all ages) attributable to cold, than would normally be expected. This figure is not statistically different to that for England or other comparator local authorities. Figure 2 provides an overview of the Index of EWD during the period 2009 to 2012 for people of all ages (lower the index the better).

Figure 2: Excess Winter Deaths Index 2009 to 2012 Southend-on-Sea and Comparator Local Authorities (People–all ages)

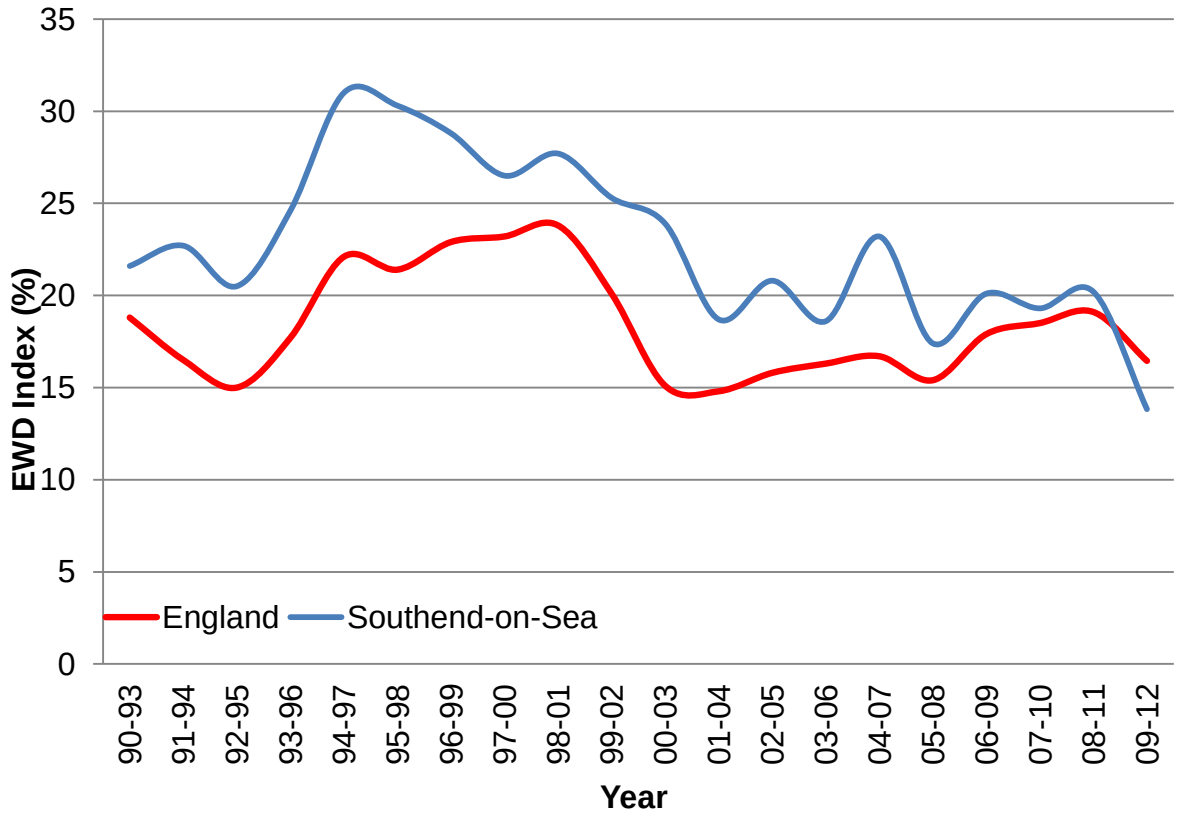


Source: Public Health England 2013

Figure 3 provides an overview of the Index of EWD in Southend-on-Sea compared to England, in the period 1990 to 2012.

It would appear that the gap between Southend-on-Sea and England in terms of EWDs has reduced. Local initiatives focussed on tackling fuel poverty and cold homes are likely to have played a part in this reduction.

Figure 3: Excess Winter Deaths Index Southend-on-Sea compared to England 1990 to 2012



Source: Public Health England

The Government has developed a Cold Weather Plan for England to prevent avoidable harm to health, by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately [9].

The plan has 5 distinct action levels, to be taken by public sector, voluntary organisations and front line staff to reduce the risks to health from cold weather.

2.3.3 Local Action on Excess Winter Deaths

Local implementation of the Cold Weather Plan for England has been overseen by a group with representation from relevant departments across the Council. There is an agreed mechanism for cascading cold weather alerts within the Council and relevant partner organisations.

The Council has also been working in partnership with the local voluntary sector organisations and local housing charities on the 'Warm and Well' project. The partnership was successful in a joint application for funding from the Department of Health to address health inequality issues associated with EWD. Actions included:

- production of an advice booklet to assist local residents to deal with cold weather
- direct mailing of information and advice on staying well in cold weather to vulnerable households

- free home visits by trained volunteers to help people in vulnerable households decide on practical measures to take during the cold weather and to facilitate access to services and support

- introduction of self-heating food stock and blankets for distribution by homeless charities

- support to local church groups to set up additional night shelter provision in winter months

- targeted support and assistance for homeless rough sleepers

3.0 Healthy Ageing – Promoting Healthy Lifestyles

To ensure the health and well-being of the growing numbers and proportion of older people there needs to be greater focus on health promotion and disease prevention in old age.

The five main risk factors contributing to early death and reduced quality of life are [(11)]:

- smoking tobacco
- having high blood pressure
- being overweight or obese
- lack of physical activity
- excessive alcohol consumption

The evidence suggests that it is especially important to take action to address these risk factors in middle age i.e. from 40-60 years, as the lifestyle choices made at this time can have a marked impact on health in later years. For example by maintaining healthy weight, taking regular physical activity and by managing blood pressure and cholesterol from middle age onwards can reduce the risk of cardiovascular disease and cancer and can also reduce the risk of developing dementia by up to 20% [(12)].

As well as reducing risk of chronic disease, improving lifestyle also impacts on other aspects of health, general well-being and overall quality of life in old age [(13)].

Nationally and locally there has been considerable effort to address these risk factors through topic based strategies e.g. tobacco control, obesity and alcohol.

Screening for conditions more prevalent later in life is also an important approach to staying physically healthy, and there are national screening programmes for breast cancer, bowel cancer and abdominal aortic aneurysm.

3.1 Smoking

Smoking remains the single greatest preventable cause of ill health, premature death and health inequalities. Smoking accounts for one third of all deaths from respiratory disease and over one quarter of all deaths from cancer and about one seventh of deaths from heart disease [(14)]. On average a smoker loses 10 years of life as a result of their habit [(15)].

Smoking reduces the general health and quality of life of those who continue to smoke. It is associated with over 50 different diseases and conditions and is responsible for many chronic disease conditions that affect older people, including: respiratory disease, coronary heart disease and stroke, lung and other cancers, eye disease (macular degeneration), osteoporosis and increased risk of fractures.

Smoking prevalence has been declining nationally and locally due to a range of interventions such as:

- legislation on smoke free places
- free NHS Stop Smoking Services
- widely available and effective medication
- health warning labels on cigarette packaging
- national and local campaigns and social marketing

However, there is still more work to do on tobacco control. The latest published data in the local tobacco control profile estimates the adult smoking prevalence in Southend-on-Sea is 22.0% which is significantly worse than the England average of 19.5%[16]. Smoking rates decline with age, mainly due to more deaths and illness in smokers resulting in fewer older smokers being left alive.

As people age they are more likely to attempt to stop smoking and be more likely to quit. It is never too late for older people to stop smoking and gain health benefits. Quitting reduces the risk of serious illness and if a person already has a smoking related disease, stopping can slow the progression of the disease. Long-term smokers who quit before the age of 50 will halve their risk of dying from smoking related illness [15]. Even quitting at the age of 60 will add on average three years to the ex-smoker's life [15].

3.1.1 Local Action on Smoking

Southend-on-Sea Borough Council hosts the Specialist Stop Smoking Service and commissions local GP practices and community pharmacies to provide a smoking cessation service. In 2013, a total of 2,818 people in Southend-on-Sea set a quit date using NHS Stop Smoking Services. Of these 458 were 60 years of age or over and 52.8% successfully quit. This compares to 46.3% of the total population achieving a successful quit.

The Specialist Stop Smoking Service also offers support to people attending outpatient departments, which increases access to the service by older people as they make up a significant proportion of hospital outpatient attendances.

3.2 Physical Activity

The most substantial body of evidence for achieving healthy active ageing relates to the beneficial effects of regular exercise. Increased physical activity is associated with a reduced incidence of coronary heart disease, hypertension, type 2 diabetes, colon cancer, depression and anxiety. In addition, increased physical activity increases bone mineral content and reduces the risk of osteoporotic fractures. It also plays an important role in helping to maintain a healthy body weight [17].

The latest national physical activity guidelines were published in 2011 by the four UK Chief Medical Officers, and include specific physical activity guidelines for those aged 65 and over [18]. The key messages are:

- older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
- older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- for those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
- older adults should also undertake physical activity to improve muscle strength on at least two days a week.
- older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
- all older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

In later life, physical activity occurs in many forms including active transportation, (such as walking to the shops), group based activities, (such as dance and movement classes, tai chi) and activities of daily living (such as climbing stairs, gardening and household activities). Regular walking is the predominant activity undertaken by older adults.

Despite the well-recognised health benefits of physical activity, fewer than 20% of men and women aged 65-74 achieve the recommended levels of physical activity of 30 minutes of activity five times per week. This reduces even further to an average of 7% of men and women aged 75 or older [19].

3.2.1 Local Action on Physical Activity

Whilst all programmes for increasing physical activity are largely accessible for independent older people, there are a number of specific programmes such as the Exercise Referral Scheme that provides one to one structured specialist support for those with long term conditions. There are also rehabilitation classes for those patients with cardiac and respiratory health problems. A programme of health walks which are led by trained volunteer walk leaders and a range of physical activity opportunities specifically designed for adults 50+.

3.3 Healthy Eating and Obesity

Nutrition plays an important role in healthy ageing. It is estimated that around 70,000 avoidable deaths in the UK are caused by diets that do not match current guidelines [20]. Increasing the consumption of fruit and vegetables to at least five portions a day can significantly reduce the risk of many chronic diseases.

General population guidelines for fat, carbohydrate and fibre are the same for older people. However, low dietary intake is common among healthy older adults and

factors such as reduced sense of taste and smell, difficulties in chewing because of poor fitting dentures and oral health problems may also limit food intake [21].

What people eat can change over time. An older person's ability to engage in healthy eating is also influenced by the social environment, including factors such as marital status and social isolation and these can affect men and women differently [22].

Malnutrition is defined as 'a state of nutrition in which a deficiency, excess or imbalance of energy, protein, and other nutrients causes measurable adverse effects on tissue and body form (body shape, size, and composition), body function and clinical outcomes'[23]. Research suggests that nationally 1 in 10 people aged over 65 years are malnourished or at risk of malnutrition, which increases their vulnerability to disease.

There are multiple risk factors for malnutrition, including:

- Poverty - leading to inability to access and afford good food
- Mobility - poor mobility, disability, poor transport links, difficulty accessing local shops
- Functional constraints – inability to prepare food, poor dental health, difficulty using food containers
- Psychological – social isolation, dementia, depression, bereavement

To tackle these multiple factors, front line health and social care professionals and individuals in regular contact with older people need to review access to good nutrition against the social context of the individuals. Other actions to address these issues include:

- specific training on malnutrition within the health and social care sector
- use of an approved nutritional screening tool for those outside the NHS
- consideration of food access as part of local planning applications
- support for older people to access good food either through assisted shopping or food brought to the house.

Overweight and obesity is generally caused by eating too much and moving too little**.** The numbers of people who are overweight or obese have increased dramatically in all age groups over the last two decades. Overweight and obesity are most commonly assessed through the Body Mass index (BMI). This is calculated by dividing a person's weight in kilograms by their height in metres squared (kg/m^2)

An individual is considered to be 'overweight' if their BMI is greater than 25 and less than 30 and obese if 30 and over.

As well as reducing life expectancy by 8-10 years, obesity is associated with an increased risk of many serious diseases including heart disease and stroke, Type 2 diabetes, hypertension, musculoskeletal issues and some cancers (breast and bowel).

Data from the Health Survey for England identifies that the proportion of people who are overweight or obese tends to increase with age. For men aged 65-74, 50% are overweight and 30% are obese; for women aged 65-74 these figures are 38% and 32% respectively. For men aged 75 and over, 28% are obese and 45% are

overweight, the levels of overweight and obesity in women aged 75 and over remain stable at 38% and 32% respectively [24].

3.3.1 Local Action on Healthy Eating and Obesity

The topic of healthy eating and obesity was discussed in detail in the 2013 Annual Public Health Report for Southend-on-Sea. In summary the local initiatives that older people can access to help them to lose weight and maintain a healthy weight include exercise referral, health trainers and weight management services including Slimming World, Active Life and More Life.

3.4 Alcohol

Although the average consumption of alcohol tends to decrease with age, there is evidence that the proportion of older people drinking more than the recommended amount is rising [25].

It is estimated that in two thirds of older drinkers their habit is long standing, with one third developing in later life. Key factors predisposing to late-onset alcohol misuse include:

- Emotional and social factors: bereavement, retirement, long-term caring role
- Health: chronic illness and pain, depression and cognitive impairment
- Practical: financial concerns, moving into residential care

Problem drinking is defined as drinking above the recommended medical guidelines [26] which currently state that:

- Men should not regularly drink more than 3 to 4 units of alcohol a day.
- Women should not regularly drink more than 2 to 3 units of alcohol a day. *'Regularly' means drinking these amounts every day or most days of the week*.

However, older people tend to have higher blood alcohol levels than younger people on drinking the same amount of alcohol. This is due to a fall in the ratio of body water to fat, decreased blood flow through the liver and inefficiency of liver enzymes associated with ageing. Recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week for both men and women [25].

Alcohol misuse in older people can be linked to, or exacerbate, a number of physical, mental, social and practical problems such as:

- cardiovascular disease and stroke
- liver and kidney problems
- memory problems
- depression
- social isolation
- falls
- incontinence

Alcohol problems in older people are often over-looked and undertreated. This is due to a number of factors including reluctance of older patients and their relatives to

accurately disclose their alcohol intake. Family members and health professionals may regard the presenting issues, such as falls and confusion to be merely signs of ageing.

Appropriate screening tools can be useful in identifying alcohol problems in older people [27]. In addition it is suggested that health and social workers should:

- know what life changes and physical signs/symptoms are associated with problem alcohol use in older people
- have a basic understanding of which medical conditions and medications may lead to adverse reactions with alcohol
- be able to screen and discuss alcohol use with older people tactfully and sensitively
- be able to collect and interpret information on alcohol use (frequency and quantity), drinking consequences and everyday functioning
- be able to deliver brief advice tailored to meet the needs of the individual
- develop links with alcohol services and know when and where to refer older people who require specialist treatment

There is evidence that older people engage better with treatment services and that late onset drinkers respond particularly well.

3.4.1 Local Action on Alcohol in Older People

The Drug and Alcohol Commissioning Team commissions a community drug and alcohol services for all age groups. This service is provided jointly by CRI and South Essex Partnership NHS Foundation Trust. This includes a prescribing service and residential detoxification and rehabilitation when required. In 2013/14, only 12 individuals aged 65 or over accessed treatment for alcohol as their primary substance, one other individual accessed treatment for another substance but reported alcohol as a secondary problem.

The NHS Health Check now incorporates questions about alcohol intake, which provides the opportunity for health professionals to engage with older people about their drinking habit. Making Every Contact Count (MECC) training also teaches front line staff to ask about alcohol consumption and identify those where the level is sufficiently high to cause concern. In both the NHS Health Check and MECC, the delivery of an alcohol ‘brief intervention’ provides information and advice to the patient to consider their drinking behaviour and signposting to services if they decide to cut down.

4.0 Screening

Alongside leading a healthy lifestyle, participation in screening is an important aspect of maintaining older people’s health. There are national screening programmes for breast cancer, bowel cancer and abdominal aortic aneurysm

4.1 The Breast Cancer Screening Programme

The incidence of breast cancer increases with age, with eighty percent of cases occurring in postmenopausal women. It is the 2nd most common cause of cancer

death among women in the UK, accounting for 15% of female deaths from cancer. [28]

The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50-70 and over using mammography. A mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor. Women aged over 70 may also self-refer to the programme. From 2010, the Breast Screening programme began phasing in an extension of the age range of women eligible for breast screening to those aged 47 to 73, this is due to be completed by 2016.

The South Essex Breast Screening Service which covers Southend-on-Sea is provided by Southend University Hospital NHS Foundation Trust. This service has a static unit as well as three mobile units which are sited in different areas of the district during the screening round.

The latest figures for breast screening coverage (proportion of eligible women who have had a screening mammogram in the last 3 years) for eligible women in South East Essex (including Southend) was 73%, which is lower than the England average. There has been ongoing work with the breast screening service and their commissioner to increase coverage.

4.2 The Bowel Cancer Screening Programme

About one in 20 people in the UK will develop bowel cancer during their lifetime and it is the third most common cancer in the UK [28]; 95% of bowel cancer cases occur in people aged 50 and over.

Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. Bowel cancer screening can also detect pre-cancerous polyps which may become malignant over time. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

Polyps and bowel cancers sometimes bleed and the bowel cancer screening programme uses the faecal occult blood test (FOBT) which detects tiny amounts of blood which cannot normally be seen in bowel motions. The FOBT test does not diagnose cancer, but the results indicate whether further investigation (usually a colonoscopy to directly visualise the large bowel) is needed.

Bowel cancer screening is offered to men and women aged between 60 and 74. They receive an invitation in the post followed by a screening test kit. Those with an abnormal result are offered an initial appointment to discuss the result and decide on the next steps. This is followed by a colonoscopy at the local screening centre if required.

Average screening test uptake for Southend-on-Sea in 2013/14 was 53.9%, which is lower than the national standard (55.8%). The Programme is preparing a health promotion plan to target wards with low uptake.

4.3 Abdominal Aortic Aneurysm Screening (AAA)

Abdominal aortic aneurysms are formed when the major blood vessel (the aorta) in the body weakens and expands. Large abdominal aortic aneurysms can be very dangerous because they can rupture – if this occurs the outcome is very likely to be fatal.

Men are six times more likely to have this type of aneurysm than women. The chance of having an aneurysm increases with age. The risk also increases if a person:

- smokes
- has high blood pressure
- has a brother, sister or parent that has, or has had, an abdominal aortic aneurysm.

Around 5,000 people, mostly men aged 65 and over, die every year from ruptured AAA. The screening programme should eventually prevent up to half of these deaths through early detection, appropriate monitoring and treatment, usually surgery.

All men in England whose 65th birthday falls on or after 1 April 2013 will automatically be invited for screening. Older men who have not previously been screened can arrange an appointment by contacting their local screening service.

5.0 Recommendations:

- Raise awareness of frontline health and social care staff of the importance of wider determinants on the health of older people to facilitate early intervention and referral to appropriate services for help and support claiming welfare and housing benefits.

- Raise awareness of the link between poor housing and poor health so that older people are referred to appropriate housing services in Southend-on-Sea.

- Promote partnership working on the identification of hazards within the homes of older people.

- Undertake an annual ‘Keep Warm Keep Well’ social marketing campaign to inform individuals, families and carers on how to protect themselves from the cold.

- Build the capacity and capability of staff in the NHS and partner agencies to provide brief interventions to tackle smoking and alcohol misuse as well as to promote healthy eating and physical activity.

- NHS England needs to provide comprehensive and timely information on the uptake of screening and immunisation programmes to the Council to enable more effective monitoring of this aspect of health protection.

Chapter 7 Dementia

1.0 Introduction

Dementia is one of the major health and social care issues of our time. Around 815,827 people in the UK have dementia and this number is set to increase by 40% in the next 12 years and 157% in the next 38 years [(1)].

The total cost of dementia to society in the UK is £26.3 billion. It is estimated that one in three people will care for a person with dementia in their lifetime.

Currently only 48% of people with dementia in England have a formal diagnosis or have contact with specialist services.

In recognition of the severe detrimental health and financial impacts of dementia on the UK population, the Department of Health published "Living Well with Dementia" a National Dementia Strategy in February 2009 [(2)].

The key principles of the national dementia strategy are:

- Improved public and professional awareness of dementia
- Earlier diagnosis and intervention
- High quality care for people with dementia and their carers from diagnosis to end of life

There have been a number of updates to the national dementia strategy since 2009, highlighting progress in identifying and assessing people with dementia as well as a reduction in the prescribing of antipsychotic medication [(3)]. However, there are still challenges in supporting people with dementia to feel part of their community and making it easier for them to access services. There are also concerns that society in general needs to adapt to deal with the growing number of people with dementia.

In 2012, the Prime Minister issued a '*Dementia Challenge'* that re-affirmed the strategic importance of the National Dementia Strategy [(4)]. This requires the health and social care sector to do more to make a real difference to the lives of people with dementia, their families and carers.

In 2013, NHS England set the first ever national ambition to improve dementia diagnosis rates by requiring commissioners and providers to ensure that by 2015, "two-thirds of people (with dementia) should have a diagnosis, with appropriate post diagnosis support".

2.0 What is dementia?

Dementia is a term used to describe a collection of symptoms. These include memory loss, mood changes and problems with communication and reasoning, and a gradual loss of skills needed to carry out daily activities.

Dementia can affect people of any age, but is more common in people aged over 65, and prevalence roughly doubles from this age onwards. This is highlighted in Table 1.

Table 1. Estimated percentage of UK population with dementia by age and gender

Age Group	Females (%)	Males (%)	Overall Prevalence of Dementia In Population (males + females) (%)
60-64	(0.9)	(0.9)	0.9
65-69	1.8	1.5	1.7
70-74	3.0	3.1	3.0
75-79	6.6	5.3	6.0
80-84	11.7	10.3	11.1
85-89	20.2	15.1	18.3
90-94	33	22.6	29.9
95 and over	44.2	28.8	41.1

Source:Knapp et al, 2014 (1)

Dementia is progressive, which means the symptoms will gradually get worse and the condition is currently incurable.

There are many diseases that result in dementia. The most common types of dementia are:

- Alzheimer's disease, which is the most common cause of dementia and accounts for around 62% of cases in England. Brain cells are surrounded by an abnormal protein resulting in their damage and loss.
- Vascular dementia. This results from damage or loss of brain cells due to a reduced or loss of oxygen supply to the brain because of narrowing or blockage of blood vessels. Vascular dementia accounts for around 17% of cases.
- Mixed dementia**,** this is when someone has more than one type of dementia, and a mixture of symptoms. These account for 10% of total cases.
- Dementia with Lewy bodies, this type of dementia accounts for around 4% of cases. It involves tiny abnormal structures (Lewy bodies) developing inside brain cells

The symptoms of these types of dementia are often different in the early stages but become more similar in the later stages as more of the brain becomes affected.

Dementia is commonly categorised into 2 major types:

- early onset dementia is thought to affect between 2 and 10% of people before the age of 65; and
- late onset dementia (onset after 65 years) affects the majority of people with the condition

People with Down's Syndrome have an increased genetic risk of developing dementia and for it to begin at an earlier age.

Although no data is currently available on incidence of dementia in different ethnic groups, it is likely that dementia will be more common among older people from Asian and Black Caribbean ethnic origin. This is because high blood pressure, diabetes, stroke and heart disease, which are risk factors for dementia, are more common in these communities [(5)].

3.0 Risk Factors and Prevention

Risk factors for developing dementia are well documented [6] [7]. Established risk factors that are (or are potentially) modifiable/preventable include:

- Hypertension
- Excessive alcohol consumption
- Smoking
- Obesity
- Diabetes
- High cholesterol

Up to 30% of dementia cases have a vascular component (i.e. vascular dementia or mixed dementia) and the effects of vascular dementia can be minimised or prevented altogether through a healthy lifestyle.

4.0 Diagnosis and Early Intervention

The timely diagnosis of dementia is very important. It is the key to helping people with dementia, their families and carers get the support they need, to plan for the future and to make informed choices about how they would like to be cared for.

More needs to be done to increase the number of people with dementia being properly diagnosed. Currently less than half of the estimated number of people with dementia in England receive a formal diagnosis or have contact with specialist dementia services. Whilst there has been a slight increase nationally in the diagnosis rate from 46% in 2011/12 to 48% in 2012/13, the diagnosis rate varies across the country from 39% in the worst performing areas to 75% in the best. In Southend-on-Sea this figure was 40.78% in 2012/13.

Currently around half of the people diagnosed with dementia are in the early stages of the condition. Early detection allows for more effective planning of a treatment regime using anti-dementia drugs.

General practitioners (GPs) play a vital role in not only timely diagnosis of dementia but also in ensuring that well planned and co-ordinated community services are in place to help the person once they have been diagnosed. Once a person is diagnosed with the condition, their details are recorded on a register held by their GP.

National initiatives to support an early diagnosis of dementia include:

- From April 2013, NHS Health Check practitioners have given attendees information about dementia, the signs and symptoms, risk factors and local services
- Supporting people to recognise the signs and symptoms of dementia. A nationwide campaign was launched in 2012 to raise dementia awareness by encouraging people to visit their doctor if they were worried or if they wanted more information, to visit NHS Choices
- Supporting GPs to identify people with dementia through the use of enhanced services in which GPs ask people in certain at risk groups about their memory,

for example, those with cardiovascular risk factors, people with long term neurological conditions and people with learning disabilities

5.0 Dementia Friendly Communities

People with dementia want to live in communities that give them choice and control over their lives and provide services and support designed around their needs. They also want to feel valued, understood and part of family and community life.

However, nearly half of UK adults acknowledge that public understanding of dementia is limited and 73 % of them do not believe society is geared up to deal with the condition [(8)].

In response to these challenges, the Alzheimer's Society set up the 'Dementia Friendly Communities' programme in 2013 [(9)]. This programme sets out criteria to be met by communities who wish to be recognised as working to become dementia friendly, such as involving people with dementia, raising awareness of dementia and setting achievable goals.

In addition to Dementia Friendly Communities, the Alzheimer's Society also launched the Dementia Friends initiative, to help to change how the public thinks and feels about dementia and understand how to help people with the condition.

Dementia Friends training allows people to have the confidence to engage with people who have dementia and provides them with the skills to interact in a way that is both useful and welcome. Dementia Friends is being implemented by a network of Dementia Friends Champions who deliver short information sessions through networks of friends, workplaces and communities. The ambition is to have one million Dementia Friends by 2015.

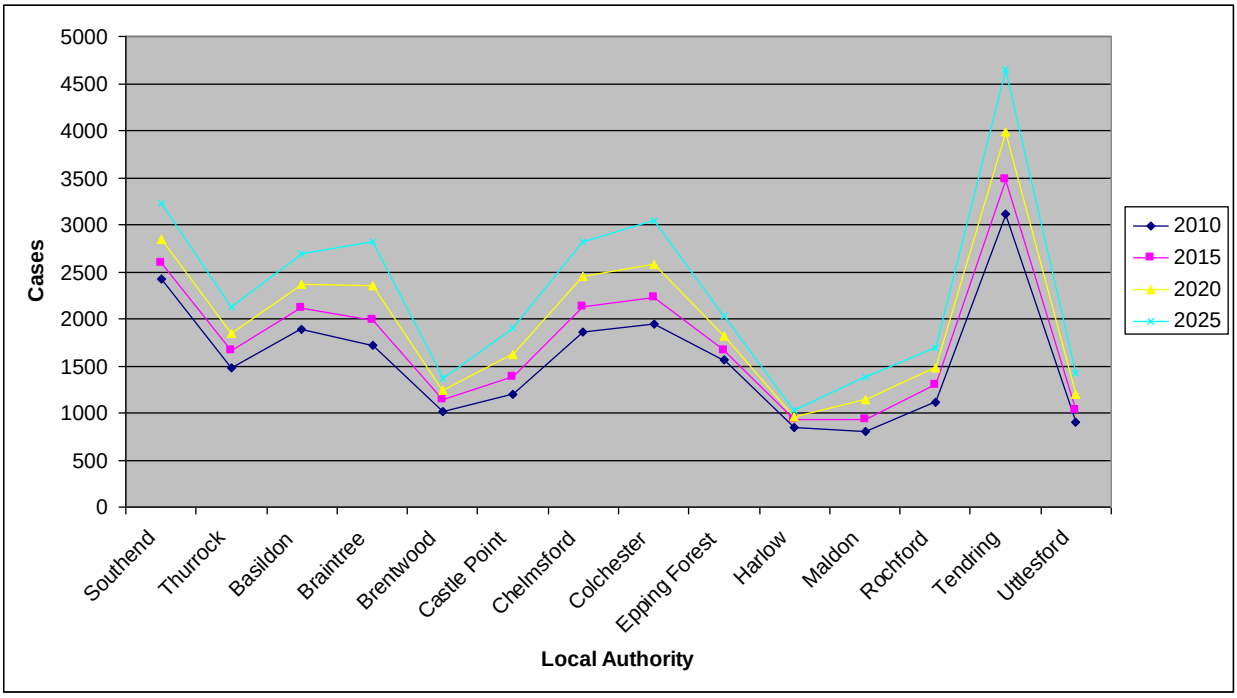
A national Dementia Action Alliance (DAA) was established in 2010, to act as a catalyst for national action and collaboration on dementia. Since its inception it has co-ordinated action on cross cutting issues affecting people with dementia and has ensured members have committed to action plans around improving the lives of people with dementia. Local dementia action alliances have the potential to be similarly transformative in their communities, bringing together organisations and individuals committed to taking action to support people with dementia and their carers.

6.0 Local Impact of Dementia

During 2012/13 there were 1139 people formally diagnosed with dementia listed on Southend-on-Sea GP registers. As national estimates suggest the prevalence of dementia in Southend-on-Sea should be in the region of 2622 persons, there are 1483 residents of Southend-on-Sea who are not currently on a disease register. The local impact of this could be that individuals with dementia, their carers/families, may not be accessing services or support to meet their needs. The Council is currently reviewing local population data related to dementia prevalence and will shortly publish an update on prevalence in the Southend-on-Sea Joint Strategic Needs Assessment.

Figure 1 shows the projected prevalence of dementia by local authority area.

Figure 1: Estimated prevalence of dementia by local authority 2010 to 2025

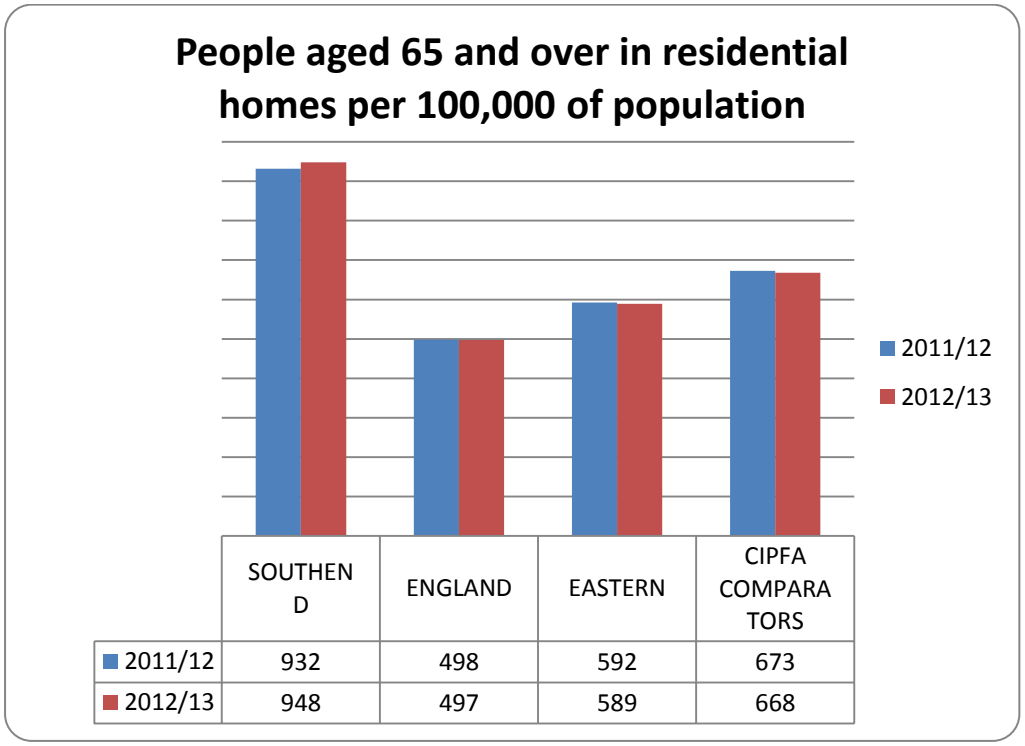


Source: NEPHO 2008

Southend-on-Sea Borough Council is second only to Tendring Council in terms of the projected number of cases of dementia within Essex local authorities. Both Southend-on-Sea and Tendring Councils have a large number of residential and nursing homes, which will have a bearing on the prevalence of dementia locally.

In 2012/13, there were nearly double the number of people aged 65 and over living in residential homes in Southend-on-Sea compared with England (948 Southend compared to 497 England per 100,000 people). This was 42% more than the Chartered Institute of Public Finance Accountants (CIPFA) comparators (Figure 2).

Figure 2: Number of People aged 65+ Living in Residential Care Homes (per 100,000 population)



	SOUTHEND	ENGLAND	EASTERN	CIPFA COMPARATORS
2011/12	932	498	592	673
2012/13	948	497	589	668

Source: Towards Excellence in Adult Social Care:

Southend-on-Sea Borough Council has developed a Southend specific dementia implementation plan linked to the Southend Essex and Thurrock Dementia Strategy.

Key outcomes arising from the plan include:

- Improved local access to memory clinics to assist with the early diagnosis of dementia.
- Improved GP engagement through awareness raising and improving knowledge of surgery staff plus regular 'dementia clinics' in GP surgeries
- A local 'dementia cafe' that enables carers and local people living with dementia, to come together and share experiences and build personal support networks
- A dementia garden that provides a creative outdoor space with proven therapeutic benefit for people in the community living with dementia and their carers (see Figure 3)
- Supporting self-care so that people are able to better manage and live well with the condition including a specific dementia advocacy service
- Improving awareness through rolling out the Dementia Friends programme and training all Council staff to be dementia friends
- Delivering better support and championing the needs of carers
- Social marketing and assertive outreach to target groups that may not traditionally identify with dementia, to encourage people to seek early diagnosis and live well with dementia

The Council has established a Local Dementia Action Alliance (DAA) to help speed the transformation of Southend-on-Sea into a dementia friendly community with a specific focus on training and facilitating earlier diagnosis. The DAA is in its infancy

with plans to recruit many more businesses and organisations into its fold. There is a planned launch for March 2015

Figure 3: The Southend-on-Sea Dementia Garden

7.0 Recommendations

- Promote lifestyle intervention and risk reduction for adults aged 40-64 years, with a specific focus on physical activity

- There should be a review of the future plans for older people's housing needs in Southend-on-Sea to identify alternatives to residential accommodation, for example extra care provision, particularly for older people with mild to moderate dementia diagnosis

Chapter 8: Long Term Conditions, Integrated Care and Services

1.0 Introduction

Effective management of long term conditions represents a major challenge for health and social care systems. It has been suggested that long term conditions represent the "healthcare equivalent to climate change" and that to effectively manage the impact of long term conditions requires a “major rethink”, and a “step change in culture and practice”.

A long term condition (LTC) or ‘chronic’ condition is a health problem “that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies” [(1)]. There is no definitive list of LTCs and the term can refer to a wide range of conditions including musculo-skeletal conditions, diabetes, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), hypertension and arthritis.

2.0 Scale of problem – national

Currently it is estimated that 15.4 million people in England (over a quarter of the population) have a long term condition [(2)]. This figure is predicted to increase by *over 20%* to 18 million by 2025 [(2)]. Some of this increase may be attributed to improved and earlier diagnosis, but in the main it relates to an ageing population, to the impact of wider health determinants such as deprivation, lifestyle, changes in the ethnic mix of the population, and to an increase in survival of previous fatal events e.g. stroke, myocardial infarction.

By 2025, it is estimated that there will be 42% more people in England aged 65 or over [(3)]. Services will be put under increasing pressure by this growing population, and will need to radically change if they are to meet their clients’ needs effectively. There will also be increased pressure on informal carers, many of whom are older and in poor health themselves.

Long-term conditions are more prevalent in older people. Approximately 14% of people under 40 have an LTC, compared with 58% of people aged over 60 [(1)].

Long-term conditions are also more prevalent in more deprived groups. People in the poorest social class have a 60% higher prevalence than those in the richest social class. Disease occurs 10 to 15 years earlier in people living in more deprived areas than amongst those living in affluent areas.

In addition, an increasing number of people have what is termed ‘multimorbidity’ i.e. two or more conditions, which makes the delivery of their care more complex [(4)]. They may need to see several health professionals to manage their conditions, and to use several medications and therapies.

Some combinations of conditions are more common than others; in particular physical and mental health co-morbidity is very common. Many people with physical long-term conditions also experience mental health problems such as anxiety and depression. People with mental health problems are more likely to have poor physical health. In addition, many older people with physical long term conditions may also have dementia [(5)].

A retrospective study in general practice indicated that more than half of the patients attending primary care in England have multiple LTCs , and one in two (50%) individuals over 65 years of age in England have at least three; one in five (20%) of them have five or more [5].

As they have such complex needs, people with long term conditions are the most intensive users of health and social care services:

- 50% of all GP appointments
- 64% of outpatient appointments
- 70% of all inpatient bed days
- In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs
- This means that 30% of the population account for 70% of the spend [3]

2.1 The scale of the problem – local

The prevalence of long term conditions can be derived from a number of sources. A key source of information that can be used to assess local prevalence is the Quality and Outcomes Framework (QOF). This is a major part of the General Practice (GP) contract to secure better health outcomes by early, systematic and sustained monitoring and treatment of people with risk factors and long term conditions.

Data on various health conditions is collected from specific GP disease registers and entered onto a national IT system, known as QMAS. The number of people on GP disease registers in Southend-on-Sea is shown in Table 1.

Table 1. Number of people on GP disease registers in Southend-on-Sea with a long term condition in 2012/13

Condition	Number of people on disease register	Southend CCG prevalence (%)
Coronary Heart Disease (CHD)	6190	3.4
Heart Failure	1541	0.8
Stroke	3071	1.7
Hypertension	28,077	15.2
Diabetes	8,812	5.9
Chronic Obstructive Pulmonary Disease (COPD)	3,399	1.8
Asthma	11,084	6.0
Depression	7799	n/a
Chronic Kidney Disease (CKD)	5,592	3.8
Atrial Fibrillation (AF)	2,881	1.6

Source: Quality Management and Analysis System (QMAS)

3.0 Living Well for Longer

As with all complex health issues there is no simple solution to the challenge of long-term conditions, but there is a growing consensus that better outcomes can be achieved by a whole system approach with a combination of:

- "upstream action" to reduce risk factors such as smoking, high blood pressure, physical inactivity, poor diet, obesity, poor mental health and alcohol
- improved access to preventative health care and to early diagnosis
- a shift from "giving care" to a system of self-management, re-ablement and independence
- development of an integrated model of care delivery

The new public health, health and social care system was established in 2013, with a focus on improving outcomes. In the same year, the Secretary of State for Health set out a challenge for the public health, health and social care system in his document, *Living Well for Longer: A Call to Action to Reduce Avoidable Premature Mortality*. The challenge was:

- to reduce the rate of premature avoidable deaths
- to improve quality of life by prevention, early diagnosis and treatment [(6)]

The Government has given local authorities new statutory duties to improve public health with protected resources through a ring-fenced budget. The local authority and its partners on the Southend-on-Sea Health and Well-being Board have assessed need and agreed priorities for action; these are set out in a series of ambitions in its Health and Well-being Strategy.

The new responsibilities for local authorities are complemented by a shift in focus in the NHS from treating ill-health to improving health through prevention and early intervention. Southend CCG has developed a 5-year system plan on how this will be achieved by investing in community and primary care services and moving from reactive to proactive disease management.

3.1 Lifestyle choices, risk factors and risk reduction

Most long-term conditions are described as 'multifactorial' i.e. they do not have a single cause, but result from a complex interplay of genetic, environmental and lifestyle factors across the life-course.

Research has identified many of the factors that significantly increase the risk of long-term condition. There is a strong link between risk factors which are unhealthy behaviours such as smoking, inactivity, poor diet, and alcohol intake, and some of the most prevalent and disabling LTCs :

- vascular disease such as heart disease, diabetes, chronic kidney disease
- some cancers e.g. lung and bowel
- respiratory disease such as chronic obstructive pulmonary disease (COPD)

There is also evidence that some of these risk factors are preventable and also 'modifiable'. By modifying behaviour i.e. making changes in lifestyle, or by active

management with drug treatment or other therapies, some LTCs may be prevented or their impact on health reduced [7] [8].

As well as reducing risk of chronic disease, improving lifestyle can also impact on other aspects of health in old age improving functional ability, mobility, general well-being and overall quality of life [9].

3.2 Clustering of unhealthy behaviours

The prevailing delivery model for lifestyle interventions has been to commission and provide single specialist services. However, there is evidence that this may no longer be fit for purpose, as most people have multiple rather than single unhealthy behaviours. [10] About 70% of adults have two or more of the main unhealthy behaviours i.e. smoking, poor diet, obesity, drinking at a harmful or hazardous level. [11]

This means that the services are often targeting the same people, and that clients, particularly those with complex needs, must be referred or self-refer to different programmes, often in different locations. It is also more difficult for these topic based services to be delivered holistically, and take account of the psychosocial, environmental, and other wider determinants of health. For example, a person's continued smoking behaviour or use of alcohol may be related to their debt or housing issues, to mental health problems or to unemployment. Professionals and the public find it difficult to 'navigate' their way around the various services.

3.3 Improving Health and Well-being - Holistic approaches

The England strategy for public health, *Healthy Lives, Healthy People*, emphasises the importance of promoting well-being and tackling both physical and mental health as part of healthy lifestyles [12].

A joint briefing issued by the Faculty of Public Health and the NHS Confederation echoed this holistic approach, stating:

> ***"Wellness services provide support to people to lead healthy lives. The wellness approach goes beyond looking at single-issue, healthy lifestyle services and a focus on illness, and instead aims to take a whole person and community approach to improving health*** [13]".

The transfer of public health to the local authority provides the opportunity to take this broader approach to well-being and to integrate public health approaches across local government departments (such as transport, leisure, culture, housing, learning) and with NHS, third sector and business communities.

The Department of Health views the Public Health role of local government as:

> ***"tailoring services to individual needs based on holistic approach, focusing on wellness services that address multiple needs, rather than commissioning a plethora of single issue services, and using new technologies to develop services that are easier and more convenient to use***[14]. "

3.4 Local initiatives

A key approach to encouraging and helping people adopt healthier lifestyles is the promotion of Making Every Contact Count (MECC). This is a large scale behaviour change programme using the contacts that people have with frontline staff to deliver brief lifestyle interventions and then signpost people to the services that can help them change. The NHS Future Forum made the recommendation that every healthcare organisation should deliver MECC and "build the prevention of poor health and the promotion of healthy living into their day to day business [(14)]".

Southend Adult Community College has been commissioned to provide training to frontline staff across public, private and third sector organisations to build their knowledge about lifestyle issues, and their confidence in discussing health issues.

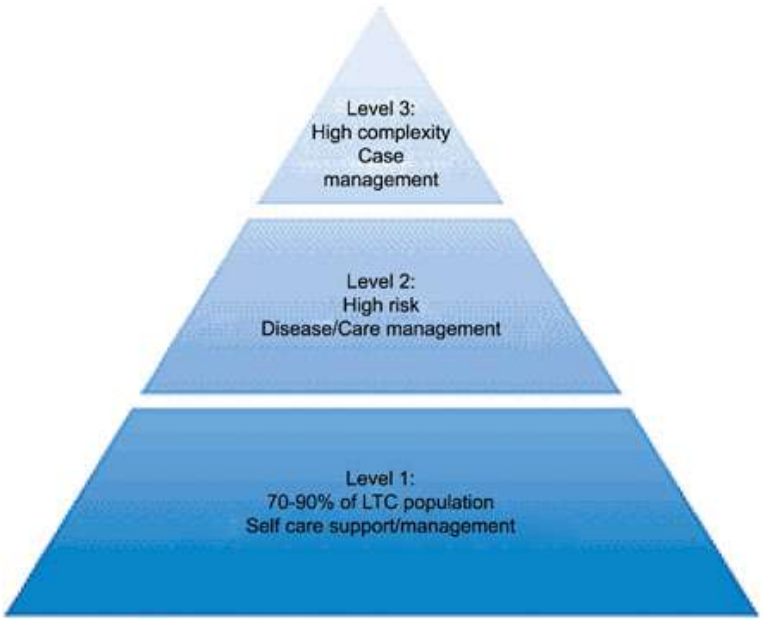
The Public Health department is working with partners to develop an integrated healthy lifestyles service for Southend residents. The service will offer:

- information and signposting for those who wish to self-help or self-manage
- face to face assessment to identify health issues and any associated social issues
- tailored support

4.0 Risk prediction and stratification

There is a strong evidence base for what works to improve outcomes in people with LTCs and this has been developed into a generic model to assist:
clinicians in planning care, commissioners planning services, and local health and social care partnerships in identifying levels of need in the population [(5)].

Figure 1: The NHS and Social Care Long-Term Conditions Model



Source: Department of Health

The model stratifies the population using a risk prediction approach to help commissioners quantify levels of need and then design services to provide appropriate levels of care and support. Figure 1 shows that approximately 5% of

people in a population have complex needs, around 25% have a moderate level of need and around 70% have a low level of need.

Building on this approach it is important to identify individuals in the population that have complex needs, as this group will be at particular risk of acute episodes of illness and will be more likely to require higher levels of primary or community care contact and/or hospital admission. Proactive and anticipatory strategies can be put in place for these individuals to help them retain their independence and avoid hospital admission and if a period in hospital is needed, to ensure timely rehabilitation and re-ablement after a period of illness.

Similarly identifying and engaging with those people with long-term conditions who have moderate or low levels of need, gives the opportunity to promote prevention services, self-management and self-care skills, national and local support groups and access to high quality information on their long term condition.

4.1 Early diagnosis and early intervention

Identifying risk factors and diagnosing LTCs at an early stage allows appropriate lifestyle advice, treatment and management to be provided to slow disease progression, minimise the long-term impact of the condition and improve health outcomes.

4.1.1 NHS Health Check

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease, and certain types of dementia. Everyone between the ages of 40-74, who has not already been diagnosed with one of these conditions or has certain risk factors, are invited (once every five years) to have a check to assess their risk of vascular disease and are then given support and advice to help them reduce or manage that risk. Fully implemented the programme is expected each year to detect 20,000 cases of diabetes and kidney disease early [15].

4.1.2 Blood Pressure Programme

High blood pressure affects around 30% of adults in England - over five million are undiagnosed, and around 40% of those in treatment are not well ‘controlled’ i.e. <140/90mmHg. A new area of work being developed by Public Health England is a Blood Pressure Programme with a systematic approach to preventing, detecting and better managing hypertension [16].

5.0 Care delivery

The good physician treats the disease. The great physician treats the patient who has the disease.

William Osler

5.1 House of Care

NHS England have summarised the main barriers to developing improved care for people with LTCs as:

- services dealing with single conditions
- care fragmented and not coordinated
- lack of emotional and psychological support
- lack of continuity with care records
- services are reactive to deterioration/complications of a LTC rather than identifying and planning for these to avoid hospital admission
- services not working in partnership with patient and encouraging self-management

NHS England have supported the development of a model called the 'house of care' (Figure 2) to help plan services for people with LTCs [17]. The model represents a 'whole system approach' to long term condition management, and provides a framework to help construct services. The house framework is based on three themes:

- **foundations -** commissioning for outcomes with high quality care based on science and evidence
- **roof -** guidelines and standards to support care
- **pillars -** care to be collaborative person-centred and, to include support for individuals to self-manage

Figure 2: The House of Care

Alongside this new model there are a number of national interventions and tools to support local health and social care commissioners improve holistic provision for people with LTCs. These address the key national drivers for change: patients to have more control over their care and the personalisation agenda, the move from care in acute settings to community, and the financial pressures on the health and social care sectors.

These interventions and tools include: risk stratification and development of pathways, care coordination and integration, care planning, use of new technology, self-management and support for carers.

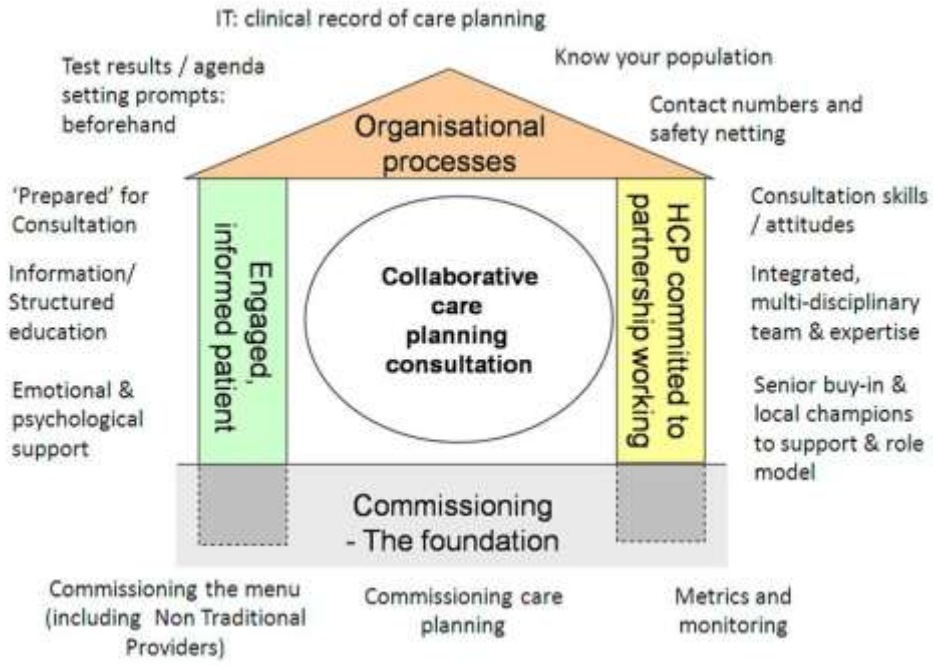
5.2 Care Planning and Integrated Care

Southend-on-Sea is a Year of Care early implementer and an Integrated Health and Social Care Pioneer.

Care planning has become a key feature of national and local policy for people with LTCs. A named health professional works collaboratively with the person with a LTC to agree a personalised package of care for their condition(s). Care planning is complex. The Year of Care programme was introduced in 2010 to look at the practical issues of procuring the tailored and personalised support the care planning approach required for people with diabetes and used the House of Care model [18].

Figure 3 illustrates the core features of the house surrounded by the details Southend and the other pilot sites identified as important in practice for the management of diabetes.

Figure 3: The House of Care Planning Model for Year of Care Pilot Sites



As an integrated health and social care pioneer site, Southend on Sea must demonstrate the “use of ambitious and innovative approaches to deliver person-centred, coordinated care and support”. Southend-on-Sea Borough Council and Southend CCG have taken the first steps towards a fully integrated commissioning service.

5.3 Technology

There is increasing interest in using assistive technology to help provide care and support for older people and those with LTCs.

Telehealth is the use of electronic equipment to help monitor a person's vital signs (e.g. pulse, blood pressure, and breathing); telecare is the use of electronic equipment to support independent living (e.g. personal alarms, motion sensors).

The Department of Health has estimated that at least three million people with long-term conditions could benefit from telehealth and telecare. The DH funded a randomised control trial of telehealth and telecare focused on three conditions: diabetes, COPD and coronary heart disease. The trial showed that if used well across a whole system, technology can reduce the need for hospital admissions for people with LTCs, and the amount of time they spend in A&E [(19)].

5.4 Frail Elderly People and the Frailty Integrated Care Pathway

A recent development in care of older people has been the defining of and greater understanding of frailty as a clinical condition. The term frailty is used to identify a group of older people who as a result of ageing and long-term conditions are at high risk of hospital admission or of adverse events such as falls. Age-related decline in multiple body systems alongside LTCs means there is a group of older people who can have sudden deterioration in their health from apparently small changes e.g. infections, change in medication, or change in environment.

NHS England has published guidance "*Safe, compassionate care for frail older people using an integrated care pathway"* for commissioners on identifying frail older people and providing their care and support. [(20)].

Locally work on tackling frailty is being taken forward through the integrated health and social care pioneer programme. A new frailty strategy is being developed and commissioning strategies aligned to take account of local need. This new strategy focuses on assessing and supporting frail older people and ensuring they receive re-ablement and extra care services that meet their needs. This strategy will also take account of specific issues such as supporting people with dementia and end of life care.

6.0 Preventing Falls and Fractures

Falls and fall-related injuries are a common and serious problem for older people. More than 33% of people aged over 65 and more than 40% of people aged over 75 will fall at least once a year [(21)], 60% of people living in residential homes will fall repeatedly [(22)]. Around 10% of falls results in serious injuries such as head injury and hip fractures, and half of those who suffer a hip fracture never regain their former level of function, with 1 in 5 dying within three months of the event [(23)].

Older people who survive a fall often experience an increased fear of falling which may lead to social isolation and poor physical and mental health, loss of independence and higher rates of institutionalisation.

Falls and fractures in people aged 65 and over account for over 4 million hospital bed days each year in England [(24)]. The cost of treating and supporting a person who has sustained a hip fracture, ranges from £11,700 to the NHS and over £3,800 for social care costs. The estimated combined health and social care costs for a single hip fracture, amount to in excess of £28,000 over a 2 year period [(24)].

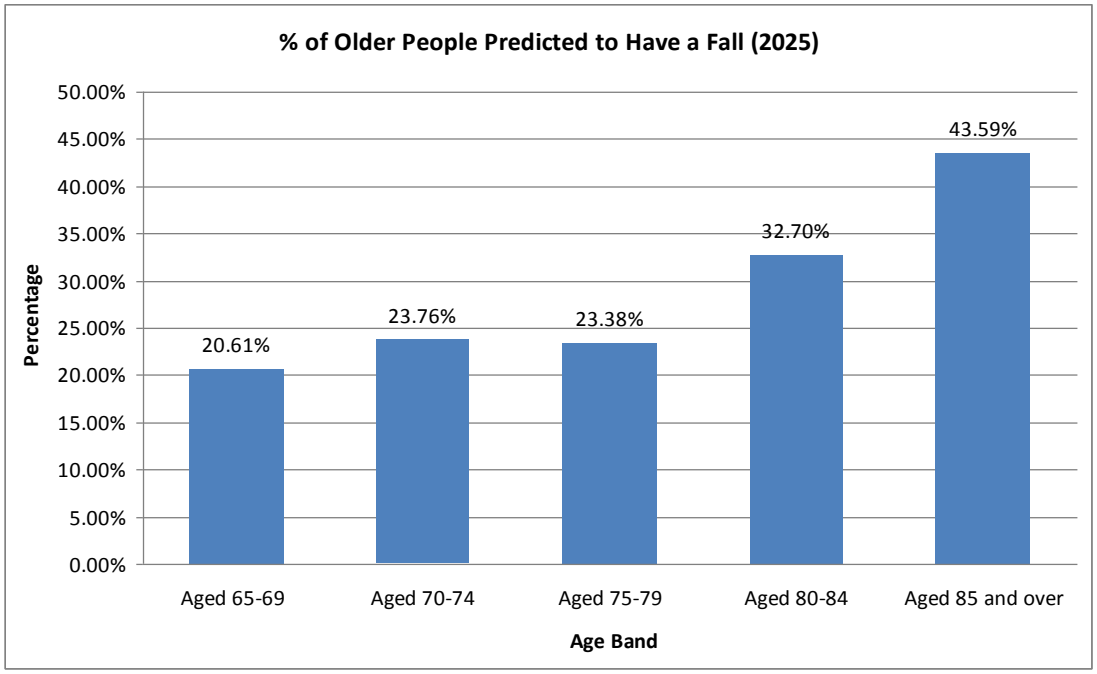
Age is a significant risk factor for falls; however, falls are not an inevitable part of the ageing process. The causes of falls are multifactorial. Risk factors for falls can be classified into three categories: intrinsic, extrinsic and exposure to risk. Intrinsic factors include age, medication and medical history. Extrinsic factors include trip hazards such as uneven flooring and poorly fitting footwear. Exposure to risk refers to behaviour likely to result in a fall, such as falling from a ladder.

6.1 The Local Picture

The number of older adults in Southend-on-Sea is forecast to rise dramatically. By 2025, it is estimated that the older adult population will increase by 22% to 40,700 people aged 65 and over of which, 12,800 will be aged 80 and over. This means there are likely to be more people suffering injurious falls (a fall resulting in a fracture or soft tissue damage that requires treatment). Figure 4 shows the estimated percentage of people over 65 years in Southend-on-Sea who will have a fall in 2025.

It is estimated that 9,185 local older people will have experienced a fall in the last 12 months which is 27.5% of the total population aged 65+. Of those experiencing a fall 2.8% of those in the over 65's will be an injurious fall[(25)]. In addition to the increased likelihood of falling, people aged 75 and over are also more likely to be admitted to hospital as a result of a fall.

Figure 4: Proportion of People Predicted to Have a Fall in 2025 by age Group in Southend-on-Sea



Source: POPPI

There were 224 hip fractures in people aged 65+ living in Southend-on-Sea during 2012/13. Using national reference values, these fractures are likely to cost the Southend-on-Sea health and social care economy in the region of £6.7 million in the period 2012 to 2014 [(26)]. The majority of these fractures occurred in people aged 80+. Although not significantly worse than the England average, the data suggests that 44 people may have died as a result of their hip fracture within 3 months of occurrence and 88 are likely to have lost their independence. As the number of our

very elderly population increases we can anticipate an increase in the number of falls and injuries and significant pressure on the local health and social care system.

6.2 Local Action

For the over 65's most falls occur when performing every day activities in and around the home and between 15% to 30% of these falls could be prevented through the implementation of comprehensive falls prevention programmes including [27]

- Identification of those who are at risk
- Strength and balance training
- Secondary prevention
- A postural stability programme [18]
- Home exercise programme based on the Otago model
- Calcium and vitamin D supplements for patients at risk of osteoporosis
- Prescribing of bisphosphonates for those diagnosed with osteoporosis
- Medication review, as some have a sedative effect or cause a sudden drop in blood pressure

The falls prevention programme for Southend-on-Sea consists of:

- Community Falls Service

The community falls service supports local people at risk of falling. A team of specialist nurses, physiotherapists, occupational therapists and other support staff manage people who may have been admitted and discharged from hospital because of a fall or referred by a health or social care professional. They increase patient awareness and education to prevent and manage falls and osteoporosis. They also refer people to programmes of muscle strengthening and balance training.

- Postural Stability Instructor (PSI) Programme

The Council commissions an evidence based PSI programme to improve postural stability, self-confidence and reduce the fear of falling and the rate of injury in older adults. The service is provided within community venues across the borough. People are referred to these programmes by GP's, the Community Falls Service, local hospital, other health and social care professionals. People can also self-refer.

- Re-ablement services

Re-ablement offers short term support to people following a short term illness or hospital admission to help maintain their independence. Re-ablement services help people learn or relearn skills needed for everyday life following their illness or hospital admission.

- Fracture Liaison Service (FLS)

The fracture liaison service is based in Southend Hospital and aims to reduce the risk of osteoporotic fractures in older people. The primary focus of FLS is to identify people who are at risk of fractures and provide advice and/or therapy including medication to help develop bone strength.

- Telecare services

Telecare can be used to help people who may be at risk of falling to alert carers that they have fallen. There are a range of devices available including community alarms and motion sensors.

- Papworth Trust Handyperson service

The handyperson service aims to improve the home safety of older people and minimise risks of accidents that lead to hospital admission. They provide home repairs and maintenance and raise awareness of home safety issues and risk factors among older people. The Council commissions the Papworth Trust to carry out modifications to people's homes (grab rails, anti-slip services etc.) that will reduce the risk of falling.

6.3 Home from Hospital Services

This service provides carer support to accompany home any patient who has no immediate support on discharge from hospital, but feels they need someone to assist with basic help to return home.

With the permission of the patient, a health care assistant will accompany them home and settle them until they feel confident to stay.

If required the service can also provide:

- Basic essential shopping from local shops
- Preparation of a snack and a drink
- Change of bedding and/or clothing
- Contact with family/friends or neighbours to inform them of the return home
- Check that the heating and lights are on to the patient's requirements
- Check their medicines have arrived
- Immediate personal care if required

If there is a problem on returning home a telephone call can be made to a friend or relative, or back to the discharge co-ordinator to provide advice. There is also further support available via volunteers if required.

6.4 Single Point of Referral (SPoR)

In Southend-on-Sea there is a Single Point of Referral to an integrated health and social care assessment and response. GPs and other professionals can make one referral, which covers all health and social care agencies, into a single team that will focus on the specific needs of the older person.

The SPoR is open seven days a week and provides a mechanism for each individual patient to have care delivered holistically and in a way that will best meet their individual needs in the most appropriate setting for them. As a result of this, the service is able to reduce the level of hospital admissions as many of the patients can be treated in their own home and facilitated into community based re-ablement services. This in turn allows for more timely transfers of care, reduces delays in accessing re-ablement and increases the recovery to independent living.

7.0 Carers

Anyone who provides unpaid care and support to a friend or family member that cannot manage without their help are considered to be a carer.

In the 2011 Census 6.5 million people in the UK identified themselves as a carer, compared to 5.8 million people in 2001. It is estimated that 3 in 5 people will become carers at some point in their lives [(28)].

The majority of carers are of working age and the peak age for caring is 50-64. However, the number of carers over the age of 65 is increasing more rapidly than the general carer population. Whilst the total number of carers has risen by 11% since 2001, the number of older carers rose by 35%.

The amount and type of care that carers provide varies considerably. Caring responsibilities may include a few hours of care a week, such as help with shopping, or they may provide around the clock care. Approximately 4 million of carers in the UK provide care for 1-19 hours each week, however, the numbers caring for 50 hours or more each week have increased by 25% in the last ten years compared to an 11% rise in the total number of carers. It is estimated that the unpaid care provided by carers saves the economy £119 billion per year [(29)].

Supporting carers has the following benefits for health and social care systems [(30)]. :

- Delayed admission to residential care
- Delayed uptake of social care
- Reduced hospital admissions
- Carer is able to remain in employment/ reduction in likelihood of reduced working hours
- Savings from improving carer (physical and mental) health and subsequent reduction in their use of health and social care systems

It has been calculated that the social return on investment for carers services is almost £4 for every £1spent [(31)].

Although for many the experience of caring can be rewarding, the consequences of caring can have detrimental effects.

Many carers report that caring results in a negative and often lasting impact on their physical and mental wellbeing. As with the rest of the population, many people with existing disabilities or long-term conditions also take on caring responsibilities:

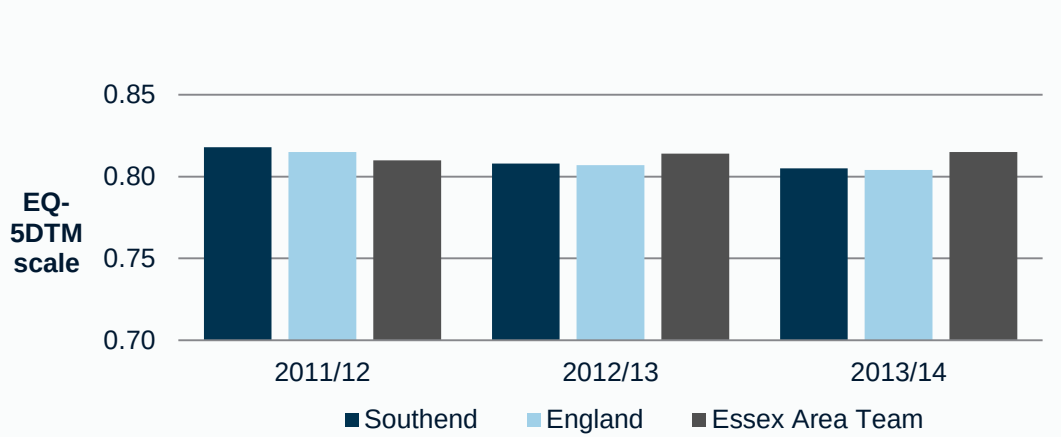
- The pressures of caring can have a negative impact on the carer's physical and mental health, including stress and depression [(32)]
- Carers often have a lower income as caring and ill-health reduce their ability to work. Almost half of carers report having to cut back on essentials like food (45%) and heating (44%) [(33)]
- Carers often report becoming socially isolated as a result of their caring responsibilities and are at risk of social exclusion [(34)]

7.1 The Local Picture

Southend-on-Sea does not differ significantly from the national average for people providing unpaid care per week [35]. However, there are six wards where people provide levels of high-end care (over 50 hours per week) that are significantly higher than the national average. These wards are: Blenheim Park, Southchurch, Belfairs, Shoeburyness, West Shoebury and St. Laurence.

Figure 5 provides an overview of the health related quality of life of carers aged 18 and over from 2011 to 2014, based on the responses to the GP Patient Survey (GPS). The data shows that there appears to have been a slight decrease in the self-assessed quality of life of carers resident in Southend-on-Sea in the period 2011-2014 when compared to other local authority areas within Essex.

Figure 5: Health-related quality of life for carers, aged 18 and above



Source: Health and Social Care Information Centre

In 2012/13, the average health quality of life score for all respondents to the GPS in Southend-on-Sea was 0.823 compared with 0.803 for people classified as carers. This finding reaffirms the poorer quality of life those with caring responsibilities have In addition, 40.8% of people being cared for in Southend-on-Sea had a chronic long-term condition, compared to the England average of 38.3%. Carers in Southend-on-Sea were also more likely to be looking after people with a learning disability or difficulty (25.6%) compared to carers in the rest of England (16.5%) These facts suggest the burden on the physical and emotional health of carers in Southend-on-Sea is significant.

Supporting carers is important because if they are not able to continue to provide care to the person they are looking after, this support will inevitably need to be provided by statutory organisations.

Locally there has been extensive planning to take into account the requirements of the Care Act 2014 for local authorities and other statutory organisations to prioritise the needs of carers. The Care Act 2014 entitles a carer to an assessment even if the person they care for does not get any help from the Council, the cared for person will not need to be assessed. As a result of the assessment, the carer may be eligible for support from the Council; the Council will also offer the carer advice and guidance to help them with their caring responsibilities. The physical and emotional wellbeing of

the carer will be at the heart of their assessment. It will look at the different ways caring affects their life and work out how they can carry on doing the things that are important to them and their family.

The Southend Integrated Health and Social Care Pioneer Programme has a number of objectives relating to the needs of carers.

The Council currently supports around 1,090 carers by providing services or through the use of a carer's budget. It also commissions the following services:

- Carers Forum. This provides a range of services and support for all carers. They also produce a carers newsletter for the Council.

- Carers Emergency respite. Carers who have registered with the Carers Emergency Respite Scheme (CERS) can nominate family or friends who CERS can contact in an emergency.

  Up to 48 hours of free support can be provided at home by a trained member of staff (up to 72 hours on a Bank Holiday).

- Flexi Break Scheme. This entitles the carer to 30 hours of respite per financial year.

- Prescribed Breaks Scheme. Up to 30 hours of respite per financial year can be prescribed by a healthcare professional.

- Hospice at Home. This offers support and respite for those caring for someone with a life-limiting condition at the end of life.

- Dementia Cafes and One-to-One Sessions. These are regular meetings held across the Borough for carers of people with dementia. The carers of people with dementia can also benefit from one-to-one support.

- Trust Links. A range of services and support for carers of people with a mental health condition.

- Carer Aware. Free on line training is available for carers

Carers can also get free admission to local theatres if they are supporting someone. The AdVantage card is also free for carers and offers discounts on local health and leisure facilities.

8. Recommendations

- An overarching falls prevention strategy should be developed that includes factors related to wider determinants such as housing, environmental hazards as well as other local strategies that impact on older adults

- All front-line staff who are routinely in contact with older people (such as sheltered housing and care home staff, GP practice staff, fire service,

community transport and library staff and pharmacists) should receive update training on falls risk assessment and referral pathways to local services

- To continue to support carers to access the services offered by statutory and voluntary organisations

- To look into support required by carers from Black, Asian and Minority Ethnic Groups and Lesbian, Gay, Bisexual and Transgender communities

- Work with Southend Clinical Commissioning Group, third sector organisations and carers to create an integrated carers pathway

- Work should be undertaken with Southend Clinical Commissioning Group to look at carer support within GP practices

- Work should be undertaken with Southend Clinical Commissioning Group to jointly re-commission carer support services

Chapter 9 Health Protection

1.0 Introduction

Health protection seeks to prevent or reduce the harm caused by infectious diseases and minimise the health impact from environmental hazards, contamination, and extreme weather events [(1)].

As well as major programmes such as the national immunisation programmes and the provision of health services to treat infectious diseases, health protection involves planning and emergency preparedness, surveillance and response to incidents and outbreaks.

From 1 April 2013, the responsibility for health protection at a local level transferred from Primary Care Trusts and the Health Protection Agency, to Public Health England. Local authorities have maintained their responsibility for aspects of health protection. In addition unitary and upper tier local authorities have a new health protection duty to ensure that threats to health are understood and properly addressed.

2.0 Immunisation

Immunisation is one of the most effective public health interventions in the world in terms of saving lives and protecting health. The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others, reducing the risk of unvaccinated individuals being exposed to infection. This concept is called population (or 'herd') immunity.

The World Health Organisation generally recommends vaccination uptake of at least 95% of the eligible population to achieve 'herd immunity'.

Under the Health and Social Care Act (2012), from 1st April 2013, the responsibilities of Directors of Public Health in local authorities have changed from providing leadership for commissioning of vaccination programmes to seeking and providing assurance that the population is appropriately protected.

2.1 The Routine UK Immunisation Schedule

The overall aim of the routine immunisation schedule is to provide protection against the following vaccine preventable infections:

- diphtheria
- tetanus
- pertussis (whooping cough)
- Haemophilus influenzae type b (Hib)
- polio
- meningococcal serogroup C disease (MenC)
- measles
- mumps
- rubella
- pneumococcal disease (certain serotypes)

- human papilloma virus types 16 and 18 (also 6 and 11)
- rotavirus
- influenza
- shingles

2.2 Childhood and School-Based Vaccinations

The effectiveness of the national childhood routine immunisation programme is carefully monitored by Public Health England, through looking at the percentage of eligible population immunised in the given period. The programme COVER (cover of vaccination evaluated rapidly) data looks specifically at the percentage of the population that has received each vaccination by ages one year, 2 years and 5 years within certain timeframes (i.e. quarter and annual).

There is generally good uptake of primary childhood immunisations in Southend, with sufficient uptake to achieve herd immunity for most of the programmes. Uptake of the second dose of MMR (measles, mumps and rubella) vaccine, however, still remains an issue and remains around 5% below the target uptake. This has important implications for herd immunity against measles.

2.3 Measles and the National MMR Catch up Campaign

Measles is an illness caused by a viral infection. There is an early 'prodromal stage' characterised by the onset of fever, malaise, cold like symptoms, cough, conjunctivitis with greyish white spots in the mouth and throat. The rash starts at the head and spreads over the limbs.

Measles is highly infectious and is spread by droplet. It can be passed onto other people from the time the symptoms appear until four days after the rash disappears.

The most common complications of measles infection are

- otitis media (7 to 9% of cases)
- pneumonia (1 to 6%)
- diarrhoea (8%)
- convulsions (one in 200, or 0.5%)

Other, rarer complications include

- encephalitis (one in 1000 cases of measles) and
- sub-acute sclerosing pan-encephalitis (SSPE)
- Death occurs in one in 5000 cases in the UK

In the last 2 years there have been several large outbreaks of measles in England and Wales, the most recent being in Swansea, South Wales in spring 2013. These outbreaks were mostly attributed to the proportion of unprotected 10-16 year olds who missed out on MMR vaccination in the late 1990s and early 2000s when concern around the discredited link between autism and the vaccine was widespread.

In April 2013, a national MMR catch up campaign was launched with the aim of preventing further measles outbreaks by vaccinating as many unvaccinated and

partially vaccinated 10-16 year olds by September 2013, the start of the new school year [2].

The catch up programme for Southend-on-Sea was led by the NHS England Essex Area Team, working through school programmes and GPs to identify and give MMR to the identified at risk cohort of 10-16 year olds.

An evaluation of the national campaign [3] found that the occurrence of outbreaks in different parts of the country in 2013 was due to pockets of populations with lower vaccination coverage. Overall in England, estimated coverage was high, but given the high transmissibility of measles, particularly in the secondary school setting, those specific schools with coverage below 95% were at risk of small outbreaks. Further efforts are required to increase uptake of MMR in localities where there are areas or population groups with low coverage.

2.4 Changes to the National Immunisation Programmes in 2013/14

A number of changes to the national immunisation programme were made during 2013-14 to reflect the planned and phased implementation of a series of recommendations by the national Joint Committee on Vaccination and Immunisation (JCVI) to improve the overall level of protection against preventable diseases.

Rotavirus

Rotavirus infection is the most common cause of gastroenteritis in children under five years of age worldwide. Rotavirus is highly contagious and symptoms include severe diarrhoea, stomach cramps, vomiting dehydration and mild fever. These symptoms usually last from three to eight days.

In England and Wales it is responsible for an estimated 130,000 episodes of gastroenteritis each year in children under five years of age and approximately 12,700 of these children are hospitalised.

The rotavirus vaccine is administered as an oral liquid to infants alongside other routine immunisations when they are two and three months of age.

Menningitis C

The objective of the routine Meningitis C vaccination programme is to protect those under 25 years of age and individuals outside this age range who may be at increased risk from meningococcal serogroup C disease. Recently published studies show that vaccination against meningococcal serogroup C later in childhood provides higher levels of antibodies that persist for longer. The JCVI therefore recommended that the second priming dose currently given at four months should be replaced by a booster dose given in adolescence.

Shingles

Shingles is an infection of a nerve and the area of skin around it. It is caused by the herpes varicella-zoster virus, which also causes chickenpox.

The affected area may be intensely painful and intense itching is common. The rash typically lasts between two and four weeks. Following the rash, persistent pain at the site, known as post herpetic neuralgia (PHN), can develop and is seen more frequently in older people. PHN typically lasts from three to six months, but can persist for longer.

The incidence of shingles in England and Wales is estimated to be around 790 to 880 cases per 100,000 people per year for those aged 70 to 79 years. The risk and severity of shingles increases with age however, the estimated effectiveness of the vaccine decreases with age. The shingles vaccination programme commenced in September 2013, for people aged 70 years in addition to a catch-up programme for people aged 79 years.

Childhood Flu: This is detailed in the section below on seasonal influenza.

2.5 Seasonal Influenza

Influenza or 'flu' is an acute respiratory illness associated with infection by the influenza virus. Symptoms frequently include fever chills, headache, cough, sore throat, aching muscles and joints and fatigue.

The flu virus is highly contagious and is easily passed from person-to-person when an infected person coughs or sneezes. Transmission can also occur by touching a surface contaminated with respiratory secretions**.**

The risk of serious illness and complications e.g. bronchitis and pneumonia from influenza is higher amongst children under six months of age, older people and those with underlying health conditions such as respiratory disease, cardiac disease, immunosuppression as well as pregnant women.

The seasonal flu vaccine is offered free on the NHS to everyone aged 65 or over, and those under the age of 65 with the identified underlying health problems, as well as pregnant women.

The aim of the influenza immunisation programme is to protect those who are at a higher risk of serious illness or death should they develop influenza. It also helps to reduce transmission of the infection.

In 2012, the JCVI recommended that the programme should be extended to all children aged two to 16 years. In addition to providing direct protection from flu for the children who are vaccinated, once fully implemented this will help to interrupt transmission of influenza reducing the spread to unvaccinated children and adults.

The phased introduction of this extension began in 2013 with the inclusion of children aged two and three years in the routine programme. There were also seven geographical pilots of primary school aged children, including one in South East Essex, which will continue. For the 2014/15 season children aged two, three and four years will be included in the routine programme**.**

Local Statistics

For the 2013/14 season the national target for seasonal influenza vaccine uptake is 75% for those over 65 years of age and 75% for those under 65 years in the risk groups.

Table 1 shows the level of achieved coverage from the NHS England Essex Local Area Team.

Table 1. Percentage of at risk population immunised (2013)

	Southend	England
Over 65	66%	73.20%
Under 65 at risk groups	46%	52.30%
Pregnant women	33.50%	39.80%

The 2013/14 Flu Plan for England [(4)] contains a good practice guide for GPs to assist them with increasing uptake of flu vaccine in high risk groups locally. This focuses on up-to-date practice registers of high risk individuals, robust call and recall systems and efficient data collection. The NHS England Essex Area Team undertook a flu immunisation pilot with a number of community pharmacists, which evaluated positively. Consideration will continue to be given to improving access arrangements.

2.6 Tuberculosis

Tuberculosis (TB) is a bacterial infection that can occur in any part of the body, but most commonly affects the lungs. Symptoms generally include cough, fever, weight loss and night sweats. Not everyone who comes into contact with TB gets the disease. In some individuals the disease does not progress but the TB bacteria remains in the body without causing any symptoms– this is known as latent TB. This could progress to active TB at a later date, particularly if an individual's immune system has become weakened e.g. due to cancer chemotherapy, or in old age.

Enhanced Tuberculosis Surveillance (ETS) was introduced in England and Wales in 1999, to provide timely, accurate and detailed information on the epidemiology of TB. The latest UK annual TB report based on surveillance data [(5)] shows that rates of TB have stabilised in the UK over the past seven years, following the increase in the incidence from 1990 to 2005.

The latest local surveillance data (2010-12), highlights that there were on average 20 cases of TB per year in Southend (an average rate of 11.5 cases per 100,000 population).

The Clinical Commissioning Groups in South Essex commission the community TB service from South Essex Partnership NHS Foundation Trust. The TB nursing service forms the core element of this service, which aims to prevent the spread of TB in the community by providing rapid assessment of those suspected to have active TB and work closely with the consultant respiratory physicians in the acute hospital to arrange treatment at the earliest opportunity. They also identify and screen those who have been in contact with the case and provide support to people with TB and their families. In addition, the service provides education programmes

aimed at promoting TB prevention and awareness of service provision and treatment availability.

3.0 Emergency Preparedness

Threats to the public's health such as outbreaks of disease, environmental hazards and severe weather conditions are continually emerging and can arise at any time. On occasions these can escalate into a major incident in a short space of time, requiring the implementation of special arrangements by one or a number of agencies such as the emergency services, the NHS or the local authority.

It is therefore essential that there are robust and practised plans in place to help to manage and mitigate the threat to the public's health and safety, and that all of the relevant agencies are fully prepared to work together to deal quickly and effectively with such incidents. Emergency planning is the process and management structures put in place to reduce the impact of a major incident on an organisation or community.

The Government is responsible for emergency planning and brought in the Civil Contingencies Act 2004 (CCA) [(6)], to ensure that there is a consistent level of civil protection across the United Kingdom. The Act defines an emergency as:

- an event or situation which threatens serious damage to human welfare
- an event or situation which threatens serious damage to the environment
- war or terrorism, which threatens serious damage to security

The Act divides local responders into two categories depending on the extent of their involvement in civil protection work, and places a proportionate set of duties on each.

Category 1 responders are those organisations at the core of emergency response (e.g. emergency services, local authorities, acute hospitals) and are subject to the full set of civil protection duties.

Category 2 responders include the utilities, transport, the Health and Safety Executive and Clinical Commissioning Groups. They generally support the emergency response through the provision of specialist support, equipment or advice.

The CCA requires multi-agency co-operation in emergency preparedness. At a local level this is fulfilled by the Essex Local Resilience Forum (ELRF) which brings together Category 1 and 2 responders. There is also a requirement for the ELRF to compile a Community Risk Register based on an assessment of the key risks facing the local community. The Risk Register is then used to inform emergency planning.

The Emergency Planning Lead Officer for Southend-on-Sea Borough Council and the Director of Public Health are both members of the Essex Local Resilience Forum.

4.0 The Essex Local Health Resilience Partnership

Local Health Resilience Partnerships (LHRP) was established from April 2013 as the strategic forum for organisations in the local health sector to facilitate health sector

preparedness and planning for emergencies at a Local Resilience Forum level [7]. The key responsibilities of the LHRP are to facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning; and to provide assurance about the ability of the health sector to respond in partnership to emergencies at an LRF level.

Each constituent organisation remains responsible and accountable for their effective response to emergencies, in line with their statutory duties and obligations.

Essex has its own Local Health Resilience Partnership, which is co-chaired by the Director of Public Health for Southend-on-Sea Borough Council and Thurrock Council and the NHS England Essex Local Area Team Director of Operations. The membership includes senior representatives from the health sector across Essex and the Essex Health Protection Team of the Anglia and Essex Public Health England Centre.

NHS England is responsible for seeking assurance on the preparedness of the NHS in England to respond to an emergency and that there is resilience in relation to continuing to provide patient care. A recent assurance exercise concluded the processes undertaken in the region and area were sufficient and that NHS England and the NHS in England are ready to respond to an emergency [8].

5.0 Climate Change and Health

Our climate is changing and evidence suggests that more extreme changes to our climate and extreme weather events can be expected in the future.

Changing climate will affect people's health, both directly and indirectly. Taking appropriate action and preparing for these changes now should lessen their impact.

5.1 The Heatwave Plan for England

The Heatwave Plan for England is a plan intended to protect the population from heat related harm to health by raising awareness of the negative health effects of severe heat and enabling services and the public to prepare and respond appropriately [9].

In contrast to deaths associated with cold snaps in winter, the rise in mortality as a result of very warm weather follows very sharply – within one or two days of the temperature rising. This means that by the time a heatwave starts, the window of opportunity for effective action is very short indeed and therefore advanced planning and preparedness are essential.

The Heatwave Plan and Heat Health Watch alert system were first developed following the Heatwave in 2003 when there were an estimated 2000 extra deaths in England. A Heatwave Plan for England has been published annually, since 2004. Since then there have been subsequent heat waves in England during 2006 and 2009.

To support the Plan, the Met Office issues Heatwave Alerts from 1 June to 15 September each year.

At a local level, Southend-on-Sea Borough Council facilitates the planning for the distribution of relevant heatwave planning guidance to the relevant non NHS agencies in the community (including educational establishments and residential homes) and cascades the Heat Alert Level notifications. The NHS England Essex Local Area Team made similar arrangements for NHS organisations.
The Southend Association of Voluntary Services (SAVS) also liaises with the local voluntary sector.

5.2 Cold Weather Plan

There is a large and strong evidence base about the risk to health from cold weather and the effects of cold weather on health are predictable and mostly preventable.

The purpose of the Cold Weather Plan (CWP) [10] is to avoid the adverse health effects of cold weather by raising public awareness and triggering actions by those in contact with people who are most at risk. This is discussed further in Chapter 6.

6.0 Recommendations

- Southend-on-Sea Borough Council should work closely with NHS England Essex Local Area Team, Public Health England, GPs, community pharmacists and Southend Clinical Commissioning Group to promote flu vaccination to at risk groups, targeting those areas that have lower uptake rates.

- On 1st April 2013, the commissioning of all immunisation programmes transferred to NHS England, supported by public health advice from Public Health England. Southend-on-Sea Borough Council must remain assured that immunisations services for local people meet required standards. To enable this NHS England Essex Area Team should provide timely and comprehensive information on immunisation coverage in Southend.

- The Southend Health and Well-being Board should receive an Annual Report from the Essex Local Health Resilience Partnership to provide assurance to the Council on local health sector emergency preparedness.

Progress on Recommendations in 2013 Annual Public Health Report

Chapter 1 - Smoking	**Update and Issues**
Increase awareness of dangers of second hand smoke and encourage parents to protect their families by making homes and cars smoke free	Training on risks of second-hand smoke delivered to children's centres and midwifery staff. Risk of second-hand smoke incorporated into all training with nurses, midwives, pharmacy staff etc. Risk of second-hand smoke promoted at respiratory network group and with community safeguarding sub-group
Ensure clear referral pathways are in place for women who are trying to conceive, those women who are pregnant women and their partners, to help them access effective support to stop smoking	Clear referral pathway in place for couples preconception and for pregnant women and their partners, to help them access effective support to stop smoking
Ensure all providers commissioned to deliver services to the public on behalf of Southend-on-Sea Borough Council have in place appropriate policies to protect workers and visitors from the effects of tobacco smoke	Pledge developed for businesses to commit to supporting employees to stop smoking and to support smoke free environments as part of the responsibility deal
Develop clear protocols and pathways for local health visiting and school nursing services to support the identification and referral of parents who smoke to Stop Smoking Services	Smoking and second hand smoke discussed in new birth check in health visiting. Smoking discussed by school nurses as part of an adolescent health review
Ensure staff with a front facing role in local public sector organisations (e.g. benefits, housing, social care, parks, highways, leisure) receive training in brief advice so they are able to signpost smokers to appropriate support (Making Every Contact Count MECC)	Pledge in Public Health Responsibility Deal to build MECC into the culture of the organisations which sign up. MECC training is being delivered by Southend Adult Community College to public and third sector staff E-Learning module developed for Council staff MECC is included in Council staff induction programme
Chapter 2 - Obesity, Physical Activity and Healthy Eating	

Develop a Southend obesity strategy	Strategy development delayed pending the appointment of a lead specialist obesity commissioning manager. Post currently being recruited to
Develop new approaches to improve breastfeeding initiation and continuation rates	Southend University Hospital NHS Foundation Trust and South Essex Partnership NHS Foundation Trust have achieved UNICEF Baby Friendly Level 2 accreditation. Public Health and the Early Years Team are working together to implement UNICEF Baby Friendly Level 2 accreditation in local Children's Centres
Increase emphasis on healthy eating and active play in Early Years	In partnership with the School Food Trust, the Council has rolled out the voluntary guidelines on food and drink in early years settings. The focus for active play has been to encourage settings to have periods of outdoor play, and to introduce the concept of Forest School and Beach School
Work with Southend CCG, social care and maternity services to commission adult weight management services including support for obese pregnant women	New obesity pathway in place. Integrated weight management service commissioned. At least 50 pregnant women have been referred for weight management support
Increase uptake of NHS Health Checks and referral to appropriate risk-management services, particularly in those communities at greatest risk	The Council met the nationally set target for numbers of NHS Health Checks offered. NHS Health Checks are also offered as part of an outreach programme
Develop a local public health responsibility deal and network to share best practice and promote healthy eating, increased physical activity and reduced alcohol consumption, all of which can promote a healthy weight	Southend Public Health Responsibility Deal in place. Local businesses and organisations being recruited
Continue to deliver population-wide programmes to encourage active play for young children and active lifestyles for older children and adults	Change4Life equipment and training delivered by School Sport Partnerships, Schools now delivering multi-skill change4life clubs before and after school. One school has been identified as a "health and wellbeing lead school" for the Youth Sport Trust; it is currently developing a range of programmes for schools and communities. Active Southend have accessed a range of external funding to deliver physical activity interventions for adults and children

Chapter 3 - Alcohol	
A multi-agency group should be formed to refresh the Southend-on-Sea Alcohol Harm Reduction Strategy and identify partnership actions to tackle alcohol related harm	Draft alcohol, substance misuse and gambling Strategy developed. Multi agency discussions regarding data flows regarding alcohol related violent crime
Sexual health services should provide information that highlights the link between alcohol consumption and poor sexual health outcomes and signpost sources of useful advice on drinking sensibly. They should provide clear information about self-referral options as additional support for people wishing to reduce their alcohol intake	New Integrated Sexual Health Service Specification requires providers to collect data on alcohol use, to deliver alcohol brief interventions to service users were alcohol has been identified as a specific risk factor and signposting to appropriate treatment services
Clinicians providing sexual health services should be trained in asking about drinking habits through use of a recognised screening tool and implementing a single brief intervention	Training and awareness raising amongst primary care staff has taken place as part of the development of a new alcohol recovery pathway. Further training will take place following the award of the new contract for integrated sexual health services
Deliver an alcohol awareness campaign when the new sensible drinking guidelines are published by the Chief Medical Officer for England	New CMO sensible drinking guidelines still not published Alcohol specific social marketing being scoped for 2015 Dry January Campaign planned for January 2015
Work with small and medium enterprises in Southend-on-Sea to sign up to alcohol pledges as part of the Southend-on-Sea Public Health Responsibility Deal	Alcohol pledge developed for the off trade pledging to cease the sale of cheap beers, ciders and lagers with an alcohol by volume of above 6%. Two small businesses signed up as pathfinders, roll out to other businesses from December 2014. New alcohol specific pledge developed specifically for small and medium sized businesses as part of the Southend-on-Sea Public Health Responsibility Deal.

Chapter 4 - Sexual Health	
Develop a comprehensive sexual health strategy for Southend-on-Sea Review, redesign and commission an integrated sexual health service and pathway for Southend-on-Sea	Strategy developed, new service specification developed and 5 year contract for the service to be awarded
Develop a bespoke social marketing programme for Southend-on-Sea that normalises sexual health screening in the context of chlamydia in the most disadvantaged communities in the borough	Sexual health needs assessment undertaken. Social marketing programme scoped and will be taken forward from 2015
Implement alcohol brief interventions for all attendees at GUM and community sexual health settings	New Integrated Sexual Health Service Specification requires providers to collect data on alcohol use, to deliver alcohol brief interventions to service users where alcohol has been identified as a specific risk factor and signposting to appropriate treatment services
Identify follow- up and engage with all young people admitted to hospital for an alcohol-attributable condition, signpost to appropriate agencies to enable screening for STIs and interventions to prevent unintended teenage pregnancy	Acute hospital alcohol liaison nurse service currently being commissioned in partnership with Essex County Council. New Integrated Sexual Health Service out to tender. Service specification requires future providers to provide assurance that they have taken account of local sexual health and alcohol specific pathways

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