East Sussex
County Council

Annual Report of the Director of Public Health

2014/15

Foreword

Welcome to the 2014/15 Annual Public Health Report of the Director of Public Health. I hope you will find this both interesting and useful.

We need to concentrate our efforts as much on improving and sustaining good health and positive wellbeing as we do on identifying risk, preventing illness and reducing premature death.

The aim of this report is to 'flip the lens' so that there is a focus on the resources, capacity and strengths of people and communities to maintain and improve health and wellbeing rather than solely focus on their needs, deficits and problems.

Taking an asset based approach involves building and mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations. The approach aims to empower individuals and communities to take action. It fosters skills and capabilities that can improve health and wellbeing and support those in need of health and social care support. This could bring multiple long term benefits for individuals, families, communities, public services and society as a whole.

This report is available in hard copy and also at www.eastsussexjsna.org.uk together with the associated Wellbeing and Resilience Measure (WARM) maps at electoral ward and GP practice level.

Cynthia Lyons
Acting Director of Public Health

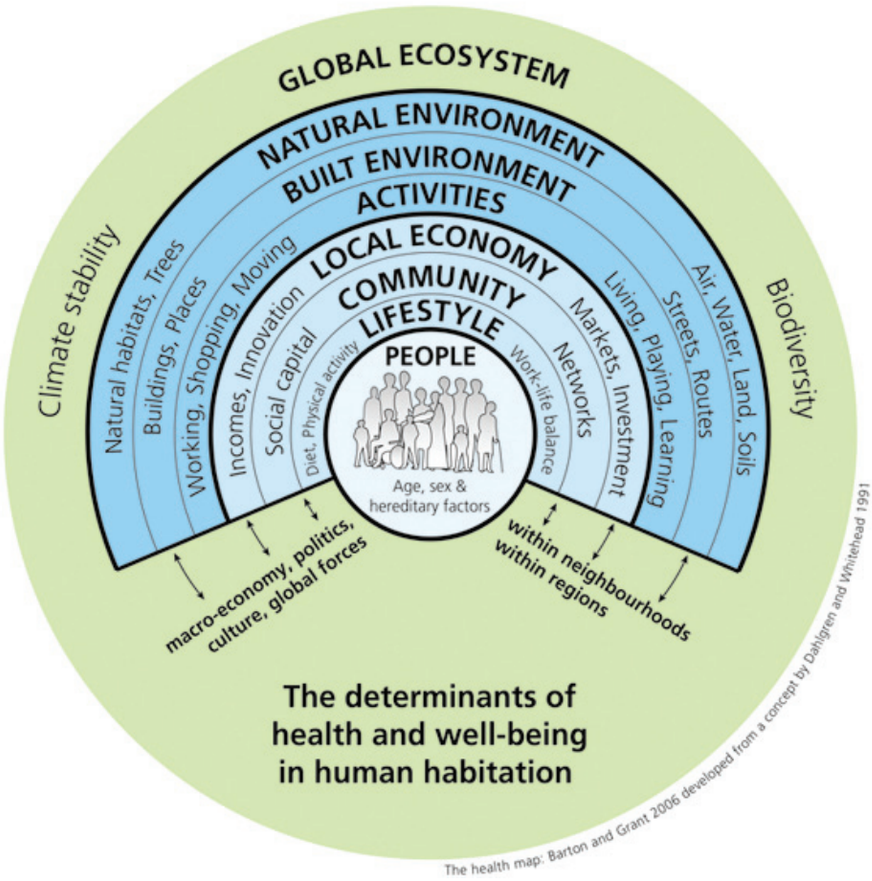
Acknowledgements
My thanks to everyone who contributed to this report, both those who provided content and those who helped directly in the production. There are a number of case studies included in this report and I would especially like to thank the people that provided them.

Contents

1. Introduction

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment (Figure 1). The determinants of health are presented below in the updated version of the well-known diagram by Dahlgren and Whitehead[1] that appeared in the Acheson Inquiry Report.[2] It shows that there are many determinants of health and these can be grouped into layers of influence. These different layers of influence do not operate in isolation, but interact in complex relationships. Some determinants of health, such as age, gender and genetic make-up, are fixed and little can be done to change them. Other determinants, such as individual lifestyle factors, social and community networks and general socioeconomic, cultural and environmental conditions, are amenable to change – they are modifiable.

Figure 1: The main determinants of health



Source: Barton H and Grant G (2006) adaptation of Dahlgren G and Whitehead M (1991) from UN Economic Commission for Europe (2007), Resource Manual to Support Application of the Protocol on Strategic Environment Assessment

[1] Dahlgren G and Whitehead M. Policies and Strategies to Promote Social Equity in Health. Stockholm, Institute for Future Studies, 1991.
[2] Independent Inquiry into Inequalities in Health (Acheson Inquiry). Report of the Independent Inquiry into Inequalities in Health, 1998.

The social determinants of health directly impact upon the health and wellbeing of individuals and communities. In 2010 the independent Marmot Review "*Fair Society - Healthy Lives*" produced an evidenced based approach to health inequalities in the UK which brought the social determinants of health, and new ways to address them, to the top of the political agenda.[3] It demonstrated that the "conditions in which people grow, live, work and age" have a powerful influence on our health, our life expectancy and how long we live with life-limiting illness. These same conditions not only make us ill but determine our access to health services and influence our lifestyle choices.

The impact of social conditions can be seen in the continuing and striking gradient in health. That is, the more affluent your circumstances the more likely you are to have good health and wellbeing, spend less of your life with life-limiting illness, and live a long life. There is increasing consensus that many of the solutions to challenges such as improving public health need to be much more rooted in local circumstances.[4] Much work has been done on individual resilience to understand how the interplay of biological, psychological and socio-cultural factors allow some individuals to bounce back or flourish in the face of adversity or risk and not others. Research on community resilience is less developed, but extends these approaches to look beyond individual characteristics to how people relate to and interact with wider social environments to help communities to thrive.[5] Community resilience is "the existence, development and engagement of community resources by community members… [who]…intentionally develop personal and collective capacity to respond to and influence change, to sustain and renew the community, and to develop new trajectories for the communities' future".[6]

Since the election of the coalition Government in 2010 there has been a shift in political ideology. There is a new emphasis on the development of "localism" with its focus on co-production, community commissioning and the disaggregation of services and delivery down to neighbourhood level, wherever possible.[7] In response to the Marmot Review, the Government's White Paper - *Healthy Lives, Healthy People* set out a new approach seeking to empower local communities, putting local government and communities at the heart of improving health and wellbeing for their populations and tacking inequalities.[8]

The challenges posed by the current economic climate of efficiency savings and reduced budgets means there is a need for a radical change in the delivery of public service. The Commission for the Future Delivery of Public Services (2011) states that in order to achieve this goal public services must be "built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience".[9] Central to this reform process is the empowerment of individuals and local communities by involving them in designing and delivering the services they use and the requirement for public services to work in partnership with other organisations and communities to improve outcomes.

[3] The Marmot Review. 2010. Fair Society Healthy Lives – Strategic Review of Health Inequalities in England Post 2010 http://www.marmotreview.org/
[4] Nelson, Campbell & Emanuel (2011) Development of a Method for Asset Based Working. Commissioned by NHS North West
5 Mguni, N and Bacon N. (2010) Taking the temperature of local communities: The Wellbeing and Resilience Measure
[6] Magis, K. 2010. Community resilience: an indicator of social sustainability. Society and Natural Resources. 23, 5, 401–416
[7] Commission on the Future Delivery of Public Services (Christie, 2011)
[8] Department of Health 2010. Healthy Lives, Healthy People. http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm
[9] Commission on the Future Delivery of Public Services (Christie, 2011)

Locally, these challenges are being addressed in health and social care services through 'East Sussex Better Together'. 'East Sussex Better Together' is the large scale change programme through which commissioners of health and social care services are working together with local people, providers and stakeholders to transform local services in a way that improves quality, provides services people want and need, and is more sustainable in the long term.

The asset approach can support East Sussex Better Together. It is not a way of getting communities to provide public services that are being cut. It is a way of valuing the contributions of everyone involved, acknowledging and building what people value most and ensuring that public services are provided where and how they are needed.

About this Report

East Sussex has significant strengths and performs better than the national average for many indicators in the Public Health Outcomes Framework (see www.eastsussexjsna.org.uk). There remains, however, the challenge faced by all statutory commissioning bodies of how to continue to improve outcomes whilst significant cuts are made to funding. Therefore, if we want to reduce the burden of illness, disability, old age, loneliness and isolation, both personal and financial, we need to consider how we can build resilience by growing the assets of wellbeing across East Sussex. Assets are any factor (or resource), which enhances the ability of individuals, communities, and populations, to maintain and sustain health and wellbeing and to help to reduce health inequities.[10]

The asset approach builds on the resources, capacity and strengths of people and communities and engages people in taking action. It fosters skills and capabilities that can improve health and wellbeing and support those in need of health and social care support. Importantly the approach also promotes and recognises assets in those that may need support and in turn this can be of mutual benefit to all concerned.

The benefits of an approach which acknowledges the strength of community assets and the potential to further build on these is supported by evidence. Building and strengthening assets together means that people and services work together to support health and wellbeing which can reduce both the need for services and the impact of poor health.

[10] A Glass Half-Full- How an Asset Based Approach Can Improve Community Health and Wellbeing, IDeA, 2010

This Annual Public Health Report looks at how we can identify, better understand and support development of existing and potential new community assets. It focuses on identifying the key features of asset-based approaches and how we can make further progress in a sustainable manner. It initially focuses on describing what an asset based approach involves and how it is different from focusing on deficits in the current services and support people receive. It describes how individuals can play a significant role in increasing community resilience. The report describes how systematic processes can be used to support this work and monitor its impact particularly in developing sustainability.

There are already many good examples of this approach in East Sussex. Included within the report are some case studies of East Sussex projects and services which use an asset based approach or elements of an asset based approach. The case studies provide a further source of evidence, supplementing the academic research, and demonstrating what can be achieved.

Based on a review of the evidence, this report recommends further work to enhance community resilience which seeks positively to develop, harness and mobilise the assets, capacities and resources available to individuals and communities to enable them to gain more control over their lives and circumstances and to meet primary prevention, health, wellbeing and social care support needs.

The second part of this report sets out a relatively new way to measure the wellbeing and resilience of communities. It describes a tool – Wellbeing and Resilience Measure (WARM) – that has been designed to support local agencies and communities to better understand, plan and act. WARM provides a way of understanding and identifying an area's strengths, such as levels of social capital, confidence amongst residents, the quality of local services or proximity to employment; as well as vulnerabilities such as isolation, high crime, low savings and unemployment. The tool identifies these factors using routinely available information. WARM has been calculated for East Sussex at ward and district and borough level and also modelled at clinical commissioning group and GP practice level. All the WARM maps at ward and GP practice level are available to download as separate documents, along with this report at www.eastsussexjsna.org.uk.

WARM is a starting point which needs to be built upon and supplemented with community asset mapping to build a more comprehensive picture of the assets that currently exist and can be harnessed and mobilised and the new assets that can be developed to help build resilience in East Sussex.

The report concludes by summarising the approach outlined in the report and drawing on the evidence and best practice looks at the ways in which the skills, knowledge, connections and resource of individuals, communities and organisations might best be captured, harnessed and strengthened.

The report makes ten recommendations for supporting community resilience in East Sussex:

1. Develop the Joint Strategic Needs Assessment into a Joint Strategic Needs and Asset Assessment by building in strengths and assets to produce a more holistic assessment and to enable a broader and richer perspective to be offered into the planning process.
2. Commissioning organisations to work together to enhance community resilience.
3. The East Sussex Better together programme to take full account of the opportunities of this approach.
4. Enhance community resilience through an asset based approach which seeks positively to develop, harness and mobilise the assets, capacities and resources available to individuals and communities which could enable them to gain more control over their lives and circumstances and to meet primary prevention, health, wellbeing and social care support needs.
5. Build on existing skills and abilities for working directly with communities and current asset based projects and consider developing opportunities for individuals and groups to further enhance their work.
6. Further develop mapping of community assets as part of East Sussex Better Together including the use of directories of services.
7. Further promote volunteering and consider how we can best support volunteers through good quality experiences and, where appropriate, resource to maintain their level of volunteering. To also consider how volunteering can support access to qualifications and work.
8. Put in place a robust and sensitive evaluation framework that identifies a series of reliable indicators to assess the impact and cost-effectiveness of community asset-based programmes. Any services that are commissioned should be evaluated to demonstrate outcomes after one year, including social return on investment.
9. Undertake a state of the community health check (incorporating mental wellbeing) survey to include an update on the Place Survey data that is used to support some of the WARM indicators. To repeat the survey at appropriate intervals to monitor change and support evaluation of community health.
10. Promote the 5 ways to wellbeing and include in everyday life: connect; be active; take notice; keep learning; give. If practiced regularly they can improve personal wellbeing.

2. The Asset Based Approach

Adopting the asset based approach follows the general shifts in policy thinking which have refocused interventions[11]:

- from a disease prevention model targeting morbidity and mortality to a more positive approach targeting general health and wellbeing;
- from a model of single disease causality to a multiple dynamic model of health and its determinants; and
- from the notion of passive recipients of health programmes to a more active public participation movement in health.

Traditional approaches to improving wellbeing, reducing health inequalities and achieving other social goals have focused on the deficits and problems of individuals and communities. In contrast, using an approach that values assets identifies the skills, strengths, capacity and knowledge of individuals increases the social capital of communities and values what works well.

High levels of social capital and trust are essential elements of resilient communities. The World Bank defines Social Capital as **"… the institutions, relationships, and norms that shape the quality and quantity of a society's social interactions … Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together."**[12] The Office for National Statistics[13] sets out the different types of social capital. These are described in terms of different types of networks:

bonding social capital – describes closer connections between people and is characterised by strong bonds, for example, among family members or among members of the same ethnic group; it is good for 'getting by' in life.

bridging social capital – describes more distant connections between people and is characterised by weaker, but more cross-cutting ties, for example, with business associates, acquaintances, friends from different ethnic groups, friends of friends, etc; it is good for 'getting ahead' in life.

linking social capital – describes connections with people in positions of power and is characterised by relations between those within a hierarchy where there are differing levels of power; it is good for accessing support from formal institutions. It is different from bonding and bridging in that it is concerned with relations between people who are not on an equal footing. For example, a social services agency dealing with an individual, for example, job searching at the Benefits Agency.

However social capital (like any other form of capital) is not always a positive or even benign force. The Organisation for Economic Co-operation and Development (OECD) identifies that tightly knit communities may have strong bonds, but much weaker bridges into the rest of society potentially

[11] Hills, D. (2004) Evaluation of community levels interventions for health improvement: a review of experience in the UK. Health Development Agency, London

[12] The World Bank (Accessed Sept 2014) What is Social Capital http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTTSOCIALCAPITAL/0,,contentMDK:20185164~menuPK:418217~pagePK:148956~piPK:216618~theSitePK:401015,00.html

[13] Office for National Statistics (Accessed Sept 2014) The Social Capital Project Guide to Social Capital http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html

leading to, or reinforcing, social exclusion. Access to bridging capital may be helpful in finding employment and taking advantage of other opportunities, and linking capital may assist in having positive dealings with institutions. Strong bonds also exist among deviant groups e.g. organised crime groups or gangs and this can be used for negative outcomes.[14]

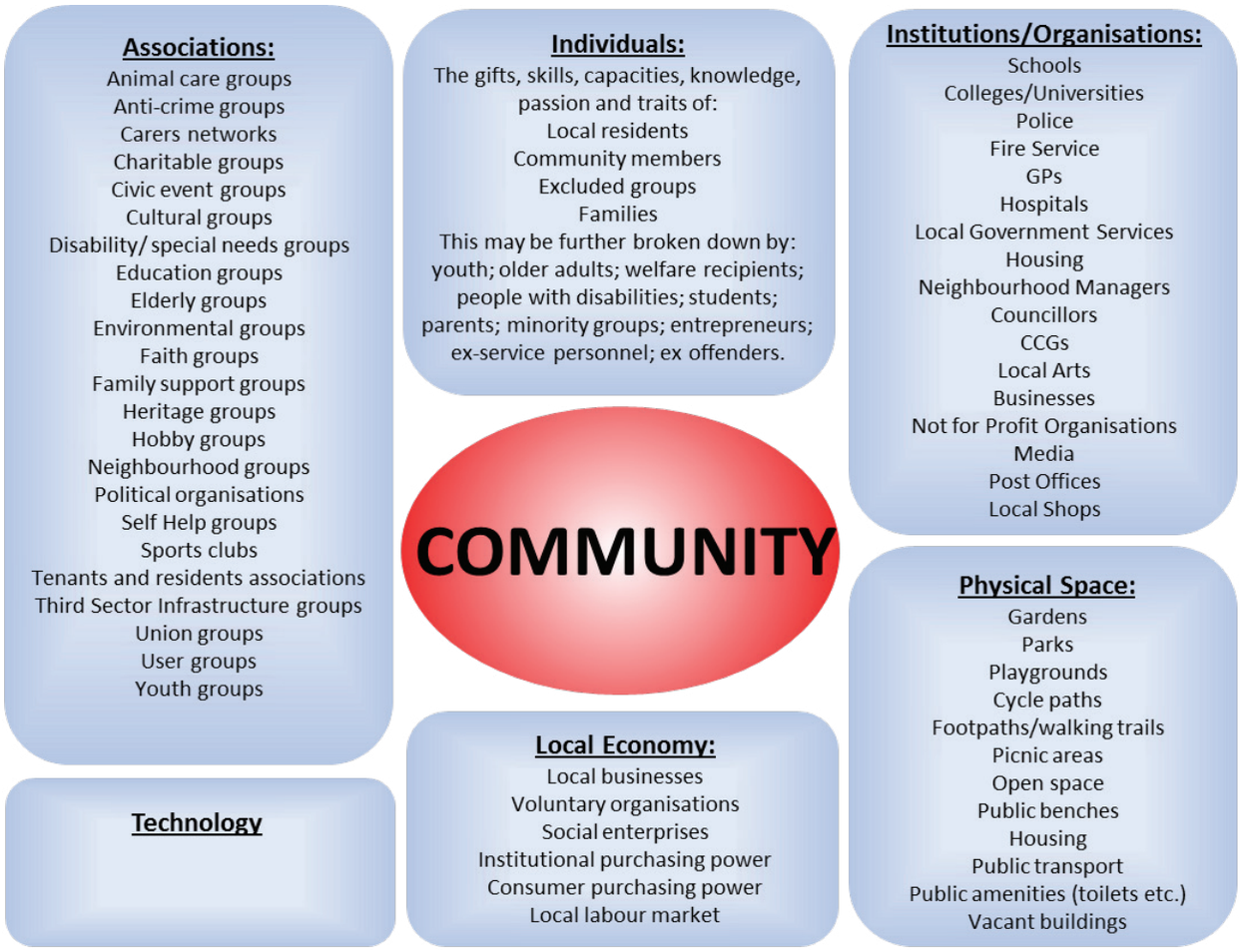
Understanding the interplay and relative merits of the different aspects of social capital can help to hone approaches which seek to make the best use of local networks, and which utilise and value the contribution of all members of communities.

Asset-based approaches are approaches of engagement, which aim to support communities to identify and strengthen the resources and capabilities that exist across communities, groups or individuals.[15] The literature contains a number of definitions of assets but the definition used by Morgan and Ziglio[16] is often used. They define health assets as any factor (or resource), which enhances the ability of individuals, groups, communities, populations, social systems and /or institutions to maintain and sustain health and wellbeing and to help to reduce health inequities. These assets can operate at the level of the individual, group, community (Figure 2), and/or population as protective (or promoting) factors to buffer against life's stresses.

Asset based approaches have evolved as models that challenge the more widely used deficit approaches. The deficit approach assumes a range of needs or problems that must be exposed and addressed. While many people are incontrovertibly confronted by a number of specific issues, the deficit model can reproduce these problems and create new ones.[17] The damage of positioning groups in 'deficit' or seeing them as problems has been articulated by research in community development[18], education[19] and wider.[20]

14 OECD (2007) Human Capital: How what you know shapes your life. P102-105 http://www.oecd.org/insights/37966934.pdf
[15] Lynch H (2008) Lifelong learning, policy and desire, British Journal of Sociology of Education 29 (6), 677–689
[16] Morgan, A., and Ziglio, E. Revitalising the evidence base for public health: an assets model. Promotion & Education 2007 14: 17
[17] Kretzmann J and McKnight J (1993) Building communities from the inside out: a path towards building and mobilizing a communities assets, Illinois: Institute for Policy Research
[18] Cook B and Khotari U (2001) Participation: The new tyranny, London: Zed Books.
[19] Lynch H and Allan J (2007) Target practice? Using the arts for social inclusion, International Journal of Arts and Education 8 (12), 1–12
[20] Bogenschneider K and Olson J (Eds). (1998) Building resiliency and reducing risk: What youth need from families and communities to succeed Available from: http://familyimpactseminars.org/doc.asp?d=s_wifis10exec.pdf (retrieved May 2011)

Figure 2: Community Assets



Source: NHS North West, 2011

Working together, assets based approaches add value to the deficit model by:

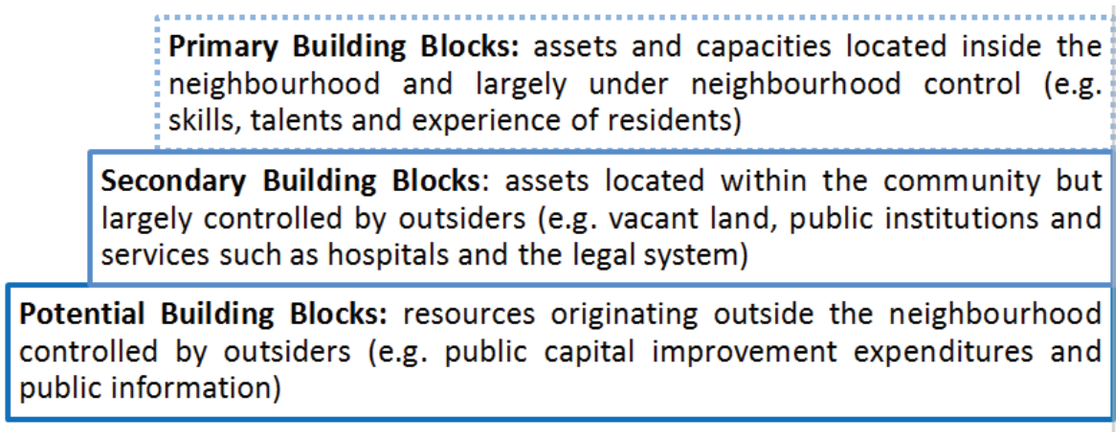
- identifying the range of protective and health promoting factors that act together to support health and wellbeing and the policy options required to build and sustain these factors;
- enabling the population to be co-producers of health rather than simply consumers of health care services, thus reducing the demand on scarce resources;
- strengthening the capacity of individuals and communities to realise their potential for contributing to health development;
- empowering approaches which have health benefits in their own right; and
- contributing to more equitable and sustainable social and economic development and hence the goals of other sectors.

In Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets, Kretzmann and McKnight[21] interviewed numerous individuals from hundreds of neighbourhoods to identify the characteristics that make communities strong. Even in the most distressed-appearing neighbourhoods, they discovered that 5 major assets are used in creative ways for problem solving and community building. When all 5 assets within communities are mobilized, they provide powerful resources for change. These five major assets are:

- the skills and capacities of the individuals who reside in the community;
- the formal and informal associations found within all communities;
- the institutions, which include government agencies, businesses, and non-profit organizations operated by paid staff, not volunteers;
- the economic development potential; and
- the land and other physical assets.

McKnight and Kretzmann[22] identify the following distinct categorisations for asset identification:

Figures 3: Building blocks for asset identification

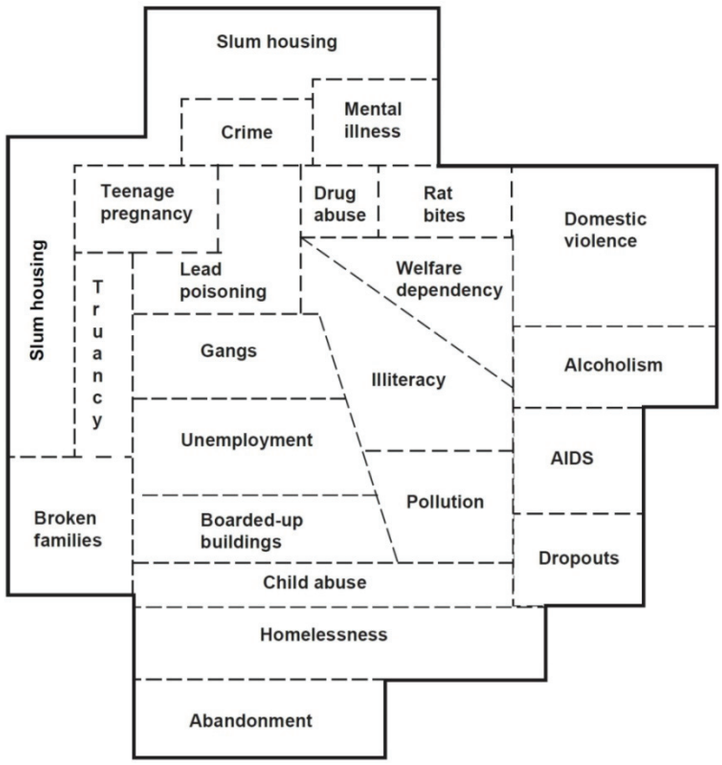


Source: McKnight and Kretzman, 1997

Figures 4 and 5 from McKnight and Kretzmann[23] illustrates first a community from a deficit perspective and then from an asset perspective.

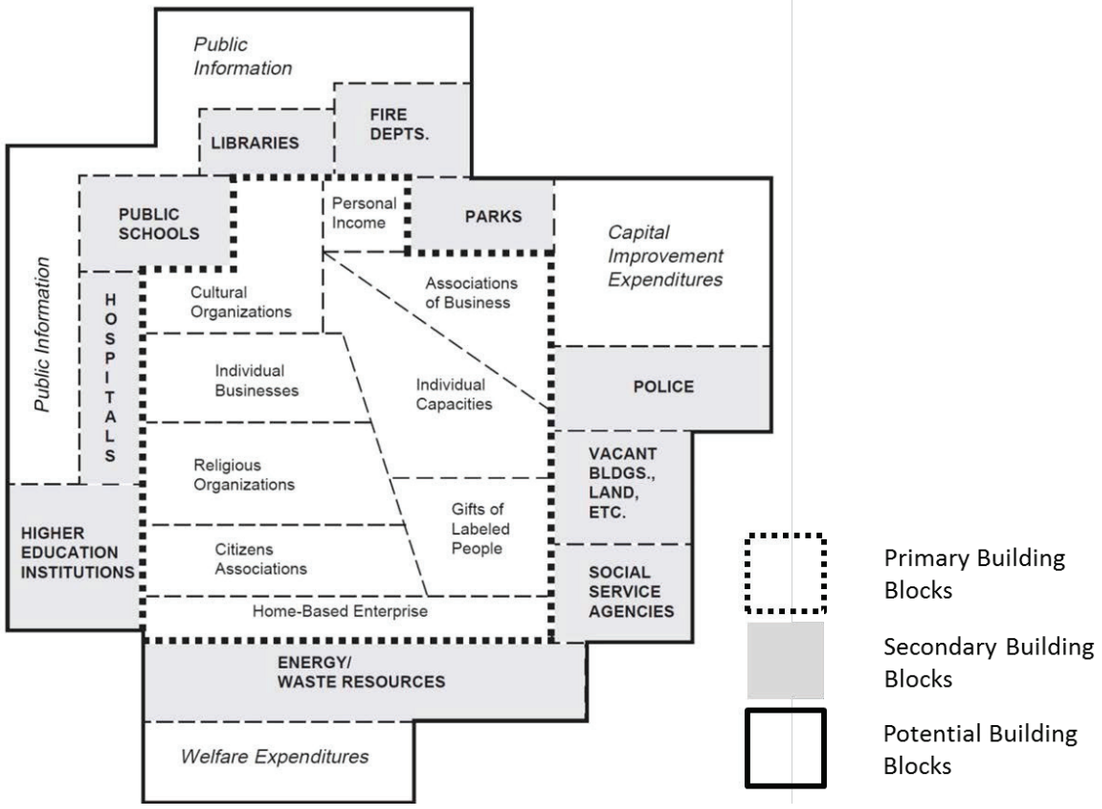
[21] Kretzmann J and McKnight J (1993) Building communities from the inside out: a path towards building and mobilizing a communities assets, Illinois: Institute for Policy Research
[22] McKnight, John & Kretzmann, John 1997 Mapping Community Capacity, in Minkler ed. Community organizing and community building for health, Rutgers Uni Press, New Brunswick
[23] McKnight, John & Kretzmann, John 1997 Mapping Community Capacity, in Minkler ed. Community organizing and community building for health, Rutgers Uni Press, New Brunswick

Figures 4: A community from a deficit perspective



Source: McKnight and Kretzmann, 1997

Figure 5: A community from an asset perspective



Source: McKnight and Kretzmann, 1997

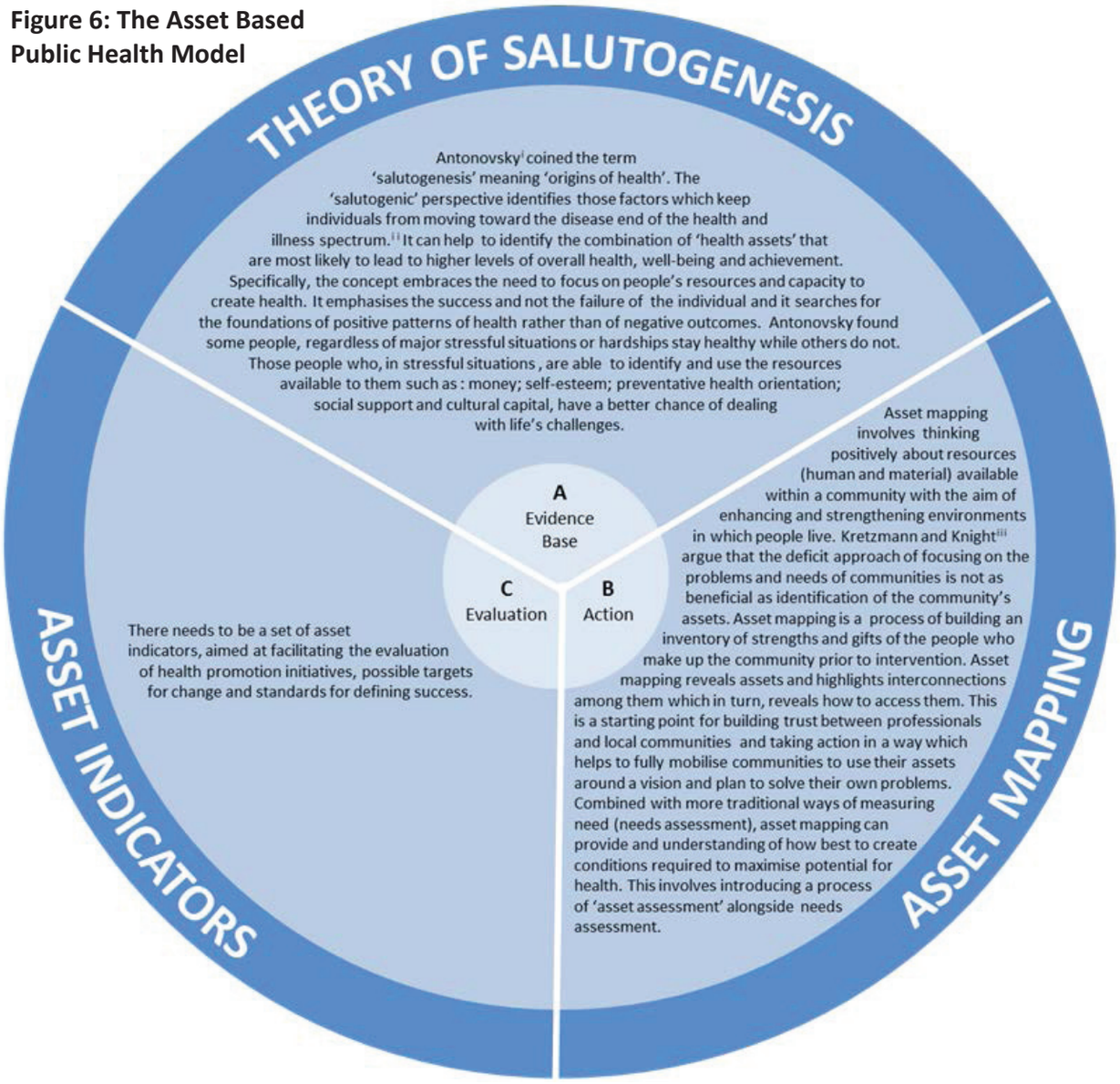
The Asset Based Public Health Model

Morgan and Ziglio (2007)[24] have offered the asset-based public health model with the aim of reducing health inequalities. The model integrates three key aspects that seek to enable policy makers and practitioners to consider the promotion of health from a positive angle:

- the theory of salutogenesis (creating good health), to provide an evidence base;
- asset mapping, to identify actions; and
- asset indicators, to evaluate outcomes.

Figure 6 summarises the three components of the model. These three arms are consistent with the three key areas of the literature that have made a significant contribution to the development of the concept of health assets and asset-based health promotion approaches.

Figure 6: The Asset Based Public Health Model



i. Antonovsky, A. (1996) The salutogenic model as a theory to guide health promotion. Health promotion International 11(1): 11-18
ii. Lindstrom, B . & Erikksson, M. (2006) Contextualising salutogensis and Antonovsky in public health development. Health promotion International vol 212, No. 3, pp. 238-244
iii. Kretzmann, J. and McKnight, J. (1993) Building communities from the inside out: a path towards building and mobilizing a community's assets, Illinois: Institute for Policy Research

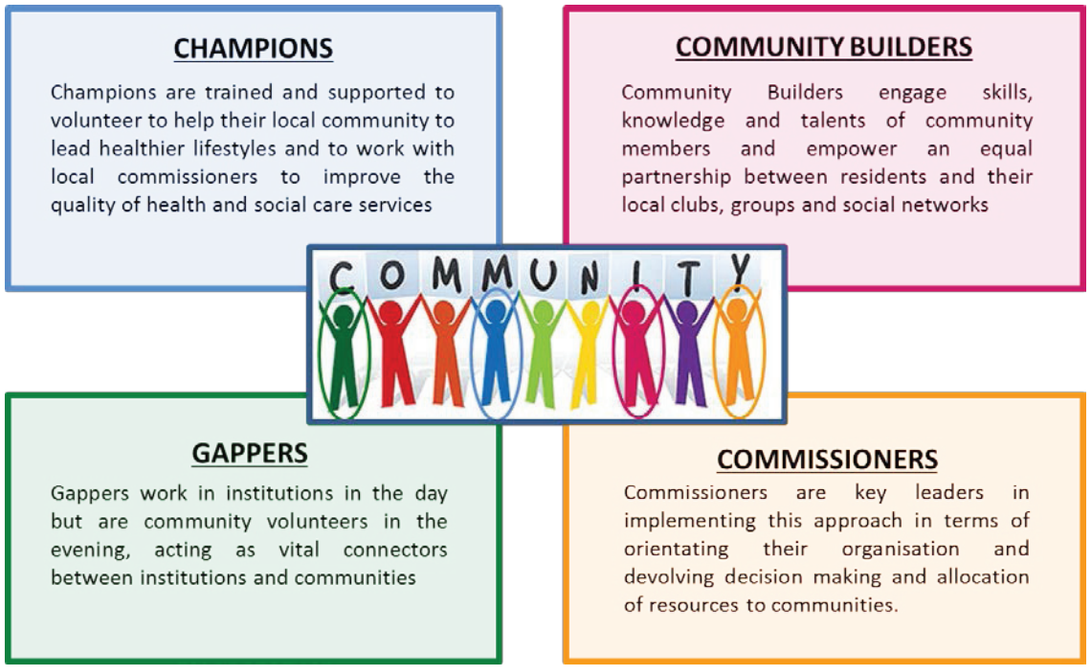
[24] Morgan, A., and Ziglio, E. Revitalising the evidence base for public health: an assets model. Promotion & Education 2007 14: 17

These three steps provide a framework for the process of adopting an asset based approach – using the evidence base, followed by asset mapping in the community, and finally identification of outcomes to evaluate.

Agents for Change in the Asset Based Approach Model

Effective interventions and large scale change are dependent on the roles commissioned and networks developed as part of an asset based approach. Figure 7 outlines agents of change that commissioners could use based on the experience of experts who have implemented such an approach. This is not an exhaustive list, but represents the core roles that should underpin the introduction of an asset based approach:

Figure 7: Agents of Change



Champions

The following summary is based on work by the NHS Confederation and Altogether Better.[25] Community health champions are individuals who are engaged, trained and supported to volunteer and use their life experience, understanding and position of influence to help their friends, families, neighbours, communities and work colleagues lead healthier lives. They are able to inspire and support others to make positive lifestyle changes and they also work with local service commissioners and providers to improve the quality of local health and social care services by contributing local intelligence, experience and knowledge of community skills and resources.

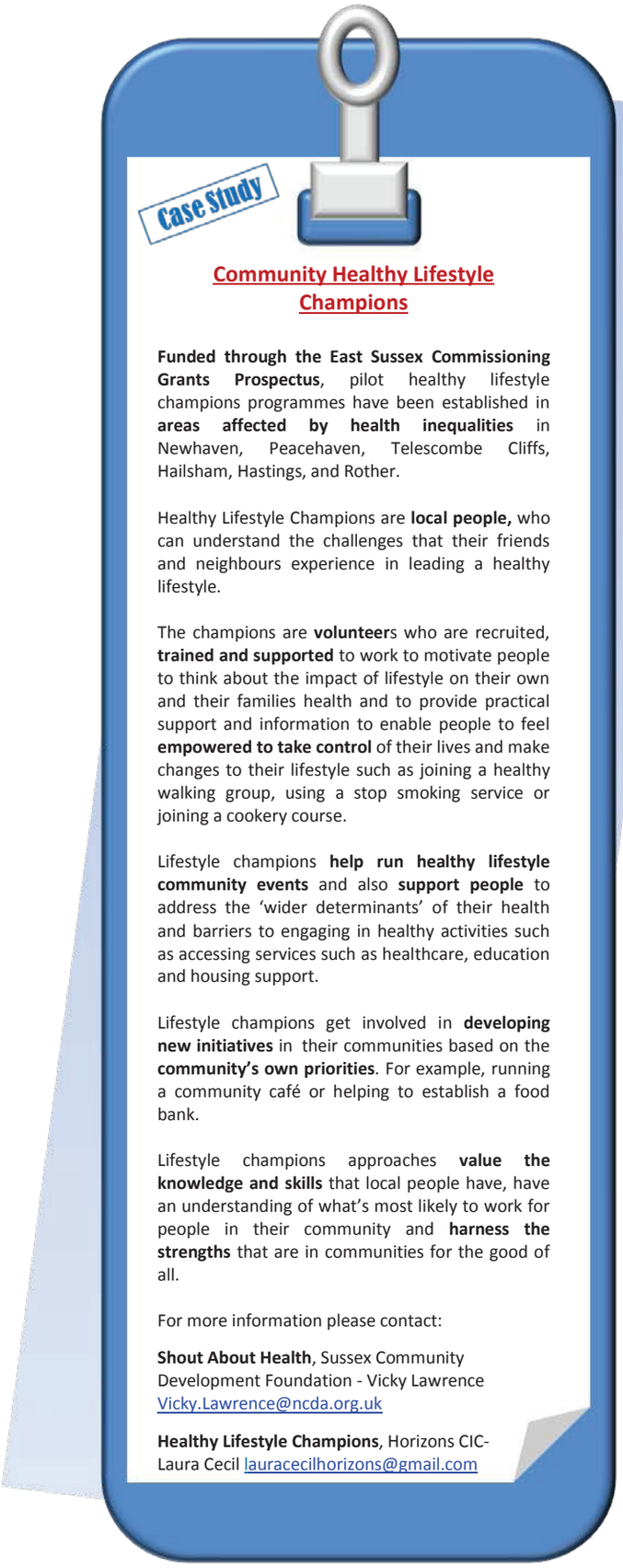
[25] The NHS Confederation and Altogether Better 2012. Community health champions: creating new relationships with patients and communities http://www.nhsconfed.org/Publications/Documents/community_health_champions.pdf

This is about people taking responsibility and acting for themselves to improve their own health and wellbeing and that of their friends and neighbours. It involves recognising that people would rather make a contribution and take control of their own health and wellbeing than have things done for them. The approach increases the voice of under-represented groups, increases volunteering and involvement in easily ignored neighbourhoods, creating a resource of volunteer health champions to work alongside the health and social care system to improve the health and wellbeing and transform the lives of people experiencing the poorest health.

Evidence from community health champions research and evaluation demonstrates that when individuals are encouraged and enabled to contribute their expertise, time and learning and feel valued and respected then positive changes are made and creative, cost-effective programmes can be co-produced.

Community Builders

The following summary is based on work undertaken by Russell for the ABCD Institute.[26] An Asset Based Community Builder is someone who is focused on engaging the skills, knowledge and talents of every community member, as well as the institutional, associational, physical, economic and cultural resources that are part of every community to a greater or lesser extent. The Community Builder's main concern is how to empower a wider, equal partnership between residents and the clubs, groups and social networks within their community and the institutions that serve them. They are community



Community Healthy Lifestyle Champions

Funded through the East Sussex Commissioning Grants Prospectus, pilot healthy lifestyle champions programmes have been established in **areas affected by health inequalities** in Newhaven, Peacehaven, Telescombe Cliffs, Hailsham, Hastings, and Rother.

Healthy Lifestyle Champions are **local people,** who can understand the challenges that their friends and neighbours experience in leading a healthy lifestyle.

The champions are **volunteer**s who are recruited, **trained and supported** to work to motivate people to think about the impact of lifestyle on their own and their families health and to provide practical support and information to enable people to feel **empowered to take control** of their lives and make changes to their lifestyle such as joining a healthy walking group, using a stop smoking service or joining a cookery course.

Lifestyle champions **help run healthy lifestyle community events** and also **support people** to address the 'wider determinants' of their health and barriers to engaging in healthy activities such as accessing services such as healthcare, education and housing support.

Lifestyle champions get involved in **developing new initiatives** in their communities based on the **community's own priorities**. For example, running a community café or helping to establish a food bank.

Lifestyle champions approaches **value the knowledge and skills** that local people have, have an understanding of what's most likely to work for people in their community and **harness the strengths** that are in communities for the good of all.

For more information please contact:

Shout About Health, Sussex Community Development Foundation - Vicky Lawrence Vicky.Lawrence@ncda.org.uk

Healthy Lifestyle Champions, Horizons CIC- Laura Cecil lauracecilhorizons@gmail.com

[26] Russell, C. A Practitioners Guide to Asset Based Community Development. An ABCD Europe Publication - 2012 http://www.abcdinstitute.org/publications/downloadable/

weavers, intent on knitting the community together relationship by relationship, asset by asset.

In the neighbourhood context the Community Builder working for a Community either directly or in partnership with an outside agency will:

- Conduct Learning Conversations: these are one-to-one, and group based conversations that last between 30-60 minutes. At least half the time of a Community Builder will be given over to these conversations (15-20 hours). These conversations are aimed at: a) developing stronger relationships with and between residents; b) discovering individual and collective motivation to act towards the common good; c) understanding what supports would be needed to support people to work with others who share their passions d) exploring mutual interests, passions and creative ideas for community building and clarifying possible next steps, e) discovering more prospects for citizen led action, f) cross fertilising stories from within the community and sharing inspiring stories from other communities.
- Develop an Initiating Group: at the beginning of every community building effort it is important to nurture groups of connectors and leaders from the community who are prepared to commit to continually widening the circle of participation. This is something that happens week by week and is fed by the learning conversations, which reveal those who are passionate about community building and inclusion.

Community Speed Watch

Community Speed Watch (CSW) is a **locally driven initiative** where active members of the community join together with the support of the Police to **monitor speeds of vehicles** using speed detection devices. Vehicles exceeding the speed limit are referred to the Police with the aim of educating drivers to reduce their speeds. Speed Watch activity is a **proactive solution to improve the safety and quality of life** for everyone in the community.

Volunteers receive **appropriate training**, and are supported by neighbourhood policing team (NPT) staff. The scheme aims to address real or perceived speed related offending, and through **partnership with the community** it is to be used in circumstances that are necessary, justifiable and proportionate to:

- **Reduce death and injury on the roads**
- **Improve the quality of life for local communities**
- **Reduce the speed of vehicles to the speed limit**
- **Increase public awareness of inappropriate speed**

There are **over 60 Community Speed Watch schemes** operating in East Sussex, with more being set up as residents and local communities embrace the opportunity to get involved in a self-help scheme that is seen as a positive benefit to road safety.

Rother District has the highest concentration of speed watch schemes, with a recent survey of speeds on Netherfield Hill show the **average speed has reduced from 45mph to 43 mph**.

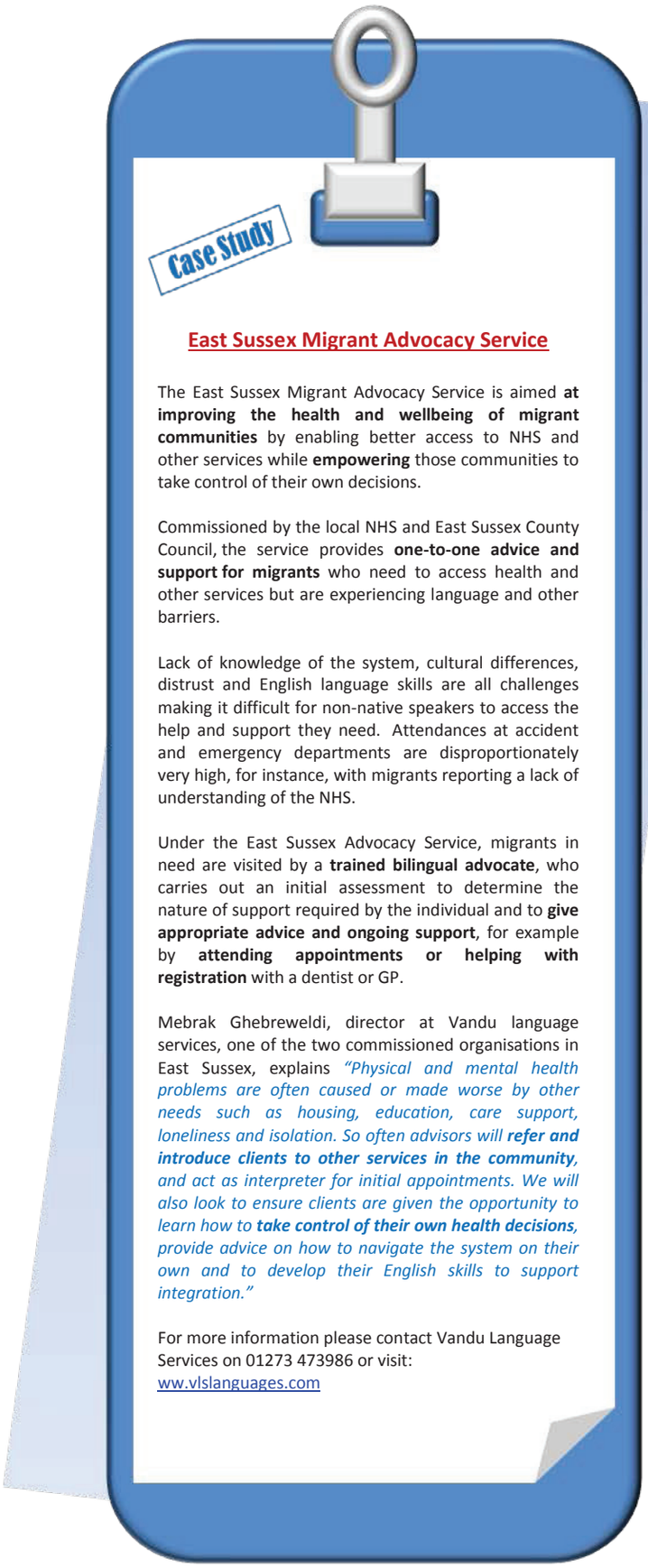
Over the last year Operation Crackdown have received over **26,000 reports of anti –social driving**, the majority supplied by active CSW Groups. In response, Sussex Police made **18,000 interventions**, with 16,000 letters sent to registered keepers of vehicles that were witnessed driving in an anti-social manner. A further **40 to 50 drivers were referred to the Roads Policing Unit** and were actively targeted. All validated reports to Operation Crackdown are kept on file for a 12 months so repeat reports about one vehicle can be identified and a higher level of intervention exercised.

Funding for schemes is available through the Sussex Safer Roads Partnership with support from Sussex Police and others.

For more information, please contact Mark Dunn, Traffic Management Officer, Sussex police: mark.dunn@sussex.pnn.police.uk.

- Build a bridge to the edge and back again: the Community Builder will have their antennae up for people who are usually left out of community life and not seen as having a contribution to make. They will take clear steps on a daily/weekly basis to reach such individuals and groups (e.g. young people) and invite them to identify, connect and contribute their knowledge, skills and talents.
- Steward citizen-led action: the Community Builder works to support citizens to ensure that the agenda is being set by a growing community partnership between citizens rather than being led by funders, government, donors or development professionals.
- Support Citizen-led action: the Community Builder will support the introduction of a matching grant scheme into the neighbourhoods they work in to support citizen led action, they will also use a range of facilitation methodologies to continue to bring residents into creative, collaborative conversations.

Moving towards a resident-led neighbourhood vision the Community Builder will work with residents through the initiating group to support them: to increase their impact and effectiveness; in reaching out to new members and making connections; including neighbours in action around the things they care about and want to work on using people power; setting project goals and building individual and community agency; doing research,



East Sussex Migrant Advocacy Service

The East Sussex Migrant Advocacy Service is aimed **at improving the health and wellbeing of migrant communities** by enabling better access to NHS and other services while **empowering** those communities to take control of their own decisions.

Commissioned by the local NHS and East Sussex County Council, the service provides **one-to-one advice and support for migrants** who need to access health and other services but are experiencing language and other barriers.

Lack of knowledge of the system, cultural differences, distrust and English language skills are all challenges making it difficult for non-native speakers to access the help and support they need. Attendances at accident and emergency departments are disproportionately very high, for instance, with migrants reporting a lack of understanding of the NHS.

Under the East Sussex Advocacy Service, migrants in need are visited by a **trained bilingual advocate**, who carries out an initial assessment to determine the nature of support required by the individual and to **give appropriate advice and ongoing support**, for example by **attending appointments or helping with registration** with a dentist or GP.

Mebrak Ghebreweldi, director at Vandu language services, one of the two commissioned organisations in East Sussex, explains *"Physical and mental health problems are often caused or made worse by other needs such as housing, education, care support, loneliness and isolation. So often advisors will **refer and introduce clients to other services in the community**, and act as interpreter for initial appointments. We will also look to ensure clients are given the opportunity to learn how to **take control of their own health decisions**, provide advice on how to navigate the system on their own and to develop their English skills to support integration."*

For more information please contact Vandu Language Services on 01273 473986 or visit: ww.vlslanguages.com

mapping and connecting assets; producing results, projects; and once the agency of the community reaches a critical mass supporting the development of a citizen-led neighbourhood vision/plan that is clear about what citizens can do with people power, what actions require outside support, and what outside agencies must do alone.

Gappers

'Gappers' are vital as they act as a connector between institutions and communities.[27] These are people who work in institutions, but who are committed to community development activity. They wear two hats – that of a bureaucrat in the day time and a community volunteer in the evening. Identifying "gappers" will point you in the direction of potential partnerships.

Leaders (e.g. at a government office) who are 'gappers' (also lives in the community as an active citizen, takes part in community initiatives) have a unique opportunity to help connect their communities with important institutional assets.[28]

Commissioners

Commissioners are key leaders in implementing a community wide Asset Based Approach. The challenge for commissioners when introducing a community wide asset based approach is to manage their own organisation. It is important that their organisations are orientated to this new approach and committed to making a success of it.

Pub is the Hub

Pub is the Hub is a national organisation of voluntary advisors for licensees of rural pubs who are thinking of broadening their range of services. They encourage licensees, communities, pub owners, breweries, local authorities and the private sector to **work together to match community needs with additional services** which can be provided by the local pub.

East Sussex County Council, Wealden District Council and "Pub is the Hub" are working together to **encourage and support pubs** who want to expand into new services for their communities.

The Brewers Arms in Herstmonceux has become a local pilot site to test out different ideas and inspire other landlords and landladies. Rebecca Elms took over the pub almost a year ago and have turned it around from being boarded up and not in use, to a successful rural country pub.

During the pub's quieter times people in the village are **encouraged to get out more** and be a **part of the local community** and a number of different initiatives are being developed to see what works and appeals to people. So far, the East Sussex Library and Information Service has put a **small book loan collection** in the pub and Rebecca is trialling a weekly **1940s lunch club** which is proving very popular.

Rebecca says ***"We get quite a few people visiting who are housebound and it gives them the opportunity to be part of the community, by coming along to one of our regular events. I spoke to a carer the other day and the lady she looks after had travelled from Uckfield. They both really enjoyed the music and it was a nice trip out for them."***

Rebecca is excited to try out the other ideas that we have, including opportunities to **link with public health initiatives**, and feels confident that possibilities for the pub are ever growing.

For more information about **Pub is the Hub**, please contact Candice Millar, Policy Development Manager, East Sussex County Council, candice.miller@eastsussex.gov.uk

For more information about the **Brewers Arms** please call 01323 831653 or visit: www.facebook.com/brewersarms

[27] Kretzmann J and McKnight J (1993) Building communities from the inside out: a path towards building and mobilizing a communities assets, Illinois: Institute for Policy Research

[28] Asset-Based Development: Success Stories from Egyptian Communities. A Manual for Practitioners - 2005 http://www.coady.stfx.ca/tinroom/assets/file/resources/abcd/CDS_manual.pdf

Some organisations are reluctant to release power to communities especially in relation to decision-making regarding allocation of resources and redeployment of finances. Experience has shown that many organisations experience difficulty in changing the culture.

Many organisations are focused on short term gains which are not realisable for some asset based initiatives. It is important that organisations involved in asset based approaches recognise that the commitment is for 3 to 5 years and that they are partners in the learning process. Not every initiative will be successful and it is important that following review, lessons are learnt and alternative strategies sought.

Processes in the Asset Based Approach Model

The key processes in the Asset Model include the following:

1. Create a Joint Strategic Asset Assessment Framework
2. Community Asset Transfer
3. Volunteering
4. Economic Assessment
5. Measuring Success

1. Create a Joint Strategic Asset Assessment Framework

The creation of a joint strategic asset assessment (JSAA) framework[29] provides a greater understanding of community assets and how they fit with Joint Strategic Needs Assessment (JSNA) to enable a broader and richer perspective to be offered into the strategic planning process. By having the strengths and assets built into a JSNA it will be easier to see the whole picture rather than just one facet of the problem or issue, thus highlighting the activity and capacity within both public sector and the community to respond to health inequalities and provide increased equity.

The JSAA can therefore support the asset mapping approach, which aims to identify the assets in an area as well as understanding the interconnections or relationships between assets within communities and individuals and organisations. The overall aim is to identify what assets are available to individuals and communities so that the community and commissioners can jointly use these assets to sustainably solve local issues and ensure that external support (through health and wellbeing service provision) can be used more effectively. The Improvement and Development Agency report “A Glass Half Full” draws together a number of tools that could be employed in a variety of combinations to achieve this (Table 1):

[29] Nelson, Campbell & Emanuel (2011) Development of a Method for Asset Based Working. Commissioned by NHS North West

Table 1: Techniques for an asset based approach

Tool	Key features
Asset mapping (AM)	Participants make an inventory of resources and skills of individuals, associations and organisations to link different parts of the community and agencies. This knowledge is used to revitalise relationships, rebuild communities, and rediscover collective power.
Asset based community development (ABCD)	ABCD builds up community groups and voluntary organisations and their informal associations and networks, collaborative relationships, shared knowledge and social capital by building pride in achievements and a realisation of their contribution. Through this, communities create confidence in their ability to be producers not recipients of development and engage in collaborative relationships with agencies.
Appreciative Inquiry (AI)	AI is a process for valuing and drawing out the strengths and successes in the history of a group, a community or an organisation, which are then used to develop a realistic and realisable vision for sustainable action. The inquiry appreciates the best of what is, thinks about what should be, and creates a shared vision and ways to achieve it.
Participatory appraisal (PA)	Local community members are trained to research views, knowledge and experience within their neighbourhood to inform assessment of future needs and priorities.
Open Space Technology (OST)	OST is a meeting to enable a diverse group to work on a complex and real issue determined by themselves. A central and open-ended question frames the event, and individuals use a "marketplace" to propose topics they want to discuss. The process works best if representatives from 'the whole system' are in the same room; that is, all the different professional, political and community stakeholders.

The JSAA framework seeks to provide a mechanism for a systematic, area-wide approach to asset mapping which links it firmly to the deficit-led Joint Strategic Needs Assessment.[30]

2. Community Asset Transfer

Community asset transfer involves the transfer of ownership or management of land and buildings of a range of types, from central government departments, agencies and local authorities to community organisations. As can be seen from Table 2 there are a variety of effective opportunities with varying degrees of flexibility for commissioners to explore following an asset mapping exercise.

Table 2: Types of Asset Transfer

Levels of community asset transfer ↑

Type	Key features
Social Enterprise	Assets used to develop more complex forms of community business with multiple objectives and diverse forms of loan and community finance
Local Development	Organisations with strong property portfolios based on asset transfer but which achieve social and environmental outcomes, including the management of contested spaces
Hybrid Assets	Assets co-financed by the state and private sector but with guaranteed community uses locked in to asset development
Short-term lease or license	A landlord, such as the Housing Executive, acts as a *wholesaler* leasing out facilities for community uses
Meanwhile Use	Temporary, short-term and flexible uses that help generate areas and make effective use of redundant assets

Joseph Rowntree Foundation, 2012

[30] Nelson, Campbell & Emanuel (2011) Development of a Method for Asset Based Working. Commissioned by NHS North West

Critical success factors for the transfer of assets include[31]:

- The transfer of the asset is just the start of the process and the best examples are linked to functioning community organisations with a clear business case, viable uses, market prices for services and revenue funding in place to sustain the facility.
- Grant investment is also important to refurbish or re-equip the asset and incubate businesses capable of producing a revenue stream at the point of transfer.
- Progressive policy-makers and an entrepreneurial attitude have helped to support responsible forms of asset transfer, trust and effective working relationships between partners.
- Skilled leaders and competent managers capable of developing the potential of the asset are also critical, and many of the most successful schemes are associated with charismatic individuals, although this is risky if succession planning is not put in place.
- Relevance to local needs is essential, and the best schemes offer a range of services and mechanisms to keep local people on board, including community financing and share options.

East Sussex Fire and Rescue Service Community Volunteer Scheme

Due to the success of a 2009 pilot of the East Sussex Fire and Rescue service Community Volunteer Scheme there are now 60 volunteers in place across East Sussex and Brighton and Hove. Motivations for getting involved range from a desire to help the local community to recipients of the fire and rescue service's help wanting to give something back.

Volunteers undertake a range of activities from role playing in training activities to telling householders about free home safety visits, to supporting the service with the work it carries out with partnership agencies. Volunteers act as the eyes and ears on a local level to reach those who are most vulnerable, and also bring additional skills, for example one volunteer was able to use their British Sign Language skills to communicate with a deaf couple at a safety event.

The Scheme was recently awarded funding for a three year Health and Wellbeing project after a successful pilot in 2013. Volunteers are trained to undertake health and wellbeing visits to those who have already received a Home Safety Visit (HSV) from the service and have been identified as vulnerable. Volunteers work through a checklist of health and wellbeing questions (around fuel poverty, slips/trips/falls, healthy eating, mobility, etc) and if necessary, ESFRS refer the individuals for additional support. Examples of support they have been able to access for individuals include grabrails, winter warmth checks, and many referrals to Living Well service. A key element of the project is to explore ways to fund effective preventative interventions locally.

In 2014 the scheme was awarded a grant to pilot a *Safe as Houses* project to support the police services with burglary prevention and after incident support by providing support and advice to residents.

For more information please contact Claire Harris, Scheme Manager, ***East Sussex Fire and Rescue Service***
Headquarters, 20 Upperton Road,
Eastbourne, BN21 1EU
Phone 07950 876771
www.esfrs.org/communityvolunteers
E-mail claire.harris@esfrs.org

31 Murtagh, B., Bennett, E., Copeland, L and Goggin, N. (2012) Community Asset Transfer in Northern Ireland. Joseph Rowntree Foundation Report

3. Volunteering

The asset based approach aims to bring about the conditions within a community under which individuals are more likely to volunteer (an 'emergent' behaviour). Pursuing the broader agenda of the asset based approach is therefore an effective way of increasing volunteering in the long-term.

Volunteering is any activity in which time is given freely to benefit another person, group or cause. Volunteering is part of a cluster of helping behaviours, entailing more commitment than spontaneous assistance but narrower in scope than the care provided to family and friends.

Volunteering has been shown to have benefits to the individuals themselves as well as communities. The amount of time spent by an individual in volunteerism is positively related to agreeableness, conscientiousness, emotional stability, and low psychoticism. These findings are more robust when individuals are psychologically committed to rather than simply demographically associated with the volunteering role.[32]

Volunteering has also been found to have positive effects on life-satisfaction, self-esteem, self-rated health, and for educational and occupational achievement, functional ability, and mortality.

Case Study

Building Stronger Bridges Project

The Building Stronger Bridges project aims to establish a network of volunteer good neighbour groups (and to identify and build upon existing networks) across the County which can provide for low to moderate care needs and hopefully reduce the demand for formal social care services. This builds on a model already established in Rother.

'Rother Friends' are self-sustaining local groups of volunteers who arrange their own training and insurance checks, raise money to support themselves and provide social contact, helping hands, advice and information for those needing support.

There are currently five local voluntary organisations contracted until at least May 2015 to develop good neighbour programmes across the county:

Coverage	Organisation	Contact Details
High Weald including Chailey)	**Action in Rural Sussex**	Teresa Gittins (01273 407306 or 07825506652) Teresa.Gittins@ruralsussex.org.uk
Lewes and down to the Havens area	**Royal Voluntary Service**	Nadine Fry on 0742347101 Nadine.Fry@royalvoluntaryservice.org.uk
Hailsham area including Polegate and Herstmonceux)	**Hailsham Trust**	**(01323 446404)** Tammy Milne 01323 446404; 07518566880 (m) Tammy@ncda.org.uk
Hastings and Rother District	**Rother Voluntary Action**	Jan Cutting (01424 217259 or 07866 637 574) jan.cutting@rva.uk.com
Eastbourne and Seaford area	**Age Concern Eastbourne**	Lisa Gillette (01323 638474). lisa.gillette@ageconcerneastbourne.co.uk

To date 21 potential groups have been identified across the county, with more expected to be added, including further development of the eleven Rother Friends groups.

Once each group is established Adult Social Care will support them to enable them to feel confident taking referrals from social care and other organisations including GP surgeries.

The first good neighbour schemes should be able to take referrals by November 2014.

[32] Lodi-Smith J, Roberts BW. Social investment and personality: a meta-analysis of the relationship of personality traits to investment in work, family, religion, and volunteerism. Pers Soc Psychol Rev. 2007 Feb;11(1):68-86. doi: 10.1177/1088868306294590. http://www.ncbi.nlm.nih.gov/pubmed/18453456

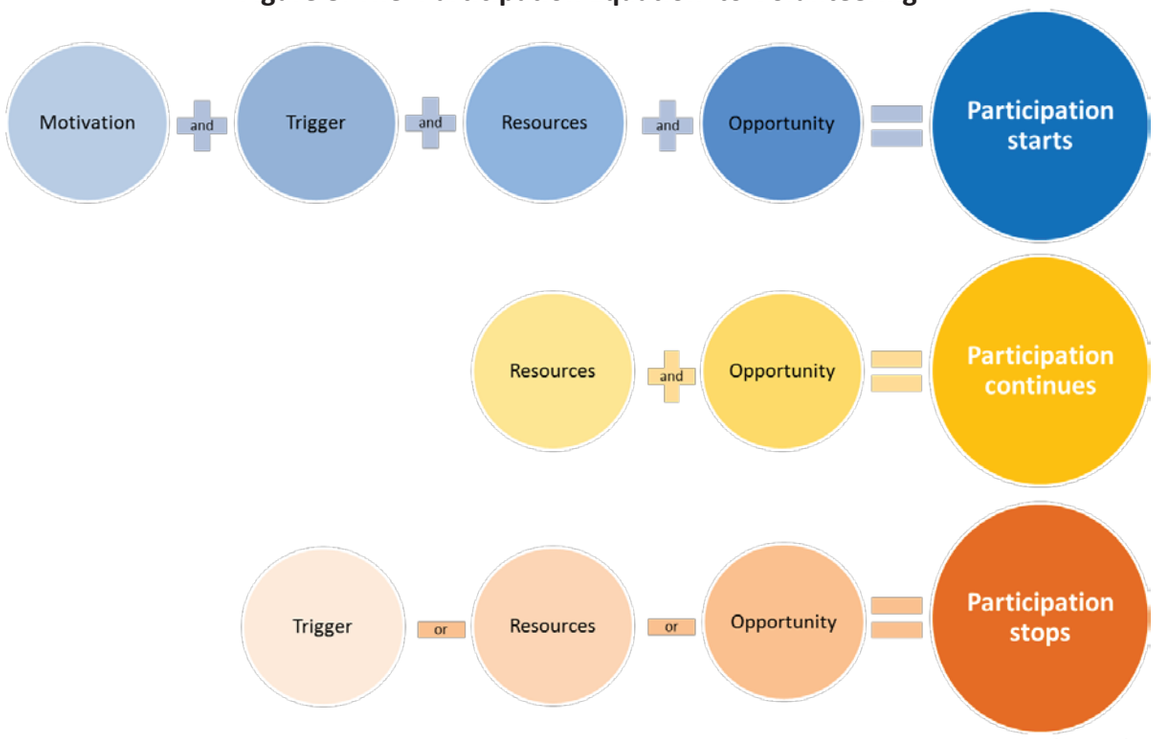
Innovative forms of volunteering include time-banking, an asset-based approach in which community members or service users support each other directly. Participants contribute according to their particular skills, exchanging unpaid labour in hourly units and earning time credits by doing so. There are more than 250 recognised time banks in the UK, including more than 50 that have a particular focus on health, mental health or social care (see www.timebanking.org).[33]

Volunteering produces financial benefit with each £1 investment in a volunteering programme yielded an average return of between £4 and £10, with these returns shared between the organisation, service users, volunteers and the wider community.[34]

Research suggests motivations keeping volunteers going, include: the quality of the volunteering experience; whether the volunteer feels like they are making a difference and having impact; if the volunteer feels valued; if the volunteer is enjoying their experience; and the quality of their relationships with others while volunteering. These are likely to be affected by both individual and organisational factors.[35] The concept as summarised by Brodie et al is shown in Figure 8.[36]

[33] Mundle C, Naylor C, Buck D (2013). 'Volunteering in health and care – a summary of key literature'. Available at: www.kingsfund.org.uk/publications/volunteering-health-and-care (accessed on 6 November 2013)
[34] Teasdale S (2008). In Good Health. Assessing the impact of volunteering in the NHS. London: Institute for Volunteering Research. Available at: www.volunteering.org.uk/NR/rdonlyres/47F941B1-F3A2-4F4D-971E-9DCCD23408E2/0/in_good_health_final_report.pdf
[35] The King's Fund. Volunteering in health and care in England. A summary of the key literature. July 2012
[36] Brodie E, Hughes T, Jochum V, Miller C, Ockenden N, Warburton D (2011). Pathways Through Participation: What creates and sustains active citizenship? Summary report. London: Pathways through Participation

Figure 8: The 'Participation Equation' to Volunteering



Source: Brodie et al, 2011

4. Economic Assessment

Evidence on the economic paybacks of investing in community assets is as yet limited. However, there is strong and growing evidence that social networks and social capital increase people's resilience to and recovery from illness.

Research from the field of social capital suggests that there is a relationship between social capital and labour force status, but this is not always straightforward. For those with limited social capital the strength of their close ties may be important in helping to find work, whereas for other bridging capital is important. Research in Australia concluded that a combination of different types of social capital are important in determining labour market outcomes.[37]

There is better evidence on some of the individual components of a local strategic approach to building and utilising community assets.[38] For example, as mentioned earlier, every £1 spent on health volunteering programmes returns between £4 and £10, shared between service users, volunteers and the wider community.

British Red Cross volunteers have been shown to generate cost-savings equivalent to three and a half times their costs.[39] An evaluation of 15 specific community health champion projects found

[37] Stone, Gray and Hughes (2003) Social Capital at work: How families, friends and civic ties relate to labour market outcomes. Research Paper No. 31. Australian Institute of Family Studies

[38] Knapp M, Bauer A, Perkins M, Snell T (2011). Building Community Capacity: Making an economic case [online]. Available at: www.thinklocalactpersonal.org.uk/BCC/Latest/resourceOverview/?cid=9300

[39] Naylor C, Mundle C, Weaks L, Buck D (2013). Volunteering in Health and Care: Securing a sustainable future. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/volunteering-health-and-care

that they delivered a social return on investment of between around £1 and up to £112 for every £1 invested.[40]

The Building Community Capacity for Putting People First project commissioned Professor Martin Knapp of the National Institute for Health Research School for Social Care Research at London School of Economics to show the economic impact of the community capacity-building initiative compared to what would happen in the absence of such an initiative.[41]

The research concluded that it was not possible in the time available to attach an economic value to a broadly based community development programme as had been intended. The reasons being that such programmes are necessarily complex, multi-faceted and evolve through contestation; evaluation work has focused on process rather than outcomes and been qualitative rather than quantitative.

They therefore chose three specific interventions that could be a component of a wider effort to build community capacity, and ones for which they could calculate the costs of the intervention and the potential savings and economic benefits that arise as a result. Their study shows the following:

Chances4Change(C4C)

The Chances4Change programme is a two year Big **Lottery funded project** in Hastings and Eastbourne. Working through local voluntary and community organisations Chances4Change **engages local people** in a programme to:

- **Support local community members** to make best use of community resources such as community centres, pubs, church halls, and outdoor spaces that could be available and are under- utilised by marginalized groups for health improvement activities;
- **Identify previously untapped volunteers.** Local people who would be willing to 'lend a hand' or help their neighbours but who wouldn't usually see themselves as 'volunteers'; and
- **Link vulnerable people** who may be socially isolated and/or have care and support needs into low level and informal health improvement support in their area.

To date, the programme has **enabled community assets to be identified** through a mapping process, recruited local people to act as **volunteers** in their neighbourhoods, supported small and/or informal **community clubs and groups** to reach into local communities and to **work more closely** with each other to open up their groups to others, and encouraged local eating establishments to get involved with work to develop **healthier eating** opportunities.

Following the positive reception of the programme in Eastbourne and Hastings, public health funded pilot projects have been established across the rest of the county. In addition to the kinds of activity identified above, the Chances4Change district pilots have a particular focus on **developing participatory approaches**, helping to understand how to best engage local people and measure success.

The Chances4Change strength based approach aims to **identify and grow local assets,** focussing in particular on communities that may have previously been viewed as having few or no resources.

For more information on what is happening in each area please contact the following

- Hastings: **HVA.** Contact Su Barnicoat, su@hvauk.org
- Eastbourne: **3VA** Contact Helen Meade helen.meade@3VA.org.uk or Jo Leinster, Jo.Leinster@3va.org.uk
- Weald District: **AirS** Contact Teresa Gittins, Teresa.Gittins@ruralsussex.org.uk
- Lewes District: **SCDA** Contact Ian Kedge, ian@ncda.org.u

For more information about the programme as a whole please contact: Tina Cook, Health Improvement Principal tina.cook@eastsussex.gov.uk

[40] Hex N, Tatlock S (2011). Altogether Better: Social Return on Investment (SROI) Case Studies. York: York Health Economics Consortium. Available at: ww.altogetherbetter.org.uk/Data/Sites/1/sroiyhecreport1pagesummaryfinal.pdf

[41] Knapp, Bauer t al. http://www.thinklocalactpersonal.org.uk/_library/BCC/key_issues_06.pdf

- **Befriending schemes** typically cost about £80 per older person but could save about £35 in the first year alone because of the reduced need for treatment and support for mental health needs. There could well be savings in future years too. Knapp et al state: "If we then also look at quality of life improvements as a result of better mental health – using evidence from some of the Partnerships for Older People Projects pilots – their monetary value would be around £300 per person per year.
- The cost per member of a **time bank** would average less than £450 per year, but could result in savings and other economic payoffs over £1,300 per member. Knapp et al add: "This is a conservative estimate of the net economic benefit, since time banks can achieve a wider range of impacts than those we have been able to quantify and value."
- **'Community navigators'** working with hard-to-reach individuals to provide benefit and debt advice cost just under £300 but the economic benefits from less time lost at work, savings in benefits payments, contribution to productivity and fewer GP visits could amount to £900 per person in the first year.

Patients in Control

Launched in 2014, the *Patients in Control* pilot project is **a joint venture** on behalf of GP practices and their patients within Eastbourne, Hailsham and Seaford Clinical Commissioning group, East Sussex County Council and Healthwatch East Sussex (the independent consumer champion for health and social care services), and is aimed at **helping patients better manage their own long-term conditions** through **peer support**, **training** and use of **technology.**

In England over 15 million people have a long-term condition - a health problem that can't be cured but can be controlled by medication or other therapies, for example high blood pressure, depression, dementia, arthritis and diabetes.

Funding has been awarded to offer a **six-week programme** to 40 local patients (ten each from four GP practices) with long-term conditions. **Specially-trained volunteer coaches** will work with patients to help build the **confidence, knowledge and skills** to improve the way they manage their long-term health condition, including use of the internet and technology.

Patients will be enabled to use an online platform called *Know Your Own Health,* where they will be able to **set goals** and **access personalised knowledge and advice** on a range of ways to stay healthy including exercise, nutrition and other lifestyle factors.

Based on the success of this model elsewhere in England, it is anticipated that *Patients in Control will* **help develop knowledge** in primary care and the wider community about **successful management** of long-term conditions. It will also enable **more integrated and personalised care** for the many local people receiving both NHS and social care.

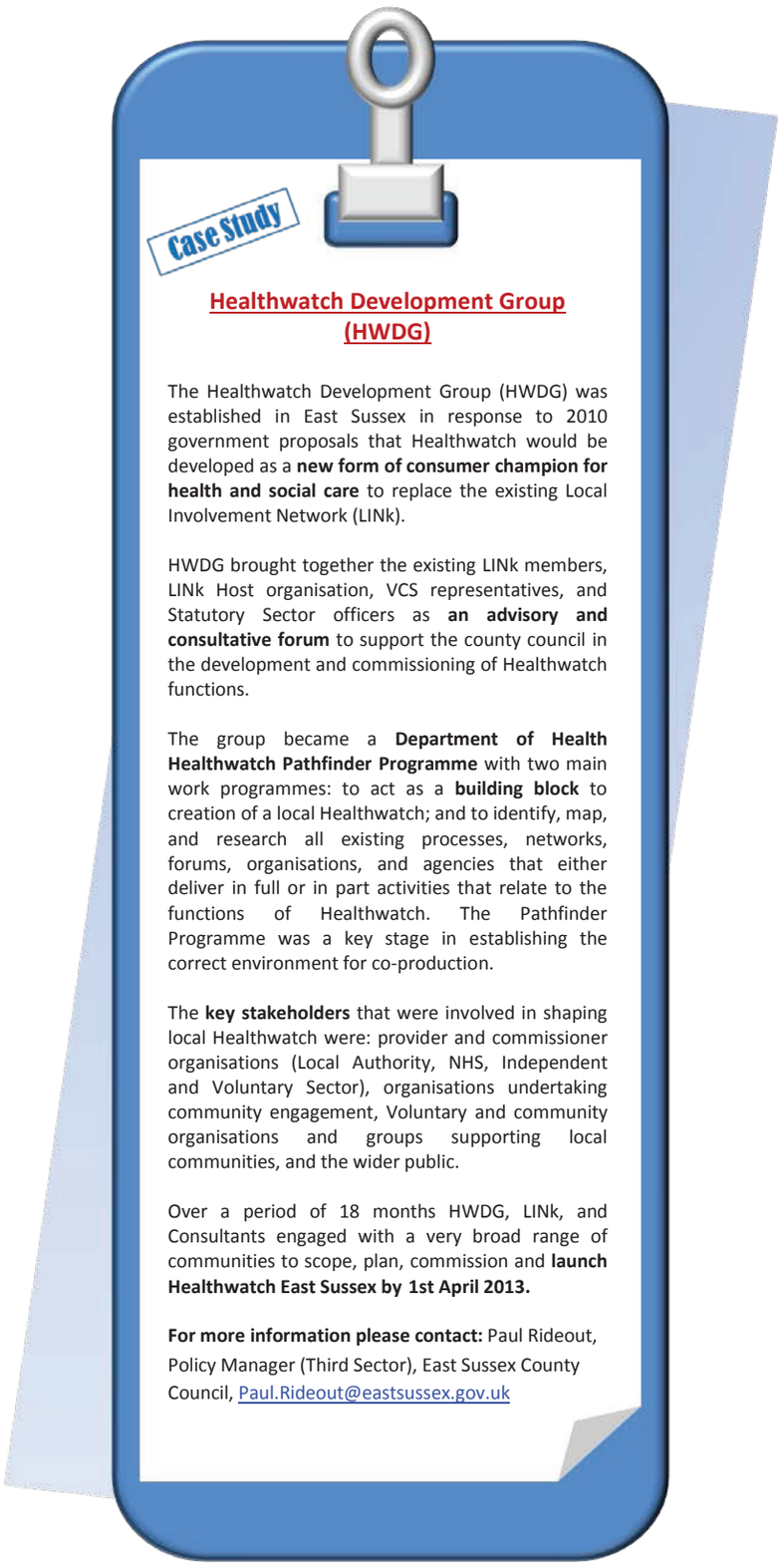
Patients in Control supports the aims of the East Sussex Better Together programme – our over-arching approach to working together to transform and improve health and social care.

Social Return on Investment Framework

New Economics Foundation's model of social return on investment (SROI) is a well-established framework and is recognised by HM Treasury. It helps organisations understand and quantify their impact and social value. It applies 'financial values' to social and environmental outcomes that do not have a 'market traded price', such as self-esteem, resilience, meaning and purpose, and supportive relationships. It is therefore of potential interest to asset practitioners, commissioners and decision-makers who want to demonstrate the cost effectiveness of their work, manage their business to maximise social value and take account of the full range of costs and benefits to all stakeholders.

New Economics Foundation and the Community Development Foundation sponsored the Community Catalysts action research project,[42] which used SROI with four local councils to evaluate their community development activity. Their headline findings were:

- "For each £1 invested by a local authority in community development activities and by the volunteers' time input to deliver activities, £2.16 of social and economic value is created.
- For every £1 that a local authority invests in a community development worker, £6 of value is contributed by community members in volunteering time."



Healthwatch Development Group (HWDG)

The Healthwatch Development Group (HWDG) was established in East Sussex in response to 2010 government proposals that Healthwatch would be developed as a **new form of consumer champion for health and social care** to replace the existing Local Involvement Network (LINk).

HWDG brought together the existing LINk members, LINk Host organisation, VCS representatives, and Statutory Sector officers as **an advisory and consultative forum** to support the county council in the development and commissioning of Healthwatch functions.

The group became a **Department of Health Healthwatch Pathfinder Programme** with two main work programmes: to act as a **building block** to creation of a local Healthwatch; and to identify, map, and research all existing processes, networks, forums, organisations, and agencies that either deliver in full or in part activities that relate to the functions of Healthwatch. The Pathfinder Programme was a key stage in establishing the correct environment for co-production.

The **key stakeholders** that were involved in shaping local Healthwatch were: provider and commissioner organisations (Local Authority, NHS, Independent and Voluntary Sector), organisations undertaking community engagement, Voluntary and community organisations and groups supporting local communities, and the wider public.

Over a period of 18 months HWDG, LINk, and Consultants engaged with a very broad range of communities to scope, plan, commission and **launch Healthwatch East Sussex by 1st April 2013.**

For more information please contact: Paul Rideout, Policy Manager (Third Sector), East Sussex County Council, Paul.Rideout@eastsussex.gov.uk

[42] Catalysts for Community Action and Investment: a social return on investment analysis of community development work based on a common outcomes framework. (ref October 2010) www.cdf.org.uk/web/guest/publication?id=362954

5. Measuring Success

Measuring outcomes is less straight forward under an asset based approach. Quantitative indicators are less useful and timescales for returns are more uncertain. Organisationally measurements are also more challenging as investment by one institution (e.g. health) may accrue benefits in another (e.g. criminal justice). It should also be noted that as the ultimate aim of an asset based approach is to create communities that solve their own problems, if successful, institutions will not be involved. Such success is therefore 'under the radar'.

Outcomes vary according to the stage of the development of a community wide asset based approach. There are early indicators of engagement: willingness to try new approaches; willingness to establish cross boundary communications and activities between organisations; willingness to delegate responsibility to the community; and willingness to reallocate funding. The challenge is to identify indicators that measure the processes being implemented and the useful outcomes, for example delivery of better services, developing more trusting relationships with local people, or gaining better knowledge of local needs.

Developing Assets – a whole system approach

The 2011 NHS Northwest document 'Living well across local communities – Prioritising wellbeing to reduce inequalities: the asset approach to living well' is the North West's call to action to reduce inequalities. It recommends that for the asset approach to work effectively it needs to be applied across many parts of the local system(s). Figure 9 and Table 3 are adapted from the 2011 NHS Northwest document.

This report identifies some of the things that can be done differently across the whole system in order to implement an asset based approach. However, developing a whole system approach takes time. It is not developed overnight and launched in a big bang approach. A whole system approach starts by building on what already exists and is built up progressively.

Figure 9: Whole system asset approach

Source, NHS Northwest, 2011

Table 3: Applying a whole system asset approach

Key task	Practical application
1. Leadership and vision	Personal commitment and Health and Wellbeing strategies.
2. JSNA	Enhanced Joint Strategic Needs and Asset Assessment.
3. Asset mapping	Public sector engagement with community-led initiatives. Asset maps to inform JSNA/JSAA.
4. Community development infrastructure	Developing a local infrastructure for (asset based) community development.
5. Strengths based working and referral	Strength based assessment processes, referral pathways and social interventions.
6. Community budgets and commissioning	Use of community budgets and commissioning which recognises and builds on strengths, skills and resources.
7. Appreciative Inquiry	Use of appreciative inquiry (AI) in organisational development processes. AI is a process for appreciating the best of what is, thinking about what should be, and creating a shared vision and ways to achieve it.
8. Organisational asset and skills audit	Skills audits and personal development plans aligned to emerging organisational priorities. Sharing resources.
9. Time banking transfer	Transfer of physical assets to communities. Credit exchange schemes.
10. Indicators and measures	Use of local asset based outcomes and indicators for monitoring purposes.

Source, NHS Northwest, 2011

Using an Asset Based Approach to Improve Outcomes

There is strong evidence to suggest interventions which increase people's support networks and social connections improve health and reduce illness and death rates. Dr Brian Fisher of the Health Empowerment Leverage Project (HELP) has written a comprehensive literature review of the impact of community development.[43] Among the many findings in his review, he shows that low levels of social integration, and loneliness, significantly increase mortality whilst people with stronger networks are healthier and happier[44] and social networks are consistently and positively associated with reduced illness and death rates.[45,46,47]

Five Ways to Wellbeing

The Five Ways to Wellbeing is a set of evidence-based public mental health messages aimed at improving the mental health and wellbeing of the whole population. They were developed by NEF (the New Economics Foundation) as the result of a commission by Foresight, the UK government's futures think-tank, as part of the Foresight Project on Mental Capital and Wellbeing.[48] The five ways to Wellbeing are:

Strategic Property Asset Collaboration Programme in East Sussex (SPACES)

SPACES is a **partnership** between local authorities, emergency services, some central government departments, health and the community and voluntary sector to **identify and deliver opportunities for collaboration and co-location** with a property emphasis using existing skills and resources.

As well as **financial savings targets**, service related benefits include **co-location of related services enabling service transformation**, provision of **outreach** from partners premises, and a more coherent and coordinated response to service user needs.

SPACES operate around a **joint vision and principles** rather than joint policies and strategies to allow partners to move in a joint direction while retaining their own ways of working.

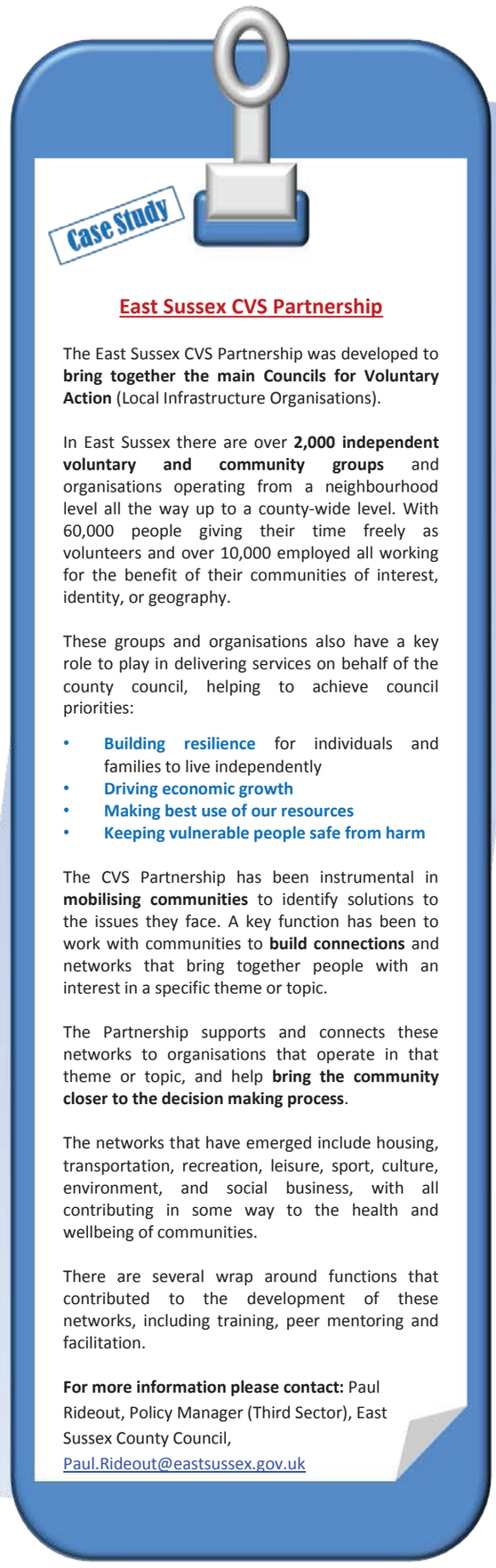
Key activities within SPACES include:

- **Co-location** (for example Sussex Police and Eastbourne and Hastings Councils, and Jobcentre Plus using council premises for outreach)
- **Joint procurement** (for example two joint contracts have been awarded)
- **Storage** (more cost effective storage by organisations working together)
- **Collaborative Workspace** (flexible sharing of spaces)

For more information please contact: Simone Cuthbert, SPACES Programme Manager, Simone.Cuthbert@eastsussex.gov.uk

[43] Fisher B. (2011) Community Development in Health – A Literature Review www.healthempowermentgroup.org.uk
[44] Bennett K. (2002) 'Low level social engagement as a precursor of mortality among people in later life' Age and Ageing 31: 165-168
[45] Fabrigoule C, Letenneur L, Dartigues J et al. (1995) 'Social and leisure activities and risk of dementia: A prospective longitudinal study' Journal of American Geriatric Society 43: 485-90
[46] Bassuk S, Glass T and Berkman L. (1999) 'Social disengagement and incident cognitive decline in community-dwelling elderly persons' Annals of Internal Medicine 131: 165-73
[47] Berkman LF and Kawachi I (2000) 'A historical framework for social epidemiology' in Berkman LF and Kawachi I (Eds.) Social epidemiology. Oxford: Oxford University
[48] New Economics Foundation (2008) Five Ways to Wellbeing: The Evidence. http://www.neweconomics.org/page/-/files/Five_Ways_to_Wellbeing_Evidence.pdf

- **Connect…** With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
- **Be active…** Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
- **Take notice…** Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
- **Keep learning…** Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.
- **Give…** Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.



East Sussex CVS Partnership

The East Sussex CVS Partnership was developed to **bring together the main Councils for Voluntary Action** (Local Infrastructure Organisations).

In East Sussex there are over **2,000 independent voluntary and community groups** and organisations operating from a neighbourhood level all the way up to a county-wide level. With 60,000 people giving their time freely as volunteers and over 10,000 employed all working for the benefit of their communities of interest, identity, or geography.

These groups and organisations also have a key role to play in delivering services on behalf of the county council, helping to achieve council priorities:

- **Building resilience** for individuals and families to live independently
- **Driving economic growth**
- **Making best use of our resources**
- **Keeping vulnerable people safe from harm**

The CVS Partnership has been instrumental in **mobilising communities** to identify solutions to the issues they face. A key function has been to work with communities to **build connections** and networks that bring together people with an interest in a specific theme or topic.

The Partnership supports and connects these networks to organisations that operate in that theme or topic, and help **bring the community closer to the decision making process**.

The networks that have emerged include housing, transportation, recreation, leisure, sport, culture, environment, and social business, with all contributing in some way to the health and wellbeing of communities.

There are several wrap around functions that contributed to the development of these networks, including training, peer mentoring and facilitation.

For more information please contact: Paul Rideout, Policy Manager (Third Sector), East Sussex County Council, Paul.Rideout@eastsussex.gov.uk

The Five Ways to Wellbeing has great synergies with the asset based approach. There is growing support for the promotion of the Five Ways to Wellbeing' as something we should all include in our everyday lives. Irrespective of your state of physical or mental health, engaging in the Five Ways to Wellbeing is beneficial.

Prevention

The asset based approach can be harnessed around any preventative issue. For example, the approach can be used in the context of health protection with communities being prepared for extreme weather conditions that might impact adversely. Another example is a rural community mobilising its assets to develop and procure a rapid broadband facility for the benefit of all sections of the community. This action can be seen to:

- prevent poor performance in school by school children being able to effectively do homework;
- prevent carers from having to give up work by enabling access to web-based employment opportunities, for example being able to run businesses from home; and
- prevent further isolation and loneliness of people with mobility issues or disabilities by keeping them connected with family, friends and facilities.

Within the realm of health, wellbeing and social care prevention, the asset based approach can: promote independence, prevent or delay the deterioration of wellbeing resulting from unhealthy lifestyles, ageing, illness or disability, delay the need for more costly and intensive services. Preventive services represent a continuum of support covering a range of primary, secondary and tertiary preventative services:

- **Primary prevention** is aimed at people who have no particular social care needs or symptoms of illness, i.e. to prevent onset of a problem in the general population. The focus is therefore on maintaining independence, good health and promoting wellbeing. Interventions include promoting health and active lifestyles, supporting people to change health related behaviour, providing universal access to good quality information, activities to reduce social isolation, practical help with tasks like shopping or gardening, intergenerational activities and transport and other ways of helping people get out and about, supporting safer neighbourhoods, etc.
- **Secondary prevention** aims to identify people at risk or with a known problem at an early stage and to halt or slow down any deterioration, and actively seek to improve their situation. The focus is on a target population. Interventions include medication to treat people with high blood pressure, weight management programmes for those overweight, screening and case finding to identify individuals at risk of specific health conditions or events, or those who have existing low level social care needs.
- **Tertiary prevention** is aimed at minimising disability or deterioration from established health conditions or complex social care needs. The focus here is on maximising people's functioning and independence through interventions such as rehabilitation, reablement services and joint case management of people with complex needs.

An important element in asset based approaches to public health prevention is aiming to take a whole person and community approach to improving health rather than looking at a single health issue. Wellness services are one approach to this which aims to change the relationship between service users and services by empowering individuals to maintain and improve their own health. A key aim is to use the combined resources of health, social care and the assets of the community to deliver care.

The Liverpool Public Health Observatory report[49] reviewed different wellness services, ranging from partnerships for older people to Job Centre Plus condition management programmes. The majority of services reviewed were found to be cost-effective and showed potential to give a return on investment and save future costs due to ill health.

Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live independently. The report also found wellness services could provide an effective response to frequent attendees in primary care, while tackling the underlying causes of their visits. Many of the services, such as social prescribing, have little or no cost in comparison to medical treatment.

Other reports and guides demonstrate the value and cost effectiveness of wellness services, such as a guide to developing and commissioning non-traditional providers to support the

Patient Participation Groups

Patient Participation Groups (PPGs) are **small independent groups** of motivated and passionate patients, registered with an individual GP practice and who **work closely with the staff** from that practice to **discuss, plan and inform improvements and developments** within their local surgery.

As well as working on local practice issues, PPG members are an **engaged and informed network** of local people, interested in local healthcare issues and who have **valuable skills, knowledge and insight** into patient experiences that commissioners and providers local services need to hear.

The newly reformed NHS structure has **reinvigorated opportunities** for patient and public participation which Clinical Commissioning Groups (CCGs) across East Sussex have truly embraced. CCGs have recognised a need for a **more formal network** to bring local groups together within their localities and create a space and **forum to share ideas, best practice and develop a joint approach** to tackle the challenges and opportunities they face.

Over the last 18 months, CCGs have established a **regular cycle of locality based PPG forums** which provide important news, updates and context on local health issues. CCGs have also used their networks and relationships with other organisations including NHS providers and other partners, to ensure **PPGs have a direct route to share local patient voice** and ensure it is taken into consideration on a diverse range of issues affecting local healthcare, such as the recent consultation on local maternity and paediatric services.

Working together with Healthwatch, the health and social care consumer champion and local Voluntary Action groups, CCGs have also facilitated a **series of learning and development days for over 100 PPG members** who were keen to explore opportunities for further training and development to equip members to form much **more effective relationships** with their local practice patient populations.

Moving forward, they have a **fundamental role to play** in the patient and public engagement which is at the heart of **East Sussex Better Together**, a programme which has commissioners of health and social care services working together to transform local services.

If you are interested in finding out more or getting involved with your local patient participation group, please contact your GP practice manager in the first instance.

[49] Winters L, Armitage M, Stansfield J, Scott-Samuel A, Farrar (2010) A: Wellness services – evidence-based review and examples of good practice. Observatory Report Series No.76, Liverpool Public Health Observatory. www.apho.org.uk/resource/item.aspx?RID=105856

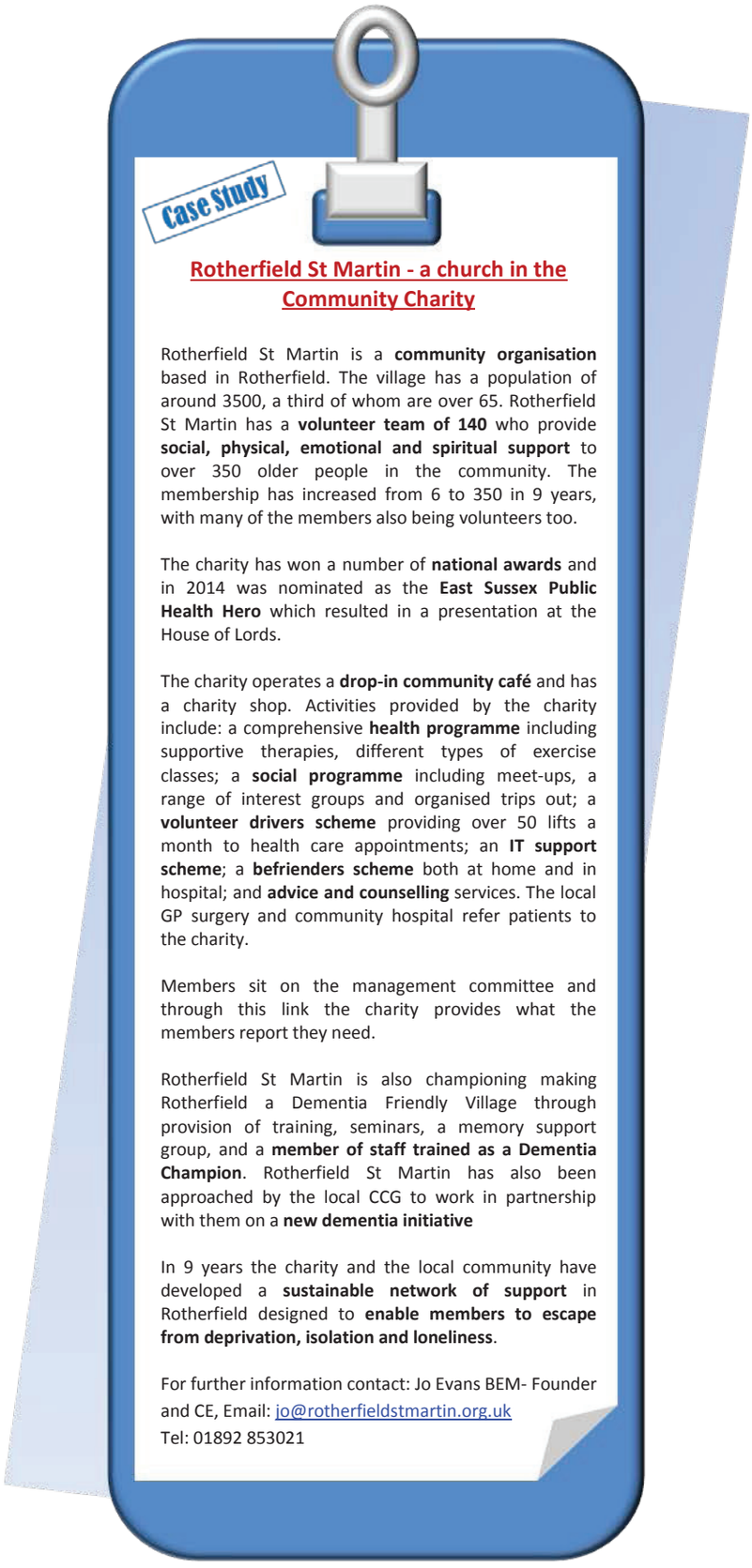
self-management of people with long-term conditions.[50]

Loneliness and Isolation

Social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services. There are a number of population groups vulnerable to social isolation and loneliness, (e.g. young care-leavers, refugees and those with mental health problems). Nevertheless, older people (as individuals as well as carers) may have specific vulnerabilities associated with 'loss of friends and family, loss of mobility or loss of income.

The benefits to individuals and the wider community of reducing loneliness or social isolation are therefore self-evident. For the individual, mitigating loneliness will improve quality of life. Similarly, such changes may impact on subsequent health and social care service use, limiting dependence on more costly intensive services and contributing to the 'healthy ageing' agenda by 'compressing' morbidity. Supporting social engagement also provides benefits to the wider community.

Reducing social isolation enables a possible 'harnessing' of potential contribution to the community through, for example volunteering and caring responsibilities.



Rotherfield St Martin - a church in the Community Charity

Rotherfield St Martin is a **community organisation** based in Rotherfield. The village has a population of around 3500, a third of whom are over 65. Rotherfield St Martin has a **volunteer team of 140** who provide **social, physical, emotional and spiritual support** to over 350 older people in the community. The membership has increased from 6 to 350 in 9 years, with many of the members also being volunteers too.

The charity has won a number of **national awards** and in 2014 was nominated as the **East Sussex Public Health Hero** which resulted in a presentation at the House of Lords.

The charity operates a **drop-in community café** and has a charity shop. Activities provided by the charity include: a comprehensive **health programme** including supportive therapies, different types of exercise classes; a **social programme** including meet-ups, a range of interest groups and organised trips out; a **volunteer drivers scheme** providing over 50 lifts a month to health care appointments; an **IT support scheme**; a **befrienders scheme** both at home and in hospital; and **advice and counselling** services. The local GP surgery and community hospital refer patients to the charity.

Members sit on the management committee and through this link the charity provides what the members report they need.

Rotherfield St Martin is also championing making Rotherfield a Dementia Friendly Village through provision of training, seminars, a memory support group, and a **member of staff trained as a Dementia Champion**. Rotherfield St Martin has also been approached by the local CCG to work in partnership with them on a **new dementia initiative**

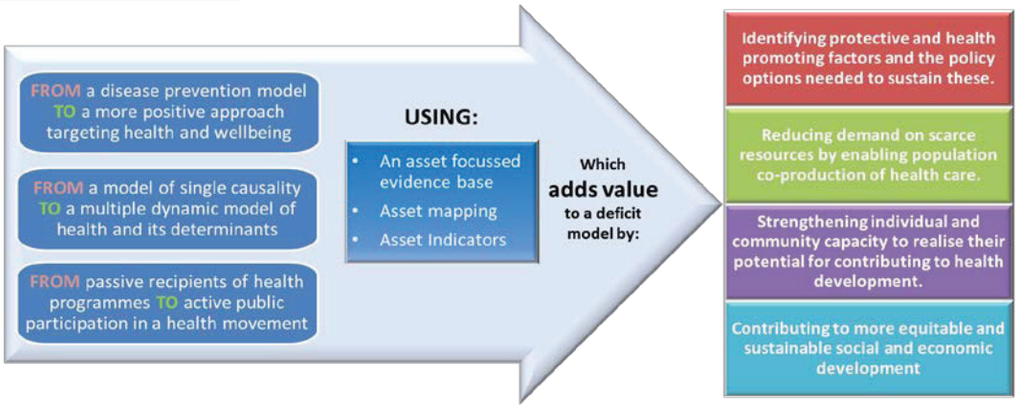
In 9 years the charity and the local community have developed a **sustainable network of support** in Rotherfield designed to **enable members to escape from deprivation, isolation and loneliness**.

For further information contact: Jo Evans BEM- Founder and CE, Email: jo@rotherfieldstmartin.org.uk
Tel: 01892 853021

[50] Thanks for the petunias: a guide to developing and commissioning non-traditional providers to support the self management of people with long-term conditions
www.diabetes.nhs.uk/year_of_care/commissioning/thanks_for_the_petunias__a_guide_to_developing_and_commissioning_nontraditional_providers

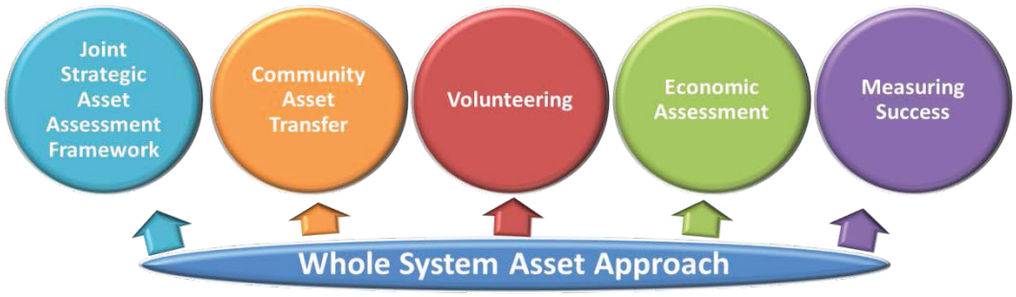
SECTION SUMMARY:
THE ASSET BASED APPROACH

Adopting, and realising the benefits of an asset based approach means **refocusing both policy thinking and interventions**:



Key agents within an asset based approach are: **CHAMPIONS**; **GAPPERS**; **COMMUNITY BUILDERS**: and **COMMISSIONERS.**

Key Processes in an asset based approach are:



The asset approach can:

- Give a **richer and broader perspective** to the strategic planning process
- **Highlight capacity** in both public sector and community to provide more equity.
- **Increase support networks** and connections to improve health and reduce illness
- Promote independence and **build community resilience**
- **Improve outcomes** and delay the need for more costly and intensive services
- **Reduce social isolation** and enable "harnessing" of potential community contribution
- Develop **more trusting partnerships** between communities and organisations
- **Yield financial benefits** for organisations, service users, volunteers and wider community

ULTIMATELY CREATE COMMUNITIES THAT ARE MORE INDEPENDENT AND CAN SUSTAINABLY SOLVE LOCAL ISSUES SO THAT EXTERNAL SUPPORT (PRIMARY PREVENTION, HEALTH, WELLBEING AND SOCIAL CARE SERVICE PROVISION) CAN BE USED MORE EFFECTIVELY

3. Wellbeing and Resilience Measure (WARM)

The last chapter explained the asset based approach and highlighted the importance of measuring success. This chapter presents a tool that uses already available data to measure community assets at a population level.

The Local Wellbeing Project was a three-year initiative to explore how local government can improve the wellbeing of its citizens. The project brought together the Young Foundation, Lord Professor Richard Layard at the London School of Economics' Centre for Economic Performance, the Local Government improvement and Development Agency (formerly IdeA), Hertfordshire County Council, Manchester City Council and South Tyneside Metropolitan Borough Council.

This work was underpinned by a measurement strand which culminated in the publication of the Wellbeing and Resilience Measure (WARM). The work, published in 2010,[51] set out a model to measure wellbeing and resilience at community level.

There is no universally accepted definition of 'wellbeing'. Academic research on wellbeing has emphasised various factors as being particularly important in shaping wellbeing. These tend to include family relationships, financial situation, health, friends, work, freedom and values. The community matters too as most people's individual wellbeing is influenced by the wellbeing of the community in which they live. Resilience involves bouncing back or flourishing in the face of adversity or risk. Resilience and wellbeing are inextricably linked. Resilient behaviours impact on wellbeing and positive feelings of wellbeing associated with resilience can lead to higher levels of wellbeing. Definitions of wellbeing and resilience also indicate the importance of social capital because relationships with family, friends, neighbours, colleagues and wider community, support the ability to bounce back or withstand adversity. Some structural features also contribute to a resilient community, such as good transport links and proximity and quality of services such as schools, GP surgeries, etc. Also important are local buildings and organisations that allow communities to come together, have a collective voice and access support.

WARM sets out an approach to measuring the wellbeing and resilience of communities, and provides a way of understanding and identifying an area's strengths (or assets), such as levels of social capital, confidence amongst residents, the quality of local services or proximity to employment; as well as vulnerabilities (or deficits) such as isolation, high crime, low savings and unemployment[1].

WARM therefore combines assessments of wellbeing with assessments of resilience, the ability to bounce back from adversity and resist shocks. This is shaped by the interaction of personal and community assets, such as strong social supports and deficits such as poor health. WARM shifts focus away from a purely deficit model and directs attention towards what assets exist, and how they can be amplified to absorb risk. A focus on resilience sharpens attention on what a community can do to meet its own needs and on what assets are available.

[51] Mguni N and Bacon N (2010) Taking the temperature of local communities: the Wellbeing and Resilience Measure (WARM). The Young Foundation

WARM is an analytical tool to bring into view, measure and compare levels of wellbeing and resilience in geographical areas. At the most basic level, a WARM analysis provides: description of which geographical areas have particular characteristics (wellbeing and resilience) and different ways of making sense of the data and prompts to action on the basis of these interpretation.

The WARM tool uses already available data to help identify community assets and deficits that are most likely to future success and how resilient the community will be to shocks. It helps local agencies to assemble local data, assess levels of wellbeing, alongside community assets and deficits to decide on priorities for action.

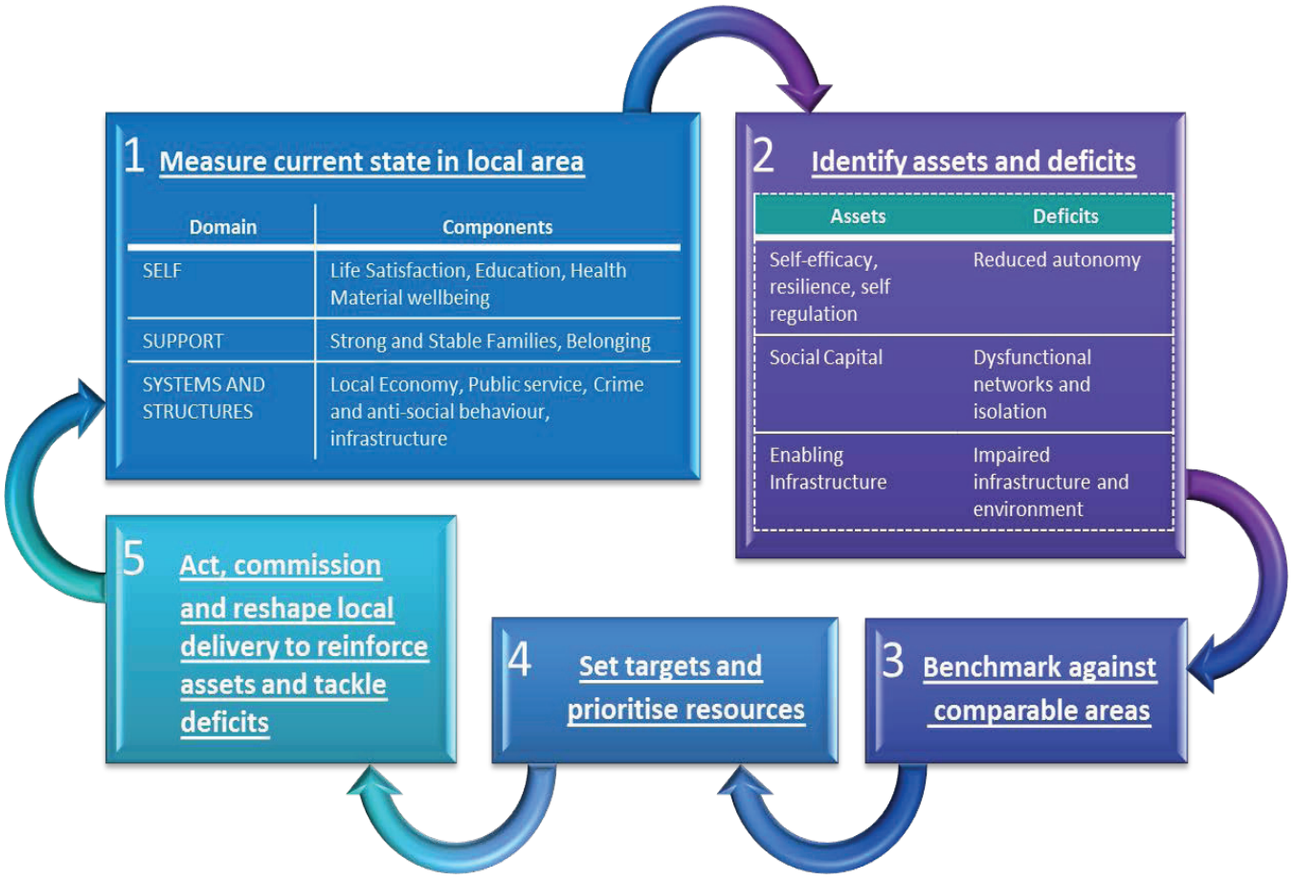
The structure of WARM falls into three overarching domains: **Self** (the way people feel about their own lives); **Supports** (the quality of social supports and networks within the community); and **Systems and Structures** (the strength of the infrastructure and environment to support people to achieve their aspirations and live a good life). The components of these three domains are presented in Table 4, each component being made up of a number of indicators.

Table 4: Domains of the WARM Tool and their Components

Domain	Components
SELF	Life satisfaction
	Education
	Health
	Material wellbeing
SUPPORT	Strong & stable families
	Belonging
SYSTEMS AND STRUCTURES	Local economy
	Public service
	Crime and anti-social behaviour
	Infrastructure

The WARM tool has five stages, however, it is not a linear process finishing at stage five, it is a cyclical process (Figure 10) in which the stages and domains interrelate to continuously inform and refine local decision making processes and priorities for action as communities themselves evolve.

Figure 10: Interrelationship of WARM domains, stages and outputs.



Constructing WARM for East Sussex

For this report we have replicated the methodology outlined by the Local Wellbeing Project using a range of local and national data sources to identify community assets and deficits. Sixty two indicators across the three domains (Self; Supports; Systems and Structures) and ten components (Life Satisfaction; Education; Health; Material Wellbeing; Strong and Stable families; Belonging; Local Economy; Public Services; Crime and Anti-Social Behaviour; Infrastructure) have been calculated at electoral ward level and also modelled at general practice level.

Indicators were modelled from ward to GP practice level by identifying wards in which patients live and allocating the population weighted average of the combined ward scores to each practice. The indicators are detailed in Table 5. A full explanation of all indicators used in the various components is included in Appendix 1 of this report.

Table 5: Domain and component indicators for WARM tool

Domain: SELF

Components	Indicators	Source
Life satisfaction	**% people who are very or fairly satisfied with the local area as a place to live**	**Place Survey (%, 2008/09)**
Education	Five GCSEs A*-C grades including English & Maths	Children's Services ESCC, JSNA scorecards (% 2012/13)
	Adults (25-54 years) with no or low qualifications rate	2011 Census (% 2011)
	16-18 year olds Not in Employment Education or Training (NEET) (%, 2012/13)	Children's Services ESCC, JSNA scorecards (% 2012/13)
	Working age population qualified to at least level 2 or higher	2011 Census (% 2011)
	Working age population qualified to at least level 4 or higher	2011 Census (% 2011)
	Child wellbeing index education score	*CWI 2009, Communities and Local Government (Score, 2005)*
Health	% of households with one or more person with a limiting long term illness or disability	2011 Census (%, 2011)
	Years of potential life lost indicator	Indices of Deprivation 2010, Department for Communities and Local Government (Ratio, 2008)
	Child wellbeing index health and disability score	*CWI 2009, Communities and Local Government (Score, 2005)*
	% of people who self-reported good health	2011 Census (%, 2011)
	Comparative illness and disability ratio	Indices of Deprivation 2010, Department for Communities and Local Government (Ratio, 2008)
	Measures of adults suffering from mood or anxiety disorders	Indices of Deprivation 2010, Department for Communities and Local Government (Ratio, 2008)
Material wellbeing	Income support	Department for Work and Pensions (% Aug 2013)
	Incapacity benefits	Department for Work and Pensions (% Feb 2013)
	Job Seekers Allowance – Claimants for less than 12 months	Department for Work and Pensions (% Oct 2013)
	Indices of deprivation – income domain	Indices of Deprivation 2010, Department for Communities and Local Government (% 2008)
	Job Seekers Allowance Claimant count	Department for Work and Pensions (%, Jan 2014)
	Job Seekers Allowance Claimants aged 50 years or over	Department for Work and Pensions (average %, Aug 2013)
	Job Seekers Allowance Claimants aged 18-24 years	Department for Work and Pensions (average %, Aug 2013)
	Child wellbeing index material wellbeing score	*CWI 2009, Communities and Local Government (Score, 2005)*
	Income deprivation affecting older people index (IDAOPI)	Indices of Deprivation 2010, Department for Communities and Local Government (% 2008)
	Total count court judgements	*Office for National Statistics (Count, 2005)*
	Average value of county court judgements	*Office for National Statistics (£, 2005)*
	Average household income (£, 2013)	CACI (£, 2013)

Domain: SUPPORT

Components	Indicators	Source
Strong & stable families	Households containing persons who are divorced	2011 Census (%, 2011)
	Households with no adults in employment with dependent children	2011 Census (%, 2011)
	Elderly living alone	2011 Census (%, 2011)
	Households with dependent children containing married/cohabiting couples	2011 Census (%, 2011)
	Households with dependent children containing lone parents	2011 Census (%, 2011)
	Lone parent claimants	Department for Work and Pensions (%, Aug 2013)

Components	Indicators	Source
	Carer claimants	Department for Work and Pensions (%, Aug 2013)
Belonging	*% of people who feel they belong to their neighbourhood*	*Place Survey (%, 2008/09)*
	% who have given unpaid help at least once per month over the last 12 months	2011 Census (%, 2011)
	A member of a group making decisions on local health or education services	*Place Survey (%, 2008/09)*
	A member of a decision making group to regenerate local area	*Place Survey (%, 2008/09)*
	A member of a decision making group to tackle local crime problems	*Place Survey (%, 2008/09)*
	A member of a tenants' group decision making committee	*Place Survey (%, 2008/09)*

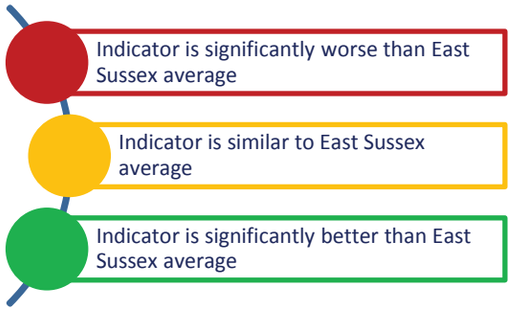
Domain: SYSTEMS AND STRUCTURES

Components	Indicators	Source
Local economy	Travel time to nearest employment centre by walking/public transport	Department for Transport (minutes, 2011)
	% of working age population within 20 minutes of an employment centre by walking/public transport or cycling	Department for Transport (%, 2011)
	VAT based local units by employment size band (0-4 employees)	*Office for National Statistics (Count, 2007)*
	VAT based local units by employment size band (20+ employees)	*Office for National Statistics (Count, 2007)*
	Job Seekers Allowance Claimants per job vacancy	Department for Work and Pensions (Number, 2010-12)
	Distance travelled to work (% less than 2km)	2011 Census (%, 2011)
Public service	*People who are very/fairly satisfied with the Local Police in their local area*	*Place Survey (%, 2008/09)*
	People who are very/fairly satisfied with Fire & Rescue services in their local area	*Place Survey (%, 2008/09)*
	Patients whose experience of their GP surgery was fairly or very good	GP patient survey (2012/13)
	People who are very/fairly satisfied with the local hospital in their local area	*Place Survey (%, 2008/09)*
	Travel time to nearest GP by walking or public transport	Department for Transport (minutes, 2011)
	Households within 15 minutes of GPs by walking or public transport	Department for Transport (%, 2011)
	Number of further education institutions within 30 minutes by walking/public transport	Core accessibility indicators (Number, 2011)
	Number of primary schools within 15 minutes by walking/public transport	Core accessibility indicators (Number, 2011)
Crime and anti-social behaviour	*Child wellbeing index crime score*	*CWI 2009, Communities and Local Government (Score, 2005)*
	People who are feel very/fairly safe when outside in their local area during the day	*Place Survey (%, 2008/09)*
	People who are feel very/fairly safe when outside in their local area after dark	*Place Survey (%, 2008/09)*
	All crime offences	Safer Communities ESCC (Rate per 1,000 population, 2012/13)
	Burglary offences	Safer Communities ESCC (Rate per 1,000 population, 2012/13)
	Anti-social behaviour incidents	Safer Communities ESCC (Rate per 1,000 population, 2012/13)
	Violent crime offences	Safer Communities ESCC (Rate per 1,000 population, 2012/13)
Infrastructure	Barriers to housing and service score	Indices of Deprivation 2010, Department for Communities and Local Government (Score, 2008)
	Child wellbeing index housing score	*CWI 2009, Communities and Local Government (Score, 2001)*
	Housing in poor condition score	*Neighbourhood statistics (Score 2005)*

WARM For Local Authorities and Wards, Clinical Commissioning Groups and GP Practices

Every indicator is given a Red/Amber/Green (RAG) rating based upon the following classification:

Figure 11: Rag rating classification



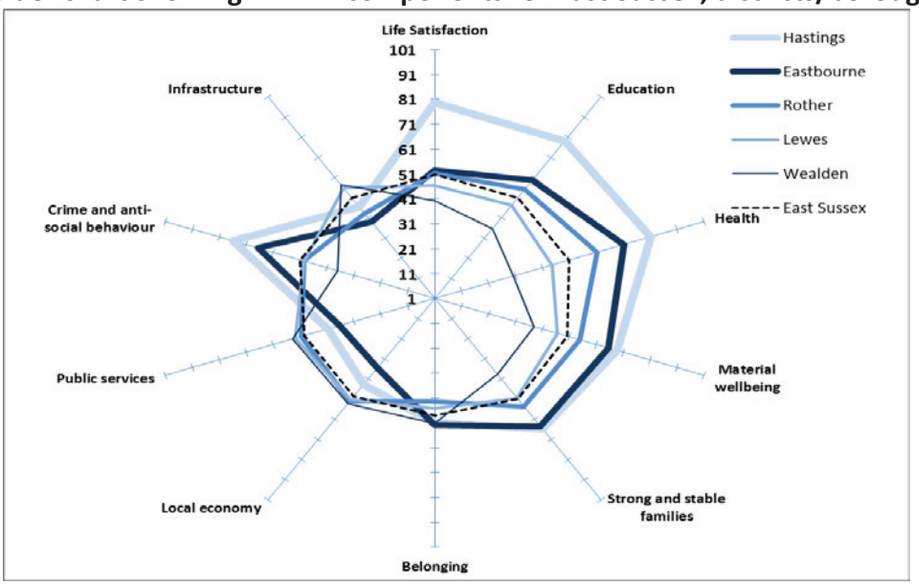
Indicators are RAG rated based on 95% Confidence Intervals (CI) or, where this information is not available they are ranked using top and bottom quartiles. From these, community assets and deficits have been identified to build a picture of community resilience across the county. 'Red indicators' are identified as deficits and 'Green indicators' as assets.

An overall RAG rating is also calculated for each component based on the number of red, amber and green indicators that constitute the component. (Some indictors have been identified as "weak", either due to the quality of the data or the age of the data available. Weak indicators are marked in italics in Table 4. These scores have been weighted so that weak indicators carry half the weight of strong indicators.) 'Red components' are where the majority of indicators are identified as deficits and 'Green components' are where the majority of indicators are identified as assets.

Figure 12 shows how each of the district and borough local authorities score for each of the ten WARM components. Wards are ranked from 1 (most assets) to 101 (Least assets) as benchmarked against East Sussex. The average ranking for the wards within each District or Borough is plotted against the East Sussex average for all WARM components and an average rank is then calculated for each District or Borough. The better average ranks are towards the centre of the chart and the worse average ranks are towards the outside. Figure 13 presents the same process for each CCG by ranking the 74 GP practices in the county from most assets (1) to least assets (74).

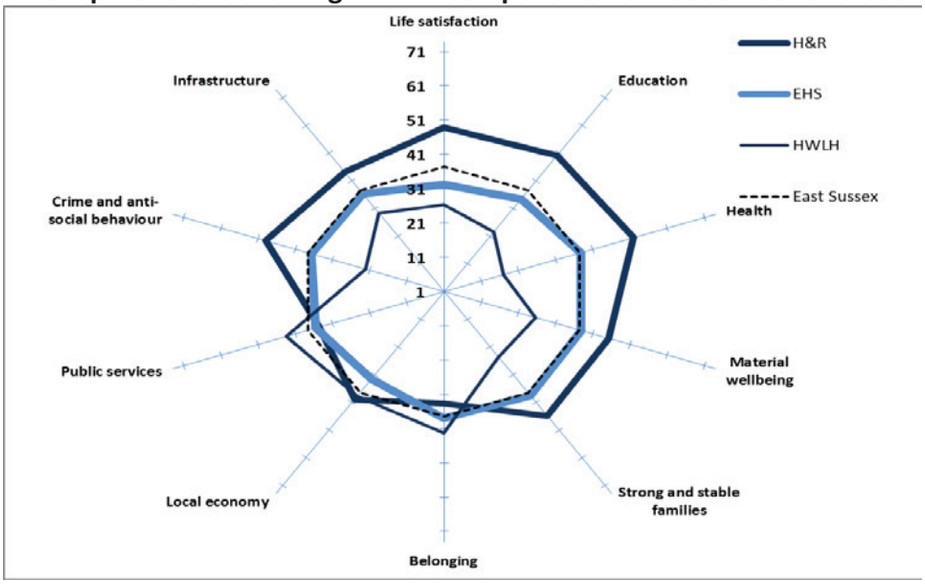
For the Life Satisfaction, Education, Health, Material Wellbeing, Strong and Stable Families and Crime and Antisocial Behaviour components, Wealden and then Lewes have the best ranked wards and Hastings followed by Eastbourne and Rother have the worst ranked wards. The Infrastructure component is very different with Eastbourne, then Rother then Hastings having the best ranked wards and Lewes and Wealden both having the worst ranked wards. This is similar for Public Services and Local Economy, with Eastbourne having the best ranked wards followed by Hastings, in part due to several major indicators being around proximity to services. For the Belonging component the average ranks are very similar across all areas but Rother and then Lewes have the best ranked wards.

Figure 12: Spider chart showing WARM components for East Sussex, districts/boroughs



Looking at the CCGs in East Sussex (Figure 13), Hastings and Rother CCG (H&R) has the worst average ranking for all components except Public Services and Belonging. High Weald Lewes Havens CCG (HWLH) has the best average rankings for all except Public Services (worst), Belonging (worst) and Local Economy (similar to East Sussex average). Eastbourne, Hailsham and Seaford CCG (EHS) shares very similar average rankings to East Sussex overall, with the exception of Life Satisfaction and Local Economy where East Sussex ranks better.

Figure 13: Spider chart showing WARM components for East Sussex and each CCG



As would be expected, there is significant variation in RAG ratings at ward and GP practice level. This variation is shown in the following tables. For each district/borough local authority the RAG rated components at ward level are presented in Tables 6-10. For each clinical commissioning group the RAG rated components at GP practice level are presented in Tables 11-14.

Within components, at indicator level, there is also significant variation so for each ward and GP practice a detailed report has been developed. These contain a description of all indicators within the ward or practice that are significantly different than the county average and whether this is better or worse in terms of the health and wellbeing of residents.

The description also outlines whether the ward or GP practice is within the ten best or worst in the county for each indicator. Assets and deficits are then summarised for all strong indicators. Where indictors are ranked within the best or worst ten wards/GP practices they are described as “very high” or “very low” and where they are significantly different they are described as “high” or “low”.

Table 6: WARM component ratings for Eastbourne Borough

Eastbourne	Self				Support		Systems and Structures			
Table 6 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Devonshire		R	R	R	R	A	G	A	R	A
Hampden Park		R	R	R	R	A	G	A	R	A
Langney		R	R	R	R	A	A	A	A	G
Meads		G	R	A	A	A	G	A	R	G
Old Town		G	A	A	A	A	A	A	G	A
Ratton		A	R	A	A	A	A	A	G	A
Sovereign		A	A	A	A	A	A	A	G	A
St Anthony’s		A	R	A	A	A	A	A	A	A
Upperton		G	R	R	A	A	G	A	R	A

Table 7: WARM component ratings for Hastings Borough

Hastings	Self				Support		Systems and Structures			
Table 7 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Ashdown		A	A	A	G	A	G	G	G	A
Baird		R	R	R	R	A	A	A	R	A
Braybrooke		A	R	R	R	A	G	A	A	A
Castle		R	R	R	R	A	G	G	R	A
Central St Leonards		R	R	R	R	A	A	G	R	A
Conquest		A	A	A	A	A	A	A	G	A
Gensing		R	R	R	R	A	A	A	R	A
Hollington		R	R	R	R	A	G	A	R	A
Maze Hill		A	R	A	A	A	A	A	G	A
Old Hastings		A	R	A	A	A	A	G	R	A
Ore		R	R	R	R	A	R	G	R	A
Silverhill		A	A	A	A	A	A	G	A	R
St Helens		A	R	A	G	A	A	A	G	A
Tressell		R	R	R	R	A	G	G	R	A
West St Leonards		R	A	A	A	A	A	A	R	A
Wishing Tree		R	R	R	R	A	A	A	A	R

Table 8: WARM component ratings for Lewes District

Lewes	Self				Support		Systems and Structures			
Table 8 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Barcombe and Hamsey		G	G	G	G	G	R	R	A	G
Chailey and Wivelsfield		G	G	G	G	A	A	A	G	G
Ditchling and Westmeston		G	A	G	G	A	R	A	G	A
East Saltdean & Telscombe Cliffs		A	A	A	A	A	R	A	G	R
Kingston		G	G	G	G	G	A	A	A	G
Lewes Bridge		G	A	A	A	A	G	A	R	A
Lewes Castle		G	A	A	A	A	A	A	R	A
Lewes Priory		G	A	A	A	A	G	A	A	R
Newhaven Denton and Meeching		R	A	A	R	A	A	A	A	A
Newhaven Valley		R	A	R	R	A	A	R	R	A
Newick		G	G	G	G	A	A	A	A	R
Ouse Valley and Ringmer		G	A	A	G	A	A	A	G	G
Peacehaven East		A	R	A	A	A	R	A	A	A
Peacehaven North		A	A	A	A	A	A	A	G	A

Lewes	Self				Support		Systems and Structures			
Table 8 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Peacehaven West		R	R	R	R	A	A	A	R	R
Plumpton, Streat, East Chiltington & St John		G	G	G	G	A	A	A	G	A
Seaford Central		A	R	A	R	A	A	A	A	A
Seaford East		A	A	A	A	A	A	A	G	A
Seaford North		A	A	A	A	A	G	A	G	A
Seaford South		A	A	A	A	A	A	A	A	R
Seaford West		A	A	G	G	A	A	A	G	A

Table 9: WARM component ratings for Rother District

Rother	Self				Support		Systems and Structures			
Table 9 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Battle Town		A	A	A	A	A	A	A	G	A
Brede Valley		A	A	A	G	A	R	A	G	G
Central (Bexhill)		R	R	R	R	A	G	A	R	A
Collington (Bexhill)		G	A	G	G	A	A	A	G	A
Crowhurst		A	A	A	G	A	R	R	G	G
Darwell		G	A	A	G	A	R	A	G	G
Eastern Rother		R	A	A	A	G	R	A	R	G
Ewhurst and Sedlescombe		A	A	A	A	A	R	A	A	A
Kewhurst (Bexhill)		A	A	A	G	A	A	A	G	A
Marsham		A	A	A	A	A	R	A	G	A
Old Town (Bexhill)		A	R	A	A	A	G	A	A	A
Rother Levels		A	A	A	G	A	R	A	G	A
Rye		R	A	R	A	A	A	A	A	A
Sackville (Bexhill)		A	R	A	R	A	G	A	A	A
Salehurst		G	G	A	G	A	R	A	G	A
Sidley (Bexhill)		R	R	R	R	A	A	G	A	A
St Marks (Bexhill)		A	A	G	A	A	A	A	G	R
St Michaels (Bexhill)		R	R	A	A	A	A	A	G	R
St Stephens (Bexhill)		A	R	A	R	A	A	A	A	R
Ticehurst & Etchingham		G	G	A	G	A	R	A	G	G

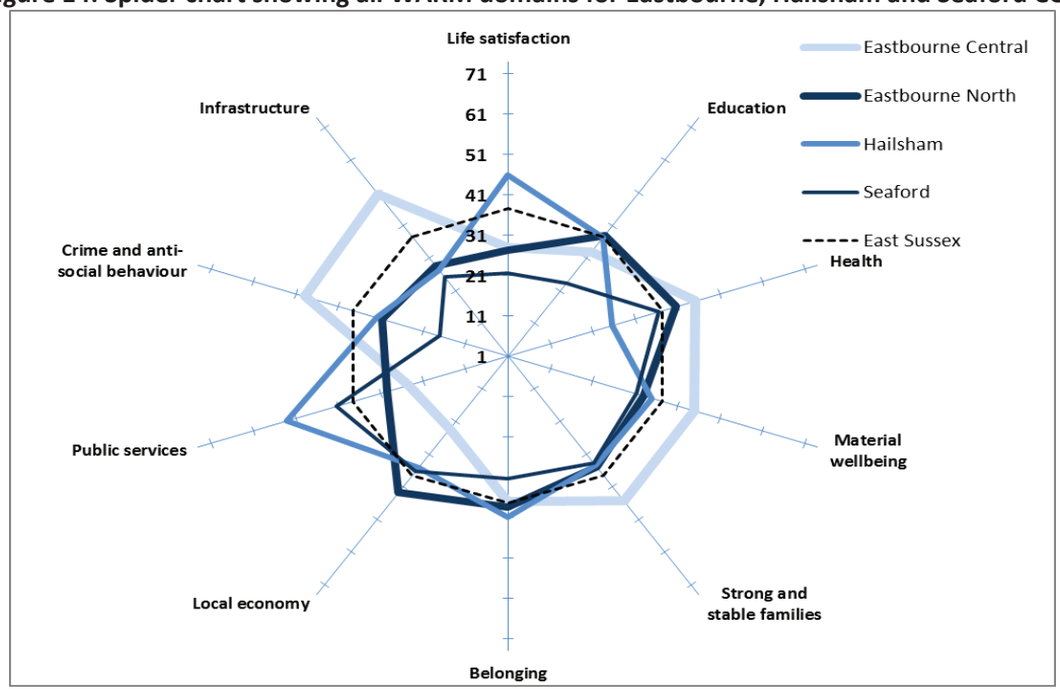
Table 10: WARM component ratings for Wealden District

Wealden	Self				Support		Systems and Structures			
Table 10 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Alfriston		G	R	G	A	A	R	A	G	G
Buxted and Maresfield		G	G	A	G	A	R	A	G	A
Chiddingly and East Hoathly		G	G	A	G	A	A	A	G	G
Cross in Hand/Five Ashes		G	G	A	G	A	R	A	G	A
Crowborough East		A	G	A	A	A	G	A	G	A
Crowborough Jarvis Brook		A	G	A	A	A	A	A	A	A
Crowborough North		G	G	G	G	A	A	A	G	R
Crowborough St Johns		G	G	G	G	A	R	A	G	A
Crowborough West		G	G	G	G	A	G	A	G	A
Danehill/ Fletching/ Nutley		G	G	G	G	A	R	A	G	G
East Dean		G	G	G	G	A	R	A	G	G
Forest Row		G	G	G	A	A	A	R	G	A
Framfield		G	G	G	G	A	R	A	G	G
Frant and Withyham		G	G	G	G	A	A	R	G	G
Hailsham Central and North		A	A	A	G	A	G	A	A	R
Hailsham East		R	R	R	R	A	A	R	A	A
Hailsham South and West		R	A	A	A	A	G	A	A	A
Hartfield		G	G	G	G	A	A	A	A	G
Heathfield East		G	G	G	G	A	R	A	G	G
Heathfield North and Central		A	G	A	A	A	A	A	G	R
Hellingly		G	G	A	G	A	A	A	G	A
Herstmonceux		A	G	A	A	A	R	A	G	A
Horam		A	A	A	A	A	A	A	A	A
Mayfield		G	G	G	A	A	R	R	G	A
Ninfield and Hooe with Wartling		A	A	G	G	A	R	A	G	G
Pevensey and Westham		A	A	A	G	A	A	A	G	A
Polegate North		A	A	A	A	A	A	A	G	R
Polegate South		A	A	A	A	A	R	A	G	R
Rotherfield		G	G	G	G	A	R	R	G	A
Uckfield Central		A	A	A	A	A	G	A	R	R
Uckfield New Town		A	A	A	A	A	G	G	A	R
Uckfield North		A	G	A	A	A	G	A	G	A
Uckfield Ridgewood		G	G	G	G	A	A	A	G	R
Wadhurst		G	G	G	G	A	A	A	G	G
Willingdon		A	A	A	G	A	R	A	G	R

Figures 14, 15 and 16 show how each of the clinical commissioning group localities fare for each of the ten components benchmarked against East Sussex. For these charts the average ranking of GP practices within each clinical commissioning group locality for each of the WARM components is plotted against the East Sussex average. GP practices are ranked from 1 (the best) to 74 (the worst) across the whole of East Sussex.

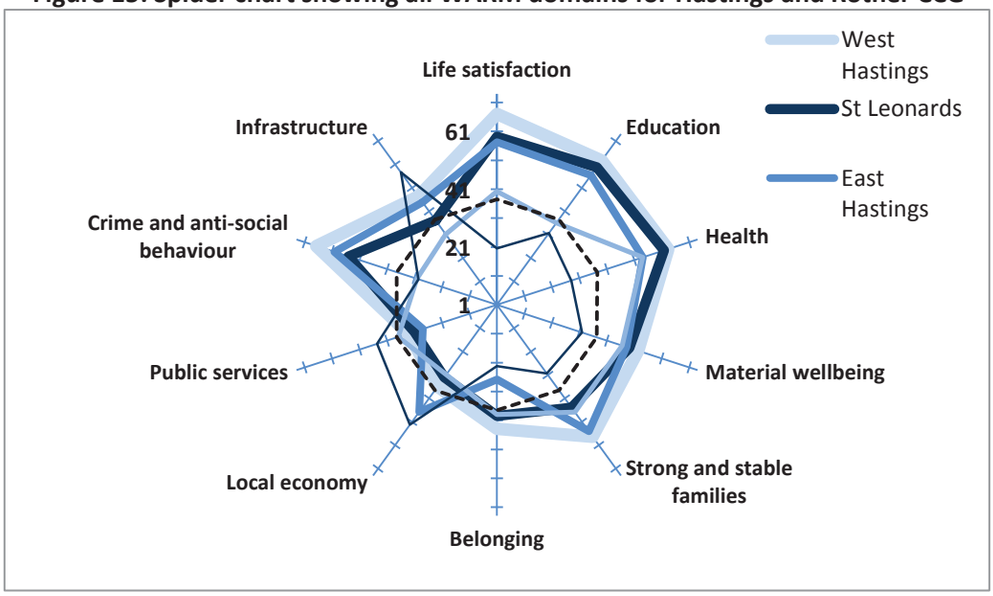
Within Eastbourne, Hailsham and Seaford CCG (Figure 14), Eastbourne Central locality has the worst average ranks for Health, Material Wellbeing, Strong and Stable Families, Crime and Antisocial Behaviour and Infrastructure; however it has the best average ranks for Public Services and Local Economy. Hailsham has the worst average ranks for Life Satisfaction, and Public Services, but the best average ranks for Health. Seaford has the best average ranks for Life Satisfaction, Education, Material Wellbeing, Strong and Stable Families, Belonging, Crime and Antisocial Behaviour and Infrastructure.

Figure 14: Spider chart showing all WARM domains for Eastbourne, Hailsham and Seaford CCG



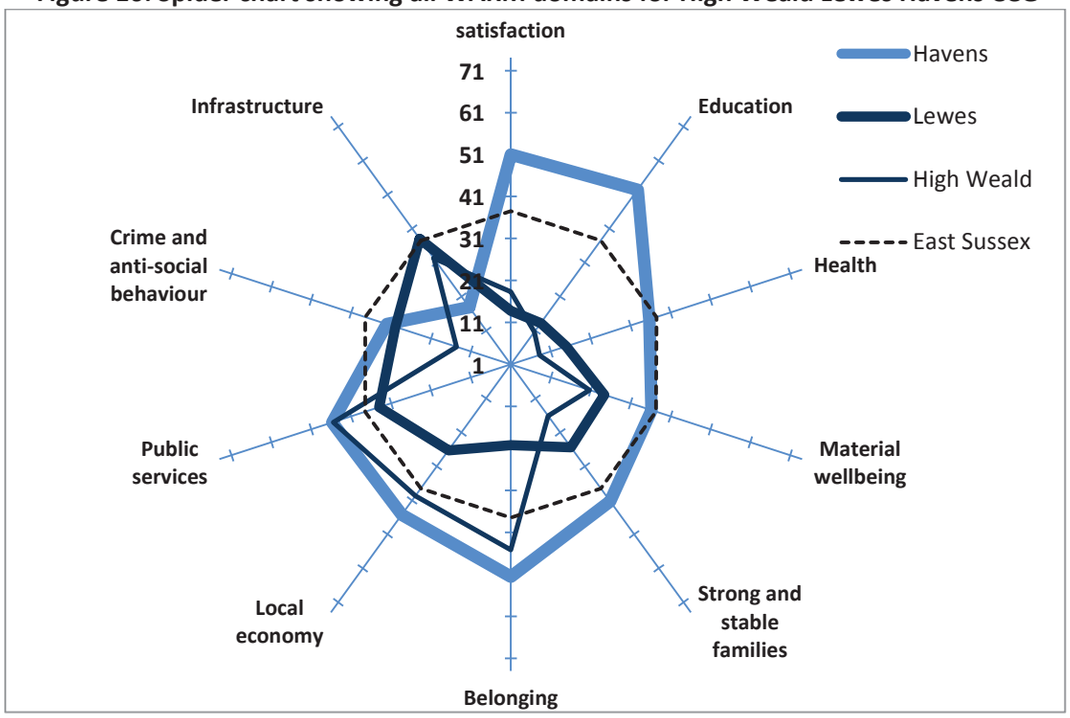
Within Hastings and Rother CCG (Figure 15), West Hastings locality has the worst average ranks for all components except Local Economy, Public Services and Infrastructure. In those same three components it is Rural Rother that has the worst average ranks, although it has the best average ranks in all of the rest.

Figure 15: Spider chart showing all WARM domains for Hastings and Rother CCG



Within High Weald Lewes Havens CCG (Figure 16), Havens locality has the worst average rank for all components with the exception of Infrastructure, where it has the best. Lewes locality appears within the East Sussex average position for all components (equal for Infrastructure). High Weald locality shows a less consistent picture with very good average rankings for Health and worse than average for Belonging, Local Economy and Public Services.

Figure 16: Spider chart showing all WARM domains for High Weald Lewes Havens CCG



Tables 11-13 present the RAG rated components at GP practice level for each Clinical Commissioning Group.

Table 11: WARM component ratings for Eastbourne, Hailsham and Seaford CCG

EH&S CCG	Self				Support		Systems and Structures			
Table 11 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Bolton Road Surgery		A	A	A	A	A	G	A	R	A
Seaside Medical Centre		A	A	R	R	A	G	A	R	A
Lighthouse Medical Practice		A	A	A	R	A	A	A	R	R
Grove Road Surgery		A	A	A	A	A	G	A	R	A
Sovereign Practice		A	A	A	A	A	A	A	R	R
Enys Road Surgery		G	A	A	A	A	G	A	R	A
Arlington Road Medical Centre		A	A	A	A	A	G	A	R	A
Green Street Clinic		G	A	A	A	A	A	A	G	A
Park Practice		R	A	A	R	A	A	A	A	A
Harbour Medical Practice		A	A	A	A	A	A	A	A	A
Manor Park Medical Centre		A	A	A	A	A	A	A	A	A
Stone Cross Surgery		A	A	A	A	A	A	A	G	A
Downlands Medical Centre		A	A	A	A	A	A	A	G	G
Vicarage Field Surgery		A	A	A	A	A	A	A	A	A
Seaforth Farm Surgery		R	A	A	A	A	G	A	A	A
Bridgeside Surgery		A	A	A	A	A	A	A	A	A
Crescent Medical Centre		A	A	A	A	A	A	A	A	A
Quintin Medical Centre		A	A	A	G	A	A	A	A	A
Herstmonceux Surgery		A	G	A	A	A	R	A	G	A
Seaford Medical Practice		A	A	A	A	A	A	A	G	G
Old School Surgery		G	A	A	A	A	R	A	G	A

Table 12: WARM component ratings for Hastings and Rother CCG

H&R CCG	Self				Support		Systems and Structures			
Table 12 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
The Plaza Surgery		R	R	R	R	A	G	A	R	A
Cornwallis Surgery		R	R	R	R	A	G	A	R	A
Priory Road Surgery		R	R	R	R	A	A	A	R	A
The Station Practice		R	R	R	R	A	A	A	R	A
Beaconsfield Road Surgery		R	R	R	R	A	A	A	A	A
Warrior Square Surgery		R	R	R	R	A	G	A	R	A
Carisbrooke Surgery		R	R	R	R	A	G	A	R	A
Churchwood Medical Practice		R	R	R	R	A	G	A	R	A
Essenden Road Surgery		R	R	R	R	A	G	A	A	A
High Glades Medical Centre		R	R	R	A	A	G	A	A	A
Sedlescombe House Surgery		R	R	R	A	A	G	G	A	G
Silver Springs Practice		R	R	R	R	A	G	A	R	G
South Saxon House Surgery		R	R	A	A	A	A	A	A	A
Little Ridge Surgery		A	A	A	A	A	A	A	A	A
Shankill Surgery		R	R	R	A	A	A	A	R	A
Roebuck House – Practice 5		A	R	R	A	A	G	A	R	A
Roebuck House – Practice 1 & 2		R	R	R	R	A	A	G	R	A
Roebuck House – Practice 4		R	R	R	R	A	A	A	R	A
Harold Road Surgery		R	A	R	R	A	A	A	R	A
Roebuck House – Practice 3		A	A	A	A	A	A	A	R	R
Sidley Surgery		R	R	R	R	A	A	A	A	G
Pebsham Surgery		A	R	A	R	A	A	A	A	G
Collington & Ninfield Surgery		A	A	A	A	A	A	A	G	A
Little Common Surgery		A	A	A	A	A	A	A	G	G
Ferry Road Health Centre		R	A	A	A	G	A	A	R	R
Rye Medical Centre		R	A	A	A	G	A	A	R	R
Sedlescombe & Westfield Surgery		A	A	A	A	A	R	A	G	R
Martins Oak Surgery		G	A	A	A	A	R	A	G	R
Northiam Surgery		A	G	A	G	A	R	A	G	R
Oldwood Surgery		G	G	G	G	A	R	A	G	R
Fairfield Surgery		A	G	G	G	A	R	A	G	R

Table 13: WARM component ratings for High Weald Lewes Havens CCG

HWLH CCG	Self				Support		Systems and Structures			
Table 13 Component	Life Satisfaction	Education	Health	Material Wellbeing	Strong & Stable Families	Belonging	Local Economy	Public Services	Crime & Antisocial Behaviour	Infrastructure
Quayside Medical Practice		R	A	A	R	A	G	R	R	A
Chapel Street Surgery		R	A	A	A	A	G	R	A	A
Meridian Surgery		A	A	A	A	A	R	A	A	G
Rowe Avenue Surgery		A	A	A	A	A	R	A	A	G
Central Surgery		A	A	A	A	A	R	A	A	G
Foxhill Medical Centre		A	A	A	A	A	R	A	A	G
School Hill Medical Practice		G	G	A	A	A	A	A	A	A
River Lodge Surgery		G	G	A	A	A	A	A	A	R
St Andrews Surgery		G	G	A	A	A	G	A	A	A
Mid Downs Medical Practice		G	G	G	G	A	R	A	G	R
Manor Oak Surgery		A	G	G	G	A	A	A	G	A
Buxted Surgery		G	G	G	G	A	R	A	G	A
The Meads Medical Centre		G	G	G	G	A	A	A	G	A
Groombridge & Hartfield Medical Group		G	G	G	G	A	R	A	G	R
Belmont Surgery		G	G	G	G	A	R	R	G	R
Heathfield Surgery		G	G	G	G	A	R	A	G	R
Ashdown Forest Health Centre		G	G	G	G	A	R	A	G	R
Bird-In-Eye Surgery		G	G	G	G	A	A	A	G	A
Rotherfield Surgery		G	G	G	G	A	R	A	G	A
Woodhill Surgery		G	G	G	A	A	R	A	G	A
Saxonbury House Surgery		G	G	G	G	A	A	A	G	A
Beacon Surgery		G	G	G	G	A	A	A	G	A

WARM Mapping

This section focuses on the WARM domains and their components and maps the assets at ward level. In all the maps, the darkest coloured wards are the wards with the greatest number of assets. (Appendix 2 of this report has an East Sussex ward map with all wards identified by name.)

Self Domain: The Way People Feel About Their Own Lives

The Self domain is made up of four components: life satisfaction, education, health and material wellbeing. There are a total of 25 potential assets in the self domain. Each 'strong' asset scores 1.0 and each 'weak' asset scores 0.5, making a total potential score of 18.5.

Figure 17: Ward map showing number of assets for the self domain

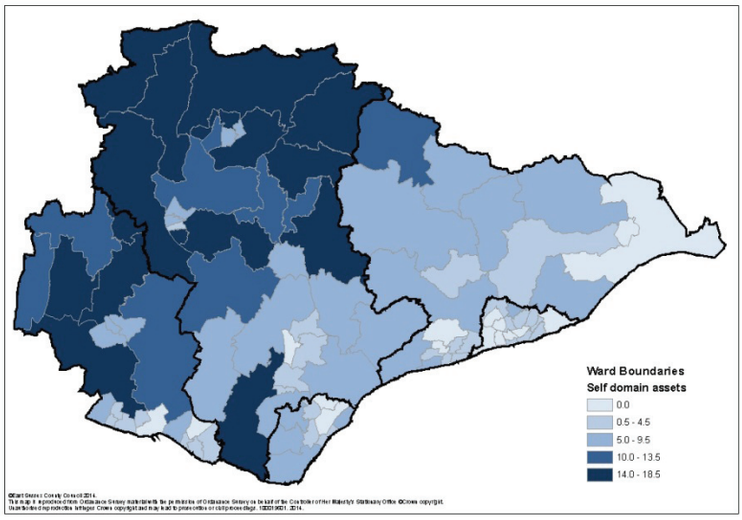


Figure 17 maps the total number of self assets. This shows that the greatest number of assets are in Lewes and Wealden districts.

Figure 18: Ward map showing number of assets for the life satisfaction component

Figure 18 maps the Life Satisfaction component. Only one indicator is included in this component and as it is a weak indicator it only scores a maximum of 0.5 for each ward. This shows that all districts and boroughs have wards with a greater life satisfaction except Hastings borough where there are none.

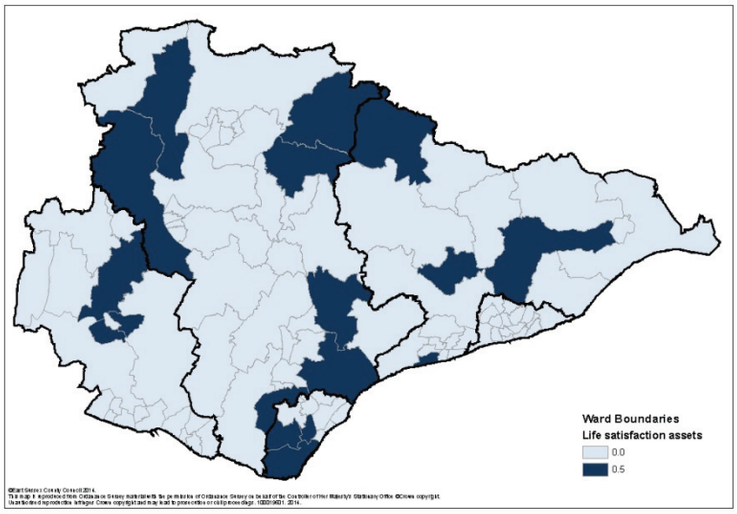


Figure 19: Ward map showing the number of assets for the education component

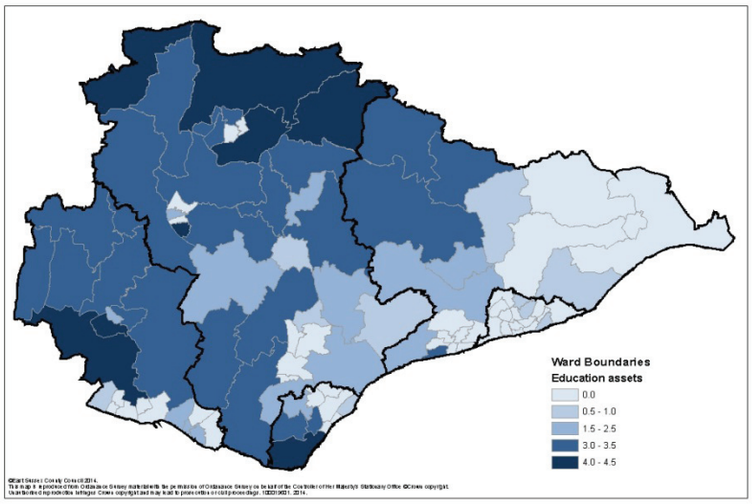


Figure 19 maps the education component which has a potential total of 6 assets, making a score of 5.5. Wards in Hastings borough and parts of Rother district have the lowest number of assets while eight wards have the greatest number: Kingston, Lewes Priory, Uckfield Ridgewood, Forest Row, Frant/ Withyham, Hailsham Central & North, Wadhurst and Meads.

Figure 20: Ward map showing the number of assets for the health component

Figure 20 maps the Health component which has a potential 6 assets with a total score of 5.5. Wards in north of the county have the greatest number of assets and those on the coast and to the east of the county have the lowest number of assets.

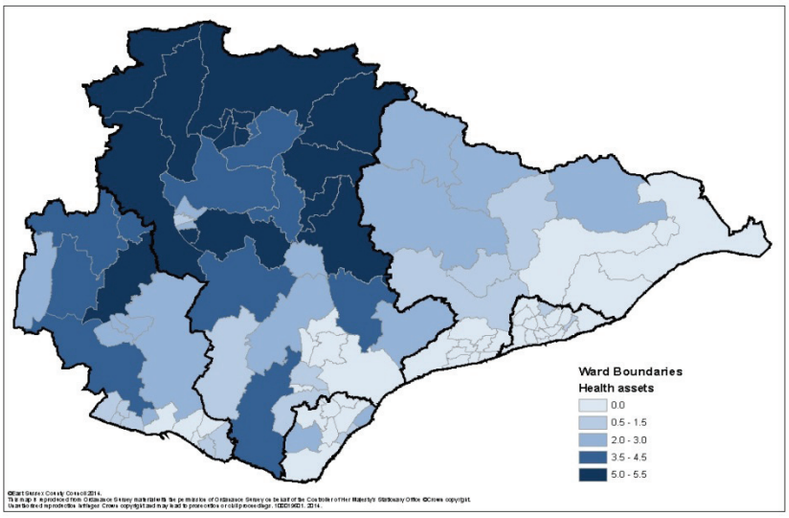


Figure 21: Ward map showing the number of assets for the material wellbeing component

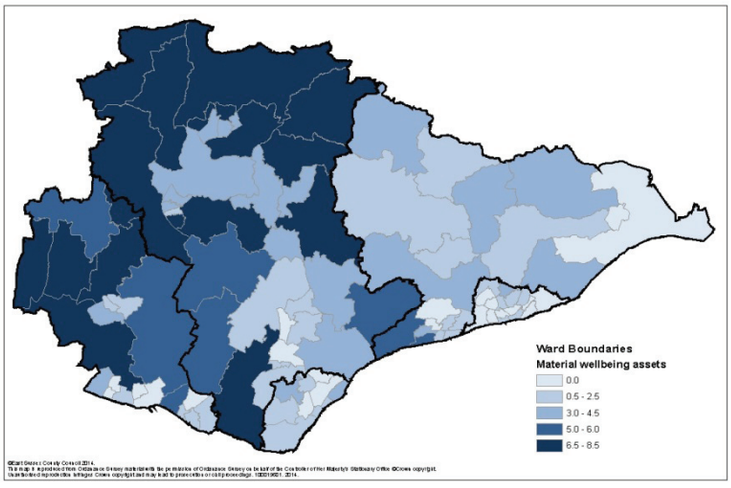


Figure 21 maps the material wellbeing component. There are a potential 12 assets with a total score of 10.5 assets in this component. Wards in Lewes and Wealden districts have the greatest number of assets.

Support Domain: The Quality of Social Support and Networks Within the Community

The Support domain is made up of two components: strong and stable families and belonging. There are a total of 13 potential assets in the self domain making a potential total score of 10.5 in this domain.

Figure 22: Ward map showing the number of assets for the support domain

Figure 22 maps the total number of support assets. This shows that the greatest number of support assets are in Lewes district. Eastbourne borough has the fewest support assets.

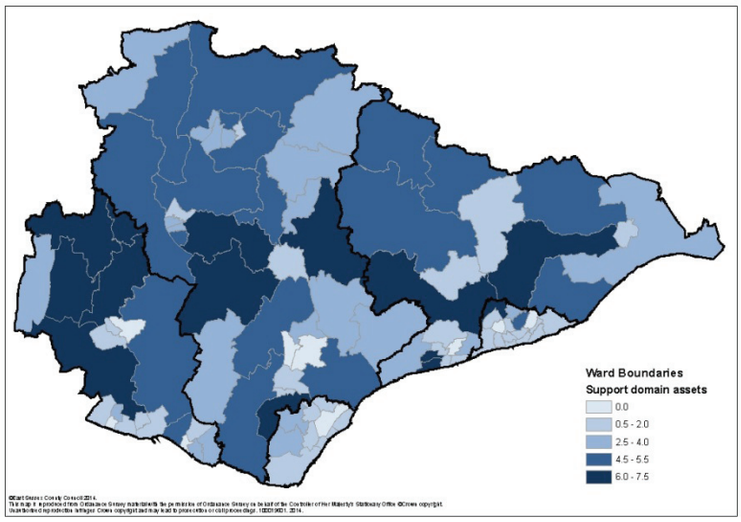


Figure 23: Ward map showing the number of assets for the strong and stable families component

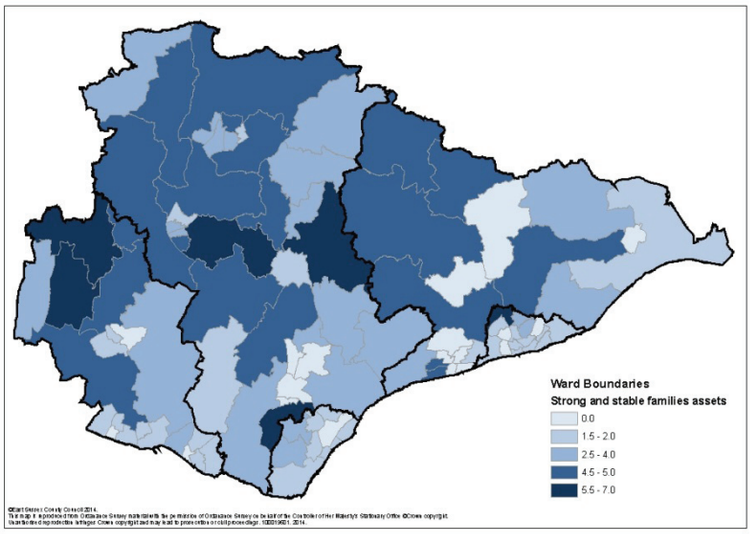
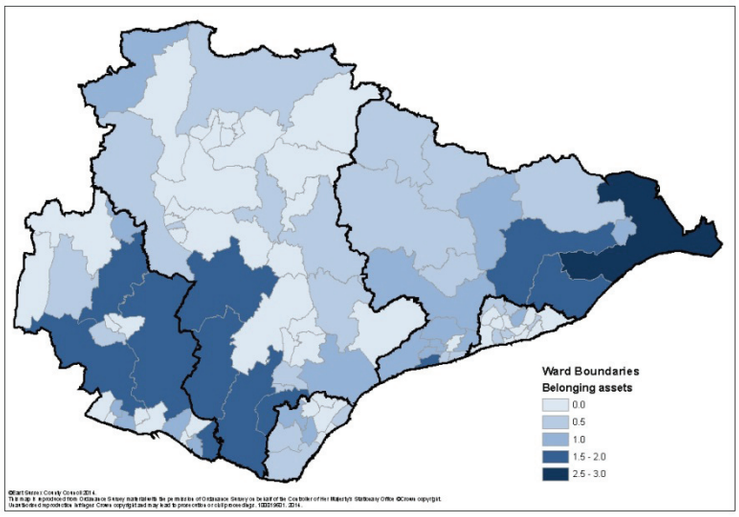


Figure 23 maps the Strong and Stable Families component which has a total of seven assets, with a potential score of 7 as all indicators are strong. Six wards: Chailey & Wivelsfield, Plumpton, Framfield, Heathfield East, Ashdown and Willingdon, have the greatest number of assets and Eastbourne and Hastings boroughs have the lowest number.

Figure 24: Ward map showing the number of assets for the belonging component

Figure 24 maps the Belonging component which has a potential total of 6 assets with a score of 3.5. This shows that Eastern Rother has the greatest number of assets.



Systems and Structures Domain: The Strengths of the Infrastructure and Environment to Support People to Achieve their Aspirations and Live a Good Life

The Systems and Structures domain is made up of four components: local economy, public service, crime and anti-social behaviour and infrastructure. There are a total of 24 potential assets in the Systems and Structures domain making a potential total score of 19.

Figure 25: Ward map showing number of assets for the systems and structures domain

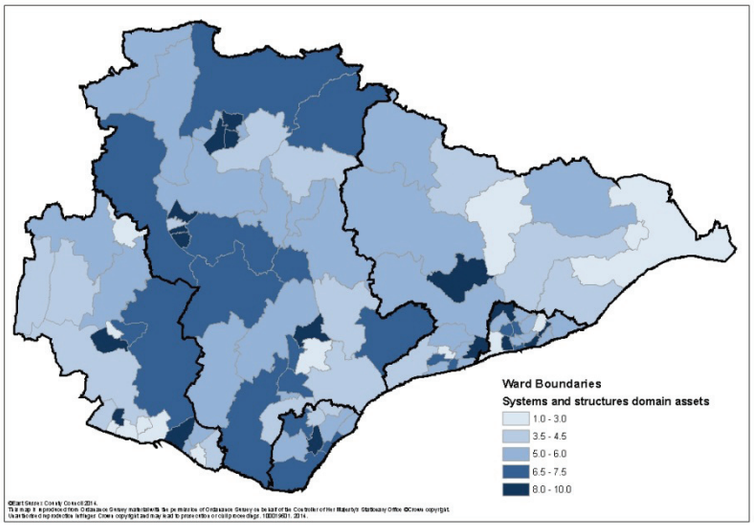


Figure 25 maps the total number of systems and support assets and shows a mixed picture with wards with the greatest number of assets being distributed across the county.

Figure 26: Ward map showing the number of assets for the local economy component

Figure 26 maps the Local economy component which has a potential of 6 assets with a score of 5. This shows that Eastbourne borough has the greatest assets.

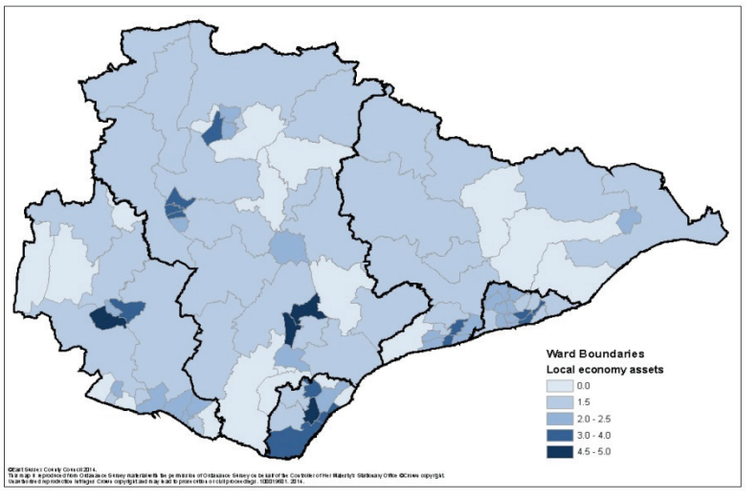


Figure 27: Ward map showing the number of assets for the public service component

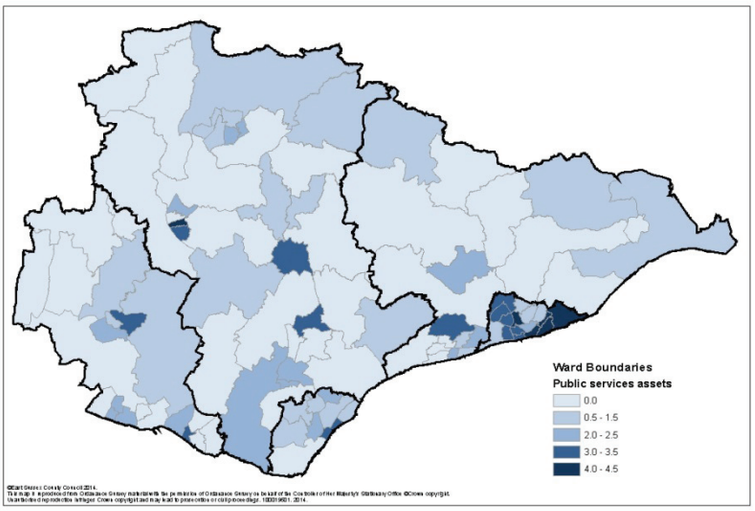


Figure 27 maps the Public Service component. There are a potential total of 8 assets in this component with a score of 6.5. Six wards, Uckfield New Town, Silverhill, Ore, Old Hastings, Tressell and Castle have the greatest number of public service assets.

Figure 28: Ward map showing the number of assets for the crime and antisocial behaviour component

Figure 28 maps the Crime and Anti-Social Behaviour component. There are a potential total of 7 assets in this component with a score of 5.5. Hastings borough has lowest number of assets.

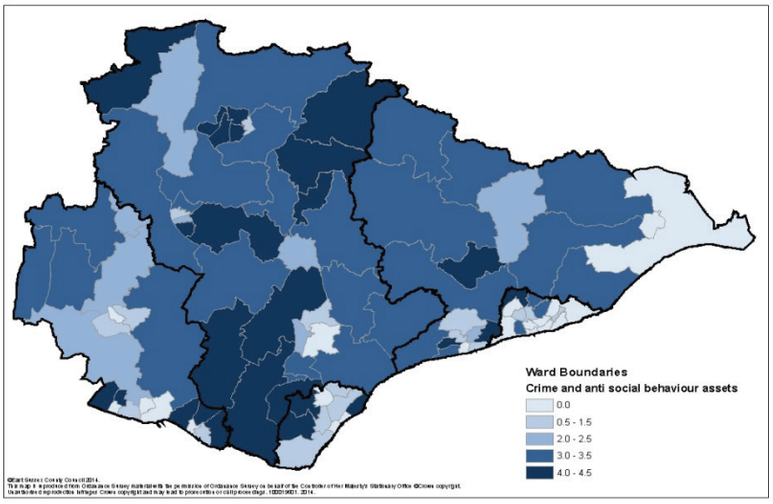


Figure 29: Ward map showing the number of assets for the infrastructure component

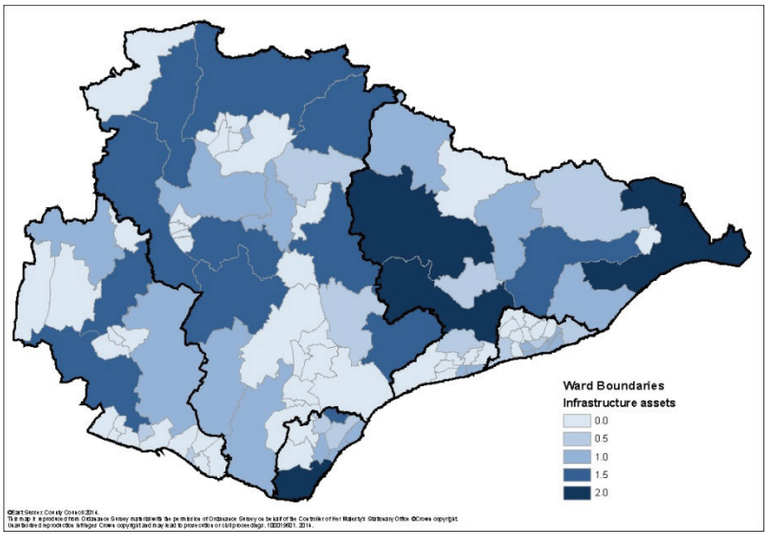
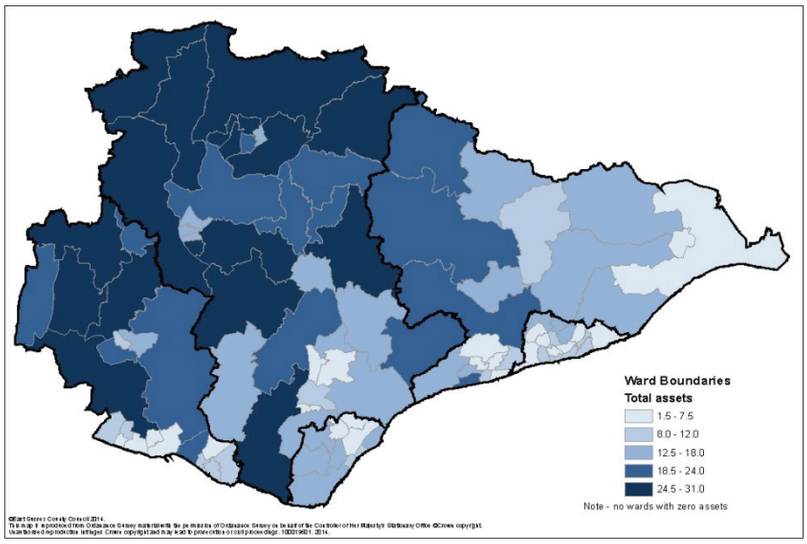


Figure 29 maps the Health component which has a potential total of 3 assets with a score of 2. Four wards, Darwell, Eastern Rother, Crowhurst and Meads have the greatest number of infrastructure assets.

All Domains and All Assets

Figure 30 shows the total number of assets based on all WARM indicators in each domain and their components.

Figure 30: Ward map showing assets across all the domains and their components



There are a potential total of 62 assets, with a potential highest score of 31. There are no wards with no assets. Fewer assets are generally along the coast and in eastern parts of the county.

Figures 31 and 32 map the number of assets and deficits for each ward and GP practice. Figure 31 shows the number of assets for each ward (green bars) as positive values and deficits (red bars) as negative values. The data is ordered by number of assets. Frant and Withyham and Uckfield Ridgewood have the greatest number of assets and Hailsham East the fewest.

Figure 32 shows the number of assets (green bars) as positive values and deficits (red bars) at GP practice level. This demonstrates that Ashdown Forest Health Centre and Beacon Surgery have the greatest number of assets and Roebuck House Practice 3 the fewest assets.

Figure 31: The total number of assets and deficits by ward

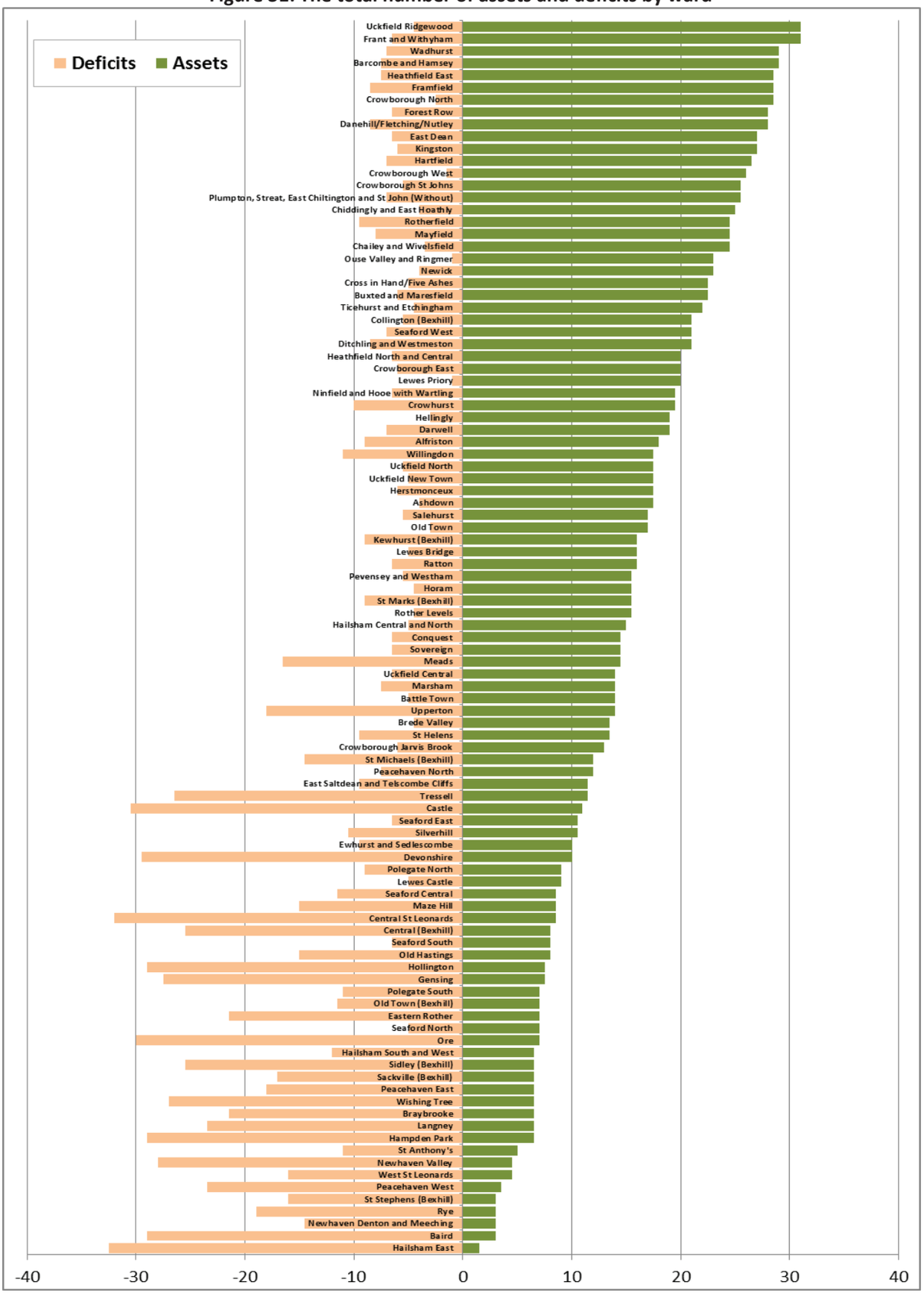
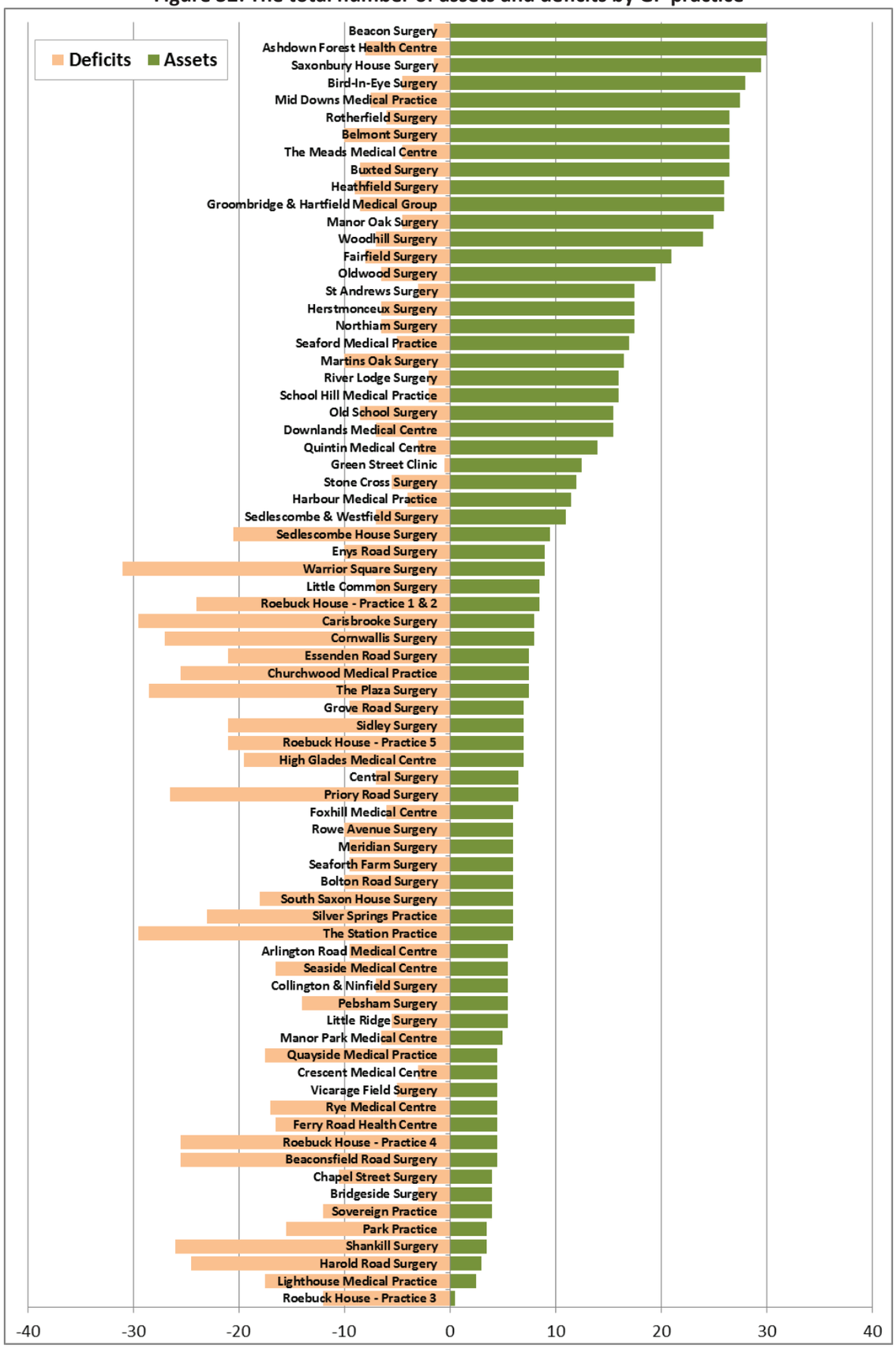


Figure 32: The total number of assets and deficits by GP practice



Figures 33 to 36 map the assets and deficits found in the Ward and GP practice with the most assets (Frant and Withyham and Ashdown Forest Health Centre) and those with the least assets (Hailsham East and Roebuck House Practice 3). Each block represents one of the indicators within each of the WARM components. Green represents indicators which are significantly better than the East Sussex average, yellow are similar to the average and red indicators are those which are significantly worse. These maps illustrate that even in wards with higher numbers of deficits, there are still assets (The weaker indicators are highlighted in Italics).

Figure 33: Assets and Deficit Indicators in Frant and Withyham (Wealden)

All WARM maps at ward and GP practice level are available to download, as separate documents, at www.eastsussexjsna.org.uk along with this report.

Figure 34: Assets and Deficit Indicators for Ashdown Forest Health Centre (HWLH CCG)

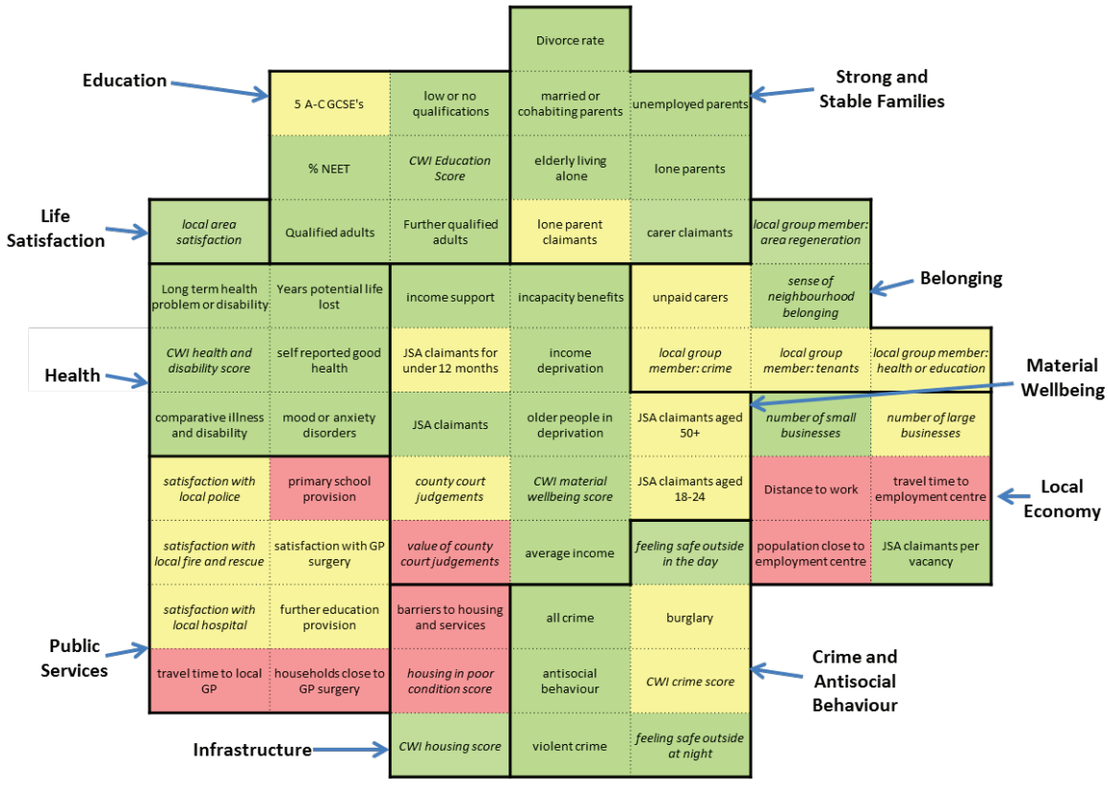
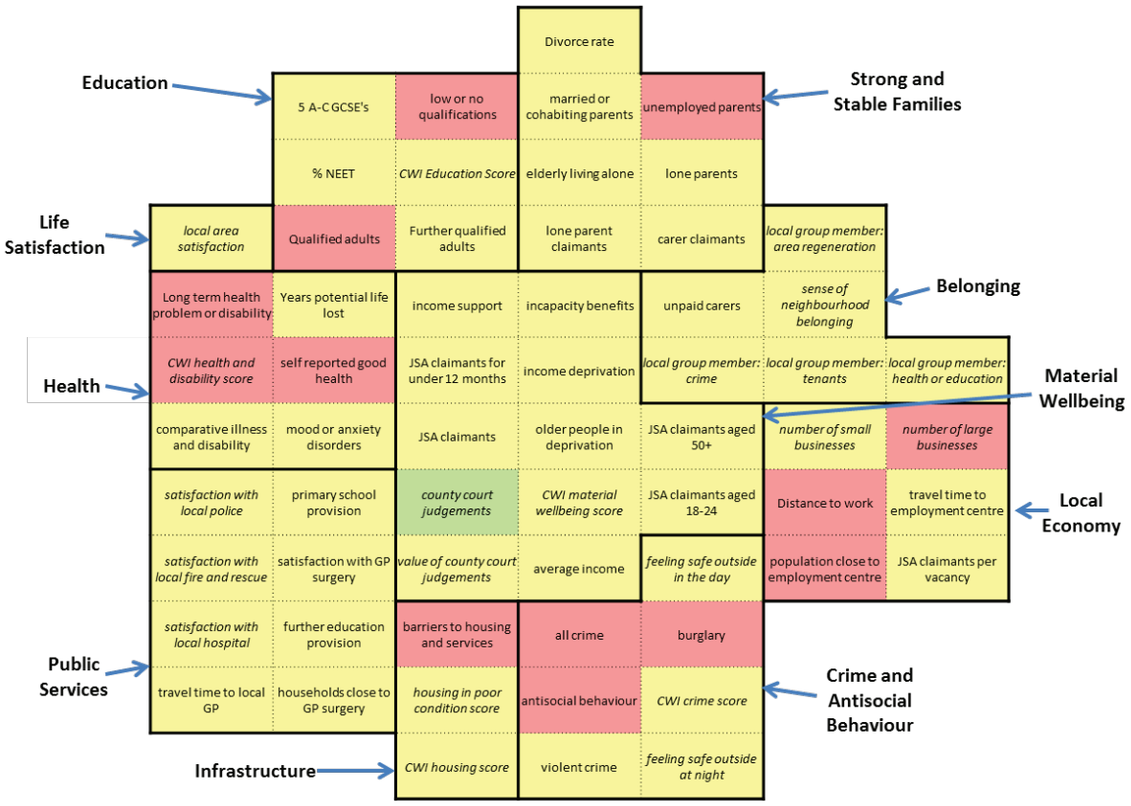


Figure 35: Assets and Deficit Indicators in Hailsham East (Wealden)

Figure 36: Assets and Deficit Indicators for Roebuck House Practice 3 (H&R CCG)



Deprivation and Assets

Although disadvantaged social groups and communities have a range of complex and inter-related needs, they also have assets that can help improve health and strengthen resilience.

Figure 37: Ward map showing the Index of Multiple Deprivation 2010

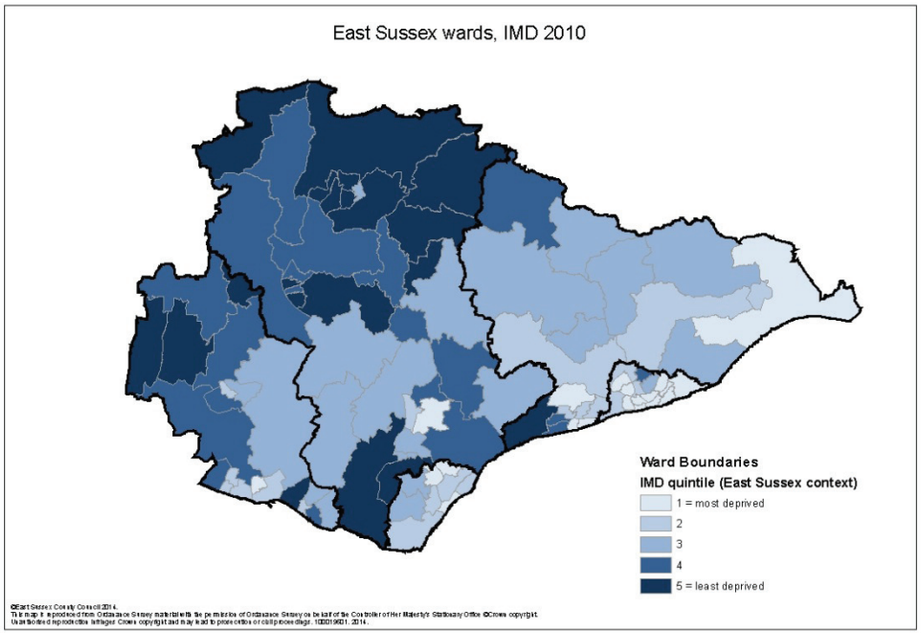


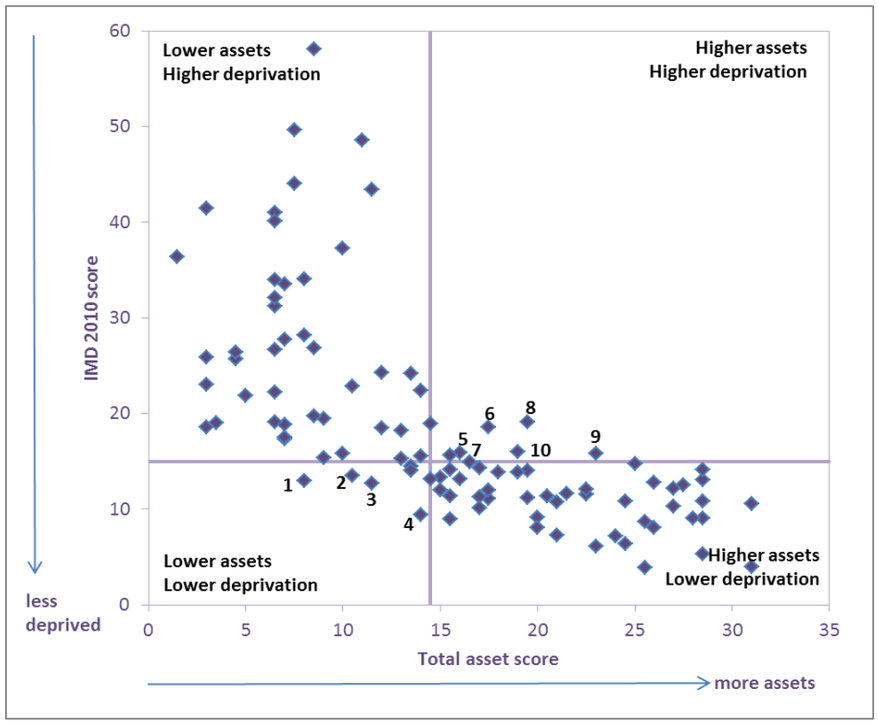
Figure 37 maps the Index of Multiple Deprivation (IMD) 2010 for electoral wards in East Sussex. Wards are grouped by quintiles where group 1 are amongst the most deprived 20% of wards in East Sussex and group 5 are amongst the least deprived wards in East Sussex.

Within East Sussex the five least deprived wards are (in order): Crowborough St John; Uckfield Ridgewood; Crowborough North; Newick and Rotherfield. The five most deprived wards are all in Hastings and include (in order): Central St Leonards; Gensing; Castle; Hollington and Tressell.

The scatter chart in Figure 38 contains each ward in East Sussex with their IMD 2010 score plotted against their total number of WARM assets. The horizontal and vertical lines are the median values for East Sussex overall. It shows that here are a greater number of assets in less deprived wards and therefore fewer assets in more deprived wards. However, it also shows that there are some exceptions.

- Seaford South, Seaford East, East Saltdean & Telscombe Cliffs and Uckfield Central are **less deprived wards but they have fewer assets**
- Ratton, Ashdown, Eastbourne Old Town, Crowhurst, Ouse Valley & Ringmer and Darwell are **more deprived wards but they have greater assets**

Figure 38: Scatter plot of IMD 2010 score (low is good) vs Total asset score across all sub domains (high is good)

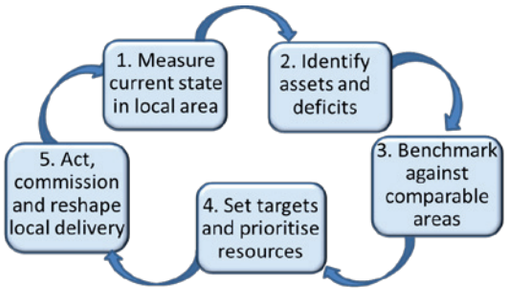


	Ward Name
1	Seaford South
2	Seaford East
3	East Saltdean & Telscombe Cliffs
4	Uckfield Central
5	Ratton
6	Ashdown
7	Eastbourne Old Town
8	Crowhurst
9	Ouse Valley & Ringmer
10	Darwell

More detailed asset mapping and understanding of the assets than afforded by the WARM analysis could help understand why these wards are exceptions. This in turn can help inform how assets are developed and sustained to support and reshape local delivery.

SECTION SUMMARY:
WELLBEING AND RESILIENCE MEASURE (WARM)

'WARM' is a model to measure community wellbeing and resilience by using available data to understand and identify an area's strengths (assets) and vulnerabilities (deficits).



The WARM tool looks at a number of indicators across three domains (Self, Supports and Systems and Structures) and ten components (Life Satisfaction; Education; Health; Material Wellbeing; Strong and Stable families; Belonging; Local Economy; Public Services; Crime and Anti-Social Behaviour and Infrastructure). It is a **cyclical process** continuously informing priorities for action.

Wellbeing and Resilience in East Sussex

In East Sussex, 62 indicators (calculated at Ward and GP Practice level) were examined and ranked across the WARM domains and components.

Assets exist for all wards and GP Practices

Life satisfaction/ Education/ Health/ Material Wellbeing/ Strong and stable families and Crime and antisocial behaviour	• **Wealden** then **Lewes,** and **High Weald Lewes Haven CCG** have the best average rankings • **Hastings** then **Eastbourne,** and **Hastings and Rother CCG** have the worst average rankings.
Belonging	• **Rother** then **Lewes** and **Hastings,** and **Rother CCG** have the best average rankings • **Eastbourne** then **Hastings,** and **High Weald Lewes Havens CCG** have the worst average rankings.
Local Economy	• **Eastbourne** then **Hastings,** and **Eastbourne Hailsham and Seaford CCG** have the best average rankings • **Wealden** then **Lewes,** and **Hastings and Rother CCG** have the worst average rankings.
Public Services	• **Eastbourne** then **Hastings** and **Hastings and Rother CCG** have the best average rankings • **Wealden** then **Lewes,** and **High Weald Lewes Havens CCG** have the worst average rankings.
Infrastructure	• **Eastbourne** then **Rother** and **High Weald Lewes Haven CCG** have the best average rankings • **Wealden** then **Lewes,** and **Hastings and Rother CCG** have the worst average rankings.

There are a greater number of assets in less deprived wards and therefore fewer assets in more deprived wards. There are some **exceptions** to this:

- Seaford South, Seaford East, East Saltdean & Telscombe Cliffs and Uckfield Central are **less deprived wards but they have fewer assets**
- Ratton, Ashdown, Eastbourne Old Town, Crowhurst, Ouse Valley & Ringmer and Darwell are **more deprived wards but they have greater assets**

More detailed asset mapping and understanding of the assets is needed to inform and reshape local delivery

4. Resilience in East Sussex

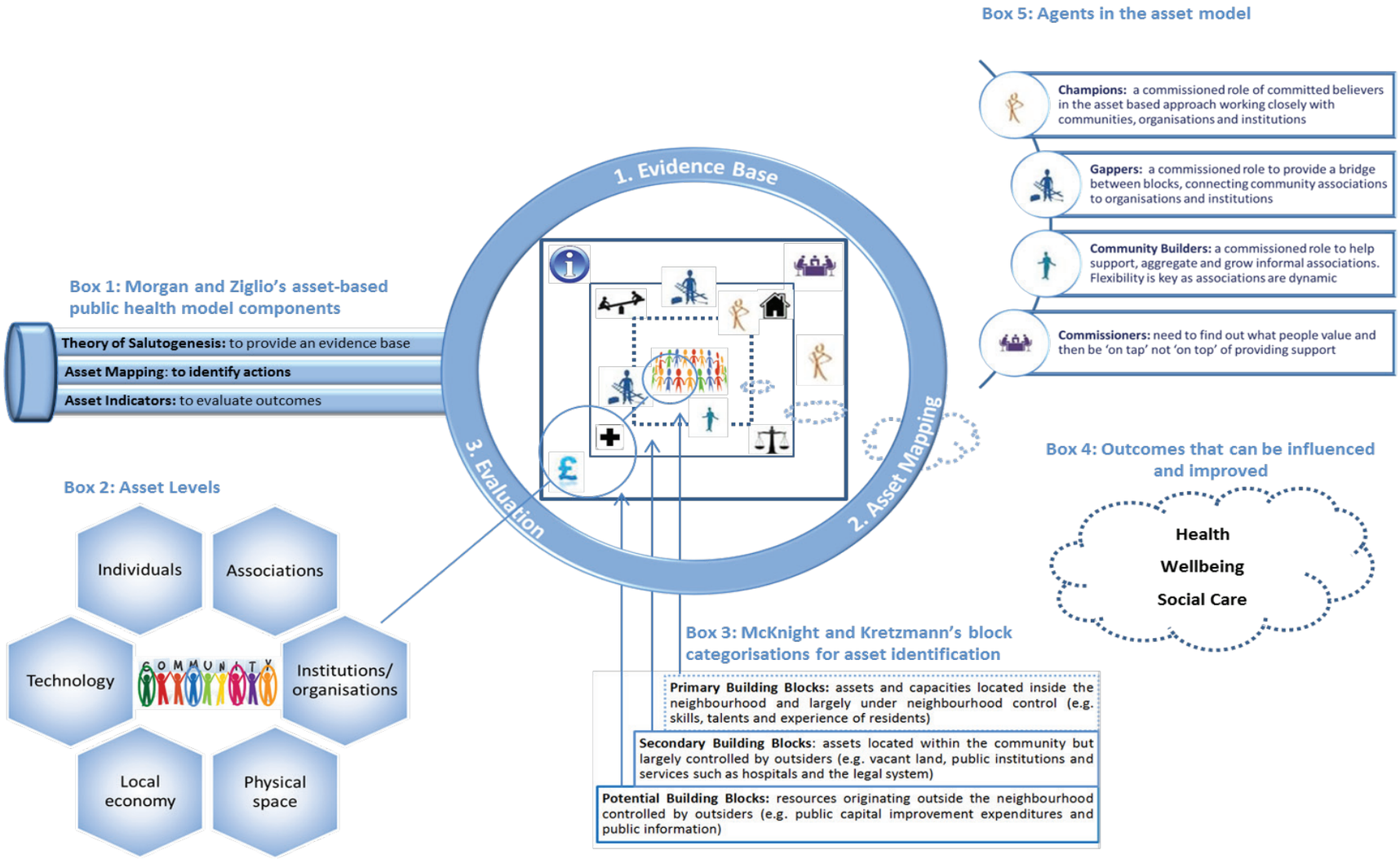
At a time of major transformation in East Sussex, developing an asset based approach presents a key opportunity.

Taking an asset-based approach involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services. The asset based approach allows for strong social networks, social capital and building of relationships to flourish and produces resilience amongst individuals and communities that impacts on health and wellbeing (Figure 40).

Table 14 provides a summary of the asset model, the key elements being:

Box 1:	**Morgan and Ziflio's asset based public health model**	A 'hand lens' or magnifying glass symbolising the need for commissioners to 'flip the lens' from looking at things from a deficient based perspective to an asset based perspective Morgan and Ziflio's model comprises: creating an evidence base; followed by asset mapping in the community; and finally identification of outcomes to evaluate.
Box 2:	**Kretzmann & McKnight and Morgan & Ziflio's categorisation of assets**	This element of the model assists in asset mapping and targeting of actions. The focus is on harnessing the 'gifts' of individuals, the benefits of which are increased when pooled in community associations, and further enhanced when these associations are supported by external organisations.
Box 3:	**Kretzmann & McKnight's categorisation of 'green space' building blocks**	These blocks further assist with asset mapping, grouping assets by the level of community control. Such a perspective helps commissioners to see where new links can be forged and barriers to organisations or resources need to be broken down.
Box 4:	**Individual and Community Outcomes**	A list of individual or community outcomes that can be influenced and improved.
Box 5:	**Agents of change**	A summary of the agents of change that commissioners can use to bring about the conditions under which asset based health benefits accrue. The three roles are: 'champions', 'gappers' and 'community builders'.

Figure 40: Summary of the Asset Model: Looking Through the Asset Lens



Wellbeing and resilience provide a useful lens through which to understand how people feel and think about their lives and what is happening in communities. WARM is a model to measure community wellbeing and resilience by using available data to understand and identify an area's assets and deficits. The picture that emerges from mapping WARM at local authority, ward and GP practice level within East Sussex is complex. With five district and borough local authorities, one hundred and one wards, three clinical commissioning groups and seventy four GP practices it was never going to be simple.

The WARM mapping in this report shows that even in wards with higher numbers of deficits there are still assets, and that there are no wards with no assets. However, this type of mapping can only give a partial picture. To complement this work, an asset based approach to asset mapping at a local level and exploration of resilience with regard to particular groups is needed. This in turn can help inform how assets are developed and sustained to support and reshape local delivery.

It is important to recognise that asset based working requires change over a considerable period of time. It often requires a cultural shift in how the current system is working, and changes to many operational aspects. This will not be achieved, therefore, through one discrete programme or through one project lead – however, such an approach can be used as a catalyst for developing asset based working throughout all parts of the system. It is also important to start with small achievable actions and to acknowledge small scale successes as collectively these contribute to wider change. Projects are happening already and organisations are working on an asset or strengths approach, even if these terms are not used. These need pulling together at the start, rather than assuming it is a completely new way of working for all.

Why is Evaluation Essential?

Measuring the impact of complex community interventions on health and social outcomes is not straight-forward. Concepts like participation, community cohesion and social capital are difficult to define or measure and interventions will inevitably be influenced by a host of other factors affecting the lives of individuals or the wider community. Evaluating asset-based approaches is therefore challenging, particularly when attempting to assess whether or not a given intervention has had a beneficial effect on the health of the individuals or communities it has involved. However, it is only by conducting careful evaluations that the contribution of asset-based approaches can be measured, judged and learned from.

It is important to ensure that alongside implementing a community wide asset based approach a robust and sensitive evaluation framework is established that identifies a series of reliable indicators to assess the impact and cost-effectiveness of asset-based programmes. Using existing data that focuses on the positive and can be understood as a health asset, for example: self-reported health; mental wellbeing using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS);[52] levels of physical activity; breastfeeding; educational attainment; employment rates; affordable housing; healthy school status; healthy workplace status; and volunteering rates. Such an evaluation framework should include an analysis of stakeholder perspectives, particularly of participants, other local community members and relevant service providers.

[52] The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a 14-item self-report measure of mental wellbeing. It was developed because of the importance of mental wellbeing in leading to positive outcomes in term of health and social costs and of preventive programmes in the community. WEMWBS has been included in the Health Survey for England since 2010 and is a component of the subjective wellbeing indicator in the Public Health Outcomes Framework.

5. Recommendations

The annual report of the Director of Public Health makes ten recommendations for supporting community resilience in East Sussex:

1. Develop the Joint Strategic Needs Assessment into a Joint Strategic Needs and Asset Assessment by building in strengths and assets to produce a more holistic assessment and to enable a broader and richer perspective to be offered into the planning process.
2. Commissioning organisations to work together to enhance community resilience.
3. The East Sussex Better together programme to take full account of the opportunities of this approach.
4. Enhance community resilience through an asset based approach which seeks positively to develop, harness and mobilise the assets, capacities and resources available to individuals and communities which could enable them to gain more control over their lives and circumstances and to meet primary prevention, health, wellbeing and social care support needs.
5. Build on existing skills and abilities for working directly with communities and current asset based projects and consider developing opportunities for individuals and groups to further enhance their work.
6. Further develop mapping of community assets as part of East Sussex Better Together including the use of directories of services.
7. Further promote volunteering and consider how we can best support volunteers through good quality experiences and, where appropriate, resource to maintain their level of volunteering. To also consider how volunteering can support access to qualifications and work.
8. Put in place a robust and sensitive evaluation framework that identifies a series of reliable indicators to assess the impact and cost-effectiveness of community asset-based programmes. Any services that are commissioned should be evaluated to demonstrate outcomes after one year, including social return on investment.
9. Undertake a state of the community health check (incorporating mental wellbeing) survey to include an update on the Place Survey data that is used to support some of the WARM indicators. To repeat the survey at appropriate intervals to monitor change and support evaluation of community health.
10. Promote the 5 ways to wellbeing and include in everyday life: connect; be active; take notice; keep learning; give. If practiced regularly they can improve personal wellbeing.

APPENDICES

6. Appendices

Appendix 1: Indicator definitions for WARM tool

SELF

Component	Indicator and source	Definition
Life satisfaction	*% people who are very or fairly satisfied with the local area as a place to live* ***Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
Education	Five GCSEs A*-C grades including English & Maths **Children's Services, JSNA scorecards (% 2012/13)**	JSNA Scorecard 2.31: Percentage of pupils at Key Stage 4 achieving 5 or more GCSE passes at A*-C including Maths and English, resident-based, June 2013.
	Adults (25-54 years) with no or low qualifications rate **2011 Census (% 2011)**	The percentage of adults aged 25–54 with no qualifications or low qualifications.
	16-18 year olds Not in Employment Education or Training (NEET) **Children's Services, JSNA scorecards (% 2012/13)**	Scorecard 2.41 Young people aged 16 to 18 years who are not in education, employment or training (NEET), monthly average, November 2012 to January 2013.
	Working age population qualified to at least level 2 or higher **2011 Census (% 2011)**	People are counted as being qualified to level 2 and above if they have achieved at least either 5+ O Level (Passes)/CSEs (Grade 1)/GCSEs (Grades A*-C), School Certificate, 1 A Level/ 2-3 AS Levels/VCEs, Intermediate/Higher Diploma, Welsh Baccalaureate Intermediate Diploma, NVQ level 2, Intermediate GNVQ, City and Guilds Craft, BTEC First/General Diploma, RSA Diploma.
	Working age population qualified to at least level 4 or higher **2011 Census (% 2011)**	Working age population qualified to at least level 2 or higher. People are counted as being qualified to level 4 and above if they have achieved at least either Degree (for example BA, BSc), Higher Degree (for example MA, PhD, PGCE), NVQ Level 4-5, HNC, HND, RSA Higher Diploma, BTEC Higher level, Foundation degree (NI).
	Child wellbeing index education score CWI 2009, Communities and Local Government (Score, 2005)	*This uses a variety of indicators of education: • two year rolling average of points score at Key Stages 2 and 3 derived from test score • two year rolling average of capped points score at Key Stage 4 • secondary school absence rate – based on two year average • proportion of children not staying on in school or non-advanced further education or training beyond the age of 16 • proportion aged under 21 not entering higher education.*
Health	% of households with one or more person with a limiting long term illness or disability **2011 Census (%, 2011)**	A long-term health problem or disability limits a person's day-to-day activities, and has lasted, or is expected to last, at least 12 months. This includes problems that are related to old age. People were asked to assess whether their daily activities were limited a lot or a little by such a health problem, or whether their daily activities were not limited at all.
	Years of potential life lost indicator **Indices of Deprivation 2010 (Ratio, 2008)**	The indicator is a directly age and sex standardised measure of premature death. The numerator is mortality data in five year age-sex bands from 2004-2008 and the denominator is the total population in five year age-sex bands from 2008.
	Child wellbeing index health and disability score CWI 2009, Communities and Local Government (Score, 2005)	*Three health indicators were combined with equal weights: proportion of children aged 0–18 admitted to hospital in an emergency; proportion of children aged 0–18 attending hospital as outpatients; and proportion of children aged 0–16 receiving Disabled Living Allowance.*
	% of people who self-reported good health **2011 Census (%, 2011)**	Based on Census question - How is your health in general? (good or very good).
	Comparative illness and disability ratio **Indices of Deprivation 2010 (Ratio, 2008)**	This is a directly age and sex standardised rate of morbidity and disability. The numerator is a non-overlapping count of individuals receiving benefits due to ill health in five year age-sex bands for 2008. The denominator is the total population in five year age-sex bands for 2008.
	Measures of adults suffering from mood or anxiety disorders **Indices of Deprivation 2010 (Index, 2008)**	A modelled measure of adults under 60 with mood (affective), neurotic, stress-related and somatoform disorders. Based on prescribing data, hospital episodes, deaths attributed to suicide and health benefits.

Component	Indicator and source	Definition
Material wellbeing	Income support **Department for Work and Pensions (% Aug 2013)**	
	Incapacity benefits **Department for Work and Pensions (% Feb 2013)**	
	Job Seekers Allowance - Claimants for less than 12 months **Department for Work and Pensions (% Oct 2013)**	% of Job Seeker's Allowance (JSA) claimants claiming for less than 12 Months.
	Indices of deprivation – income domain **Indices of Deprivation 2010 (%, 2008)**	This domain aims to capture the proportion of the population experiencing income deprivation. The indicators that make up this domain include: • Adults and children in Income Support families • Adults and children in income-based Jobseeker's Allowance families • Adults and children in Pension Credit (Guarantee) families • Adults and children in Child Tax Credit families (who are not claiming Income Support, income-based Jobseeker's Allowance or Pension Credit) whose equivalised income (excluding housing benefits) is below 60% of the median before housing costs • Asylum seekers in England in receipt of subsistence support, accommodation support, or both.
	Job Seekers Allowance Claimant count **Nomis (%, Jan 2014)**	
	Job Seekers Allowance Claimants aged 50 years or over **Nomis (average %, Aug 2013)**	
	Job Seekers Allowance Claimants aged 18-24 years **Nomis (average %, Aug 2013)**	
	Child wellbeing index material wellbeing score CWI 2009, Communities and Local Government (Score, 2005)	A comprehensive, non-overlapping count of children living in households in receipt of both in-work and out-of-work means-tested benefits. Indicators are the percentage of children aged 0–15 who live in households claiming: Income Support; Income-Based Jobseeker's Allowance; Pension Credit (Guarantee); Working Tax or Child Tax Credit whose equivalised household incomen (excluding housing benefits) is below 60 per cent of the median before housing costs; or Child Tax Credit whose equivalised income (excluding housing benefits) is below 60% of the median before housing costs. Indicators are summed and expressed as a rate of the total child population aged 0–15.
	Income deprivation affecting older people index (IDAOPI) **Indices of Deprivation 2010 (%, 2010)**	Proportion of the population aged 60 and over who have Income Support, Jobseeker's Allowance or Incapacity Benefit claimants.
	Total count court judgements ***Office for National Statisticss (Count, 2005)***	*You may get a county court judgment (CCJ) or high court judgment if someone takes court action against you (saying you owe them money) and you don't respond. If you get a judgment, the court has formally decided that you owe the money.*
	Average value of county court judgements ***Office for National Statistics (£, 2005)***	*You may get a county court judgment (CCJ) or high court judgment if someone takes court action against you (saying you owe them money) and you don't respond. If you get a judgment, the court has formally decided that you owe the money.*
	Average (median) household income **CACI (£, 2013)**	This data is modelled using a variety of Government data sources combined with data from lifestyle surveys. Household income includes gross income before tax from: wages, investments, income support and other welfare benefits such as tax credits and pensions. Household income is the combined income of all household members. The mean is derived by adding all annual household incomes for a given area and dividing the result by the total number of households. The median household income is determined by ranking all household incomes in ascending order. The median is the mid-point of this ranking with 50% of households having an income below the median and 50% above.

SUPPORT

Component	Indicator and source	Definition
Strong & stable families	Households containing persons who are divorced **2011 Census** (%, 2011)	
	Households with no adults in employment with dependent children **2011 Census** (%, 2011)	
	Elderly living alone **2011 Census** (%, 2011)	
	Households with dependent children containing married/cohabiting couples **2011 Census** (%, 2011)	
	Households with dependent children containing lone parents **2011 Census** (%, 2011)	
	Lone parent claimants **Department for Work and Pensions (%, Aug 2013)**	Working Age Benefit Claimants is derived from the Work and Pensions Longitudinal Study (WPLS). Benefit claimants categorised by their statistical group (main reason for interacting with the benefit system). In the case of lone parents it is Income Support claimants with a child under 16 and no partner. This dataset does not double count claimants who receive multiple benefits.
	Carer claimants **Department for Work and Pensions (%, Aug 2013)**	Working Age Benefit Claimants and is derived from the Work and Pensions Longitudinal Study (WPLS). Benefit claimants categorised by their statistical group (their main reason for interacting with the benefit system). In the case of lone parents it is Carers' Allowance claimants. This dataset does not double count claimants who receive multiple benefits.
Belonging	*% of people who feel they belong to their neighbourhood **Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	% who have given unpaid help at least once per month over the last 12 months **2011 Census (%, 2011)**	A person is a provider of unpaid care if they look after or give help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age. This does not include any activities as part of paid employment. No distinction is made about whether any care that a person provides is within their own household or outside of the household.
	*A member of a group making decisions on local health or education services **Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	*A member of a decision making group to regenerate local area **Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	*A member of a decision making group to tackle local crime problems **Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	*A member of a tenants' group decision making committee **Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*

SYSTEMS AND STRUCTURES

Component	Indicator and source	Definition
Local economy	Travel time to nearest employment centre by walking/public transport **Department for Transport (minutes, 2011)**	Average minimum travel time (minutes) to reach an employment centre by Public Transport / Walking.
	% of working age population within 20 minutes of an employment centre by walking/public transport or cycling **Department for Transport (%, 2011)**	
	VAT based local units by employment size band (0-4 employees) ***Office for National Statistics (Count, 2007)***	
	VAT based local units by employment size band (20+ employees) ***Office for National Statistics (Count, 2007)***	
	JSA claimants per job vacancy, **Department for Work and Pensions** (number per vacancy, 2010-2012)	
	Less than 2km distance travelled to work **2011 Census (%, 2011)**	The number of people aged 16–74, who were usually resident in the area at the time of the 2011 Census, and travelled less than 2km to their place of employment.
Public service	*Satisfaction (very or fairly satisfied) with local police* ***Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	Satisfaction (very or fairly satisfied) with local fire and rescue ***Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	Patients experience of their GP surgery (fairly/very good) **GP patient survey (2012/13)**	
	Satisfaction (very or fairly satisfied) with your local hospital ***Place Survey (%, 2008/09)***	*Question in ESCC Place Survey - no longer undertaken*
	Travel time to nearest GP by walk/public transport **Department for Transport (minutes, 2011)**	Average minimum travel time (minutes) to reach a GP by Public Transport / Walking.
	% of target population weighted by the access to GPs by walking/public transport **Department for Transport (%, 2011)**	
	Number of further education institutions within 30 minutes by walking/public transport **Department for Transport (Number, 2011)**	
	Number of primary schools within 15 minutes by walking/public transport **Department for Transport (Number, 2011)**	
Crime and anti-social behaviour	*Child wellbeing index crime score CWI 2009, Communities and Local Government (Score, 2005)*	Four component indicators are weighted according to maximum likelihood factor analysis for the population aged 0–15. The indicators are: Burglary rate, Theft rate, Criminal damage rate, and Violence rate.
	People who are feel very/fairly safe when outside in their local area during the day ***Place Survey*** *(%, 2008/09)*	*Question in ESCC Place Survey - no longer undertaken*
	People who are feel very/fairly safe when outside in their local area after dark ***Place Survey*** *(%, 2008/09)*	*Question in ESCC Place Survey - no longer undertaken*
	All crime offences **Safer Communities, East Sussex County Council (Rate, 2012/13)**	Total number of recorded crimes per 1,000 population, 2012/13.
	Burglary offences **Safer Communities, East Sussex County Council (Rate, 2012/13)**	Total number of recorded burglary offences per 1,000 population, 2012/13.
	Anti-social behaviour incidents **Safer Communities, East Sussex County Council (Rate, 2012/13)**	Total number of recorded anti-social behaviour offences per 1,000 population, 2012/13.
	Violent crime offences (Sometimes referred to as "violence against the person" - not including sexual offence/ robbery) **Safer Communities, East Sussex County Council (Rate, 2012/13)**	Total number of recorded violent crime offences per 1,000 population, 2012/13.

Component	Indicator and source	Definition
Infrastructure	Barriers to housing and service score **Indices of Deprivation 2010 (Score, 2008)**	The indicator is a combination of two indicators: 'Geographical Barriers', which measures road distances to: GP surgery, primary schools, Post Office, and supermarket/general stores; and 'Wider Barriers', which includes: difficulty of access to owner-occupation, homelessness and overcrowding.
	Child wellbeing index housing score CWI 2009, Communities and Local Government (Score, 2001)	*Four indicators are used to measure access to housing and quality of housing, which are then combined with equal weights. Indicators of access to housing are: Overcrowding (occupancy rating); Shared accommodation: (people aged 0–15 living in shared dwellings as a proportion of all children 0–15 in each LSOA); and Homelessness (concealed families containing dependent children as a proportion of all families with dependent children). Quality of housing is measured by: Lack of central heating (children aged 0–15 years old living in accommodation without central heating as a proportion of all children aged 0–15).*
	*Housing in poor condition score **Indices of Deprivation 2007 (Score 2005)***	*Probability that any house in the LSOA will fail to meet 'Decent Homes Standard' as modelled by the Building Research Establishment.*
	Child wellbeing index crime score CWI 2009, Communities and Local Government (Score, 2005)	Four component indicators are weighted according to maximum likelihood factor analysis for the population aged 0–15. The indicators are: Burglary rate, Theft rate, Criminal damage rate, and Violence rate.

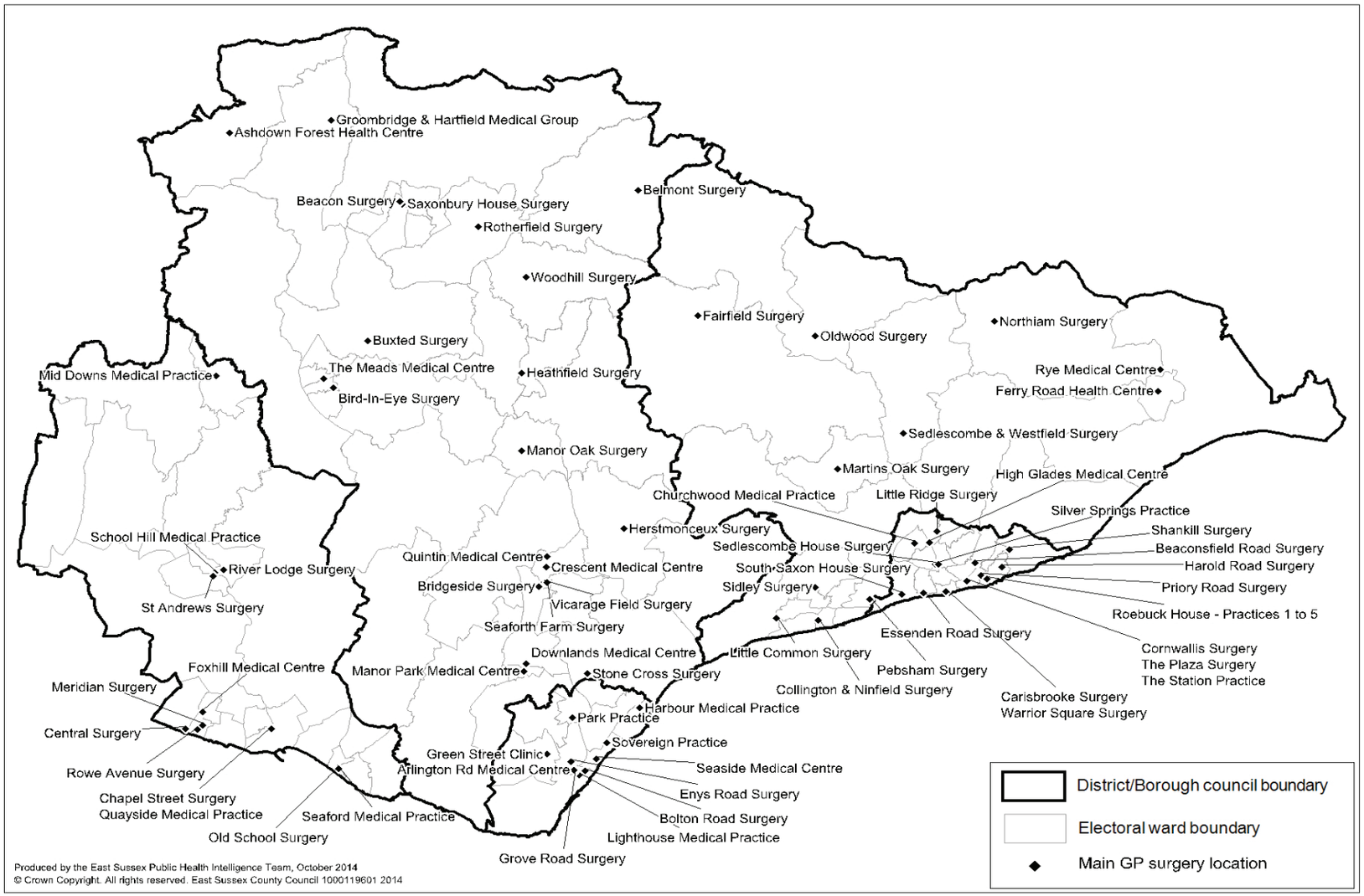
Appendix 2: Map of electoral wards in East Sussex

The following is a list of wards in East Sussex where the boundary area on the map is too small to display full name.

Ward Name	Ward Code	Short Name
Eastbourne wards		
Devonshire	E05003920	EW1
Hampden Park	E05003921	EW2
Langney	E05003922	EW3
Meads	E05003923	EW4
Old Town Eastbourne	E05003924	EW5
Ratton	E05003925	EW6
St Anthony's	E05003926	EW7
Sovereign	E05003927	EW8
Upperton	E05003928	EW9
Lewes wards		
Lewes Bridge	E05003950	LW1
Lewes Castle	E05003951	LW2
Lewes Priory	E05003952	LW3
East Saltdean and Telscombe Cliffs	E05003948	LW4
Peacehaven East	E05003957	LW5
Peacehaven North	E05003958	LW6
Peacehaven West	E05003959	LW7
Newhaven Denton and Meeching	E05003953	LW8
Newhaven Valley	E05003954	LW9
Seaford Central	E05003961	LW10
Seaford East	E05003962	LW11
Seaford North	E05003963	LW12
Seaford South	E05003964	LW13
Seaford West	E05003965	LW14
Rother wards		
Central	E05003968	RW1
Collington	E05003969	RW2
Kewhurst	E05003974	RW3
Old Town Bexhill	E05003976	RW4
Sackville	E05003979	RW5
St Marks	E05003980	RW6
St Michaels	E05003981	RW7
St Stephens	E05003982	RW8
Sidley	E05003984	RW9

Ward Name	Ward Code	Short Name
Hastings Ward		
Ashdown	E05003929	HW1
Baird	E05003930	HW2
Braybrooke	E05003931	HW3
Castle	E05003932	HW4
Central St Leonards	E05003933	HW5
Conquest	E05003934	HW6
Gensing	E05003935	HW7
Hollington	E05003936	HW8
Maze Hill	E05003937	HW9
Old Hastings	E05003938	HW10
Ore	E05003939	HW11
St Helens	E05003940	HW12
Silverhill	E05003941	HW13
Tressell	E05003942	HW14
West St Leonards	E05003943	HW15
Wishing Tree	E05003944	HW16
Wealden wards		
Crowborough East	E05003990	WW1
Crowborough Jarvis Brook	E05003991	WW2
Crowborough North	E05003992	WW3
Crowborough St. Johns	E05003993	WW4
Crowborough West	E05003994	WW5
Rotherfield	E05004014	WW6
Hailsham Central and North	E05004000	WW7
Hailsham East	E05004001	WW8
Hailsham South and West	E05004002	WW9
Heathfield East	E05004004	WW10
Heathfield North and Central	E05004005	WW11
Polegate North	E05004012	WW12
Polegate South	E05004013	WW13
Uckfield Central	E05004015	WW14
Uckfield New Town	E05004016	WW15
Uckfield North	E05004017	WW16
Uckfield Ridgewood	E05004018	WW17

Appendix 3: Map of main GP surgery locations in East Sussex



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