STRENGTHENING PERSONAL RESILIENCE IN EAST SUSSEX

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2015/16
Welcome to the 2015/16 Director of Public Health Annual Report on strengthening personal resilience.

This report builds upon the 2014/15 Director of Public Health Annual Report, Growing Community Resilience in East Sussex, by focussing on the need to develop and strengthen personal resilience to underpin and support growing community resilience.

Resilience is the result of individuals being able to interact with their environments and the processes that either promote well-being or protect them against the influence of risk factors. Risk factors such as poverty, low socioeconomic status, parental mental health issues, etc. are correlated with poor or negative outcomes. Even when these risk factors occur, resilient individuals avoid the negative outcomes usually associated with those risk factors and develop positive outcomes nonetheless.

As individuals live and work within communities, personal and community resilience are closely linked. For example, communities provide the social networks and opportunities to build self-esteem and purposeful lives which are essential components of personal resilience. Likewise, communities are dependent on the contribution of healthy, resilient individuals. Individual and community resilience support one another. Communities make individuals resilient but it is individual engagement with others and community mindedness that builds a community.

Public services are working under intense pressure to develop long-term sustainable responses given the significant budget cuts that are being made. Resilience is a thread that can bind efforts together and support us to make transformational change. Growing and strengthening community and personal resilience has the potential to alleviate pressures on health and social care caused by rising demand for services, population increases, ageing and budgetary constraints. However, it is not a panacea. An overriding recommendation of this report is that reducing health inequalities must continue to be a focus of our efforts as they are sources of vulnerability and lessen resilience.

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This report is available in hard copy and also at www.eastsussexjsna.org.uk

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**Introduction**

With reductions to public funding, we are going to have to make increasingly difficult decisions about entitlements and the provision of services which will impact on individuals and population groups. This will mean making tough choices. Savings have been generated in a range of ways’ from efficiency measures designed to help authorities work smarter; to ‘invest to save’ activities focused on reducing future needs and costs; to reductions in services, changes in eligibility thresholds and consolidations of facilities. The scale of the reductions required for the future will mean that the viability of some services will be compromised and cannot be continued as before. These challenges will be addressed through the County Council’s Reconciling Policy Performance Resources framework and by all other East Sussex public bodies through their core planning and prioritisation processes.

We need to enable and support individuals and communities to become stronger and more independent, with less reliance on the public sector. This involves being responsive not only to local needs but also to strengths. By mobilising and building on the resources and strengths in our communities, we can deliver better outcomes whilst encouraging people to take greater ownership of their own health and wellbeing, be more resilient, increasingly independent, self-sufficient and resourceful thus better able to help themselves.

The 2014/15 Director of Public Health Annual Report, *Growing Community Resilience in East Sussex*, focused on how we can build community resilience by growing the assets of wellbeing across East Sussex. It looked at how we can identify, better understand and support development of existing and potential new community assets. It described how individuals can play a significant role in increasing community resilience and how systematic processes can be used to support this work and monitor its impact particularly in developing sustainability.

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.¹

Based on a review of the evidence, the report recommended 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 health, wellbeing and social care support needs.

Resilience is not a rare ability but can be learned and developed: it is a process rather than a trait to be had³. The resilience perspective is associated with asset-based approaches. Both perspectives favour a focus on understanding processes and resources that keep people well and better equipped to navigate crisis and challenge. Characteristics that support resilience in individuals are those that build strong interpersonal relationships in communities and allow transfers of information and support. Empathy, intelligence, interpersonal skills, the ability to ask for help (and being able to identify and navigate appropriate sources of help) are the building blocks of wider social capital. Promoting the resilience of individuals can therefore be seen as a point of entry into building stronger networks and communities.

Resilience is the result of individuals being able to interact with their environments and the processes that either promote well-being or protect them against the overwhelming influence of risk factors⁴.
These processes can be individual coping strategies, or may be promoted by external factors such as good families, schools, communities, and social policies that make resilience more likely to occur. In this sense ‘resilience’ occurs when there are cumulative ‘protective factors’. National research has suggested that what may promote resilience for one individual may not for another.

However, there appear to be three consistent external factors where local authorities, community groups and service providers can make a significant impact on personal resilience: activities promoting wellbeing (feeling good; functioning well); building social capital and developing psychological coping strategies.

The 2008 New Economics Foundation (NEF) ‘Five Ways to Wellbeing’ (Connect; Be Active; Take Notice; Keep Learning and Give) have been widely adopted by many groups, organisations, local authorities and people as evidenced-based steps that could be taken to improve wellbeing.

In order to reduce inequalities, actions should be universal, but targeted with greater resource and intensity at those experiencing poverty or disadvantage. Prevention and early intervention are important, as resilience built in the early years could help people if they are exposed to adversity later on in life.

There are inequalities in the chances of people experiencing adversity and in the resources and protective factors necessary to build resilience and reduce vulnerability. As important as it is to enable people to build up strengths and capabilities, these do not extinguish the effects of risks such as poverty.

Living in adverse conditions of poverty and disadvantage gives people less opportunity to build up and less capability to maintain good physical and mental health. Poorer neighbourhoods are less likely to have good schools, pleasant parks and play areas for example. Those who are at most likely to face adversity and need greater resilience are least likely to have the resources to build it. This ‘double burden’ contributes to health inequalities.

At the heart of our resilience is how well we can take advantage of the opportunities available to us. Taking up the offer afforded by preventative support and services is key. The evidence shows that empowering people improves health outcomes and could save money by supporting people better to manage their conditions themselves.

A person is empowered over their health and care to the extent that they can manage and make decisions about their health, shape and choose the health and care services they use and influence the wider conditions that affect them, whether individually or through their relationships with others, so that they can lead the lives they want to live:
them build their personal resilience. Each chapter deals with a different area.

People that currently have no particular social care needs or symptoms of illness need to be empowered to take up the offer of support to prevent onset of a problem. Interventions include promoting health and active lifestyles, supporting people to change health related behaviour, combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, delivering practical services, developing environments which support health, etc. The focus is therefore on maintaining independence, good health and promoting wellbeing.

People at risk or with a known problem at an early stage need to be empowered to take up the offer of support to halt or slow down any deterioration, and which actively seek to improve their situation. Interventions include medication to treat people with high blood pressure, weight management programmes for those overweight.

Building personal resilience by protecting our health through accessing sexual health services and taking up the offer of the protection obtained by vaccination programmes and the population screening programmes helps us to be resilient.

The resilience perspective can also help us to identify how practitioners and services can support people and communities to enhance their vitality and viability. To build resilience in both individuals and communities we need to transform the support at the front line to enable people to be independent rather than dependent, as much as feasible. Enabling people to self-care or self-manage their health and social care issues builds personal resilience. It helps people to ask themselves a series of questions including:

People with established long-term health conditions or complex social care needs want more control and choice over the care and support they receive to maintain their functioning and independence. They also want much more of a say in defining the outcomes from their health and social care that are important to them, and deciding how they will be achieved.

Personal budgets are a way of enabling people to have greater choice, flexibility and control over the healthcare and support they receive, and to be more involved in discussions and decisions about their care. A personal budget is an amount of money to support a person’s health and wellbeing needs identified in their care plan, which has been planned and agreed between the person and their care and support team. There is evidence that individuals who are supported to engage more effectively with their condition and with health and care professionals have a positive experience of their care and experience better health outcomes.

‘East Sussex Better Together’ is the 150 week 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 programme started in August 2014 and is led by the three local NHS Clinical Commissioning Groups and East Sussex County Council (ESCC). It’s about making sure the combined £935million annual budget is used to achieve the best possible services for local people.

The shared ambition is to develop a fully integrated health and social care system in East Sussex by 2018, ensuring every patient or service user enjoys proactive, joined up care that supports them to live as independently as possible and achieve the best possible outcomes.

It is through ‘East Sussex Better Together’ that we will deliver the transformational shift we need to realise the aspiration for healthy, resilient individuals, communities and services in East Sussex.
The report makes NINE recommendations for supporting personal resilience in East Sussex:

| CHAPTER 1 | Reducing health inequalities through the planning and commissioning of services and through the East Sussex Better Together Programme must continue to be a focus of all our efforts as deprivation is a source of vulnerability and lessens resilience. |
| CHAPTER 2 | Current practice which incorporates the following set of evidence based principles to effectively implement interventions that build resilience should be consistently applied through the East Sussex Better Together Programme:
  - Prioritise positive approaches for wellbeing;
  - Involve individuals and local communities effectively and appropriately;
  - Connect the individual with community and broader society;
  - Recognise that individual and wider resilience is interwoven;
  - Recognise the need to invest, where possible, in wider sources of resilience for a person (community and family);
  - Work in a multi-disciplinary and multi-professional way;
  - Secure sustainability through an evidence-based approach. |
| CHAPTER 3 | Commissioners and providers of maternal, perinatal and early years health services and parenting programmes should continue to ensure that services, wherever possible, build resilience through evidence-based programmes of intervention and support. |
| CHAPTER 4 | The East Sussex County Council Health Improvement Team need to increase their work with partners to implement effective workplace interventions that promote health and wellbeing and embed action to grow personal resilience through healthy workplace programmes. |
| CHAPTER 5 | Continue to take concerted action to address loneliness and social isolation, particularly in older people, through the East Sussex Better Together Programme’s Community Resilience workstream. |
| CHAPTER 6 | Commissioners and providers of sexual health services will work together to ensure that services are promoting good sexual health and building knowledge so that individuals can maximise their personal resilience. |
| CHAPTER 7 | East Sussex Public Health, NHS England, the CCGs and General Practices need to work closely together to increase access to vaccination and screening programmes and on engagement and understanding of the public on the benefits of these programmes in making them more resilient to disease. |
| CHAPTER 8 | The East Sussex Better Together Programme needs to reinforce the current direction of travel for services to be re-orientated to be person-centred, to be patient/client focused, to promote control, independence and autonomy for the recipient, carers and families, provide choice and be based on a collaborative team philosophy. |
| CHAPTER 9 | Robust measures, from routine data sources, need to be identified so that they can be included in the East Sussex Better Together Programme key performance indicators and monitored to assess the extent to which care and support is person-centred. |
WHAT IS PERSONAL RESILIENCE?
What is Personal Resilience?

Within society, people face many adversities or stressors in their lives. Resilience is more than the ability to ‘bounce back’ from this adversity, it is *the successful adaptation to life tasks in the face of social disadvantage or highly adverse conditions*. Stress and adversity can be caused by, for example, family or relationship problems, health problems, or workplace and financial stressors.

Resilience is not a rare ability, but one can be learned and developed by anyone: it is an outcome (relatively good functioning or well-being), as well as a set of qualities or processes that enable a person to make use of internal and external resources (adaptability in the face of adversity).

A resilient person is someone who, despite living in adverse or difficult conditions, can navigate relationships, respond to challenges, learn new skills and achieve tasks that would normally be expected at a particular age or stage in life.

Being resilient involves being able to identify resources, whether psychological, social, cultural and physical, that may sustain health and well-being. Once these resources have been identified, a resilient individual is able to individually and collectively negotiate for these resources to be provided and experienced in meaningful ways. It is up to families, communities and governments to provide these resources in the way individuals’ value.

The three internal building blocks of resilience are: a secure base (sense of security); good self-esteem and a sense of self-efficacy (sense of control over our lives). The external building blocks include: at least one secure attachment relationship; access to wider support; and positive nursery, school or community experiences.
Therefore, our personal skills, experiences and upbringing are essential to our resilience and are interwoven with the resilience of the communities we live in and the economic circumstances we face. Our individual, social, political and economic contexts are crucial in determining the type and level of resources available to us (Figure 1) and this varies for each person.

Building resilience is not simply a matter of building individual capacity, it is about holistically building both the internal and external resources available to a person and how they can use these.

The need for a new approach to empower individuals to make healthy choices has been highlighted by the Department of Health Strategy for Public Health which has five core aims:

- **Starting well**: enabling good health in mothers before, during and after pregnancy and good parenting
- **Developing well**: encouraging healthy habits, building self-esteem and avoiding harmful behaviours
- **Growing up well**: identifying, treating and preventing mental health problems and creating resilience and self-esteem
- **Living and working well**: choosing lifestyles and behaviours that influence health and productivity
- **Ageing well**: supporting resilience through social networks and activity and providing protection from preventable ill-health

**Figure 1: A network of resilience**

Source: Runswick-Cole et al, 2014
Why is Personal Resilience important?

As society becomes more complex and unpredictable, it becomes more difficult to foresee where the next serious challenge will present itself. Consequently, where resilience has often been focussed around preparedness and the ability to 'predict and control' responses to risk, it is evolving beyond this definition to explain and identify how we can support people and communities to enhance their 'vitality and viability' in the face of challenge and change.24

The NHS, public health and social care system has a shared principle purpose to improve health and wellbeing. It does this by treating those with ill health, caring for those in need, and protecting and promoting the public’s health. This cannot be achieved without taking every opportunity to support communities and people to be resilient, independent and to self-manage conditions and events.25 This is particularly important considering that as much as 40% of all spending on public services is on interventions which could have been avoided by prioritising a preventative approach.26

Risk and Protective Factors

There are two key elements contributing to a person’s resilience: risk factors and protective factors. Risk factors are related to poor or negative outcomes.27 For example, poverty, low socioeconomic status and parental mental health issues are correlated with lower academic achievement and more emotional or behavioural problems. However, even when these risk factors occur, resilient individuals avoid the negative outcomes usually associated with those risk factors and develop positive outcomes. These positive outcomes are attributed to protective factors which act as a buffer against stress and adversity, for example, good parenting or positive school experiences.28,29

Resilience is the result of individuals being able to interact with their environments and the processes that either promote well-being or protect them against the overwhelming influence of risk factors.2 These processes can be individual coping strategies, or may be promoted by external factors such as good families, schools, communities, and social policies that make resilience more likely to occur.3
There are three main levels at which protective influences for personal resilience have been identified: the individual level, the family level and the community level. At an individual level (internally), protective factors include: emotional regulation, temperament, positive self-identity, optimism, self-esteem, self-efficacy, empathy, ability to form relationships that provide care and trust, ability to understand experiences, opportunities to express feelings, ability to resolve conflicts, coping strategies and social skills.30,31,32,17,33

Fostering resilience in children at a family level requires caring and stable family environments which hold high expectations for a child’s behaviour and participation in family life34. At the family level, protective factors include family cohesion, warm and emotionally responsive care giving, and parent-child relationships.37

The 2014/15 Director of Public Health Report ‘Growing Community Resilience in East Sussex’ highlighted the huge role communities play in fostering personal resilience. At community level, support for personal resilience building includes peer networks, supportive communities and environments such as schools.37

Additional factors have also been identified for specific individuals or groups, for example racial identity, and bicultural identity have been suggested as potential sources of protection for minority groups.35 In this sense ‘resilience’ occurs when there are cumulative ‘protective factors’ influencing the individual.

In the face of adversity, resilient individuals may show better outcomes than more vulnerable people:

- lower incidence of unhealthy or risky behaviours36,7,37
- higher attainment at school, qualifications, and skill levels36,38,39
- better employment prospects40
- better mental wellbeing41
- improved recovery from illness36,42,43

How can we support personal resilience?

If our responsibility is to improve people’s life chances and to reduce preventable health inequalities, our explicit aim should be to promote and strengthen factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health44.

One approach to supporting resiliency is through salutogenesis. A salutogenic way of working highlights the resources and capacities that positively impact people’s health and wellbeing, particularly their mental wellbeing45 (see Figure 1).

Salutogenesis focuses on people’s capacity to create good health and searches for the resources that some people have which give them a better chance of dealing with life’s challenges (Figure 2). This approach provides a framework through which to build individual and community resilience.

The evidence suggests that incorporating resilience-promoting strategies in services can make a difference to a person’s health and wellbeing46,47 and a comprehensive understanding of the factors that foster resilience may serve to inform the development of more holistic policies and programmes to support optimal outcomes for individuals and families48.

The most effective interventions are ‘multi-faceted’ in that they attempt to reduce modifiable risk, strengthen ‘assets’ and foster key developmental processes within individuals and communities.49
Developing and adapting interventions to build individual resiliency

Working towards the promotion and protection of positive health outcomes requires us to continue to tackle health inequalities whilst incorporating resilience focussed approaches into mainstream interventions, policies and practices. This is alongside strengthening our workforce and community’s capacity to incorporate skills and knowledge of how to support and build resilience into their work practices and relationships.44

Expectations and indicators of resiliency change with age, so interventions need to understand and be built around appropriate expectations and developmental needs.

Resilience promoting interventions need to define their outcomes in relation to positive, age appropriate development, resources and adaptive capabilities, and not just rely on the absence of symptoms or risks.50 Evidence indicates that, in order to effectively implement interventions that build resilience a set of practical principles should be followed:

- Prioritising positive approaches for wellbeing
- Involving individuals and local communities effectively and appropriately
- Connecting the individual with community and broader society
- Recognising that individual and wider resilience is interwoven
- Recognising the need to invest in wider sources of resilience for a person (community and family)
- Working in a multi-disciplinary and multi-professional way
- Securing sustainability through an evidence-based approach51,24
These principles are not in themselves new insights as current practice in East Sussex incorporates these, but they do need to be consistently applied and that is something that is being strengthened through East Sussex Better Together.

National research consistently identifies three external factors where local authorities, community groups and service providers can make a significant impact on personal resilience: activities promoting self-esteem and wellbeing (feeling good; functioning well); building social capital and developing psychological coping strategies. However, there are inequalities in the chances of people experiencing adversity and in the resources and protective factors necessary to build resilience and reduce vulnerability.

Key causes of inequalities in both adversity and resilience are: inequities in power, money and resources which shape the conditions in which people live.

Those who are most likely to face adversity and need greater resilience are least likely to have the resources to build it. This ‘double burden’ contributes to health inequalities. In order to reduce inequalities, actions should be universal, but targeted with greater resource and intensity at those experiencing poverty or disadvantage. Prevention and early intervention are crucial, because building resilience in the early years could help people exposed to adversity later in life.

**Promoting self-esteem and wellbeing**

Self-esteem is a person’s beliefs about themselves, what they think about the type of person they are, their abilities, their positive and negative traits and what they expect for their future. Having high self-esteem is related to a person feeling successful, which has been linked to having positive relationships, support networks and participating in valued activities. Self-esteem can be built-up by services and interventions which actively promote positive images (this can help tackle stigma), which
recognise, respect and engage with individual’s unique skills and talents, and which are supportive and allow access to wider community support such as peer support networks.53

Wellbeing has two main elements; feeling good and functioning well. A small improvement in wellbeing can help to decrease some mental health problems and help people to flourish. The NEF ‘Five Ways to Wellbeing’ set of evidence-based actions help to promote personal wellbeing: connect with people around you; be active; take notice or your surroundings and experiences; keep learning and try new things; and give to friends and strangers. These steps have been widely adopted by many groups, organisations, local authorities and people as actions that could be taken to improve wellbeing.5

Addressing mental health and resilient behaviours and strategies through public health programmes will also make it easier to achieve other public health outcomes, such as reduced smoking54, alcohol intake55 and delinquent activity.56,57

Building social capital

Social capital is a crucial element of the social conditions required for resilient individuals and communities as it enables certain ways of functioning and thinking which build resilient responses to stress and adversity. There are three types of social capital required for this: bonding capital (links people with similar values for social support); bridging capital (links people with different values to develop new perspectives from which to respond to stress); and linking capital (links to people who interact across formal organisation networks or levels of authority).58

Building social capital is a core role of the NHS, Public Health and Social Care System, with the aim of developing prepared communities, local community leadership, and improved health outcomes.25 There is strong and growing evidence that social networks and social capital increase people’s resilience to and recovery from illness59, as well as improving the chances of avoiding lifestyle risk factors such as smoking.60

However, in the most deprived communities, almost half of people report severe lack of support making those at greater risk less resilient to the health effects of social and economic disadvantage.61 Local authorities can bolster personal resilience by helping individuals and communities to develop and build social capital. For example, volunteering is known to enhance health and wellbeing62, and reduce social isolation, exclusion and loneliness63,64, and can be supported through the creation of health champions65, befriending schemes66, and by supporting social network interventions67.

Developing psychological coping strategies

Coping refers to a continuous and fluctuating process through which a person changes their behaviour, thoughts and strategies to manage external and/or internal demands which are seen to exceed their individual resources68,69,70. The ability to cope varies relating to a person’s approach and attitude towards a situation and their ability to manage the circumstances.69 Two of the key ways through which individuals cope with adverse situations are by modifying the adverse situation (problem solving) or regulating the emotions that the situation evokes.

A focus on the ways people adapt and cope with adverse situations is important to both understanding health needs and problems, and developing interventions to prevent problems or improve health and wellbeing.69
Common features of interventions to improve coping skills include building self-esteem, decreasing anxiety, communicating effectively, and developing relationships. These can be divided into developing general skills to improve effective coping methods in stressful situations (individual resources), focusing on what people think and do to handle situations threatening their wellbeing (meaning and control), and focusing on enhancing support (external and community resources). For example, within schools, interventions might include developing an individual’s skills to resist social influences, such as pressure to use substances.

These skills are enhanced by further resilience building within schools focusing on the wider context of the individual. For example by positive reinforcement for active participation, mentoring programmes, strengthening of positive parenting practices, enhancing academic and cognitive efforts, increasing family support, and enhancing interaction with peers and adults in school.

In everyday language ‘resilience’ is associated with bouncing back or being able to recover quickly or easily from or resist being affected by something adverse. It provides a framework for enabling people and communities to bounce back and thrive beyond crisis. Personal and community resilience support one another and can be developed, supported and grown.

1. Current practice which incorporates the following set of evidence based principles to effectively implement interventions that build resilience should be consistently applied through the East Sussex Better Together Programme:
   - Prioritise positive approaches for wellbeing;
   - Involve individuals and local communities effectively and appropriately;
   - Connect the individual with community and broader society;
   - Recognise that individual and wider resilience is interwoven;
   - Recognise the need to invest, where possible, in wider sources of resilience for a person (community and family);
   - Work in a multi-disciplinary and multi-professional way;
   - Secure sustainability through an evidence-based approach.
3 PRIMARY PREVENTION

- BEHAVIOUR CHANGE
- EARLY INTERVENTION
- EMPOWERMENT
- PEER SUPPORT
- POSITIVE PARENTING
- SCHOOL BASED INTERVENTIONS
- MINDFULNESS
- HEALTHY BEHAVIOURS
Many health and wellbeing issues can and should be approached proactively, promoting development and preventing disorders by moving from an approach focussing on relative risk, towards one focussing on relative resilience.77

Research suggests that primary prevention strategies (i.e. strategies that prevent to onset of a condition or problem in the general population) should be framed around what makes some (people) relatively vulnerable and others relatively resilient by looking for protective factors as well as addressing inequalities in those more vulnerable to risk factors.

Protective factors can be internal (intelligence, self-esteem, personality, competence, embracing change, learning from experiences, autonomy, problem solving skills, coping skills, and a sense of self-efficacy), familial (quality of relationships, family or peer support, cohesion) and societal (level of social support, social capital, education, paid work and opportunities to take valued social roles).78,79,80,46,81,57,82 Recognition and fostering of protective factors can have a profound effect on the success of individuals and groups.

By definition, primary prevention focuses on populations, and to build resilience, all interventions should have: grassroots input to utilise the skills and expertise of individuals in the community; an active strategy such as social marketing to advance methods; and alliances between different agencies, disciplines and stakeholders.77 It is the cumulative effect of internal protective factors and external resources which counteract the effects of adversity.83

Individuals and local communities not only need the right services, facilities and resources to build resilience, but also the capacity and infrastructure to support people to access them.15,84 Primary prevention is at its most effective when it values the individual and promotes a sense of shared investment.85,86

A prevention agenda should contribute to the realisation of broad goals: 1) promote individual development; 2) reduce the need for diagnostic, curative and therapeutic services; and 3) reduce the need for rehabilitative, corrective, remedial and other intensive programmes.77 These goals are consistent with the three levels of prevention: primary prevention [to reduce the incidence (new cases) of an identified problem or condition], secondary prevention [lowering the prevalence (existing cases) of the condition or problem], and tertiary prevention (reducing any further conditions or complications resulting from the original issue).86

Prevention activities should be prioritised in terms of their main focus, to reduce vulnerability, increase resilience, or modify transactions (Figure 3).77
This can be achieved in two major ways: the provision of supportive services; and equipping people with the education and skills to manage their health and wellbeing in competent and responsive ways by building skills, promoting their sense of self, exercising control over their lives, and acknowledging personal capability. For example, resilience is a significant protective factor for alcohol and substance misuse risk. Effective community based, holistic and systematic prevention programmes can modify behaviours of the individual and their environment by both helping to reduce drug use and by adding positive experiences into their lives to help identify alternative positive behaviours. The resilience model can be applied across all primary prevention activities.

Resilience across the life course

Positive relationships, along with a sense of meaning and accomplishment, are of real importance to good quality of life and resilience in all life stages. Equally, a lack of positive relationships can lead to vulnerability. The ability to access and maintain positive relationships is a product of multiple factors, such as involvement with an empowering social network of work colleagues, friends and family.

Active involvement contributes to forming social networks and to increased community cohesion. People with these kinds of social networks also tend to receive higher levels of social support and, as such, involvement in family and the community is an important source of resilience, particularly during older age.
An evidence review for the NEF ‘5 Ways to Wellbeing’ (connect; be active; take notice; keep learning; give - which if included in everyday life and practiced regularly can improve personal wellbeing)\(^3\) found that:

- Social relationships are critical for promoting well-being and acting as a buffer against mental ill health.
- Happiness and life satisfaction is strongly associated with active participation in social and community life.
- For older people, volunteering is associated with ‘more positive effect and more meaning in life’.
- Supporting others has been shown to be associated with reduced mortality rates.

The following sections discuss personal resilience across the life-course and in key settings for each life-course stage.

Resilience in children and young people

A child’s development begins before birth when the health of a baby is crucially affected by the health and wellbeing of their mother.\(^9\) Both social and biological influences on a child’s resilience are therefore present during pregnancy, at birth and continue throughout early years. From the time a child is born they are exposed to innumerable influences and experiences that shape the individual throughout different stages of their life.\(^36\)

Evidence suggests that personal resilience in children can be built through modelling and early intervention to promote accomplishment and responsibility\(^90\) through the presence of a responsible, predictable and caring adult, supporting development of children through early years high quality pre-school education.\(^36,91\)

The emotional stimuli generated by the parental bond plays an important role in brain development and modelling.\(^92\) This bond can help to develop self-esteem, trust, autonomy, empathy, social communication and confidence – making it an important resilience promoting factor. A parental bond which is high in warmth and lacking in severe criticism is one of the strongest protective factors in a child’s health.\(^93\)

The importance of a resilient home and family environment is integral. Such an environment provides adults who role model healthy relationships, positive relationships between the child and the care-giver, adults adopting and promoting healthy behaviours, strong social networks and a stable living environment.\(^94,95\)

Strengthening children and young people’s personal resilience can help reduce vulnerability to poorer health and wellbeing outcomes and can help protect young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol.\(^36\)

The foundations for physical, intellectual and emotional development are all laid in early childhood and have lifelong effects on many aspects of health and wellbeing. Key life stages include pre-school, going to school and then eventually starting work, retirement and bereavement.\(^36\) Not only is giving every child the best start in life crucial, but so too is improving the lives and health of young people who have already reached school. Investing in the early years is key to preventing ill health later in life, as is investing in whole-school approaches to health and wellbeing (see key settings for primary prevention for children and young people).\(^9\)

Parenting and the parental bond are not the only influencers on resilience. The mix of temperament, genetics, environment and societal factors all combine to shape a child’s development and capacity for personal resilience. The relationship between nature and nurture is much contested; however, there is growing evidence that parenting interacts with genetic risk so that, for example, the genetic risk for depression occurs less frequently in the child if parenting is of high quality.\(^97,98,99\) It is suggested that children differ in their susceptibility to both good and poor parenting.
Genetic variants affecting the serotonin transporter and dopamine receptor seem to influence ‘plasticity’; that is, the extent to which children are receptive to the developmental process. Positive parenting can enhance the benefits from such plasticity for the child.97 Essentially the quality of parenting and child development are inextricably linked.

The relationship between parenting and poverty is also complex, with both good and bad parenting seen in all social groups.100 Yet resilience among children growing up in poverty is more common than expected due to a combination of personal capacities and environmental supports, such as helpful parenting practices and improved socioeconomic conditions for the family.101

Academic ability in early life is generally not enough to protect against the effects of childhood economic disadvantage. At age 16, a child from a poorer background who has above-average reading skills early in life will likely do worse in exams than an economically privileged child who has lower reading skills early in life.102 This does not contradict the evidence that protective factors in early life increase resilience in later life, but indicates that sources of resilience (for example breast feeding, parental behaviours promoting self-esteem, social support and support from other adults, the home as a learning environment) are even more important for children with particular risk factors such as low income families.103

Resilience in adolescence can help people to move away from economic and social disadvantage, decrease mental health issues in adulthood and provide the resources to deal with the stresses involved in later life experiences.104

Resilience in children and young people in East Sussex

There are some indicators linked to aspects of personal resilience and mental health of children and young people which can be used to better understand outcomes in East Sussex compared with the national average:

- The percentage of children achieving a good level of development at the end of the reception year of school in East Sussex (65.6%) in 2013/14 was significantly higher than the England average (60.4%).105
- A longer duration of breastfeeding may be a predictor of positive mental health outcomes throughout the developmental trajectory of childhood and early adolescence.\textsuperscript{106} Breastfeeding may also be associated with the development of attachment.\textsuperscript{107} In 2013/14, breastfeeding initiation in East Sussex was 77.3\%, significantly higher than the England rate of 73.9\%.\textsuperscript{108}

- Current smoking is associated with an increased risk of onset of depression, including postnatal depression, and people with depression are more likely to become smokers. It is also associated with an increased risk of onset of anxiety disorders, and people with anxiety disorders are more likely to take up smoking.\textsuperscript{109} Children whose parents smoke are more likely to become smokers themselves. In 2013/14, 13.6\% of East Sussex mothers smoked at the time of delivery which was higher than the England rate of 12\%.\textsuperscript{110}

Subjective indicators of children and young people’s quality of life including sense of purpose and how happy they are can be linked to resilience.

The 2012 East Sussex Health Related Behaviour Survey – involving 85\% of year 10 pupils on the school roll – explored a number of topics related to personal resilience and health and wellbeing. The survey found that:

- 75\% of boys and 63\% of girls said they were quite or very happy with their life at the moment.
- The proportion of pupils who scored a high level of self-esteem (based on a 10 question composite score) is significantly higher in Lewes district (49.3\%) than the East Sussex average (42.3\%).
- The proportion of pupils eating at least 5 portions of fruit and vegetables on the day before the survey was significantly higher in Lewes district (23.9\%) compared with the East Sussex average (16.1\%)
- The proportion of pupils exercising five or more times per week was fairly consistent in districts and boroughs of East Sussex, with an average of 28.5\% across the County.
Reducing vulnerability and increasing personal resilience

The accumulation of childhood experiences shapes the outcomes and choices made in adulthood.9 The ability to self-regulate emotions is an important aspect of personal resilience. Being able to process, manage and express feelings such as anger, excitement, sadness and joy is a valuable skill and important in the development of emotional intelligence. Children with effective strategies for dealing with events which cause disappointment, loss and upset, are more likely to bounce back from adversity. Similarly, the ability to manage positive emotions is important.

Children’s personal resilience can be strengthened through early intervention, secure relationships and attachment with a responsible, predictable and caring adult.

Good outcomes and healthy development for children and young people can be achieved through effective and high quality early years and pre-school education provided by competent staff.36,111 Likewise, once at school, young people’s personal resilience and life skills can be effectively strengthened through school-based interventions (primary and post-primary) and out-of-school multicomponent interventions111

Resilience can be strengthened by enhancing the factors which promote and protect positive child and adolescent mental health (Table 1).112,113

Taking a resilience promoting approach will also help to reduce the impact of personal resilience risk factors, such as communication difficulties, difficult temperament, physical illness, academic failure and low self-esteem.112,113

Resilience can be learnt implicitly – through exposure which enables observation and replication – and explicitly through structured information. High quality service provision (in a range of settings) which seeks to enhance protective factors and skills universally to all children and parents/carerers, as well as targeting specific groups, can effectively contribute to children and young people’s capacities for personal resilience.

Developing individuals’ health literacy can also help to improve knowledge and capability for self-help, how and when to recognise that additional support is needed, and where to seek help when required. Building personal resilience can consequently mean that individuals utilise services more effectively.

Table 1: Risk and protective factors for personal resilience in children and young people

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific learning difficulties</td>
<td>Secure early relationships and attachment experience</td>
</tr>
<tr>
<td>Communication difficulties</td>
<td>Good communication skills and sociability</td>
</tr>
<tr>
<td>Specific developmental delay</td>
<td>Being female</td>
</tr>
<tr>
<td>Genetic influence</td>
<td>Higher intelligence</td>
</tr>
<tr>
<td>Difficult temperament</td>
<td>Easy temperament when an infant</td>
</tr>
<tr>
<td>Physical illness</td>
<td>Problem solving skills and a positive attitude</td>
</tr>
<tr>
<td>Academic failure</td>
<td>Being a planner and having a belief in control</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>Humour</td>
</tr>
<tr>
<td></td>
<td>Faith or spirituality</td>
</tr>
<tr>
<td></td>
<td>Capacity to reflect and be mindful</td>
</tr>
</tbody>
</table>

PRIMARY PREVENTION 23
Parents and carers – as well as professionals or services that support parents, carers and children and young people – can adopt personal resilience enhancing practices by providing and promoting:

- education and support for good communication;
- social skills development;
- approaches that enable a strong locus of control for the individual;
- problem solving skills;
- the ability to recognise, celebrate and apply personal strengths;
- the ability to reflect;
- positive self-image including self-esteem and healthy body image;
- confident health choices, and;
- a strong sense of belonging.

Promoting resilience in children and young people East Sussex

A range of programmes and interventions operate in East Sussex in order to promote positive parenting outcomes and improved resilience for parents, children and young people. Some programmes and services are available universally to all families and others are targeted according to need and where additional family support is required. These services are able to impact on the potential to improve personal resilience in children and young people.

Examples of universal provision in East Sussex

- An information service for all families about childcare, finances, education, and support for families, as well as special educational needs and disability information.
- Pre-school provision, including nurseries and playgroups, provides learning through games and play in areas including development of communication and language, personal, social and emotional development and understanding of the world.
- Early Years interventions such as support to nurseries and child minders to improve their provision of healthy lifestyle activities.
- Children’s Centres offer families with children under five a range of services, information and support.
- The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. The Health Visiting and School Health services form an important part of the Healthy Child Programme and the provision of early help support for families.
- Evidence-based parenting programmes, such as Triple P and Incredible Years.
- A number of programmes to support health improvement and aspects of personal resilience in children and young people in schools are already operating in East Sussex, some of which have been established as a result of schools’ identified needs. They include:
  - a tiered programme of support for schools to facilitate the delivery of high quality Personal, Social, Health and Economic (PSHE) education;
  - a long-running targeted school based teenage pregnancy prevention and sex and relationships education enrichment project;
  - a peer-led smoking prevention programme;
  - a pilot social norms intervention designed to address adolescent attitudes, perceptions and participation in risky lifestyle behaviours (in those aged 11-16 years old).
Key settings for promoting resilience in children and young people

Resilience in schools

School can be a protective health asset that provides children with the learning opportunities and competencies to develop a positive identity and healthy behaviours as well as the skills that enable successful negotiation of life challenges. There is a growing evidence base that whole-school approaches to promote children and young people’s resilience are effective and can result in improved outcomes including: higher academic attainment; better employment; healthy behaviours; better mental wellbeing; and; the acquisition of life skills.

A whole-school approach involves facilitating ways to embed health, wellbeing and sustainable development in the ethos, culture, policies and daily processes of the institution. It is concerned with the entirety of school life and the health and wellbeing of students, staff, parents and the community and can have a significantly positive effect on resilience. Health promoting schools can actively and systematically improve the ‘social and emotional learning’, ‘emotional literacy’, ‘emotional intelligence’, ‘life skills’ and ‘character education’ of children and young people.

School-based programmes of social and emotional learning have the potential to help young people acquire the skills they need to make good academic progress. They can produce benefits to pupils’ health and wellbeing, offering a significant return for the resource and time investment by schools to establish such programmes.

Curriculum-based emotional resilience programmes, have found short-term improvements in pupil attendance and attainment rates, particularly among those eligible for free school meals and pupils performing below the national average in maths and English. Schools can therefore reduce vulnerability to low levels of resilience by being a positive influence on pupil mental health and creating resilience universally for all pupils and staff (Table 2).

Social and emotional skills development can successfully be integrated within all areas of the curriculum including motivation, self-awareness, problem-solving, conflict management and resolution, collaborative working, how to understand and manage feelings, and how to manage relationships with parents, carers and peers.

Positive relationships between teachers and pupils, and between pupils, are critical in promoting pupil wellbeing and encouraging them to avoid risky behaviour.

Table 2: Risk and protective factors for child and adolescent mental health in schools

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying</td>
<td>Clear policies on behaviour and bullying</td>
</tr>
<tr>
<td>Discrimination</td>
<td>‘Open-door’ policy for children to raise problems</td>
</tr>
<tr>
<td>Breakdown in or lack of positive</td>
<td>A whole-school approach to promoting good</td>
</tr>
<tr>
<td>friendships</td>
<td>mental health</td>
</tr>
<tr>
<td>Deviant peer influences</td>
<td>Positive classroom management</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>A sense of belonging</td>
</tr>
<tr>
<td>Poor pupil to teacher relationships</td>
<td>Positive peer influences</td>
</tr>
</tbody>
</table>

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Positive relationships between teachers and pupils, and between pupils, are critical in promoting pupil wellbeing and encouraging them to avoid risky behaviour.
This is especially true for children who are negatively influenced at home and in their neighbourhoods. Here, the intervention of the school can be a turning point for children with few other supports.123

Schools provide opportunities for involvement and responsibility, building character and competence, and identifying universally held values, beliefs and ideas about wellbeing.77 Successful school experience and intellectual capacity are protective factors which encourage many resilient behaviours including: high self-esteem, confidence, self-efficacy, a sense of direction, the ability to change, perseverance, problem solving skills, and a feeling of choice and control.9,124,81

A number of specific social and emotional competencies have positive effects on academic achievement. Pupils who can set goals, manage stress and organise their school work achieve higher grades,125 pupils who use problem-solving skills to overcome obstacles do better academically,126 and social and emotional competencies have been found to be a more significant determinant of academic attainment than IQ.125

Some of the evidence-based characteristics and principles for the development of resilience promoting schools are listed in Box 1.

There is no doubt that schools in East Sussex are already delivering significant levels of activity to strengthen the personal resilience of children, young people and families; including both targeted programmes for those at risk and wider approaches to health, wellbeing and resilience.

A diverse range of existing delivery methods demonstrating or contributing to whole-school approaches to resilience and emotional wellbeing are currently being employed by schools.

Box 1: Principles and characteristics of resilience promoting schools

To drive effective approaches and interventions in promoting resilience, schools can:

- Work holistically to understand the underlying causes of behaviour, such as emotions, attitudes, and beliefs of all parties, and understanding the influence of the surrounding cultural context, rather than focusing only on managing students’ overt behaviour;
- Introduce foundation work on generic social and emotional learning early with the youngest children and continuing to reinforce this learning through the school career of students;
- Take a broad focus on positive mental health and wellbeing within which a concern with mental health problems is located;
- Introduce relevant topics, such as conflict and bullying, and assertiveness, as young people mature;
- Mobilise the curriculum by identifying the key skills for wellbeing and teaching them explicitly;
- Integrate work to promote well-being with the academic goals of the school, including learning and behaviour for learning;
- Balance targeted and universal approaches in ways that are appropriate for the specific context;
- Allow time – both in terms of the life course of the child and the amount of time to allow a programme to develop;
- Develop a school ethos that ensures the right balance between key factors, such as warmth, respect, boundary setting, participation, and autonomy;
- Use appropriate leaders at different points in the life course of a project, with some specialist input at the start to ensure program fidelity, and handing over to teachers to ensure that programmes are integrated with the overall work of the school;
- Liaise effectively with parents and community;
- Embed work within a whole-school approach that includes, for example, the school ethos, school policies, school staff development, teaching and learning and the curriculum, and the involvement of parents and the community, and;
- Achieve an optimal balance in whole-school interventions, between using them as loose frameworks with flexibility and a sense of ownership, and including within the more focussed elements which are implemented with high levels of fidelity and clarity and can be subject to controlled evaluations.

Sources: Weare and Nind 2014127 and 2011
These include PSHE delivery, assemblies, peer support, student leadership, incorporating programmes across the curriculum, delivering the Social and Emotional Aspects of Learning (SEAL) Programme and holding 'thematic weeks'.

Other approaches include making use of tutor time, embedding resilience and emotional wellbeing within report cards and school ethos, P.E. and additional physical activity, parent forums, aspiration work, behaviour workshops and extracurricular activity.

Numerous other services provided in the statutory and voluntary and community sectors are also contributing to strengthening personal resilience schools, such as the ESCC Education Support, Behaviour and Attendance Service (ESBAS) which provides support to pupils and families to help develop closer links between home and school and the School Health Service which provides health services to children and young people in order that they are given the very best chance to achieve good health.

**What more could we do to promote resilience in children and young people?**

Local strategic approaches, commissioning activity, delivery and support services, and of course parents and carers themselves, can contribute to the development of personal resilience in children and young people by recognising the importance of protective factors and adopting resilience enhancing practices.

Services can continue to deliver and promote holistic, whole-family approaches to family support, education and relationship building through parenting, education and family literacy, recognising the importance the contextual family role has in nurturing development of the child.

Local schools, when asked about areas for development relating to health improvement, have identified that mental and emotional wellbeing is the top priority for both primary and secondary schools. Schools have suggested that the most helpful support that could be provided would be around engaging children, young people, parents/careers and the local community on health and wellbeing.

The preferred type of support that schools said they would like to receive included tailored support and advice and specialist packages enabling health and wellbeing to be incorporated into the curriculum. The following barriers and support needs relating to the development of improved whole-school approaches have been reported by schools:

1 In December 2013, a survey of East Sussex schools was carried out as part of the school health service stakeholder consultation. The survey included questions around health improvement priorities and was completed by 87 individuals, 43 of whom were head teachers / teacher, 16 other school staff, 2 governors, and 26 other stakeholders. In 2015, all East Sussex schools were asked to input into the development of a number of health improvement interventions to be made available to targeted schools during 2015, including a whole-school approach to resilience and emotional wellbeing programme. In January and February 2015 the Public Health team met with head teachers and PSHE leads from 17 East Sussex schools, including primary, secondary, special schools and PRUs, in order to better understand: 1) features of existing provision; 2) success and barriers of current approaches, and; 3) the best way that whole-school approaches to resilience and emotional wellbeing could be supported.
Table 3: Barriers and needs relating to whole school approaches as reported by schools

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Support Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staff confidence and knowledge to deliver key messages</td>
<td>• Provision of resources including lesson content on resilience</td>
</tr>
<tr>
<td>• The lack of coordinated and planned approach along with few resources</td>
<td>• Consultancy support to embed bespoke whole-school resilience and emotional</td>
</tr>
<tr>
<td>to support delivery</td>
<td>wellbeing approaches</td>
</tr>
<tr>
<td>• Pressures on staff time and staff appraisals that are linked to exam</td>
<td>• Training and continuing professional development for staff</td>
</tr>
<tr>
<td>success (not pupil wellbeing)</td>
<td>• Parental and community engagement</td>
</tr>
<tr>
<td>• Timetable and curriculum constraints</td>
<td></td>
</tr>
<tr>
<td>• Difficulty with parental and wider community engagement</td>
<td></td>
</tr>
</tbody>
</table>

Source: Lindstrom and Eriksson, 2005

National Institute for Health and Care Excellence (NICE) guidance suggests that primary schools are well placed to provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems, that policies should include aspects relating to social and emotional wellbeing, and that teachers should receive training and support in how to develop children’s social, emotional and psychological wellbeing.²⁹

This does not mean that classroom teachers need to become experts in psychology or counselling, but that every single teacher-child interaction could be an opportunity to promote resilience in one way or another. This not only brings benefits for young people, but also for staff and teachers who will have increased job satisfaction, less stress and better capacity to cope with change.²⁶,²⁹,³₂

Commissioners, policy makers, school leaders, teachers, governors, parents and the local school community can work together to support schools to:

• fully understand the concept of resilience and its evidenced links to pupil academic achievement, attendance and health and wellbeing;

• provide leadership to adopt and drive forward a whole-school approach to resilience with the aim of improving the resiliency of children and young people across all levels of the continuum of need;

• work to an evidence based framework where schools can review their current approaches to strengthening resilience and develop a whole-school resilience action plan, and;

• provide schools with guidance and support to foster whole-school approaches to resilience to:
  o improve attainment and attendance levels, child happiness and emotional wellbeing;
  o implement preventive approaches with regards to behavioural and mental health problems, and;
  o increase parental involvement and development of parents’ resilience

Working age resilience

Most studies on resilience have focused on children and there is less understanding of how adults may overcome the risks and adversities they face.²⁹. However, those adults who are most resilient are likely to have a range of intrinsic and extrinsic factors which enable them to stay healthy and deal with crisis and adversity. Intrinsic factors include intelligence and academic ability, positive mental health and wellbeing including optimism, self-efficacy and self-esteem,²⁴,²⁹,³₂ and extrinsic factors include positive family and social support, secure housing and greater productivity, employment and earnings.²⁴,³₂,³³,³⁴,³⁶.
Resilience in adults is closely related to resilience within the local community (as outlined in the 2014/15 East Sussex Annual Report of the Director of Public Health) in terms of the development and use of community resources, availability of meeting spaces and activities, and a person’s social participation. All of these factors are associated with reduced risk of common mental health problems and better self-reported health.

As previously mentioned, the NEF Five Ways to Wellbeing evidence review found that social interactions (both one to one relationships and group and community activity) are important protective factors for mental wellbeing and mental ill-health.

Adopting healthy routines and habits such as eating a nutritious diet, getting adequate sleep, and engaging in regular exercise also promote mental health and resilience.

**Working age resilience in East Sussex**

One geographical area within East Sussex which stands out as particularly resilient to ill health is Wealden district. In terms of factors associated with resilience, the district benefits from:

- 29% of working population educated to level 4 or higher
- Significantly higher reported levels of satisfaction with the local area as a place to live and feeling of belonging to the immediate neighbourhood than the England average.
- 4% of households considered as overcrowded and 8% of households being socially rented, significantly lower than East Sussex
- 1% of working age people claiming jobseekers allowance. Significantly lower than East Sussex
- 64% of adults achieving at least 150 minutes of physical activity per week, the highest value of all East Sussex districts and boroughs
- GP reported prevalence of smoking for people aged 15 years and over of 15%. Significantly lower than East Sussex and the lowest percentage of all its districts/boroughs
These protective factors manifest themselves in the following health outcomes:

- A significantly lower GP reported prevalence rate of mental health disorders than East Sussex and the lowest of all its districts/boroughs
- The lowest rate of mortality from causes considered preventable in East Sussex
- Life expectancy for people living in the area is significantly higher than the county average at 83.1 years.

Reducing vulnerability and increasing personal resilience

A range of approaches and interventions have been shown to be effective in reducing risk factors and improving protective factors for health in working age adults. These include:

Social norms work programmes

Social norms programmes are predicated on how an individual's perceptions and beliefs about what constitutes 'normal' behaviour in their peers influence their own behaviour. So, for example, if an individual believes that his or her peers drink heavily, this influences the amount of alcohol that that individual drinks and may result in the individual drinking heavily themselves. Research has found however that our perceptions are often inaccurate as we will usually overestimate prevalence of unhealthy or risk associated behaviours and underestimate prevalence of healthy or protective behaviours.

Social norms marketing seeks to address these misperceptions through the dissemination of information on actual norms in a population and so reduces vulnerability within individuals by reducing the likelihood of them adopting risk associated behaviours.

Targeted risk identification programmes

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia by inviting everyone aged 40 to 74 who are not being treated for one of these conditions, or the associated risk factors, to have a health check and receive support and advice to help reduce or manage their own risk of developing these conditions.

NHS Health Checks is the first programme of its kind internationally, and while there is a lack of evidence evaluating individual health outcomes resulting specifically from Health Checks, there is a large body of evidence showing how behaviour change in these areas of risk can improve different elements of personal resilience. (There is more detail on this programme in the Building community resilience through person-centred care and support chapter.)

Developing resilience through participation

Service user involvement within intervention/work programme/policy development not only ensures acceptability and relevance to target population groups but can also build personal resilience through increased confidence, skills and social inclusion. As a result, it is important that services work with communities and individuals to co-produce interventions and programmes thus ensuring individuals are active participants in building their own protective factors rather than passive recipients of an intervention designed and implemented by practitioners.
Support to Change Lifestyle Behaviour

There is overwhelming evidence that changing people’s health-related behaviour can have a major impact on some of the greatest causes of mortality and morbidity. Increasing ability to change health related behaviour therefore increases personal resilience though building the protective factors such as increasing self-efficacy and agency. The stressors that impact on the likelihood of people experiencing health inequalities also impact on people’s ability to change their behaviour.

The following is drawn from NICE guidelines which identify that actions to bring about behaviour change may be delivered at individual, household, community or population levels using a variety of means or techniques. The outcomes do not necessarily occur at the same level as the intervention itself. For example, population-level interventions may affect individuals, and community- and family-level interventions may affect whole populations.

Significant events or transition points in people’s lives present an important opportunity for intervening at some or all of the levels, because it is then that people often review their own behaviour and contact services. Typical transition points include: leaving school, entering the workforce, becoming a parent, becoming unemployed, retirement and bereavement.

Effective interventions which increase resilience through supporting people to change their behaviour should enable people to: understand the short, medium and longer-term consequences of their health-related behaviours, for themselves and others; feel positive about the benefits of health-enhancing behaviours and changing their behaviour; plan their changes in terms of easy steps over time; recognise how their social contexts and relationships may affect their behaviour, and identify and plan for situations that might undermine the changes they are trying to make; plan explicit ‘if–then’ coping strategies to prevent relapse; make a personal commitment to adopt health-enhancing behaviours by setting (and recording) goals to undertake clearly defined behaviours, in particular contexts, over a specified time; share their behaviour change goals with others.

Interventions which support people to change their behaviour may focus on a single area of behaviour e.g. smoking or alcohol use or address a combination of lifestyle factors.

Supporting people to consider and then act upon a decision to change health related behaviour requires consideration of which staff in contact with the public are best placed to deliver different levels of behaviour change intervention. Staff delivering behaviour change interventions should be equipped with the skills to deliver the intervention at the indicated level.

Social marketing

Social marketing in public health is a planning approach that is used to encourage the adoption of specific behaviours that are seen as being beneficial for both individuals and wider society. The approach utilises exchange theory to facilitate transition to a new behaviour which is healthier and is likely to build resilience. This theory suggests that, when considering adopting a new behaviour, individuals will go through a cost-benefit analysis at some level before they decide to act. The practitioner’s task is to ensure that the benefits associated with the new behaviour are equal to or greater than the costs.

Promoting resilience in the working age population in East Sussex

A range of lifestyle behaviour change services are commissioned to support people to make lifestyle changes (these services are open to all adults not just working age adults). These include:

- Health Trainers. Health trainers support people to look at how their way of life might be impacting on their health and wellbeing, and what sorts of changes might be beneficial to them. They provide six to eight 1:1 sessions which combine a number of behaviour change theories and techniques (for example; Theory of Planned Change,
Self-Efficacy, Motivational Interviewing) to enable people to make positive lifestyle choices and learn skills and techniques to continue this throughout their lives.

- **Smoking Cessation.** Smoking cessation services are commissioned from General Practices and Pharmacies across the county. In addition a specialist stop smoking service is commissioned to: provide community clinics; target groups who are likely to have the lowest levels of personal resilience or specific vulnerabilities e.g. pregnant women, mental health service users; to create a system of support and quality improvement to other providers of stop smoking services and to all those who might have a role in supporting smokers to consider stopping and access a service.

- **Weight management service.** The adult weight management service helps service users to make changes to their lifestyle as well as their patterns of thinking and feeling in order to improve health and wellbeing whilst losing weight. The impact of this approach is likely to be more sustainable due using evidence based approaches to teach people the skills to improve confidence and self-control, and improve personal levels of wellbeing and happiness.

- **Behaviour change training.** Making Every Contact Count (MECC) encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices and exploring the wider social determinants that influence all of our health.

- **Co-ordinating communications and using social marketing approaches.** Partnership mechanisms are utilised e.g. the East Sussex multi agency Alcohol Steering Group and the Hastings and Rother Clinical Commissioning Group Inequalities plan to develop, agree and co-ordinate evidence based targeted activity which used insight from partners and communities to plan and deliver interventions which build the resilience to address poorer health outcomes.

- **Targeted community support.** To address extrinsic factors which impact on personal resilience a range of community services which develop social capital and community capacity for health have been funded. For example a community health walks programme, volunteer led group health promotion sessions.

- **Developing whole systems approaches.** The East Sussex Better Together programme is a whole systems approach to improving outcomes in East Sussex. The primary prevention, self-care and self-management workstream and sub groups are co-ordinating planned programmes of action across the health and social care system.

**Key settings for promoting resilience in the working age population**

**Workplace resilience**

An individual's workplace can have a significant impact on their health and wellbeing\(^{26}\). For those companies which build resilience in the workforce by promoting and protecting their health, the impact can be very positive and can result in low levels of sickness absence, increased productivity and high staff retention. For example, an evidence review conducted by PricewaterhouseCoopers (PwC) evaluated 55 UK case studies of organisations which had implemented health and wellbeing programmes. It found that as a result of these programmes 45 studies reported a reduction in sickness absence, 18 studies reported a reduction in staff turnover, 16 studies a reduction in accidents and injuries and 14 studies an increase in employee satisfaction.

In Healthy workplaces: A model for action\(^{147}\) the World Health Organisation (WHO) defines a healthy workplace as one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace.

WHO describes four arenas in which actions can be taken in the creation of a healthy workplace:
1. **Physical work environment** - The structure, air, machinery, furniture, products, chemicals, materials and production process in the workplace.

2. **Psychosocial work environment** - The culture, attitudes, values, beliefs and daily practices which affect mental and physical wellbeing of employees.

3. **Personal health resources** - The health services, information, resources, opportunities, flexibility and support provided to employees to support or motivate efforts to improve and maintain healthy personal lifestyles and monitor and support physical and mental health.

4. **Enterprise community involvement** - The activities, in which an enterprise might engage, or expertise and resources it might provide, to support the social and physical wellbeing of the community in which it operates.

Building personal resilience through primary prevention is associated with all four of these arenas, however arenas 2 and 3 are most likely to be directly associated with personal resilience.

Poor conditions in the workplace can cause stress and exacerbate mental health problems. The Health and Safety Executive describes six areas of work that can increase vulnerability to stress and mental ill-health if not properly managed. They are:

- **Demands** – includes workload, work patterns and the work environment
- **Control** – how much say a person has in the way they do their work
- **Support** – includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
- **Role** – whether people understand their role within the organisation and whether the organisation ensures they do not have conflicting roles
- **Change** – how organisational change (large or small) is managed and communicated in the organisation
- **Relationships** – promoting positive working to avoid conflict and dealing with unacceptable behaviour

By working together to make improvement in these areas of work, management and staff can reduce the risk of work related stress impacting on the health and wellbeing of the whole workforce. In addition because much of the working age population spend significant amounts of time in work, workplaces can be effective settings in which to deliver interventions which reduce risk or build protective factors for health.

The return on investment for some workplace health programmes can range from £2 to £34 for every £1 spent. Typically, programmes that address overall health pay back over two to three years, while more targeted interventions – such as weight management, or smoking cessation - can be even quicker. Workplace health programmes can take up to 12 months to plan and roll out, so realistic timelines, objectives for participation and outputs should be set. Some examples of effective services addressing risk factors are set out below:

**Health checks provided in workplace** settings have been found to be effective at supporting routine and manual workers to reduce risk factors for poor health through lifestyle changes. A randomised control trial of general health checks provided in a factory workplace setting in Glasgow, found that of those receiving a workplace health check 36% reported at least one lifestyle change at 6 months and 43% at 12 months (includes people where the outcome is not known because they did not respond to follow up).

The evidence base for **smoke free settings** is well established and as a result of this smoking is prohibited in all enclosed public places in the UK. Since 2006 the provision of smoking shelters outside requires planning permission and any shelter (new or existing) should not be wholly or substantially enclosed (more than 50% enclosed including walls, doors, windows). Because of the potential ‘norming’ effect of providing opportunities to smoke new NICE guidance
published in 2015 recommends that healthcare settings should not allow smoking anywhere in their grounds and remove any areas previously designated for smoking.

Interventions which aim to support smoking cessation in the workplace are more likely to be effective and build resilience if they have multiple components including: group counselling; individual therapy, pharmaceutical intervention and tailored incentive schemes specific to the workforce sector. NICE Guidelines recommend that employers allow employees to access evidence-based ‘stop smoking’ support during working hours without loss of pay should be encouraged to provide advice, guidance and support to help employees who want to stop smoking.

Evidence suggests that workplace walking interventions which use pedometers and focus on goal setting, diaries and self-monitoring, and promotion of safe, pleasant and accessible walking routes can produce positive results. Other workplace interventions which have been shown to increase physical activity include individual or team activity challenges, reduced rate gym membership programmes and promotion of active travel within workplace travel policy.

Small changes to catering facilities within workplace settings can support a person’s resilience by encouraging healthier behavioural choices in relation to healthy eating. For example, passive nudges such as; changing the layout of the food in the café area or changing the position of foods on the menu to give prominence to healthier foods can bias behaviour towards dietary improvements. Calorie labelling food, prominent displays of fruit and vegetables and healthier options within vending machines can encourage individuals to make healthier decisions when they are at the point of choice and reduce the pull towards unhealthy risk factors.

**Resilience training** provides employees with the skills they need to identify and maintain healthy levels of stress, and to quickly recover from challenging situations. This training has been shown to have the capability to benefit stress management and to strengthen resilience. Studies have indicated that resilience training can improve self-esteem, quality of life, value of living, mindfulness and positive emotions, as well as have a positive impact on anxiety, depression and negative emotions. Other positive impacts of resilience training have been recorded for interpersonal relations, communication, mastery, personal growth, acceptance and autonomy.
The Workplace Wellbeing Charter provides materials and guidance to enable employers to review their workplace practices against recommended standards and to develop actions plans to make improvements where required. It is an opportunity for employers to demonstrate their commitment to the health and well-being of their workforce. All materials and guides are funded by Public Health England and free to use.

The charter involves:

- Self-assessing against an established and independent set of national standards which identify what the organisation already has in place and what gaps there may be in the health, safety and wellbeing of employees.
- Devising an action plan to drive future change.

A lack of suitable facilities can impact on the success of physical activity programmes in the workplace as well as being a significant barrier in increasing active travel. As such, wherever possible, employers should endeavour to provide safe bicycle storage and shower and changing facilities within the workplace in order to support employees to participate. Where this is not possible, employers could signpost to community facilities instead.

In order to promote healthier journeys to work and to reduce environmental pollution, the 1999 Finance Act introduced an annual tax exemption, which allows employers to provide loans for cycles and cyclists' safety equipment to employees as a tax-free benefit. This means that employees can save up to 42% on a new bike and accessories through tax and national insurance benefits. Employers of all sizes across the public, private and voluntary sectors can provide the scheme to their employees as long as they achieved broad compliance for food hygiene and food standards. Bronze, silver and gold awards are granted depending on how many criteria are met by the venue being assessed. Successful venues receive an award to display on the premises, enjoy free publicity in the local authority and any relevant publications, and have the right to use the Eat Out Eat Well award logo on their stationery/menus/boards.

The Workplace Challenge is a national programme which aims to engage workplaces in sport and physical activity. It is funded by Sport England and delivered in partnership by The County Sports Partnership Network and the British Heart Foundation. Workplaces compete with each other by logging levels of sport, physical activity and active travel. The programme is delivered throughout East Sussex by Active Sussex.

What more could we do to promote resilience in working age adults in East Sussex?

It is important that effective approaches are embedded across the system, including ensuring that NICE guidance is systematically reviewed and recommendations which contribute to building personal resilience are implemented in all settings. Developing the skills and capacity of people in contact with vulnerable groups will enable them to contribute to building resilience. Also important is using collaborative and co-production approaches, including service user involvement, as well as working with a wide range of organisations. More could be done through using social marketing approaches and applying systematic behaviour change approaches which identify and address risk and protective factors for personal resilience.

Targeted programmes

The Eat Out, Eat Well scheme is a quality standards programme which assesses catering venue’s approach to increasing accessibility to healthier food options, good food hygiene practices, and delivery of services within a healthy environment. The programme is delivered by environmental health departments and is available to any organisation which has a catering venue across East Sussex as long as they achieved broad compliance for food hygiene and food standards. Bronze, silver and gold awards are granted depending on how many criteria are met by the venue being assessed. Successful venues receive an award to display on the premises, enjoy free publicity in the local authority and any relevant publications, and have the right to use the Eat Out Eat Well award logo on their stationery/menus/boards.
In general, evidence\textsuperscript{174,175} suggests that workplaces can further improve health and wellbeing by:

- Targeting multiple risk factors, specifically those representing highest disease burden in the region where the workplace is located.
- Engaging senior management as enablers/leaders to proactively promote wellness initiatives, for example by highlighting the business case for workplace health programmes.
- Combining health education (including the importance of screening programmes) with changes in the physical and social workplace environment so wellness is integral to the company, e.g. quiet areas or additions such as a blender in the kitchen.
- Engaging employees either through incentives: direct (e.g. subsidised gyms) or indirect (e.g. employer charity contributions or company sponsored participation in local events); or through social marketing techniques to encourage behaviour change. Examples of best practice choose different communication methods for different populations (e.g. from intranet and podcasts to pamphlets and informal team meetings).
- Designing and delivering initiatives in consultation with employees.
- Forming partnerships with other organisations as low cost, effective ways to raise participation.
- Continually evaluating health and wellbeing programmes, for example through a ‘dashboard of wellbeing success’, through self-completed wellness scores that can be mapped, and through financial evaluation via cost of sickness absence, readily available costs savings information such as recruitment costs, liability claims and healthcare expenditure, increased revenue (per employee) and overtime payments.

**Resilience in older people**

Resilience for older people appears to be positively associated with life satisfaction, quality of life and longevity.\textsuperscript{176} At a population level, age and socio-economic status may not necessarily be related to differing levels of resilience but further exploration is needed in this area.\textsuperscript{176} Consequently strengthening personal resilience in older people requires ongoing concerted action by individuals, communities, service providers and policy makers.

**Resilience in East Sussex**

Wide-ranging and reliable measures of personal resilience at a local level are not currently readily available. Life satisfaction and the feelings of worth are however linked to personal resilience and these are measured nationally as part of the Office of National Statistics (ONS) annual population survey on personal wellbeing.\textsuperscript{177} Through this survey individuals are asked how satisfied they are with their lives and the extent to which they feel the things they do in their lives are worthwhile (on a scale of 0 to 10, where 0 is ‘not at all worthwhile’ and 10 is ‘completely’).
In East Sussex, 79% of individuals rate their life satisfaction as high or very high (7 or higher) and 82% of individuals rate the extent to which they feel the things in their lives are worthwhile as high or very high, compared with 77% and 81% respectively for England. The average rating across age groups in the UK reveals that life satisfaction and feelings of worth are higher among older people aged between 65 and 79 years than most other age groups (Figure 4). The UK life satisfaction and ‘worthwhile’ ratings for retired individuals are also higher than the ratings for those in work and those in any other economically inactive groups.

**Reducing vulnerability and increasing resilience**

Remaining socially engaged can have a profoundly positive impact on health and wellbeing, reducing the risk of depression, physical and cognitive decline and increasing healthy life expectancy. Choosing to have paid work beyond the normal retirement age, volunteering or being involved with grandchildren seem to improve quality of life of older people, as they all help to maintain involvement with a social network of work colleagues, friends and family.102

**Figure 4: Life satisfaction and feeling of worth by age group, United Kingdom**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Life satisfaction</th>
<th>Worthwhile</th>
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<tbody>
<tr>
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<td>80 and over</td>
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*Source: Apr 11 to Mar 14, Annual Population Survey Personal Well-being 3-year National Statistics dataset, ONS*
Volunteering among retired people (and others) has potential benefits for both the volunteer and recipient by building self-esteem and promoting a sense of purpose and self-worth.¹⁷⁸ ¹⁷⁹

Various factors can however cause greater likelihood of social detachment, including personal situations – such as loss of a loved one, leaving a job and chronic illness – or environmental limitations. Older individuals who are more likely to become disengaged from social networks include those who are less educated, poorer, without a partner, have developed a limiting chronic health condition, or have lost access to transport. Most people are able to maintain a good level of social participation in later life, although men have been found to have a higher likelihood of experiencing detachment than women.¹⁸⁰

Promoting the resilience of older people and enabling active self-help are far wider than the concepts of isolation and loneliness and involve action at a number of different levels, including individuals, communities, service providers and policy makers.

When seeking to minimise risk factors, it’s crucial to recognise that ‘isolation’ and ‘loneliness’ are two distinct concepts. Interventions for isolation should focus upon enhancing the number of contacts a person has and the number of links in their social network. Interventions to combat the vulnerability conferred by loneliness would focus upon enhancing the quality of relationships but not necessarily the quantity. In addition to personal characteristics that may restrict an individual’s type and level of social participation, aspects of the social and physical environment can also affect the engagement of older adults living in the community.

At the individual level, resources and support for maintaining social participation for those at risk of social detachment and isolation must be enabling, encouraging and enhance the older person’s autonomy. A review of evidence on interventions to increase socialisation showed that group-based educational and social activities for specific groups of older people were particularly effective.¹⁸¹ Some positive outcomes have also been found for low-level one-to-one interventions such as telephone befriending in helping users gain confidence and re-engage with community and social activities.¹⁸²
The social environment, including cultural norms and values about ageing and age-appropriate behaviours for older people, should seek to maximise opportunities for participation. Stereotypical media images of older people reflect and reinforce ageist assumptions about older people’s capabilities and aspirations, and internalised negative views of ageing can potentially act as a barrier to opportunities for social participation among older individuals, especially amongst those who may be developing a dementia.

The built environment and local infrastructure can be an important factor in the continued social participation of older people, for example:

- accessibility of services and amenities including ready access to lifts for individuals with mobility problems;
- the ‘walkability’ of neighbourhoods, including pavements with even surfaces;
- adequate signage to help with ‘way-finding’ for those with vision problems or dementia;
- environments that can increase perceived safety from crime;
- the availability and accessibility of public transport, and;
- the availability of community venues and hubs where older people can meet and interact.180

Policies and practices should seek to maximise older adults’ ability to participate on an equal footing with other age groups in areas such as paid work, learning, and decision-making. Among other benefits, this will strengthen possibilities for social engagement and increase the opportunities that institutions can offer to promote increased intergenerational interactions.180

The World Health Organisation’s concept of ‘age-friendly’ environments represents an approach which fosters older people’s social participation at the individual, neighbourhood and community levels; enabling older people to continue to do those things that are important to them.

The age-friendly environments framework aims to be ‘accessible, equitable, inclusive, safe and secure, and supportive’, promoting the health, wellbeing and participation of older people by modifying key aspects of the social and built environment (Figure 5).183

**Promoting resilience in East Sussex**

A wide range of services and activities working to strengthen personal resilience in older people are available in East Sussex. For example, some of these can be found via the universally accessible East Sussex 1Space online directory ([www.eastsussex1space.co.uk](http://www.eastsussex1space.co.uk)) where services pertinent to the creation and maintenance of social networks are listed under categories such as:

- Befriending;
- Social and lunch clubs, and;
- Faith and cultural organisations.
- Confidential telephone information, friendship and advice
- Community activities such as Men in Sheds’
- Targeted lifestyle services such as peer led Healthy Living Clubs
- General community health improvement activities such as volunteer health walks
- Informal and formal volunteering opportunities

**Key settings for promoting resilience in older people**

**Community**

Communities are an important setting for building and promoting personal resilience. For older people, remaining socially engaged and playing an active role in society are key protective factors, consequently for older people who are less likely to benefit from opportunities for social engagement offered in the workplace, community settings are of particular importance in promoting resilience.
The important contribution of communities as a setting for promoting resilience in older people is recognised through the range of NICE guidelines which include community based interventions. For example NICE guidance on excess winter deaths and morbidity and the health risks associated with cold homes\textsuperscript{184} identify the benefits of addressing the health risks of cold homes, a particular risk factor for mortality and morbidity for older people; NICE guidance on promoting mental wellbeing in older people identifies the importance of promoting older peoples mental wellbeing through tailored, community-based physical activity programmes and offering regular sessions that encourage older people to construct daily routines to help maintain or improve their mental wellbeing (sessions should also increase knowledge of a range of issues, from nutrition and how to stay active to personal care).

New draft guidelines currently under consultation on older people: independence and mental wellbeing\textsuperscript{185} identify a number of actions that should be taken or considered in community settings to promote the health and wellbeing of older people. These include promoting or providing opportunities which meet the needs of older people including opportunities to socialise and those which promote social connectedness and physical health, interventions which provide group based activities, encourage volunteering, one-to-one support including befriending, involve a wide range of partners, be underpinned by needs assessment and evaluation.

Evidence of the cost effectiveness of community centred approaches is still limited but suggests that community capacity building and volunteering can produce significant returns on investment. For example an estimated £325 is
saved annually per person who takes part in befriending schemes and £850 per member of a time bank186 (a reciprocal scheme where people give their time in exchange for that of other people).

What more could we do to increase resilience in older people?

In order to promote greater personal resilience of older people in East Sussex we can:

- seek to gain better understanding of levels of loneliness and personal resilience in different areas and for different groups (e.g. through a local population survey);
- commission, provide and influence services to enhance and promote personal resilience, for example by adopting the Five Ways to Wellbeing and age-friendly frameworks as part of service delivery, and; continue to evaluate the impact of our work to promote personal resilience in older people.
- review and implement all relevant aspects of NICE guidance.

Personal resilience plays an important part in promoting good health and preventing poorer health outcomes for individuals. High levels of personal resilience can reduce the impact of other risk factors, and contributes to understanding why some individuals have better outcomes than others in seemingly similar circumstances. The evidence indicates that personal resilience can be grown and supported, and there are opportunities for this at each life stage.

The recommendations are:

1. Commissioners and providers of maternal, perinatal and early years health services and parenting programmes should continue to ensure that services, wherever possible, build resilience through evidence-based programmes of intervention and support.

2. The East Sussex County Council Health Improvement Team need to increase their work with partners to implement effective workplace interventions that promote health and wellbeing and embed action to grow personal resilience through healthy workplace programmes.

3. Continue to take concerted action to address loneliness and social isolation, particularly in older people, through the East Sussex Better Together Programme’s Community Resilience workstream.
‘Health protection’ relates to a set of activities within public health which aim to prevent or reduce the harm and health impact of communicable diseases and environmental hazards. As well as major programmes such as national immunisation programmes and provision of health services for infectious diseases, health protection also involves planning, surveillance and response to incidents and outbreaks.

Recent research has identified that personal resilience is crucial to health protection: that is the capacity of individuals or groups of people to cope with adversity and continue functioning.

This section focuses on the role of Sexual Health, Vaccinations and Immunisations, and Screening services in terms of contributing to promoting and supporting personal resilience. It demonstrates how individuals can help build their personal resilience by taking up the offer of these services.

Sexual health

Sexual health is an important component of overall health and wellbeing. Good sexual health contributes to building personal resilience in terms of physical, emotional and mental wellbeing. It contributes through: supporting the formation of relationships that provide care and trust; building positive self-identity; building self-esteem; as well as avoiding Sexually Transmitted Infections (STIs) and unplanned pregnancies.

Sexual Health Improvement

Sexual health outcomes can be improved through preventative interventions that build knowledge, personal resilience and self-esteem and promote healthy choices. Approaches to help achieve good sexual health include: high quality sex and relationships education at home, school and in the community; understanding of issues of consent, building confidence and emotional resilience in young people; access to confidential advice and support and services about wellbeing, relationships and sexual health. Effective education and advice enables young people to understand the benefits of loving, healthy relationships and delaying sex.

Many different factors can influence relationships and safer sex. These are a complex mix of personal attitudes and beliefs, interpersonal skills, social norms, peer pressure, religious beliefs, culture, confidence and self-esteem, substance use and, coercion and abuse. Good access to services is crucial for those who are sexually active. How individuals respond to pressures
around their sexual and relationship behaviour is therefore closely linked to the development of personal resilience.

A life-course approach to sexual health improvement recognises that age-appropriate education, information and support is required to help children, young people and adults make informed and responsible decisions. Resilience can be built among people at risk by helping them to develop the personal assets that their more resilient peers already possess. Likewise, the resilience of adults particularly at risk of health harms, such as HIV, and poorer sexual health can be strengthened through interventions that increase personal skills and self-efficacy. In this way, individuals’ sexual health can be improved, as well as their ability to enjoy life, survive challenges, and maintain positive wellbeing and self-esteem.

The following activities are effective in promoting sexual health improvement:

- Provision of high quality relationships and sex education, information and resources to young people.
- Targeted work with individuals from communities with higher levels of teenage pregnancy and poor sexual health
- Supporting those at risk of HIV infection to maximise their sexual health

There are a number of services being delivered in East Sussex to support the development and acquisition of knowledge and skills for sexual health improvement throughout the life course.

The contribution of schools is vital in providing young people with the skills and resources they need to improve their sexual health. As well as support for the delivery of high quality Personal, Social Health and Economic education (PSHE), schools in East Sussex are supported to deliver a targeted sex and relationships education enrichment programme which aims to ensure young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex. Group work is provided in a supportive environment and explores self-esteem, aspirations, contraception, how STIs are contracted, physical and emotional development, healthy relationships, sexual consent and delaying sexual activity. The aim is to equip young people with skills for their future sexual and emotional relationships.

**Sexual health training** is offered to children and young people’s workforce including, youth support services, key workers, family support services, and schools. This training is designed to support the development of skills of the workforce to have productive and helpful interventions with young people so they have access to information, resources and services around contraception and sexual health. It gives participants the knowledge, skills and confidence to talk to young people about relationships and readiness for sex so that they can have open, honest and practical conversations that will strengthen the personal resilience of children and young people.

**The East Sussex C-Card condom distribution scheme for 15-24 year olds** provides access to confidential advice and support about relationships and sexual health; understanding of issues of consent; and building confidence and emotional resilience in young people so they understand the benefits of loving, healthy relationships and delaying sex. The scheme has been established in East Sussex for a number of years and currently includes providers from the following local NHS organisations, pharmacies, GP surgeries, local colleges and schools, youth groups and other community and voluntary sector organisations.

The East Sussex HIV Prevention Service supports individuals and communities at risk of HIV to develop safer sex skills. The service offers advice, information and support to achieve sustainable behavioural change among communities at the highest risk of contracting HIV, including men who have sex with men and Black African men and women. It delivers a range of activities to promote positive sexual health and personal resilience such as one-to-one support, peer-led group-work, outreach and community engagement and online interventions. Promoting a personal sense of self and exercising a personal
sense of control is key element of resilience. The It Starts With Me campaign focuses on this sense of personal control by encouraging individuals to protect themselves and the community through the consistent use of condoms, regular testing for HIV and, for those with HIV, to take treatment. An effective treatment regime is also important in the prevention of HIV as it reduces viral load and infectiousness.

The East Sussex HIV Support Service, as well as voluntary and community sector services for people living with or affected by HIV, provides opportunities for people to connect.

**Contraception**

Contraception is the best way that people can protect themselves from unplanned pregnancies and from sexually transmitted infections. In East Sussex there are a range of options for accessing a full range of contraception, which is mostly free of charge:

- GP Practice
- Community Pharmacy*
- Specialist Sexual Health Service
- School Health Service
- Other youth services including Targeted Youth Service

(*charges apply for condoms outside of C Card scheme and emergency hormonal contraception for people over 25 years)

The full range of contraception includes:

- Condoms; Contraceptive pill;
- Long acting reversible contraception including depot injections and subdermal implants;
- Other, including cap, coil and female condoms.

People can access services to discuss and choose the best form of contraception for them.
Unplanned pregnancies (and teenage pregnancies)

Data on terminations of pregnancy provide some indication of unplanned pregnancies. However, it should be noted that some terminations will be linked to foetal abnormalities as opposed to being due to unplanned pregnancies. Similarly some unplanned pregnancies will not result in terminations.

There were 1,315 abortions to residents of East Sussex in 2014. The crude abortion rate of 15.2 per 1,000 resident women aged 15-44 was significantly lower than the England rate of 16.5. The crude abortion rate in 2014 was highest in East Sussex for women aged 20-24 (at 32 per 1,000). There were 92 abortions to women aged under 18 (7 per cent of the total) and 221 to women aged 35 or over (17 per cent).

Unplanned pregnancies in those aged under 18 years are associated with a high rate of negative impacts both for the mother and her child. These include worse health outcomes for the child, including low birth weight and reduced likelihood of the mother completing education or training. Rates of teenage pregnancy are closely linked to deprivation and health inequality, both of which hinder personal resilience. Of course, parenthood (even if initially unplanned) can be a life enriching experience. The Family Nurse Partnership works with first time mothers under the age of 20 years and aims to support them in a holistic way to secure good outcomes both for them and their child in terms of health and wellbeing, education, employment and income. In addition, the Healthy Child Programme is delivered by Health Visitors and School Nurses and aims to support parents and their children to secure the best physical and emotional and mental wellbeing.

Sexually transmitted infections

Protecting against sexually transmitted infections (STIs) is much better than treating them. STIs reduce personal resilience and are easily spread through sexual contact (as well as through intravenous drug use; and from a mother to her unborn child) to other individuals. The spread of STIs is further perpetuated by the fact that many of them (including chlamydia and the early stages of HIV infection) can have no symptoms.

The good news is that most STIs can be tested for and treated relatively easily in the community, via GP Practices and Community Pharmacies, as well as the open access Specialist Sexual Health Service. Of course, prevention is better than cure and the most effective way to protect yourself against sexually transmitted infections is to use an effective barrier form of contraception (condoms) to prevent both STIs and unplanned pregnancies.

Preventing the spread of both Chlamydia and HIV is probably the most important contribution in terms of building personal resilience in relation to STIs in East Sussex.

- Chlamydia

In East Sussex and nationally, the most common bacterial STI is chlamydia. The prevalence of infection is highest in young sexually active adults (15 to 24 years old). Chlamydia often has no symptoms but can lead to a wide range of complications, including pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility in women and epididymitis in men, and represents a substantial public health problem.

The national Chlamydia testing programme targets sexually active 15-24 year olds. Access is via general practice, community pharmacy, the school health service, the specialist sexual health service, and a web-based service. All testing and treatment is completely free and confidential. All young people aged 15-24 years of age who are sexually active are encouraged to have a test at least annually and on change of sexual partner.

The East Sussex target for 2013/14 is 2,000 tests per 100,000 head in the 15-24 year old population. Figure 6 shows the chlamydia diagnoses rate in East Sussex and each district and borough compared to England.
In 2013/14, sufficient numbers of 15-24 year olds are taking up the offer of tests to meet the target of positive diagnoses in Eastbourne, Hastings and Lewes. Also, across East Sussex sufficient numbers of women are taking up the offer of tests to meet the positive diagnoses target, but more needs to be done to encourage men to take up the offer. To help people access testing we are:

- Increasing access to web-based testing (this is especially helpful in encouraging men to take up tests)
- Enhancing the engagement of primary care and community pharmacy, especially in rural areas
- Using social marketing to best promote and support people aged 15-24 to take up regular testing

By taking up the offer of chlamydia testing people can help build their resilience so that they do not suffer the negative effects of having the infection, but also by protecting those around them from acquiring it.

- **HIV**

HIV is associated with significant mortality, serious morbidity and high costs of treatment and care. Around 100,000 people are living with HIV infection (diagnosed and undiagnosed) in the UK. The infection is still frequently regarded as stigmatising and has a prolonged ‘silent’ period during which it often remains undiagnosed.

Anti-Retroviral Therapy (ART) has resulted in substantial reductions in Acquired Immunodeficiency Syndrome (AIDS) and deaths in the UK. People diagnosed promptly with HIV and started on ART early can expect near normal life expectancy. Challenges remain, with high rates of late HIV diagnoses and an ageing population.

Currently in East Sussex the following groups of people are routinely offered an HIV test:

- Pregnant women
- People accessing the Specialist Sexual Health service for any STI testing and/or treatment and/or for contraception
People presenting to acute care with symptoms or co-morbidities associated with HIV should also be offered a test for HIV.

Additionally, there has been some access to HIV testing via web-based home testing for men who have sex with men and Black Africans. Also, primary care are being incentivised to offer opportunistic HIV testing.

Expanded HIV testing involves making the test more widely available. It refers to offering HIV testing on an opt-out basis to all new GP registrants and to all medical admissions to hospital.

Nationally, it is recommended to introduce expanded HIV testing in Local Authorities with prevalence rates of at least 2 cases per 1,000 population aged 15 years and over.

Although we do not as a county meet the threshold of 2 cases per 1000 population with HIV aged 15 years and over, we do in Eastbourne, Lewes and Hastings (Figure 7).

We are starting a pilot in Eastbourne for people who are new GP registrants and for medical admissions to Eastbourne General Hospital offering routine HIV testing, in order to pick up previously undiagnosed HIV. The pilot will be deemed successful if at least one new case of HIV is identified per 1,000 people tested during the pilot. If the pilot is successful then consideration will be given to extend this to other parts of the county where the prevalence is high.

Identifying people with HIV who are unaware that they have the virus will enhance personal resilience as it will help them to access treatment to reduce their likelihood of associated poor health in themselves as well as reducing the onward transmission to others.

The Specialist Sexual Health service has a Sexual Health Advisor Team who contact the sexual partner/s of any individual with Chlamydia or HIV (or any other STI) and offer them testing and treatment for all STIs. It is important that people take up the offer of testing if contacted as it will help them to protect their health.

**Figure 7: Diagnosed HIV prevalence by local authority in East Sussex, rate per 1,000 population aged 15 years and older, 2002 to 2013**

<table>
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<tr>
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<th>England</th>
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*data limited to persons aged 15 to 59 only

Source: Public Health England
The Sexual Health Advisors also work with people who may be at higher risk of poor sexual health including people not using contraception to encourage them to reduce risk-taking behaviour, minimise harm and reduce the likelihood of further infections.

• Psychosexual issues

A psychosexual disorder is defined as any form of sexual dysfunction that is caused by a psychological issue and does not stem from an actual physical illness. Factors such as stress, anxiety, depression or feelings of guilt can sometimes contribute to the development of a psychosexual disorder. Symptoms vary widely from person to person and from one gender to another and may include inability to climax, loss of libido, or even physical pain when attempting to engage in intercourse. Childhood trauma can contribute to the development of a psychosexual disorder later in life. Relationship counselling is often part of the treatment for a psychosexual disorder.

Locally, the Specialist Sexual Health Service in East Sussex offers psychosexual therapy as a counselling service with a focus on a wide range of sexual issues including difficulties with erection, ejaculation, orgasm and desire; sexual trauma or pain; sexual functioning and ill health/disability; sexual orientation; and compulsive sexual behaviour. Referral to the service is through a GP or other Doctor.

As good sexual health is an important determinant of maximising personal resilience, and given the high priority of maintaining strong, healthy relationships, people should be encouraged to seek support for any psychosexual disorders they are experiencing.

In summary, sexual health services can support building personal resilience by providing access to: high quality education, information and support to promote sexual health improvement; effective barrier methods of contraception to prevent STIs and unplanned pregnancies; regular testing for STIs; psychosexual counselling as required.

Vaccination and Immunisation

Immunisation is one of the most important health protection interventions. An individual can protect themselves from disease for years by having a primary course of vaccination. Vaccines stimulate the immune system to produce antibodies so that if a person then comes into contact with the disease the body automatically produces antibodies to fight it.

If enough people in a community are vaccinated, it’s harder for a disease to pass between people who have not been vaccinated (‘herd immunity’).

Even those who might not be able to take up the offer of vaccination (e.g. children, pregnant women, those with illness and others etc. depending on the vaccine) would get some protection as the spread of contagious disease is contained (Figure 8). For example, disease incidence has been found to decrease in populations too old to have been vaccinated, because those who have been vaccinated are both fighting the disease and becoming less infectious. This is referred to as herd immunity and is generally agreed to be when 95% of the eligible population for childhood immunisations, have received their vaccination.

Community resilience will be maximised in terms of vaccine-preventable diseases when herd immunity (or other specified vaccine targets) are met. This is both in terms of protecting the individual from acquiring the disease and protecting those who are either too young or unable to have the vaccine for other reasons (including people who are immunocompromised).
The national immunisation programme

Immunisation is the most important way of protecting people from vaccine preventable diseases. People can build personal resilience through taking up the offer of vaccinations they are eligible to receive. In doing that they are also helping to build community resilience by helping to protect those people that cannot take up the offer. The overall aim of the routine immunisation schedule is to provide protection against the following vaccine-preventable infections: diphtheria; tetanus; pertussis (whooping cough); *Haemophilus influenza* type b (Hib); polio; meningococcal serogroup C disease (MenC); measles; mumps; rubella; pneumococcal disease (certain serotypes); human papillomavirus types 16 and 18 (also 6 and 11); rotavirus; influenza; and shingles.

The following table shows the 2015 UK vaccination schedule (Table 4). New vaccines have been introduced in 2015 including Meningitis B for babies, Influenza vaccine for children in primary school years 1 and 2, and Meningitis ACWY for teenagers and first time students. People are routinely invited when they are due for vaccination. It is important that people receive the vaccinations that they are due in order to build their personal resilience against preventable illness and contribute to strengthening wider community resilience. Uptake of childhood, influenza, pneumococcal and shingles immunisations in relation to building personal resilience will be examined in more detail.
Table 4: The 2015 NHS vaccination schedule

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<th>Age Category</th>
<th>Vaccines</th>
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| 2 months                           | • 5-in-1 (DTaP/IPV/Hib) vaccine – this single jab contains vaccines to protect against five separate diseases: diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenzae type b (known as Hib – a bacterial infection that can cause severe pneumonia or meningitis in young children)  
• Pneumococcal (PCV) vaccine  
• Rotavirus vaccine  
• Meningitis B vaccine (from 1 September 2015) |
| 3 months                           | • 5-in-1 (DTaP/IPV/Hib) vaccine, second dose  
• Meningitis C  
• Rotavirus vaccine, second dose |
| 4 months                           | • 5-in-1 (DTaP/IPV/Hib) vaccine, third dose  
• Pneumococcal (PCV) vaccine, second dose  
• Meningitis B vaccine, second dose (from 1 September 2015) |
| Between 12 and 13 months           | • Hib/Men C booster, given as a single jab containing meningitis C (second dose) and Hib (fourth dose)  
• Measles, mumps and rubella (MMR) vaccine, given as a single jab  
• Pneumococcal (PCV) vaccine, third dose  
• Meningitis B vaccine, third dose (from 1 September 2015) |
| 2, 3 and 4 years plus school years one and two | • Children’s flu vaccine (annual) |
| 3 years and 4 months, or soon after | • Measles, mumps and rubella (MMR) vaccine, second dose  
• 4-in-1 (DTaP/IPV) pre-school booster, given as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio |
| Around 12-13 years (girls only)    | • HPV vaccine, which protects against cervical cancer – two injections given between six months and 2 years apart |
| Around 13-18 years                 | • 3-in-1 (Td/IPV) teenage booster, given as a single jab which contains vaccines against diphtheria, tetanus and polio  
• Meningitis ACWY vaccine |
| 19-25 years (first time students only) | • Meningitis ACWY vaccine |
| 65 and over                        | • Flu (every year)  
• Pneumococcal (PPV) vaccine |
| 70 years (and 78 and 79 year-olds as a catch-up) | • Shingles vaccine |
| Vaccines for special groups        | There are some vaccines that aren’t routinely available to everyone on the NHS, but that are available for people who fall into certain risk groups, such as pregnant women, people with long-term health conditions and healthcare workers. Additional ones include Hepatitis B vaccination, TB vaccination and chickenpox vaccination |

Source: NHS Choices, accessed 05/08/15  
http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx
Childhood immunisations

The immunisation schedule of childhood vaccinations has been designed to provide early protection against infections that are most dangerous for the very young. This is particularly important for diseases such as whooping cough, and those due to pneumococcal, haemophilus and meningococcal infection. Providing subsequent immunisations and booster doses as scheduled should ensure continued protection.

The aim of all childhood programmes is to reach 95% coverage to protect the health of the whole population and the most vulnerable.

In the Public Health Outcomes Framework, East Sussex is currently significantly worse than the national average for MMR for 2 doses at 5 years (pre-school booster).

However, although East Sussex is significantly better than the national average for the remaining 9 childhood vaccination indicators we only achieve herd immunity for 2 out of the 10 childhood vaccination indicators (Dtap/ IPV/ Hib at 1 year and at 2 years).

There is significant variation by Clinical Commissioning Group (CCG) and by GP practice, with rates as high as 100% for some vaccines and GP practices and others as low as 74% for others. Overall, for primary vaccinations by age 1, Eastbourne Hailsham Seaford CCG and Hastings and Rother CCG achieved 95% uptake or more. High Weald Lewes Havens CCG have less than 95% uptake (94.2%) but are working to increase this. 2013/14 data shows an increase in coverage for vaccines given at or around 5 years across the CCGs.
Figure 9 shows rates of primary immunisations (given at 2, 3 and 4 months of age) for Diphtheria, Tetanus, Polio, Whooping cough and Haemophilus influenzae type b (DTaP/ IPV/ Hib) by 1 year of age by district, borough and ward. The darkest shading shows the areas that have achieved herd immunity in 2013/14. These include just over half of all wards in East Sussex. The lighter shading indicates areas where as few as 50% of children are vaccinated for primary immunisations by 1 year of age.

Figure 10 shows the uptake of full immunisation for MMR (two doses) by age 5 years across East Sussex by district, borough and ward in 2013/14.

The map shows that only a few wards in each district and borough area achieve herd immunity for MMR. The rates are as low as 49% in the areas with the lightest shading. The areas that achieve herd immunity include the wards of Peacehaven North, as well as the Seaford wards, apart from Seaford Central, in Lewes District Council, Crowborough St Johns, Crowborough Jarvis Brook and East Dean in Wealden District Council, Ticehurst, Salehurst and St Stephens in Rother District Council and Central St Leonards and Hollington in Hastings Borough Council. Parents need to ensure that their children are vaccinated to build their resilience. There are several factors that determine variation in uptake of childhood vaccines. These include:

- **Access**

The way that primary care is organised can impact positively or negatively on the uptake of vaccines. Practices that are able to offer a range in terms of day and time of vaccine clinics generally have better uptake. Also, the use of reminders and follow up for those who do not attend can also improve uptake. Finally, the way that information is provided to parents who have concerns about immunisations or are undecided whether to have their child/children immunised can also have an impact. Different ways of delivering vaccine can increase uptake. For example, an outreach vaccination clinic provided from a Children’s Centre encouraged parents of unvaccinated or partly vaccinated children to have their vaccines.
Alternate views and beliefs on use of vaccination

There is a cohort of the population who hold alternate views about the relative benefits of vaccination and choose to not have their children vaccinated. Previously there have been outbreaks of vaccine-preventable illnesses in these communities.

Seasonal flu immunisation

Influenza is an acute viral infection of the respiratory tract. For otherwise healthy individuals, influenza is an unpleasant but usually self-limiting disease with recovery usually within two to seven days. The illness may be complicated by (and may present as) bronchitis, secondary bacterial pneumonia or, in children, otitis media. Influenza can be complicated more unusually by meningitis, encephalitis or meningoencephalitis. The risk of serious illness from influenza is higher amongst children under six months of age, older people and those with underlying health conditions such as respiratory or cardiac disease, chronic neurological conditions, or immunosuppression and pregnant women.

People in the following categories are eligible for free influenza vaccination and should take up the offer of a free influenza jab

- Anyone aged 65 or over
- Adults with chronic underlying health conditions
- Pregnant women
- Adults and children with weakened immune systems
- All 2, 3 and 4 year olds are eligible to receive the vaccine via their GP (Nasal Spray)
- All children of school years 1 and 2 age will be given the opportunity to be vaccinated at school. (Nasal Spray)
- Health care workers and other health and social care employees who work with patients and clients including those who are vulnerable
women. Conditions, or immunosuppression and pregnant or cardiac disease, chronic neurological underlying health conditions such as respiratory from influenza is higher amongst children under two to seven days. The illness may be self-limiting disease with recovery usually within individuals, influenza is an unpleasant but usually respiratory tract. For otherwise healthy Influenza is an acute viral infection of the vaccine-preventable illnesses in these communities. Previously there have been outbreaks of vaccination and choose to not have their children alternate views about the relative benefits of There is a cohort of the population who hold alternate views and beliefs on use of vaccination

Figure 11: Seasonal influenza vaccine uptake amongst GP patients: September to January 2014-15

Source: Public Health England

Figure 11 shows that we nearly meet the national target for those aged 65 years and older, but not for the other groups so we need to improve uptake for the under 65 year olds in clinical risk groups, pregnant women and 2, 3 and 4 year olds.

The following map shows the take up of influenza vaccination by those aged 65 years and older across East Sussex by district, borough and ward in 2013/14 (Figure 12)
This shows that 17 wards have uptake rates above the 75% target and include parts of Peacehaven, Polegate, Willingdon, and Bexhill and surrounding areas.

Ensuring good uptake of influenza vaccination will improve personal resilience and community resilience within East Sussex in many ways. Firstly, the vaccination programme includes everyone aged 65 years and over because older people are more vulnerable to influenza infection and are more likely to have complications which may be severe. By achieving the target of 75% vaccination this will provide enough protection to reduce the circulation of influenza.

Similarly, those with chronic conditions aged under 65 are also more likely to have complications resulting from influenza. By reducing the incidence of influenza in the population via vaccination, individuals will make an investment in their personal resilience to fight influenza, avoid complications and avoid passing influenza onto others (including carers and others looking after them, who themselves may be vulnerable).

The importance of front-line health and social care workers taking up the offer of vaccination is that it will both protect them from getting influenza (hence allowing them to continue to deliver their essential roles) and protect the (often) vulnerable patients and clients that they care for from getting it. In relation to the ongoing potential for there to be an influenza pandemic this is even more important.

For the first time this year all school children in Key Stage 1 at Primary School (those in school years 1 and 2) will be offered the influenza nasal vaccine at school. This is a national extension to the existing programme of offering vaccination to 2, 3 and 4 year olds.

The target for effective uptake in children has been set nationally at 40%. This is the level of vaccination required in children of these ages in order to effectively reduce influenza circulating in the population.

Vaccinated children will be offered some protection against getting influenza and passing it to those around them. In turn, community resilience will be supported by the associated reduction in need for parents/carers to take time out of work to look after them.

**Pneumococcal**

All people aged 65 years and over are offered a single pneumococcal polysaccharide vaccination, which offers protection for life.

Pneumococcal disease is caused by the bacterium Streptococcus pneumonae (pneumococcus) and infections are either non-invasive or invasive. Non-invasive diseases include middle ear infections (otitis media), sinusitis and bronchitis.

Invasive pneumococcal disease includes septicaemia, pneumonia and meningitis and is a major cause of illness and death. It particularly affects the very young, the elderly, those with an absent or non-functioning spleen and those with other causes of impaired immunity. There is seasonal variation in pneumococcal disease, with peak levels in the winter months.

Within East Sussex, Hastings and Rother CCG achieve the highest uptake at over 70% (Figure 13).

In order to reduce the risk of harm caused by pneumococcal infection, people aged 65 years and over should all have a one-off pneumococcal vaccine in order to build their personal resilience to the infection and in turn add to community resilience to fight preventable disease.
Shingles

The routine national shingles immunisation programme started on 1 September 2013. The programme now offers routine vaccination for those aged 70 years and a catch up campaign targeted at 78 and 79 year olds.

Shingles, also known as herpes zoster, is an infection of a nerve and the skin around it. It is caused by the varicella-zoster virus, which also causes chickenpox. The main symptom is a painful rash that develops into itchy blisters. Shingles can affect any area of the skin including the face and around the eye. An episode of shingles usually lasts around two to four weeks, although one in five people go on to develop nerve pain called postherpetic neuralgia in the affected area of skin.

The nerve pain can be severe and last for several months or more after the rash has gone. Complications such as these are usually in elderly people and those with a weakened immune system.

Figure 14 shows that within East Sussex there is some variation across the CCGs in terms of shingles vaccination uptake in 2013/14. Hastings and Rother CCG appear to have a slightly higher uptake for the routine 70 year old programme and the catch up for those aged 79 years. Generally, High Weald Lewes Havens CCG has slightly lower rates of uptake.

People invited to have a shingles vaccine should take up the offer in order to build their personal resilience against shingles infection.
Screening

Screening is the process of identifying apparently healthy people who may be at increased risk of a disease or condition, and then enabling information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.\textsuperscript{196}

Screening is an important way of detecting disease early, before the individual experiences any symptoms. Detecting disease in this way reduces the amount of disease in the population. It also reduces the impact of disease on the individual. It can improve quality of life in those who can receive earlier treatment than they would otherwise have done, and gives people information to make choices. The current national screening programmes can be divided into the following groups:

Cancer screening

Taking part in cancer screening programmes in a timely way can help support personal resilience through early identification of illness and disease that can be treated in order to either eliminate or reduce the associated harms of the illness. Screening might lead people to feel that they are ‘safe’ from acquiring illness and so may continue with unhealthy behaviours including smoking and high alcohol use but screening should be viewed as part of an individual’s health promoting practice, as opposed to being used instead of it.

Again, uptake of screening varies by CCG and GP Practice across the county. The reasons for variation in uptake are again similar to those for uptake of childhood vaccinations (issues with access and holding an alternative view).

Breast screening

Breast cancer screening is offered to women aged 50 to 70 to detect early signs of breast cancer. Women are invited for a mammogram every three years and from the age of 70 can self-refer. Mammograms are able to detect abnormalities including lumps in women’s breasts that may be cancerous.

Breast screening uptake in East Sussex is at 76% but this is lower than the national target of 80%. Rates appear to be highest in Rother and Wealden (78%) and lowest in Hastings (73%).
By attending regular breast screening appointments, as well as being aware of any changes to the breasts between screening, women can have any potentially cancerous lumps, or other breast changes or symptoms investigated further which will contribute to reducing their risk of breast cancer.

**Bowel screening**

Bowel screening involves a faecal occult blood home test kit offered to all 60-74 year olds. It involves providing a stool sample that is sent by post to be checked for the presence of blood which could be an early sign of bowel cancer. Men and women are offered a test every two years from the age of 60-74. Those aged 75 and over are able to self-refer to obtain a test.

In 2013/14, 60% of people aged 60-74 years in High Weald Lewes Havens CCG and 57% of those living in Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG took up the offer of a bowel screening test. Figure 15 shows uptake of bowel cancer screening across the county by district, borough and ward in 2013/14. The map shows a mixed picture of take up of bowel screening across the county with higher uptake generally seen in Rother District Council as well as much of the West side of Wealden District Council.
Eastbourne Borough Council, Hastings Borough Council and much of Lewes District Council appear to have lower uptake, particularly in the Central St Leonards, Castle and Ginseng areas of Hastings. By taking up the offer of bowel screening people can have any early signs of potential bowel cancer identified, through the screening programme, further investigated and treated as required.

Cervical screening

Cervical screening is offered to women aged 25 to 64 years old to check the health of the cells in the cervix. It is offered every three years between the ages of 26 and 49 years old and every five years between the ages of 50 and 64 years old. Cervical screening is able to detect changes to cells in the cervix that may, if left untreated, progress to cervical cancer.

By having a cervical screen in a timely way when invited, women can have any potential pre-cancerous changes further investigated and treated as required. The national target for having the test is 80% but there has been a slight reduction in coverage of cervical screening of women in East Sussex over the last four years from 78% in 2010/11 to 77% in 2013/14 for women aged 50-64. For women aged 25-49, who are offered screening every three and a half years, there has been a reduction from 77% to 75%.

Figure 16 shows coverage of Cervical screening by women aged 50-64 years old as of the end of March 2014 by district, borough and ward. This map shows we only achieve the 80% target for women aged 50-64 years in a few wards across the county, mainly in Wealden District Council. Coverage appears to be particularly poor in the North West part of Wealden District Council, the southern part of Eastbourne Borough Council and the western part of Hastings Borough Council.
Non-cancer screening

Abdominal Aortic Anuerysm screening

Abdominal Aortic Anuerysm (AAA) screening is offered to men in their 65th year to detect abdominal aortic aneurysms, a dangerous swelling in the aorta. If left undetected the swelling can cause the aorta to rupture which has a high death rate from emergency surgery to repair it. Any swelling identified through the screening programme can be closely monitored and repaired surgically if required in a planned way, which has a lower associated death rate. Men aged over 65 years of age can self-refer to the AAA screening programme. Sussex as a whole had an AAA screening uptake rate of 80% in 2013/14, higher than the national rate of 77%.

Diabetic Eye screening

Diabetic eye screening is offered to all people with diabetes from the age of 12 years as an annual test to check for early signs of diabetic retinopathy. Left untreated, diabetic retinopathy can lead to a reduction in sight and eventual blindness. East Sussex is above the national average for diabetic eye screening uptake. In 2012/13, 83% of people with diabetes took up the offer of diabetic eye screening compared to 79% for England as a whole. People with diabetes should be encouraged to take up the offer of their annual diabetic eye test in order to reduce the risk of potential eye problems that if left untreated can lead to sight loss and blindness.

Antenatal and newborn screening

Antenatal screening

Antenatal screening relates to a set of blood tests and ultrasound scans that are offered to pregnant women to detect infections and abnormalities in pregnancy. This includes testing for infectious diseases including HIV and hepatitis B; diseases including Sickle Cell and Thalassaemia; and ultrasound scans for checking healthy and timely growth development of the foetus.

Newborn screening

Newborn screening relates to a set of tests and examination that are offered to newborn babies to detect abnormalities. This includes the newborn blood spot test, which is able to test for a range of rare but serious conditions including Sickle Cell Disease/Thalassaemia and Cystic Fibrosis. Babies are also offered a physical examination and newborn hearing screening. Women should be encouraged to book their pregnancy within 12 weeks of conception and accept NHS antenatal and newborn screening tests offered in a timely way in order to identify any problems early on when they can either be remedied or measures put in place following birth in order to maximise personal resilience for both themselves and their baby.
PERSON CENTRED CARE AND SUPPORT

5

PARTNERSHIP APPROACH

REABLEMENT

SHARED RESPONSIBILITY

SUPPORTIVE HOME

CARERS SUPPORT

SELF CARE

INDEPENDENCE

DIGNITY
1. Building personal resilience through person-centred care and support

Whilst there is no universally agreed definition of person-centred care, a person-centred system is one that supports people to make informed decisions about, and to successfully manage, their own health and care.

The Health Foundation identified principles of person-centred care that recur in the literature:

- Getting to know the patient/client as a person and recognising their individuality and specificity;
- Taking an holistic approach to assessing needs and providing care (which may include families and recognising social and environmental factors as part of a bio-social perspective);
- Seeing the patient/client as an expert about their own health and care;
- Recognising autonomy and thus sharing power and responsibility, including enablement and activation in decisions about care;
- Ensuring that services are accessible, flexible to individual needs and easy to navigate;
- Co-ordination of services into an integrated pathway that views the whole experience of care from the patient/client’s point of view and strives for continuity;
- Ensuring that the physical, cultural and psychosocial environment of services is conducive to person-centred care;
- Having supportive staff who are well trained in communication and engagement and strive to put patients/clients at the centre of their care.197

Person-centred care is fundamental to transforming services and an important part of the East Sussex Better Together programme.

Self-care in its broadest sense is the actions we take to look after our own health, the health of our family and the health of our community.198 Self-care is something that is important for everyone in daily life. It is knowing what you can do to manage your needs, feeling in control of those needs and taking responsibility for your own health and wellbeing.

Self-care is a key approach to supporting people to become more resilient and increasingly independent, self-sufficient and resourceful. Thus better able to help themselves; no matter their level of dependence. Combining self-care with effective prevention and early intervention helps people to live as well as they can and maintain their dignity for as long as possible.

Self-care is ‘the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital’. 198

Self-care also has wider impacts, for example evidence indicates that GP visits can decrease by 40%, A&E visits by 50% and hospital admissions can be halved due to self-care199, thus sustaining the financial viability of the NHS200.
A key aim of the Department of Health’s visions for Public Health is self-care through ‘people and families to be able to take care of their own health and wellbeing’.23

In order to obtain the best possible health gains with scarce public resources, preventive measures enhancing individual’s commitment to their own health and supporting lifestyle improvements are increasingly needed.201

**Why is self-care important?**

There are currently 15.4 million people in England with a Long-Term Condition (LTC), such as hypertension, depression, asthma, diabetes, coronary heart disease, chronic kidney disease, or other health problem or disability.202 Between a quarter and two fifths of the population live with a LTC.202

Table 5 shows the number of people recorded as having a LTC in East Sussex general practices. It is important to note that people may be on more than one register as they may have more than one LTC and that people not registered with a GP practice will not be included in the figures. Also, it does not provide a picture of multi-morbidity (the number of patients with more than one condition or disease).

However, they do give an indication of the level of need within the population. From the table it can be seen that individual registers range from 9 per 1,000 population for dementia to 167 per 1,000 for hypertension.

Due to an ageing population, it is estimated that by 2027 over 20% of the East Sussex population will be aged 65 or over203, this represents a 21% increase compared to 2014 figures, although in Hastings it will be a 25% increase (Figure 17).
This will mean that the number of people with at least one LTC will also rise. People with long term conditions are the highest users of health and social care services, and taking a self-care approach to care means users feel more in control and have less need to use services. This type of self-care is known as self-management.

For those with a LTC different types of self-care are needed, for example the ability to manage tests and medicines, make changes to their lifestyle or to cope with the emotional and social impacts of living with a long-term condition. This type of self-care is known as self-management.

### Why is it important?

- The number of people with multiple long-term conditions is predicted to rise by a third by 2020.
- People with long-term conditions are the most frequent users of healthcare services, accounting for 50% of all GP appointments and 70% of all inpatient bed days.
- Treatment and care of those with long-term conditions accounts for 70% of the primary and acute care budget in England.
- At the heart of the chronic disease management model is the informed, empowered patient with access to continuous self-management support.
- Around 70-80% of people with long-term conditions can be supported to manage their own condition.

- The King’s Fund 2012
If people are supported to get the right skills and tools they can become more personally resilient and can:

- Actively manage their own health and improve their quality of life.
- Be treated by health and care systems as assets rather than problems.
- Contribute to the quality of health and care services they receive.

The average individual with type 2 diabetes will spend three hours a year with a health professional managing their condition, and the remaining 8,757 hours caring for themselves (Figure 18).  

Building the resilience of the individual by developing their self-care skills, as well as ensuring that the time spent in contact with health professionals is used in the most efficient and effective way for that person, will maximise their health outcomes and impact on the need for further health support, for example from related complications.

Nearly a quarter of the population (23%) have multiple chronic conditions (multi-morbidity), and there is a growing body of evidence that people who recognise their role in self-managing their condition and have the skills and confidence to do so experience better health outcomes, improved physical quality of life; have more positive attitude and behaviours, are able to remain in their own homes longer; have better mental health; lower perceived severity of symptoms and less use of healthcare services. With effective support and education, these skills can be developed and strengthened, even among those who are initially less confident, less motivated or have low levels of health literacy.

Awareness and use of training aimed at the skills individuals need to become more resilient and to help them care for their condition is low, with just one person in twenty accessing them.
However, the proportion of people with long term conditions who are taking an active role in managing their condition is increasing, with increases in information and advice (mainly from hospitals and GPs) enabling this participation, making people feel involved in their care decisions and able to manage their health issue.213 Nine in ten people with LTCs are interested in becoming more active self-carers, three quarters of whom would feel more confident about doing so with healthcare professional or peer support.204

**Active support for self-care and self-management**

In self-management, the role of professionals is to collaborate with the individual, empowering and supporting them through joint decision-making, providing training and equipment for self-diagnosis and self-monitoring, and education and motivation as required.214,215,216 Support aims to encourage resilience and build knowledge and technical skills as well as self-efficacy (confidence to self-care)208 (Figure 19) focusing on quality of life and wellbeing rather than solely on the illness or impairment202.

The Department of Health outlines several ways that individuals with long term conditions can be supported to be more resilient and to self-care, including: engaging GPs to increase referrals to self-care courses; understanding and designing services catering to individual’s needs; motivational interviewing and counselling services; design services with ‘expert users’; and jointly develop care planning with service users.204

Support for self-care and is best achieved with integrated self-care support resources using a range of activities and interventions.215,212 Figure 20 illustrates some of the interventions and activities required to support self-care and increase personal resilience.
Figure 20: Activities and interventions to support personal resilience through self care

Self-care and self-management support

There are a number of well-established self-management programmes that aim to empower patients to be more resilient and to improve their health. A review of the evidence has highlighted the importance of ensuring the intervention is tailored to the condition. For example, structured patient education can be beneficial for people with diabetes, while people with depression may benefit more from cognitive and behavioural interventions.214

Exercise and Education courses

Locally, the Stroke Association is commissioned to deliver free Exercise and Education courses. Courses run for 10 weeks in local leisure centres and are conducted by exercise trainers with specialist training in stroke. Education is in the form of hand-outs, stroke association resources and a presentation provided mid-way through the course. The classes aim to increase physical activity, knowledge and education about stroke and its risk factors as well as dietary advice. The groups are also designed to increase social interactions and reintegration, using community resources. In 2014-15 the courses supported 72 people.

Self-care and self-management form an important part of the East Sussex Better Together programme, with the vision that all people are enabled and supported in achieving their full health and wellbeing potential through primary prevention, proactive self-care and supported self-management. It is a transformational programme, which will set out a new approach to ensuring the principles and approaches of self-care and self-management are central to the health and care system in the county. There are a number of features that systems and services need to think about in making themselves self-care friendly. They need to ensure their users:

- are active partners with their care providers so they are fully involved in decision making.
- can talk confidently with their health and social care providers about their needs.
- can develop a self-authored care plan, which includes self-assessment so they can identify their priorities and feel ownership of the plan.
- can manage risk taking in maximising their independence and choice.
- can access networks to be able to talk to others in the same situation about wider needs.
- have support from significant others in their life/carers.
- experience timely, consistent and effective support.

Special Educational Needs and Disability commissioning

The Children and Families Act 2014 has brought with it major reforms to the way local authorities support children and young people with special educational needs and disabilities. It puts the independence of children and young people at the heart of services. The aim is to empower children, young people and their families to enjoy even more fulfilled lives, and positive outcomes.

These will, in part, be achieved through ensuring information advice, independent mediation and advocacy services are available for families. Helping promote effective choices and increase resilience by:

- Enabling young people, parents and carers feeling able to make informed decisions;
- Ensuring young people, parents and carers feel supported with any choices and actions they take relating to the services they receive.
Care planning

Care planning is one way of creating an environment through which clinicians can support patients to be more resilient and to understand and confidently self-manage their LTC. It refers to regular, structured and proactive contact between the person with an LTC and the health service to jointly work out the most holistic and effective way to manage the condition, the consequences of living with an LTC, and how their lifestyle may impact on it. This may involve providing information about the condition, personalised expertise, coaching, problem solving, goal setting, or a chance to process the emotional burden of living with an LTC.

NHS Health Checks

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia by inviting everyone aged 40 to 74 who are not being treated for one of these conditions, or the associated risk factors, to have a health check and receive support and advice to help reduce or manage their own risk of developing these conditions. This involves enabling individuals to be more resilient and to take positive changes to reduce that risk by: lowering their blood pressure, stopping smoking, reducing cholesterol, tackling obesity, improving diet, increasing physical inactivity and reducing alcohol consumption.

The programme aims to achieve this by improving early identification and management of behavioural and physiological risk factors, and by providing information, advice and interventions to support individual behaviour change and management. NHS Health Checks is the first programme of its kind internationally, and while there is a lack of evidence evaluating individual health outcomes resulting specifically from Health Checks, there is a large body of evidence showing how behaviour change in these areas of risk can improve different elements of personal resilience.

NHS Health Check programme has both primary and secondary prevention objectives, aiming to reduce vulnerability of risk factors to help people remain well and reduce the likelihood of developing cardiovascular disease and other lifestyle related non-communicable diseases. It also screens for existing cardiovascular conditions not previously diagnosed to aid early diagnosis, allowing individuals to be better managed and improve their quality of life, accept their own health status and set goals for improving this.
In East Sussex 65% of 179 individuals surveyed after receiving an NHS Health check in a community pilot said that their check had motivated them to make lifestyle changes.

Approximately a third of the East Sussex adult population are eligible for an NHS Health Check. The programme is a key opportunity to engage the local population in highlighting behavioural and physiological risk factors and work together on appropriate action to reduce or manage those risks.

All 72 GP practices across East Sussex offer and provide NHS Health Checks for their patients. Since April 2013 nearly half (49%) of adults eligible for a Health Check in East Sussex, over 81,000 adults have been offered their check. A quarter of the eligible population has gone on to receive their NHS Health Check and will have been given personalised results for risk factors and offered personalised advice and on-going support to reduce those risk factors.

Initial results from satisfaction surveys from local GP Health Checks report that many patients say that as a result of their Health Check they aim to take more personal responsibility and make changes to their lifestyle, to reduce their vulnerability of risk factors that will support increased resilience and improve wellbeing.

- 38% motivated to lose weight
- 35% motivated to be more active
- 16% motivated to eat more healthily
- 8% motivated to stop smoking
- 5% motivated to drink less alcohol

**Telecare and telehealth**

Technologies such as telehealth and telecare, have the potential to transform the way people engage in and control their own healthcare, empowering them to manage it in a way that is right for them. **Telecare** is a system of sensors in the home, which can detect household dangers or risks to older people and those with disabilities, like fires, floods, or falls, and alert professionals and family members. Telecare is designed not only to get help, but to reassure the individual and their family. The majority of telecare accessed is for personal alarms (74%), over half of which are for people over 75 years.

**Telehealth** is a system of sensors and monitors for people with long-term health conditions to check on their health whilst they are at home and alert a medical professional if anything gives cause for concern. For example, monitors can check blood pressure and heart rate, temperature and weight. By showing people the different ways their actions affect their health, this systems helps people manage their own health condition and become more resilient. Telehealth is provided through the NHS and accessed through health professionals.

Appropriate use of Telehealth and Telecare can lead to improved outcomes and reduced admission to hospital and care homes. Telecare and telehealth have been shown to ensure safety and support, and to maximise independence and provide peace of mind for both individuals and their families/carers by reducing stress and worry, improving sleeping patterns and enabling carers to socialise and juggle work and care.

By preventing both absence from work and crisis at home, telecare and telehealth can mean the difference between illness and disability leading to debt and hardship and families remaining resilient. It can also improve confidence and esteem for those using the technologies as the earlier intervention means needs can be met while enabling ongoing independence rather than potential hospitalisation with exacerbated conditions.

Telecare and telehealth are elements which enhance support systems already in place, they do not replace them. For example, for telecare to be effective the individual using the technology needs to be able to proactively use the devices...
and needs to have a social network of support either in place or developed.\textsuperscript{227,228}

In East Sussex, the number of clients being supported by Telecare increased from 3,900 in April 2014 to 4,500 in March 2015. Approximately 80\% of clients also had additional equipment such as door and bed sensors installed. These alert to a 24/7 call monitoring centre if people fall, wander or have an accident at home. Clients report that they feel more confident living independently at home with the support of Telecare.

Adult Social Care are currently trialling new personal locator devices for people with dementia or short term memory loss to help to locate them quickly if they wander. One of our pilot schemes is being run in partnership with Sussex Police and aims to assist people to live safely, providing peace of mind to families.

A Telecheck service has also been commissioned locally. This provides reassuring telephone calls for clients who need support to live independently, particularly older and disabled people, and people with long term conditions who are vulnerable, isolated or lonely.

In 2014/15:

- 172 clients were supported by the service.
- The service supported an average of 97 people every month.
- Each client received an average of 47 call checks per month.

The service has been supporting people through regular call checks, which can:

- Provide a range of reminders to eat, drink or take medication.
- Motivate people to engage with other services and community resources to reduce social isolation.
- Promote client’s sense of security to stay in their own homes.
- Motivate health improvements.
- Support carers and reduce the need for respite care.

Clients report that they await regular check calls, noting that they have their medication ready, and enjoy the opportunity for a brief chat. The Telecheck service was a finalist in the July 2015 Sussex Collaborative Innovation Awards.

Through the East Sussex Better Together primary prevention, self-care and self-management workstream we are exploring a phased approach to commissioning telehealth in East Sussex. The programme aims to deliver:

- Increase access to care for people with remote access from place of residence.
- Improve self-management by supporting newly diagnosed patients to make changes to their day to day living (e.g. diet, exercise, medication).
- Enable people to receive the care that meets their needs in a way that they choose.
- Enable the existing workforce to focus time, maximising face to face clinical contact.
- Increase people’s confidence and knowledge of their condition.
- Improved data monitoring for patients with LTC.
Know Your Own Health is a digital healthcare business providing a platform for self-management support through health coaching. It aims to enable patients to have the skills, knowledge and expertise to make positive choices about their health and healthcare and to make long-term positive changes to health behaviours. Helping people to transition from a ‘passive’ position, where they are dependent on a clinician to prescribe treatments or medicines, to a proactive and ‘activated’ position involves the provision of a range of things to help them. This service is being trialled locally to support patients to be less dependent on health services and medications and capable and confident enough to take greater control of their own condition. It provides:

- Support people to identify the tools and skills they could use to self-manage.
- Personalise the local support options for people that integrate with their other self-management activities.

The service also works with service providers to enable partners to work together to deliver personalised self-management support across large populations.

**Community Pharmacies**

The NHS Five Year Forward View describes how we need to make greater use of pharmacists, including in prevention and support for healthy living and in support to self-care for minor ailments and long term conditions. Pharmacists have an increasing role in providing self-care advice with many pharmacy-led minor ailment (for example, coughs, colds, sore throats and earaches) schemes throughout the country providing information and advice on when to seek professional help and assisting people’s skills and knowledge to manage their own health by promoting healthier lifestyles.

By supporting self-care and treating minor illnesses, community pharmacies play an important role in building personal resilience by increasing choice and improving access to services, and supporting self-management and confidence by patients becoming experts in their condition and knowing when to manage their own health and how to use their medication effectively. This is particularly important because evidence shows that improving medicine-taking could have a far greater impact on health outcomes than improvements in treatments. Approximately 9 in 10 people are aware that the pharmacist can offer advice on treatment, symptoms and medicines for minor ailments and LTCs.
sale of medicines. Above the provision of general advice and dispensing services, a high proportion of pharmacies in East Sussex provide additional services. Through these they provide support to people with LTCs in the management of their medicines. The aim of these services is to increase individual’s understanding of the importance of taking prescribed medication, addressing concerns around side effects and interactions and giving individual’s the opportunity to take control of their own health.

**Other self-management initiatives**

Across East Sussex there is an increased focus on self-care and self-management and a range of different services to support these approaches are being tested out. In 2015/16 we plan to:

- Develop an East Sussex wide strategy for supporting self-management
- Test out more approaches to support people to self-care
- Report on the success of current self-management initiatives

### Falls prevention

The Otago falls prevention exercise programme was commissioned in October 2013. The service meets the needs of individuals who are experiencing problems with their strength and balance, have experienced two or less falls in the past year, and may also have a fear of falling. Otago programmes are proven to reduce falls and improve strength and balance in people aged 65+, and are particularly effective in individuals aged 80+. Participants are invited to attend hourly sessions once a week, for a period of 16 weeks. During each class, participants practice a range of exercises which they are also encouraged to practice at home twice a week between sessions. At the end of year one, 296 individuals had been referred to the service countywide.

### Personalisation

Self-Directed Support is a keystone of the personalisation agenda. Personalisation means that everyone who receives support, whether provided by statutory services or funded by themselves, has choice and control over the shape of their support in all care settings. It moves away from a 'one size fits all' approach, where people are required to fit into what is provided for them and puts people at the forefront of building care and support that is designed with their full involvement and tailored to meet their own unique needs. It assumes that people are best placed to understand their own needs and how to meet them and hence it helps to promote personal resilience. Irrespective of illness or disability, people are assisted in identifying what support will enable them to live independently, to stay healthy and to recover quickly from illness.

Early identification of need and early help to prevent needs from escalating are at the heart of personalisation, which requires targeted services, to reduce or delay the need for more intensive support, and universal services to build capacity and resilience within individuals and communities. Personalisation includes support for self-management, shared decision making, better information to improve knowledge and understanding, advocacy and advice - including peer support and mentoring, and the promotion of prevention.

Personalisation focuses on building resilience through four key areas:

1. promoting rights and inclusion (through the provision of universal services to support people such as housing, transport, information and advice);
2. strengthening citizen capabilities (through prevention and early intervention to help people live independently at home for as long as possible);
3. family and community development (by fostering strong and supportive communities);
4. self-directed support (by promoting understanding about funding entitlement and allowing people to choose how to spend it) (Figure 21)

Central to personalisation is the co-production of services between commissioners, providers, adults with care and support needs and carers; accessibility of information is key to this to enable individuals and their carers to be equal partners.

**Real wealth**

In Control (an independent network for social innovation) advocates a whole life approach to personalisation (Figure 22) Such an approach supports individuals to self-direct all aspects of their lives, over the whole course of their lives, within the context of community, i.e. the context in which people live their lives. They use the model of ‘real wealth’ as a way of understanding what is important to people and hence what services should acknowledge when thinking about interventions.

Real wealth is the sum total of resources available to an individual including:

- **Connections** - Our family networks, the people we know and socialise with, our extended networks, the groups and people we know in our community and more widely.
- **Capacities** - Our abilities, strengths, skills and those we can draw on from our connections.
- **Access** - Access to knowledge, the physical environment, information, trusted advice and guidance.
- **Assets** - Financial, capital, material wealth.
- **Resilience** - Our physical and mental health, our emotional wellbeing, our inner strength.

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![Figure 21: Four quadrants of personalization](source: Adapted from Crosby et al, 2010)
What lies at the base of ‘real wealth’ is investing in the real wealth of the local population. Hence it is important that local authorities know what is happening in their own area and understand how much of this provides the structure upon which a genuine and united whole life ‘offer’ can be made to its population.242

Figure 23 illustrates the shift in the relationship between services and the person needing support: from the statutory delivery of services to a situation where support is integral to a person’s life; where they can use their entitlement to direct their own support, make their own decisions, and build support systems with family and friends.242,237

Personalisation applies to both adults and children. Whilst initially focussing on social care services, the principles of personalisation are being embedded into a range of other service areas such as health and education.239

Building on the principles of direct payments, personal budgets were introduced so that people could become the purchasers and commissioners of their own care and support.

Personalisation has also shifted the focus of social care to become more outcome focused. Outcome-focused assessments and reviews identify a person’s strengths, capacity and aspirations as well as needs and risks. Working together with the individual and relevant others, the assessment is then used to co-produce a support plan, which considers how their identified needs, goals and aspirations might be met. In this way the assessment process focuses on building personal resilience.243

In 2014, the Care Act enshrined personalisation in statute, making individual wellbeing central to the care and support system as well as the provision of preventive services to help prevent, delay or reduce the development of care and support needs (including carer’s support needs).
Local authorities should actively promote participation in providing interventions that are co-produced with individuals, families, friends, carers and community. ... Such interventions can contribute to developing individual resilience and help promote self-reliance and independence, as well as ensuring that services reflect what the people who use them want.

- Department of Health, Care and Support
Statutory Guidance, 2015

If someone has social care needs, they should be offered self-directed support to help them choose how best to meet their needs. This could include help to employ their own staff to support them, should they wish to do this, to identify the tasks that need to be undertaken and the activities that will facilitate social inclusion.

In short, SDS enables people to achieve the social interactions and self-efficacy necessary to promote their wellbeing and protect them against the risk factors that inhibit personal resilience. People who are entitled to ongoing support from social care will receive a personal budget and if they have continuing health care needs they may also get a personal health budget.

Self-Directed Support

Self-Directed Support (SDS) is the person-centred framework through which personalisation is delivered. Implementation of SDS was developed and supported through the Putting People First Programme. The intention being to work towards a society where everyone can expect the same regard for their independence, opportunities, choice and control, whether they have a long term condition, social care need or mental health issue.

Personal Budgets

A personal budget is money allocated by social services, either adult social care or children’s services, that is available to those with eligible social care needs. Personal budgets are also available for carers to pay for activities that give them time for themselves, opportunities to pursue their own interests, and one off occasional replacement care.
People can choose for the local authority to commission care and support on their behalf or can choose to take a ‘direct payment’\(^{247}\) where the council pays money into their bank account for them to use to buy the support they need. This could involve the person organising the money themselves or arranging for a family member, friend, broker or social worker (indirect payment)\(^{245,246}\) to manage it for them.

A recent annual national survey of over 4,000 carers and people using personal budgets, identified that for three out of four people, personal budgets had improved their dignity, independence, ability to arrange support, their relationships with people paid for support and their quality of life (Figure 24).

Two thirds or more people reported improved mental health, feelings of safety, control over their lives, family and paid relationships, and self-esteem. Better outcomes were reported when people felt fully included in budget setting and support processes.

Experience also plays a part, in that those who had had their budget for longer had better outcomes, as did those who spent their budgets on community or leisure activities and personal assistants instead of ‘traditional services’ demonstrating the importance of personal choice.\(^{248}\)

More than two thirds of carers reported that personal budgets had improved their quality of life, allowed them to continue caring and improved the life of the person they care for. Personal budgets have also been found to improve the resilience of carers by reducing day-to-day stress, increasing choice and control, and improving their relationship with the person they care for.

Carers who report themselves in good health were more likely to report a better quality of life, reduced levels of stress and greater opportunity for paid working or volunteering due to personal budgets.\(^{248}\) As for those in receipt of personal budgets, better outcomes were reported when carers felt included in the process and where the personal budget had been in place for a longer time.\(^{248}\)

**Figure 24:** Where a personal budget has made things “better” or “a lot better”

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity in support</td>
<td>82</td>
</tr>
<tr>
<td>Quality of life</td>
<td>81.4</td>
</tr>
<tr>
<td>Arranging support</td>
<td>79.9</td>
</tr>
<tr>
<td>Independence</td>
<td>78.9</td>
</tr>
<tr>
<td>Relationships with people paid for support</td>
<td>75.9</td>
</tr>
<tr>
<td>Family relationships</td>
<td>74.6</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>73.2</td>
</tr>
<tr>
<td>Feeling safe</td>
<td>72.8</td>
</tr>
<tr>
<td>Control over life</td>
<td>70.6</td>
</tr>
<tr>
<td>Paid relationships</td>
<td>67.8</td>
</tr>
<tr>
<td>Mental Health</td>
<td>66</td>
</tr>
</tbody>
</table>

*Source: In Control, 2014*
For children with special educational needs and disabilities (SEND) personal budgets were introduced alongside Educational, Health and Care plans (EHCPs); all children with an EHCP are entitled to a personal budget. A recent survey of parents/carers of children with SEND found most were positive about the impact of EHC plans or personal budgets on the lives of their children.\textsuperscript{249}

**Personal Health Budgets**

Personal Health Budgets (PHB) are an allocation of money from the NHS to a person with an established health and wellbeing need.\textsuperscript{245} As with funding from social care, PHBs can be used in a variety of ways: to buy care and support services, to access personal assistants, to access community or leisure services, and to buy equipment. They can be managed through a direct payment given to meet the identified needs and health and wellbeing goals identified in the care and support plan.\textsuperscript{241} Being able to easily access support to plan the PHB, particularly regarding information and advice, leads to better outcomes for the individual.\textsuperscript{250}

Personal Health Budgets have been shown to increase personal resilience through: increased independence, improved quality of life, better family relationships, improved self-esteem, positive friendships, mental and physical wellbeing, and increased choice and control. These outcomes are likely to be more positively reported for those on personal health budgets with poor self-reported health.\textsuperscript{250} Carers also report the same benefits as reported for personal budgets and, in addition, that they improve their relationship with family and friends.\textsuperscript{250}

**Reablement**

Recently, reablement has been given increasing focus with funding transferred from the NHS to Local Authorities for its delivery.

Reablement is a short and intensive service (usually between 2–6 weeks) usually delivered in the home, to help people with disabilities and those who are frail or recovering from an illness or injury, to regain the ability to look after themselves. It is about promoting and optimising independent functioning rather than resolving health issues, helping people do as much as possible for themselves rather than doing things for them. The intention is to keep people as independent as possible for as long as possible. Adapting to change, setting goals and taking care of one’s own needs are all factors that contribute to personal resilience.
Research evidence demonstrates that reablement improves wellbeing and independence, prolongs people’s ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care).

Whilst the research evidence about savings to health care is less convincing, the evidence from practice shows that reablement facilitates earlier hospital discharge and reduces hospital readmissions. Enabling people to be independent rather than dependent promotes both individual and community resilience.  

Recovery

In terms of mental health and substance misuse provision, self-directed support fits with the recovery agenda. Working with people in a way that takes account of their lived experience, and fully involves them and the significant others in their life (such as family or support providers) in the process, can enable them to take more control, and focus on what they need to live a fulfilling and satisfying life.

When we ask questions about what people can’t do (their deficits), then the solution is often defined in terms of some service that could make up for that deficit. However, if we ask people about what a ‘good life’ means to them and we consider their own vision, gifts and the possible contribution of all those around them, then we find that a whole range of new possibilities are opened up.

- Broad, R. (2012) Local Area Coordination: From service users to citizens

Recovery is characterised by continual growth and improvement in health and wellbeing but may involve setbacks; as setbacks are a natural part of life, personal resilience becomes a key component of recovery. Optimism and the ability to remain hopeful are essential to personal resilience and the process of recovery.

Self-directed support in East Sussex

In 2014/15, in East Sussex, all adults and older people using social care and receiving long-term community based services (4,482 people) were receiving SDS, as were all carers in receipt of carer-specific services paid through carers grants (3,297), demonstrating that this approach has now been mainstreamed in adult services. In addition, 80% of young people aged 16-25 years supported by the Transitions Service were in receipt of SDS. In this same period 42% (1,183) of adults and older people and 100% of carers (3,297) received direct payments. Table 6 provides a breakdown by client group.

Families in East Sussex can also apply for personal budgets for their children if they are eligible for health and social care services, and arrangements for the use of personal budgets for education support (not including school places) are currently being put in place. In addition, ESCC has published a local offer identifying all the support available to children and families, as well as how to access it, in order to help meet their support needs. About a third of children with Special Educational Needs or a Disability (SEND) are receiving direct payments, which are gradually being rolled out across the county.

As well as introducing structures and processes to implement SDC, a number of parallel developments have taken place including the development of small micro providers able to support needs through more bespoke provision, a personal assistant development project in Hastings and Rother to support people to take a direct payment, and the development of East SussexSpace (an on-line directory) to enable people to access up-to-date information about what is available to meet their support needs. Taking care of one’s own needs is an important part of being resilient. In 2014/15, 43,511 people accessed information and advice through the EastSussexSpace website which has 1,874 services registered.
In the current financial climate, operationalising personalisation can be challenging in that local authorities need to balance promoting and enabling choice against their duty to manage budgets effectively, and to ensure that these are targeted at those with the greatest need.256

However the Government vision for the transformation of social care is not limited to personal budgets or to public services targeted at people eligible for state support, but is also about ‘how people help themselves and each other as individuals, in groups and communities and how they make best use of the resources available for all citizens in their area.’255

The Care Act has a strong focus on helping adults with care and support needs and their carers to tap into local sources of support and social networks with the aim of improving their quality of life (e.g. tackling problems like social isolation) and their access to some of the practical help needed to enable them to live independently.256

To investigate the potential for such support in East Sussex, ESCC has been working with the three Councils for Voluntary Services (CVS) to explore different and imaginative ways of meeting needs and working with local communities. One project that has emerged is the Building Stronger Bridges pilot, targeted at older and disabled people with care and support needs.257 This action-learning project aims to help communities become more resilient by fostering the right conditions for bonds and friendships to grow between people in order to strengthen community networks.

In April 2014, a number of partner organisations were commissioned to both develop existing local good neighbour schemes and establish new ones across six areas: Eastbourne, Hailsham and Seaford North and South; Hastings and Rother East and West; High Weald, Lewes and Havens North and South. In the first year, over 80

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**Table 6: Number and percentage of people receiving long term care in receipt of Direct Payments (as at March 2015)**

<table>
<thead>
<tr>
<th>No. receiving long-term community packages</th>
<th>No. receiving direct payments</th>
<th>% of long-term community-based packages that are direct payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65+</td>
<td>2,490</td>
<td>865</td>
</tr>
<tr>
<td>Physical Support</td>
<td>788</td>
<td>524</td>
</tr>
<tr>
<td>Sensory Support</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Support with Memory and Cognition</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Learning Disability Support</td>
<td>701</td>
<td>190</td>
</tr>
<tr>
<td>Mental Health Support</td>
<td>345</td>
<td>215</td>
</tr>
<tr>
<td>Social Support - Substance Misuse Support</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Social Support - Support for Social Isolation and Other Support</td>
<td>94</td>
<td>57</td>
</tr>
<tr>
<td>Totals</td>
<td>4,482</td>
<td>1,883</td>
</tr>
</tbody>
</table>

*Source: East Sussex County Council Performance and Engagement Unit.*

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ultimately, every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population. Binding together local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training.

- **HM Government (2007) Putting People First**
potential Good Neighbour Schemes have been identified across the county, and 12 are now fully operational and taking referrals from Adult Social Care (ASC) operational teams.\textsuperscript{254,258, 259}

Personal resilience is closely linked to connecting with others in their communities; to develop resilience people need supportive peers and friends, to be accepted, trusted and respected by society. Projects such as Building Stronger Bridges will become ever more important as budgets reduce and the potential demand for services increases as society ages. They are integral to the East Sussex Better Together programme which aims to transform the delivery and commissioning of health and social care provision locally so people receive an integrated service.

The East Sussex Better Together community resilience workstream aims to foster ways of strengthening the links and trust between the formal health and social care system, and the full range of naturally occurring sources of support available to people in their local environments. The development of community support together with establishment of joint assessment processes and joint funding arrangements, mean that East Sussex Better Together has the potential to implement self-directed care more fully. It will also be necessary to design services that enhance resilience, some of the principles being: trust and respect (both in what people say and do); recognising and releasing capabilities; listening to and involving people.\textsuperscript{260}

Rich and diverse communities that welcome the involvement of all their members are perhaps more than an essential ingredient for success. They are the soil in which the seeds of good support and family wealth can produce fruit. We need to see how best to invest in our own society to ensure that we genuinely support success.\textsuperscript{-}


People may want to become more resilient and improve their own health and that of their family, but without support to do so often find it difficult to turn good intentions into sustained action.\textsuperscript{261} With the right support, self-care and self-management can build personal resilience through: better symptom management (leading to reduction in pain, anxiety and tiredness), increased control and confidence (Self-efficacy), increased ability to problem solve, planning and decision making skills, use of supportive resources and active participation of health and wellbeing matters in partnership with practitioners.\textsuperscript{199,262} This can cause slower health deterioration and prevention of complications or other conditions developing, improved feelings of wellbeing, better compliance with interventions, increase in life expectancy and quality of life, and greater independence.\textsuperscript{199,222,263,264}

The evidence highlights the important role of self-directed support in building the personal resilience of people with care and support needs and also that of their carers. It is an approach that is sensitive to the complexity of human life and the need for both self-determination and richer communities. It requires an individual’s financial resources to be connected to all their other resources and strengths as well as those of their wider support network, in order to ensure resilience is built holistically across the individual’s whole life and way of living.

The recommendations are:

1. Robust measures, from routine data sources, need to be identified so that they can be included in the East Sussex Better Together Programme key performance indicators and monitored to assess the extent to which care and support is person-centred.

2. The East Sussex Better Together Programme needs to reinforce the current direction of travel for services to be re-orientated to be person-centred, to be patient/client focused, to promote control, independence and autonomy for the recipient, carers and families, provide choice and be based on a collaborative team philosophy.
HELPING PEOPLE HELP THEMSELVES

SKILLS

HOLISTIC APPROACH

EARLY INTERVENTION

PEER SUPPORT

SOCIAL NETWORKS

AUTONOMY

PERSON-CENTRED APPROACH

SELF-EFFICACY
HELPING PEOPLE HELP THEMSELVES THROUGH PERSONAL AND COMMUNITY RESILIENCE

The communities we live in and the relationships and networks we are part of are all important features of resilience. Personal and community resilience are intertwined because support networks are stronger when made up of resilient individuals, and forming meaningful relationships takes confidence and other personal capabilities. Having a broad and diverse set of networks and relationships is good for individual wellbeing and life chances but is also good for the community as a whole.

Communities are an important setting for building and promoting personal resilience across the life course. Individual resilience is closely related to resilience within the local community, whether that community is place-based or where peoples share a common interest or identity.

As evidenced throughout this report, resilience is the result of individuals being able to interact with their environments and the processes that either promote health and wellbeing or protect them against the influence of risk factors such as poverty or low socio-economic status. Figure 25 outlines some of the key environments and processes which promote resilience as highlighted in this report. It illustrates the inter-relationship between personal characteristics and wider community, societal and organisational influences and enablers of resilience, and illustrates the types of interventions through which personal and community resilience are being strengthened locally.

There is a growing body of evidence showing how elements of an asset, or community centred, approach can lead to an increase in the protective factors in an individual’s resilience across the life course. These protective factors include self-esteem, sense of self-efficacy, autonomy, level of social support and social capital, and opportunities to take on valued social roles. The features of personal resilience linked to community resilience are in turn linked to improved health and wellbeing outcomes.

Public Health England suggests that local leaders, commissioners and service providers should:

- consider how community-centred approaches that build on individual and community assets can become an essential part of local health plans (rather than on the fringes of mainstream practice);
- recognise the scope for action, as there are a diverse range of approaches that can be used, and they are often misunderstood;
- use the ‘family of community-centred approaches’ recently developed by Public Health England as a tool to consider potential options for commissioning health improvement and preventive services;
- involve those at risk of social exclusion in designing and delivering solutions that address inequalities in health;
- celebrate, support and develop volunteering as the bedrock of community action;
- apply existing evidence to the local context, but be prepared to evaluate.

In East Sussex, this is embedded in the approach we are taking through East Sussex Better Together.
The health and social care system is under pressure due to increasing demand from an ageing population, in the context of substantial cuts to funding and increased pressure to significantly reduce costs. In order to continue to improve outcomes for local people we need to transform health and care by taking a more integrated approach.

Significant change is required to meet the financial challenges that we face, including reductions in some services and the provision of other services in new ways. Building and developing personal and community resilience has the potential to alleviate these pressures. Resilience needs to be incorporated into planning and delivery of services as a desired outcome. For example, ensuring services enable and empower individuals to take responsibility.
for their own health, focus on the whole person and address prevention of future health challenges as well as treatment of current conditions.

Services are well placed to engage with patients, or clients, families and carers to influence positive choices and behaviours to improve health and wellbeing as part of their everyday activity. A brief structured conversation with service users, providing consistent simple health benefit messages and tips, then signposting to allow them to follow up any guidance can change the expectations of service users. If every opportunity is taken to do this, there is scope, over time, to change the expectations, health beliefs and behaviours of both clients and staff.

The evidence is clear that supporting self-management can have real benefits for people using the services and their families, and the wider economy. The attitudes and skills of the workforce can have a significant effect on the extent to which people feel engaged and supported. If people are to be more involved in decisions about their care and more active in keeping themselves well, staff need to be able to communicate information effectively and to consider what level of involvement is appropriate for different people.

However, implementing one-off interventions will not make a significant impact on the overall health of the population or on the sustainability of health and social care systems. It is likely to work best when implemented as part of wider system transformation. That is why community resilience is an important workstream under the East Sussex Better Together programme, the large scale transformation programme in East Sussex. It is through the East Sussex Better Together programme that we will need to deliver the transformational shift we need to realise the aspiration for healthy, resilient individuals, communities and services in East Sussex.
Appendix 1: 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.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Key</th>
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<tbody>
<tr>
<td>Devonshire</td>
<td>EW1</td>
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<tr>
<td>Hampden Park</td>
<td>EW2</td>
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<tr>
<td>Langney</td>
<td>EW3</td>
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<tr>
<td>Meads</td>
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<tr>
<td>Old Town Eastbourne</td>
<td>EW5</td>
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<tr>
<td>Ratton</td>
<td>EW6</td>
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<tr>
<td>St Anthony's</td>
<td>EW7</td>
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<tr>
<td>Sovereign</td>
<td>EW8</td>
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<tr>
<td>Upperton</td>
<td>EW9</td>
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<tr>
<th>Ward Name</th>
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<tr>
<td>Lewes Bridge</td>
<td>LW1</td>
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<tr>
<td>Lewes Castle</td>
<td>LW2</td>
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<tr>
<td>Lewes Priory</td>
<td>LW3</td>
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<tr>
<td>East Saltdean and Telscombe Cliffs</td>
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<tr>
<td>Peacehaven East</td>
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<tr>
<td>Peacehaven North</td>
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<td>Peacehaven West</td>
<td>LW7</td>
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<tr>
<td>Newhaven Denton and Meeching</td>
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<tr>
<td>Newhaven Valley</td>
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<tr>
<td>Seaford Central</td>
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<td>Seaford West</td>
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<tr>
<td>Central</td>
<td>RW1</td>
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<tr>
<td>Kewhurst</td>
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<tr>
<td>Old Town Bexhill</td>
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<td>Sackville</td>
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<td>St Marks</td>
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<td>St Michaels</td>
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<td>St Stephens</td>
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<td>Sidley</td>
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<tr>
<td>Bewertung</td>
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<td>Baird</td>
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<td>Braybrooke</td>
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<td>Castle</td>
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<tr>
<td>Central St Leonards</td>
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<td>Conquest</td>
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<td>Gensing</td>
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<td>Hollington</td>
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<td>Maze Hill</td>
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<td>Old Hastings</td>
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<td>Ore</td>
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<td>St Helens</td>
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<td>Silverhill</td>
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<td>Tressell</td>
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<td>West St Leonards</td>
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<td>Wishing Tree</td>
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<tr>
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<td>WW1</td>
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<tr>
<td>Crowborough Jarvis Brook</td>
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<tr>
<td>Crowborough North</td>
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<td>Crowborough St. Johns</td>
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<td>Crowborough West</td>
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<td>Rotherfield</td>
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<td>Hailsham Central and North</td>
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<td>Hailsham East</td>
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<td>Hailsham South and West</td>
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<td>Heathfield East</td>
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<tr>
<td>Heathfield North and Central</td>
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<td>Polegate North</td>
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<td>Polegate South</td>
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<td>Uckfield Central</td>
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<td>Uckfield New Town</td>
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<td>Uckfield North</td>
<td>WW16</td>
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<tr>
<td>Uckfield Ridgewood</td>
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4. MIND (2013) Building resilient communities: Making every contact count for public mental health
6. PHE (2014) Local action on health inequalities: building children and young people’s resilience in schools
21. Newham London (2011) Quid Pro Quo, not status quo: why we need a welfare state that builds resilience
52. Mind (accessed July 2015) How to increase your self esteem
57. MIND and the MHF (2013 Building resilient communities: making every contact count for public mental health
59. Beck and Gregory (2013) Improving the Public’s Health: A resource for local authorities. The King’s Fund
81. ENCARE (accessed 2015) Risk, protective and resilience factors for children
86. Caplan and Grunebaum (1967) Perspectives on primary prevention. In Archives of General Psychiatry
BIBLIOGRAPHY

on Domestic Violence and Sexual Assault; Center for Social Work Research.
91. Barry and Petersen (2014) Promotion of Mental Health and Primary Prevention of Mental Disorders: Priorities for Implementation, evidence Brief
94. Futures without violence (2014) Promising Futures Promoting Resiliency
109. Smoking and mental health. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. 2013
111. Barry and Petersen (2014) Promotion of Mental Health and Primary Prevention of Mental Disorders: Priorities for Implementation, evidence Brief
115. PHE (2014) Briefing for head teachers, governors and staff in education settings on the link between pupil health and wellbeing and attainment.
117. Weare K, Markham W. What do we know about promoting mental health through schools? Promotion & education. 2005;12(3- 4)
BIBLIOGRAPHY


144. National Social Marketing Centre (2012) What role can social marketing play in tackling the social determinants of health inequalities?

145. The National Social Marketing Centre (2011) Big Pocket Guide to using social marketing for behaviour change.


158. PHE (2014) Everybody active every day.


BIBLIOGRAPHY

177. Demakakos, P. et al. Resilience in older age: a depression-related approach
183. Mentoring and Befriending Foundation (2010) Befriending works: building resilience in local communities. A report into an intervention that can help improve health and well-being at all levels of need.
185. Excess winter deaths and morbidity and the health risks associated with cold homes. NICE guidelines [NG6].
186. Older people - independence and mental wellbeing. NICE in development [GID-PH65].
188. DoH, PHE, LGA (2013) Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.
204. ESiF East Sussex demographic projections in brief 2014.
209. Health Foundation (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management.
BIBLIOGRAPHY

231. NHS England (2014) Community pharmacies - helping provide better quality and resilient urgent care: three services for commissioners to consider
235. Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X. Interventions for enhancing medication adherence. A Cochrane Review
237. HM Government (2007) Putting People First: a shared vision and commitment to the transformation of Adult Social Care
238. Local Government Association (2014) Personalisation
240. Personalisation agenda (accessed July 2015) Personalisation for providers: can you afford to bury your head in the sand?
245. In Control (2011) What are the benefits of self-directed support?
246. In Control (2011) What is self-directed support?
266. PHE (2015) A guide to community centred approaches for health and wellbeing
PARTNERSHIP APPROACH DEVELOP ASSETS AUTONOMY HEALTHY BEHAVIOURS HEALTHY SEXUAL CHOICES DIGNITY AUTONOMY MOBILISE RESOURCES SELF-EFFICACY MINDFULNESS CONFIDENCE INDEPENDENCE SOCIAL NETWORKS BUILD SOCIAL CAPITAL SELF ESTEEM POSITIVE PARENTING HERD IMMUNITY SELF CARE PEER SUPPORT STRENGTHEN COPING STRATEGIES SKILLS SCHOOL BASED INTERVENTIONS EARLY DETECTION CARERS SUPPORT HOLISTIC APPROACH REDUCE VULNERABILITY EMPOWERMENT EARLY INTERVENTION IMMUNISATION SUPPORTIVE HOME PERSON-CENTRED APPROACH EMBRACE OPPORTUNITY KNOWLEDGE BEHAVIOUR CHANGE SCREENING SHARED RESPONSIBILITY MANAGE RISKS COPING SKILLS REABLEMENT