NHS
West Essex
Clinical Commissioning Group

NHS West Essex Clinical Commissioning Group

Equality and Diversity Strategy

2016/19

Board approved – November 2015

Introduction

NHS West Essex Clinical Commissioning Group (the CCG) gives an absolute commitment to equality and diversity in respect of the services that we commission for the population of our local area and our staff.

Our Constitution sets out our assurance that we will meet the Public Sector Equality Duty (PSED) and be compliant with the specific duties of the Equality Act 2010.

As Board leads we provide the leadership to drive forward our awareness and understanding of the equality and diversity needs of the population of west Essex in addressing equality and health inequalities; as commissioners, as employers and as local and national system leaders, in creating high quality care for all. We will seek to set an example of best practice as an employer and are committed to offering all staff equality of opportunity. We will ensure that our employment practices are designed to promote diversity and to treat all individuals equally.

This strategy provides the context for our equality objectives for the next three years. Reports on our progress on implementation will be reported to the Executive Committee and thereafter to the Board as part of our organisational development update.

We commend this strategy to the Board.

Dr. Rob Gerlis **Chair**	**Dr. Kamal Bishai** **Vice Chair & Board Clinical Lead for Equality and Diversity**	**Clare Morris** **Chief Officer & Board Executive Lead for Equality and Diversity**

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1. Background

Alongside our values based commitment to 'high quality care for all', sit our legal duties to promote equality. As set out in the NHS England's *Guidance for NHS commissioners on equality and health inequalities legal duties*[1] the CCG plays a key role in addressing equality and health inequalities; as commissioners, as employers and as local and national system leaders, in creating high quality care for all.

The CCG has two separate key duties, one on equality from The Equality Act 2010 and one on health inequalities from The National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

1.1 Equality

The legal obligation in relation to equality relates to:

- Section 149 of the Equality Act 2010 (the Public Sector Equality Duty), and
- The Equality Act 2010 (Specific Duties) Regulations 2011.

The CCG has a legal obligation to have due regard to the need to:

- **Eliminate unlawful discrimination,** harassment and victimisation and any other conduct prohibited by the Act;

- **Advance equality of opportunity** between people who share a protected characteristic and those who do not share it: and

- **Foster good relations** between people who share a protected characteristic and those who do not.

These are often referred to as the three aims of the general equality duty and apply to the following protected characteristics:

- Age
- Disability
- Gender
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sexual orientation
- Marriage and Civil partnership (but only in regards to the first aim – eliminating discrimination and harassment)

[1] Guidance for NHS Commissioners on equality and health inequalities legal duties – NHS England 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/12/hlth-inqual-guid-comms.pdf

The overall aim of the **Public Sector Equality Duty** is to make sure that public authorities take equality into account as part of their decision making processes. It applies to the 'exercise of functions' and includes for example, any decision made, any policy developed, any programme implemented and any practices driving activity. It also applies to functions and services provided by others on behalf of the organisation.

'Having due regard' to the Public Sector Equality Duty (PSED) involves the consideration of the aims of the Duty in a way that is proportionate to the issue at hand.

These duties must be met together with the specific requirements of:-

- Publishing information to demonstrate compliance with the PSED at least annually. The information that must be included relates to people who share a protected characteristic who are:-
    - Employees (unless the CCG employees less than 150 employees);
    - People affected by its policies
- Publishing equality objectives at least every four years, which must be specific and measurable.

1.2 Health Inequalities

The specific legal duties for the CCG from the **The Health and Social Care Act 2012** are to:-

- have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved
- exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (health-related services can be any services which impact on health, including those outside health and social care);
- include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities
- include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities.

'Have regard to the need to reduce' means health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors. This includes accurate record keeping of how the need to reduce health inequalities has been taken into account when making decisions or exercising functions.

The duty must be exercised with rigour and an open mind and should not materialise as an afterthought in the process of reaching a decision.

2. Meeting our legal duties

The CCG could be challenged in several ways on whether the duties have been complied with, including through judicial review. This will test whether a decision was lawful and give a judgement on whether the duty has been complied with. It is likely to rely on evidence including primary documentation, effective governance processes and risk management when reaching a decision.

Robust processes and documentation of compliance with the duty therefore mitigates the risk of any challenge being successful.

Meeting our legal duties are through:-

- fulfilling our Constitutional commitment to meet the Public Sector Equality Duty by:

  - *Being compliant with the specific duties of the Equality Act 2010 in relation to meeting the publication of relevant proportionate information and in setting, reviewing and publishing equality objectives. Publishing annually and revising objectives at least every four years;*
  - *Adopting the Equality Delivery System (EDS) as the framework to review compliance with the Equality Act 2010;*
  - *Appointing an Equality and Diversity Lead on the Board.*

  (extract 5.1.2.2. of the CCG Constitution)

- obtaining annually the information for publication relating to people who share a protected characteristic who are:-

  - employees, (as CCG employs less than 150 people, a decision will be made each year regarding whether to publish the information or obtain and use for internal review)
  - people affected by its policies

- adopting the 'Brown principles'[2] which are also relevant to the health inequalities duty and keeping an adequate record showing the duty has been considered. The principles are that:-

  1. the decision maker must be aware of his / her duty to have 'due regard';
  2. the 'due regard' must be fulfilled before and at the time a particular decision is considered;
  3. the duty must be exercised in substance, with rigour and an open mind;
  4. the duty is non-delegable;
  5. the duty is a continuing one; and
  6. it is good practice to keep an accurate record.

[2] Guidance for NHS Commissioners on equality and health inequalities legal duties – NHS England 2014 - Appendix B http://www.england.nhs.uk/wp-content/uploads/2014/12/hlth-inqual-guid-comms.pdf

- having due regard to the Workforce Race Equality Standard (WRES) – Appendix A.

  For WRES, as an **employe**r we will take account of the NHS Constitution in our decisions and actions. The NHS commits to provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential. Staff have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

  For WRES as a **Commissioner**, through the NHS Standard Contract 2015-16 we must ensure that the provider[3] complies with the WRES standards.

- fulfilling our Constitutional commitment to the need to reduce inequalities by:-

  - *ensuring the Joint Strategic Needs Assessment (JSNA) reflects the differences in our population allowing us to target those communities with poorer health outcomes to reduce health inequalities*
  - *working in partnership with public health and our second tier authorities to ensure we are well informed of where and what our inequalities are and supporting innovative ways in reaching out to those communities with identified poorer health outcomes*
  - *adapting our engagement activities to meet the specific needs of the different patient groups and communities*
  - *ensuring our commissioning and investment decisions evidence the needs identified in the JSNA and our engagement activities.*

  (extract 5.2.6. from the CCG's Constitution)

- considering the following as part of our planning and commissioning processes:-

  - the impact on inequalities as part of all decision making processes, and keeping a record of such processes
  - which dimensions of inequalities are relevant to our work, taking account of how inequalities could be reduced
  - the potential impact that we could have strategically on reducing health inequalities and the application of the duty to our functions.

- providing an explanation in our annual commissioning plan of how we propose to discharge its duty to have regard to the need to reduce inequalities – reference the CCG's Operational Plan 2015/6-7 http://www.westessexccg.nhs.uk/news/docs/news-events/the-library/plans/operational-plan

- providing an assessment in an annual report, of how we have effectively discharged our duty relating the need to have regard to reducing inequalities. http://www.westessexccg.nhs.uk/about-us/library/annual-reports

[3] (does not apply to small providers whose aggregate annual income for the relevant Contract Year in respect of services provided to any NHS commissioners commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200,000.

- following our policies on Equality, Diversity and Human Rights Policy – Service Users, Relatives and Carers and our policy Equality, Diversity and Human Rights Policy for Staff which provide our commitment to ensuring equality and fairness is provided to the local population through the services we commission.

3 Equality Objectives for 2016/19

To ensure that we are meeting our duties there will be development of a number of key areas within our new objectives. These objectives have resulted from the undertaking of the Equality Delivery System 2[4] assessment and an external review by the CCG's Sounding Board (the public and patient engagement group) for Goals 1 and 2 together with the Equality and Diversity Group assessing on Goal 3 and the Board on Goal 4. The equality objectives are provided in headline terms below with the measures of success and timeline in Appendix B.

Goal 1 Better health outcomes for all:

- Increase the diversity of local people involved in the CCG's commissioning.
- Ensure commissioners have up to date data and access to information to inform commissioning decisions.

Goal 2 Improved patient access and experience:

- Enable and support compliance by providers in implementing the Accessible Information Standard.
- Review and improve our own accessible information and communication support.
- Work with partners, improve ease of access and connectivity for the public to the Patient Advisory Liaison Service (PALS) across west Essex health organisations.

Goal 3 Empowered, engaged and included staff:

- Improve our staff's ability to commission services for diverse communities by providing further equalities training.
- Explore equality of access, consistency of request consideration and outcomes for special leave, study leave and flexible working and act on the findings.

Goal 4 Inclusive leadership at all levels:

- Further embed an effective process for equality impact assessments and achieve full mainstreaming into business planning processes.
- Sign up for the Learning Disability Employment Pledge and deliver actions to achieve.
- Achieve the Workforce Race Equality Standard within the CCG.

[4] A refreshed equality delivery system for the NHS EDS2
https://www.england.nhs.uk/?s=equality+and+diversity+2

- Ensure providers comply with the Workforce Race Equality Standard.

The detailed actions for these objectives, the further development of the success measures together with the baseline assessment, key performance indicators and the need for benchmarking data for comparisons will all form part of the Equality and Diversity Group's work programme.

There will in addition be other supporting developments that will take place including for example, the exploration of the experience by vulnerable groups of services that we commission.

These objectives will further support the development in the following strategic areas.

4. Strategic Alignment

4.1 Integrating equality into commissioning

Equality must be an integral part of the way in which informed decisions are made. To be an effective commissioner we need to know who we are commissioning our services for. We need to have insight into local communities and specific health issues from these to help us achieve our vision of working together for a healthier west Essex. We will want to support this information base through local insight and individual practices to build a clear understanding of their communities.

Essex County Council is a source of expertise in using health related data sets to inform commissioning, reducing health inequalities and other variation in the local area, identifying vulnerable populations and marginalised groups and supporting commissioning to meet their needs. Part of this involves awareness of and joint discussions around the wider determinants of health as well as health services. We can contribute to addressing the wider underlying causes in partnership with the Health and Wellbeing Board (HWB), including identifying where the integration of services would improve quality and reduce inequalities and developing commissioning pathways to support such integration.

We use the information gathered from the Joint Strategic Needs Assessment –(pen portrait of equality and diversity and inequalities in west Essex - Appendix C – from which we know that our key priority groups for west Essex have been identified as follows:-

- Those with mental illness ('parity of esteem' agenda)
- Geographical based social inequalities, particularly a focus on Harlow and some parts of Epping Forest
- Loneliness and social isolation – not simply in older people or rural communities but including, for example, new mothers

All service reviews, design and delivery works will be assessed for their impact on communities, taking into account any specific insight or needs already understood or gathered from existing work with diverse communities. We will continue to gather views from our communities to help inform decisions.

Influencing our providers through our community engagement and contractual relationships will be key to ensuring the approach to equality is mainstreamed across health services. We will monitor and establish reporting from all providers on their approach to promoting equalities and ensuring that they are working to reduce health inequalities in their services.

Where we are lead commissioners for providers, we will ensure that they meet the Workforce Race Equality Standard and provide evidence of the compliance with this mandatory requirement.

4.2 Partnership working and Realising Integration Potential

The CCG plays an active role on all the Local Strategic Partnerships across Essex including the Essex Health and Wellbeing and has contributed to the development of action plans focussing on delivering outcomes associated with reducing health inequalities and narrowing the gap in life expectancy. This is particularly on both the use and development of the JSNA and implementing the joint health and wellbeing strategy. The HWB is one way of developing this partnership working to ensure that joint decisions are appropriately assessed and meet any specific needs for the community.

We work together with other public sector organisations to develop and improve services. We will ensure that our transformational programmes have the appropriate equality data and patient insight to understand the impact of their commissioning decisions.

Our integrated care programme aims to address fragmentation, secure sustainable services and deliver better care for local people. The idea is to create a single integrated care system over the next two years bringing together primary, secondary, community, social care, mental health and voluntary care services based on two elements, that is, empowered locality delivery and networks of services or pathways designed around patient needs not organisations.

4.3. Regional Equality and Diversity Network

We will continue to have membership of the Essex Regional Equality and Diversity Network to share best practice and work together on joint equality and diversity developments.

Representatives from NHS Employers, NHS England, South Essex Partnership Trust, North Essex Partnership Foundation Trust, Mid Essex Hospitals and Colchester Hospital University Foundation Trust are represented. The network shares good practice, focuses on areas of joint developments and provides an educational opportunity.

4.4 Equality Impact Assessments

The Equality Act 2010 requires public bodies to consider how the decisions that they make and the services they offer affect people who share different protected characteristics. The specific duties require public bodies to publish information to show they do this.

Our decision making processes on business cases, strategies, plans, policies and procurement processes include the need to be informed by an Equality Impact Assessment.

We have reviewed our process for undertaking equality impact assessments to enable us to understand the potential effect of policies and practices on people with characteristics that have been given protection under the Act, especially in relation to their health outcomes and the experiences of patients, communities and the workforce.

There is still the need to ensure that equality impact assessments are completed in all the required areas and to ensure that this is fully embedded throughout all business and governance processes. The understanding of the value and necessity of having an equality analysis and how this informs our plans, will be reinforced through training and development to our staff.

We will also look to how we can enhance our joint commissioning work with Essex County Council and other commissioners by exploring a joint Equality Impact Assessment to gain together the perspectives from health and social care.

4.5 Workforce data

As an employer we are committed to having a workforce that reflects the diverse communities we serve, ensuring our policies and procedures promote equality and inclusion and that our staff feel confident and capable in their roles and engaged.

Our equality workforce data was collected and published in May 2015 with a repeat exercise planned annually. We will also aim to collect additional information regarding the outcome of recruitment processes and additional information where possible to do so and where within available human resources. This will be on staff recruitment and career development, such as equality data on applications, job offers, training opportunities, retention rates, promotions, disciplinary and grievance proceedings and redundancies, recruitment, attendance figures, retention, success and progression rates.

Data collection has commenced in relation to the Workforce Race Equality Standard with the outcome of the national 2015 staff survey required to enable completion of the data. We will then review this information to see whether there are identified actions.

We will develop and implement talent identification and management programmes aimed at nurturing and encouraging more diverse leadership in the CCG.

We will ensure through our Equality and Diversity training that we educate our staff in relation to equality issues and outcomes. This will include dignity at work, learning and development and recruitment as well as equality impact assessments. We will ensure that our staff feel confident and capable around issues of equality and inclusion and will provide further training programmes on equality, particularly to enable the comprehensive completion of equality impact assessments.

4.6 Operational Plan for 2015/16-17

Our Operational Plan for 2015/16-17[5], which is updated each year, provides our plans to reduce health inequalities and our equality objectives.

Our analysis of the ambition to reduce premature mortality – typically an issue of inequalities – shows that the greatest influences are coronary heart disease, stroke, cancers and respiratory disease which in turn are driven by a high prevalence of lifestyle behaviours, for example smoking and obesity.

It focuses on the implementation of the five most cost effective high impact interventions recommended by the National Audit Officer report on health inequalities – these are on alcohol, blood pressure, cholesterol, tobacco and overweight. It sets out the commissioning strategies to address these, particularly in relation to that undertaken by Essex County Council and our approach to achieving the parity of esteem.

The Operational Plan also sets out each year our commitment to deliver on our Public Sector Equality Duty, our adoption of the Equality Delivery System and our aim to comply with the WRES.

5. Governance and Monitoring

5.1 The CCG's Equality and Diversity Group reports to the Executive Committee and will lead and report on the delivery of this strategy. The membership includes as GP member with representation from transformation, primary care, human resources, communications, governance, public health, quality and contracting and performance.

5.2 It will be through the NHS England CCG assurance framework that includes a focus on equality and reducing inequality, that the CCG will aim to provide to internal and external stakeholders and the wider public confidence that the CCG is operating effectively to commission safe, high quality and sustainable services within the CCGs resources.

6. Risk Areas

The risk areas in our equality assurance and our mitigating actions are:-

- publishing guidance or policies, or making decisions without demonstrating how the CCG has paid due regard to the Duty leaves the organisation open to legal challenge.

  We will ensure that there are robust processes and documentation of compliance with the Duty to mitigate the risk of any challenge being successful.

- Publishing our WRES data which may lead to identification of staff within what is a small organisation

[5] http://www.westessexccg.nhs.uk/news/docs/news-events/the-library/plans/operational-plan

We will produce an annual report showing the results of our staff survey and workforce data for internal analysis but caution will be used regarding wider publication due to Data Protection Act considerations and a decision made at the time as to what will be published externally.

Appendix A

Workforce Race Equality Standard

As an **employer** we will:-

- demonstrate that the CGG is giving due regard to using the indicators contained in the WRES to help improve workplace experiences and representation at all levels within our workforce, for black and minority ethnic (BME) staff and, assurance through the provision of evidence, that our providers are implementing the NHS WRES.
- collect data on our workforce by protected characteristic and in particular by ethnicity both on workforce and staff survey data and will analyse this against each of the WRES metrics.
- approach data analysis with some caution because the number of staff employed is small, with the result that very small changes in numbers on workforce and survey metrics may result in substantial changes in percentage terms.
- produce an annual report showing the results of our staff survey and workforce data for internal analysis but caution will be used regarding wider publication due to Data Protection Act considerations. For 2016 the CCG will be expected to produce a report by May 1st 2016. Notwithstanding data concerns, it may be that BME staff are under-represented in the most senior employed posts within the CCG for which considered actions may result to address.

As a **commissioner** we will ensure that providers for whom we are a lead commissioner will:-

- implement the Equality Delivery System 2
- implement the national WRES and submit an annual report to the co-ordinating commissioner on their progress in implementing that standard.
- abide by and promote awareness of the NHS Constitution including the rights and pledges set out in it
- ensure that all sub-contractors and all staff abide by the NHS Constitution
- carry out staff surveys which must, where required by staff survey guidance, include the appropriate NHS staff survey
- review and provide a written report to us on the results of each survey; identifying any actions reasonably required to be taken by them in response to the survey
- implement those actions as soon as practicable
- apply the principles of good employment practice, the staff pledges and responsibilities outlined in the NHS Constitution and must ensure that all staff are aware of and respect equality and human rights of colleagues, service users, carers and the public.

Appendix B

Equality Objectives for 2016/9

Strategic Priority	Success Measure	Timeframe	
Goal 1 **Better health outcomes for all**			
Increase the diversity of local people involved in CCG's commissioning	Change in membership of commissioning committees; employing different ways in which to seek engagement and acting on information received from public engagement activities and consultations	November 2019	
Ensure commissioners have up to date data and access to information to inform commissioning decisions.	Quality of business cases as assessed by Executive Health and Care Committee which are informed by outcome of equality analysis.	November 2019	
Goal 2 **Improved patient access and experience**			
Enable and support providers in their compliance in implementing the Accessible Information Standard.	Provider achieving standard.	March 2016	
Review and improve our own accessible information and communication support.	Self assessment against the Accessible Information Standard	March 2016	
Improve ease of access and connectivity for the public to the Patient Advisory and Liaison Service (PALS) across west Essex health organisations.	A more proactive PALS service to enable easier access through one point of contact or having less points of contact.	November 2019	
Goal 3 **Empowered, engaged and included staff**			
Improve our staff's ability to commission services for diverse communities by providing training and development.	Quality equality analysis which informs any risk mitigations.	November 2019	
Explore equality of access, consistency of request consideration	Data will inform outcome of actions to demonstrate if equality of access is achieved supported by staff survey outcomes; number of appeals; number of	November 2019	

and outcome for special leave, study leave and flexible working and act on the findings.	grievances		
Goal 4 Inclusive Leadership at all levels			
Further embed effective process for equality impact assessments and achieve mainstreaming in business planning processes.	Quality equality analysis which informs any risk mitigation.	November 2019	
Sign up for Learning Disability Employment Pledge and deliver actions to achieve.	Increased recruitment of people with learning disabilities	November 2019	
Implement the Workforce Race Equality Standard.	Identifying any issues to address within an annual report showing the results of our staff survey and workforce data for internal analysis	May 2016	
Ensure providers implement the Workforce Race Equality Standard	Providers identifying any issues to address within an annual report showing the results of our staff survey and workforce data for internal analysis	May 2016	

Appendix C

Pen Portrait of Equality and Diversity and Inequalities in West Essex

West Essex[6] covers three local authority areas, Epping Forest, Harlow and Uttlesford plus the extra ward of Steeple Bumpstead in Braintree[7], and stretches over an area of approximately 400 square miles.

Epping Forest district is a mixture of rural and urban areas and experiences large inequalities and has varying health needs in different areas. The more rural areas tend to have poorer access to services and the urban areas with high deprivation experience poorer health outcomes and have a large proportion of the population taking part in unhealthy life style behaviour.

Harlow is one of a number of 'new towns' built in the 1950s to provide social housing to people living in London. It is considered to be relatively deprived. The population generally experience poorer health outcomes than the other districts in west Essex and a larger proportion of the population taking part in unhealthy life style behaviour.

Uttlesford district is a largely rural area of approximately 250 square miles. Due to the rural nature of the area many parts of the area experience poor access to services. Overall Uttlesford is considered to be quite affluent and compared to the other local authority areas in west Essex has better health outcomes and more people taking part in healthy life style behaviours.

West Essex CCG currently has a population of 295,597 (2014), with an over 65 population of 53,736. The total population is expected to grow by 5.34% by 2019, 10.88% by 2024 and 20.79% by 2034.

The over 65 cohort is expected to experience a more substantial increase in the same time period (10.25% in 5 years, 23.24% in 10 years, & 57.02% within 20 years). This means that by 2034 there will be an extra 30,642 older people in west Essex.

The population of west Essex is less ethnically diverse than the England average. Harlow and Epping Forest have the highest and second highest reported diversity in Essex; Uttlesford is among the lowest. 'Asian / Asian British' represent the second largest ethnic group after 'White'.

Harlow has the highest proportion of people reporting no religious beliefs. Christianity is the largest reported religious belief. Epping has the highest proportion of people from religious minority groups. Epping has a comparatively high Jewish population.

All three districts have rates of people expressing no limited activities better than the England average and fewer people reporting activities are limited a lot; this definition is likely to be broader than that of disabilities.

[6] Throughout this document West Essex is used to refer to the area served by the NHS West Essex CCG, including the ward in Braintree, while west Essex refers to the area covered by the three districts of Epping Forest DC, Harlow DC and Uttlesford DC.

[7] When comparing information at a district level the ward of Bumpstead is not included unless stated.

Information on the remaining protected characteristics – where available - will be published as part of the upcoming 'Groups at risk of disadvantage in Essex' JSNA. For the latest data please refer to Essex Insight for thematic and location JSNA products.
http://www.essexinsight.org.uk/mainmenu.aspx?cookieCheck=true

In addition to the protected characteristics, West Essex CCG acknowledges that there are other inequalities that have an impact on access and or outcomes. These may be 'place' based, for example Harlow and some locations in Epping Forest which have higher levels of deprivation, or issues of rural deprivation in Uttlesford. Or they may be 'people' based, for example gypsies and travellers, homelessness, prisoners and ex-offenders, those where English is not their first language, veterans, those with substance misuse or those who smoke, looked after children or low levels of literacy.

There are life expectancy differences for a variety of characteristics but not all are quantified and regularly reported. Life expectancy is higher for women than for men. The average life expectancy for west Essex is above the England average with 80.1 years for males and 83.7 years for females for 2010 -12 (most up to date release). Within west Essex, mortality rates have largely improved steadily over the last ten years, although the rate of improvement has tended to be faster for males. Circulatory diseases (including stroke and heart disease) remain the most common cause of death with cancer a close second.

There are geographic variations in life expectancy – between and within the districts that make up west Essex. Harlow men have the lowest life expectancy across all of the three districts in west Essex and the lowest across the whole of Essex County Council. The life expectancy for men and women in Harlow is 78.4 years and 83.0 years respectively. The life expectancy for men in Epping Forest in was 80.8 years and for women 83.9 years. Life expectancy for men and women in Uttlesford is statistically higher than national average – 82.8 years and 85.4 years respectively.

There is a variation in life expectancy between the least and most deprived in each district (2011-2013 data). There is a 5.3 years and a 4.6 years gap in life expectancy between the most and least deprived communities in Harlow (men and women respectively, this is a narrowing from previous period). For Epping it is 5.3 years and 4.6 years for men and women respectively (slight widening of the gap compared to last period). In Uttlesford life expectancy in men and? women is higher in the least deprived areas than in the most.

West Essex has some of the most affluent and some of the most deprived areas in the country. The Index of Multiple Deprivation (IMD, 2010)[8] ranks Harlow as the 95th most deprived area out of 326 local authorities in England (where 1 is the most deprived). This puts Harlow in the bottom 30% of most deprived local authorities in England. Uttlesford is ranked 312th, putting it in the 5% least deprived local authorities in England, while Epping Forest is ranked 209th. The IMD will be updated this year.

Only a small proportion of people in west Essex live in the most deprived 20% of the national population. Harlow has the majority of its population living in the second most deprived 20% whilst Uttlesford has the majority living in the least deprived 20%; Epping's population is more equally distributed.

[8] Communities and Local Government (2010). Indices of Multiple Deprivation 2010.

There are also deprivation differences for 'people' based groups across the geography of Essex. Overall income deprivation is concentrated on Harlow with some locations in Epping Forest. For deprivation affecting children and older people, there are more concentrated areas within Harlow and Epping plus a few areas within Uttlesford.

Information on other groups can be found on Essex Insight and includes veterans (search Armed Forces JSNA, 2015), child poverty (2014), homelessness (2014), autism, (2013), loneliness and social isolation (2013), vulnerable children (2012), learning disabilities (2011), substance misuse (2010), Gypsies and Travellers (Mid Essex only, 2009) Please note that some of these reports may be out of date.

Key Health Inequalities

We are responsible for improving the health of all the population we serve. This requires a focus on the needs of both deprived and excluded groups, but also more universal outcomes to improve the health of the population as a whole. While the health of the population in many areas across Essex is generally good, there are still too many people in all areas dying early from conditions such as heart disease and stroke, suffering from mental health issues and/or at increased risk of diseases due to poor lifestyle choices around smoking, physical activity, diet and risky behaviours with respect to sexual health and substance misuse. We therefore need to introduce a range of interventions that improve the health of the wider population as well as focused early interventions that will provide better opportunities for health improvement in socially deprived and excluded groups.

We will work closely with partners to target health and wellbeing programmes in those communities that demonstrate the greatest inequalities. Using the evidence from a range of sources including the Joint Strategic Needs Assessment, Health Needs Assessments and social marketing insight reports, commissioning intentions will be systematically targeted where need has been identified as greatest.

Key priority groups for west Essex have been identified as follows:-

- Those with mental illness ('parity of esteem' agenda)
- Geographical based social inequalities, particularly a focus on Harlow and some parts of Epping Forest
- Loneliness and social isolation – not simply in older people or rural communities but including eg new mothers