Essex Joint Strategic Needs Assessment – Countywide Report 2013

Executive Summary

Essex Population and Health Determinants

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

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

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

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

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

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

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

Community cohesion cannot be maintained without balancing the need for targeted and universal interventions and explicitly addressing the socioeconomic wellbeing of communities, including

engaging with young people, enabling social inclusion for marginalised groups and instilling a sense of localism.

Health, Community Wellbeing and Inequalities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children, Young People and Families

Early & Effective support for Children

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

Maternal and Infant Health and Wellbeing

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

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

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

Early Years development

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

Family Environment

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

Educational achievement

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

Lifestyle Issues

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

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

Child and Adolescent Mental Health and Wellbeing

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

Children with Disabilities

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

Young Carers

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

Crime and Young People

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

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

Children at Risk and Safeguarding Issues

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

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

county with four or more vulnerabilities, with a greater concentration of these families in deprived areas.

Adults and Vulnerable Groups

Working Age Population

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key Issues

Social and Economic Factors

Population Growth

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

Deprivation

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

Educational Attainment

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

Impact of Economic Downturn

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

Stresses on Family Life

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

Stresses on Communities

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

Life Expectancy Gap

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

Behavioural Factors

Smoking

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

Younger men and women in routine and manual groups as well as teenagers are most likely to smoke.

Diet and Exercise

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

Alcohol

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

Safeguarding

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

Immunisation

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

Services

Access to Services

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

Satisfaction with Services

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

Integrating Health and Social Care Systems

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

Balance between Community and Secondary Services

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

1. Essex Population and Health Determinants

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

1.1 Population of Essex

Profile

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

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

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

Projections

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

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

Ethnicity and Sexual Orientation

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

The 2011 Census tell us that Essex is home to 181,300 residents from BME groups (including Irish, Gypsy or Irish Traveller and other white). There are 116,600 residents from ethnic groups other than white and 64,700 from white minority groups. The BME groups made up 10.5% of Essex residents (9.2% in Essex County Council area), which is less than the England average (20.2%).

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

According to the 2011 census[8], the highest concentration of ethnic minorities (including white other, irish and traveller) is in the young population, specifically people aged 0 to 24 (4%) and 25 to 49 (5%).

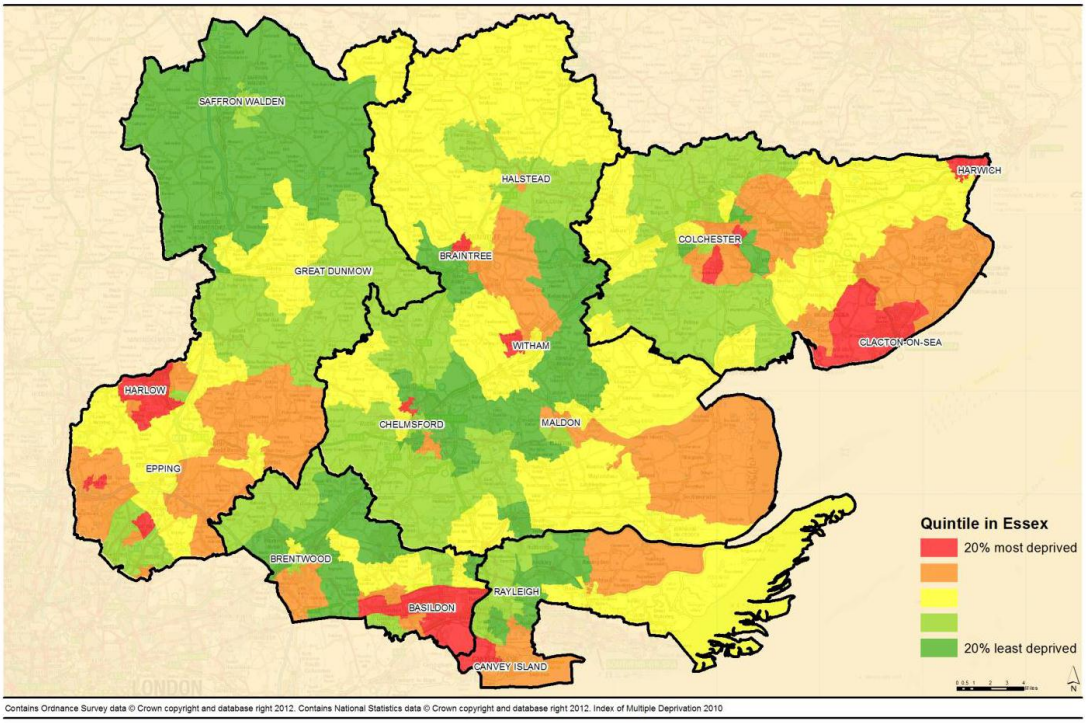
It is becoming more customary for gypsy and travelling families to live in more formal style of housing. Of people living in caravans, most are on authorised public or private sites and around 20% are on unauthorised sites. Whilst the trend in unauthorised encampments and trespass has diminished over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

1.2 Deprivation and Wider Impact on Population

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

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

Deprivation in Essex



1.3 Employment and Aspirations

GDP

Last year, GDP was estimated to be about four percentage points below what it would have been on pre-recession growth trends. GDP is estimated to have been flat between 2011 and 2012[9], and latest figures suggest that it is still 2.5% below the 2008 peak.[10]

Given issues around the scale of both public and private debt, consequent falls in the level of aggregate demand, and liquidity problems in the financial sector, many commentators expect a long period of low growth ahead. However growth of GDP in the third quarter of 0.8% seems to suggest that UK's economy is beginning to recover.[11]

Labour Market

Recent national analysis of labour market conditions[12] indicates that from May to July 2013 employment rate for those aged from 16 to 64 was 71.6%, up 0.2 percentage points from February to April 2013 and up 0.4 from a year earlier.

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

Full time and permanent jobs reduced in number and the number of part time and temporary jobs rose correspondingly. More recently, the labour market has shown only a modest recovery, with employment rising by less than in previous recoveries from recession. The labour market has also adjusted to the recession through slower earnings growth.

Earnings continue to rise slowly with a 1.1% rise (including bonuses) over May to July 2013 when compared to the same period in the previous year. The Bank of England's inflation forecasts for the next three years, based on market interest rate expectations, show a probability of Consumer Pricing Index (CPI) inflation remaining above 2%. The Bank of England Committee's best collective judgement is that the average probability of inflation 18 to 24 months ahead being at or above the 2.5% knockout is less than 50% [13] These changes in the structure of the labour market if they persist over a period of sluggish economic growth may create some stresses for households in Essex in terms of lower earnings and job instability. The Consumer Prices Index (CPI) grew by 2.7% in the year to August 2013, down from 2.8% in July. The largest contributions to the fall in the rate came from the transport (particularly motor fuels and air transport) and clothing sectors. These were partially offset by an upward contribution from furniture, household equipment & maintenance.

Unemployment Level

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

Unemployment rates have risen sharply since the end of 2008 as the UK economy has gone into recession. The rate in Essex[14] (7.3%) is above the average for the Eastern region (6.6%), but was below the UK average (7.8%) as of March 2013.

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

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

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

Qualifications and Skills

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

As a result, skills in Essex[15] tend to be lower than elsewhere, with the percentage with higher skills levels (NVQ4+) being much lower than the national average (28.1% and 34.4% retrospectively). Those with no qualifications present the biggest concern and at a district level, in 2012 Harlow

(15.9%) and Tendring (15.4%) have the highest proportions of people without qualifications and these are also the more deprived districts in the county. Conversely, Harlow also has the second biggest proportion of people with NVQ 4+ (34.7% vs. Essex 28.1%) and Colchester the biggest (37.5%).

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

Mental Health and Employment

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

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

Migration and Welfare reform

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

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

Colchester has seen the biggest net international migration, followed by Chelmsford and Epping Forest. Colchester has also seen the biggest increase of in migration (an increase of 19%), whereas Chelmsford has seen a small decrease (-1%). [17]

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

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

1.4 Access to Services and Transport

Access to services, regardless of the purpose (eg to work, hospital, educational establishment, recreational activities), is closely linked to transportation. The chosen modes of travel (walking,

cycling or motorised) can vary according to people's means (can they afford a car or bus fare), their personal mobility (are they able to walk or cycle) and the availability of public or alternative transport. It is also important to note that lack of transport may not always be a factor in addressing inequity in access to services, as issues such as homelessness and lack of information also have an effect.

Impact on Community Health and Wellbeing

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

This over dependence has increased the volume of traffic in the UK over the last ten years by 6.2%. Provisional estimates for the second quarter of 2013 show that traffic volumes increased on all road types when compared to the same quarter in 2012. However, traffic volumes were still lower than in 2007, before the downward trend began.[18] In Essex, the same pattern is seen with traffic volume rising over the last year[19] but reaming lower than 2007. Increased traffic volume causes long delays and impacts on air quality with an increase in carbon dioxide emissions, which can have a detrimental effect on people who have respiratory problems.

Generally if you are young and in a good state of health, moderate air pollution levels are unlikely to have any serious short term effects. However, elevated levels and/or long term exposure to air pollution can lead to more serious symptoms and conditions affecting human health. This mainly affects the respiratory and inflammatory systems, but can also lead to more serious conditions such as heart disease and cancer. People with lung or heart conditions may be more susceptible to the effects of air pollution.[20]

Children from the lowest social classes are five times more likely to die in road accidents than those from the highest social class. More than 1 in 4 of child pedestrian/cyclist casualties happen in the 10% most deprived wards[21]. Good accident prevention work must be sustained if we are to reassure parents and encourage young people to walk and cycle more regularly.

Utilisation and Satisfaction with Public Transport

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

Another survey asked to passengers at the point of use[22] found that 79% of Essex Residents were satisfied with the bus services they had used. This was slightly lower than Residents in Kent (84%).

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

1.5 Crime and Community Safety

Crime Rates

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

The latest Crime Survey for England (2012/13) shows that there has been a 9% decrease in crime compared with last years British Crime survey (2011/12). This latest estimate is the lowest since the survey began in 1981 and is now less than half its peak level in 1995. In Essex overall crime has reduced by 5% but burglary (2%) and domestic burglary (12%) have increased.[23]

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

Hate Crime

The term 'hate crime' covers crimes that are driven by hostility or personal hatred because of race, religion, sexuality or disability. Nationally, the number of such crimes referred by the police to the Crown Prosecution Service (CPS) for decision rose from 14133 in 2006/07 to 15519 in 2010/11, ie, by nearly 10%. In 2011/12, the number of hate crime cases referred to the CPS by the police for decision fell by 5.0% to 14,781 from 15,519 the previous year. This is the first year that the number of referrals has fallen since 2006/07[24]. In the Essex CPS area in 2011/12 there were 277 prosecutions, of which 88.1% were successful (1% increase from previous year). Of these prosecutions, 238 involved race or religious hatred, 28 homophobic or transphobic hatred, and 11 hatred of people with disabilities.

Crimes against Older People

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

Fear of Crime

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

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

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

Drug and Alcohol Related Criminality

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

Domestic Abuse

Domestic abuse impacts on both adults and children, and makes up one fifth of all police incidents (29,000)[25]. Around half of these are repeat police incidents, with women most likely to be the victims. It is difficult to determine actual victims of domestic abuse but in 2010 it was estimated that over 35000 females aged 16 to 59 years may have been the victim of domestic abuse with a further 11000 victims of sexual assault in Essex.

Domestic abuse has a detrimental effect on Health and it is estimated that the financial impact of these incidents on the NHS in Essex is £20 million[26].

A violence against women and girls (VAWG) policy was published in 2012 which has set in motion proposals to standardise and rationalise national operating practices. For VAWG this involved addressing charging procedures across VAWG; ensuring domestic violence was a central part of the standard operating practice for magistrates' courts and rolling out Rape and Serious Sexual Offence Units across all Areas in 2013-14. The majority (86%) of crimes grouped under VAWG for performance management purposes are domestic violence with rape at 4.5% and sexual offences, excluding rape, at 9.5%. Overall, VAWG makes up approximately 10% of the CPS workload. In 2012/13 the proportion of successful prosecutions rose to 74.1%, delivering the highest VAWG conviction rates ever. In Essex the number of successful domestic abuse prosecutions has risen to 81.7% in 2012/13, which is higher than the East of England (80.7%).[27]

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

Recent analysis showed that 21% of incidents are witnessed by a child, the same analysis estimated that 18% of these children were known to social care. It is estimated that around one in four children who have witnessed domestic violence suffer from post traumatic stress and have serious social and behavioural problems including school absenteeism, ill health, bullying, anti-social behaviour, drug and alcohol misuse, self-harm and psychosocial impacts (and are 2.5 times more likely to have these problems than children from non-violent backgrounds).[28]

Incidents and Crime involving Young People

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

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

1.6 Poverty and Social Class

All the evidence suggests that social class inequalities persist throughout life and post retirement. Life expectancy is 7.3 years lower for men and 4.9 years lower for women in the most deprived areas of Essex than in the least deprived areas.[29]

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

Home Ownership

Tracker surveys have shown that a higher proportion of Essex residents (75% in 2011[30], 76% in 2013[31]) own their own homes compared to the England average (69%), although commuting patterns into London is also suggesting that Essex's residents are benefitting from higher salaries. Castle Point (89.6%) and Rochford (90.1%) have the highest proportion of households owning their accommodation while Harlow (63.1%) has the lowest. Basildon (11596) has the highest number of local authority dwellings and Braintree (17%) the highest proportion of registered social landlord stock, also known as housing association.

Childhood Poverty

Despite the relative affluence of Essex, 17.1% of children (around 52,500) live in poverty[32]. This proportion is lower than East of England (17.3%) and England (19.6%). In Harlow (23%), Basildon (24%) and Tendring (26%) a quarter of all children are in poverty, the highest proportions in the county. In Tendring's Rush Green and Golf Green wards, the majority of children (over 50%) are estimated to be in poverty. Wards[33] with high levels of child poverty often have high proportions of

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

Additionally, there has been a significant increase in the number of pupils assessed as eligible for Free School Meals over the last 7 years[34]. This is likely to be the result of both increased financial hardship and increased awareness of eligibility. FSM eligibility is particularly high in known areas of deprivation however large increases have been seen in Brentwood, Braintree and Uttlesford.

Evidence suggests that socially disadvantaged groups suffer poorer physical health and lower life expectancy than the more advantaged, have higher incidence and prevalence of acute and chronic illness, and are more likely to smoke and have a poor diet. Children from poorer backgrounds suffer higher rates of accidental injury, infections, failure to thrive, general ill health, anaemia, dental caries and teenage pregnancy. In addition, poorer families are less likely to have access to, and make appropriate use of, health services than those from more advantaged circumstances, and they are less likely to benefit from health promotion services and advice. Collaborative intensive support for families and children with the most need can prevent a decline in their quality of life.[35]

Although the educational attainment of children living in poverty is improving (as it is nationally), there remains a significant gap between the performance of children receiving free school meals and those who do not. On average, pupils receiving free school meals have lower attainment than pupils who do not at each key stage. The gap in attainment at GCSE in those children achieving 5+ A*- C grades in 2012[36] was especially pronounced in Brentwood (35%), Epping Forest (34%), Uttlesford (31%) and Chelmsford (30%). Where local interventions can raise young people's aspirations, this can lead to improvement in educational attainment, reduction in 'planned' teenage pregnancy and better job prospects.

Low Income and Poor Housing

Low income and the rising cost of heating can contribute to high levels of fuel poverty. A recent report by the ONS showed that the proportion of household income accounted for by essentials rose from 19.9% in 2003 to 27.3% a decade later.[37] And a recent report by the Childrens society (2013) showed that over half of all children in the UK who say they are in poverty are living in homes that are too cold and a quarter live in damp or mould-ridden conditions, a new The Children's Society report today reveals.[38]

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

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

1.7 Housing and Environment

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

House prices in the East of England fell by 0.3% over the year to December 2011 although over England as a whole they rose by 0.5%. Most commentators expected prices to level out over the next twelve months, however the average house price has increased by 1.3% over the last year (12/13) bringing the average house price in England and Wales to £164,654. In the East there has been an increase of 0.9%, but Essex has only seen an increase of 0.4% making average house prices at £189,033, which is marginally higher than our comparator neighbour of Kent (184,249) which has seen an annual increase of 1.3%.[39] High house prices can have a detrimental effect on the sustainability of communities, leading to increased levels of homelessness and forcing people on low income to seek housing in poorer condition to facilitate their access to work. Developing affordable housing for first time buyers and low income families will continue to be critical for both urban and rural communities.

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

Ageing Population and Supported Living

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

For the majority of older people, staying in their own home, being cared for by members of their family and dying in their own home are their preferred options. Despite home ownership being fairly high in Essex[40], many cannot afford to adapt their home or keep it in good repair,[41] therefore making this preference difficult to achieve.

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

Fuel Poverty

Fuel poverty occurs when a household needs to spend more than 10% of its income on fuel to maintain satisfactory heating and other energy services. The consequences of fuel poverty include cold and damp homes, reduced quality of life, poor health and debt. Fuel poverty is particularly an issue in rural areas, for instance the north of Uttlesford and Braintree districts and the east of Rochford and Maldon. This is generally because homes in these areas are detached and may offer poor heat insulation, meaning high heating costs.[42]

Waste Management and Recycling

90.8% of Essex's residents indicated in the 2010 tracker survey, that they already recycle as much as possible. The districts where this is highest are Braintree (96.1%), Castle Point (94%) and Harlow (92.9%). The following three areas have rates below 88%, Colchester (87.3%), Maldon (87.5%) and Chelmsford (87.9%). Better education and continued work around raising awareness, especially among children and young people, will provide Essex with a better outlook on recycling.

Carbon Footprint

Although Essex has a relatively low carbon footprint, road transport emissions are high due to the M11 and M25 passing through Uttlesford, Epping Forest and Brentwood. In 2011 Essex produced 6.1 tones of CO2 per person, falling from 7.4 in 2005. Uttlesford produced the highest amount of carbon dioxide per person in the district (10.2) Castlepoint (4.1) and Rochford (4.4) had the lowest levels. With almost 99% of the energy consumption in Essex coming from unsustainable source, realising opportunities in environmental technology are seen as key to improving both the local economy and the environment. [43]

Air Quality

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

1.8 Community Cohesion

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

Attitudes to community cohesion also differ according to how residents rate the local area and local services. Compared with the Essex average of 78%, residents are more likely to think that their area is cohesive if they themselves are satisfied with the area (84%) or the County Council (85%).[44]

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

Socioeconomic wellbeing, the labour market, immigration, housing policy and the economy, all play a significant role in defining the interaction in a given community which can promote community

participation (eg in crime prevention or volunteering), life ambitions (eg seek education and civic responsibilities) and promoting equality (eg race relations, access to services).

1.9 Recommendations to the Health and Wellbeing Board

Population

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

Deprivation and Wider Determinants

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

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

Employment and Aspirations

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

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

Access to Services and Transport

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

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

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

Poverty and Social Class

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

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

Housing and Environment

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

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

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

Community Cohesion

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

2. Health, Community Wellbeing and Inequalities

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

2.1 Life Expectancy and Quality of Life

Causes of Reduced Life Expectancy

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

Trends in Life Expectancy

In Essex, the trend in life expectancy for both males and females is upward, with male life expectancy currently at 79.9 years and at 83.4 years for women (at birth 2009-2011). Life expectancy is 7.3 years lower for men and 4.9 years lower for women in the most deprived areas of Essex than in the least deprived areas.[45]

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

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

Quality of Life

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

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

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

2.2 Mortality and Trends

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

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

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

Cancer

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

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

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

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

There is also an indication that user experience in Mid Essex is poor, as nearly a third of the indicators included in the national cancer patient experience programme are in the lowest 20% of trusts nationally. The reasons for this are worth further investigation.[46]

Cardiovascular Diseases

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

Broad public health and healthcare interventions to address heart disease have contributed to a significant reduction in associated mortality in Essex from 121.6 per 100,000 (1995/97) to 51.8 (2008/10). Higher mortality rates are associated with deprivation with Harlow (57.0), Tendring, (55.9) and Basildon (54.6) all recording higher mortality rates.[47]

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

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

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

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

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

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

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

Chronic Kidney Disease (Renal Failure)
Chronic kidney disease (CKD) is often caused by diabetes or by high blood pressure (hypertension). Since 2007 the number of deaths from chronic renal failure in people of all ages has reduced from 45 deaths in 2007 to 29 deaths in 2010. Between 2007/09, Essex saw 23 deaths from chronic renal failure in people under 75, in 2008/10 there were 20 deaths. Numbers are too small at district level

for any meaningful comparison. With smoking being a key risk factor, it is likely that the high prevalence of this condition persists in the more deprived communities.

Accidents and Suicides

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

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

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

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

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

Excess Seasonal Mortality

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

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

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

Communicable Diseases

Because the number of deaths is small, we can only draw conclusions with caution. Over 2008/10 there were 281 deaths caused by infectious and parasitic disease (4.05 deaths per 100,000). This was

lower than the rate for England (6.56). Similarly all districts of Essex, except Harlow (7.99) had rates lower than England over 2008/10. Basildon(2.69) and-Maldon (2.93) had the lowest mortality rates There was a slight increase in mortality rates for Essex in 2006 and 2007 but the rate has since fallen over 2008/10 . This reduction is possibly as a result of better surveillance and increase in immunisation rates.

2.3 Disease Burden – Prevalence and Hospitalisation

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

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

Cancer Incidence and Prevalence

There are more than 200 types of cancer but breast (most common cancer in women), lung, skin, bowel (colon) and prostate (most common cancer in men) accounted for most new cases (incidence). Risk factors for lung and bowel cancers in men are strongly linked to lower income. However, the opposite is true with breast, prostate and skin cancers, being more common in higher income groups[48] .

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

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

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

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

Cardiovascular Diseases

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

A number of chronic illnesses associated with CVD can prevent people from retaining employment and claim incapacity benefit due to the severity of their illness and/or poor management of their condition. It is also recognised that with an ageing population, Essex will have more people with CVD on the GPs disease registers with increased demand on health and social care services in years to come.

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

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

Diabetes

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

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

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

Chronic Kidney Disease

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

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

Respiratory Diseases

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

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

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

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

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

Liver Disease

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

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

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

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

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

Mental Health

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

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

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

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

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

In a recent report on dementia care in Mid Essex, carers of people with dementia raised concerns over the co-ordination of care, there was also some concern about the understanding that health and social care staff had of their burden. Support from local voluntary groups, such as Alzheimers Society and Action for Family Carers were an essential lifeline. Excellent and innovative pockets of care in Essex were highlighted, including the “My Home Life Essex” programme which focuses on creating a positive culture in care homes by engaging with residents on an emotional level, not just a practical one. Other examples include creative dementia rehabilitation programmes, communal singing, and “Dementia Adventure” holidays. [49]

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

Over 30,000 children aged 5-16 across Essex (10%) are estimated[50] to have a diagnosable mental health disorder while the number of pupils (aged 8-16) with poor emotional wellbeing is estimated[51] at nearly 16,000 (9%). Prevalence rates are higher amongst boys than girls and amongst 11 to 15 year olds when compared to younger children. Mental health difficulties are particularly prevalent among young prisoners, homeless young adults and children in care/care leavers, plus children living in poverty, children who are bullied, those with substance misuse problems, teenage mothers and children whose parents have mental health issues or substance misuse . Poor mental health in childhood affects educational attainment, social skills and physical health. It also increases the likelihood of smoking, alcohol and drug use. There are also wider consequences for later in life as it increases the risk of poorer physical health, unemployment, reduced earnings and criminal activity.

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

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

2.4 Lifestyle Behaviours

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

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

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

The Proportion of adults participating in recommended levels of physical activity[52] in Essex (10.9%) is lower than England (11.2%), however the proportion of people in Uttlesford (14.8%), Maldon

(13.0%), Rochford (12.1%), Epping Forest (12.0%) and Colchester (11.5%) that participate in recommended levels are all above the England Average.

35% of primary pupils in Essex[53] say that they have exercised to the right intensity five or more times in the last week, but just 22% of secondary pupils say this, with both proportions being slightly lower than in 2012 and lower than the national average. Boys are more likely to be exercising frequently than girls and the percentage of pupils exercising five times or more per week decreases as they get older, from 35% in Year 4 to 27% in Year 7 and 16% in Year 11. This year there were no districts with a significantly different percentage of pupils who exercise five times or more. While 84% of primary pupils enjoy physical activities at school, fewer secondary pupils (71%) say the same, with a similar pattern for how much pupils enjoy physical activities outside of school.

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

It is still encouraging that around half of secondary pupils[54] usually walk to school with a third travelling to school by car/van and a third taking the bus. Less encouraging is that just 7% of primary and 3% of secondary pupils cycle to school in Essex. However, in Essex, more people cycled at least once for approximately 30 minutes at moderate intensity per week, males 12.8% (an increase of 2.6%) and females 6.9% (an increase of 1.2%), over 3 years up to 2008/09. It should be noted that areas with the highest level of deprivation, such as Tendring and Harlow, have seen no or very little increase. Generally more men are taking up cycling than women, especially in Colchester (19.6%), Braintree (15.9%) and Maldon (15.7%).

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

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

Diet and Obesity

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

According to 2008/10 data on obesity prevalence, 28.9% of people in Essex are obese. This is higher than both the East of England (24.3%) and the national average (25.8%). Out of the districts/boroughs, the estimates suggest that Harlow (31.1%), Castle Point (27.3%) and Braintree

(26.7%) have the highest prevalence. The lowest prevalence areas are Brentwood (19.4%), Uttlesford (21.7%) and Epping Forest (22.4%).

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

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

However, the 2011 NCMP lifestyle statistics data (LB0I 11.9) indicates that this is much lower. In reception year (children aged 4 to 5 years) obesity for England is 9.4%. Maldon (11.0%), Tendring (10.9%), Chelmsford (10.7%) and Harlow (10.4%) were all above this rate. The NCMP data also shows that 17.3% of year 6 children in Essex were Obese[55], which was significantly better than the England average (19.2). Harlow (20.8) and Castle point (20.4) had the highest proportion of children classified as obese but this was not significantly different from England. We now have several years of data but there are no clear trends in prevalence at local level.

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

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

Smoking and Tobacco Control

Smoking is the UK's single greatest cause of preventable illness and early death. Nationally, the prevalence of cigarette smoking in the adult population was estimated at 20% in 2011/12[56] Data from the 2011/12 Integrated Household Survey, indicates that Essex (18.7%) has a smoking prevalence lower than both regional (19.6%) and national (20%) estimates.

Overall in Essex it is estimated that 25.1% of the 20% most deprived communities smoke compared to only 17.5% in the remaining 80% of the population[57]. The prevalence is estimated to be as high as 33.6% in the most deprived communities of Tendring. Younger men and women in routine and manual groups as well as teenagers are most likely to smoke. The smoking prevalence is estimated to be 26.9% in Essex overall.

According to the 2012 SHEU survey[58] 81% of all secondary pupils in Essex say that they have never smoked and just 3.3% say they smoke regularly or every day, a figure that has fallen in the last seven years. There is very little difference in smoking behaviours by gender but there is a significant difference by age as while 97.5% of Year 7 pupils have never smoked, this proportion falls to just 54.5% of those in Year 12.

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

Excessive Alcohol Consumption

2008/09 estimates suggested that adults in Essex were taking part in increasing and higher risk drinking. In 2011/12 binge drinking was highest in West (19.6%) and Mid Essex (20.5 %). North East Essex (18.7%), South East Essex (18.8%) and South West Essex (18.9%) all had rates similar to the East of England (18.3%). This behaviour increases the risk of CVD, cirrhosis, poor mental health, unemployment, accidental injury and death. Factors which can trigger hazardous drinking amongst adults include bereavement, mental stress, physical ill health, loneliness, isolation and loss.

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

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

10% of all secondary pupils in Essex[59] say that they have been drunk at least once in the last four weeks: 4% once, 3% twice and 2% three times or more. This percentage has fallen significantly in the last five years. There is no difference between genders but the percentage of those being drunk increases significantly with age, from just 1% of Year 7 pupils to 32% of Year 12 pupils.

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

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

Alcohol misuse can also contribute to an increase in criminal behaviour. Harlow (10.5 per 1000) had the highest alcohol related crime rate in 2010/11, with Basildon (7.2) and Epping Forest (7.1) also above the regional average (6.2). Rochford (2.7 per 1000 was ranked 10th lowest nationally), Maldon (3.6) and Uttlesford (4.2) were the districts with the lowest recorded alcohol related crime

rates. It is also important to take note of the effect of alcohol abuse on families, with the risk of domestic abuse. Intoxication also increases the risk of accidental injuries, including road traffic incidents.

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

Drug Misuse

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

They are also more likely to be experiencing a range of health and social care related issues and will be linked to a number of services such as Mental Health, Primary Care and other non medical service provision and are frequently also known to criminal justice services due to offending behaviour often associated with this client group.

The Problem Drug Use (PDU) now defined as Opiate and Crack Users (OCU) prevalence estimate for Essex was 4668 people in 2009/10, this estimate fell in 2010/11 to 4556 people[60]. Latest figures from the local data in 2012/13 show that treatment for PDU is highest in Basildon (OCUs 418, others 132) and Colchester (OCUs 370, others 104), whilst Maldon (OCUs 40; others 25) and Uttlesford (OCUs 59; others 25) had the lowest proportion of users in treatment. This is fairly consistent with the previous year end data.

For many young people drug and alcohol use is a part of growing up, but for a small proportion of young people experimental and recreational use becomes problematic. 9% of all secondary pupils in Essex[61] say that they have ever taken drugs, with boys being slightly more likely to say this and with age having a significant impact on behaviour: while 3% of Year 7 pupils say they have taken drugs, this rises to 23% of Year 12 pupils. 39% of pupils who have taken drugs also say that they have been drunk three times or more in the last month, while 55% of those who have been drunk three times or more in the last month have ever taken drugs.

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

Sexual Health

Unprotected sex can lead to STIs, unwanted pregnancy and preventable terminations. The health and social consequences associated with contracting STIs, such as HIV, are enormous to the individual, their relatives and the health economy. HIV sufferers can feel excluded and people are

often so worried about stigmatisation that they avoid checking whether they may have accidentally contracted a STI following unprotected sex.

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

There is a major need in the HIV positive population in Black African women living in the second most deprived areas of Harlow, aged 35 to 44. The prevalence of diagnosed HIV in Harlow exceeds the threshold of 2 per 1000, and general testing of the population for HIV is recommended by NICE, BHIVA and other national organisations. [62]

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

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

Good contraceptive services can keep the demand for terminations low and reduce the risk of teenage pregnancy. Based on information gathered through the Chlamydia screening programme, it is evident that poor sexual health practices prevails in the younger age groups (people under 25 years), across Essex. Just 36% of all secondary pupils in Essex[63] say that lessons on sex and relationships are useful, and the proportion saying this falls significantly from Year 10 onwards. Half of pupils say they would know where to go for advice and/or support on sexual health, although the percentage saying they know where to go increases from 42% in Year 7 to 60% in Year 12.

A study by Healthwatch Essex[64] found that some young people access advice about sexual health on the internet but that this is not always a reliable source. This risk is particularly relevant when considering young people aged 16-25 who are not connected to a school or employment. There are also gaps in sex education for disabled people and for young people with special needs.

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

2.5 Interventions to Reduce Health Inequalities

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

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

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

Early Years and Children

Pre-birth to five are considered key developmental years for a child's health and wellbeing habits and foundations. Parental and in particular maternal characteristics and behaviour during pre-conception, the antenatal period and post birth play key roles in the child's development alongside the general wider determinants of health such as family income, access to health care interventions such as immunisations and access to early education. Our local emphasis on early years' interventions is consistent with the life course approach to tackling inequalities. More targeted services in children's centres have been established, and centres are also focusing on reducing the impact of child poverty.

The main presenting issues for families seen by children's centres in Essex[65] include: poor or inadequate parenting; adult mental health and emotional issues; the impact on children of domestic abuse or parental substance misuse; finding employment; advice/support on benefits and debt management; child behaviour issues; and parental isolation or poor self-esteem. The most common reasons for referrals for targeted support include supporting families with: basic parenting skills, including play; managing challenging behaviour in children; understanding the impact of domestic abuse; emotional and social development; and accessing community services/building support networks.

Nearly 54,000 children under five are currently registered with children's centres in Essex[66], representing 64% of all children under five, although the percentage varies, with the lowest proportion in Uttlesford (48%) and the highest in Harlow (75%) and Tendring (74%). 33% of children under five who are registered with a children's centre have attended an event during a three month period.

Research evidence[67] shows the majority of parents using children's centres in Essex appear to be satisfied with them and the help/advice/service they have received there, and although they generally feel catered for, they would appreciate some additional services. 68% of children's centres inspected were rated by Ofsted as good or outstanding under 'Overall Effectiveness', while none were rated as inadequate. The needs of most families can be met through what is currently on offer at centres, although some gaps in services have been identified. For many, though, the issues are deep-rooted from cycles of poor parenting and counselling could support parents if it were to be made available.

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

Early Identification

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

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

A more comprehensive alcohol pathway is being developed across Essex to ensure that we can identify people who are dependent drinkers as well as consuming harmful levels of alcohol and signpost them to services to help them. The IBA scheme in primary care has been rolled out across Essex, with additional liaison nurses based in acute hospitals to provide timely assessment of people at risk of alcohol abuse.

Community Based Interventions

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

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

Improving Disease Management in Primary Care

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

2.6 Population Protection

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

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

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

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

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

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

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

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

2.7 Recommendations to the Health and Wellbeing Board

Life Expectancy and Quality of Life

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

Cancers

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

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

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

Cardiovascular Diseases

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

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

Respiratory Diseases

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

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

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

Liver Disease

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

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

Diabetes

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

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

Chronic Kidney Disease

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

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

Accidents and Suicides

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

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

Excess Seasonal Mortality

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

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

Mental Health

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

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

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

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

Physical and Recreational Activities

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

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

Diet and Obesity

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

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

Smoking Prevalence

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

Alcohol Misuse

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

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

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

Drug Misuse

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

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

Sexual Health

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

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

Interventions to Reduce Health Inequalities

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

Population Protection

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

3. Children, Young People and Families

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

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

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

For those children whose needs are intensive, a co-ordinated multi-disciplinary approach is usually best, in which a lead professional works closely with the child and family to ensure they receive all the support they require. Children, young people and their families[68] want to be: treated with dignity and not judged or stigmatised; listened to and their opinions respected; given choices and involved in making decisions.

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

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

Children and young people and their parents receiving support from the D-bit wanted the support to continue, either through more targeted or specialised support, or to have support available on hand when families need it, such as through telephone support or drop in facilities. All members of the family appeared to want to be able to talk to someone when they feel they need help, with many wanting to remain in contact with their current workers. [69]

Some children's needs are so great that statutory and /or specialist intervention is required to keep them safe or to ensure their continued development. Examples of specialist services are Children's

Social Care, Child and Adolescent Mental Health Service (CAMHS) Tier 3 and 4 or Youth Offending Service.

3.2 Maternal and Infant Health and Wellbeing

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

The majority of women are judged to be at low risk of developing complications during pregnancy or childbirth, with around 20 to 25% at higher risk. These risks may also include factors such as smoking, diet and substance misuse all of which can contribute to low birth weight and infant mortality. These factors are more prevalent amongst younger pregnant women, especially teenagers. There are an estimated 1,180 young mothers under 20 in Essex[70]. Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health and have lower rates of economic activity in adult life. The health risks to the children of teenage parents include a much higher infant mortality rate (60% higher than older mothers). Teenage mothers are more likely to smoke during pregnancy and are less likely to breastfeed.

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

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

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

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

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

Breastfeeding is an important part of maternal and child health and provides the best start in life for a new born child as well as offering many benefits for mothers. Breastfeeding has an essential role to play in improving the public's health and reducing health inequalities; by preventing disease in both the short and long term, for mother and child. It also supports the development of an intimate and affectionate bond between mother and child.

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

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

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

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

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

A recent survey[71] of maternity services highlighted some areas of concern, including lack of information about new mothers' emotional health (21%), about their physical health (17%) and about infant feeding (13%). Hospital level patient ratings across Essex were poor (between 5.8 to 6.5 out of 10) in comparison to the rest of England. Only 74% of patients felt they were involved in decisions about their care and only 63% reported being treated with 'kindness' and understanding in hospital after birth.

3.3 Early years development

Supporting children and parents during a child's early years of development is key for children's health and wellbeing. Educational attainment is influenced by both the quality of education children

receive and their family's socioeconomic circumstances. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources and has an impact on health and health inequalities. The factors associated with low achievement are eligibility for free school meals, levels of unemployment single parent households, having parents with low educational qualifications and being persistent truants.

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

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

A recent needs assessment of children centre services has revealed a number of gaps in the service and difficulties in obtaining services. For example, a lack of childcare/crèche provision for parents to attend services; uncertainty around the referral criteria and thresholds for other agencies; Long delays in accessing specialist support, or a lack of support, from agencies providing services such as counselling, mental health or SEN support; Joint antenatal and breastfeeding support/advice; Transition to pre-school/nursery settings and schools.[72]

3.4 Family environment and impact on outcomes for children

Poor family environment can have a significant impact on good outcomes for children. Research[73] has suggested that a number of factors such as mental health, behaviour and youth offending etc. are influenced by the quality of the parent-child relationship and by improving this relationship it has a positive impact on outcomes for the child, the family as a whole and society (e.g. the social, health and economic costs of unemployment and poor health). Concerns about finances, lack of employment, the risk of eviction and homelessness alongside families with complex / multiple needs increases the risk of poor outcomes for children.

In Essex there is a growing population of families with younger children and lone parents. The child and young people population is expected to increase by 10% by 2021. An increase will occur across all districts but will be greatest in Colchester. Findings from the Essex Residents' Survey (2013) suggest in comparison with all respondents, people with children in the household are more likely to be concerned about financial issues. In Essex, there are approximately 19,600 families that have dependent children but where no one aged 16 or older in the household is in employment[74].

Supporting parents to reduce their costs and increase their income is therefore important in improving both the family environment and longer-term improved outcomes for children.

Housing and homelessness

There are four groups of children and young people who are at particular risk of poor outcomes resulting from homelessness: those aged 16 to 17 years who are homeless or at risk of homelessness; care leavers aged 18 to 21 years; children of families living in temporary accommodation; and children of families who have been, or are at risk of being, found intentionally homeless by a housing authority. People with children are the biggest priority need identified in applicants eligible for assistance and unintentionally homeless. Additionally there has been a large increase in applicants from lone parents. Over a quarter of all applicants lost their last settled accommodation due to the termination of assured short hold tenancy or accommodation tied to a job which is no longer available.

A total of 1,117 households were accepted as homeless by Essex district councils (excluding Colchester)[75] in the 12 months ending 30/9/2012, up from 1,023 a year earlier. Of these, 799 households had dependent children or a pregnant female within them. Children's social care carries out 500 to 600 joint assessment interviews with housing departments each year, but this is not the full number across the county. In addition there are just under 300 children in care aged 16 or 17 who will require housing support as they leave care and around 400 18-19 year olds known to the Leaving and Aftercare Team[76], many of whom will have housing needs.

Homelessness can significantly increase child vulnerability and care leavers may go into bed and breakfast accommodation increasing their risk of outside influences. Those from disadvantaged backgrounds or who have experienced trauma are at increased risk of homelessness. The main 'trigger' for youth homelessness[77] is the breakdown of family relationships, often compounded by difficulties at school (for 16/17 year olds), overcrowding at home, mental health problems, substance abuse and crime. Up to half of single homeless youths have experienced being looked after. Children who have been excluded from school are 90 times more likely to end up living on the streets than those who stay on and pass exams. Young homeless people often do not get the help they need from local authorities or formal support services but instead get by in hidden homelessness situations such as rough sleeping and squatting. They are more likely to sleep in dangerous places, travel longer distances and have mental health, drug and alcohol problems.

Since 2009, there has been a year on year increase in the number of housing benefit claimants with children[78]; both single claimants (25%) and couples (63%). Basildon, Colchester and Tendring are all areas with high levels of housing benefit claimants that are likely to attract additional families seeking affordable housing.

Welfare reforms are likely to have a greater impact on areas with higher concentrations of benefit claimants and particularly social housing estates and low income areas. This impact will be two fold both in terms of the impact on existing families but also on families migrating to the area seeking affordable housing. Estimates by the Essex Welfare Reform group suggest 1,000 existing households

with children are likely to be affected by the benefit cap; 150 families will see reductions in excess of £600 per month and an estimated 14,200 claimants will be affected by social sector under occupancy and reductions in housing benefit. Disabled children may lose up to £28 per week and reassessment for adult Disability Living Allowance is likely to see a reduction in eligible claimants and young people being found fit for work. This may impact on 'Not in Employment, Education or Training' figures.

Families with multiple needs

Living in a family with multiple needs or a particularly disadvantaged household increases the risk that children in the family will also have a number of different needs[79] and experience difficulty reaching their full potential. This could include; mental health issues, drug and alcohol misuse, poor health, additional educational needs, persistence absences from school leading to poor educational attainment and employability issues, behavioural problems, youth offending and anti-social behaviour and risk of eviction or homelessness.

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

The term 'Toxic Trio' has been used to describe the issues of domestic violence, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people. Analysis was carried out to identify where children may be at increased risk of harm as a result of living in a household where both substance misuse and domestic violence are both present and hot-spots were found in Basildon, Harlow, Central Colchester, Central Chelmsford, Witham, Braintree and Jaywick/Harwich[80]. A further refinement of this analysis should be possible if/when adult mental health service data becomes available.

3.5 Educational attainment and aspiration

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

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

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

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

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

Young People Not in Employment, Education or Training

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

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

3.6 Lifestyle Issues

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

The consumption of alcohol by young people is a growing area of concern. It causes a wide range of problems including increased risk of injury, accidents, risk taking behaviour, cognitive problems and a long term risk to health. Under the influence of alcohol, young people are more likely to indulge in unprotected sex (which can lead to unwanted pregnancies and contracting STIs) and may also be subject to unwanted sexual advances or abuse/rape. Adolescent binge drinking is a risk behaviour associated with significant later adversity and social exclusion[81]. By the time the teenage binge drinkers reach 30 they are 60% more likely to be an alcoholic, nearly twice as likely to have a criminal conviction, 40% more likely to use illegal drugs, 40% more likely to suffer mental health problems and 60% more likely to be homeless. They are also 40% more likely to have suffered accidents, almost four times as likely to have been excluded from school and 30% more likely to have gained no qualifications.

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

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

Pupils who have had a Police warning and those with poor emotional wellbeing are significantly more likely to say that they smoke/drink regularly, have been drunk at least once in the last month or have taken drugs than their peers[82].

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

3.7 Child and Adolescent Mental Health and Wellbeing

In evidence collected as part of the national 'Good childhood Inquiry'[83] positive wellbeing for children was held to depend on good relationships, especially within the family; on a sense of

purpose and achievement; on freedom and autonomy; and on a positive sense of self. Support for parents, valuing all the professions charged with the care of children, and the role of schools, were all felt to be important. Young people highlighted the importance of being free from stress, pressure and worry. Some children and young people explicitly linked pressure to school, the influence of peers, bullying, family expectations and their looks.

Primary pupils report a higher level of overall wellbeing[84] than secondary pupils, with an index score (out of 20) of 14.1 compared to 13.1. This is lower than the scores seen in the 2011 and 2012 surveys and below or in the bottom range of the mean scores from the national Children's Society survey of young people, where the mean scores tend to be between 14 and 16 out of 20 depending on the age group surveyed. (This equates to a score of between 70 and 80 out of 100, which is very much in line with surveys of the wellbeing of adults which have tended to find mean overall life satisfaction scores for adults in the region of 75 out of 100.) Mirroring the national findings, the level of wellbeing is stable during primary years but declines for secondary pupils as they get older and secondary school girls are less happy with life as a whole. Primary pupils in Castle Point appear to have higher wellbeing scores than pupils in other districts, while secondary pupils in Maldon appear to have slightly higher average scores and secondary pupils in Chelmsford appear to have lower scores than average.

The issues of most concern for young people in Essex[85] are bullying and substance misuse, followed by crime/feeling safe and exam stress and jobs. 10% of primary and 6% of secondary pupils[86] say they feel afraid to go to school because of bullying either 'very often' or 'often', similar to national levels. The percentage of pupils saying they are afraid to go to school because of bullying at least sometimes declines with age, from 52% of Year 4 pupils to 24% of Year 7 pupils and 11% of Year 12 pupils. The percentage of primary pupils saying that they feel afraid to go to school because of bullying has shown a continuous decline over the last seven years but the percentage for secondary pupils rose by 2% in 2011 before falling slightly again in the following two years.

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

The 2013 SHEU survey identified that 5% of all primary and 9% of all secondary pupils have poor emotional wellbeing[87], which is very similar to the 2012 survey data. There is little difference between genders at primary school, but secondary girls are ten percentage points more likely than boys to have poor emotional wellbeing and the proportion of all pupils with poor emotional wellbeing shows a steady increase with age, from 6% in Year 4 to 14% in Year 11. The survey

responses have been used to estimate that the number of pupils (aged 8-16) with poor emotional wellbeing in Essex is nearly 16,000. Pupils who are bullied very often are between three and five times more likely to have poor emotional wellbeing than their peers, and this gap has been evident over the last three years. Secondary school young carers are also significantly more likely to have poor emotional wellbeing, while LGBT young people and those not living with their parents also appear to be more likely to have poor emotional wellbeing. Pupils with poor emotional wellbeing have significantly less positive views about their lives than all pupils.

The national evidence highlights the interplay between good parenting, education achievement and lifestyle choices. While we have a wealth of local information to focus our interventions there is a lack of robust data on the prevalence of mental health issues in children and young people as well as a clear understanding of complex needs. However, in Essex, it is estimated that 10% of children aged 5 to 19 years have a diagnosable mental health condition[88] (equating to 25,000 children in Essex) and a further 10% have an emotional or behavioural problem requiring targeted support. These children have a wide range of conditions including clinically significant conduct disorders, self harm, depression, hyperactivity and less common disorders such autistic disorders and eating disorders. Many young people suffer from multiple problems such as bullying and learning difficulties. Prevalence rates are higher among boys than girls and amongst those aged 11 to 15 years compared to younger children. Mental health difficulties are particularly prevalent among young prisoners, homeless young adults and young adults leaving care. Over half of adults with a mental illness will have begun to develop this by the time they were aged 14 years.

During 2012/13, just over 3,400 young people received Tier 2 direct intervention services from ECC provided services or Mind, plus consultation/advice was provided by staff for a further 3,000 children. Around 4,500 young people received Tier 3 interventions during the same period, which equates to 75% of expected numbers according to ChiMat estimates. However, there are substantial difficulties in gaining a basic understanding of the numbers using CAMHS services across Essex. This has made it difficult to identify the characteristics of service users but initial data[89] shows that the main reason for referral to Tier 2 services was conduct disorders, followed by stress/anxiety, attachment problems and anger management problems while the main reasons for young people being referred to Tier 3 services were emotional disorders, anxiety/stress and depression.

Accidental Injuries

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

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

The need for more support for schools in dealing with pupils' emotional wellbeing and mental health difficulties has been identified as a key priority[90] since schools may well be the one stable factor in a child's life and education staff are the professional group with most contact with children who already have, or are developing, mental health difficulties. Also necessary is a

greater focus on family work and earlier intervention, both at an early stage of a child or young person developing mental health problems and a focus on 0-5 years olds with parents who themselves have mental health disorders, learning disabilities, are teenage parents or are affected by domestic violence.

3.8 Children with Disabilities

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

Families of disabled children commonly experience exclusion from ordinary child and family activities, as well as some mainstream and community services, including education, healthcare, leisure activities, transport and housing. Families with disabled children often face high levels of day to day stress and many have high levels of unmet need for support services, which can lead to higher levels of stress and ill health than those experienced by other parents. In particular, families of children with learning disabilities show greater levels of unmet need than those with children who are not disabled. Lowering stress levels in families is important for the wellbeing of the whole family and is also likely to reduce the number of children who require residential placements or who are looked after. Disabled children and their families face challenging times in coping with their physical and/or learning disability, which can increase the risk of experiencing further ill health, unless we gear up universal services and provide additional specialist services to support them. Their needs are unique to them, often complex, and change over time.

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

SENCAN estimates[91] that there are around 4,000 children with severe disabilities aged 0-19 in Essex, but only 1,200 receive a service from social care. There are just under 6,000 school pupils in Essex who have a Statement of Educational Needs[92], accounting for 3.2% of the total pupil population, and the SENCAN pre-school teams have just under 1,000 children aged under 5 on their database[93]. The proportion has gradually risen from 2.7% in 2008, in contrast to the proportion in England which has remained static over the last four years. Just under 600 pupils with a Statement have a physical or sensory impairment, around 850 have behavioural and emotional support needs (BESD) and around 750 have speech and language communication needs. Around 900 have autistic spectrum disorders and just under 2,800 have learning disabilities.

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

Young people with disability often do not access health and social care services readily and we need to better understand why this is the case. For epilepsy admissions in those under 19 years North East Essex had the highest rate (81 per 100,000) in the County, although this was more in line with

regional admission rates (78), West Essex had the lowest rate of admission (51). Better management of this condition can minimise the need for hospital admissions.

3.9 Young Carers

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

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

There are an estimated 13,500 young carers aged 11-18 in Essex who provide care every day to someone, with around 9,000 providing more than one hour of care per day. Although this figure is lower than the 2011 Census data of just over 9,000 carers aged 24 or under in Essex, the Census figure is likely to be an underestimate, given this was dependent on the person completing the questionnaire recognising the caring role of the child or young person. Just over 1,000 young people are supported by young carer groups across the county[94] which is less than 10%. All young carers[95] are significantly more likely to receive free school meals and have special needs and are more likely to be bullied very often, to have had a Police warning and to have poor emotional wellbeing. Secondary young carers are more likely to live with a single parent (and so less likely to live with both parents).

A recent Carers' Needs Assessment[96] in North East Essex estimated that this group made up 2.4% of the carer's population. Nationally it is estimated that of the young carers known to support services, 66% care for parents/step parents (especially in one parent families) while 31% care for their siblings. Notably, 12% of young carers are caring for more than one person. Most of the care provided is in the form of emotional support, domestic support (eg cooking, ironing and general support (eg administering medicines, assisting with mobility, etc), with a relatively small group (18%) involved in providing intimate care (ie washing, dressing, toileting). Young carers in Essex[97] feel that schools should be better at supporting them and being flexible while GPs need to improve their services, including listening to them more and understanding that they have additional responsibilities and needs. They also want to be consulted as carers and listened to by other professionals, including housing, health professionals and social workers - both for them and their cared for.

3.10 Crime and Young People

A number of risk factors can contribute to the likelihood of young people (10 to 17 years) becoming known to the local police and entering the youth justice system. These range from; poor family relationships, poor educational attainment, absenteeism or exclusion from school, associating with offending or risk-taking peers, drugs or alcohol use, mental health issues, accommodation in a high

crime area or temporary accommodation / homelessness, poor communication or comprehension skills, anti-social attitudes or behaviour and thinking skill issues including impulsivity, risk taking and lack of victim empathy. Children who are in care or looked after are over-represented in the youth justice system.

Research[98] suggests that young people who offend have greater health needs than young people in the general population and that access to services tends to be during crisis periods rather than for prevention purposes or resolving health complaints as they occur. These health implications tend to be more severe at the point of receiving a referral order or YRO and worse still when a young person is sentenced to custody. Early intervention and access to mainstream services is seen as important and specialist services should not be necessary if accessed in time[99]. Emphasis should not only be around eliminating or reducing these health concerns but also ensuring wellbeing. Whilst contact with the YOS tends to be for short periods of time, young people who offend often exhibit behaviours and have contact with other statutory authorities e.g. schools and social care who also are also able to help improve outcomes for young people.

There are a number of areas of health concerns which are more prevalent in young people who offend including physical and mental health and substance misuse. Self-harming is more prevalent in young people in custody than in the general population. Approximately a fifth of young people in custody had tried to harm themselves (compared to 7% of the general population), and around a tenth had tried to commit suicide at some point in their lives.[100]

83% of a sample (n=302) of young people interviewed in custody and 90% of questionnaire respondents (n=232) reported having smoked prior to custody.[101] Of the interviewees, 29% felt that their offence was related to drinking and 38% that their offence was related to drugs.

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

In Essex[102] (2012/2013) there are 3,569 offences where a young person aged 10-17 years old has been suspected as having committed the offence; a rate of 26.2 offences per 1000 10-17 year old population[103]. Including 18 year olds this is an additional 924 offences or 29.3 per 1000 10-18 year old population. This includes young people who are in the youth justice system awaiting an outcome which could include being found not guilty at trial and those that have received a sanction. Highest levels of offences are occurring in the North East quadrant[104] (40.1 offences per 1000 10-17

year old population) and Violence against the person and Theft & Handling are the biggest volume crimes where young people have been identified as suspects. Males are over-represented in the YJS and are more likely to be given an in court sanction compared with females who are more likely to receive a pre-court sanction; the difference in this data is statistically significant. There are statistically significant differences in terms of males and females and the mean age which they commit certain offence types (e.g. Criminal damage and Violence against the person). Some outcomes are dependent on the type of offence and age is also a factor. Both of these may be impacted by the number of previous convictions, the type of outcome previously given and seriousness of the offence. Additionally, White British young people commit offences at a statistically significant younger age than those that are BME.

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

3.11 Children at Risk and Safeguarding Issues

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

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

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

Domestic abuse[105] may be so embedded in the daily life of some families that it may not be recognised as domestic abuse and this could be a barrier in seeking help. Information about the impact of domestic abuse on children is largely centred on their emotional wellbeing and development and rarely their experiences. Interventions may assist female victims and their relationship with the perpetrator but often children are not included, may not be given the

opportunity to express how they feel or their relationship with their father may not be incorporated in interventions.

A recent NSPCC national study[106] of 6,195 children and young people showed that in the past 12 months at least 3% of both the under 11 year olds and the 11 to 17 year olds, and 12% of the 18 to 24 year olds had witnessed at least one type of domestic abuse incident. Additionally, 12% of under 11 year olds, 18% of 11 to 17 year olds and 25% of 18 to 24 year olds had said that they had witnessed at least one type of domestic abuse incident during their childhood. Also, 4% of under 11 year olds and 11 to 17 year olds and 6% of 18 to 24 year olds had seen one parent kick, choke or beat up the other parent.

In Essex (2012/13), there were an estimated 5,800[107] domestic abuse offences where children were present in households (although they may not have been in the same room). This is 28% of all domestic abuse offences and an increase of 6% on the previous year. The Community Budget Project in Essex[108] has a number of different strands of which reducing domestic abuse is one of them. The aim is to improve multi-agency working, reducing duplication, improving efficiency and providing improved intelligence to disrupt the activities of perpetrators through management and intervention and support victims and families. Research conducted for Community Budgets project (Nov 2013) suggested that there was a small but statistically significant increase in the risk to the parent identified by the DASH model when the incident was witnessed by a child.

Children known to Children's Social Care

Research by the NSPCC[109] has found that there is a substantial minority of children and young people who are severely maltreated and experiencing abuse at home, in school and in the community, from adults and from peers. Over half of the 4,800 children identified as children in need in Essex had the primary reason[110] of abuse or neglect at initial assessment, 22% had a primary reason of the child's disability/illness and 21% were due to parenting/family issues. Nearly half of the 570 children with a Child Protection Plan had an initial category of abuse[111] as neglect, 24% had emotional abuse as the initial category and 20% had multiple categories.

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

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

Children in need

Nationally, there has been an increase in the number of children in need of 2.5%. In Essex there were 18,882 children in need during 2012-13 (including Southend-on-Sea and Thurrock). The rate in Essex (452.5 per 10,000) was lower than the East of England (536.8) and England (645.8) rate. However, the rate in Thurrock was much higher than both England and the East of England at 780. Similarly the rate in Southend-on-sea (639.9) was higher than the East of England rate[112] . As at July 2013 there were 6,364 open Children's Social Care cases[113] (including Children Looked After and those on a Child Protection Plan) in Essex and 4,624 of these are Children in Need. Disability is a key factor among Children in Need representing 25% (1,136) of the cohort (smaller proportions of children with a disability exist in the general population).

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

The most frequent category of need for CiN is abuse or neglect (58% of the cohort), followed by disability (19%), family dysfunction (9%) and family in acute stress (7%). Disabled children are known to be at greater risk of abuse and neglect[114] and there has been little research investigating how well child protection services respond to disabled children's needs[115].

Child Protection[116]

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

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

Three quarters of children on a child protection plan are under the age of 10 years. Children of dual or multiple heritage are over represented and children of White other ethnicity (including Irish, Gypsy-Roma, Traveller, Eastern European) and Black African ethnicity are underrepresented. These differences may suggest the incidence or reporting detection of child abuse and neglect is lower or

higher in some ethnic groups than others. There is also the possibility that the ethnicity of the child and parents may be impacting upon referral practices and child protection decision-making.

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

Children in Care

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

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

National research shows that children in care are seven times more likely than their peers in the wider population to suffer from mental health problems and also seven times more likely to misuse alcohol or drugs. 20% have a statement of special educational need (compared with 3% of the general population). Young people who were looked after at one point are twice as likely to become teenage parents: 17% of young women leaving care are pregnant or already mothers while 50% of looked after girls are pregnant within two years of leaving care. Young people in care are over represented in the youth justice system (9% are cautioned for, or convicted of, an offence, three times higher than other young people) while about a quarter of adults in prison were looked after as a child. Between a quarter and a third of rough sleepers were looked after at one point in their lives. It is therefore vital that children in care or with a CPP have their needs adequately assessed to ensure the best placement (including fostering) and to provide stability. This would ensure the best outcome for them as well as represent better value for ECC.

In Essex, most children in care are placed in directly provided placements and increasing numbers of children enjoy more stable placements with fewer children experiencing three or more moves within the year. In 2012-13, 68.7% of children in care have been in the same placement for two years but a small proportion (9.2%) of children in care had three or more placements. Stability of placement has been shown to impact positively on young people's experience and children in longer term

placement have positive perceptions about where they live, their social worker and their school. They are also positive about their family and friends contact arrangements and understand their long-term plan. As a priority for 2013-14, work is being carried out to develop permanence plans for children in care early.

Children and young people's happiness appears to vary considerably depending on where they are placed within the county, with children in care in South (83%) significantly more likely to 'really like' their placement compared to those in West (73%). Gaps in happiness are also evident depending on the type of placement the child or young person is in, with those living in residential or hostel provision (51%) or independently living or no longer in care (53%) being significantly less likely to be happy compared to their peers living in foster care (83%) or kinship care (89%).[117]

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

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

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

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

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

Most children in care in Essex[118] feel healthy and well most of the time and most feel they have an adult to talk to when they have a problem, although those in foster placements and kinship care are more likely to feel this than those in residential/school provision, independent living or no longer in care. The majority feel safe in their school/college and where they live and the percentage of children in care who say they have been bullied in school is similar to that of the total school population. Most say that their education is going well and only a few that it is going badly. 60% say that they get help at school/college from a member of staff who is there especially to help children in care (lower than the national average). Up to a third of young people say that they need more help with school/college.

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

Care leavers

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

Care leavers in discussion groups in 2013[119] highlighted a number of things as being essential in order to live independently. These included finance, having emotional wellbeing and health, keeping in contact with family and friends, and having stability.

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

Nationally, the proportion of care leavers not in employment, education or training has fluctuated from 33% (2010-11) to 37% (2011/12) and back down again to 34% (2012/13) and the proportion of young people in education has remained at around 35% for the last three years. However, in Essex has been a 21% reduction in Care Leavers in education, employment and training and the number of Care Leavers NEET continued to rise from 32% in 2010/11 to 45% in 2011/12 and to 50% in 2012/13.

Despite the a high proportion of young people leaving care at the age of 18 as recommended there has been a shift away from education but the number in training and employment has also gone down. The incidence of NEET is higher for girls than for boys and just over half of this is down to parenthood (there has been an increase in the incidence of teenage pregnancy within this cohort).

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

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

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

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

Children and young people in alternative education

The commissioner for alternative education recognises that although the majority of children's educational needs are best met in school, some children, at specific times may need alternative arrangements. The children most likely to need alternative arrangements include those on permanent exclusion, those with illness, anxiety, late pregnancy and early motherhood or other exceptional circumstances. Pro-active 'positive referrals' may also be given for pupils who are at risk of exclusion.

There are currently 4 referral units in the mid, north east, south and west of the county which support a total of 420 pupils (as of September 2013) . The attainment level of these pupils is generally much lower than their peers, with 4.5 % (n=19) achieving 5 GCSE's at A* - C, falling to 3% (n=13) when including English and Maths.

Children missing from care

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

Developing support for children missing from care has been identified as a priority and access to independent interviews are now accessible to all children missing from care on their return.

Child Sexual Exploitation (CSE)

Child sexual exploitation is a form of abuse where a young person receives something, such as money, food and clothing, drugs or alcohol, or attention in exchange for taking part in a sexual act. It is largely hidden and the true scale is unknown. A study conducted by the Children's Commissioner[120] suggests that there are at least 16,000 young people at high risk of sexual exploitation during any one year. The nature of and pathways into CSE are varied involving both face-to-face contact and electronically via the internet or mobile phone, and affects both young males and females. Young people may be unaware that they are being exploited and may feel that they are in a genuine relationship or friendship with their abuser. Children's Social Care are currently carrying out research with young people in Essex to explore their understanding of sexual exploitation and related topics, and their experience of how sex and relationship education in school deals with such topics.

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

3.12 Recommendations to the Health and Wellbeing Board

MATERNAL and INFANT HEALTH

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

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

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

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

EARLY DEVELOPMENT

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

FAMILY ENVIRONMENT

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

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

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

EDUCATION and NEET

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

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

MENTAL HEALTH and BULLYING

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

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

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

CHILDREN WITH DISABILITIES

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

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

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

ACCIDENTAL INJURIES

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

YOUNG CARER'S HEALTH

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

CRIME and YOUNG PEOPLE

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

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

CHILDREN AT RISK and SAFEGUARDING

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

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

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

Improve outcomes for Care leavers

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

4 Adults and Vulnerable groups

4.1 Working Age Population

While generally an area of prosperity, some parts of Essex have high unemployment rates and higher levels of deprivation. Being employed plays a key role in mental and physical wellbeing. However, jobs that are insecure, low paid and that fail to protect employees from stress and danger can contribute to ill health.

The number of people likely to become unemployed in coming months will rise as will the number of long term unemployed in the over 50 population[121].

Work and Health

The impact of poor health or disability on a person's likelihood of finding and keeping a job is significant. Prevalence estimates suggest that in Essex, about 162000 people of working age have a disability of some sort. Nationally only 46% of people with a disability are in work compared to 76% of those without a disability this would equate to 66700 people being unemployed in Essex. This effect can be mitigated by educational qualifications.[122] Recent labour market statistics (2013) suggest that 52% of all people with a long term health problem or disability are in employment, which is a 0.7% increase on the previous year.

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

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

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

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

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

Disability

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

Supported Housing

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

In order to obtain social care provision, people are assessed against the 'Fair Access to Care' (FACS) criteria. FACS is a national eligibility framework that classifies a person's needs as either low, moderate, substantial or critical. In Essex, the council funds services for people who are assessed as having 'Critical or Substantial' needs. As at 31st March 2013 approximately 25500 adults in Essex were being provided with ECC-funded social care support, a quarter of which (6180) were residential services and the remaining 19300 people were given access to community services to support their needs. 79% (4862) of all residential services were provided to adults over the age of 65 compared with 52% (10053) of all community services. Although a lack of suitable housing for people with a physical impairment can lead to admissions into residential care, adults with mental health (3700 non-resi) or physical impairments (2800 non-resi) were more likely to receive community based services than residential services, helping people to maintain their independence for longer.

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

4.2 Learning Disabilities

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

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

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

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

4.3 Physical and Sensory Impairment

Physical disability has far reaching implications not only for a person's own circumstances in terms of healthy living but, depending on the level of disability; there are implications in terms of health and

social care resources. Across Essex, there are estimated to be just over 67500 people of working age with a moderate disability which is estimated to rise to just over 71250 by 2020. In terms of serious physical disability it is estimated that we have 20250 people as at 2012 with this figure expected to rise to over 21500 by 2020. 47% of adults with moderate or serious physical disabilities require personal care assistance which includes getting in and out of bed or a chair, dressing, washing, feeding or use of a toilet.

Mobility and Falls

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

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

Almost two million people in the UK are living with sight loss (vision less than 6/12). By 2020 this number is predicted to increase by 22%. It will double to four million people by the year 2050. These increases are mainly due to the demographics of the population and eye health will be particularly subject to this because over 80% of sight loss occurs in people over 60 years. Visual impairment is another serious debilitating condition that can have implications for a person's health and ability to stay independent. Visual impairments and sight loss can double the likelihood of falls and thus greatly increase the chances of someone losing their independence. Sight loss is associated with age due to conditions such as macular degeneration (MD), cataract and refractive error. It is estimated that the cost to the NHS of falls associated with sight loss is at least £25.1 million per annum [123].

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

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

ECC engages with a number of planning groups which focus on sensory and physical impairments and other issues of relevance to older people and vulnerable groups[124]. These groups have outlined a number of actions to help improve awareness and accessibility of information and services, for example the updating of the 'what next?' booklet for deaf and hard of hearing people and the introduction of hospital translation and interpretation policies. Visual impairment and deaf or hard of hearing awareness training is also a key priority for all front line staff, in all service areas, including

health, education, social care and transport and should include those who work on reception desks in county and district councils.

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

4.4 Adult social care services

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

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

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

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

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

58.5% of service users were satisfied (extremely, very or happy for LD) with care and support services in Essex, this was higher in Thurrock (59.6%) and in Southend (61.9%), satisfaction was also higher for the 18-64 population in both Essex (66.8) and Southend (65.9). [125]

Complaints

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

4.5 Carers

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

Research suggests that the economic value of the contribution made by carers in Essex is £2.4 billion per year which is £45.4 million per week.[126]

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

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

Older Carers

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

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

Essex assessed or reviewed 11009 carers needs during 2012-13, of which 1988 received a carers assessment in their own right. 40% of these assessments were for older carers aged 65 years and over. A carers assessment aims to help a carer access support, which can help them to carry on with their caring role or help them to take a break from caring. Only 36.1% of carers in Essex (not including Thurrock and South-end) said they were very or extremely satisfied when asked how satisfied they were with social services. A higher percentage were satisfied in Thurrock (45.4) and South-end (43.8). In Essex (excluding South-end and Thurrock) higher rates of satisfaction were also found when asking Older Carers (51.1%).[127]

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

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

National research has highlighted the need to support carers and has shown that breaks from caring (through respite and carer's breaks), assistive technology, advocacy, manual handling, training [128] and flexible working[129] can help carers to carry out their caring role. This evidence also shows that interventions work better when they are targeted at the carer and help to address specific groups of carers, such as carers of dementia. They also delay admission into residential care. However, further analysis is needed on how effective this support is in preventing carers from acquiring their own impairments and health problems due to caring.

4.6 Older People

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

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

The living circumstances of older people and people with mental health issues affect both opportunities for social interaction and the need for additional support from formal and informal

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

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

Locating the lonely and socially isolated is key to successfully implementing and developing effective interventions. A model using modelling techniques involving Mosaic Customer Profiling has indicated locations of 15,297 households where there could be a potential "high risk" of isolation with a further 12,973 households at "above average risk" of isolation. [130]

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

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

Areas where there is a higher proportion of the population receiving more than one benefit include Harlow (36%), Tendring (36%) and Thurrock (35%) South-end on sea (34%) and Basildon (34%). Areas where there is a lower proportion include the more affluent areas of Uttlesford (24%), Brentwood (24%) and Chelmsford (24%)[131].

Mental Health

Mental health and dementia account for more years of disability than any other condition, including stroke, cardiovascular disease and cancer. Cases of dementia are expected to double by 2030 and increase rapidly with age. There are nearly 8700 people on GP registers with dementia across Essex. By 2021, the projected increase in prevalence is expected to reach 38%[132].

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

Excess Seasonal Deaths and Flu Immunisation

Excess seasonal deaths are an important public health concern which sees an increase in mortality among people with cardiovascular diseases, from respiratory diseases and amongst older people, mostly during winter but also during heat waves[133]. Links between poor quality housing, fuel poverty

and health are widely recognized. Lower/ higher temperatures, people's lowered resistance to illnesses (due to disease), safety in the home and the incidence and intensity of influenza outbreaks, all contribute to a higher mortality rate during winter.

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

People aged over 65 years and those who are at risk (eg due to chronic illness) are eligible to an annual flu jab. The 2012/13 target for immunisation in those aged 65 was 75%, which is higher than the previous years level of 70%. None of the PCTs achieved this target 72.5% mid essex 71.8% north east, 69.1% southeast Essex, 72.6 (southwest Essex) 70.7%(west Essex). With new strains of viruses emerging and the risk of a flu pandemic, the uptake of flu immunisation must be kept at a high level to ensure protection for our population. [134]

End of Life Care

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

Nursing and Residential Care

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

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

Special Housing Needs

It is estimated that there should be 22236 specialist housing units available to the over 75 population in Essex whilst 15612 were currently provided as at 2012. This is a shortfall of 6624 units. It is estimated that Tendring (1794), Colchester (1096) and Castle Point (1088) have the largest deficits in terms of supported housing requirements. The over 75 years population in Essex is

expected to increase significantly over the next 20 years and if the need for supported housing units follows this trend, it is estimated to increase to 26996 units in 2020 with a potential deficit of over 11384 units.

4.7 Vulnerable Adults

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

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

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

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

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

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

Travelling Families

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

In April 2013, LINks was superseded by Healthwatch Essex which is a new 'consumer champion' for health and social care services. One role of Healthwatch is to reach out into local communities so that it hears and adequately represents a wide range of experiences to both health and social care commissioners. It is hoped that engagement with local communities will help to tackle some of the inequalities experienced by these minorities and other sections of the community.

4.8 Recommendations to the Health and Wellbeing Board

WORK and HEALTH

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

ACCOMMODATION and WELLBEING

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

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

PHYSICAL and SENSORY IMPAIRMENT

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

CARERS HEALTH

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

MENTAL HEALTH and DEMENTIA

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

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

EXCESS SEASONAL MORTALITY

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

SOCIAL CAPITAL

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

VULNERABLE ADULTS

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

TRAVELLING FAMILIES

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

Glossary

ASCOF

Adult Social Care Outcomes Framework

BME

Black and Minority Ethnic groups

CAMHS

Children and Adolescent Mental Health Services

CHD

Coronary Heart Disease

CKD

Chronic Kidney Disease

CLA

Children Looked After

COPD

Chronic Obstructive Pulmonary Disease

CPA

Care Programme Approach

CPI

Consumer Pricing Index

CPP

Child Protection Plan

CPS

Crown Prosecution Service

CVD

Cardio Vascular Disease

DNR

Do Not Resuscitate

ECC

Essex County Council

EDAAT

Essex Drug and Alcohol Action Team

EDAP

Essex Drug and Alcohol Partnership

E-PAG

Essex Patient Advisory Group

FACS

Fair Access to Care

GDP

Gross Domestic Product

HPA

Health Protection Agency

HPV

Human Papillomavirus

IAPT

Increasing Access to Psychological Therapies

IBA

Identification and Brief Advice on alcohol

IMD

Index of Multiple Deprivation

JSA

Job Seeker's Allowance

JSNA

Joint Strategic Needs Assessment

LINks

Local Involvement Networks

MEND

Mind, Exercise, Nutrition, Do it

MMR

Mumps, Measles and Rubella vaccine

MRSA

Methicillin-resistant Staphylococcus aureus

NEET

Not in Education, Employment or Training

NICE

National Institute of Clinical Excellence

NVQ

National Vocational Qualification

OCU

Opiate and Crack Users

OIL

Options for Independent Living

ONS

Office of National Statistics

PCT

Primary Care Trust

PDU

Problem Drug Users

QIPP

Quality, Innovation, Productivity and Prevention

QOF

Quality and Outcomes Framework

SEN

Special Educational Needs

SENCAN

Special Educational Needs and Children with Additional Needs

SHEU

School Health Education Unit

STI

Sexually Transmitted Infections

VAT

Value Added Tax

YEA

Young Essex Assembly

YJS

Youth Justice Service

YOS

References

[1] ONS mid-2012-unformatted-syoa-data-file
[2] Essex Police recorded crime data was obtained in Jul 2013 and therefore may not be comparable to previous years i.e. the number of offences where suspects have been detected may increase with time as cases are solved. Essex Force statistics include Southend-on-Sea and Thurrock UAs but for the purposes of this report Essex excludes the unitary areas.
[3] At the time of this report the latest mid-year ethnicity data was for 2009, therefore Census 2011 data has been used, for age, gender and ethnicity populations. In Essex there are 136,390 young people aged 10 to 17 years, representing 9.8% of the population. Source: Office of National Statistics.
[4] Mid-year 2012 population estimates (ONS)
[5] Population Density 2012 (ONS)
[6] Subnational Population Projections (ONS)
[7] 14 -Essex Joint Strategic Needs Assessment 2012
[8] Nomis based on 2011 census actual
[9] http://www.ons.gov.uk/ons/rel/gva/gross-domestic-product--preliminary-estimate/q4-2012/stb-gross-domestic-product-preliminary-estimate--q4-2012.html N/B subject to revision.
[10] http://www.publicfinance.co.uk/news/2013/10/economic-growth-08-in-third-quarter/?utm_source=Adestra&utm_medium=email&utm_term
[11] http://news.sky.com/story/1159517/uk-economy-gdp-growth-accelerates-to-0-8-percent_original source ONS October 2013
[12] http://www.ons.gov.uk/ons/dcp171778_325094.pdf
[13] http://www.bankofengland.co.uk/publications/Documents/inflationreport/2013/ir13aug3.pdf
[14] http://www.nomisweb.co.uk/reports/lmp/la/1941962833/subreports/ea_time_series/report.aspx ONS Annual Population survey.
[15] http://www.nomisweb.co.uk/reports/lmp/la/1941962833/report.aspx?#wab ONS Annual population survey 2012.
[16] ECC internal data, 2013
[17] 2011 census Mid 2012 Population estimates
[18] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226935/road-traffic-estimates-quarter-2-2013.pdf
[19] http://www.dft.gov.uk/traffic-counts/area.php?region=East+of+England&la=Essex
[20] http://uk-air.defra.gov.uk/air-pollution/effects
[21] Social Exclusion Unit (2003)- Making the connections: Transport and Social Exclusion
[22] http://www.passengerfocus.org.uk/research/publications/bus-passenger-survey-full-report-march-2013
[23] http://www.ons.gov.uk/ons/dcp171778_318761.pdf
[24] http://cps.gov.uk/publications/docs/cps_hate_crime_report_2012.pdf
[25] Essex Police data
[26] The Cost of Domestic Violence (Walby, 2004 - update 2009) from the Summary of NHS evidence base
[27] http://www.cps.gov.uk/publications/docs/cps_vawg_report_2013.pdf
[28] Summary of NHS evidence base
[29] http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50242
[30] Tracker 9
[31] Tracker 11
[32] Source: End Child Poverty (2012). Regional Child Poverty figures.
[33] Source: HMRC: Children in families in receipt of CTC (<60% median income) or IS/JSA. Some figures may not total due to rounding (2010)
[34] Source: Essex County Council. School census Jan 2013 compared with previous years.
[35] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[36] ECC internal data
[37] http://www.theguardian.com/business/2013/oct/30/household-spending-income-fuel-essentials-ons-energy

[38] http://www.childrenssociety.org.uk//sites/default/files/tcs/poverty_commission_2pp_summary_final.pdf
[39] http://www.landregistry.gov.uk/public/house-prices-and-sales
[40] Tracker 11 (2013) and Tracker 9 (2011)
[41] Guidance note: Lifetime Homes Standard – Essex Planning Officers Association (March 2008)
[42] http://www.essexinsight.org.uk/ViewPage.aspx?c=datasetinformation&did=64&v=937 (2007 data)
[43] Department of Energy and climate change_Local Authority CO2 emissions estimates 2011
[44] Tracker 11 (2013)
[45] www.healthprofiles.info
[46] Mid Essex CCG profile
[47] http://www.apho.org.uk/resource/view.aspx?RID=126453
[48] Cancer Incidence UK and National Cancer Intelligence Network (2009): www.ncin.org.uk
[49] Healthwatch Essex (2013) The impact of dementia – a Mid Essex perspective
http://www.healthwatchessex.org.uk/sites/default/files/documents/Exec%20Summary%20-%20Dementia%20HWE%200913.pdf
[50] Estimate based on national research from the ONS (2004).
[51] Estimate based on findings from 2013 SHEU survey of 10,000 pupils across Essex.
[52] Nhs ic Indicator 7.2
[53] 2013 SHEU survey of 10,000 pupils across Essex.
[54] 2013 SHEU survey of 10,000 pupils across Essex.
[55] http://www.apho.org.uk/resource/view.aspx?RID=126453
[56] http://www.tobaccoprofiles.info/tobacco-control#gid/1000110/par/E12000006/ati/102/page/1 - integrated Household survey
[57] East of England Lifestyle survey 2008
[58] 2013 SHEU survey of 10,000 pupils across Essex.
[59] 2013 SHEU survey of 10,000 pupils across Essex.
[60] http://www.nta.nhs.uk/statistics.aspx and https://indicators.ic.nhs.uk/download/LBOI/Data/LBOI_04.06_13_05_V1.xls
[61] 2013 SHEU survey of 10,000 pupils across Essex.
[62] http://www.essexinsight.org.uk/Resource.aspx?ResourceID=740 Sexual Health Needs Assessment.
[63] 2013 SHEU survey of 10,000 pupils across Essex.
[64] Healthwatch Essex (2013) Young people's experience of sexual health services and sex education in Mid Essex
http://www.healthwatchessex.org.uk/sites/default/files/documents/Exec%20Summary%20-%20Sexual%20Health%20HWE%200913.pdf
[65] Information from providers of children's centres in Essex, Children's Centre Needs Assessment 2013.
[66] Internal ECC data from providers of children's centres.
[67] Research carried out by ECC for Children's Centre Needs Assessment 2013.
[68] The Review of Assessment, Referral and Access Routes to Services (2012). ECC.
[69] Summary of feedback from children receiving social care services in Essex May 2013.
[70] Estimate calculated from three years of conception/abortion data 2008-2010.
[71] Maternity Services survey 2010, Care Quality Commission
[72] Children centres needs assessment 2013
[73] O'Connor, T.G. and Scott, S.B.C (2007). Parenting and outcomes for children.
[74] Source: Office of National Statistics. National 2011 Census (Table KS106EW)
[75] Data from Essex district councils.
[76] ECC internal data.
[77] Quilgars, D., Johnsen, S. and Pleace, N. (2008) Youth Homelessness in the UK: http://www.jrf.org.uk/sites/files/jrf/2220-homelessness-young-people.pdf
[78] https://stat-xplore.dwp.gov.uk/
[79] Whole Essex Community Budget. Families with complex needs. Appendix 8
[80] Internal report: Vulnerable Children Index
[81] R M Viner and B Taylor (2007). Adult outcomes of binge drinking in adolescence: findings from a UK national birth cohort.

[82] 2013 SHEU survey of 10,000 pupils across Essex.
[83] The Children's Society (2008). Good Childhood Inquiry.

[84] Using the methodology devised and tested by the Children's Society in parallel to their 'Good Childhood Inquiry' reports.
[85] Young Essex Assembly election survey of 12,000 pupils voting, December 2012.
[86] 2013 SHEU survey of 10,000 pupils across Essex.
[87] Identified as those pupils saying they often feel sad/tearful, and have felt so for over six months.
[88] Estimate based on national research by ONS (2004).
[89] Data from ECC, North Essex Mental Health Partnership Trust and South Essex Mental Health Trust.
[90] Essex Joint Strategic Needs Assessment for Children's Emotional WellBeing and Mental Health, 2013.
[91] Based on 1.2% of the total child population in 2010, the percentage recommended nationally by Together for Disabled Children to estimate the number of disabled children and young people.
[92] ECC internal data from the 2013 January School Census.
[93]ECC internal data as at February 2012.
[94] Young carer group provider monitoring returns, Quarter 4 2011/12 .
[95] 2013 SHEU survey of 10,000 pupils across Essex.
[96] NE Essex Carers' Needs Assessment July 2011
[97] Essex County Council, Internal report on consultation with young carers, 2012.
[98] Macdonald, W. (2006). The health needs of Young Offenders. http://www.ohrn.nhs.uk/resource/Research/PCSysRevYO.pdf [Retrieved June 25,2013]
[99] HM Government (2009). Healthy Children, Safer Communities. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109772.pdf
[100] Jacobson, J., Bhardwa, B., Gyateng, T., Hunter, G., & Hough, M. (2010). *Punishing Disadvantage: a profile of children in custody.* London: Prison Reform Trust.
[101] Galahad SMS Ltd (2004) *Substance misuse and juvenile offenders.* London: Youth Justice Board. http://www.galahad.co.uk/publish/SubstanceMisuseJSEfull.pdf
[102] Essex Police recorded crime data was obtained in Jul 2013 and therefore may not be comparable to previous years i.e. the number of offences where suspects have been detected may increase with time as cases are solved. Essex Force statistics include Southend-on-Sea and Thurrock UAs but for the purposes of this report Essex excludes the unitary areas.
[103] At the time of this report the latest mid-year ethnicity data was for 2009, therefore Census 2011 data has been used, for age, gender and ethnicity populations. In Essex there are 136,390 young people aged 10 to 17 years, representing 9.8% of the population. Source: Office of National Statistics.
[104] Essex County Council (2013 unpublished). Youth Offending Chapter
[105] Stanley N. (2011). Children Experiencing Domestic Violence: A Research Review. http://www.wolvesscb.org.uk/files/useful_links_and_publications/RIP%20-%20Children%20Experiencing%20Domestic%20Violence%20A%20Research%20Review.pdf
[106] *Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011) Child abuse and neglect in the UK today. London: NSPCC.: www.nspcc.org.uk/childstudy*
[107] This figure may differ from published figures as the methodology is different
[108] Essex County Council. Whole Essex Community Budgets Programme. Reducing Domestic Abuse Executive Summary
[109] Lorraine Radford, Susana Corral, Christine Bradley, Helen Fisher, Claire Bassett, Nick Howat and Stephan Collishaw (2009). Child abuse and neglect in the UK today. NSPCC.
[110] Primary need indicates the main reason why a child started to receive services. It should not be left blank and only one reason should be recorded.
[111] Category of abuse as assessed when the child protection plan commenced.
[112] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/253711/SFR45-2013_Tables.xlsx
[113] Source: Essex County Council, figure provided is as per DfE definition
[114] Sullivan, P.M., & Knuton, J.F. (2000). Maltreatment and disabilities: A population-based epidemiological study. Child Abuse & Neglect, 24(10), 1257-1273
[115] Stalker, K. and McArthur, K. (2012), Child abuse, child protection and disabled children: a review of recent research. Child Abuse Review, 21: p24-40.

[116] Essex Safeguarding Children Board Performance and Quality Assurance report. Childrens Social Care Overview of reporting year 2012-13.
[117] Summary of feedback from children receiving social care services in Essex. May 2013
[118] Various internal ECC research reports.
[119] Leaving and Aftercare Research (April 2013). Essex County Council internal report.
[120] (CSEGG) "I thought I was the only one. The only one in the world" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups Interim report, November 2012
[121] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199851/OWSIB_Official_Statistics_2012.pdf
[122] http://www.ons.gov.uk/ons/rel/lmac/people-with-disabilities-in-the-labour-market/2011/people-with-disabilities-in-the-labour-market--supporting-data.xls
[123] http://www.pocklington-trust.org.uk/Resources/Thomas%20Pocklington/Documents/PDF/Research%20Publications/RDP%2012_final.pdf
[124] OIL Transport group , E-PAG, the Learning Disability People's Parliament, the Participation Networks Forum and HealthWatch Essex.
[125] https://indicators.ic.nhs.uk/download/Social%20Care/Data/3A%20-%20Jul.xls
[126] 'University of Leeds Valuing carers, 2011'
[127] https://indicators.ic.nhs.uk/download/Social%20Care/Data/3B%20-%20Jul.xls
[128] Victor (2009), Pincess Royal Trust (2010) Elvish et al (2012)
[129] Bryan (2011) Access to flexible working and informal care, ISER, University of Essex.
[130] http://www.essexinsight.org.uk/Resource.aspx?ResourceID=641 Loneliness and social isolation.
[131] http://tabulation-tool.dwp.gov.uk/100pc/pa/tabtool_pa.html
[132] Dementia UK, Alzheimer's Society 2007
[133] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317139321787
[134] Seasonal flu vaccine uptake (GP) 2012/13