

Essex, Southend-on-Sea and Thurrock

Joint Strategic Needs Assessment 2008



ACKNOWLEDGEMENTS

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With special thanks to Amy Trindall and Vittoria Polito

FOREWORD

We are proud to introduce the first pan-Essex Joint Strategic Needs Assessment (JSNA). It represents a fantastic partnership effort across health and local authorities (county, unitary, district and borough¹) and has already played a significant role in enabling partners to determine shared priorities for inclusion in local and county sustainable community strategies. It has also helped shape the future priorities that partners need to include in our next Local Area Agreement.

We produced this JSNA in response to the Department of Health's consultation document, *Commissioning Framework for Health and Well-Being*. It is intended to help us achieve:

- a shift towards services that are personal, sensitive to individual need and that maintain independence and dignity;
- a strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs;
- a stronger focus on commissioning services and interventions that will achieve better health and improve the quality of life with all partners working together to promote inclusion and tackle health inequalities.

This JSNA is the first step in helping us accomplish this. It provides analyses of data to show the health and well-being status of local communities; defines where inequities exist. It also incorporates, where possible, local community views around priorities for service improvement. It is therefore a robust evidence-base for us to agree the strategic direction of service delivery and we will use it to inform our future commissioning and to improve outcomes for the residents of Essex, Southend-on-Sea and Thurrock.

In recognition of the importance of engaging all key partners and understanding the distinctive nature of different parts of Essex, we have produced a local profile for each of the twelve district / borough councils and the two unitary authorities together with a full JSNA covering the whole of the county of Essex. While not wishing to duplicate work already undertaken, the JSNA takes a broad view of health and well-being, considering the wider determinants of health and quality of life.

We are aware that, this time round, all is not perfect. Some data is not available in the form we would like it and there are more powerful analytical tools that would support better identification and understanding of geo-demographic groups for the effective targeting of our resources. The focus for this JSNA has been to streamline existing intelligence but the intention is to strengthen population segmentation, forecasting and community involvement in future.

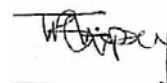
Our thanks goes out to all those who were involved in the production of this JSNA and we look forward to continued collaboration and integrated working to enhance the lives of the people of Essex, Southend-on-Sea and Thurrock.



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¹ please see the Glossary for an explanation of the differences between these terms

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EXECUTIVE SUMMARY

As part of their service planning and commissioning, local authority and health partners across the county of Essex have undertaken a high level Joint Strategic Needs Assessment (JSNA). This JSNA has been derived after extensive analysis of comparative and epidemiological data. The key findings of this work will inform priority-setting as part of the Essex Strategy and Local Area Agreement and the commissioning of health and social care services.

Geography & Demographics

Essex² has a population of around 1.66m, residing in its twelve district and borough councils and the two unitary authorities of Southend-on-Sea and Thurrock. Compared to the national profile, Essex has a smaller proportion of 15-34 year olds and greater proportions of people in higher age groups (from age 55 upwards).

By 2029, the population of Essex is expected to grow by somewhere in the region of 6.5% and 14%. This reflects government plans for housing development (including the Thames Gateway, Haven Gateway and London, Stansted, Cambridge and Peterborough Corridor), past trends in births, deaths and migration and the fact that older people are living longer. These same factors also mean that the concentration of people aged over 65 – and indeed those aged over 85 – will increase dramatically and at a higher rate in Essex than nationally. We can also expect a step-change in the ratio of working-age people to older people.

Back in 2001, Essex had 72,000 residents from black and minority ethnic (BME) groups (5.5% compared to 13% for England) and 37,200 residents (2.3%) of a faith other than Christian. Experimental statistics suggest that the population is becoming increasingly diverse with the highest proportions of people from BME groups residing in Epping Forest, Harlow and Brentwood. We know also that just over 8,855 economic migrants from A8 countries have registered to work in Essex – largely in the northern half of the county (Tendring, Colchester, Braintree and Uttlesford) – since the expansion of the European Union and that 9.4% of our younger residents are from BME communities.

Gypsies and travellers have long featured in Essex. There are 11 registered gypsy / traveller sites in Essex which have a total of 164 pitches (all of which are residential rather than transient) and capacity for 305 caravans. The county is also host to over a third of the East of England's unauthorised developments, many of which are in Basildon.

Social & Environmental Factors

There is a tangible link between deprivation and poor health, economic and social outcomes. Essex has some of the most affluent and some of the most deprived areas in the country. Although at district level Tendring and Southend are the most deprived, there are pockets of deprivation overshadowed by overall affluence in most districts / boroughs. Residents in

² Throughout this document, the term 'Essex' is used to refer to the county of Essex, which includes the unitary authorities of Southend-on-Sea and Thurrock. Where information only applies to the county council locality, the term 'ECC' is used.

Harlow are most likely to be in receipt of means-tested benefits, to be in low-skilled occupations and least likely to own their own homes.

Across the county as a whole, a higher proportion of residents are owner-occupiers (75% compared to 69% nationally), despite house prices being higher than the national average. There is, however, an acute shortage of affordable housing, especially in rural areas and for local workers whose salaries do not compete with that on offer in London. Nearly 36,000 households (approx 5%) are on local authority waiting lists for housing, with demand highest in Chelmsford, Harlow and Epping Forest.

A further 2,500 households a year are accepted as homeless, with Harlow showing a significantly higher rate than elsewhere. Drug, alcohol and mental health problems are inextricably linked with a large section of the homeless client group. Research shows that 83% of homeless people take some form of drug (other than alcohol); one in four tenants with mental health problems risks losing their home; and 25% of offenders known to NACRO (National Association of the Care and Rehabilitation of Offenders) have mental health problems.

Poor quality housing is associated with poor health and psychological problems. Only 1% of Essex households have more residents than rooms and only 2.1% of dwellings are deemed to be 'unfit'. This is the lowest proportion in the East of England and only 3% of 'unfit' dwellings are public-sector owned.

Street cleanliness is a key priority for many residents, especially in Colchester, Epping Forest and Harlow. In 2005-06, there were higher than average levels of litter in Tendring and Rochford and, despite a relatively low county rate, the level of abandoned vehicles in Thurrock is over six times higher than average (38 per 1,000 households compared to 6 per thousand for England).

In terms of pollution, Essex has a relatively low carbon footprint. However, Thurrock has more than four times the carbon emissions of Maldon and, on a per capita level, Uttlesford has a higher tonnage than the UK.

The Essex economy has been one of the fastest-growing in the East and South East since 2000. However, productivity levels are below national and regional averages and there are fewer local jobs than in the rest of the region. Without inward investment and local job development, this situation will only intensify with housing and population growth.

In Essex, as in England, 59% of pupils gained five or more high-grade GCSEs in 2006. However, in Tendring and Maldon results were below the 50% mark, whilst in Rochford they were nearer 80%.

Only 21% of working-age adults in Essex have a level 4 qualification or above (England 27%) and 17% have no qualifications (England 14%). Parts of Essex suffer from an even greater skills deficit; in Maldon, Tendring and Uttlesford more than a fifth have no qualifications and in Maldon and Castle Point the proportion with level 4 qualifications is half that for England.

Despite low local job density, only around 4% of people in Essex are unemployed (England 5.4%). Lower unemployment rates and higher earnings are largely due to the fact that 15% of

residents commute to London for work. However, there are pockets of high unemployment with rates in Tendring and Southend above 7%.

Despite Essex's relatively low crime rate (46 crimes per 1,000 population compared to 61 per 1,000 in England), the reduction of crime / anti-social behaviour and fear of crime are afforded very high priority across districts / boroughs. Thurrock, Harlow and Southend have higher than average crime rates. Harlow also has a higher than average violent crime rate and alcohol-related crime rate.

Poor transport systems limit life opportunities and good health and, in Essex, is the biggest contributory factor to people feeling isolated. The county's road and rail networks take well over half a million people to and from work every day. Growing car use and new housing developments are set to increase congestion and pollution levels as well as the need for network maintenance.

Health & Welfare

Life expectancy is a measure of overall life chances, can indicate areas of poor health and is influenced by economic and social determinants. Life expectancy varies across the region with Southend (78.1 years) and Thurrock (78.2 years) having the shortest life expectancy in Essex (England 78.3 years). Brentwood, Uttlesford, Rochford and Chelmsford have the longest life expectancy (80 years or over).

At ward level, the differences in life expectancy are even more pronounced. Residents in Pier ward (Tendring) have a life expectancy of only 70.1 years compared to Littlebury ward (Uttlesford) with 88.7 years. This is a difference of 18.6 years from one part of the county to another.

Research indicates lower life expectancy among vulnerable groups; life expectancy tends to be below that of the general population for the gypsy/traveller population, those with serious mental illness and those with severe learning disabilities.

Mortality reflects both the incidence of disease and the ability to treat it. Across Essex mortality rates have largely improved steadily over the last ten years. Although the rate of improvement has been faster for males, female mortality rates are, without exception, lower than those for males. Circulatory diseases remain the most common cause of death with cancer a close second now for females. There is wide variation in mortality rates across Essex with, for example in Southend, a five-fold variation among males and an eight-fold variation among females in circulatory disease mortality.

When considering male mortality from all causes, both Thurrock and Southend have rates above the national average closely followed by Tendring and Harlow. In the female population, Southend, Basildon and Thurrock are all above the national average. There's a similar picture in premature mortality (among those aged under 75). Detailed analysis shows that there are marked inequalities both between and within districts / boroughs.

In relation to circulatory diseases (heart diseases, strokes), male mortality rates are below the national average in all districts / boroughs but for females they are higher in Thurrock, Maldon,

Braintree and Epping Forest. Those with severe mental illness have a greater risk of dying from coronary heart disease and Basildon, Southend and Thurrock have higher rates of hospital admission for circulatory disease than the Essex average.

In relation to all forms of cancer, male mortality rates are above the national average in Maldon, Tendring, Basildon and Harlow and female rates higher in Basildon, Southend, Uttlesford and Castle Point. Hospital admission rates for cancer vary widely across Essex with 13 of the 14 districts / boroughs being significantly different from the Essex average.

If you are a male living in Harlow, you are twice as likely to die from lung cancer, than if you live in Uttlesford and Southend has high lung cancer mortality rates for both genders. Uttlesford, however, has the highest mortality rates for both breast and prostate cancers.

In the UK, it is estimated that over 15 million people report living with a long-term condition. People with long-term illnesses often suffer from more than one condition, making their care even more complex. Eighty percent of primary care consultations and two thirds of emergency hospital admissions in the UK are related to long-term conditions. As well as geographical differences in the prevalence of long-term conditions, some populations are also known to have higher prevalence (eg diabetes among those with mental health problems).

In Essex, 215,471 people (16.2%) consider themselves to have a limiting long-term illness (LLTI). All of Tendring and most of Southend have high levels of LLTI, with particularly high levels in Tendring's coastal areas. LLTI is often associated with mental ill-health, unemployment and benefit claims. With adequate support, training and supervision, many of those affected can find employment, regain their social status and improve their well-being.

Children & Young People

Low birth weight babies (<2.5kg) were traditionally linked to high deprivation but are increasingly also a result of improved medical technology. Thurrock and Uttlesford have the highest rates of babies born with low weight.

Harlow is the only area to have an MMR vaccination rate higher than the England average. The incidence of measles varies hugely across Essex; Thurrock, Southend, Braintree, Castle Point and Epping Forest all have higher than average rates (and also some of the lowest uptake for the MMR vaccine).

Childhood obesity is on the rise with a 22% increase in those overweight or obese between 1995 and 2003. Given the difficulty in obtaining good data, a local baseline of 11.3% for childhood obesity has been agreed from the 2006 NHS data collation. Tendring, Thurrock and Colchester appear to have the highest obesity levels in reception year whilst Harlow and Thurrock the highest among children in year 6.

Babies who are breastfed are less likely to be obese in adulthood. However, breastfeeding initiation rates in the UK remain relatively low compared to other countries, particularly among women in lower income groups.

In the UK, around 10% of 5-15 year olds have a behavioural or mental health problem. They are more likely to be boys, living in a lower income household and in social sector housing. Many of them will have poor education, are more likely to be in trouble with the police and have poorer life chances. Children and young people who are looked after are more likely than others to suffer from poor emotional well-being and to misuse drugs and alcohol. Local estimates of prevalence indicate over 19,200 children and young people diagnosed with behavioural or mental health problems.

Among 15-year-olds in Essex, 55% drink alcohol, 19% are regular smokers and 13% use drugs. It is also known that 14.5% of care leavers misuse drugs or alcohol and that 8% of young offenders re-offended with an offence related to drugs or alcohol.

In Essex, 49% of primary school pupils and 27% of secondary school pupil felt afraid of going to school as a consequence of bullying. There were 8,292 incidents of serious crime affecting children and young people reported to Essex police in 2006-07.

Early pregnancy brings health risks for mothers and an increased likelihood of poor outcomes for children. Essex has seen a steady decline in teenage conceptions over the last few years but they remain higher than the national average (41 per 1,000 aged u18) in Basildon (47/1000), Southend (47/1000) and Thurrock (44/1000). At ward level, there are pockets of very high teenage pregnancy rates, often located in more disadvantaged communities and linked to poor educational attainment. The highest rate in Southend is more than five times the regional average.

Across Essex, the proportion of year 11 statutory school leavers remaining in education has increased since 2004 and there has been a significant reduction in the proportion not in education, employment or training (NEET). However, there remains a 'hard core' of difficult to engage young people (approximately 13%) who are being targeted through specialist school intervention.

Essex is home to a number of very vulnerable children at risk of poor health, education and social outcomes. At any one time, there are around 700 children on the Child Protection Register and 1,700 children and young people looked after. Southend, Basildon, Tendring, Thurrock and Colchester all have over 150 children looked after with the rate in Southend nearly double that in ECC (86 per 1,000 aged u18 compared to 44 per 1,000).

Working Adults & Older People

The population in the UK is ageing fast and a key factor in determining demand on health and social care services, is the living circumstances of older people. In 2008, it is estimated that there will be around 86,100 people aged 65 years and over living alone. By 2025, this figure could rise to 124,200.

As residents grow older, levels of impairment and disability will rise. Almost 10% of the population is involved in providing informal care to relatives, friends and neighbours. Although the majority receive some form of support from local authorities and voluntary organisations, about a third does not receive any support at all. Nationally, 8.9 carers per 1,000 adults are supported by social services. Thurrock and ECC support well below this figure (4.8/1000 and

6.9/1000 respectively) but Southend supports more (9.4/1000). Tendring is the only district council with a higher than average rate (9.4/1000).

In Essex, over 17,000 units of housing-related support services are provided through Supporting People across a range of client groups. Over 90% of service users are older people. As our population ages, we can expect to see 24% more frail elderly people, more age-related mental health problems and a dramatic rise in the need for housing-related support. Of those currently living in social rented housing, just under a third live in sheltered housing.

Mental health and well-being is an area of concern nationally. Southend, Tendring, Harlow, Basildon, Colchester and Thurrock have above average proportions of their working age population claiming benefit/allowance for a mental or behavioural disorder – Uttlesford has the lowest rate.

Southend, Harlow, Thurrock, Basildon, Castle Point and Tendring all have above average proportions of their working age population suffering from a neurotic disorder / depression. And there is large variation at district level in terms of hospital admission rates for mental illness. The male mortality rate for suicide is markedly higher than the female rate with both rates seeing an increase in recent years. In Harlow, the male rate is considerably higher than in other areas in Essex and than the national average.

Depression is the most common mental illness in older people and the second commonest single underlying cause for all GP consultations. There are currently nearly 44,000 (highest prevalence estimate) people aged 65+ in Essex who are suffering from depression. By 2025, it is predicted that there will be over 62,000 sufferers aged over 65 years.

Dementia can affect people of any age, but is most common in older people and in women (especially Alzheimer's). One in 14 people over 65 years and one in six people over 80 years, have a form of dementia. It is estimated that there are around 22,300 sufferers in Essex, with the prevalence estimated at 1.14% in ECC, 1.61% in Southend and 0.71% in Thurrock (1.1% in UK). The number of people suffering from dementia is expected to increase to just under 33,500 by 2025. This is a much greater rate of increase (50%) than in England (44%).

Looking after people with chronic conditions is costly and consumes a large proportion of health and social care resources, especially in older age. Obesity is a major problem and is likely to get worse over the next 20 years. Obesity is already known to have serious health implications such as diabetes, cardiovascular disease, arthritis and many more. In Essex the current number of older people thought to be obese is around 71,300 and by 2025 it's estimated it will top 100,000.

Mobility problems and incontinence among women are expected to increase at faster rates than nationally – 48% and 37% respectively over the next 20 years. The risk of suffering from heart disease, stroke and cancer also increases with age. Co-morbidities such as diabetes or other chronic illnesses increase the risk of having heart disease or associated illnesses. Essex has a high rate of cardiovascular disease and this is predicted to be well above the national average by 2025. It is also estimated that, by 2025, there will be over 48,500 (highest prevalence estimate) people aged over 65 in Essex with a chronic respiratory condition.

Falls are a common problem amongst the older population and can often result in fracture of the wrists or femur. Older people take longer to recover, become more dependent (through subsequent mobility issues and lack of confidence) and are at greater risk of isolation. Currently there are 18,300 attendances at Accident & Emergency (A&E) departments as a result of falls among older people. By 2025, this is expected to rise to 27,100.

Nationally 158 older people per 1,000 adults are supported by social services. Rates across Essex are lower than this: ECC 151/1000; Southend 147/1000; Thurrock 106/1000. Within ECC, the highest rate of service users open to an older people's team is in Braintree (113/1000) and the lowest is in Harlow (73/1000).

People Living with Disabilities

Levels of disability are expected to increase sharply as our population ages and as more children with complex and multiple disabilities survive into adulthood.

Nationally 3.9 people with learning disabilities per 1,000 adults are supported by social services. The rate in Southend is the same but rates in ECC (3.5/1000) and Thurrock (2.7/1000) are lower. There are currently 4,500 (4.4/1000) people registered with a learning disability in ECC. North East Essex (Tendring 7.2/1000 and Colchester 6.6/1000) has the highest prevalence.

In England, 27 people per 1,000 population aged 18+ have a physical disability, temporary disability or are considered frail and are supported by adult social services. ECC (32/1000) and Southend (30.3/1000) rates are higher than this but Thurrock's is lower (16.9/1000). In ECC, the highest rates of service users open to physical impairment teams are in Tendring (3.1/1000), Colchester (2.9/1000), Harlow (2.9/1000) and Braintree (2.8/1000).

ECC (1.3/1000), Southend (1.7/1000) and Thurrock (0.7/1000) all have rates of sensory impairment below the national rate (2.2/1000) for population aged 18yrs+. However, the inclusion of those with mild or secondary impairment (eg uncertified sight loss or hard of hearing) increases the ECC rate to 4.6/1000. The highest rates of all forms of impairment can be found in Colchester (6.7/1000) and Tendring (5.8/1000) while the lowest rates are in Harlow (2.4/1000) and Epping Forest (3.1/1000).

Quality of Life

Quality of Life means different things to different people, but it often includes enjoyment of the local environment; good personal health; quality time with friends and family; a strong community spirit and positive perceptions about the quality of services received.

73% of those living in ECC reported that living in Essex has a positive impact on their quality of life, 81% were satisfied with their local area as a place to live and 76% were happy overall.

In regards to personal safety, 84% said they felt safe during the day but only 47% felt safe after dark. People felt safest in Uttlesford (91%), Braintree (88%) and Chelmsford (87%) and least safe in Castle Point (77%). Older people generally feel less safe and people living in urban areas tend to feel less safe after dark.

Common high priority themes for improvement are: the level of crime, activities for teenagers, health services, clean streets, level of traffic congestion, affordable decent housing, public transport and road / pavement repairs. District differences include: Tendring affording higher priority to job prospects; education provision being more of an issue in Basildon, Colchester and Epping Forest; parks and open spaces being of greater concern in Castle Point and Rochford; facilities for young children given higher priority in Harlow; better cultural facilities needed in Brentwood and Maldon; and Uttlesford being the only area to identify pollution as a key issue.

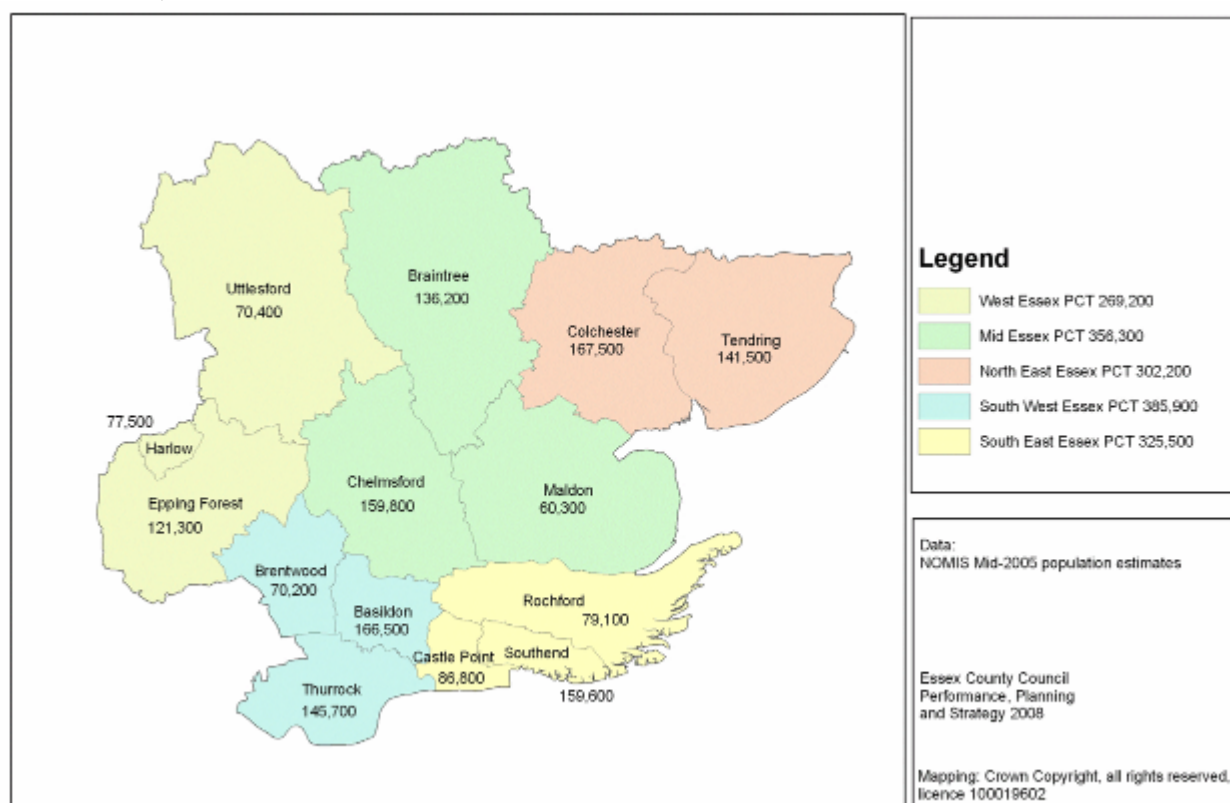
Generally, people's lifestyle choices are having a negative impact on their health with obesity now one of the major public health issues. In Tendring, Basildon, Thurrock and Harlow the prevalence of obesity is higher than national levels and only in Uttlesford, Colchester and Brentwood are exercise levels better than average. Smoking remains the single greatest cause of preventable illness and early death. However, alcohol and drug misuse also have a significant impact on health, crime and society. Chelmsford, Harlow, Colchester and Thurrock have binge-drinking rates above the regional average and the prevalence of drug misuse is highest in Southend, Harlow and Maldon. Despite overall improvements in road safety, there are some worrying upward trends in people killed or seriously injured as a result of risk-taking behaviour among young people.

England has an ecological footprint of 5.47 global hectares per person, which is 65% higher than its ecological budget. The ecological footprint for Essex is 5.54 with only Harlow, Thurrock and Basildon below the England figure. We need to reduce the impact that our lifestyles have on the environment and minimise the environmental impact of housing and business development.

CHAPTER 1: GEOGRAPHY AND DEMOGRAPHICS

Essex³ has a population of around 1.66m, residing in its twelve district and borough councils and the two unitary authorities of Southend-on-Sea and Thurrock (ONS 2005 MYE, revised). It is the sixth most populous county in England with the second-largest population of any non-metropolitan county after Kent, making up a quarter of the population of the East of England region. The biggest towns in Essex are Chelmsford, Colchester and the seaside town of Southend. In October 2006, there were mergers of primary care trusts leaving the county with five PCTs (Figure 1.1).

Figure 1.1: Population of Essex



1.1 Structure of the Population

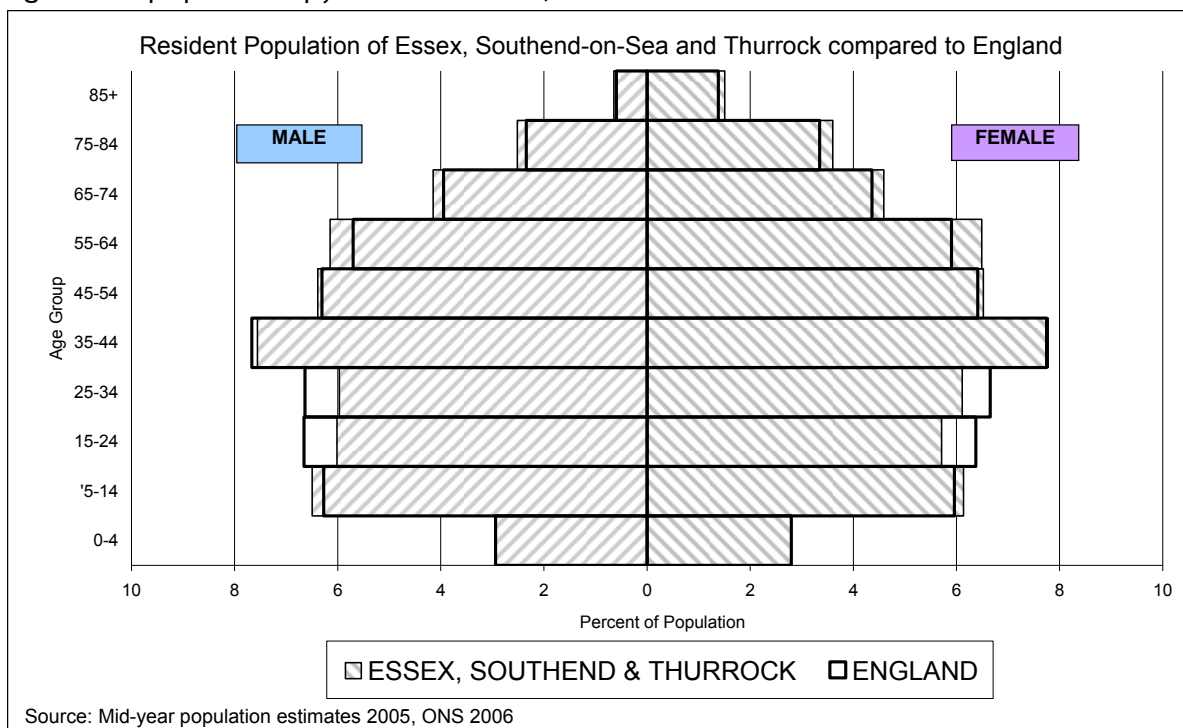
Essex has a different population structure to that of England as a whole; it has proportionally more children and older aged people. There is a similar proportion of u5s but there are marginally more 5-14 year olds in Essex. There are fewer 15-34 year olds than in England, which may reflect the movement of this portion of the population to other areas. The relative size of the 34-44 age group is similar to England, but all older age groups are larger in Essex.

³ Throughout this document Essex is used to refer to the county of Essex, which includes the unitary authorities of Southend-on-Sea and Thurrock. Where information only applies to the county council locality, the term ECC is used.

Tendring has the highest proportion of older people⁴ in the East of England, with 1 in 3 residents over the age of 65. Within this district are the seaside towns of Clacton-on-Sea and Frinton-on-Sea. Castle Point also has a relatively older population where almost 1 in 4 of the population is aged 65+. Thurrock has a much younger population with only 1 in 7 people aged 65+ and 21% children (aged 0-15).

As indicated in the chart below, males slightly outnumber females up until the age of 30. Of the population aged 65+ around 56% are women and by the age of 85+ this figure has increased to over 68%. These differences are largely due to consistent patterns of longer life expectancy in women. They are expected to continue but to decrease substantially in the long-term.

Figure 1.2: population pyramid for Essex, 2006



Essex has a working age population of 825,800, making up 60.7% of the total population, similar to the composition of the Eastern region (61.2%) and just under the working age composition of Great Britain (62.2%).

1.2 Projected Population Changes

Essex is home to a number of 'growth areas', identified for regeneration and growth:

- Thames Gateway South Essex (incorporating Basildon, Castle Point, Rochford, Southend and Thurrock)
- M11 Corridor (including Braintree, Epping Forest, Harlow and Uttlesford)
- Haven Gateway (including Colchester and Tendring).

The number of additional homes required within sub-regional development areas is shown in the following table.

⁴ Older people are males 65 and over and females over the age of 60.

Figure 1.3: Essex allocations for minimum dwelling provision, 2001-2021

	Total to build
Maldon	2,400
Brentwood	3,500
Epping Forest	3,500
Castle Point	4,000
Rochford	4,600
Southend	6,000
Braintree	7,700
Uttlesford	8,000
Tendring	8,500
Basildon	10,700
Chelmsford	16,000
Harlow	16,000
Colchester	17,100
Thurrock	18,500
TOTAL	126,500

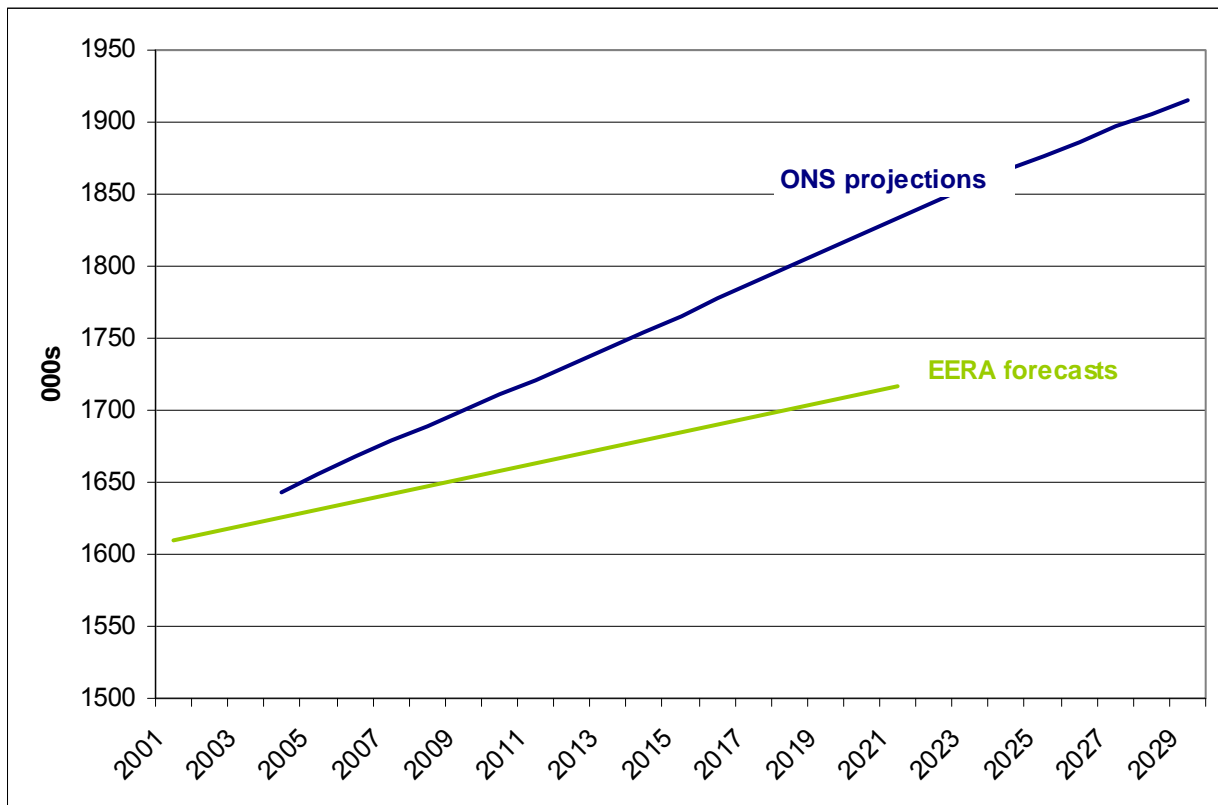
Source: Secretary of State's proposed changes to the Regional Spatial Strategy, policy H1 (Dec 2006)

Population forecasts developed for the East of England Regional Assembly (EERA) by the Population and Housing Research Group at Anglia Ruskin University (Dec 2006) taking into account the Secretary of State's proposed changes to the Regional Spatial Strategy forecast an increase in the population across Essex of 6.5% between 2001 and 2021. In Thurrock where the most additional homes are required, the population is forecast to increase by 16% over the same timeframe.

As shown in Figure 1.4, these forecasts differ significantly from the ONS population projections. There are complex methodological reasons for this but, simply, the ONS projections assume continuation of recent trends in births, deaths and migration but do not take into account any future policy changes. The EERA population forecasts show the future population arising from the Regional Spatial Strategy policy to build the minimum number of dwellings shown in Figure 1.3 above.

ONS data shows that, over the last 10 years, the Essex population has grown at an average rate of 0.7% per year and is projected to grow to over 1.9 million (14% increase) by 2029.

Figure 1.4: Essex growth in population



Source: ONS SNPP 2007; EERA forecast 2006

While new housing will lead to considerable population growth, population ageing will also be an important demographic trend over coming years. In general, people are living longer and therefore there are increasing numbers and proportions of older people. Population ageing in Essex is predicted to occur at a higher rate than nationally but, according to the 2001-2021 EERA forecasts, there are some significant differences in expected population structures between areas. The highlights are summarised below.

u5 population	Across Essex this population is expected to decrease by nearly 5%, but potentially by as much as a fifth in Braintree, Maldon and Tendring. A significant increase is expected in Harlow.
5-15 year olds	Across Essex this population is expected to decrease by over 10%, but potentially by as much as a fifth in Braintree, Maldon and Tendring.
Working age population	Across Essex this population is expected to stay about the same but a significant increase is expected in Harlow.
Aged 65+	Across Essex this population is expected to increase by 45%. Expected increases are significantly lower for Southend and Epping Forest and highest in Maldon and Uttlesford.
Aged 85+	Across Essex this population is expected to increase by over 75%. The expected increase is significantly lower for Southend whereas populations are expected to at least double in Rochford, Castle Point, Harlow, Basildon, Brentwood, Maldon and Uttlesford.
Total population	Across Essex the population is expected to increase by 6.5%. The most significant increase is expected in Harlow.

As mentioned above, it is expected that the over-representation of women in older age groups will decrease in the long-term. For example, among those aged 85+, it is estimated that the proportion of women will decrease from 68% in 2008 to 61% in 2025.

1.2.1 Balance of population

With these changes, 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. As with much of the UK, the ratio of older people to those of working age across Essex is forecast to drop in all districts / boroughs – in many areas by over a third. The following table shows the number of people aged 15-64 per person aged over 65 and illustrates the demographic shift forecast to occur. This needs to inform workforce planning because less people of working age will be available to care for and support older people.

Figure 1.5: Number of people aged 15-64 per person aged over 65

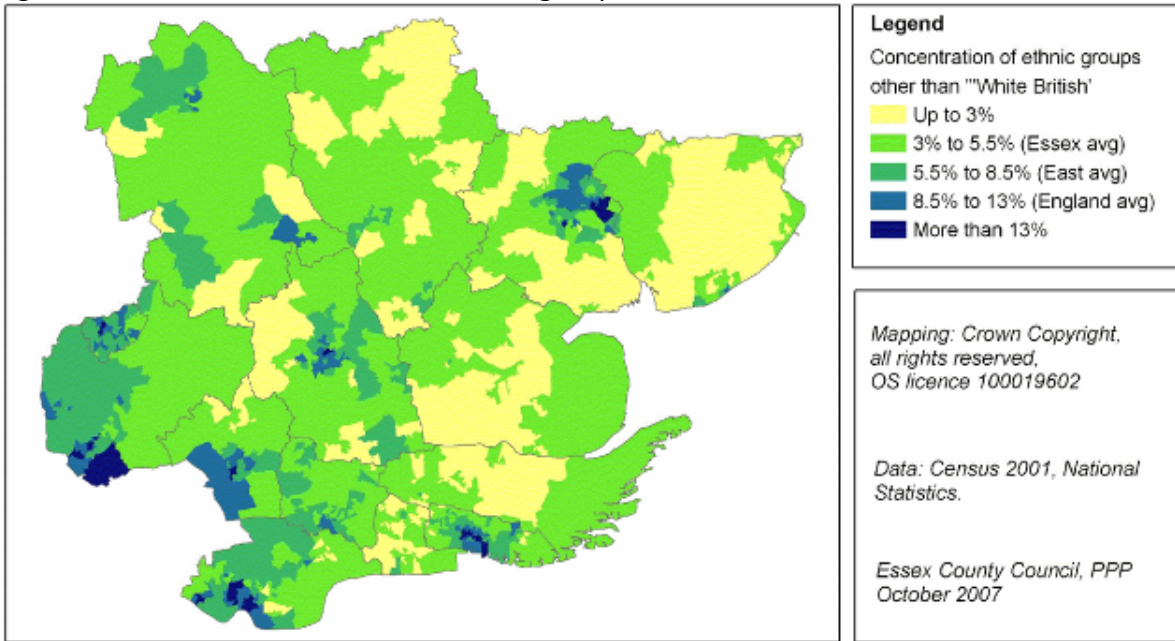
	2004	2029	% change
<i>Essex</i>	<i>3.83</i>	<i>2.56</i>	<i>33.1</i>
Brentwood	3.44	2.77	19.5
Harlow	4.37	3.42	21.6
Epping Forest	3.81	2.91	23.8
Southend	3.33	2.38	28.6
Tendring	2.21	1.54	30.5
Basildon	4.35	3.00	31.0
Colchester	4.57	3.12	31.7
Thurrock	5.14	3.44	33.2
Chelmsford	4.45	2.92	34.3
Rochford	3.44	2.18	36.5
Braintree	4.34	2.64	39.2
Uttlesford	4.11	2.33	43.3
Castle Point	3.52	1.97	44.0
Maldon	3.96	2.12	46.4

Source: ONS SNPP, 2004

1.3 Ethnic Breakdown

According to the Census, Essex has 72,000 residents from black and minority ethnic (BME) groups. There are 38,000 residents from ethnic groups other than white and 34,000 from white minority groups. People from all BME groups made up 5.5% of Essex residents - across England, 13.0% of people belonged to BME groups. People from ethnic groups other than white made up 2.9% of Essex residents. Three times as many people across England were from these groups (9.1%). White minority groups contained 2.6% of the Essex population compared to 3.9% across England.

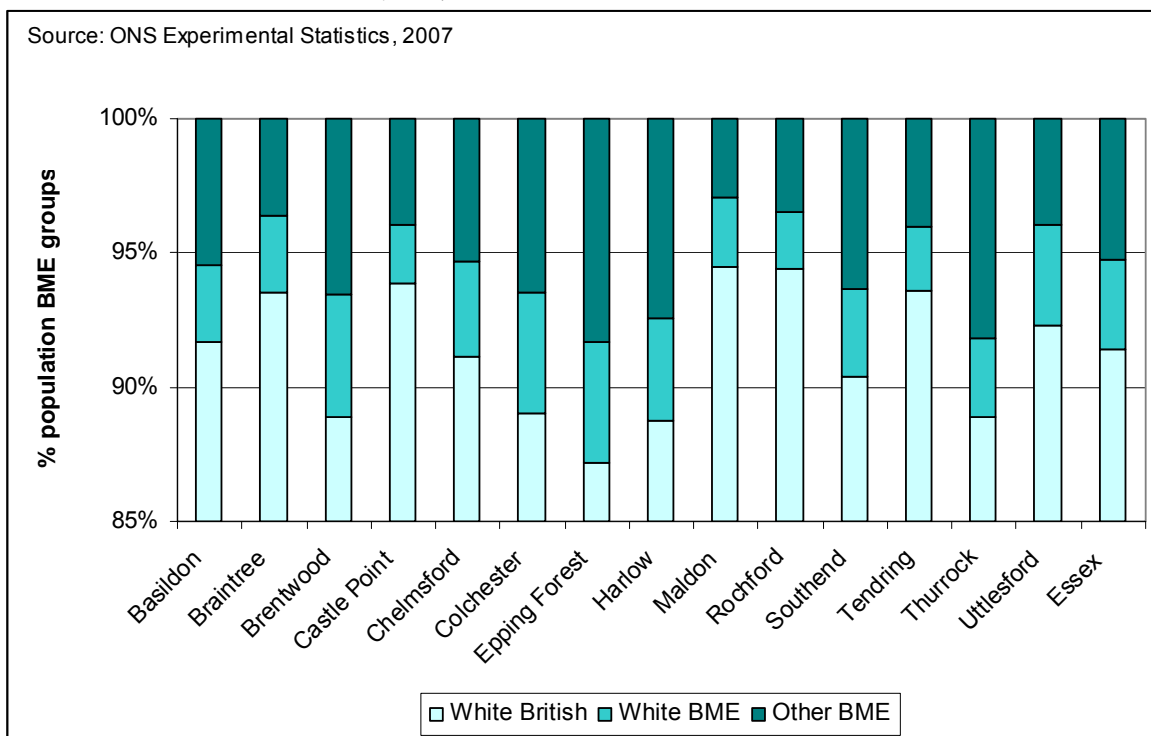
Figure 1.6: Essex concentrations of BME groups



1.3.1 Growth in diversity

It should be noted that the Census information dates back to 2001. ONS has produced experimental statistics on ethnicity although it is not clear the extent to which new growth is reflected. The following chart shows that Essex has become more diverse with the areas closest to London and those containing the largest towns tending to have the highest concentrations of people from BME groups. For example, the proportion of BME residents in Thurrock has risen from 7.2% at the time of Census to 11.1% in 2005. The highest proportions of people from all BME groups are residing in Epping Forest, Harlow and Brentwood.

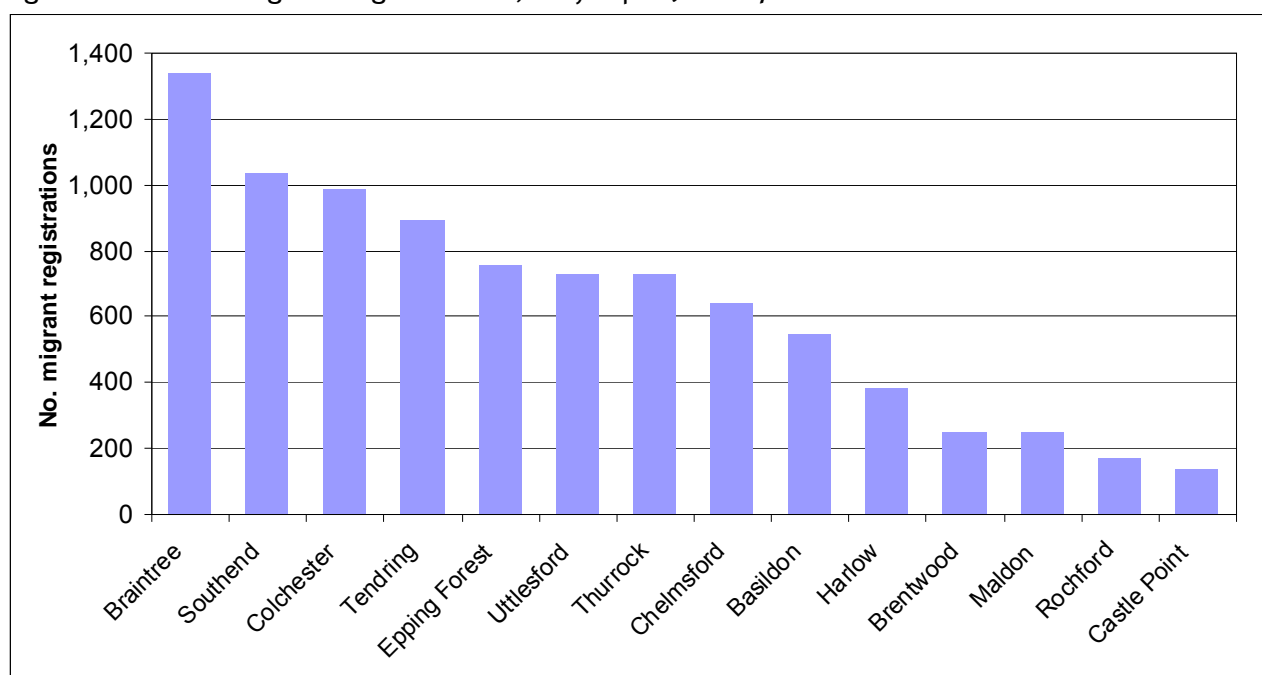
Figure 1.7: Essex ethnic groups by district / borough, 2007



1.3.2 Economic migration

The advent of economic migration associated with the expansion of the European Union has led to significant inward migration from the ‘A8 countries’⁵ into Essex. A cumulative total of 8,855 migrants registered to work in Essex between May-04 and Jun-07⁶. This represents 1.5% of the cumulative total for the UK as a whole – half what we would expect had the migrant population been dispersed in line with the overall resident population. Figure 1.8 shows the number of migrant registrations per district / borough and percentage of ECC total accounted for by each. Migrants tend to be young adults aged 18-34 and two thirds are Polish migrants. There are variations between areas: relatively high proportions of Czech workers in Chelmsford and Rochford; Slovakian workers in Chelmsford, Harlow and Basildon; Lithuanian workers in Castle Point and Tendring; and Latvian workers in Tendring.

Figure 1.8: Essex migrant registrations, May 04 to June 07



1.3.3 Travelling families

The travelling community includes Romany gypsies, Irish travellers and new travellers. In England & Wales, 91% of local authorities have travellers either living within them or passing through. Most of the travelling community live in caravans on sites that are either local authority managed or on private sites. A small proportion lives in caravans on unauthorised sites.

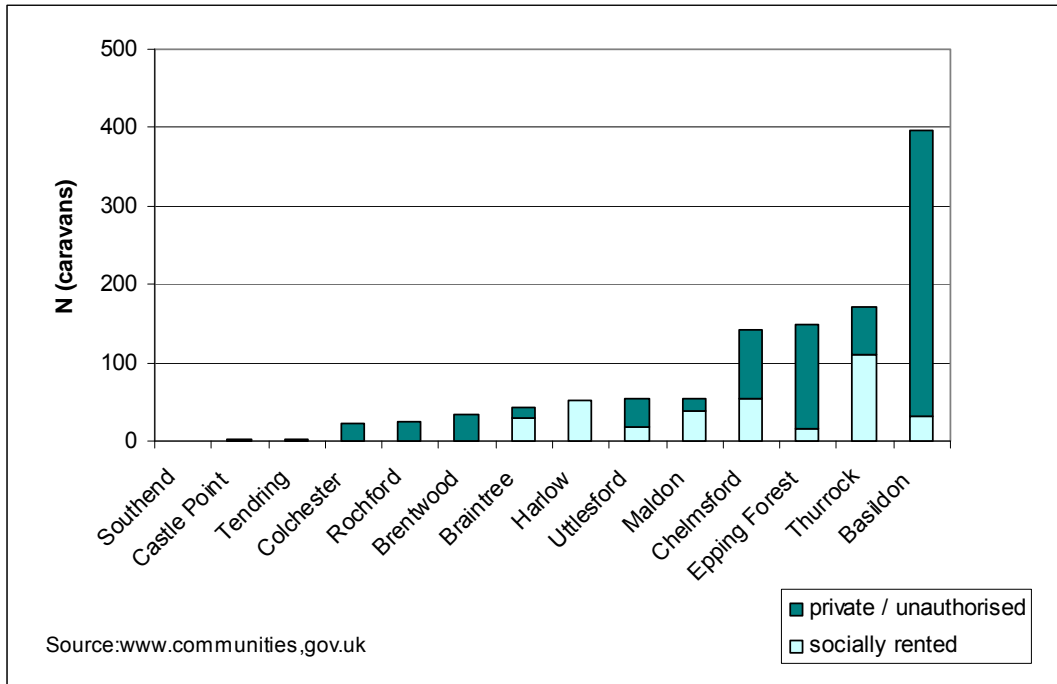
Gypsies and travellers have long featured in Essex. There are eleven registered sites, all of which are residential rather than transient. This affords a total of 228 pitches and capacity for 433 caravans. There are nearly 800 additional caravans on private / unauthorised sites across the county. Of all the counties in the East of England region, only Cambridgeshire has a larger caravan count but Essex hosts over a third of the region’s unauthorised developments. As can be seen from the chart below, 35% of the total number of caravans in Essex is in Basildon. Despite socially rented caravans only amounting to 9% of the total, Basildon is home to 40%

⁵ Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia

⁶ Figures are indicative and not national statistics

of private caravans and over 50% of caravans on unauthorised sites, the vast majority of which are classed as ‘not tolerated’.

Figure 1.9: Caravans at registered and unregistered sites in Essex, Jan 07



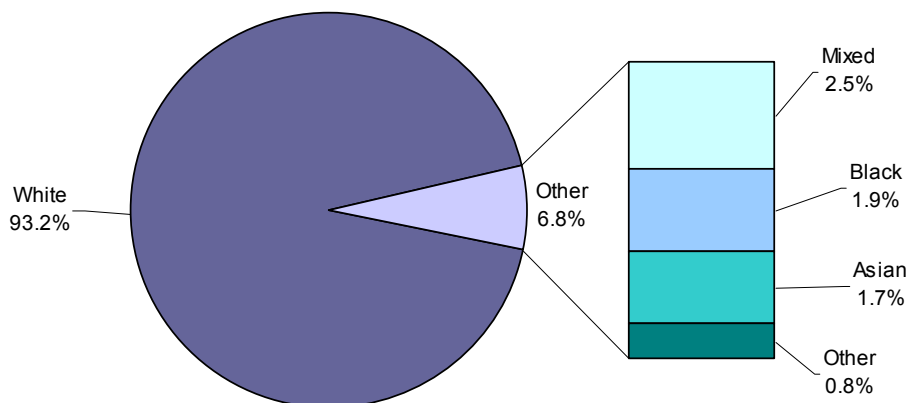
Life expectancy in the gypsy/traveller population tends to be below that of the general population with the literature highlighting high smoking prevalence and levels of coronary heart disease.

1.3.4 Younger residents

Ethnicity data from our schools can tell us more about current diversity within the younger population. Across the county, 9.4% of pupils are from all black and minority ethnic groups (compared to 5.5% in 2001 Census) and 6.8% from ethnic groups not classified as white (compared to 2.9% in 2001 Census). This suggests that the population of Essex is becoming increasingly diverse.

Figure 1.10: Essex breakdown of pupil ethnicity, 2007

Source: PLASC

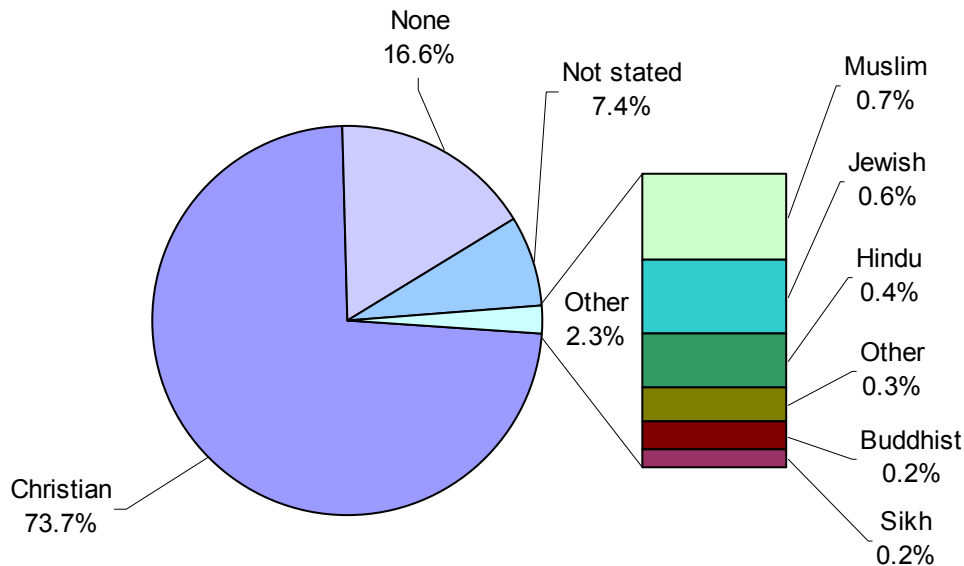


1.4 Religion

According to the 2001 Census, 74% of Essex residents are Christian and only 2.3% are of other faiths. However, as set out above, the population is growing increasingly diverse which may well have had an impact on the religious profile of the county.

Figure 1.11: Essex breakdown of religion, 2001

Source: Census



1.5 Conclusion

As a nation, our population is getting older but the older population in Essex is growing faster than average for the UK. Over the next 15 years, we can expect a 45% increase in the over-65s and a 75% increase in the over-85s.

Central government plans will also bring significant housing development to the county. Current proposals will increase the number of homes by almost a fifth.

As Essex grows, it is becoming more diverse. There is evidence to suggest that economic and inward migration is increasing the ethnic mix of our population – especially in areas close to London and our larger towns.

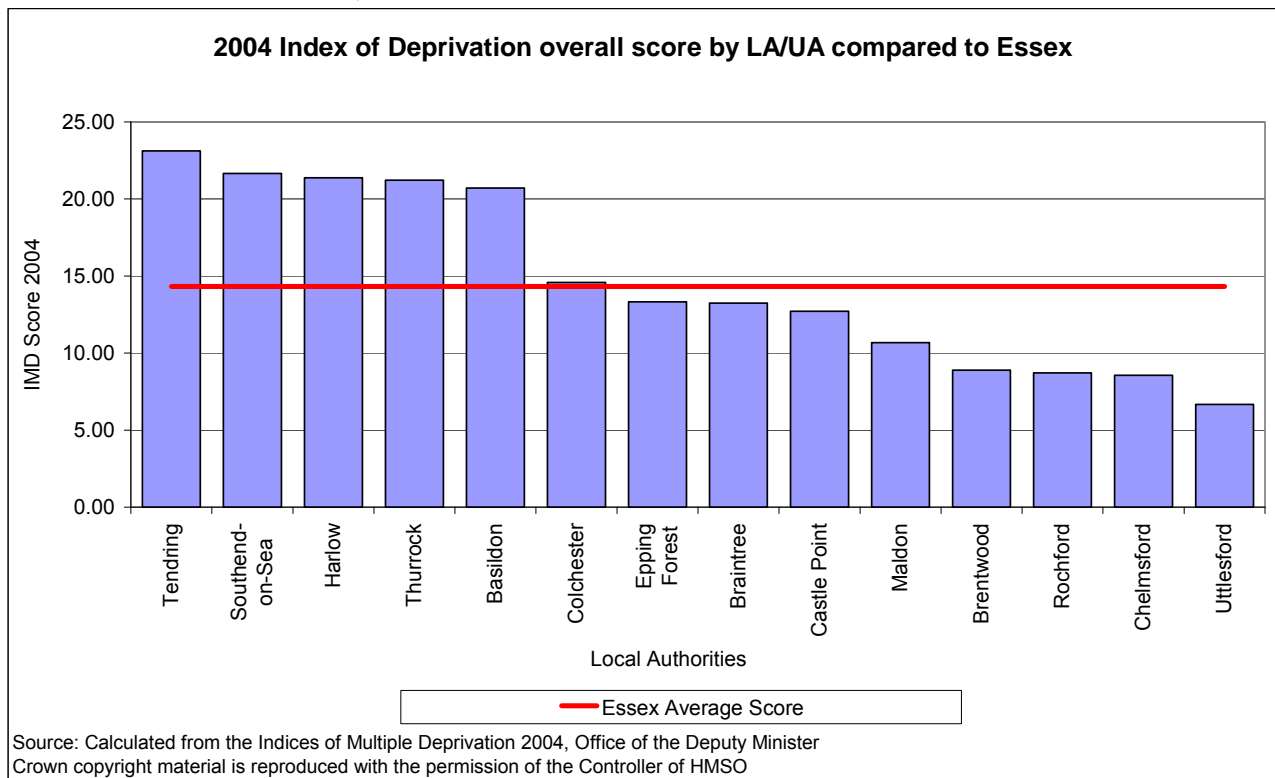
CHAPTER 2: SOCIAL & ENVIRONMENTAL CONTEXT

2.1 Deprivation

There is now good evidence to suggest that deprivation and social exclusion can impact on a number of aspects of life including employment and the economy; crime; education and skills; health; housing and the environment. One of the common measures used is the Index of Multiple Deprivation (IMD). IMD 2004 is a measure of multiple deprivation and comprises of seven domains denoting social or material deprivation which are combined into one index. The domains are: income; employment; health and disability; education; housing; living environment and crime. The higher the IMD score, the more deprived an area is said to be. Using the IMD 2004 score, the 354 local authorities in England are then ranked from 1 (most deprived) to 354 (least deprived).

Essex has some of the most affluent and some of the most deprived areas in the country, with Tendring and Southend being the most deprived (Figure 2.1). Many of the most deprived areas also experience the lowest levels of life expectancy.

Figure 2.1: Essex IMD 2004 scores



The IMD 2004 provides deprivation indices at sub-district level (super output area, SOA)⁷ which can highlight small areas of deprivation otherwise masked by proximity to relative affluence. This allows pockets of deprivation to be targeted more effectively by services.

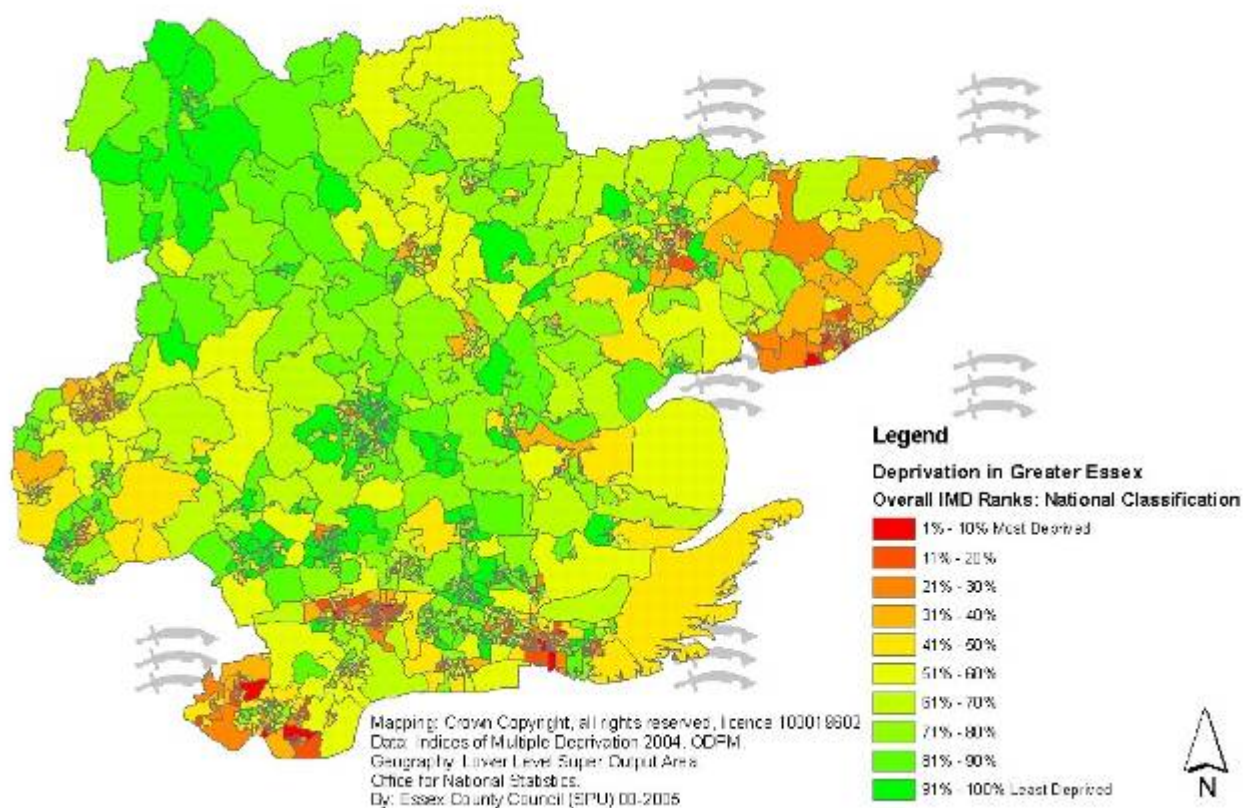
As can be seen from Figure 2.2 which shows deprivation at SOA level, areas across Essex show significant deprivation. Coastal Jaywick in Tendring is the most deprived SOA in Essex and is among the worst off 1% of areas in England. Parts of Clacton are in the 10% most deprived

⁷ See Glossary for definition

areas nationally. Southend has pockets of high affluence and wards which suffer extreme deprivation. An estimated 45% of the borough's population lives within the 20% most deprived areas in the East of England. Although Harlow shows higher levels of deprivation relative to other areas of Essex, this is not acute when compared with the national picture – its relative position is more a case of there being no large areas of particular affluence within the district. Deprivation in Thurrock is concentrated in the west and south of the borough with three of the five areas in the 10% most deprived in England situated in Tilbury. A number of neighbourhoods around the Basildon town urban area fall within the most deprived 10% and 20% in England and Colchester's main concentrations of deprivation can be found in Colchester Town. Many areas in Chelmsford are among the least deprived in the country although north-west of the town has pockets of relative deprivation. Uttlesford is the least deprived district in Essex and one of the least deprived in the East of England. Most of the district falls within the 20% least deprived areas nationally.

Figure 2.2: Essex IMD 2004 rank by national decile group

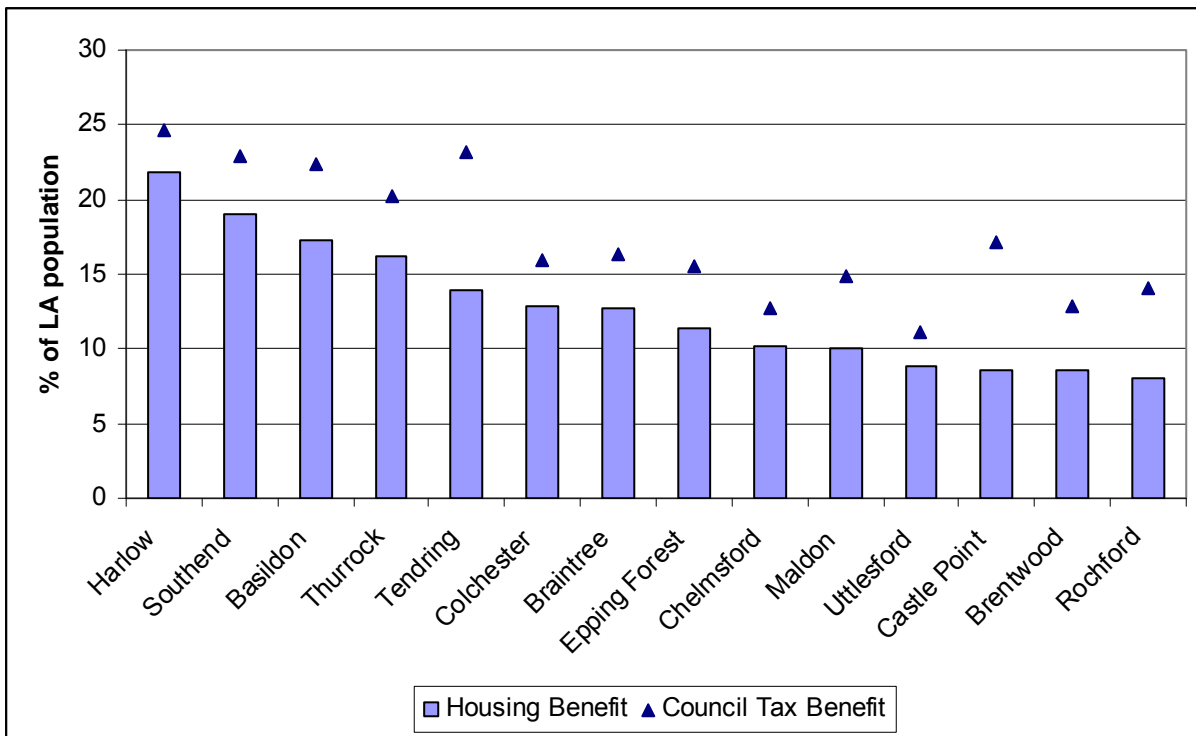
Deprivation in Greater Essex: Overall IMD 2004 Rank by National Decile Group



2.2 Poverty and Social Class

Take-up of means-tested benefits can act as an indicator of income-based poverty. Harlow has the highest percentage of residents receiving both housing benefit (22%) and council tax benefit (25%). Southend and Basildon also have high proportions in receipt of these benefits. Rochford has the lowest percentage of housing benefit recipients and Uttlesford the lowest number of council tax benefit recipients.

Figure 2.3: Essex recipients of Housing Benefit and Council Tax Benefit



Source: DWP, February 2007

2.2.1 Social class

All the evidence suggests that social class inequalities – present early in life – persist throughout life and post retirement. Life expectancy at birth differs by three years for women and five for men between social classes I/II and IV/V. A number of measures can give an indication of social class including occupation and housing tenure.

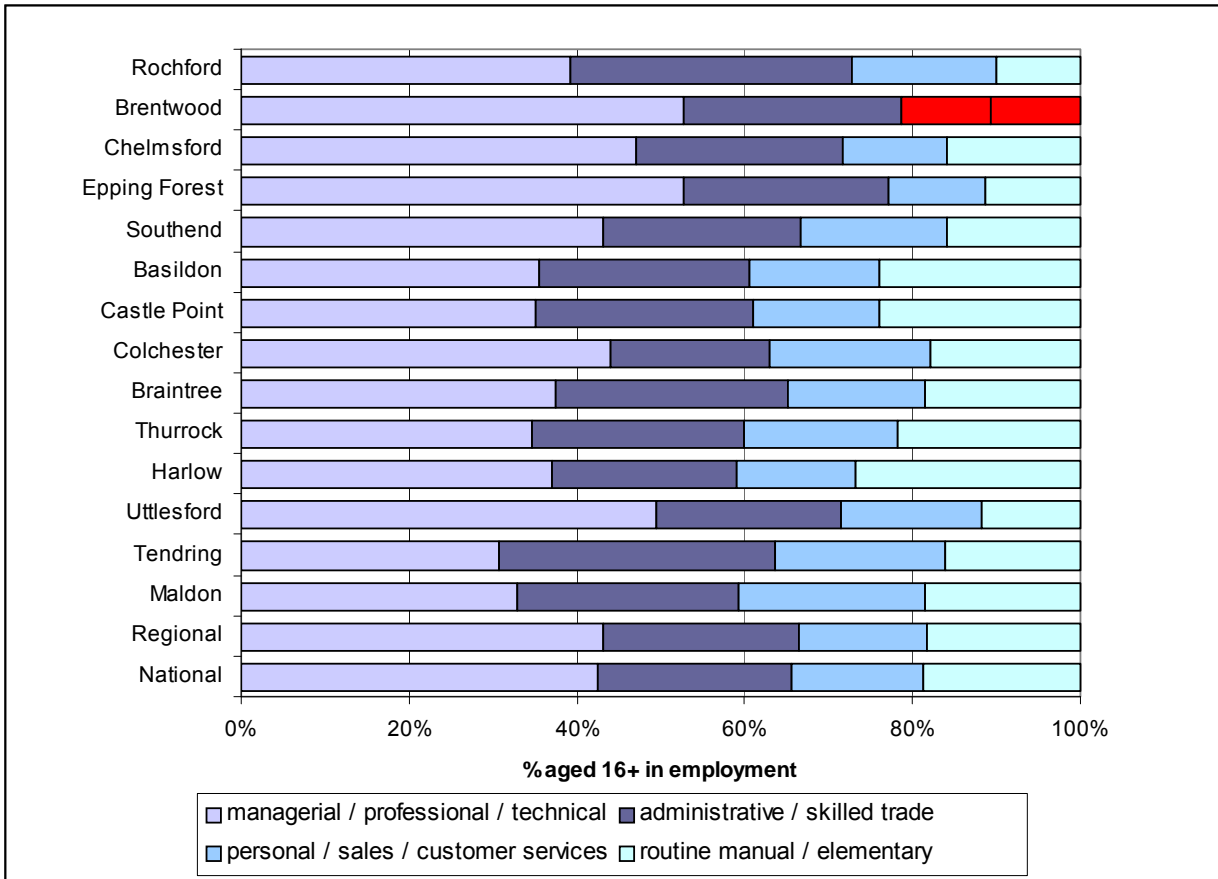
The charts below show the profile of occupation and housing tenure across Essex. Brentwood, Uttlesford and Chelmsford have a high percentage of managerial and professional workers whereas residents in Harlow, Basildon and Castle Point are more likely to be in very low-skilled occupations.

A high proportion of Essex residents own their own homes⁸: 75% compared to 69% across England. As detailed below, many Essex residents work in London and benefit from higher salaries, so that housing tenure is almost more an indication of commuting patterns than social class. Castle Point (with its good rail links and proximity to London) has the highest proportion of households owning their accommodation (88%) while Harlow (where more people work locally) has the lowest (60%). Basildon has the highest number of local authority dwellings and Chelmsford the highest proportion of registered social landlord stock⁹.

⁸ National Statistics: Census 2001

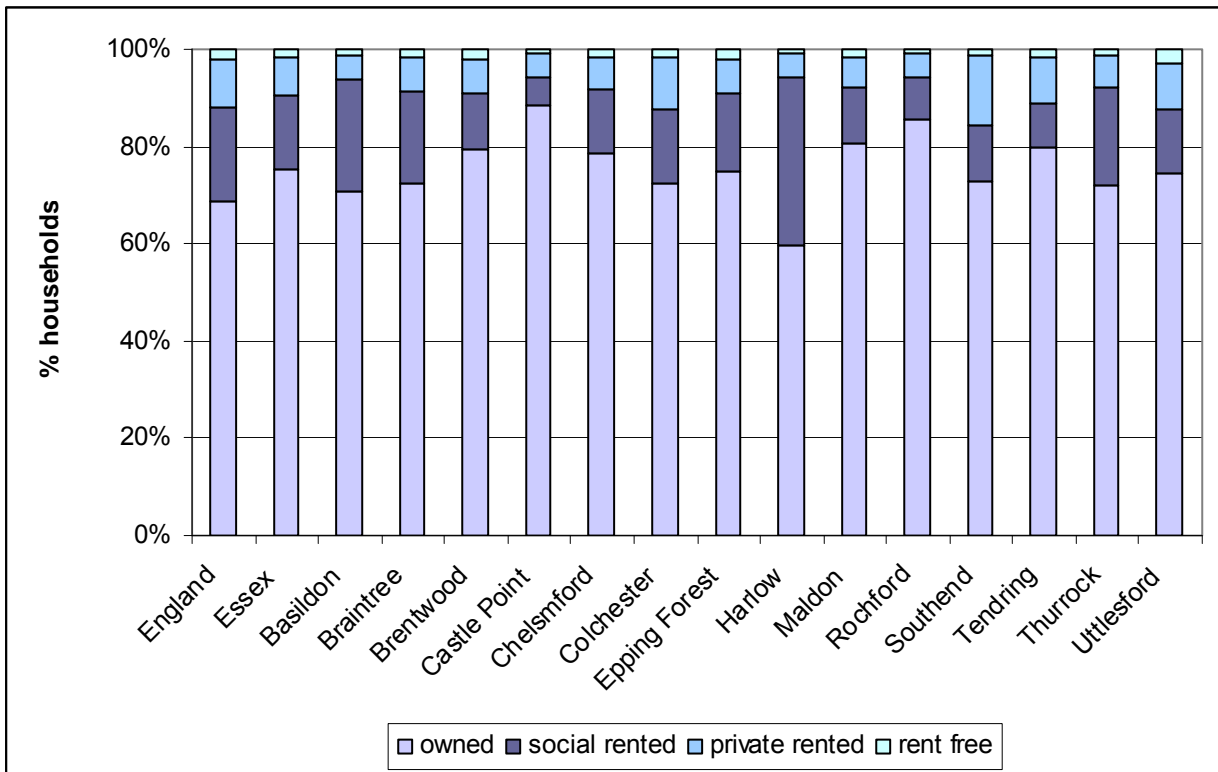
⁹ NeSS: Dwelling Stock by Tenure and Condition, 2005

Figure 2.4: Essex occupational breakdown, 2006



Source: ONS Annual Population Survey (red indicates sample size too small for reliable estimate)

Figure 2.5: Essex housing tenure



Source: Census, 2001

2.3 Housing

2.3.1 Household composition

Household size is decreasing, which affects housing markets and the need for affordable housing. Chapter 5 considers the impact of older people living on their own but here we consider the economic and social vulnerability of lone parents. Poor outcomes are by no means inevitable for children growing up in one-parent families; outcomes depend on a range of factors, including conflict between parents, parental involvement and whether children grow up in poverty. One-parent families are less likely to own their own homes than other families, their housing is more likely to be in poor condition, they tend to live on lower incomes and are therefore more likely to face poverty, financial exclusion and debt than other families. Combining work and family is often difficult for lone parents due to lack of childcare and flexible working, poorer qualifications and the fact that work does not always provide a route out of poverty.

The number of one-parent families has grown over recent years. Figure 2.6 shows what proportion of households with dependant children are headed by a lone parent. The percentage for Essex is lower than the national figure, although there is considerable variation between areas.

Figure 2.6: Essex lone parent households

	% households with dependant children headed by lone parent
Southend	27.6%
Harlow	26.6%
Basildon	25.1%
Thurrock	22.7%
Tendring	21.9%
Colchester	20.8%
Epping Forest	19.9%
Braintree	18.4%
Castle Point	18.2%
Chelmsford	17.9%
Brentwood	17.2%
Maldon	17.1%
Rochford	15.9%
Uttlesford	14.2%
Essex	20.0%
England	24.5%

Source: Census 2001

2.3.2 Affordable Housing

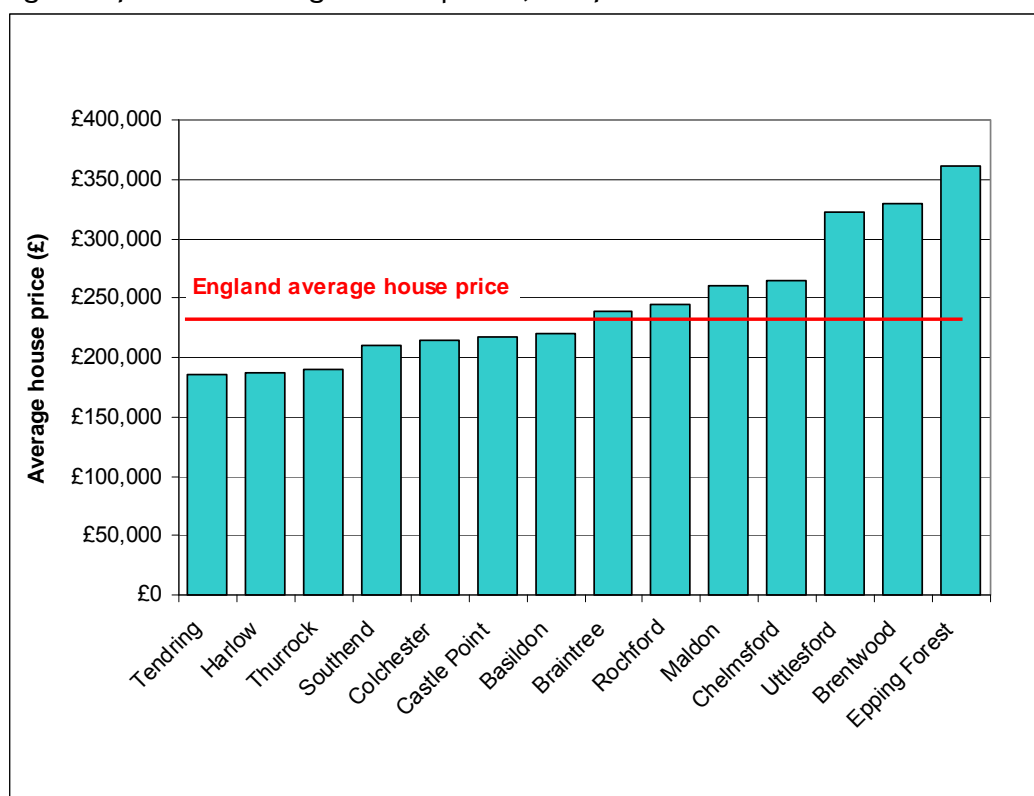
An adequate supply of good, affordable housing is essential to the quality of life of residents who cannot afford to compete in the open market. Affordable housing includes social rented accommodation (generally provided through Registered Social Landlords), shared ownership,

other intermediate tenures such as sub-market rent and key worker housing and supported housing. Affordable housing is aimed particularly at those on low incomes who earn too much to qualify for social housing but not enough to afford private sector rents or to participate in home ownership.

The need for affordable housing has increased in recent years as a result of high rates of growth in property prices combined with lower rates of growth in income and a widening of the gap between social sector rents and the costs of home ownership. There is a particularly acute shortage of affordable housing in many rural areas and, regionally, there is an expectation that some 35% of housing coming forward should be affordable¹⁰.

House prices in Essex are higher than the national average and very high in relation to average earnings. This raises challenges with regard to affordability, particularly for local workers whose salaries do not currently compete with that on offer in London. Clearly this is a challenge to creating a more self-contained economy and highlights the importance of creating high value jobs. Residents rated affordable decent housing as the third highest overall priority in the 2007 ECC Tracker Survey with Uttlesford and Harlow affording it particularly high priority.

Figure 2.7: Essex average house prices, 2007

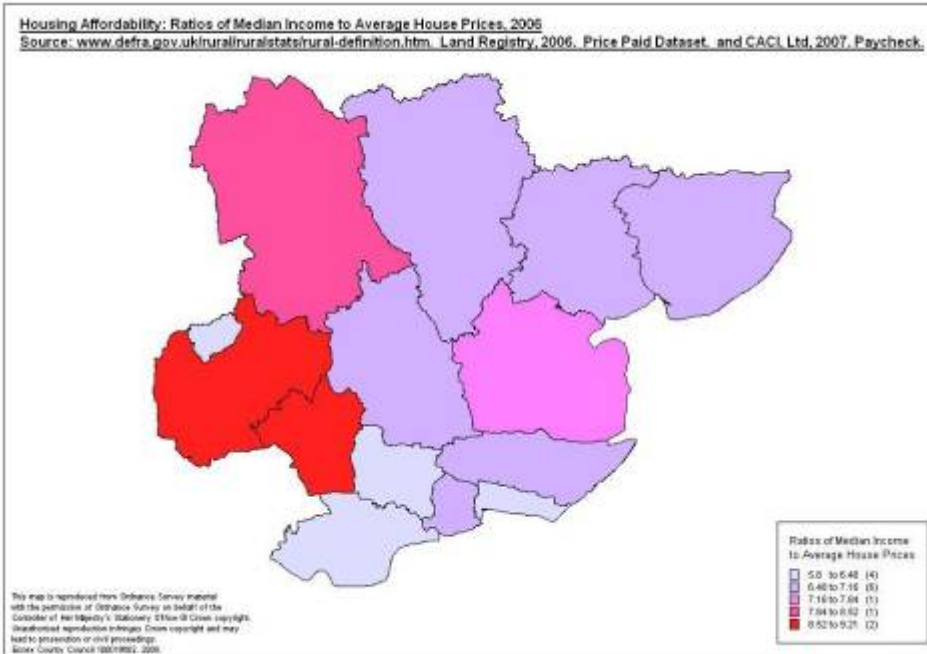


Source: Land Registry of England and Wales, 2007

Figures 2.7 and 2.8 show that not only are house prices highest in Epping Forest, Brentwood and Uttlesford but these areas are also those where they are greatest in relation to average income.

¹⁰ Secretary of State's proposed changes to the Regional Spatial Strategy, December 2006

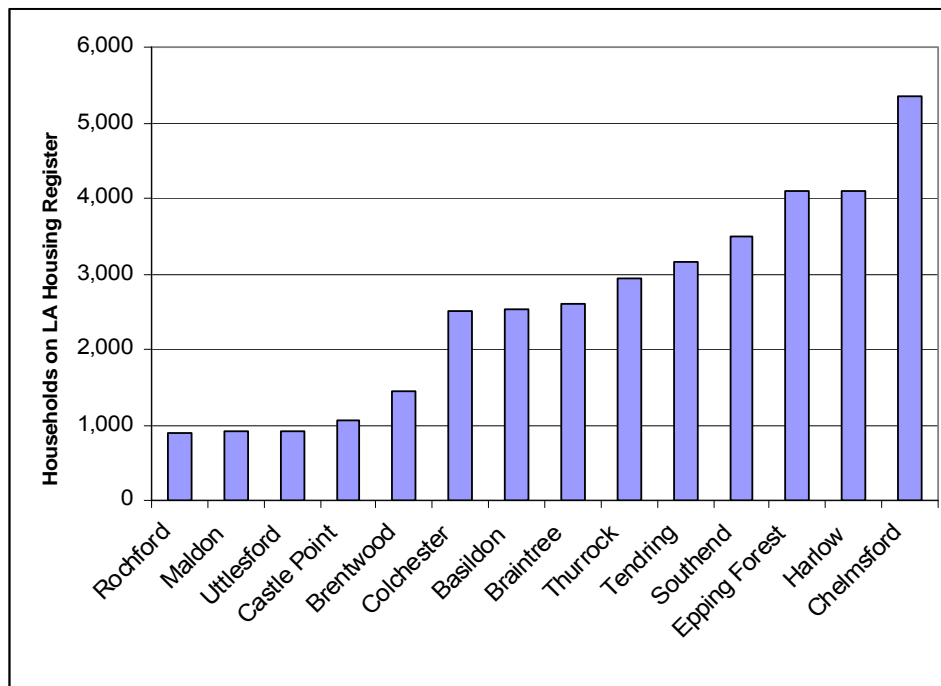
Figure 2.8 Essex map of housing affordability



Source: State of the Countryside. Commission for Rural Communities, 2007

In 2006 there were nearly 36,000 households (approx 5%) that had applied to a local authority for social rented housing and were waiting to be housed (includes those both in and not in housing need but excludes those seeking a transfer)¹¹. The following chart shows that demand in Chelmsford is particularly high (approx 8% of all households). However, at 13% Harlow has the highest proportion of households on the local authority waiting list.

Figure 2.9: Essex demand for social housing, April 2006



Source: Housing Strategy Statistical Appendix. DCLG

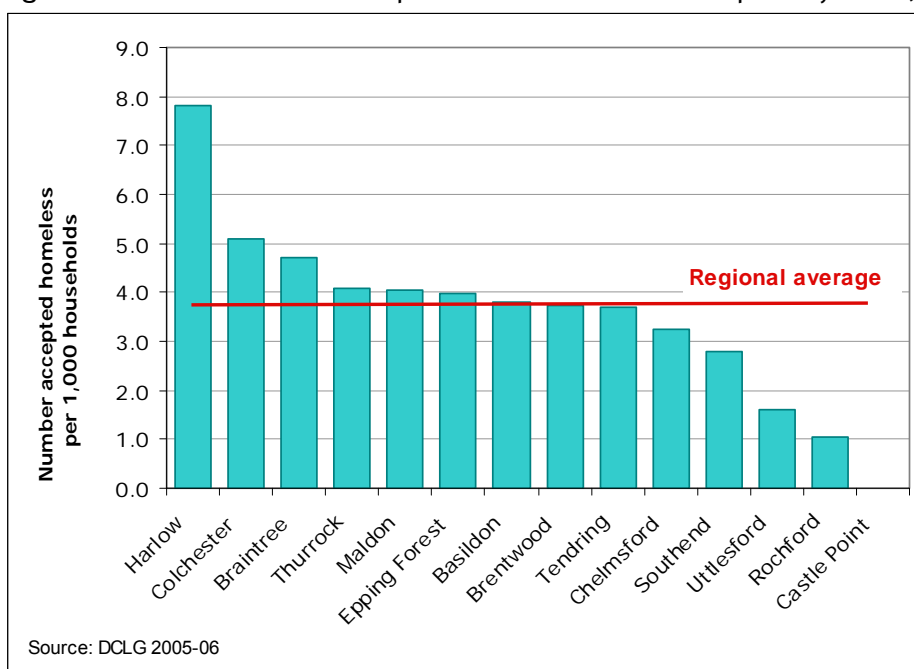
¹¹ Housing Strategy Statistical Appendix, April 2006. DCLG

2.3.3 Homelessness

Homelessness is associated with severe poverty and is associated with adverse health, education and social outcomes, particularly for children. Homeless people tend not to have equal access to adequate healthcare and chronic mental and physical illness is widespread among them. Moreover, their health needs can be directly related to their chaotic lifestyle. They regularly suffer from chronic respiratory and cardiac ailments (asthma and tuberculosis are particularly worrying), various skin diseases and mental health disorders such as schizophrenia and depression (Health Evidence Network, 2005). To be deemed statutorily homeless, a household must have become unintentionally homeless and must be considered to be in priority need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. National statistics suggest that 62% of officially accepted homeless households include dependent children or an expectant mother. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector.

The number of Essex households ‘officially’ accepted as homeless each year has shown an annual decrease of around 500 over the past three years. According to the most recent published data, around 2,500 households in Essex were accepted as homeless during 2005-06 with the highest rate in Harlow¹². These figures do not include households that have become unintentionally homeless but are not considered to be in priority need or households that have become intentionally homeless. Nor are rough sleepers included. The measure is, therefore, an underestimate of the extent of homelessness.

Figure 2.10: Households accepted as homeless and in priority need, 2005-06



2.4 The Environment

Conditions in the home and of the neighbourhood can have a big impact on our health and well-being. The physical, chemical, biological, social, and psycho-social factors in the

¹² HSSA (Housing Strategy Statistical Appendix) 2005/06. DCLG

environment can affect a number of aspects of human health and quality of life. The contamination of water and the air can trigger diseases, both chronic and acute in the population. Planning our towns, location of services and access to green spaces are all important issues to the well-being of the population.

2.4.1 Housing quality

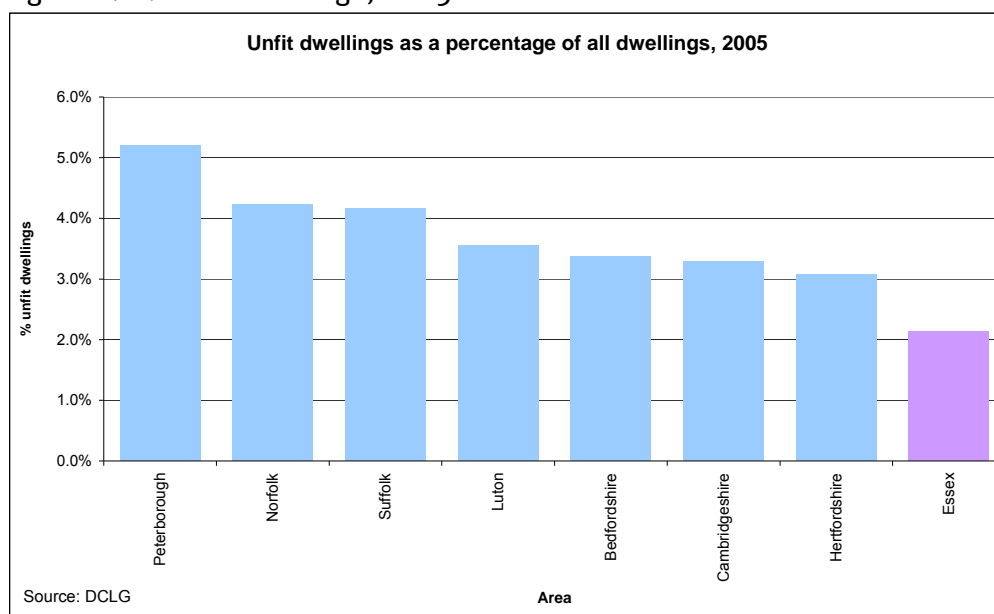
Poor quality housing is associated with increased levels of limiting long-term illness, respiratory and infectious diseases, accidents, psychological problems, perceived poor general health and even increased mortality. The most important risks appear to be cold, damp and mouldy housing conditions. Cold housing is one of the factors associated with excess winter deaths.

Overcrowding and living in high-rise flats is associated with psychological symptoms including depression. *Our Healthier Nation* recognises the importance of good housing in reducing stress and its association with other factors such as poverty, pollution, crime and poor access to facilities.

Overcrowding is not an issue in Essex. At the time of the Census (2001), the majority of Essex's 686,650 households (some 73%) had a ratio of less than 0.5 persons per room. This is equivalent to a family of four living in a house with four bedrooms, a kitchen, dining room and living room. Only 1% of Essex households have more residents than rooms.

Figure 2.11 shows the proportion of dwellings in Essex and comparator areas that are 'unfit'¹³. Of Essex's 715,000 dwellings, some 15,000 (2.1%) are unfit. This is the lowest percentage of dwellings of any county or upper tier authority area in the East of England region. Of the 15,000 unfit dwellings within Essex, the vast majority (97%) are privately owned. Only 3% of dwellings classed as unfit are public-sector owned.

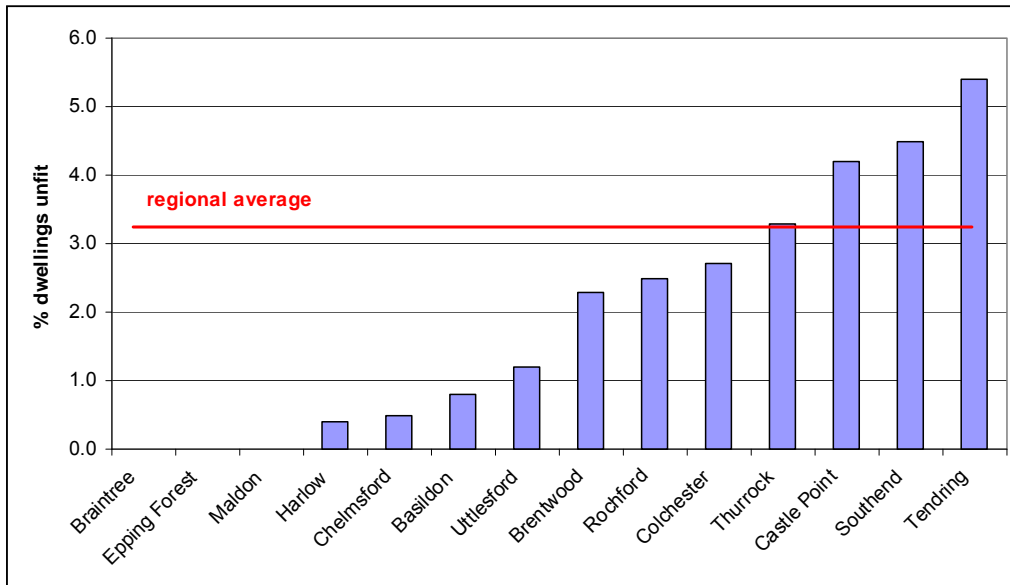
Figure 2.11: Unfit dwellings, 2005



¹³ See glossary for full definition

However, as can be seen in the following chart, there is variation across the county with Castle Point, Southend and Tendring appearing significantly above the regional average.

Figure 2.12: Essex dwellings deemed unfit, 2005

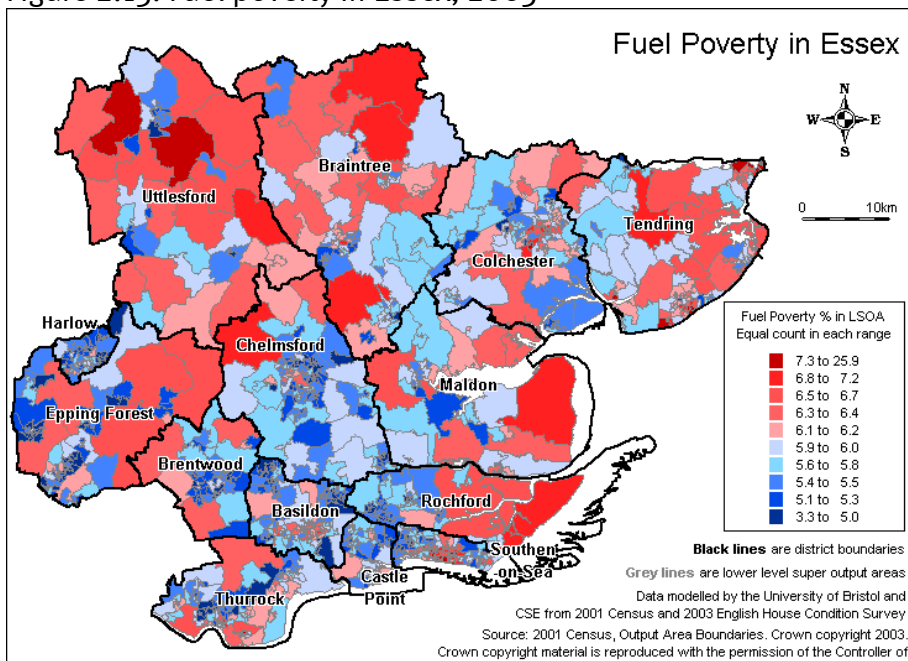


Source: DCLG

2.4.2 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. In 2004 there were around 1.2m households in fuel poverty in England, according to official figures. However, the Government estimates that fuel poverty doubled between 2004 and 2006, due to the rise in fuel prices over this period. The consequences of fuel poverty include cold, damp homes; reduced quality of life; poor health and debt. The following map identifies those areas in greatest fuel poverty across Essex; colours relate to decile ranges for England.

Figure 2.13: Fuel poverty in Essex, 2003

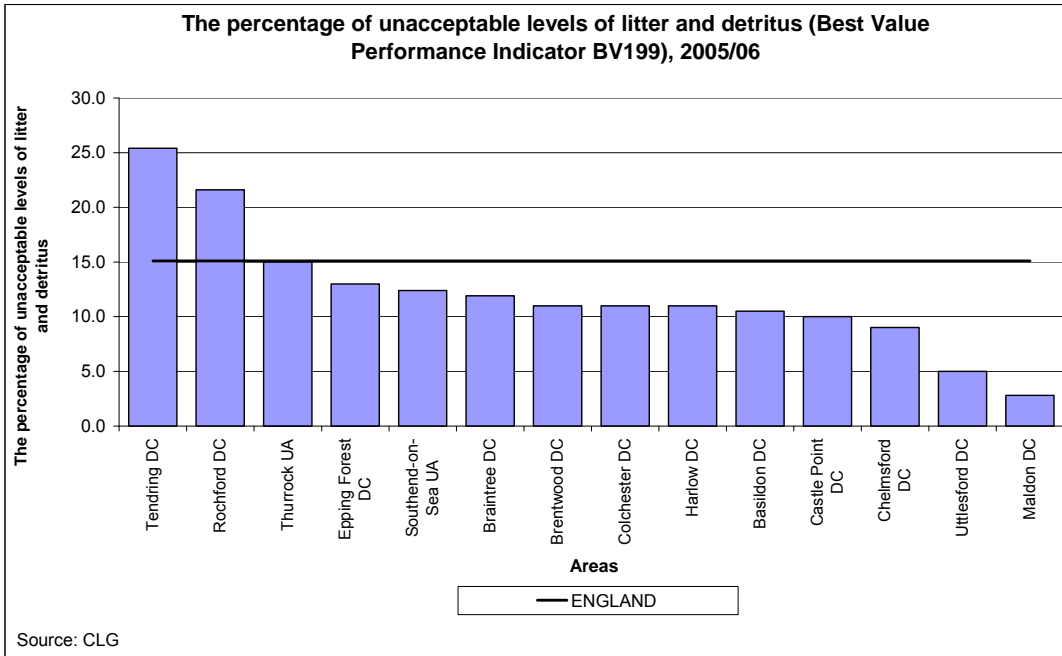


Source: www.fuelpovertyindicator.org.uk

2.4.3 Street cleanliness

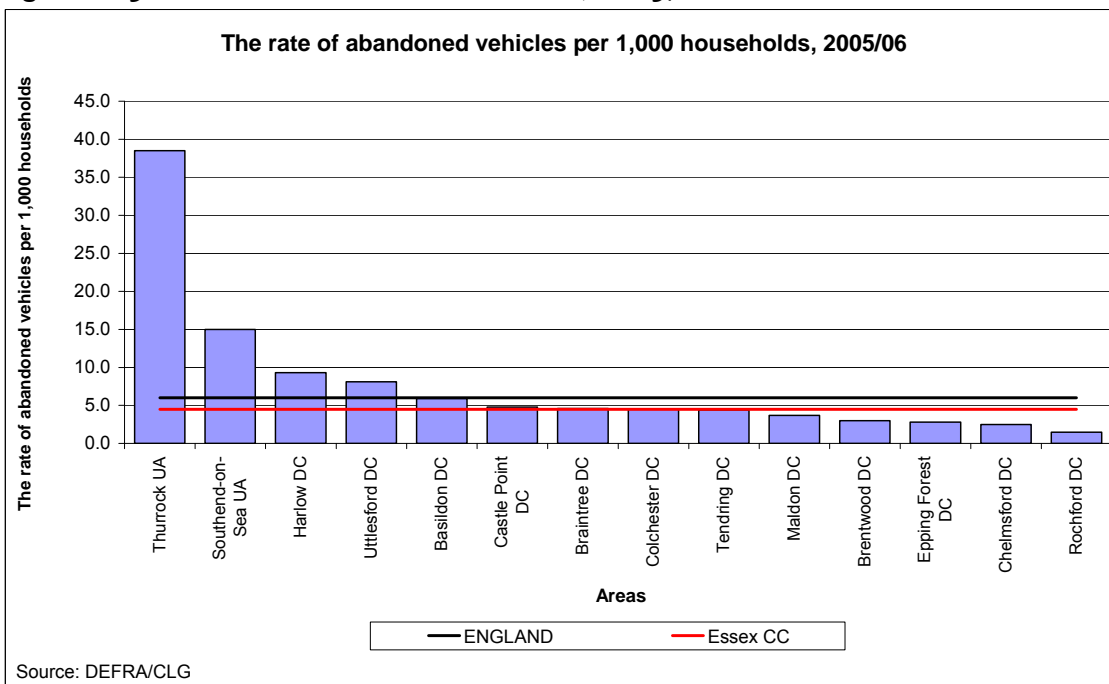
Street cleanliness was considered the sixth highest overall priority according to the ECC 2007 Tracker Survey and fell within the top two in Colchester, Epping Forest and Harlow. A survey of sites throughout the Essex area showed that Essex has two areas – Tendring and Rochford – which have higher than average percentages of unacceptable litter and detritus levels.

Figure 2.14: Essex litter and detritus levels, 2005/06



In 2005/06 there were 4.5 abandoned vehicles per 1,000 households in Essex – below the England average of 6.0 per 1,000 households. Four areas in Essex have rates higher than the England average although levels in Thurrock are six times higher.

Figure 2.15: Essex abandoned vehicle rates, 2005/06

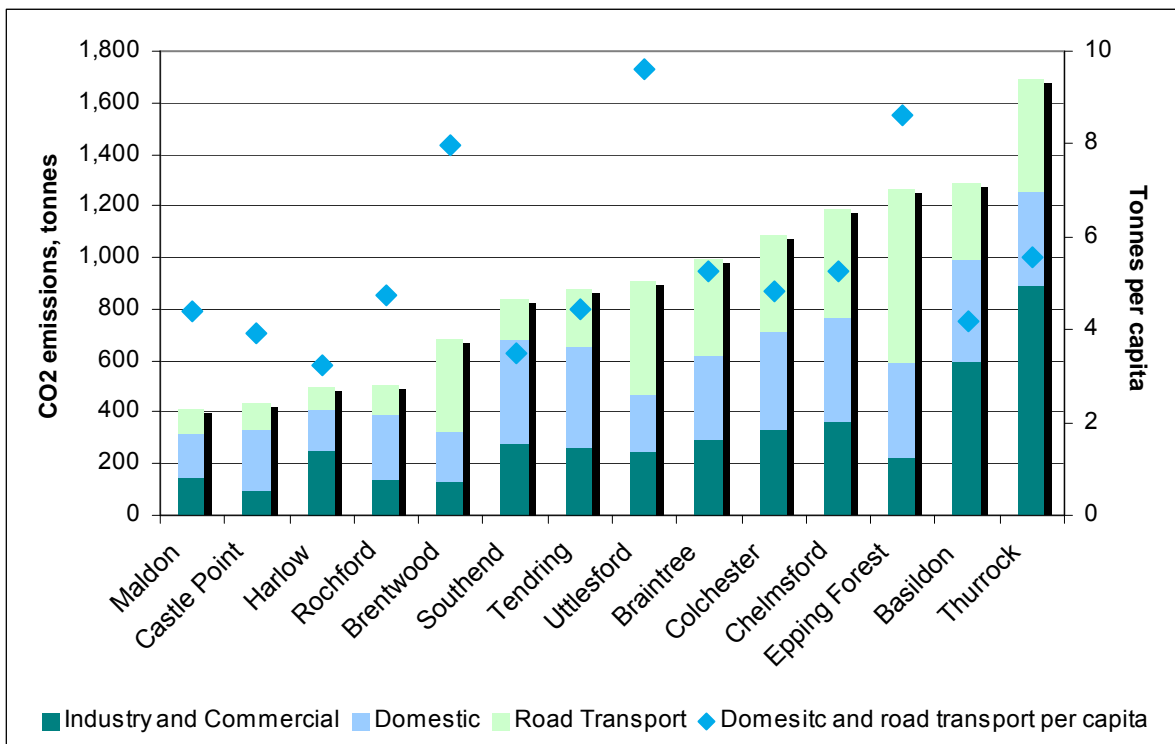


2.4.4 Pollution / CO₂ emissions

In 2004 ECC produced a total of 10,131 kilo tonnes of CO₂ which equates to 8.5 tonnes per capita. This is almost 1 tonne per person per year less than the UK average (9.2 per capita) which is due to relatively low levels of emission from industrial and commercial sources. Road transport makes up the highest proportion of CO₂ emissions in ECC, accounting for 35% of all emissions. This is higher than both national (27%) and regional (34%) averages.

Although Essex has a relatively low carbon footprint, the following chart shows significant differences exist across Essex. Thurrock has the highest total carbon emissions and Maldon has the smallest, emitting less than a quarter of the level in Thurrock. This reflects the fact that Maldon is a particularly rural district, with a relatively small population whereas Thurrock has the highest concentration of industry and several major transport links. However, on a per capita level, Uttlesford, Epping Forest and Brentwood have high emission rates, largely as a result of high levels of road transport emissions associated with the M11 and M25 motorways.

Figure 2.16: Essex CO₂ emissions, 2004

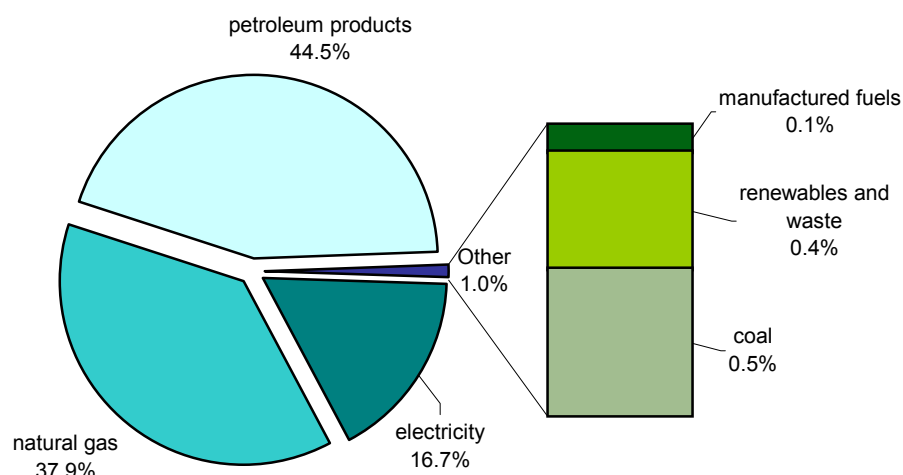


Source: AEA Energy & Environment for DEFRA

Most of the energy consumed in the UK is derived from the burning of fossil fuels (oil, natural gas and coal). Fossil fuels are finite in supply and are regarded as unsustainable energy sources. Figure 2.17 gives a breakdown of energy consumption in Essex. It shows that over 99% of all energy consumed in Essex is derived from fossil fuels.

Figure 2.17: Essex energy sources, 2004

Source: Department for Trade and Industry



2.5 The Local Economy

The Essex economy has been one of the fastest-growing in the East and South East since 2000¹⁴. The county has a dynamic business community and residents generally enjoy high salaries and low unemployment as a result of the county's proximity to London, its transport gateways and connections and because it hosts some of Europe's leading companies. However, Essex's productivity rate is below both regional and national averages and there is a need to create more local jobs. Without locally available work, future growth in our population and housing stock will lead to increased commuting and dependence on London. We need to stimulate local job growth and attract inward investment.

In November 2007, the Greater Essex Prosperity Forum approved five key priorities developed through extensive consultation and based on evidence contained within the Greater Essex Economic Framework¹⁵. The five priorities are to:

- make a difference to the improvement of low skills attainment in Essex;
- create a competitive economy which is an international leader rather than a follower;
- create the right conditions in which businesses and people can flourish;
- be a leader in environmental technology and in helping our businesses to reduce their carbon footprint;
- build on the Essex entrepreneurial spirit by helping companies to start-up, innovate and grow.

Most partners agree that skills attainment is of the most pressing concern as it impacts on so many other areas. However, there are some important local differences, for example, there is variation across the county in terms of the skills gap requiring differential investment; business start-up and survival rates are lower in Southend; some of the largest development work will be taking place in Thurrock, calling for partners to work together to minimise the environmental impact; Harlow is home to some world-leading companies but lacks the

¹⁴ based on GVA estimates produced by National Statistics

¹⁵ The Framework and background information can be viewed at: <http://www.exdra.co.uk/programmes/greater-essex-prosperity-forum/economic-framework.cfm>

appropriate local skills-base to take full advantage of this; and the Bathside Bay development in the Haven Gateway area offers opportunities which need to be maximised.

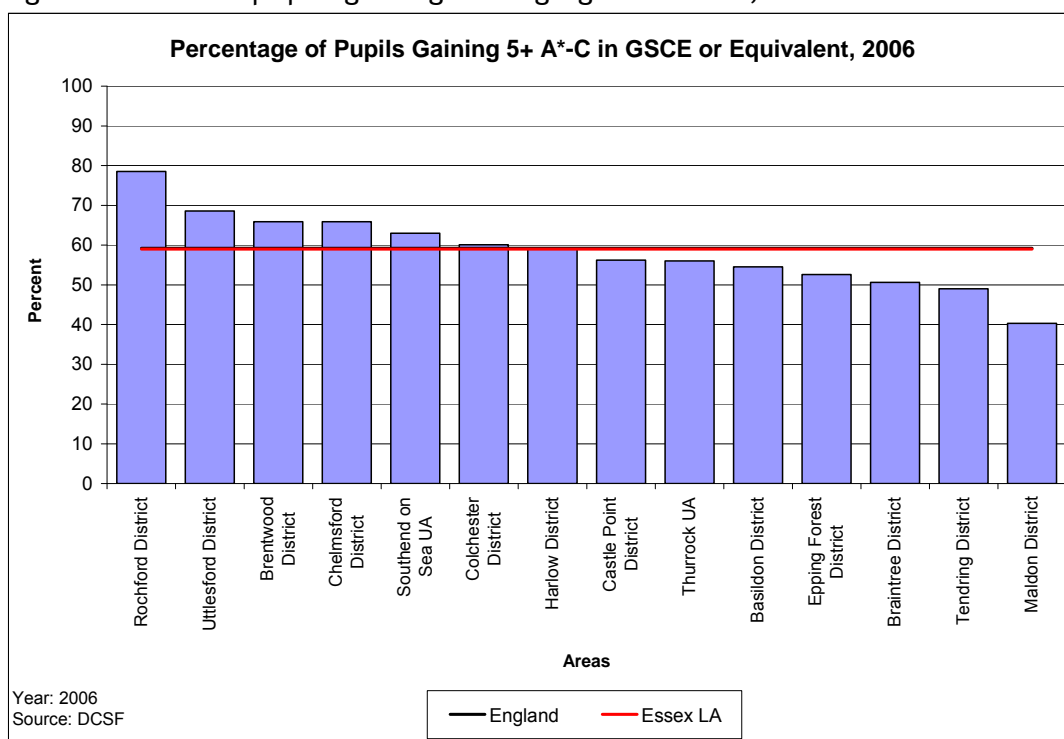
2.6 Education and Skills

2.6.1 Educational attainment

Educational attainment is influenced by both the quality of education children receive and their family socio-economic circumstances. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities. Young people who do not get 5 A*-C grade GCSEs (or equivalent) by age 16 tend not to have good opportunities to achieve success later (14-19 White Paper).

In 2006, 59% of Essex pupils gained 5+ A*-C grade GCSEs (or equivalent). Although this is just below the England average of 59.2%, half of Essex areas show attainment levels the same or higher than the England average. However, there is wide variation between areas with nearly 80% of pupils in Rochford gaining 5+ higher grade GCSEs compared to only 40% in Maldon. Across Essex as a whole, only 2.4% of pupils left school without a GCSE or equivalent qualification – slightly more than the England average (2.2%).

Figure 2.18: Essex pupils gaining five high-grade GCSEs, 2006

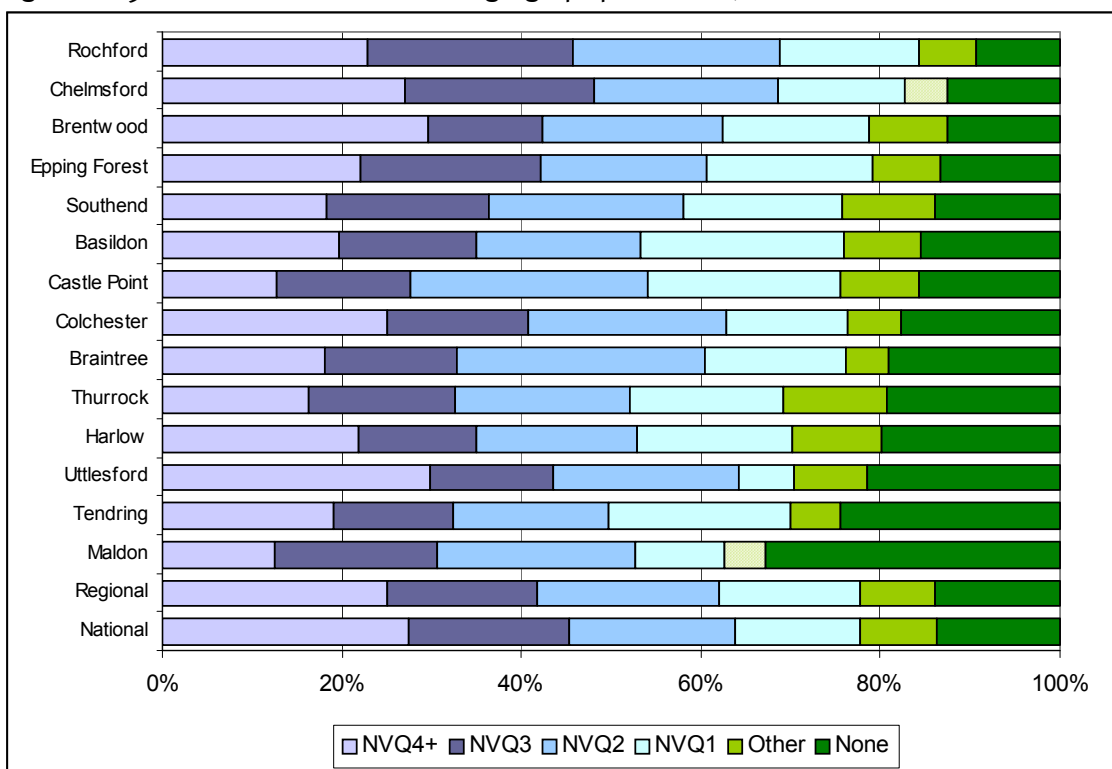


If, as set out above, Essex is to become a leader in environmental technology and help businesses reduce their carbon footprint, it is recognised that local pupils need to be encouraged to take up STEM (Science, Technology, Maths, & Engineering) subjects at school in order to try to affect development of the right skills set at the earliest opportunity.

2.6.2 Adult qualifications

The workforce in Essex tends to be slightly older than that across England and older people tend to have fewer qualifications. Essex is also a net exporter of 16-24 year olds who are more likely to hold qualifications. As a result, skills in Essex tend to be lower than elsewhere. Census data revealed that less than 15% of Essex adults had a degree or higher qualification (compared to 20% of the adult population in England) and that nearly 30% of the Essex working age population had no qualifications. More recent data from the ONS Annual Population Survey shows that the picture has improved although parts of Essex are still significantly behind both national and regional averages. For example, in Maldon 33% of the working population have no qualifications (compared to 14% nationally and regionally) and only 12.5% have a degree or higher qualification (compared to over 25% nationally and regionally).

Figure 2.19: Qualifications of working age population¹⁶, 2006



Source: ONS Annual Population Survey (shading indicates sample size too small for reliable estimate)

In order to improve the local economy, it is essential to develop more local high-value jobs and the skills to match. The challenge is to encourage both residents and employers to invest more time and money in skills. This will not be easy as many residents already enjoy a high standard of living with few formal qualifications and the proximity of London gives residents access to relatively highly-paid jobs but reduces competition for local opportunities.

¹⁶ NVQ1: equivalent to fewer than 5 GCSEs grade A-C; NVQ2: equivalent to 5 GCSEs grade A-C; NVQ3: equivalent to 2+ A levels; NVQ4+: degree and higher

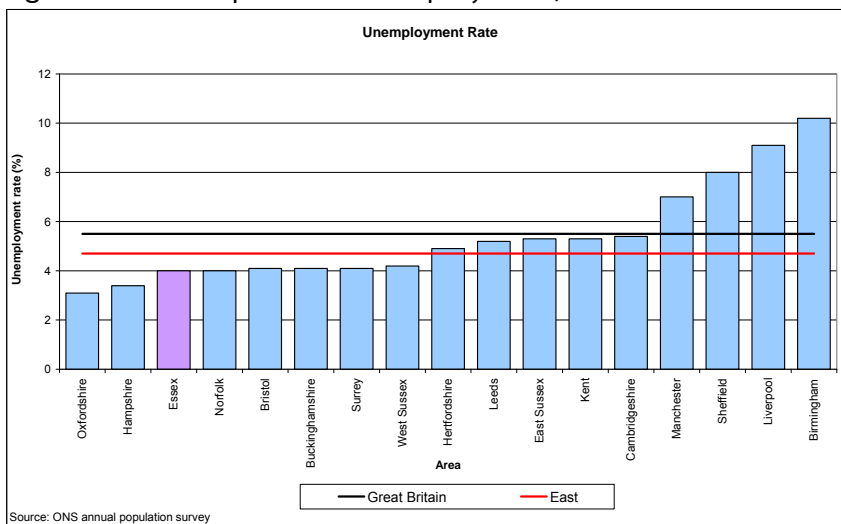
2.7 Employment and Unemployment

Work can be the basis of good health (particularly mental health), prosperity and well-being but there are also certain aspects of work that can adversely affect us. Unhealthy work patterns and workplaces and a lack of job security can all lead to poor mental health. The move towards less secure, short-term employment affects most of us, especially less-skilled manual workers, already faced with longer working hours for very low pay.

Unemployment can affect an individual's health and lifestyle dramatically. Long-term effects may include depression, loss of identity and self worth. In addition, work can play an important role in our social networks and the ways we participate in society. Mounting debts and hardship for the unemployed can create stress and anxiety in coping with their lives.

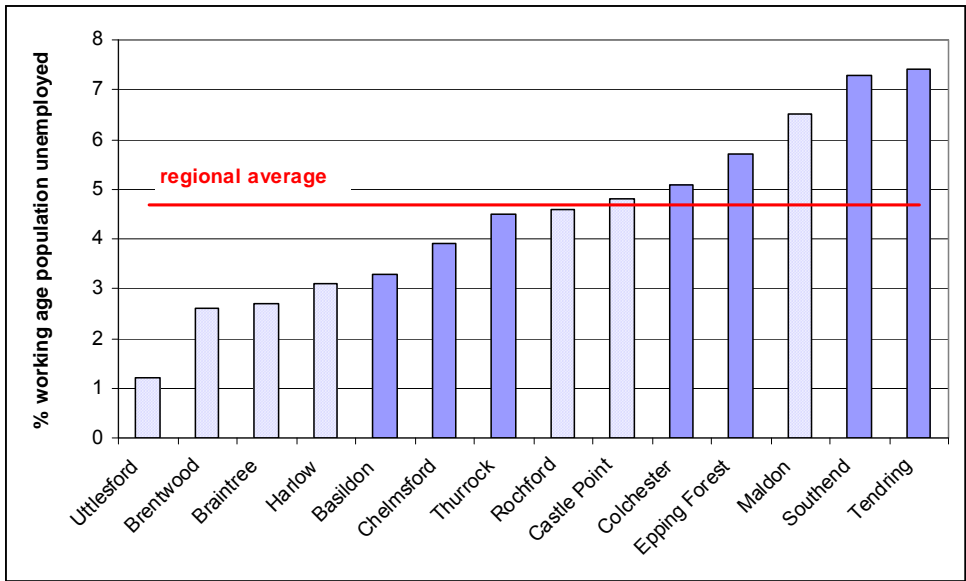
Around 31,900 people (4%) are unemployed in Essex. Mid-year population estimates show that Essex residents are 1.6% more likely to be in employment than the average person in Great Britain. As shown in Figure 2.20, the unemployment rate in Essex is low compared to other counties and lower than both the regional and national averages.

Figure 2.20: Comparative unemployment, 2006



Unemployment rates have remained relatively stable over the past year. However, as can be seen from the following chart, there is still wide variation across the county (NOTE in some areas, figures should be treated with caution due to sample sizes).

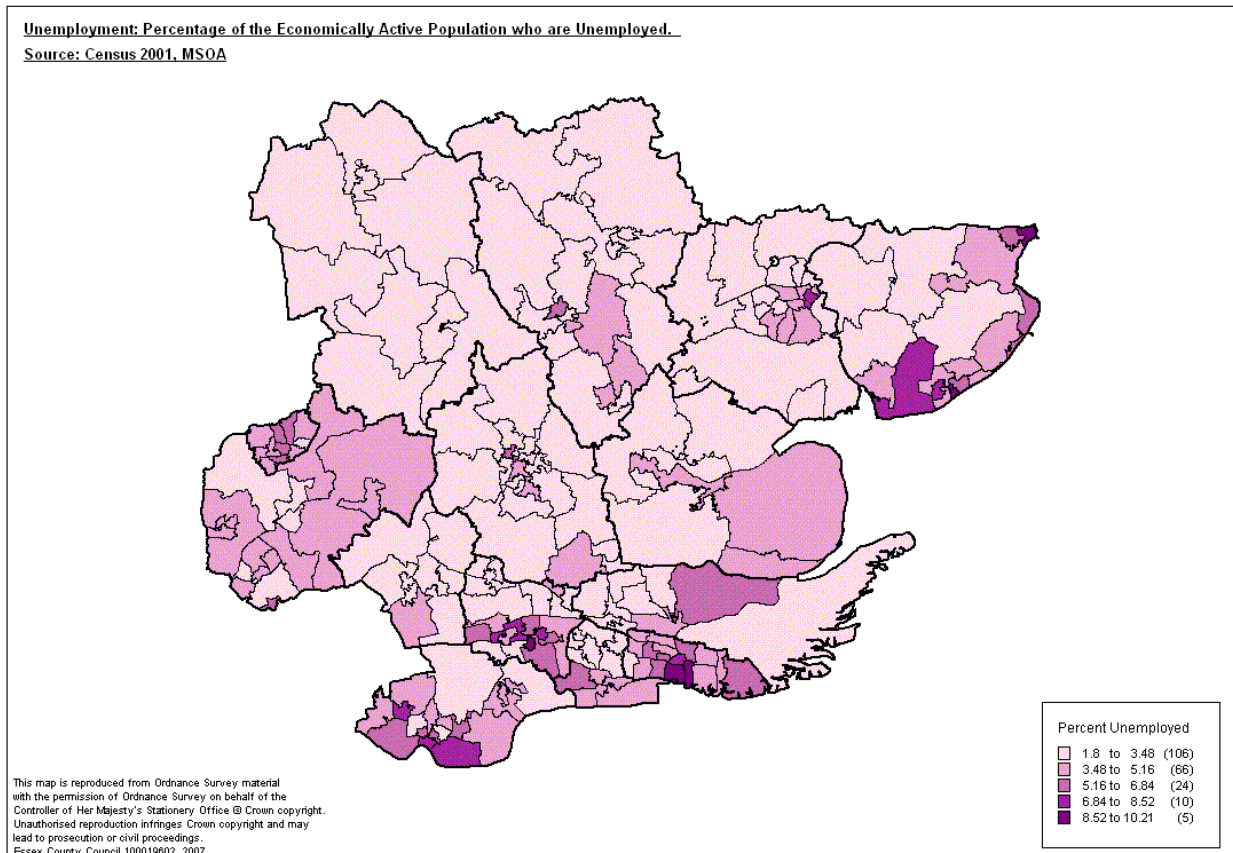
Figure 2.21: Essex unemployment rates, 2006



Source: ONS Annual Population Survey (shading indicates sample size too small for reliable estimate)

Although unemployment has fallen since the Census, the following map shows that a below district / borough level analysis is needed to identify pockets of high unemployment. Back in 2001, areas to note included the centre of Basildon, south and north east corner of Tendring, and parts of Southend and Thurrock.

Figure 2.22: Unemployment by MSOA, Census 2001



There are 730 jobs per 1,000 working age residents in Essex, compared to the Eastern average of 820 jobs per 1,000¹⁷. Despite local job shortages, unemployment in Essex is kept low in part by good transport links and Essex's proximity to London. Nearly 15% of Essex residents commute to London. This also explains the higher average income in Essex (£576 per week – £36 higher than the average in Great Britain¹⁸) despite the higher proportion of residents with no qualifications.

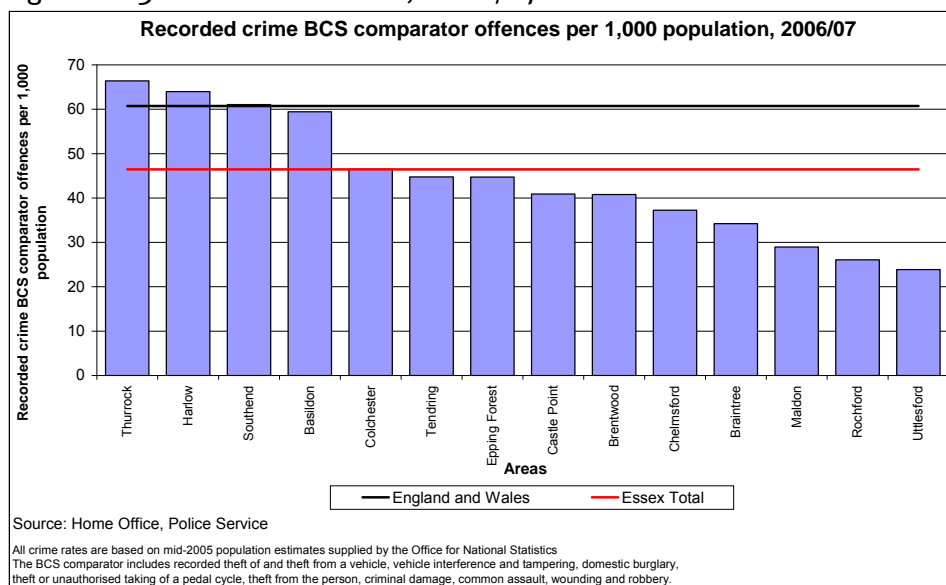
2.8 Crime and Disorder

Crime is associated with social disorganisation, low social capital, relative deprivation and health inequalities. The same social and environmental factors that predict geographic variation in crime rates may also be relevant to explaining community variations in health and well-being. Level of crime is afforded the top overall priority by residents according to the 2007 ECC Tracker Survey with only Maldon giving highest priority to activities for teenagers (associated with anti-social behaviour).

2.8.1 Crime rates

Crime rates can be compared by using a sub-set of recorded crimes that can be aligned to categories in the British Crime Survey. This is known as the BCS comparator rate¹⁹. Crime in Essex is relatively low (46 per 1,000 population compared to 61 per 1,000 for England & Wales) and, since 2003/4, BCS crimes have consistently fallen year on year. However, crime rates across Essex are variable and are typically higher in urban areas. For example, in 2005/6 the rate of crime was 72 crimes per 1,000 people in Harlow but only 23 per 1,000 in Uttlesford.

Figure 2.23: Essex crime rates, 2006/07



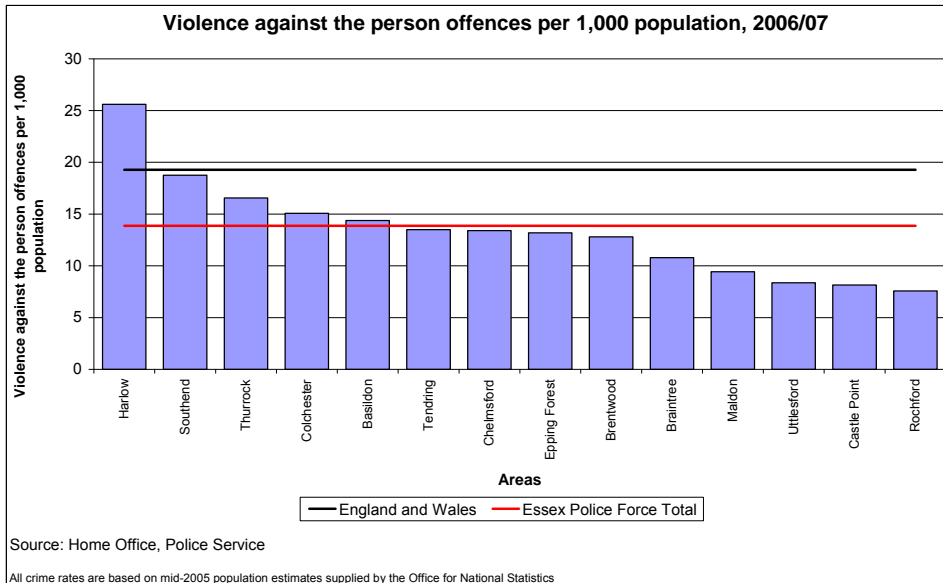
Essex also has a lower rate of violence against the person than the England and Wales average (13.87 per 1,000 population compared to 19 per 1,000). Harlow has a significantly higher rate than elsewhere in Essex.

¹⁷ Labour Force Survey 2007

¹⁸ Source: ONS Annual Survey of Hours and Earnings 2006

¹⁹ See Glossary for full definition.

Figure 2.24: Essex violent crime rates, 2006/07



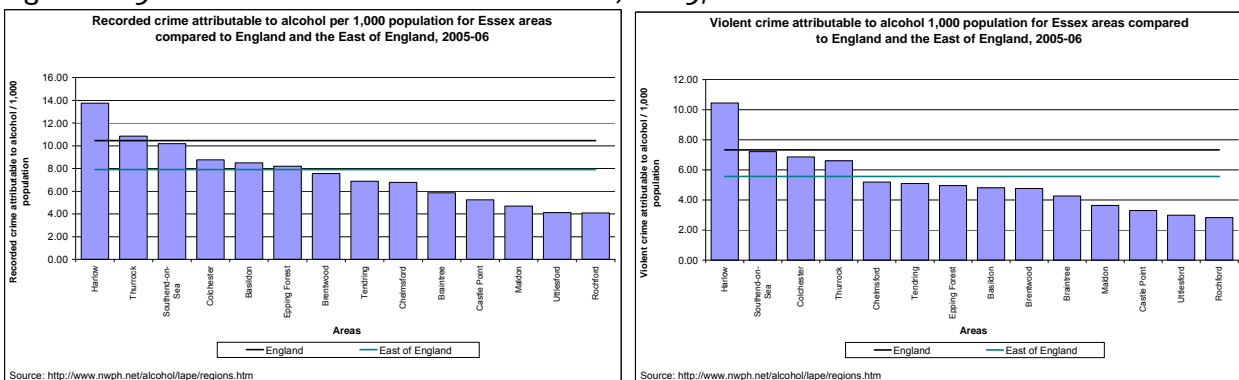
2.8.2 Alcohol-related crime

There is a strong link between excessive alcohol consumption and crime, particularly violent crime, assaults, accidents and anti-social behaviour. It has been estimated that alcohol misuse now costs around £20bn a year through its health, crime and social impacts.

Indications of Public Health in the English Regions (APHO, 2007) uses 36 different indicators relating to individual, community and population implications of alcohol use and their effects on health and wellbeing. The only indicators where East of England region performance is worse than average are associated with alcohol-related road accidents.

In Essex, Harlow and Thurrock have a rate of alcohol-related crime higher than the England average. In terms of violent crime, Harlow again shows a significantly higher than average rate.

Figure 2.25: Essex alcohol-related crime rates, 2005/06



2.8.3 Crime and disorder priorities

At local level, each district / borough is required to conduct a local crime and disorder audit to inform the development of their Crime & Disorder Reduction Partnership Strategies. The audit is a review of both statistical evidence and the views of the community about levels of crime and disorder. The 2004 audits highlighted significant commonality with drug and alcohol use;

anti-social behaviour; reducing crime and the fear of crime; dealing with domestic violence and hate crime all almost universally identified as local priorities.

From the local audits and a review of the evidence, the following issues were identified as crime and disorder priorities and adopted in the 2006-09 Essex Local Area Agreement:

- reduce the number of young victims of crime;
- reduced drug and alcohol use by children and increased successful completions of adult treatment programmes;
- reduction in rates of 10 key crimes;
- reduction in fear of crime;
- increased sanction detection rate for domestic violence offences;
- reduced re-offending;
- reduced public perception of drug dealing and drug use as a problem;
- build respect in communities and reduce anti-social behaviour.

2.9 Transport

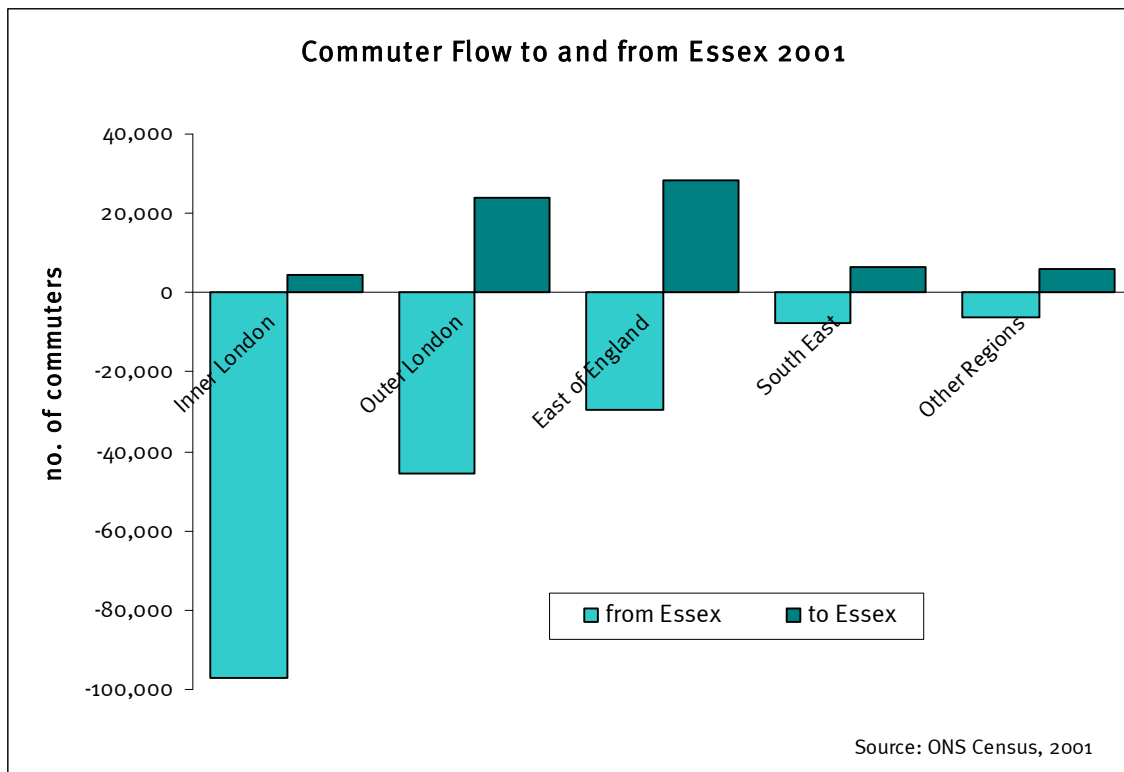
Transport includes walking and cycling, as well as the use of private vehicles, public transport and goods vehicles. Transport can have a wide range of beneficial and deleterious effects on health. Positive effects include recreation; exercise; and access to employment, education, shops, recreation, social support networks, health services and the countryside. Negative effects include: pollution; traffic injuries; noise; stress and anxiety; danger; land loss and planning blight; and severance of communities by roads (Transport & Health Study Group, 2001). Data from the ECC Tracker and Disadvantaged Neighbourhood Surveys shows that poor transport is the biggest single factor that makes people feel excluded from society, especially in disadvantaged neighbourhoods.

Essex has an extensive bus network (including a 'Village Link' network of rural bus services) and is served by good rail links. Some areas of west Essex also have London underground stations and there are frequent trains into London from all over Essex as well as to other counties including Suffolk, Norfolk, Hertfordshire and Middlesex. The Tilbury to Gravesend ferry is subsidised by Thurrock Council and Kent County Council and there are three foot ferries: the Harwich Foot Ferry, Brightlingsea Foot Ferry and the Wallasea Island to Burnham-on-Crouch ferry. The county is also home to Stansted Airport in Uttlesford and London Southend Airport.

The road and rail networks in Essex take well over half a million people to and from work every day. Almost a third of Essex workers commute out of the county with two thirds of this group heading for London²⁰. Essex's urban and rural mix, coupled with the distances between its larger towns, means that almost a quarter of those who live and work in the county commute outside their own district¹⁹.

²⁰ Census 2001. National Statistics

Figure 2.26: Travel patterns of Essex commuters, 2001



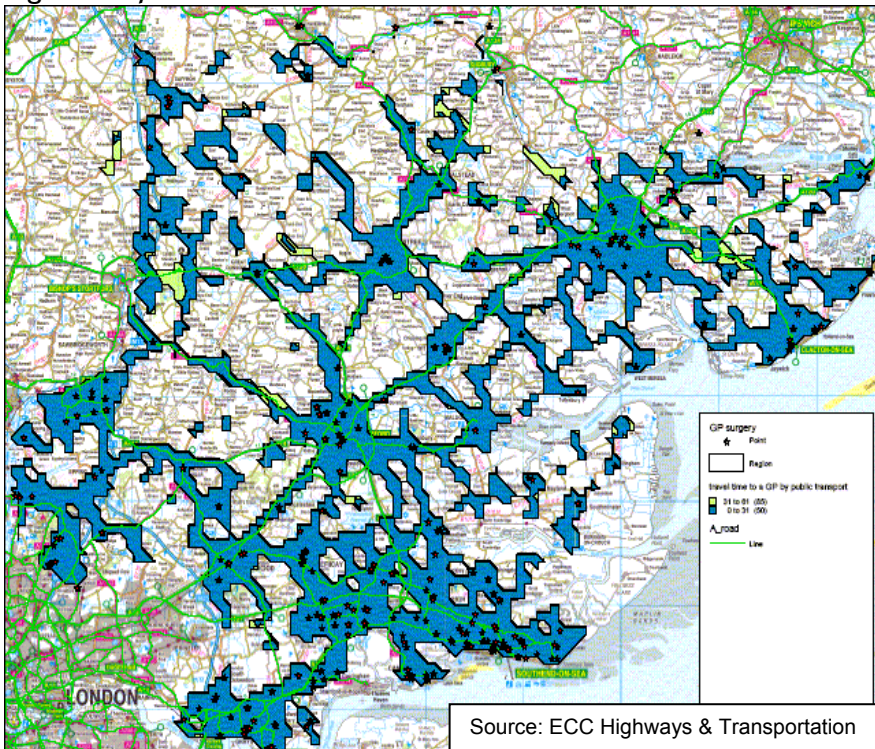
Our roads and rail network also support freight going to and from London, people and goods traveling to and from Stansted and some of the nation's busiest port complexes. The importance of these destinations means local networks are becoming overloaded by high traffic volumes and high levels of commuting. New housing growth will only make these problems worse. Continuing growth in car use is also raising levels of congestion and pollution and it is estimated that, without action, there will be a 31% increase in road traffic and a 30% increase in congestion on the roads by 2025²¹.

2.9.1 Access to health services

Sophisticated mapping software enables journey times to be calculated for individual households. The following map shows from which geographic locations residents are able to access a GP surgery within 30 and 60 minutes travel time by bus. Blue areas are those within 30 minutes of a GP, green are those within 30-60 minutes and areas of no colour are in excess of an hour's travel.

²¹ Eddington Transport Report, 2006

Figure 2.27: access to GP



2.10 Conclusion

As a county, Essex is relatively affluent with no large concentrations of disadvantage. However, there are pockets of severe deprivation in many districts / boroughs with one area in Tendring falling within the worst 1% in England.

The county's proximity to London acts as a mixed blessing; it helps keep earnings high and unemployment low but inflates house prices and increases congestion on our roads and railways. As population growth and housing development accelerate, the need for inward investment and local job growth will intensify. Key to creating a more self-contained economy is affordable housing and increasing local skills. A relatively high proportion of the workforce has no qualifications and relatively few are well-qualified.

Although Essex has a relatively low carbon footprint, road transport emissions are high in certain areas due to major transport links and, in Thurrock, high levels of industry. With 99% of energy consumed unsustainable, realising opportunities in environmental technology is seen as a key means by which to improve both the local economy and the environment.

Despite Essex's relatively low crime rate, the reduction of crime, anti-social behaviour and fear of crime are given very high priority across districts / boroughs.

CHAPTER 3: HEALTH AND WELFARE

3.1 Life Expectancy

The health of the population has been improving steadily. However, despite this general improvement, the gap in the main causes of death between those in advantaged and disadvantaged groups widened in the latter part of the 20th century. Those in disadvantaged groups are more likely to die earlier and to be in poorer health compared with the rest of the population.

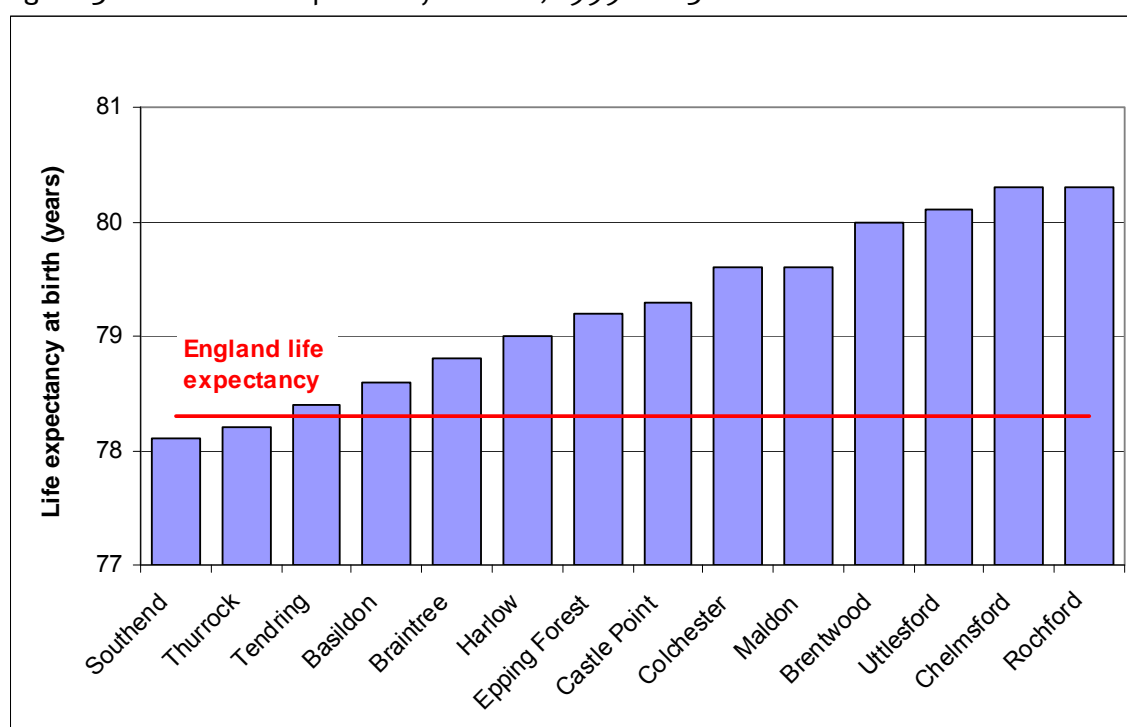
The reasons for these health inequalities are complex. There are links with people's social and demographic circumstances such as their educational attainment, occupation, income, type of housing, sex, ethnicity and where they live. These factors also relate to lifestyle behaviours such as smoking, drinking, diet and risk taking (Focus on Social Inequalities, 2004).

The Government has stated a commitment to tackling health inequalities and has set a national target for England to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth by the year 2010. The aim of this target is to narrow the health gap in childhood and throughout life between socio-economic groups and between the most disadvantaged areas and the rest of the country.

3.1.1 Unitaries and districts

Life expectancy varies across Essex with Southend and Thurrock having the lowest life expectancy in Essex (78.1 and 78.2 years respectively) compared to Rochford and Chelmsford, which have the longest life expectancy (80.3 years). The England average life expectancy is 78.3 years.

Figure 3.1: Essex life expectancy at birth, 1999-2003

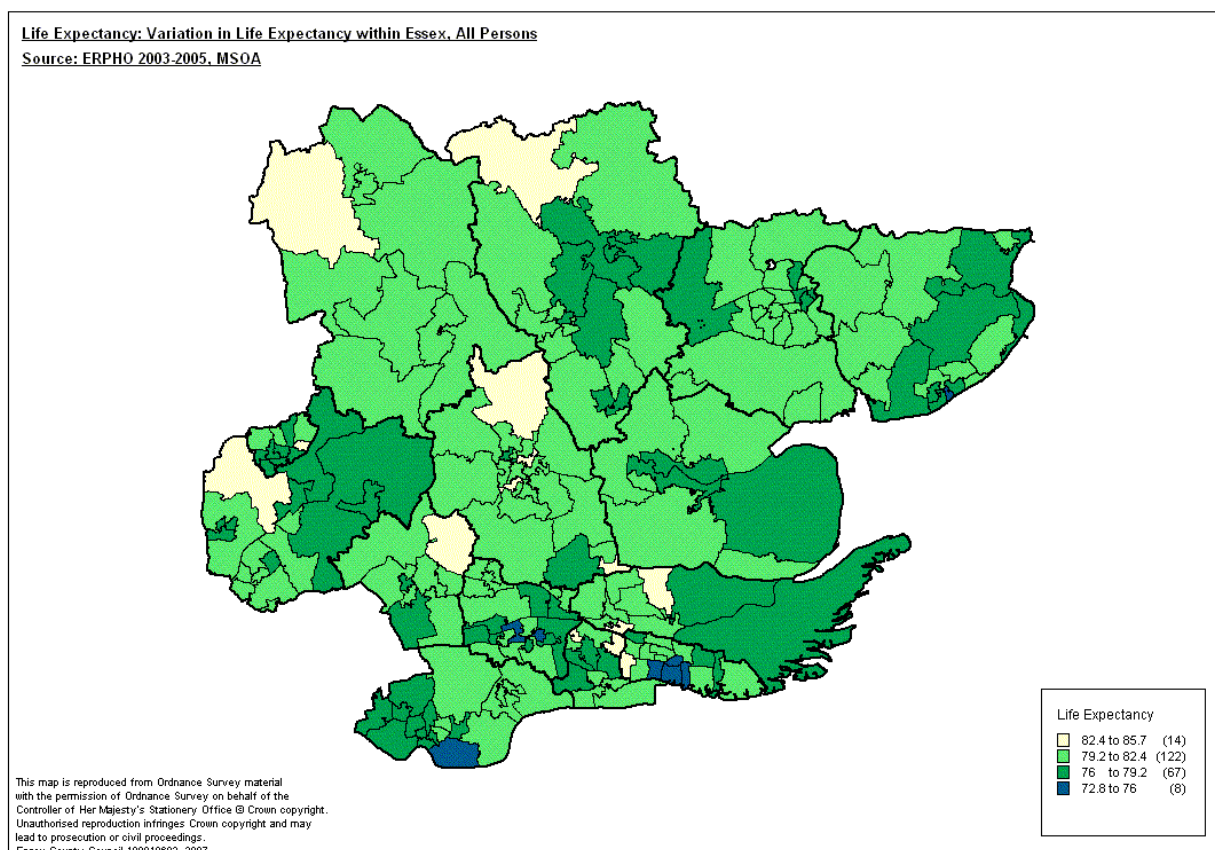


Source: ONS, 2006

3.1.2 Ward Level

Although at district level the lowest life expectancy is 78.1 years, a ward level analysis exposes areas where life expectancy is even lower. The lowest ward life expectancy is in Pier ward in Tendring (70.1 years) whereas the highest is in Littlebury ward in Uttlesford (88.7 years). This is a difference of 18.6 years from one part of the county to another.

Figure 3.2: Essex life expectancy by MSOA, 2003-05



3.1.3 Vulnerable Groups

Research studies demonstrate differences in life expectancy between vulnerable groups of people and the general population. People with serious mental illness have a reduced life expectancy of ten years compared to the general population. This difference is more marked for men than women and is largely due to physical health problems, such as coronary heart disease, respiratory and infectious disorders.

Life expectancy has been increasing in people with learning disabilities but is still lower than in the general population. Some studies suggest that reduced life expectancy is confined to people with more severe learning disabilities, which is also frequently associated with marked physical health problems.

3.2 Mortality

Mortality is a direct measure of health care need reflecting the overall disease burden on the population, both the incidence of disease and the ability to treat it. The mortality rate may be

improved by reducing the population's risk (eg encouraging healthier lifestyles and reducing exposure to smoking), by earlier detection of disease and by more effective treatment. This section presents a summary of the data (full information can be found in the appendix).

Across Essex, mortality rates have largely improved steadily over the last ten years. Although the rate of improvement has been faster for males, female mortality rates are, without exception, lower than those for males. Circulatory diseases remain the most common cause of death with cancer a close second now for females. There is wide variation in mortality rates across Essex with, for example in Southend, a five-fold variation among males and an eight-fold variation among females in circulatory disease mortality. The following table provides a summary of the data on mortality with further detail and comparative district data set out in the Appendix.

Figure 3.3: Essex summary of mortality, 2007

Mortality	Improvement over 10 years	Compared to national level	Compared to regional level	Highest mortality	Lowest mortality
ALL CAUSES					
All age ◇	◇	below	just below	Thurrock	Uttlesford
All age ◇	◇ but slower	below	just below	Southend	Rochford
<75 ◇	◇	below	just below	Tendring	Uttlesford
<75 ◇	◇ but levelling off	below	just above	Basildon	Chelmsford
CIRCULATORY DISEASE					
All age ◇	◇	below	same	Thurrock	Chelmsford
All age ◇	◇ but slower and slowing	below	just below	Thurrock	Chelmsford
<75 ◇	◇	below	just above	Harlow	Uttlesford
<75 ◇	◇ but slower and slowing	below	same	Thurrock	Chelmsford
CANCER					
All age (all) ◇	◇	below	just above	Maldon	Brentwood
All age (all) ◇	◇ but levelling off	just below	just above	Basildon	Brentwood
<75 (all) ◇	◇ but slowing	below	just above	Tendring	Uttlesford
<75 (all) ◇	◇ but slower	just below	just above	Basildon	Brentwood
All age (lung) ◇	◇ but slowing	below	just above	Harlow	Uttlesford
All age (lung) ◇	x stayed level	below	just above	Castle Point	Brentwood
All age (breast) ◇	◇	above	just above	Uttlesford	Epping Forest
All age (prostate) ◇	◇ more recently	below	below	Uttlesford	Epping Forest
RESPIRATORY DISEASE					
All age ◇	◇	below	just above	Harlow	Uttlesford
All age ◇	x slight worsening	below	above	Basildon	Brentwood
SUICIDE AND UNDETERMINED INJURY					
All age ◇	x wide fluctuations; starting to rise	below	just below	Harlow	Castle Point
All age ◇	x starting to rise but much lower than ◇	below	just below	Maldon	Harlow

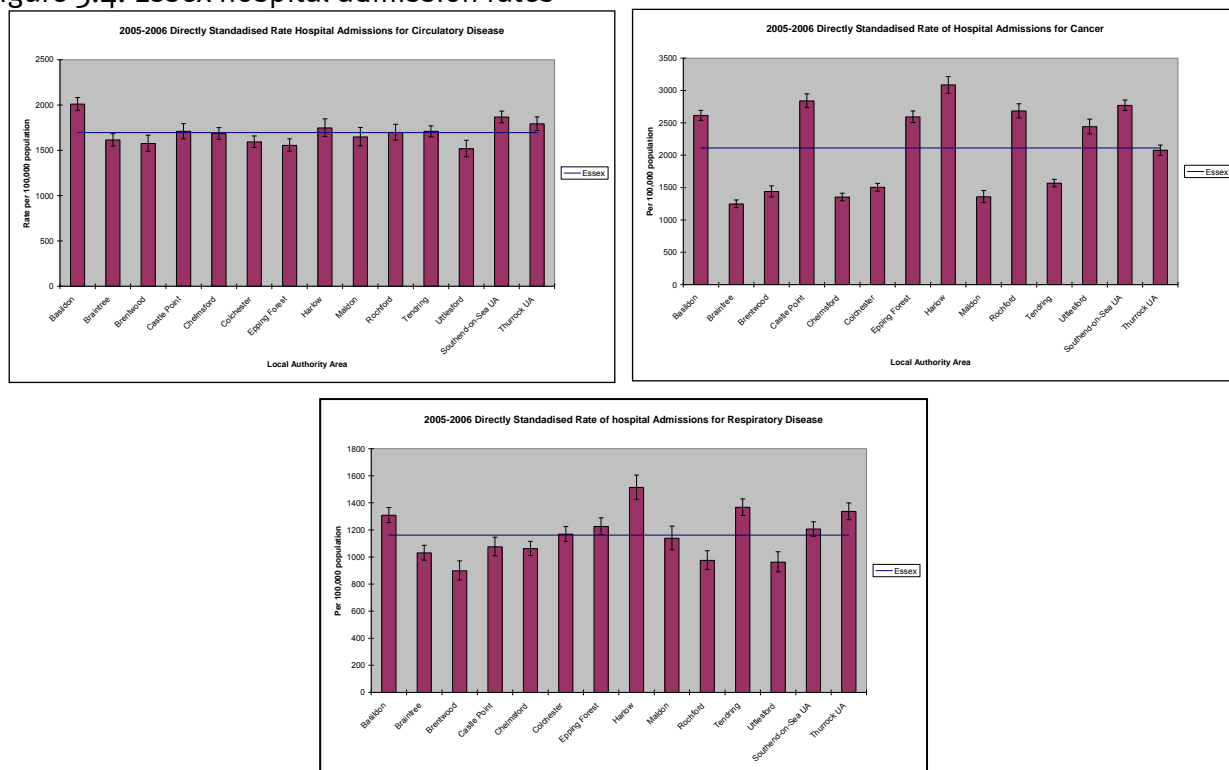
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge

3.3 Hospital Admissions

Basildon, Southend and Thurrock have higher than average hospital admissions for circulatory disease. For hospital admissions classified as respiratory disease, Basildon Harlow, Tendring and Thurrock all stand out as having higher than Essex averages.

Hospital admission rates for cancer vary widely across Essex with 13 of the 14 areas being significantly different from the Essex average. Basildon, Castle Point, Epping Forest, Harlow, Rochford, Uttlesford and Southend all have higher than Essex average rates.

Figure 3.4: Essex hospital admission rates



Source: Eastern Region Public Health Observatory

3.4 Long Term Conditions

Long-term conditions (also called chronic conditions) are those conditions that cannot, at present, be cured, but can be managed by medication and other therapies sometimes over a period of years or decades. It is estimated that over fifteen million people in this country are living with a long-term condition, and six out of ten adults. People with long-term illnesses often suffer from more than one condition, making their care even more complex. Eighty percent of primary care consultations and two thirds of emergency hospital admissions in the UK are related to long-term conditions²².

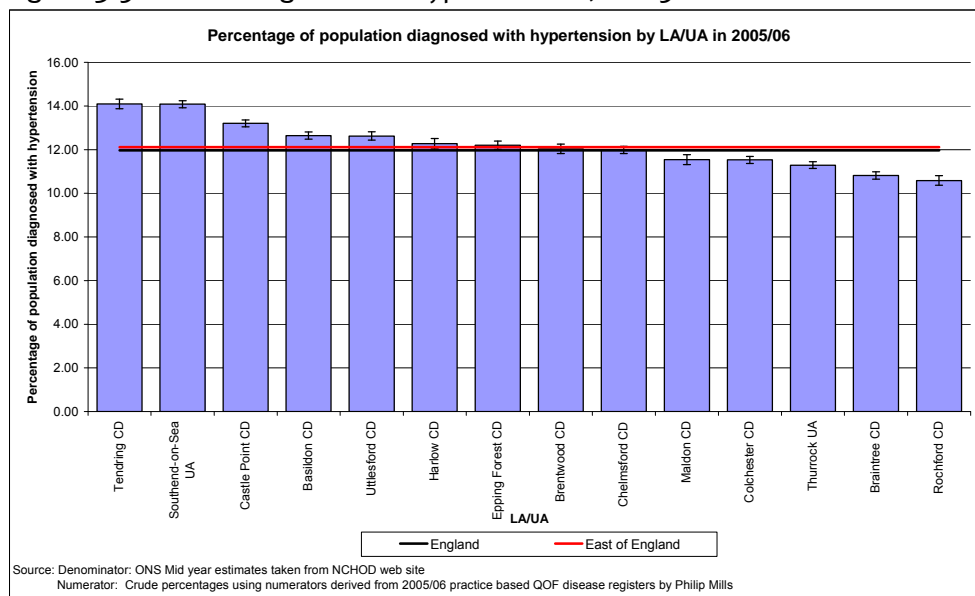
In this section, a diagnosis of a condition means those on a GP register for that condition. A higher percentage can therefore mean an area is better at identifying and recording people with the condition rather than it having a higher prevalence per se.

²²British Medical Association, June 2006

3.4.1 Hypertension

Figure 3.5 shows the percentage of the population that has been diagnosed with hypertension (high blood pressure) across Essex. Half of the areas in Essex have higher percentages than the England average.

Figure 3.5: Essex diagnosis of hypertension, 2005-06



It is thought that the number of people with hypertension is a lot higher than recorded. Figure 3.6 shows the results of a model to try and work out what the percentage of the population with hypertension might be. Compared to figure 3.5, we can see that perhaps only half those with hypertension are diagnosed.

Figure 3.6: Expected percentage of the population with hypertension

Area	Persons	Males	Females
ENGLAND	23.8%	24.7%	23.0%
NORTH EAST ESSEX PCT	26.5%	26.8%	26.1%
WEST ESSEX PCT	24.3%	25.2%	23.4%
MID ESSEX PCT	24.2%	25.2%	23.2%
SOUTH EAST ESSEX PCT	23.4%	24.3%	22.4%
SOUTH WEST ESSEX PCT	23.2%	24.1%	22.4%

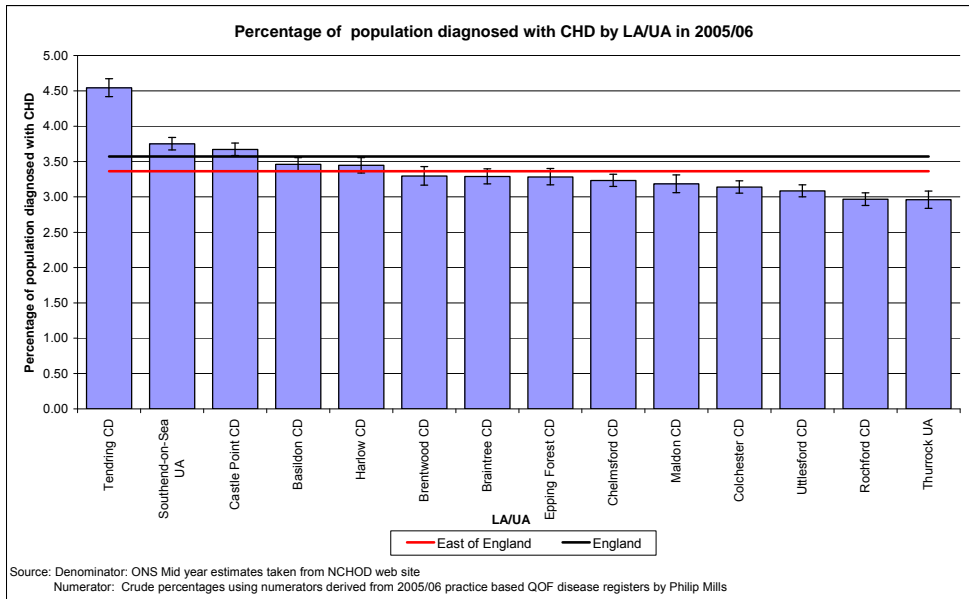
Note: Hypertensive= SBP>=140mmHg and DBP>=90mmHg and/or taking medicine prescribed for high blood pressure

Source: Hypertension model developed by David Merrick (YHPHO) and Julian Flowers (ERPHO), <http://www.apho.org.uk/apho/models.aspx>

3.4.2 Coronary Heart Disease (CHD)

Figure 3.7 shows the percentage of the population diagnosed with CHD in Essex. Tendring, Southend and Castle Point have a higher percentage of the population diagnosed with CHD than the England average. The number of people with CHD is thought to be much higher than recorded. Moreover, the UK general practice research database shows that people with severe mental illness who are less than 50 years old, have over three times a greater risk of dying from coronary heart disease compared to the general population, and nearly twice this risk when they are aged 50-75.

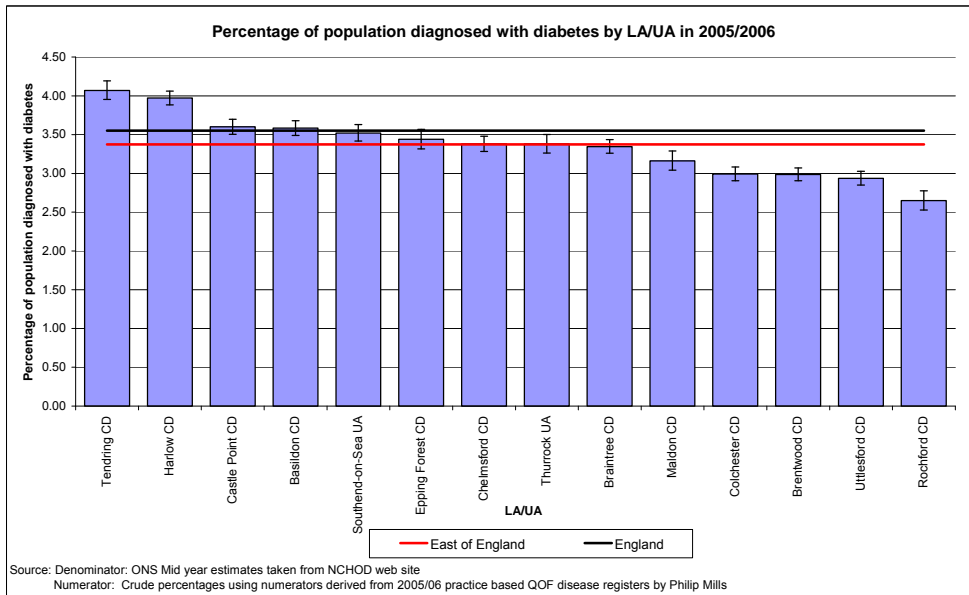
Figure 3.7: Essex diagnosis of coronary heart disease, 2005-06



3.4.3 Diabetes

Figure 3.8 shows the percentage of the population diagnosed with diabetes in Essex. Tendring, Harlow, Castle Point and Basildon have higher percentages of the population diagnosed with diabetes compared to the England average. It is thought that far more people have diabetes than is recorded.

Figure 3.8: Essex diagnosis of diabetes, 2005-06

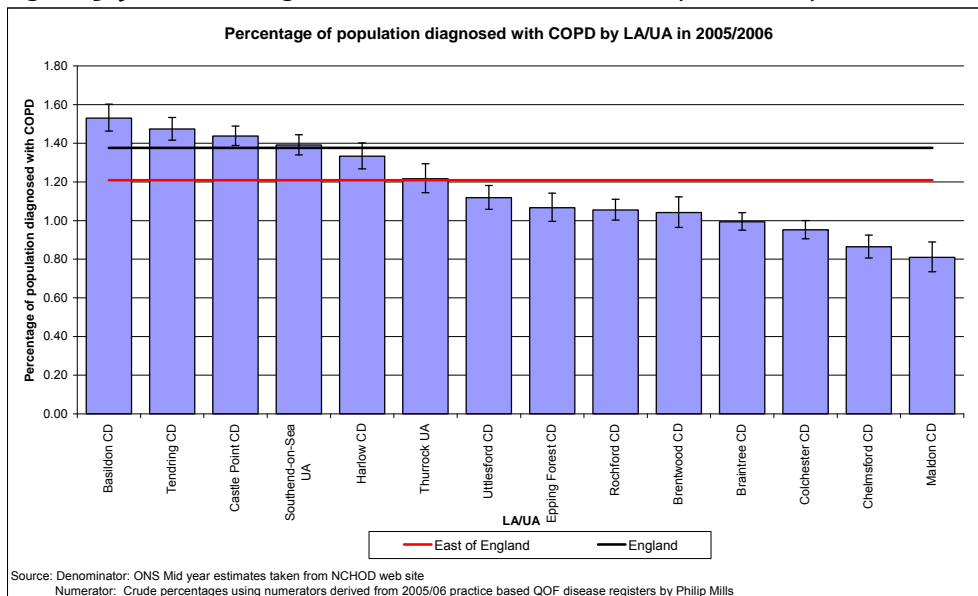


Diabetes is more prevalent among people with mental health problems than in the general population. People with schizophrenia are two to four times more likely than the general population to have diabetes, accounting for 15-18% of all people with schizophrenia. Prevalence of diabetes is two to three times higher in people with bipolar disorder. The interaction between diabetes and serious mental illness is complex and multi-factorial, and includes genetic and environmental factors, as well as the direct side effects of antipsychotic medication.

3.4.4 Chronic obstructive pulmonary disease (COPD)

Figure 3.9 shows the percentage of the population diagnosed with COPD in Essex. Basildon, Tendring and Castle Point have higher percentages diagnosed with COPD than the England average.

Figure 3.9: Essex diagnosis of chronic obstructive pulmonary disease, 2005-06



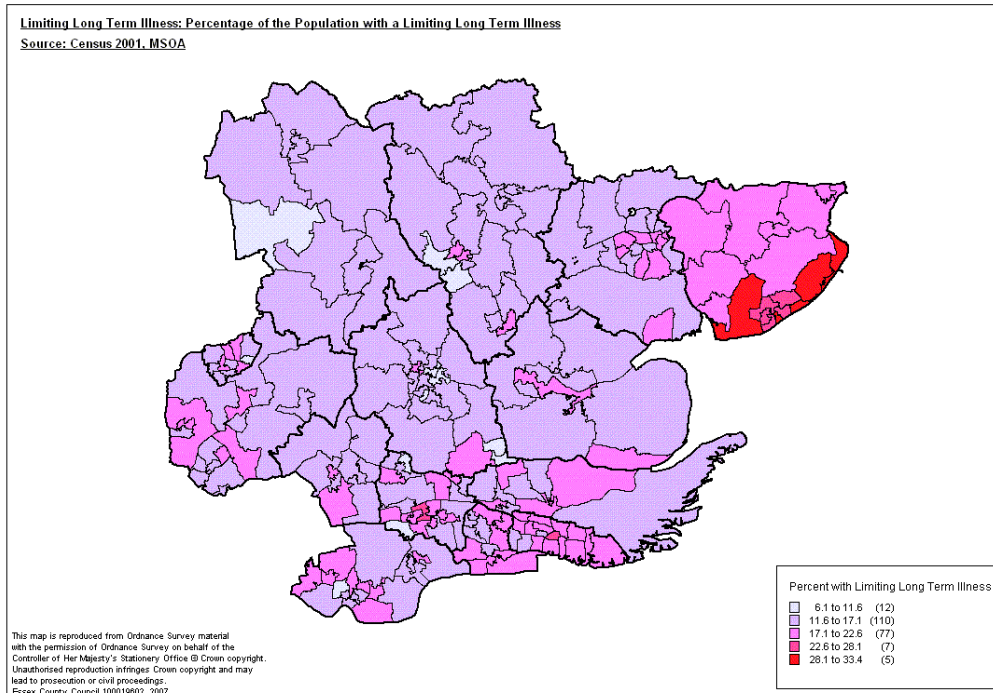
3.5 Limiting Long-Term Illness (LLTI)

LLTI is a Census measure of whether or not a person considers themselves to have a long-term illness, health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age.

LLTI can have a profound effect on quality of life and capacity to be economically active. Within Essex, the proportion of people with a LLTI is 16.2% or 215,471 people (Census 2001). This compares to a national rate of 17.9%.

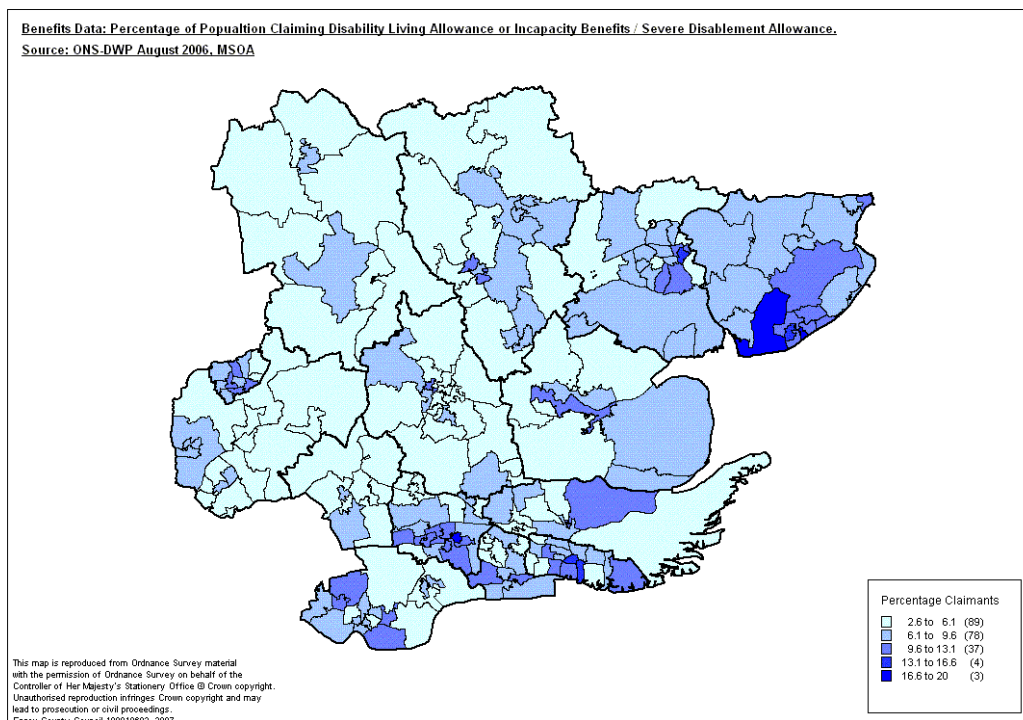
The map below shows levels of LLTI across Essex, according to the 2001 Census. All of Tendring and most of Southend have high levels of LLTI, with particularly high levels in Tendring's coastal areas. There are pockets of higher LLTI elsewhere also.

Figure 3.10: Essex limiting long-term illness by MSOA



Those areas where there is a high prevalence of limiting long-term illness also have high benefit claimant rates. The map below shows the claimants for Disability Living Allowance and Incapacity Benefit by MSOA. Looking at the two maps together, it can be seen that there is close correlation between areas with higher proportions of benefit claimants and LLTI prevalence.

Figure 3.11: Essex disability benefits claimants by MSOA



Unemployment tends also to be associated with LLTI as those suffering with a long-term illness may find it difficult to work. Figure 2.22 (see p34) maps unemployment and shows that, where there are higher levels of LLTI prevalence there are corresponding higher unemployment rates. However, unemployment rates are also higher in some other parts of the region indicating that LLTI is not the only contributing factor in unemployment.

3.6 Conclusion

In general, the health of the people in Essex is good. Compared to the national picture, fewer residents consider themselves to have a limiting long-term illness and life expectancy is longer. There are, however, dramatic health inequalities both between and within districts / boroughs. Most shocking is that there is a difference of 18.6 years between highest and lowest life expectancies.

CHAPTER 4: CHILDREN AND YOUNG PEOPLE

Children are particularly vulnerable to social and environmental conditions within the household and wider community. Disadvantage in childhood compounds problems experienced in later life; healthy children are vital to the future health and productivity of society as a whole. Tackling inequalities and eliminating child poverty are thus major national priorities requiring multi-agency action locally.

Much information on the needs of children and young people is contained in the Children & Young People's Plans of ECC, Southend and Thurrock. Based on this evidence, each identifies priorities to improve outcomes for their local children and young people. The plans can be found at:

- ECC: <http://www.essexcc.gov.uk/vip8/ecc/ECCWebsite/dis/cha.jsp?channelOid=14181>
- Southend: <http://www.southend.gov.uk/content.asp?section=176&content=7804>
- Thurrock: <http://www.thurrock.gov.uk/children/>

Factors particularly pertinent to health and well-being are included here.

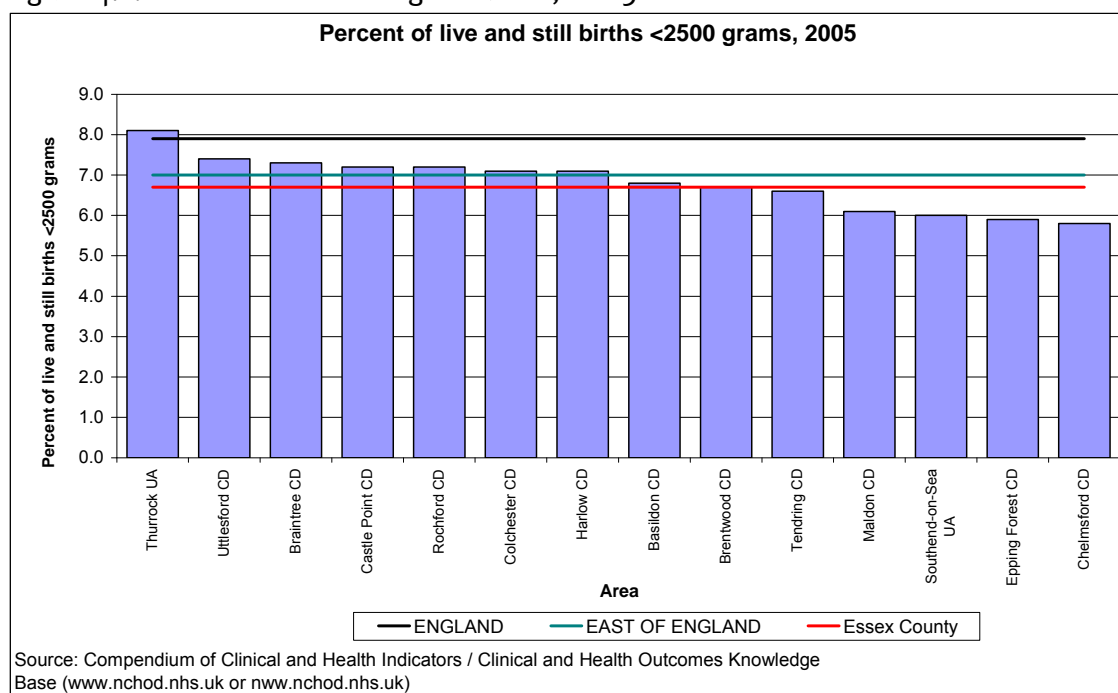
4.1 Infant Health

4.1.1 Low birth weight

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. It is a good indicator of a newborn's chances for survival, growth, long-term health and psychosocial development. The World Health Organisation (WHO) defines low birth weight as a birth weight less than 2,500 grammes. Below this, birth-weight-specific infant mortality begins to rise rapidly. Low birth weight babies were traditionally linked to high deprivation. This is still the case, but some low birth weight babies are now attributable to improved medical technologies, resulting in more successful deliveries of low birth weight babies, and increased fertility treatment which is more likely to lead to a low birth weight baby.

Figure 4.1 shows that Thurrock has a higher proportion of low birth weight babies than nationally.

Figure 4.1: Essex low birth weight babies, 2005



4.1.2 Breastfeeding

Breast milk is considered to be the best form of nutrition for infants and breast-fed babies are five times less likely to be admitted to hospital with common infections, such as gastroenteritis, during their first year of life.

Breastfeeding initiation rates in the UK remain relatively low compared to other countries, particularly among women in lower income groups. The Infant Feeding Survey (2005) found that 77% of mothers in England initially breastfed their babies. This represented an improvement on the 71% previously reported (2000). Excluding areas where the numbers of 'not knowns' are over 5%, the proportion of mothers initiating breastfeeding in Essex increased from 67.7% in 2004-05 to 70.1% in 2006-07. Rates are highest in the north east but all areas are well below the 2005 national rate²³.

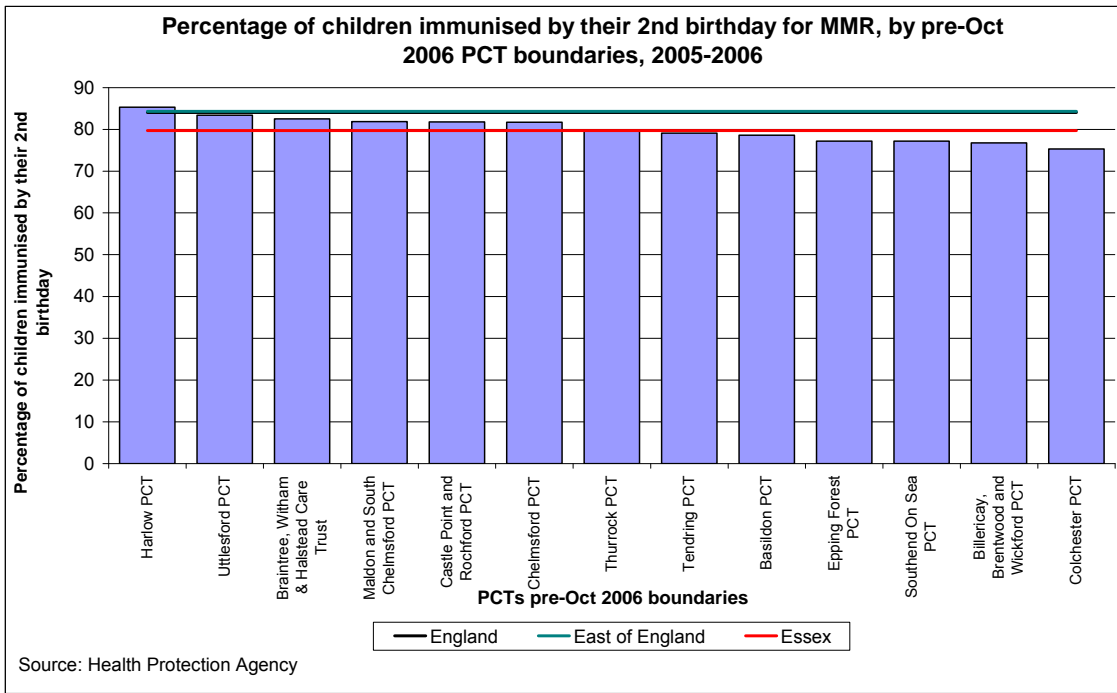
4.1.3 MMR immunisation

MMR is the combined vaccine to prevent measles, mumps and rubella, all of which are diseases with serious complications. There has been some controversy about the MMR vaccine in recent years, which has resulted in a decrease in the number of children being vaccinated. Current WHO recommendations are that at least 95% of children receive a first dose of a mumps-containing vaccine (eg MMR) at age 12-18 months; and that at least 95% receive a measles vaccine by 2 years of age.

Figure 4.2 shows the proportion of children who, by their second birthday, have received an MMR vaccination. It shows that Harlow is the only area to have a vaccination rate higher than the England and regional averages, but all areas are lower than the recommended level of vaccination.

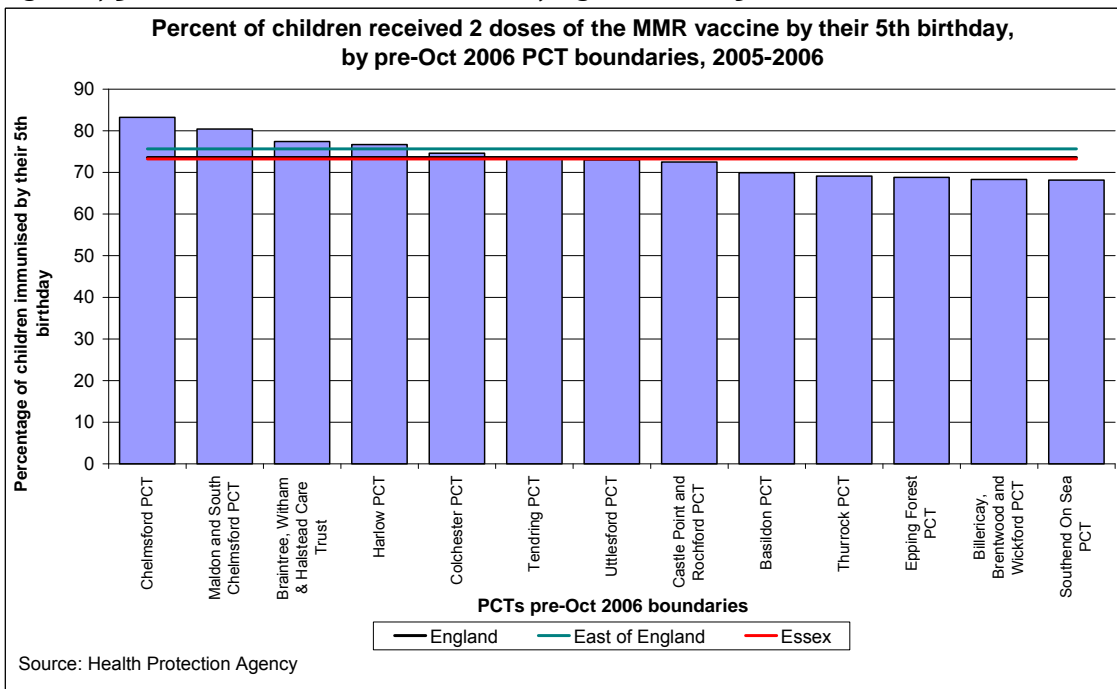
²³ PCT Local Delivery Plan Reporting 2006-07

Figure 4.2: Essex MMR immunisations by age two, 2005/06



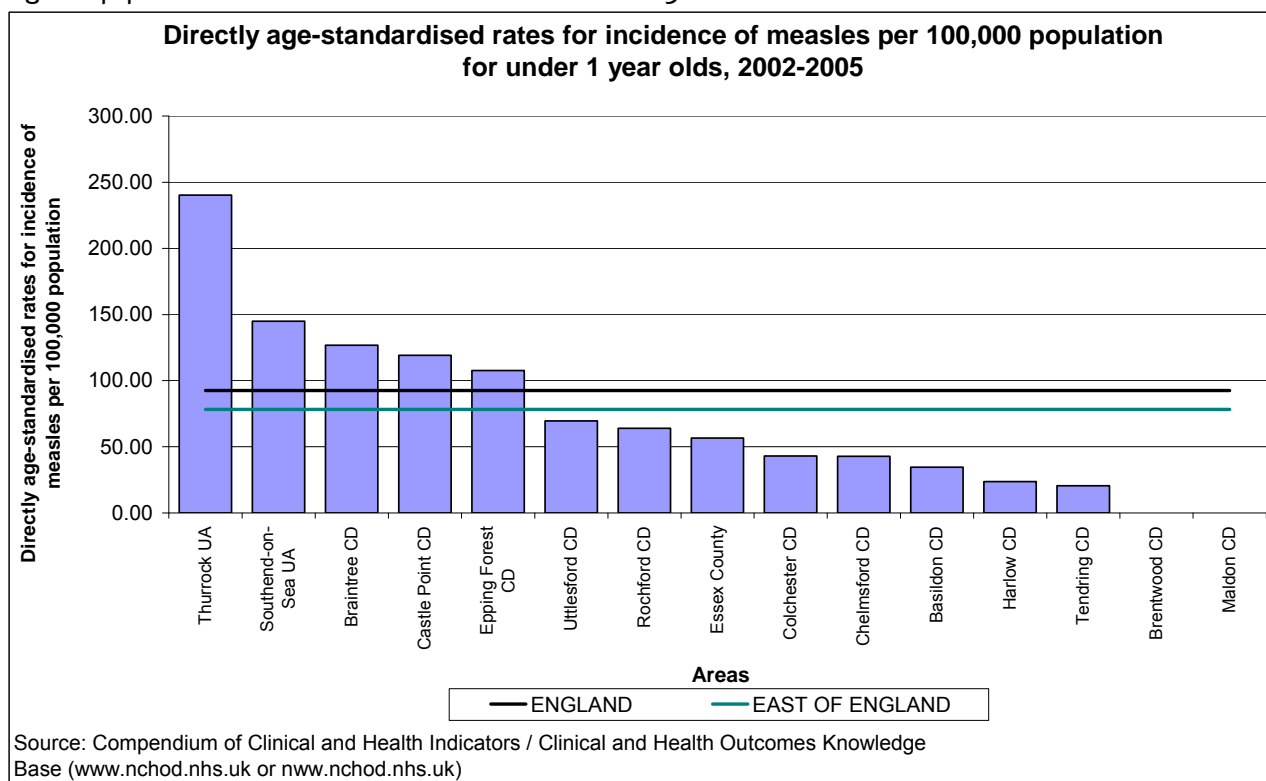
By the time children are five, more areas have vaccination rates better than national and regional levels but all are still below the recommended level of vaccination.

Figure 4.3: Essex MMR immunisations by age five, 2005/06



The incidence of measles varies across Essex. Figure 4.4 shows that in recent years Thurrock, Southend, Braintree, Castle Point and Epping Forest have all had higher rates of measles in u15 than the national and regional averages.

Figure 4.4: Essex incidence of measles 2002-2005



4.2 Childhood Obesity

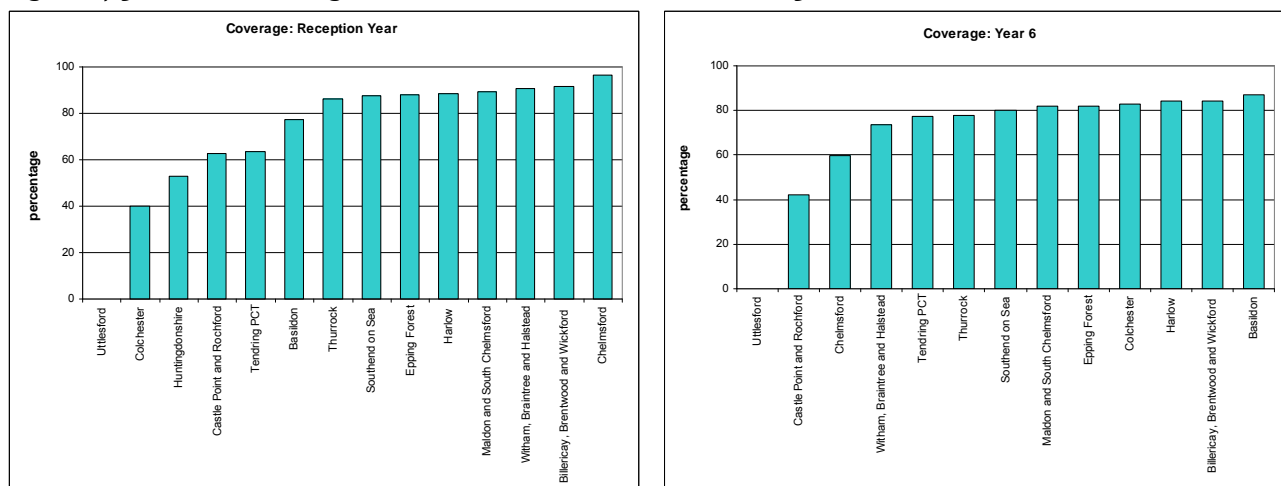
Childhood obesity is a complex public health issue that is a growing threat to children's health. The United Kingdom has seen an unprecedented rise in obesity; the proportion of children aged 2 to 10 who were overweight or obese increased from 22.7% in 1995 to 27.7% in 2003, with the level obesity in the same age group increasing from 9.9% to 13.7% (Jotangia et al, 2005). If the number of obese children continues to rise, children will have a shorter life expectancy than their parents.

Tackling childhood obesity requires changes in the behaviour of individual children and their parents and of society in general and reflects recent trends across most developing countries to greater fat and sugar consumption and reduced physical activity. There is also evidence to suggest that babies who are breastfed are less likely to be obese in adulthood.

Since 2005, PCTs have been required to collect height and weight data for BMI (Body Mass Index) on all primary school children in reception year (ages 4/5) and year 6 (ages 10/11). Figures 4.5 and 4.6 are based on only the first year of child BMI measurement when many areas experienced difficulties in data collection and collation. As systems for data collection become more established, data on the distribution of BMI in the child population should improve both in coverage and quality, furthering our understanding of the epidemiology of the BMI distribution in the child population. However, current evidence suggests that a population-wide strategy supplemented by more targeted action in some areas may be the most effective approach in halting the rise in childhood obesity prevalence.

The number of children measured varied across the region. The lower the coverage, the less reliable the results.

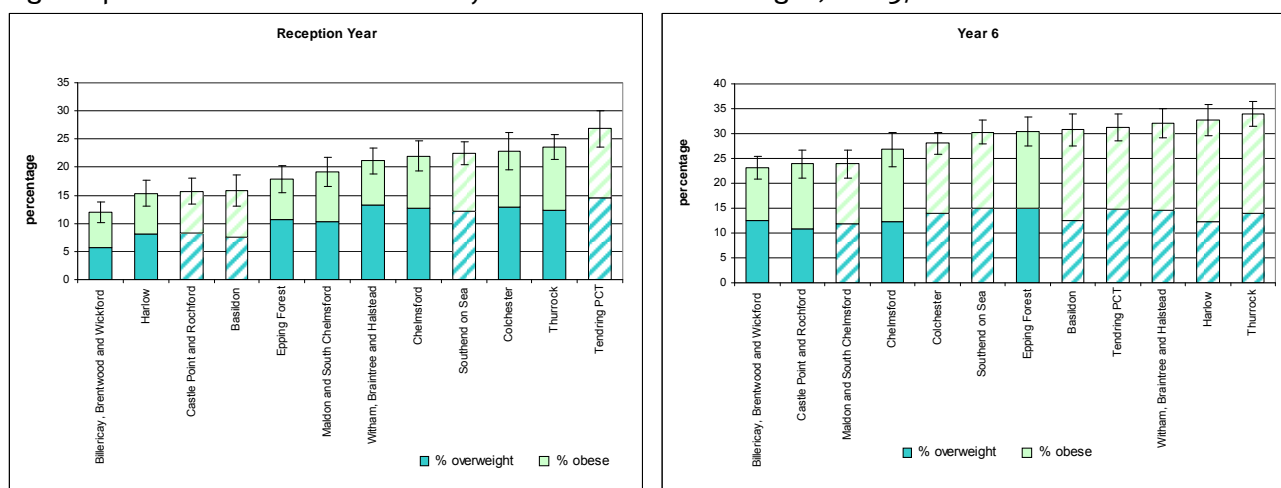
Figure 4.5: Essex coverage of child BMI measurement, 2005/06



Source: ERPHO

A baseline of 11.3% has been agreed from the PCT data. Tendring, Thurrock and Colchester appear to have the highest obesity levels in reception year. However, care should be taken when looking at the Tendring results as they had a lower coverage so the data is less reliable. Areas in Essex which appear to have high obesity levels in year 6 are Harlow and Thurrock.

Figure 4.6: Essex childhood obesity and children overweight, 2005/06



Prevalence estimates for Mid Essex PCTs are based on NCOD data. PCTs that achieved coverage of at least 80% are shown with diagonal shading, while the remainder achieved less than 80% coverage.

Source: ERPHO

4.3 Behavioural and Mental Health Issues

According to a national survey (ONS 2000), about 10% of children aged 5-15 years in Great Britain have a mental disorder, 5% have clinically significant conduct disorders; 4% were assessed as having emotional disorders (eg anxiety and depression) and 1% was rated as hyperactive. The less common disorders (autistic disorders, tics and eating disorders) were attributed to 0.5% of the sampled population.

Children with a mental disorder compared with other children were more likely to be boys, living in a lower income household and in social sector housing. Half those children with a mental disorder had at one time seen the separation of their parents, compared with 29% with

no disorder. The corresponding figures for problems with the police were 15% and 5%, and for a parent or sibling dying – 6% compared with 3%.

Projections from a University of Essex study in 2005 indicated that the following numbers of cases could be expected of children and young people with a diagnosis of a mental health difficulty.

Figure 4.7: ECC prevalence of mental health difficulties among children and young people

PCT area (pre-Oct 2006)	N (cases)
Uttlesford	680
Castle Point and Rochford	950
Maldon and South Chelmsford	1,020
Billericay, Brentwood and Wickford	1,295
Harlow	1,410
Chelmsford	1,610
Witham, Braintree and Halstead	1,920
Epping Forest	1,980
Tendring	2,325
Colchester	2,730
Basildon	3,290
<i>TOTAL</i>	19,210

Source: S Musgrave and L Cooper, *CAMHS Needs Assessment*, University of Essex (July 2005)

4.4 Drug and Alcohol Use

Supporting the Well-Being of Children and Young People in Essex (2007) collected data from a sample of primary and secondary school pupils and has been used to set baselines on a number of indicators. According to this study:

- 55.4% of 15 year olds drink alcohol
- 19% of 15 year olds are regular smokers
- 12.7% of 15 year olds use drugs

According to national data from the Ofsted TellUs2 survey of summer 2007:

- 74% of 15 year olds drink alcohol
- 41% of 15 year olds have smoked
- 13%, 4% and 4% of 15 year olds have taken cannabis, solvents and other drugs respectively in the last four weeks

It is also known that 14.5% of care leavers misuse drugs or alcohol and that 8% of young offenders re-offended with an offence relating to drugs or alcohol (2006-07).

There is also evidence to suggest that traders across the county are not universally requesting ID and are, in some cases, selling alcohol and tobacco to u18s²⁴. Although not direct evidence of need, it is an indication of ease of access. Requesting ID is set to become an increasingly significant issue (especially now the age limit for tobacco sales has been raised to 18) and impacts on safety issues in relation to fireworks, knives, replica firearms etc.

²⁴ ECC ‘mystery shopper’ project

4.5 Bullying and Crime

According to Supporting the Well-Being of Children and Young People in Essex (2007), 49% of primary school pupils and 27% of secondary school pupil felt afraid of going to school sometimes because of bullying. There were 8,292 incidents of serious crime affecting children and young people reported to the police in 2006-07.

Nationally, the Youth Survey of 2004 provides an indication of the levels of concern of young people aged 11-16 years about their safety.

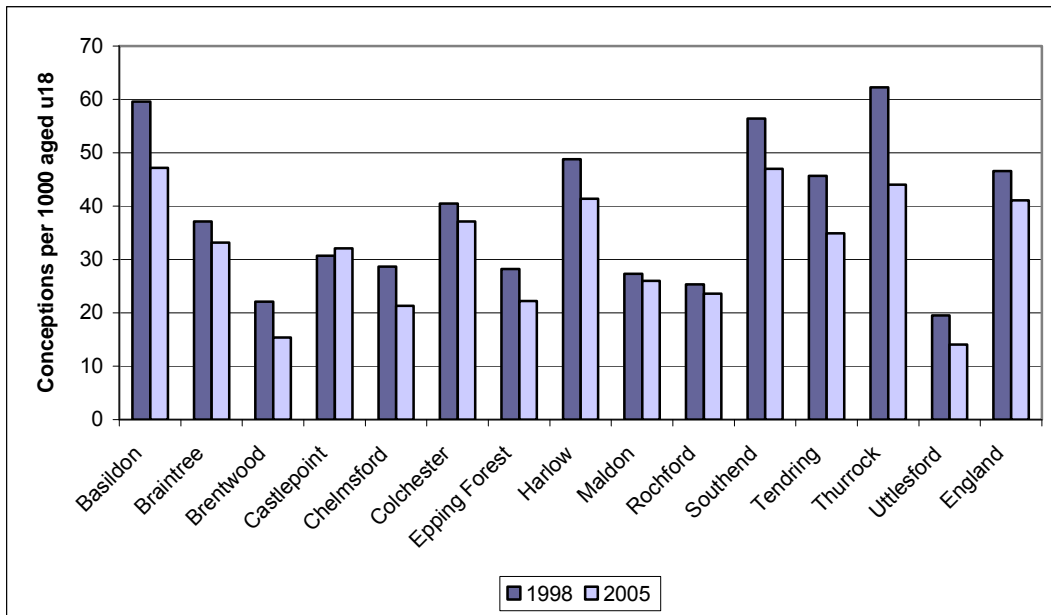
- 47% of young people in mainstream school worry about physical attack
- young people tend to worry less about the possibility of being physically assaulted as they progress through school: 49% of 11 year olds compared to 42% of 15-16 year olds
- 45% of young people in mainstream education are concerned about theft
- 49% of pupils have been the victim of an offence including being bullied, had something other than a mobile phone stolen from them, had their property damaged or destroyed or been physically attacked
- mainstream pupils are more likely to be victimised at school than elsewhere for each of the offences they have experienced
- girls (78%) feel safer at mainstream school than boys (74%).

4.6 Teenage Pregnancy and Sexual Health

Improving the nation's poor sexual health remains a major public health priority. Sexually transmitted infections continue to increase and, while high levels of teenage pregnancy are slowly decreasing in some areas, the decline is not rapid enough to meet the target of a 50% reduction by 2010. Good local access to sexual health services plays an essential part in improving sexual health and reducing the rate of teenage pregnancy. Early pregnancy brings health risks for the mothers and, on average, poor outcomes for the resulting children. Contraception or condom use tends to be lowest where intercourse is unexpected and/or carried out for the first time with a partner of less than a month's duration. Such unprotected sex carries the greatest health risks.

Essex has seen a steady – and in some areas (most notably Thurrock) dramatic – decline in teenage conceptions over the last few years. However, rates are higher than the national average in Basildon, Southend, Thurrock and Harlow and more needs to be done across Essex to tackle this problem effectively. Data from the EST Connexions service indicates that 233 young women are not available to the labour market as they are supporting their children / families.

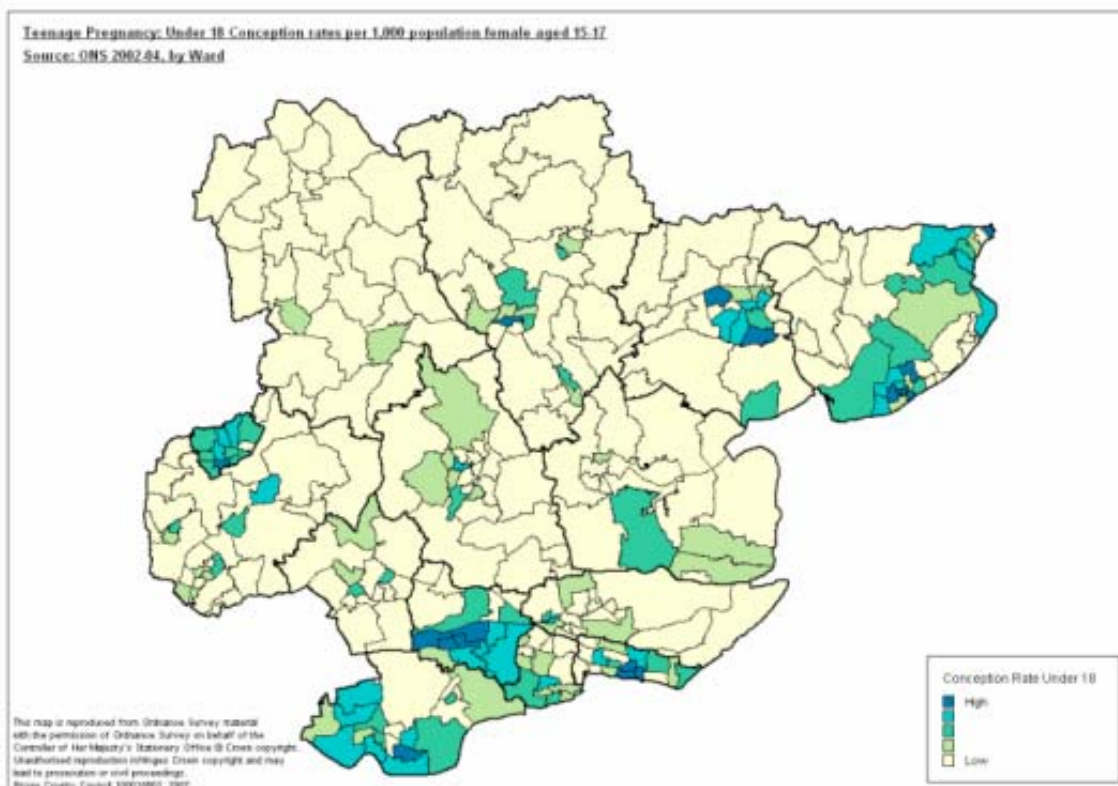
Figure 4.8: Essex teenage conceptions, 2005 provisional performance compared to baseline



Source: Teenage Pregnancy Unit

Figure 4.9 shows that, as well as the between-district variation seen above, there is wide variation within districts also. The highest rate is in Southend and is over five times the regional average.

Figure 4.9: Essex teenage conceptions by quintile by ward

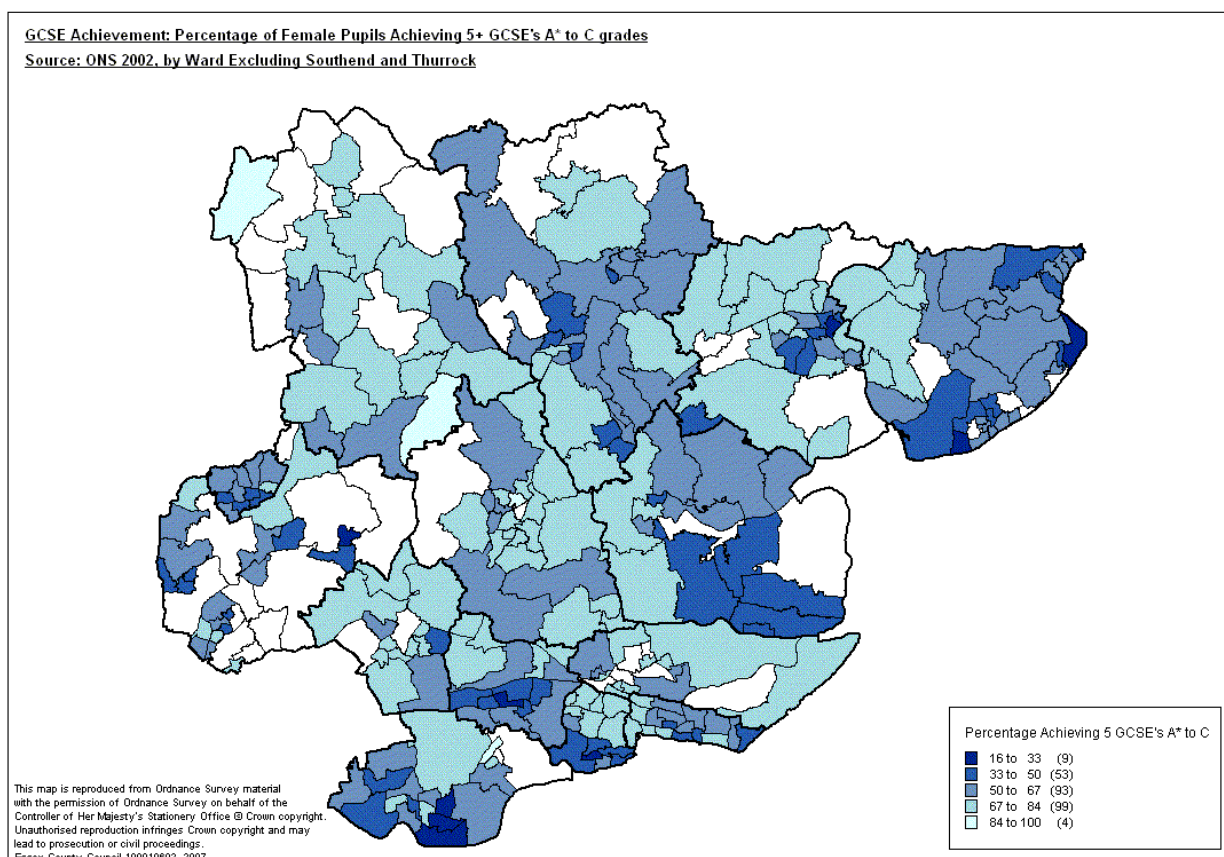


4.6.1 Educational achievement in girls

As set out in Chapter 2, poor educational attainment plays a vital role in defining socio-economic status. Low educational achievement, truancy and exclusion from school, all contribute detrimentally to events in later life such as increased likelihood of teenage pregnancy, inability to find employment and poorer health in general.

Figure 4.10 sets out girls' educational attainment. White areas are those where data was unavailable at the time of mapping. When considered alongside the map of teenage conceptions, it can be seen that there is a good degree of correlation between those areas where girls have lower educational achievement and those with a higher incidence of teenage conception. This is particularly true of Harlow, Tendring and parts of Basildon and Castle Point.

Figure 4.10: Girls' GCSE passes 5 x A-C grades by ward



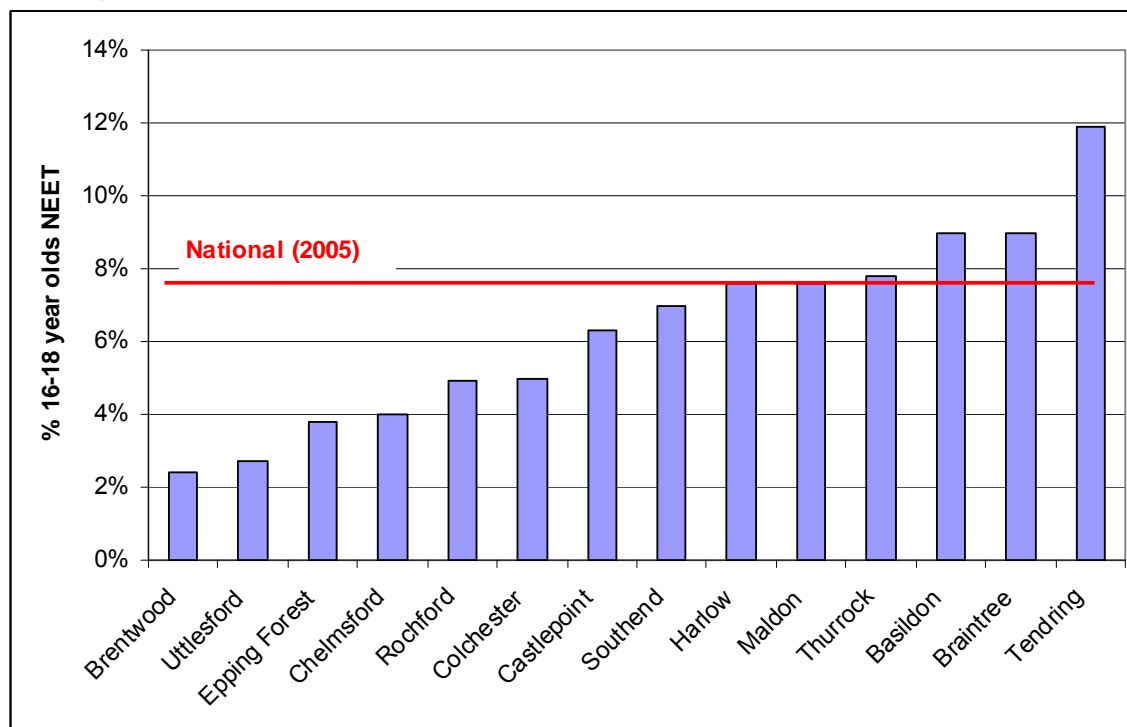
4.7 Not in Employment, Education or Training (NEET)

As already noted, educational attainment and employment are important for health and well-being. Across Essex, the proportion of Y11 statutory school leavers remaining in education has significantly increased since 2004 and there has been a significant reduction in the proportion not in education, employment or training (NEET) since 2005²⁵. Looking across districts / boroughs, Tendring, Braintree, Basildon and Thurrock have above national average proportions of young people with an unsettled destination. It is likely that, once national

²⁵ EST Connexions, 2006-07

tables are published, EST (Essex, Southend & Thurrock) Connexions performance will compare favourably with that of other areas and with the national picture.

Figure 4.11: Essex NEETs, 2006-07



Source: EST Connexions

A total of 22 secondary schools in Basildon, Colchester, Braintree, Harlow, Tendring and Maldon have been selected for specialist input around NEET (over 4,000 students representing some of the hardest to engage in terms of progression). In 2006, 12.8% of Y11 leavers from these schools did not progress into education, employment or training.

A higher proportion of young women go on to higher level courses, while young men are more likely to be on low level courses, in jobs without training or unemployed. Young people from BME communities tend to do as well or better than their white counterparts – ie in each ethnic group a higher percentage remain in education and a lower percentage become NEET. Although there are some concerns about the data, it would appear that young people with learning difficulties / disabilities are more likely to become NEET as compared to the total cohort.

Fewer young people are entering skilled trades on leaving school (eg electrical, electronic, motor vehicle, engineering) and more are taking up clerical/ secretarial, sales and service occupations (eg catering and hairdressing). Young people still tend to opt for those occupational areas traditionally dominated by their own gender. It should also be recognised that local availability of opportunities also impacts on the occupational ‘choices’ young people make.

4.8 Vulnerable Children

The term ‘children in need’ refers to those children receiving support from social services. The term ‘looked after children’ refers specifically to those who are in the care of the local

authority. Those considered to be at risk of abuse or neglect are placed on the Child Protection Register (CPR). Around 700 children are on the CPR at any one time across Essex²⁶. Although numbers showed a sharp dip in 2003, overall the trend has been slightly upward over the past five years. The latest comparative data available gives a national rate of 24 children per 10,000 children aged <18. By comparison the rate is 17 per 10,000 for both ECC and Thurrock and 29 per 10,000 in Southend. Within ECC, numbers are more than three times higher than average in Basildon.

Many children in need will have health needs arising from:

- living in families affected by drugs, alcohol and domestic violence;
- special needs or a disability;
- experience of trauma, abuse and/or neglect;
- coming from highly mobile families.

They may also have experienced poorer access to services including universal services (eg dental services, immunisations, routine child health surveillance and health promotion because of language or cultural barriers). Further barriers for looked after children are

- the lack of parents who are able to advocate on behalf of the child to ensure any needs they have are recognised and met; and
- the rate of movement between placements which many looked after children and young people experience.

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. These greater needs however, often remain unmet. As a result, many children and young people who are looked after experience significant health inequalities and on leaving care experience very poor health, educational and social outcomes. They show higher levels of substance misuse, higher rates of teenage pregnancy and a much greater prevalence of mental health problems with as many as 45% having a mental disorder and 37% having clinically significant conduct disorders (ONS, 2003).

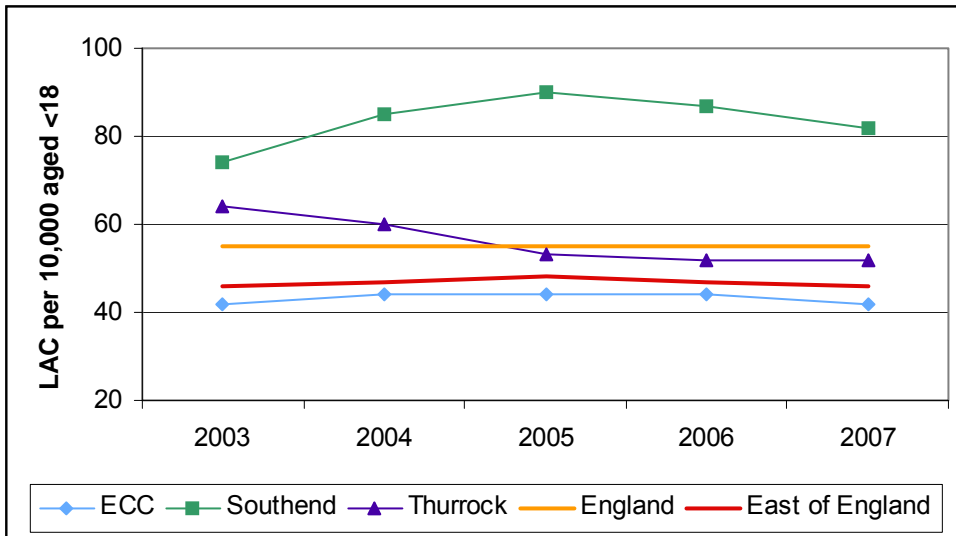
The life chances of looked after children depend to a great extent on personal achievement. In 2005, 3% of young people looked after by ECC entered higher education compared to 45% of all students; and in 2006, 11.9% obtained 5 or more A*-C grades at GCSE compared to 59% of all students²⁷.

Around 1700 children are looked after at any one time across Essex²⁷. The following chart illustrates how rates and trends in looked after children vary across the top-tier authorities in Essex. The rate of looked after children in ECC has remained stable at below both national and regional averages. Thurrock has managed to reduce its rate and now sits between the national and regional averages whereas Southend's rate has increased over time and is significantly above the regional average.

²⁶ CPR3 return on child protection and referrals, DCSF 2007

²⁷ SSDA903 return on children looked after, DCSF 2007

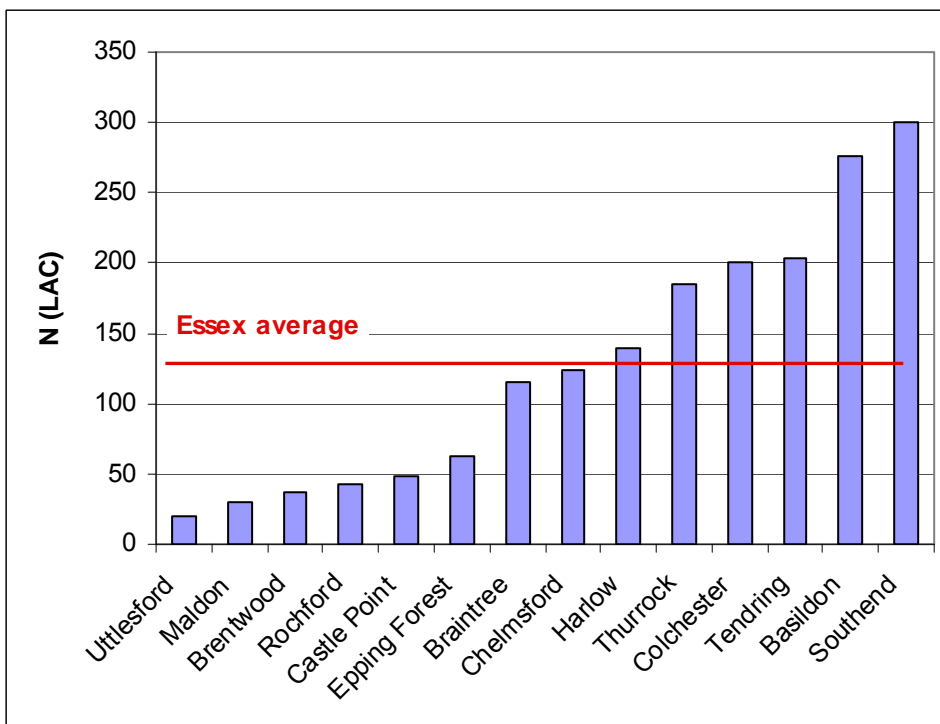
Figure 4.12: Essex rates of children looked after, 2007



Source: SSDA903 return on children looked after

The final chart on looked after children demonstrates variation at district level also.

Figure 4.13: Essex children looked after, March 2006



Source: SSDA903 return / Swift

4.9 Conclusion

With MMR immunisation rates well below the WHO recommendation, it is perhaps unsurprising that the incidence of measles in very young children is well above the national rate in a number of Essex districts / boroughs. Breastfeeding initiation rates are also low.

The growing prevalence of obesity among the child population is an important public health issue and a national priority. If we fail to halt the rise in childhood obesity, we could see children having a shorter life expectancy than their parents.

Across the county, teenage conception rates are falling but not quickly enough to meet the government target. And in some areas rates are well over double the regional rate. In many of these same areas, there is also poor educational attainment.

There is disparity in educational attainment and progression into learning and employment both geographically and between those looked after and their peers. A higher proportion of young people with disabilities are also not in employment, education or training.

Across Essex there are significant numbers of children and young people experiencing mental health difficulties, making poor choices in terms of healthy lifestyles (eg smoking and alcohol use), suffering as a result of crime / bullying and at risk of very poor health, educational and social outcomes associated with being looked after.

CHAPTER 5: WORKING ADULTS AND OLDER PEOPLE

As set out in Chapter 1, Essex's changing demographic profile will see more residents reaching retirement while fewer workers will be supporting them. Demands on services will increase as the resources to provide these same services diminish. More staff or radically different models of service delivery will be needed to meet increasing demands. In addition, as people get older they can become less mobile and many could become isolated and unable to access the services they need. Parts of Essex – particularly rural areas – already suffer problems of service access and there is evidence to suggest that this is getting worse²⁸.

5.1 Older People Living Alone

The living circumstances of older people 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+ living on their own will have increased by 44% by 2025 and by 53% for those aged 75+. This is likely to impact on feelings of isolation and, in rural areas particularly, on the cost of providing services as levels of travel for support staff increase.

Figure 5.1: Essex population projections for people aged 65+ living alone by age band and gender

	2008	2010	2015	2020	2025
Men aged 65-74 living alone	12,036	12,852	15,368	15,963	15,827
Men aged 75+ living alone	15,680	16,408	18,844	21,868	26,684
Women aged 65-74 living alone	25,905	27,621	33,099	34,452	33,462
Women aged 75+ living alone	50,976	51,566	55,283	61,714	73,750
<i>Total aged 65-74 living alone</i>	<i>37,941</i>	<i>40,473</i>	<i>48,467</i>	<i>50,415</i>	<i>49,289</i>
<i>Total aged 75+ living alone</i>	<i>66,656</i>	<i>67,974</i>	<i>74,127</i>	<i>83,582</i>	<i>100,434</i>

Source: POPPI, 2007 (based on Census 2001)

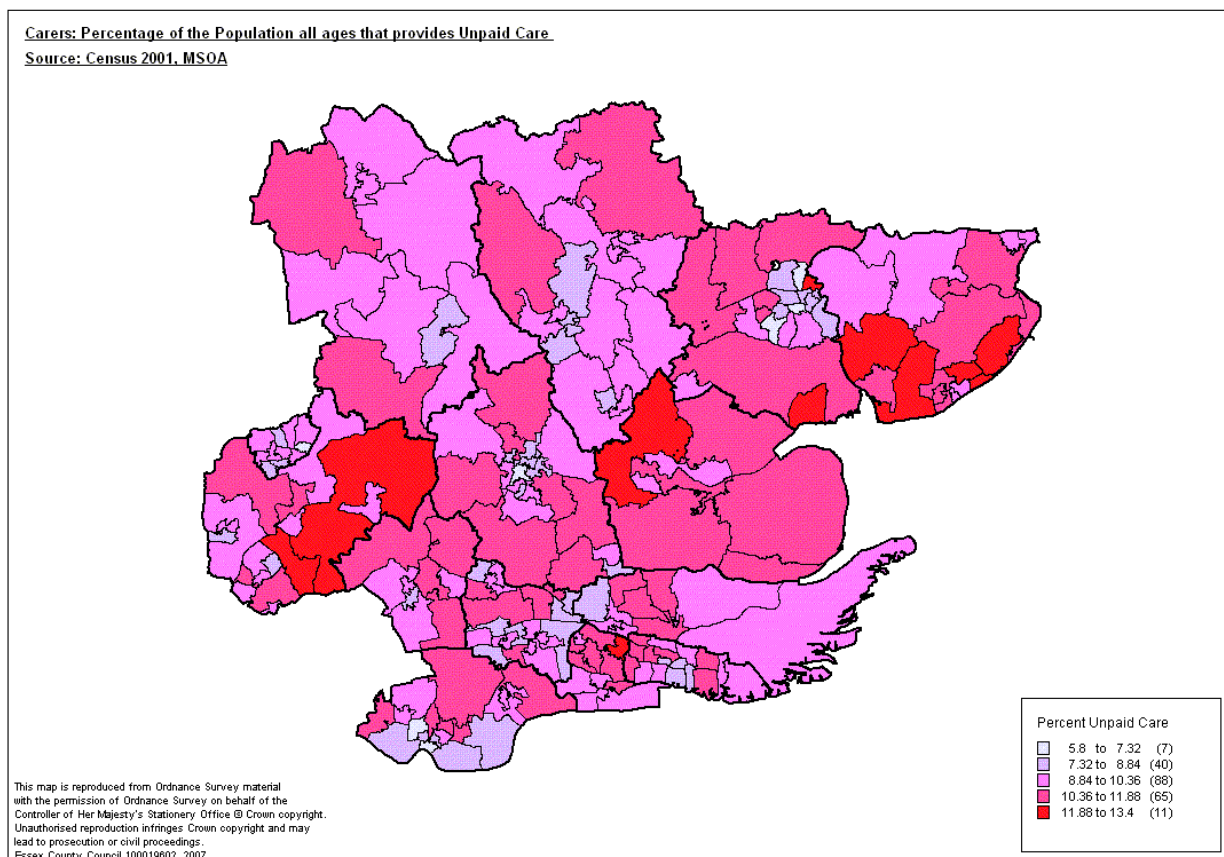
5.2 Carers

As our residents grow older, levels of impairment and disability will rise. Many people with long-term health problems are already cared for by family members – often a child or partner. The number of unpaid carers in the county is staggering; in 2001 approximately 159,000 – almost 10% of the Essex population. Some 30,000 of these spend 50 hours or more on caring tasks every week and almost half of this group are themselves aged over 60. Although the majority of unpaid carers receive some form of support either from the local authority or from the voluntary sector, a third do not appear to receive any support at all and just over a third are not satisfied with the support that they get²⁹.

²⁸ based on rural services series 2001 and 2005, Countryside Agency

²⁹ Evaluating Services and Support for Carers (2004) Essex County Council

Figure 5.2: Essex unpaid carers, Census 2001



58% of carers currently receive support from social services for themselves or the person they look after in the form of day care, home care or respite breaks. 14% think these services are 'completely sufficient', 41% 'mostly sufficient' and 32% 'partly sufficient'.³⁰

In 2005-06 the number of carers assessed / reviewed by social services was 6.9 per 1,000 adults in ECC, 9.4 per 1,000 in Southend and 4.8 per 1,000 in Thurrock. The national rate is 8.9 per 1,000 adults.

The following table shows both the total number of carers identified through the Census and those assessed / reviewed by ECC social services in 2006-07. Both measures show high rates of carers in Tendring. The lowest rate according to Census information is in Harlow whereas for those supported by social services it is in Chelmsford and Epping Forest.

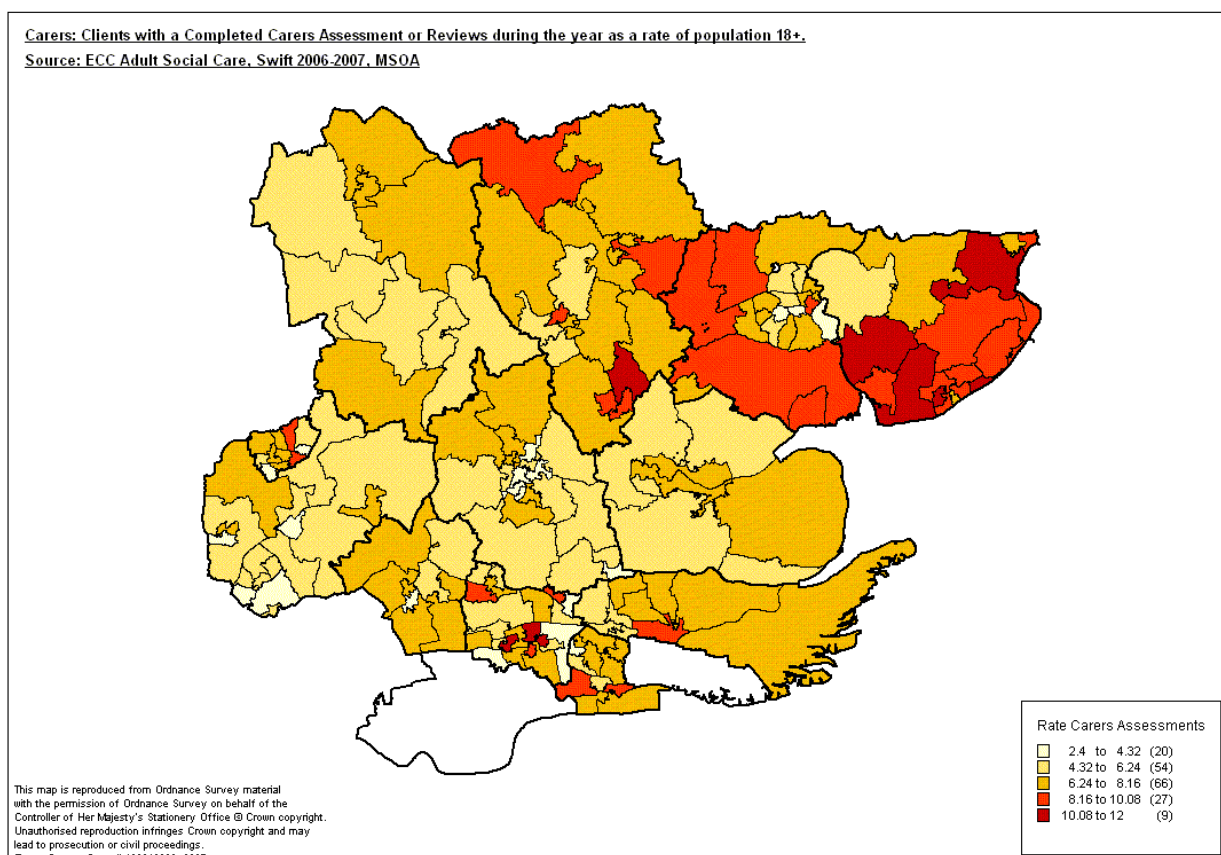
³⁰ Evaluating Services and Support for Carers (2004) Essex County Council

Figure 5.3: ECC carers in the general population and known to social services

	General population		Known to social services	
	N (unpaid carers)	Rate per 1,000 18+	N (carers)	Rate per 1,000 18+
Basildon	15685	124.3	860	6.8
Braintree	12396	122.3	782	7.7
Brentwood	6902	128.5	356	6.6
Castle Point	8998	133.0	459	6.8
Chelmsford	15009	123.4	631	5.2
Colchester	14516	119.9	785	6.5
Epping Forest	12247	129.8	494	5.2
Harlow	7022	117.3	392	6.6
Maldon	6211	135.5	278	6.1
Rochford	8022	131.4	407	6.7
Tendring	15581	140.0	1,051	9.4
Uttlesford	6647	125.5	303	5.7
ECC	129236	127.1	6,798	6.7
Outside ECC		-	524	-
TOTAL	129,236	127.1	7,322	7.2

Source: Census 2001 / Swift 2006-07

Figure 5.4: ECC carers known to social services, 2006-07



Comparable data unavailable for the two UAs. Please refer to local JSNAs for further information.

5.3 Housing Related Support

Housing-related support is required for a wide range of vulnerable groups. Supporting People – a programme concerned with housing-related support – aims to help vulnerable people live independently in their homes. It offers a range of services, including:

- life skills training
- assisting people in dealing with landlords, neighbours etc
- assisting people with personal budgeting
- support with moving to more independent accommodation.

In Essex, over 17,000 units of Supporting People services are provided across a range of client groups.

Figure 5.5: Essex provision of housing-related support

Client group		Units supplied
Older people	with support needs	13,295
	frail elderly	322
	with mental health problems / dementia	38
Homeless people	single with support needs	937
	rough sleepers	0
	families with support needs	243
Young people	teenage parents	97
	leaving care	31
	at risk	435
Others	travellers	155
	refugees	0
	offenders / at risk of offending	4
	mentally disordered offenders	0
	people with mental health problems	475
	people with learning disabilities	905
	people with a physical or sensory disability	69
	women at risk of domestic abuse	238
	people with HIV / AIDS	0
	people with alcohol problems	7
people with drug problems	26	
TOTAL		17,277

Source: Supporting People 5 Year Strategy for Essex, 2005-2010

Although the need for housing-related support for different client groups is often hard to quantify, benchmark analysis suggests that the main gaps in Essex services are for:

- frail elderly people
- homeless families and single homeless people (especially young people and those with chaotic lifestyles)
- young people leaving care

5.3.1 Older people

Housing is, in many ways, the cornerstone of older people remaining within the community. Of those living in social rented housing, just under a third live in sheltered housing but for most older people, staying in their own home and being cared for by members of their family is their preferred housing option³¹. According to the Census (2001), 73% of Essex older people live in owner-occupied accommodation but many cannot afford to adapt their home or keep it in good repair³². This highlights the importance of care and repair services, private sector renewal, Disabled Facilities Grants and of developing new homes to the Lifetime Homes Standard.

Older people are the largest Supporting People service group both nationally and in Essex. They currently make up more than 90% of service users in the county. As our population ages, we can expect to see 24% more frail elderly people, more age-related mental health problems and a dramatic rise in the need for housing-related support.

5.3.2 Chaotic lifestyles

Drugs, alcohol and mental health problems are inextricably linked with a large section of the homeless client group. The Regional Housing Strategy quotes the following recent research findings:

- 83% of homeless people had taken some form of drug (other than alcohol) in the previous month
- 66% of those surveyed said that drug or alcohol use had contributed to their becoming homeless
- 80% said that they had started using at least one new drug since becoming homeless
- there is a close relationship between drug and alcohol misuse and mental health problems.

In addition, *Mental Health and Social Exclusion* (SEU, 2004) found that one in four tenants with mental health problems have serious rent arrears and risks losing their home and NACRO estimate that 25% of the offenders they work with have mental health problems.

5.3.3 Young people

Young people with housing needs tend to have multiple and complex problems. Typically they are homeless and can have substance misuse issues, mental health needs, low-life skills (bordering on learning disability) and a history of care and anti-social behaviour / offending. Figures for NE Essex show that 1 in 12 young people leaving care has an issue with class A drugs with a further 1 in 6 experiencing alcohol problems. Moreover, 1 in 5 of Essex care leavers has been involved with the criminal justice system.

5.4 Mental Health

One in four British adults experiences at least one diagnosable mental health problem in any one year, and one in six experiences this at any given time³³. These findings suggest that almost 150,000 people across Essex are experiencing mental health problems.

³¹ Our homes, our lives: choice in later life living arrangements (2002) Housing Corporation and Centre for Policy on Ageing

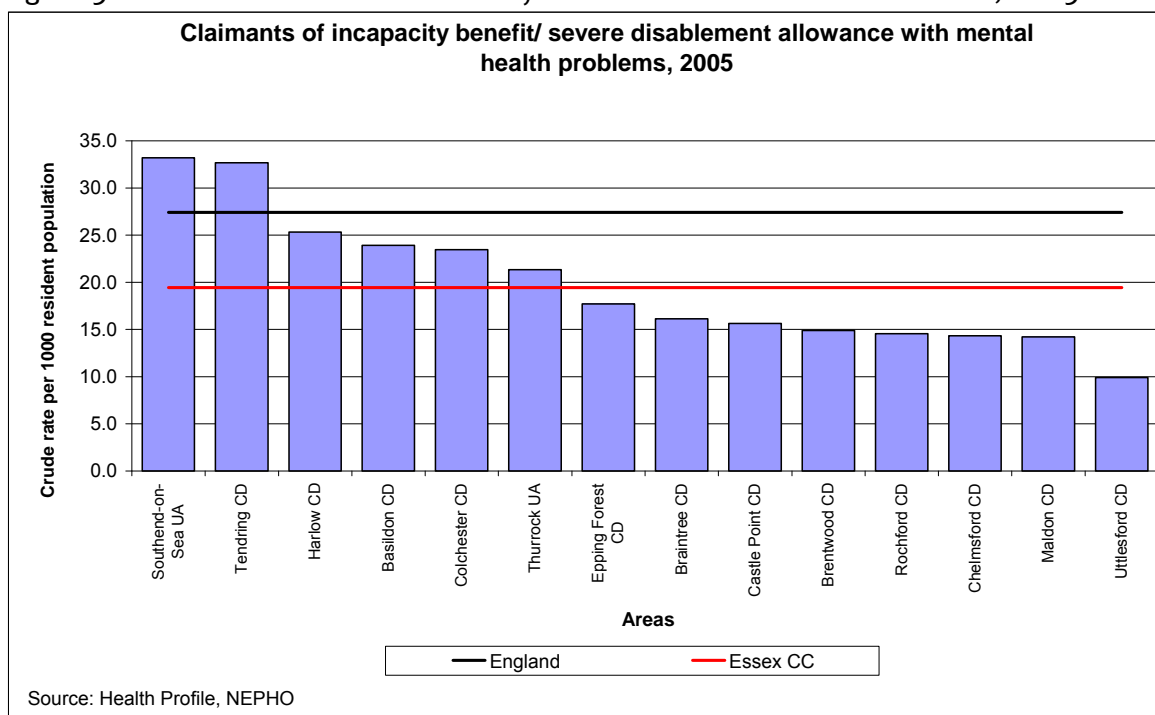
³² Housing and health: building for the future (2003) British Medical Association

³³ Office for National Statistics Psychiatric Morbidity Report, 2001

5.4.1 Claiming benefit

Incapacity Benefit claimants make up the largest group of economically inactive people of working age in Britain and almost 40% are on Incapacity Benefit because of mental health conditions³⁴. Previous research has shown that, once on Incapacity Benefit, this group is less likely to return to work and more likely to experience detrimental effects to their well-being in terms of financial circumstances and general health. The following chart details the rate per 1,000 working age population who were claiming Incapacity Benefit or Severe Disablement Allowance with a diagnosis in the mental and behavioural disorders category.

Figure 5.6: Essex claimants of disability benefit for mental health reasons, 2005



Six areas have more than the Essex average proportions of their working age population claiming benefit / allowances for a mental or behavioural disorder. Southend and Tendring have the highest claimant rates. Uttlesford has the lowest proportion claiming benefit of this type.

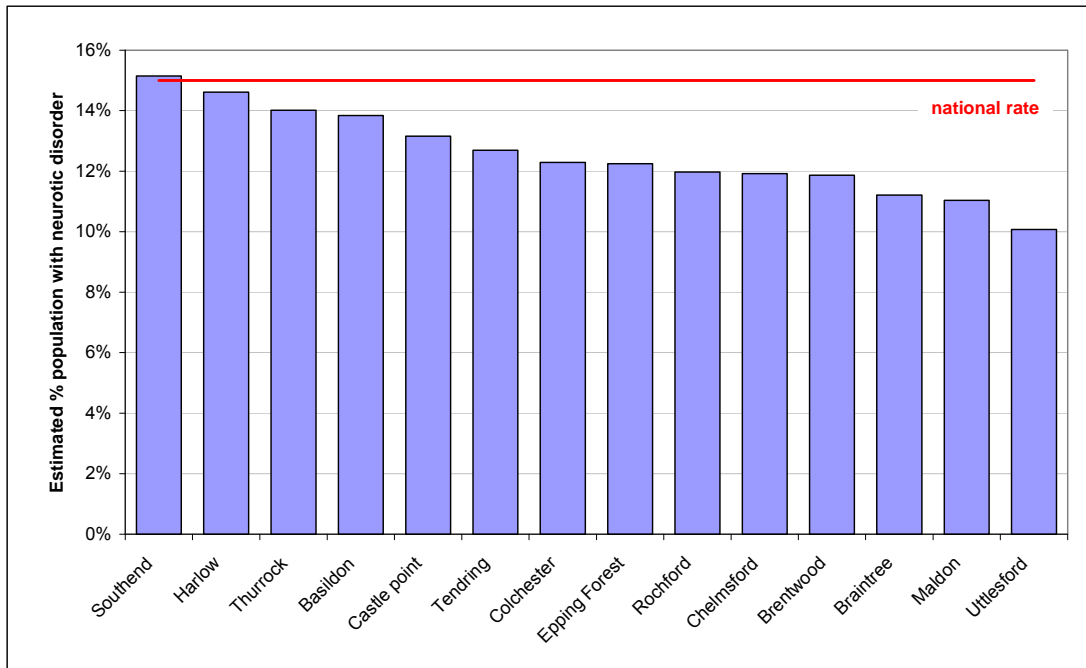
5.4.2 Neurotic disorder and depression

The following charts present estimates of the percentage of the working age population that is experiencing any type of neurotic disorder / depression. The data is derived from the ONS national epidemiology survey, *Psychiatric morbidity among adults living in private households (2000)*, modelled using an ONS mathematical model that factors in four variables that were found to best explain variation in psychiatric morbidity.

As can be seen from the following charts, there is significant variation across Essex in the prevalence of neurotic disorders but, with the exception of Southend, all are below the national estimate. The prevalence of depression shows a similar pattern.

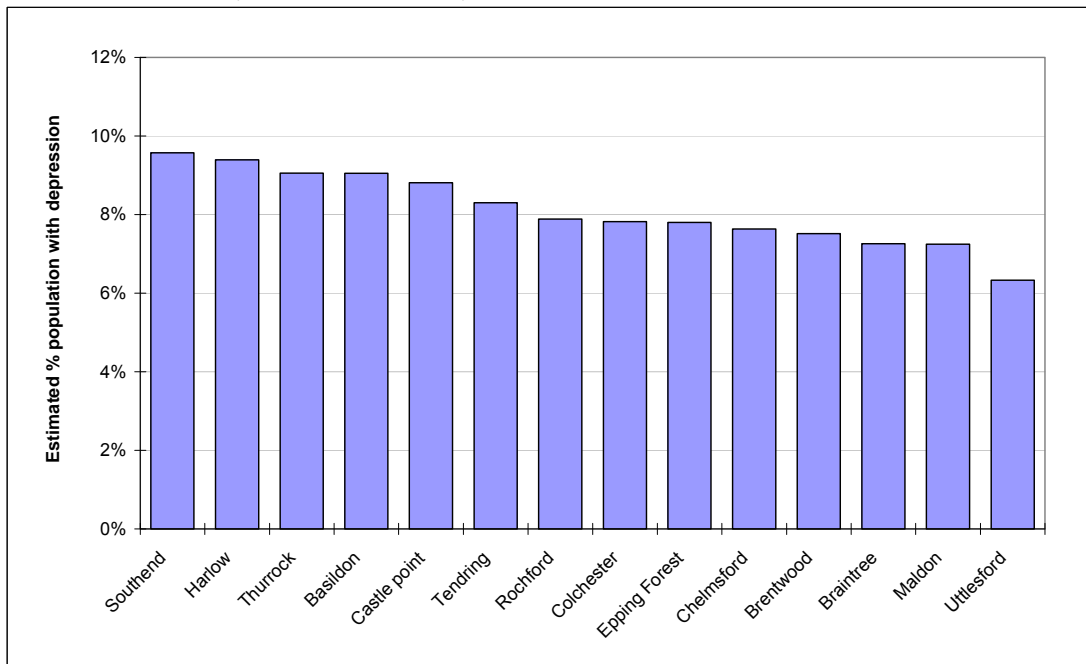
³⁴ <http://www.york.ac.uk/inst/spru/research/summs/mentalhealth.html>

Figure 5.7: Essex prevalence of neurotic disorder, 2000



Source: Centre for Mental Public Health

Figure 5.8: Essex prevalence of depression, 2000

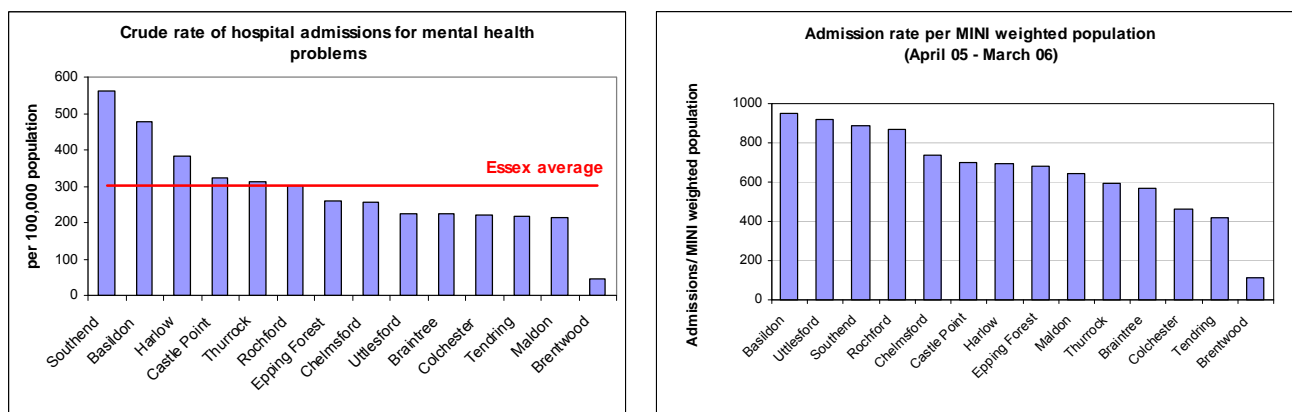


Source: Centre for Mental Public Health

5.4.3 Hospital Admission Rates

Hospital admission rates for mental health problems also show significant variation across the county with the crude rate in Southend nearly twelve times higher than that in Brentwood. In order to even out the effects of deprivation and allow for better comparison, MINI-adjusted figures can be used. This gives a slightly different picture across Essex (although still characterised by large variation).

Figure 5.9: Hospital admission rates for mental health problems, 2005/06



Source: Dr Foster Mental Health Activity Tracker / ONS population estimates

As set out in the appendix, male suicide mortality rates are considerably higher than for females and both have started to increase in recent years. Harlow has a considerably higher male rate than other areas in Essex and the national average. However, caution needs to be exercised in interpreting these figures as small numbers can cause wide fluctuation.

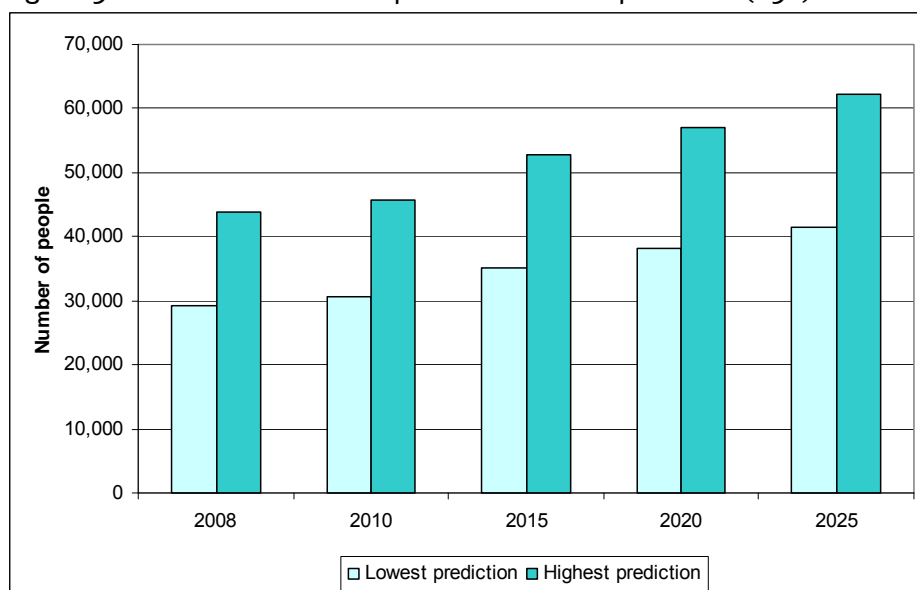
5.4.4 Depression among older people

Depression is the most common mental illness found in older people and the second most common single underlying cause for all GP consultations for people over 70 years of age³⁵.

Figure 5.10 shows the future impact of depression among older people in Essex using highest and lowest prevalence estimates (taken from POPPI). According to the highest estimate, there are currently nearly 44,000 people aged 65+ in Essex suffering from depression. Come 2025, it is predicted that this figure will rise to over 62,000. This represents a higher rate of increase than in England – 42% compared to 37%.

³⁵ http://www.netdoctor.co.uk/diseases/depression/depressionintheelderly_000602.htm

Figure 5.10: Essex estimated prevalence of depression (65+)



Source: Depressive Illness (1996) Baldwin, R

5.4.5 Dementia

The term ‘dementia’ is used to describe a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer’s disease. The following findings are taken from *Dementia UK (2007)* published by the Alzheimer’s Society.

5.4.5.1 Prevalence

Dementia can affect people of any age, but is most common in older people. One in six people over 80 has a form of dementia and one in 14 people over 65 has a form of dementia. Alzheimer’s disease is considered to be the dominant subtype, particularly among older people, and in women. The prevalence of both early onset and late onset dementia increases with age, doubling with every five-year increase across the entire age range from 30 to 95+.

Figure 5.11: UK consensus estimates of population prevalence of late onset dementia by age and gender, 2007

Age (years)	F (%)	M (%)	Total (%)
65–69	1.0	1.5	1.3
70–74	2.4	3.1	2.9
75–79	6.5	5.1	5.9
80–84	13.3	10.2	12.2
85–89	22.2	16.7	20.3
90–94	29.6	27.5	28.6
95	34.4	30.0	32.5

Early onset dementia is comparatively rare, accounting for 2.2% of all people with dementia in the UK. Its prevalence is adjudged to be higher in men than in women for those aged 50-65, while late onset dementia is considered to be marginally more prevalent in women than in men. Among those with late onset dementia, 55.4% have mild dementia, 32.1% have moderate dementia and 12.5% have severe dementia. The proportion considered to have

severe dementia increases with increasing age, from 6.3% for those aged 65-69 to 23.3% for those aged 95 years and over.

The prevalence of dementia in institutions varies little by age or gender, increasing from 55.6% among those aged 65-69 to 64.8% in those aged 95+. Estimated prevalence of dementia among those aged 65+ living in EMI (elderly mentally infirm) homes is 79.9% compared to 66.9% in nursing homes and 52.2% in residential care homes.

Local authorities with larger proportions of older inhabitants and with a higher relative density of institutional places will tend to have a higher whole population prevalence of dementia. Rural authorities with dispersed populations may face increased costs and logistical difficulties in providing home-based care in the community. The following table sets out variations in the estimated prevalence of dementia across the county of Essex. For comparison, it is estimated that 1.1% of the total UK population has dementia.

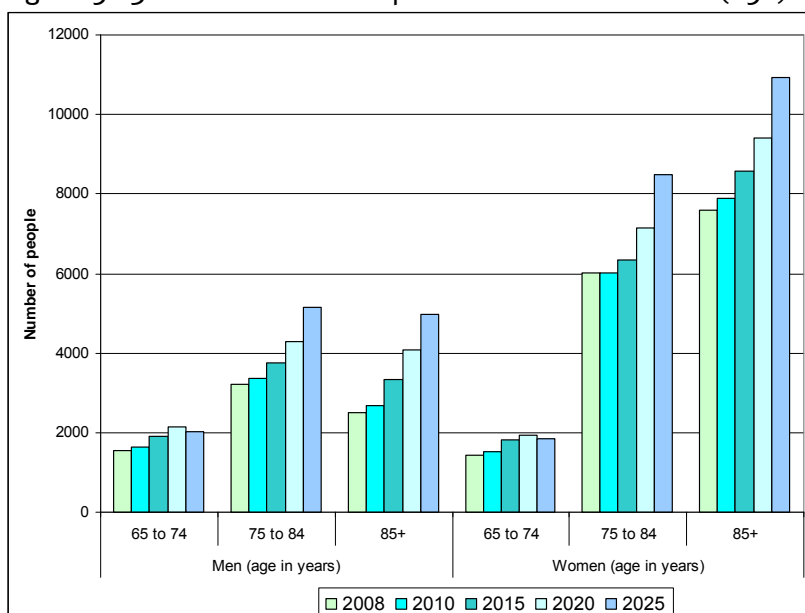
Figure 5.12: Essex consensus estimate of dementia prevalence

Area	Men			Women			Total
	Total	% over 65s with dementia	% total pop with dementia	Total	% over 65s with dementia	% total pop with dementia	% total pop with dementia
ECC	5,273	5.0	0.8	9,994	7.5	1.5	1.14
Southend	783	6.2	1.0	1,779	1.0	2.2	1.61
Thurrock	354	4.2	0.5	692	6.0	0.9	0.71

5.4.5.2 Expected Growth

Dementia is a fast-growing problem which is likely to put a huge strain on local authorities and the NHS as people are living longer and surviving common forms of cancer and heart disease. According to POPPI, around 22,300 people aged 65+ in Essex currently have dementia and this figure is expected to increase to just under 33,500 by 2025. This is a greater rate of increase than in England – 50% compared to 44%.

Figure 5.13: Essex estimated prevalence of dementia (65+)



Source: Cognitive Function and Ageing Study (2002) Medical Research Council

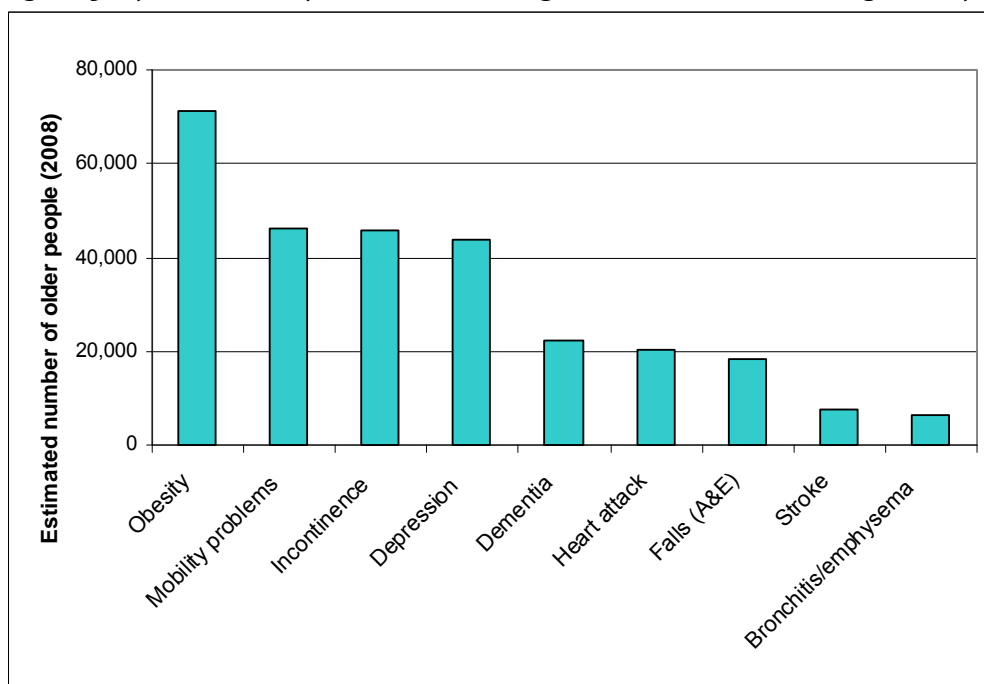
5.5 Older People and Long-term Conditions

The World Health Organisation has identified that long-term conditions will be the leading cause of disability by 2020 and that, if not successfully managed, will become the most expensive problem for health care systems³⁶. Long-term conditions are those that can only be controlled and not, at present, cured. They include diabetes, asthma, arthritis, heart failure, dementia and other neurological diseases.

Long-term conditions can have a huge impact on quality of life both for those living with the condition and their close family. As we get older the likelihood of developing a long-term condition increases and people often find themselves living with more than one such condition and facing particular medical and social challenges.

Looking after patients with long-term conditions is very costly and uses a large proportion of health and social care resources. People with long-term conditions are significantly more likely to see their GP (accounting for about 80% of GP consultations), to be admitted as in-patients and to use more in-patient days than those without such conditions³⁷. Figure 5.14 shows the number of over-65s estimated to have a range of long-term conditions³⁸.

Figure 5.14: Estimated prevalence of long-term conditions among older people (2008)



Source: POPPI

5.5.1 Obesity

Obesity is such a problem in the young today that the future impact over the next 20 years will have serious implications for the health service. Obesity is already known to have serious health implications (eg diabetes, hypertension and heart attacks) and, long-term, can reduce

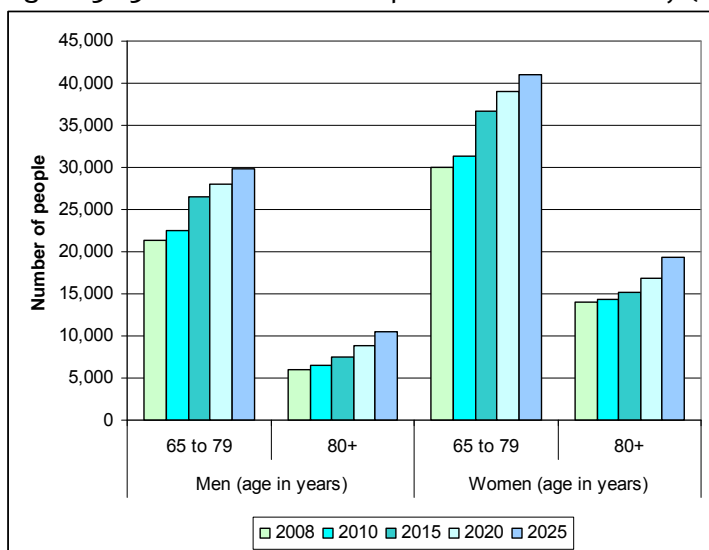
³⁶ www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=GET_FILE&dID=9015&Rendition=Web

³⁷ Improving the management of long-term conditions in the face of system reform. BMA, June 2006

³⁸ The information contained in this section uses data taken from POPPI (Projecting Older People Population Information System www.poppi.org.uk).

life expectancy by up to nine years. In Essex the number of people currently thought to be obese is around 71,300 and by 2025 it is estimated this will have topped 100,000. This is a higher rate of increase than nationally – 41% compared to 36%.

Figure 5.15: Essex estimated prevalence of obesity (65+)

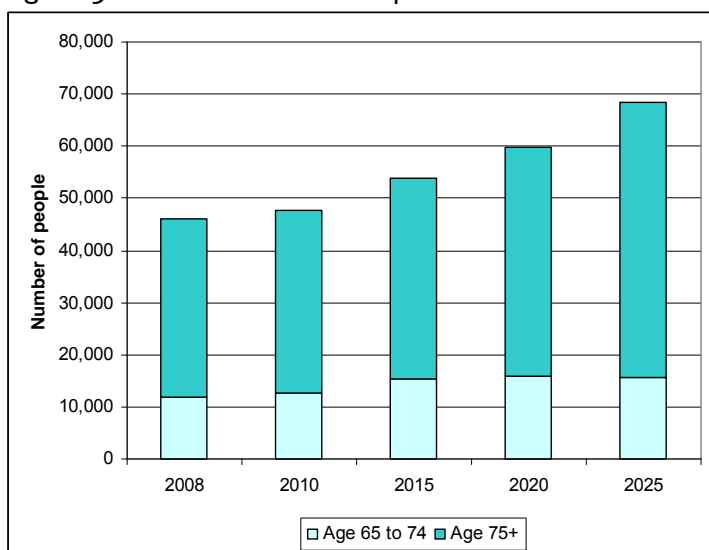


Source: Health Survey for England 2000

5.5.2 Lack of mobility

Mobility is the ability and willingness to move freely. Mobility can depend on motor skills but is known to decrease with age. Special tools such as a walking stick, walker, mobile standing frame or wheelchair maybe used to aid mobility. In Essex the current number of people unable to manage at least one mobility activity³⁹ on their own among those aged 65+ is over 46,100 and is likely to increase to over 68,400 by 2025. The rate of increase is higher than that for England – 48% compared to 42%.

Figure 5.16: Essex estimated prevalence of lack of mobility (65+)



Source: Department of Health (part of the 1998 General Household Survey)

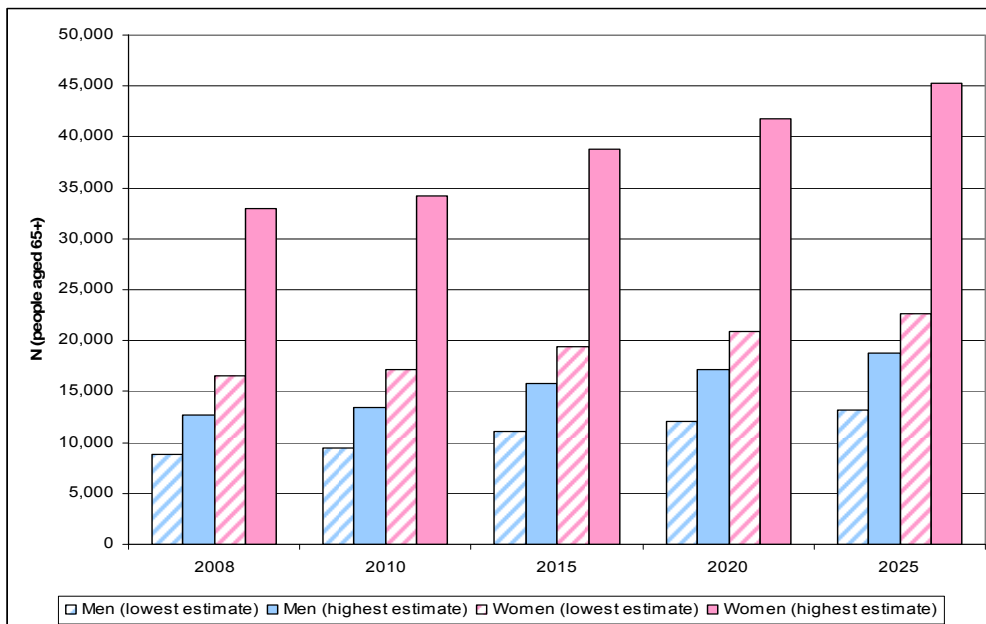
³⁹ Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed

5.5.3 Incontinence

Incontinence is an issue that is hidden but as we get older is one that we may have to face. Prevalence rates of urinary incontinence in the UK vary from between 5% and 20% among women and between 3% and 10% among men, particularly affecting those who are aged 65+ (Royal College of Physicians 1995).

The chart below shows levels of continence problems among those aged 65+ living in the community according to the highest and lowest predictions. The highest estimate for men in Essex is 12,700 rising to 18,800 by 2025. That for women is 33,000 predicted to rise to 45,300 by 2025. These increases are roughly in line with those for England, although slightly higher for women (37% increase compared to 32%).

Figure 5.17: Essex estimated prevalence of incontinence (65+)

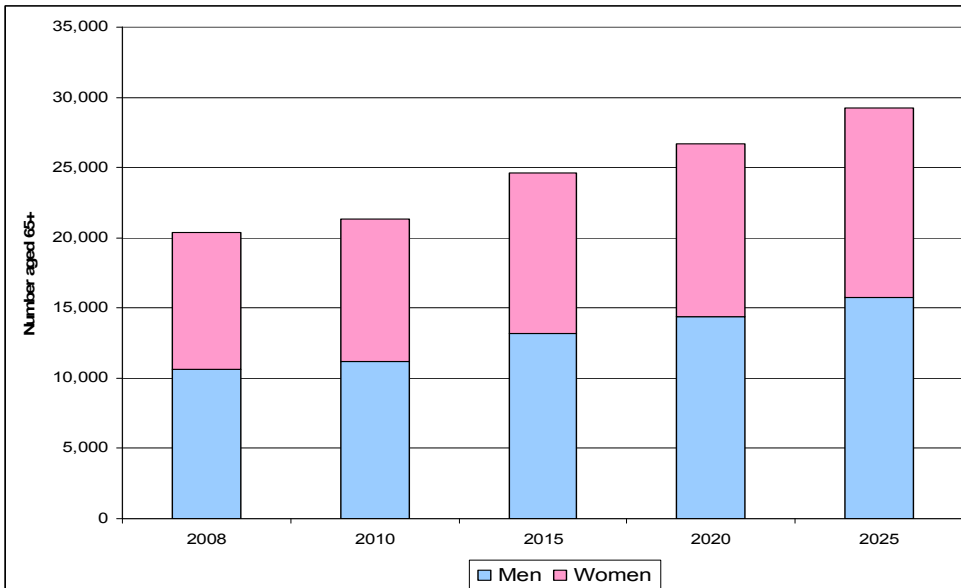


Source: Good Practice in Continence Services (2000) Department of Health

5.5.4 Cardiovascular disease

As the body ages, the risk of suffering from heart disease increases as lifestyle effects take their toll on the heart and arteries. Co-morbidities such as diabetes also increase the risk of having heart disease or associated illnesses. In Essex the number of heart attacks in the over 65s is almost 20,400 rising to 29,300 by 2025. This is significantly higher than national rate of increase – 44% compared to 28%.

Figure 5.18: Essex estimated prevalence of heart attacks (65+)



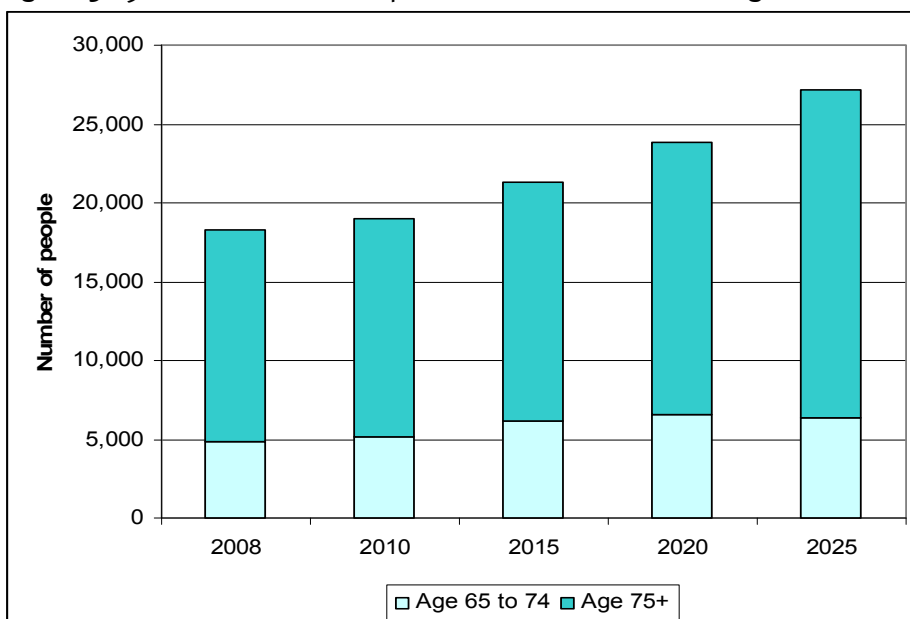
Source: 2004/05 General Household Survey

5.5.5 Falls

Falls are a common problem amongst the older population as they are more likely to happen due to reduced mobility and eyesight. The outcome of falls in the elderly is also likely to be more severe and often results in either fracture of the wrists or fracture of the femur. An elderly patient can take a long time to recover from these injuries and are at further risk if they have to undergo an operation.

Currently there are 18,300 attendances at Accident & Emergency (A&E) departments as a result of falls among those aged 65+. The majority (13,500) are among those aged 75+. By 2025, these figures are expected to have risen to 27,100 and 20,800 respectively. The rates of increase are higher than for England: 48% compared to 42% for the 65+ and 54% compared to 47% for the 75+.

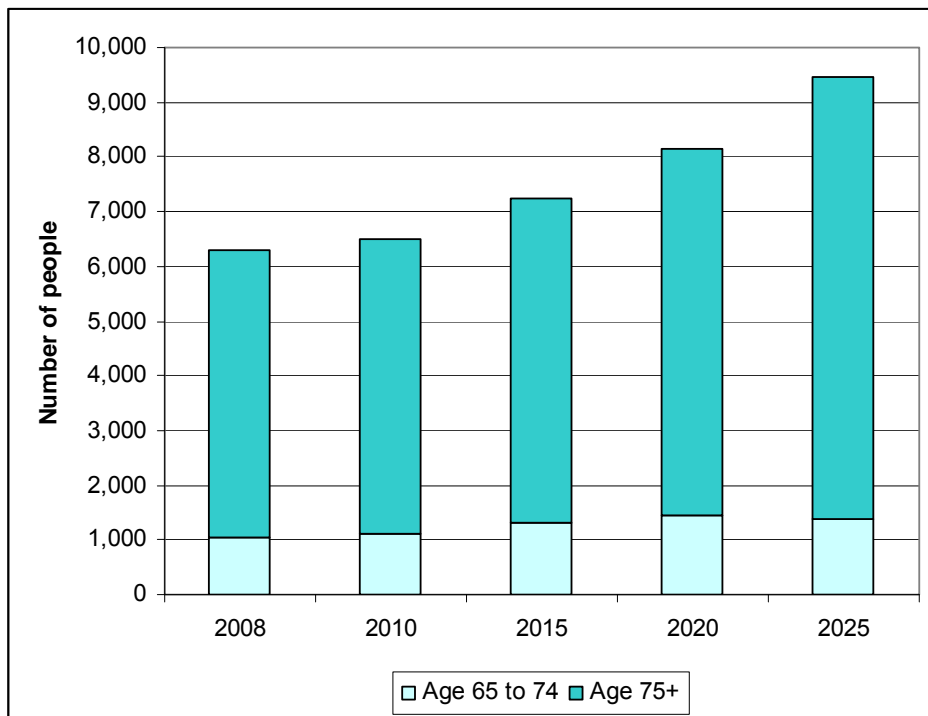
Figure 5.19: Essex estimated prevalence of falls resulting in A&E attendance (65+)



Source: Journal of Epidemiology and Community Health, 2003

Of those that attend an A&E department for a fall, it is likely that a third of them will be admitted as an inpatient. Current estimates for admission after a fall among the 65+ are 6,300 rising to 9,500 admissions by 2025. Again this is a greater increase for Essex than for England – 51% compared to 44%.

Figure 5.20: Essex estimated prevalence of falls resulting in hospital admission (65+)



Source: Journal of Epidemiology and Community Health, 2003

5.5.6 Stroke

Stroke is the most common cause of severe disability and is often fatal⁴⁰. Every year in the UK, around 130,000 people have a first stroke - about one person every five minutes. Although stroke can affect people of any age, nine out of ten occur in people over the age of 55. Men are more often affected than women, as are people from Asian, African and Afro-Caribbean backgrounds. High blood pressure, smoking, diabetes, atrial fibrillation, a previous mini-stroke, binge drinking and a family history of stroke also increase risk.

The current number of strokes in Essex is just over 7,500 and is likely to increase to just under 11,500 by 2025. Again, this is a higher rate of increase than for England – 53% compared to 45%.

⁴⁰ <http://www.bbc.co.uk/health/conditions/stroke1.shtml>

Figure 5.21: Essex estimated prevalence of stroke (65+)



Source: 2004/05 General Household Survey

5.5.7 Bronchitis and emphysema

Figure 5.22 shows those aged 65+ predicted to have a long-standing health condition caused by bronchitis and emphysema. By 2025 it is estimated that there will be over 250,000 people aged over 65 in England with a chronic respiratory condition and Essex will be home to just over 9,000.

Figure 5.22: Essex estimated prevalence of bronchitis and emphysema (65+)



Source: 2004/05 General Household Survey

5.6 Care and Support for Older People

A substantial number of older people receive care and support from a range of agencies including local authorities, health services, mental health services and the voluntary sector.

Each individual has different needs and will require different levels of support at different stages of their life.

In 2005-06 the rate of older people receiving social care services was 151.1 per 1,000 of the population aged 65+ in ECC, 147.1 per 1,000 in Southend and 106.5 per 1,000 in Thurrock. Each of these rates is below the England rate of 157.7 per 1,000⁴¹.

In 2006-07 ECC had 22,800 clients known to an older person's team⁴². Converting numbers into rates shows that the lowest rate is in Harlow and the highest in Braintree, with a variance between areas of 40.2 per 1,000 aged 65+.

Figure 5.23: ECC numbers and rates of service users open to OP team

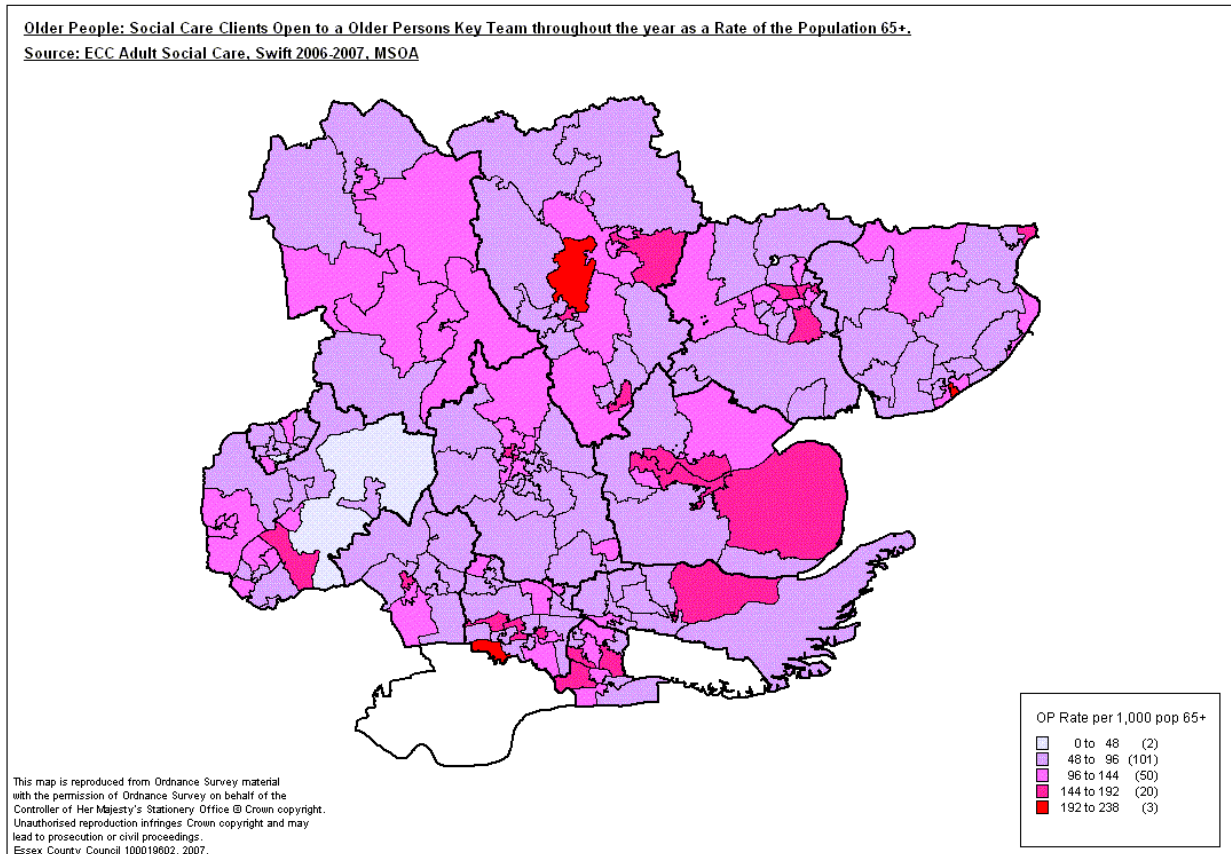
	Open to Older People's Team	
	N	Rate per 1,000 65+
Basildon	2,447	100.3
Braintree	2,233	113.0
Brentwood	1,228	97.4
Castle Point	1,645	111.3
Chelmsford	2,040	88.8
Colchester	2,232	97.3
Epping Forest	1,981	97.1
Harlow	843	72.8
Maldon	1,008	110.7
Rochford	1,242	90.6
Tendring	3,540	98.2
Uttlesford	1,114	105.8
ECC	21,553	98.5
Outside ECC	1,247	-
TOTAL	22,800	104.2

38% of MSOAs in ECC show rates above that for ECC (104.2 per 1,000 aged 65+) and 2% have at least double. These are located in Braintree, Tendring and Basildon. The highest rate is in Braintree at 237.9 per 1,000 aged 65+.

⁴¹ RAP 2005-06

⁴² Clients open to a key team during 2006-07. Comparable data unavailable for two UAs.

Figure 5.24: ECC rates of service users open to OP team by MSOA, 2006-07



Comparable data unavailable for the two UAs. Please refer to local JSNAs for further information.

5.7 Conclusion

Essex's ageing population presents one of our most significant challenges and will require radically different models of service delivery. The shift in national and local policy towards independence, choice and control means we must make better use of technology to support people and provide a wide range of supported housing options. We know also that as we get older, the likelihood of developing long-term conditions increases and that people with these conditions already account for around 80% of GP consultations. In the future, we will see dramatic increases in the numbers of older residents with, for example, mobility problems, suffering from depression or dementia.

The number of people with mental health problems is also set to increase. Already, six districts / boroughs have higher than average proportions of their working age population claiming benefit / allowances for a mental or behavioural disorder.

Almost 10% of our residents provide informal care to relatives, friends or neighbours. Approximately one third receive no support from either social services or the voluntary sector and just over a third are not satisfied with the support that they get.

CHAPTER 6: PEOPLE LIVING WITH DISABILITIES

About 21% of the total adult population is disabled⁴³. Compared with non-disabled people, disabled people are⁴⁴:

- more likely to live in poverty (having on average less than half the income earned by non-disabled people)
- less likely to have educational qualifications and two and half times more likely to be economically inactive
- more likely to experience problems with hate crime or harassment
- more likely to experience problems with housing and with transport (most often identified by disabled people as their biggest challenge)
- 27% of disabled 19 year olds are not in education, training or employment, compared with 10% of their non-disabled peers⁴⁵.

As our population ages, levels of disability will increase sharply. Research suggests that older people are generally free of prolonged disability until they reach their 70s, after which they may face accelerating disability levels until death. But disability does not only affect older people. Around 3% of u16s have functional disabilities and the majority of those claiming disability benefits have learning difficulties and mental health problems. Among our working-age population, between 14% and 16% of adults – around 120,000 people – have a disability.

The number of severely disabled people is likely to increase among the youngest age groups. Improvements in neonatal health care mean more children survive increasingly premature births. These advances – although welcome – impact significantly on patterns of disability; around half of all premature babies born before 26 weeks are disabled; a quarter are severely disabled. As more premature babies survive, the number of young people with severe disabilities is likely to rise and, in the longer term this will filter through into our working-age population.

6.1 Learning Disabilities

In 2005-06 the rate of people with learning disabilities receiving social care services was 3.5 per 1,000 of the population aged 18+ for ECC, 3.9 per 1,000 for Southend and 2.7 per 1,000 for Thurrock. The national rate is 3.9 per 1,000.

The ECC Learning Disabilities Register contains current NHS and social care service users and is therefore a more comprehensive estimate of need. As at 31 July 07, there were 4,500 people registered with a learning disability. This is equivalent to a rate of 4.4 per 1,000 of the population aged 18+⁴⁶. As set out in the table below, highest rates can be found in Tendring and Colchester and the lowest in Epping Forest and Rochford. The variance between areas is 5.2 per 1,000 population 18+.

⁴³ General Household Survey (ONS) 2002

⁴⁴ Improving the Life Chances of Disabled People. Prime Minister's Strategy Unit, January 2005

⁴⁵ Youth Cohort Study, DCSF 2003

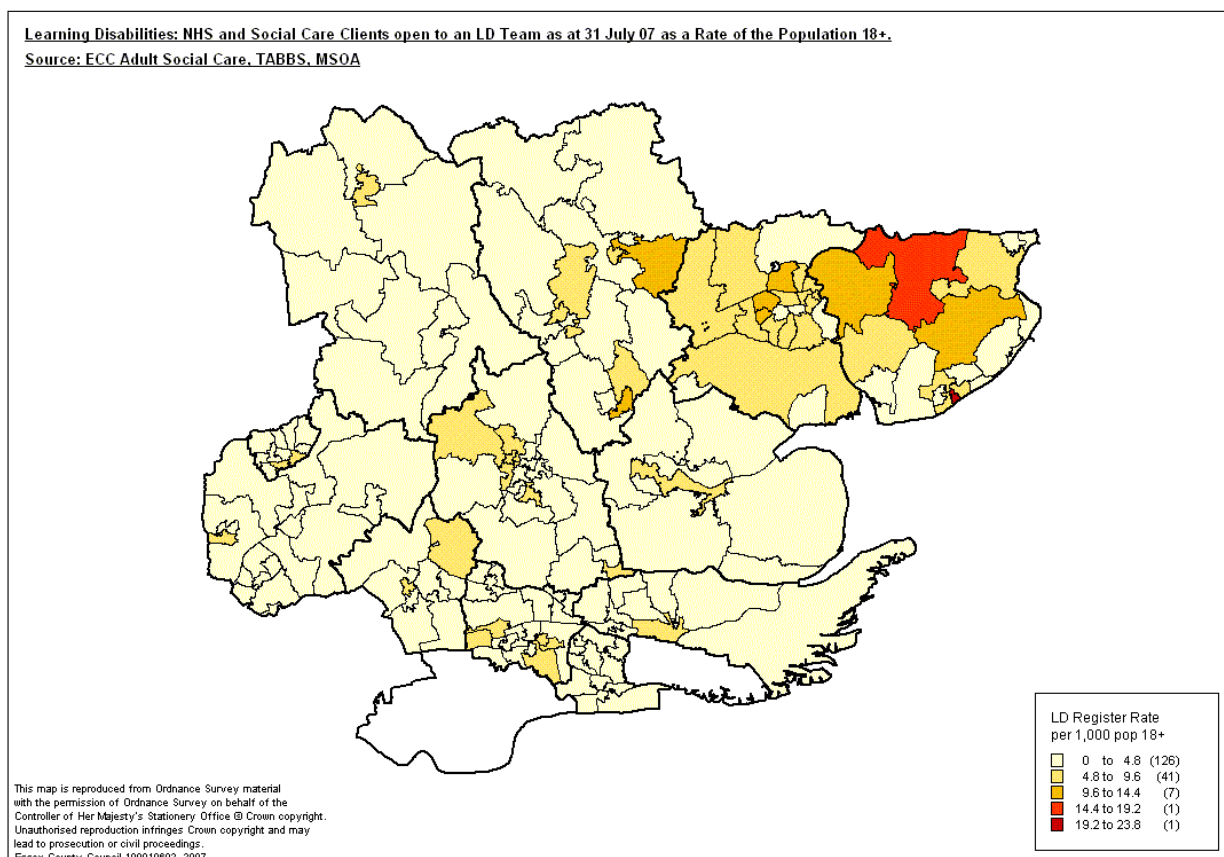
⁴⁶ Comparable data unavailable for two UAs.

Figure 6.1: ECC Learning Disabilities Register

	N	Rate per 1,000 aged 18+
Basildon	445	3.5
Braintree	502	5.0
Brentwood	191	3.6
Castle Point	179	2.6
Chelmsford	395	3.2
Colchester	801	6.6
Epping Forest	201	2.1
Harlow	199	3.3
Maldon	131	2.9
Rochford	123	2.0
Tendring	796	7.2
Uttlesford	128	2.4
ECC	4,091	4.0
Outside ECC	409	-
TOTAL	4,500	4.4

Of the 176 MSOAs in ECC, 40% are above the ECC LD Register rate of 4.4 per 1,000 aged 18+. In areas where there were previously large long-stay hospitals for adults with learning disabilities, rates are double the ECC rate. People have more likely resettled in these areas.

Figure 6.2: ECC rates of people on the Learning Disability Register by MSOA, Jul-07



Comparable data unavailable for the two UAs. Please refer to local JSNAs for further information.

6.2 Physical Impairment

In England 27 people per 1,000 population aged 18+ have a physical disability, temporary disability or are considered frail and are supported by adult social services (RAP, 2005-06). By comparison, the ECC rate is 32.0 per 1,000, that for Southend is 30.3 per 1,000 and for Thurrock is 16.9 per 1,000.

In ECC there were 2,548 service users open to physical impairment teams during 2006-07. This equates to a rate of 2.5 per 1,000 of the population aged 18+⁴⁷. As can be seen from the table below, highest rates can be found in Tendring, Colchester and Harlow and the lowest in Rochford, Epping Forest and Uttlesford. The variance between areas is 1.4 per 1,000 18+.

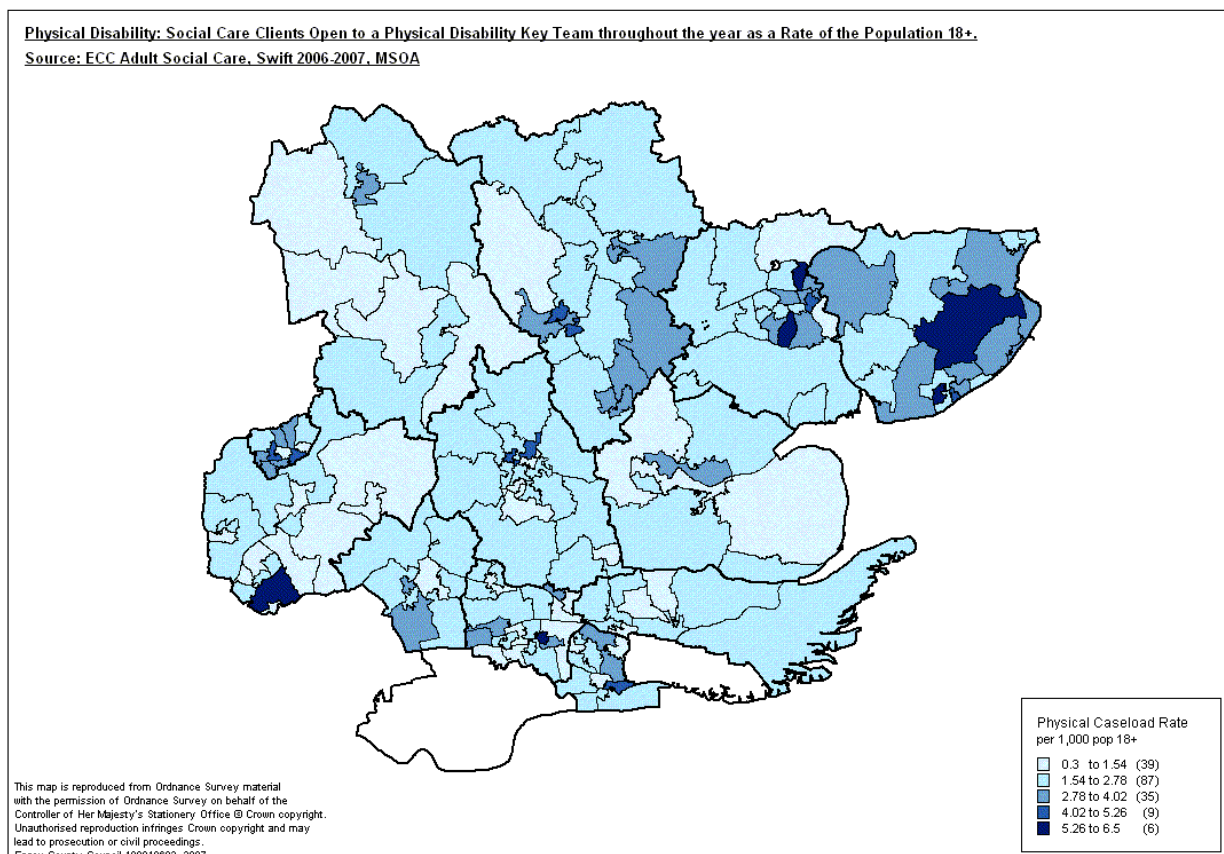
Figure 6.3: ECC numbers and rates of service users with physical impairment

	N	Rate per 1,000 aged 18+
Basildon	272	2.2
Braintree	282	2.8
Brentwood	114	2.1
Castle Point	145	2.1
Chelmsford	268	2.2
Colchester	350	2.9
Epping Forest	168	1.8
Harlow	171	2.9
Maldon	91	2.0
Rochford	102	1.7
Tendring	346	3.1
Uttlesford	93	1.8
ECC	2402	2.4
Outside ECC	146	-
TOTAL	2548	2.5

Of the 176 MSOAs in ECC, 36% are above the ECC physical impairment rate of 2.5 per 1,000 of the population aged 18+. Five per cent have double the ECC rate with the highest rate of 6.5 per 1,000 in Basildon.

⁴⁷ Service users open to a physical impairment team during 2006-07. Comparable data unavailable for two UAs.

Figure 6.4: ECC rate of physical impairment by MSOA, 2006-07



Comparable data unavailable for the two UAs. Please refer to local JSNAs for further information.

6.3 Sensory Impairment

The latest comparative information available (RAP 2005-06) shows that ECC (1.3 per 1,000), Southend (1.7 per 1,000) and Thurrock (0.7 per 1,000) all have rates of sensory impairment in receipt of social services below the national rate of 2.2 per 1,000 population aged 18+.

However, the inclusion of those with mild or secondary impairment (eg uncertified sight loss or hard of hearing) increases the ECC rate to 4.6 per 1,000 of the population 18+ while limiting it to only those with severe sensory impairment decreases the rate to 0.6 per 1,000 of the population aged 18+ ⁴⁸. As the table below shows, highest rates of all forms of sensory impairment can be found in Colchester, Tendring and Castle Point, while lowest rates are in Harlow and Epping Forest. Variance between areas is 4.3 per 1,000 18+.

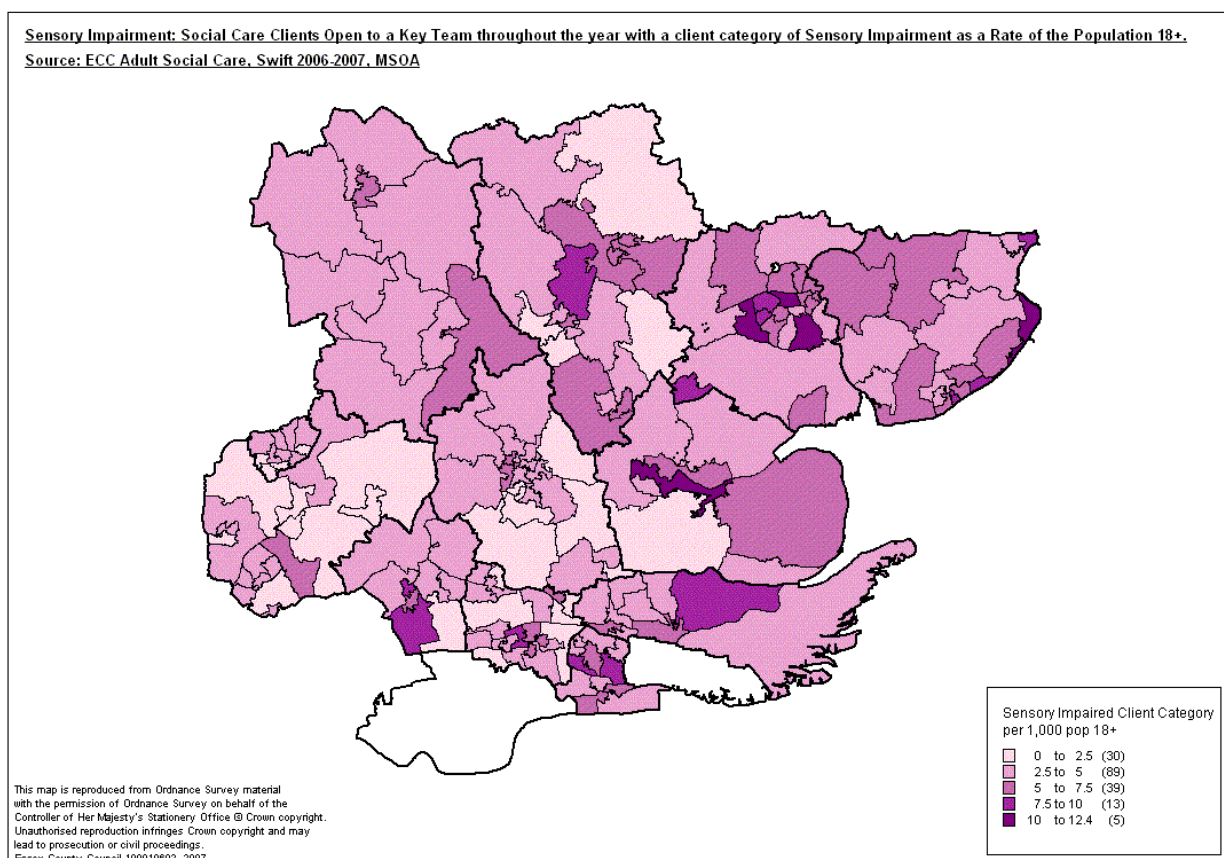
⁴⁸ Service users open to a sensory impairment team during 2006-07. Comparable data unavailable for two UAs.

Figure 6.5: ECC levels of sensory impairment, 2006-07

	Severe sensory impairment	Rate per 1,000 18+	All forms of sensory impairment	Rate per 1,000 18+
Basildon	93	0.7	468	3.7
Braintree	53	0.5	440	4.3
Brentwood	31	0.6	252	4.7
Castle Point	44	0.7	339	5.0
Chelmsford	68	0.6	404	3.3
Colchester	77	0.6	815	6.7
Epping Forest	50	0.5	289	3.1
Harlow	33	0.6	144	2.4
Maldon	27	0.6	206	4.5
Rochford	40	0.7	291	4.8
Tendring	94	0.8	642	5.8
Uttlesford	22	0.4	211	4.0
ECC	632	0.6	4,501	4.4
Outside ECC	15	-	187	-
TOTAL	647	0.6	4,688	4.6

In terms of all forms of sensory impairment, 38% of MSOAs in ECC have a higher than average rate of service users with a sensory impairment. Six per cent have rates that are double that for ECC.

Figure 6.6: ECC all forms of sensory impairment by MSOA, 2006-07



Comparable data unavailable for the two UAs. Please refer to local JSNAs for further information.

6.4 Conclusion

As our population ages, more people are needing support. In addition, more children with complex and multiple disabilities are surviving into adulthood. Levels of learning disability in north east Essex are significantly higher than elsewhere, largely because Essex was home to a number of specialist residential hospitals and, when they closed, many residents continued to live locally.

CHAPTER 7: QUALITY OF LIFE

Quality of Life means different things to different people, but it includes some common themes such as: enjoyment of the local environment; good personal health and well-being; quality time with friends and family; satisfying work or voluntary activities; and a strong community spirit. It is also about ensuring a good quality of life for future generations, so this means taking seriously the actions needed to minimise the impacts of climate change.

7.1 Satisfaction with Local Area

Over the summer of 2007, ECC conducted its first Quality of Life Survey⁴⁹. The results showed that:

- just over half of respondents rate the countryside and coast as being the best thing about living in Essex
- 73% of respondents are proud to live in Essex with a similar proportion feeling that living in Essex has a positive impact on their quality of life
- 81% of respondents are satisfied with their local area as a place to live
- 76% of respondents put their current level of overall happiness as 7 out of 10 or above.

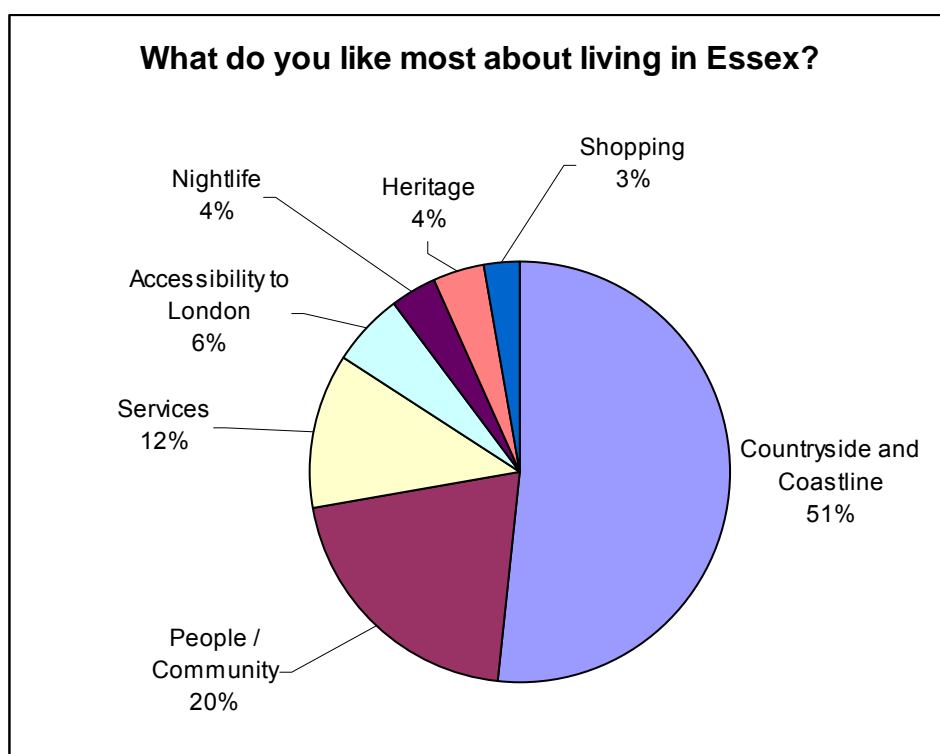


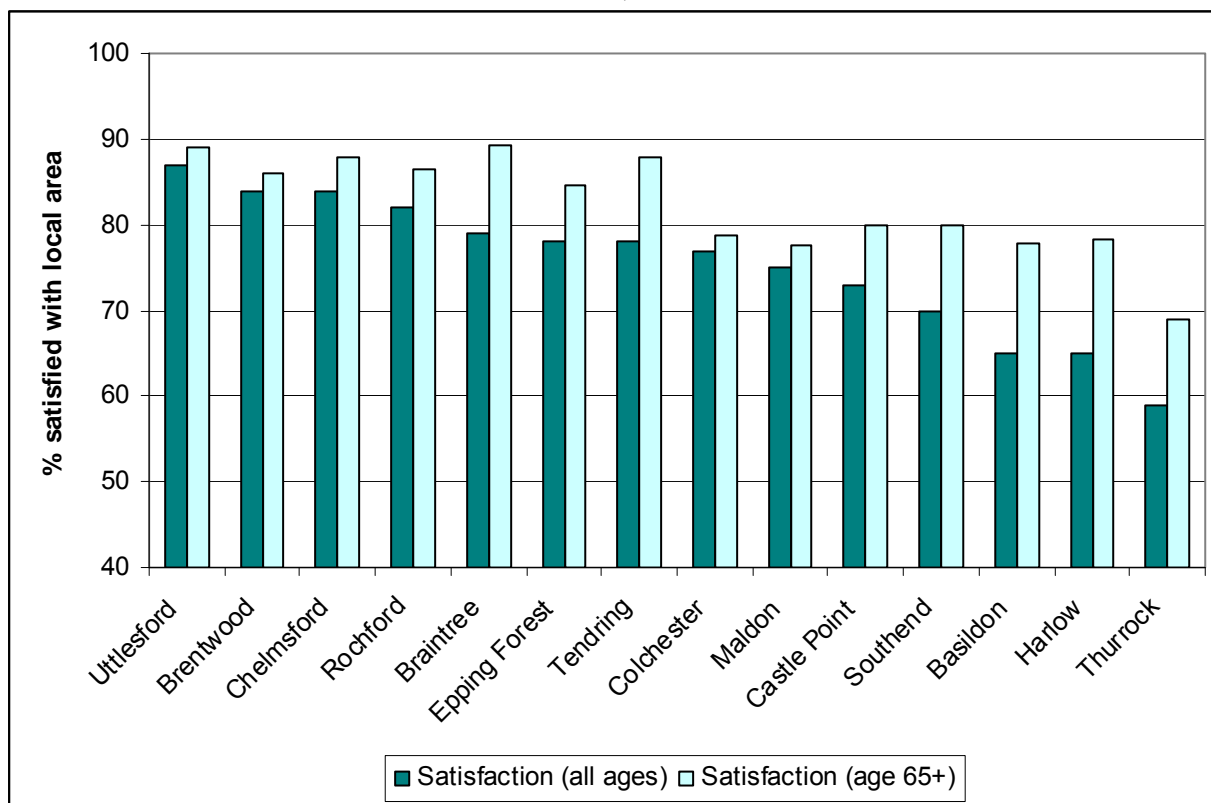
Figure 7.1: ECC QoL Survey, 2007

All local authorities are required to conduct a user satisfaction survey every three years. Results show that, although satisfaction outweighs dissatisfaction in all areas, rates range

⁴⁹ The Quality of Life Survey was published in *Essex Matters* and local papers. The 761 responses have not been weighted to reflect the profile of Essex residents.

from 89.2% satisfied among those aged 65+ in Braintree to 59% satisfied among all ages in Thurrock.

Figure 7.2: Essex satisfaction with local area by age, 2006



Source: Best Value

In general, residents in rural areas report a higher overall level of satisfaction with their local area and, as respondent age increases, so does satisfaction with the local area. Respondents with disabilities or long-term illnesses are less likely to report satisfaction than those without (ECC Tracker Survey, 2006).

7.2 Feelings of Safety

According to the ECC Tracker Survey, feelings of safety are less positive with regard to safety after dark than during the day:

- 84% of respondents state they feel safe during the day
- 47% feel safe after dark.

Respondents in rural locations are more likely to feel safe outside, especially after dark – 58% of rural and 46% of urban respondents indicating they feel safe. By contrast, during the day, 85% of urban and 84% of rural respondents feel safe.

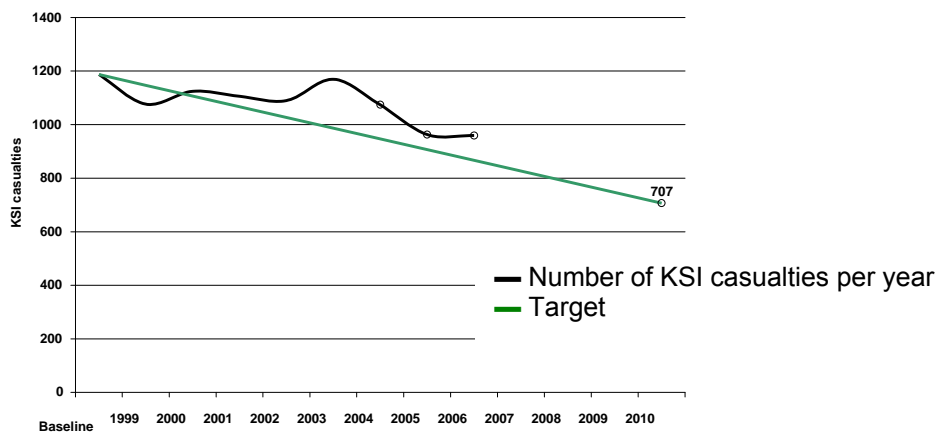
At a district level, respondents in Uttlesford (91%), Braintree (88%), and Chelmsford (87%) feel safest whereas those in Castle Point are least likely to feel safe outside during the day (77%). After dark, respondents in Uttlesford (64%), Maldon (57%), and Braintree (54%) feel safest whereas only 37% of respondents in Harlow feel safe in a similar situation. Respondents from Harlow are indeed the only cohort more likely to feel unsafe than safe whilst outside in Essex after dark.

There is a more positive perception of safety amongst BME respondents than their white counterparts (57% vs 47% feel safe). And older respondents are less likely to feel safe than those from younger age groups (43% of those aged 65+ vs 50% of those aged 35-64 feel safe).

7.3 Road Safety

During 2006, 987 people were killed or seriously injured (KSI) in road traffic collisions in ECC. Although there has been a downward trend over the past few years, the 2007 PSA target of 842 or fewer KSI casualties requires at least a 15% reduction on the 2006 level.

Figure 7.3: ECC progress towards 2010 target for KSI casualties



Source: ECC Highways & Transportation

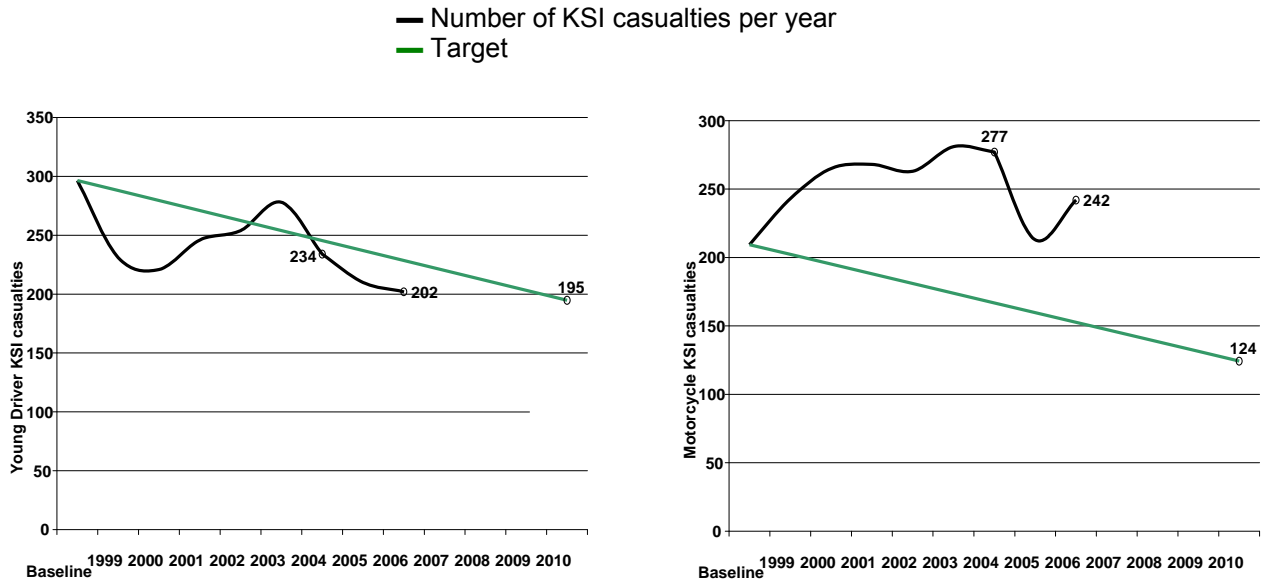
Four target groups have been identified as requiring particular attention: young car drivers (aged 17-25), motorcyclists, drink driving and speeding. These groups are over represented in the KSI casualty data set and are the focus of attention for intervention work.

7.3.1 Young car drivers / motorcyclists

There is a long term downward trend in young car driver KSI casualties. However they remain over-represented in the KSI casualty data set and involvement in high-risk and poor driving behaviours is high. Young drivers are the most likely to fail a breath test and 25% of young car driver crashes involve excessive speed.

Motorcycle KSI casualties increased in 2006 and remain significantly above the target level. Comparison with national data for 2006 shows Essex to have amongst the highest numbers of motorcycle KSI casualties in the country. Nationally motorcyclists account for 19% of all KSI casualties, in Essex they account for 26%.

Figure 7.4: ECC progress towards 2010 target for young driver / motorcycle KSI casualties

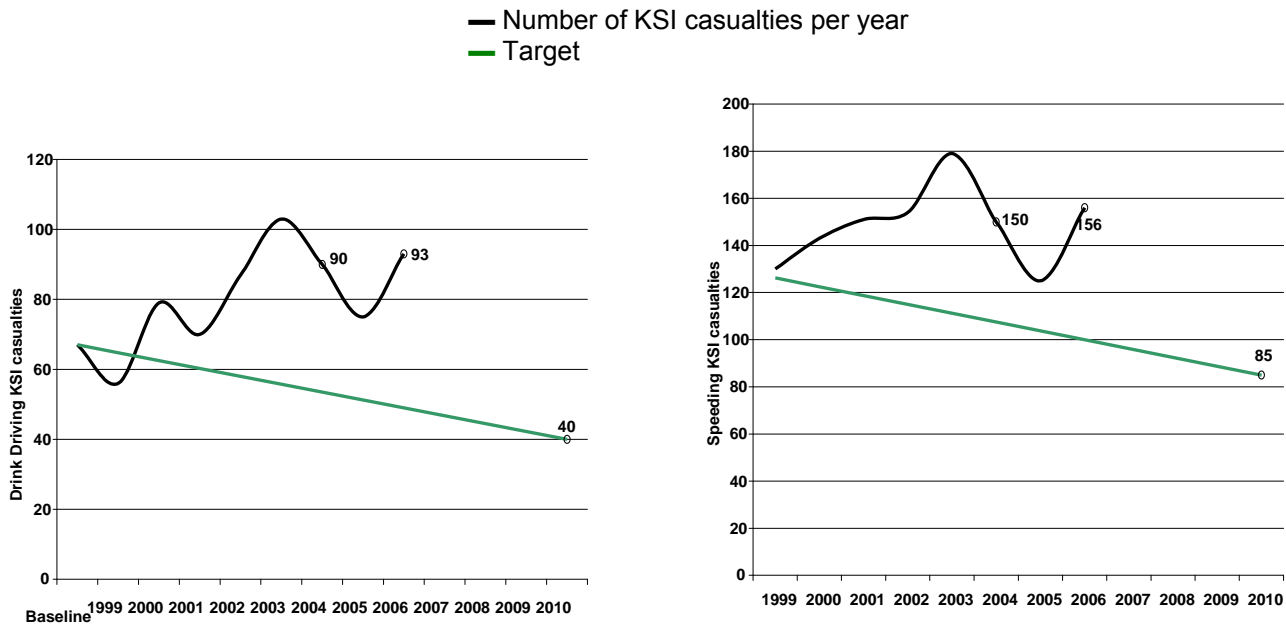


Source: ECC Highways & Transportation

7.3.2 Drink driving / speeding

There is a long-term increase in the level of drink drive KSI casualties in Essex and they now account for 9% of the total. Speed-related KSI casualties increased in 2006 and accounted for 16% of the total.

Figure 7.5: ECC progress towards 2010 target for drink driving / speeding KSI casualties

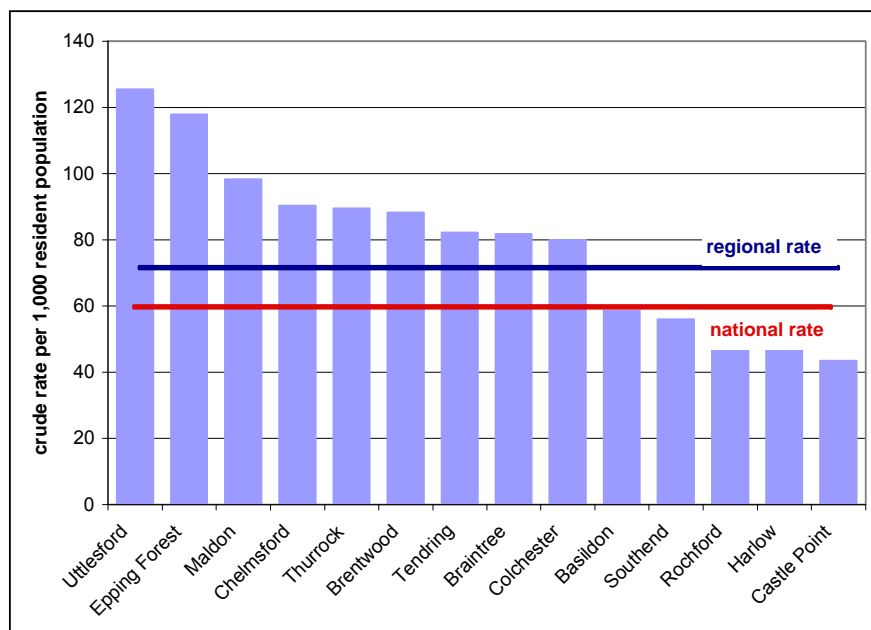


Source: ECC Highways & Transportation

7.3.3 Unitary and district performance

As can be seen from the chart below, rates of KSI casualties are above national and regional levels in most areas. It should be noted that it is the location of the collision not the person(s) involved which is recorded and there are major differences in the road types in each area.

Figure 7.6: Essex KSI casualties per resident population, 2003-05



Source: Health Profile, SWPHO

The table below shows the distribution of types of KSI casualty across ECC districts / boroughs. Young drivers, motorcycles and speeding appear to contribute to the high levels in Epping Forest, Chelmsford and Uttlesford respectively.

Figure 7.7: ECC KSI casualties by district / borough, 2006

	KSI casualties 2006				
	All	Drink Driving	Motorcycles	Speeding	Young Drivers
Epping Forest	143	16	27	24	34
Chelmsford	130	17	45	22	23
Colchester	116	7	33	18	27
Braintree	109	7	27	15	21
Tendring	99	10	23	12	21
Basildon	91	12	22	10	17
Uttlesford	74	3	20	18	14
Brentwood	62	3	12	14	18
Maldon	59	4	13	13	14
Castle Point	42	7	9	4	7
Rochford	39	4	5	3	2
Harlow	23	4	6	3	4
ECC Total	987	94	242	156	202

Source: ECC Highways & Transportation

7.4 Priorities for Improvement

Information on quality of life can also be obtained from the ECC Tracker Surveys. Although the methodology has changed slightly over time, the results show that, broadly, people's perceptions are relatively stable in terms of what is important in making somewhere a good place to live and which factors most need improving locally. The following table shows the top ten priorities across ECC.

Figure 7.8: ECC Tracker Survey priorities, 2006 and 2007

	MOST IMPORTANT (2007)	MOST NEEDS IMPROVING (2007)	PRIORITY INDEX ⁵⁰ (2007)	2007 RANK	2006 RANK
Level of crime	57.00	29.00	66.82	1	1
Health services	48.70	22.90	45.08	2	2
Affordable decent housing	35.30	26.70	38.10	3	4
Activities for teenagers	18.70	43.10	32.58	4	5
Road and pavement repairs	17.00	43.40	29.82	5	7
Clean streets	36.20	19.70	28.83	6	3
Public transport	24.70	28.10	28.06	7	8
Level of traffic congestion	15.90	35.40	22.75	8	6
Care services for older people	23.40	19.30	18.26	9	NEW
Shopping facilities	23.30	13.00	12.24	10	9

The darker the colour coding in the columns, the higher the score.

The five things most in need of improvement across the county were:

2007	2006
1. Road and pavement repairs	Activities for teenagers
2. Activities for teenagers	Road and pavement repairs
3. Level of traffic congestion	Level of traffic congestion
4. Level of crime	Level of crime
5. Public transport	Affordable decent housing

Many of these issues pose a challenge to the Essex Partnership. With the exception of crime, they are not well represented in the current Local Area Agreement.

According to Thurrock's Quality of Life 2006 Survey, the three main priorities for improving Thurrock were: better policing and more emphasis on tackling crime (40%), more for children and young people to do (31%) and cleaner streets (19%).

7.4.1 District results

A key design principle of ECC's Essex Strategy is that it should recognise different needs in different parts of the county. It is therefore important to look at what the district survey results tell us about relative priorities locally. There are slight differences both between the areas and in comparison to ECC results overall.

- High priority themes are level of crime, activities for teenagers, health services, clean streets, level of traffic congestion, affordable decent housing, public transport and road / pavement repairs.
- Shopping facilities is a middle-ranking priority for all districts / boroughs except Harlow where it is a lower priority.
- Job prospects tends to be a lower-ranking issue, except in Braintree, Chelmsford, Harlow and, especially, Tendring where it is afforded higher priority.

⁵⁰ The Tracker Survey is one of many ways to look at priorities. The priority index for each domain is calculated in the following way: Priority Index = (MI Score x MNI Score) / (Max MI score x Max MNI score) where MI Score = Most Important and MNI = Most Needs Improving

- Education provision is more of an issue for Basildon, Colchester and Epping Forest.
- Parks and open spaces is more of an issue for Castle Point and Rochford.
- Facilities for young children is more of an issue in Harlow.
- Cultural facilities are more of an issue for Brentwood and Maldon.
- The level of pollution is more of an issue for Uttlesford.
- The level of traffic congestion is less of an issue in Tendring.

7.5 Lifestyle Choices

7.5.1 Adult obesity

Obesity is one of the major public health issues that face the developing world. It can lead to increased risk of heart disease, type 2 diabetes and some cancers.⁵¹ The trend in increasing obesity levels is thought to be related to:

- Increased food portion sizes;
- Increased availability of fast food, processed foods and snack foods;
- Reduction in the physical activity we do, such as walking less; and
- People doing less physically demanding jobs.

Obesity and its consequences costs the NHS approximately £1 billion per year. However, it has been estimated that the total economic cost of obesity is £3.3-3.7 billion per year and of obesity plus overweight, £6.6-7.4 billion (Select Committee on Health, 3rd Report, May 2004). Adult obesity figures have almost quadrupled over the last 25 years with approximately two thirds of adults being overweight. Of these people 22% of men and 23% of women are classed as obese⁵². Obesity and its consequences costs the NHS approximately £1 billion per year. However, it has been estimated that the total economic cost of obesity is £3.3-3.7 billion per year and of obesity plus overweight, £6.6-7.4 billion (Select Committee on Health, 3rd Report, May 2004). Adult obesity figures have almost quadrupled over the last 25 years with approximately two thirds of adults being overweight. Of these people 22% of men and 23% of women are classed as obese⁵³. As can be seen from Figure 7.8, many areas in Essex are above the national rate. The National Audit Office found that, on average, each person whose death is attributable to obesity had lost 9 years of life.

⁵¹ DH www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Obesity/DH_078098

⁵² NHS Direct www.nhsdirect.nhs.uk/articles/article.aspx?articleId=265§ionId=34

⁵³ NHS Direct www.nhsdirect.nhs.uk/articles/article.aspx?articleId=265§ionId=34

Figure 7.8: Essex estimated prevalence of obesity, 2003-05

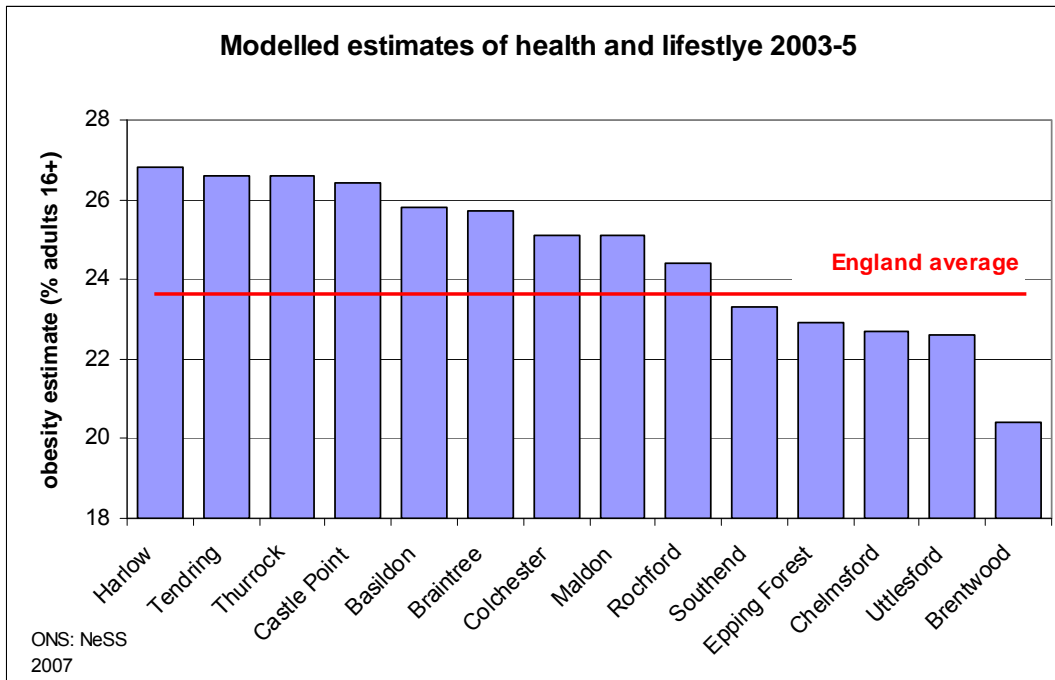
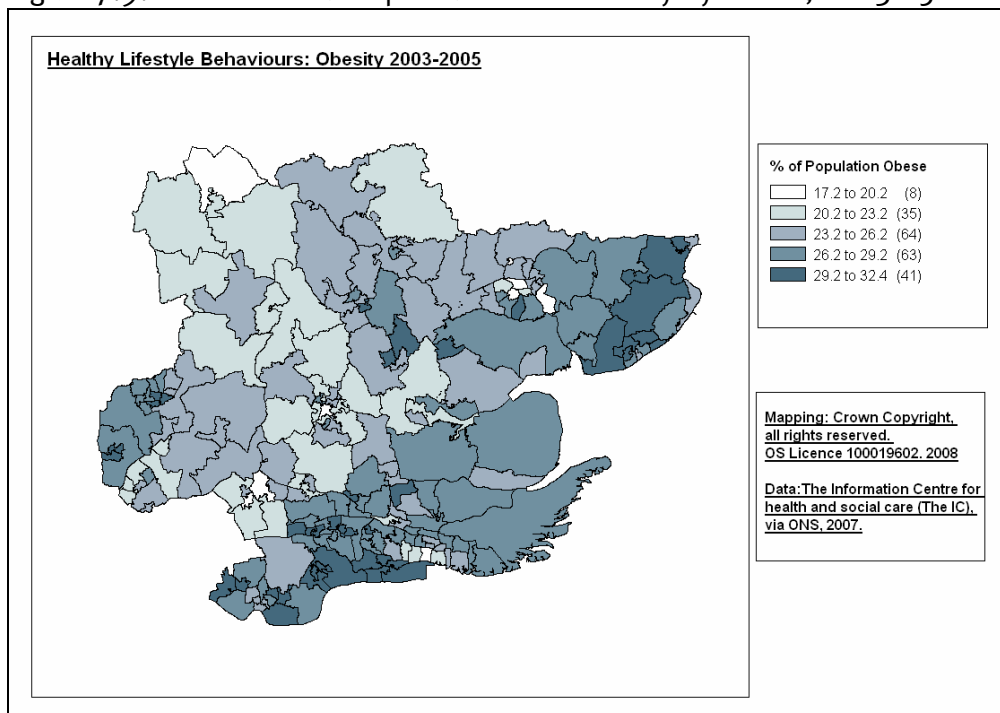


Figure 7.9: Essex estimated prevalence of obesity by MSOA, 2003-05



7.5.2 Smoking

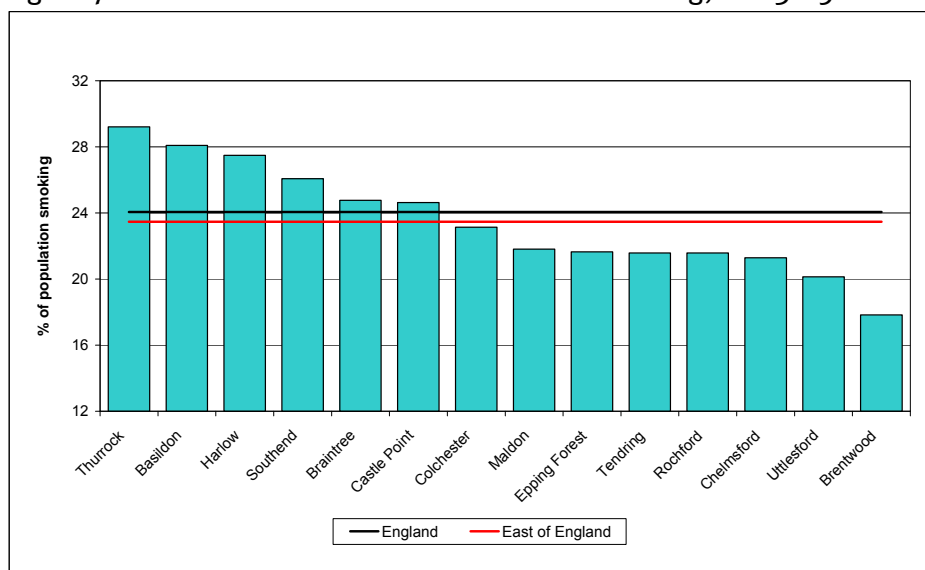
Smoking is the UK's single greatest cause of preventable illness and early death, most dying from the three main diseases: cancer, COPD and CHD. Half of all smokers will be killed by their habit⁵⁴. Nationally, the prevalence of smoking in the adult population is estimated at 24%⁵⁵. Figure 7.10 shows that Thurrock, Basildon, Harlow and Southend are all significantly above the

⁵⁴ Health Statistics Quarterly. National Statistics, Winter 2006

⁵⁵ Community Health Profiles. SEPHO, 2007

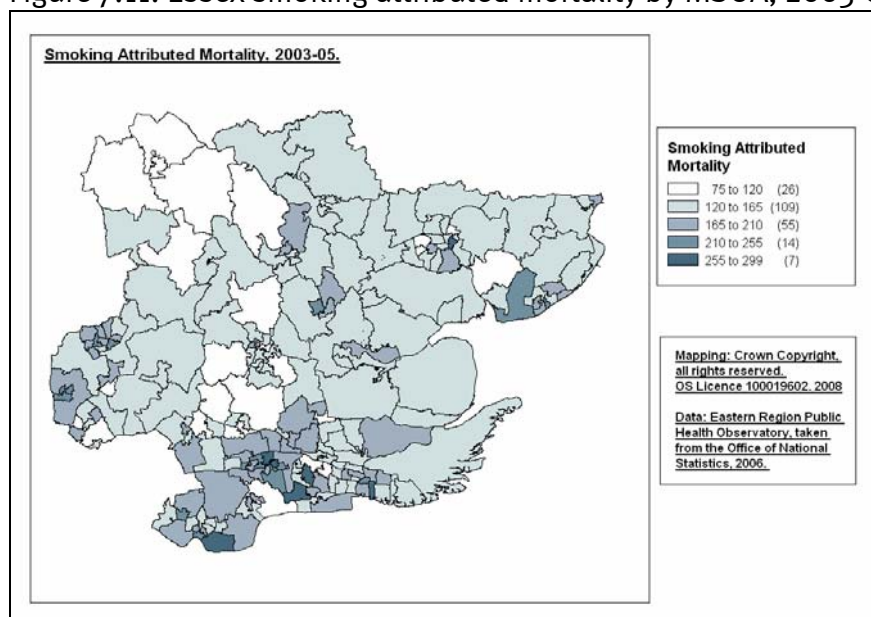
national rate but Figure 7.11 shows that several other areas also have pockets of high smoking-attributed mortality. PCTs have been working hard to support people to quit smoking and reduce the prevalence of smoking. During 2006/07, Essex PCTs helped 10,907 people to quit.

Figure 7.10 Essex model-based estimate of smoking, 2003-05



Source: Information Centre via ONS, 2007

Figure 7.11: Essex smoking attributed mortality by MSOA, 2003-05

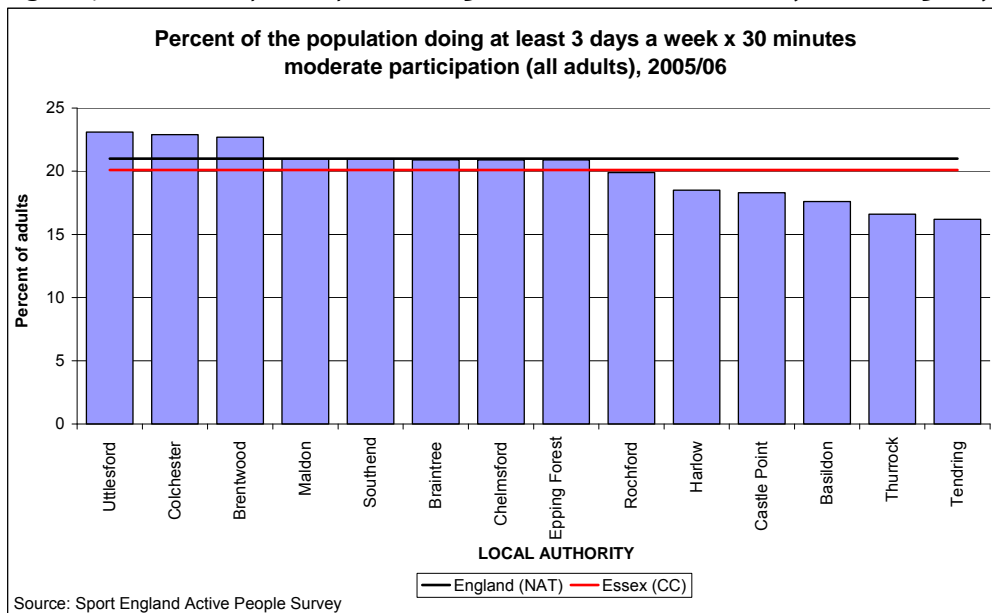


7.5.3 Physical activity

Over the last 25 years there has been a significant decrease in physical activity as a part of daily routines, but a small increase in the proportion of people taking physical activity for leisure in the UK (Faculty of Public Health, 2005). Walking and cycling as a mode of transport has decreased since the 1970s and the dramatic increase in the use of cars has contributed significantly to this. Types of employment are now also less physically demanding, and the introduction of newer time- and energy-saving devices in the household contributes to a sedentary lifestyle.

A recent Active People survey by Sport England in 2005/06 found that 23.7% of adult males did at least 30 minutes of moderate physical activity three times a week and only 18.5% of adult females. Within Essex there are only three areas which have a rate above the England average, Uttlesford, Colchester and Brentwood. The area with the lowest participation rate is Tendring at 16.2%.

Figure 7.12: Essex participation in 30mins moderate activity at least 3 days a week

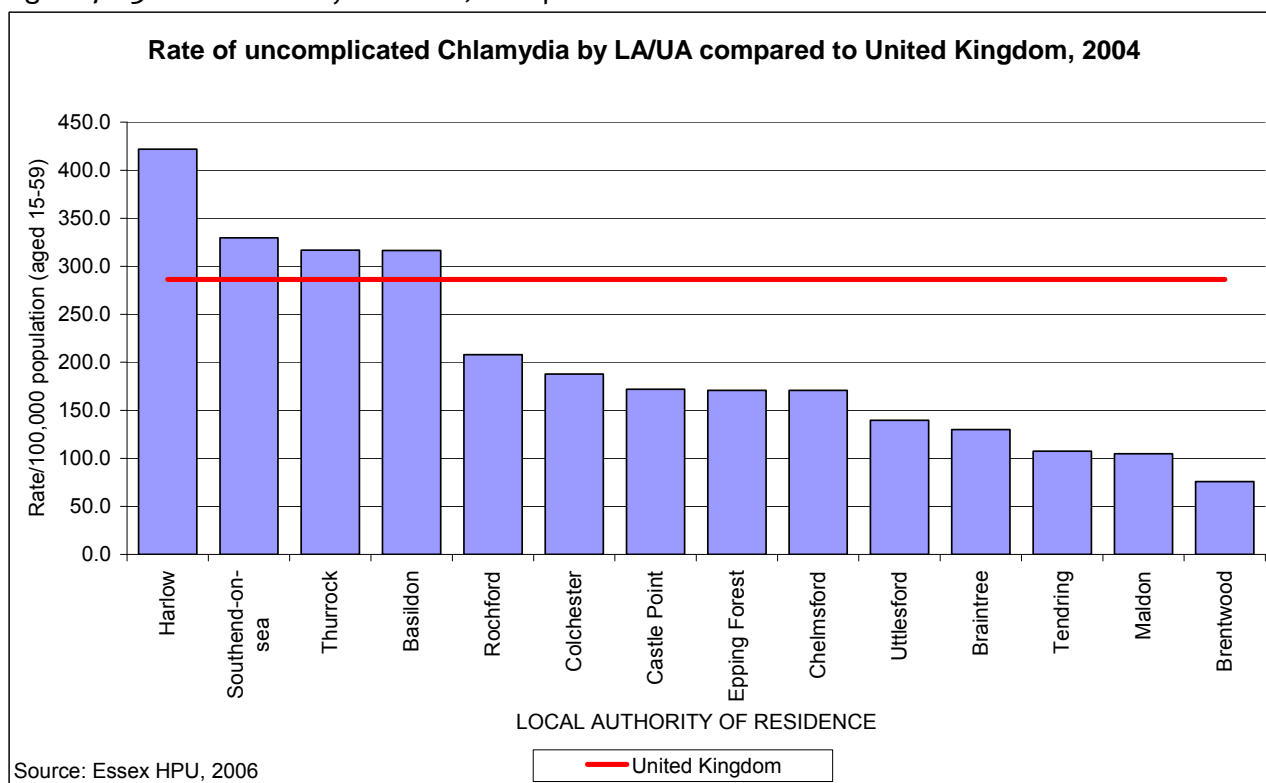


7.5.4 Sexual activity

Sexual risk-taking behaviour is increasing across the population. This is supported by increases in sexually transmitted infections (STIs) such as chlamydia, warts and syphilis. In Essex, there have been large increases in the diagnosis of chlamydia and warts. Some of this increase is due to increased testing and improved access to sexual health services, particularly for young people. However, it is likely that there is a real increase in the prevalence of these STIs in the population due to unsafe sexual health practices.

Chlamydia is a sexually transmitted infection which gives us an idea of what the STI rate is like in a population. Figure 7.13 shows that there are four areas in Essex with a rate higher than the UK. The Harlow rate is nearly 50% more than the UK rate – 422 cases per 100,000 population compared to 286.4 per 100,000 in the UK (2004).

Figure 7.13: Essex chlamydia rates, 2004



7.5.5 Alcohol and drugs

Alcohol and drug misuse can have a significant impact on health, crime and society. For some people alcohol and drug misuse is a very real problem which can result in harm to themselves or to others and affect the wider community. People can easily become dependent or addicted often without realising they have a problem, yet they are more likely to suffer from mental health problems and premature death.

The vast majority of people can enjoy alcohol without causing harm to themselves or others and there is growing evidence that a small amount of alcohol can be beneficial to a person's health, but this has to be balanced against the damaging effects it can have. Heavy drinking is linked to a number of diseases, including cirrhosis of the liver, certain cancers, heart muscle damage and alcoholic dementia. It also raises blood pressure, leading to an increased risk of stroke and coronary heart disease. Binge drinking (drinking a large amount of alcohol at once) can not only be harmful to both physical and mental health in the longer term, but can lead to coma and even death.

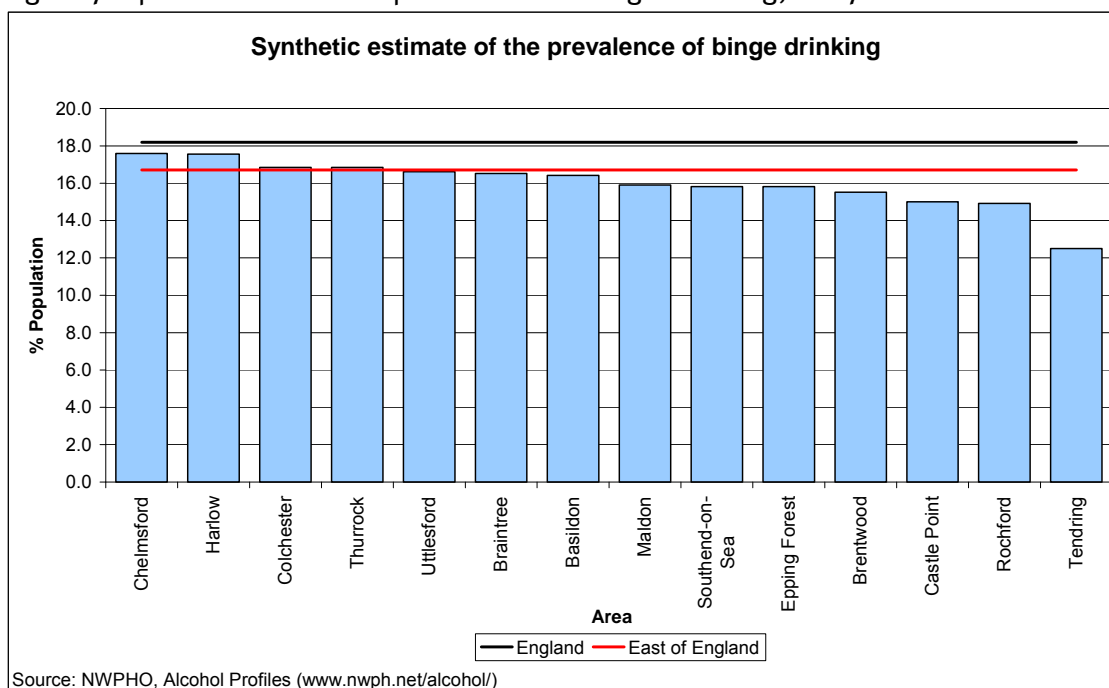
There is a strong link between excessive alcohol consumption and crime, particularly violent crime, assaults, accidents and anti-social behaviour. It has been estimated that alcohol misuse is now costing around £20bn a year through its health, crime and social impacts⁵⁶, and accounts for almost 10% of the disease burden, surpassed only by tobacco and blood pressure.

⁵⁶ Alcohol Harm Reduction Strategy for England. Prime Minister's Strategy Unit, March 2004

It is estimated that 18.2% of adults binge drink in England, that over 600 hospital admissions per 100,000 people are related to alcohol and that 10.45 crimes per 1,000 people can be attributed to alcohol.

No areas in Essex have been estimated as having a binge drinking prevalence over the England average but four areas have prevalence rates over the East of England average: Chelmsford, Harlow, Colchester and Thurrock whose prevalence rates range from 17.6% to 16.8%.

Figure 7.14: Essex estimated prevalence of binge drinking, 2007

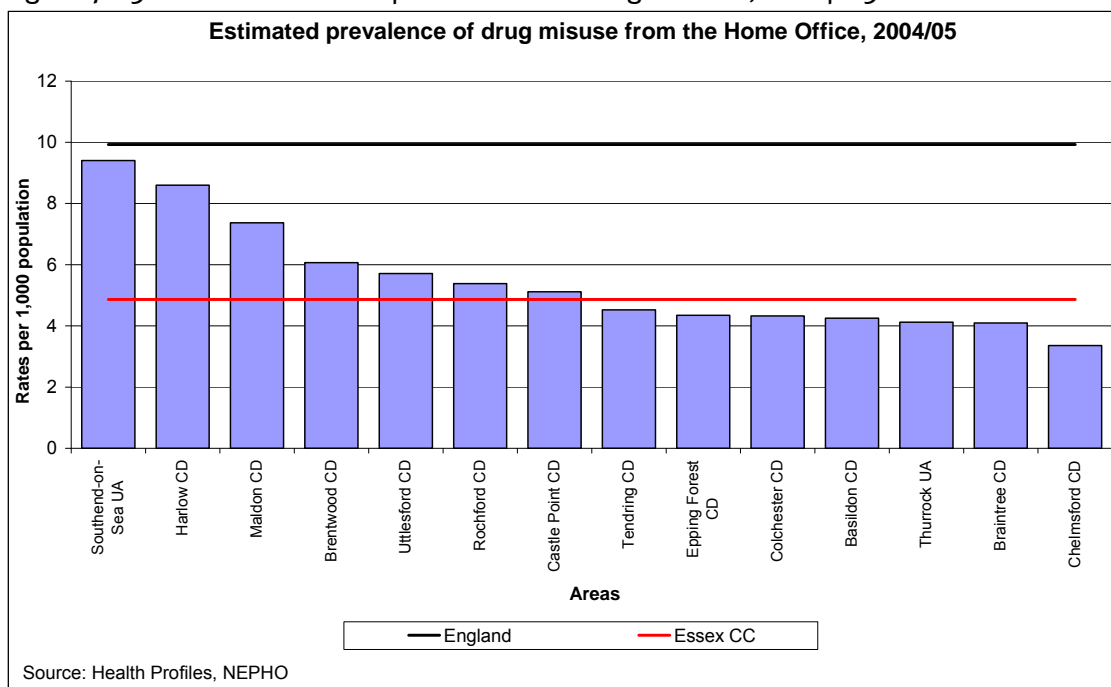


The problem use of illicit or prescription drugs carries many serious health risks. As well as the possibility of physical or psychological dependency, heavy or long-term use of some illegal drugs may cause the user to overdose, which can cause permanent damage to the body or a fatality. Drug misusers can suffer from blood born viruses (HIV, hepatitis), injecting related injuries, poor diet, personal neglect and mental illness, such as depression and paranoia, all of which put an increased demand upon health care services. Drug use can also cause significant social problems involving, for example, increases in acquisitive crime, prostitution, unemployment, family breakdown and homelessness.

The UK has a higher prevalence of drug misuse than any other country in Europe and it has been estimated that almost 3 million people in England and Wales aged 16 to 24 have used illicit drugs in their lifetime.

ECC has been estimated as having a drugs misuse prevalence of 4.86 per 1,000 population. No areas in Essex have been estimated as having drug misuse prevalence over the England average but seven areas have prevalence rates over the ECC average ranging from 9.41 to 5.12 per 1,000 population.

Figure 7.15: Essex estimated prevalence of drug misuse, 2004-05



7.6 Ecological Footprint

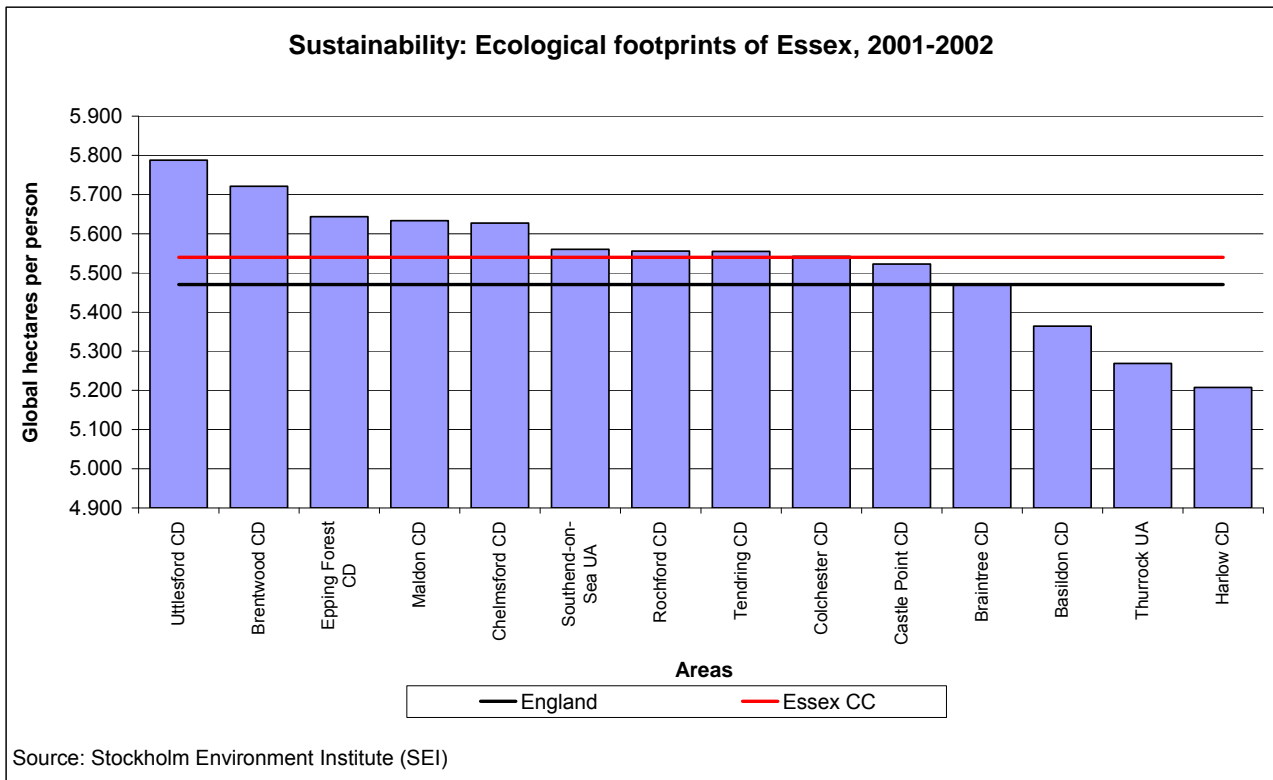
The majority of residents consider the countryside and coastline as the best thing about living in Essex⁵⁷ and parks and open spaces are a particular priority for Castle Point and Rochford⁵⁸. However, climate change and rising sea levels are already changing our environment and pose a serious future threat. Our impact on the environment can be measured by our 'ecological footprint'. This allows us to benchmark the amount of resources we use and compare it to the level of resources available. The ecological footprint for the world is 2.2 global hectares per person but the UK average is 5.4 global hectares per person. This is 65% higher than our ecological budget (the sustainable amount we can use) and the UK has an ecological footprint among the highest 15 countries on a per person basis.

Essex has an ecological footprint of 5.5 global hectares per person, which is just above the England average. This is higher than the ecological budget, which means that residents of Essex are using resources at a rate that cannot be sustained. Of the areas within Essex only four are below the England average. Comparing the breakdown of the ecological footprints in those areas with the highest and lowest score, the most significant differences are in the following categories: food and drink consumption; energy consumption; travel; and holiday activities.

⁵⁷ ECC Quality of Life Survey (2007)

⁵⁸ ECC Tracker Survey (2007)

Figure 7.16: Essex Ecological Footprint, 2001-02



The Greater Essex Business Consortium has also recognised that ‘sustainability’ needs to be at the heart of the planning and economic vocabulary and that there are now increasing expectations of how industry and commerce should adapt to energy conservation through alternative fuel sources and carbon neutrality. One of the priorities agreed by Greater Essex Prosperity Forum is for Essex to be a leader in environmental technology and in helping businesses to reduce their carbon footprint.

7.7 Conclusion

Generally, residents are satisfied with the area where they live. There is, however, room for improvement. Older people and those living in urban areas tend to feel less safe, especially after dark. There is also an almost universal desire for two things – a reduction in crime and the ability to get from A to B quickly and easily. With increasing traffic volumes, road safety is important too. Despite overall improvements, there are some worrying upward trends in people killed or seriously injured as a result of risk-taking behaviour among young people.

We are becoming increasingly aware of how our own lifestyle choices impact on our health and – long term – quality of life. Although the choices we make about diet, exercise, smoking and drinking are not so different to elsewhere in the UK, the biggest preventable contributors to health inequalities and future service demand remain obesity, smoking and alcohol misuse.

The Essex countryside and coast is valued highly but is under threat. We must reduce the impact that our lifestyles have on the environment and minimise the environmental impact of housing and business development.

APPENDIX

This appendix presents trend charts showing three year moving averages of annual mortality rates from 1993-1995 to the most recently available years of data (2003-05 average) and comparing local data against national and regional trends.

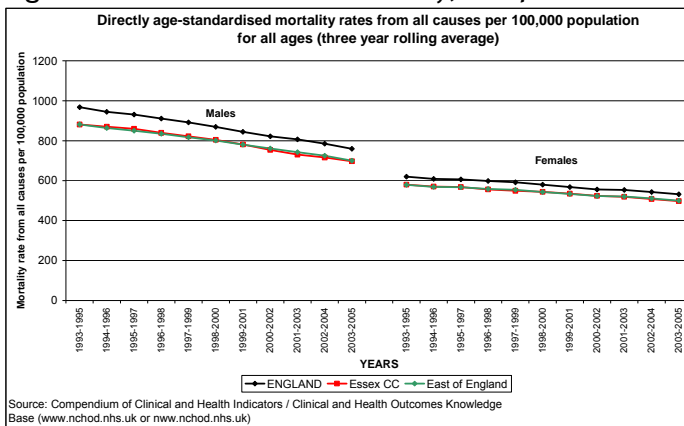
1 All Cause Mortality

All-cause mortality by age group is the number of deaths in a given age group per the population in that age group (usually expressed per 100,000). In this case we are looking at all ages and under 75 year olds. Mortality in people under 75 years old is examined as it is considered premature mortality.

1.1 All ages

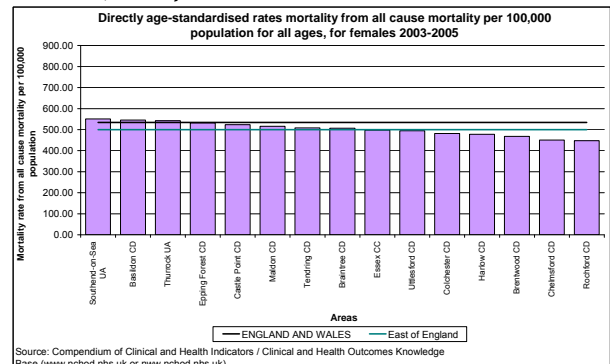
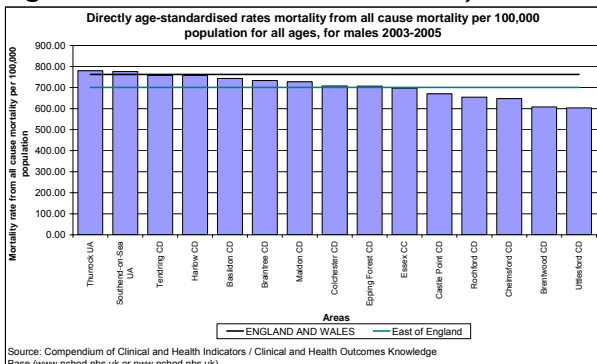
The all cause mortality for all ages in ECC has shown a steady improvement in males for the 10 years from 1993-1995. Females have also shown an improvement but not at such a rate as males, and their rate is appearing to level off. The trend line for ECC in both males and females is consistently below the trend line for England for the stated period and just below the regional average.

Figure A1: ECC all cause mortality, 2007



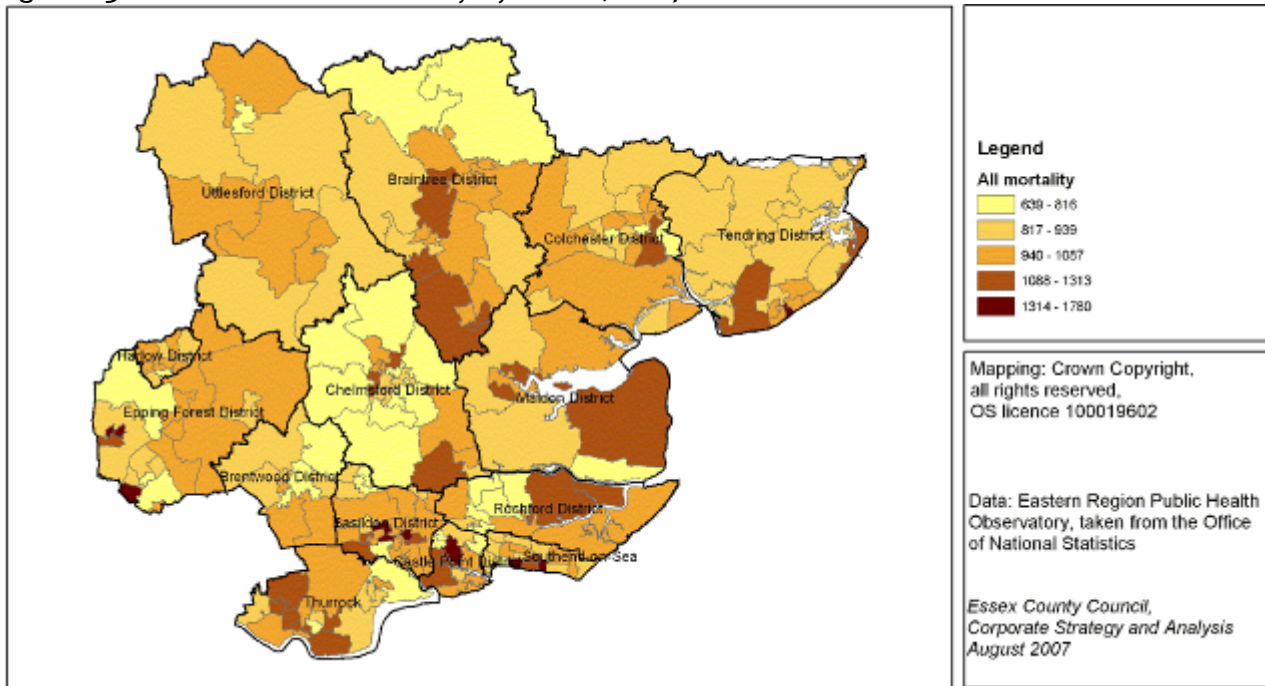
There is wide variation in rates across Essex and between males and females. The most recent data for males shows that Thurrock and Southend are both above the national average, closely followed by Tendring and Harlow. In females Southend, Basildon and Thurrock are all above the national average, followed by Epping Forest and Castle Point.

Figure A2: Essex all cause mortality for males and females, 2007



When examining all cause mortality at middle super output area (MSOA), we can see that there is still further variation across Essex. The MSOAs with the highest mortality rates can be found in Epping Forest and Castle Point and those with the lowest are in Epping Forest, Chelmsford and Castle Point. These extremes highlight large inequalities within and between areas.

Figure A3: Essex all cause mortality by MSOA, 2007



1.2 Under 75 year olds

The all cause mortality for u75s is similar to that of all ages with a steady improvement in males over the last ten years, improvements levelling off for females and both rates consistently below that of England. District analyses show that, for males, Tendring and Harlow are above the national average and for females, Basildon and Thurrock are above the average. And again, MSOA analysis shows even greater variation with the highest mortality rates being found in Southend and Tendring and the lowest in Castle Point, Brentwood and Chelmsford.

Figure A4: ECC <75 all cause mortality, 2007

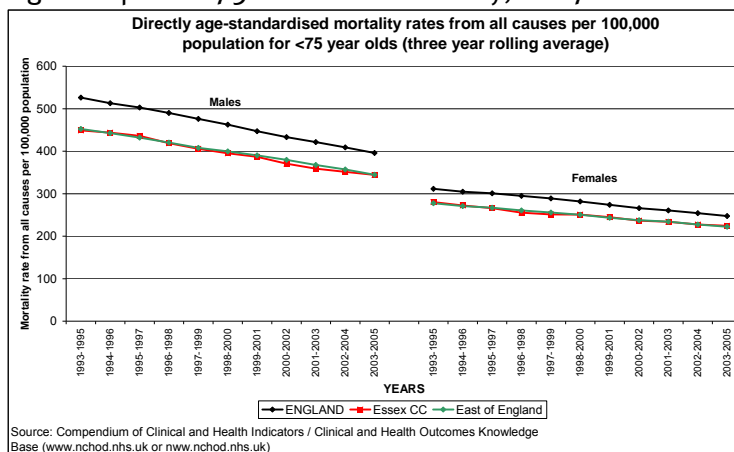


Figure A5: Essex <75 all cause mortality for males and females, 2007

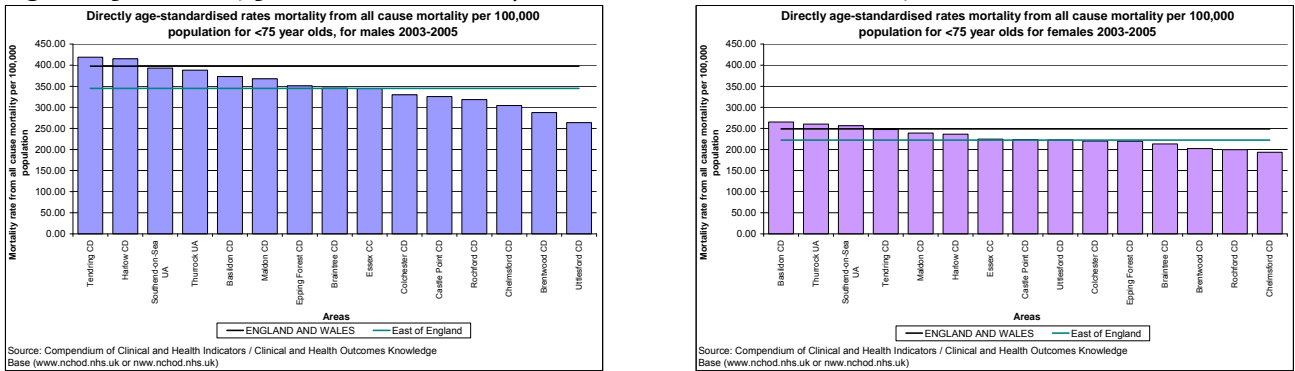
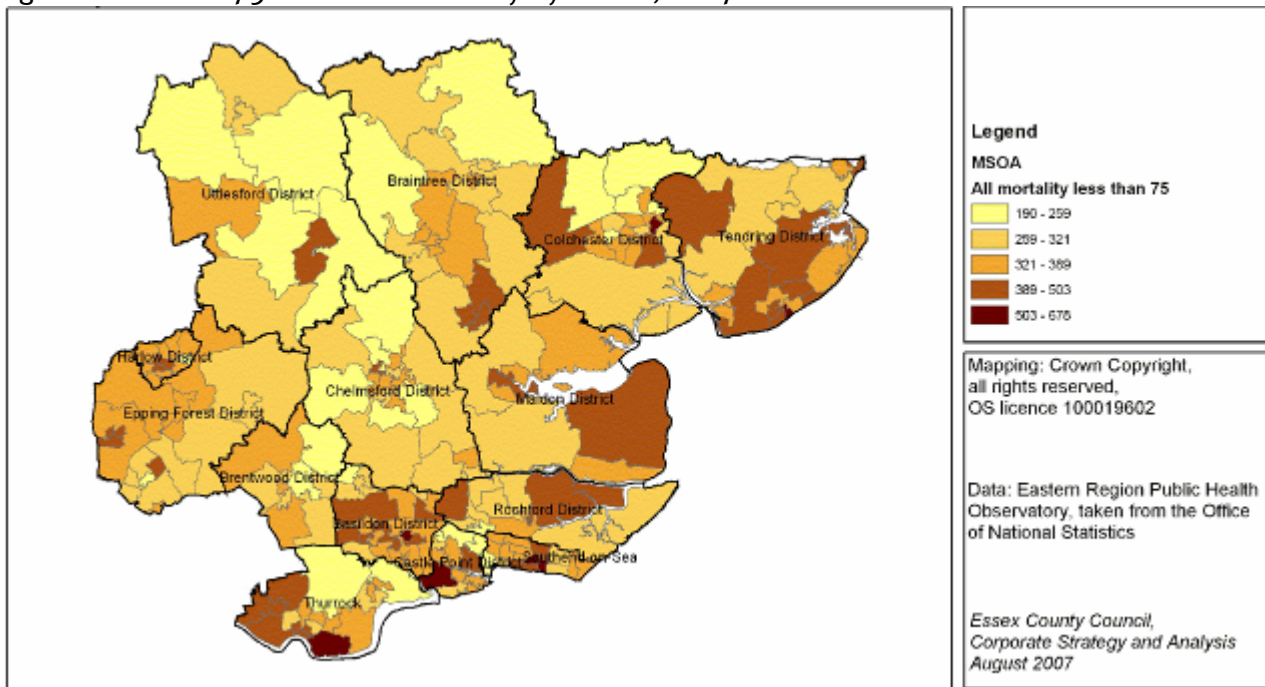


Figure A6: Essex <75 all cause mortality by MSOA, 2007

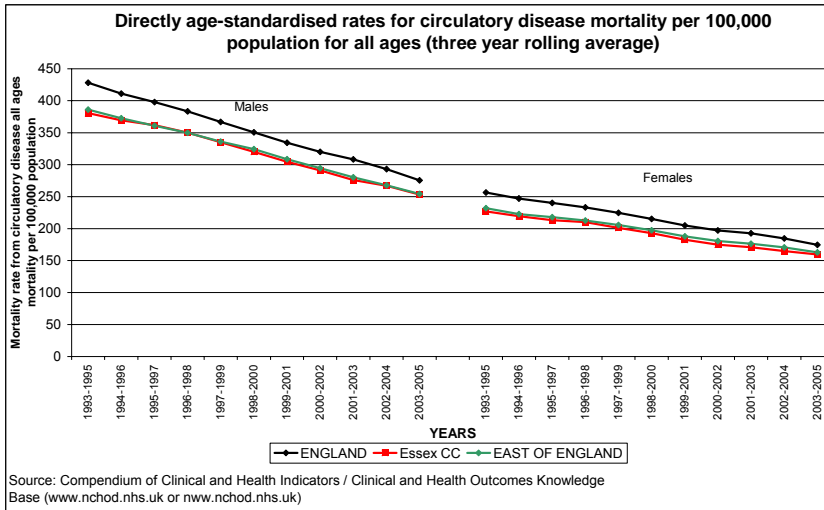


2 Circulatory Disease Mortality

2.1 All ages

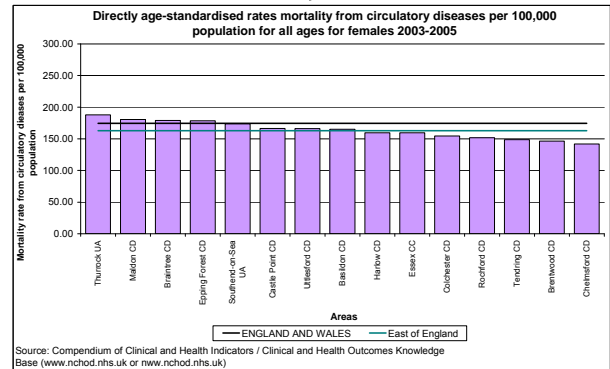
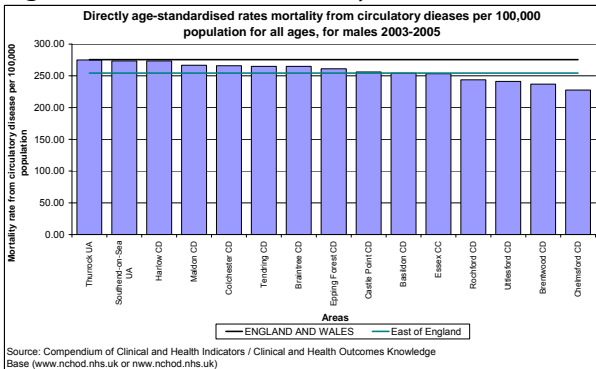
The ECC circulatory disease mortality for all ages has shown a steady improvement in males for the last 10 years. Females have shown a slower improvement and their rate of decrease also appears to be slowing down. The female rate is below the national rate and now just below the regional average. The trend line for males is consistently below the trend line for England and nearly the same as the regional rate.

Figure A7: ECC circulatory disease mortality, 2007



Thurrock, Southend and Harlow are all just below the national average for males and Thurrock, Maldon, Braintree and Epping Forest are above the national average for females.

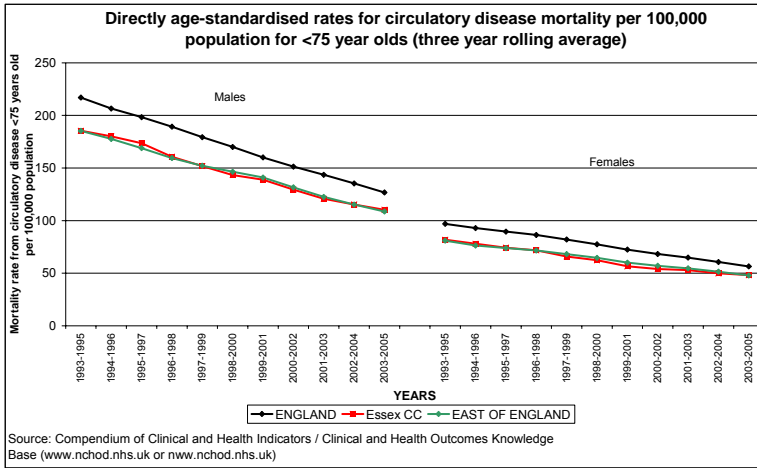
Figure A8: Essex circulatory disease mortality for males and females, 2007



2.2 Under 75 year olds

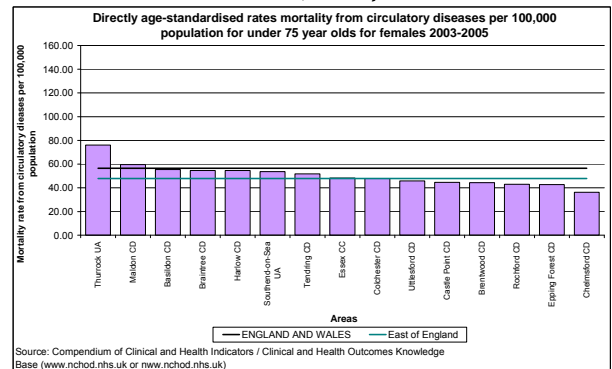
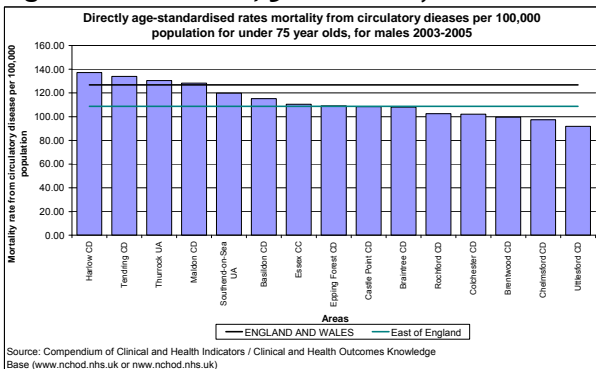
As for all ages, there has been a steady improvement in male circulatory disease mortality for under 75 year olds in ECC for the last 10 years whereas the female rate of decrease seems to be slowing down. The female rate is below the national rate but in line with the regional. The male trend line is consistently below that for England and nearly the same as the regional.

Figure A9: ECC <75 circulatory disease mortality, 2007



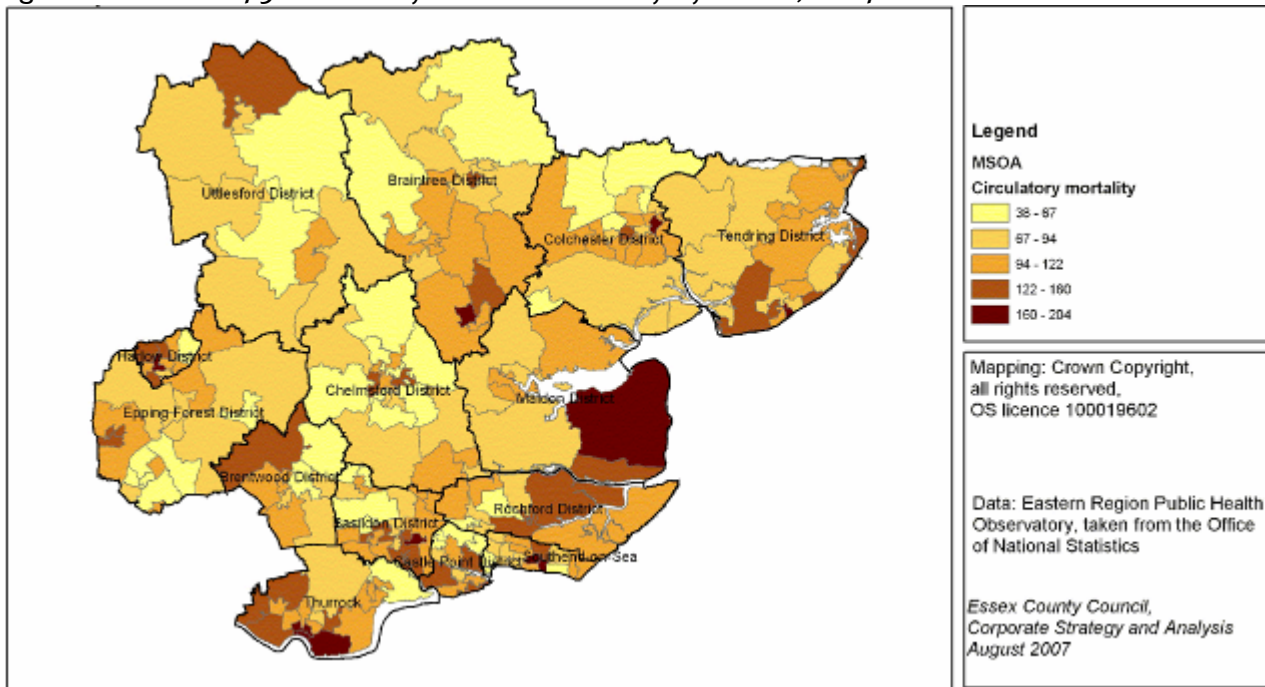
There is wide variation in the rates both across Essex and between males and females. Harlow, Tendring, Thurrock and Maldon are all above the national male average and Thurrock and Maldon are above the national female average.

Figure A10: Essex <75 circulatory disease mortality for males and females, 2007



The MSOAs with the highest circulatory disease mortality rate for under 75 year olds can be found in Southend, Thurrock and Maldon while the lowest can be found in Colchester and also Southend.

Figure A11: Essex <75 circulatory disease mortality by MSOA, 2007

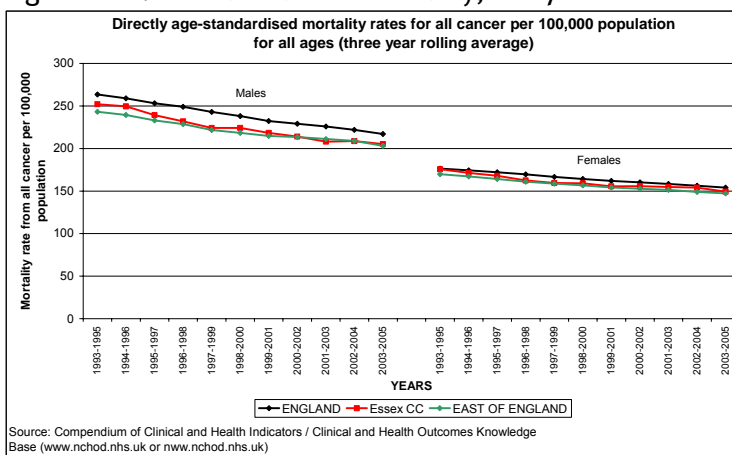


3 Cancer Mortality

3.1 All ages

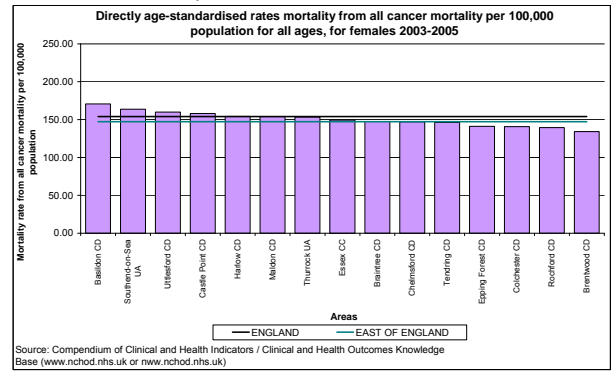
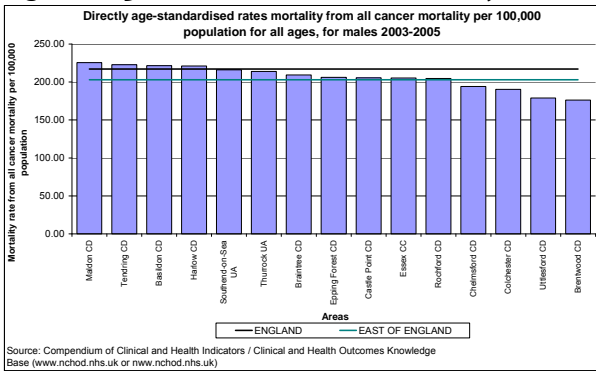
The all cancer mortality for all ages in ECC has again shown a steady improvement in males over the last 10 years but the improvement in females appears to be levelling off. The female rate is now only just below the national rate and is above the regional average. The trend line for males is consistently below that for England but often just above the regional rate.

Figure A12: ECC all cancer mortality, 2007



Again there is wide variation in rates across Essex and between males and females. The most recent data shows that Maldon, Tendring, Basildon and Harlow are all above the national average for males and that Basildon, Southend, Uttlesford and Castle Point are above the national average for females.

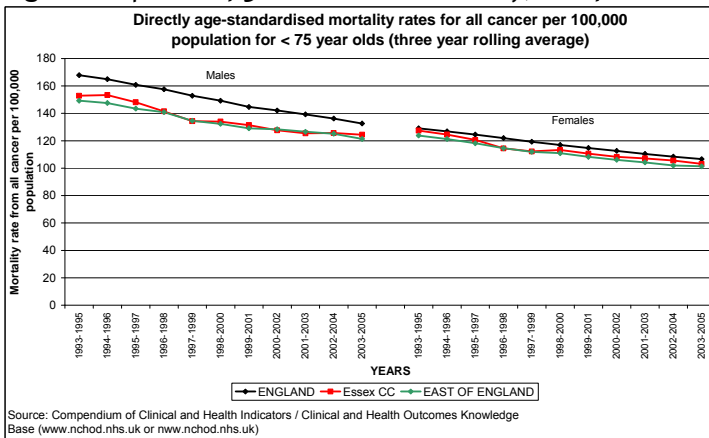
Figure A13: Essex all cancer mortality for males and females, 2007



3.2 Under 75 year olds

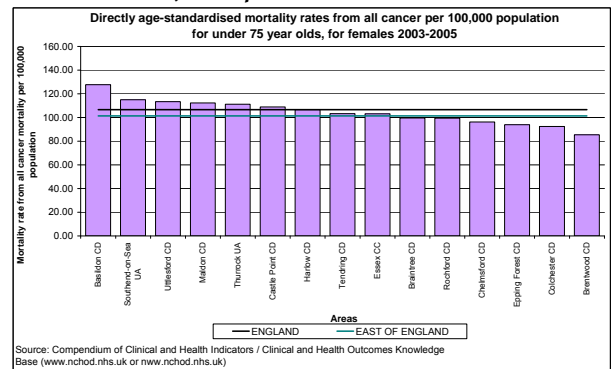
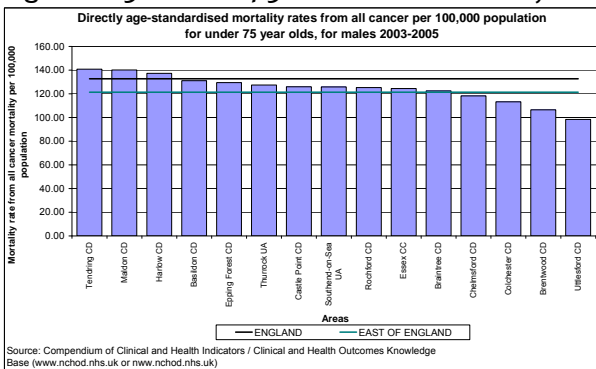
The all cancer mortality for under 75 year olds in ECC has shown a steady improvement in males over the last 10 years. This improvement has slowed down in recent years and the male rate has started to converge with the national rate, showing that the inequality between the two rates has decreased. Females have also shown some improvement but not at such a rate as males and they have been above the regional average for several years.

Figure A14: ECC <75 all cancer mortality, 2007



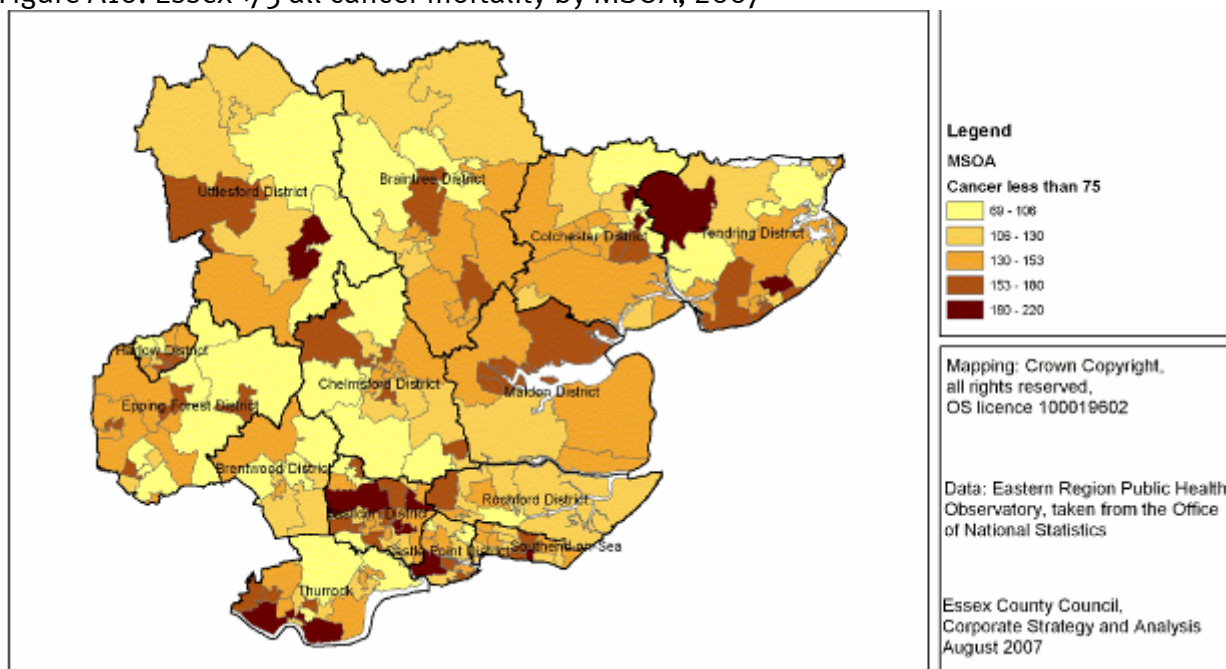
There is wide variation in rates across Essex; Tendring, Maldon and Harlow are all above the national average for males and Basildon, Southend, Uttlesford, Maldon and Thurrock are all above average for females.

Figure A15: Essex <75 all cancer mortality for males and females, 2007



The MSOAs with the highest mortality rate from cancer in under 75 year olds can be found in Castle Point and Thurrock and the lowest mortality rate in Colchester and Brentwood.

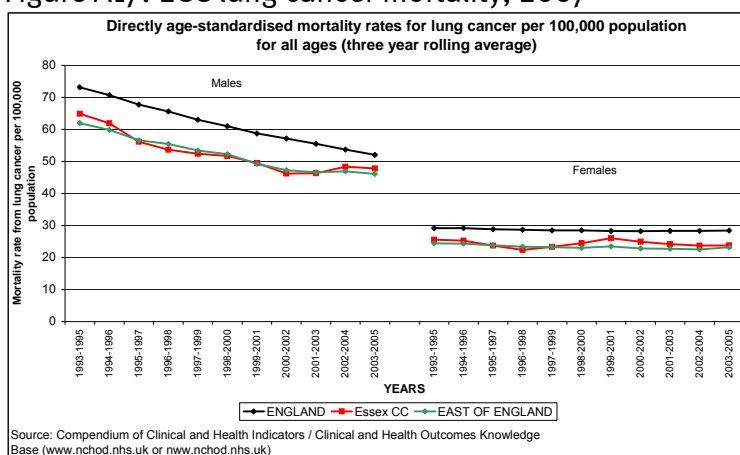
Figure A16: Essex <75 all cancer mortality by MSOA, 2007



3.3 Lung cancer

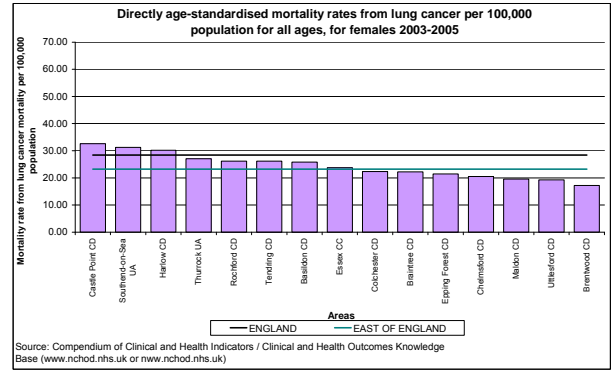
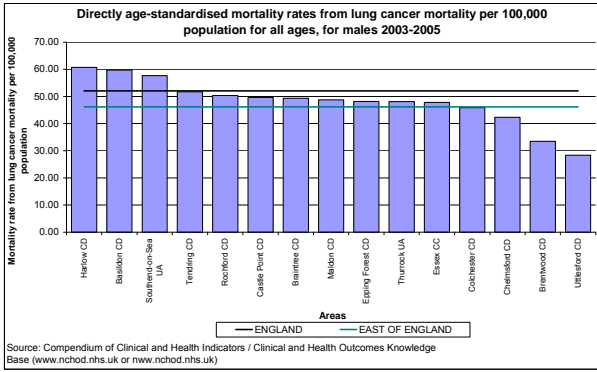
Lung cancer mortality for all ages in ECC has shown a steady improvement in males for the last 10 years. The male rate has been consistently below the national rate, yet in recent years the rates have started to converge showing a narrowing of inequalities. The female rates have shown no real improvement, which is consistent with the national picture. The ECC female rate had a peak in 1999-2001 but, since then, it has been decreasing slightly to just above the regional average.

Figure A17: ECC lung cancer mortality, 2007



At a district level, Harlow, Basildon and Southend are all above the national average for males and Castle Point, Southend and Harlow are above the national average for females.

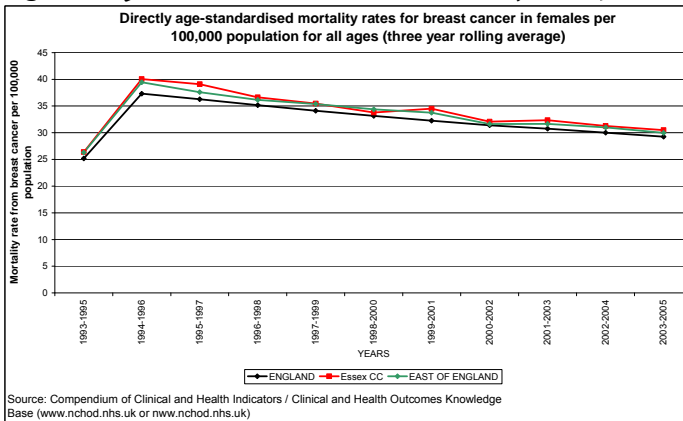
Figure A18: Essex lung cancer mortality for males and females, 2007



3.4 Breast cancer

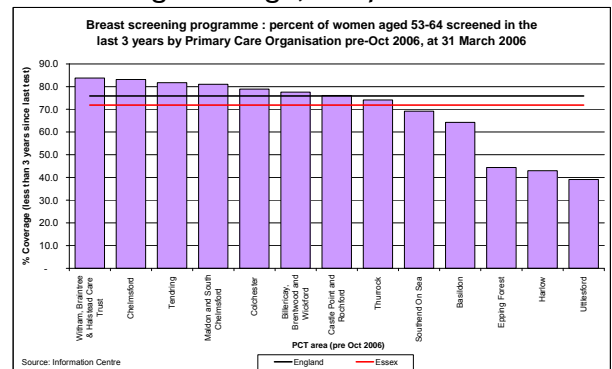
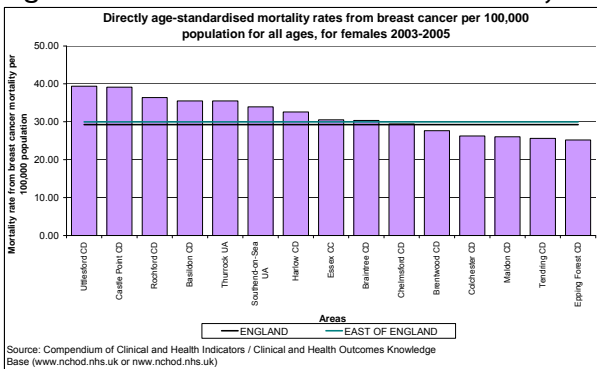
Breast cancer mortality in ECC has shown a steady improvement since 1994-96, but has consistently remained above the England and regional trend lines.

Figure A19: ECC breast cancer mortality, 2007



Across Essex only five districts – Epping Forest, Tendring, Maldon, Colchester and Brentwood – are below the national rate. There is some correlation between this and coverage of breast screening across the districts. However, the picture is complicated as the unit in the west of Essex was temporarily closed.

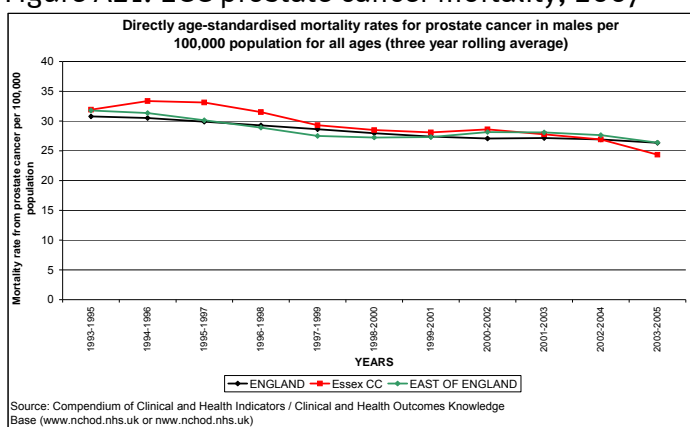
Figure A20: Essex breast cancer mortality and breast screening coverage, 2007



3.5 Prostate cancer

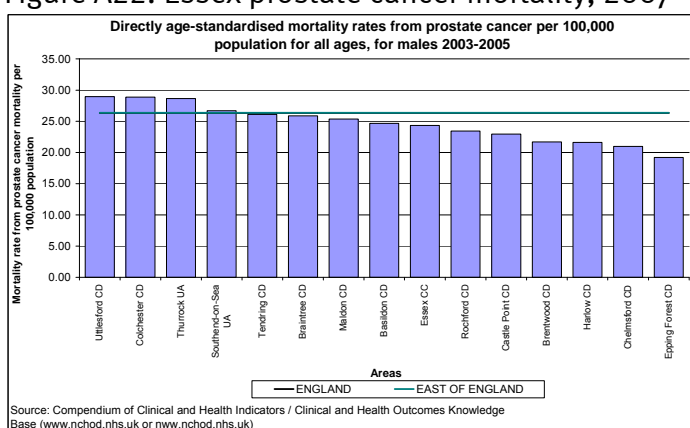
Prostate cancer mortality for all ages in ECC has shown a steady improvement since 1995-1997. It had consistently been above the England and regional trend lines but recently fell below.

Figure A21: ECC prostate cancer mortality, 2007



Across Essex the areas of Uttlesford, Colchester, Thurrock and Southend are all above the national and regional averages.

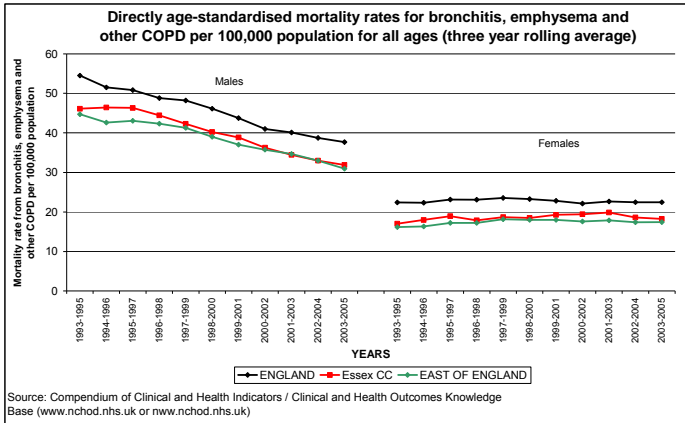
Figure A22: Essex prostate cancer mortality, 2007



4 Respiratory Disease Mortality

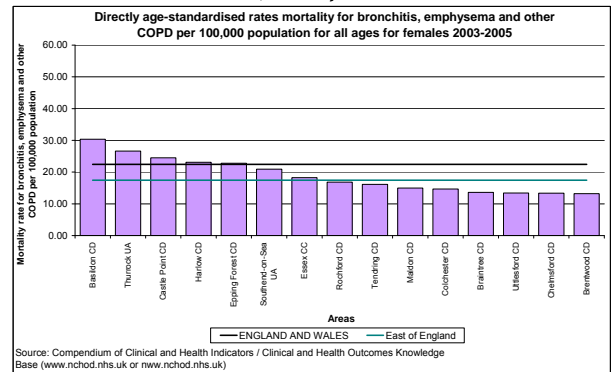
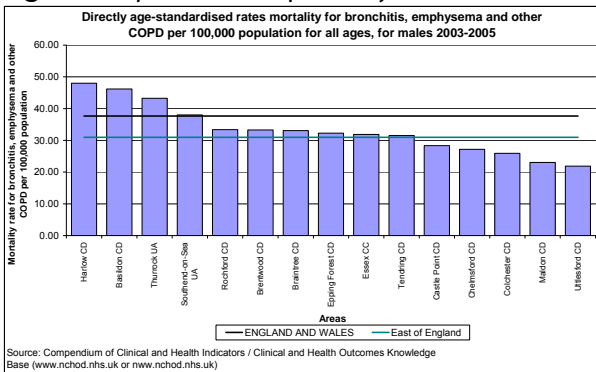
The ECC bronchitis, emphysema and other COPD mortality for all ages has shown some improvement in males for the last 10 years. It has consistently been below the trend line for England and is just above the regional rate. The female rate has shown a slight increase and is consistently above the regional average.

Figure A23: ECC respiratory disease mortality, 2007



Male rates in Harlow, Basildon, Thurrock and Southend are all above the national average as are female rates in Basildon, Thurrock, Castle Point, Harlow and Epping Forest.

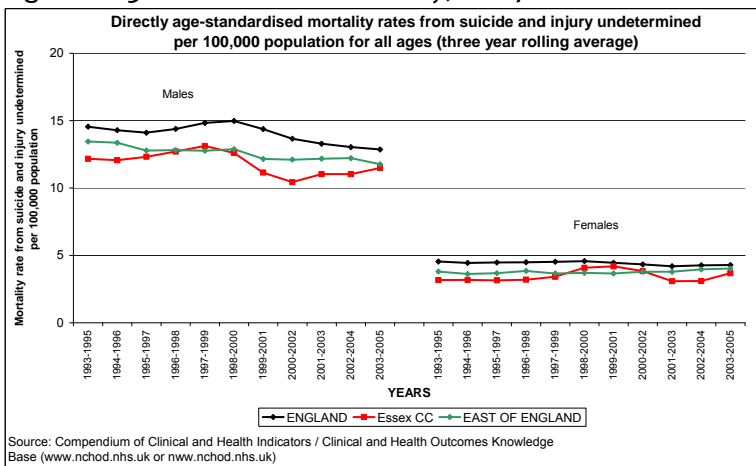
Figure A24: Essex respiratory disease mortality for males and females, 2007



5 Suicide and Undetermined Injury Mortality

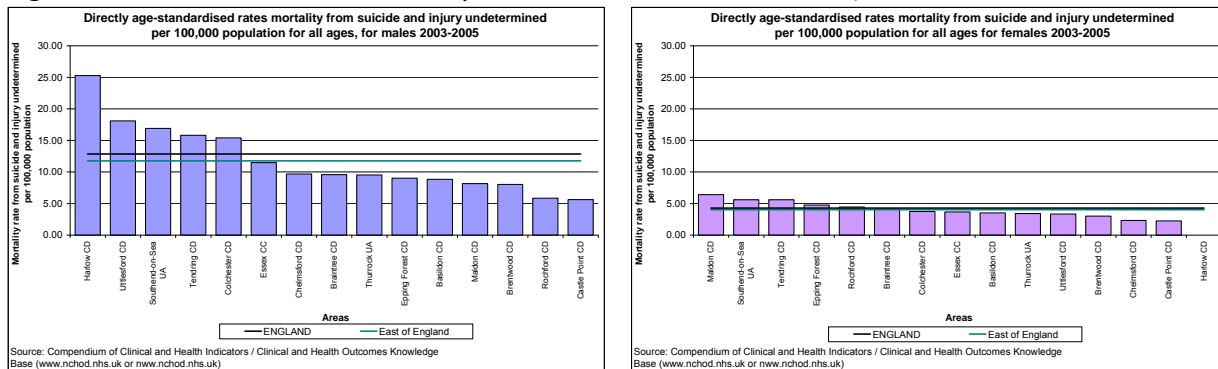
The ECC suicide and undetermined injury mortality for all ages has shown wide fluctuations over the last 10 years. This may be due to the small numbers involved. The male rate is considerably higher than the female but both have started to increase in recent years. Though both rates are below the national average they are only just below the regional.

Figure A25: ECC suicide mortality, 2007



There is wide variation in rates across Essex and between males and females. Harlow has a considerably higher male rate than both other areas in Essex and the national average. Uttlesford, Southend, Tendring and Colchester all also have above average male rates. For females Maldon, Southend, Tendring, Epping Forest and Rochford are above the national average.

Figure A26: Essex suicide mortality for males and females, 2007



GLOSSARY AND KEY DATA SOURCES

A8 COUNTRIES – the eight countries that joined the European Union in May 2004.

AGE STANDARDISED MORTALITY RATE (ASMR) – is calculated to compensate for the fact that men and women have different death rates that also vary by age. ASMRs then allow for different populations to be compared. ASMRs applied to a standard population (an ideal population that doesn't actually exist) are known as Directly Standardised Mortality Rates (DSMRs).

ASSOCIATION OF PUBLIC HEALTH OBSERVATORIES (APHO) – www.apho.org.uk

BINGE DRINKING – a pattern of heavy drinking that occurs during an extended period of time set aside for drinking. Has been described as 5/4 binge drinking: five or more drinks in a row on a single occasion for a man or four or more drinks for a woman.

BRITISH CRIME SURVEY (BCS) COMPARATOR GROUP – The group of BCS comparator crimes are made up of the following crime categories: robbery of personal property, theft of a vehicle, theft from a vehicle, vehicle interference and tampering, domestic burglary, theft of a pedal cycle, theft from the person, criminal damage, common assault and wounding.

BME (BLACK AND MINORITY ETHNIC) – refers to all ethnic groups that are not recorded under the “White British” ethnic group category.

BMI (BODY MASS INDEX) – an estimation of body fat based on height and weight. BMI can be used to determine if people are at a healthy weight, overweight, or obese. To figure out BMI, use the following formula:

$$\text{Weight in kg} \div (\text{Height in metres} \times \text{Height in metres})$$

A body mass index (BMI) of 18.5 up to 24.9 refers to a healthy weight, a BMI of 25 up to 29.9 refers to overweight and a BMI of 30 or higher refers to obese.

CENSUS 2001 – The census is a survey of all people and households in the country. It provides essential information from national to neighbourhood level for government, business, and the community. The most recent census was on 29 April 2001. Plans are being made to hold the next census in 2011. Census data is available through ONS.

CHLAMYDIA – a common sexually transmitted infection which many people do not know they have because they often don't have any symptoms. Left untreated, Chlamydia can cause infertility in women.

COMMUNITIES AND LOCAL GOVERNMENT (CLG) – www.communities.gov.uk

CONFIDENCE INTERVAL – The range of values within which we are 95% confident that the true population value lies.

CONFIDENCE LIMITS – The upper and lower values of a confidence interval.

CONNEXIONS – service offering advice on education, careers, housing, money, health and relationships for 13-19 year olds.

CO-TERMINOUS – areas that have the same boundaries.

DEPARTMENT FOR ENVIRONMENT, FOOD AND RURAL AFFAIRS (DEFRA) – www.defra.gov.uk

DEPARTMENT FOR WORK AND PENSIONS (DWP) – www.dwp.gov.uk

DIRECTLY AGE STANDARDISED RATES – Standardisation adjusts rates to take into account any changes in the age structure of the population at risk and allows comparison over time and between different geographical locations. Rates have been standardised to the European Standard Population.

EASTERN REGION PUBLIC HEALTH OBSERVATORY – www.erpho.org.uk

ECOLOGICAL FOOTPRINT – tool used to measure the impact of human activities on the environment. It estimates the surface area required to produce everything that an individual or population consumes (transport, accommodation, food, etc) and to absorb the resulting waste. It is expressed in hectares per person per year, or in planets.

GREATER ESSEX BUSINESS CONSORTIUM – provides the Greater Essex Prosperity Forum with its private sector membership and is made up of business leaders that provide an economically-relevant business voice to the economic debate at regional and sub-regional levels.

GREATER ESSEX PROSPERITY FORUM – one of nine sub-regional economic partnerships in the East of England bringing together local government, employers and local business partners.

HIV – stands for Human Immunodeficiency Virus and is a virus that can damage the body's defence system so that it cannot fight off certain infections. If someone with HIV goes on to get certain serious illnesses, this condition is called AIDS which stands for Acquired Immune Deficiency Syndrome.

HEALTH SURVEY FOR ENGLAND (HSE) – series of annual surveys about the health of people in England, beginning in 1991. Each year the HSE focuses on a different demographic group and looks at such health indicators as cardio-vascular disease, physical activity, eating habits, oral health, accidents and asthma

INCIDENCE – rate of occurrence of new cases of disease (within a given population over a given time period)

INDEX OF MULTIPLE DEPRIVATION SCORE – This is calculated by scoring different dimensions of deprivation – income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services. A higher score implies greater deprivation. For more information see the CLG website.

INFANT MORTALITY RATE – The number of deaths of infants under age 1 per 1,000 live births in a given year.

INEQUALITIES – a lack of equality or fair treatment in the sharing of wealth or opportunities between different groups in society

KSI – people killed or seriously injured in road traffic accidents.

LIFE EXPECTANCY – an estimate of the number of years a new-born baby would survive if they were to experience the particular area age-specific mortality rates for that time period they were born in throughout their lives. It is important to note that a life expectancy at birth of 80 years does not mean that someone born today can, on average, expect to live 80 years (in fact, they can expect to live longer if mortality rates continue to fall). It is legitimate to say however, that a population with a life expectancy of 80 years is healthier (or at least has lower mortality) than a population with one of 70 years.

LOCAL AUTHORITY – an administrative unit of local government. There are several tiers of local government in Essex. Essex County Council is responsible for strategic planning, highways, traffic, social care services, education, libraries, fire, refuse disposal and consumer protection. The twelve district / borough councils within Essex County Council are responsible for local planning, housing, environmental health, markets and fairs, refuse collection, cemeteries and crematoria, leisure services and parks, tourism and electoral registration. The two unitary councils (Southend and Thurrock) are responsible for all the services in their areas. Parish and town councils can influence planning applications and community strategies and can provide local recreational facilities, crime prevention, tourism, allotments, footpaths and commons.

LOCALITY – a particular neighbourhood, place, district or borough

LOW BIRTHWEIGHT – Any baby weighing less than 2,500 grams at birth.

NEET – not in employment, education or training. Generally refers to 16-18 year olds.

ONS – The Office for National Statistics (ONS) is the government department that provides UK statistical and registration services. It is one of the key sources of the information in this document. For further information and access to the raw data, see the ONS website (www.statistics.gov.uk).

POPPI (PROJECTING OLDER PEOPLE POULATION INFORMATION SYSTEM) – web-based demand forecasting and capacity planning system. It gives easy access to forecasts of the numbers and characteristics of older people in local authority areas. For further information and access to the raw data, see the POPPI website (www.poppi.org.uk).

PRIMARY CARE TRUST (PCT) – an NHS statutory body which is responsible for the planning and securing of health services and improving the health of their local population.

PREVALENCE – the total amount of something within a population at a given time or over a given period.

QUARTILE – a quarter of a distribution (eg the first, second and third quartile points of 100 are 25, 50 and 75).

QUINTILE – a fifth of a distribution (eg the first, second, third and fourth quintile points of 100 are 20, 40, 60 and 80).

RAP (Referrals, Assessments and Packages of Care) – statistical return on adult social care (www.dh.gov.uk/en/Publicationsandstatistics/index.htm)

REGION – top level of local government in England. Essex falls within the East of England region. The region also consists of the counties of Hertfordshire, Bedfordshire, Cambridgeshire, Norfolk and Suffolk.

REGISTERED POPULATION – the population who are registered with GP practices in an area

REGISTERED SOCIAL LANDLORDS (RSLs) – independent, not-for-profit, private sector organisations providing social housing.

RESIDENT POPULATION – the population who are resident in an area as determined by the 10 year census

SSDA903 – statistical return on children looked after by local authorities (www.dfes.gov.uk/rsgateway)

SUPER OUTPUT AREA (SOA) – These are geographic areas generally smaller than electoral wards designed to improve statistical reporting. They exist at three levels: lower layer (average population 1,500); middle layer (average population 7,200) and upper layer (minimum population 25,000).

SWIFT – comprehensive social care database used by Essex County Council.

SYNTHETIC ESTIMATES – the expected prevalence of a behaviour for any ward or primary care organisation (PCO), given the characteristics of that area. The synthetic estimates are not estimated counts of the number of people or prevalence of a behaviour (eg smoking in a ward or PCO). They are the expected prevalence of a behaviour for any ward or PCO, given the characteristics of that area (demographic and social characteristics).

TRACKER SURVEY – survey conducted by Essex County Council to track public perception of various local issues.

UNFIT DWELLINGS – Dwellings are deemed unfit if they fail to meet one or more of the following fitness criteria: structurally stable; free from serious disrepair; free from dampness prejudicial to the health of the occupants; adequate lighting, heating and ventilation; adequate supply of wholesome water; satisfactory facilities for the preparation and cooking of food, including a sink with a satisfactory supply of hot and cold water; suitably located water-closet for occupants' exclusive use; suitably located fixed bath or shower and hand-wash basin each of which is provided with a satisfactory supply of hot and cold water for the exclusive use of the occupant, effective system for draining foul water/surface water.

WARD – An administrative area that is laid down in statute. There are 665 wards in Essex.

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0845 758 5592**

**By email:
contactessex@essexcc.gov.uk**

**Visit our websites:
www.essexpartnership.org**

Local JSNAs are available from the following websites:

- Basildon www.swessexpct.nhs.uk
- Braintree www.midessexpct.nhs.uk
- Brentwood www.swessexpct.nhs.uk
- Castle Point www.see-pct.nhs.uk
- Chelmsford www.midessexpct.nhs.uk
- Colchester www.northeastessexpct.nhs.uk
- Epping Forest www.westessexpct.nhs.uk
- Harlow www.westessexpct.nhs.uk
- Maldon www.midessexpct.nhs.uk
- Rochford www.see-pct.nhs.uk
- Southend www.see-pct.nhs.uk
- Tendring www.northeastessexpct.nhs.uk
- Thurrock www.swessexpct.nhs.uk
- Uttlesford www.westessexpct.nhs.uk
- Southend www.southend.gov.uk
- Thurrock www.shapingthurrock.org.uk

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