

**Essex County Council**

# Annual Public Health Report 2008/09

September 2008

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It is with great pleasure that I write the foreword to this, the first Annual Public Health Report by the new Essex County Council Director of Public Health.

Many of the areas for which the County is responsible and that underline Essex Works have a major impact on health. These include education, employment, support for vulnerable people, safer stronger communities, transport and sustainability agendas. We also have a role in encouraging healthy choices around obesity, smoking and sexual health.

While a relatively affluent county, in Essex we also serve some populations who suffer poorer health as a result of social and economic deprivation. The County is well placed through a range of services and interventions to address these inequalities to ensure all the population we serve can optimise their life chances and community well being.

Improving the health of the people we serve in Essex will be a key challenge for the County Council and our partners and we are committed to playing a full role in this. This report outlines what we need to do together, to make this happen.



This first report of the Director of Public Health for Essex County Council draws on the findings of the Essex Joint Strategic Needs Assessment undertaken in 2007 by a range of County, Primary Care Trust (PCT), District, Borough and Unitary partners working together as well as the Commissioning Needs Analysis and Initial Strategic Response produced by County around Children's Services.

This document attempts to draw key messages from these works to inform interested partners around the key health issues for Essex County Council and it begins to draw out a number of recommendations to address these issues. It is my first report and is not comprehensive although it attempts to provide an overview of key issues to inform members.

Population health is determined by a wide range of interventions and experiences that affect people over a variable, often long period of time, many of these factors lie within the gift of County Council to address, and others sit with PCTs, still others with Districts and Boroughs. It is clear that only through partnership working can these issues be adequately addressed.

Essex has 5 PCTs each with a Director of Public Health charged with improving the health of the population they serve. All these colleagues have agreed the content and proposed changes that I have endeavoured to include. Readers are directed to the Annual Public Health reports of these colleagues to best understand the detailed work required in each of these areas.

This document profiles key issues for Essex County Council to consider and to influence. An Essex wide Annual Public Health Report was one of the recommendations of the Audit Commission Report into Health Inequalities and while health inequalities are not the only issue in health, they are a crucial issue to address locally especially given the wide variance in health experience across the population we serve. In parallel to this work an Essex County Council Health Inequalities Action Plan will therefore be produced.

## Our ageing Population

Essex County Council serves around 1.3 million people. The key feature of the population demographically is the retirement areas of Tendring where 1 in 3 people are aged 65+ and Castle Point where the figure is 1 in 4. The East of England Regional Assembly (EERA) has developed predictions of future structural change and these are detailed in the Joint Strategic Needs Assessment (JSNA). In brief the population of Essex in 2021 will have a lower proportion of children, a similar proportion of working age people and a major increase in older people with a 49% increase in those over 65 and a 88% increase in those over 85.

**We need to ensure people can live and enjoy healthy independent lives. We need now to be developing services and interventions to prevent premature illness and long term disabilities. These might include:-**

- **Ensuring access to opportunities for exercise and healthy food**
- **Optimal tobacco control and support to stop smoking**
- **Services to prevent falls and ensure mobility**
- **Interventions to address high blood pressure as a key risk for stroke and certain forms of dementia**
- **Reduction in harm caused through misuse of alcohol**

The Essex County Council Prevention Strategy will be key in ensuring progress in these areas.

## An increasingly diverse population

Census data on ethnicity is pretty out of date and Office of National Statistics (ONS) experimental statistics provide a better picture about the numbers of people in different ethnic groups. While numbers remain relatively low they are especially significant in Epping Forest, Harlow and Brentwood.

Similarly economic migration is leading to an increasingly diverse population. Migrants tend to be young adults aged 18–34 and two thirds are from Poland. Essex also has the second highest level of travelling families in the East of England and has a high proportion of unauthorised developments. A high proportion of the caravans in Essex County Council are in Basildon and most of these are private or/and on unauthorised sites.

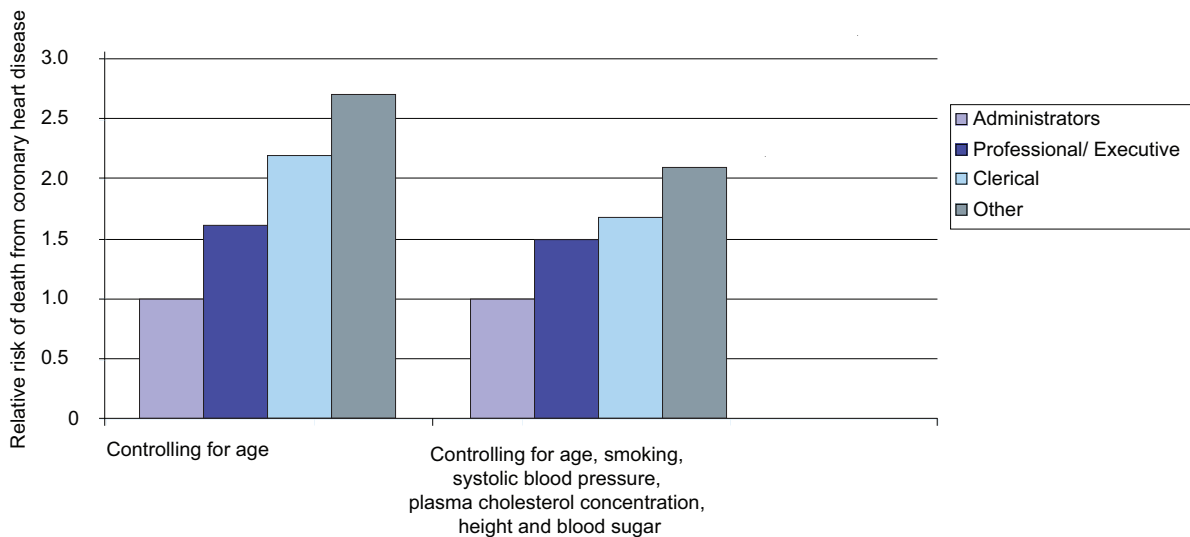
The traveller population suffers from low life expectancy, with an average in the 40's. These are high levels of smoking and Coronary Heart Disease. **These diseases are often amenable to intervention and consideration needs to be given as to how best to optimise access to effective interventions for this often socially excluded group.**

**We need to increasingly tailor commissioned services to ensure inclusion and to specifically meet the health needs of these groups.**

### Material Deprivation

Material deprivation affects health. While risk factors associated with ill health such as smoking and poor diet are often higher in deprived groups, this is not the only reason. The Whitehall study looked at Civil Servants of different grades from highly paid administrators to those in manual work. The study measured a range of risks like blood pressure, cholesterol and smoking and then followed the groups up. It was found that for heart disease deaths for example, there was 2.7 times difference between the administrators and the manual group but this only dropped to 2.2 times difference when all the risk factors were controlled for (taken out). In brief, even after all those factors were removed those in the lower paid jobs were twice as likely to die of a heart attack early, than those in the higher paid jobs.

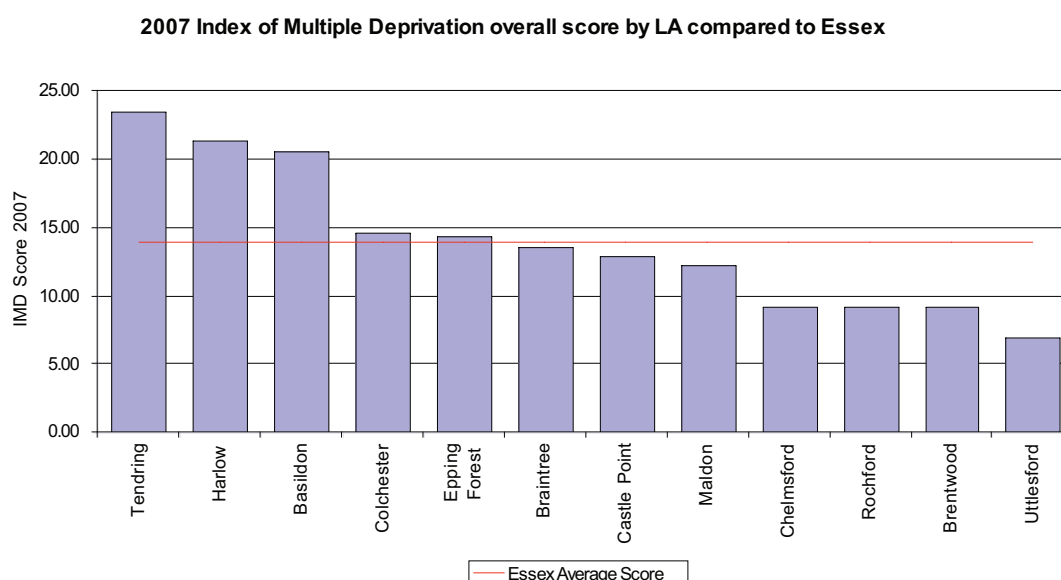
Figure 1.0  
**Relative risk of coronary heart disease in 10 years, controlling for age and other risk factors**



The most commonly used measure of deprivation is the IMD 2004 (Index of Multiple Deprivation). This looks at a combination of income, employment, health and disability, education, housing, living environment and crime.

Essex is very heterogeneous and the smaller the area we consider the more marked this difference is. Recent data has placed a super output area (sub district level) in Jaywick (in Tendring) as the third most deprived (of around 36,000) in the whole of the country (including all inner city areas). Parts of Clacton are in the most deprived 10% nationally; parts of Basildon and some areas of Colchester fall within the worse 20%. By contrast there are areas of high affluence with most of Uttlesford being in the 20% least deprived areas nationally.

*Figure 1.1*  
**Essex IMD 2007 scores**



Source: Calculated from the Indices of Multiple Deprivation, 2007, Department of Communities & Local Government  
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Deprivation has a profound effect on health and action though all partners are required to address this. It leads to health inequalities with high level of almost all physical and mental health problems as well as lower life expectancy being endured by the more deprived groups.

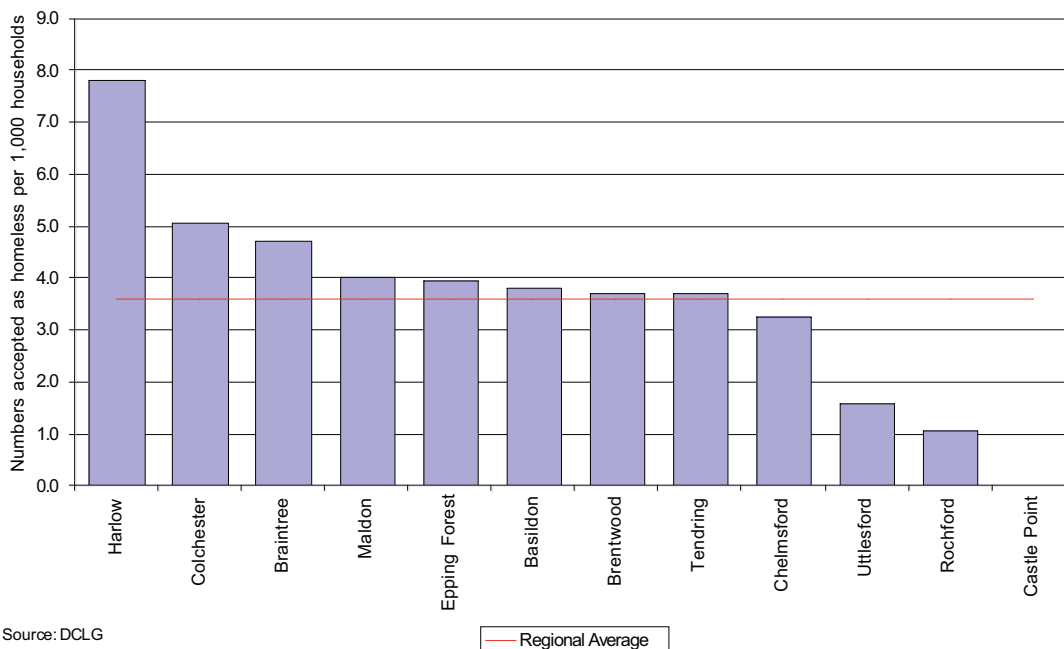
**If Essex County Council is committed to improving the health of these groups key actions will require:-**

- **Focus of resources in addressing inequalities**
- **Ensuring optimal uptake of benefits**
- **Ensuring optimal access to job opportunities**
- **Ensuring appropriate skills and training are available**
- **Targeting third sector funding to address the needs of the excluded groups in high need areas**
- **Potentially hard decisions around areas for less investment**
- **Ongoing political drive to secure support for Jaywick and other deprived areas**

### Homelessness

Homelessness is associated with severe poverty and adverse health, education and social outcomes, especially for children. Homeless people can often not access appropriate help and support with poor access to, for example, health services. Additionally they often suffer high levels of mental health problems, physical illness and substance misuse. To be deemed homeless statutorily, a household must be “unintentionally” homeless but those with the most chaotic lifestyles may lose homes and be recorded as “intentional”. The number of official homeless households in Essex is dropping, details are in the JSNA but the highest rate is in Harlow, followed by Colchester and Braintree. The figures do not include those “intentionally” homeless or “unintentionally” homeless but not in priority need, nor rough sleepers.

Figure 1.2  
Households accepted as homeless and in priority need, 2005–06

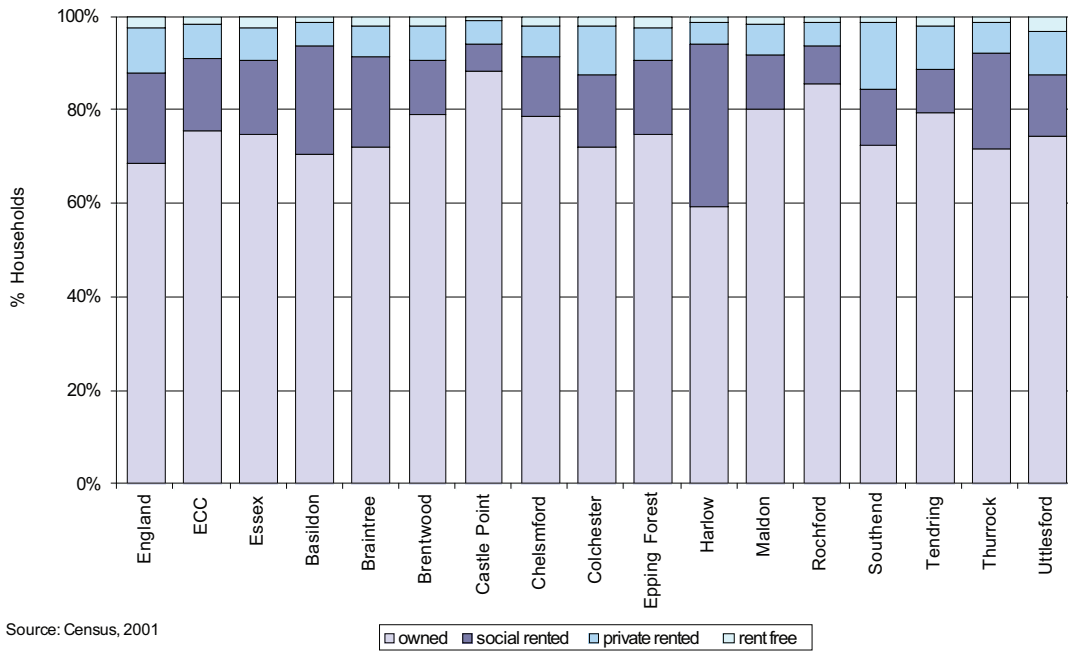


- Essex County Council should ensure vulnerable clients are supported to prevent chaotic lifestyles leading to homelessness.
- County should work with partners to secure optimal access for homeless people to high quality primary care.
- Essex County Council should work through third sector partners to help meet the needs of this group including access to virtual (or real) 24/7 beds for those with illnesses that would normally require simple bed rest at home.

### Housing

Housing is important for health. A high proportion of Essex residents own their own homes.

Figure 1.3  
Essex housing tenure

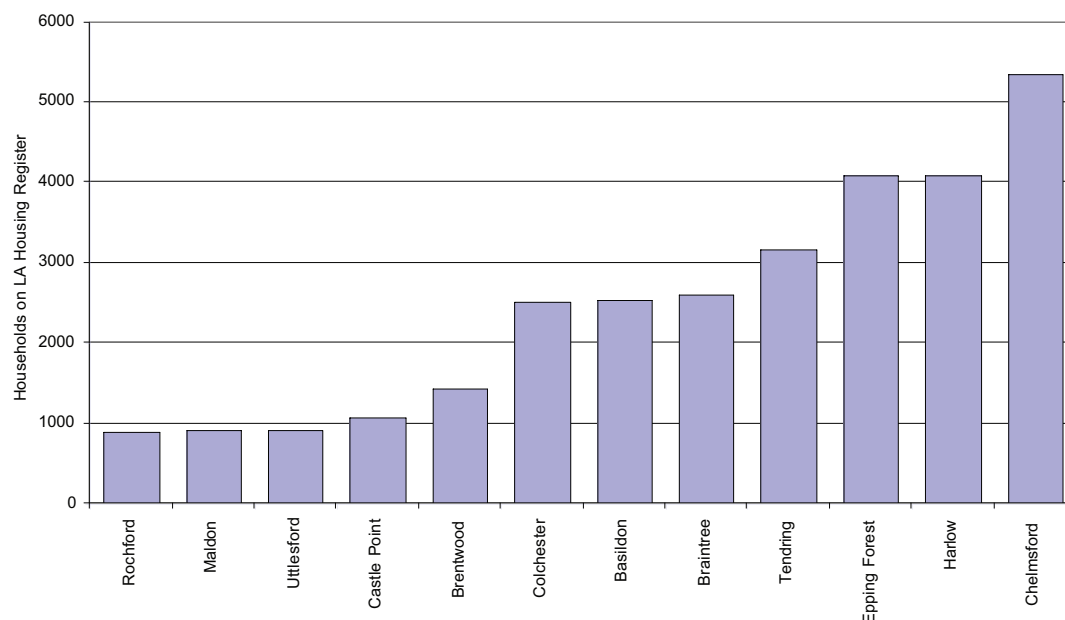


Source: Census, 2001

From the table it can be seen 88% of households in Castle Point own their own accommodation, against 60% in Harlow. Basildon has the highest number of local authority dwellings and Chelmsford the highest proportion of registered social landlord stock.

The demand for social housing by district is shown below.

Figure 1.4  
Essex demand for social housing, April 2006



Source: Housing strategy statistical appendix, DCLG

This includes those defined as both in and not in housing need but excludes those seeking a transfer. Demand is especially high in Chelmsford (8% of households) but at 13% Harlow has the highest proportion of households on the local authority waiting list.

Fuel poverty is an important factor in housing as it has significant consequences, such as cold, damp homes, reduced quality of life, poor health and debt. Fuel poverty is when a household needs to spend more than 10 % of its income on fuel to maintain satisfactory heating and other energy services. Nationally, fuel poverty has been estimated to have doubled between 2004 and 2006; this is predominantly due to the rise in fuel prices. Across Essex there is a varied picture for fuel poverty, the main areas affected mapping to areas of older people and deprivation. The elderly living alone are at greatest risk of fuel poverty, nationally about 63% of single pensioner households experience fuel poverty.

**It is important district and boroughs continue to work to ensure a range of high quality affordable housing options are available to the local population.**

**All partners need to work to reduce potential excess winter mortality due to fuel poverty by ensuring appropriate support is available to those in need.**

The needs of particular vulnerable groups are discussed later.

### Educational Attainment

If we accept that Social Class is a key determinant of future health, then academic attainment in turn is a key driver for future affluence and social position. Educational qualifications and skills are a key determinant of an individual’s position in the labour market, which influences income, housing and health. The 14-19 White Paper states children who do not get 5 A+ - C grade GCSEs by age 16 tend not to have good opportunities to achieve success later.

Taken as an average, Essex GCSE attainment is very close to the England average. The problem is that Essex is a comparatively affluent county with far lower levels of deprivation than England average. This means the relative educational attainment is poorer than one might expect and if such attainment is a strong driver for future social position and affluence, then the children in the population we serve may not be able to aspire to the same relative level of affluence their parents enjoy. This may be the major future health issue for Essex. While there is variation within electoral wards across Essex, it is time that in many areas, affluent or not, that the score against the education domain of this IMD, is lower than that of the combined IMD. The data below shows this for Castle Point but it is an issue across Essex.

Figure 1.5  
 Castle Point IMD & Education Domain, 2007

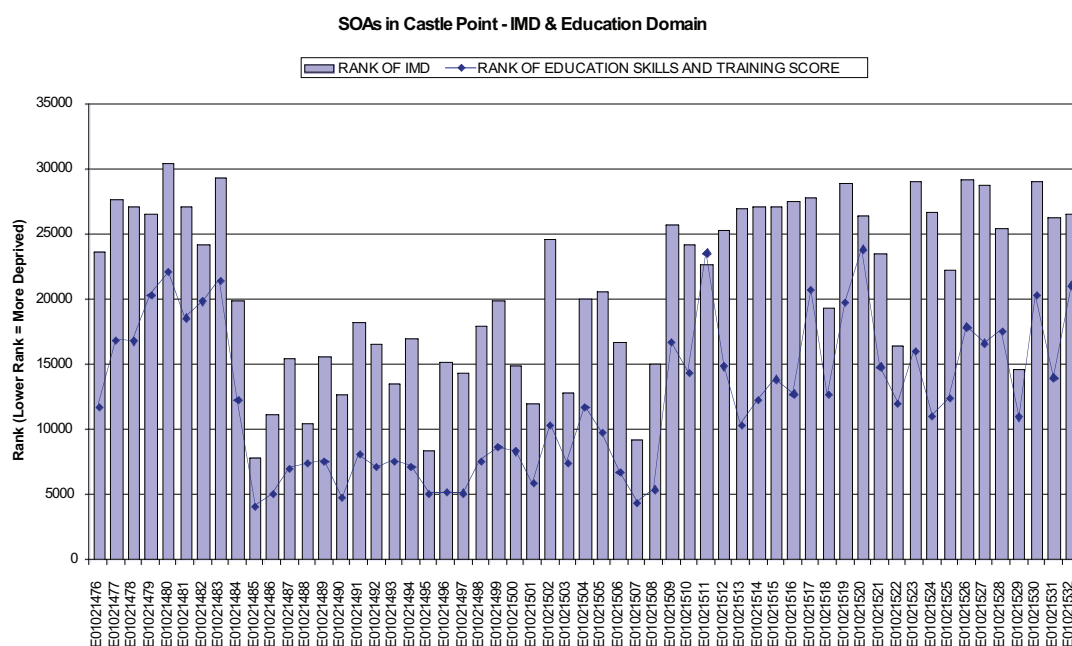
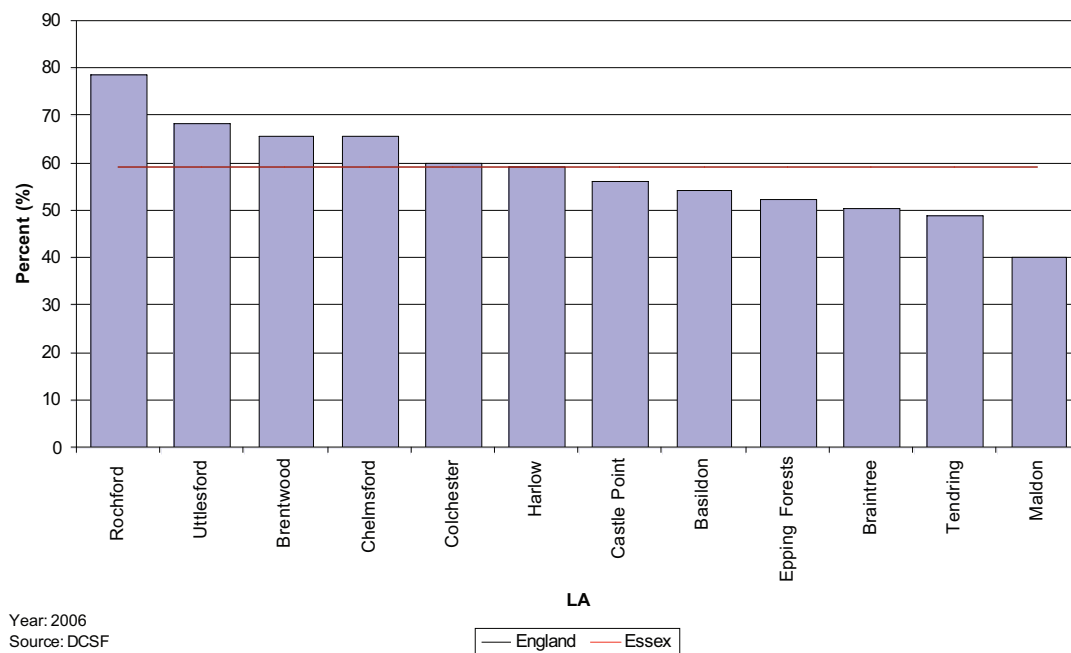


Figure 1.6  
Essex pupils gaining 5+ GCSEs at A\*-C, 2006



The above graph (Fig 1.6) shows considerable variation in attainment within Essex and variation with each district and borough is even greater with some areas achieving a very poor level of performance.

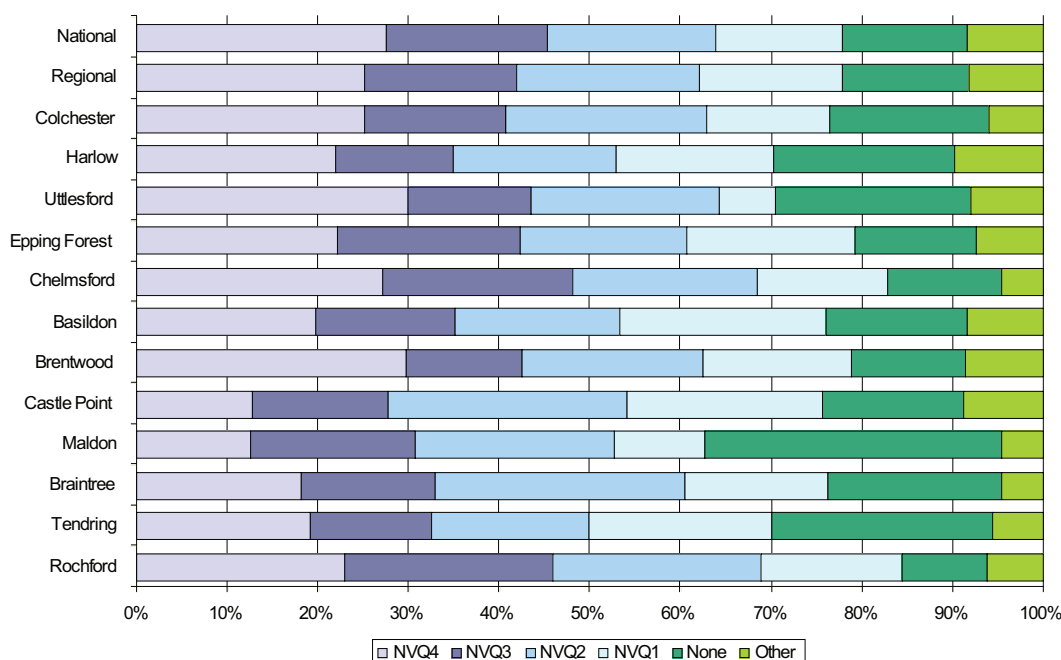
**Improving academic attainment across Essex with particular focus on poorer performing area is key to ensuring optimal future health.**

### Adult Qualifications

The Essex workforce is slightly older than that nationally and older people tend to have lower qualifications. Essex is also ‘a net exporter’ 16-24 year olds who may have more qualifications.

The JSNA describes qualifications in the working population of Essex.

Figure 1.7  
Qualifications of working age population, 2006



**To improve the local economy, it is essential to develop more local high value jobs and to ensure the workforce have the skills to match. This will include further development of apprentice schemes.**

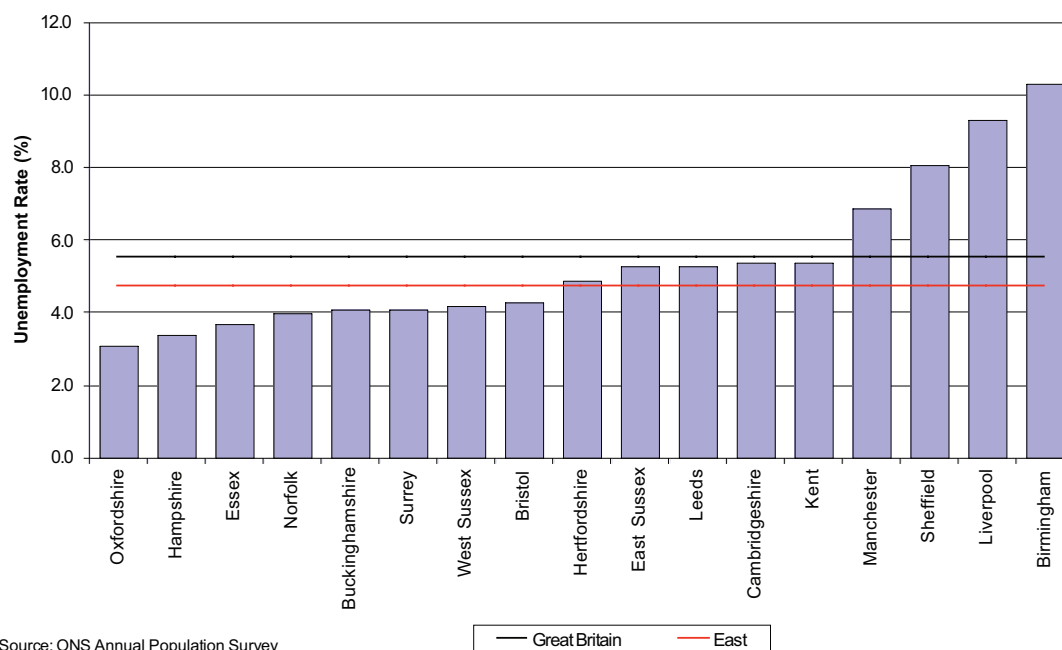
### Unemployment

Unemployment is associated with poor health in workers and their families. While this appears self evident, it was only proven in the 1980’s through the work of ‘Nethercott & Beale’ in general practice in Wiltshire. Prior to this, critics of the hypothesis could claim illness leads to worklessness not vice versa. Closure of a major local employer allowed Nethercott & Beale the opportunity to study the impact of the threat of unemployment and then unemployment in workers and their families and to compare this to a coastal group. They found a doubling of markers relating to poor health e.g. hospital referrals in both the workers and their families. Unemployment is clearly a key determinant of an individual’s health.

On average unemployment rates in Essex have been low but there are pockets of high unemployment and it is likely future recession will worsen the position. Levels of unemployment geographically vary with high levels in central Basildon and South and North East Tendring.

Figure 1.8

### Comparative unemployment, 2006



Additionally, unemployment is particularly common in certain client groups. Many people with mental health problems are able to work but remain unemployed. Local Area Agreement 2 (LAA) has a specific target around getting these people back into education and employment and this is to be applauded. Similarly there needs to be more opportunities for people with learning difficulties to access employment opportunities.

#### Essex County Council with partners should:

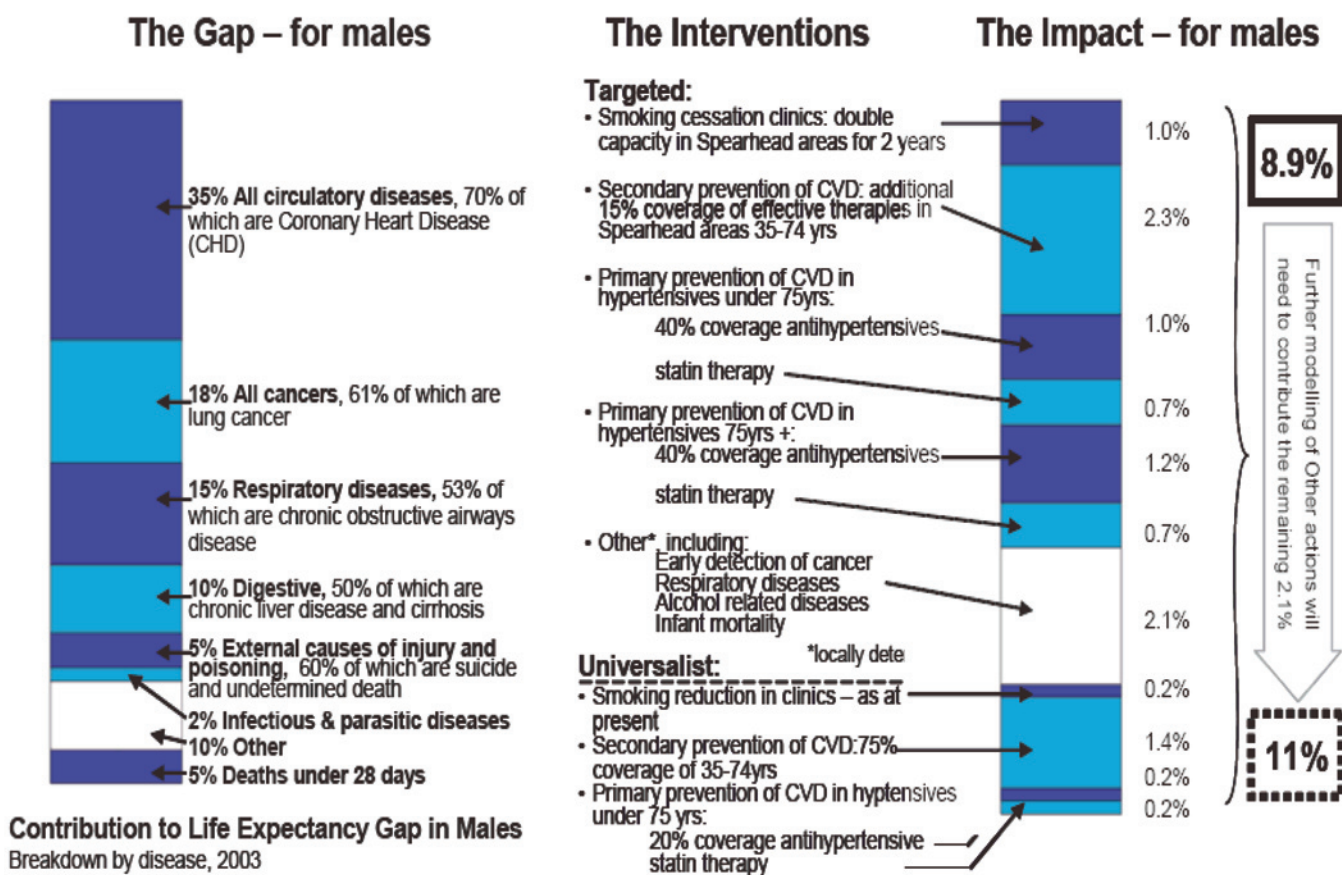
- Ensure best employment practice around people with mental health problems and learning difficulties
- Support and develop initiatives to optimise education and employment for people with mental health problems or learning difficulties
- Encourage investment with a focus on areas of high employment
- Work with partners to develop access to appropriate skills training
- Ensure unemployed people in contact with services are signposted to health services where there may be assessed if at high risk of illness such as heart disease
- Develop with partners and the third sector initiatives to help engage hard to reach populations such as the “Reach Out” door to door project in the North West that has led to over 900 people taking up employment. A local version is proposed for LAA2 performance reward funding.
- Support key economic regeneration initiatives and developments such as Bathside Bay and around Jaywick.

### Life Expectancy

The health of the population we serve has been gradually improving however gains are not uniform across the whole population with those in less deprived populations benefiting more than the most deprived with increasing inequalities. The reasons are complex and include educational attainment, occupation, income, sex, ethnicity and lifestyle factors such as smoking, drinking alcohol, exercise and diet. The net result is there is a group within the population we serve who are likely to have shorter lives and who are often the hardest to engage with services.

In this group it is imperative to act quickly to address their existing high risk. This will in the very short time be largely through clinical interventions as described in the “Community Framework for Health and Well Being”.

The nature of these interventions and their contributions are shown in Fig 1.9.



**All partners in the County should ensure provided service initiatives including those run by third sector partners can identify people at potential high risk of early death and signpost them to appropriate clinical services.**

**All partners in the County should work with PCTs to help them to target high risk populations with evidence based interventions.**

Life expectancy for Essex is above the England average but it varies considerably across the population we serve. It is now well known that the average difference in life expectancy between someone in Littlebury ward and Pier ward is a wholly unacceptable 18.6 years. Additionally, Pier ward has the seventh lowest life expectancy of any ward in the country. This is unacceptable and demands special attention. **Essex County Council should consider specific work focussing on Pier ward including work with partners to develop a Community Well Being Centre.**

Other key groups with poor life expectancy include people with mental health problems who often ignore signs and symptoms and may be financially compromised and may have unhealthy lifestyles. People with learning difficulties who often have poor access to general services and may be at high risk due to co-existing illness, deprivation and lifestyles and people from travelling communities. Similarly people who are homeless are at very high risk.

**Essex County Council should work with partners supporting these groups to ensure signposting and access to appropriate clinical review and should work with PCTs to ensure they can be assessed by appropriate services and offered a full range of timely interventions.**

The action above focuses on the role of Essex County Council in working with partners to ensure the population we serve have rapid access to effective clinical interventions that will reduce risk in the short term and may impact on our LAA2 All Age All Cause Mortality target. All districts and boroughs have areas within the poorest 20% for mortality. While Basildon and Tendring have high numbers of areas, there are extreme differences across Epping Forest that has Middle Super Output Area's (MSOA) with the best and the worst mortality. Essex are to be congratulated for being the only LAA in the region that has focussed this target on the most deprived, 20% of wards and therefore explicitly address inequalities.

**ECC, all boroughs and districts and PCTs need to work together to target the most deprived 20% of wards.**

## **Lifestyle Interventions**

In the short to medium term also relevant to the LAA2 target there are a number of lifestyle related interventions that should be specifically targeted at these groups including smoking cessation advice, access to exercise and dietary advice. These are discussed later. Longer term interventions will include those previously discussed including access to benefits, education support and opportunities for employment.

## Mortality

The key causes of death in Essex mirror those across the developed world. Heart disease (which is decreasing quite quickly) remains the commonest cause but cancer (which is decreasing but more slowly) is an increasingly high proportion and is likely to overtake imminently.

While heart disease death rates continue to improve, levels remain higher than those in many other countries and much work still needs to be done across the whole of Essex to address this issue. Work around reducing levels of smoking and improving diet and exercise will be key in addition to the focussed activity described above. The JSNA contains details by area of the burden of these diseases but it is important to remember that they are all too high across Essex and work is required now and into the future to improve lifestyles. LAA2 places appropriate emphasis on these factors and is to be applauded.

- **Essex County Council will continue to fully support the Essex Tobacco Alliance to achieve ongoing reductions in the prevalence of Smoking through a multi agency approach.**
- **Essex County Council will support further the Essex Obesity Alliance is ensuring coordinated optimal approaches to improving exercise and improving diet across Essex.**
- **Essex will play a key role in achieving the LAA2 Children's sport and adult sport engagement targets.**

## Long Term Conditions

Long term conditions are those that while currently not amenable to care, can be managed by a range of therapies over a long period of time. These conditions are common (as many as 6 out of 10 adults may suffer). According to the BMA, 80% of Primary Care consultations and 2/3 of emergency hospital admissions are related to long term conditions, in addition, people with these conditions often have a range of social care needs of varying complexity. Management and where possible prevention of these conditions is essential to the health and well being of the population we serve.

The conditions highlighted in the health and welfare chapter of the JSNA include hypertension (although stroke is the key long term condition resulting from hypertension), Coronary Heart Disease (which in turn is a key cause of heart failure), diabetes which is both a key disease in itself but also precipitates Coronary Heart Disease, kidney disease and blindness and chronic obstructive pulmonary disease (COPD).

## Prevention and Management of Long Term Conditions

Management of high blood pressure is key to stopping strokes as well as identifying and managing heart irregularities (Atrial Fibrillation) and quick assessment of people who have suffered a minor stroke Transient Ischemic Attack (TIA). Proper treatment of people who have had a stroke including aspirin where appropriate, will help stop a second one.

Management of high blood pressure is very effective in older people who should benefit from treatment where clinically appropriate.

**Essex County Council should ensure via providers that people in contact with services have had a blood pressure check and a pulse check (for irregularities) and have onward referral if appropriate. Essex County Council may work with partners to try and ensure appropriate use of medicines in people assessed as requiring them.**

Heart disease prevention is through stopping smoking and improving diet and exercise. These will be discussed under lifestyles. **The potential role of Essex County Council is in supporting and signposting high risk groups have been discussed above.**

Diabetes in the form most common in adults is related to obesity and lack of exercise, can be prevented. Again the role of county in improving exercise uptake will be discussed.

People with diabetes can be prevented from getting complications through stopping smoking, appropriate diet and exercise and close control of blood pressure and cholesterol through appropriate drugs.

**Essex County Council through provider carers could ensure people with diabetes are taking prescribed drugs appropriately such as blood pressure and statin medications. High risk patients could be signposted for review including those with mental health issues who are often prone to diabetes and whose medication compliance may be poorer.**

COPD prevention and indeed management is largely around smoking cessation. While there are a range of drugs that help symptoms in this disease, the only way to stop progression is through stopping smoking.

**Essex County Council providers should work with PCT partners to ensure people with COPD can access smoking cessation services as a priority group.**

## Older People Living Alone

Figure 1.10

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          | 10,013        | 10,659        | 12,716        | 13,158        | 13,039        |
| Men aged 75+ living alone            | 13,020        | 13,804        | 16,100        | 18,984        | 23,436        |
| Women aged 65-74 living alone        | 21,582        | 22,968        | 27,489        | 28,545        | 27,654        |
| Men aged 75+ living alone            | 41,713        | 42,598        | 46,492        | 52,628        | 63,484        |
| <i>Total aged 65-74 living alone</i> | <i>31,595</i> | <i>33,627</i> | <i>40,205</i> | <i>41,703</i> | <i>40,693</i> |
| <i>Total aged 75+ living alone</i>   | <i>54,733</i> | <i>56,402</i> | <i>62,592</i> | <i>71,612</i> | <i>86,920</i> |

The table above looks at the current and future projections of numbers of people living alone in Essex aged over 65 and 75. Living alone may be associated with social isolation and with failing mobility and increasing dependence and this can be exacerbated to the detriment of mental health and physical health.

- **Essex County Council with partners need to introduce a range of interventions to help ensure optimal future independence.**
- **Essex County Council with partners including the third sector need to ensure accessible support to help maintain independence e.g. toe nail cutting service.**
- **Essex County Council with partners including the third sector need to develop quality opportunities for social engagement using the Community Well Being Centre model including lunch clubs, dances, exercise classes, dog sitting and allotments.**

## Carers

In 2001, there were approximately 130,000 unpaid carers in Essex and 25,000 spend over 50 hours a week on caring tasks. Half of this group are aged over 60. The County document 'Evaluating Services and Support for Carers' suggested in 2004 that a third of carers received no support and a third were unsatisfied with the support they received.

The health and social care system in Essex as elsewhere is highly dependant on the input of these carers and we must ensure their needs are recognised and met. This group often have high levels of unmet health needs.

**Essex County Council with partners needs to continue to develop systems to ensure optimal support is available to carers.**

## Dementia

1 in 14 people aged over 65 years and 1 in 6 over 80 years suffer from dementia. While most cases are due to Alzheimer’s disease there are some kinds that are preventable in the same way stroke is prevented, particularly through good management of high blood pressure.

Of people with dementia it is mild in 55% of cases, moderate in 32% and severe in around 13%. It is estimated 80% of people in Elderly Mentally Ill (EMI) homes have dementia, 67% in nursing homes and 52% in residential homes.

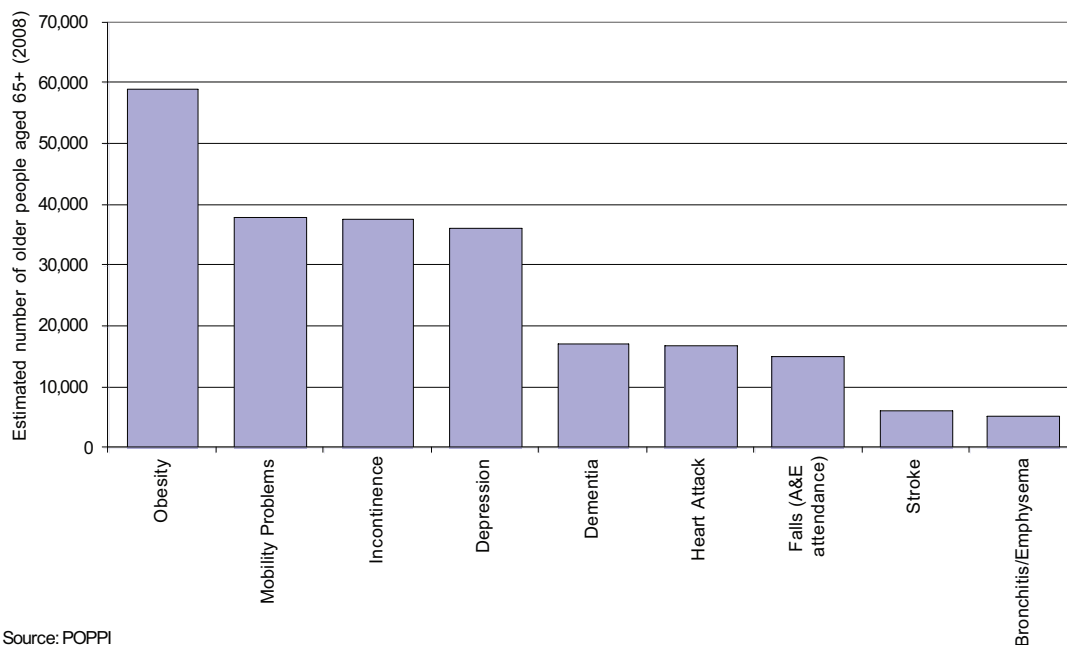
Currently around 17,300 people across Essex suffer from dementia and the figure is predicted to increase to 27,800 by 2025 requiring considerable service development and redesign.

**Partners have agreed to create an older adult mental health programme board to implement key commissioning work streams. This should be afforded high priority.**

## Long Term Conditions in Older People

The POPPI (Projecting Older People Population Information) system informs us of known numbers of people in Essex suffering from a variety of long term conditions

*Figure 1.11*  
**Estimated prevalence of long term conditions among older people (2008)**



## Obesity

Obesity affects 59,000 people in Essex and the number is set to increase. Obesity contributes to a range of health problems and can shorten the life expectancy by up to 9 years with increased heart disease and diabetes. It in turn can link to problems of mobility and continence.

**While LAA2 targets in line with national indicators focus on childhood obesity, partners need to increasingly develop services to address obesity in adults. This will include health walks, access to a range of exercise choices, subsidised if required, range of weight loss opportunities and full use of health trainers.**

## Cardiovascular Disease

Cardiovascular disease has been discussed earlier but the importance of continued efforts to reduce into older age should be emphasised. Evidence shows that treatment of high blood pressure is especially effective in older people in reducing risk of stroke and heart attacks. Older people should have their blood pressure checked and treated where appropriate. Statin drugs are also effective in people into their 80's. Stopping smoking will have a benefit even in later life and increasing exercise levels will in a very short time reduce the chances of having a heart attack.

**We must ensure older people can fully benefit from available effective interventions to reduce cardiovascular disease.**

## Falls

Falls remain a key preventable cause of death and disability. Across Essex A&E departments there are 15,100 annual attendances for people over 65 with falls of which 11,000 are in people over 75.

There has been much good joined up working between partners in developing falls services and introducing preventative measures in the community. These vary from modifications to houses to reviews of medications and exercise classes. **We must work together to ensure optimal access to evidence based interventions to reduce falls.**

Stroke and respiratory diseases have been discussed earlier.

## Care and Support for Older People

Figure 1.12

### ECC number 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              |
| <b>ECC</b>                  | <b>21,553</b> | <b>98.5</b>        |
| <b>Outside ECC</b>          | <b>1,247</b>  | -                  |
| <b>Total</b>                | <b>22,800</b> | <b>104.2</b>       |

The table above shows numbers and rates of service users known to the older persons team in Essex. The data as a rate per 1,000 65+ shows considerable variation across Essex. It is unclear why this variability exists and there may be merit in reviewing to ensure equitable access based on need.

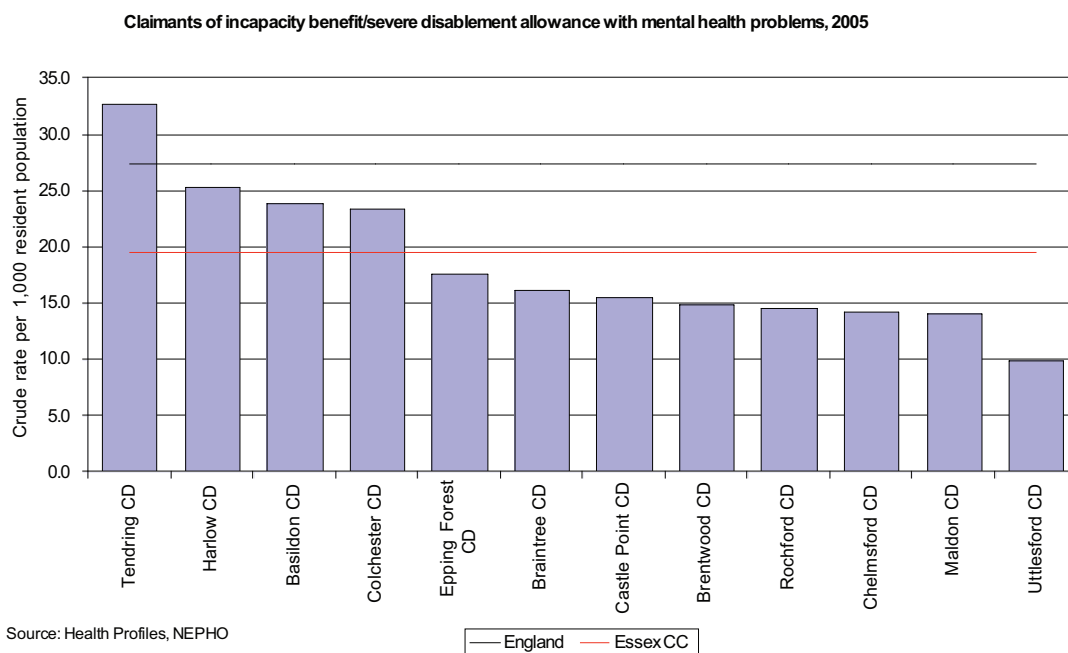
### Mental Health

At any time more than 1 in 6 people will be experiencing a mental health problem. There is a wide spectrum of such illness and many services have historically focused on the needs of people with severe enduring mental health problems. While these services remain essential there is increasing recognition of the needs of the large group of people with less severe but still often debilitating problems. JSNA shows about 12% of the Essex Population have a neurotic disorder and 8% of depression at any one time.

PCTs are urged to increasingly develop “Step Care” models enabling people with a wide spectrum of disease to be dealt with via self help, in partnership with our library services, through primary care including access to ‘Talking Therapies’ in primary care through to more specialist services.

40% of people claiming incapacity benefit do so because of mental health problems. It is also known that once on benefits the group is less able to return to work suffering further as a result of worklessness and associated financial hardship.

Figure 1.13  
**Essex claimants of disability benefit for mental health reasons, 2005**



The graph above shows rates of such claimants across Essex. It is very positive that Essex LAA2 has a specific target around getting these people back into work.

**Primary Care Stepped Care Models should include as part of any pathway, a clear focus on returning people to work. Consideration at Essex County Council should be given to performance reward grants supporting initiatives to get this group of people to return into employment.**

Depression is very common especially in older people where the diagnosis can be overlooked. It is the second most common underlying cause of GP consultations in people aged over 70 years, There may be as many as 36,000 people aged over 65 in Essex suffering from depression and the number is likely to rise to 53,000 by 2025. **It is important that where possible this condition can be recognised and appropriately treated.**

### People Living with Disabilities

The General Household Survey showed about 21% of the adult population have a disability. Such people are more likely to live in poverty (average income is less than half than that of non-disabled) often suffer more hate crime and harassment, endure problems with housing and transport and are less likely aged 19 to be in education, training or employment (27% of group with a disability v 10% non-disabled). About 15% of the working age population have a disability.

People with disabilities represent a substantial proportion of the population we serve.

We need to work to optimise opportunities for work and education to assist in their fulfilling their potential. Socio-economic deprivation impacts on risk of diseases such as heart disease and consideration should be given to interventions at lower assessed risk sources for this group. PCTs may wish to consider initiatives to help ensure this group have optimal access to such assessments.

### Learning Disabilities

ECC learning disabilities register contains a current list of care users. At July last year there were 4,500 people registered with a learning disability (4.4 per 1,000 population aged over 18+) Rates vary across Essex between and indeed within District and Borough Council areas.

Figure 1.14  
ECC Learning Disabilities Register

|                    | N            | Rate per 1,000 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                |
| <b>ECC</b>         | <b>4,091</b> | <b>4.0</b>         |
| <b>Outside ECC</b> | <b>409</b>   | <b>-</b>           |
| <b>Total</b>       | <b>4,500</b> | <b>4.4</b>         |

People with learning disabilities often have a low life expectancy, they suffer from a range of common diseases including a high incidence of heart diseases, it is also often difficult for this excluded group to optimally access services.

**Given this it is recommended PCTs consider working with primary care teams and specialist providers to ensure optimal access to services and assessment. The audit and subsequent work in Mid Essex PCT led by Equip and the Local Enhanced Service (LES) is in place in North East Essex PCT are commended as ways to improve access to services for this population.**

## Housing Related Support

”Supporting People” ensures housing related support to vulnerable people, to enable them to live independently in their homes through life skills training, assisting in dealing with land lords, assisting personal budgeting and support to more independent accommodation. JSNA outlines groups at priority one frail elderly, homeless people and young people leaving care.

## Older People

Maintaining independence depends on appropriate housing. 73% of older people in Essex live in owner occupied homes but often it’s hard to adapt their homes. Care and Repair Services, private sector renewal, disabled facilities grants and new homes to the Lifetime Homes Standard are important. As the population we serve ages we will see a dramatic rise in the need for housing related support.

## Chaotic Lifestyles

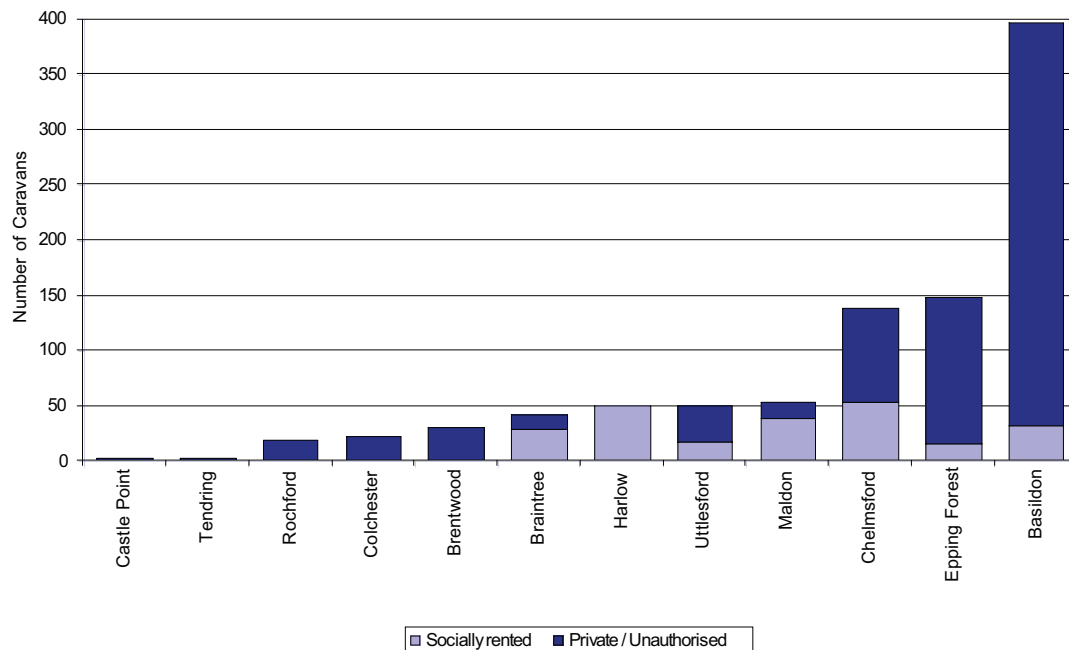
Supporting people are crucial to help this group maintain independence ‘Mental Health and Social Exclusion’ (SEV, 2004) found 1 in 4 tenants with mental health problems had serious rent arrears and NACRO estimate 25% of the offenders they work with have mental health problems.

## Traveller 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, 38% 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% of private caravans and over 50% of caravans on unauthorised sites, the vast majority of which are classed as ‘not tolerated’.

Figure 1.15  
**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.

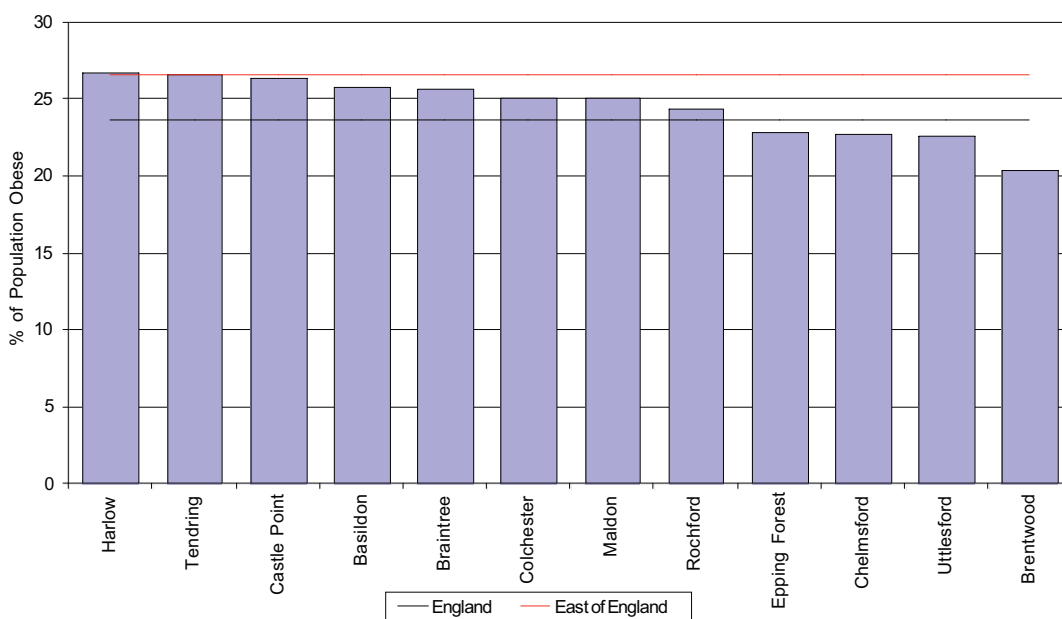
**Essex County Council need to continue to work with partners to ensure appropriate access to services from this high need, socially excluded group.**

**Obesity and Physical Activity**

Obesity has already been mentioned both in terms of children and older people. The trend in increasing obesity is due to:

- Increased food portion sizes
- Increased availability of fast, processed and fatty food
- Reduced physical activity, less walking
- Less physically demanding jobs

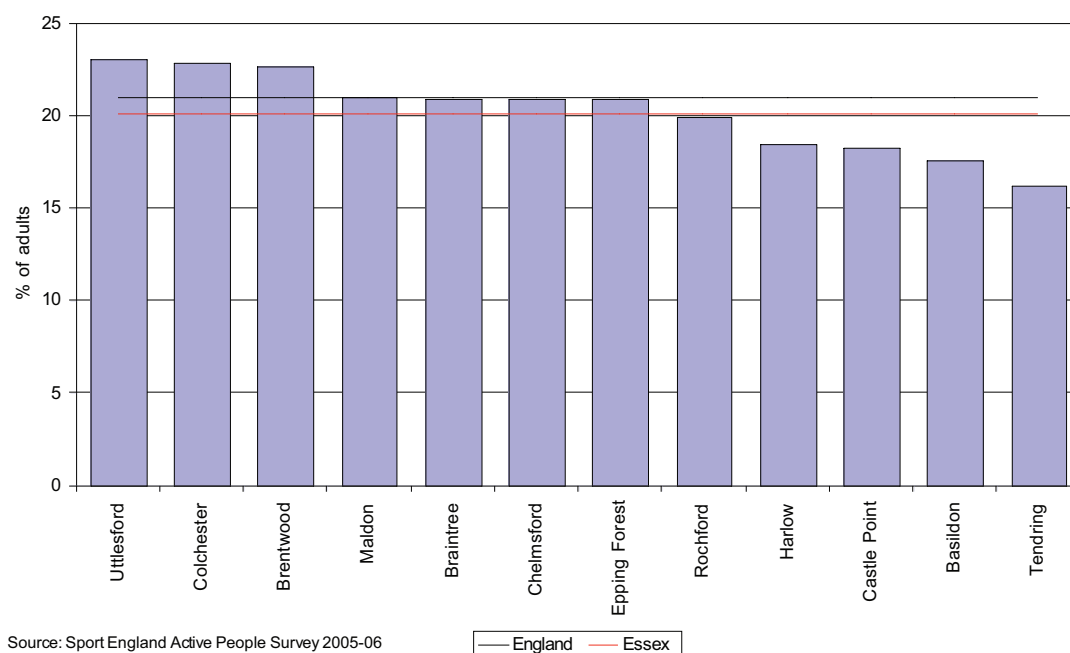
Figure 1.16  
Essex estimated prevalence of obesity, 2003–05



Source: The Information Centre for Health & Social Care, (The IC) via ONS, 20087

The graph above shows modelled structure of obesity for Essex. It can be seen that in a number of areas the obesity estimates exceed the national average reaching over 26% in the worst areas.

Figure 1.17

**Essex participation in 30mins moderate activity at least 3 days a week, 2005-06**

The table above shows Essex levels of participation in moderate activity. Most areas are worse than the England average. In Essex only 1 in 9 adults participate in physical activity on a regular basis. PCTs offer a range of weight reducing initiatives. County through library services have a range of courses to help people exercise and lose weight. There has been much work across Essex in improving access to outdoor walks and parks as well as support to cycling initiatives.

**As discussed before with an impact on life expectancy of up to 9 years, action is needed to identify and offer interventions to this population. Primary care teams need to develop better prevalence data for obesity and a range of services potentially driven by health trainers needs to be in place to address obesity and physical activity issues.**

**Essex County Council needs to continue to encourage exercise and healthy eating through library services, leisure opportunities and cycling initiatives.**

## Smoking

Smoking remains the major preventable cause of avoidable deaths in Essex. The area has already been discussed and the importance of a range of interventions is stressed. Opportunities to support people to quit are of key importance and the LAA2 target in this area is to be applauded. Stop smoking interventions do work and it is possible for anyone to stop smoking in 2006/7 Essex PCTs helped just under 11,000 people to stop smoking. **These services remain key to this endeavour. Additionally partnership working with schools, district and boroughs and trading standards are required to control tobacco. In Essex illegal tobacco sales fell from 21 to 12% in a year.**

**Partnership working led by the Essex Tobacco Alliance must continue to reduce consumption across Essex.**

## Chlamydia

Rates of Chlamydia infection are increasing in Essex. While this is in part due to better recognition of the disease, it is in part a very real increase. Chlamydia can cause infertility, pelvic pain and ectopic pregnancies. It however often produces no clear symptoms.

PCTs have a challenging target to hit in terms of screening people for Chlamydia. Hitting this target will be aided through joint work between partners to ensure services for screening are brought to places where young adults are likely to be including clubs, events, schools and colleges as well as through healthcare providers and in primary care teams.

**Essex County Council can play a role in helping secure access to some of these potential screening sites. Additionally we need to ensure looked after children and young people where appropriate have access to such screening.**

## Alcohol

Alcohol has a significant impact on health, crime and society. Heavy drinking causes cirrhosis, certain cancers, heart muscle damage and alcoholic dementia. It raises blood pressure increasing the risk of heart attack and stroke. Binge drinking affects physical and mental health in the long term and can lead to coma and even death.

Alcohol misuse is linked to crime particularly violent crime, assaults and anti social behaviour. It causes an increase in accidents. Alcohol is increasingly recognised as a key cause of disease responsible for 10% behind only smoking and blood pressure. LAA2 recognises this with a target related to reducing alcohol related admissions to hospital.

**Reducing alcohol misuse must be seen as an increasing priority over the next few years. Partners need to engage in a wide range of interventions including a focus on education within schools and for other young people as well as assessment of harm and offering of support and interventions to heavy drinkers in a primary care setting.**

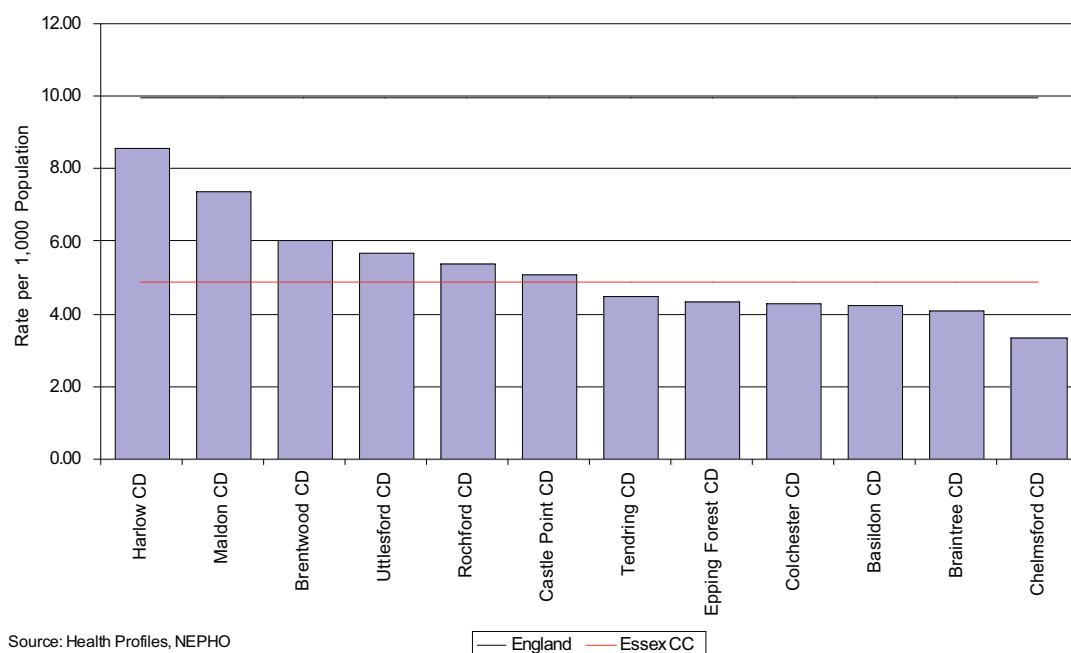
## Substance Misuse

Substance Misuse is a key health as well as social issue. As well as the possibility of physical and psychological dependency, heavy or long term use of some illegal drugs may cause permanent damage through overdose. Drug misusers can suffer from blood borne viruses (Hepatitis, HIV), injecting related injuries, poor diet, personal neglect and mental illness such as depression and paranoia. Social problems include acquisitive crime, prostitution, unemployment, family breakdown and homelessness.

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

Essex has been estimated to have a drugs misuse prevalence of 4.86 per 1000 population with highest rates in Harlow and Maldon.

Figure 1.18  
Essex estimated prevalence of drug misuse, 2004-05



**Agree need to continue to work together including voluntary sector groups, who can often best access this client group, to ensure an appropriate range of services to support this group. Additionally work must continue to prevent young people from starting to misuse drugs.**

### Road Safety

During 2006, 987 people were killed or seriously injured (KSI) on Essex roads. There has been a downward trend over recent years and this is an area of considerable success for partnership working locally.

Four target groups require particular attention – younger drivers (aged 17–25), motorcyclists, drink driving and speeding. These groups are over represented in the KSI data set.

These figures are decreasing but remain a high proportion of KSI due to high risk and poor driving behaviour. Young drivers are most likely to fail a breath test and 25% of young car driver crashes involve excessive speed. Motorcycle KSI’s remain high accounting for 26% of KSI in Essex in 2006 compared with 19% nationally.

### Drink Driving/Speeding

There has been a long term increase in drink drive KSI in Essex and they now account for 9% of the total. Speed related casualties vary and in 2006 was 16% of the total.

**This has been an area of considerable improvement in Essex through partnership working, this should continue with focus on areas with particular high risk.**

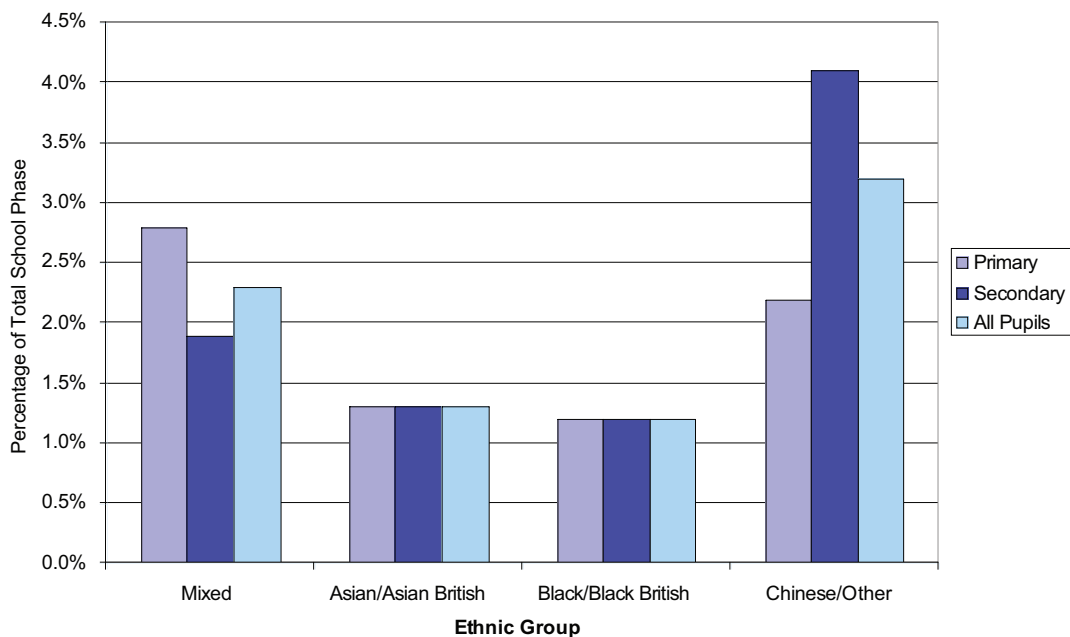
### Children and Young People

Information in this section is largely drawn from “Commissioning Needs Analysis and Initial Strategic Response” 2007/08 produced by the Schools, Children & Families Directorate. Developments with local services are happening fast and already much of the information has been surpassed.

It is recommended the Essex JSNA this year focuses particularly on the needs of the Children in the population we serve.

Around 24% of the 1.37million population of Essex are children and young people under age 19. While at the last census only 2.9% of the county’s population belonged to minority ethnic groups, ethnic diversity is increasing. In 2007 around 8% of pupils in both primary and secondary schools belonged to ethnic minority groups as shown below.

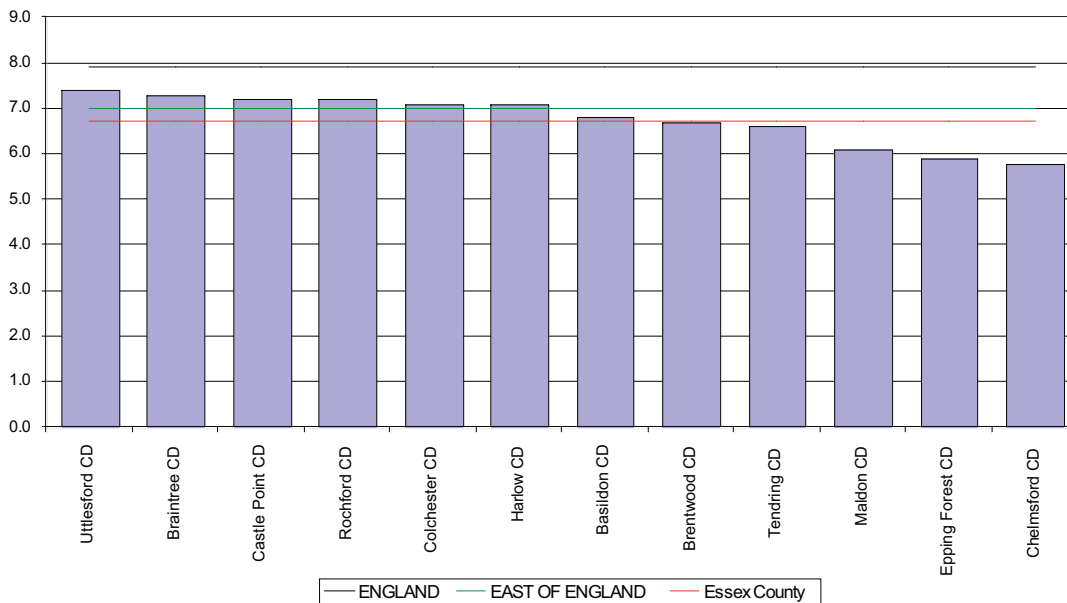
*Figure 1.19*  
**Percentage of young people within ethnic groups by phase of education (2007)**



### Being Healthy

Reflecting the relative affluence of Essex the rates of low birth weight babies is below national average as is the incidence of mothers smoking through pregnancy. Nonetheless levels are too high and concerted efforts to reduce smoking in pregnancy need to be continued. An LAA reward grant bid in this area has been developed.

Figure 1.20  
**Essex low birth weight births (<2500 grams), 2005**



Source: Compendium of Clinical & Health Outcomes Knowledge Base ([www.nchod.nhs.uk](http://www.nchod.nhs.uk))

Breast feeding initiation rates in the UK remain low compared to other countries and especially in low income groups.

Breast fed babies are five times less likely to be admitted to hospital with a range of common infections such as gastroenteritis, in the first year of life.

The Infant Feeding Survey (2005) found 77% of mothers in England initially breastfed their babies compared with 71% in 2000. In Essex the proportion initiating went from 67.7% in 2004-05 to 70.1% in 2006-07, below national averages. This is perhaps surprising given the relative affluence of the population we serve and needs to be addressed. Rates are highest in the north east of the county but are still well below national average.

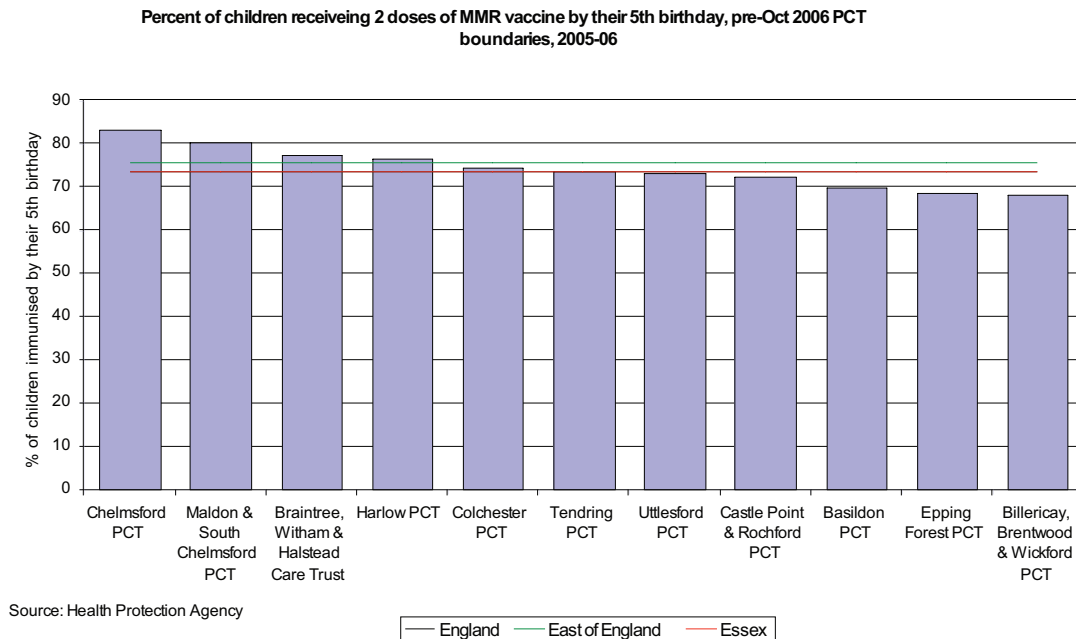
**Partners need to work together to improve breast feeding rates across Essex as a priority. Essex County Council should work to develop breast feeding friendly areas around public places for which it is responsible.**

### MMR Immunisation

Measles, mumps and rubella are all serious diseases that can be associated with major illness and serious complications. Unfortunately the MMR vaccine went through a period of bad press when it was incorrectly felt to be associated with autistic spectrum disorders. THIS HAS BEEN ABSOLUTELY DISPROVEN but rates remain suboptimal.

Figure 1.21

#### Essex MMR Immunisation, 2005–06



Across Essex, Harlow is the only area to have a vaccination rate higher than the England average but all areas are below the WHO recommended level of 95%. There is a national catch up campaign now underway to improve uptake of MMR.

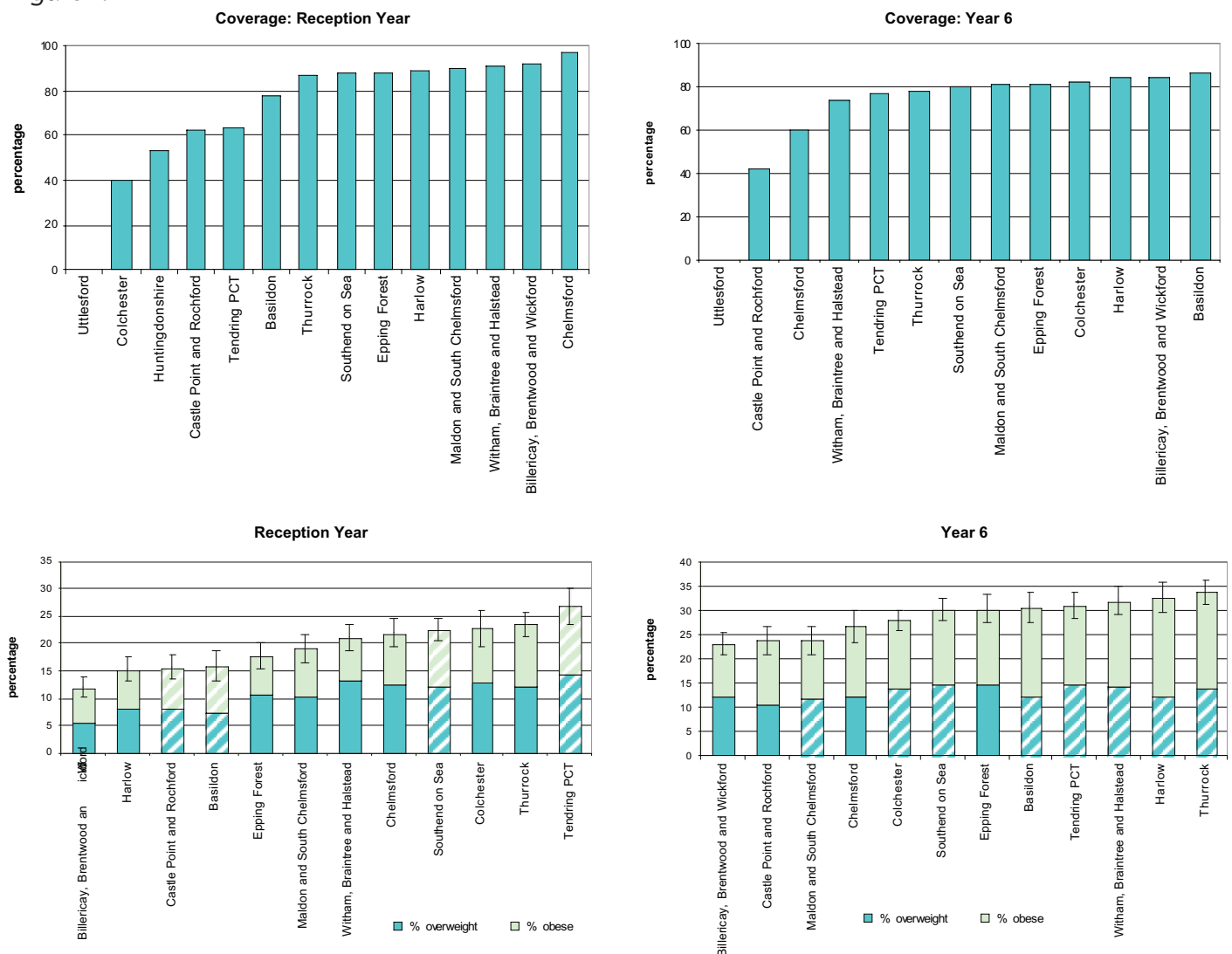
**MMR is safe and should be given; plans are underway for a national catch up campaign in this area which should be prioritised locally. Essex County Council are looking at how PCTs may be supported in this work with work driven by the area forum in the East of the County.**

## Childhood Obesity

Possibly the biggest threat to the future health of our children is the rise in obesity. Nationally, the proportion of children aged 2-10 years overweight or obese increased from 22.7% in 1995 to 27.7% in 2003 with the level of obesity going from 9.9% to 13.7%. It is possible that if this continues, the children within our population may live shorter lives than their parents. Childhood obesity is a key priority for County and partners and this is reflected in it being featured in LAA2.

Since 2005 PCTs have been working with schools to collect height and weight data to calculate obesity and overweight levels at reception year (age 4/5) and year 6 (age 10/11).

Figure 1.22



Figs 1.22 are based on the 1st year's data but illustrate the scale of the problem in Essex. Interventions should be aimed at both the population to change dietary and exercise habits as well as being targeted at specific identified obese and overweight children and families. The Essex Obesity Alliance has been restructured to help optimise best practice across the county.

**Key interventions will include the Healthy Schools Programme, improving breast feeding levels and introduction of evidence based focused interventions across Essex such as MEND and mini MEND. Essex County must continue to role out Fitbods programme for primary school children and work to improve access to sport and physical education in secondary schools and progress improvements around school meals. District Councils and Borough Councils need to work with PCTs and County to optimise exercise opportunities including access to free swimming.**

## Behaviour and Mental Health Issues

ONS (2000) estimate 10% of children aged 5-15 years have a mental health disorder, 5% have clinically significant conduct disorders, 4% emotional disorders (e.g. anxiety & depression) and 1% hyperactive. Less common disorders (autistic disorders, TICS and eating disorders) made up 1/2%.

Children with mental health disorders are more likely to be boys, live in low income families and in social sector housing. Half these children have seen separation of parents compared with 29% with no disorder. 15% v 5% has problems with the police and 6% v 3% experience of a parent or sibling dying.

The table below shows likely numbers with mental health problems across Essex County and was produced based on projections by the University of Essex.

Figure 1.23

### Essex prevalence of mental health difficulties among children & 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     |
| TOTAL                              | 19,210    |

Source: S Musgrave & L Cooper, CAMHS Needs Assessment, University of Essex, 2005

Despite the numbers estimated just over 1,580 children and young people were treated by CAMHS tier 2 or 3 services in Essex in 2006/07.

While this may suggest a mismatch in services, relative to statistical neighbours and nationally, hospital admissions in this group are low in Essex and local mental health trusts are generally prompt in responding to referrals and exceed national average referral times.

**Review of CAMHS services are ongoing to ensure appropriate targeted services at the right level across Essex.**

## Substance Misuse

The SHEU survey in 2008 shows 32% of secondary school pupils say they drink alcohol occasionally or regularly, although 17% said they have never drunk alcohol. 12% of year 7-8 boys said they drank regularly or occasionally rising to 5.7% of 11-13 year boys (profile is similar for girls).

Alcohol misuse is becoming an increasing problem nationally and across Essex. **County and PCTs should develop a clear strategy to address this issue including schools based and primary care based interventions in addition to specialist services.**

The SHEU study showed 69% of secondary school children said they had never smoked a cigarette however 19% of 15 year olds are regular smokers.

9% of 15 year olds in the SHEU 2008 said they had taken drugs in the last month (figure was 16% in the 2007 survey). Cannabis was the most popular drug followed by `poppers`. Within the last year 16% of year 11-13 pupils said they had taken cannabis.

Drug & Alcohol Action Team (DAAT) data shows that in the year ending March 2007, 153 young people were in Tier 3 structures counselling and 599 in Tier 2 one to one work. Hospital Episode Statistic (HES) data shows a relatively low hospital admission rate in people under 20 for substance misuse. The number was 231 from 2003-2006, 45% less than the benchmark group average of 426. The rate was below national and benchmark average for all 12 local districts.

## Emotional Well Being

The 2007 Ofsted survey TellUs2 asked children what worries them. Exams (52%) and schoolwork (39%) featured highly as well as friendships (44%).

The 2008 SHEU survey showed children at primary school worried about tests/SATs (44%), the environment (32%), family problems (3%) and their safety (29%).

“Supporting the Well Being of Children and Young People in Essex” (2007) stated 41% of primary and 27% of secondary school pupils felt afraid of going to school sometimes because of bullying.

**The County’s action on bullying including the appointment of a dedicated resource to tackle this issue is to be strongly applauded. Evaluation should define future impact.**

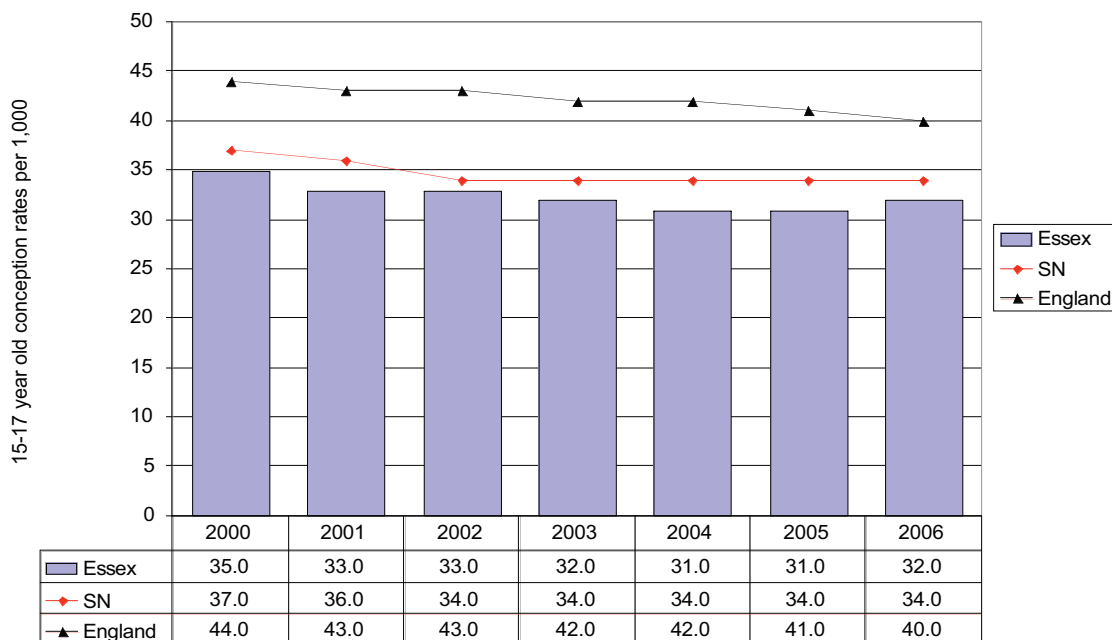
### Teenage Pregnancy

Levels of teenage pregnancy have declined from the 1998 benchmark figures. From 1998-2006 levels dropped 12.1% across Essex, to 32 per 1000 female population 15-17 compared with a national decline of 13.4% to 40 per 1000.

In 2006 54% of teenage pregnancies in Essex led to abortion against a national 50%.

The trend data for 1998-2006 suggests a slowing down in the overall rate of decline. In 2006, 453 young women in Essex faced abortion and 386 faced the challenges of parenthood. Within Essex, rates vary considerably related largely to socio economic factors. Rates are highest in Basildon and Harlow and lowest in Brentwood and Uttlesford.

Figure 1.24  
**Teenage Conceptions in Essex, 2000 - 2006**



Teenage pregnancy brings health risks for mothers and often poorer outcomes for children. Accordingly reducing teenage pregnancies is an LAA target.

Key work needs to be directed at reducing pregnancies through appropriate education and access to contraception including wide signposted availability of emergency hormonal contraception (“morning after pill”).

Additionally services need to focus on ensuring optimal opportunities in education and employment for teenage mothers. In North East Essex plans are in hand for midwives to refer these mothers directly to social care colleagues at an early stage of pregnancy. It is recommended this systematic practice may be of value more widely.

## Sexual Health

Young people are most likely to undertake unsafe sexual practices where intercourse is unexpected and/or carried out for the first time with a partner of less than a months duration.

Levels of sexually transmitted infections (STI's) have increased significantly over recent years. One key driver is the increase in levels of Chlamydia, a key cause of infertility, pelvic pain and ectopic pregnancies that is worryingly more common.

Chlamydia is problematic in that often it has no symptoms. It can however be treated and a screening programme is in place to try and ensure sexually active 15-24 year olds are tested and treated if necessary.

County and PCTs need to work together to optimise access to this screening young people.

**The SHA have recently produced a list of best practice and this should be implemented together with shorter term initiatives to improve the proportion of the population screened.**

### Initiatives could include:

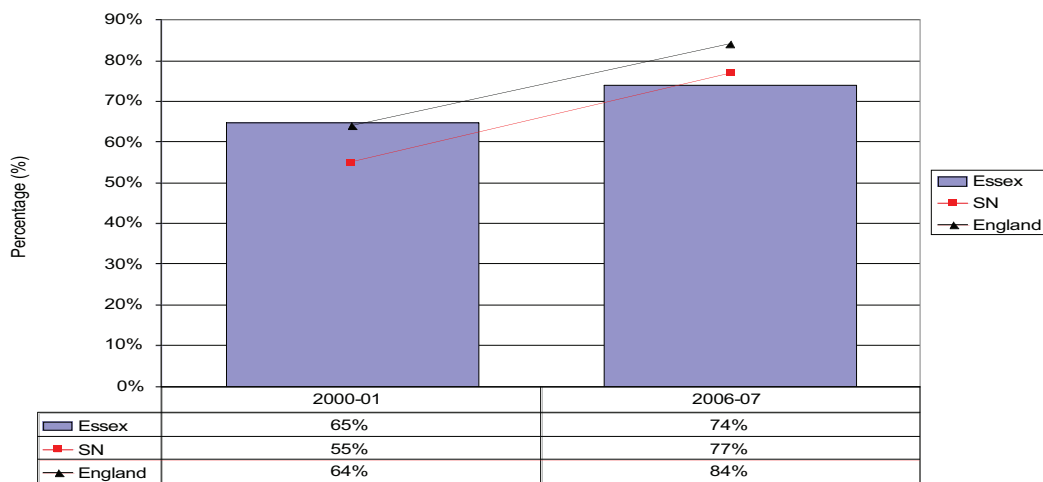
- **Ensuring all family planning clinic attendees are offered screening**
- **Developing primary care based initiatives perhaps using LES to increase coverage**
- **Work with schools, colleges and universities to provide opportunities for screening of these sites.**
- **Direct contact/ mailing of the older people target group (18-24)**

### Health of Looked after Children (LAC)

There is limited information about the health care needs of LAC in Essex. One indicator is the incidence of children looked after for at least 12 months who have had a dental check and annual health assessment. In 2000/01 Essex exceeded the performance of statistical neighbours and England. Since this time however, improvements in Essex have been less dramatic than elsewhere and levels are now lower than both statistical neighbours and England.

Figure 1.25

#### Annual Health Check of Looked After Children



The percentage that had an Annual Health Check rose in 2007/08 to 78% (74% in 2006/07).

Essex has a Health Strategy Group for Looked after Children that is working to tackle this issue.

**Actions could include incentivising children to attend for health checks and developing a Leaving and Aftercare Health Worker role (currently funded in some PCTs) to optimise appropriate engagement with this group.**

Data is available on the percentage of LAC misusing drugs and alcohol. This is around 3.5% compared to an England average of 5.4%. Of those identified, 36.7% received an intervention for substance misuse and 63.3% refused such support. Of 947 Looked after Children screened for drugs in 2006/07, 30 screened positive and of these only 11 accessed support. In Essex in 2006 data suggests 19% of care leavers were misusing drugs or alcohol but this figure may be unreliable.

## Environmental Safety

The number of children aged 0-15 years killed or seriously injured in road traffic accidents in Essex has declined from 1994-98 average of 145 deaths per year to 74 in 2006. However, there is no cause for complacency as this 49% decline was less than the England average fall of 51% over the same period of time.

## Crimes against Children and Young People

The Essex School Health Education Unit (SHEU) survey in 2008 found that 14% of secondary school pupils in Essex have been a crime victim in the last 12 months. 5% were attacked and 3% had a mobile phone stolen. Half of the crimes were at school and 78% by a perpetrator aged under 18. Essex Police recorded 11,299 offences in the County involving victims of crime aged 13-19 years from July 06 to June 08.

The impact of crime in children can be considerable in terms of mental health and emotional well being. Bullying is a particular concern and was discussed earlier. The TellUs2 study found 57% of children felt schools dealt well with bullying but 29% of children felt schools dealt with bullying “not very/not at all well” (England figure is 30%). More work is clearly required to address this key cause of poor emotional well being. This has been touched on earlier.

The British Medical Association (BMA) estimates 75-90% of incidents of domestic violence have children in the same or next room. Around 10% of under 16 year olds will have lived with domestic violence in the preceding year. Conservatively 30% of children in these circumstances are themselves physically abused by the perpetrator and also use violence against their mothers. Essex Police reported 3,498 cases from July 2006 – July 2007.

**Domestic violence is a key area of health need and it features in the LAA as a local target. Work to reduce this crime and to support victims is strongly endorsed as a key health improvement initiative.**

## Homelessness

A fifth of 16-24 year olds experience homelessness at some time. Odds are higher in frequent movers, those who have been in care or lived with a step parent at age 14, Black Caribbean and runaways under aged 16. Half have been Looked After. An audit by EST Connexions in 2007 suggested they get about 780 homelessness enquires from young people each year. Based on national data there are 2,300 young runaways in Essex each year. We need to consider how best we can meet the needs of this group.

## Enjoying and Achieving

Education has already been discussed as key to ensuring the future health of the population of children in Essex.

Pre-school education is important in ensuring the right start and evidence from studies such as the `Highscope` Project shows the value of such interventions in disadvantaged groups when the children become adults.

Ofsted judged pre-school education in the county as good. However, Essex Child Minders scored less highly than statistical neighbours and England with respect to quality of teaching and crèche provision could be improved with respect to enjoying and achieving and organisational criteria.

While educational attainment is key across Essex there are groups at high risk of social exclusion where particular focus may be appropriate.

While most Looked After Children have a school attendance similar to that of other children, there is a small but increasing group missing substantial periods of school. From 2002/03 to 2007/08 the % of children looked after by Essex for over 12 months missing at least 25 days of school rose from 6.7% to 17%. The rise is greater than statistical neighbours and much greater than the England average over this time (from 12% to 13%).

The % of children looked after with at least 1 GCSE/GVQ has risen from 43% to 61% from 2003/04 to 2006/07; a better performance than neighbours or England (48.6 – 55.1%). This is encouraging. In 2003 the Government set a target of 15% of these children would achieve 5 or more GCSE at A\* to C. The Essex average has fallen from 10.4 in 2005/06 to 5.1% in 2006/07 which is clearly of concern (although numbers are small). In England there has been an improvement (7.2 to 9.8%) as there has in statistical neighbours (8.2 – 10.6%). **Work in this area to improve grades is important in optimising life chances for this group.**

A second group of importance are children with learning difficulties and/or disabilities (LDD). Progress in this group is satisfactory or better in 98% of primary schools with 69% being good or better compared to 64% in similar authorities. In secondary schools, children and young people with LDD made satisfactory or better progress in 92% of schools and good or better progress in 56% compared to 62% in similar authorities.

Figure 1.25 shows the proportion of young offenders in contact with youth offending services in education, training and employment. This number is lower in Essex than statistical neighbours and England averages.

Figure 1.26

**Proportion of supervised juveniles in full time education, training and employment**

|              | Essex | England | SN    |
|--------------|-------|---------|-------|
| Jan–Mar 2007 | 68.4% | 69.0%   | 69.0% |
| Apr–Jun 2007 | 64.2% | 68.7%   | 66.3% |
| Jul–Sep 2007 | 65.7% | 70.7%   | 71.0% |
| Oct–Dec 2007 | 63.0% | 72.9%   | 71.6% |

Educational attainment is possibly the key challenge for all in Essex in ensuring a high standard of future health. This applies across the whole of the county. Additionally special focus is required on deprived geographical populations including action at a pre-school stage as well as a focus on vulnerable and potentially excluded groups.

**Making a Positive Contribution – Young Carers**

The particular needs and stresses of carers have been mentioned earlier along with the need to ensure support for the group. It is estimated that there are 5,000 young carers in Essex. National research suggests 100 young carers in Essex provide over 50 hours of care per week while 800 care for over 20 hours. Only 600 young carers are known to be supported by the Essex Young Carers Team.

In the 2008 SHEU survey 52% of boys and 57% of girls at secondary school said they helped care for relatives or friends with an illness or disability. 9% of boys and 12% of girls said they do this every day.

It is important that systems are in place to ensure identification and appropriate support to those young carers whose lives are often dominated by providing high levels of care to others.

**Achieving Economic Well Being – Families**

Data from 2003-2005 suggests 15% of Essex children aged 0-14 years are in families where no adult is working and where the family is dependant on benefits. As recession threatens, it is likely these numbers may increase. The statistical neighbour average is 13.6% and England is 20.5%. Health in adulthood as well as childhood is dependant on early life experience with adult health and longevity in part driven by the social class of the father.

Access to local childcare is an incentive to encourage parents of pre-school children to resume or seek work. Figures from 2005-2007 suggest a slight decline in the level of provision across Essex. (0.9% decrease against 2.1% statistical neighbour decrease and England 2.5% decrease).

However, within this there is a 28.8% increase in full day care, no change in out of school day care and a 9.4% decrease in sessional day care, 2.5% decrease in child minders and 13.3% decrease in crèche day care.

As of April 2008, Children’s Centres were available to 50,000 children aged 0-5 covering all of the 30% most deprived areas. All parents who want it can access a reasonable choice of Early Years provision. As discussed such pre-school support can not only allow the parent to work but can also provide a firm basis to ensuring optimal outcomes for the child in the future.

Out of school childcare has also been developed as part of extended schools strategy with 37% of schools achieving by April 2008.

### Education, training and NEET

As repeatedly stated, health relates to education, employment and social class with material deprivation being the key underlying determinant.

In 2006/07 90.9% of young people after year 11 continued in learning in Essex, this is higher than England average (87.2%) or statistical neighbours (88.7%). In 2007/08, 1,410 young people were involved in the Learning Agreement Pilot aimed at young people in employment without training. Development of such opportunities will be crucial to ensuring optimal future health of the population we serve.

Work related learning is delivered through the education business links consortium – Link – ED LTD with 17,500 young people in work experience placements each year, 24 schools involved in a work related leaving programme and 1,250 young people in a young enterprise initiative. Young people completing a work based apprenticeship has increased for the last 2 years (44.7% - 2005, 32.5% - 2006. The number is much higher than the statistical neighbour and England figures (although % increases lower in 2006/07).

For young people with LDD engaged in work places, Essex scores well with 16.1% of the total in 2006 (national 14.5%).

This is a key socially excluded group at high risk of poverty and early death through health problems. Effort in this area should continue as a priority.

Numbers of young people not in education, employment and training (NEET) are shown below. Although higher than statistical neighbours, the rate is dropping and for 2006/07 figures for 19 year olds in NEET were better than comparators (Essex - 6.5%, Statistical neighbours – 6.7%, England – 8.2%).

Figure 1.27

#### Percentage of young people aged 16-19 not in education, employment or training in 2006/07

|  | Essex | SN    | England |
|--|-------|-------|---------|
| % of 16–18 year olds NEET                              | 6.9%  | 6.1%  | 7.7%    |
| % of 19 year olds NEET                                 | 6.5%  | 6.7%  | 8.2%    |
| % of 16–18 year olds whose current activity is unknown | 6.6%  | 6.3%  | 6.9%    |
| % of 19 year olds whose current activity is unknown    | 28.7% | 27.8% | 23.7%   |

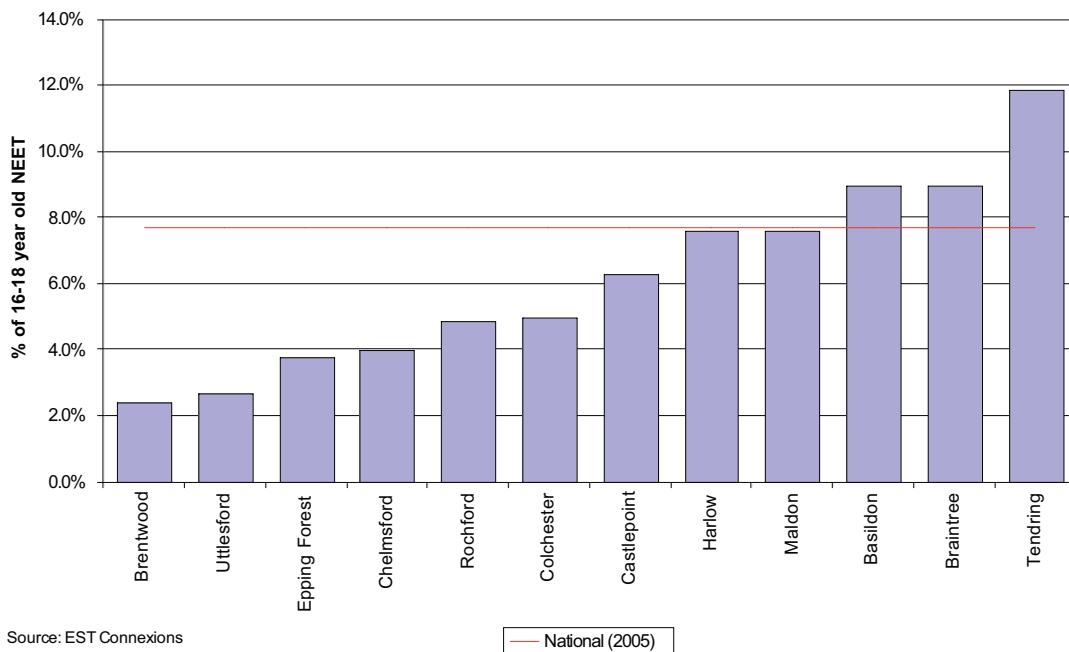
In 2006/07 the NEET group was 8,301 aged 16-18 years and 2,660 aged 19 years. A statistical modelling exercise using Essex data has shown risk factors for NEET at year 11:

- **Teenage parents are 28x more likely to be NEET**
- **YOT supervision are 3x more likely**
- **Less than 80% school attendance are 3x more likely**
- **Key stage 3 average level, for every higher level achieved, odds of learning NEET at year 11 fell**
- **Ethnicity – white 2x more likely than other ethnicity**
- **Social deprivation – highly deprived areas 12x more likely than most affluent.**

Connexions also publish data identifying those most vulnerable to NEET:-

Only 14.5% of 16–19 teenage mothers were in NEET in 2006/07, compared to 29.8% in neighbours and 30.3% in England. This is a matter of concern. As mentioned above action is in place in North East Essex to try and alert pregnant teenagers to appropriate services at an early stage via midwives to ensure all we know to and can access services. This should strongly be considered elsewhere. Reducing NEET is a key part of the first priority of Essex LAA2.

Figure 1.28  
**Essex NEETs, 2006-07**



The table above shows levels of NEET by District and Borough. It can be seen that the levels in Tendring, especially, but also Braintree and Basildon are above national average.

**Particular focus of initiatives in these areas may be appropriate.**