Essex Health and Wellbeing Board Intelligence Report

Health and Wellbeing Report for Essex 2016

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Produced by Organisational Intelligence

Essex County Council

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1. Executive summary

This Joint Strategic Needs Assessment (JSNA) looks at the health needs of people within Essex, in three main themes: starting and developing well; living and working well; and aging well. A large number of indicators were assessed for each of these themes and are summarised below.

1.1. Children and Young People

Starting and developing well means that all children have the best start in life. Children under 17 account for approximately one fifth of the population in Essex. Key priorities within these early years are set out in a joint Children and Young People's Plan and include the need for independence and joined up care for children with SEND, improved emotional well-being and mental health, self-care, positive choices and maintaining a healthy lifestyle and avoiding emergency and urgent care pathways. This plan is currently in development and is supported by commissioning and delivery models at CCG level.

Some of the worst areas (the most deprived one per cent of nearly 33,000 areas in England) are within Essex: six in Tendring and two in Basildon.The five wards with the highest prevalence of children in low-income families (2013) are: Golf Green Tendring (50%), Rush Green Tendring (48.6%), Pier Tendring (42.3%), St Andrew's Colchester (37.1%) and Alton Park Tendring (36.7%).

Essex has a significantly lower prevalence of excess weight in children aged both 4-5 and 10-11 when compared to the national average. . In 2013/14, the prevalence in Essex was 21.2%, (national average 22.5%) for 4-5 year olds. For 10-11 year olds it was 30.7% (33.5%).

Analysis by district for 10-11 year olds in 2013/14 shows that only Tendring, which has the highest prevalence in Essex, is greater than the national average. Its prevalence of 33.6% is unlikely to be significantly different to that of England (33.5%). For 4-5 year olds, both Braintree and Tendring have a greater prevalence than the national average but again these figures are unlikely to be significantly different.

Smoking is an addiction which most often starts in adolescence and the uptake of smoking in the teenage years is a major public health problem. Prevalence of smoking in school pupils has most recently been measured by the What about Youth (WAY) survey (2014/15), which showed that Essex had a significantly greater prevalence of current (10.5%) and occasional smokers (4.5%) at age 15 than the national average (8.2% and 2.7%).

Alcohol misuse is a major cause of harm in the UK, including in school-aged children, although it is difficult to measure. The percentage of secondary school pupils in Essex who said they drink regularly was 3.1% in 2014. The percentage who said they had been drunk at least once in the last month was 10.9%. As no national average exists it is difficult to say what significance this has, if any; though in 2009 18 percent of school pupils in Essex said they drink compared to 15 percent nationally. Alcohol-specific hospital admissions in under 18s are found to be very low in Essex.

Overall, the average rate of teenage conception in Essex is consistently lower than the national average. In 2013 in Essex, there were 22.3 conceptions in under 18s per 1,000 females aged 15-17. The national average was 24.3.

In general, Essex has greater vaccination coverage for MMR vaccine than the national average. The most recent data, for the year of 2013/14, shows 93.9% of children in Essex have had 1 dose of the vaccine by age 2 (national average is 92.7%) and 90.5% have had both doses by age 5 (88.3%).

Essex is currently ranked in the second quartile nationally for children achieving a good level of development in the early years. Performance in 2015 was 67.7%, and the threshold for the top quartile was

68.6%. All districts have improved over the last two years, with Braintree and Castle Point consistently below county average, indicating an association with material deprivation.

Educational attainment is a powerful predictor of well-being. Young adults who have completed higher levels of education are more likely to achieve economic success than those who have not. Essex is currently ranked in the second quartile nationally for GCSE attainment. At 67.0% Essex is above regional, statistical neighbour and national averages for the first time (the threshold to the top of the quartile is 70.3%).

NEET levels have been consistently falling in Essex, however Basildon, Harlow and Tendring have consistently had levels of NEETS above national average.

The majority of the districts in Essex are in line with or above the national average percentage of Primary schools graded as good or outstanding by Ofsted. Brentwood, Uttlesford and Basildon have a higher percentage of Primary schools graded as good or outstanding in comparison to the national average. Tendring, Harlow, Maldon and Rochford all have a lower percentage of Primary schools graded as good or outstanding in comparison to the national average.

The majority of Secondary schools across the twelve districts in Essex are performing in line with or above the national average percentage of Secondary schools graded as good or outstanding by Ofsted. Despite having 100% of their Secondary schools graded as good or outstanding, Harlow, Maldon and Rochford Primary schools are all below the national average for Primary schools.

Tendring, Harlow and Basildon are in the top quartile in Essex for safeguarding needs, though this varies when looking on a ward basis. District level analysis shows emerging areas of safeguarding need are Braintree, Chelmsford and Colchester. Domestic abuse and mental health are the most prominent assessment factors across the wards identified in the top 10%.

Domestic Abuse is a contributor to causes of ill health and poor wellbeing in local communities. As well as the personal cost, domestic abuse imposes a considerable financial burden on local healthcare systems. Significant health inequalities are experienced by people who are at risk of causing violence, at risk of experiencing violence, and victims of violence. Exposure to violence as a child has particularly negative impacts, not only increasing the risks of involvement in future violence but of substance abuse, poor mental health and chronic illness in later life. In 2013/14 the rate of Domestic abuse in Essex was 20 per 1,000 compared to the regional average of 16.7 per 1,000.

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. Research demonstrates consistently high levels of complex developmental issues and unmet emotional and other mental health needs among children in the youth justice system. In Essex the latest measurement year 2014 had 464 per 100,000 first time entrants to the youth justice system, this is significantly worse than the regional average of 395 per 100,000.

The rate of Violent Crime In Essex (2014) was 10.4 (per 1,000 population). This is higher than the East of England average (9.6) but still lower that the England average figure (11.1) Essex is ranked 6th in the region for violent crime offences, with Southend of Sea recording the highest rate (15.4).

Essex has lower levels of CP plans and monthly referrals in comparison to National figures and statistical neighbours.

1.2. Working Age Adults

Excess weight (a category that includes the overweight and obese) can lead to medical, psychological and social ill health. It is a leading cause of increased morbidity and mortality. The proportion of Essex adults who have excess weight is 66.5%. This is significantly higher than either the English or Regional average (64.6% and 65.6% respectively). Within Essex, there is significant variation and inequality. The proportion carrying excess weight varies from Uttlesford (62.2%, in the second quintile nationally) to Castle point (70.8%, in the fifth quintile).

Essex in 2014, 57.9% of people had the recommended amount of physical activity. This is similar to the English (56.0%) and regional (57.8%) averages, and has been stable over the last three years. There is significant variation by district, with a range of 12% between Colchester (63.8%, in the highest quintile nationally) and Castle point (51.8%, in the lowest quintile nationally).

In 2014, Essex's smoking prevalence was 18.0%, similar to English (18.0%) and regional (17.9%) averages. However, smoking prevalence in Essex has remained static over the last five years, whilst the rates in the region and the nation have seen a slow decline over the same period.By district, smoking varies from 6.6% (Uttlesford, with the 3rd lowest prevalence in England) to 26.9% (Castle point, with the 5th highest prevalence in England.)

Cardiovascular disease is the leading cause of death in the developed world, and much of its risk can be attributed to lifestyle factors (exercise, diet, smoking, alcohol). In 2012-2013, Essex had an under 75 mortality rate of 64.2 per 100 000. This compares favourably with the national average (75.7), and the region (67.4).

Cancer is a leading cause of death generally, and is the leading cause of premature mortality in the child and working age population. After a steady decline in mortality from 2001-2014, Essex now has a significantly higher under 75 mortality rate than the region. There is a similar (but milder) trend for *preventable* early cancer deaths. There is not a neat account when disaggregated by gender: although in the most recent data the above-average mortality was driven by men, it was previously driven by women.

Mental health is a major cause of morbidity in the working age population, and rehabilitating people who have had (or are having) severe mental health issues is challenging. Employment is also known to be a protective factor in terms of long term health. The gap in employment rate for those in contact with secondary care services and the overall employment rate in Essex was 68.8% in 2013/2014 (from 6.4% of those with contact with secondary mental services to 75.2% in the general population). This is dramatic, but similar to national (66.1%) and regional (69.2%) figures.

Stable and appropriate accommodation is an important factor in the illness trajectory of those with mental health issues. Essex has 49.2% of adults with input from secondary mental health services living in stable and appropriate accommodation, worse than national (59.7%) and regional (56.0%) averages.

The suicide rate in Essex has been generally climbing from 2007 to 2014, in the opposite direction to a mild reduction in the region and nationally. The most recent figure of 9.1 per 100 000 is worse than the regional (8.1) and national (8.9) averages. When analysed by gender, this has been mainly driven by increasing rates of suicide among females (5.2 per 100 000, in 2014 higher than regional and national figures of 3.8 and 4.0 respectively).

1.3. Older People

In an ageing population there will be an impact on Dementia prevalence and thus a considerable effect on the volume of people requiring Dementia services. NICE guidelines state that Diagnosis is an important factor in supporting people to live well with Dementia

Essex CCGs achieved a 52.4% diagnosis rate but there is a large variation in diagnosis rates by CCG area (61.1%West, 44.9% North East). Essex is just below the national average (59.17%) for registered population with Dementia

In an ageing population, a major cause of both morbidity and mortality is a fractured neck of femur (hip fracture). Rates of hip fractures in Essex have been persistently higher than the national average in the over 80 population (the commonest age for hip fracture to occur), and significantly higher in all over 65s since 2012. There is disparity across Essex, with Braintree, Chelmsford, Tendring and Uttlesford having the greatest number of hip fractures in the 65+ population, all significantly greater than the national average.

Reported health status allows us to assess whether health-related quality of life is changing over time

The average health status score (health related quality of life) for Essex adults aged 65 and older was higher than the national average of but lower than the East of England average.

Health related quality of life trends show that all districts in Essex are either better or similar to the national average and scores have remained similar between 2011- 2014. However, there is a variation amongst districts in Essex and at CCG level for those with long term conditions

Reablement outcomes data shows that the percentage of people still at home 91 days after reablement for Essex is 81.9% which less than that of the region and England average but in line with similar local authorities. Compared with data for 2013-2014, there has been little change.

41.3% of adult social care users in Essex last year reported they have as much social contact as they would like. This is lower than the national average of 44.8%.

Overall, there has been a decline in excess winter deaths. However, there are variations by gender with the rate for males being greater than females. There are also notable variations across the districts in Essex.

Overall, there has been a decline in hospital deaths in Essex to a percentage lower than the national average and an increase in deaths at home. This is reflected in those aged 65+

The percentage of hospital deaths in those aged 85+ for the districts in Essex are similar or lower compared to national and regional figures with the exception of Basildon that has higher rates.

There is variation amongst the districts in Essex for the percentage of care home deaths in those aged 85+. Interestingly Basildon has lower rates of care home deaths where it has high rates of death in hospital. Colchester has a higher rate of care home deaths, whereas districts such as Chelmsford and Harlow have lower rates.

74.9% of bereaved carers views on the quality of care in the last 3 months of life score outstanding, excellent or good, nationally (2015).

1.4. Challenge for Partners

Across many measures, Essex is a high performer, comparing favourably with national or regional figures. However, there are some areas of need: in some cases Essex performs poorly; in others, performance is deteriorating; in others, good performance across the region conceals considerable inequalities within Essex. All demand action.

This report has prioritized areas of greatest unmet need, listed below:

Starting and Developing well	Living and Working well	Aging well
Safeguarding children	Domestic abuse	Hip fractures
Childhood obesity	Violent Crime	Dementia diagnosis
Childhood smoking	Overweight and obesity	
First time entrants to youth justice system	Early cancer deaths	
	Mental health support	
	Suicide	

In this report, these areas of need have had further analysis (section7), and some provisional recommendations have been made. In some cases, further research products by Organisational Intelligence would likely have value: these are listed later in this section.

Across nearly all areas of concern the importance of consultation with relevant stakeholders is noted: they can provide 'on the ground' and local insight as to what factors may be contributing to these areas of unmet need, as well as further recommendations for intervention. Emerging challenges for partners are:

Safeguarding children

Investing in safeguarding, the welfare of children and young people is a core statutory responsibility, but also a building block on which children and young people can thrive and develop, free from harm. Essex has experienced an increase in the number of children subject to child protection programme compared with the previous year yet it holds significantly fewer children per head of population on child protection plans than either England as a whole, our statistical neighbour authorities and Eastern region authorities

The key to effective safeguarding of children and young people is for safeguarding to be seen as 'everyone's business', but also for all statutory agencies in Essex that work with children to comply with their responsibilities under Section 11 of the Children Act 2004, and the 'Working Together to Safeguard Children' national guidance. The Essex Safeguarding Children Board has an important role in challenging and supporting partner agencies, and in auditing their compliance with safeguarding standards including Senior level commitment, Governance, Policies and Procedures, Safe Recruitment, Training and Inter-Agency Working. Multi-agency safeguarding training and learning opportunities, multi-agency case audits, and learning from Serious Case Reviews all contribute to identifying best practice.

Childhood Obesity

There is a noted inequality for childhood obesity in the district of Tendring, which has the highest prevalence in Essex and is greater than the national average. In addition or 4-5 year olds, both Braintree and Tendring have a greater prevalence than the national average but again these figures are unlikely to be significantly different.

Influence environmental and behavioural drivers of childhood obesity through programmes led by agencies such as Sport England and Active Essex, ensuring engagement particularly in the Tendring and Braintree district.

Anti-smoking campaigns targeted at adolescents:

The impact of adolescent smoking is significant across England. It has been recognised that if smoking does not start in childhood/adolescence, it is unlikely ever to occur therefore intervening early on provides the best chance of preventing uptake.

There are a number of Cochrane Reviews which address the effectiveness of different interventions. They show that family interventions and school-based interventions which are based on social competence, with or without social influence, are the only recognised interventions that significantly reduce the numbers of adolescents starting smoking. Adding family intervention to school-based intervention can significantly improve outcomes from school-based intervention alone.

Further investigate areas with high prevalence such as Harlow and Castle-point. Consider evidence-based family interventions to target smoking in families. Utilisation of the new Lifestyle service integrated service via Risk Avert programmes for example (developed by ECC/Training Effect) which works in schools across the county to identify and engage with young people who are vulnerable to multiple risk taking.

Invest in preventing first time entrants to the criminal justice system:

Although the rate of first time entrants to the criminal justice system has reduced in Essex, it has consistently been worse than the regional and national average. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. Evidence of what works includes:

- A ‘centre of excellence approach’ in youth justice which supports innovation by using and interpreting available evidence to support the delivery of youth justice services in custody and the community.
- Developing and championing a child-centred and distinct youth justice system, in which a designated youth justice service keeps children and young people safe and addresses the age-specific needs of the child, to the benefit of the community

Address domestic abuse

Targeted interventions (particularly in childhood) and monitor the reporting of domestic incidents to ensure reporting increases and awareness of the issue increases:

National and local research has indicated that victims of domestic abuse need services which will support them to recover from abuse and to live independently in the community. The problem of Domestic Abuse cannot be solved by one agency alone and partners must work together to raise awareness of the issue and agree an approach to tackling it. Successful interventions include:

- A Joint Partnership approach
- Independent Domestic Violence Advocate (IDVA) service for high risk victims.
- Perpetrator Programmes
- Refuge Accommodation
- Risk Avert and other education based preventative programmes

Work to prevent violent crime:

Preventing violence must be seen as a priority for public health, health care and multi-sectoral working in England. Violence is a major cause of ill health and poor wellbeing as well as a drain on health services and the wider economy. Evidence of what works include:

- Developing life skills in children and young people
- Drug and alcohol interventions
- Community interventions
- Interventions that challenge social norms aim to prevent violence by making it less socially acceptable
- Programmes that identify victims of violence and provide effective care and support are critical for protecting the health and wellbeing of victims and breaking cycles of violence

Invest in prevention of overweight/obese adults:

In Essex, two-thirds (66.5%) of adults are either overweight or obese. This is significantly greater than the UK and national averages, and continues to grow. Successful initiatives include the following themes:

- To promote children's health
- Promoting healthy food
- Building physical activity into our lives
- Creating incentives for better health
- Personalized advice and support

Early Identification of Cancer and well performing treatment pathways:

Cancer is one of the leading causes of death and the leading cause of lost years of life in the UK. Thus the public health impact of poor or lagging cancer survival is obvious. Variation within Europe, variation within the UK, and reduction in cancer mortality over time in various areas all suggest cancer mortality can be reduced.

Essex does better than the region for cervical or breast cancer screening coverage. However, it does worse for bowel cancer and cancers diagnosed at an early stage. Partners should work together to identify issues and solutions in cancer screening/identification and treatment pathways

Although effects will not be observed immediately, Essex's performance should provide further impetus for modifying environmental factors (particularly smoking and excess weight) in the population

Support mental health and wellbeing:

Mental health issues are prevalent, and a leading cause of morbidity in the population. Essex's performance in terms of employment and housing of those in contact with secondary care services for mental health is numerically worse than the region and the nation, and has deteriorated over the last two years

Five key areas found to ensure good accommodation for those with mental health problems: Quality, Co-production, Staff recruitment and training, Policy informed practice, and Resourced, appropriate accommodation.

The large adverse movement of these indicators over a short time period suggests an acute deterioration in mental health services, rather than changes in wider determinants of mental health. As such, the recommendations are broadly targeted at trying to identify any source of this hypothesized deterioration

- We suggest a review by relevant commissioners to see whether any commissioning decisions in the last two years could have had an adverse impact on mental health service provision
- To consult relevant providers to see if they have noticed deterioration in performance, and if so, any causes they identify.

Suicide Prevention

Suicide in Essex increased from 2007 to 2014, while the regional and national trend was a small decline, and suicide in Essex is now above the regional and national average. Essex was one of four local areas in the East of England selected as pathfinders in 2013 for new approaches to suicide prevention, and has recently begun work to undertake a suicide audit and develop a new suicide prevention strategy. Further recommendations include:

- To consult with stakeholders to gather intelligence as to what factors may explain why Essex fares worse than expected in terms of female suicide.
- To contemplate any association between this indicator and indices of mental health support

Partners may wish to consider a large WHO evidence synthesis that suggested the following areas were promising (but with many caveats) given the current evidence base: school-based programs teaching emotional resilience and coping strategies; restricting supply of means to commit suicide (e.g. firearms, certain drugs); and multifaceted programs utilizing risk stratification

Hip fractures

There is a persistently high rate of hip fracture in Essex among over 65s, and particularly over 80s. Currently the explanation for this is not entirely clear. Partners should engage in further investigative work:

- Research need for relationship between falls prevention and hip fracture rates.
- Review of relationship between falls and hip fractures in Essex.
- Investigation of diagnosis rates of osteoporosis in Essex and what true prevalence is likely to be.
- Reasons for variation within regions, focus on reasons for better performance in Basildon and Brentwood.

With the responsibility for commissioning fall services transferring from ECC to CCGs, it is important that service specifications and pathways are developed jointly.

Dementia Diagnosis and Risk Reduction

Nationally there is an issue of under recording Dementia prevalence. Essex GPs experience the same problem. Only 7 of the 206 Essex GP Practices do not have a recorded prevalence significantly below the expected level based upon demographics of the area.

Most GP practices in Essex have a recorded prevalence significantly below the expected level based upon the demographics of the area. As a key contact point for the cohort of undiagnosed dementia, collaborative working across partners to identify those individuals is essential

Increased partnership working with Public Health could support improved overall health goals and thereby potentially lower the risk of dementia.

1.5. Recommended Further Deep Dive Analysis

Suicide: Perform an audit of recent suicides in Essex. Greater analysis could be done around the suicide figures for Essex. Essex's relatively poor performance in the region is attributable to the *female* suicide rate. In men, the rate tracks the regional average closely.

Safeguarding:

- Predictive analysis into domestic abuse affecting children- A predictive analysis exploring the indicating factors related to domestic abuse to help early identification of children at risk
- Evaluation of the suicide prevention toolkit issued to schools to understand how effective the toolkit has been to schools.

Domestic Abuse:

- More research into the needs of over 65's when victims of domestic abuse.
- Research to provide more evidence around interventions and prevention of domestic abuse especially for younger people

First time Juvenile entrants into criminal justice: Further analysis of smaller area statistics samples.

Violent crime: Report giving an update on local intelligence when small area statistics samples come online.

Early Cancer Deaths: A focussed JSNA on cancer: is the reason for worse performance later diagnosis, less effective treatment, or something else?

Smoking: There is little evidence that smoking cessation is effective in younger age groups, and evidence on smoking prevention strategies is limited. Further analysis would be useful on this topic; especially as targeting the problem as early as possible is important to tackle smoking prevalence in adults. In particular:

- Further investigate areas with high prevalence such as Harlow and Castle-point
- Consider evidence-based family interventions to target smoking in families

Obesity: Further research on what behavioural interventions have a proven track record of success in improving obesity

Hip fractures:

- Review of the literature on the efficacy of falls prevention in reducing hip fracture
- Local investigations into falls prevention and osteoporosis in Essex.

2. Background

2.1. Report context

The Essex Health and Wellbeing Board requested a Joint Strategic Needs Assessment report to support the ongoing implementation and annual update of the Health and Wellbeing Strategy. The requirement for the products was to provide intelligence on the three priority areas of the Strategy:

- Starting and developing well: ensuring every child in Essex has the best start in life.
- Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life.
- Ageing well: ensuring that older people remain as independent for as long as possible.

Whilst also incorporating the five cross cutting themes of:

- Tackling health inequalities and the wider determinates of health and wellbeing
- Transforming services: developing the health and social care system
- Empowering local communities and community assets
- Prevention and effective intervention
- Safeguarding

The latest refresh of the strategy was presented at the Health and Wellbeing Board held on the 31st March 2015 - http://tinyurl.com/p7zqbup

This report provides a body of intelligence to help the Health and Wellbeing Board to prioritise areas for the refreshed strategy to focus the Boards collective energy on.

The Joint Health and Wellbeing Strategy Vision is:

> *"By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the* ***inequalities within and between our communities will have reduced****. Every child and adult will be given more opportunities to enjoy better health and wellbeing."*

As a core element of the Strategy's vision is on inequalities, the report has a focus on identifying any inequitable variation in outcomes between the communities living and working in Essex.

2.2. Report layout

2.2.1. Structure

The report is divided in to three sections based around the broad age bands of; children & young people, working age adults and older people.

Each of the three areas is laid out with:

- National and local policy context
    - Recent changes to any of the priority area's influencers
- Areas for focus for the life of the Joint Health and Wellbeing Strategy
    - For each of the three priorities, topic areas were identified which would be of focussed effort for the 5 years of the strategy.
    - Each of the key performance indicators for the areas of focus will be analysed by:
        - trends,
        - current performance against benchmarks,
        - the inequalities within Essex
- Areas for focus each year
    - The strategy is reviewed and refreshed on an annual cycle to ensure relevance. Within each refresh areas of focus are identified for particular effort that year.
    - Performance of these will be analysed where they differ from the indicators above.
- Cross cutting themes
    - Where the 'areas for focus' indicators do not sufficiently cover and provide intelligence on any of the five cross cutting themes, key measures will be included to provide information on them.
- Two page overview on 2 to 4 identified indicators where:
    - Essex or the internal inequalities is not improving fast enough, not improving at all or getting worse
    - The overview will explore further intelligence around the indicator to give a fuller picture of the issues
- Recommendations for JSNA Deep Dive/Specialist Topic Reports on the worst performing indicators
    - Prioritised list

3. Starting and Developing Well: ensuring every child in Essex has the best start in life

3.1. National and local policy context

3.1.1. Essex context

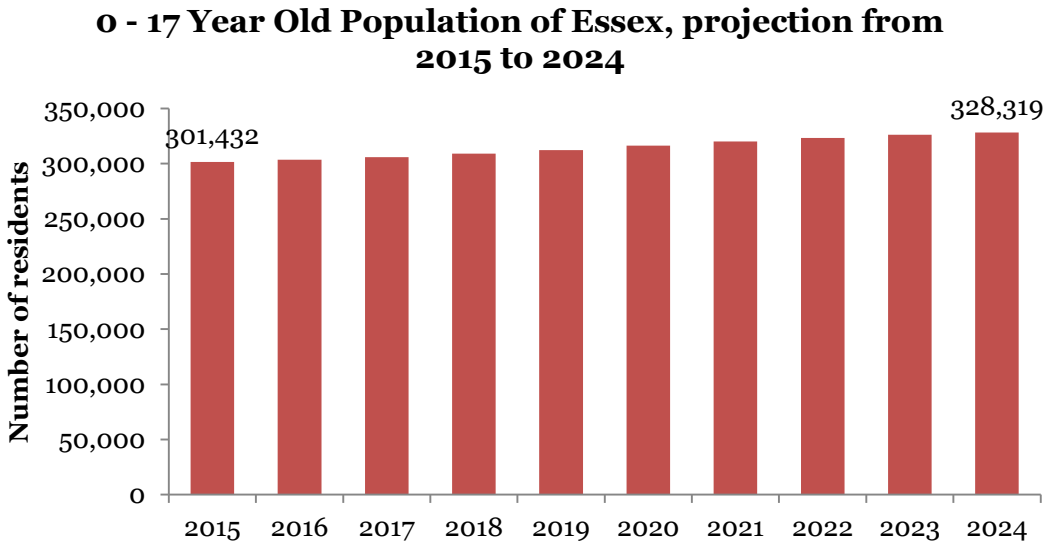


Figure 1 The projected population of 0 to 17 year olds in Essex, 2015 to 2014

In 2015, the population of 0 to 17 year olds is estimated to be c301,000, accounting for one fifth of the total Essex population [1].

The population of 0 to 17 year olds is estimated to grow by c27,000 (or 8.9%) to over 328,000 by 2024 [1].

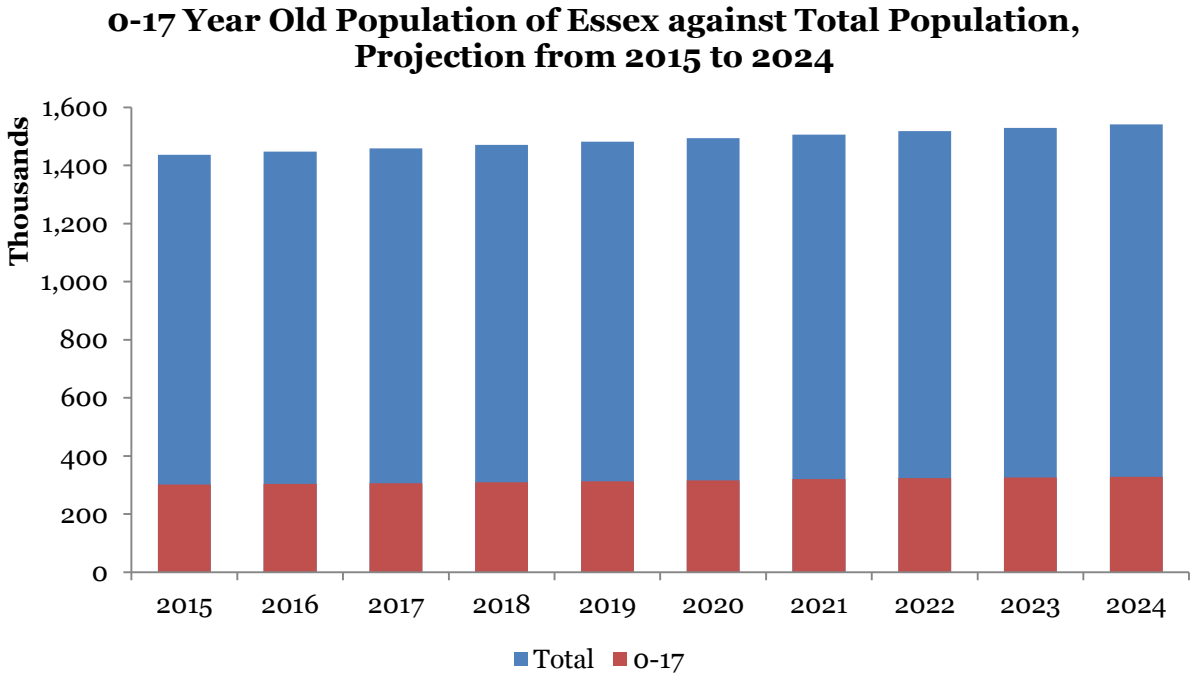


Figure 2 The population of 0 to 17 year olds in Essex compared to the total population

3.1.2. National context

The 2015 JHWS refresh identified the development of a 'definitive shared vision for children between NHS and social care' as a priority. A joint Children and Young People's Plan is in development supported by commissioning and delivery models at CCG level. Key themes include independence and joined up care for children with SEND, improved emotional well-being and mental health, self care, positive choices and maintaining a healthy lifestyle and avoiding emergency and urgent care pathways.

Families with complex needs. The second phase of the Troubled Families initiative was rolled out from April 2015. Local authorities signed up to commitments including to achieve significant and sustained progress with an agreed total number of families over a 5 year period from 2015/16. In Essex, this work is being developed through the Family Solutions programme.

Early years. Commissioning responsibilities for 0-5 year olds (the Healthy Child Programme) transferred from NHS England to Local Authorities from 1 October 2015, which completes the public health transfer under the Health and Social Care Act 2012. This means local authorities are now responsible for commissioning health visitors and family nurses. This provides an opportunity to join up commissioning for 0-19 years (and up to 25 years for children with Special Educational Needs), and potentially to improve continuity of care and transition support. A consultation on Essex's approach is being conducted in 2016, including the future role of Children's Centres.

An Early Years Pupil Premium (EYPP) of £300 per pupil has been available from April 2015 to provide tailored support for learning and development to the most vulnerable children, and a new Ofsted Single Inspection Framework was introduced in September 2015, with an emphasis on early years provision and supporting transition into school. This EYPP augments existing arrangements for a pupil premium to support children in school, which are managed through the 'virtual school' in Essex.

The Government has committed to double the Free Early Education Entitlement for three and four years olds where both parents work more than 16 hours a week. Engagement with Early Years and Childcare providers suggests that the Living Wage (to be introduced from April 2016 for adults over 25) and planned increases in Pension Auto-Enrolment from 2% contribution to 5% (now delayed to 2018) will have a significant impact. This will require ECC and partners to review the structure of charges for Free Early Education Entitlements.

There will be significant changes in assessment of early years provision. 2016 will be the last year that statutory returns are made against the Early Years Foundation Stage Profile. Neither the Department for Education nor the Standards and Testing Agency have said what measures will be used in future to demonstrate accountability. Schools will be using a combination of 'on entry' data analysis with the Baseline Assessment from 2016 but methods are likely to vary from school to school and there is no duty on schools to share data that is currently available to assess school readiness and children's development.

Introduction of the Prevent Duty (July 2015) provides a clear role for Early Years and Childcare (as well as schools) to be alert to the radicalisation of vulnerable children and to take action when they observe behaviour of concern.

Looked after children. The Education and Adoption Bill will enable and support the creation of regional adoption agencies.

The National Audit Office published a review of Care Leavers' transitions to adulthood in July 2015, which concluded that the system for supporting young people leaving foster or residential care in England is not working effectively. It found that £265 million was spent by local authorities on services for care leavers in 2013-14, but that 64% of these services 'require improvement or are inadequate'. Forty one per cent of care leavers were NEET in 2013-14 compared with 15% of other 19 year olds. 17% of 19-21 year old care leavers did not have their accommodation or activity reported by local authorities in 2013-14.

The Education Select Committee is conducting an inquiry on the mental health and emotional well-being of looked after children, and will report in 2016. Essex provided written evidence and gave evidence in person to the Select Committee.

Education and Schools. The Spending Review 2015 set out to protect schools funding in England in real terms over the Spending Review period and introduced a new national funding formula for schools, which is intended to ensure that 'funding is transparently and fairly linked to children's needs'. The Government will consult on the new formula in 2016, with implementation in 2017-18.

A new apprenticeship levy on large employers will be introduced in April 2017 at a rate of 0.5% of an employer's pay bill to deliver 3 million apprenticeship starts by 2020.

The Education and Adoption Bill will create new powers for government to intervene in failing schools and to create academies, with Government estimating that an extra 1,000 schools could be converted to sponsored academy status in the current parliament.

Child Poverty. The Department of Work and Pensions announced changes to the definition of child poverty in July 2015. It argued that the 60% of median income definition failed to capture the causes of poverty. The new approach focuses on levels of work within a family and educational attainment, which are viewed as critical for social mobility.

Childhood obesity. In November 2015, the Health Select Committee published a report on childhood obesity, which identified 'areas of improvement', including: 'a sugary drinks tax'; education and information; universal school food standards; greater powers for local authorities to tackle the environment leading to obesity; and early intervention with families. The Government is committed to producing a Childhood Obesity Strategy in 2016. In October, Public Health England, Youth Sports Trust and Association of College Sports published What Works in Schools and Colleges to Increase Physical Activity?, linking to Ofsted and NICE guidelines and providing good practice examples.

Child and Adolescent Mental health. In March 2015, the Government published the Future in Mind: Report of the Children and Young People's Mental Health Task Force, with recommendations including: waiting-time targets; one-stop shop services in communities; transition support for young adults; improved use of on-line tools and apps; improved crisis care and support; and training and workforce development. In August 2015, NHS England published Guidance and Support for Local Areas to develop Local Transformation Plans to support improvements in Children and Young People's Mental Health and Wellbeing, including additional funding.

The Independent NHS Mental Health Task Force report will include proposals for a transformation of peri-natal mental health.

In November 2015, the 'Emotional Well-Being and Mental Health Service for Children and Young People in Southend, Essex and Thurrock' was launched. This new service has been commissioned by three local authorities and seven CCGs through a single 'collaborative commissioning forum', with delivery by a single provider (NELFT) operating through locality based teams. Essex has also prepared and submitted its 'Future in Mind Transformation Plan for the Emotional Well-Being and Mental Health of Children and Young People in Southend, Essex and Thurrock 2015-20'.

3.1.3. Indices of Deprivation 2015

Deprivation in Essex is widespread. The map below shows how the new Index of Multiple Deprivation (IMD) ranks the areas within Essex – the darker shades are the most deprived.

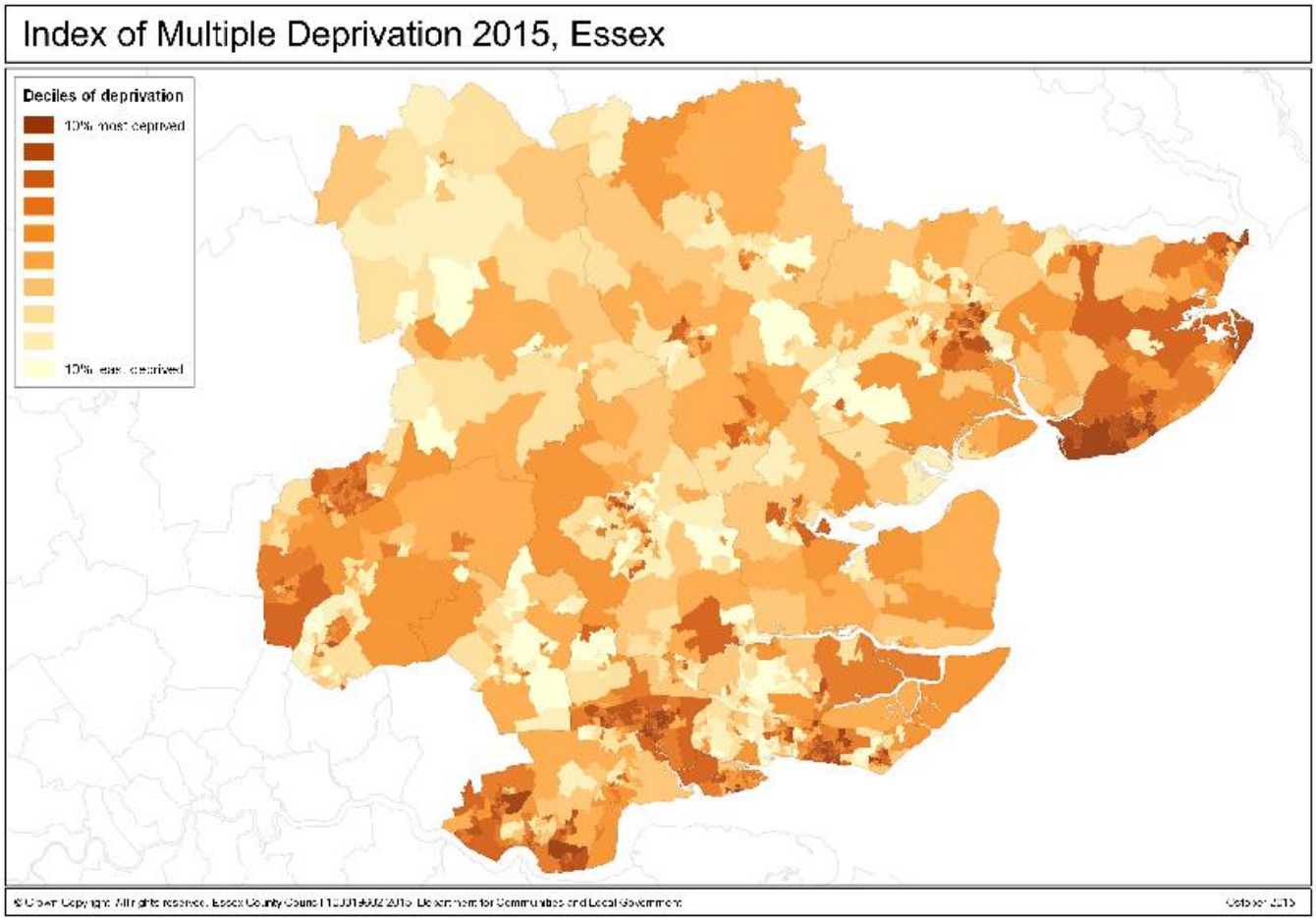


Figure 3 Index of Multiple Deprivation 2015

Some of the worst areas (the most deprived one per cent of nearly 33,000 areas in England) are within Essex: six in Tendring and two in Basildon. Uttlesford is the only local authority in Essex with no areas in the most deprived 20 per cent of England [2].

3.1.4. Children in low-income families and customer segmentation (MOSAIC)

Customer segmentation helps us to understand the needs, lifestyle choices and interests of people in Essex and how best to engage with them. The five wards with the highest prevalence of children in low-income families are: Golf Green Tendring (50%), Rush Green Tendring (48.6%), Pier Tendring (42.3%), St Andrew's Colchester (37.1%) and Alton Park Tendring (36.7%). The most prevalent customer segmentation (MOSAIC) types in these wards are: L50 Renting a Room, M54 Childcare Squeeze and M55 Families with Needs [3]. Parents in these areas would prefer to be contacted by email. Descriptions of these segmentation types are presented in

Table 1.

Table 1 Geodemographic segmentation types of residents in the wards with the highest prevalence of children in low-income families

Most prevalent segmentation type in households with children in the ward [3]	**Ward details**
M54 Childcare Squeeze . Younger families with children who own a budget home and are striving to cover all expenses. • The number of parents in poor health is above the norm. • They drink typically two or three times a month rather than any more frequently and more likely to smoke than average. • Fewer than average actively keep in shape, take part in sport or eat the recommended five portions of fruit and vegetables a day. • They have an above average dependency on the state across all working-age benefits, but not the highest. • Crime is generally above average in the areas where they have settled. • They are more than twice as likely to feel troubled by anti-social behaviour e.g. noisy neighbours, teenagers loitering around & littering. • A result, their fear of crime is somewhat higher than average. • They have a reasonable knowledge of environmental issues, but make little effort to adopt environmentally friendly behaviours at home . • **Channel preference:** Being contacted: 61% email; Contacting organisations: 31% email, 26% phone.	**Golf Green Tendring** • 50.0% Children in low-income families • 322 households with children • 88 households with children in the M54 type • Also has fairly large proportion of M53 (73 households with children) **Alton Park Tendring** • 36.7% Children in low-income families • 658 households with children • 263 households with children in the M54 type
M55 Families with Needs Families with many children living in areas of high deprivation and who need support. • High levels of unemployment and low incomes. • Amongst the most likely types to depend on a number of benefits, including the highest levels of dependency on Income Support and Tax Credits. • Most likely to experience debt issues. • Fairly young families with poor health and around 50 per cent more likely to be in bad or very bad health than people in general. • Adults are twice as likely to smoke and are two and a half times more likely to be heavy smokers. However, they drink less than once a month. • Significantly fewer people than average follow healthy eating guidelines or do a lot to keep in shape. • These families are amongst the most likely to say that crime is a very big problem in their area. They are also most likely to feel that rubbish and littering is a major issue, and also perceives far more problems than average with drug dealing and noisy neighbours. • They are 50 per cent more likely to fear being a victim of crime, but this fear is not as high as with many other types. • There is a relatively low awareness of and concern for environmental issues. • **Channel preference:** Being contacted: 55% email; Contacting organisations: 33% email, 23% phone.	**Rush Green Tendring** • 48.6% Children in low-income families • 735 households with children • 385 households with children in the M55 type **St Andrew's Colchester** • 37.1% Children in low-income families • 1335 households with children • 255 households with children in the M55 type • Also has fairly large proportion of M56 (225 households with children)
L50 Renting a Room. Transient renters of low cost accommodation often within subdivided older properties. • The most likely among Transient Renters to rely on the state for financial assistance e.g. Job Seeker's Allowance & Income Support. • Despite being largely aged under 35, poor health is at above average levels. • They are fairly moderate drinkers, they smoke far more than people in general – and almost three times as likely to be heavy smokers. • Less active when it comes to sport and exercise than many and, most do not follow healthy eating guidelines.	**Pier Tendring** • 42.3% Children in low-income families • 420 households with children • 110 households with children in the L50 type

- The areas they live in have a higher than average crime rate, though by no means the highest.
- Tend to feel that anti-social behaviour, especially drunk and rowdy behaviour is a problem in their area.
- More likely to worry about being a victim of crime and in particular can feel unsafe when out after dark.
- Knowledge of environmental issues and interest in being green is lower than average.
- **Channel preference:** Being contacted by email (64%); Contact organisations by email (26%), phone (26%) and online (24%).

Figure 4 shows a thematic map with the percentage of children in low-income families by quintile and associated most prevalent MOSAIC Type code. Table 18 in Appendix 1 presents these codes with descriptions. Additionally Table 20 in Appendix 2 shows the most prevalent MOSAIC types in the top 10% of wards with highest % of children in low income families.

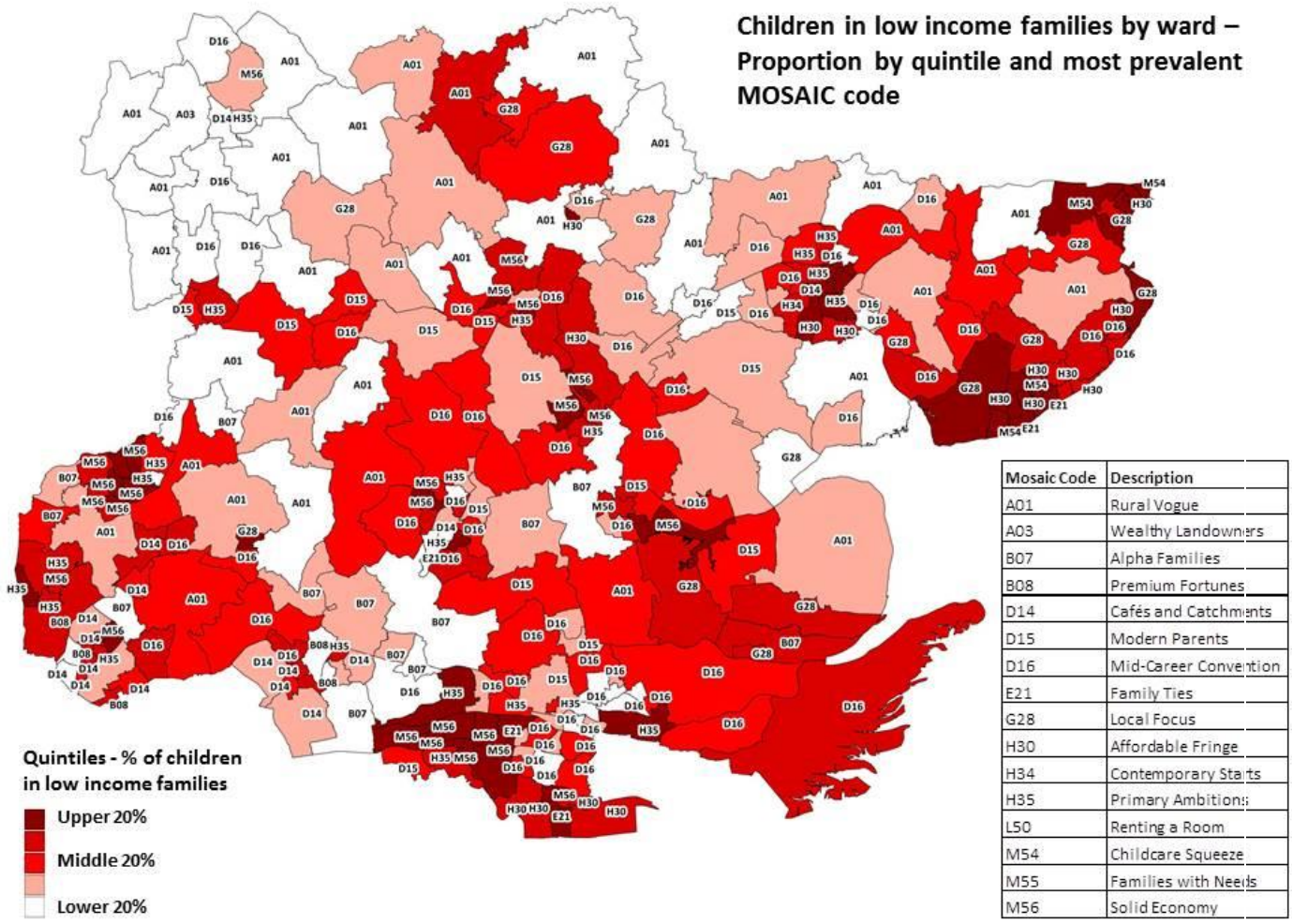


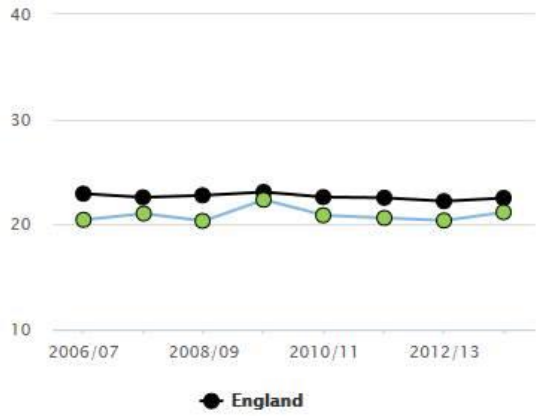
Figure 4 Children in low income families and most prevalent household type in households with children

3.2. Health

3.2.1. Lifestyle: Excess weight in children

3.2.1.1. Rationale/Background

3.2.1.1.1. What has been described as the obesity epidemic is becoming (if it is not already) the focus of public health teams across the country. Excess weight in childhood is a major risk factor for obesity and related health problems in adulthood and must be tackled as one of the many strategies to slow the epidemic.



3.2.1.2. Trend in excess weight in children

Figure 5 Percentage of excess weight in 4-5 year olds

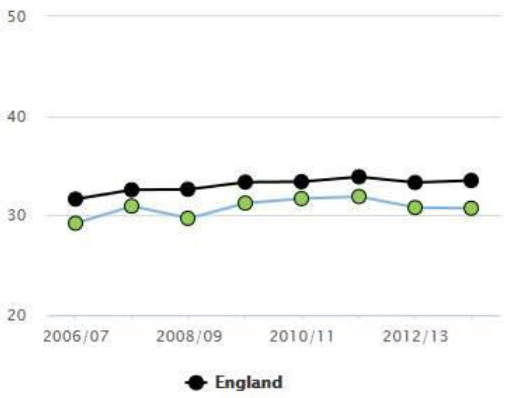


Figure 6 Percentage of excess weight in 10-11 year olds

Essex has a significantly lower prevalence of excess weight in children aged both 4-5 and 10-11 when compared to the national average. In 2013/14, the prevalence in Essex was 21.2%, (national average 22.5%) for 4-5 year olds. For 10-11 year olds it was 30.7% (33.5%) [4].

Analysis by district for 10-11 year olds in 2013/14 shows that only Tendring, which has the highest prevalence in Essex, is greater than the national average. Its prevalence of 33.6% is unlikely to be significantly different to that of England (33.5%) [4]. For 4-5 year olds, both Braintree and Tendring have a greater prevalence than the national average but again these figures are unlikely to be significantly different.

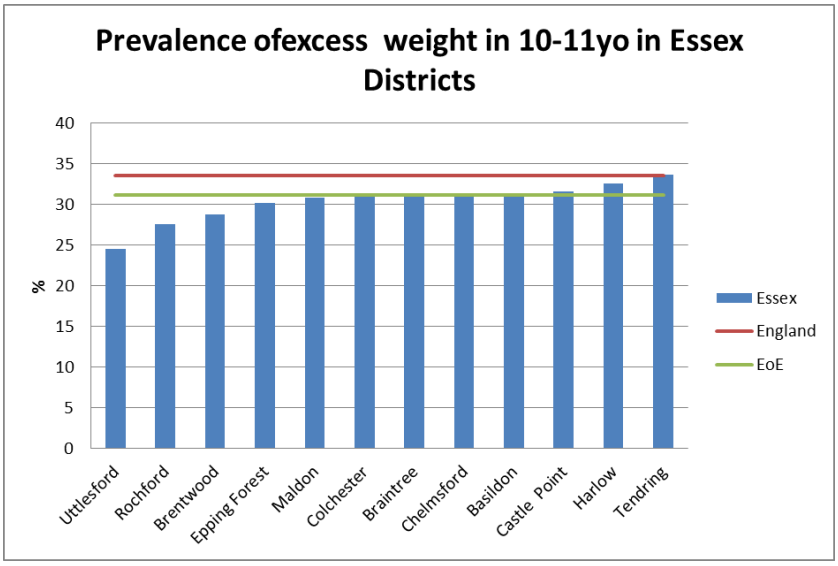


Figure 7 Prevalence of excess weight for each district in Essex 2013/14 compared to national and regional averages.

3.2.2. Lifestyles: smoking in children

3.2.2.1. Rationale/Background

Smoking is an addiction which most often starts in adolescence. The uptake of smoking in the teenage years is a major public health problem, leading to lifelong health issues and proving very difficult to quit [5] [6]. There needs to be more of a focus on preventive strategies aimed at teenagers in order curb the prevalence of smoking and smoking related illnesses.

3.2.2.2. Trend in childhood smoking

Prevalence of smoking in school pupils has most recently been measured by the What about Youth (WAY) survey (2014/15), which showed that Essex had a significantly greater prevalence of current (10.5%) and occasional smokers (4.5%) at age 15 than the national average (8.2% and 2.7%). The East of England as a whole also had a significantly greater prevalence of current smokers (8.9%) than the national average, but no significant difference when compared to Essex [4].

Indicator	Period	Essex		Region	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	-	10.5%	8.9%	8.2%	14.9%		3.4%
Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	-	6.1%	5.7%	5.5%	11.1%		1.3%
Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	-	4.5%	3.2%	2.7%	7.6%		0.6%

Better Similar Worse

Figure 8 Prevalence of current, regular and occasional smokers in Essex 2014/15

Smoking prevalence at age 15 - current smokers (WAY survey) 2014/15 Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	8.2	8.1	8.3
East of England region	-	8.9	8.4	9.4
Bedford	-	9.3	7.6	11.0
Cambridgeshire	-	8.2	6.6	9.8
Central Bedfordshire	-	7.1	5.5	8.7
Essex	-	10.5	8.6	12.4
Hertfordshire	-	7.2	5.6	8.8
Luton	-	5.3	3.8	6.8
Norfolk	-	11.4	9.5	13.3
Peterborough	-	9.1	7.4	10.8
Southend-on-Sea	-	9.9	8.1	11.7
Suffolk	-	8.6	7.0	10.2
Thurrock	-	4.7	3.3	6.1

Better Similar Worse

Figure 9 Prevalence of current smokers in all counties in the East of England 2014/15

3.2.3. Children and alcohol

3.2.3.1. Rational/Background

Alcohol misuse is a major cause of harm in the UK, including in school-aged children. Measuring alcohol use is difficult as populations' accounts of how much they drink may not match up to actual consumption.

3.2.3.2. Trend in children and alcohol

The percentage of secondary school pupils in Essex who said they drink regularly was 3.1% in 2014. The percentage who said they had been drunk at least once in the last month was 10.9% [7]. Without a national average/estimation it is difficult to determine if this is significant. We do know that in 2009, the percentage of school pupils in Essex who said they drink (had been drunk in the last 4 weeks) was 18%, with a national average of 15%, suggesting that at that time our prevalence was greater than average [8].

We can see a breakdown of consumption prevalence by district for the 2014 data, which shows areas with higher prevalence to be; Rochford, Castle Point, Brentwood and Basildon [7]. There may be some problems with the quality of this data, in particular response bias could be an issue, as the figures are quite varied and numbers who drink regularly in certain districts don't necessarily correspond with the numbers who have been drunk in the last month.

	Drink Regularly	Drunk in last month
Basildon	5	14.7
Braintree	2.9	11.2
Brentwood	6	18.8
Castle Point	4.4	15.2
Chelmsford	1.5	7.6
Colchester	3.1	11
Epping Forest	0	1.7
Harlow	2.2	13.3
Maldon	1.8	10.6
Rochford	6.4	2.1
Tendring	4.4	9.6
Uttlesford	2	11.2

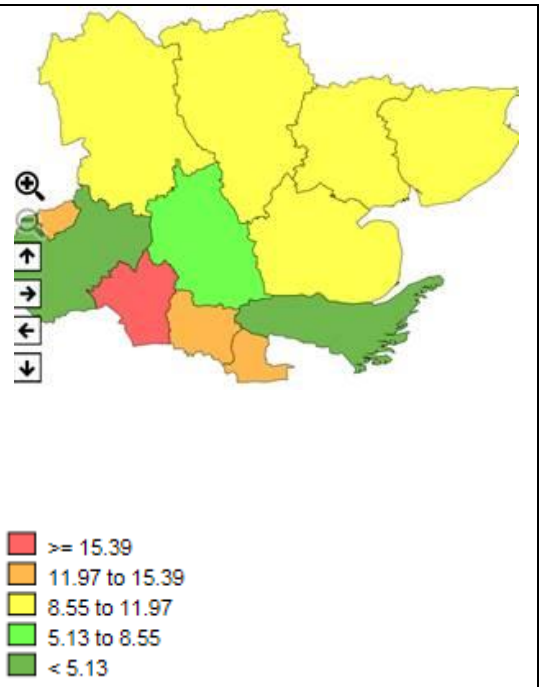


Figure 10 Prevalence of regular drinking and being drunk in the last month in children for each district within Essex in 2014. The map in the right panel is shaded according to prevalence of children being drunk in the last month.

Alcohol-specific hospital admissions in under 18s are very low in Essex. From 2011/12-2013/14, the number of admissions was 24.1 per 100,000 of the population compared to a 40.1 average across England. This would suggest that alcohol is not as big a problem for school-age children in Essex as it is across the rest of the country [4].

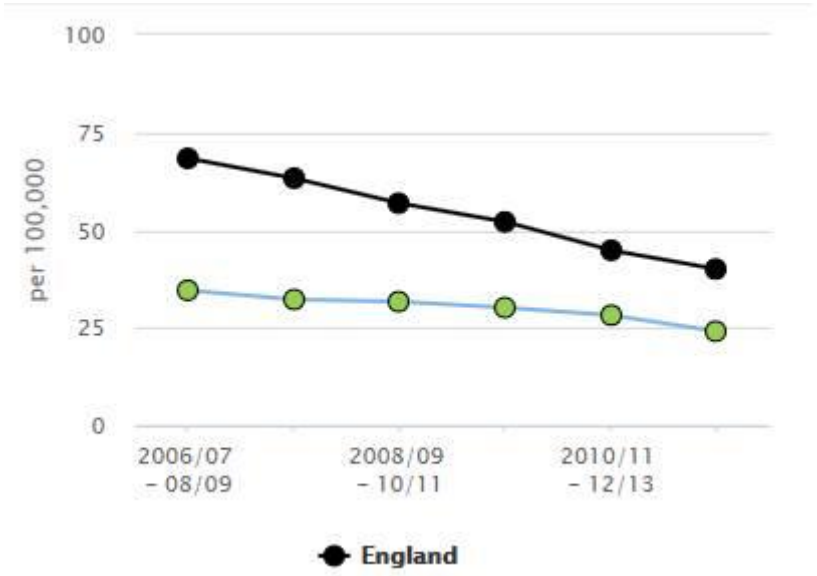


Figure 11 Alcohol related admission in children per 100,000 compared to the national average

3.2.4. Lifestyle - teenage conception

3.2.4.1. Rationale/Background

While the results of teenage pregnancy can be positive, it can also lead to termination and/or poor health and financial outcomes for both mum and baby [4]. The majority are unplanned and a lot of public health resources have been spent in health education about preventative measures, most recently long acting reversible contraception.

3.2.4.2. Trend in teenage conceptions

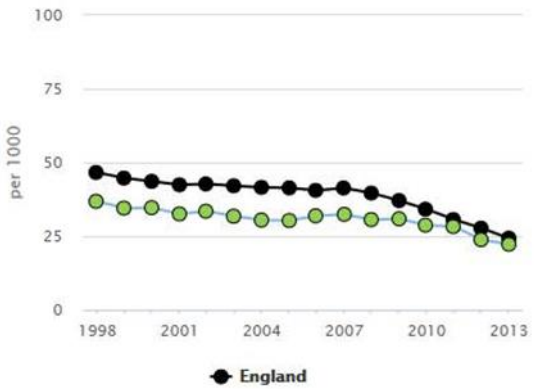


Figure 12 Teenage conceptions in Essex versus the English average

Overall, the average rate of teenage conception in Essex is consistently lower than the national average. In 2013 in Essex, there were 22.3 conceptions in under 18s per 1,000 females aged 15-17. The national average was 24.3 [4].

The highest rates in 2013 were in Harlow (38.3), Basildon (32.9) and Tendring (30.3) [4]. When compared to their most similar local authorities, as deemed by the ONS from the 2011 census data [9], Basildon and Tendring perform particularly poorly, given comparator figures of Dartford (19.5) and Rother (18.5) respectively.

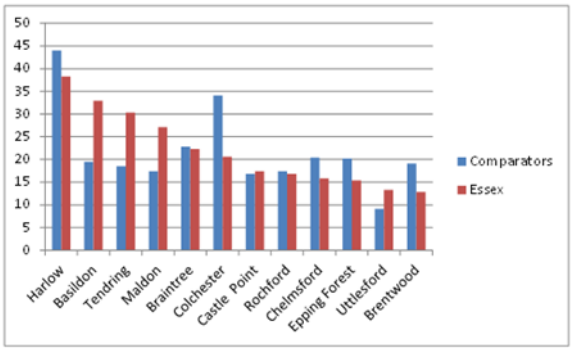


Figure 13 Teenage conception rates in each of Essex's districts in 2013 (red) compared to ONS comparator local authorities (blue

A similar pattern is reflected in the number of deliveries to teenage mothers as seen in the map below.

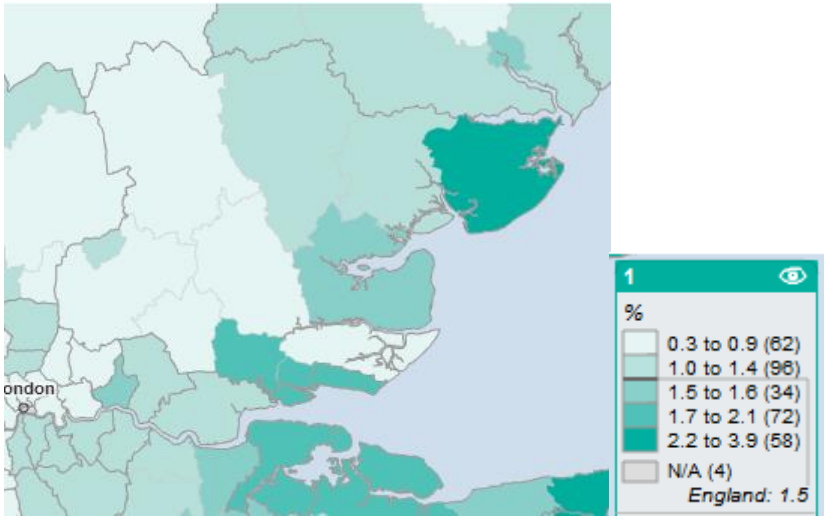


Figure 14 Percentage of deliveries where mother is aged 12-17 in years 2008/9 - 2012/13

3.2.5. Lifestyle: Breastfeeding

3.2.5.1. Rationale/Background

Breast feeding is an important public health outcome as it has been shown to be protective against childhood infection and obesity. It is recommended for the first 6 months of life and then in conjunction with solid foods. (citation needed)

Breast feeding at 6-8 weeks (the time of the national baby check) is a Clinical Commissioning Group (CCG) outcome indicator and is therefore reported quarterly by the Health and Social Care Information Centre (HSCIC) [10].

3.2.5.2. Trend in breastfeeding

Much of the most recent data for breast feeding prevalence in Essex has been deemed not of an adequate quality to report on accurately. Data from previous years (2012/13) implies that Essex has been performing consistently below the national average with a prevalence of 43.4% compared to 47.2%. A spike in prevalence in 2013/14 to 52.3% suggests improvement, but as a one-off it is difficult to determine the significance of this [4].

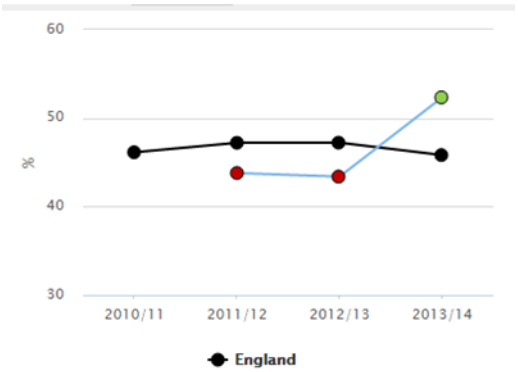


Figure 15 Breastfeeding prevalence in Essex at 6-8 weeks after birth (%)

Quarterly data reported by CCGs has been published where deemed of sufficient quality. This shows a decline in prevalence for Mid, North East and West Essex CCGs since the spike in 2013. Basildon and Brentwood and Castle Point and Rochford CCGs have a lower prevalence than the rest.

Table 2 Breastfeeding prevalence in all CCGs over the last two years (%) [10]

	Mid Essex	NE Essex	West Essex	Basildon and Brentwood	Castle point and Rochford
Q3 14/15		49.3		38.2	
Q2 14/15	46.8	48.8	49.1	39.4	38.1
Q1 14/15	48.1	50.1		39.8	
Q4 13/14		48.9			
Q3 13/14	48.2	48.2	48.4		35.7
Q2 13/14	48.2	52	47.7		36.1
Q1 13/14	50.2	50.3			30.9

3.2.6. Immunisation – MMR vaccination

3.2.6.1. Rationale/Background

The MMR vaccine is on the national immunisation schedule, to be given to all children in the UK. The MMR schedule consists of 2 vaccines, the first at 13 months of age and the second prior to starting school at age 4. The vaccine protects against the diseases of measles, mumps and rubella, which are highly contagious and can cause serious harm in some, especially immunocompromised people and pregnant women [11]

3.2.6.2. Trend in MMR immunisation

In general, Essex has greater vaccination coverage for MMR vaccine than the national average. It has improved since 2010, when percentages for each stage of the vaccination programme were all below 90% (national benchmark) and the percentage of children who had received 1 dose by the age of 5 was particularly ipoor (89.6% in Essex compared to 91.9% national average) [4].

The most recent data, for the year of 2013/14, shows 93.9% of children in Essex have had 1 dose of the vaccine by age 2 (national average is 92.7%) and 90.5% have had both doses by age 5 (88.3%) [4].

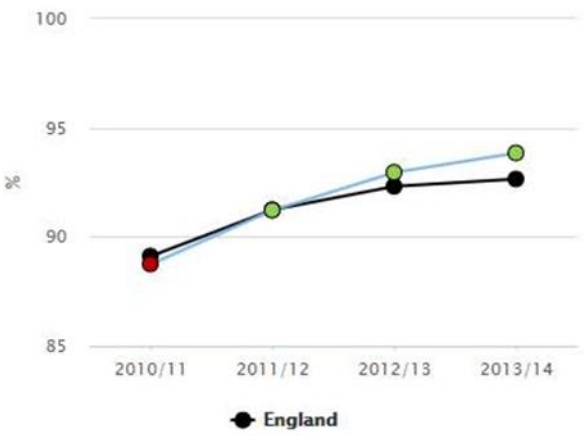


Figure 16 2 year dose

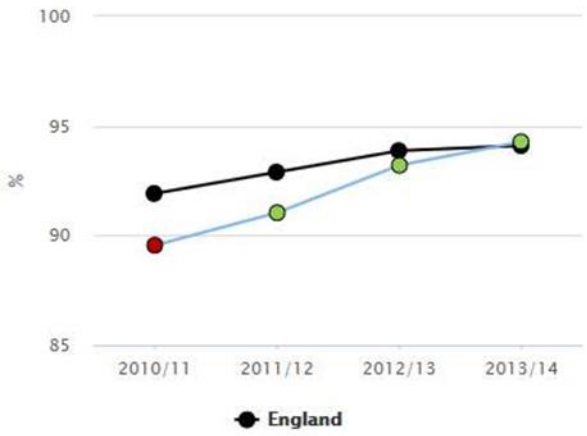


Figure 17 1 dose 5 yrs

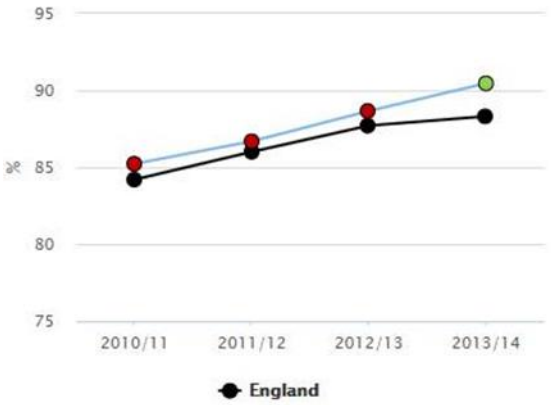


Figure 18 2 doses 5 years

3.3. Education

3.3.1. Free early education entitlement (FEEE) background

The early learning offer benefits children's social, physical and mental; development while also helping them to prepare for school. Research (Universities of Essex and Warwick and the IFS) has demonstrated several benefits of the entitlement, including positive impacts on mother's work patterns (around 6 more mothers in work for every additional 100 funded places provided). They also found that the impact of free early education on both children and mothers was considerably larger for those children who would not have used early education had it not been free.

Collectively, early years and childcare settings in Essex provide a service to approximately 84,419 children age 5 years and under (based on the ONS 2013 mid-year estimates, which are the latest available) and approximately 47,500 families with children age 5 years and under.

3.3.2. Free early education entitlement for 2 year-olds (FEEE2)

3.3.2.1. Rationale/background

Piloted in 2010 (only in selected Essex districts initially)v and nationally introduced in 2012, Free Entitlement Funding for two year-olds has been targeted to the4 most disadvantaged families in the country.. Initially this equated to 20% of the population receiving specific benefits but in Autumn 2014 it was extended to include low income working households (equivalent to 40% of children nationally and 30.5% of two year olds in Essex).

The two year old free early learning offer is for up to 25 hours free education per week for those children who commence the term after they turn two, and then like all children, they will subsequently become eligible for a three and four year old place.

3.3.2.2. Trends in FEEE2

The proportion of 2 year olds accessing free entitlement funding is slightly above national average rates but below regional and statistical neighbour averages.

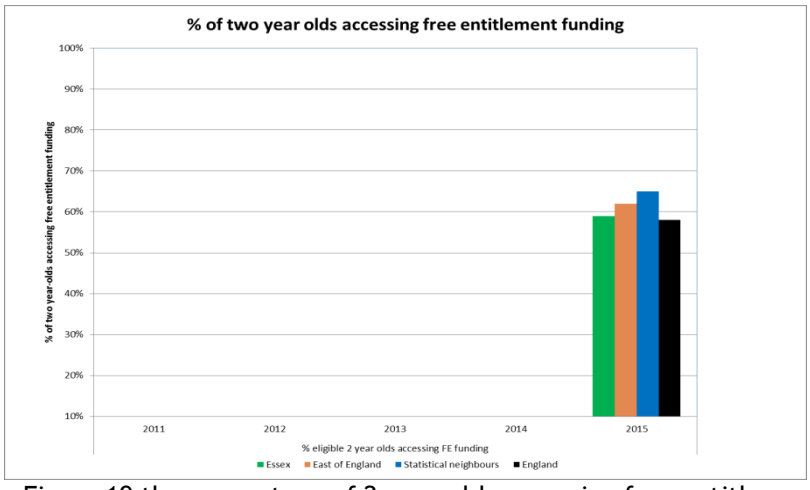


Figure 19 the percentage of 2 year-olds accessing free entitlement funding

3.3.2.3. District level variation

Table 3 District level variation in the numbers of two year old children eligible for free entitlement and the proportion taking up the offer

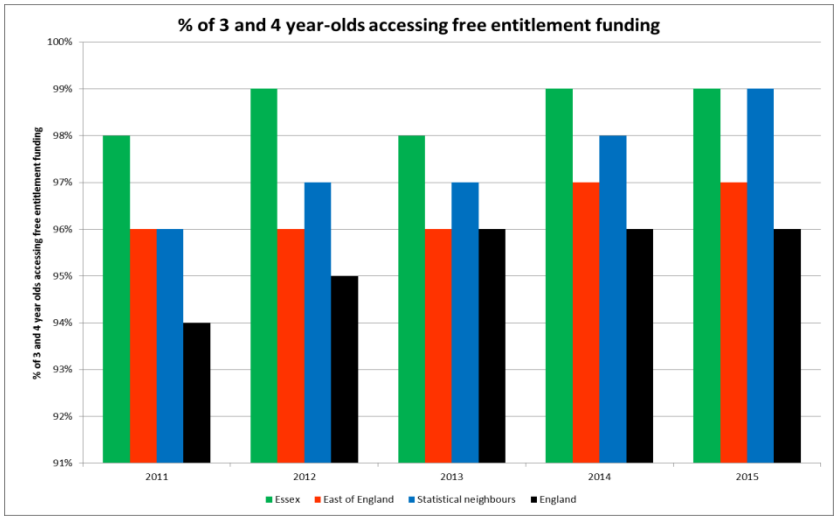
	Spring 2015 numbers eligible	% eligible taking up a place
Basildon	922	***54.4%***
Braintree	481	***59.5%***
Brentwood	185	***65.9%***
Castle Point	333	***53.2%***
Chelmsford	465	***57.4%***
Colchester	796	***52.3%***
Epping Forest	394	***46.7%***
Harlow	521	***47.4%***
Maldon	148	***73.0%***
Rochford	192	***74.0%***
Tendring	706	***70.5%***
Uttlesford	157	***50.3%***
Essex County	**5300**	***57.1%***

There is a 27.3 percentage point variation at district level in the proportion of eligible two year olds taking up the offer of free entitlement funding.

3.3.3. Free early education entitlement for 3 and 4 year olds (FEEE3&4)

3.3.3.1. Rationale/background

See section 3.3.1



3.3.3.2. Trends in FEEE3&4

Figure 20 The percentage of 3 and 4 year-olds accessing free entitlement funding

3.3.3.3. District level variation

Table 4 District level variation in the percentage of three and four year old children accessing free entitlement funding

	% accessing free entitlement funding for 3 & 4 year olds	
	2014	2015
Basildon	93.6%	99.1%
Braintree	94.1%	99.6%
Brentwood	91.1%	101.2%
Castle Point	94.9%	102.2%
Chelmsford	95.8%	102.3%
Colchester	92.4%	98.4%
Epping Forest	86.4%	91.6%
Harlow	91.9%	94.3%
Maldon	96.8%	104.8%
Rochford	90.5%	96.5%
Tendring	94.6%	101.0%
Uttlesford	92.7%	100.8%
Essex County	**92.9%**	**99.0%**

The figures can exceed 100% at district levels as they are based on take-up figures against and mid-year population estimates. At small levels of geographical disaggregation the population estimates can be unreliable, and take-up figures can exceed them, leading to levels of access greater than 100%.

District level variation in take up is around 12 percentage points, with Epping Forest having the lowest uptake levels in both years.

3.4. School readiness and development

3.4.1. Year 1 phonics screening check

3.4.1.1. Rationale/background

The phonics screening check was introduced in 2012 as a statutory assessment for all children in year 1 (typically aged 6). All state funded schools with a year 1 cohort must administer the checks. Children who do not meet the standard in year 1 or who are were not tested are re-checked at the end of year 2.

The phonics screening check indicates whether children have achieved a basic proficiency in identifying word structures. It is a screening test, rather than an evaluating one, and the information it provides is descriptive.

The checks consist of 40 words and non-words that a child will read one-on-one with a teacher. Non-words (or pseudo words) are a collection of letters that will follow phonics rules a child has been taught, but do not mean anything – a child will need to read these with the correct sounds to show that they understand the phonics rules behind them.

3.4.1.2. Trend in phonics screening check

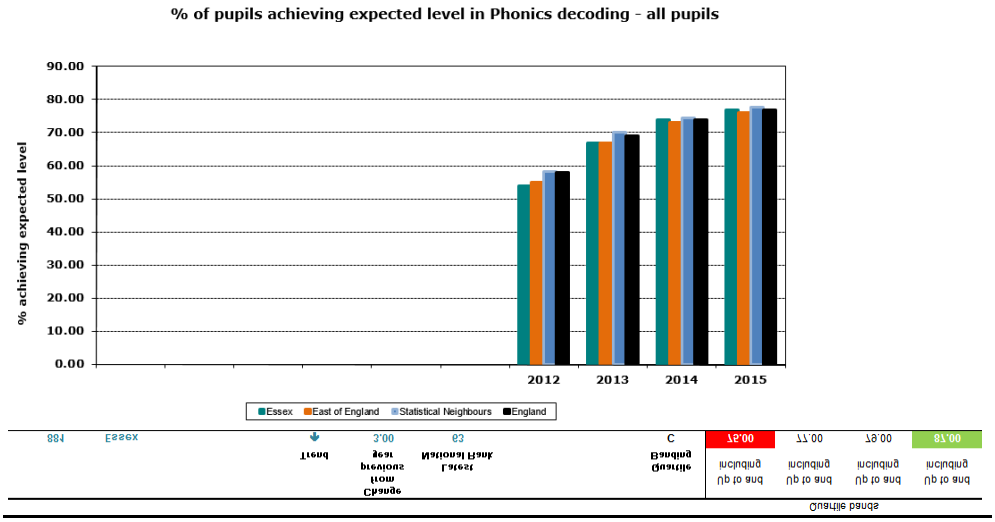


Figure 21 Performance in phonics screening check

Performance has improved year on year since the introduction of the screening check. In 2012 Essex was in the lowest quartile nationally and below East of England, statistical neighbour and national averages.

Performance in 2015 was 77%, which falls into the second quartile nationally. The threshold for top quartile performance was 79%.

3.4.1.3. District level variation

Table 5 District level variation in the percentage of children achieving the expected level in the phonics screening test

District	2013	2014	DOT 13-14	2015	DOT 14-15	One year change (14 - 15)	Two year change (13 - 15)
Basildon	63%	72%	↑	76%	↑	4%	13%
Braintree	64%	72%	↑	75%	↑	3%	11%
Brentwood	75%	78%	↑	81%	↑	3%	6%
Castle Point	66%	73%	↑	72%	↓	-1%	6%
Chelmsford	70%	74%	↑	80%	↑	6%	10%
Colchester	68%	76%	↑	76%	↔	0%	8%
Epping Forest	67%	74%	↑	78%	↑	4%	11%
Harlow	66%	68%	↑	76%	↑	8%	10%
Maldon	72%	77%	↑	79%	↑	2%	7%
Rochford	70%	78%	↑	77%	↓	-1%	7%
Tendring	61%	70%	↑	76%	↑	6%	15%
Uttlesford	74%	81%	↑	80%	↓	-1%	6%
Essex	67%	74%	↑	78%	↑	4%	11%
England	69%	74%	↑	77%	↑	3%	8%

All districts have improved performance on the phonics screening measure since 2013. Basildon, Braintree, Castle Point, Harlow and Tendring have been consistently below county average (indicating a link between performance and deprivation) but these districts (except Harlow) have also been improving faster than the overall county average.

3.4.2. Percentage of children achieving a good level of development in the Early Years Foundation Stage Profile (EYFSP)

3.4.2.1. Rationale/background

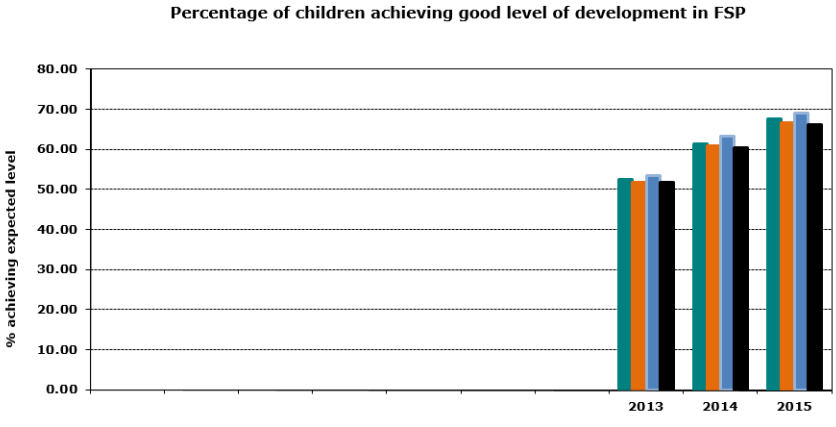
The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children's development at the end of the EYFS (the end of the academic year in which the child turns five). It is intended to facilitate a smooth progression to Key Stage 1 by informing professional dialogue between teachers. It also assists Year 1 teachers plan an effective, responsive and appropriate curriculum that meets the needs of all children. The profile is also designed to inform parents or carers about their child's development.

The indicator is defined as the percentage of children achieving at least the expected levels in the Early Learning Goals (ELGs) within the three prime areas of learning (communication and language, physical development and personal, social and emotional development) and the specific areas of literacy and numeracy.

Following an independent review of the EYFS, a new profile was nationally implemented for the 2012/13 school year. The new profile made changes to the way children are assessed at the end of the EYFS and require practitioners to make a best-git assessment of whether children are 'emerging', 'expected' or 'exceeding' against each of the early learning goals. These changes mean that data obtained through the previous assessment system (i.e. pre 2013) cannot be compared, and there is a break in the time series.

High achievement within the EYFS is associated with higher attainment throughout a child's subsequent educational career, and therefore is associated with the positive outcomes linked to higher levels of educational attainment and progression.

3.4.2.2. Trend in good level of development in EYFSP



	Trend	Change from previous year	Latest National Rank	Quartile Banding	Quartile bands: Up to and including	Up to and including	Up to and including	Up to and including
Essex	↑	6.30	52	B	63.35	66.10	68.60	77.50

Figure 22 Performance in percentage of children achieving a good level of development

Performance has improved broadly in line with local, statistical neighbour, and national averages, and Essex is currently ranked in the second quartile nationally. Performance in 2015 was 67.7%, and the threshold for the top quartile was 68.6%.

3.4.2.3. District level variation

Table 6 District level variation in the percentage of children achieving a good level of development in the early years foundation stage profile

District	2013	2014	DOT 13-14	2015	DOT 14-15	One year change (14 - 15)	Two year change (13 - 15)
Basildon	52%	61%	↑	67%	↑	6%	15%
Braintree	52%	57%	↑	65%	↑	8%	13%
Brentwood	52%	63%	↑	70%	↑	7%	18%
Castle Point	52%	59%	↑	65%	↑	6%	13%
Chelmsford	55%	65%	↑	69%	↑	4%	14%
Colchester	56%	61%	↑	66%	↑	5%	10%
Epping Forest	54%	62%	↑	68%	↑	6%	14%
Harlow	38%	59%	↑	66%	↑	7%	28%
Maldon	54%	67%	↑	73%	↑	6%	19%
Rochford	56%	62%	↑	72%	↑	10%	16%
Tendring	50%	58%	↑	66%	↑	8%	16%
Uttlesford	57%	65%	↑	73%	↑	8%	16%
Essex	53%	61%	↑	68%	↑	7%	15%
England	52%	60%	↑	66%	↑	6%	14%

All districts have improved over the last two years, with Braintree and Castle Point consistently below county average, indicating an association with material deprivation.

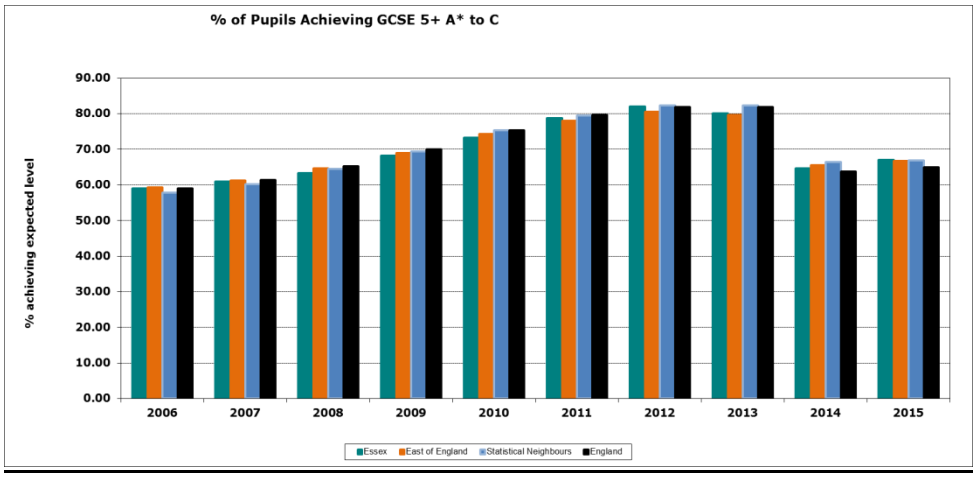
3.4.3. GCSE: the percentage of pupils achieving 5 or more grades A*-C, including English and mathematics

3.4.3.1. Rationale/background

The General Certificate of Secondary Education (GCSE) was introduced in 1986, with first examinations in 1988. It is the principal means of assessing pupil attainment at the end of compulsory secondary education.

Educational attainment is a powerful predictor of well-being. Young adults who have completed higher levels of education are more likely to achieve economic success than those who have not. In addition to qualifying one for a broader range of jobs, completing more years of education also protects against unemployment. higher levels of educational attainment often lead to higher wages and income Adults with higher levels of education also report being in better health and having higher levels of socio-emotional well-being.

3.4.3.2. Trends in GCSE attainment



		Trend	Change from previous year	Latest National Rank	Quartile Banding	Quartile bands: Up to and including	Up to and including	Up to and including	Up to and including
881	Essex	↑	2.30	71	B	62.90	66.60	70.30	84.20

Figure 23 percentage of pupils achieving 5 or more A*-C grades, including English and mathematics

Note that reforms to GCSE in 2014 mean that direct comparisons with previous years cannot easily be made; however, historical data has been retained in the trend chart, as comparisons with local, statistical neighbour and national averages can still be meaningfully made. The reforms included a restriction in the range of qualifications which are considered 'equivalent' to GCSEs and an early entry policy to count only a pupil's first attempt at a qualification, rather than their best result from several attempts. These changes resulted in a national fall in attainment on this measure, from 60% to around 57%.

Performance in 2015 took Essex above regional, statistical neighbour and national averages for the first time. Essex is currently ranked in the second quartile nationally at 67.0%; the threshold to the top of the quartile is 70.3%.

3.4.3.3. District level variation

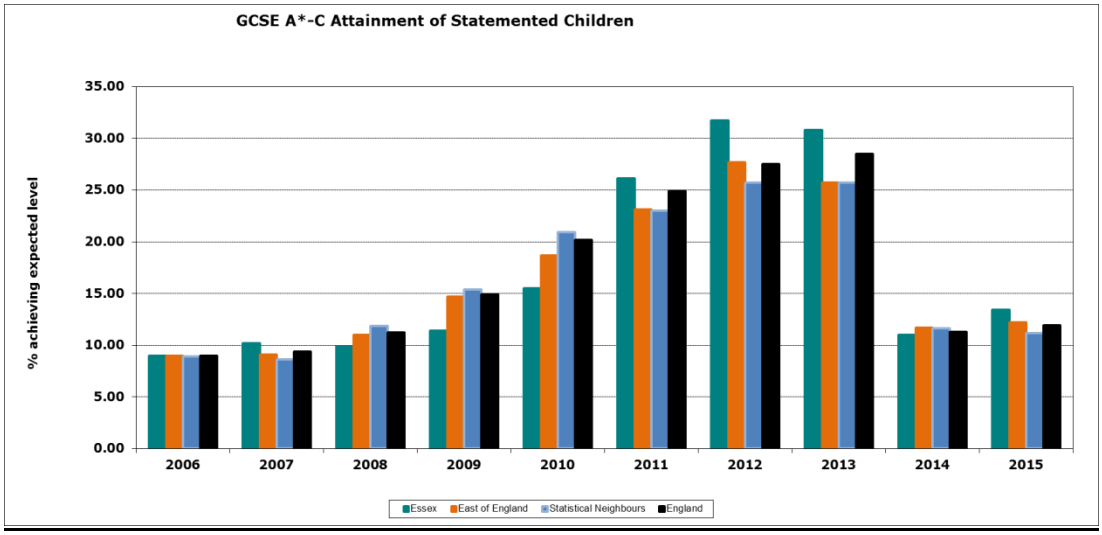
Table 7 District level variation in the percentage of children achieving 5 or more grades A*-C (including English and mathematics) at GCSE

District	2013	2014	DOT 13-14	2015	DOT 14-15	One year change (14 - 15)	Two year change (13 - 15)
Basildon	56.6	53.8	↓	51.6	↓	-2.2	-5.0
Braintree	53.0	47.6	↓	50.9	↑	3.3	-2.1
Brentwood	70.9	64.5	↓	64.1	↓	-0.4	-6.8
Castle Point	61.1	54.1	↓	54.6	↑	0.5	-6.5
Chelmsford	62.4	61.7	↓	67.3	↑	5.5	4.9
Colchester	66.2	56.3	↓	64.6	↑	8.3	-1.6
Epping Forest	68.7	61.4	↓	58.2	↓	-3.2	-10.6
Harlow	52.7	59.2	↑	53.3	↓	-6.0	0.6
Maldon	54.5	51.9	↓	51.1	↓	-0.9	-3.5
Rochford	60.6	63.5	↑	59.2	↓	-4.3	-1.4
Tendring	61.0	52.4	↓	45.3	↓	-7.1	-15.6
Uttlesford	64.3	63.7	↓	67.0	↑	3.3	2.7
Essex	60.5	56.5	↓	57.6	↑	1.1	-2.9
England	60.8	56.8		56.3	↓	-0.5	-4.5

Changes in attainment between 2013 and 2014 are not easy to interpret because of the changes described in section 1.10.3.2.1.

Basildon, Braintree, Castle Point, Maldon and Tendring districts have consistently scored lowest on this measure, demonstrating the link between attainment and

3.4.3.4. GCSE attainment of children with a statement of Special Educational Need (SEN)



		Trend	Change from previous year	Latest National Rank	Quartile Banding	Up to and including	Up to and including	Up to and including	Up to and including
881	Essex		2.40	51	B	8.43	11.70	14.88	27.30

Figure 24 Trends in GCSE attainment for pupils with a statement of Special Educational Need

Changes in attainment between 2013 and 2014 are not easy to interpret because of the changes described in section 1.10.3.2.1.

Performance in 2015 took Essex above regional, statistical neighbour and national averages. Essex currently sits in the second quartile with an average of 13.4% of pupils with a SEN statement achieving passes at GCSE at the end of KS4.

3.4.3.5. SEN Performance gaps

Table 8 Summary of SEN gaps (SEN v no SEN)

KS4	5+ A*-C					5+ A*-C inc EM					5+ A*-G					5+ A*-G inc EM				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Essex	40.3	35.6	34.6	49.0	49.3	48.4	49.9	52.2	47.5	47.0	17.6	16.5	18.4	26.0	21.8	20.2	18.8	23.8	30.3	27.7
Statistical Neighbours	37.8	34.3	33.8	48.7	47.8	46.5	48.0	48.4	46.3	45.0	14.4	13.6	14.9	23.9	23.2	17.7	17.5	19.2	27.5	28.9
Eastern Region	38.5	35.8	34.4	47.3	47.7	47.5	47.5	48.6	45.8	45.3	15.6	14.4	15.4	22.7	21.6	18.7	17.7	20.0	26.7	27.2
England	35.2	32.1	31.0	47.0	47.0	47.6	47.1	47.4	45.2	44.6	14.2	13.7	14.0	21.9	21.8	17.6	17.3	18.5	26.2	27.4

The SEN v non SEN gap is defined as being the performance of non-SEN pupils – the performance of (any) SEN pupils. This includes both pupils with a statement of SEN and pupils receiving any type of SEN support.

2015 saw gaps stabilise for 5+ A*-C measures. Essex gaps remain higher than those seen nationally, however, Essex did see gap reductions for 5+ A*-G measures in 2015 and is now in line with England averages.

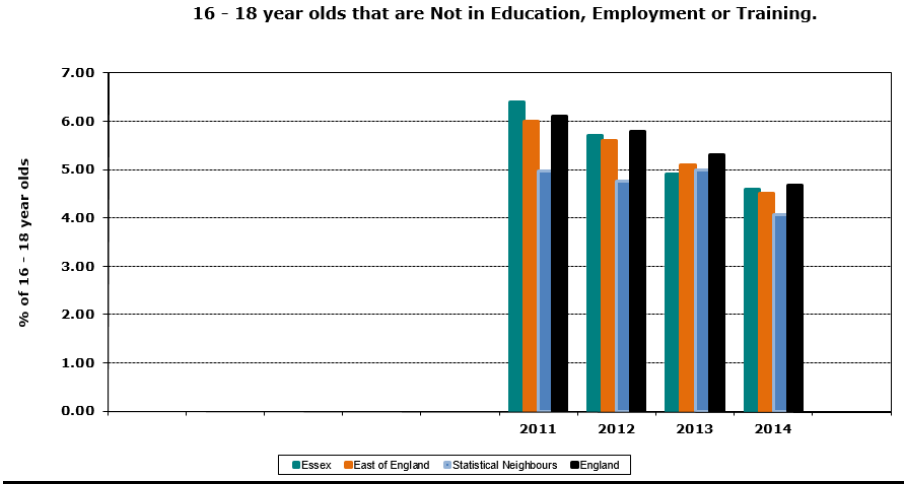
3.4.4. Not in education, employment or training (NEET)

3.4.4.1. Rationale/background

The measure is the percentage of 16 to 18 year olds who are not in education, employment or training. Although data are collected monthly, this indicator uses an annual result based on three one month snapshots at the end of November, December and January each year. Data relates to young people who were aged 16-18 on the day of the count. Data for 2011 cannot be compared with previous years because the latest data on young people have been recorded according to where they live, rather than where they study, as had been the case in the past.

Whatever its underlying cause, being NEET is associated with later forms of disadvantage and poor welfare outcomes. These include: regular bouts of unemployment post-18; when in employment, lower job security and lower rates of pay (under-employment); teenage pregnancy and earlier parenting; persistent youth offending, resulting in custodial sentences; insecure housing and homelessness; mental and physical health problems; use of illicit drugs and transition to the use of class A drugs; earlier death.

3.4.4.2. Trends in NEETS



	Trend	Change from previous year	Latest National Rank	Quartile Banding	Quartile bands: Up to and including	Up to and including	Up to and including	Up to and including
Essex	↓	-0.30	78	C	3.50	4.50	5.70	9.00

Figure 25 Percentage of young people aged 16-18 NEET

NEET levels have been consistently falling in Essex, as have regional, statistical neighbour and national averages. The latest figures place Essex in the third quartile nationally, although performance in very close to the second quartile threshold.

There has been a focus on the needs of NEET young people with special educational needs. ADD TEXT

3.4.4.3. District level variation

Table 9 District level variation in the percentage of 16-18 year-olds who are not in education, employment or training

District	2013	2014	DOT 13-14	2015	DOT 14-15	One year change (14 - 15)	Two year change (13 - 15)
Basildon	7.53	6.00	↓	5.89	↓	-0.11	-1.65
Braintree	5.70	4.60	↓	4.08	↓	-0.51	-1.62
Brentwood	5.33	4.40	↓	3.44	↓	-0.95	-1.89
Castle Point	5.73	4.96	↓	3.79	↓	-1.17	-1.94
Chelmsford	5.00	3.78	↓	4.16	↑	0.38	-0.84
Colchester	5.40	5.29	↓	4.72	↓	-0.57	-0.68
Epping Forest	5.57	4.14	↓	3.51	↓	-0.63	-2.06
Harlow	7.10	6.02	↓	4.81	↓	-1.21	-2.29
Maldon	6.13	4.49	↓	4.49	↓	-0.01	-1.65
Rochford	4.73	3.47	↓	3.81	↑	0.35	-0.92
Tendring	6.73	6.76	↑	6.73	↓	-0.03	0.00
Uttlesford	4.37	3.10	↓	2.82	↓	-0.28	-1.55
Essex	5.67	4.93	↓	4.55	↓	-0.38	-1.12
England	5.80	5.30	↓	4.67	↓	-0.63	-1.13

Generally, district performance has been below (i.e. better than) national averages for the last few years. Basildon, Harlow and Tendring however, despite year on year improvements, have consistently had levels of NEETS above national average.

3.4.5. School absence

3.4.5.1. Rationale/background

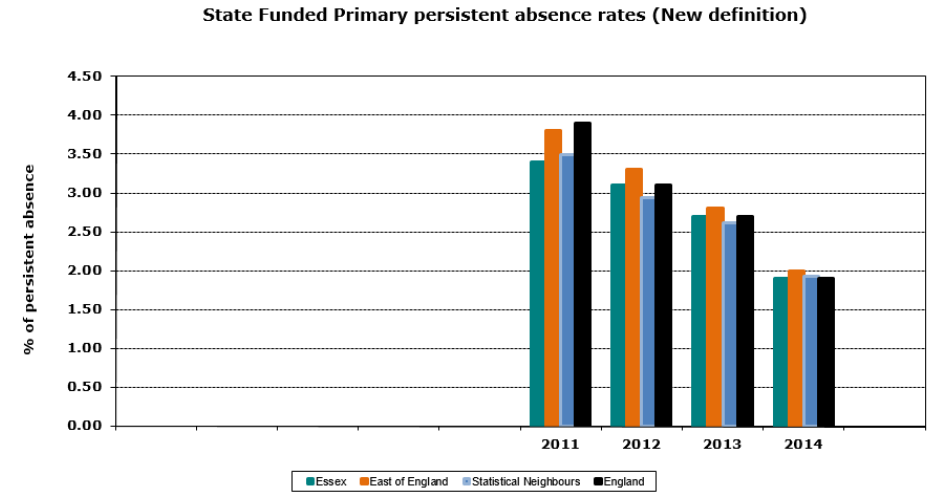
In law, parents of children of compulsory school age are required to ensure that they receive a suitable education by regular attendance at a school or otherwise. Schools are required to take an attendance register twice a day, once at the beginning of the morning session and once during the afternoon session. In the register, schools are required to distinguish whether pupils are present, engaged in an approved educational activity, or absent.

Poor attendance at school can have a serious impact on a child's education which can be permanent and damaging. For example, children who attend secondary school regularly are four times more likely to achieve five or more good GCSEs, including English and Maths, than those who are persistently absent. The poor attendance of a number of pupils can disrupt their own learning and that of other pupils. Low attenders can quickly fall behind their peers and often never fully catch up with gaps in their skills and knowledge. Over time these pupils can become bored and disillusioned with education, making them the most likely to become 'Not in Education, Employment and Training' (NEET) when they leave school.

The figures below refer to the percentage of children who are *persistently absent*. Persistent absentees are defined as having an overall absence rate of around 15% or more of possible attendance sessions, which equates to 46 or more sessions of absence.

3.4.5.2. Trends in absence

3.4.5.2.1. Persistent absence rates in primary schools

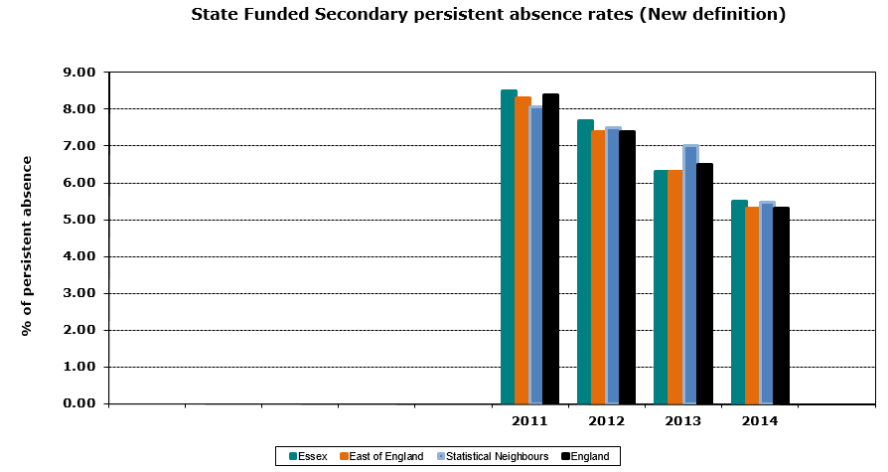


	Trend	Change from previous year	Latest National Rank	Quartile Banding	Quartile bands: Up to and including	Up to and including	Up to and including	Up to and including
Essex	↓	-0.80	70	B	1.70	1.90	2.20	3.30

Figure 26 Persistent absence rates in primary school

Persistent absence levels for primary schools in Essex have been falling consistently since the measure was introduced, and have been low compared to East of England and national averages. For the 2013/14 school year, persistent absence rates were 1.9%, below regional and statistical neighbour averages, and on the borderline of the second quartile nationally.

3.4.5.2.2. Persistent absence rates in secondary schools



	Trend	Change from previous year	Latest National Rank	Quartile Banding	Quartile bands: Up to and including	Up to and including	Up to and including	Up to and including
Essex	↓	-0.80	90	C	4.60	5.20	5.80	10.50

Figure 27 Persistent absence in secondary school

Persistence absence rates for secondary schools in Essex have also fallen consistently since the measure was introduced, although performance is not so good when compared to East of England and national averages. The latest available data for the 2013/14 school year show a persistent absence rate of 5.5%, higher than that of all comparator groups, and falling in the third quartile nationally.

3.4.5.3. District level variation in persistent absence

Table 10 District level variation in the percentage of secondary school pupils classified as persistent absentees

District	2013	2014	DOT 13-14	2015	DOT 14-15	One year change (14 - 15)	Two year change (13 - 15)
Basildon	9.59%	8.30%	↓	5.97%	↓	-2.33%	-3.62%
Braintree	7.68%	5.27%	↓	5.37%	↑	0.10%	-2.31%
Brentwood	6.27%	6.07%	↓	4.78%	↓	-1.29%	-1.48%
Castle Point	7.69%	6.65%	↓	4.81%	↓	-1.84%	-2.88%
Chelmsford	8.09%	7.02%	↓	5.36%	↓	-1.66%	-2.73%
Colchester	6.59%	5.32%	↓	5.24%	↓	-0.08%	-1.35%
Epping Forest	7.71%	5.78%	↓	5.22%	↓	-0.56%	-2.49%
Harlow	5.43%	4.07%	↓	3.88%	↓	-0.19%	-1.55%
Maldon	9.97%	8.68%	↓	6.09%	↓	-2.59%	-3.87%
Rochford	7.56%	6.47%	↓	4.83%	↓	-1.64%	-2.73%
Tendring	7.95%	7.34%	↓	6.57%	↓	-0.77%	-1.38%
Uttlesford	7.26%	5.87%	↓	4.55%	↓	-1.32%	-2.71%
Essex	7.66%	6.40%	↓	5.30%	↓	-1.11%	-2.36%
England	7.70%	6.30%	↓	6.50%	↑	0.20%	-1.20%

Note: persistent absence at district level is only available for secondary schools; primary schools often have relatively low numbers of persistent absentees, and low number data is suppressed by the DfE, making district level figures unreliable.

Almost all districts had reduced levels of absence in 2015, and all except Tendring were below national average.

3.4.6. Schools rated by Ofsted as good or outstanding

3.4.6.1. Rationale/background

Ofsted inspects schools to provide information to parents, to promote improvement and to hold schools to account for the public money they receive. School inspections are required by law. Inspectors make graded judgements on the following areas using a four-point scale: effectiveness of teaching, leadership and management; quality of teaching, learning and assessment; personal development, behaviour and welfare; outcomes for children and learners.

Schools are also given an overall grade from 1 to 4, where grade 1 is outstanding and 2 is good. The measure here is of the percentage of primary or secondary schools rated good our outstanding in their most recent Ofsted inspection.

Good/outstanding schools are effective/highly effective in delivering outcomes that provide well for all their pupils' needs. Pupils are well prepared/very well equipped for the next stage of their education, training or employment.

3.4.6.1.1. Primary schools rated good/outstanding by Ofsted

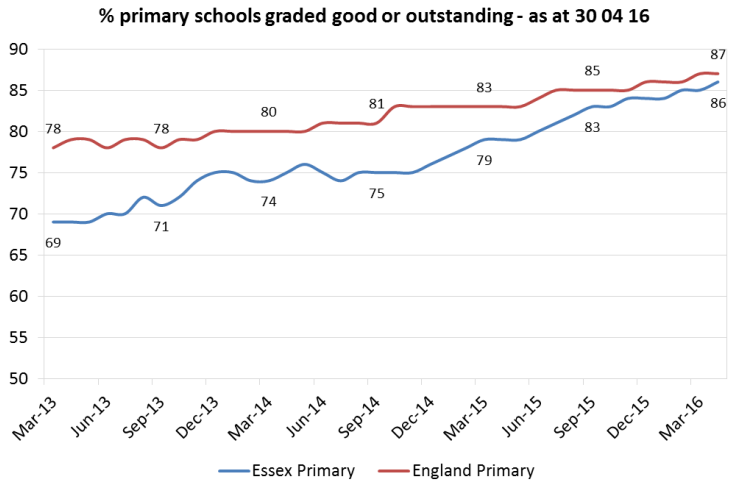


Figure 28 Percentage of primary schools rated as good or outstanding

The percentage of Essex primary schools rated good or outstanding by Ofsted has been improving steadily over the last few years. Nationally the overall rate has also been improving, but less rapidly. Consequently the gap has been narrowing over time.

3.4.6.1.2. Secondary schools rated good/outstanding by Ofsted

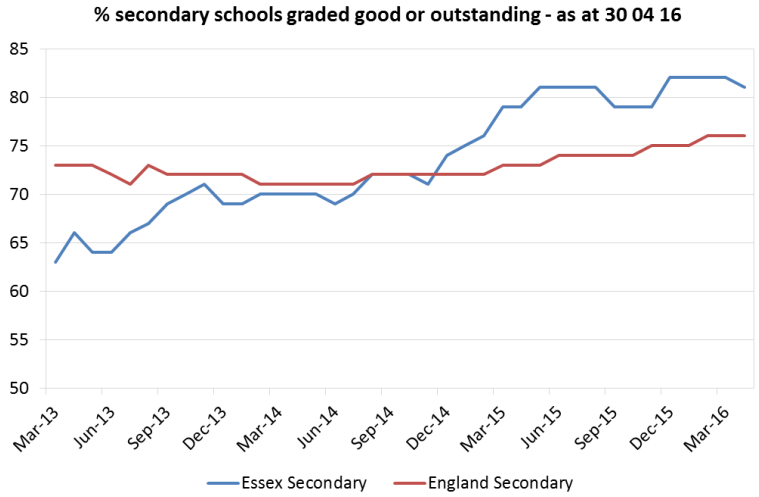


Figure 29 Percentage of secondary schools rated as good or outstanding

Whilst the overall performance of Essex secondary schools on this measure has been steadily improving on this measure over the last few years, the national average has remained almost static. Consequently, the percentage of Essex secondary schools rated good our outstanding is now well above the national average.

3.4.6.2. District level variation

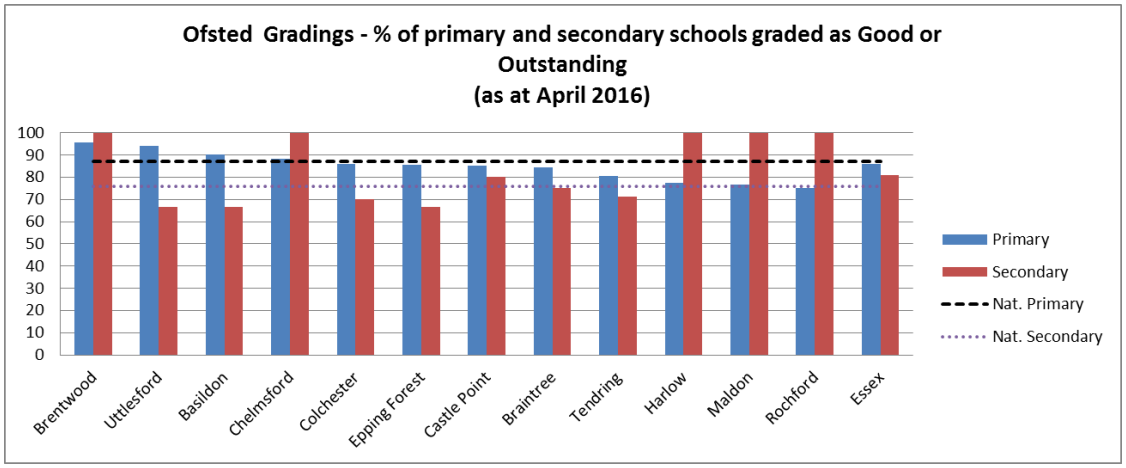


Figure 30 Percentage of primary and secondary schools rated as good or outstanding by district

The majority of the districts in Essex are in line with or above the national average percentage of Primary schools graded as good or outstanding by Ofsted. Brentwood, Uttlesford and Basildon have a higher percentage of Primary schools graded as good or outstanding in comparison to the national average. Tendring, Harlow, Maldon and Rochford all have a lower percentage of Primary schools graded as good or outstanding in comparison to the national average.

The majority of Secondary schools across the twelve districts in Essex are performing in line with or above the national average percentage of Secondary schools graded as good or outstanding by Ofsted. Brentwood, Chelmsford, Harlow, Maldon and Rochford all have 100%.

Despite having 100% of their Secondary schools graded as good or outstanding, Harlow, Maldon and Rochford Primary schools are all below the national average for Primary schools.

3.5. Safeguarding

3.5.1. Safeguarding areas of need within Essex

3.5.1.1. Rationale/Background

With growing challenges, for example economic factors and demographic changes, it is important to understand where there is a high risk of safeguarding need and to identify emerging areas of risk. This will enable more effective and targeted safeguarding work.

A factor analysis has been carried out in order to identify areas of need within Essex. The following factors were considered; Children on CP plans, CIN, New CP plans, Children in Care, DV incidents, Sexual offences, Violence against the person, poverty and assessment factors e.g. Mental Health, Drugs, and Emotional Abuse etc. Once all factors were correlated, wards in the 10% were identified as an area of need.

Please note, there is no causal link between any of the above factors and safeguarding risk. This report is based on correlations of factors co-occurring. Therefore the presence of one factor may not result in the presence of another factor or of a safeguarding risk, it is merely a useful tool to guide initiatives and establish overall areas of need based on National research and statistical analysis.

3.5.1.2. Trends in Child Protection Plans

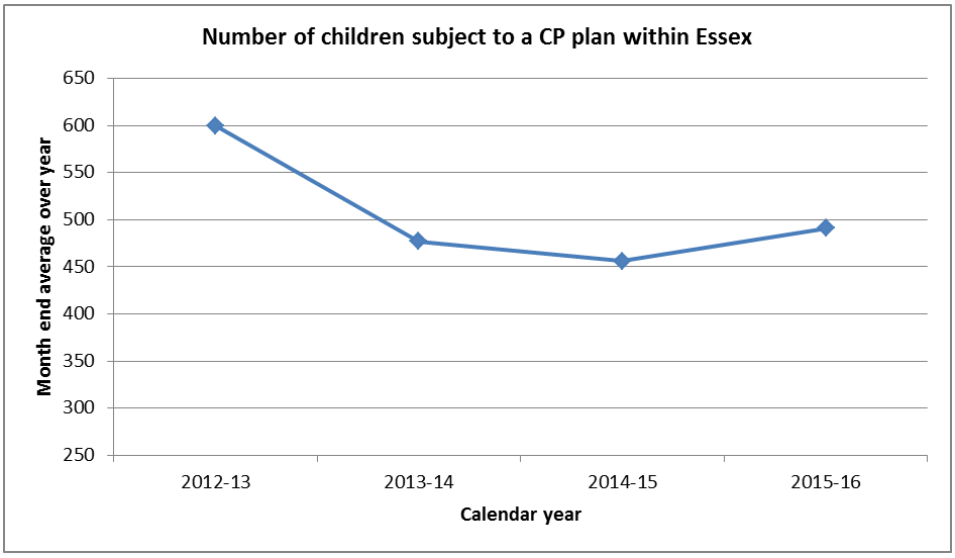


Figure 31 Number of Children in Essex Subject to a Child Protection Plan

When comparing the month end average over a year, of children subject to a child protection plan in Essex, there has been an 8% increase in comparison to last year.

The current figure for the rate of child protection plans per 10,000 for Essex is 19, an increase in comparison to the figure of 15 in 2015.

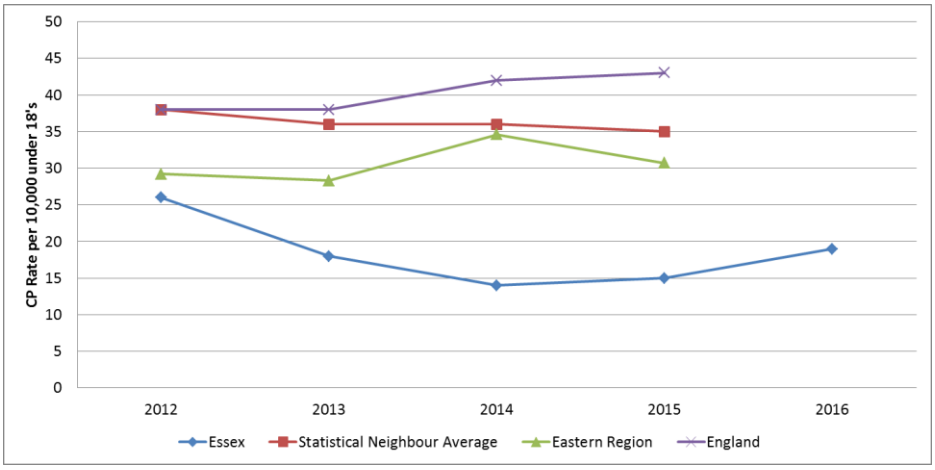


Figure 32 Child protection plans in Essex in comparison

Essex holds significantly fewer children per head of population on child protection plans than either England as a whole, our statistical neighbour authorities and Eastern region authorities.

3.5.1.3. District Variation

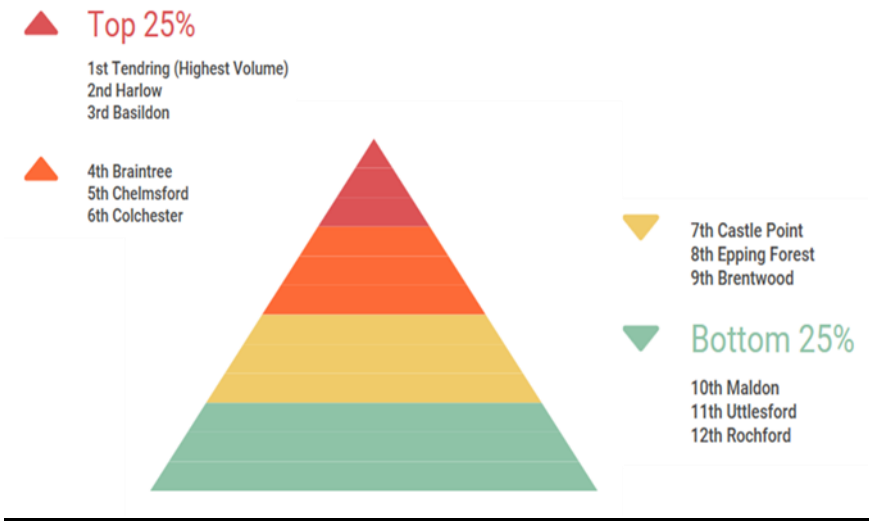


Figure 33 District variation of safeguarding areas of need

Tendring, Harlow and Basildon are in the top quartile in Essex; however this varies when looking on a ward basis.

District level analysis shows emerging areas of safeguarding need are Braintree, Chelmsford and Colchester.

Domestic abuse and mental health are the most prominent assessment factors across the wards identified in the top 10%.

3.5.1.4. Ward Variation

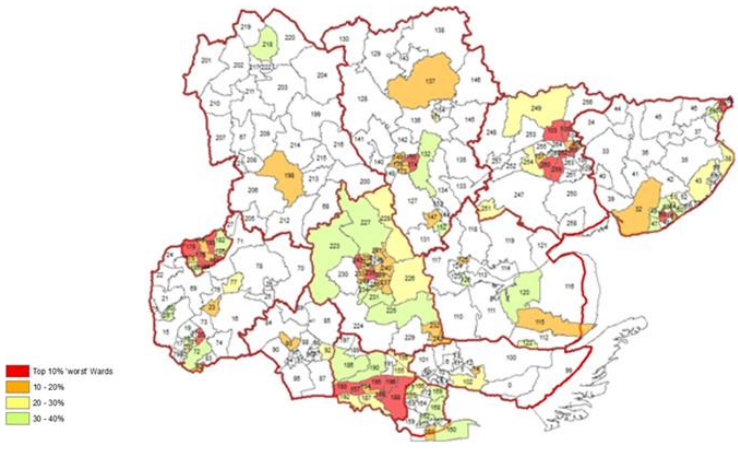


Figure 34 Map of safeguarding areas of need

11 wards within 4 districts were identified as the hotspot areas of safeguarding need based on a multi-factor analysis. These areas were, Colchester (Mile End, Berechurch), Harlow (Little Parndon & Hare Street, Toddbrook), Tendring (Pier) and Basildon (Fryerns, Lee Chapel North, Pitsea North West, Pitsea South East, St Martins, Laindon Park)

3.5.2. Domestic Abuse

3.5.2.1. Rationale/Background

Domestic abuse has a huge impact on quality of life and can ultimately destroy people's lives. Despite being a significant contributor to crime statistics it is also a pattern of behaviour that often happens behind closed doors and is grossly under-reported. It is an issue that cuts across all social, geographical and cultural groups.

Domestic Abuse is a contributor to causes of ill health and poor wellbeing in local communities. As well as the personal cost, domestic abuse, imposes a considerable financial burden on local healthcare systems. Significant health inequalities are experienced by people who are at risk of causing violence, at risk of experiencing violence, and victims of violence. Exposure to violence as a child has particularly negative impacts, not only increasing the risks of involvement in future violence but of substance abuse, poor mental health and chronic illness in later life. Furthermore, violence impacts on the wider wellbeing of local communities.

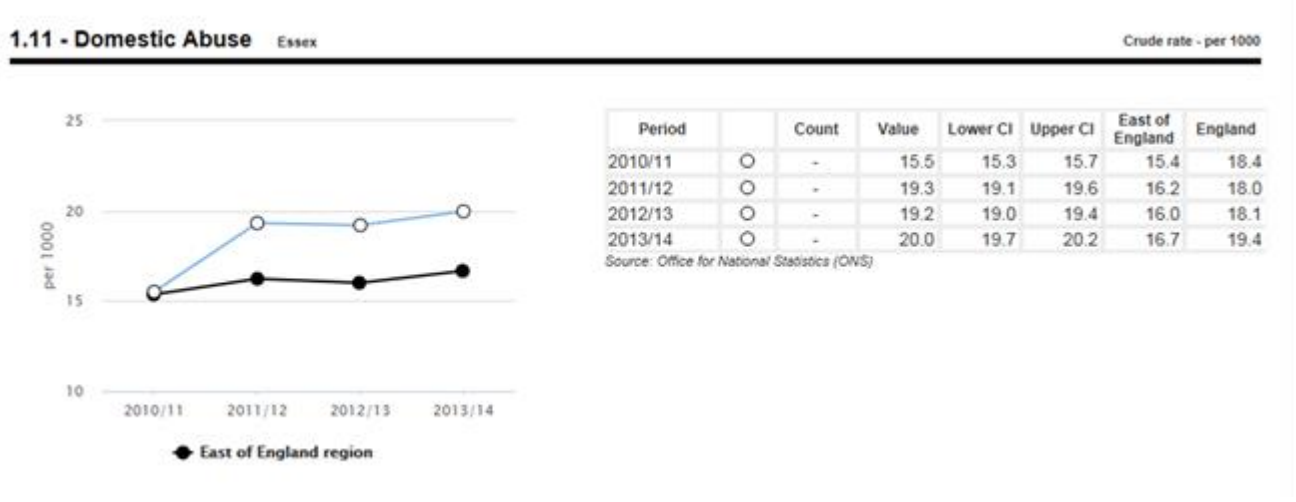
There is also a potential hidden victimisation of domestic abuse that occurs in over 65's. This age group is also more likely to report to agencies other than the police, placing increased importance on considering multi-agency data in commissioning services.

Tackling domestic abuse as a public health issue is vital for ensuring that some of the most vulnerable people in our society receive the support, understanding and treatment they need.

Home Office 2013 Definition:

> *'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological; physical; sexual; financial and emotional'*

3.5.2.2. Trend in domestic abuse incidents



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11	○	-	15.5	15.3	15.7	15.4	18.4
2011/12	○	-	19.3	19.1	19.6	16.2	18.0
2012/13	○	-	19.2	19.0	19.4	16.0	18.1
2013/14	○	-	20.0	19.7	20.2	16.7	19.4

Source: Office for National Statistics (ONS)

Figure 35 Rate of domestic abuse incidents recorded by police [4]

Figure 35 presents the last four years of police recorded incidence of domestic abuse in Essex. The trend shows that the rate of domestic abuse has risen since 2010/11 and is higher than the average for the region. It is important to note that the increase could be due to a rise in reporting levels, especially as there has been a recent focus on campaigns to increase reporting. In 2013/14 the rate of Domestic abuse in Essex was 20 per 1,000 compared to the regional average of 16.7 per 1,000. However, this is not a negative as domestic abuse is seen as a hidden crime and it is important the reporting levels are high.

1.11 - Domestic Abuse 2013/14 Crude rate - per 1000

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	19.4	19.3	19.4
East of England region	-	16.7	16.6	16.8
Essex	-	20.0	19.7	20.2
Thurrock	-	20.0	19.7	20.2
Southend-on-Sea	-	20.0	19.7	20.2
Cambridgeshire	-	17.8	17.5	18.1
Peterborough	-	17.8	17.5	18.1
Central Bedfordshire	-	16.1	15.7	16.4
Bedford	-	16.1	15.7	16.4
Luton	-	16.1	15.7	16.4
Norfolk	-	14.9	14.7	15.2
Hertfordshire	-	14.7	14.4	14.9
Suffolk	-	13.3	13.0	13.5

Source: Office for National Statistics (ONS)

Figure 36 Variation of Domestic abuse within the East of England

Figure 36 demonstrates that Essex, Southend and Thurrock have the highest rate per 1,000 of Domestic abuse within the region.

The Essex Joint Strategic Commissioning Strategy presents ambitions to increase reporting of domestic abuse initially through activities from the strategy and to reduce the percentage of repeat victims.

The issue of domestic abuse is expanded in more detail in a two page overview

3.5.3. First time entrants in to the youth criminal system

3.5.3.1. Rationale/Background

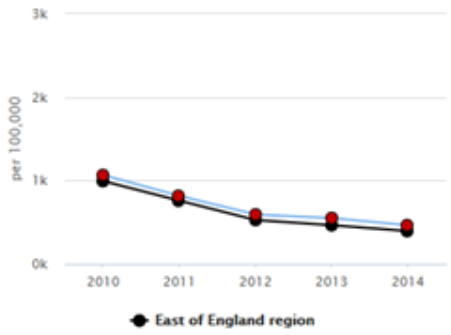
Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. Research demonstrates consistently high levels of complex developmental issues and unmet emotional and other mental health needs among children in the youth justice system.

Mapping relevant risk factors associated with youth crime such as loss of contact with families and substance misuse can help inform commissioning of evidence based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them.

3.5.3.2. Trend in Juvenile 1st time entrants to criminal justice system

Compared with benchmark: Better Similar Worse

1.04 - First time entrants to the youth justice system Essex Crude rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010		1,480	1,067	1,013	1,122	994	902
2011		1,122	817	770	866	759	726
2012		805	593	553	636	527	556
2013		733	551	512	592	465	448
2014		611	464	428	503	395	409

Source:

Numerator - Police National Computer

Denominator - ONS population estimates

Figure 37 Juvenile 1st time entrants to criminal justice system

Within Essex the rate of first time entrants to the youth justice system has decreased significantly since 2010, similar to the regional pattern, however has been consistently worse than the regional average. In

Essex the latest measurement year 2014 had 464 per 100,000 first time entrants, this is significantly worse than the regional average of 395 per 100,000.

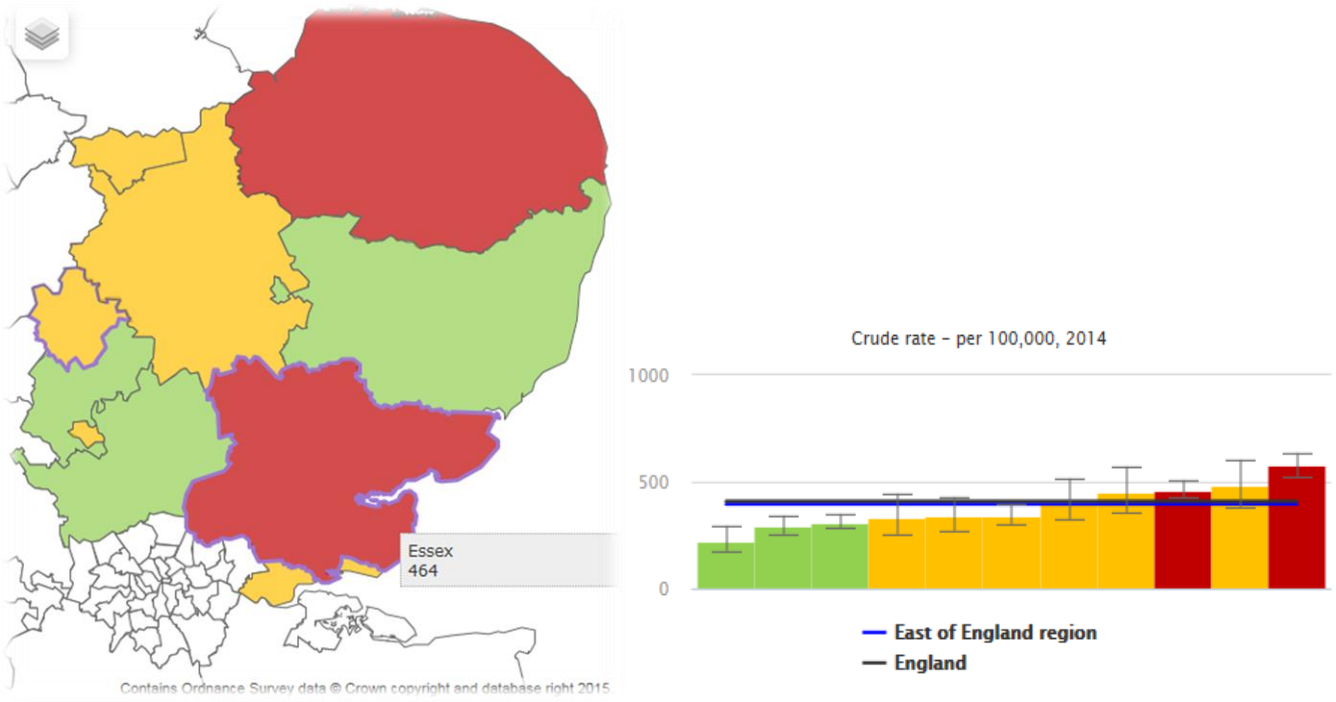


Figure 38 Variation in first time entrant within the East of England

The map demonstrates the performance of Essex in relation to other areas in the East of England.

3.5.4. Violent Crime

3.5.4.1. Rationale/Background

For the purpose of this JSNA we will be using the following definition of 'violent crime'. 'Violent crime covers a wide range of offences, from minor assaults such as pushing and shoving that result in no physical harm through to serious incidents of wounding and homicide. Sexual offences include rape, sexual assault and unlawful sexual activity against adults and children, sexual grooming and indecent exposure.' The primary data set for this indicator will be the rate of hospital admissions (as reported by Public Health England), it will be used alongside the rate of violent crime offences (per 1,000 population) as reported by the office of national statistics. Interesting data is also recorded in the crime survey for England and Wales but reporting rates of these types of crimes is often problematic and not truly representative of the levels of harm being experienced.

3.5.4.2. Trend in violent crime

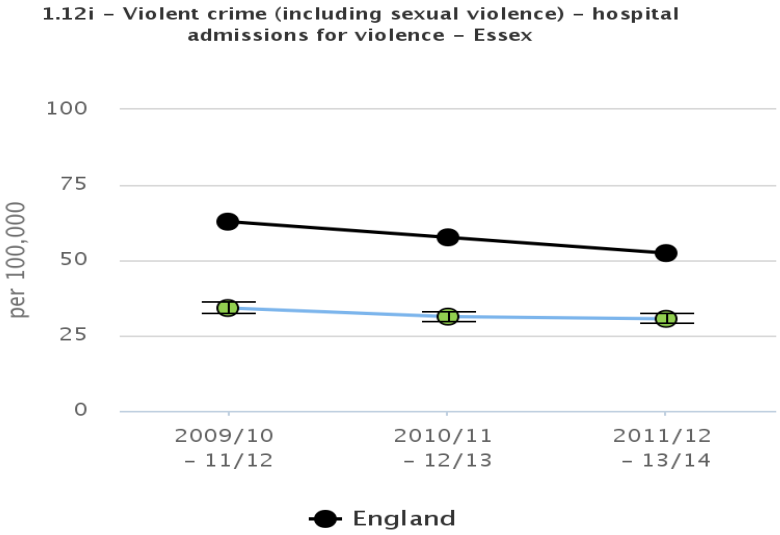


Figure 39 Violent crime (including sexual violence) hospital admissions for violence

Table 11 Violent Crime

Period		Count	Value	Lower CI	Upper CI	East of England	England
2009/10 - 11/12		1,400	34.1	32.4	36.0	37.0	62.8
2010/11 - 12/13		1,285	31.3	29.6	33.0	35.1	57.6
2011/12 - 13/14		1,257	30.5	28.9	32.3	33.3	52.4

Source: Data supplied by Hospital Episode Statistics, Health and Social Care Information Centre (HSCIC). Values calculated by KIT(NW

Hospital Admissions as a result of violence in Essex have decreased slightly since 2009. The figures for the east of England region and England as a whole have reduced at more significant level.

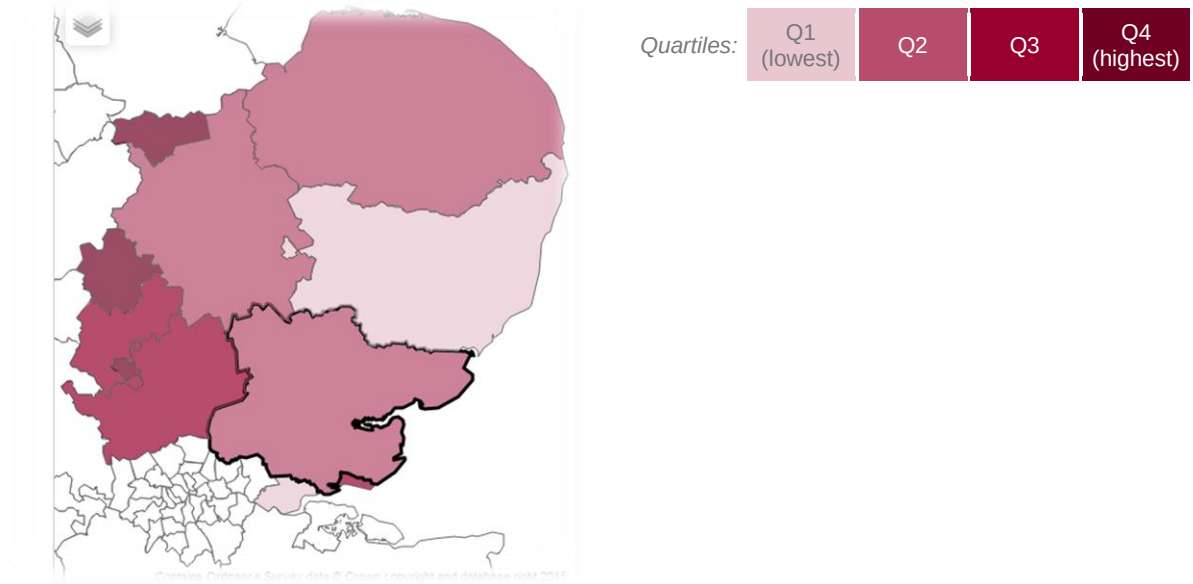


Figure 40 Hospital admissions for violence (including sexual violence)

The current (2014) figure for Essex is 30.5 (per 1,000 population) This is significantly better than the England average (52.4), Essex ranks 5th out of the 11 authorities in the East of England. The highest levels (Esat of England 33.3). There are significant differences when reviewed against the indices of deprivation. The levels of hospital admissions for those area's in the lower 5th deprived decile are significantly better than the England average, however the rate for those in Essex, in the most deprived decile is over 80%.

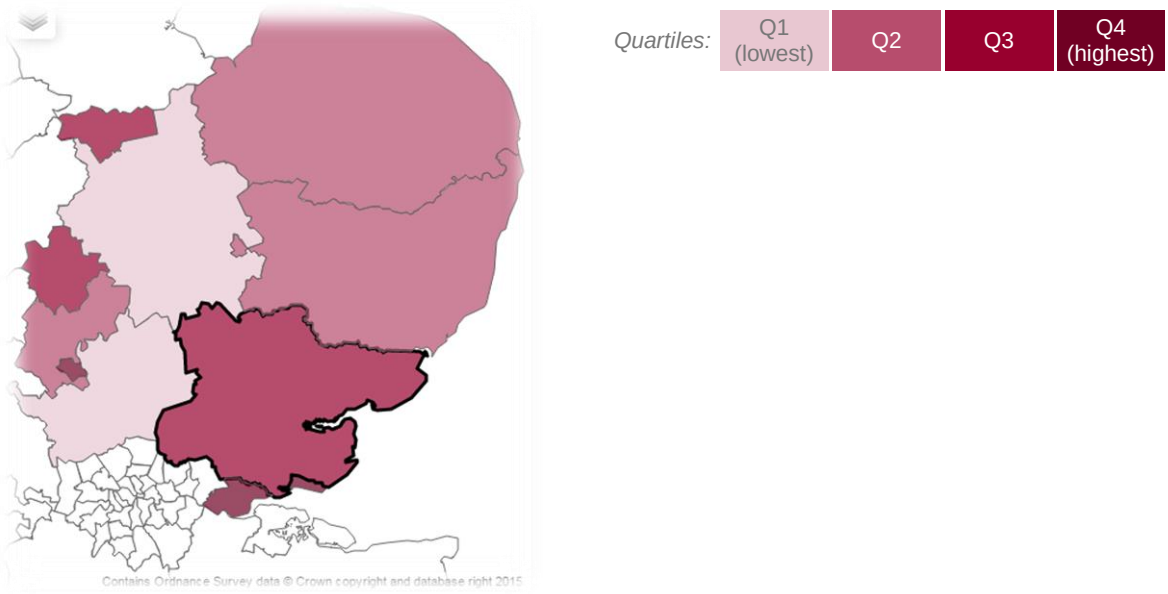


Figure 41 Violence Offences (including sexual violence) per 1,000 Population

The rate of Violent Crime In Essex (2014) was 10.4 (per 1,000 population). This is higher than the East of England average (9.6) but still lower that the England average figure (11.1) Essex is ranked 6th in the region for violent crime offences, with Southend of Sea recording the highest rate (15.4). Factors such as deprivation have less of an impact here, where recorded figures show a generally consistent trend, regardless of the deprivation decile, though the most deprived decile does have the highest levels, these only equate to just over 15%

3.5.5. Injuries in 0-14 year olds, hospital admissions

3.5.5.1. Rationale/Background

Childhood injury, whether accidental or intentional, can have serious consequences including mental health disorder, disability and at worst, premature mortality [4]. Monitoring is important for the analysis and implementation of preventative strategies.

3.5.5.2. Trend in childhood injuries

Essex has a lower rate of hospital admissions as a result of unintentional and deliberate injuries in children aged 0-14 than the national average. In the year 2013/14, there were 92.3 admissions per 10,000 resident population in Essex. The national average was 112.2 [4].

When analysed by district/borough, it appears that those with significantly lower rates than the national average (2013/14) were; Basildon, Brentwood, Castle Point, Epping Forest, Harlow, Rochford and Uttlesford. The remaining districts were not significantly different from the national average, with Colchester's rate being just above at 115.9 [4].

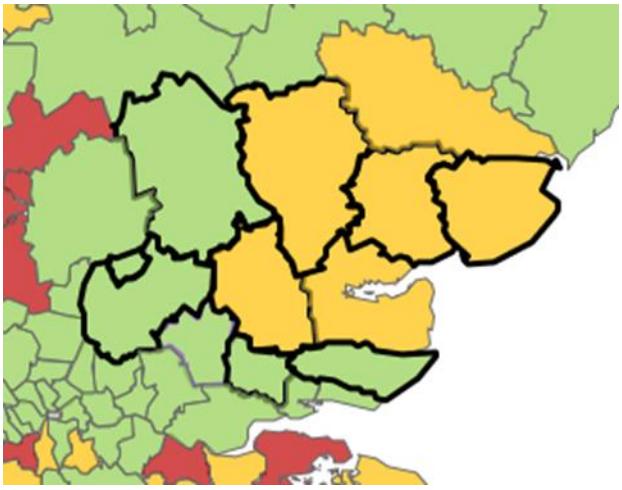


Figure 42 Number of Hospital Admissions as a result of unintentional or deliberate injuries in children aged 0-14 per 100,000 of population in 2013/14

3.5.6. Safeguarding children in Essex

3.5.6.1. Rationale/Background

Safeguarding relates to the action taken to promote the welfare of children and protect them from harm.

There is a necessity to safeguard children who face additional risks of abuse or exploitation. These safeguards include child protection policies and procedures for dealing with issues of concern or abuse.

3.5.6.2. The National Picture

Table 12 The table below indicates where Essex sits within its Statistical Neighbour (SN) and England for Child protection (CP) and referrals to Social Care.

2014/15	CP Plans per 10,000	CP Plans lasting 2+ yrs	Second or subsequent CP Plan	Number of referrals to Social Care (monthly)
Essex v Stat Neighbours				
Good to be…	▼	▼	▼	▼
Benchmarking	Essex is significantly below both SN and England rates	Essex figures are significantly below SN and slightly below England	Essex is below both SN and England averages	Essex usually has with a lower rate than SN and England but in 2015 Essex's rate was slightly above SN

Essex has lower levels of CP plans and monthly referrals in comparison to National figures and statistical neighbours.

3.5.7. Referrals to Social Care

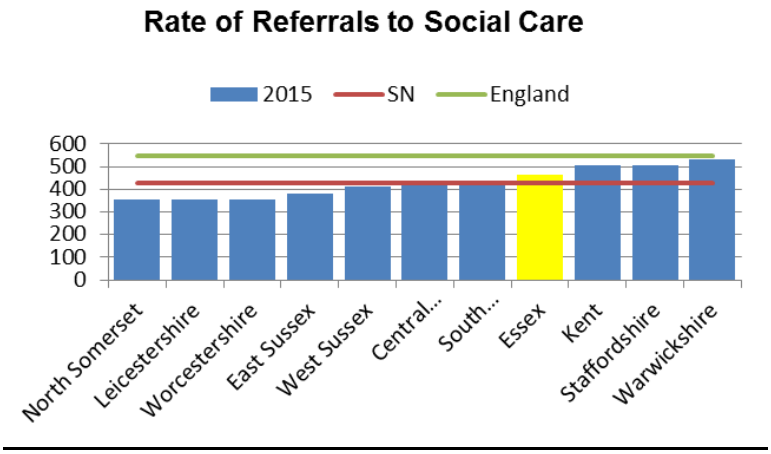


Figure 43 Essex rates of referrals to Children's Social Care in comparison to England and Statistical neighbour rates

Over the last 3 years Essex has seen a lower referral rate per 10,000 residents than both its statistical neighbours and the England rate.

2015 Essex had a rate slightly above its statistical neighbours, however, the difference is relatively small and referral rates are still significantly below the England Referral rate.

1. **Focussed areas for 2014/15 from annual refresh**
    a. Improve pre-school support, in particular for the 0-2 age group
        i. 3 & 4 Year Old Free Entitlement Funding
        ii. FEEE2 Year Old FEEE
    b. Improve educational achievement
        i. Schools rated by OfSTED as good or outstanding
    c. Deliver the Family Solutions project
2. **Additional measures based on the five cross cutting themes**
    a. Tackling health inequalities and the wider determinates of health and wellbeing
    b. Transforming services: developing the health and social care system
    c. Empowering local communities and community assets
    d. Prevention and effective intervention
    e. Safeguarding
3. **Recommendations for Deep Dive/Specialist Topic reports**

4. Living and working well priority review content

4.1. National and local policy context

4.1.1. Essex context

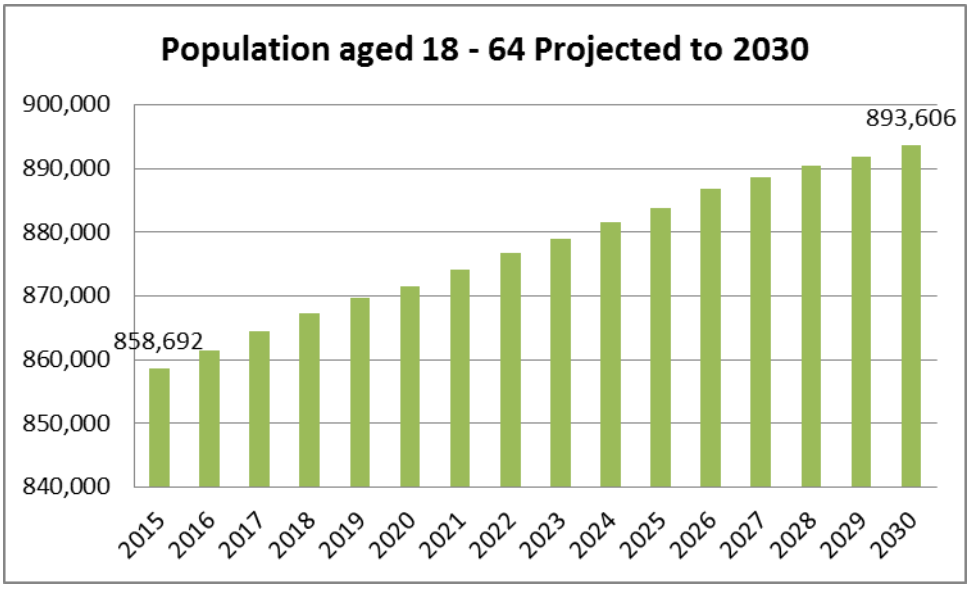


Figure 42 The projected population of 18 to 64 year olds in Essex, 2015 to 2030

In 2015, the population of 18 to 64 year olds is estimated to be c858,692

The population of 18 to 64 year olds is estimated to grow by c34,914 by 2030 to 893,606

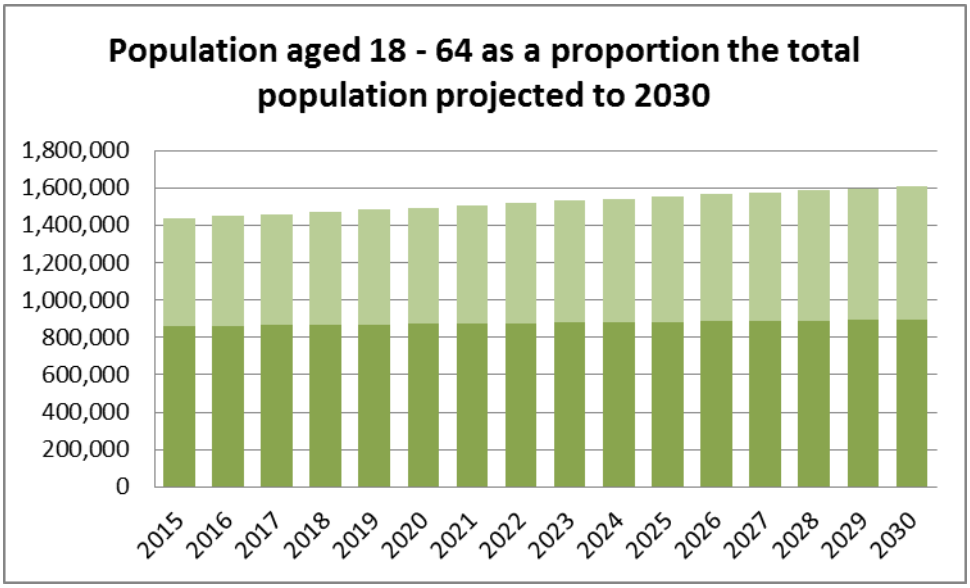


Figure 44 The population of 18 to 64 year olds in Essex compared to the total population

4.1.2. National context

Alcohol and drug misuse. Public Health England figures on adult and young people's drug and alcohol services in England for 2014 to 2015 show that adults starting treatment are increasingly aged 40 or over. It highlights the challenges of an ageing population of heroin users in drug treatment who have wide ranging health and social problems, including unemployment, homelessness or insecure housing and limited social

networks. Adults starting treatment for alcohol misuse tend to be even older and often have alcohol related illnesses. They are more likely to have 'capital' that supports recovery, such as employment and housing. Public Health England has called on local authorities to continue to invest to support recovery. There was a review of Drug Misuse and Dependence: UK guidelines on clinical management in 2014 with an expectation that new guidelines will be published in 2016.

Drug-related deaths in England and Wales have increased, according to ONS figures for 2014. The mortality rate from drug misuse was the highest ever recorded with the highest rate among people aged 40 to 49.

In January 2016, the Department of Health published new guidelines for alcohol consumption for consultation. The Chief Medical Officers' guideline for both men and women is:

- You are safest drinking no more than 14 units per week;
- If you do drink as much as 14 units per week it is best to spread this evenly over three days or more;
- The risk of developing a range of illnesses increases with any amount you drink on a regular basis;
- A good way to cut down on the amount you're drinking is to have several drink free days each week.

Increased physical activity and improved diet. In October, Public Health England published an evidence review on measures to reduce sugar consumption. It identified a range of factors contributing to increased consumption. Evidence based measures to reduce consumption include: reducing the volume and number of price promotions in retail and restaurants; tackling the marketing and advertising of high sugar products to children; and reducing the sugar content in and portion size of everyday food and drink products.

Adult mental health and well-being. Essex has conducted a strategic review of adult mental health services and will be developing its approach in 2016. Policy discussion is framed by the commitment in the NHS mandate to 'parity of esteem' for physical and mental health problems. This work is supported by the Mental Health Crisis Care Concordat, a national agreement with a focus on: support before crisis point; urgent and emergency access to crisis care; quality of treatment and care when in crisis; and recovery and staying well. The Government is considering responses to a consultation on the new mandate to NHS England to 2020. The consultation document highlighted 'parity' and the need for 'transparency on the quality and outcomes of care' to assess progress.

In November, the King's Fund published an analysis of Mental Health Under Pressure. It noted that many mental health providers had embarked on transformation programmes based on reducing costs, shifting demand away from acute services and delivering focussed care and recovery management. While cost reductions had been achieved and new approaches could augment mental health service provision, there was a concern that a wider reconfiguration of evidence-based services could represent 'a leap in the dark'.

The Spending Review 2015 provided for an additional £600 million for mental health services to improve access to talking therapies every year up to 2020. The Prime Minister has since announced a total of nearly 1 billion to be invested in mental health services to support the proposals for the independent mental health taskforce and its five year plan for NHS mental health provision across the life course [insert para on the Taskforce report on publication]. Pledging 'a revolution in mental health treatment', the PM highlighted:

- £290 million for peri-natal mental health;
- Introduction of waiting time targets for teenagers with eating disorders and people experiencing psychosis;
- Nearly £250 million for mental health services in hospital emergency departments;
- Over £400 million to enable 24/7 treatment in communities as an alternative to hospital.

Sexual health. PHE published Sexual and reproductive health and HIV: Strategic Action Plan, 2016 to 2019. It provides guidance around four priorities from the Department of Health's A framework for Sexual Health

Improvement in England (2013): reduce the burden of HIV infection with a focus on at risk populations; reverse the rapid increase in STIs in populations most at risk of infection; minimise the proportion of pregnancies that are unplanned; and reduce the rate of under 18 and under 16 conceptions and variations across the country.

Smoking. In September, PHE produced a joint statement on e-cigarettes with other UK public health organisations, including the Royal College of Physicians and Royal Society for Public Health. This stated that e-cigarettes were significantly less harmful than smoking and 'the health risks posed by e-cigarettes are relatively small by comparison', but with a need to 'continue to study the long term effects'. In October the law changed to make it illegal to smoke in a car (or other vehicle) with anyone under 18. The law does not apply to e-cigarettes (vaping).

Increased opportunities for training, apprenticeships, employment and skills. The Spending Review provides £115 million for a Joint Work and Health Unit, including at least £40 million for a health and work innovation fund, to pilot new ways to join up health and employment systems. Dame Black has conducted an independent review for the Department of Work and Pensions on employment outcomes, drug/alcohol addiction and obesity, including options for employment support and incentives/barriers n the welfare system. Findings will be published in 2016 [insert details on publication].

Affordable housing. The Spending Review 2015 set out a five point plan for housing:

- 400,000 affordable housing starts by 2020-21 focussed on low cost home ownership (this includes at least 8,000 specialist homes for older people and people with disabilities);
- Extend the right to buy to Housing Associations, with a pilot in five Housing Associations to inform design of the final scheme;
- Accelerate housing supply, including releasing public sector land for housing development, brownfield developments, amending planning policy to support small sites and investing £310 million in a new garden city at Ebbsfleet;
- Extending Help to Buy;
- Higher stamp duty on buy to let properties and second homes.

The Spending Review included over £500 million by 2019-20 for the Disabled Facilities Grant, which it said would fund around 85,000 home adaptions in that year. The Government announced it would end the current management fee for temporary accommodation, while devolving an increased level of funding to local authorities with flexibility to invest in preventing homelessness, and provide £40 million for investment in services for victims of domestic abuse.

4.2. Health

4.2.1. Excess weight in adults

4.2.1.1. Background

Excess weight (a category that includes the overweight and obese) can lead to medical, psychological and social ill health. It is a leading cause of increased morbidity and mortality.

4.2.1.2. Trends in excess weight in adults

The most recent available data (2012-2014) shows the proportion of Essex adults who have excess weight is 66.5%. This is significantly higher than either the English or Regional average (64.6% and 65.6% respectively). [12]

As the data comes from a newly-inaugurated data source, it is difficult to compare to previous data. For adult obesity, 24.1% were obese in 2008 in a different dataset, compared to 24.5% in 2012. [13]

Within Essex, there is significant variation and inequality. The proportion carrying excess weight varies from Uttlesford (62.2%, in the second quintile nationally) to Castle point (70.8%, in the fifth quintile). There is no 'ward level' data available since 2008 [12].

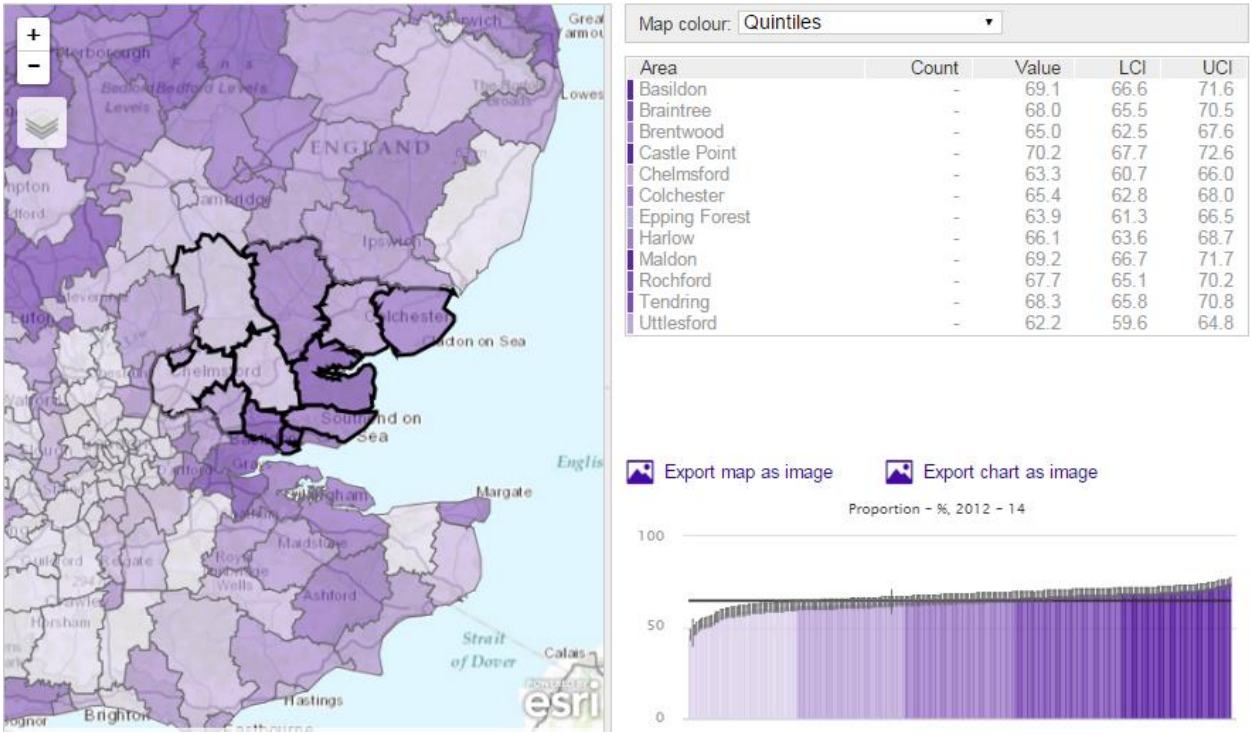


Figure 45 Proportion with excess weight in each district of Essex in 2012-2014, shaded by Quintile. Source: Public Health Outcomes Framework.

4.2.2. Percentage of adults doing enough physical activity

4.2.2.1. Background

Inactivity is thought to account for 6% of all deaths worldwide. A physically active lifestyle is known to be protective for a wide range of conditions, from mental health, to coronary heart disease, to bowel cancer. The chief medical officer recommends adults undertake at least 2.5 hours of moderate activity each week.

4.2.2.2. Trend in physical activity levels

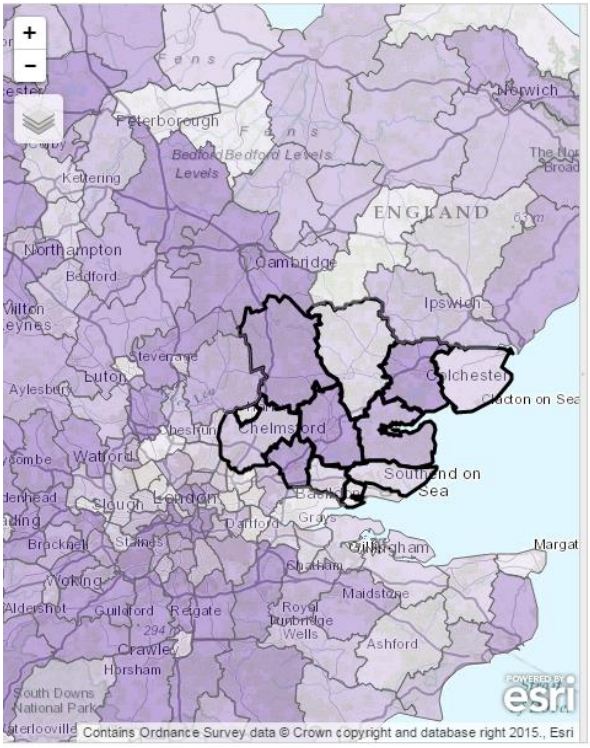
In Essex in 2014, 57.9% of people had the recommended amount of physical activity. This is similar to the English (56.0%) and regional (57.8%) averages, and has been stable over the last three years [14].

Period		Count	Value	Lower CI	Upper CI	East of England	England
2012	●	-	57.4	56.2	58.7	57.1	56.0
2013	●	3,173	57.6	56.4	58.9	57.8	56.0
2014	●	3,178	57.9	56.6	59.1	57.8	57.0

Source: Active People Survey, Sport England

Figure 46 Fraction of physically active adults in Essex 2012-2014, compared against the East of England (black line). Source: Public Health outcomes framework

There is, however, significant variation by district, with a range of 12% between Colchester (63.8%, in the highest quintile nationally) and Castle point (51.8%, in the lowest quintile nationally).



Map colour: Quintiles

Area	Count	Value	LCI	UCI
Castle Point	262	51.8	47.4	56.1
Harlow	239	52.0	47.6	56.3
Braintree	239	54.9	50.5	59.3
Rochford	251	55.0	50.7	59.3
Tendring	228	55.1	50.8	59.5
Basildon	265	55.4	51.2	59.7
Epping Forest	259	56.7	52.4	61.1
Maldon	274	60.3	56.0	64.6
Uttlesford	296	61.8	57.7	66.0
Brentwood	286	62.1	57.9	66.4
Chelmsford	292	62.7	58.5	66.9
Colchester	287	63.8	59.7	68.0

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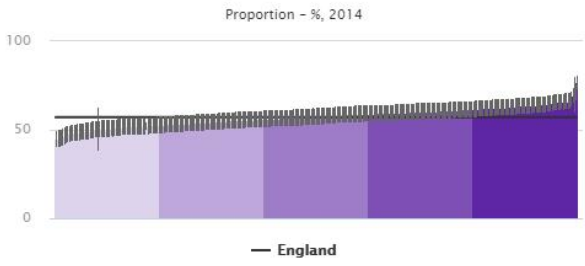


Figure 47 Map of proportion of physically active adults in each district of Essex in 2014, shaded by quintile. Source: Public Health Outcomes Framework

4.2.3. Proportion eating 5-a-day

4.2.3.1. Background

Diets rich in fruits and vegetables provide protection against cardiovascular disease and cancer. Monitoring what proportion of people have at least 5 portions of fruit and vegetables tracks an important determinant of healthy living.

4.2.3.2. Trend in fruit and vegetable consumption

53.4% of adults in Essex report having five or more portions of fruit and vegetables each day. This is similar to the national average (53.5%) but slightly (but significantly) worse than the regional average (55.0%). [15] This indicator was developed from 2014 survey data, and thus no direct assessment for trend can be made. Another indicator surveyed in 2008 suggest that 29.6% of Essex adults reported having five or more portions of fruit and vegetables a day, similar to the national average reported (28.2%). [16] Given the considerable difference in percentages reported, these are data are unlikely to be directly comparable.

There is considerable geographic variation: Chelmsford has a significantly higher percentage than the region (59.5%), whilst Colchester, Harlow, and Tendring are all significantly lower (50.0%, 45.5%, and 46.9% respectively.

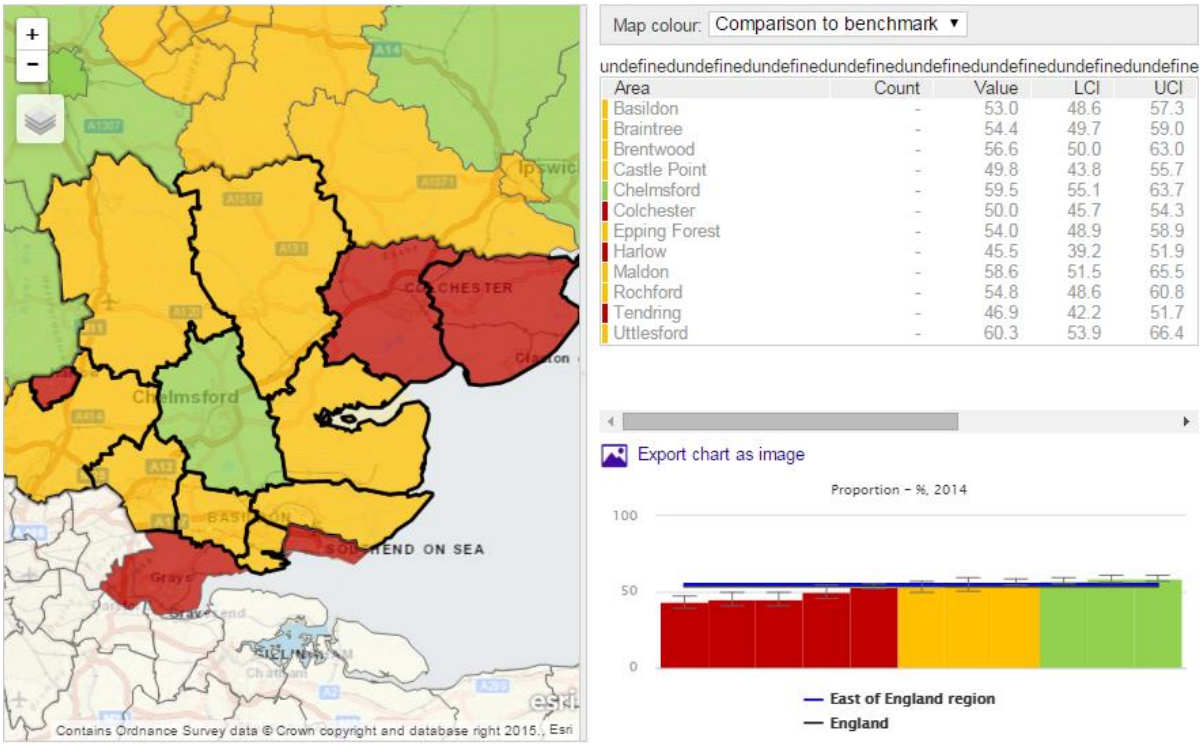


Figure 48 Proportion having 5 or more portions of fruit and vegetables a day for each district in Essex, 2014. Red indicates regions significantly below the regional average, green regions significantly above. Source: Public Health Outcomes Framework.

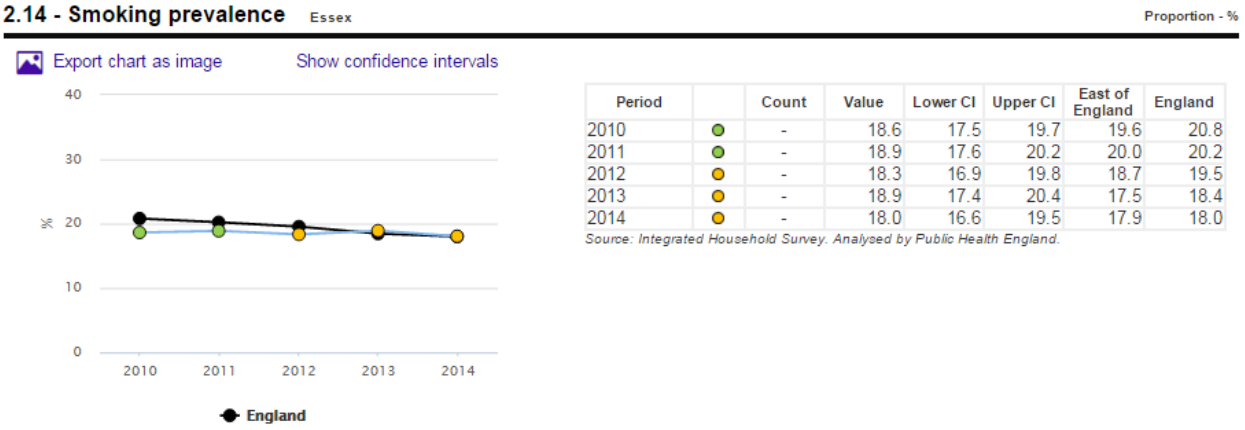
4.2.4. Smoking Prevalence

4.2.4.1. Background

Smoking is a significant risk factor for mortality and morbidity, via cancer, cardiovascular disease, stroke, respiratory disease, and many others. Reducing smoking remains a key public health imperative.

4.2.4.2. Trend in smoking prevalence

In 2014, Essex's smoking prevalence was 18.0%, similar to English (18.0%) and regional (17.9%) averages. However, smoking prevalence in Essex has remained static over the last five years, whilst the rates in the region and the nation have seen a slow decline over the same period [17].



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010		-	18.6	17.5	19.7	19.6	20.8
2011		-	18.9	17.6	20.2	20.0	20.2
2012		-	18.3	16.9	19.8	18.7	19.5
2013		-	18.9	17.4	20.4	17.5	18.4
2014		-	18.0	16.6	19.5	17.9	18.0

Source: Integrated Household Survey. Analysed by Public Health England.

Figure 49: Smoking prevalence in Essex 2010-2013, compared to the national average (black line). Source: Public Health Outcomes Framework

By district, smoking varies from 6.6% (Uttlesford, with the 3rd lowest prevalence in England) to 26.9% (Castle point, with the 5th highest prevalence in England.) Harlow, Maldon, Tendring and Colchester are also in the 5th quintile nationally. Note however that there is considerable uncertainty in these point estimates, so there can be considerable year on year variation. Harlow, although it remains in the 5th quintile, had the third highest estimate for smoking prevalence in England in 2013.

The Public Health Outcomes framework also has an indicator for smoking of those in routine and manual occupations. The pattern for this indicator closely matches that of smoking prevalence in the general population, with similar trends and geographic distribution within Essex.

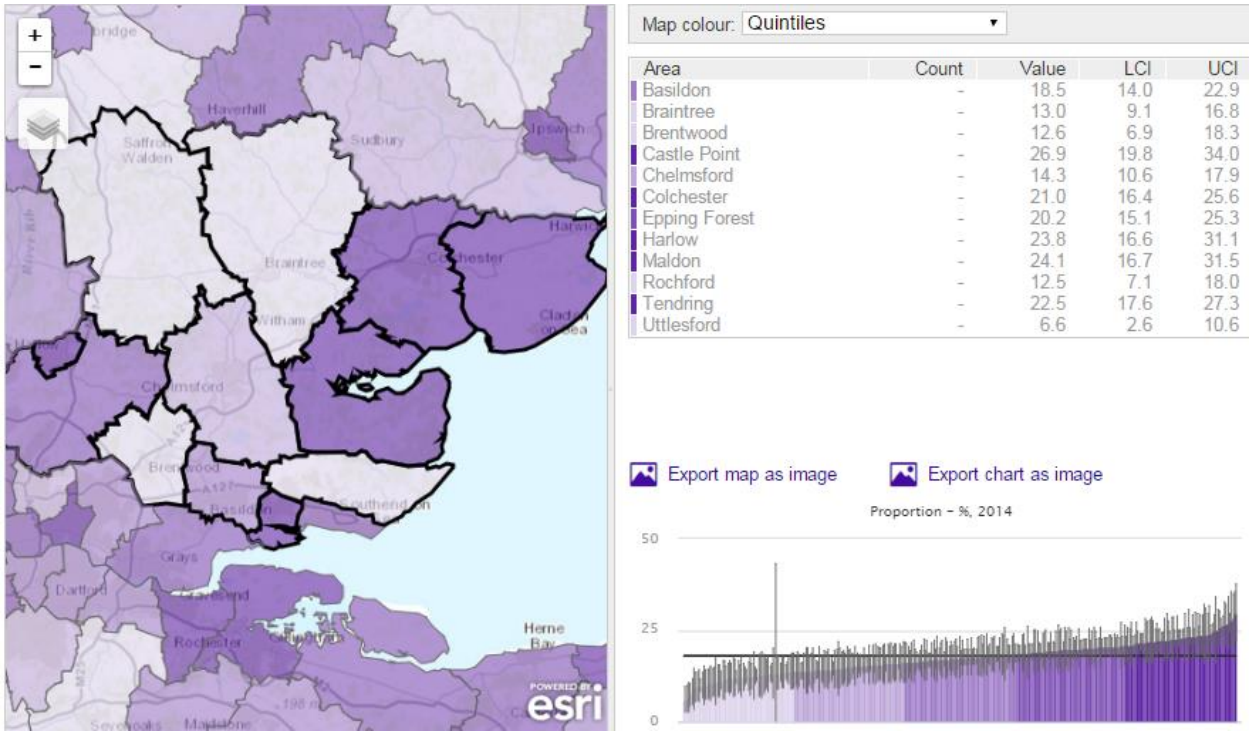


Figure 50 Map of smoking prevalence in each Essex District, shaded by quintile. Source: Public health outcomes framework

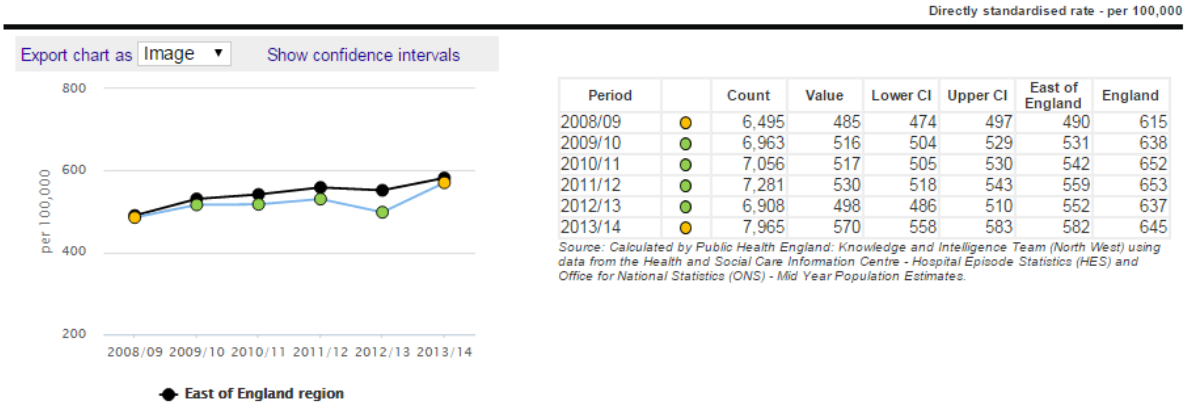
4.2.5. Alcohol related admissions to hospital

4.2.5.1. Background

Excessive alcohol consumption can have immediate health consequences via drunkenness, but also long term chronic impacts on disease. Measuring standardized rate of alcohol-related admissions captures how harmful drinking is to the health of communities in Essex.

4.2.5.2. Trend in alcohol related admissions

In 2013/2014, the alcohol-related admission rate was 570 per 100 000, lower that both regional (582) and national (645) averages. Rates have been creeping up steadily in the East of England (from 490 in 2009/10 to 582 in 2013/14), and Essex's rates have tracked this trend (485 to 570 over a similar period) [18].

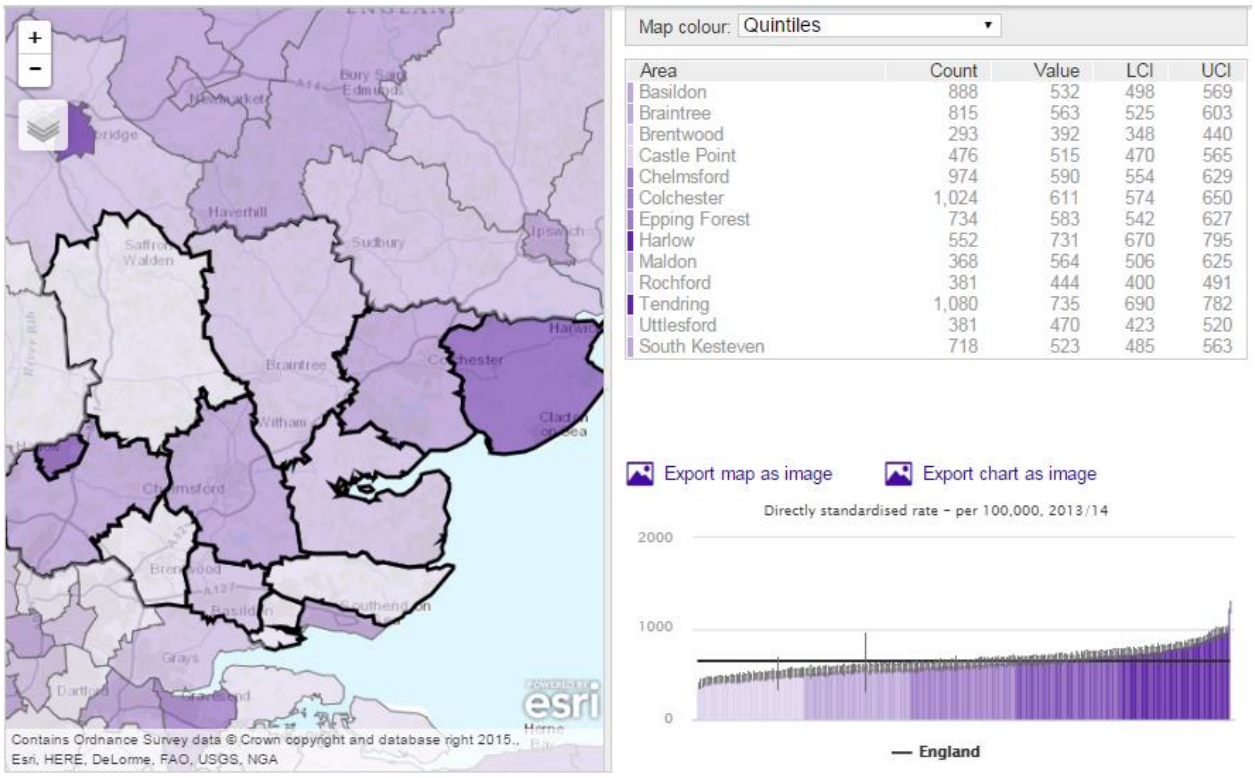


Period		Count	Value	Lower CI	Upper CI	East of England	England
2008/09		6,495	485	474	497	490	615
2009/10		6,963	516	504	529	531	638
2010/11		7,056	517	505	530	542	652
2011/12		7,281	530	518	543	559	653
2012/13		6,908	498	486	510	552	637
2013/14		7,965	570	558	583	582	645

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Figure 51 Admission episodes for alcohol-related conditions in Essex from 2008/9 to 2013/2014, compared to regional average (black line). Source: Public Health Outcomes Framework

By district, Tendring and Harlow are hot spots, with rates in the worst quintile nationally. By contrast, Brentwood has the lowest rate in the region and one of the lowest in the country.



Area	Count	Value	LCI	UCI
Basildon	888	532	498	569
Braintree	815	563	525	603
Brentwood	293	392	348	440
Castle Point	476	515	470	565
Chelmsford	974	590	554	629
Colchester	1,024	611	574	650
Epping Forest	734	583	542	627
Harlow	552	731	670	795
Maldon	368	564	506	625
Rochford	381	444	400	491
Tendring	1,080	735	690	782
Uttlesford	381	470	423	520
South Kesteven	718	523	485	563

Figure 52 Alcohol related admissions in each Essex District, shaded green if significantly below regional average, red if above. Source: Public Health Outcomes Framework

4.2.6. Prevalence and treatment of those with drug misuse

4.2.6.1. Background

Drug misuse (such as of cocaine, opiates, or crack) are known to damage physical and mental health, and often lead to wider social problems and criminality. We try and monitor the prevalence of drug use in Essex, and how effectively services for drug users have been functioning.

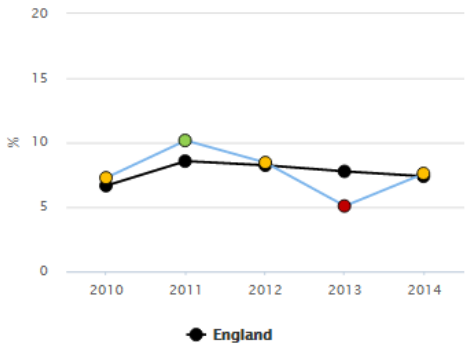
4.2.6.2. Trend in prevalence and treatment of those with drug misuse

It is difficult to gain robust data on the exact prevalence of drug misuse. The national drug monitoring system reports an estimated prevalence of just over 4,300 Opioid or crack cocaine users (OCU) in Essex in 2011/12, giving a point prevalence of 4.83 per thousand people, lower than most other regions in the East of England. [19] This rate has been declining year-on-year (4852 in 2009/10, 4556 in 2010/11), but the wide confidence intervals of a factor of 2 make this change likely non-significant. Looking at other drugs of misuse (cocaine, cannabis) has a similar story. There is not data available for individual districts.

Successful treatment of opiate users in Essex is 7.6%, similar to both national (7.4%) and regional (8.1%) benchmarks. This trend is unstable, with Essex swinging both significantly above and below these benchmarks in the last 5 years. [20]

2.15i - Successful completion of drug treatment - opiate users Essex Proportion - %

Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010		144	7.3	6.2	8.5	7.5	6.7
2011		198	10.2	8.9	11.6	9.1	8.6
2012		168	8.5	7.3	9.8	7.8	8.2
2013		108	5.1	4.2	6.1	7.4	7.8
2014		171	7.6	6.6	8.8	8.1	7.4

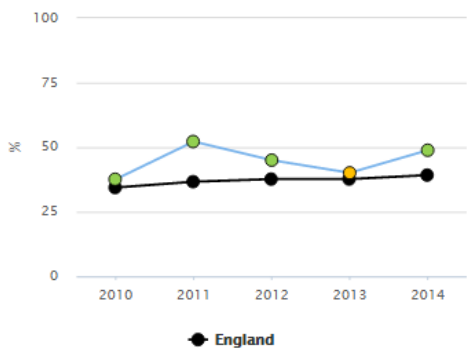
Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Figure 53 Proportion of opiate users successfully treated in Essex, compared to the national average (black line). Source: Public Health England.

Non-opiate users had a 48.8% success rate, significantly better than the regional and national benchmarks. Although there is significant year-on-year variation, Essex has been generally tracking above the national and regional trend [21]

2.15ii - Successful completion of drug treatment - non-opiate users Essex Proportion - %

Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010		466	37.6	34.9	40.3	37.4	34.4
2011		511	52.2	49.1	55.3	40.8	36.6
2012		449	45.0	41.9	48.1	36.9	37.7
2013		491	40.1	37.4	42.9	34.8	37.7
2014		645	48.8	46.1	51.5	39.8	39.2

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

Figure 54 Proportion of non-opiate users successfully treated in Essex, compared to the national average (black line). Source: Public Health England

4.2.7. Early Deaths (under 75s) - Liver disease

4.2.7.1. Background

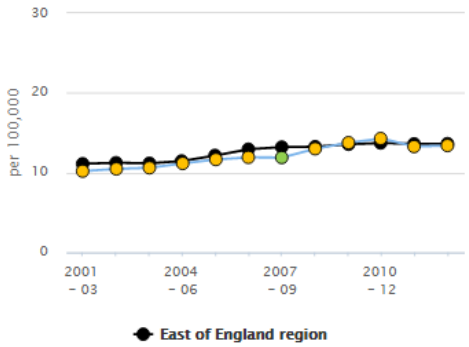
Premature deaths from liver disease are commonly due to conditions related to lifestyle (particularly alcohol and drug misuse). As such, monitoring this rate surveys both the performance of medical care, but also the health needs of our population, and may serve as a time-lagged signal of sub-optimal health behaviour.

4.2.7.2. Trend in liver disease early deths

Essex consistently follows the regional average: 13.4 deaths per 100 000, compared to 13.6 in the region and 17.8 nationally. [22] This has been stable over the last decade. Disaggregating into regions results in district samples too small to be reliable. Looking at each gender individually does not reveal any new pattern.

4.06i - Under 75 mortality rate from liver disease (Persons) Essex — Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03		343	10.2	9.1	11.3	11.1	15.8
2002 - 04		357	10.5	9.4	11.6	11.2	16.4
2003 - 05		366	10.6	9.5	11.8	11.2	16.8
2004 - 06		386	11.2	10.1	12.3	11.5	17.1
2005 - 07		409	11.7	10.5	12.8	12.2	17.5
2006 - 08		422	11.9	10.8	13.1	12.9	17.9
2007 - 09		426	11.9	10.8	13.1	13.2	17.9
2008 - 10		472	13.0	11.8	14.2	13.3	17.9
2009 - 11		509	13.8	12.6	15.0	13.6	18.0
2010 - 12		534	14.3	13.1	15.5	13.7	18.0
2011 - 13		504	13.3	12.1	14.5	13.6	17.9
2012 - 14		519	13.4	12.3	14.6	13.6	17.8

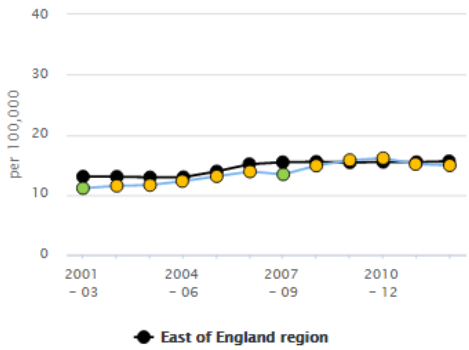
Source: Public Health England (based on ONS source data)

Figure 55 Under 75 mortality from liver disease in Essex, compared to the regional average (black). Source: Public Health Outcomes Framework.

In terms of liver deaths deemed to be preventable, again Essex closely follows the regional average (and, again, the district-level data is too small-sample to be reliable): [23] Looking at each gender individually does not reveal any new pattern.

4.06ii - Under 75 mortality rate from liver disease considered preventable (Male) Essex — Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03		182	11.1	9.5	12.8	13.0	18.6
2002 - 04		190	11.5	9.9	13.3	13.0	19.3
2003 - 05		195	11.6	10.0	13.4	12.9	19.9
2004 - 06		205	12.3	10.6	14.1	12.9	20.3
2005 - 07		222	13.1	11.4	14.9	13.9	20.8
2006 - 08		238	13.9	12.1	15.7	15.1	21.3
2007 - 09		233	13.4	11.7	15.2	15.4	21.2
2008 - 10		261	14.9	13.1	16.8	15.5	21.3
2009 - 11		283	15.8	14.0	17.7	15.4	21.2
2010 - 12		292	16.1	14.3	18.0	15.5	21.1
2011 - 13		279	15.1	13.4	17.0	15.4	21.1
2012 - 14		280	14.9	13.2	16.8	15.6	21.0

Source: Public Health England (based on ONS source data)

Figure 56 Under 75 mortality from liver disease considered preventable in Essex, compared to the regional average (black). Source: Public Health Outcomes Framework

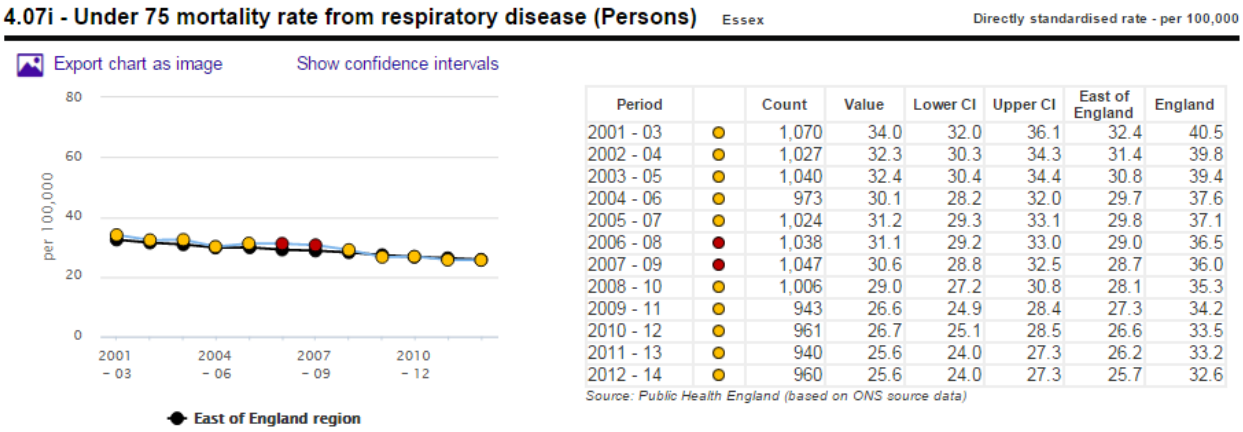
4.2.8. Early deaths - Respiratory disease

4.2.8.1. Background

Premature death from respiratory disease is primarily caused by smoking. The value of tracking this measure is to see how large the burden of this disease is, whether the healthcare services are performing well and (in the case of preventable deaths) whether preventative efforts have proven effective.

4.2.8.2. Trend in respiratory disease early death

Essex has closely followed the regional average in terms of mortality rate (2012-2014, Essex: 24.2, EoE: 25.7, England 32.6). [24] Like the wider region, this rate is on a gradual downward decline.

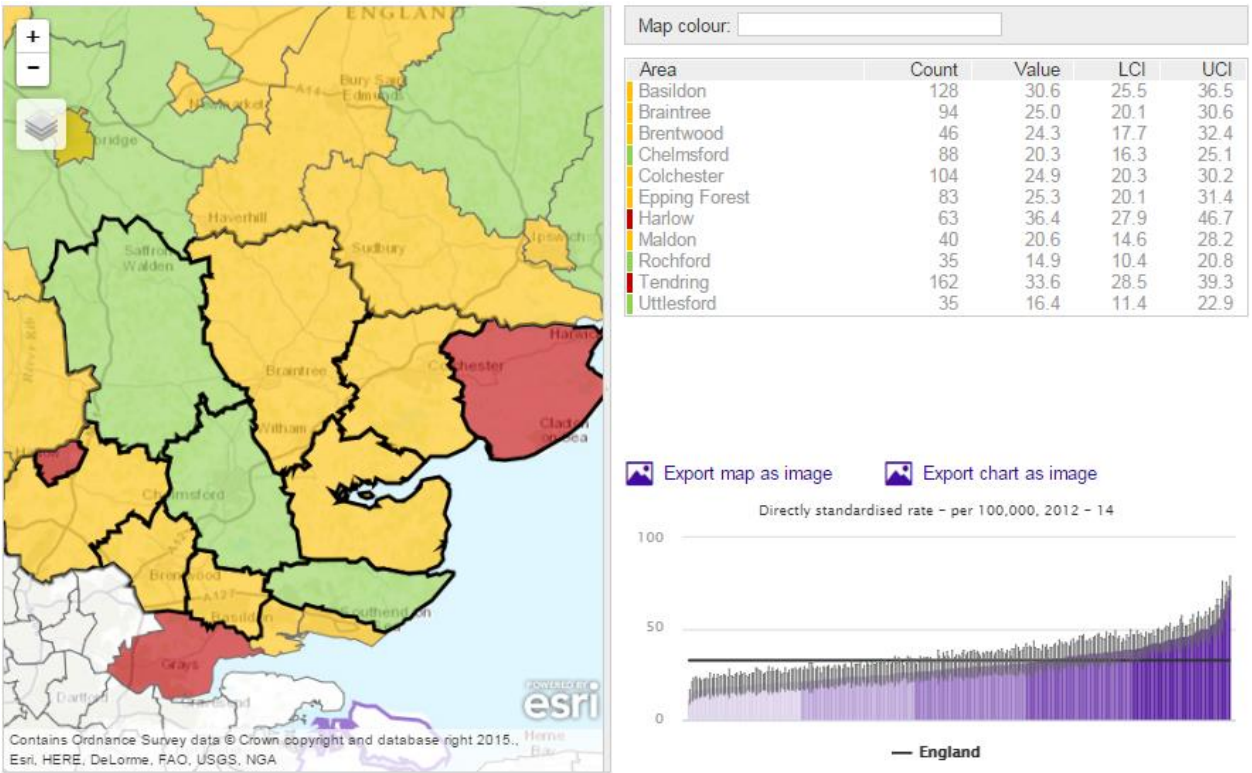


Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03		1,070	34.0	32.0	36.1	32.4	40.5
2002 - 04		1,027	32.3	30.3	34.3	31.4	39.8
2003 - 05		1,040	32.4	30.4	34.4	30.8	39.4
2004 - 06		973	30.1	28.2	32.0	29.7	37.6
2005 - 07		1,024	31.2	29.3	33.1	29.8	37.1
2006 - 08		1,038	31.1	29.2	33.0	29.0	36.5
2007 - 09		1,047	30.6	28.8	32.5	28.7	36.0
2008 - 10		1,006	29.0	27.2	30.8	28.1	35.3
2009 - 11		943	26.6	24.9	28.4	27.3	34.2
2010 - 12		961	26.7	25.1	28.5	26.6	33.5
2011 - 13		940	25.6	24.0	27.3	26.2	33.2
2012 - 14		960	25.6	24.0	27.3	25.7	32.6

Source: Public Health England (based on ONS source data)

Figure 57 Under 75 mortality rate from respiratory disease in Essex 2001-2012, compared to the regional average (black). Source: Public Health Outcomes Framework

Within the region Tendring and Harlow are outliers, with rates significantly worse than the regional average (33.6 and 36.4 per 100 000 respectively. The other districts perform similar to or better than the regional average.



Area	Count	Value	LCI	UCI
Basildon	128	30.6	25.5	36.5
Braintree	94	25.0	20.1	30.6
Brentwood	46	24.3	17.7	32.4
Chelmsford	88	20.3	16.3	25.1
Colchester	104	24.9	20.3	30.2
Epping Forest	83	25.3	20.1	31.4
Harlow	63	36.4	27.9	46.7
Maldon	40	20.6	14.6	28.2
Rochford	35	14.9	10.4	20.8
Tendring	162	33.6	28.5	39.3
Uttlesford	35	16.4	11.4	22.9

Figure 58 Under 75 mortality from respiratory disease of Essex districts. Red is significantly worse than regional average, green is significantly better. Source: Public Health Outcomes Framework.

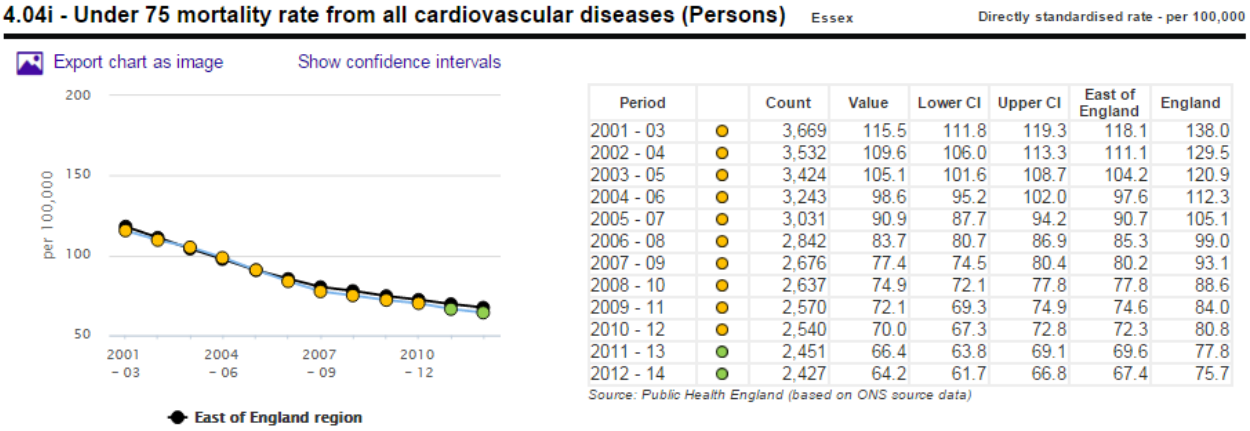
4.2.9. Early deaths - Cardiovascular disease

4.2.9.1. Background

Cardiovascular disease is the leading cause of death in the developed world, and much of its risk can be attributed to lifestyle factors (exercise, diet, smoking, alcohol). Early mortality from cardiovascular disease can monitor both treatment and prevention of these diseases.

4.2.9.2. Trend in CVD early deaths

In 2012-2013, Essex had an under 75 mortality rate of 64.2 per 100 000. This compares favourably with the national average (75.7), and the region (67.4). [25] The trend for Essex is a steady year-on-year decline, parallel to the region and the nation. Disaggregating by gender does not reveal any significant patterns.

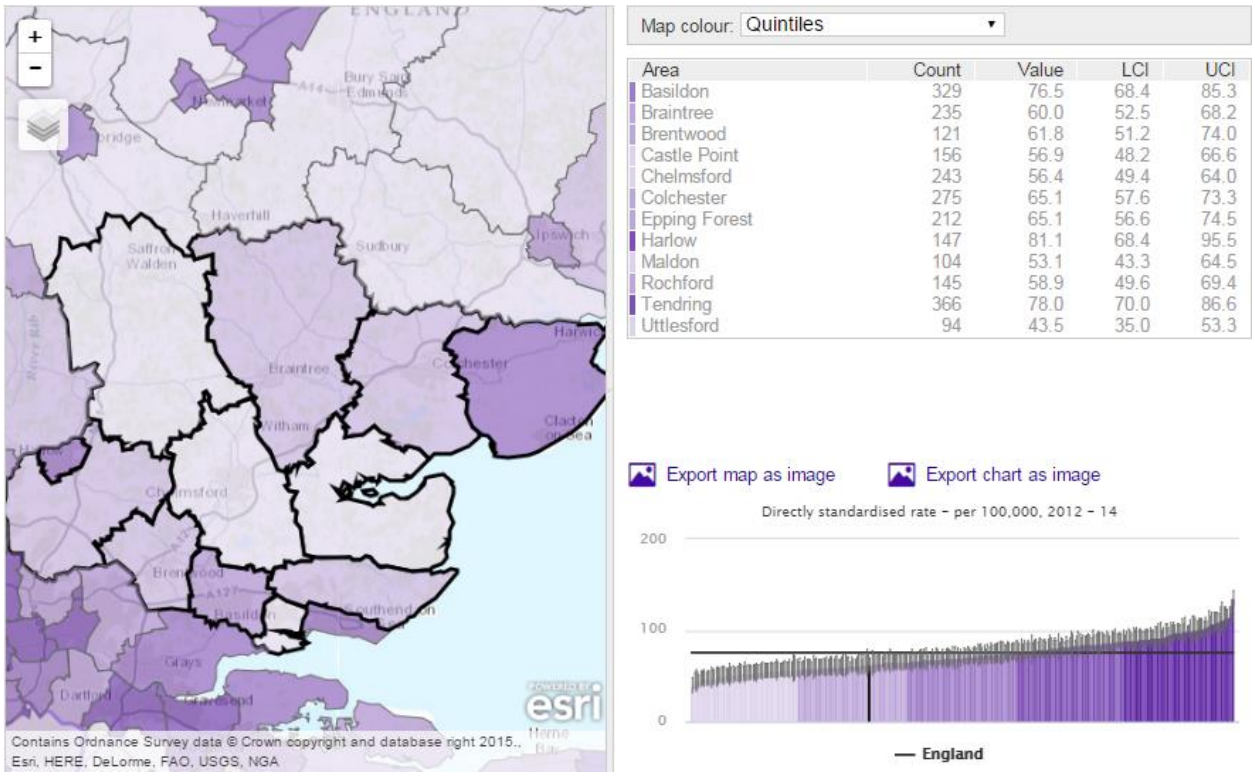


Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03		3,669	115.5	111.8	119.3	118.1	138.0
2002 - 04		3,532	109.6	106.0	113.3	111.1	129.5
2003 - 05		3,424	105.1	101.6	108.7	104.2	120.9
2004 - 06		3,243	98.6	95.2	102.0	97.6	112.3
2005 - 07		3,031	90.9	87.7	94.2	90.7	105.1
2006 - 08		2,842	83.7	80.7	86.9	85.3	99.0
2007 - 09		2,676	77.4	74.5	80.4	80.2	93.1
2008 - 10		2,637	74.9	72.1	77.8	77.8	88.6
2009 - 11		2,570	72.1	69.3	74.9	74.6	84.0
2010 - 12		2,540	70.0	67.3	72.8	72.3	80.8
2011 - 13		2,451	66.4	63.8	69.1	69.6	77.8
2012 - 14		2,427	64.2	61.7	66.8	67.4	75.7

Source: Public Health England (based on ONS source data)

Figure 59 Under 75 Mortality from all cardiovascular diseases in Essex, 2001-2012, compared against the regional average (black). Source: Public Health Outcomes Framework

There is significant variation between districts within Essex, from Uttlesford with the 2nd lowest rate in the country, to Harlow and Tendring in the fourth quartile. Fortunately, the trend in all of these areas is the steady year-on-year decline seen in Essex generally. Looking at under 75 mortality from cardiovascular diseases considered preventable, the same trends are seen.



Area	Count	Value	LCI	UCI
Basildon	329	76.5	68.4	85.3
Braintree	235	60.0	52.5	68.2
Brentwood	121	61.8	51.2	74.0
Castle Point	156	56.9	48.2	66.6
Chelmsford	243	56.4	49.4	64.0
Colchester	275	65.1	57.6	73.3
Epping Forest	212	65.1	56.6	74.5
Harlow	147	81.1	68.4	95.5
Maldon	104	53.1	43.3	64.5
Rochford	145	58.9	49.6	69.4
Tendring	366	78.0	70.0	86.6
Uttlesford	94	43.5	35.0	53.3

Figure 60 Under 75 mortality from cardiovascular diseases in the districts of Essex, shaded by national quintiles. Source: Public Health Outcomes Framework

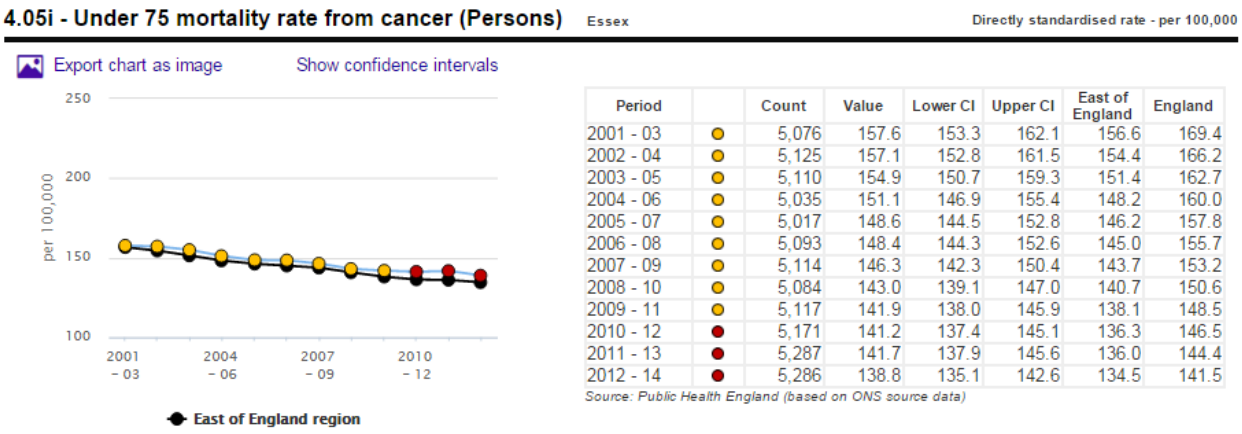
4.2.10. Early deaths - Cancer

4.2.10.1. Background

Cancer is a leading cause of death generally, and is the leading cause of premature mortality in the child and working age population. Part of the burden of these diseases is mediated by lifestyle factors, and another part via effective screening. Premature mortality measures the efficacy of these programs.

4.2.10.2. Trend in cancer early deaths

There has been a steady decline in mortality in Essex from 2001-2014. Of concern, however, is this decline has levelled off in the recent years, and Essex now has a significantly higher under 75 mortality rate than the region. [26] There is a similar (but milder) trend for *preventable* early cancer deaths. There is not a neat account when disaggregated by gender: although in the most recent data the above-average mortality was driven by men, it was previously driven by women.

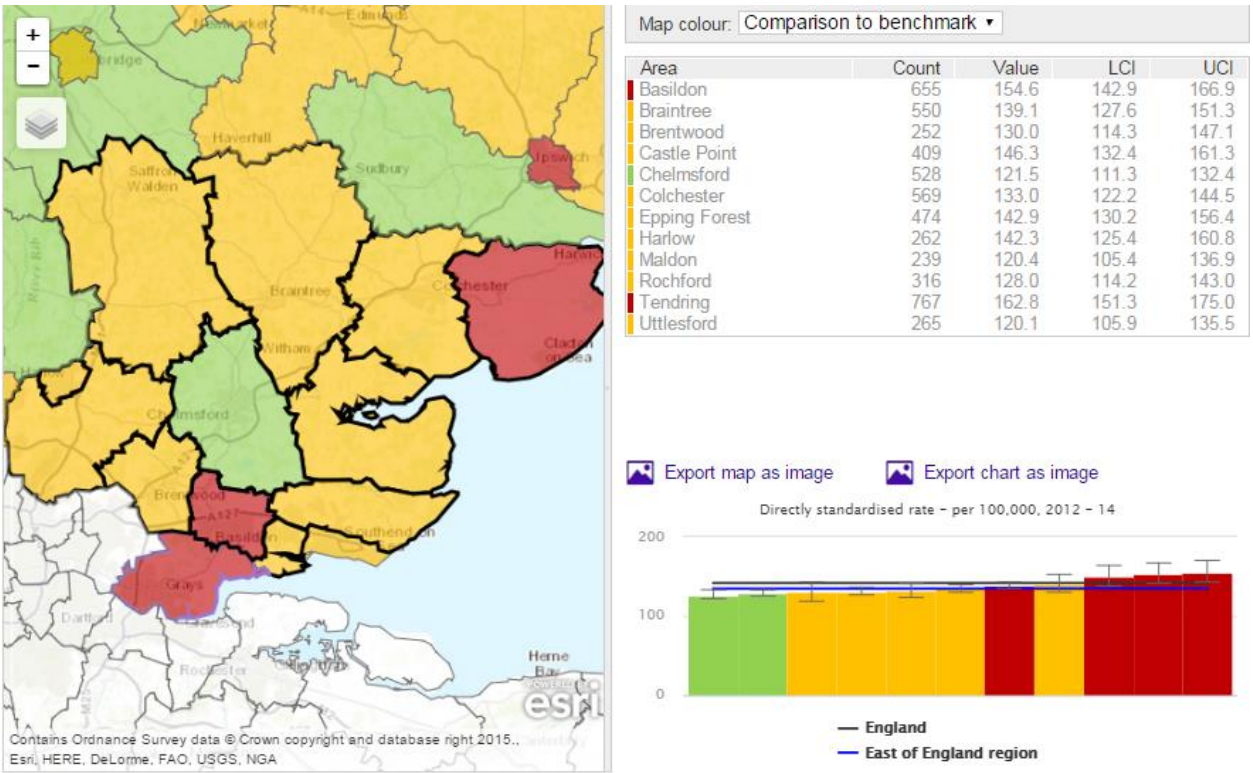


Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03		5,076	157.6	153.3	162.1	156.6	169.4
2002 - 04		5,125	157.1	152.8	161.5	154.4	166.2
2003 - 05		5,110	154.9	150.7	159.3	151.4	162.7
2004 - 06		5,035	151.1	146.9	155.4	148.2	160.0
2005 - 07		5,017	148.6	144.5	152.8	146.2	157.8
2006 - 08		5,093	148.4	144.3	152.6	145.0	155.7
2007 - 09		5,114	146.3	142.3	150.4	143.7	153.2
2008 - 10		5,084	143.0	139.1	147.0	140.7	150.6
2009 - 11		5,117	141.9	138.0	145.9	138.1	148.5
2010 - 12		5,171	141.2	137.4	145.1	136.3	146.5
2011 - 13		5,287	141.7	137.9	145.6	136.0	144.4
2012 - 14		5,286	138.8	135.1	142.6	134.5	141.5

Source: Public Health England (based on ONS source data)

Figure 61 Under 75 mortality from cancer in Essex, 2001-2013, compared to the regional average (black). Source: Public Health Outcomes Framework

By region, Basildon and Tendring are have particularly high mortality compared to regional norms; Chelmsford has significantly lower rates.



Area	Count	Value	LCI	UCI
Basildon	655	154.6	142.9	166.9
Braintree	550	139.1	127.6	151.3
Brentwood	252	130.0	114.3	147.1
Castle Point	409	146.3	132.4	161.3
Chelmsford	528	121.5	111.3	132.4
Colchester	569	133.0	122.2	144.5
Epping Forest	474	142.9	130.2	156.4
Harlow	262	142.3	125.4	160.8
Maldon	239	120.4	105.4	136.9
Rochford	316	128.0	114.2	143.0
Tendring	767	162.8	151.3	175.0
Uttlesford	265	120.1	105.9	135.5

Figure 62 Under 75 mortality from cancer in the districts of Essex. Red is worse than regional norms, green is better. Source: Public Health Outcomes Framework

4.2.11. Mental Health Employment

4.2.11.1. Background

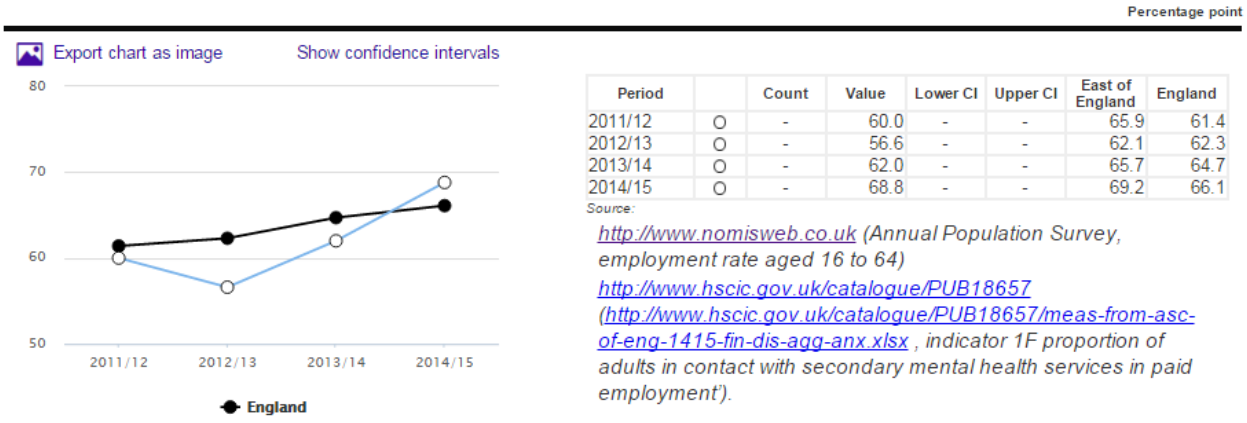
Mental health is a major cause of morbidity in the working age population, and rehabilitating people who have had (or are having) severe mental health issues is challenging. Employment is also known to be a protective factor in terms of long term health. Measuring the gap in employment between those having contact with secondary care population services and the general population measures both the gap in outcomes between these groups, and the efficacy of rehabilitation in the Essex community.

4.2.11.2. Trend

The gap in employment rate for those in contact with secondary care services and the overall employment rate in Essex was 68.8% in 2013/2014 (from 6.4% of those with contact with secondary mental services to 75.2% in the general population). This is dramatic, but similar to national (66.1%) and regional (69.2%) figures. However, there are no formal benchmarks or confidence intervals to assess whether these differences are statistically significant. [27]

One cause for concern is that Essex's figure has been steadily rising against these average trends over the last three years. Disaggregating by gender did not reveal any new pattern. There is no district level data available.

1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate (Persons) Essex



Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12		-	60.0	-	-	65.9	61.4
2012/13		-	56.6	-	-	62.1	62.3
2013/14		-	62.0	-	-	65.7	64.7
2014/15		-	68.8	-	-	69.2	66.1

Source:

http://www.nomisweb.co.uk (Annual Population Survey, employment rate aged 16 to 64)
http://www.hscic.gov.uk/catalogue/PUB18657 (http://www.hscic.gov.uk/catalogue/PUB18657/meas-from-asc-of-eng-1415-fin-dis-agg-anx.xlsx , indicator 1F proportion of adults in contact with secondary mental health services in paid employment').

Figure 63 Employment rate gap between the general population and those in contact with secondary mental health services in Essex, 2011-2015, compared to the national average (black). Source: Public Health Outcomes Framework

4.2.12. Mental health - Suitable accommodation

4.2.12.1. Background

Stable and appropriate accommodation is an important factor in the illness trajectory of those with mental health issues.

4.2.12.2. Trend

Essex has 49.2% of adults with input from secondary mental health services living in stable and appropriate accommodation, worse than national (59.7%) and regional (56.0%) averages. However, there is substantial variation in this indicator between regions, and Essex is broadly in the 'middle of the pack' [28] This has remained fairly static over the last three measurements. There is no data disaggregated into districts, and disaggregating by gender reveals no new pattern.

Of greater concern is the trend. Essex previously had a figure of 73.7%, making for a drop of a third in the performance by this indicator.

1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons) 2014/15

Proportion - %

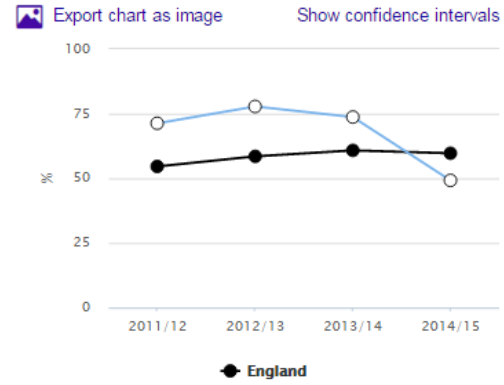
Area	Count	Value	Lower CI	Upper CI
England	-	59.7	-	-
East of England region	-	56.0	-	-
Bedford	-	63.6	-	-
Cambridgeshire	-	33.3	-	-
Central Bedfordshire	-	78.0	-	-
Essex	-	49.2	-	-
Hertfordshire	-	25.9	-	-
Luton	-	61.2	-	-
Norfolk	-	62.3	-	-
Peterborough	-	32.4	-	-
Southend-on-Sea	-	70.3	-	-
Suffolk	-	77.4	-	-
Thurrock	-	75.4	-	-

Source: The Health and Social Care Information Centre. Measures from the Adult and Social Care Outcomes Framework. Source of raw data: Mental Health Minimum Dataset (MHMDS)

Figure 64 Percentage of adults in contact with secondary mental health services who have stable and appropriate accommodation for all counties in the East of England region. Source: Public Health Outcomes Framework.

1.06ii - Percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons) Essex

Proportion - %



Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12	O	12,665	71.3	-	-	45.7	54.6
2012/13	O	13,220	77.8	-	-	65.5	58.5
2013/14	O	-	73.7	-	-	66.0	60.8
2014/15	O	-	49.2	-	-	56.0	59.7

Source: The Health and Social Care Information Centre. Measures from the Adult and Social Care Outcomes Framework. Source of raw data: Mental Health Minimum Dataset (MHMDS)

Figure 65 Trend in Percentage of adults in contact with secondary mental health services in stable and appropriate accomodation, compared to the national average (black line). Source: Public Health Outcomes Framework

4.2.13. Mental Health - Mortality

4.2.13.1. Background

Those with mental health issues are known to have a greater mortality than the general population. Excess mortality can therefore broadly indicate how well those will mental health issues are being cared for.

4.2.13.2. Trend

The under 75 excess mortality rate in Essex was 266.3 in 2013/4, which has remained basically static over the previous three years. Essex compares favourably to the nation (average 351.8) and the region (although confidence intervals overlap). [29] No district-level data is available.

4.09 - Excess under 75 mortality rate in adults with serious mental illness 2013/14 — Indirectly standardised ratio

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	351.8	347.3	356.3
East of England region	-	290.6	277.7	304.0
Bedford	-	173.5	126.6	232.2
Cambridgeshire	-	309.6	272.5	350.5
Central Bedfordshire	-	215.3	165.8	275.0
Essex	-	266.3	242.4	291.9
Hertfordshire	-	316.9	279.0	358.5
Luton	-	264.8	208.0	332.5
Norfolk	-	367.9	327.3	412.2
Peterborough	-	264.1	206.7	332.6
Southend-on-Sea	-	213.3	167.8	267.4
Suffolk	-	362.9	319.7	410.3
Thurrock	-	233.8	177.1	302.9

Source: HSCIC

Figure 66 Excess under-75 mortality in adults with serious mental illness in all counties in the east of england region. Source: Public Health Outcomes Framework.

4.2.14. Suicide

4.2.14.1. Background

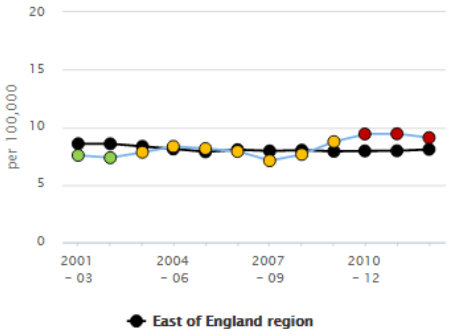
Suicide can be precipitated by a variety of factors, and mental health issues are commonly implicated. The suicide rate is an outcome of great importance in its own right, but also indirectly indicates burden of mental illness, and efficacy of care and support.

4.2.14.2. Trend

The suicide rate in Essex has been generally climbing from 2007 to 2014, in the opposite direction to a mild reduction in the region and nationally. The most recent figure of 9.1 per 100 000 is worse than the regional (8.1) and national (8.9) averages. When analysed by gender, this has been mainly driven by increasing rates of suicide among females (5.2 per 100 000, in 2014 higher than regional and national figures of 3.8 and 4.0 respectively).

4.10 - Suicide rate (Persons) Essex — Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03		290	7.6	6.7	8.5	8.6	9.2
2002 - 04		285	7.3	6.5	8.3	8.6	9.1
2003 - 05		307	7.8	7.0	8.8	8.3	9.0
2004 - 06		328	8.3	7.4	9.3	8.1	8.8
2005 - 07		324	8.1	7.3	9.1	7.9	8.4
2006 - 08		317	7.9	7.0	8.8	8.0	8.2
2007 - 09		289	7.1	6.3	8.0	7.9	8.3
2008 - 10		311	7.6	6.8	8.5	8.0	8.4
2009 - 11		356	8.7	7.9	9.7	7.9	8.5
2010 - 12		385	9.4	8.5	10.4	7.9	8.5
2011 - 13		389	9.4	8.5	10.4	7.9	8.8
2012 - 14		380	9.1	8.2	10.1	8.1	8.9

Source: Public Health England (based on ONS source data)

Figure 67 Suicide rate in Essex, 2001-2015, compared to the regional average (black). Red circles represent values significantly greater than the regional average. Source: Public Health Outcomes Framework.

Although the low counts prevent deriving confidence intervals for the rate in all districts, Colchester and Tendring are hotspots. [30] Data is too sparse to offer a breakdown by district for each gender.

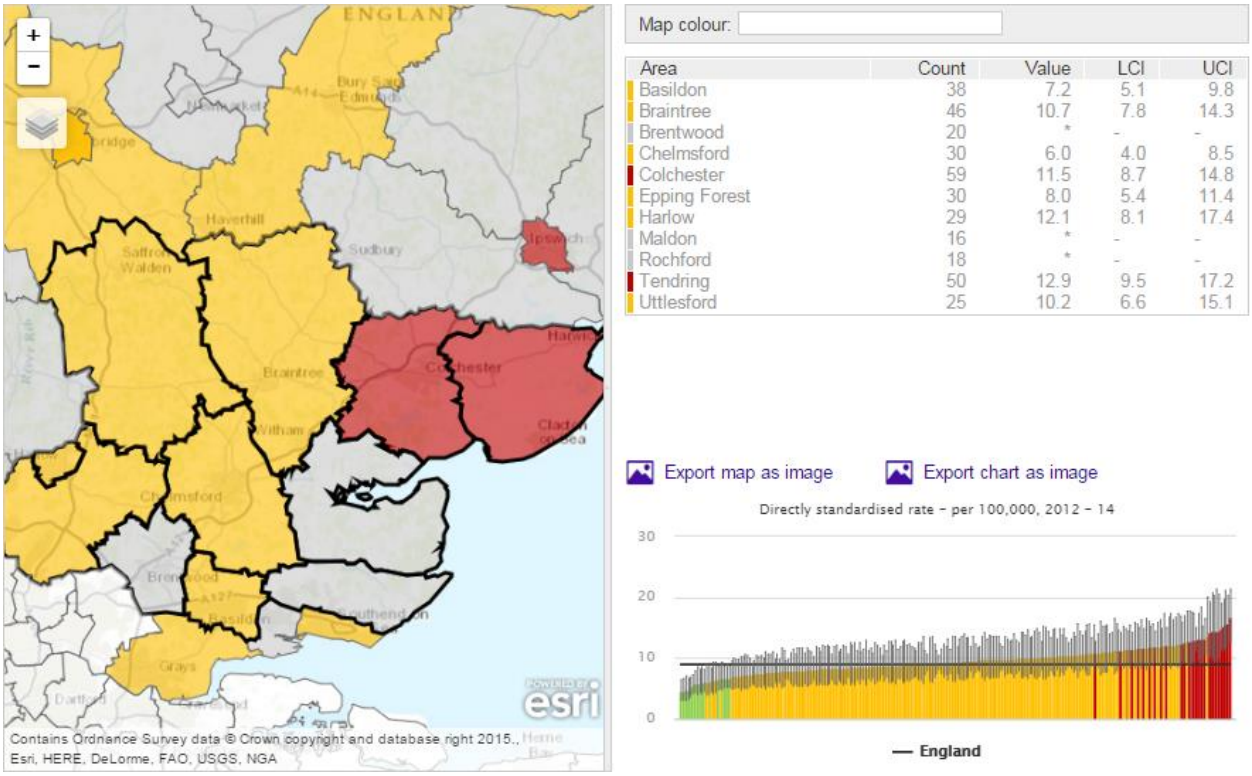


Figure 68 Suicide rate for the districts of Essex. Red areas are significantly worse than the regional average, yellow are not significantly different, and grey are districts with counts too low to derive confidence intervals. Source: Public Health Outcomes Framework

4.2.15. Long Term Conditions - Support

4.2.15.1. Background

There are distinct links between physical and mental health. People with chronic health conditions are at particular risk of developing mental health disorders. Supporting them to manage their condition can be of benefit to their physical health and mental wellbeing.

4.2.15.2. Regional variation

The proportion of respondents to the GP patient survey with a long term health problem who report that they feel supported by local services to manage their condition is lower in Basildon and Brentwood, Castle Point and Rochford and West Essex CCG compared to the England average.

Support for people with LTCs: % of people with long term conditions visiting GP who feel they have had enough support from local services in last 6 months 2014/15

Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	256,152	63.3	63.2	63.5
East of England region	28,416	62.5*	-	-
NHS Basildon And Brentwoo...	1,212	60.3	58.1	62.4
NHS Bedfordshire CCG	2,082	64.1	62.4	65.7
NHS Cambridgeshire and Pe...	4,010	63.7	62.5	64.9
NHS Castle Point And Roch...	815	59.7	57.1	62.3
NHS East And North Hertfo...	2,405	60.1	58.6	61.6
NHS Great Yarmouth And Wa...	1,211	64.5	62.3	66.6
NHS Herts Valleys CCG	2,488	59.0	57.5	60.5
NHS Ipswich And East Suff...	2,030	67.3	65.6	69.0
NHS Luton CCG	817	60.3	57.7	62.9
NHS Mid Essex CCG	1,746	62.6	60.8	64.3
NHS North East Essex CCG	1,612	61.8	59.9	63.6
NHS North Norfolk CCG	947	64.9	62.4	67.3
NHS Norwich CCG	1,072	65.1	62.8	67.4
NHS South Norfolk CCG	1,181	65.1	62.9	67.2
NHS Southend CCG	792	58.9	56.3	61.5
NHS Thurrock CCG	671	59.6	56.7	62.4
NHS West Essex CCG	1,284	61.1	59.0	63.2
NHS West Norfolk CCG	878	63.4	60.9	65.9
NHS West Suffolk CCG	1,165	63.6	61.3	65.7

Source: GP Patient Survey The data used are from GP Patient Surveys undertaken in July - September and January - March. This is equivalent to financial year data.

Figure 69 Support for people with LTCs: Proportion of people with long term conditions visiting GP who feel they have had enough support from local services in last 6 months. Source: Public Health Profiles

4.2.16. Long term conditions - Employment

4.2.16.1. Background

People with long term health conditions may struggle in employment, either due to direct impacts on their physical or mental health, or secondary issues such as loss of confidence or ostracization. Employment is also a protective factor in many mental and physical health problems.

4.2.16.2. Trend

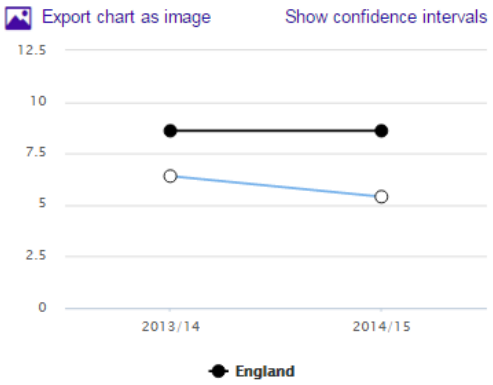
The difference in employment between those with long term health conditions and the general population is 5.4% (from 69.8% to 75.2%). [31] Although confidence intervals are ill-defined, and thus claims of significant difference cannot be made, Essex's gap is numerically lower than the average across either England or the region.

Data is too sparse to assess trend, or to disaggregate by district.

Figure 70 Gap in employment between the general population and those with a long-term illness for counties in the East of England. Source: Public Health Outcomes Framework

1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate Essex

Percentage point



Period		Count	Value	Lower CI	Upper CI	East of England	England
2013/14		-	6.4	-	-	6.8	8.6
2014/15		-	5.4	-	-	6.5	8.6

Source: Annual Population Survey - Labour Force Survey

Figure 71 Gap in employment between the general population and those with a long-term illness for counties in the East of England. Source: Public Health Outcomes Framework

4.2.17. NHS Health Checks

4.2.17.1. Background

NHS health checks screen for common conditions before they present with sequelae or symptoms, and thereby improve population health. These indicators look at the coverage and success of this scheme.

4.2.17.2. Data

In 2013-2015, 23.2% of the eligible population in Essex had an NHS health check; [32] 41.4% were offered one. [33] In both cases, these figures are above the National and Regional averages. There are no meaningful data available for districts or the trend over time.

5. Ageing well priority review content

5.1. National and local policy context

5.1.1. Essex context

In 2015, the population of 65+ year olds is estimated to be c276,529. The population of 65+ year olds is estimated to grow by c103,650 by 2030 to 380,179.

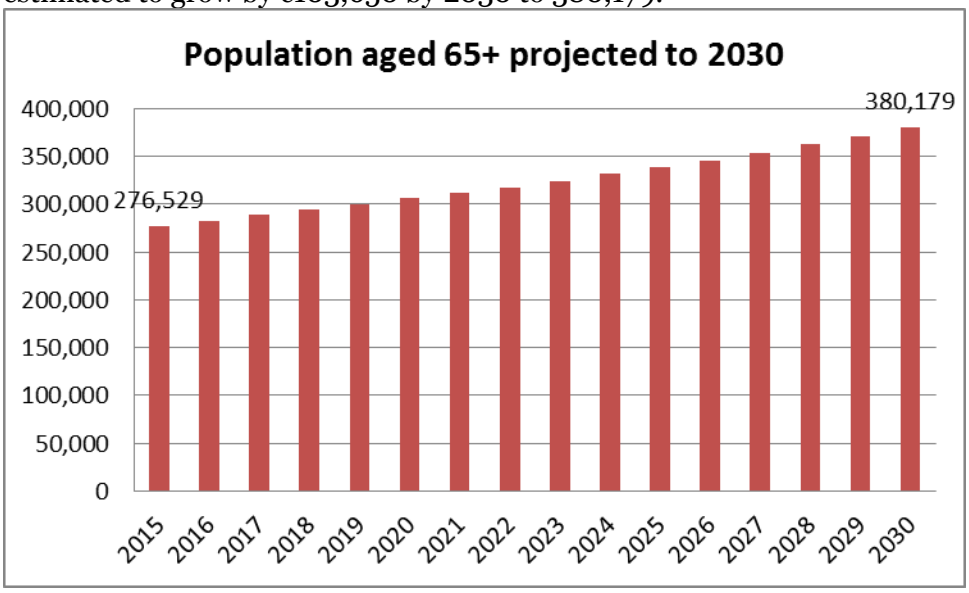


Figure 72 The projected population of 65+ year olds in Essex, 2015 to 2030

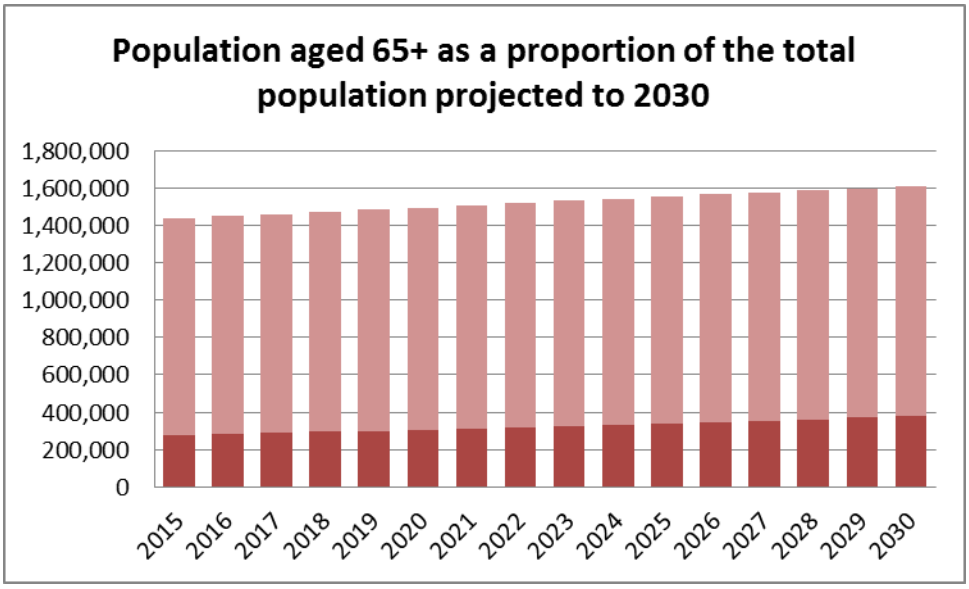


Figure 73 The population of 65+ year olds in Essex compared to the total population

5.1.2. National context

The Care Act. In 2012 the Government set out its plan to reform care and support in the White Paper, Caring for our future: reforming care and support. The objectives were to reduce reliance on formal care, to promote people's independence and wellbeing and give people more control of their own care and support.

The Care Act 2014 consolidated and updated existing laws relating to care and support for adults and placed new legal responsibilities on local authorities. The key changes were:

- A new legal framework for adult safeguarding;
- A new national eligibility framework for both adults and carers;
- New duties on local authorities to delay or prevent care needs from becoming more serious;
- New duties in relation to carers, including a duty to meet carers' needs on a similar basis to the person they care for;
- New duties to provide information and advice to all, regardless of care need;
- A new duty to provide independent advocacy to those who need it;
- New duties to assess the care and support needs of children who may need support after they turn 18, and those of their carers;
- Duties to work with care providers to ensure the availability of a diverse and high quality range of local services;
- Duties to arrange and fund services to meet the eligible care and support needs of prisoners.

A second phase of Care Act implementation would have introduced a cap on the amount someone would pay towards their care and support. However, following concerns from stakeholders, in July 2015 the Government announced the decision to delay the introduction of the Care Cap until April 2020.

Dementia. In February 2015, the government published an update on the Prime Minister's Challenge on dementia. Progress has been made on identification and diagnosis and improved training but more progress is needed on public awareness; meaningful support and follow up and improved training in hospitals and care homes. A study by the Alzheimer's Society found that there were large variations in access to community support post diagnosis. Essex County Council is currently working with partners on the development of a dementia strategy.

Pension changes. New rules came into force in April 2015 which give people more flexibility to drawdown from their pension fund throughout retirement. In addition, from April 2016, a new single tier State Pension will be introduced for future pensioners.

Fuel poverty. Fuel poverty is a known and recognised risk factor for health: living in a cold home can cause or exacerbate mental and physical (particularly circulatory and respiratory) health problems with many older people estimated to live in homes that are harder to keep warm or to face energy costs exceeding 10% of their income. The Government published a new Fuel Poverty Strategy for England in March 2015 that sets a new target that as many fuel poor homes as possible achieve a Band E energy efficiency standard by 2020 and Band D by 2025. The Department of Energy and Climate is working with the NHS to focus on the links between health and fuel poverty.

End of life. In July 2015 the Government published an update to One Chance to Get it Right, which established five priorities for care of the dying person. These are that when it is thought that a person may die within the next few days or hours:

- This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes;
- Sensitive communication takes place between staff and the dying person and those important to them;
- The dying person, and those important to them, are involved in decisions about treatment and care to the extent that the dying person wants;
- The needs of families and others important to the dying person are actively explored, respected and met as far as possible;
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

5.2. Health

5.2.1. Older Population (65 years and over) and customer segmentation (MOSAIC)

Customer segmentation helps us to understand the needs, lifestyle choices and interests of people in Essex and how best to engage with them. There are six wards whose population of 65+ year olds [34] is over 40% of the total population in the ward. All of these are in Tendring which has the highest proportion of older people in the County. These Wards are: Homelands Tendring (50.3%), Haven Tendring (47.5%), St Bartholomew's Tendring (45.6%), Frinton Tendring (42.5%), Bursville Tendring (42.4%) and Hamford Tendring (41.5%). The most prevalent customer segmentation (MOSAIC) types in these wards where people had Bad or Very bad health are in F24 Bungalow Haven households types and for Frinton N58 Aided Elderly [3]. Descriptions of these segmentation types are presented in

Table 13.

Table 13 Geodemographic segmentation types of residents in the wards with the highest prevalence of older people aged 65 years and over.

Most prevalent segmentation type in households with people with bad and very bad health	Ward details (examples)
F24 Bungalow Haven • Retired people, elderly couples and singles almost all of whom are aged 66 or over • Living in bungalow estates designed with older residents in mind with neighbours who share similar interests and attitudes. • Some residents who are still married may be fulfilling a caring role. • Most consider themselves in good health and are comfortable or coping on their retirement incomes. • Bungalow Haven try to lead healthy lifestyles. They do not smoke and drink only very moderately. • Over half make the effort to eat five portions of fruit or vegetables a day – considerably more than the average. • Few participate in sport or actively keep in shape. • Very few feel crime is a problem in their area, but their main safety concerns are safety after dark and having their homes broken into. • Although now in retirement, they rarely access any benefits at all, with the exception of the State Pension. Some may receive Pension Credits.	**Homelands Tendring** • 50.3% (951) of the population in Ward is 65 years and older (the highest in the County) • 9.4% (177) of the population in Ward is 85 years and older (the highest in the County) • 59 households with bad or very bad health in Ward • 36 households with bad or very bad health are the F24 type (61% of bad or very bad health households in the area) **Haven Tendring** • 47.5% (956) of the population in Ward is 65 years and older • 6.9% (138) of the population in Ward is 85 years and older • 56 households with bad or very bad health in Ward • 32 households with bad or very bad health are the F24 type (61% of bad or very bad health households in the area)
N58 Aided Elderly • Mostly aged in their late 70s or older with some in their 90s. • Most are living alone, widowed and high levels of single females. • Homes are mostly purpose-built fairly modern flats with one or two bedrooms, within private communities. • Two-thirds of residents are owner occupiers, having downsized from their own larger homes due to their advancing years, possibly as a result of declining health rather than financial factors. • Disposable incomes vary, with a number likely with income from an occupational pension as well as their state pension. • They prefer to keep up-to-date with the world by watching TV news channels and reading newspapers. • They are considerably less likely to access benefits, including those around incapacity and disability than peers. • Few in this type smoke. • They are more likely to drink more frequently than others – particularly when compared to other elderly types. • They are better at ensuring they eat five portions of fruit and vegetables a day than their peers or people in general. • They try to reduce their energy and water use, probably driven by	**Frinton Tendring** • 42.5% (1685) population in Ward is 65 years and older • 8.7% (347) population in Ward is 85 years and older • 134 households bad or very bad health • 43 households with bad or very bad health in the M58 type

thriftiness as much as a concern for the environment.	

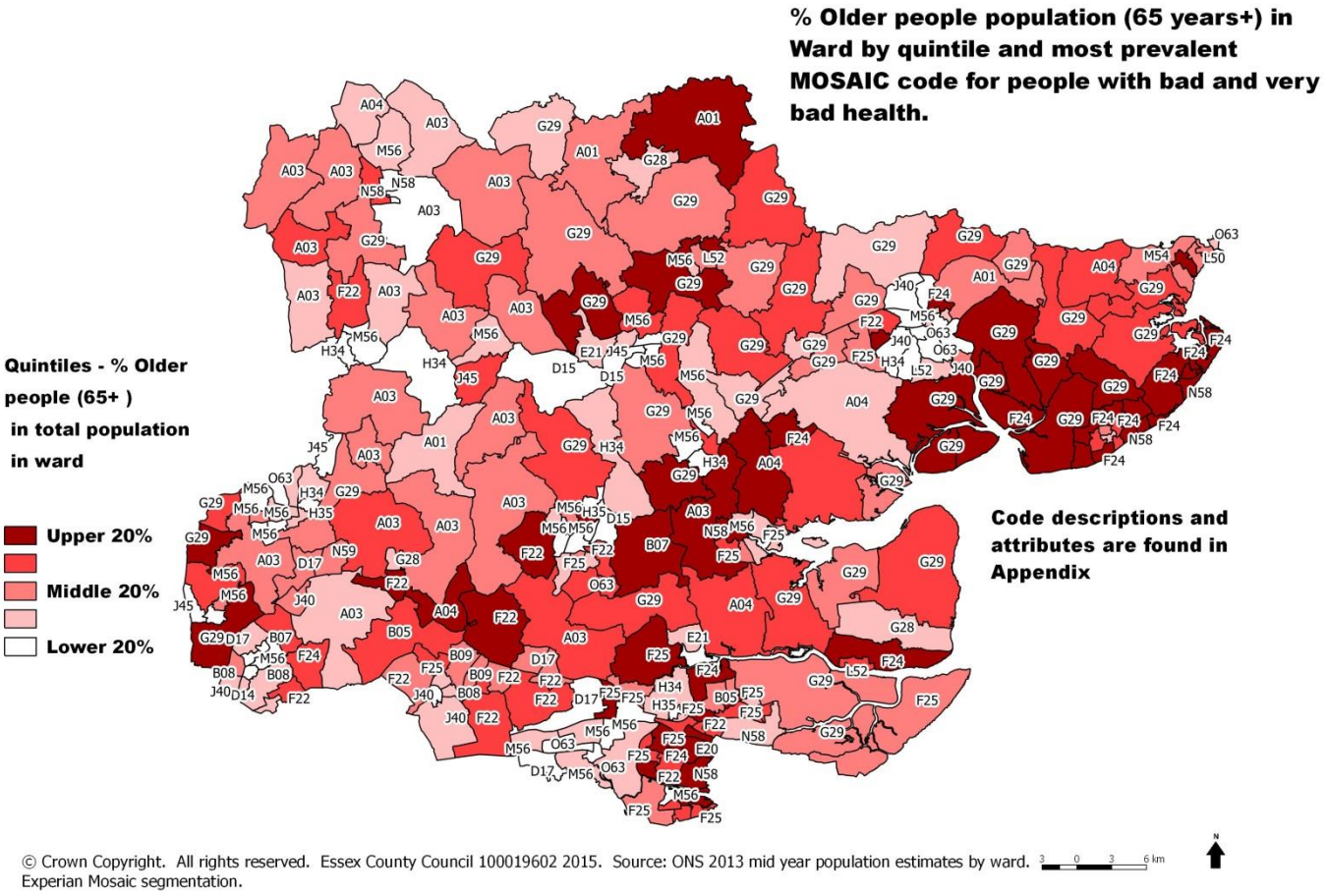


Figure 74 Older population (65+ years) and most prevalent household type with bad and very bad health

5.2.2. Life expectancy

5.2.2.1. Background

Survival is a fundamental aspect and pre-requisite for health, and an overall measure for the success of the health ecosystem within Essex. Healthy as well as long lives are important, and thus healthy (or disability-free) life expectancy is a good measure of how successfully people in Essex can enjoy a healthy old age.

5.2.2.2. Overall performance

For both sexes over life expectancy at age 65 is greater in Essex than the national average (for women, 21.3 years versus 21.2 years; for men 19.2 years versus 18.8 years), and broadly similar to both the local region and the 'nearest neighbour' regions. [35] [36]

Healthy life expectancy is greater in Essex than the national average for both sexes (for women, 66.5 years versus 64.0 years; for men 65.4 years versus 63.4 years. Again, these are broadly similar to the local region and 'nearest neighbour' regions. [37] [38]

5.2.2.3. Trend

Life expectancy at 65 is steadily improving in Essex over the period of measurement, tracking the rising trend in England as a whole. For disability free life expectancy, Essex's figures remain stable, similar to the national picture.

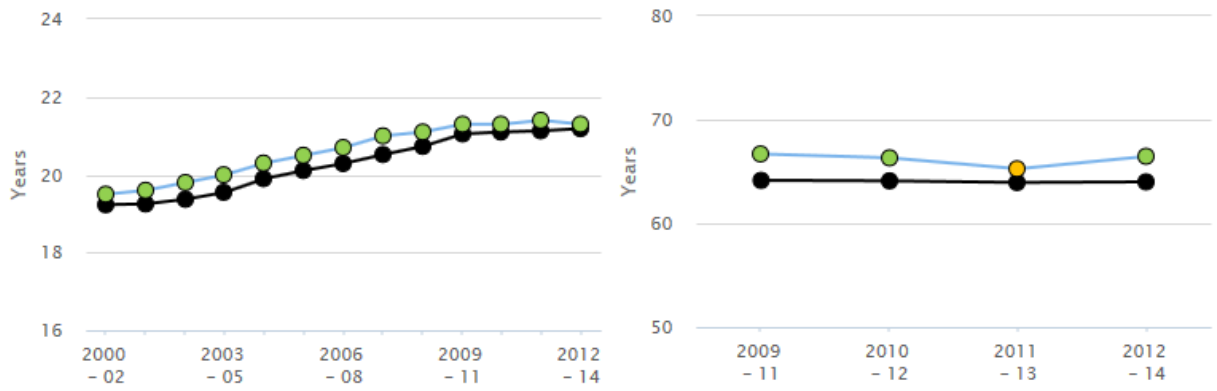


Figure 75 Life expectancy at 65 and Disability Free Life Expectancy in Essex over time. Left panel life expectancy at 65, left panel disability free life expectancy, both for women. The trends observed in men are similar.

5.2.2.4. Regional variation

Healthy life expectancy is not available disaggregated by district. For over 65 life expectancy, there are significant variation by district: Castle point and Tendring do significantly worse than the national average, whilst Chelmsford, Rochford and Uttlesford do better.

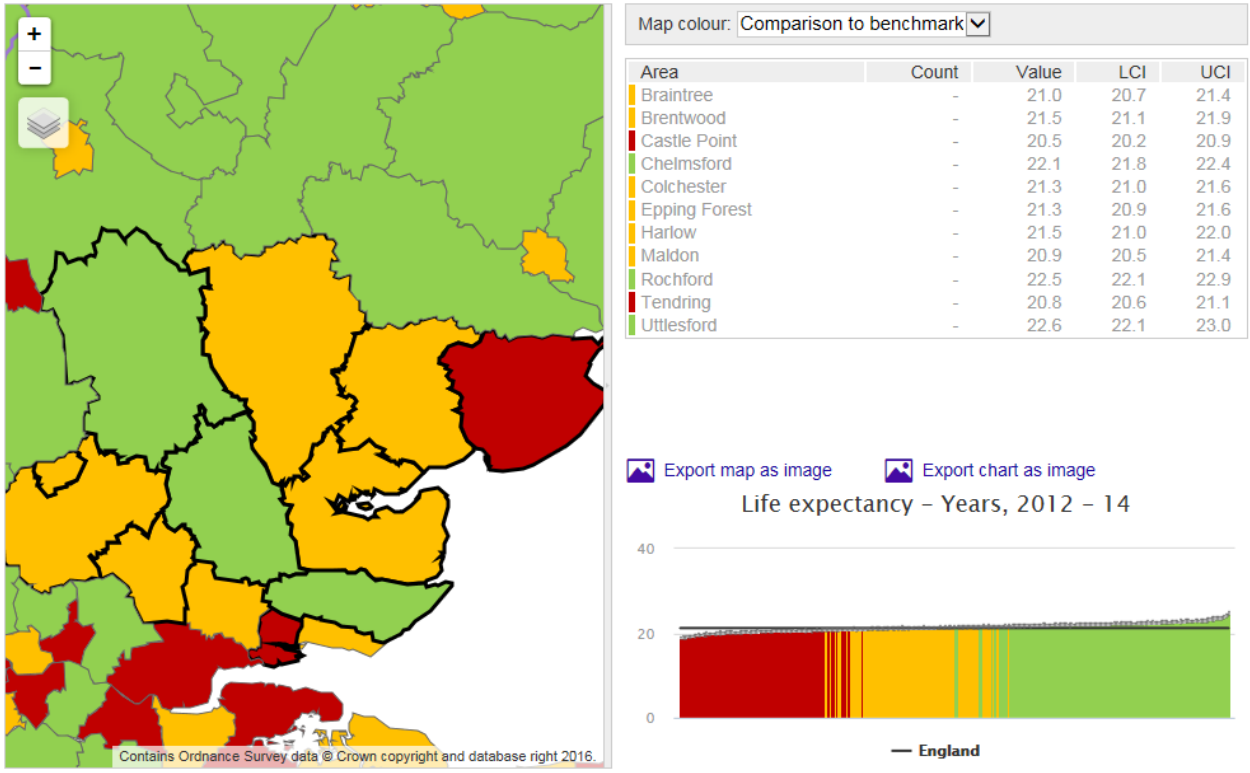


Figure 76 Over 65 life expectancy (female): Districts significantly worse than the national average are shaded red, significantly better green, and those insignificantly different in yellow.

5.2.3. Dementia diagnosis rates

5.2.3.1. Background

There is an estimated 650,000 people in England with dementia, a number expected to double in the next 30 years. Dementia accounts for more expenditure than heart disease and cancer combined and costs society around £20bn a year. In an ageing population there will be an impact on Dementia prevalence and thus a considerable effect on the volume of people requiring Dementia services. NICE guidelines state that Diagnosis is an important factor in supporting people to live well with Dementia

5.2.3.2. Trend

In 2013 the NHS England Everyone Counts: Planning for Patients 2014/15 - 2018/19 document (2013) set a target to increase the Dementia diagnosis rate to 67 per cent by March 2015. The 67% diagnosis rate reflects the highest performing local area at the time it was set (2013) compared to the average at that time of around 45%. The Diagnosis rate of the Essex CCG areas presented below refers to the number of people who have received a diagnosis as a percentage of those estimated to have the condition. Total numbers are estimated using the Adjusted National Dementia Prevalence Rate (aNDPR) , and the number with a diagnosis using the QOF Dementia register.

Essex CCGs achieved a 52.4% diagnosis rate but there is a large variation in diagnosis rates by CCG area (61.1%West, 44.9% North East). Essex is just below the national average (59.17%) for registered population with Dementia.

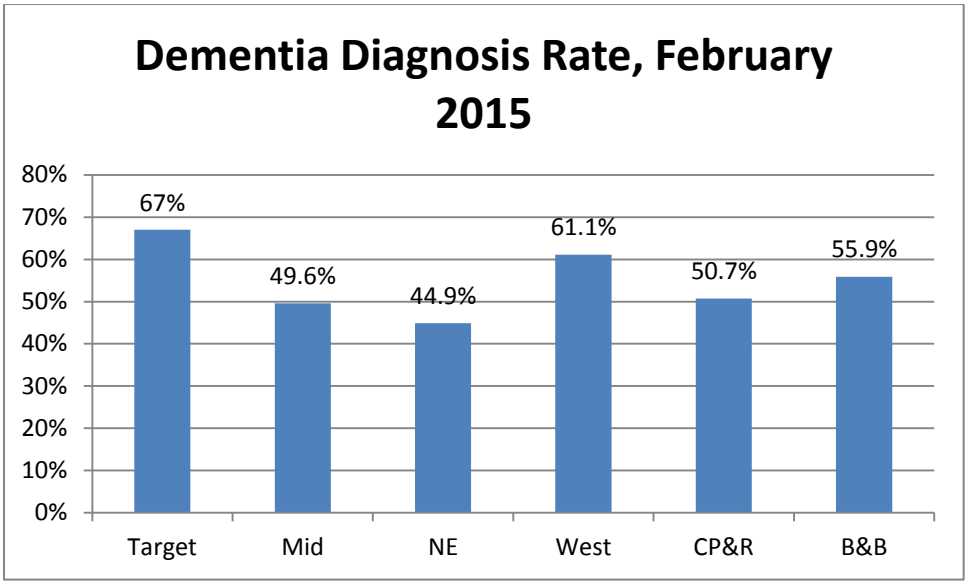


Figure 77 Dementia diagnosis rate

5.2.4. Quality of Life

5.2.4.1. Background

Older people are the biggest and costliest users of health and social care - those with complex needs, long-term conditions, functional, sensory or cognitive impairment are the highest cost and volume group of service users. Dementia also accounts for more expenditure than heart disease and cancer combined. Reported health status allows us to assess whether health-related quality of life is changing over time, while controlling for potential measurable confounders (age, sex, long-term conditions, caring responsibility etc.)

5.2.4.2. Trend

The average health status score (health related quality of life) for Essex adults aged 65 and older was 0.737 for 2012-2013. This is higher than the national average of 0.727 but lower than the East of England average (0.744).

4.13 - Health related quality of life for older people 2012/13 Score

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	0.726	0.725	0.727
East of England region	-	0.743	0.741	0.746
Bedford	-	0.729	0.712	0.746
Cambridgeshire	-	0.750	0.742	0.759
Central Bedfordshire	-	0.752	0.738	0.765
Essex	-	0.737	0.731	0.742
Hertfordshire	-	0.753	0.747	0.760
Luton	-	0.727	0.709	0.745
Norfolk	-	0.748	0.741	0.754
Peterborough	-	0.721	0.704	0.738
Southend-on-Sea	-	0.728	0.715	0.741
Suffolk	-	0.758	0.751	0.765
Thurrock	-	0.715	0.699	0.731

Source: GP Patient Survey

Figure 78 Health Related Quality of life for Older People by Essex District (2013-14)

Health related quality of life trends show that all districts in Essex are either better or similar to the national average and scores have remained similar between 2011- 2014. However, there is a variation amongst districts in Essex and at CCG level for those with long term conditions.

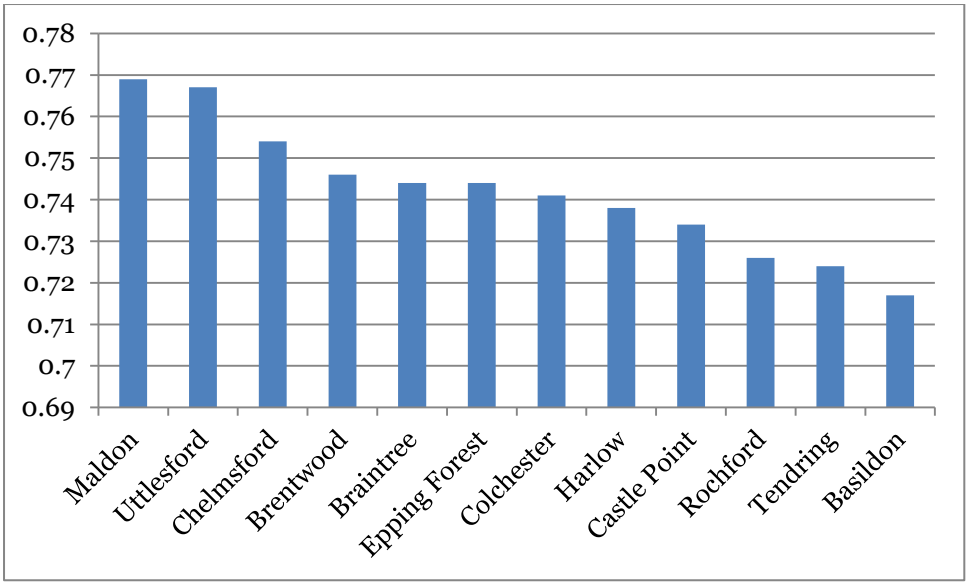


Figure 79 Health related quality of life score by district of Essex

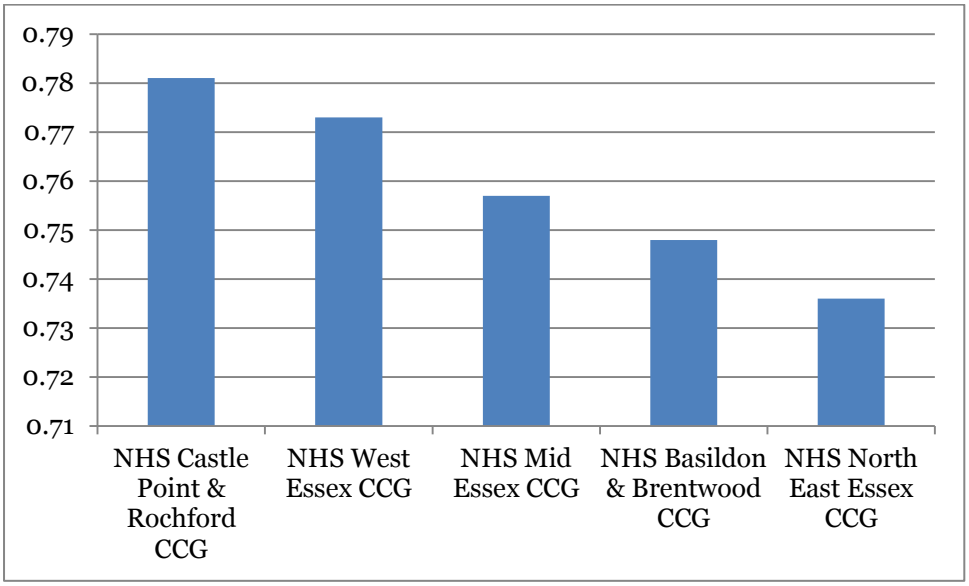


Figure 80 Health Related Quality of life for People with Long Term Conditions by CCG (2015)

5.2.5. Hip fracture

5.2.5.1. Background

In an ageing population, a major cause of both morbidity and mortality is a fractured neck of femur (hip fracture). Causes range through a spectrum of social problems to physical pathology, many of which can be avoided. The cost to the health service is huge and the impact on the individual can be catastrophic. [39] [40] [41]

5.2.5.2. Data

Rates of hip fractures in Essex have been persistently higher than the national average in the over 80 population (the commonest age for hip fracture to occur), and significantly higher in all over 65s since 2012.

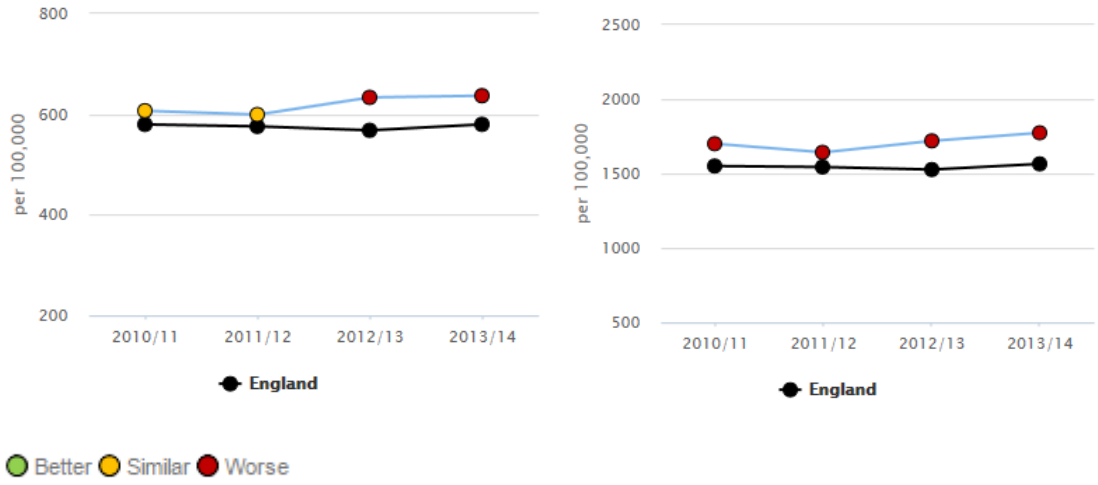
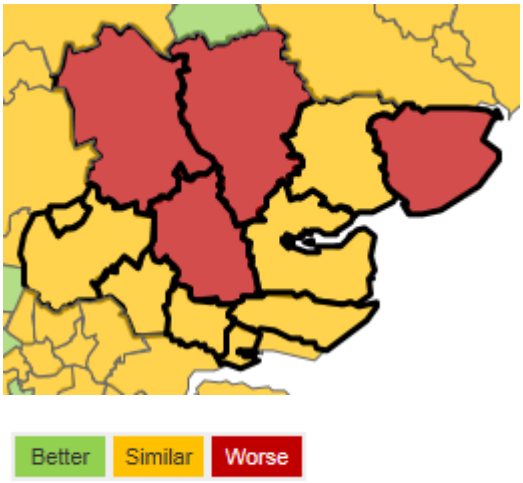


Figure 81 Hip fractures in people aged 65 and over, left: all over 65s, right: 80 years old and over (84) (85) compared to national average

There is disparity across Essex, with Braintree, Chelmsford, Tendring and Uttlesford having the greatest number of hip fractures in the 65+ population, all significantly greater than the national average.



Area	Count	Value
Basildon	192	587
Braintree	192	686
Brentwood	98	568
Castle Point	117	557
Chelmsford	232	725
Colchester	196	636
Epping Forest	165	599
Harlow	86	625
Maldon	83	621
Rochford	96	485
Tendring	291	684
Uttlesford	123	782

Figure 82 Age-sex standardised rate of emergency admissions for fractured neck of femur in 65+ population per 100,000 by district/unitary authority in 2013/14 compared to national average [42]

5.2.6. Residential and Nursing Care

Permanent admissions to residential and nursing care homes per 100,000 aged 18-64 were 9.5 from 2013-14, lower than the England average of 14.4 (PHE). For those 65+ the rate increases to 604 per 100,000 (England average 605 per 100,000).

5.2.7. Recovery to previous levels of mobility

The proportion of patients with a hip fracture recovering to their previous levels of mobility/walking ability at 30 days broken down by CCG (2014) (*NHS Castlepoint & Rochford CCG is unknown)

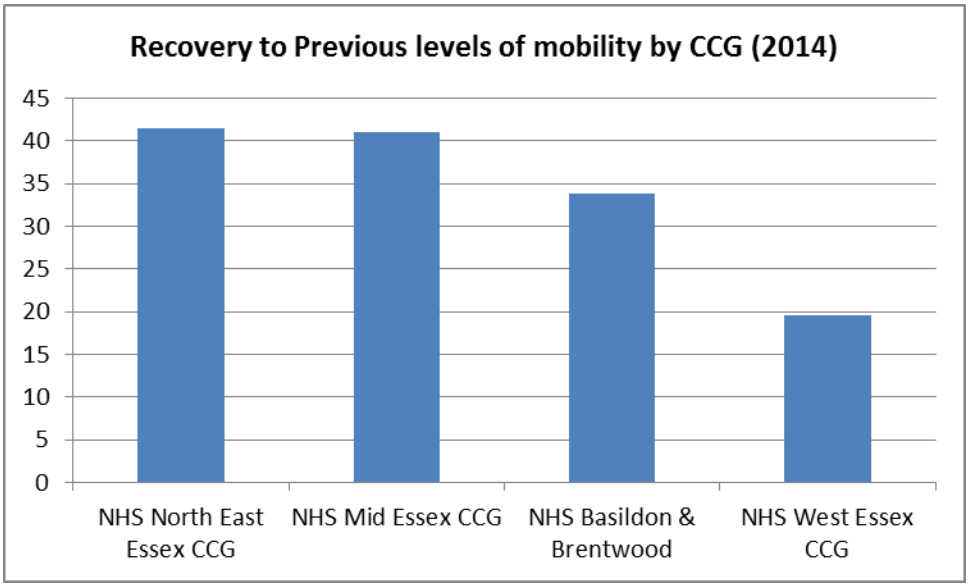


Figure 83 Recovery to previous levels of ability

5.2.8. Reablement outcomes

5.2.8.1. Background

Once adults leave hospital, how successful the reablement services that they receive can influence if and how well individuals can look after themselves. This measure demonstrates the quality of reablement services available. A higher score is better.

5.2.8.2. Trend

Reablement outcomes data shows that the percentage of people still at home 91 days after reablement for Essex is 81.9% which less than that of the region and England average but in line with similar local authorities

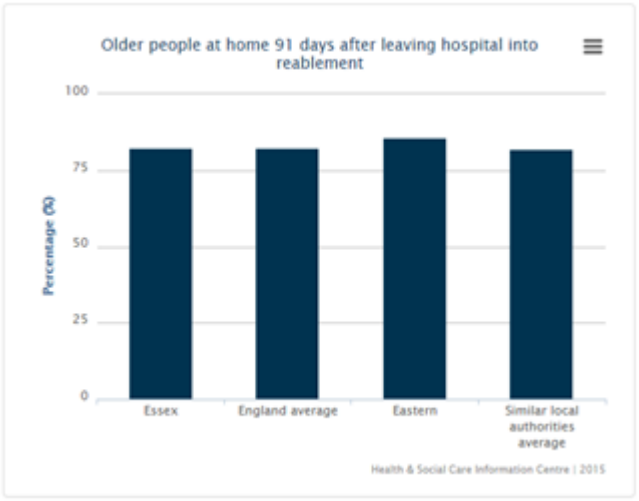


Figure 84 Reablement outcomes in Essex, England, East of England, and local authority

Compared with data for 2013-2014, 82% of older people (65+) in Essex were still at home 91 days after discharge from hospital showing there has been little change.

5.2.9. Social contact

41.3% of adult social care users in Essex last year reported they have as much social contact as they would like. This is lower than the national average of 44.8%.

5.2.10. Excess winter deaths

5.2.10.1. Background

Excess seasonal deaths are an important public health concern which sees an increase in mortality, with an estimated half of deaths from cardiovascular and circulatory diseases and a third from respiratory disease, mostly during winter but also during hotter periods. In non-epidemic years, influenza was found to account for a tenth of deaths and hypothermia for less than 500 deaths (just over 1%). The key issue with excess winter deaths is that a proportion of them are avoidable. Links between poor quality housing, fuel poverty and health are widely recognized. Lower/ higher temperatures, people's lowered resistance to illnesses (due to disease), safety in the home and the incidence and intensity of influenza outbreaks, all contribute to a higher mortality rate during winter.

5.2.10.2. Trend

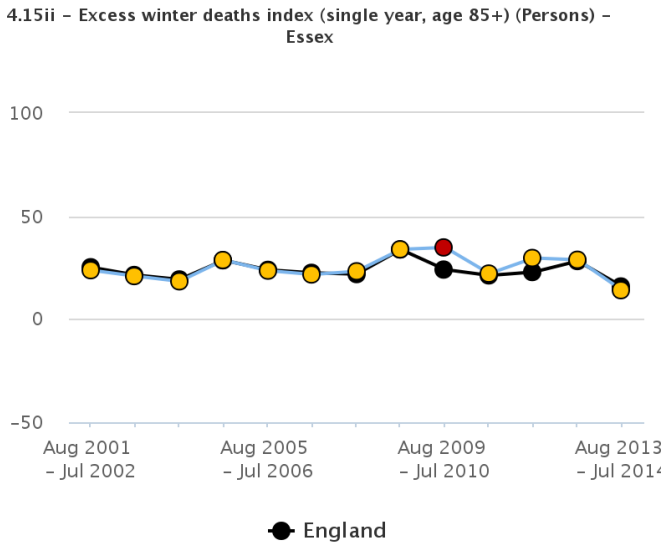


Figure 85 Excess winter deaths over time, compared to national average (black)

Overall, there has been a decline in excess winter deaths. From 2011-2014 the excess winter deaths index (aged 85+) for Essex was 14, slightly lower than the national index of 15.8. There are variations by gender with the rate for males being 17.4 compared to 12 for females. The same rate over a 3 year period from 2011-2014 was 16.4 compared to 15.6 nationally and 15.8 for the East of England. There are also notable variations across the districts in Essex.

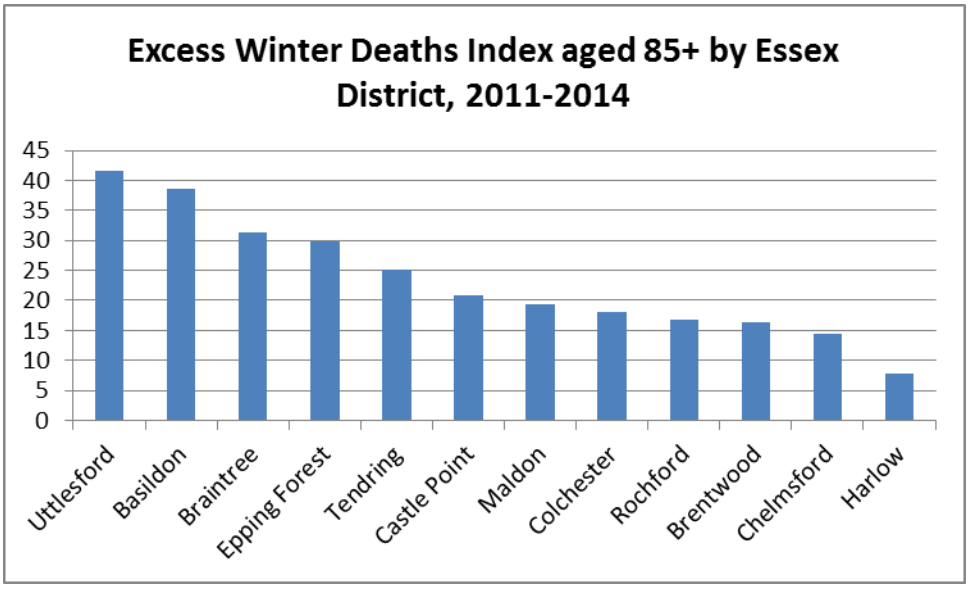


Figure 86 Excess winter deaths by district within Essex

5.2.11. End of Life

5.2.11.1. Background

Across Essex, end of life care programmes are in place to support people to enable them to make decisions about their palliative care packages and preferred place of death. The majority of deaths occur in hospital but the vast majority of people would choose to die at home in their own surroundings. End of life care aims to support these people and to increase the proportion of people that are able to fulfil this wish.

5.2.11.2. Trend

Overall, there has been a decline in hospital deaths in Essex to a percentage lower than the national average and an increase in deaths at home. This is reflected in those aged 65+ (Data not shown)

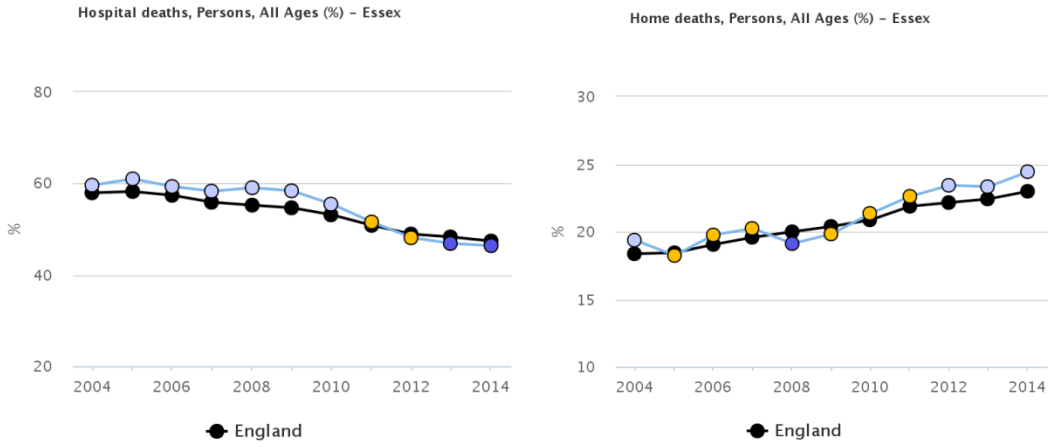
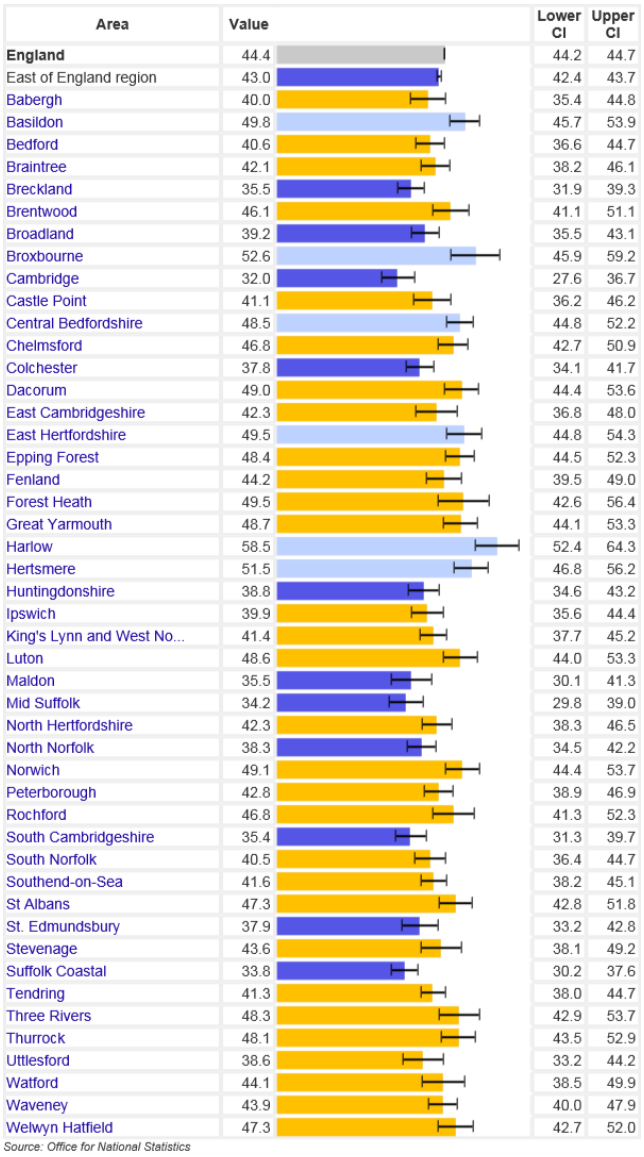


Figure 87 Hospital and home death percentage over time in Essex

5.2.11.3. District variation

The percentage of hospital deaths in those aged 85+ for the districts in Essex are similar or lower compared to national and regional figures with the exception of Basildon that has higher rates.



Area	Value	Lower CI	Upper CI
England	44.4	44.2	44.7
East of England region	43.0	42.4	43.7
Babergh	40.0	35.4	44.8
Basildon	49.8	45.7	53.9
Bedford	40.6	36.6	44.7
Braintree	42.1	38.2	46.1
Breckland	35.5	31.9	39.3
Brentwood	46.1	41.1	51.1
Broadland	39.2	35.5	43.1
Broxbourne	52.6	45.9	59.2
Cambridge	32.0	27.6	36.7
Castle Point	41.1	36.2	46.2
Central Bedfordshire	48.5	44.8	52.2
Chelmsford	46.8	42.7	50.9
Colchester	37.8	34.1	41.7
Dacorum	49.0	44.4	53.6
East Cambridgeshire	42.3	36.8	48.0
East Hertfordshire	49.5	44.8	54.3
Epping Forest	48.4	44.5	52.3
Fenland	44.2	39.5	49.0
Forest Heath	49.5	42.6	56.4
Great Yarmouth	48.7	44.1	53.3
Harlow	58.5	52.4	64.3
Hertsmere	51.5	46.8	56.2
Huntingdonshire	38.8	34.6	43.2
Ipswich	39.9	35.6	44.4
King's Lynn and West No...	41.4	37.7	45.2
Luton	48.6	44.0	53.3
Maldon	35.5	30.1	41.3
Mid Suffolk	34.2	29.8	39.0
North Hertfordshire	42.3	38.3	46.5
North Norfolk	38.3	34.5	42.2
Norwich	49.1	44.4	53.7
Peterborough	42.8	38.9	46.9
Rochford	46.8	41.3	52.3
South Cambridgeshire	35.4	31.3	39.7
South Norfolk	40.5	36.4	44.7
Southend-on-Sea	41.6	38.2	45.1
St Albans	47.3	42.8	51.8
St. Edmundsbury	37.9	33.2	42.8
Stevenage	43.6	38.1	49.2
Suffolk Coastal	33.8	30.2	37.6
Tendring	41.3	38.0	44.7
Three Rivers	48.3	42.9	53.7
Thurrock	48.1	43.5	52.9
Uttlesford	38.6	33.2	44.2
Watford	44.1	38.5	49.9
Waveney	43.9	40.0	47.9
Welwyn Hatfield	47.3	42.7	52.0

Source: Office for National Statistics

Figure 88 Hospital death percentage by district in the East of England

There is variation amongst the districts in Essex for the percentage of care home deaths in those aged 85+. Interestingly Basildon has lower rates of care home deaths where it has high rates of death in hospital. Colchester has a higher rate of care home deaths, whereas districts such as Chelmsford and Harlow have lower rates.

Area	Value	Lower CI	Upper CI
England	37.0	36.7	37.2
East of England region	37.7	37.1	38.4
Babergh	41.5	36.8	46.3
Basildon	31.8	28.1	35.7
Bedford	42.0	38.0	46.1
Braintree	39.6	35.7	43.6
Breckland	46.2	42.4	50.1
Brentwood	37.1	32.4	42.1
Broadland	45.3	41.5	49.3
Broxbourne	22.3	17.2	28.4
Cambridge	43.9	39.1	48.8
Castle Point	38.1	33.2	43.2
Central Bedfordshire	32.5	29.2	36.1
Chelmsford	32.0	28.4	36.0
Colchester	44.4	40.5	48.3
Dacorum	30.4	26.3	34.8
East Cambridgeshire	32.1	27.0	37.6
East Hertfordshire	30.0	25.8	34.5
Epping Forest	36.9	33.2	40.8
Fenland	37.0	32.5	41.8
Forest Heath	30.3	24.3	37.0
Great Yarmouth	35.2	30.9	39.6
Harlow	20.4	15.9	25.7
Hertsmere	32.2	27.9	36.7
Huntingdonshire	37.0	32.9	41.4
Ipswich	43.3	38.9	47.8
King's Lynn and West No...	38.7	35.1	42.5
Luton	35.6	31.3	40.2
Maldon	40.2	34.6	46.1
Mid Suffolk	46.7	41.9	51.5
North Hertfordshire	43.0	39.0	47.2
North Norfolk	43.9	40.0	47.8
Norwich	30.5	26.3	34.9
Peterborough	36.3	32.6	40.3
Rochford	25.6	21.1	30.8
South Cambridgeshire	37.4	33.3	41.7
South Norfolk	43.2	39.0	47.4
Southend-on-Sea	41.1	37.7	44.6
St Albans	32.4	28.3	36.7
St. Edmundsbury	39.9	35.2	44.8
Stevenage	38.3	33.0	43.9
Suffolk Coastal	44.2	40.3	48.1
Tendring	39.4	36.1	42.8
Three Rivers	34.7	29.7	40.0
Thurrock	32.6	28.3	37.1
Uttlesford	33.9	28.8	39.4
Watford	39.9	34.4	45.7
Waveney	40.8	37.0	44.7
Welwyn Hatfield	31.4	27.2	35.9

Source: Office for National Statistics

Figure 89 Home death percentage for each district in the east of england

5.2.12. Bereaved Carers view

74.9% of bereaved carers views on the quality of care in the last 3 months of life score outstanding, excellent or good, nationally (2015).

6. Overviews of areas of unmet need

6.1. Safeguarding Children

6.1.1. Why invest?

Safeguarding encompasses protecting children from maltreatment, preventing impairment of children's health or development, and ensures children grow up in safe circumstances. Child protection is part of this definition and refers to activities undertaken to prevent children "suffering, or likely to suffer, significant harm" (as defined under Section 47 of the Children Act 1989). Investing in safeguarding, the welfare of children and young people is therefore not only a core statutory responsibility, but also a building block on which children and young people can thrive and develop, free from harm. Essex County Council is the lead agency with responsibility for receiving referrals in relation to concerns of the welfare of a child, conducting assessments under Section 47 of the Children Act 1989 in conjunction with other Agencies, arranging child protection conferences, and managing a Child Protection Plan for the child where required.

6.1.2. Influencers and determinants

Over the last 3 years a number of changes have taken place within the Family Operations service to provide greater consistency and quality assurance around child protection planning, to try to ensure that the right children have a child protection plan. Considerable quality assurance of child protection plans and data cleaning on the children's social care database in 2012 led to a substantial reduction in open plans. The introduction of Quadrant based Child Protection Co-ordinators provided scrutiny, oversight, and consultation around child protection conferences and child protection planning. The Strengths Based Approach to child protection conferencing is now used by all professionals across the partner agencies, and is working to more clearly identify family strengths, risks, and what needs to change.to keep the child safe. The CIN reviewing service which commenced in 2014 reassures agencies that there is a robust framework of service for children who do not need a CP plan. Therefore more likely to be able to end CP plans and help families sustain changes at a lower level of service. All these factors will have influenced the reduction in CP plans in Essex 2012 - 2014, and our low comparative rate per head of under 18 yr. old populations during these years. An increase in the number of children subject to s.47 child protection investigations since the second half of 2015-16 can in part explain the increase in CP plans since 2015. Another explanation for this increase could be down to an increase in sibling group size at initial child protection conferences which has been observed between 2014-2015 and 2015-2016.

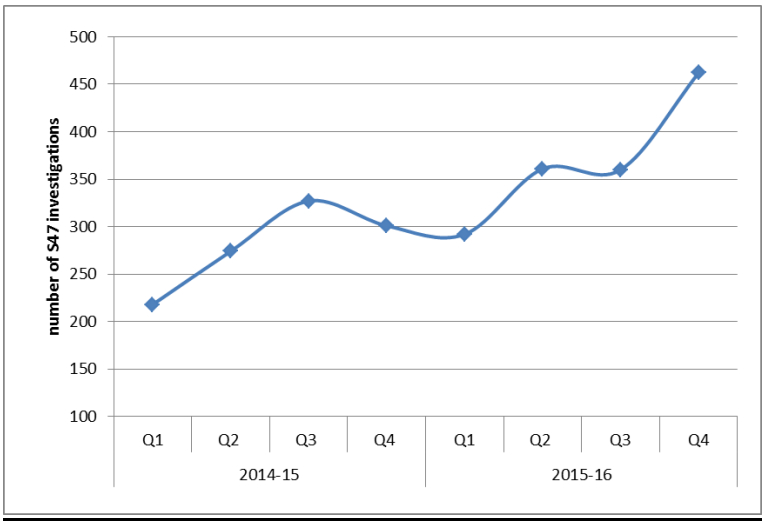


Figure 90 Number of S.47 Child Protection investigations 2014-2016

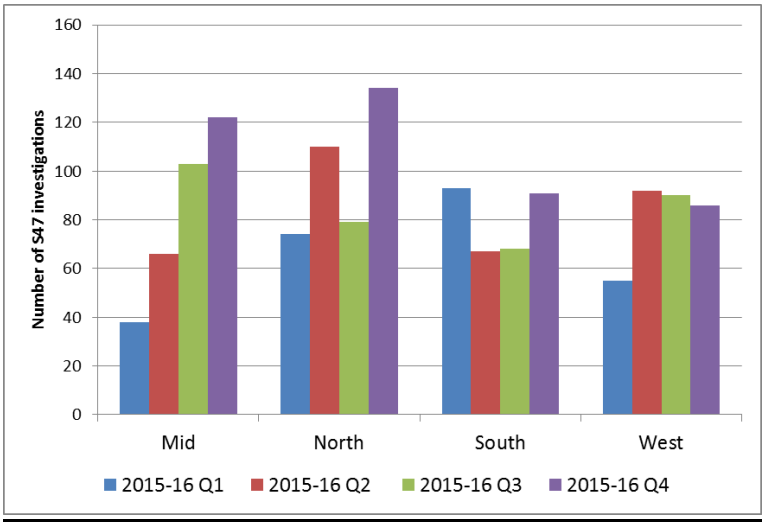


Figure 91 Quadrant breakdown of S.47 Child Protection investigations 2015-2016

Table 14 Difference in sibling group size at ICPCs 2014-2016

Quadrant (from child's address	Mid	North	South	West
% of 5+ children families 2014-15	5%	2%	1%	1%
% of 5+ children families 2015-16	5%	3%	11%	4%

6.1.3. What works

The key to effective safeguarding of children and young people is for safeguarding to be seen as 'everyone's business', but also for all statutory agencies in Essex that work with children to comply with their responsibilities under Section 11 of the Children Act 2004, and the 'Working Together to Safeguard Children' national guidance. The Essex Safeguarding Children Board has an important role in challenging and supporting partner agencies, and in auditing their compliance with safeguarding standards including Senior level commitment, Governance, Policies and Procedures, Safe Recruitment, Training and Inter-Agency Working. Multi-agency safeguarding training and learning opportunities, multi-agency case audits, and learning from Serious Case Reviews all contribute to identifying best practice.

6.1.4. Small area statistics analysis

Table 15 Lower Tier LA overview of child protection and safeguarding

Lower Tier LA ranked by pop'n size	Population Size (per 10,000 under 18 population divisor)	Average number of CP plans at Quarter end (average over 2 yrs)	Number of CP plans ranking	Rate of CP plans per 10,000 (average over 2 years)	CP plan rate ranking
Basildon	4.1	87	1st	21	3rd
Colchester	3.8	54	5th	14	6th
Chelmsford	3.6	57	4th	16	5th
Braintree	3.3	58	3rd	18	4th
Epping Forest	2.7	26	7th	10	8th
Tendring	2.6	69	2nd	27	1st
Harlow	2.0	47	6th	23	2nd
Uttlesford	1.9	10	10th	5	11th
Rochford	1.7	8	11th	5	12th
Castle Point	1.7	18	8th	11	7th
Brentwood	1.6	10	9th	6	9th
Maldon	1.2	8	11th	6	10th

Geographical differences in the extent and distribution of safeguarding risk across Essex has been examined at a Ward level, ranking a range of safeguarding indicators for both total number, and rate per 10,000 under 18 yr olds, and assigning a decile score to each District which has then been mapped. The Districts with the highest number of children on child protection plans (in the top 10% of all Essex Districts) come as little surprise in the majority of cases, including Basildon, Harlow and Tendring. However a number of Wards not necessarily associated with safeguarding concerns are also flagged up in other Districts, partly as a result of high child population (such as Chelmer Village and Beaulieu Park Chelmsford):

6.1.5. Recommendations

More detailed examination into the drivers behind the increase in s.47 child protection investigations, in particular

- Geographical differences
- Source of referrals e.g. schools, police.
- Demographic changes
- Impact of migration within Essex/migration into Essex from London Boroughs
- Impact of increased awareness of child protection within social services among professionals and general the public via media campaigns in particular CSE.

6.2. Childhood Obesity

6.2.1. Why invest?

Obesity is a growing problem with overweight and obesity in adults predicted to reach 70% by 2034 and the proportion that is morbidly obese is increasing. A high BMI is costly to health and social care and has wider economic and societal impacts.

Obesity harms children and young people in a number of ways including; Emotionally and behaviourally through stigmatisation, bullying and low self-esteem; Higher school absence; Poor health – high cholesterol, high blood pressure, pre-diabetes, bone& joint health, breathing difficulties; Increased risk of becoming overweight as an adult and risk of ill-health and premature mortality in adult life

As an obese adult the harm continues; Less likely to be employed and those employed have higher sickness absence; Discrimination; Increased risk of hospitalisation; 3 times more likely to need social care; Average reduction of 3 years in life expectancy with severe obesity recuing by 8-10 years.

Inequality exists between groups with obesity more common in; those from deprived communities; Older age groups; Some black and minority ethnic groups; People with disabilities

Obesity costs the economy; £27 billion to wider economy; £13.3 million in obesity medication; £16 million days sickness; £5.1 billion NHS costs; £352 million social care costs.

6.2.2. Influencers and determinants

- Societal influencers
- Food supply

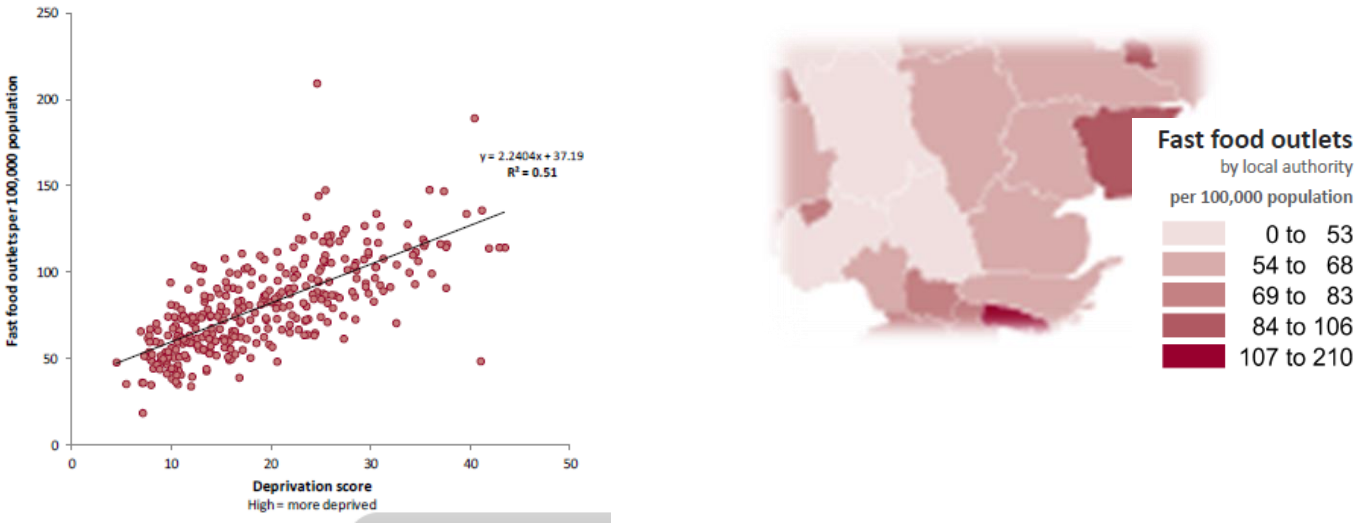


Figure 92 Relationship between density of fast food outlets and deprivation

People generally have easy access to cheap, highly palatable and energy-dense food frequently lacking in nutritional value - such as fast food. Research into the link between food availability and obesity is still relatively undeveloped. The concentration of fast food outlets and takeaways varies by local authority in England. The scatter plot shows a strong association between deprivation and the density of fast food outlets, with more deprived areas having more fast food outlets per 100,000 population.

- Activity environment
- Biology and individual behaviours

6.2.3. Evidence of what works

- Whole system approach and partnerships

6.2.4. Lower tier authority analysis

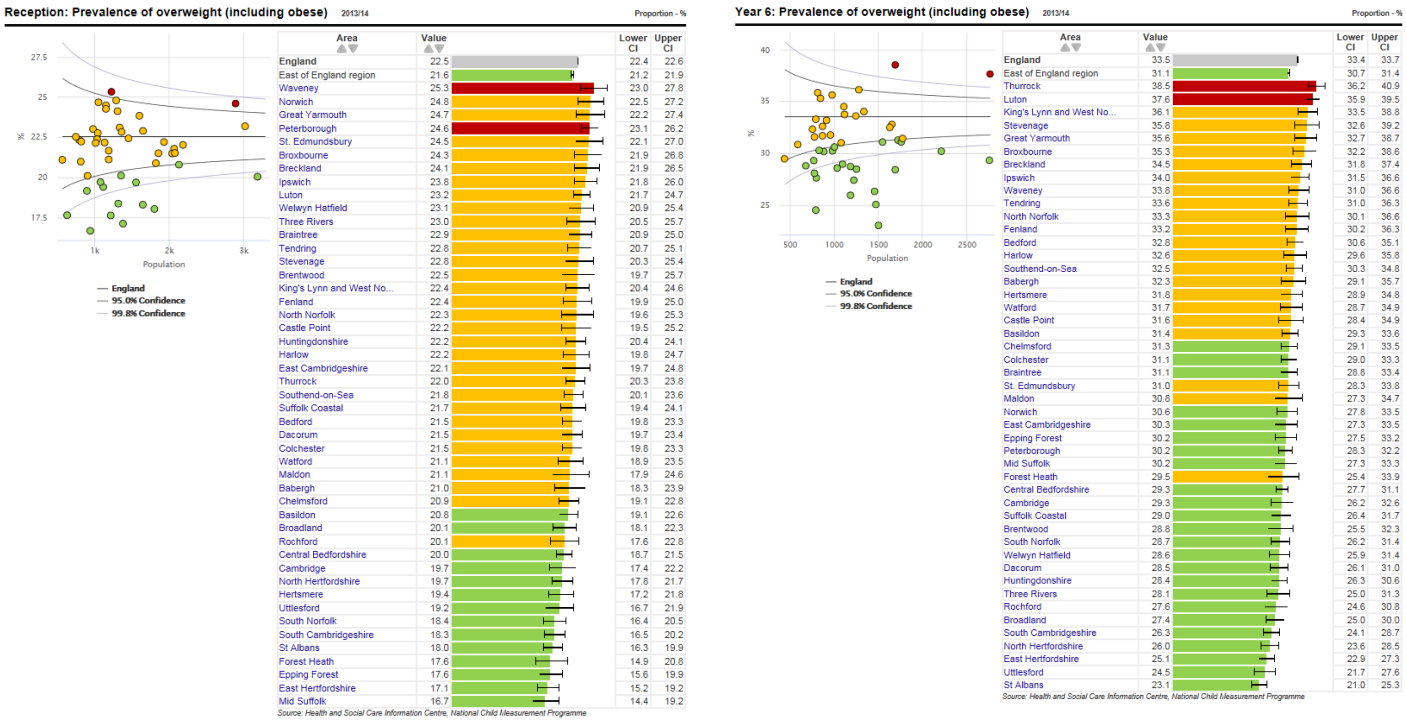


Figure 93 Childhood obesity rates by district within the east of england

6.2.7.2. Small area statistics analysis

Table 16 The 5 wards with the highest prevalence of Excess weight in reception year children

Ward	District	% excess weight	95% confidence limits	
			Lower	Upper
Maldon East	Maldon District	36.4%	24.9%	49.6%
Golf Green	Tendring District	32.0%	23.7%	41.7%
Alton Park	Tendring District	31.9%	25.9%	38.5%
Stour Valley South	Braintree District	30.9%	20.3%	44.0%
Pier	Tendring District	30.3%	23.4%	38.3%

Ward	District	% excess weight	95% confidence limits	
			Lower	Upper
Tollesbury	Maldon District	47.8%	36.3%	59.5%
Maldon East	Maldon District	46.0%	35.9%	56.4%
Ashingdon and Canewdon	Rochford District	44.7%	36.9%	52.7%
St Pauls	Tendring District	43.9%	34.9%	53.4%
Berechurch	Colchester District	43.5%	37.8%	49.3%

6.2.7.3. Recommendations

6.3. Smoking in School-aged Children

6.3.1. Why Invest?

Smoking needs no introduction when it comes to long-term harm and costs to our health service, but less well recognised is that the majority of regular smokers report to have started smoking in adolescence or late childhood [5]. Early uptake of smoking leads to an increased likelihood of regular, heavier smoking as an adult, with a greater number of pack years, difficulty in quitting and early mortality [5] [43]. It is also linked with other types of substance abuse such as alcohol and drugs [44] [45]. Furthermore, it has been recognised that if smoking does not start in childhood/adolescence, it is unlikely ever to occur [46].

6.3.2. Impact and changeability

The impact of adolescent smoking is significant across England and the rest of the Western World for the reasons listed above. In the 2009/2010 Health Behaviour in School-Aged Children Study (HBSC) by the WHO, England was ranked 31 out of 38 countries across Europe and North America for prevalence of 15 year olds who smoke at least once per week. Overall prevalence ranged from 57% in Greenland, to 6% in Armenia. The average across all 38 countries was 18%, with England falling below this at 11.5% [47].

In Essex, adolescent smoking has recently been reported in the local press following the release of the HSCIC data from its What About Youth (WAY) Study [48] [49]. The WAY survey showed that the prevalence of current smokers in Essex (includes regular smokers and occasional smokers) was 10.5%, which was significantly greater than the national average of 8.2%. While the number of regular smokers in Essex was similar to the national average, the number of occasional smokers was significantly greater, contributing to the greater overall prevalence of current smokers.

Across the country, the prevalence of regular smokers at age 15 has decreased to 8% from 21% in 2004 [50] [51]. This was shown to be even lower (5.5%) by the WAY survey (thought to be a consequence of survey methodology), with Essex at a similar value of 6.1% (no significant difference) [49]. There is no Essex specific data for the trend in prevalence.

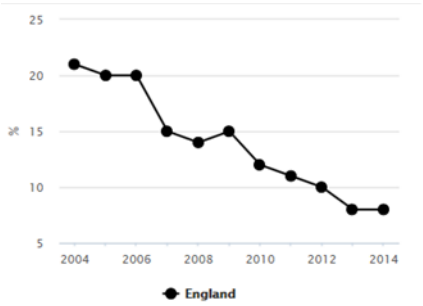


Figure 94 Smoking Prevalence (regular smokers) youths aged 15 years, England

6.3.3. Influencers, Determinants and What Works

England was one of the 15 countries in the WHO study that showed a significant gender difference in smoking prevalence, but one of only 4 of these 15 that showed a significantly greater prevalence in females. [47] The WAY survey also showed that girls were more likely to smoke than boys (10% vs 7%), and young people from the most deprived areas were more likely to be regular smokers. [49]

Evidence of modifiable influencers has shown that young people seem more sensitive to pricing, with high prices driving down prevalence and also the success of new legislation preventing sales to under 18s. [44]

Adult smoking prevalence is important when considering adolescents, both because adult smokers usually start in adolescence, but also because young people are more likely to smoke if they come from smoking households. [5] Smoking prevalence has not changed significantly in Essex since 2010, while nationally it is decreasing. [52] [53]

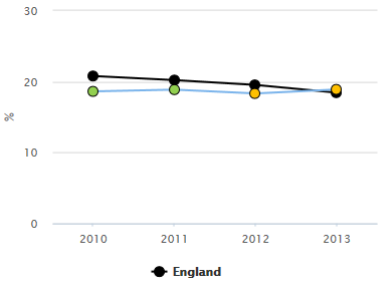


Figure 95 Smoking Prevalence in adults in Essex vs. England

It is no surprise that adolescent prevalence across districts within Essex bears similar resemblance to adults', with Harlow, Castle Point and Maldon 3 of the worst performing districts, and Brentwood one of the best. [54] [55]

Figure 96 % of secondary school pupils saying they smoke regularly 2014

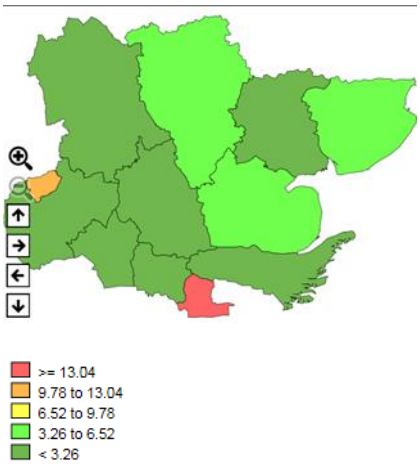
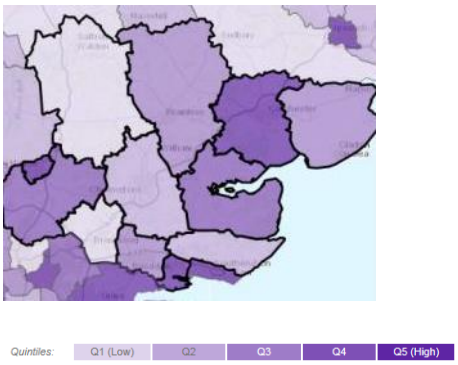


Figure 97 Smoking Prevalence in Essex Adults by quintile 2013



It follows that in order to tackle smoking prevalence in adults, as well as the health implications that come with it, it is necessary to intervene at an early age. The difficulty is that there is little evidence that smoking cessation is effective in younger age groups, and evidence on smoking prevention strategies is limited.

There are a number of Cochrane Reviews which address the effectiveness of different interventions. They show that family interventions [56] and school-based interventions which are based on social competence, with or without social influence [57], are the only recognised interventions that significantly reduce the numbers of adolescents starting smoking. Adding family intervention to school-based intervention can significantly improve outcomes from school-based intervention alone.

Essex have a number of initiatives in place to both prevent young people from starting smoking, and help them quit. The Youth Health Champion Programme is a peer led programme based in schools, which encourages young people to make healthy lifestyle choices. There are also campaigns in place throughout the county to alert young people to the issues of smoking, including prevention lessons which are offered to all secondary schools. Essex has specially trained smoking cessation advisors to treat young people, who are available from schools, doctors' surgeries and pharmacies, and all young people who engage with smoking cessation are offered a young person toolkit with additional advice. ACE helped 109 under 19s across Essex to quit smoking in 2014-15, and 250 to make positive changes to their smoking habits. On top of this, Essex Trading Standards work hard to reduce illegal sales of tobacco to underage consumers

6.3.4. Recommendations

Further investigate areas with high prevalence such as Harlow and Castle-point. Consider evidence-based family interventions to target smoking in families

6.4. Domestic Abuse

6.4.1. Why invest?

Domestic abuse impacts on quality of life and can ultimately destroy people's lives. Despite being a significant contributor to crime statistics it is also a pattern of behaviour that often happens behind closed doors and is grossly under-reported. It is an issue that cuts across all social, geographical and cultural groups.

Domestic abuse is a contributor to causes of ill health and poor wellbeing in local communities. It causes harm to both adults and children, both directly and indirectly, and is of high financial cost to public agencies, the economy, the individuals concerned and wider society. Furthermore it produces patterns of behaviour that are often replicated from generation to generation.

6.4.2. Impact and changeability

Domestic abuse impacts on the wider wellbeing of local communities and has a wide range of effects on its victims and their families ranging from poor educational attainment to social isolation and in the most serious cases death. Yet violence is preventable through appropriate targeted interventions, especially in childhood. National and local research has indicated that victims of domestic abuse need services which will support them to recover from abuse and to live independently in the community. The problem of Domestic Abuse cannot be solved by one agency alone and partners must work together to raise awareness of the issue and agree an approach to tackling it.

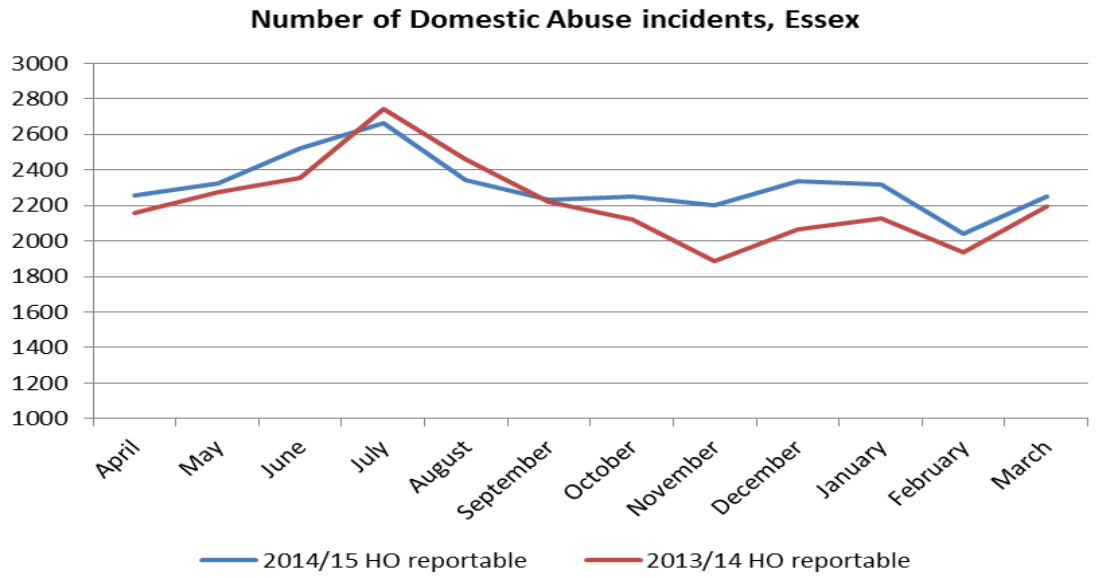


Figure 98 Number of incidents of domestic abuse 2014/15

Table 17 Percentage of repeat incidents of domestic abuse 2014/15

APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
14	14	14	14	14	14	14	14	14	15	15	15
48%	46%	49%	48%	48%	50%	48%	49%	46%	47%	47%	48%

There is a perceived under-reporting of domestic abuse nationally and locally, in order to change this and increase reporting figures, communities need a greater awareness of what an abusive relationship is and how to report it.

6.4.3. Influencers and determinants

Domestic abuse, mental ill health and substance misuse have all been identified as common features where harm in families occurs. Children who are exposed to the domestic abuse of a parent are often found to have greater behavioural and emotional problems when compared to other children.

Domestic abuse is often perceived as an 'adult' issue, something that happens between adults who are in, or have been, in an intimate relationship and research has tended to focus more on these relationships. More recently, intimate partner violence among young people has been highlighted as 'an understudied' area of maltreatment in the UK. Furthermore, adolescents involved in dating violence are at higher risk of further violence in future relationships, riskier sexual behaviour, and increased rates of substance use and eating disorders. Research also suggests there is a hidden victimisation of domestic abuse that occurs in over 65's.This age group is also more likely to report to agencies other than the police.

Other determinants:

- A significant factor for women experiencing abuse in the last 12 months was having a household income of less than £10,000 and low qualification levels (CSEW).
- There is a geographical clustering of domestic abuse incidents and repeat incidents in urban areas.

6.4.4. Evidence of what works

Successful interventions include:

- A Joint Partnership approach
- Independent Domestic Violence Advocate (IDVA) service for high risk victims.
- Perpetrator Programmes
- Refuge Accommodation
- Risk Avert and other education based preventative programmes.

6.4.5. Lower tier authority analysis

The rate of violent crime hospital admissions for violence in Essex is below the national average in all districts other than Harlow. Harlow's rate is 57.8 per 1,000 which is similar to the national average.

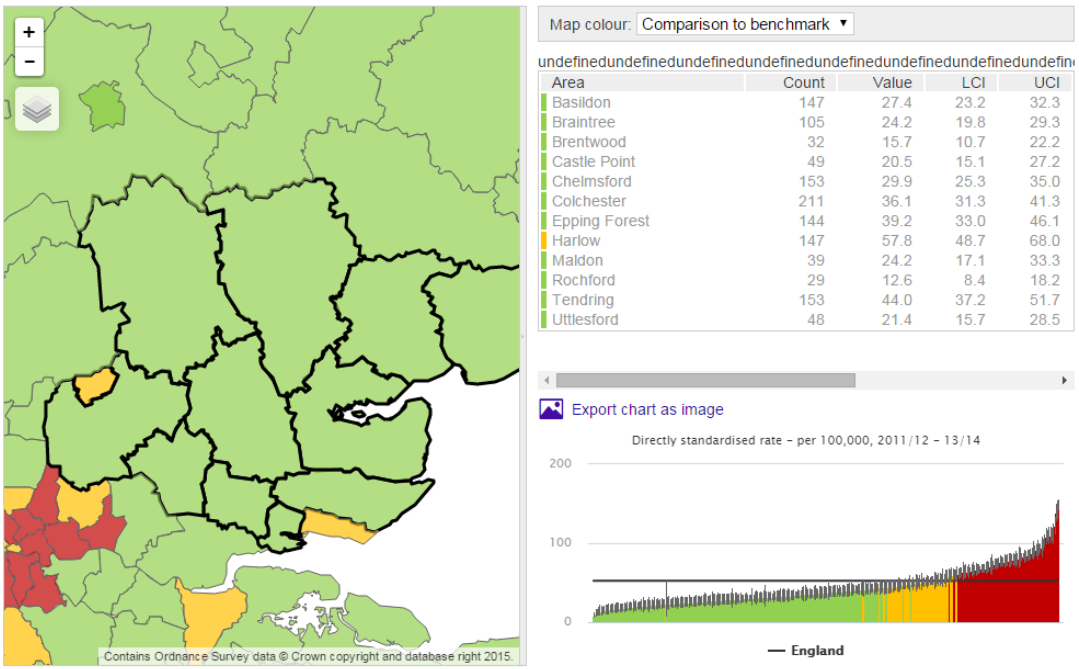


Figure 99 Violent crime (including sexual violence) hospital admissions for violence per 1,000

6.4.5.1. Small area statistics analysis

Lower tier authority statistics for domestic abuse are not available to publish

6.4.5.2. Recommendations

- Monitor the reporting of domestic incidents to ensure reporting increases and awareness of the issue increases.
- More research into the needs of over 65's when victims of domestic abuse.
- Research to provide more evidence around interventions and prevention of domestic abuse especially for younger people.

6.5. First time Juvenile 1st time entrants to criminal justice system

6.5.1. Why invest?

Although the rate of first time entrants to the criminal justice system has reduced in Essex, it has consistently been worse than the regional and national average. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system.

Investing in first time entrants also has the potential benefit of impacting on a young person's wider family now and in the future, particularly when they may already be parents themselves.

Increasingly, young people in the youth justice system are affiliated to gangs which, in turn, is linked to other crimes such as sexual exploitation, drug offences and organised crime.

6.5.2. Impact and changeability

The Youth Justice Board for England and Wales Strategic Plan 2015–18 states that in order to improve performance future challenges need services to concentrate their efforts on addressing needs at an early stage and prevent children and young people being drawn into the system in the first place. There is, in addition, a clear need for upskilling staff to deliver more intensive and targeted work to address the underlying causes of entrenched offending behaviour.

6.5.3. Influencers and determinants

Within the overall reduction in numbers in the youth justice system, there is still a significant over-representation of black and minority ethnic groups – particularly in custody and on remand. In addition, we know that children who are – or have previously been – looked-after are over-represented in the youth justice system when compared to their peers.

Inequalities exist between groups, with first time entrants to the criminal justice system more common in those from deprived communities. The chart below demonstrates the relationship between first time entrants to the youth justice system and deprivation. It shows that the rate of first time entrants to the youth justice system for the most deprived decile was 484 per 100,000 compared to 284 per 100,000 for the least deprived decile.

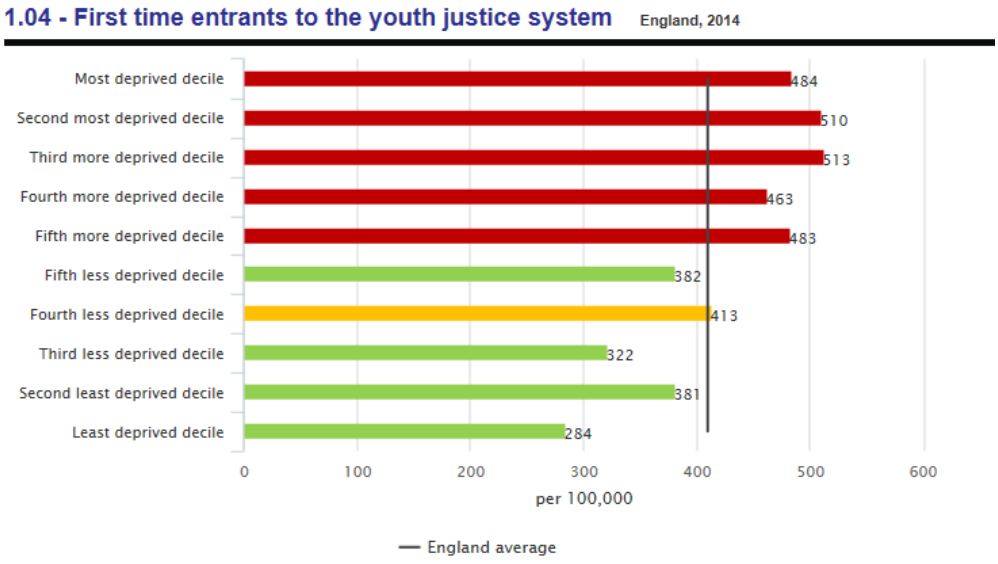


Figure 100 First time entrants to the youth justice system in England by deprivation decile

Other influences and determents include:

- Family Risk Factors e.g. loss of contact of family, Children in care
- Individual Risk Factors e.g. Substance misuse, mental health needs

- Societal Risk Factors e.g. Involvement in gangs
- Community risk actors e.g. deprived areas, low levels of community cohesion

6.5.4. Evidence of what works

A 'centre of excellence approach' in youth justice which supports innovation by using and interpreting available evidence to support the delivery of youth justice services in custody and the community.

Developing and championing a child-centred and distinct youth justice system, in which a designated youth justice service keeps children and young people safe and addresses the age-specific needs of the child, to the benefit of the community.

6.5.5. Lower tier authority analysis

No access to this data

6.5.6. Small area statistics analysis

No access to this data

6.5.7. Recommendations

- Further analysis required to identify why the first time entrant rate is worse than the regional and national average - Work with partners to access lower level data.
- Further research and understanding of good practice in order to improve performance

6.6. Violent Crime

6.6.1. Why invest?

Preventing violence must be seen as a priority for public health, health care and multi-sectoral working in England. Violence is a major cause of ill health and poor wellbeing as well as a drain on health services and the wider economy.

The impact of violence on health is huge, for instance, exposure to violence as a child can increase risks of substance abuse, obesity and illnesses such as cancer and heart disease in later life.

Continuing to reduce the levels of violent crime would have a positive impact in many aspects of health and social care. Not only would it have a decreased impact on the demand of A&E and other primary care providers but it will also have an impact on the demands of mental health and counselling services.

6.6.2. Impact and changeability

Violence damages physical and emotional health and can have long-lasting negative impacts across a wide range of health, social and economic outcomes. It increases individuals' risks of a broad range of health damaging behaviours – including further violence – and reduces their life prospects in terms of education, employment and social and emotional wellbeing.

Violence prevention is a critical element in tackling other public health issues. A range of different interventions throughout the life course can reduce individuals' propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require.

Data on violence are increasingly available from health services, police, other routine sources and a variety of surveys. These identify individual and community level risk and protective factors. Such data can be used to target interventions at those most at risk and monitor progress.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216977/Violence-prevention.pdf)

6.6.3. Influencers and determinants

There is no single reason to explain why some people or populations are vulnerable to violence. Instead, a wide range of factors relating to individuals, their relationships, and the communities and societies in which they live can interact to increase or reduce vulnerability to violence

As discussed, levels of deprivation have a significant impact on the rate of violent crime experienced Indicating that social demographical background is an important contributing factor. There are also geographical variations on the levels of violent crime, with Luton and Peterborough displaying high levels in the Eastern region and the North of England showing large pockets of high levels.

Exposure to violence, especially a child, makes individuals more likely to be involved in violence in later life.

6.6.4. Evidence of what works

Programmes that support parents and families, develop life skills in children, work with high-risk youth and reduce the availability and misuse of alcohol have proven effective at reducing violence. Measures to ensure appropriate identification, care and support mechanisms are in place are important in minimising the harms caused by violence and reducing its recurrence.

This includes:

- Developing life skills in children and young people
- Drug and alcohol interventions
- Community interventions

- Interventions that challenge social norms aim to prevent violence by making it less socially acceptable.
- Programmes that identify victims of violence and provide effective care and support are critical for protecting the health and wellbeing of victims and breaking cycles of violence. (source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216977/Violence-prevention.pdf)

6.6.5. Lower tier authority analysis

Please see previous section

6.6.6. Small area statistics analysis

Not currently available

6.6.7. Recommendations

Access small area statistics to carry out further analysis

6.7. Excess weight

6.7.1. Why focus on this?

In Essex, two-thirds (66.5%) of adults are either overweight or obese. This is significantly greater than the UK and national averages, and continues to grow. There is considerable inequality in Essex, with individual districts ranging from the second to the fifth quintile nationally. [12]

6.7.2. Why Invest?

Weight is one of the greatest public health challenges facing populations in the developed world. In many countries (including the UK), the majority are now either overweight (BMI 25+) or Obese (BMI 30+), and this proportion is steadily growing.

There is a well-studied 'J shaped' relationship between weight and mortality: being either underweight or overweight increases one's likelihood of dying, and the more overweight or underweight one is, the greater this risk: at a BMI of 30 (obesity), the increased risk of death is 10%. [58] Obesity causes morbidity in addition to mortality: it is associated with disability in general and common disabling conditions (e.g. back pain, joint pain, mental health issues) in particular, although the direction of causation is unclear: obesity might be the *result* of these conditions, rather than their cause. [59]

It can therefore stop people living and working well, and heralds an unhealthy old age and a shorter life. These costs to welfare of those with excess weight are mirrored by economic costs to wider society: those with excess weight (particularly the obese) are more likely to be unemployed, take more sickness absence, and have higher rates of health and social care spending. The cost of obesity has been estimated as high as £27 billion in 2015. [60]

6.7.3. Impact and changeability

Widespread overweight and obesity is a recent phenomenon. As nature does not change so rapidly, environmental factors must have a strong role to play in whether someone develops excess weight or not. By targeting and modifying features of the environment implicated in making people gain weight, we can reduce the numbers gaining excess weight, and so reduce the burden of this public health threat.

6.7.4. Determinants

The causes of excess weight remain unknown. Studies vary widely in how much of it is 'genetic', but reviews of scientific work suggest it slightly over half the risk is heritable. [61] People have varying levels of 'genetic risk' of gaining excess weight, and this risk can be triggered or not depending on the features of the surrounding environment.

Available evidence implicates several environmental factors: cars over walking for transportation [62]; a sedentary lifestyle [63]; and a food environment prevalent with fatty, high-calorie foods [64]. General social deprivation is also a factor. Analysis of the data contained in the public health outcomes framework across the UK suggests that regular physical activity is an important factor.[1]

6.7.5. What works?

'Curing' excess weight, especially when one becomes obese, is very challenging. Longitudinal studies of weight management programs show modest weight loss (often insufficient to move from obese to overweight, or overweight to normal weight) with high attrition rates. A longitudinal survey of GP records show a 1-2% chance of a person recorded as being obese returning to a normal weight, with annual rates less than 1%, which compares unfavourably to alcohol, tobacco, and drugs of abuse. [65]

[1] One can model the data available in public health England to see which factors are most closely correlated to an area having a higher proportion of people with excess weight. When one does this, the indicator that correlates strongest is the number of adults having regular exercise (it is, indeed, better correlated than all the others put together). Technical details: all PHOF variables included in analysis, generalized linear model fitted with forward stepwise information criterion for variable selection, performed on SPSS 20.

NICE provides a comprehensive clinical knowledge summary of management of overweight and obesity. Their survey of the evidence recommends a combined attempt to reduce calorie intake and increase exercise in the first instance, and subsequent consideration of pharmacological, psychological or surgical methods in the morbidly obese in whom initial treatment is ineffective. [66]

Current national strategy to prevent obesity is described in *Healthy Weight, Healthy Lives*, and successor documents. The five key themes are:

- To promote children's health
- Promoting healthy food
- Building physical activity into our lives
- Creating incentives for better health
- Personalized advice and support.

The evidence that any initiative based on these themes is successful is circumstantial at best, and the general secular trend of rising rates of overweight across the developed world despite governmental efforts to curtail it suggests no 'silver bullet' has been found.

6.7.6. Local area authority analysis

Essex ranges from the second to fifth quintile nationally with excess weight. The areas with the greatest need are: Castle point (70.2% excess weight), Maldon (69.2%), and Basildon (69.1%).

6.7.7. Small area statistics samples

There are no ward-level data available since 2008, and no direct proxy indicators. The Quality Outcomes Framework (QOF) shows varying obesity rates recorded by GPs: the three highest rates reported by Felmore's surgery in Basildon (20.3%), Dr. Mohanty's Practice in Witham (19.5%), and Southview Park Surgery in Basildon (19.3%); the three lowest being Chelmer Village Surgery in Chelmsford (4.53%), Dr. S S Gill in Benfleet (3.77%), and High Road Surgery in Loughton (3.60%). It should be noted that these figures are only of patients who present to GP practices who are recorded as obese, and thus figures will depend not only on 'true' prevalence of obesity, but also on health behaviour (some may be more willing to present to primary care than others) and reporting (some practices may assess the weight of their patients more avidly than others).

6.7.8. Recommendations

- Further research on what behavioural interventions have a proven track record of success in improving obesity.
- To contemplate shifting priorities for commissioning from weight management services for those trying to lose weight to preventative efforts, given the former's modest performance.
- Childhood overweight (see above) and physical exercise look like two areas that deserve particular focus, given their importance in determining adult excess weight.

6.8. Cancer

6.8.1. Why focus on this?

Essex has a greater under-75 mortality from cancer than other areas within the east of England, and Essex's performance on this measure compares unfavourably with most 'nearest neighbour' local authorities: those most similar to Essex in terms of population characteristics.

6.8.2. Why invest?

Collectively, cancers are the leading cause of death in the UK. They also inflict the greatest amount of years lost through premature death across all categories of diseases. [67] The UK performs poorly for most cancers compared to other affluent European countries, but has shown incremental improvement. Essex's rate of improvement has been slower than that seen nationally or regionally, and it has started to lag behind the regional norms

6.8.3. Impact and changeability

Cancer is one of the leading causes of death and the leading cause of lost years of life in the UK. Thus the public health impact of poor or lagging cancer survival is obvious.

Variation within Europe, variation within the UK, and reduction in cancer mortality over time in various areas all suggest cancer mortality can be reduced.

6.8.4. Determinants

Cancer covers a multitude of conditions, which vary in their aetiology. There are general overarching themes on what determines population wide survival of cancer.

First, patient factors. Most cancers have a heritable component which is not malleable, but many have environmental factors that play a large role. The third biggest cause of years of life lost in the UK is lung cancer, well-known to be strongly associated with smoking. Lifestyle factors (smoking, alcohol intake, obesity) are axes of risk common to many cancers. Others environmental risks have a large effect size on a smaller subset of cancers (e.g. HPV).

Second, detection. Late-stage cancer is usually fatal; early detection can save lives. Although the impact of screening is controversial, earlier detection by primary care services and prompt referral for definitive treatment are key.

Third, treatment. Access to treatment, and the efficacy of that treatment can have measurable differences in survival. In the case of Ovarian cancer, the UK seems to perform as well as other countries in terms of detection, however, its poorer performance is attributed to less effective management leading to reduced stage-specific survival. [68]

6.8.5. What works?

Successive governments have made improving cancer mortality a priority, and have had some measured success. The current cancer strategy is contained in *Improving Outcomes: A Strategy for Cancer*. [69]

The strategy is comprehensive, intervening across all three main areas for cancer: prevention (via risk factor control and modulation), early diagnosis (via raising public awareness, providing better support for primary care, and providing better access to screening), and treatment (via improving speed of access and building capacity of surgical, radiological and chemotherapeutic services), with an extensive monitoring and research program undergirding it. They assert this program saved approximately 7000 lives in 2014.

6.8.6. Local authority analysis

Essex does par for the nation, but significantly worse than the region in terms of under-75 mortality from cancer (138.8 versus 134.5 per 100 000, approximately 60 excess deaths per year in Essex). [26] Although it remains significantly higher for men but not for women, both are numerically greater than the regional norms. It is also numerically higher (although not significantly so) when looking at cancers considered

preventable. Essex also does relatively poorly on these measures when compared to 'nearest neighbours' of areas with similar populations.

Looking at process indicators (e.g. screening prevalence) a broadly similar picture emerges. Although Essex does better than the region for cervical or breast cancer screening coverage, it does worse for bowel cancer and cancers diagnosed at an early stage.

6.8.6.1. Small area statistics samples

Within Essex, Tendring (162.8 per 100 000) and Basildon (154.6) do particularly badly compared to the region as a whole. Chelmsford does relatively better (121.5). These trends are broadly repeated when looking at under 75 mortality by gender.

6.8.6.2. Recommendations

First, to better investigate the precise reason Essex's survival is lagging behind the region. Is our stage-specific survival worse, implying poor progress in treatment? Is early detection not working as well? Does the population have a greater intrinsic risk?

Second, the relatively poor performance of bowel cancer screening suggests this as a likely area for improvement.

Third, although effects will not be observed immediately, Essex's performance here should provide further impetus for modifying environmental factors (particularly smoking and excess weight) in the population.

6.9. Mental Health support

6.9.1. Why focus on this?

Mental health issues are prevalent, and a leading cause of morbidity in the population. Essex's performance in terms of employment and housing of those in contact with secondary care services for mental health is numerically worse than the region and the nation, and has deteriorated over the last two years.

6.9.2. Why invest?

Mental health issues inflict a high burden of disease across the developed world, principally via reducing quality of life. [67] They can also shorten life, both via impairing the ability of those with mental health to maintain their physical health, but also directly via increased risk of suicide (see later).

Employment and stable accommodation are known to be important factors in protecting the health of those with serious mental health problems.

6.9.3. Impact and changeability

There is a very large of burden of disease from mental health conditions across the UK. The quality of support for those with mental health conditions will affect a lot of people. There are also 'knock-on' effects: problems with mental health can affect the families and friends of the affected. Further, as the burden of disease tends to fall during working age, there can be significant economic damage, estimated by one source to be 30.3 billion pounds in the UK in 2009-2010. [70]

The variation in the indicators for mental health between places suggests this can be changed. Regrettably, both employment in gap and appropriate accommodation have fallen dramatically in Essex in the last two years - this implies (and perhaps demands) similarly dramatic recovery is possible.

6.9.4. Determinants

The aetiology of mental health conditions vary, but most comprise interplay of biological, social, and psychological factors. [71] Many of these risk factors are challenging to modify.

The trajectory of someone with a mental health problem is similarly variable, and has a similarly large number of determinants: from the particular condition, the particular patient, to their family structure, social position, and wider social events.

There is a complicated interrelationship between employment and mental health: on one hand, mental health issues can harm employment and increase risk of becoming unemployed or finding it difficult to return to work. On the other, employment conditions can provide additional risk or protective factors towards someone's mental health.

6.9.5. What works?

Mental health is complicated, and many of the factors the determine whether one has mental health problems or ones trajectory after mental health problems are not modifiable. But some are.

There has been a recent systematic review of employment and mental health, looking both at how changes to employment can protect mental health, but also how those with mental health problems can be supported to remain or rejoin employment. They suggest aspects to the nature of work (improving control and empowerment), and involvement of supervisors and manager are key to success. [72]

A recent policy paper by the mental health providers forum suggests five key areas to ensuring good accommodation for those with mental health problems: Quality, Co-production, Staff recruitment and training, Policy informed practice, and Resourced, appropriate accommodation. [73]

6.9.6. Local authority analysis

Two indicators for mental health support services are proportion in stable an appropriate employment, and the gap in proportion employed between those with mental health problems and the general population.

For accommodation, 49.2% of people in Essex with mental health problems have stable and appropriate accommodation, worse than the national average (59.7%). This has deteriorated markedly from 2 years ago (77.8%). [28]

The picture for employment is similar, albeit less stark. There is a 68.8% gap in employment rate in Essex, greater than the national average (66.1%). This has also deteriorated in the last 2 years, from 56.6%

6.9.7. Small area statistics samples

Smaller area statistics are not available for these indicators.

6.9.8. Recommendations

The large adverse movement of these indicators over a short time period suggests an acute deterioration in mental health services, rather than changes in wider determinants of mental health. As such, the recommendations are broadly targeted at trying to identify any source of this hypothesized deterioration.

- We suggest a review by relevant commissioners to see whether any commissioning decisions in the last two years could have had an adverse impact on mental health service provision.
- To consult relevant providers to see if they have noticed deterioration in performance, and if so, any causes they identify.

6.10. Suicide

6.10.1. Why invest

Suicide is both a personal tragedy, an important public health indicator, and an important outcome in its own right. Preventing suicide saves lives, and it also acts a barometer for wider measures of mental health in the community. Essex appears to perform worse than relevant comparators in terms of suicide rate, principally being driven by *female* suicides.

6.10.2. Impact and changeability

Suicide is a rare but believed to be preventable cause of death. Current rates in the UK are 8.9 per 100 000 people. Beyond the death of the individual, suicide can cause considerable harm and distress to that person's family and community. [74]

The variation in suicide rate suggests there are means of influencing it. That said, the precise nature of what causes and prevents suicide is difficult to establish.

6.10.3. Determinants

There are well-studied associations between so-called 'social determinants of health' and suicide: relative poverty, unemployment and lack of social support are all risk factors.

Further to this, a large number of individual factors have also been identified, from single-gene associations, to broader considerations like educational level, mental health, and personality traits. [75]

6.10.4. What works?

The English suicide prevention strategy is outlined in *Preventing Suicide in England*. The principal focus of the strategy is mental health services, although access to means of suicide and media portrayal are also areas of the strategy. [76]

The evidence for the efficacy of individual suicide prevention strategies remains scant, in part because suicide is a relatively rare event, and thus demonstrating a reduction in its rate attributable to a particular program is challenging. A large WHO evidence synthesis suggested the following areas were promising (but with many caveats) given the current evidence base: school-based programs teaching emotional resilience and coping strategies; restricting supply of means to commit suicide (e.g. firearms, certain drugs); and multifaceted programs utilizing risk stratification. [77]

6.10.5. Local authority analysis

Essex shows a greater suicide rate for persons compared to regional benchmark, albeit somewhat similar to 'nearest neighbour regions. This seems to be mainly driven by an elevated risk of female suicides. Although the rate is lower in absolute terms than that for men, it is relative greater than female suicide rates in other areas.

6.10.6. Small area statistics

Suicide is a rare event, and thus many districts had too few suicides to allow them to be helpfully compared to the national or regional average. No districts of Essex had a rate significantly lower than benchmark, whilst Tendring and Colchester did worse.

6.10.7. Recommendations

- To perform a suicide audit on recent suicides in Essex
- To consult with stakeholders to gather intelligence as to what factors may explain why Essex fares worse than expected in terms of female suicide.
- To contemplate any association between this indicator and indices of mental health support.

6.11. Dementia Diagnosis

6.11.1. Why invest

Nationally there is an issue of under recording Dementia prevalence. Essex GPs experience the same problem. Only 7 of the 206 Essex GP Practices do not have a recorded prevalence significantly below the expected level based upon demographics of area. In an ageing population there will be an impact on Dementia prevalence and thus a considerable effect on the volume of people requiring Dementia services. NICE guidelines state that Diagnosis is an important factor in supporting people to live well with Dementia

6.11.2. Impact and changeability

Dementia is more prevalent in the older population, and after the age of 65 the likelihood of developing Dementia roughly doubles every five years. Although, it can start before the age of 65. Dementia is now one of the top five underlying causes of death and one in three people who die after the age of 65 have Dementia.

The total cost of Dementia to society in the UK is £26.3 billion, with an average cost of £32,250 per person[2]. This is based on an estimate by the Alzheimer's Society of the overall economic impact of Dementia in the UK in 2013. Dementia has, and will continue to have, a huge impact on people living with the condition, their carers, families and society.

6.11.3. Determinants

Age is the most significant known risk factor for Dementia. However it is possible to develop Dementia early in life, but the chances of developing it increase as we get older

Some evidence suggests other lesser risk-factors may be worth observing including: Smoking; Excessive Alcohol; Obesity; Diabetes; Hypertension; Raised Cholesterol

6.11.4. What works?

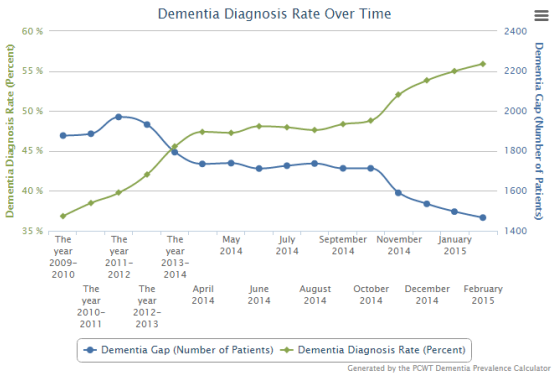
NICE Guidelines advise when managing risk factors and prevention not to conduct general population screening. Instead, in middle-aged and older people, review and treat vascular and other risk factors for Dementia mentioned above.

NICE guidelines state that people with mild cognitive impairment (MCI) should be considered for referral to memory assessment services to aid early identification of Dementia, as people with MCI may be at risk of developing Dementia later in life.

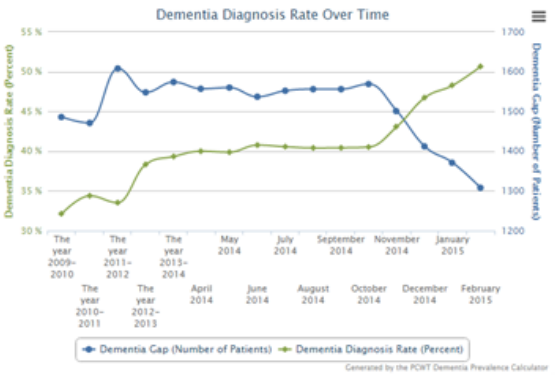
Quality Standards also state that local authorities and other commissioning services commission services from providers that can produce evidence of protocols for training staff to be alert to the symptoms and signs of mental health conditions in older people in care homes and to record them in a care plan.

6.11.5. Local authority analysis

Basildon and Brentwood CCG

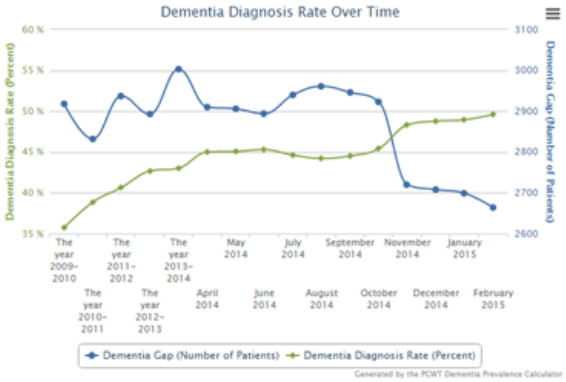


Castle Point and Rochford CCG

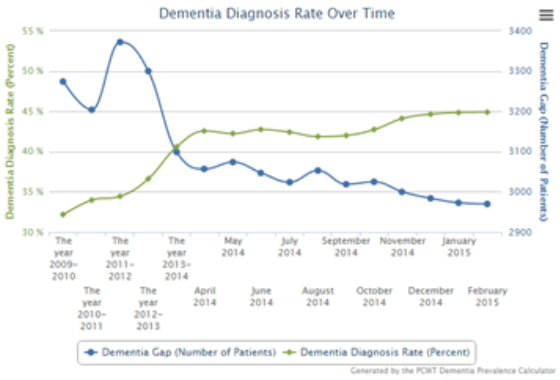


[2] Dementia UK Update, Alzheimer's Society, 2014

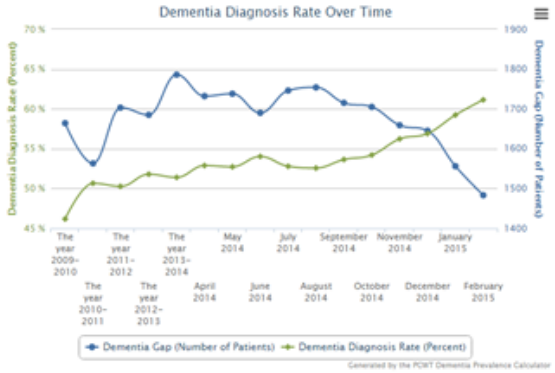
Mid Essex CCG



North East Essex CCG



West Essex CCG



6.11.6. Recommendations

Most GP practices in Essex have a recorded prevalence significantly below the expected level based upon the demographics of the area. As a key contact point for the cohort of undiagnosed dementia, collaborative working to identify those individuals is essential

Increased partnership working with Public Health could support improved overall health goals and thereby potentially lower the risk of dementia.

6.12. Hip Fractures

6.12.1. Why Invest?

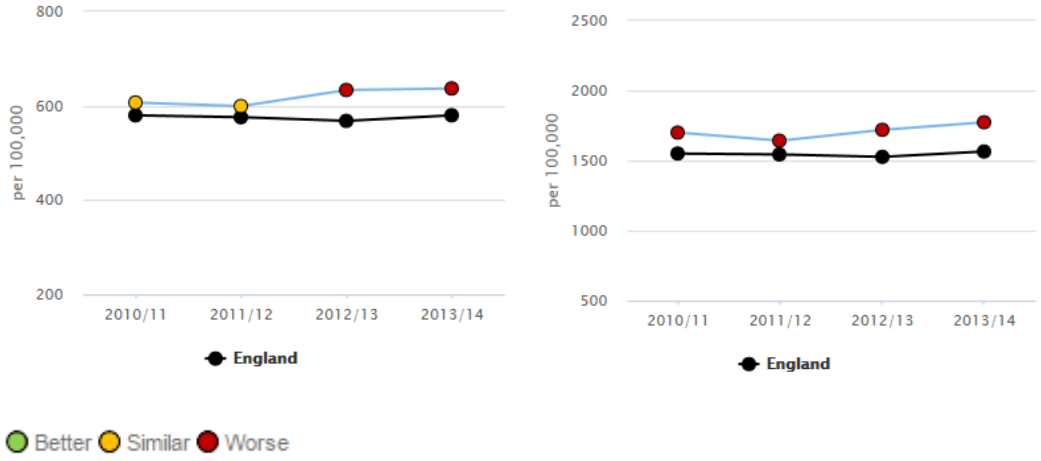
With an ageing population, hip fractures are becoming increasingly important as a cause of morbidity and mortality. It is estimated that they account for 1.5% of all deaths in the over 50s and 50% of fracture related deaths in women [40] [39]. Those who survive often require much greater input from social and nursing care [40], putting increasing pressures on our health and social care services.

6.12.2. Impact and Changeability

The impact of hip fractures in Essex appears to be greater than in other counties throughout England.

Figure 101 Hip fractures in people aged 65+ in Essex compared to national average

Figure 102Hip fractures in people aged 80+ in Essex compared to national average

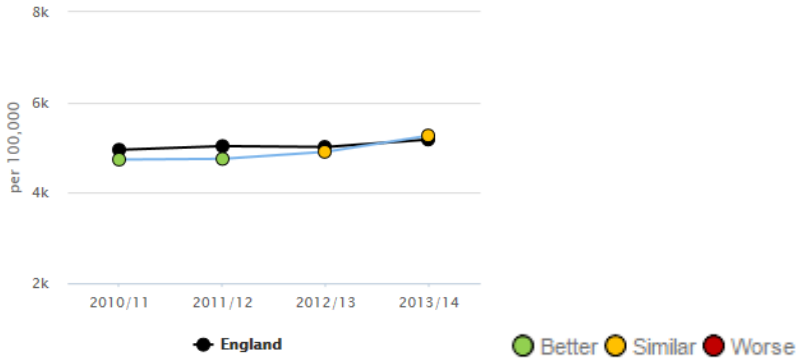


Source: [78] [79]

Numbers of hip fractures in the over 80 years old population are significantly greater in Essex compared to the national average [79], and this has spread to the total population of over 65s since 2012 [78].

Interestingly, rates of injuries due to falls in Essex have been level with the national average since 2012, although they too have been increasing [80]. In fact, Essex is in the 2nd quartile for injuries due to falls [81] but the 4th quartile for hip fractures (in the over 65 population) [82].

Figure 103 Injuries due to falls in people aged 80+ in Essex compared to the national average



Source: [80]

These figures beg the question, if injuries due to falls are average or better than, why does Essex have such a high number of hip fractures? Could it be that although people are not falling as much, those who do break their hip?

6.12.3. Influencers, Determinants and What Works

Fall-related injury has been described as having a 'complex causal web' [41]. Rates of hip fractures increase with age as a result of both decreasing bone density and increasing numbers of falls [83]. Hip fractures also occur more frequently in women due to increased bone loss following menopause and a longer life span [83].

Given the discrepancies in the data, the relationship between number of falls, fall-related injuries and number of hip fractures is unclear in Essex. It is presumed that falls prevention services will impact on the numbers of hip fractures but a more in-depth review of the situation is needed both locally and in this field of research.

There is evidence that falls prevention programmes can reduce numbers of falls. Exercise interventions reduce numbers of fall related fractures as well as risk and number of falls. Home safety assessment and modification interventions reduce rate and risk of falling, especially if delivered by occupational therapists. Cataract treatment, pacemakers, anti-slip shoe devices and prescribing modification programmes for GPs all reduced falls and vitamin D may reduce falls in people whose levels are low but not others. Interventions which educated people about falls prevention did not make any significant difference [84].

There is some positive evidence that population based approaches to falls prevention can reduce the number of fall-related injuries but this represents a gap in the literature which is partly due to the fact that an injury is a relatively rare event compared to that of falling [41]. Some trials have been done looking at the use of hip protectors in people at risk but there were only small improvements in hip fracture rates and adherence was poor [85].

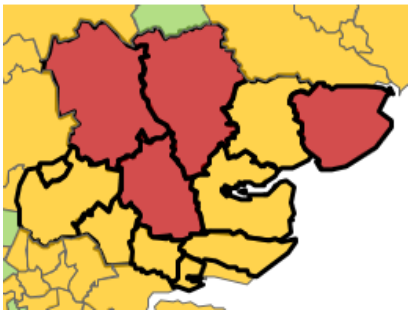
Osteoporosis is a major contributing factor to many hip fractures and there are a number of lifestyle risk factors for this including; poor vitamin D and calcium intake, inactivity, smoking, caffeine, excess alcohol and liability to falls. Primary prevention of osteoporosis starts during childhood to promote a high peak bone mass, and secondary prevention later in life, aiming to identify low bone mass and risk factors then implement pharmacological and lifestyle interventions [83].

One possible explanation for the difference between hip fractures and fall-related injuries would be a high prevalence of osteoporosis in Essex. This is not supported by the QOF (Health and Social Care Information Centre, Quality and Outcomes Framework) data however, which shows the prevalence of osteoporosis in the over 50s as recorded by GPs to be lower than the national average for the last 2 years (when it became a QOF indicator). In 2012-2013, prevalence in Essex was 0.2% with a national average of 0.25%, and this increased in 2012/13 to 0.31% in Essex and 0.4% nationally [86].

The increase in prevalence can be accounted for by the recent introduction of the indicator and the GP database of these patients growing as more people are identified. It may be that osteoporosis prevalence is still high in Essex but we are not effectively identifying it, and our registers are not as full as they should be. This is something that needs to be explored in more detail.

6.12.4. Lower Tier Authority Analysis

There does appear to be some discrepancy in numbers of hip fractures among boroughs/districts in Essex.



Area	Count	Value
Basildon	192	587
Braintree	192	686
Brentwood	98	568
Castle Point	117	557
Chelmsford	232	725
Colchester	196	636
Epping Forest	165	599
Harlow	86	625
Maldon	83	621
Rochford	96	485
Tendring	291	684
Uttlesford	123	782

Figure 104 Hip fractures in people aged 65+ in Essex districts 2013/14, compared to national average Source: [42]

A breakdown shows that the areas of Braintree, Chelmsford, Tendring and Uttlesford perform significantly worse than national average [42]. Public Health Outcomes Framework suggest an association between deprivation and number of fractures [87] but this cannot be applied in Essex, given that Uttlesford is the least deprived district.

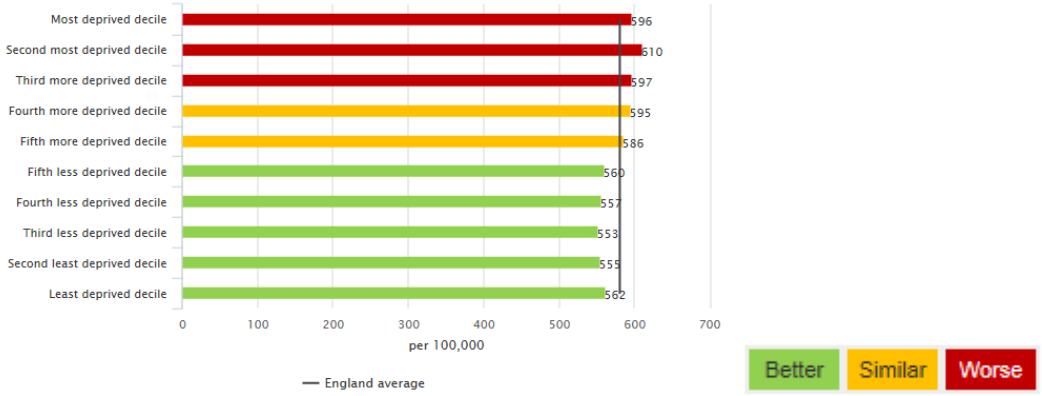


Figure 105 Hip fractures in people aged 65+ by district and unitary authority deprivation decile 2013/14 Source: [87]

Comparing each district to its most similar English local authority area, as deemed by the ONS from the 2011 census data [88], all districts other than Basildon and Brentwood perform worse than their comparators regarding number of hip fractures in the over 65 population [89] (Castle Point and Rochford have been removed as they are most similar to each other). This would support the conclusion that Essex as a whole performs worse than national figures for numbers of hip fractures, and that more in-depth area analysis is needed to determine why this might be, perhaps looking at what Basildon and Brentwood are doing differently.

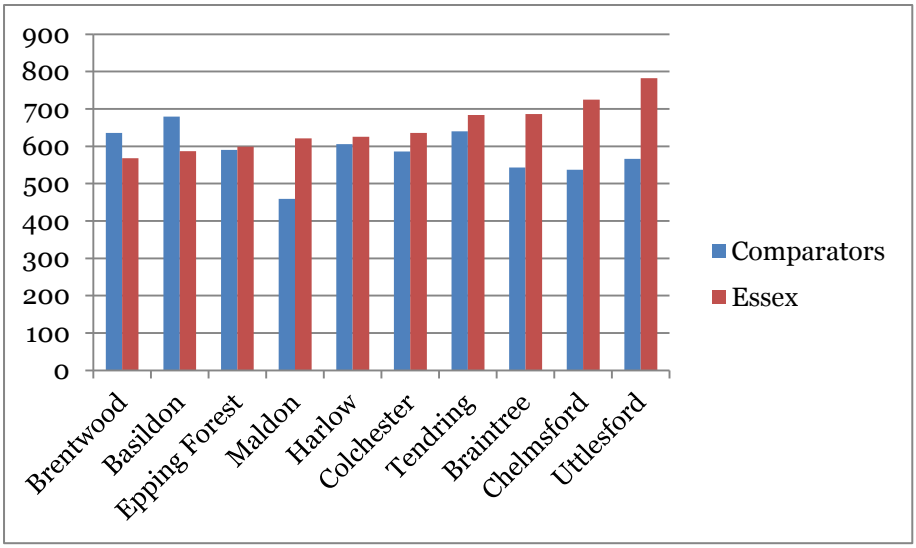


Figure 106 Hip fractures in people aged 65+ in Essex districts 2013/14 compared to their most similar local authority Source: [88] [89]

6.12.5. Recommendations

- Research need for relationship between falls prevention and hip fracture rates.
- Review of relationship between falls and hip fractures in Essex.
- Investigation of diagnosis rates of osteoporosis in Essex and what true prevalence is likely to be.
- Reasons for variation within regions, focus on reasons for better performance in Basildon and Brentwood.

7. Recommendations for Deep Dive/Specialist Topic reports

7.1. Following the analysis presented in this report it is recommended that the following Deep Dive/Specialist topic JSNA reports are produced:

7.1.1. Safeguarding

- Predictive analysis into domestic abuse affecting children- A predictive analysis exploring the indicating factors related to domestic abuse to help early identification of children at risk
- Evaluation of the suicide prevention toolkit issued to schools to understand how effective the toolkit has been to schools.

7.1.2. Domestic violence

- Scoping review into causes and interventions in domestic violence, with particular emphasis on children and the elderly.

7.1.3. First time Juvenile entrants into criminal justice

- Further analysis of smaller area statistics samples.

7.1.4. Violent crime

- Report giving an update on local intelligence when small area statistics samples come online.

7.1.5. Obesity

- Scoping review into behavioural interventions proven to be effective at reducing prevalence of obesity and overweight.

7.1.6. Early Cancer Deaths

- A focussed JSNA on cancer: is the reason for worse performance later diagnosis, less effective treatment, or something else?

7.1.7. Suicide

- Perform an audit of recent suicides in Essex.

7.1.8. Hip fracture

- Review of the literature on the efficacy of falls prevention in reducing hip fracture
- Local investigations into falls prevention and osteoporosis in Essex.

8. Appendix 1 - Customer segmentation (MOSAIC) types in households with children

Table 18 Most prevalent types in households with children in Top 10% and top 20% of wards in Essex with highest proportion of children in low income families

Mosaic code	Type name	Description
E21	Family Ties	Active families with teenage and adult children whose prolonged support is eating up household resources
G28	Local Focus	Rural families in affordable village homes who are reliant on the local economy for jobs
H30	Affordable Fringe	Settled families with children owning modest, 3-bed semis in areas of more affordable housing
L50	Renting a Room	Transient renters of low cost accommodation often within subdivided older properties
M54	Childcare Squeeze	Younger families with children who own a budget home and are striving to cover all expenses
M55	Families with Needs	Families with many children living in areas of high deprivation and who need support
M56	Solid Economy	Stable families with children renting better quality homes from social landlords

Table 19 Most prevalent types in households with children in rest of wards in Essex with highest proportion of children in low income families

Mosaic code	Type name	Description
A01	Rural Vogue	Country-loving families pursuing a rural idyll in comfortable village homes while commuting some distance to work
A03	Wealthy Landowners	Prosperous owners of country houses including the rural upper class, successful farmers and second-home owners
B07	Alpha Families	High-achieving families living fast-track lives, advancing careers, finances and their school-age children's development
B08	Premium Fortunes	Influential families with substantial income established in large, distinctive homes in wealthy enclaves
D14	Cafés and Catchments	Affluent families with growing children living in upmarket housing in city environs
D15	Modern parents	Busy couples in modern detached homes balancing the demands of school-age children and careers
D16	Mid-Career Convention	Professional families with children in traditional mid-range suburbs where neighbours are often older
H34	Contemporary Starts	Young singles and partners setting up home in developments attractive to their peers
H35	Primary Ambitions	Forward-thinking younger families who sought affordable homes in good suburbs which they may now be out-growing

9. Appendix 2 - Most prevalent segmentation (MOSAIC) types in households with children, in the Top 10% of wards with highest prevalence of children in low income families

Table 20 Most prevalent segmentation (MOSAIC) types in households with children, in the Top 10% of wards with highest prevalence of children in low income families

Ward name	District	% children in low-income families (HMRC: 2013)	Total households with children in ward	Most prevalent type in households with children in ward	Most prevalent type name	Total number of households in most prevalent MOSAIC type
Golf Green	Tendring	50.0%	322	M54	Childcare Squeeze	88
Rush Green	Tendring	48.6%	735	M55	Families with Needs	385
Pier	Tendring	42.3%	420	L50	Renting a Room	110
St Andrew's	Colchester	37.1%	1135	M55	Families with Needs	255
Alton Park	Tendring	36.7%	658	M54	Childcare Squeeze	263
Vange	Basildon	36.6%	1849	M56	Solid Economy	648
Harwich East	Tendring	34.7%	324	M54	Childcare Squeeze	117
Lee Chapel North	Basildon	32.9%	2335	M56	Solid Economy	781
St Marys	Tendring	32.4%	638	M54	Childcare Squeeze	180
Pitsea North West	Basildon	31.7%	2032	M56	Solid Economy	415
Walton	Tendring	30.4%	357	G28	Local Focus	85
St Martin's	Basildon	30.1%	1198	M56	Solid Economy	303
Fryerns	Basildon	27.1%	2019	M56	Solid Economy	430

Pitsea South East	Basildon	27.1%	1420	M56	Solid Economy	313
St James	Tendring	26.7%	406	E21	Family Ties	109
Canvey Island South	Castle Point	26.5%	629	E21	Family Ties	236
Canvey Island Central	Castle Point	26.4%	760	H30	Affordable Fringe	160
Bocking South	Braintree	26.3%	760	M56	Solid Economy	254
St Johns	Tendring	26.2%	472	H30	Affordable Fringe	204
New Town	Colchester	25.7%	1331	H35	Primary Ambitions	687
Bockings Elm	Tendring	25.5%	612	H30	Affordable Fringe	168
Staple Tye	Harlow	25.0%	1110	M56	Solid Economy	285
Marconi	Chelmsford	24.8%	938	M56	Solid Economy	385
Harbour	Colchester	24.3%	877	H35	Primary Ambitions	149
Harwich East Central	Tendring	24.2%	602	H30	Affordable Fringe	175
Canvey Island Winter Gardens	Castle Point	23.8%	1183	M56	Solid Economy	223

10. Appendix 3 - Customer segmentation (MOSAIC) types in households with bad and very bad health

Table 8 Most prevalent types in households with bad and very bad health in Top 20% of wards in Essex with highest proportion of 65+ year old population

Mosaic code	Type Name	Description
A01	Rural Vogue	Country-loving families pursuing a rural idyll in comfortable village homes while commuting some distance to work
A03	Wealthy Landowners	Prosperous owners of country houses including the rural upper class, successful farmers and second-home owners

A04	Village Retirement	Retirees enjoying pleasant village locations with amenities to service their social and practical needs
B07	Alpha Families	High-achieving families living fast-track lives, advancing careers, finances and their school-age children's development
E20	Boomerang Boarders	Long-term couples with mid-range incomes whose adult children have returned to the shelter of the family home
F22	Legacy Elders	Elders now mostly living alone in comfortable suburban homes on final salary pensions
F24	Bungalow Haven	Seniors appreciating the calm of bungalow estates designed for the elderly
F25	Classic Grandparents	Lifelong couples in standard suburban homes enjoying retirement through grandchildren and gardening
G29	Satellite Settlers	Mature households living in expanding developments around larger villages with good transport links
N58	Aided Elderly	Supported elders in specialised accommodation including retirement homes and complexes of small homes

Table 9 Most prevalent types in households with bad and very bad health in rest of wards in Essex with highest proportion of 65+ year old population

Mosaic code	Code Name	Description
B05	Empty-Nest Adventure	Mature couples in comfortable detached houses who have the means to enjoy their empty-nest status
B06	Bank of Mum and Dad	Well-off families in upmarket suburban homes where grown-up children benefit from continued financial support
B08	Premium Fortunes	Influential families with substantial income established in large, distinctive homes in wealthy enclaves
B09	Diamond Days	Retired residents in sizeable homes whose finances are secured by significant assets and generous pensions
D14	Cafés and Catchments	Affluent families with growing children living in upmarket housing in city environs
D15	Modern Parents	Busy couples in modern detached homes balancing the demands of school-age children and careers
D17	Thriving Independence	Well-qualified older singles with incomes from successful professional careers living in good quality housing
E21	Family Ties	Active families with teenage and adult children whose prolonged support is eating up household resources
G28	Local Focus	Rural families in affordable village homes who are reliant on the local economy for jobs
H34	Contemporary Starts	Young singles and partners setting up home in developments attractive to their peers
H35	Primary Ambitions	Forward-thinking younger families who sought affordable homes in good suburbs which they may now be out-growing
J40	Career Builders	Singles and couples in their 20s and 30s progressing in their field of work from commutable properties
J41	Central Pulse	Youngsters renting city centre flats in vibrant locations close to jobs and night life
J45	Bus-Route Renters	Singles renting affordable private flats away from central amenities and often on main roads

L50	Renting a Room	Transient renters of low cost accommodation often within subdivided older properties
L52	Midlife Stopgap	Maturing singles in employment who are renting short-term affordable homes
M54	Childcare Squeeze	Younger families with children who own a budget home and are striving to cover all expenses
M55	Families with Needs	Families with many children living in areas of high deprivation and who need support
M56	Solid Economy	Stable families with children renting better quality homes from social landlords
N59	Pocket Pensions	Elderly singles of limited means renting in developments of compact social homes
O63	Streetwise Singles	Hard-pressed singles in low cost social flats searching for opportunities

11. Quality Assurance

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Quality assured by [Name] on [date]

Signed off by [Name] on [date] for publication

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