Southend Joint Strategic Needs Assessment

April 2008

Executive Summary

In 2006, the Department of Health White Paper *'Our health, our care, our say'* identified the need for Directors of Public Health to work with Directors of Adult Social Services and Children's Services to jointly undertake regular strategic needs assessments of the health and well being status of their population.

The concept of a Joint Strategic Needs Assessment (JSNA) was further expanded in the *'Commissioning Framework for Health and Well being',* which was published in March 2007. The publication of the Local Government and Public Involvement in Health Act (2007) subsequently placed a statutory duty on upper-tier local authorities and PCTs to produce a JSNA, with effect from 1st April 2008.

Definition of Joint Strategic Needs Assessment:
'A process that identifies current and future health and well being needs in light of existing services, and informs service planning taking into account evidence of effectiveness'.

The key focus of JSNA includes:

- Identifying and understanding the current and future health and well being needs of the population over both the short term (three-five years) to inform Local Area Agreements, and the longer term future (five to ten years) to inform strategic planning

- Commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities

Crucially the process for developing a JSNA should be underpinned by partnership working and involve all the important stakeholders in identifying needs and acting upon them. Community engagement in particular will provide information on whether services have delivered what was expected and whether service users have had their needs met.

The Joint Strategic Needs Assessment for Southend 2007

This first JSNA for Southend has been developed by an Essex wide JSNA Steering Group which included representatives from South East Essex PCT and Southend Borough Council. This process has ensured consistency of approach across Essex and has provided a critical mass for data collection as well as the expertise of a number of information analysts to assist with the development of the Southend JSNA.

A detailed investigation and review into the current health and well being needs of the population of Southend has been performed and is presented in this report.
Recommendations for action have been developed based on the review of the information available. These recommendations will feed into Local Area Agreement process and help to inform future commissioning and service developments to improve the health and well being of the population of Southend.
It is envisaged that the JSNA will develop into an ongoing process of joint review of the health and well being needs of the Southend population.

Table of Contents

CHAPTER 1: GEOGRAPHY AND DEMOGRAPHICS

Southend is the largest conurbation in the East of England and the closest seaside resort to London. It is located on the north side of the Thames estuary approximately 40 miles east of central London, and is bordered to the north by Rochford and to the west by Castle Point.

The borough has 7 miles of award-winning beaches and coastal nature reserves; has over 80 parks and green spaces and 14 conservation areas and is home to the longest leisure pier in the world.

Southend has many geographic, demographic and economic characteristics that make it distinctive compared to other areas. Excluding the London Boroughs, Southend is the seventh most densely populated area in the United Kingdom, with 38.8 people per hectare compared to a national average of 3.77.

Local economic activity focuses on providing employment and services to the local community and to support the tourism industry. Around 6.4 million tourists come to Southend each year, generating income revenues estimated at £200 million. The town also hosts some key manufacturing businesses such as Olympus KeyMed and Ipeco, as well as an important financial cluster of bank credit card operations including RBS and HSBC, and specialist service companies such the aircraft maintenance and development hub at Southend Airport.

The Higher and Further Education sector is an ongoing success story in Southend, with the opening of the University of Essex, Southend campus in 2006 and its phased programme of development, as well as further expansion of South East Essex College.

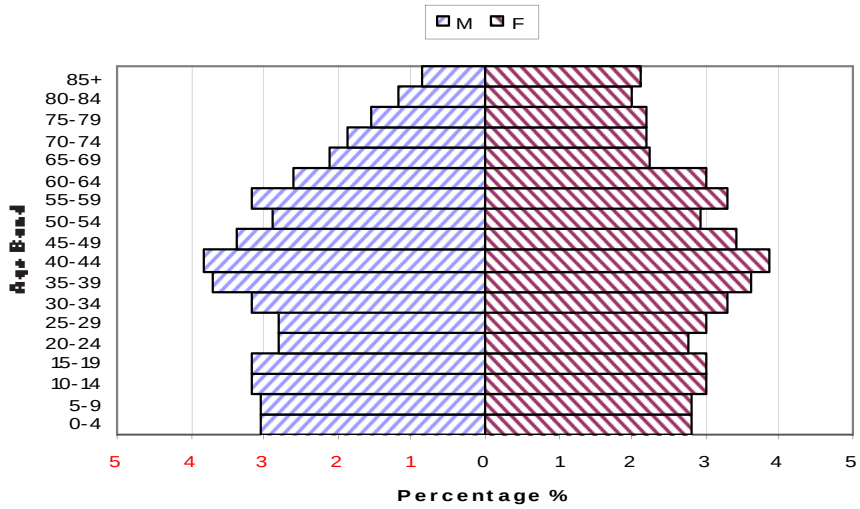
Southend is served by two railway lines linking to London, with 9 railway stations and many local bus routes. The levels of highway congestion on the main highway corridors in Southend are already a major and growing problem.

1.1 Structure of the Population

The total estimated population for Southend-on-Sea as at mid 2006 is 160,200. The proportion of the population aged 65 and over currently stands at 18% with the proportion of the population aged under 15 also at 18%. The age groups of 55-64, who will be the next generation of retirees is currently at 12%.

As indicated in Figure 1.1, there is roughly an equal proportion of males and females up until the age of 60. Of the population aged 65+ around 56% are women and by the age of 85+ this figure has increased to over 68. These differences are largely due to consistent patterns of longer life expectancy in women.

Figure 1.1: Population pyramid for Southend-on-Sea, 2006

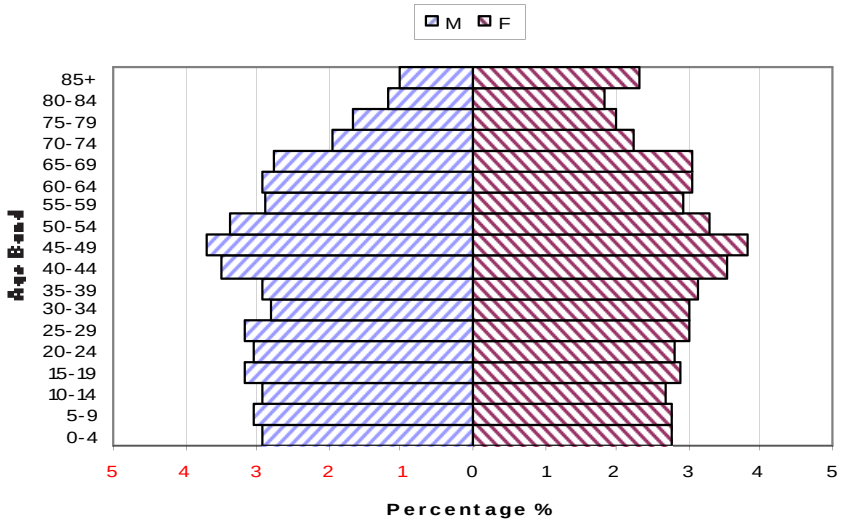


Source: Mid-year population estimates (Mid 2006), Office for National Statistics

1.2 Projected Population Changes

The population of Southend-on-Sea is set to increase over the next 5 years by 0.06% The 65 and over a is predicted to increase by 9%. The proportion of the population aged 15 and under will decrease by 5 will also be a 3% reduction in the 55-64 year olds compared to the mid 2006 population estimates. Figu shows how the population structure will change over the next 5 years.

Figure 1.2: Population projection in Southend-on-Sea (2012)



Source: Office for National Statistics

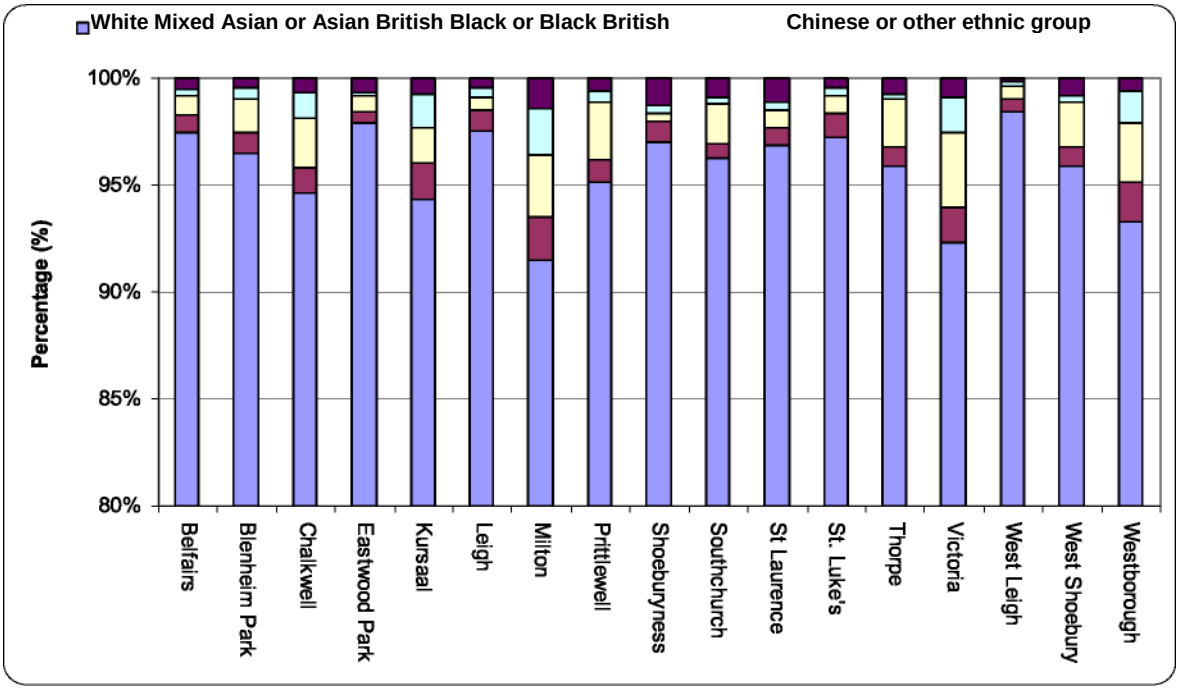
1.2.1 Balance of Population

With these changes, the balance of the population of working age compared to the 'dependent' population is likely to shift. This changes the proportion of people likely to be economically active in relation to the proportion of people more likely to be supported by the state. The dependency ratio (i.e. the number of people aged 15-64 per person aged over 65) for Southend is forecast to drop by 28.6% by 2029. This needs to inform workforce planning because less people of working age will be available to care for and support older people.

1.3 Ethnic Breakdown

While 96% of the population of Southend are white, ethnic diversity is increasing at a faster rate than county and regional levels. Some 12.3% of pupils at primary schools and 12.3% at secondary schools are from ethnic minorities.

Figure 1.3: Ethnicity by Ward in Southend-on-Sea



Source: ONS

Figure 1.3 shows the ethnic breakdown by wards within Southend. The wards with the highest percentage of ethnic minority population are Victoria and Milton wards. West Leigh has the lowest percentage of ethnic minority population.

Further work is required to develop a more comprehensive picture of the ethnic minority population in Southend to ensure that services are able to respond to their needs.

1.3.1 Gypsies and Travellers

The travelling community include people who have a traditional cultural preference for living in caravans and who either pursue a nomadic habit of life or have pursued such a habit but have ceased traveling. In England and Wales, 91% of local authorities have travellers either living within them or passing through. Most of the travelling community live in caravans on sites that are either local authority managed or on private sites. A small proportion lives in caravans on unauthorised sites of which there are two types of unauthorised site:

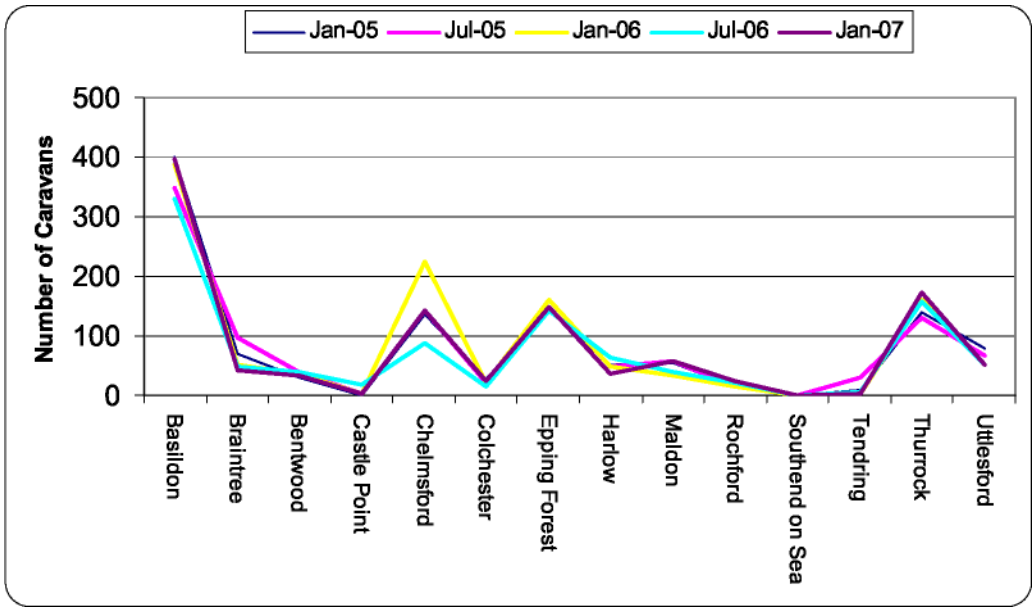
1) *Unauthorised Encampments* - where gypsies and travellers are unlawfully parked on land that does not belong to them

2) *Unauthorised Developments* - where the gypsies and travellers own the land but have established it into a site without planning permission

Gypsy and traveller sites can now be managed by Registered Social Landlords (RSLs) who purposely set up and manage a site specifically for the travelling community. There are 11 registered gypsy sites in Essex which have a total of 164 pitches and capacity for 305 caravans. However there are no such sites that are registered in Southend-on-Sea.

Figure 1.4 shows the number of caravans at the sites in Essex over the last two years. Southend-on-Sea has not had any caravans within its area for the last 2 years (January 2005 – January 2007) on any unauthorised land.

Figure 1.4: Caravans at Registered & Unregistered Sites in Essex



Source:www.communities.gov.uk

1.4 Conclusion

The population of Southend is getting older. Over the next 15 years we can expect a 14.4 % increase in the over 65's and a 12.2 % increase in the over 85's.

Analysis of school admission data will help develop a more detailed profile of Southend's changing ethnic minority population.

Southend is becoming more diverse and further work is required to develop a more comprehensive picture of the ethnic minority population in Southend to ensure that services are able to respond to their needs.

CHAPTER 2: SOCIAL & ENVIRONMENTAL CONTEXT

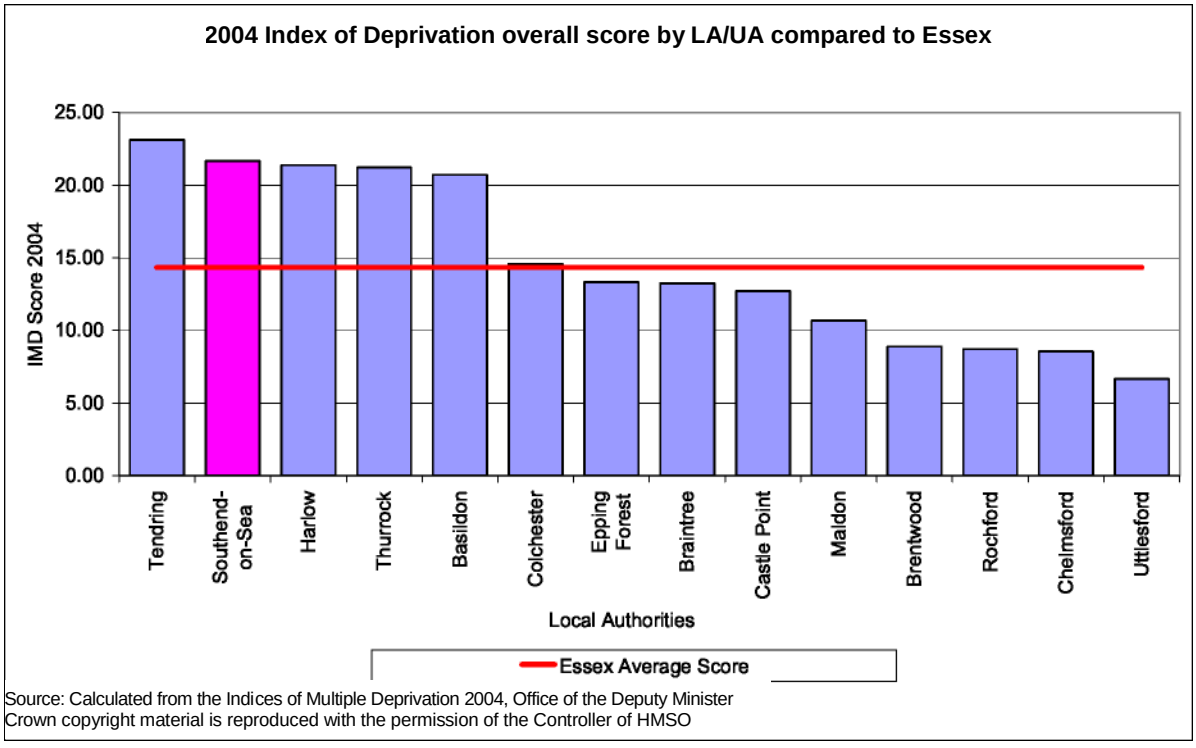
2.1 Deprivation

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

Southend has the second highest deprivation score in Essex (Figure 2.1).

It is noted that IMD 2007 is due to be released in March 2008 and as such further analysis will be available.

Figure 2.1: Index of Deprivation 2004 scores for areas in Essex

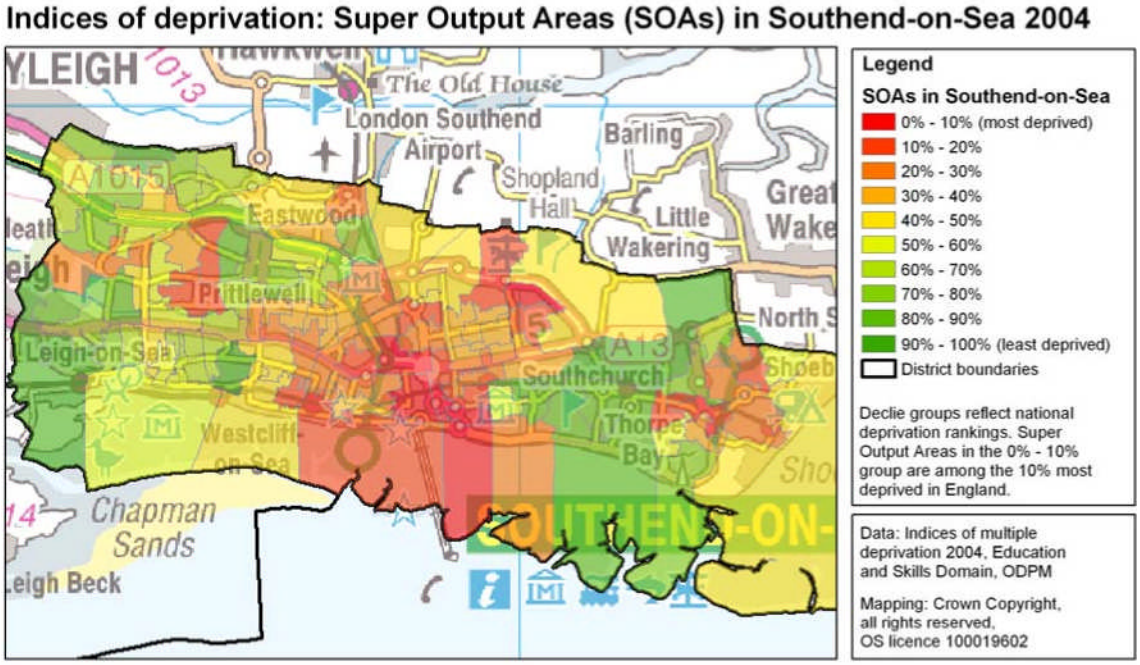


Source: Calculated from the Indices of Multiple Deprivation 2004, Office of the Deputy Minister

The IMD 2004 provides deprivation indices at super output area (SOA) level. These are generally smaller than electoral wards and consist of communities of around 1,000-1,500 people. The use of SOAs can highlight small areas of deprivation that can otherwise be masked by their being situated in a relatively affluent area. This allows pockets of deprivation to be targeted more effectively by services. In England there are over 32,000 SOAs that aggregate up into electoral wards.

Southend-on-Sea is one of Essex's most deprived areas. It has pockets of high affluence and wards which suffer extreme deprivation. Five SOAs fall within the 10% most deprived areas in England (within the Kursaal, Milton, Southchurch and Victoria wards) and an estimated 45% of the borough's population lives within the 20% most deprived areas in the East of England. Conversely SOAs within West Leigh rank among the 20% least deprived in England.

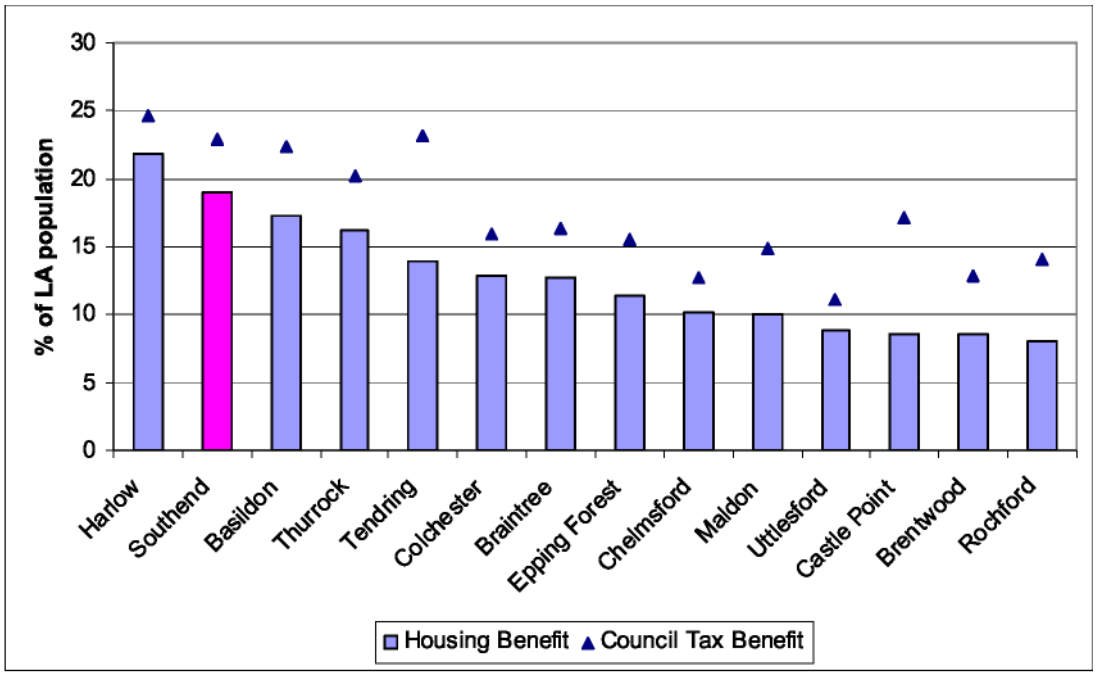
Figure 2.2: IMD 2004 by super output area in Southend: rank by national decile group



2.2 Poverty & Social Class

Take up of means-tested benefits can act as an indicator of income-based poverty. Within Essex, Southend has the highest percentages of residents receiving housing benefit (19%) and the third highest percentage of residents receiving council tax benefit (Figure 2.3).

Figure 2.3 Recipients of Housing Benefit and Council Tax Benefit in Essex



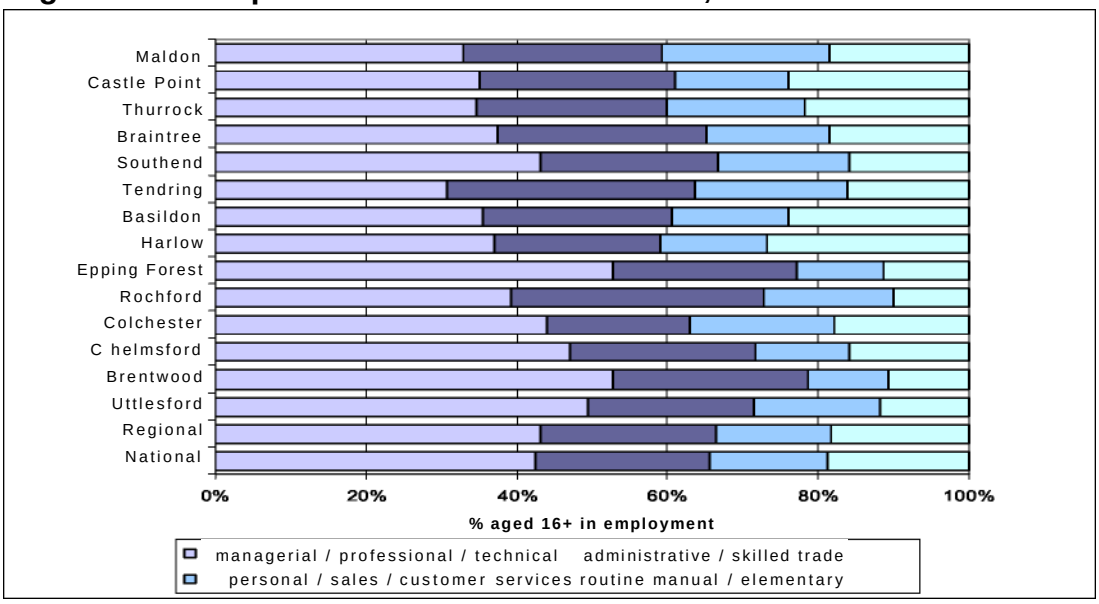
Source: DWP, February 2007

2.2.1 Social Class

All the evidence suggests that social class inequalities present in early life – and persist throughout life and post retirement. Life expectancy at birth differs by three years for women and five for men between social classes I/II and IV/V.

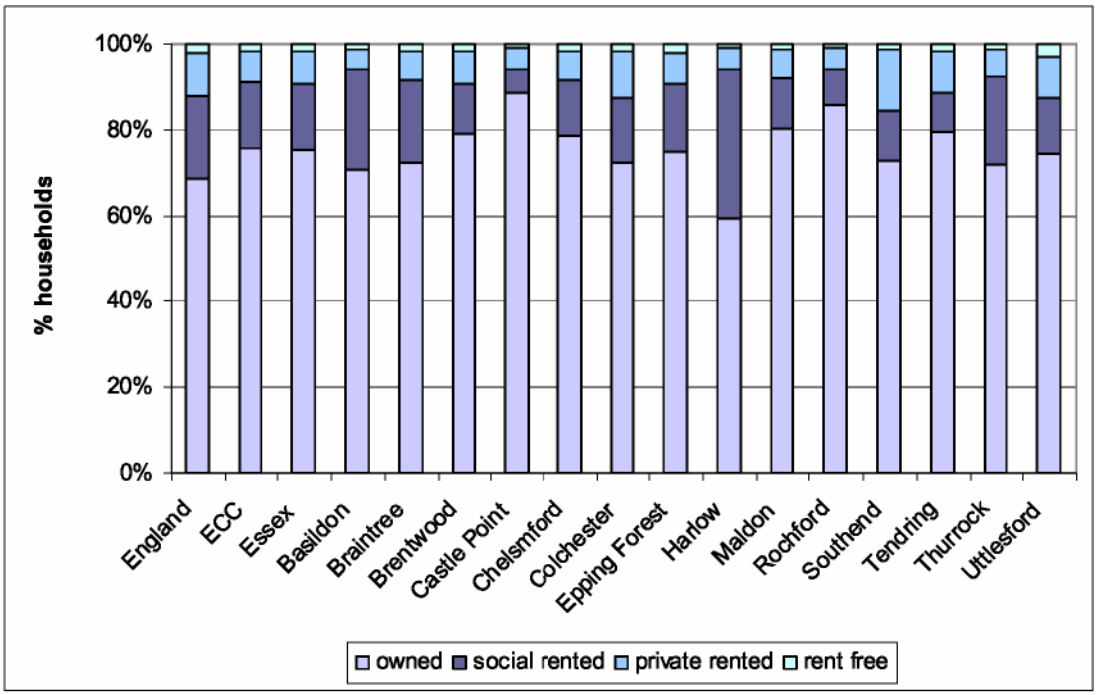
Figures 2.4 and 2.5 show the profile of occupation and housing tenure in Southend compared with rest of Essex. Just over 42% of the working age population in Southend are in managerial and professional posts.

Figure 2.4 Occupational breakdown for Essex, 2006



Source: ONS Annual population survey

Figure 2.5 Housing tenure in Essex



Source: Census 2001

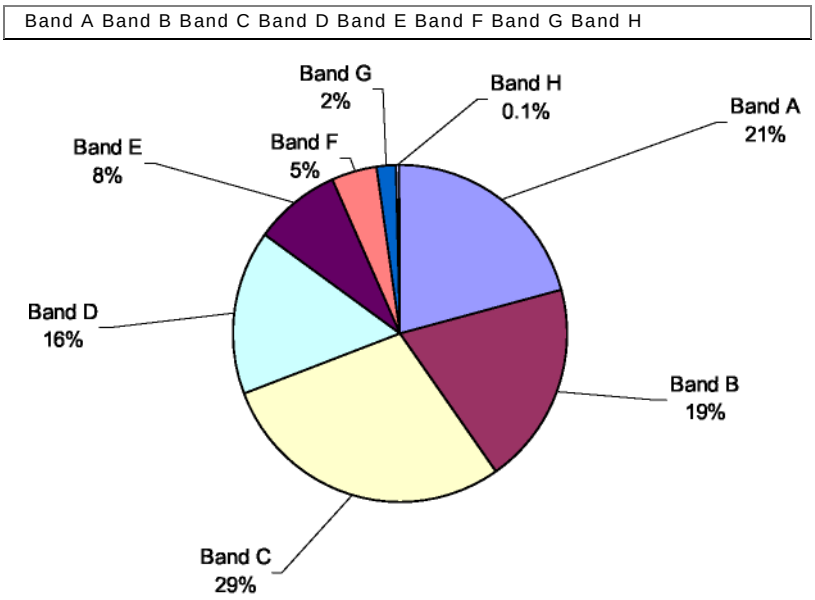
At 71%, Southend has the third lowest level of home ownership in Essex (75%), but is still above the England average (69%).

2.2.2 Affordable Housing

There are two main forms of affordable housing: social rented accommodation (generally provided through Registered Social Landlords) and key worker homes. An adequate supply of good, affordable housing is essential to the quality of life of residents who cannot afford to compete in the open market.

House prices in Southend are lower than the national average, but still high in relation to average earnings. Figure 2.6 shows the proportion of houses in Southend by council tax banding. Of the 75,900 total dwellings in Southend, the largest majority (29% or 21,963 dwellings) is within Band C. The most affordable properties (Band A) only account for only 21% of the total housing stock, or 15,817 dwellings. In 2006 Southend residents ranked affordable decent housing in their top five most important factors in making somewhere a good place to live.

Figure 2.6: Housing Stock in Southend-on-Sea



Key workers make an important contribution to the economy and addressing their housing needs is essential to ensuring there are adequate levels of staff for infrastructure and lower value jobs. Supporting such employees in terms of affordable housing is an important function. As well as public sector key worker jobs (e.g. nurses, teachers, police), there may also be a need to provide affordable housing for those working in low value, but essential, jobs within the private sector. Such jobs may prove increasingly difficult to fill if there is insufficient affordable housing.

Housing Needs Surveys undertaken for Southend Borough Council in 2002 and 2004 identified a need for an additional 6,815 affordable dwellings over a 5 year period in order to address backlogs and newly arising need.

As part of the Thames Gateway South Essex, Southend is producing a Sub Regional Strategic Housing Market Assessment and Sub Regional Housing Strategy which are due to be adopted in May 2008. This work will provide the opportunity for further analysis in this area.

2.2.3 Household composition

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

The proportion of children in Britain living in a 'lone parent' family has increased from 12% to 23% over the last 20 years. Since the mid 1980's most of this rise is due to an increase in single lone mothers.
In Southend, 25% of dependent children are living in lone parent families, which is significantly higher than England, East of England and Essex.

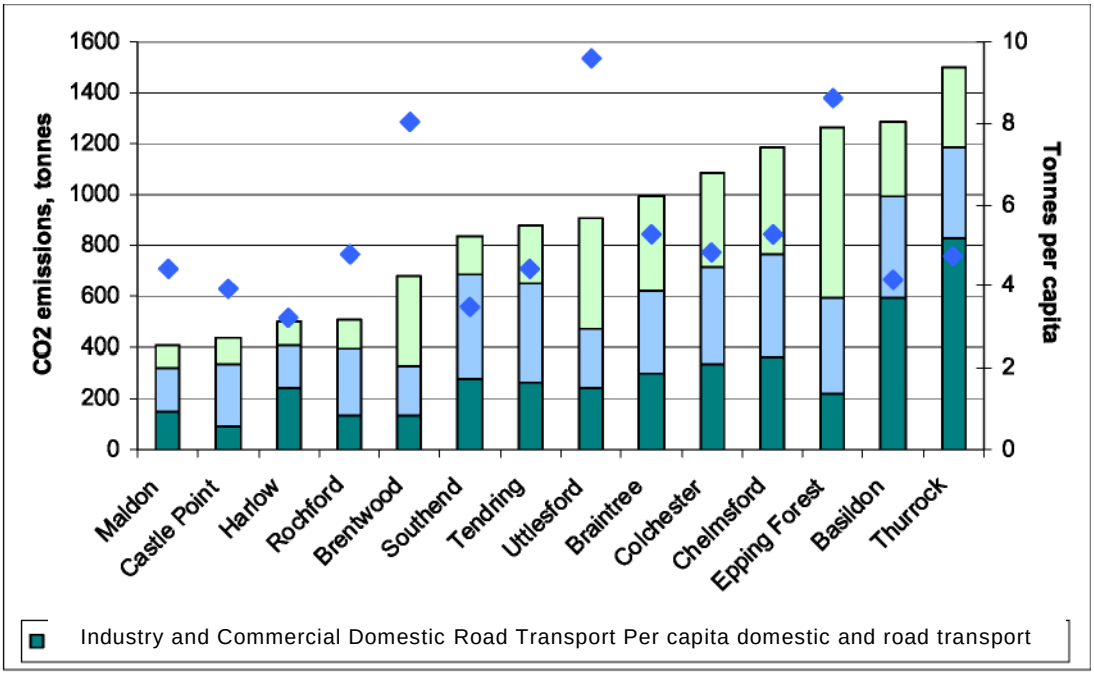
2.3 The Environment

Conditions in the neighbourhood and conditions in the home can have a big impact on our health and well-being. The physical, chemical, biological, social, and psychosocial factors in the environment can affect a number of aspects of human health and quality of life. The contamination of water and the air can trigger diseases, both chronic and acute in the population which is why clean air and water and good sanitation are so important. How we plan our towns, the location services and access to green spaces are all important issues to the well-being of the population.

2.3.1 CO2 emissions

In 2004, 10,131 kilo tonnes of CO_2 were produced in Essex, which equates to 8.5 tonnes per capita. This is almost 1 tonne per person per year less than the UK average (9.2 per capita), which is due to relatively low levels of emission from industrial and commercial sources. Domestic CO_2 emissions make the greatest contribution to total CO_2 emissions in Southend (Figure 2.7).

Figure 2.7 CO_2 emissions in Essex, 2004

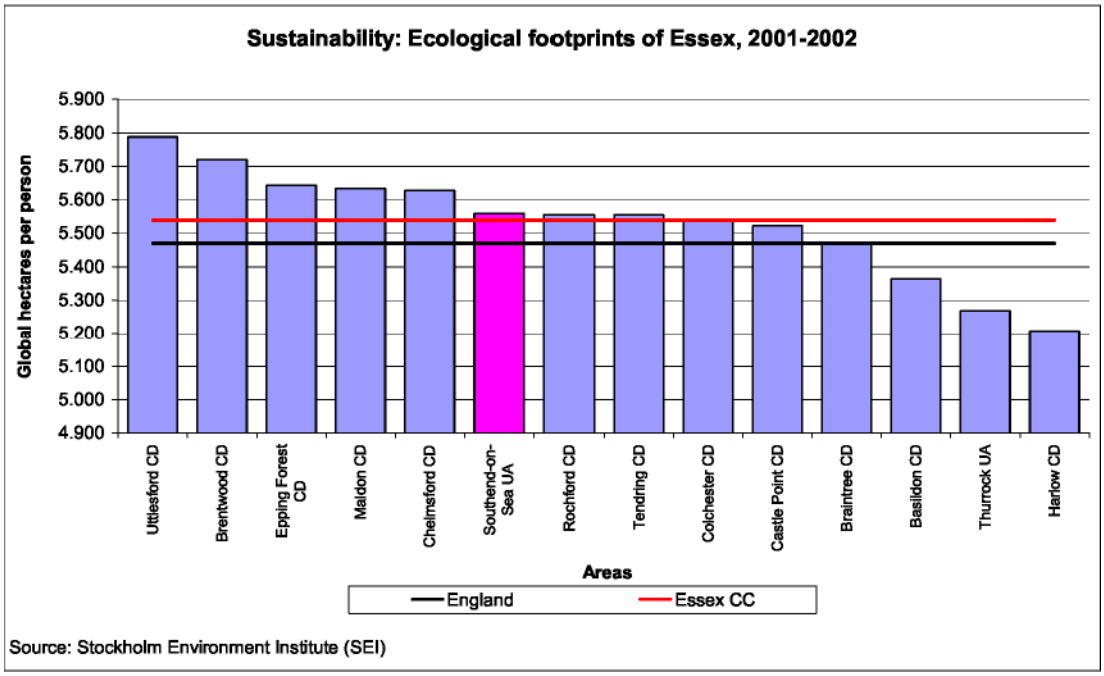


Source: AEA Energy & Environment for DEFRA

We are increasingly becoming interested in how we use our environment and what impact we have on it. A useful way to measure a population's effect on the environment is by ecological footprints. The ecological footprint measures the amount of productive space required to support the resource requirements and waste production for the average person, measured in global hectares per person per year.

The ecological footprint for the world is 2.2 global hectares per person but the UK average is 5.4 global hectares per person. This is 65% higher than our ecological budget (the sustainable amount we can use) and the UK has an ecological footprint among the highest 15 countries on a per person basis.

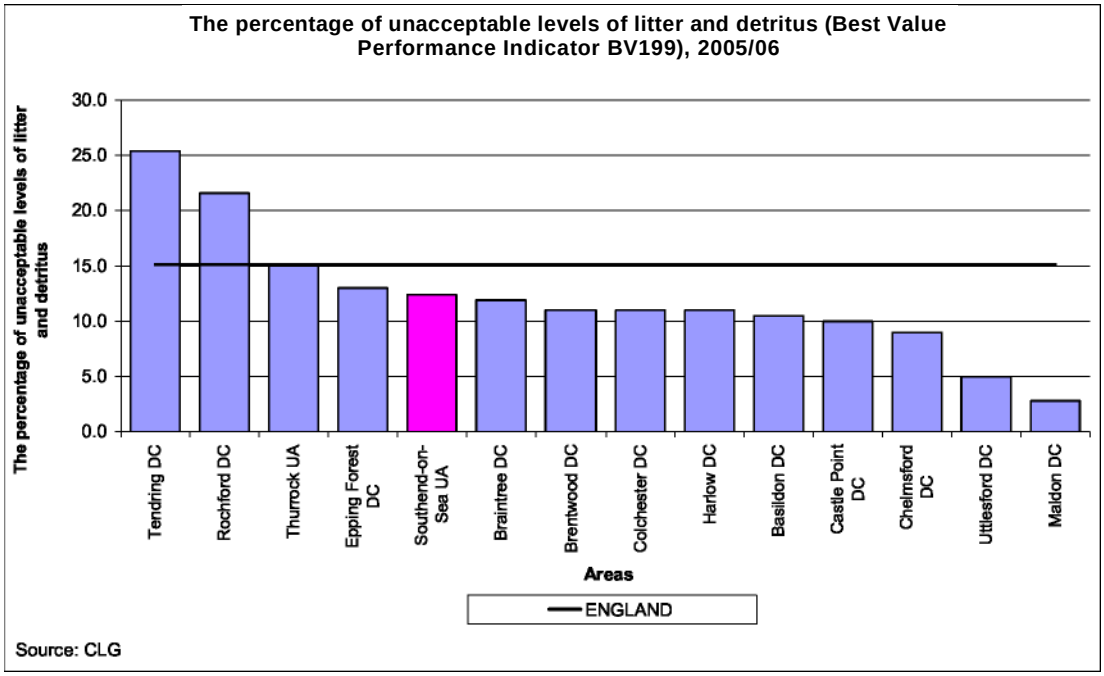
Figure 2.8: Sustainability: ecological footprints of Essex – 2001/02



2.3.2 Street cleanliness

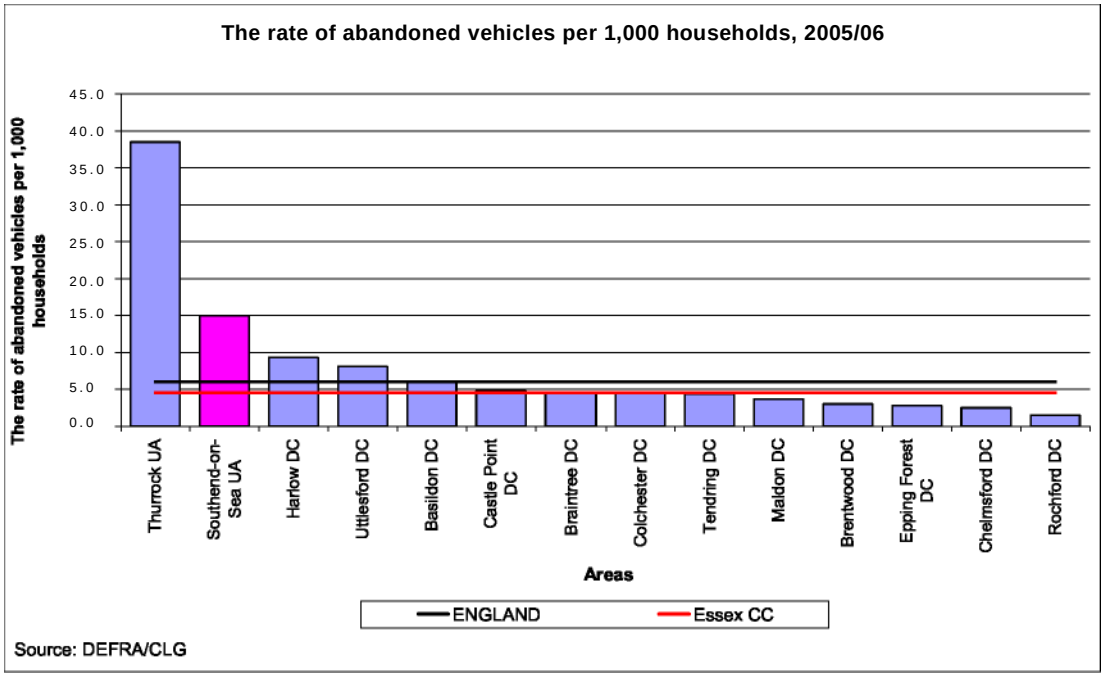
In 2006 Southend residents ranked clean streets in their top five most important factors in making somewhere a good place to live. Southend has a lower than average percentage of unacceptable litter and detritus levels.

Figure 2.9: Unacceptable levels of litter and detritus in Essex, 2005/06



In England there were 6.0 abandoned vehicles per 1,000 households. Southend has the second highest level of abandoned vehicles in Essex, which is also above the national figure (Figure 2.10),

Figure 2.10: Rate of abandoned vehicles per 1000 households in Essex (200 5/0 6)



Abandoned vehicles are not however regarded as a cause for concern in Southend as improved reporting systems have resulted in higher detection and action, contributing to the relatively high rate.

2.3.3 Housing quality

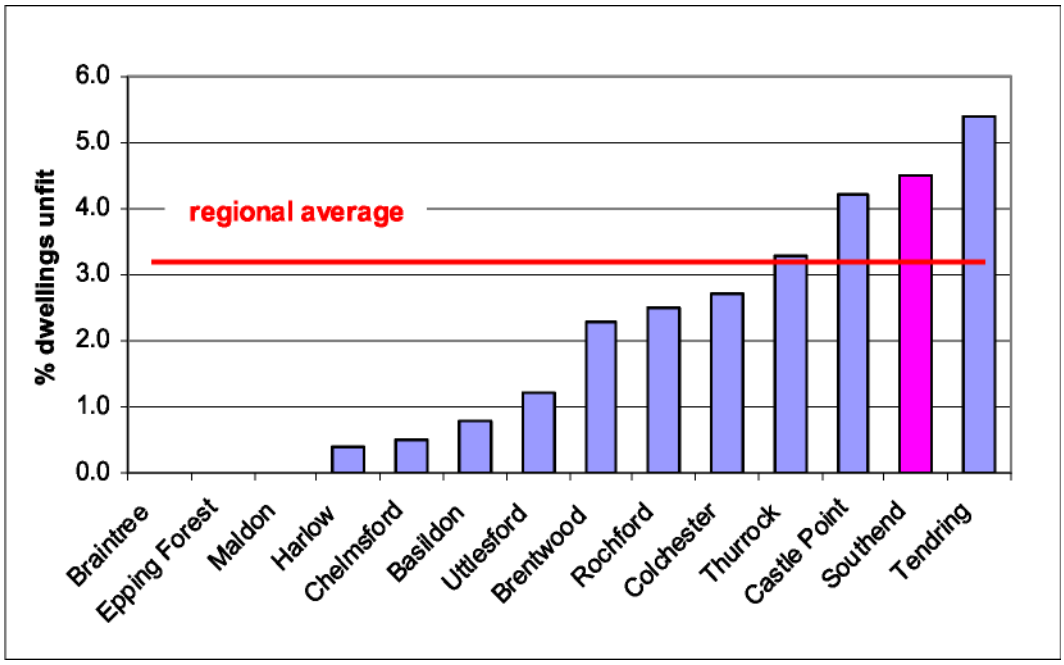
Poor quality housing is associated with increased levels of limiting long term illness, respiratory and infectious diseases, accidents, psychological problems, perceived poor general health and increased mortality. The most important risk appears to be cold damp and mouldy conditions. Cold housing is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

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

At the time of the Census (2001) nearly 8% of households in Southend were classified as overcrowded. This is above the national and Essex figures at 7% and 5% respectively.

Southend also has one of the highest proportions of dwellings deemed to be unfit in Essex, which is also significantly above the national average (Figure 2.11).

Figure 2.11 Proportion of dwellings deemed unfit in Essex, 2005



Source: DCLG

2.4 The Local Economy

Southend is well known as a tourist destination, but the town needs to make a step change to improve the economic prosperity and to become a significant regional centre serving local people and Thames Gateway.

Southend has an entrepreneurial culture with a high volume of business start –ups (122/10,000 people of working age in 2004) and high levels of self employment. However, there are also high levels of business closure and a 6% contraction in business stock. Southend has slightly higher levels of business density at 38 per 1000 residents compared to the national level of 37.5 and Thames Gateway at 35. There are also significant levels of innovation with 25% of production being based in the knowledge economy, compared to 23% nationally and 20% in Thames Gateway South Essex.

Without locally available work, future growth in our population and housing stock will lead to increased commuting and dependence on London. It is recognised that there is a need to attract inward investment and achieve greater diversification of the employment base to attract a range of employment opportunities.
It is recognised that skills attainment is one of the most pressing concerns as it impacts on so many other areas.

2.5 Education and Skills

2.5.1. Educational attainment

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

2.5.2 Attainment in English and Maths: Key Stage 2 and 3

Southend has a slightly higher percentage of 11 year olds achieving the required level (4) in Key Stage 2 English compared with England (80% compared to 79% in 2006). This is the same as the Essex average (Figure 2.12).

In Maths, 78% of 11 year old pupils in Southend achieved the required level (4) in 2006, which is slightly higher than the England and Essex average (76%) (Figure 2.13).

Figure 2.12: Key stage 2 results at age 11 – percentage of pupils achieving level 4 or above in English – 2006

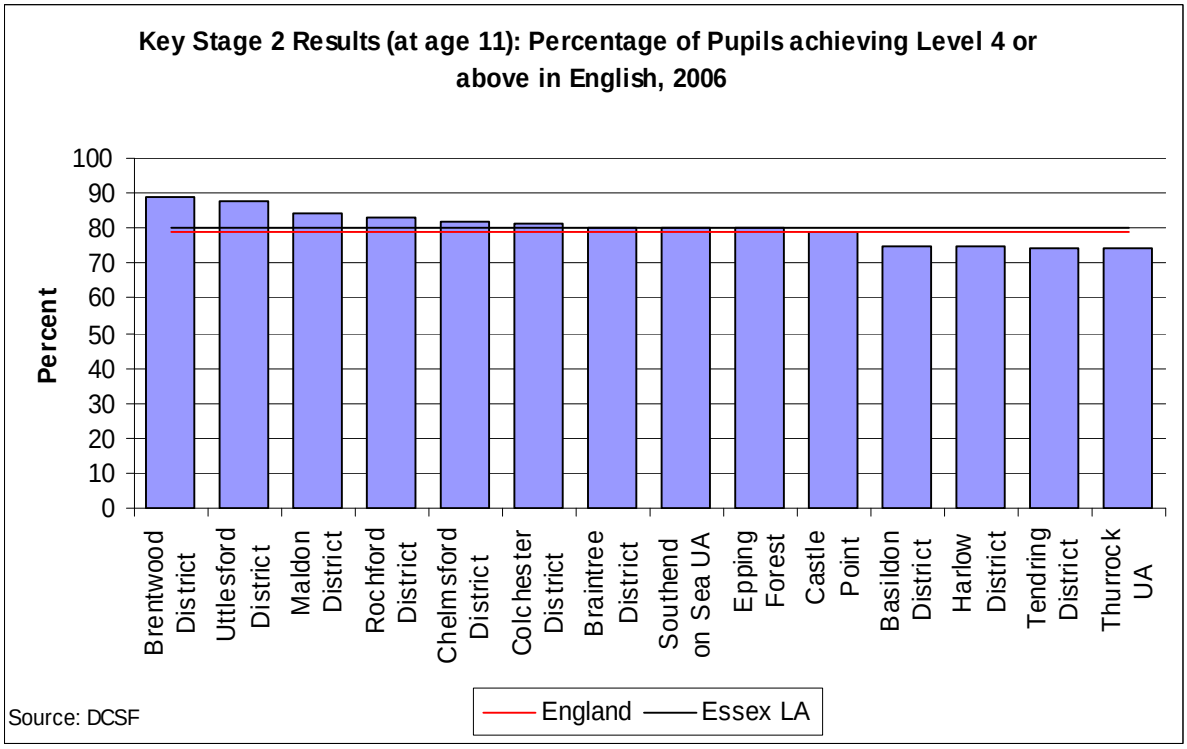
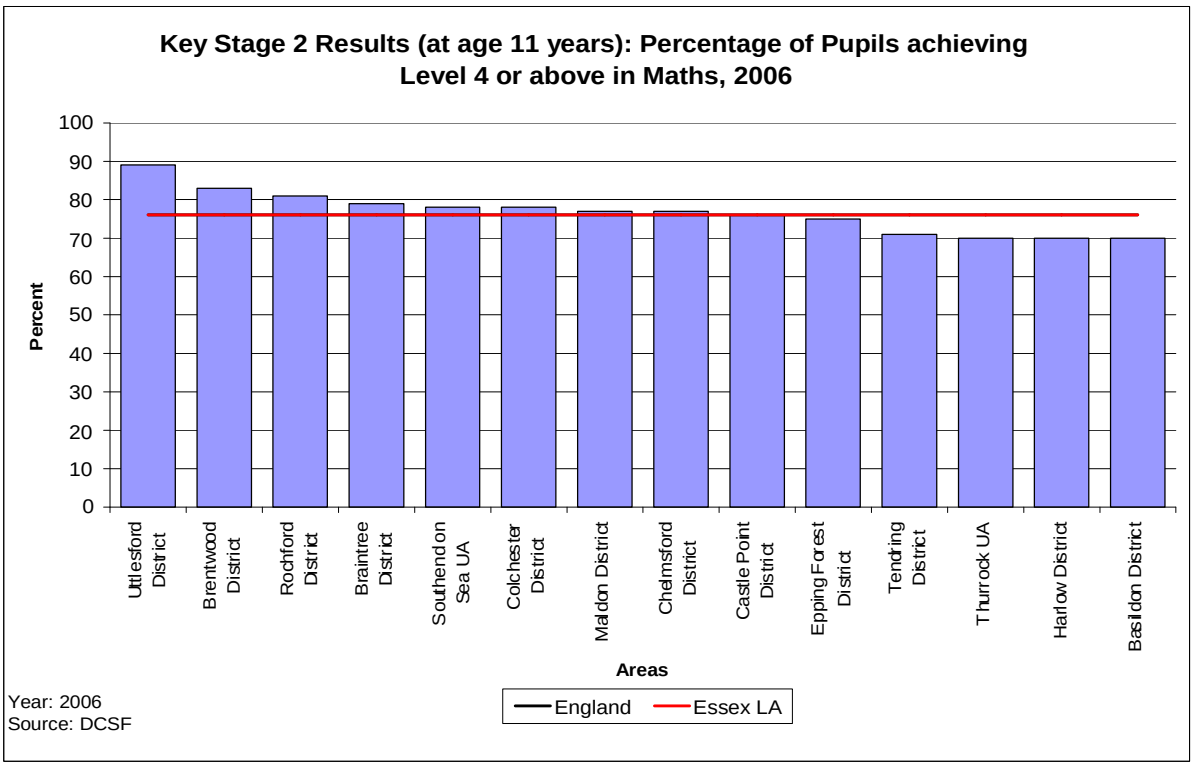


Figure 2.13: Key stage 2 results at age 11 – percentage of pupils achieving level 4 or above in Maths - 2006



However, there is wide variation at MSOA level in both English and Maths achievement at Key Stage 2 in Southend-on-Sea. The percentage of pupils achieving the required level 4 or above in English varies from 54% in the lowest achieving MSOA to 92% in the highest achieving MSOA. In Maths, only 63% of pupils achieve level 4 in the lowest achieving

MSOA compared to 87% in the highest achieving MSOA.

Figure 2.14 shows that Southend-on-Sea achieves above both the English and Essex averages with 76% of 14 year olds achieving level 5 or above.

A total of 78% of pupils in Southend achieved at least a level 5 in Key Stage 3 Maths at age 14, which is slightly better than the England average (77%) and the same as the Essex average (Figure 2.15).

Figure 2.14: Key stage 3 results at age 14 – percentage of pupils achieving level 5 or above in English - 2006

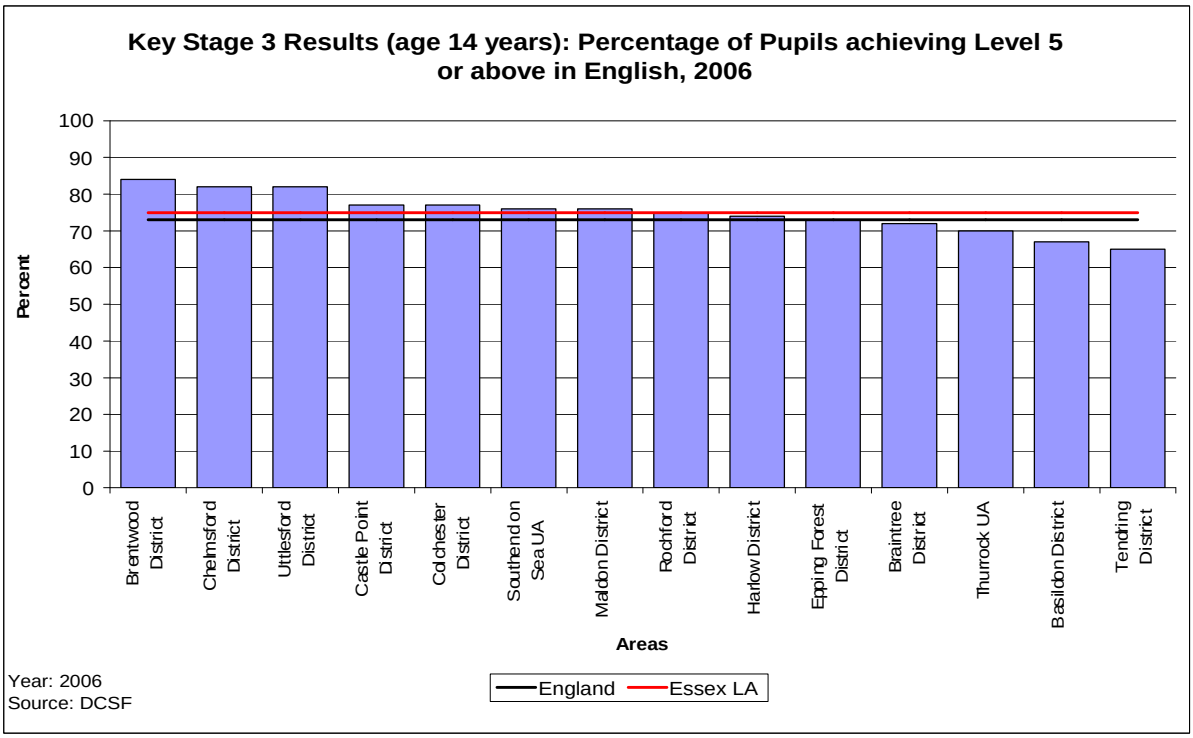
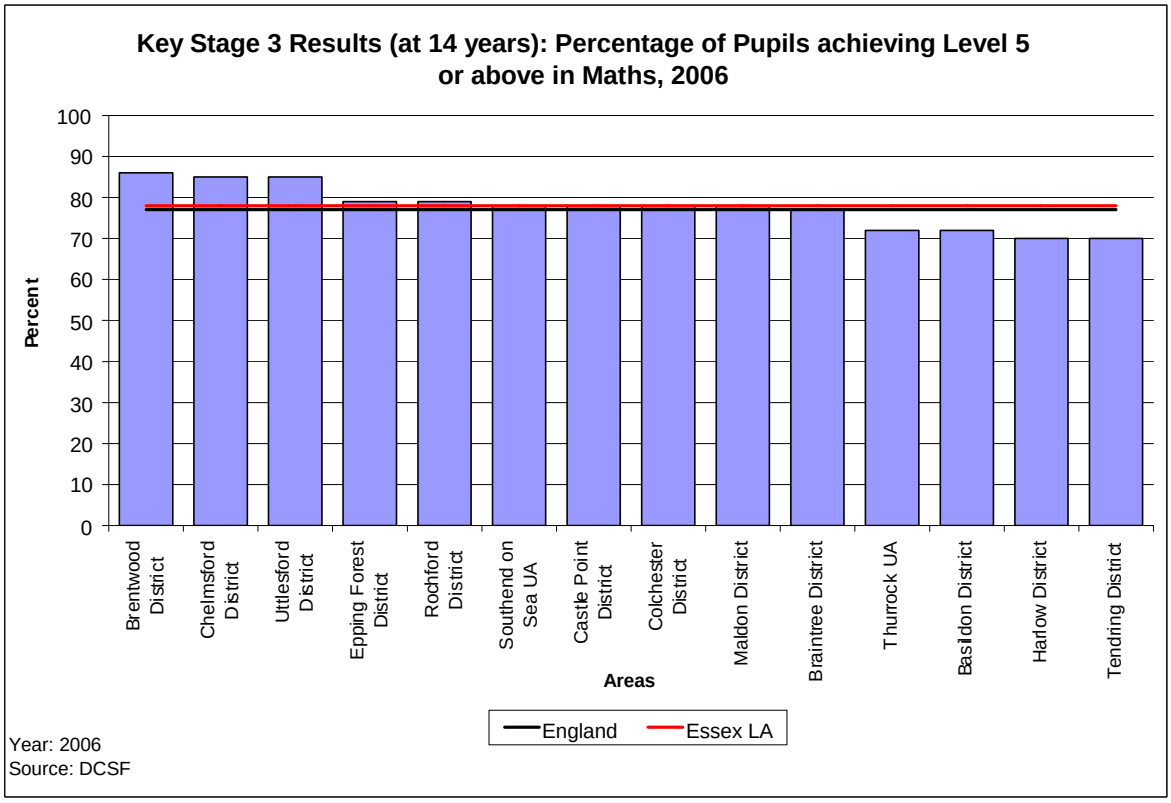


Figure 2.15: Key stage 3 results at age 14 – percentage of pupils achieving level 5 or above in Maths – 2006

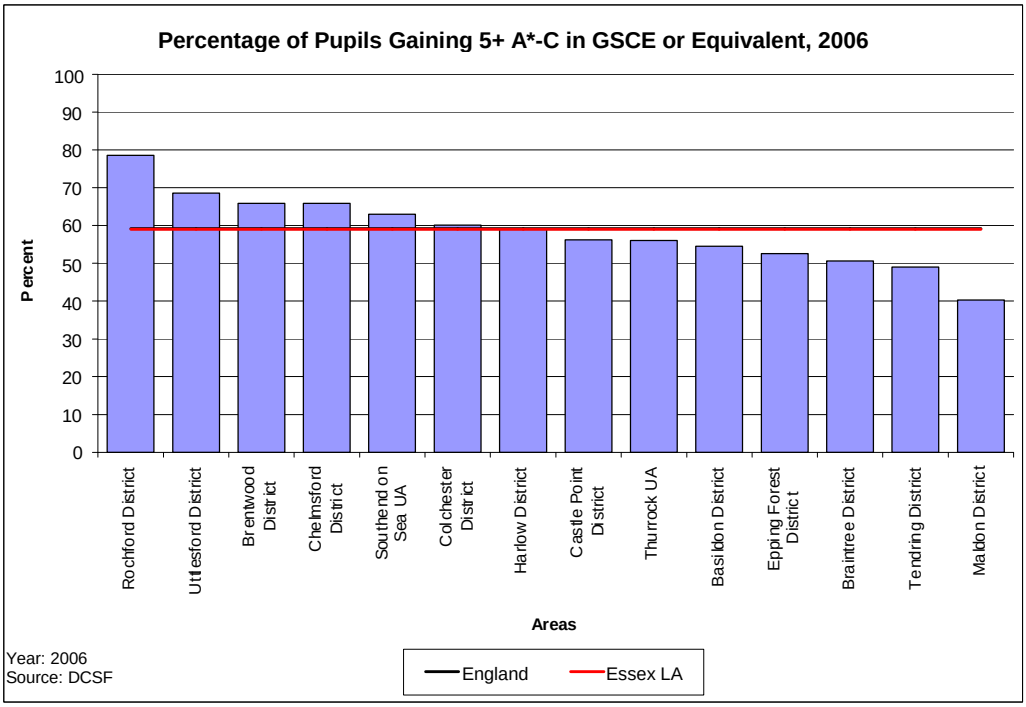


Comparisons of the percentage of 14 year old pupils achieving the required level in Key Stage 3 in different MSOA's in Southend-on-Sea reveal that levels vary from 52% to 93% in English and 60% to 92% in Maths.

2.5.3 Attainment in GCSEs

In Southend-on-Sea, 63% of pupils achieved 5+ A*-C in GSCE's or equivalent which is higher than the Essex average (59%) and is the 5th highest in Essex.

Figure 2.16: Percentage of pupils gaining A*-C in GCSE or equivalent, 2006



However, examining GCSE achievement at MSOA level reveals that the percentage of pupils in Southend-on-Sea achieving at least 5 A*-C in GSCE's varies from 39.7%, which is much lower than the England average, to 77.9% which is much higher than the England average.

In 2006, 90.1% of pupils in Southend achieved 5+ A*-G in GSCE's or equivalent which is slightly lower than both the England and Essex average (90.5% and 91.7% respectively) (Figure 2.17).

The percentage of pupils gaining any passes in GSCE's or equivalent in Southend-on-Sea was 96.8%, which is slightly below both the English and Essex average (97.8% and 97.6% respectively) (Figure 2.18).

Figure 2.17: Percentage of pupils gaining 5+ A* - G in GCSE or equivalent

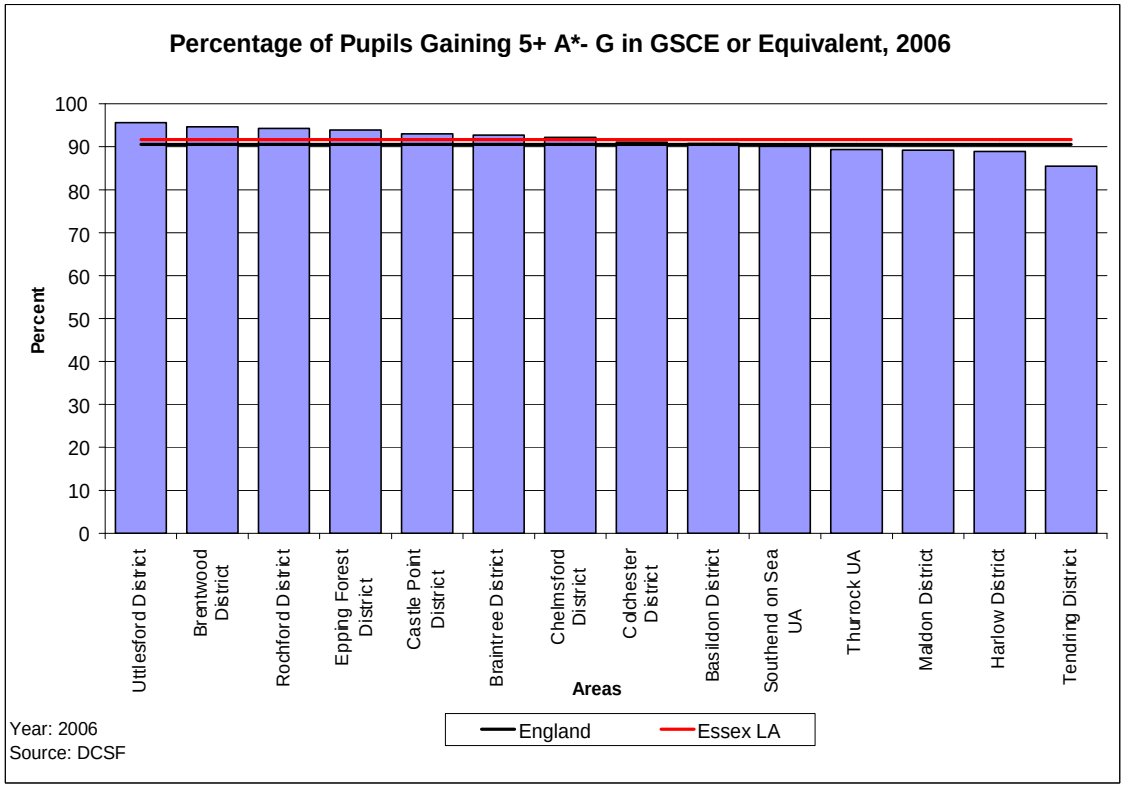
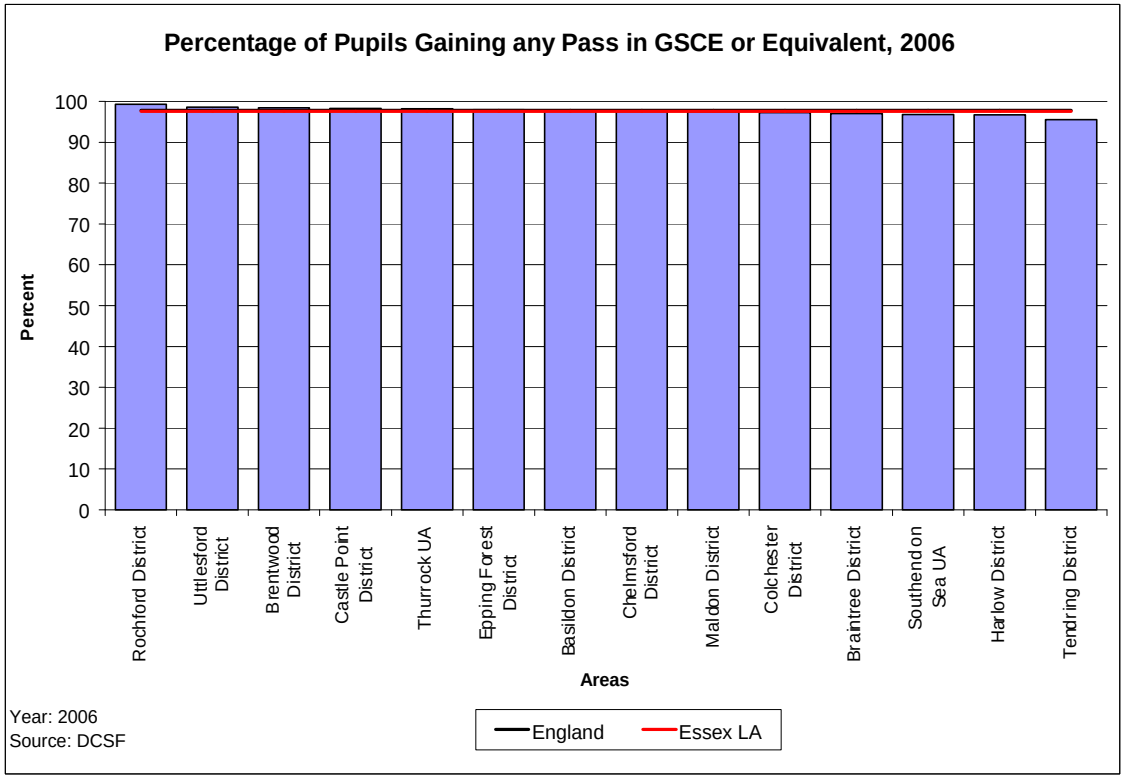


Figure 2.18: Percentage of pupils gaining any pass in GCSE or Equivalent

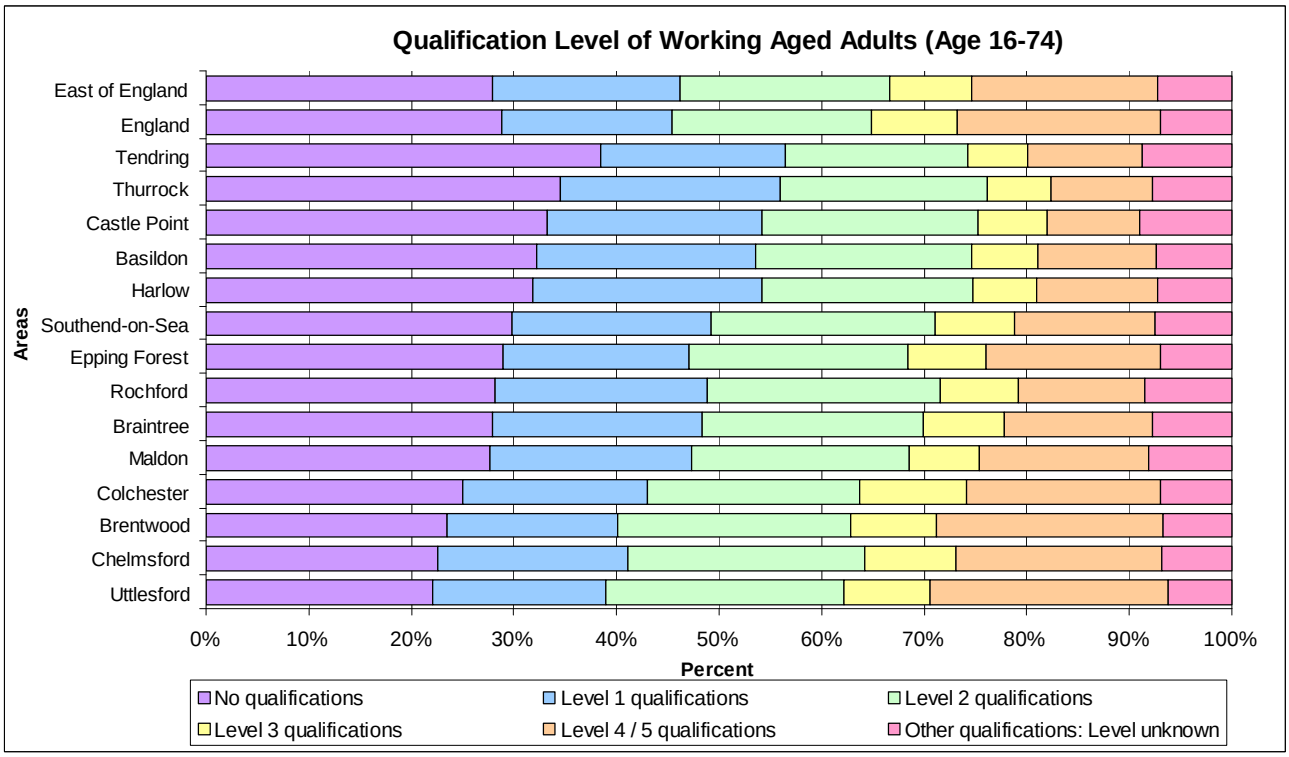


2.5.4 Adult Qualifications

The workforce in Essex tends to be slightly older than that across England and older people tend to have fewer qualifications.

In Southend only 13.6% of residents have a level 4 or above qualification. This compares to 14.8% in Essex and 19.9% in England. In addition, 29.8% of the working age population in Southend have no qualifications. This is comparable to the figure for Essex overall (29.3%).

Figure 2.19: Qualification level of working aged adults (16-74), 2006



Source: ONS Annual Population Survey

In order to improve the local economy, it is essential to develop more local high-value jobs and the skills to match. The challenge is to encourage both residents and employers to invest more time and money in skills.

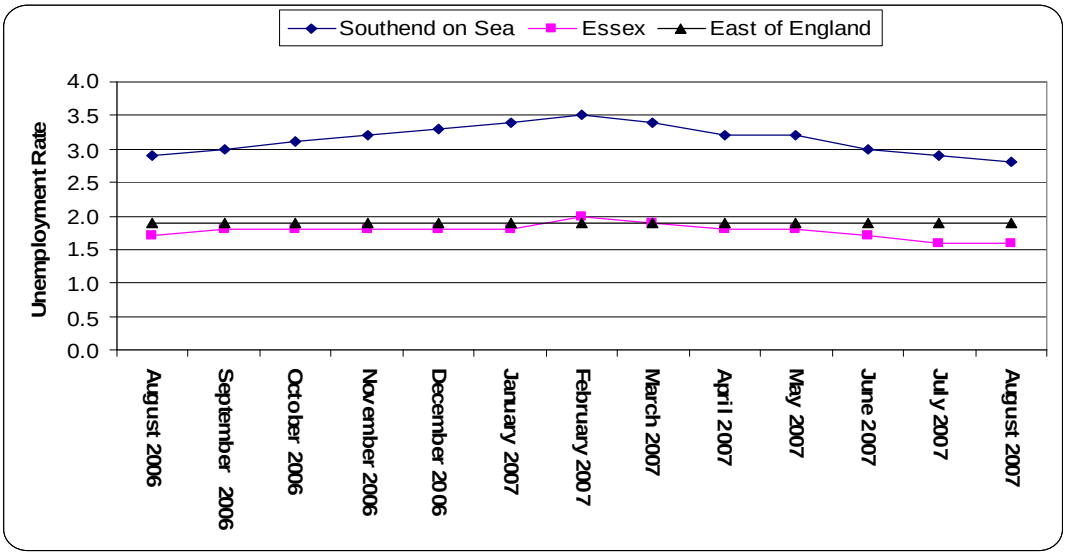
2.6 Employment and Unemployment

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

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

In Southend there are 111,789 people aged between 16-74 years, of which 67% are economically active. Approximately 26,600 people commute out of borough, with 10,500 commuting to London and the remainder primarily to the neighbouring borough. Unemployment rates have remained relatively stable around 3% since 2003, which compares unfavourably with the regional and national rates (1.9% and 2.6% respectively).

Figure 2.20: Unemployment in Southend 2006-7



Source: ONS

Figure 2.20 demonstrates the higher unemployment rate in Southend compared to Essex and East of England during the 12 month period August 2006 to August 2007.

2. 7 Crime and Disorder

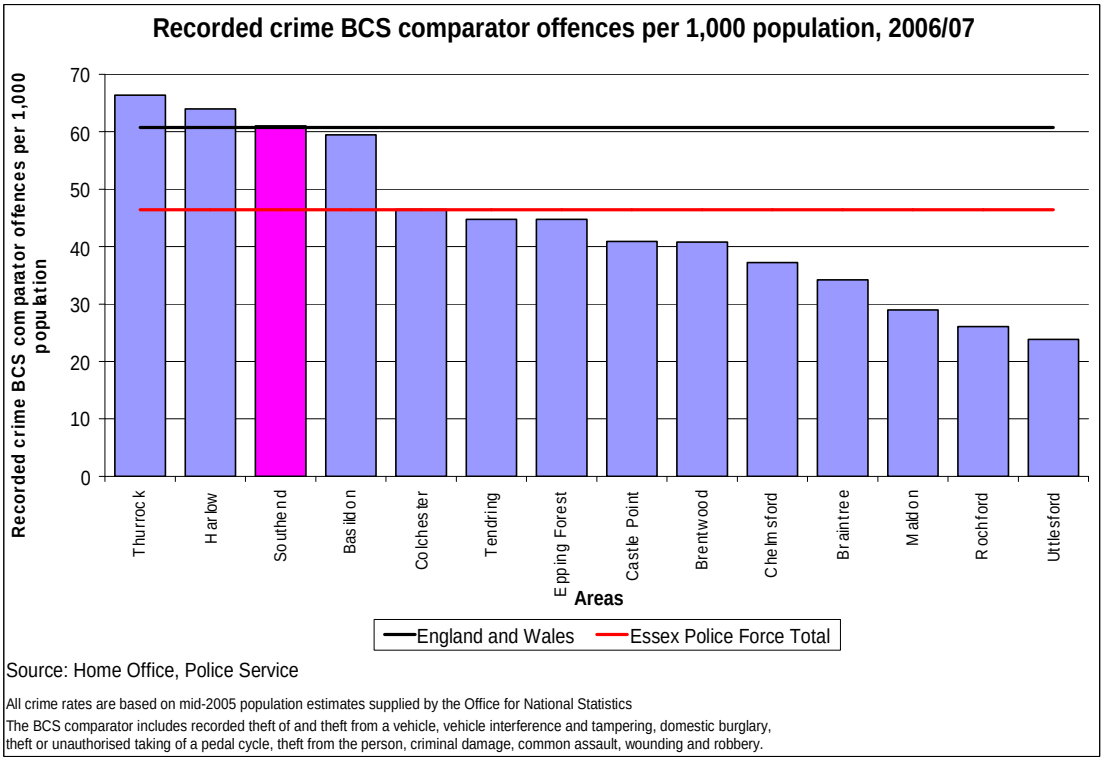
Crime is associated with social disorganisation, low social capital, relative deprivation and health inequalities. The same social and environmental factors that predict geographic variation in crime rates may also be relevant to explaining community variations in health and well-being. The level of crime is one of the top five priorities for residents in Southend

2.7.1 Crime rates

Crime rates can be compared by using a sub-set of recorded crimes that can be aligned to categories in the British Crime Survey. This is known as the BCS comparator rate.

Southend has one of the highest rates of recorded crime in Essex, but similar to that for England and Wales (Figure 2.21). However, recorded crime has continued to fall over the last 3 years (Figure 2.22).

Figure 2.21: Recorded crime BCS comparator offences per 1000 population in Essex – 2006/07

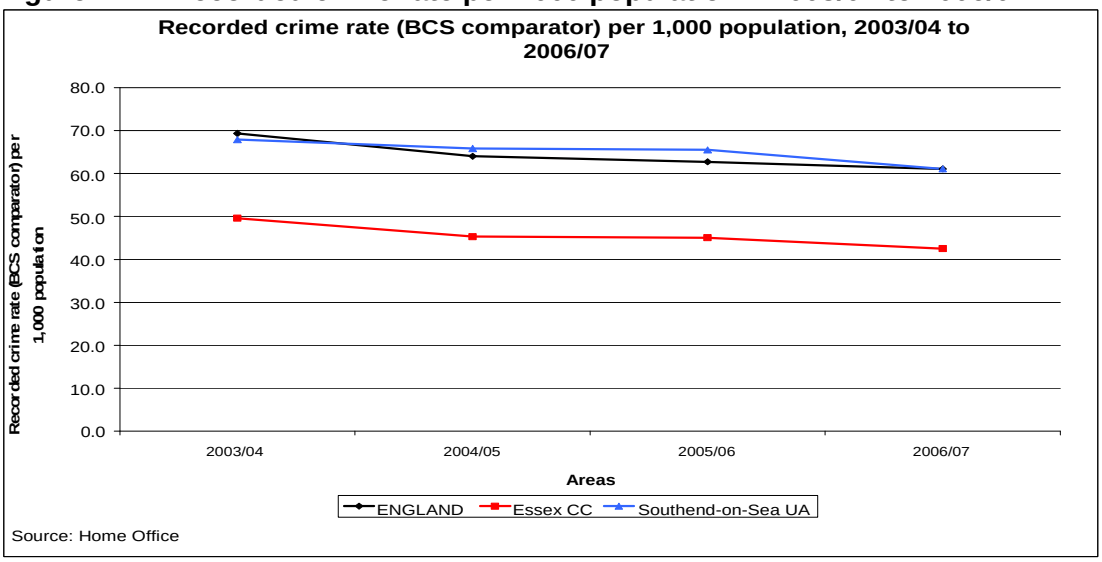


Source: Home Office, Police Service

All crime rates are based on mid-2005 population estimates supplied by the Office for National Statistics

The BCS comparator includes recorded theft of and theft from a vehicle, vehicle interference and tampering, domestic burglary, theft or unauthorised taking of a pedal cycle, theft from the person, criminal damage, common assault, wounding and robbery.

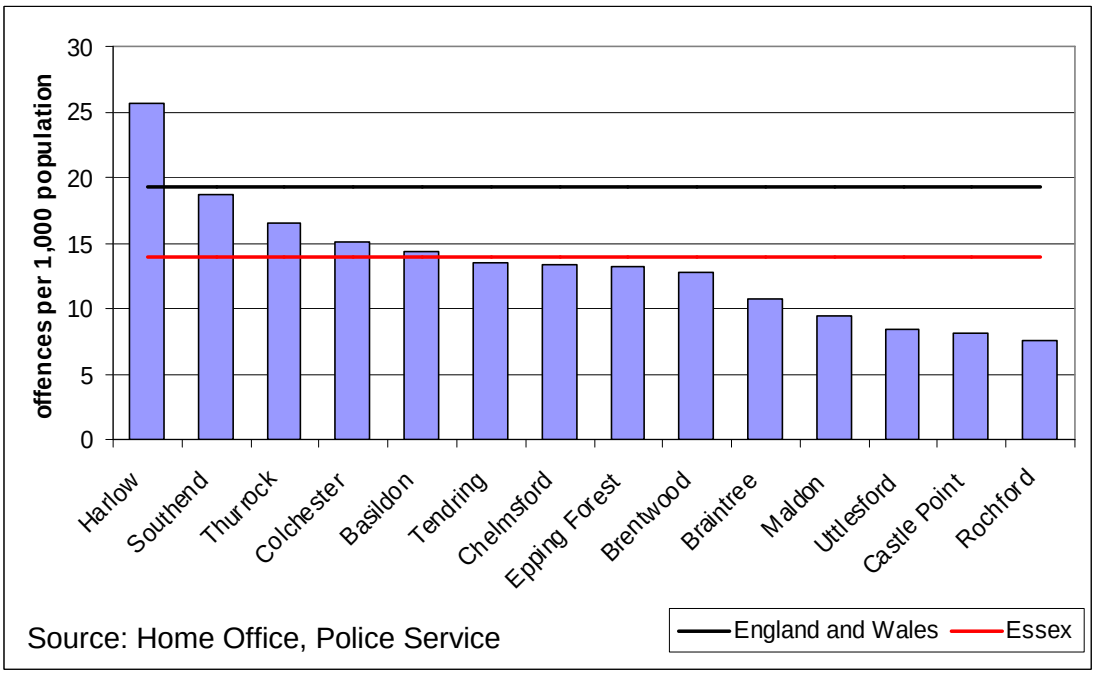
Figure 2.22: Recorded crime rate per 1000 population – 2003/04 to 2006/07



The BCS sample survey indicates that Southend also has a higher rate of violence against the person than the Essex average, (18 per 1,000 population compared to per 1,000) which is just below the England and Wales average at19 per 1,000 (Figure 2.23).

However the 2006/07 'Notifiable Offences Recorded by the Police' dataset indicates that Southend has a slightly lower crime rate than England and Wales (84 per 1000 population compared to 89 per 1000). A large survey of older people in Southend (carried out as part of Southend's Older People's Strategy 2007-2010) also gives a local indication of the fear of crime. The majority of respondents, 79% felt either 'very' or 'fairly' safe living in Southend.

Figure 2.23: Recorded crime BCS comparator offences per 1000 population in Essex – 2006/07

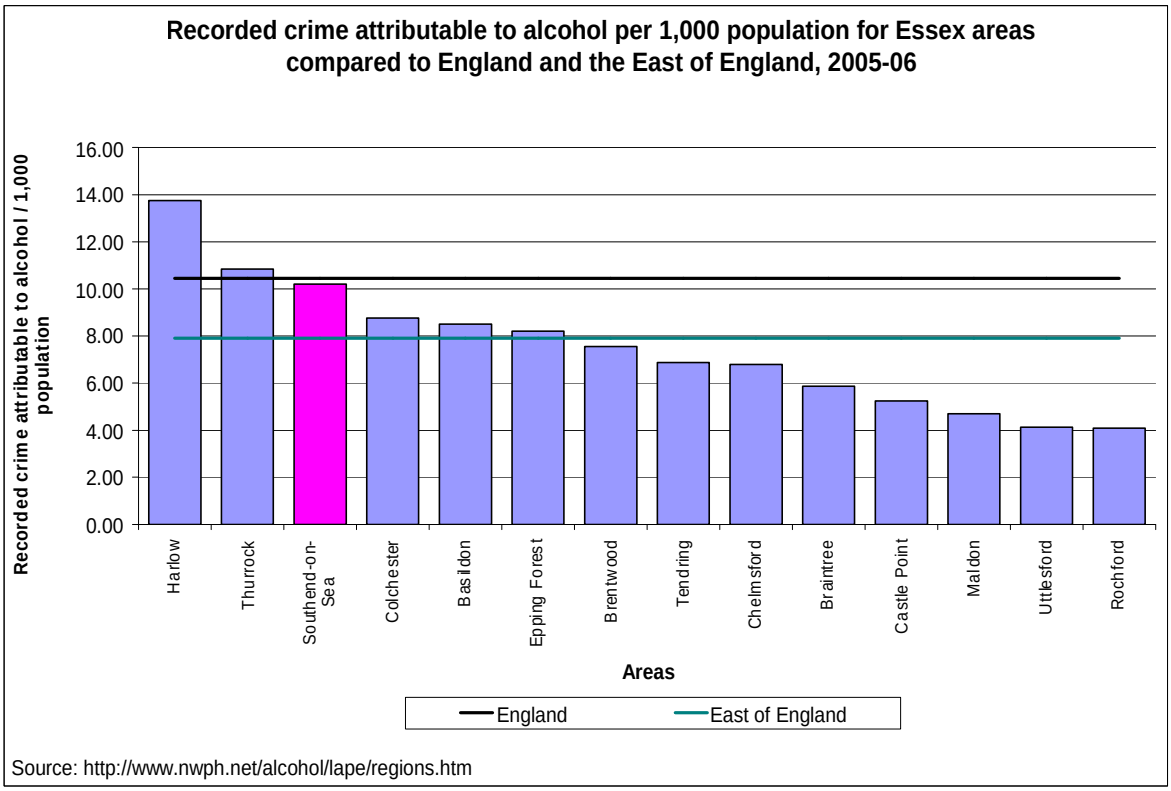


2.7.2 Alcohol related crime

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

Southend-on-Sea reflects the national picture with an increase in alcohol-fuelled crimes. Southend has the third highest level of recorded crime attributable to alcohol in Essex, which is just below the rate for England.

Figure 2.24: Recorded crime attributable to alcohol per 1000 population for Essex compared to England and East of England, 2005-6



Source: http://www.nwph.net/alcohol/lape/regions.htm

2.7.3 Crime and disorder priorities

Each district / borough is required to conduct a local crime and disorder audit to inform the development of their Crime & Disorder Reduction Partnership Strategies.

From the local audits and a review of the evidence, the following issues were identified as crime and disorder priorities and adopted in the 2007-2010 Southend Local Area Agreement:

- reduction in the basket of BCS comparator crimes (with sub-target for three Town Centre wards)
- reduce in the proportion of adult and young offenders and prolific and other priority offenders who re-offend
- increase the number of reports of domestic violence incidents to the police either by victim or third party
- reduce the fear of crime
- reduce the harm caused by illegal drugs
- build respect in communities and reduce antisocial behaviour

2.8 Transport

Transport includes walking and cycling, as well as use of private vehicles, public transport and goods vehicles. Transport can have a wide range of beneficial and deleterious effects on health. Positive effects include recreation, exercise and access to employment, education, shops, recreation, social support networks, health services and the countryside. Negative effects include: pollution; traffic injuries, noise, stress and anxiety; land loss and planning blight; and severance of communities by roads.

Southend has a Strategy for Cycling and Walking which forms part of an overall Southend Borough Local Transport Plan. The Strategy, via 32 individual actions aim to make Southend a place where everyone can walk and cycle conveniently and in safety.

Southend is characterised by predominantly east/west travel movements serving the wider conurbation of South East Essex.

The levels of congestion on the main highway corridors are a major and growing problem. Growth in travel demand is expected to increase by up to 20% over the next 5 years and 35% by 2016.

Southend is served by two railway lines linking to London, with 9 railway stations and many local bus routes. These services require improvement and better integration to provide sufficiently attractive alternatives to the car, which will bring about a significant change in travel patterns.

2.8.1 Access to Health Services by Public Transport

The two maps show the geographical locations which can access either a GP surgery or a hospital within 30 and 60 minutes travel time by public transport.

The calculation measures the journey time by bus on a Monday between 9.30am and 5.00pm to the nearest service, either the GP or Hospital depending on the map. The calculation includes the time to walk to the bus stop, travelling on the bus, changing bus services if needed and walking to the destination. The location of the GP was provided by colleagues within the Primary Care Trust. The hospital information was obtained from an NHS web site.

To match the Local Development Framework monitoring assessment, travel time is monitored in 30 minute bands. The blue shows areas of the county which can access their nearest GP or Hospital within 30 minutes. The Green band shows areas which are within 30 and 60 minutes travel time. Where there is no colour shown, these areas are in excess of 60 minutes travel time by public transport of a healthcare facility. It is these areas where the provision or delivery of healthcare services could potentially be reviewed.

The subject of local transport was also included as part of a large survey of older people in Southend (carried out as part of Southend's Older People's Strategy 2007-2010). Findings showed that 65% of respondents felt they could travel around Southend where and when they want to.

Figure 2.25: Geographical locations that can access a hospital within 30 and 60 minutes travel time by public transport

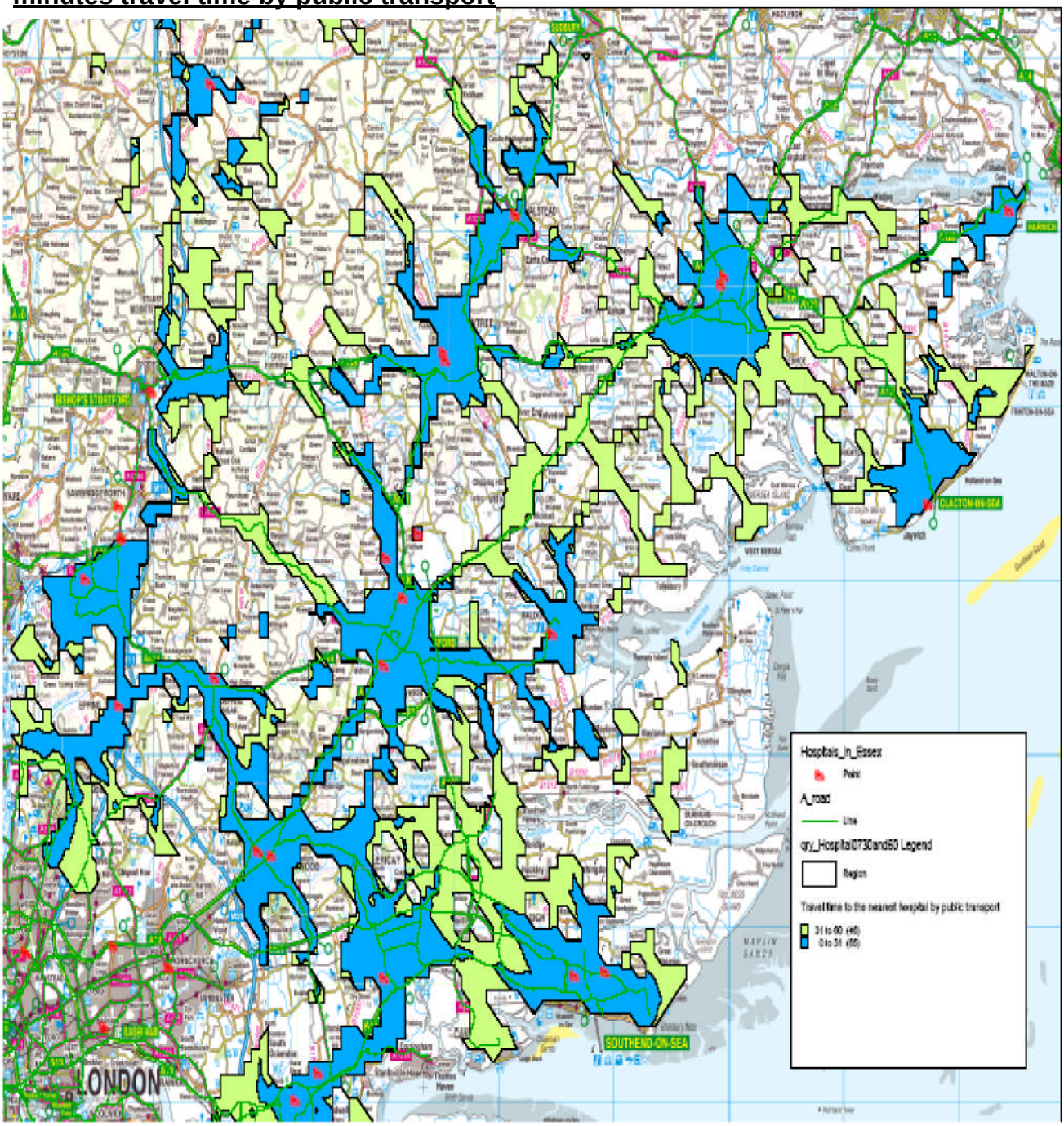
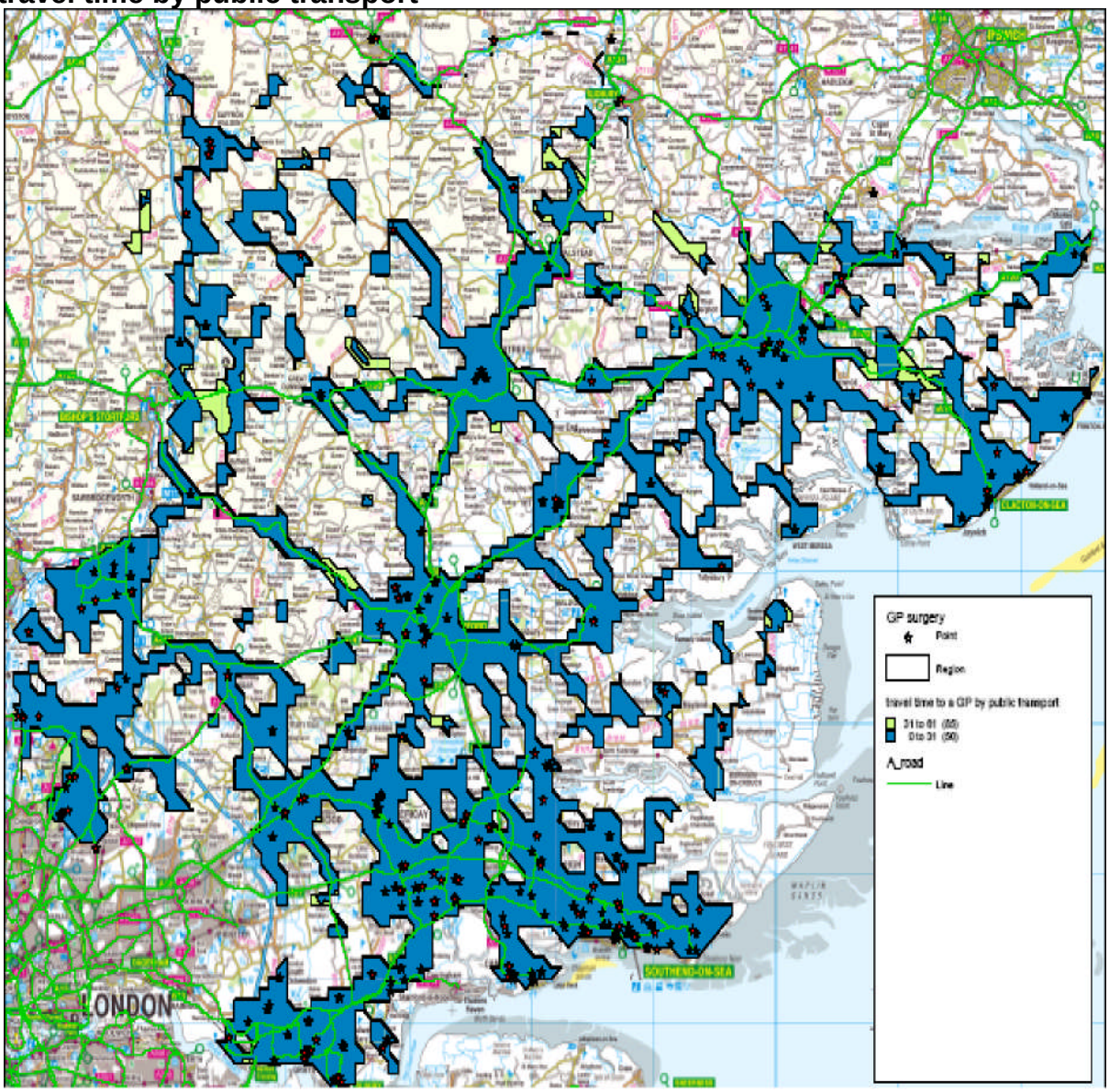


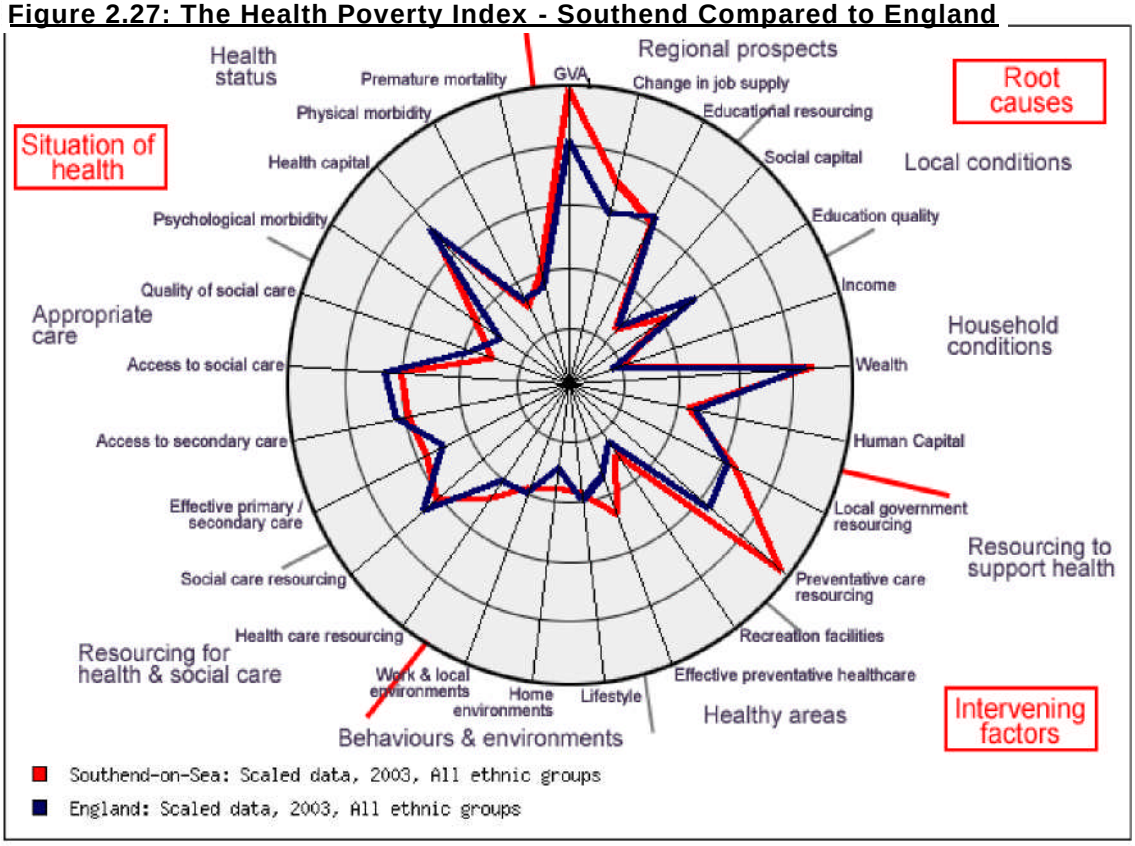
Figure 2.26: Geographical locations that can access a GP within 30 and 60 minutes travel time by public transport



2.9 The Health Poverty Index

The Health Poverty Index (HPI) is a new innovative visualisation tool, which can be used to identify areas of health poverty or wealth. The HPI attempts to provide a holistic picture describing an area's health situation as a combination of its present state of health and its future health potential. The HPI currently consists of 26 indicators presented for LAs in England. The diagram aims not to provide a single numerical score, but to provide evidence of a wide range of contributing factors. Essentially, the higher the value achieved by an indicator, and the further it is from the centre of the circle, the worse the health situation.

Figure 2.27: The Health Poverty Index - Southend Compared to England



2.10 Conclusion

Like many seaside towns, Southend has areas of social and economic deprivation, with five areas that lie within the 10% most disadvantaged in the country.

As population growth and housing development accelerate, the need for inward investment and local job growth will intensify. Key to creating a more self-contained economy is affordable housing and increasing local skills. A relatively high proportion of the local workforce has no qualifications and relatively few are qualified.

Crime in Southend reflects the national picture and Southend's Safer and Stronger Communities board continues to have a strong emphasis on the reduction of the fear of crime.

CHAPTER 3 HEALTH AND WELFARE

3.1 Life Expectancy

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

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

3.1.1 District level

Life expectancy varies across the region with Southend on Sea having the lowest life expectancy in Essex (78.1 years); this is comparable to the England average life expectancy at 78.3 years (Figure 3.1).

Figure 3.1: Life Expectancy at Birth by Local & Unitary Authority

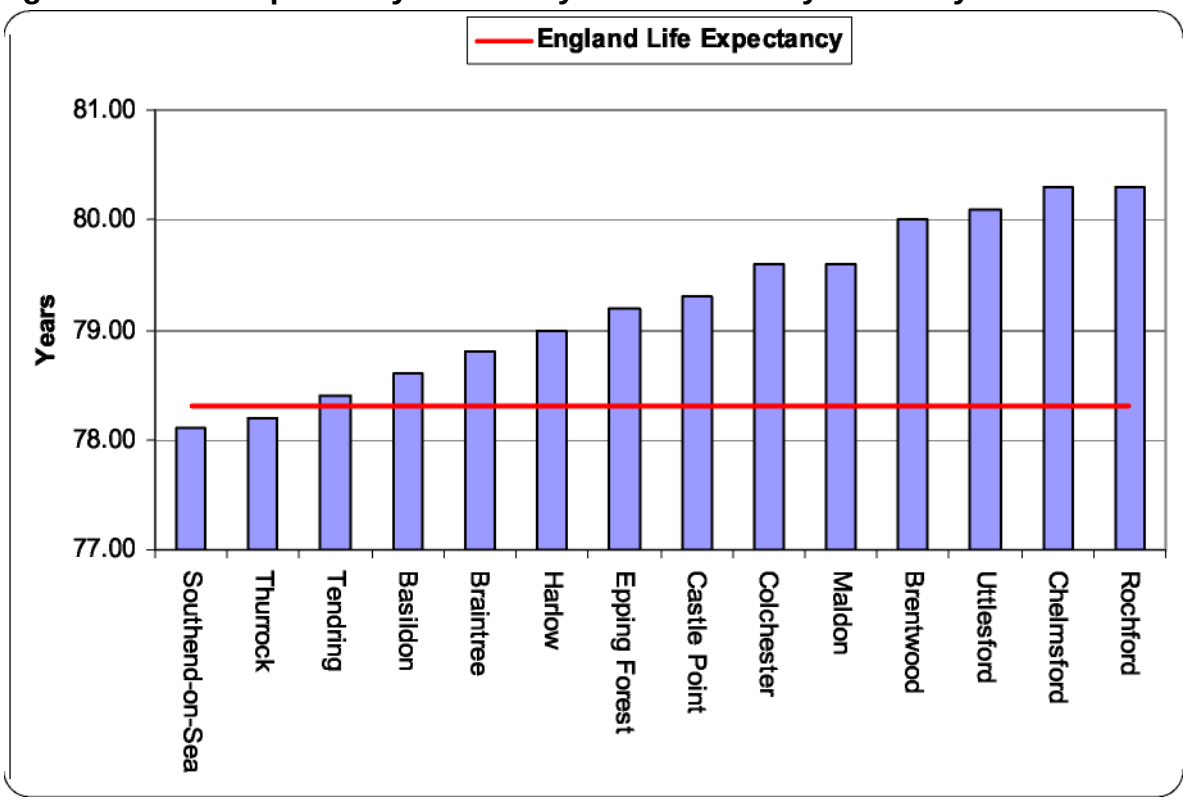


Figure 3.2: Life Expectancy at Birth by Ward in Southend

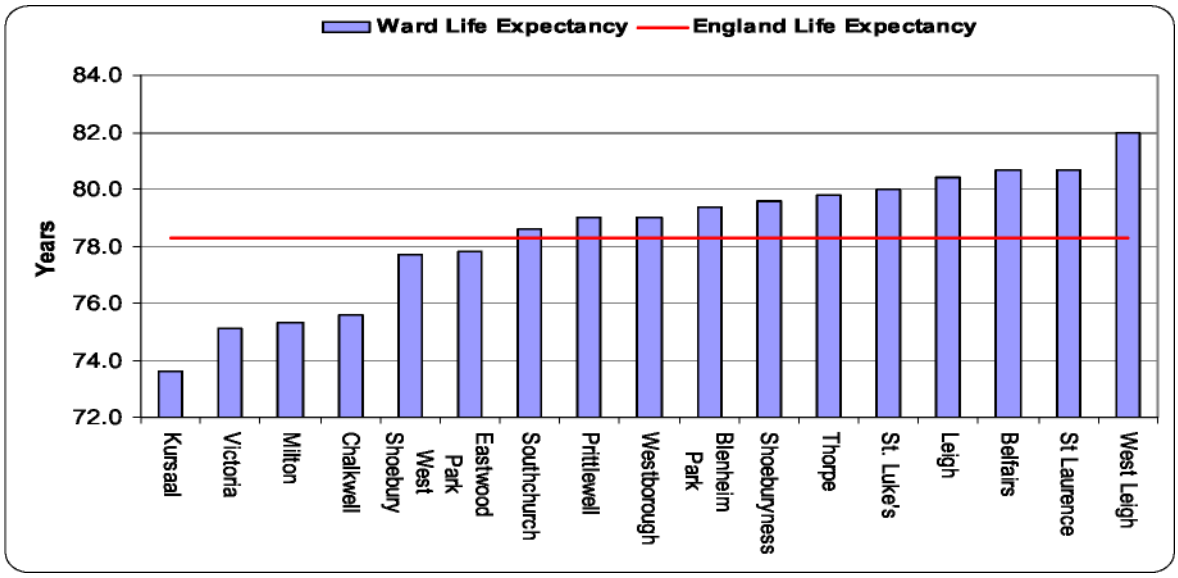


Figure 3.2 shows the life expectancy in Southend by ward. There is an 8.4 year variation in life expectancy across the wards, ranging from just under 74 years to 82 years.

3.1.2 Vulnerable Groups

Research studies demonstrate differences in life expectancy between vulnerable groups of people and the general population.

People with serious mental illness have a reduce life expectancy of ten years compared to the general population. This difference is more marked for men than women and is largely due to physical health problems, such as coronary heart disease, respiratory and infectious disorders.

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

3.2 Mortality

Mortality is a direct measure of health care need reflecting the overall disease burden on the population, both the incidence of disease and the ability to treat it. The mortality rate may be improved by reducing the population's risk (e.g. encouraging healthier lifestyles and reducing exposure to smoking), by earlier detection of disease and by more effective treatment. The trend charts presented in this section show the three year moving averages of annual mortality rates from all circulatory disease from the 1993-1995 to the most recently available years of data (2003-05 average) compared against the national and regional trends.

3.2.1 All Cause Mortality

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

All cause mortality – all ages

The most recent data confirms that all cause mortality rates for males and females of all ages in Southend are both above the national average. However, all cause mortality rates have continued to fall over the last ten years for both males and females.

Figure 3.3: Directly age-standardised mortality rates from all causes per 100,000 population for all ages (three year rolling average)

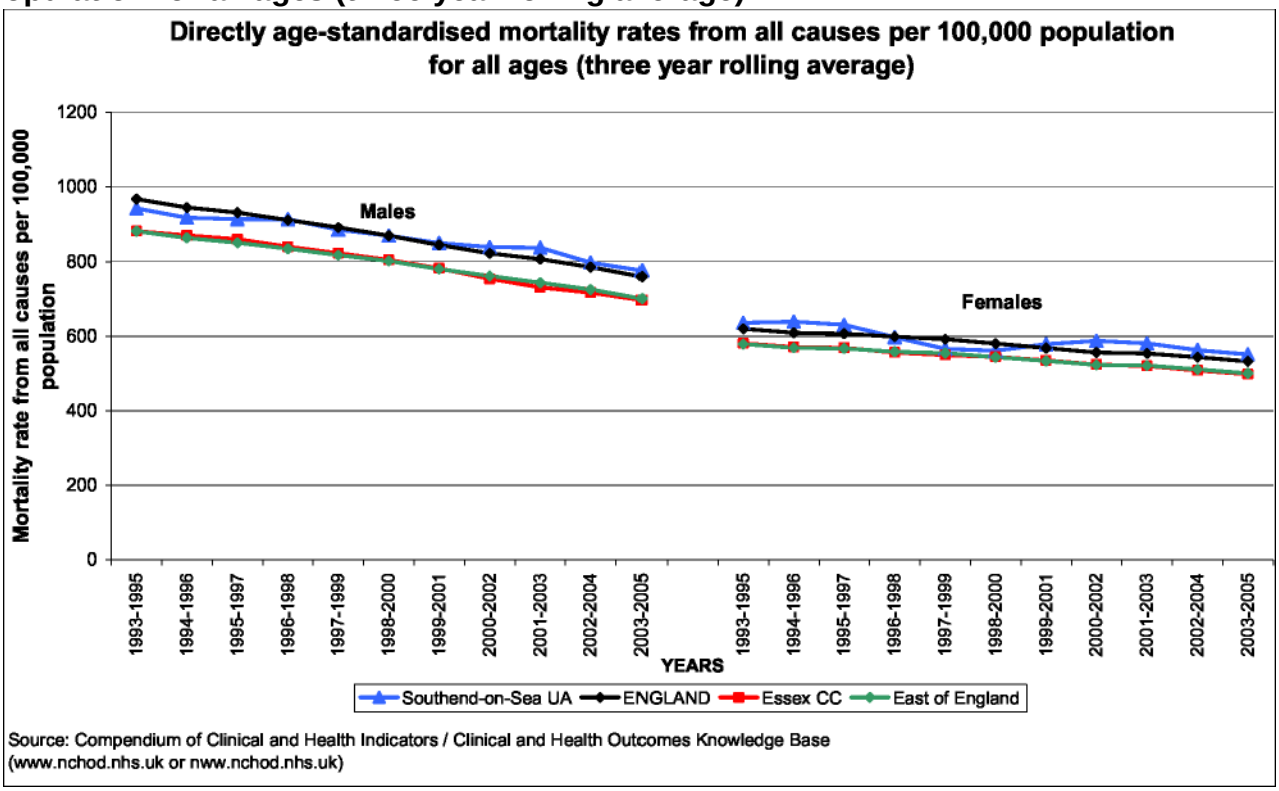
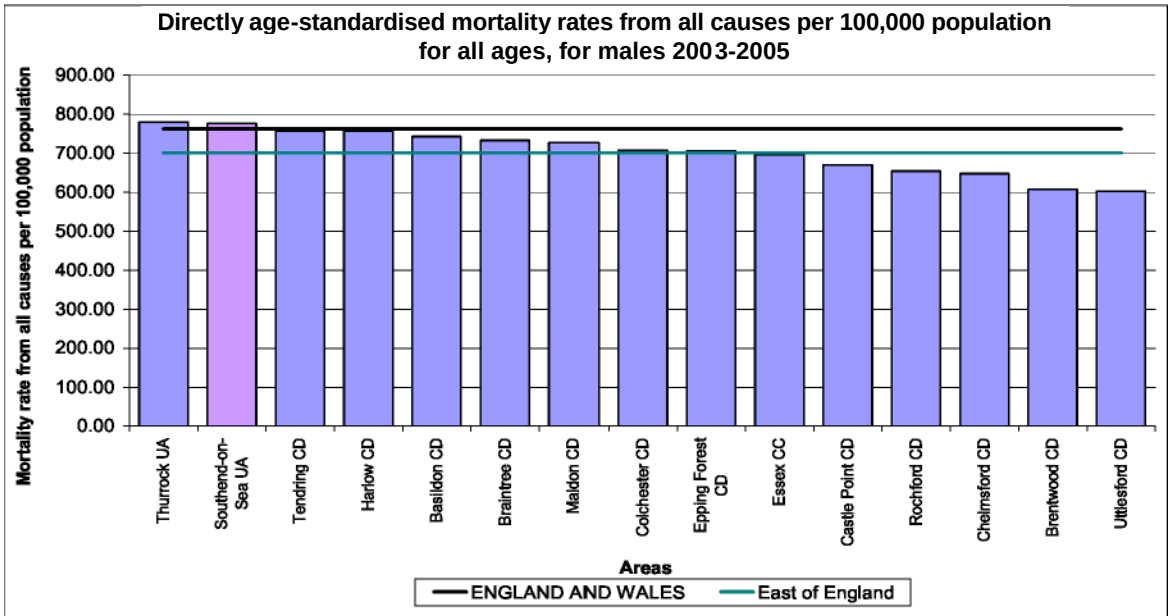


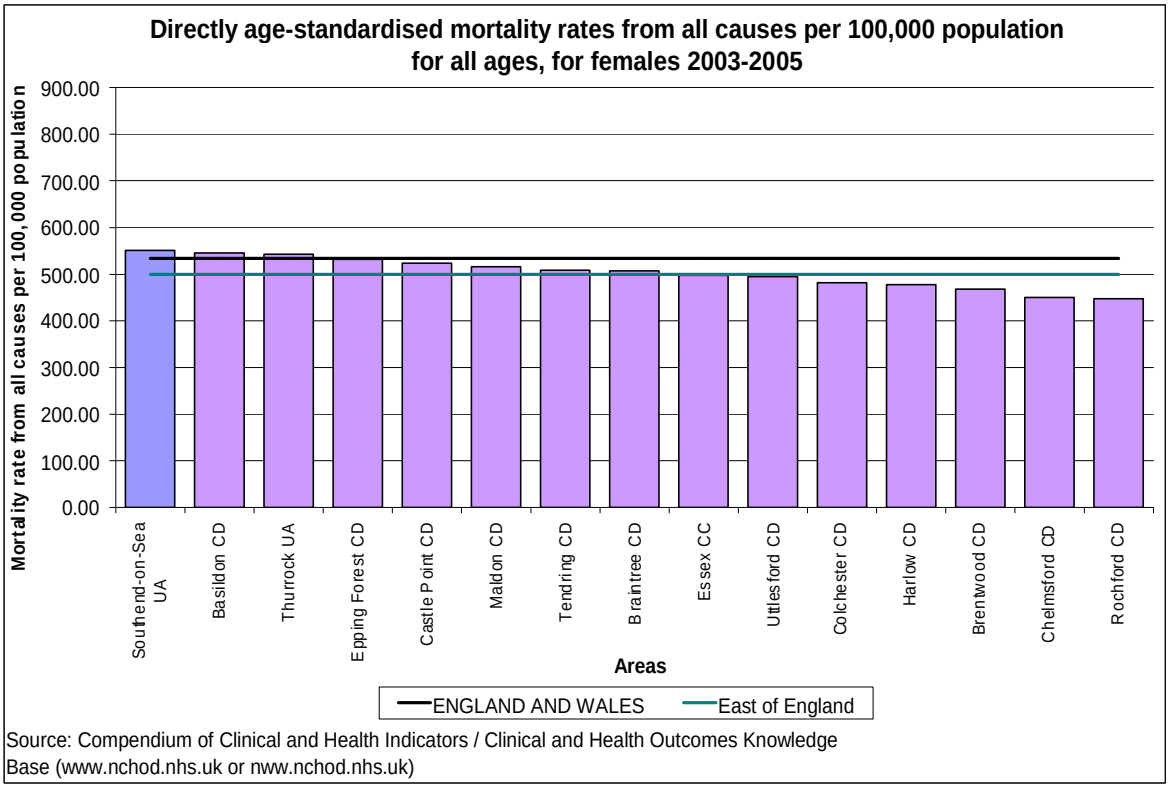
Figure 3.4: Directly age standardised mortality rates from all causes per 100,000 population for all ages – males 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Southend has the second highest all cause mortality rates for males of all ages in Essex, which is slightly higher than the England and Wales average. The all cause mortality rate for females of all ages in Southend is the highest in Essex.

Figure 3.5: Directly age standardised mortality rates from all causes per 100,000 population for all ages – females 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.6: Directly age standardised mortality rates from all causes per 100,000 population for all ages by Medium Super Output Area – All people 2003-2005

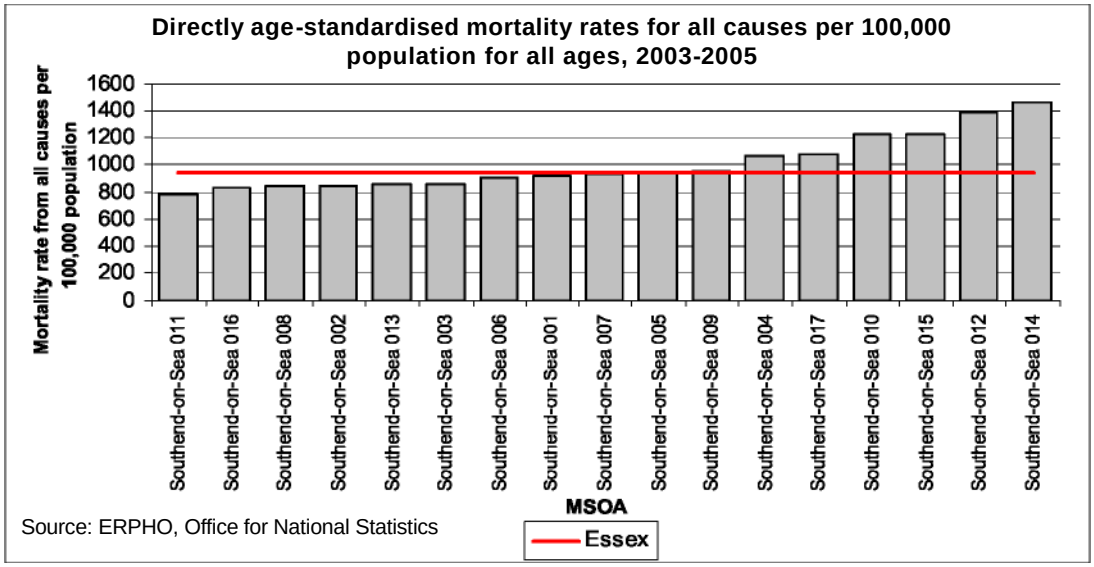
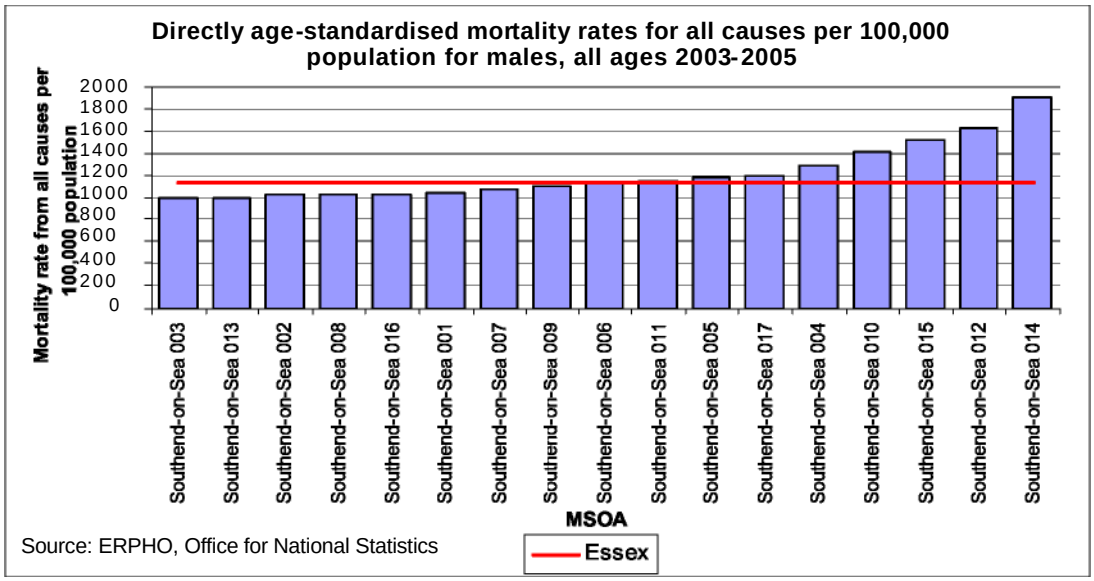


Figure 3.7: Directly age standardised mortality rates from all causes per 100,000 population for all ages by Medium Super Output Area – Males 2003-2005



There is a wide variation in the all cause mortality rates for males and females of all ages at Medium Super Output Area (MSOA) in Southend (Figures 3.7 and 3.8).

Figure 3.8: Directly age standardised mortality rates from all causes per 100,000 population for all ages by Medium Super Output Area – Females 2003-2005

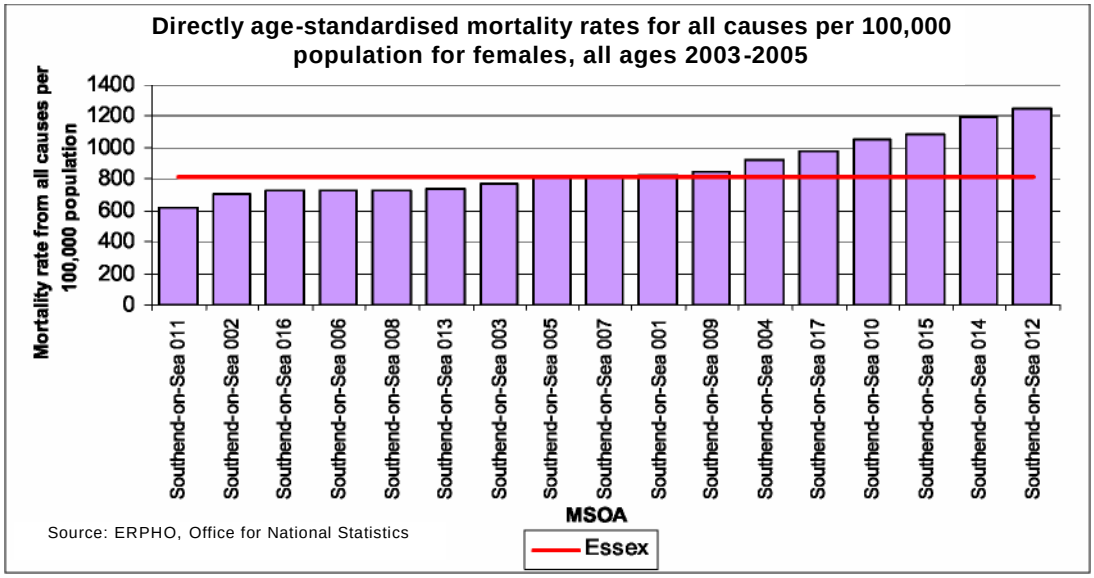
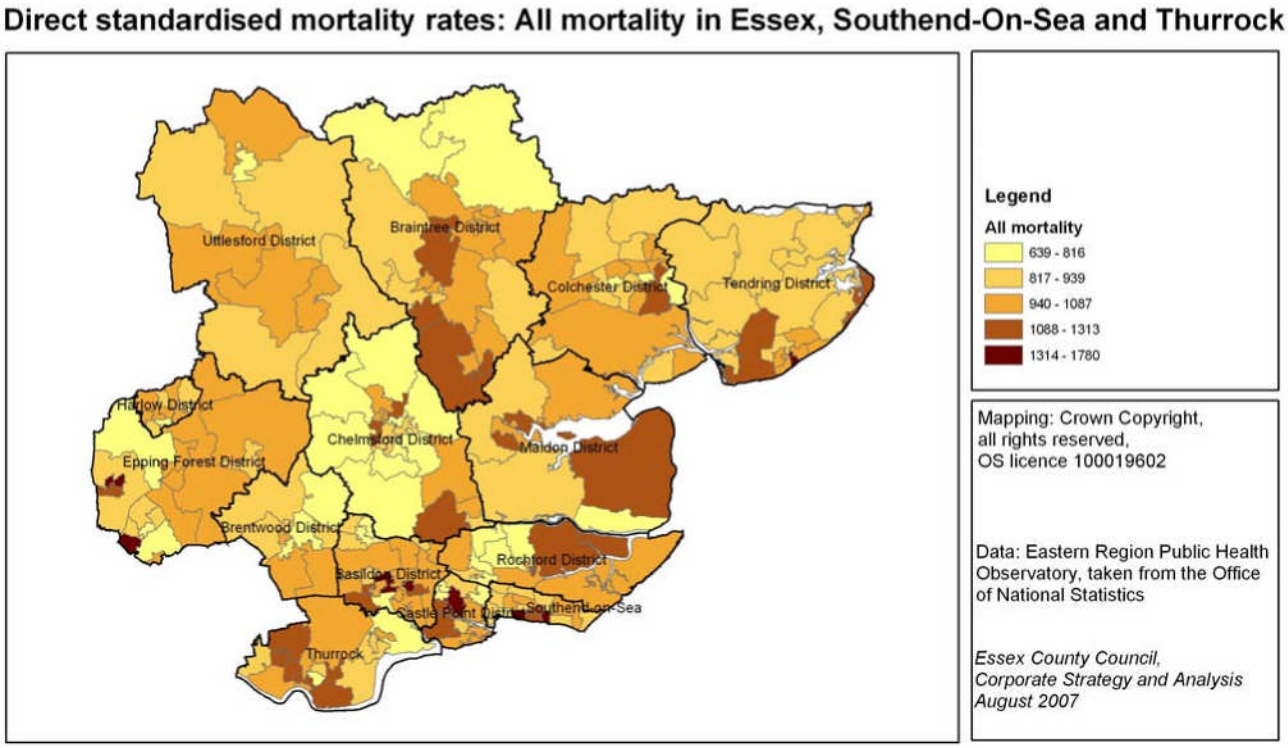


Figure 3.9: Directly standardised mortality rates: All mortality in Essex, Southend and Thurrock

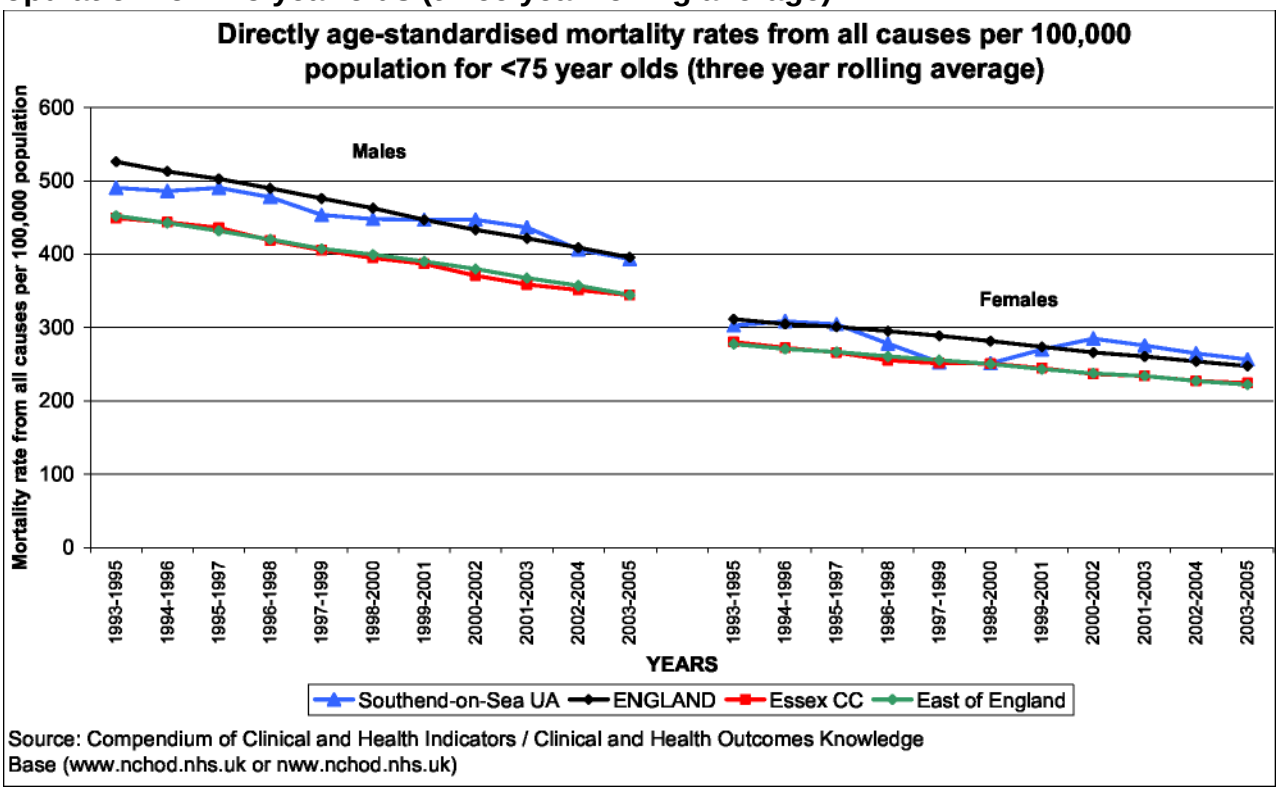


All cause mortality - under 75 year olds

The all cause mortality rate for males under 75 years old in Southend has shown an overall improvement over the last 10 years. Whilst there has been an overall reduction in all cause mortality rate for females under 75 years old in Southend, there was a slight increase 1999 and 2001 before falling again.

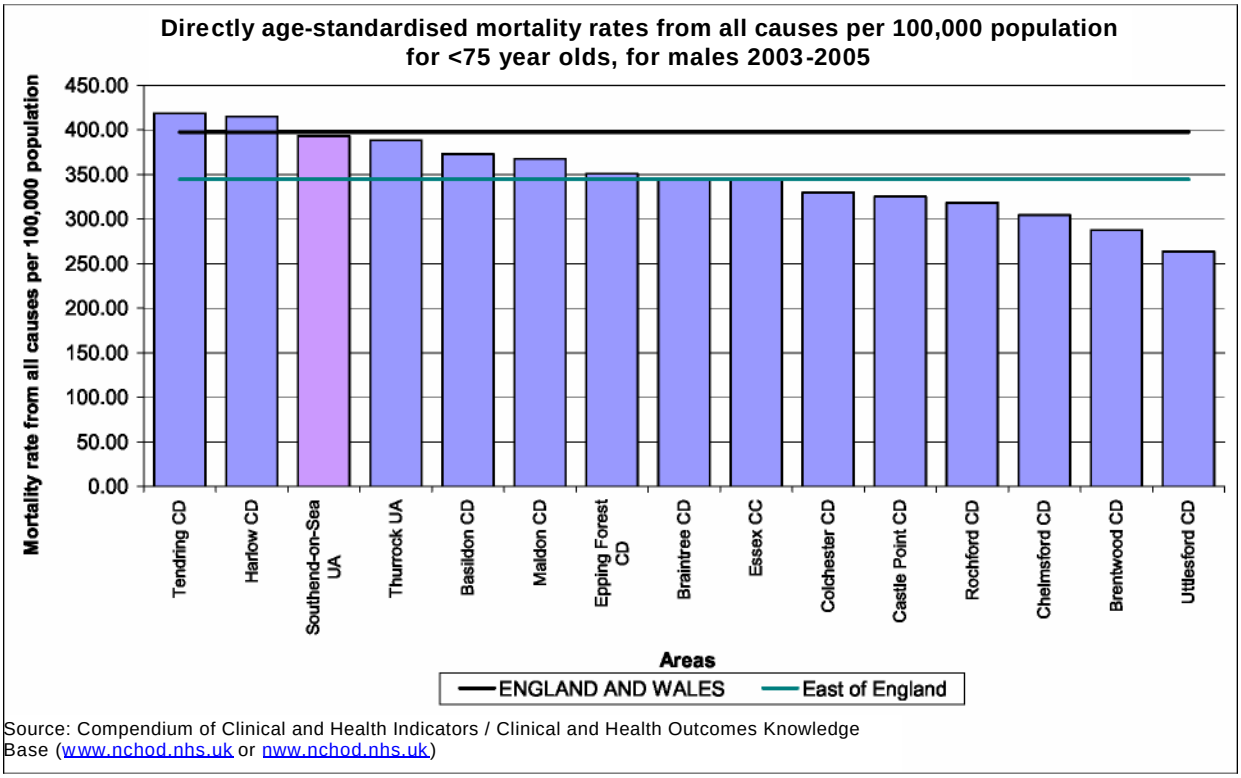
Compared with the rest of Essex, Southend has the third highest all-cause mortality rate for both males and females under 75 years old (Figures 3.11 and 3.12). The trend line for all cause mortality rates in under 75 years old in both males and females is generally above the trend line for Essex and East of England for the stated period.

Figure 3.10: Directly age standardised mortality rates from all causes per 100,000 population for <75 year olds (three year rolling average)



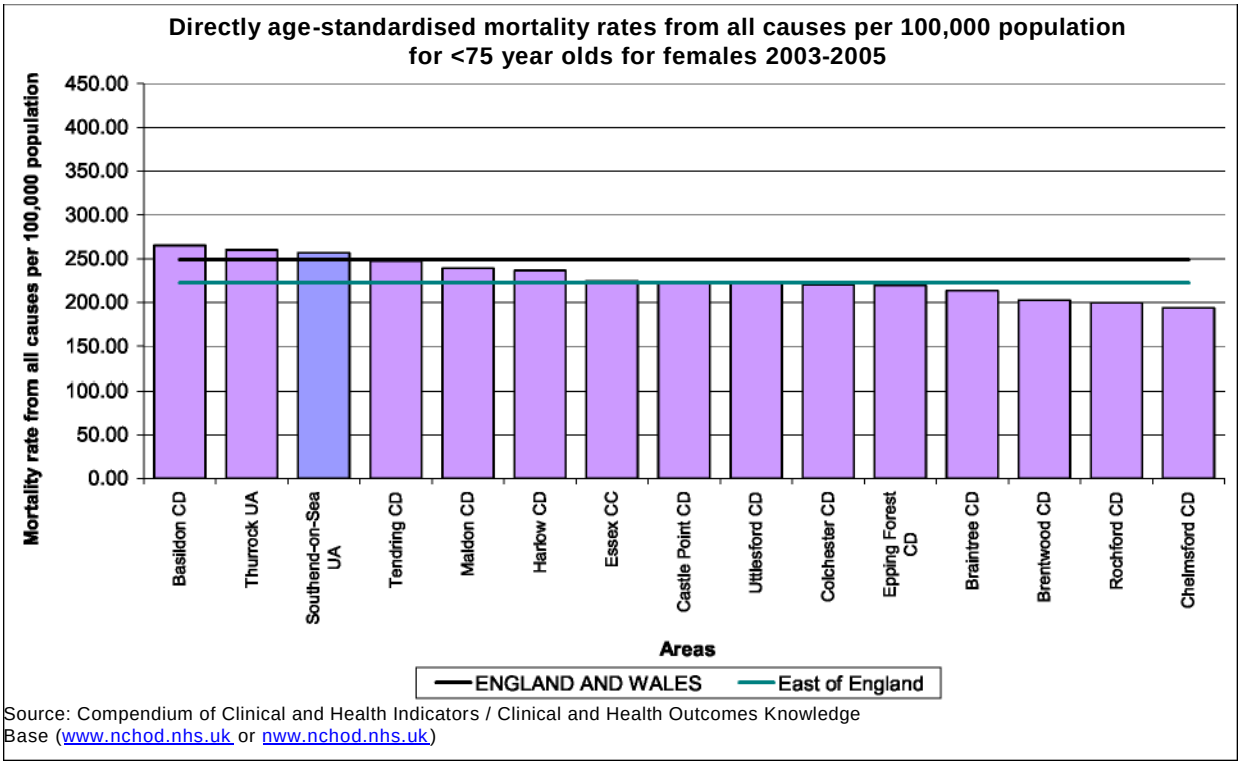
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.11: Directly age standardised mortality rates from all causes per 100,000 population for <75 year olds - Males (three year rolling average)



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.12: Directly age standardised mortality rates from all causes per 100,000 population for <75 year olds - Females (three year rolling average)



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.13: Directly age standardised mortality rates from all causes per 100,000 population for <75 year olds – by MSOA (three year rolling average)

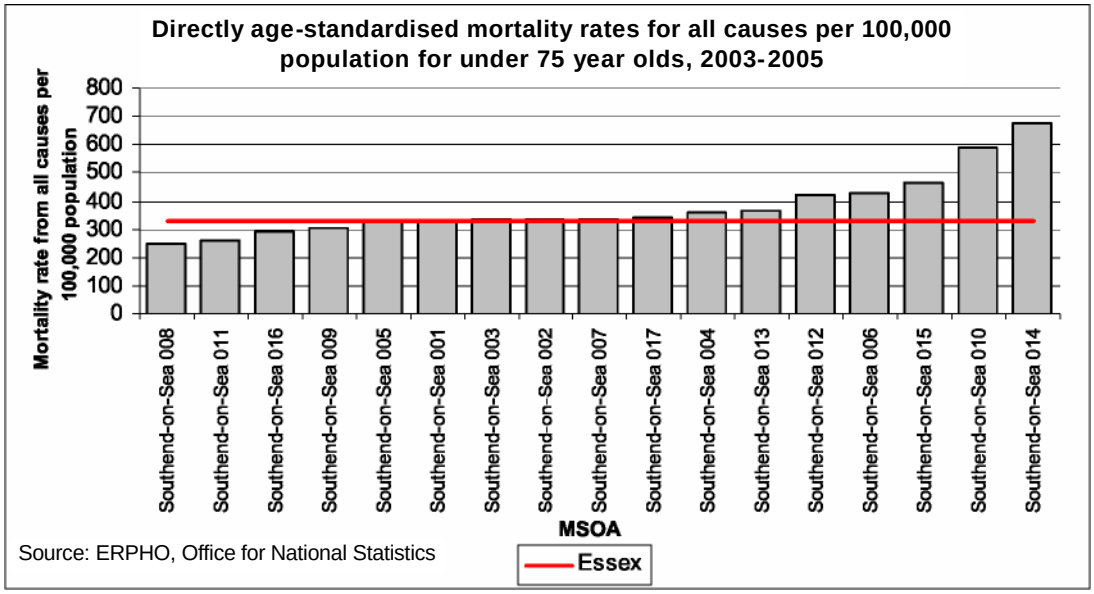
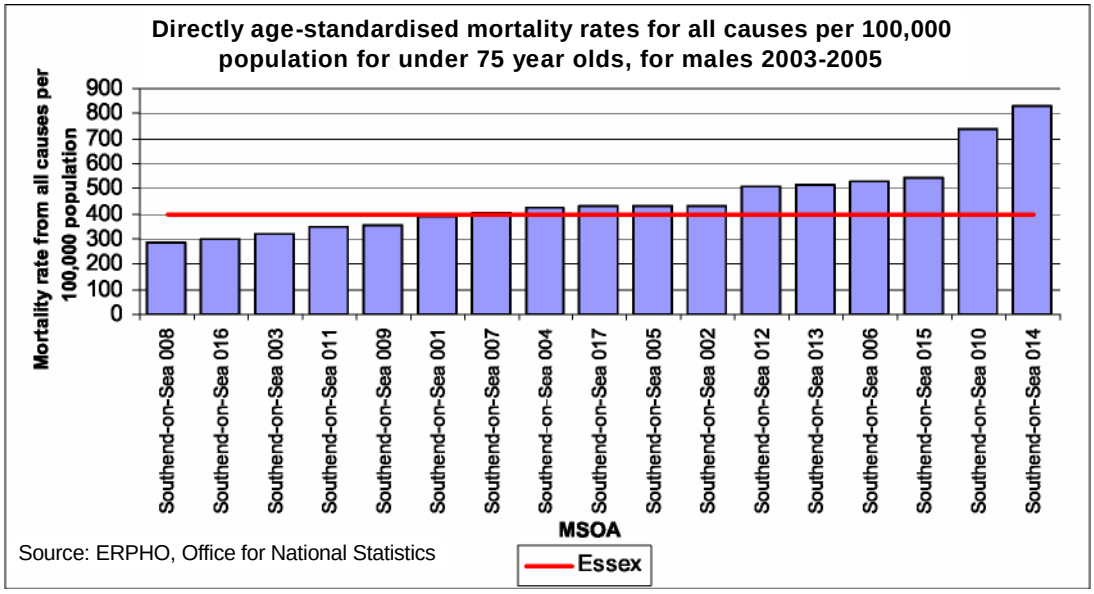


Figure 3.14: Directly age standardised mortality rates from all causes per 100,000 population for <75 year olds – by MSOA - Males (three year rolling average)



Figures 3.14 and 3.15 demonstrate the wide variation all cause mortality rates for males and females under 75 by Medium Super Output Area (MSOA) in Southend.

Figure 3.15: Directly age standardised mortality rates from all causes per 100,000 population for <75 year olds – by MSOA - Females (three year rolling average)

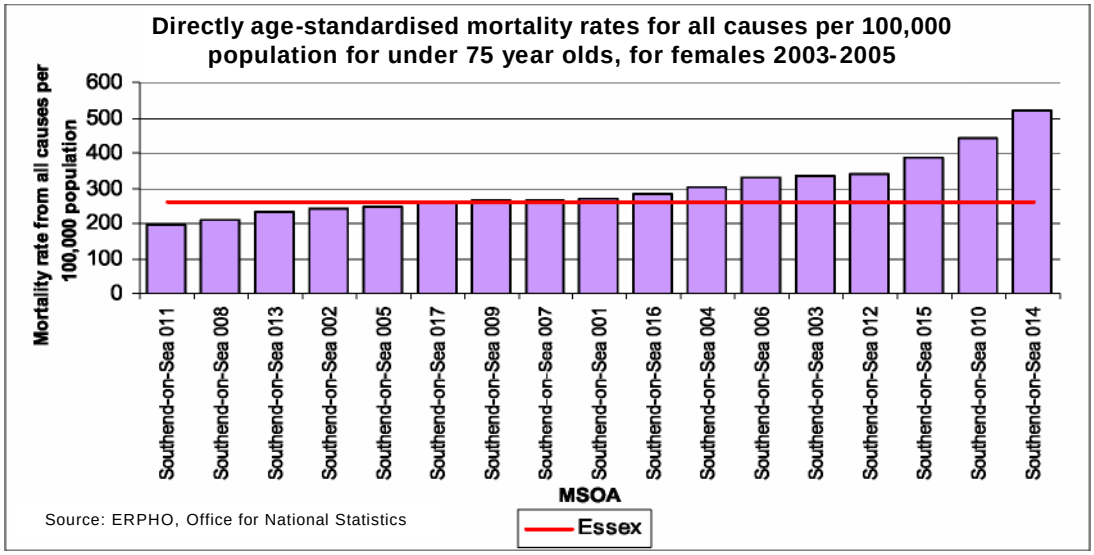
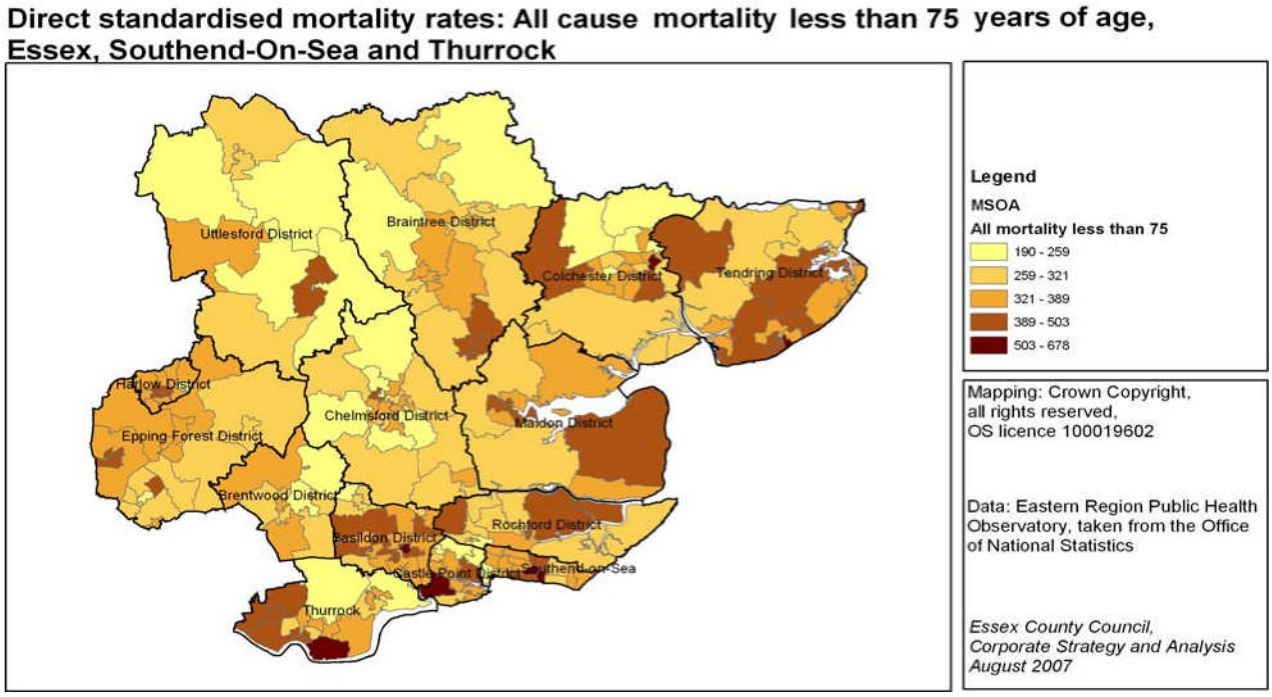


Figure 3.16: Direct standardised mortality rates – All cause mortality less than 75 years old – Essex, Southend and Thurrock



3.2.2 Cancer Mortality

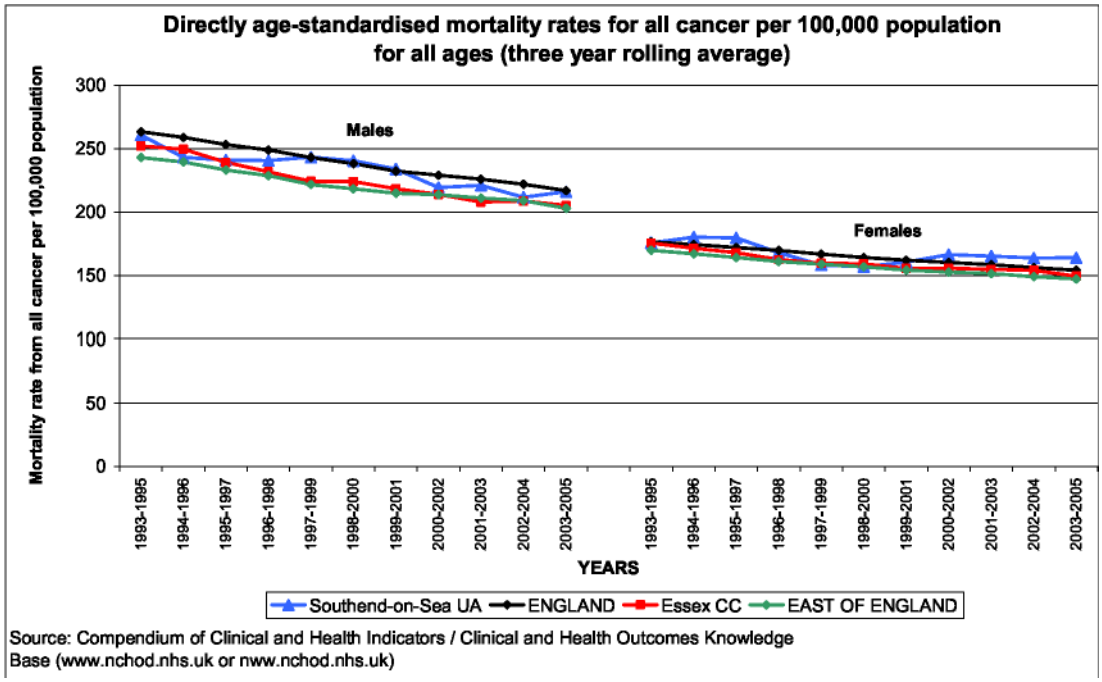
All ages

The all cancer mortality rate for males of all ages in Southend has shown an overall improvement over the last 10 years (from 1993/95 to 2003/05).

The trend line in the all cancer mortality rate for all cancers in males of all ages in Southend is generally above that for Essex and East of England over this period, but generally below the England rate (Figure 3.17).

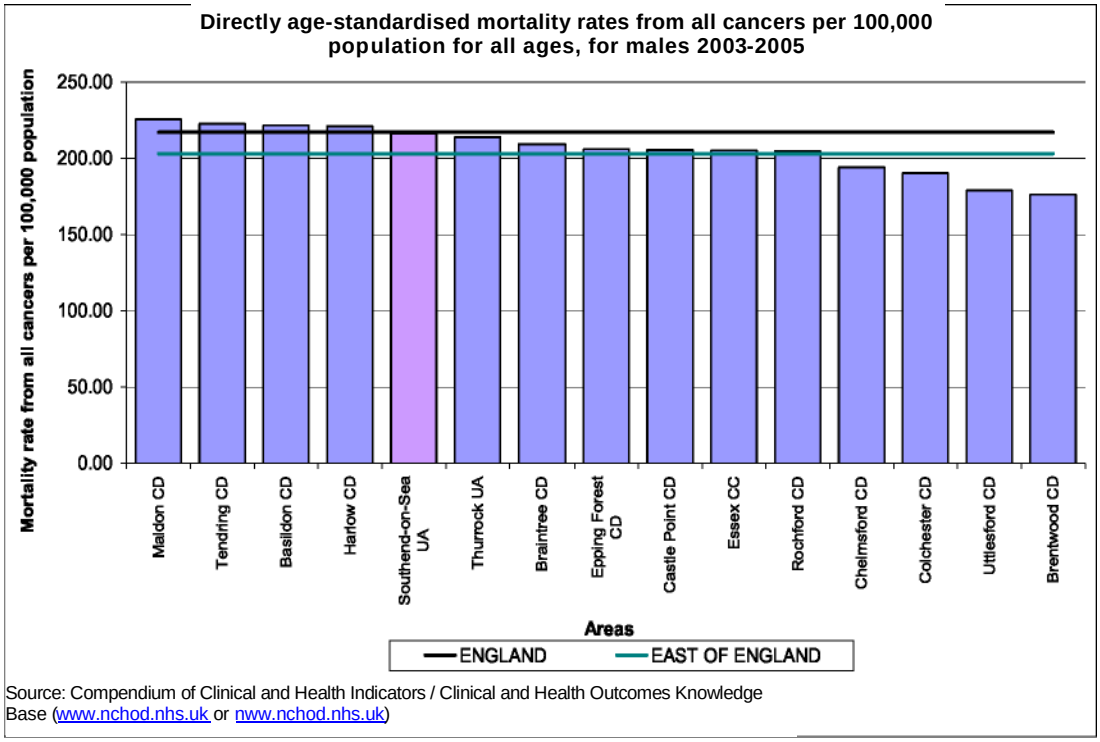
Figure 3.17 shows that there was an initial reduction in the mortality rate for all cancers for females of all ages from 1993/95, but this trend reversed in 1999/2001 and increased slightly before appearing to level off. The mortality rate for all cancers for females of all ages is now above that of England, East of England and Essex.

Figure 3.17: Directly age-standardised mortality rates for all cancers per 100,000 population for all ages (three year rolling average)



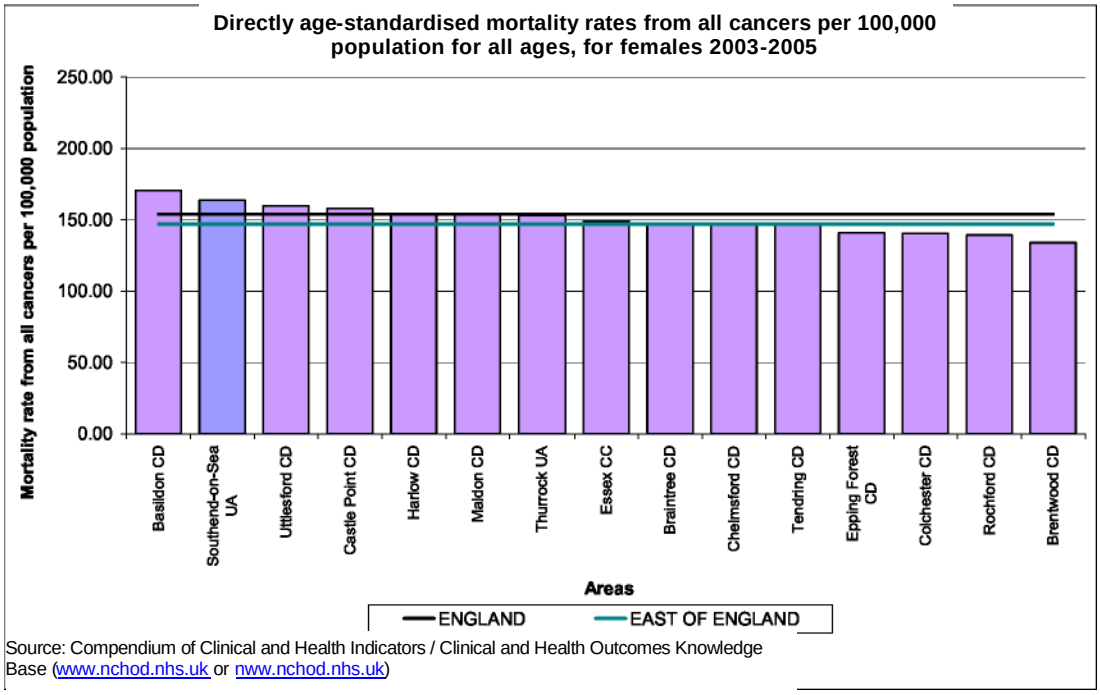
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.18: Directly age-standardised mortality rates for all cancers per 100,000 population for all ages – males 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.19: Directly age-standardised mortality rates for all cancers per 100,000 population for all ages – females 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

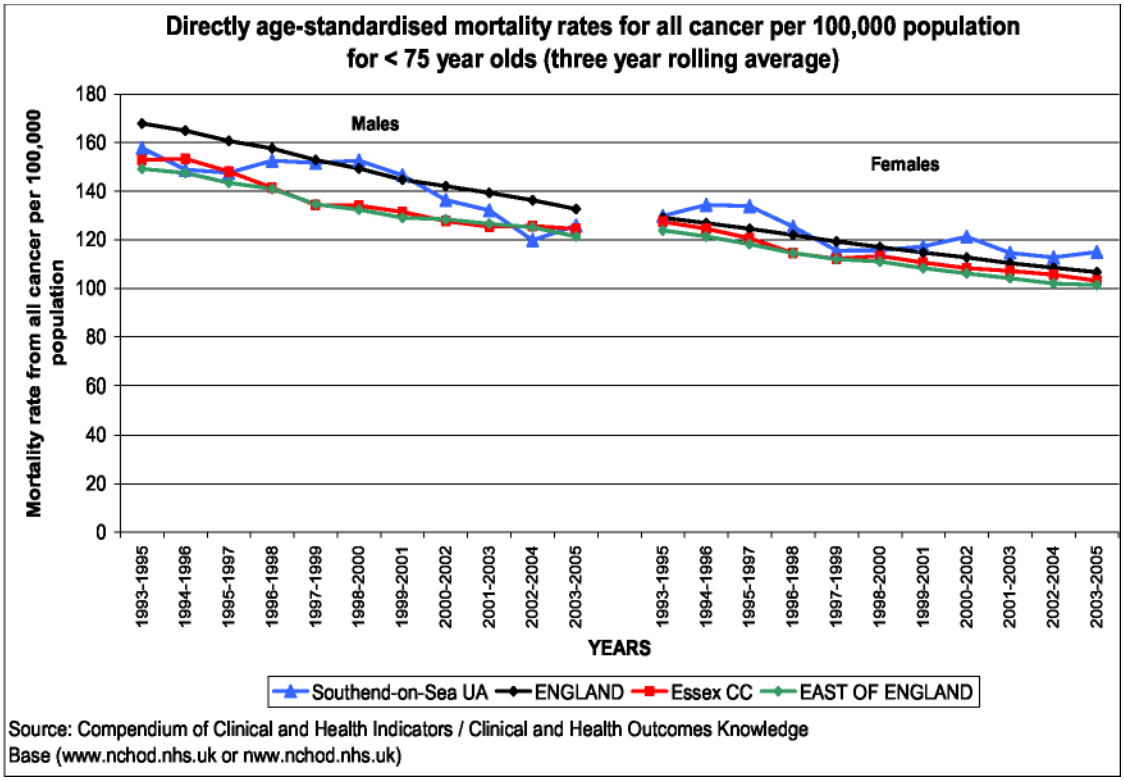
Under 75 year olds

The trend in the all cancer mortality for males under 75 year olds in Southend has shown a variable picture over the last 10 years. The initial downward trend reversed in 1996/98 and then levelled off for a short period before resuming a downward trend. This improvement has slowed down in recent years and the male rate for Southend is now similar to that of Essex and East of England, and below the national rate (Figure 3.20)

The all cancer mortality rate for females under 75 years in Southend has also shown some improvement but for the most part has remained above the regional and national average.

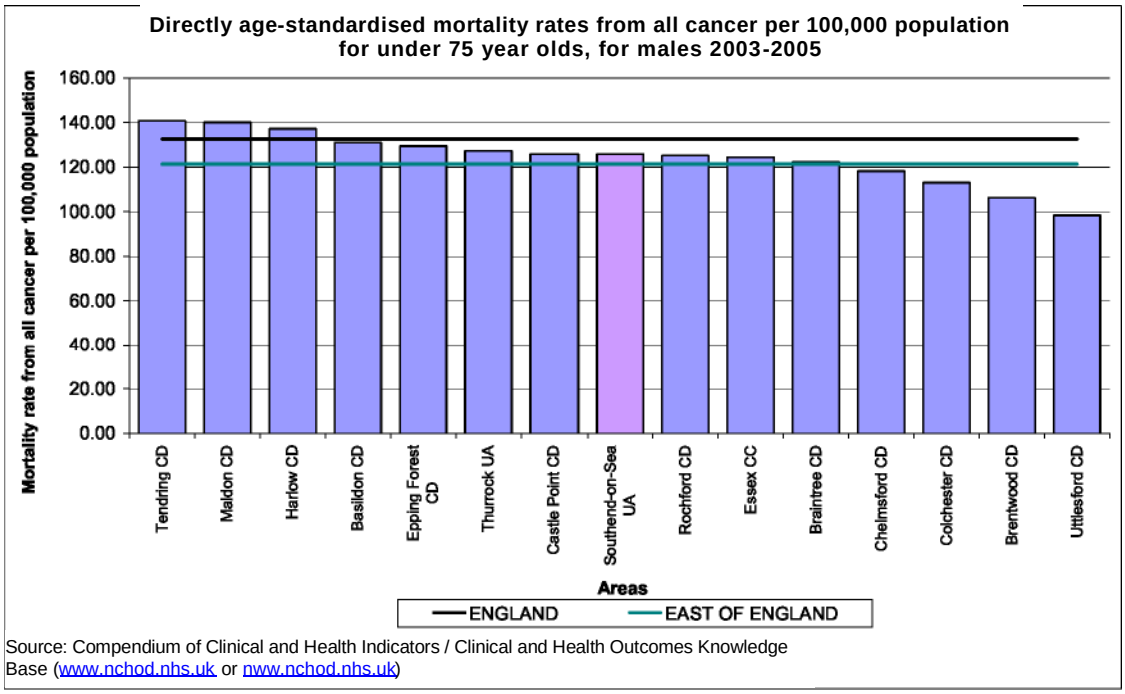
When examining all cancer mortality rates in all persons under 75 years old at MSOA level, the rate in 10 out of the 17 MSOAs in Southend is at or above the average across Essex (Figure 3.23). This picture is similar for males and females (Figures 3.24 and 3.25).

Figure 3.20: Directly age-standardised mortality rates for all cancers per 100,000 population for under 75s (three year rolling average)



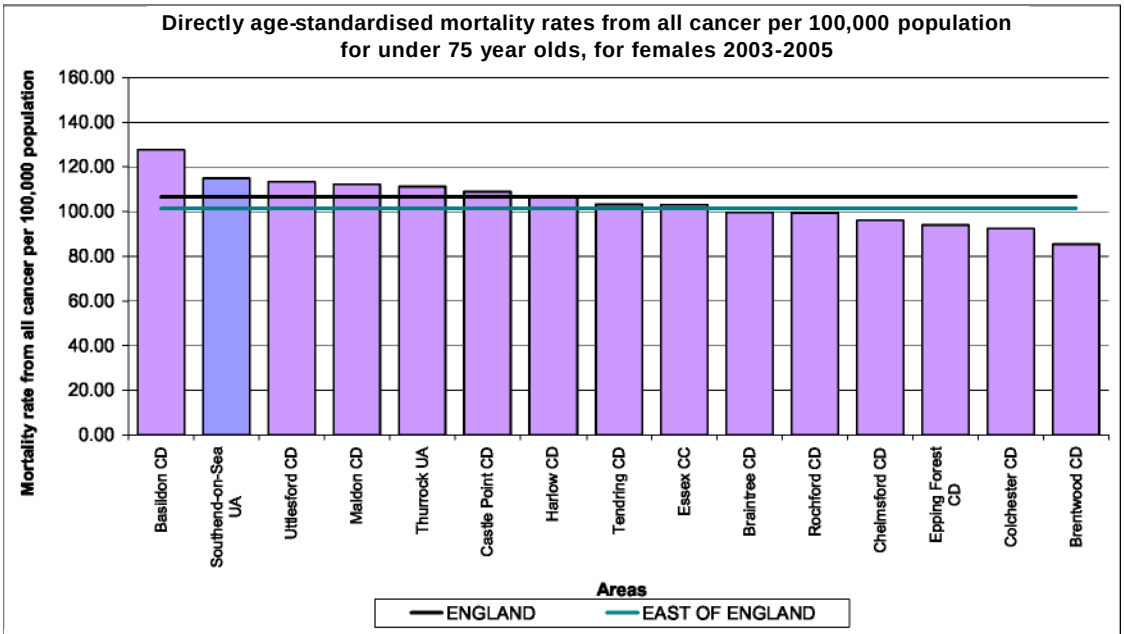
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.21: Directly age-standardised mortality rates for all cancers per 100,000 population for under 75s – males 2003-2005



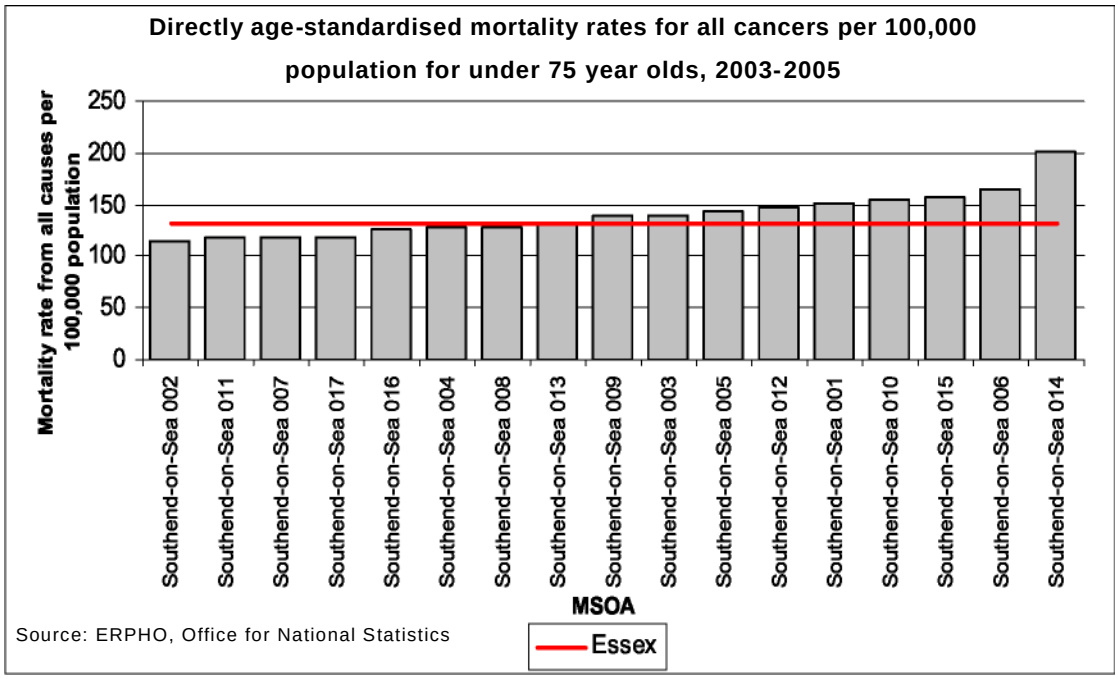
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.22: Directly age-standardised mortality rates for all cancers per 100,000 population for under 75s – females 2003-2005



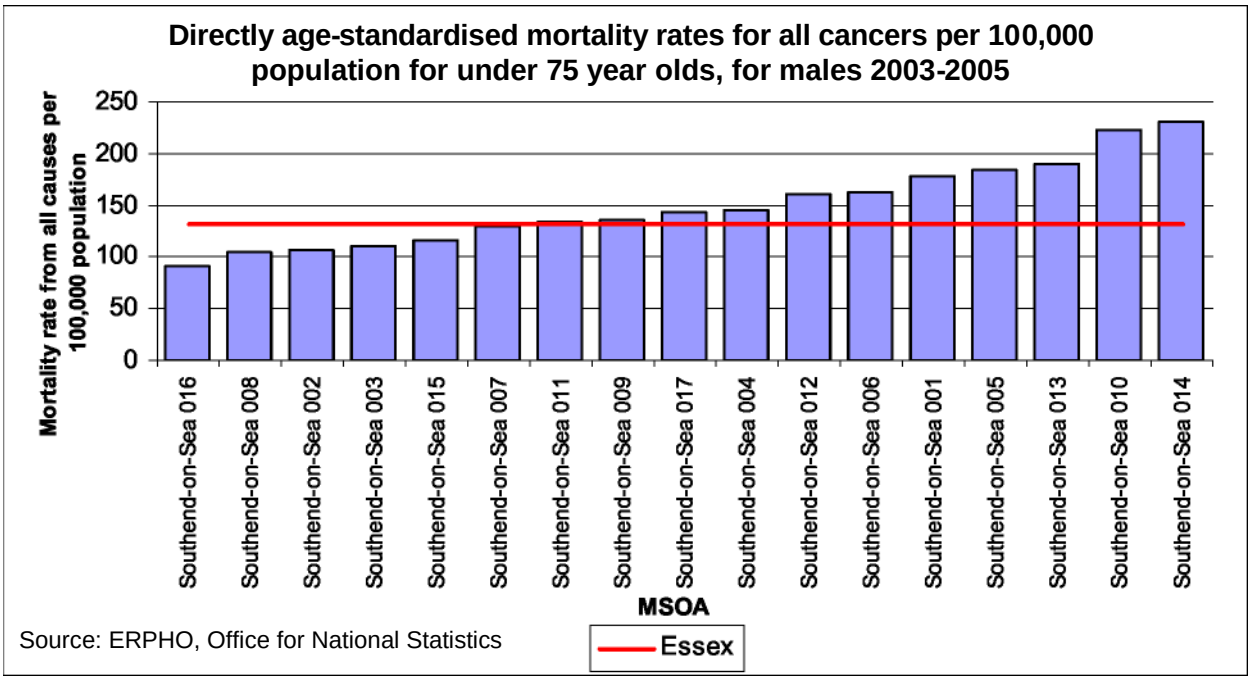
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.23: Directly age-standardised mortality rates for all cancers per 100,000 population for under 75s – by MSOA 2003-2005



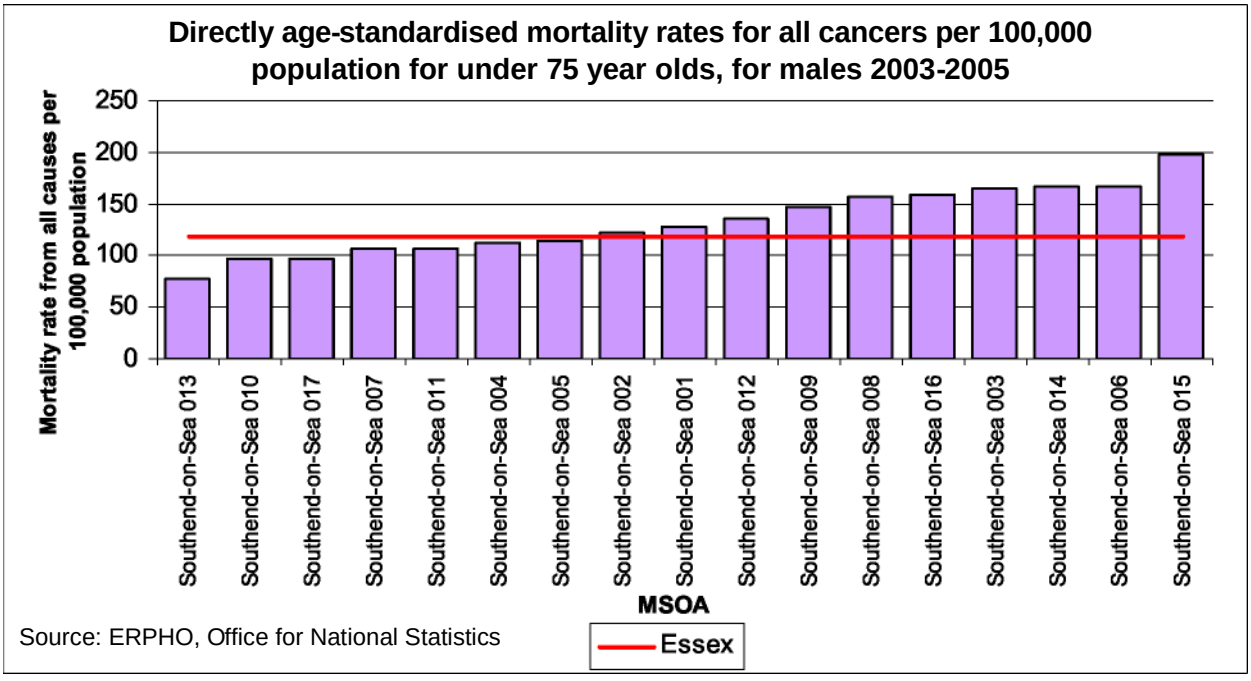
Source: ERPHO, Office for National Statistics

Figure 3.24: Directly age-standardised mortality rates for all cancers per 100,000 population for under 75s – by ward 2003-2005 - Males



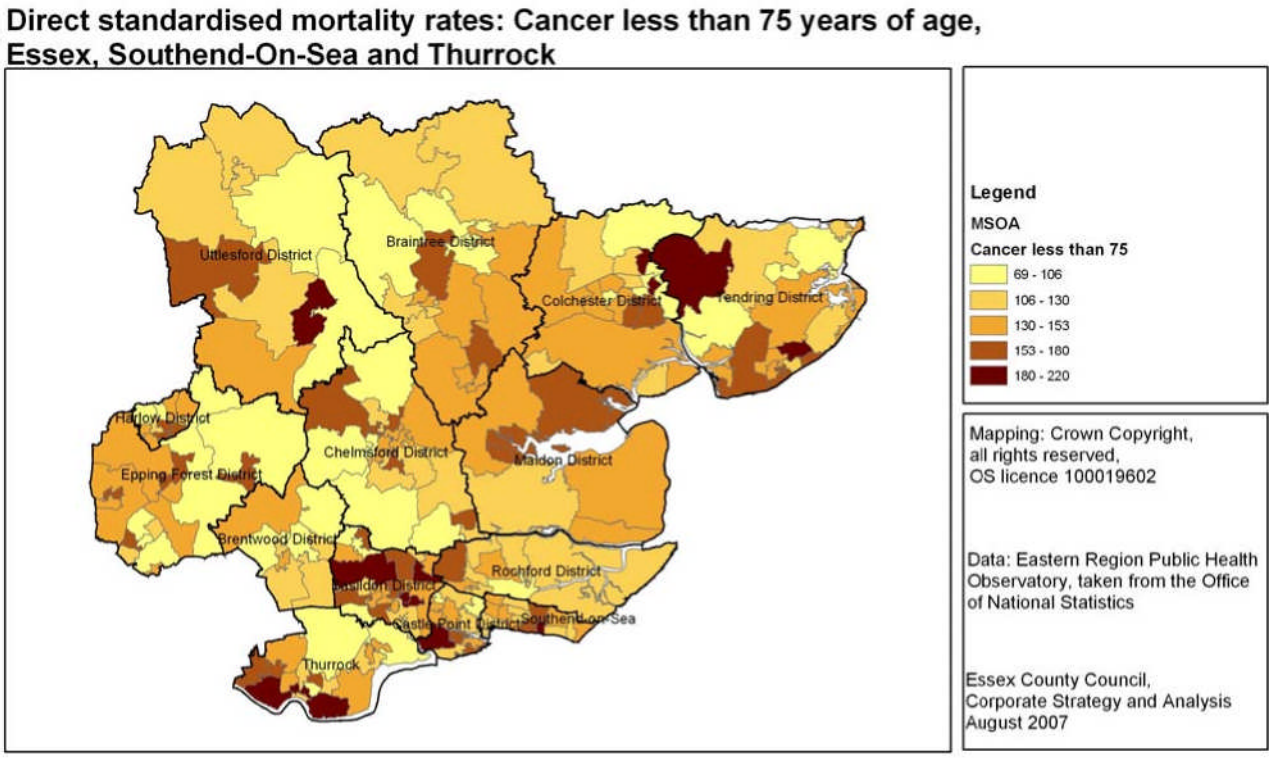
Source: ERPHO, Office for National Statistics

Figure 3.25: Directly age-standardised mortality rates for all cancers per 100,000 population for under 75s – by ward 2003-2005 - Females



Source: ERPHO, Office for National Statistics

Figure 3.26: Direct standardised mortality rates – Cancer under 75s – Essex, Southend and Thurrock MSOA



3.2.3 Lung Cancer all ages

The lung cancer mortality for males of all ages in Southend has shown an overall improvement in males for the last 10 years from 1993-1995. However, this has consistently been above the Essex and regional rates, and more recently has increased above the national rate (Figure 3.27).

The lung cancer mortality rate for females of all ages in Southend initially showed some improvement, but has continued to increase since 2001-2003 to overtake the national rate.

Figure 3.27: Directly standardised mortality rates for lung cancer per 100,000 population for all ages

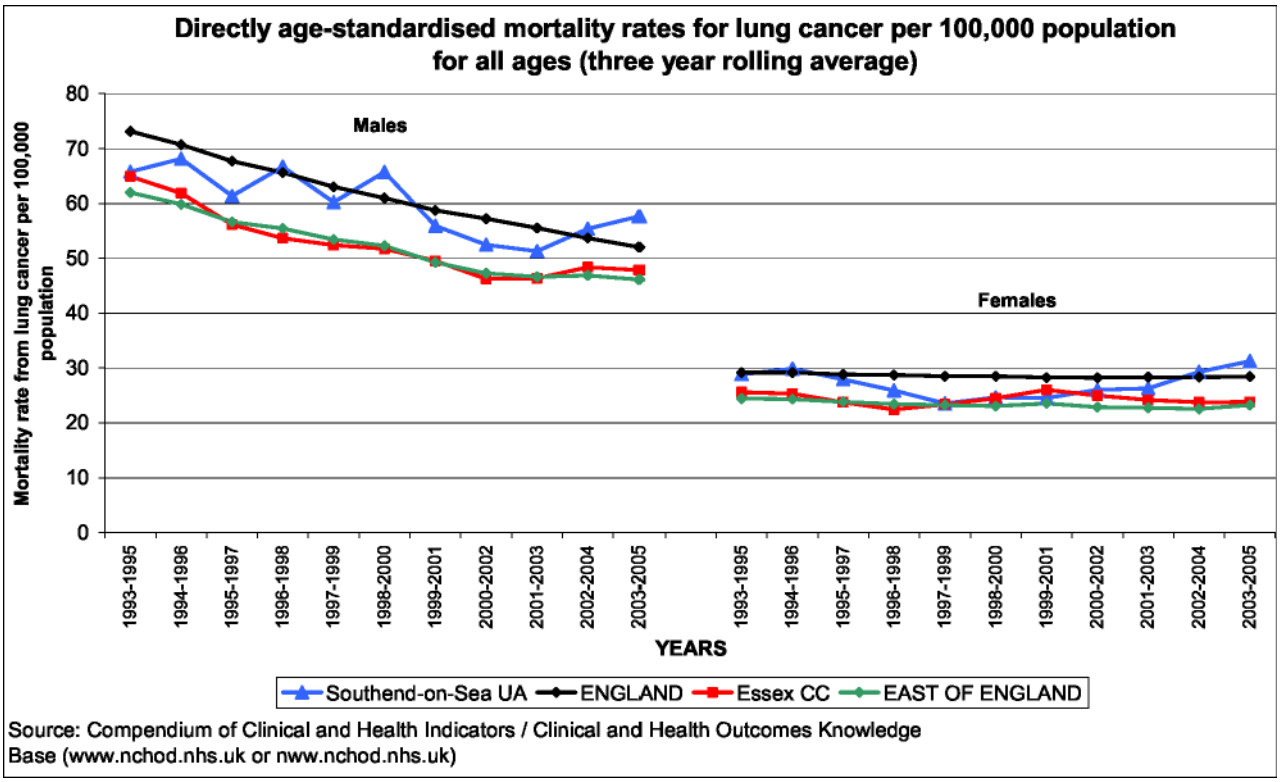


Figure 3.28: Directly standardised mortality rates for lung cancer per 100,000 population for all ages - Males

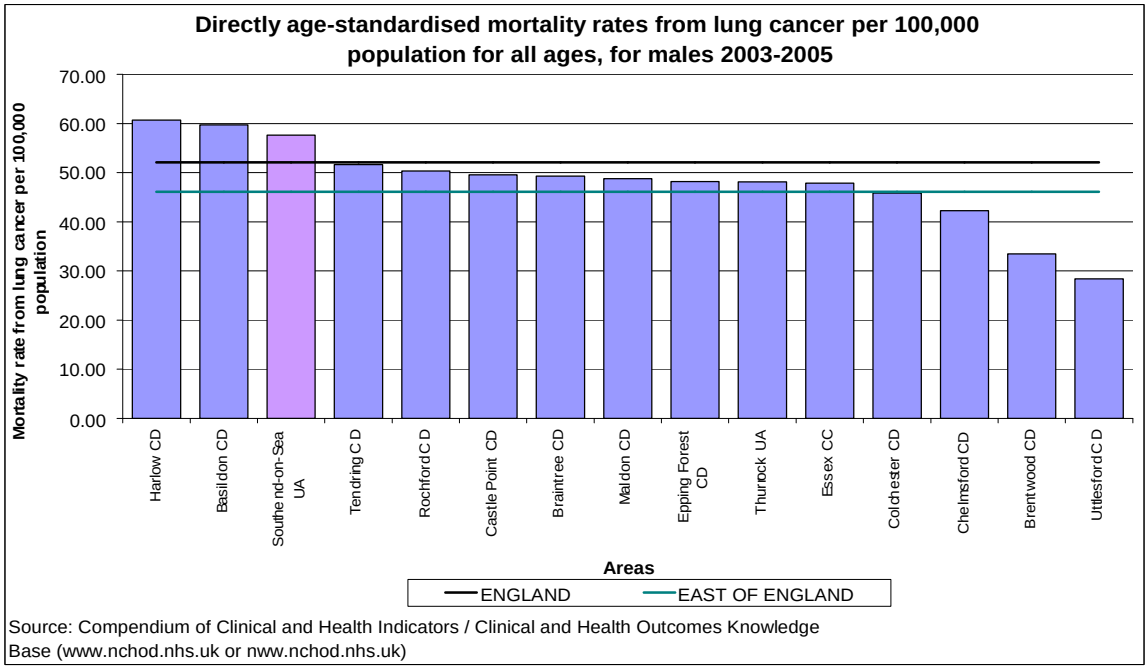
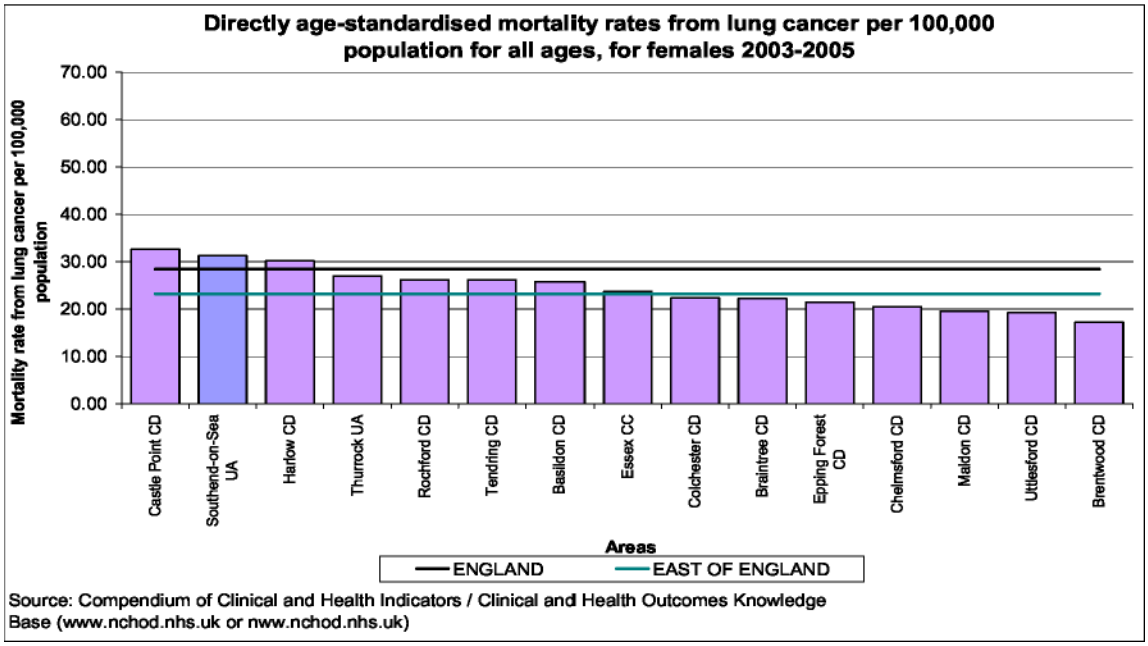


Figure 3.28 shows that Southend has the third highest death rate from lung for males of all ages compared with the rest of Essex, and is above the rate for England and East of England.

Southend also has the second highest death rate from lung cancer for females of all ages compared with the rest of Essex. It is also above the rate for England and East of England.

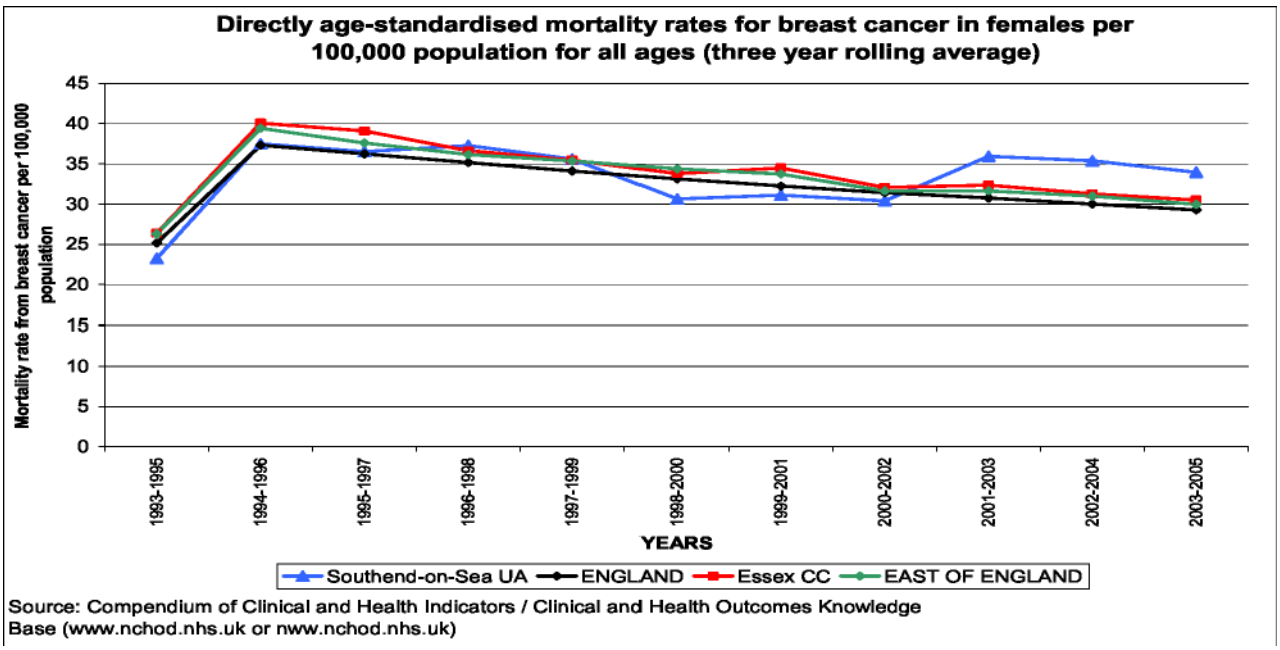
Figure 3.29: Directly standardised mortality rates for lung cancer per 100,000 population for all ages – Females (2003-2005)



3.2.4 Breast Cancer

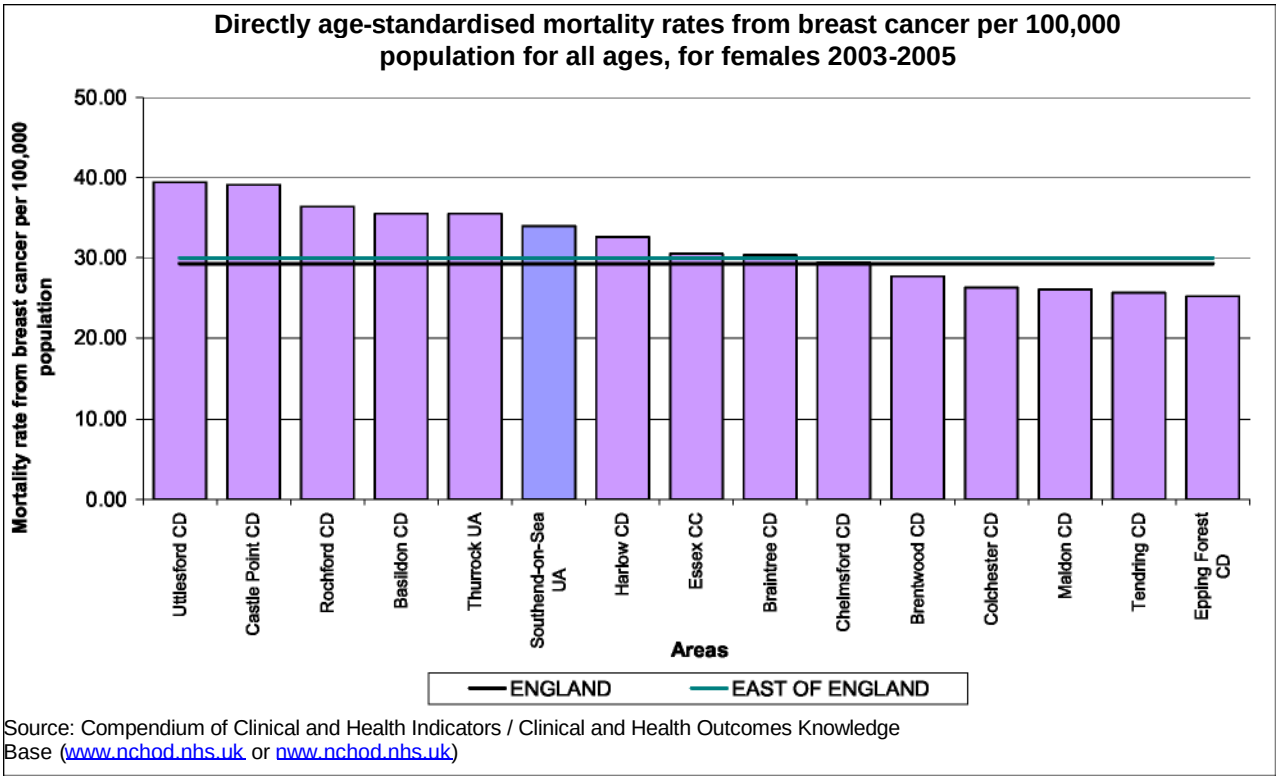
The breast cancer mortality in females for all ages in Southend steadily improved from 1994-1996 until 2000-2002, when it was below the national, regional and county levels. However, this trend was reversed in 2001-2003 when the rate increased again to overtake the national level.

Figure 3.30: Directly standardised mortality rates for breast cancer per 100,000 population for all ages



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.31: Directly standardised mortality rates for breast cancer per 100,000 population for all ages - Females

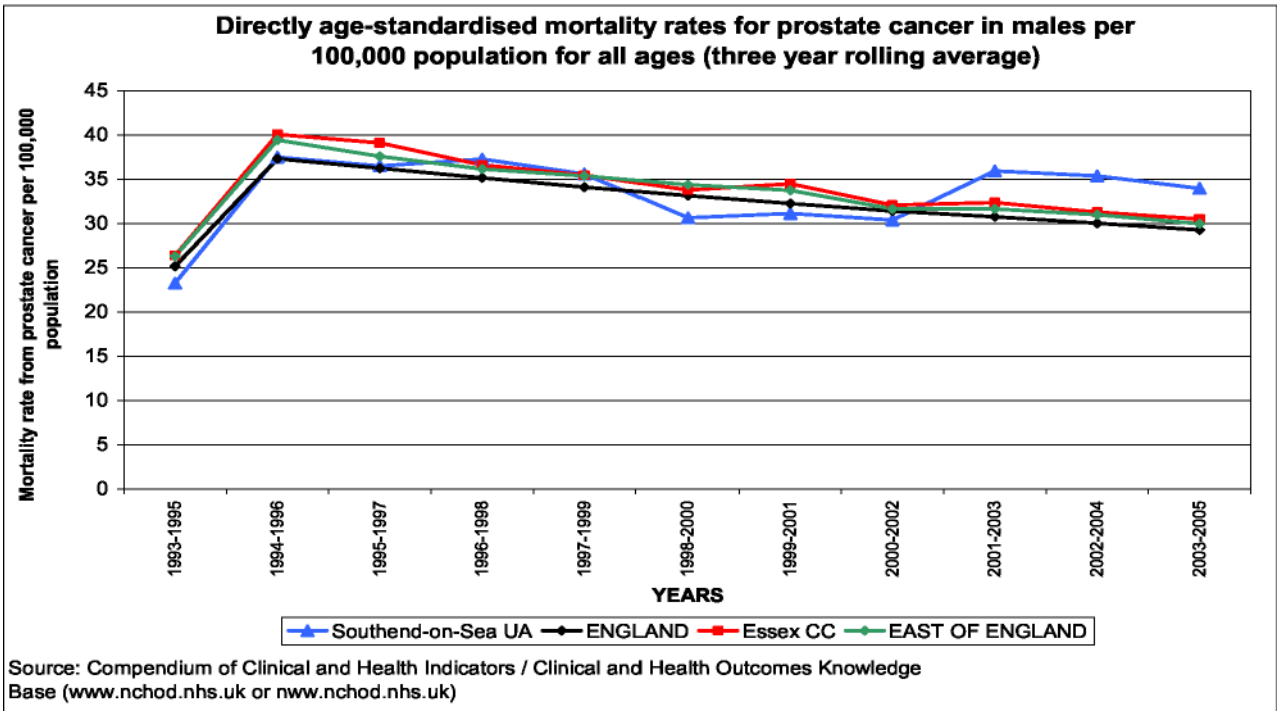


Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

3.2.5 Prostate Cancer

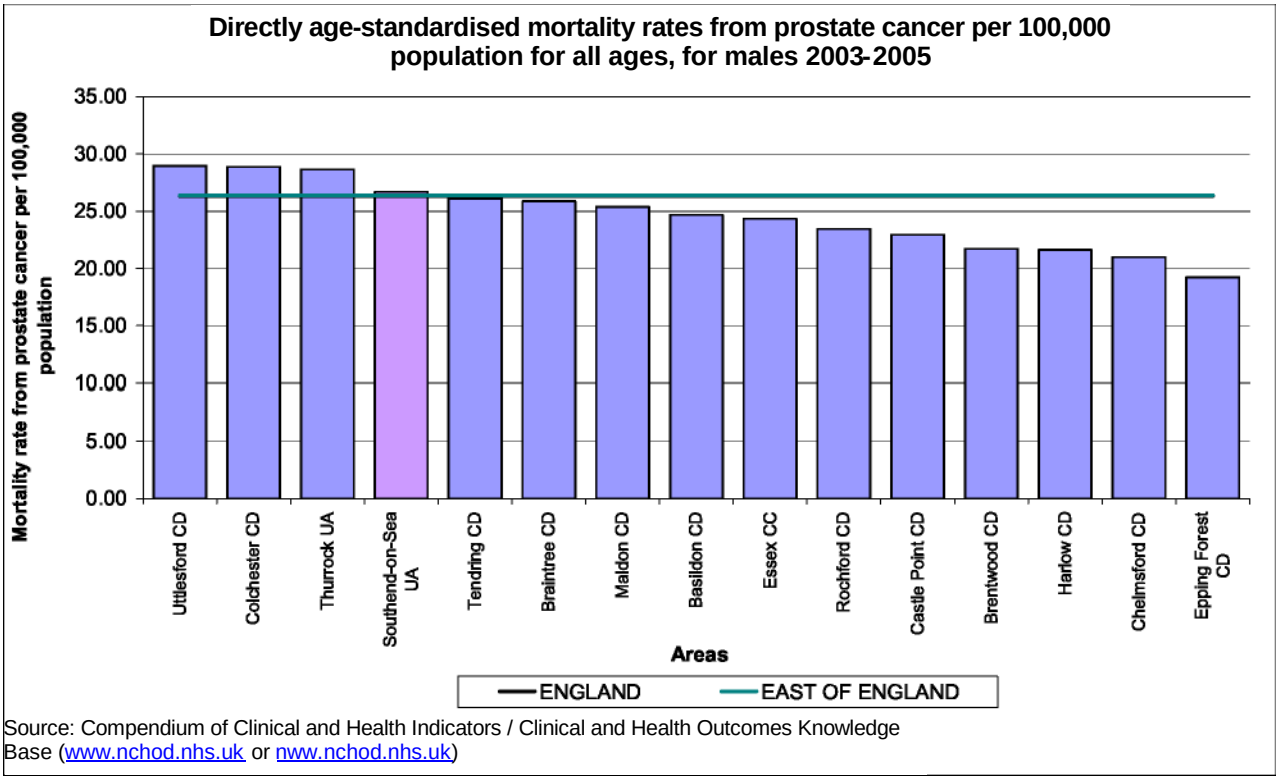
The prostate cancer mortality for males of all ages in Southend has shown a steady improvement from 1995-1997 to 2000-2002. However, this trend reversed in 2001-2003, and even though is has continued to fall since, it still remains above national, regional and county average.

Figure *3.32:* Directly standardised mortality rates for prostate cancer per 100,000 population for all ages - males



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.33: Directly standardised mortality rates for prostate cancer per 100,000 population for all ages – males 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

3.2.6 Circulatory Diseases Mortality

All ages

The circulatory disease mortality rate for males of all ages in Southend has shown a steady improvement since 1996-1 998, and is now below the national rate. Circulatory disease mortality rates in females of all ages in Southend have also shown an improvement, and after a slight increase during 1999-2001, the rate has continued to fall to below the national rate. However, both the male and female circulatory disease mortality rates for all ages are consistently above the regional and county rates (Figure 3.34).

Figure 3.34: Directly standardised mortality rates for circulatory diseases per 100,000 population for all ages

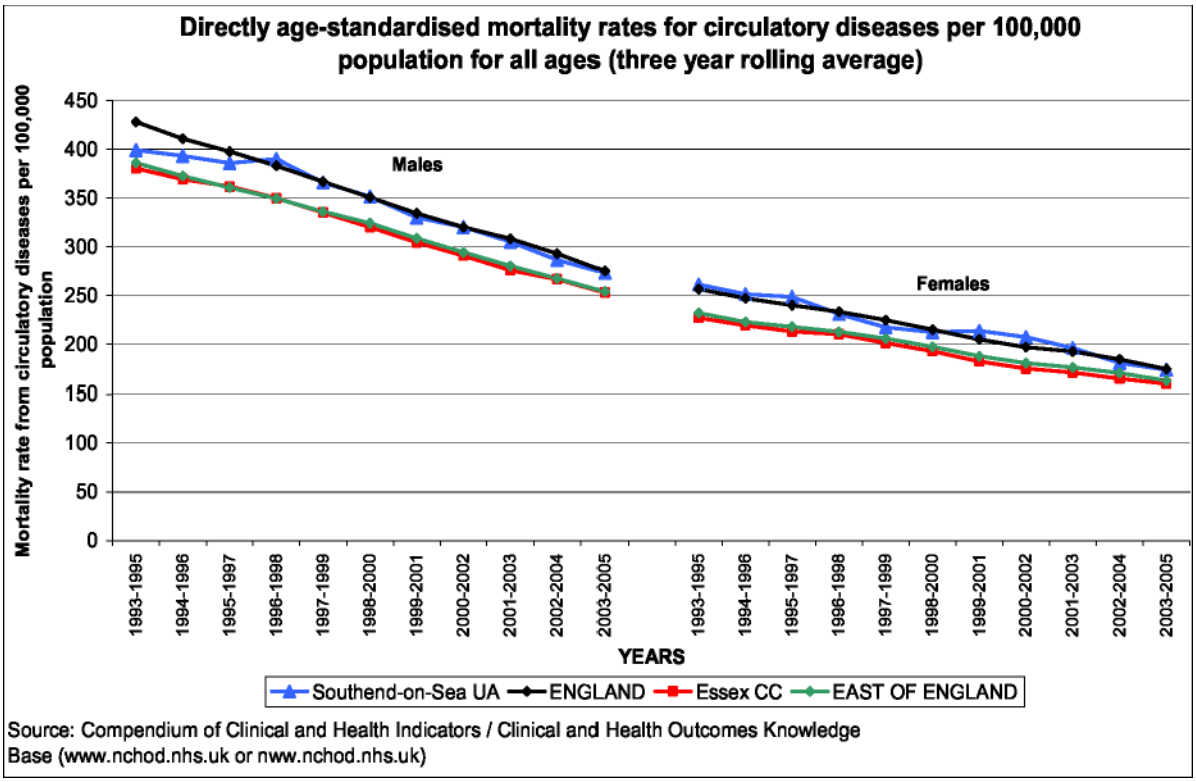


Figure 3.35: Directly standardised mortality rates for circulatory diseases per 100,000 population for all ages – Males 2003-2005

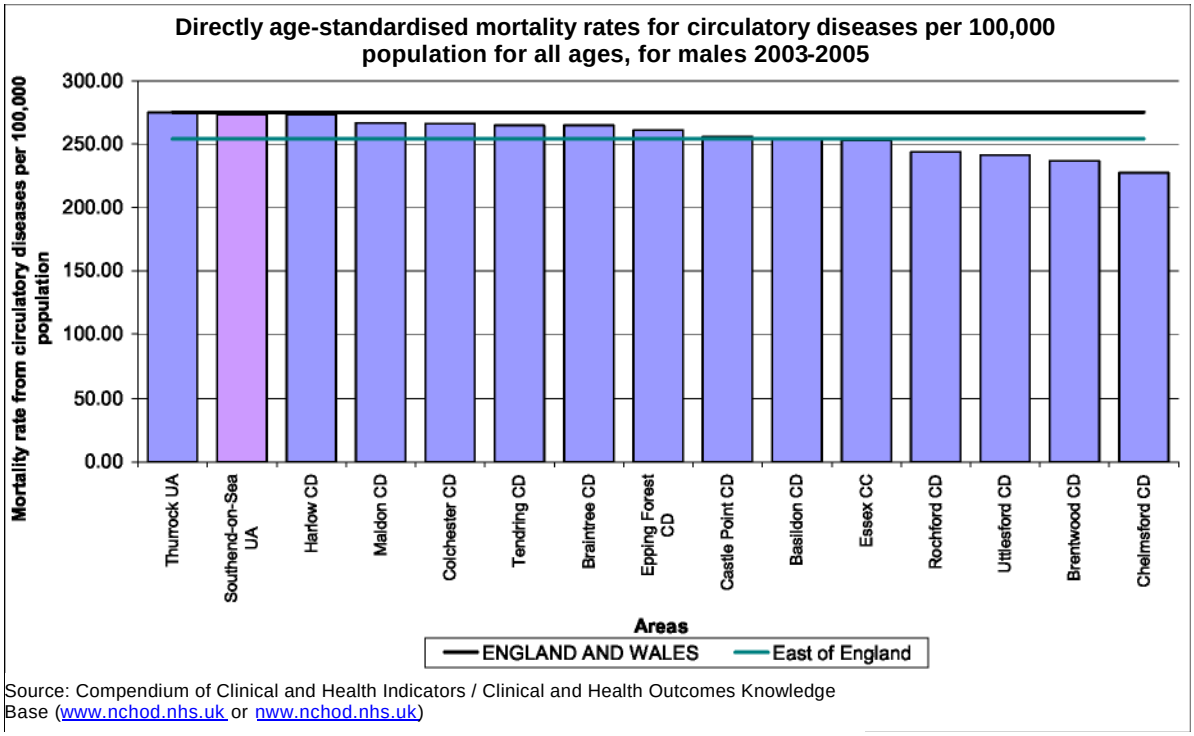
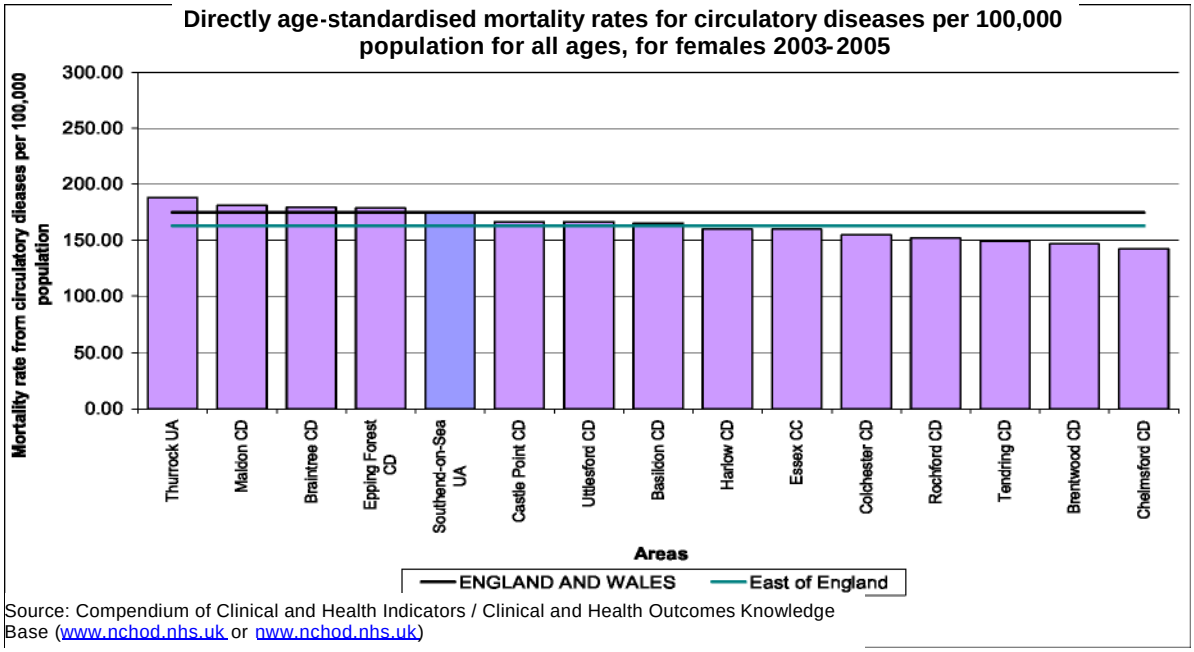


Figure 3.36: Directly standardised mortality rates for circulatory diseases per 100,000 population for all ages – Females 2003-2005



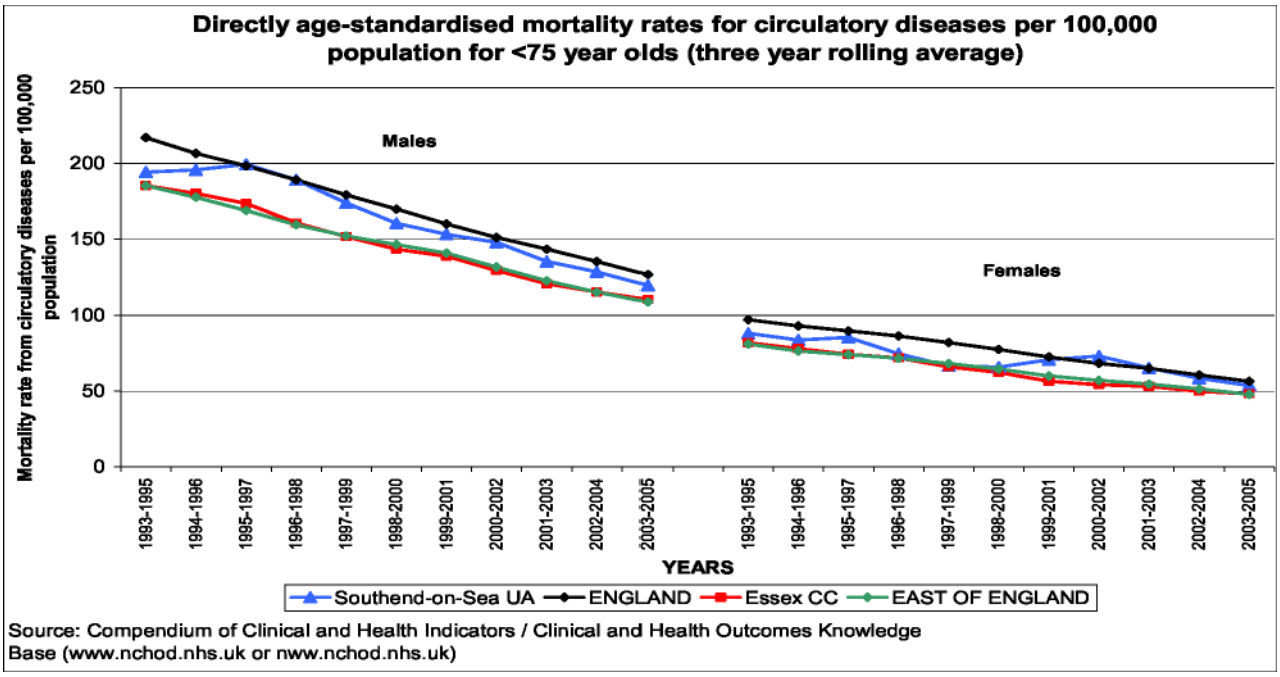
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Circulatory disease mortality rates in under 75 year olds

The circulatory disease mortality for males under 75 year olds in Southend has shown a steady improvement since 1995-1997, but remains consistently above the regional and county rates (Figure 3.37).

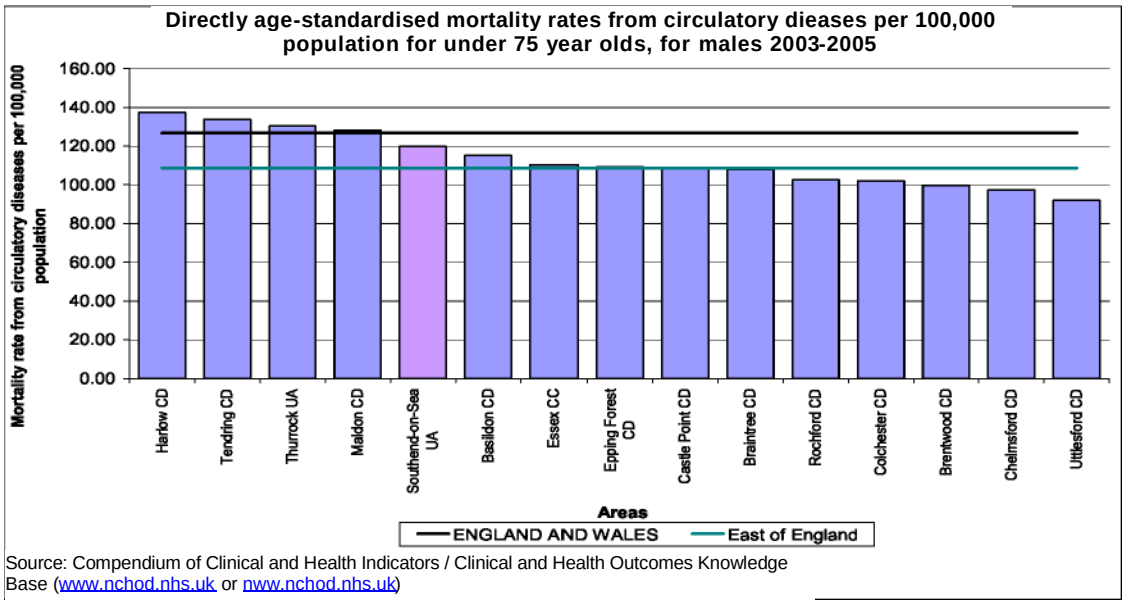
The circulatory disease mortality rate for females under 75 years old has also shown an overall improvement, although from 1998/2000 to 2000/2002 the mortality rate actually increased before continuing to fall. It has now fallen to below the national rate but is slightly above the county and regional rates (Figure 3.37).

Figure 3.37: Directly standardised mortality rates for circulatory diseases per 100,000 population for under 75s



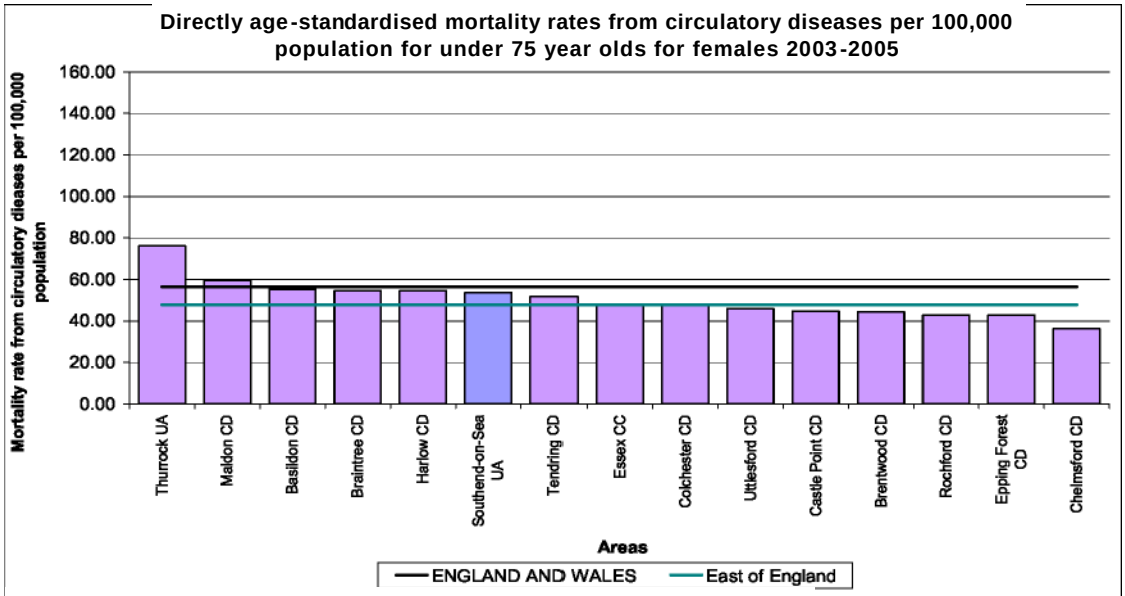
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.38: Directly standardised mortality rates for circulatory diseases per 100,000 population for under 75s – males 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

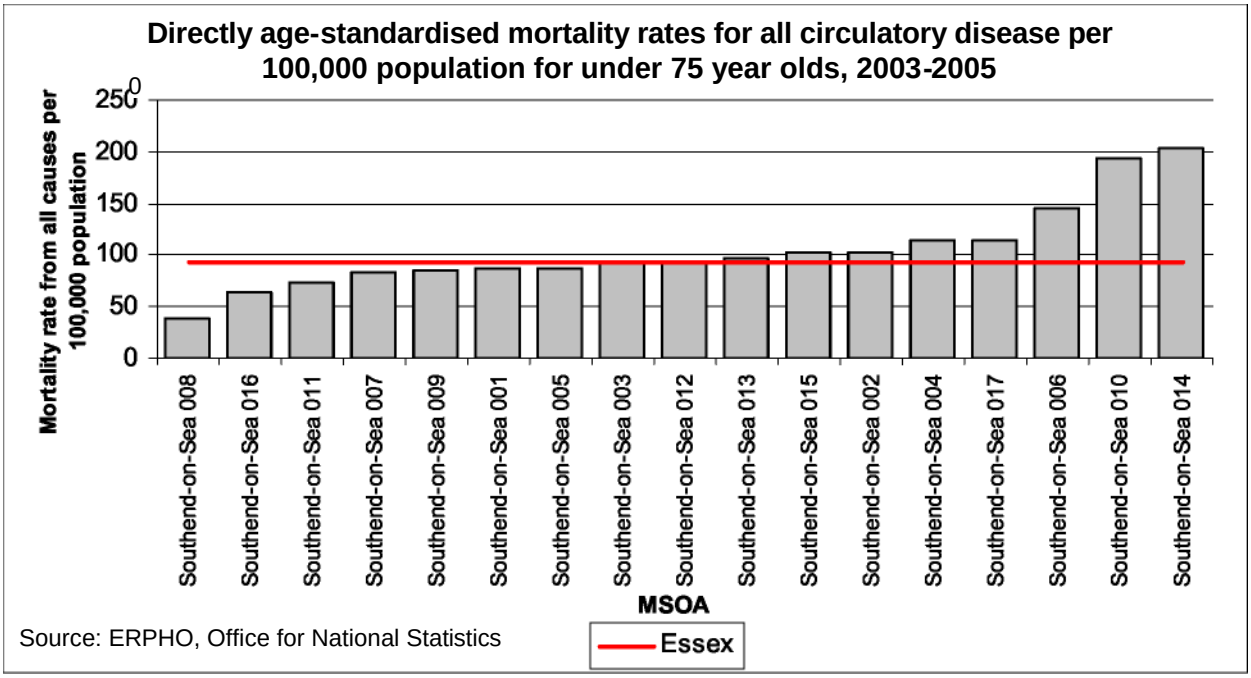
Figure 3.39: Directly standardised mortality rates for circulatory diseases per 100,000 population for under 75s – females 2003-2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

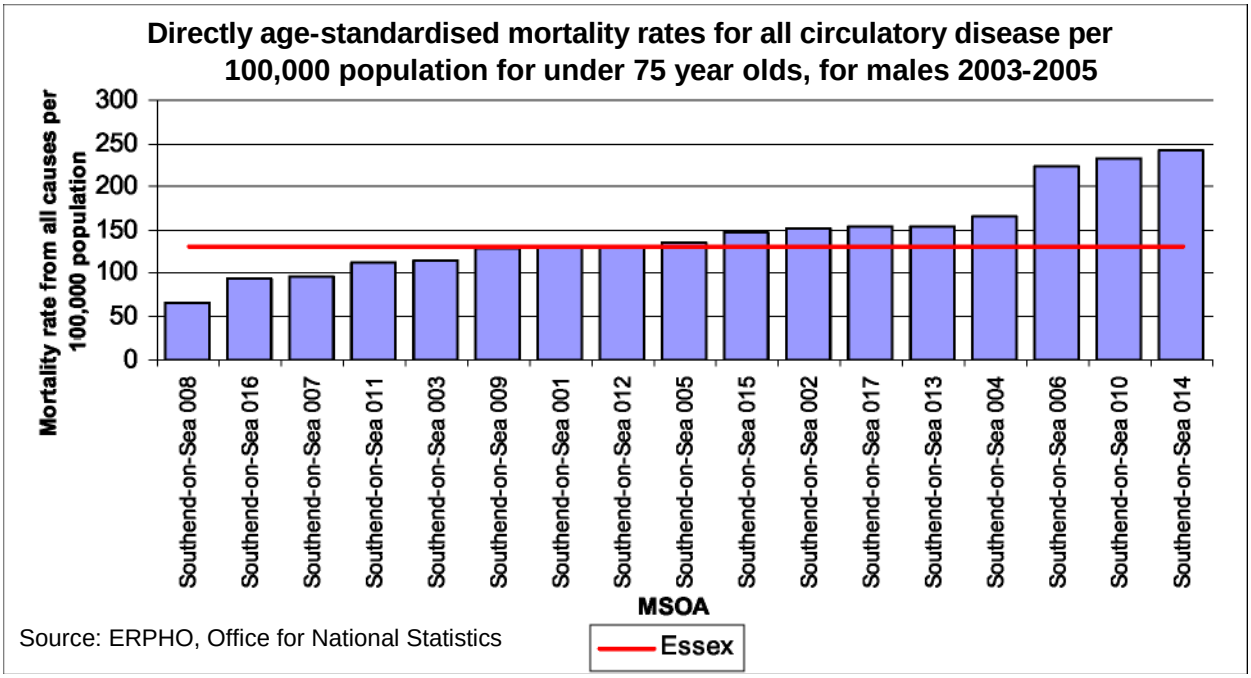
When examining circulatory disease mortality in under 75 year olds at MSOA level we can see that there is an almost five fold variation across Southend for males (Figure 3.41) and an eight fold variation for females (Figure 3.42).

Figure 3.40: Directly standardised mortality rates for circulatory diseases per 100,000 population for under 75s by Medium Super Output Area (2003-2005)



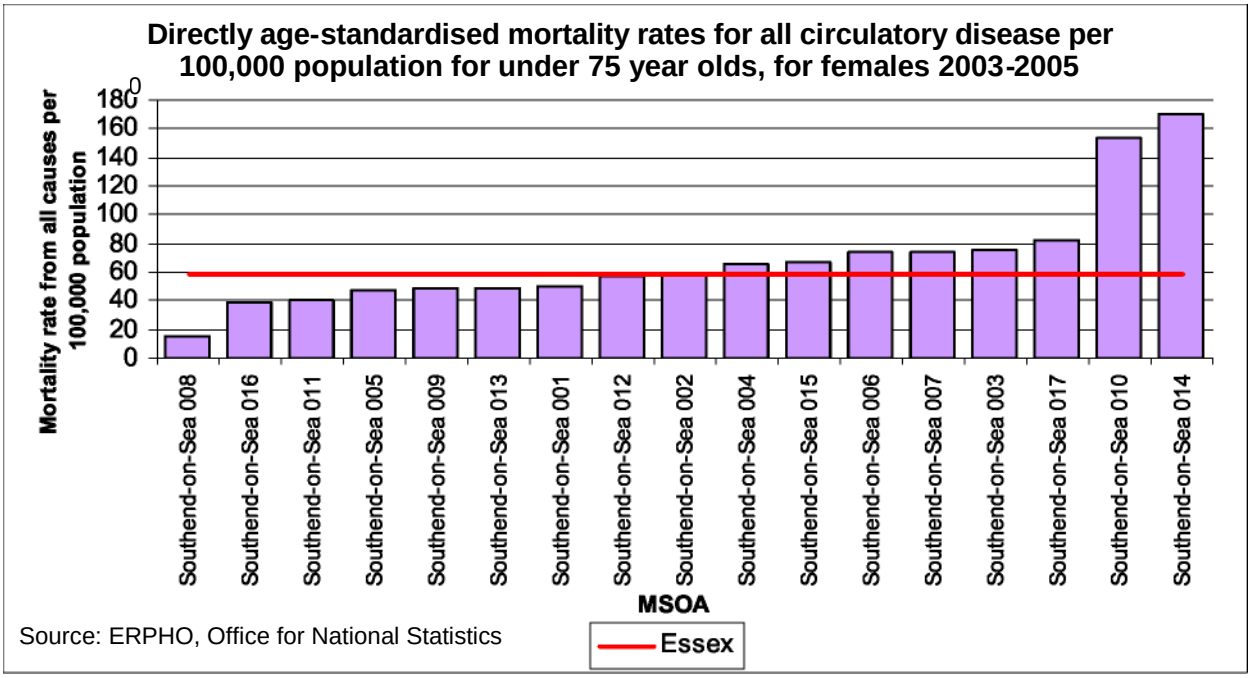
Source: ERPHO, Office for National Statistics

Figure 3.41: Directly standardised mortality rates for circulatory diseases per 100,000 population for males under 75s by Medium Super Output Area (2003-2005)



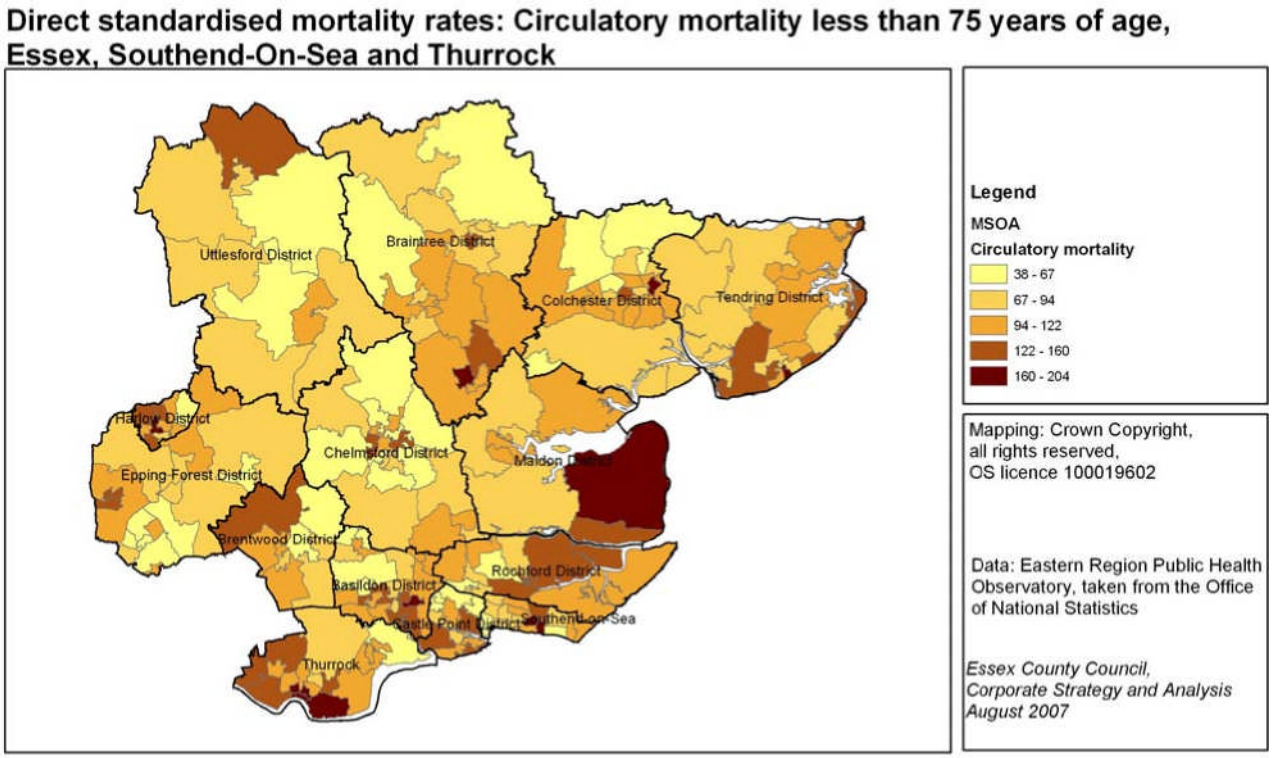
Source: ERPHO, Office for National Statistics

Figure 3.42: Directly standardised mortality rates for circulatory diseases per 100,000 population for females under 75s by Medium Super Output Area (2003-2005)



Source: ERPHO, Office for National Statistics

Figure 3.43: Direct standardised mortality rates – circulatory mortality less than 75 years, Essex, Southend and Thurrock



3.2.7 Respiratory Diseases Mortality

Mortality rate from bronchitis, emphysema and other chronic obstructive pulmonary disease - all ages

The mortality rate from bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD) for males of all ages in Southend has shown an overall improvement over the last 10 years. However, the initial steep decline in mortality from these conditions from 1993-1995 to 1996-1998 was reversed in 1997-1999, when rates continued to rise for 4 consecutive years before starting to fall again to reach the national level by 2003-2005 (Figure 3.44).

The pattern in the mortality rates from bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD) for females of all ages in Southend is very similar to that for males. However, following a consistent increase in the mortality rate from 1997/99 to 2001/3, the rate then fell to below the national level (Figure 3.44).

Figure 3.44: Directly standardised mortality rates for COPD per 100,000 population for all ages

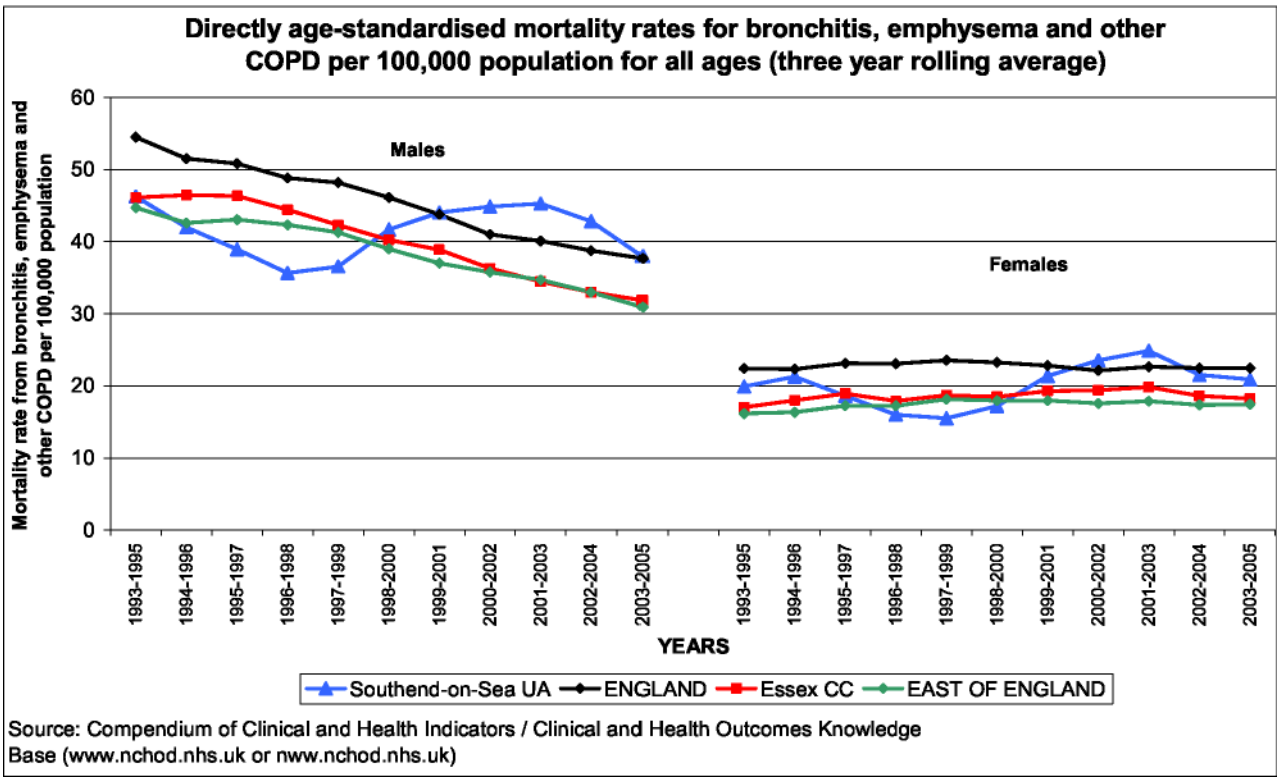


Figure 3.45: Directly standardised mortality rates for COPD per 100,000 population for all ages – males 2003-2005

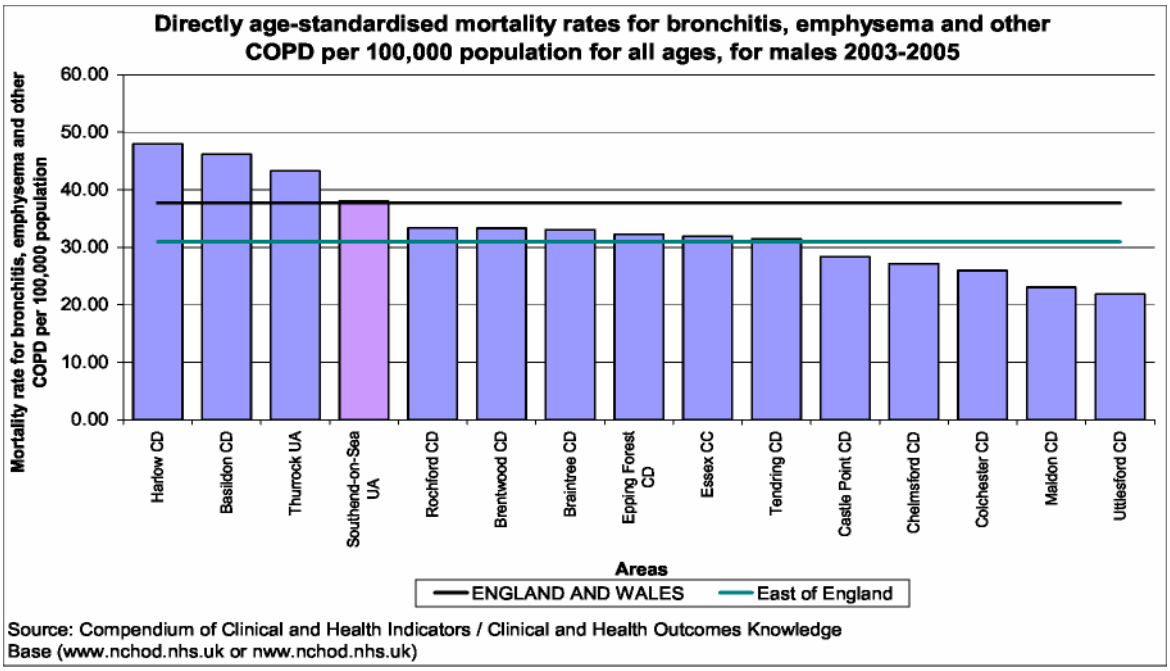
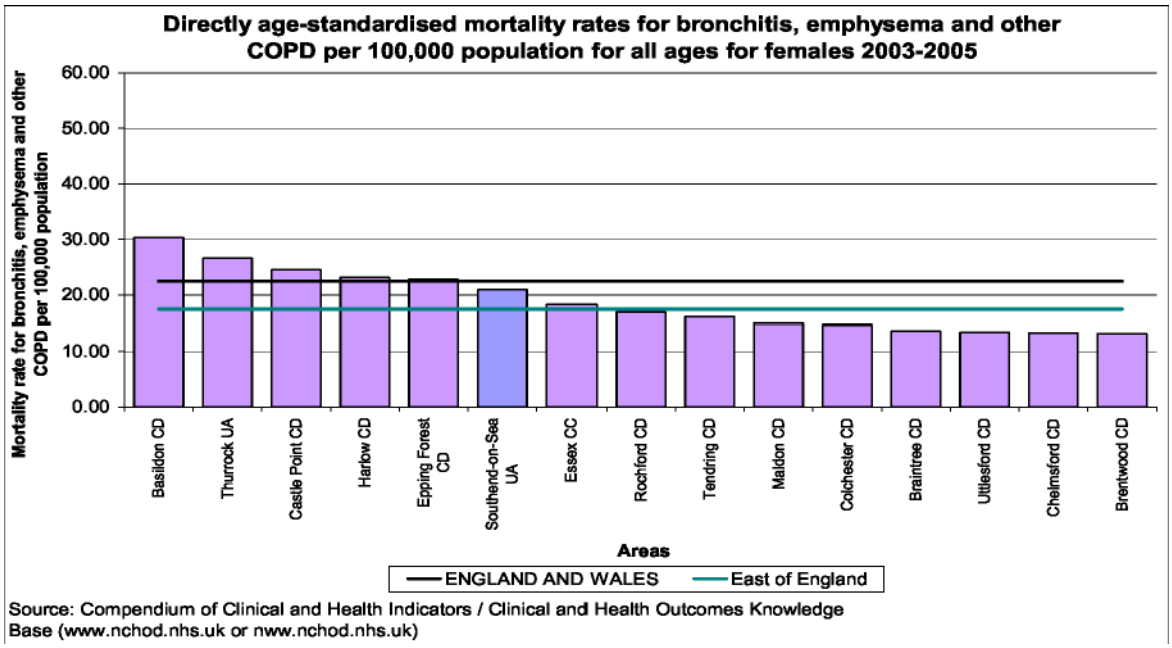


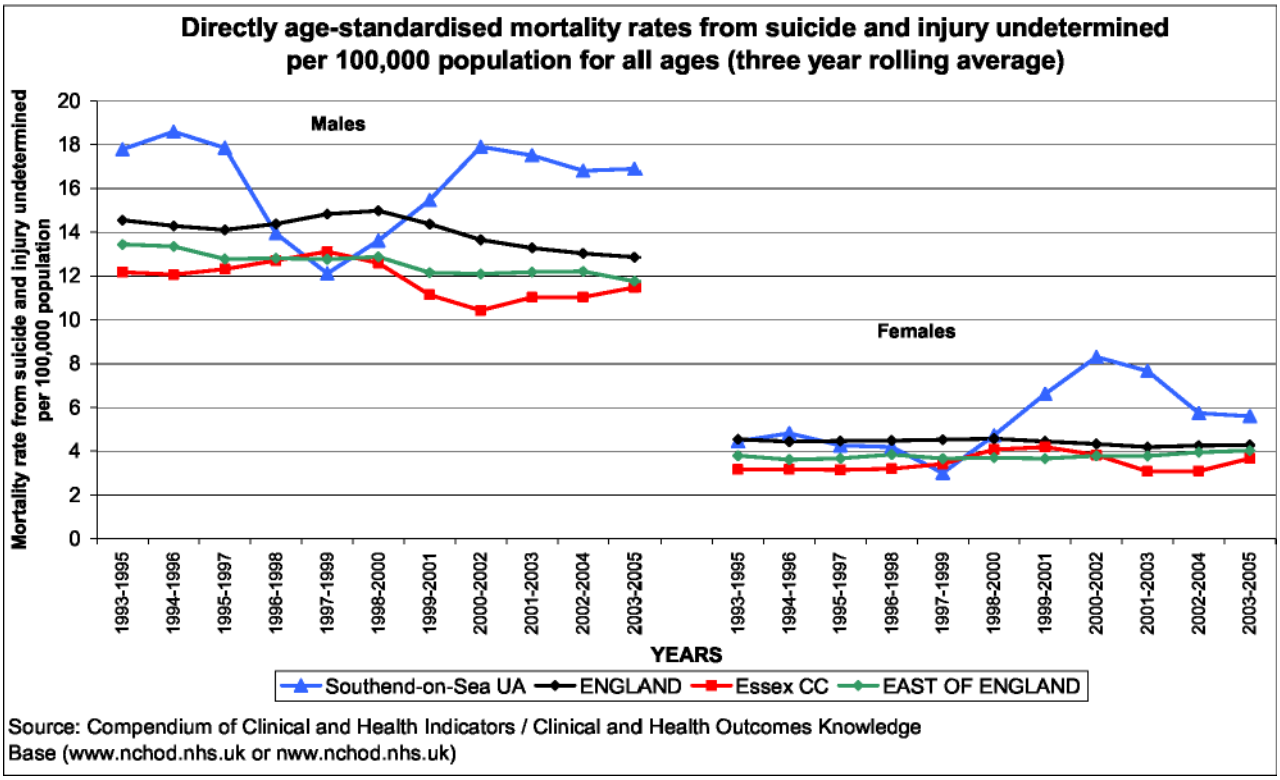
Figure 3.46: Directly standardised mortality rates for COPD per 100,000 population for all ages – females 2003-2005



3.2.8 Suicide and undetermined injury mortality rates

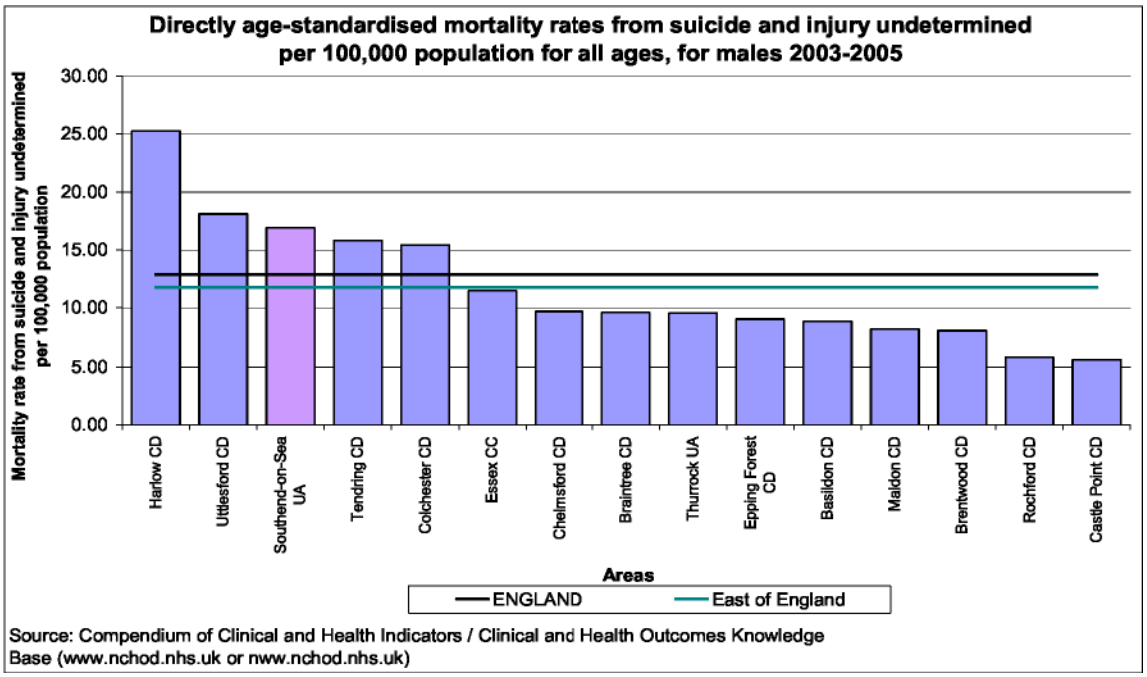
The suicide and undetermined injury mortality for all ages in Southend has shown wide fluctuations over the last 10 years. This maybe due to the small numbers involved. The male rate is considerable higher than the female rate and both have started to fall and then level off in recent years. The mortality rates from suicide and undetermined injury for both males and females in Southend the rates are above national, regional and county rates.

Figure 3.47: Directly standardised mortality rates for Suicide and undetermined injury per 100,000 population for all ages



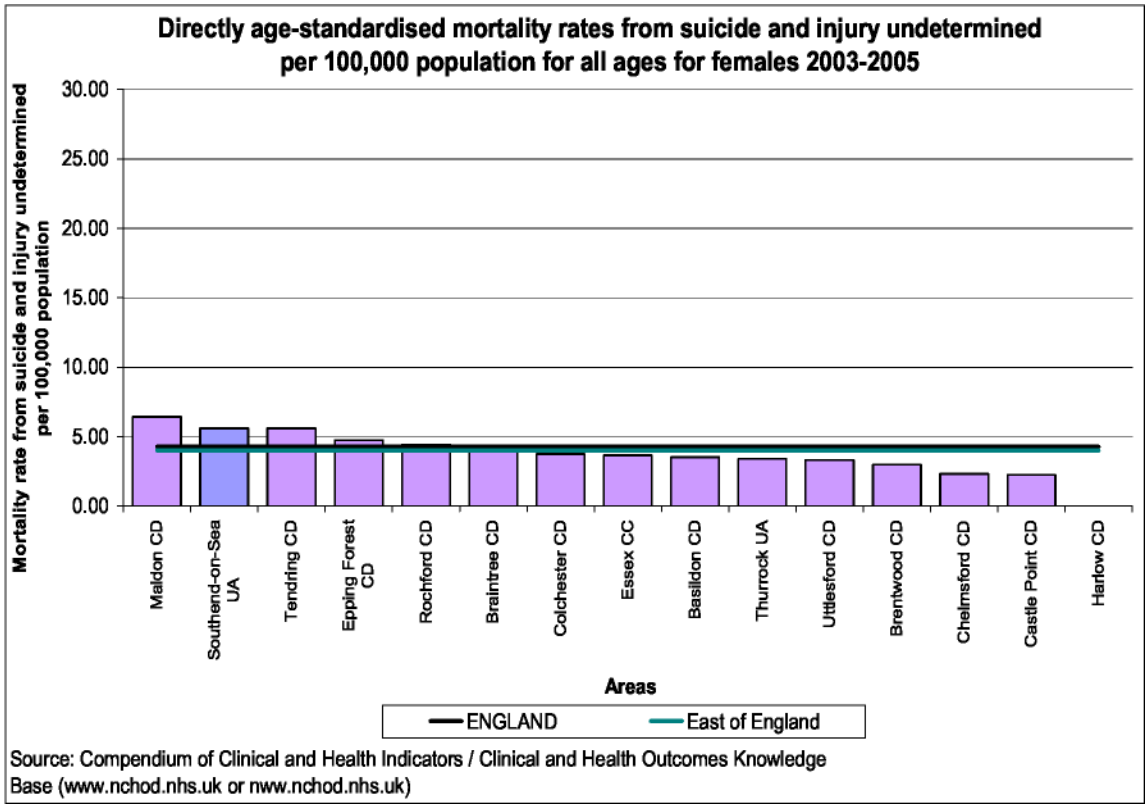
Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.48: Directly standardised mortality rates for Suicide and undetermined injury per 100,000 population for all ages - Males



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

Figure 3.49: Directly standardised mortality rates for Suicide and undetermined injury per 100,000 population for all ages - Females



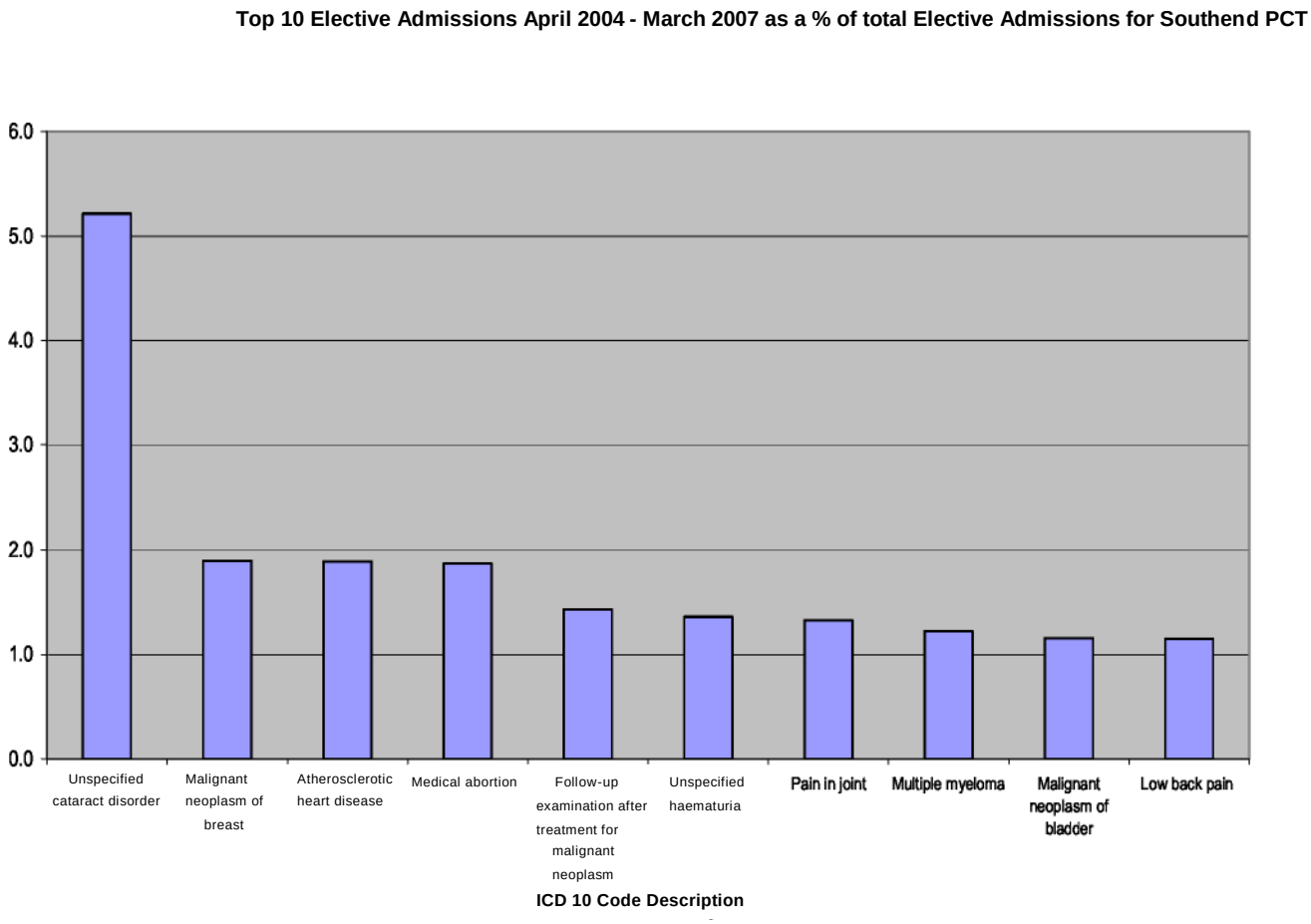
3.3 Hospital Admissions

3.3.1 Hospital Admissions by PCT

Hospital admissions between 2003-2007 were recorded in relation to the 13 Primary Care Trust configuration for Essex. Some of the PCTs boundaries were co-terminus with the local authority.

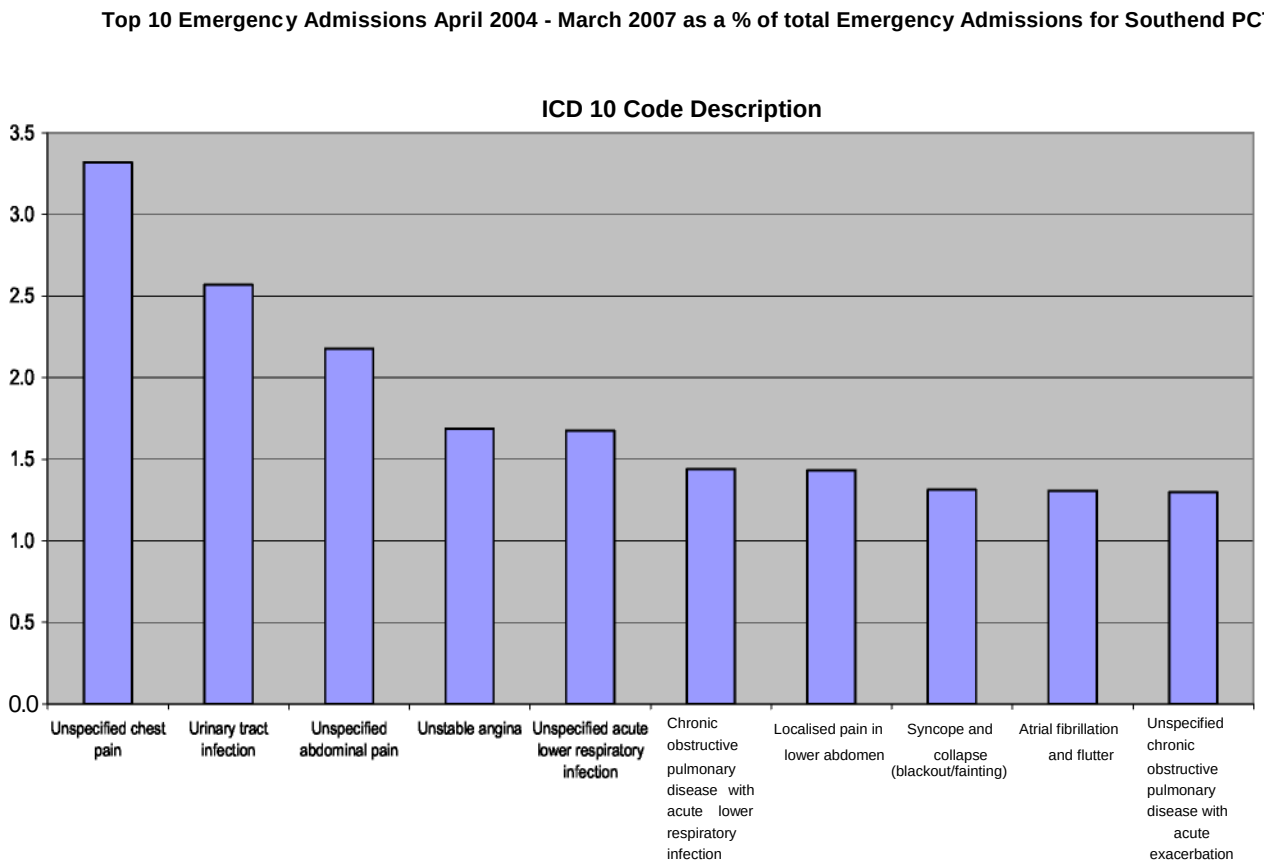
The International Classifications of Diseases (ICD) is the international standard diagnostic classification for all general epidemiological and many health management purposes. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records.

Figure 3.50: Top 10 Elective admissions to hospital for Southend 2004-2007



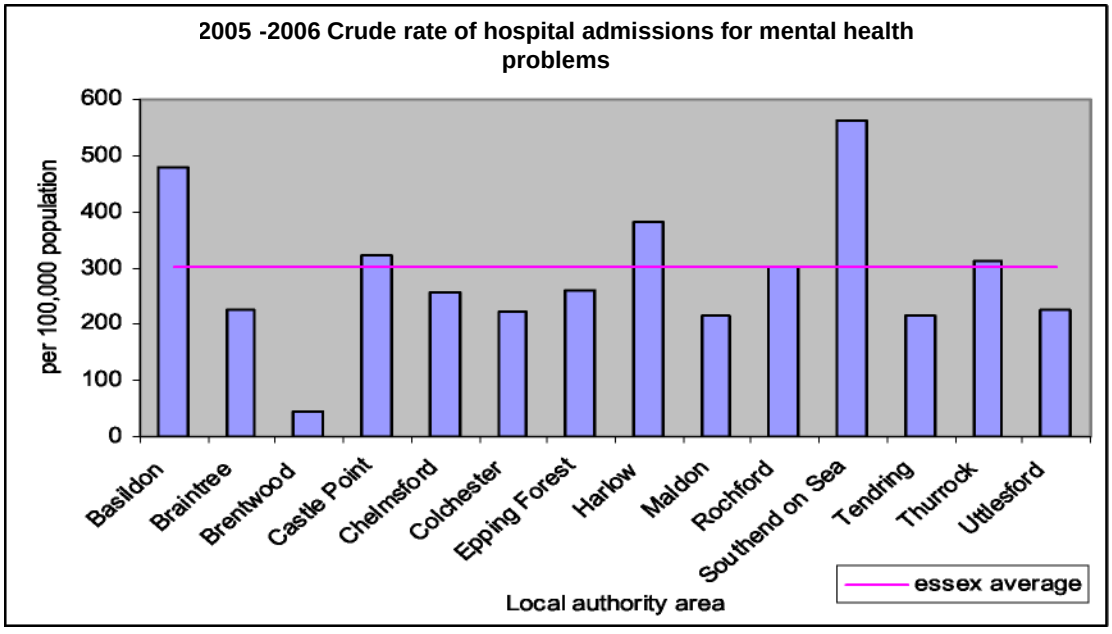
The main reason for elective admissions between 2004-2007 for those living within the Southend PCT area was unspecified cataract disorder (ICD-10 H269). Just over 5% of all admissions (3,507/ 67,253) in this time period were classified for this condition. The other top 9 conditions of all elective admissions ranged from 1.9% to 1.2% for malignant neoplasm (cancer) of breast (C509) to low back pain (M545).

Figure 3.51: Top 10 Emergency admissions to hospital for Southend 2004-2007



Emergency admissions for residents from the Southend area between April 2004 and March 2007 ranged from chest pain to chronic obstructive pulmonary disease. The most admissions were for unspecified chest pain (R074) with 3.3% of all admissions (1,463/44,087).

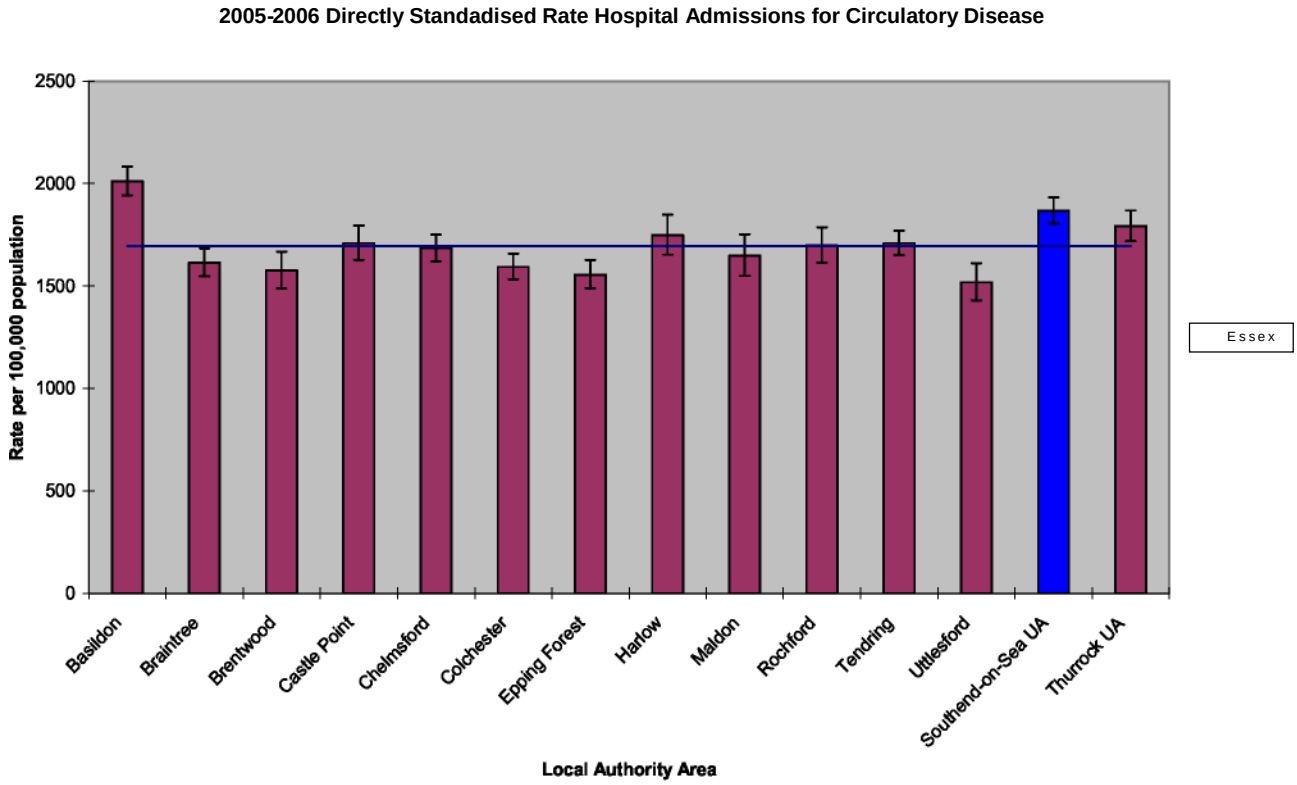
Figure 3.52: Hospital admissions for Mental Health Problems



Source, Dr Foster Mental Health Activity Tracker; ONS population estimates

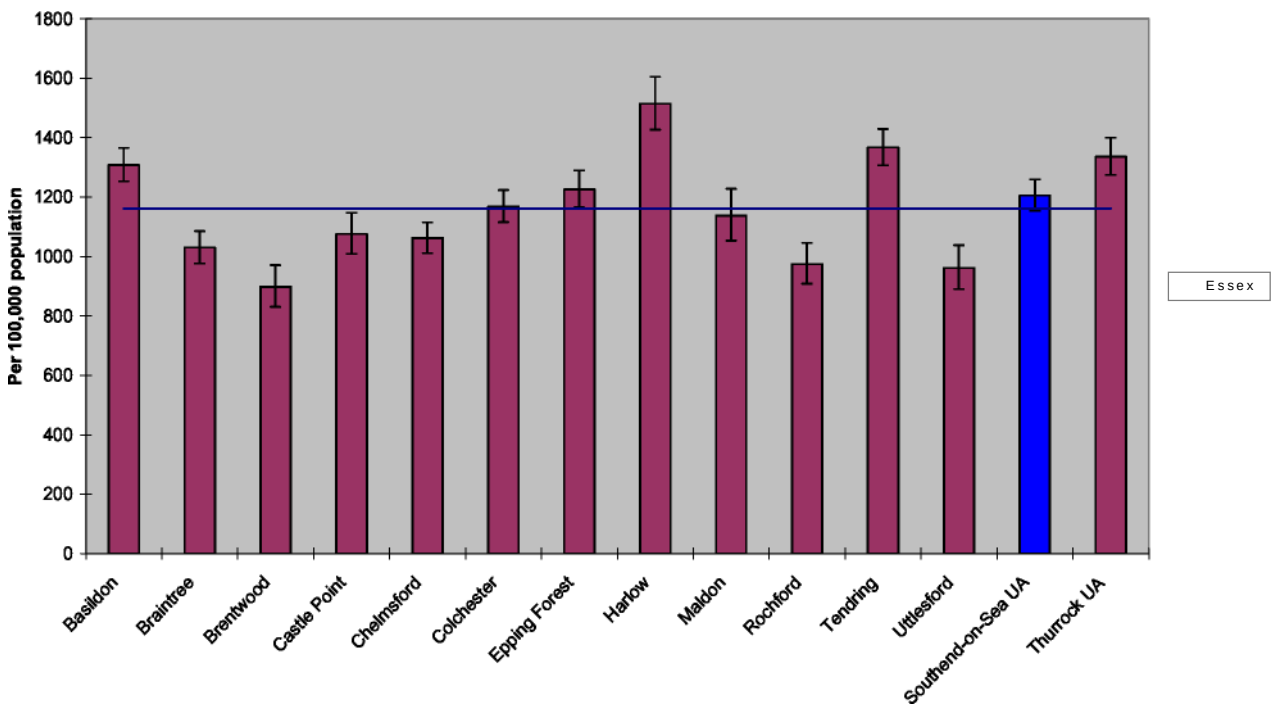
3.3.2 Hospital Admissions by Local Authority

Figure 3.53: Directly standardised rate hospital admissions for circulatory disease 2005/06



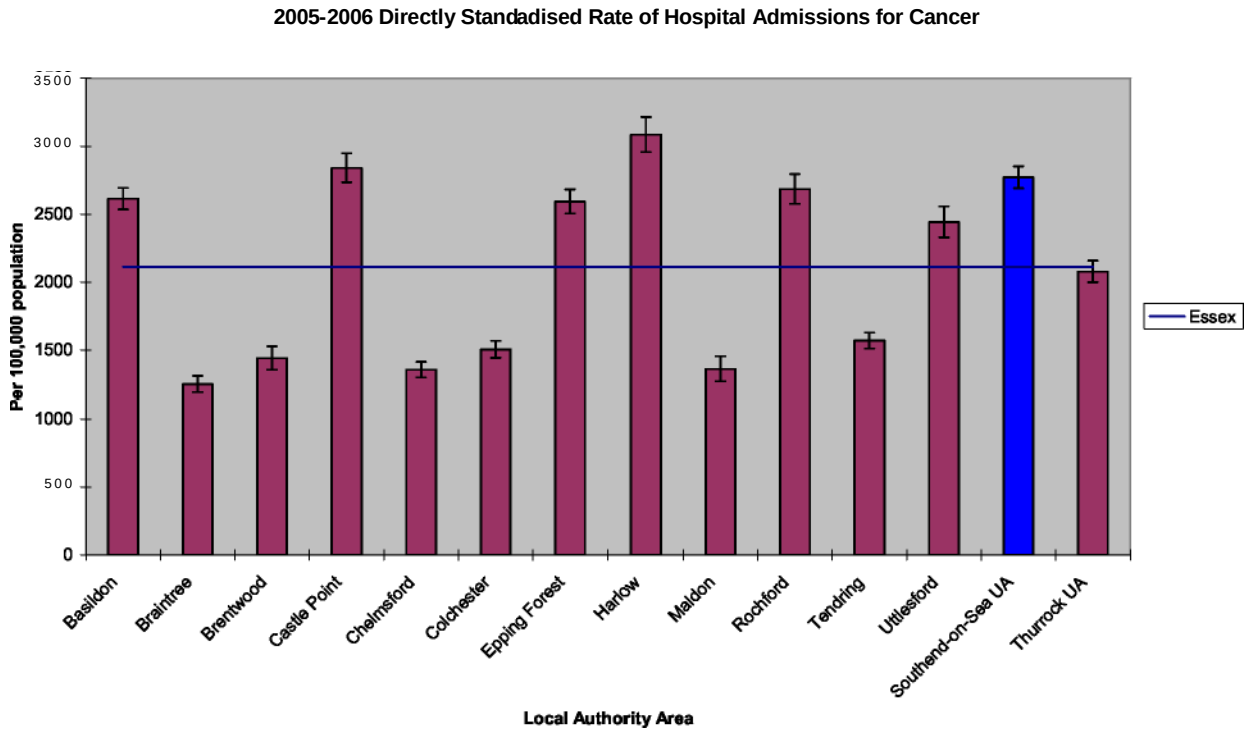
The Southend area has a significantly higher rate of hospital admissions for circulatory disease than the Essex average.

Figure 3.54: Directly standardised rate of hospital admissions for respiratory disease – 200 5/06



Southend's hospital admission rate for respiratory disease is not significantly different from the average Essex rate.

Figure 3.55: Directly standardised rate of hospital admissions for cancer – 2005/06



The hospital admission rate for cancer in the Southend area in significantly higher than the Essex average. It is one of seven areas in the County to have the above average rate of admissions.

Data Source: Eastern Region Public Health Observatory

3.4 Long Term Conditions

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

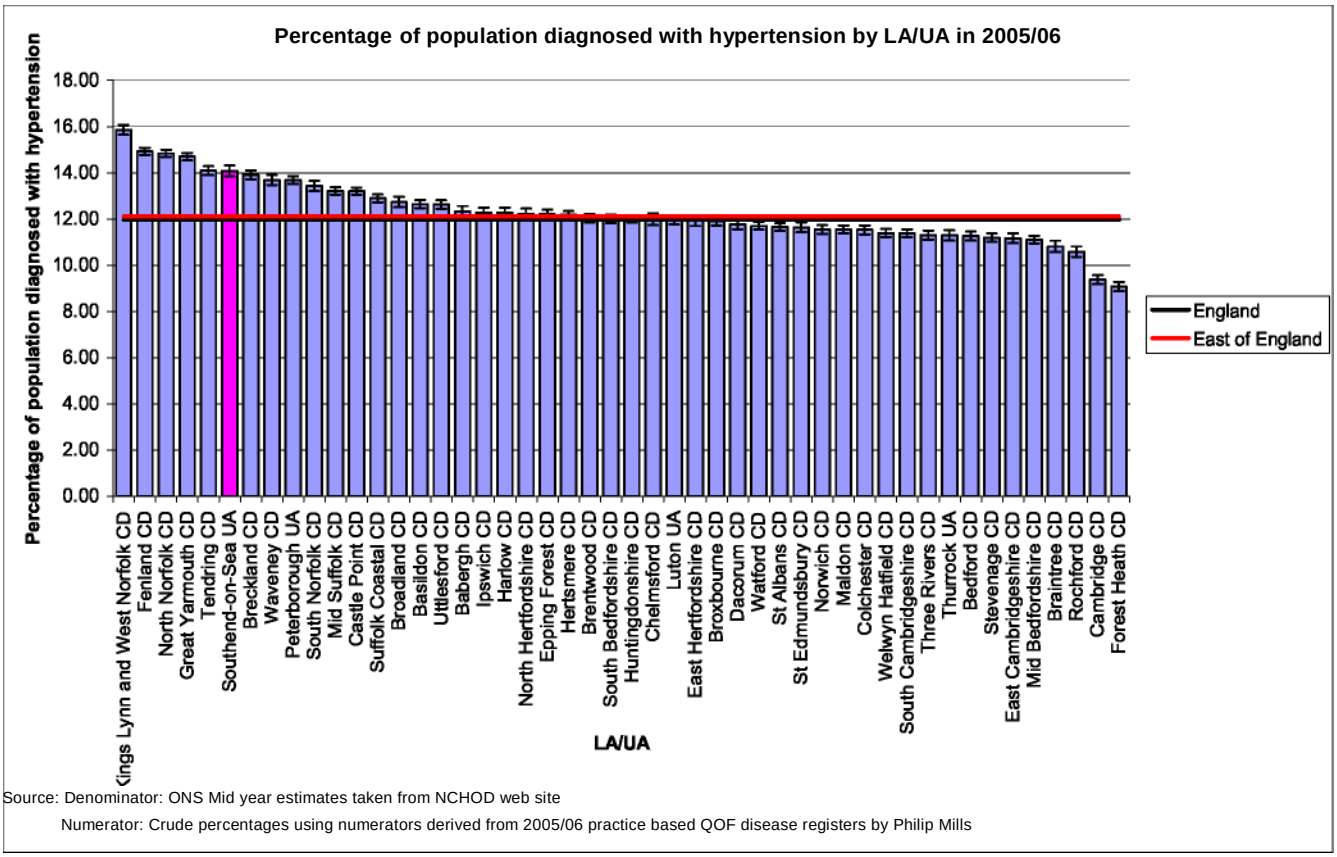
In this section, a diagnosis of a condition means those on a GP practice register for that condition. A higher percentage can therefore mean an area is better at identifying and recording people with the condition rather than it having a higher prevalence per se.

3.4.1 Hypertension

Figure 3.56 shows the percentage of the population which have been diagnosed with hypertension (high blood pressure) by local authority and unitary authority in the East of England. Seven areas in Essex, including Southend, have a higher percentage of the population diagnosed with hypertension than the England average. It is thought that the number of people with hypertension is a lot higher then recorded.

Figure 3.56 shows the results of a model to try and work out what the percent of the population with hypertension might be. When compared to Figure 3.56 it can be seen that a large proportion of hypertension is undiagnosed.

Figure 3.56: Percentage of population with hypertension by LA/UA in 2005/06



Source: Denominator: ONS Mid year estimates taken from NCHOD web site

Numerator: Crude percentages using numerators derived from 2005/06 practice based QOF disease registers by Philip Mills

Figure 3.57: Expected percent of the population with hypertension

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

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

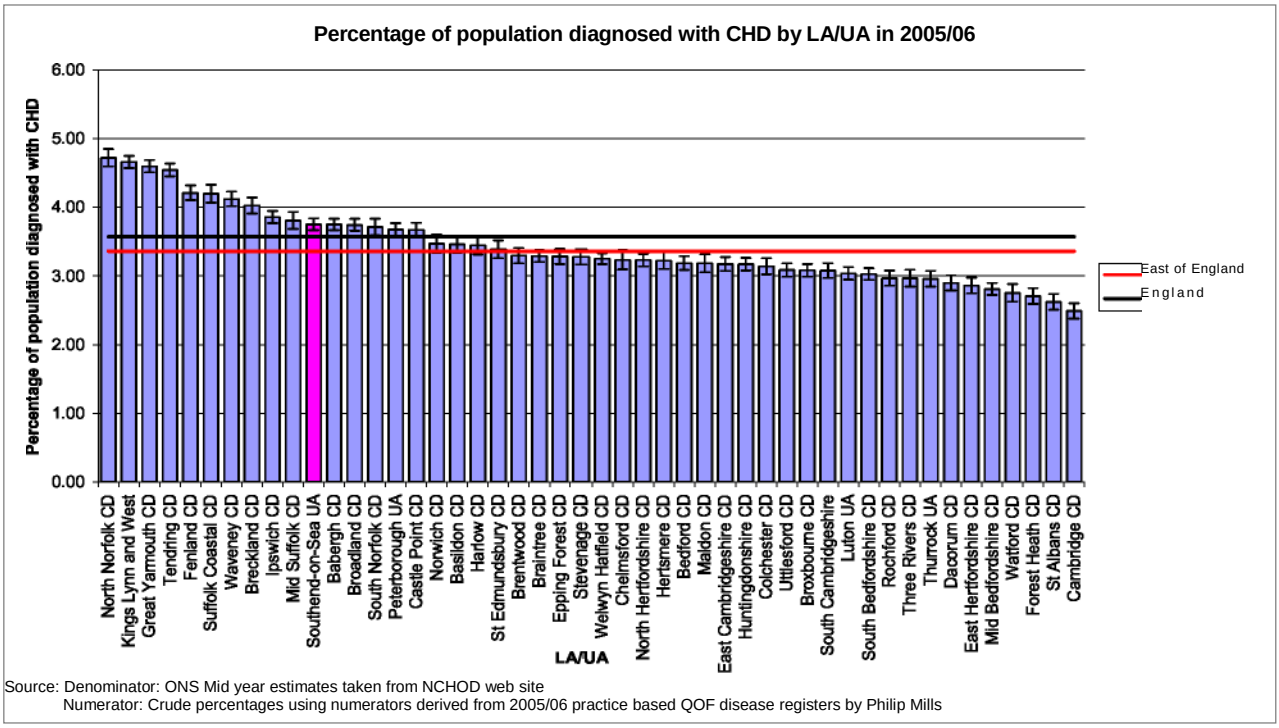
Source: Hypertension model developed by David Merrick (YHPHO) and Julian Flowers (ERPHO), http://www.apho.org.uk/apho/models.aspx

3.4.2 Coronary Heart Disease (CHD)

Figure 3.58 shows the percent of the population which have been diagnosed with coronary heart disease (CHD) by local authority and unitary authority in the East of England. Three areas in Essex have a higher percentage of the population diagnosed with CHD then the England average. The number of people with CHD is thought to be a lot higher then recorded.

The UK general practice research database shows that people with severe mental illness who are less than 50 years old, have over a three times greater risk of dying from coronary heart disease compared to the general population, and nearly twice this risk when they are aged 50 -75.

Figure 3.58: Percentage of population with CHD by LA/UA in 2005/06



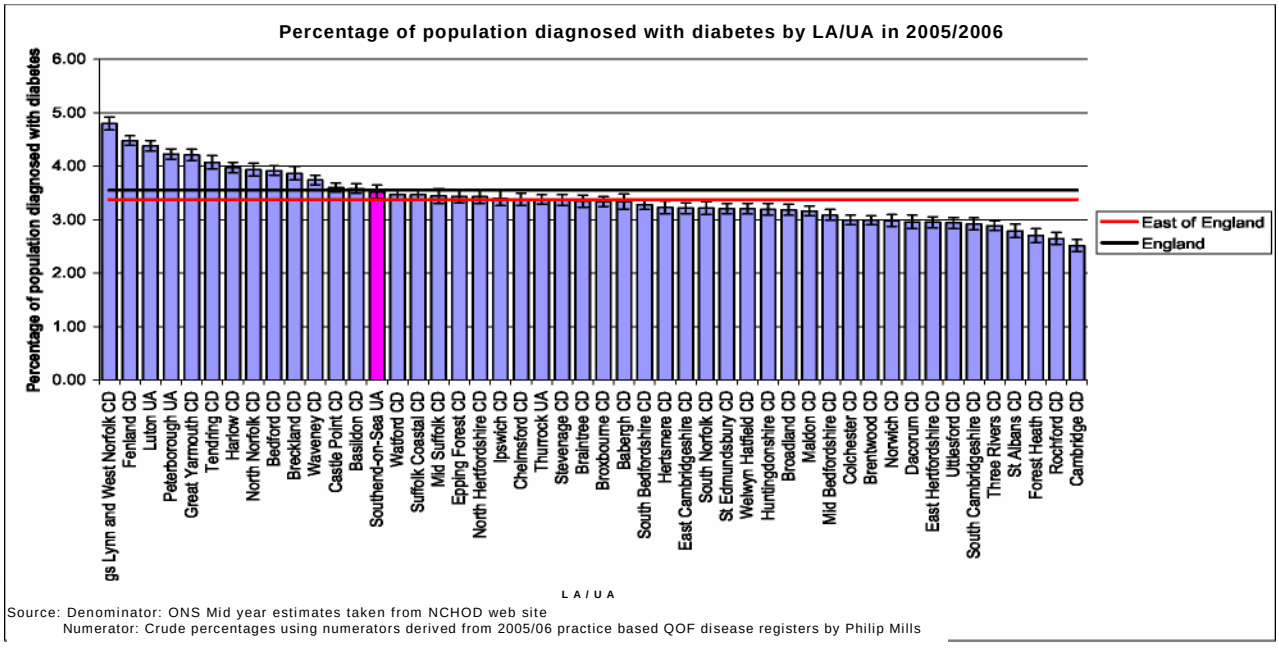
Source: Denominator: ONS Mid year estimates taken from NCHOD web site
Numerator: Crude percentages using numerators derived from 2005/06 practice based QOF disease registers by Philip Mills

3.4.3 Diabetes

Figure 3.59 shows the percentage of the population which have been diagnosed with diabetes by local authority and unitary authority in the East of England. Four areas in Essex have a higher percentage of the population diagnosed with diabetes then the England average. It is though that the number of people with diabetes is a lot higher then recorded.

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

Figure 3.59: Percentage of population diagnosed with diabetes by LA/UA in 2005/06

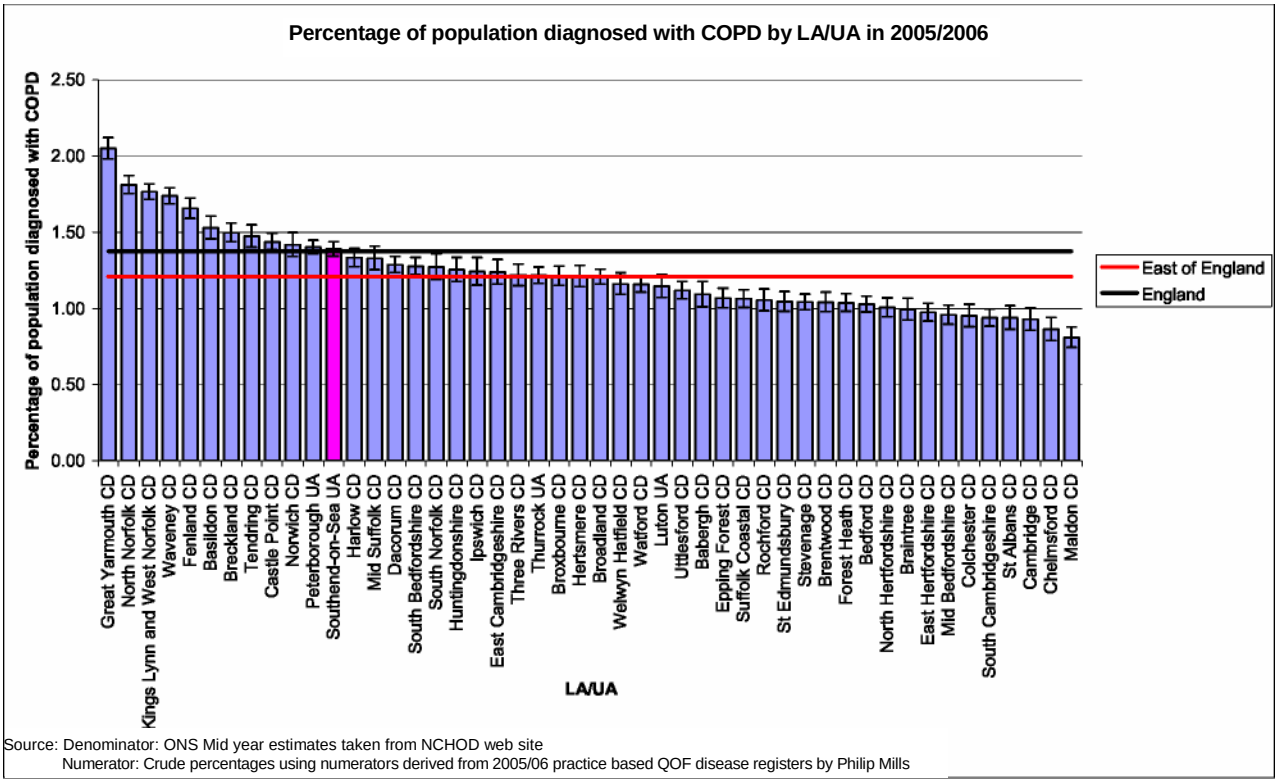


Source: Denominator: ONS Mid year estimates taken from NCHOD web site
Numerator: Crude percentages using numerators derived from 2005/06 practice based QOF disease registers by Philip Mills

3.4.4 Chronic obstructive pulmonary disease (COPD)

Figure 3.60 shows the percent of the population which have been diagnosed with chronic obstructive pulmonary disease (COPD) by local authority and unitary authority in the East of England. Three areas in Essex have a higher percentage of the population diagnosed with COPD then the England average.

Figure 3.60: Percentage of population diagnosed with COPD by LA/UA in 2005/06



Source: Denominator: ONS Mid year estimates taken from NCHOD web site
Numerator: Crude percentages using numerators derived from 2005/06 practice based QOF disease registers by Philip Mills

3.5 Limiting Long Term Illness (LLTI)

Limiting long-term illness is a measure of whether a person considers themselves to have a long-term illness, health problem or disability which limits their daily activities or the work they can do, including problems that are due to old age.

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

The map below shows the proportion of people by ward that stated they had a limiting long-term illness from the Census 2001. The majority of wards in Southend have higher levels of LLTI than Essex.

Figure 3.61: Limiting Long-term Illness by Ward

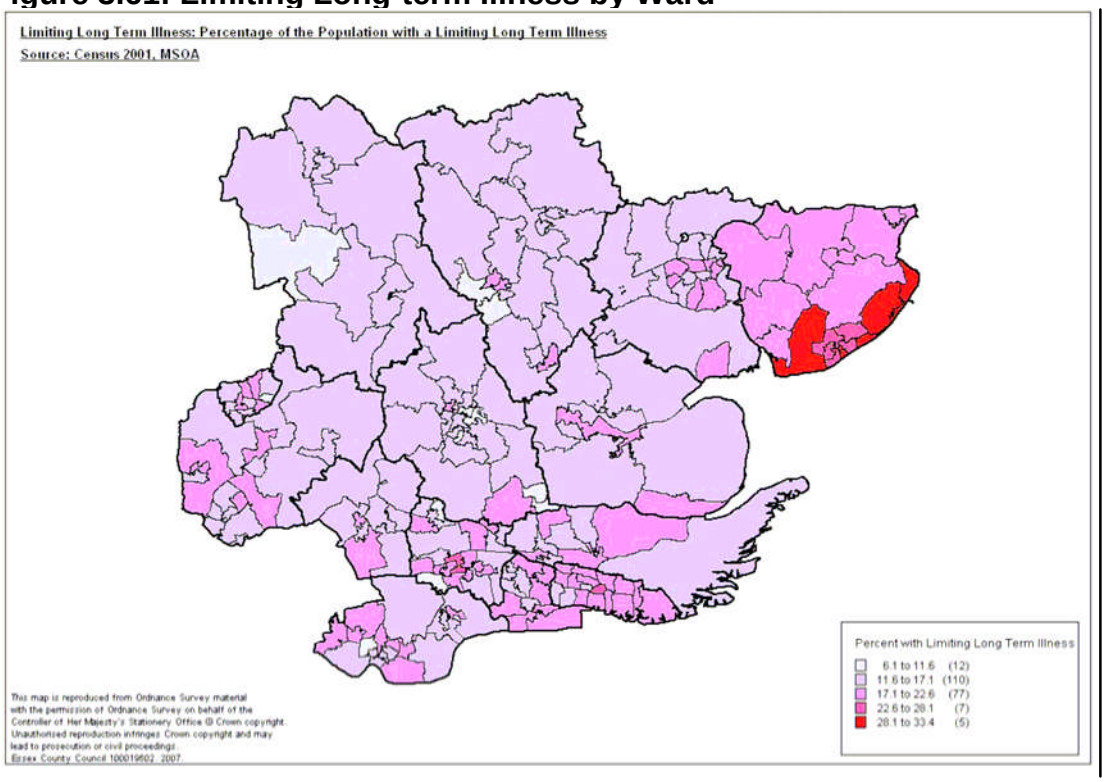
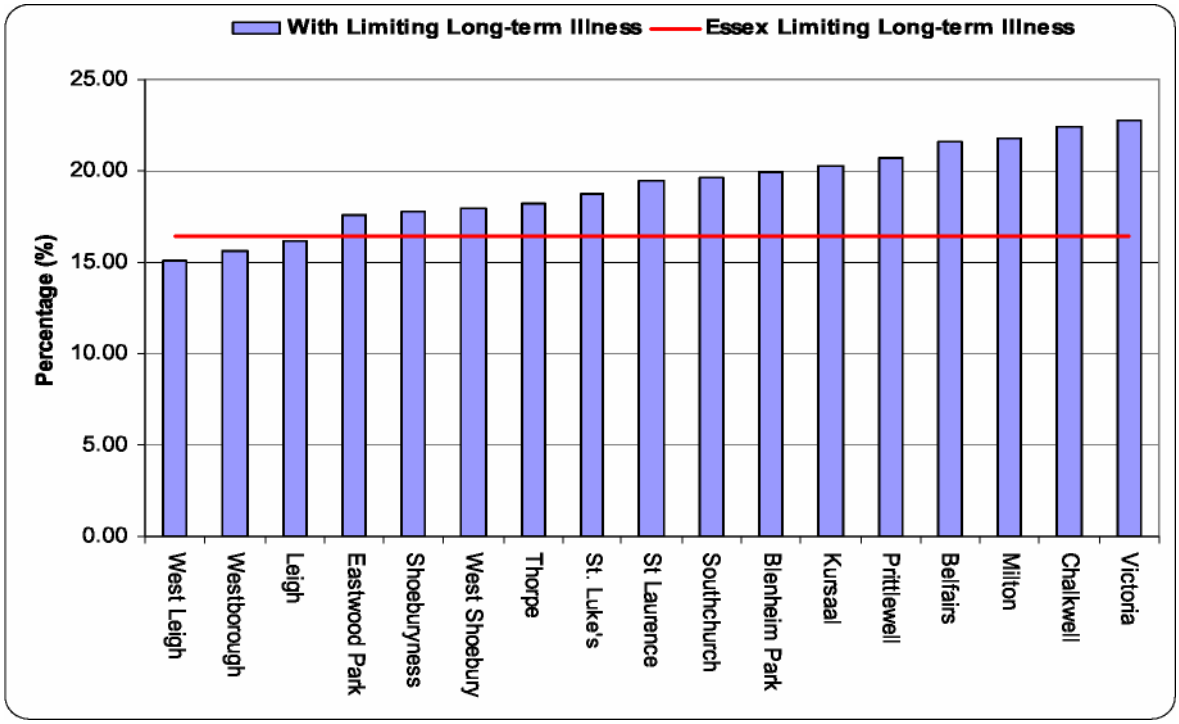
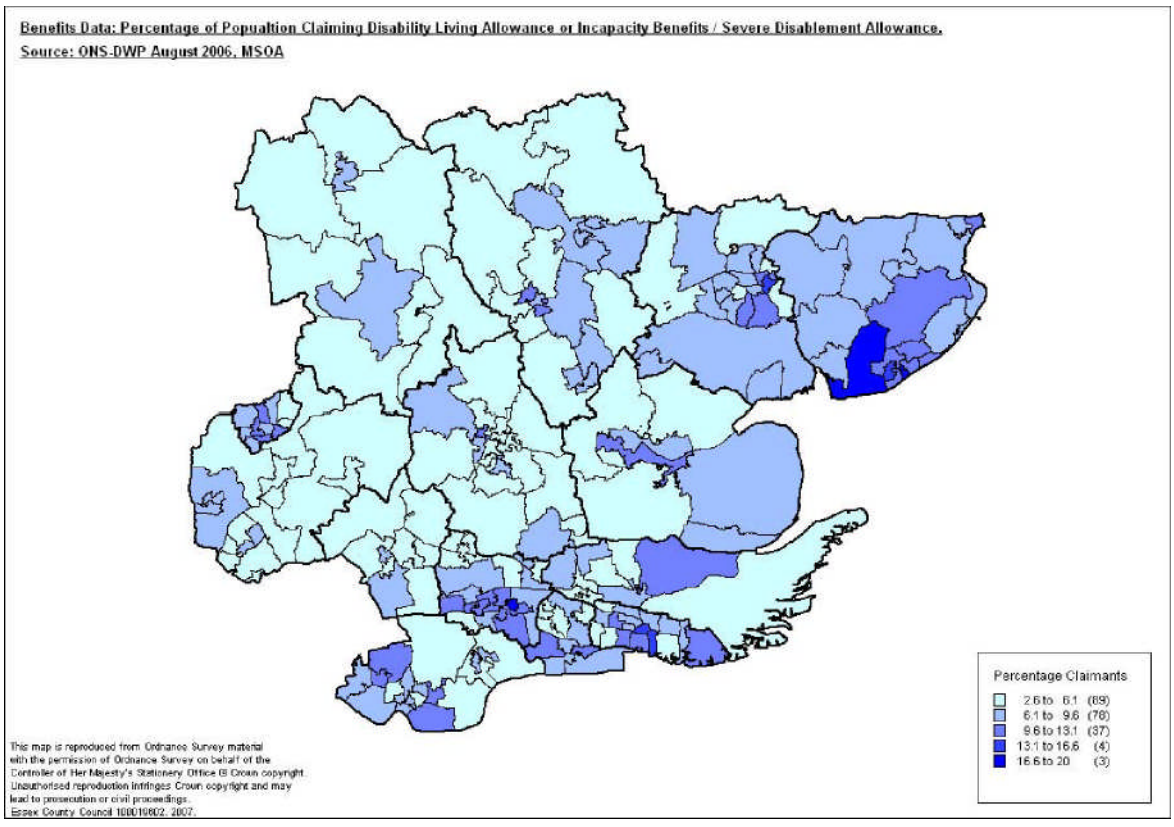


Figure 3.62: Limiting Long-term Illness by Ward in Southend-on-Sea



Those areas where there is a high prevalence of limiting long-term illness also have high benefit claimant rates. Figure 3.63 below shows the claimants for Disability Living Allowance and Incapacity Benefit by MSOA. Looking at the maps in Figures 3.62 and 3.63 together, it can be seen that there is close correlation between areas with higher proportions of benefit claimants and LLTI prevalence.

Figure 3.63: Benefit Claimants by MSOA - 2006



Unemployment tends to be associated with LLTI as those suffering with a long-term illness may find it difficult to work.

The map below (Figure 3.64) shows that limiting long-term illness again plays a role in the unemployment rate of each MSOA. Where there is higher limiting long-term illness prevalence there are higher corresponding unemployment rates.

Unemployment rates are also higher in some other parts of the region, namely some MSOAs in Maldon and a high proportion in Epping Forest. Braintree also has some MSOAs that have higher levels of which correspond to having high benefit claimant rates but not overly high proportions of people with limiting long-term illness.

Figure 3.64: Percentage of the economically active population who are unemployed by MSOA

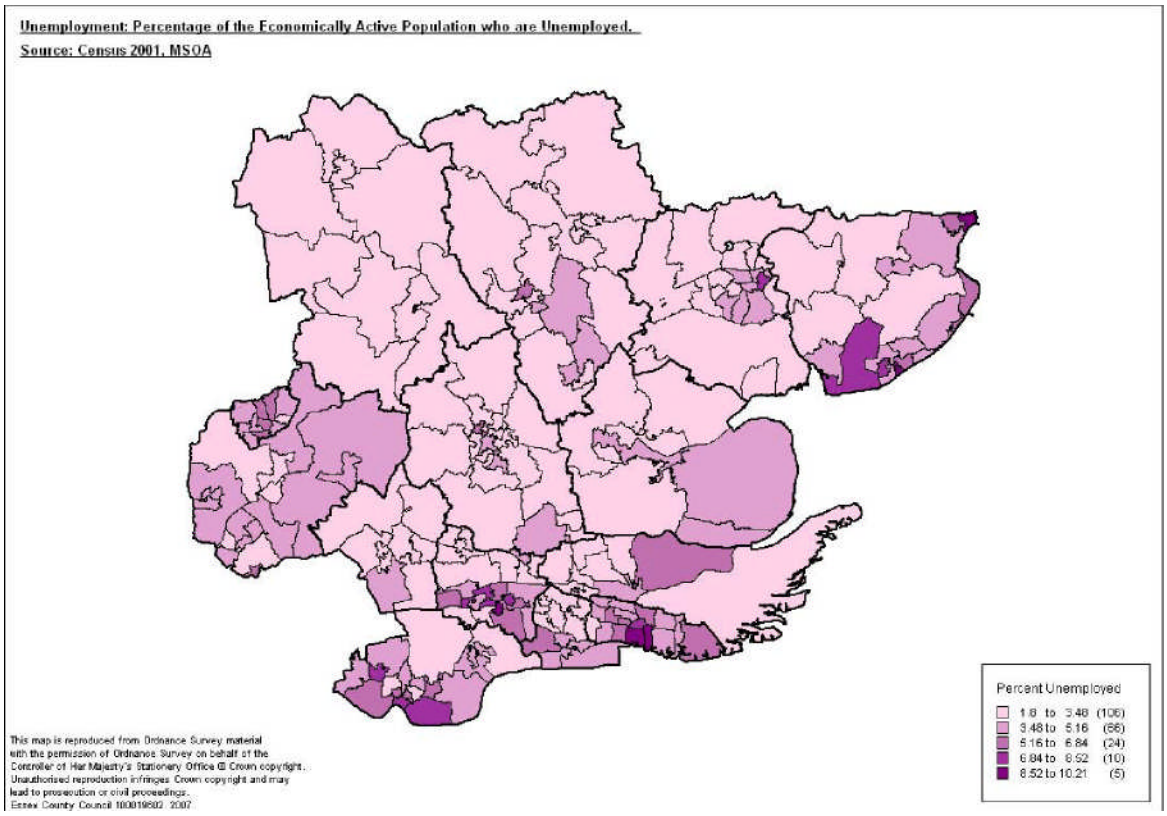
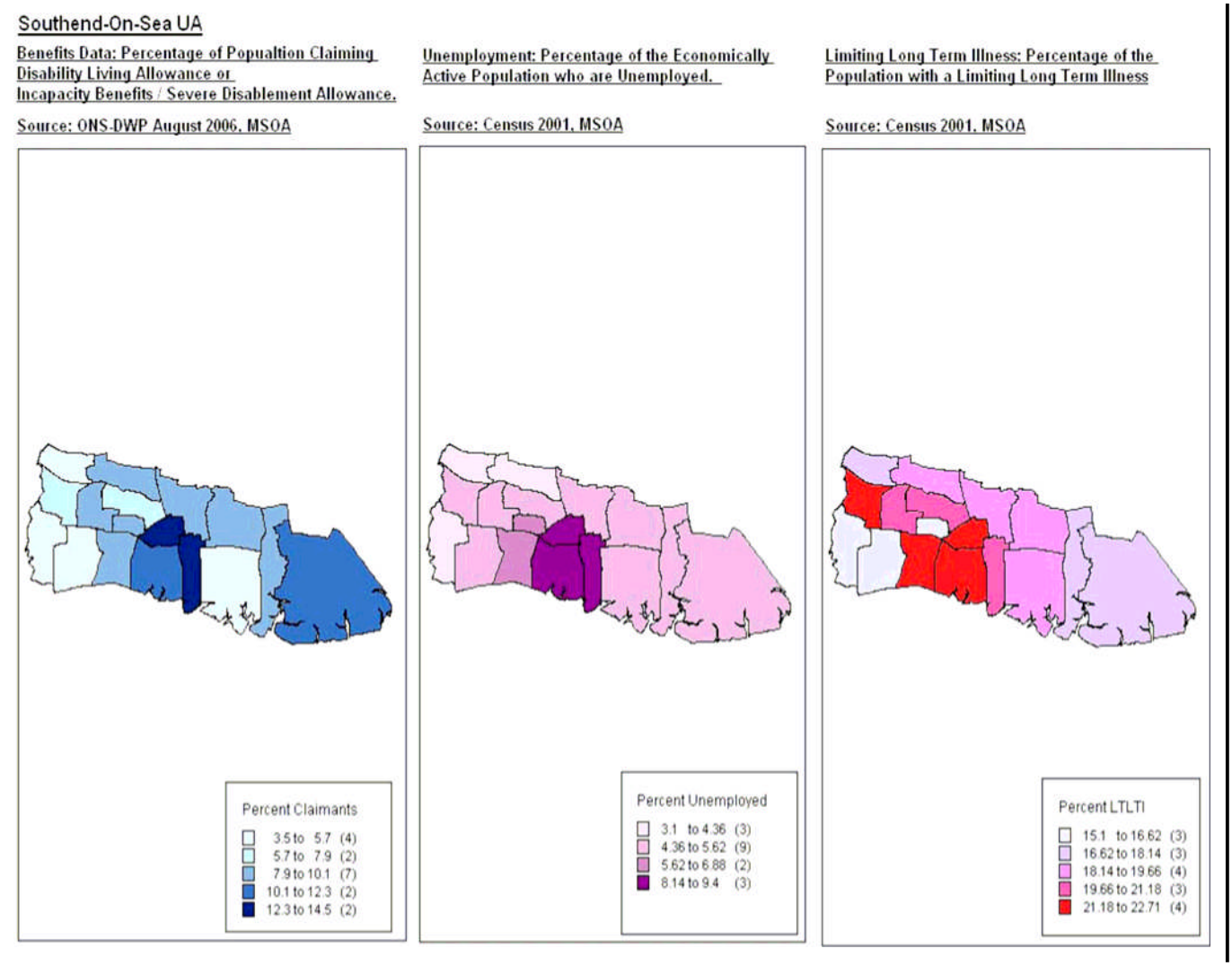


Figure 3.65 highlights the relationship between benefit claimants, unemployment and long term limiting illness by medium super output area in Southend.

Figure 3.65: Benefit claimants, those unemployed and those with a limiting long term illness by MSOA



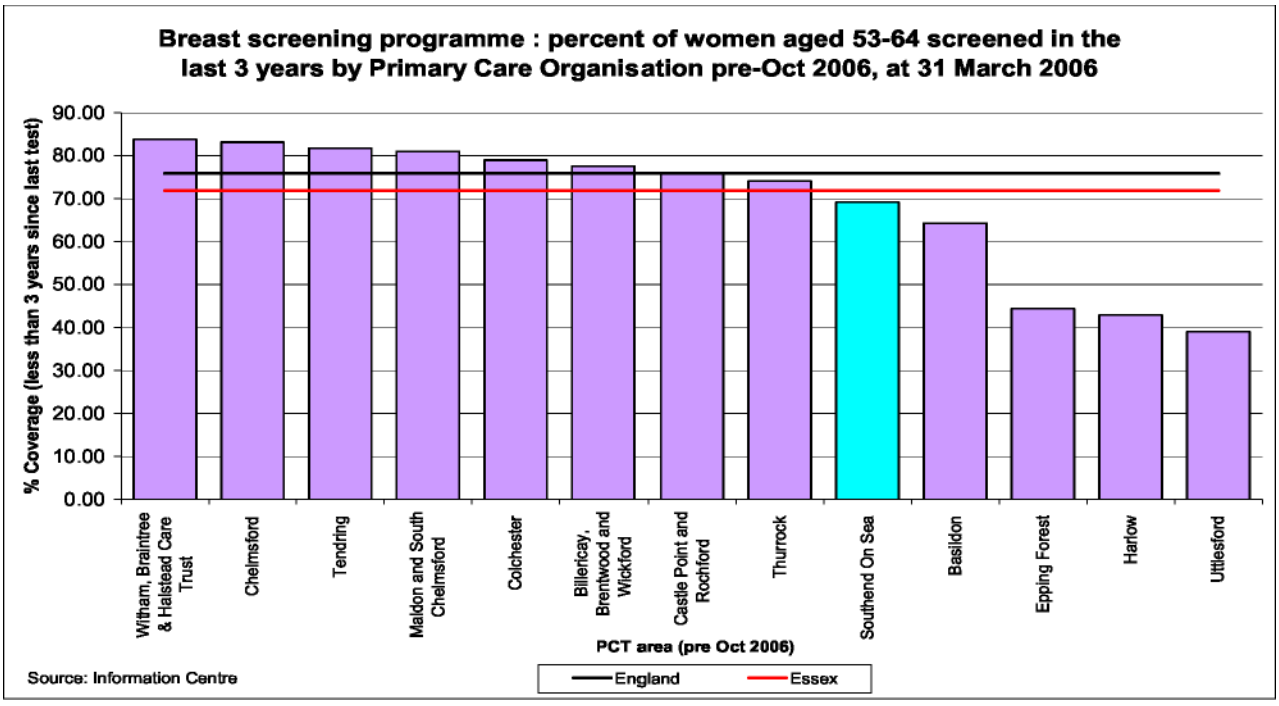
3.6 Health Protection and Screening

Screening is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test,. The purpose of screening is to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.

The introduction of new screening programmes is overseen by the National Screening Committee. Two of the more long established population screening programmes include the breast screening and cervical screening programmes.

The breast screening programme covers women aged 50-64 but it was extended to invite women aged 65-70 in April 2001. The coverage of the screening programme is the proportion of women resident and eligible who have had a test with a recorded result at least once in the previous 3 years. Figure 3.66 shows the breast screening coverage in Essex by pre-Oct 2006 PCT boundaries. Southend has the fifth lowest uptake of breast screening compared with the rest of Essex, and is below the national and Essex average. The west of Essex has low coverage due to the unit being suspended for a period of time but it is now back up and running so the coverage should improve.

Figure 3.66: Percentage of women aged 53-64 screened in the last 3 years as at March 2006



National policy for the cervical screening programme is that eligible women should be screened every 3 or 5 years depending on age. Figures 3.67 and 3.68 show that there is considerable difference across Essex, in the percentage of people being screened. At 73% Southend has the lowest uptake of cervical screening in Essex, and considerably below the England average, which is just below 80%.

Figure 3.67: Percentage of cervical screening target age group that have been screened in the last 5 years – 2005/06

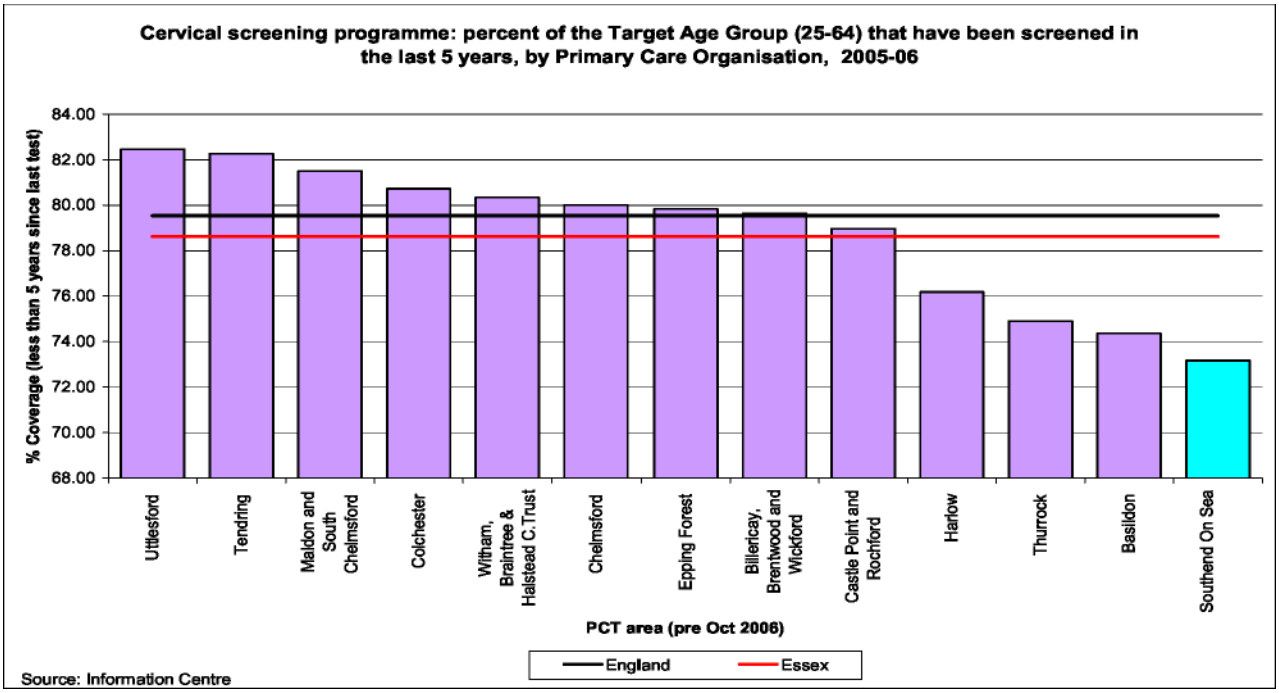
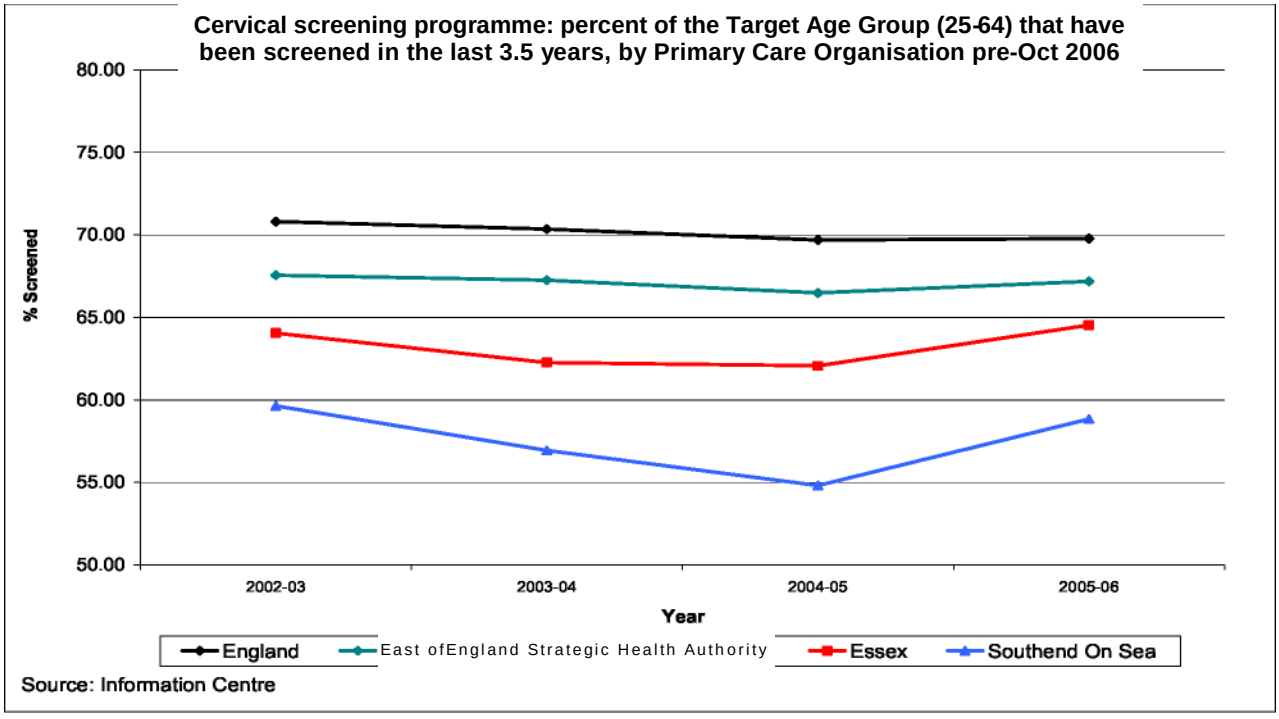


Figure 3.68: Percentage of cervical screening target age group in Southend that have been screened in the last 3.5 years compared with Essex, East of England and England.



3.7 Conclusion

Life expectancy in Southend is the same as the national average. There are, however, health inequalities both between men and women in Southend and across the borough, with a difference of 8.4 years in life expectancy between wards.

CHAPTER 4 CHILDREN AND YOUNG PEOPLE

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

4.1 Infant Health

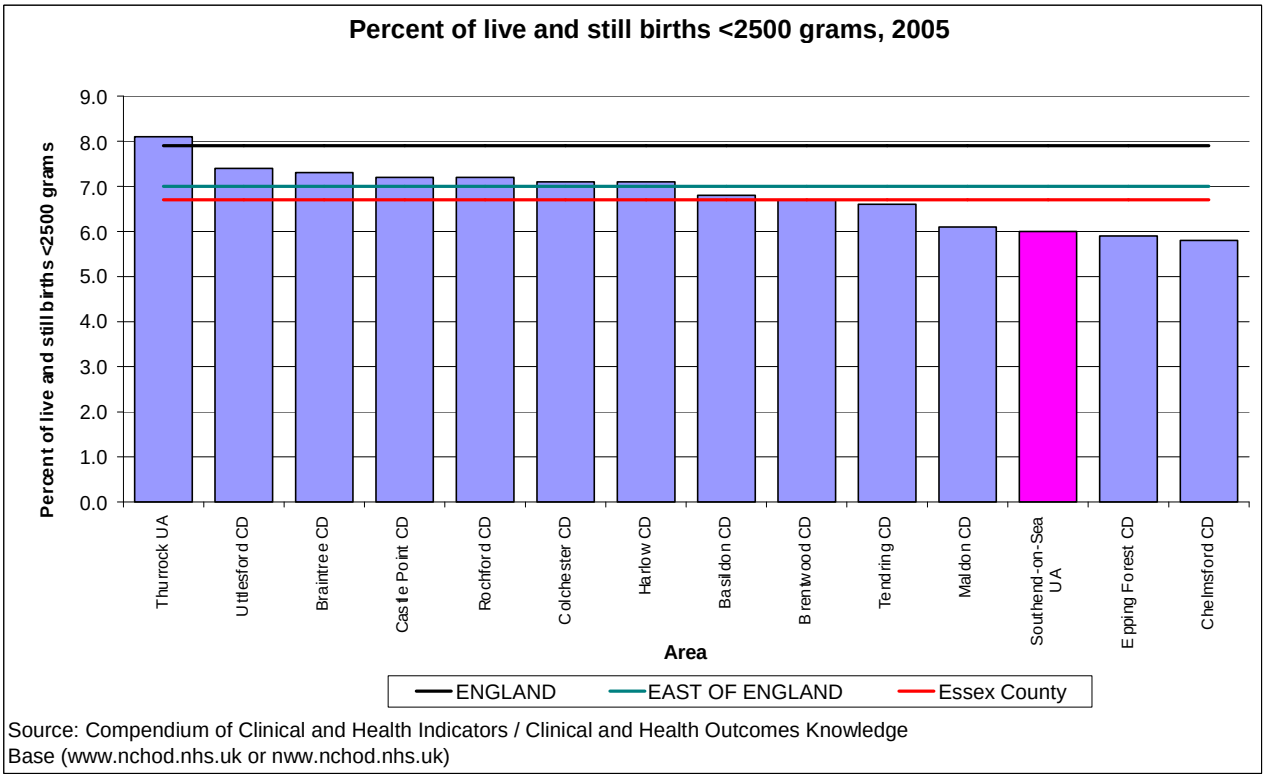
4.1.1 Low birth weight

Low birth weight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life. It is a good indicator of the newborn's chances for survival, growth, long-term health and psychosocial development. Low birth weight is defined by the World Health Organisation as a birth weight less than 2500 grammes. Below this value, birth weight-specific infant mortality begins to rise rapidly.

Low birth weight babies where traditionally linked to high deprivation. This is still the case, but some low birth weight babies are now attributable to improved medical technologies, resulting in more successful deliveries of low birth weight babies, and increased fertility treatment which is more likely to lead to a low birth weight baby.

Figure 4.1 shows that Southend has a low proportion of low birth weight babies compared with England, East of England and Essex.

Figure 4.1: Percentage of live and stillbirths below 2,500 grams in 2005



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk or nww.nchod.nhs.uk)

4.1.2 MMR Immunisations

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

Figure 4.2 shows the proportion of children who at their second birthday have received an MMR vaccination. It shows that Southend has one of the lowest MMR immunisation rates within Essex.

Figure 4.2: Percentage of children immunised for MMR by their 2nd birthday – 2005/06

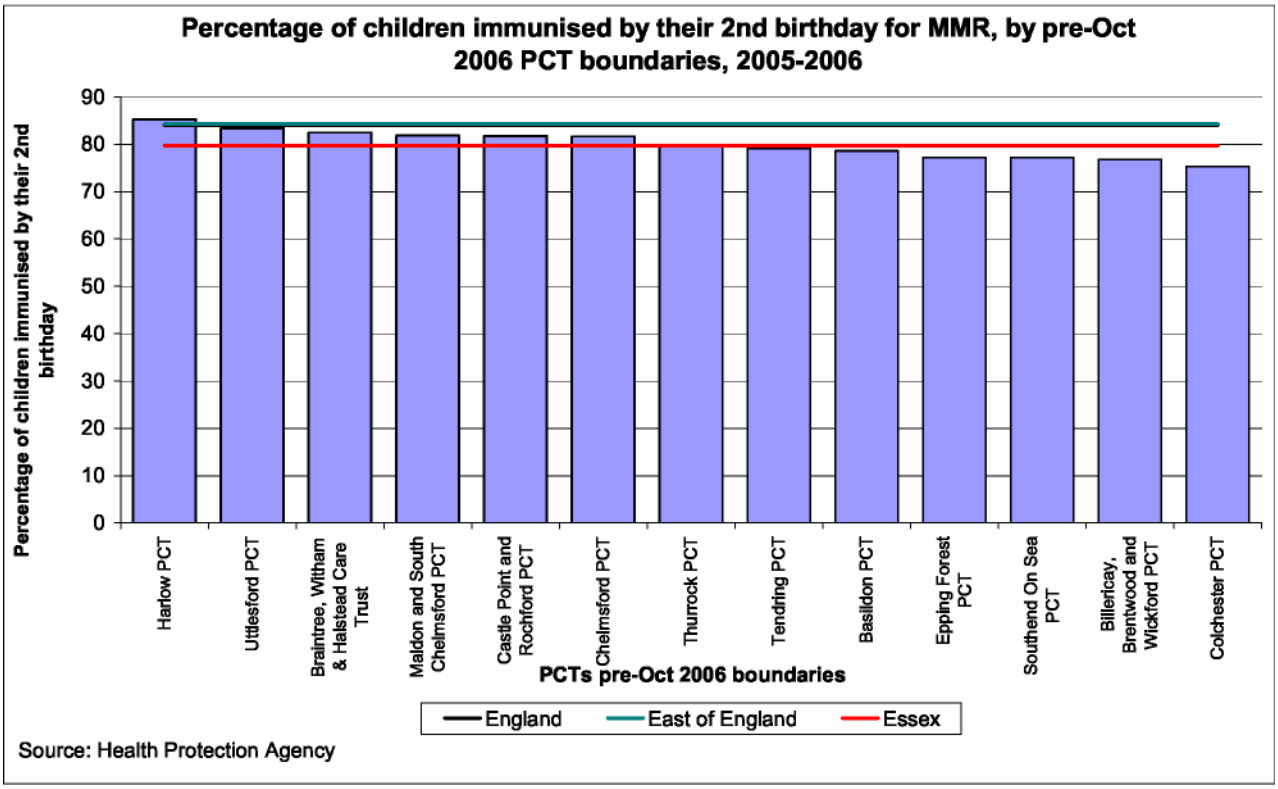
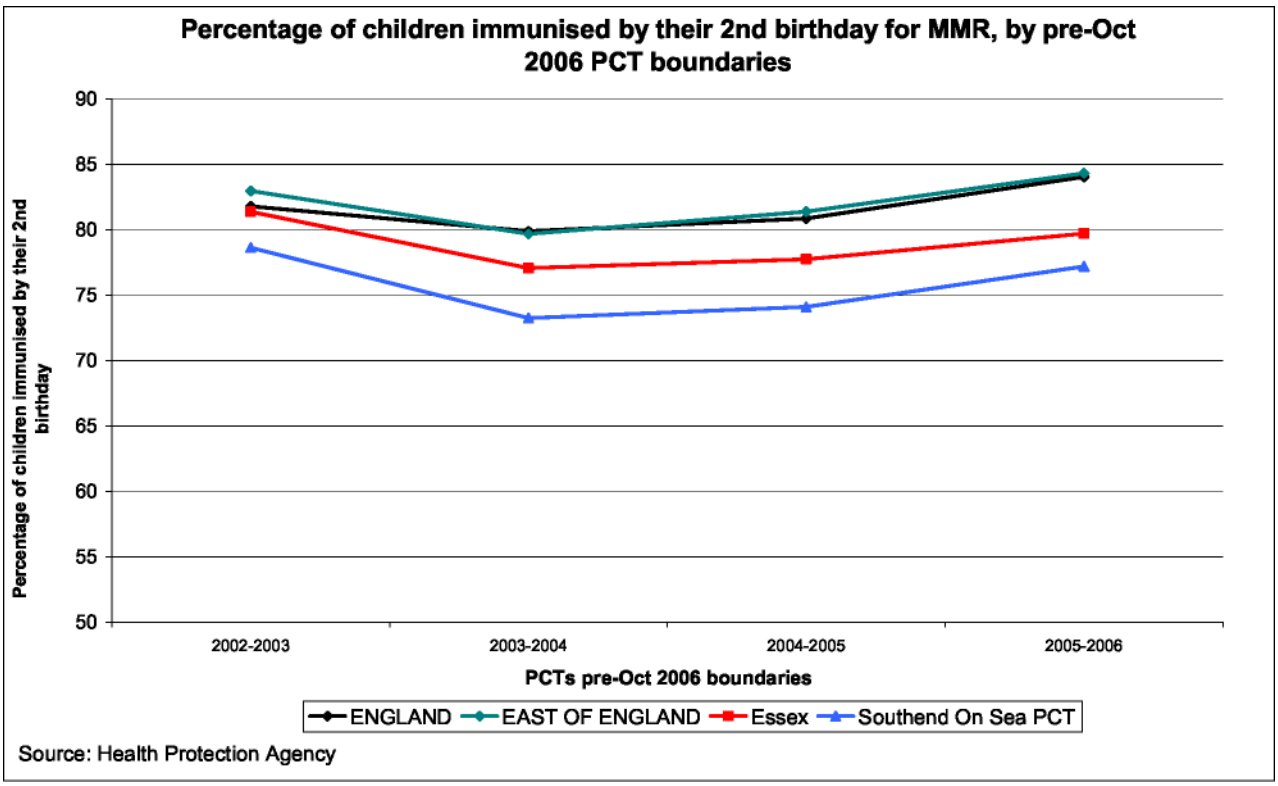


Figure 4.3: Percentage of children immunised for MMR by their 2nd birthday



By the time children are five the number who have received two doses of MMR in Southend is below the national and regional average, and significantly below the recommended level of vaccination.

Figure 4.4: Percentage of children receiving 2 doses for MMR by their 5th birthday – 2005/06

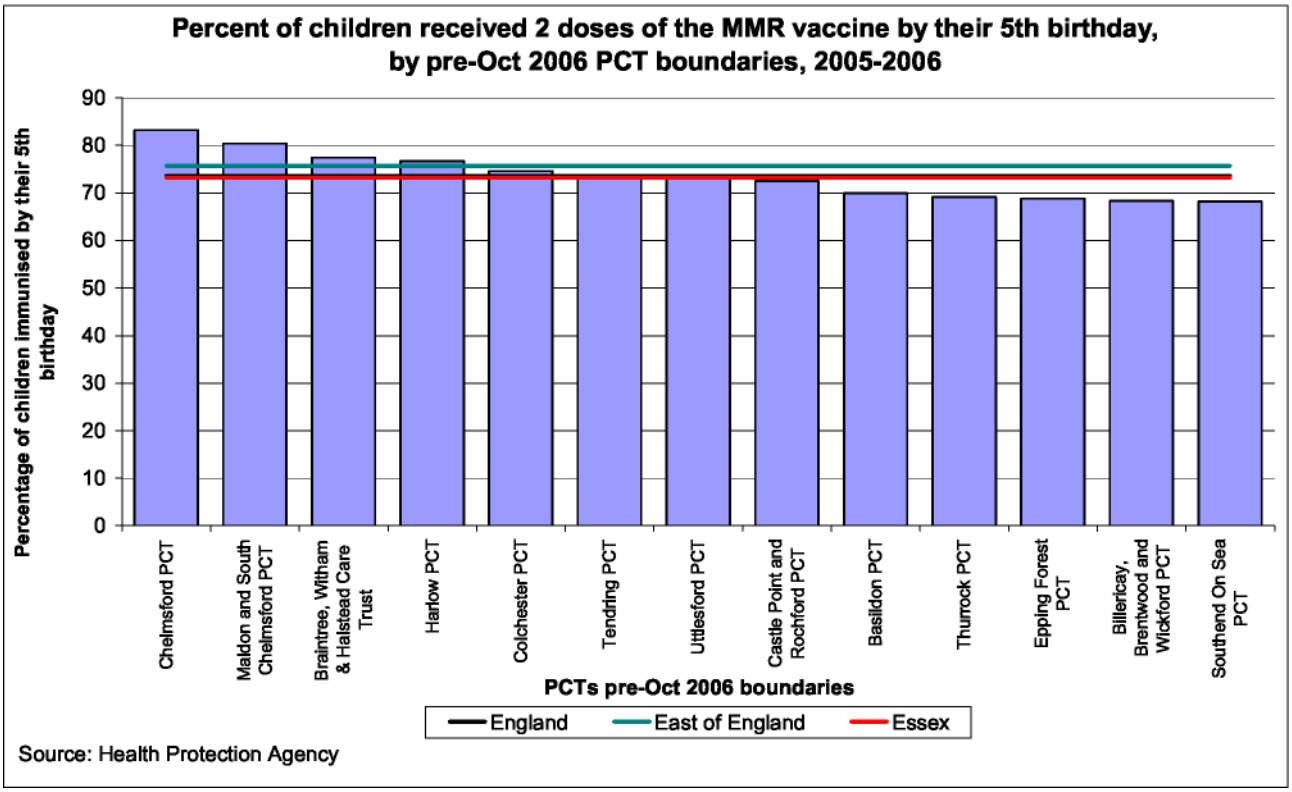
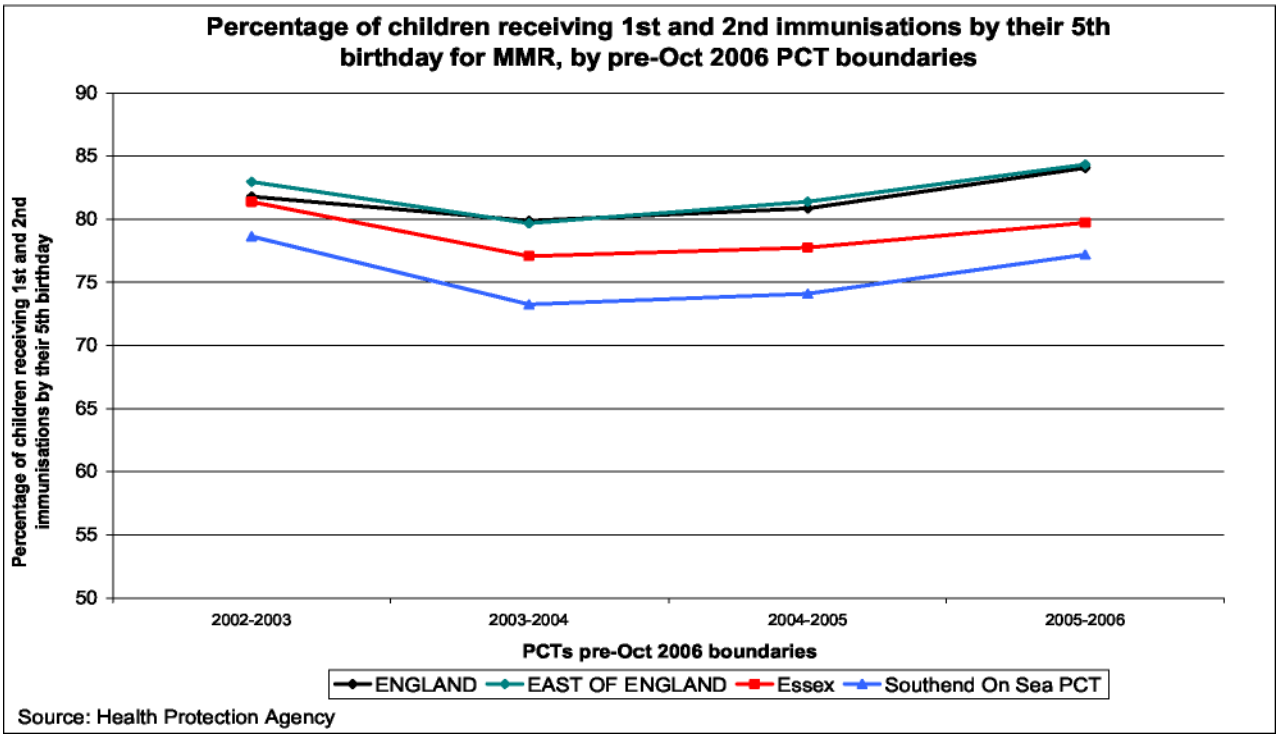
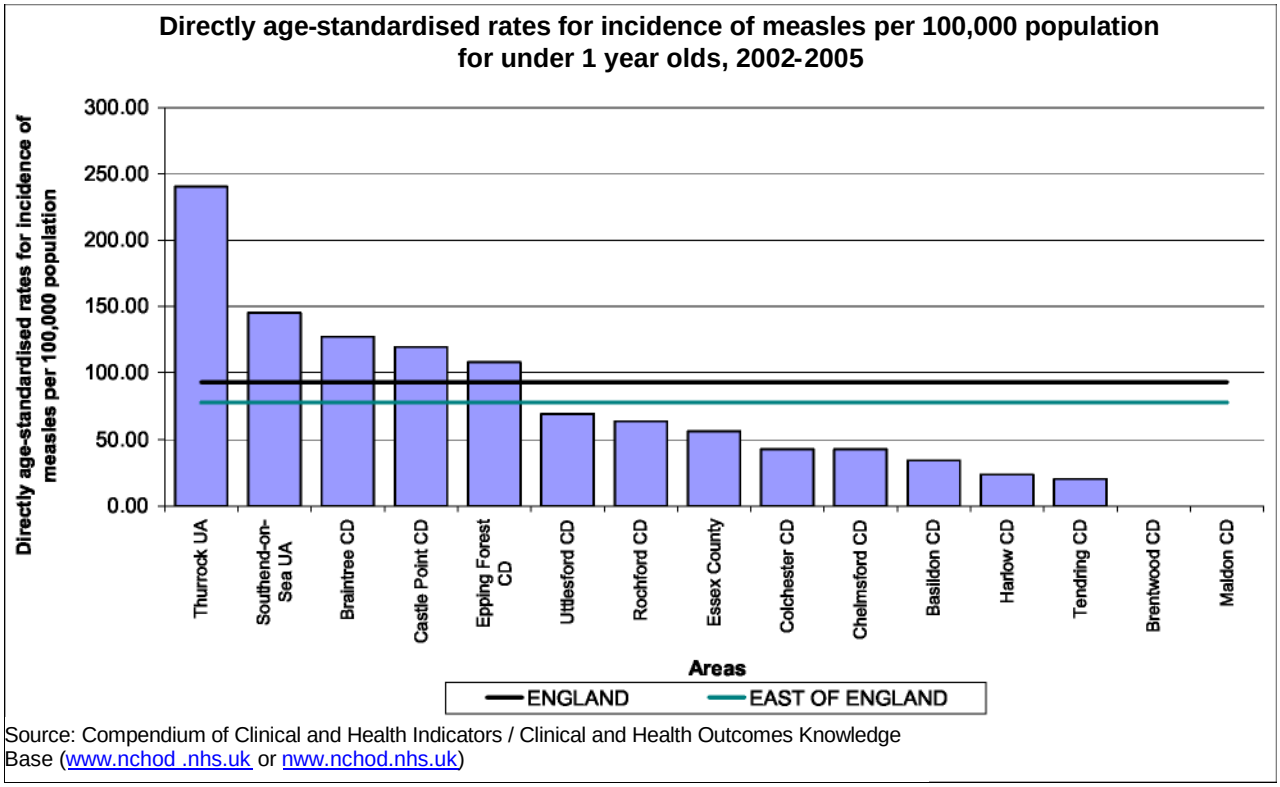


Figure 4.5: Percentage of children receiving 1st and 2nd immunisations by their 5th birthday for MMR



The incidence of measles varies across Essex. Figure 4.6 shows that in recent years Thurrock, Southend-on-Sea, Braintree, Castle Point and Epping Forest have all had higher rates of measles in infants under 1 year old compared with the national and regional average.

Figure 4.6: DSR for incidence of measles per 100,000 for under 1 year olds 2002-05



Source: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod .nhs.uk or nww.nchod.nhs.uk)

4.2 Childhood Obesity

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

Tackling childhood obesity requires changes in the behaviour of individual children,their parents and of society in general. The increasing numbers of overweight and obese children reflects recent trends across most developing countries to greater fat and sugar consumption and reduced physical activity. There is also evidence to suggest that babies who are breastfed are less likely to be obese in adulthood. However, breastfeeding initiation rates in the UK remain relatively low compared to other countries, particularly among women in lower income groups.

Since 2005, PCTs have been required to collect height and weight data for the monitoring of body mass index (BMI) of all primary school children in Reception (ages 4/5) and Year 6 (ages 10/11). These findings in Figures 4.7 to 4.10 are based on only the first year of child BMI measurement when many areas experienced difficulties in data collection and collation. As systems for data collection become more established, data on the distribution of BMI in the child population should improve both in coverage and quality, furthering our understanding of the epidemiology of the BMI distribution in the child population. However, current evidence from these data suggest that a population-wide strategy supplemented by more targeted action in some areas may be the most effective approach in halting the rise in the prevalence of childhood obesity.

The number of children measured varied across the region (Figures 4.7 and 4.8), and the lower the coverage the less reliable the results.

Figure 4.7: Height and weight recording coverage for pupils in Reception

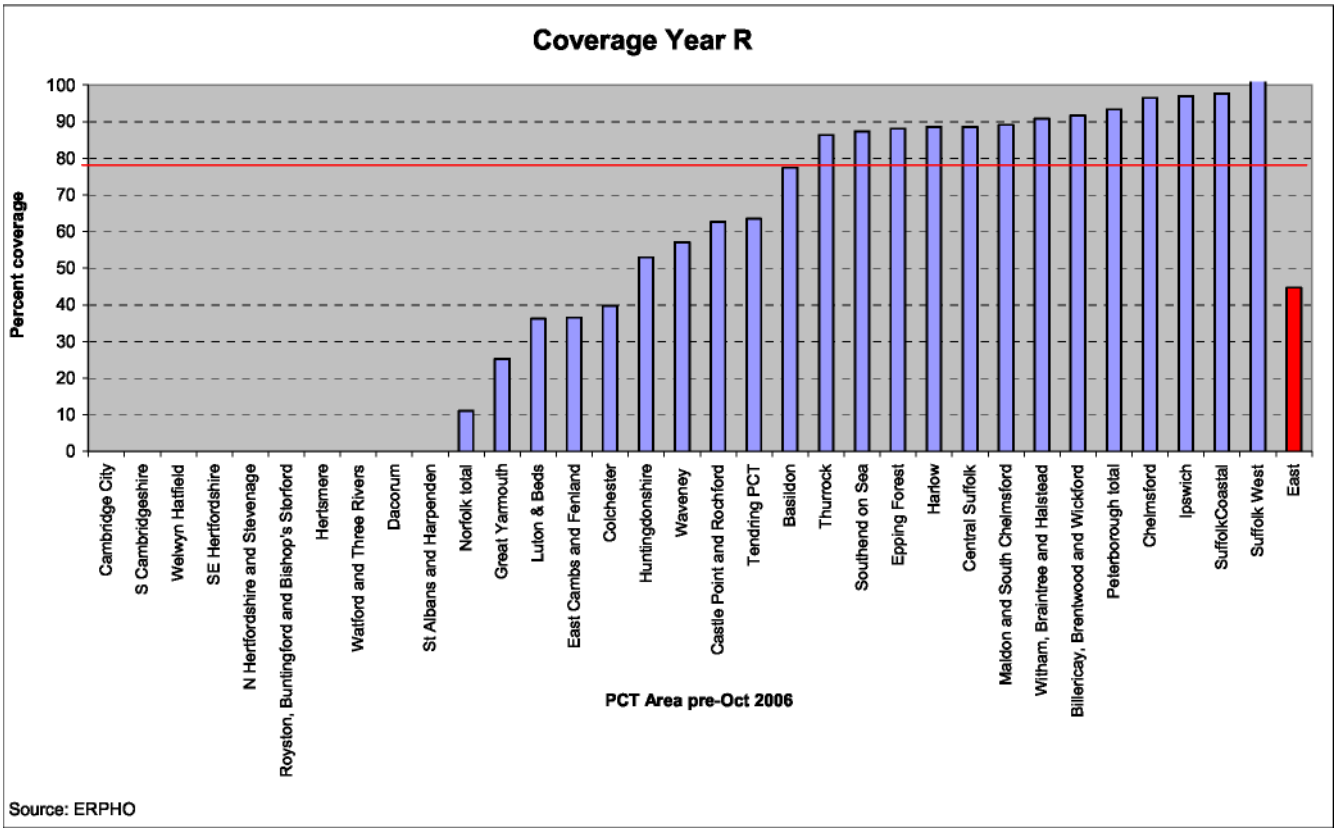
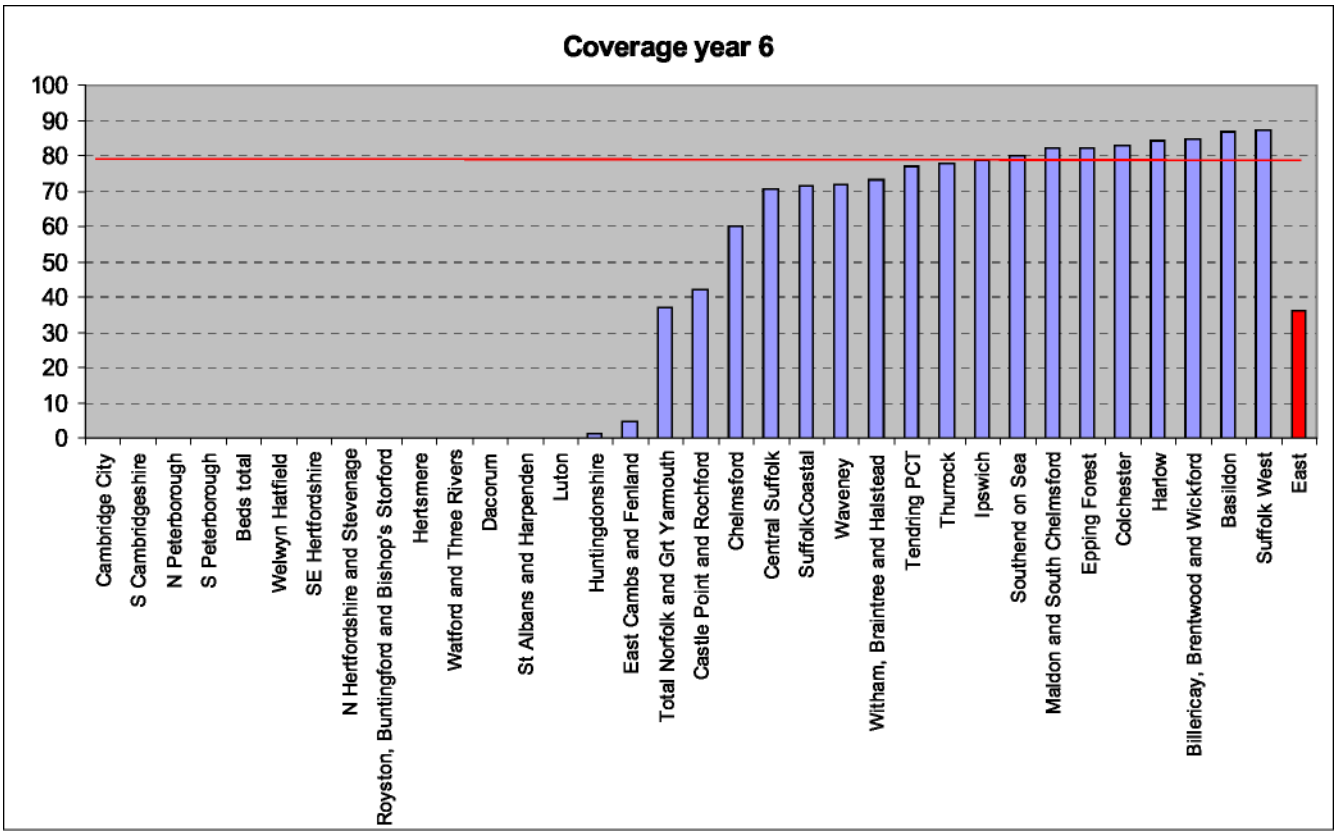


Figure 4.8: Height and weight recording coverage for pupils in Year 6



The areas in Essex which appear to have high childhood obesity levels in Reception are Tendring, Thurrock and Southend-on-Sea. Care should be taken when looking at the Tendring results as they had a lower coverage so the result is less reliable. Areas in Essex which appear to have high childhood obesity levels in Year 6 are Harlow and Basildon

Figure 4.9: Obesity levels in pupils at reception year by area

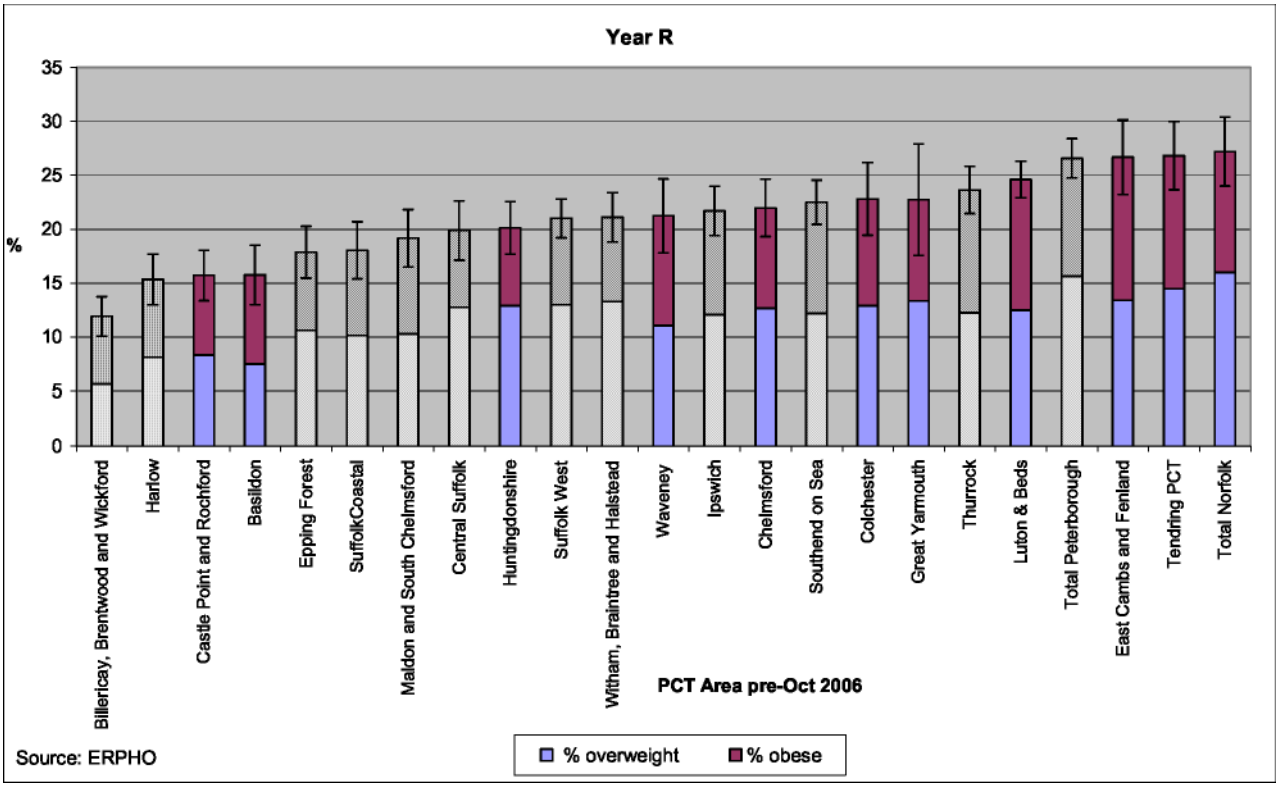
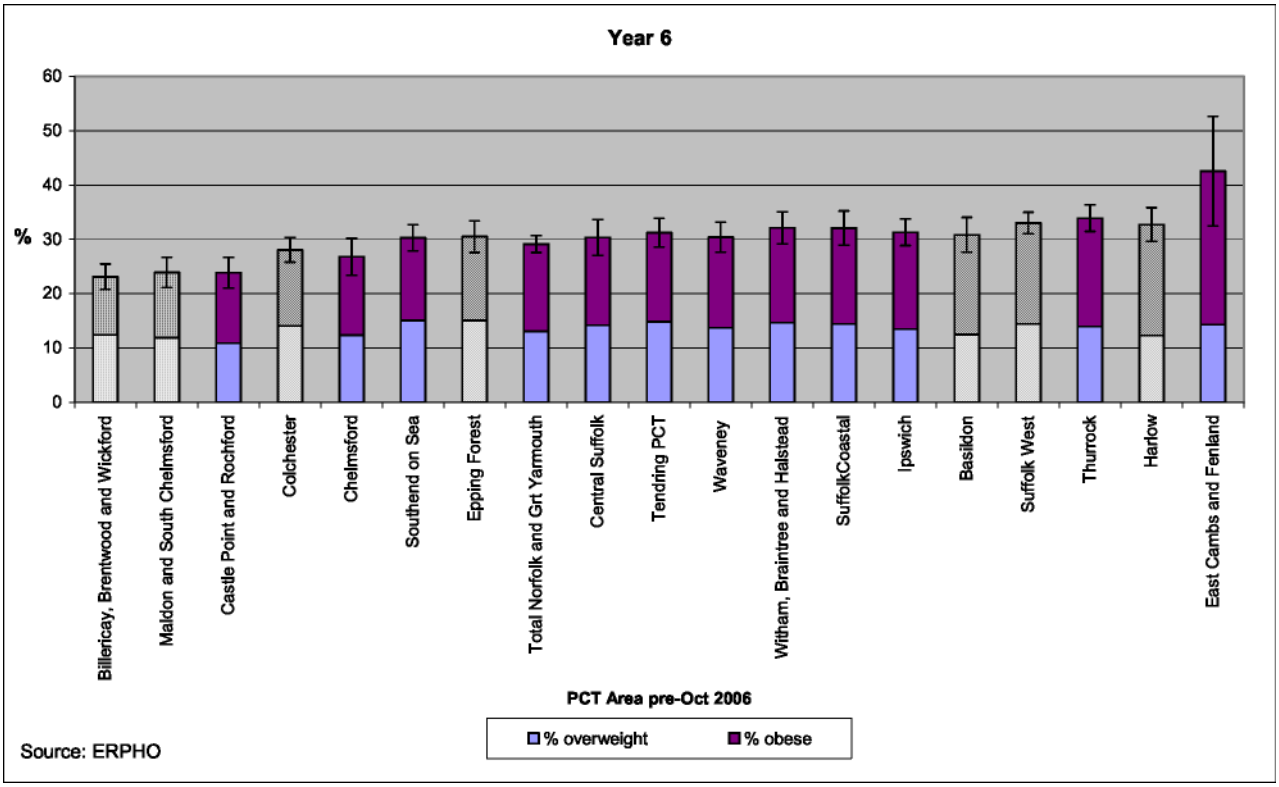


Figure 4.10: Obesity levels in pupils at Year 6 by PCT area



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

4.3 Not in Employment, Education or Training (NEET)

Educational attainment and employment are important for health and well-being. All Connexions services are required to carry out an annual survey of the destinations of Year 11 statutory school leavers. Across Essex, the proportion of Y11 statutory school leavers remaining in education has significantly increased since 2004 and there has been a significant reduction in the proportion not in education, employment or training (NEET) since 2005. The introduction of Education Maintenance Allowances (EMA) is likely to be a contributing factor; however no data is yet available on the take up of EMA'S for 2006.

In all three local authorities, Essex, Thurrock and Southend-on-Sea, there has been a reduction in the percentage entering non employed status work based training. This can be attributed to the withdrawal of non-employed apprenticeships and a reduction in the take up of E2E programmes.

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

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

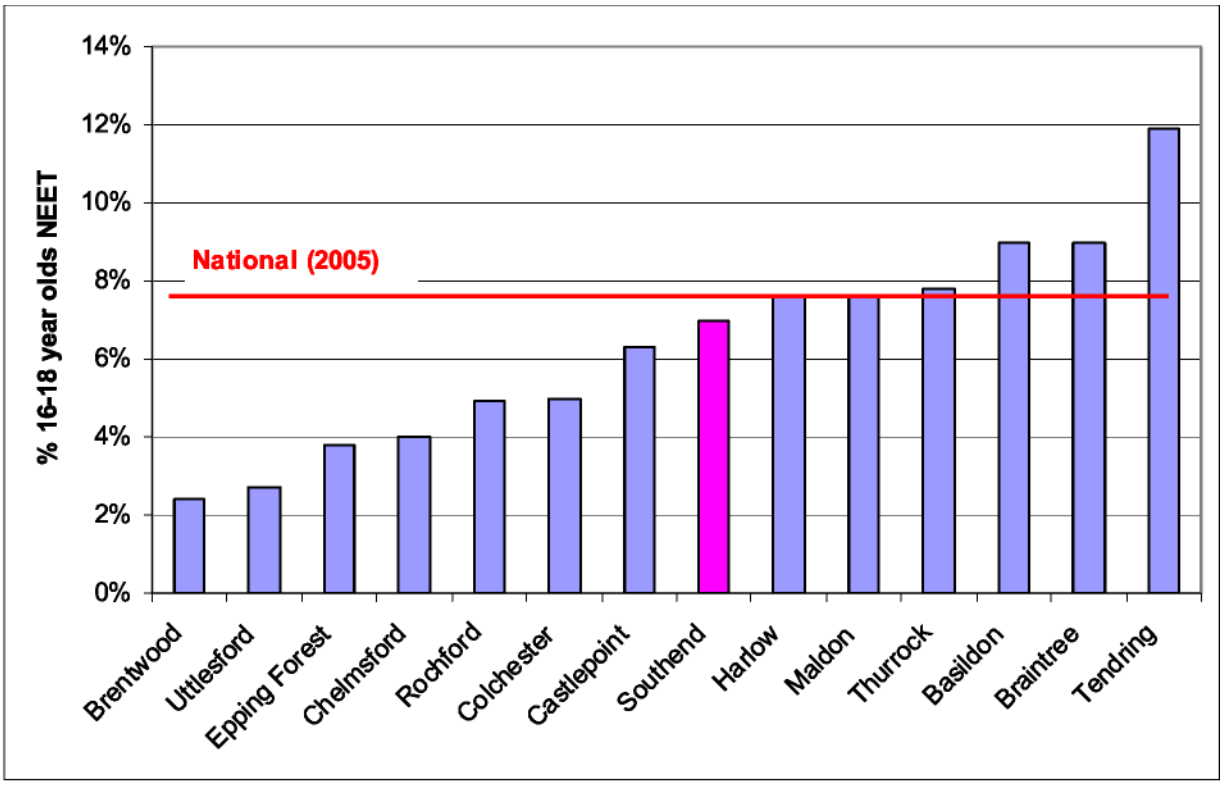
As national tables have yet to be published, we are currently unable to benchmark our performance in 2006 against other partnerships or with the regional and national results. However, the key headline data for 'Into Learning' and 'Unsettled' in all three local authority areas shows an improvement on 2005, as Figure 4.11 illustrates:-

Figure 4.11: EST connexions survey results

Local Authority	% Into Learning		% Unsettled	
	2006	**2005**	**2006**	**2005**
National average		85.9%		7.8%
Essex	90.9%	89.6%	7.5%	7.8%
Southend	91%	86.3%	6.8%	9.8%
Thurrock	86%	83.2%	9.9%	11.9%

The results of the EST Connexions survey show positive trends and evidence progress in engaging young people and moving them on into positive outcomes.

Figure 4.12 Essex NEETs, 2006-07



Source: EST connexions

4.4 Educational Achievement

Poor educational attainment plays a vital role in defining socio-economic status. Low educational achievement, truancy and exclusion from school all contribute detrimentally to events in later life such as increased likelihood of teenage pregnancy, inability to find employment and poorer health in general. Education plays an important part in reducing health inequalities. Education is dealt with in more detail in Chapter 2.

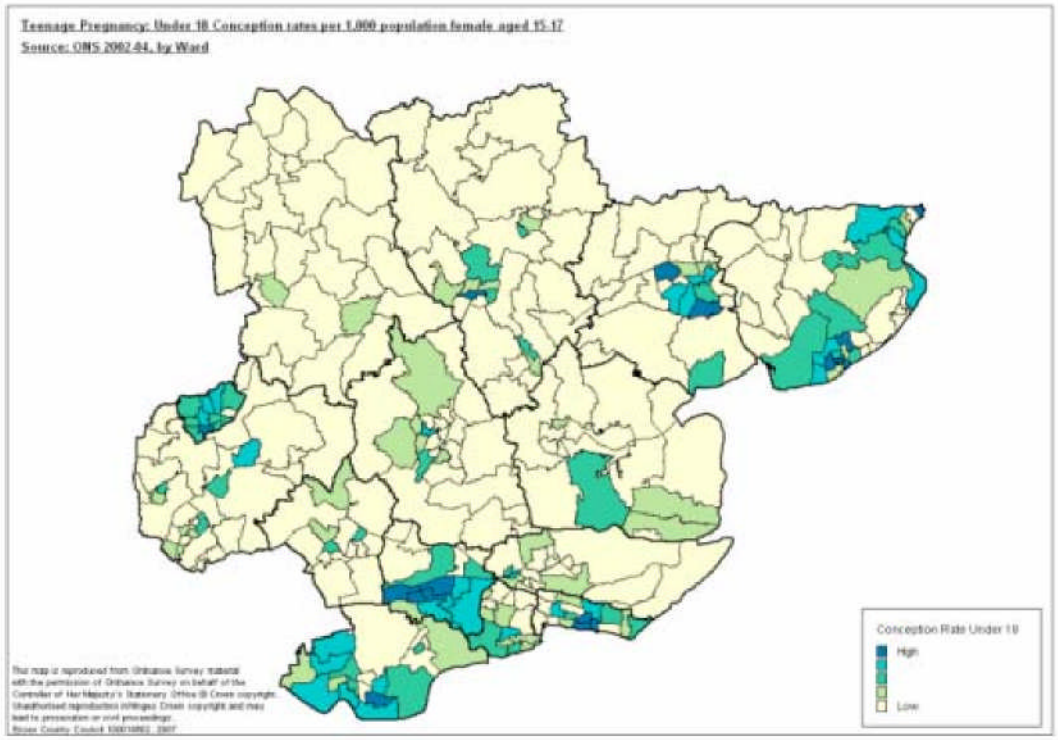
4.5 Teenage Pregnancy & Sexual Health

Improving the nations' poor sexual health remains a major public health priority. Sexually transmitted infections continue to increase, and while the high levels of teenage pregnancy are slowly decreasing in some areas, the decline is not rapid enough to meet the Government's target of a 50% reduction in the rate by 2010. Good local access to sexual health services plays an essential part in improving sexual health and reducing the rate of teenage pregnancy.

Southend has a provisional rate of 47 conceptions per 1,000 girls under 18 (2005 data). This compares to a teenage conception rate of 41 per 1,000 girls under 18 for England and 33 per 1,000 for the East of England and 31 per 1,000 for Essex.

Southend has seen a gradual decline over the last few years; however more needs to be done in this field if we are going to be able to tackle this problem effectively.

Figure 4.13: Under 18 Conception rate in quintiles for females aged 15 -17 in Essex by Ward



Where Figure 4.13 shows white areas, numbers are so small they have been suppressed to protect privacy.

4.6 Vulnerable Children

The term ‘children in need’ refers to those children receiving support from social services. The term ‘looked after children’ refers specifically to those who are in the care of the local authority. Those considered to be at risk of abuse or neglect are placed on the Child Protection Register (CPR). Around 700 children are on the CPR at any one time across Essex. Although numbers showed a sharp dip in 2003, overall the trend has been slightly upward over the past five years. The latest comparative data available gives a national rate of 24 children per 10,000 children aged <18. By comparison the rate is 17 per 10,000 for both ECC and Thurrock and 29 per 10,000 in Southend.

Many children in need will have health needs arising from:

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

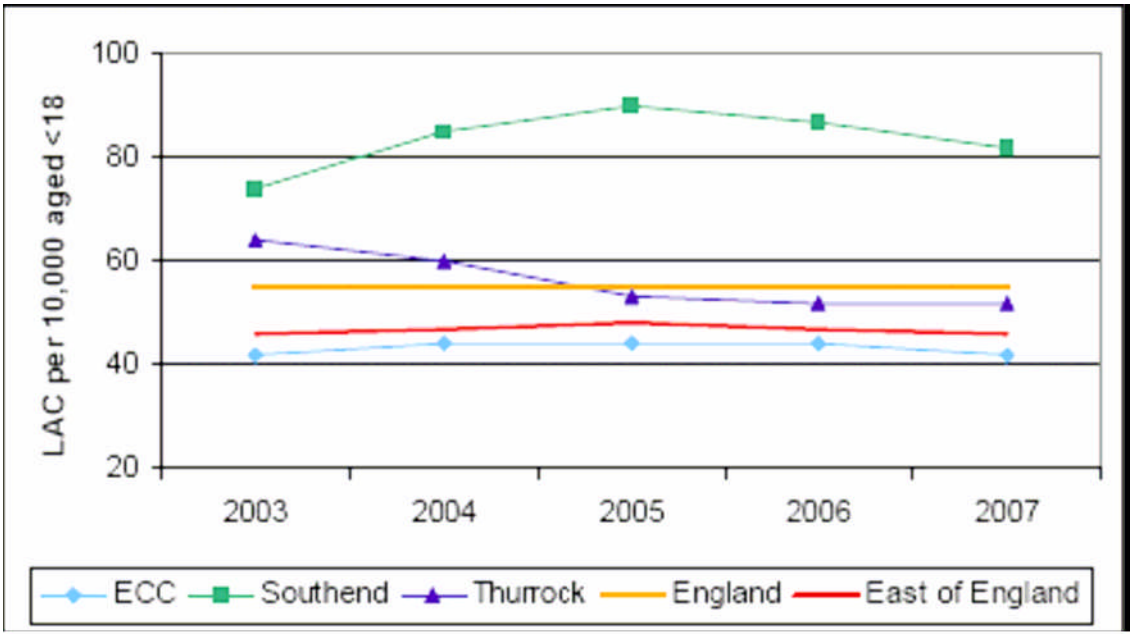
They may also have experienced poorer access to services including universal services (e.g. dental services, immunisations, routine child health surveillance and health promotion because of language or cultural barriers). Further barriers for looked after children are:

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

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

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

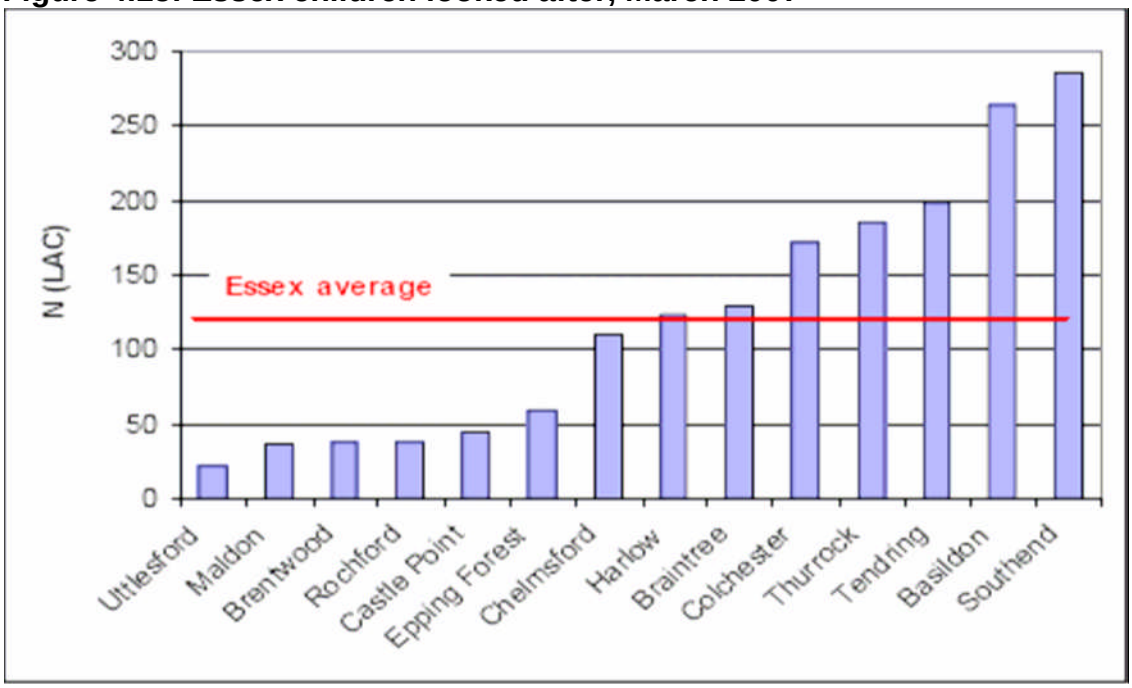
Figure 4.14: Essex rates of children looked after, 2007



Source: SSDA903 return on children looked after

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

Figure 4.15: Essex children looked after, March 2007



Source: SSDA903 return / Swift

4.7 Conclusion

With MMR immunisation rates well below the WHO recommendation, it is perhaps unsurprising that the incidence of measles in very young children is well above the national rate in Southend.

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

CHAPTER 5 WORKING ADULTS AND OLDER PEOPLE

5.1 Older People Living Alone

The living circumstances of older people affect both opportunities for social interaction and the need for additional support from formal and informal services. It is estimated that the number of people aged 65+ living on their own will have increased by 44% by 2025 and by 53% for those aged 75+. This is likely to impact on feelings of isolation and, in rural areas particularly, on the cost of providing services as levels of travel for support staff increase. Below are the estimates of those who will live alone in Essex over various different time periods.

Figure 5.1: Living arrangements of people aged 65 and over by age bands (65-74, and 75 and over) and gender and numbers living alone, projected to 2025

	2008	2010	2015	2020	2025
Males aged 65-74 predicted to live alone	10,098	10,744	12,801	13,277	13,090
Males aged 75 and over predicted to live alone	13,048	13,776	15,876	18,424	22,428
Females aged 65-74 predicted to live alone	21,582	23,001	27,555	28,545	27,621
Females aged 75 and over predicted to live alone	41,418	42,067	45,489	50,976	61,065
Total population aged 65-74 predicted to live alone	31,680	33,745	40,356	41,822	40,711
Total population aged 75 and over predicted to live alone	54,466	55,843	61,365	69,400	83,493

Figure 5.2 below shows the burden that will be placed on local authority care homes in Essex over the next 20 years

Figure 5.2: People aged 65 and over by age (65-74, 75-84, 85 and over) living in a care home with or without nursing by local authority / non-local authority, projected to 2025

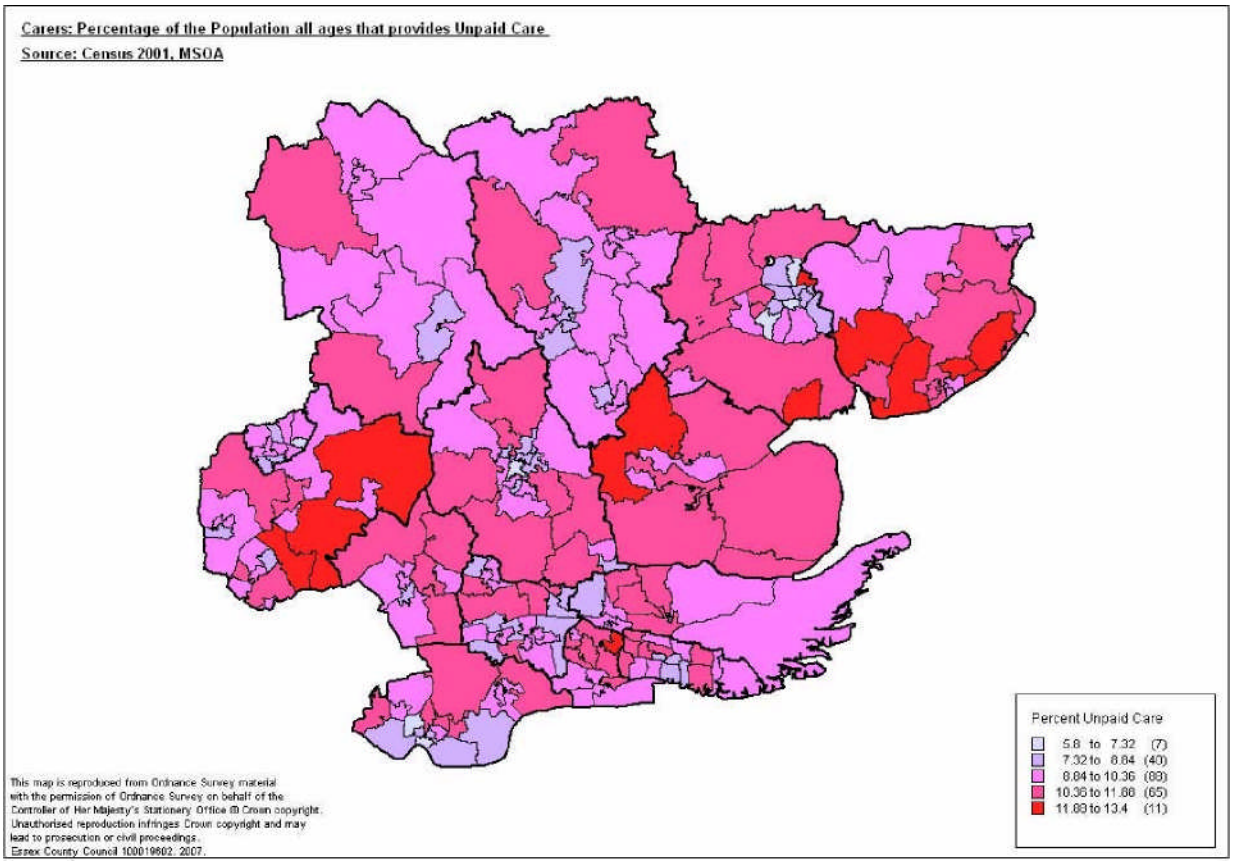
	2008	2010	2015	2020	2025
People aged 65-74 living in a LA care home with or without nursing	64	68	81	84	82
People aged 75-84 living in a LA care home with or without nursing	310	316	347	393	476
People aged 85 and over living in a LA care home with or without nursing	649	685	784	904	1,075
People aged 65-74 living in a non LA care home with or without nursing	513	546	653	676	660
People aged 75-84 living in a non LA care home with or without nursing	1,658	1,694	1,857	2,103	2,549
People aged 85 and over living in a non LA care home with or without nursing	3,505	3,698	4,236	4,881	5,806
Total population aged 65 and over living in a care home with or without nursing	6,699	7,007	7,958	9,041	10,649

5.2 Carers

In 05-06 the rate of carers in Southend receiving a carers assessment or review was 9.4 per 1,000 of the population aged 18+, this is above the national rate of 8.9 and Essex county rate of 6.9 per 1,000 of the population aged 18 and above.

Information on informal care can be obtained from the census. In ECC 127.1 people per 1,000 of the population aged 18+ are providing unpaid care. This can be compared to a rate of 7.2 carers known to social services with an assessment per 1,000 of the population aged 18+. Although we would expect this to be lower than the census data, this equates to a difference of 120 per 1,000 of the population 18+.

Figure 5.3: Percentage of population all ages that provide unpaid care by MSOA



58% of carers currently receive support from social services for themselves or the person they look after in the form of day care, home care or respite breaks. 14% think these services are .completely sufficient., 41% .mostly sufficient. and 32% .partly sufficient.[14]
In 2005-06 the number of carers assessed / reviewed by social services was 6.9 per 1,000 adults in ECC, 9.4 per 1,000 in Southend and 4.8 per 1,000 in Thurrock. The national rate is 8.9 per 1,000 adults.

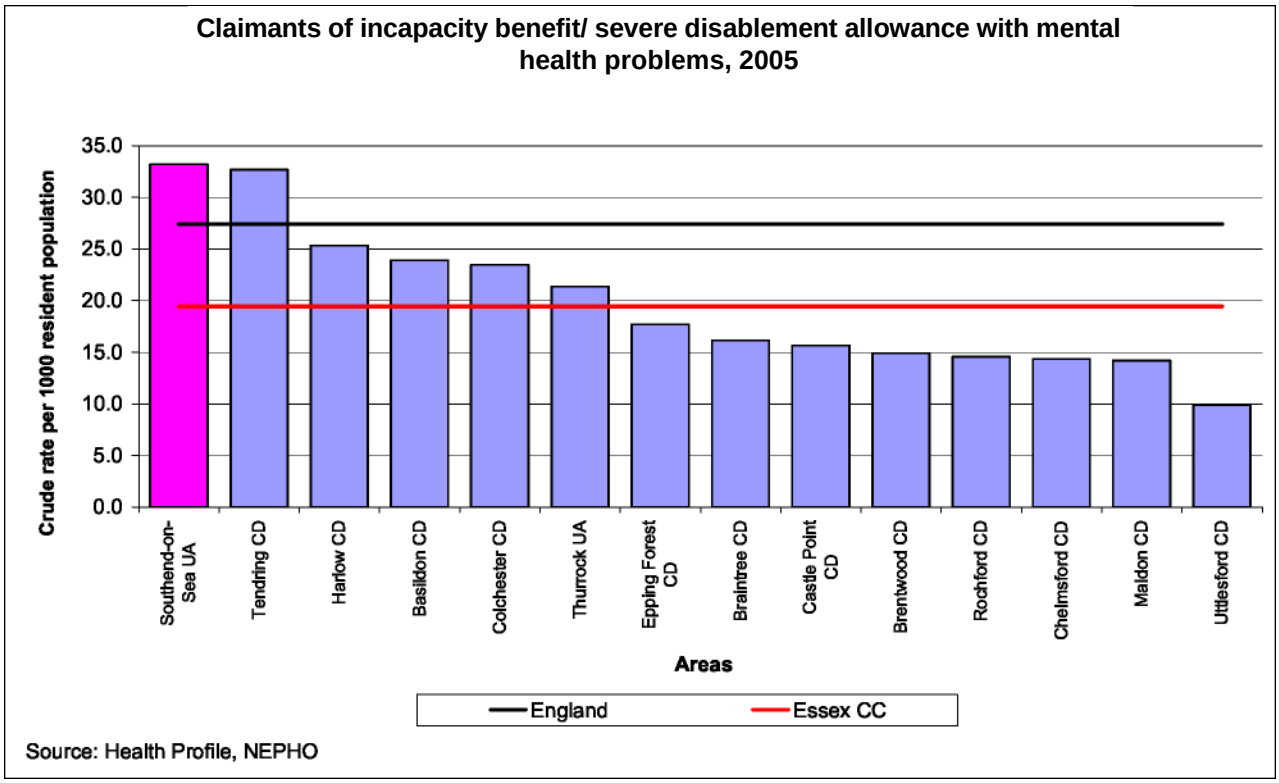
Over 3000 people in Southend provide over 50 hours of care every week with 37% of that delivered by carers aged 65 and over. In 2006 a sample survey was carried out with older people living in Southend. 70% of respondents providing care felt that their caring role had an impact on their daily life.

5.3 Mental Health

5.3.1 Claiming benefit

Figure 5.4 details the rate per 1,000 working age population who were claiming benefit or severe disablement allowance with a diagnosis in the mental and behavioural disorders category. This is a direct measure of economic disadvantage as a consequence of severe mental illness.

Figure 5.4: Claimants of incapacity benefit/severe disablement allowance with mental health problems - 2005



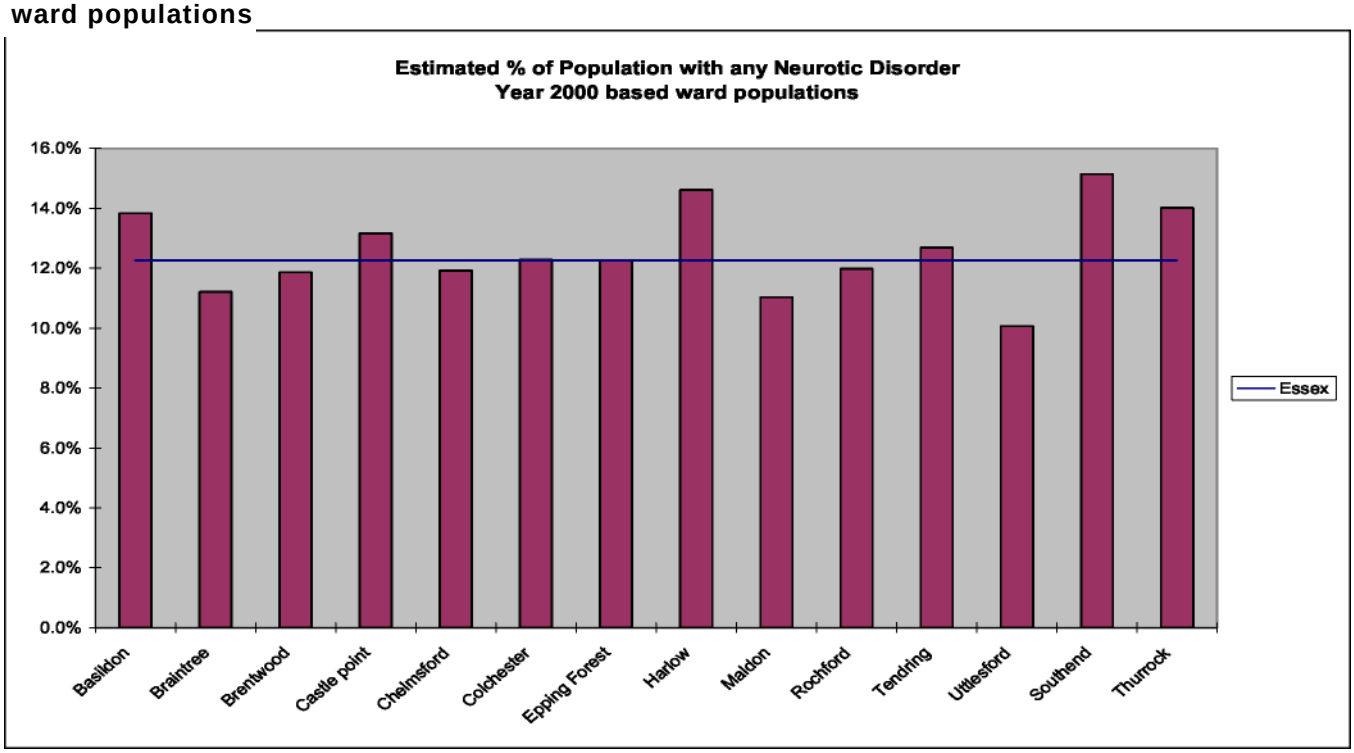
This highlights that within Essex Southend has the highest rate of the working age population claiming benefit/allowance for a mental or behavioural disorder. Southend is statistically significantly higher than England's claimant rate.

Data source: Association of Public Health Observatories – Community Profile 2007

5.3.2 Neurotic disorder and depression

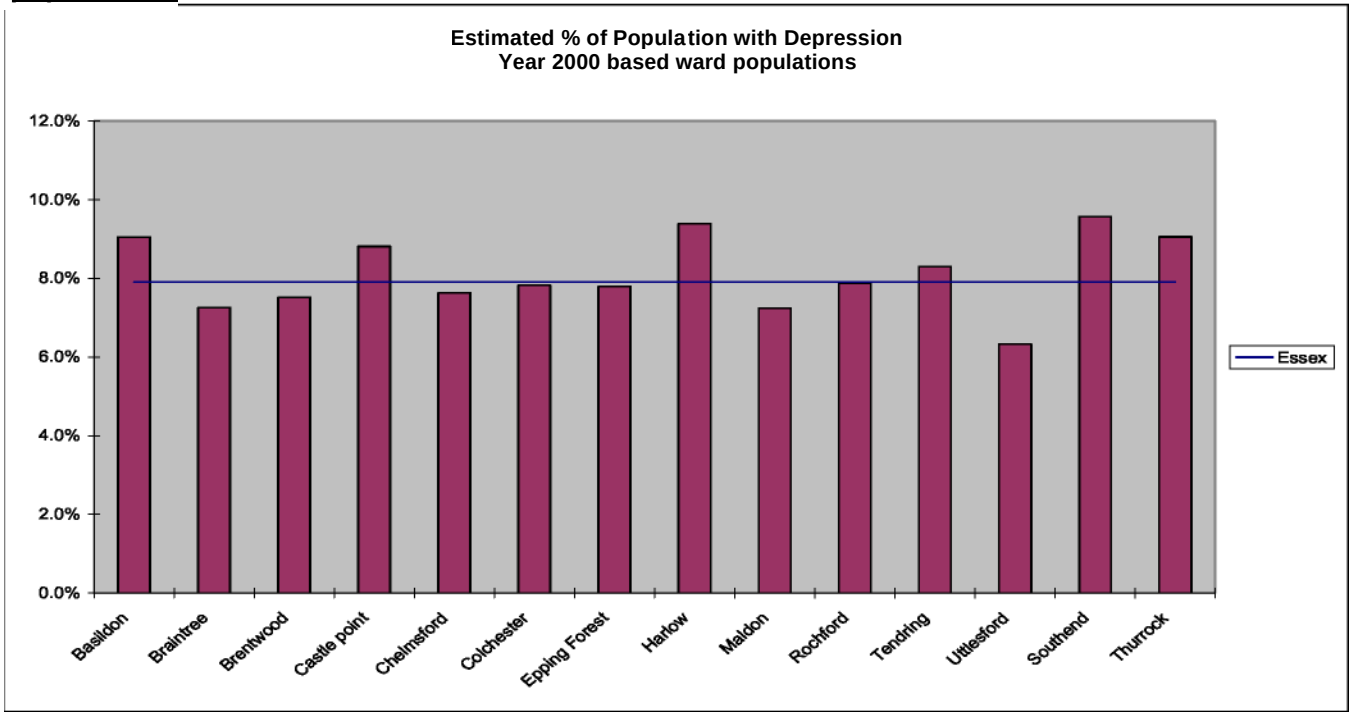
Figures 5.5 and 5.6 present estimates of the percentage of the working age population that is experiencing any type of neurotic disorder and depression. The data is derived from the ONS national epidemiology survey, 'Psychiatric morbidity among adults living in private households, 2000', modelled using an ONS mathematical model that factors in four variables that were found to best explain variation in psychiatric morbidity.

Figure 5.5: Estimated percentage of population with any neurotic disorder – 2000 based on ward populations



At just over 14% Southend has the highest estimated percentage of the working age population suffering from a neurotic disorder.

Figure 5.6: Estimated percentage of population with depression – 2000 based on ward populations



Data source: Centre for Mental Public Health

At just over 9%, Southend has one of the highest estimated percentage of the working age population suffering from depression.

5.3.3 Dementia

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

Prevalence of dementia
Dementia can affect people of any age, but is most common in older people. One in six people over 80 has a form of dementia and one in 14 people over 65 has a form of dementia. Alzheimer's disease is considered to be the dominant subtype, particularly among older people, and in women.

As the population ages, the number of people with dementia will climb rapidly. The number of people with dementia in the UK is forecast to increase by 38% over the next 15 years.

The prevalence of both early onset and late onset dementia increases with age, doubling with every five-year increase across the entire age range from 30 to 95+.

Figure 5.7: Estimates of the population prevalence of late onset dementia

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

Consensus estimates of the population prevalence of late onset dementia

Early onset dementia is comparatively rare, accounting for 2.2% of all people with dementia in the UK. Its prevalence is judged to be higher in men than in women for those aged 50-65, while late onset dementia is considered to be marginally more prevalent in women than in men.

Among those with late onset dementia, 55.4% have mild dementia, 32.1% have moderate dementia and 12.5% have severe dementia. The proportion considered to have severe dementia increases with increasing age, from 6.3% for those aged 65-69 to 23.3% for those aged 95 years and over.

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

There is a much higher prevelance of dementia in people with learning disabilities. According to the foundation for People with Learning Disability and the Alzheimers Society 54.5% of people with Down's syndrome will develop this condition. 15-20% of the learning disability population have Down's syndrome and it is estimated that 36% of people with Down's syndrome between 50 and 59 will have dementia.

5.3.4 Regional variation

Local authorities with larger proportions of older inhabitants and with a higher relative density of institutional places will tend to have a higher whole population prevalence of dementia. In addition, rural authorities with dispersed populations may face increased costs and logistical difficulties in providing home-based care in the community. Chart 5.8 sets out the variation in the prevalence of dementia across Southend, Essex and Thurrock. For comparison, it is estimated that 1.1% of the total UK population have dementia.

Fi[g]ure 5.8: Percentage of over 65s with dementia

	Men			Women			Total
Area	Total	% over 65s with dementia	% total pop with dementia	Total	% over 65s with dementia	% total pop with dementia	% total pop with dementia
Essex	5,273	5.0	0.8	9,994	7.5	1.5	1.14
Southend-on-Sea	783	6.2	1.0	1,779	9.6	2.2	1.61
Thurrock	354	4.2	0.5	692	6.0	0.9	0.71

Figure 5.9: Estimate of Dementia in the Elderly - Essex

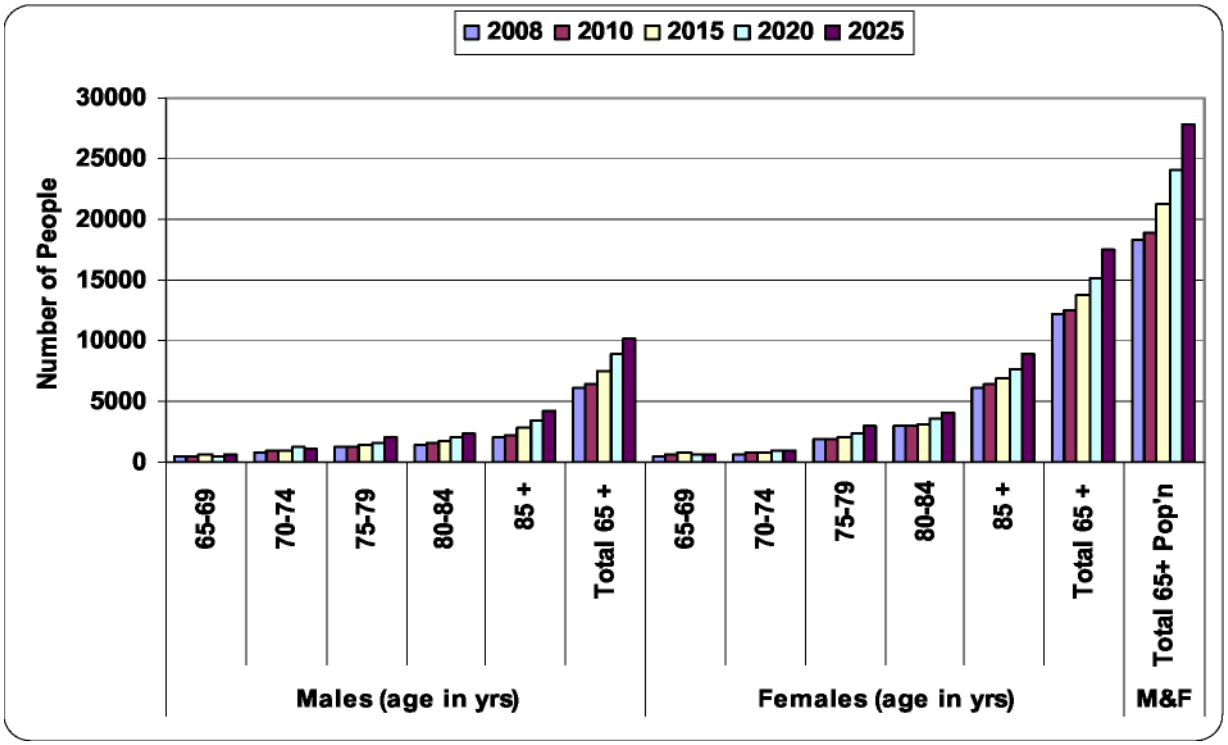
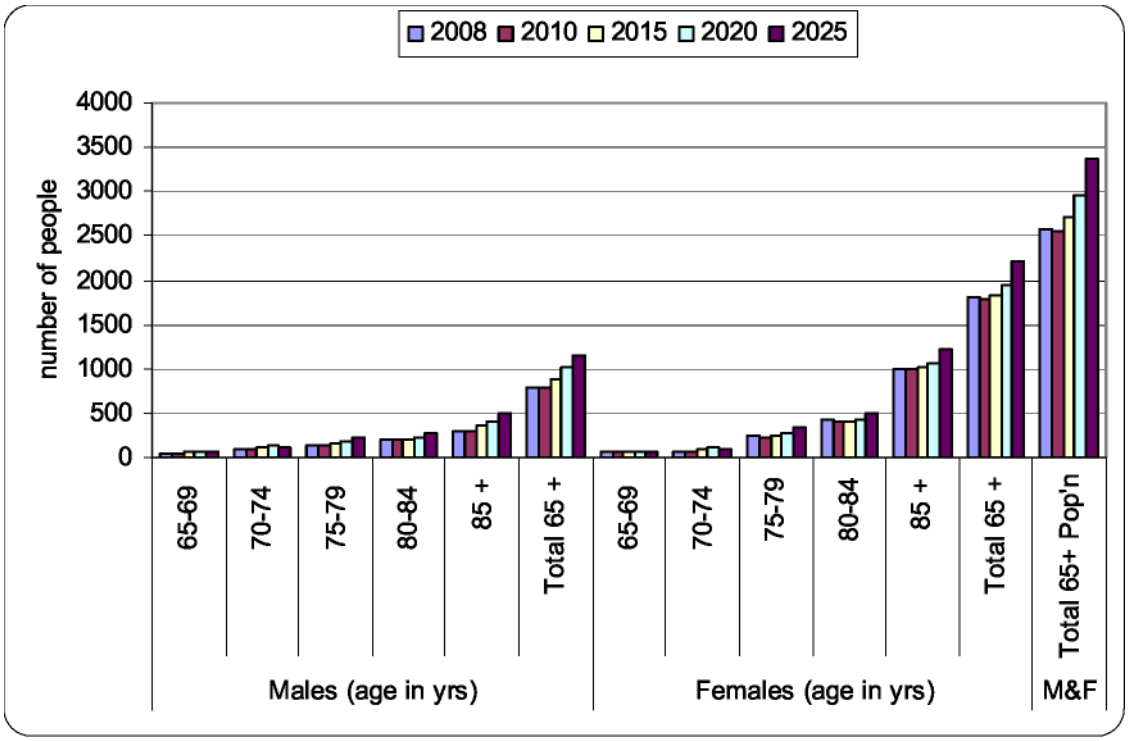


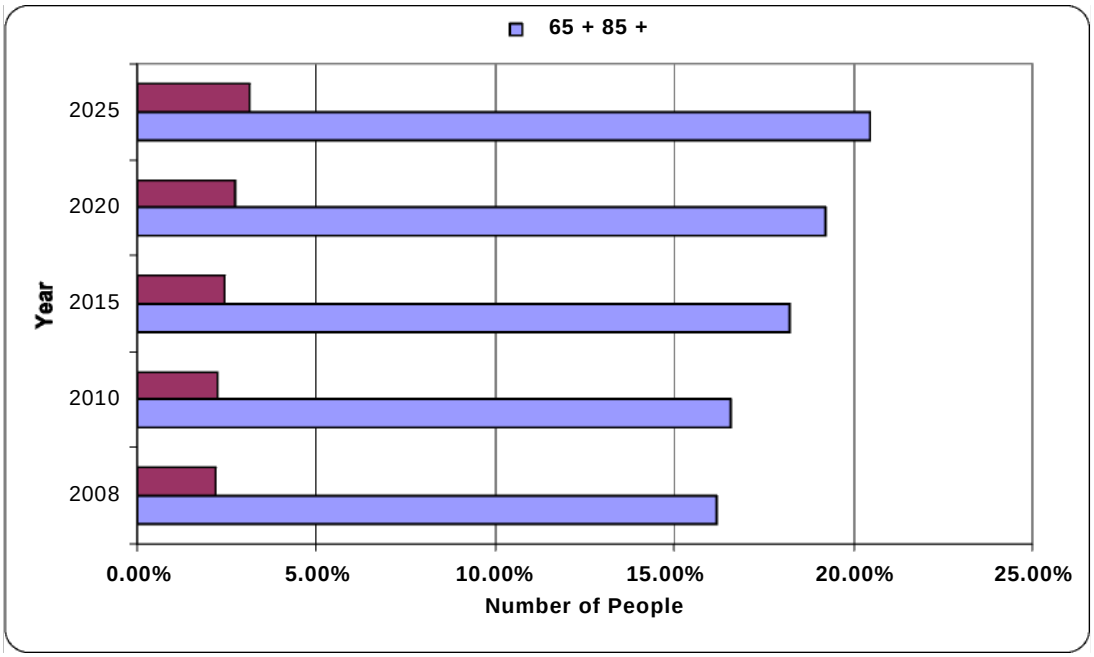
Figure 5.10: Estimate of Dementia in the Elderly – Southend



5.4 Older Population

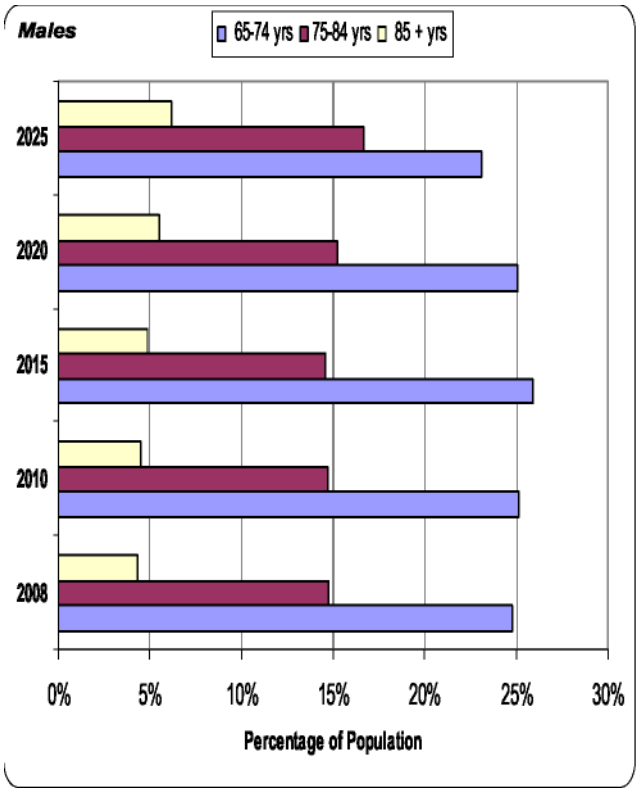
As a country and indeed as a county we are becoming an increasing older population. Figure 12 below shows how the population in England is becoming increasing older. In 2008 approximately 16% of people will be aged 65 and over and a further 2% of the population will be aged 85 and over. By 2025 the proportion of people aged 65 and over is set to increase to over 20%, with 3% aged 85 and over.

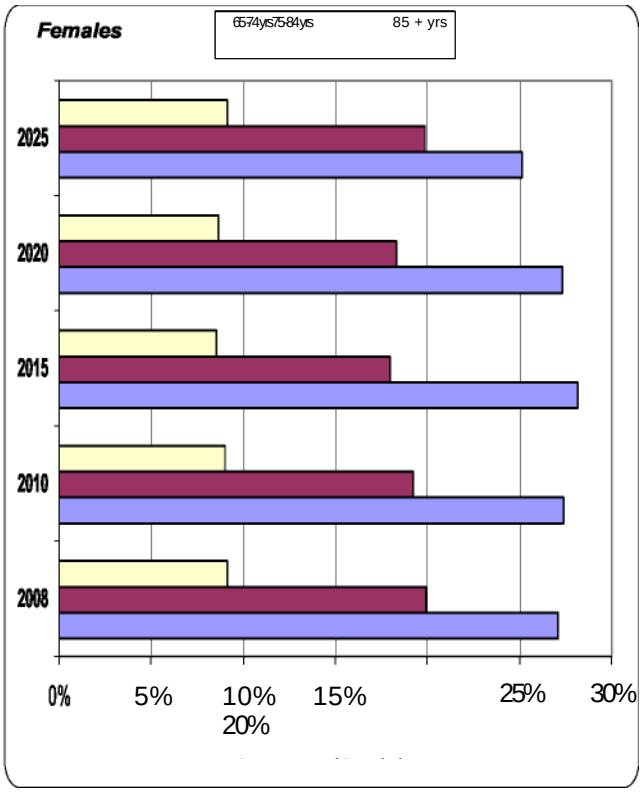
Figure 5.11: Proportion of People Aged 65+ in England at various time points



The gender split as the population gets older stays roughly the same at age 65-74 years at around 27% for females and 25% for males and this continues to 2025. In the 85+ age group there is a bigger difference with approximately 9% of females in this age band compared to only 4% of males. However by 2025 the proportion of males increases to around 6% but the proportion of females stays static at the 9% mark.

Figure 5.12 Estimated proportion of males and females aged between 66 – 85+ years in England between 2008 and 2025





The age-gender split as a proportion of 65-74 year olds is fairly static in males and females at 24% and 27% respectively in 2008. By 2025 the proportion of males has decreased to 22% and females to 24%. The Essex 85+ and over follows the same pattern as the England 85+ with males around 4% in 2008 increasing to 6% in 2025 and female at 9% and staying static at 9% over the same time period.

5.5 Older people and Long-term Conditions

The World Health Organisation has identified that long-term conditions will be the leading cause of disability by 2020 and that, if not successfully managed, will become the most expensive problem for health care systems[17]. Long-term conditions are those that can only be controlled and not, at present, cured. They include diabetes, asthma, arthritis, heart failure, dementia and other neurological diseases.

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

Looking after patients with long-term conditions is very costly and uses a large proportion of health and social care resources. People with long-term conditions are significantly more likely to see their GP (accounting for about 80% of GP consultations), to be admitted as in-patients and to use more in-patient days than those without such conditions.

The information contained within the following sections uses data taken from POPPI (Projecting Older People Population Information System www.poppi.org.uk).

5.5.1 Bronchitis and emphysema

Figure 5.13: Estimate of Bronchitis and Emphysema in the Elderly - Essex

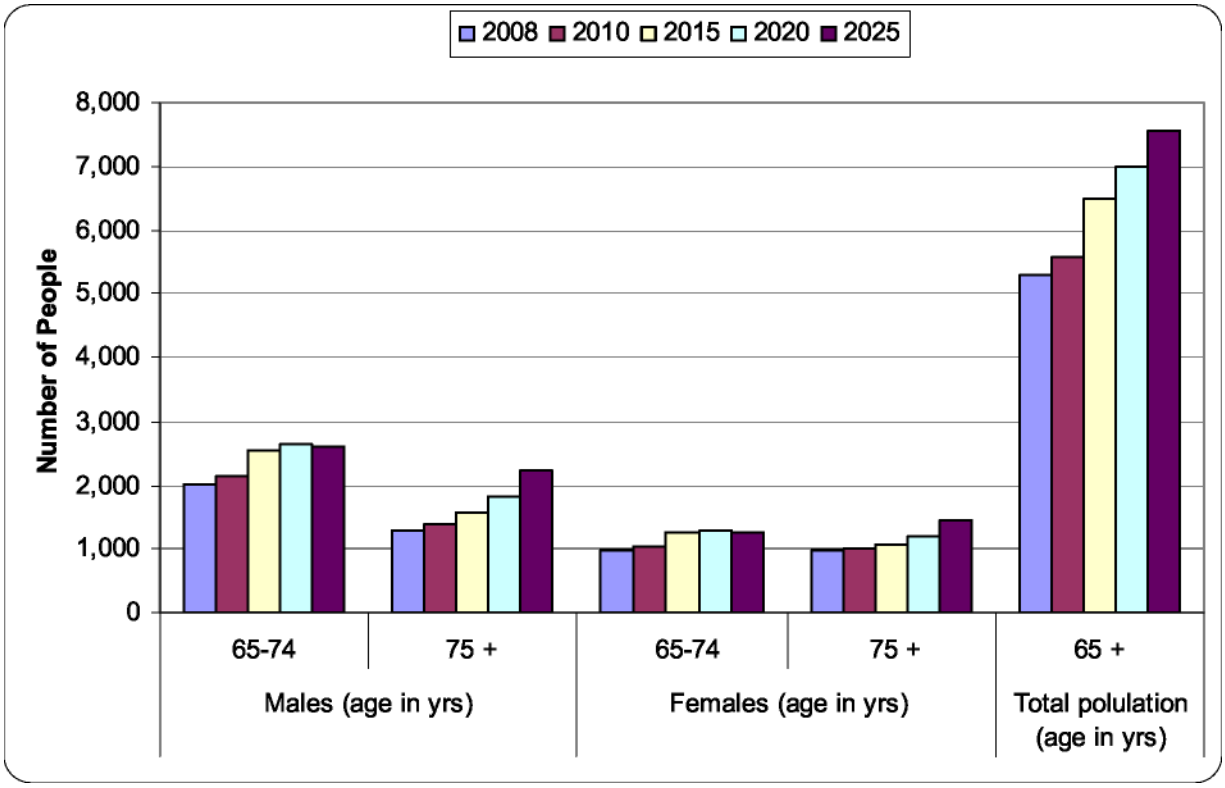


Figure 5.14: Estimate of Bronchitis and Emphysema in the Elderly - Southend

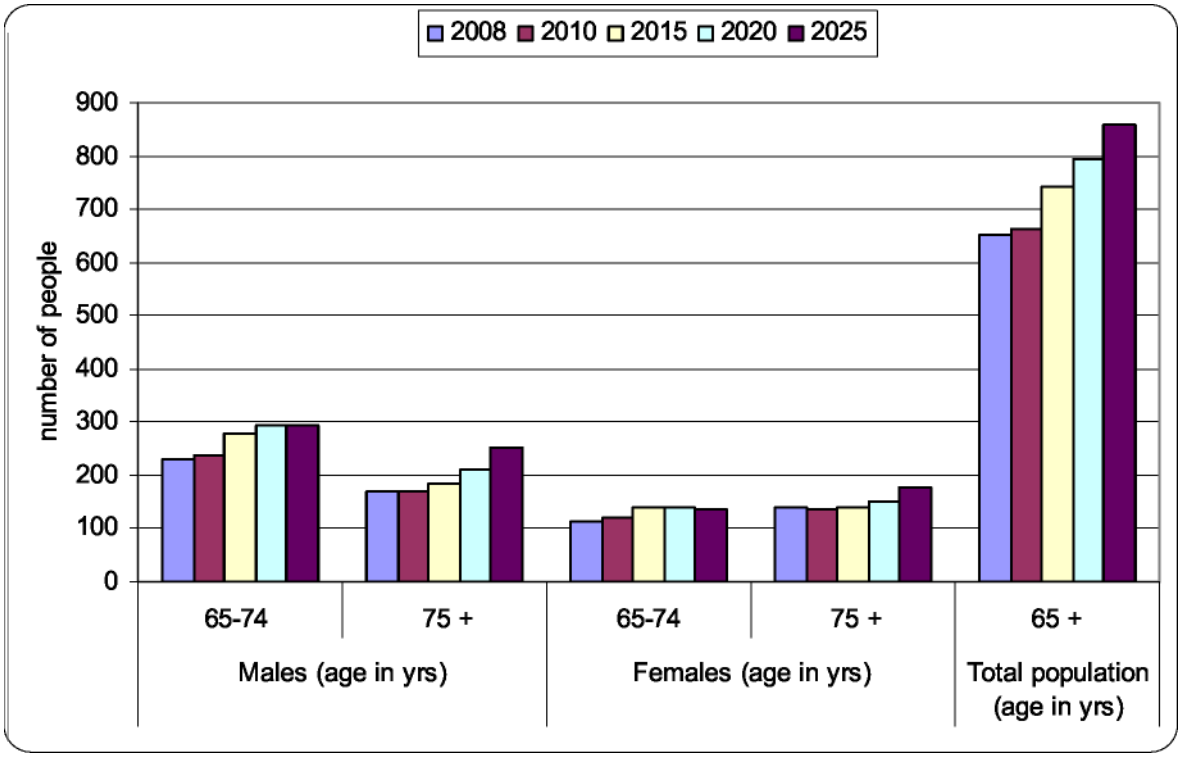


Figure 5.14 shows those aged 65 and over in Southend predicted to have a longstanding health condition caused by bronchitis and emphysema.

In England it is estimated that by 2025 there will be over 250,000 people aged over 65 with a chronic respiratory condition and Essex will have just over 7,500 of these patients.

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

The graph below shows those aged 65 and over with the highest and lowest estimated level, predicted to have a continence problem and living in the community. Currently the highest prediction for males in England is 363,000 and for females it is 930,000. The estimated highest prediction for males is set to rise to 522,000 by 2025 and to 1.2 million for females in 2025.

The figures for Essex are males current highest estimate is 11,000 but will rise to 16,000 by 2025. Female current highest estimate 30,000 predicted to rise to 40,000 by 2025.

5.5.2 Continence

Figure 5.15: Estimate of Continence in the Elderly - Essex

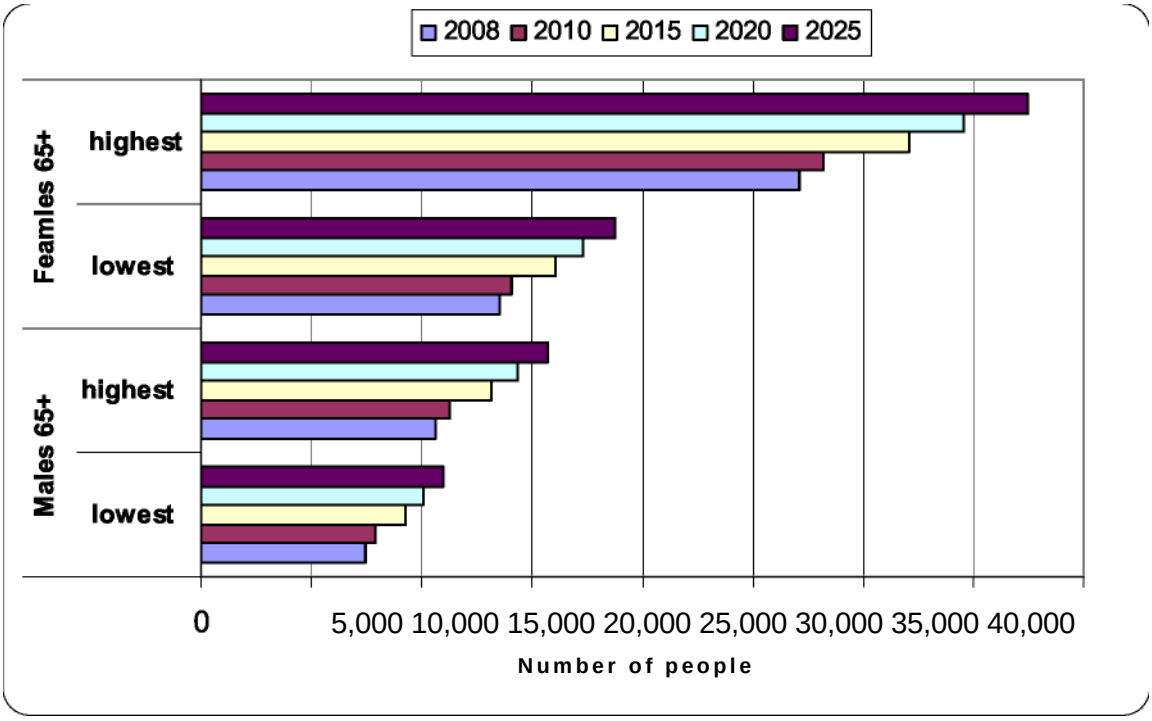
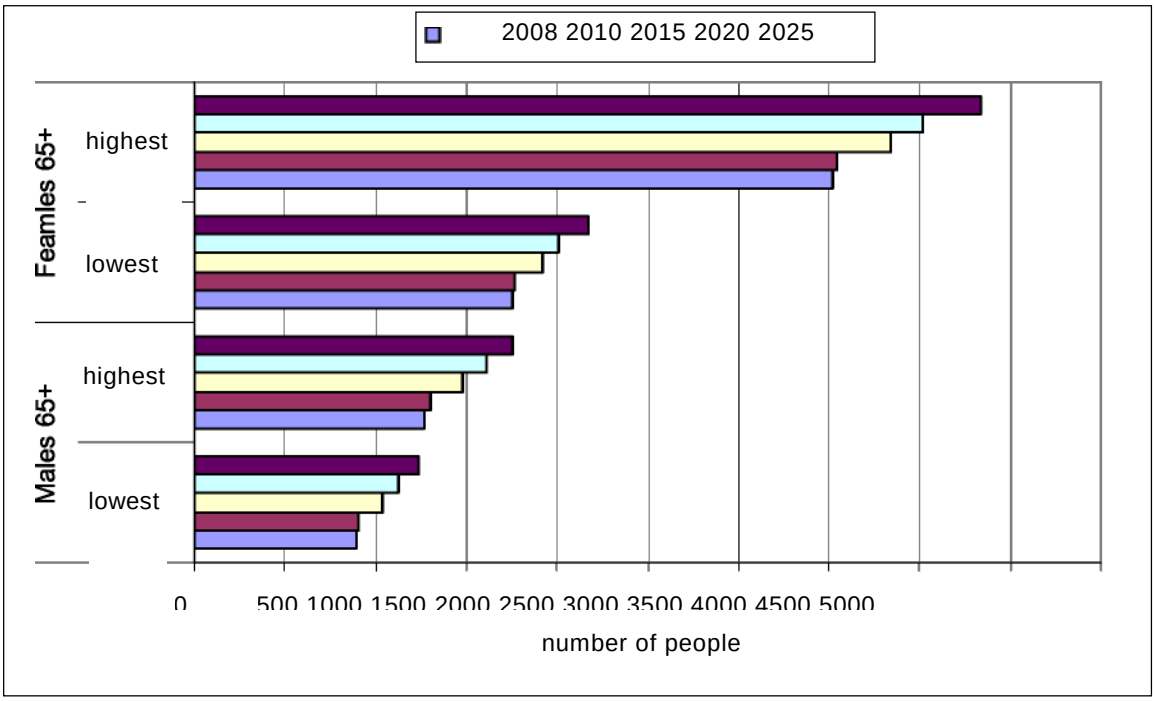


Figure 5.16: Estimate of Continence in the Elderly - Southend



5.5.3 Depression

Depression is the most common mental illness found in old people and the second commonest single underlying cause for all GP consultations for people over 70 years of age.[1]

Figures 5.17 and 5.18 show the future impact of depression in Essex and Southend at the lowest and highest predictions. The highest prediction for Essex currently is approximately just under 40,000 people aged over 65 suffer with depression. For Southend this figure is 4,500. By 2025 Southend is predicted to have almost 6,000 sufferers aged 65 and over.

[1] http://www.netdoctor.co.uk/diseases/depression/depressionintheelderly_000602.htm

Figure 5.17: Depression in the Elderly – Essex (POPPI)

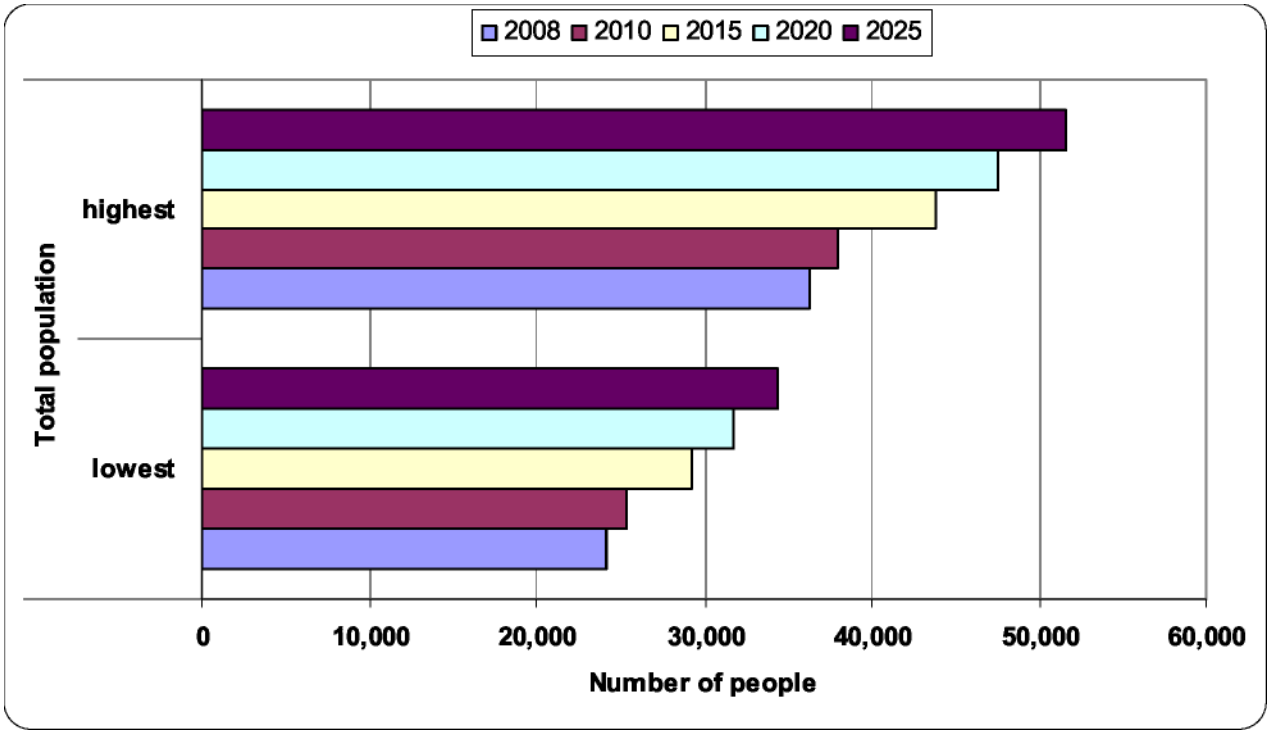
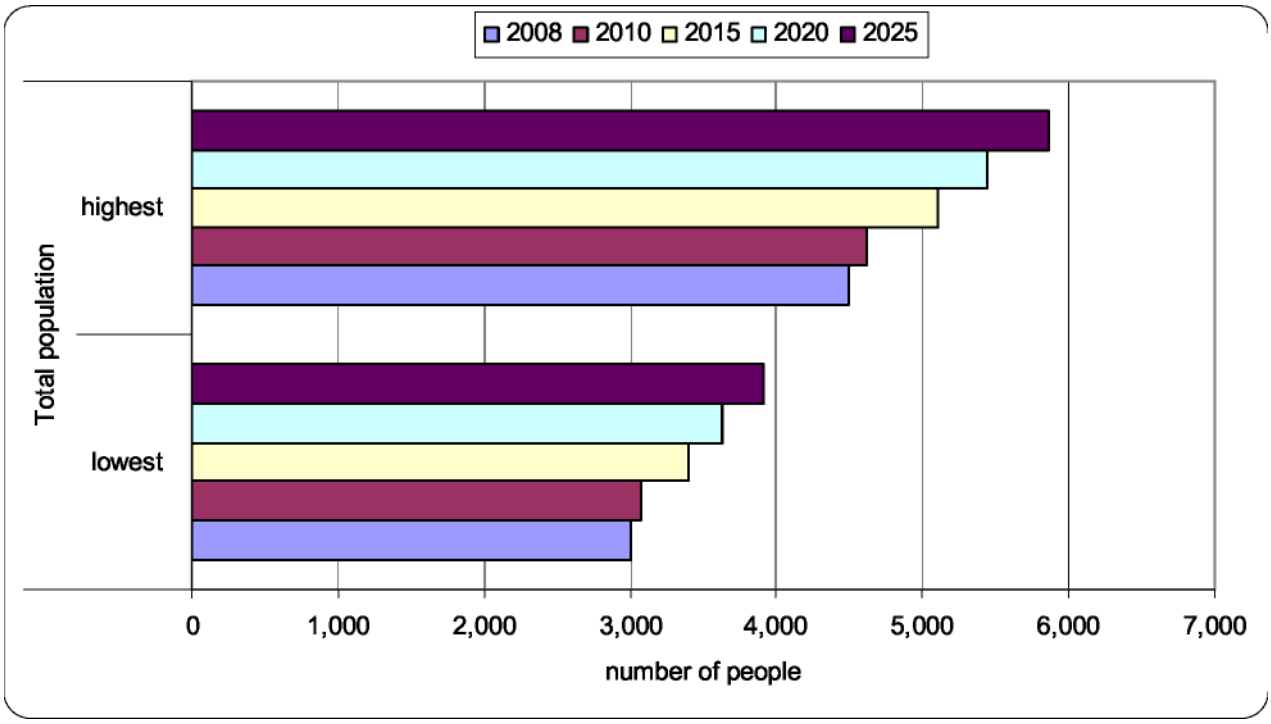


Figure 5.18: Depression in the Elderly – Southend (POPPI)



5.5.4 Falls

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

Those aged 65 and over predicted to attend Accident and Emergency (A&E) departments as a result of falls is currently at 516,000 for England of which 377,000 are in the 75 and over population. By 2025 total attendances at an A&E department is set to be 740,000 again with the largest proportion being in the 75 and over age group which is expected to be 560,000 attendances. Southend currently has a total of almost 2,000 attendances in all ages over 65, of which 1,500 are in the 75s and over. In 2025 the 65 and over age group are expected to have just under 2,600 attendances at an A&E department with the 75 and over age group accounting for 2,000 of these.

Figure 5.19: Estimate of falls that result in A&E attendance in the Elderly - Essex

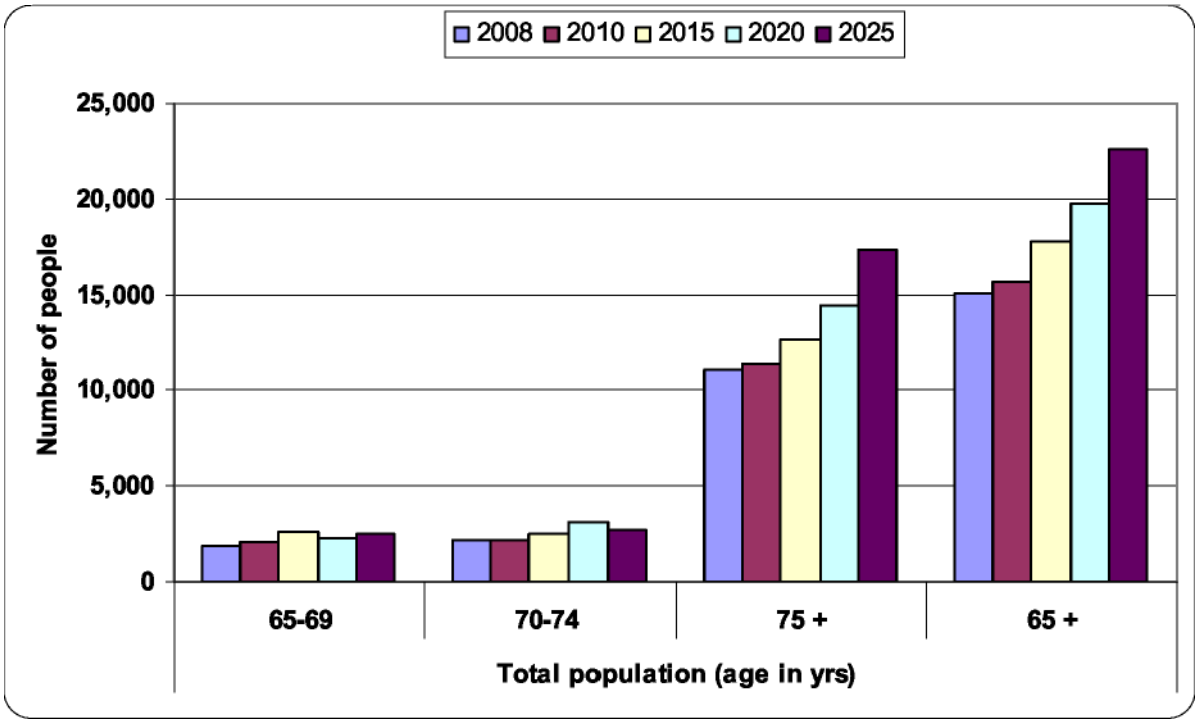
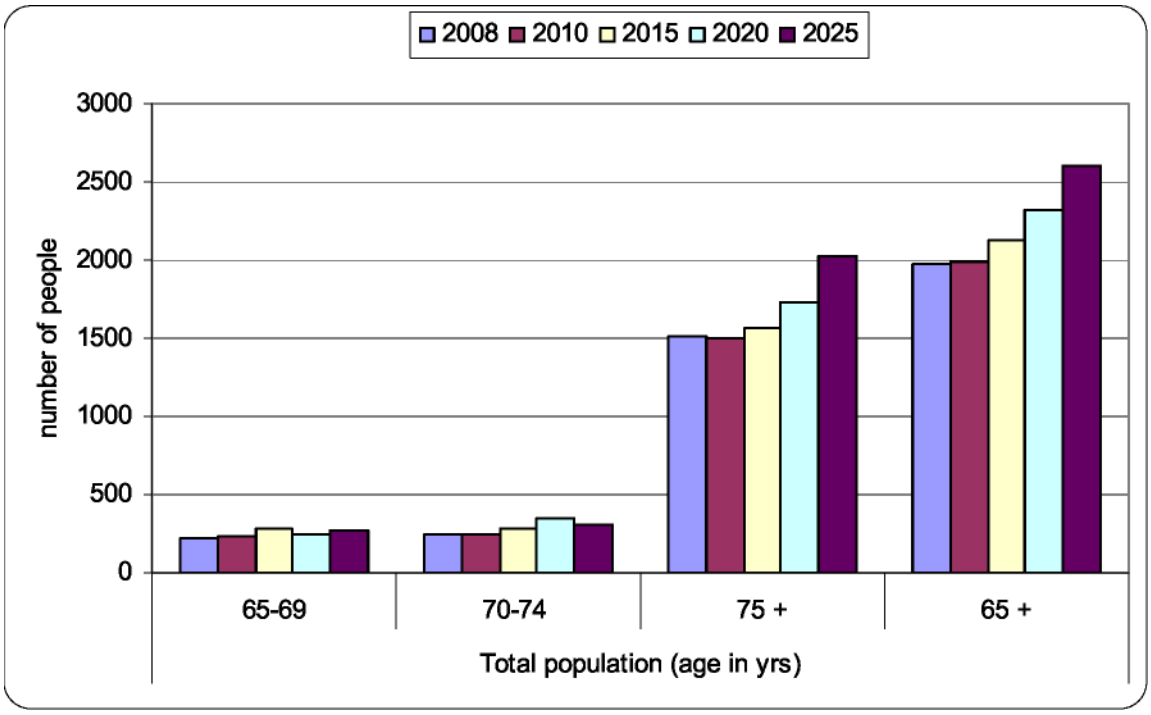


Figure 5.20: Estimate of falls that result in A&E attendance in the Elderly – Southend



Of those that attend an A&E department for a fall, it is likely that a third of them will be admitted as an inpatient. Current estimates for admission after at fall are 177,000 for England rising to 255,000 by 2025. In Southend the current estimates of admissions for the over 65s is 667 rising to 833 admissions by 2025.

5.5.5: Cardiovascular disease

The likelihood of developing most illnesses increases with age, and cardiovascular disease is no exception. As the body ages the risk of suffering from heart disease increases as over the years the effects of a lifestyle takes its toll on the cardiovascular system. Co-morbidities such as diabetes also increase the risk of having heart disease or associated illnesses.

Heart attacks for those aged 65 and over in England currently stand around 580,000, by 2025 this will be over 800,000. In Southend the burden of heart attacks in the over 65s is 2,100 rising to 2,800 by 2025.

Figure 5.21: Estimate of Heart Attacks in the Elderly – Essex

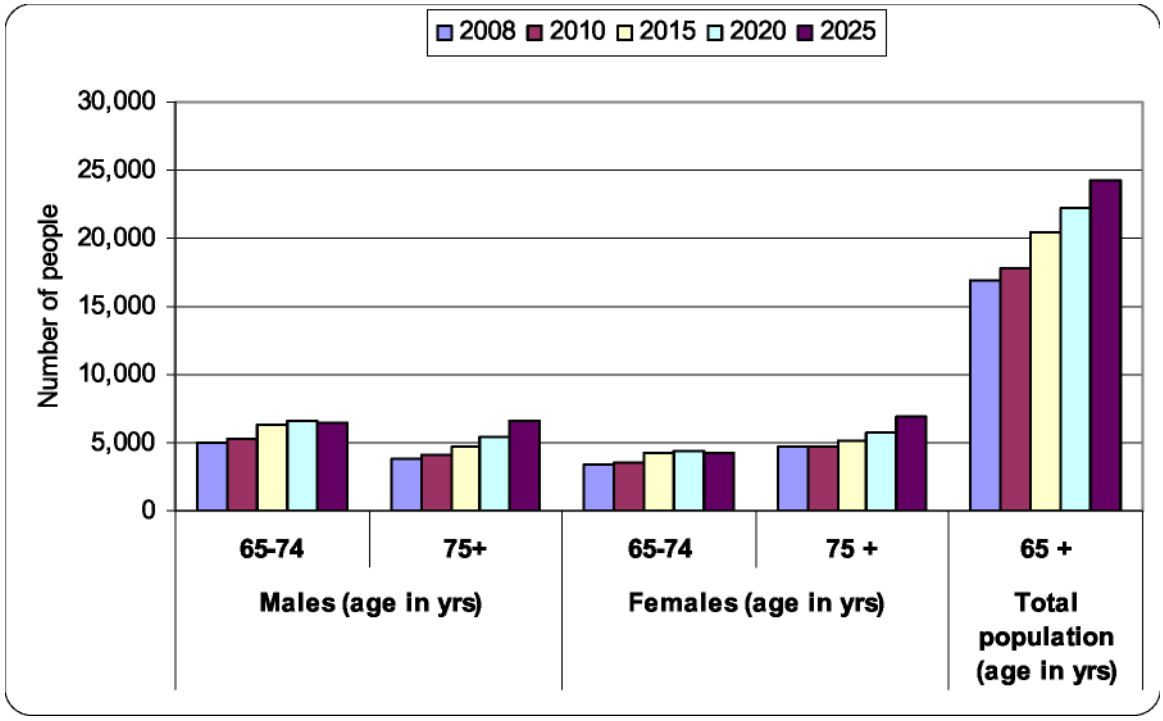
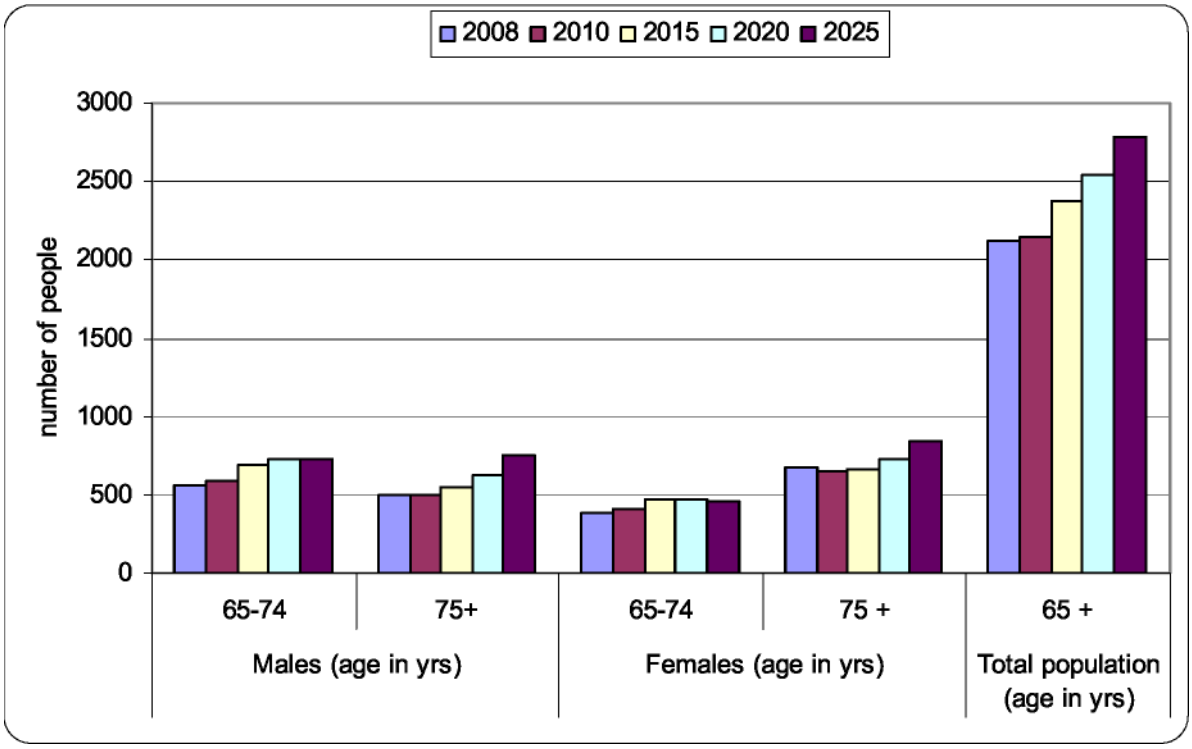


Figure 5.22: Estimate of Heart Attacks in the Elderly – Southend



5.5.6 Stroke

Every year in the UK, around 130,000 people have a first stroke - about one person every five minutes.

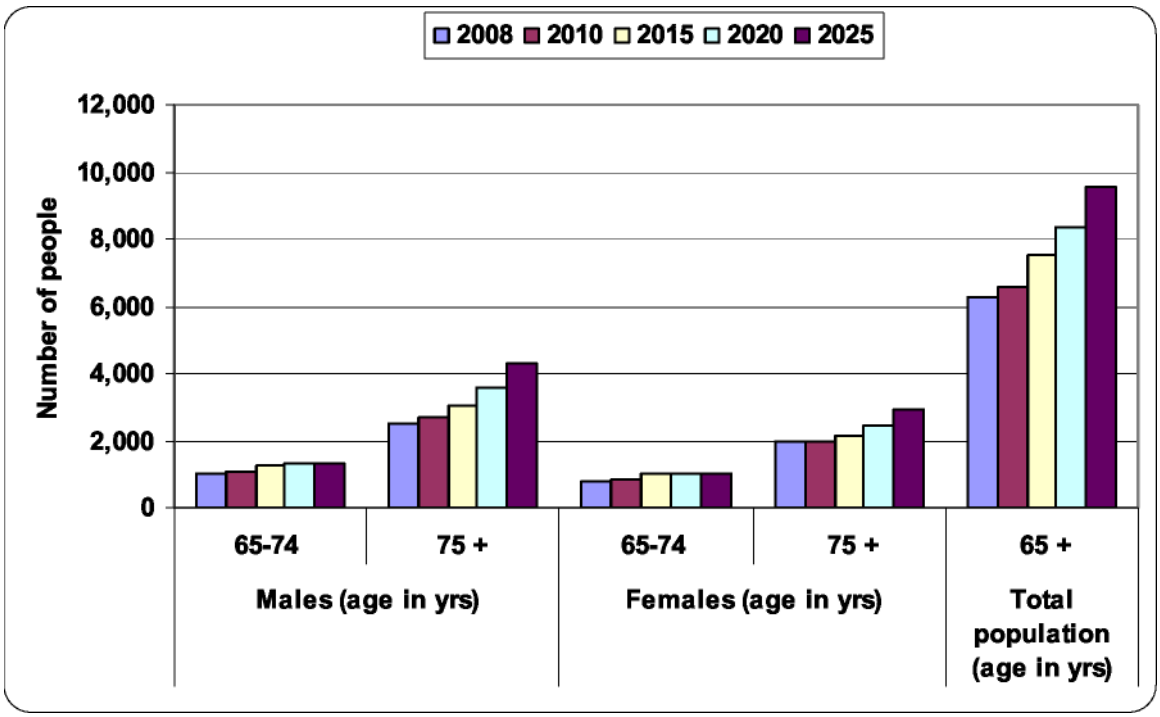
Stroke can affect people of any age. Nine out of ten strokes occur in people over the age of 55. Men are more often affected than women. People from Asian, African and Afro-Caribbean backgrounds are more at risk.

High blood pressure, smoking, diabetes, atrial fibrillation, a previous mini-stroke (TIA), binge drinking and a family history of stroke increase the risk.

Stroke is the most common cause of severe disability and is often fatal[2].

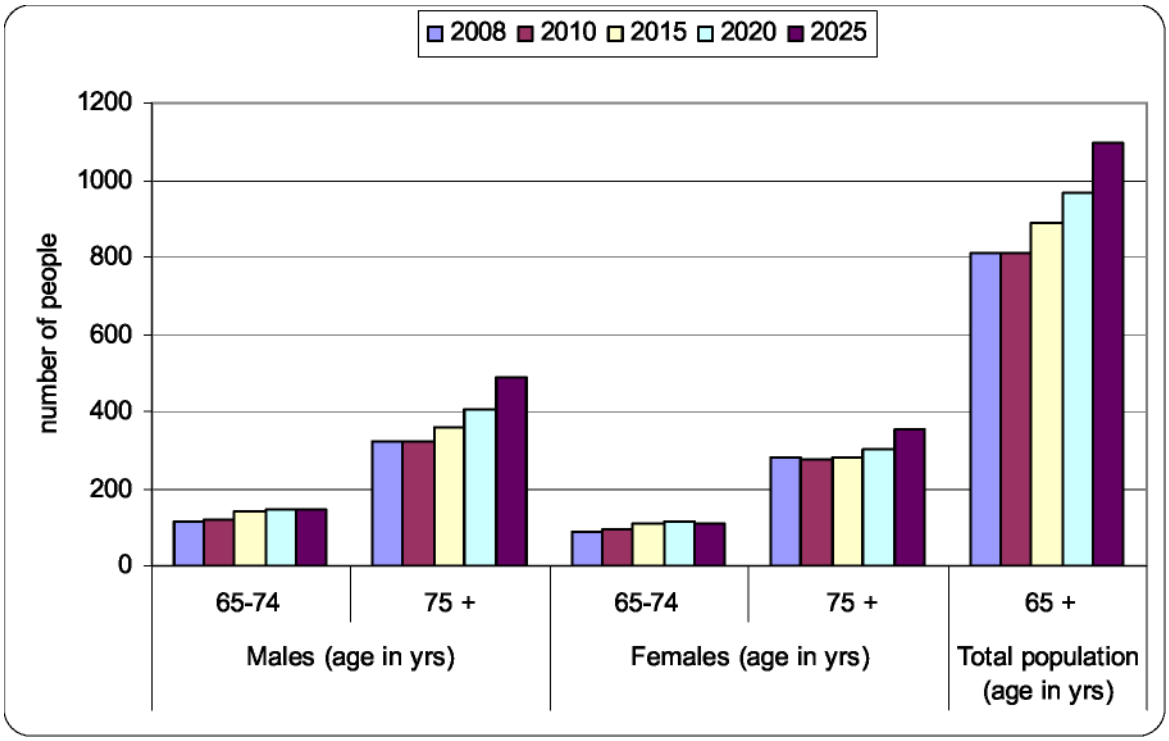
In England the current number of strokes in those over 65 is 215,000. This is set to rise to almost 312,000 by 2025. The Southend burden is currently 800 and likely to increase to 1,100 per year by 2025.

Figure 5.23: Estimate of Stroke in the Elderly – Essex



[2] http://www.bbc.co.uk/health/conditions/stroke1 .shtml

Figure 5.24: Estimate of Stroke in the Elderly – Southend



5.5.7: Lack of mobility

Mobility is the ability and willingness to move freely. Mobility can depend on motor skills but it is known to decrease with age. Special tools such as a walking stick, walker, mobile standing frame or wheelchair maybe used to aid mobility.
In England the current number people with a lack of mobility in those over 65 is over 200,000. This is set to rise to over 1,800,000 by 2025. The Southend burden is currently 5,000 and likely to increase to over 6,500 per year by 2025.

Figure 5.25: Lack of Mobility in the Elderly - Essex

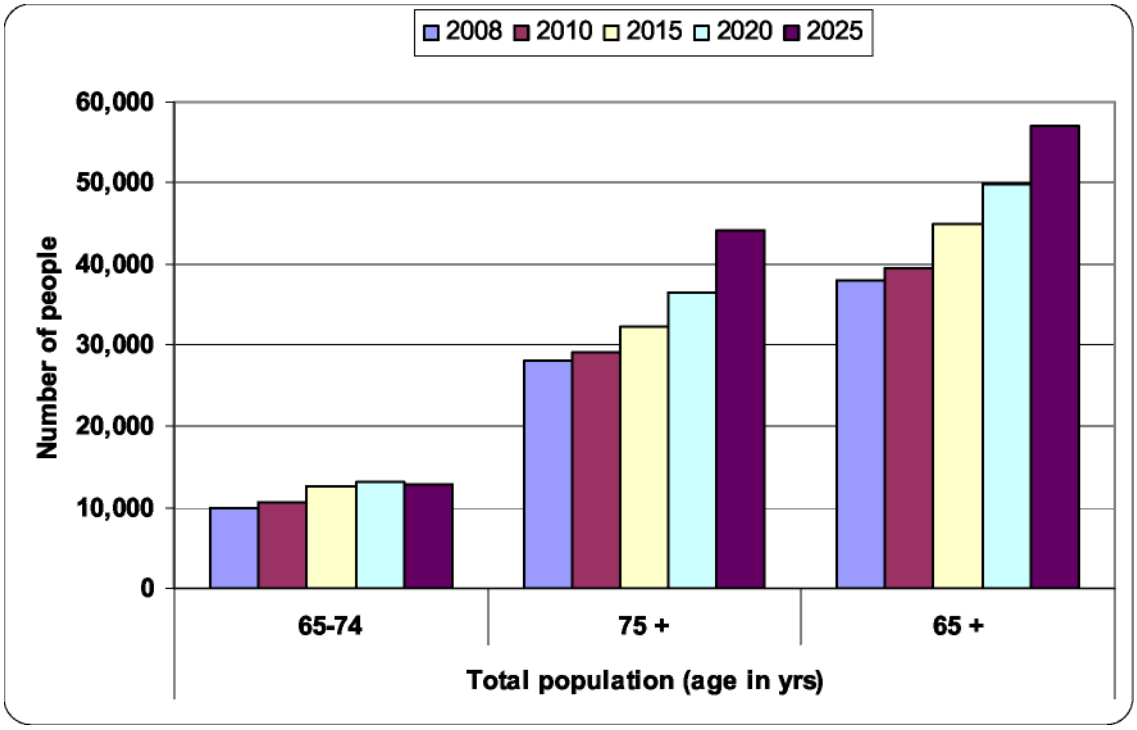
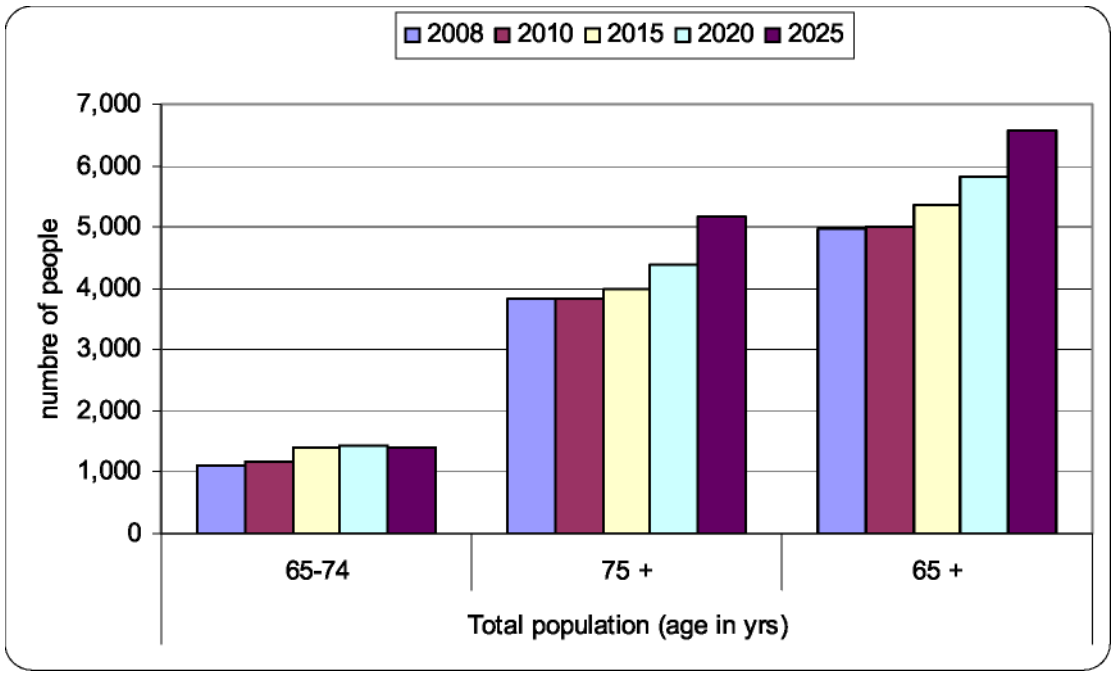


Figure 5.26: Lack of Mobility in the Elderly – Southend



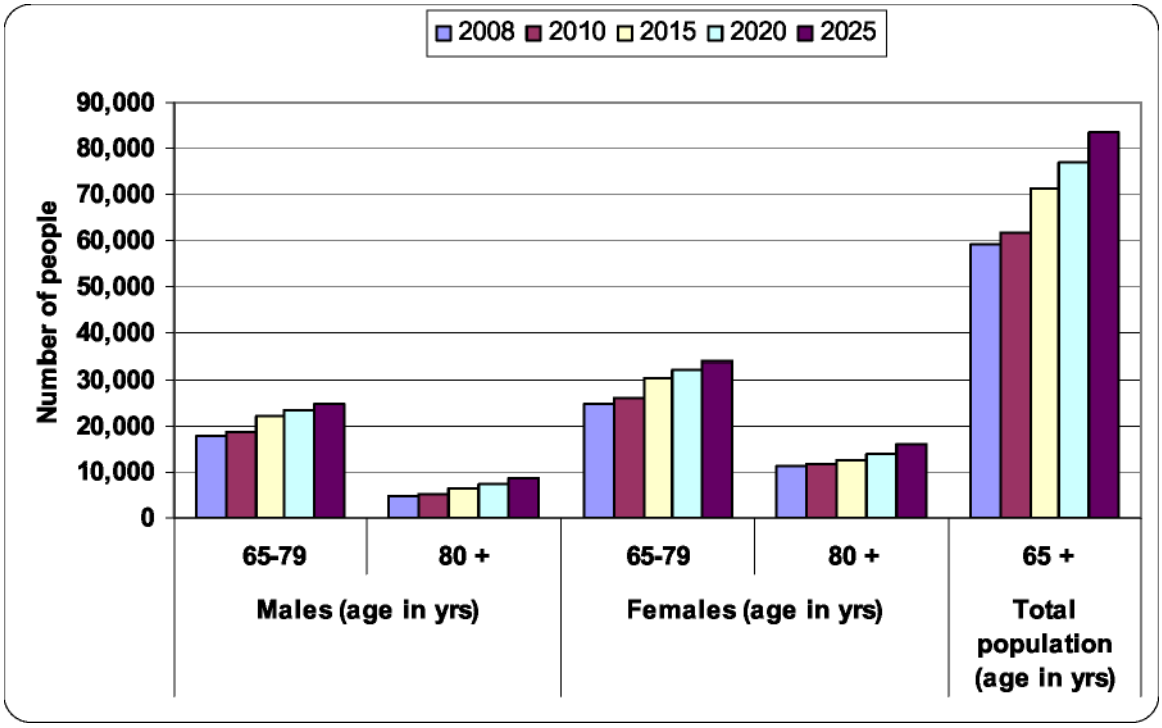
5.5.8: Obesity

Obesity is such a problem in the young today that the future impact over the next 20 years will cause serious implications for the health service. Obesity is already known to have serious health implications such as diabetes, cardiovascular disease, arthritis and many more.

The current estimate of obesity for those aged over 65 in England is approximately 2 million people and this is set to rise to just under 3 million by 2025.

In Essex the current number of people estimated to be obese is around 60,000 and by 2025 this will be just under 85,000

Figure 5.27: Estimate of Obesity in the Elderly - Essex



5.6 Care & Support for Older People

In 2005-06 the rate of older people receiving social care services in Southend 147.1 was per 1,000 of the population aged 65+; this is slightly below the England rate of 157.7 and the Essex rate of 151.1 per 1,000 population aged 65+. Thurrock UA had a rate of 106.5 per 1,000 65+ [1]. This also includes anyone who is 65+ with a learning disability, physical and sensory impairment.

In 06-07 ECC had 22,800 clients open to an older person's team during the year, which equates to a rate of 104.2 per 1,000 of the population aged 65+ [2]. Tendring by far has the highest numbers of OP clients compared to other districts, as it also has a higher population 65+. However the number of older people using adult social care service users per 1,000 of the population aged 65+ is evenly distributed throughout the county with the exception of Harlow. Higher rates are in Braintree, Castlepoint and Maldon. Low rates and persons are in Harlow; there are a lower number of registered residential and nursing beds in this area. Greatest variance between districts is 40.2 per 1,000 65+.

Figure 5.28: Rate of older people receiving social care services

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

38% of MSOAs in ECC are above the ECC older person's rate of 104.2. 2% are double the ECC rate, which are located Braintree, Tendring and Basildon. The highest rate is in Braintree at 237.9 per 1,000 65+.

Figure 5.29: Social care clients open to an older persons key team 2006/07 MSOA

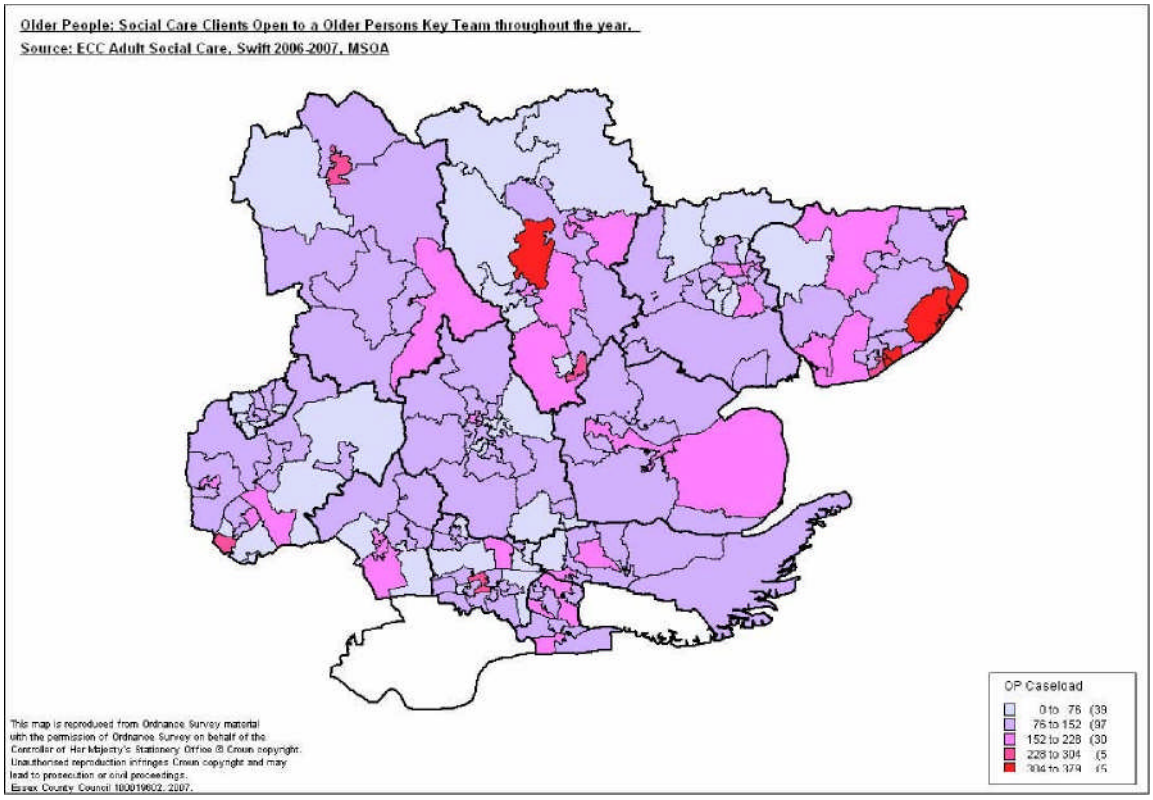
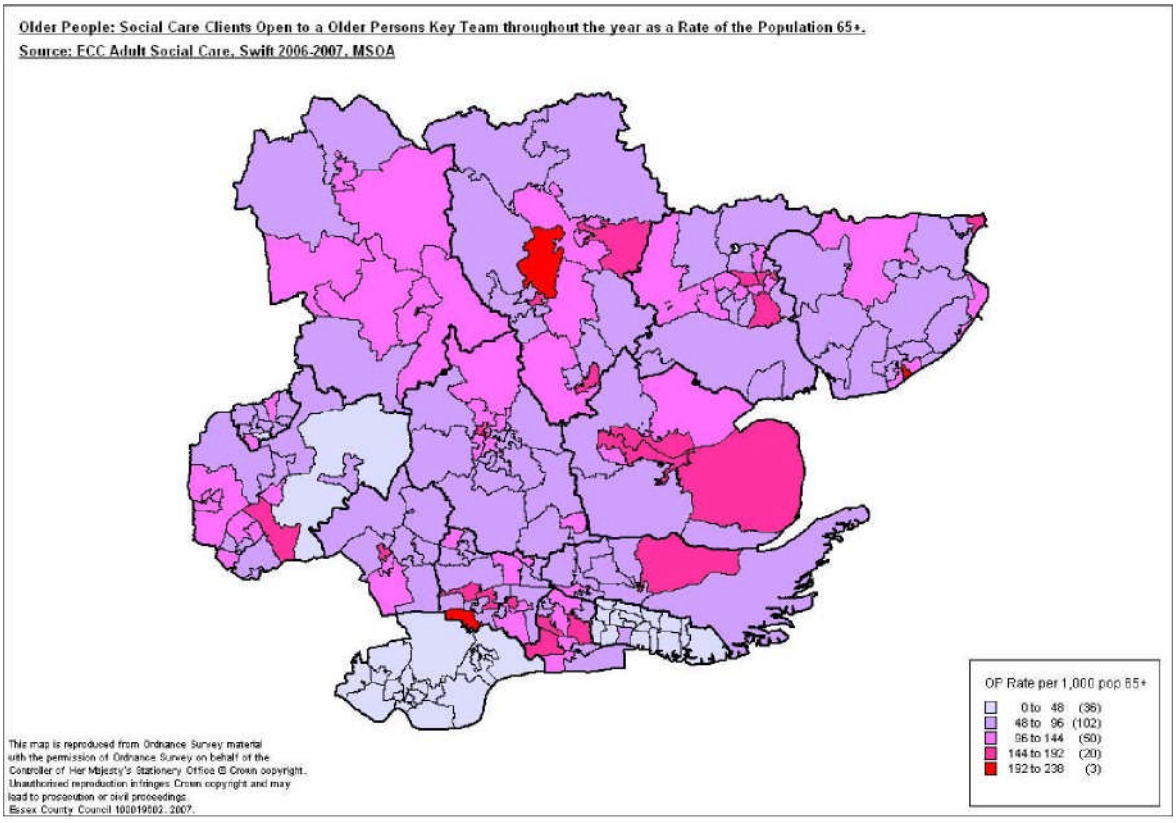


Figure 5.30: Social care clients open to an older persons key team as a rate of the population 65+ by MSOA



5.7 Admission Avoidance

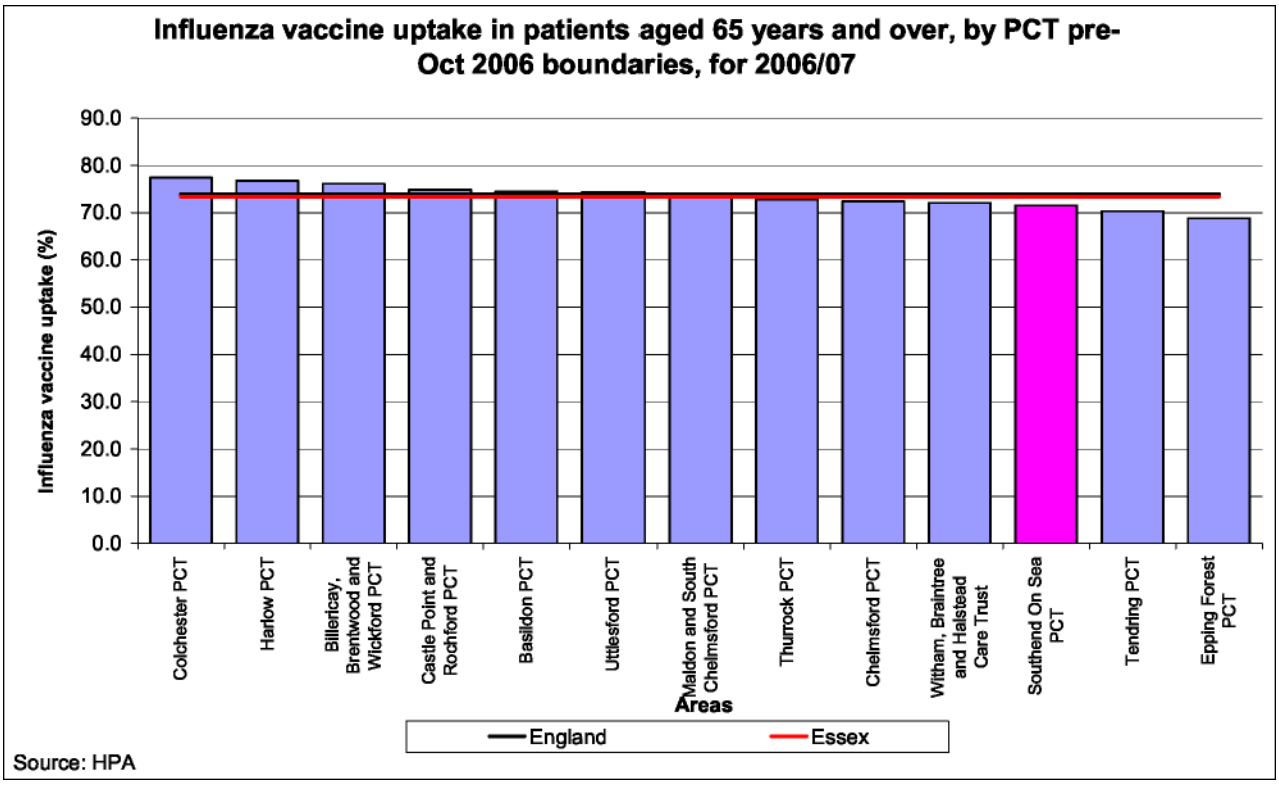
The local NHS trust carry out schemes to try and avoid people going into hospitals when it can be avoid. These schemes include vaccinating the over 65 year olds against pneumoccocal and influenza infections, and to try and better manage those already with conditions.

5.7.1 Influenza Vaccinations

The targeted risk groups for vaccination against influenza are persons aged 65 and over, and persons in clinical high risk groups, which include those with chronic heart disease, lung disease (including asthma), renal disease or diabetes, and those with immuno-suppression. These groups are vaccinated against influenza as they are most at risk of having complications if they catch influenza. At risk groups need to be vaccinated every year as the strains of influenza which circulate in the population change.

Figure 5.31 shows the uptake of influenza vaccine in over 65 year olds across Essex in 2006/07. The uptake in Southend was just above 70%, which is below the England average of 73.9%.

Figure 5.31: Flu vaccine uptake in those aged 65+ - 2006/07

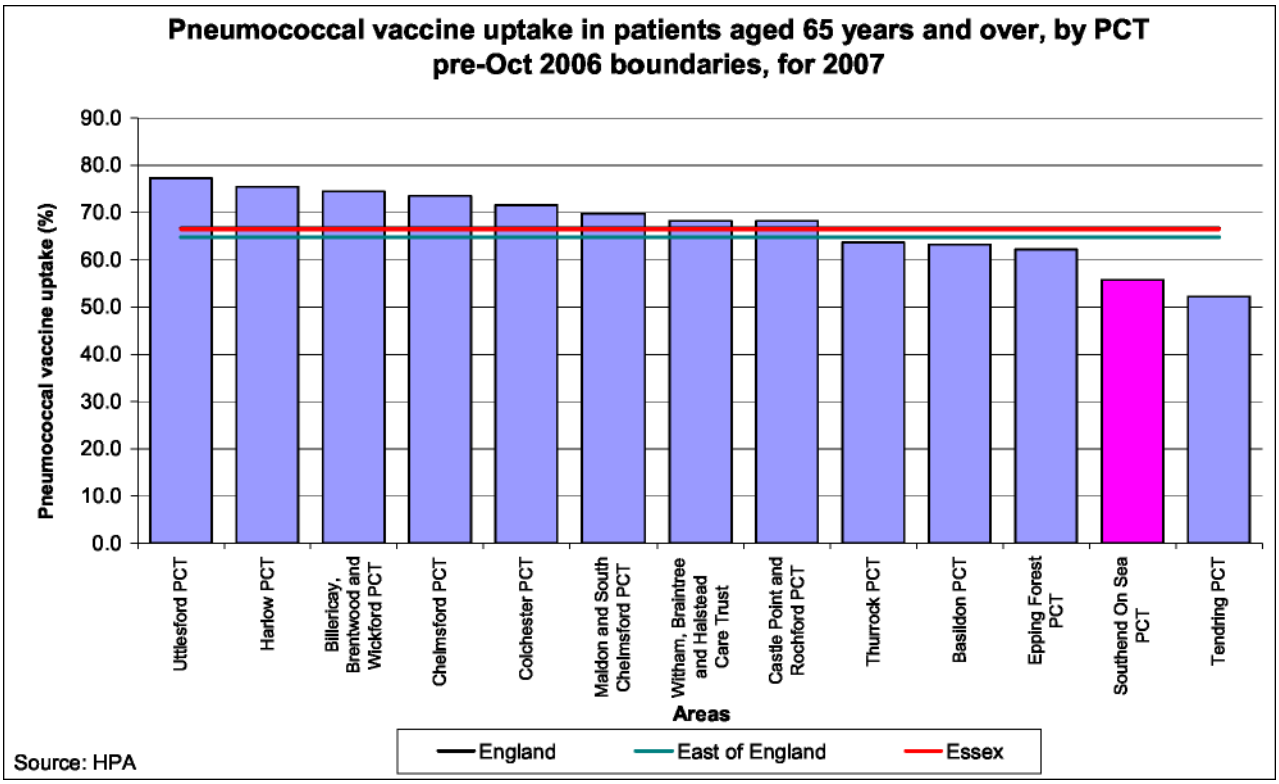


5.7.2 Pneumoccocal Vaccinations

The increased risk of pneumococcal disease begins in those aged over 45 and rises sharply in those over 75. Pneumococcal infection can cause diseases such as pneumonia, septicaemia (blood poisoning) and meningitis. Persons aged 65 and over, and persons in clinical high risk groups, which include those with chronic heart disease, lung disease (including asthma), renal disease or diabetes, and those with immuno-suppression are routinely vaccinated to protect them against the disease as they are most at risk of having complications if they catch the disease. People normally only have to be vaccinated once to be protected.

Figure 5.32 shows the uptake of pneumococcal vaccine in the over 65's across Essex. Whilst there is no specific target for the uptake of pneumococcal vaccination in over 65's but it is thought it should be in line with the influenza vaccination uptake target of 70%. At 55%, Southend has the second the lowest uptake rate in Essex, and is considerably lower than the average rate of uptake England (66.6%).

Figure 5.32: Pneumococcal vaccine uptake in those aged 65+ - 2007



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

The number of people with mental health problems is increasing. Already, six districts / boroughs have higher than average proportions of their working age population claiming benefit / allowances for a mental or behavioural disorder.
Almost 10% of our residents provide informal care to relatives, friends or neighbours. Approximately one third receive no support from either social services or the voluntary sector and just over a third are not satisfied with the support that they get.

CHAPTER 6 PEOPLE LIVING WITH DISABILITIES

About 21% of the total adult population is disabled[23]. Compared with non-disabled people, disabled people are:

- more likely to live in poverty (having on average less than half the income earned by non-disabled people)
- less likely to have educational qualifications and 50% more likely to be economically inactive
- 25% more likely to experience problems with hate crime or harassment
- more likely to experience problems with housing and with transport (most often identified by disabled people as their biggest challenge)
- 27% of disabled 19 year olds are not in education, training or employment, compared with 10% of their non-disabled peers[24].

As our population ages, levels of disability will increase sharply. Research suggests that older people are generally free of prolonged disability until they reach their 70s, after which they may face accelerating disability levels until death. But disability does not only affect older people. Around 3% of u16s have functional disabilities and the majority of those claiming disability benefits have learning difficulties and mental health problems. Among our working-age population, between 14% and 16% of adults. around 13-1 5,000 people. have a disability.

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

6.1 Learning Disabilities

In 2005-06 the rate of people with learning disabilities receiving social care services from Southend Borough Council was 3.9 per 1,000 of the population aged 18+[1] which is equivalent to the national rate. This compares to 3.5 per 1,000 of the population aged 18+ for Essex County Council and 2.7 per 1,000 for Thurrock.
Valuing People (2001) estimated the number of adults with severe and profound learning disabilities to be 145,000, a rate of 3.7 per 1000 18+ population.

Currently there are 601 (September 2007) LD service users in receipt of a service from Southend Borough Council. This figure can be broken down in terms of;

- 120 are aged 55 to 64
- 45 are over 65 years
- 45 people are aged 14 to 19 years
- 28 people are from BME groups
- 50 people have a profound and multiple learning disability

As well as anticipating an increase in the numbers of people with a learning disability at the levels shown above, research indicates particular impacts in terms of increased numbers of older people, younger people with complex needs and people from BME groups.

6.2 Physical Impairment

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

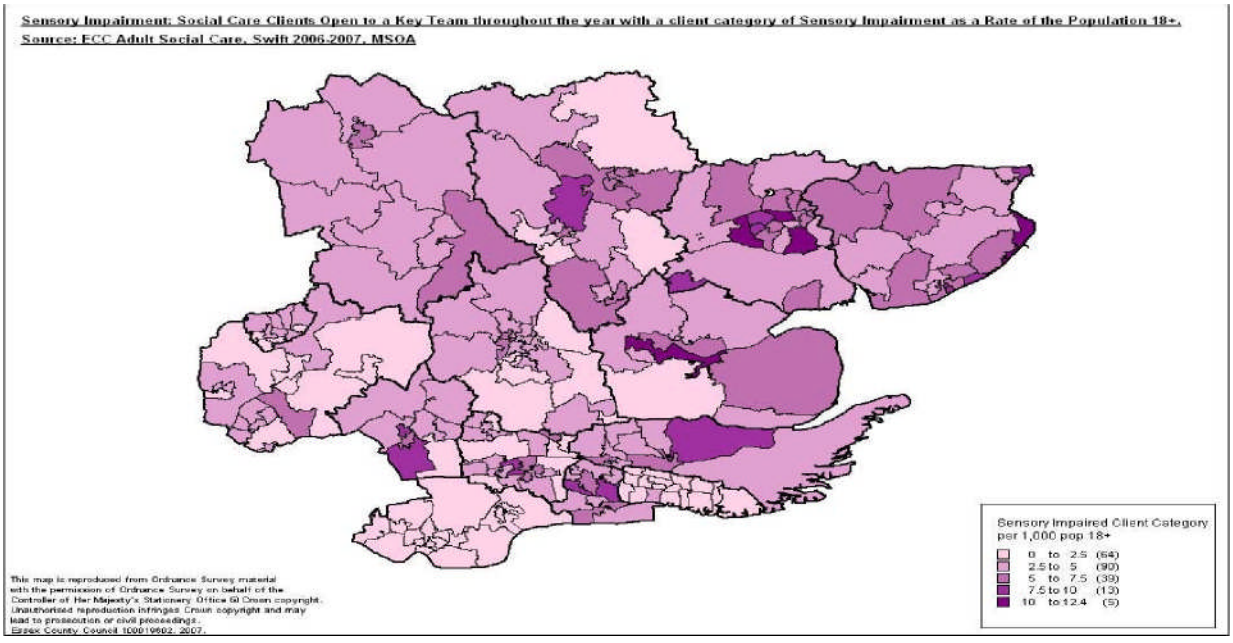
In Southend there were 538 service users aged 18-64 with physical impairment during 2006-2007. This equates to a rate of 5.7 per 1,000 18-64. There were 2,979 people aged 65+ with a physical impairment which equates to a rate of 97 per 1,000 65+.

6.3 Sensory Impairment

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

According to 2006/2007 data for Southend the number of people with a severe sensory impairment (Visual impairment and dual sensory loss) total 20 giving a rate of 0.21 per 1,000 18-64. All forms of sensory impairment in Southend make up 223, or 2.38 per 1000 18-64.

Figure 6.1: Clients open to a key team with a category of sensory impairment as a rate of the population 18+



6.4 Conclusion

As our population ages, more people are needing support. In addition, more children with complex and multiple disabilities are surviving into adulthood.

CHAPTER 7 QUALITY OF LIFE

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

7.1 Satisfaction with Local Area

During 2006/7, Southend Borough Council conducted its Local Government User Satisfaction Survey. Residents were asked about which factors are important in making Southend a good place to live and which areas are most in need of improvement.

The residents ranked:

- the level of crime
- clean streets
- health services
- affordable decent housing
- parks and open spaces

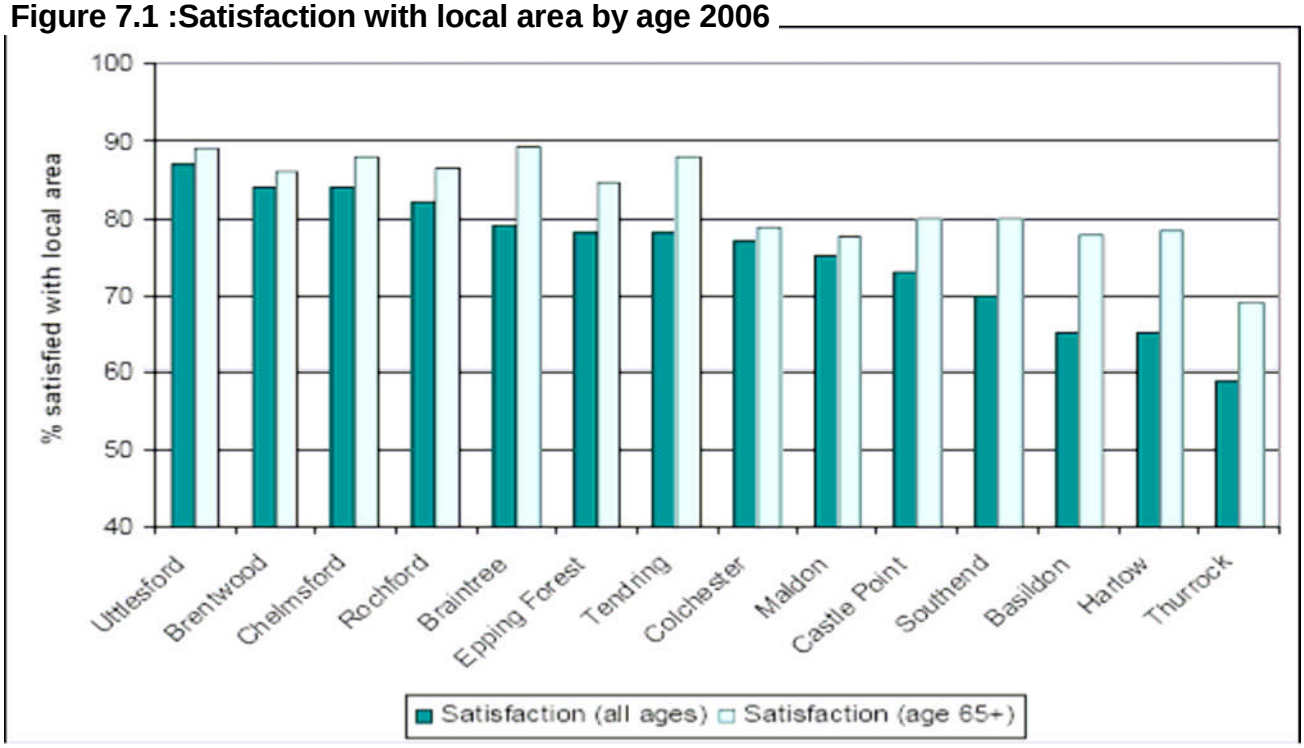
as their five most important factors in making somewhere a good place to live.

They also identified:

- traffic congestion
- inactivities for teenagers
- levels of crime
- road and pavement repairs
- clean streets

Crime data referred to in section 2.7.1 of this document shows that Southend reflects the national picture. In relation to fear of crime, a large survey of older people in Southend (carried out as part of Southend's Older People Strategy 2007-2010) which found that the majority of respondents, 79% felt either 'very' or 'fairly' safe living in Southend.

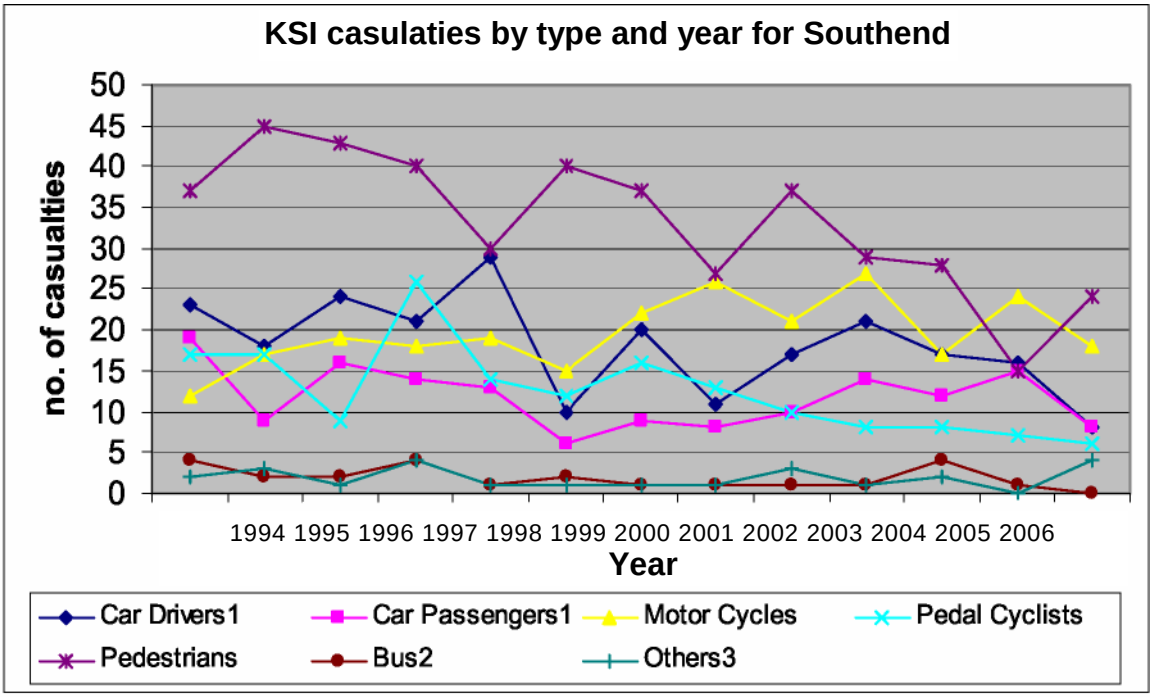
Figure 7.1 :Satisfaction with local area by age 2006



7.2 Road Safety

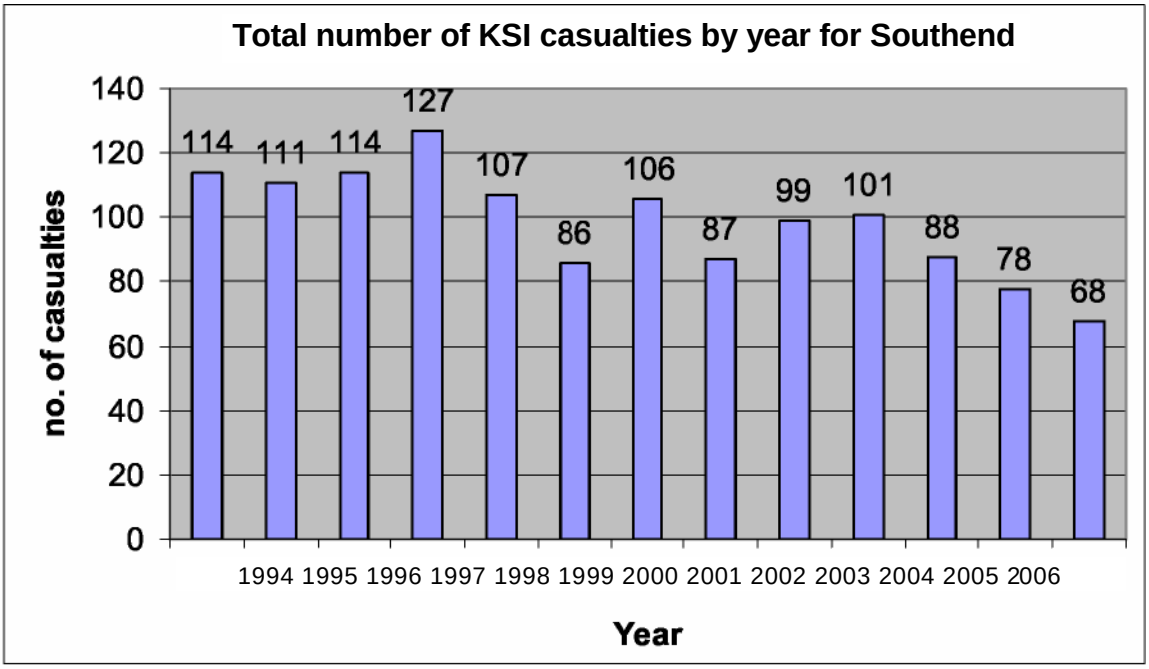
987 people were killed or seriously injured (KSI) in road traffic collisions in Essex (County Council Area) during 2006, exceeding the target of 938 by 49. The PSA target of 842 or fewer KSI casualties in 2007 requires a reduction of at least 145 on the 2006 level.

Figure 7.2: KSI casualties by type and year for Southend



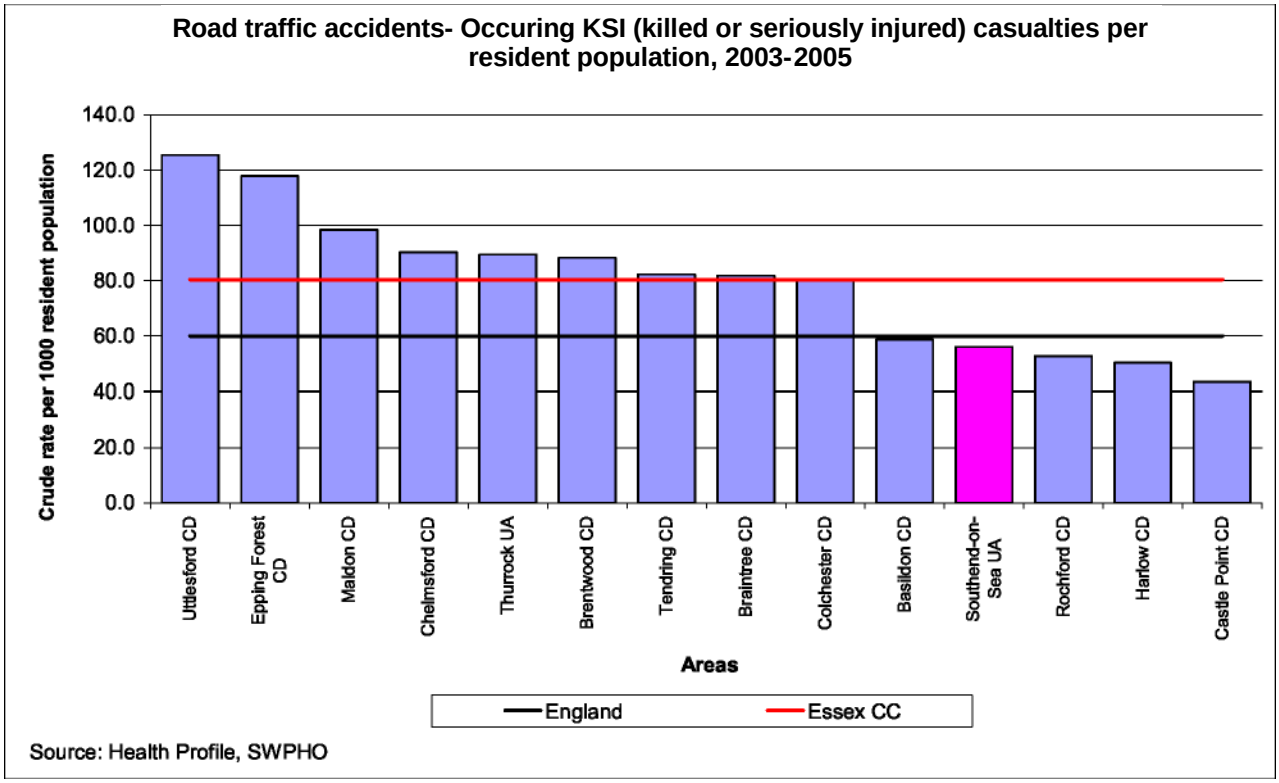
Source: Southend Council

Figure 7.3: Total number of KSI casualties by year for Southend



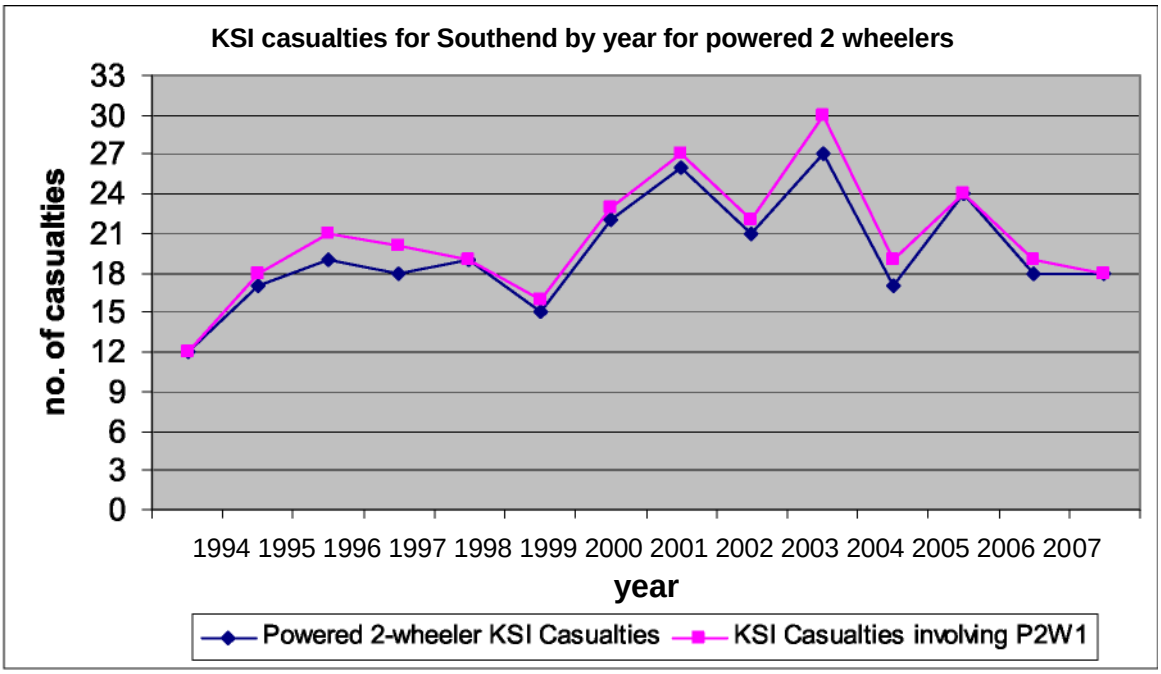
Source: Southend Council

Figure 7.4: Road traffic accidents – killed or seriously injured per 100,000 resident population – 2003-2005



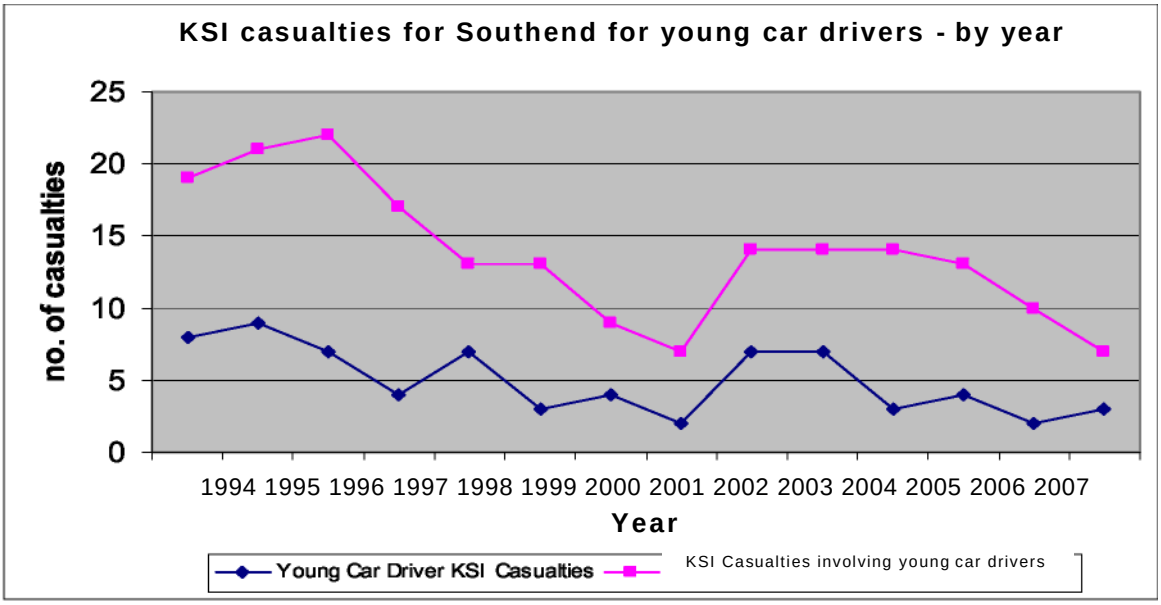
Southend has the fourth lowest rate of death or serious injury resulting from road traffic accidents in Essex, it is below both the England and Essex average.

Figure 7.5: KSI casualties for Southend for powered 2 wheelers – by year



Source: Southend Council

Figure 7.6: KSI casualties for Southend – young car drivers by year



Source: Southend Council

7.3 Lifestyle Choices

7.3.1 Adult Obesity

Obesity is one of the major public health issues that face the developing world. It can lead to increased risk of heart disease, type 2 diabetes and some cancers.[3] The trend in increasing obesity levels in thought to be related to:

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

Obesity and its consequences cost the NHS approximately £1 billion per year. However it has been estimated that the total economic cost of obesity is £3.3-3.7 billion per year and of obesity plus overweight, £6.6-7.4 billion (Select Committee on Health, 3rd Report, May 2004). Adult obesity figures have almost quadrupled over the last 25 years with approximately two thirds of adults being overweight. Of these people 22% of men and 23% of women are classed as obese[4]. The National Audit Office has found that on average, each person whose death is attributable to obesity had lost 9 years of life.

The Office for National Statistics (ONS) released synthetic estimates of healthy lifestyle behaviours in 2005. The estimates are based on modelling and show the expected prevalence of obesity given the demographic and social characteristics of that area.[5]

---

[3] Department of Health –http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Obesity/DH_078098
[4] NHS Direct - http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=265&sectionId=34
[5] Synthetic Estimates of Healthy Lifestyle Behaviours - http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalworkareaneighbourhood/DH_41 16713

The graphs below are based on the synthetic estimates. Obesity is classed as a BMI of 30 or greater and the estimates are based on ages 16 and over.

Figure 7.7: Percentage of the population who are obese in Essex (Synthetic estimates pre Oct-2006 PCT boundaries)

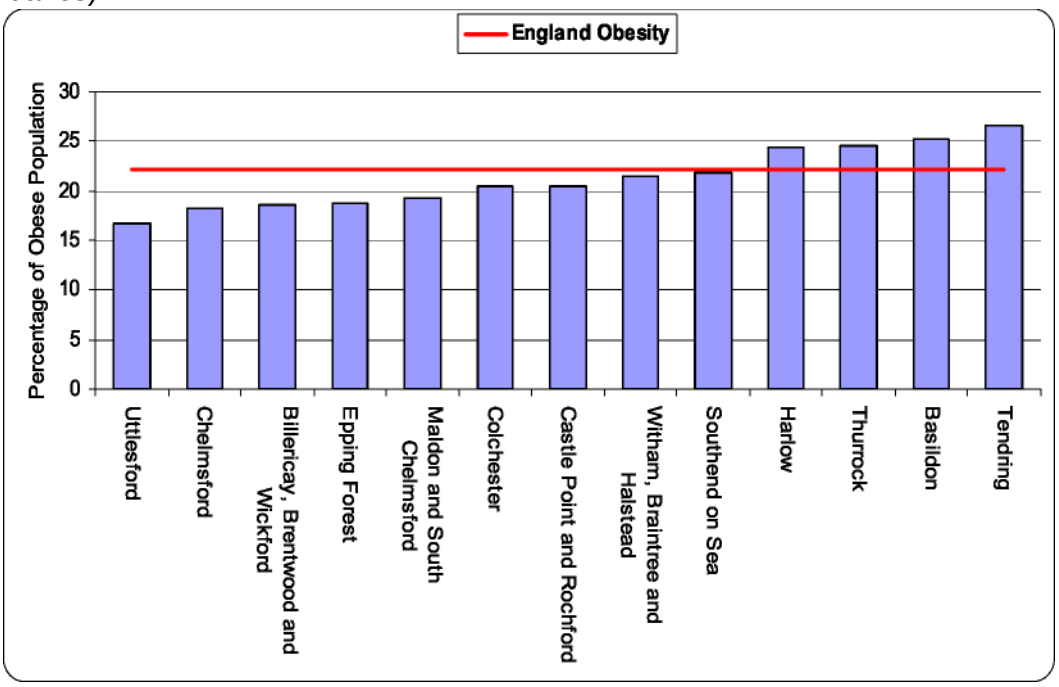
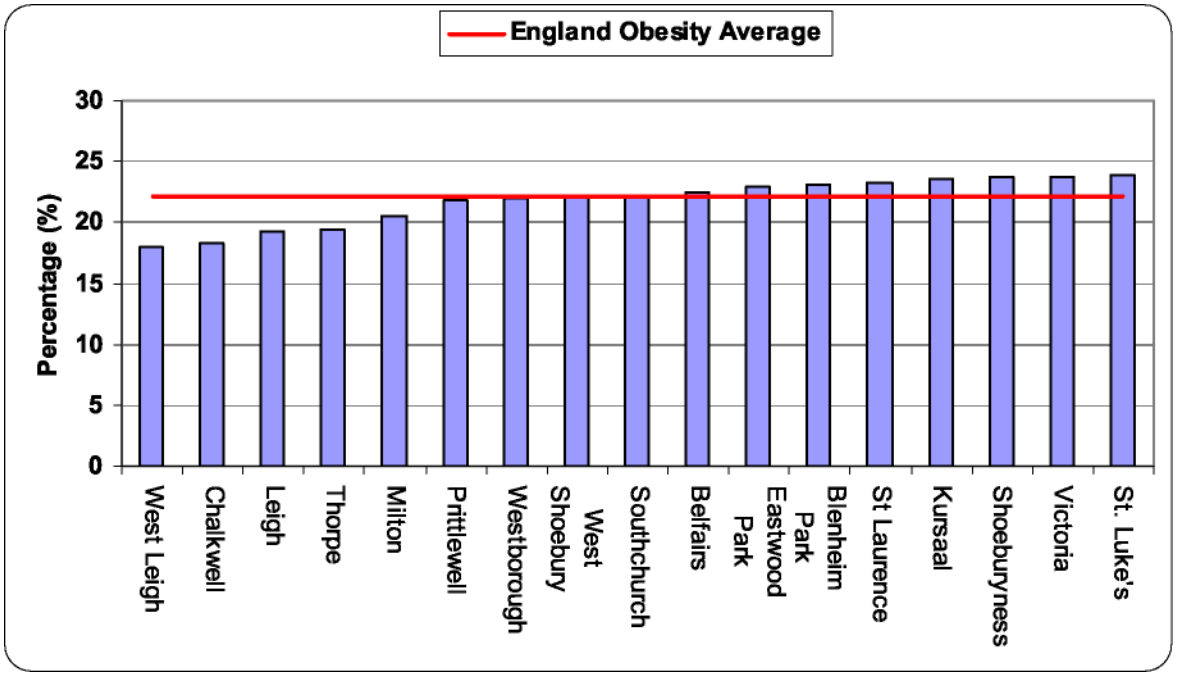


Figure 7.8: Percentage of the population that are obese by ward in Southend



Source: Synthetic Estimates of Obesity – Office for National Statistics

There is considerable variation in the levels of obesity at ward level within Southend. At 23.9% St Luke's has the highest proportion of adult obesity compared to West Leigh which has the lowest obesity rates (18%).

An estimated 22.1 % of the adult population in England are obese; Southend has 9 wards that have levels of adult obesity that are greater than this. These are St Luke's (23.9%), Victoria (23.8%), Shoeburyness (23.8), Kursaal (23.6%), St Lawrence (23.3%), Blenheim Park (23.1%), Eastwood Park (23%), Belfairs (22.4%) and Southchurch (22.2%).

7.3.2 Smoking

Smoking is the UK's single greatest cause of preventable illness and early death, most dying from the three main diseases: cancer, COPD and CHD. Half of all smokers will be killed by their habit. The prevalence of smoking in the adult population in Southend was 26.4 % in 2003. PCTs have been working hard to support people to quit smoking to help reduce the prevalence of smoking.

Figure 7.9: DSR mortality rates for smoking attributable mortality by MSOA – 2007

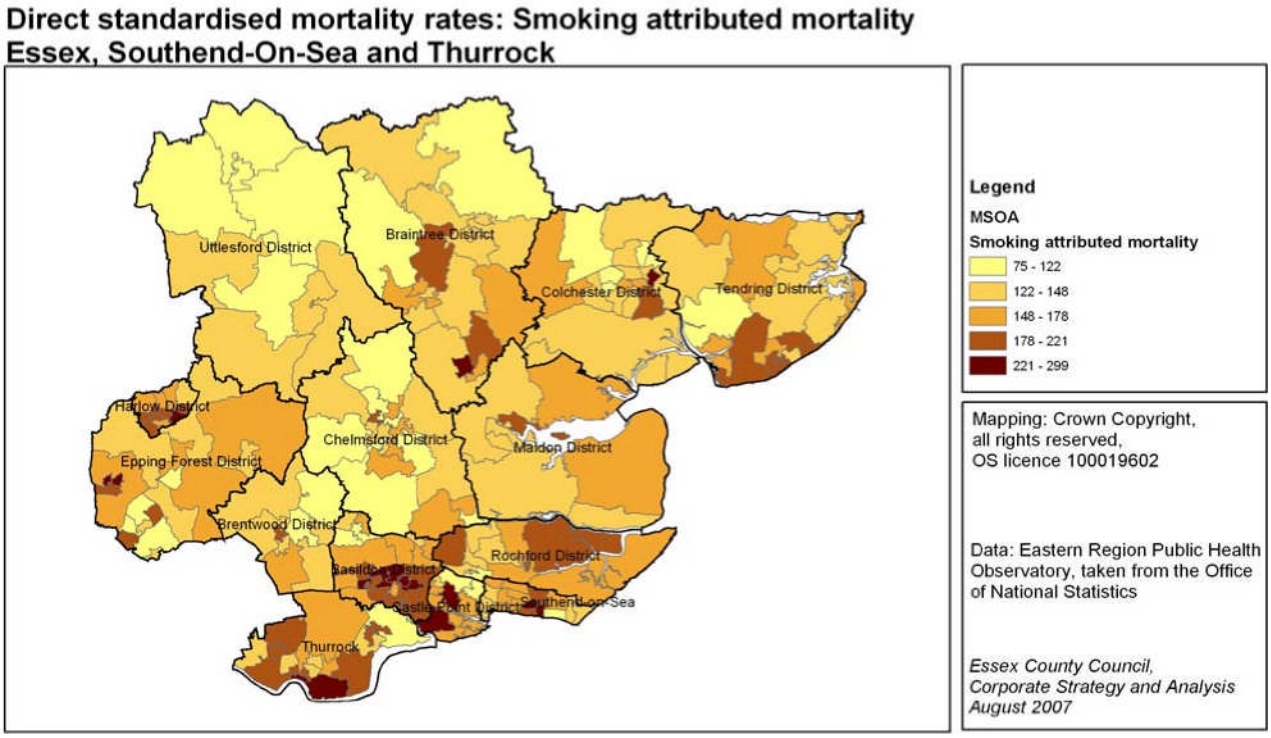
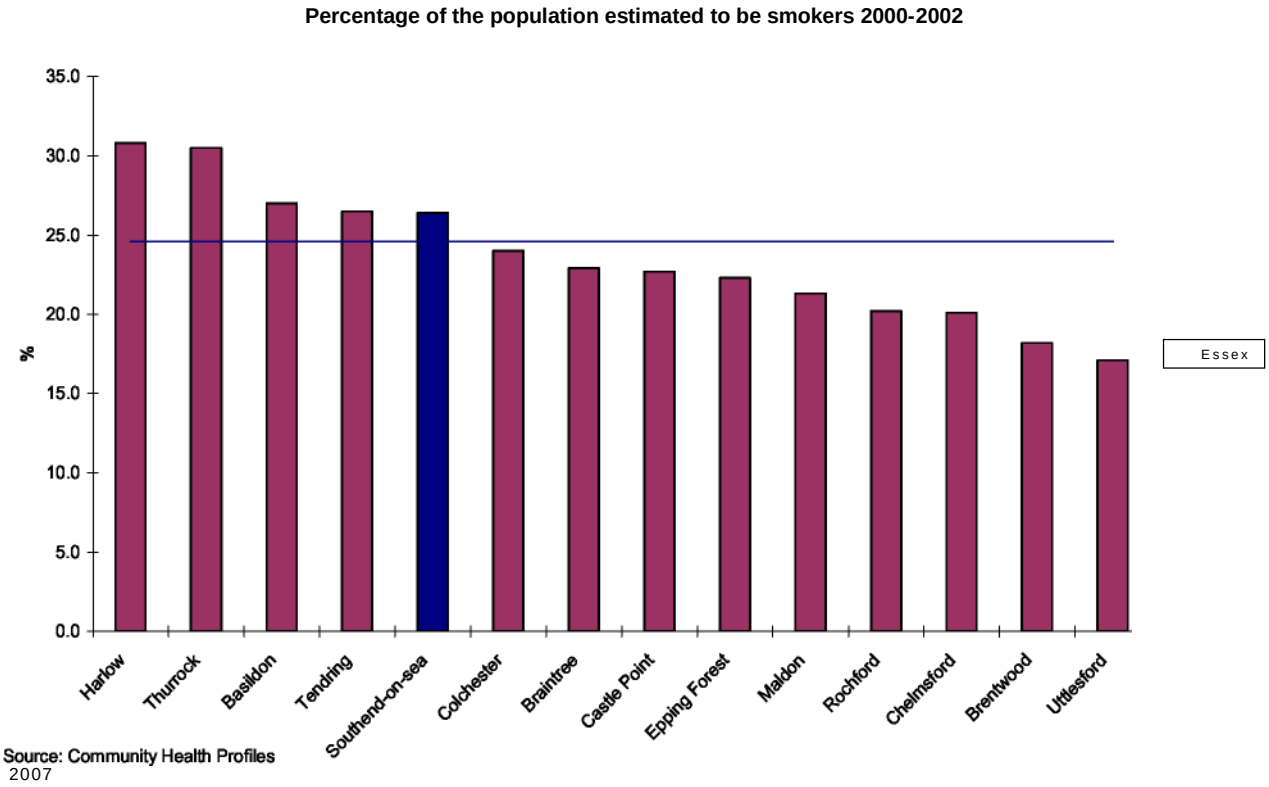


Figure 7.10: Percentage of the Essex population estimated to be smokers – 2000/02



Source: Community Health Profiles 2007

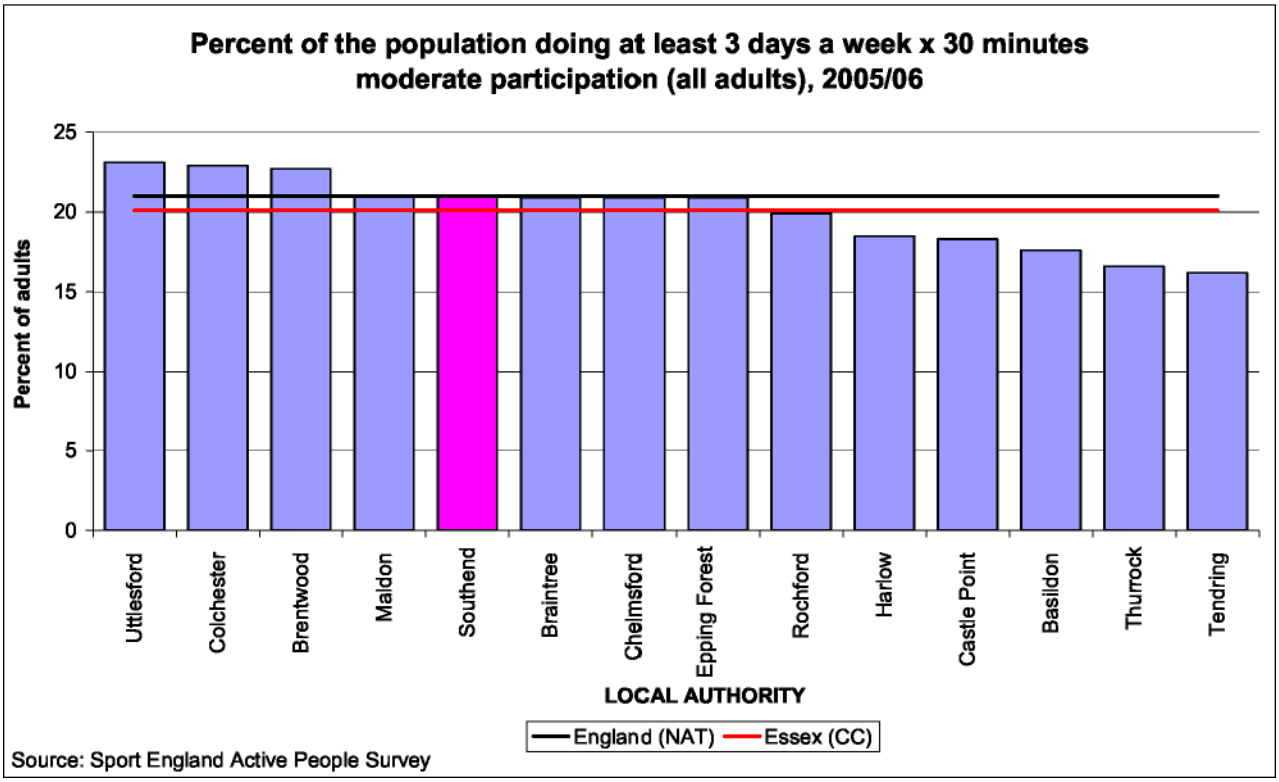
7.3.3 Physical activity

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

A recent Active People survey by Sport England in 2005/06 found that 23.7% of adult males did at least 30 minutes of moderate physical activity three times a week and only 18.5% of adult females.

At just over 21 % Southend has the fifth highest level of the adult population participating in moderate physical activity in Essex.

Figure 7.11: Percentage of population doing 30 minutes moderate physical activity at least 3 days a week – 2005/06

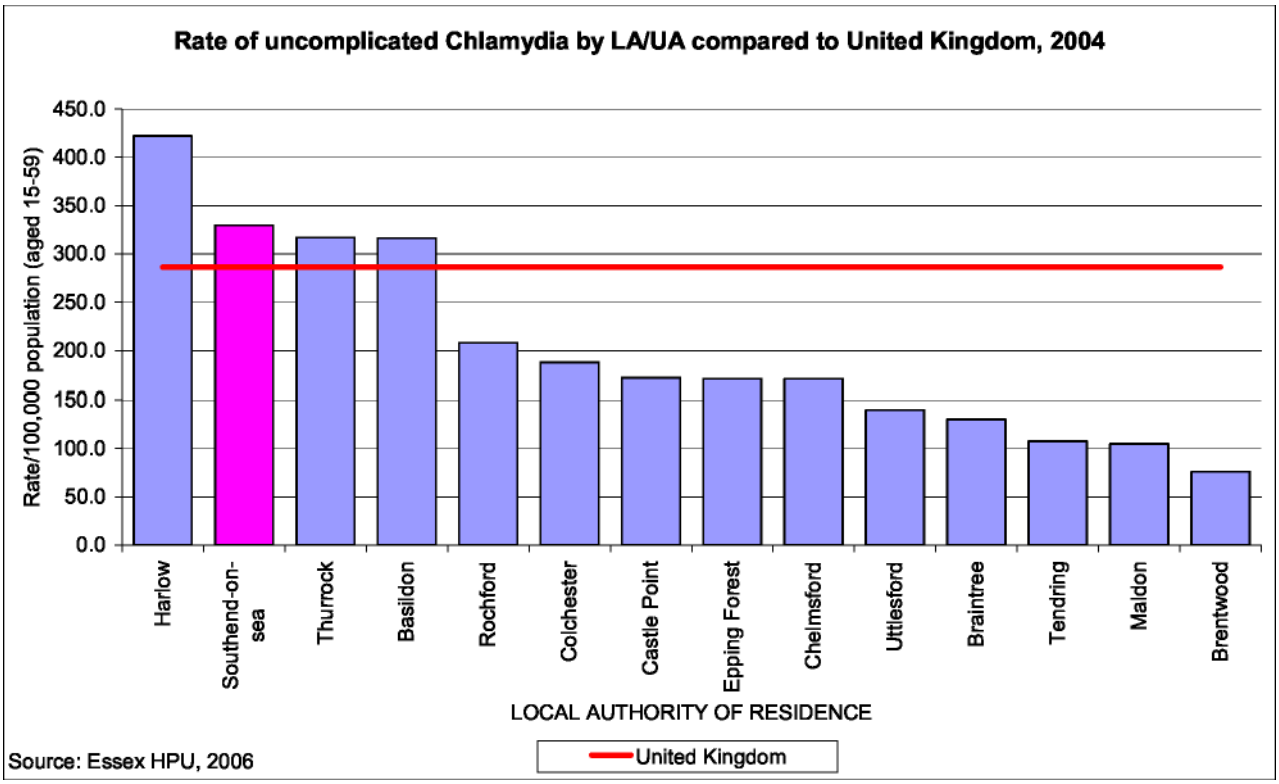


7.3.4 Sexual Activity

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

Chlamydia is a sexual transmitted infection which gives us an idea of what the STI rate is like in a population. Figure 7.8 shows the rate of uncomplicated chlamydia across Essex. Southend has the second highest rate of uncomplicated chlamydia in Essex, which is also above the UK average.

Figure 7.12: Rate of uncomplicated chlamydia by LA/UA - 2004



7.3.5 Alcohol and Drugs

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

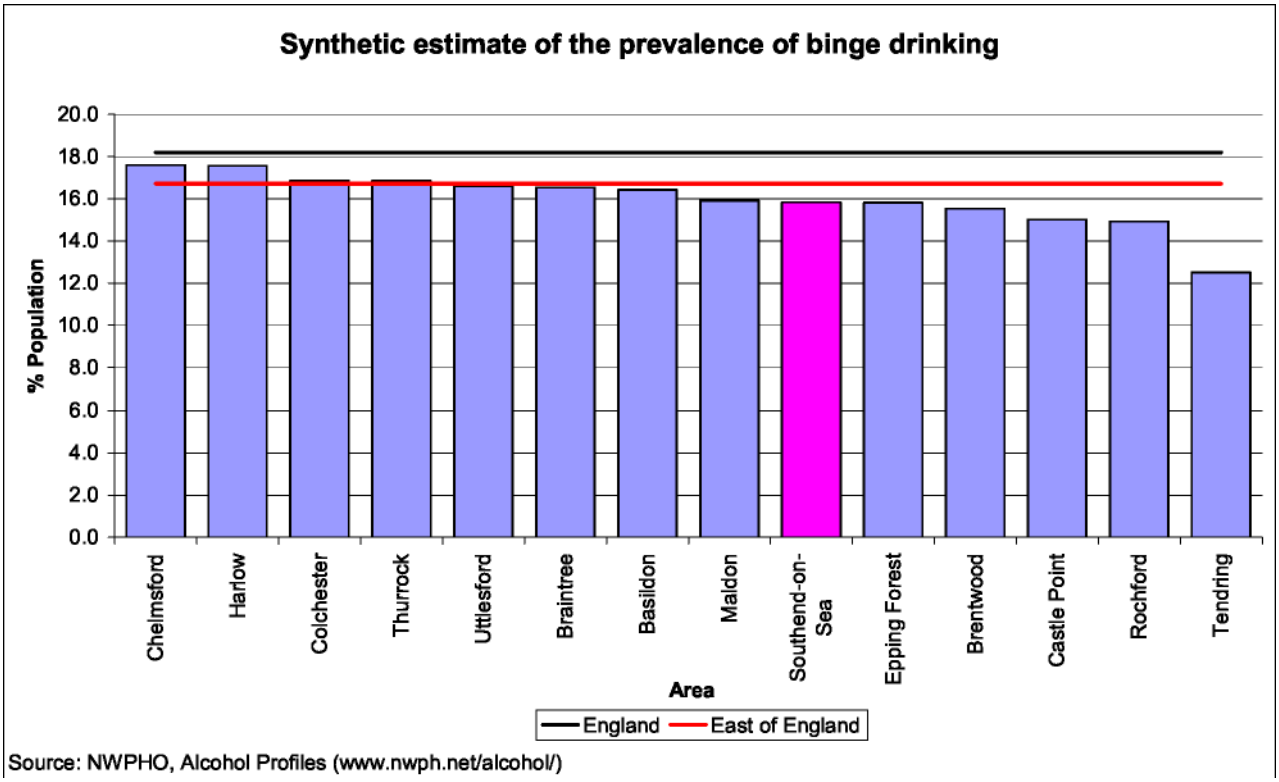
The vast majority of people can enjoy alcohol without causing harm to themselves or others, and there is growing evidence that a small amount of alcohol can be beneficial to a person's health, but this has to be balanced against the damaging effects it can have. Heavy drinking is linked to a number of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

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

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

Figure 7.13 shows the estimated numbers of the population that binge drink by local authority area across Essex. At just under 16% Southend has the sixth lowest proportion of adults in Essex who are binge drinkers. This level is below the England and East of England average.

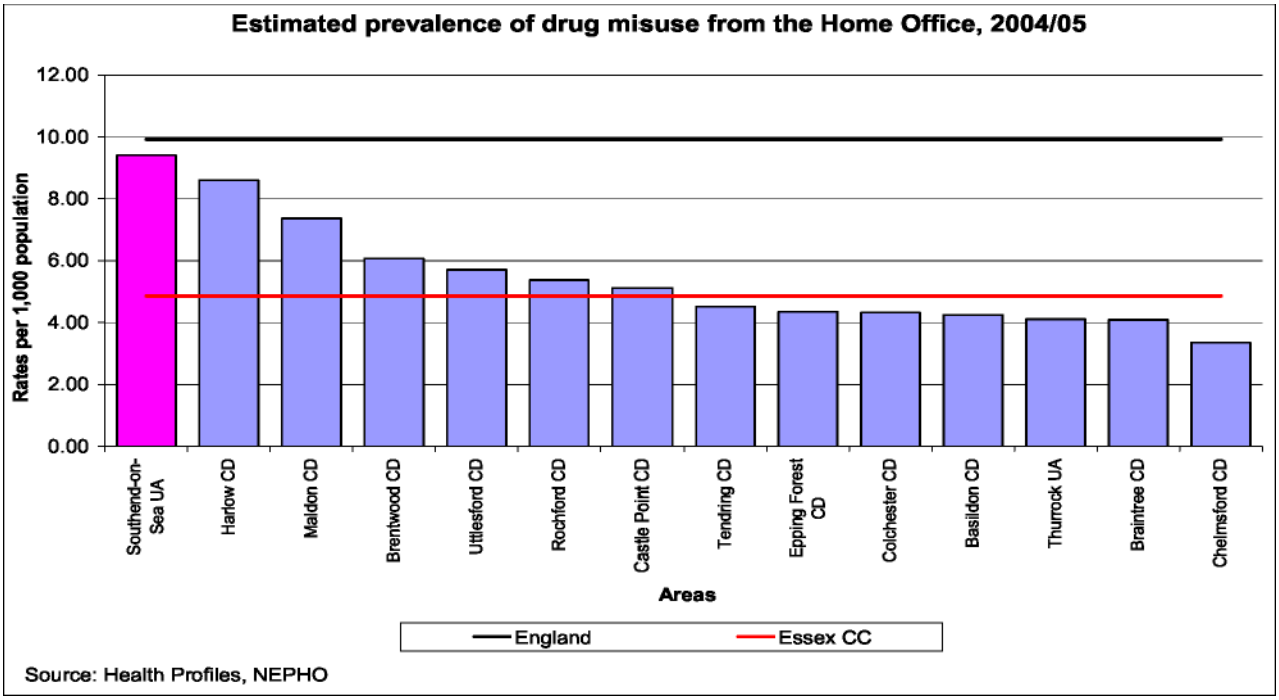
Figure 7.13: Estimate of the percent of the population who binge drink by local authority area in Essex, compared to England and the Eastern Region.



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

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

Figure 7.14: Estimated prevalence of drug misuse - 2004/05



Southend has the highest rate of estimated drug misuse prevalence in Essex, it is almost double that of the Essex average, although still lower than the England average.

7.4: Conclusion

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

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

When asked about aspects that are most important in making somewhere a good place to live, the level of crime (59%), clean streets (47%), health services (42%), and affordable decent housing (32%) are the issues mentioned most often (taken from Southend's 2006 Best Value User Satisfaction survey). Seven in ten respondents rate themselves as satisfied with their local area as a place to live, with over one in ten rating themselves as very satisfied, conversely one in ten are also dissatisfied to some extent.

For improvements, the aspects that respondents mentioned needed most attention and were priorities were crime (39%), activities for teenagers (41%), road and pavement repairs (33%), and clean streets (30%).

In 2006 a large survey of older people living in Southend also gave a positive indication of quality of life among older people. The survey showed that 87% of respondents felt their quality of life was either ‘good’ or ‘very good’ and over half felt emotionally ‘content’ living in Southend. In relation to transport 65% felt they could travel around Southend when and where they wanted to and the majority of those that couldn’t cited ‘illness/disability’ as the reason they couldn’t. The majority of respondents, 79% also felt either ‘very’ or ‘fairly’ safe living in Southend.

GLOSSARY

ACUTE HOSPITAL – a hospital that provides urgent or planned treatments or operations, and outpatient appointments.

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

ANTIDEPRESSANTS - medications used to treat depression

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

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

Weight in kg ÷ (Height in metres X Height in metres)

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

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

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

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

CO-TERMINUS - areas that have the same boundaries.

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

GONORRHOEA – is a common sexually transmitted infection also known as 'the clap'. It's serious because if not treated early it can lead to some very serious health problems.

GUM CLINIC - Genitourinary Medicine clinics, sometimes known as Sexual Health clinics for all aspects of sexual health. You receive free, confidential advice and treatment.

HEPATITIS B – is an infection of the liver caused by a virus. It can be transmitted by sexual contact, shared needles, or contaminated blood products and is much easier to get than HIV, and can cause permanent liver disease and cancer. Most people have no obvious symptoms, and there is no known cure.

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

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

INCIDENCE - Rate of occurrence of new cases of disease (within a given population over a given time period)

INDEX OF MULTIPLE DEPRIVATION SCORE - This is calculated by scoring different dimensions of deprivation – income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services. A higher score implies greater deprivation. (For more information see the website for Communities and Local Government http://www.communities.gov. uk)

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

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

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

LOCALITY - a particular neighbourhood, place, or district

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

NRT - Nicotine replacement therapy (NRT) is the use of various forms of nicotine delivery methods intended to replace nicotine obtained from smoking or other tobacco usage

ONS - The Office for National Statistics (ONS) is the government department that provides UK statistical and registration services.

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

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

QUARTILE - a quarter of a distribution i.e., the first, second and third quartile points of 100 are 25, 50 and 75.

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

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

SEDENTARY OCCUPATIONS - non-active jobs, such as those that require people to be at desks.

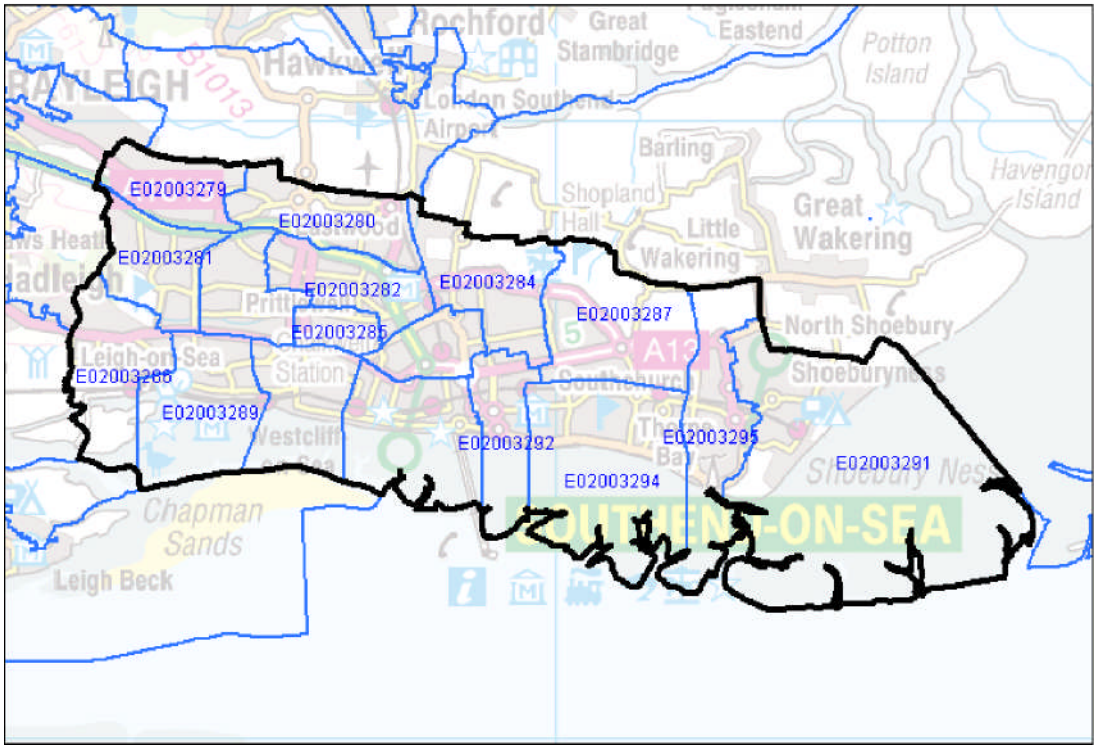
SYNTHETIC ESTIMATES - the expected prevalence of a behaviour for any ward or Primary Care Organisation, given the characteristics of that area. The synthetic estimates are not estimated counts of the number of people or prevalence of a behaviour e.g. smoking in a ward or PCO. They are the expected prevalence of a behaviour for any ward or PCO, given the characteristics of that area (demographic and social characteristics).

SYPHILIS – is a sexually transmitted infection that can spread without either partner knowing. The first signs are often painless sores or rashes followed by flu-like symptoms. Left untreated, it can lead to heart disease or brain damage.

WARD - An administrative area that is laid down in statute. Essex covers x wards.

APPENDICES

Southend-On-Sea UA District and MSOA Areas



1 = Worst Rank	All cause mortality rate		All smoking attributable mortality rate in all ages by county and Middle Super Output Area (MSOA), 2003-2005, by sex					
	Rank Persons	DSR Persons	Rank Persons	DSR Persons	Rank Males	DSR Males	Rank Females	DSR Females
Essex		944.3		150.1		225.2		98.14
Southend-on-Sea		1020.48		167.55		255.66		111.56
Thurrock		1027.74		174.24		261.43		119.75
Epping Forest 007	1	1779.84	15	226.23	13	359.63	24	140.93
Castle Point 004	2	1533.14	7	258.25	9	386.4	7	193.03
Southend-on-Sea 014	3	1461.64	5	263.99	8	396.23	6	199.33
Basildon 015	4	1451.87	13	227.27	10	380.4	14	154.6
Tendring 016	5	1439.93	18	216.04	23	331.53	23	142.27
Epping Forest 015	6	1408.2	48	183.23	77	248.09	22	143.83
Southend-on-Sea 012	7	1385.98	80	162.14	78	247.54	73	112.66
Basildon 013	8	1354.81	6	262.22	7	399.34	2	201.4
Thurrock 018	9	1312.96	3	288.61	4	450.9	3	200.67
Castle Point 010	10	1311.31	1	299.41	5	441.85	4	200.61
Thurrock 007	11	1275.37	21	212.12	72	257.48	8	182.44
Colchester 008	12	1268.33	2	298.6	3	452.3	1	203.13
Thurrock 011	13	1268.2	165	126.37	33	304.88	209	34.96
Thurrock 016	14	1232.81	22	202.84	17	349.47	45	123.99
Southend-on-Sea 015	15	1231.14	49	182.85	62	265.55	27	139.22
Southend-on-Sea 010	16	1222.15	9	241.06	20	338.54	9	173.36
Braintree 007	17	1220.27	47	184	40	290.71	75	111.63
Basildon 021	18	1218.87	75	165.68	188	167.92	11	158.83
Maldon 006	19	1212.94	101	154.16	144	203.94	87	106.8
Braintree 018	20	1194.79	117	145.89	88	239.83	117	98.64
Thurrock 006	21	1192.83	28	198.98	11	369.14	118	98.3
Rochford 004	22	1187.97	37	189.87	24	325.01	128	92.91

Braintree 017	23	1175.84	70	168.06	118	219.51	29	137.34
Epping Forest 008	24	1163.29	16	221.19	99	232.3	5	200.25
Thurrock 012	25	1160.45	77	163.56	64	262.78	90	105.93
Chelmsford 004	26	1156.47	93	157.96	116	220.95	69	113.5
Chelmsford 021	27	1147.7	73	167.23	56	269.89	158	81.67
Maldon 003	28	1142.86	42	185.53	37	300.05	74	111.76
Tendring 018	29	1142.03	17	217.26	16	355.46	76	111.13
Basildon 016	30	1130.43	14	226.86	12	359.79	21	143.9
Castle Point 007	31	1125.85	102	153.76	115	221.4	71	113.27
Colchester 016	32	1125.28	32	194.08	54	273.2	18	145.67
Braintree 013	33	1116.32	164	126.42	152	198.88	180	71.81
Basildon 018	34	1107.4	8	251.08	2	488.11	52	122.76
Maldon 005	35	1101.12	122	144.65	82	244.09	186	68.4
Chelmsford 009	36	1098.65	158	130.8	117	219.76	193	65.13
Tendring 006	37	1097.18	82	161.45	52	274.1	147	84.7
Tendring 017	38	1086.98	39	187.93	46	288.05	54	121.63
Colchester 006	39	1080	135	139.41	110	224.97	159	80.58
Southend-on-Sea 017	40	1073.51	126	144.09	113	222.75	111	99.9
Rochford 010	41	1073.42	105	152.08	106	226.41	139	88.89
Basildon 012	42	1069.28	4	264.15	1	497.07	48	123.75
Basildon 014	43	1068.61	78	163.05	26	319.03	170	75.47
Southend-on-Sea 004	44	1066.38	71	167.89	101	230.04	56	119.63
Braintree 009	45	1064.71	136	139.24	128	213.14	98	103.65
Colchester 010	46	1064.58	103	152.58	90	238.07	129	92.66
Chelmsford 006	47	1060.62	31	197.07	18	341.89	81	108.93
Maldon 004	48	1054.92	150	132.27	131	210.63	115	99.55
Rochford 006	49	1054.78	24	201.95	34	304.6	31	134.51
Harlow 008	50	1053.51	10	238.53	6	433.13	61	117.06
Thurrock 017	51	1050.36	12	229.22	21	338.27	26	140.08
Tendring 001	52	1048.67	57	175.49	73	256.86	91	105.48
Castle Point 011	53	1043.06	100	154.46	159	193.47	44	124.52

Chelmsford 016	54	1041.08	128	143.89	158	195.88	68	114.5
Brentwood 008	55	1035.08	52	178.18	48	280.52	93	105.19
Thurrock 004	56	1034.61	61	174.13	55	271.39	67	115.1
Basildon 007	57	1034.39	56	175.62	44	288.22	140	88.41
Uttlesford 001	58	1031.21	190	117.44	185	171.43	168	76.28
Colchester 005	59	1030.9	197	109.18	207	115.82	96	104.19
Basildon 011	60	1027.52	26	201.11	49	278.69	25	140.57
Braintree 006	61	1024.45	170	124.27	174	181.21	137	89.71
Harlow 007	62	1023.99	19	215.77	22	335.19	34	133.16
Epping Forest 006	63	1022.62	187	118.34	143	204.7	184	69.93
Braintree 004	64	1018.6	141	136.76	83	244.08	192	65.23
Basildon 009	65	1017.13	66	169.9	25	319.12	190	65.58
Epping Forest 005	66	1017.12	69	168.56	145	203.38	20	144.83
Basildon 022	67	1015.77	20	214.94	30	307.35	15	149.26
Uttlesford 007	68	1014.02	143	133.97	187	170.17	62	116.47
Braintree 012	69	1013.78	149	132.53	169	188.2	108	100.96
Thurrock 015	70	1013.35	30	197.79	15	357.54	92	105.32
Harlow 006	71	1009.31	29	198.35	19	338.62	82	108.46
Basildon 008	72	1008.88	67	169.73	142	205.07	33	133.46
Tendring 014	73	1004.94	155	131.71	138	205.73	136	89.92
Maldon 001	74	1002.74	81	162.09	80	246.93	135	91.17
Epping Forest 003	75	1002.23	84	161.32	111	224.66	85	107.44
Colchester 009	76	998.44	203	102.63	199	154.83	185	68.83
Thurrock 002	77	997.87	40	187.35	43	288.53	35	133.03
Uttlesford 005	78	995.98	148	132.79	180	175.36	94	105.05
Thurrock 009	79	994.43	98	155.91	94	233.77	65	115.22
Epping Forest 001	80	989.63	129	143.14	89	238.74	178	72.72
Braintree 016	81	989.54	11	230.51	14	358.48	19	145.04
Colchester 007	82	988.27	177	122.64	112	223.77	156	81.95
Uttlesford 006	83	987.61	202	102.79	183	172.8	201	55.18
Colchester 019	84	980.65	138	137.59	130	211.3	166	76.53

Colchester 018	85	976.73	163	126.51	166	189.07	152	83.66
Tendring 015	86	975.53	34	192.6	45	288.19	58	117.48
Basildon 017	87	973.56	33	193.93	27	311.57	40	128.62
Braintree 015	88	972.16	25	201.15	42	288.71	41	127.77
Harlow 009	89	970.04	51	179.59	39	297.4	55	119.65
Epping Forest 017	90	968.65	124	144.38	170	187.28	47	123.8
Chelmsford 002	91	968.35	181	121.4	165	190.14	176	73.43
Tendring 010	92	965.37	46	184.02	67	261.34	39	129.61
Brentwood 009	93	962.64	137	138.46	179	175.51	77	111.05
Harlow 002	94	961.83	60	174.68	86	241.89	36	131.65
Epping Forest 010	95	960.38	140	136.77	154	198.53	125	95.56
Castle Point 009	96	960.26	79	162.35	74	250.9	100	103.19
Chelmsford 019	97	957.88	59	175.12	65	262.12	84	107.46
Basildon 006	98	957.84	68	168.62	59	266.8	83	107.64
Braintree 008	99	956.28	53	177.2	28	311.52	171	75.45
Southend-on-Sea 009	100	955.94	62	173.15	75	249.72	57	119.19
Rochford 007	101	955.44	99	155.14	114	221.88	49	123.74
Brentwood 004	102	955.17	50	180.54	70	258.19	53	122.03
Tendring 012	103	952.98	44	184.37	68	260.46	32	133.61
Harlow 004	104	951.3	63	173	109	225.29	17	147.62
Braintree 003	105	949.31	132	141.06	151	199.12	121	97.21
Castle Point 006	106	948.79	55	176.47	71	257.7	37	130.47
Southend-on-Sea 005	107	946.03	54	177.08	29	308.62	97	104.01
Colchester 002	108	945.77	180	121.69	202	148.54	105	101.64
Castle Point 012	109	945.34	64	172.01	91	236.58	13	155.09
Basildon 019	110	945.15	58	175.13	47	286.36	88	106.7
Brentwood 001	111	939.29	166	126.31	125	214.63	196	62.86
Thurrock 003	112	937.38	38	189.01	100	232.06	12	155.29
Braintree 011	113	934.65	88	160.58	103	229.06	95	105.02
Basildon 010	114	932.85	45	184.36	120	218.35	10	164.69
Tendring 011	115	932.32	97	156.57	126	213.96	64	115.26

Braintree 005	116	929.4	204	102.07	153	198.74	206	45.12
Harlow 011	117	927.27	41	185.66	107	225.76	38	129.68
Southend-on-Sea 007	118	926.91	107	151.71	162	193.03	60	117.27
Thurrock 005	119	925.65	146	133.47	147	203.04	146	85.09
Thurrock 013	120	921.38	23	202.31	32	305.18	43	125.18
Southend-on-Sea 001	121	918.53	104	152.53	121	218.11	112	99.68
Harlow 003	122	912.88	65	171.63	79	247.48	78	110.87
Uttlesford 008	123	910.6	125	144.17	146	203.04	120	97.69
Uttlesford 009	124	908.48	174	123.66	155	198.26	163	78.62
Southend-on-Sea 006	125	907.04	35	190.94	36	301.7	70	113.42
Brentwood 003	126	906.9	168	125.06	163	191.02	149	84.53
Chelmsford 020	127	902.92	188	118.2	211	101.65	46	123.94
Epping Forest 012	128	896.96	185	119.6	198	158.22	124	95.72
Colchester 004	129	896.49	169	124.61	140	205.48	199	57.84
Thurrock 008	130	895.92	110	148.23	129	212.99	109	100.94
Rochford 008	131	891.88	139	137.55	84	243.22	179	72.39
Tendring 013	132	888.52	83	161.44	69	258.56	161	79.25
Tendring 007	133	887.64	161	128.18	168	188.54	169	75.6
Castle Point 008	134	885.08	74	166.34	124	215.04	30	135.17
Castle Point 002	135	883.44	198	108.2	182	172.96	197	61.43
Tendring 003	136	882.83	87	160.86	96	233.15	104	102.07
Epping Forest 004	137	878.8	113	147.53	123	216.26	113	99.61
Maldon 007	138	875.81	131	141.83	135	207	116	99.02
Thurrock 010	139	875.8	114	147.24	171	185.45	50	123.36
Harlow 005	140	871.17	27	200.92	38	298.52	16	147.84
Maldon 002	141	869.35	142	135.01	76	248.11	202	52
Tendring 002	142	867.03	147	133.11	192	165.46	102	102.11
Chelmsford 010	143	866.65	151	132.25	141	205.08	126	94.26
Colchester 001	144	864.72	173	123.66	173	183.31	155	82.65
Tendring 009	145	863.9	189	117.75	127	213.54	207	43.66
Colchester 021	146	863.44	159	130.62	139	205.59	174	74.36
Chelmsford	147	863.29	178	122.2	150	200.59	183	70.47

012								
Braintree 014	148	862.05	86	161.11	60	266.6	144	86.68
Basildon 005	149	860.36	162	127.4	195	164.86	63	115.85
Basildon 004	150	858.3	191	116.46	203	141.88	99	103.36
Southend-on-Sea 003	151	856.51	111	147.85	105	226.9	103	102.08
Colchester 013	152	856.48	72	167.77	50	275.92	132	91.43
Epping Forest 011	153	856.31	36	190.26	51	275.9	51	123.33
Southend-on-Sea 013	154	855.48	116	147.13	108	225.73	127	93.74
Brentwood 006	155	855.19	134	139.46	98	232.91	153	83.23
Harlow 001	156	855.02	133	139.74	157	196.74	101	102.54
Epping Forest 014	157	854.43	194	114.9	184	171.75	188	67.44
Colchester 020	158	851.55	171	123.79	156	197.47	151	84.01
Tendring 008	159	850.62	156	131.52	148	201.27	157	81.9
Colchester 012	160	847.3	176	123.53	136	206.83	177	72.91
Southend-on-Sea 002	161	847.1	94	157.35	81	246.92	130	92.49
Southend-on-Sea 008	162	844.29	144	133.7	132	210.62	138	89.37
Braintree 010	163	842.88	109	149.71	66	261.83	191	65.29
Chelmsford 008	164	839.08	91	159.56	97	233.01	79	110.05
Tendring 004	165	838.65	172	123.68	178	177.03	160	80.56
Colchester 003	166	835.85	184	119.78	193	165.36	143	86.8
Uttlesford 003	167	834.3	200	107.11	208	115.21	106	101.19
Epping Forest 009	168	830.89	76	164.81	63	263.49	165	78.56
Uttlesford 004	169	830.58	186	118.9	201	150.27	122	97
Southend-on-Sea 016	170	830.47	179	121.93	122	217.32	195	63.83
Colchester 015	171	825.91	112	147.63	58	267.1	164	78.6
Tendring 005	172	825.52	157	130.84	172	184.44	133	91.32
Basildon 002	173	824.87	175	123.63	200	150.66	86	107
Chelmsford 015	174	820.74	118	145.65	186	170.87	28	137.89
Thurrock 014	175	815.88	152	132.18	164	190.76	123	96.89
Rochford 005	176	812.53	154	131.81	181	174.51	110	100.92
Rochford	177	811.94	127	143.97	104	228.55	141	87.86

003								
Chelmsford 003	178	811.64	145	133.59	177	178.25	89	106.22
Maldon 008	179	811.38	119	145.5	87	240.05	173	75.32
Brentwood 002	180	810.84	196	110.94	194	165.32	181	71.75
Epping Forest 002	181	805.81	123	144.46	175	180.23	66	115.21
Castle Point 003	182	802.76	90	160.38	92	236	80	109.57
Chelmsford 014	183	799.73	85	161.12	35	301.74	162	79.21
Colchester 011	184	796.23	95	156.89	53	273.77	134	91.18
Harlow 010	185	794.2	89	160.43	57	268.47	145	85.26
Basildon 001	186	793.8	108	150.55	167	188.93	59	117.33
Uttlesford 002	187	790.41	193	115.03	161	193.07	187	67.92
Brentwood 007	188	789.94	160	129.61	176	179.89	107	101.05
Southend-on-Sea 011	189	786.71	96	156.67	61	266.27	114	99.57
Epping Forest 016	190	782.97	195	113.37	137	206.24	204	46.86
Chelmsford 017	191	780.05	92	159.53	41	289.98	167	76.43
Basildon 020	192	779.45	43	185.15	31	306.08	72	112.85
Rochford 002	193	773.55	106	151.99	85	243.18	154	82.7
Colchester 017	194	772.69	115	147.21	93	235.05	148	84.67
Chelmsford 018	195	772.53	192	115.51	197	161.81	142	87.07
Braintree 002	196	771.87	182	120.66	119	218.85	205	45.14
Basildon 003	197	765.77	205	101.6	210	105.18	119	97.77
Rochford 001	198	759.78	130	141.97	189	167.53	42	126.6
Braintree 001	199	758.51	153	132.04	160	193.19	131	92.45
Chelmsford 005	200	751.43	120	145.33	102	229.85	172	75.35
Chelmsford 011	201	743.53	206	99.99	190	166.98	194	64.78
Chelmsford 013	202	742.55	211	75.25	209	107.75	203	51.06
Brentwood 005	203	737.83	208	92.51	206	116.35	175	73.68
Colchester 014	204	733.79	207	94.87	205	128.93	182	70.56
Chelmsford 001	205	724.16	209	89.24	191	165.57	208	38.5
Rochford 009	206	710.15	183	120.42	134	207.25	200	55.52
Castle Point 001	207	708.55	121	145.17	95	233.51	150	84.38

Thurrock 001	208	684.81	201	103.74	149	201.03	211	33.22
Castle Point 005	209	683.29	199	107.21	196	164.04	198	60.99
Chelmsford 007	210	682.65	210	82.08	204	131.09	210	34.66
Epping Forest 013	211	638.5	167	125.15	133	209.3	189	65.73

Source: ERPHO nesstar, data from Office of National Statistics