Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Health and Wellbeing Board

The meeting will be held at **2.00 pm** on **12 March 2015**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Cllr Barbara Rice (Chair), Cllr John Kent, Cllr Tunde Ojetola, Cllr Joy Redsell

Mandy Ansell, (Chief Operating Officer, Thurrock NHS Clinical Commissioning Group)
Dr Andrea Atherton, (Director of Public Health, Southend and Thurrock Councils)
Dr Anand Deshpande, (Chair, Thurrock NHS Clinical Commissioning Group)
Len Green, (Lay member, Clinical Commissioning Group)
Barbara Brownlee, (Director of Housing, Thurrock Council)
Roger Harris, (Director of Adults, Health and Commissioning, Thurrock Council)
Kim James, (Chief Operating Officer, Healthwatch Thurrock)
Carmel Littleton, (Director of Children's Services, Thurrock Council)

Agenda

Open to Public and Press

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Please contact Ceri Armstrong, Strategy Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **4 March 2015**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated "Good" or better
- Raise levels of aspirations and attainment so that local residents can take advantage of job opportunities in the local area
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Provide the infrastructure to promote and sustain growth and prosperity
- Support local businesses and develop the skilled workforce they will require
- Work with communities to regenerate Thurrock's physical environment

3. Build pride, responsibility and respect to create safer communities

- Create safer welcoming communities who value diversity and respect cultural heritage
- Involve communities in shaping where they live and their quality of life
- Reduce crime, anti-social behaviour and safeguard the vulnerable

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being
- Empower communities to take responsibility for their own health and wellbeing

5. Protect and promote our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Ensure Thurrock's streets and parks and open spaces are clean and well maintained

Minutes of the Meeting of the Health and Wellbeing Board held on 9 February 2015 at 2.00 pm

Present:	Councillors Barbara Rice (Chair), John Kent and Joycelyn Redsell Mandy Ansell, (Chief Operating Officer, Thurrock NHS Clinical Commissioning Group) Dr Andrea Atherton, (Director of Public Health, Southend and Thurrock Councils) Len Green, (Lay member, Clinical Commissioning Group) Barbara Brownlee, (Director of Housing, Thurrock Council) Roger Harris, (Director of Adults, Health and Commissioning, Thurrock Council) Kim James, (Chief Operating Officer, Healthwatch Thurrock) Carmel Littleton, (Director of Children's Services, Thurrock Council)
Apologies:	Councillors Tunde Ojetola
In attendance:	Sharon Grimmond – HWBB Business Manager Beata Malinowska - Senior Delivery Improvement Consultant, North East London Commissioning Support Unit Christopher Smith - Adults, Health and Commissioning Programme Manager Sean Clark – Head of Corporate Finance

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

41. Minutes

The Minutes of the Health and Wellbeing Board, held on 09th February 2015, were approved as a correct record.

42. Urgent Items

There were no items of urgent business

43. Declaration of Interests

There were no declarations of interested declared.

44. Developments in Primary Care Thurrock CCG report

The CCG has a Primary Care Steering Group which includes partners from Thurrock Council and Thurrock Healthwatch.

The three areas Thurrock CCG sees as challenges are:

- Primary Care estate;
- Recruitment of GPs and Practice Nurses; and
- The profile of the workforce

The focus of activity is to ensure that spend is focused on services that have the greatest impact on patient care.

The CCG has been working with the Council's Adult Social Care and Regeneration teams to scope a health facility as part of the Purfleet regeneration programme.

The CCG has successfully secured funding of £248,996 to support the extended opening of four Thurrock-based GP 'Hubs' from 9am -12pm at weekends. The Hubs will accept both booked and walk-in appointments. The first hub is expected to open in early March. This is a 7 year project to provide extended provision for Primary Care.

Each hub has different needs and therefore joint working between Hubs will ensure that resources are appropriately shared.
A public consultation event will take place on Wednesday 11th February at Orsett Hall.

There is no end date for the Primary Care Strategy and the GP Hubs are not co-dependant on the future of the Thurrock Walk-in Service as these are two separate initiatives. Through the Primary Care steering groups, the CCG will review priorities at each stage. Updates will be brought back to the Board as appropriate.

The CCG is not responsible for the commissioning of the Grays High Street GP practice, only the Walk-in Service. NHS England is responsible for ensuring adequate primary care provision.

The Board was told that the CCG had submitted a bid for the Prime Minister's Challenge Fund. If successful the funding would be used to extend services for weekend opening and would enhance the capacity of Primary Care.

It was noted that the report will come back to the Board for a review.

RESOLVED:

Recommendations agreed

45. The future of the Walk in Service Report

Beata Malinowska presented the report on the future of Thurrock's Walk-in Service.

Established in March 2010 the Walk-in Service is currently undergoing a public consultation from 2nd February to 24th March, this was launched by the CCG to gather input from the community around the Walk-in Service in Grays.

According to research 37% of patients who use the Walk-in Service do so as a reassurance of service e.g. secondary reviews after a patient has already visited their registered GP – which isa duplication of service.

Analysis was carried out and patient surveys initiated due to the numbers of patients scheduling appointments and then not attending.

Attendance costs at one of the Hubs is approximately £12-£15 per head. This is compared to an average of £32 per head for an attendance at the Walk-in Service.

Concerns were raised about where people living in the east of the Borough were going, and whether they were attending Basildon Accident and Emergency.

Research had concluded that people did not travel to the Hospital due to the distance.

RESOLVED:

Recommendations agreed.

46. The Better Care Fund pooled fund Section 75 Agreement Report

The report was presented by Roger Harris, Mandy Ansell, and Christopher Smith.

The Better Care Fund Plan has now been approved by Minsters, with confirmation received from Dame Barbara Hakin.

Cabinet will be asked to approve the section 75 pooled fund agreement in March, followed by the CCG Board.

The Plan focuses initially on older people's services. The mandated amount was £10 million with Thurrock's pooled fund being £18 million. The Plan will enable the CCG and Council to consider innovative ways of approaching joined-up services at a local level.

A payment-for-performance element will release funding but is dependent upon reducing hospital admissions by 3.5%.

New governance arrangements will be established, with the membership comprised of senior management, to oversee the fund. A pooled fund manager will report directly to the new arrangements on performance, activity and quality.

Thurrock Council will be the host organisation for the Better Care Fund which will be governed via the section 75 agreement.

A performance framework will be established, with a scorecard in place to measure progress and outcomes.

The Board were made aware that regular financial reports will be required as part of the Agreement.

RESOLVED:

Recommendation agreed.

47. Forward Plan

Cllr Rice informed the Board of the dates of future meetings, it was agreed that a meeting should be organised for June.

The meeting finished at 3.05 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

12 March 2015	ITEM: 5
Thurrock Health and Wellbeing Board	
Health and Social Care Learning Disability Self Assessment	
Report of: Kelly Jenkins Commissioner for Learning Disability and Mental Health and Catherine Wilson Strategic Lead for Commissioning and Procurement, Adults, Health and Commissioning	
Accountable Director: Roger Harris Director Adults Health and Commissioning	
This report is Public	
Purpose of Report: The purpose of this report is to ensure that the Health and Well Being Board are informed about the Learning Disability Self-Assessment in order to ratify the document.	

1.0 Introduction and Background:

1.1 The background to the introduction of the Learning Disability Self Assessment is that 12 years ago as part of the White Paper Valuing People it was created as a consistent tool to support the development and implementation of the initial 11 objectives of Valuing People and has changed and developed with all subsequent work around learning disability and the introduction of the Care Act 2014. As noted the assessment gives a bench marking tool across the country and affords the opportunity to learn from good practice nationally.

1.2 The Thurrock Learning Disability Self Assessment focuses on three key areas described above, Staying Healthy, Saying Safe and Living Well and provides a measure locally and nationally as to the progress made in each area for those who have a learning disability. It continues to give support to the Local Authority and CCG to measure and maintain improvements through the Health and Well Being Board, the CCG Board and the Disability Partnership Board.

2.0 Recommendation(s):

2.1 That the Health and Wellbeing Board endorses the Learning Disability Self Assessment which has already been submitted in draft to the LD Observatory.

2.2 That a further report is brought back to the HWB Board in six months time on those areas currently rated as either Amber or Red with details on how it is proposed they move towards Green.

3.0 Key Issues :

3.1 The Learning Disability Self-Assessment Framework is completed annually to support national benchmarking for the provision of services for people with learning disabilities across Health and Social Care. From year to year the parameters of the Self-Assessment change with developing focus this year on Staying Healthy, Saying Safe and Living Well. These areas cover the key concerns that have driven all changes over the last 12 years for the provision of care and support for people with learning disabilities and their carer's.

3.2 The three key areas highlighted above are divided into subsections and the Local Authority and the Clinical Commissioning Group (CCG) are asked to RAG (red, amber, green) rate progress. There are 24 questions and the RAG rating for Thurrock is as follows 5 rated green, 17, rated amber and 2, rated red.

3.3 The Learning Disability Self-Assessment Framework has been submitted to the Learning Disability Observatory so that national and local prevalence data can be added; this is completed for all self-assessments. We are asked to ensure that the document is ratified by both the Health and Well Being Board and the Disability Partnership Board by the end of March 2015. To support this process we have engaged with Thurrock Coalition to ensure that an independent view is taken of the self-assessment and we asked Cariads to support Carers to respond to the information required about carer's services and experiences. There will be an opportunity to include the comments from Thurrock Coalition, the Health and Well Being Board and the Disability Partnership Board at the end of March. The initial submission had to be made by the end of January in order to allow time for the national and local data to be added by the Learning Disability Observatory.

3.4 Nationally many local authorities and CCG's have been reluctant to complete the assessment and sign up to the process, Thurrock has under taken the assessment again as we acknowledge the value of understanding our individual progress and where we are nationally in developing our learning disability services. The analysis will also support the sharing of good practice which is invaluable. This year Thurrock Council and Thurrock CCG together with the Health and Well Being Board and Disability Partnership Board want to agree to use our identified areas of improvement to form a joint strategic approach to further service development in Thurrock.

3.5 The key difficulty we have found in Thurrock, which is replicated nationally is that we are unable to retrieve certain health data particularly around screening for conditions such as cancer, diabetes, BMI results and obesity rates within the learning disabled population. Although providers and primary health care have been requested to disaggregate this information the CCG still have difficulty in retrieving it form GP's, the Hospital and other specialist services. The CCG have asked for this information in good time for the self-assessment both this year and last year and the response has been very limited. This will need to be one of our key areas of development over the next year.

3.6 Attached at appendix one is a detailed breakdown of each area to be RAG rated the guidance for that area, the measures and the RAG rating for Thurrock, below is a summary of the red, amber and green ratings for ease of reference.

3.7 There are two areas which currently are assessed as red:

3.8 The first is Health Services for people with a learning disability who experience the criminal justice system. To achieve an amber/green rating a system wide approach is required to the early identification of people entering the criminal justice system who may have a learning disability. Community nurses do currently provide services but they are not clearly linked to the system as a whole and this requires more development. There is a commitment from colleagues within the criminal justice system to work on this approach.

3.9 The second area which is identified as red is concerning commissioning strategy impact assessments. Each strategic approach across the Council and CCG is required to have an element that will identify how the needs of those with learning disability will be met either through specific responses or through reasonable adjustments. A great deal of work has already been achieved through the development of the Market Position Statement and the exploration of a joint health and social care commissioning approach to learning disability, however we were not able to indicate an amber/green rating at this point. The work will continue this year and we are confident the rating will improve next year.

3.10 There are 17 areas that have been identified as amber:

3.11 The 17 areas that have been rated as amber are across all 3 sections, they reaffirm the areas that we are currently working on and give the Local Authority and the CCG clear guidance of what needs to be achieved to reach a green rating. Appendix one attached contains the detail for each section.

3.12 In summary Health need to undertake more work to ensure that the Learning Disability (LD) registers are aligned and that GP's are fully aware of all their patients with learning disability, in the main this has been achieved this year but a clear system is required for ensuring regular updates and cross referencing. The preventative and diagnostic screening programmes require improvement to make sure that people with learning disability have the same access as the general population. The percentage of health checks and health action plans need to increase to expand knowledge and support reasonable adjustments to be made to mainstream health services.

3.13 Health and social care reviews of care packages are very high 95% and 90% respectively but the requirement is 100% of reviews carried out annually.

3.14 A great deal of work has been done to expand the number of people who use services and carers participating in recruitment and training however the self assessment wants to make sure that all services deliver this approach.

3.15 Another area that was answered by carers and self advocates was concerning services treating individuals with dignity, respect and compassion; this produced a mixed response indicating that all providers and commissioners need to be mindful and more rigorous in ensuring this is intrinsic to every aspect of service delivery.

3.16 Integrating health and social care commissioning and operational delivery is essential for service improvement, there is a great deal of collaborative working in Thurrock but this needs to move on to formally integrated services.

3.17 There is some good local work regarding transport, local amenities, arts, culture, sports and leisure and the aim over the next year will be where ever possible to expand ease of access and to make more reasonable adjustments to provision in Thurrock.

3.18 Employment is another important area both the Local Authority and the CCG are continuing to fund an employment programme delivered through Thurrock Centre for Independent Living through the next financial year, recognising this is a critical area to support independence.

3.19 Preparing for adulthood is another area in Thurrock with significant achievements which did not quite reach the green rating, the transition strategy and steering group is making excellent progress but there are still some barriers which will require partnership working across all areas particularly in access to higher education and work opportunities another piece of ongoing work for this year.

3.20 There are 5 areas that have been identified as green:

3.21 The five green rated areas are essential to the provision of a positive and safe service for people with learning disabilities in Thurrock. The first highlights a liaison nurse in post at Basildon and Thurrock Hospital to ensure that the needs of people with learning disability are highlighted to hospital staff, the second is contract compliance where 100% of the services provided to people with learning disability are monitored annually, the third is the delivery of the assurance and monitor compliance framework for foundation trusts for Thurrock this is the compliance framework for South Essex Partnership Foundation Trust (SEPT), the fourth is safeguarding and the self assessment reaffirms the high standard of delivery here in Thurrock of this key area of work and finally learning from complaints which is analysed, acted on and reported quarterly to the Departmental Management Team (DMT).

4.0 Recommendation(s):

4.1 That the Health and Wellbeing Board endorses the Learning Disability Self Assessment which has already been submitted in draft to the LD Observatory.

4.2 That a further report is brought back to the HWB Board in six months time on those areas currently rated as either Amber or Red with details on how it is proposed they move towards Green.

5.0 Reasons for Recommendation(s):

5.1 To ensure that the Health and Wellbeing Board are well informed regarding the Learning Disability Self Assessment for Thurrock and have detailed information to monitor the work of the Disability Partnership Board and its sub groups to deliver improvement in the amber and red rated areas and maintain the progress identified in the green rated areas.

6.0 Consultation (including Overview and Scrutiny, if applicable)

6.1 N/A

7.0 Impact on Corporate Policies, Priorities, Performance and Community Impact

7.1 The failure to deliver high quality services and support to people with learning disabilities would affect a significant number of Thurrock residents, it is important therefore to recognise that the self assessment assists in monitoring equality of opportunity for learning disabled people.

8. Implications

8.1 **Financial**

Implications verified by: **Michael Jones**
Management Accountant

There are no financial implications for this report.

8.2 **Legal**

Implications verified by: **Dawn Pelle**
Adult Care Lawyer

There are no legal implications for this report.

8.3 **Diversity and Equality**

Implications verified by: **Becky Price**
Community Development Officer

The work being undertaken regarding the self-assessment ensures that learning disabled people continue to be supported with dignity and respect, recognising their diversity needs.

8.4 **<u>Other implications</u> (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

N/A

Background papers used in preparing this report (include their location and identify whether any are exempt or protected by copyright):

Appendices to this report:

- Summary of the Thurrock Learning Disability Self Assessment

Report Author Contact Details:

Kelly Jenkins Commissioner for Learning Disability and Mental Health and Catherine Wilson Strategic Lead for Commissioning and Procurement, Adults, Health and Commissioning

Appendix 1: Learning Disability Self Assessment Framework
RAG Rating for Thurrock
Health and Well Being Board March 2015

SECTION A Staying Healthy	Guidance note	Measure	THURROCK RAG RATING
A1: Learning disabilities Quality Outcomes Framework (QOF) register in primary care	There is concern that many people with learning disabilities (LD) are unknown to services and do not subsequently get access to the healthcare they need. This indicator aims to encourage the building of accurate registers to ensure equity of access to healthcare for people with learning disabilities. All people with learning disabilities need to be identified using the QOF. Local data needs to be scrutinised and systems put in place in primary care to ensure that all people with learning disabilities are put on the QOF register.	LD registers reflect prevalence data AND data stratified in every required data set (e.g. age / complexity / autism diagnosis / black and minority ethnicities etc.). LD registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity). The numbers of people on LD registers reflect the requirements outlined in the QOF.	**Data cleansing of the registers is ongoing to ensure all relevant information has been recorded for each individual**
A2: Finding and managing long term health conditions: obesity, diabetes, cardiovascular disease, epilepsy	Currently there is little specific comparative data between the health of people with learning disabilities and the non-learning disabled population, yet we know that people with learning disabilities have poorer access to healthcare and die younger than their non-learning disabled peers. There is a lack of robust data from which the Joint Strategic Needs Assessment (JSNA) and Health and Well-Being Strategy can	We compare treatment and outcomes for all four conditions between people with learning disabilities and others in: the area and at local GP level. We compare treatment and outcomes for some of the conditions	**People with LD continue to access preventative support services through Health Facilitators. Health Checks continue to be carried out and Thurrock has recently been successful at a NDTi (National Development Team for Inclusion)/NHS England Co-production programme where learning sets will be delivered to support improved quality and coverage of health checks for people with LD**

	be informed. This indicator looks at four major long term health conditions (obesity, diabetes, cardiovascular disease and epilepsy) to enable localities respond more effectively to clinical needs and be in a strong position for future planning of reasonably adjusted health services for people with learning disabilities.	between people with learning disabilities and the general population in the area. No comparative data available.	
A3: Annual health checks and annual health check registers	IHAL (Improving Health and Lives) will complete this measure for all localities from the national data source.	80% or more health checks complete 41% to 79% health checks complete Fewer than 40% health checks complete	**Not to be completed locally the LD Observatory will complete from national data**
A4: Specific health improvement targets (Health Action Plans) are generated at the time of the Annual Health Checks in primary care	The LD DES (Directed Enhanced Services) (2013/14) guidance puts the onus on GPs to generate meaningful health improvement targets (health action plans) at the time of the annual health check to address health priorities. Integrated annual health checks and health improvement targets (health action plans) will ensure person centred care and improved individualised health outcomes. This indicator provides an opportunity to improve primary, secondary and specialist community team engagement which supports the reduction of inappropriate secondary care	70% or more than of Annual Health Checks generate specific health improvement targets (health action plan). 50% - 69% of Annual Health Checks generate specific health improvement targets (Health action plan). Fewer than 50% of Annual Health Checks generate specific health improvement targets (health action plan).	**Health Action Plans are generated at the time of the Annual Health Checks and there is active engagement and collaborative work by Health Facilitators to ensure people are supported to meet identified needs with a view to improving health outcomes. The support is through accessing various community services and partners in the voluntary sector work closely with the LA (Local Authority) and CCG (Clinical Commissioning Group)to promote access to programmes.**

	referrals. It also provides the person with a learning disability (and their carer, if appropriate) with a clear understanding of 'what needs to happen' over the next 12 months.		
A5: National Cancer Screening Programmes (bowel, breast and cervical)	IHAL will complete this measure for all localities from the national data source.	Screening takes place for the same proportion of learning disabled people as the general population Screening takes place for half the proportion Screening takes place for less than half the proportion	Not to be completed locally
A6: Primary care communication of learning disability status to other healthcare providers	Healthcare providers continue to state that having no prior warning of somebody's learning disability and specific needs resulting from their disability prevents them from being able to fully meet their needs through reasonable adjustments. This indicator encourages the development of standardised local systems to address this problem. The patient journey of people with learning disabilities needs to be track able as identified within primary and secondary care. By including the learning disability status in the referral will give notice to the secondary care provider enabling them to make reasonable adjustments if necessary. This will	Secondary care and other health care providers can evidence that they have a system for identifying LD status on referrals based upon the LD identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed. There is evidence of a local area	**Progress is being made to ensure that a wider CCG/LA system standardises indication of LD status in the referral process. Reasonable adjustments is a key focus to facilitate access as well as having specialist LD nurses in place so that there is harmony between health action plans and other services such as hospital passport with a 999 card to be utilised in an emergency denoting a person's vulnerability due to their LD, ensuring reasonable adjustments are made..**

	potentially lead to a reduction in DNA's (Did Not Attends) , length of stay and inappropriate repeat attendances.	team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals. There is evidence that both an individual's capacity and consent are inherent to the system employed. There is no local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments are included in the referrals.	
A7: Learning disability liaison function or equivalent process in acute setting	In *Healthcare for All (recommendation 10)* the value of advocacy, including learning disability liaison is clearly described, as well as a clear call for Trust Boards to publicly report they have effective systems to deliver reasonably adjusted health services. Many Trusts have appointed learning disability liaison nurses though there is more than one way in which the learning disability liaison function can be delivered.	Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting/ monitoring routes Designated learning disability liaison function or equivalent process in place and details of the provider sites covered has been submitted. Providers are not yet using known activity data to effectively employ LD liaison function against demand	**Basildon and Thurrock University Hospital NHS Foundation Trust employs a full time Learning Disability Nurse Specialist. The nurse and appropriate service leads receive regular data in regards to people with Learning Disabilities activity within the hospital. This enables the planning of services and care to be implemented on a daily basis. This is monitored through regional self-assessment and the trusts on-going learning disability action plan. The chair through our clinical assurance committee feeds up progress from the LD committee / action plan to the Executive**

	This indicator seeks to explore the full extent of the learning disability liaison function in England. Of particular importance is whether providers and commissioners are gathering and using HES (Hospital Episode Statistics) data to inform decisions on where the greatest need for a learning disability function may be given trends and evidenced need.	No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per site.	**board. The also Learning Disability Nurse completes a quarterly policy compliance audit, which is fed back to the learning disability committee and feeds into the overall action plan.**
A8:NHS commissioned primary care: dentistry, optometry, community pharmacy, podiatry	Any health service accessed by a person with learning disability may need to reasonably adjust what it does in order to meet their additional needs. This indicator captures examples of where this is happening well in wider primary care services including dentistry, optometry, community pharmacy and podiatry. In order for reasonable adjustments to occur routinely, services need a way to both record the patients learning disability status and describe the reasonable adjustment required. This measure is specifically about the 4 listed, NOT those services specifically commissioned for people with a learning disability.	All people with learning disability accessing/using service are known and patient experience is captured. All of these services are able to provide evidence of reasonable adjustments and plans for service improvement. Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements. People with learning disability accessing/using these services are not flagged or identified. There are no examples of reasonable adjusted care	**Reasonable adjustments in place in other mainstream services e.g. dentistry, optometry, community pharmacy, podiatry, community nursing and midwifery.**
A9: Offender health and the Criminal	Evidence suggests 7% of the prison	Local Commissioners have and	No current system wide approach

Justice System	population, and a greater number in the criminal justice system have learning disabilities. It is important that these individuals have access to a range of health services. Information gathered from local criminal justice systems on prevalence will inform provision regarding: • What is available including prevention • Development required • Ensuring accessible health services. This indicator captures local information and data about people with learning disabilities in prison and the criminal justice system and how their health needs are being met.	act on data about the numbers and prevalence of people with a learning disability in the criminal justice system. Local commissioners have a working relationship with regional, specialist prison health commissioners AND There is good information about the health needs of people with LD in local prisons and wider criminal justice system and a clear plan about how such needs are to be met AND Prisoners and young offenders with LD have had an annual health check which generates a health action plan, or are scheduled to have one in the coming 6 months AND Evidence of 100% of all care packages including personal budgets reviewed at least annually. In the absence of the above (or elements of the above) an assessment process has been agreed to identify people with LD in all offender health services e.g. learning	for collation of data for individuals with LD within the Criminal justice system. LD community nurses work with and support individuals diagnosed with a learning disability and known to services that are sometimes going through the criminal justice system.

		disability screening questionnaire. Offender health teams receive LD awareness training to know how best to support individuals to meet their health needs AND There is easy read accessible information provided by the criminal justice system There is no systematic collection of data about the numbers of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability.	
Section B Staying Safe	**Guidance note**	**Measure**	**THURROCK RAG RATING**
B1: Individual health and social care package reviews	Regular Care Review – This measure is about ensuring that in all cases where a person with a learning disability is receiving care and support from commissioned services, the needs behind this support are reviewed in a co-productive and inclusive way	Commissioners know that all funded individual health and social care packages for people with learning disability across all life stages are reviewed regularly. Evidence of 100% of all care packages including personal budgets reviewed within the 12 months are covered by this self-assessment	**Social Care** **Over 90% of Learning Disability clients receive regular reviews, and at least annually. All are face to face.** **NHS** **Over 95% reviews are completed within a year.**

		Evidence of at least 90% of all care packages including personal budgets reviewed within the 12 months are covered by this self-assessment. Less than 90% of all care packages including personal budgets reviewed within the 12 months is covered by this self-assessment	
B2: Learning disability services contract compliance	This measure asks localities to demonstrate how thorough their contracting processes are. This is important to ensure individual reviews are complimented by robust contract management	Evidence of 100% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance and including un announced visits. Evidence that the number regularly reviewed is reported at executive board level in both health and social care. Evidence of at least 90% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract	**Monitoring visits will be completed on 100% of Working Age Adult Homes by the year end for both Health and Social Care commissioned placements. All monitoring visits are unannounced these include full Compliance & follow up and out of hours visits. The team use the ADASS Regional Workbook; this is monitoring tool monitors standards in line with CQC standards for care homes in borough. The benefit of the ADASS Regional Workbook is that this gives a robust and thorough indication of the service being delivered. If an out of borough visit is required, this will be unannounced and a report completed with any findings and feedback given to the Provider. Part of the monitoring is to have interviews with staff, service users and family members to ensure that**

		reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance. Evidence that the number regularly reviewed is reported at executive board level in both health and social care. Less than 90% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance.	**staff receive mandatory training and an additional training required. Any safeguarding alerts are dealt with as matter of urgency; the team will liaise with other agencies and carry out joint meeting if required**
B3: Monitor assurances	Following the publication of Healthcare for All in 2008 the Care Quality Commission (CQC) developed a number of essential standards for healthcare providers to meet in order to assure a minimum standard of care, to be offered to people with learning disability. Subsequently MONITOR (the independent regulator of Foundation Trusts (FT) adopted the same standards into their compliance framework. As these are minimal quality standards it would be expected that all FT's should be	Commissioners review monitor returns and review actual evidence used by FT's in agreeing ratings. Evidence that commissioners are aware of and working with non-FT's in their progress towards monitor compliance Commissioners review monitor returns of FT providers. Evidence that commissioners are aware of and working with non-FT's in their progress towards monitor compliance Commissioners do not assure	**Assurance of Monitor Compliance Framework for Foundation Trusts (SEPT)**

	meeting these. This indicator not only seeks confirmation that this is the case but expects commissioners to demonstrate the evidence gathered from providers to confirm this and the evidence that where trusts strive to achieve foundation status, commissioners support the attainment of monitor standards.	themselves of the on-going compliance via monitor returns for each FT OR for non-FT. Commissioners are not aware of the Trust's position in working towards monitor standards and FT status	
B4: Adult safeguarding	Governance, safety, quality and monitoring. Learning from Winterbourne View review and good commissioning practice identifies failures and risks within the quality and safety of people's placements, both individually and across organisations. This must cease. This measure asks localities to robustly evidence the safeguarding governance for people with learning disability in all provided services and support.	Comprehensive evidence of robust, transparent and sustainable governance arrangements in place overseen by a Safeguarding Adults Board which has representation from chief officers and representatives of people who use services and their families. Every learning disability provider service has assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. There are contractual clauses requiring providers to work in line with the local multi-agency policy for safeguarding. There is evidence of active provider forum work addressing the learning disability agenda in relation to safeguarding which has produced action plans for and evidence of change in response to learning from Serious Case	**Thurrock Safeguarding Adults Partnership Board includes among its members representatives from service providers for people with learning disabilities as well as representatives from a Service User Led Organisation, and advocacy providers. A representative from the Board also attends the regular provider meetings which discusses contractual aspects as well as learning from any relevant serious case reviews. Local providers are all offered training from the Local Authority in basic safeguarding awareness. Via the Board and the Community Safety Partnership there are Stay Safe events for people with learning disabilities to attend and learn about personal safety. Multi-disciplinary/agency teams meet regularly to discuss issues about**

		Reviews and Local Learning From Experience Exercises. Assurance is received by the local Safeguarding Adults Board which includes using DH Safeguarding Adults Assurance Framework (SAAF) or equivalent AND reported measures of whether people's desired outcomes of the beginning of the process were met at the end. Some Evidence of robust, transparent and sustainable governance arrangements in place overseen by a Safeguarding Adults Board which has representation from chief officers and representatives of people who use services and their families. Some evidence that every learning disability provider service has assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. There are contractual clauses requiring providers to work in line with the local multi-agency policy for safeguarding. There is some evidence of active provider forum work addressing the learning disability	**anti-social behaviour, neighbourhood crime etc. relating to all vulnerable people in the authority - from which action planning takes place.**

		agenda in relation to safeguarding. Limited assurance is received by the local Safeguarding Adults Board which includes using DH Safeguarding Adults Assurance Framework (SAAF) or equivalent AND reported measures of whether people's desired outcomes of the beginning of the process were met at the end There is little or no evidence of clear local governance and action in relation to safeguarding people with learning disabilities	
B5: Self-advocates and carers in training and recruitment	This measure is about the nature and benefit of involving 'Experts by Experiences'. A number of best practice reports suggested that there are improved outcomes when families and people with learning disabilities are involved in services. Localities should provide evidence from providers of routinely involving people with learning disabilities and family carers in recruitment and training.	In learning disability specific services there is evidence of all of services involving people with learning disabilities and families in recruitment and training. Commissioners of universal services can provide evidence of contracting for learning disability awareness training (for example as part of Disability Equality training). In learning disability specific services there is evidence of involving some people with learning disabilities and families in recruitment and training Commissioners of universal services	**Some carers known to Cariads have been asked to be involved in the recent recruitment for the LAC (Local Area Co-ordinator) posts. These were the parents of a young lady with learning difficulties. Cariads have also had carers on their interview panels for their support worker staff. Thurrock Lifestyle Solutions have also had carers and service users sit on their interview panels too. Cariads have delivered training on various subjects in which carers and the cared for are invited – such as Occupational Therapy Equipment, financial advice etc. We**

		can provide evidence of contracting for Learning disability awareness training (for example as part of Disability Equality training). There is no evidence of involvement in recruitment and training and appropriate levels of disability equality training	**have not been made aware of any other providers or local authority doing this, although there could be, but the carers asked didn't know.**
B6: Compassion, dignity and respect. To be answered by self advocates and family - carers	Commissioners can show that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. It is clear from the Winterbourne View report and wider evidence from Six Lives and the Confidential Inquiry that compassion is core to the best care for people. This measure asks commissioners to think about how this can be assured in all care for people with a learning disability. This is a challenging measure but it is felt to be vital that all areas consider this. In this year's self-assessment	Family carers and people with a learning disability agree that providers treat people with compassion, dignity and respect: Family carers and people with a learning disability agree that all providers do Family carers and people with a learning disability agree that some providers do. Family carers and people with a learning disability agree that few or no providers do	**There was a mix of answers; some people felt that all providers show compassion and dignity. However, some had felt that there was no respect by anyone. Given the mixed views and the amount of people asked, there was much more positive than negative, especially by the providers of the practical support (PA's). Providers of the personal care side had more negativity. Given this feedback the scoring couldn't be anything other than Amber. As there were some green and some red.**

	commissioners are requested to ensure that this question is answered by people who use services and their family members. The reason for this is that they are best placed to answer the question on the basis of their experience. This question will be best answered by the local Learning Disability Partnership Board (or equivalent) representatives of family carers and self-advocates.		
B7: Commissioning strategy impact assessments	This measure is about how effectively your locality assesses and addresses the needs and support requirements of people with learning disabilities through local and health authority strategies with clear reference to current and future demand. In particular impact assessments will ensure that Equality Act 2010 duties are met.	Commissioning strategies for support, care and housing is the subject of Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities. Impact Assessments and strategies have been developed with and presented to people who use services and their families Not all commissioning strategies and Impact Assessments are in place	Although not all strategies are in place we have developed a Market Position Statement from which will come a Category Plan, giving considerable detail around the direction of services for Learning Disability. We have a number of ongoing projects which will feed into a revision of our strategic approach for Learning Disability for Thurrock. Impact Assessments are an integral part of our strategic approach.
B8: Complaints lead to changes	This standard requires evidence of a learning organisation that integrates learning from complaints, incidents, patient,	90% or more of commissioned services can demonstrate improvements based on the	**We had no provider complaints during this period but we do use Learning from Complaints form, which is analysed and the findings**

	carer and staff feedback with wider learning from national reports and incidents to improve the quality safety, safeguarding and provision to people with learning disabilities. Failings by Services to respond to concerns raised about the quality of services are at the centre of the Winterbourne View Review. Evidence need to be provided of robust partnership working to assure the safety, quality and safeguarding of people's commissioned placements	use of feedback from people who use services, (e.g. complaints, surveys and quality checking). There is evidence of effective use of a whistleblowing policy where appropriate. 50-89% of commissioned services can demonstrate improvements based on the use of feedback from people who use services, (e.g. complaints, surveys and quality checking). There is evidence of effective use of a whistleblowing policy where appropriate. Less than 50% of commissioned services can demonstrate improvements based on the use of feedback from people who use services, (e.g. complaints, surveys and quality checking). There is evidence of effective use of a whistleblowing policy where appropriate	**presented to DMT (Departmental Management Team) quarterly.**

Appendix 1: Learning Disability Self Assessment Framework
RAG Rating for Thurrock
Health and Well Being Board March 2015

SECTION C Living Well	Guidance note	Measure	THURROCK RAG RATING
C1: Effective joint working	This measure looks for the evidence that formal arrangements are in pace which foster the best joint working between commissioners. Informal arrangements and evidence of good practice are also welcomed, as are future plans, particularly where these have been signed up to formally if not yet implemented.	There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of single point of health and social care leadership, joint commissioning strategies and or pooled budgets, integrated health and social care teams. There are some examples of functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of at least one of the following: Single point of health and social care leadership Joint commissioning strategy and/ or pooled budget Integrated health and social care teams	**Thurrock has a joint Commissioning approach within Health and Social Care, working closely with our CCG colleagues on such areas as LD health checks, the Winterbourne Agenda and we are working towards creating a virtual Health and Social Care Commissioning response to LD.**

		Joint working has not met either of the above measures.	
C2: Local amenities and transport	This measure asks for evidence of reasonable adjustments within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. It is important that the assurances are provided by commissioners of those services which show that they are ensuring that local amenities and transport are provided in a way that makes reasonable adjustments for people with learning disabilities.	Extensive and equitably distributed examples of people with learning disability having access to reasonably adjusted local transport services, changing places and safe places, (or similar schemes), in public venues and evidence that such schemes are communicated effectively Local but not widespread examples of all of these types of schemes Reasonably adjusted levels of support in these schemes do not reach any of the standards above	• **Buses are low floor for easy access** • **Leaflets sent on line to library's** • **Comms Team – can do translations / Braille etc.** • **Reasonable Adjustments made for service users i.e., translation of policy** • **Carers buss pass free when used in conjunction with the person they are accompanying who has a concessionary pass. Cannot be used on national transport such as National Express.** • **Sign post service users to train companies for saver cards / deals** • **The Tilbury Ferry contract is operated by Kent Council with an agreement that Thurrock service users who have a concessionary pass can use it free of charge.**
C3: Arts and culture	This measure asks for evidence of reasonable adjustments within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. It is important that the assurances are provided by commissioners of those services which show that they are	Extensive and equitably distributed examples of people with learning disabilities having access to reasonably adjusted facilities and services that enable them to use amenities such as cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated	**The Thameside Theatre runs 'Liam's Disco' for people with a Learning Disability to socialise; stage has ramp access as one of the DJ's is wheelchair bound. Each evening is themed to add to the sense of fun i.e; Halloween, Birthday parties. Thurrock Council fund a drama club who are local and run a special**

	ensuring that local amenities and transport are provided in a way that makes reasonable adjustments for people with learning	effectively Local but not widespread examples of people with learning disabilities having access to reasonably adjusted facilities in these amenities. The accessibility of such events and venues are communicated effectively Reasonable adjustments of these amenities do not reach any of the standards above.	**needs drama group every Friday morning at the theatre. Razed Roof Theatre company from Harlow put on shows for people with an LD. Southend Toy Library (high dependency client group) visit for shows and parties .Work experience; currently two LD service users are accessing opportunities ; one is helping with Front of House , the other undertakes Ushering and plays a professional role. We are employing a young man as an usher who is diagnosed on the Aspergic spectrum. Change of seating arrangements to enable more wheelchair access to the theatre as a result of requests traditionally had 4 wheelchair spaces – can now accommodate 10 wheelchairs**
C4: Sports and leisure	This measure asks for evidence of reasonable adjustments within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. It is important that the assurances are provided by commissioners of those services which show that they are ensuring that local amenities and transport are provided in a way that makes reasonable adjustments for	Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups. Designated participation facilitators with learning disability expertise are available. There is evidence that	**Impulse Leisure frontline staff and management undertake general diversity training and use a self read book and online assessment by Grass Roots 'Respect for People'. All the instructors have at least level 2 qualifications in their specialist areas. Many have level 3 and the supervisor of the majority of the sessions has higher level qualifications level 4 in supporting with 'special populations' including**

	people with learning disabilities.	such facilities and services are communicated effectively. Local but not widespread examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups. Designated participation facilitators with learning disability expertise are available. There is evidence that such facilities and services are communicated effectively Reasonable adjustments of these amenities do not reach any of the standards above	**children. The swimming instructors are mostly ASA level 2 qualified which includes an element of learning disability and some have level 3 qualifications in teaching swimming to those with a disability; only level 3 teachers are used for disability sessions. Registered carers are generally admitted to the sessions at no charge. There is a discounted disabled membership scheme and concession scheme with discounted prices for swimming.**
C5: Employment	This measure is about the importance of employment and the support that needs to be provided to people with learning disabilities to ensure they have the best chance of getting a job. Evidence of initiatives that find the appropriate mix of support by mainstream and specialist agencies, and data of the local picture are important. There is an important link to the standard relating to support for preparing for adulthood (C6)	Clear published local strategy for supporting people with learning disabilities into paid employment. Relevant data is available and collected and shows the strategy is achieving its aims Clear published strategy for supporting people with learning disabilities into paid employment but limited evidence of aims being met or outcomes achieved	**Thurrock work with Thurrock Centre for Independent Living for the 'World of Work' programme as part of an end-to-end strategy to provide Thurrock citizens of working age (including those aged 16 in transition) with a Learning Disability, the opportunity to explore and improve their work readiness and work related skills; giving them a personalised plan, CV, and actual work experience, appropriate to their individual**

	where strategies and pathways should include access to support to get jobs	Not meeting either of the above measures.	**needs and capabilities. Some of the outcomes achieved have been • A recognised qualification • A work experience placement • A mentor for support and decision making • A detailed Individual Working Lifestyle Plan • An updated CV • An opportunity to contribute • An opportunity to be included in the Community • An experience of working in a Social Firm • An assessment of work readiness • An understanding of the impact of working on individual benefits • A maximising of income • A move towards independent living**
C6: Preparing for adulthood	Delivering effective transitions for young people is recognised as a way of addressing the difficulties confronted by young people with learning disabilities and their families at transition. Previous research has demonstrated that information is a key need at this time, the delivery of a 'local offer' within the scope of the Children and Families Act will support this.	There is a monitored strategy, service pathways and multi-agency involvement across education, health and social care. There is evidence of clear preparing for adulthood services or functions that have joint health and social care scrutiny and ownership across children and adult services There is some evidence of clear preparing for adulthood services or	**There is a detailed transitions Strategy signed up to by all partners, the strategy is produced in easy read. The delivery of the strategy is monitored through a multi-agency Transition Strategy Implementation Group; Carers are part of this group and young people participate in a sub group to ensure their voice is heard. Currently the group is contributing to the SEND (Special Educational Needs and**

	A foundation for good support during the transition from childhood to adult life is co-production of local plans and having a sound knowledge base of future need to inform commissioning strategies. This descriptor ascertains if localities have good plans in place to ensure locally available provision of the future mainstream and specialist health and social care services needed to support young people approaching adulthood.	functions that have joint education, health and social care scrutiny and ownership across children and adult services There is no evidence of clear preparing for adulthood services or functions that include joint education, health and social care scrutiny and ownership across children and adult services	**Disabilities) reforms and has been instrumental in supporting the design of the ONE PLAN. We are working hard to engage Health and have a firm commitment from them, it is anticipated that this question will be rated green next year due to the ongoing work.**
C7: Involvement in service planning and decision making	This is about people with learning disabilities and family carers involvement in service planning and decision making, including personal budgets. This measure seeks to stimulate areas to continually review and improve the involvement of people who use and rely on services in strategic development and planning.	Clear evidence of co-production in universal services and learning disability services. The commissioners use this to inform commissioning practice Clear evidence of co-production in all learning disability services that the commissioner uses to inform commissioning practice. Inconsistent or no evidence of co-production in universal services. There is no evidence that people with learning disability and families	**There is evidence from providers of services that there is co-production in the development of the service plan to users of the service. However, there was quite a lot of negative feedback that people felt the initial assessment from local authority were not co-production it was a case of being told what is available and what they could get commissioned. This was not in all cases and it did seem to depend on knowledge and experience of workers. Felt that there was too much commissioned services as opposed to persona budgets and alternative solutions.**

		have been involved in co-production of service planning and decision making.	
C8: Carer satisfaction rating. To be answered by family carers	Consultation on the SAF (Self Assessment Framework) raised a strong call for family carers to be given a place to specifically contribute about their needs in the measures. This measure asks for evidence that family carers are involved not only in service design and commissioning, but in wider strategies as not all people with learning disabilities and family carers are known to or use services but need a voice in the shaping of the community. This measure should be rated by family carers. Examples of the forums that could do this are Carers' Partnership Boards, Carers Centres or local carer networks. It is important to include as wide a range of family carers as possible. This measure uses a question informed by the National Valuing Families Forum: How satisfied are you that your needs as a family carer are met?	Most carers are satisfied that their needs were being met Most carers were neither satisfied nor dissatisfied that their needs were being met Most carers thought that their needs were not being met.	**Carers were quite positive that their needs were being met. A lot felt that they were getting a break because their loved ones were going out to day care or to school etc., but this came about due to the needs of the cared for rather than being identified as a need for the carer. Most carers didn't look at their own needs i.e. own health, work, education and no-one else had looked at this either, apart from Cariads. So they felt that they were getting support but not necessarily in the right way as those that did have a carers assessment from local authority was not holistic as only looked at what they are doing for who they care for. However, there were many that didn't have assessments in their own rights and only a paragraph on the cared for assessment. Every carer with Cariads is offered an assessment in their own right and is holistic and this has been very welcomed and support provided to meet these identified needs.**

	Consider carers' health checks from GP's, carers' assessments from the Local Authority and relevant information advice and guidance/ training from mainstream and carers' services. We will want to know how this question was answered and how many carers were involved in the process.		

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12 March 2015	ITEM: 6
Health and Wellbeing Board	
Health and Social Care Transformation Programme Update	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Roger Harris, Director of Adults, Health and Commissioning	
Accountable Head of Service: Les Billingham, Head of Adult Social Care	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

The Health and Social Care Transformation Programme is a significant change programme comprised of a number of elements:

- Care Act Implementation
- Whole System Redesign
- Short-Term Efficiency
- Better Care Fund Section 75 Agreement

This report's purpose is to provide an overview of progress made and bring the Board's attention to any key issues. This report is focused in the main in relation to the implementation of the Care Act given that the Section 75 agreement has only recently been to the Board for sign-off and the majority of the Act's provisions come in to operation as of April 2015. In addition to being a progress report, the update also therefore provides assurance of the Council's readiness to meet the requirements of the Act. Other elements of the programme, including programme arrangements themselves, are in the process of being reviewed and will be reported to the Board in a future update.

In addition, the report updates the Board on a joint expression of interest submitted in relation to the NHS 'new models of care' programme. The expression of interest is aligned with work planned as part of the Better Care Fund Plan and Whole System Redesign Project. A further more detailed report on this piece of work will be brought to a future Board meeting subject to whether the expression of interest has been successful.

1. Recommendation(s)

1.1 That the Health and Social Care Transformation Programme update be noted.

2. Introduction and Background

2.1 Thurrock's Health and Social Care Transformation Programme oversees the delivery of four specific projects:

- Better Care Fund Section 75 Pooled Fund Agreement
- Care Act 2014 Implementation
- Whole System Redesign
- Short-Term Efficiencies

2.2 More recent reports to the Health and Wellbeing Board have focused on the development and agreement of the section 75 agreement. This includes arrangements that will be put in place to oversee the delivery of the agreement. The Board agreed the section 75 agreement at a special February meeting. The Agreement will be in place as of April 2015 – subject to agreement by Cabinet and the CCG Board. Section 75 agreement progress reports will be brought to the Board as part of the Agreement's governance arrangements.

2.3 With a 'case for change' being developed for Thurrock's Whole System Redesign programme, the detail of which will be part of a future progress report, the remainder of this report focuses on the implementation of the Care Act, and the recent NHS 'new models of care programme' expression of interest which if successful, will be developed as a component of the Health and Social Care Transformation Programme.

3. Issues, Options and Analysis of Options

Care Act Overview

3.1 The Act becomes operational in April 2015, with some further provisions being introduced in April 2016: extended means test; care accounts; capped charging system – a separate consultation on the 2016 provisions was published on the 4th February, with final guidance on those provisions expected towards the end of 2015.

3.2 The Act aims to make care and support clearer and fairer by:

- Establishing a single national eligibility threshold for care and support;
- Requiring local authorities to provide all local people with information and advice related to care and support, to help them understand their rights and responsibilities, and plan for their future needs;
- Introducing new rights for carers, putting them on the same footing as adults they are caring for;
- Introducing a lifetime cap on eligible care costs, with monitoring of expenditure towards the cap; and

- Establishing protection so that people do not go without care if their provider fails, regardless of who pays for their care.

3.3 The Act introduces a number of new general duties for local authorities, some of which have implications for partners. These include:

- Duty to promote individual wellbeing;
- Duty to provide services which prevent the need for care and support;
- Duty to promote the integration of care and support with health;
- Duty to provide information and advice;
- Duty to promote diversity and equality in the provision of services; and
- Duty to cooperate.

3.4 The delivery of the Act's requirements is being overseeing by the Care Act Implementation Project Group. The Group includes representatives from the voluntary and community sector, Thurrock CCG, and NHS providers NELFT and SEPT.

Care Act Readiness

3.5 Upon publication of draft guidance in June 2014, the Project Group carried out a readiness assessment against each of the 23 sections. This was then updated upon release of the final guidance in October. The assessment highlighted specific areas for focus – either due to the nature of the work required to ensure compliance or because of the level of risk posed by the requirement:

- Information and Advice – the duty placed on local authorities to ensure the availability of information and advice services for all people in its area – including how to access independent financial advice and advice on the system of care and support and how it operates;

- Personal Budgets – every person whose needs are met by the local authority must receive a personal budget stating how much their care package is worth;

- Carers – carers are placed on an equal footing with the person they care for, including having a right to their own assessment on the appearance of need and a specific eligibility criteria;

- Advocacy – local authorities must arrange an independent advocacy to facilitate the involvement of a person with substantial difficulty and with no one appropriate available to support them in any part of the care and support process; and

- Assessment and Eligibility – application of a new national eligibility standard and ensuring the assessment is carried out the appearance of need, and focuses on the outcomes an individual wishes to achieve.

3.6 In addition to the specific areas of focus, the Group also identified a number of other areas of work that would be required to both ensure compliance and increase awareness of the Act:

- Workforce Development;
- Communication (both external and internal);
- System upgrades;
- Policy Development;
- Resourcing; and
- Risk management.

3.7 The Project Group has worked to ensure any potential risks to compliance are reduced – for example the development and launch of an Information and Advice Portal www.mycare.thurrock.gov.uk

3.8 The implementation of and adherence to the Care Act brings with it resource implications. This includes the following areas (excluding 2016 changes):

- Workforce Development
- Communications
- Policy Development
- Application of national Eligibility Criteria
- System Development – RAS, Information and Advice, Controq, LAS etc.
- Increased demand for assessment – carers and service users
- Increase in demand for advocacy
- Increase in demand for deferred payment agreements

3.9 In recognition of the costs involved with meeting the Care Act's requirements, the Government has already committed some additional resource from April 2015 – 'New Burdens' funding. Thurrock's allocation is as follows:

Area	**Amount**
Early Assessment Revenue Grant	£344,783
Deferred Payment Agreement Revenue Grant	£204,122
Carers and Care Act Implementation Revenue Grant	£151,285
Total	**£690,190**

This funding has been allocated to meet the new additional, statutory duties listed above. Our current assessment is that this will just be sufficient to meet the new duties. The area of most risk is forecasting whether this will result in an increase in demand – either through more carers requiring support or the revised national eligibility criteria. The Adult Social Care management team

will be assessing the situation and the level of spend monthly throughout the year.

In addition, the Better Care Fund has allocated £522,000 for the purpose of meeting the Care Act's new duties especially in relation to joint working across health and social care. This is part of the ring fenced pooled fund within the Section 75 agreement.

3.10 With regard to the final true cost of the Care Act, we are unclear as to the actual impact the Act will have on resources – for example additional demand for carers assessments and potential increase in number of individuals eligible for social care. We hope to off-set any risk with the arrangements we are putting in place, but will need to closely monitor demand throughout the year. The 2016/17 changes will undoubtedly place further pressure on resources due to changes to funding – e.g. £72k care cap. We have carried out draft work on the impact of those changes and will be reviewing our assumptions and findings in light of the newly published guidance on changes to care funding.

3.11 Whilst the Council has taken steps to ensure its readiness for the Care Act's 2015 requirements, a number of risks remain. These include:

- Uncertainty about additional demand from carers
- Managing additional assessments
- New national eligibility threshold
- Impact on local provider market
- Public expectation
- Available resource for preventative services
- Implementation costs

3.12 We feel that we are as prepared as possible for the Act's requirements, but realistically it is likely that some of the aforementioned risk areas will not be fully mitigated. Areas of risk will be monitored by the Care Act Implementation Group as from April 2015. In addition, the Council is part of a number of regional groups focused on different elements of the Act. This ensures that the Council is aware of best practice, and can also identify and look for solutions that allow us to, as far as possible, control the level of risk.

'New Models of Care' – NHS 5-Year Plan

3.13 The delivery of the transformation ambitions contained within the NHS 5 Year Forward Plan is outlined within the supporting document 'Forward View in Action'. This includes the development and delivery of new care models. As part of this, the NHS has invited expressions of interest in becoming a 'forerunner' site in developing one of four possible models:

- Multi-speciality community providers (MCPs);
- Integrated primary and acute care systems (PACS);
- Additional approaches to creating smaller viable hospitals; and
- Models of enhanced health in care homes.

3.14 The CCG and Council have submitted a joint bid based on the model 'enhanced health in care homes' (appendix 2). The bid has the support of community and mental health providers (NELFT and SEPT), and also Directors of Public Health and Housing. Thurrock's expression of interest is consistent with the schemes contained within the Better Care Fund Plan – particularly scheme 3 (intermediate care). If successful, being a 'forerunner' would allow Thurrock to further its plans for an integrated approach to keeping people out of hospital, which would include ensuring that people can remain independent for as long as possible and furthering an approach that shifts towards prevention.

3.15 Whilst a successful 'bid' will not attract additional funding, it will allow access to specialist advice and support, and may also enable current barriers to integration to be resolved.

4. Reasons for Recommendation

4.1 To provide the Health and Wellbeing Board with an update on the Health and Social Care Transformation Programme.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Any changes being implemented by the Council are to ensure compliance with the Care Act are as a result of statute. Currently, changes being made in order to ensure compliance are not detrimental to existing service users.

5.2 The Council has worked alongside Thurrock Coalition and Thurrock Diversity Network to develop and test the new information and advice portal.

5.3 The Council will continue to consider if there are any changes being made that require consultation.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The Care Act and its underlying philosophy contributes towards the corporate priority 'improve health and wellbeing'.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Management Accountant

Financial implications are contained within the body of the report.

7.2 Legal

Implications verified by: **Dawn Pelle**

Adult Care Lawyer

The Care Act provides the Council with a number of new legal responsibilities. This report establishes how the Council is preparing to meet those responsibilities.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Community Development Officer

The changes being made by the Council to ensure compliance take account of equality and diversity considerations. For example, the new Information and Advice Portal has been developed in conjunction with service users and is accessible.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Care and Support Statutory Guidance

9. Appendices to the report

- Appendix 1 – Summary Readiness Assessment
- Appendix 2 – New Models of Care Expression of Interest

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Health and Commissioning

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Forward View into Action

Registering interest to join the new models of care programme

Q1. Who is making the application? (What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)
This is a joint expression of interest between Thurrock Council and NHS Thurrock Clinical Commissioning Group. The expression of interest has full sign-up from community care provider North East London Foundation Trust (NELFT), and mental health provider South Essex Partnership Foundation Trust (SEPT). Signatories to this expression of interest: Roger Harris – Director of Adults, Health and Commissioning Mandy Ansell – Acting Interim Accountable Officer Malcolm McCann – Executive Director (SEPT) Michelle Stapleton – Director of Integrated Commissioning (NELFT) Andrea Atherton – Director of Public Health Barbara Brownlee – Director of Housing Key contact: Mandy Ansell Acting Interim Accountable Officer NHS Thurrock Clinical Commissioning Group mandy.ansell@nhs.net 01375 365810
Q2. What are you trying to do? (Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)
In Thurrock, we have already established a Health and Social Care Transformation Programme which aims, through whole system redesign, to deliver an integrated vision for health and social care. In the first instance, work will focus on older people aged 65 and above. Our vision and the initial building blocks of transformation activity are detailed within Thurrock's Better Care Fund Plan – and in particular the schemes appended to it. The main aim of our BCF, and of our Transformation Programme, is to reduce the number of people admitted to an acute setting and to ensure as far as possible that those discharged from Hospital are not readmitted and are rehabilitated and supported to live as independently as possible – regardless of the setting. Achieving this requires an integrated yet flexible approach. Broader than this, our whole system development programme focuses on keeping people healthier for longer, which emphasises an approach that will require a focus on prevention and on shifting resources. We have existing approaches that we want to expand and build

on which includes a Borough-wide Local Area Coordination scheme. We want to ensure that we have solutions that are 'right time, right place, right solution', and importantly, we want to develop a system that wraps around the person, with that person firmly at the centre. To do this, we need a 'system' that is not only flexible, but that incorporates for example housing, the voluntary sector, and the important role communities themselves play.

If successful, we will use becoming a 'vanguard site' as a way of accelerating and expanded the work planned, particularly the work that focuses on robust intermediate care solutions to keep people out of hospital and on solutions that keep people well for longer – this includes ensuring that people are effectively supported in their own homes as well as care homes.

Our main objectives

- To provide an integrated single offer to all registered care homes in Thurrock to increase their capacity to maintain people in that setting
- Increasing the availability of step-up provision
- Increased use of telecare and assistive technology in the home
- To explore the potential to develop a single provider arrangement across primary, community, and social care
- To consider how to make the move from a funding model to an investment model – whilst maintaining 'business as usual'
- Integration of both provision and commissioning
- Developing the market to ensure a broad range of choices
- Ensure a focus on the outcomes the individual wishes to achieve
- Building on a focus on prevention and further developing the shift of resource upstream – e.g. via schemes such as Local Area Coordination
- Look at integrated solutions not just across health and social care, but with housing and with the voluntary and community sector
- Delivering an increased range of settings in which reablement, physical and mental health care can be provided – and extending the range of people who can use those settings
- An asset based community development approach – looking at capabilities and strengths and the delivery of outcomes as opposed to a deficit based model
- Ability to identify people at risk of admission at the earliest stage and provide a co-ordinated approach to those deemed at most risk
- Delivering a coordinated approach to overseeing an individual's care and support needs

Key Changes

- Develop and embed a multi-agency risk stratification approach that identifies people at most risk of admission
- Use of the community geriatrician, positioned at the single point of access, to ensure older people most at risk of admission are accessing the right part of the pathway quicker, and helped to navigate through it – this includes identification of people most at risk of admission to hospital from a care home setting
- Co-ordinated approach to care through the commissioning of integrated

provision – including primary care, community care, and social care, and also housing
- An approach that shifts towards prevention
- Build on multi-agency and multi-disciplinary teams – for example MDTs within a care setting
- Increase the menu of choices available for intermediate care solutions – e.g. interim beds, step up and step down, extra care housing, nursing care with independent living – all as part of the integrated health and care agency
- Build on the use of assistive technology and telecare solutions – e.g. building on the success of existing evaluations

What will changes look like for staff?
- Greater and easier access to different disciplines
- Integrated approach across primary, community and social care – development of 'one culture'
- Multi-professional decision making – single approach
- Integrated/single approach to care planning

What will changes look like for the local community?
- Reduced interactions with professionals
- Reduced admissions or repeat admissions as care better co-ordinated
- Ability to stay independent for longer in a home setting
- Ability to achieve a 'good life' – through identification of the outcomes an individual wishes to achieve

Q3. Which model(s) are you pursuing? (of the four described)

Enhanced integration with care homes and social care - this model best fits with our approach for redesign across the health and care system. Our focus is on keeping people healthier for longer – which includes managing the shift upstream. Key to this includes ensuring we develop an effective and resilient approach to intermediate care. Alongside our approach to developing our intermediate care offer, we want to ensure that we are able to identify those most at risk of admission with a co-ordinated approach to keeping those at risk out of hospital and as independent as possible for as long as possible.

As part of this we are going to be reviewing all existing bed based services, including:
- Existing intermediate care beds;
- Existing step down provision;
- Existing nursing home placements; and
- Existing use of extra care housing.

Q4. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

- Development of integrated approach to governance through an Integrated Commissioning Executive
- Establishment of Health and Social Care Transformation Programme –

including Whole System Redesign Project Group
- Appointment of Community Geriatrician
- Commenced review of Frailty Pathway
- Step Up and Step Down beds in place
- Multi-disciplinary Team meetings in care homes
- Well established integrated Rapid Response and Assessment Team
- Well established Joint Reablement Team
- Asset Based Community Development approach in place and developing
- Close working relationship established with key partners – providers, Housing, CCG, Local Authority etc.
- Introduction of Local Area Coordinators across the Borough with evidence of success – e.g. of keeping people out of the system.

Q5. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.)

- Review current intermediate care services and spend
- Strengthened the capacity of local care home sector to manage the increasing complexity of patient/residents
- Fully scoped 'keeping people out of hospital' approach – including business case
- Agreed approach to single health and care organisation focused on keeping people out of hospital or from being readmitted – e.g. across community care, primary care, social care, housing
- Colocation of staff
- Outline incentivised approach for keeping people out of hospital – e.g. PbR-type approach for community rather than acute provider
- Fully developed risk stratification tool
- Single approach to care coordination and planning for those identified as most at risk
- Programme of engagement with the public and users of services
- Establish project plan and project arrangements
- Greater intelligence and analysis through work with GP surgeries
- Potential contractual changes

Q6. What do you want from a structured national programme?

(Aside from potential investment and recognition: i.e. what other specific support is sought?)

Putting in place the organisational and system changes which will support a fully integrated offer in Care Homes, and to help frail older adults remain at home or to return home, will be very challenging. While the Council, the CCG and their providers are confident that the move to integrated delivery set out in out better Care Fund Plan will result in more effective and better co-ordinated care, a number of aspects of the current health and social care system may serve to limit our transformation. We feel that in addition to redesigning our offer we will need to address a range of issues over which the Council, CCG, and providers as local organisations, may have limited control. These include

- Addressing information governance and technical issues related to interoperability of different IT systems so as to enable shared information systems for health, housing and social care across all relevant service areas
- Investigating the benefits of new forms of organisation and delivery structures/vehicles that can host the integrated offer (a one stop shop comprising general practitioner services, a range of community health care services, Care Home provision and step up/step down accommodation and adaptations and equipment services)
- Examining clinical and professional boundaries, and opportunities to develop the workforce capability, so as to maximise the potential for individual members of staff to deliver the range of treatments/interventions a patient/service user may require, while minimising hand offs
- Exploring approaches to procurement and contracting that, while ensuring compliance with the new EU Procurement Directive and the NHS procurement choice and competition regulations, will:
    - enable the delivery vehicle to provide the broadest offer to meet the health, housing and social care needs of patients/service users
    - allow commissioners and providers, with the objective of creating a stable market place in which to innovate and to manage change, a time limited period to focus on redesigning the system within the current contracting arrangements and without the threat of competition
- pricing frameworks which would allow providers maximum flexibility to achieve the desired outcomes while ensuring that all costs are transparent, and gain share arrangements encourage continuous improvements in quality and cost
- arrangements which will cover the commissioner's double running costs where, for example, primary care services are delivered by a community provider to patients/service users who remain registered with a GP Practice.

Please send the completed form to the New Care Models Team (england.fiveyearview@nhs.net) by **9 February 2015**.

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12 March 2015	ITEM: 7
Health and Wellbeing Board	
The 2014 Annual Public Health Report	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Andrea Atherton, Director of Public Health	
Accountable Head of Service: Debbie Maynard, Head of Public Health	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning / Andrea Atherton, Director of Public Health	
This report is public	
Purpose of Report: To provide the Health and Wellbeing Board with details of the 2014 Annual Public Health Report for Thurrock.	

Executive Summary

The Health and Social Care Act 2012 requires the Director of Public Health to prepare an independent report on the health of the people in the area of their local authority each year. This year the focus of the Thurrock Annual Public Health Report is on the health and wellbeing of older people.

1. Recommendation(s)

1.1 The Health and Wellbeing Board is asked to consider and note the contents and recommendations of the 2014 Annual Public Health Report.

2. Introduction and Background

2.1 Annual Public Health Reports have played an important part in public health practice ever since the early days of Medical Officers of Health. They remain an important vehicle for informing local people about the health of their community as well as providing the necessary information for decision makers in local authorities and local health services on key priorities that need to be addressed to improve the health and wellbeing of the population.

2.2 The Annual Report of the Director of Public Health is intended to be an independent assessment of the health of the community based on sound

epidemiological evidence and interpreted objectively. With the transfer of public health into local authorities, the Health and Social Care Act 2012 has placed a statutory duty on the Director of Public Health to prepare an Annual Report and on the local authority to publish it.

3. The 2014 Thurrock Annual Public Health Report: Key Issues

3.1 This year's Annual Public Health Report focuses on the health and wellbeing of older people. Thurrock has a lower proportion of people aged 65 years and over compared to the England average (13.6% of the total population compared to 17.3% respectively). However, the number of older people in Thurrock is set to increase substantially over the next 20 years, with the greatest increase in those aged 85 years and over. There are significant implications for health and social care services associated with managing issues arising from an ageing population.

3.2 The health and wellbeing of older people is influenced by an interplay of the determinants of health, such as poverty and housing, genetic factors and lifestyle behaviours. This makes it vitally important for agencies and communities to work together to ensure that older people have active, independent and fulfilling lives for as long as possible.

3.3 To ensure the health and wellbeing of the growing numbers of older people there needs to be greater focus on health promotion and disease prevention in old age. The evidence suggests that making healthy lifestyle choices particularly at the age of 40-60 years can have a marked impact on health in later years, including a reduction in the risk of developing cardiovascular disease, cancer, other long term conditions and dementia.

3.4 In 2012/13, it is estimated that only 41.89% of people with dementia in Thurrock had received a formal diagnosis. Further work is required to reduce this 'dementia gap' to ensure that people with dementia, and their family and carers have early access to services and support.

3.5 Disability -free life expectancy in people aged 65 years and over is significantly lower for males and females in Thurrock compared to the England average. Respiratory conditions including chronic obstructive pulmonary disease and pneumonia, and urinary tract infections are the most common causes of emergency hospital admission for people aged 65 year and over in Thurrock. A review of respiratory services has been undertaken by Thurrock Clinical Commissioning Group.

3.6 Carers play a vital role in helping to maintain the independence and wellbeing of those they support. There are approximately 300 carers aged over 65 who are known to the Care and Information Advice Service in Thurrock. It is recognised that demands of being a carer can have a negative impact on their quality of life, including their ability to work, their finances and their physical and mental health. The 2012-13 Carers Survey highlighted that carers aged

65 years and over in Thurrock report a better quality of life compared to the England average.

4. Reasons for Recommendation

4.1 The Health and Social Care Act 2012 requires Directors of Public Health to prepare an annual report on the health of the local population.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 None

6. Impact on corporate policies, priorities, performance and community impact

6.1 The report highlights the key actions that will help to improve the health and wellbeing or people aged 65 and over in the local population.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**
Finance Manager

There are no direct financial implications that relate to this report however the content raises concerns for future cost pressures in Adult Social Care. Decisions arising from recommendations by the Director of Public Health that may have a future financial impact for the council would be subject to the full consideration of the cabinet before implementation.

7.2 Legal

Implications verified by: **Dawn Pelle**
Adult Care Lawyer

There are no legal implications as the report is being compiled in accordance with our statutory duty under the Health and Social Care Act 2012.

7.3 Diversity and Equality

Implications verified by: **Rebecca Price**
Community Development Officer

An equality impact assessment on the annual report of the Director of Public Health has not been carried out. The report contains key data which should inform equality impact assessments of health and social care programme

areas, strategies and policy. Each programme included in the annual report identifies relevant inequalities and variations.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

There are no other implications.

8. Background papers used in preparing the report (including their location)

Background papers are referenced in the Annual Public Health Report.

9. Appendices to the report

None

Report Author:

Andrea Atherton
Director of Public Health

Ageing Well: Opportunities of a healthy later life in Thurrock

Annual Public Health Report 2014

For Thurrock, the issue locally is one which is represented nationally:

"We are living longer but with many of our later years troubled by ill health" [1]

Our vision for Thurrock is one where people can enjoy their later years:

"People in Thurrock enjoy an independent, rewarding, healthy and active later life."

CONTENTS

Acknowledgements

Key Authors
Helen Horrocks – Strategic Lead Commissioner for Public Health
Andrea Atherton – Director of Public Health
Nicola Smith - Public Health Intelligence Analyst
Maria Payne – Health Needs Assessment Manager

Contributors
Debbie Maynard – Head of Public Health, Sue Matthews – Public Health Registrar, Sue Bradish – Public Health Manager, Leroy Richards – Public Health Manager, Kevin Malone – Public Health Manager, Jacquie Sweeney – Health Improvement Officer, Alison Nicholls – Carers Strategy Officer, Sarah Turner- Older People Commissioner, Tania Sitch - Strategic Lead Prevention and Independence
Ceri Armstrong – Strategy Officer, Christopher Smith – BCF Programme Manager

Foreword

The purpose of the Annual Public Health Report is to provide an important record of the health of the local population, highlighting major issues and problems and making recommendations to address them. This year I have chosen to focus on the health and wellbeing of older people in Thurrock.

Both nationally and locally we are seeing a shift in the age structure of the population, with significant increases in the proportion of the population aged over 65.

Ill health and the need for health and social care services is greater in old age and particularly in the over 80's, where we expect to see the largest relative growth in population size in the next twenty years. In addition to meeting this growing demand we are faced with the challenge of a reduction in the growth of public funding for these services over the coming years.

The health and well-being of older people is influenced by an interplay of the determinants of health – such as poverty and housing, genetic factors and lifestyle behaviours. This makes it vitally important for agencies and communities to work together to ensure that older people have active, independent and fulfilling lives for as long as possible.

To achieve this we need to have a positive approach to ageing, whilst recognising that at times people will need extra help and support, particularly in their later years. There needs to be a key focus on prevention and helping people to make healthy lifestyle choices throughout the life course and during older age.

In such times of austerity, it is vitally important that we spend our collective resources wisely. Protecting the health of older people through immunisation, the prevention of falls and fractures and managing long term conditions well in the community, will help to achieve better outcomes and individual experience, as well as realising savings.

I hope that you find my report interesting and I would welcome your feedback, comments and suggestions.

Dr Andrea Atherton
Director of Public Health, Thurrock Council

Executive summary

The 2014 Annual Public Health Report for Thurrock focuses on the key health and wellbeing issues for those people aged 65 years and over.

The proportion of people aged 65 and over currently living in Thurrock is lower than the average for England (13.6% compared to 17.3% respectively). However, the number of older people in Thurrock is expected to grow sharply in the coming years, particularly those aged 85 years and over. This will have significant implications for health and social care services.

Addressing the issues impacting on older people is a complex undertaking. A wide range of factors, including quality of housing, poverty and fuel poverty can greatly affect the health of older people. Thurrock has the 10th highest level of older people living in poverty in the East of England

Locally there are various housing options for older people including sheltered housing, extra care housing and the HAPPI housing scheme. The Well Homes project, a joint initiative between public health and the private sector housing team in the Council offers private sector residents a 'well homes visit' which provides advice on a wide variety of issues.

Older people living in cold homes are at greater risk from heart disease and stroke and have reduced resistance to respiratory infections and poor mental health. In addition to local housing initiatives the messages of the national 'Keep Warm, Keep Well' campaign have been promoted locally. Excess winter deaths in all age groups in Thurrock have fallen since 2007.

Healthy lifestyle choices during the ages of 40-60 years can have a marked impact on health in later years. It is never too late to make lifestyle changes and older people, particularly those with long term chronic health conditions, need to be supported to address negative lifestyle behaviours. For example stopping smoking results in health benefits for the individual at any age.

There are well evidenced benefits associated with being physically active, however, less than 40% of people aged 65 and over meet the recommended physical activity guidelines. Diet also affects key aspects of health in old age. The proportion of people who are overweight or obese tends to increase with age. An estimated 26.4% of people aged over 65 in Thurrock are obese, which is similar to the national average. Being obese is not the only issue for older people. Research suggests 1 in 10 of people aged over 65 are malnourished or at risk of malnutrition.

Older people often consume alcohol above recommended levels. Excessive alcohol consumption can have a significant impact on the physical and mental health of older people, increasing risks related to injurious falls and also a number of clinical conditions. The NHS Health Check programme for people aged 40-74 now incorporates questions on alcohol intake.

There is greater recognition of the impact that loneliness and social isolation has on the quality of life in older age as well as its contribution to premature death.

Thurrock's Health and Wellbeing Strategy has been awarded 'gold standard' accreditation by the 'Campaign to End Loneliness' for the inclusion of actions and targets to address loneliness. The Local Area Co-ordinators have an important role in helping the more vulnerable members of the community, such as the frail elderly to engage more with other members of the community.

Depression in later life can be triggered by a variety of factors, including social isolation. The local voluntary sector plays an important part in supporting positive mental health and well-being, with community mental health services in place for those with greater mental health difficulties.

Flu vaccination is a safe and effective way to protect older people and reduce avoidable illness, hospitalisation and excess seasonal deaths. Only 69.2% of people aged 65 and over living in Thurrock received flu vaccine in 2013, which is below the England average (73.2%) and below the World Health Organisation target of 75%.

Dementia is one of the major health and social care issues of our time. Currently around 815,827 people in the UK have dementia and this number is set to increase by 40% in the next 12 years. It is more common in people aged over 65 and prevalence roughly doubles from this age onwards. In Thurrock currently less than half (41.89%) of the estimated number of people with dementia have received a formal diagnosis. Early detection allows for more effective planning of treatment and appropriate support for the person and their family.

There are a range of local initiatives being delivered to increase awareness of dementia and provide support to those with a diagnosis of dementia as well as their carers. These include the roll out of the Dementia Friends initiative and plans for a local Dementia Action Alliance, will which help to facilitate earlier diagnosis and support from local services.

Although life expectancy has been increasing, people are not necessarily living longer in good health. Disability-free life expectancy at 65 years is significantly lower for males and females in Thurrock compared to the England average. Conditions including urinary tract infection, chronic obstructive pulmonary disease and pneumonia are the leading causes of emergency hospital admissions in people aged 65 and over in Thurrock.

Falls and fall-related injuries are a common and serious problem for older people. It is estimated that 30% of people aged over 65 years and 50% of people over 80 have a fall at least once a year. Hip fracture is the most common injury related to falls and can lead to loss of mobility and independence. In 2013-14, there were 91 emergency admissions of people aged 65 in Thurrock with a hip fracture, at a cost of over half a million pounds. The local falls service includes a community falls clinic a falls group programme, which helps to reduce the risk of falls and reablement services.

Thurrock Council and the local NHS work closely in a number of areas linked to reducing admissions for the over 65, this includes the Rapid Response and Assessment Service. In partnership with Thurrock Clinical Commissioning Group, Thurrock Council also has an integrated Joint Reablement Team with the NHS community service provider. This team provides support for people to regain skills or

mobility after a period of illness or hospital admission, and supported 531 people in 2013/14.

Long term conditions (LTC) are more prevalent in older people, 58% of people aged over 65 have an LTC compared to 14% of people under 40. Most long term conditions are multifactorial, however, there is a strong link between unhealthy lifestyle behaviours and some of the most prevalent and disabling long term conditions.

The NHS Health Check programme, which aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia, is delivered in GP practices and community outreach events.

A wide range of initiatives are available to provide help and support to patients with the management of their long term conditions, with an increasing focus on supporting people to self- care.

In the 2011 Census, 6.5 million people in the UK identified themselves as carers, compared with 5.8 million people in 2001. Of the carers in Thurrock aged 65 and over, 45% report providing a minimum of 50 hours of unpaid care per week. The demands of being a carer can have a negative impact on their quality of life, including their physical and mental health. Older carers in Thurrock report a significantly better quality of life compared to the national average. The Council and local voluntary sector provide a range of services to support carers with their caring responsibilities.

Summary of Recommendations

- Raise awareness of frontline health and social care staff, the voluntary sector and local area co-ordinators of the importance of wider determinants on the health of older people, to facilitate early intervention and referral to appropriate services for help and support in claiming welfare and housing benefits to which they are entitled

- Raise awareness with Thurrock residents and frontline services of the link between poor housing and poor health so that older people are referred to appropriate housing services in Thurrock

- Promote partnership working and utilise the community network to ensure that hazards in the home are identified

- Encourage and support people in later life to quit smoking

- That the Tobacco Control Strategy for Thurrock includes actions to support older people as a target group

- Ensure information about age-appropriate lifestyle activities is accessible to communities

- Work with communities to identify and remove barriers to lifestyle services

- To cascade 'Making Every Contact Count' awareness training, which includes brief alcohol interventions to staff in the NHS, Council, Local Area Co-ordinators, community groups and other relevant local organisations

- To promote alcohol-related public health campaigns such as 'Dry January'

- Work in partnership with Thurrock Adult Community College (TACC) and the University of the Third Age (U3A) to deliver messages around a healthy and active retirement

- Develop a peer mentor programme in partnership with existing agencies such as Thurrock Age Concern, local colleges, Cariads and faith groups

- Local Area Coordinators to work alongside vulnerable individuals within the community and increase the number of referrals to lifestyle and other preventative programmes

- Work with commissioners within Thurrock Clinical Commissioning Group and adult social care to jointly improve identification of depression in older people and access to psychological therapies

- Encourage and support people aged 65 and over to have their annual flu jab

- Promote and engage frontline health and social care staff in the take-up of the flu jab

- The Thurrock Health & Wellbeing Board should review the local work being undertaken to increase the proportion of people who receive an earlier diagnosis of dementia

- The Thurrock Health and Wellbeing Board should consider the specific needs of carers of people with dementia

- Develop a training programme for health and social care staff to identify dementia symptoms to ensure timely referral to specialist dementia services, including memory clinics, to facilitate formal diagnosis

- Further work is done to promote dementia friends training within the Council, with external partners and the community

- Review current provision related to falls prevention and develop a comprehensive cost-effective falls prevention programme focused on early detection, management and treatment of risk factors that lead to falls in the elderly

- Work with our wider health and social care partners and our communities to support self- care of long term conditions

- Work is undertaken with health and social care to raise awareness of services to support end of life care, including greater use of end of life registers and supporting patients around choices such as preferred place of death

- Continue to support carers to access services offered by statutory and voluntary organisations

- Health and well-being services are promoted to carers through the Carers Information and Advice Service

Chapter 1 A Profile of Older People in Thurrock

Key Messages

- People aged 65 and over represent 13.6% of the total population in Thurrock compared to the national average of 17.4%
- The population of older people is set to increase dramatically over the next 23 years, particularly those aged 85 years and over
- The proportion of older people from a black, Asian and minority ethnic group is set to increase

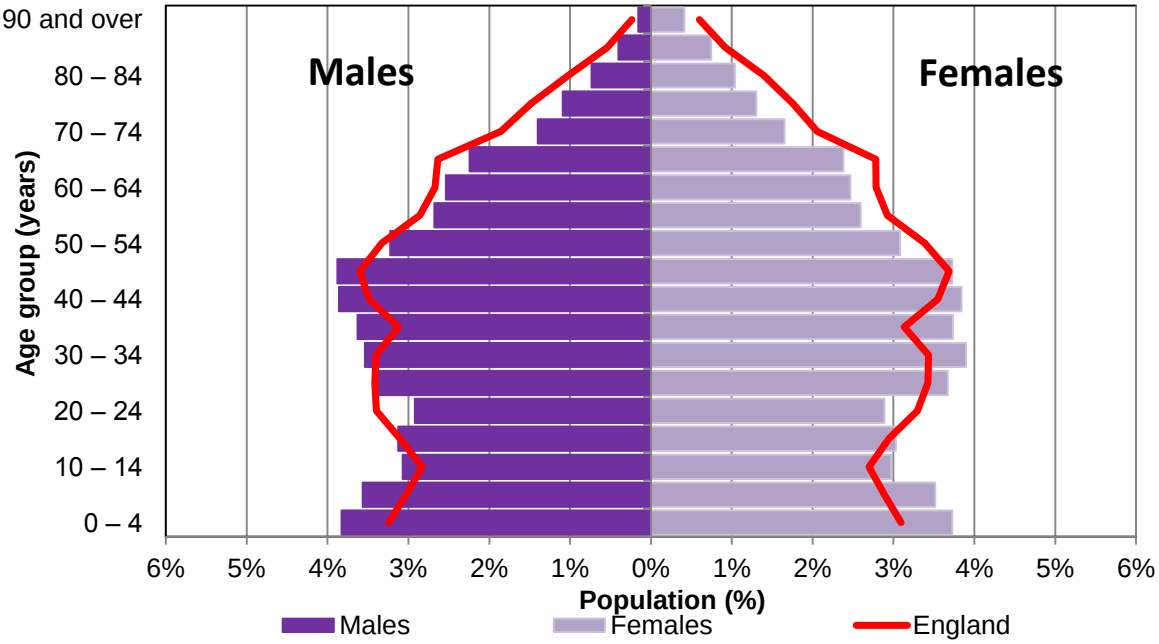
Introduction

Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person. This definition has been adopted for the purpose of this report. However, it is recognised that this age cut off point is arbitrary and cannot reliably predict a person's health and level of function.

The Current Population

The latest figures indicate that there are 21,815 people aged 65 and over in Thurrock. Of these 9,468 are aged 75 and over and 2,762 are aged 85 and over. The 65 and over age group represents 13.6% of the total population, which is lower than the regional average of 18.7% and the national average of 17.3%. Figure 1 shows the population of older people within Thurrock is lower than the national average, with proportionately more females than males in those aged over 70.

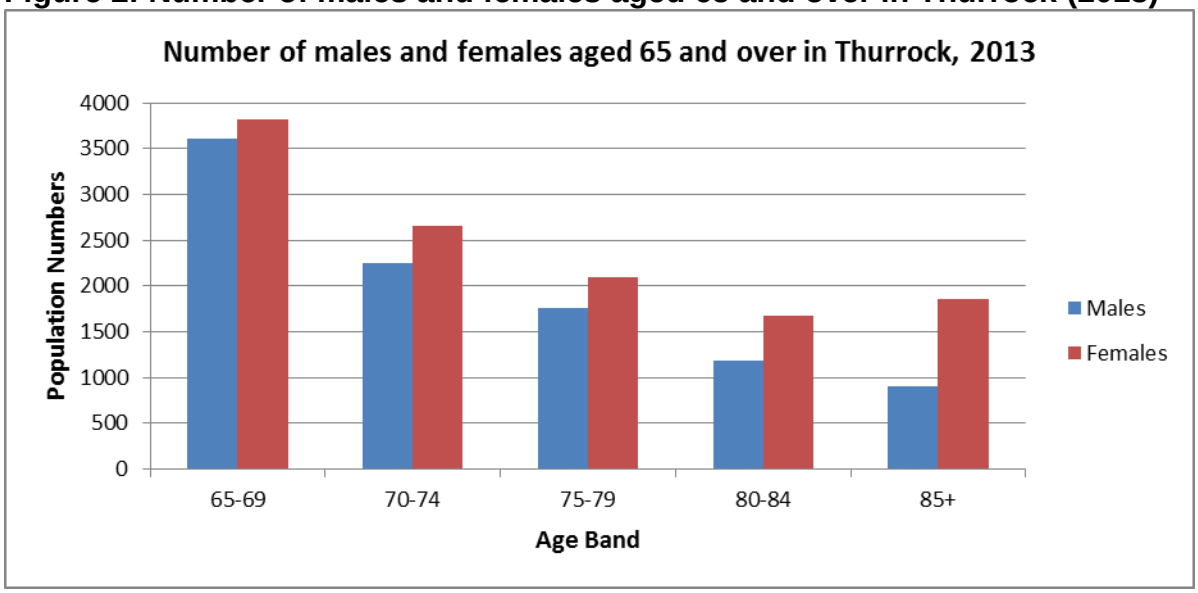
Figure 1: Population Structure of Thurrock, all ages (2013)



Source: ONS, Population Mid-Year Estimates 2013

Around 52% of the Thurrock population in the 65 -69 year age group are female. As females live longer than males, the difference between numbers of females and males becomes more apparent in the older age bands. In Thurrock there is more than double the number of females than males in the 85 and over age group (1859 females compared to 903 males). Figure 2 shows the breakdown of males and females aged 65 and over in Thurrock.

Figure 2: Number of males and females aged 65 and over in Thurrock (2013)



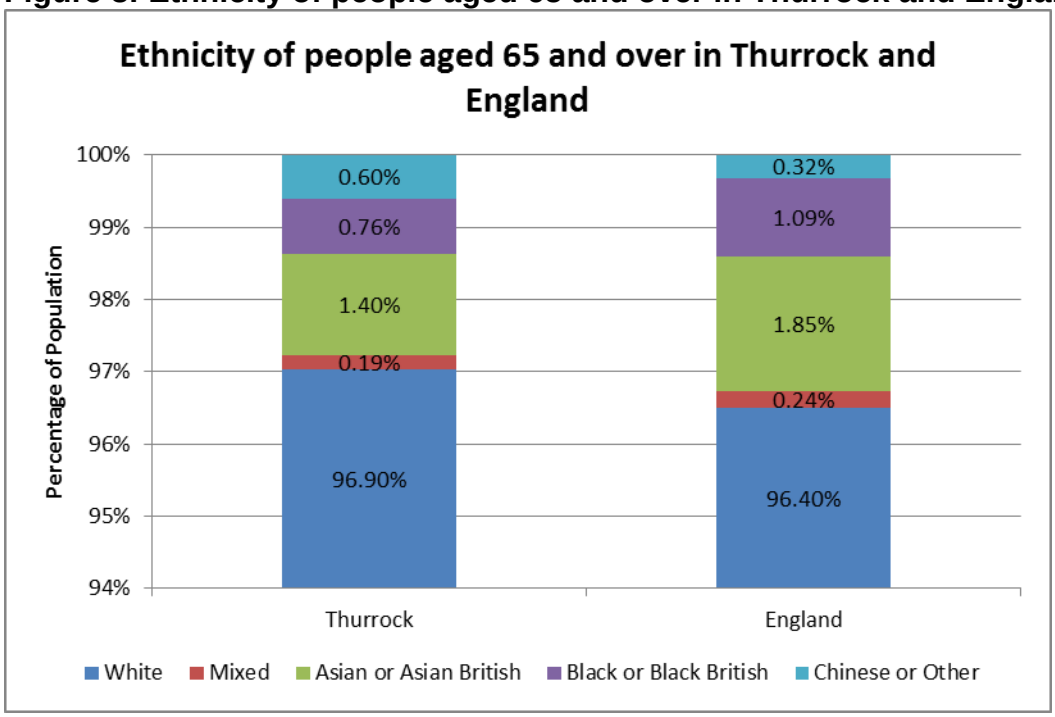
Source: ONS, Population Estimates 2013

Ethnicity

Only 2.7% of people aged 65 and over in Thurrock are from a black, Asian and minority ethnic (BAME) group, which is lower than the national average of 4.7% (Figure 3). However, as ethnic diversity in younger age groups in Thurrock has increased over the last decade at a faster rate than the national average (2014 school census data shows the proportion of pupils from a BAME group is 28.9%), the proportion of older people from a BAME group in Thurrock is set to increase.

Local health and social care services should recognise the greater prevalence of some illnesses among specific groups of people, for example increased rates of hypertension and stroke among African-Caribbeans and of diabetes among South Asians. This will become increasingly significant as these populations continue to age.

Figure 3: Ethnicity of people aged 65 and over in Thurrock and England, 2011

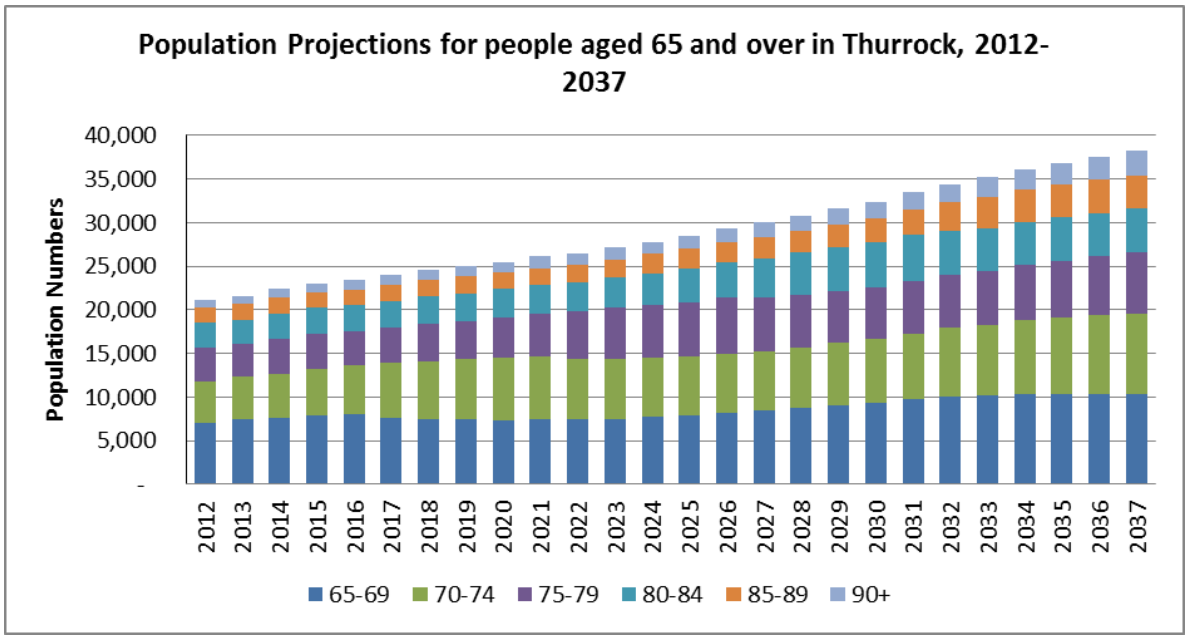


Source: POPPI (calculated using ONS statistics, 2011)

Population Change

In Thurrock, the population aged 65 and over is expected to increase by 17,100 by 2037 (Figure 4), which is an increase of 81% from 2012, this compares to 65% nationally. There are particularly noticeable increases in the number people aged 85-89 years and those aged 90 and over.

Figure 4: Population projections for people aged 65 and over in Thurrock, 2012- 2037

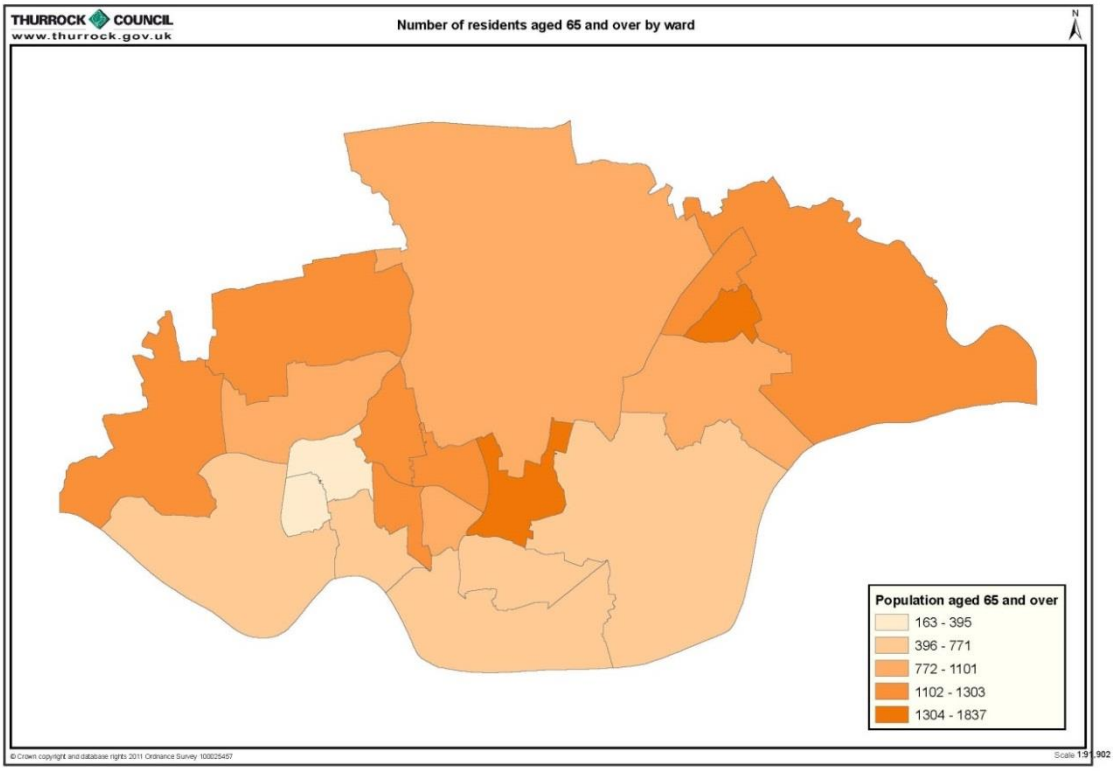


Source: ONS, Subnational Population Projections 2012

The Location of Older People in Thurrock

Figure 5 shows the distribution of where people aged 65 and over live in Thurrock. Chadwell St. Mary, Corringham and Fobbing wards have the highest number of residents aged 65 and over, with 1837 in each ward. South Chafford has the lowest number with just 163 residents aged 65 years and over.

Figure 5: Number of residents aged 65 and over by ward in Thurrock



Source: ONS, 2011

Household characteristics

The living circumstances of older people affect both opportunities for social interaction and the need for additional support from formal and informal services.

Evidence suggests that older people who live alone are more likely to report fair or poor health, social isolation, difficulties in the basic activities of daily living, lower mood and lower levels of physical activity, which has implications for the potential level of support that may be required from external agencies.

In Thurrock it is estimated that 20% of men and 30% of women aged 65-74, and 34% of men and 61% of women aged over 75 years live alone. Table 1 provides a breakdown of the predicted number of those aged 65 and over living alone over the next 16 years.

Table 1: Predicted number of people aged 65 and over living alone in Thurrock, by age and gender (2014-2030)

	2014	2015	2020	2025	2030
Males aged 65-74 predicted to live alone	1,220	1,260	1,400	1,420	1,620
Males aged 75 and over predicted to live alone	1,326	1,394	1,598	2,074	2,380
Females aged 65-74 predicted to live alone	1,980	2,070	2,250	2,250	2,580
Females aged 75 and over predicted to live alone	3,477	3,477	3,843	4,758	5,429
All persons aged 65-74 predicted to live alone	3,200	3,330	3,650	3,670	4,200
All persons aged 75 and over predicted to live alone	4,803	4,871	5,441	6,832	7,809

Source: POPPI – based on 2007 figures

Chapter 2 Ageing Well

Healthy ageing may be considered as 'the promotion of healthy living and the prevention and management of illness and disability associated with ageing' [2]. It is often used interchangeably with other such terms 'active ageing', 'successful ageing' and 'positive ageing'.

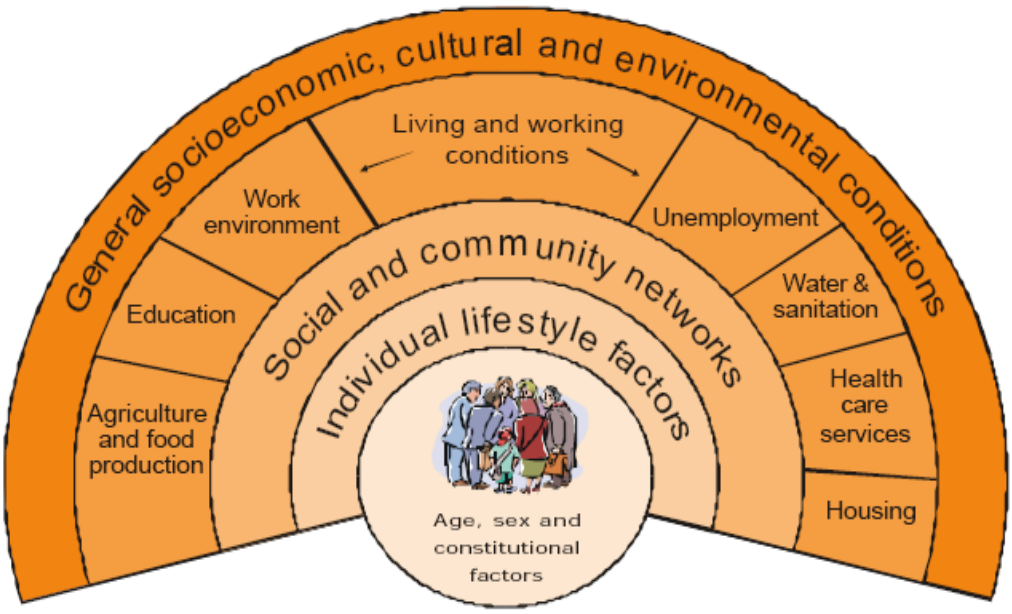
The ageing process itself is caused by a gradual build-up of subtle faults in the cells and organs of our bodies, with genes influencing cellular repair. However, evidence suggests that genetic factors only account for 25% of human longevity and much can be gained from targeting the non-genetic factors that impact on the ageing process such as nutrition, lifestyle and factors such as poverty, housing, transport and employment, often referred to as the wider determinants of health.

2.1 Healthy, Supportive and Safe Environments

Determinants of Health

A wide range of factors beyond health and social care have a major effect on the health and well-being of older people. These factors include poverty, housing, the environment, transport and employment, and are referred to as the wider determinants of health. Figure 1 shows the complex interrelationship of all the issues that impact on the health and well-being of a population. This complexity highlights the need to work collaboratively across different agencies and communities to ensure that older people have active, independent and fulfilling lives for as long as possible.

Figure 1: The Determinants of Health



Source: Dahlgren G and Whitehead M, 1991.

Poverty and Deprivation

Key Messages

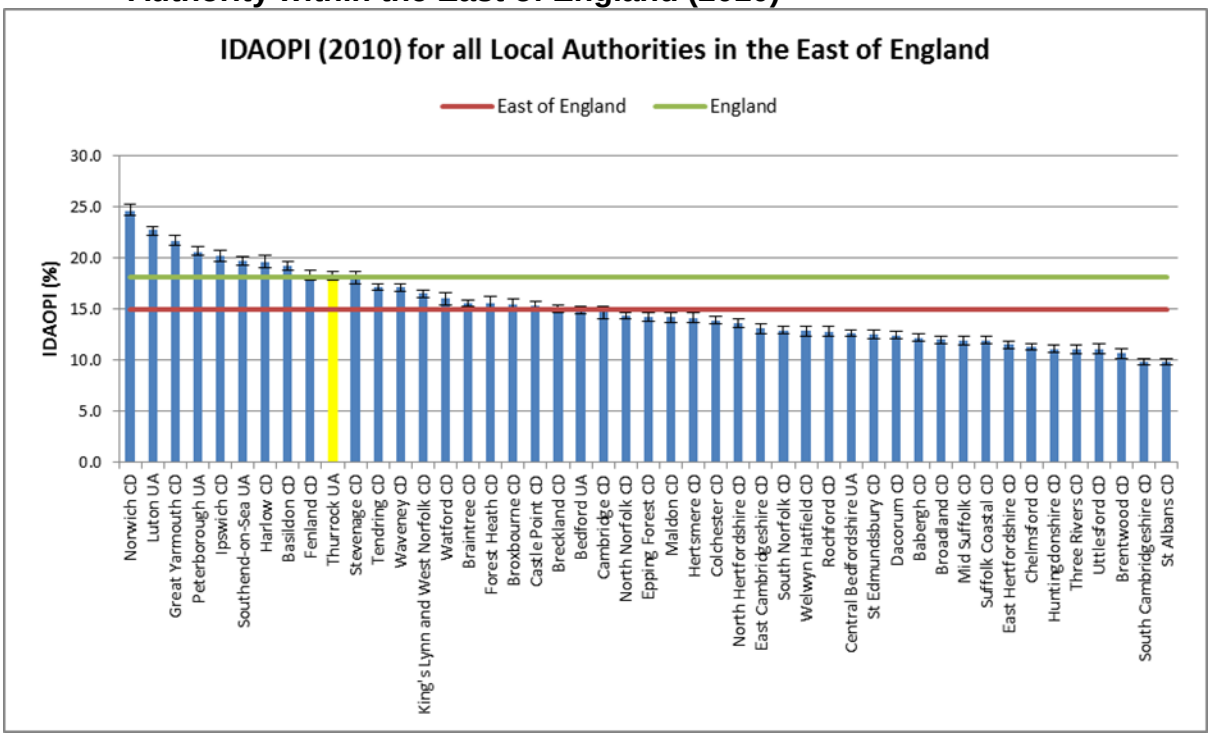
- Thurrock has the 10th highest level of older people living in poverty in the East of England
- This has the potential to impact on the health and well-being of older people in Thurrock

"Not having enough money can lead to an inability to buy a healthy diet, adequate accommodation, heating, and to not have enough money to participate in society." [3].

The current difficult financial climate and increasing costs have become key issues for many older people. Having an adequate income is essential if older people are to maintain an appropriate standard of living to maintain their health and wellbeing.

The Income Deprivation Affecting Older People Index (IDAOPI), a subset of the Index of Multiple Deprivation 2010, is a measure of older people living in poverty. The score for this Index gives the proportion of adults age 60 or over living in income deprived households (i.e. someone in the family is claiming Income Support or income based Jobseeker's Allowance or Pension Credit [Guarantee]).

Figure 2: Income Deprivation Affecting Older People Index (IDAOPI) by Local Authority within the East of England (2010)

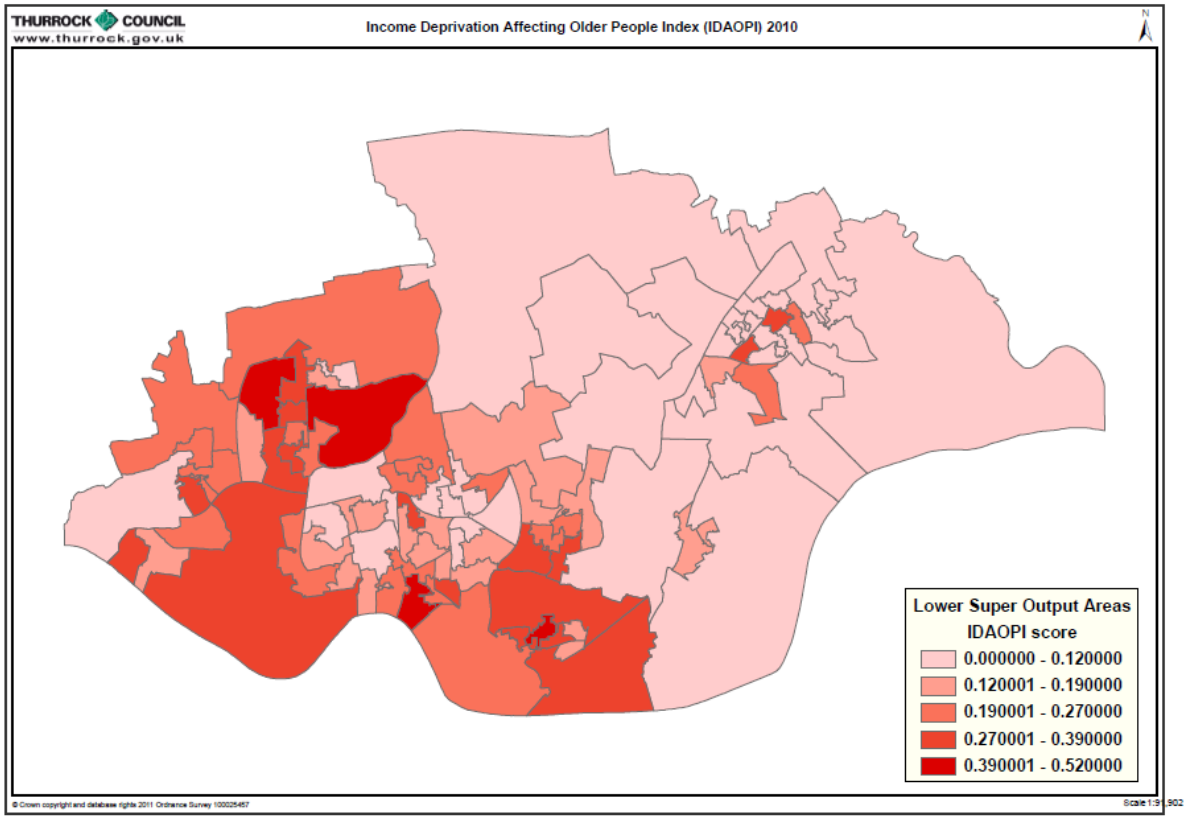


Source: APHO

At a local authority level there are significant differences between levels of income deprivation in older people, with Thurrock having the 10th highest level within the East of England (Figure 2).

The level of income deprivation among older people varies within Thurrock, with areas in Belhus and Ockendon having the highest levels (Figure 3).

Figure 3: Income Deprivation Affecting Older People Index (IDAOPI) by Lower Super Output Area in Thurrock, 2010



Source: Department for Communities and Local Government, Indices of Deprivation 2010

Local Action

Advice and information services are provided by the Thurrock Citizen's Advice Bureau. Residents can access this service in a number of venues or by phone to obtain practical help and advice, including financial and debt relief services, housing advice, and benefits advice. These services help increase incomes in low-income households and contribute to increased standards of living. In 2013/14 the Thurrock Citizen's Advice Bureau (CAB) supported 5,640 residents with a total of 11,552 issues [4], 21% were aged between 50 and 64 years and 8% were aged 65 years and over. During 2013/14, the top advice issues were welfare and benefits (31% of advice in Thurrock) and debt (21% of advice in Thurrock) (CAB, 2014 [4]).

Adult social care undertakes assessments of financial eligibility for care and support and will signpost to the CAB if there are any financial issues identified.

In Thurrock the Local Area Coordinators help to identify and signpost older people to appropriate services. The latest evaluation of this service highlighted that to date 20 individuals have been supported to access benefits that they were entitled to. Nine of these

individuals received additional income, which helped them live more comfortably or pay off debt. Examples included applying for and accessing pensions that they may be entitled to or supporting individuals to reclaim funds from TV licences that had been incorrectly paid, and helping and supporting individuals to make appeals [5]. This will impact on well-being through reduction of stress relating to financial challenges.

Housing and Well-homes

Key Messages:

- A large proportion of older people in Thurrock own their own home
- Good quality housing can protect and promote health, whilst poor quality housing can contribute to or exacerbate poor health

There is a wealth of evidence linking housing and health [6]. There are aspects of poor housing that are known to impact on health. These are likely to affect older people to a greater extent as they spend more time at home and may be unable to afford heating or ongoing repairs.

Health problems may be caused by a number of hazards within the home:

- Excessive cold
  Older people living in cold homes are at a greater risk from heart disease and stroke, reduced resistance to respiratory infections, poor mental health and are also at risk from hypothermia. Cold housing can also cause an exacerbation of arthritic symptoms. This then impacts on strength and dexterity, which both decrease as temperatures drop, increasing the risk of falls and other non-intentional injuries in the elderly [7]. The particular issue of fuel poverty is considered in the next section.

- Damp and mould growth
  Key factors contributing towards damp and mould include cold housing due to poor construction, along with poor ventilation and inefficient heating within homes. Those living in damp mouldy homes are more likely to experience health problems such as respiratory infection, allergic rhinitis and asthma [6].

- Quality of housing
  Poor housing conditions such as poor lighting, unsafe stairs or lack of stair handrails, electrical hazards and disrepair can all increase the risk of accidents and injuries within the home, with older people being particularly at risk. The majority of injuries to people aged 75 and older occur at home.

Housing services can play a vital role in ensuring that an older person's home is fit to provide a safe environment and to maximise independence [8].

Good quality housing can protect and promote health. The health and wellbeing of older people can be improved by:

- Adequate heating and ventilation
- Basic safety checks and minor repairs
- Adaptation of existing homes to facilitate independent living at home

Table 1 shows that in Thurrock, the proportion of householders owning their home is highest for those aged 65-74, with 74.8% owning their home. The proportion of older people renting their home is highest in the 85 and over age group.

Table 1: Proportion of Thurrock population aged 65 and over by age and tenure

	People aged 65-74	**People aged 75-84**	**People aged 85 and over**
Owned	74.8%	72.6%	62.07%
Rented from council	19.3%	21.95%	31.38%
Other social rented	1.29%	0.95%	1.32%
Private rented or living rent free	4.61%	4.51%	5.24%

Source: POPPI – based on 2011 figures

Local Action

There is much local action on supporting older people to live independently and promoting their health and well-being in their own homes.

Development of HAPPI (Housing our Ageing Population: Panel for Innovation) housing scheme concentrates on the development of more homes that can be flexible to the changing needs of older people can support people to maintain better health and independence. Thurrock Council, a stock-holding authority, is using its housing revenue account (HRA) settlement to develop new housing options for older people, alongside appraisals of existing stock. New developments, such as South Ockendon, are bespoke models built to HAPPI design standards with high levels of energy efficiency. A second HAPPI housing scheme is being considered for Tilbury.

Thurrock Council is also **working with private housing developers** to engage them with the opportunities for bespoke developments for older people in the borough.

Sheltered Housing - There are 29 complexes in Thurrock which allow older people to live independently in their own property, with the support of a sheltered housing officer. In addition to making regular contact with residents as required, the sheltered housing officer liaises with health workers and social services to meet specific needs. They also deal with day to day issues of home maintenance and repairs and help to arrange social activities for residents.

Extra Care Housing - Thurrock Council owns two extra care housing schemes, with a third scheme managed by a housing association. All three provide extra care to meet the needs of older people and help them to stay in their own home for as long as possible.

Specialist Advice and Support -Thurrock Council works in partnership with Papworth Trust Home Solutions to provide specialist advice and support to repair, improve or adapt the homes of disabled and older people. The services offered include:

- handy person scheme
- home safety check
- gardening
- decorating
- Home from Hospital
- benefit entitlement
- housing options advice
- case management
- architectural/technical services
- Hospital Prevention Service providing adaptations such as grab rails and stair rails to assist with hospital discharge or help prevent admission to hospital

Well Homes - the Well Homes project is a new project through the Papworth Trust, which has been implemented since May 2014. Public health are working jointly with Thurrock Council's housing team to offer private sector residents in Tilbury Riverside, Thurrock Park, Grays Riverside, West Thurrock and South Stifford a 'well homes visit' which advises tenants on:

- Improvements to the home
- Energy efficiency grants for boiler replacements/repairs, loft and cavity wall insulation
- Raising health and safety issues with landlords
- Financial assistance to owner occupiers to carry out repairs in their home
- Reduced cost gas safety checks and boiler services
- Reduced cost electrical safety checks
- Handyman and gardening services

The **Oven Cleaning Project** - A safeguarding adults and fire prevention initiative in partnership with Fire Service. This is a service that helps to prevent kitchen fires, the biggest cause of fires in the over 65 age group in Thurrock. A person is referred for a free oven cleaning when they are too frail to be able to do it themselves and there is a noticeable build-up of grease and food that could present a hazard. The fire service receives the referrals. General advice and fire safety is also given to any resident that qualifies for this support. To date there have been 50 ovens cleaned.

Fuel Poverty

Key Messages:

- Nationally the proportion of households where older people reside which are fuel poor has fallen; however, the fuel poverty gap has increased for this group
- Older people living in cold homes are at a greater risk of heart disease, stroke, falls and poor mental health and well-being
- Fuel poverty can contribute to excess winter deaths, particularly In older people

Older people can be more susceptible to fuel poverty as they are likely to spend more time in their home and therefore need to heat it for longer, but may be unable to do so due to their low income.

Through the Energy Act 2013, there is now a new legal framework to monitor fuel poverty in England using the Low Income High Costs Indicator (LIHC). A household is considered to be fuel poor if:

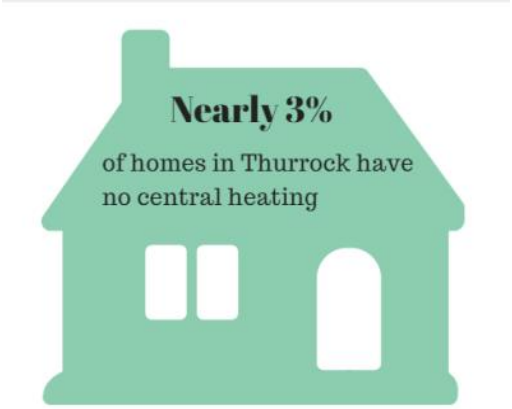
- they have required fuel costs that are above average (the national median level)
- were they to spend that amount, they would be left with a residual income below the official poverty line.

Under this indicator, overall there are around 2.4 million households and 1.14 million older people in England living in fuel poverty [9].

The key elements in determining whether a household is fuel poor are:

- Income
- Fuel bills
- Energy consumption (dependent on dwelling characteristics and the lifestyle of house holders).

Nationally the proportion of households which are fuel poor has fallen between 2003 and 2012, from 12% to 8% in households where the oldest person is aged 60-74 and from 15% to 7% in households where the oldest person is aged 75 or more.



However, the average fuel poverty gap increased from £241 to £504 in households where the oldest occupant is 60-74year and £261 to £557 where the oldest occupant is 75 years and older [10]. This increase in the fuel poverty gap is the result of rising fuel prices.

The health implications of living in cold homes have been described earlier, and range from cardiovascular and respiratory disease to depression, at an estimated cost to the NHS of £1.36bn a year.

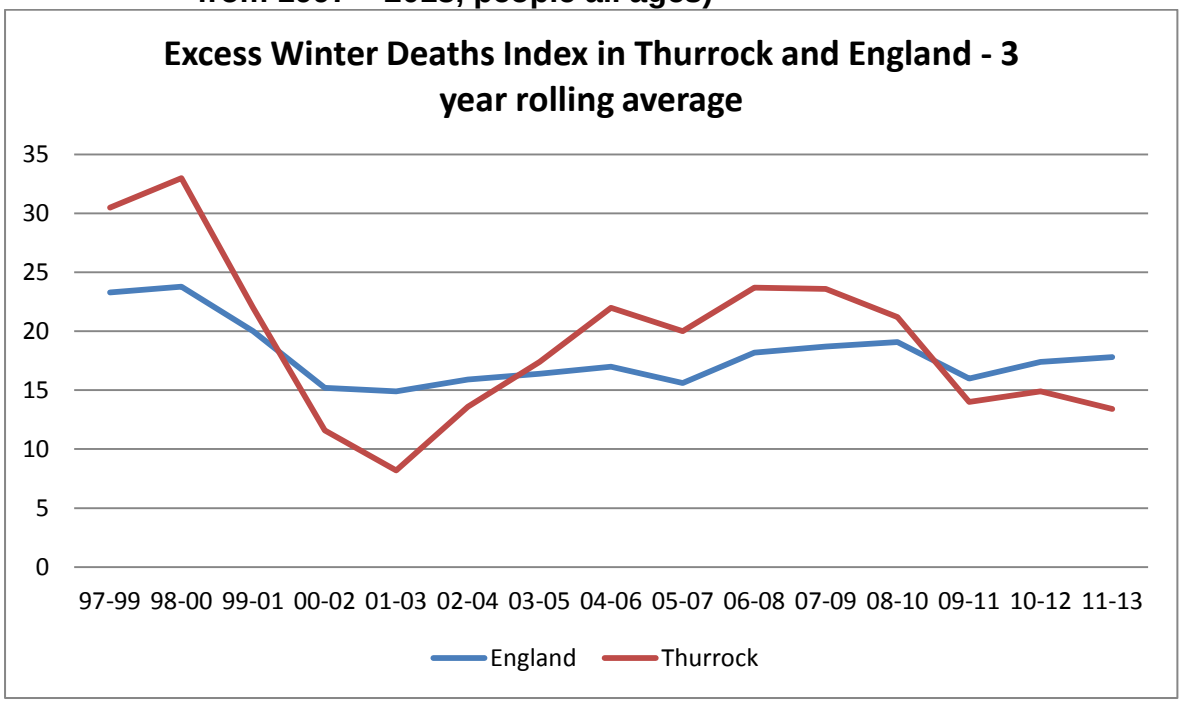
Fuel poverty can also contribute to excess winter deaths in all age groups, but the proportion of excess deaths is greater in older age groups.

Excess Winter Deaths (EWD) are defined as the difference between the number of extra deaths that occur in the winter months (December-March) compared to the average number of deaths in non-winter months (August-November and April-July).

In the winter of 2012/13, there were 31,100 ‘excess winter deaths’ (EWD) in England and Wales, the majority of which occurred in people aged 65 and over [11]. The majority of deaths were from complications associated with respiratory infections (41%) and dementia (29%).

In 2012/13, there were 70 more deaths in Thurrock (people of all ages) attributable to cold, than would normally be expected. This figure is not statistically different to that for England or other comparator local authorities. Figure 4 provides an overview of EWD for Thurrock during the period 1997-2013 for people of all ages.

Figure 4: Excess Winter Deaths in Thurrock and England (3 year rolling average from 1997 – 2013, people all ages)



Source: ONS

Local Action

The Cold Weather Plan for England (CWP) aims to prevent avoidable harm to health by alerting people to the negative health effects of cold weather, and enabling them to prepare and respond appropriately. The CWP also aims to reduce pressure on the health and social care system during winter through improved anticipatory actions with vulnerable people [12]. In Thurrock, local implementation of the cold weather plan has been overseen by relevant departments across the Council and Thurrock Clinical Commissioning Group (CCG).

Local action also includes the promotion of the Keep Warm, Keep Well initiative. This government campaign provides messages to the public to help protect health, especially over the winter period:

Keep Warm Keep Well – Key Messages

1. Get your free flu jab if you are aged 65 or over, pregnant, have certain medical conditions, live in a residential or nursing home or are the main carer for an older or disabled person
2. Keep warm - by setting your heating to the right temperature (18-21 c or 65-70f), you can keep your home warm and your bills as low as possible
3. Look after yourself and check on older neighbours or relatives to make sure they are safe, warm and well. Layer your clothing and wear shoes with a good grip if you go outside
4. Food is a vital source of energy, which helps to keep your body warm. Try to make sure that you have hot meals and drinks regularly throughout the day and keep active in the home if you can
5. Get financial support - there are grants, benefits and sources of advice available to make your home more energy efficient, improve your heating or help with the bills. It's worthwhile claiming all the benefits you are entitled to before the winter sets in
6. Have your heating including your boiler and cooking appliances checked – carbon monoxide is a killer.

Recommendations:

- Raise awareness of frontline health and social care staff, the voluntary sector and local area co-ordinators of the importance of wider determinants on the health of older people, to facilitate early intervention and referral to appropriate services for help and support in claiming welfare and housing benefits to which they are entitled

- Raise awareness with Thurrock residents and frontline services of the link between poor housing and poor health so that older people are referred to appropriate housing services in Thurrock

- Promote partnership working and utilise the community network to ensure that hazards in the home are identified

2.2 Promoting Healthy Ageing

To ensure the health and wellbeing of the growing numbers and proportion of older people there needs to be greater focus on health promotion and disease prevention in old age.

The five main risk factors contributing to early death and reduced quality of life are:

- smoking tobacco
- having high blood pressure
- being overweight or obese
- lack of physical activity
- excessive alcohol consumption

[13]

Nationally and locally there has been considerable effort to address these risk factors, through topic based strategies e.g. tobacco control, obesity and alcohol. Tobacco control and obesity prevention have been identified as local priorities.

The evidence suggests that it is especially important to take action to address these risk factors in middle age i.e. from 40-60 year, as the lifestyle choices made at this time can have a marked impact on health in later years. At age 65, men in the UK can expect to live on average another 10.1 years in good health. Women can expect to live 11.6 years in good health. For both sexes, this constitutes 56.8% of their expected remaining life span [14] [15].

Public Health is working with a number of departments in the Council (including transport, education, housing and social care) in identifying joint projects and working practices that reflect their current preventative strategies.

Public Health is also working with the voluntary and community sector in using an Asset Based Community Development (ABCD) approach to identify community based strengths and assets that can be utilised to deliver preventative health outcomes by communities at a local level. Public Health, working with the Thurrock Council for Voluntary Services (CVS) has developed a funding stream that encourages local community and voluntary groups to identify health promoting activities within their own communities and bid for funding to achieve these.

Smoking

Key Messages:

- Smoking remains the single greatest preventable cause of ill health, premature death and health inequalities
- Approximately 16% of people aged over 50 in Thurrock smoke
- As people age they are more likely to attempt to stop smoking and be more likely to quit. It is never too late for older people to stop smoking and gain health benefits

Smoking remains the single greatest preventable cause of ill health, premature death and health inequalities. Smoking accounts for one third of all deaths from respiratory disease and over one quarter of all deaths from cancer and about one seventh of deaths from cardiovascular disease (CVD) [16]. On average a smoker loses 10 years of life as a result of their habit [17].

Smoking reduces the general health and quality of life of those who continue to smoke. It is associated with over 50 different diseases and conditions and is responsible for many chronic disease conditions that affect older people, including: respiratory disease such as chronic obstructive pulmonary disease, coronary heart disease and stroke, lung and other cancers, eye disease (macular degeneration) , osteoporosis and increased risk of fractures.

Smoking prevalence has been declining nationally and locally due to a range of interventions such as:

- legislation on smoke free places
- free NHS Stop Smoking Services
- widely available and effective medication
- health warning labels on packaging
- national and local campaigns and social marketing

Currently 1 in 5 adults in Thurrock are smokers [18]. Smoking rates decline with age, mainly due to more deaths and illness in smokers resulting in fewer older smokers being left alive.

According to GP practice records, 16% of people aged over 50 in Thurrock are smokers. However, there is considerable variation in recorded smoking status ranging from around 2% to 27%.

People are more likely to quit when they attempt to stop smoking at an older age. It is never too late for older people to stop smoking and gain health benefits. Quitting reduces the risk of serious illness, and if a person already has a smoking related disease, stopping can slow the progression of the disease. Long-term smokers who quit before the age of 50 will halve their risk of dying from smoking related illness [17]. Even quitting at the age of 60 will add on average three years to the ex-smoker's life [17].

In 2013, a total of 2372 people in Thurrock set a quit date using the Thurrock Local Stop Smoking Services and 1145 (48%) successfully quit. Of these 333 were aged 60 or over and 189 (58%) successfully quit.

Local Action

The Public Health team is in the process of producing a tobacco control strategy for Thurrock that will cover prevention, enforcement and treatment. This will outline our priorities and actions to achieve a coordinated reduction in prevalence of smoking within Thurrock in all age groups.

Thurrock Council Public Health Team commissions a Local Stop Smoking Service (LSSS) from North East London NHS Foundation Trust (Vitality), local GP practices and community pharmacies. The service offers behavioural support and smoking cessation aids such as nicotine replacement therapy.

In addition to the LSSS, work has been ongoing to support the reduction of prevalence in smoking locally, including:

- Local promotion of national health campaigns such as Stoptober.
- Working with Action on Smoking and Health (ASH) and the Chartered Institute of Environmental Health (CIEH) to update the Council's smoke free policy for staff
- Establishing a multi-agency smoke free work stream that will evolve into a Tobacco Control Alliance in 2015, which will oversee the delivery of the Tobacco Control Strategy

The Stoptober Campaign 2014

- **22** locations were visited stimulating an estimated **25,000** visual hits.
- The Stoptober team estimated speaking to over **1000** residents throughout September.
- Over **200** people were tested using the CO (carbon monoxide) monitor.

Stoptober 2014 resulted in 857 estimated sign ups

There are also plans to redesign the LSSS during 2015 to have a strong focus on prevention, enforcement of tobacco legislation and to support the reduction in prevalence of smoking in all age groups.

Recommendations:

- Encourage and support people in later life to quit smoking
- That the Tobacco Control Strategy for Thurrock includes actions to support older people as a target group

Healthy Eating and Obesity

Key messages:

- Eating a healthy diet can significantly reduce the risk of many chronic diseases and premature mortality
- 26.4% of people aged 65 an over in Thurrock are obese, which is similar to the national average

Nutrition plays an important role in healthy ageing. It is estimated that around 70,000 avoidable deaths in the UK are caused by diets that do not match current guidelines [19]. Increasing the consumption of fruit and vegetables to at least five portions a day can significantly reduce the risk of many chronic diseases.

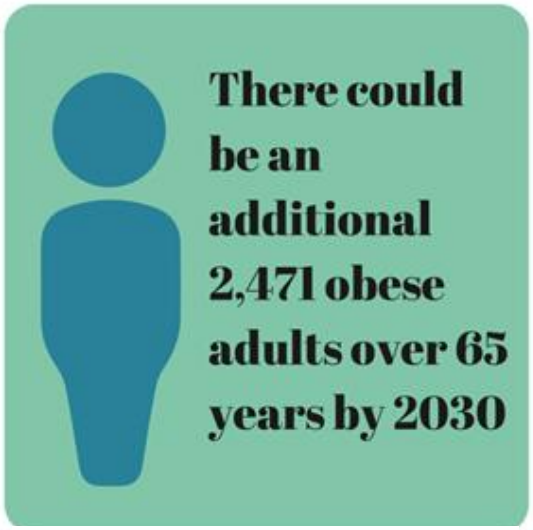
Nutritional guidelines for fat, carbohydrate and fibre are the same for older people as for adults of working age. However, low dietary intake is not uncommon among healthy older adults. **Malnutrition**, defined as 'state of nutrition in which a deficiency, excess or imbalance of energy, protein, and other nutrients causes measurable adverse effects on tissue and body form (body shape, size, and composition), body function and clinical outcomes'. Nationally 1 in 10 people aged over 65 are malnourished or at risk of malnutrition [20].

There are multiple risk factors for malnutrition, including:

- Poverty - leading to inability to access and afford good food
- Mobility - poor mobility, disability, and poor transport links can all lead to difficulties accessing local shops
- Functional constraints – inability to prepare food, poor dental health, difficulty using food containers
- Psychological factors – social isolation, dementia, depression and bereavement can all lead to reduced food intake

The numbers of people who are **overweight or obese** have increased dramatically in all age groups over the last two decades. Overweight and obesity are most commonly assessed through the Body Mass index (BMI). This is calculated by dividing a person's weight in kilograms by their height in metres squared (kg/m^2) An individual is considered to be 'overweight' if their BMI is 25-30, and obese if 30 or above. As well as reducing life expectancy by 8-10 years, obesity is associated with an increased risk of many serious diseases including heart disease and stroke, type 2 diabetes, hypertension, musculoskeletal issues and some cancers (breast and bowel).

Nationally, the proportion of people who are overweight or obese tends to increase with age. It is estimated that there are approximately 5,910 adults aged over 65 in Thurrock (approximately 26.4% of the over 65 population) who are obese in 2014 (POPPI data). This is a similar proportion to the national average of 26.1%. This number is set to increase with the projected rise in population.



Source: POPPI

The prevalence of some long-term conditions associated with obesity (such as diabetes) is high in Thurrock. An increase in the number of obese older adults is likely to further increase demand on primary and secondary care services in the future.

Local Action

There are a range of initiatives in place locally to support older people in Thurrock to lose weight and maintain a healthy weight.

The Council's Social Care department can arrange meals for those people who meet the relevant criteria. For those requiring assistance with personal care and meal preparation, the Joint Reablement Team support adults discharged from hospital for up to six weeks, and support in the longer term is provided by a variety of home care agencies.

A variety of healthy eating initiatives take place within the local sheltered housing complexes, and the new extra care facility Elizabeth Garden has a community café to enable non-residents to access nutritional meals.

Other opportunities exist within the borough to facilitate older residents to eat healthy meals and combat social isolation. A Diners Club has recently been established in Purfleet and provides affordable food and entertainment in a local public house on Monday and Tuesday lunchtimes. This enables elderly residents to come together and share a meal whilst enjoying some entertainment.

The Thurrock Healthy Weight Strategy was developed in partnership with the Council, Thurrock Clinical Commissioning Group (CCG) and the community and voluntary sector. This strategy was produced to ensure that the local population receives the most appropriate support to address weight management issues.

The Public Health team commissions an adult weight management programme for adults of all ages with a BMI of 28 and above, which focuses on healthy eating, behaviour change and advantages of physical activity.

Making Every Contact Count (MECC) is a fundamental approach to encourage and support people to adopt healthier lifestyle, which includes weight management. This is a project that uses the everyday contact people have with frontline staff, to deliver brief lifestyle interventions and signpost them to services that can help them modify their behaviour and manage any existing long term condition better. Work is underway to ensure that frontline staff are trained in MECC. The NHS Future Forum has been directive in its advice in the role of the NHS in the public's health "Every healthcare professional should "make every contact count": use every contact with

an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact" [21].

It is recognised that supporting residents to maintain a healthy weight requires a joint approach from a range of organisations.

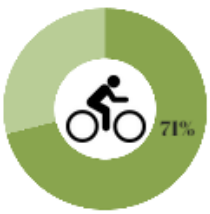
Physical Activity

The most substantial body of evidence for achieving healthy active ageing relates to the beneficial effects of regular exercise. Increased physical activity is associated with a reduced incidence of coronary heart disease, hypertension, type 2 diabetes, colon cancer, depression and anxiety. In addition, increased physical activity increases bone mineral content and reduces the risk of osteoporotic fractures. It also plays an important role in helping to maintain a healthy body weight.

The latest physical activity guidelines were published in 2011 by the four UK Chief Medical Officers, and include specific physical activity guidelines for those aged 65 and over [22]. The key messages are:

- Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
- Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
- For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.
- Older adults should also undertake physical activity to improve muscle strength on at least two days a week.
- Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
- All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

of those aged 65 years and over meet the recommended physical activity guidelines



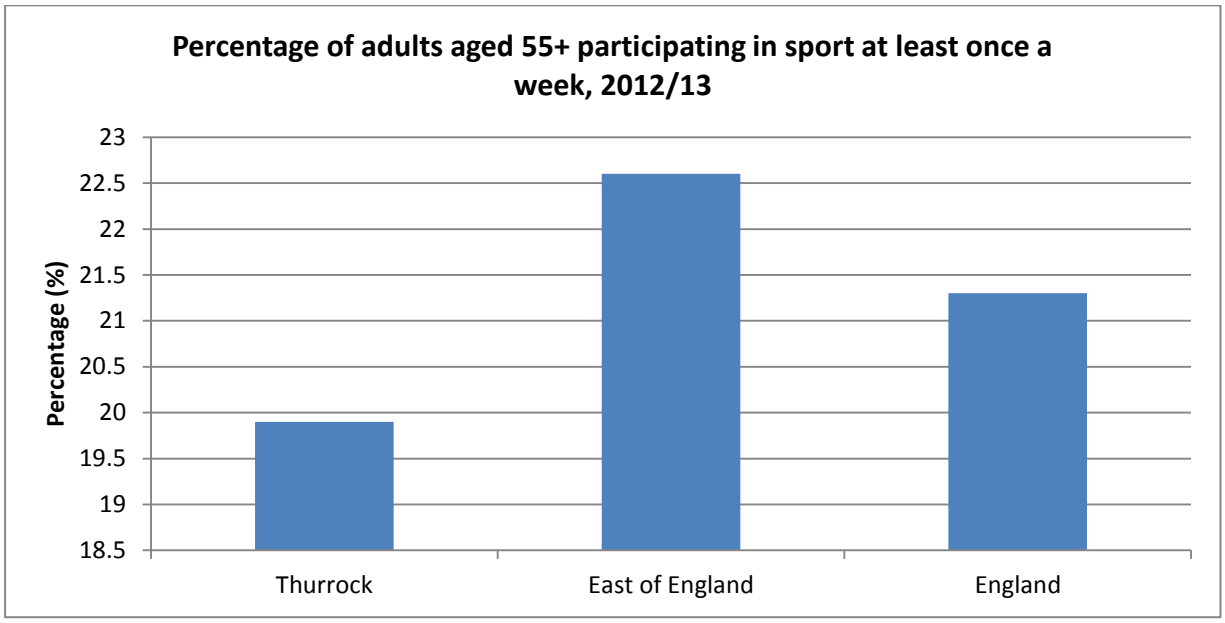
of those aged 16-18 years meet the recommended physical activity guidelines

In later life, the most popular forms of physical activity include active transportation, (such as walking to the shops), group based activities, (such as dance and movement classes, tai chi) and activities of daily living (such as climbing stairs, gardening and household activities). Regular walking is the predominant activity undertaken by older adults.
Participation in physical activity decreases with age: fewer than 40% of those aged 65 and above meet the

recommended physical activity guidelines, compared with 71% of 16-18 year olds (Active People's Survey, 2012/13).

The latest Active People's Survey data shows that Thurrock has a lower proportion of adults aged 55 years and over who are participating in sport at least once a week than the regional and national average (Figure 5).

Figure 5: Percentage of adults aged 55 and over participating in sport at least once a week



Source: Active People's Survey

Local Action

Strong partnerships have been made with the local county sports partnership – Active Essex. A Physical Activity Connector has been jointly appointed between Active Essex and Thurrock Council to strengthen links between existing physical activity groups in Thurrock and identify future funding bids. A community database of physical activity opportunities within the borough has been developed and can be accessed by all residents to source suitable activities.

Those adults who are currently inactive and have a BMI of 28 or above with no comorbidities, can access a Sport England funded project 'Active Sport 4 Life. This offers the opportunity to participate in a sporting opportunity for 12 weeks. There is also a Tilbury-based physical activity project involving mainly younger people but some intergenerational work is undertaken. An exercise on referral scheme is being piloted in partnership with Impulse Leisure.

Active travel is promoted for all age groups, with the Council's Transport Team working with local residents to develop cycling skills and promote active ways of travel. Alongside this, a successful project called **Beat the Street** was run during the summer of 2014 which aimed to increase walking and cycling in all residents of Thurrock.

Following the success of Beat the Street, the **Thurrock World 100** project is being developed to keep people walking. The project will enable participation in an exciting arts based walking project that will inspire hundreds of local participants to get involved. Thurrock World 100 will be a sustainable programme of physical activity across the borough.

Funding opportunities have also been made available to local community and voluntary groups to support them to run health promoting activities within their local areas.

Recommendations:

- Ensure information about age-appropriate lifestyle activities is accessible to communities
- Work with communities to identify and remove barriers to lifestyle services

Alcohol

Key Messages:

- Alcohol misuse in older people is a serious and growing public health challenge in England
- Alcohol problems in older people are often overlooked and undertreated

Although the average consumption of alcohol tends to decrease with age, there is evidence that the proportion of older people drinking more than the recommended amount is rising [23].

Problem drinking is defined as drinking above the recommended medical guidelines [24] which currently state that:

- Men should not regularly drink more than 3 to 4 units of alcohol a day.
- Women should not regularly drink more than 2 to 3 units of alcohol a day.

'Regularly' means drinking these amounts every day or most days of the week.

However, older people tend to have higher blood alcohol levels than younger people on drinking the same amount of alcohol. This difference is attributable to a lower

body mass: water ratio and less efficient alcohol metabolism in older people. Recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week for both men and women [23].

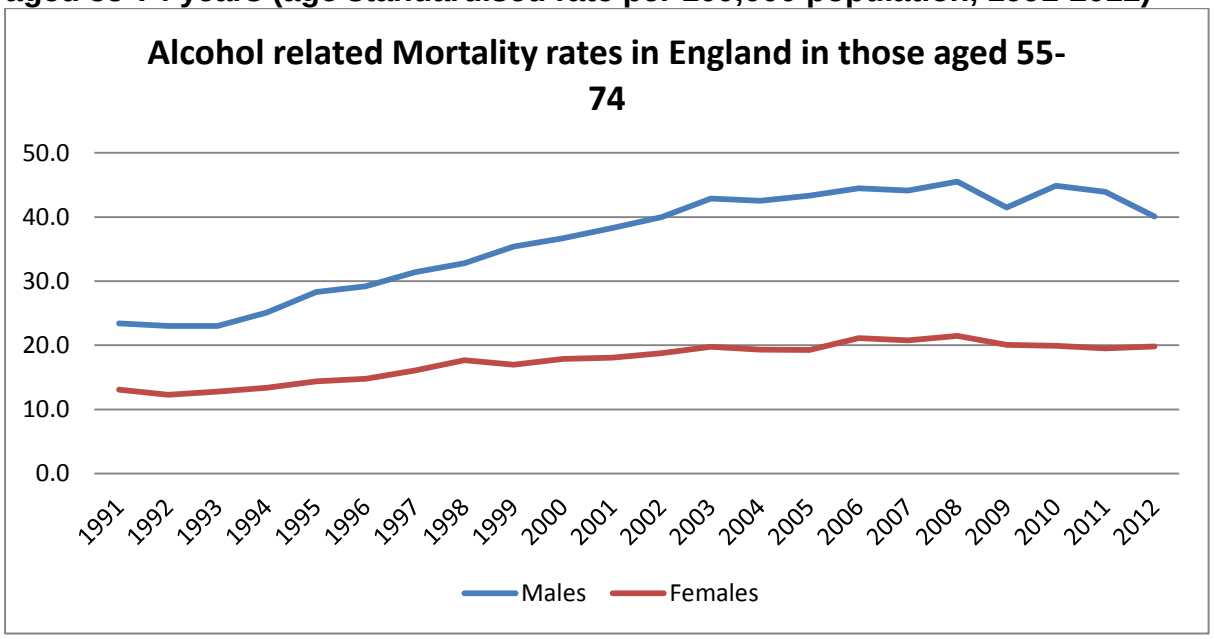
Alcohol misuse in older people can be linked to, or exacerbate, a number of physical, mental, social and practical problems such as:

- cardiovascular disease and stroke
- liver disease
- cancers
- malnutrition/ weight gain
- loss of sense of balance, possibility of falls and accidents
- blackouts or fits
- high blood pressure

Alcohol misuse in older people is often overlooked and undertreated. This is due to a number of factors including reluctance of older patients and their relatives to accurately disclose their alcohol intake. Family members and health professionals may regard the presenting issues, such as falls and confusion to be merely signs of ageing.

The Royal College of Psychiatrists have highlighted particular risk factors for alcohol misuse in older age which includes homelessness, bereavement, retirement and depression [23] [25].

Figure 6: Alcohol related mortality rates in England, in males and females aged 55-74 years (age standardised rate per 100,000 population, 1991-2012)

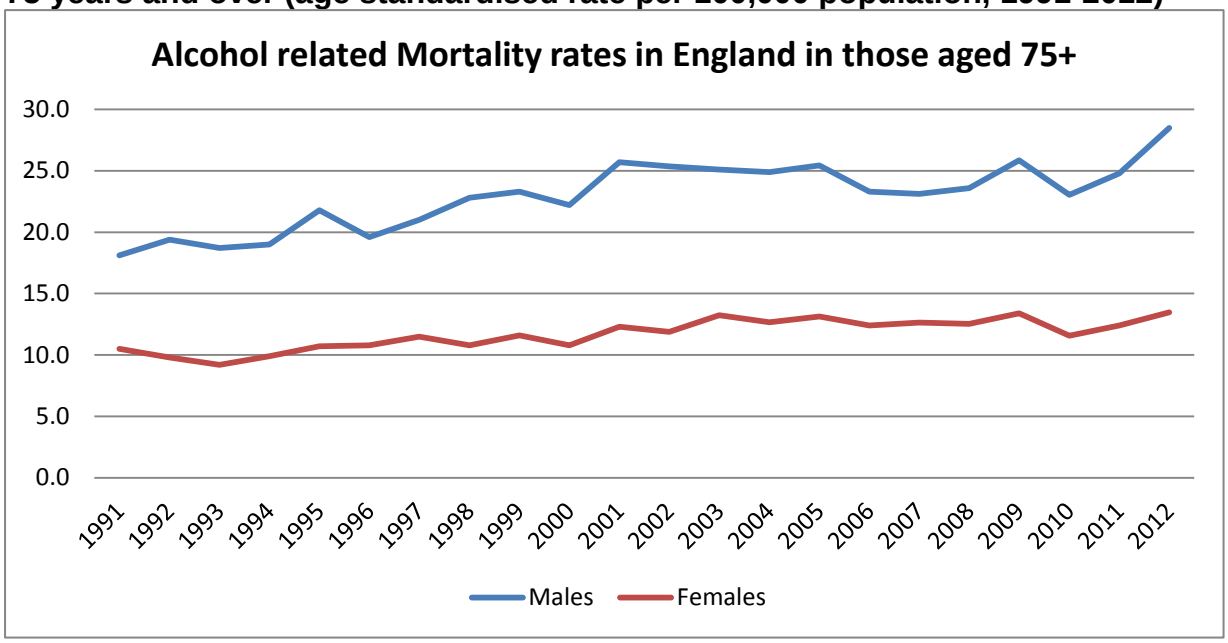


Source: Office for National Statistics 2014

Figure 6 shows that the alcohol related mortality rate in England has been increasing in those aged 55-74 years, particularly for men. This increasing trend in alcohol

related mortality rates is also observed in males and females aged 75 years and over (Figure 7), although the rates are lower compared to those aged 55-74.

Figure 7: Alcohol related mortality rates in England, in males and females aged 75 years and over (age standardised rate per 100,000 population, 1991-2012)



Source: Office for National Statistics 2014

Thurrock has a lower rate of alcohol related hospital admissions (461 per 100,000 population, 2012/13 data) compared to the England and East of England average. There may be a number of reasons for this low figure, including the under reporting and under recording of alcohol-related illness and injury. A new identification and reporting system has recently been introduced at Basildon & Thurrock University Hospital NHS Foundation Trust (BTUH) to capture accurate data on patients presenting with an alcohol related condition.

Nationally those aged 65 and over form a small proportion of those in alcohol treatment – 4% of women and 3% of men [26] . However, an estimated 1.4 million people in this age group currently exceed recommended drinking limits [25], indicating that this is a hidden problem that is not recognised generally.

In partnership with Essex County Council and BTUH, Thurrock Council works with an Alcohol Liaison Service based within the hospital. A key role of the Alcohol Liaison Service is to train health professionals, raise the profile of alcohol attributable illness and injury, and to ensure that these patients are identified and receive the appropriate management. During a 12 month period (September 2014 to September 2014) 10% of patients seen by the Alcohol Liaison Service were aged 65 years and over.

A growing body of evidence suggests that older drinkers are just as likely to benefit from intervention as younger drinkers but embarrassment, shame and the cultural inappropriateness of some mixed-age addiction services can deter older people from seeking alcohol treatment. Lack of transportation and mobility problems may prevent older people from attending services [25].

Local Action

Public Health in collaboration with the Drug and Alcohol Action Team (DAAT) commission a community drug and alcohol service for all age groups. The over 18 service is called KCA Visions and is provided by KCA. There is a prescribing service within this provision including residential detoxification and rehabilitation where applicable.

As a part of the General Medical Services Contract 2014/15, NHS England commissions a Directed Enhanced Service for an alcohol related risk reduction scheme. This scheme requires general practices to case find newly-registered patients aged 16 or over who are drinking at increased or higher levels. Once identified as at risk, patients receive simple brief advice and where identified as alcohol dependent are considered for referral to specialist services. Under this enhanced service, these patients are also assessed for anxiety and depression and are provided with treatment and advice as appropriate.

Local Area Coordinators, adult social workers and sheltered housing officers are have undertaken brief and opportunistic advice (BOA) training delivered by Alcohol Concern. Public Health and the DAAT coordinated this successful multi-agency event and staff from KCA Visions and the Alcohol Liaison Service at BTUH also attended to appraise attendees of the local services and referral pathways.

Recommendations:

- To cascade ‘Making Every Contact Count’ (MECC) awareness training, which includes brief alcohol interventions to staff in the NHS, Council, Local Area Co-ordinators, community groups and other relevant local organisations
- To promote alcohol-related public health campaigns such as ‘Dry January’

Mental health and social interaction in later life

Key Messages:

- Social networks and social contact increase levels of wellbeing in older people
- Social isolation increases the risk of premature death

- Depression is the most common mental health problem in older people

Although mental health problems are not uncommon in older people, they are not an inevitable part of getting older.

The demand for mental health services is likely to increase [27] whilst there is also pressure on public spending to make budget savings. A focus on preventative mental health may prove more cost effective, particularly during a period of economic downturn where the rates of depression tend to increase, along with suicide, attempted suicide and other types of mental illnesses.
Two key areas of focus for older people are the growing issue of loneliness and social isolation and the impact of depression on quality of life in older age.

Loneliness

"Loneliness can escalate to people becoming more isolated, leading to mental health problems and depression and that has a physical impact as well. There's a risk of people losing their independence as result of all of that..." [28]

The LGA guide, Combating Loneliness, describes loneliness as "a subjective state - a response to people's perceptions and feelings about their social connections – rather than an objective state" [29] .

Marmot noted that: *"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill."* [30]

This effect on premature death is comparable with the well-established risk factors of smoking and alcohol abuse [31]; [32].

Key risk factors for loneliness include being in later older age (over 80 years), on a low income, in poor physical or mental health [33], and living alone or in isolated rural areas or deprived urban communities [34]

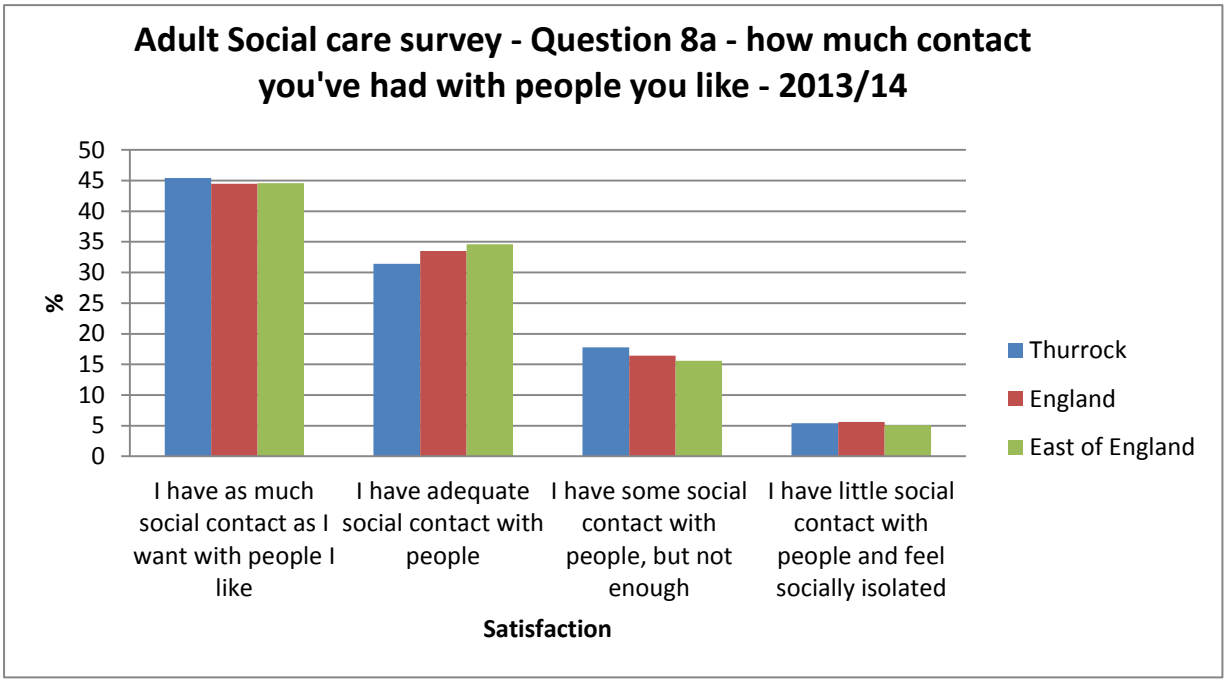
Research has shown that poor mental health and sensory impairments are associated with smaller and less satisfying support networks, as well as lower levels of contact with social networks. Loneliness increases the risk of cognitive decline and dementia, while frequent emotional support and social activity reduce the risk of cognitive decline [31].

Social networks can be important tools in building people's resilience and increasing social contact can increase the levels of wellbeing of older people [35] [36]

The 2013/14 Adult Social Care Survey identified those users of adult social care services in Thurrock are fairly satisfied with their social contact. However, nearly

18% feel that they do not have enough social contact and over 5% feel socially isolated.

Figure 8: Adult Social Care Survey. Response to question on how much social contact adult social care users have had in 2013/14.



Source: HSCIC Personal Social Services Adult Social Care Survey 2013/14

There is some evidence to support mentoring and befriending models although more research is required [37].

Local Action

Thurrock Council's Health and Wellbeing Strategy has been awarded 'gold standard' accreditation by the 'Campaign to End Loneliness', on account of the measurable actions and targets to address loneliness included in the strategy. Thurrock is one of only eight councils in the country to receive this accreditation.

Thurrock Council commission Age UK Essex to provide a home befriending service which provides one-to-one telephone and home based befriending and coffee mornings. Age UK Essex also provide an 'Active Lives' service. This is a volunteer led programme where for a time limited period (approx. 12 weeks) a volunteer helps people aged over 60 on a 1-2-1 basis to access the community, helping them to regain independence and/or confidence by supporting them to attend clubs, visit shops, restart a hobby etc. This intervention is being used with people with no mobility issues but who have become lonely and lost confidence, often after the death of a loved one, when caring responsibilities end or after an illness.

Community Hubs - A co-production between the community, council and partners, Community Hubs are places for services and offer help and support to communities on a variety of issues. Hubs are in place or in progress in Aveley and Uplands, Ockenden and Belhus, Corringham and Stanford, Chadwell St Mary and Tilbury Riverside.

Alongside the Community Hubs, Community Organisers and Community Builders, work in local communities, Community Organisers bring people together, build networks and support people to tackle the local issues which are important to them. Community Builders make connections across communities and organisations.

Local Area Coordinators (LACs) are provided by Thurrock Council and help people who are vulnerable through age, frailty, disability or mental health issues to find their own local solutions, and use a strength-based approach on hopes, aspirations and needs. The 14-month evaluation report for the project has shown that to date more than 46 individuals over the age of 60 have been helped to engage more with other local people [5]. The LACs help with connecting people and communities, an example of this work includes developing a lunchtime club for socialising and healthy eating in partnership with a local public house in Purfleet.

The Public Health Grant is providing seed funding for local activities to enable communities to come together and support one another, leading to improved health and well-being. One example is the community garden in Chadwell. This aims to bring all sections of the community together to achieve a community space for activity and play.

Depression

Depression is a disorder of mood characterised by low mood and feelings of sadness, loss of interest or enjoyment, poor memory and concentration, poor appetite and weight loss, tiredness and feelings of guilt. When severe, sufferers may be unable to cope with everyday life and they may have suicidal thoughts or impulses.

"Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention." [27]

The rate of depression is higher for those older people living in a care [38]. Older people with physical ill health, and socially isolated older people are at higher risk [39].

Depression in later life may be triggered by a variety of factors such as bereavement and loss, life changes such as unemployment or retirement, and social isolation. Older people can also become depressed because of increasing illness or frailty or following a stroke or fall.

Early recognition and prompt treatment of depression can reduce distressing symptoms and help to prevent more serious consequences including physical illness, self- neglect, self- harm or suicide.

There are a number of actions an individual may take to help them cope with depression. Asking for help is key, but only one in six older people with depression discuss this with their general practitioner and less than half of these receive adequate treatment [40]. Keeping active, eating healthily and moderating alcohol

intake are also important and can help to improve mood. Enhancing social interaction through hobbies and interests and visiting friends and family can all help to improve mood and assist recovery.

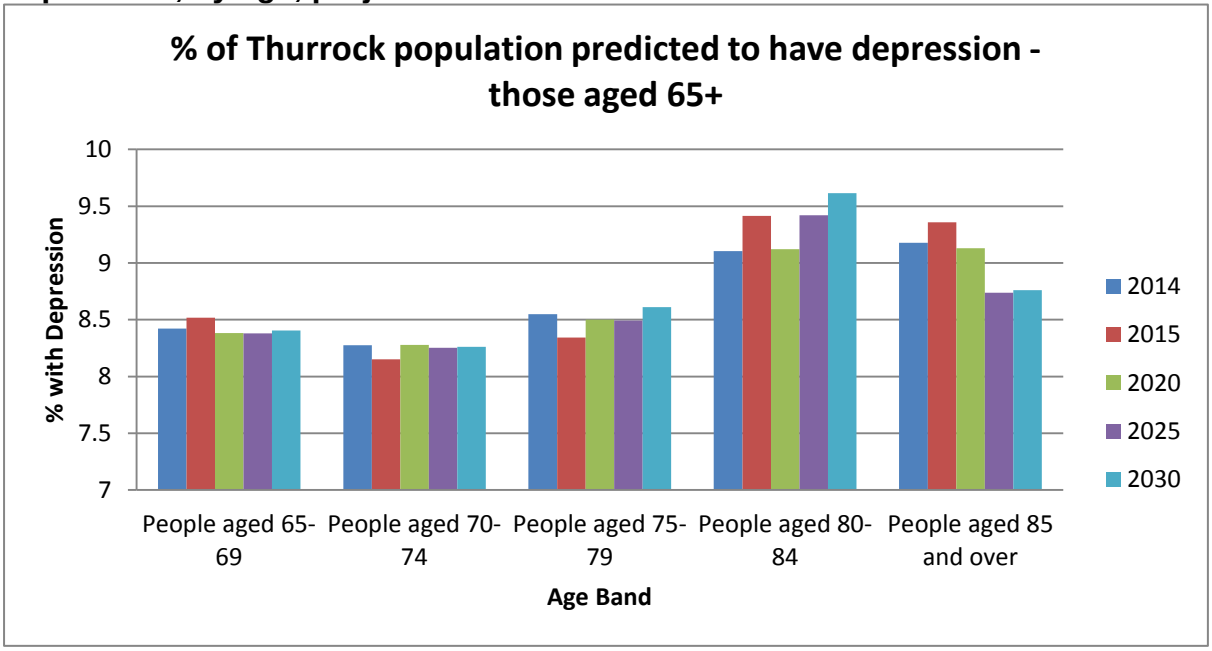
Untreated depression can have a detrimental impact on quality of life in older people, but in addition to this it can increase need for other services, including residential care [27].

Treatment for depression includes antidepressant medication and talking therapies such as psychotherapy and cognitive behavioural therapy in the community. The DH [17] report that older people can respond very well to psychological and medical treatments.

Referral to specialist services is required if treatment has failed to make any improvement. Admission to hospital may be required for a small number of older people who are very unwell with their depression e.g. unable to eat or drink or has attempted suicide.

Figure 9 shows the proportion of older people aged 65 and over predicted to have depression from 2014 to 2030.The predictions show that depression is likely to be highest in the 80-84 age group.

Figure 9: Percentage of People aged 65 and over predicted to have depression, by age, projected to 2030.



Source: POPPI (2013)

Local Action

Improving Access to Psychological Therapies (IAPT) – There are a range of interventions available under the umbrella 'Therapy for You' including psychological interventions such as cognitive behavioural therapy (CBT), counselling and group therapy. They also offer guided self-help through bibliotherapy (book prescription

scheme) and online CBT programmes such as Beating the Blues, Fear Fighter and The Mood Gym.

Public Health within the Council has funded an **exercise referral scheme** for emotional well-being which is being delivered by Impulse Leisure from January 2015. The programme is available to people of all ages and requires a referral by a professional for a well-being assessment.

Public Health has recently commissioned the Thurrock CVS to administer a **preventative mental health grant funding programme** in Thurrock. The aim is to provide funding for community-led initiatives that will improve mental health promotion and mental illness prevention within local communities. Three key areas have been identified for preventative mental health, including: dementia, suicide prevention and depression.

The **voluntary sector** plays an important part in supporting positive mental health and well-being locally. Thurrock MIND offers a range of services to promote positive mental well-being and relief from emotional distress through a range of community services including: befriending, counselling, stepping stones (support with returning to work), Community Bridge Building (one-to-one support in the community) and the Well-being Centre. The Well-being Centre supports adults diagnosed with mental health difficulties to be empowered to take responsibility for themselves by working in a recovery-focused model.

For people with mental health difficulties there are **Community Mental Health services** available. Thurrock Council in partnership with the Alzheimer's Society and South Essex Partnership University NHS Foundation Trust (SEPT), offer advice, information, social activities, short-term intermediate care and assessments and help to access appropriate social and health services. There is an **Older Peoples Community Mental Health Team**, provided by SEPT. This is available to support older people requiring specialist mental health services and provides assessment, care planning, coordination and monitoring, rehabilitation, occupational therapy and domiciliary support.

Recommendations:

- Work in partnership with Thurrock Adult Community College (TACC) and the University of the Third Age (U3A) to deliver messages around a healthy and active retirement
- Develop a peer mentor programme in partnership with existing agencies such as Thurrock Age Concern, local colleges, Cariads and faith groups
- Local Area Coordinators to work alongside vulnerable individuals within the community and increase the number of referrals to lifestyle and other preventative programmes
- Work with commissioners within Thurrock Clinical Commissioning Group and adult social care to jointly improve identification of depression in older people and access to psychological therapies

2.4 Protecting health in later life

Health protection seeks to prevent or reduce the harm caused by infectious diseases and minimise the health impact from environmental hazards [41].

As well as major programmes such as the national immunisation programmes and the provision of health services to treat infectious diseases, health protection involves planning and emergency preparedness, surveillance and response to incidents and outbreaks.

From 1 April 2013, the responsibility for health protection at a local level transferred from Primary Care Trusts and the Health Protection Agency, to Public Health England. Local authorities have maintained their responsibility for aspects of health protection. In addition unitary and upper tier local authorities have a new health protection duty to ensure that threats to health are understood and properly addressed.

The NHS England (Essex Area Team) Screening and Immunisation Team is responsible for commissioning the screening and immunisation programmes covered by the Section 7a agreement of the NHS Act 2006 (amended by the Health and Social Care Act 2012).

For older people, the key areas of focus for protecting health and well-being are seasonal influenza and the uptake of relevant age-related screening programmes.

Seasonal Influenza

Influenza or 'flu' is an acute respiratory illness associated with infection by the influenza virus. Symptoms frequently include fever chills, headache, cough, sore throat, aching muscles and joints and fatigue.

The incubation period, i.e. the period between infection and the appearance of symptoms, is about two to three days. Adults are usually considered to be infectious once symptoms appear and for 3-5 days afterwards.

The flu virus is highly contagious and is easily passed from person-to-person when an infected person coughs or sneezes. Transmission can also occur by touching a surface contaminated with respiratory secretions and then putting the fingers in the mouth or nose or near the eyes. The flu virus can live on a hard surface for up to 24 hours and a soft surface for around 20 minutes.

The Influenza Immunisation Programme

The aim of the influenza immunisation programme is to protect those who are at a higher risk of serious illness or death should they develop influenza. It also helps to reduce transmission of the infection,

The seasonal flu vaccine is offered free on the NHS to the following at-risk groups:

- People aged 65 years or over
- All pregnant women

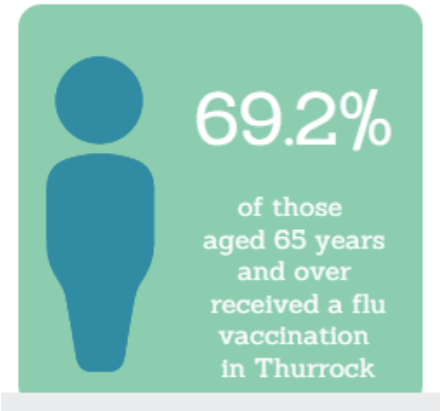
- People with a serious medical condition such as:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease
  - chronic liver disease
  - chronic neurological disease, e.g. Parkinson's disease or motor neurone disease
  - diabetes
  - splenic dysfunction
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
- People living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality (excluding prisons, young offender institutions, or university halls of residence)
- People who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill

As a part of occupational health, all front line health and social care workers should also be offered flu vaccination.

In 2012, the national Joint Committee on Vaccination and Immunisation (JCVI) recommended that the programme should be extended to all children aged two to 16 years. In addition to providing direct protection from flu for the children who are vaccinated, once fully implemented this will help to interrupt transmission of influenza reducing the spread to unvaccinated children and adults.

Local Statistics

For the 2013/14 season NHS England, Public Health England and the Department of Health set the target for uptake of seasonal influenza vaccine at 75% for those over 65 years of age and 75% for those under 65 years and in risk groups.



NHS England Essex Local Area Team achieved coverage in the over 65 age group in Thurrock of 69.2% (England 73.2%). Uptake in those under 65 years in high risk groups however was 45.2% (England 52.3 %). Vaccine uptake by frontline healthcare workers reached 65.8% in Basildon & Thurrock University Hospitals NHS Foundation Trust (2013-14). The overall uptake for frontline healthcare workers – all trusts in England was 54.8% [42].

In Thurrock, uptake of flu vaccination by those aged over 65 years varies considerably by GP practice from 58-80% (2013/14).

Local Action

The 2014/15 Flu Plan for England [43] contains a good practice guide for GPs to assist them with increasing uptake of flu vaccine in high risk groups locally. This focuses on up-to-date practice registers of high risk individuals, robust call and recall systems and efficient data collection. The NHS England Essex Area Team undertook a flu immunisation pilot with a number of community pharmacists, which evaluated positively. Consideration will continue to be given to improving access arrangements.

Shingles

Shingles is an infection of a nerve and the area of skin around it. It is caused by the herpes varicella-zoster virus, which also causes chickenpox.

The affected area may be very painful and intense itching is common. The rash typically lasts between two and four weeks. Following the rash, persistent pain at the site, known as post herpetic neuralgia (PHN), can develop and is seen more frequently in older people. PHN typically lasts from three to six months, but can persist for longer.

The incidence of shingles in England and Wales is estimated to be around 790 to 880 cases per 100,000 people per year for those aged 70 to 79 years. The risk and severity of shingles increases with age however, the estimated effectiveness of the vaccine decreases with age. The shingles vaccination programme commenced in September 2013, for people aged 70 years in addition to a catch-up programme for people aged 79 years.

Public Health England has published shingles vaccine coverage in England by age cohort and Clinical Commissioning Group (CCG) for the year 1 September 2013 to 31 August 2014. This shows that for NHS Thurrock CCG, 57.2% of the routine 70 year cohort have been vaccinated (compared to 61.8% in England) and 55.2% of those in the 79 year old catch up cohort (compared to 59.6% in England). 100% of practices in Thurrock are reporting annual data (compared to 89.9% in England) [44].

Screening

Alongside leading a healthy lifestyle, participation in screening is an important aspect of maintaining older people's health. There are national screening programmes for breast cancer, bowel cancer and abdominal aortic aneurysm.

The Breast Cancer Screening Programme

The incidence of breast cancer increases with age, with eighty percent of cases occurring in postmenopausal women. It is the 2nd most common cause of cancer death among women in the UK, accounting for 15% of female deaths from cancer [45].

The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50-70 and over using mammography. A mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor. Women aged over 70 may also self-refer to the programme. From 2010 the Breast Screening programme began phasing in an extension of the age range of women eligible for breast screening to those aged 47 to 73, this is due to be completed by 2016.

The South Essex Breast Screening Service which covers Thurrock is provided by Southend University Hospital NHS Foundation Trust. This service has a static unit as well as three mobile units which are sited in different areas of the district during the screening round. The service intends to commence age extension in January 2016.

The latest figure (2013/14) for breast screening coverage (proportion of eligible women who have had a screening mammogram in the last 3 years) for women in South West Essex was 70.9%. There has been ongoing work with the breast screening service and their commissioner to increase coverage.

The Bowel Cancer Screening Programme

About one in 20 people in the UK will develop bowel cancer during their lifetime and it is the third most common cancer in the UK [46]; 95% of bowel cancer cases occur in people aged 50 and over.

Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. Bowel cancer screening can also detect pre-cancerous polyps which may become malignant over time. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

The average uptake for bowel screening was 49.8% (July 2013-June 2014)

Polyps and bowel cancers sometimes bleed and the bowel cancer screening programme uses the faecal occult blood test (FOBT) which detects tiny amounts of blood which cannot normally be seen in bowel motions. The FOBT test does not diagnose cancer, but the results indicate whether further investigation (usually a colonoscopy to directly visualise the large bowel) is needed.

Bowel cancer screening is offered to men and women aged between 60 and 74. They receive an invitation in the post followed by a screening test kit. Those with an

abnormal result are offered an initial appointment to discuss the result and decide on the next steps. This is followed by a colonoscopy if required.

The local bowel screening programme is provided by Basildon & Thurrock University Hospitals NHS Foundation Trust.

Uptake of bowel cancer screening has varied from between 45.3% to 56.8% during the year July 2013 to June 2014; the national standard is 55.8%. The Programme is preparing a health promotion plan to target wards with low uptake.

Abdominal Aortic Aneurysm Screening (AAA)

Abdominal aortic aneurysms are formed when the major blood vessel (the aorta) in the body weakens and expands. Large abdominal aortic aneurysms can be very dangerous because they can rupture – if this occurs the outcome is very likely to be fatal.

Men are six times more likely to have this type of aneurysm than women. The chance of having an aneurysm increases with age. The risk also increases if a person:

- smokes
- has high blood pressure
- has a brother, sister or parent that has, or has had, an abdominal aortic aneurysm.

Around 5,000 people, mostly men aged 65 and over, die every year from ruptured AAA. The screening programme should eventually prevent up to half of these deaths through early detection, appropriate monitoring and treatment, usually surgery.

All men in England whose 65th birthday falls on or after 1 April 2013 will automatically be invited for screening. Older men who have not previously been screened can arrange an appointment by contacting their local screening service.

The local AAA screening programme which covers Thurrock is provided by Southend University Hospital NHS Foundation Trust. Screening commenced in August 2013.

For 2013/14, the Essex-wide programme screened a total of 4,679 men of 5,713 invited, an uptake of 82.5%. (This compares to a national average of 81.5%) Of self-referrals, 100% were screened. Four clinics are run in the Thurrock area, at Langdon Hills, Corringham, Grays and Tilbury.

Recommendations:

- Encourage and support people aged 65 and over to have their annual flu jab
- Promote and engage frontline health and social care staff in the take-up of the flu jabs

Chapter 3 In Focus - Dementia in Thurrock

Key messages:

- Dementia is a term used to describe a collection of symptoms, including memory loss, mood changes and problems with communication and reasoning.
- In 2013 there were an estimated 1469 people in Thurrock with dementia
- In 2013 the overall diagnosis rate for dementia in Thurrock was 41.89%

Introduction

Dementia is one of the major health and social care issues of our time. Around 815,827 people in the UK have dementia and this number is set to increase by 40% in the next 12 years [47]. The total cost of dementia to society in the UK is currently £26.3 billion.

It is estimated that one in three people will care for a person with dementia in their lifetime.

Currently only 48% of people with dementia in England have a formal diagnosis or have contact with specialist services.

In recognition of the severe detrimental health and financial impacts of dementia, the Department of Health published a national Dementia Strategy [48]. The key principles of this strategy are:

- Improved public and professional awareness of dementia
- Earlier diagnosis and intervention
- A higher quality of care for people with dementia from diagnosis to end of life.

A follow up report to the Dementia Strategy [49] highlighted that there has been some major progress. This has particularly been in the area of identifying and assessing people with dementia as well as a reduction in the prescription of antipsychotic medication. However, there are still challenges in supporting people with dementia to feel part of their community and making it easier for them to access services. There are also concerns that society in general needs to adapt to deal with the growing number of people with dementia.

What is dementia?

Dementia is a term used to describe a collection of symptoms. These include memory loss, mood changes and problems with communication and reasoning, and a gradual loss of skills needed to carry out daily activities.

Dementia can affect people of any age, but is more common in people aged over 65. Dementia is progressive, which means the symptoms will gradually get worse and the condition is currently incurable. However, medicines and other interventions can lessen symptoms and people may live with their dementia for a further 7-12 years after diagnosis.

There are many diseases that result in dementia. The most common types of dementia are:

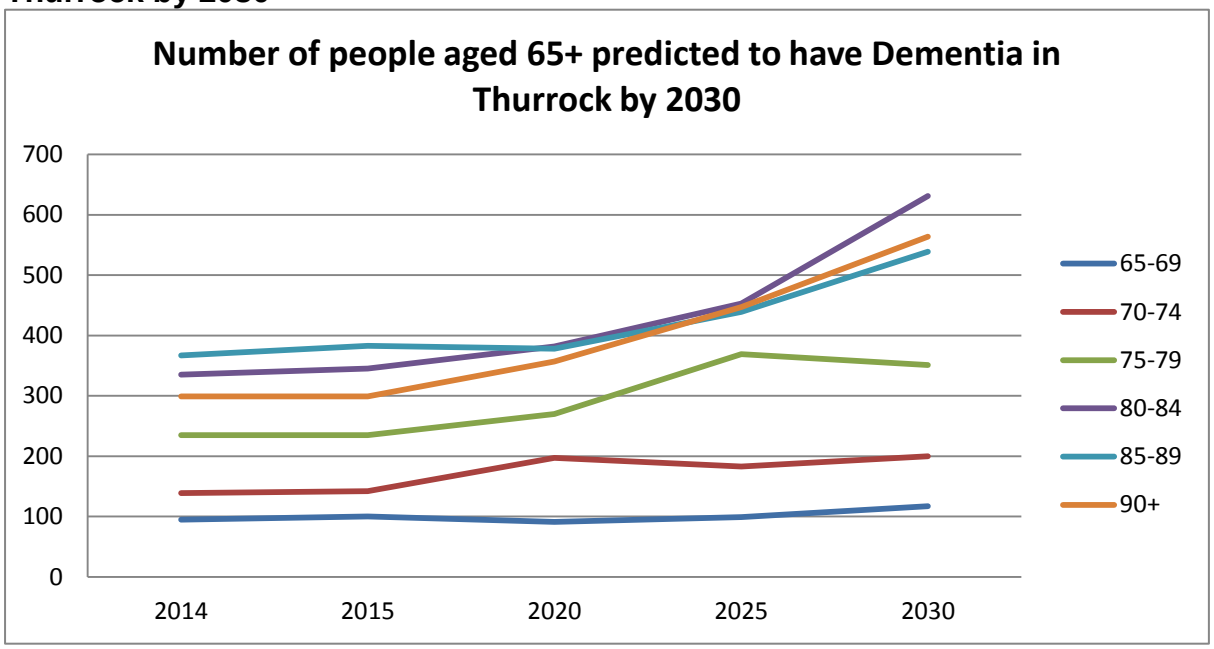
- Alzheimer's disease, which is the most common cause of dementia and accounts for around 62% of cases in England. Brain cells are surrounded by an abnormal protein resulting in their damage and loss.
- Vascular dementia. This results from damage or loss of brain cells due to a reduced or loss of the oxygen supply to the brain because of narrowing or blockage of blood vessels. Vascular dementia accounts for around 17% of cases.
- Mixed dementia**.** This is when someone has more than one type of dementia, and a mixture of symptoms. These account for 10% of total cases.
- Dementia with Lewy bodies – This type of dementia accounts for around 4% of cases. It involves tiny abnormal structures (Lewy bodies) developing inside brain cells.

The symptoms of these types of dementia are often different in the early stages but become more similar in the later stages as more of the brain becomes affected.

People with learning disabilities have an increased risk of developing dementia than other people and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s.

If the prevalence of dementia remains the same, the number of people with dementia in the UK is forecast to increase to 1,142,677 by 2025 and 2,092,945 by 2051, an increase of 40% over the next 12 years and of 157% over the next 38 years [47]. Latest estimates suggest that there are **1469 people in Thurrock with dementia** in 2014 and **1503** predicted in 2015 [47].

Figure 1: Number of people aged 65 and over predicted to have Dementia in Thurrock by 2030



Source: POPPI

Figure 1 shows that the number of people in Thurrock predicted to have dementia by 2030 is highest in those aged 80 and over.

Dementia can affect people of any age, but is more common in people aged over 65, and prevalence roughly doubles from this age onwards. Table 1.0 shows the population prevalence of late onset dementia.

Table 1.0 UK estimated percentage of UK population with late onset dementia by gender and age

Age Group	Females (%)	Males (%)	Overall Prevalence of Dementia in Population (males and females)
60-64	0.9	0.9	0.9
65-69	1.8	1.5	1.7
70-74	3.0	3.1	3.0
75-79	6.6	5.3	6.0
80-84	11.7	10.3	11.1
85-89	20.2	15.1	18.3
90-94	33.0	22.6	29.9
95 and over	44.2	28.8	41.1

Source; Knapp et al, 2014 (1)

People from all ethnic groups are affected by dementia. It is estimated that there are nearly 25,000 people living with dementia from black, Asian and minority ethnic groups in the UK. This is expected to rise significantly as the BAME population ages to nearly 50,000 by 2026 and over 172,000 by 2051 [50].

The cost of dementia

The overall economic impact of dementia in the UK is estimated to be £26.3 billion. This includes:

- £4.3 billion spent of healthcare costs, of which around £85 million is spent on diagnosis.
- £10.3 billion is spent on social care for people with dementia (£4.5 billion publicly funded and £5.8 billion privately funded
- The cost of unpaid care for people with dementia in the UK is £11.6 billion,

The total number of unpaid hours of care provided to people with dementia in the UK is £1.34 billion. Around £111 million is spent on other dementia costs.

Prevention

Risk factors for developing dementia are well documented [51] [52]. Established risk factors that are (or are potentially) modifiable/ preventable include:

- Hypertension
- Excessive alcohol consumption
- Smoking
- Obesity
- Diabetes
- Head injury

Up to 30% of dementia cases have a vascular component (i.e. vascular dementia or mixed dementia) and the effects of vascular dementia can be minimised or prevented altogether through a healthy lifestyle.

Early intervention

Currently only about one-third of people with dementia receive a formal diagnosis at any time in their illness [53]. When a diagnosis is made, it is often too late for those suffering from the illness to make choices.

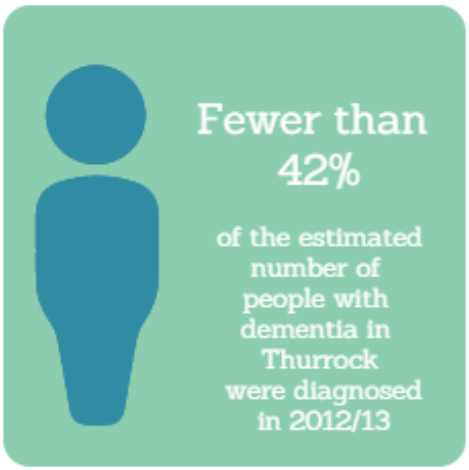
Diagnosis is not an end in itself, but a gateway to making informed personal life choices. It should provide access to a full range of treatment, including medical and psycho-social interventions, and importantly, post-diagnosis support and services. There is also strong evidence that early diagnosis and intervention can help to delay or prevent unnecessary admissions into care homes by up to 22% [54].

Diagnosis

The timely diagnosis of dementia is very important. It is the key to helping people with dementia, their families and carers get the support they need, to plan for the future and to make informed choices about how they would like to be cared for.

More needs to be done to increase the number of people with dementia being properly diagnosed. Currently less than half of the estimated number of people with dementia in England receive a formal diagnosis or have contact with specialist

dementia services. While there has been a slight increase nationally in the diagnosis rate from 46% in 2011/12 to 48% in 2012/13, the diagnosis rate varies across the country from 39% in the worst performing areas to 75% in the best.
In Thurrock this figure was 41.89% in 2012/13 [55]. Similar to the national picture, there is a wide variation in the dementia diagnosis among GP Practices in Thurrock.



The GP disease registers for dementia in 2012/13 indicates that 715 people have been identified with Dementia in Thurrock.

Currently around half of people diagnosed with dementia are in the early stages of the condition, which provides a greater opportunity for planning for the future and increased efficacy of anti-dementia drugs.

Living with dementia

Once someone has received a diagnosis of dementia there will be a range of different types of support they and their families will need. Depending on how advanced their dementia is they may need health and care support straight away. Everyone will need support, advice and help to understand what it means to have dementia, what they can do to live as well as possible with the condition and to enable them to plan for the future.

Post-diagnosis help and support includes:
- information about available services and sources of support
- a dementia adviser to facilitate access to care and advice
- peer support to provide practical and emotional support to reduce isolation and promote self-care.

Helping communities to become dementia-friendly is an important part of what we as a society can do to help support people after they have been diagnosed with dementia.

Supporting carers

The majority of people with dementia are cared for at home by a relative or friend. The average age of unpaid family carers is between 60 and 65 years, and many are much older. Given the nature of dementia, and the effect it can have, such as changes in personality and mood, carers of people with dementia can experience stress over many years of caring.

Most family carers want to be able to support the person they are caring for at home, but they sometimes need more assistance in terms of information and advice on caring for someone with dementia while also looking after their own health.

Supporting carers must become an integral part of the care and support package for people with dementia. When carers are well supported, they can provide better care for the person with dementia, leading to better outcomes for all.

The Dementia Action Alliance launched a 'Carers Call to Action' in 2013 [56] setting out goals to bring about real change for carers. It calls for a society where carers of people with dementia:

- have recognition of the unique experience of caring for someone with dementia
- are recognised as essential partners in care – valuing their knowledge and the support they provide to enable the person with dementia to live well
- have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia

The Dementia Action Alliance is approaching Health and Wellbeing Boards in England to sign up this shared vision for carers of people with dementia.

End of life care

One in three people over the age of 65 will die with dementia [57] and dementia is now one of the top five underlying causes of death. Early conversations with people with dementia are important so that plans can be made well in advance about their future care, including palliative and end of life care. All too often emotional decisions are made in a crisis when the wishes of the person with dementia, including for example where they want to die, cannot be taken into account.

Every person with dementia should receive excellent care at the end of their life and be treated with dignity and respect. More health and care professionals need to be aware of the possible alternatives to hospitalisation and having 'planning ahead' conversations with people with dementia and their families. This will allow more choice and control over their care, an improved experience and their needs and wishes respected.

Dementia Friendly Communities

People with dementia want to live in communities that give them choice and control over their lives and provide services and support designed around their needs. They also want to feel valued, understood and part of family and community life.

However, nearly half of UK adults acknowledge that public understanding of dementia is limited, and 73 % of them do not believe society is geared up to deal with the condition [57].

In response to these challenges, the Alzheimer's Society set up the 'Dementia Friendly Communities' programme in 2013 [58]. This programme sets out criteria that communities who wish to be recognised as working to become dementia friendly are expected to achieve, such as involving people with dementia, raising awareness of dementia and setting achievable goals.

In addition to Dementia Friendly Communities, the Alzheimer's Society also launched the Dementia Friends initiative, to help to change how the public thinks and feels about dementia and understand how to help people with the condition.

Dementia Friends training allows people to have the confidence to engage with people who have dementia and provides them with the skills to interact in a way that is both useful and welcome. Dementia Friends is being implemented by a network of Dementia Friends Champions who deliver short information sessions through networks of friends, workplaces and communities. The ambition is to have one million Dementia Friends by 2015.

Establishment of Dementia Action Alliances

A national Dementia Action Alliance (DAA) was established in 2010, to act as a catalyst for national action and collaboration on dementia. Since its inception it has co-ordinated action on cross cutting issues affecting people with dementia and has ensured members have committed to action plans around improving the lives of people with dementia.

Local dementia action alliances have the potential to be similarly transformative in their communities, bringing together organisations and individuals committed to taking action to support people with dementia and their carers.

Local Action

The Council has pledged its support for Thurrock to become a Dementia Friendly Community. A significant proportion of the staff who work for the Council also live in Thurrock and this provides a unique opportunity for them to be the catalyst for local change around raising awareness of dementia in the wider community.

There has been top level support for Dementia Friends training, with senior officers receiving the training as well as supporting its roll out more widely in the Council. All Members agreed a motion for Thurrock Council to work towards 'Dementia Friendly' status, and have attended Dementia Friends information sessions.

During 2014, the Council worked jointly with the Alzheimer's Society to deliver Dementia Friends sessions to all Council staff and the wider community. There are also plans to build a local Dementia Action Alliance.

The local Neighbourhood Watch have been introduced to individuals that could provide dementia friends training, thus providing existing community support networks with the tools they need to continue and better support vulnerable individuals within the communities they live.

The Council offer a range of services to help people live independently at home, including personal care services, domestic help and day care services. Residential care is also available for people with significant need who qualify.

GPs play a vital role in not only timely diagnosis of dementia but also in ensuring that well-planned and co-ordinated community services are in place to help the person once they have been diagnosed.

National initiatives to support an earlier diagnosis of dementia include:

- The introduction of a memory test as part of the assessment of NHS Health Checks in those aged 65 -74 will help to identify those people requiring further assessment in the local Memory clinic.
- Supporting people to recognise the signs and symptoms of dementia. A nationwide campaign was launched in 2012 to raise dementia awareness by encouraging people to visit their doctor if they were worried or if they wanted more information, to visit NHS Choices. The campaign reached over 27 million people.
- Supporting GPs to identify people with dementia through the use of enhanced services in which GPs ask people in certain at risk groups about their memory, for example, those with cardiovascular risk factors, people with long term neurological conditions and people with learning disabilities.

The Alzheimer's Society in Thurrock offer a range of services and activities including a Memory Group, support group for men, keep fit for younger people with dementia, information provision and awareness events, community support service, the carer information and support programme (CrISP), and one-to-one dementia support,

The Council also commissions POhWER to deliver Independent Mental Capacity Advocacy, Deprivation of Liberty Safeguards, Paid Relevant Persons Representative Advocacy Services and Community Advocacy. POhWER hold regular drop in services at the South Ockendon Centre, Corringham Library, Grays Library, Tilbury Library. POhWER has a free one-to-one advocacy service for people with dementia.

Recommendations:

- The Thurrock Health & Wellbeing Board should review the local work being undertaken to increase the proportion of people who receive an earlier diagnosis of dementia
- The Thurrock Health and Wellbeing Board should consider the specific needs of carers of people with dementia
- Develop a training programme for health and social care staff to identify dementia symptoms to ensure timely referral to specialist dementia services, including memory clinics, to facilitate formal diagnosis
- Further work is done to promote dementia friends training within the Council, with external partners and the community

Chapter 4 Maintaining Independence and Self-care

Introduction

The challenge being faced in Thurrock is one which is being faced nationally. A growing population of older people placing an increasing demand on health and social care services. While providing excellent quality services remains an important aim, preventing ill-health, maintaining independence and self-care have all become a significant focus of work to help people in Thurrock have a better quality of life in old age.

This means working in partnership with communities and statutory, voluntary and private sectors to shift resources towards preventative well-being services and community solutions to meet needs and support individuals to remain independent [59].

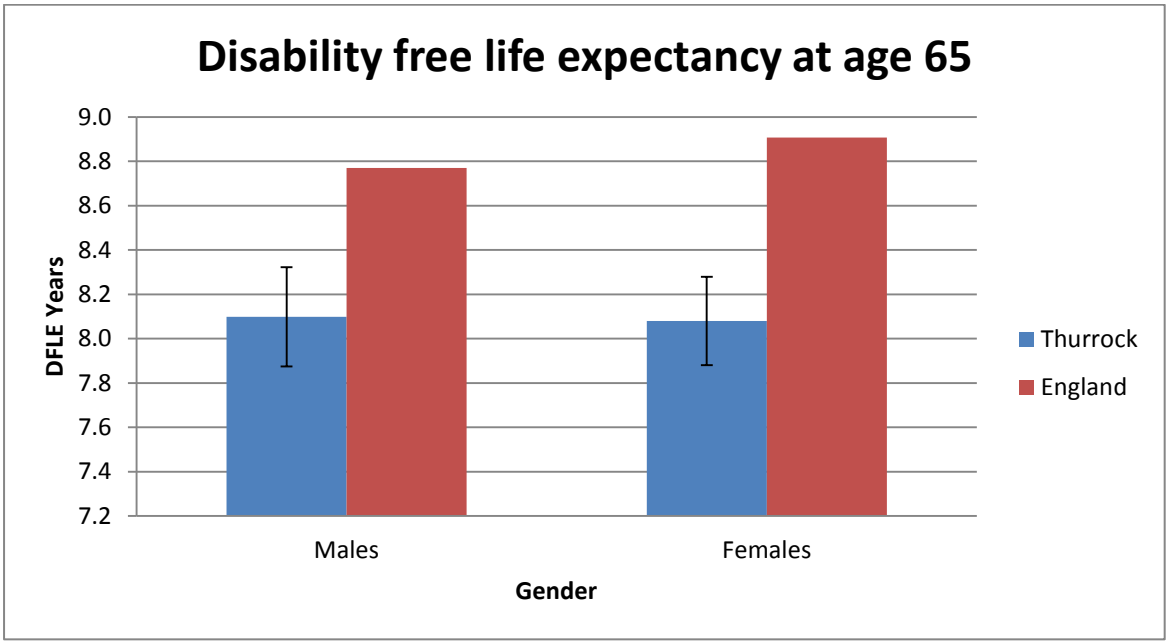
Prevention is embodied by the Care Act, approved by Parliament in May 2014. The Act establishes new duties and responsibilities on councils. The key changes include:

- New duty to provide clear information and advice to help people understand what help they can get
- New duty to promote a principle of well-being
- Stronger emphasis on prevention and focusing on people's own strengths and capabilities, and those, that may exist in the communities and networks around them to support people to live as independently as possible
- Increased rights for carers
- New minimum eligibility threshold that will determine whether people can access support from the council
- Reforms to the way in which people pay for care and an introduction of a cap on care costs

The Government has also introduced the Better Care Fund. The purpose of the fund is to use existing pooled money shared between the Council and Health (Thurrock NHS Clinical Commissioning Group (CCG)) to support integration between social care and health services to provide people with better, more holistic care and support. This fund is to help with the new duty in the Care Act 2014.

Nationally life expectancy has been increasing; however, people are not necessarily living longer in good health. This is a particular issue locally, Figure 1 highlights that disability-free life expectancy at 65 years is significantly lower for males and females in Thurrock compared to England.

Figure 1: Disability-free life expectancy at age 65 years



Source: ONS

Understanding the factors determining people's use of health and social care services can help to inform the care and support provided to people to help them live well for longer.

4.1 Hospital Admissions

Key Messages

- The main reasons for emergency hospital admissions and readmissions for people aged 65 years and over in Thurrock are urinary tract infections and respiratory problems - chronic obstructive pulmonary disease and pneumonia

Emergency admissions are unpredictable and happen at short notice [60]. Emergency admissions may represent a life event which may change the health and social care needs of an individual, and may highlight that a condition or illness had been previously identified or not managed.

Emergency Hospital Admissions

Table 1 provides a summary of the top 5 reasons for emergency admissions of people aged 65 and over in Thurrock, and their associated costs for 2013-14. Urinary tract infection caused the highest number of emergency

For people aged 65 years and over

In 2013/14:

There were 4,935 emergency admissions

The total cost of emergency admissions was £15,527,498

admissions and had the highest associated cost.

Although there were only 91 emergency admissions from fractured neck of femur in 2013/14, they accounted for the third highest level of expenditure (£559,821) for emergency admissions in older people.

Table 1: Thurrock Emergency Hospital Admission by Primary Diagnosis and Cost, People aged 65 years and over, 2013-14

Thurrock Emergency Admissions Summary by Volume		
Primary Diagnosis	**Volume**	**Cost**
Urinary tract infection, site not specified	278	£956,195
Chronic obstructive pulmonary disease with acute lower respiratory infection	190	£509,296
Lobar pneumonia, unspecified	164	£582,336
Pneumonia, unspecified	128	£445,637
Unspecified acute lower respiratory infection	120	£320,028

Source: SUS data

Emergency Re-admissions

Emergency re-admission data shows a similar picture, with urinary tract infection being the primary cause of emergency re-admission (Table 2).

For people aged 65 years and over

In 2013/14:

There were 1,175 emergency readmissions

The total cost of emergency readmissions was £3,581,989

Table 2: Thurrock Emergency Re-Admissions, by Primary Diagnosis and Cost, People aged 65 years and over, 2013-14

Thurrock Emergency Re-Admissions Summary by Volume		
Primary Diagnosis	**Volume**	**Cost**
Urinary tract infection, site not specified	57	£195,388
Chronic obstructive pulmonary disease with acute lower respiratory infection	54	£171,454
Congestive heart failure	48	£169,194
Pneumonia, unspecified	34	£107,136
Lobar pneumonia, unspecified	30	£100,846

Source: SUS data

Urinary Tract Infection

A recent review [61] highlighted that urinary tract infections (UTIs) are one of the top ambulatory care sensitive conditions (considered preventable) which disproportionately affect older people. The prevalence of UTI increases with age and this increase is seen in both sexes [62]. It is estimated that 10% of men and 20% of women over the age of 65 years have asymptomatic bacteriuria [62].

It is particularly important to promote prevention messages among patients at risk of UTI, particularly patients with continence problems. These messages include maintaining fluid intake and hygiene.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, and emphysema. It is one of the most common respiratory diseases in the UK and the main cause of COPD is smoking [63].
Local tobacco control profiles for Thurrock show that smoking attributable mortality and smoking attributable hospital admissions are significantly worse than the England average (all ages) [64]. Stopping smoking is the single most effective way to reduce the risk of getting COPD [63].

Pneumonia

Pneumonia is inflammation of the tissue in one or both of the lungs, usually caused by an infection [65]. The most common form of pneumonia is caused by the bacteria Streptococcus pneumonia, also known as pneumococcal pneumonia.
Good hygiene and a healthy lifestyle can help to prevent pneumonia and smoking can increase the chances of infection [65]. People at high risk of pneumonia should be encouraged to have the pneumococcal (pneumo) jab and an annual flu jab.

Falls

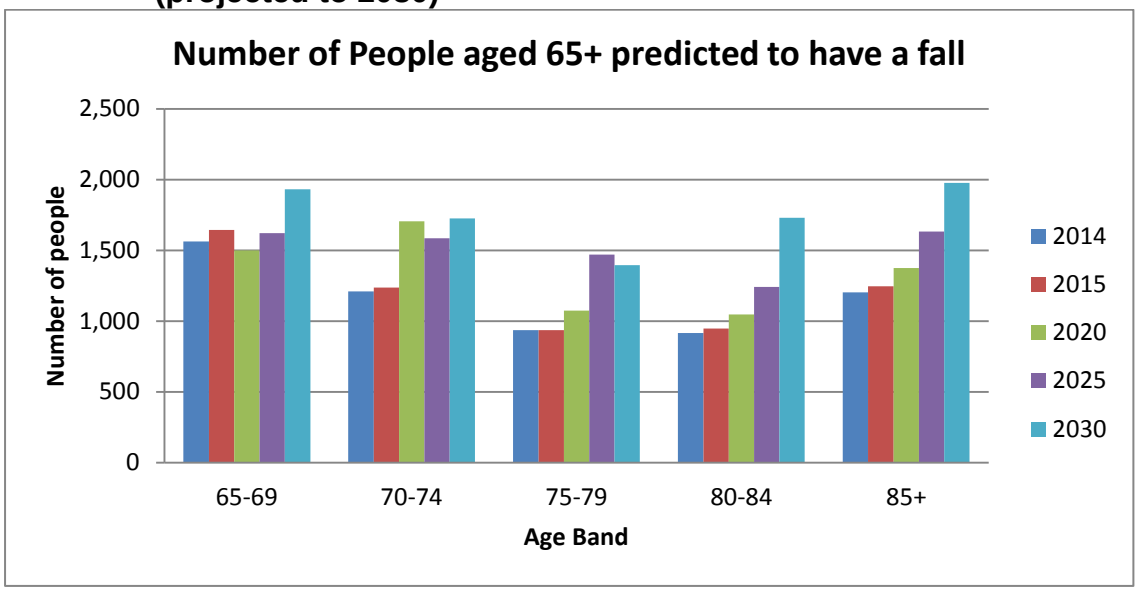
Hip fracture is the most common injury related to falls in older people and is a major cause of disability and the leading cause of mortality due to injury in older people aged 75 and over. NICE [66] report that 30% of people aged over 65 and 50% of people aged over 80 have a fall at least once a year.

Hip fractures in the elderly can lead to loss of mobility and loss of independence. For many older people it is the event that forces them to leave their homes and move into residential care. Half of those with a hip fracture never regain their former level of function and one in five dies within three months [67]. Mortality after hip fracture is high, around 30% at one year.

The annual cost to the UK Government from falls in those aged 60+ is £1 billion with the average cost of a single hip fracture estimated at £30,000. This is five times the average cost of a major housing adaptation (£6,000) and 100 times the cost of fitting hand and grab rails to prevent falls. [68].

With the predicted increase in the number of older people in the population, there is likely to be an increase in the numbers of older people who have a fall (Figure 2).

Figure 2: People aged 65 and over predicted have a fall, by age and gender, (projected to 2030)



Source: POPPI, version 9.0

It is estimated [69] that a falls prevention strategy could reduce the number of falls by 15 – 30%. NICE have issued a clinical guideline [66] on the assessment and prevention of falls in older people which recommends:

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s and considered for their ability to benefit from interventions to improve strength and balance.

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service.

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.

- In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
    - strength and balance training
    - home hazard assessment and intervention
    - vision assessment and referral
    - medication review with modification/withdrawal

There is strong evidence that [70] that regular exercise may be one way of preventing falls and falls-related fractures. Participation in a weekly group exercise programme with ancillary home exercises has been shown to improve balance and reduce the rate of falling in at-risk older people living in the community. Exercise

interventions should be acceptable to older people and sustainable in the long-term. GPs are in an ideal position to identify and support those who would derive the greatest benefit from the programmes [71].

Age UK have put together 8 Top Tips to help support older people to reduce their chance of a fall:

1. Exercise regularly – focusing on activities that challenge your balance, such as gardening or dancing
2. Ask about your medicines – certain medicines can make you feel faint or affect your balance
3. Check your eyes and hearing – problems with either could affect your balance and coordination
4. Visit your GP – if you have had a fall or are worried about falling, a
5. Vitamin D for vitality – it's essential for keeping your bones strong and the best source is sunshine
6. Count your calcium – a balanced diet rich in calcium helps to keep bones strong too, so make milk and dairy foods part of your diet
7. Check for home hazards – make sure your home is hazard free and well lit to prevent tripping
8. Look after your feet – problems with your feet can affect your balance and be sure to wear well fitted shoes and slippers.GP can help to put your mind at rest

Local Action

COPD & Pneumonia

NHS Thurrock CCG jointly worked with NHS Basildon and Brentwood CCG on a **respiratory review,** with a focus on chronic obstructive pulmonary disease (COPD) services provided within primary, community and secondary care. This identified some gaps within the existing service provision and the CCG are now working with the providers in delivering services in line with best practice guidelines.

COPD winter planning - As part of winter planning initiatives, NHS Thurrock CCG in collaboration with NHS Basildon and Brentwood CCG and the community COPD team have implemented a new model of care provision for COPD patients. Each patient seen by the COPD team receives:

- An offer of smoking cessation support services if a smoker
- Review by nurse specialist
- Offer of referral for pulmonary rehabilitation
- Review of the their COPD medication
- Review of their rescue pack/plan
- Pneumonia or flu vaccine
- Spirometry review
- Referral for oxygen assessment if relevant [72]

COPD Nurses now form a part of the Rapid Response and Assessment Service.

Falls

NELFT provide a **falls clinic** which operates from Thurrock Day Hospital. The patient is assessed for various risk factors relating to falls including cardiovascular, neurological and cognitive examination, medication review, vision assessment, osteoporosis risk assessment, strength, balance and mobility assessment, functional assessment and home hazards.

A **Falls Group Programme** operates within Thurrock and Brentwood Day hospitals. This once weekly, ten-week programme includes education and exercises to help improve an individual's strength and balance to reduce the risk of falls.

Public Health commission a **pilot exercise referral scheme** which includes a referral pathway for older people. Activities include chair based exercise, swimming, and strength and mobility based exercise programmes. The focus of the programme is the reduction of falls.

Under the Better Care Fund programme there has been further development of a **comprehensive falls prevention programme** that provides multidisciplinary assessment, a programme of falls risk reduction (including exercise programmes, adaptations, prescribing interventions etc.) and on-going follow up. This will target patients that have experienced falls to reduce risk of recurrence, in addition to those identified as at risk by primary care and acute and community services.

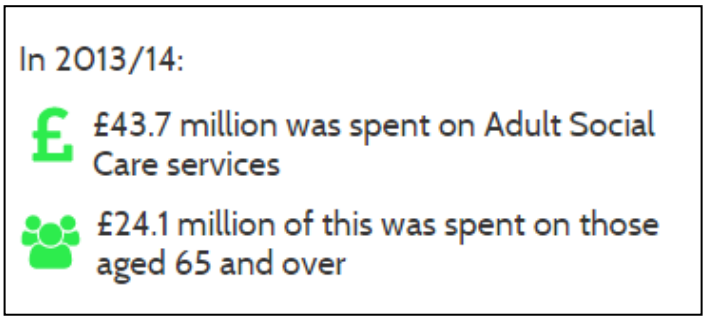
The **Well Homes project** which works with private sector housing, includes the identification and rectification of trip hazards.

4.2 Use of Social Care

Key Messages:

- **5% of older people receive reablement services after leaving hospital (excluding NHS reablement)**
- **Nearly 90% of older people are at home 91 days after leaving hospital into reablement**
- **Referrals to adult social care from secondary care are increasing**

The use of social care differs according to the presence of certain long-term conditions. For example people with mental health problems, falls and injury, stroke, diabetes and asthma tend to use local-authority funded social care more; those with cancer appear to use relatively less [73].



The Adult Social Care Outcomes Framework looks at how social care is performing across the country. Overall, Thurrock has similar or better outcomes in comparison to England, Eastern region, and similar local authorities.

Source: [59]

The number of permanent admissions to residential and nursing care homes can be used as a measure of the effectiveness of care and support in delaying dependency on care and support services. Reablement or rehabilitation services seek to support people, in order to minimise their need for on-going support and to maximise their independence [74].

Supporting people to achieve and maintain independence at home through effective discharge from hospital into reablement services is a priority for Thurrock. Overall, Thurrock performs well with 89.9% of people discharged into these services still at home 91 days after their intervention.

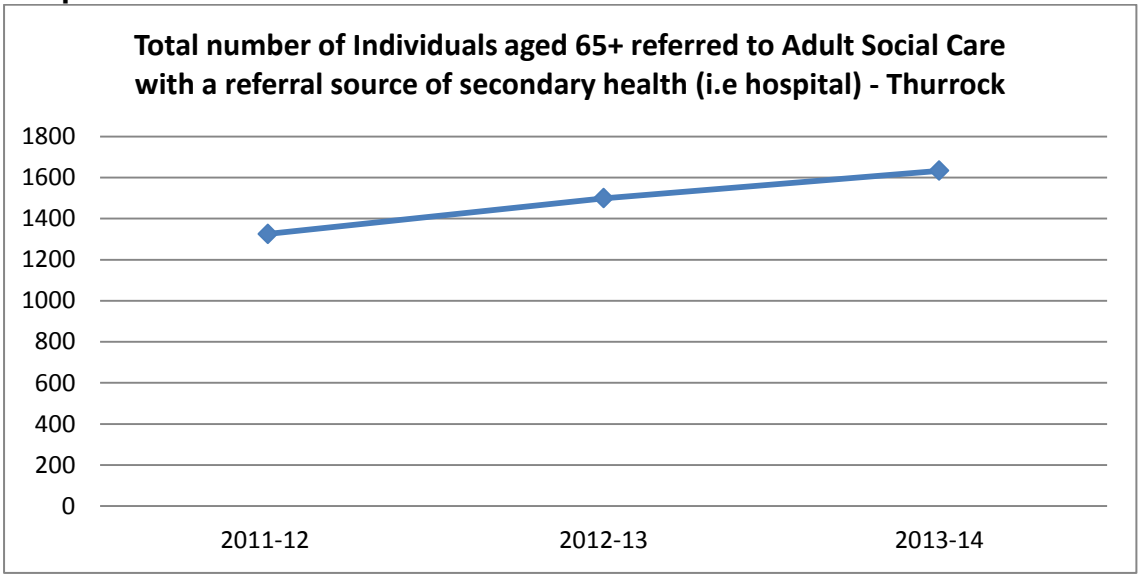
Table 3: Adult Social Care Outcomes Framework indicators relating to supporting people to maintain independence.

Permanent admissions to care homes in people aged 65 years and over	623.4 per 100,000
Older people who are at home 91 days after leaving hospital into reablement	89.9%
Older people receiving reablement services after leaving hospital (Social Care only, excludes NHS reablement)	5%

Source: HSCIC, 2014

A recent review looking at older people with complex needs highlighted that important service-level design elements of care for older people with chronic and multiple conditions include holistic care assessments, care planning, a single point of entry, and care co-ordination. Successful models also demonstrated effective working with individuals and informal carers to support self-management. Personal contact with a named care co-ordinator and/or case manager was also shown to be more effective than remote monitoring or telephone-based support [8].

Figure 3: Referrals of patients aged 65 years and over to social care from hospital.



Source: Thurrock Council Referrals to Social Care

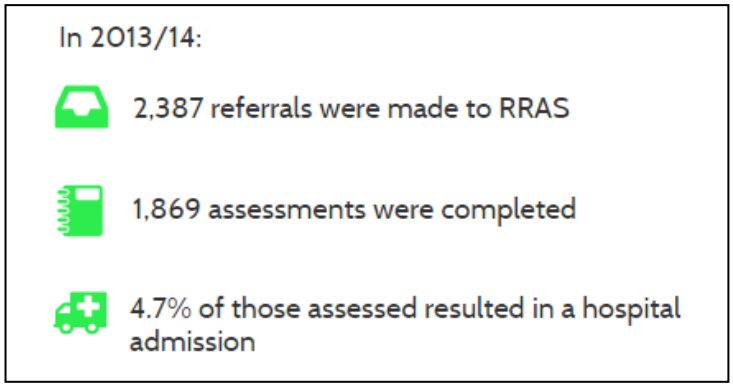
Figure 3 shows that there has been a steady rise over the last three years in those aged 65 and over being referred to adult social care from a secondary health source i.e. hospital. There were an additional 300 referrals in 2013/14 compared to 2011/12, which equates to a 23% increase.

Local Action

Under the **Better Care Fund** the Council and Thurrock Clinical Commissioning Group (CCG) have established a Whole System Redesign Project Group as part of their Health and Social Care Transformation Programme. Guided by data and intelligence and patient and service user experience, the Group is reviewing how and what requires redesign, with the focus on reducing hospital and residential home admission for adults aged 65 and over.

Thurrock's strategy to ensure people age well focuses on solutions – recognising that a service response is not the only response. Our ageing well strategy is known as **Building Positive Futures** and has a number of strands:

- Create the homes and neighbourhoods that support independence;
- Create the communities that support health and wellbeing; and
- Creating the social care and health infrastructure to manage demand.



The Council and NHS already work closely in a number of areas linked to reducing admissions for the over 65s. This includes the **Rapid Response and Assessment Service** – an integrated service between adult social care and the NHS community health

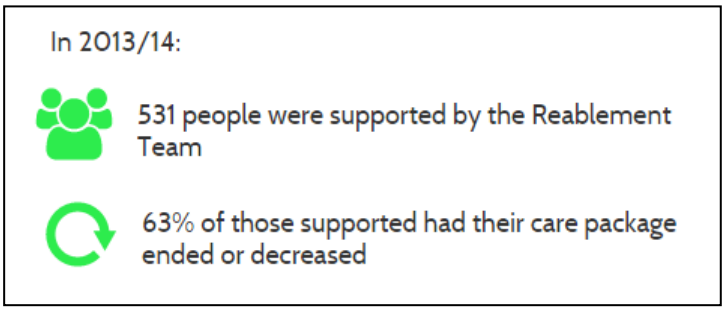
provider aimed at identifying individuals who are at risk of hospital admission and preventing that admission. The service relies heavily on GPs recognising those at risk and linking in to the service.

The Council, in partnership with Thurrock CCG, also has an integrated **Joint Reablement Team** with the NHS community service provider aimed at preventing readmission to hospital through the provision of a 6 week support for people to regain skills or mobility after a period of illness or hospital admission.

Telecare and **assistive technology** services are designed to enable independence for disabled and older people. In Thurrock, Careline is an emergency home alarm system that runs 24 hours a day, 365 days of the year. It is available for all tenants in Thurrock who are elderly, disabled, vulnerable or suffering from a chronic sickness.

The Council also provides i**nterim beds** in a Council-run care home in Corringham, which is a short-term service to help people regain their independence after an illness or hospital admission. Interim extra care flats are also available. In 2013/14 30% of people were able to return home from interim beds.

Under the **Better Care Fund** a number of projects, including a joint frailty model to enhance services for people with complex needs (including dementia and frailty) are currently being developed [59].



4.3 Long term conditions

Key Messages:

- **58% of people aged over 60 have a long term condition**
- **People with long term conditions are the most intensive users of health and social care services**
- **The NHS Health Check presents an opportunity in mid-life for checking risk of disease and offering action which could prevent ill health, or risk factors from getting worse, particularly in older age.**

A long term condition is a condition that cannot presently be cured, but can be controlled by medication and /or other treatments and therapies [75]. There is no definitive list of long term conditions (LTCs) and the term can refer to a wide range of conditions including chronic obstructive pulmonary disease (COPD), diabetes, asthma, coronary heart disease (CHD), hypertension, neurological conditions, musculo-skeletal conditions and arthritis.

It is estimated that 15.4 million people in England (over a quarter of the population) live with a long term condition [76]. This figure is predicted to increase by nearly 17% to 18 million by 2025 [76].

"People with long-term conditions now account for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days." [76] [75]

In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs [75].

Long term conditions are more prevalent in older people. Approximately 14% of people aged under 40 have an LTC, compared with 58% of people aged over 60 [75]. The population of people aged 65 or over is set to increase and services will be put under pressure by the growing population of older people with an LTC. Services will need to radically change if they are to meet their clients' needs effectively. There will also be increased pressure on informal carers, many of whom are older and in poor health themselves.

Long term conditions are also more prevalent in more deprived groups. People in the poorest social class have a 60% higher prevalence than those in the richest social class, and 30% greater severity of disease [75].

In addition, an increasing number of people have what is termed 'multi-morbidity' i.e. two or more long term conditions, which makes the delivery of their care more complex [77]. Although the prevalence of multi-morbidity increases with age, more than half of all people with multiple long term conditions are younger than 65 years [77]. Care for people with multi-morbidity can be complex and become fragmented, as they will often see a number of different specialists to manage their individual long term conditions.

Some combinations of conditions are more common than others, in particular physical and mental health co-morbidity is very common. Many people with physical long -term conditions also experience mental health problems such as anxiety and depression. People with mental health problems are also more likely to have poor physical health.

The prevalence of long term conditions can be derived from a number of sources. A key source of information that can be used to assess local prevalence is the Quality and Outcomes Framework (QOF). This is a major part of the General Practice (GP) contract to secure better health outcomes by early, systematic and sustained monitoring and treatment of people with risk factors and long term conditions.

Data on various health conditions is collected from specific GP disease registers and entered onto a national IT system, known as QMAS. The number of people on GP disease registers in Thurrock is shown in Table 4.

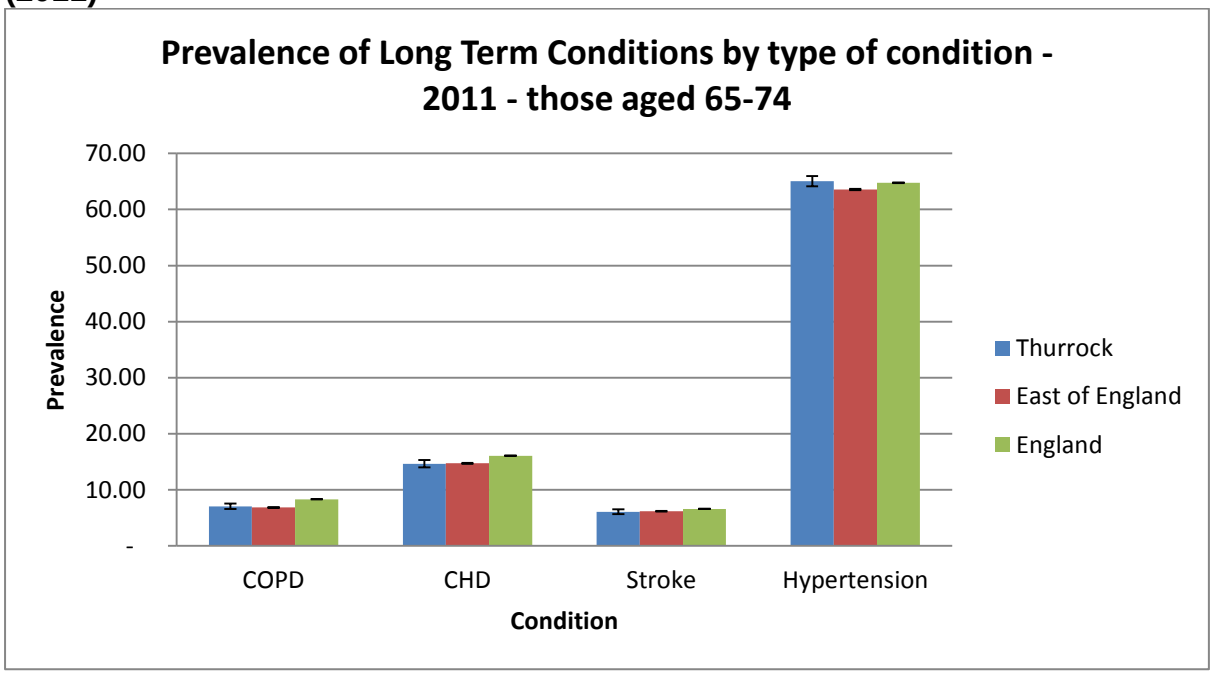
Table 4: Number of people on GP disease registers in Thurrock with a long term condition in 2013/14 (People aged 16 and over)

LTC	Thurrock		Midlands & East of England	England
	Register Size	Prevalence %		
COPD	2989	1.8	1.77	1.78
Obesity	14691	11.3	9.86	9.42
Cancer	2762	1.66	2.17	2.1
CKD	5304	4.22	4.21	4
Diabetes	7901	6.18	6.53	6.21
Dementia	715	0.43	0.62	0.62
Depression	9339	7.42	6.8	6.52
Mental Health	1119	0.67	0.8	0.86
CHD	4497	2.71	3.36	3.29
CVD	5362	3.23	2.89	2.81
HF	1103	0.66	0.75	0.71
STIA	2469	1.49	1.75	1.72

Source: Quality and Outcomes Framework (QoF)

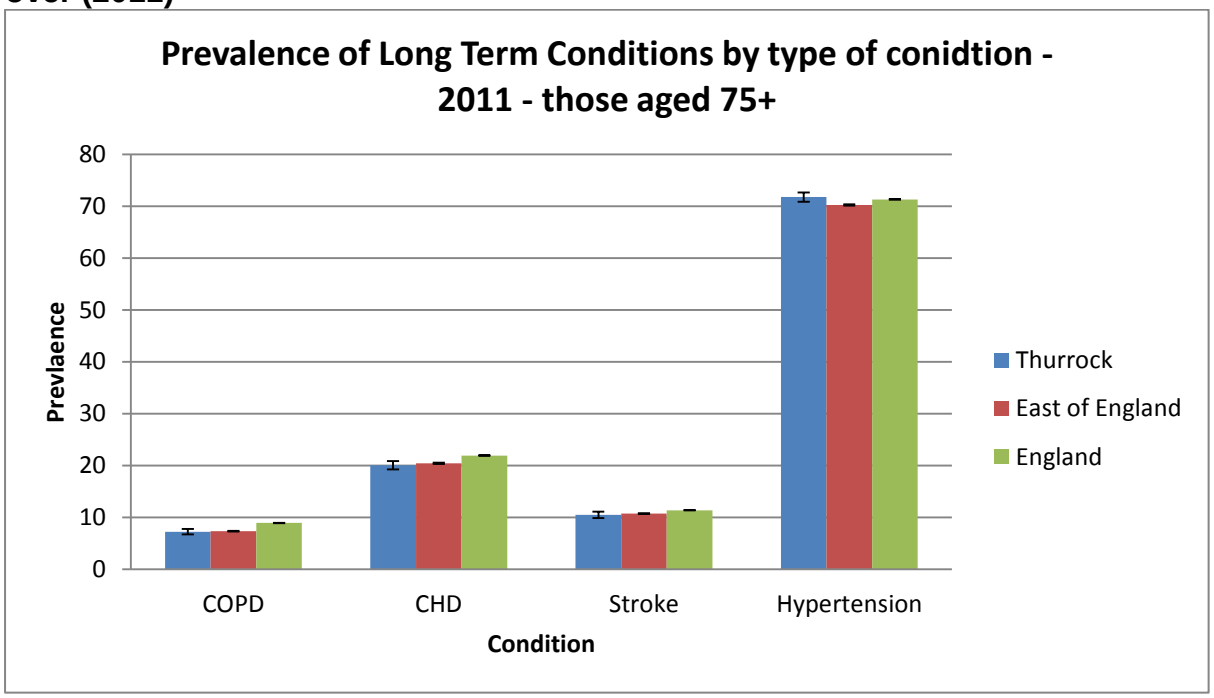
Modelled estimates of long term conditions based on local demographics for those aged 65-74 years (Figure 4) and those aged 75 years and over (Figure 5) indicate that the prevalence of these diseases is not significantly different to the national average.

Figure 4: Modelled Prevalence of Long-Term Conditions in people aged 65-74 (2011)



Source: ERPHO

Figure 5: Modelled Prevalence of Long-Term Conditions in people aged 75 and over (2011)



Source: ERPHO

As with all complex health issues there is no simple solution to the challenge of long-term conditions, but there is a growing consensus that better outcomes can be achieved by a whole system approach with a combination of:

- "upstream action" to reduce risk factors such as smoking, high blood pressure , physical inactivity, poor diet, obesity, poor mental health and alcohol
- improved access to preventative health care and to early diagnosis
- a shift from "giving care" to a system of self-management , reablement and independence
- development of an integrated model of care delivery

The new public health, health and social care system was established in 2013, with a focus on improving outcomes. In the same year, the Secretary of State for Health set out a challenge for the public health, health and social care system in his document, *Living Well for Longer: A Call to Action to Reduce Avoidable Premature Mortality* [19]. The challenge was to:

- to reduce the rate of premature avoidable deaths, and
- to improve quality of life by prevention, early diagnosis and treatment [19]

The Kings Fund [78] report that less than one in four people over 75 self-report receiving any support or advice in preventing further falls or progression of osteoarthritis or in managing their own diabetes, despite a growing focus on supported self-management for people with long-term conditions.

The Government has given local authorities new statutory duties to improve public health with protected resources through a ring-fenced budget. The local authority

and its partners on the Thurrock Health and Well-being Board have assessed need and agreed priorities for action, which are set out in a series of ambitions in its Health and Well-being Strategy.

The new responsibilities for local authorities are complemented by a shift in focus in the NHS from treating ill-health to improving health through prevention and early intervention. Thurrock CCG has developed a 5-year system plan on how this will be achieved by investing in community and primary care services and moving from reactive to proactive disease management.

Prevention of long term conditions - lifestyle behaviours

Most long-term conditions are multifactorial i.e. they do not have a single cause, but result from a complex interplay of genetic, environmental and lifestyle factors across the life-course.

There is a strong link between unhealthy lifestyle behaviours such as smoking, inactivity, poor diet, and alcohol intake, and some of the most prevalent and disabling LTCs:

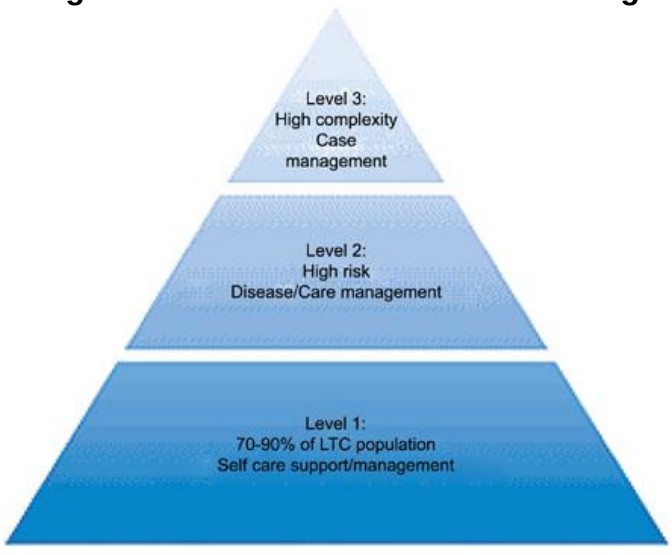
- vascular disease such as coronary heart disease, diabetes, chronic kidney disease
- some cancers e.g. lung and bowel
- respiratory disease such as chronic obstructive pulmonary disease (COPD)

By modifying behaviour i.e. making changes in lifestyle, or by active management with drug treatment or other therapies, some LTCs may be prevented or their impact on health reduced.

Risk prediction and stratification

There is a strong evidence base for what works to improve outcomes in people with LTCs and this has been developed into a generic model to assist clinicians in planning care, commissioners planning services, and local health and social care partnerships in identifying levels of need in the population [79].

Figure 6 The NHS and Social Care Long-Term Conditions Model



The model stratifies the population using a risk prediction approach to help commissioners quantify levels of need and then design services to provide appropriate levels of care and support. Figure 6 shows that approximately 5% of people in a population have complex needs, around 25% have a moderate level of need, and around 70% have a low level of need.

Source: Department of Health

Building on this approach it is important to identify individuals in the population that have complex needs, as this group will be at particular risk of acute episodes of illness, and will be more likely to require higher levels of primary care and/or hospital admission. Proactive and anticipatory strategies can be put in place for these individuals to help them retain their independence and avoid hospital admission, and if a period in hospital is needed, to ensure timely rehabilitation and reablement after a period of illness.

Similarly identifying and engaging with those people with long-term conditions who have moderate or low levels of need, gives the opportunity to promote prevention services, self-management and self-care skills, national and local support groups and access to high quality information on their long term condition.

Local Action

Early Diagnosis and Early Intervention

The **NHS Health Check programme** aims to help prevent coronary heart disease, stroke, diabetes, chronic kidney disease, and certain types of dementia.

Everyone between the ages of 40-74, who has not been previously diagnosed with one of these conditions or has certain risk factors [80] are invited (once every five years) to have a check to assess their risk of vascular disease and given support and advice to help reduce or manage that risk.

The programme is an important part of ensuring that individuals stay healthy for longer by identifying any potential underlying conditions. Vascular disease accounts for about 66,000 deaths each year in people aged under 75 years. With age, the risk of developing these diseases increases.

All of these diseases are also linked by a common set of risk factors, some of which we cannot change, such as age, gender, ethnicity and family history. However, many of the risk factors are things that we can change, including being overweight, our diet and physical activity levels, smoking, blood pressure and cholesterol [81].

The evidence suggests that it is especially important to take action to address these risk factors in middle age i.e. from 40-60 years, as the lifestyle choices made at this time can have a marked impact on health in later years. For example by maintaining a healthy weight, taking regular physical activity and by managing blood pressure and cholesterol from age middle age onwards an individual can reduce their risk of cardiovascular disease and cancer, but can also reduce their risk of developing dementia by up to 20% [82].

As well as reducing risk of chronic disease, improving lifestyle can also impact on other aspects of health in old age including functional ability, mobility, general wellbeing and overall quality of life. [83]

Following on from the health check, participants will be referred to their GP if required and informed about how they can make important lifestyle changes to reduce their risk of developing life-altering disease.

In 2013/14, over 5,900 people in Thurrock received a health check of which 13.9% were aged 65 or over.

Local Action

A borough wide program of NHS health checks is undertaken by Vitality (commissioned by Thurrock Council Public Health with North East London Foundation Trust) through GP practices and outreach events.

Workplace health checks are also promoted and supported through local businesses. This includes Thurrock Council as a large employer of people who reside in Thurrock.

Signposting and referral is provided following the health check to the relevant service e.g. Stop Smoking Service, exercise on referral, and weight management programmes. GPs are notified of any clinical outcomes which might need further investigation (e.g. high blood pressure or cholesterol).

Blood Pressure Programme - High blood pressure affects around 30% of adults in England, over five million are undiagnosed and around 40% of those in treatment are not well 'controlled' i.e. <140/90mmHg. A new area of work being developed by Public Health England is a Blood Pressure Programme with a systematic approach to preventing, detecting and better managing hypertension.

Primary Care Management of Long Term Conditions

General practice has changed dramatically over the last decade and patients who would have previously needed hospital referral and follow up are now managed in primary care. The maintenance of disease registers of patients with a range of long term conditions play a key role within these primary care long term condition management services. These registers enable the primary care team to improve the quality of care offered by ensuring the regular, systematic monitoring of people with long term conditions.

As a part of the Better Care Fund new ways of working between primary care, public health and social care are being explored to prevent emergency admissions in those aged 65 years and over. This will also look at closer working with care homes.

Community Based Care and Resources

Thurrock Clinical Commissioning Group and Thurrock Council commission an integrated health and social care **Rapid Response and Assessment Service**. This service is discussed in more detail in the Social Care Use section.

Primary Care Multi-Disciplinary Team (MDT) meetings are established across GP practices in Thurrock to discuss and review patients identified as vulnerable and at risk of admission to hospital. The meetings include Primary Care, Community, Mental Health and Social Care providers to create a personalised care plan that responds to the patient's circumstances and conditions [72].

Integrated Community Geriatrician - Utilising the expertise of Consultant Geriatricians within a community setting, Community Geriatrician-led MDT reviews (escalation of primary care MDT reviews and enhanced community hospital bed criteria *and* Care Home MDT reviews help to improve health outcomes for patients in residential and nursing homes.

Community matrons and **condition specific services** are provided by NELFT within the Thurrock area.

Community matrons manage people with long term conditions who have complex clinical problems and/or social needs, and those at risk of re-admission to hospital. The majority of patients accessing the service are aged 65 and over.

Condition specific services offered in the community include a COPD team, Diabetes Specialist Nursing, Heart Failure service and a Stroke Hub team.

There is increasing interest in using **assistive technology** to help provide care and support for older people and those with LTCs.

The Department of Health has estimated that at least three million people with long-term conditions could benefit from telehealth and telecare. The DH funded a randomised control trial of telehealth and telecare focused on three conditions: diabetes, COPD and coronary heart disease. The trial showed that if used well across a whole system, technology can reduce the need for hospital admissions for people with LTCs, and the amount of time they spend in A&E.

Telehealth is electronic equipment used to read a person's vital health signs including pulse, weight, respiration and blood oxygen levels. These measures are then automatically transmitted to a clinician or monitoring centre, where staff can observe the person's health status without the person having to leave home. Staff examine the readings every day to check whether a person's condition is getting worse and whether action should be taken to help them [84].

The use of telehealth locally has contributed to a reduction in acute admissions [85].

Complex Social Work team also support people with long-term and complex conditions, working with health to ensure needs are met.

Self-care

The **Prevention and Early Intervention Scheme**, as a part of the Better Care Fund, aims to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health and social care system [85].
This model will also interface with the risk stratification of Thurrock residents, encompassing physiological and social indicators, to ensure targeted promotion and uptake is facilitated.

As part of Thurrock's vision for **Building Positive Futures,** from June 2013 Local Area Coordinators (LAC) have been introduced to Thurrock. Their role has since been developed to discuss with individuals their general health and wellbeing, and to promote public health initiatives to help people stay well.

Another aspect of LAC has been to build more inclusive communities that are great places to grow old in. The LACs has worked within the community to support them in various ways, including, setting up groups that are aimed at the over 65 age group and linking them with small sparks funding and providing assistance where possible.

Feelings of loneliness can turn to depression, and some older people may stop looking after themselves properly. We are actively working with our communities to identify what types of wellbeing activities could be delivered in their communities. Activities being identified are gardening clubs, walking clubs, tai chi, yoga, allotment and gardening clubs, gentle exercise and chair based exercise. Some of these services will be developed in local communities this year.

4.4 End of Life Care

The General Medical Council [86] define that people are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent, i.e. expected within a few hours or days, and those with:

- advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events. [86]

End of Life Care Profiles published by Public Health England, look at both the place of death and the causes of death to specific age groups at local levels, and calculate the proportion of deaths attributable to cancer, cardiovascular disease, respiratory conditions or other causes. In 2014, the Thurrock CCG End of Life Care profile [87] highlights that a significantly higher proportion of deaths occur in hospital and a significantly lower proportion of deaths occur in a care home or a hospice.

The profile shows that the proportion of deaths attributable to cancer was significantly higher than the England average. Deaths from cardiovascular disease (CVD) and respiratory disease are similar to the England average. However, Thurrock has a statistically higher proportion of deaths due to CVD in males aged over 65 years and for respiratory conditions in males aged 85 and over.

The provision of end of life care is becoming increasingly complex, with people living longer and the incidence of frailty and multiple conditions in older people rising. Information on peoples' wishes is often not captured or shared and a lack of services to support them at home may lead to unplanned and unwanted admissions to hospital.

Dignity at the end of life is a subjective concept. However, there are certain fundamental principles that are deemed essential to the maintenance of a dying patient's dignity, e.g. holistic assessment and care, privacy, symptom control, provision of choice and psychological and spiritual support.

End of life registers support healthcare staff in working with patients to put plans in plans for their care at the end of life. The registers can also record preferences such as place of death for those patients approaching end of life.

Around 1% of patients per GP practice die each year [88]. The National End of Life Strategy [89] encourages GPs to identify this cohort of patients and ensure they are included on a palliative care register, and to predict how many people may still need to be identified within their practice population as approaching end of life.

Local Action

The **One Response Support, Assessment & Advice Service** (provided by NELFT) was launched in November 2014 with the aim of coordinating palliative and end of life care services across South West Essex. Patients, carers and other family members as well as professionals will have one number to ring to address new and existing problems.

The end of life care service offers a range of services to support both individuals nearing the end of their lives and the people that are important to them. The end of life care team also provides education, information and support for health and social care providers.

The **Community Macmillan palliative care** team offers specialist palliative care assessment, advice, support and symptom management for those in our community with life limiting illness and complex needs.

The **Macmillan specialist occupational therapy** team offers specialist assessment for people affected by life limiting illness who need occupational therapy support. The team liaise with other professionals to ensure that people have access to appropriate resources at the end of life. This may include accessing specialist equipment.

Recommendations:

- Review current provision related to falls prevention and develop a comprehensive cost-effective falls prevention programme in Thurrock focused on early detection, management and treatment of risk factors that lead to falls in the elderly
- Work with our wider health and social care partners and our communities to support self- care of long term conditions
- Work is undertaken with health and social care to raise awareness of services to support end of life care, including greater use of end of life registers and supporting patients around choices such as preferred place of death

Chapter 5 Carers

Key Messages:

- 45% of carers aged 65 and over are providing a minimum of 50 hours of unpaid care per week.
- In Thurrock, around 300 carers aged 65 and over have been identified.
- Caring responsibilities can have a negative impact on the health and well-being of carers
- Older carers in Thurrock report a significantly better quality of life compared to the national average

Introduction

"A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support." [90]

In the 2011 Census 6.5 million people in the UK identified themselves as a carer, compared to 5.8 million people in 2001. It is estimated that 3 in 5 people will become carers at some point in their lives.

The majority of carers are of working age and the peak age for caring is 50-64. However, the number of carers over the age of 65 is increasing more rapidly than the general carer population. Whilst the number of carers nationally has risen by 11% since 2001, the number of older carers rose by 35%.

The duties, whether recognised as caring or not, can include a wide variety of activities. The Carers UK State of Caring Survey 2014 showed that:

- 93% provide practical help such as preparing meals, doing laundry or shopping.
- 87% provide emotional support, motivation or keeping an eye on someone either in person or by phone.
- 85% arrange or co-ordinate care services or medical appointments.
- 83% manage paperwork or financial matters for the person they care for.
- 71% provide personal care like help with washing, dressing, eating or using the toilet
- 57% assist the person they care for with their mobility – getting in and out of bed, moving around or getting out of the house.

[91]

Under the Care Act 2014 carers are placed on an equal footing to the person they are caring for and that they are entitled to an assessment, information and advice and where required support and services [92].

One of the biggest issues is identifying carers, as many carers may not identify themselves as one, and therefore may not have an understanding about what support is available to them or the people they are caring for.

Data from the Care and Information Advice Service (Cariads) in Thurrock confirms that there are approximately 300 carers over 65 known to them at the moment, which represents 25% of the carers identified in Thurrock.

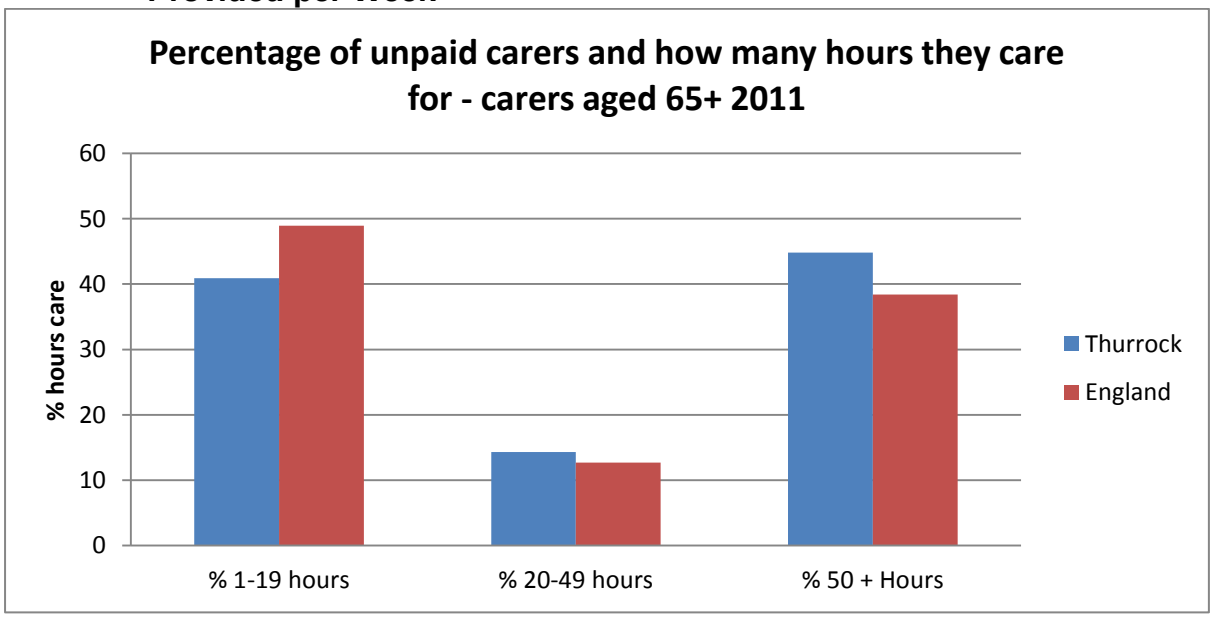
Although for many the experience of providing care can be rewarding, the consequences of caring can have detrimental effects on physical and mental health [93].

The Carers UK (2014) Carers Manifesto reported that:

- Full-time carers are more than twice as likely to be in bad health as non-carers
- 80% of carers say caring has had a negative impact on their health
- Half of carers say they have experienced depression after taking on a caring role
- 61% of carers say they are at breaking point

[94]

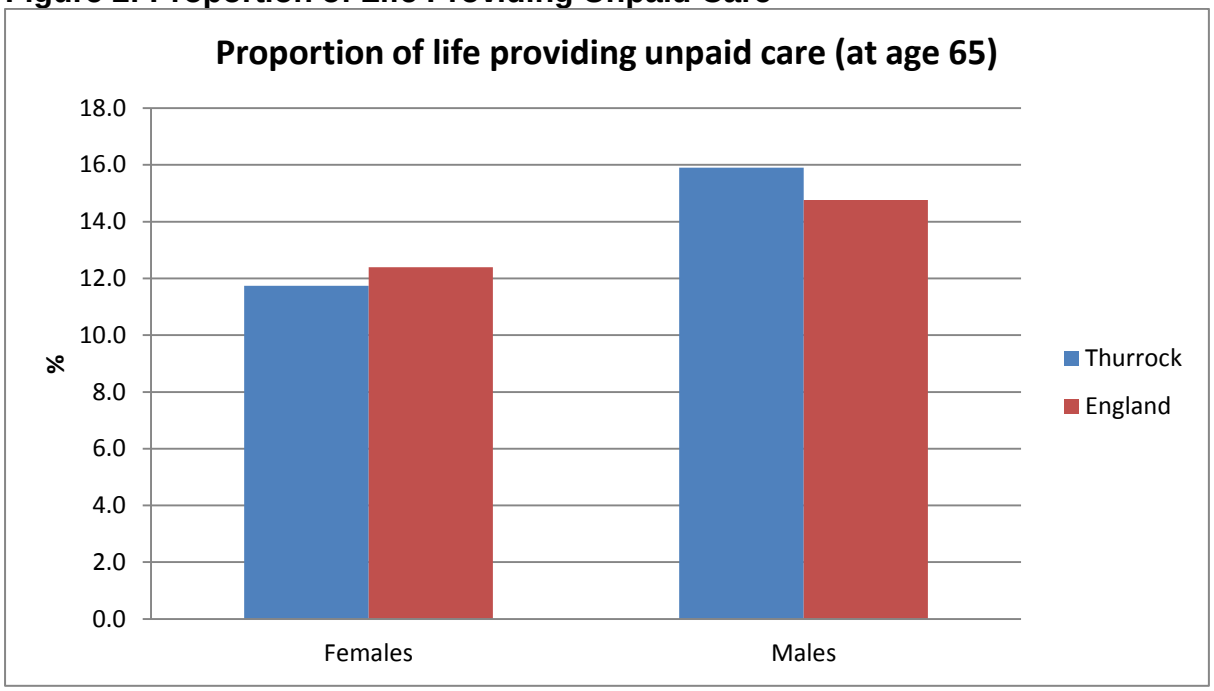
Figure 1: Unpaid Carers Aged 65+ years and Number of Hours of Care Provided per Week



Source: ONS

Figure 1 shows that of those carers aged 65+ that provide some level of unpaid care, just over 40% provide between 1-19 hours of unpaid care and around 45% provide 50+ hours of unpaid care. Almost half of unpaid carers in Thurrock aged 65+ are providing 50+ hours of care, which is higher than the England average.

Figure 2: Proportion of Life Providing Unpaid Care



Source: ONS

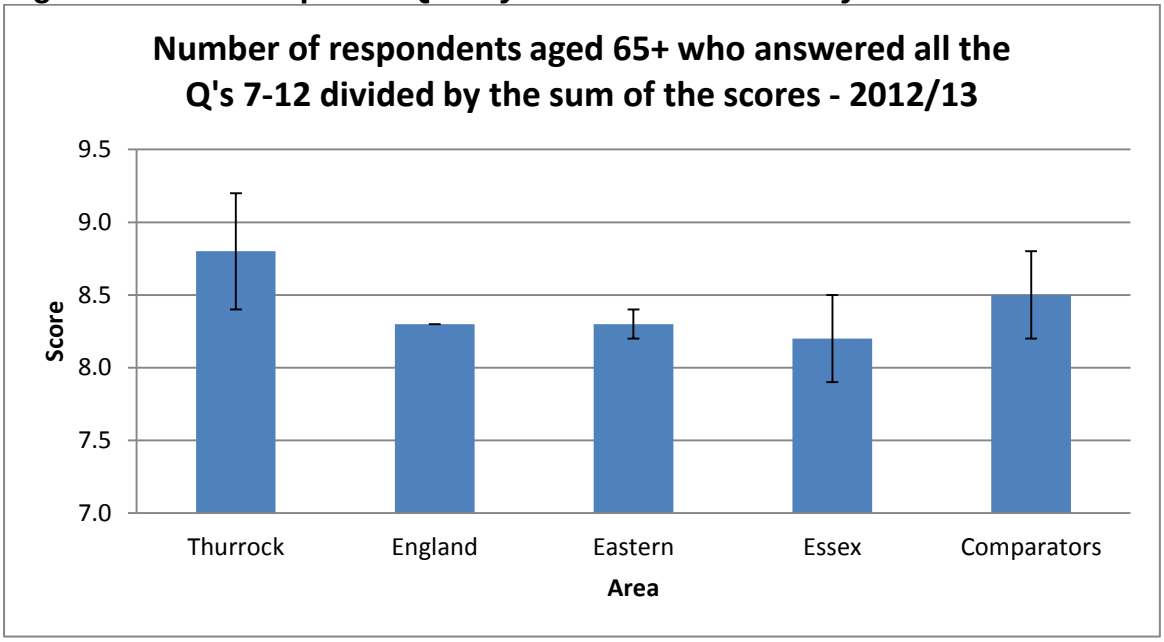
Figure 2 shows the proportion of life that is expected to be spent on unpaid care at age 65. It can be seen that in females the percentage (11.7%) is slightly lower than that of England overall (12.4%) but for males in Thurrock it is slightly higher (15.9%) than the England average (14.8%). In Thurrock, it is estimated that females at the age of 65 will spend 2.4 years providing unpaid care and males 2.9 years.

Supporting carers has the following benefit for health and social care systems:

- Delayed admission to residential care
- Delayed uptake of social care
- Reduced hospital admissions
- Carer is able to remain in employment / reduction in likelihood of reduced working hours
- Savings from improving carer (physical and mental) health and subsequent reductions in their use of health and social care systems

Figure 3 shows the results from the Carers Survey 2012-13 [95] for the Adult Social Care Outcomes Framework indicator on the Carer reported quality of life. This shows that Thurrock residents aged over 65 who are carers report a significantly better quality of life compared to the national average.

Figure 3: Carer Reported Quality of Life: Carers Survey 2012-13



Source: HSCIC, 2013

Local Action

The Care Act 2014 ensures that local authorities identify carers early on and are well-informed about what support is available to them through information and advice.

The Thurrock Carer Strategy 2012-2017 and sets out how carers will be supported to maintain their own health and well-being through a range of health-promoting schemes, including therapy and training sessions, group and individual support.

Thurrock Council commissions Carers Information and Advice Services (Cariads), a dedicated information and advice service for carers. Three voluntary sector providers are commissioned to provide the service - MIND, Independent Living and Thurrock Lifestyle Solutions.

The service supports access to day care for older people, care home respite beds and a sitting service, all designed to give the carer a break and/or allow carers to look after their own needs (for example health appointments or short breaks). The service also provides counselling support and access to a number of support groups such as the all Carer Support Group, the Mental Health Support Group and the Art and Craft Group.

Of the 300 carers aged over 65 identified by the service, around 1% has accessed support groups, nearly 7% over 60 have accessed counselling services and a high number have accessed training, particularly dementia awareness and power of attorney.

People who are in receipt of a carer's allowance, or those who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill are

eligible for a free flu jab under the Influenza Immunisation Programme. Carers' taking up their flu jab is an important factor in protecting the health of the people they are caring for during the winter period.

Recommendations:

- Continue to support carers to access services offered by statutory and voluntary organisations
- Health and well-being services are promoted to carers through the Carers Information and Advice Service

Appendix 1 Update on Recommendations of 2013 Annual Public Health Report

Recommendation	Update
Work with Thurrock schools to commission evidence-based interventions to improve children and young people's health, for example healthy eating and physical activity programmes.	A number of projects and initiatives have been commissioned to increase healthy lifestyle behaviours in children and young people, including 'Beat the Street' to increase physical activity and work with the School Food Trust on healthy eating. A new model of school nursing will be offered in schools in 2015 to enhance support for emotional wellbeing and children's weight management
Undertake a value for money exercise for tobacco and weight management public health programmes in 2013/14	A benchmarking exercise with CIPFA comparator authorities was undertaken on children's and adult weight management, which has led to a new community commissioning model for these services in 2015/16. Work has been undertaken with the current provider of stop smoking services to look at developing a more prevention focused model. Further work will be undertaken in this area in 2015/16.
Produce a new Joint Strategic Needs Assessments (JSNA) to include Assets working through the JSNA Delivery Group	A new format for the JSNA refresh has been agreed, to include information on assets. A JSNA chapter on local demography and a Children and Young People's JSNA have been produced.in 2014/15.
Review seasonal mortality rates in Thurrock and produce recommendations on reducing excess deaths	The current data confirms that excess winter deaths have fallen in Thurrock. There are mechanisms to inform vulnerable groups about Met Office weather warnings. A cold weather action plan and heatwave plan have been produced.
Continue to work with all directorates within the council to embed public health principles.	Members of the Public Health Team are linked to each directorate in the Council and attend their key senior management team meetings. The Public Health Strategy Board has been established with cross departmental members, this Board reports into the Health and Wellbeing Board
Develop a Healthy Weight Strategy in 2014	A Thurrock Healthy Weight Strategy has been completed.
Develop a Tobacco Control Strategy in 2014	A draft Thurrock Tobacco Control Strategy has been developed and will be completed in 2015.

Recommendation	Update
Develop a Public Health Responsibility Deal for Thurrock Council and across local businesses.	A Public Health Responsibility Deal is in place for Thurrock Council, with a key focus on workplace health. Further work will be undertaken to develop a Thurrock Public Health Responsibility Deal for local businesses.
Review the needs of the local population in recognition re changing demography of Thurrock and need to look at health needs within the BME community	The demography chapter of the JSNA has been completed, which identifies the local population characteristics. The health needs of each group will be considered in each particular JSNA topic area.
Undertake health impact audits for the new regeneration projects in Thurrock.	Public health has provided input into proposed housing developments in Thurrock. Regeneration projects requiring an environmental permit are reviewed by Public Health England and the local public health team. The team have produced a Health Impact Assessment process for key planning and regeneration proposals which feeds into the work of the new Planning and Advisory Board.
Work with NHS England (Essex Area Team) to prepare for the smooth transition of the 0-5 service in 2014 into Local Authority, and work with key stakeholders to develop a comprehensive 0-19 service.	The public health team have been working closely with the NHS England Essex Area Team on the transfer of commissioning responsibility of 0-5 service from 1st October 2015. Further work is required to look at the development of a 0-19 service.
Support Thurrock Clinical Commissioning Group as public health specialists as agreed within the Memorandum of Understanding	There has been limited progress with this recommendation due to the inability to recruit key public health staff. An interim appointment has been made to lead this work.

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12 March 2015	ITEM 8
Health and Wellbeing Board	
Troubled Families Programme	
Report of: Teresa Goulding, Service Manager, Troubled Families	
Wards and communities affected: All	**Key Decision:** Non-Key
Accountable Head of Service: Andrew Carter, Head of Care and Targeted Outcomes	
Accountable Director: Carmel Littleton, Director of Children's Services	
This report is Public	
Purpose of Report: To inform the Health and Wellbeing Board of the Troubled Families Programme and the introduction of Phase 2	

Executive Summary

The purpose of this report is to provide the Health and Wellbeing Board with an update on the progress and performance of Thurrock's Troubled Families Programme.

Significant progress has been made since October 2014, with the total number of families turned around, increasing from 169 (47%) to approximately 306 (85%), which has been achieved through effective practice evaluation and data management.

The high level of progress made, secured Thurrock's place in the national role out of Phase 2 of the Troubled Families programme, which commences in April 2015. This was only possible for Local Authorities achieving 75% of their target by February 2015.

Phase 2 of the Troubled Families Programme carries the same objective, however the way in which families are identified and 'turned-around' is locally decided. This will enable Thurrock to work closely with key partners to identify and address local need and determine measures of significant and sustained progress.

1 Recommendation(s):

1.1 In order to meet and exceed the national target to enter the second phase of the Troubled Families Programme, a number of activities were carried out, including; robust family and data analyses and financial framework workshops.

1.2 Whilst the completion of these activities enabled the target to be met, they also highlighted areas of improvement surrounding practice into data management and further development work, surrounding the understanding and application of the Financial Framework (2012).

1.3 Strengthening these areas, will provide a reflection on lessons learned from Phase 1, enabling a seamless transition into Phase 2. Robust identification processes are essential to manage the increased number of Troubled Families. Furthermore, in order to effectively measure significant and sustained progress, a local formula must be determined and embedded in practice to satisfy future payment by result windows.

1.4 The key recommendations are as follows:

1.4.1 Full independent evaluation of Phase 1: Practice and Data Management to identify lessons learned and effectively manage risk and opportunity ahead of national role out.

1.4.2 Workforce development. Accredited bespoke training for Management, Programme Managers and identified lead professionals.

1.4.3 Outcomes Framework Planning. This should be underpinned by Thurrock's strategic vision for children, families and communities and be developed in synergy with key partners, to ensure their corporate objectives are measured to secure their long-term buy-in.

1.4.4 Develop robust data and quality management plan, and embed this in policy for the anticipated life of the programme (2015-2020).

2 Introduction and Background:

2.1 The Prime Minister first announced the Troubled Families initiative in December 2010. The programme was designed to identify families with a high cost on the public purse and for Local Authorities to work in new and systemic ways to 'Turn Around' identified families. When achieved and evidenced, a quarterly payment by result would be awarded. This aimed to serve two purposes: a reduction in spending and more importantly, to provide Thurrock families with greater opportunities now and for generations to come. Thurrock's target, as set by the DCLG, was to 'Turn Around' 360 families by May 2015.

2.2 Thurrock Council alongside 151 other authorities signed up to the Troubled Families Agenda. The aim of the Troubled Families programme is to change the lives of families who have multiple problems and indeed cause many problems in their local area; these are families who, despite the best efforts of partners, have not been changed.

2.2 These are families who are involved in crime and anti-social behaviour, have children not in school, have an adult on out of work benefits and cause a high cost to the public purse.

2.3 These families almost always have other often long-standing problems, which can lead to generational cycles of disadvantage. One estimate shows that in over a third of the identified troubled families, there are child protection problems. Another estimate suggests that over half of all children who are permanently excluded from school in England come from these families, as do one-in-five young offenders.

2.4 Other problems such as domestic violence, relationship breakdown, mental and physical health problems and isolation make it incredibly hard for families to start unravelling their problems, which is why Thurrock has also chosen these areas of significant concern as additional ways to identify and work with Troubled Families.

2.5 The cost of these families to the public purse is very significant – approximately £9 billion a year, with roughly £8 billion of this being spent on reacting to their problems. Most importantly, this spending had not delivered sustainable results, having little impact on recidivism.

2.6 This waste of human potential is not sustainable and therefore the Government is committed to a renewed drive to deal with these so called "troubled families". As part of the Troubled Families programme, the DCLG puts in resources to incentivise and encourage local authorities and their partners; to develop new ways of working with families, which focus on lasting change, recognising that these approaches are likely to incur extra costs in the short-term but that they will result in a shift in the way we work systemically to address the needs of these families in the future – reducing costs and improving outcomes for generations to come.

2.7 The results-based funding scheme provides an important financial incentive to get to grips with and deal with troubled families. However, the ambition here is greater. Through this programme we want to learn not only about changing the trajectory for families but also to change the way services are delivered to them. The numbers claimed in Thurrock are improving all the time.

2.8 Initially all authorities were provided with figures on the indicative numbers of troubled families in their area. This figure represents the number of families that we are being asked to turn around.

2.11 The Troubled Families team, fall within the Early Offer of Help level of service; this enables the team to not only work with families with many issues but also

reduce recidivism. Taking a family centred approach, bespoke intervention, joined-up with key partners, reduces duplication of services involved at any one time, without compromising essential information sharing, to ensure the right partners are involved at the right time.

3. Structure and Staffing

3.1 The Troubled Families' team consists of one Service Manager, 3 Programme Managers, 1 family support worker, 2 Parental Outreach Workers to connect with schools, Business Support, Admin support and an apprentice to link in and support young people who have low school attendance.

3.2 The design of the local programme was very much along the strategic plan for early help to children and families and the Troubled Families teamwork by supporting the Lead Professional for each family. That will be the Social Worker in the most serious cases but will more often be pastoral care members of staff from schools. In this way, the programme is an extension of existing work on early help and a pilot to our ambitions for the future.

3.2 Thurrock Council has also match-funded Troubled Families, not in terms of direct money, but in resources including all services and staff supporting Troubled Families. One example of this is the Lead Professional role, which is specific to services and their staff across the council

4. Funding

4.1 Thurrock Council has now received £760,000 in attachment fees from the DCLG to work with all 360 (100%) families meeting the Troubled Families criteria as set out in the Financial Framework 2012. An additional £225,000 has been received to cover the costs of the Troubled Families Co-ordinator and any other supporting resources required to deliver the Programme. To date Thurrock has achieved £122,100 in payment by results claims. The total amount received from the DCLG to date is £1,107,100.

4.2 At the time of writing this report the next window of opportunity to evidence where families are turned around and claim a payment by result is on the 20th February 2015. The expected amount received from such claims, will be in the region of £155,000.

4.3 Funding has enabled access to the Family Intervention Programme (FIP), which case manages up to 30 Troubled Family cases at one time. Furthermore the TF team have developed strong partnerships with the voluntary sector to commission a consortium of voluntary services that gives priority to referred troubled families, including such services as; SERICC, MIND and Open Door. The TF team has also identified a number of positive links with local charities that offer white goods and furniture to troubled families who need it, with minimum or no cost to the authority or the family.

4.4 Thurrock TF team ensures intervention delivery is always bespoke, centred round the needs of the family. The team look for innovative ways of working

to a family centred approach to meet specific and often complex needs. Existing high performing services such as the Family Intervention Programme and Coram for parenting are still used. However, the bespoke, family centred-approach is applied.

4.5 Payment by Result monies are used to further support Social Care cases. This enables Social Workers to apply for small amounts of money for basic items and/or small commissioned pieces of work for the families they're working with. This is to support the family with the view to reducing their dependency on the local authority and reducing the cost to the public purse.

4.6 Using monies awarded through the programme, the TF team trained and appointed two volunteers who had previously successfully engaged with and were turned-around under the TF Programme. These volunteers have helped engage hard to reach families, which are proving to be an effective resource. Particularly in cases where identified families can see and hear first hand- the holistic benefits of engaging in the programme. The TF team are scoping ways to build on this success as the programme expands, moving into Phase 2. One of these volunteers is now paid through the TF programme, but continues to volunteer for our ADHD group.

5. Good News/Case Studies

5.1 **Good News –**

- **ADHD Group** – Thurrock TF sponsor and facilitate Thurrock's only ADHD parents support group and has proved to be very successful with good attendance

- **Summer Arts** – Troubled Families supported and delivered a Summer Arts programme in conjunction with UNITAS – focusing on E Safety – Service Manager and Programme Manager attended the House Of Lords for celebration ceremony – Thurrock were the only TF in the country to pilot the programme.

- **Firebreak** - Troubled Families facilitate a firebreak programme in conjunction with Essex County Fire and Rescue Service. During the course students will take part in activities aimed at improving self-esteem, self-discipline and responsibility. This is achieved by employing fundamental Fire Service principles of leadership, teamwork and motivation against a context of value driven behaviour. These fundamental principles are now complimented by bespoke Firebreak packages designed to meet TF's needs. Domestic abuse, road safety, crime prevention and consequences of alcohol and drug abuse are all areas that can be delivered by the team – most recently we piloted a Parent and Child Firebreak which proved successful in improving communication/relationships between the parent and the child.

- **Family Fest** – TF have run two successful activity days for families in conjunction with Thurrock Community Safety Parntership, working with a range of services and organisations. The event aimed to provide a range of fun activities for families but also a range of information, guidance and help for families from the agencies taking part.

5.2 **Case Study**

Family's ethnicity is white/British and consists of one adult who is the parent and two children, who are female and male. 3 other younger children had been removed and placed in Foster Care due to the family's extremely poor living arrangements that affected their care.

The family met three of the National criteria:
- Multiple Educational Issues (15% unauthorised attendance/exclusions)
- Under 18 years offending.
- Out of work benefit (DWP)

Local Criteria/Other Issues:
- Both children living at home were on Child Protection (CP) Plans.
- Male child did not leave the family home and had not been attending fully at school for around a year.

Agencies involved include:

Social Care, Education, Catch 22, Health, Open Door, TTTS and REED.

What worked well for the family with Troubled Families involvement:
- TF Programme Manager regularly attending protection meetings and core group meetings.
- Consistency of support offered, which allowed family to gain trust in TF staff (parental outreach worker)

What worked well for parent:
- The parent has taken action to remedy some of the family home concerns and is making the home fit for habitation.
- The parent has attended all required meetings re her children's Education and this ensures they remain in the family home and are not taken into care. The parent had previously been taken to court due to the non-attendance of her children.
- Catch 22/FIP have supported her in dealing with historic debts, reducing the risk of losing the family home.

What worked well for the female child:
- Improved school attendance above 85%.
- Some mentoring support that is enabling some key Education subjects to be prioritised. This is viewed as being particularly important as she is year 11.

- School are looking at work placements to up-skill and make her more employable due to low academic achievement expectations.
- Female has now been reduced to Child In Need and taken off Child Protection.

What worked well for the male child:

- He was never going out of the house so Troubled Families put in place a worker to encourage him out of the house to do "Positive Activities". This has resulted in the child who is 14 years old going out on weekly sports sessions.
- The Troubled Family worker has supported weekly attendance at TTTS (Thurrock Therapeutic Treatment Service), which was not happening before engagement.
- Support for a clinical appointment to diagnose the Child's anxiety disorder that prevents him easily going out of the family home.
- Home Tuition has now started

6. Diversity and Equality

6.1 The current list of Troubled Families does not have over or under representation of Thurrock's BME community. However, effective data and practice recording management strategies can ensure this is carefully monitored (as recommended in 1.4.4)

6.2 The initial identification of families as set out in the Financial Framework, did not make consideration for adults in receipt of out of work benefits due to a disability or illness. This has since been addressed and families, identified as eligible under the programme for being in receipt of out of work benefits, but are registered disabled and or incapable of working can now be noted as neutral. This enables the lead professional, to address remaining unmet needs, without prejudice.

7. Issues and/or options:

7.1 Recent analyses have identified opportunities whereby the quality of data and evidenced-based practice can be improved to maximise payment by results and effectively monitor progress/regress of families, including the early detection and action against outstanding areas of family-need. This point supports the recommendation to develop a robust data and quality management plan (1.4.4)

7.2 Thurrock Council has successfully secured its place in the national role out of the Troubled Families Programme (Phase 2). However, the expanded programme is more demanding on resource, financially and on capacity, therefore, a thorough evaluation of Phase 1 is integral to the development of the next outcomes framework, as well as also ensuring a deeper working knowledge of the latest DCLG Financial Framework 2014 is understood and embedded by all services involved in this next phase. This supports recommendations 1.4.1 and 1.4.3.

7.3 The TF team work in partnership with a range of services (internal and external) to ensure that information on identified troubled families is accurate, and updated where necessary. As Thurrock makes its transition into Phase 2, MASH will be the initial point of contact however, until all systems are fully embedded alternative nomination routes to the programme must be in place. This will ensure all partners can identify with the programme and intervention can be provided to those families with a wider range of needs. Workforce development will help lead professionals identify such families, and managers can oversee these routes through reflective supervision of its staff and share based practice though regular networking meetings or online portals. This point in part, is recommended in section 1, under 1.4.2.

7.4 The number of families has increased from 360 over three years (2012-2015) to 1160 over five years (2015-2020). This represents a 3.2 increase from Phase 1. Furthermore, the overall payment by result and attachment fee total will be significantly less, moving from £4,000 to £1,800 (£2,200 difference). This reduction clearly indicates the need for SMARTER working, and this has been addressed across the range of recommendations as set out in section 1.

8. Consultation (including Overview and Scrutiny, if applicable)

Not Applicable

9. Impact on the Corporate Policies, Priorities, Performance and Community Impact

Although not a statutory agency, the success of the Troubled Families Programme in Thurrock aims to positively impact on the outcomes and resources of other services and agencies, to significantly and sustainably improve the quality of life for families and communities.

10. Implications

10.1 **Financial**

Implications verified by: Kay Goodacre
Finance Manager
Kgoodacre@thurrock.gov.uk

The immediate financial implications of the programme are included in the main body of the report.

However, the programme has potential to bring about significant long-term savings to the Council, by breaking the cycle of demand from troubled families who have major calls on many areas of council resources.

10.2 **Legal**

Implications verified by: Lindsey Marks
Lindsey.Marks@BDTLegal.org.uk

At present there are no legal implications arising from this report.

10.3 **Diversity and Equality**

Implications verified by: Natalie Warren
Community and Diversity Manager
nwarren@thurrock.gov.uk

This is an update report that refers to the council's Troubled Families support service and the provision provided for those families affected by domestic violence, relationship breakdown, mental and physical health problems and isolation. The Children's Services directorate maintains data on service users to date and notes no specific equality and diversity implications arising from this information.

10.4 **Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

No other implications.

11 **Conclusion**

11.1 For Information

Background Papers used in preparing this report:

- Financial Framework for the Troubled Families Programme's payment-by-results scheme for local authorities
- Troubled Families criteria and nomination details, finance details sent from DCLG

Appendices to this report:

DCLG Financial Framework 2014

The 'health offer' to support the expanded Troubled Families programme has been published. We are hoping it will enable local doctors, nurses and community health workers to work more closely with TF. The offer includes:

- a leadership statement from the Department of Health, Public Health England and NHS England setting out for health partners the importance of working with you;
- a practical data sharing protocol with a working example of how families can be identified for the expanded programme. This was developed with the

Department of Health, Public Health England and, crucially, with advice from Dame Fiona Caldicott (Chair of the Independent Information Governance Oversight Panel);
- access to specialist health training.

All the documents can be accessed here:
https://www.gov.uk/government/publications/troubled-families-supporting-health-needs

Please do share the offer with your health colleagues as this could take some time to filter through and we want to start benefitting from it as soon as possible. This 'offer' is a first step in the efforts to help work more closely with health partners and we hope to improve and build on this over the coming months.

Report Author:

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Department for Communities and Local Government

Financial Framework for the Expanded Troubled Families Programme

November 2014

This document/publication is also available on our website at www.gov.uk/dclg

If you have any enquiries regarding this document/publication, complete the form at http://forms.communities.gov.uk/ or write to us at:

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Contents

Introduction

In April 2012, the Government launched the Troubled Families Programme a £448 million scheme to incentivise local authorities and their partners to turn around the lives of 120,000 troubled families by May 2015. The current programme works with families where children are not attending school, young people are committing crime, families are involved in anti-social behaviour and adults are out of work. The programme is making strong progress and as at the end of August 2014, had already turned around nearly 70,000 families.

In June 2013, the Government announced plans to expand the Troubled Families Programme for a further five years from 2015/16 and to reach up to an additional 400,000 families across England. £200 million has been committed to fund the first year of this five year programme.[1] This increased investment is testament to the Government's ongoing commitment to improve the lives of troubled families and as this work is taken to a significantly greater scale, to transform local public services and reduce costs for the long-term.

The Government announced in the Budget 2014 that it would offer the highest performing areas (those that have 'turned around' the lives of the most families in the current Programme) the opportunity to start delivery of the expanded Troubled Families Programme early – during 2014/15. Fifty-one such areas have been identified and signed up to be part of the first wave of 'early starter' areas. These areas began delivery in September 2014 and are working intensively with the Troubled Families Team to implement and refine the operating model for the national roll out of the expanded Troubled Families Programme. There will be a second wave of early starters announced later this year who will begin delivery in January 2015.

In September 2014, the Troubled Families Team published an interim version of this Financial Framework and sought feedback from the early starter areas and other government departments. This was followed by a series of thematic workshops with areas to discuss the identification indicators in more depth and begin conversations about appropriate outcomes. This Financial Framework reflects as much of this feedback as possible and provides the terms on which the expanded Troubled Families Programme will operate for the remainder of 2014/15.

Ahead of the national roll out of the expanded Programme in April 2015, the Department for Communities and Local Government's Troubled Families Team (TFT) will provide a further iteration of the Financial Framework. This will reflect learning and examples drawn from work with the 'early starter' areas during the remainder of 2014/15. However, in order to

[1] The remaining funding commitment will be determined as part of the next Spending Round process.

provide financial certainty to early starter local authorities, the core components of the operating model and its financial terms will not change.

The Role of 'Early Starter' Local Authorities

The 'early starter' areas have an important role to play; they are critical to maintaining the momentum of the current Troubled Families Programme and helping to build a strong evidence base in order to inform the case for continued investment in the expanded programme beyond 2015/16. Furthermore, these areas will work with the TFT on the detail of this Financial Framework over the coming months and help refine and improve the guidance and support offered to other local areas as they join the programme. The early starters are the best performing areas in the country. The flexibility of this Financial Framework reflects the Government's trust in their ability to shape and deliver the next phase of the Programme.

TFT is working collaboratively with the early starter areas with a particular focus on the following:

- The development of an independent national evaluation for the expanded Troubled Families Programme;
- The completion and continued improvement of the Troubled Families online cost savings calculator;
- The design and implementation of a new system of Family Progress Data;[2]
- The refinement of the indicators suggested to identify families and the development of best practice approaches to measuring significant and sustained progress with families;
- The design of the 'spot check' process for results and engagement of local authority Internal Auditors in the approval of local results claims; and
- The introduction of a model of transparent local accountability for the success of the programme as a tool to drive greater service transformation, using streamlined data collection tools.

[2] Currently local authorities provide family monitoring data for a 10% sample of families worked with. This system of data collection will be developed to have a greater focus on tracking the progress of families against a range of outcome measures.

Identifying Families

The current Troubled Families Programme has led the way for the first systematic identification of families with multiple problems across England. Although faced with data sharing, partnership working and service development challenges, the programme has identified and is working with nearly all 120,000 troubled families who are receiving support. This is a major achievement upon which the expanded programme will build.

The expanded Troubled Families Programme will retain the current programme's focus on families with multiple high cost problems and continue to include families affected by poor school attendance, youth crime, anti-social behaviour and unemployment. However, it will also reach out to families with a broader range of problems, including those affected by domestic violence and abuse, with younger children who need help, where crime and anti-social behaviour problems may become intergenerational and with a range of physical and mental health problems.

Reflecting the expanded programme's focus on a broader range of family problems, rather than a small number of nationally defined criteria, the inclusion of families into the programme will be based upon a cluster of six headline problems. Below these problems will sit a basket of indicators, suggested nomination[3] routes and information sources, which local authorities should use to identify families with these problems. While the headline family problems on which the programme focuses are unlikely to change, the indicators and information sources underneath are designed to be flexible and can be updated over the course of the programme's proposed five year life.

There will not be a sign off process where local authorities look to introduce new or different indicators under any of the six problems as this is intended to be a locally responsive and flexible model. However, to ensure best practice examples are shared and the list of indicators provided to local authorities is up to date, local authorities should inform the Troubled Families Team if they would like to use new or different indicators or information sources.

[3] The interim Financial Framework referred to 'referral routes'. However, local authorities fed back that the term 'nominations' is more appropriate at identification stage, because referrals suggest work will be undertaken and a nomination is for identification screening purposes. A family's suitability for an intervention will only be agreed once the prevalence of other problems is understood and the local area has prioritised families for support.

To be eligible for the expanded programme, each family must have at least two of the following six problems:

1. Parents and children involved in crime or anti-social behaviour.

2. Children who have not been attending school regularly.

3. Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan.

4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness.

5. Families affected by domestic violence and abuse.

6. Parents and children with a range of health problems.

While families may be identified as eligible for the programme on the basis of two problems, the information available at the point of identification may not reflect the entirety of each family's complexity of problems. Some problems, such as domestic violence or mental illness, may be hidden from public services until work begins with the family and uncovers the full extent of their needs. A similar situation has been apparent in the current Troubled Families Programme whereby families have entered the current programme having met at least three eligibility criteria, but our evaluation has so far found that, on average, families have nine significant problems on entry to the programme[4]. The expanded Troubled Families Programme remains a programme for families with multiple, high cost problems, although the profile and extent of these problems may differ from those of families supported by the current programme.

The formula for identifying families allows for a level of discretion which should be exercised reasonably. Local authorities should identify families across all six problems and ensure the Programme's resources are being used to best effect. Families should be prioritised for inclusion in the programme on the basis of the following:

- They are families with multiple problems who are most likely to benefit from an integrated, whole-family approach; and
- They are families who are the highest cost to the public purse.

[4]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336430/Understanding_Troubled_Families_web_format.pdf

While the detail of this prioritisation should be agreed locally, the periodic collection and publication of Family Monitoring/ Progress Data and the cost savings calculator[5] for every local area will provide a form of accountability. These will show the types of families and problems that areas are prioritising. The TFT will also consider this information as part of the programme's ongoing 'spot check' processes. The TFT will collect examples from 'early starter' areas over the coming months to gather information regarding the prioritisation of families, which will inform guidance for the national roll out.

The first group of 'early starter' local authorities began delivery of the expanded programme on 1 September 2014 and the second group will begin on 1 January 2015. Families who meet the eligibility criteria for the programme from these dates onwards may be considered as part of each area's delivery commitments, irrespective of whether they were already receiving a targeted family intervention. However, no results may be claimed for successes achieved with families prior to these dates.

Annex A provides further information on the principles underpinning the identification process. Annex B provides more detail on the indicators and suggested information sources underpinning each of the headline problems. Annex I provides details on some of the data sharing arrangements and this will be updated over the lifetime of the programme to reflect the latest information, advice and best practice.

[5] See Annexes F and G for further information.

Measuring Success

The expanded Troubled Families Programme has ambitious service transformation goals and therefore differs from the current programme in how it will measure, and pay for success. Rather than focusing on a small number of relatively tightly defined national results to be achieved with each family it asks local authorities and their partners to measure success in three main ways for which funding is available:

1. Firstly, by demonstrating either **significant and sustained progress** or **continuous employment** with an agreed number of families in each upper-tier local authority, representing the area's share of the estimated national total of 400,000 families. Each family's achievement of 'significant and sustained' progress will be assessed against a locally defined Troubled Family Outcomes Plan. This will provide a new, more flexible approach to measuring results. See Annex D and E for more detail.

   Funding for this is available for each family who achieves success and will be paid in two parts: an upfront attachment fee of £1,000 per family and a results-based payment of £800 per family. Once the programme is rolled out nationally from April 2015, payments of attachment fees will normally be made in the first quarter of each financial year, subject to satisfactory performance against the previous year's agreed commitments in regard to the number of families for which attachment fees were received.

2. Secondly, by capturing a much richer understanding of the progress achieved with a representative sample of families across a broader range of outcomes. This will be achieved during 2014/15 through the collection and publication of **Family Monitoring Data** (using existing systems). However, this approach will be improved through a co-design process with 'early starter' areas to focus more on capturing a richer picture of the progress achieved (**Family *Progress* Data**) with a representative sample of families through the programme. See Annex F for more detail on the transition from Family Monitoring Data to Family Progress Data.

3. Finally, by developing a much better understanding of the financial benefits achieved through the programme and by stimulating ongoing service transformation through transparent local accountability for these benefits. All local authorities will be asked to complete the online troubled families **cost savings calculator**, which has already been made available. The calculations produced by local areas and Family Progress Data analysis will be published periodically. This will show the complexity of the families supported by the programme, the effectiveness of interventions and the benefits of this work to local services and the taxpayer. Work is already

underway with a group of ten 'exemplar' areas[6] and a HM Treasury led group of economists from across government departments to improve the functionality of this tool and the unit costs available. See Annex G for more detail on the the cost savings calculator.

Funding to support the collection, analysis and publication of the Family Monitoring/Family Progress Data and the completion of the cost savings calculator is provided via the Service Transformation Grant (STG). To reflect the increased data collection requirements of the programme, this is higher than the funds offered for troubled families coordinators in the current programme, but remains weighted in accordance with the number of families that each area will be working with. The bandings for this grant are set out in Annex H.

Once the programme is rolled out from 1 April 2015, STG payments will normally be made in the first quarter of each financal year subject to satisfactory compliance with requirements to provide Family Progress Data, to participate in the National Impact Study7 and to complete the costs savings calculator during the previous year.

Verification and Validation of Results

It is important that each local authority puts in place robust results verification and validation systems. Learning from the current Troubled Families Programme suggests that those areas that invested early on in good local data management and in analytical resources have strongly benefited. To deliver the increased evidential expectations of the expanded programme, most areas will need to at least retain (and most likely increase) this resource.

As per the current programme, results should be claimed under the powers of the local authority's Chief Executive. The local authority's Internal Auditor should check and verify at least a random representative sample of results for each claim before it is made. The Internal Auditor should refer to the area's Troubled Family Outcomes Plan (see Annex E) and, therefore it is recommended that s/he is consulted during the development of that plan.

The first opportunity to claim a result as part of the expanded programme will be during January and February 2015. Given the emphasis on sustained outcomes, it is unlikely that areas will be in a position to claim many results at this stage. Results should only be claimed once a Troubled Families Outcomes Plan is in place and has been shared with the area's Internal Auditors as part of their sign off process.

[6] Members include the London Borough of Wandsworth, Manchester, Salford, Bristol, Redcar & Cleveland, Staffordshire, Derbyshire, Birmingham, Newcastle and Leeds.

[7] A project initiated under the current programme's evaluation, which makes a quantitative assessment of the impact of the Programme, but matching data about individuals in troubled families to national administrative datasets held by government departments (e.g. Police National Computer and DWP's benefits systems).

As with the curent programme, there will be regular ‘spot checks’ of a sample of local authorities’ claims for payment. The TFT is planning to work with internal auditors across a range of the ‘early starter’ areas over the coming months to review the lessons learnt from the current ‘spot check’ process and refine the approach as necessary ahead of the national roll out of the expanded programme. The new process will have particular reference to local authorities’ Troubled Family Outcomes Plans.

Annex A - Principles for Identifying Families

There are three key principles that underpin the expanded programme's approach to the identification of troubled families. These reflect the programme's broader policy purpose:

1. The Troubled Families Programme aims to work with families who have multiple problems, who will in turn benefit from a integrated whole family approach. To reduce the likelihood that a family becomes eligible for the Programme exclusively on the basis of a problematic individual without reference to their wider family, an adult with parenting responsibilities who does not live with his/her children on a full-time basis may only acccount for only one of the problems that deems a family eligible. For example, a father leaving prison who will not live with his children but has some parenting responsibilities may only account for one of the problems that deems a family eligible for the expanded Programme, even if he is an individual with multiple problems. There should be at least one other member of the family who has at least one of the other headline problems targeted by the programme for the family to be eligible.

2. The programme aims to improve outcomes for children and intervene earlier in families with problems; all eligible families must include dependent children[8].

3. To identify the estimated 400,000 troubled families across England, we expect all local authorities to identify families across all six headline problems. The scale of the programme means it is unlikely to be possible to focus on only some of these problems and still identify the volumes of families that this programme aims to reach. However, if a local authority and its partners identify more families than its mutually agreed share of the overall 400,000, families should be prioritised on the basis of need and those with more than two problems should be offered support first.

   As explained above, the level of discretion that this formula allows local areas in regard to the identification of families for the expanded programme should be used reasonably with regard to relevant factors. Like the current programme, the expanded Troubled Families Programme remains a programme for families with multiple problems. Local authorities need to be satisfied that the programme's resources are being used for families who will most benefit from an integrated, whole-family approach to their problems and that the highest cost families are being prioritised for support.

[8] For the purposes of the programme, a dependent child is a person aged 0-15 in a household or aged 16-18 in full-time education, in training or unemployed and living in a family with his or her parent(s).

Annex B - Indicators and Nomination Routes to Assist in the Identification of Families

1. Parents and children involved in crime or antisocial behaviour.

The Troubled Families Programme works with families who have significant problems with some families who also cause problems. The current Programme's focus on youth crime and anti-social behaviour across the family has enabled local areas to reach families whose problems span not only behavioural issues, but are also strongly related to wider family issues such as substance misuse, domestic violence and mental illness. Many areas have also used these criteria as a basis on which to build strong partnerships with local criminal justice and housing services on which the expanded programme will look to build.

The expanded programme retains the current programme's youth crime and anti-social behaviour criteria, but broadens the reach to families including an adult offender with parenting responsibilities. This reflects the evidence that a significant family factor in youth offending is having criminal or anti-social parents. Furthermore, children of offenders are also more likely to be excluded from school and twice as likely to suffer from behavioural and mental health problems.

The indicators below also offer the flexibility for criminal justice professionals to nominate parents and children where there is a potential crime problem, but no proven offence and they think this could be a sign of wider family problems. This may be particularly helpful when identifying families where there is strong intelligence about a family's involvement in activities such as gang and youth violence or serious organised crime, but no proven offence.

Indicators	**Suggested Information Source**
The family includes at least one of the following…	
A child[9] who has committed a proven offence[10] in the previous 12 months.	Information provided by Youth Offending Teams and the Police.
An adult or child who has received an anti-social behaviour intervention (or equivalent local measure) in the last 12 months.	Information provided by the Police, anti-social behaviour teams and housing providers.

[9] under 18 year olds
[10] A proven offence is one where a formal outcome is given, either in or out of court.

Indicators	Suggested Information Source
The family includes at least one of the following…	
An adult prisoner who is less than 12 months from his/her release date and will have parenting responsibilities on release.	Information provided by probation providers[11] and prisons.
An adult who is currently subject to licence or supervision in the community, following release from prison, and has parenting responsibilities.	Information provided by probation providers[12] and prisons.
An adult currently serving a community order or suspended sentence, who has parenting responsibilities.	Information provided by probation providers[13].
Adults or children nominated by professionals because their potential crime problem or offending behaviour is of equivalent concern to the indicators above.	Nominations from the Police, multi-agency gang units, probation providers, Serious Organised Crime Partnerships, Integrated Offender Management Teams and CHANNEL coordinators[14].

2. Children who have not been attending school regularly.

Suitable full time education is not only an essential pre-requisite to better attainment; but also strongly associated with a broad range of family outcomes including reducing the risk of worklessness, youth crime and anti-social behaviour. In light of this, the expanded programme's indicators generally mirror the education criteria used in the current programme. However, where the current programme has focused exclusively on persistent unauthorised absence, the expanded programme offers a broader opportunity to identify children whose absence is persistent but authorised and a cause for concern. This reflects feedback from local authorities about different recording practices and also the broader policy intent of the expanded programme.

The suggested information sources also reflect learning from the current programme. While information collected locally for submission to the Department for Education should provide most of the information needed to identify families against these indicators, some supplementary information may be needed from Education Welfare Officers (or equivalent) to produce a complete picture of each child's circumstances and the reason for their absence. See Annex I for further information on data sharing arrangements.

[11] National Probation Service, Community Rehabilitation Companies and other providers of probation services.
[12] As above.
[13] As above.
[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118194/channel-guidance.pdf

Indicators	Suggested Information Source
The family includes at least one of the following…	
A child who is persistently absent[15] from school for an average across the last 3 consecutive terms.	Information compiled locally for submission to the Department for Education for the School Census and Alternative Provision Census. Information provided by Education Welfare Officers.
A child who has received at least 3 fixed term exclusions in the last 3 consecutive school terms; or a child at primary school who has had at least 5 school days of fixed term exclusion in the last 3 consecutive terms; or a child of any age who has had at least 10 days of fixed term exclusion in the last 3 consecutive terms.	
A child who has been permanently excluded from school within the last 3 school terms.	
A child who is in alternative educational provision for children with behavioural problems.	
A child who is neither registered with a school, nor being educated in an alternative setting.	Information compiled locally from within the local authority
A child nominated by education professionals as having school attendance problems of equivalent concern to the indicators above because he/she is not receiving a suitable full time education[16].	Nominations from teachers and education welfare officers (or equivalent).

3. Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan.

The national eligibility criteria for the current Troubled Families Programme are purposely weighted towards families with school age children and based on assessments of poor school attendance and youth crime. However, in light of the broader focus of the expanded programme, the indicators below will enable local authorities and their partners to identify a wider group of families who may benefit from family intervention. These are: children who have been identified or assessed as needing early help; and children who have been

[15] Currently measured as missing 15% of sessions. Threshold will reflect Department for Education metric
[16] Sections 7 and Section 19 of the Education Act 1996 provide a definition of a 'suitable' education. In summary, this means it is appropriate to the child's age, ability and aptitude; and to any special educational needs, either by regular attendance at school or otherwise.

identified as a 'child in need', children subject to a Child Protection Plan or have been subject to section 47 enquiries. In these cases, the social worker will put forward a family that they believe would benefit from family intervention.

Indicator	Suggested Information Source
The family includes at least one of the following…	
A child who has been identified as needing early help.[17]	• Information from local authority early years foundation stage providers (e.g. children's centres) about children who don't take up the Early Years Entitlement, by cross-referencing a list of those children eligible with those who are not in an early years setting.[18] • Information from local schools, academies and education welfare teams, Special Educational Needs Coordinators (SENCOs) or equivalent about children identified in the School Census as having social, emotional and mental health problems[19]. • Information from the Police and Children's Services (including youth services) about children who have been reported missing from home and identified as of concern[20].
A child who has been assessed as needing early help.[21]	Information from Children's Services or related multi-agency teams[22] about children who are: • repeatedly assessed under Section 17 or 47, of the Children Act 1989, but not deemed a 'child in need', or • subject to Early Help Assessments (or equivalent).

[17] This may include children below the threshold for services under Section 17, Children Act 1989 and those experiencing or at risk of poor parenting, with developmental delay, at risk of exploitation, with challenging behaviours and those previously accommodated and returning home from care.
[18] All three and four year olds are entitled to free 15 hours of Early Years Entitlement per week; All two-year-olds who live in households which meet the eligibility criteria for free school meals are entitled to a free early education place, along with children who are looked after by the state; and From September 2014, the two-year-old entitlement will be extended to 40% of the least advantaged two-year-olds (meaning up to 260,000 children could benefit from the two year offer offer).
[19] From September 2014, the school census code for social, emotional and mental health problems will use the following code - SEMH
[20] For example, this may include local information following 'safe and well' checks carried out by the Police or Independent Return Interviews.
[21] This may include children , who when assessed were deemed below the threshold for services under Section 17, Children Act 1989.
[22] For example, Team around the Child, a Team Around the Family or a Team Around the School.

Indicator	Suggested Information Source
A child 'in need' under Section 17, Children Act 1989.	Information provided by Children's Services.
A child who has been subject to an enquiry under Section 47, Children Act 1989.	
A child subject to a Child Protection Plan.	
A child nominated by professionals as having problems of equivalent concern to the indicators above.	Nominations[23] from schools, social workers, early years providers (including Children's Centres), health visitors, education psychologists, school Special Educational Needs Coordinators (SENCOs), Youth Offending Teams and the Police.

4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness.

The focus on employment in the current Troubled Families Programme is one of its most powerful elements. It has had a transformative impact not only on family outcomes, but also on the approach and design of local family intervention services. The financial case for the prioritisation of employment outcomes for troubled families is compelling. Welfare benefits are the single greatest area of public expenditure on these families and the wider benefits of reducing welfare benefit dependency are felt across improvements in health, reductions in crime and local economic growth.

In light of this, the expanded Troubled Families Programme's indicators mirror the existing worklessness criterion, while taking account of the transition from the current welfare and tax benefits system to Universal Credit; and go further to reach young people at high risk of worklessness and those experiencing problematic debt, particularly those who have financial responsibilities in their household.

[23] Where there are concerns about children at risk of abuse or neglect, the existing referral route to local child protection teams should be followed in accordance with the statutory guidance - *Working together to Safeguard Children* https://www.gov.uk/government/publications/working-together-to-safeguard-children

Indicators	Suggested Information Source
The family includes at least one of the following…	
An adult in receipt of out of work benefits.[24] or An adult who is claiming Universal Credit and subject to work related conditions[25].	All 'early starters' now have access to the Department for Work and Pension's Automated Data Matching Solution (ADMS) for the Troubled Families Programme.
A child who is about to leave school, has no/ few qualifications and no planned education, training or employment.	Information drawn from Personal Learner Records[26] and the local authority's Client Caseload information System (or equivalent)[27] Information collected by local schools, academies and alternative providers for the Department for Education's School Census and Alternative Provision and Youth Contract providers[28] Key Stage 4 data compiled by schools and academies' pupil level for the production of published school performance tables.
A young person[29] who is not in education, training or employment.	Local authorities' Client Caseload Information Systems (or equivalent)[30], which indicates whether young people have been identified as not in education, training or employment (NEET) or whether their activities are 'not known'.

[24] As per the current programme, this includes adults in receipt of Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support, Job Seekers Allowance and Severe Disablement Allowance.
[25] To be consistent with the Department for Work & Pension's approach, this includes adults required (i) to attend 'work focused interviews'; (ii) to meet 'work preparation requirements' (e.g. those with limited capability for work currently, but could make reasonable steps to prepare for work); and (iii) to proactively look for work (e.g. those expected to look and be available for work).
[26] All 16-18 year olds should have a Personal Learner Record (PLR) and most local authorities already have access to this information as registered providers of education and training.
[27] Local authorities are required to encourage young people to participate in education and training and identify those who are not engaged. For most areas, a key part of this is collecting good information about young people with few/ no qualifications and many record these details on a Client Caseload Information System (or equivalent) and others have arrangements in place to gather attainment data from providers.
[28] https://www.gov.uk/government/publications/youth-contract-16-and-17-year-olds
[29] See Annex C
[30] See above comment.

Indicators	Suggested Information Source
The family includes at least one of the following…	
Parents and families nominated by professionals as being at significant risk of financial exclusion. This may include those with problematic/ unmanageable levels and forms of debt and those with significant rent arrears.	Nominations from organisations specialising in debt and finance, such as the Money Advice Service, Jobcentre Plus and housing providers.

5. Families affected by domestic violence and abuse.

Domestic violence and abuse has been a damaging and widespread problem across families in the current Troubled Families Programme. Its prioritisation in the expanded Programme is led by a clear request from local areas and is reinforced by a compelling financial imperative; the consequences of domestic violence and abuse are felt across health, police, housing and Children's Services budgets.

While the expanded Troubled Families Programme will explicitly focus on reaching families affected by domestic violence and abuse, the definition of indicators and suggested information sources is by no means straightforward. By its very nature, domestic violence and abuse often goes unreported for some time and this means the indicators and suggested information sources used must capture what is often considered 'hidden harm'. In response, local authorities will have the flexibility to draw upon the intelligence of specialist agencies, rather than just formal reporting mechanisms. This means they are likely to lend themselves to nomination-based models of identification, rather than the cross-referencing of larger datasets.

The Troubled Families Programme will apply the agreed cross-government definition of domestic violence and abuse, which defines it as: 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over[31] who are, or have been, intimate partners or family members[32] regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial and emotional.'[33]

[31] Violence or abuse between those under the age of 16 should be captured as part of the youth crime or children who need help indicators.
[32] This may include adult siblings, grandparents, uncles, aunts etc.
[33] https://www.gov.uk/domestic-violence-and-abuse

Indicator	Suggested Information Source
The family includes at least one of the following…	
A young person or adult known to local services has experienced, is currently experiencing or is at risk of experiencing domestic violence or abuse.	Nominations from local domestic violence and abuse services or professionals, such as Independent Domestic Violence Advisors (IDVAs), housing providers, health services, the Police, Children's Services and Youth Offending Teams.
A young person or adult who is known to local services as having perpetrated an incident of domestic violence or abuse in the last 12 months[34].	Local Police data and intelligence. Nominations from local domestic violence and abuse services or professionals, such as Independent Domestic Violence Advisors (IDVAs), housing providers, health services, the Police, Children's Services and Youth Offending Teams.
The household or a family member has…	
Been subject to a police call out for at least one domestic incident in the last 12 months[35].	Information from the Police, Multi-Agency Safeguarding Hubs (MASH) and Multi-Agency Risk Assessment Conferences (MARAC).

6. Parents and children with a range of health problems.

Health problems for families in the current Troubled Families Programme are costly and pervasive. Troubled families have disproportionately high levels of health problems compared to the general population. Findings from the current programme's independent evaluation indicate that, on entry to the programme, 71% of families included someone with at least one health problem; 46% included an adult with a mental health problem; a third (33%) of children were suffering from a mental health problem; nearly a third (32%) of families included an adult with a long-standing illness or disability; and one-in-five (20%) families included a child or children with a long-standing illness or disability. Building on these findings, the expanded programme will place an even greater emphasis on reaching families with a range of physical and mental health problems.

[34] The time limitation is to ensure the data share is proportionate and in line with the requirements of the Data Protection Act. However, is local authorities and their partners (particularly the Police can agree alternative local arrangements whereby information covering a longer period of time is shared where relevant) this is entirely permissible and in line with the programme's broader policy objectives.
[35] As above.

Following extensive joint work with local authorities, the Department of Health, Public Health England and NHS England, the expanded programme's indicators and suggested information sources reflect three main health priorities: mental illness, substance misuse and vulnerable new mothers. Improved data sharing will be integral to success in these areas as well as a much deeper and wider programme of integration and service transformation to improve health outcomes for families.

On 5 November, a new national health offer was launched to help health professionals and councils work more effectively together to improve troubled families' health. This includes:

- A leadership statement setting out how local doctors, nurses and community health workers should work more closely with councils' troubled families teams;
- A new protocol to enable health information to be safely shared with troubled families' key workers; and
- Troubled families teams being able to access specialist health training.

The national 'health offer' is accessible on the www.gov.uk website.

Indicator	Suggested Information Source
The family includes at least one of the following…	
An adult with mental health problems who has parenting responsibilities or a child[36] with mental health problems[37] [38].	Nominations from Community Mental Health Services, Child & Adolescent Mental Health Services, local GPs, education psychologists and school Special Educational Needs Coordinators (SENCOs).
An adult with parenting responsibilities or a child with a drug or alcohol problem.	Information drawn from the National Drug Treatment Monitoring System. Nominations from local GPs, the Police or local substance misuse support services.

[36] This includes children with conduct disorders.
[37] The adult or child does not need to be in receiving specialist treatment.
[38] This report provides information on recognising and working with young people with mental health in schools: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326551/Mental_Health_and_Behaviour_-_Information_and_Tools_for_Schools_final_website__2__25-06-14.pdf

Indicator	Suggested Information Source
The family includes at least one of the following…	
A new mother who has a mental health or substance misuse problem and other health factors associated with poor parenting. This could include mothers who are receiving a Universal Partnership Plus service[39] or participating in a Family Nurse Partnership.	Nominations from health visitors, midwives, family nurses or local GPs. Information from the Local Child Health Information System.
Adults with parenting responsibilities or children who are nominated by health professionals as having any mental and physical health problems of equivalent concern to the indicators above. This may include unhealthy behaviours, resulting in problems like obesity, malnutrition or diabetes.	Nominations from health professionals, including GPs, midwives, health visitors, family nurses, school nurses, drug and alcohol services and mental health services.

[39] Universal Partnership Plus is a service offered by a health visiting team and local services to support families with children under 5 years old who have complex issues that require more intensive support.

Annex C – Age Thresholds for Eligibility and Measuring Results

The programme aims to improve outcomes for children and intervene earlier in families with problems, all eligible families must include dependent children. For the purposes of the programme, a dependent child is a person aged 0-15 in a household or aged 16-18 in full-time education, in training or unemployed and living in a family with his or her parent(s).

Family Problem	Age Threshold
If a child is involved in crime or anti-social behaviour…	…the relevant family member should be between 10[40] and 18 year olds. If 18 or over, the family member is considered an adult for these purposes.
If a child or young person has not been attending school regularly…	…the relevant family member should be in suitable *full-time* education, if the child is under 16 years old[41]. This rises to 25 years old if the child or young person is under an education, health and care plan[42]. This applies to children who currently have a statement of special educational needs.
If a young person is not in education, training or employment…	…the relevant family member should be 16-18 years old.
If a child has been identified/assessed as needing early help; or is a child in need under S.17, Children Act 1989; or is a child who has been subject to enquiry under S. 47, Children Act 1989…	…the relevant family member should be under 18 years old[43].

[40] https://www.gov.uk/age-of-criminal-responsibility
[41] or last Friday in June if you will turn 16 by the end of the school holidays.
[42] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/349053/Schools_Guide_to_the_0_to_25_SEND_Code_of_Practice.pdf
[43] Working Together to Safeguard Children defines a child as anyone who has not yet reached their 18th birthday (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf)

Family Problem	Age Threshold
If an adult is in receipt of out of work benefits; or an adult is claiming Universal Credit and subject to work related conditions…	…if the relevant family member is 18 years or over. However, there are a small number of exceptions whereby 16 and 17 year olds can claim the following benefits under specific circumstances: Jobseekers Allowance, Employment and Support allowance and Carer's Allowance.
If a person is experiencing or perpetrating domestic violence…	…the relevant family member should be 16 years old or over[44]. If under 16 years old, violence or abuse should be captured as part of youth crime or children who need help indicators.

[44] https://www.gov.uk/government/news/new-definition-of-domestic-violence

Annex D – Success Measures for 400,000 Families

While maintaining the current programme's powerful focus on the measurement of multiple outcomes at a per family level, the payment by results framework for the expanded Troubled Families Programme will operate differently. A results payment can be claimed by a local authority if it can demonstrate that a family who was eligible for the Troubled Families Programme has either:

1. **Achieved significant and sustained progress, compared with all the family's problems.**

Or

2. **An adult in the family has moved off benefits and into continuous employment.**

Sustained and Significant Progress

Descriptions and definitions of the outcomes and measures that constitute and demonstrate significant and sustained progress for all troubled families in each local authority should be agreed locally and set out in a Troubled Family Outcomes Plan. The purpose of these local Plans is three-fold:

1. To lay out **what your local authority aims to achieve with each family** in regard to the six problems the programme aims to tackle; and how this supports your wider **service transformation** objectives (e.g. how these 'per family' outcomes support broader area wide goals in terms of demand reduction for services or fiscal savings);

2. To provide a basis against which your local authority can determine when **significant and sustained progress** has been achieved and, therefore, a results claim may be made for the family.

3. To provide a framework against which your **internal auditors** (and the TFT's 'spot checks') may establish whether a result is valid.

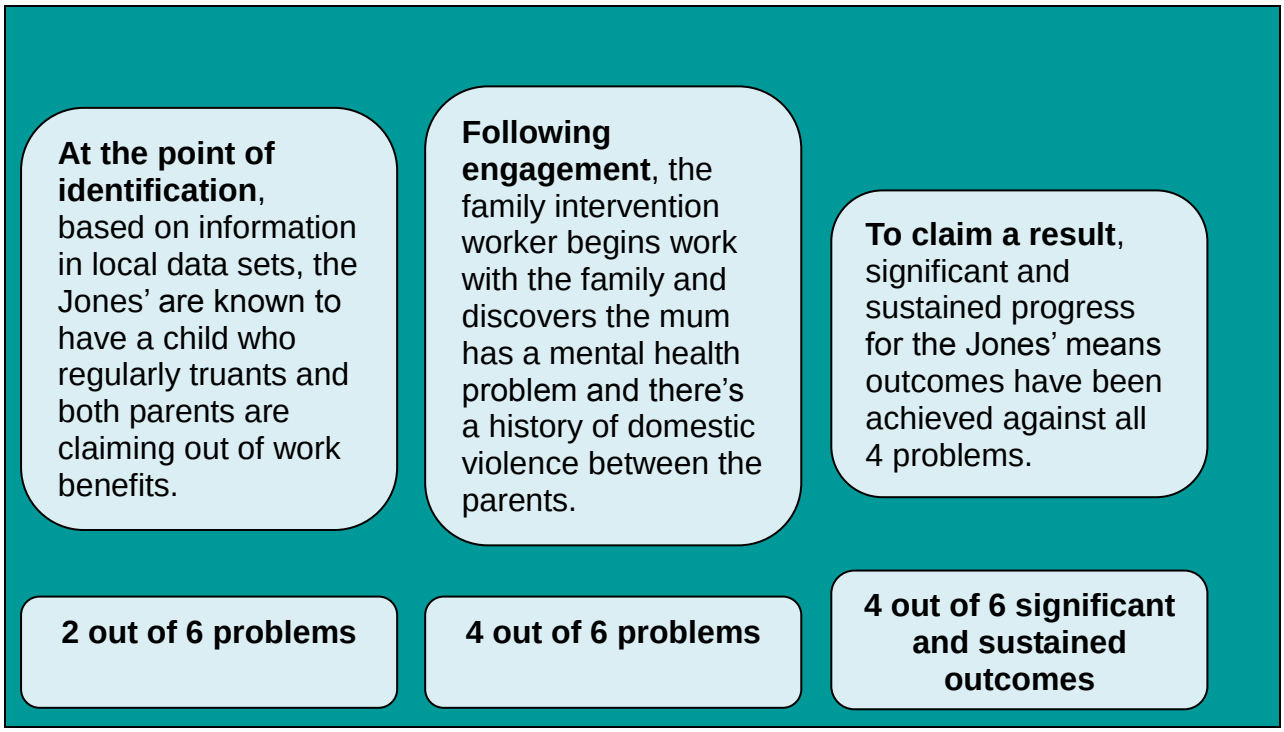
The Troubled Family Outcomes Plan will provide an area-wide set of success measures applicable to all families, from which the outcomes and measures relevant to each family may then be drawn. For example, if a family has a debt problem, domestic violence problem and is unemployed at the point of engagement, then relevant outcomes would be drawn from the area's Troubled Family Outcomes Plan and form the goals against which significant and sustained progress would be judged for this family.

There are eight key principles that all Troubled Family Outcomes Plans should reflect:

Principle 1: Troubled Family Outcomes Plans should focus on the demonstration of outcomes, rather than inputs, processes and outputs. For example, the completion of a course or intervention would be a process or input, whereas the outcome should focus on the measurable change achieved by the family as a result.

Principle 2: As some family problems may not be evident at the point of identification and only become apparent following engagement and trust is established with the family intervention work (e.g. domestic violence and abuse), the relevant outcomes within the Troubled Family Outcomes Plan should be set at this later point, when a fuller picture of the family is known.

Figure 1: Principle 2



Principle 3: Where some problems are not relevant to a family at the point of engagement (e.g. the adults are in work and therefore worklessness is not an issue), the local authority does not need to demonstrate significant and sustained progress against this problem to claim a result, but must ensure that the family's status has not regressed (e.g. has not become unemployed between engagement and claim)[45]. This is consistent with the approach adopted by the current Troubled Families Programme.

[45] There may be exceptions to this if the circumstances are considered particularly unusual. Such cases should be agreed with TFT on a case-by-case basis.

Principle 4: All school age children in every family for whom significant and sustained progress is claimed must be receiving a suitable[46] full time education. This should include ensuring all school age children attend at least 85% of possible sessions on average[47] across three consecutive school terms[48]. This measure has been set to be equivalent to the Department for Education's measure of persistent absence.

Principle 5: As far as possible, local authorities should develop and agree outcomes with local partners in the relevant public service areas. For example, health outcomes should be developed and agreed with local health partners and with reference to the Public Health[49] and NHS Outcomes Frameworks[50] and employment outcomes should be developed and agreed with local Jobcentre Plus District Managers, with reference to local skills, job market and growth objectives.

Principle 6: Where unemployment is a problem for a family on entry to the programme, an adult in the family does not have to secure continuous employment in order that a result for significant and sustained progress can be claimed. Instead, in these cases, as a minimum, a family should demonstrate significant and sustained progress towards work. For example, this might include outcomes such as achieving a recognised vocational qualification, undertaking significant relevant work experience over a sustained period of time or successful completion of an apprenticeship[51]. This progress should be undertaken with a view to securing work ultimately and a 'subsequent continuous employment' outcome may be reported in these cases (see below).

Principle 7: Areas may wish to have reference to the measures used in the programme's Family Monitoring / Progress Data and the troubled families cost savings calculator in their Troubled Families Outcomes Plans to reduce any data collection burdens.

Principle 8: The purpose of a Troubled Family Outcomes Plan is to provide a short and simple account of the goals that each local authority strives to achieve with its troubled families, against which success claims may be measured and verified. It should not be a complex, bureaucratic process.

This approach aims to provide the flexibility to measure success in a way which reflects the service transformation and costs reduction priorities of each local authority and its partners.

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[46] Sections 7 and Section 19 of the Education Act 1996 provide a definition of a 'suitable' education. In summary, this means it is appropriate to the child's age, ability and aptitude; and to any special educational needs, either by regular attendance at school or otherwise.

[47] As per the current programme, this outcome is measured as an average across three consecutive terms rather than an average per term.

[48] If a child ages between entry to the programme and when significant and sustained progress is claimed and is no longer of 'school age', this measure is no longer relevant to this child. However, we would still expect the local authority to demonstrate significant and sustained progress in the form of another locally determined education, training or progress to work outcome. This means a claim should not be made if the child is considered Not in Education, Employment Training (NEET) after leaving school.

[49] https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

[50] https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

[51] Unlike the current programme, there is no separate 'progress to work' measure. This should form part of the significant and sustained progress where unemployment is a problem for the family on entry to the programme.

Given the five year duration of the programme, it provides the scope to update and refresh outcome measures to reflect changes in delivery and information sharing arrangements over time. Outcome measures may increase in their ambition as the programme progresses. While the TFT will not mandate the outcomes, we will work with the early starters to support this process and develop guidance and examples for other areas on the best approach.

Further detail on the proposed structure of a Troubled Family Outcomes Plan is provided in Annex E.

Off Benefits and into Continuous Employment

Worklessness is a problem across troubled families in the current programme and achieving continuous employment has often been a transformative outcome. Findings from Troubled Families Programme's independent national evaluation found that an estimated 83% of families were receiving an out-of-work benefit on entry to the programme – compared with around 11% of the population nationally[52] - and the programme's latest results show that nearly 6,500 adults in troubled families have moved into work so far[53].

During the current Troubled Families Programme, in recognition of the scale of the challenge and importance of its success, the Department for Work and Pensions seconded 152 Jobcentre Plus advisors into local authorities to support troubled families into work. Known as Troubled Families Employment Advisors, this additional resource and expertise has been widely welcomed and local authorities have reported its significant impact on employment outcomes. To date, this resource has been concentrated in the 94 local authorities with the highest numbers of troubled families. From April 2015, this resource will be increased to 300 Troubled Families Employment Advisors. This means a further 57 local authorities will benefit and many others will see an increase in their existing capacity. Further details on the distribution of these secondees will be finalised alongside the proposed distribution of families for 2015/16 onwards. This information will be available in December 2014. The Troubled Families Team is working with the Department for Work and Pensions and the 'early starter' areas to review the role of the Troubled Families Employment Advisors and how we can use this valuable resource to best effect.

The movement of a family off benefits and into continuous employment often represents the culmination of significant and sustained progress across a range of outcomes for many families. For example, mental illness, substance misuse, offending behaviour, poor school attainment and experience of domestic violence and abuse are all well evidenced barriers to employment. To overcome these barriers, secure work and maintain it for at least 13 weeks represents a major outcome for most families.

[52]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336430/Understanding_Troubled_Families_web_format.pdf
[53] As per the end of August 2014.

As per the current Programme, this results has two parts:

1. The movement off out of work benefits (or off Universal Credit, as appropriate), and

2. The sustainment of a period of continuous employment.

For the first part, where family members are in receipt of Universal Credit (UC) and remain on benefit, the outcome must satisfy an earnings threshold of £330 (for people aged 25 and over) or £270 (for people aged under 25; and apprentices). Where families move onto UC, Troubled Families Employment Advisors will help local authorities with any queries and provide the information they need. This will include information about earnings thresholds.

If an adult moves into self-employment or is under a zero hour contract, in the interim local authorities should agree the best measurement approach with their Troubled Families Employment Advisors and local auditors. A longer-term approach will be agreed ahead of national roll out.

For the second part of the result, the length of time an adult must remain in work depends on the type of benefit they were receiving previously. These measurement periods reflect the Department for Work and Pensions' previous approach with its own providers.

Benefit	**Period of continuous employment**
Job Seekers Allowancee	26 weeks (out of the last 30 weeks)
Job Seekers Allowance (ex-Incapacity Benefit claimant)	13 consecutive weeks
Employment Support Allowance	
Income Support	
Incapacity Benefit	
Carer's Allowance	
Severe Disablement Allowance	

Subsequent Continuous Employment

Where a family member has already achieved significant and sustained progress towards work, but not yet secured a job, many local authorities have emphasised the importance of ensuring this is followed through and an adult in the family is moved into work.

While no additional central funding is available for these additional outcomes, many local authorities have asked to ensure that the total employment outcomes achieved with families

is recorded systematically and forms part of their published results figures. This accountability and clear prioritisation of employment outcomes will serve as an incentive to ensure employment outcomes are maximised and the local fiscal and social benefits are realised.

In response to this feedback, from January 2015, local authorities will be able to report a ‘subsequent continous employment’ outcome. This outcome is based on the following terms:

- It should only be reported for families where a sustained and significant progress result has already been claimed;
- It should not be reported for families where a continous employment result has already been claimed;
- The adult in the family should have moved off out of work benefits and maintained a job for the same amount of time as the continous employment result requires; and
- The outcome should be approved to the same standards as other results by the local authority’s internal auditors.

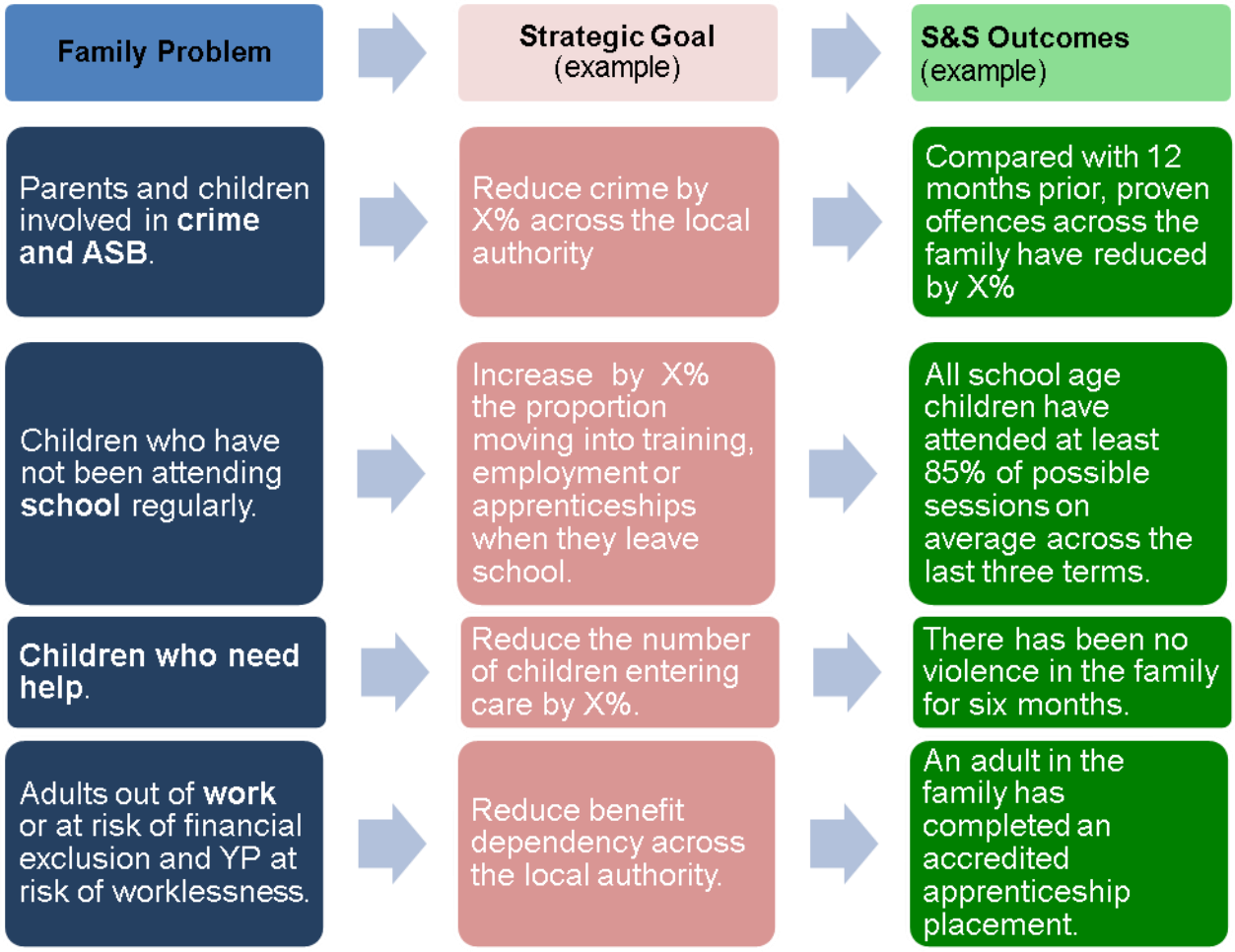
These outcomes will be published regularly on a per local authority basis as part of the programme’s management information.

Annex E - Proposed Structure of Troubled Families Outcomes Plan

The Troubled Family Outcomes Plan for each local area should be a short, simple and clear articulation of each area's definition of success through the programme. The Plans should be agreed as a local authority wide set of expectations, although they should be based on outcomes which may then be applied on a per family basis. Some local authorities are agreeing Troubled Families Outcomes Plans with their neighbouring areas in order to reinforce more ambitious service transformation objectives.

While the form and content of the Troubled Families Plan is for each local area to agree, the TFT is working with the 'early starters' to understand the approaches being adopted and will showcase best practice examples ahead of national roll out. This is part of the programme's work with early starter areas to design the detail of the programme and is currently only at an initial stage, but the following reflects the emerging lessons:

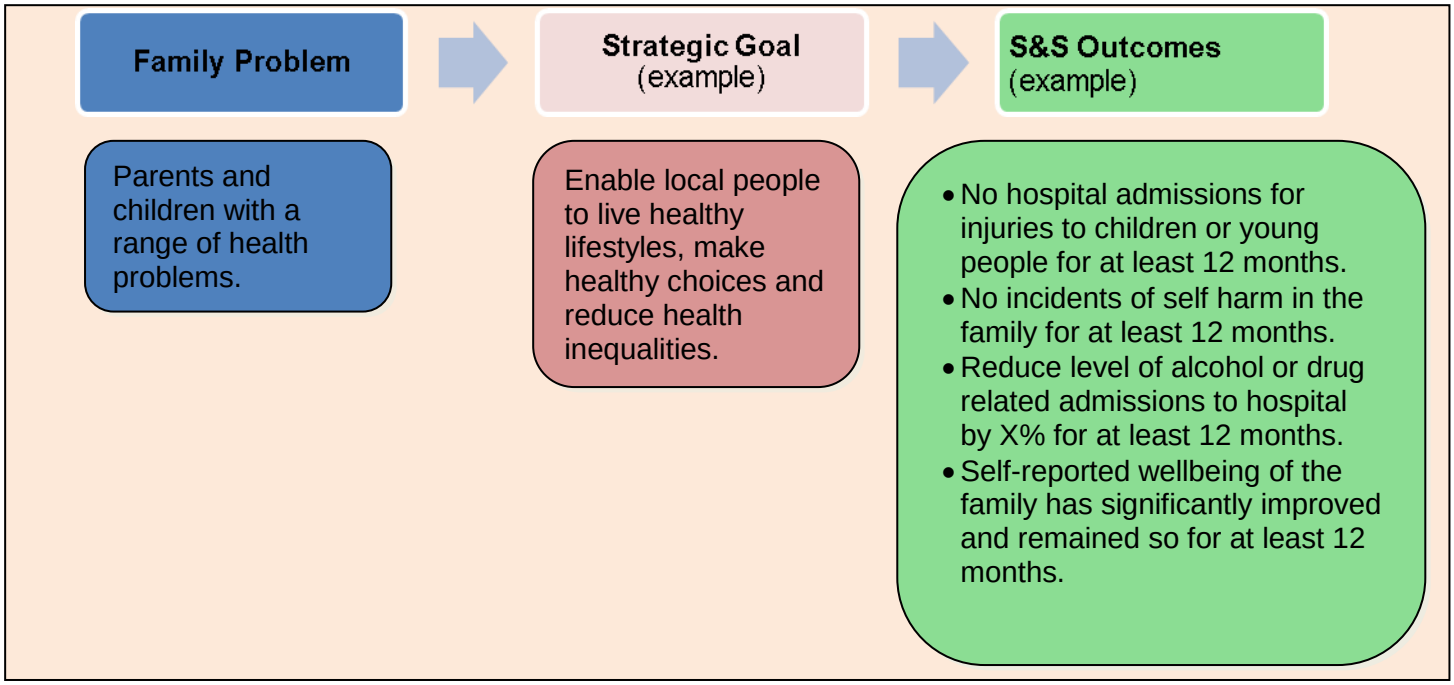
Figure 2: An example of the possible structure of the Troubled Families Outcomes Plan, using hypothetical strategic goals and significant and sustained outcomes.



The TFT will not sign off each area's Troubled Families Outcomes Plan as these should be agreed locally. However, the Team would like local authorities to share these with them as part of the regular and ongoing discussions between local areas and the Team. While some areas are working to share examples sooner, the TFT will ask all wave 1 'early starters' to share their Troubled Families Outcomes Plan with the Team in January 2015 in order that we may share good practice examples more widely alongside the Financial Framework ahead of the programme's national roll out.

Many of the early starter areas are developing wider operational and information management arrangements to support the implementation of their Plans locally and the measurement of outcomes.

Figure 3: Example Structure of section in a Troubled Family Outcome Plan plus possible supporting agreements



Indicators and suggested information sources in the *Financial Framework.*

Local data sources, information sharing protocols and agreed data owners.

Reference to existing strategic goals (e.g. Health & Wellbeing Board priorities).

Workforce development strategy

Reference to Public Health and NHS Outcomes Frameworks.

Info sources and data sharing arrangements to measure the outcomes. May be combination of hard data and key worker assessments, but should be agreed with your internal auditors.

Consider aligning with Family Progress Data and cost savings calculator unit costs to streamline data collection.

Annex F - From Family Monitoring Data to Family Progress Data

As part of the current Troubled Families Programme's independent national evaluation, local authorities are providing detailed information about the characteristics and problems of at least a 10% sample of their troubled families across a broad range of public service areas, including health, crime, education, worklessness, housing, child protection and housing. An initial report, based on information relating to nearly 8,500 families, was published in July 2014.[54] For the remainder of the current Programme, local authorities will continue to provide this information at six-monthly intervals and, over time, this will build a significant evidence base on the problems experienced by these families and the change demonstrated across these problems.

In January 2015, as an interim approach, all of the first wave of 'early starter' local authorities will provide Family Monitoring Data using the existing system. This information will be provided for a random representative sample of at least 10% of families who enter the expanded Troubled Families Programme in this year. This information will help us to map the profile of families reached by the expanded programme and will help build a strong evidence base for continued investment.

By April 2015, we will move from the collection of Family Monitoring Data to the collection of Family Progress Data, with a greater emphasis on the change achieved by family members. Where existing measures are valuable and collectable locally, we will retain them. However, the purpose of this change in approach is to focus more on measures which will demonstrate the progress achieved with families, streamline the number of measures we ask local areas to collect and align them with unit cost measures in the cost savings calculator as far as possible. Achieving this involves a number of pieces of work:

- To minimise the amount of data collected locally, we will maximise the use of the National Impact Study (NIS) in the expanded programme. NIS is a project initiated under the current programme's evaluation, which makes a quantitative assessment of the impact of the programme, by matching data about individuals in troubled families to national administrative datasets held by government departments (e.g. Police National Computer and DWP's benefits systems). Furthermore, it provides an estimate of the added value of the programme by comparing families who have received an intervention with individuals in families before they started intervention and/ or who fell just short of eligibility for the programme.

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54 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336430/Understanding_Troubled_Families_web_format.pdf

The TFT is exploring options to increase the number of national data sets against which local family data is matched as part of the National Impact Study and also to provide localised findings. We will ask all local authorities to participate in this work as part of the sign up process ahead of national roll out. It will be an integral part of the expanded Troubled Families Programme.

- Where outcomes are not recorded in national datasets, our understanding of the change achieved by the programme will be supplemented with the collection of Family Progress Data for a random and representative sample of families. As far as possible, the TFT are working to align these with the measures collected locally for the cost savings calculator.

- To inform the development of the Family Progress Data measures, the TFT hosted an initial consultation workshop with a group of 'early starter' areas in September 2014. This provided feedback on the current system and ideas for the new approach.

- One of the ideas provided during the workshop was to assess the usefulness and availability of the data collected in the current Family Monitoring Data and cost savings calculator. In response, the TFT has issued a questionnaire to all 'early starter' areas. The findings will inform the selection of the finalised list of Family Progress Data measures.

- The TFT has started work on the development of a new streamlined system for the collection of data which aims to enhance its usefulness locally and reduce the bureaucratic burden on local authorities and their partners.

- In December, we will be hosting a market testing event for the evaluation of the expanded programme in order to gauge the interest of the potential providers.

The progress being achieved with families as evidenced through collection and submission of Family Monitoring and Family Progress Data, and the financial benefits evident from each local authority's completion of the cost savings calculator (see Annex G), will be included in regular publications by the TFT, as part of the expanded Programme's drive to help transform services through transparent local accountability.

Annex G - Troubled Families Cost Savings Calculator

In May 2014, the Troubled Families Team provided all local authorities with a new online cost savings calculator. This incorporates unit costs information approved by HM Treasury and other government departments and has been tailored to focus on the fiscal, social and economic benefits of greatest relevance to the Troubled Families Programme. It is an evaluative tool which enables local authorities and their partners to calculate the savings achieved through the delivery of the current programme with real families by looking at their actual outcomes before and after intervention. For some time, many areas have showcased striking examples of the costs and savings derived from work with individual troubled families. However, this tool aims to take this work to a more comprehensive, rigourous and representative level and thereby ensure the programme is well placed to make a compelling case locally and nationally about the value for money it achieves.

During 2014/15, all early starter areas will complete the cost savings calculator for a random representative sample of families in the current Programme and the first wave of early starters will complete it for a further 25% random representative sample of families who enter the expanded programme in 2014/15. This will be used alongside the Family Monitoring Data and this evidence will not only be essential in building a strong evidence base for continued central investment in the programme but will also provide useful evidence to support local discussions about the relative resource contributions of local authorities and their partners to the delivery of the programme.

The Troubled Families is working with a group of local authorities (primarily early starters) and a HM Treasury led group of economists from across government to test and improve the cost savings calculator. While the calculator is currently the most credible and robust tool available to evaluate the cost benefit of the Troubled Families Programme, we know there is a lot of work that can be done to improve it. This includes joint work with early starters to align the information collected for the Family Progress Data and the unit costs contained within the the cost savings calculator as far as possible. We are exploring a number of options to achieve this and aim to have made significant progress towards this before national roll out in April 2015.

The financial benefits evident from each local authority's completion of the cost savings calculator, and the progress being achieved with families as evidenced through collection and submission of Family Monitoring and Family Progress Data (see Annex F), will be included in regular publications by the Troubled Families Team, as part the expanded Programme's drive to transform services through transparent local accountability. For each local authority, this will lay out the form and extent of the problems of families in the programme, the progress achieved with these families and the fiscal benefits realised as a

result. This rich information will enhance local accountability for the success of the programme and help shape discussions about the service transformation objectives and overall effectiveness of delivery.

Annex H - Payment Terms

As per the current Troubled Families Programme, the majority of the funding will be available on a per family basis for the achievement of significant and sustained progress or continuous employment outcomes. It will remain in two parts: an upfront attachment fee and a results-based payment.

All early starters have committed to bring an agreed number of families into the expanded programme during 2014/15. An upfront attachment fee of £1,000 will be paid to these areas for each of these families. Each local authority will be asked to report on their progress against this commitment in January and then again, ahead of national roll out, in March. If an area does not fulfil its 2014/15 commitment, the Department may withhold future funding in 2015/16[55].

A results based payment of £800 will be offered for each family for whom the local authority claims to have either (a) achieved significant and sustained progress, or (b) moved off out of work benefits and into continous employment. The first available opportunity to claim results will be in January/ February 2015. However, given families may take time to achieve change and demonstrate the sustainability of their outcomes, we expect most families to achieve results later in 2015.

If a family has achieved significant and sustained progress and a claim for a results payment is made, the local authority may not claim a further result payment if an adult in the family subsequently moves off benefits and into continuous employment. This would constitute double payment for the same family. However, a field will be available on the results claim form (on the existing Logasnet system) to record that a 'subsequent continuous employment' outcome has been achieved. While no additional funding will be paid for this outcome, the results will be published to evidence each area's overall success in terms of employment outcomes for families.

Local authorities may not receive further funding payment for a family for whom any payment have already been received as part of the current Troubled Families Programme. While it remains in areas' wider interests to ensure the improved outcomes of these families are sustained and they do not deteriorated, outcomes achieved with these families should not be counted twice. **The estimated 400,000 families supported by the expanded programme are in addition to the 120,000 families supported by the current programme.**

[55] Unlike the current programme, local authorities will not be asked to report against the number of families identified and being worked with every 3 months. Instead, areas will be asked to provide a single number – the number of families brought into the programme in January and then again by the end of March 2015. A schedule of reporting arrangements for 2015/16 will be set out for all local authorities ahead of national roll out in April 2015.

In addition to the funding for achieving outcomes with each of the estimated 400,000 families, each participating local authority will also be offered a Service Transformation Grant. This grant will be weighted in accordance with the number of families that the TFT and the local authority mutually agree will be part of the expanded programme in each area. It will follow a comparable band structure to the current programme. During 2014/15, the funding is offered as an additional *pro-rata* supplement to each early starter's existing Troubled Families Coordinator grant at the following levels:

Estimated number of families in the expanded Troubled Families Programme	**2014/15 grant for service transformation for the first wave of 'early starter' areas (Sept 2014)**	**2014/15 grant for service transformation for the second wave of 'early starter' areas (January 2015)**
0-150	£17,500	£7,500
151-1500	£44,000	£19,000
1500-3500	£58,500	£25,000
3501-6500	£102,000	£44,000
6501-10,000	£116,500	£50,000
10,001-13,000	£146,000	£62,500
13,001 +	£175,000	£75,000

In 2015/16, we expect the level of service transformation grant offered to each area to be around double that which each area currently receives as a Troubled Families Coordinator Grant. This reflects the increased challenges of coordinating the programme at this scale, as well as the programme's expectations in terms of wider service transformation and the increased provision of evidence via Family Progress Data and the completion of the costs savings calculator. Some areas' Service Transformation Grant may not be double because the work to update the evidence on the distribution in families across local authorities may mean they move up or down bands. Further detail on this will be provided to local authorities in December 2014.

The Troubled Families Team may withhold future funding if commitments made by the local authority before the release of funding are not achieved[56]

[56] For example, if a local authority commits to bring an agreed number of families into the Programme in 2014/15 and receives attachment fees for this number, but then does not fulfil this commitment. The Troubled Families Team may withhold any or some future payments until this commitment is fulfilled. Similarly, if a local authority does not provide Family Monitoring / Progress Data or complete the costs savings calculator as agreed, the Troubled Families Team may withhold any or some future Service Coordination Grant payments until these commitments are fulfilled.

Annex I - The Expanded Troubled Families Programme: Data Sharing Guidance and Principles

The current Troubled Families Programme has driven significant changes in the ways that local authorities, government departments and local partner agencies systematically share information to identify and work with troubled families. The expanded programme offers an opportunity to build and extend upon this area of important public service transformation.

Given the importance of data sharing arrangements, this annex highlights the different sources of information that are available to local authorities to help identify families who are eligible for support under the expanded Troubled Families Programme. It also includes potential gateways, including statutory and common law powers, for sharing information.

The information provided represents work in progress. Together with the 'early starter' local authorities the Troubled Families Team will seek to understand further, the specific barriers that might hinder data sharing under the expanded Troubled Families Programme and identify opportunities to address them. This information will therefore, be refreshed ahead of the expanded programme's national roll out in 2015.

Please note that local authorities are responsible for ensuring that any data sharing arrangements comply with the Data Protection Act 1998 and relevant data sharing legislation.

As with the current programme, families will be identified on a 'household' basis. For these purposes, the definition used by the Census 2011 may be useful – i.e. 'a group of people who either share living accommodation, or share one meal a day and who have the address as their only or main residence'. For the purposes of the programme, families must contain dependent children[57].

In some areas, population churn and engagement across local authority boundaries may present issues. For example, some children may live in one local authority, but attend school in another; and some families may move between local authorities mid-intervention. The Troubled Families Team will not prescribe how local authorities should manage these issues, but encourage collaboration to agree pragmatic and legally compliant local data sharing solutions between local authorities.

[57] A dependent child is a person aged 0-15 in a household or aged 16-18 in full-time education and living in a family with his or her parent(s). Non-dependent children in families are those living with their parent(s), and either (a) aged 19 or over, or (b) aged 16 to 18 who are not in full-time education or who have a spouse, partner or child living in the household. Such children are often young adults, but may be older.

1. Parents and children involved in crime or antisocial behaviour

In most cases, the main sources of information on parents or children involved in crime or anti-social behaviour are likely to be the police, anti-social behaviour teams, youth offending teams, housing providers, prisons and providers of probation services[58].

A significant proportion of crime and anti-social behaviour data is likely to be drawn from the local police, using the Police National Computer and local youth offending teams. The police have a general common law power to share information to prevent, detect, and reduce crime.

There are also legal gateways that support data sharing in prescribed circumstances such as section 115 of the Crime and Disorder Act 1998, which allows the police, local authorities, health authorities, providers of probation services and other relevant agencies to share information about any person for a purpose linked to any provision under the Crime and Disorder Act, including where it is necessary for crime reduction. Section 115 of the Crime and Disorder Act was relied upon under the previous programme and is still applicable.

In addition, section 17 of the Crime and Disorder Act 1998 recognises that local authorities have responsibility for the provision of a wide and varied range of services to and within the community. In carrying out these functions, section 17 places a duty on them to do all they can to reasonably prevent crime and disorder in their area.

As part of the expanded programme, local authorities may also need to obtain data in relation to prisoners and adult offenders with parenting responsibilities, for which the main sources be the National Probation Service, Community Rehabilitation Companies and prisons. This information can, in some circumstances, be shared under section 14 of the Offender Management Act, which permits the sharing of data that would assist with the supervision or rehabilitation of offenders.

Given that the National Probation Service and Community Rehabilitation Companies are new organisations, the TFT will work at a national level with the Ministry of Justice to promote the importance of sharing data with these bodies over the coming months. However, local authorities should also seek to build relationships with local providers and encourage them to collect and share the data that will help them identify troubled families in a legally compliant manner.

Many local authorities have highlighted the need to strengthen data sharing arrangements between the Troubled Families Programme. The importance of this for prisoners nearing release who are not in custody locally has been a particular issue. Linked to wider discussions about data sharing with the National Probation Service and new Community

[58] National Probation Service, Community Rehabilitation Companies and other providers of probation services.

Rehabilitation Companies, the Troubled Families Team will work with the Ministry of Justice and HM Prison Service to progress these issues ahead of national roll out.

2. Children who have not been attending school regularly

As the indicators suggested under this headline problem broadly mirror the education criteria in the expanded programme, the data sharing arrangements are broadly the same.

Most of the relevant education data is already collected by local authorities on a termly basis using Unique Pupil Numbers, as part of standard data collection requirements for the Department for Education as part of the returns to the School and Alternative Provision Census'. The Troubled Families Team recommends the use of this locally collected data to ensure the information is as current as possible.

There are a number of limited exceptions, where the information collected locally for the School Census may need to be supplemented by other sources:

- Academies: Academies collect this data through compatible systems and are legally able to share this with local authorities using Part 4 section 23 of the School Discipline (Pupil Exclusions and Reviews) (England) Regulations 2012. Around half of academies already share their data with local authorities.

- Fixed exclusions: This data is not always collected for children in alternative provision, independent schools or non-registered alternative provision providers. As such, local authorities should identify these children within their own local systems and through discussions with such schools. We expect these to be relatively small numbers. Some supplementary information may be needed from Education Welfare Officers (or equivalent) to produce a complete picture of each child's circumstances. For example, this may relate to children who are in reception year classes and sixth form.

There are a small number of children who are considered 'missing' because they are not on the school roll. These children are likely to be among the most vulnerable category of children and therefore, it is important that the Troubled Families programme identifies them as far as possible. However, it is not our intention to target children who are being appropriately home schooled, as these children will be receiving an education from their parents.

Local authorities may collect and share attendance under the school census regulations – Education (Information about Individual Pupils) (England) Regulation 2013, S.I. 2013/94 - which require maintained schools and pupil referral units to share information about pupil attendance.

3. Children who need help

Most of the information needed to apply the suggested indicators under this headline problem is already collected within local authorities, as part of their Children Services arrangements (or equivalent). However, it will typically require local authorities to combine information from across a range of sources.

For example, to identify children who have not taken up the early education entitlement, this may include cross-referencing information relating to two years old children who are eligible for the early education entitlement with information about those who are actually attending an early year setting. Under section 99 of the Children's Act 2006, local authorities obtain information about individual children who are receiving early years provision; and under s13A of Childcare Act 2006 Her Majesty's Revenue and Customs shares tax benefit credit and benefit information with local authorities for the purpose of determining whether or not a particular family may have a child who is eligible for funded early education.

Local authorities are also likely to draw a significant amount of the data relating to children who need help from their own local authority Children Services. Some of this information is already shared within the current programme and the relevant gateway is the implied powers to share information under section 17 of the Children Act 1989 in order to enable assessments to be undertaken as to whether services may be required by a child in need. More generally, implied data sharing powers under section 10 of the Children Act 2004 may also provide a means of obtaining information in order to safeguard and promote the wellbeing of children.

4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness

For the current programme, the Department for Work and Pensions created a new legal gateway under the regulations of the Welfare Reform Act 2012. This allowed the Department for Work and Pensions to share data with local authorities – without informed consent – for the sole purpose of identifying troubled families.

The new regulations came into effect in May 2012 and they will continue to provide the gateway for identifying young people and adults in receipt of out of work benefits under the expanded programme. They will also provide the gateway for the sharing of this data once Universal Credit comes into effect, providing a gateway for adults claiming Universal Credit and subject to work related conditions.

Under the current programme, most local authorities have accessed this information via a manual data sharing arrangement with the Department for Work and Pensions. However, as part of a phased roll out, most local authorities are now moving onto a more flexible, frequent, accurate and cost effective automated system – known as the Automated Data

Matching Solution (ADMS) for the Troubled Families Programme. Guidance will be available to you on the 'Supporting families' Knowledge Hub.

Where family members are in receipt of Universal Credit (UC) Troubled Families Employment Advisors and Jobcentre Plus Single Points of Contact will help local authorities with any queries and provide information they need. This will include information about earnings threshold.

DWP are currently assessing how data sharing processes, for example the Labour Market System marker management information reports and ADMS, will work for families on Universal Credit. We will provide updated guidance on UC and the expanded programme ahead of its national roll out.

To identify young people who are risk of or are already not in education, training or employment, local authorities may draw on information held in their Client Caseload Information Systems (or equivalent). Local Authorities have a statutory duty to encourage and assist young people to participate in education or training. This stems from sections 68 and 70 of the Education and Skills Act 2008. As part of this duty local authorities collect information on 16 to 19 year olds and will be aware of those who are not in any form of education, employment or training, including those who are not able to work because of illness or other reasons such as caring for dependant or family members. Local Authorities may choose to share this information internally further to their general power of competence under section 1 of the Localism Act 2011. This information could be defined as individual pupil information under section 537A(9) of the Education Act 1996 so could also be shared by local authorities using section 537A(6) of that Act.

5. Families affected by domestic violence and abuse

In most cases, the main sources of information on families affected by domestic violence and abuse are likely to be the police or local domestic violence support services.

Like crime and anti-social behaviour, data obtained from the police can be shared using section 115 of the Crime and Disorder Act 1998.

Under section 54 of the Domestic Violence, Crime and Victims Act 2004 information can be disclosed by police to victim support groups (with consent). The data can also be shared between agencies via Information Sharing Agreements (ISAs). It is advised that ISAs between local services and local authorities should conform to IDVA Protocol, MARAC Protocol, MARAC/MAPP Protocol and SDAC Procedures.

Given the sensitive circumstances and nature of these cases, it is most likely that agencies will refer cases to a local authority on an individual basis (see Nomination section below).

6. Parents and children with a range of health problems

The sharing of health data for the identification of troubled families has been one of the biggest challenges of the current Troubled Families Programme. The expanded Troubled Families Programme aims to prioritise efforts to overcome these issues and ensure greater collaboration between local troubled families teams and health bodies. Given the particular sensitivities around the sharing of personal health data, the Troubled Families Team has been working with Public Health England, Department of Health and NHS England to agree an approach that allows families to be identified for support under the expanded programme on the basis of their health needs.

We have agreed a recommended minimum approach that local authorities and health partners may use to identify families on the basis of their health needs. The approach was published on 5 November in draft data sharing guidance with advice from the health data sharing governance body (Information Governance Alliance) and national health agencies.

The approach recommends that a list of families that have already been identified as meeting one of the programme's indicators is shared with relevant health partners so that they can use this to flag whether any of the suggested health indicators are met. You will then need to talk to your relevant health partners and/or governing bodies to work out the best ways of gathering and sharing this data.

While we recognise this is unlikely to unlock all the data you need to work with families, it will start the process of identifying the families in the health system that may be eligible for support. Some local authorities may already be receiving health data or have negotiated alternative data sharing arrangements with local health partners. The new data sharing guidance will not override this and should be used to help reinforce the health system's support of the Troubled Families Programme.

Further information on the interim health data sharing protocol for the Troubled Families Programme is available here:

https://www.gov.uk/government/publications/troubled-families-supporting-health-needs

Nominations

The financial framework suggests a range of indicators that can be used to identify families under the 6 headline problems. However, within this Financial Framework, we recognise that nominations will be one important way through which local authorities can identify the families with the breadth of problems that the expanded programme is targeting. This is why there are suggested indicators under each of the headline problems referring to 'problems of equivalent concern'.

These indicators enable nominations from professionals locally and, depending on the nature of the risk and seriousness of the circumstances, may be undertaken with or without the individual's consent. In some cases, consent must be obtained by law before a nomination is made. However, in cases where consent is not prescribed by law, individuals should be made aware that their data is being shared and their consent should be sought wherever possible. However, this will be a matter for local assessment and professional judgment in the circumstances of each case.

Given the scale of the programme, nomination arrangements are unlikely to be sufficient to identify the required volumes of families in each local authority. However, the expanded programme provides the flexibility to identify families through these means, where appropriate and as a supplement to other sources of identification.

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12 March 2015	ITEM: 9
Health and Wellbeing Board	
Children and Young People's and Demography JSNA documents	
Wards and communities affected: All	**Key Decision:** Key
Report of: Debbie Maynard, Head of Public Health and Maria Payne, Health Needs Assessment Manager	
Accountable Head of Service: Debbie Maynard, Head of Public Health	
Accountable Director: Dr Andrea Atherton, Director of Public Health / Roger Harris, Director of Adults Health and Commissioning	
This report is Public	

Executive Summary

Every Health and Wellbeing Board has the responsibility to produce a Joint Strategic Needs Assessment for their area, which should give a comprehensive overview of the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services. This paper aims to update the Health and Wellbeing Board with the progress of the new JSNA process, and to request approval for the drafts of the Children and Young People's and Demography documents.

1. Recommendation(s)

1.1 Supporting the key recommendations and priorities identified in the documents

1.2 Approving the Children and Young People's and Demography JSNA documents for publication

1.3 Commit to supporting the process required to maintain future JSNAs

2. Introduction and Background

2.1 Since 2013 it has been the responsibility of every Health and Wellbeing Board to produce a Joint Strategic Needs Assessment for their area to provide a comprehensive overview of the current health and wellbeing of their population, form an evidence base for future commissioning priorities, and inform a Health and Wellbeing Strategy. Within Thurrock, the Health and

Wellbeing Board have delegated this responsibility to the Public Health team to coordinate.

2.2 The current JSNA in place for Thurrock was published in 2012, and is available here (https://www.thurrock.gov.uk/healthy-living/joint-strategic-needs-assessment) . This document provides an overarching view of the whole population, and is very data-focussed. A proposal for the new JSNA which was agreed by Directors Board in January 2014 was to produce separate JSNA documents for key population groups or topic areas, which together would form a comprehensive overview, but could stand alone and give more detailed information about current services and needs. The documents would also have more focus on what we are doing locally already to address needs, and move further towards an asset approach. In particular, the considerable regeneration and population growth that Thurrock has begun and will continue to experience will lead to a number of benefits, opportunities and challenges, and it is hoped that the JSNA documents will support commissioners and decision-makers in identifying and meeting future needs. A timeline was agreed to enable these documents to be produced in a staged process between 2014-2016.

2.3 Whilst each JSNA document is project-managed and collated from within the Public Health team, each document has been and will be produced with contributions from a range of internal and external partners in order to ensure the accuracy and usefulness of the information. Focussed Task and Finish groups have been established to ensure the right people are involved in producing the documents and submitting recommendations for consideration when making commissioning decisions.

2.4 As per the agreed timescales, a JSNA on the Demography of the Thurrock population was the first to be produced. The aim of this document is to give an overview of the characteristics of the local population, including where there might be differences within the borough, in order to underpin the other JSNA documents which will focus on key groups.

2.5 The second JSNA document to be produced has focussed solely on the needs of Children and Young People in Thurrock. The Task and Finish group agreed that it should follow the structure determined by Every Child Matters, in order to fully cover the needs of our Child population.

2.6 The plan is for JSNAs on the Wider Determinants of Health, Adults and Older People, and Assets to be produced in 2015.

2.7 It is recognised that it will require a large amount of capacity and resource to maintain and produce JSNA documents to constantly ensure we have got the most current information available. There is the potential to include the JSNA as part of the work of the Thurrock Digital Board in order for future JSNAs to be more accessible and easier to maintain. Work is in process to explore this opportunity in time for the updates to all documents.

2.8 Support will be required in order to ensure the information presented in this document remains current in the future. Whilst this process could be coordinated within the Public Health team, support would be required from various partners to ensure that the latest data is provided to keep each section up to date. This approach has been supported by Children's Partnership Board and Health Overview and Scrutiny Committee.

3. Issues, Options and Analysis of Options

3.1 The options identified for consideration by the Health and Wellbeing Board are:

- **Do nothing** – this gives no commitment to approving the two draft JSNA documents or the future approach to JSNAs. However this carries a risk that Thurrock would not be meeting its responsibilities to maintain a JSNA that provides a current overview of the population and their needs. It will also mean that the current Thurrock JSNA produced in 2012 will become further and further out of date and therefore less meaningful.

- **Give formal approval to the publication of the Children and Young People's and Demography JSNA documents, but give no further support to the future process for maintaining JSNAs electronically** – this would enable a current overview of the key demography of Thurrock and a separate comprehensive picture of the Children and Young People to be known now, but run the risk of future JSNAs becoming dated more quickly.

- **Give formal approval to the publication of the Children and Young People's and Demography JSNA documents, and give support to the future process for maintaining JSNA electronically** - this would enable a current overview of the key demography of Thurrock and a separate comprehensive picture of the Children and Young People to be known now, and facilitate the process of maintaining JSNAs in the future.

4. Reasons for Recommendation

4.1 The preferred option for the Health and Wellbeing Board is to approve the two documents and give support to the future process for maintaining JSNA documents electronically. This is preferred in order to ensure the information in the documents is still current when they are published, and to facilitate the process of maintaining JSNAs in the future.

4.2 If these documents are not published, there is a risk that Thurrock will not meet its responsibilities to maintain a JSNA that provides a current overview of the population and their needs.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 These documents were completed in collaboration with a wide range of partners. Regular updates on progress were provided to the Public Health Strategy Board and the JSNA Delivery Group, both of which have a range of internal and external members. The multi-agency Children's Partnership Board gave their approval and support to the Children and Young People's JSNA document on 12th January 2015.

5.2 An update on the progress of the JSNA process, including the proposed future process, was presented at Health Overview and Scrutiny Committee on 13th January 2015. Members were supportive of the way in which the documents have been developed, and the future JSNA process.

6. Impact on corporate policies, priorities, performance and community impact

6.1 Publication of both JSNA documents will ensure the priorities and recommendations set forth can be used to effectively underpin and support commissioning decisions in the future.

6.2 The proposed future digital approach should invite stakeholders and residents to feel confident that information from these JSNAs is current and accurate, and gives a good understanding of the needs and priorities for our local population.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Finance Officer

There are no implications currently – But in the future the JSNA could have future financial implications to commissioners both in health and social care.

7.2 Legal

Implications verified by: **Dawn Pelle**

Adult Care Lawyer

There are no legal implications for the following reasons:

The report sets out the options to be considered by the HWBB and the ones chosen to give an overview of the current demography and to allow for the process of maintaining future JSNAs.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Communities and Diversity Manager

The JSNA captures robust up-to-date details around diversity and equality and should inform commissioners and members of the current position locally.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Demography JSNA
- Children and Young People's JSNA

9. Appendices to the report

Report Author:

Debbie Maynard / Maria Payne

Head of Public Health / Health Needs Assessment Manager

Public Health

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Thurrock

Joint Strategic Needs Assessment

Demographics and Population Change

Contents

Introduction to the JSNA

The Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of the local community – these are needs that could be met by the local authority, Clinical Commissioning Groups (CCGs), or NHS England. It is intended to provide a shared, evidence based consensus about key local priorities and support commissioning to improve health and well-being outcomes and reduce inequalities. In order to appropriately identify needs within our local community, it is paramount we review the demographic structure. This chapter sets to profile the demography of Thurrock showing projections for the future. This will inform other chapters within the JSNA as well as provide a baseline for commissioning priorities.

Chapter Summary

Age Structure

- In 2013 the total population of Thurrock was 160,850 (ONS mid-year estimates 2013) of which 79,330 (49.3%) were male and 81,520 (50.7%) female.
- Thurrock's age structure is similar to that of, regional and national figures but generally has a larger young population aged 0-19 years – particularly 0-4 year olds, and a larger population in their 30s and early to mid-40s than both East of England and England. Conversely, Thurrock has a smaller proportion of older people than both East of England and England.

Population Distribution

- The population is not evenly distributed across the borough - there are more densely populated areas within the southern and central areas of Thurrock
- The areas with the highest percentage of under 15s in Thurrock are heavily clustered around the south and south west of the borough including the wards of Tilbury St Chads, Chafford and North Stifford, South Chafford and West Thurrock and South Stifford where up to 34% of the population fall within this age group
- The highest proportion of the over 65s (22-36%) reside in the north of the borough in areas such as Orsett, Corringham and Fobbing.

Population Change between the 2001 and 2011 Census

- There has been a 20% increase in 0-4 year olds between 2001 and 2011 (equating to almost 2,000 additional residents in this age group since 2001). This age group makes up 7.6% of the Thurrock's population which is greater than the proportion of the national population.
- The borough's population aged 60 years and above has increased by 16.5% since 2001. However, the proportions of people in each of the 60+ age groups are lower than the England and East of England averages.
- There has been a 47.5% increase in the over 85 population, equating to 846 more residents in this age group since 2001.

Population Projections

- The ONS subnational population projections (2012) estimate that, from 2012, the total population will increase to 176,500 by 2022 and 192,535 by 2032 (an increase of 10.6% and 20.7% respectively).
- The population is predicted to increase for almost all quinary age groups. However, the most significant increases occur in age groups clustered in the 0-14, 25-29, 50-59 and 70 and over age groups. As a

proportion of the total population, the largest percentage increases from 2012 to 2022 are predicted to occur in the 5-9, 50-54 and 70-74 years age groups.

Ethnic groups

- Despite an overall population increase, the White British and Irish groups have decreased in number from 134,348 residents representing 93.9% of the resident Thurrock population in 2001 to 128,348 in 2011 representing 81.6% of the total population. All other main groups have increased both in number and proportion, particularly within the Black groups and Other White Group.

Components of population change

- The number of births in Thurrock has continued to increase, from 1,852 births in 2001, to 2,326 in 2013.
- The number of deaths has decreased from 1,216 in 2001 to 1,170 in 2013.
- The natural population change (births minus deaths) shows a large increase in number of people from 636 in 2001 to 1,213 in 2013. This accounted for 12,898 additional residents between 2001 and 2013.
- There has been substantial movement of people from London to Thurrock, particularly from geographically close boroughs, including Havering, Barking and Dagenham and Newham. The London boroughs as a whole account for over 50% of all internal migration into Thurrock.
- Since 2001, ONS has estimated that international migration into Thurrock has varied from about 500 people annually in 2001, rising to a peak of 1,300 in 2006/7, before decreasing to 723 in 2012/13 - leading to a net flow of about 4,200 people over the period.

Tenure

- There has been a small increase in number of total households rising from 58,485 to 62,353 between 2001 and 2011: a 3.6% increase.
- There has been a significant rise in the proportion of private rented sector housing from 5.9% in 2001 to 13.2% in 2011. The number of households in this sector has risen from 3,456 to 8,220 representing an increase of 137.9%.

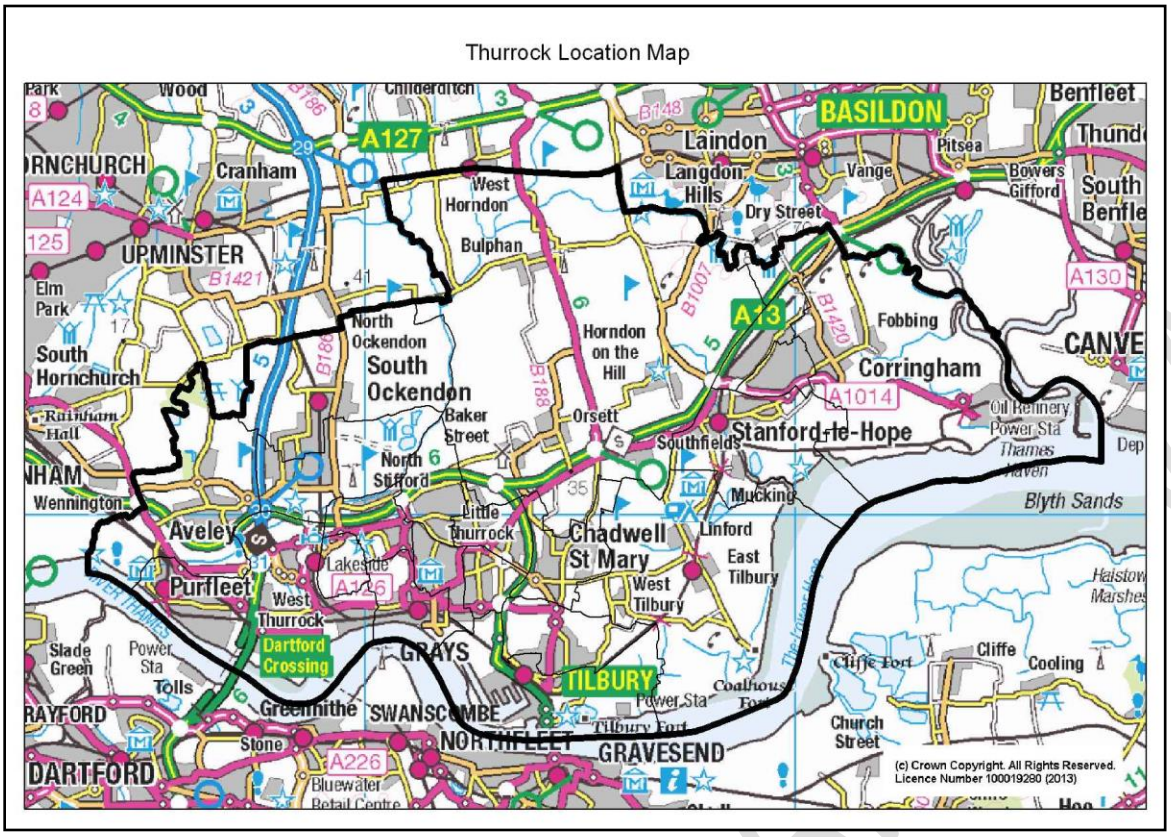
Household Structure

- There has been a 12.5% decrease in one person households aged 65 and older, and a 9.7% decrease in family households all aged 65 and over, together representing 10,379 households in 2011. The overall borough household proportion for both of these groups is substantially less than for either the East of England or England.
- Lone parent households with dependent children have increased by 880 to 4,744 in 2011, representing a rise of 22.7% between 2001 and 2011. Thurrock has 7.6% lone parent households with dependent children, which is a slightly higher proportion than for the East of England but similar to the 7.1% for England.

1 Location

Thurrock is situated in the south of Essex and lies to the east of London on the north bank of the River Thames with an area of 165 square kilometres. It has a diverse and growing population with a population density of 976 persons per square kilometre. Figure 1 shows Thurrock and its surrounding areas.

Figure 1: Thurrock



2 Population

This section describes the population of Thurrock by age, gender, and ethnic group.

2.1 Age Structure

Three key sources are used in this section: the Office for National Statistics (ONS) mid-year estimates and the ONS Census for 2011 and 2001. A summary of the age structure for the authority as a whole is provided together with the key changes over 10 years to 2011. The distribution of the total population and key age groups in Thurrock is then described.

2.1.1 Mid Year Estimates

Table 1 shows the age profile of the total population by sex and age-group. The total 2013 mid-year estimated population of Thurrock was 160,850 of which 79,330 (49.3%) were males and 81,520 (50.7%) females. This is the latest population estimate for the authority and is published annually.

Table 1: 2013 Mid-Year Estimates ONS by Age-Group

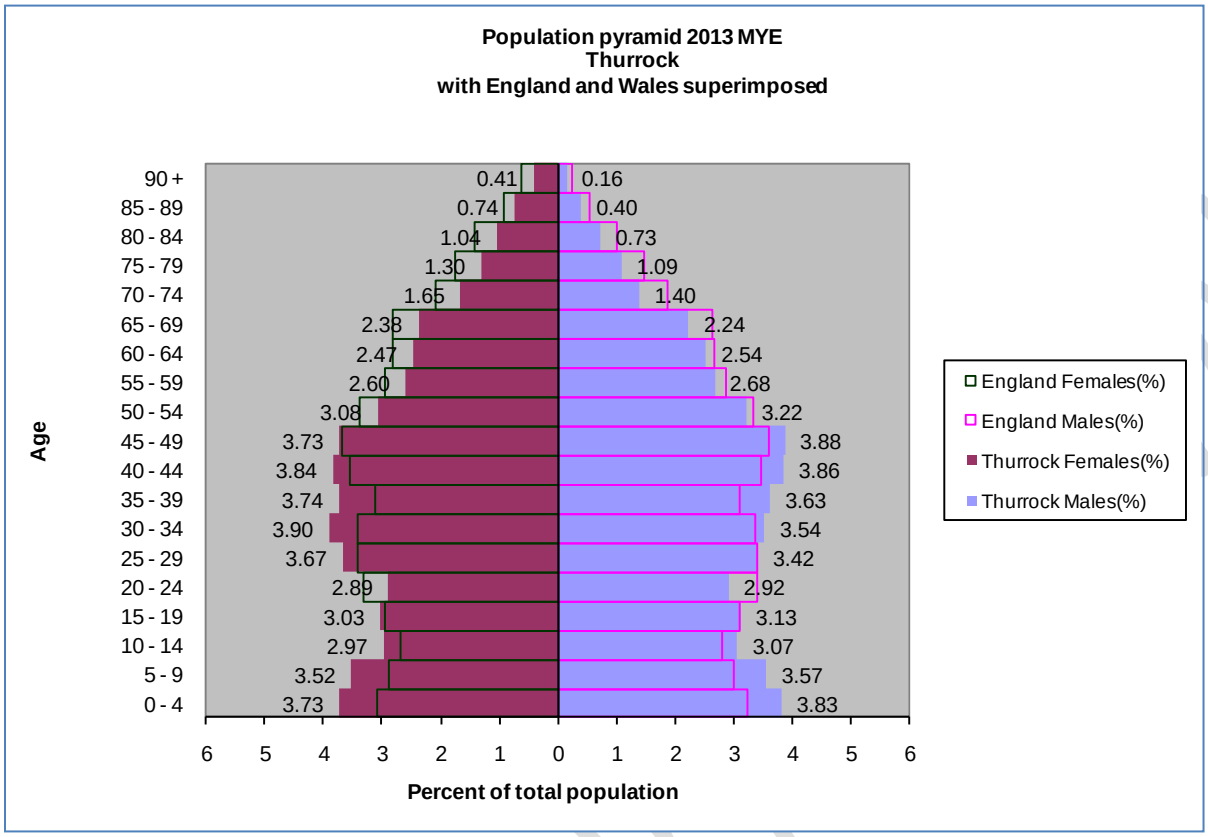
Age Group	Males	Females	Persons	Males	Females	Persons
	Number	Number	Number	% of males	% of females	%
0 - 4	6,160	6,000	12,150	7.8%	7.4%	7.6%

5 - 9	5,740	5,660	11,400	7.2%	6.9%	7.1%
10 - 14	4,940	4,780	9,720	6.2%	5.9%	6.0%
15 - 19	5,030	4,870	9,900	6.3%	6.0%	6.2%
20 - 24	4,700	4,640	9,340	5.9%	5.7%	5.8%
25 - 29	5,510	5,910	11,410	6.9%	7.3%	7.1%
30 - 34	5,690	6,270	11,960	7.2%	7.7%	7.4%
35 - 39	5,840	6,010	11,850	7.4%	7.4%	7.4%
40 - 44	6,210	6,180	12,380	7.8%	7.6%	7.7%
45 - 49	6,240	5,990	12,240	7.9%	7.3%	7.6%
50 - 54	5,190	4,960	10,150	6.5%	6.1%	6.3%
55 - 59	4,310	4,180	8,490	5.4%	5.1%	5.3%
60 - 64	4,080	3,970	8,050	5.1%	4.9%	5.0%
65 - 69	3,610	3,830	7,430	4.6%	4.7%	4.6%
70 - 74	2,260	2,660	4,910	2.8%	3.3%	3.1%
75 - 79	1,760	2,100	3,860	2.2%	2.6%	2.4%
80 - 84	1,180	1,670	2,850	1.5%	2.0%	1.8%
85 - 89	650	1,200	1,850	0.8%	1.5%	1.2%
90 +	250	660	920	0.3%	0.8%	0.6%
Total	79,330	81,520	160,850	100.0%	100.0%	100.0%

Source: ONS mid-year estimates

Figure 2 shows a population pyramid which depicts the age structure of Thurrock in 2013 compared to that of England and Wales. Whilst the pyramids are similar there are some clear differences: Thurrock has a relatively young population with almost all the quinary age groups under 50 years forming a greater proportion of the total population compared to England and Wales; and conversely the age groups over 50 years forming a lower proportion of the total population compared to England and Wales.

Figure 2: Population Pyramid by Quinary Age-Group in Thurrock and England



Source: ONS mid-year estimates

2.1.2 Census 2011 Age Structure and Change

Whilst the mid year estimates provide the latest population figures, the 2011 Census is a much richer source of information.

Table **2** describes the change in age structure between 2001 and 2011.

Table 2: Age Structure Change between 2001 and 2011 Census

	Thurrock (Number)		Number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
	2011	2001			2011	2001		
All People	157,705	143,128	14,577	10.2%				
0-4	12,005	10,008	1,997	20.0%	7.6%	7.0%	6.2%	6.3%
5-7	6,428	5,817	611	10.5%	4.1%	4.1%	3.4%	3.4%
8-9	3,803	3,785	18	0.5%	2.4%	2.6%	2.2%	2.2%

	Thurrock (Number)		Number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
10-14	9,949	9,956	-7	-0.1%	6.3%	7.0%	5.9%	5.8%
15	2,113	1,862	251	13.5%	1.3%	1.3%	1.3%	1.2%
16-17	4,117	3,463	654	18.9%	2.6%	2.4%	2.5%	2.5%
18-19	3,623	3,060	563	18.4%	2.3%	2.1%	2.3%	2.6%
20-24	9,804	8,839	965	10.9%	6.2%	6.2%	6.0%	6.8%
25-29	11,162	11,106	56	0.5%	7.1%	7.8%	6.2%	6.9%
30-44	36,566	33,944	2,622	7.7%	23.2%	23.7%	20.2%	20.6%
45-59	29,375	26,605	2,770	10.4%	18.6%	18.6%	19.8%	19.4%
60-64	8,739	6,004	2,735	45.6%	5.5%	4.2%	6.4%	6.0%
65-74	10,738	9,975	763	7.6%	6.8%	7.0%	9.1%	8.6%
75-84	6,657	6,924	-267	-3.9%	4.2%	4.8%	6.0%	5.5%
85-89	1,844	1,212	632	52.1%	1.2%	0.8%	1.6%	1.5%
90 and over	782	568	214	37.7%	0.5%	0.4%	0.8%	0.8%

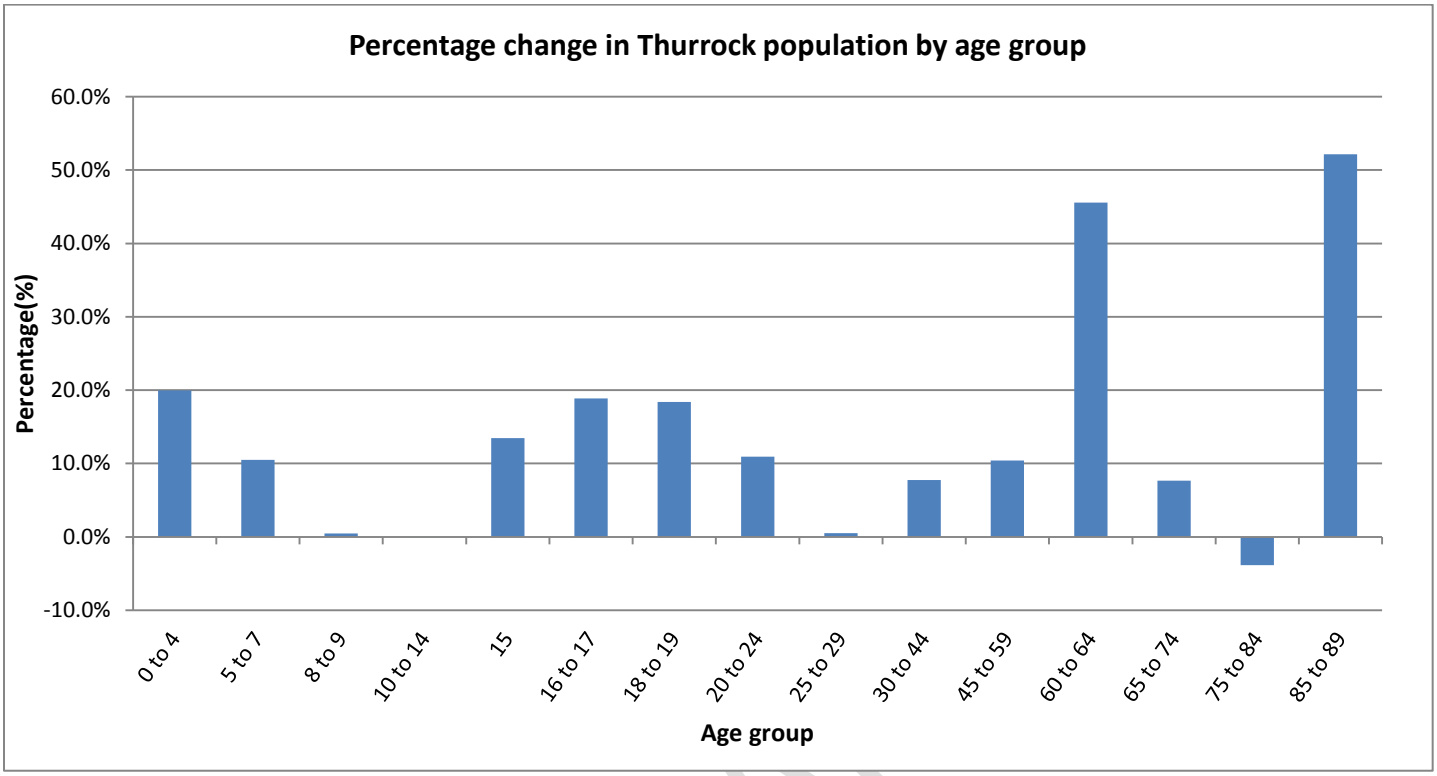
Source: Census 2011 and 2001

- There has been a 20% rise in 0-4 year olds between 2001 and 2011. This age group makes up 7.6% of the Thurrock's population which is greater than the England average.
- The borough's population aged over 60 years has increased by 16.5% since 2001. However, the proportions of people in each of the 60+ age groups are less than the England and East of England averages.
- There has been a 47.5% increase in the over 85 population.

The percentage change for each age group is depicted in

Figure 3.

Figure 3: Percentage change in age groups between 2001 and 2011

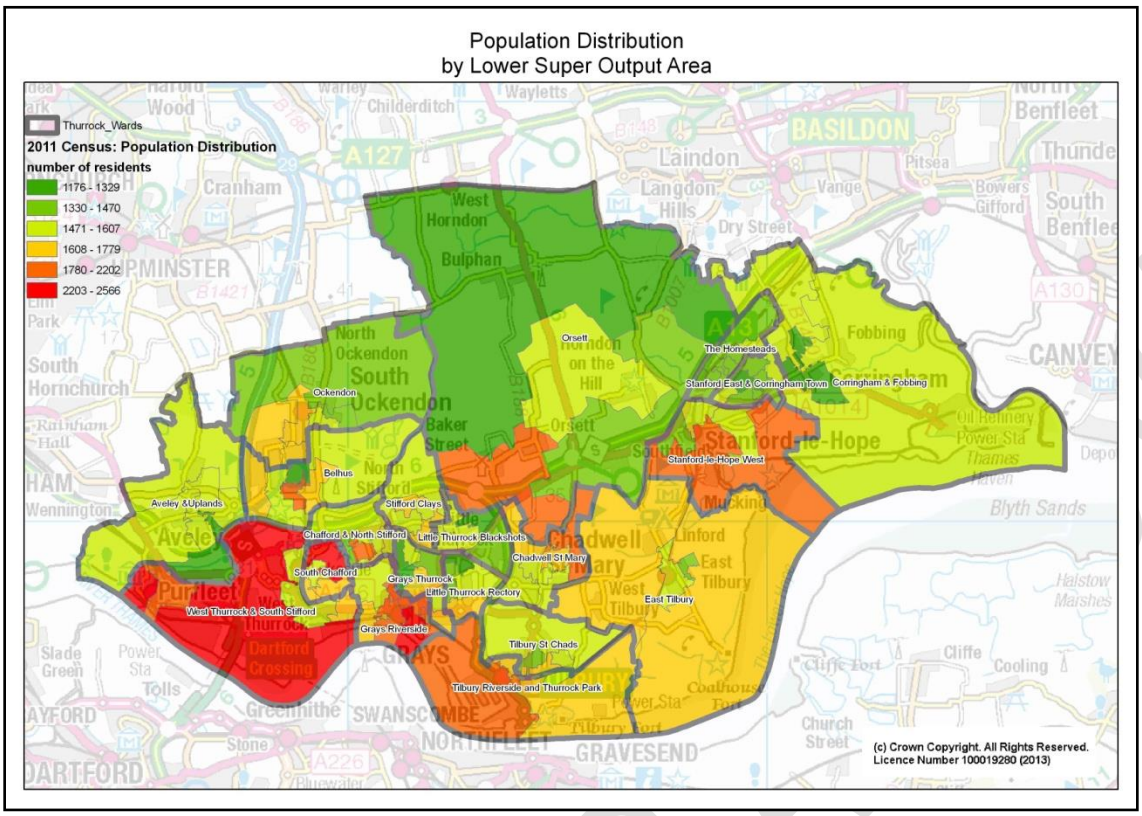


Source: Census 2011 and 2001

2.1.3 Geographical Distribution of Thurrock's Population

The population density and distribution in Thurrock varies considerably from low density in the more rural areas to high in the urban areas. At the time of the 2001 Census, the average population density in Thurrock was measured at 8.8 persons per hectare compared to 9.7 persons per hectare in the 2011 census, demonstrating the recent increase in population. Distribution of population by Lower Super Output Area is shown in Figure 4 highlighting that generally the southern and central areas of Thurrock have the wards with the largest numbers of residents, often in quite small, built up areas such as within the Grays Riverside ward. When planning services, deprivation levels of an area should also be taken into account, as these are also not uniform across the borough. An overview of levels of deprivation within Thurrock can be found within the Wider Determinants JSNA chapter.

Figure 4: ONS 2011 Population Distribution by Lower Super Output Area



Source: Census 2011

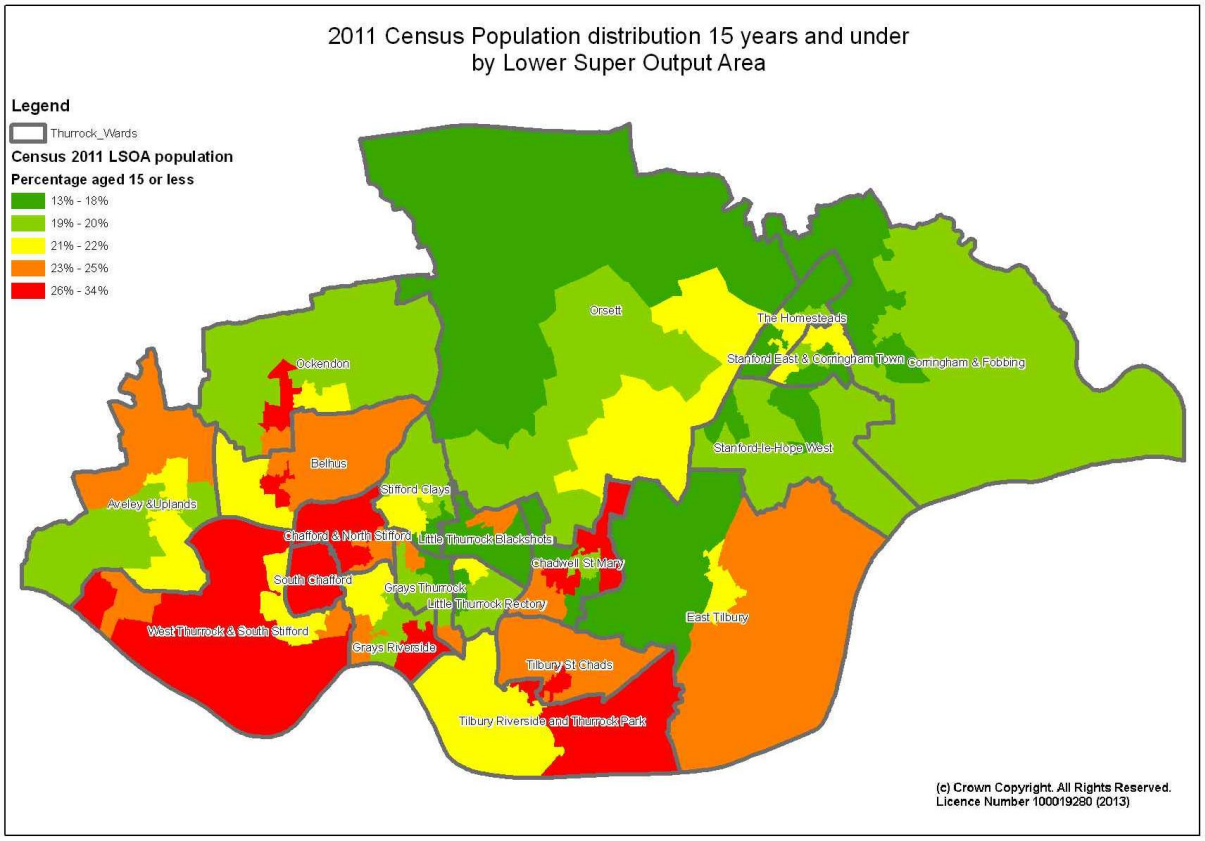
2.1.4 Geographical distribution of key age groups

This section provides the geographical distribution of two key age groups: under 15s and 65 years and over. Health needs differ for both of these groups and it is useful to understand how the proportion of each varies geographically to aid in targeting resources. The maps below show this distribution by Lower Super Output Area.

2.1.4.1Population aged under 15 years

Figure 55 illustrates that the areas with the highest percentage of under 15s in Thurrock are heavily clustered around the south and south west of the borough including the wards of Tilbury St. Chads, Chafford and North Stifford, South Chafford and West Thurrock and South Stifford where up to 34% of the population fall within this age group. This impacts on the type of services commissioned within those areas for the under 15s. [Further information on the child population in Thurrock will be detailed in the Children's JSNA Chapter.]

Figure 5: Population Distribution for people aged under 15 years by Lower Super Output Area

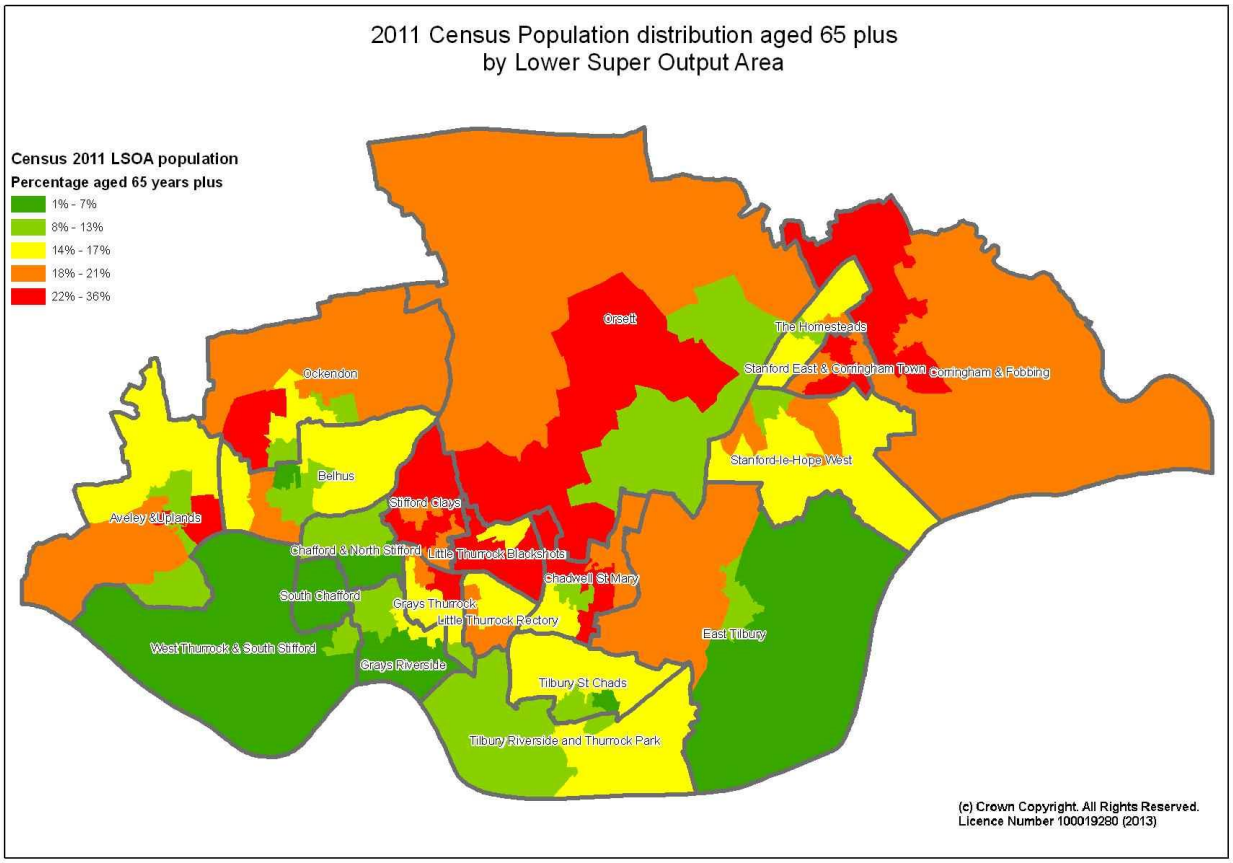


Source: Census 2011

2.1.4.2Population aged over 65 years

Figure 6 shows population distribution of those aged 65 and over by LSOA across Thurrock. The highest proportion of the over 65s (22-36%) reside in the north of the borough in areas such as Orsett, Corringham and Fobbing. Although the impact of the ageing population on health and social services is difficult to predict, it gives an idea of how services for this population group might be planned and prioritised. Work is underway in reviewing how health and social care services will work more closely together to provide better services for this age group. [Further information on the population aged over 65 years in Thurrock will be detailed in the Thurrock Annual Public Health Report 2014]

Figure 6: Population Distribution for people aged 65 years plus by Lower Super Output Area



Source: Census 2011

2.2 Gender

In 2011 there was almost a 50/50 split between males and females. Since 2001 the male population has increased by 11.7%, whereas the female population has increased by 8.7%. When comparing the proportions of males and females in Thurrock to regional and national proportions, it can be seen that Thurrock has a higher proportion of males than both East of England and England populations.

Table 3: Gender Structure Change between 2001 and 2011 Census

	Thurrock (Number)		number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
	2011	2001			2011	2001		
Total	157,705	143,128	14,577	10.2%				
Male	77,823	69,669	8,154	11.7%	49.3%	48.7%	48.4%	48.7%
Female	79,882	73,459	6,423	8.7%	50.7%	51.3%	51.6%	51.3%

Source: Census 2011 and 2001

2.3 Ethnic Group

An understanding of a population's ethnic diversity is important as it is recognised that there is variation on the impact of some wider determinants of health, health behaviour and health conditions across different ethnic groups. Over that last decade, ethnic diversity in Thurrock has increased at a rate faster than the national average.

Table 4 shows the main changes between the 2001 and 2011 Census, while Figure 7 and 8 depict the relative proportions of ethnic groups in 2001 and 2011. Despite an overall population increase, the White British and Irish groups have declined in number from 134,348 residents representing 93.9% of the resident Thurrock population in 2001 to 128, 348 in 2011 representing 81.6% of the total population. All other main groups have increased both in number and proportion, particularly within the Black groups and Other White Group.

Table 4: Changes in Ethnic Groups between Census (2001 and 2011)

Main Ethnic group					
	2011		2001		2001 to 2011
	number of residents	% of total population	number of residents	% of total population	absolute change
White:British and White:Irish	128,695	81.6%	134,348	93.9%	-5,653
White: Other	6,734	4.3%	2,051	1.4%	4,683
Mixed	3,099	2.0%	1,319	0.9%	1,780
Asian	5,927	3.8%	3,405	2.4%	2,522
Black	12,323	7.8%	1,659	1.2%	10,664
Other	927	0.6%	346	0.2%	581
TOTAL	157,705	100.0%	143,128	100.0%	14,577

Figure 7: 2001 Condensed Ethnic Groups

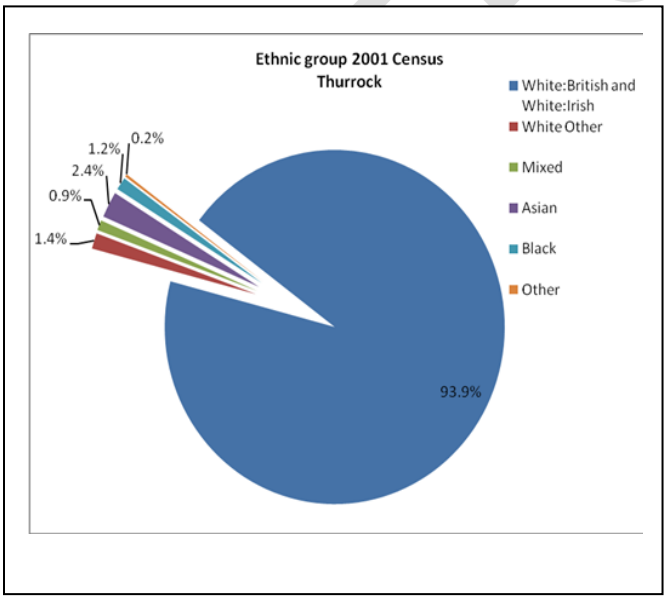
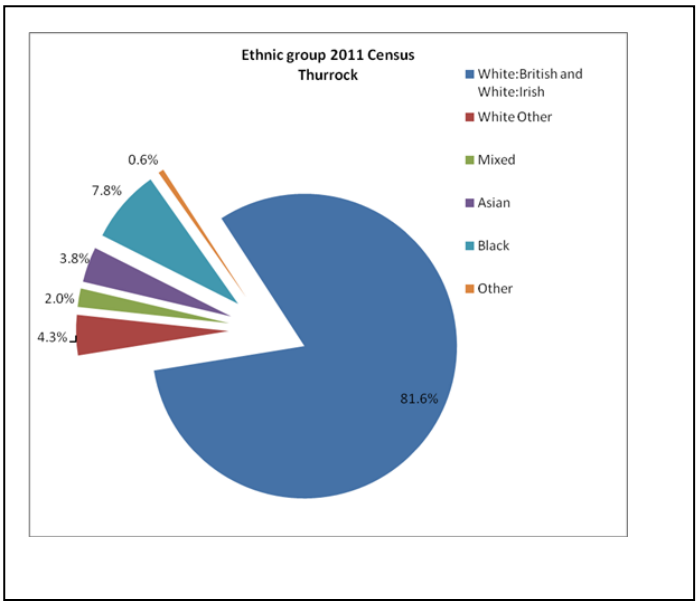


Figure 8: 2011 Condensed Ethnic Groups



Source: Census 2011 and 2001

The increase in the proportion of many ethnic groups can in part be attributed to substantial inward migration to Thurrock from East London coupled with rising levels of international migration mainly from parts of Africa and Eastern Europe. The pattern of international and internal migration is described in more detail in Section 0.

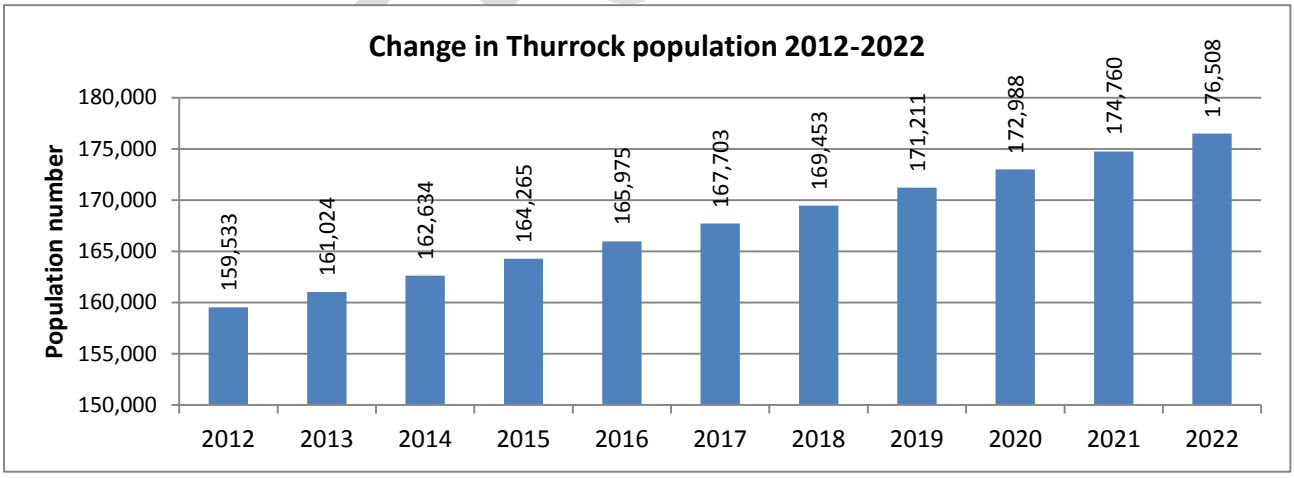
2.4 Population Projections.

Population projections estimate the future population of an area. This is useful to inform commissioners of major future trends that may affect health, social and economic development of an area and assess future demands on services. It enables commissioners to incorporate these demands and trends in planning processes to meet population need / demand. It helps raise awareness of issues such as affordable housing and fuel consumption among policy makers and initiate policy dialogue and effective and efficient service provision. The official population projections at local authority level are produced every 2 years by the ONS. They are trend based projections and take no account of changes in availability of housing. The latest official projections are the 2012 Subnational Population Projections, released in 2014. The following information shows the projections up to 2022; although they are available up to 2037.

Error! Reference source not found. shows projections from 2012 to 2022. The population of Thurrock is rojected to grow to 176,508 by 2022. This equates to an increase of 11% or about 16,975 people over the 10 years. This will require health and local government partners to ensure appropriate additional levels of service provision and supporting infrastructure, e.g. transport housing, health, schools, leisure and cultural facilities.

It is important to note that these projections are trend based and do not take into account future planned development or regeneration. The projections do indirectly pick up the effect of new housing as it is built and occupied, which consequently readjusts the trend reflecting the increase in the availability of housing, but change in the rate of regeneration planned for the future is not accounted for. A number of regeneration plans are in place for the borough which will impact on the size and demography of the local population – these are described in the Wider Determinants JSNA.

Figure 9: Population Projections, 2012-2022



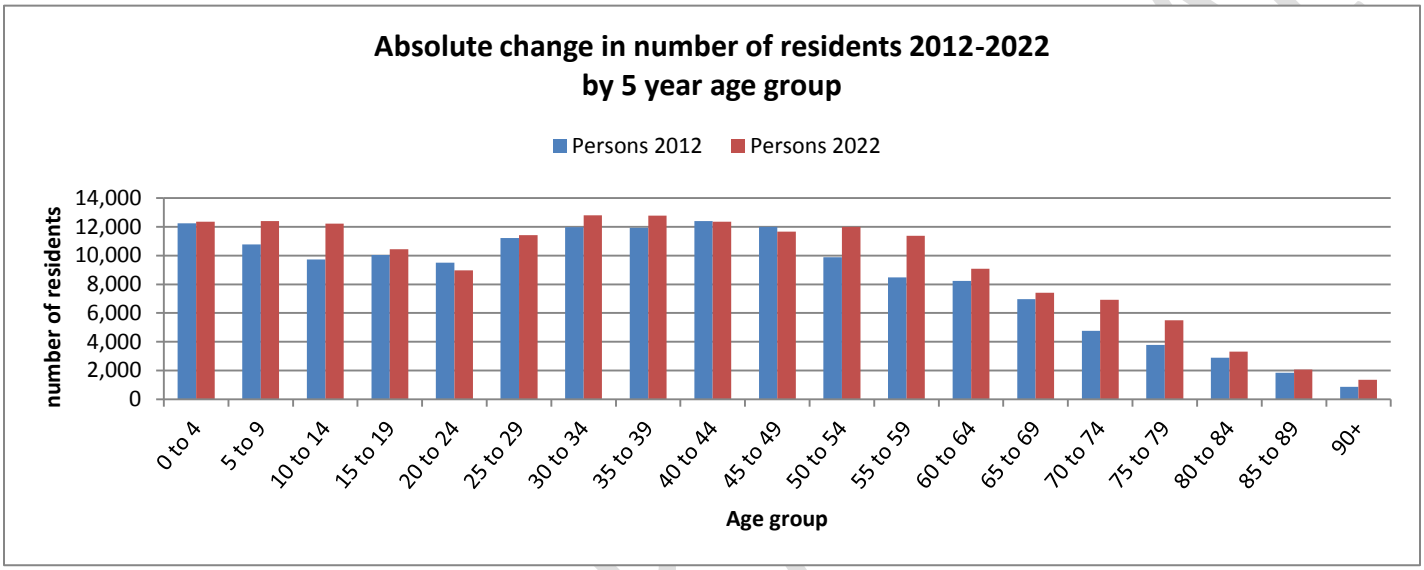
Source: ONS Subnational population projections; 2012

2.4.1 Projected Change in Age Structure

The age and sex distribution within our population has an impact on the level of need for health services. Older people and the very young tend to have a greater utilisation of health services. An increase in a younger population indicates opportunities to maximise an Early Offer of Help and prevent future ill health, in line with local authority public health responsibilities. An increase in the older population has implications for service provision and the levels and ways that care and social services are provided to meet needs.

Figure 10 shows the projected change from 2012 to 2022, by five year age group. Clearly there is predicted to be a rise in number for almost every age group. However, the most significant rises occur in age groups clustered in the 0-14, 25-29, 50-59 and 70 plus age groups.

Figure 10: Population Projection Age Structure 2012-2022



Source: Subnational Population projections; ONS; 2012

Table 5 shows the same information as Figure 10 but each 5 year age group is shown as a percentage of the total population for the years 2012 and 2022. The key differences are:

- In 2022 there is predicted to be a higher percentage of 5-9 year olds, 50-59 year olds, 65-84 year olds and 90 years and over.
- In 2022 there is predicted to be a lower percentage of 15-29 year olds and 30-49 year olds.

Table 5: Proportion of Thurrock residents by age group in 2012 and 2022

Age Group	% of population in 2012	% of population in 2022
0 - 4	7.7%	7.0%
5 - 9	6.8%	7.0%
10 - 14	6.1%	6.9%
15 - 19	6.3%	5.9%
20 - 24	6.0%	5.1%
25 - 29	7.0%	6.5%
30 - 34	7.5%	7.3%
35 - 39	7.5%	7.2%
40 - 44	7.8%	7.0%
45 - 49	7.5%	6.6%
50 - 54	6.2%	6.8%

55 - 59	5.3%	6.5%
60 - 64	5.2%	5.2%
65 - 69	4.4%	4.2%
70 - 74	3.0%	3.9%
75 - 79	2.4%	3.1%
80 - 84	1.8%	1.9%
85 - 89	1.1%	1.2%
90+	0.5%	0.8%
Total	100.0%	100.0%

Source: ONS Subnational Population projections; 2012

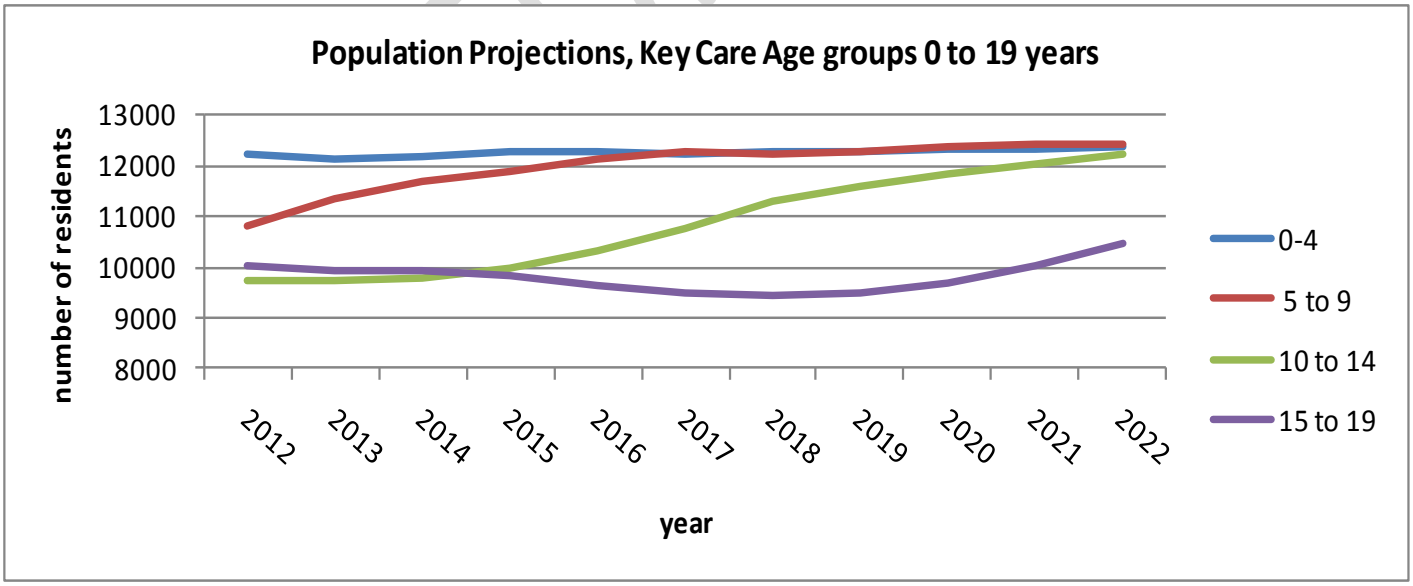
2.4.2 Key Care Groups

This section provides detail on projected change for the younger population (0-19 years) and the older population (50 years and over) up to 2022. Each of these overall age groups is subdivided into smaller groups as there are some key differences within them.

2.4.2.1Residents aged 19 years and under

Figure 11 shows the ONS absolute population projections up to 2022 by four age bands for the 0-19 population. Thurrock currently has a significantly greater proportion of young people than England and this trend is likely to continue into the future. The 5-14 year age groups, particularly, are predicted to increase sharply over the 10 years from 2012.

Figure 11: Population Projections by Key Care Group – Younger People 2012-2022



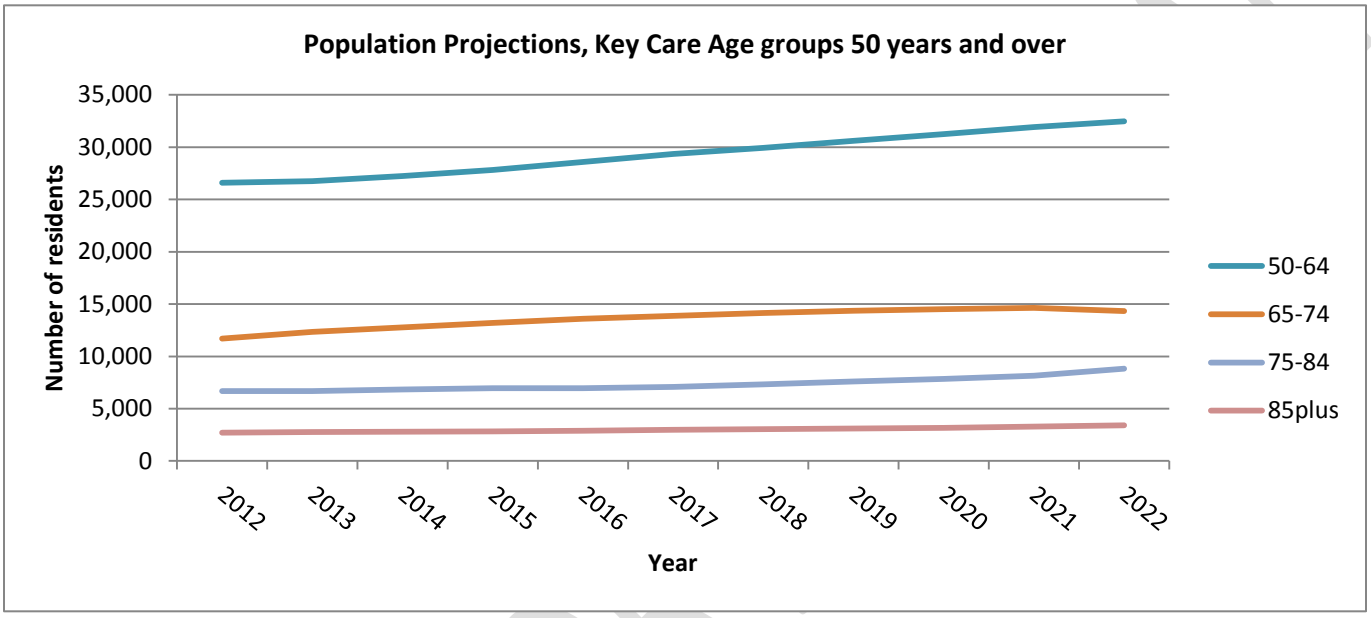
Source: Subnational Population projections; ONS; 2012

2.4.2.2 Residents aged 50 years and over:

Figure **12** shows the ONS absolute population projects for four age bands for the population aged 50 years and over. As the figure shows, Thurrock will see a significant ageing of its population among the key older care groups – 50-64, 65-74, 75–84 and 85+, all of which will increase in absolute terms and as a proportion of the population.

By 2022, the population group aged 50-64 is projected to increase by 5,900, which is an 18% increase, and the population group aged 75-84 is projected to increase by 2,139 (26%).

Figure 12: Population Projections by Key Care Group – Older People 2012-2022



Source: ONS Subnational Population projections; 2012

2.5 Components of Population Change

Population change reflects the influence of several different components. The principal components of change are births and deaths (reflecting fertility and mortality rates), and internal and international migration. This section describes the effect these components have on the population of Thurrock.

Table 6 shows the details of these components of population change for the latest 2013 mid-year estimates.

Table 6: Components of change 2012-2013 (figures are rounded to the nearest hundred)

	2012	2013
Population	159,500	160,800
Natural Change		1,200
Births		2,400
Deaths		1,200
All Migration NET		300
Internal Migration In		*6,300*
Internal Migration Out		*6,100*
International Migration In		*800*

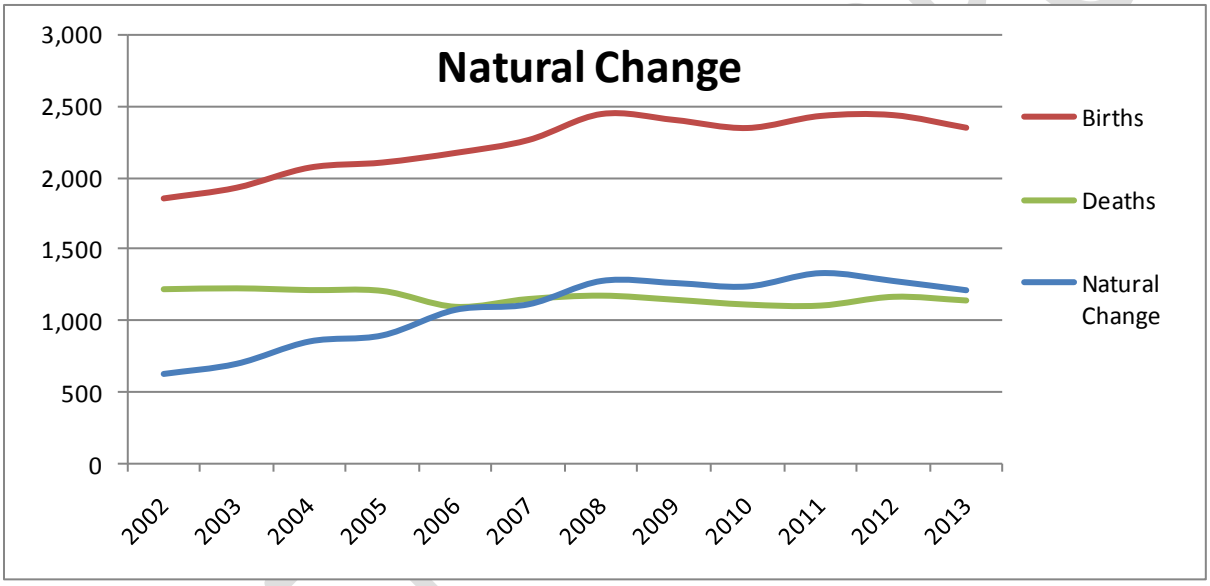
International Migration Out		*700*
Cross-border Migration In		*100*
Cross-border Migration Out		*200*

Source: ONS

2.5.1 Natural Change

The reason for a net population increase has been the process of natural change which is the difference between the number of births and number of deaths in an area. Figure 13 shows the natural change between 2002 and 2013. The net effect of these components (births minus deaths) shows a large increase from 636 in 2002 to 1,213 in 2013. Further information on births and deaths in Thurrock is provided further down in this chapter.

Figure 13: Natural Change: Components of population change between 2002 and 2013

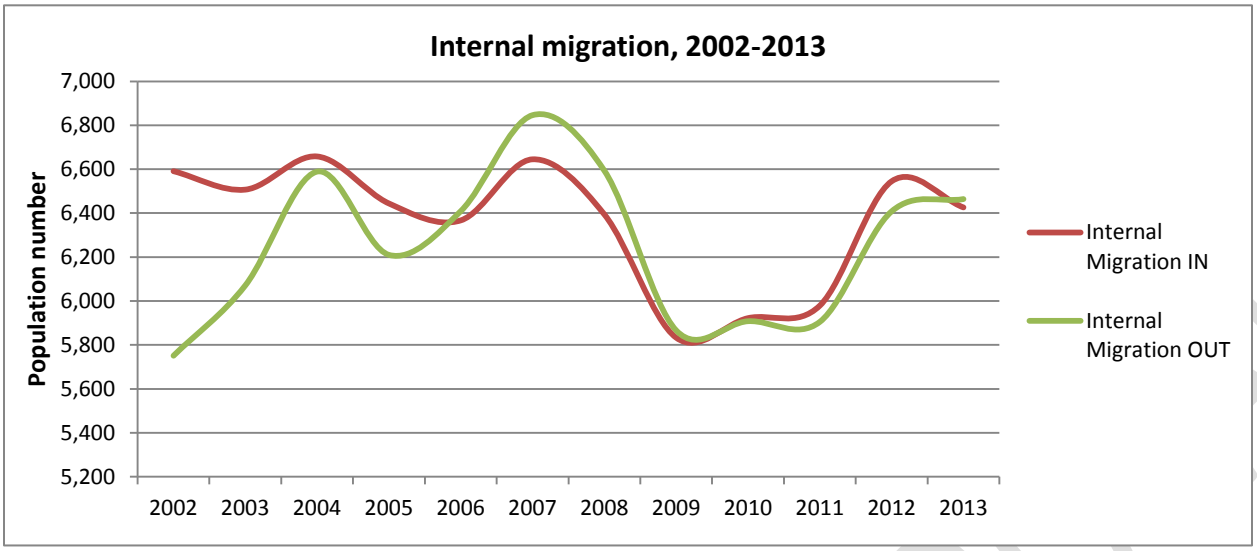


Source: ONS mid-year estimates

2.5.2 Internal Migration

Internal migration defines movement of people between one area of England and Wales to another. This is principally measured by changes in home address registered with a General Practitioner. Figure 14 shows movement in and out of Thurrock within England and Wales for each year between 2002 and 2013.

Figure 14: Internal migration between 2002 and 2013



Source: ONS mid-year estimates

6,591 people moved into Thurrock from other parts of England in 2001/02. This annual number has remained fairly stable up to 2012/13 (6,426). The number of people moving out of Thurrock has also remained fairly stable over the period and has roughly balanced the inward internal migration. There has been a net increase of 1,291 people due to internal migration over the period.

Internal migration is an important component influencing the characteristics of the population. Even though overall, the number of people moving out of and into Thurrock has roughly balanced over the 10 years, the demographic characteristics of these people may be substantially different. Internal migration data indicates that there are a larger proportion of children and adults under 30 years moving into Thurrock than older adults. There has been substantial movement of people from London to Thurrock, accounting for 62% of all internal migration into the area. This has come particularly from geographically close boroughs, including Havering, Barking and Dagenham and Newham - between 2012 and 2013, 3,860 people moved from these areas to Thurrock. Internal migration out of Thurrock tends to be much more confined to other parts of Essex and the eastern region rather than London which only accommodates 27% of people leaving Thurrock.

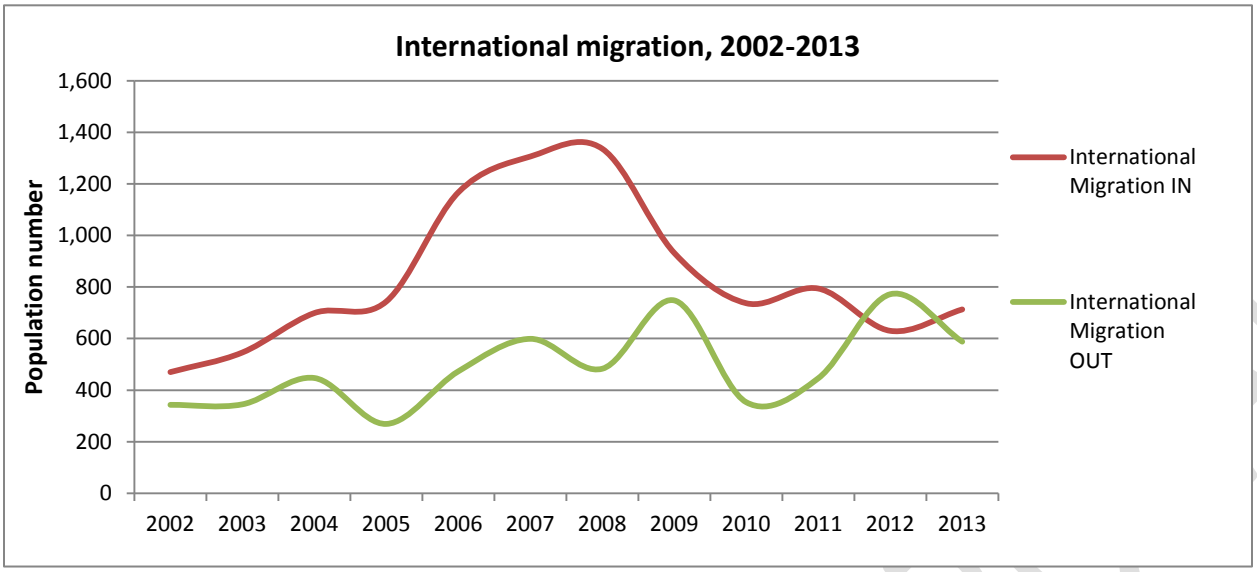
2.5.3 International Migration

This section describes international migration into Thurrock. Information is taken from a number of sources:

- The International Passenger Survey (which feeds into the mid year estimates)
- National Insurance registrations for overseas nationals
- Detail taken for the 2011 Census on country of birth and length of time resident in the UK.

International migration estimates are largely derived from sample surveys (International Passenger Survey) and at local level are subject to more error than internal migration estimates. Since 2001, ONS has estimated that international migration into Thurrock has varied from about 500 people annually in 2001, rising to a peak of to 1,300 in 2006/7 before decreasing to 713 in 2012/13. International migration out of Thurrock has consistently been less than this, leading to a net increase of about 4,200 over the period.

Figure 15: International Migration between 2002 and 2013



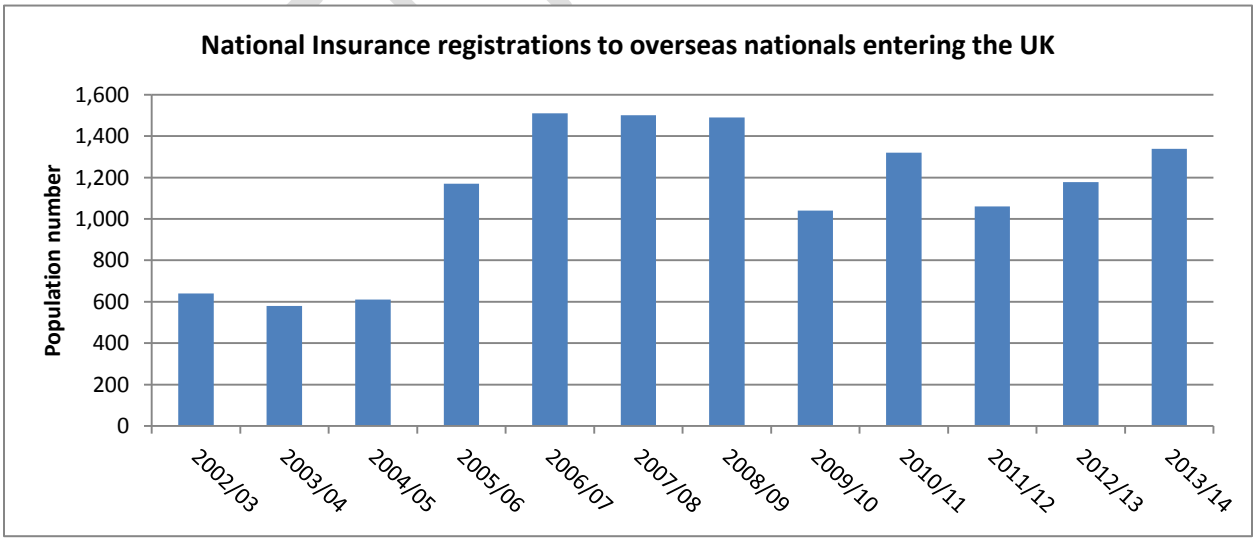
Source: ONS mid-year estimates

2.5.3.1 Economic Migration – National Insurance Number Registrations

The number of new national insurance number registrations by non-UK nationals provides another indication of the extent of international migration. This data suggests that economic international migration has been increasing in Thurrock in recent years, although falling slightly since 2009/10.

In 2013/14 1,338 non-UK nationals registered for a new NI number in Thurrock. Most new registrations in the decade occurred in 2006/7 to 2008/9 at about 1,500 per annum. The figures are higher than official ONS estimates for international migration suggest, but will also include short term migrants. It can be seen from figure 16 below that registration numbers have been increasing since 2011/12.

Figure 16: National Insurance Registrations to overseas nationals entering the UK



Source: DWP 2014

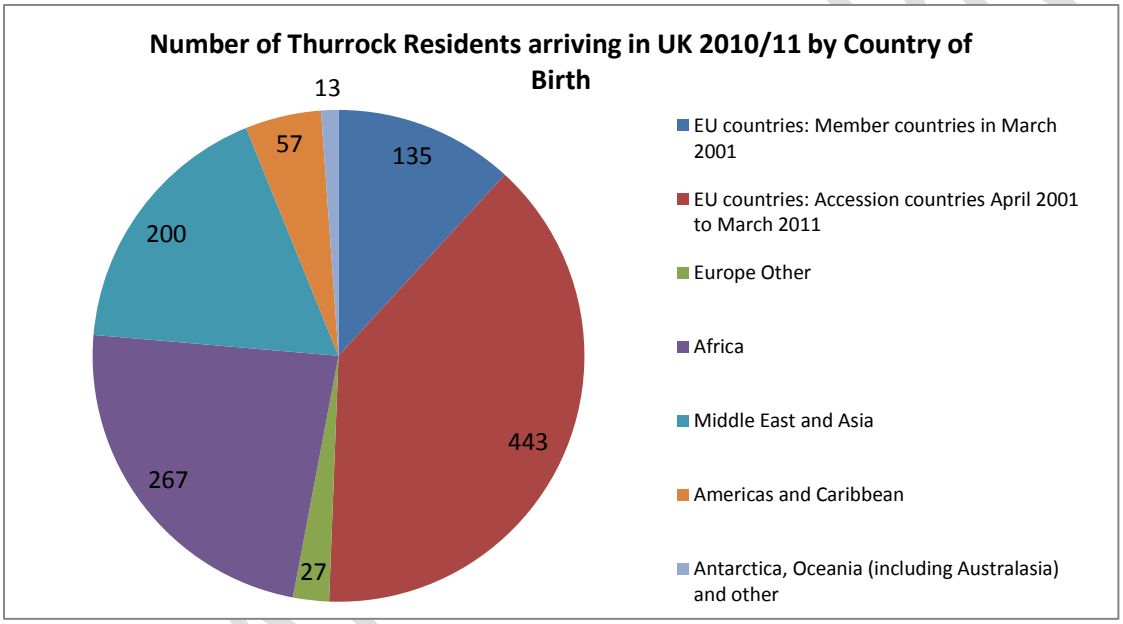
The majority of migrants newly registered with a national insurance number in Thurrock came from Eastern Europe and Africa. The top five countries of origin in 2013/14 were Poland (306), Romania (186) Nigeria (118), Slovak Republic (117) and Lithuania (102). These 5 countries accounted for 63% of all registrations in that financial year.

2.5.3.2 Arrival in UK by Country of Birth

The 2011 Census provides further sources of information on international migration including a question which asks for country of birth and year of arrival in the UK. (Please note that country of birth does not necessarily equate to last country of residence or length of time in the UK)

In 2011 there were 1,142 Thurrock residents who arrived in the UK in the previous year. Almost 40% of these residents were born in a European Union Accession Country (2001 to 2011). The second largest group at 23% were born in an African country (predominantly Western African countries). This was followed by Middle Eastern and Asian countries of birth for 17.5% of this group.

Figure 17: Number of Thurrock residents arriving in UK by country of birth



Source: 2011 Census Table LC2804EW

3 Births and Deaths

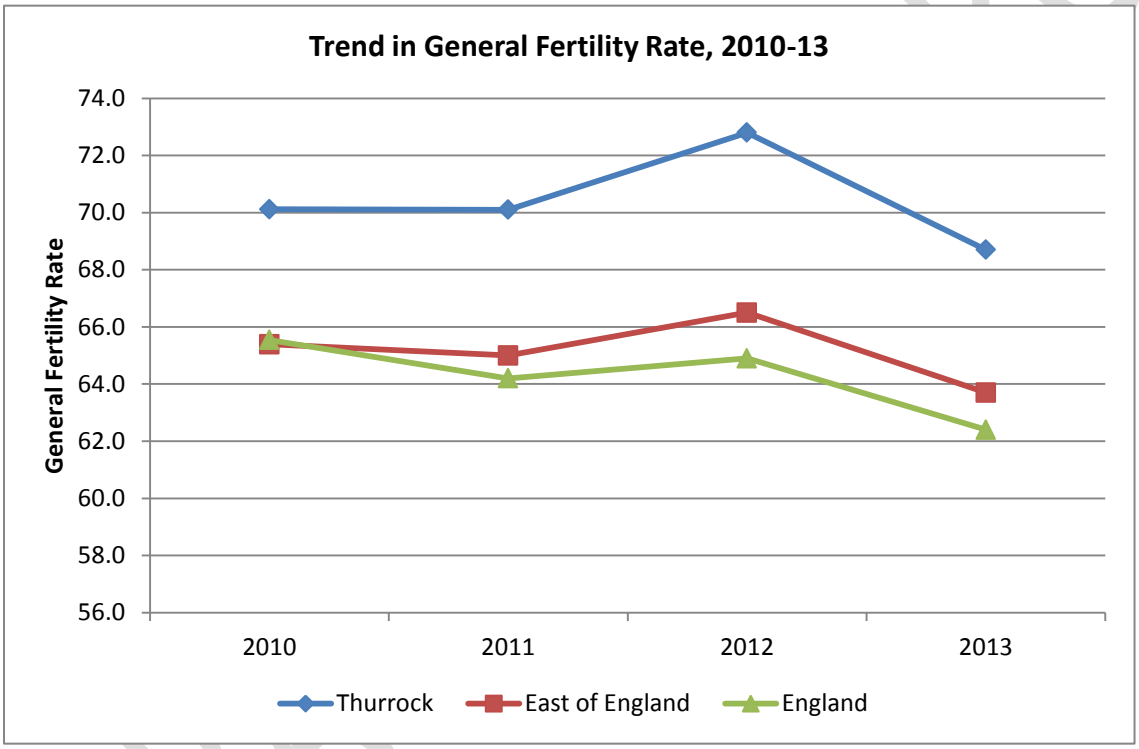
The number of babies being born is one of the main factors which will lead to an increase in an area's population size, whilst the number of deaths is one of the main factors which reduces it. Monitoring the births and deaths within Thurrock is crucial in ensuring that service provision meets the needs of the population. This is useful in terms of looking at where we might need to focus maternity, early years and childcare services, as well as social care and end of life provision; however this information should be read in conjunction with information on deprivation to ensure those most at need (i.e. the most deprived who are more likely to have poorer health and in need of services) are being targeted effectively. In addition, commissioners should

particularly look to address the lifestyle choices of the population, as these can have a great impact on reducing avoidable mortality.

3.1 Births

Population change is affected by the counts of births in an area. Figure 18 shows the General Fertility Rate since 2010, which is the number of live births per 1,000 of women aged 15 – 44. In Thurrock, there were 2,326 live births - 68.7 births per 1,000 women aged 15 – 44 in 2013, which is higher than the regional and national rates. It can be observed that the GFR has decreased since 2012 in line with both regional and national trends. The Office for National Statistics reported that the fall in fertility in England in 2013 was the largest annual decrease seen since 1975, and suggest this may be down to factors such as uncertainty of employment, welfare and current financial and housing position all impacting on the timing of childbearing and on the completed family size.

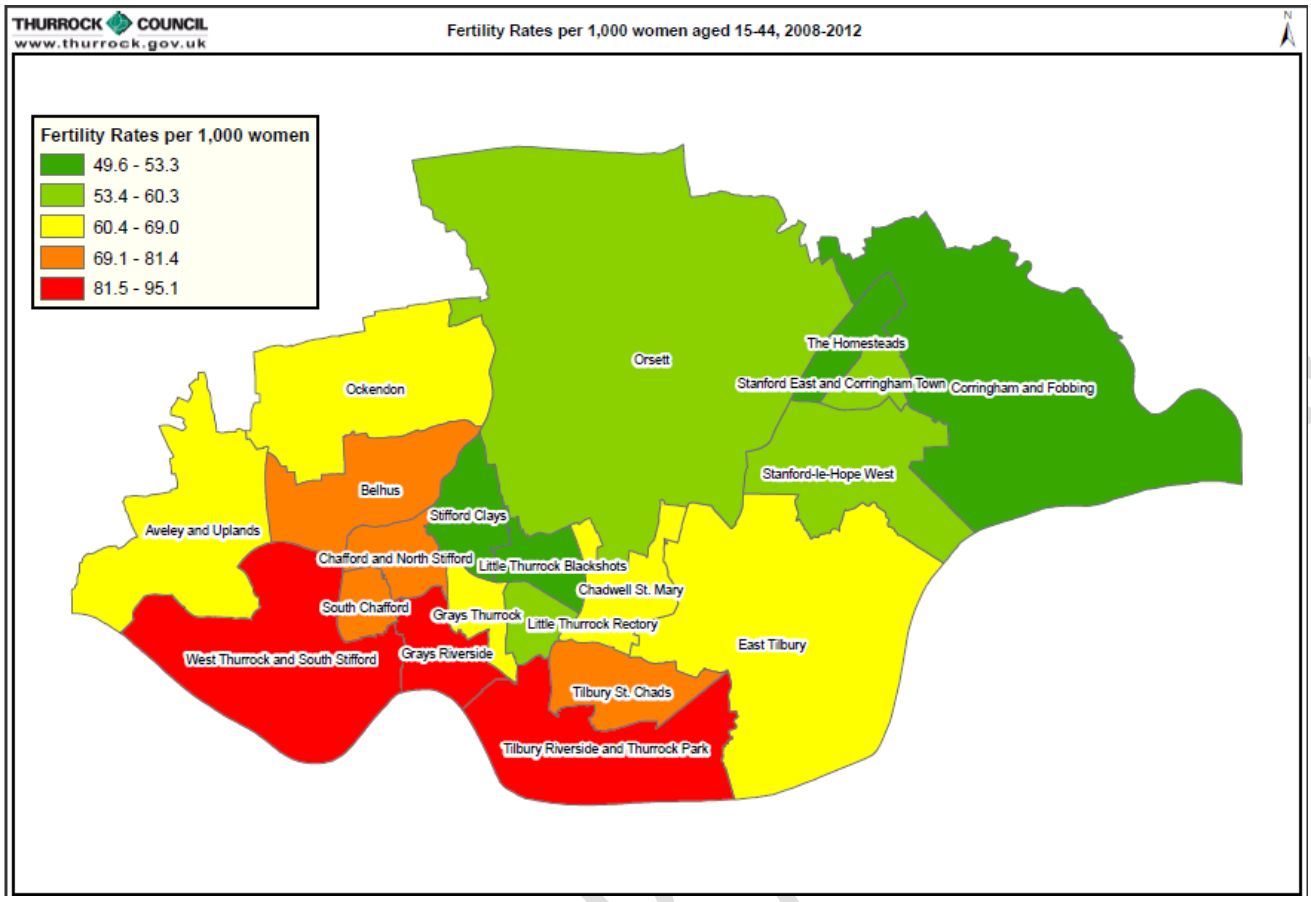
Figure 18: Trend in General Fertility Rate, 2010-2013



Source: NHS Indicators

Births are not uniform across the borough. Figure 19 below is a map showing the fertility rates by ward in Thurrock. It can be seen that there are higher rates in the south and west of the borough, particularly in West Thurrock and South Stifford, and Tilbury Riverside and Thurrock Park. The lowest rates are in Stifford Clays, The Homesteads and Corringham and Fobbing.

Figure 19: Fertility Rates by ward, 2008-2012



Source: Local Health

3.2 Deaths

Mortality measures the number or proportion of deaths, in general or due to a specific cause, in a given population scaled to the size of that population at a particular time. Age at death and cause can give a picture of health status, however as survival improves with modernization and populations age, mortality measures do not provide enough information, and indicators of morbidity such as the prevalence of chronic diseases and disabilities become more important. According to the Office of National Statistics, the main causes of death for all age groups in England and Wales in 2013 were cancer, which accounted for 29% of deaths, and circulatory diseases, which accounted for 28% of deaths. Data from the End of Life Care Profiles indicated that Thurrock had a statistically higher proportion of deaths attributable to cancer than the national average (30.52% compared to 28.51% in 2010-2012), and a statistically similar proportion of deaths attributable to cardiovascular disease and respiratory conditions.

All age all-cause mortality rates have decreased in both males and females in Thurrock since 2000, which mirrors the national trend. Although Thurrock has slightly higher rates of all age, all-cause mortality than England in 2012, the rates are not too different to the national average. The table below shows the Directly Standardised Mortality Rates (DSRs), which are age-standardised rates per 100,000 population for males and females in Thurrock and England for 2000 and 2012.

Table 7: Change in Directly Standardised Mortality Rates (DSRs) for Males and Females between 2000 and 2012 in Thurrock and England.

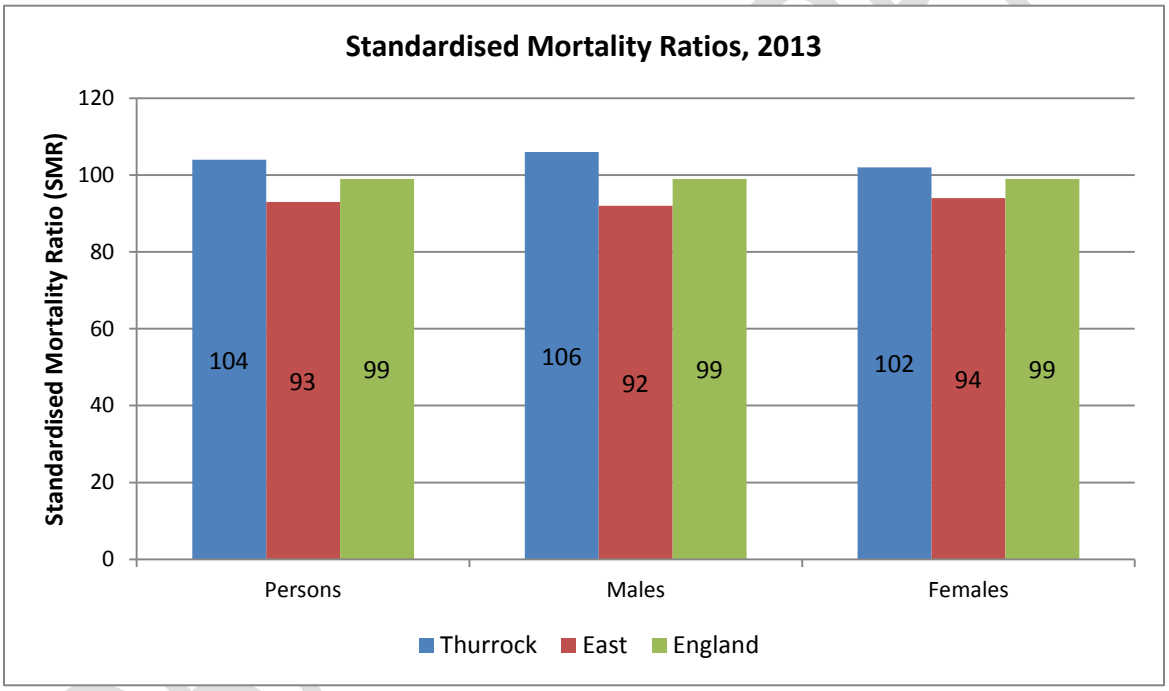
Area	Males			Females		
	2000	**2012**	**% change**	**2000**	**2012**	**% change**
Thurrock	839.94	624.88	-25.6%	594.80	479.06	-19.4%
England	841.84	614.31	-27.02%	564.50	447.70	-20.69%

Source: Health and Social Care Information Centre

The **Standardised Mortality Ratio** (SMR) is the number of observed deaths divided by the expected number of deaths, multiplied by 100. (A number higher than 100 implies an excess mortality rate whereas a number below 100 implies below average mortality.)

The latest mortality data shows that Thurrock has a higher mortality rate than both the regional and national averages for both males and females. (Rates are expressed per 100,000 population) This can be seen in figure 20 below.

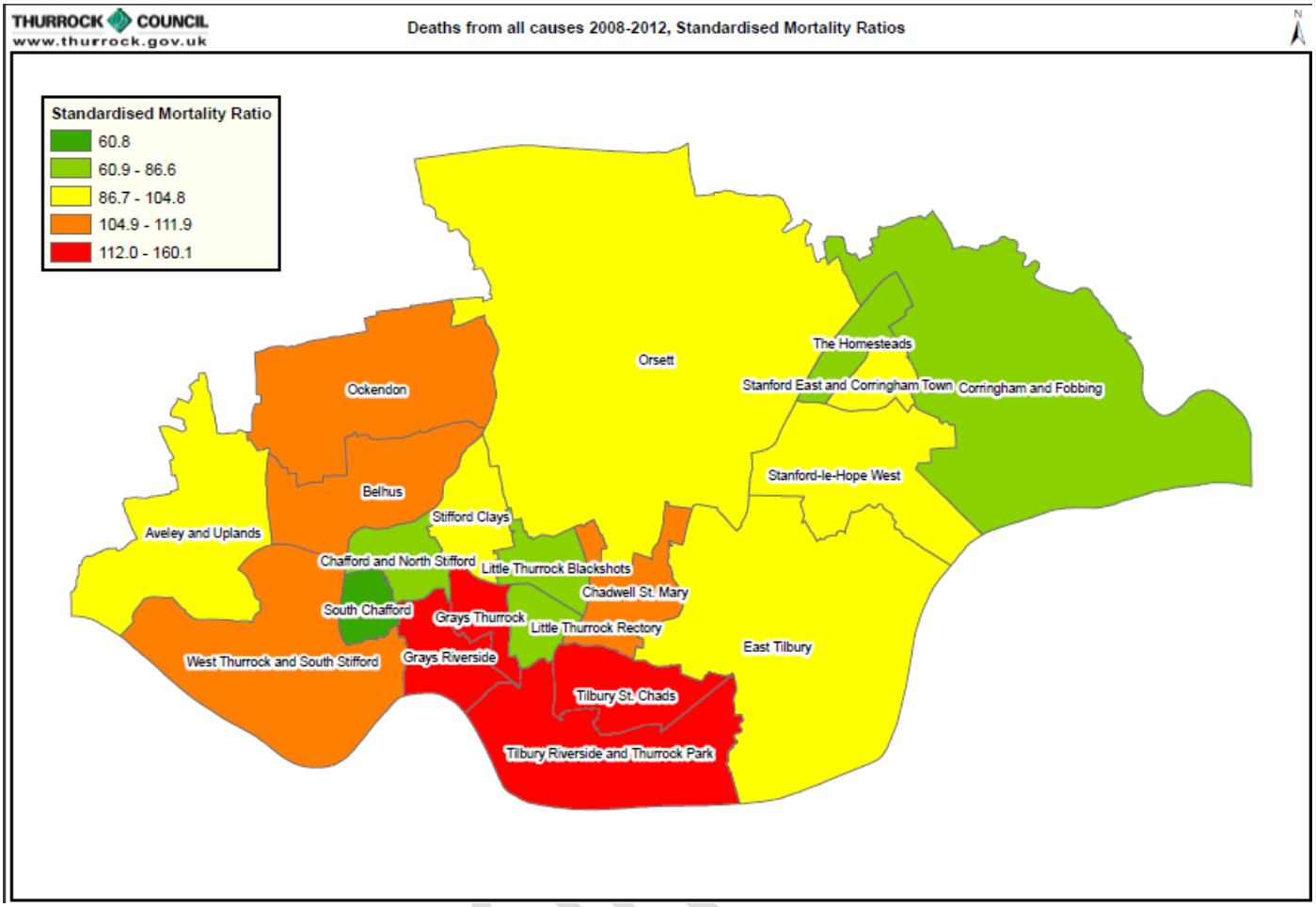
Figure 20: Standardised Mortality Ratios for Thurrock, East of England and England by gender, 2013



Source: ONS

Figure 21 shows that standardised mortality ratios for all deaths are not uniform across the borough. The highest SMR is found in Tilbury Riverside and Thurrock Park (160.1), with the surrounding areas of Grays Riverside, Grays Thurrock and Tilbury St Chads also having high ratios. The lowest SMRs are in South Chafford (60.1) and The Homesteads.

Figure 21: Deaths from all causes in Thurrock by ward, 2008-2012, Standardised Mortality Ratios

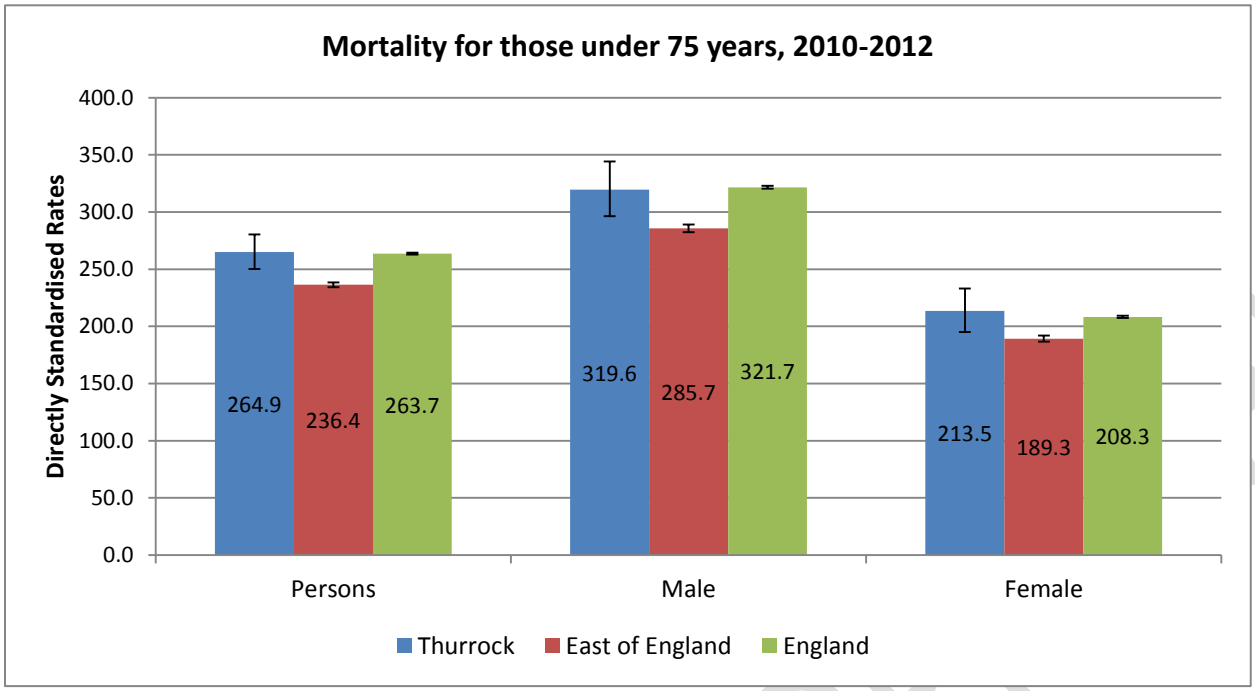


Source: Local Health

3.2.1 Premature mortality

Deaths in under 75 year olds is often taken as a proxy measure for premature mortality. In other words many of the deaths that occur in this age group are potentially preventable and therefore avoidable. Figure 22 below shows pooled all age all cause directly standardised mortality rates for those aged under 75 years in Thurrock, East of England and England, and it can be seen that Thurrock has similar premature mortality rates to both the regional and national values for persons, males and females.

Figure 22: Mortality in those aged under 75 years, 2010-12



Source: NHS Indicators

4 Tenure and Household Structure

This section provides detail of the type of tenure in which Thurrock residents live, the relative proportions and how this has changed over time. The actual structure of households is also described providing detail of the type of household and the change over time.

4.1 Tenure

Table 8 gives details of type of tenure and change between 2001 and 2011. The key points are:

- Almost two thirds of properties in Thurrock are owned – 25.5% outright and 40.7% with a mortgage. This is similar to regional and national proportions, although fewer Thurrock properties are owned outright.
- There has been a small increase in total households, from 58,485 to 62,353 between 2001 and 2011, which equates to a 3.6% increase.
- There has been a large increase in the proportion of private rented sector housing from 5.9% in 2001 to 13.2% in 2011. The number of households in this sector has risen from 3,456 to 8,220 representing an increase of 137.9%. The proportion for Thurrock is now more similar to the regional and national averages.
- Thurrock has a higher proportion of properties rented by the local authority than the regional or national averages, although the proportion has decreased since 2001.

Table 8: Tenure change between 2001 and 2011 Census

	Thurrock (Number)		number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
	2011	2001			2011	2001		
All Households	62,353	58,485	3,868	3.58%				
Owned Outright	15,899	13899	2,000	14.39%	25.5%	23.8%	32.9%	30.6%
Owned with a Mortgage	25,379	28016	-2,637	-9.41%	40.7%	47.9%	34.7%	32.8%
Shared Ownership	302	180	122	67.78%	0.5%	0.3%	0.7%	0.8%
Rented from the Council	10,055	10764	-709	-6.59%	16.1%	18.4%	7.8%	9.4%
Rented from Housing Association	1,448	1148	300	26.13%	2.3%	2.0%	7.9%	8.3%
Privately Rented: Private Landlord or Letting Agency	8,220	3456	4,764	137.85%	13.2%	5.9%	13.3%	15.4%
Private Rented: Other	552	1022	-470	-45.99%	0.9%	1.7%	1.5%	1.4%
Other or Living Rent Free	498	0	498	n/a	0.8%	0.0%	1.3%	1.3%

Source: Census 2011 and 2001

4.2 Household Structure

Table 9 shows the proportion and number of different household types and how this has changed between 2001 and 2011. The key points are:

- There has been a 12.5% decrease in one person households aged 65 and older, and a 9.7% decrease in family households all aged 65 and over, together representing 10,379 households in 2011. The overall borough household proportion for both of these groups is substantially less than for either the East of England or England.
- One person households (under 65 years old) have risen by 14.5% to 9,989 in 2011. This is the second largest individual household group representing 16% of all households.
- In general, there has been a substantial increase in the number of households with dependent children, although the number of married couple households with dependent children has remained about the same at 11,175. Altogether there were 21,719 households with dependent children in 2011, an increase of 2,830 between the 2001 and 2011 census (a 13% increase overall).
- There has been a substantial 42.4% increase in cohabiting couples with dependent children. There were 3,703 households falling into this category in 2011.
- Lone parent households with dependent children have increased by 880 to 4,744 in 2011 representing a rise of 22.7%. Thurrock has 7.6% lone parent households with dependent children, which is a slightly higher than for the East of England but similar to the 7.1% for England.
- “Other” household types with dependent children have increased by 897 to 2,097 in 2011 (an increase of 74.8%).

Table 9: Household Structure Change between 2001 and 2011 Census

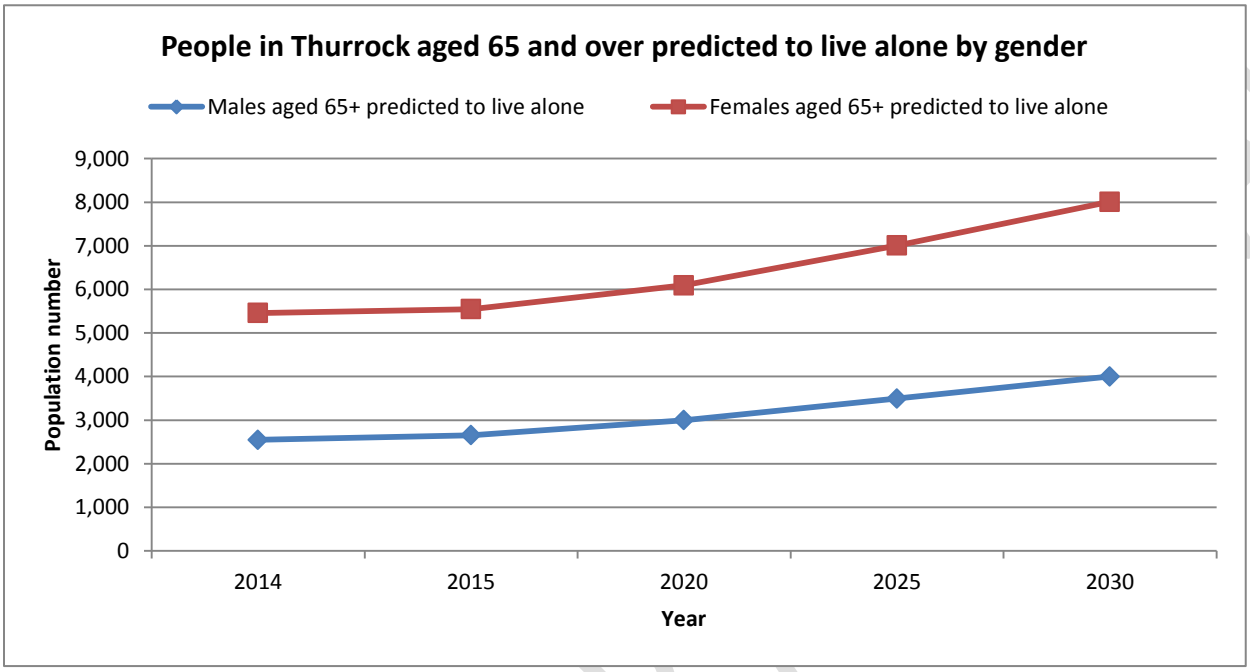
	Thurrock (Number)		number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
	2011	2001			2011	2001		
One person household: Aged 65 and over	6,379	7,289	-910	-12.5%	10.2%	12.5%	12.7%	12.4%
One person household: Other	9,989	8,723	1,266	14.5%	16.0%	14.9%	15.8%	17.9%
One family only: All aged 65 and over	4,000	4,427	-427	-9.6%	6.4%	7.6%	9.4%	8.1%
One family only: Married or same-sex civil partnership couple: No children	7,283	7,612	-329	-4.3%	11.7%	13.0%	13.5%	12.3%
One family only: Married or same-sex civil partnership couple: Dependent children	11,175	11,224	-49	-0.4%	17.9%	19.2%	16.7%	15.3%
One family only: Married or same-sex civil partnership couple: All children non-dependent	4,236	4,131	105	2.5%	6.8%	7.1%	5.9%	5.6%
One family only: Cohabiting couple: No children	3,367	3,399	-32	-0.9%	5.4%	5.8%	5.4%	5.3%
One family only: Cohabiting couple: Dependent children	3,703	2,601	1,102	42.4%	5.9%	4.4%	4.3%	4.0%
One family only: Cohabiting couple: All children non-dependent	457	242	215	88.8%	0.7%	0.4%	0.5%	0.5%
One family only: Lone parent: Dependent children	4,744	3,864	880	22.8%	7.6%	6.6%	6.2%	7.1%
One family only: Lone parent: All children non-dependent	2,210	2,070	140	6.8%	3.5%	3.5%	3.2%	3.5%
Other household types: With dependent children	2,097	1,200	897	74.8%	3.4%	2.1%	2.2%	2.7%
Other household types: All full-time students	44	12	32	266.7%	0.1%	0.0%	0.3%	0.6%
Other household types: All aged 65 and over	137	174	-37	-21.3%	0.2%	0.3%	0.3%	0.3%
Other household types: Other	2,532	1,517	1,015	66.9%	4.1%	2.6%	3.7%	4.5%

Source: Census 2011 and 2001

Although the Census data has shown a decrease in one person households aged 65 and over since 2001, recent projections indicate that Thurrock will see a large increase in this group in the future, with an additional

4,006 people aged 65 and over estimated to live alone by 2030. This should be considered in line with the projected increase in the older population as shown in figure 12, which forecasts a large increase in the number of older people living in the borough. Figure 23 below depicts the estimated increase in people living alone by gender up to 2030.

Figure 23: People aged 65 and over predicted to live alone by gender, 2014-2030



Source: Projecting Older People Population Information (POPPI) System

5 Recommendations

- It can be seen that Thurrock can expect to accommodate an increasing population within future years, with 10.6% more residents by 2022. We should ensure there are suitable plans in place to accommodate this population.
- The expected increase in the number of children and young people in the borough means that emphasis should be placed on preventative services aimed at this population in order to improve health and wellbeing and enable reduced future demand on services.
- Whilst the population of Thurrock has historically been fairly young, the number of older people in Thurrock is expected to increase, and service provision should also take this into account. In particular, health and social care services should explore how they can take a joined up approach to explore how wider needs such as housing adjustments, isolation, diet and self-care can be identified and managed more proactively for this increasing proportion of older residents.
- The ethnic diversity of Thurrock has been increasing, with both internal and international migration affecting the ethnic profile of the borough. We need to make sure that our services meet the needs of these people so that everyone can be supported to take responsibility for their own and their families' health and have timely access to services and interventions to improve health and wellbeing.
- The differences in population demographics at lower-level geographies such as wards or Lower Super Output Areas mean that there are inequalities in level of need for particular services and support. These differences should be considered when planning services to ensure resources are targeted appropriately.
- Professionals working with data and intelligence on the local population should continue to consider joint-working approaches in order to maximise our ability to analyse and understand our changing population and their needs.

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Thurrock

Joint Strategic Needs Assessment

Children and Young People

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Contents

Executive Summary

Demography

1. Thurrock has a higher proportion of children and young people aged 0-19 years (26.84%) than the national average (23.9%).
2. The number of 0-19 year olds in Thurrock is set to increase to 50,500 by 2037.
3. Thurrock's younger population is more ethnically diverse than the all-age population, with areas to the west of the borough seeing the highest proportion of school-children from minority ethnic groups.

Being Healthy

1. Breastfeeding initiation in Thurrock has remained significantly lower than regional and national averages, with only 69.5% mothers initiating breastfeeding in 2012/13.
2. Data from 2012/13 indicates that 9.6% of reception-aged children and 19.8% of Year 6-aged children in Thurrock are obese, which is similar to the national average but higher than the regional average.
3. Child oral health in Thurrock is fairly poor, and it is estimated that about 30% of children and young people in Thurrock have experience of tooth decay that can lead to pain and costly NHS procedures.
4. Although Thurrock exceeded the national target for vaccination of Year 1 DTaP/IPV/HiB, uptake is considerably lower than the national targets for Year 2 PCV, Year 2 MMR and Year 5 MMR.
5. Thurrock has a significantly lower rate of Chlamydia diagnoses than the national (2,016 per 100,000) and regional (1,719 per 100,000) averages.
6. Thurrock had a rate of 30.5 per 1,000 under 18 conceptions in 2012, which is similar to the national average, and has been decreasing.
7. 4% of Thurrock children in years 6, 8 and 10 usually smoke at least one cigarette per week, which was the same as the national average but higher than the regional average (3.4%).
8. The percentage of women smoking at time of delivery has decreased in recent years to 10.6% and is similar to the national average.
9. South West Essex has the highest number of children with sickle cell disorders in Essex, with an estimated 66.5% of all children with these disorders living in the South West of the county. Work is underway to review the existing sickle cell service to ensure needs are appropriately met.
10. It has been identified that further work needs to take place to meet the needs of children and young people with mental health disorders and problems in Thurrock, and plans are in place to deliver an integrated service known as the Children and Young People's Emotional Wellbeing and Mental Health Service (The CYP EWMH Service).

Staying Safe

1. Thurrock has a high rate of children subject to child protection plans, and it increased by 41% since 2012/13.
2. The number of Looked After Children in Thurrock has been increasing over recent years and is projected to increase further.
3. Thurrock has a higher proportion of pupils with SEN that have Statements than the regional or national averages.

4. As of September 2014, there are 462 Young Carers known to Thurrock Council's Young Carer services – 50 of whom are aged between 4-8 years.
5. The latest available data (2012) indicates that Thurrock may have a slightly higher prevalence of Gypsy, Roma and Traveller children than the national average (0.3% compared to 0.2%).
6. Due to high migration from the London Boroughs Thurrock YOS is supervising a number of young people who have links to serious youth violence and gangs.
7. The number of young people accessing services for sexual violence has increased to 130 in 2013/14 (2012/13 figure was 97); however research indicates that the need remains higher than this.
8. The rate of infant mortality in Thurrock is significantly lower than regional and national averages.
9. Emergency hospital admissions for children in Thurrock have increased by 18.9% between 2012/13 and 2013/14.
10. Thurrock has recently launched a Multi Agency Safeguarding Hub (MASH) which brings together representatives from numerous different organisations in order to share relevant information and work together to safeguard vulnerable children and young people.

Enjoying and Achieving

1. 66% of Thurrock's reception-aged children achieved a 'Good Level of Development' in their Early Years Foundation Stage in 2014, which is 6% higher than the national average.
2. School attendance has been improving in both primary and secondary schools, with Thurrock having similar levels of absence to regional and national averages.
3. Fixed-term exclusions have been decreasing in both primary and secondary schools, with Thurrock having lower levels of fixed-term exclusions in secondary schools than the national average.
4. The gender inequality observed in EYFS outcomes (14% difference) is dramatically reduced by Key Stage 2 – where the difference between male and female outcomes is only 8%.
5. 57.4% of pupils at the end of Key Stage 4 achieved five or more GCSEs at grade A*-C or equivalent including English and Maths in 2013/14. Thurrock is ranked 59th out of 151 authorities and is currently above the national average of 56.1%.

Making a Positive Contribution

1. Thurrock has two successful routes to enable young people to become involved in local democracy: the Youth Cabinet and the Children in Care Council. Members of these groups have been actively involved in local decision making and influencing policy, and encouraging other young people to get involved.
2. Work is underway to enhance the range of volunteering opportunities available to Thurrock young people, as the uptake of young volunteers is lower than the national average.

Achieving Economic Wellbeing

3. 20.0% of children in Thurrock are living in low income families, which is greater than the national average. Deprivation varies across the borough – one LSOA in Corringham and

Fobbing only has 3% of children living in poverty, whilst one LSOA in West Thurrock and South Stifford has 54% of its children living in poverty.

4. The proportion of young people aged 16-19 who are NEET (Not in Education, Employment or Training) has decreased in recent years to 5.4% and is now similar to regional and national averages.

Summary of Final Recommendations

- To reduce smoking in pregnancy targeted particularly within more deprived areas
- To offer more school based interventions and prevention programmes with a focus in secondary schools to ensure pupils know how to access advice and support about preventing and stopping smoking
- To work with children centres and schools to improve family diets and raise awareness about nutrition and access to more affordable food
- To work in partnership with schools around raising the awareness of the importance of increasing physical activities incorporating family programmes
- To look at the close proximity of takeaways to schools in Thurrock and work with food outlets within close proximity to schools to promote healthier options.
- To work with children centres and schools to educate parents and children on portion sizes
- To ensure consistent oral health messages (e.g. around the use of fluoride toothpaste, smoking cessation and diet) are delivered by health professionals and those working with children in children's centres and schools
- To ensure that services will be commissioned to ensure our young people are safe from sexual exploitation.
- To engage all secondary schools around sexual health education and promotion from the new school nursing service including flexible confidential drop-in services, specialist and up-to-date advice on sexual health
- To engage primary schools in appropriate early sex education
- To raise the profile of good mental health with children and young people to reduce stigma and health inequalities.
- To increase the ratio of foster caring enquiry to approval to 10% in 2014/15.
- To Identify which types of foster carers are specifically needed and target advertisements and information accordingly
  To ensure that the mental health needs of children with SEND is addressed as part of the delivery of CAMHS services.
- To ensure new systems are in place to address the continued increase in migration from the London boroughs, especially in relation to the management of young people who have been involved in serious youth violence. Also to develop partnership working and form working relationships with the London boroughs
- To encourage parents of eligible two year olds to take up the offer of free childcare and early education.
- To look to minimise variation between schools in the borough to ensure all children and young people have access to high quality education
- To develop the next stage of Thurrock's response to child poverty by writing the new strategy for 2015-2018
- To focus on early intervention – strategies aimed at young people before the age of 16 years to prevent them from becoming NEET are likely to have the largest impact
- To develop strategies to address hidden harm for young people with the changing demographics of BME populations and migration of families from London.

Introduction

This Chapter provides an overview of the needs of children and young people in Thurrock. It demonstrates the various considerations that affect and define children's health, wellbeing and chances in life and looks at these in a national and local context.

Starting as early as pregnancy the mental health and health behaviour of a mother can have a substantial effect on the wellbeing of their unborn child. Socioeconomic status, parents' health, subjective wellbeing and education are all closely interconnected. The first five years establish an important foundation for their later wellbeing and is a particularly critical time for the development of social skills needed to contribute to future wellbeing. As the child continues to grow family relationships are an important predictor of children's wellbeing. Quality family time and good sibling relationships predicts higher levels of wellbeing and these children with positive family relationships go on to enjoy good relationships during their school life. Family relationships continue to be important during adolescence, although growing older often results in lower levels of wellbeing for both genders, reaching its lowest point in 14-15 year olds and then improving for 16-17 years as they become more independent and have greater choices in their lives.

Purpose/Aims/Objectives

The purpose of this document is to provide a comprehensive picture of the health and wellbeing needs of children and young people, now and in the future.

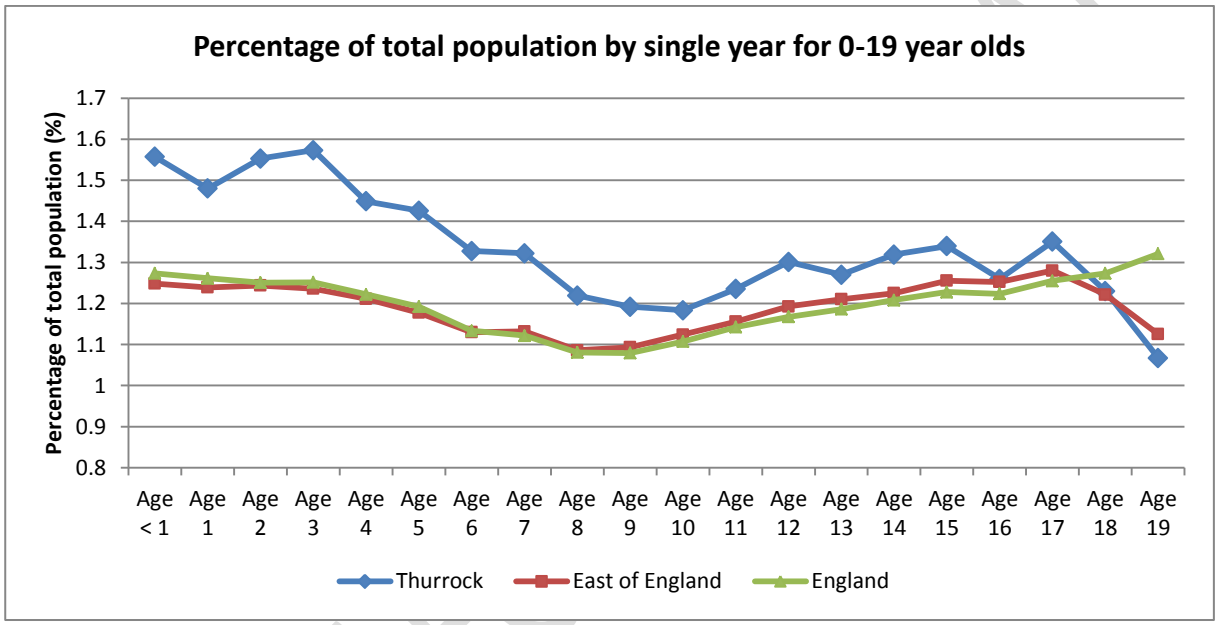
This report will help us:

- Understand the health and wellbeing needs and assets of children and young people in Thurrock.
- Benchmark against national standards and/or best practice
- Identify priorities for Thurrock's children and young people
- Review Thurrock's strategic plans
- Review existing evidence to establish the key determinants affecting children and young people's health and wellbeing
- Provide analysis of data to show health and social wellbeing status of children and young people
- Define and identify where inequalities exist and making recommendations for improvement
- Produce recommendations for the Health and Wellbeing Board
- Influence the commissioning of children's services

1. Demographics

As can be seen in the Demography Chapter of the JSNA, Thurrock has a higher proportion of young people than the national average, with 26.84% of the Thurrock population aged between 0-19 years, compared to 23.9% of the national population being aged 0-19 years. Figure 1 compares the percentage of residents in Thurrock, East of England and England who are aged 0-19 years by single year, and shows Thurrock to have a higher proportion of young people for almost all ages than the regional and national averages. The proportion of those aged 17-19 decreases in Thurrock and East of England, but rises nationally.

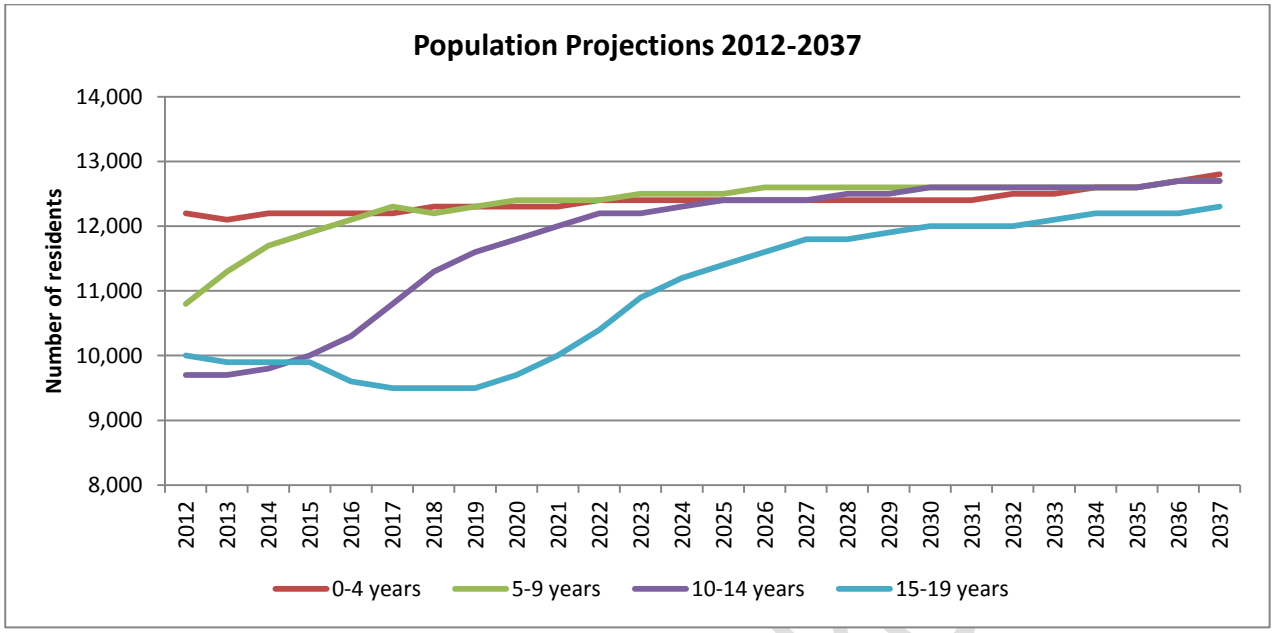
Figure 1: Percentage of total population by single year of age, 0-19 year olds



Source: ONS, 2011

According to ONS subnational population projections, the number of young people aged 0-19 years in Thurrock is going to increase from 42,700 in 2012, to 50,500 in 2037. When breaking this down by age group, figure 2 shows that, other than a small decrease between 2015-2019 for 15-19 year olds, all age groups will see an increase up to 2037, with the largest increase seen in the 10-14 year old age group.

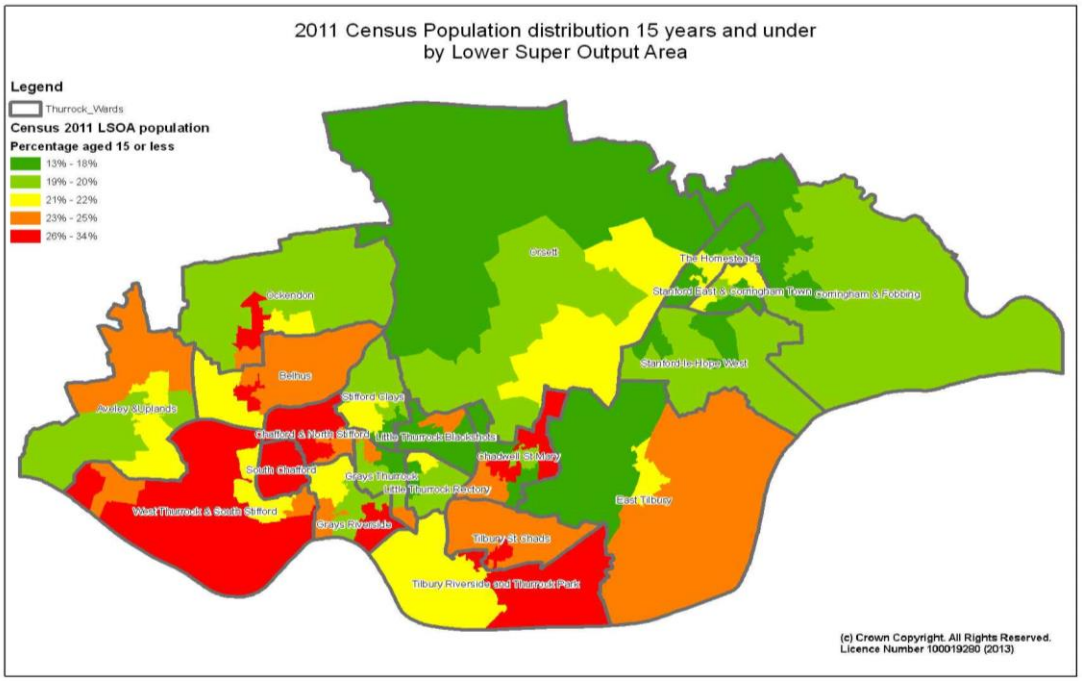
Figure 2: Population projections 2012-2037



Source: ONS, 2012 subnational population projections

Figure 3 illustrates that the areas with the highest percentage of under 15s in Thurrock are heavily clustered around the south and south west of the borough including the wards of Tilbury St. Chads, Chafford and North Stifford, South Chafford and West Thurrock and South Stifford where up to 34% of the population fall within this age group.

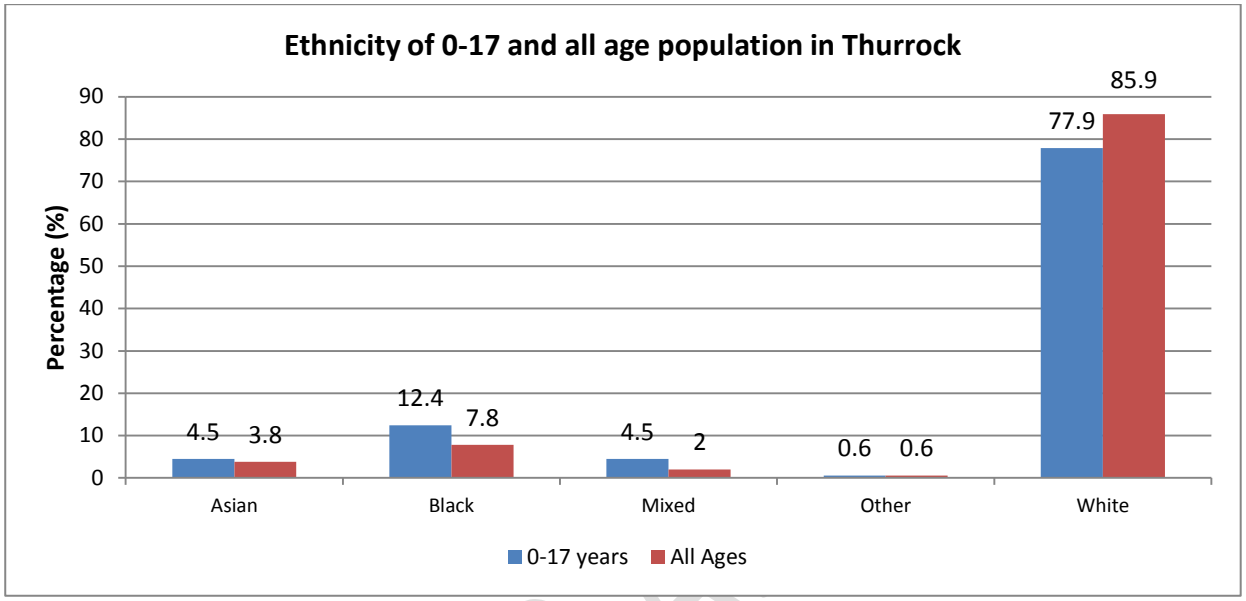
Figure 3: Population Distribution for people aged under 15 years by LSOA



Source: Census 2011

Our child population in Thurrock is more ethnically diverse than the all age population. Figure 4 below compares the ethnicity of the local population aged 0-17 years with the ethnicity of the total Thurrock population. From this, it can be seen that there is a lower proportion of White residents in the 0-17 population and a higher proportion of Asian, Black and Mixed ethnic groups.

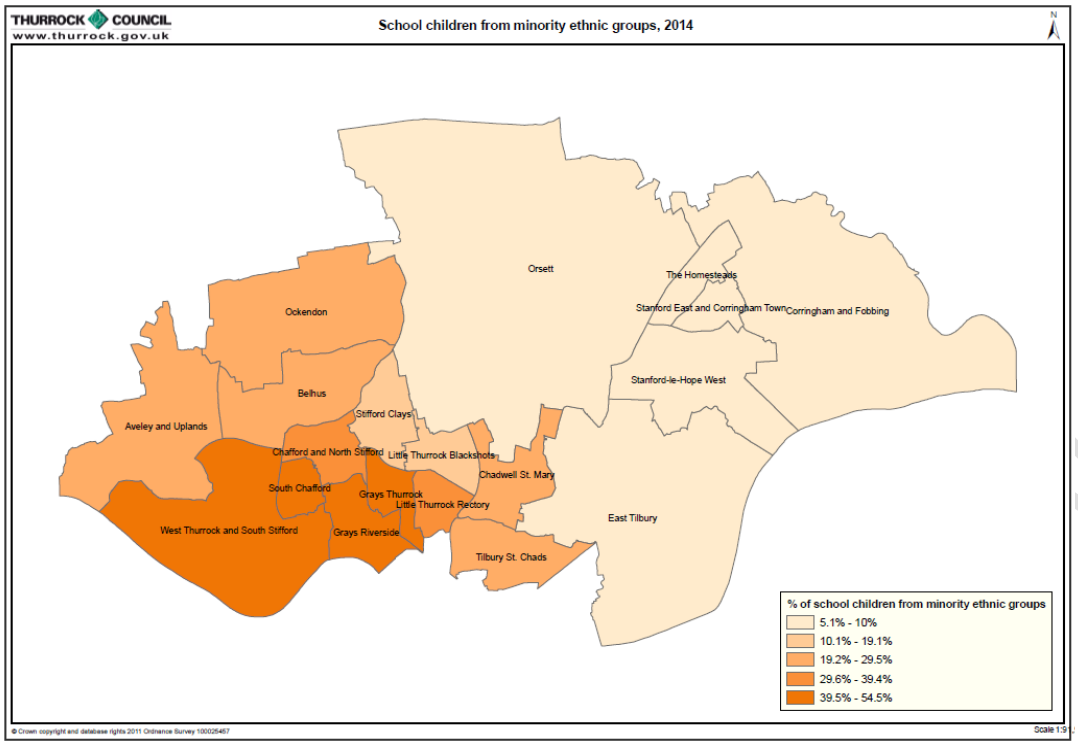
Figure 4: Ethnicity of 0-17 population and all age population in Thurrock



Source: Child and Maternal Health Intelligence Network

The ethnicity of our school aged population is captured within the School Census data, and shows there to be variation across the borough. Wards in the west of the borough have the highest proportion of school children from minority ethnic groups, with the highest proportion residing in Grays Riverside (54.5% of their child population), and the lowest proportion of children from minority ethnic groups living in Corringham and Fobbing (5.1%). As mentioned in the Demography chapter, there has been substantial inward migration into Thurrock from East London, so the higher proportions of children from minority ethnic groups is consistent with this expectation.

Figure 5: Ethnicity of our school aged population by ward



Source: Spring School Census data, 2014

Information on the variation in deprivation in children and young people in Thurrock can be found in the Low Income Families and Child Poverty section of the JSNA document.

What do children and young people think about their health?

When considering the provision of services for children and young people that aim to improve their health and wellbeing, it is important to ensure that the views of children and young people are incorporated into the decision-making process. Children and young people often struggle to get their voices heard despite numerous recommendations stating that services provided should reflect children and young people's views. There have been several national studies conducted aiming to highlight children and young people's views of services they receive. Some consistent themes emerge amongst the research:

- Children and young people often feel that professionals do not involve them in decisions about their care and support
- Poor communication or lack of information is often experienced – information needs to be child-friendly and enable them to understand how to access support and what that support will entail
- There is inconsistency in experiences of transition between services – transitions should be more carefully managed and planned in collaboration with young people and their families

In Thurrock, engagement with young people has been integral to shaping many of the services delivered to them. A local survey carried out in 2013 (HealthWatch Thurrock, 2013) with 420

young people aged 11-19 years asked what their biggest health and wellbeing concern was, and the top three answers were:

- Obesity and not getting enough exercise – young people said they would like to have more access to or cheaper exercise facilities.
- Diet - particularly takeaways and junk food were of concern and linked to the lack of affordability of healthy food.
- Idealistic images from magazines and peer pressure to be a certain size; linked to this was dieting at a young age and being underweight.

The Council's Children's Commissioning Team carried out some research in 2011 (Thurrock Council, 2011) with pupils in a selection of schools looking at what areas of help young people would like more of in the borough. They found that pupils in primary schools (Years 3-6) would value more help when they feel upset and aren't able to tell anyone, with boys also valuing additional help with staying healthy, and girls additional help with self-esteem issues. Amongst pupils in secondary schools, the top area was to provide more advice so that young people would not start using drugs, with alcohol prevention and bullying advice ranked highly also.

Another example of feedback gained from engaging with young people followed a survey to 93 pupils by the Public Health team in 2014 (Thurrock Council, 2014) which looked at the current school nursing service and how it might be delivered differently in the future. Young people said that they knew who their school nurse was, but not necessarily the services they offer or how to make an appointment. A large number of young people are aware that they can speak to their school nurse in confidence, and many felt the school nurse was approachable and friendly. This feedback has been used to inform the commissioning of a new school nursing service from September 2015.

Other examples where the views of local children and young people were sought to shape service redesign include:

- Future of pharmacy provision in Thurrock (part of the Pharmaceutical Needs Assessment process)
- Smoke-Free survey – to inform the Tobacco Control Strategy
- User feedback on current Sexual Health service provision

Research with children and young people should be a key point when considering proposals for change, and should form part of an evidence base for any major decision.

2. Being Healthy

Breastfeeding

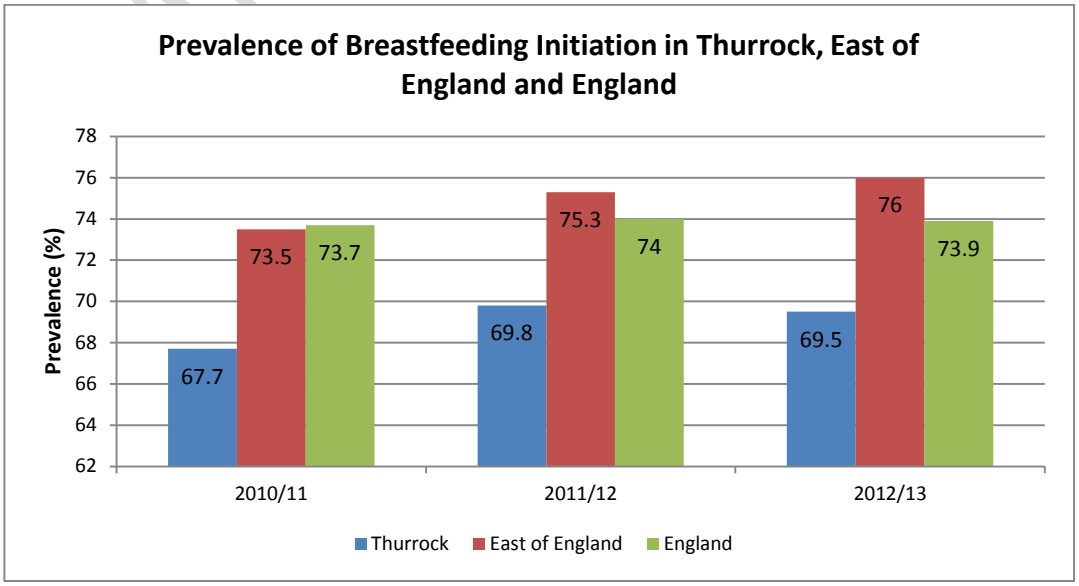
There has been significant reliable evidence produced over recent years to show that breastfeeding is a major contributor to public health and has an important role to play in reducing health inequalities even in the industrialised countries of the world. Breast milk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life; additionally there is evidence that the longer the duration of breastfeeding, the greater the health benefits in later life. According to a review undertaken by the World Health Organisation in 2007, the available evidence suggests that breastfeeding has long term benefits such as lower blood pressure and lower total cholesterol for breastfed subjects, as well as a reduced prevalence of overweight/obesity and type 2 diabetes. There was also evidence to suggest breastfed subjects performed better in intelligence tests. Another review also looked at evidence for health outcomes for breastfeeding mothers, and found lactation to be associated with reduced risk for type 2 diabetes, breast and ovarian cancer. Early cessation of breastfeeding or not breastfeeding was associated with an increased risk of maternal postpartum depression.

What do we know?

Breastfeeding Initiation

The prevalence of mothers initiating breastfeeding is measured as an indicator on the Public Health Outcomes Framework as an important measure of public health. It is quantified as the percentage of mothers who give their babies' breast milk within 48 hours of delivery.
The prevalence of mothers initiating breastfeeding in Thurrock was significantly lower than both the regional and national averages in 2010/11, 2011/12 and 2012/13 (data for full year 2013/14 is not yet available). This is shown in figure 6.

Figure 6: Breastfeeding Initiation in Thurrock, East of England and England, 2010/11-2012/13.



Source: Public Health England

There are a number of factors which may affect breastfeeding initiation levels, including:

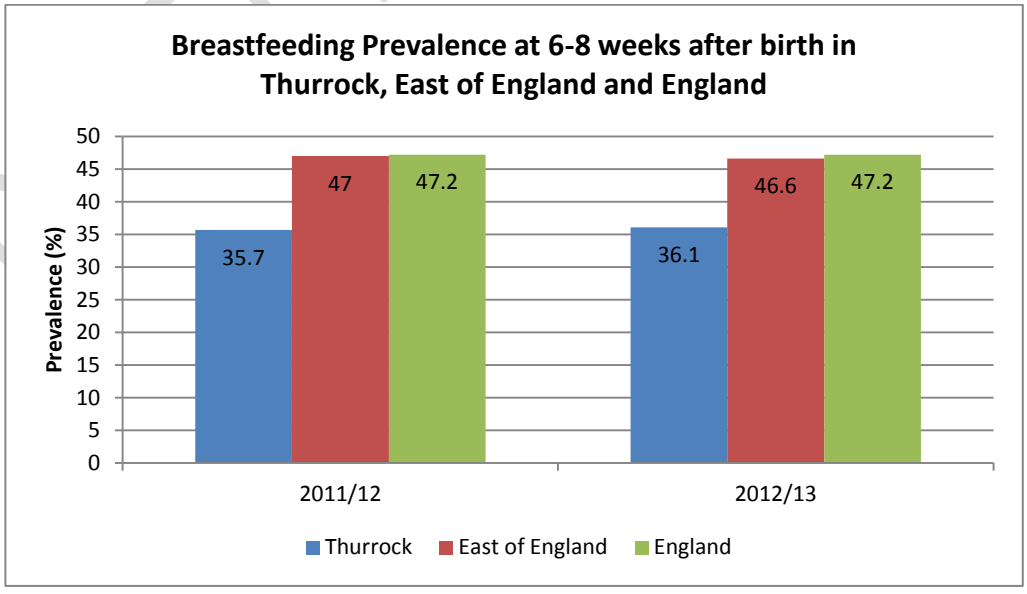
- Personal choice
- Cultural - a lot of ethnic groups choose not to commence breastfeeding until 'proper milk' comes in
- Extended families can have added pressure, especially where older generations have not breastfed
- Teenagers are not always willing to engage with health professionals and do not always see breastfeeding as 'cool'.
- Peer pressure
- With transient migrant groups, understanding and education around benefits of breastfeeding prior to coming into the area not given
- An area of lower socio-economic groups

Professionals in Thurrock may benefit from further analysis as to why the local levels of breastfeeding initiation have been historically lower than regional and national averages.

Breast Feeding at 6-8 weeks

The prevalence of mother's breastfeeding at 6-8 weeks is also measured as an indicator on the Public Health Outcomes Framework as an important measure of public health. It is quantified as the percentage of infants at 6-8 weeks who are totally breastfed – i.e. exclusively receiving breast milk, or partially breastfed – infants who are currently receiving breast milk and formula milk.
The prevalence of mothers breastfeeding at 6-8 weeks in Thurrock was significantly lower than both the regional and national averages in 2011/12 and 2012/13 (data for full year 2013/14 is not yet available). This is shown in figure 7.

Figure 7: Breastfeeding prevalence at 6-8 weeks in Thurrock, East of England and England.



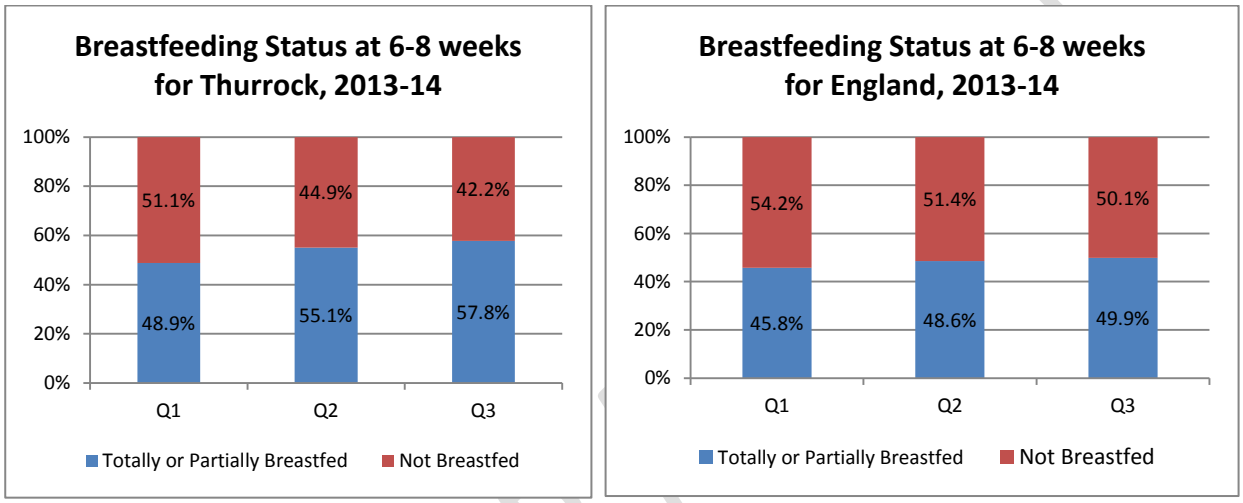
Source: Public Health England

Data from Quarters 1-3 from 2013/14 is available at CCG and practice level, and shows some slight variation throughout the year. When breastfeeding status is viewed per quarter, the prevalence of infants totally or partially breastfed increases between quarter 1 and 3 for both Thurrock and England. It is of interest to note that this data shows Thurrock to have a higher prevalence of breastfeeding at 6-8 weeks than the national average for all quarters, which is not in line with the trend data displayed above.

Figure 8: Breastfeeding Status at 6-8 weeks for Thurrock

Figure 9: Breastfeeding Status at 6-8 weeks for England

(*Percentages are of the infants where breastfeeding status is known.)*

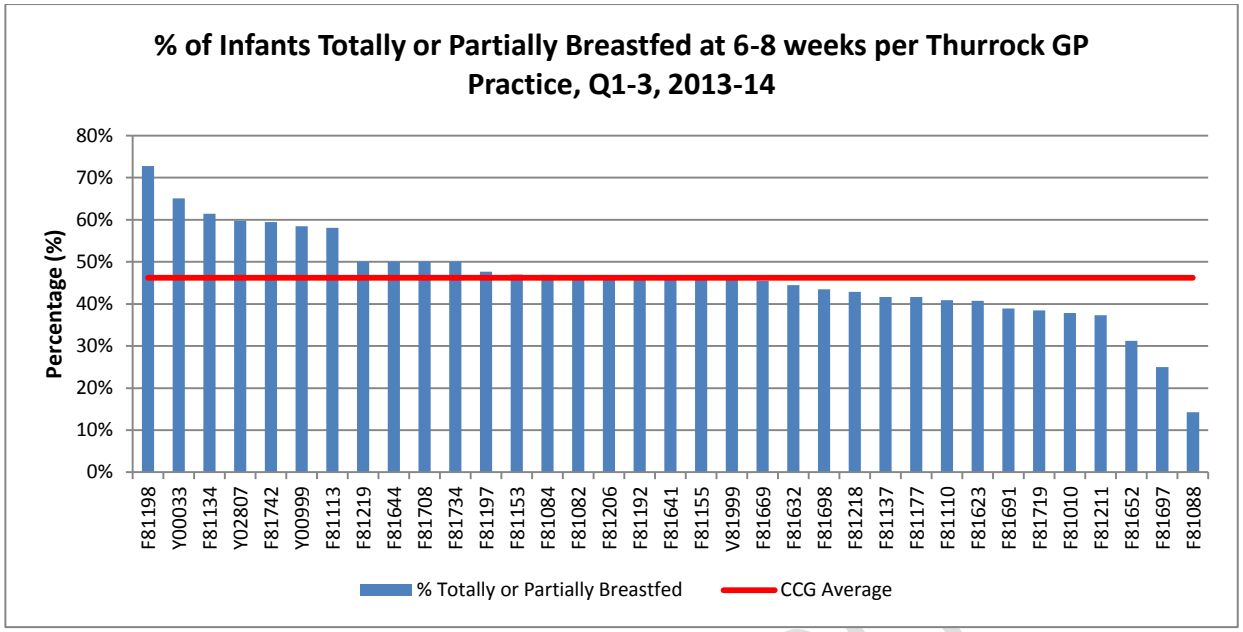


Source: Unify2

There is a large amount of variation in breastfeeding status at 6-8 weeks between GP practices within Thurrock. Practice F81198 had the highest percentage of infants totally or partially breastfeeding across Q1-3 with 72.7%, whilst practice F81088 had the lowest percentage with 14.3%. The mean for Thurrock CCG was 46.2% across the three quarters. Figure 10 shows this below.

Figure 10: % of infants totally or partially breastfed at 6-8 weeks at GP practice level for Quarters 1-3 combined, 2013-14.

Percentages are of the infants where breastfeeding status is known.



Source: Unify2

What are we doing in Thurrock?

There are currently 4 providers in Thurrock that offer a range of programmes to parents; these consist of Community Mums and Dads, Parents 1st, Coram and Family Nurse Partnership. These organisations work with parents with children between the ages of 0-19 years offering a variety of services and support such as:

- Understanding parent and child relationships
- Recognising child and parent behaviours and work on improvement
- Developing parenting skills
- Running informal and formal groups for first time parents
- One to one support
- Home visiting
- Early prevention for mothers in pregnancy, birth and post-birth.
- Supporting and encouraging mums to breastfeed

All of these organisations have strong connections with mothers to encourage and support breastfeeding; this is carried out with home and telephone support, group support discussions and the loan of breast pumps where required. Most develop a relationship with parents at the late stages of pregnancy which is easier to continue their support post-birth. Staff and volunteers are required to work to Baby Friendly Initiatives (BFI) standards. Most of these organisations will work closely with each other sign posting parents into the necessary services available and generally with the children's centres where they can engage with parents and deliver the support groups. Midwives and Health Visitors also support all mothers in early parenthood.

Breastfeeding services are offered to all mothers. 95% of new mothers have a contact attempted within 48 hours (2 working days) of notification of discharge from Basildon and

Thurrock University Hospital (BTUH) where initiation of this will begin for some parents. Key groups that are focussed on include:

- lone parents, and those affected by child poverty,
- mums aged 20 and under,
- parents to be,
- new first time parents and
- those relocating into the defined disadvantaged communities
- those identified by the 0-19 service as requiring additional support

Breastfeeding is actively encouraged at Basildon and Thurrock University Hospital via:

- Informing all mothers prior to discharge of an app created in-house called 'Feeding Together' and all are also encouraged to access website and social media information.
- Having achieved full accreditation as a 'Baby Friendly Accredited Unit', the majority of staff are trained in two full days of Infant Feeding with annual updates
- Paediatricians on their induction are introduced to maternity staff in order to work in partnership to promote breastfeeding
- N.I.C.U./paediatric staff have Unicef Baby Friendly training
- Running *Parentcraft* classes about Infant Feeding
- Participating in local baby related events and at hospital open days

Thurrock's Children's Centres also play an integral role in supporting mothers to breastfeed, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to increasing the number of mothers who breastfeed and ensuring that children are physically healthy.

Future work

The Public Health team have undertaken a review of all services and will be commissioning a new parent and breastfeeding service from July 2015.

Recommendations

- To promote activities to raise awareness of breastfeeding benefits
- Further joint working between professionals
- Reducing inequalities and improving access to breastfeeding support for women in low-income groups
- Increasing choice, by providing access to a range of services across different settings

Low Birth Weight

Birth weight is a good measure of infant health. Low birth weight (defined as births under 2,500g) is strongly associated with poorer health and poorer life chances and is an important predictor of future infant, child and adult health. Low birth weight babies are at greater risk of dying in their first year than heavier babies. Low birth weight is more common for babies born:

- To mothers under the age of 20 and over the age of 40

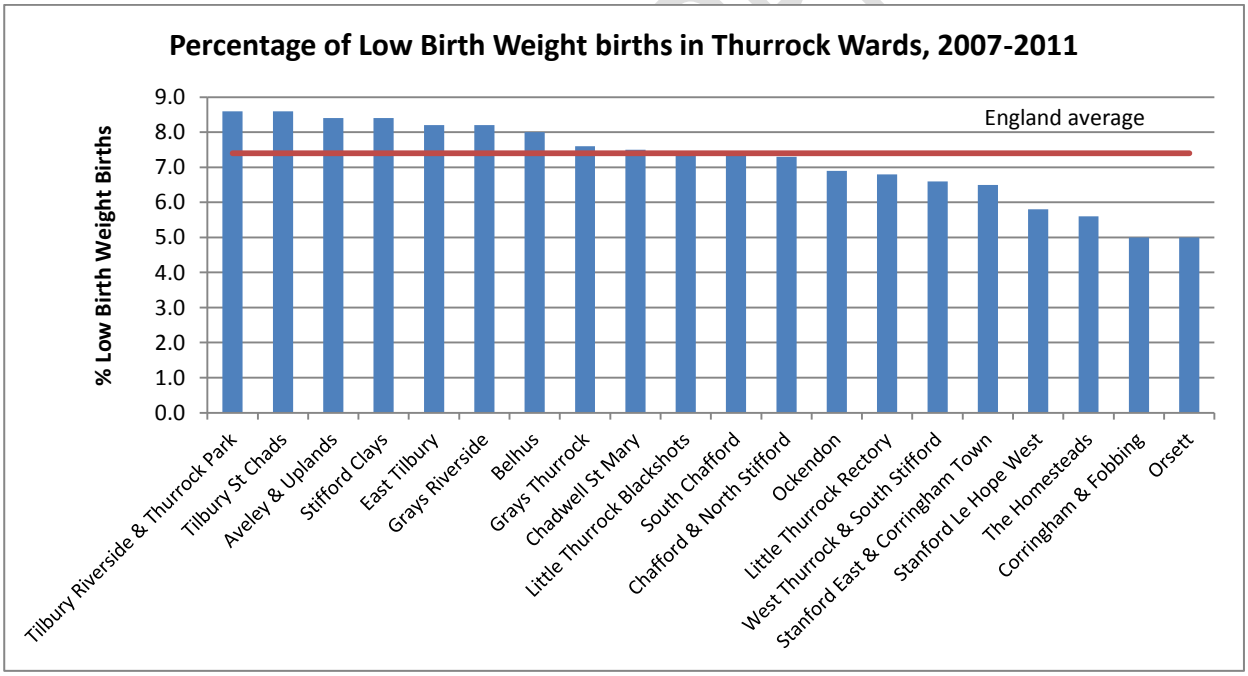
- In deprived areas
- To parents in social class 4 and 5
- To lone mothers
- To mothers born outside the UK

Babies born to mothers who smoked during pregnancy may also be at risk of low birth weight – further information can be found in the Smoking in Pregnancy section.

What do we know?

The latest data indicates that Thurrock has a similar percentage of low weight births as the national average (7.4% of all live and still births, compared to the national average of 7.3%, 2012). Ward level analysis shows that levels are higher in areas such as Tilbury Riverside and Thurrock Park, and Tilbury St Chads, and lower in areas such as Corringham and Fobbing and Orsett. When considered against the Index of Multiple Deprivation, it can be seen that generally the areas with the highest percentage of low birth weights are more deprived.

Figure 11: Percentage of Low Birth Weight Births (all live and still births) in Thurrock Wards, 2007-11.



Source: Local Health

What are we doing in Thurrock?

Support and delivery to parents in Thurrock focusing on premature babies and low birth weight is delivered through the Family Nurse Partnership (FNP). The programme aims to:

- improve the outcomes of pregnancy by helping young women aged 19 and under (and their partners) improve their ante-natal health and the health of their unborn baby

- improve children's subsequent health and development by helping parents to provide more consistent, warm and competent care for their children
- improve women's life course by planning subsequent pregnancies, increasing parents aspirations, economic and self-sufficiency through finishing their education and finding employment.

The FNP service operates to reduce inequalities in outcomes across the life course and to ensure a strong focus on prevention, health promotion and early identification of needs, with an aim to improve maternal, child and family functioning. It delivers this by mainly working as a home based visiting programme, however, family nurses are required to offer parents a choice of location, e.g. GP surgeries, children's centres, community health services, extended schools, health centres, cafés, etc.

Thurrock's Children's Centres also play an integral role in supporting parents both before and after the child is born, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to ensuring parents have a greater understanding of how to manage their pregnancy, and ensuring that children are physically healthy.

Recommendations

- Addressing the wider determinants of health, including low income and housing needs
- Reducing smoking in pregnancy targeted particularly within more deprived areas
- Improve family diets and understanding about nutrition and access to more affordable food
- Raise the profile of taking Folate supplements for pregnant women
- Services to promote fewer subsequent pregnancies and greater intervals between births
- Improve awareness of home safety measures
- Maintenance of services that improve parenting skills and techniques
- Increase promotion of opportunities to increase employment and education

Healthy Weight

Childhood obesity is a complex public health issue that is a growing threat to children's health. If the number of obese children continues to rise, today's children and future generations could have shorter life expectancies than their parents. In addition, overweight and obesity has serious economic costs, with the direct costs of treatment to the NHS being estimated at £4.2 billion per year, and the indirect cost to the wider economy at £15.8 billion per year (Butland, et al., 2007). Tackling childhood obesity requires changes in the behaviour of individual children, their parents and of society in general and reflects recent trends across most developing countries to greater fat and sugar consumption and reduced physical activity. There is also evidence to suggest that babies who are breastfed are less likely to be obese in adulthood. The term 'obesogenic environment' refers to the role environmental factors may play in determining both energy intake and expenditure. It has been defined as the 'sum of the influences that the

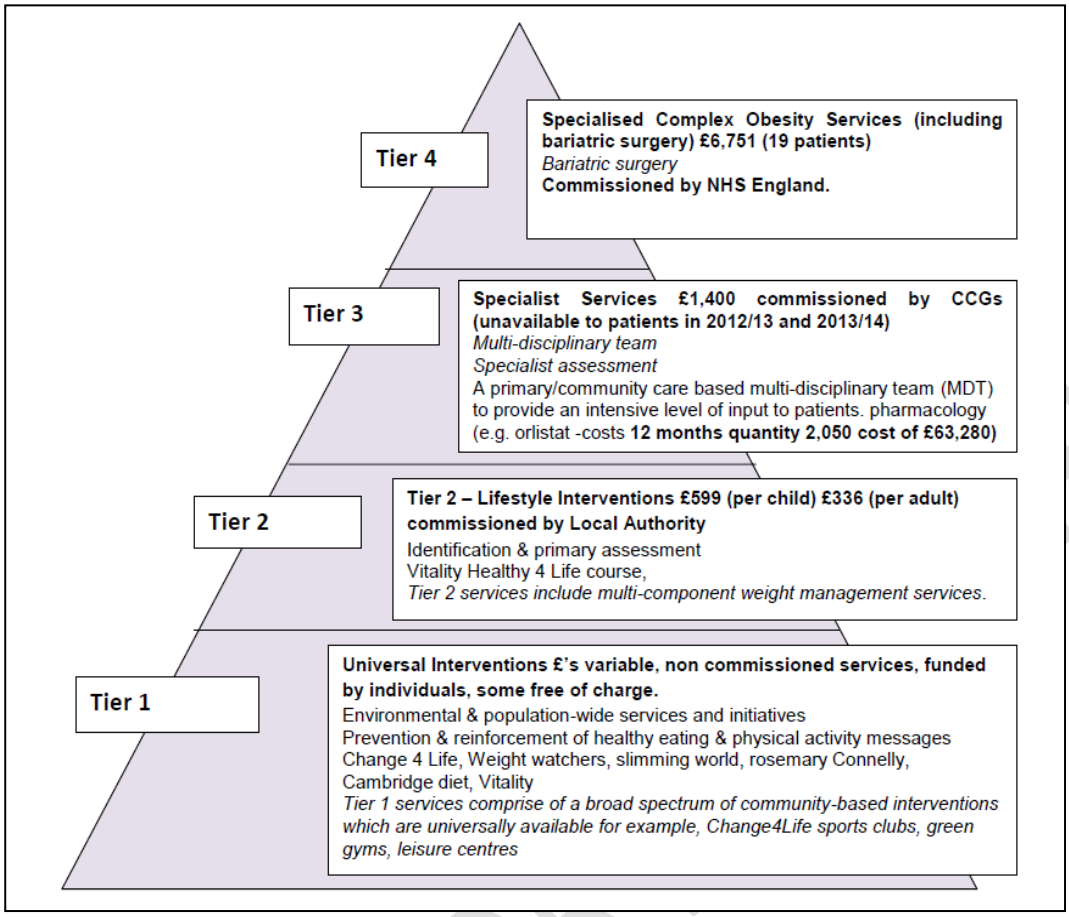
surroundings, opportunities or conditions of life have on promoting obesity in individuals and populations'. Research has also explored the influence maternal weight may have on the prevalence and severity of obesity, in future generations identifying pregnancy as a key time to target weight management. Weight is a sensitive issue, especially for parents and evidence suggests that many parents:

- struggle to assess their children's weight status accurately.
- over-estimate activity levels and underestimate the amount of high-fat, high-sugar foods that the child and family eat.
- make no connection between poor diet and low activity levels in their children and long-term health problems.

The Department of Health reports that by 2020 they want to see "A sustained downward trend in the level of excess weight in children." To achieve the desired outcome, the Department for Health have commissioned the Change4Life programme, and continue to work towards improved labelling requirements on foods and drinks enabling consumers to make better informed choices and similarly encouraging businesses to responsibly advertise the calorie information on all menus. Finally, the Department of Health have been a source of guidance around recommended physically activity levels for adults and children. (Department of Health, 2011) It is recommended that children are active for at least an hour every day.

It is essential to work with the CCG and NHS partners around a whole system approach for healthy weight management and there is work ongoing to change the commissioned services. Figure 12 below shows the costs associated with commissioned tiers of services.

Figure 12: Tier Pathway, costs estimated per person based on commissioned services 2012/13



Source: Thurrock Healthy Weight Strategy, 2014

Defining Childhood obesity

Presently there is debate about the definition of childhood obesity and the best way to measure it in England. For clinical practice the Royal College of Paediatrics and Child Health growth charts are recommended, which include BMI, for children aged 2-18 years (2012). For public health programmes, such as the NCMP and the Health Survey for England, the British 1990 growth reference (UK90) charts are used. Assessing the Body Mass Index (BMI) of children is more complicated than for adults because a child's BMI changes as they mature. Growth patterns differ between boys and girls, so both the age and sex of a child needs to be taken into account when estimating BMI.

Although child obesity is seen as a priority, there is still a proportion of children defined as underweight. Reasons for underweight children can be an illness, malnourishment or more commonly, eating disorders. Eating disorders are typically associated with young girls and has a strong correlation with poor mental health, poor self-image, low self-esteem and a sense of a lack of control. The local CAMHS service offer Cognitive Behavioural Therapy (CBT), nutritional advice and counselling to support young people with an eating disorder; as do a local children's commissioned service provider Catch-22.

Inequalities

Socio-economic status

It has long been known that people from lower socio economic groups have poorer health. The socioeconomic inequalities have increased in the UK since the 1960s leading to a wider gap in regards to both child and adult obesity with differences in prevalence in both age and gender. Evidence from the analysis of data from the National Child Measurement Programme (NCMP) suggests that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (measured by the 2010 Index of Multiple Deprivation (IMD) score). Nationally obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10% (Marmot, 2010).

Ethnicity

There are a range of broad and complex factors with minority ethnic communities that could be influencing the proportion of children that are of a healthy weight. There is a lack of evidence to explore these and although there is data available from 2004 including a "boost sample" from minority groups it doesn't effectively reflect the national picture in combination with there being almost non-existent information for many smaller ethnic groups. The National Obesity Observatory does explain that there is an ongoing debate around the validity of information around the definition of obesity within different ethnic groups for adults and children by exploring that different groups are associated with "a range of different body shapes and different physiological responses to fat storage".

Disability

Similarly to ethnicity there is limited data about the link between disabilities and obesity. It is accepted that those people with disabilities are more likely to be obese because of the assumed lower rates of physical activity compared to the general population. However it is also acknowledged that those people with learning difficulties often fall within the underweight or obesity group which suggests a number of other factors may be having an influence here.

Childhood Obesity Surveillance

The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obese levels within primary schools. The programme is now recognised internationally as a world-class source of public health intelligence and holds UK National Statistics status. It is has been in operation since 2006. The NCMP was set up in line with the Government's strategy to tackle obesity and to:

- inform local planning and delivery of services for children
- gather population-level data to allow analysis of trends in growth patterns and obesity
- increase public and professional understanding of weight issues in children and be a vehicle for engaging with children and families about healthy lifestyles and weight issues.

National policy has recently changed with the introduction of the School Food Plan (Dimbleby & Vincent, 2013), the introduction of universal free school meals for 4-7 year olds, and the return of cookery to the national primary curriculum. In addition, new Ofsted guidance (Ofsted, 2013) states inspectors should ‘ask school leaders how they help to ensure a healthy lifestyle for their children’.

Physical Activity

As well as the importance of maintaining a healthy weight, physical activity has an impact on education and academic attainment. Physical activity positively affects cognition in children - being physically active releases hormones, neurotransmitters and a protein responsible for learning, memory and higher thinking. Sport and recreation can also lead to increased self-esteem and the development of motivation and determination – these skills are useful for acquiring new information for passing exams. (Sport and Recreation Alliance, 2012) There is now a wide range of research into this relationship with the consensus that in the majority of instances physical activity enhances school performance. One study that involved 243 school children aged nine to 10 years old found that daily 10 minute physical activity breaks significantly increase on-task behaviour by 8% on average, and that the average was a much higher 20% for the least on-task behaviour pupils, whilst those who took a 10 minute break without being physically active demonstrated a 3% reduction in on-task behaviour (Mahar, et al., 2006).

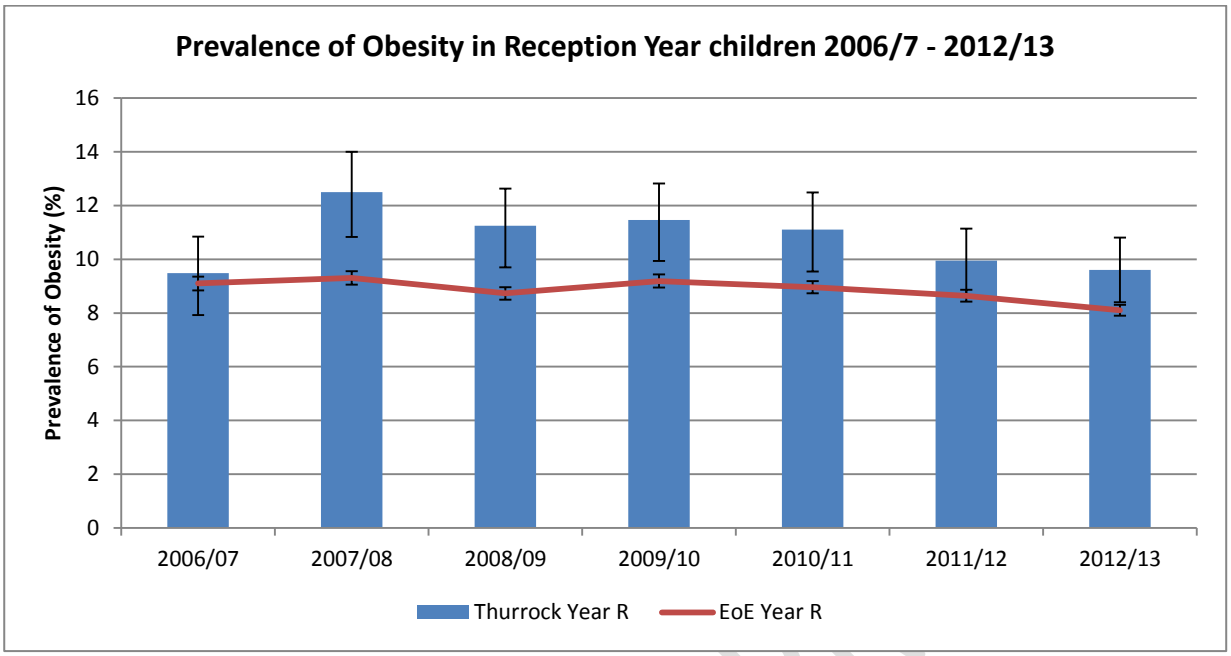
What do we know?

The most recent NCMP data was released at Local Authority level in December 2013, which reports on the measurements of children in Reception and Year 6 during the 2012/13 academic year. All data is sourced from the Health and Social Care Information Centre.

Reception Aged Children

The 2012/13 data shows Thurrock to have an obesity prevalence in Reception-aged children of 9.6%, which is significantly higher than the East of England average (8.1%), and is above the England average of 9.3%, although not significantly so. Upon comparing this to data from previous years, the obesity prevalence has decreased in line with the regional trend – see Figure 13 below. For 2012/13 the Thurrock prevalence is statistically significantly higher than the East of England prevalence, whereas in 2011/12 there was no significant difference.

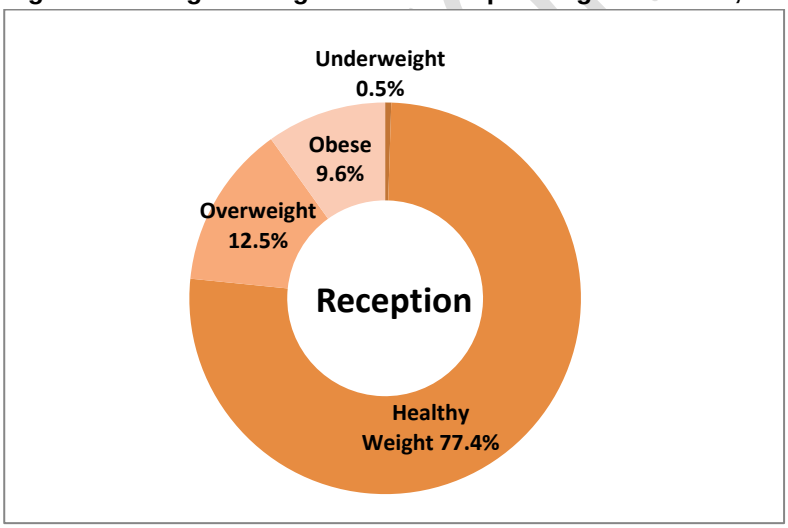
Figure 13: Obesity prevalence in Reception-aged children from 2006/07–2012/13 for Thurrock and East of England.



Source: Health and Social Care Information Centre

The figure below shows the percentage split of weight categories in 2012/13 of Reception year children in Thurrock. It shows that almost a quarter of children were outside of the healthy weight range.

Figure 14: Weight Categories for Reception-aged children, 2012/13

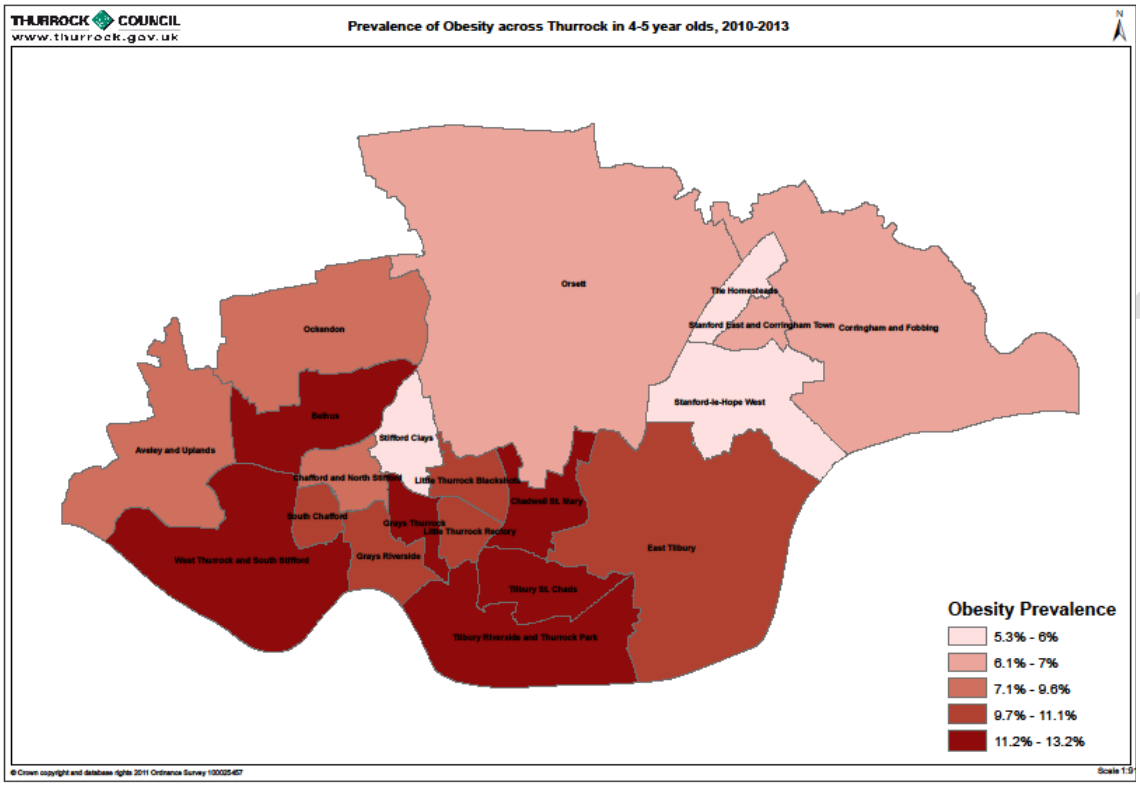


Source: Health and Social Care Information Centre

When Thurrock is compared to its CIPFA comparator sites, its obesity prevalence falls in the middle of the group, and it has the lowest percentage of children below a healthy weight (0.4%). This is an important positive statistic to note alongside the less positive generally high prevalence of obesity and overweight children in this age range.

Obesity varies across the borough, with areas within the south and west of Thurrock showing the greatest concentrations (the maximum prevalence is 13.2%). The figure below depicts how obesity in Reception-aged children varies across the borough.

Figure 15: Obesity prevalence across Thurrock in Reception-aged children, 2010-13

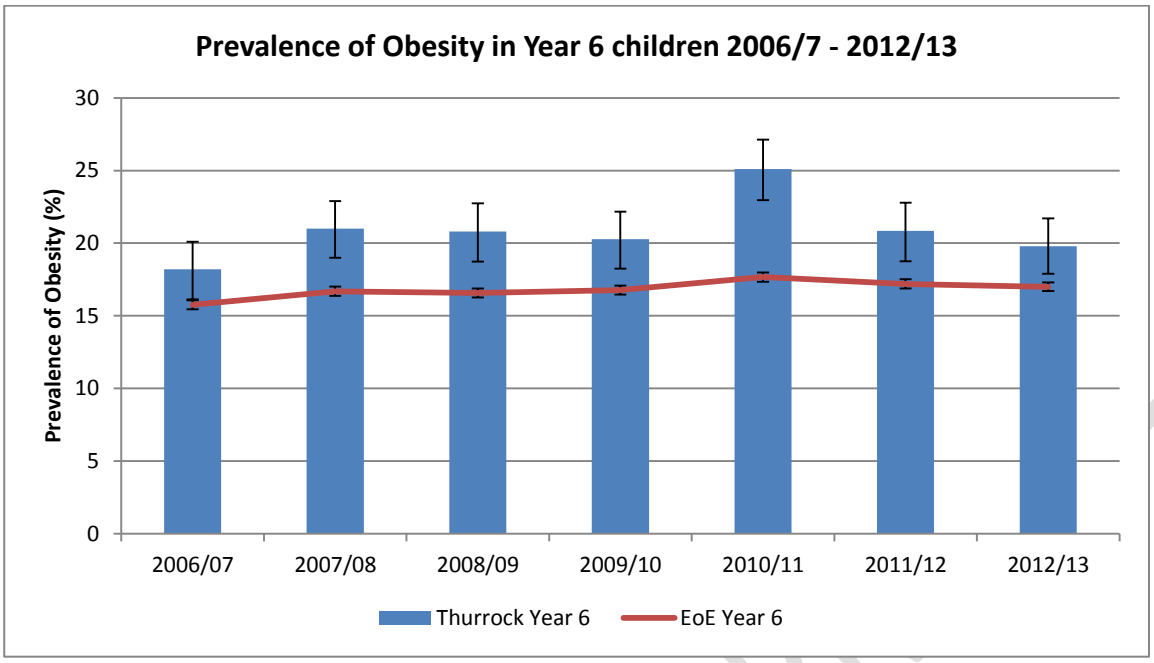


Source: Health and Social Care Information Centre

Year 6 Aged Children

The 2012/13 data shows Thurrock to have an obesity prevalence in Year 6-aged children of 19.8%, which is more than double the local prevalence at Reception Year. Thurrock's prevalence is significantly higher than the East of England average (17.0%), and is above the England average of 18.9%, although not significantly so. Upon comparing this to data from previous years, the obesity prevalence has decreased in line with the regional trend – see Figure 16 below. The Thurrock prevalence is statistically higher than the East of England prevalence, which continues the trend observed since the 2007/08 data.

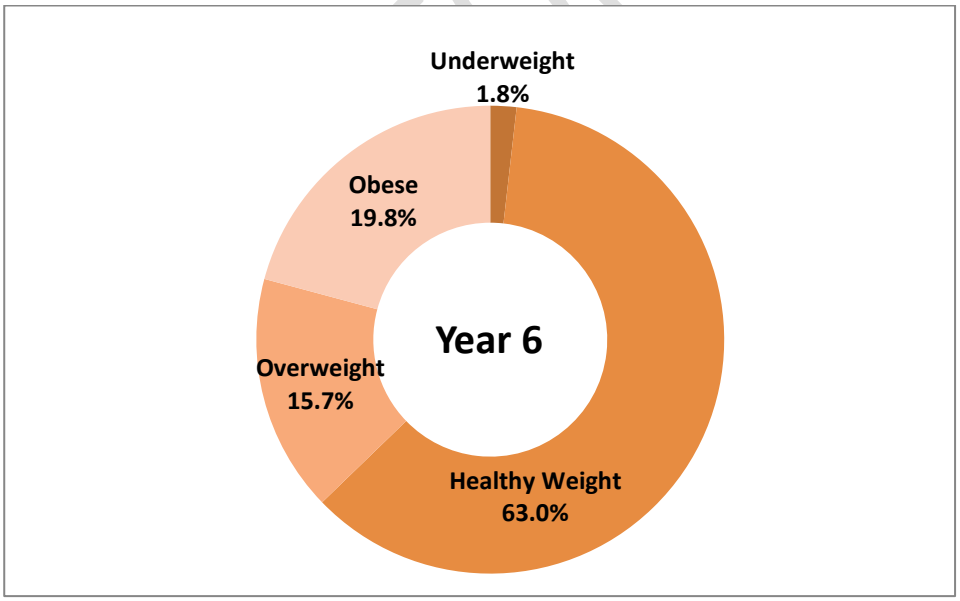
Figure 16: Obesity prevalence in Year 6-aged children from 2006/-7–2012/13 for Thurrock and East of England.



Source: Health and Social Care Information Centre

The figure below shows the percentage split of weight categories in 2012/13 of Year 6-aged children in Thurrock. It shows that over 35% of children were outside of the healthy weight range.

Figure 17: Weight Categories for Year 6-aged children, 2012/13

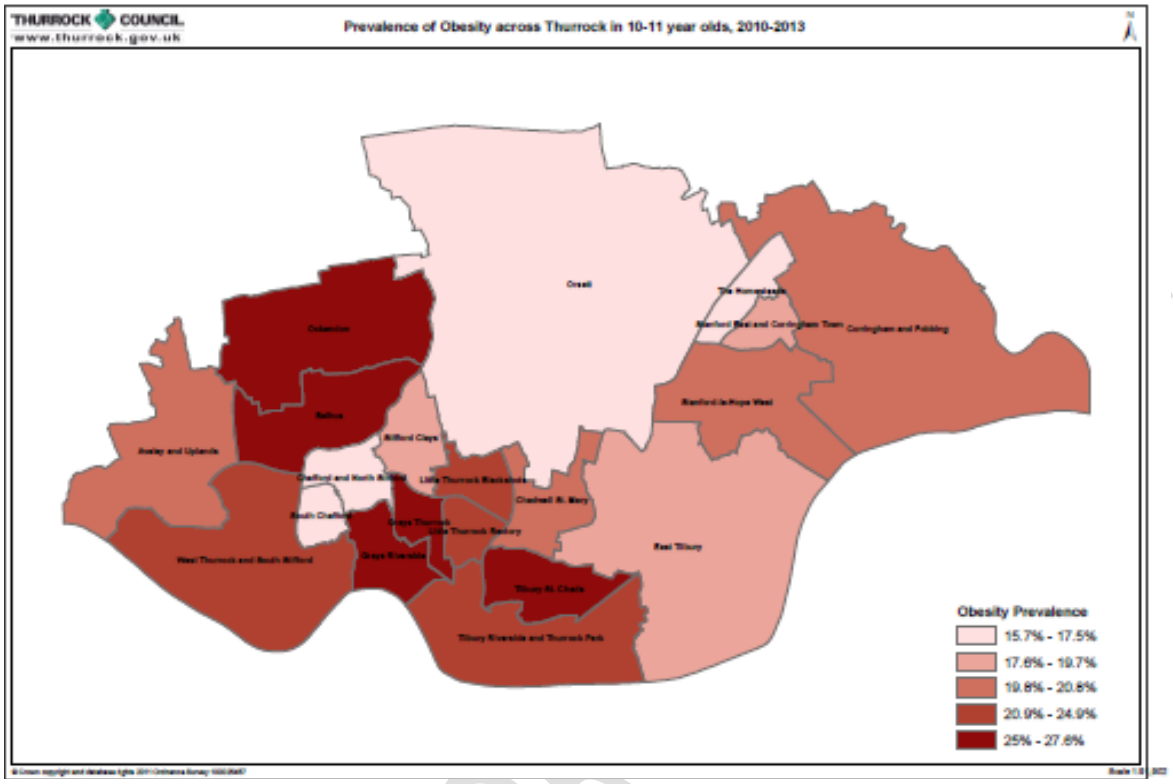


Source: Health and Social Care Information Centre

When Thurrock is compared to its CIPFA comparator sites, its obesity prevalence falls in the middle of the group.

Obesity varies across the borough, with areas within the south and north-west of Thurrock showing the greatest concentrations (the maximum prevalence is 27.6%). The figure below depicts how obesity in Year 6-aged children varies across the borough.

Figure 18: Obesity prevalence across Thurrock in Year 6-aged children, 2010-13



Source: Health and Social Care Information Centre

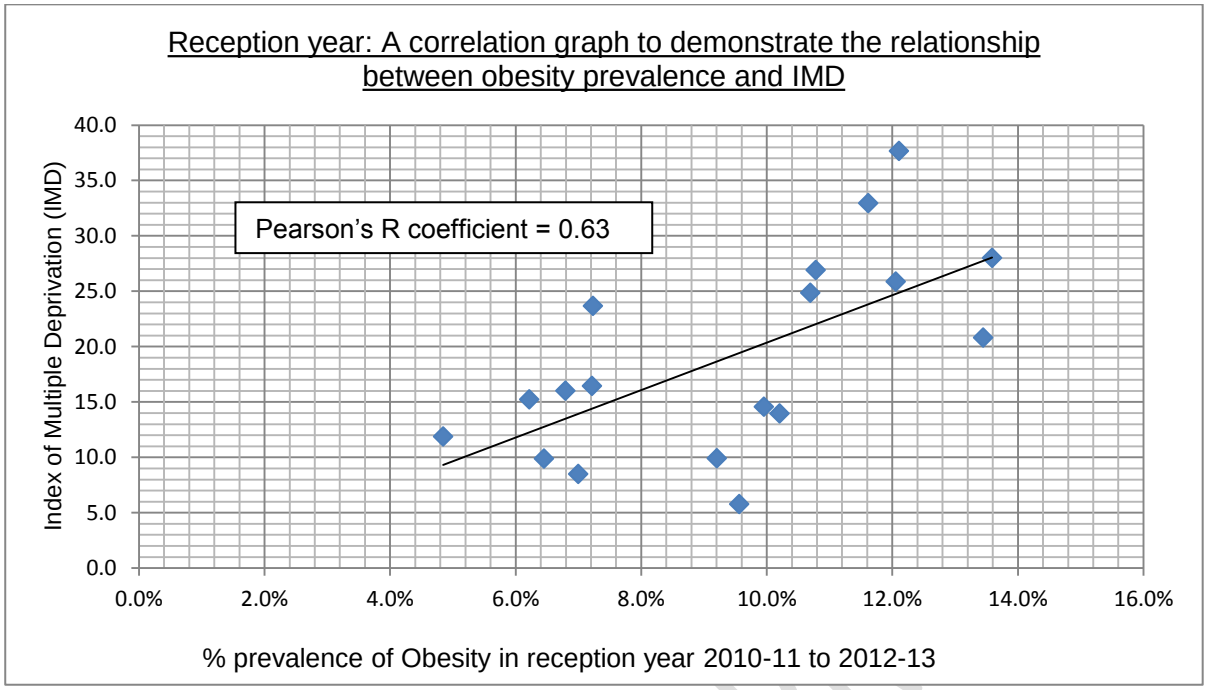
These maps are also comparable with the maps showing levels of socioeconomic deprivation across Thurrock demonstrating a clear health inequality.

Association with Deprivation

An association between high obesity prevalence and areas of high deprivation can be observed for both Reception-aged and Year 6-aged children in Thurrock. The two figures below show the correlation between percentage of obesity prevalence and deprivation by MSOA level in Thurrock 2012-13 for both Reception year and Year 6 children (each blue dot is an MSOA area).

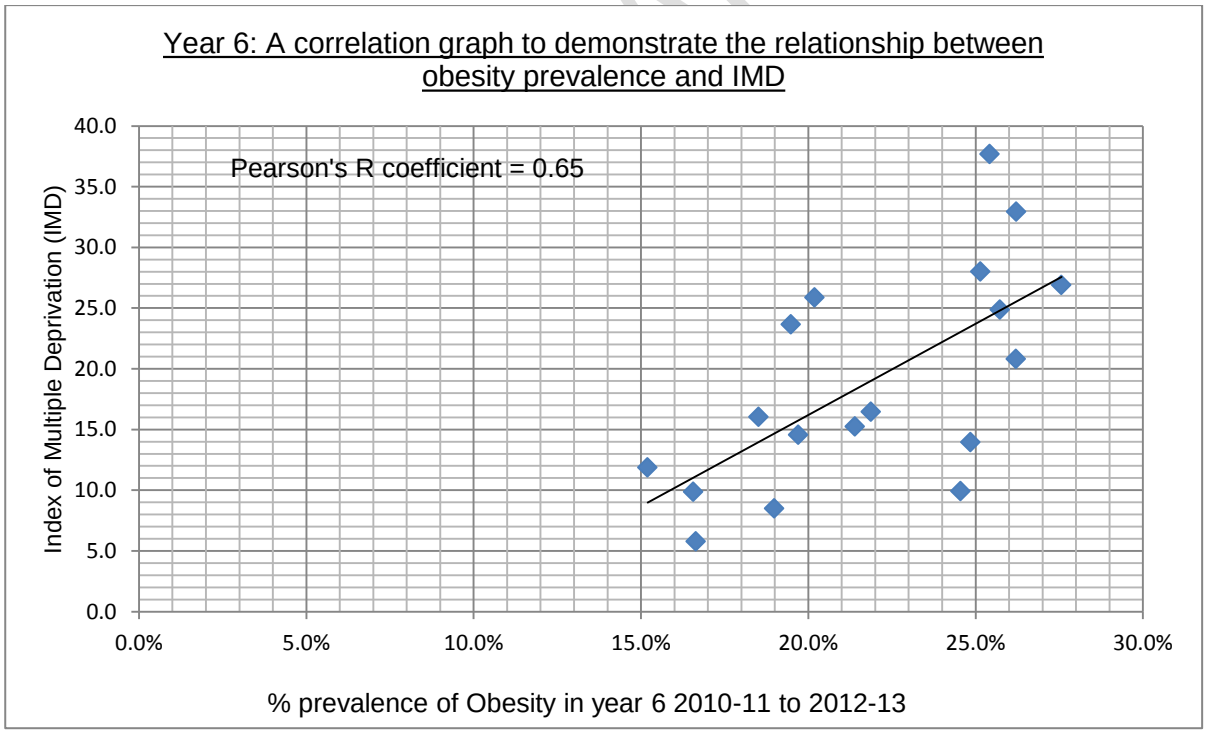
[The Pearson product-moment correlation coefficent is a measure of the correlation (linear dependence) of two variables where the r value = 1 it denotes a perfect correlation and where r= 0 it denotes no correlation.] Both figures show a positive correlation which is statistically significant between the percentage of obese children and level of deprivation.

Figure 19: Correlation between obesity prevalence and IMD in Reception-aged children



Source: Health and Social Care Information Centre and DCLG

Figure 20: Correlation between obesity prevalence and IMD in Year 6-aged children



Source: Health and Social Care Information Centre and DCLG

This is important data for commissioning health services as it indicates a health inequality and shows that services to tackle childhood obesity need to be focused towards areas of higher deprivation within Thurrock.

Physical Activity

Although not graphically depicted, Thurrock has relatively low levels of physical activity levels for children in school compared to CIPFA comparators. Levels of physical activity are statistically lower than 12 out of 15 CIPFA comparator Local Authorities and regional and national rates.

What are we doing in Thurrock?

These statistics highlight a need to tackle obesity in Reception age children and preschool children as the levels of obesity are already very high by the time children start school.

Children's Centres

Thurrock's Children's Centres also play an integral role in supporting parents and children maintain a healthy weight, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to encouraging mothers to breastfeed, and ensuring that children are physically healthy.

Transport

In general in the last 50 years or so there has been an increase in car use and decrease in cycling, walking and active travel. We aim to maximise the potential to encourage these forms of active travel. This also contributes to objectives in relation to sustainability and congestion. The Road Safety team/Local Sustainability Transport Fund are also supporting initiatives which affect child weight and promote active travel, such as Walk to School Week. Partnerships have developed with the Local Sustainable Transport team and initiatives such as 'Bike it', health walks, and cycle pit stops have evolved. Beat the Street Thurrock was a joint-funded project rolled out in Thurrock in June and July 2014 encouraging people to walk more. Over 100 boxes were placed around the whole of Thurrock and players were given pre allocated fobs to allow them to track walks as part of the challenge raising money for charity (inactive adults and school children were targeted in different ways). The programme was very well taken up with in excess of 14,000 people registering to play. More information on projects run by the LSTF which also increase physical activity can be found in the 'Accidental Injuries and Deaths' section].

Planning and Environment

Work has progressed looking at the close proximity of takeaways to schools in Thurrock and a paper was taken to Overview and Scrutiny Committee in collaboration with the Planning team. A number of local authority areas have already taken steps to limit the growth of fast food takeaways through supplementary planning policies which Thurrock can explore further.
The development of links between the Public Health and Planning teams will allow closer collaboration on projects of joint interest; for example working together to create a healthier built environment that allows people more opportunity to by physically active in the way buildings and spaces are designed.

Sports and Physical Activity

Thurrock Sports and Physical Activity Partnership Group which has a wide membership including local leisure centres, school sports co-ordinators, Active Essex, providers of weight

management services, Council members and officers, including Public Health as well as volunteers of sporting, exercise and physical activities in Thurrock. The partnership identifies funding opportunities and works with other organisations in identifying and initiating sporting/activity projects. The partnership will develop and has secured a 'Physical Activity connector' post on a part time basis to shape the work of the partnership and facilitate more joined up working. This partnership is ideally placed to drive forward projects that increase physical activity and sports in Thurrock and the members to be ambassadors for projects in their workplace and communities.

County Sports Partnership

Through the Thurrock Sports and Physical Activity Partnership the relationship with the County Sports Partnership 'Active Essex' has been strengthened. Through active engagement with Active Essex Thurrock can benefit from taking a joined up approach to projects, support and shared learning with other areas around sports and physical activity as well as opportunities to access Sport England funding such as 'Sportivate'. A directory has also been piloted in partnership with Active Essex to co-ordinate local sports clubs and activities in a user friendly and accessible place. This was an action following the Healthy Weight workshop facilitated by the Public Health team in December 2013.

Parks and green spaces

Parks and green space are important for communities and provide people the opportunity to be active in their leisure time. Maintenance and improved quality results in increased use of these facilities. Through the Healthy Weight Strategy delivery, the Sports and Physical Activity action plan will look to improve signage and facilities. A pilot of the 'playing out' project is aspired to as part of this delivery which involves encouraging children to play outside more through coordinated temporary road closures in residential areas. We have seen a significant amount of children using our spaces due to limited funds for holidays now having an impact on local households. The Friends of Parks groups have been able to change people's perceptions of certain key parks without the need for equipment just utilising the space.

Education and learning

The NCMP is delivered in schools by the provider school health teams providing a method of surveillance for child obesity prevalence. The current services use this programme to identify children that would benefit from weight management programmes which can then be offered to them and their family. There is potential to build upon this service model and to create a closer link with schools and weight management services. Working together with schools can only benefit pupil's health and wellbeing with the potential to influence educational attainment.
The school sports premium allows schools the opportunity to direct funds towards local solution around sport and physical activity. Working together with school games organisers could benefit this and an offer designed to allow schools control to shape programmes to suit children's needs.

Programmes that link schools on an area wide basis such as 'Beat the Street' offer the opportunity not only to increase activity in school age children and their families but allow the opportunity for pupils to work together towards a shared goal, allowing social inclusivity with the added benefit of decreasing traffic around the school and thereby improving pupil safety.

Programmes around healthy eating can be explored with schools alongside physical activities to commission evidence based programmes that will engage schools and pupils and promote achieving a healthy weight.

The Public Health team have worked with the Learning and Skills team to deliver the 'Eat Better, Start Better' programme in Thurrock, a two-year programme to improve food provision for children aged 1-5 in early years settings. The project aims are: Improved, healthier food provision, including increasing nutrition and cooking skills knowledge in the workforce and parents, for children aged 1-5 in early year's settings and at home. Following on from an evaluation, work continues to ensure the programme's sustainability.

Recommendations

- All healthy weight initiatives and programmes will have defined priorities, key action points and reporting methods in line with the Healthy Weight Delivery Plan.
- Activity Directory to be provided to GP's and Primary Care Professionals to support them in undertaking brief interventions around healthy weight and referring into the relevant tier of weight management services and physical activity programmes.
- School activities and family programmes around healthy weight will be an important element in combating the rise in obesity between Reception and Year six children and these should be evaluated to measure success.
- In response to the engagement to date, specific programmes/projects will be commissioned with the objective of working to reduce the obesogenic environment in Thurrock.
- Continue to develop the partnership working that has started with the Healthy Weight strategy delivery group following the workshop held in December 2013
- Using local leadership such as Hubs and the Local Area Coordinators (LAC's) and the Asset Based Community Development (ABCD) principles, communities will have played an important role in identifying and developing physical activity and healthy eating opportunities that are relevant to their local areas and resources.
- Communities should be involved in physical activity challenges such as 'Beat the Street'.
- Looking at the close proximity of takeaways to schools in Thurrock and work with food outlets within close proximity to schools to promote healthier options.
- A new tier 1 to tier 4 weight management pathway should be developed alongside health and CCG colleagues.
- Monitor the take up of the new school meal premium across primary schools and health professionals to have the opportunity to influence school menus.
- Develop a sustainable follow on programme/offer following the Eat Better Start Better programme completed in 2013 with pre-school settings to tackle healthy weight in 0-5 year olds
- Review the provision of nutritional and weaning advice within Health Visiting services
- Work more closely with dental services around oral health and the link between sugar decay and healthy diets.
- Work with schools to educate children on portion sizes.

Obesity remains one of the biggest public health risks nationally and will continue to be a priority in Thurrock which is reflected in the Thurrock Health and Wellbeing Strategy.

Oral Health

Oral health refers to the condition of gums, teeth, surrounding bone and soft tissues of the mouth enabling function and being free of disease and pain. Oral health problems for children include dental caries, gum disease, and facial and dental injuries. Although the oral health of children in England has been improving over the last 30 years – improvements attributed to advances in medical science, use of fluoride toothpaste, better nutrition and increased awareness of dental health issues, inequalities are still observed which are strongly associated with deprivation and social background. Some vulnerable groups, e.g. minority ethnic groups, may encounter language and cultural barriers to accessing dental services, increasing their risk of oral disease, and adolescents have been identified as a group in which there is a large reduction in dental visits, also increasing their risk of developing poor oral health. If tooth decay in children is not treated, the consequences can include pain and discomfort on chewing, abscesses and extractions, which may affect children's growth and development. Poor oral health can lead to difficulties in eating, sleeping and socialising, thereby affecting health-related quality of life.

Advice in *Delivering Better Oral Health* (2014), the evidence based guidance for dentists and their teams, recommends that a person should visit a dentist for routine care at a time interval agreed between the patient and the dentist dependant on the risk of developing dental disease. This may be three monthly, six monthly, annually or once every two years. Tooth decay in children is largely preventable, with a large body of evidence advocating regular brushing and reduction of sugar intake. The availability of topical fluoride such as in toothpastes, varnishes and mouthwashes also helps to prevent tooth decay.

Local authorities improving oral health: commissioning better oral health for children and young people (2014) evidences ways for local authorities to champion oral health and address inequality across the life course, using universal or targeted interventions working closely with NHS, Public Health England and other partners. Training in oral health and hygiene for all staff who work with children and young people is one example. Improving the oral health of children is also identified as a priority within the *NHS Operating Framework 2011/12*, as well as in *Equity and Excellence: Liberating the NHS* (2010) and *Healthy Lives, Healthy People – Our Strategy for Public Health in England* (2010). Tooth decay in 5 year olds is now included in the list of public health outcomes measures (Department of Health, 2012). The Department of Health's Oral Health Strategy for England (1994) set national dental health targets for the country's children:

- Five year old children are to have no more than 1 decayed, missing or filled first tooth (on average); and
- 70% of five year olds should have no experience of tooth decay.

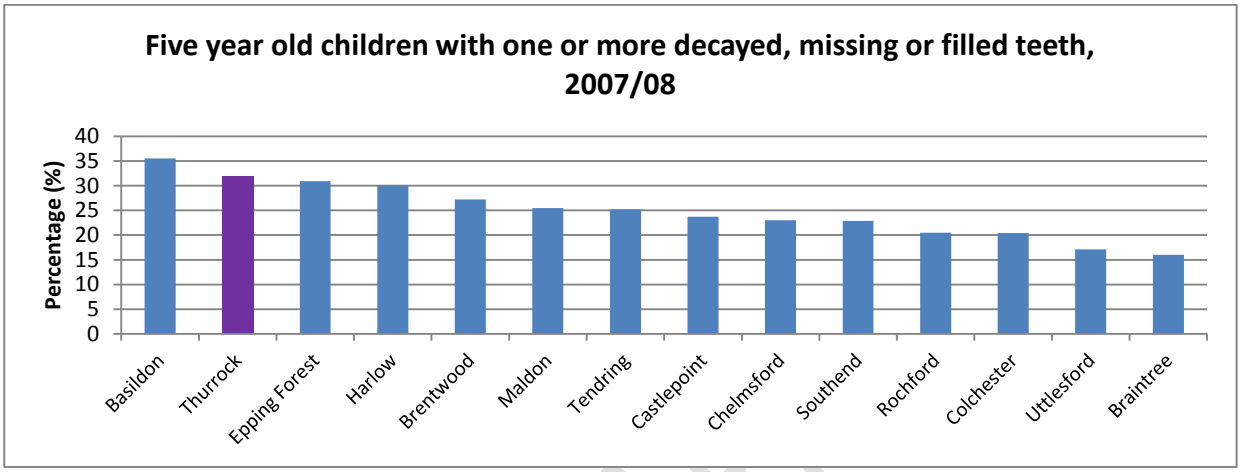
What do we know?

The level of dental need may be estimated from national dental health surveys of 5 and 12-year-olds, and data detailing the percentage of children aged 0-19 years admitted to hospital for dental extractions.

<u>5 year old children</u>

Data from the 2007/08 oral health survey of 5 year old children showed that 31.8% of Thurrock children had decay experience (one or more decayed, missing or filled teeth), which was the second highest local authority in the county and also above the national average of 30.9%. This indicates that only 68.2% of five year olds in Thurrock had no experience of tooth decay, which was lower than the Department of Health target (70%). Figure 21 below shows the geographical distribution across Essex.

Figure 21: Percentage of five year olds across Essex with experience of dental decay 2007/8



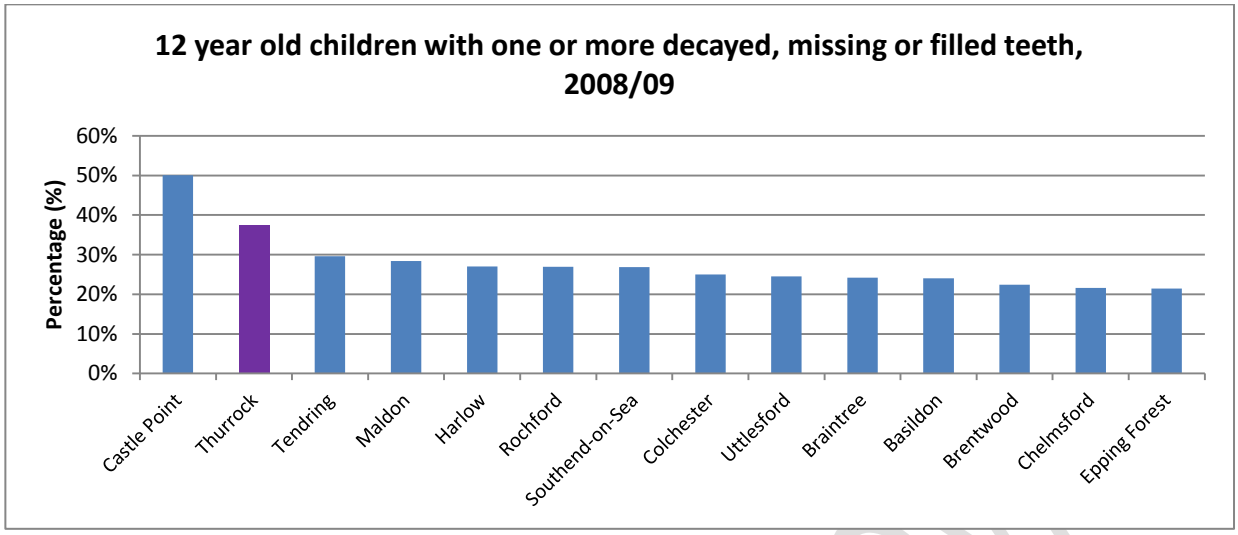
Source: NHS Information Centre

Although this survey is repeated every two years, unfortunately the data for Thurrock was not collected for the subsequent survey relating to data collected in 2009/10. This data, nationwide, showed an overall drop in rates since 2007/08, but there were local exceptions, and so it would be unwise to draw conclusions about changes in rate amongst the children of Thurrock. The survey was repeated in 2013/14 and results are expected in the near future.

12 year old children

Data from the 2008/09 oral health survey of 12 year old children showed that 37.5% of Thurrock children had decay experience (one or more decayed, missing or filled teeth), which was the second highest local authority in the county and also above the national average of 33.4%. Figure 22 below shows the geographical distribution across Essex.

Figure 22: Percentage of 12 year olds across Essex with experience of dental decay 2007/8

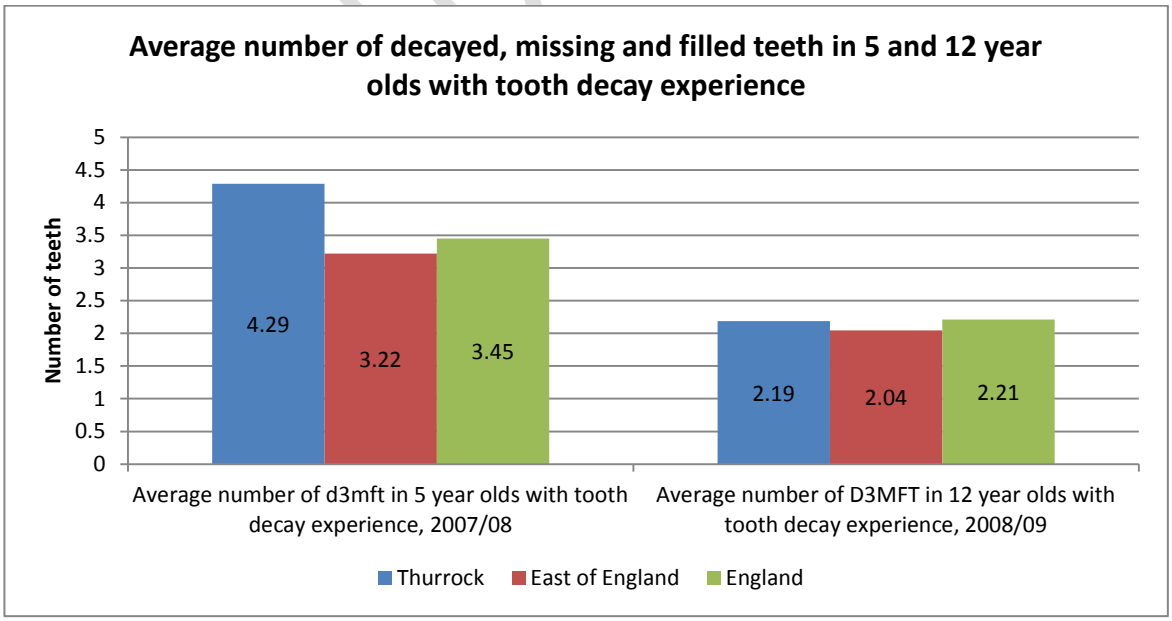


Source: NHS Dental Epidemiology Programme, 2008/09

Children with tooth decay

For those children who have experience of tooth decay, an average of 4.29 decayed, missing and filled teeth (d3mft) was reported for 5 year olds in Thurrock, which is greater than the regional and national averages. An average of 2.19 decayed, missing and filled teeth (D3MFT) was reported for 12 year olds in Thurrock, which was similar to the regional and national averages. This is shown in Figure 23 below.

Figure 23: Average number of decayed, missing and filled deciduous teeth (d3mft) in 5-year-olds and permanent teeth (D3MFT) in 12-year-olds, 2007/08 and 2008/09.

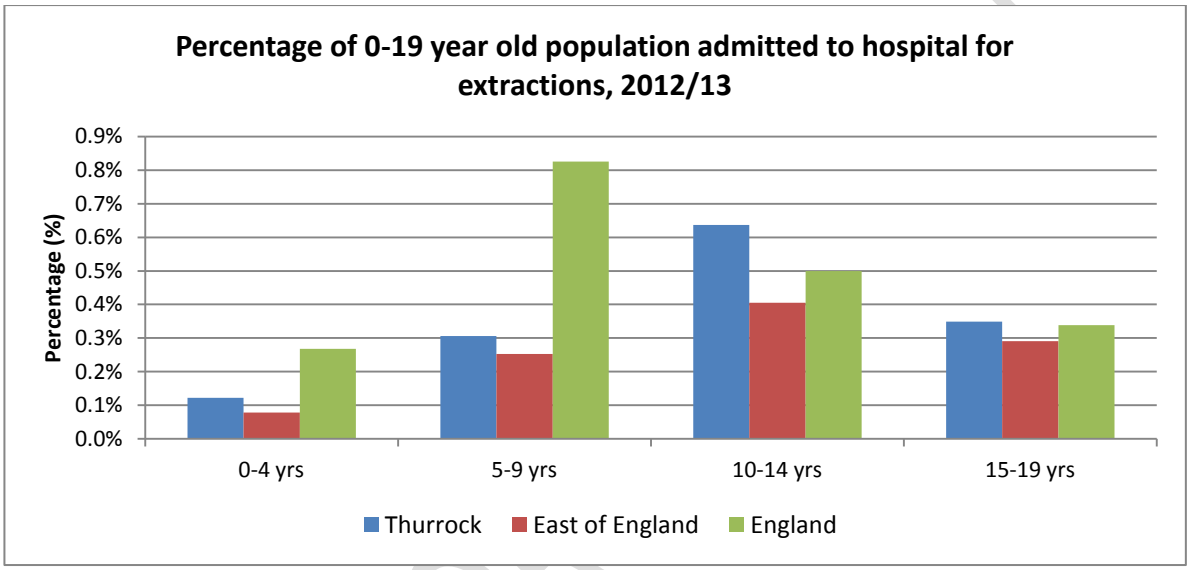


Source: NHS Dental Epidemiology Programme, 2007/08 and 2008/09

Dental Extractions

Cases of advanced tooth decay may result in extraction. The latest data shows that 0.3% of children aged 0-19 years in Thurrock were admitted to hospital for a dental extraction during 2012/13, which is the same as the regional average and less than the national average of 0.5%. Figure 24 below shows the admissions broken down by age group, and it can be seen that, when compared to the national average, Thurrock had a lower percentage of children aged 0-4 and 5-9 years admitted but a higher percentage of children aged 10-14 and 15-19 years admitted.

Figure 24: Percentage of 0-19 year old children admitted to hospital for extractions in Thurrock, East of England and England, 2012/13.



Source: Hospital Episode Statistics

In summary, it is likely that about 30% of children and young people in Thurrock have experience of tooth decay that can lead to pain and costly NHS procedures. Children with decay are likely to have more than one tooth affected.

What are we doing in Thurrock?

It is currently recommended that regular dental attendance for all children is promoted by early years staff so that 1:1 advice can be given to parents and carers by dental care professionals. A dentist is likely to start recording a child's attendance at the surgery from the age of 2 years even though they will start seeing a child younger than this informally at the appointment of the parent or carer.

The data denotes that 7985 different children from Thurrock aged 3-5 years were seen in the two years up to February 2014. Between them they had 10,099 courses of treatment of which 7,916 were for a check-up and preventive advice only.
1 465 different children had a 'band 2' course of treatment, denoting that this was more than just a check-up and preventive advice, probably for treatment for tooth decay. It is good that the disease was being treated rather than neglected, but bad in that the treatment is needed at all. If there are high levels of disease in a population, then there should be high levels of dental service use. 1 754 courses of 'band 2' treatment were undertaken on the 3 – 5 age group over the two years which means that some of the 1 465 children had more than one course of

restorative care such that their problems weren't solved the first time. This may have been because of poor compliance, because of continuing disease progression or because the disease was extensive and it was practical to deal with it in stages within the child's capability. 382 children had urgent dental care in the two year period, and all together there were 407 such episodes, denoting that up to 25 children had more than one urgent episode.

However it should be noted that access information alone does not tell us much about oral health – higher access rates may be due to children with toothache seeking treatment or due to children with good oral health going for a check-up and preventive advice. Additionally, in affluent areas, low access rates may be due to patients visiting a private dentist (which is not included in the NHS information reported).

Children's centres are well placed to provide information and support for families to improve oral health and to establish links with local dental services. There are some examples in Thurrock where this is already taking place. One of their 28 outcomes in their Outcomes Framework specifically relates to ensuring that children are physically healthy.

Recommendations

The evidence base provided by Public Health England in their evidence-informed toolkit for local authorities (2014) indicates that local authorities should be looking to ensure that oral health is integrated within broader Public Health and Children's Services initiatives that aim to address the underlying causes of health inequalities and the causes of poor general and oral health.

Practical ways to address this might include:

- Promotion of regular dental attendance for all children
- Ensure consistent oral health messages (e.g. around the use of fluoride toothpaste, smoking cessation and diet) are delivered by health professionals and those working with children in children's centres and schools
- Care should be taken to ensure that oral health care is accessible to all, particularly those in vulnerable groups of the population such as looked after children, children with disabilities and traveller children
- Ensure Thurrock's participation in the National Dental Epidemiological Programme to establish a more accurate picture of the local need
- Review oral health training needs for the wider health, social care and education workforce to support oral health improvement in their daily role.

Immunisations and Screening

Immunisation is one of the most effective public health interventions in the world in terms of saving lives and protecting health. A given percentage of the population (the World Health Organisation recommends this to be 95%) needs to have been immunised against a specific disease in order to prevent its spread and outbreaks; this concept is known as herd immunity. The routine childhood immunisation programme for the UK includes immunisations as defined by the Department of Health in Immunisation against infectious diseases (the Green Book). The

new schedule for the programme is shown in Figure 25 below. Information on the programme for adults will be covered in the Adults chapter of the JSNA.

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. Whilst the majority of screening programmes are targeted at adults, there are antenatal and newborn screening programmes offered nationally.

Figure 25: Routine Childhood Immunisations from summer 2014

When to immunise	Diseases protected against	Vaccine given	Immunisation site[1]
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)[2]	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate)[2]	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)[2]	Upper arm/thigh
Two, three and four years old[3]	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV (Infanrix IPV or Repevax)[2]	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)[2]	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC[5]	MenC (Meningitec, Menjugate or NeisVac-C)[2,5]	Upper arm
65 years old	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
65 years of age and older	Influenza[4]	Flu injection (annual)	Upper arm
70 years old	Shingles (from September)	Shingles (Zostavax)	Upper arm (subcutaneous)

Immunisations for those at risk[6]

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
Six months up to two years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm/thigh
Two years up to under 65 years	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
Over two up to less than 18 years	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
18 up to under 65 years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm
From 28 weeks of pregnancy[7]	Pertussis	dTaP/IPV (Boostrix-IPV)[8]	Upper arm

Source: Public Health England

What do we know?

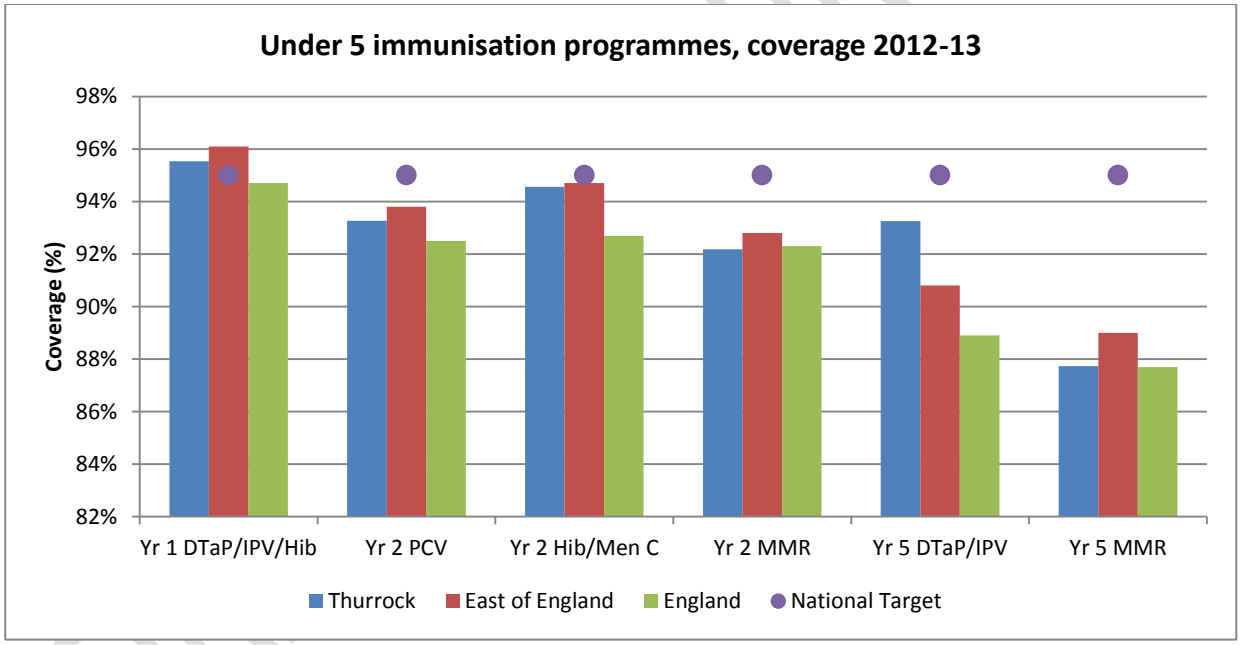
Under 5s vaccination programmes

The delivery of the national childhood routine immunisation programme is carefully monitored by Public Health England through COVER (cover of vaccination evaluated rapidly) data, which measures the percentage of the eligible population that has received each vaccination by 1,2 and 5 years within certain timeframes. The uptake target for all of the childhood vaccinations for children under 5 years was set by the World Health Organisation (WHO) and the Green Book as 95% in 2012-13. The vaccinations measured are:

- Diphtheria, tetanus, pertussis, polio and Haemophilius influenza type b at Year 1 (abbreviated as DTaP/IPV/Hib)
- Pneumococcal conjugate vaccine at Year 2 (abbreviated as PCV)
- Haemophilius influenza type b and Meningococcal group C disease at Year 2 (abbreviated as Hib/Men C)
- Measles, mumps and rubella at Year 2 (abbreviated as MMR)
- Diphtheria, tetanus, pertussis and polio at Year 5 (abbreviated as DTaP/IPV)
- Measles, mumps and rubella at Year 5 (abbreviated as MMR)

Figure 26 below shows the uptake of childhood vaccinations for Thurrock, East of England and England in 2012-13. It can be seen that Thurrock exceeds the national target for Year 1 DTaP/IPV/Hib and mirrors the regional and national coverage for several of the vaccinations; however uptake is considerably lower than the national targets for Year 2 PCV, Year 2 MMR and Year 5 MMR. It is worth noting however that in most cases the national average does not meet the national target, and whilst Thurrock may have fallen short of the 95% target, the national, and often regional, average was exceeded for almost all under 5s vaccinations.

Figure 26: Uptake of childhood vaccinations in Thurrock, East of England and England, 2012-13

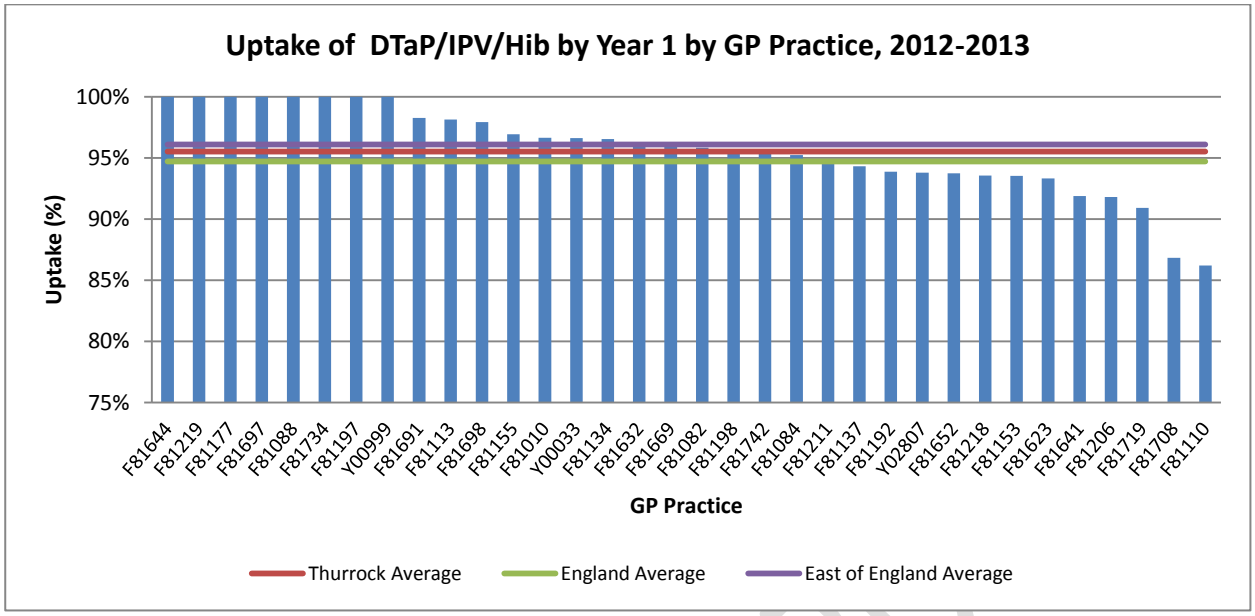


Source: Health and Social Care Information Centre

DTaP/IPV/Hib Year 1 Uptake

Figure 27 depicts the percentage of children aged one who have completed immunisations for diphtheria, tetanus, polio, pertussis, Haemophilus influenza type b (Hib) – (i.e. all three doses of DTaP/IPV/Hib) per GP practice in Thurrock from 2012-2013.

Figure 27: DTaP/IPV/Hib Year 1 Uptake by Thurrock GP practice for 2012-2013



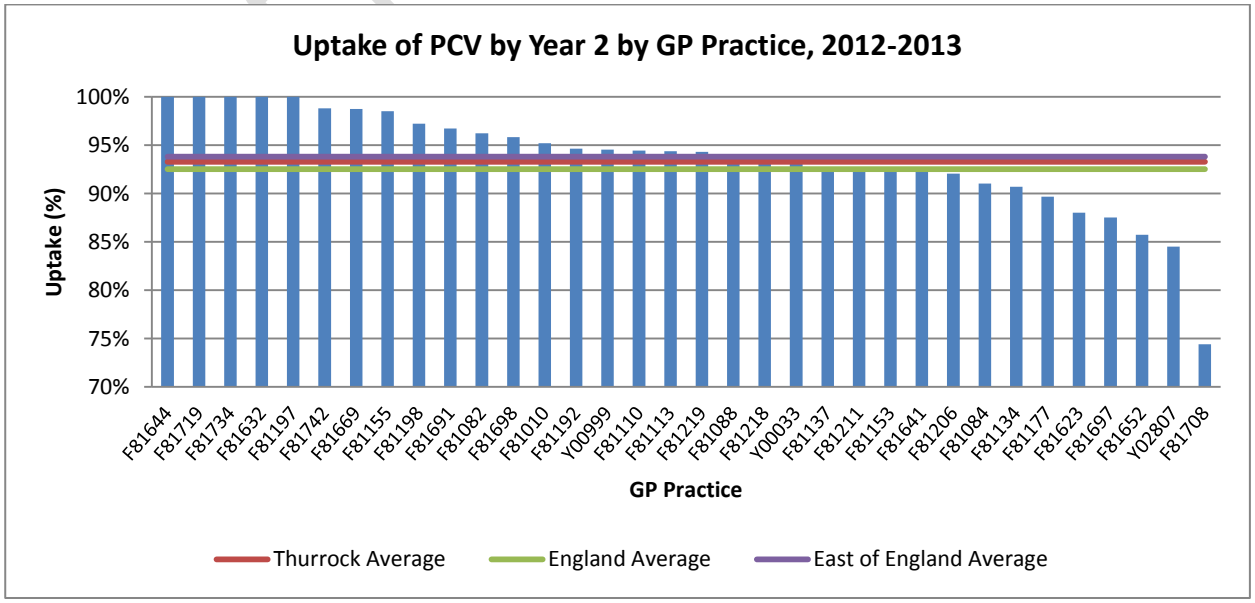
Source: Child Health SystmOne Körner data

Of the GP practices depicted, almost two thirds achieved the WHO target of 95%, and the same number exceeded the England average (94.7%). The Thurrock coverage for 2012-13 (95.53%) had increased from 2011-12 (94.5%).

Pneumococcal Conjugate Vaccine (PCV) Year 2 uptake

Figure 28 depicts the percentage of children aged two who have completed immunisations for pneumococcal infection (i.e. received pneumococcal booster) per GP practice in Thurrock from 2012-2013.

Figure 28: Year 2 Pneumococcal coverage by Thurrock GP practice for 2012-2013



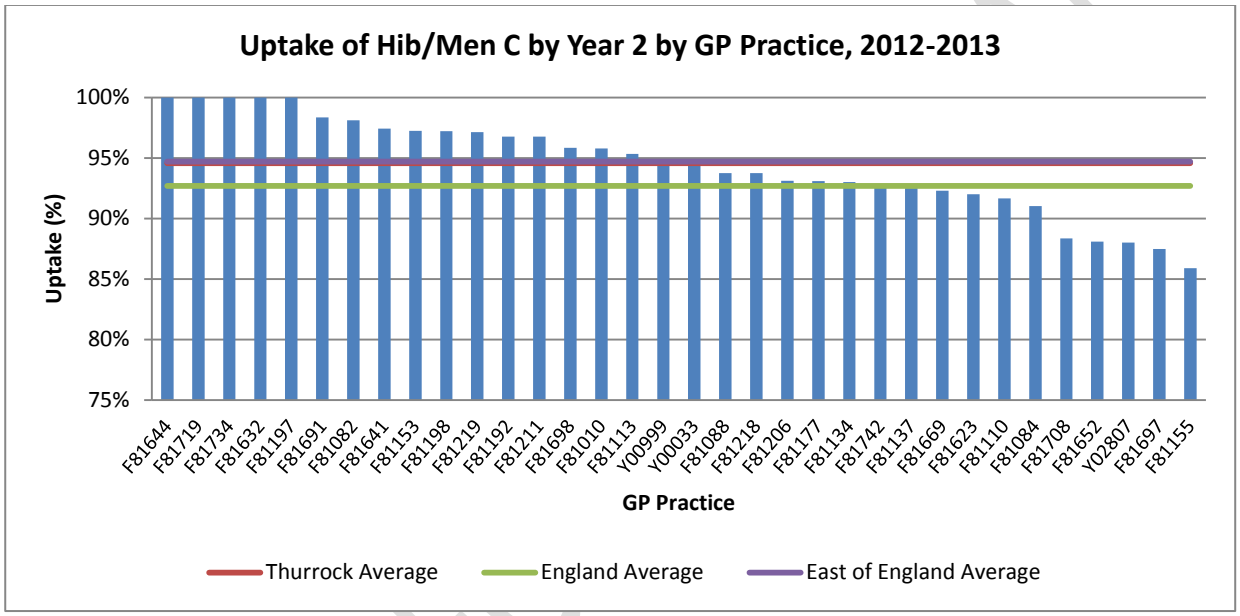
Source: Child Health SystmOne Körner data

Of the GP practices depicted, more than a third achieved the WHO target of 95%, and over half exceeded the England average (92.5%) and the East of England average (93.8%). The Thurrock coverage for 2012-2013 (93.3%) had increased from 2011-12 (89.6%).

Hib/Men C Year 2 uptake

Figure 29 depicts the percentage of children aged two who have completed immunisations for Haemophilus influenza type b (Hib) and Meningococcal C (Men C) – (i.e. received Hib/MenC booster) per GP practice in Thurrock from 2012- 2013.

Figure 29: Hib/MenC Year 2 uptake by Thurrock GP practice for 2012-2013



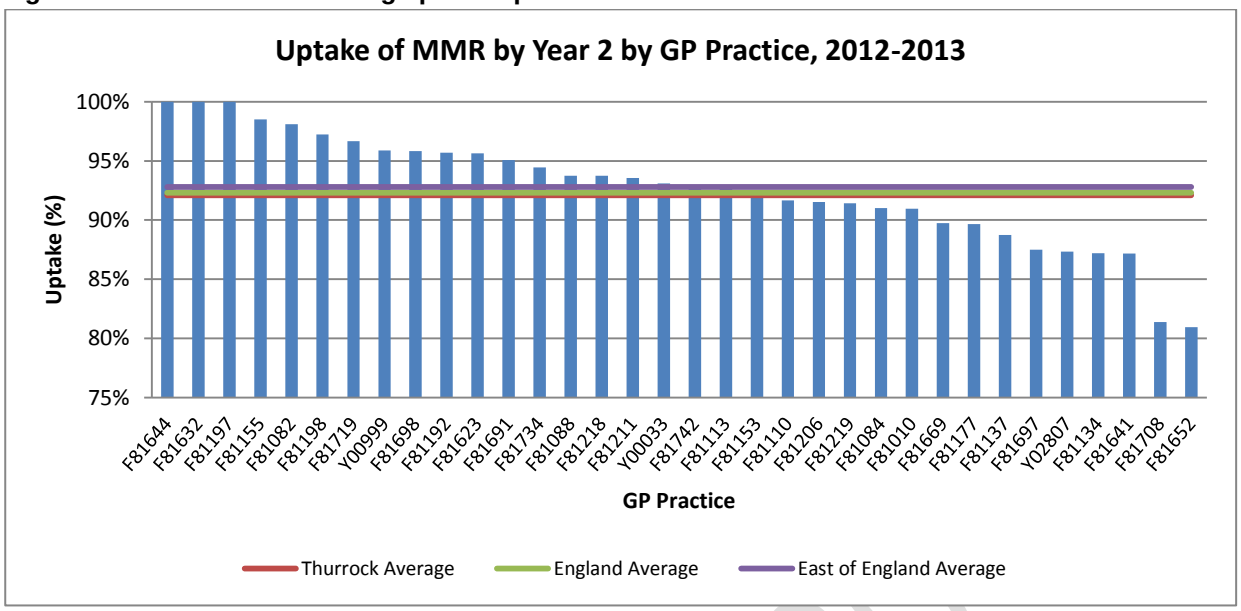
Source: Child Health SystmOne Körner data

Of the GP practices depicted, almost half met the WHO target of 95% and exceeded the East of England average (94.7%), while two thirds exceeded the England average (92.7%). The Thurrock coverage average for 2012- 2013 (94.6%) had increased from 2011-12 (93.6%).

MMR Year 2 uptake

Figure 30 depicts the percentage of children aged two who have completed immunisations for measles, mumps and rubella (MMR) – (i.e. one dose of MMR) per GP practice in Thurrock from 2012-2013.

Figure 30: MMR Year 2 coverage per GP practice for 2012-2013



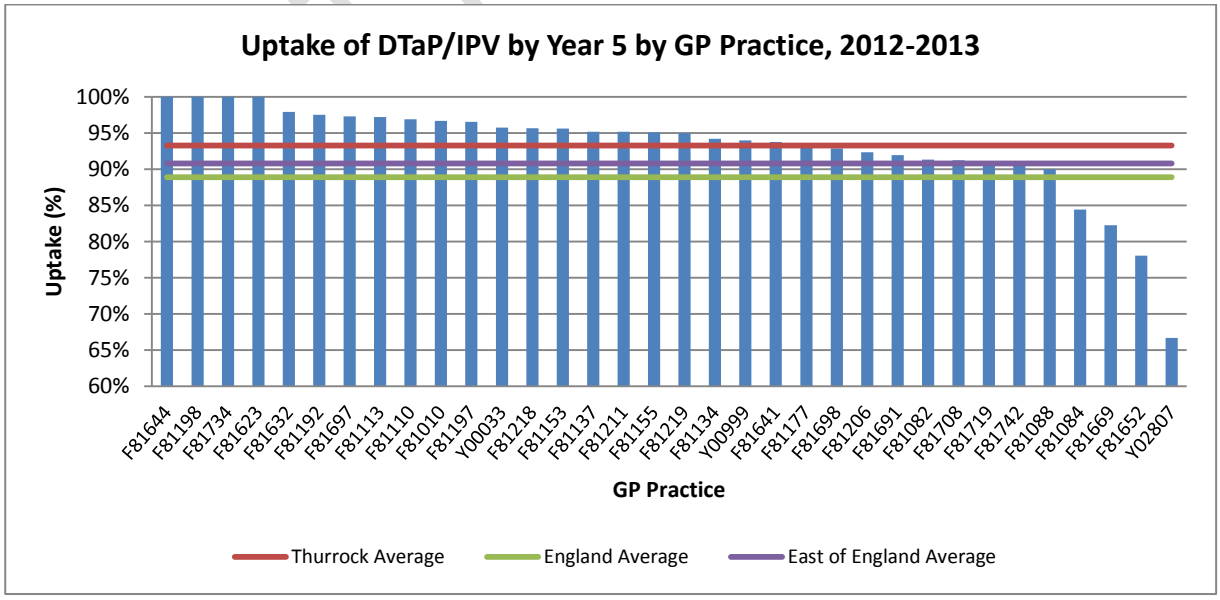
Source: Child Health SystmOne Körner data

Of the GP practices depicted, more than a third achieved the WHO target of 95%, and over half exceeded the England average (92.3%) and the East of England average (92.8%). The Thurrock coverage for 2012-2013 (92.18%) had increased from 2011-12 (89.26%).

Pre-school booster Year 5 uptake

Figure 31 depicts the percentage of children aged five who have completed immunisations (i.e. all four doses) for diphtheria, tetanus, polio, pertussis (DTaP/IPV) per GP practice in Thurrock from 2012-2013.

Figure 31: Pre-school booster Immunisation uptake children aged 5



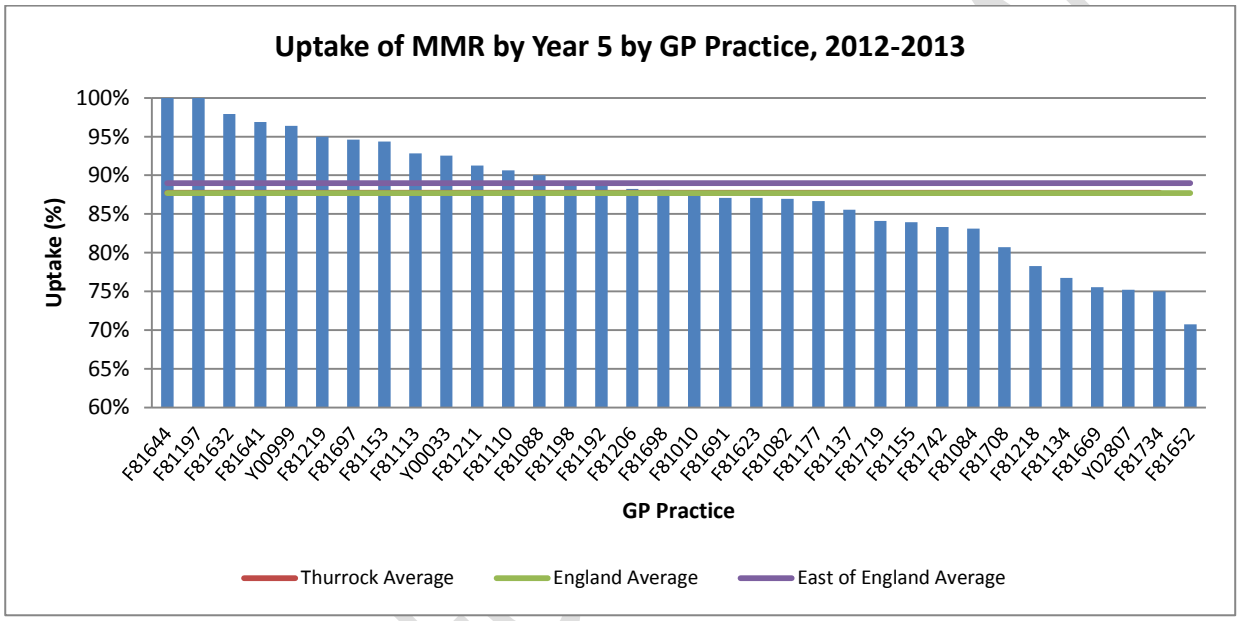
Source: Child Health SystmOne Körner data

Of the GP practices depicted, more than half achieved the WHO target of 95% and the majority exceeded the England (88.9%) and East of England averages (90.8%). The Thurrock coverage for 2012-13 (93.3%) had increased since 2011-12 (87.6%).

MMR Booster Year 5 uptake

Figure 32 depicts the percentage of children aged 5 who have completed immunisations for measles, mumps and rubella (MMR booster) (i.e. two doses of MMR) per GP practice in Thurrock from 2012-2013.

Figure 32: MMR Booster Year 5 uptake by Thurrock GP practice for 2012-2013



Source: Child Health SystmOne Körner data

Of the GP practices depicted, only six met the WHO target of 95%. Nevertheless, less than half fell below the England average (87.7%) and half below the East of England average (89%). The Thurrock coverage for 2012-2013 (87.7%) had increased since 2011-12 (85.7%).

Changes to the routine vaccination schedule in 2013/14

Public Health England announced a series of changes to the existing national vaccination schedule during 2013/14 which are described in detail in the 'Green Book' *Immunisation against Infectious Disease.* Table 1 below summarises these changes:

Table 1: Summary of changes to national immunisation programmes for children in 2013/14

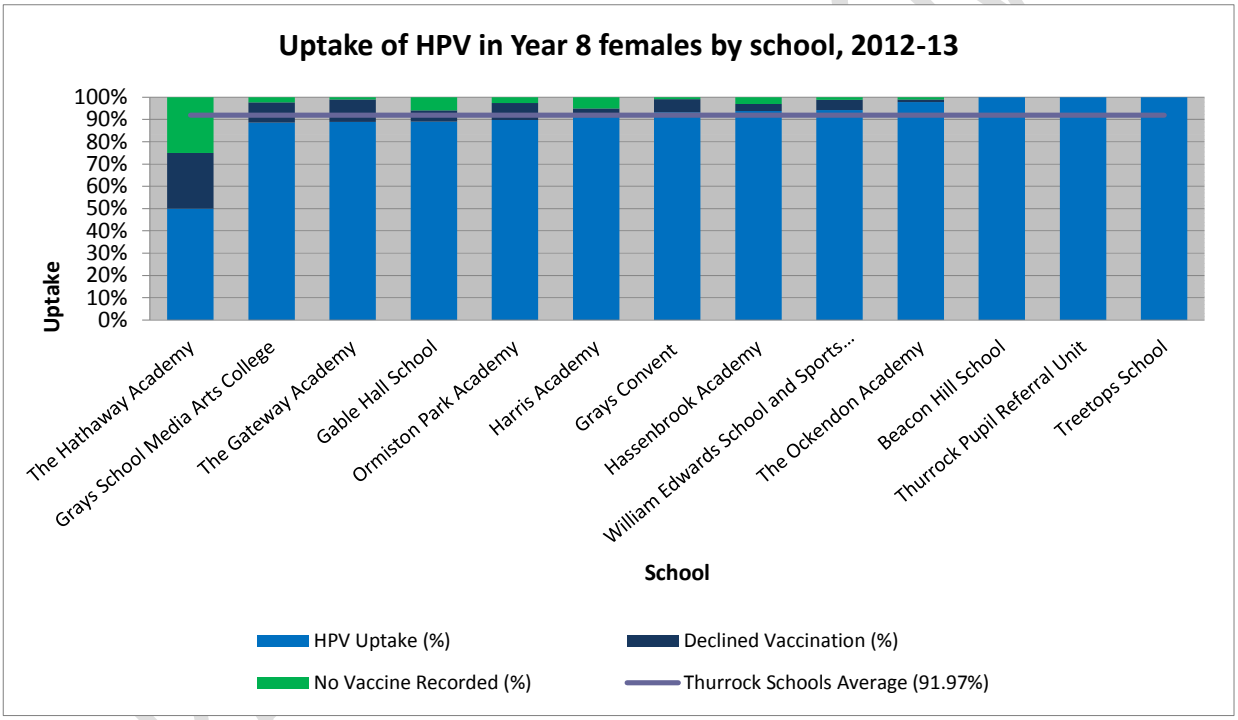
Date	Change	Rationale
June 2013	Meningococcal C (Men C) vaccine: removal of one primary dose	Second primary dose is being replaced by booster dose in adolescence.
July 2013	Rotavirus vaccine: introduced at 2 months and 3 months	Protects infants against rotavirus infection – common cause of gastrointestinal infection in infants.

September 2013	Men C vaccine: adolescent dose introduced via school-based programme	Protects children and young people against illnesses caused by meningococcal (group C) infection.
	Flu vaccine: introduced for 2 and 3 year olds	Protects children against flu, and reduces circulating flu in the community.
	Flu vaccine: pilot for 4 to 10 year olds in 7 areas in the country	Protects children against flu, and reduces circulating flu in the community.

School-age vaccinations

The Human Papillomavirus (HPV) vaccine is generally given to girls around 12-13 years in Year 8. Figure 33 below depicts coverage of the third dose of HPV by school.

Figure 33: HPV coverage of all three doses for 2012-2013 for 12 to 13 year old females by school.



Source: NHS England Local Area Team

The average coverage for girls attending Thurrock schools in 2012-13 was 91.97%, which is higher than the national target of **90%**. It must be noted that this cohort includes students who live outside the Thurrock area and commute in for schooling, plus omits girls who reside in Thurrock and are educated outside of the locality. Declined rates remain low, with a small proportion of patients refusing the HPV vaccination. In the case of the Hathaway Academy, there were a small number of girls recorded which has affected the proportions shown. Following up of students who are not presenting should be a priority so that they are offered the HPV vaccine in future clinics.

The **Bacillus Calmette-Guérin** (BCG) vaccine is routinely given to children in areas with a high rate of TB or who have a parent or grandparent from a country with a high rate of TB. Thurrock does not routinely give this vaccine.

What are we doing in Thurrock?

The Screening and Immunisations team within the Essex Area Team (part of NHS England) have held the commissioning responsibilities in Thurrock for these programmes since 1st April 2013. The Area Team has a programme of visits planned to the practices in Essex with the poorest performance against a range of indicators including immunisations and screening, in order to investigate the reasons for poor performance. A local plan was also implemented as part of the national catch up programme for the MMR vaccine in 2013.

Recommendations

All of the infections that are in the childhood immunisation programme can develop into serious illnesses and have the potential to cause disability or death. Immunising children means that they are protected from these serious diseases and their potentially devastating effects. Many of these diseases have no cure so vaccination can prevent any unnecessary illness. Immunisation is complex and various factors should be consistent across GP practices in the borough. To improve the offer of childhood immunisations and screening in Thurrock, emphasis should be placed on strengthening the following:

- Patient reminder and recall systems in GP practices
- High quality patient education and information resources in a variety of formats to ensure access to hard-to-reach groups
- Ensuring accurate data is held on the immunisation status of the population
- Maintenance of staff knowledge and awareness with regard to immunisations and screening to ensure accurate and consistent advice is provided to patients
- Partnership working to promote and deliver immunisation programmes
- Effective performance management of the commissioned service provided, to ensure it meets the requirements of the area

Focus for future improvements will look to improve uptake where Thurrock is below the regional and national averages or the WHO target – particularly for Year 2 MMR and Year 5 MMR.

When planning services, consideration should also be given to the projected increase in the local child population within the next few years to ensure there is sufficient provision to meet the increasing demand.

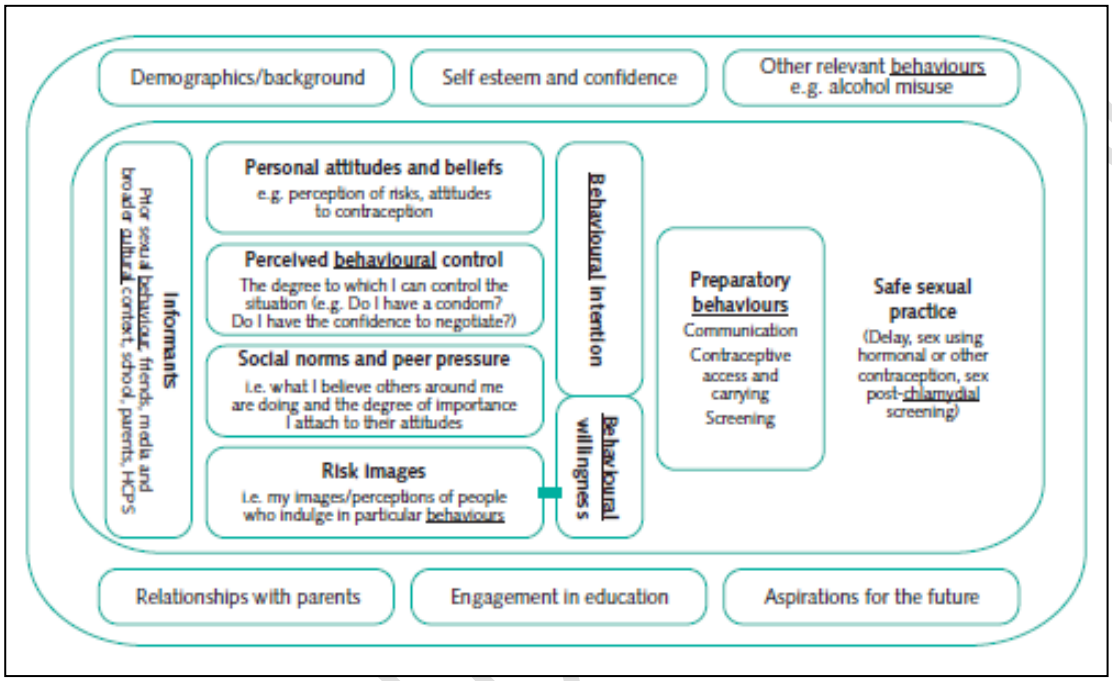
Sexual Health

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including human immunodeficiency virus (HIV) testing) and abortion. Provision of sexual health services is complex and there is a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector. The consequences of poor sexual health can be serious. Unintended pregnancies and STIs can have a long lasting impact on people's lives, and the latter are the main preventable cause of infertility particularly in women. Untreated STIs can facilitate HIV transmission and increase susceptibility to HIV. The number of visits to genito-

urinary medicine (GUM) clinics has been increasing steadily since the 1960s, and now stands at over a million a year (Department of Health, 2001).

Groups known to be at risk of worse sexual health outcomes include those living in deprived areas, gay and bisexual men and certain minority ethnic groups (HIV). However there are a number of other factors that can influence sexual health outcomes. Figure 34 below depicts some of the key influences on safer sex practice.

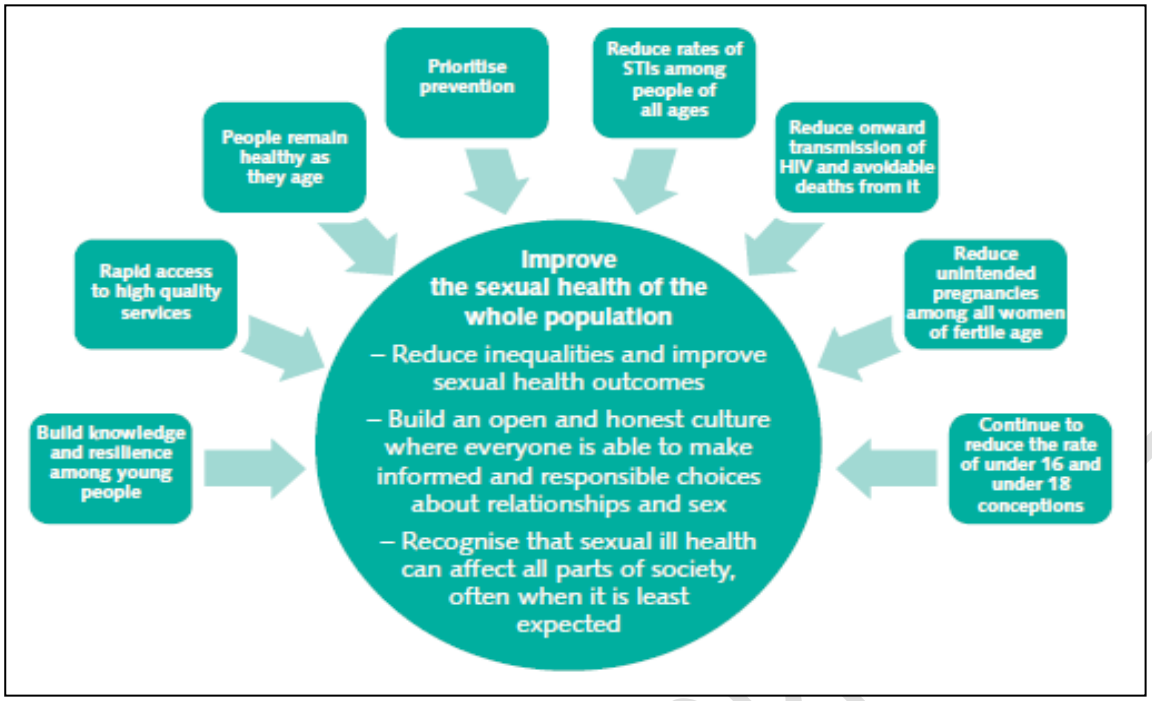
Figure 34: Influences on Safer Sex Practice



Source: Department of Health, 2013

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF): under-18 conceptions, Chlamydia diagnoses (15–24 year-olds), and people presenting with HIV at a late stage of infection. The Department of Health have set out some key objectives within their latest best practice guidance for sexual health services (Department of Health, 2013), which look to reduce inequalities and improve the sexual health of the population. These are shown in Figure 35 below.

Figure 35: Key Objectives: A Framework for Sexual Health Improvement in England, 2013



Source: Department of Health, 2013

For the minority of young people aged under 16 who are sexually active, it is important that they have confidence to attend free and open access sexual health services, thus giving early access to professional advice, support and treatment to prevent pregnancy and STIs. In addition, sexual health service providers should be aware of child protection and safeguarding issues and take very seriously the possibility of abuse and/or exploitation. [Information on children and young people at risk of exploitation, abuse and sexual violence can be found in other sections of the JSNA].

What do we know?

Rates of Chlamydia are substantially higher in young adults than in any other age group. Launched in 2003, the National Chlamydia Screening Programme (NCSP) aims to test all sexually active people under the age of 25 annually or with each change of sexual partner as a routine part of primary care and sexual health consultations. There were 1,529 per 100,000 diagnoses of Chlamydia to young people aged 15-24 years in Thurrock in 2013, which has decreased since 2012 (1,606 per 100,000). Thurrock has a significantly lower rate of Chlamydia diagnoses than the national (2,016 per 100,000) and regional (1,719 per 100,000) averages. [Chlamydia data before 2012 cannot be compared to 2012 or 2013 figures due to changes made to the surveillance system].

It should be noted however that data showing the rate of positive screens may not show the full picture of Chlamydia in Thurrock, this could be because a large number of young people who have the disease may not be being screened at all. The latest data on the proportion of young people aged 15-24 years being screened for Chlamydia indicate that there were a statistically lower number of young people being tested in Thurrock than nationally or regionally (18.0% of the eligible population of 15-24 year olds were screened in Thurrock in 2013, compared to 24.9% nationally and 22.4% regionally).

Data on the diagnosis rates of other sexually transmitted diseases and the rates of teenage conceptions can be found elsewhere in the JSNA.

What are we doing in Thurrock?

Thurrock Council commissions North East London Foundation Trust (NELFT) to offer a comprehensive community based service that includes advice and guidance on relationships and safer sex, contraception, pregnancy testing, testing and treatment for STIs and testing for HIV. Services provided are highly accessible to the population groups most in need of them and are non-discriminatory.
The current service provision includes:

- **Early diagnosis of HIV infection and Genito-Urinary Medicine service (GUM):** GUM services support sexual and reproductive healthcare needs. The service offers screening for STIs and HIV, distributing condoms and delivering health education on sexual health and general health issues. Some clinics offer psychosexual counselling and specialist HIV treatment and care which is commissioned by the CCG.
- **C-Card** The c-card scheme provides free condoms, sexual health advice and routine Chlamydia screening to under 25 year olds. Young people are required to visit a c-card assessor to get a c-card, which can then be presented at outlets across Thurrock to receive free condoms.
- **Sexual and reproductive healthcare**: These are community based contraceptive services delivering focused, holistic care for women and men. They provide training and advice to primary care practitioners, contribute to the reduction of sexually transmitted infections, and contribute to the reduction of unplanned pregnancies. The emergency contraception scheme offers free emergency contraception to under 19s from a range of service providers across Thurrock.
- **Training to professionals:** Our provider offers a suite of sexual health training to multi-agency professionals who work with young people:
    - *Sexual Health Awareness Foundation Training* (SHAFT) - a one day course which enables participants to consider approaches to sexual health and learn about sexual health of young people in Essex, the services that are available and the initiatives which are in place to support good sexual health for young people.
    - *Go Girls* – a one day course which provides practical strategies for emotional development and building self-esteem in girls and young women.
    - *Delay* training - to ensure that young people feel equipped to resist peer pressure and other influences, and encourage young people to make healthy and responsible decisions about relationships and sexual health.

It should be noted that the current sexual health service in Thurrock is undergoing a full service review with a consultation and benchmarking exercise, with the aim to have a comprehensive integrated sexual health service in place by April 2015. Part of this involves consultation with schools, colleges, primary and secondary care providers, other stakeholders and service users to fully engage with them around this process. The future model proposes to offer a full GUM level one service within the Contraceptive and Sexual Health (CASH) clinic in Grays Health Centre which proved successful in a recent pilot. A review of current workforce will be undertaken.

Recommendations

- The population in Thurrock has been subject to many changes over recent years, and is set to increase. In addition, the opening of the new South Essex College campus in Grays is likely to increase demand on our open access sexual health services. Services should ensure that they can meet the changing needs – which will be more fully understood following the full service review.
- Prevention strategies to improve STI screening coverage should be sustained and continue to focus on groups at highest risk. However, promotion campaigns should fully encapsulate as wide an audience as possible and involve all relevant stakeholders and providers. Many STIs do not have any symptoms, and so raising awareness of the risks of infection may be the only way to ensure people understand the risks and how these can be reduced.
- Continuation of sexual health training to professionals, and continued promotion of these courses amongst all professionals who work with young people will ensure young people are able to be supported to experience good sexual health.
- Future services will be commissioned to ensure our young people are safe from sexual exploitation.

Teenage Pregnancy

Teenage pregnancy is a complex issue affected by a wide range of factors, and is a cause of health inequalities. It is an issue that is monitored at a national level - as well as being included in the Public Health Outcomes Framework, teenage pregnancy has also been included as an indicator to be monitored within the "A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives" document, published by the Department for Work and Pensions and Department for Education in 2011.
The evidence shows that children born to teenage mothers are more likely to experience a range of negative outcomes in later life and are more likely, in time, to become teenage parents themselves – perpetuating the disadvantages that young parenthood brings from one generation to the next. The Department for Children, Schools and Families (2010) identified several socio-economic risk factors associated with teenage pregnancy:

- Living in a deprived area - measures such as housing, income, employment and benefits are often closely related to the teenage pregnancy rate
- Limited knowledge regarding contraception and sexual health advice – some young people still do not fully understand risk associated with sex, how the body works or how to use contraception. There also may be a reduced awareness with regard to the social and economic consequences of pregnancy.
- Family structure – children living in care or those from lone parent backgrounds may be more likely to become teenage parents. Additionally, those whose mothers were teenage parents are also more likely to become teenage parents.
- Educational attainment - on average, deprived wards with poor levels of educational attainment have under-18 conception rates twice as high as similarly deprived wards with better levels of educational attainment (Department for Education and Skills, 2006).

In addition, research found that those leaving school with no qualifications were more likely to use no contraception when having sex, compared to those with higher levels of educational attainment (Department for Education and Skills, 2006).

- Disengagement from school – the Department for Education and Skills found that among the most deprived 20% of local authorities, areas with higher rates of absenteeism have higher under-18 conception rates.
- Participation in early and risky behaviours – including early onset of sexual activity, and substance misuse
- Mental health problems – particularly self-esteem and confidence levels, which can impact on their choices
- Some ethnic groups are more likely to experience teenage pregnancy than others – however it is unclear whether this is an independent factor.

Where young women choose to go ahead with the pregnancy, they can be at greater risk of experiencing a range of poor outcomes, which include:

- Teenage mothers are less likely to finish their education, and more likely to bring up their child alone and in poverty
- The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life. Sons of teenage mothers are more likely to be imprisoned when compared to their peers born to older mothers.

It is likely that when identifying teenage parents locally, it will emerge that many will have more than one of the identified risk factors, as the link with deprivation for many of these factors is widely known. Services within local areas should work together and invest in actions to maintain the preventative services offered to potential teenage parents, particularly in the current climate of reducing public spend, in order to improve outcomes for teenage parents and their children.

What do we know?

Under 18 conceptions

The data shows that Thurrock had 93 conceptions in females aged under 18 years in 2012. This equates to a conception rate of 30.5 per 1,000, which is higher than the England average. Thurrock has a lower percentage of conceptions ending in abortion than the England average. When comparing the 2012 and 2011 data, Thurrock has 11 fewer under 18 conceptions in 2012 than 2011 and the rate is therefore lower. The percentage of conceptions ending in abortion has reduced in Thurrock in 2012. These key figures can be seen in Table 2 below.

Table 2: Headline under 18 conception figures for Thurrock, East of England and England

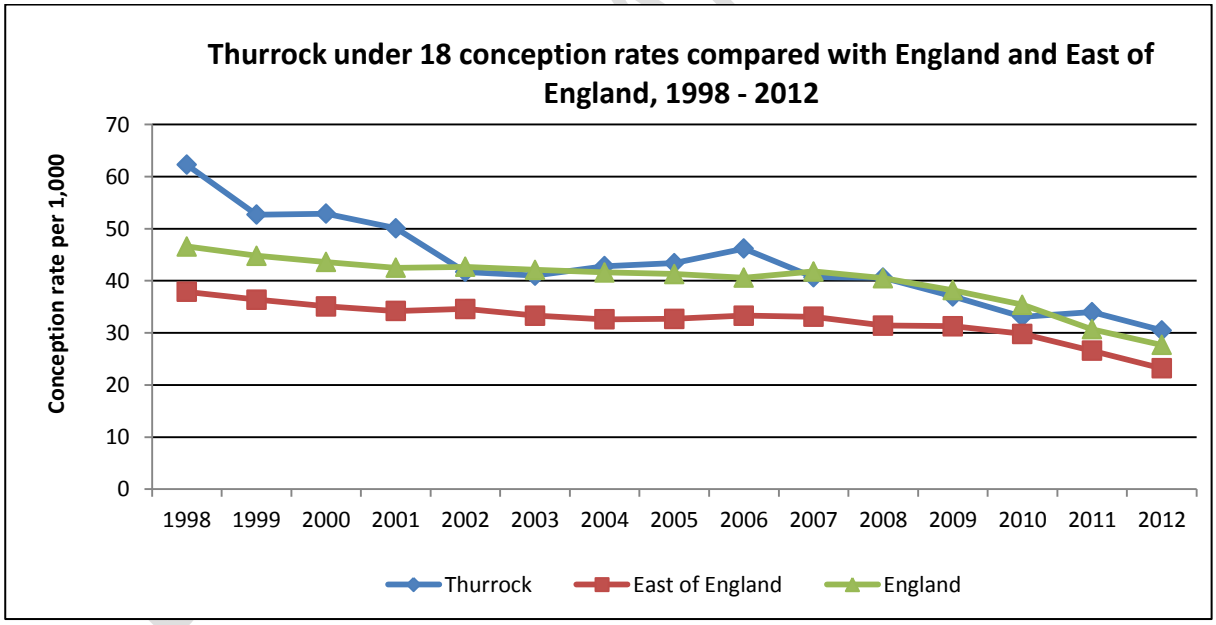
	2012 conceptions (number and rate	2011 conceptions (number and rate	2012 conceptions	2011 conceptions

	per 1,000)	per 1,000)	leading to abortions	leading to abortions
Thurrock	93 – equates to 30.5 per 1,000	104 – equates to 34.0 per 1,000	41.9%	54.8%
East of England	2,467 – equates to 23.2 per 1,000	2,860 – equates to 26.6 per 1,000	49.2%	50.2%
England	26,157 – equates to 27.7 per 1,000	29,166 – equates to 30.7 per 1,000	49.1%	49.3%

Source: ONS

It should be noted that Thurrock's reduction in under 18 conceptions is in line with the national trend – this can be seen graphically in Figure 36. Thurrock has dramatically decreased its rate of under 18 conceptions by 51% since the national teenage pregnancy strategy was launched in 1998. This impact is far greater in comparison to national and regional figures that have decreased by 40.6% and 38.8% respectively and is the 6th biggest reduction by a council outside of London. No single factor can be entirely credited with this achievement since the interdependencies are complex. Instead it is a series of marginal gains that are the likely cause, including but not limited to the availability of free and open access community contraceptive services for young people and having dedicated staff to support teenage parents and strategically plan the service provision.

Figure 36: Under 18 conception rates in Thurrock, East of England and England, 1998-2012

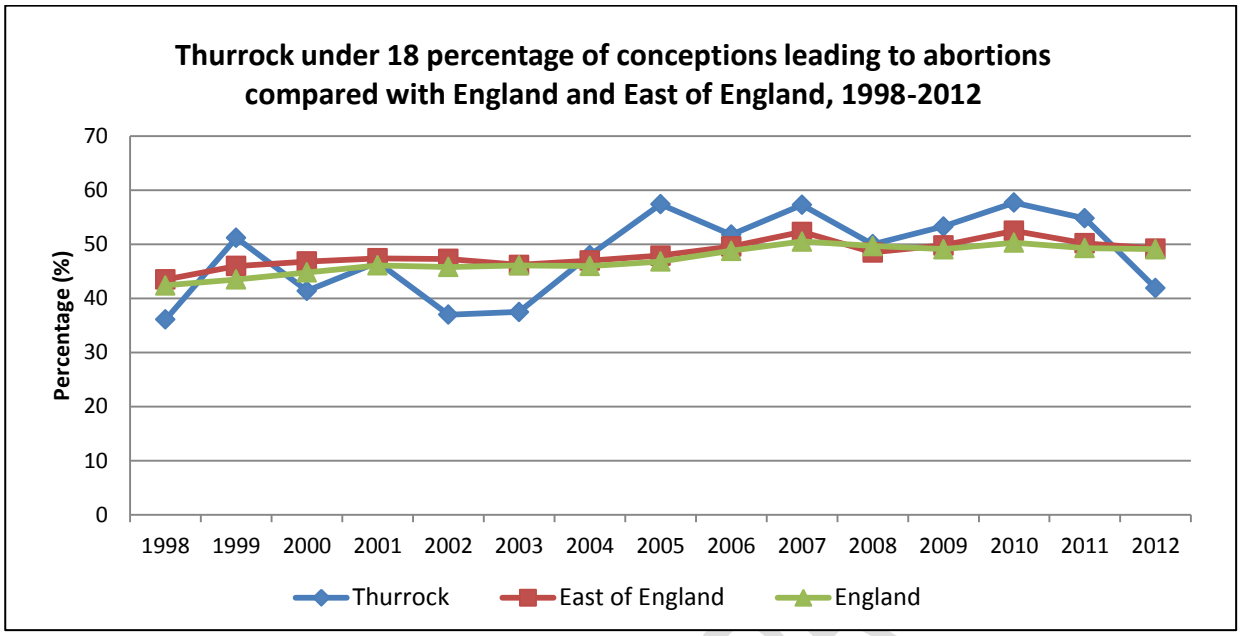


Source: ONS

In Figure 36 above it is possible to see how on a number of occasions Thurrock's conception rate has dropped below that of the national rate and in 2010 was very close to the regional rate.

Figure 37 below shows the percentage of under 18 conceptions that led to abortion from 1998-2012, and depict that whilst the national and regional percentages have been relatively stable, the Thurrock percentages have more variation between years. The smaller numbers involved should be considered when reviewing this data.

Figure 37: Percentage of under 18 conceptions leading to abortions in Thurrock, East of England and England, 1998-2012



Source: ONS

It should be noted that the most recent abortion data from the Department of Health showed that Thurrock had a higher rate per 1,000 of abortions in 2013 to females aged under 18 than the national and regional averages (18 per 1,000 compared to 11.7 per 1,000 and 10 per 1,000 respectively).

Ward-level data

Ward-level data on numbers and rates of conceptions to females aged under 18 is produced by the ONS as an aggregation of three years' data. The most recent data (2010-12) shows that the wards with the highest rates of conceptions are Tilbury St Chads, Stanford Le Hope West and Tilbury Riverside and Thurrock Park. In 2009-11, the top three wards were Tilbury Riverside and Thurrock Park, Tilbury St Chads and Belhus. These wards contain some of the most deprived LSOAs in England, showing an association between increased teenage conceptions and poverty at a local level.

Under 16 conceptions

The data shows that Thurrock had 19 conceptions in females aged under 16 years in 2012. This equates to a conception rate of 6.3 per 1,000, which is higher than the England average. Thurrock also has a higher percentage of conceptions ending in abortion than the England average. When comparing the 2012 and 2011 data, Thurrock has four fewer under 16 conceptions in 2012 than 2011 and the rate is therefore lower. The percentage of conceptions ending in abortion has been suppressed for 2011 and is unavailable for comparison. These key figures can be seen in Table 3 below.

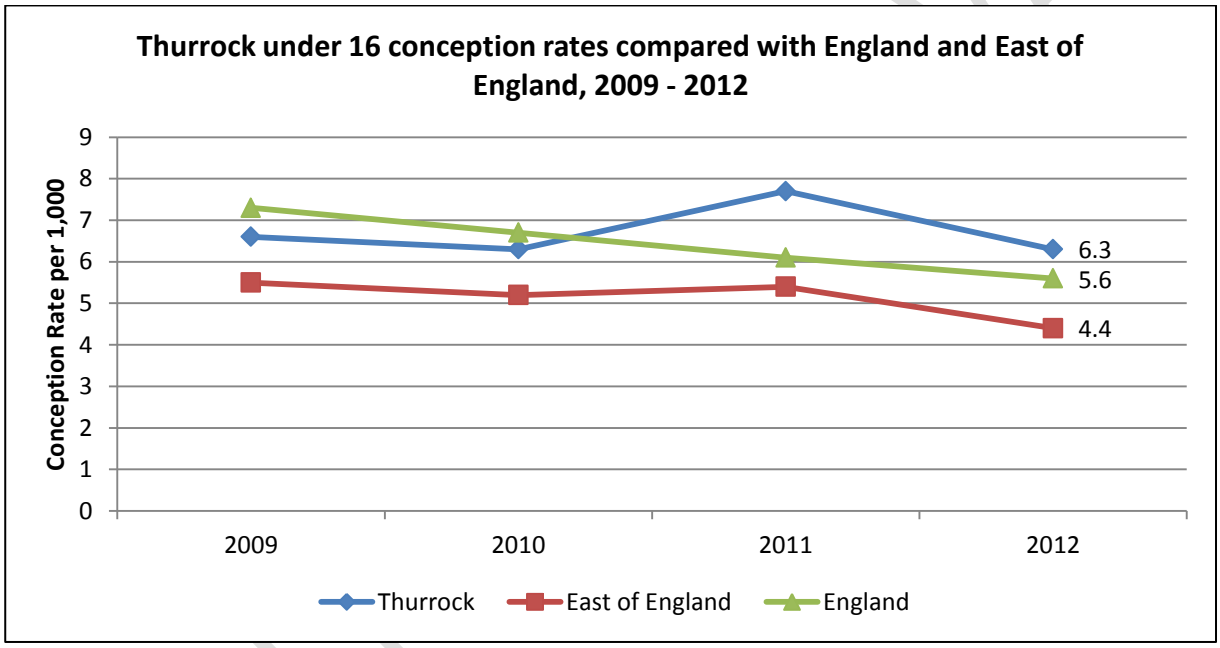
It should be noted that Thurrock's reduction in under 16 conceptions is in line with the national trend – this can be seen graphically in Figure 38.

Table 3: Headline under 16 conception figures for Thurrock, East of England and England

	2012 conceptions (number and rate per 1,000)	2011 conceptions (number and rate per 1,000)	2012 conceptions leading to abortions	2011 conceptions leading to abortions
Thurrock	19 – equates to 6.3 per 1,000	23 – equates to 7.7 per 1,000	63.2%	Suppressed
East of England	459 – equates to 4.4 per 1,000	569 – equates to 5.4 per 1,000	58.0%	58.3%
England	5,131 – equates to 5.6 per 1,000	5,661 – equates to 6.1 per 1,000	60.1%	60.5%

Source: ONS

Figure 38: Under 16 conception rates in Thurrock, East of England and England, 2009-2012



Source: ONS

What are we doing in Thurrock?

North East London Foundation Trust (NELFT) provide community contraceptive services in Thurrock via sexual health clinics and services available through GP surgeries and pharmacies, including a specialist genitourinary medicine (GUM) clinic in Orsett. NELFT also provide our school nursing service that promote and provide aspects of the sexual health service and support Personal, Social and Health Education (PSHE) and Sex and Relationships Education (SRE) in schools where possible. Children's centres also have capacity to deliver some sexual health services such as C-card in addition to midwifery services, and offer support to parents to ensure they have a greater understanding in how to manage their pregnancy (which is one of their 28 outcomes under their Outcomes Framework).

The Family Nurse Partnership is now established in Thurrock with 44 places for teenage mothers and partners on an intense programme of support over 3 years (further information can be found in the Low Birth Weight section).

For teenage parents, there are currently two teenage parent-supported housing schemes able to support 16 people. There are also some flats specifically for young parents to move into once they have completed a period of support in either of the two schemes. Once they have demonstrated that they can sustain independent living, they are supported to move into the local community. In addition, there is a floating support service that supports 7 young women at a time in the local community, either to support them to remain living with parents or to support women moving on from the housing scheme.

Recommendations

- Future commissioning of any interrelated service across the council should include consideration for the impact on teenage conceptions and have this as a target within the service specification e.g. school nursing, sexual health services, residential foster placements
- Staff working in related fields should be able to demonstrate their understanding of and ability to effectively engage vulnerable young people who are at risk of becoming a teenage parent and provide or signpost to services for appropriate support. Such staff might include GPs, teachers, social workers, school nurses, Local Area Coordinators, Troubled Families team staff and associated outreach workers that may come into contact with children and young people from time to time. Spotting the risk factors and effectively responding to these early is key to the success of the prevention agenda where shared targets need to be the norm; improved school attendance and attainment of our young people is everyone's business. Legislation to raise the participation age for education, training or work-based learning makes getting this right ever more important.
- Work should continue to support and engage all secondary schools in offering the full range of services available from the school nursing service including flexible confidential drop-in services, specialist and up-to-date advice on sexual health for PSHE and SRE lesson plans including cross-cutting subjects such as the sciences, and supporting teaching staff with the delivery of such lessons. Our staff and services need to remain responsive to the changing needs of our communities such as population growth in some parts of the borough due to regeneration and the likely increase in demand on local services that the new college campus will have in Grays. For example, the GUM clinic is preparing to offer a permanent satellite service in Grays to respond to such impending demand.
- Appropriate early education delivered at all primary schools
- Sexual health service training should continue to be offered to frontline staff across social care, education and health such as C-card, Go Girls and Speakeasy.
- Young males should not be overlooked when planning services.
- You're Welcome is a health-based audit to measure how young-person friendly a service is. NELFT have been targeted with achieving the standard and work is under way to ensure all of our Children's Centres achieve the standard too.

Smoking

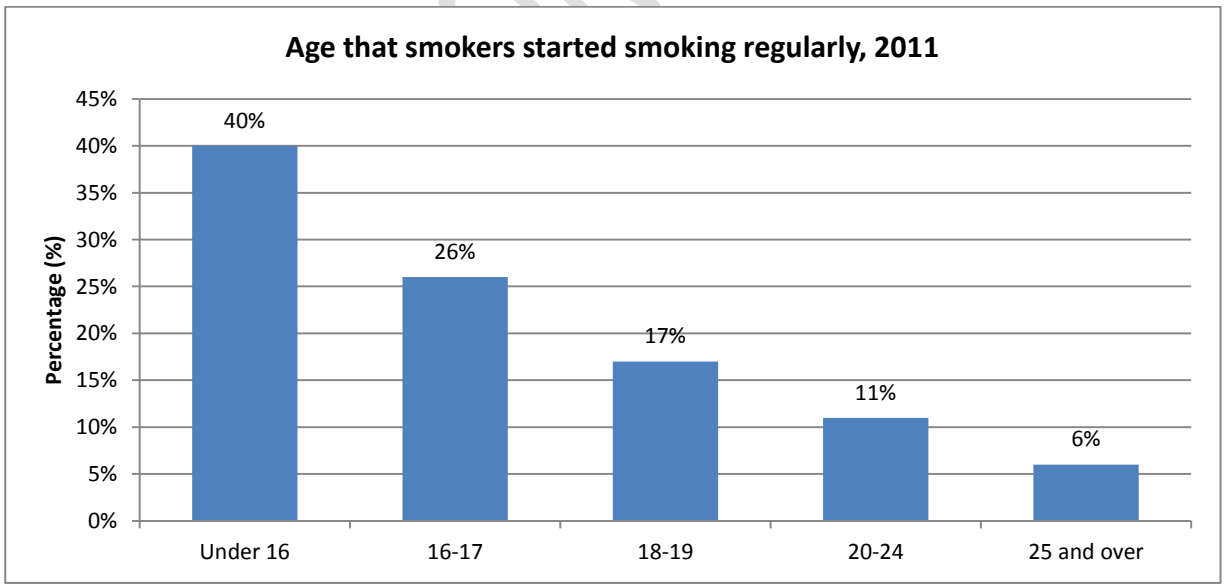
Smoking in Children and Young People

Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and increased phlegm, wheeziness and shortness of breath than those who do not smoke. They are also more likely to continue smoking during their adult lives and have a lower chance of quitting. Smokers who start smoking at an early age have a higher risk of developing lung cancer or heart disease. In addition, there are enormous economic costs to society associated with smoking. Research by Action on Smoking and Health (ASH) estimated that smoking costs the UK economy £13.1 billion per year, including £2 billion in direct treatment costs to the NHS. (Action on Smoking and Health, 2014)

Children and young people are also more susceptible to the effects of passive smoking, particularly if there is a parent at home who smokes. They are at higher risk of respiratory infections, asthma, bacterial meningitis and cot death. Second-hand smoke has been linked to around 165,000 new cases of disease among children in the UK each year (Cancer Research UK). Passive smoking is particularly dangerous in cars, as just one cigarette smoked in a car can create pollution levels 35 times greater than those deemed safe by the World Health Organisation. More than 430,000 children are exposed to second hand smoke in the family car each week. (British Lung Foundation, 2013)

Cancer Research UK (2011) found that over 200,000 children aged between 11 and 15 start smoking in the UK every year. Research by the Office of National Statistics (2011) found that almost two thirds of adult smokers started smoking before the age of 18 – the figure below depicts smoking uptake by age.

Figure 39: Age at which smokers started smoking regularly, 2011



Source: General Lifestyle Survey, 2011

In their factsheet, Action on Smoking and Health (2014) wrote that initiation of smoking is associated with risk factors which include:

- Parental or sibling smoking – children who live with parents or siblings who smoke are up to 3 times more likely to become smokers themselves than children of non-smoking households.
- The ease of obtaining cigarettes
- Smoking by friends and peer group members
- Socioeconomic status
- Exposure to tobacco marketing
- Depictions of smoking in the media

Surveys undertaken by the Health and Social Care Information Centre have found that smoking in children and young people is associated with other substance abuse - the 2013 survey found that of the 6% of pupils who reported smoking in the week before the survey, most (4%) had also drunk alcohol or taken drugs recently, or had done both. It is also associated with truancy or exclusion from school - the 2012 survey found that young people who played truant from school or who had been excluded from school in the previous 12 months were almost twice as likely to smoke regularly compared to those who had never been truant or excluded.

Effective interventions

Research suggests that knowledge about smoking is a necessary component of anti-smoking campaigns but by itself does not affect smoking rates. It may, however, result in a postponement of initiation. Young people may be deterred from smoking due to high prices if they do not possess a large disposable income; however this alone is not sufficient as a deterrent. In fact the existence of an illegal trade in tobacco products reduces the effectiveness of tobacco control measures as it is often available at cheaper prices and is available from a range of sources (Tackling Illicit Tobacco for Better Health, 2014). The National Institute for Health and Clinical Excellence (NICE) has issued guidance on school-based interventions to prevent the uptake of smoking amongst children, and has recommended that a combination of community-based activity, mass media campaigns and systematic tobacco education in schools is an effective approach in reducing smoking uptake in children and young people.

There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level. There are other national tobacco control initiatives in place; these include:

- Standardised cigarette packaging – evidence shows that removing all branding and design from the packs makes cigarettes less attractive, particularly to children and young people.
- Outlawing smoking in cars – Parliament have spoken in favour of a ban to outlaw smoking in cars carrying children, which is likely to be introduced before the next election in 2015.
- Removing tobacco products from display in large stores - research by the Centre for Tobacco Control Research (2008) shows that Point of Sale (PoS) display has a direct impact in young people's smoking, stating that almost half (46%) of UK teenagers were aware of tobacco display at PoS and those expressing an intention to smoke were more likely to recall brands that they had seen at the point of sale.

- Legislation around the sale of tobacco - updated regulations came into force on 1st October 2007 which makes it illegal to sell tobacco to anyone under the age of 18 and authorities may confiscate tobacco from anybody under the age of 16.

The rise of e-cigarettes has meant that it is now unknown how many children and young people are using them as they can legally be sold to children. The lack of restrictions on advertising strategies have led to a range of flavours and colours available which are likely to appeal to young people. Although they are perceived as a better option than smoking and a helpful aid for quitting, concerns have been raised as it is not yet known what harm the tobacco-free devices could inflict on young people's health. However it is likely that at least one e-cigarette product may be licensed as a prescription medicine for nicotine replacement therapy (NRT) in the near future.

What do we know?

Data collected by the Health and Social Care Information Centre (2013) indicates that 3% of pupils in England reported that they smoked at least one cigarette per week. When results were broken down by age, it can be seen that the prevalence of smoking increased with age: less than 0.5% of 11 and 12 year olds said that they smoked at least one cigarette per week, compared with 4% of 14 year olds and 8% of 15 year olds.
Research undertaken by Essex County Council's Research and Analysis Unit (2013) found that pupils receiving Free School Meals, with poor emotional wellbeing or have received a police warning are significantly more likely to smoke, demonstrating clear socioeconomic differences from an early age.

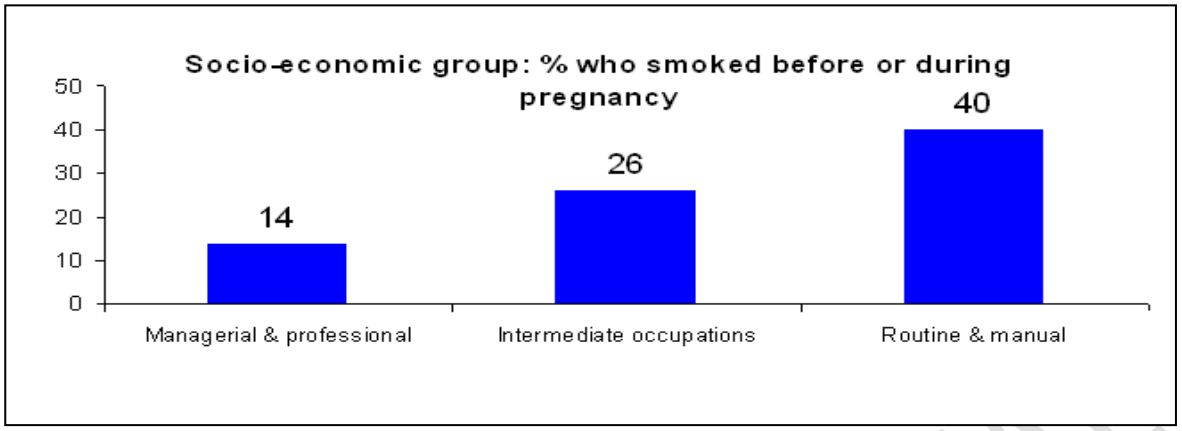
Accurate local data is limited. The most recent data on smoking habits in children and young people originates from the TellUs4 survey (2009), which indicates that 4% of Thurrock children in years 6, 8 and 10 usually smoke at least one cigarette per week, which was the same as the national average but higher than the regional average (3.4%).

There has been a general decline in recent years in the number of smokers engaging with a quit attempt with a recognised stop smoking service. At the same time there has been a sharp rise in the sales of electronic cigarettes due to the increasing range of products available. Even though not all the evidence suggests these smokers are quitting with the help of an e-cigarette and many are simply switching products or dual-using, this has a large impact on quit rates both locally and nationally.

Smoking in pregnancy

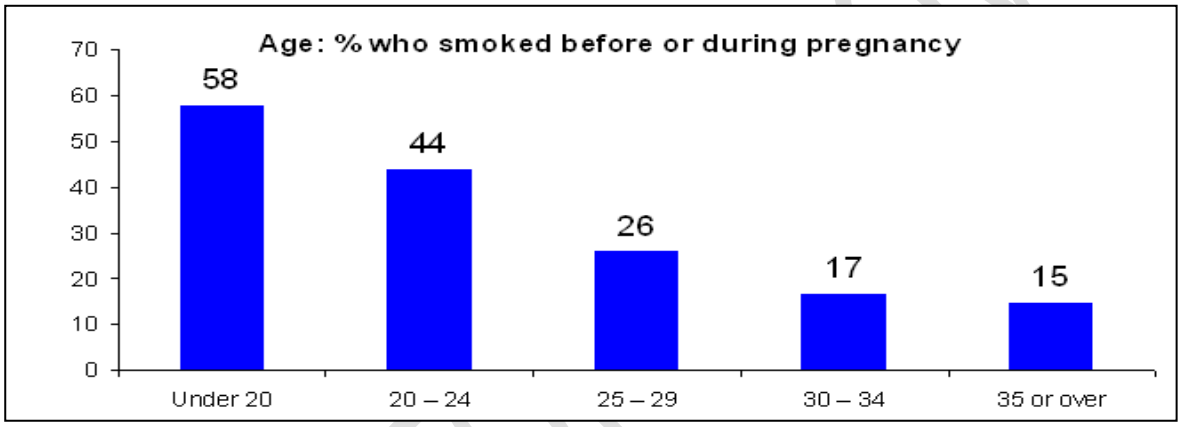
Smoking during pregnancy can cause serious pregnancy-related health problems, complications during labour and an increased risk of miscarriage, premature birth, still birth low birth-weight and sudden unexpected death in infancy. It has been found to increase the risk of infant mortality by 40% (National Institute for Health and Clinical Excellence, 2010). Results from the Infant Feeding Survey (2005) indicate that more than 1 in 6 mothers smoke during pregnancy. Evidence has shown that smoking prevalence during pregnancy is much higher among lower socioeconomic groups (Gray, et al., 2009) and teenage mothers – this can be seen in the two figures below (40 and 41):

Figure 40: Women who smoked before or during pregnancy, by socio-economic group



Source: Infant Feeding Survey, 2005

Figure 41: Women who smoked before or during pregnancy, by age group



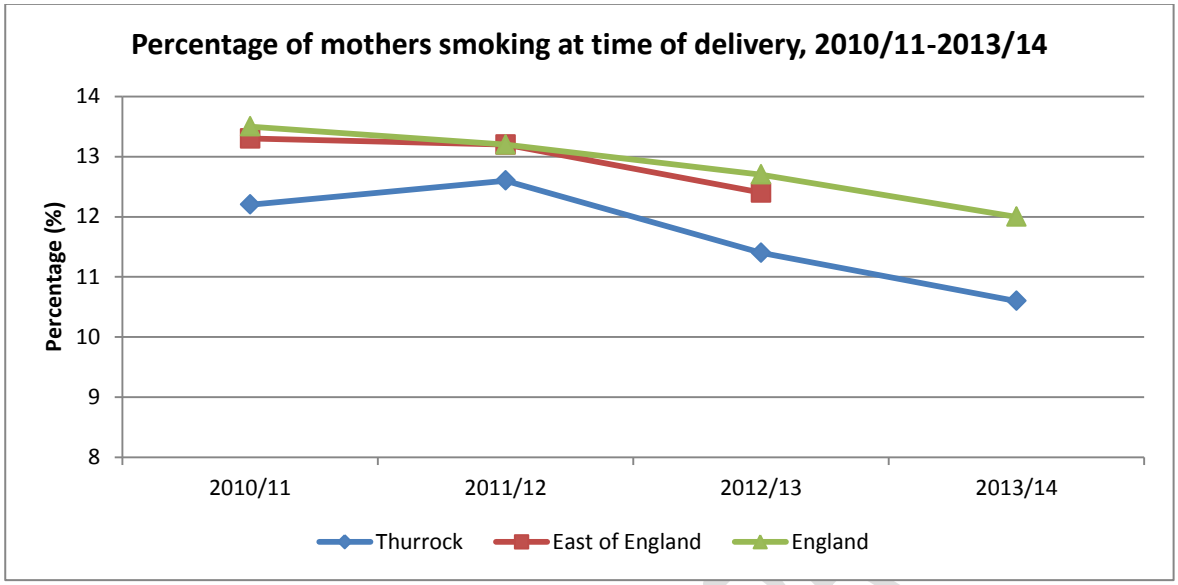
Source: Infant Feeding Survey, 2005

Reducing smoking during pregnancy is one of the three national ambitions in the Tobacco Control Plan – the aim is to reduce the proportion of women smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

What do we know?

The latest information shows that 10.6% of women in Thurrock were smoking at the time of delivery in 2013/14, which is lower than the previous two years. Comparing the data to East of England and England, Thurrock's figures do appear to be consistently lower; however confidence intervals mean that the authority is statistically similar to the national average.

Figure 42: Percentage of mothers smoking at time of delivery in Thurrock, East of England and England, 2010/11-2013/14



Source: Public Health England / Health and Social Care Information Centre

What are we doing in Thurrock?

The Government's tobacco control plan target is to reduce the number of 15 year olds smoking in England to 12% by 2015. In 2013 Thurrock Council signed up to the Local Government Declaration on Tobacco Control and is listed on the Smokefree Action website. A key tenet of this includes developing plans with partners and local communities to address the causes and impacts of tobacco usage.

Thurrock is also in the process of writing a Tobacco Control Strategy and has an aspiration to reduce the number of under 20 year olds that smoke by half before 2020. There is currently a shortage of local statistical data quantifying smoking prevalence in the under-17 age group and more evidence based research is needed within this group to support future strategies.

Thurrock commission local stop smoking services (LSSS) which look to raise awareness of the harms of tobacco, help to prevent young people from starting smoking, and make sure that people who want to quit have as much support as they need. The 5-19 service also works with young people who smoke and provide advice to support young people to stop smoking. Pregnant women are all routinely screened for smoking status and given specialist support and advice to help them stop smoking. Children's Centres actively work with parents to reduce the number of parents who smoke (which is one of their 28 outcomes under their Outcomes Framework).

Recommendations

- More school based interventions and prevention tools with further support and education within Thurrock schools themselves (in accordance with NICE guidelines). NICE recommend information on smoking to be included in the curriculum – classroom discussions could be relevant when teaching Biology, Chemistry, Citizenship and Maths.
- Targeting our LSSS to deliver preventative interventions in schools such as ASSIST or KickAsh as an integral part of service delivery.
- Targeting smokers from disadvantaged groups by developing decision making skills and include strategies for enhancing self-esteem such as the UK Resilience Programme in schools.
- Ensure adequate provision for compliance and enforcement to support new and existing government legislation on:
    - The sale of cigarettes to under 18's (both in shops and via other people)
    - The ban on cigarette displays in retail outlets
    - Passive smoking such as in cars when children are present
    - The existing ban on smoking in public places
    - The use of e-cigarettes particularly in children and young people.
- Closely monitor research and evidence on the use of e-cigarettes amongst children and young people and actively ensure that young people recognise the smoking-related behaviours and risks associated with these products.
- More frequent collection and analysis of smoking data amongst children and young adults in schools.
- Particular focus should be given in secondary schools to ensure pupils know how to access advice and support about smoking and to ensure this service is accessible and approachable.

Smoking remains one of the biggest public health risks and reducing levels of smoking in Thurrock will remain a top priority in improving the health of the local population.

Substance Misuse

Substance misuse is often a symptom rather than a cause of vulnerability among young people. Many have broader difficulties in their lives that are compounded by drugs and alcohol and that need addressing at the same time. Young people's substance misuse services engage vulnerable young people and intervene early to stop escalating risk and harm from substance misuse. Evidence shows that young people's lives can improve when they have access to substance misuse services alongside support to address their wider health and wellbeing needs. This means that the commissioning and delivery of specialist drug and alcohol interventions should take place within wider service structures that meet a range of needs. A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and almost £2 within two years, meaning that this can be a cost-effective way of reducing future demand on health and social care services. A life course approach to drug prevention that covers early years,

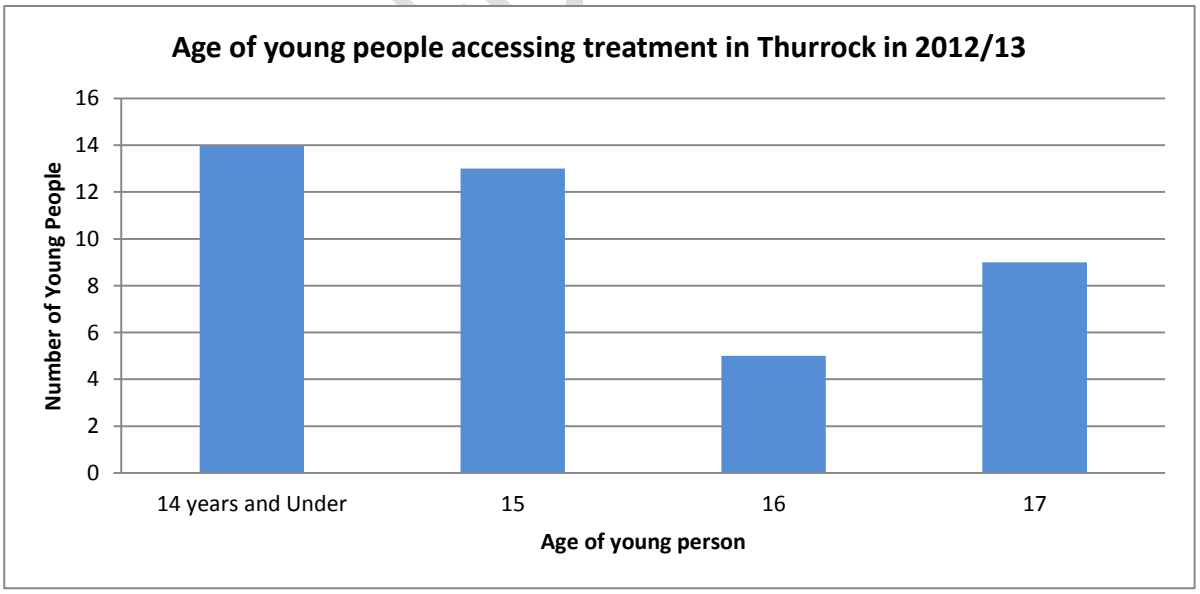
family support, universal drug education, and targeted and specialist support for young people is one of the key aims of the Government's 2010 Drug Strategy.
Parental drug use can compromise children's health and development, as well as impact on parenting capacity. Research cited in the Government's Hidden Harm report (2004) estimated that there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems – representing 2-3% of children under 16. Children of parental drinkers are also at risk of Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD) – which is a series of preventable birth defects caused entirely by a woman drinking alcohol at any time during her pregnancy, often even before she knows that she is pregnant. Estimates by Alcohol Concern suggest that there were 7,317 children born in England in 2012 with FASD. The lifetime cost to the economy for a child born with FAS was estimated at £1,500,000, and the adverse consequences experienced by children can include: weakened immune systems, a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment.

What do we know?

Entering Treatment

In Thurrock, there were 39 new entrants to treatment services in 2012/13, which was lower than the number of new entrants for 2011/12 (59). Age of initiation is often the strongest predictor of the length and severity of substance misuse problems – the younger the age they start to use, the greater the likelihood of them becoming adult problematic drug users. (It is noted that this does not necessarily indicate the age of initiation).

Figure 43: The age of young people entering treatment services in Thurrock in 2012/13

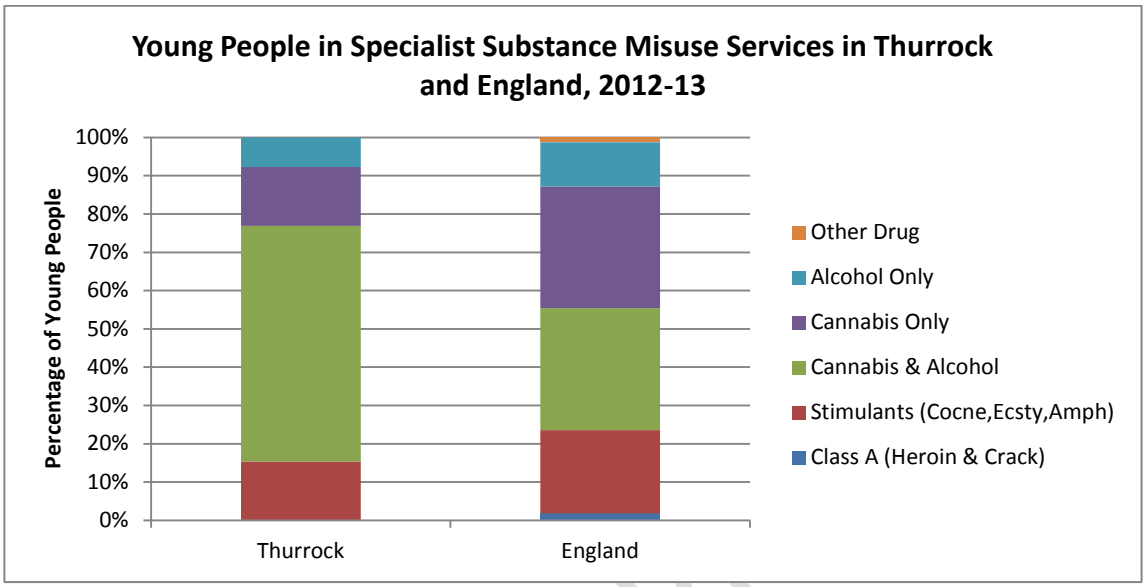


Source: NDTMS

The main type of substance misuse service offered in Thurrock in 2012/13 was for Cannabis and Alcohol combined – 24 out of the 39 entrants were in this category, equating to 61.5%. When compared to the national average, Thurrock had more young people presenting for

Cannabis and Alcohol combined, but reduced proportions presenting for Cannabis and Alcohol separately, and none for Class A drugs.

Figure 44: Young people entering treatment services in 2012/13 in Thurrock and England by substance type.



Source: NDTMS

When categorising the 39 young people by referral source, it can be seen that the largest number of referrals were received from universal sources – these might include GPs, hospitals, school nurses or family members, or specialist sources – e.g. social care or youth offending services. No referrals were received from targeted sources – e.g. Targeted Youth Support services.

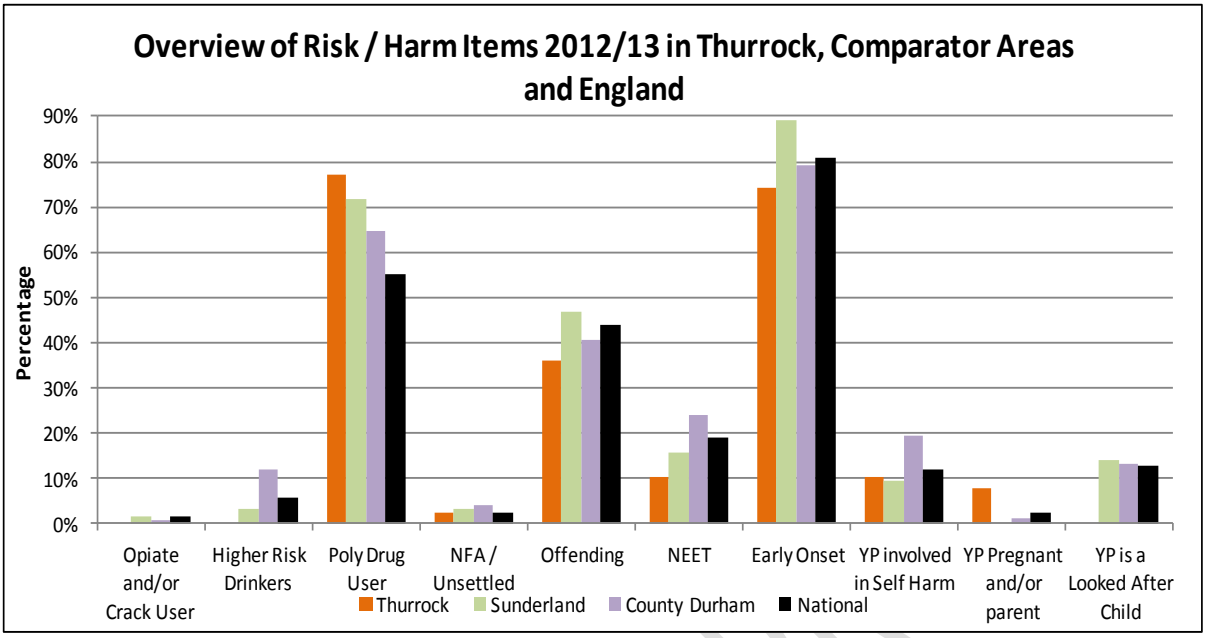
Table 4: Entrants into Thurrock treatment services in 2012/13 by source of referral.

	Specialist	Targeted	Universal/Other
All Substance Types	18	0	21

Source: NDTMS

In order to better understand and inform the commissioning of services, information is captured from each young person at the start of their treatment to identify if they have any of 10 key risks or harms that may lead to adult dependencies. The figure below outlines the percentage of entrants to treatment services which have the identified vulnerabilities in Thurrock, England and the two most similar authorities to Thurrock in the Child Wellbeing Index. From this, it can be seen that although there were no young people identified as higher risk drinkers, opiate users or Looked After Children, 77% of Thurrock entrants to services were classified as poly drug users and 74% as early onset. Overall Thurrock has a similar risk harm profile to those of similar partnerships. below outlines the percentage of entrants to treatment services which have the identified vulnerabilities in Thurrock, England and the two most similar authorities to Thurrock in the Child Wellbeing Index.

Figure 45: Risk Harm Profile of young people entering treatment in Thurrock, Comparator Areas and England, 2012/13.



Source: NDTMS

In Treatment

The table below outlines the length of time that young people were in treatment services in Thurrock in 2012/13. It should be noted that this figure includes not only those starting treatment within the year but also anyone who started treatment prior to 1st April 2012 but were still accessing structured treatment at the start of the year. Young people generally spend less time in specialist interventions than adults because their substance misuse is not entrenched; however those with complex care needs often require support for longer.

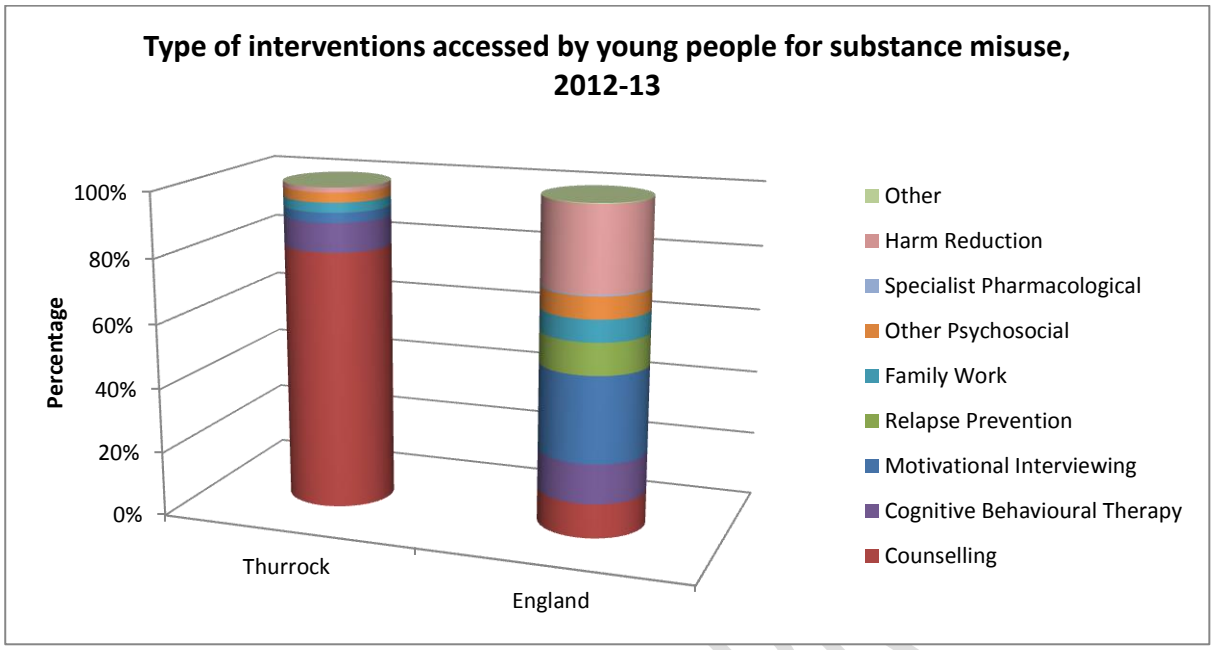
Table 5: The length of time young people were in treatment services in Thurrock, 2012/13.

Total	0-12 weeks	13-26 weeks	27 weeks or more
All Substance Types	36	9	14

Source: NDTMS

Young people have better outcomes when they receive a range of interventions as part of their personalised package of care. The figure below outlines the percentage of young people accessing different types of interventions in Thurrock and England. The majority of young people in Thurrock access counselling as an intervention whereas Motivational Interviewing and Harm Reduction are more common interventions accessed nationally. 6 of the 59 young people in Thurrock accessing treatment in 2012-13 were accessing multiple interventions.

Figure 46: Types of substance misuse interventions accessed by young people in Thurrock and England, 2012-13.



Source: NDTMS

Foetal Alcohol Spectrum Disorder

Data supplied by Alcohol Concern estimated that there is likely to have been approximately 22 children born with FASD in Thurrock in 2012. Whilst this is a crude estimate based on the prevalence of 9.1 per 1,000 births calculated by Sampson *et al* (1997), it gives an indication of likely need in the borough. Alcohol Concern estimated that the lifetime cost to Thurrock from children born in 2012 with FAS to be in the region of £7,500,000.

What are we doing in Thurrock?

The Thurrock Drug and Alcohol Action Team commission a young person's service which contributes to the following aim:

'Putting Thurrock young people in the best position to resist, recover and move on from substance misuse to provide the potential of positive, healthy and fulfilling lives' (Thurrock Council, 2013)

This service is known as *Wize-Up*, and is an integrated service offering universal, targeted and specialist substance misuse interventions to young people in Thurrock. Targeted provision is accessible by young people who are considered to be vulnerable or who have been identified as having needs that require some low intensity intervention and monitoring. Thurrock DAAT has identified the following groups of young people in Thurrock as highly vulnerable to substance misuse:

- Those who are homeless and/or 'runaways';
- Those engaged in offending

- Those engaged or being inducted into sex work;
- Those who have been 'Looked After' by the local authority;
- Those who live with parents and/or siblings who are substance misusers
- Those who truant from school or who have been excluded;
- Those who are experiencing mental health problems;
- Domestic abuse and/or sexual violence.

There is also an element of partnership working with Thurrock Youth Offending Service by means of an agency Substance Misuse Worker when this is required. This is to ensure that the specific substance related issues of young offenders are met.

Recommendations

- Preventative work in schools was a key focus of the outgoing young people substance misuse service and the new provider of this service (since 1st April 2014) has been working to ensure this legacy is built upon.
- The number of young people in treatment recorded as being a parent or pregnant in figure 45 is less than 10%, yet this number is high in relation to comparator areas. Work should be conducted by commissioners to better understand this data.
- Counselling support in Thurrock is utilised far more when compared to national trends where the two prominent interventions are Motivational Interviewing and Harm Reduction. A deeper analysis of this intervention should be conducted by commissioners to understand whether our new service provider should use a broad or narrow suite of interventions on our clients.
- Our Stop Smoking Service has been tasked with ensuring effective partnership working with our substance misuse services since the latest evidence shows that this can be a mutually beneficial investment.
- Novel Psychoactive Substances (NPS's, AKA Legal Highs or Club Drugs) can have devastating and sometimes fatal consequences for users and we know the Internet makes these substances readily available. This will be reviewed locally.
- Reaching treatment naive parents who require treatment for substance misuse, due to children experiencing hidden harm, is a challenge for treatment services and something they must maintain a focus on.
- Ensure that appropriate links are being made locally between services for domestic and sexual violence, young people and substance misuse.
- Initiatives to raise awareness of FAS and FASD amongst all professionals working with pregnant women or women who may be planning a family.

Long Term Conditions

The World Health Organisation defines long term conditions as health problems that require ongoing management over a period of years or decades. Long term conditions (LTCs) can also be defined as conditions that cannot currently be cured but can be controlled with the use of medication and/or other therapies (WHO 2002). This includes a very broad range of conditions which can be classified as:

- Cerebral conditions

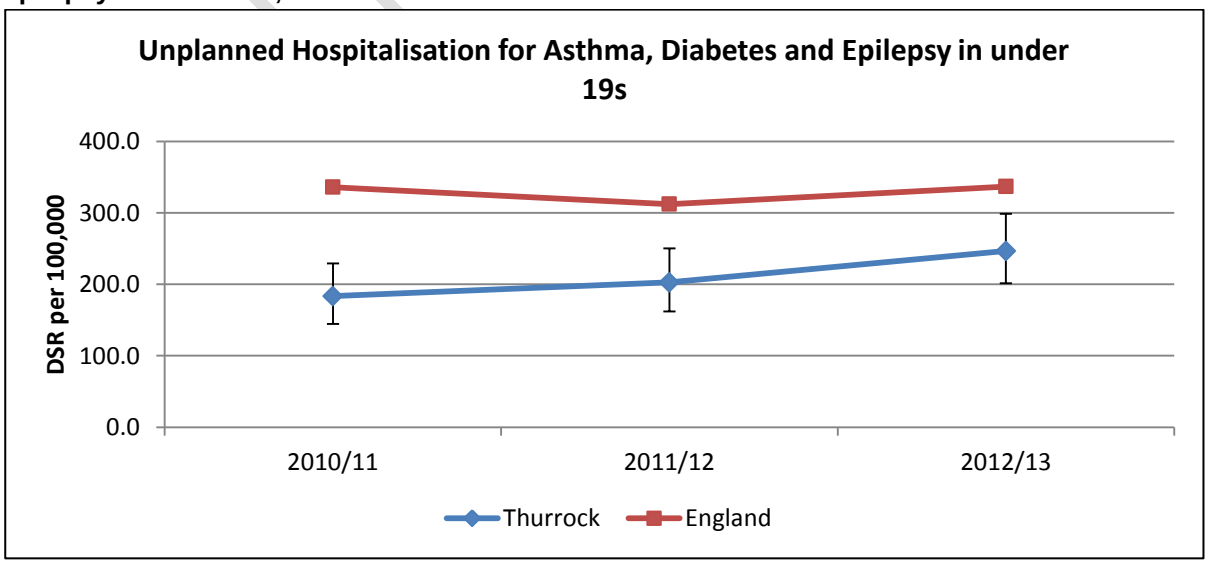
- Respiratory conditions, of which asthma is the most common in children
- Cardiac conditions
- Metabolic conditions, including diabetes
- Neurological conditions, including epilepsy
- Haematological conditions
- Gastrointestinal conditions
- Genito-urinary conditions
- Structural impairments, including hearing or sight impairments, bone and joint disorders
- Communicable diseases, including HIV/AIDS
- Neoplasia, including benign and malignant tumours and conditions such as leukaemia

Long term conditions have become a priority because of the increasing prevalence of conditions such as asthma, diabetes, cancer and epilepsy which account for a significant and growing proportion of our health and social care resources (DH 2008).

What do we know?

Asthma, epilepsy and diabetes account for approximately 94% of emergency hospital admissions for children under 19 years with long-term conditions. Providing effective ambulatory care for these conditions will lead to better patient care and case-management, as well as a reduction in preventable emergency admissions which are costly and expose patients to otherwise avoidable clinical risks such as health care acquired infections. Data for unplanned hospitalisation for the three conditions shows that Thurrock has had a significantly lower rate of admissions than the national average (local rate was 246.5 per 100,000 in 2012/13 compared to the national average of 336.9). However this rate has been increasing over the last three years and commissioners should remain mindful of this to ensure appropriate resources are available. Figure 47 shows this trend below.

Figure 47: Unplanned Hospitalisation in Thurrock CCG and England for Asthma, Diabetes and Epilepsy in under 19s, 2010/11-2012/13.



Source: NHS Indicators

When the rate of admissions is separated by gender, it can be seen that at the national level, the rate has remained higher in males compared with females. However in Thurrock in 2012/13, the rate was higher in females (263.8 compared to 230.0 per 100,000 in males); although still lower than national rates.

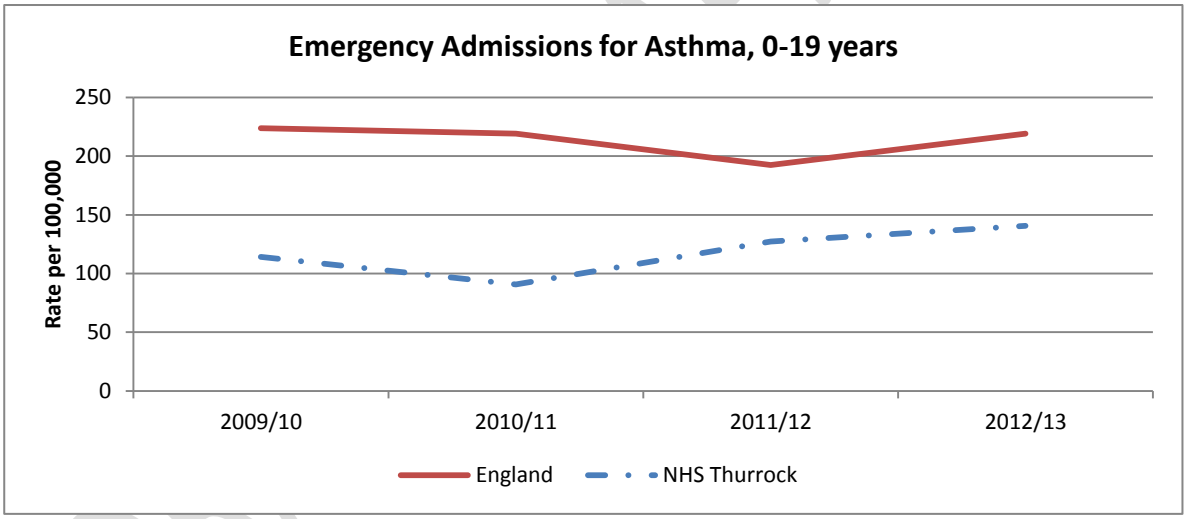
Asthma

According to www.asthma.org.uk, asthma is the most common long-term medical condition, affecting 1.1 million children in the UK – one in 11. The usual symptoms of asthma in children are:

- wheezing, or a whistling noise in the chest
- getting short of breath
- coughing, particularly at night and after exercise
- feeling tight in the chest

In some circumstances, asthma can lead to unplanned hospital admissions, or even death. There were 25,073 emergency hospital admissions for children in the UK in 2011-2012 – which is 69 per day. In Thurrock, emergency hospital admissions for asthma for children under 19 are lower than the national average. Figure 48 displays this below.

Figure 48: Emergency hospital admissions for asthma for children under 19 in Thurrock and England, 2009/10-2012/13.



Source: Hospital Episode Statistics

Local data indicates that there were 31 admissions of Thurrock residents aged 0-19 years due to asthma between April 2013 and March 2014, with over 75% aged 0-9 years. This is a large decrease from the admissions between April 2012 and March 2013, when there were 62 admissions for asthma – 71% of these were aged 0-9 years. When the average length of stay is considered, Thurrock has a higher average length of stay following emergency admission for asthma, with 1.52 days during 2012/13 (England average = 1.25 days).
Although Thurrock is performing well with respect to asthma, asthma has been identified as a priority area in children and young people's healthcare both regionally and nationally, with the commissioned report "Why Asthma Still Kills" focussing on prevention of asthma deaths and the East of England Paediatric Asthma forum looking to standardise and improve care across the region.

Epilepsy

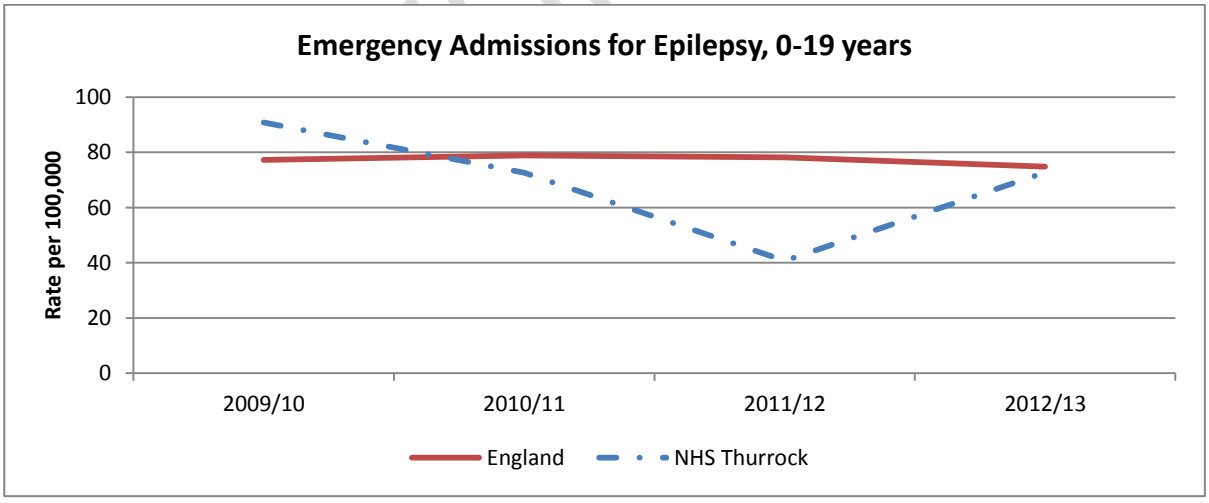
Epilepsy is a neurological condition that can affect people of any age group. However there are a number of issues specific to the management of epilepsy in children. These include the following:

- epilepsy may have a significant impact on a child's ability to learn and participate fully in educational activities, so it is vital that good links are forged with educational services. Up to 50% of children with epilepsy require some additional support in school.
- children with epilepsy may be more psychologically vulnerable and more likely to develop psychiatric disorders.
- an estimated 15% of children with mild learning disabilities and 30% with severe learning disabilities have epilepsy
- Some forms of treatment may affect fertility and contraception – this should be considered particularly when treating teenage patients

Source: Epilepsy UK

It is estimated that there are 51,500 children in the UK under the age of 16 living with epilepsy (Epilepsy UK). Hospital admissions data capturing the rate per 100,000 of children aged 0-19 years admitted for epilepsy indicates that there were 73 admissions per 100,000 in 2012/13, which is similar to the national average of 75 per 100,000. This is shown in Figure 49 below. Local intelligence indicates that as of September 2014, there were 240 children in Thurrock on the GP register for all degrees of epilepsy.

Figure 49: Emergency hospital admissions for epilepsy for children under 19 in Thurrock and England, 2009/10-2012/13.



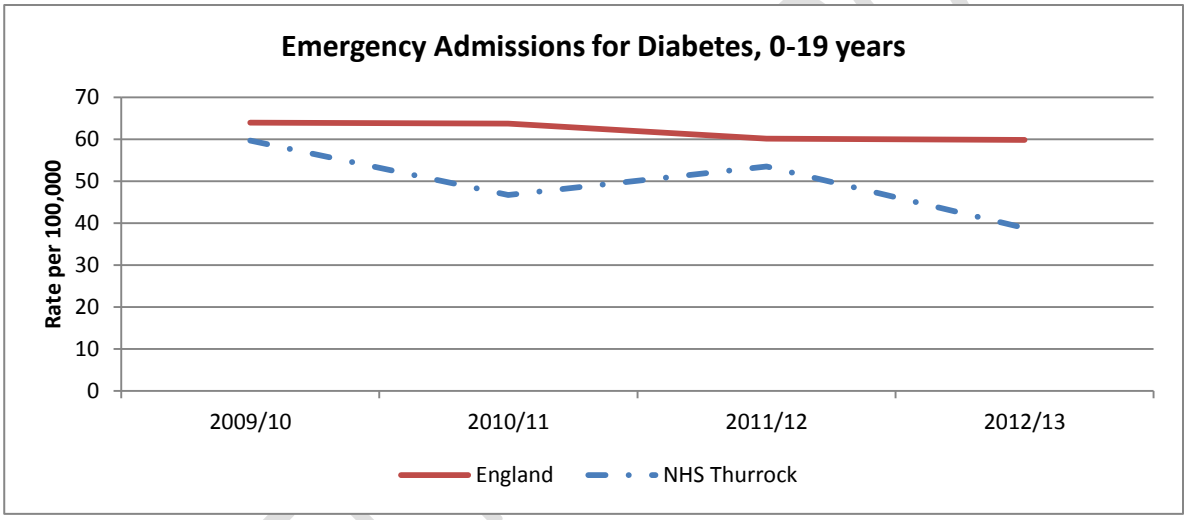
Source: Hospital Episode Statistics

Local data indicates that there were 23 admissions of Thurrock residents aged 0-19 years due to epilepsy between April 2013 and March 2014, with almost 70% aged 0-9 years. This is a decrease from the admissions between April 2012 and March 2013, when there were 30 admissions for epilepsy – 70% were aged 0-9 years. When the average length of stay is considered, Thurrock has decreased markedly in recent years from 4.37 days in 2009/10 to 1.9 days in 2012/13, which is similar to the national average of 1.91 days.

Diabetes

According to estimates by Diabetes UK, there are about 29,000 children and young people with diabetes in the UK. About 26,500 of them have Type 1 diabetes and about 500 have Type 2 diabetes. There are a further 2,000 children and young people in the UK with diabetes whose diagnosis is not known. The risk of developing diabetes is higher in children of south east Asian origin, who are up to 13 times more likely to develop type 2 diabetes than white children (Source: Diabetes UK). It should be noted that type 2 diabetes is associated with obesity and the prevalence in the national population has increased in recent years. Hospital admissions data capturing the rate per 100,000 children aged 0-19 years admitted for diabetes indicates that there were 39 admissions per 100,000 in 2012/13, which is lower than the national average of 60 per 100,000. This is shown in Figure 50 below. Local intelligence indicates that as of September 2014, there were 75 children in Thurrock on the GP register for diabetes.

Figure 50: Emergency hospital admissions for diabetes for children under 19 in Thurrock and England, 2009/10-2012/13.



Source: Hospital Episode Statistics

Local data indicates that there were 26 admissions of Thurrock residents aged 0-19 years due to diabetes between April 2013 and March 2014, with almost 70% for children aged 10-19 years. This is a slight increase from the previous year – 19 admissions for diabetes were seen between April 2012 and March 2013, and only 37% of those were for children aged 10-19 years. When the average length of stay is considered, Thurrock has a similar length of stay to the national average (2.0 days, compared to 2.04 days).

Sickle Cell disease

Sickle cell disease affects approximately one in every 2,000 births in England. It is estimated that there are 380,000 healthy carriers of unusual haemoglobin variants, most of which are sickle. According to data captured by the National Sickle Cell and Thalassaemia programme (available via www.sct.screening.nhs.uk), the highest prevalence of sickle cell disease is among Black Africans and Black Caribbean ethnic groups, with 63% of positive screens being for newborn babies within these ethnic groups in 2012/13. The 2012/13 screening programme identified a national rate of 0.46 per 1,000 as having a significant condition. In Thurrock, local

admissions data indicates that there were 26 admissions for sickle cell disease in children between April 2013 and March 2014, which is much lower than the 87 admissions observed between April 2012 and March 2013. In 2013/14 the age group with the largest proportion of admissions was 15-19 years (38%) whereas in 2012/13 there was a larger proportion of 5-9 year olds (45%). The average length of stay in hospital was 1.27 days in 2013/14, compared to 0.74 days in 2012/13 – indicating that although the number of admissions has dropped, the patients are spending longer in treatment.

South West Essex has the highest number of children with sickle cell disorders in Essex, with an estimated 66.5% of all children with these disorders living in the South West of the county. This equates to in excess of 145 children living in South West Essex with sickle cell disorders, all of whom will need to access services on at least an annual basis.

What are we doing in Thurrock?

Thurrock's priorities around these long term conditions include:

Sickle Cell disorders

Work is focusing on repatriating the large number of patients from South West Essex who travel to London for their clinics back to a localised service. As there is currently no complete sickle cell pathway in Essex, work is underway to consider extending the existing service (currently offered to those aged 0-1 years and their families) to cover a wider age range. It is hoped that this work will reduce untimely admissions – i.e. children and young people not waiting for extended time periods whilst in A&E whilst experiencing a crisis, and also prevent unnecessary hospital admissions for management of less serious sickle cell crises. If children and their families can gain increased education, and consequently increased confidence, in the ability to manage their condition, there should be a reduction in inappropriate hospital admissions for all but the most serious of crises. This also increases quality and meets the care closer to home agenda. By offering a joined-up acute and community approach, too, patients' care will be better integrated and holistic, meaning the patient will only have to tell 'their story' once, and feel more comfortable with consistent practitioners. Equally, by including such best practice elements as the patient passport, patients' voice will be heard in their care.

Asthma

Asthma is one of the High Impact Pathways to be launched in Thurrock. These pathways are aimed at empowering parents/ families / carers to manage common conditions at home and develop pathways to ensure care is delivered at the most appropriate setting. As part of this work, there is a regional focus on Asthma from the East of England Strategic Clinical Network, which covers off the clinical pathway, ensuring information technology and systems are in place, and education.

Recommendations

Work in Thurrock around Long Term Conditions needs to focus on a variety of aspects:

- Management within the Community
    - As level of need increases and acute settings become increasingly busy, the community has a key part to play in the management of Long Term Conditions. This includes ensuring primary care and community-providers are enabled to offer support to families who need it, and begin to play a role in managing those more complex conditions within the community, while also ensuring basic work such as inhaler technique for asthma sufferers is delivered correctly. Work needs to focus on education, capacity building, and confidence-building, to ensure both patient quality of life improves, and unnecessary hospital admissions and attendances reduce.
- Patient-focus and voice of the patient
    - SEND reforms will focus partners on this increasingly. It is essential to ensure the patient comes first in all our decision making and scoping, particularly those most vulnerable children.

Mental Health

Mental health has been defined as 'the strength and capacity of our minds to grow and develop, to be able to overcome difficulties and challenges and to make the most of our abilities and opportunities (Young Minds, 2006). Young people's emotional health and wellbeing is important, both for the impact that it has on their present quality of life, and also for the implications it has for their future social and emotional development, academic experience and achievement. National research highlights that good emotional and mental health is fundamental to the quality of life and productivity of individuals, families, communities and nations. Positive mental health is associated with enhanced psychosocial functioning, improved learning, increased participation in community life, reduced risk-taking behaviour, improved physical health, reduced mortality and reduced health inequality. Poor emotional well-being and mental health can lead to negative outcomes for children, including educational failure, family disruption, poverty, disability and offending.

Although children and young people are healthier now than ever, inequalities persist and evidence suggests that mental ill health affects one in ten of 5-16 year olds (Green, et al., 2004). There is also a sizeable economic burden associated with mental health, with the Department of Health estimating that mental illness costs approximately £105.2 billion per year (Department of Health, 2011).

The Department of Health publication *No Health Without Mental Health* (2011) emphasised the importance of promoting good mental health and intervening early, particularly in the childhood and teenage years, in order to prevent mental illness from developing and mitigate its effects when it does. This should begin with health promotion programmes delivered during pregnancy, in order to reduce the impact of maternal stress and promote attachment, as it is known that this phase strongly influences outcomes in later life. A child's experience in their first two years sets the foundation for their future years, with inappropriate child-rearing practices potentially leading to language delay and emotional or behavioural disorders. Professionals working in schools

also have an important role to play in promoting emotional health and wellbeing, recognising potential problems and intervening appropriately. There are large economic benefits associated with early intervention into mental health problems – NICE estimated the potential long-term savings from each case of severe conduct disorder prevented to be £150,000 (National Institute for Health and Care Excellence, 2013). School-based interventions have also been shown to provide large amounts of savings, with bullying-prevention programmes estimated to generate savings of £1,080 per school pupil, and violence-prevention programmes for 6 year old children saving £829 per child at age 6 and increasing to £8,223 at age 15 (Department of Health, 2011).

The Thurrock CAMHS (Child and Adolescent Mental Health Service) Strategy for 2014 – 2017 identifies four specific groups who have a greater risk of developing mental health problems. These are children:

- with learning difficulties & disabilities, developmental disorders & in residential schools
- in short stay schools
- on a child protection plan
- who are looked after

Thurrock Council has also determined that a range of other factors known to put certain groups of children more at risk of mental health problems should also be monitored.
The identified groups are children:

- living in poverty
- With behavioural, emotional and social difficulties
- With ADHD
- Who self harm
- At risk of suicide
- Who are bullied (often or very often)
- With substance misuse problems
- Teenage parents
- Excluded from school
- Young offenders
- 16-17 year olds and young people in transition
- With physical disabilities
- From BME background
- Witnessed domestic violence
- Attachment disorders

Half of lifetime mental illness arises by the age of 14, and widespread research has shown that early intervention and preventative strategies are effective and crucial to improve the emotional wellbeing and mental health of populations. Resilience to poor psychological health can be developed at individual, family and community levels and interventions are most effective when they take a holistic, family centred approach.

What do we know?

There are a multitude of estimates of the numbers of children and young people with mental health problems. These come from a variety of sources, with different sample sizes and definitions of mental health conditions. This all contributes to potential confusion over which would be the most representative figures to use as a basis for service planning.
When discussing mental health, two terms are useful.

> **"Mental health disorder"** - describes a clinically recognisable onset of symptoms or behaviours.
>
> **"Mental health problems" -** is used to describe a broad range of emotional and the behavioural difficulties that may cause concern or distress. These problems are relatively common and encompass mental disorders which are more severe and/or persistent mental health conditions.

Prevalence of mental health disorders

There is relatively little data about the prevalence of mental health disorders in pre-school children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H *et al*, 2006, cited by CHiMat). Applying this average prevalence rate to the estimated population within the area gives a figure of 1,890 children aged 2 to 5 years inclusive living in Thurrock who may have a mental health disorder.

The research referred to previously by Green *et al* (2004) for the Office of National Statistics estimated the national prevalence of any clinically diagnosed mental disorder in 5-16 year olds to be almost 10%; of these:

- 4% had an emotional disorder (such as anxiety or depression),
- 6% had a conduct disorder,
- 2% had a hyperkinetic disorder; and
- 1% had a less common disorder (such as autism, ticks, eating disorders and selective mutism).

Prevalence rates were shown to vary by age and by gender – in both age groups boys were found to have a higher prevalence of mental health disorders than girls and were highest in boys aged 11-16 years.

Table 6: Variation in prevalence of mental health disorders observed by Green et al (2004)

Age Group	Prevalence in boys	Prevalence in girls	Prevalence for both genders
5 – 10	10.2%	5.1%	7.7%
11 – 16	12.6%	10.3%	11.5%
All (5 – 16)	11.4%	7.8%	9.6%

Source: Green et al, 2004

Applying these prevalence rates to the 2012 estimate of Thurrock's population means that approximately 2375 children aged 5-16 years in the borough have a diagnosable mental health condition. The table below shows the estimated number of children in Thurrock with mental health disorders by age and sex, calculated using Green *et al* (2004) prevalence rates.

Table 7: Estimated number of children with mental health disorders in Thurrock by age and gender

Age Group	Estimated number of boys	Estimated number of girls	Estimated number of both genders
5 – 10	660	320	980
11 – 16	780	610	1390
All (5 – 16)	1440	950	2375

Source: ChiMat – produced using ONS Mid Year Estimates 2012 and Green et al, 2004

These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders. The following table shows estimates of the numbers of children aged 5-16 with conduct, emotional, hyperkinetic and less common disorders, and neurotic disorders for those aged 16-19, calculated using ONS 2012 population estimates and Green *et al* (2004) prevalence rates.

Table 8: Expected number of children in Thurrock with mental health disorders by type, 2012

	Estimated no. with conduct disorders aged 5-16 years	Estimated no. with emotional disorders aged 5-16 years	Estimated no. with hyperkinetic disorders aged 5-16 years	Estimated no. with less common disorders aged 5-16 years	Estimated no. with neurotic disorders aged 16-19 years
Thurrock	1,381	886	361	324	1,088

Source – ChiMat – produced using ONS Mid Year Estimates 2012 and Green et al, 2004

Green *et al* (2004) also found that one in five of the children with a mental disorder were diagnosed with more than one of the main categories of mental disorder. This figure represented 1.9% of all children. The most common combinations were conduct and emotional disorder, and conduct and hyperkinetic disorder. Applying the 1.9% prevalence to the local population would equate to approximately 799 children in Thurrock who may have more than one type of mental health disorder.

Children at risk of developing mental health problems across Thurrock

The section above focused upon those children and adolescents with mental health *disorders* and not individuals with less serious mental health *problems*. The possible extent of mental health *problems* is obviously far larger, and estimates of the numbers of children and young people with mental health problems vary between 10 and 14%.
In order to target services and resources more effectively, it is useful to estimate the number of children in groups who have specific needs which makes them at greater risk of developing a mental health problem. Only a minority of young people with mental health problems receive professional help, and social factors and mental health can often have a reciprocal effect upon each other. Existing UK statistics do not separate mental health causes/factors from non-mental health factors.

The following section provides an estimate of the number of children and young people in each of the categories identified as high risk by Thurrock CAMHS Strategy 2014-2017 and Thurrock Council. It should be noted that many children will be in more than one of these groups.

Children with a learning disability

It is known that people with learning disabilities are more likely to experience mental health problems. Estimation of the population with learning disabilities with mental health problems was undertaken by applying prevalence rates researched by Emerson *et al,* (2008) and Foundation for People with Learning Disabilities (2002) – referenced by CHiMat, to the local population. The research undertaken by the Foundation for People with Learning Disabilities (2002) estimated that up to 40% of those with learning disabilities might have mental health problems, and this is applied to the Thurrock population in the table below.

Table 9: Estimated number of children with learning disabilities who might experience mental health problems in Thurrock

Age group	Number estimated to have a learning disability	Number estimated to have a learning disability with mental health problems
5 – 9 years	105	45
10 – 14 years	220	90
15 – 19 years	270	110

Source: CHiMat – produced using research by Emerson et al (2008), ONS Mid Year Estimates 2012 and Foundation for People with Learning Disabilities (2002).

When the ChiMat estimates were compared to local data, it was of interest to observe that actual numbers of children known to have learning disabilities was higher than the ChiMat estimates, resulting in a higher estimated number with mental health needs when the 40% prevalence was applied.

Table 10: Estimated number of children with learning disabilities with mental health needs

	Number of fully statemented children	Number of children on School Action	Number of children on School Action Plus	Number of children in residential schools	Total number of children with learning disabilities	Estimated number with MH needs (40%)	% of 5-19 population
Thurrock	892	2,396	1,611	22	4,921	1,968	6.55%

Source: Thurrock Council, 2013

Children in short stay schools (Pupil Referral Units)

Data provided by Thurrock Council shows that there were 88 children in short stay schools in 2011/12. It is expected that all of these children and young people will require some mental health intervention.

Children on a Child Protection Plan

Children on a child protection plan who have been subjected to abuse and neglect are likely to experience a wide range of debilitating emotional and behavioural problems, and could lead to serious impairment of health and development – all of which may persist into adulthood.
Data provided by Thurrock Council (2013) shows that there were 200 children subject to a Child Protection Plan which equates to 0.48% of the local 0-19 year old population.

Children in Care

Looked after children are more likely to experience mental health problems (Ford, T. *et al*, 2007 – referenced by Essex Joint Strategic Needs Assessment, 2013). It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder. Results from the Strengths and Difficulties Questionnaire (SDQ) completed by children in care can indicate mental health needs, and the table below estimates the number of children in care in 2012 that might have had mental health needs.

Table 11: Estimated number of children in care who might have had mental health needs in Thurrock, 2012.

	Number	% of 0-19 population	% of children in care with SDQ score considered to be a concern	Expected number with MH needs
Thurrock	260	0.62%	48%	125

Source: Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health, 2013.

Other groups of children at risk of developing mental health problems

The table below outlines the vulnerable groups suggested by Thurrock Council who have a higher risk of developing mental health problems.

Vulnerable Group	Rationale	Estimated Local Need	Data source
Children living in poverty	It is estimated that children living in poverty are three times more likely to suffer mental health problems.	20.0% of children are estimated to live in low income families – which equates to 7,950 children in Thurrock. As deprivation is a risk factor for mental ill health, consideration should be given to ensure service provision is targeted in areas of high deprivation. Further information on deprivation can be found in the Child Poverty section.	HMRC
Children with behavioural, emotional and social difficulties	Children with a SEN are more likely to develop a mental health problem, or to have their mental health needs overlooked. In addition, they are more likely to be excluded from school (resulting in lower educational attainment) and to become known to the young offenders' service.	Based on an estimate of 6.9% of pupils in Essex, this would be approximately 2,072 children in Thurrock.	Schools Health Education Unit (SHEU)
Children with Attention Deficit Hyperactivity Disorder (ADHD)	There is some evidence that children who are diagnosed with attention deficit hyperactivity disorder at an early age are at greater risk of depression and suicide than other teens. Conduct disorder was also the primary reason for referral to the Thurrock Tier 2 service.	The expected prevalence of ADHD is included as part of the ChiMat estimates for all hyperkinetic disorders No current data on the number of children with ADHD with mental health problems.	
Children at risk	Self-harming is usually triggered by		NHS

of self-harm or suicide	a set of circumstances that leave young people feeling overwhelmed and can be a sign of emotional difficulties. It is estimated that 90% of people who attempt or die by suicide have one or more mental health conditions. In addition, Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood	Further information on children who were admitted to hospital for self-harm and estimated number of suicides can be found in the Staying Safe chapter.	Choices
Children who are bullied	Bullying can have significant impact on the mental health of children and young people resulting in depression, low self-esteem, and anxiety.	10.4% of pupils reported that they were currently being bullied.	Tell Us survey (2010)
Children with substance misuse problems	Substance abuse may sharply increase symptoms of mental illness or trigger new symptoms. Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective. The mental health problems that most commonly occur with substance misuse are depression, anxiety and bipolar disorder.	Further information on children with substance misuse problems can be found in the children's Substance Misuse section.	
Teenage parents	National data shows teenage mothers are three times more likely to develop post natal depression and experience poor mental health for up to 3 years after the birth of their child.	Further information on teenage conceptions in Thurrock can be found in the Teenage Pregnancy section.	
Young offenders	Findings have indicated a high prevalence of complex and persistent mental health and social care needs among children and young people in contact with the youth justice system. One quoted study reported that one third of these children and young people have mental health needs, often undiagnosed and untreated.	One third of the Thurrock Youth Offending Service would equate to 135 children with mental health needs.	Centre for Mental Health / Thurrock Council
Children with physical disabilities	Physical health problems significantly increase the risk of poor mental health, and vice versa.	There are 850 children known to the CWD team – but only 427 on the disability register (2013)	Thurrock Council
Children from a BME background	Research shows that children from BME backgrounds are under-represented in CAMHS services, and that it is more likely that their problem will reach a crisis point before they come into contact with services.	Further information on the ethnicity of children in Thurrock can be found in the children's Demography section.	
16-17 year olds and young people in transition	The prevalence of mental health disorders is known to increase throughout adolescence, and young people in transition are	Applying the prevalence of 21.5% would equate to 885 16 and 17 year olds in Thurrock with mental health disorders.	(McManus, et al., 2009)

	additionally at risk of having their mental health needs overlooked. One survey indicated that as many as 21.5% of women aged 16-24 years have a mental health disorder.		
Children with parents who have mental health issues	Poor parental mental health is significantly associated with children's social and emotional development and their mental health, as it affects the upbringing of a child. Children with parents who have mental health issues are twice as likely to experience a childhood psychiatric disorder. National research indicates that 17.8% of parents have a mental health issue.	Figures from the CAMHS service in Essex show that 50% of those attending CAMHS had at least one parent who had had contact with adult mental health services.	
Children with parents with substance misuse problems	The misuse of drugs and/or alcohol may adversely affect the ability of parents to attend to the emotional, physical and developmental needs of their children. Research indicates that children are twice as likely to use alcohol and/or drugs at an earlier age, and have higher rates of psychiatric disorder. They are also at high risk of being put onto a Child Protection Plan.	Figures from the CAMHS service in Essex show that 25% had a substance misusing parent.	
Children who have witnessed domestic violence	It is now well accepted that witnessing abuse in childhood is a significant factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse.		Women's aid
Attachment disorders	There is a sizeable body of literature on the relationship between types of early childhood attachment and a variety of negative health and mental health consequences		Bowlby – Ethological Theory of Attachment

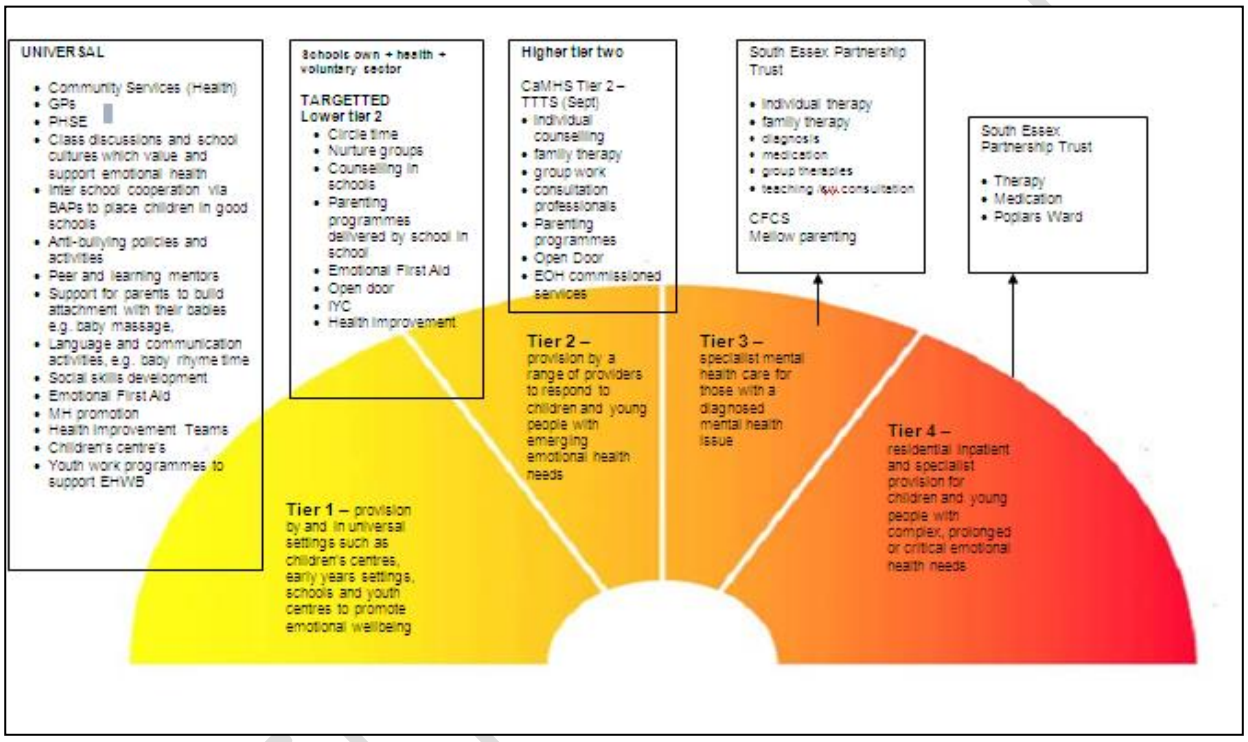
What are we doing in Thurrock?

In 1995, the document Together We Stand laid out a strategy to improve mental health services for children, young people and families. *Together We Stand* laid out a tiered service structure to clarify this and better deliver the care pathways. This covers four tiers of provision for emotional wellbeing and mental health:

Tier 1: provided by practitioners who are not mental health specialists working in universal settings such as schools and early years settings, offering general advice and support aimed at promoting emotional wellbeing and preventing mental illness.

Tier 2: a service provided by specialist individual practitioners in primary and community settings including assessment, care and interventions for children and young people with emerging emotional health needs.
Tier 3: a specialised multi-disciplinary service for more severe, complex or persistent mental health problems.
Tier 4: essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised out-patient teams and in-patient units providing 24 hour nursing care.

Figure 51: The range of CAMHS services delivered in Thurrock, 2014



Source: Adapted from Thurrock Multi agency assessment and responses to children.

Children's centres

Thurrock's children's centres play an integral role in promoting positive mental health and emotional wellbeing in both children and their parents, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to ensuring parents feel adequately supported and that they have good mental wellbeing and self-esteem.

Family Nurse Partnership

The recently launched Family Nurse Partnership (FNP) programme aims to provide ongoing intensive support to new teenage parents and their babies. As the programme helps first-time parents to adapt to parenthood, it also provides support with mental health needs. Further information on the FNP can be found here.

Estimated need for services

Data from ChiMat estimated the below numbers of Thurrock children aged 17 and under who may require a service from CAMHS:

Table 12: Estimated need for CAMHS services in Thurrock

	Tier 1	Tier 2	Tier 3	Tier 4
Thurrock	5,855	2,735	725	30

Source: ChiMat – produced using Office for National Statistics mid-year population estimates for 2012 and research by Kurtz, Z. (1996).

CAMHS Crisis Team

The Crisis teams across Essex provide emergency assessments, and where appropriate, home treatment to avoid the admission of a child or young person. These services are currently delivered from within CAMHS Tier 3 provision and act as the gateway into Tier 4 inpatient services. An assessment by the crisis team could result in a complete discharge from CAMHS services, a referral to CAMHS Tier 3 community service, or an inpatient admission.

Access for children and young people with a learning disability

South Essex Partnership Trust (SEPT) has a specialist CAMHS LD service which works with children with mental health needs aged 5 to 12 who have a severe and profound learning disability and a statement of special educational needs. In addition, individuals with a less severe learning disability may receive interventions from generic CAMHS teams. The 2012/13 contract monitoring data reports that between 60 and 70 individuals with a diagnosed learning disability are recorded as being on CAMHS caseloads each month in South Essex.

Tier 4 services

Nationally NHS England commissions a variety of beds that Thurrock can access, including general inpatient adolescent beds, Psychiatric Intensive Care Unit (PICU), Eating Disorder beds, and low and medium secure adolescent beds. Where a young person's needs cannot be met within the region, other national providers will be considered and these include specialist provision for complex, high risk or dual diagnosis. As of November 2014, there were 9 Thurrock children known to the NHS England East Anglian Mental Health team, and the majority of these were treated within the Thurrock area. Treating needs within tier 4 services can incur high costs – the average cost for the patients referred from South Essex Partnership Trust was £7,123.18. In 2011, the Department of Health estimated that improvements to the acute care pathway for mental health could result in national savings of around £224 million per annum by 2014/15 (Department of Health, 2011) and sets out a number of suggested approaches that may help to achieve this reduction.

Identifying unmet needs

Partners across Southend, Essex and Thurrock have been engaged since 2011 in reviewing the response to children and young people's emotional wellbeing and mental health needs. It has been recognised that the current model of emotional wellbeing and mental health provision for children, young people, their families and carers is not providing sufficient integration. Consultations with partners, children and young people and their parents/carers during 2011,

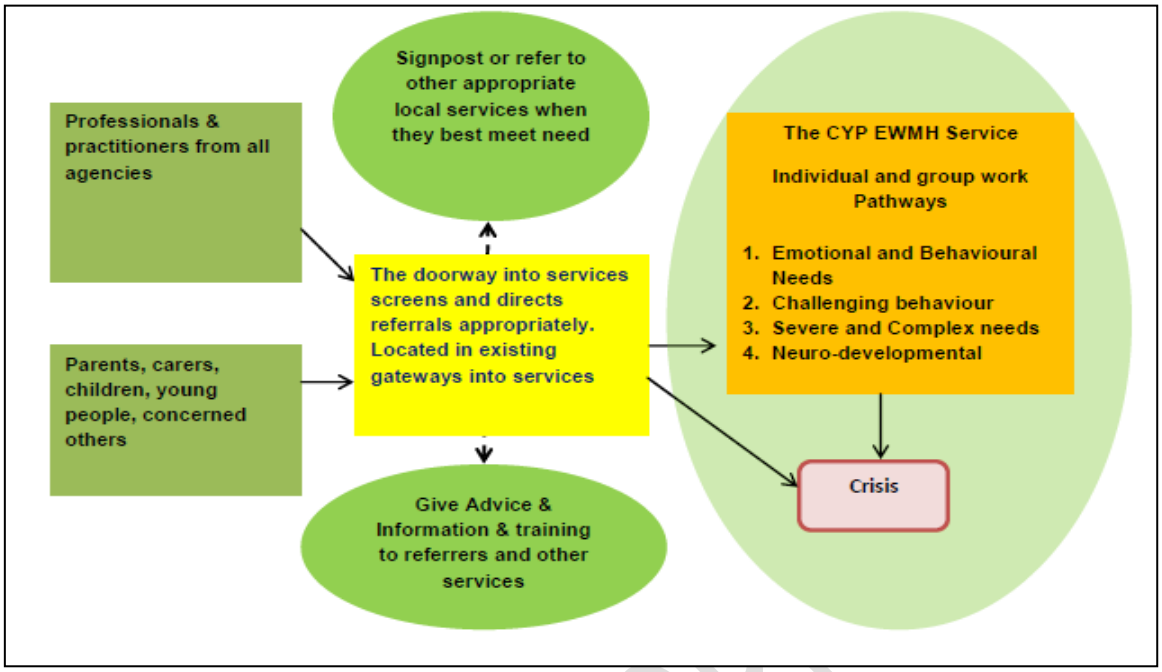
2012 and 2013 focused on the experience of CAMHS Tier 2 and Tier 3 and what a good service would consist of.
The key emerging themes were:

- Supporting parents/carers and the whole family
- Having local or community based services and engaging with young people
- Improved access to support, advice with quick and easy access/referral to appropriate services.
- Workforce training (including universal staff)

The Essex Joint Strategic Needs Assessment of Child and Adolescent Emotional Wellbeing and Mental Health completed in summer 2013 concluded that there is no overall coherent integrated strategy within which services are commissioned and there is a complex, fragmented and poorly understood and accessed set of services in place. The Health and Social Care reforms together with the current financial climate have given added impetus for an integrated commissioning approach. A desktop analysis of good practice was also undertaken.

A wide range of stakeholders have been working in partnership during 2013 to develop a service model that integrates the Tier 2 and Tier 3 Services (which are currently separate), to reflect good practice and address the gaps and approaches identified in these consultations and the 2013 Essex Joint Strategic Needs Assessment. The redesigned model consists of a Single Point of Access and a service providing direct interventions to children and young people with emotional wellbeing and mental health needs. It eliminates the separation between Tiers 2 & 3 CAMHS, collapsing them to deliver an integrated service known as the Children and Young People's Emotional Wellbeing and Mental Health Service (The CYP EWMH Service). The new service will provide a comprehensive, outcomes based and innovative approach using targeted and specialist, evidence based interventions and an integrated pathway approach across health, social care, education and the voluntary and community sector to respond to the varying emotional wellbeing and mental health needs of children and young people. It will advise, inform and support universal services and provide training to maximise capacity to build resilience and provide appropriate early intervention to children and young people with emotional wellbeing and mental health needs. It will work closely with a wide range of partners to ensure an integrated, effective service.

Figure 52: Proposed model of the Children and Young People's Emotional Wellbeing and Mental Health Service for Southend, Essex and Thurrock



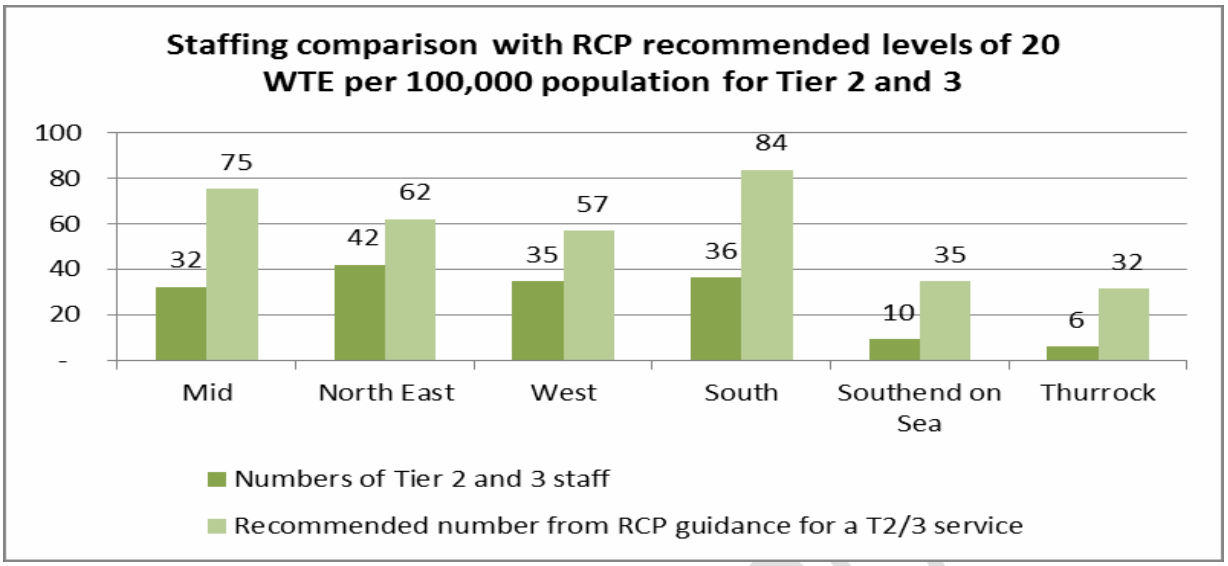
Source: Southend, Essex and Thurrock Children and Young People Emotional Wellbeing and Mental Health Service Model, 2014

The CAMHS workforce

Work was undertaken as part of the Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health (2013) to review staffing numbers across the county. The National Service Framework (2007) recommendations state that a Tier 3 service with teaching responsibilities for 0-17 year olds would need a minimum of 20 whole time equivalents (WTEs) per 100,000 total population, or 15 per 100,000 for a non-teaching service. The Royal College of Psychiatry put forward a recommended staffing level of 20 WTEs per 100,000 for an integrated Tier 2 and 3 service for 0-16 year olds, of which 5 WTE should be primary mental health workers.

Whilst it is known there are variations in staffing across the county, and it is difficult to directly compare to these recommendations as services are currently delivered in Essex to 0-18 year olds, calculations show that the known numbers of Tier 2 staff, together with those in SEPT Tier 3 services represent 47% of the numbers recommended by the Royal College of Psychiatry.

Figure 53: Royal College of Psychiatry workforce recommendations and actual numbers of Tier 2 and 3 staff



Source: Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health, 2013.

Future Public Health Preventative Mental Health Service

The Public Health team are working with school nursing teams in primary schools to develop a one year pilot to support emotional health and mental wellbeing in children aged 4-11 years. This approach will improve health and reduce health inequalities by working with individuals and families building on the child-centred approach within the 5-19 healthy child programme (HCP).

Recommendations

- Planning and commissioning of services should take account of the predicted population changes.
- Robust contract management with Commissioning partners to ensure the ambitions and outcomes are achieved to the agreed timescales.
- Commissioners should consider increasing prevention and early intervention capacity particularly to the at risk groups identified via the local CAMHS consultation work in 2011-2013
- Parents and carers need information on child development, the causes of emotional distress and signs of mental ill health so that they can support their children and build resilience
- Raise the profile of good mental health with children and young people to reduce stigma and health inequalities.
- Staffing levels and workforce training are featured strongly in the new model of service delivery and detailed within the service specification
- Referral criteria for the new model of integrated provision are clear and account for co morbidities
- Further work should be undertaken to ensure the new service meets the needs of young people in transition between children's and adult's mental health services.

3. Staying Safe

Vulnerable Groups

It is noted that particular groups of children may be considered more vulnerable to poor outcomes. The sections below describe some of these.

Children In Need

A general duty is placed on every local authority to safeguard and promote the welfare of children who are in need within their area. This duty is set by:

1. Section 17 of the Children Act 1989
2. Section 10/11 of the Children Act 2004
3. recommendations in the Munro Review of Child Protection, 2011
4. the Working together to safeguard children statutory guidance 2013

Children's social care must, so far as is consistent with this duty, promote the upbringing of children in need by their families, through provision of a range and level of services appropriate to the child's needs.

The Children Act 1989 states that a child shall be considered "in need" if:

1. s/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority
2. their health or development is likely to be significantly impaired, or further impaired, without the provision of such services
3. s/he is disabled

If children in need are not identified early and referred onto appropriate support they may be at risk of experiencing poor outcomes (Department for Children, Schools and Families, 2010). These may include:

1. **Health** – their physical health might deteriorate or they may develop mental health disorders.
2. **Safety** – they may become more at risk of serious harm.
3. **Development** – their learning, social and emotional development may suffer as a result of not having appropriate educational support and inadequate opportunities to socialise with their peers.
4. **Behaviour** – they may participate in risk taking activities such as anti-social or criminal behaviour, or take risks with their health, experimenting with dangerous substances or risky sexual behaviours.
5. **Employment** – ultimately, poor outcomes may impact on a young person's ability to acquire the key skills for employment and find a decent job.

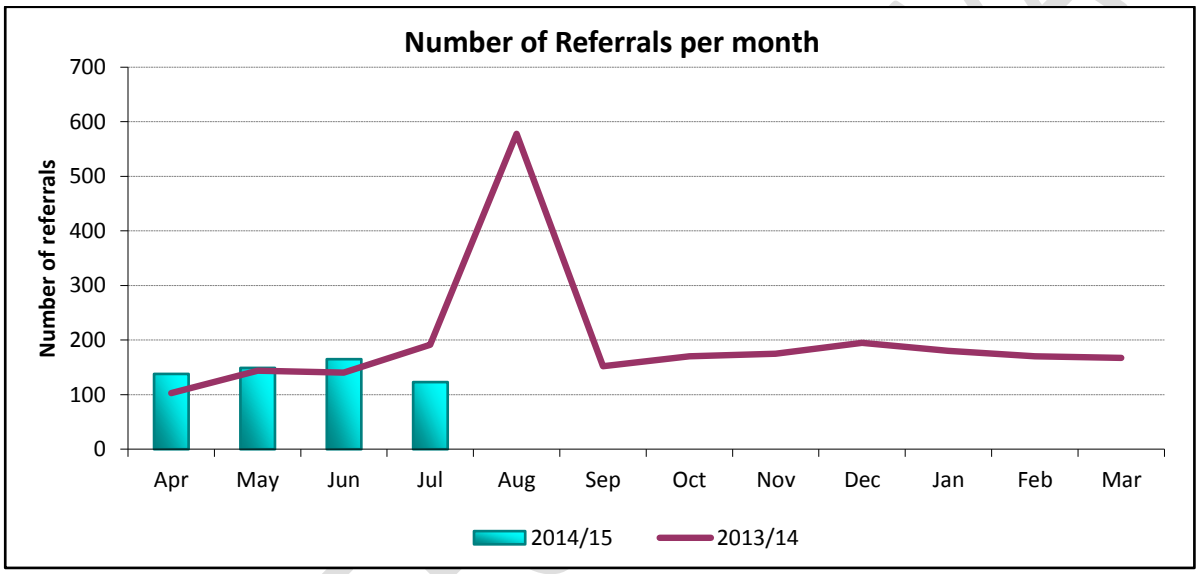
If the problems faced by children in need are not effectively addressed, they may escalate and the child or young person may become subject to a Child Protection Plan or a Looked After Child (LAC).

What do we know?

Referrals

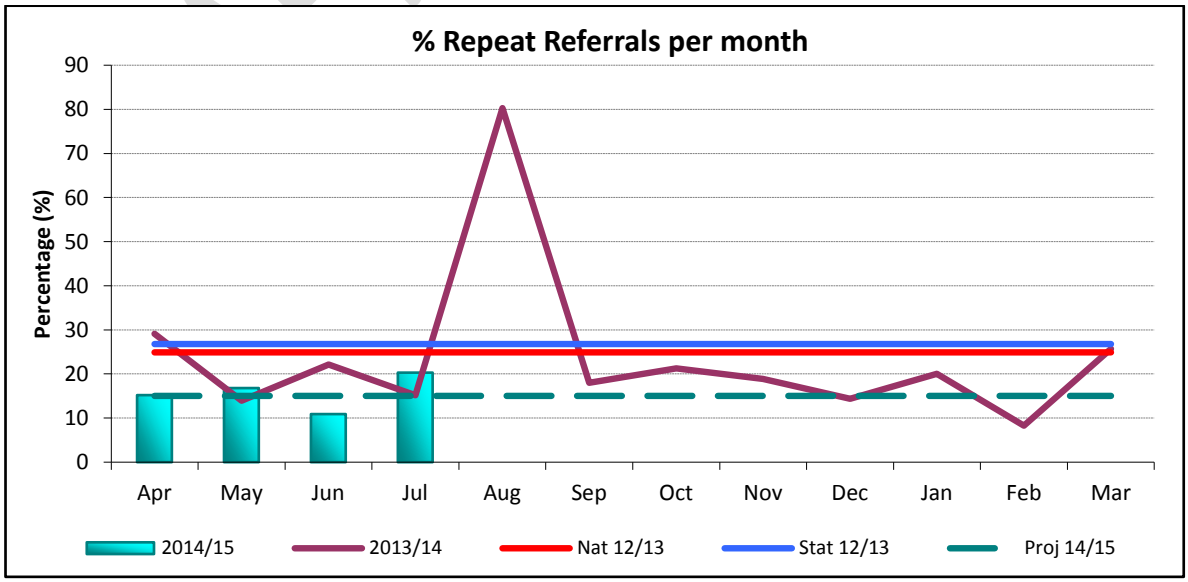
There have been 575 referrals between April 2014 and July 2014, which remains consistent with the 578 during the same period in 2013. The proportion of repeat referrals is currently 15.5% which is lower than the proportion of 18.9% in 2013/14. There is a dip in referrals in July – however it is too early to consider a trend or pattern. In addition, the service has recently introduced the MASH and the impact on referrals will be monitored. Figure 54 and Figure 55 show the volume of referrals received per month, and the proportion of referrals that are repeat referrals.

Figure 54: Referrals per month in Thurrock in 2014/15 and 2013/14



Source: Thurrock Council

Figure 55: % of referrals that are repeat referrals per month in Thurrock in 2014/15 and 2013/14

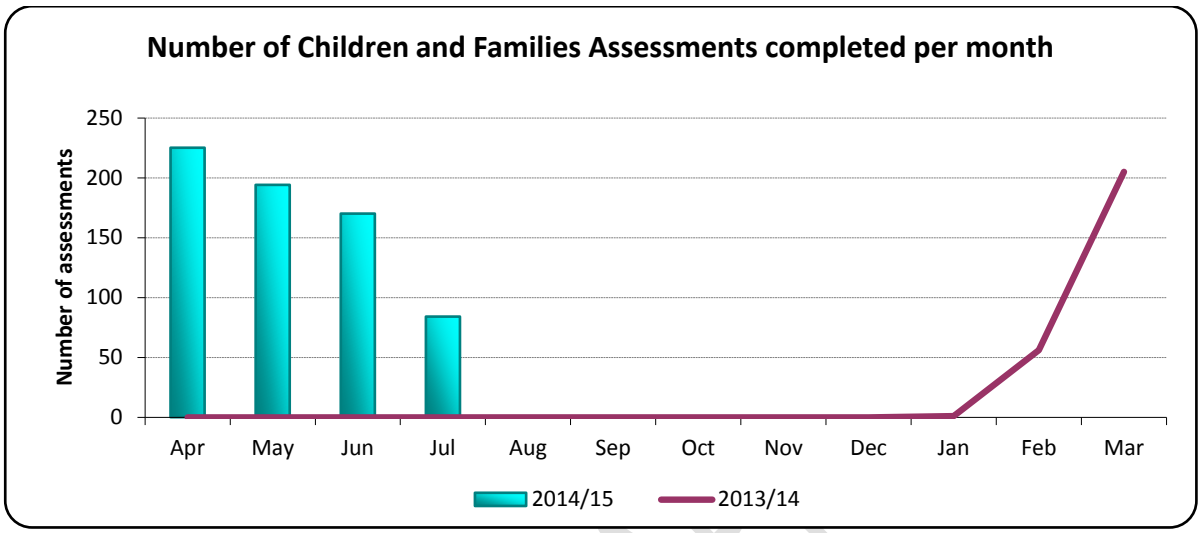


Source: Thurrock Council

Children and Family Assessments

673 Children and Family assessments have been completed between April and July 2014. July appears to show a dip in the number of assessments completed (84); however it is too early to identify a trend. Figure 56 shows this below.

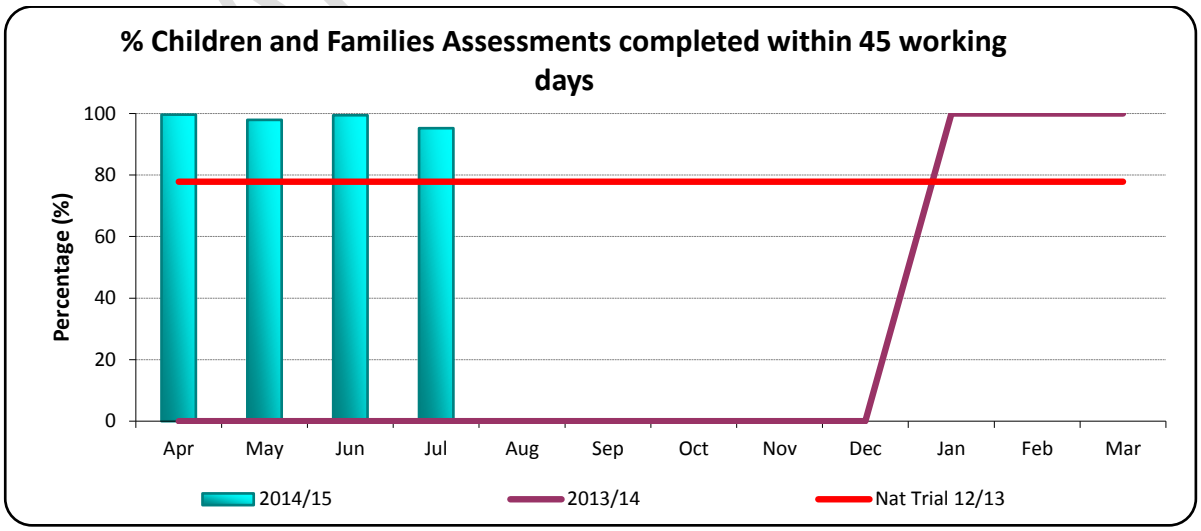
Figure 56: Volume of assessments completed per month



Source: Thurrock Council

As of July 2014, 98.5% of assessments are completed within the 45 day timescale. However, it is important to note that timeliness performance shows a declining trend month on month since April, and was 95.2% in July. There are no national or comparator council performance averages to compare our performance with, and the release of national 2013/14 data will provide the first set of data for benchmarking in this area. However, we are able to provide an indicative comparison against the 2012/13 national Children and Families assessment trial average which was 77.8%. Thurrock therefore remains significantly better.

Figure 57: Proportion of assessments completed within 45 working days



Source: Thurrock Council

What are we doing in Thurrock?

A new multi-agency model for delivering services to children and families in Thurrock was introduced in July 2014. This model incorporates the MASH (Multi agency safeguarding hub) and enhancing the Early Offer of Help.

Multi Agency Safeguarding Hub (MASH)

The MASH is a single point of entry for all referral, notifications and police reports in Thurrock and where there is a need for support or where there is a specific concern about the welfare of a child or a young person. It brings together a variety of agencies into an integrated co-located multi agency team; where information is shared appropriately and securely on children, families and adults around the child or young person in order to make timely and appropriate decisions. By working closely together across professional boundaries MASH will help to ensure early identification of concerns and provisions of help to families; which is vital in promoting children and young people's wellbeing.

MASH core agencies include:

1. Children Social Care (MASH screening desk)
2. Essex Police
3. Health
4. Troubled Families Programme Manager
5. Probation
6. Housing
7. Education Welfare (EWO)
8. Youth offending service (YOS)
9. Independent domestic violence advocate (IDVA)

MASH satellite agencies include:

10. Adult services (Community solutions team linked to the Adult Safeguarding team)
11. Link to SEPT - Community mental health services (CMHT and CAMHS)
12. Link to Education Psychologist (EP)
13. Link to children missing from education
14. Basildon hospital

Confidentiality:

MASH acts as an intelligence hub, in which each agency identifies what information they hold on a child/ young person and the adults around them. This process is initiated when the MASH Team Manager identifies the need for a MASH enquiry to commence. Each agency then assesses whether it is appropriate for their information to be shared (in line with the information sharing arrangement) with partners in the hub as well as outside of the hub. A risk assessment is undertaken on those cases where there are concerns about child sexual exploitation, and an

agreement will be made collectively on the best course of action for that referral. The information sharing document is published on the Thurrock council website.

Thurrock's Early Offer of Help:

Linked as a function to the MASH is the Early Offer of Help, which is designed to ensure that children and families receive support if they do not meet the threshold criteria for support through statutory social work services, (i.e. section 17 or 47) or are stepped down from children's social care services. Situated in the hub but with a very specific early intervention role is a Locality senior practitioner (x3 in post and who will be rotating on a weekly basis connected to both the MASH and area Localities) and a CAF coordinator. The aim of the early offer of help is to offer appropriate help, which ranges from offering advice and information to parents, carers and partner agencies, signposting families to appropriate services, including parenting support services. The link with a senior practitioner in the MASH and within the Early offer of help service will not only make it easier to get the right help for a child or young person but ensures the help they receive is holistic, well-coordinated and efficiently delivered so that everyone involved has the best possible experience of getting' and 'receiving' help from Thurrock partners.

The ethos of early intervention has been given greater impetus due to the Graham Allen MP report into it. This is also supported by Munro.

Locality based services

Locality teams are multi-disciplinary teams providing early intervention and prevention services for children, young people and families across Thurrock. There are three locality teams in Thurrock East, Central & West. These teams support families where they do not meet the threshold for statutory intervention but require support or where cases are stepped down from Social Care to provide ongoing support to families. This aspect of the Early Offer of Help Strategy is key to delivering earlier intervention and avoiding costly interventions with Children's Social Care. A multi-agency approach is adopted with a senior practitioner heading the teams providing a crucial social work input to the area. The teams are positioned strategically across the area to offer a wide range of services through a single point of contact and have multi-agency management including Health and Social Care. Work in the service area is focused on whole family engagement, assessment and intervention for children and young people aged up to 19 years. It works to promote collaboration with families and a range of partners to give support when it can make the most difference.

Locality teams include:

1. **Evidence-based parenting -** These parenting programmes have been extensively researched and have a solid international reputation. They are proven to have positive outcomes for families.
2. **Funded day care -** This provides support for families, so they are able to access other services. Places are requested by a professional working with the family and provision is purchased from providers with whom there is already a contract.

3. **Children's centres -** Children's centres will link closely to the Locality based services. They are places where children up to 19 years of age and their families can receive seamless integrated services and information, and where they can access help from multi-disciplinary teams of professionals. The Public Health Outcomes Framework for children's centres specifically focuses on supporting both parenting practices and child development.

Data for the new locality teams is not yet available since they only became operational recently. However data is available for 2013/14 in respect of the previous MAGS service:

- In 2013/14 there were 283 new referrals
- 153 cases were open as at March 2014
- The largest number of referrals came from the Lakeside and Central localities, however this is not necessarily representative of need since Tilbury and Chadwell saw the lowest number of referrals. There can be issues around effective use of these pre-statutory interventions and willingness for families to engage in what is a voluntary service.
- The largest volume of referrals was from schools with the next largest from Health Visitors
- Referrals were predominantly White British and not representative of the demography of Thurrock. Again there may be issues with some communities not willing to engage in voluntary interventions, despite considerable effort having gone in to increasing referrals.
- Two thirds of referrals were boys

A recent small sample of cases that has successfully closed evidenced that 90% of those cases were not re-referred to either the MAGS service or to statutory services.

Child and Family Assessment teams /Family support teams/ Adolescent support teams

The child and family assessment team now receives its work directly from the MASH and undertakes assessments and S47 enquiries. The Adolescent support team also receives work from MASH where the issue involves a young person who has specific problems due to their behaviour. These teams undertake a child and family assessment and decide whether further social work is needed with the family and whether to progress the case if it requires a response as a Child in need or if there are safeguarding concerns whether there is a need for a multiagency child protection plan. Nationally published data about Children in Need shows that the rate per 10,000 0-17 population in England increased by 26% between 2008/09 and 2013/14, with over two thirds of local authorities experiencing an increase in numbers of CIN.

Troubled Families

The national Troubled Families programme focuses on families with worklessness, poor school attendance and anti-social behaviour as problem features. This is operated locally under the national descriptor and uses Programme Managers to work to support the lead professional for each family, as is identified in the early help model of delivery. Thurrock Council is committed to working with their partners to help those identified as meeting the criteria to turn their lives around with the appropriate intervention, advice and signposting of services. We want to ensure the children in these families have the chance of a better life.

As part of the Troubled Families programme, we will work to:

1. get children back into school
2. reduce youth crime and anti-social behaviour
3. put adults on a path back to work
4. reduce the high costs these families place on the public sector each year

Troubled families workers are also located in the MASH to pick up families that meet their criteria. This is a "payment by results" programme and as at August 2014 Thurrock has claimed for 136 families. Thurrock's Troubled Families are currently working with their 3rd year cohort and the programme is becoming fully embedded into services within the local authority. This government has extended the programme from 2015 for 5 years with initial funding agreed for 2015/16.

Targeted youth work

The youth work team delivers a number of targeted projects aimed at reaching those young people deemed with the most need. The team works with internal and external partners such as:

- MASH
- Troubled Families
- YOT
- Social Care
- Thurrock Careers
- Catch 22
- Alternative Education Centres
- Schools and Academies
- Young Carers

to identify young people who need further support in their personal and social development. A referral is then made to the team identifying the young person's areas of development, and a young person is then referred onto a youth work project that aims to achieve the required outcomes. If for instance a particular need is identified, a project targeting specific issues will be delivered and young people are referred onto this project through the team's links with internal and external partners. The youth work team also makes its own referrals to its targeted projects.

The team's targeted provision includes:

- *The Goal Project* – this is a 12 project aimed at developing the personal and social skills of disengaged young people by using football as a learning tool. This project had a weekly slot at the PSS as well as being delivered at The Gateway Academy, Hassenbrook Academy and to Thurrock Young Carers.
- *Street Football Project* – this project is aimed at engaging young people into positive activity and steering them towards positive pathways. The project delivers 9 hours a week of football to young people in targeted areas in Thurrock. The sessions take place in ball courts, parks and school fields.
- *Re:Cycle* - the re:cycle project is a 12 week project aimed at developing transferable skills to young people. Young people learn the basics of bike mechanics whilst stripping

down and building back up a recycled bike. At the end of the project young people get to keep their bike which they can use as a form of transport as well as a means of keeping fit and healthy.

- *ID Project* – this is aimed at developing the self-esteem of young people through exploring different communities and values in a youth work setting.
- *Girls Group* – this is a 12 week project aimed at developing the awareness of the social issues young woman may face.
- *Extreme 360* – The E360 project is a project that uses extreme sports to develop young people's personal and social skills.
- *Project ME* – A 12 week project for 16-19's who are currently NEET. This project will support young people's next steps into employment or training by breaking down barriers and building skills to use in the workplace.

The team also delivers targeted provision in the school holidays; for example the summer holiday activity project provided activities to over 100 targeted young people. The activities included white water rafting, laser tag, grangewaters, and the Royal Opera House. *Soccability* sessions are also offered at the special schools in the borough and summer holiday provision at the Sunshine Centre.

Recommendations

- Review the implementation of MASH and monitor impact on children and families
- Review the provision of services to families and ensure they meet local need and demand following the JSNA.
- Further work to take place to evidence the reduction of demand on statutory services and impact on numbers of open CIN, CP and Looked after children

Children subject to a Child Protection Plan

Children and young people that become subject to Child Protection Plans do so because they are considered to be, or likely to be, suffering significant harm. Any child or young person under the age of 18 can be subject to a child protection plan in order to safeguard them from significant harm. The *Children Act 1989* introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

Working Together to Safeguard Children (2010) describes four broad categories of abuse:

- **Emotional abuse** - persistent emotional maltreatment of a child which is likely to adversely affect their emotional development
- **Physical abuse** – any treatment of a child or young person which causes physical harm to them.
- **Sexual abuse** - involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening
- **Neglect** - persistent failure to meet a child's basic physical and/or psychological needs

It should be noted that some level of emotional abuse is involved in most types of ill treatment of children.

There are some key factors that are often found in cases of abuse and/or neglect, and whilst their presence is not proof abuse has occurred, they must be regarded as indicators of possible significant harm. These include:

- **Deprivation** – many families face unemployment, financial hardship, social isolation, and other problems associated with living in disadvantaged areas. Children and young people from deprived backgrounds are at greater risk of experiencing poorer health, development and educational outcomes than their peers
- **Family circumstances presenting challenges for children, such as substance abuse, mental health problems or domestic violence** – poor parental health may affect parents' ability to look after both themselves and their children. **Parenting experiences** – some adults have negative childhood experiences which may impact on their parenting skills.
- **Parental learning disability** – parents with learning disabilities may impact on their ability to care for their child, depending on their cognitive ability. This could manifest itself in poor decision making and lack of awareness around issues such as child safety, diet, hygiene and learning.
- **Unaccompanied Asylum Seeking Children and Trafficked children** - Many of these children will have suffered physical abuse on their way to the United Kingdom. The process of identifying these children and keeping them safe presents difficult challenges, especially as many of them will have complex needs.
- **Disabled children at residential special schools**
- **Children who have been privately fostered**

Working Together to Safeguard Children (2013) also outlines that professionals should be alert to the potential need for early help for children who:

- are disabled and have specific additional needs;
- have special educational needs;
- are young carers;
- are showing signs of engaging in anti-social or criminal behaviour;
- are showing early signs of abuse and/or neglect.

As a result of abuse and neglect, children and young people are at risk of a number of poor outcomes. *Working Together to Safeguard Children* (2010) includes a summary of the known impacts of abuse on children's health and development. These include:

- Poor mental health including disorders such as anxiety, depression, and eating disorders
- Participation in risk-taking behaviours such as substance abuse, youth offending and anti-social behaviour
- Impaired growth, poor emotional and intellectual development and poor social functioning
- Physical injury leading to neurological damage, disability or in extreme cases death

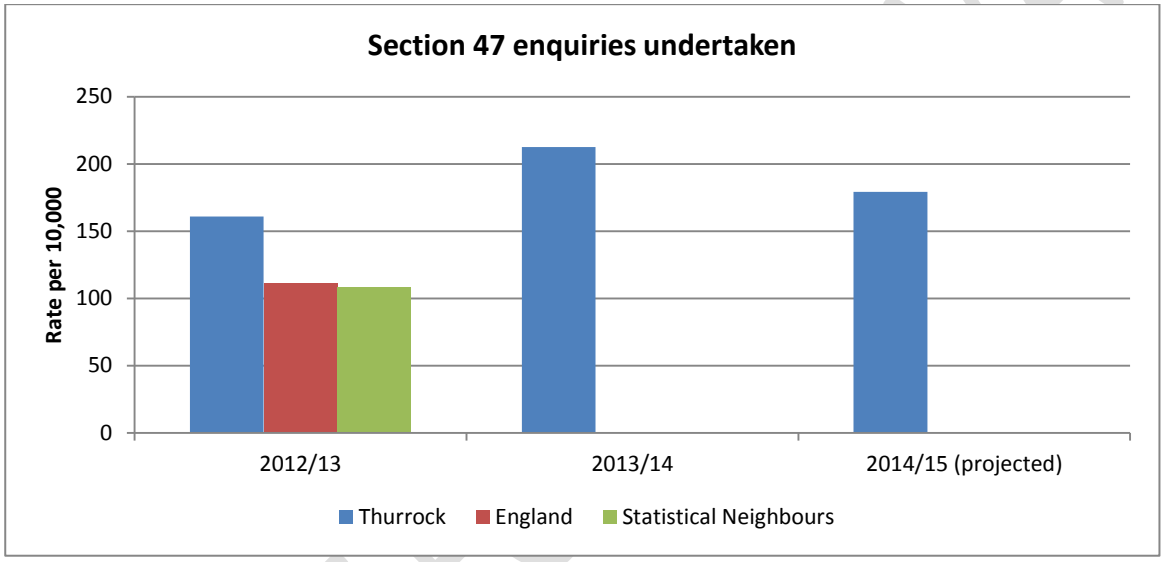
The Local Authority has a lead role as an investigating agency, statutory holder of cases for children who are subject to child protection plans and the agency responsible for initiating care proceedings whereby the court has considered the need for the Local Authority to share parental responsibility.

What do we know?

Section 47 investigations

The projected year end rate for 2014/15 of section 47 investigations per 10,000 population is 179.3. This would be below the rate of 212.6 in 2013/14 though remaining above the latest data for both national (111.5) and statistical neighbour areas (108.2).

Figure 58: Rate per 10,000 of section 47 enquiries undertaken

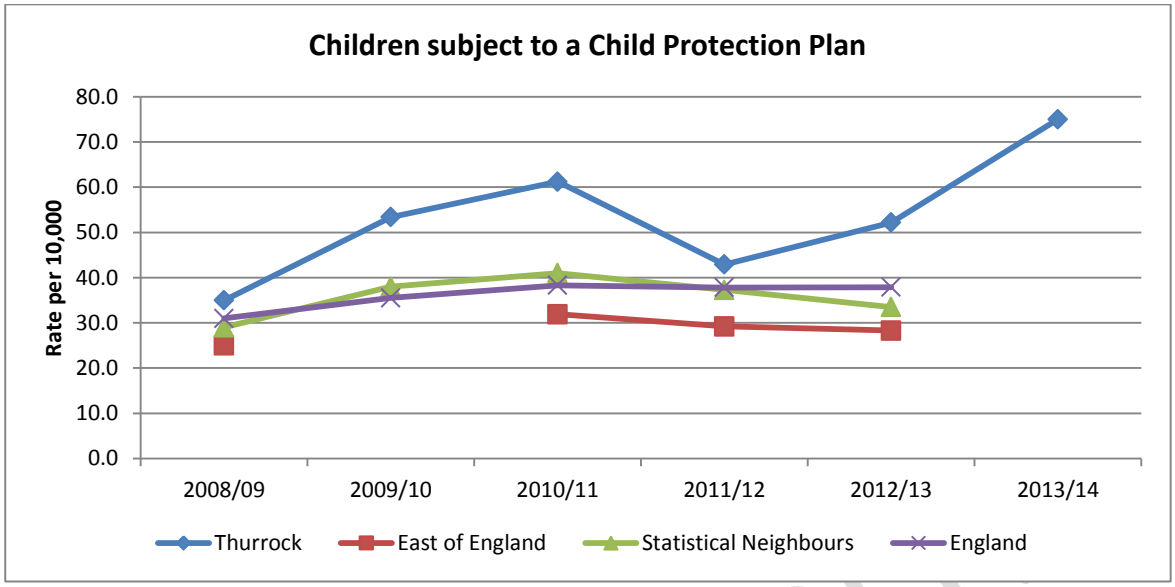


Source: Thurrock Council

Children subject to a Child Protection Plan

The rate of children subject to child protection plans had been on an upwards curve in Thurrock and continued to rise through 2013/14. The rate per 10,000 children in 2013/14 was 75 (288 children). This compared to a rate of 53 in 2012/13 – an increase of 41%. The rate also placed Thurrock significantly above both 2012/13 national (38) and statistical neighbours (34) averages. The trend can be seen in Figure 59 below.

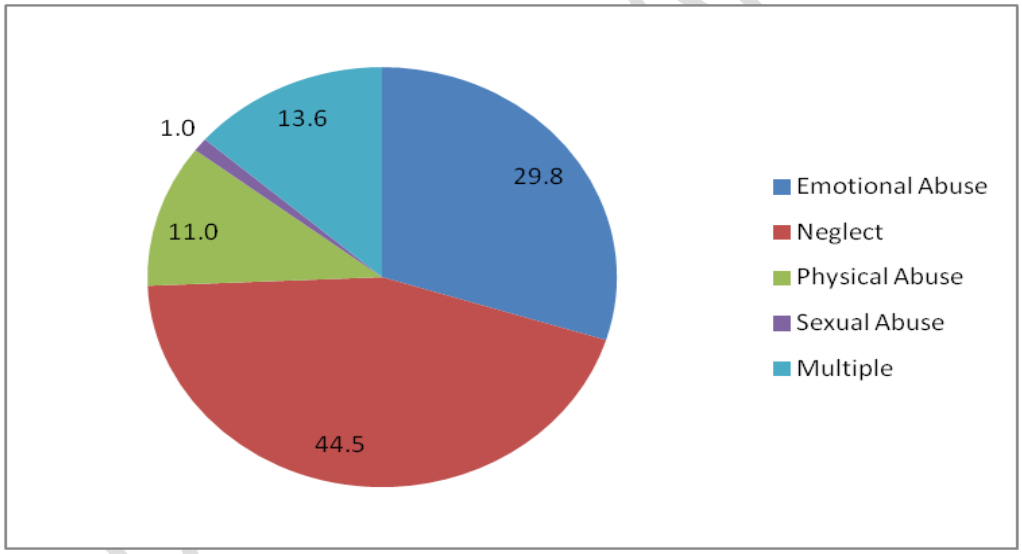
Figure 59: Rate per 10,000 of children subject to a Child Protection Plan



Source: Thurrock Council

When analysed by category of abuse, it can be seen that the most prevalent category of abuse is neglect (44.5%) followed by emotional abuse (29.8%).

Figure 60: Children subject to a Child Protection plan in Thurrock by category of abuse, 2014



Source: Thurrock Council

The gender split in 2014 is broadly even with 49% being males and 50% being females. Analysis of the age profile shows that the majority of children subject to plans are aged between 0-4 (45%) and 5-11 (43%).

What are we doing in Thurrock?

There has been considerable focus has been made on understanding why Thurrock has a higher level of S47 enquiries and children subject of a child protection plan and to explain the considerable rise in children being subject of plans. There has been a national rise in numbers

but this has been higher in Thurrock than in other areas. External scrutiny and internal auditing has been undertaken to review thresholds and evaluate decisions for s47 enquiries. These have generally found that thresholds are sound and enquiries undertaken appropriately. This work has specially considered those cases that have been on a plan for more than two years. This has resulted in a significant reduction in numbers of children subject of a plan in the last 6 months (April – Sept 14) This work is intended in the future to have partnership engagement to monitor children on plans for over 12 months to prevent drift and ensure effective multi agency working.

Thurrock had an inspection of its Youth Offending Service (YOS) in 2012, an Ofsted inspection of Safeguarding and looked after services (SLAC) in June 2012 and more recently an inspection of Fostering Services in March 2013. The YOS inspection rated the service as creditable, while the other two inspections found the service to be rated as Good.

Child protection and Child in need plans continue to be an area for further development to ensure that they are SMART and fully responsive to the family's needs to ensure positive outcomes. Work is underway to review the current Child protection conferencing style, taking advantage of the Transformation Programme to ensure that conference facilities are family-friendly and lend themselves to a Strengths-based approach to conferencing.

Thurrock has implemented a multi-agency Missing Children Panel which will incorporate those at risk of sexual exploitation. The panel tracks individual cases but has also contributed to identifying patterns of absconding and behaviour to minimise the impact of child sexual exploitation. The panel also monitors those missing from education and regular absconders. The multi-agency approach to this work has been seen as successful is being considered as a model across Greater Essex.

The E-Safety sub group from the LSCB has recently embarked on a series of "Roadshows" in partnership with Essex Police, reaching an audience of almost 5,000 students aged 9-11 across the Borough giving clear messages about the dangers of the on-line world. The roadshows have been well received and have generated further debate within the community, following some of the findings generated by a questionnaire completed by the students about their on-line habits. The proposal is to develop this forum further to include parents and carers.

Child Sexual exploitation has also been a significant focus, a county wide strategy has been developed with training being rolled out across the borough to 5,000 staff, making them aware of the signs of exploitation and how best to respond. A local strategy needs to be developed.

Parents of Children in Need, children on Child Protection Plans and those who do not met the threshold for statutory intervention and receive a locality based service (previously known as MAGS) have access to a wide range of services. This is primarily delivered through the Early Offer of Help (EOH) strategy which has a suite of commissioned services central to it. These include the following:

- Domestic violence perpetrators programme
- for women including a targeted 10 week programme and a universal drop-in service
- Sexual violence support for women who have suffered any form of sexual violence

- Drug and alcohol support programme – an intensive package of support that takes a whole family approach
- A range of parenting programmes
- Family Intervention Project (FIP) – an intensive package of support for families with multiple complex issues

These services were commissioned following a local needs analysis and using the 2012 JSNA. They are currently all well-utilised with some of the services slightly under capacity, partly due to awareness rather than need. Services are subject to continual review and a full analysis of impact will be conducted prior to any re-commissioning exercise.

In addition other support services exist:

- The current re-commissioning of the pan-Essex CAMHS service will see emotional well-being provision more widely available to children in need and those not known to statutory services. The current service only works primarily with looked after children.
- Mentoring and awareness programmes are in place for young people who are exhibiting risky behaviours or at risk of doing so.
- All children's centres across Thurrock support families via a range of support for parents and their children through early intervention and to avoid families escalating to statutory services. They also play a crucial role in supporting families that have been closed to Social Care but require ongoing support to avoid issues escalating in the future.
- The provision of a Substance misuse and mental health and a domestic violence worker within Children's social care ensures advice / assessment and referral on to appropriate services.

Recommendations

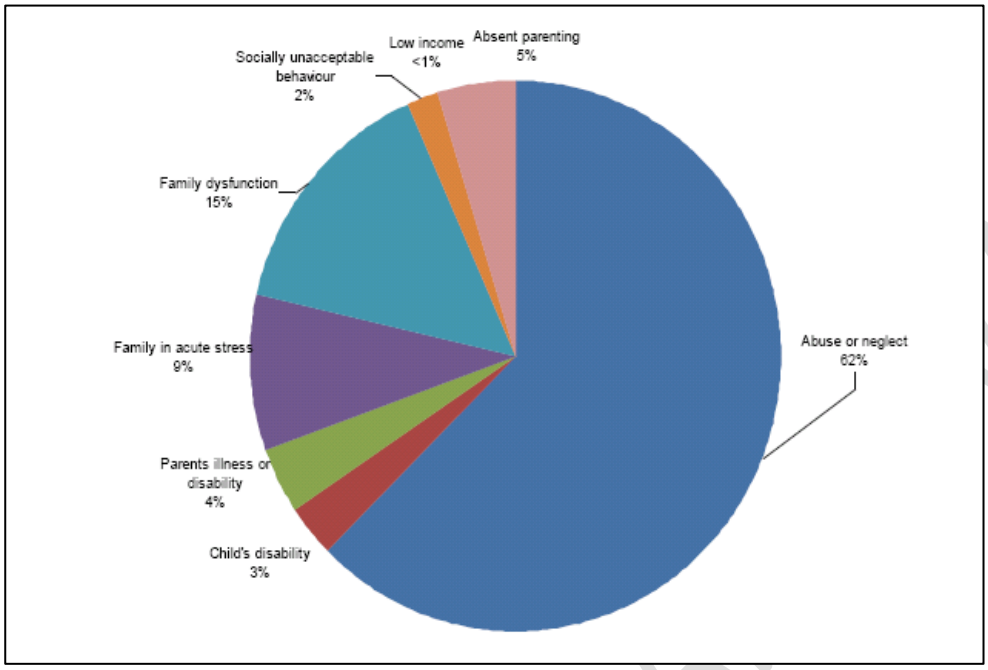
- Implement strengthening families approach to child protection conference process
- Develop a local CSE strategy and ensure the incidents of CSE are known and addressed across Thurrock
- Develop and implement a neglect strategy through the LSCB, especially addressing adolescent neglect
- Children subject of plans for over 2 years are monitored closely by a multiagency group.

Looked After Children

Looked after children and young people are particularly vulnerable by virtue of the fact that they are no longer living with birth family for a number of reasons. The majority of looked after children are provided with a service due to abuse or neglect. Some may be in care because of the illness or death of a parent. Others may have disabilities and complex needs. Most young people in care come from families who experience hardship and are separated from them because their family was unable to provide adequate care. Unaccompanied minors seeking asylum in the UK may also become looked after. In addition, a minority are in care because of offences they have committed. The reasons why looked after children are provided with a

service have been relatively stable since 2009. The chart below shows the reasons for a child to be provided with a service and the proportions of children looked after recorded in each category as of 31 March 2013.

Figure 61: Primary Need for a service, England as of 31st March 2013.



Source: Department for Education, 2013

In England as of March 2013 there were 68,110 looked after children, an increase of 2% compared to 31 March 2012 and an increase of 12% compared to March 2009.

Placement of Looked After Children

National data from the Department for Education indicates that the number of looked after children placed in foster care has increased by 16% since 2009. The percentage of looked after children cared for in foster placements was 72% in 2009, in 2013 it increased to 75%. There were 3,350 looked after children placed for adoption at 31 March 2013. This is an increase of 16% from 2012 and an increase of 25% from 2009.

Care Leavers (18+)

All local authorities have a duty to provide services to young people who were previously looked after and are leaving care. This is governed by legislation, such as the Children (Leaving Care) Act 2000 and subsequent legislation.

All local authorities have to provide information to the Government in respect to those young people who are not in education, employment or training (NEET) and their living arrangements as at the age of 19. As of 31st March 2013, there were 6,930 young people aged 19 who were looked after when aged 16. Of these young people, 2,360 (34%) are NEET. This is a decrease of 1% since 2012, reversing the upward trend seen in previous years.

According to the Department for Education, most young people now aged 19 who were looked after at 16 are in independent living arrangements (37%). This percentage has decreased over the last 5 years – in 2009 the percentage in independent living arrangements was 43%. The majority (88%) of young people are classed as being in suitable accommodation. There were 330 young people living with their former foster carers, this represents 5% of this cohort of young people and is a similar figure to that of 2012.

What do we know?

Since its creation as a Unitary Authority Thurrock Council historically had relatively low numbers of Looked After Children. However this profile has changed radically over the last few years, with a significant year on year rise, as can be seen below.

Table 13: Children in Care in Thurrock and England, 2009-2015. Data as of 31st March each year.

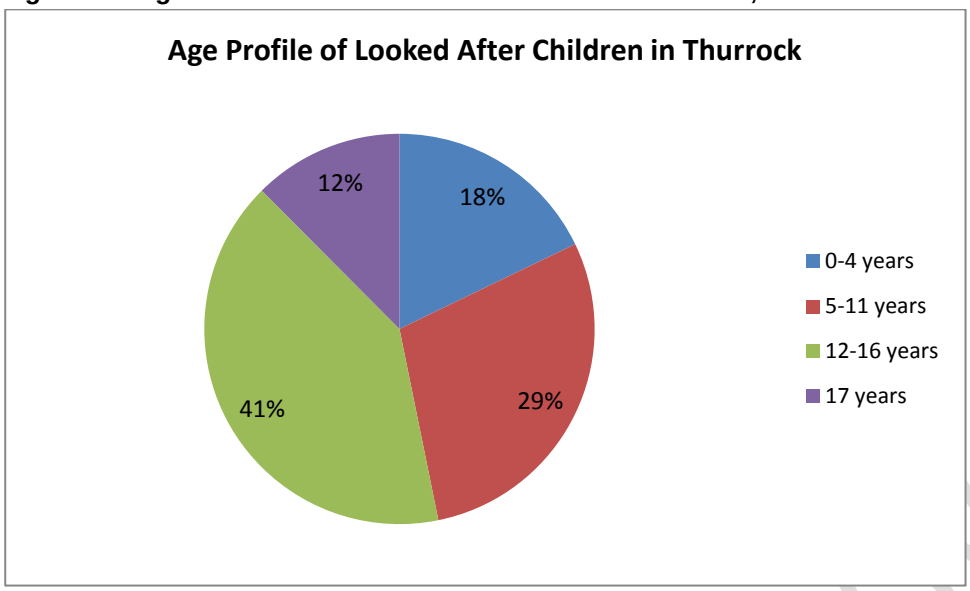
	2009	2010	2011	2012	2013	'14 proj	'15 proj
Total children in care (under 18)	**220**	**235**	**210**	**240**	**264**	**291**	**297**
Thurrock Unaccompanied Asylum Seeking Children (under 18)	25	35	20	24	19	17	18
Thurrock other (under 18)	195	200	190	216	245	274	279
Thurrock (per 10,000) (under 18)	**60**	**63**	**56**	**62**	**68**	**75**	**76**
England (per 10,000)	55	59	59	59	60		
Statistical neighbours (per 10,000)	58	62	63	65	67		

Source: Thurrock Council

Whilst it is anticipated that the ongoing development of our strategies for early intervention will begin to reduce the rate of looked after children per 10,000, which is currently well above the national average, this may to an extent be offset by the projected overall rise in numbers of children and young people.

As of 10th June 2014, there were 297 looked after children in Thurrock. The age groups of this population are shown in Figure 62 below:

Figure 62: Age Profile of Looked After Children in Thurrock, June 2014

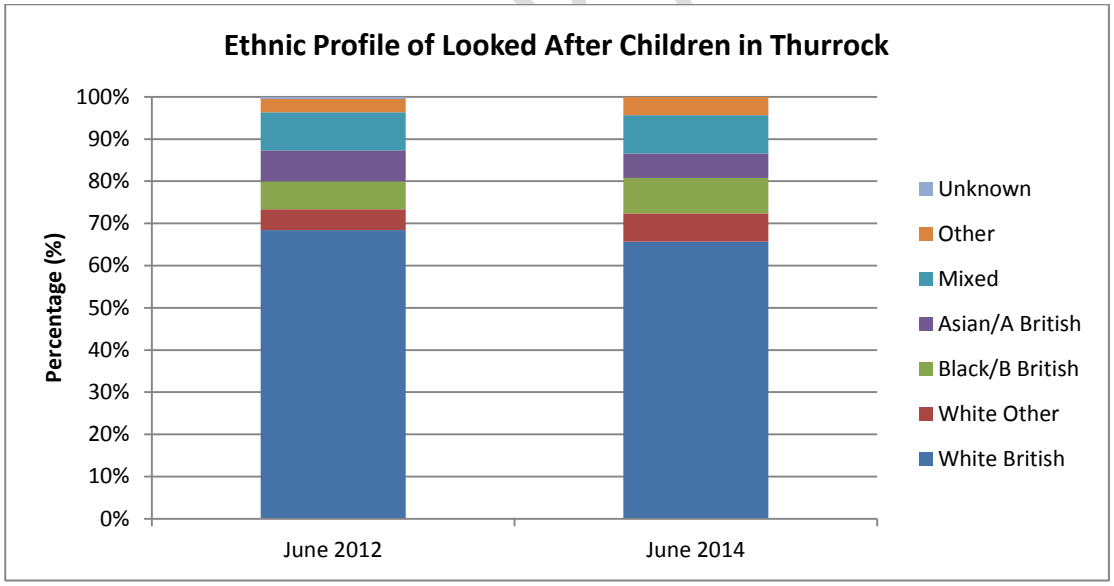


Source: Thurrock Council

Of the 297 children, 179 (60%) were male and 118 (40%) female.

The ethnicity of current children is as follows, and shows a relatively stable profile over the last two years:

Figure 63: Ethnicity of Looked After Children in Thurrock, 2012 and 2014.



Source: Thurrock Council

This suggests that at present there is reasonable consistency regarding the ethnic profile of Looked After Children in Thurrock. However the overall population profile has changed over recent years with a growth particularly in Black African and East European families. It is therefore reasonable to presume that these groups will become more heavily represented in the Looked After population in years to come.

<u>Placement of Looked After Children</u>

Of the 297 looked after children in Thurrock cited above, the spread of placements was as follows:

Table 14: Age of Looked After Children in Thurrock and type of placement.

Age of child	In house fostering	Independent Fostering	Residential	Other	Total by age
Under 1	7	3		5	15
1-5	19	20		10	49
6-11	30	35	6	2	73
12-15	30	39	21	1	91
16+	28	16	15	10	69
Total by provision type	114	113	42	28	297

Source: Thurrock Council

In total therefore 227 children (or almost 77%), were living in foster placements, 42 (or just over 14%) were living in a variety of residential provision, and 28 (9%) had other arrangements, such as living with someone with parental responsibility or currently placed for adoption. The total for in-house foster care includes 23 Family and Friends Foster Carers, some of whom were currently Temporarily Approved and undergoing assessment as Connected Persons.

Thurrock has been consistent in our relatively high use of foster placements over time; our performance has regularly been above the national average, which for 2012-2013 was 75%. However we have fared less well in our capacity to place within the boundaries of Thurrock Unitary Authority. Of the 297 placements, only 101 were within our boundaries and 196 were outside. However this needs to be seen in the context of our relatively small geographic area, and in fact of those outside, 127 were placed in the neighbouring or nearby authorities of Essex, Havering, Barking and Dagenham and Southend. It is also the case that a number of these placements were with in-house carers who have chosen to foster for Thurrock but live outside the Thurrock boundaries. 72% of Looked After Children in Thurrock were placed within 20 miles of the child's home address, which is slightly below the national average of 76% for 2012/13 but above the regional average of 67%.

Currently we have 42 young people in a variety of residential provision, such as Children's Homes and Residential Special Schools. However the cases of around 33% of these children are held within the Team for Disabled Children, although this team hold only 8% of all looked after children. This reflects their high levels of need, and consequent costs which arise in trying to meet them. Interestingly the average age of this group at 15.2 years is slightly above the average for all children in residential provision, which is 14.5 years. Recently published data by the Department for Education (Children's Homes Data Pack June 2014 Update) reports that the average age nationally for 2012-2013 was 14.6 years and that around 75% of young people in residential homes are between 14-17. Thurrock's profile at 78.5% is thus broadly in line with the national picture.

Given Thurrock's size and levels of demand it has not been considered economically viable to maintain our own directly managed residential resources and therefore the last remaining

children's home closed a few years ago. In this Thurrock is not unique and 51 other authorities are reported to have no provision of their own, although most do have at least one independent provider within their boundaries. This clearly increases the possibility that a child in a residential placement will be placed outside the authority, although we have some placements with local providers.

Care Leavers (18+)

Out of the 110 young people in Thurrock aged 19, 20 and 21 leaving care, 41% are NEET. 75% of the 110 young people are reported to be in suitable accommodation, which is lower than the national average cited above of 88%.

What are we doing in Thurrock?

Whilst it is anticipated that the ongoing development of our strategies for early intervention will begin to reduce the rate of looked after children per 10,000, which is currently well above the national average, this may to an extent be offset by the overall rise in numbers of children and young people.

At a time of significantly diminishing budgets, this will clearly place serious demands on the resources of the Council, and poses a major challenge in endeavouring to ensure that children are found appropriate placements when they are needed. The role of the Corporate Parenting Committee, which consists of Councillors, senior offices and other key people, oversee the work of the department's looked after children, through scrutiny and challenge.
A Placement Panel chaired by senior managers oversees the placements of all looked after children to again provide challenge and ensure that children are placed in the right placements for their needs, and a new Threshold to Care Panel began in September 2014 to ensure the best use of available resources to keep children in the community and out of the care system. The Panel will be chaired by the Head of Service.

A Looked After Children's Surgery has also been set up to look at all care plans for looked after children to ensure they are appropriate and robust.

Placements for Looked After Children

Thurrock's in-house foster care continues to be at the heart of our provision of placements, as reflected in the current distribution of placements. The service is made up of a number of constituent parts:

- Foster Care Support Team
- Therapeutic Foster Care Team
- Supported Lodgings Team
- Recruitment and Assessment Team
- Shared Care

As of 31st March 2014, Thurrock had a total of 98 fostering households, with a potential occupancy of 181 children. However it is recognised that because of needing to avoid

inappropriate combinations of children, or because carers are on temporary hold because of personal circumstances there will never be 100% occupancy. Nevertheless we attempt to make use of in-house foster carers wherever possible. At any given point a proportion of in-house carers will be from Friends and Family placements, sometimes still temporarily approved pending full assessment. These numbers can fluctuate significantly but represent a significant resource which reduces the demands on other carers.

Overall numbers of in-house carers have remained relatively stable, increasing only slightly, as although we have continued to bring in new foster carers through our Recruitment and Assessment Team, the age profile of our existing carers means that a proportion each year will decide to retire or otherwise resign because of changed personal circumstances. Our aim is to increase the pool of in-house carers for our children, identifying areas of specific needs and focusing recruitment activity in these areas.

Care Leavers (18+)

There is a specific team called the After Care Team that works with those young people who have left care and are entitled to a service under the current legislation. The team liaises and works in partnership with a number of organisations such as Education, Health (including Mental Health Services), Adults, Home Office, DWP, Housing and other local authority departments. Within the team there is a member of staff who has sole responsibility for accommodation, which means that he manages a range of accommodation that is used for this cohort of young people. He liaises with the Housing Department, attends a Panel that allocates supported housing, which is a partnership between Social Care, Housing and the Voluntary Sector, and is involved in the current changes with the benefit system and supporting young people to ensure they receive their entitlement.

The role of this service is to ensure that young people have a smooth transition to adulthood through attending reviews of looked after children from the age of 15 and over, advising social workers and carers about independent living and young people's entitlements once they reach 18.

The Council's Learning and Skills team provide 1:1 support for care leavers (16-24 years) to move into full time education or apprenticeships. Further information on this can be found in the Further Education, Employment and Training section.

Recommendations

In order to ensure we are targeting our placement resources most effectively towards those children who need to be in the care system, we need to develop more assistance to children and young people on the "edge of care". This includes reviewing the effectiveness of our work in returning children to their birth families where appropriate. For teenagers this may be channelled through our Adolescent Team, but for younger children we need to consider whether the services currently operating under our Early Offer of Help provision are being sufficiently effective. We also need to consider whether some work could be more successfully channelled through alternative providers, who may have an advantage of appearing more independent of the local authority, and we are piloting the use of an external organisation to facilitate the return home of a looked after child. Ultimately this could prove to be an *invest to save* opportunity. Similarly we should explore alternative opportunities such as Volunteers in Child Protection, which could be brought into the Early Offer Strategy.

Placements for Looked After Children

As in-house fostering will continue to be at the heart of our provision it is vital that we continue to expand our numbers through our marketing strategy. Our Thurrock Fostering Marketing Strategy 2012-2015 set out the following objectives:

- To increase the ratio of enquiry to approval to 7% in 2012/13 and 8.5% in 2013/14 and 10% in 2014/15.
- Identify which types of foster carers are specifically needed and target advertisements and information accordingly
- Increase fostering awareness to BME communities.
- To ensure the provision of foster carers matches the needs and diversity of the children and young people in care and increase the stability of placements (This includes therapeutic and supported lodgings placements).

These general objectives still hold good. However in terms of our specific needs we are clear that the issue of finding carers with capacity for sibling groups must be a priority, as is expanding our capacity in house to provide Parent and Child Placements which can support the authority's work in developing Community Based Assessments. We need to develop greater market management strategies, particularly in relation to 16+s. This applies both to new late entrants to the system, and those who have been with us some time and may need assistance to prepare for independence post 18. Aligned with this is the need to explore options for young people remanded into the care of the local authority, and developing some specific capacity within the in-house fostering service might be an option.

In addition Thurrock has a particular challenge in finding placements for Unaccompanied Asylum Seeking Young People. At the time these young people come to our attention there will usually have been only limited scope to complete the full age assessment, and we will have no real information about their background or circumstances. As a consequence we need to avoid placement with younger children, and have therefore identified some providers of semi-supported accommodation who can provide an immediate response. Although these work reasonably well we are often placing some distance away from Thurrock, making follow up work by Social Workers more difficult and time-consuming. A more local resource would therefore be valuable.

Care Leavers (18+)

- To continue to develop links with other agencies that provide services to care leavers, such as the DWP and Housing
- To develop and ensure there is a range of accommodation to suit the needs of our care leavers
- To provide training to others in regard to the needs of care leavers

Children With Disabilities

Children and young people with disabilities are a particularly vulnerable group in society. To reach their potential to make a positive contribution, children and young people with disabilities and their families need effective support from statutory health, education, social care and the voluntary services at the appropriate stages of their lives. Current financial pressures and the new national SEND reforms call for a more integrated, joint agency approach to ensure the best use of resources in commissioning these services.

Projections suggest the volume and prevalence of children and young people with disabilities may rise over the next 10 years. It is therefore important to ensure that the correct services are in place at an early stage to support those that are disabled and their families.

The primary equalities issue in relation to children with disabilities is the overrepresentation of families from more disadvantaged socio-economic groups amongst those affected by disabilities. Some of the causes of low birth weight, prematurity and perinatal complications leading to childhood disabilities are more frequent among economically disadvantaged families, even in a nation with well- developed welfare systems. Disability can also be a major contributor to material disadvantage and poverty. Families with disabled children are likely to have low incomes because caring for disabled children limits parents' earning capacity. In addition the costs for caring for a disabled child are greater compared with a non-disabled child.

What do we know?

1399 disabled children and young people have been known to the Team for Disabled Children in Thurrock since recording began in 1992, and 773 have been registered as disabled. As of August 2014, there are 233 disabled children currently open to the Team for Disabled Children in Thurrock. Of these children, the ward where the largest number live is Grays Riverside (21). When considering the nature of disabilities experienced by all 1399 children, it can be seen that the most prevalent types (where a type was recorded) are Autism/Aspergers (338), and Learning Disability (234).

Table 15: Nature of disabilities experienced by the 1399 previously known or open cases to Social Care, 1992-2014.

Category of Disability	Number
Behaviour or Conduct Disorder	53
ADHD	28
Emotional/Behavioural Difficulties	9
Sensory Disabilities	29
Communication	52
Consciousness	8
Diagnosed with Autism/Aspergers	338
Hand Function	11
Hearing	37
Incontinence	13
Learning	234
Mobility	139
Other DDA	102

Personal Care	31
Profound Physical and Learning Disabilities.	27
Vision	65
Not recorded	223

Source: Thurrock Council

What are we doing in Thurrock?

Early Years Services

There are a number of services for pre-school children with disabilities, including the Early Support Programme, Educational Psychology, Sensory Support, Portage, Sunshine Centre and School for Parents at Beacon Hill School. Early Support meetings and the identification of a Lead Professional ensure that Multi agency plans are developed and reviewed at the earliest point. Educational Psychologists play a key role in ensuring the needs of children are identified and assessed. Portage provides a range of home- based teaching services for children with significant developmental delays or complex needs. Sensory Support is provided via specialist teachers. The Sunshine Centre provides an opportunity for Pre School children to have access to additional stimulation via group work. The School for Parents supports carers of young children with complex physical needs.

Early Offer of Help

This is the provision of universal and targeted support that meets the needs of all children. However the Sunshine Centre offers targeted, early intervention and prevention via group work, befriending and support to access mainstream and universal social and leisure activities.

Social Care Services

Children and young people with disabilities between birth and 18 years are eligible to receive support from children's social care services. If their development is significantly impaired and they need to receive more personal care and supervision than a child without disabilities of similar age and circumstances. Parents and the Government have emphasised the importance of Education, Health and Social Care being joined up.

Short Breaks

Daytime, evening, weekend and overnight activities that provide a break for parents and an activity for children and young people are available via a number of organisations. These services provide sitting and befriending, group activities, individual support and residential stays. Engagement with parents has highlighted how much value is placed upon the short breaks provision and the role it can play in preventing family breakdown.

NHS Continuing Care Packages

Children and young people receive continuing care health packages to meet complex health needs including those with congenital conditions, those with conditions acquired as a result of accidents or illnesses and those that are approaching the end of their lives. These children and

young people often also have complex social and learning needs, which require additional social care resources and SEN provision.

Direct Payments/ Personal Budgets

Thurrock Council continues to promote the take up of Direct Payments. Since the introduction of Direct Payments to children in 2000, the number of families in receipt of them has increased.

In 2008/2009 there were 48 families in Thurrock in receipt of Direct Payments; the current total as of August 2014 is 82. The uptake of Direct Payments is concentrated in children and young people over 6 years of age. Proportionally few families with children under 5 years chose direct payments.

As Direct Payments are offered to all families who are eligible to receive support in this way, the numbers of families receiving them are likely to increase, particularly with the implementation of Personal Budgets via the Education, Health and Care Plans from September 2014.

Transition

The Thurrock Transition service sits within Adult Social Care. There is a team of 3 social workers and one deputy manager, and they are based within the Social Work Intervention and Transition Team. The Transition service supports all young people between 14 and 25 with eligible special educational needs.

The Team works with different agencies to plan and provide young people with the support they need. They:

- Attend school reviews if required to help young people at the age of 14 to start considering their long term ambitions and goals
- At 16 work closely with the Children With Disabilities Team to identify those young people with more complex needs and jointly plan for their future
- At 17 a transitions worker will be allocated and will assess using the adult social care eligibility criteria, ensuring smooth transitions across the services

The Team aims to:

- help young people to make the right choices and decisions with the support of their families
- provide young people with support and assistance to help them to maximise their education, training and employment potential
- help young people with impairments to live as independently as possible
- help young people to use leisure and recreation facilities
- Signpost families and carers and young people to local support services

Recommendations

Best practice suggests the following factors are important for the successful delivery of services for children with disabilities:

- Support that is tailored to the child and family.
- Early intervention and prevention of family breakdown
- Seamless and coordinated services across all agencies.
- Having a well-trained and confident workforce.
- Effective data collection and data sharing protocols across agencies
- Service users, individual agencies and providers treated as equal partners.
- Parents and Carers to influence strategy via co production.
- Ongoing Joint commissioning of short break services.

Children with Special Educational Needs

Children with Special Educational Needs and Disabilities (SEND) are children or young people who have a learning difficulty or disability which calls for special educational provision to be made for them. Their needs may include:

- Profound and multiple learning difficulty
- Behaviour, emotional and social difficulty
- Speech, language and communication needs

Children with SEN may experience a number of educational inequalities when compared with their peers; including lower levels of attainment, lower rates of sustained education, and higher rates of absence or exclusion (Department for Education, 2014). Evidence has shown that lower educational attainment can affect future achievements [further detail can be found in the Educational Attainment section]. Children who are not receiving adequate educational provision risk impairing their academic, personal and social development, which shape their life-chances and the contribution that they are capable of making to society. In addition, children who do not experience proper inclusion amongst their peers during school age risk longer-term difficulties within inclusion in society. Other outcomes that children with SEN are at higher risk of experiencing include: increased likelihood of teenage pregnancy, poorer mental health and increased risk of familial economic hardship – often a loss of income due to caring requirements is experienced (Boyle & Burton, 2004).

The prevalence of children with Special Educational Needs is not uniform across the whole child population. Findings from the Department of Education (2014) indicated that:

- **Boys are much more likely to have SEN than girls** (two and a half times more likely to have statements in primary school, and nearly three times more likely in secondary school)
- **Older age groups are more likely to have statements**
- **Pupils with SEN are more than twice as likely to be eligible for free school meals**

- **Black pupils are more likely and Chinese pupils are least likely to have SEN**
- **Almost 70% of looked after children have SEN** (compared with 17.9% of all pupils in January 2014)

The statutory processes for identifying and meeting the needs of children and young people with SEND has undergone significant changes with the introduction of the Children and Families Act 2014. (Department for Education, 2014)

The key changes in the way in which children and young people with SEND are supported in the new systems of SEND are:

- A unified Education Health and Care Plan (EHCP) bringing together support for all children and young people with SEND aged 0-25 years.
- A clear focus on the participation of children and young people and their parents in decision making at both an individual and strategic level.
- New duties on the joint commissioning of services bringing together Education, Health and Social Care commissioning to provide clearly joined up services based on the current and predicted future needs of the local population.
- A clear system of planning, identifying and disseminating information on services for all children and young people with SEND known as the Local Offer
- New arrangements for Personal Budgets allowing young people and parents of children with SEND to hold a personal budget to secure provision in the Education, Health and Care Plan.
- A clear focus on high aspirations and outcomes for children and young people with SEND ensuring a successful transition to adulthood.

What do we know?

As of 1st September 2014 there are 1,176 children and young people with Statements of Special Educational Need in Thurrock. The children and young people range in age from 3 to 19 years of age. The data showing the categories of Primary Need as identified on the child or young person's statement is shown in the table below.

Table 16: Statement of SEN by category of need

Category of Need	Number
Autism	243
Behaviour Emotional Social Difficulties	205
Hearing Impairment	22
Moderate Learning Difficulties	233
Multi-sensory impairment	3
Other	21
Physical Difficulties	83
Profound and Multiple Learning Difficulties	19
Speech Language and Communication Needs	212
Severe Learning Difficulties	29
Specific Learning Difficulties	28

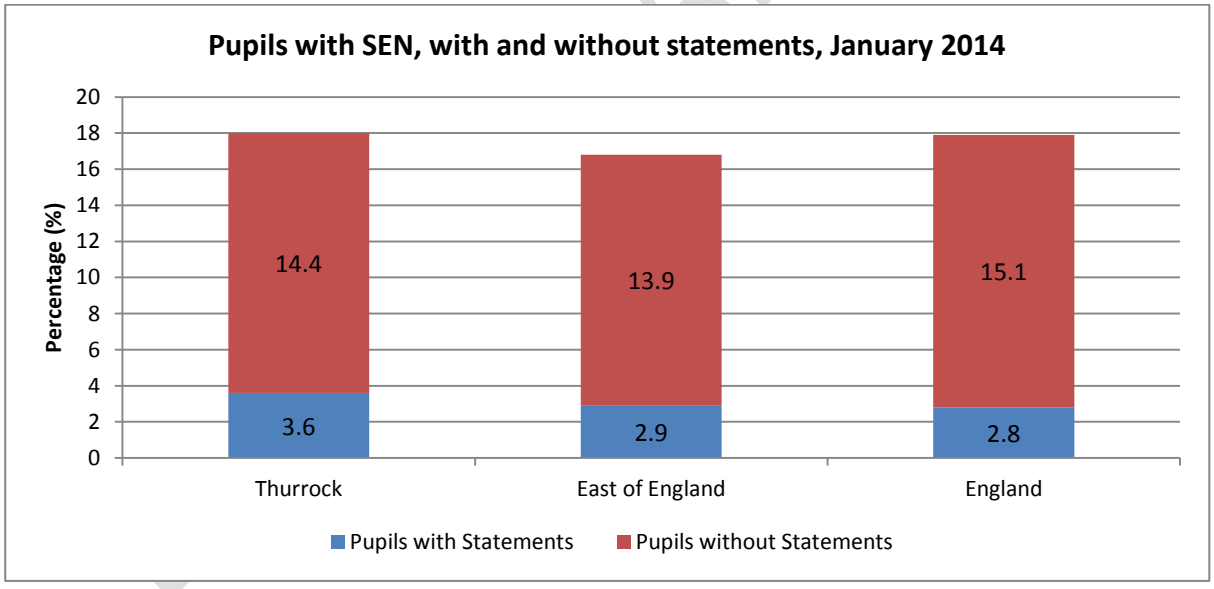
Visual Impairment	14
Not Specified	64

Source: Thurrock Council

The above table does not include young people who previously had statements for SEND but have left full time school education and transferred to a mainstream or specialist college. The statements for these young people would have ceased at this time under the previous SEND Code of Practice. These young people would have had a Post-16 Learning Difficulties assessment and support needs identified through this. The above table includes pupils who are over the age of 16 but have remained in schools such as special school post 16 bases.

When all pupils with SEN are considered, it can be seen that Thurrock has a higher proportion of pupils with SEN having Statements than the regional or national averages. This can be seen in Figure 64 below. On a national level, the proportion of pupils who have an SEN has been decreasing since 2010 (21.1%) and is largely due to a decrease in SEN without a statement. The continued decline in the number of children with SEN could be as the result of better identification of those children who have SEN and those who do not. This may have been as a consequence of the 2010 Ofsted Special Educational Needs and Disability review which found that a quarter of all children identified with SEN, and half of the children at School Action, did not have SEN.

Figure 64: Percentage of pupils with SEN in Thurrock, East of England and England, 2014



Source: Department for Education

What are we doing in Thurrock?

Mainstream Schools/ Settings / Colleges

Mainstream schools, settings and colleges have significant numbers of children and young people with SEND attending these facilities and being supported through their SEN services. Mainstream resources have worked closely with the Local Authority on the development of the new SEND arrangements and there are significant demands being placed on these mainstream services during the transfer of the SEN Statements to the new EHC Plans and the introduction

of new EHC Plans. Mainstream schools have identified particular challenges on ensuring that there is good communication and contact between Health services and schools in relation to planning support for children and young people's SEND.
It is anticipated that with the introduction of EHC plans for young people attending college and the continuation of these plans in college where needed, (as opposed to the ceasing of statements) there is likely to be a significant increase in demand for assessment and support services across Education, Health and Social Care agencies from September 2014.

Special Schools
Thurrock has two special schools, Treetops School for children with autism, and moderate learning difficulties and Beacon Hill School for children with severe learning difficulties and profound and multiple learning difficulties. Both of these schools are outstanding schools and have strong regional and national reputations for expertise in the education of pupils with particular Special Educational Needs.

There has been an exceptionally high demand for places in Treetops school for children with Autism whose parents wish to access the Applied Behavioural Analysis / Verbal Behaviour programmes run in the school. This has included families moving into Thurrock from other areas in the UK and from abroad. The very high level of demand for places has led to an increase in the number of places offered in the school in recent years and additional demands for all other services supporting these pupils and their families.

Beacon Hill School has experienced a significant change in the complexity and severity of complex needs of the pupil population. There is a significant increase in the number of children who have very complex health needs requiring a high level of nursing care, and exceptional vulnerability.

Resource Bases
Thurrock has the following resource bases located within mainstream schools for children with special educational needs:

Primary	**Places**
Dilkes Base for children with Emotional Social and Behavioural Difficulties	10
Lansdowne Base for children with Learning difficulties/ social communication difficulties	10
Stanford Le Hope Primary Base for children with Visual Impairment	5
Warren Primary Base for children with Hearing Impairment	14
Corringham Base for children with speech and language difficulties	
Secondary Age	
St Clere's Base for Hearing Impairment	11
St Clere's Base for Visual Impairment	6
Harris Base for Speech and Language/Autistic Spectrum Disorder	20
Ormiston Park ASCEND Base for Behavioural, Emotional and Social difficulties	15

In addition to the above resource bases there are a significant number of children and young people attending the Primary or Secondary Pupil Referral Units who have special educational needs and require access to services particularly with regard to emotional and mental health services.

Preschool Services

Thurrock has a well-established pre-school home visiting service, the Portage Service which supports parents of children with SEND both at home and with support activities hosted through the two special schools. The Early Support Programme also involves staff from both special schools and supports the identification and co-ordination of support for children with SEND and their parents. There are additional support services for children with Speech and Language needs through the ICAN Nursery at Chafford Hundred Primary school and additional designated nursery places at Stanford Le Hope Nursery. A significant number of pre-school children with SEND are supported in mainstream pre-school settings.

There has been a significant rise in the number and complexity of medical referrals (332 Notifications) to the Local Authority in recent years. The data for this is shown below.

Table 17: Medical Referrals by year

Year	Referrals
July 2006 – June 2007	*55*
July 2007 – June 2008	*65*
July 2008 – June 2009	*73*
July 2009 – June 2010	*77*
Jan 2011 – Dec 2011	*77*
Jan 2012 – Dec 2012	*115*
Jan 2013 – Dec 2013	*92*
Jan 2014 – Dec 2014	*110 (predicted)*

Source: Thurrock Council

Recommendations

- There is a need to ensure that all services supporting children and young people with SEND in Thurrock are clearly co-ordinated across Health, Social Care and Education in line with the joint commissioning arrangements set out in the SEND Code of Practice and developed in close partnership with parents and young people to ensure they meet the changing needs of the local population.
- It is important that services for children and young people of all ages work in co-production with parents and young people to identify gaps and key areas of service to ensure local needs are being met fully. The Local Parent Carer Forum can support this alongside agencies such as HealthWatch and other groups across the borough.
- The significant growth in numbers and complexity of young children with SEND will need to be addressed through ongoing support for services such as the Early Support Programme and close joint working arrangements such as the joint professional multi agency assessment work for pre-school children.
- The need for family-centred approaches and joint agency work as part of the new Education and Health Care Assessments will need to be taken into account in the delivery of all Health services to ensure full engagement of all staff in this.
- The significant need for access to timely support in the area of mental health needs of children with SEND will need to be addressed as part of the delivery of CAMHS services.
- The growth in the numbers of children with autistic spectrum disorders in Thurrock due to the outstanding local services and the increase in the complexity of medical needs at Beacon Hill school needs to be taken into account in the provision of local Health services both with regard to assessment and diagnostic services, nursing services and specific areas of service such as speech and language therapy services.

Young Carers

Young carers are children and young people under 18 who provide, or intend to provide, care, assistance or support to another family member who is disabled, physically or mentally ill or has a substance misuse problem. Young carers carry out both practical and emotional tasks on a regular basis, taking on a level of responsibility that is inappropriate to their age or development. It is also recognised that young carers are likely to be providing care or assistance that is not formally recognised by them, their carers, or professionals involved.

The 2011 Census identified that there were 166,363 young carers in England; however it is widely accepted that this is an underestimate. Many young carers remain hidden from official sight for numerous reasons, including family loyalty, stigma, bullying and lack of knowledge around support services. The Children's Society (2013) found that young carers are 1.5 times more likely than their peers to be from BME communities, and twice as likely not to speak English as their first language. They also found that young carers are 1.5 times more likely than their peers to have a Special Educational Need or a disability. Other characteristics identified by this research to be associated with young carers include a reduced median family income, increased likelihood to live in a household with no working adults, and increased likelihood to live in a household with three or more other children.

Although being a young carer can offer many positive experiences for young people and their family, it has been reported in national research and surveys that it can also result in negative outcomes. These could include:

- Mental health problems – these could arise due to anxiety for their loved one or due to neglect of their own needs
- Risk of isolation and bullying – young carers may find difficulties building and maintaining friendships, and could find themselves stigmatised
- Physical health problems – these could arise due to inappropriate lifting, or the following of an unhealthy lifestyle including poor diet and lack of exercise
- Risk of lower educational attainment – this could be due to absence due to their caring responsibilities, difficulties in completing homework outside of school, or anxiety. The Children's Society (2013) found that young carers have significantly lower educational attainment at GCSE level equating to 9 grades lower overall than their peers. This could impact on future achievement: the same research found that young carers are more likely than the national average to be not in education, employment or training (NEET) between the ages of 16 and 19.

Young carers who are well supported are likely to build resilience, build support networks and develop skills that will support them into adulthood.

What do we know?

The 2011 Census identified that there were 1,126 children and young people aged 0-24 years providing unpaid care in Thurrock, which corresponds to 2.17% of children in that age group. This is lower than the regional (2.28%) and national (2.54%) proportions. However, as highlighted above, this is likely to be a large underestimation.

Data supplied by the Young Carers services in Thurrock indicate that there are 50 Young Carers known to them that are between the ages of 4 and 8, and 412 between the ages of 8 and 18 (correct as of June 2014). Of those aged between 8 and 18 years, 305 are attending respite activities with the service.

What are we doing in Thurrock?

Thurrock has produced a Young Carers Strategy (2012) which highlights the need to recognise our young carers and include them in the services offered.

The Carers of Barking and Dagenham offer support to carers in Thurrock aged 8 and above. Services provided are:

- **Home Visit**- A home visit to the Young Carer and their family is arranged for every new referral made to get to know the young person and get an idea of their caring role. At this visit they are given the option to attend the respite activities.
- **One to One Support (ongoing)**
- **Respite Activities**- Activities run on two weekday evenings, Saturdays and throughout the school holidays. These can range from cooking, bowling, rolla disco, games & quiz night, jewellery making and many more.

- **Residential-** Depending on funding one or more residential stays a year may be arranged for Young Carers with a high caring role.
- **Opportunity to meet new friends (within activities)**
- **Training/Workshops-** Workshops are run such as stress & anger management training, Face 2 Face training (understanding their caring role), self-esteem training and many more.
- **Newsletter & Information Updates**
- **Volunteer Opportunities-** Some young carers feel they have grown out of the activities or have reached 18 but still want to be involved so they volunteer their time either in the office or on activities with the younger group.

Thurrock is one of very few authorities who also offer a separate service to Young Carers between the ages of 4-8, which is based at the Sunshine Centre in Tilbury. Two sessions are run each week on a booking-in system with up to 30 children attending. There is no formal structure to the sessions, as they are designed as opportunities for children to come and play and just have fun in the centre; however staff are available for any children wishing to speak about their home situation. The sessions also promote children to talk to each other, and often they open up and realise that they are not the only one in their position. The service runs occasional trips, such as a trip to a local farm, and also has good links with local charities and the rotary club who have donated funds to pay for taxis to transport children to the centre.

Recommendations

The provision of support to Young Carers aged under 8 years should be continued to give young children the opportunity for time away from their caring responsibilities and access to extra support should they need it. In addition, the service is seeking additional funding to enhance their offer of support to Young Carers who care for parents with mental health issues or substance misuse problems. The new Care Bill puts a focus on young adult carers (aged 18-25 years), and this group should be a priority going forward to ensure they have access to their own Carers Assessments.

Gypsy, Roma and Traveller Children

Children and young people from Gypsy, Roma and Traveller (GRT) communities have been acknowledged in multiple sources as a population experiencing inequalities in their health. Research (Parry, et al., 2004) has suggested that, when compared to the national child population, GRT children may experience:

- Reduced access to primary care services
- Higher rates of perinatal and infant mortality
- An increased likelihood of having conditions such as asthma or cystic fibrosis
- A lower life expectancy – national research has shown life expectancy for Gypsies, Roma and Travellers to be 10 years lower than the rest of the population
- Lower educational attainment and reduced school attendance, particularly at secondary level – linked to the culture of educating children outside of school (Wilkin, et al., 2010)

- Increased levels of stress and anxiety – potentially linked to a feeling of social isolation and stigmatisation, and also may result from repeated evictions
- Living in deprivation – often the GRT sites are situated in hostile environments deemed unsuitable for other development, and are situated away from local amenities or play facilities.

What do we know?

The latest data indicates that there are over 1,290 gypsy and traveller residents in Thurrock, living in 13 private sites, 2 showman sites and 3 council-run sites. Distribution is not uniform across the borough, with the majority of families residing in sites in the west of the borough. The largest site is Buckles Lane in South Ockendon, which is home to approximately 1,000 residents.

It is difficult to gain current information about the number of children registered with schools in the borough, as GRT is not listed as an ethnic category in the most recent school census figures. Data from the 2012 school census showed Thurrock to have 68 children with an ethnic group of Gypsy/Roma, which equates to 0.3% of all children for whom an ethnic group is known. This is above the national figure of 0.2%. However it should be noted that ethnicity is not recorded for all pupils, and the ethnicity for some GRT children may not have been recorded correctly.

What are we doing in Thurrock?

Thurrock Council runs the Thurrock Traveller Achievement Service (TTAS), which aims to work directly with the GRT community to address their needs. Their services include:

- supporting pupils that are highly mobile to secure access to school
- transfer to secondary school
- assessing pupil need and providing support
- sign-posting support agencies and offering to act as intermediaries

The TTAS bus travels between known traveller sites in the borough looking to engage with the GRT community, promoting initiatives and working with residents to address their issues. Some of the recent health campaigns that TTAS have been actively promoting within the GRT community include the SMILE campaign (oral health), Stoptober, flu immunisation and diabetes awareness. Feedback received indicates that these generated a lot of interest in the sites and resulted in numerous referrals to services and an increase in flu immunisations.

Recommendations

- Improved joint working between public sector organisations, voluntary organisations and GRT families to assist identification and addressing of community issues
- To ensure that local policies look to address the inequalities experienced in educational attainment
- Services should continue to seek and listen to the voices of GRT children and incorporate these into their future planning.
- Development of staff within education, health and social care organisations to ensure full awareness of the cultural barriers faced by the GRT community
- Supporting of an improved information collection system to ensure data held on the local GRT community is accurate and robust. GRT should be included as a category in all health records.
- To consider commissioning a Specialist Health Visitor with a clear remit for Gypsy, Roma and Traveller families
- To consider training of GRT Health Ambassadors sourced from within the communities who are able to teach health and social care skills to their community, and who can also work with the Traveller Achievement Service to ensure their needs are recognised.

Young Offenders

Young offenders (or those at risk of offending) are a highly marginalised group and often have greater health needs than the non-offending population, experiencing exposure to inequalities in health that persist into adult life, including a higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females.
The Crime & Disorder Act 1998 puts a statutory duty on local authorities and its partners to form Youth Offending Teams (YOT)/Services whose primary task is to reduce offending and re-offending by young people. Teams consist of professionals from Social Care, Probation, the police, Health & education. They work with young people aged 10-17 who have been either convicted in the Courts or have been made subject to a pre-Court outcome. Interventions can take place in the community or in the secure estate and are designed and implemented to address the risk factors that each young person presents. They also work with the victims of Youth Crime and manage restorative justice processes.
YOT prevention work focuses upon young people aged 8 to 17 years before they enter the criminal justice system but are presenting offending or anti-social behaviour.

The Youth Justice Board for England and Wales have established the following strategic priorities for 2014-2017:

- prevent offending
- reduce reoffending
- protect the public and support victims
- promote the safety and welfare of children and young people in the criminal justice system.

Research by the NSPCC has highlighted a range of risk factors that could lead to a young person becoming involved in crime and anti-social behaviour. These include:

- peer influence
- poverty and social exclusion
- parenting and family environment
- experience of abuse or neglect
- substance misuse
- mental health issues
- exclusion from school/poor educational attainment

Further research by the Youth Justice Board also indicates that unemployment and poor physical health could be risk factors for future offending.

What do we know?

There were 207 offences committed in Thurrock in 2013/14 that were known to the Youth Offending Team – 174 were committed by males and 33 by females. This is in line with national and adult data. The number of offences increases by age – this is shown in Table 18 below.

Table 18: Offences in Thurrock in 2013/14 by age of offender

	Number of offences
10-13 years	23
14 years	33
15 years	37
16 years	42
17 years	72
All ages	207

Source: Thurrock Youth Offending Service

The most common type of offence committed was Violence against a person, with 53 of the 207 offences falling into this category. This is in line with national and adult data.

Table 19: Offences in Thurrock in 2013/14 by type of offence

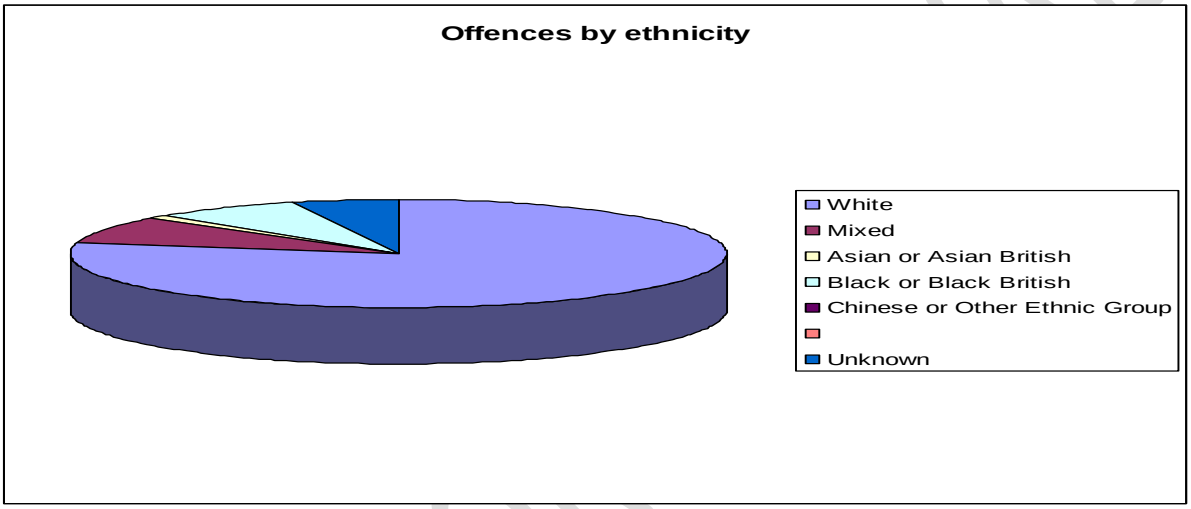
Offence	**Number of offences** (* Data has been suppressed)
Violence Against Person	53
Theft & Handling	39
Criminal Damage	21
Domestic Burglary	19
Drugs Offence	18
Breach of Statutory Order	13
Robbery	11
Vehicle Theft	7
Motoring Offences	6
Public Order	6
Fraud & Forgery	*
Racially Aggravated	*
Non Domestic Burglary	*

Other	*
Breach of Bail	*
Sexual Offences	0
Death or Injury by Reckless Driving	0
Arson	0
Breach of Conditional Discharge	0

Source: Thurrock Youth Offending Service

Figure 65 below shows the offences committed by ethnic group in Thurrock – this is in line with national and adult data.

Figure 65: Offences in Thurrock in 2013/14 by ethnic group



Source: Thurrock Youth Offending Service

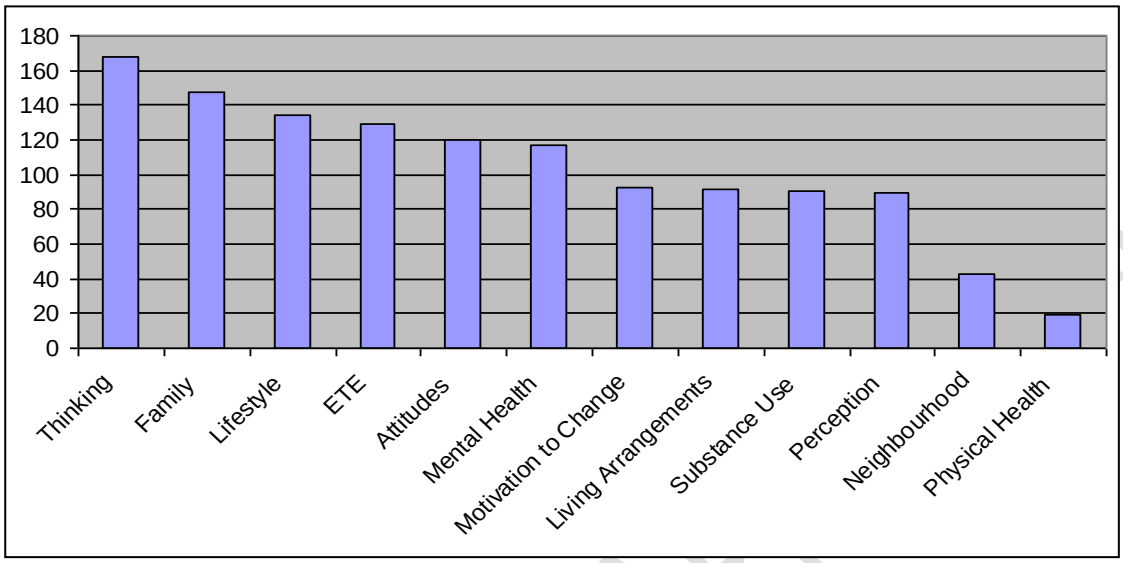
On average **29%** of young people who are subject to Court Orders in Thurrock are assessed as vulnerable and consequently are subject to Vulnerability Management plans. These vulnerabilities include issues concerning alcohol & substance misuse, self-harm, sexual exploitation, at risk of harm from others or their own behaviour and mental health. Additionally, **45%** of young people who are subject to Court Orders in Thurrock are assessed as presenting a risk of serious harm and consequently are subject to Risk Management plans. The identified risk factors include connections to serious youth violence and gangs, possession of offensive weapons, sexual offences and anger management issues. Some young people are assessed as both vulnerable and a risk of serious harm.

Education, Training & Employment (ETE) remains an issue with over **35%** of our client base not being in fulltime ETE. A high majority have identified behavioural or learning difficulties and are, or were, subject to Statements of Special Educational Needs as a result, with Attention Deficit, Hyper-activity Disorder being the most common.

The assessed generic risk factors for young people offending and re-offending in Thurrock indicate that the most common risk factor is thinking & behaviour, followed by family and personal relationships, emotional and mental health, education training and employment and attitudes to offending. The least common is physical health. An increase has been observed in young people presenting Emotional & Mental Health issues linked to their offending. However,

this may be due to the increase of increasingly robust services within the YOS which is ensuring that issues are identified and managed. There also may be a link to the increase of young people being supervised who have been involved in serious youth violence and the emotional issues it can instigate. This can be seen in Figure 66 below.

Figure 66: Assessed Risk Factors in Young Offenders in Thurrock, 2013-14



Source: ASSET Management Tool and Thurrock Youth Offending Service

Due to high migration from the London Boroughs Thurrock YOS is supervising a number of young people who have links to serious youth violence and gangs.

Thurrock Youth Offending Service report performance against a number of indicators, with comparisons to 'family' areas (YOTs within England and Wales of a similar size and budget) and national data. These enable a rounded picture of the service performance to be ascertained and areas of concern to be highlighted. Below are the indicators reported to Thurrock Council:

First Time Entrants			
	2011-12	**2012-13**	**2013-14**
Thurrock	-35% (69)	- 34% (67)	44
Family	-23%	-24%	Not available
National	-19%	-33%	Not available
Annually Thurrock continues to perform well in the reduction of first time offenders compared to the baseline figure (10-11), we are performing above the national and family average. The figure for 13-14 is the lowest we have ever had and could be a result of the extension and promotion of YOS preventative service. However only the final PNC outrun for 13-14 will fully evidence this (this will result in the percentage reduction on the baseline and is yet to be published).			

Source: Thurrock Youth Offending Service

Prevention			
	2011-12	**2012-13**	**2013-14**
Thurrock	91	40	44
Recidivism	28%	26%	0%*
Reduction %	+ 28%	-2%	N/A
* *Please remember that this data has a 3 month drag.*			

The year 12-13 saw a significant reduction in those referred for prevention services, this was as a result of the reduction of TRIAGE (referred by the police). Consequently in March 13 YOS re-introduced the Youth Inclusion & Support Programme – YISP). From a resource point of view it should be noted that TRIAGE is a short 28 day intervention, whereas YISP interventions can last up to 12 months, are more intensive & address specific identified risk factors.

Source: Thurrock Youth Offending Service

Re-Offending			
	2011-12	**2012-13**	**2013-14**
Thurrock	46%	43%	27%
Family	Not available	Not available	Not available
National	Not available	Not available	Not available
The final figure for 12-13 (reported on in Q1 13-14) shows a marginal reduction in offending on the previous year. Due to the reduction in FTE's & young people receiving outcomes in court the cohort for the 12-13 data was the smallest in Thurrock's history (42 as opposed to 61 in 10-11 and 138 in 9-10). As mentioned, this is a result of the prevention agenda from both the YOS and the police. Therefore, by the time young people meet the criteria for the cohort their offending has often become entrenched and they are at high risk of offending.			

Source: Thurrock Youth Offending Service

Court Disposal			
	2011-12	**2012-13**	**2013-14**
Thurrock	201	184	158
Despite the initial drop in the number of Court disposals as a result of TRIAGE, Community Resolutions and the political change (in 10-11 the annual figure was 369), numbers now seemed to have bottomed out and the outrun at three quarters through the reporting period 13-14 is in line with the previous two years. The YOS has adapted it's service to address this with the reduction in core case managers and an increase in prevention services.			

Source: Thurrock Youth Offending Service

Use of Custody			
	2011-12	**2012-13**	**2013-14**
Thurrock	11%(18)	10%(14)	6%(8)
Family	Not available	Not available	Not available
National	Not available	Not available	Not available
*As a result of community solutions and the success of TRIAGE in greatly reducing the first time entrants to the youth justice system in Thurrock (a reduction of 40% on the 2010 cohort), the reduction in those appearing before the Courts & undergoing sentencing has greatly reduced (see below) & those that are appearing for sentencing are therefore the more serious & persistent offenders and at higher risk of a custodial sentence. Additionally the lesser crimes are now being dealt with by the prevention/pre-Court disposal and can no longer be used to counter balance custodial sentences. This is reflected in the figures above (*young people v percentage).*			

Source: Thurrock Youth Offending Service

Education, Training and Employment			
	2011-12	**2012-13**	**2013-14**
Thurrock	65%	64%	65%
Family	70.9%	Not available	Not available
National	72.8%	Not available	Not available
Young people completing orders who are in full time Education, Training & Employment has been relatively static for a number years, despite numerous interventions by the YOS to address it..			

Source: Thurrock Youth Offending Service

Thurrock has the smallest YOS in the country and enjoys good value for money indicators. The most recent inspections in January 2012 from the Care Quality Commission and HMI Probation had positive outcomes, with the subsequent action plan having been fully implemented. Feedback from the Youth Justice Board has suggested that they are pleased with the current performance of Thurrock YOS.

What are we doing in Thurrock?

Mental Health: Thurrock YOS has two fulltime practitioners from the Children & Adolescent Mental Health Service who work with young people sentenced through the Courts and those subject to prevention interventions. Every young person's emotional & mental health is screened by a YOS case manager and if they present as medium risk or above they are referred to the CAMHs practitioners for a full assessment and then an intervention if deemed necessary. CAMHs practitioners will also oversee every initial assessment and give advice in respect of core interventions.

Substance Misuse: Despite previously employing a full time substance misuse worker in YOS, we now refer and facilitate interventions by Thurrock YP substance misuse service – *Wize-Up*. In 2013-14 over 8% of convictions were in relation to possession or possession with intent to supply of illegal substances but the use amongst our clients base is far bigger. However, whilst this can increase other risk factors it is rarely the sole reason for their offending. The use of class A drugs is rare in young people in Thurrock, but there were a number of convictions of young people dealing crack & heroin in 13-14.

Serious Youth Violence: Since the appointment of a Senior Officer with a specific responsibility for Serious Youth Violence and high risk cases, there have low levels of re-offending and thus far no serious incidents. Thurrock are also part of the Serious Youth Violence Group with partners in Community Safety and the police. Local programmes such as *The Prison group* and *Streetwise* look to address high risk offenders, serious youth violence and weapons awareness.

Prevention work in respect of Youth Inclusion and Support takes all of its referrals from schools via the MAGS panel. We also link closely with the Thurrock Schools Police Officer (now called a Youth Officer). Additionally we have extended our prevention service to offer interventions within local schools.

Recommendations

The major issues and future risk factors for Thurrock are the continued increase in migration from the London boroughs, especially in relation to the management of young people who have been involved in serious youth violence. The increasingly diverse population and consequent increase in the BME population will result in changing risk factors and a change in interventions and supervision will be needed to meet these. With the increase of young people involved in gangs comes the increased risk of sexual exploitation and the increase in vulnerability and safeguarding which has been evident over the preceding years. The strategy to manage this risk is more partnership working and form working relationships with the London boroughs which are the sources of the migration. Additionally, although it is not yet presenting itself, there may be an increase in substance misuse issues specifically related to Class A addiction in young people.

Children experiencing sexual violence

Sexual violence can take many forms, mainly: rape, sexual assault (including intimate partner violence), childhood sexual abuse, sexual harassment, stalking, female genital mutilation (FGM) and sexual exploitation, which is increasingly becoming focussed on grooming children and young people on-line. National research by the NSPCC (2014) and (2013) shows that 34% of children under the age of 18 who experienced contact sexual abuse by an adult did not tell anyone about this, and 82.7% who experienced contact sexual abuse from a peer did not tell anyone. The issue is therefore significantly under reported across the UK. Based on national research, where young people had experienced a positive disclosure there were three key elements: a.) the young person felt believed; b.) the young person had some kind of emotional support; c.) young people wanted someone to notice when something was not right, someone to ask when they have concerns and someone to hear them when they do disclose.

There is no nationally comparable data for access to specialist sexual violence services; however it is recognised that there are significant shortfalls in sexual violence services for both children and for adults across the UK.

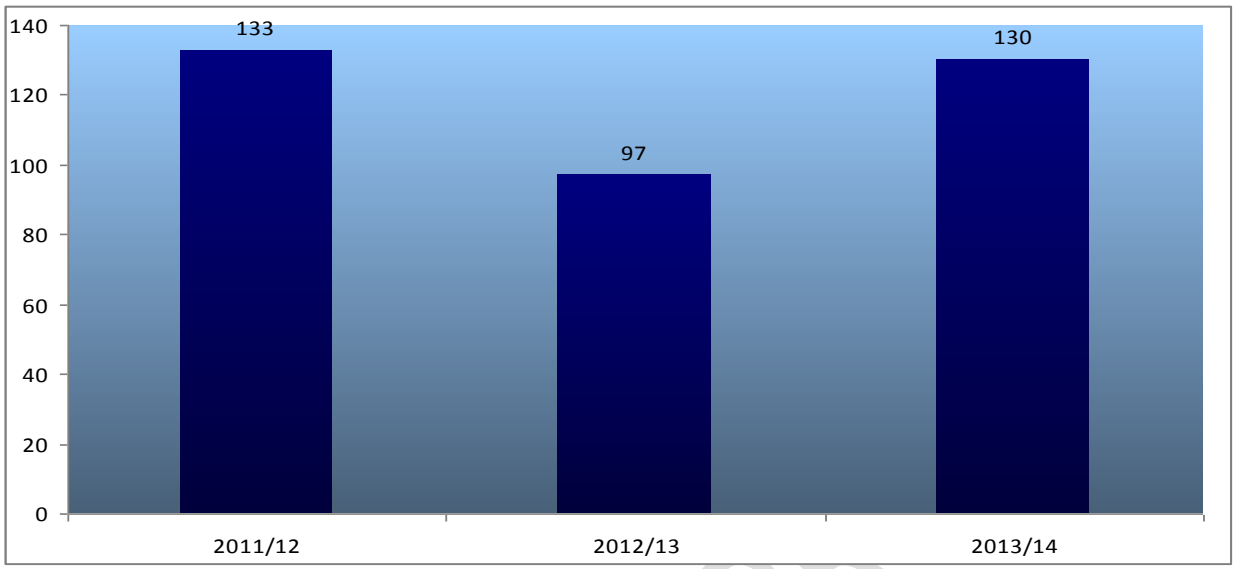
What do we know?

Data from South Essex Rape and Incest Crisis Centre (SERICC) shows that the breakdown of perpetrator relationship is: 35.2% male relative; 6.8% partner or ex-partner; 8.0% friend; 9.1% friend of family; 15.9% acquaintance; 12.5% stranger; 4.5% professional; 8.0% multiple (i.e. gang rape) in 2012/13.

It should be noted that there is currently no collection of local data for FGM prevalence.

SERICC reported that 130 young people accessed services in 2013/14, which is an increase from 2012/13. However, taking the national research into consideration, the actual need for services could be as high as 751 young people, based on the fact that 82.7% of those experiencing sexual abuse nationally did not report it to anyone. Figure 67 shows the number of young people accessing services in Thurrock by year.

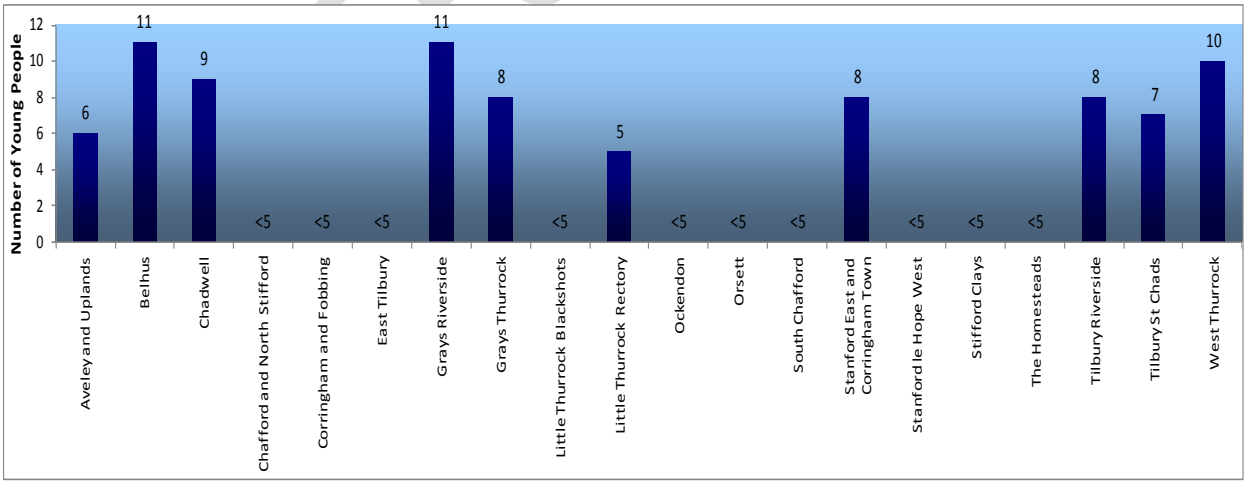
Figure 67: Number of young people (13-21 or <25 with learning disabilities) accessing specialist sexual violence services in Thurrock, 2011/12 to 2013/14.



Source - South Essex Rape and Incest Crisis Centre (SERICC)

Locally there is a relatively equal distribution of referrals by ward, although there are seven wards where prevalence (based on access to services and not necessarily need) is slightly more prominent: Grays Riverside, Belhus, West Thurrock, Chadwell St Mary, Tilbury Riverside, Grays Thurrock and Stanford East & Corringham Town.

Figure 68: Breakdown of young people (13-21 or <25 with learning disabilities) accessing specialist sexual violence services in Thurrock by ward 2013/14



Source: South Essex Rape and Incest Crisis Centre (SERICC)

The primary ethnic group is White British at 91%; however this may not be representative of need.

Over three quarters of under 18's that local services work with are where there has been childhood sexual abuse with the next significant category being rape. From the 18-21 (25 if young person has learning disabilities) years olds around half of young people that local services work with are where rape has taken place. The current trend demonstrates a decrease in the age group for referrals for the local 'young person's sexual violence counsellor service'.

What are we doing in Thurrock?

The local response is delivered primarily via a charitable organisation, SERICC (South Essex Rape and Incest Crisis Centre). The organisation works with young people through a counselling and advocacy service. Services are however usually at capacity, and whilst service users are never refused access, the continued increase in demand will inevitably see waiting times lengthen. The organisation also works to raise the issue with professionals and within schools, when funding permits.
The Local Safeguarding Children's Board (LSCB) has delivered child sexual exploitation sessions to years 5 and 6 primary schools in Thurrock. This work is helping to raise awareness for young people and is continuing need, rather than a one off exercise.

Recommendations

- Further community awareness raising - young women who are asylum-seeking, migrant, not eligible and have no recourse to public funds, BME communities, disabled or who have mental health issues, all face additional and sometimes significant barriers to accessing services.
- Awareness raising and training for agencies such as police, health and schools with the desired outcome that more cases are reported and young people are believed and supported when they disclose.
- Increased capacity in therapeutic services to support young people.
- Improved data collection and sharing procedures

Accidental Injury and Death

Infant and Child Mortality

Infant mortality is defined as the death of a child in the first year of life, and is quantified as the number of babies born alive, who die in the first year of life per 1,000 live births. There is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation's health as well as a predictor of health inequalities. Low Birth Weight is also linked with premature death or poorer life outcomes. On a national level, there are large inequalities in infant mortality rates between ethnic groups – Caribbean and Pakistani babies are more than twice as likely to die before the age of one as White British or Bangladeshi babies. This may be due to a higher prevalence of preterm birth and congenital anomalies in these groups; however more research is needed into this area. Deaths in childhood are very rare but can be used as an indicator of child health. Nationally,

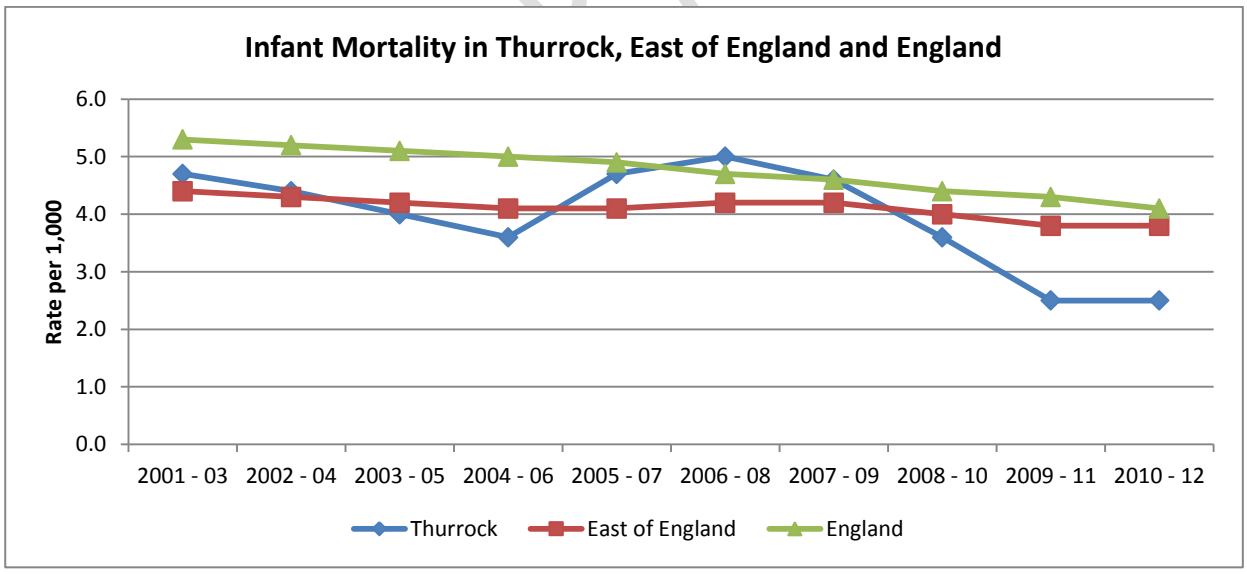
numbers and rates of death among children aged under five years have been falling, but despite this reduction nationally, deprivation is still linked with higher mortality for deaths after the neonatal period. Beyond the 5-9 age group, male mortality exceeds female mortality, with the difference becoming greater in later childhood and young adulthood.

According to the Office for National Statistics, the leading cause of death for children aged 1-4 years was congenital malformations, deformations and chromosomal abnormalities (14% of boys, 16% of girls). These conditions are usually present at birth or develop shortly after, and include congenital heart defects. These conditions were also the leading cause of death for girls aged between 5 and 19, accounting for 7% of deaths. Brain cancers, lymphoid cancers (including leukaemia) and land transport accidents each accounted for 6% of deaths to 5-19 year old girls, while the leading cause of death for boys of the same age was land transport accidents.

What do we know?

Figure 69 shows the infant mortality rates for Thurrock since 2001-03, compared with the regional and national rates, and shows that Thurrock's current infant mortality rate is 2.5 per 1,000, which is significantly lower than regional and national rates. However it should be noted that Thurrock's figures are very low and small changes in the numbers of deaths each year will have a large impact on the rates.

Figure 69: Infant Mortality in Thurrock, East of England and England, 2001-03 – 2010-12



Source: Public Health England

The rate of child mortality in Thurrock is statistically similar to the national average, with a rate of 14.2 per 100,000 in 2010-12 for children aged 1-17 years, compared to the national average of 12.5 per 100,000. The local rate has increased since 2009-11 (17.0 per 100,000); however the small numbers involved should be considered.

Child Death Review Panel Activity

The local Child Death Review Panel (CDRP) reviews childhood deaths in Southend, Essex and Thurrock, particularly considering any modifiable factors contributing to each death and lessons to be learnt. The table below summarises the main activity and conclusions reached by the CDRP from 2008/09-2013/14. It should be noted that not all child deaths that occurred in each year had their completed review within the same year as some may take many months to complete.

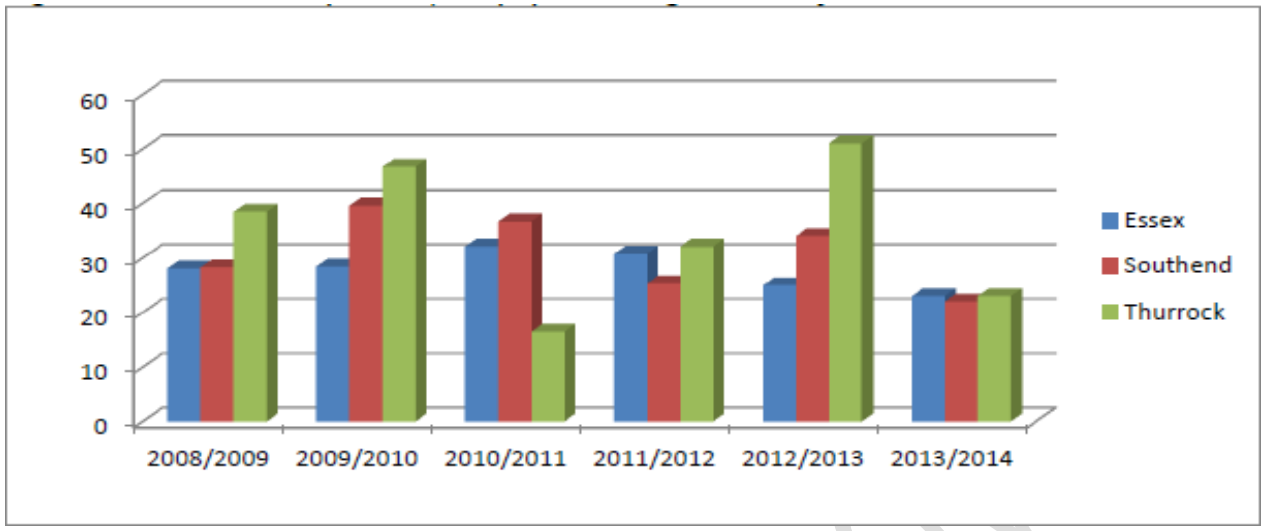
Table 20: Summary of SET Local Child Death Review Activity 1st April 2008 – 31st March 2014

Child Death Review Activity	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**
Total child death notifications received for Essex resident child deaths	108	116	115	112	106	96
Total child deaths discussed at review meetings	76	100	115	86	86	82
Child Death Review Findings *(Deaths reviewed at panel meetings rather than death notifications - findings may not be presented against the year in which the death occurred)*	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**
Total cases adopted as a Serious Case Review	0	<5	0	<5	0	0
Total deaths due to external causes	9	11	7	6	5	12
Total deaths classified as having modifiable factors	9	20	29	22	24	29
Total child deaths classified as not preventable	64	80	95	64	62	53

Source: Southend Essex and Thurrock Child Death Review Annual Report, 2014

Of the 96 deaths notified for review for SET residents, 10 of these occurred in Thurrock children. When converting these numbers to rates, it can be seen that Thurrock has a similar rate per 100,000 population aged 0-17 years for 2013/14 when compared with Essex and Southend; however in previous years the rate in Thurrock has been considerably higher than both Essex and Southend. Care should be given however to the small numbers involved.

Figure 70: Crude Death Rate per 100,000 population aged 0-17 years in Essex, Southend and Thurrock, 2008-2014



Source: Southend Essex and Thurrock Child Death Review Annual Report, 2014

Since April 2010, CDR Panels have identified where modifiable factors were present which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. Modifiable risk factors were identified in 35% of the completed reviews in 2013-14 for the SET area – this is a small increase on the proportion for 2012-13, when 28% of deaths reviewed had modifiable risk factors.

Modifiable factors were found in each of the deaths in the trauma and external events category (11% of deaths were in this category), and factors identified included:

- Unfenced residential swimming pools
- Prior surgical intervention
- Alcohol/substance misuse by a child
- Emotional/behavioural and mental health of the child

Modifiable factors found in other categories of death included:

- Factors related to service provision
- Vitamin D deficiency in pregnancy
- Parental smoking during pregnancy or in the household
- Housing conditions
- Parenting capacity
- Co-sleeping

What are we doing in Thurrock?

Over the last year, some changes have been made to practice in order to look to reducing deaths. These have included:

- Ensuring midwives emphasise the importance of vitamin D and good nutrition during pregnancy
- Lullaby Trust Safer Sleeping Advice cards are now given out to all new mothers along with the Personal Child Health Record (red book)
- Rapid Response training rolled out to relevant professionals

- Increased use of the Essex Safeguarding Children's Board website and twitter feed to disseminate information

Recommendations

Although Thurrock's current position is good, work should continue to improve factors that are known to increase the risk of infant mortality. Maternal age at time of delivery may have an impact on risk of infant mortality, and work to reduce teenage conceptions and support older mothers who may have more complications will help to reduce the risk. It is also imperative to promote the health of the mother, reducing smoking prevalence, alcohol intake and obesity, and supporting them in breastfeeding and immunisations to help protect their children. Targeted approaches should also focus on the more deprived areas of the borough in order to improve health outcomes.

Whilst the CDR Panel has identified a number of modifiable factors that have been present in deaths of our local children, priorities for the future should include raising awareness of these and working to prevent future deaths caused by these factors.

Childhood Injuries and Accidents

According to the National Child Bureau, unintentional injuries are the major cause of death for children under the age of 19 years in England. It is a major cause of avoidable ill health, disability and death and has a disproportionately large effect on people in deprived communities. The most common types include road traffic injuries, drowning, poisoning, burns and falls. In their guidance on preventing unintentional injuries in the under 15s, the National Institute for Health and Clinical Excellence highlight specific groups of children that are more vulnerable in terms of having increased risk of injury (NICE 2010). These include children:

1) under the age of 5 years (generally, under-5s are more vulnerable to unintentional injuries in the home)
2) over the age of 11 (generally, over-11s are more vulnerable to unintentional injuries on the road)
3) who have a disability or impairment (physical or learning)
4) from some minority ethnic groups
5) who live with a family on a low income
6) who live in accommodation which potentially puts them more at risk (this could include multiple-occupied housing and social and privately rented housing).

There is a body of evidence to show that many accidents are preventable and the impact of those that do occur can be reduced. Avoiding injury requires a collective effort across all sectors of society and this needs to take place at all levels, from individuals being aware of risk and adjusting their behaviour accordingly to governmental legislation aimed at pre-empting risk.

What do we know?

Hospital Admissions

- Thurrock has a significantly lower rate of hospital admissions for injury when compared with the national average for both the 0-14 years and 15-24 years age groups.
- Thurrock has a statistically similar rate of hospital admissions for mental health conditions when compared with the national average
- Thurrock has a significantly lower rate of hospital admissions for self-harm when compared with the national average

Table 21: Hospital Admissions in Thurrock and England

	Thurrock	England
Hospital Admissions for Injury (0-14 years) (rate per 10,000) *2012/13*	78.1	103.8
Hospital Admissions for Injury (15-24 years) (rate per 10,000) *2012/13*	88.0	130.7
Hospital Admissions for Mental Health Conditions (0-17 years) (rate per 100,000) *2012/13*	64.1	87.6
Hospital Admissions for Self-Harm (10-24 years) (rate per 100,000) *2012/13*	82.4	346.3

Source: CHiMat

Emergency Hospital Admissions

There were 11,566 A & E admissions for Thurrock residents aged 0-19 years in 2013/14, which is an 18.9% increase from 2012/13 (9,731 admissions). When the primary diagnosis was considered, it can be seen that the three highest categories of diagnosis (where diagnosis was known/recorded) in both 2012/13 and 2013/14 were respiratory conditions, gastrointestinal conditions and admissions for dislocation/fracture/joint injury/amputation. However it should be considered that multiple diagnoses are often recorded for patients, so this only records the first diagnosis. The largest increases between 2012/13 and 2013/14 can be seen for infectious diseases, allergies and gastrointestinal conditions. Table 22 below shows admissions for children aged 0-19 years in 2012/13 and 2013/14 by primary diagnosis.

Table 22: Emergency admissions to children aged 0–19 years shown by primary diagnosis, 2012/13 and 2013/14

Primary Diagnosis	2012/13	2013/14	Difference	% change
Diagnosis not classifiable	1457	1856	399	27.39
NONE	1364	1657	293	21.48
Respiratory conditions	734	955	221	30.11
Gastrointestinal conditions	670	951	281	41.94
Dislocation/fracture/joint injury/amputation	706	802	96	13.60
Sprain/ligament injury	528	660	132	25.00
Head injury	516	590	74	14.34
ENT conditions	438	556	118	26.94
Soft tissue inflammation	557	463	-94	-16.88
Laceration	362	410	48	13.26
Infectious disease	207	345	138	66.67
Contusion/abrasion	232	231	-1	-0.43

Nothing abnormal detected	176	222	46	26.14
Other	138	90	-48	-34.78
Muscle/tendon injury	195	187	-8	-4.10
Urological conditions (including cystitis)	174	184	10	5.75
Central Nervous System conditions	200	179	-21	-10.50
Dermatological conditions	136	150	14	10.29
Local infection	145	145	0	0.00
Allergy (including anaphylaxis)	95	136	41	43.16
Foreign body	128	134	6	4.69
Poisoning	118	124	6	5.08
Ophthalmological conditions	108	106	-2	-1.85
Cardiac conditions	80	100	20	25.00
Psychiatric conditions	61	71	10	16.39
Gynaecological conditions	73	64	-9	-12.33
Burns and scalds	68	54	-14	-20.59
Bites/stings	53	40	-13	-24.53

Source: NHS Thurrock CCG Performance Team

When categorised by incident location, the majority of incidents occurred in the home (68.70%) and this was true for all age groups, although highest in the 0-4 year old age group (82.86% of their incidents took place in the home). Incidents in educational establishments, public places, work and other locations were higher in older age groups. Table 23 below shows the percentage of incidents that resulted in an A & E admission for children aged 0–19 years in Thurrock by location of incident in 2012/13 and 2013/14 combined.

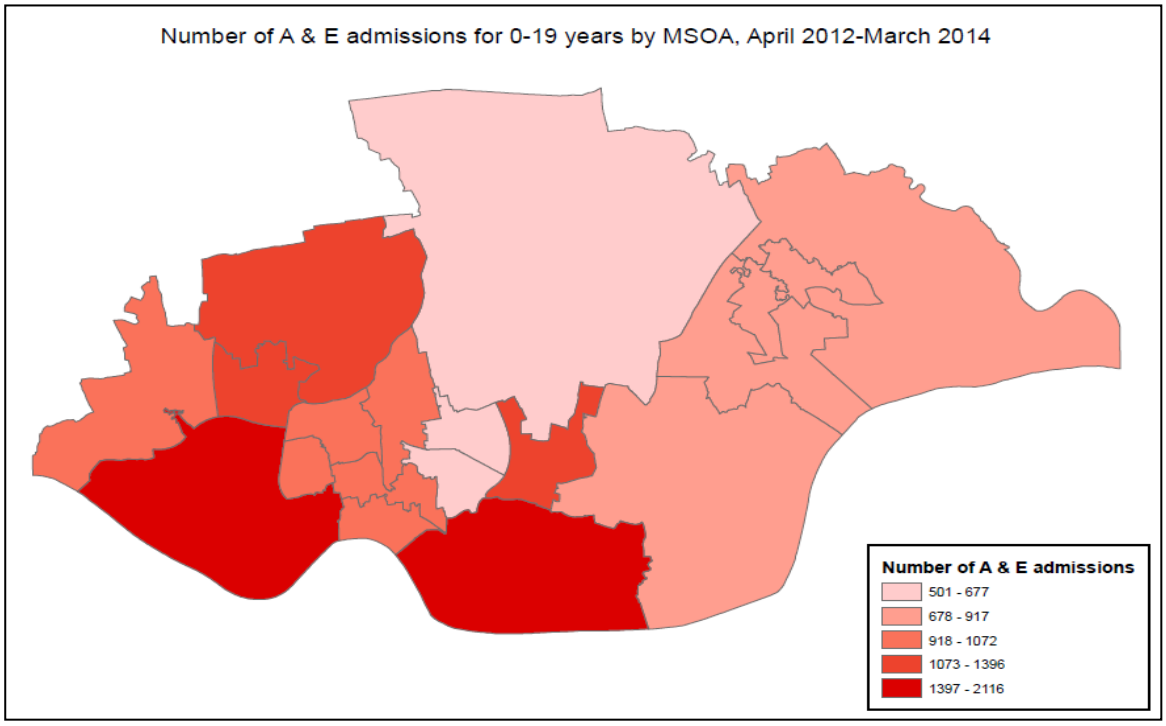
Table 23: Emergency admissions to children aged 0–19 years shown by incident location and age group, April 2012-March 2014

Location	0-19 years	0-4 years	5-9 years	10-14 years	15-19 years
Educational establishment	5.81%	1.29%	9.52%	14.91%	4.35%
Home	68.70%	82.86%	66.30%	50.65%	56.44%
Other	15.19%	11.42%	12.88%	19.59%	21.29%
Public place	8.70%	3.58%	10.28%	13.66%	13.88%
Work	0.74%	0.02%	0.03%	0.06%	3.44%
Not recorded	0.86%	0.83%	0.99%	1.14%	0.60%

Source: NHS Thurrock CCG Performance Team

A & E attendance by Thurrock children was not resident across the borough between 2012/13 and 2013/14. Figure 71 shows A & E attendance between April 2012 – March 2014 by MSOA of residence, and it can be seen that the highest number of admissions came from the Tilbury Riverside and Tilbury St Chads, and West Thurrock and South Stifford areas. When considering the proportion of 0 – 19 year olds that live in these areas, whilst West Thurrock and South Stifford does have a high number of 0–19 year olds, Tilbury Riverside and Thurrock Park, and Tilbury St Chads have 0 – 19 populations that fall in the middle of the Thurrock wards, and it would therefore not be expected for them to present with such a high number of admissions when considering this alone.

Figure 71: Number of A & E admissions for 0 – 19 years by MSOA in Thurrock, April 2012-March 2014



Source: NHS Thurrock CCG Performance Team

Children Killed or Seriously Injured in Road Traffic Accidents

Road traffic collisions are a major cause of deaths in children, and comprise higher proportions of accidental deaths as children get older. Parents cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity. A large proportion of childhood injuries occur as a pedestrian or on bicycle, and incidence increases with age, which could be due to increased unsupervised exposure. Children from lower socioeconomic groups are at higher risk of serious injury. In 2010-12, 17.5 per 100,000 children aged 0-15 years in Thurrock were killed or seriously injured in road traffic accidents, which is similar to the regional and national rates.

What are we doing in Thurrock?

Whilst the rate of children killed or seriously injured in road traffic accidents is not significantly different from the regional or national rates, focus should not be removed from services to reduce the number of these largely preventable accidents. Thurrock Council's Road Safety team has been successful at securing funding to deliver Level 2 *Bikeability* training, which provides children with the skills to cycle safely and with confidence on the local transport network. In addition funding has also been secured to deliver Level 1 *Bikeability* and Scooter training until March 2015. Pedestrian training is delivered to parents of reception pupils and to Year 3 and 6 pupils, including the use of a speed gun for pupils to judge the speed of vehicles. *Kerbcraft* (a prescriptive form of pedestrian training) is delivered to Year 2 pupils and the Young

Driver programme is delivered to Year 10/11 students. *Cyclicious*, a cycling project specifically for female students is undertaken in secondary schools.
To support the training programmes, the council organises events and activities to embed positive walking and cycling behaviours, including Walk Once a Week (WoW), the Zig Zag scheme for key stage 1 pupils, Walk to School Week, Park and Stride, Theatre in Education (TIE), and Crucial Crew, a multi-agency initiative reaching 1,800 Year 6 pupils. A Bike It Officer is employed to provide intensive cycling support at 15 primary schools. A budget is also allocated to ensure walking and cycling infrastructure is adequate in and around school sites. Infrastructure measures include installing cycle parking, upgrading footpaths and improving parking restrictions.

Recommendations

In order to reduce A&E admissions:

- Work on culture shift to ensure parents, carers, families feel confident and enabled to manage CYP's condition at home
- Work to increase community's role in managing conditions

4. Enjoying and Achieving

School Readiness

Too many children start schools without the range of skills they need. The quality of a child's early life experience is shaped by a number of factors, including socio-economic status, access to high-quality early education and care, and the influence of 'good parenting' (Ofsted, 2014). The gap between those eligible for free school meals and their peers is clearly established by the age of 5, and this has serious implications for future development. Research cited by the Department for Education (2011) found that vocabulary at age 5 is the best predictor of later social mobility for children from deprived backgrounds. Children who start school as confident speakers with good language skills are more likely to become successful learners and achieve in life.

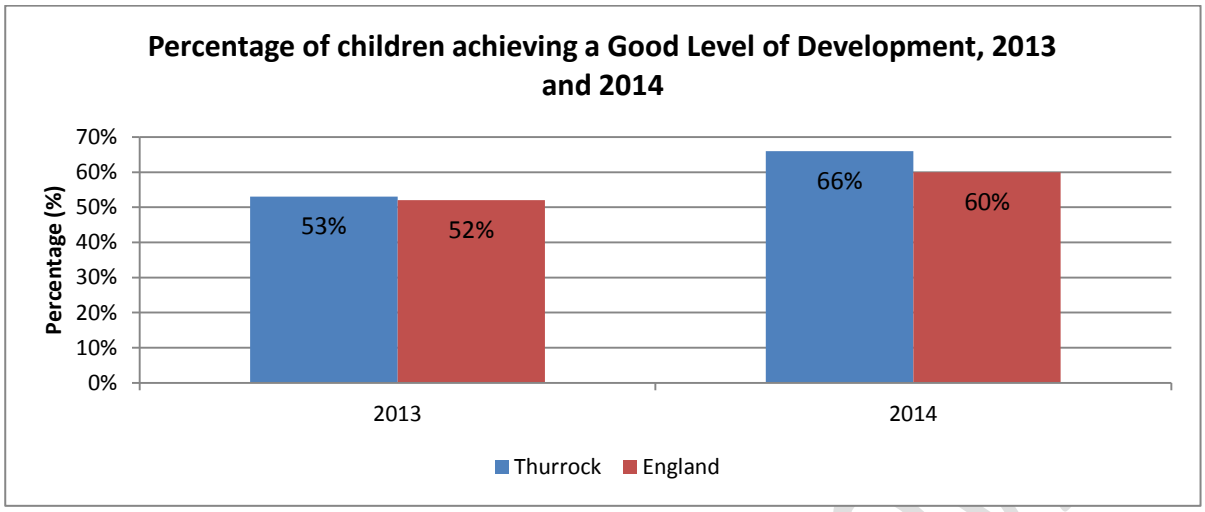
High-quality early education is crucial in supporting children to have the best start in life. The period before entering into primary school education is vital in providing children with the broad range of knowledge and skills that provide the right foundation for good future progress through school. The former Children and Families Minister Sarah Teather said of school readiness in 2011: "This isn't just about making sure they can hold a pencil - children need the resilience, confidence and personal skills to be able to learn."

The term "school readiness" does not yet have a nationally agreed definition, despite its appearance in many reviews of education and statutory guidance. A recent report by Ofsted (2014) identified in a survey that it is interpreted differently by providers across the country, and calls for a definition to be agreed. From 2016 there will be a new indicator which will support measuring of school readiness.

What do we know?

School readiness can currently be measured by the percentage of children achieving a "Good Level of Development" (GLD) in the Early Years Foundation Stage (EYFS). According to the Department of Education, children will be defined as having reached a GLD at the end of the EYFS if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy. From the below it can be seen that Thurrock is 6% above the national average in 2014 for children achieving a GLD.

Figure 72: Percentage of children achieving a Good Level of Development in Thurrock and England

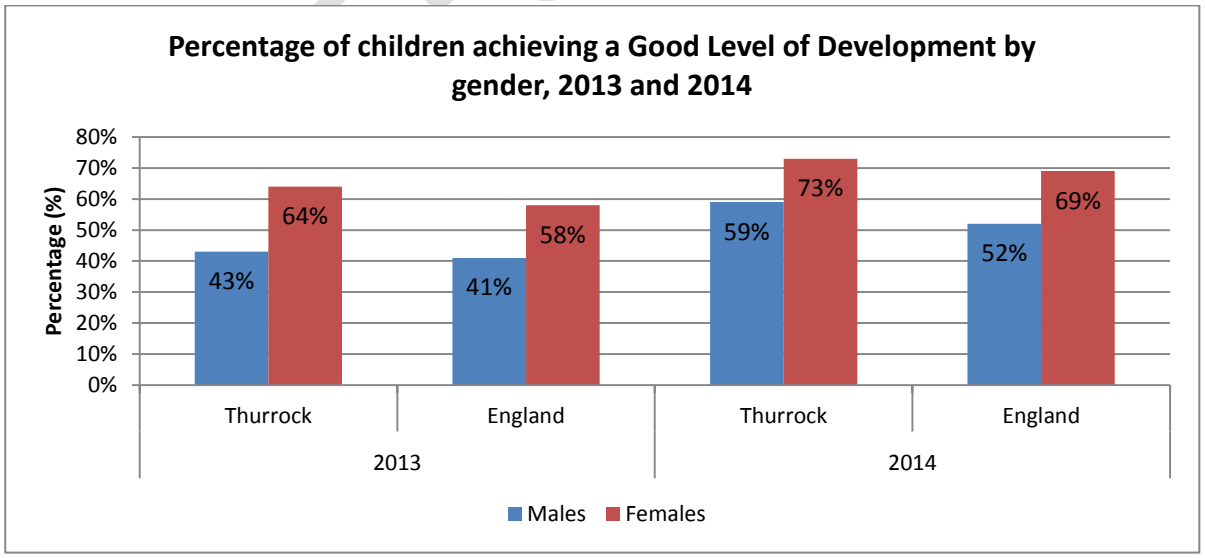


Source: Thurrock Council

It should be noted that data prior to 2013 was measured differently and cannot be directly compared to the above.

Vast inequalities can be seen between achievements of GLD by gender, as even by the age of 5, females are performing better than males. Locally in 2014, only 59% of males achieved a GLD, compared with 73% of females. This is a smaller difference than in 2013, when 43% of males and 64% of females achieved a GLD. This gender inequality is also present nationally, and can be seen graphically in **Error! Reference source not found.** below.

Figure 73: Percentage of children achieving a Good Level of Development in Thurrock and England by gender



Source: Thurrock Council

The Two Year Old Early Entitlement provides funded childcare for children whose parents/carers meet the required eligibility criteria. Up to 15 hours per week of free Ofsted registered childcare may be accessed per week during term time, or over a longer period of

time for fewer hours per week. The aim is to improve outcomes for eligible disadvantaged two year olds, benefitting their social, physical and mental development and helping them to prepare for school. Early education is also available for all 3 and 4 year olds but must be provided by Ofsted registered providers. Take up of early education and childcare fluctuates throughout the year, but taking Spring 2013 data as a snapshot in time, it can be seen that there were 422 children aged 2, 3 and 4 years in Thurrock who were eligible but who did not take up any early education. A break down by age can be found below in Table 24.

Table 24: Eligible children and children accessing early education in Thurrock, Spring 2013

	2 year olds	3 year olds	4 year olds	Total
Children accessing Early Education	369	2144	2285	4798
Eligible Children	443	2360	2417	5220
Number of Eligible Children NOT accessing early education	74	216	132	422

Source: Thurrock Childcare Sufficiency Assessment, 2014 [Data based on ONS mid year estimates 2012, DWP 2013 data and Spring Census data 2013]

Thurrock's Childcare Sufficiency Assessment (2014) outlines the early education and childcare provision in the borough, and determined that there was sufficient provision in Thurrock, albeit with individual ward pressures. The table below outlines the number of providers by type of provision with the number of registered places. Of the 8414 Ofsted registered places, 7822 can deliver early education (15 hour) places, indicating that there is a surplus supply of 2602 places if all the eligible children had taken them up. The take up of fee paying childcare accessed by working parents does impact on place availability for early education.

Table 25: Summary of early education and childcare in Thurrock

Type of provision	Total Number of Providers	Total Ofsted Registered places per session	Early Education (15 hour) places
Accredited Childminders (can deliver early education)	13	66	24
After school club	21	635	0
Breakfast club	23	697	0
Childminders	187	863	0
Day Nursery	25	1264	2985
Holiday Club	15	541	0
Preschool	25	720	1185
School nursery	22	1334	1334
School reception class	37	2294	2294
Total	368	8414	7822

Source: Thurrock Childcare Sufficiency Assessment, 2014

What are we doing in Thurrock?

Thurrock has 9 Children's Centres, which aim to *improve outcomes for young children and their families and to reduce inequalities.* Five are run by the council directly, and four are commissioned to *4children*. The overall outcomes framework for those run by the Local Authority has 28 statements; 8 of which look to shape the work that Children's Centres do with regard to child development and school readiness:

1. To increase the level to which children pay attention to activities and people around them (PSE)
2. Children show increasing enjoyment of looking at books
3. Children are read to at home more often.
4. Children are learning to share and take turns with friends.
5. Children have age-appropriate self-management skills and self-control (behaviour)
6. Children develop and improve their listening skills
7. Children develop and improve their speaking skills.
8. Children develop age-appropriate early drawing and writing skills.

The centres run a range of universal and targeted services (which are based on data showing needs relevant to vulnerable groups in each area) to support school readiness; these include:

- Three *Stay and Play* sessions (0-12 months, 12-36 months, 36-60 months)
- *Bookstart*
- *Speech and Language* Drop In
- *Parent Outreach Worker*
- *Two year old offer*
- *Early Offer of Help Commissioned Services*

Recommendations

- It is a priority to encourage parents of eligible two year olds to take up the offer of free childcare and early education.
- Ensure parents are informed about choices and provision in the area
- Targeted work to ensure needs of vulnerable groups in each area should be maintained
- Ensure appropriate data monitoring in order to demonstrate good progress of two year olds
- Good partnership working with schools/parents/other agencies working with vulnerable children

School Attendance

Poor attendance can disrupt a pupil's learning and mean they fall behind their peers academically. Persistent absence (measured by the percentage of pupils with less than 85% attendance) can also have an impact beyond educational attainment of a pupil at school, as evidence has found persistently absent pupils are more likely to be NEET (not in education, employment or training), less likely to attend university, more likely to claim state benefits, and more likely to be in temporary rather than permanent employment. (Department for Education, 2011) The same research also found:

- Pupils eligible for Free School Meals (FSM) have over twice the odds of being a persistent absentee as similar pupils who are not eligible for FSM.
- Pupils with Special Education Needs (SEN) have greater odds of being persistently absent than pupils without SEN.
- Girls are more likely to have absences due to illness than boys; boys however, are more likely to have absences due to exclusions than girls.
- Persistent absentees are more likely to come from lone parent households or households with no parents, compared to their non-PA peers.
- Almost a third of persistent absentees come from households where the principal adult/s are not in any form of current employment – this compares to just over a tenth of non-PAs
- Evidence suggests that persistent absentees are more likely to be bullied, excluded from school and be involved in risky behaviours (experiment with drugs, alcohol etc.) than non-PAs.

The Department for Education published a separate report profiling school exclusions in England (2012), and found that:

- Boys are more likely to be excluded (both permanently and for a fixed period) at all ages than girls, with very few girls being excluded during the primary years. The most common time for both boys and girls to be excluded is at ages 13 and 14.
- Pupils with a statement of Special Educational Needs (SEN) were almost seven times more likely to receive a permanent exclusion than pupils with no SEN, and were nine times more likely to receive a fixed period exclusion.
- Pupils who were known to be eligible for Free School Meals were around four times more likely to receive a permanent exclusion, and were around three times more likely to receive a fixed period exclusion than children who were not eligible for Free School Meals.
- The rate of exclusions was highest for Traveller of Irish Heritage, Black Caribbean and Gypsy/Roma ethnic groups. Black Caribbean pupils were nearly four times more likely to receive a permanent exclusion than the school population as a whole and were twice as likely to receive a fixed period exclusion.

Both pupil attendance and behaviour are analysed by Ofsted under their Framework for School Inspection (updated July 2014).

What do we know?

Attendance levels at primary school continue to improve in Thurrock with total primary absences remaining constant at 4.7%, which is in line with both regional and national averages. Persistent Absence has been improving from 4.4% in 2010/11 to 3.1% in 2012/13, reducing the gap with the regional and national average to 0.1%.

Table 26: Percentage of Total and Persistent Absences at primary schools in Thurrock and comparators, 2008/09 – 2012/13.

Total Primary Absence (%)					
	08/09	**09/10**	**10/11**	**11/12**	**12/13**

Thurrock	5.6	5.5	5.1	4.7	4.7
England	5.3	5.2	5.0	4.4	4.7
East of England	5.1	5.1	5.0	4.5	4.7
Statistical Neighbours *(correct as of August 2014)*	5.2	5.1	4.9	4.3	4.6

Total Primary Persistent Absence (%)			
	10/11	**11/12**	**12/13**
Thurrock	4.4	3.5	3.1
England	3.9	3.1	3.0
East of England	3.8	3.3	3.0
Statistical Neighbours *(correct as of August 2014)*	3.8	3.1	2.9

Source: Thurrock Council

Attendance levels at secondary school have also been improving in recent years, with Thurrock's percentage of total secondary absences reducing over the last four years to 5.7%, which is statistically similar to the regional and national averages, and our statistical neighbours. The percentage of Persistent Absence in secondary schools has also decreased since 2011/12 to 6.5%, which is statistically similar to the regional and national averages, and our statistical neighbours.

Table 27: Percentage of Total and Persistent Absences at secondary schools in Thurrock and comparators, 2009/10 – 2012/13.

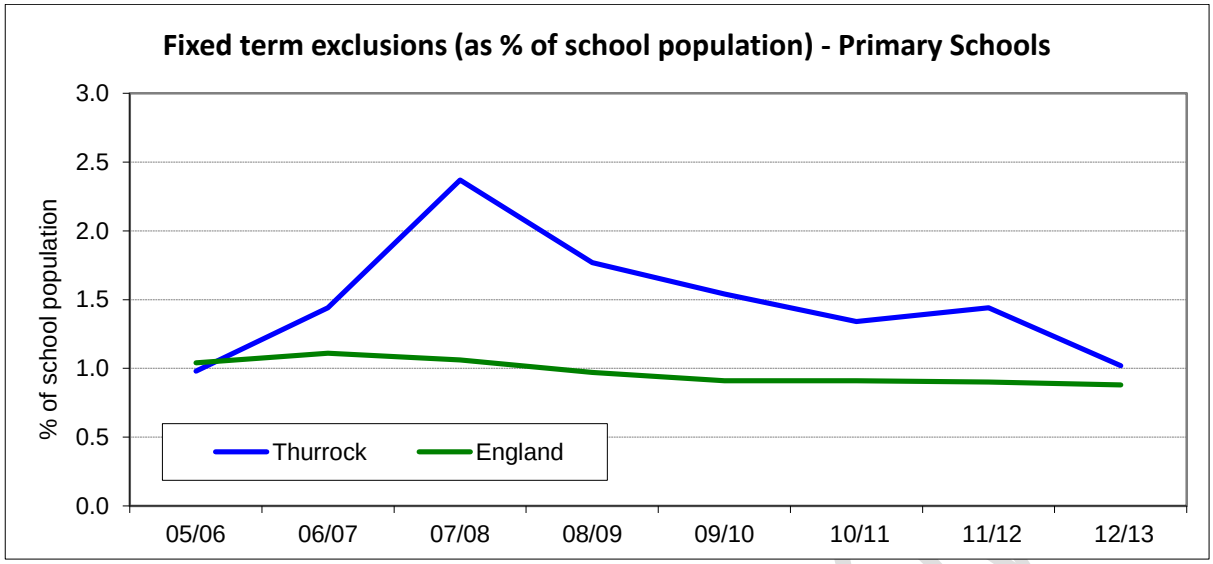
Total Secondary Absence (%)				
	09/10	**10/11**	**11/12**	**12/13**
Thurrock	6.5	6.0	6.0	5.7
England	6.9	6.5	5.9	5.9
East of England	6.8	6.6	6.0	5.8
Statistical Neighbours *(correct as of August 2014)*	6.6	6.3	5.8	5.8

Total Secondary Persistent Absence (%)			
	10/11	**11/12**	**12/13**
Thurrock	7.5	8.3	6.5
England	8.4	7.4	6.2
East of England	8.3	7.4	6.4
Statistical Neighbours *(correct as of August 2014)*	8.0	7.4	6.5

Source: Thurrock Council

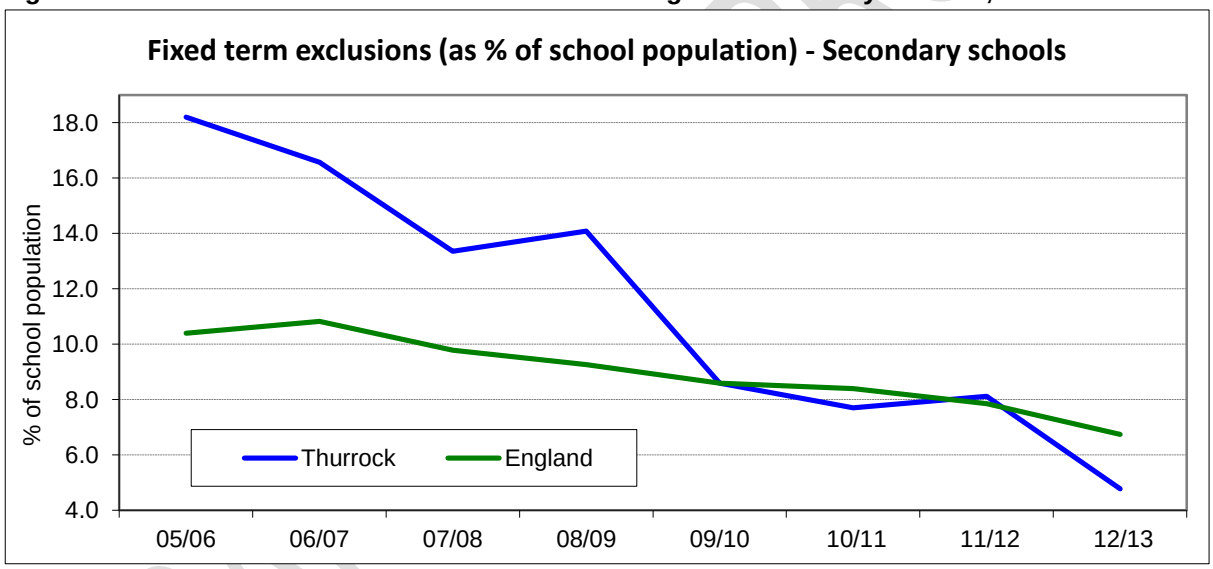
Data showing the proportion of fixed term exclusions in Thurrock highlights that exclusions have decreased dramatically over recent years. Fixed term exclusions in primary schools decreased from a peak of 2.4% in 2008 to 1.0% in 2013, bringing them closer to the national average, which remained fairly constant during this period showing just a slight decrease. In secondary schools there has been an even more dramatic decrease in fixed term exclusions, from a peak of 18.2% in 2006 to 4.8% in 2013. Figure 74 and Figure 75 show exclusions in primary and secondary schools against the national average.

Figure 74: Fixed term exclusions in Thurrock and England primary schools, 2006-2013



Source: Department for Education and Thurrock Council

Figure 75: Fixed term exclusions in Thurrock and England secondary schools, 2006-2013



Source: Department for Education and Thurrock Council

What are we doing in Thurrock?

School attendance is a key focus for the officer led Schools Standards and Progress Board meetings where individual school attendance is scrutinised and strategies to support improvement are agreed as part of the overall school improvement function supported by the Education Welfare Service. Links between the Education Welfare and School Improvement Officers have become more clearly focused since 2011 in relation to how attendance affects pupil outcomes.

Arrangements have been introduced locally to improve access to school for pupils who have experienced difficulties in schooling or who have moved into the area. This has been through a renewed Fair Access Protocol and Access Panel. This has led to significant improvements in

access to mainstream schools for these pupils and the utilisations of managed moves to prevent exclusion.

Fixed Term Exclusions in primary schools is a priority for Thurrock with ongoing support to key schools through work from a behaviour worker including training for teachers and teaching assistants. A new audit of behaviour approaches was carried out in key schools in the summer term of 2013 which has been used to inform a new programme of behaviour support for these schools.

Thurrock's Children's Centres also play an integral role in supporting parents and children with behaviour management, and offer a range of supportive services to do this. Many of their 28 outcomes in their Outcomes Framework specifically relate to giving parents confidence in their parenting ability and supporting them to set and reinforce boundaries at home.

Recommendations

Thurrock Council's Behaviour Strategy outlines a number of recommendations for the Local Authority to help manage pupil behaviour:

- Relevant teams and services are coordinated and managed so as to provide effective support for pupils' social, emotional and behavioural development in schools and other settings
- Effective partnerships are created and maintained with schools, other agencies and organisations to support implementation
- Effective challenge to and support for schools is provided in order to ensure continuous improvement in both policy and practice for improving pupils' social, emotional and behavioural skills
- Regular audits of the range of provision available to schools to support positive pupil behaviour for learning are carried out
- Exemplars of good practice are identified and widely disseminated
- Clarity for schools around sustainable funding sources for improving behaviour for learning is established and maintained

Educational Attainment

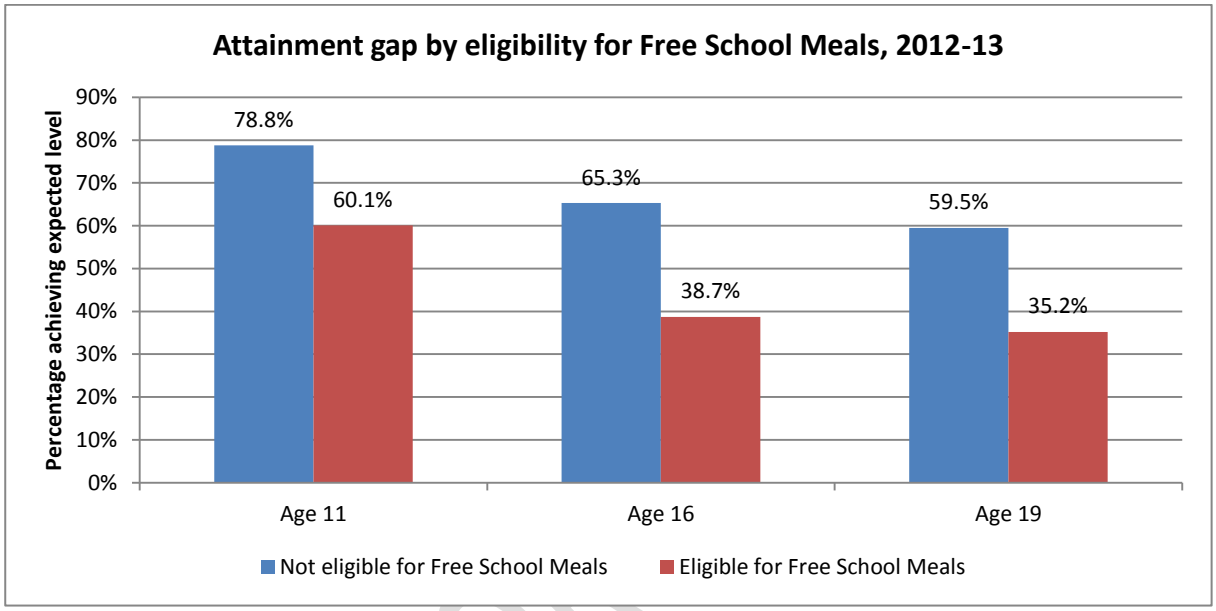
There is a strong association between educational attainment and good health and wellbeing outcomes. The Fair Society, Healthy Lives paper (2010) showed that a range of interacting factors impact on educational outcomes:

- Distal factors – socio-demographic features such as income and parental education
- Proximal factors – parental support and parent-child relationships
- School-peer factors - the nature of the school and its population
- Individual factors of the child – prior educational attainment of the child

It is a complex relationship which connects these factors to educational attainment, with some being stronger predictors of attainment than others.

Educational attainment is lower in deprived areas, and this can affect future life chances – young people with fewer qualifications are more likely not to be in education, employment or training (NEET) after leaving school and find it more difficult to secure employment as they get older. Eligibility for free school meals provides a broad indicator of **deprivation** for pupils attending a school – Figure 76 below shows the association between eligibility for free school meals and educational performance nationally. It has been identified as a leading Government priority to narrow the attainment gaps between disadvantaged pupils and their peers.

Figure 76: Attainment gap from age 11 to age 19 by eligibility for free school meals, 2012-13



Source: Department for Education

Gender has also been demonstrated to affect attainment. Research undertaken by the Department for Education and Skills (2007) shows that the gender gap is wide in English and narrower in Maths, with girls performing better than boys on average. The gender gap in the Sciences has been traditionally very small. Girls are more likely to gain an A* grade at GCSE, whereas boys are a little more likely to gain a G grade or to gain no GCSEs at all. The differences at A-Level are smaller, but girls are still more likely to perform better than boys in terms of those attaining an A grade (for the majority of subjects), which is a significant change over the last ten years. Some reasons behind the gender gap were suggested:

- Girls and boys tend to use different styles of learning
- Girls find it easier to succeed in school settings
- Boys are more likely to be influenced by their male peer group which might devalue schoolwork and so put them at odds with academic achievement.
- The use of coursework in examinations may advantage girls, but analysis does not find that this alone accounts for the gender gap

The latest information also indicates that there is variation in educational attainment between different **ethnic groups**. GCSE A*-C data from 2012/13 indicate that Chinese and Indian students have much higher levels of attainment compared to the national level, whereas Pakistani, Black Caribbean and Gypsies, Roma and Travellers. Black Caribbean boys in particular are 37 times more likely to be excluded from school than girls of Indian origin, which would have a large impact on attainment and future employment.

The Government have committed to raising the achievement of disadvantaged pupils by providing Pupil Premium funding to schools and monitoring use and impact of this funding, utilising Ofsted inspections and performance tables to hold schools to account for achievement of disadvantaged pupils, and investing in funding streams such as the Education Endowment Foundation to help schools raise attainment levels. Moreover, by increasing the autonomy and flexibility of schools, the Academies programme has offered schools considerable opportunity to improve education for their pupils. In particular, academy chains which can share experience and expertise are delivering considerable improvement to schools which have long suffered disadvantage. Likewise, Free Schools are also bringing greater innovation in the sector (Centre for Social Justice, 2014).

Educational outcomes are normally considered alongside the performance of schools in Ofsted inspections. Schools are normally assessed under four key judgement areas: achievement, teaching, behaviour and leadership, and given an overall rating of *Outstanding*, *Good*, *Requires Improvement* or *Inadequate*. Local authorities monitor the proportion of schools in their areas receiving *Good* or *Outstanding* results as an indicator of schools that are performing well.

What do we know?

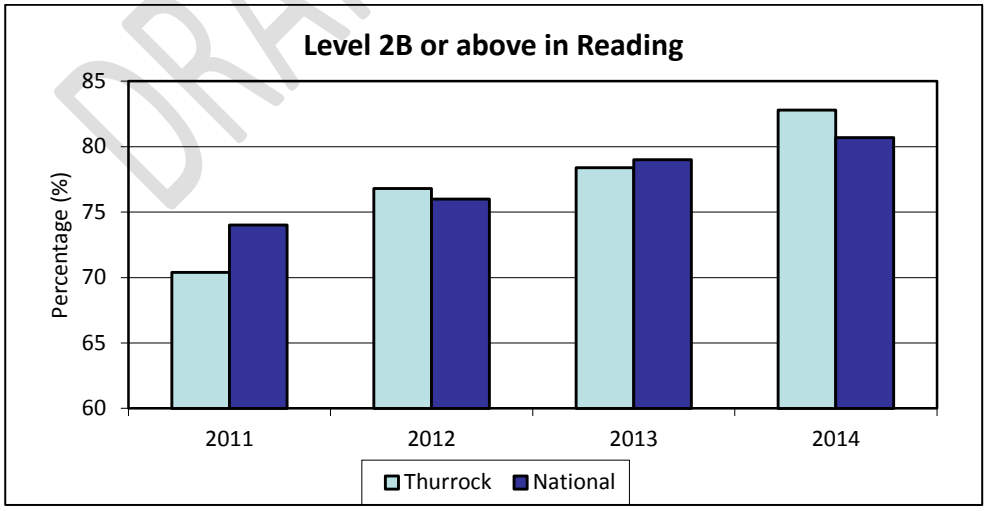
Early Years Foundation Stage

The Early Years Foundation Stage (EYFS) is used as a common measure for school readiness for pupils in Reception Year aged 4-5 years. This data can be found in the School Readiness section.

Key Stage 1

Key Stage 1 is the term for the period of schooling up to Year 2 for pupils aged 5-7 years. Attainment in Thurrock can be seen broken down by subject and year in Figure 77, Figure 78 and Figure 79 below.

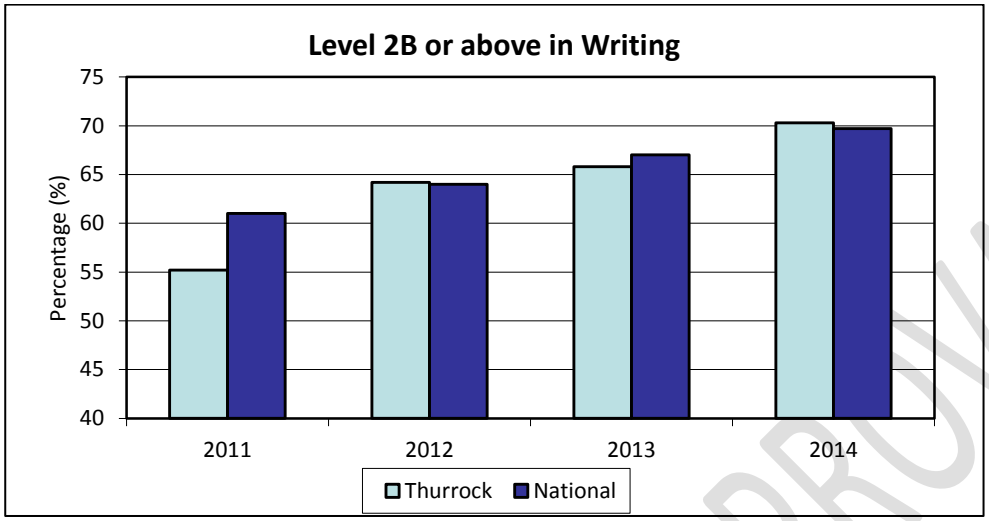
Figure 77: Percentage of pupils achieving a level 2B or above in Reading, 2011-2014



Source: Department of Education and Thurrock Council

Reading: Performance has improved by 12% from 2011 with 82.4% of children in Thurrock achieving a Level 2B or above in reading. Attainment has continued to increase each year, and it is now above the national average by 2%.

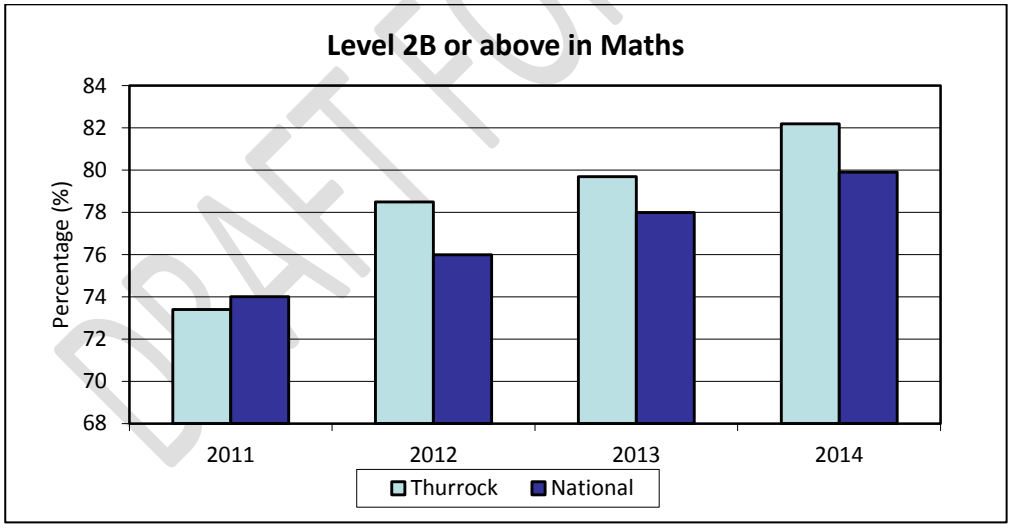
Figure 78: Percentage of pupils achieving a level 2B or above in Writing, 2011-2014



Source: Department of Education and Thurrock Council

Writing: Performance has improved by 15% from 2011 with 70.3% of children in Thurrock achieving a Level 2B or above in writing. This is slightly higher than the national average by 0.6%.

Figure 79: Percentage of pupils achieving a level 2B or above in Maths, 2011-2014



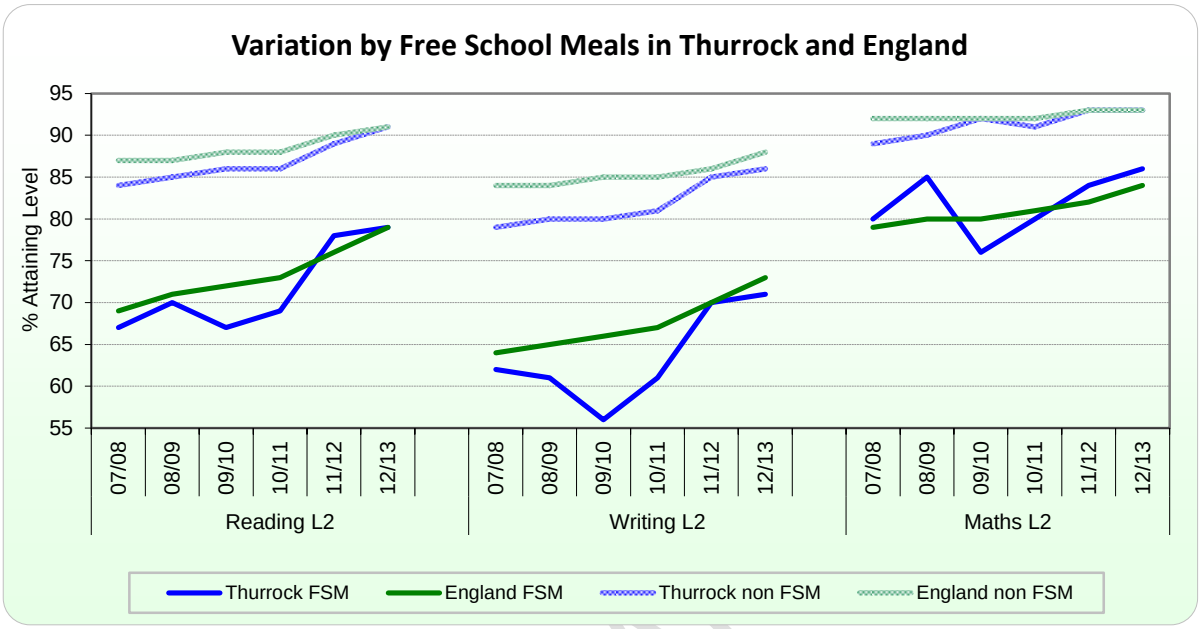
Source: Department of Education and Thurrock Council

Maths: Performance has improved by 9% from 2011 with 82% of children in Thurrock achieving a Level 2B or above in maths. Attainment remains higher than the national average, with a gap of 2.3%.

Variation by Free School Meals

As mentioned above, eligibility for free school meals is an indicator for deprivation and impacts on educational attainment. Figure 80 below depicts the variation between those eligible and not eligible for free school meals for each subject.

Figure 80: Variation by Free School Meal eligibility in Thurrock and England, 2008-2013



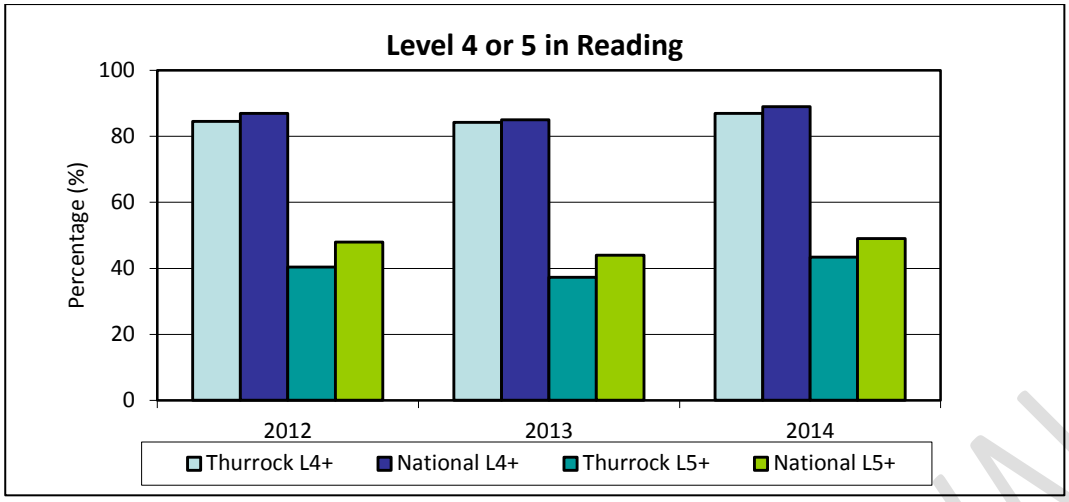
Source: Department of Education and Thurrock Council

The percentage achieving Level 2B or above is lower for all subjects for those eligible for free school meals both locally and nationally. However it can be seen that performance has been increasing in Thurrock over recent years, with attainment for reading and maths scoring above or equal to the national average in 2012/13.

Key Stage 2

Key Stage 2 is the term for the period of schooling up to Year 6 for pupils aged 7-11 years. Attainment in Thurrock can be seen broken down by subject and year in Figure 81, Figure 82 and Figure 83 below.

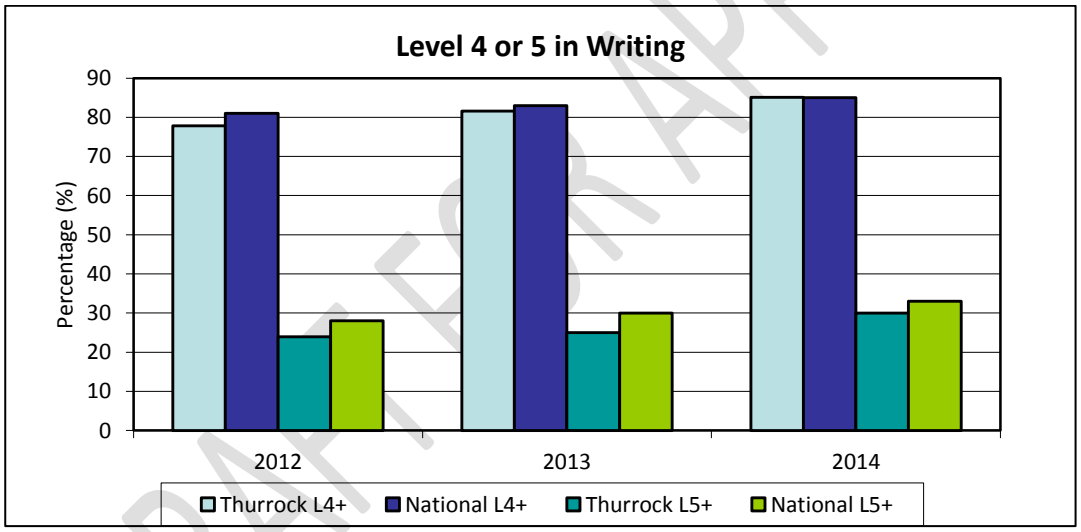
Figure 81: Percentage of pupils achieving a level 4 or above in Reading, 2012-2014



Source: Department for Education and Thurrock Council

Reading: Performance has improved from 2013 with 87% of children in Thurrock achieving a Level 4 or above in reading and 43.4% achieving a Level 5 or above. Performance is broadly in line with the national average.

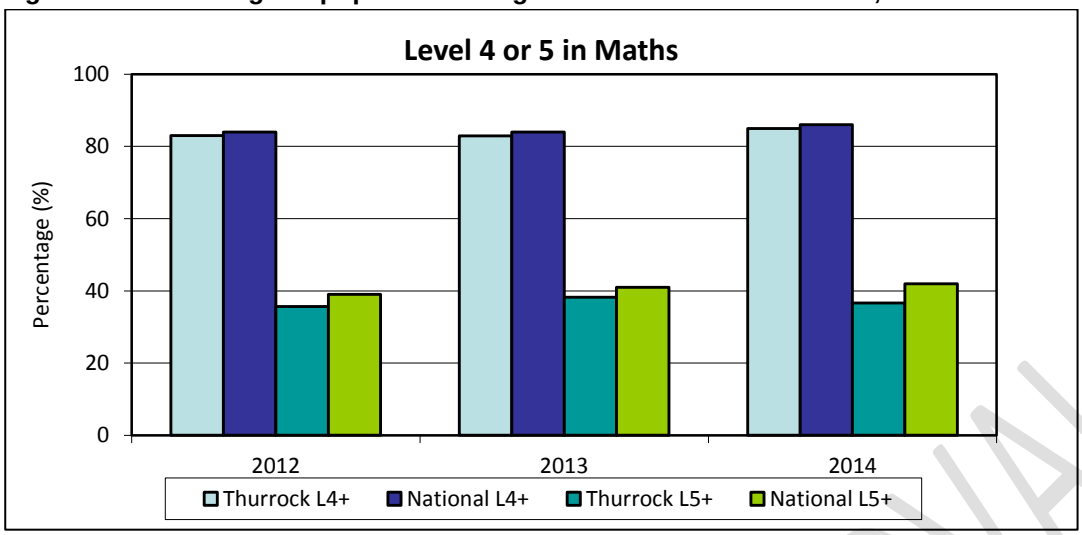
Figure 82: Percentage of pupils achieving a level 4 or above in Writing, 2012-2014



Source: Department for Education and Thurrock Council

Writing: Performance has improved from 2012 with 85.1% of children in Thurrock achieving a Level 4 or above in writing and 30% achieving a Level 5 or above. In 2014, the percentage achieving level 4 or above was equal to the national average.

Figure 83: Percentage of pupils achieving a level 4 or above in Maths, 2012-2014



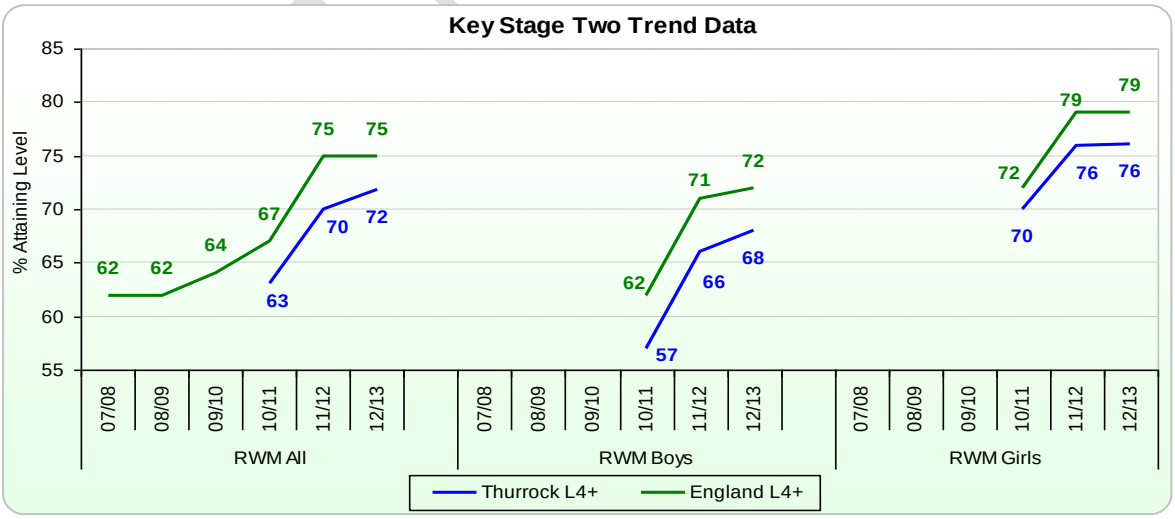
Source: Department for Education and Thurrock Council

Maths: Performance has improved from 2012 with 85% of children in Thurrock achieving a Level 4 or above in maths; however the proportion of children achieving a level 5 or above has decreased since 2013 (36.6% achieved level 5 or above in Thurrock in 2014, compared to 38.2% in 2013). Performance is broadly in line with the national average.

Variation by Gender

Looking at the Key Stage 2 data for all subjects by gender, it can be seen that boys have had lower attainment both locally and nationally over the last few years than girls. Performance has been increasing in Thurrock over recent years; however still is lower than the national average.

Figure 84: Variation by gender in Thurrock and England, 2008-2013



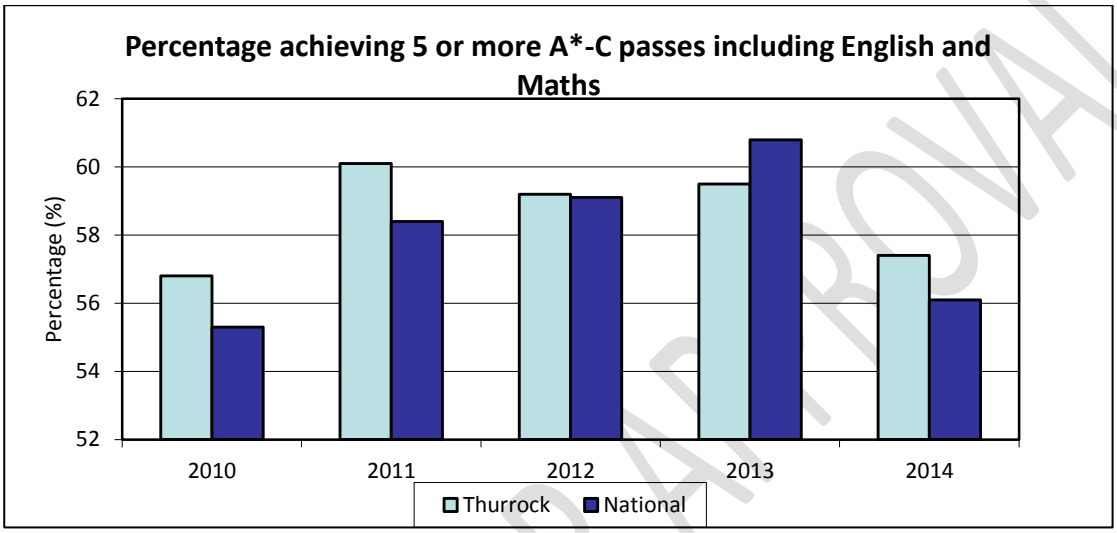
Source: Department for Education and Thurrock Council

It should be considered that the gender inequality gap has narrowed considerably since the EYFS data (which can be viewed in the School Readiness section) – the gap at EYFS between boys and girls was 14 percentage points in 2014 (boys = 59% and girls = 73%), whilst at Key Stage 2 in 2013 the gap was only 8 percentage points.

Key Stage 4

Key Stage 4 is the term for education for pupils who complete this stage in the year of their 16th birthday. The percentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) is a measure included by Public Health England on its Children and Young People's Benchmarking Tool as an indicator of educational attainment.

Figure 85: Percentage of pupils achieving 5 or more GCSE's at grades A*-C including English and Maths, 2010-2014



Source: Department for Education and Thurrock Council

In Thurrock, 57.4% of pupils at the end of Key Stage 4 achieved five or more GCSEs at grade A*-C or equivalent including English and Maths in 2013/14. Thurrock is ranked 59th out of 151 authorities and is currently above the national average of 56.1%. When all subjects are considered, 65.7% of Thurrock pupils achieved five or more A*-C grades in 2013/14, which is slightly higher than the national average of 65.3%.

Variation by Free School Meals

The percentage achieving five or more GCSEs at grade A*-C or equivalent including English and Maths is lower for those eligible for free school meals both locally and nationally. Pupils eligible for free school meals in Thurrock have seen a drop in performance in 2013 of almost 9.7% compared to national levels which increased by 1.6%. Performance for FSM pupils in Thurrock was high in 2012 so this decrease has resulted in a gap with national of 7.1%. Pupils not eligible for FSM improved in 2013 in line with national performance with the gap remaining around 1%.

Variation by Gender

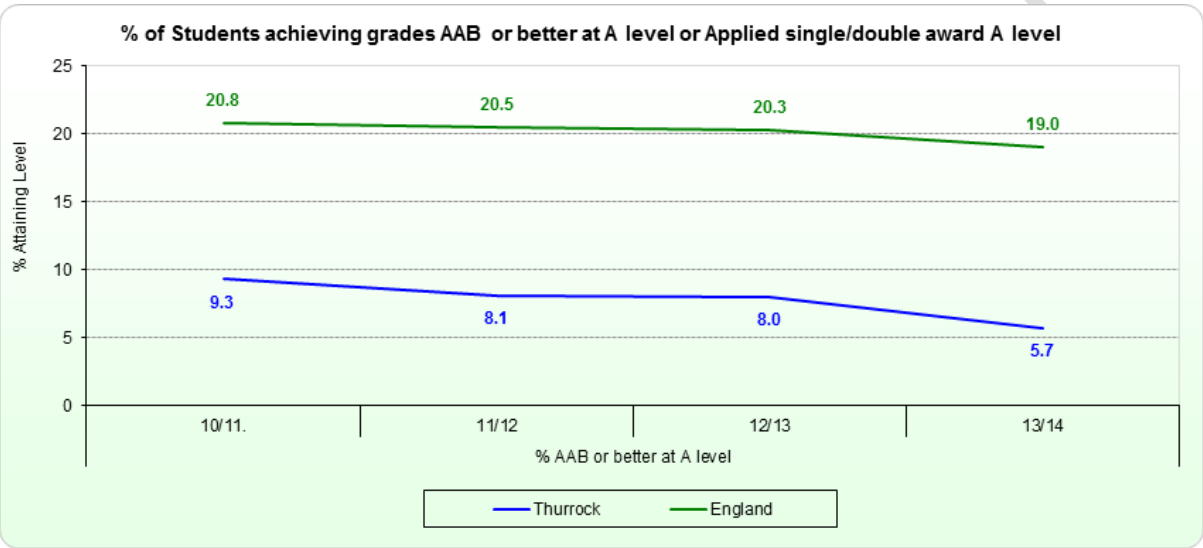
There are gender differences in the level of achievement at both a national and local level. The percentage of boys in both Thurrock and England achieving five or more GCSEs at A*-C or equivalent including English and Maths is consistently lower than the percentage of girls over the same period – only 51.7% of boys achieved this target compared to 63.1% of girls in

Thurrock in 2014. Whilst in 2013 the gender gap was, at 6.6, the lowest it has been in nine years and was a much smaller gap than the national average, in 2014 it is now larger than the national average.

Key Stage 5

Key Stage 5 (KS5) is the two years of education for students aged 16-18. Young people study Level 3 qualifications including AS/A Level, NVQ at Level 3 and BTEC award.

Figure 86: Percentage of pupils achieving AAB or above at A Level in Thurrock and England



Source: Department for Education and Thurrock Council

In Thurrock, the percentage of pupils achieving AAB grades or higher has followed a decreasing trend since 2010/11 and is now 5.7%, which is below the national average of 19.0%.

What are we doing in Thurrock?

The School Improvement Team works with the Thurrock Teaching Schools, 0-11 Strategy Group and the 11-19 Strategy Group to identify current needs through data analysis, school improvement consultant visits and Ofsted reports. Recommendations have been made to Thurrock Education Alliance who commission Thurrock Excellence Network to commission and deliver continuous professional development through courses, bespoke training and Specialist Leaders in Education deployment. Targeted training is commissioned to meet the needs of the Thurrock schools and academies. A comprehensive brochure has been collated and sent to all schools and included training in all the focus areas.

TEN has commissioned a successful Head Teacher to develop a recruitment and retention strategy. Alongside this work Thurrock has developed a high quality induction programme and mentoring programme for each new Head Teacher or Deputy Head.

We have commissioned SEND and Governance reviews in schools where these are a priority. Early Excellence was also commissioned to develop practice in schools where Early Years was

a priority. This has had a positive impact on Early Years provision in those schools, as Thurrock EYFS data now exceeds national data. KS1 and KS2 data for age-related expectations is in line or exceeds national with the exception of level 5+ maths.

Work is underway to refresh the current 0-19 Education Improvement Strategy, which has identified the following key areas upon which to focus future work:

- SEN outcomes
- EAL – a growing community
- Attainment of Higher levels (EY to KS5)
- Closing the gap – particularly around boys and girls
- Transition and continuity of effective provision
- Recruitment and retention high quality teachers and leaders
- A level average points score and challenge for more able young people at KS5
- Achievement of Level 2 and 4 by the age of 19

Thurrock's Children's Centres also play an integral role in supporting parents and children in enjoying and achieving well, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to encouraging parents to support their children's learning at home, and encouraging parents to read to their children.

Recommendations

The *Ambition, Achievement and Aspiration in Thurrock* Strategy (June 2014) outlines a number of suggested ways to drive improvement in educational outcomes for local children and young people, with the aspiration for Thurrock's children to be the best performers in the region and for every school to have a *good* or *better* Ofsted rating by 2016. In order to achieve this, Thurrock should:

- Work with a range of partners to ensure that all Thurrock's children have the best possible start in life to enable them to progress successfully in their education
- Continue to support parents and carers to engage positively in their children's education
- Drive practice to narrow the identified gaps in attainment, particularly for children and young people who are vulnerable
- Look to minimise variation between schools to ensure all children and young people have access to high quality education
- Ensuring that the benefits of schools becoming academies are realised to support rapid improvement, e.g. making best use of the capacity of academy chains and partnerships and the use of teaching schools
- Work in partnership to help Thurrock become an attractive and successful place to train, develop and retain teachers and leaders of effective schools and settings
- Ensure that young people aged 14-19 years benefit from expert careers education information and guidance in order to meet their interests, aspirations and needs
- Look to raise awareness in schools and colleges of the career opportunities opened up by the recent investments within the borough to support young people onto the necessary progression pathways

5. Making a Positive Contribution

Volunteering is generally considered an altruistic activity and is intended to promote goodness or improve human quality of life. Central Government is committed to getting younger people involved in public decision making and wants all young people to have a positive and active role in their communities and the wider society. The government looks towards local authorities to identify and resource arrangements to ensure young people are involved in influencing the designing of the policies that concern them. Volunteering also has wider social aspects and, as well as being fun, you can also choose to, do the things that are of interest to you, meet new people in the process or volunteer with friends.
Volunteering is…

- giving up your time and energy;
- for the benefit of society, the community, the environment or individuals outside of your immediate family;
- unpaid;
- your choice!

Some important themes in youth volunteering include increasing social inclusion and community participation, creating ownership through youth-led opportunities and recognising young volunteers through specific awards and accreditation. Volunteering is not only about what you can give back to your community, but also what you get out of it - many young people who volunteer find that their experience increases their confidence and self-esteem, teaches them new skills and gives a boost to their education and employment opportunities through building new skills/ training and additional qualifications that can be used on CV's and UCAS applications. Volunteering can also improve health and wellbeing through such opportunities as sporting activities and being part of a team.

Many young people are already involved in volunteering either through their school, local youth groups or their faith groups; some of these voluntary roles are:

- Faith based activities
- Sports clubs
- Uniformed groups such as scouting/ cadets/ first aid
- Youth club
- Supervision/prefect duties at schools
- Bands
- Peer mentoring
- Helping out at school events

What do we know?

Through Ngage, the Thurrock Volunteer Centre, there are many varied opportunities for young people to be able to take an active part in their community. As of 22nd October 2014, Ngage is working with:

- 3 volunteers under 15 years
- 297 volunteers between 15-18 years

- 617 volunteers between 19-25 years

Information collected in Thurrock Council's activity report indicated that in November 2013, there were 0.4% of 16-19 year olds volunteering in Thurrock, which is lower than the national average.

What are we doing in Thurrock?

Thurrock has a long history of proactive volunteering and a thriving and robust programme of youth opportunities ranging from more formal volunteering such as Young Leader programmes within uniformed groups to informal volunteering at local riding stables. In line with the Governments wish to involve young people in local democracy, Thurrock has two opportunities which provide this for young people:

1. Youth Cabinet

This group enables young people to get actively involved in local decision making. 31 members (11-19 years) from various schools and community groups sit on the Youth Cabinet. Some of the examples of young people's involvement are as follows:

Make Your Mark Ballot: Every year there is a national youth ballot named Make Your Mark which gives an opportunity for every young person (11-18 years) in the UK to vote on their top issue. Youth Cabinet members go out and about in their local areas encouraging young people to get involved and vote. In 2014 there were 4,326 Thurrock young people that voted in Make Your Mark. This is up from 1,735 (2013) and 698 (2012). The Youth Cabinet will now look at what issues received the top votes locally and see what work/campaigns can be run from this.

Interviewing commissioned providers: The Youth Cabinet work in partnership with the Council's Children's Commissioning Team to get young people involved in the commissioning process. Youth Cabinet members have carried out a number of interviews/service reviews with different commissioned providers. Their findings are then written up and passed back to the Council.

Interviewing new staff: Youth Cabinet members have sat on interview panels for new members of staff that come to work within Children's Services at the Council. These have included officer posts right up to director level.

Young people scrutinising decisions: The Youth Cabinet has 2 representatives on the Council's Children's Overview & Scrutiny Committee. These young people play an active role in the meetings and ensure young people's voices are heard at the committee.

Monthly youth cabinet meetings: The Youth Cabinet meet every month and as part of this a range of guest speakers engage with them to seek their views and opinions. These guest speakers include a range of officers and councillors at Thurrock Council covering areas such as safety, public health, regeneration and youth services.

2. Children in Care Council (CICC)

The CICC is a group of young people in care aged 11-21 who meet monthly to discuss issues that matter to them and their peers. They take part in consultations about services provided to them. They inform Thurrock directors, the corporate parent panel and local councillors of their wishes and feelings about the topics they have discussed. Professionals such as health and education also meet with the CICC to consult and obtain their feedback on current affairs affecting young people in Thurrock. In July 2014 the CICC facilitated a workshop for the social work interview day which allowed the CICC to be part of the recruitment process for new social workers who would like to join Thurrock. The CICC have also been involved in the commissioning process in regards to foster care recruitment and have framed questions for 2 tender evaluations. Health, education, team managers for social care and Thurrock's commissioning team have also visited the CICC to consult with them.
They have recently taken part in the local youth debate and support other young people with their campaigns. The CICC are currently reviewing the Pledge (promises Thurrock make to those young people in care). They are also taking the lead in supporting young people to completing the annual national survey for children in care and care leavers.

Future work

Ngage volunteering centre are in the process of developing a new one year project for young people aged 16-24 with the aim of recruiting 200 volunteers to the programme.

Recommendations

- Opportunities identified through commissioning and providers processes to increase the inclusion of NEET's into volunteering opportunities to improve their employment chances.
- Commissioners and providers to enhance the promotion of volunteering opportunities for young people.
- Local Authority to closer align the different youth voice mechanisms enabling the Youth Parliament to have a greater understanding of the views and needs of young people and the ability to inform the commissioning process.
- Timebanking and Carebanking information and opportunities to be cascaded out to young people.

6. Achieving Economic Wellbeing

Low Income Families and Child Poverty

Although the greatest factor for childhood poverty is growing up in a workless family or a family with low income, there are often a complex interplay of influences involving factors in individual families, the local economy and low levels of attainment. Children who grow up in poverty are often at risk of social exclusion and there are clear links between poverty and lower educational attainment, poorer health outcomes and intergenerational disadvantage.

Children living in areas of high deprivation:

- Experience a higher risk of infant mortality
- Are at higher risk of acute illnesses requiring hospital admission
- May be more likely to experience emotional and behavioural problems
- Are less likely to maintain a healthy weight
- Are more likely to experience problems with oral health
- Are more likely to achieve lower levels of educational attainment

In addition, young people growing up in areas of high deprivation:

- Are more likely to conceive and become teenage parents
- Are more likely to enter the youth justice system
- Are more likely to smoke
- Are at higher risk of becoming NEET
- May experience lower earnings and poorer qualifications in adulthood

There are some factors known to influence child poverty, which include family size and structure, the age and educational qualifications of parents, low earnings, ethnicity and lack of employment. Lone parent families are particularly vulnerable to poverty and teenage mothers are three times as likely to suffer poverty compared with older mothers. Disabled adults of working age are twice as likely as non-disabled adults to live in poor households and more than half of families with disabled children live on low incomes. In all parts of the country, people from ethnic minorities are, on average, more likely to live in low income households than white British people.

The Government is focussed on breaking the cycle of disadvantage and ending child poverty and remains committed to the goal of ending child poverty in the UK by 2020. The Child Poverty Strategy 2014-17 (HM Government, 2014) focuses on three key areas:

- Supporting families into work and increasing earnings
- Improving living standards
- Preventing poor children becoming poor adults through raising their educational attainment

The Child Poverty Act 2010 set four challenging targets to be met by 2020. The targets are:

- *Relative poverty* – to reduce the proportion of children who live in relative low income (in families with income below 60% of the median) to less than 10%
- *Material deprivation* – to reduce the proportion of children who live in material deprivation and have a low income to less than 5%
- *Persistent poverty* – to reduce the proportion of children that experience long periods of relative poverty, with the specific target to be set at a later date
- *Absolute poverty* – to reduce the proportion of children who live below an income threshold fixed in real terms to less than 5%

The Act also tasked local authorities with producing local child poverty needs assessments and strategies to improve understanding of drivers of child poverty, and to set out measures that can be undertaken to reduce child poverty in their local area.

Defining and measuring Child Poverty

Child poverty is defined by the national child poverty indicator (NI 116) as the percentage of children who live in families in receipt of out-of-work benefits *or* in working families with income less than 60% of the median national income (taking account of differences in household size and composition).

However, when considering levels of child poverty, low income families should also be considered – these are defined as working households (where at least one adult works more than 16 hours per week) which are receiving both Child Tax Credit and Working Tax Credit. Many of these families will be above the 60% income threshold used and are not counted within child poverty statistics, but the Government considers their income to be low enough to qualify for additional support.

What do we know?

The National Child Poverty Unit provides information on a range of indicators including the proportion of children living in low income families. This shows that 20.0% of children in Thurrock live in low income families, which is slightly higher than the national figure of 18.6% and shows an improvement of 1.4% from 2011.

Table 28: Children living in low income families, 2006-2012

	Thurrock		East of England		England	
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
2006	7,335	20.1%	191,885	15.8%	2,298,385	20.8%
2007	7,485	20.4%	200,435	16.4%	2,397,645	21.6%
2008	7,335	19.8%	199,060	16.1%	2,341,975	20.9%
2009	8,040	21.1%	212,645	16.9%	2,429,305	21.3%
2010	8,160	21.1%	209,255	17.1%	2,367,335	20.6%
2011	8,385	21.4%	206,280	16.2%	2,319,450	20.1%
2012	7,950	20.0%	194,380	15.1%	2,153,985	18.6%

Source: HMRC

This data also shows a 74% employment rate in Thurrock with 47% of children living in working households. This is slightly lower than the regional and national averages. This can be seen in Table 29.

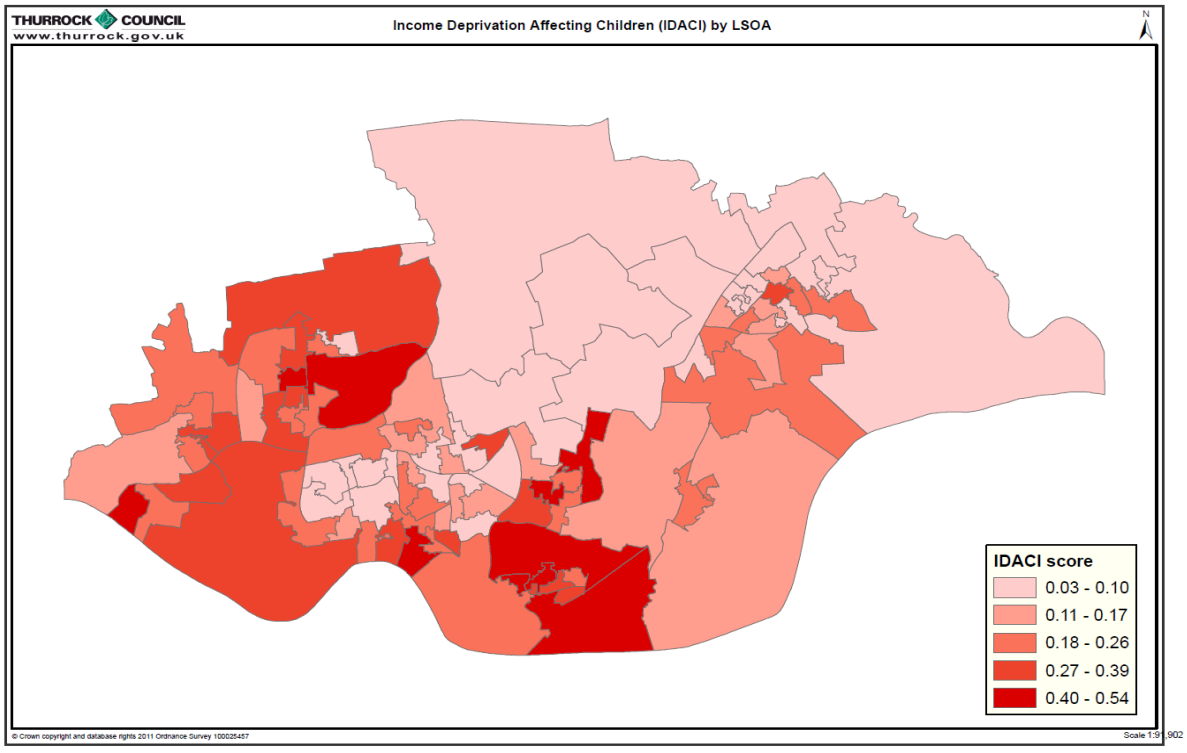
Table 29: Employment Profile, 2012

	Thurrock	East of England	England
Children in Workless Households (2012)	14%	12%	15%
Children in Working Households (2012)	47%	56%	51%
Overall employment rate (2013)	74%	76%	72%
Average earnings of employees (2013)	£552.10	£542.70	£520.70

Source: ONS

Child poverty exists everywhere in Thurrock but is most concentrated in the deprived parts of the borough. The Income Deprivation Affecting Children Index (IDACI) measures the proportion of children in each Lower Super Output Area (LSOA) aged under 16 years that live in income-deprived households. This can be viewed in Figure 87 below, and shows that there is wide variation across the borough – 3% of children in one LSOA in Corringham and Fobbing live in low income households, compared with one LSOA in West Thurrock and South Stifford, where 54% of children live in low income households.

Figure 87: Income Deprivation Affecting Children (IDACI) across Thurrock by LSOA, 2010



Source: Department for Communities and Local Government, Indices of Deprivation 2010

In Thurrock, the areas that have the highest levels of child poverty in most cases have the lowest educational attainment, more people in poor health or with disabilities that prevent them

from working, higher proportions of workless families, more families who lack bank accounts or home insurance, fewer car owners and higher proportions of adults who have poor basic skills or who lack qualifications.

What are we doing in Thurrock?

The Thurrock Child Poverty Strategy 2011-2014 has set the following strategic priorities:

- To increase parental employment and skills by providing access to adult training and skills development through the Wishes Adult Skills Programme and progression to adult learning opportunities.
- To increase benefit take up by improving providing high quality advice and guidance targeted to areas where there is a high prevalence of poverty and workless households.
- To reduce attainment gaps between children living in poverty and those who don't by targeting school improvement to those areas and supporting parents to be able to support their children through, for example, adult learning opportunities.
- To reduce the health inequalities faced by some families by developing a targeted, integrated approach to local delivery of services.
- To support the need to prevent homelessness from occurring by addressing the underlying causes of homelessness through effective partnerships, collaboration and the co-ordination of services.

The reduction of child poverty remains a key focus and the strategy for 2015 onwards will continue to reflect the national strategic priorities.

Since the introduction of a child poverty strategy locally there has been:

- A reduction in the number of children living in workless households from 19% in 2010 to 14% in 2012, this compares to the England average of 16% in 2010 and 15% in 2012.
- A reduction in the number of young people who are not in education, employment or training to 5% with a broader offer of training and employment opportunities linked to sector based skills linked to local regeneration.
- The continuation of the Wishes entry into adult learning programme which has supported on average 40 learners per year with low or no qualifications into level one and two training programmes.
- The development of joint working with Job Centre Plus as a part of the Troubled Families Programme
- The provision of support to families through partnership working with the Citizens Advice Bureau
- An increased supply of early education and childcare places, particularly for two year olds from low income families, with approximately 800 two year old children now accessing funded early education.
- A narrowing of the gap in attainment between those children living in areas of deprivation and others.
- The introduction of multi-agency planning of services and co-location to improve access for families to support.

- The introduction of a service targeted at preventing homelessness in young people

Thurrock's Children's Centres also play an integral role in supporting parents and children within low income families, and offer a range of supportive services to do this. Five of their 28 outcomes in their Outcomes Framework specifically relate to improving parent aspirations and focus on supporting parents to improve their basic literacy and numeracy skills, to ensure they have sufficient skills to access work, to help parents in managing their financial situation, helping parents enrol onto further training, and giving volunteers more confidence in progressing onto training or work.

Recommendations

- To further develop partnership working to reduce child poverty
- To develop the next stage of Thurrock's response to child poverty by writing the new strategy for 2015-2018
- To continue to embed child poverty reduction across the council and its partners

Further Education, Employment or Training

Young people over the age of 16 years who are not in education, employment or training (NEET) are at a greater risk of a range of negative outcomes. These include increased risk of living in areas of high deprivation, social exclusion and isolation, poor mental health and an increase in unhealthy behaviours such as substance misuse and smoking.

According to Allen (2014), almost half of those who are NEET at age 17-18 are still NEET one year later, and those who are NEET at age 18-19 are 28% more likely than others to be unemployed 5 years later. There are numerous other reasons why unemployment early on in life is particularly damaging; these include the increased likelihood of developing a mental health problem such as depression which could ultimately result in suicide – a large killer of young men in the UK. Allen (2014) also found that young men who are NEET were 5 times more likely to have a criminal record than their peers, citing that it could be necessity-driven. There is also evidence that when those who were NEET do move into work, they are more likely to be in low-paid jobs or receive no further training.

The Audit Commission (2010) produced a report which examined factors that increased young people's risks of becoming and remaining NEET. They found that being NEET at least once increased the chance of becoming NEET again for 6 months or more by almost 8 times. The full list can be seen in the table below.

Table 30: Factors leading to an increased chance of becoming NEET for 6 months or more

Factor	Increase in chance of being NEET for 6 months or more
Being NEET at least once before	7.9 times more likely
Pregnancy or parenthood	2.8 times more likely

Supervision by youth offending team	2.6 times more likely
Fewer than three months post-16 education	2.3 times more likely
Disclosed substance abuse	2.1 times more likely
Responsibilities as a carer	2.0 times more likely

Source: Audit Commission, analysis of Connexions data from fieldwork areas (approximately 24,000 young people), 2010

Other population groups associated with increased risk of becoming NEET include young people with special educational needs, learning difficulties or disabilities, care leavers, those with existing health problems, and those being classed as 'gifted and talented' but bored by school.

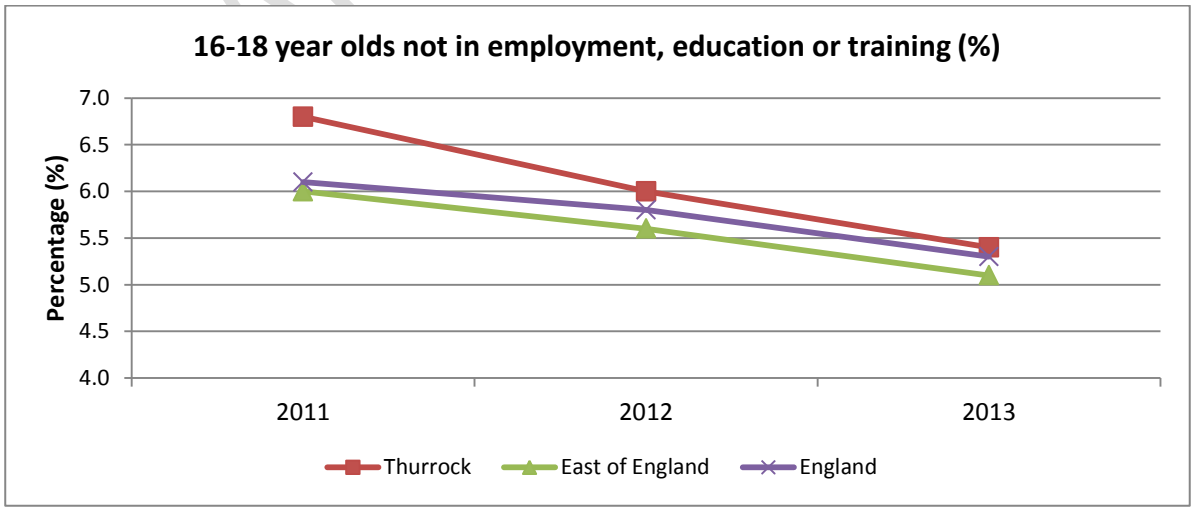
Allen (2014) indicates that remaining in education has a protective effect on health, concluding that four more years of schooling relates to up to a 16% reduction in mortality rates and reduces risk of heart disease and diabetes. The UK government has several schemes in process which aim to reduce the number of young people who are NEET, including:

- Raising of the Participation Age (from 2015, young people will be required to continue in education or training until they turn 18)
- the Youth Contract (package of schemes aimed at helping young people into sustained employment),
- the Work Programme (offering support to groups of long-term unemployed people).

What do we know?

Data showing the percentage of 16-18 year olds who are NEET is returned to the Department for Education on an annual basis. The most recent data (covering the period between November 2013 and January 2014) indicates that 5.4% of 16-18 year olds in Thurrock are NEET, which is similar to the regional average of 5.1% and the national average of 5.3%. As can be seen from the figure below, the Thurrock proportion has been decreasing in recent years in line with regional and national averages.

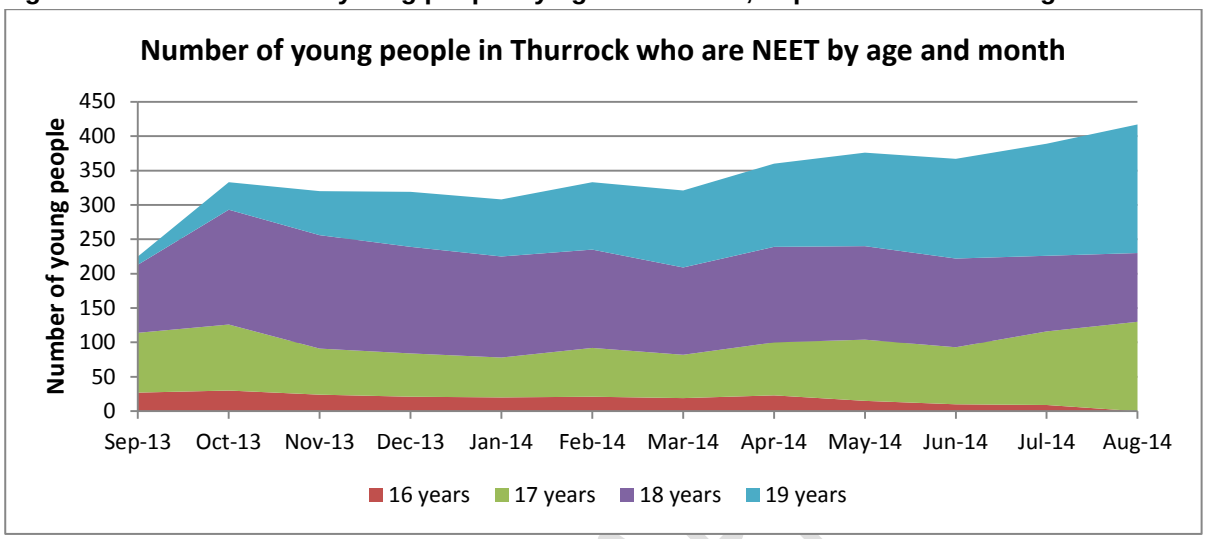
Figure 88: The percentage of 16-18 year olds who are not in education, employment or training in Thurrock, East of England and England, 2011-2013



Source: Public Health England

When this percentage is further analysed in terms of age and distribution over the course of an academic year, it can be seen that the numbers of NEET young people fluctuate throughout the year. Figure 89 below shows how the number of 16, 17, 18 and 19 year old NEETs in Thurrock change over 12 months, and it can be seen that the highest number of NEETs were seen in August 2014.

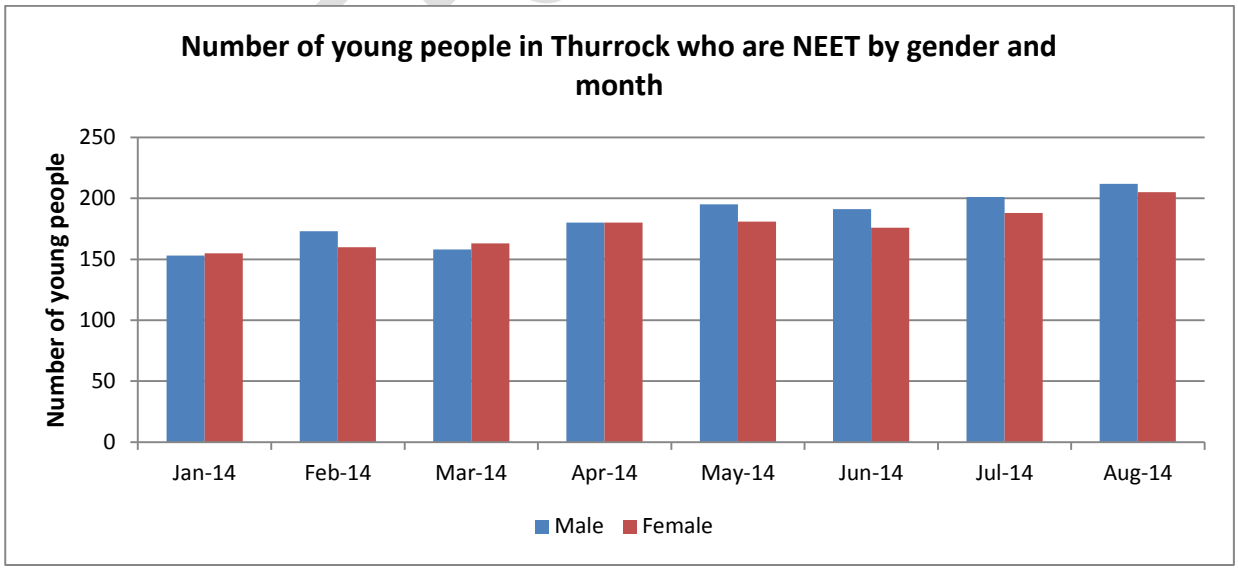
Figure 89: Thurrock NEET young people by age and month, September 2013 to August 2014



Source: Thurrock Council

With regards to gender, it can be seen from the figure below that for most months there are more NEET males than females, and that the numbers of both genders increase throughout the year up to August.

Figure 90: Thurrock NEET young people by gender and month, January to August 2014

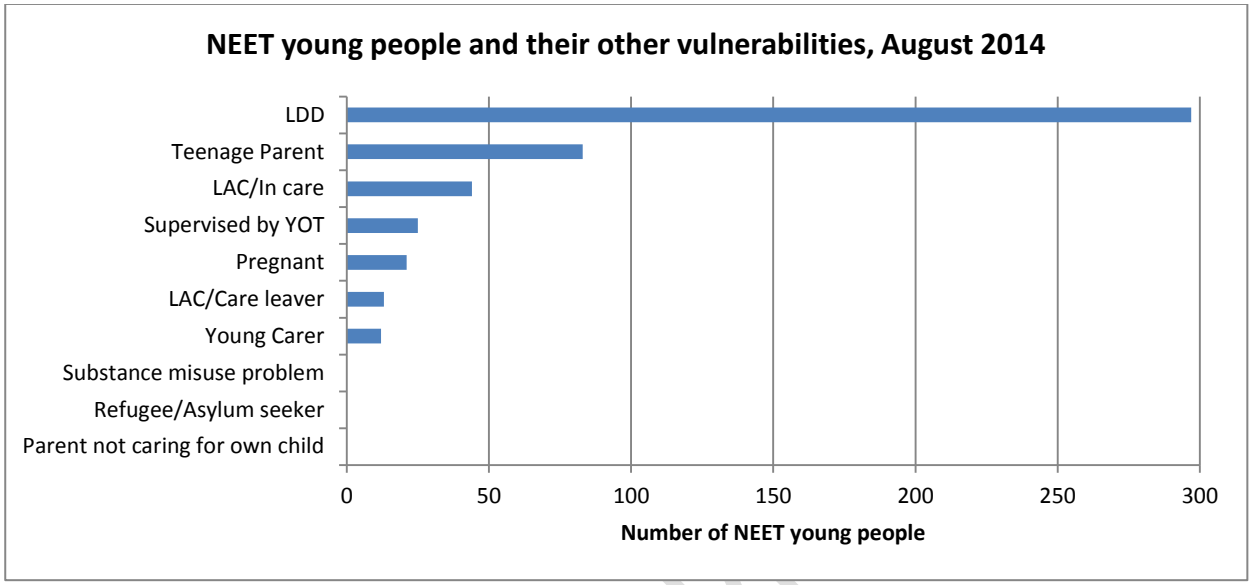


Source: Thurrock Council

The figure below outlines some of the other vulnerabilities recorded for the NEET population of Thurrock as of August 2014. It can be seen that a high number (297) of NEET young people have a learning difficulty or disability, which is one of the risk factors for becoming NEET.

Teenage parents and girls who are pregnant also represent a large proportion of the Thurrock NEET population (104). (It should be noted that one young person could be recorded in several groups).

Figure 91: NEET young people and other vulnerabilities



Source: Thurrock Council

What are we doing in Thurrock?

The Council's Learning and Skills team provides a service to residents of all ages, working with partners to develop skills and promote opportunities for further education, employment or training. Their work in supporting young people includes:

- Working with partners in the design and delivery of short 2-12 week programmes, comprising of sector specific training, employability skills training and work placement that should lead to employment. The programmes delivered have focused on Thurrock's key priority sectors and others: Construction, Logistics, Health and Social Care (elderly and childcare), Hospitality, Retail, Public Services, Creative and Cultural, Horticulture, Engineering. Following feedback from NEET young people that they are unable to afford transport and food costs associated with the programmes, we secured payment of transport and food on some of the programmes which slightly increased participation and outcomes.
- Providing 1:1 support to young people with the delivery of employability skills training. This includes support with CVs, job applications and interview skills, until they secure employment with training or volunteering.
- Working with schools and employers to create meaningful work experience placements. A suite of documents is provided to each school/academy to enable robust documentation for Ofsted to measure quality of the experience.
- Working with employers to create apprenticeship placements. The team facilitate this in a number of ways, including completing recruitment paperwork, advising on apprenticeship issues and supporting interview processes. Thurrock Council has 54 Apprentices in post; 13 of these are appointed Ambassadors who will promote the benefits of their route into employment in schools from September 2014.

- Providing 1:1 support for care leavers (16-24 years) to move into full time education or apprenticeships. This includes a *personalised package of learning* that can include literacy, numeracy, employability and life skills training before work experience placements/volunteering and ultimately secure employment. An effective cross directorate partnership reviews progress/services being accessed every two weeks. Since April 2014, 5 care leavers have secured employment (and they continue to receive ongoing support).
- Working closely with partners to create internships for local LDD residents (16-24 years) that are keen to be employed.

Future initiatives that will impact on local young people include:

- A new approach to employer engagement is emerging with a partnership collaborative comprising Thurrock Council, South Essex College, JobCentre Plus, Reed NCFE, National Apprenticeship Service and others to share vacancies and improve the recruitment of local people by local employers. Thurrock Council's employer engagement strategy will be updated to reflect the changes.
- The piloting of a job shop for one day a week in Tilbury library that is staffed by representatives from Thurrock Council and its partners to give high quality advice on how to access services and employment. It is envisaged that training courses will be delivered from the library in the future.
- The recent Partnership Agreement with JobCentre Plus which looks to reduce NEET in Thurrock as a priority.

Recommendations

Allen (2014) put forward a number of suggestions outlining what works in terms of reducing the proportion of NEET young people. These include:

- The need to focus on early intervention – strategies aimed at young people before the age of 16 years to prevent them from becoming NEET are likely to have the largest impact.
- Tackling barriers faced by NEET young people – such as housing provision, debt and health problems.
- Working across organisations – whilst this is already happening in Thurrock, this should be continued to ensure young people's needs are considered in a holistic way.
- Working with local employers – the current work and future approach that Thurrock will roll out should enhance these relationships and help ensure young people have the right skills and opportunities to enter the workplace.
- Track and monitor progress – Thurrock should continue to collect and maintain accurate data and intelligence around our NEET population, and also undertake effective monitoring and evaluation of initiatives aiming to reduce the level of NEET.
- Base interventions on features of other successful programmes – future initiatives should ensure they are based on sound evidence and best practice.

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Appendix 2: Glossary of Terms

Term	Definition
A&E	Accident and Emergency
ALS	Alcohol Liaison Service
ASD	Autistic spectrum disorder
BCG	Bacillus Calmette-Guérin (vaccine)
BME	Black and minority ethnic
BMI	Body mass index
BTUH	Basildon and Thurrock University Hospital
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
Chimat	National Child and Maternal Health Intelligence Network - part of Public Health England
CIN	Child In Need
CIPFA	Chartered Institute for Public Finance and Accountancy
Commissioning	A continuous cycle of activities that contribute to the securing of services, including the specification of services to be delivered, contract negotiations, target setting, monitoring and managing performance.
Confidence Interval (CI)	A 95% confidence interval is a range within which the true population would fall for 95 per cent of the times the sample survey was repeated. It depends on the amount of variation in the underlying population and the sample size, and is a standard way of expressing the statistical accuracy of a survey-based estimate.
CP	Child Protection
CSE	Child Sexual Exploitation
CVS	Councils for Voluntary Services
DAAT	Drug and Alcohol Action Team
Dental caries	A disease that damages tooth structures, resulting in what is commonly called tooth decay or cavities, which are holes in the teeth.
DH / DoH	Department of Health
DSR	Directly Standardised Rate
DTaP	Diphtheria, Tetanus and Pertussis (vaccine)
EAL	English as an Additional Language
Elective admission	A planned admission
Emergency admission	An unplanned admission
FNP	Family Nurse Partnership - a voluntary home visiting programme for first time young mums aged 19 or under (and dads)
GP	General Practitioner
GUM	Genito-urinary medicine
Hib	Haemophilus influenza type b
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
HPV	Human Papilloma Virus
HWB	Health and Wellbeing Board

IMD	Index of Multiple Deprivation - Combines a range of indicators into a single deprivation score, including social and economic measures and a measure for “Health Deprivation and Disability”. These measures may be used individually, or can be combined to rank areas relative to each other so that comparisons can be made.
Incidence	The rate at which new cases of a disease occur.
IPV	Injectable polio vaccine
JSNA	Joint Strategic Needs Assessment
Key Stage	Educational assessment stage
KSI	Killed or seriously injured
LA	Local authority
LAC	Looked after Child - a child is looked after when in the care of the local authority
LD	Learning difficulties
LSCB	Local Safeguarding Children Board. An authority-wide forum involving all agencies participating in child protection, used to set and monitor procedures and promote inter-agency co-operation.
LSOA	Lower level super output area - a geographic hierarchy designed to improve the reporting of small area statistics
MAGS	Multi Agency Groups
MASH	Multi Agency Safeguarding Hub
MECC	Making Every Contact Count
MMR	Measles, mumps and rubella (vaccine)
Mortality	The condition of being mortal, or susceptible to death
MSOA	Middle level super output area - a geographic hierarchy designed to improve the reporting of small area statistics
NCMP	National Child Measurement Programme
NCSP	National Chlamydia Screening Programme
NEET	Young people not in education, employment and training
NELFT	North East London Foundation Trust
Net migration	Inward migration minus outward migration
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NICU	Neonatal Intensive Care Unit - an intensive care unit specialising in the care of ill or premature newborn infants
Obese	Body mass index of over 30
ONS	Office for National Statistics
Overweight	Body mass index 25-30
PCT	Primary Care Trust
PCV	Pneumococcal disease
PHE	Public Health England
PHOF	Public Health Outcomes Framework - sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.
Prevalence	The proportion of a population who have a disease.
QOF	Quality Outcomes Framework (indicator)
Section 47 Inquiry	Investigation legally required of a local authority for any child considered at risk of harm

SEN	Special educational needs
SEPT	South Essex Partnership Trust
STI	Sexually transmitted infection
TTAS	Thurrock Traveller Achievement Service
Ward	Electoral and administrative boundary.
WHO	World Health Organisation
YOS	Youth Offending Service

Appendix 3: Document Contributors

Key Contributors:

Name	Team	Organisation
Beth Capps	Public Health Team	Thurrock Council
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Khurram Jamal	NHS Thurrock CCG	Tom Hopkins	Thurrock Council
Kim Stevens	Thurrock Council		

12 March 2015	ITEM: 10
Health and Wellbeing Board	
Charter for Older People	
Wards and communities affected: All	**Key Decision:** Key
Report of: Sarah Turner – Older People Commissioner	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris – Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

Building on the success of the Veterans Charter, it was agreed that Thurrock would develop a Charter for Older People. A consultation exercise was carried out during January and February (including a public event, utilising our on-line consultation portal and sending out hard copies of consultation documents to those who requested it) to ensure that Older People are able to shape the Charter.

1. Recommendation(s)

1.1 That the Board notes the consultation response and agrees the Charter for Older People prior to Full Council approval.

2. Introduction and Background

2.1 The success of the Veterans Charter in Thurrock has led to cross party support to develop a Charter for Older People

2.2 This Charter is a pledge of the values and standards Older People should expect from the Council and its partners.

2.3 The current consultation draft has been developed with Older People (please see section 5 for consultation activity).

2.4 Support from the Board for the Charter is being sought prior to Full Council.

3. Issues, Options and Analysis of Options

3.1 Thurrock is seeing a significant growth in its older people's population (particularly those aged 75+). This document reflects both the challenges and opportunities we face as a community in responding to this change in demographics.

4. Reasons for Recommendation

4.1 There has been support both politically and from older people for the development of this charter. This document has been shaped by older people.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 In early January a Charter for Older People in Thurrock was drafted. This was circulated internally (Adult Social Care DMT and with Cllr. Rice and Cllr. Halden) for comment before progressing with the consultation.

5.2 Thurrock Coalition - our User Led Organisation (ULO) ran a consultation event with Older People on 26th January 2015. This event was publicised at the Older People's Parliament, Thurrock Over Fifties Forum (TOFF) and via housing colleagues in sheltered housing complexes.

5.3 The event was successful and changes made to the original draft as a result of the day. This version (the attached consultation draft) was then published on Thurrock's consultation portal for comment. Hard copies of the consultation were also sent to Older People who requested it in this format.

5.4 The consultation ran between the 26th January 2015 and 16 February 2015.

5.5 7 written responses were received. All of which were positive.

5.6 1 respondent did indicate that they did not agree with pledges 1, 6 and 7. However, the text explanation they provided showed that they were actually supportive of the pledge content but had chosen to indicate 'no' to use the text box facility to provide suggestions to Social Care and Housing on desired improvements to services.

5.7 There was also an opportunity for respondents to provide additional comments at the end of the questionnaire. Respondents largely concentrated on the need for high quality housing for older people, built in the communities they live in (so they don't need to move away from friends, neighbours and family etc.) close to shops, doctors and good transport links. One respondent commented on the need to encourage more dialogue between different generations.

6. Impact on corporate policies, priorities, performance and community impact

6.1 Although the creation of a charter would support all of Thurrock's priorities, it specifically supports the priority;

- To improve health and well-being'.

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**
Management Accountant

There are no financial implications.

7.2 **Legal**

Implications verified by: **Dawn Pelle**
Adult Care Lawyer

There are no legal implications.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**
Community Development and Equalities Manager

There are no negative diversity and equality implications. The Charter for Older People is being developed to support the equal treatment of older people in Thurrock and to stop discrimination based on age.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

- None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- None

9. Appendices to the report

- Appendix 1 – Consultation draft: Charter for Older People

Report Author:

Sarah Turner
Older People's Commissioner
Adult Social Care: Commissioning Department

NOTHING ABOUT ME WITHOUT ME

Thurrock Council - Charter for Older People

This Charter is a pledge of the values and standards Older People should expect from the Council and its partners.

This Charter compliments the Building Positive Futures programme in which Housing, Adult Social Care and Health (alongside many other partners) are working together to find a local solution to enable older people to age well in Thurrock.

The Charter recognises both the challenges faced by older people but also the contribution they make to Thurrock. As such this document pledges to improve the quality of life of Older People by undertaking to;

1. Provide good **information** and advice
2. Treat older people with **dignity** and **respect**
3. Give older people a **voice** and an opportunity to shape services
4. Give older people **choice** and **control** over the services they receive and where they receive them. Develop health and care solutions that can be accessed close to home
5. Ensure that older people don't suffer **discrimination** because of their age. Create communities where people who are diagnosed with dementia and their carers are nurtured, understood and supported.
6. Focus on **prevention** to enable older people to stay healthy and live as independently as possible
7. Work across service and professional **boundaries** to support and care for older people in a way that meets older people's needs not ours.
8. Support older people to be free from **abuse** and harm
9. Build more hospitable, age friendly communities. Reduce social isolation and **loneliness** and help older people to enjoy life.
10. Build high quality **housing** with the right neighbourhood facilities for older people. As regeneration takes place in Thurrock, ensure older people benefit equally from this.

We also commit to review and develop the Charter with Older People on a regular basis

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12 March 2015	ITEM: 11
Health and Wellbeing Board	
Care And Support Specialised Housing Fund: Phase 2	
Wards and communities affected: All	**Key Decision:** Non-Key
Report of: Barbara Brownlee and Roger Harris	
Accountable Head of Service: Kathryn Adedeji and Les Billingham	
Accountable Director: Barbara Brownlee : Director of Housing and Roger Harris : Director of Adults Health and Commissioning	
This report is Public	

Executive Summary

Health and Wellbeing Board (HWB) members will be aware that the Council bid successfully to Phase 1 of the Care and Support Specialised Housing Fund in July 2013 and the resulting HAPPI standard (Housing Our Ageing Population: Panel for Innovation) scheme for older people is now under construction at Derry Avenue, South Ockendon. The Department of Health, in association with the Homes and Communites Agency (HCA), has now launched phase 2 of the Fund. This will support housing for older people and adults with disabilities or mental health problems. The closing date for bids is 29 May 2015 and bids require evidence of the bidder's "Board" approval.

This report provides a brief summary of the bidding prospectus and requirements and proposes that the Council should submit a bid for this second phase. Given there will not be another HWB Board meeting prior to the bidding deadline, it further proposes that delegated approval be given to the Director of Housing, in consultation with the Director of Adults, Health and Commissioning and their respective Portfolio Holders, to agree the detail of, and submit, the bid on behalf of the Council and the HWB Board.

1. Recommendation

1.1 That, the Health and Wellbeing Board support the submission of a bid to Phase 2 of the Care and Support Specialised Housing Fund.

1.2 That, subject to the decision of Cabinet on March 11th, authority be delegated to the Director of Housing, in consultation with the Director of Adults, Health and Commissioning and the respective Portfolio Holders to agree the details of the final bid to be submitted by 29 May 2015.

2. Introduction and Background

2.1 The Care and Support Specialised Housing (CASSH) Fund was announced in July 2012 and Thurrock Council was successful in bidding for funding from phase 1 in July 2013. This bid was for £1.327m of grant towards the cost of the HAPPI scheme for 28 flats for older people at Derry Avenue in South Ockendon. This scheme is now under construction and due for completion in November this year.

2.2 Phase 2 of the CASSH Fund was announced on 17th February with a bidding deadline of 29th May 2015.

2.3 This report provides further details regarding the bidding requirements as set out in the Funding Prospectus in order that the HWB Board can approve the principles for submission of a second bid by the deadline.

3. Issues, Options and Analysis of Options

DoH Funding Prospectus

3.1 The prospectus for this second phase of funding under the CASSH programme makes available up to £120m of grant available for affordable housing for older people and specialist housing under the following three adult (18+) client groups:

1) People with learning disabilities or autism,
2) People with physical or sensory disabilities,
3) People with mental health problems.

3.2 Phase 2 aims to encourage private sector developments through the provision of mixed tenure developments to stimulate the market and extend the range of specialised housing options available including private market housing. However, CASSH funding will only be available for affordable housing provision on such schemes: either Affordable Rent, Shared Ownership or Older People's Shared Ownership housing.

3.3 Proposals to remodel existing schemes will be acceptable provided they represent value for money.

3.4 Bidders are encouraged to engage with NHS providers to offer good value for money, including through making sustainable savings to local health budgets. In addition optimising the use of public land holdings and innovation, including different forms and models of housing, such as mutual or co-housing, is welcomed.

Bidding Requirements

3.5 Key bidding requirements are as follows:

1) Bidding organisation must be qualified as HCA investment partners, which the Council is,
2) Schemes must be completed by 31 March 2018 and those with planning consent and/or that can start in 2015/16 will be prioritised,
3) Priority will be given to housing for adults with mental health problems which support greater independence and to affordable housing as part of mixed tenure sites,
4) Schemes should provide for safe and convenient access to local amenities and support services, including local health, social care and community services,
5) Schemes should offer long term housing,
6) Schemes should provide for flexibility as individual needs change, including ability to adapt of install equipment or assistive technology in the home,
7) Schemes must demonstrate how they will meet individual requirements for care and support. Care and support packages can be provided as part of the scheme but there may not be a need for personal care and care and support can be provided by appropriate nearby facilities,
8) Residential care homes or general needs housing developments restricted to older people are not eligible,
9) All dwellings must have individual front doors and, for housing for older people, communal areas must be included. Schemes for shared accommodation must demonstrate how they will support independence and well being,
10) Bids will be judged on how well they respond to local needs,
11) Funding will only be available on Section 106 sites where evidence is provided that the funding will result in provision that is additional to that required through the Section 106 agreement.

Council's Proposed Response

3.8 It is proposed that the Council should bid under this programme and that a project group be formed immediately to develop the bid, based on the key requirements set out above.

3.9 The following information will need to be developed and submitted as part of the bid:

1) Details of the bidding organisation (presumably the Council although we could work with another registered provider)– and whether the Council will do so in partnership with the private sector,
2) Details of the proposed registered provider (again could be the Council or another registered provider),
3) Details of the proposed scheme including:
    a. Number, size and tenure mix of the properties,
    b. Client groups to be housed,
    c. Financial information including: breakdown of cost contributions, proposed rents and sales values
    d. Scheme programme including date that planning consent is forecast to be achieved,

4) Evidence of Cabinet approval,
5) Evidence of fit with local strategic priorities,
6) Details of Innovation and sustainability including:
    a. Level and type of care and/or support provided,
    b. Revenue funding,
    c. Demonstration of resilience to future needs of targeted groups,
    d. Innovation in use of communal/shared space,
    e. Integration with local health, social care and community service provision,
    f. Partnerships with NHS providers and information regarding how the scheme will help to reduce the burden on health and care budgets.
7) Design Statement: description of the proposed design, site and floor plans and statement of good practice providing examples of innovative design that will enable the occupant to live independently.
8) Employment and skills statement showing how the scheme will support employment and skills opportunities in the local area.
9) It is also expected that the bid demonstrates evidence of buy-in by members of the Health and Wellbeing Board and, where possible demonstrate potential savings to the local health, social care and housing budgets.

4. Reasons for Recommendation

4.1 Phase 2 of the CASSH Fund has a bidding deadline of 29th May. This means the Council's bid will have to be submitted before the next HWB Board meeting in June. However, given the bid announcement was only made on 19th February it has not been possible to develop the Council's bid for this March meeting.

4.2 Therefore it is proposed that the Health and Wellbeing Board give delegated authority to the Director of Housing, in consultation with the Director of Adults, Health and Commissioning and their respective Portfolio Holders, to agree the details of the final bid and ensure submission by the deadline. A further HWB Board report in June will set out full details of the final bid submitted.

4.3 A parallel report is going to the Council's Cabinet on 11th March (ie the day before the HWB Board) – the report of the discussions and decision of that meeting will be reported verbally to the HWB Board.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Given the very recent announcement of this bidding opportunity and the relatively short timescale to bid submission it will not be feasible to hold detailed consultation on the final bid to be submitted. However, the project working group will endeavour to undertake as much consultation as possible. The working group will ensure also that the proposals within the bid are in line with the Council's approved strategies and policies, in particular its Housing and Health and Wellbeing Strategies, and upon which there has been

extensive consultation. The proposal will also be discussed with the Thurrock Clinical Commissioning Group as the prospectus is clear that NHS partners should also be fully engaged.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The Community Strategy and Corporate Plan, the Housing Strategy and the Health and Wellbeing Strategy plus the Adult Social Care Market Position Statement are relevant to this bid.

7. Implications

7.1 Financial

Implications verified by: **Sean Clark**

Head of Corporate Finance (S 151 Officer)

The bid details have yet to be finalised but any affordable housing to be provided by the Council as part of the bid will be funded within the HRA Business Plan. The capital programme allows for any scheme that is funded from third party contributions, such as grant in this case, to be deemed as part of the capital programme thus providing Council approval.

7.2 Legal

Implications verified by: **Assaf Chaudry**

Major Projects Solicitor

This report seeks approval to submit a bid for a Phase 2 funding offered by the Department of Health, in association with the Homes and Communities Agency (HCA). This is subject to producing a further Cabinet report once the proposed bid succeeds. In these circumstances there are no legal implications arising from this report.

7.3 Diversity and Equality

Implications verified by: **Teresa Evans**

Equalities and Cohesion Officer

If the proposed bid is successful, the development will be undertaken with due regard to equality and diversity considerations and, in particular, will ensure that any third party partners and contractors involved in the final scheme will be required to fulfil the requirements of PSED and will deliver social value including through training and apprenticeships.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report

The Care and Support Specialised Housing Fund: Phase 2 Bidding Prospectus, February 2015

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404757/CASSH_phase_2_prospectus_full.pdf

9. Appendices to the report

- There are no appendices to this report.

Report Author:

Barbara Brownlee

Director of Housing

Roger Harris

Director of Adults, Health and Commissioning

Health and Wellbeing Board Forward Plan

Date	Agenda	Lead
15/06/15	• Mental Health Crisis Care Concordat	Mark Tebbs/ Catherine Wilson
	• Health and Wellbeing Board Development Session Report and Action Plan	Sharon
	• Homelessness Strategy Review	Dawn Shepherd
	• Health and Wellbeing End of Year Report / Delivery Plan 14/15	Sharon
	• Update on CAMHS procurement and award of contract	Paula McCullough
	• Air Quality Report	Catherine Edwynn
16/07/15	• Autism Strategy	Alison Hall
	• Market Position Statement	Sarah Turner
	• Health Protection Report	Maria Payne /Catherine Edwynn
	• Healthwatch Annual Report	Kim James
	• Health and Transformation Report	Ceri
	• Joint Commissioning Statement Special Educational Needs Report	Malcolm Taylor
	• Health and Wellbeing Strategy Refresh /HWBB Membership	Sharon
	• BTUH Update and CCG Developments	Mandy

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