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 **1 October 2015**

Committee Room 2, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Barbara Rice (Chair), John Kent, Brian Little, Bukky Okunade and Joycelyn Redsell

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Lesley Buckland, Lay Member Thurrock CCG
David Bull, Interim Director of Housing
Graham Carey, Chair of Safeguarding Adults Board
Stephanie Dawe, North East London Foundation Trust
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Thurrock Clinical Commissioning Group
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
Malcolm McCann, South Essex Partnership Foundation Trust
Sean O'Callaghan, Vice Chair of Thurrock Community Safety Partnership
Clare Panniker, Basildon and Thurrock University Hospitals Foundation Trust
David Peplow, Chair of Local Safeguarding Children's Board
Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region
Ian Wake, Director of Public Health

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes **5 - 10**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 16th July 2015.

3	**Urgent Items** To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	
4	**ITEM IN FOCUS - Demography Joint Strategic Needs Assessment**	**11 - 54**
5	**Housing and Planning Advisory Group Progress Report**	**55 - 64**
6	**Joint Health and Wellbeing Strategy 2016-2019**	**65 - 80**
7	**Health and Wellbeing Board Self-Assessment**	**81 - 86**
8	**Healthwatch Thurrock Annual Report**	**87 - 110**
9	**South Essex Emergency Doctors' Service (SEEDS) update**	**111 - 114**
10	**Public Health Grant 2015/16 - Proposed Reductions**	**115 - 128**
11	**Work Programme**	**129 - 130**

Queries regarding this Agenda or notification of apologies:

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

Agenda published on: **23 September 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?**

↓

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.

Vision: 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 aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

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 and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Health and Wellbeing Board held on 16 July 2015 at 2.00 pm

Present:	Councillors Barbara Rice (Chair), John Kent, Joycelyn Redsell and Brian Little, Bukky Okunade Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group Barbara Brownlee, Director of Housing, Thurrock Council Graham Carey, Chair of Safeguarding Adults Board 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 Ian Wake, Director of Public Health
Apologies:	Lesley Buckland, Lay Member Thurrock CCG Andrew Pike, Director of Commissioning Operations, NHS England and East Anglia
In attendance:	Kev Malone, Public Health Manager (item 8) Clare Panniker, Chief Executive, Thurrock and Basildon Hospitals Foundation Trust (item 5) Michelle Stapleton, Integrated Care Director, North East London Foundation Trust Ceri Armstrong, Strategy Officer

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.

17. Minutes

The minutes of the Health and Wellbeing Board, held on 15th June 2015, were approved as a correct record.

Public Health Grant 2015/16

At the last meeting, the Board had been made aware that the Council had received notification that the currently ring-fenced Public Health Grant was to be cut nationally by £200m during 15/16. This equated to a 7.4% cut to the total Grant across England. If 7.4% was applied to Thurrock's current Grant, this would result in a reduction of £614k.

Ian Wake, Director of Public Health, updated the Board that he had looked at the current Public Health budget and identified potential savings options which

include the restructuring of the core Public Health Team; and reduced spend on breastfeeding and parenting support as the current contract is due to end with NELFT, no bidders have come forward in the retendering process, and there are opportunities with the 0-5 years agenda transferring to Public Health from October 2015. NHS England has yet to confirm how the reduction in the Grant will be distributed between authorities. Once this has been confirmed, plans will be finalised.

RESOLVED:

That the update on the Public Health Grant be noted.

Success Regime
Roger Harris, Mandy Ansell and Clare Panniker, Chief Executive, Basildon & Thurrock University Hospitals Foundation Trust, had attended a Stakeholder 'kick-off' meeting on July 15th where the purpose and delivery plan was discussed.

The focus of the Regime is to create the conditions for success in challenged local health and social care economies like Essex.

Roger Harris commented that the concern for the local authority is the enormity of the task which may pose a big distraction from the current transformation programmes already taking place.

Mandy Ansell commented that the workforce challenge was the greatest issue for Thurrock CCG.

Clare Panniker commented that the intended outcomes of the regime are not clear and would like to see clear objectives on what Health and Social Care will look like in 5 years' time.

Ian Wake raised concerns about the potential centralising of health structures and services on an Essex-wide basis and that this was not always the best solution.

Board members agreed with Clare's concerns about the lack of clarify over the process, but felt there could be opportunities as well as threats.

RESOLVED:

That the update on the NHS Success Regime in Essex be noted.

Suicide Prevention
Ian Wake, Director of Public Health updated the board on the Suicide Prevention Strategy stating that Cate Edwynn, the Consultant in Public Health is conducting a Suicide Audit and presented preliminary results to the Adults, Health and Commissioning Directorate Meeting on the 14th July. Cate is currently in the process of conducting a review with GPs in Thurrock. Options include broadening the Mental Health Strategy to incorporate suicide

prevention – focusing on good mental health, rather than a separate Suicide Prevention Strategy. Options will be considered as the work progresses.

RESOLVED:

That the update on the development of a Suicide Prevention Strategy be noted.

18. Urgent Items

Coach House Residential Home
The Chair requested an update relating to discussions around the potential closure of Coach House Residential Home.

Mandy Ansell updated that due to the 40% uplift per patient being requested by the provider – Family Mosaic, placements were no longer viable or affordable for the CCG. Thurrock has nine residents in Coach House, and they are all CCG-funded via Continuing Health Care. Mandy also updated the Board that the uplift was only one factor and that in discussions with the Home she had been made aware that it was likely to close regardless of whether the additional charge was paid.

Kim James told the Board that relatives were distressed by the potential closure, and that they had been communicated with prior to the CCG being made aware.

Cllr John Kent requested clarity around the legal requirement regarding the closure and the duty of care for the residents. Mandy Ansell replied stating that the legal obligation will be to assess the residents need and to commission a bed at an alternative location if eligible for care.

Roger Harris updated that we will work jointly with the provider and the social care team in Thurrock to create a plan for patients and a communication plan to ease concern for the residents and their relatives.

19. Declaration of Interests

No interests were declared.

20. Basildon and Thurrock University Hospitals Foundation Trust - Item in Focus

Clare Panniker, Chief Executive of Basildon and Thurrock Hospital delivered a presentation on activity levels at the Hospital. Thurrock CCG represents approximately a third of the Trust's activity which includes a 12.7% growth in Accident and Emergency (A&E) attendances. Clare made the Board aware that A&E attendances were increasing rapidly, but that Thurrock resident admissions resulting from an A&E attendance had only increased by 1%.

Clare made the Board aware that the Hospital's mortality rate (SHMI) is now in the expected range and the ambulatory care admission rate has reduced. Clare also told the Board that patient and staff satisfaction had increased, but there was further to go in improving satisfaction levels. A recent CQC inspection had rated the Hospital as 'good', with maternity services being rated as 'excellent'. It was likely that the Hospital would retain its 'good' rating, and this was waiting to be confirmed by CQC.

The Hospital's financial situation was of concern, with a £38 million deficit predicted for 15/16. Other Trusts were in a similar or worse position.

The Chair asked whether some patients attend on a regular basis, and Clare replied that there are a small proportion of people who repeatedly use A&E instead of using other suitable provisions as the service is easier to access and the A&E brand is trusted. Secondly, chronically sick patients do attend A&E frequently due to aspects of their condition, although this contributes very little to the attendance rate. Clare thought it was the Out of Hospital offer was often confusing to patients.

Roger Harris commented that resources from both the Council and the CCG had already been focused around prevention and early intervention. For example work on building on community strengths, local area coordination, and also the work of the Rapid Response and Assessment Service. Despite this work, demand continued to grow and it was unclear as to why this was.

Clare stated that there were three main strands to reducing the current financial situation. These were: Internal efficiency and productivity review; Vertical Integration (Better joining up with services within the community); Horizontal Rationalisation (Consolidate Services). Clare further commented that the public should be made aware that there needed to be a trade off between access and quality.

In response to Councillor Little, Clare stated that ideally, a 20-30% reduction in admissions was desirable as this would allow a decrease in the Hospital's bed base. Attendances were not the key issue.

21. Thurrock Adult Autism Strategy

Roger Harris, Director of Adults Health and Commissioning presented the Thurrock Adult Autism Strategy.

A draft Strategy had been presented at the January meeting prior to consultation taking place. Between January and March 2015 Thurrock Council consulted on the Strategy and minor amendments were made to the Strategy and action plan following this.

Cllr Brian Little raised a question in relation to the cost between transitioning from Children's Social Care to Adults Social Care. Roger updated that the current indications suggest that total weekly cost of those that will transition from Children's to Adults is £59k per week, an annual cost of £3.1m.

The Board asked for assurance that the Strategy would be a live document. Roger assured the board that the Strategy would be a live document, and also that it had formed a big part in the CASSH Bid which had been submitted to fund housing for adults with Autism, including the proposal for a capital contribution of £140,000

RESOLVED:

That the Health & Wellbeing Board formally adopts the Strategy.

22. Market Position Statement

Roger Harris presented the Market Position Statement

Roger updated the board that the document sets out how we see the social care market developing over the next 3-5 years. The document sets out the current and predicted need; the strategic context we are operating in; what we spend and changing trends and implications for providers.

The document will be used as a basis of discussion with current and potential providers to ensure that the market changes meet our vision of where we want to be.

RESOLVED:

The Board are asked to note the outcome of the public consultation and approve the document for publication

23. Tobacco Control Strategy

Kev Malone, Public Health Manager presented the Tobacco Control Strategy.

Kev updated the Board that this strategy was tabled at the June meeting where two amendments to the delivery plan were requested by the board. These have now been actioned.

Cllr Joy Redsell raised a concern regarding employees smoking outside of office buildings in relation to Thurrock Civic Offices and Thurrock Hospital. A second concern was made regarding Children smoking outside of school gates. Kev replied stating that mechanisms are currently being put in place to tackle smoking in schools as part of the Public Health Responsibility Deal. Secondly, the Tobacco Control Alliance is working with Basildon and Thurrock Hospital to tackle staff smoking.

RESOLVED:

1. **That the board ratify the Thurrock Tobacco Control Strategy 2014-2019.**

2. **That the board ratify the Delivery Plan contained within this document.**

24. Joint Health and Wellbeing Strategy End of Year Report 2014 - 2015 (Children and Young People) and Delivery Plan 2015 - 2016

Ceri Armstrong, Strategy Officer presented the Joint Health and Wellbeing Strategy End of Year Report 2014-15 and Delivery Plan 2015-16.

Ceri updated the Board that this report provides the End of Year report against the 2014-15 Health and Wellbeing Strategy Delivery Plan for Children and Young People, and the proposed Delivery Plan for both Adults and Children and Young People for 2015-16. The End of Year Report details the progress against the 14/15 actions as provided by the action owners.

RESOLVED:

1. **That the board endorses the Children and Young People's End of Year Report 2014/15.**

2. **That the board endorses the Delivery Plan for 2015/16 for both Children and Young People and Adults.**

25. Forward Plan

The Board's Forward Plan was updated.

The meeting finished at 3.57 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

thurrock.gov.uk

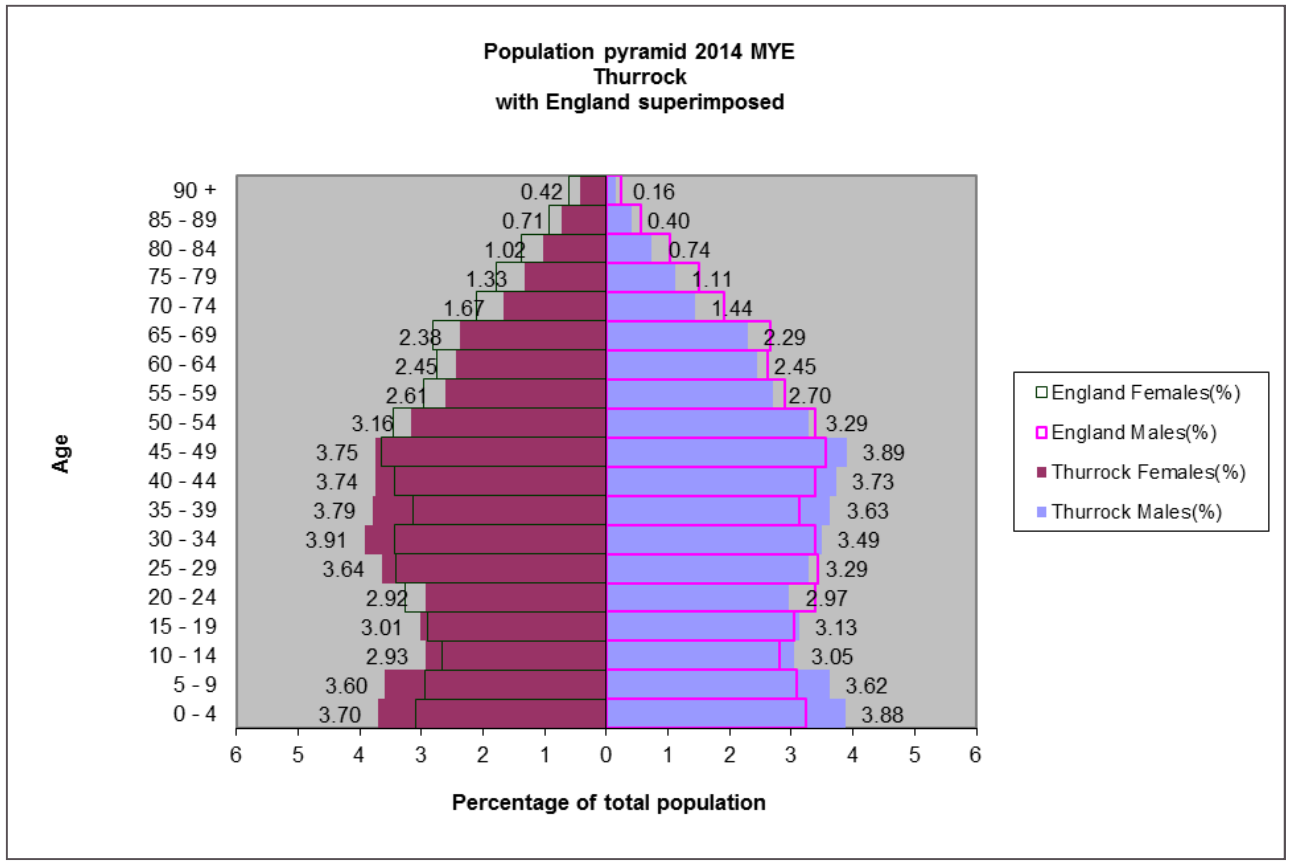
Demography JSNA

Maria Payne
Health Needs Assessment Manager

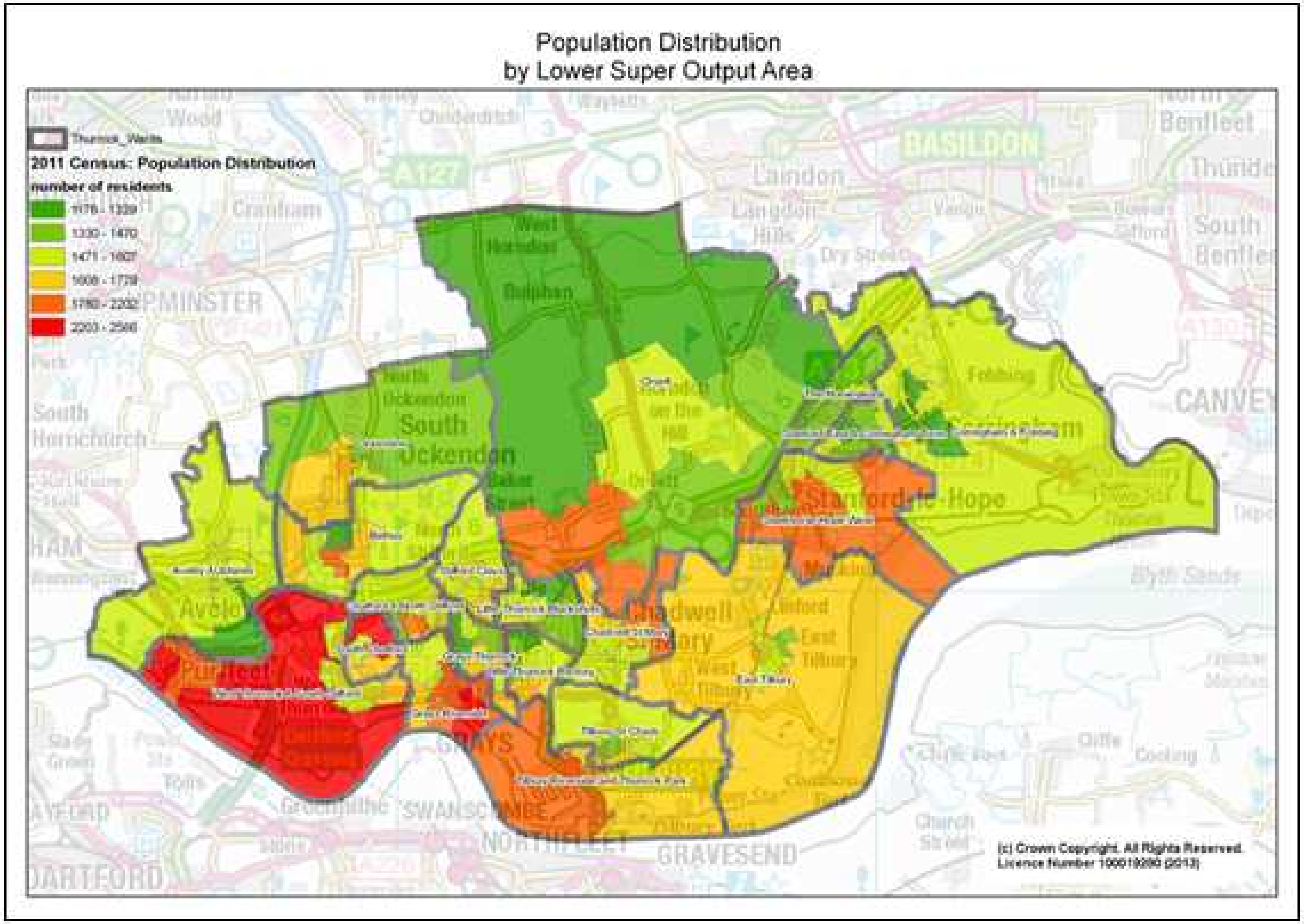
1st October 2015

Population by age and gender

Thurrock has an estimated population of 163,270.

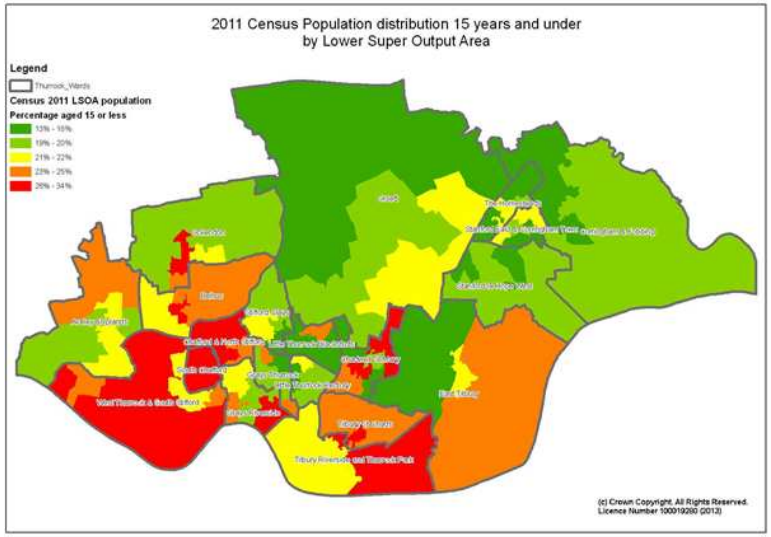


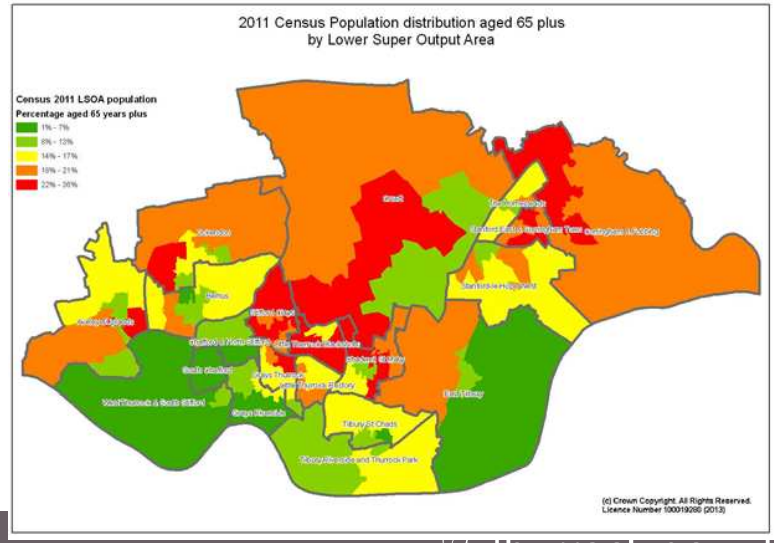
Population Distribution



Population Distribution – key age groups

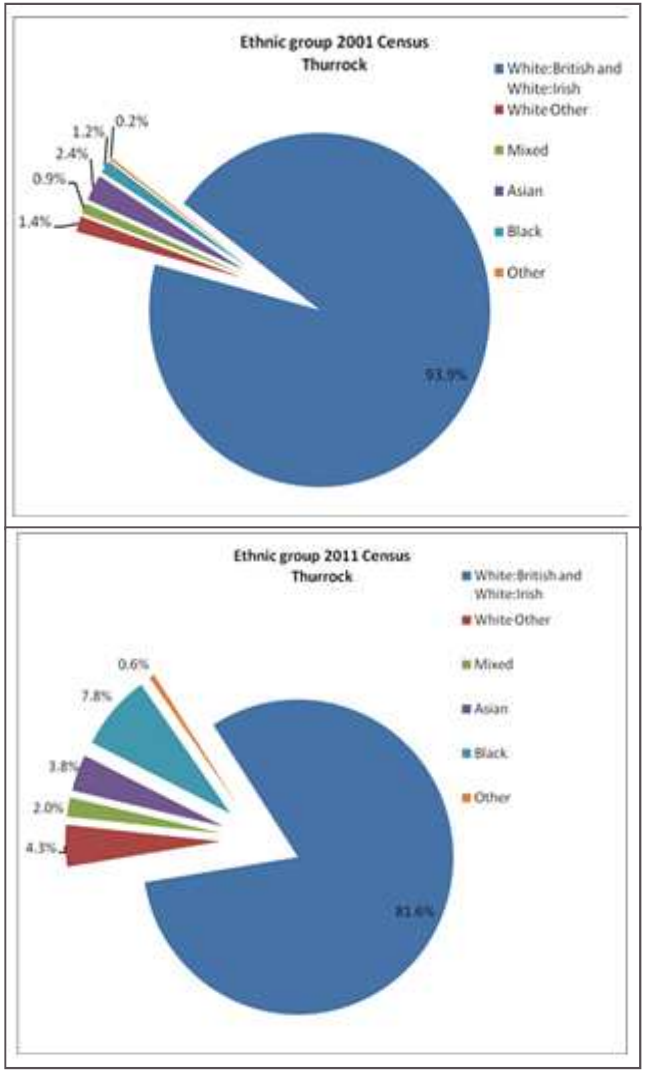
- Areas with highest proportions of 0-15 year olds are generally in the south and south west of the borough.
- Areas with highest proportions of those aged 65 years and over are generally in the north of the borough.



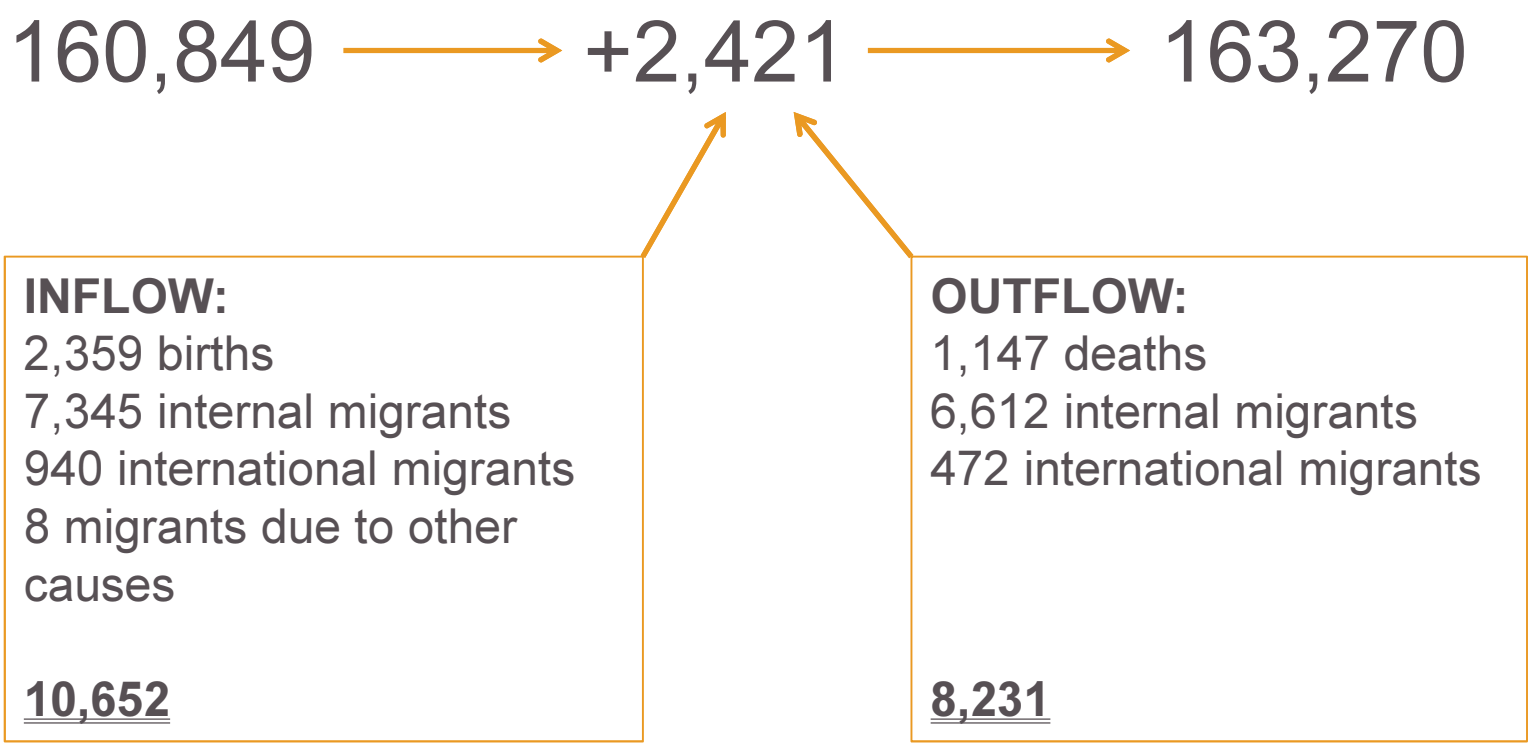


Ethnicity

- Thurrock's population is becoming more ethnically diverse
- In 2001, 93.9% residents were White British and Irish – in 2011, this was 81.6%.
- Particularly large increases within the Black and Other White Groups.

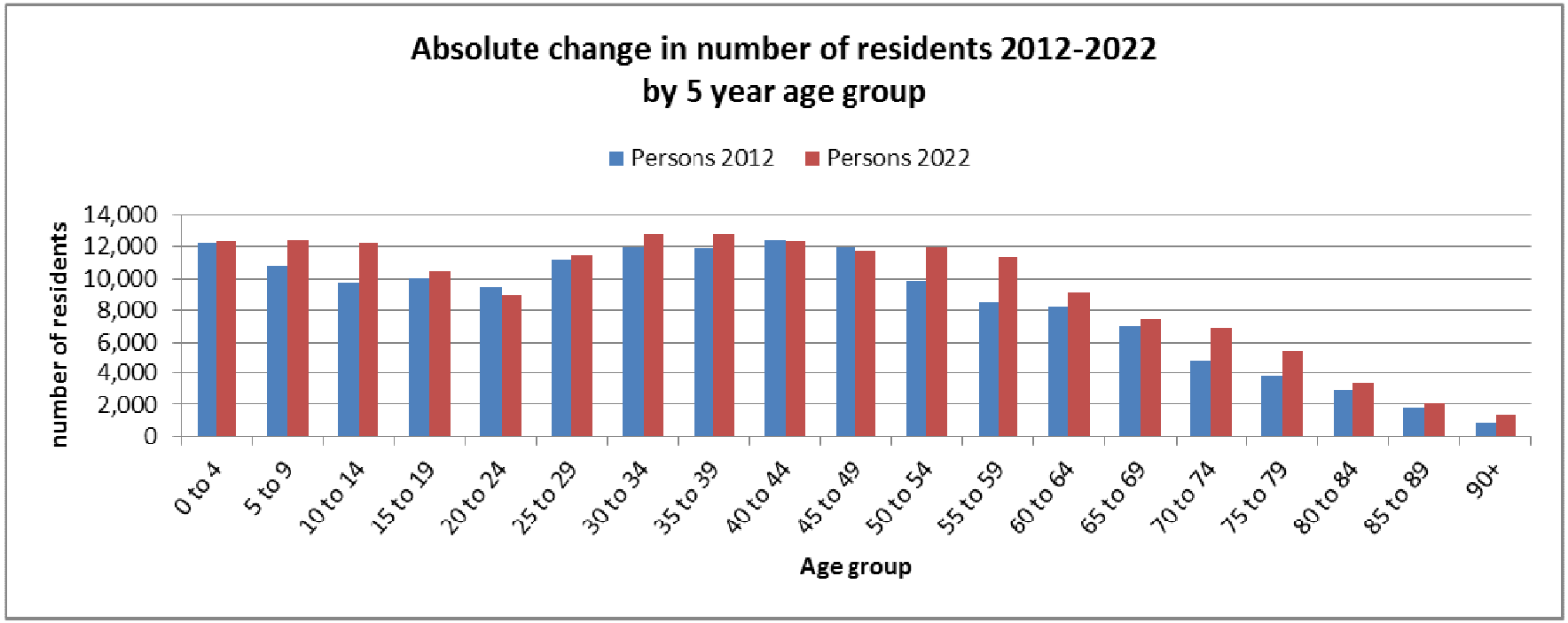


How else has Thurrock's population changed?



Population Projections

- Thurrock's population is increasing – between 2012 and 2022 there will be an additional 16,975 residents in the borough, equating to an increase of 11%.
- The most significant rises will occur in age groups clustered in those aged 0-14 years, 25-29 years, 50-59 years, and 70 years and over.



Housing Tenure

- Almost two thirds of properties in Thurrock are owned, which is similar to regional and national proportions.
- Total number of households has increased by 3.6% between 2001 and 2011.
- Private sector rented housing has increased by 137.9%.

Household Structure

- Thurrock has fewer households aged 65 and over than regional and national averages.
- One person households have increased by 14.5% between 2001 and 2011.
- In general there has been a substantial increase in the number of households with dependent children.
- Projections estimate that an additional 4,006 people aged 65 and over may be living alone by 2030.

What can this document enable us to do?

- Understand the changing nature of our population
- Raise awareness of the differing population demographics within the borough
- Benchmark key indicators
- Inform key strategies (e.g. Health and Wellbeing Strategy)

Questions?

Thurrock

Joint Strategic Needs Assessment

Demographics and Population Change

Key Contact:

Maria Payne, Health Needs Assessment Manager, Public Health Team – publichealth@thurrock.gov.uk / 01375 652626

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.

Executive Summary

Age Structure

- In 2014 the total population of Thurrock was 163,270 (ONS mid-year estimates 2014) of which 80,424 (49.3%) were male and 82,846 (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 2,359 in 2014.
- The number of deaths has decreased from 1,216 in 2001 to 1,147 in 2014.
- The natural population change (births minus deaths) shows a large increase in number of people from 636 in 2001 to 1,212 in 2014. This accounted for 14,110 additional residents between 2001 and 2014.
- 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 940 in 2013/14.

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.

Recommendations

This JSNA product shows the dynamic and changing nature of the population of Thurrock. This demographic information, with relevant updates where necessary, will need to feed into our updated Health and Wellbeing Strategy for Thurrock (currently under production), which will come back to the Health and Wellbeing Board later in 2015 for discussion and agreement.

Key Points:

1. Thurrock 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.

2. There has been a 47.5% increase in the over 85 population between 2001 and 2011, equating to 846 more residents in this age group.

3. 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.

4. Ethnic diversity is increasing in Thurrock - all main ethnic groups excluding White British and Irish groups have increased both in number and proportion, particularly within the Black groups and Other White Group.

5. The births in Thurrock have continued to increase, from 1,852 births in 2001, to 2,359 in 2014.

6. There has been substantial movement of people from London to Thurrock, particularly from geographically close boroughs.

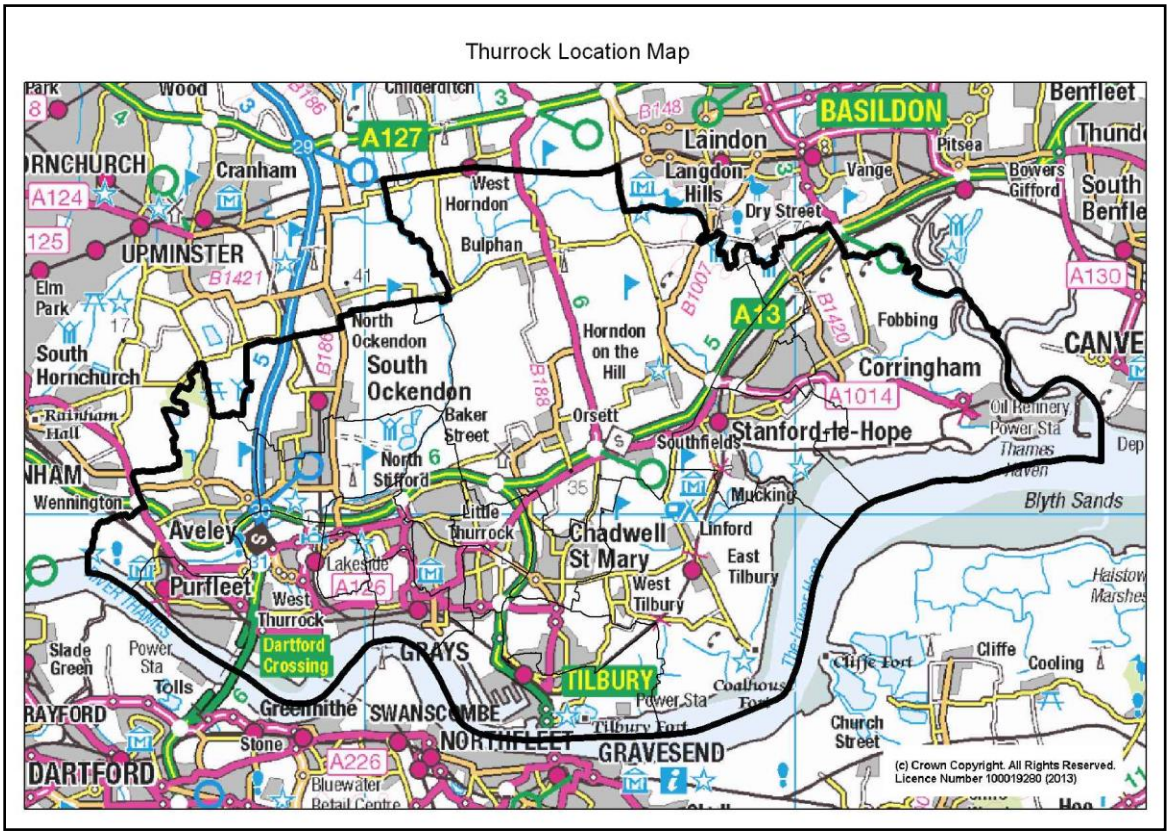
7. There has been a significant rise in the proportion of private rented sector housing from 5.9% in 2001 to 13.2% in 2011. The number of households in this sector has risen from 3,456 to 8,220 representing an increase of 137.9%.

8. 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.

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 2014 mid-year estimated population of Thurrock was 163,270 of which 80,424 (49.3%) were males and 82,846 (50.7%) females. This is the latest population estimate for the authority and is published annually.

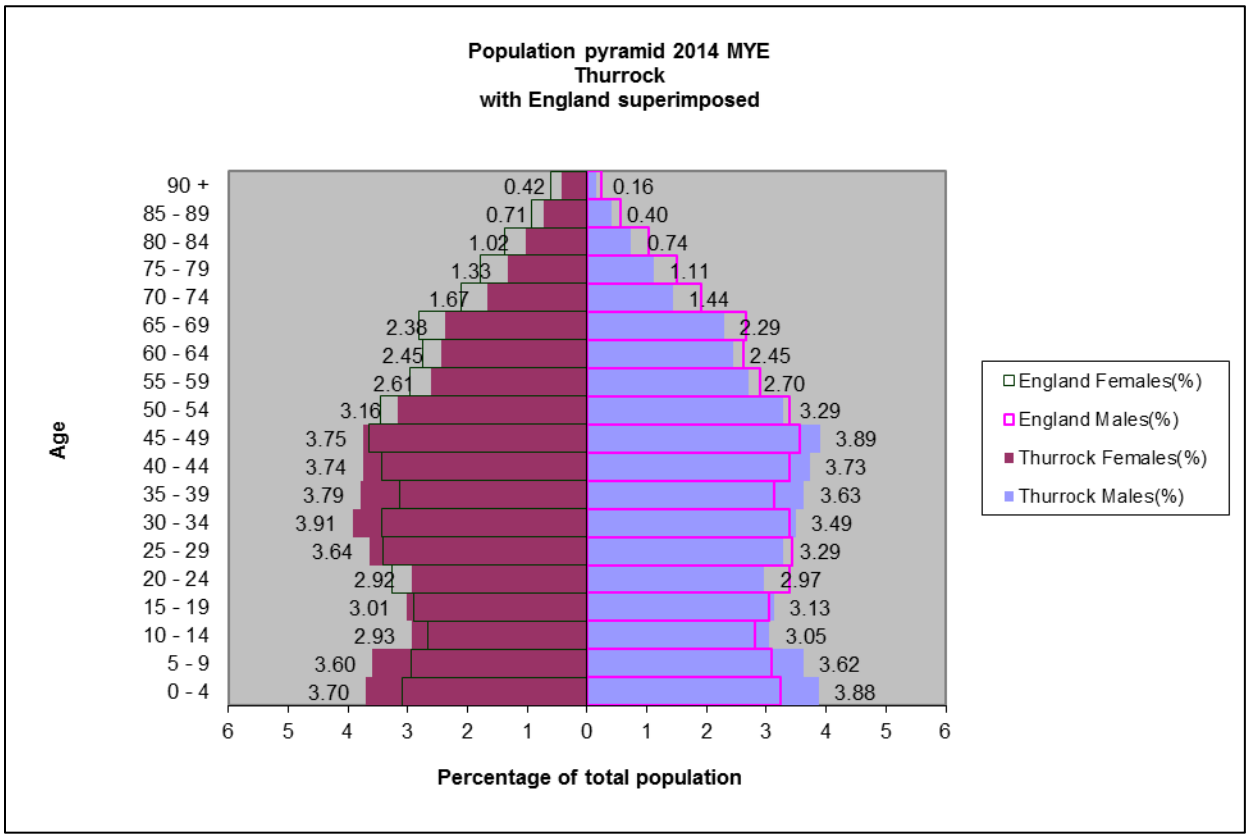
Table 1: 2014 Mid-Year Estimates ONS by Age-Group

Age Group	Males	Females	Persons	Males	Females	Persons
	Number	Number	Number	% of males	% of females	% of persons
0 - 4	6,327	6,045	12,372	7.9%	7.3%	7.6%
5 - 9	5,905	5,871	11,776	7.3%	7.1%	7.2%
10 - 14	4,983	4,791	9,774	6.2%	5.8%	6.0%
15 - 19	5,114	4,917	10,031	6.4%	5.9%	6.1%
20 - 24	4,844	4,772	9,616	6.0%	5.8%	5.9%
25 - 29	5,365	5,948	11,313	6.7%	7.2%	6.9%
30 - 34	5,697	6,382	12,079	7.1%	7.7%	7.4%
35 - 39	5,926	6,180	12,106	7.4%	7.5%	7.4%
40 - 44	6,089	6,104	12,193	7.6%	7.4%	7.5%
45 - 49	6,356	6,119	12,475	7.9%	7.4%	7.6%
50 - 54	5,370	5,153	10,523	6.7%	6.2%	6.4%
55 - 59	4,405	4,265	8,670	5.5%	5.1%	5.3%
60 - 64	3,999	3,994	7,993	5.0%	4.8%	4.9%
65 - 69	3,746	3,887	7,633	4.7%	4.7%	4.7%
70 - 74	2,355	2,733	5,088	2.9%	3.3%	3.1%
75 - 79	1,816	2,169	3,985	2.3%	2.6%	2.4%
80 - 84	1,209	1,668	2,877	1.5%	2.0%	1.8%
85 - 89	655	1,166	1,821	0.8%	1.4%	1.1%
90 +	263	682	945	0.3%	0.8%	0.6%
Total	**80,424**	**82,846**	163,270	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 2014 compared to that of England. 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 conversely the age groups over 50 years forming a lower proportion of the total population compared to England.

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%
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%

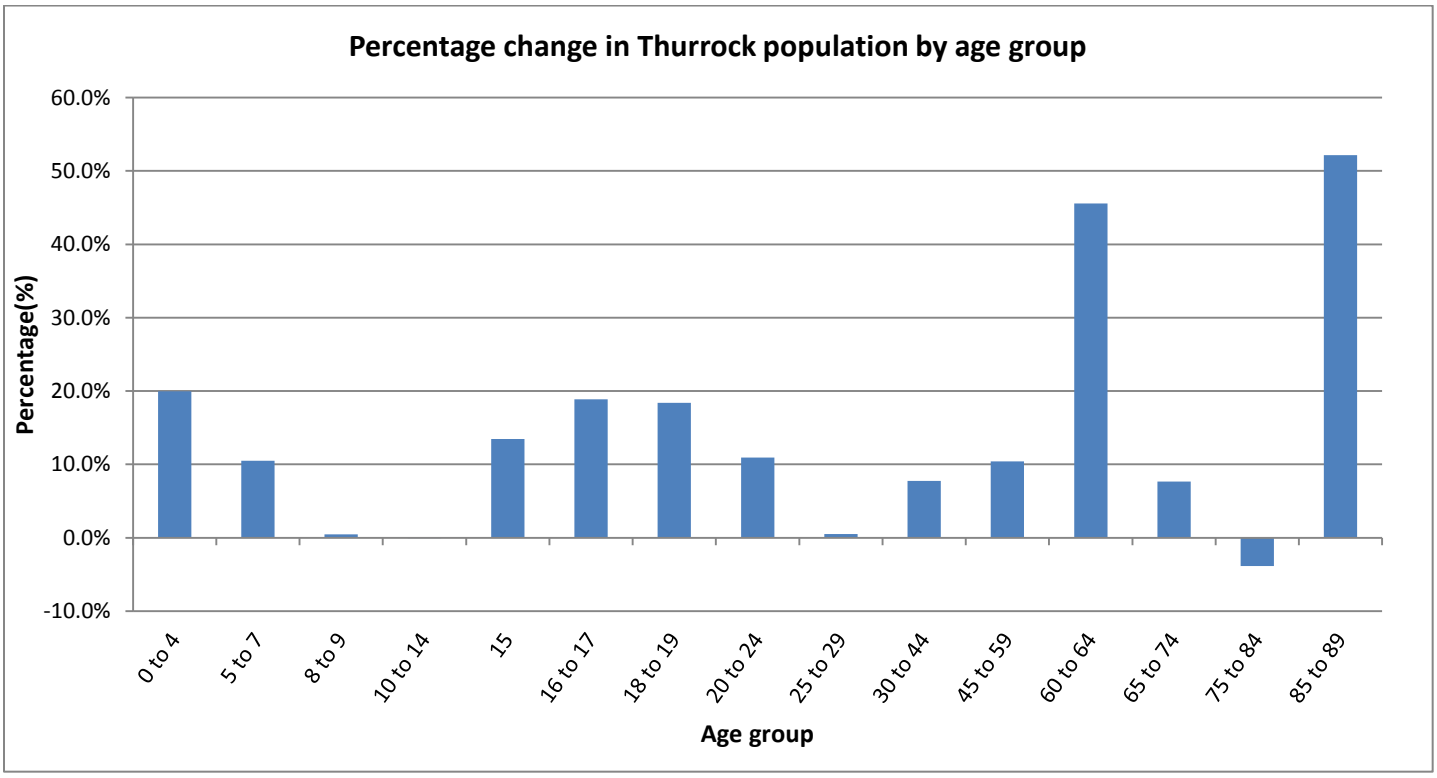
Source: Census 2011 and 2001

- 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

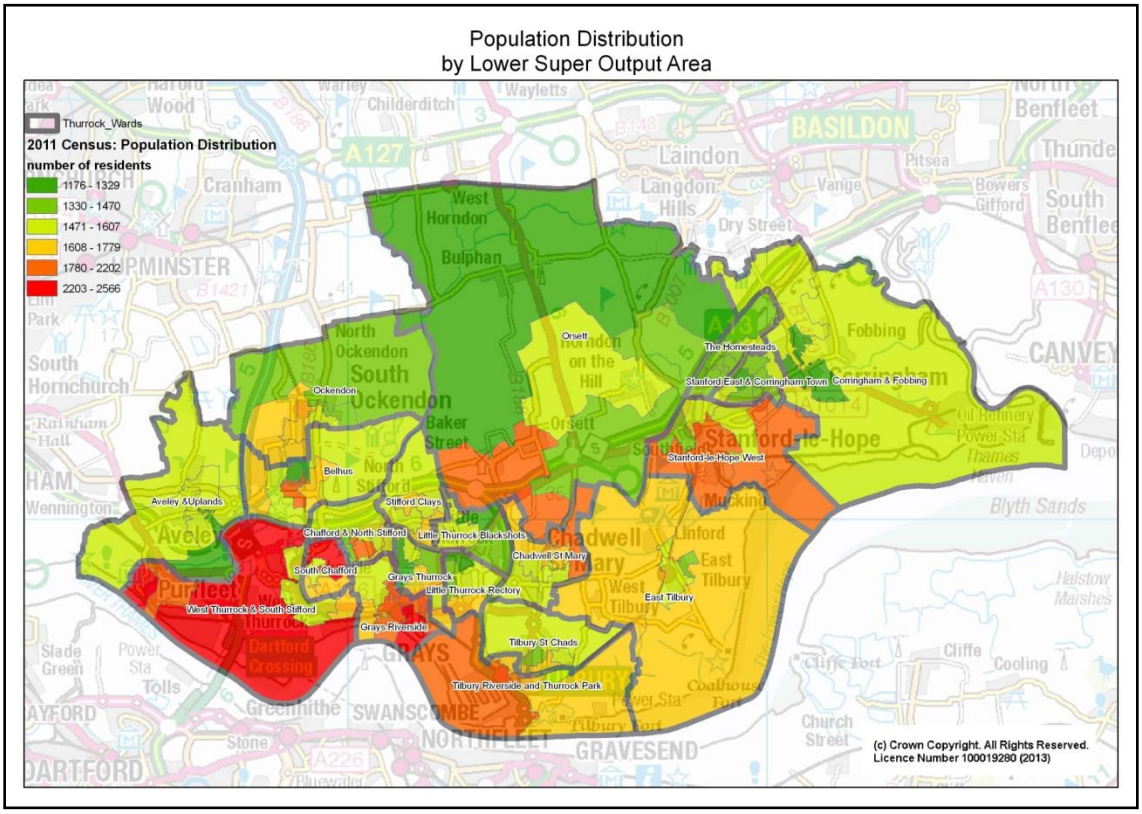


Source: Census 2011 and 2001

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 will be found within the future Wider Determinants JSNA chapter.

Figure 4: ONS 2011 Population Distribution by Lower Super Output Area



Source: Census 2011

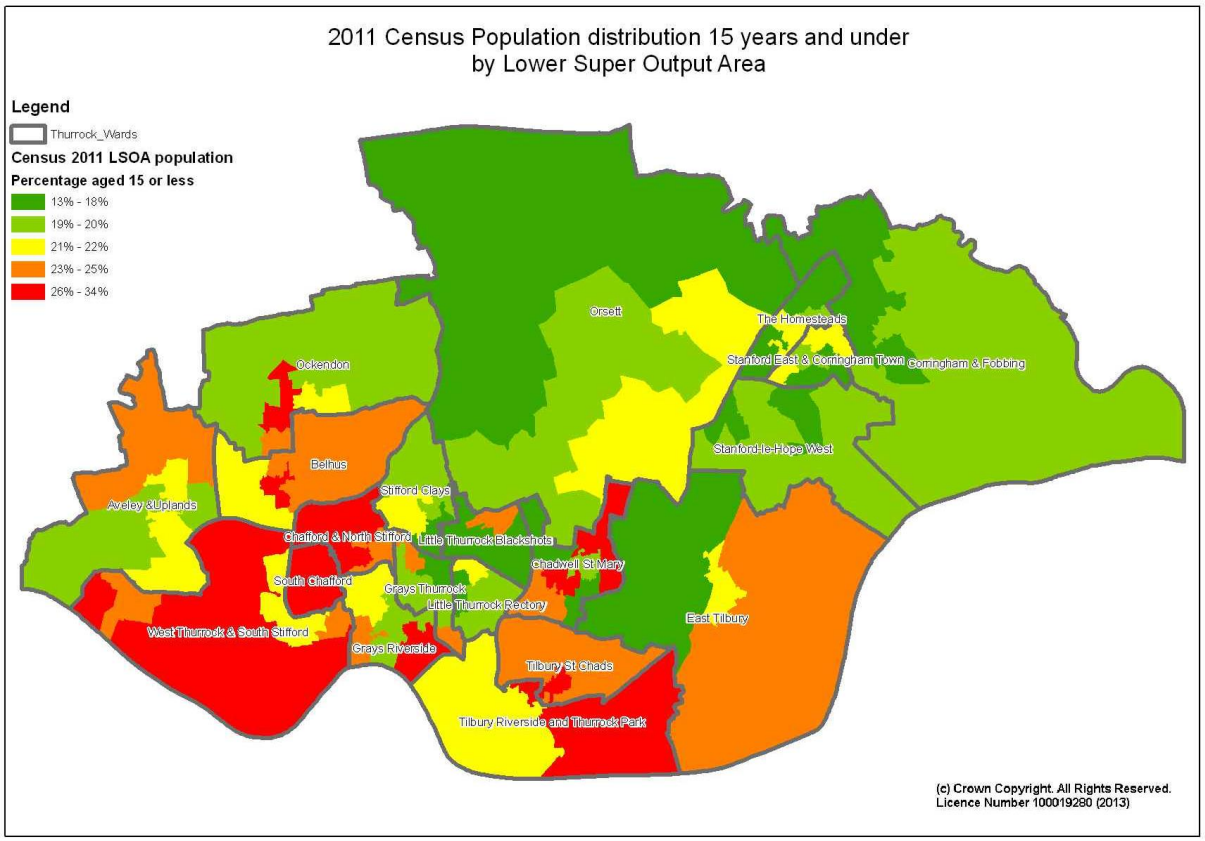
2.1.4 Geographical distribution of key age groups

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 5 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 is detailed in the Children's JSNA Chapter.]

Figure 5: Population Distribution for people aged under 15 years by Lower Super Output Area

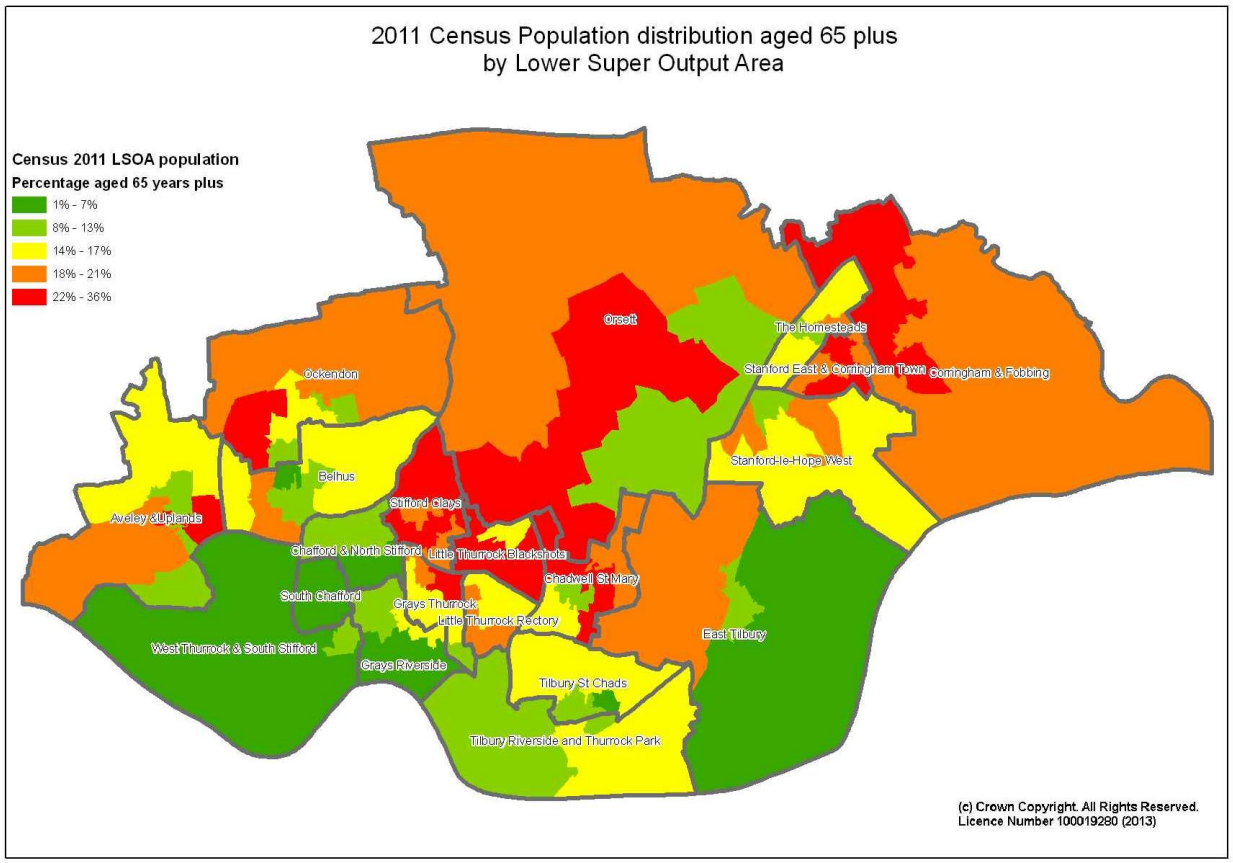


Source: Census 2011

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

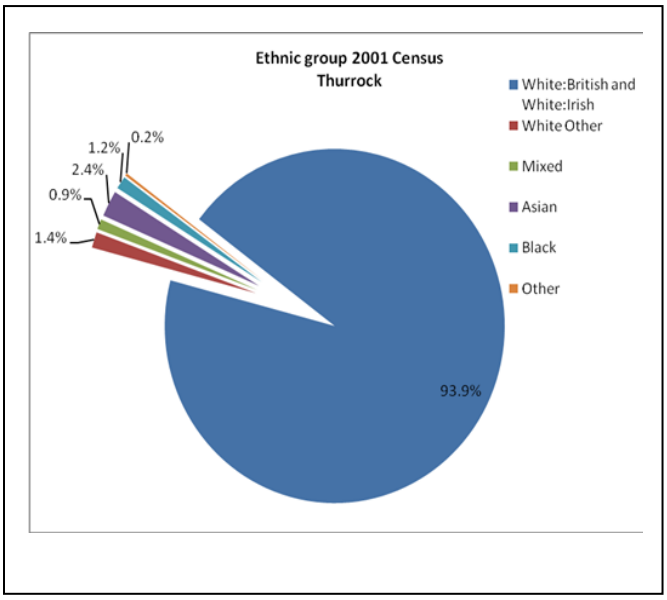
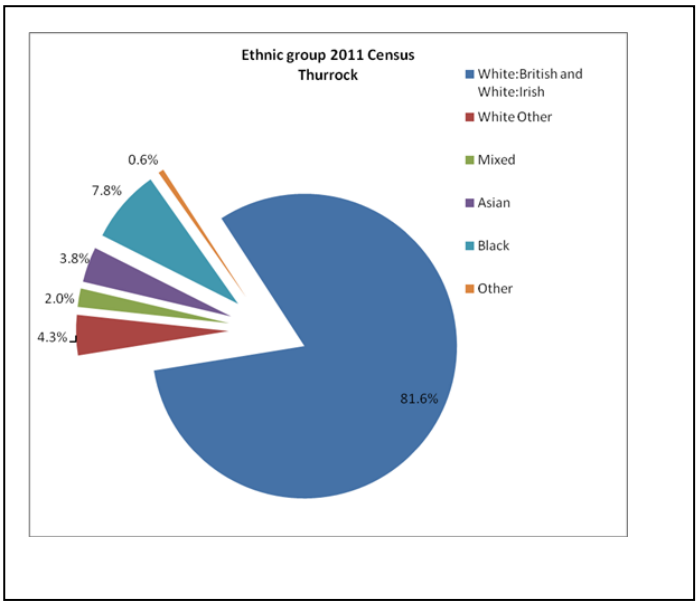


Figure 8: 2011 Condensed Ethnic Groups



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 sections 2.5.2 and 2.5.3.

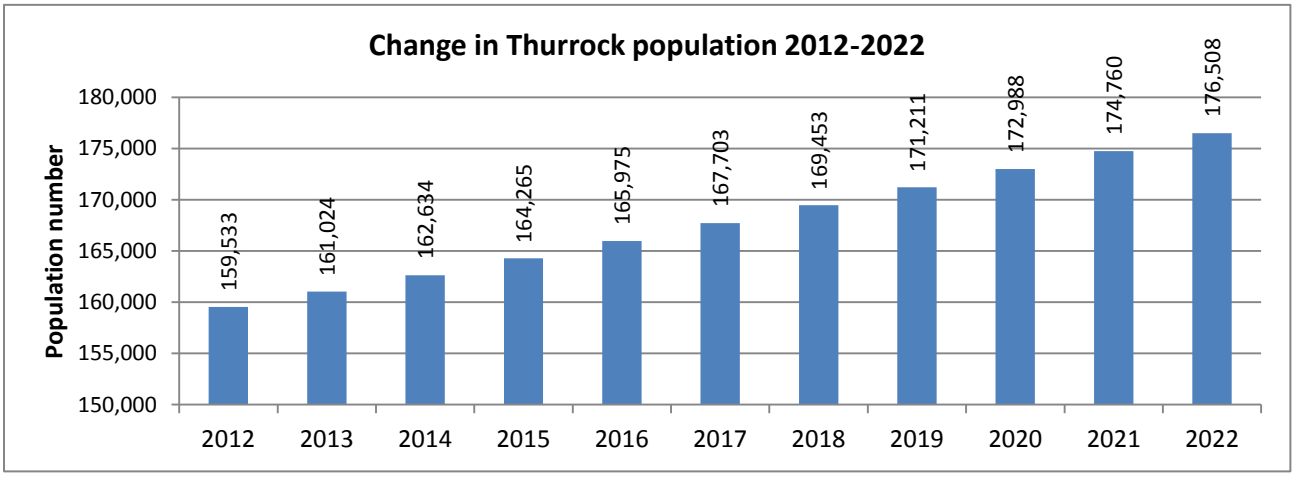
2.4 Population Projections.

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.

Figure 9 shows projections from 2012 to 2022. The population of Thurrock is projected 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 will be further described in the Wider Determinants JSNA.

Figure 9: Population Projections, 2012-2022



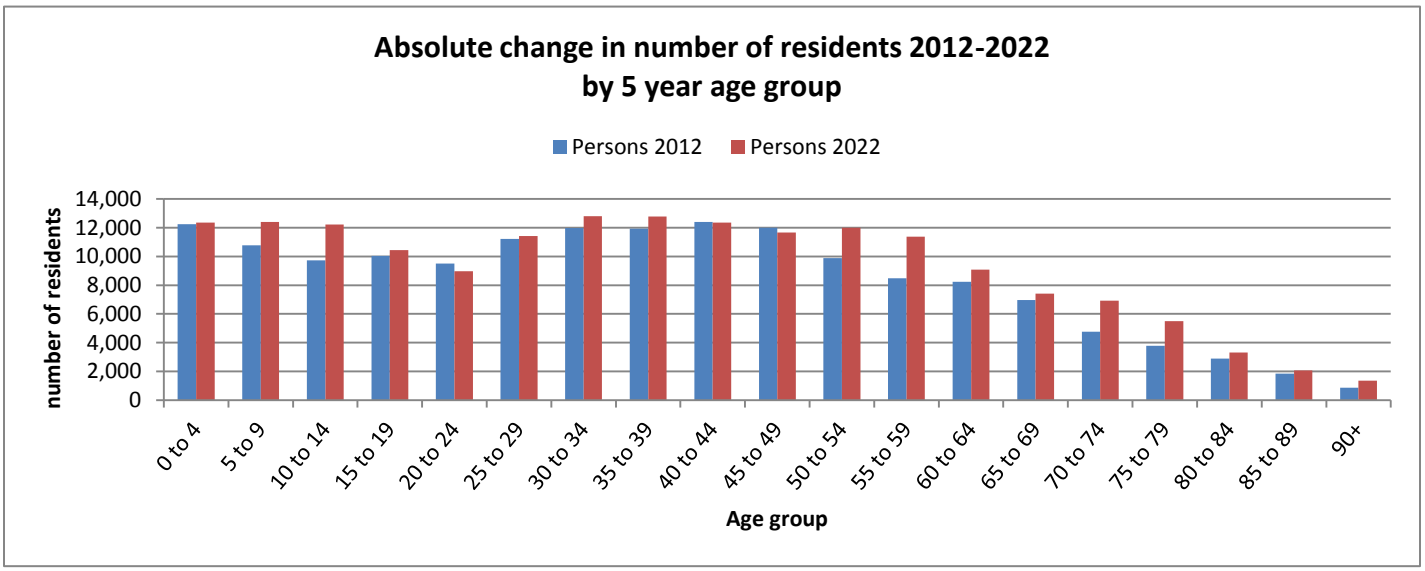
Source: ONS Subnational population projections; 2012

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

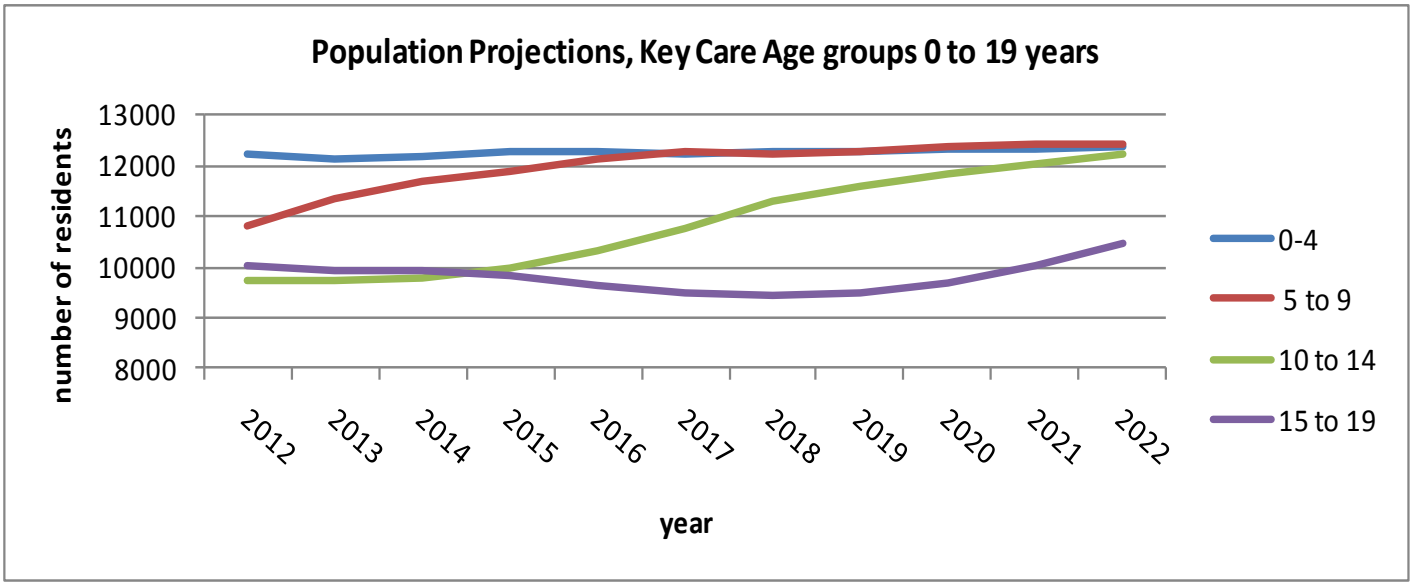
2.4.2 Key Care Groups

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



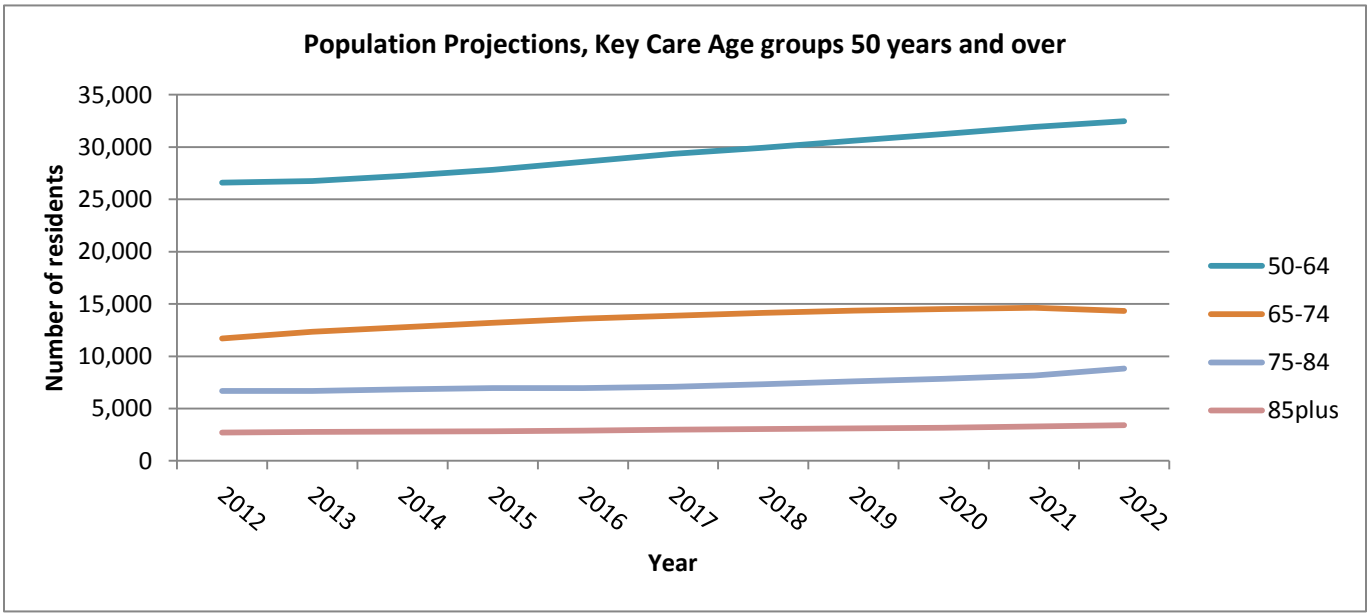
Source: Subnational Population projections; ONS; 2012

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 2014 mid-year estimates.

Table 6: Components of change 2013-2014

	2013	2014
Population	160,849	163,270
Natural Change		1,212
Births		2,359
Deaths		1,147
All Migration NET		1,201

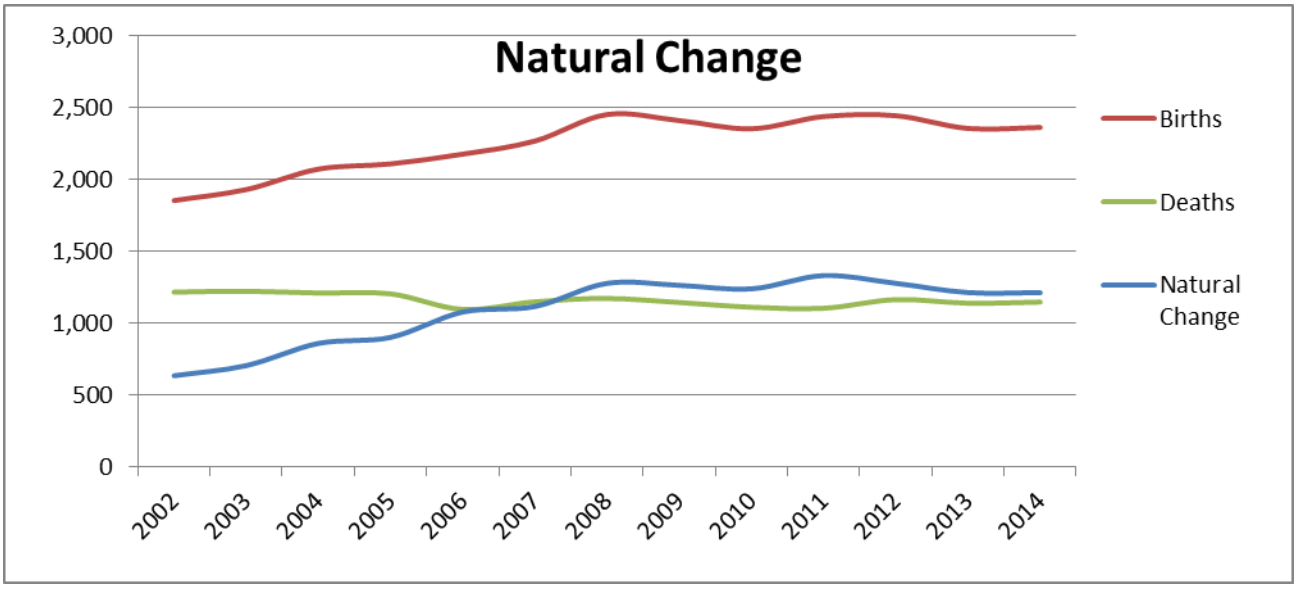
Internal Migration In		*7,345*
Internal Migration Out		*6,612*
International Migration In		*940*
International Migration Out		*472*

Source: ONS

2.5.1 Natural Change

The main 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 2014. The net effect of these components (births minus deaths) shows a large increase from 636 in 2002 to 1,212 in 2014. 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 2014

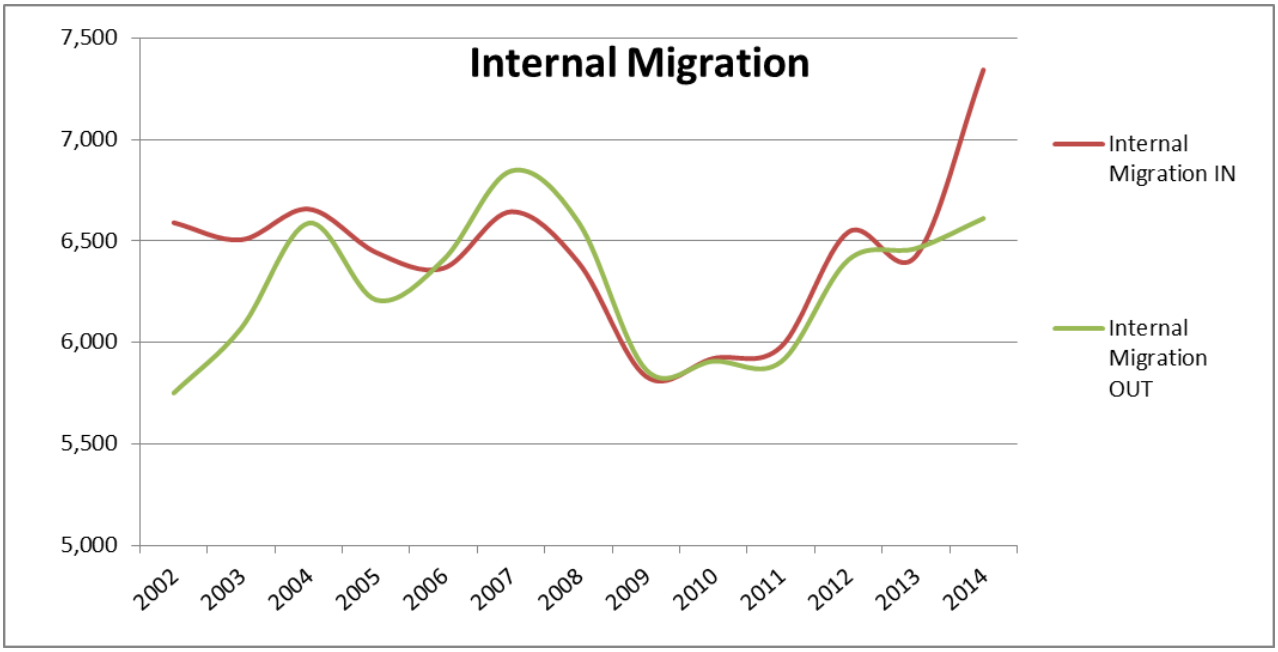


Source: ONS mid-year estimates

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 2014.

Figure 14: Internal migration between 2002 and 2014



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) before increasing to 7,345 in 2013/14. The number of people moving out of Thurrock has also remained fairly stable over the period and has roughly balanced the inward internal migration.

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.

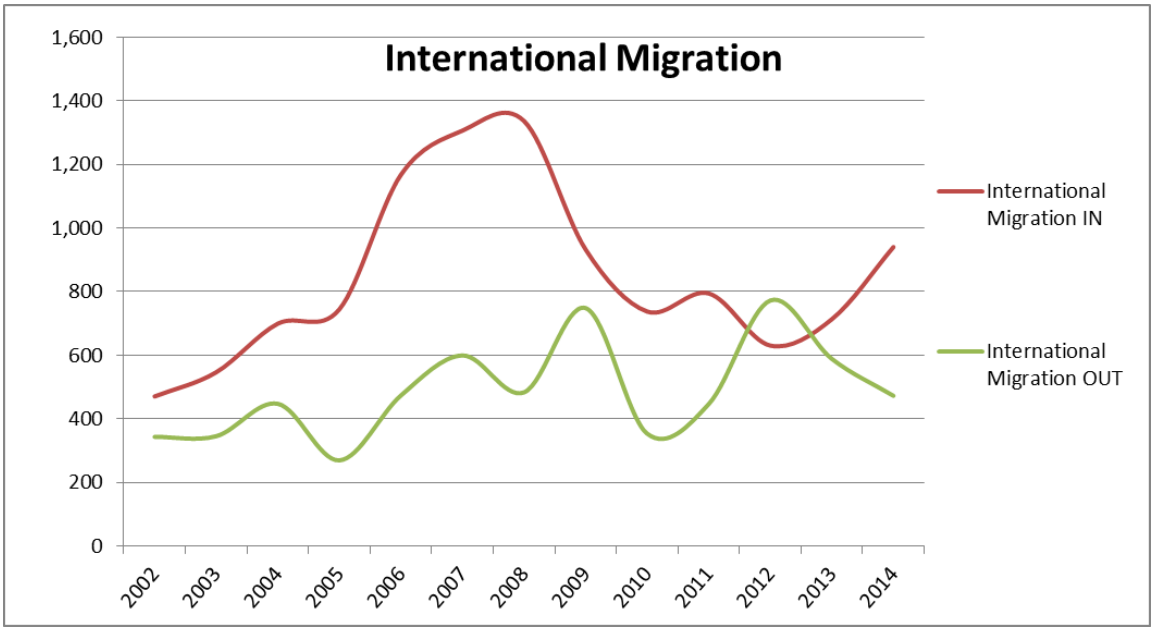
2.5.3 International Migration

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 940 in 2013/14. International migration out of Thurrock has consistently been less than this, with 472 people leaving the borough in 2013/14.

Figure 15: International Migration between 2002 and 2014



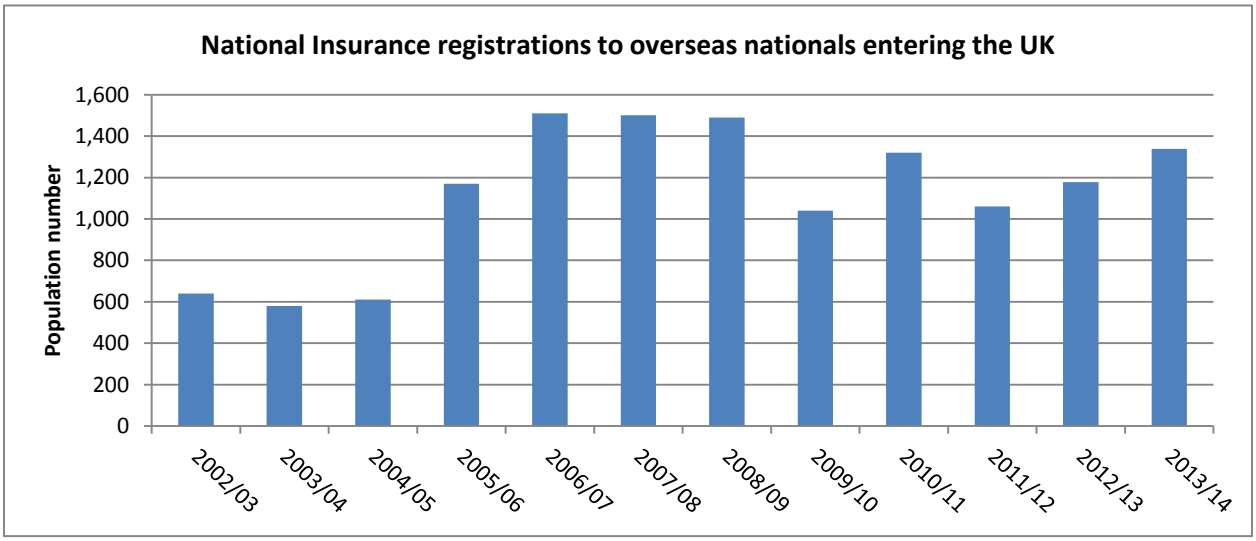
Source: ONS mid-year estimates

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

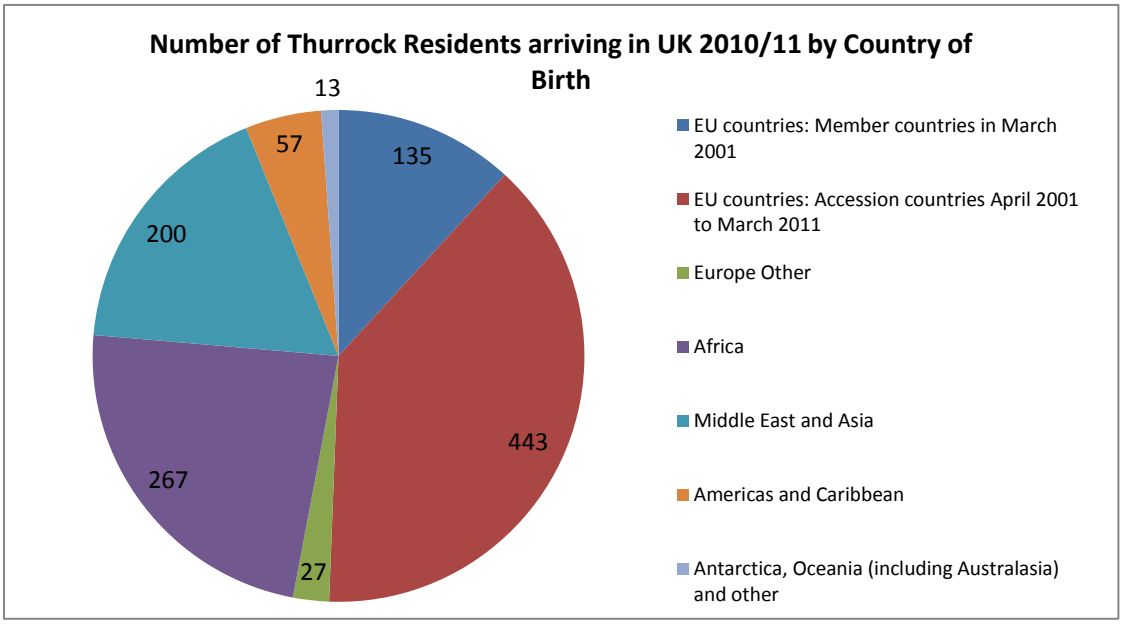
The majority of migrants newly registered with a national insurance number in Thurrock came from Eastern Europe and Africa. The top five countries of origin in 2013/14 were Poland (306), Romania (186) Nigeria (118), Slovak Republic (117) and Lithuania (102). These 5 countries accounted for 63% of all 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

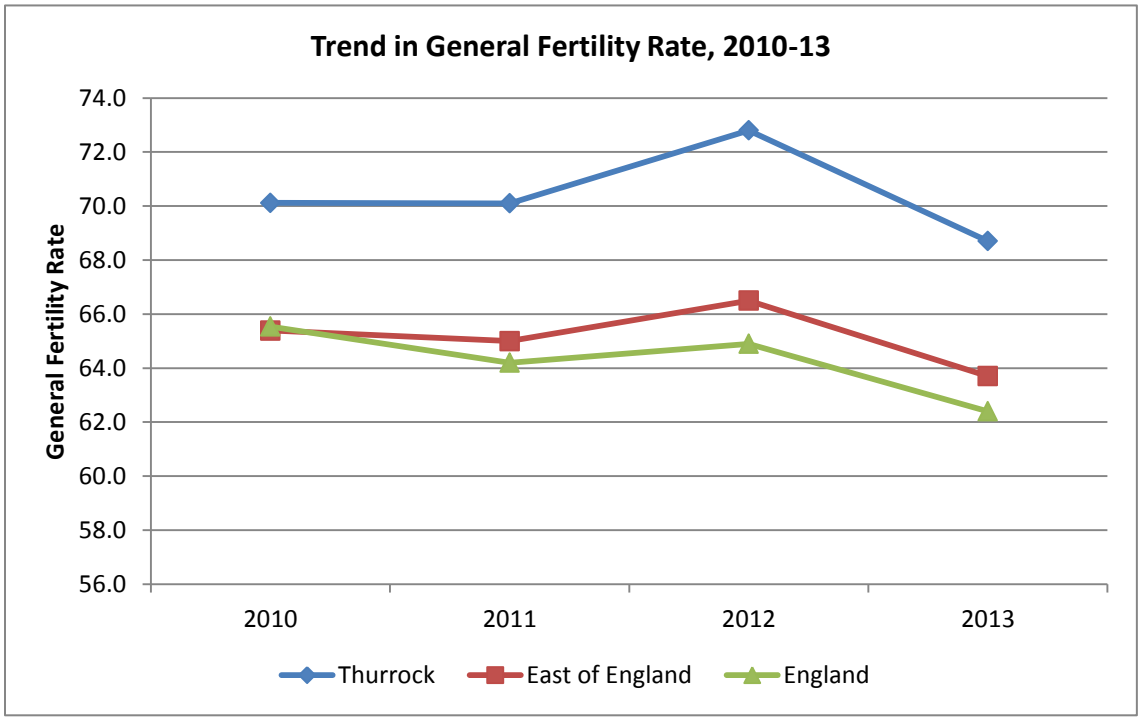
3 Births and Deaths

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 suggested 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.

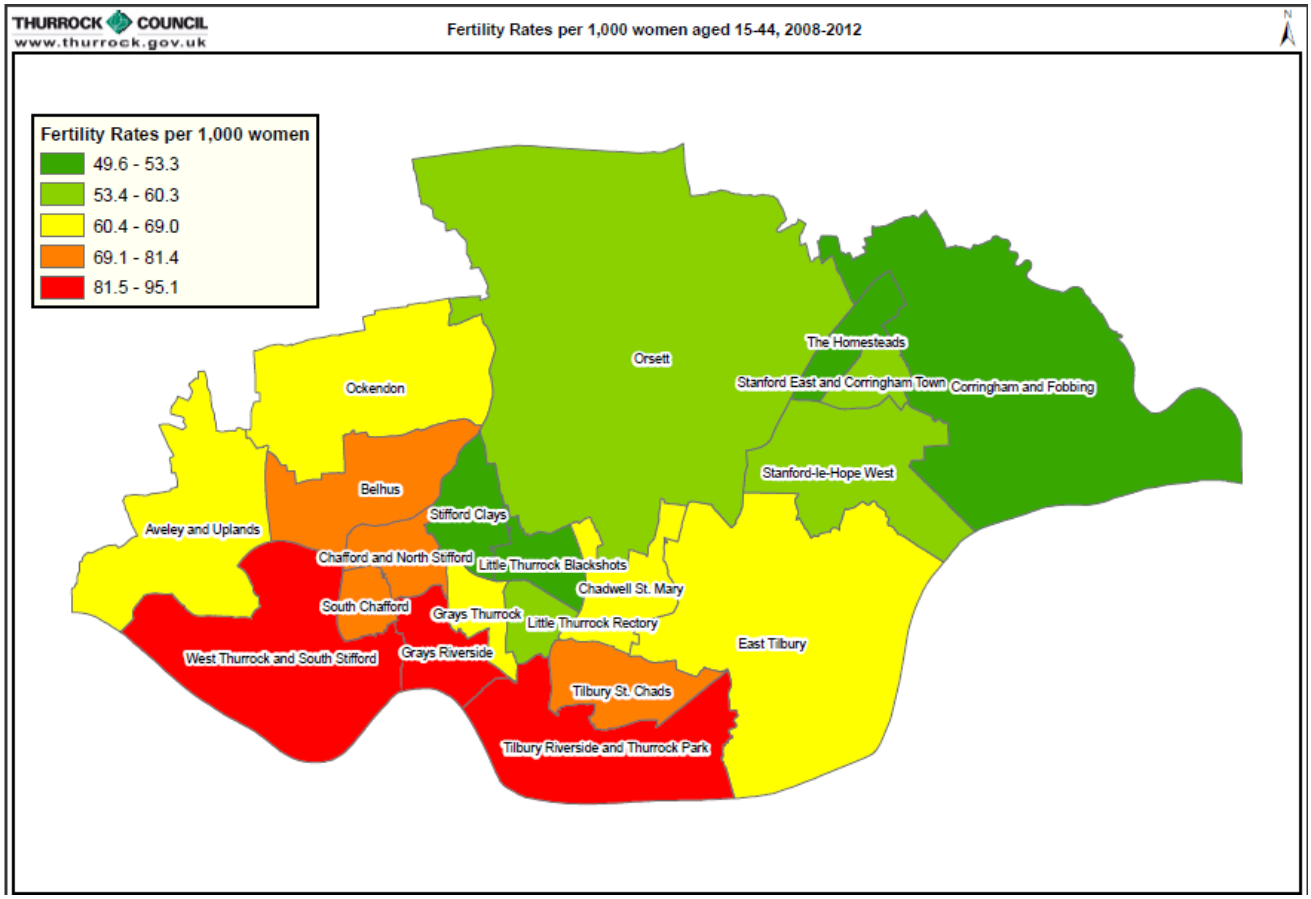
Figure 18: Trend in General Fertility Rate, 2010-2013



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.

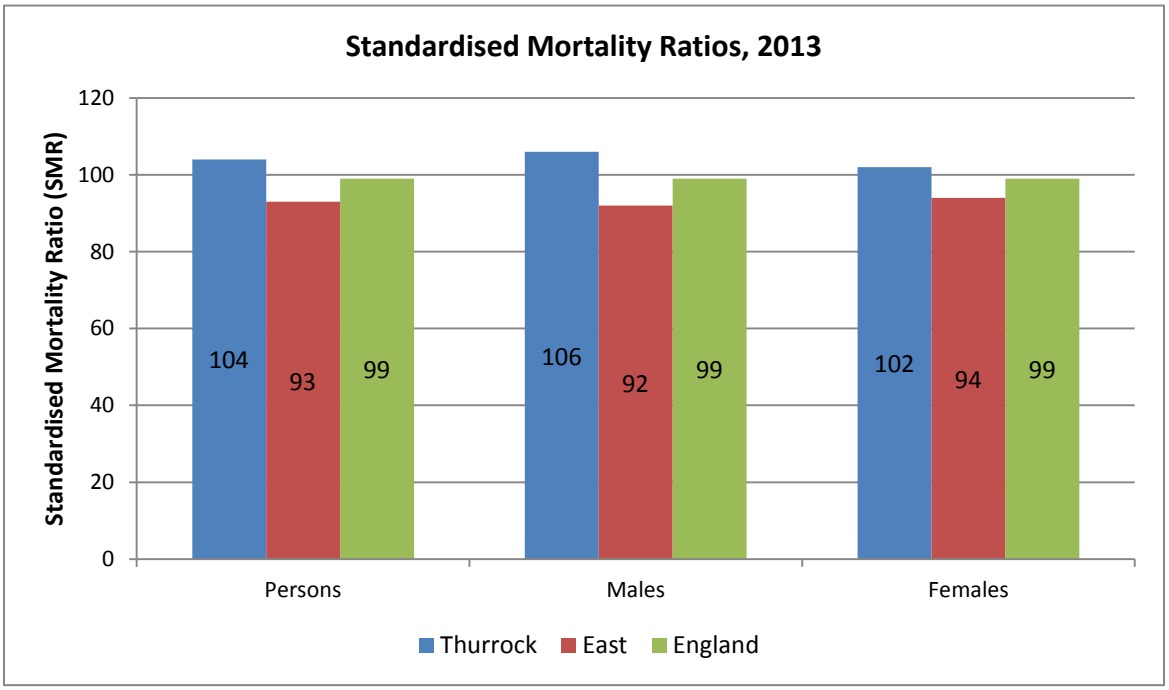
Area	Males			Females		
	2000	**2012**	**% change**	**2000**	**2012**	**% change**
Thurrock	839.94	624.88	-25.6%	594.80	479.06	-19.4%
England	841.84	614.31	-27.02%	564.50	447.70	-20.69%

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

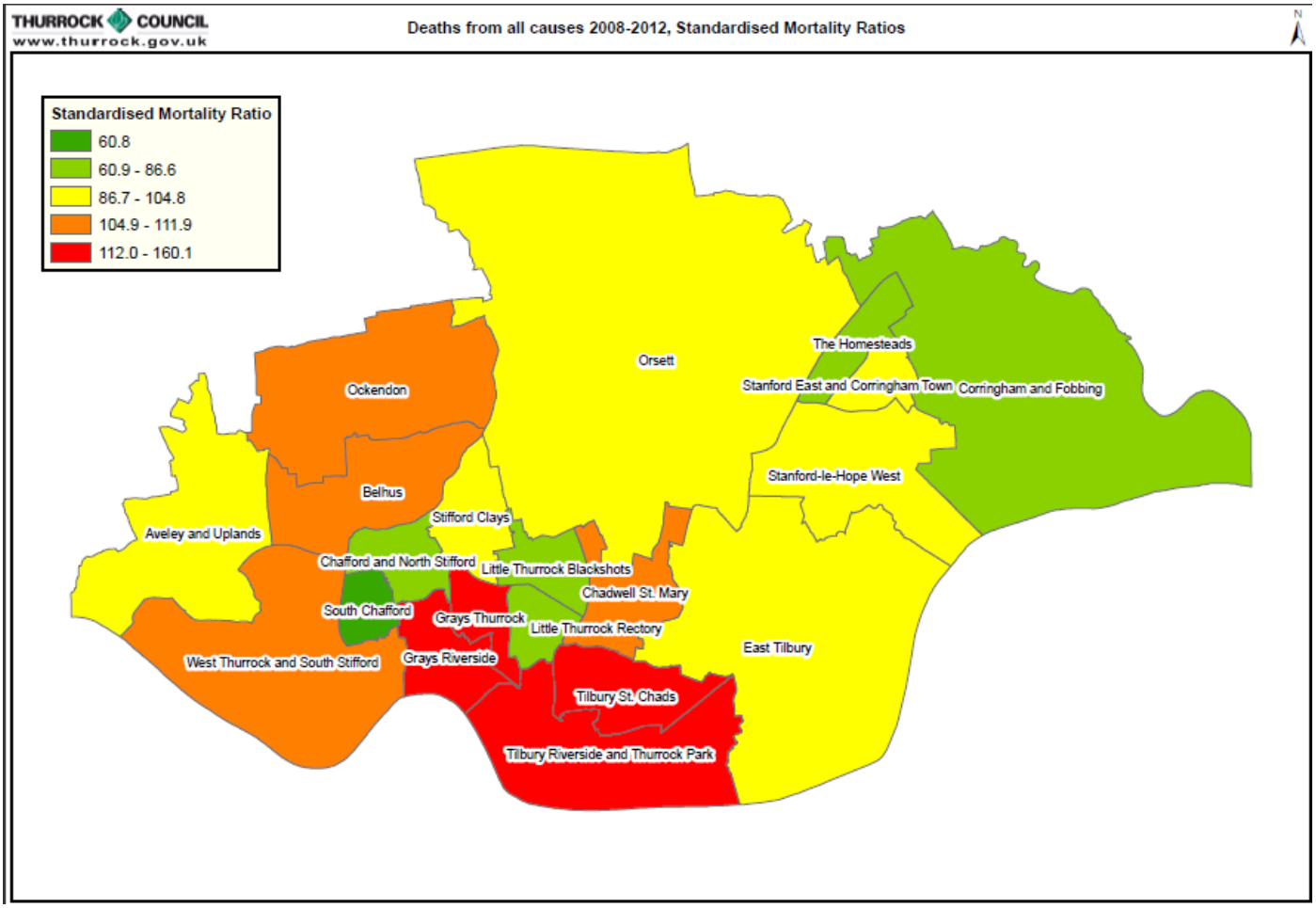


Source: ONS

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

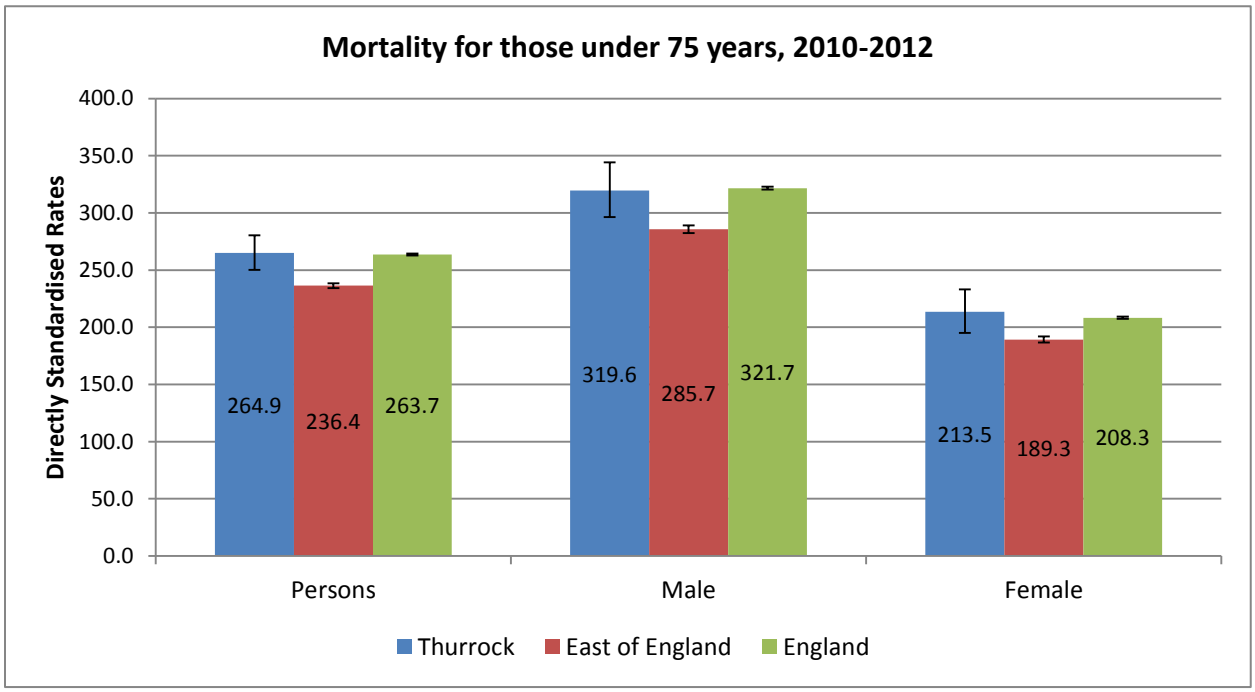


Source: Local Health

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

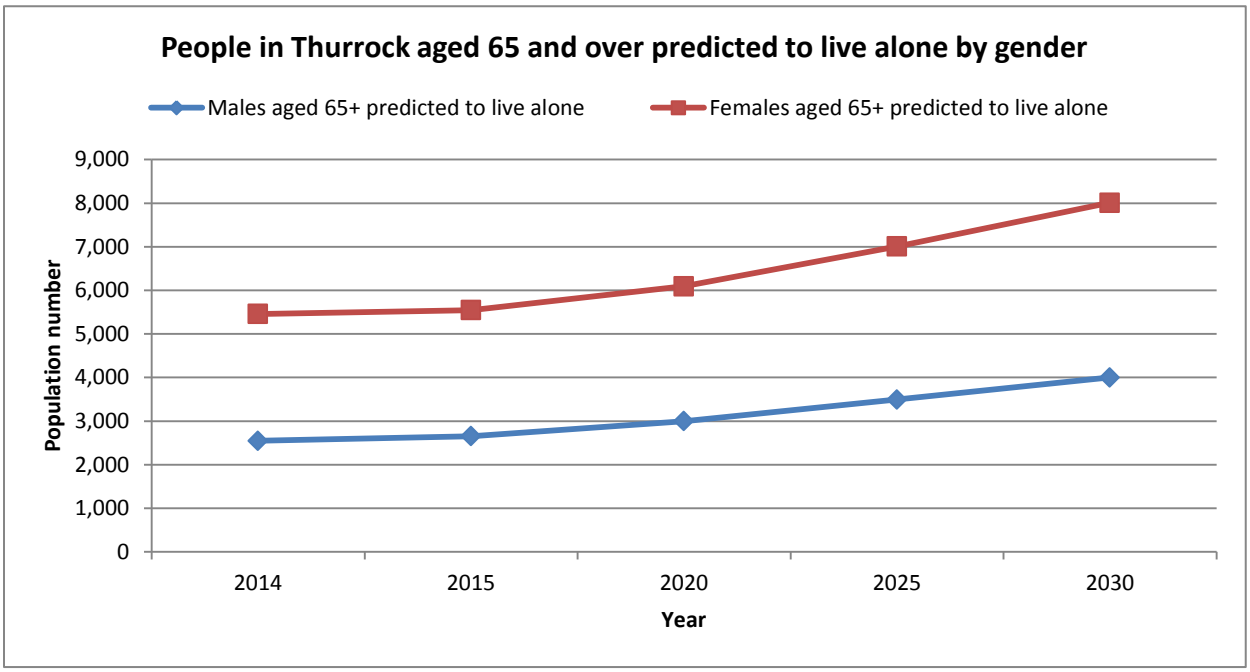
	Thurrock (Number)		number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
	2011	2001			2011	2001		
One person household: Aged 65 and over	6,379	7,289	-910	-12.5%	10.2%	12.5%	12.7%	12.4%
One person household: Other	9,989	8,723	1,266	14.5%	16.0%	14.9%	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	457	242	215	88.8%	0.7%	0.4%	0.5%	0.5%

	Thurrock (Number)		number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
children non-dependent								
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

1st October 2015	ITEM: 5
Health and Wellbeing Board	
Housing & Planning Advisory Group Progress Report and Proposals to develop a Housing Strategy for older adults (65+), and working age adults with support needs	
Report of: Ceri Armstrong	
Accountable Head of Service: Les Billingham	
Accountable Director: Roger Harris, Adults, Health and Commissioning; David Bull, Director of Planning & Transportation	
This report is public	

Executive Summary

The purpose of this report is to brief the Health and Wellbeing Board on the work of the Housing and Planning Advisory Group. The report describes the on-going work of the Advisory group and the main areas of focus in the next 12 months.

This report also proposes that the Housing and Planning Advisory Group should oversee the development of a housing strategy specifically for older adults (65+) and working age adults with support needs.

The Advisory Group was established in 2014 following a report to the Health and Wellbeing Board in January 2014. The Terms of Reference for the Group, which have been reviewed and revised by the Advisory Group, is attached at Appendix 1.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board notes the work of the Housing and Planning Advisory Group.

1.2 That the Health and Wellbeing Board approve the Advisory Group's proposal to develop a housing strategy specifically for older adults (65+), and working age adults with support needs.

1.3 That the Health and Wellbeing Board approve the revised Terms of Reference of the Advisory Group.

2. Introduction and Background

2.1 The Health and Wellbeing Board's Housing & Planning Advisory Group is a multi-agency group which considers the health and well-being implications of major planning applications, and provides advice and guidance on the health, social care and community impacts of proposed new developments.

2.2 The Advisory group comprises representatives from Thurrock Clinical Commissioning Group (CCG), NHS England (Essex Area Team), the Community and Voluntary Sector (Thurrock CVS), as well as Planning, Housing, Adults, Health and Commissioning, Public Health, Regeneration and Children's Services. It has a significant role in articulating the Health and Wellbeing Board's vision and priorities in relation to housing and the built environment. The Group also aims to influence planning policy, and thereby developers, so that planning applications when received, have already taken into consideration the impact of the proposed development on health and wellbeing. The Group plays a role in promoting good design and sustainable communities as well as influencing the provision of good quality housing for older people as part of the Building Positive Futures Programme.

2.3 The purpose of the HWB Housing and Planning Advisory Group is to:

- Review emerging development plans,
- Identify how Section 106 monies might best be used to enhance health and wellbeing,
- Input into emerging planning policy and strategy and,
- Provide an opinion on plans as part of the formal consultation process on major developments.

2.4 The Advisory Group is consulted on all planning applications and pre applications for major developments (25 dwellings or more), care homes and other specialised housing. The Advisory Group also acts as a conduit for consultations with NHS Property Services. Responses from members of the Advisory Group are co-ordinated to provide an overall response to planning applications and therefore reflect a very broad perspective on health and wellbeing issues. This co-ordinated response on development applications, including the detailed reports from NHS Property Services are submitted to the Planning Service within an agreed timeframe.

2.5 The Group's multi-disciplinary focus corresponds with a number of statutory requirements of The Care Act 2014. The Care Act establishes a duty on local authorities to promote wellbeing as well as preventing, reducing or delaying the need for care. Care Act guidance specifies that the wellbeing principle should inform the delivery of universal services not just services related to adult social care, and that the principle should be considered by the local authority 'when it undertakes broader, strategic functions such as planning, which are not in relation to one individual'. In addition the Care Act introduces a duty of integration of services and cooperation between services in relation to promoting wellbeing and preventing, reducing or delaying the need for care. The Care Act guidance states that 'suitability of living accommodation is one

of the matters local authorities must take into account as part of their duty to promote an individual's wellbeing'. The Care Act also introduces a role in market shaping and commissioning to promote wellbeing and prevent, reduce or delay the need for care.

2.6 Since its inaugural meeting in May 2014, the meetings of the Group have led to closer partnership working between diverse professional groups within the Council, and a much better understanding of the respective legislative drivers that need to be managed effectively to ensure that health and wellbeing is at the heart of decision-making. Examples of the partnership approach between council services and different professional groups include:

- the Well Homes programme,
- the HAPPI Housing schemes being developed by the Council at Derry Avenue South Ockendon and Calcutta Road Tilbury, and
- the recent bid with Family Mosaic to Phase 2 of the Care and Support Specialised Housing (CASSH) Fund to the Homes and Communities Agency for 6 units of specialist housing for young adults with autism.

2.7 The Advisory Group meets every six weeks, with regular liaison between meetings in relation to consultation requests to review pre-applications and planning applications for major developments (25 dwellings or more), care homes and other specialised housing. Areas which have addressed by the Group include:

- Purfleet Regeneration – following a workshop in January, to consider the primary care requirements of the regeneration programme, the Group has played an active part in shaping the requirements of a new health centre, including arranging visits to 'good practice' centres such as the Loxford Centre in Redbridge, and a centre in Medway. The Group has also contributed ideas in relation to creating sustainable, healthy communities in large-scale developments, and highlighted the need for housing for older people.
- The Local Plan has been considered by the Group at a number of meetings, providing valuable inputs on both the plan itself and also the wider issues of public consultation and engagement. The development of the Local Plan will continue to feature in future meetings.
- Substantive comments on the proposed Corringham Development of 750 homes
- Advice on applications to build large care homes.
- A meeting with a developer to provide guidance on HAPPI housing design in relation to a pre-application.
- Local Estate Strategy – the CCG is required to develop a strategic estates plan to ensure that the NHS primary care estate is both efficient and fit for purpose. The Group has suggested that Thurrock's Strategic Estates Plan could be developed under the umbrella of the Housing & Advisory Group.
- Involvement with the Air Quality Working Group

3. Issues, Options and Analysis of Options

3.1 The work of the Advisory Group going forward will continue to include responding to planning applications for major developments (25 dwellings or more), care homes and other specialised housing. The Group will also continue to be involved in the development of the Local Plan (including a housing land availability workshop in November), and the large scale regeneration programmes at Purfleet and Corringham. The Advisory Group will now be involved with the development of CCG's Local Estates Plan for its primary care estate. NHS Property Services are currently the statutory consultee for large-scale planning applications, Care home and extra care home applications. This arrangement is due to change, with the CCG taking over this role. The fact that the CCG is a member of the Housing and Planning Advisory Group will make this transition easier to manage.

3.2 One area that has been identified by the Advisory Group and which now needs to be given full attention is the development of a strategy to address the specific housing needs of older adults (65+) and working age adults with support needs. The development of this strategy would be consistent with the Care Act – which places significant emphasis on housing as an enabler of health and wellbeing. It would also build on the work of the 2015-2020 Housing Strategy, to "support residents to maintain and improve their independence" and to "ensure the sustainability of our homes to meet residents' needs now and in the future". The benefits of a multi-disciplinary approach would be a shared understanding of Thurrock's health profile and future projections of health and social care needs which can be translated into the Local Plan and discussions with developers. The strategy would also address housing need for older (65+) and working age adults with support needs identified in the Market Position Statement.

3.3 The bid to the Phase 2 Care and Support Specialised Housing (CASSH) Fund (jointly supported by Housing and Adults, Health and Commissioning) to finance the development of 6 units for young adults with autism provides an example of how such a strategy could be developed. The bid was built around the autism strategy, but with a housing component developed to reflect the needs for specialist accommodation identified in the strategy. This was a new departure and it is proposed that each of the commissioning plans for people needing care and support should in future include a housing component, which takes into account current provision, projections of needs, gaps in provision and quantifies the types of accommodation that will be required to fill those gaps. By involving the Advisory Group in this process, the full range of intelligence held by different services, as well as planning and housing policy requirements can be brought into play.

3.4 In relation to housing specifically for older people, a larger-scale project is required, reflecting the projected growing proportion of older adults in our communities in the coming decades. The findings of the recent Housing Needs Survey, together with the findings of the refreshed Strategic Housing Market Assessment (expected in December), will help address the

requirement in the Planning Practice Guidance "to consider the size, location and quality of dwellings needed in future for older people in order to allow them to live independently and safely". The development of design and standards statement in the autumn will also help address this requirement. This work will in turn provide evidence for consultation on issues and options for the Local Plan.

3.5 It is anticipated that in order to progress the strategy, a task and finish group will need to be convened to undertake the coordination and analysis of data, to review current provision, to analyse gaps in provision and to identify potential locations for specialist housing development. The task and finish groups would comprise officers from the range of disciplines and would report to the Advisory Group. Once completed it is envisaged the housing strategy would be adopted by the Health and Wellbeing Board.

3.6 The Advisory Group will also submit (by 30 September) an expression of interest in the new Healthy Towns initiative with Public Health England, to put health at the heart of new neighbourhoods and towns across the country. The Healthy Towns programme has three core objectives:

a) To develop new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent;

b) To show what is possible when we radically rethink how health and care services could be delivered, freed from the legacy constraints (i.e. existing services) that operate in other areas. This will support the New Models of Care programme by adding to the learning about how health and care services could be integrated to provide better outcomes at the same or lower cost;

c) To accomplish the first two objectives in a way that can be replicated elsewhere, making learning available to other national programmes as well as other local areas.

The NHS will work with selected areas to redesign local health and social care services, in line with the NHS Five Year Forward View, taking advantage of absence of legacy constraints to transform local communities and the public attitudes to healthy living.

3.6 In summary, the Group has been consulted on a significant number of planning applications; it has developed a role in relation to strategic policy development and has been pro-active in relation to large-scale regeneration plans. The Group has also raised the profile of HAPPI housing both across the council and with developers. The Group has broken down the professional barriers that can often exist between services, where there is no regular channel for communication and the sharing of information and views. This approach reflects the Care Act requirement for integration and co-operation between services.

3.7 In relation to the work over the past year and future plans, the Advisory Group has reviewed its terms of reference. In response to its developing agenda it has proposed revised Terms of Reference which are attached in Appendix 1.

The revisions are intended to ensure greater consistency with the Planning process.

4. Reasons for Recommendation

4.1 The Housing and Planning Advisory Group continually try to strike a balance between providing oversight of planning applications with fulfilling a strategic role in relation to promoting health and well-being in the built environment.

4.2 Recognising the time constraints of Advisory Group members, there is nonetheless, a commitment to articulate more clearly, the housing needs of older people and working age adults with a need for support. The development of the strategy will provide a policy framework for the Planning Service and will provide much needed evidence for developers of the full range of housing needs within Thurrock.

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

5.1 The Advisory Group is an effective mechanism for co-ordinating contributions to formal consultations on major developments. It also provides a means to ensure consultations concerning the built environment take account of the potential implications for health and well-being.

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

6.1 The Advisory Group aims to improve health and well-being by influencing planning policies and development in Thurrock to:

- make sure people stay healthy longer, adding years to life and life to years
- reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- enhance quality of life through improvements to housing and the built environment.

7. Implications

7.1 Financial

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

No legal implications have been identified.

7.2 Legal

Implications verified by: **Chris Pickering**
Principal Solicitor - Employment & Litigation

No legal implications have been identified.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**
Community Development and Equalities Manager

The Terms of Reference of the Advisory Group are intended to guide the group in reducing inequalities in health and well-being by influencing planning policies and development in Thurrock. If the Board supports the proposal for new housing strategy for older / working age adults that this will be subject to a community and equality impact assessment

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

There are 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):

- The report of the Housing Our Ageing Population Panel for Innovation: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/378171/happi_final_report_-_031209.pdf
- The Housing LIN Case Study on Building Positive Futures in Thurrock http://www.housinglin.org.uk/_library/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy72_Thurrock.pdf
- Planning Practice Guidance Methodology: assessing housing need http://planningguidance.planningportal.gov.uk/blog/guidance/housing-and-economic-development-needs-assessments/methodology-assessing-housing-need/
- Royal Town Planning Institute Handy Guide to Planning 2012 http://www.rtpi.org.uk/media/1454776/planning_handy_guide_2012_5_final.pdf
- Healthy New Towns Programme Prospectus http://www.england.nhs.uk/wp-content/uploads/2015/07/healthy-new-towns-prospectus.pdf

9. Appendices to the report

- Housing and Planning Advisory Group Terms of Reference (Revised).

Report Author:
Sue Williams
Project Manager
Adult, Health and Commissioning

Appendix 1:

Health and Wellbeing Housing and Planning Advisory Group Terms of Reference (Revised)

Background and Purpose

Improving the health and well-being of local communities requires more than improving access to medical treatment and services. There is an important link between the physical and social environment in which we live and how healthy we are, both physically and mentally.

Going forward, the Health and Wellbeing Board recognise the need to ensure that health and wellbeing implications are appropriately considered in plan making and decision taking. The Health and Wellbeing Housing and Planning Advisory Group was formed by the Board to help shape new development at the earliest possible stage and ensure that health and wellbeing impacts are fully considered

Functions of the Health and Wellbeing Housing and Planning Advisory Group

Plan Making

- Actively engage in the production of Thurrock Council's emerging Local Plan (2015-2035) including supporting documents and background evidence as and when appropriate.
- Ensure that the policies and allocations within the emerging Local Plan appropriately address local health challenges and maximise opportunities to create healthy communities.
- Provide collective feedback as part of the formal consultation process on emerging planning policy documents.
- Assist in the production of background evidence reports and topic papers to support the development of the emerging Local Plan as and where appropriate.
- Identify opportunities for joint commissioning and/or commissioning in liaison with other council services, background evidence materials including studies like the Active Place Strategy.
- Support the production of the Infrastructure Requirement List by identifying infrastructure requirements triggered as a result of new development and/or proposed allocations in the emerging Local Plan.

Decision Taking

- Identify health and wellbeing implications of significant planning applications[1] at an early stage in the application process (pre-application if possible).

[1] In this context significant planning applications are defined as: residential schemes over 25 dwellings; schemes under 25 dwellings which involve a specialist housing and/or residential institutions; medium/large scale commercial developments (including retail); community use developments and nationally significant infrastructure projects.

- Identify how proposed developments might mitigate or minimise any negative implications and emphasis any positive implications.
- Provide collective feedback as part of the formal consultation process on significant planning applications.

Membership

Membership will consist of representatives of the following:

- Planning Department
- Housing Department
- Thurrock HealthWatch
- User-Led Organisation
- NHS Thurrock Clinical Commissioning Group
- Public Health
- NHS England (Essex Local Area Team)
- Adult Social Care
- Community Representation – representative attending will be appropriate to the plans being discussed (e.g. if concerning Purfleet, then a Purfleet community representative)
- Children's Services

Membership will alter as appropriate and be reviewed regularly. Depending upon the nature of the application and its impact, individual members may also wish to submit a separate response – e.g. Public Health or CCG.

Frequency of Meetings

The Advisory Group will meet mostly virtually to consider major applications Meetings may take place where appropriate and depending upon the issues contained within particular applications

Chair Arrangements

Head of Adult Social Care

Governance

The Advisory Group has accountability to the Health and Wellbeing Board and sits within the Board's structure.

Comments made by the Group will be submitted to the Planning Department as part of the formal consultation process for major applications or the informal consultation process if commenting on a proposal pre-application

Operation

Major applications – either pre-application or post-application – will be emailed to the Health and Wellbeing Board;

Received applications will be circulated to Advisory Group members for comment;

The Chair will consider whether the Advisory Group needs to meet – depending upon the nature of the application and the extent of the impact on health and wellbeing;

Comment will be required by Advisory Group members within a week of circulation;

Comments will be collated and recirculated to Advisory Group members for sign off and final comment;

The final response will be sent to Planning within fourteen days of receipt – this includes nil responses.

Review
As the Advisory Group is a new initiative, the Terms of Reference will be reviewed on a regular basis.

Minor changes to the Terms of Reference will be approved by the Chair and Planning Department representative.

Major changes to the Terms of Reference will be approved by the Health and Wellbeing Board – after consultation with the Planning Department to ensure consistency with the Planning process.

1st October 2015	ITEM: 6
Health and Wellbeing Board	
Joint Health and Wellbeing Strategy 2016 - 2019	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Ceri Armstrong, Strategy Officer and Ian Wake, Director of Public Health	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning (Thurrock Council), Carmel Littleton, Director of Children's Services (Thurrock Council), Ian Wake (Director of Public Health), and Mandy Ansell, Acting Interim Accountable Officer (Thurrock CCG)	
This report is Public	

Executive Summary

Health and Wellbeing Strategies articulate how an area will improve health and wellbeing and reduce inequalities. For Thurrock, this means developing a health, wellbeing and care system whose focus is on prevention and early intervention and reducing the number of people reaching crisis point. Ultimately, it is about supporting people to achieve a good quality of life.

Thurrock's Strategy will both build on and aim to influence work already started across the whole health and care system – for example through Stronger Together, Building Positive Futures, and the developing Primary Care Strategy. Influencing and recognising the importance of the wider determinants of health and wellbeing will be as important as transforming how health and social care is and is not delivered.

This report sets out the proposed Direction of Travel for achieving good health and wellbeing for Thurrock's population, and proposes a refreshed set of priorities, focused on achieving a population health approach.

The report recommends testing the vision, aims and priorities through an engagement approach being developed in conjunction with Thurrock Healthwatch and Thurrock CVS.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board agrees in principal the draft outline for the refreshed Health and Wellbeing Strategy – including the direction of travel and draft priorities; and

1.2 That the Health and Wellbeing Board agrees to testing the vision, aims, priorities and direction of travel through a period of consultation and engagement – including a stakeholder workshop with the Board to be held in the Autumn.

2. Introduction and Background

2.1 The legal framework for Health and Wellbeing Boards includes the preparation of a Joint Health and Wellbeing Strategy (JHWS). The purpose of the JHWS is to improve the health and wellbeing of the local population and reduce inequalities in health and wellbeing. The JHWS should also influence the commissioning landscape across the health, wellbeing and care system.

2.2 The current Joint Health and Wellbeing Strategy (JHWBS) expires in 2016 and the process of refreshing the Strategy needs to begin. The paper attached at appendix A outlines the proposed focus and rationale for the refreshed Strategy.

3. Issues, Options and Analysis of Options

System Transformation – Setting the Direction of Travel

3.1 The current health and care system is ill-equipped to meet future need and there are a number of reasons for this. For example, when the NHS was founded in 1948, only 52% of the population lived beyond the age of 65. Today, that figure is 86% and is set to increase. 70% of the NHS budget is spent on caring for patients with long-term conditions, and the complexity of cases seen by both the NHS and Social Care has increased through the rise of conditions such as dementia, and the number of people living with multiple health conditions.

3.2 We know that the system's focus needs to shift from treating and responding to ill-health to prevention and early intervention, and that the response needs to move from services to solutions that meet the outcomes the individual wishes to achieve. This includes solutions provided from within communities themselves. Wider determinants of health are key components of this approach – e.g. education, housing, employment, planning, environment, communities. The Strategy therefore needs to influence both the 'place' and 'people' agendas. Individual responsibility will also be a key aspect of the Strategy.

3.3 Thurrock's refreshed Health and Wellbeing Strategy will encapsulate and build on the system transformation required to develop improved health and wellbeing and reduce inequalities in health and wellbeing. The Strategy will build on work already begun and also aim to assess what more needs to be done. It will also influence related strategies and plans that impact upon

improving health and wellbeing. This includes the need to influence the development of the place agenda to both reduce health inequalities and improve overall health.

3.4 The proposed Direction of Travel and priorities contained within the refreshed Strategy will reflect a population-health approach, which includes delivering the following elements:

- Pooling of data about the population;
- Segmentation of the population to enable interventions and support to be targeted appropriately;
- Pooling of budgets to enable resources to be used flexibly to meet needs;
- Place-based leadership – e.g. via the Health and Wellbeing Board;
- Shared goals for improving health and tackling inequalities;
- Effective engagement of communities; and
- Consideration of how to incentivise joint working on population health.

This approach is adopted from the King's Fund's publication 'Population Health Systems' which argues that population health 'is affected by a wide range of influences across society and within communities', and that 'improving population health is not just the responsibility of health and social care services, or of public health professionals', but 'requires co-ordinated efforts across population health systems'.

3.5 The national drivers that add weight to the Strategy and its focus include:

- the NHS 5-Year Forward View which states that 'the future of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health';
- The Care Act 2014 which places emphasis on wellbeing, and on the need to prevent, reduce and delay the need for care and support;
- The 2012 Children and Young People's Health Outcomes Strategy which makes a range of recommendations including 'acting early and intervening at the right time'; and
- The King's Fund recent publication on inequalities in life expectancy which recognise the importance of a focus on the wider determinants of health.

3.6 The refreshed Strategy will reflect an understanding of and respond to local need and the causes of that need. Thurrock's key needs have been identified via the Joint Strategic Needs Assessment and other local intelligence resources and are classified in terms of epidemiological, comparative, and corporate needs. Further detail about Thurrock's need is contained within the attached paper.

Vision, Aims and Priorities

Vision

3.7 The current vision for health and wellbeing in Thurrock is 'resourceful and resilient people in resourceful and resilient communities'. It is recommended that the vision is tested as part of our engagement approach.

Aims

3.8 Current aims are:

- Every child has the best possible start in life;
- People stay healthy longer, adding years to life and life to years;
- Inequalities in health and wellbeing are reduced; and
- Communities are empowered to take responsibility for their own health and wellbeing.

There is a question as to whether the aims add an unnecessary layer to the Strategy and it is recommended that this is tested via our engagement approach. One proposal is that the aims of the Strategy will be reflected by a clear Direction of Travel for health and wellbeing in Thurrock.

Priorities

3.9 Four draft strategic priorities have been developed to both respond to key health and wellbeing needs and to reflect the system transformation required to deliver improved population health:

- Develop a health and care system that systematically works to prevent ill-health, improve and maintain wellbeing, an intervenes at the earliest and most timely opportunity;
- Building strong and sustainable communities;
- Strengthen the mental health and emotional wellbeing of people in Thurrock; and
- Health and social care transformation.

The rationale for the draft priorities is detailed in the appended paper and reflects both the people and the place agenda and also both children and adults.

3.10 The priorities will be underpinned by a range of both planned and new activity and supported by action plans. The priorities build on work which has already begun – for example strengthening communities, building positive futures etc. The Board may also wish to include as part of the priorities, issues it consider require a higher profile – e.g. air quality.

3.11 Whilst the Strategy, its vision, direction of travel, and priorities will be 'whole population', Children and Young People will have a stand-alone delivery plan. This will allow issues specific to children and young people to be identified and addressed – e.g. educational attainment.

Next Steps

3.12 Thurrock Healthwatch and Thurrock CVS are developing a proposed engagement approach to test and develop the Strategy. This will include testing the vision, aims, and draft priorities set out within this and the attached paper.

3.13 Consultation on the draft vision, aims and priorities will also take place with key stakeholders. It is recommended that a stakeholder event with the Health and Wellbeing Board and other key organisations takes place in the Autumn.

3.14 A draft Strategy including and responding to engagement feedback will be prepared for the January Health and Wellbeing Board, and will also be discussed at the Health and Wellbeing Overview and Scrutiny Committee. The Children and Young People's part of the Strategy will be tested via the Children's Overview and Scrutiny Committee.

3.15 It is anticipated that the final Strategy will be signed off by the Health and Wellbeing Board and Council in March 2016.

Draft Timetable

Date	Audience	Activity
1st October 2015	Health and Wellbeing Board	Outline Strategy and approach
TBC	CCG Board/Seminar	Outline Strategy and approach
October – December (dates TBC)	Service Users, Carers, General Public	Engagement
November (dates TBC)	Health and Wellbeing Board plus additional stakeholder organisations	Strategy stakeholder event
5th January	Children's Services O&S Committee	Draft Strategy
11th January	Children and Young People's Partnership Board	Draft Strategy
12th January	Health and Wellbeing O&S Committee	Draft Strategy
13th January	Cabinet	Draft Strategy
14th January	Health and Wellbeing Board	Draft Strategy
27th January	CCG Board	Draft Strategy
9th March	Cabinet	Final Strategy
10th March	Health and Wellbeing Board	Final Strategy
TBC	Children and Young People's Partnership	Final Strategy
23rd March	Council	Final Strategy
30th March	CCG Board	Final Strategy

4. Reasons for Recommendation

4.1 To refresh Thurrock's Health and Wellbeing Strategy which is set to expire at the end of March 2016.

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

5.1 The Strategy's engagement approach is being developed in consultation with Thurrock Healthwatch and Thurrock CVS.

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

6.1 The Health and Wellbeing Strategy reflects the Community Strategy priorities 'Improve Health and Wellbeing' and is responsible for articulating how that priority will be delivered.

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**

Director of Adults, Health and Commissioning

Whilst there are no financial implications attached to the preparation of the Strategy, there will be implications linked to the delivery of the priorities – e.g. the ability to shift resource towards prevention and early intervention as a key driver of reducing and preventing ill health and maintaining health and wellbeing.

7.2 Legal

Implications verified by: **Roger Harris**

Director of Adults, Health and Commissioning

Preparation of the Joint Health and Wellbeing Strategy is a statutory responsibility of the Health and Wellbeing Board.

7.3 Diversity and Equality

Implications verified by: **Roger Harris**

Director of Adults, Health and Commissioning

One of the reasons for developing a Health and Wellbeing Strategy is to reduce inequalities in health and wellbeing. This includes using local intelligence to understand the key causes of the Borough's inequalities and identifying how these can be addressed – e.g. via commissioning activity or via system transformation. This includes focusing on the wider determinants of health.

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):

- Population Health Systems – Going Beyond Integrated Care (King's Fund)
- Inequalities in Life Expectancy (King's Fund)
- Good practice in joint health and wellbeing strategies: a self-evaluation tool for health and wellbeing board (LGA)
- Creating a better care system – setting out key considerations for a reformed, sustainable Health, Wellbeing and Care system of the future (Ernst Young)

9. Appendices to the report

- Thurrock Health and Wellbeing Strategy 2016-2019 – Outline Strategy

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Health and Commissioning

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Developing a new Thurrock Joint Health and Wellbeing Strategy (JHWBS)

1. Introduction

This paper sets out the steps to refresh the Thurrock Joint Health and Wellbeing Strategy as the current Strategy is due to end in March 2016. The paper also provides a draft outline for the new Strategy.

Joint Health and Wellbeing Strategies (JHWSs) are strategies to meet local population health and wellbeing needs as identified by the Joint Strategic Needs Assessment (JSNA) process, and to reduce health inequalities. They should be a key component of the local partnership and commissioning landscape.

The JHWS is the highest level strategic document of the Health and Wellbeing Board. As such, this paper recommends that the Strategy captures and drives system transformation – transformational activity aimed at shifting demand and resource away from the acute end of the system and towards preventing, reducing and delaying the need for care and support and promoting good health and wellbeing.

2. Background

The current health and care system is regularly quoted as being fragmented - working around professional and organisational boundaries as opposed to being centred on meeting the needs and outcomes of the individual. The clear boundaries between social care and health have also become increasingly blurred. When the NHS was founded in 1948, only 52% of the population lived beyond the age of 65. By 2011, the percentage had increased to 86% - although a greater number of people are living with disabilities. Service demand continues to increase alongside pressure to meet year on year savings, and the nature of that demand has increased in complexity – Department of Health states that 70% of the NHS budget is spent on caring for patients with long-term conditions, and social care is facing increasing pressure from both older client groups (e.g. dementia) and also young adults with specialist care needs (e.g. autism).

Therefore without significant system transformation, demand will continue to outstrip supply. It is widely acknowledged that there needs to be an increased focus on prevention and early intervention. This means shifting the focus of the local system on promoting health and wellbeing, and that this needs to be across the entire population.

The system driving health and wellbeing is extremely broad – expanding far beyond the NHS and Social Care, and wider determinants of health such as education, housing, employment, and planning play a much more significant role in determining health outcomes and driving health inequalities. ‘It also means that accountability for population health…..is not concentrated in single organisations or within the boundaries of traditional health and care services’ (Kings Fund, Population Health Systems, Feb 2015).

Therefore the HWBS and Health and Wellbeing Board is well placed to be able to drive the change in the system required, and define what that looks like in Thurrock.

3. National strategic drivers

This section provides a very high level view of some of the strategic drivers shaping the future of health and wellbeing and therefore influencing Thurrock's refreshed HWBS. It is by no means an exhaustive list.

Health
The NHS five year forward view:

- 'The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health'.
- The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care – with far more care delivered locally, some services delivered in specialist centres organised to support people with multiple health conditions.
- A number of new models of care – e.g. Acute Care Collaborations, Enhanced Health in Care Homes, Multi-Speciality Community Providers etc.

Adult Social Care
The Care Act 2014 sets out statutory duties for local authorities concerning care and support. This includes a new duty of wellbeing, and the duty to prevent, reduce and delay the need for care and support. The Care Act recognises the importance of strengthening and developing the market place, and the need to act before people reach crisis point or even require a service.

Children
The 2012 Children and Young People's Health Outcomes Strategy forum report makes a range of recommendations for the NHS and local authorities centred around key themes including:

- Putting children, young people and their families at the heart of what happens;
- Acting early and intervening at the right time;
- Integrating services;
- Ensuring services are safe and sustainable; and
- Developing the workforce, education and training.

Inequalities in life expectancy
A recent King's Fund publication looking at changes to inequalities in life expectancy since the Marmot Report was published made the following key findings and implications for policy:

- Health policy is too fixed on integration between health and social care – rather than wider integration with other public services and community assets – population health systems;
- Unemployment and older people's deprivation play a particularly important role in determining differences between areas in life expectancy; and

- Where we live and who we live with affects our health over and above our own individual circumstances – e.g. the negative impact of a lack of community and networks around older people.

4. Local Needs Assessment

A successful health and wellbeing needs assessment considers:

- Epidemiological need – what issues are causing significant harm to large sections of our population;
- Comparative need – what are the issues where Thurrock residents have significantly poorer outcomes than other populations in England; and
- Corporate need – what issues make the system unsustainable.

Key needs concluded from the Thurrock JSNA and other local health intelligence are:

Epidemiological Needs:
The three biggest causes of premature death in Thurrock are:

- Cardio-vascular disease;
- Cancer; and
- Respiratory disease.

The most common long-term conditions are:

- Hypertension (high blood pressure);
- Depression;
- Respiratory problems (asthma and COPD);
- Diabetes; and
- Cardio-vascular disease including strokes/TIAs, Coronary Heart Disease and Heart Failure.

Comparative Needs:
Thurrock has significantly poorer outcomes than England on:

- Slope of health inequalities (life expectancy between top and bottom decline of deprivation);
- Percentage of Children in Poverty;
- Rate of Violent Crime;
- Breast feeding initiation;
- Child and adult obesity;
- Smoking prevalence and smoking attributable mortality;
- Male life expectancy at 65;
- Female life expectancy at 65;
- Under 18 conceptions;
- Cancer screening coverage, breast and cervical;
- People presenting with HIV at late stage of infection;
- <75 mortality from cardio-vascular disease;
- Hip fractures in those aged 65+; and
- Percentage of children in care.

Corporate needs:

- Financial viability of health and social care;
- Unacceptable levels of variation in primary care quality and access – including significant levels of under-doctoring; and
- Fragmented health and wellbeing system.

5. Suggested Vision and Direction of Travel

Vision

Thurrock JHWS's existing vision is:

'Resourceful and resilient people in resourceful and resilient communities'.

We are recommending that we test whether the vision reflects what we and the community want the JHWBS to help deliver as part of our engagement activity.

Aims

The existing Strategy has four 'aims', and we are recommending that we test whether a set of 'aims' is still required (and if so, whether the current aims are still appropriate), or whether they add an unnecessary layer and can be reflected by an articulation of Thurrock's Direction of Travel.

Current aims are:

- Every child has the best possible start in life;
- People stay healthy longer, adding years to life and life to years;
- Inequalities in health and wellbeing are reduced; and
- Communities are empowered to take responsibility for their own health and wellbeing.

Direction of Travel

The purpose of the Strategy is to improve health and wellbeing and reduce inequalities in health and wellbeing as expressed by the vision. Whilst that is the purpose the Strategy, it spans just three years. It is therefore important to ensure that the Strategy is improving outcomes that reflect and help achieve Thurrock's direction of travel - which will be achieved over a longer time frame.

We are recommending that the Direction of Travel (DoT) for Thurrock's Health and Care system reflects the achievement of a population health system as articulated by the King's Fund in its publication 'Population Health Systems – going beyond integrated care'. This describes the health and care system of the future – including an emphasis on prevention and early intervention and what the health and care system needs to do to shift from responding to illness, to promoting and maintaining good health and wellbeing. This includes a focus on some of the wider determinants of health and wellbeing impacting on both adults and children.

Thurrock's Direction of Travel for the health and care system would therefore include:

- Pooling of data about the population to identify challenges and needs and to improve planning and commissioning;

- Segmentation of the population to enable interventions and support to be targeted appropriately;
- Pooling of budgets to enable resources to be used flexibly to meet population health needs – at least between health and social care but potentially going much further;
- Place-based leadership via the Health and Wellbeing Board;
- Shared goals for improving health and tackling health inequalities based on an analysis of needs and linked to evidence based interventions – e.g. JSNA;
- Effective engagement of communities and their assets through third sector organisations and civic society in its different manifestations;
- Developing a system that incentivises joint working on population health

Thurrock's refreshed JHWS would be an articulation of the steps taken over the next three years to achieve this Direction of Travel and therefore achieve a population health system aimed at improving health and wellbeing.

6. Proposed Priority Areas for a new Thurrock Joint Health and Wellbeing Strategy

In order to work towards achieving the vision and direction of travel detailed in section 5, and respond to the needs identified in section 4, four priority areas for the refreshed strategy have been identified. Further work will be carried out with Children's Service to ensure that the priorities span a 'whole population'.

Draft Priorities

1. Develop a health and care system that systematically works to prevent ill-health, improve and maintain wellbeing, and intervenes at the earliest and most timely opportunity.

This will be broken down in to:

- Primary prevention – solutions aimed at individuals or populations who have no current particular health or social care support needs. Primary prevention aims to avoid people developing care and support needs;
- Secondary prevention – solutions aimed at individuals who have an increased risk of developing needs. Secondary prevention aims to help to slow down further deterioration or preventing more serious ill-health from developing;
- Tertiary prevention – solutions aimed at minimising the effect of disability or deterioration in people with existing health conditions, complex care and support needs or caring responsibilities.

Delivery of the priority will include a focus on:

- The key lifestyle behaviours that underpin ill-health in Thurrock – smoking, obesity, diet, alcohol consumption;
- Greater investment in prevention and early intervention;
- Delivery of care closer to home;
- Development of risk stratification and early identification tools;

- Greater development of technological solutions – e.g. assistive technology/telehealth;
- Better self-management – e.g. of long term health conditions;
- Supportive communities;
- Good quality primary care; and
- A focus on wellbeing – e.g. social isolation, connectiveness etc.

2. Building strong and sustainable communities:

- Recognises that the health and wellbeing of individuals is influenced by the communities in which they live;
- Will build on work already started – e.g. via Stronger Together Programme – Building Positive Futures, Asset Based Community Development, Community Builders, Community Hubs, Local Area Coordination;
- Builds on links with wider determinants of health and wellbeing – e.g. planning and development, housing – Health and Wellbeing Housing and Planning Advisory Group etc.
- Influencing the 'place agenda' – e.g. regeneration agenda and the built environment

3. Strengthen the mental health and emotional wellbeing of people in Thurrock:

- Recognises the importance of achieving good mental health and wellbeing – e.g. 1 in 4 people will experience a mental health problem at some point in their life;
- Will include a focus on how current mental health services are provided and delivered – e.g. mental health and physical health inextricably linked;
- Will also link to non-health and social care interventions and the wider determinants of mental health and emotional wellbeing – e.g. social isolation, debt, poor housing, mental health problems in childhood etc.

4. Health and Social Care Transformation

System transformation is required if there is to be a shift away from current fragmentation and towards population health. We need to create a system focused on improving and maintaining good health and wellbeing and not a system focused on treating illness. Whilst system transformation can be seen as an enabler, the importance of transformation to delivering improved health and wellbeing is so great that we are recommending that it becomes a priority in its own right. The priority will include:

- New and alternative models of care – e.g. development of health and wellbeing hubs;
- Move towards integrated commissioning;
- Market development – to support greater choice and control;
- Further development of the Better Care Fund and pooling of budgets – e.g. to enable system redesign and the resourcing of transformation;

- A set of refreshed design principles that underpin all commissioning and service development – as agreed with the CCG in December 2013 and focused on the shift towards prevention and early intervention;
- Care closer to home – including integrated service delivery/access

7. Joint Health and Wellbeing Strategy Delivery

Governance and Monitoring
This will include:

- Outline governance arrangements including who has responsibility for ensuring the delivery of priorities or parts the priority and how the Board will receive assurance that the Strategy is a) being delivered; and b) achieving the outcomes required;
- Each priority will be supported by action/delivery plans – clearly stating who and which organisation is responsible for delivering which aspect of the priority (Children and Young People and Adults with have respective delivery plans);
- Possible development of a performance framework – e.g. how will we know if the Strategy is being successful?
- Health and Wellbeing Board work plan that reflects the Strategy;
- Possible refresh of Board responsibilities – e.g. consideration of decision making and delegations

*there are already a number of strategies and plans in place that if appropriately focused will deliver the priorities and direction of travel as described within this paper. It is expected that where necessary, the Strategy will influence the development of those related strategies – e.g. Primary Care Strategy, Building Positive Futures, Public Health Strategy.

Risks
Key risks include:

- Spread of innovation – risk appetite;
- Engagement to mobilise – engaging at the earliest opportunity;
- Shared purpose – getting clear sign up and clarity about the problem we need to fix (and does everyone agree what that is);
- System drivers – ability to understand different drivers and the impact of different parts of the system on other parts etc.; and
- Sustainability and capacity – e.g. funding, budgets, workforce development, skill sets

8. Engagement Approach

It is important to ensure effective and appropriate engagement influences the development of the Strategy. It is likely that engagement will be used to test out proposed priorities and what they mean to the community – both in terms of what works well and what needs to improve.

Initial discussions have taken place with CVS and Thurrock Healthwatch to scope the engagement approach for the Health and Wellbeing Strategy. The approach will inform engagement work on the Strategy as it is developed.

A stakeholder event for Health and Wellbeing Board members and other individuals/organisations as appropriate will be organised towards the end of the period of engagement to review feedback and to shape the final draft of the Strategy.

1st October 2015	ITEM: 7
Health and Wellbeing Board	
Health and Wellbeing Board Self-Assessment	
Report of: Ceri Armstrong, Strategy Officer	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is public	

Executive Summary

This report outlines the elements of the Local Government Association's Improvement Offer – aimed at supporting Health and Wellbeing Boards to develop towards effective system leadership. The report identifies a suggested course of action which is to commit to participating in the facilitated self-assessment process.

The LGA's improvement offer supports its view on the future of health and wellbeing boards – as contained within its report 'Making it better together – a call to action on the future of health and wellbeing boards'. The report was developed in conjunction with NHS Clinical Commissioners and endorsed by the NHS Confederation.

The improvement offer and the recommendations contained within this report therefore aim to support Thurrock's Health and Wellbeing Board to move towards a future state – one which shifts from relationship building to system leadership. The improvement offer is one means of assisting the Board with making that transition.

1. Recommendation(s)

1.1 For the Health and Wellbeing Board to agree to participate in the LGA's facilitated self-assessment process.

2. Introduction and Background

2.1 The Health and Wellbeing Board has oversight of the entire local health and care system and the factors that impact locally on health and health inequalities. As such, Health and Wellbeing Boards will have a growing role in bringing the system together and ensuring that it moves in the right direction.

2.2 The transformation of health and social care in Thurrock and its composite parts will be overseen by the Board. Thurrock's transformation journey will be captured within the refreshed Joint Health and Wellbeing Strategy.

Successful transformation will see Thurrock residents remaining healthy for longer, and better able to manage and prevent the decline of ill health – combined with greater choice and control. This will mean a health and care system that shifts resource and focus away from unplanned care and crisis management to prevention and early intervention. The extent of the success will depend upon both local and national factors and enablers.

2.3 In order to make the shift described in 2.2, Health and Wellbeing Boards will need to consider making greater use of the powers and freedoms available to them - particularly if they are to be successful in improving the population's health and wellbeing outcomes. This may lead to the Board having an enhanced role and greater responsibilities.

2.4 The Local Government Association (LGA) is a strong advocate of Boards as system leaders and as leaders of health and care place-based commissioning. Whilst the LGA recognises and has called on the Government to remove barriers at a national level to enable HWBs to become effective system leaders it also calls on Boards to use their existing powers to drive health improvement. The LGA, alongside NHS Clinical Commissioners and NHS Confederation has developed a paper 'Making it better together – a call to action on the future of health and wellbeing boards' setting out how Health and Wellbeing Boards should be supported to bring about a radical transformation in the health of communities.

2.5 To support Boards in their growing role and to ensure they 'move on from relationship building to making an impact on the delivery of services', the LGA has established an improvement programme. It is recommended that the Board uses elements of the LGA's improvement programme so that it can both consider its current and future role and assess what it and Board members need to do to become to develop into that role. The improvement programme will also help the Board to ensure it is positioned to enable the delivery of the refreshed Health and Wellbeing Strategy. This paper will outline the options available to the Board as part of the LGA's offer.

3. Issues, Options and Analysis of Options

3.1 The Care and Health Improvement Programme (CHIP) consists of the following elements:

- Health and Wellbeing Board Self-Assessment (including facilitated self-assessment);
- Leadership Offer – including HWB Chairs and Adult Social Care Portfolio Holder Induction Session and Leadership Essentials for HWB Chairs; and
- Health and Wellbeing Board Peer Challenge.

Self-Assessment Tool

3.2 The Self-Assessment Tool 'aims to support the rapid development of HWBs across the country towards effective system leadership and innovation and to step up to the challenge of an enhanced role'. It covers the following themes:

- Vision, ambition and the role of the health and wellbeing board;
- System leadership and partnership working;
- Ensuring delivery and impact;
- Communication and engagement; and
- Integration and system redesign.

3.3 The LGA suggest that the tool can be used in a number of different ways:

- As a checklist to help agenda setting;
- As part of a facilitated self-assessment;
- To focus discussions during development sessions and action plans;
- As a survey sent to each member of the health and wellbeing board with responses analysed to inform a report and discussion.

3.4 The facilitated assessment offer includes a facilitator for the day to work through the self-assessment tool with the Board and can be tailored to meet local requirements.

Peer Challenge

3.5 The Peer Challenge involves a team of between four to six people spending time on-site with Board members to challenge around the following areas:

- Clarity and purpose of the Board;
- Building a model of shared learning within the Board;
- Working with partners to develop the systems leadership role;
- Ensuring delivery and impact; and
- Integration and system redesign.

3.6 The process includes the following:

- Observation of the Board;
- Position statement prepared by the Board;
- Pre-site reading – based on evidence provided by the Council and Board;
- Pre-site analysis;
- Pre-site survey with Board members;
- 3 days of on-site activity – including a 'setting the scene' meeting, interviews with individuals and groups, focus groups, and a final feedback session;
- Written feedback; and
- Follow-up work – not part of the actual Peer Review, but available on request depending upon the outcome of the review – e.g. action planning workshop.

Leadership Offer

3.7 The leadership offer is aimed at Health and Wellbeing Board Chairs and Adult Social Care Portfolio Holders. The offer consists of an induction session for chairs and a leadership essentials course.

Recommended course of action

3.8 It is recommended that the Board participates in the LGA's offer. There is every indication that the role and focus of Health and Wellbeing Boards as system leaders will continue to grow. This coupled with the refresh of the Health and Wellbeing Strategy makes taking part in the improvement a sensible proposition.

3.9 The facilitated self-assessment would be a less resource-intensive option and provide the Board with some insight of where it is and what it needs to do to establish itself as an effective system leader. The Peer Review is a more thorough and resource-intensive piece of work, and Board members will need to fully commit to the process to make it meaningful.

3.10 The recommendation is that the Board undertake the facilitated self-assessment as a first step, and use the results of the self-assessment as a benchmark for future work – including the possibility of a peer review. The self-assessment should provide the Board with sufficient insight and enable any key areas of development to be highlighted. Depending upon the results of the self-assessment, the Board may also wish to commission an action-planning session.

4. Reasons for Recommendation

4.1 It is recommended that the Board participates in the LGA's improvement programme for the reasons outlined within this report – e.g. the growing role of Health and Wellbeing Boards as system leaders and place shapers.

4.2 It is recommended the Board participates in the facilitated self-assessment element of the improvement programme for the reasons outlined in 3.9.

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

5.1 Consultation will take place via the Health and Wellbeing Board.

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

6.1 The Health and Wellbeing Board has the lead for the Community Strategy priority 'improve health and wellbeing'. The improvement programme will ensure that the Board understands its current and future role and identifies actions required to be effective.

7. Implications

7.1 Financial

Implications verified by: **Michael Jones**
Strategic Resources Accountant

There are no financial implications arising from this report

7.2 **Legal**

Implications verified by:

Solomon Adeyeni
Legal and Democratic Services

None identified.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The Health and Wellbeing Board has responsibility for:

- Improving the health and wellbeing of the people in their area;
- Reducing health inequalities; and
- Promoting the integration of services.

Ensuring the Board is effective in fully understanding and delivering its role will help ensure these responsibilities are met.

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):

- Making it better together – a call to action on the future of health and wellbeing boards, LGA, NHS Clinical Commissioners, and NHS Confederation;
- LGA Care and Health Improvement Programme (CHIP), LGA, July 2015; and
- Creating a better care system, Ernst & Young LLP, June 2015.

9. Appendices to the report

- None.

Report Author:

Ceri Armstrong

Strategy Officer
Adults, Health and Commissioning

1st October 2015	ITEM: 8
Health and Wellbeing Board	
Healthwatch Thurrock Annual Report	
Report of: Kim James Chief Operating Officer, Healthwatch Thurrock	
Accountable Head of Service: N/A	
Accountable Director: N/A	
This report is Public	

Executive Summary

This annual report sets out to highlight some of the work Healthwatch Thurrock has achieved during the year 2014 – 2015.

Healthwatch Thurrock have spoken to over 7,000 residents both Adults and Children and Young people to ask their views on the services they receive within Health and Social Care Services and then fed those views back to the providers and Commissioners as appropriate.

Healthwatch Thurrock now provide the PALS service for primary care services in Thurrock, and have taken over 2,000 calls for information, advice and signposting, including finding a GP, a NHS Dentist, 100 hour pharmacies, how to find a residential home for someone with dementia. And support for many residents following diagnosis of a long term medical condition such as diabetes and COPD to find support groups within the Voluntary Sector.

Healthwatch Thurrock has also been able to support patients to tell the stories of their experiences using our local hospital BTUH to the Hospital Board of Directors, and have taken part in CQC visits and fed back concerns/issues and complaints from patients to the regulators.

Healthwatch Thurrock was able to support service users to help influence the decision to keep the Stroke Unit at BTUH rather than it be moved to Southend.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board note Healthwatch Thurrock's Annual Report

2. Introduction and Background

Healthwatch Thurrock is an independent organisation commissioned by Thurrock Council to gather the views of the residents of Thurrock regarding both Health and Social Care Services. Healthwatch Thurrock covers both Adults and Children's Services.

Healthwatch Thurrock is a Local Healthwatch, but is part of a national body that covers the whole of England, with 54 local Healthwatch organisations. Healthwatch England leads the work at a national level and has access to both the Department of Health and Government Office to feedback concerns and issues collated by local Healthwatch Organisations to form a national picture.

Healthwatch have powers set in statute, those powers include;

1) The power to carry out Enter and View visits to both Health and Social Care premises where services are being delivered i.e. Residential and Nursing Homes, Primary Care Services and Hospitals
2) To produce reports with recommendations to providers and Commissioners regarding any concerns raised by service users or patients, and expect those recommendations to be implemented or reasons discussed if not.
3) The power to request information from providers and commissioners regarding services and receive that information within 20 working days.

Healthwatch Thurrock holds seats on the HWBB, HOSC and Safeguarding Board for both Adults and Children's and also on partnership Boards to ensure the voices of people are heard when decisions affecting them are being made, and to raise concerns when those decisions are in direct conflict with the residents views.

4. Reasons for Recommendation

4.1 Healthwatch Organisations are required to produce an annual report, and that report to be presented to HWBB, HOSC, Commissioners, HW England, NHS England, CCG and public.

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

5.1 N/A

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

6.1 N/A

7. Implications

7.1 Financial

Implications verified by: **Roger Harris**
Director of Adults, Health and Commissioning

No implications have been identified.

7.2 Legal

Implications verified by: **Roger Harris**
Director of Adults, Health and Commissioning

No implications have been identified.

7.3 Diversity and Equality

Implications verified by: **Roger Harris**
Director of Adults, Health and Commissioning

Healthwatch helps to ensure that the health and care needs of all Thurrock residents are being met. This includes influencing health and care organisations to ensure sufficient and appropriate provision exists, equity of access, and also quality of provision.

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

N/A

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

- Annual report

Report Author:

Kim James
Chief Operating Officer
Healthwatch Thurrock

Healthwatch Thurrock

Annual Report 2014/15

Contents

Note from the Parent Company

Towards the end of 2014, Healthwatch Thurrock returned to Thurrock CVS as a project. Healthwatch Thurrock work programme and direction is now shaped and overseen by an advisory group, comprising of representatives from the Voluntary Sector, Patients Groups, Social Care Forums and Thurrock's ULO. None of this transition deflected from the good work of Healthwatch Thurrock; reaching out to communities and representing the views of patients and users, in an environment where there have been significant challenges; within NHS, Primary Care and Social Care. This next year will see the introduction of the Care Act and work continuing on integrating services under the Better Care Fund, all of this under the backdrop of the significant budget savings that need to be made by the local authority.

This report highlights the work of Healthwatch Thurrock, representing the views of the citizens of Thurrock at all strategic levels and demonstrates some of the changes they have made.

As we enter the year 2015-16 we will see further challenges for citizens and it's important that Healthwatch Thurrock continue to listen and channel those voices, in an important time of change.

Kristina Jackson

Chief Executive Officer – Thurrock CVS

Note from the Chief Operating Officer

As already stated by the CEO of our parent company, the end of 2014 saw some significant changes to how Healthwatch Thurrock was formed and how it had worked previously. This could have been a very difficult time, in fact in some areas it was, but we used the time to reflect on what had been and to look to the future.

The future was a new structure, a new strategy, new posts and new staff. This has enabled us to work better, to spread the word of Healthwatch wider across the borough, a new team brought with it new ideas, all of which have enabled us to do some important pieces of work, to influence change and more importantly to listen to the views both good and bad of the people of Thurrock around the services they use within health and social care.

As a small Healthwatch we struggle at times to reach everybody, we sometimes look at the work that bigger Healthwatch organisations carry out and feel we drag behind, but then we look at the work we have done, the people we have reached and most important those we have helped.

Please accept this annual report as the story of us, the people of Thurrock and how we have worked together to achieve some real changes in a time of significant change for our organisation.

Kim James

Chief Operating Officer- Healthwatch Thurrock

About Healthwatch Thurrock

We are here to make health and social care better for ordinary people. We believe that the best way to do this is by designing local services around their needs and experiences.

Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience. We are the only body looking solely at people's experience across all health and social care.

We are uniquely placed as a network, with a local Healthwatch in every local authority area in England.

As a statutory watchdog our role is to ensure that local health and social care services, and the local decision makers, put the experiences of people at the heart of their care.

Every voice counts when it comes to shaping the future of health and social care, and when it comes to improving it for today. Everything that local Healthwatch does will bring the voice and influence of local people to the development and delivery of local services.

People need to feel that their local Healthwatch belongs to and reflects them and their local community. It needs to feel approachable, practical and dynamic and to act on behalf of local people.

-We're helping you to shape and improve the services you use.

-We're engaging with people in your community & if you haven't met us yet, please get in touch!

-We're an open organisation and want to make it easy for you to talk to us.

-We're inclusive & we want people from every part of your community to join us.

-Ask us what we're doing & we'll always tell you what's happening.

-You can hold us to account.

-We're here to help services to improve.

-We'll notice the bad things they do, and the good.

-We use your evidence to build a true picture of your local services.

Our vision/mission

Healthwatch Thurrock aims to enable people, communities and organisations in Thurrock to have a say and influence the planning, commissioning and delivery of Health and Social Care services to improve the health and wellbeing of patients, the public and service users.

Our mission statement

Healthwatch Thurrock will enable individuals and community groups to influence the planning of all local Health and Social care services. In doing this Healthwatch Thurrock pledges to support all members of the public to promote better health and wellbeing for everyone.

2014 saw quite a few changes with Healthwatch Thurrock including staff changes and changes to the operational running but we feel we are now stronger and more eager than ever to ensure the voices of our residents are heard.

At the start of 2014 Healthwatch Thurrock was a community interest company with a board of directors that managed the company and made any decisions. This is no longer the case and as of January 2015 Healthwatch Thurrock is now a project being run and managed by Thurrock CVS. The Thurrock CVS board now has the final say on all decisions although Healthwatch Thurrock has set up an advisory group that act as a sounding board for ideas and upcoming events and pieces of work.

Healthwatch Thurrock also added 3 new staff members to the team in January 2015. Linda is the new Administrator, Samson has a joint role with Public Health as a Development Worker and Amanda is Deputy Chief Operating Officer leading on engagement with children and young people.

Our Healthwatch Team:

Kim James is Chief Operating Officer.

Amanda Perry is Deputy Chief Operating Officer.

Linda Runciman is Administrator.

Samson Odubanjo is Development Worker, a shared role with Public Health.

Engaging with people who use health and social care services

Understanding people's experiences

During 2014/15 Healthwatch Thurrock has engaged with the residents of Thurrock across of all its communities in a variety of ways.

We have specifically targeted some more seldom heard groups such as:

- Young people (under 21)
- Older people (over 65)
- People with Learning Disabilities

To reach out to younger people we have attended the local Youth Cabinet as well as set up links with existing youth groups within the borough to try to recruit some young Healthwatch Ambassadors who could champion the Healthwatch name amongst their peers. We also held a fun day at Stubbers Activity Centre. This recruitment is continuing into 2015 with Amanda scheduled to return to the Youth Cabinet and to attend meetings with all of the school heads and SENCO's to hopefully run some workshops or talks with young people in schools. We have also started making links into childrens centres to promote our services to mums and children of a preschool age.

To reach out to older people we have regularly attended the Older Peoples Parliament to promote the work that we do and also to pick up any issues that may arise during a meeting and we may have otherwise missed. We have also regularly attended the local Over 50s Forum.

Our development worker Samson is also building links with BME groups, churches and Faith groups across the borough, he is also using the contacts he made in his previous role as a community worker to talk to communities, groups and organisations about the work that Healthwatch does.

We have worked very closely across 2014/15 along with the local Learning Disability Nursing Team as well as Thurrock Lifestyle Solutions, a local organisation supporting Thurrock residents with Learning Disabilities, to look at the uptake of the LD healhtchecks and how this can be improved. This work will run into 2015 with an event being held in April 2015 to promote the importance of a healthcheck and to try and break down some of the fears we have found that people with LD have surrounding the checks.

To target the whole population of Thurrock we also started running monthly drop in sessions during 2014/15 at various locations across the borough. We currently have 6 regular drop-ins set up in 6 areas of the borough varying on time of day and location including libraries and community centres. These drop-ins will hopefully also be themed monthly during 2015 to fit in with the local Health and Wellbeing board agenda.

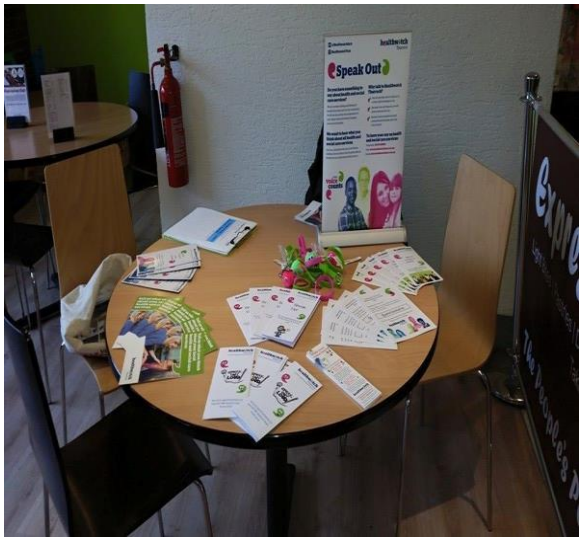
During 2014/15 we listened to many voices in our community, some were individuals who had a story to tell an experience to share. Some were groups, both community

and support groups who used their voices to tell us about the services they used and they shared their good experiences as well as their poor experiences.

We carried out some pieces of work with and for them and have some success stories to tell which are further on in this report.

We continued to use our very effective 'Change One Thing' campaign, where we just ask the residents, service users, patients; " if you could change one thing about the services you use, what would it be? And if you wouldn't change anything, tell us why" the simplicity of this has been its success and over the past year it has enabled us to collect a snap shot of views which are then fed into reports as either experiences, ideas or quotes. This concept has been adopted by other organisations and statutory services in Thurrock, for example Thurrock CCG used it very effectively to gather views on the commissioning of services.

Between November 2014 and March 2015 Healthwatch Thurrock estimates that we engaged with 7112 individuals. This equates to 4.5% of Thurrock's population.



Enter & View

Healthwatch Thurrock have not needed to use their statutory powers of enter and view in this year.

But, we have arranged and made lots of informal visits to services under the blanket of enter and view.

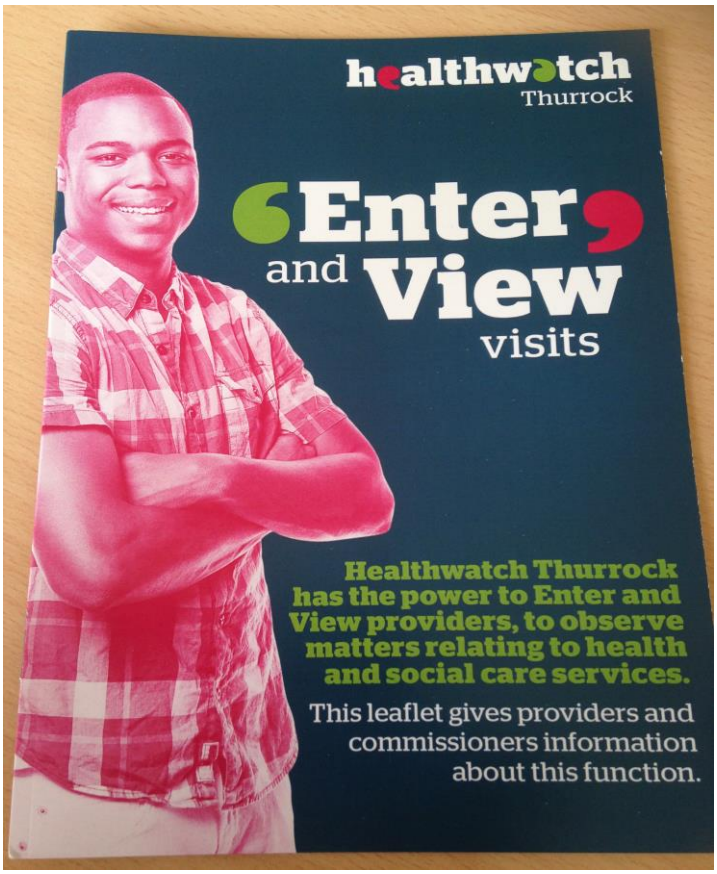
We have carried out many visits to our local hospital to take part in their audits of services, we have visited wards and spoken to patients under our 'change one thing' campaign and shared our findings with them.

We have taken part in visits to our local mental health service placements, including young people's services.

We carried out some visits to residential homes across Thurrock under the blanket of our 'Dignity in Care' work with residential and day services. We held an event to feed back to providers and commissioners our findings and also held an afternoon tea for the service users and carers.

We have also carried out visits to our GP practices to gather information and patient views to be included in the CQC Inspections, and to feed into the 5 year forward plan for NHS England and Thurrock CCG

We do have a training package in place to train our 'Enter and View' volunteers and also have a small team of authorised representatives who carry out our visits and audits of services.



Providing information and signposting for people who use health and social care services

Helping people get what they need from local health and social care services

During 2014/15 here at Healthwatch Thurrock we gave advice and signposting regarding some of the following topics:

- Social Care Rapid Response Team
- PALS service at Basildon Hospital
- Local Dentist information
- New GP Registration
- Support Groups for Long Term Conditions such as Diabetes and Lupus
- Carers Support
- Older People Support Groups
- Respite Care

We also began to advertise the Advice, Information and Signposting service as a separate service including the production on a specific poster for use in GP surgeries and pharmacies as well as hospitals and other care facilities.

We found that although we discussed this as a service we offered previously to the posters there was still a lot of confusion as to the PALS service for Primary Care including people believing that the PALS service within Basildon hospital covered primary care and also a belief that PALS for primary care had not been replaced at all.

To alleviate this confusion and to promote the service and encourage a larger number of calls we commissioned the poster as per below. The feedback we have had has been great and we hope to see a rise in calls over the upcoming year.

Through our information, advice and signposting service in 2014/15 we put two local residents both with Lupas in touch with each other providing them a local source of support and understanding. Both ladies now meet and have stated that without Healthwatch Thurrock would never have known that support could be found so locally.

Influencing decision makers with evidence from local people

Producing reports and recommendations to effect change

There are 3 main reports from pieces of work which have influenced change, they are;

- The provision of sharps boxes
- The decision not to move stroke services to another hospital out of area.
- Annual health Checks for Learning Disabled Residents

Putting local people at the heart of improving services

We have been able to support local people to represent themselves at meetings to put across their views and concerns, some of those were;

- Attendance at the Thurrock Clinical Commissioning Group Board meeting to ensure their voices were heard when decisions affecting them were heard
- Supporting patients from our local hospital to attend the Hospital Board meeting and to tell their experiences of using the hospital both good and bad.
- By planning and facilitating meetings between service users and patients with providers and commissioners to look at why one service is good and another delivers a poor service.

Working with others to improve local services

We work very closely with providers and commissioners of services in Thurrock to ensure the views and voices of their patients, service users and residents are heard and responded to. We have worked closely with our local CCG, we have a seat on their board which allows us to feed in the views of the community and also we are able to support residents to attend and give their views directly to the Board. We are invited to attend their CEG (Clinical Engagement Group, which is where all GP's, Practice Managers and Nurses come together to discuss the Board decisions and to gain their input, it also incorporates their Time to Learn programme) we are always included in these meetings and are given the opportunity to feed in any views we have been given by their patients.

We jointly chair a CRG (Commissioning Reference Group) which involves all PPG Chairs and representatives, representatives from the Voluntary Sector, representatives for organisations that represent groups of people i.e. older people, those living in residential homes or using domiciliary care services, people with long term conditions, learning disabled residents, those with mental health issues/illness and children and young people.

All of these examples result in us being in a position to ensure that those people using the services, or who would be affected in any change to services are able to have their voice heard and to be in the best possible position to influence change. (Further examples can be seen in our case work stories)

"Healthwatch have adopted an approach and way of working with partner organisations' including the CRG and as a result a number of key changes have been made including a recognised Thurrock engagement group which has developed an engagement and co-production process and way of working that has been agreed by the CCG and Thurrock council and will be taken to the Health and Wellbeing Board for their agreement"

Len Green, Lay member for PPI Thurrock CCG

We have also, as stated previously, worked closely with our Local Authority and have been involved in the work around the better care fund.

"Healthwatch are playing a vital role to ensure that Thurrock's Better Care Fund (for the integration of health and social care) reflects the voices of Thurrock people. We, along with our partners, have developed an Engagement Plan that ensures that users of services, carers, and the public are involved right from the very start. Our involvement in not only the Better Care Fund, but Thurrock's Transformation Programme for Health and Social Care, is ensuring that the voices of people are heard loud and clear and are reflected in any decisions that are made. "

Ceri Armstrong I Strategy Officer I Adults Health and Commissioning

Healthwatch Thurrock has a seat on our local Health and Well Being Board (HWBB). Our seat on the board is to represent the people of Thurrock and to ensure their voices are heard at a strategic level. We have been able to present issues and concerns and raise awareness of possible issues before they become major.

We have taken items such as; Lack of annual health assessments for residents with learning disabilities, the lack of provision for safe disposal of sharps, the moving of the stroke services to Southend, the recommissioning of stroke services, concerns around access to the upper GI cancer pathway of care, the medication policy for care homes in Thurrock, concerns around the lack of dignity in care in services in Thurrock and last but no means least the change of provision for annual servicing and repair of nebulisers in the community from our local hospital to our Community services.

We have also worked well with our local hospital and visit frequently to speak to patients, carers and visitors. We have always been included in the CQC visits and have given ports of our findings to Monitor.

Members of the Healthwatch team recently helped facilitate 2 successful listening events in the Thurrock area, which has led to further events being booked, and plans of work being generated as a result. Healthwatch Thurrock has been involved in providing information and links between the trust and patient / user groups. This information allows for informed and Patient represented discussions regarding service provision and improvement. The trust would like to thank Healthwatch Thurrock for their continues support and collaboration in helping in improving the patient experience in the trust

Diane Sarkar, Director of Nursing, BTUH

From a Portfolio holders perspective Healthwatch has proved to be invaluable to me. When I receive questions complaints or compliments relating to health services in Thurrock I consult Kim James who is tenacious in getting to the bottom of things. The fair approach taken by Healthwatch Thurrock gives me the feedback I need from the public to carry out my role on ensuring we are getting the best services we can for Thurrock residents.

Healthwatch has always been represented thus representing residents on the HWBB, Healthwatch is a strong advocate on the board for fair just services for the people of Thurrock.

Cllr. Barbara Rice, portfolio holder for Health and Social Care and Chair of HWBB

Impact Stories

Case Study One

Stroke Service Provision Locally

Healthwatch Thurrock became aware of plans to recommission a Hyper Acute Stroke unit for the area covering Thurrock. At that time, the service was being delivered from Basildon and Thurrock University Hospital Trust (BTUH).

The plans were to work with the whole of Essex, all 7 CCG's were involved, in the decision to commission 4 Hyper Acute Stroke Units (HASU) which would mean the provision for Thurrock would move from our local hospital BTUH to Southend Hospital which is situated over 20 miles away on the coast of Essex.

Thurrock had recently undergone some major increase in industry with the new super port opening in Corringham, which resulted in a whole new road network to support the traffic to and from the port. This new roadway cut across the main trunk road which led to the Hospital.

Healthwatch Thurrock attended many professional meetings where these plans were being discussed, listened to the presentations from NHS England Commissioners and felt that there had been very little discussion or consultation with the residents of Thurrock.

We raised our concerns with both Health Overview and Scrutiny Committee (HOSC) and the HWBB around the lack of consultation; they asked if we would speak with the people of Thurrock and gather their views.

We held a joint public meeting with Thurrock CCG Commissioning Reference Group, we attended our local stroke support group and spoke with them, we spoke to carers and other long term condition groups and we gathered views of the people of Thurrock. The majority of people did not want to lose their service locally and had major concerns some of which were;

- "Administering the blood clot drug is important but travelling to Southend will take longer and reduce the time available to administer it. (within the 3 hour slot)"
- "It was said in the presentation that a 24/7 service is not currently being delivered at BTUH, but it is"
- "There should 3 or 4 proposals with the pros and cons of each."
- "Everyone feels it is a done deal."

The local stroke survivors and carers group took the role of gathering views for us and over a 6 week period they gathered over 2,500 views on the proposals. We helped them to put that into a report which gave a clear feedback

of people's views which we presented to the HWBB and to HOSC.

We also sent a report, with a covering letter to the Chair of the CCG to request that as representatives of the people of Thurrock that they listen to their voices and reconsider their decision to go with the whole Essex approach and to carry on commissioning a local service for Thurrock from BTUH. We requested that representatives be able to attend the CCG Board meeting where the decision was on the agenda for voting, and that they be allowed to represent themselves and explain their concerns.

This was agreed, and although many stroke survivors and their carers, people who were concerned about the proposal attended, one representative was able to appeal to the Board and put across the very real concerns of the residents of Thurrock and to present their report on the findings. Healthwatch Thurrock and the CCG's lay member also spoke to the Board and asked them to make their decision taking into consideration the views of the people they represent.

The Board voted to pull out of the Essex wide commissioning and along with our neighbouring CCG have commissioned a stroke service from BTUH our local hospital.

The service is now being delivered locally which is as a direct result of the voices of the people of Thurrock joining together and being heard. And those voices being listened to and acted on by the commissioners and board of Thurrock CCG.

"We could never have achieved this outcome without the help and support from Healthwatch. You just don't know what this means to us"

Steve, Thurrock Stroke Group

"Healthwatch Thurrock have listened to the concerns of our members over a variety of issues including community services after discharge, they have arranged for us to meet face to face with the people who commission these services and have empowered our members to have their voices heard.

To be able to discuss their experiences and feel that they are making a difference for any future stroke sufferers has been the biggest boost to their confidence.

Thank you Healthwatch Thurrock from all the members of Thurrock stroke group"

Christine Hamilton, Manager Thurrock Stroke Group

Case Study Two

Sharps Box provision

Healthwatch Thurrock work closely with support groups and voluntary sector organisations within our community. One of those being the Diabetes UK Thurrock Branch.

During one of our visits a concern was raised regarding the disposal of sharps.

We were informed that many people with Diabetes in Thurrock have no safe way of disposing of their sharps, unless they pay for the collection of the sharps boxes, they asked if we could look into it for them.

We discussed it as a team, and with the CCG lay member, and then we jointly met with the chair of the group to find out more. It became apparent that this was an issue across Thurrock, a very small proportion of pharmacies in Thurrock would take back a sharps box, the contract for collection was under the Local Authority waste disposal team and there was a £15 charge each time a box was collected.

We put together a short questionnaire which we distributed across the borough and via groups and organisations, we put a Survey Monkey questionnaire on our website and had 176 responses. The results highlighted that there was in fact a problem and also some concerning responses to the question "how do you dispose of your sharps?"

Some responses are listed below:

- "I put them in an empty butter container and put them in my rubbish bag"
- "I usually put them in an empty plastic milk bottle and just put it in my blue bin (Recycling)"
- "I bury them in my garden, I am too old to worry about gardening, so they won't bother me"
- " I just throw them in the bin, I don't think it's fair that we should have to pay to get rid of them"

We spoke to 6 pharmacies across the borough, who explained they have to pay for the collection of sharps. We spoke to 6 GP's who also explained their contract for collection is just for those used in the surgery by them or their nurses and it would cost more to increase the amount.

We also during this discussion found that few GP's actually prescribed the sharps box as they knew their patients could not dispose of them and therefore didn't want them.

We then spoke with the manager of waste collection at the Local Authority who confirmed that as part of their clinical waste disposal contract they did collect sharps bins, and for anyone not in receipt of a benefit or over 65 that there was a cost of £15 per collection.

We put a report together for the HWBB and also raised it at HOSC. Both Healthwatch and the Lay member raised it at the CCG Board.

All were concerned about the situation and also the safety element of how people were disposing of them.

In the report we highlighted the fact that for the drug and alcohol programme in Thurrock there is a good, free needle exchange service, which is included in the specification of the contract from the Local Authority.

We used this information to highlight the inequality of services between illegal drug use and the requirement to use sharps if a resident has a long term condition.

The result has been that our Local Authority lead commissioner agreed to commission a service via Public Health, which is now in place.

7 Pharmacies across Thurrock are now contracted to take full sharps boxes and they are collected and disposed of.

We have worked to ensure this is known to those who responded to our questionnaire and to groups and organisations across the Borough, and we will continue to monitor the use of the service.

NHS England and Healthwatch Thurrock working together

The Essex Area Team has provided support and advice regarding a number of patient group issues that have been presented to Healthwatch Thurrock including the concern raised by the Local Diabetes Group relating to a new policy that had been implemented by a National Optician Group concerning eye tests for diabetic patients.

Lynn Morgan NHS England, Essex

Healthwatch Thurrock has been of great support to Thurrock Group Diabetes UK and on an Annual basis Kim James, Chief Operating Officer, will give a talk to our Group with updates on the latest developments with Healthwatch. The Healthwatch website also keeps everyone involved with current developments and we have a link on our website to access Healthwatch.

Bryan Vanderpeer, Chair Diabetes UK, Thurrock Branch

Our plans for 2015/16

Opportunities and challenges for the future

Healthwatch Thurrock has undergone some massive changes as 2015 begins. We have had to prioritise what needs to be done to ensure Healthwatch Thurrock continues to be a real consumer champion to the people of Thurrock in the delivery and provision of health and social care services.

We have become a project of our local CVS and as such the CVS Board will ensure the contract requirements between themselves and Thurrock Local Authority to deliver a high standard Healthwatch are fully met.

Our challenges are the same as every other Healthwatch as we enter our third year, to use this year to ensure we have met the requirements needed to evidence our outcomes, to be able to measure the impact we have made both locally and nationally, to have really made a difference to peoples services both in health and social care and finally to be in a position to gain funding to continue on from the 3 years.

We will continue to work hard to listen, in any way we can to those voices that have an experience to share, to those who feel lost in systems and to those who are the hardest to hear. With our new staff team and new ways of working we are hoping to continue building those relationships needed to improve services.

We have begun the work of setting our priorities for the next year by speaking to the residents of Thurrock, by asking them to come along to our public meetings and tell us what matters to them and asking what they feel our priorities should be.

We had long conversations at many tables, over many shopping trollies and over many cups of tea, we set a priori – tree which enabled those who did not feel confident to add a leaf to the tree with their views and suggestions and as a result we set the following priorities for 2015 – 16

- Primary care provision (especially GP access)
- Mental Health Services
- End of Life Care
- Discharge from hospital and social care services.

We have kept it to only 4 as it was agreed that with the changes to the Care Act and with the looming budget savings to social care services locally there will be areas we may have to look at.

Financial information

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	£159, 357
Additional income	£0.00
Total income	£159,357

EXPENDITURE	
Office costs	£25, 850
Staffing costs	£92,710
Direct delivery costs	£22, 290
Total expenditure	£140,850
Balance brought forward	£18, 507

Contact us

Get in touch

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RM17 5JB

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Website URL: www.healthwatchthurrock.org

*[*We will be making this annual report publicly available by 30th June 2015 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

1st October 2015	ITEM: 9
Health and Wellbeing Board	
South Essex Emergency Doctors Service (SEEDS) update	
Report of: Rahul Chaudhari, Head of Primary Care Strategy, Thurrock CCG	
Accountable Head of Service: Mandy Ansell, Acting (interim) Accountable Officer, Thurrock CCG	
Accountable Director: Mandy Ansell, Acting (interim) Accountable Officer, Thurrock CCG	
This report is Public	

Executive Summary

This paper aims to appraise the Health and Wellbeing board on the changes to the Out of hours (OOH) primary care emergency service and the future arrangements.

1. Recommendation(s)

1.1 The Board is asked to note the contents of the report

2. Introduction and Background

2.1 Primary care practices as part of their contract are mandated to provide OOH GP cover. IC 24 service was commissioned by the CCG to provide OOH services on behalf of those practices that Opted out of arranging their own cover. Practices which Opted in to arrange their own cover commissioned SEEDS to provide this service.

Currently there are 14 practices in Thurrock that have opted in with SEEDS. SEEDS on 5th August have informed that they would close on the 31st August 2015. As part of the contractual requirement and to maintain continuity of service NHS Thurrock CCG along with NHS England met with the SEEDS provider informing them to continue with service provision for a period of 3 months (30th November 2015). This will allow the CCG to work with the affected practices to develop a long term solution.

Thurrock CCG along with Basildon and Brentwood CCG and NHS England will also be working with SEEDS to support the short term delivery of services and on the exit strategy to ensure smooth transition of service provision to an alternate provider.

Thurrock CCG on 14th August has written to the 14 SEEDS practices advising them of the next steps and the options available to them going forward. Should the practices choose the CCG recommended option and join the IC24 service then the CCG is prepared to absorb the additional cost of the new provider.

3. Issues, Options and Analysis of Options

3.1 To maintain continuity of OOH service provided by SEEDS the two south west Essex CCGs and NHS England will be providing short term additional funds for a period of 3 months whilst we make a long term arrangement.

CCG will be working with SEEDS to ensure smooth transition of service provision to an alternate provider.

CCG will support the 14 Opted in SEEDS practices to make alternate OOH service provision from 1st Dec 2015.

4. Reasons for Recommendation

4.1 The Committee is asked to note the contents of the report.

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

N/A

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

6.1 It is envisaged that the above approach will not have an adverse impact on the current service provision

7. Implications

7.1 Financial

No financial implications have been identified.

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

7.2 Legal

The report is for noting only. Any further changes including possible TUPE transfer of staff (as noted in the report) will need direct involvement and advice from HR and legal.

Implications verified by: **Chris Pickering**

Principal Solicitor

7.3 **Diversity and Equality**

Out of hours provision supports community provision supporting all protected characteristics. Any future change to provision will be informed by an equality impact assessment.

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)
It is expected that the current staff employed by SEEDS will be Tupe'd over to the new provider

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):

- N/A

9. Appendices to the report
None

Report Author:

Rahul Chaudhari

Head of Primary Care Strategy

NHS Thurrock CCG

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1st October 2015	ITEM: 10
Health and Wellbeing Board	
Public Health Grant 2015/16 – Proposed Reductions	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Roger Harris – Director of Adults, Health and Commissioning / Ian Wake – Director of Public Health	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris / Ian Wake	
This report is Public	

Executive Summary

Thurrock received notification on Monday 8th June that the Public Health Grant was to be cut nationally by £ 200m in 2015/16 following the Chancellor's pre-budget statement the previous week.

It is not fully clear yet how this figure was arrived at nor the rationale for the decision. It amounts to a 7.4% cut to the total PHG across England.
If this is applied pro-rata to all local authorities it will amount to a cut of over £ 600k to the Thurrock's allocation.

The Department of Health ran a short consultation during August on the methodology for applying the cut (not whether the cut will happen or not). This focussed on four main options:

A. Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.
B. Identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them.
C. Reduce every LA's allocation by a standard, flat rate percentage. Nationally the £200 million saving amounts to about 6.2 per cent of the total grant for 2015/16, so that would also be the figure DH applied to individual LAs. Annex C sets out the effect on allocations.
D. Reduce every LA's allocation by a standard percentage unless an authority can show that this would result in particular hardship, taking account of the following criteria:
    - inability to deliver savings legally due to binding financial commitments;

- substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic within the meaning of section 149 of the Equality Act 2010;
- high risk that, because of its impact, the decision would be incompatible with the Secretary of State's duties under the NHS Act 2006 (in particular the duty to have regard to the need to reduce inequalities between people with regard to the benefits they can receive from public health services);
- the availability of funding from public health or general reserves; or
- any other exceptional factors.

Thurrock supported option A – to devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation. Thurrock is currently 2.9% below its target Public Health allocation. This equates to us being under funded by £322,478 by the DH's own formula. Delivery of effective local public health provision is further compounded by the fact that we are a small unitary authority and so often cannot get the economies of scale in both staffing and contracts available to larger authorities. Many local authorities are significantly above their 'fair shares' PH grant funding formula.

As of writing this report we do not know the final decision on the method of applying the cut.

1. Recommendation

1.1 To note the proposed reductions in the PHG grant and to comment on the cuts put forward.

2. Introduction and Background

2.1 The Public Health Grant is provided to local authorities to give them the funding needed to discharge their public health responsibilities. Broadly these responsibilities include:

- Improve significantly the health and wellbeing of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State;
- Reduce health inequalities for all ages, including within hard to reach groups;
- Ensure the provision of population wide healthcare advice.

Under the DoH guidance it remains essential that funds are only spent on activities whose main or primary purpose is to improve the public health of local populations.

The grant is made under Section 31 of the Local Government Act 2003 the Secretary of State has set down conditions to govern its use. The primary purpose of the conditions is to ensure that the grant is used to assist the local

authority to comply with its Public Health duties and mandatory functions, that it is spent appropriately, and accounted for properly.

2.2 **Prescribed and Non Prescribed functions**

Prescribed Functions:

- Sexual Health Services- STI testing and treatment
- Sexual Health Services- Contraception
- NHS Health Check Programme
- Local Authority role in health protection
- Public Health Advice
- National Child Measurement Programme
- Prescribed Childrens 0-5 Services

Non- Prescribed Functions commonly funded from the Public Health Grant:

- Sexual Health Services- Advice, prevention and promotion
- Obesity – Adults
- Obesity- Children
- Physical Activity- Adults
- Physical Activity- Children
- Drug Misuse- Adults
- Alcohol Misuse- Adults
- Substance Misuse (drugs and alcohol)- Youth Service
- Stop Smoking services and interventions
- Wider Tobacco Control
- Children 5-19 Public Health Programmes
- Non-prescribed Children 0-5 services

3. Issues, Options and Analysis of Options

3.1 Detailed below is a summary of the 2015/16 planned PHG allocation within Thurrock

Table 1

Budget Heading	Original 2015/16 Allocation £000s	Notes
Drug and alcohol contracts	1,310	Contract committed to March 31st 2017
Nutrition, Obesity, Physical Activity	250	Child weight management and prevention. Committed until March 2017.
Tier II Weight Management	122	Contracts and grants committed until

adults		31 March 2017.
Community Weight Management and other community development initiatives	250	For community health development initiatives and weight management.
Smoking cessation and tobacco control programmes	475	Range of services commissioned through GPs, pharmacies and through NELFT. Contract committed until 31 March 2017
Children 5-19	1,300	School nursing service via NELFT, includes mandated National Childhood Measurement Programme. Significant savings negotiated this year for 2015/16 and 2016/17. Contract committed until 31 March 2017.
Adult Health Checks	329	Mandated Service. Have already negotiated significant savings in year. Contract in place until end of June 2016.
Breast feeding and parenting support programmes	432	Notice served – main contract ends 31 August 2016. 0-5 service review in process.
Sexual Health, contraceptive advice, Genito-Urinary Medical Services, chlamydia screening	1,883	Contracts in place with NELFT, BTUH, SHUFT, GPs until March 2017. Significant savings already made on contracts.
Library and other Evidence Based Services	12	Contract in place with NELFT until March 2016.
Occupational Health	160	Core service – under review to see if savings possible.
Placements (adults)	250	Support for placements / re-ablement contracts. Resource committed.
Prevention programme – LACs; Early Offer; reablement; independent support, Community Champions	1,490	These services have been reviewed recently and were re-prioritised as part of the £ 1.49m cuts taken out of the PHG in 2015/16 already.
Core team including new full time Director post and strengthened capacity to deliver the NHS Core Offer and Health Protection functions.	955	NHS core offer and health protection functions are mandated. Vacancies have been held and temporary (9 month) 'free' PH Consultant capacity obtained as a result of placing a final year PH Senior Registrar from the Eastern Deanary.
Misc. department running costs	21	Committed
Thurrock 100	20	Committed

Community Builders	30	Committed
Corporate Recharges	200	Committed
Total Planned Spend	9489	
Original 2015/16 PH Grant	**(8631)**	
Carry forward from 2014/15	**(867)**	This was to take into account those projects that had not yet commenced by 1st April or ran across financial years and for GUM cross-charging pressures.
(Surplus) Deficit	**(9)**	

3.2 £867K has been carried forward from 2014/15. This has arisen for three main reasons – first of all a number of contracts do not run from 1st April and start mid-way through the year and secondly it has taken the PH team some time to get on top of the contracts passed over from the PCT and understand exactly what the spend and activity levels were for Thurrock. Thirdly, the team were also aware of a number of outstanding sexual health invoices for GUM cross-charging and the increasing pressure cross-charging is placing on the sexual health budget in 15/16.

3.3 If the DH were to demand the full £614K of Public Health grant to be returned in year, and PH planned spend were to remain constant, this would leave a deficit of £605K in 2015/16 and an on-going deficit of £1.053M from 2016/17. (see Table 2).

Table 2

	2015/16 £000s	2016/17 £000s
Original PH grant	(8631)	(8631)
Carry forward from 2014/15	(867)	0
Planned spend	9489	9070
Return of 7.4% of PH grant	614	614
(Surplus) Deficit	**605**	**1053**

3.4 Table 3 suggests additional savings that could be made in 2015/16 to cover the deficit, with their implications. At present we have not been able to deliver the full level of saving due to the late notification and the contracts we are tied into and this has been reported to the Head of Corporate Finance.

3.5 A re-procurement exercise for breastfeeding and parenting support failed to attract any new providers. One existing contract has been terminated and 12 months notice has been served on the other with continuation until 31 August 2016. A full service review of the HCP 0-5 will continue throughout 2015 with a stakeholder workshop planned in collaboration with Healthwatch to ensure that commissioning of the 0-5 HCP in the future looks to be as efficient as possible and to minimise the impact of the notice served on this contract. A new service is planned to be procured for 2017 onwards.

Table 3

Programme	2015/16 in year savings £000s	Implications
Halt re-procurement of Community Breast feeding and parenting support programmes	90	One contract terminated with Parents 1st. We have given 12 months notice to the NELFT service for the remaining part of the review of contracts and in light of the 0 -5 funding being transferred over from NHS England to the local authority on 1st October. This contract will end 31 August 2016.Mitigated by full 0-5 service review.
Halt further investment in Community Health/weight management initiatives	250	Thurrock is ranked sixth worst in England for levels of adult obesity. Reducing investment in this programme reduces our ability to address this complex PH issue.
Adult Health Checks	32	Saving already made in year from procurement exercise.
Reduce staff costs in PH team	59	The retirement of the Head of Public Health provides an opportunity to refocus capacity and skills in the PH team to strengthen the PH Core offer to the NHS, and Health Protection functions (both of which are currently inadequate). Recruitment to the Consultant in PH post could be delayed until March 2016 due to the free temporary resource from the Senior Registrar placement. However this post will need to be filled in 2016/17 if the Council is to have sufficient capacity to full-fill its statutory responsibilities to provide an NHS core offer and health protection functions. As the Senior Registrar does not start until November 2015, it will also place additional short-term increased workload on existing team members.
Reduce funding to in-house Occupational Health service	40	Few as spend on this service in 2014/15 was £40K less than budgeted.
Slippage in Alcohol Detox and Sexual Health Services contracts	34	None.
Total	**505**	

3.6 If the Public Health grant for 2016/17 remains the same and the 7.4% cut is applied again to Thurrock, this leaves a further £548K deficit, however at present 2016/17 PH grant funding has not been confirmed. There is more

flexibility to re-negotiate and re-commission contracts in 2016/17 as a number of current contracts and grants end at the end of the current financial year.

4. Reasons for Recommendation

4.1 The proposed reductions are required in order to deliver the savings required through the cut in the PHG.

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

5.1 HOSC is being consulted as are our partners in the Thurrock Clinical Commissioning Group.

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

6.1 This is dealt with in the body of the report. If the cuts proceed it will impact on some of the key priority areas in our Health and Well-Being strategy.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Resources Accountant

The projected £0.614m reduction in the Public Health grant will require the Council to reduce its level of public health expenditure, as detailed within the report. The Council set its budget in accordance with the grant confirmation given by central government departments, and subsequent alteration to these requires in-year adjustment, which will have a significant impact on the services that can be delivered this year and going forward.

7.2 Legal

Implications verified by: **Daniel Toohey**

Principal Corporate Solicitor

a. Section 31 of the Local Government Act 2003 provides that a Minister of the Crown may pay a grant to a local authority in England towards expenditure incurred or to be incurred by it; the Minister may determine the amount and the manner of its payment, and the conditions upon which it will be paid;

b. A broad description of the conditions and purposes of the Public Health Grant is contained within the body of this report;
c. This report puts forward a number of options in relation to the discontinuance of certain services. Legal services is available to advise and assist in relation to any consultation requirements or processes for contract termination if relevant.

7.3 **Diversity and Equality**

Implications verified by: **Roger Harris**
Director of Adults, health and commissioning

The Directorate will undertake an Equality Impact Assessment on any major reductions that are proposed.

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: Thurrock Council Response to the Department of Health's Local Authority Public Health allocations 2015/16 in-year savings consultation.

Report Author:

Roger Harris
Director
Adults, Health and Commissioning
Ian Wake
Director of Public Health

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Thurrock Council Response to the Department of Health's Local Authority Public Health allocations 2015/16 in-year savings consultation.

The Council was surprised and disappointed at the proposed £200m in-year cut to the Public Health grant of 2015/16 and provides the following response to the DH consultation:

Page 38 of the Conservative Party Manifesto reads

"We will support you and your family to stay healthy. We are helping people to stay healthy by ending the open display of tobacco in shops, introducing plain–packaged cigarettes and funding local authority public health budgets. We will take action to reduce childhood obesity and continue to promote clear food information. We will support people struggling with addictions and undertake a review into how best to support those suffering from long-term yet treatable conditions, such as drug or alcohol addiction, or obesity, back in to work."

Achieving this commitment relies on strong public health services and skills, which are funded through the public health grant. Cuts will both reduce front line services available to the public to help them with the issues described above and to public health advice to NHS commissioners vital to ensure that the health and social care system is as efficient as possible.

The NHS Five Year Forward View emphasises the value of prevention and the need to shift investment towards prevention and away from expensive treatments for potentially avoidable conditions.

Reducing the Public Health grant runs counter to this ambition. Reducing funding for prevention will result in an unhealthier population, increased health inequalities and increased demand for high cost health and care services. Saving this comparatively small amount of money in the short term gives a strong message that prevention is a lip service priority. This is compounded by other recent non supportive public health decisions such as the decrease in tax on alcohol.

The Chancellor of the Exchequer stated that savings would be taken from "non-NHS" budgets, but this is inaccurate. The bulk of the Public Health Grant funds NHS services to deliver sexual health, public health nursing, smoking cessation, drug and alcohol treatment and NHS health checks. It will be impossible for these cuts to avoid hitting the NHS thus undermining a direct manifesto commitment to protect it.

The Conservative Party Manifesto also commits to "giving every child the best start in life." The vital importance of children having a healthy weight, the work of health visitors and school nurses including their key role in child protection will be undermined by cutting the funds available. Indeed, in a recent survey of Directors of Public health, 63% identified child health as an area they would seek to make savings from if this cut was made to their budget. In Thurrock the announcement of reductions in our Public Health grant has already forced us to cease re-procurement of an NHS based parenting and breast feeding and parenting support service.

The options open to local authorities to fund public health services under different models are very limited as they are provided under NHS rules and free at the point of delivery.

Deriving income from these services is not an option, so making cuts adds a further burden to organisations already under huge financial pressure.

There has been discussion that these savings are a result of underspends in the grant. The Public Health Grant was initially given as a two year allocation with clear indication from the Department of Health that carry over was expected as services were redesigned and retendered to take account of new responsibilities and commissioning arrangements. This mature view has now been undermined by the in-year decision to cut significant sums from the grant which will lead to unplanned and reactive cuts being made to important services.

Local government is already making more than its fair share towards reducing the national debt, and the proposed cuts simply place more stress on a system already at financial breaking point. Implementing cuts to a ring-fenced grant four months into a financial year is unprecedented. Contracts have already been signed and reneging on them in-year them will result in unexpected financial penalties being levied on Thurrock Council, further increasing the financial pressure upon us.

We would urge you to reconsider this ill thought through short term measure which will have lasting consequences to the public's health.

With regard to the three specific questions in the consultation, Thurrock Council offers the following response:

Q1. Do you agree with DH's preferred option (C) for applying the £200million saving across LAs? If not, which is your preferred option?

We do not support the DH's preferred option C – a universal cut of 6.2% across all local authorities. Our preferred option is option A – to devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation. Thurrock is currently 2.9% below its target Public Health allocation. This equates to us being under funded by £322,478 by the DH's own formula. Delivery of effective local public health provision is further compounded by the fact that we are a small unitary authority and so often cannot get the economies of scale in both staffing and contracts available to larger authorities. Many local authorities are significantly above their 'fair shares' PH grant funding formula. Indeed the wealthy boroughs of Westminster, Kensington and The City of London have positive distance from target figures of 138.83%, 175.96% and 469.49% respectively. It is entirely unreasonable that this inequity is not taken into account when applying reductions to the Public Health grant.

We do not support option B – claiming back a larger percentage of grant from local authorities that carried funding forward as this may now have been committed to contracts, nor option D, which we think will be complex to administer and put an additional bureaucratic burden on local authorities to evidence. Both option B and D also fail to address the inequity in funding between local authorities as set out above.

Q2. How can DH, PHE and NHS England help LAs to implement the saving and minimise any possible disruption to services?

We do not accept the premise contained within this question. Disruption to local services is inevitability if in-year Public Health grant cuts are made. Further restructuring of system architecture as suggested in the consultation documentation will inevitably hinder rather than help an already difficult local situation by causing more disruption and short term uncertainty.

Q3. How best can the DH assess and understand the impact of the saving?

Of the suggestions made in the consultation we would favour a national survey of directors of public health and other key stakeholders, particularly CCGs. We do not feel that either of the other two suggested options of 'commissioning PHE centre directors to review the local input' or 'work through representative bodies to gather feedback on local input' will provide sufficient granularity of intelligence to assess adequately the impact of any grant cuts.

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Health and Wellbeing Board Forward Plan

Date	Agenda	Lead
12/11/15	• **Item in Focus – System Resilience (Winter Planning)** • **Update Thurrock 100 Project** • **Progress new Weight Management Programmes** • **Health and Social Care Learning Disability Self-Assessment** • **Special Education Needs and Disability Reforms**	TBC Ian Wake Ian Wake Kelly Jenkins Malcolm Taylor
14/01/16	• **Health and Wellbeing Strategy – Draft** • **Care Act 2014 – Part 2 Implications**	Ceri Armstrong Ceri Armstrong
10/03/16	• **Health and Wellbeing Strategy - Final**	Ceri Armstrong

- **Primary Care Estates Strategy**
- **Primary Care Strategy**
- **Early Offer of Help**

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