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

Health and Wellbeing Board

The meeting will be held at **1.00 pm** on **15 June 2015**

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

Membership:

Councillors Barbara Rice (Chair), John Kent and Joycelyn Redsell

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Barbara Brownlee, Director of Housing, Thurrock Council
Graham Carey, Chair of Safeguarding Adults Board
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Len Green, Lay Member Thurrock CCG
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
Sean O'Callaghan, Vice Chair of Thurrock Community Safety Partnership
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

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1 Apologies for Absence

2 Minutes **5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 12 March 2015.

3 Declaration of Interests

4 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.

5 ITEM IN FOCUS: Mental Health Crisis Care Concordat and Mental Health Services in Thurrock **15 - 34**

Presented by Jane Itangata, Senior Commissioning Manager, Mental Health & Learning Disabilities and Catherine Wilson, Strategic Lead Commissioning and Procurement.

6 Children and Young people Emotional Wellbeing and Mental Health Service Commissioning update **35 - 48**

Report submitted by Paula McCullough Commissioning Officer, Children's Services.

7 Thurrock Response to Child Sexual Exploitation **49 - 60**

Presentation by Multi-Agency leads: Andrew Carter, Alan Cotgrove and Metropolitan Police Partners.

8 Homelessness Prevention Strategy **61 - 142**

Report submitted by Dawn Shepherd, Strategy Manager, Housing

9 Demography JSNA **143 - 178**

Report submitted by Debbie Maynard, Head of Public Health.

10 Tobacco Control Strategy **179 - 218**

Report submitted by Debbie Maynard, Head of Public Health and Kevin Malone Public Health Manager.

11 Health impacts of Air Pollution in Thurrock **219 - 252**

Report submitted by Catherine Edwynn, Consultant in Public Health.

12 Health and Social Care Transformation Update **253 - 260**

Report submitted by Sharon Grimmond HWBB Business Manager.

13	**Joint Health and Wellbeing Strategy End of Year Report 2014 - 2015**	**261 - 290**
	Report submitted by Sharon Grimmond HWBB Business Manager.	
14	**Health and Wellbeing Board Development Session and Recommendations Report**	**291 - 310**
	Report submitted by Ceri Armstrong, Strategy Officer.	
15	**Proposed Amendments to Thurrock's Health and Wellbeing Board Membership**	**311 - 318**
	Report submitted by Sharon Grimmond, HWBB Business Manager.	
16	**CASSH fund bid - Bid to the Care and Support Specialised Housing Fund for housing for young people with autism**	**319 - 324**
	Report submitted by Christopher Smith, Programme Manager, Adults, Health and Commissioning.	
17	**Work Programme**	**325 - 326**

Queries regarding this Agenda or notification of apologies:

Please contact Sharon Grimmond, Health and Wellbeing Board Business Manager by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **5 June 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

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 12 March 2015 at 2.00 pm

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Present: Councillors Barbara Rice (Chair), Joy Redsell, Bukky Okunade, John Kent, Tunde Ojetola.

Mandy Ansell, Acting Interim Accountable Officer, Thurrock CCG, Dr Andrea Atherton, Director of Public Health, Barbara Brownlee, Director of Housing, Len Green, Lay Member CCG, Roger Harris, Director of Adults, Health and Commissioning, Kim James, Chief Operating Officer, Thurrock Healthwatch, Carmel Littleton, Director of Children's Services, Sean O' Callaghan, Vice Chair of Thurrock Community Safety Partnership

Apologies: Graham Carey, Safeguarding Adults Board (Chair), Dr Anjan Bose, Clinical Representative, Thurrock CCG
David Peplow Local Safeguarding Children's Board (Chair),
Andrew Pike Director of Commissioning Operations, Essex and East Anglia
Dr Anand Deshpande, Chair of CCG Board

In attendance: Sharon Grimmond – HWBB Business Manager
Ceri Armstrong – Strategy Officer
Kelly Jenkins – Commissioning Officer (item 6)
Andrew Carter - Head of Children's Services (item 9)
Teresa Goulding, - Service Manager, Troubled Families (item 9)
Justin Daniels Troubled Families Consultant (item 9)
Maria Payne Health Needs Assessment Manager (item 8)
Helen Horrocks Strategic Lead Commissioner for Public Health (item 8)

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.

48. Minutes

The Minutes of the Health and Wellbeing Board held on 9th February 2015 were approved as a correct record.

49. Urgent Items

None

50. Declaration of Interests

None

51. Matters Arising

Future of Thurrock's Walk-in Service
An update was provided on the consultation of the future of Grays Walk-in Service. Two events have been held to date, but concerns were raised that attendees were not representative of the service's users. Future consultations will include engaging with young people.

52. Care and Support Specialised Housing Fund: Phase 2 (CASSH)

The purpose of the report was to inform the Board about the development and focus of Thurrock's CASSH bid – phase 2. The Board were reminded that Thurrock had submitted a successful bid as part of phase 1 with the funding being used to develop 25 purpose-built flats for older people in Derry Avenue, South Ockendon.

Phase 2 of the CASSH fund will focus on specialist affordable housing for adults and young people aged over 18 with Learning Disabilities, Mental Health and Autism. A bid of up to £120m will be submitted before 29th May 2015. A joint working group will be established including representatives of– the CCG, Adults Social Care, Public Health and Housing.

The Board were made aware that the bid would be underpinned by a number of core documents – including the Housing Strategy. It was agreed that the Autism Strategy would also be referred to and consideration would be given to the inclusion of education, skills and training (CL to provide a link person).

It was felt that if successful, the fund would help to provide a local offer to people with needs that often had to be met out of Borough.

RESOLVED: Recommendation agreed.
To bring the completed bid to the June Board meeting

53. Health and Social Care Learning Disability Self Assessment

The report was presented by Kelly Jenkins, Commissioner for Learning Disability and Mental Health.

The Self-Assessment tool is a national tool that focuses on three main areas: Staying Healthy, Saying Safe and Living Well. The self-assessment is extremely challenging but provides a means of identifying areas of improvement. Thurrock has made progress on the ratings (rated as 'red', 'amber' and 'green') Ratings for this year include 2 red, 17 amber, and 5 green. An action plan will be developed to respond to the red and amber-rated areas and will be overseen by the Disability Partnership Board.

Concerns were raised that two of the red-rated areas related to the Criminal Justice System. Similar concerns had been raised at the Children and Young People's Partnership Board. Stronger links needed to be forged with the Probation Service in particular. RH agreed to consider how stronger links could be made.

The Board were made aware that learning disabled residents were identified via GP registers – but that some development was required. There was also a Learning Disability nurse at the Hospital.

It was agreed that a report detailing how amber and red-rated areas will be progress will be brought to the September Board.

RESOLVED: ***Recommendation agreed.***
Report to be presented at the September Board

54. Health and Social Care Transformation Programme Update

Care Act 2014
The Care Act 2014 comes into operation from April 2015 and the key changes were summarised for Board members. From 2016, there will be a £72,000 cap on care which could have a significant financial impact on the Council.

Better Care Fund
The Better Care Fund is focused on transforming the health and care system which includes integration between health and social. The Fund will be managed through a Section 75 agreement between the CCG and Council. This has now been agreed by Cabinet. Significant progress has already been made through initiatives such as the Rapid Response and Assessment Team (RRAS), Joint Reablement Team (JRT), and Local Area Coordination (LAC).

All areas have been asked to complete a readiness self-assessment which has to be signed off by the Board. It was agreed that the self-assessment would be circulated and that final sign-off would be delegated to the Chair on behalf of the Board. The CCG and Council would also be signatories and the Board asked that the self-assessment be shared with Healthwatch prior to submission.

Whole System Redesign
A 'case for change' is currently being developed which will outline the future health and social care landscape. The current health and social care system is extremely challenged and there is a need to work as a system as well as thinking of radical new ways of working and accelerating work that has already begun – for example self-care.

The 'case for change' will be brought to the June Board for discussion.

The Chair noted that there was already evidence of joint working making a difference, and shared the contents of a letter praising the work of the RRAS.

RESOLVED: Recommendation agreed.

55. The 2014 Annual Public Health Report

This was Andrea Atherton's last meeting as Thurrock's Director of Public Health and the Chair thanked her for her contribution. Interviews for a Thurrock Director for Public Health have been arranged for the 13th March.

The report presented is an annual report on the health of people in Thurrock. The report was welcomed by the Board.

Members felt that Thurrock's councillors could play a more active role – e.g. for signposting of information.

The Board discussed private home ownership and that a range of housing options for all age groups were being progressed as opposed to sheltered housing complexes.

The Board suggested that a discussion with the planners was required to review how Section 106 monies could be used to achieve flexibilities.. It was also suggested that within the planning agreements 10% of homes developed could be specially adapted for older people.

A representative from the Planning Team would be invited to a future the Health and Wellbeing Board meeting.

RESOLVED: Recommendation agreed.

56. Troubled Families Report

The report was presented by Teresa Goulding and Justin Daniels. The Troubled Families initiative was first announced by the Prime Minister December 2010. Thurrock's target, set by the Department of Communities and Local Government (DCLG), was to 'Turn-Around' 360 families by May 2015.

The Troubled Families team look for innovative ways of working in a family centred approach to meet specific and often complex needs.

The number of families supported has increased to 360 over three years (2012-
2015) and is expected to increase to supporting 1160 families over five years (2015-2020). The Board was updated on the Phase 2 programme as the Phase 1 had been completed.

It was noted that this programme is successful on a national scale. The total number of families supported through this programme increased from 169 (47%) to approximately 306(85%).

Phase 2 of the programme which commences in April 2015 works on the Lessons Learnt from Phase 1. Phase 2 of the Troubled Families programme, which commences in April 2015, was only possible for Local Authorities achieving 75% of their target by February 2015.

Recommendation summarised to focus on the Framework Planning where Thurrock Council and partners work collectively.

The Board enquired about the families that may not be identified and may be missed. Data sharing is seen as a national barrier and a policy has been drafted. A Health Champion will be assigned to the Thurrock area.

Andrew Carter Head of Children Services will undertake the Risk Assessment.

The Board noted the work of the Troubled Families Team.

RESOLVED: Recommendation agreed.

57. Children and Young People's and Demography JSNA documents

The report was presented by Maria Payne, Health Needs Assessment Manager. Two JSNA documents were presented to the Board.

The Children and Young People's JSNA had already been discussed at the Children and Young People's Strategic Partnership Board. The document was agreed by the Board and would now be published.

The Board agreed to defer the Demography JSNA to the June Health and Wellbeing Board.

RESOLVED: Recommendation 1.2 agreed for Children and Young People JSNA

58. Charter for Older People Report

The Charter for Older People will be presented at Council by Cllr Rice and Cllr Halden and aims to build on the success of the Veterans' Charter.

The Chair (Cllr Rice) requested that the Charter be amended with a space for signatures.

The Charter has been consulted on including at a specific engagement event and at the Older People's Parliament.

Suggestions were made by the Board on the wider circulation of the Charter.

Thurrock is one of a small number of councils to have an Older People's Charter.

RESOLVED: Recommendation agreed.

59. Care And Support Specialised Housing Fund: Phase 2

The purpose of the report was to inform the Board about the development and focus of Thurrock's CASSH bid – phase 2. The Board were reminded that Thurrock had submitted a successful bid as part of phase 1 with the funding being used to develop 25 purpose-built flats for older people in Derry Avenue, South Ockendon.

Phase 2 of the CASSH fund will focus on specialist affordable housing for adults and young people aged over 18 with Learning Disabilities, Mental Health and Autism. A bid of up to £120m will be submitted before 29th May 2015. A joint working group will be established including representatives of– the CCG, Adults Social Care, Public Health and Housing.

The Board were made aware that the bid would be underpinned by a number of core documents – including the Housing Strategy. It was agreed that the Autism Strategy would also be referred to and consideration would be given to the inclusion of education, skills and training (CL to provide a link person).

It was felt that if successful, the fund would help to provide a local offer to people with needs that often had to be met out of Borough.

RESOLVED: Recommendation agreed.
To bring the completed bid to the June Board meeting

60. Forward Plan

Next meeting 15th June

Reports within the notes agreed by the Board will be added to the forward plan.

The meeting finished at 4.00 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

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Health and Wellbeing Board Action Log 2015

12th March 2015				
Item No:	**Actions**	**Person**	**Date Due**	**Comments/Updates**
Item 5	Care and Support Specialised Housing Fund: Phase 2 (CASSH) It was agreed that the Autism Strategy would also be referred to and consideration would be given to the inclusion of education, skills and training (CL to provide a link person).	Roger Harris	15th June 15th June	On the HWBB agenda for 15th June *To bring the completed CASSH bid to the June Board meeting*
Item 6	Health and Social Care Learning Disability Self-Assessment Stronger links needed to be forged with the Probation Service RH agreed to consider how stronger links could be made.	Roger Harris	Ongoing	
Item 6	Health and Social Care Learning Disability Self-Assessment A report detailing the progress of RAG amber and red-rated areas will be brought to the September HWBB.	Catherine Wilson/ Kelly Jenkins	10th September	This will be noted on the Forward plan and the report authors will be notified in advance of the HWBB.
Item 7	Health and Social Care Transformation Update Report Whole System Redesign - The 'case for change' will be brought to the June Board for discussion.	Ceri Armstrong	15th June	On the HWBB agenda for 15th June
Item 10	Children and Young People's and Demography The Board agreed to defer the Demography JSNA to the June Health and Wellbeing Board.	Maria Payne / Debbie Maynard	15th June	Debbie Maynard will present this to the HWBB on 15th June.
Item 11	Charter for Older People The Chair (Cllr Rice) requested that the Charter be amended with a space for signatures. Suggestions were made by the Board on the wider circulation of the Charter.	Sarah Turner	30th April	Sarah to amend the Charter for Older People. Maybe worth a circulation list going to the Board and members to input into the circulation.

Initial Key

RH	Roger Harris
BB	Barbara Brownlee
MA	Mandy Ansell
CL	Carmel Littleton
IW	Ian Wake
SoC	Sean O Callaghan
LG	Len Green
JK	Cllr John Kent
TO	Cllr Tunde Ojetola
BR	Cllr Barbara Rice
JR	Cllr Joy Redsell
GC	Graham Carey
CA	Ceri Armstrong
BO	Cllr Bukky Okunade
SG	Sharon Grimmond
KJ	Kim James
DP	David Peplow
AP	Andrew Pike
AD	Dr Anand Deshpande
AB	Dr Anjan Bose

15 June 2015	ITEM: 5
Thurrock Health and Wellbeing Board	
Mental Health Crisis Care Concordat and Mental Health Services in Thurrock	
Report of: Jane Itangata, Senior Commissioning Manager, Mental Health and Learning Disabilities, Mark Tebbs, Head of Integrated Commission Thurrock Clinical Commissioning Group and Catherine Wilson Strategic Lead for Commissioning and Procurement, Adults, Health and Commissioning Thurrock Council	
Accountable Directors: Roger Harris Director Adults Health and Commissioning and Mandy Ansell, Acting Interim Accountable Officer, Thurrock CCG	
This report is Public	
Purpose of Report: The purpose of this report is to ensure that the Health and Well Being Board are informed about progress with the Mental Health Crisis Care Concordat and Mental Health Services in Thurrock	

EXECUTIVE SUMMARY

The purpose of this report is to outline the Mental Health Crisis Care Concordat and provide the Health and Wellbeing Board with a detailed summary of the services provided in Thurrock for people mental health issues.

The Mental Health Crisis Care Concordat was launched in February 2014. The aim of the document was to set out the standards of care people should expect from public services if they experience a mental health crisis. Its publication was intended to offer a point of reference regarding good practice to support national and local organisations to improve commissioning and the standards of delivery. Key to the implementation of the Mental Health Crisis Care Concordat is the challenge it gives to local health, social care and criminal justice partnerships to develop and improve local responses to support people experiencing a mental health crisis.

Local Mental Health services have undergone a period of change following the collaborative development of the South Essex Mental Health Strategy together with the implementation of Personal Health budgets and the re-evaluation of the market and its future development to provide a range of responses and services for people with mental ill health in Thurrock.

It has been agreed that a detailed discussion will be held with the Health and Wellbeing Board regarding mental health at this meeting and so the information

within this report will be highlighted further as a presentation from the CCG, the Council, provider services and the voluntary sector.

1 RECOMMENDATIONS:

- **That the Health and Wellbeing Board support the progress of the Mental Health Crisis Care Concordat and the proposed framework for the implementation plan for Thurrock**

- **That the Health and Wellbeing Board are aware of the services being provided in Thurrock for people experiencing mental ill health**

- **That the Health and Wellbeing Board have an opportunity to discuss in more depth mental health services in Thurrock**

2. THE MENTAL HEALTH CRISIS CARE CONCORDAT

The mental health crisis concordat is a national agreement between services and agencies involved in the care and support of people in crisis. The concordat sets out a new agreement between police, the NHS and other emergency partners in a bid to improve mental health crisis care.

The Mandate from the Government to NHS England in 2014 established specific objectives for the NHS to improve mental health crisis care. The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times accessible, responsive and high quality as other health emergency services.
- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.
- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in this Concordat.

The concordat expected that local partnerships of health, criminal justice and local authorities agreed to commit to a local Mental Health Crisis Declaration by December 2014. This was undertaken as a joint statement of intent and common purpose and consisted of a commitment and actions that would deliver services locally that meet the principles of the national concordat. In support of this declaration organisations were to develop their action plans and upload these onto the national website by 23rd March 2015.

The Police & Crime Commissioners' office led by Morris Mason the Assistant Chief Constable Essex Police, in collaboration with the safeguarding hub, coordinate the Pan Essex development and implementation of the Concordat. Through this forum the agreement was to have three action plans in the region namely North Essex, South West Essex and South East Essex.

Locally the SW Essex working group chaired by the BBCCG Clinical Director developed the action plan and is now working with partners across the health, social care and voluntary sectors to deliver an effective pathway to:

- Improve baseline and demographic data
- Commission robustly to allow earlier intervention and responsive crisis services
- Promote access to support before the crisis point
- Facilitate urgent and emergency access to care
- Enhance quality of treatment and care when in crisis
- Ensure Recovery and staying well preventing future crisis

3. CCG COMMISSIONED MENTAL HEALTH SERVICES

Thurrock CCG commission a range of services for people with mental health needs (this paper doesn't not include Children and Young People Services). The table below lists the key service lines with a brief description of the service provided and the location of this provision.

Category	Name (14/15 services)	Description	Location
Tertiary	Individual placements	Spot purchase of tertiary placements	Various locations across the country
Inpatient	Psychiatric Intensive Care Unit	High intensity, short term inpatient unit	Basildon Hospital (SEPT)
	Adult assessment unit	Short term adult assessment ward	Basildon Hospital (SEPT)
	Adult acute ward	Acute inpatient ward	Westley Ward, Basildon Hospital
	Older people acute inpatient	Inpatient ward for people with dementia with challenging behaviour	Mayfield Ward, Thurrock Hospital
	Older people assessment ward	Short term assessment ward for people with dementia	Meadowview Ward, Thurrock Hospital
	Older people continuing care	Longer term inpatient ward for people eligible for continuing health care	Rawreth and Clifton
	Dementia	Step up and step down	Mountnessing

	intermediate care	facility for people with dementia	court, Billericay
Community	Single point of contact	New configuration of service to ease access to care	Grays Hall, Thurrock
	First response service	New configuration of service to provide intensive multi-disciplinary response	Grays Hall, Thurrock
	Recovery and wellbeing service	New configuration of service to support longer term rehabilitation needs	Grays Hall, Thurrock
	Memory services	Dementia assessment service	Grays Hall, Thurrock
	Crisis resolution home treatment	Community based intensive support team for people in crisis	Mental Health Unit Basildon Hospital
	Assertive outreach	Intensive support for people who are difficult to engage, often with drug and alcohol issues.	Grays Hall, Thurrock
	Early intervention in Psychosis	Early intervention service for first episode psychosis. Linked with both CAMHS and primary care	Pride House, Laindon
	Eating Disorder Service	Both a community team and a day service supporting people with eating disorders	Mental Health Unit Basildon Hospital
	RAID	Mental health liaison service located in BTUH for both A&E and ward based assessments	Basildon Hospital (BTUH)
	Street Triage service	Mental Health assessment service located with Essex police	South Essex
	Psychology and psychotherapy	Psychological support and psychotherapy, including family and art therapy, for people with severe mental health	Basildon resource therapy centre

		problems.	
	Older people CMHT	Older people community mental health teams for organic and functional disorders	Grays Hall, Thurrock
	Older people outpatient	Consultant psychiatrist outpatient appointments	Grays Hall, Thurrock
	Dementia intensive support team	Combined with the dementia crisis response team provided by NELFT to avoid admissions	Grays Hall, Thurrock
	Community dementia nurses	Support for people with dementia in care homes	Grays Hall, Thurrock
Primary Care	IAPT	Evidence based cognitive behavioural therapy services for anxiety and depressions	Mainly within primary care settings
Third Sector	Personal health budgets	Various depending of choice	Various
	Basildon mind	Forensic advocacy at the secure mental health unit at Runwell	Runwell, Wickford
	Alzheimer's society	Carers support, based partly within the memory services	Grays Hall, Thurrock

4. COUNCIL COMMISSIONED MENTAL HEALTH SERVICES

Thurrock Council commission a range of Mental Health Services. The provision of social work and support work is delivered through the Council delegating its statutory responsibilities to undertake assessment and care management to SEPT. This is established through a Section 75 Agreement under the NHS Health Act 1977. This allows health organisations and social care to work in partnership. Social workers and support workers are seconded to SEPT, there are social care staff who deliver the social care delegated responsibilities, the cost of this to the Council is £500K per annum. In addition to this the Council also funds a proportion of administrative support and 50% of the team managers salary.

Thurrock Council also commission residential and supported living placements for people who need higher levels of support together with lower level floating support services to enable people to live more independently in the community.

The cost of this for 2014-2015 was £2 million. Accommodation and support are highlighted as key contributing factors to an individual's wellbeing so it is important wherever possible to ensure that accommodation and support is stable and consistent. Thurrock needs to expand the resource available for this and we are working hard to stimulate the market locally to develop. The recently produced Market Position Statement has indicated our direction of travel to reduce reliance on residential support and to develop the market to provide a range of services that support access to care in the right place at the right time with an appropriate level of support. We are focusing on more supported living with specialist support delivered through personal budgets enabling increases and decreases to levels of support as required, this would be envisaged as a step up with more support and a step down with lesser support in different types of accommodation.

Another key area to support wellbeing is employment and social care and health are working in partnership to facilitate the World of Work to deliver employment services within mental health. A grant of £60,000 a year for 2 years is being given to the project funded 50-50 between health and social care.

The impact of specialist health assessment and treatment for social care is often the requirement to find a specialist placement to prevent delayed discharges. Alongside this is the local authority and CCG have a duty for Section 117 Aftercare for people discharged from hospital under certain sections of the Mental Health Act meaning they have Section 117 rights under the Mental Health Act therefore an entitlement to free aftercare at the point of delivery so they make no contribution to their care and support through charging. The Thurrock section 117 register which is maintained on behalf of the CCG and LA by SEPT.

Within mental health services the focus on the personalisation agenda to support people to have autonomy over their care packages has made slow progress. A project was introduced 3 years ago to support the growth of personal budgets and direct payments in mental health this was the implementation of recovery Budgets. The recovery budget is a small amount of money up to £200 for carers and up to £300 for people who directly use services to facilitate recovery. Small items to support hobbies, wellbeing, physical fitness, breaks for care, education or something to facilitate independence have been regularly requested and anecdotal evidence has shown these budgets have been of huge support to individuals helping to reduce the impact of mental ill health on the individual and on family life. They have also supported carers to have breaks from their caring role to enable them to continue to support their relative or friend. From 1st April 2015 the CCG facilitated the introduction of Personal Health Budgets in mental health for people with social inclusion needs as a complement to Personal and Recovery Budgets.

5. VOLUNTARY SERVICE PROVISION

The voluntary sector is a focus to supporting the preventative agenda together with offering a wealth of information and advice. Mind provides specialist support in Thurrock. The Council commission a small amount of day opportunity support, the CCG and Council care commission counselling services, the Council

commission community bridge builder services. The CCG are working with Mind to commission a peer mentoring and support initiative which will support the ongoing work of the organisation, build capacity and enhance resilience for people experiencing mental health problems.

There is an active Mental Health Forum in Thurrock which is facilitated by Thurrock Coalition our local user led organisation, this is linked to the Thurrock Diversity Network which in turn supports the current Disability Partnership Board. Discussions are currently under way with the Partnership to include mental health within its remit. This will create a forum where service users across all specialisms and communities of Thurrock have an opportunity to support and monitor service development and changes.

6. RECOMMENDATIONS:

- **That the Health and Wellbeing Board support the progress of the Mental Health Crisis Care Concordat and the proposed framework for the implementation plan for Thurrock**
- **That the Health and Wellbeing Board are aware of the services being provided in Thurrock for people experiencing mental ill health**
- **That the Health and Wellbeing Board have an opportunity to discuss in more depth mental health services in Thurrock**

7. ISSUES, OPTIONS AND ANALYSIS OF OPTIONS:

7.1 N/A

8. REASONS FOR RECOMMENDATION:

8.1 To ensure that the Health and Well Being Board are well informed about Mental Health service provision in Thurrock.

9. CONSULTATION (including Overview and Scrutiny, if applicable)

N/A

10. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

10.1 The failure to deliver high quality services and support to people with mental health issues would affect a significant number of Thurrock residents, it is important therefore to raise awareness of the provision available and ensure partnership working with those who use services is key to future developments.

11. IMPLICATIONS

11.1 Financial

Implications verified by: Michael Jones
Management Accountant

There are no financial implications for this report.

11.2 Legal

Implications verified by: Dawn Pelle
Adult Care Lawyer

There are no legal implications for this report.

11.3 Diversity and Equality

Implications verified by: Becky Price
Community Development Officer

The provision of mental health services in Thurrock must ensure that people continue to be supported with dignity and respect, recognising their diversity needs.

12. Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental

N/A

BACKGROUND PAPERS USED IN PREPARING THIS REPORT (include their location and identify whether any are exempt or protected by copyright):

APPENDICES TO THIS REPORT:

Appendix 1: Action Plan

Report Author Contact Details:
Mark Tebbs, Head of Integrated Commission Thurrock Clinical Commissioning Group and Catherine Wilson Strategic Lead for Commissioning and Procurement, Adults, Health and Commissioning Thurrock Council
Jane Itangata, Senior Commissioning Manager, Mental Health and Learning Disabilities.

South West Essex Mental Health Crisis Care Concordat Action Plan

1. Commissioning to allow earlier intervention and responsive crisis services				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
1.1	Establish baseline data ▪ Street triage pilot • s136 admission • EDS/EDT service • CHRT • A&E Liaison /RAID • Public Health (JSNA) • Ambulance • 111 Flowchart • Telecare ▪ Review quality of existing data	From April 2015	All concordat stakeholders	▪ Improved demographic data on the people using crisis services to inform service development ▪ Improve services for people when in crisis – appropriate setting, readily available, smooth transition between services .Understand the effectiveness of the street triage of the s136 admissions.
1.2	Improve collection of qualitative data around experience of patients by categories defined under the Equalities Act 2010	May 2015	CCGs/LAs	▪ Improved understanding of how patients from diverse communities experience crisis services using surveys. ▪ Understanding the barriers that prevent seeking of services when in crisis
1.3	Collate service users experience "when in crisis", of all stakeholder services .This will provide qualitative data to inform future service delivery.	From July 2015	All concordat stakeholders	▪ Understanding the barriers that prevent seeking of services when in crisis ▪ Improve outcomes for service users in crisis ▪ Improve mental health awareness for stakeholders
1.4	Collect data of people attending emergency department with drug and alcohol problems	From April 2015	BTUH CDAS	▪ Understanding of gaps in service ▪ Appropriate provision of services
1.5	All partners to consider making *'reasonable adjustments'* to enable people who may be marginalised to articulate what they want	From April 2015		▪ All partner services are more sensitive to the particular needs of people experiencing mental health crisis (parity of esteem) therefore leading to reducing A+E admissions
1.6	Update on the Joint Strategic Needs Assessment (JSNA) to include more information	June 2015	Public Health ECC and	▪ Improved useable data at a local level ▪ Identify areas at risk and gaps in provision and uptake of services

	on mental health and specifically data on mental health crisis		Thurrock	▪ Improved mental health intelligence around which to plan, commission & provide mental health services & specifically crisis services ▪ Implementation of mental health metrics devised by NHS England
1.7	Extend the established GP Crisis Line to statutory and possible voluntary sector providers	From May 2015	All concordat stakeholders	▪ Clarity over criteria/ thresholds and ways to overcome them ▪ Outcomes-led/ needs-led approach ▪ Age removed as a barrier to accessing appropriate support in crisis ▪ Prevention of some crisis through listening to young carer and recognition of warning signs
1.8	Review the current communications pathway between all stake holders and develop a communication plan to raise awareness of mental health crisis and services available.	May 2015	All Concordat stake holders	▪ Standardised communication between organisations in South West Essex locality ▪ To prevent crisis admissions to hospital ▪ Raise awareness or mental health across all stakeholders ▪ Improved multiagency working and information sharing ▪ Clear and concise pathways of care which are easy to navigate for service users and professionals alike
1.9	Explore the opportunity of enabling the GP Access Numbers to be made available to all emergency services	From May 2015	South West Essex CCGs	▪ Improve responsiveness to mental health crisis ▪ Prevention of crisis admissions ▪ Reduction in s136 admissions ▪ Improved multiagency working and information sharing ▪ Bringing mental health closer to parity of esteem
1.10	Develop an information leaflet for A&E and VSO	From July 2015	All Concordat stake holders	▪ Prevention of crisis admissions
1.11	Review the current model of CRHT service and pathways. To deliver a model of Crisis Service in line with commissioning expectations and specifications	May 2015	South West Essex CCGs/SEPT	▪ CRHT service specification and agreed performance indicators are identified and implemented. ▪ Single point of access ▪ Equitable crisis provision for all ages and mental health issues ▪ Clear and concise pathways of care ▪ Standard response times, referral processes and quality standards to mental health crises ▪ Satisfactory subjective outcomes for people using services via patient/carer surveys ▪ possible co-location with other emergency services (Street triage)
1.12	Completion of the Essex wide CAMHS procurement joint exercise between Essex	New service to commence October	CCGs CAMHS Commissioners	▪ To improve value, access and responsiveness and ensure a safe, appropriate service

	County Council and CCGs	2015	ECC/TBC/SBC	
1.13	Review of CAMHS and adults transition protocols between child and adult mental health services, taking into account principles and good practice set out in the national CAMHS transition service specification	March 2015	South Essex CCGs and SEPT	▪ Intention to move to all age commissioning for mental health ▪ Integration between health, social care and physical health care ▪ To agree transition protocol to insert into SEPT contract and possible new CAMHS providers from October 2015
1.14	Investigate and understand the issues and need for care and subsequent mental health assessment for people with drug and alcohol problems	From April 2015	SEPT/CDAS	▪ Reduction in inappropriate use of S136 suites ▪ Vulnerable people are assessed in a safe place ▪ Review of resources used by partner agencies 'containing' intoxicated individuals ▪ Improved response to people lacking capacity with MH needs, but not needing the ED
1.15	Review the Psychiatric Liaison Service to consider all age approach and current gaps including hours required within the Mental Health Liaison team to best meet service users needs.	From March – May 2015	SEPT BTUH	▪ Remove age as a barrier to accessing appropriate support ▪ Crises responded to within standardised timescales and quality standards and with approved outcomes ▪ Fewer admissions ▪ Secure ongoing RAID/Liaison funding
1.16	Review current pathway /outcomes following an A&E attendance. To ensure the appropriate pathways and procedures are in place	October 2015	BTUH/SEPT	▪ Increase community support upon discharge to prevent crisis admissions. (IAPT)
1.17	Review current workforce training required across all Emergency Services	From May 2015	Essex Police /British Transport Police/SEPT	▪ Police Officers provide an informed and sensitive approach to people in mental health crisis ▪ Sharing of mandatory training
1.18	Ambulance national specification – ensuring local specifications are define waiting times target for MH service users	From April 2015	East of England Ambulance Service	▪ Ensuring ambulance service meets contract requirements ▪ 30 minute response time for s136 call coding ▪ 8 minute response where restraint is being used
1.19	Undertake a review of the needs and current provision of children and young people services (including those with behavioural problems) within South West Essex inpatient care and paediatric wards with Commissioners and providers.	By 1st November 2015 – aligned with CAMHS re-procurement	CYMS /CAMHS Commissioners SEPT	▪ Scoping exercise leading to recommendations ▪ Review of, and suggestion of improved provision for children and young people with 'behavioural issues in crisis' ▪ Improved inpatient provision for Children and Young People

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1.20	Health and Social care commissioners to establish the crisis/emergency care pathway for CYP with LDD, including children with LDD and neuro developmental disorders who present with challenging behaviour.	From May 2015	All Concordat stake holders	▪ Improve the understanding across health, education, social care, and police on the crisis/emergency pathway for CYP with LDD, and CYP with LLD and neuro developmental disorders who present with challenging behaviour.
1.21	Work with multi agency partners, building on existing joint work, to review and refresh multi-agency pathways and protocols for this client group, and identify areas for longer term service development, including potential for joint commissioning and/or service redesign.	From May 2015	CYMS /CAMHS Commissioners SEPT	▪ Improve the information available to CYP parents/carers on 'what to do' when behaviours start to escalate ▪ To help prevent CYP their families and carers reaching a crisis situation ▪ To improve multi agency working across all services ▪ Reduce inappropriate presentations to acute hospital A+E departments ▪ Reduce inappropriate admissions to acute sector paediatric wards
1.22	To undertake a needs analysis of potential service models for alternative to hospital admissions through pathway review (Mapping)	From July 2015	CCGs Thurrock BC Essex CC	▪ Reduction in hospital admissions ▪ Better experiences for people experiencing mental health crisis as evidenced through satisfaction surveys
1.23	Ensure service users with long –term conditions are screened for mental health problems and referred to appropriate mental health services (IAPT)	From April 2015	NELFT/SEPT	▪ To improve the working between mental health and physical health services. ▪ Bringing mental health closer to parity of esteem
1.24	Further evaluate the number of people using 111 who are having a mental health crisis. Including the pilot of MH trained staff in 111	From June 2015	111/CPR CCG	▪ Improved access to support for people experiencing mental health crisis ▪ Improved flow charts for 11 1 staff ▪ Sharing of 111 protocols ▪ Reduction in A&E admissions
1.25	Review current practise of Tele-care & Tele-health care. To establish opportunities to provide support to prevent crisis and give rapid response	September 2015	Thurrock BC / Essex CC/ CCGs/SEPT/ NELFT	▪ Earlier identification of impending crisis ▪ Supporting service users to remain in the community
1.26	South West Essex Crisis concordat action plan to be published on the national concordat website	March 2015	South Essex concordat action plan group chair	▪ National sharing of plans available for general public via national website ▪ To enable service users and carers to hold a stakeholder to account for implementation.
1.27	Confirm lead role of SRG mental health crisis sub group in oversight of development and implementation of action plan. Update TOR to	April 2015	All Concordat stake holders	▪ Clear governance and accountability for implementation of action plan ▪ Terms of reference in place and agreed by all stakeholders.

	reflect this.			
1.28	Work towards delivery of NICE approved care packages as part of the PbR implementation and delivery of the SEPT mental health "Super CQUIN"	April 2017	SEPT/CCG's	▪ Care packages defined and agreed ▪ Service users in secondary care mental health services receive care packages in line with NICE guidance
1.29	Review the skill mix within the current RAID service to ensure it meets best practise	June 2015	SEPT/BTUH	▪ Improve clinical outcomes of service users ▪ Increase awareness of mental health across the Acute Hospital
1.30	Commitment from all to participate in any future rolling programme of multi-agency, multi-professional mental health crisis pathway training	From July 2015	All Concordat stake holders	▪ Increased awareness of mental health issues for police officers leading to a more personalised and sensitive responses ▪ Improved understanding between operational staff in partner agencies leading to more joined up responses and less 'hand off's ▪ Direction and consistency of all aspects of policing and mental health via appropriate group ▪ Sharing of mandatory training
1.31	Ensure SEPT workforce has the correct skill mix for delivering services in line with new PbR care packages	October 2015	SEPT/CPR CCG	▪ Workforce reviewed to ensure it has sufficient capacity and appropriate skill mix to meet the clinical needs of local case mix.
1.32	Review the current CRHT skill mix to ensure this meets the needs and reflects best practice.	October 2015	SEPT/CPR CCG	▪ Workforce reviewed to ensure it has sufficient capacity and appropriate skill mix to meet the clinical needs of local case mix.
1.33	Review outcome of Pilot Shared Care Protocol	From April 2015	SEPT	▪ Improved information sharing across the partner organisations ▪ Fewer A&E attendances ▪ Fewer emergency admissions ▪ Improved medication management ▪ Appropriate and prompt re-entry to services as required
1.34	Review/analysis of partner agencies mental health crisis related policies, procedures and protocols	July 2015	All Concordat stake holders	▪ Reflects best practice as evidences by analysis of national documentation including NICE guidance ▪ Evidence of a personalised approach ▪ Involvement of carers/friends and 'protected characteristic groups' ▪ Consistent with service specifications
	2. ACCESS TO SUPPORT BEFORE CRISIS POINT			
2.1	Review information provision and pathway for patients who attend or access A&E following self-harm, who are not admitted	From April 2015	SEPT/BTUH	▪ Ensuring that patients are identified, and managed to prevent crisis and attendance at Emergency Department

2.2	Establish a South West Essex link with the British Transport Police to involve them in prevention projects to tackle mental health and suicidal behaviour challenges	From May 2015	SEPT/British Transport Police	▪ Prevention of people seeking to harm themselves on the railway
2.3	CAMHS self-harm reduction strategy to be developed	October 2015	CAMHS providers/ CCGs / ECC	▪ Reducing self-harm episodes in children and young people
2.4	Develop interface with Crisis Resolution Home Treatment Team and Independent Mental Health Advocacy	From May 2015	SEPT/CCGs	▪ Clarity of relevance of statutory advocacy to users of Crisis Resolution Home Treatment Team ▪ Service users empowered through access to appropriate advocacy in crisis
2.5	Analysis of service user experience	From July 2015	Healthwatch/ CCGs	▪ involvement of service users in assessment of current pathways and redesign of new ones
2.6	Promote use of personal health budgets to provide individualised care	From April 2015	CCGs/SEPT/ VSOs	▪ Improved use of services according to need ▪ Improve mental well-being and preventative measures
3. URGENT AND EMERGENCY CARE ACCESS TO CARE				
3.1	Local implementation of the Association of Ambulance Chief Executive national S136 guideline for transportation of people under Section 136 detention	From April 2015	East of England Ambulance service	▪ All Section 136 requests for ambulance transportation would be categorised as appropriate
3.2	Discuss and review of multi-agency 'Standards/pathway to be utilised for mental health assessment' around crisis focusing: • Training • Communications • Pathway	From April 2015	All Concordat stake holders	▪ A set of multi-agency standards around MH assessment to be defined by the CCC group ▪ Shared understanding between key stakeholders ▪ Users/carers know what they can expect from key agencies in a MH assessment ▪ A timely and efficient assessment process
3.3	Development of an improved approach between CCGs and NHS England commissioners in relation to the availability and access to CAMHS beds and the step up and step downs services required	From April 2015	NHS England, South West Essex CCGs	▪ Improved multiagency communications
3.4	Essex wide GP CAMHS crisis line to be	February 2015	South West	▪ Improve communication between GPs and CAMHS providers

	developed for advice support and signposting.		Essex CCGs	▪ To ensure the most appropriate response is delivered to the service user ▪ Regular audit of the use and effectiveness of the line
3.5	Review and evaluate street triage model delivery to ascertain possible service gaps in current provision.	May 2015	Essex Police	▪ Improve out comes for service users in crisis ▪ Reduction in s136 detentions ▪ Reduction in usage of s12 doctors ▪ Improved mental health awareness in Police
3.6	Explore options for developing an advise and helpline for service users and carers	From July 2015	SEPT/ECC/TBC CCGs	▪ Reduce crisis episodes ▪ Support carers
3.7	Develop the MH Crisis Specific Information Exchange Agreement (SIEA) or equivalent addressing safeguarding concerns	From July 2015	All Concordat stake holders	▪ Information is appropriately shared in mental health crisis safeguarding situations ▪ Avoid duplication ▪ Ensure service users safety
3.8	Audit current safeguarding referrals where there is an underlying mental health problem (including carers)	From July 2015	South West Essex CCG's	▪ Improved understanding of mental health safeguarding situations
3.9	Review interface between daytime Approved Mental Health Professional and EDT (to include planned OOH Mental Health Act assessments)	July 2015	ECC	▪ Ensure that Mental Health Act assessments are undertake in a timely fashion in accordance with the legislation/Code of Practice ▪ To ensure workforce levels are at the required standards to meet level demand in services
3.10	Review housing and accommodation needs as part of crisis pathways for people with mental health long terms conditions	From May 2015	District Councils /VSOs	▪ Improved access to housing support for people with mental health problems
3.11	Data collection and Audit of experience of subjects of s135 ands136	From April 2015	Essex Police/SEPT	▪ Detainee experience of 136 Suite Opportunity to improve experience of S136 detainees
3.12	Independent Mental Health Advocacy service information material to front line staff	From May 2015	Basildon Mind	▪ Improved awareness and understanding of the IMHA role. ▪ Increase in referrals for clients to the IMHA service ensuring service user involvement in decisions affecting their lives.
3.13	To develop a campaign to raise awareness of services available to people in mental health crisis. To coincide with World Mental Health Day "Dignity in Mental Health"	10th October 2015	All Concordat stake holders	▪ Raise awareness of mental health issues ▪ Improve patient experience and quality outcomes ▪ Reduce stigma ▪ Improve diagnosis, timely access and early intervention ▪ Reduce crisis episodes

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South West Essex action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat

4. QUALITY OF TREATMENT AND CARE WHEN IN CRISIS				
4.1	Review existing patient pathways in place for frequent attenders with mental health problems at the	October 2015	BTUH/SEPT	▪ Work with partners to review frequent attenders ▪ Develop pathway plans for better management to prevent attendance ▪ Increase community support upon discharge to prevent crisis admissions. (IAPT)
4.2	Ensure all organisations are aware of the work of the British Transport Police surrounding suicide prevention at Railways	From June 2015	British Transport Police	▪ Dissemination of the BTP crisis number ▪ Earlier intervention of potential railway suicides Reduction in railway suicides
4.3	Collaboration between Police, primary care, mental health providers and social care to produce a local mental health information sharing system in order to identify people at risk of serious mental illness	From July 2015	All Concordat stake holders	▪ Improved quality of assessments ▪ Prompt identification of people with mental health problems leading to more appropriate care
5. RECOVERY AND STAYING WELL/PREVENTING FUTURE CRISES				
5.1	Information for the Independent Mental Health Advocacy service and engagement with Service User Group	From May 2015	Basildon Mind	▪ Opportunities to engage with other service users and play an active role in the forum, contributing in consultations etc., raising their awareness of existing or alternative services increasing their choices and improving their knowledge ▪ Improved awareness and understanding of the IMHA role. ▪ Increase in referrals for clients to the IMHA service ensuring service user involvement in decisions affecting their lives
5.2	Provide coping with crisis and developing plans (Recovery Colleges)	From October 2015	South West Essex CCGs	▪ All Wellbeing Plus clients will be able to attend workshops to develop their own personal plans (or review existing ones) and share strategies and techniques with other clients
5.3	Undertake audit of A&E attendances for people with mental health problems, to support identification of any gaps in current service provision and pathways.	From April 015	BTUH	▪ Reduction in crisis admissions
5.4	Implementation of social prescribing scheme across BBCCG	From April 2015	ECC	▪ Improving support in primary care ▪ Improving community resilience
5.5	Promote and extend the use of Advance Care Plans, Crisis Plans Decisions and Advance Decisions for mental health patients including	From April 2015	SEPT	▪ All known service users will have a future crisis plan that lessens the likelihood of a repeat crisis and ensures the wishes of the service user are taken into consideration

	Children and Young People and people with dementia			▪ Evidence that these plans are routinely part of the CPA process
5.6	Audit current use of Crisis Care Plans in line with NICE quality standard 14 – Crisis planning	January 2015	SEPT/CPR CCG	▪ Establish current practice and standards related to crisis plans ▪ Establish what learning is required and promote a standardised approach to crisis plans ▪ Ensuring adherence to national standards
5.7	IAPT services continued development to support people with mild to moderate mental health problems	From April 2015	IAPT providers /South West Essex CCGs	▪ Improving recovery in service users with mild to moderate anxiety and depression, reducing risk of future criris
5.8	Explore use of Personal budgets and Personal health budgets to support people frequently in crisis	From April 2015	LAs/SW CCGs	▪ Improving the individualised care of people frequently presenting in crisis to promote recovery, independence and better quality of life

KPI Reporting data set to complied by the end of April 2015 to assist with evaluating the success of implementation plan

To include:

- Reduction in section 136 detentions
- Reduction in A&E crisis admission s and readmissions
- Elimination of the use of police cells as a place of safety under section 136
- No child or young person under the age of 18 to be detained in a police cell under section 136
- Reduction in Section 12 doctors assessment required
- A&E breaches eliminated
- 4 hour response target within MH service - response time and percentage within target
- National Ambulance response targets for MH
- Increase in the number of appropriate calls from stakeholders to the MH crisis line.
- Reduction in police restraint

Soft KPIs

- Service user feedback on experience when in crisis from all key stakeholders services
- Improved experience for service users detained under the MH act
- Carer feedback on crisis services
- Training programmes in place across all stakeholders

Crisis Care Concordat

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South West Essex action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat

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15 June 2015	ITEM: 6
Health and Wellbeing Board	
Children and Young people Emotional Wellbeing and Mental Health Service Commissioning update	
Wards and communities affected: All	**Key Decision:** n/a for information
Report of: Paula McCullough, Commissioning Officer, Emotional Wellbeing and Mental Health	
Accountable Head of Service: Andrew Carter, Head of Children's Social Care	
Accountable Director: Carmel Littleton, Director of Children's Services	
This report is Public	

Executive Summary

The Seven CCGS, Essex County Council, Southend Council and Thurrock Council have been working closely to jointly re-commission integrated targeted and specialist emotional wellbeing and mental health services for children and young people.

A redesigned and comprehensive service model that integrates Tier 2 and Tier 3 services has been produced, based on the findings from needs assessment and consultation with young people, clinicians and stakeholders. We believe an integrated approach will improve resilience and life chances and better support vulnerable young people.

All partnership organisations approved the business cases/cabinet reports during May and June 2014 and this enabled a procurement process to start on the 7th July 2014.

Procurement

Three bidders responded to the first stage of the procurement (the Pre-Qualification Questionnaire (PQQ)) and all three passed and were put through to the next stage. The three bidders are;

- SEPT (in partnership with NEPT and Barnardo's)
- Tavistock and Portman
- NELFT (North East London Foundation Trust)

The second stage of procurement (Invitation to Submit Outline Solutions (ISOS)) saw all three bidders being issued detailed feedback from the PQQ that enabled them to start work

on their outline solutions. During November and December 2014 the outline solutions were received from all three bidders and reviewed by the evaluation team.

Dialogue commenced on the 5th January 2015. This process allowed bidders the opportunity to discuss their proposal and any areas of concerns raised from the review of their outline solution. Dialogue closed on the 20th March 2015 and final tender documentation was issued to the bidders.

Final tenders were received from all three bidders on the 10th April 2015. The evaluation team reviewed and scored the final tenders and participated in a moderation session on the 28th April 2015.

The CYP EWMH Partnership Project Board approved the outcome of the evaluation on the 30th April 2015.

- Preferred Bidder - North East London Foundation Trust (NELFT)
- Reserve Bidder – Tavistock & Portman NHS Foundation Trust

We adopted a voluntary minimum ten calendar day standstill period. The standstill period expired on 12th May 2015 and was successfully completed without any challenge being received.

New services are planned to commence from 1st November 2015 with an Initial Contract Term of 3 years and options to extend for two further 12 month periods.

Summary of preferred provider offer

NELFT have offered a balanced, comprehensive model rooted in the child and young person at the centre, with robust and deliverable systems to ensure this can be delivered systematically, safely and effectively across the partnership. This model is clearly tailored to each locality and based on a strong analysis of local needs and demand in each area. The service model clearly outlines how this demand will be met in each area.

The model proposed is evidence based and outcomes focused, with tried and tested ways to deliver across our partnership, using CYP-IAPT principles and tools that the trust has evidenced have been successfully implemented elsewhere.

The bid had strong levels of innovation and added value clearly demonstrated in the range of therapeutic interventions, programmes and workforce development offered.

Reassurance was given within the bid that each of the key elements of service requested by commissioners will be delivered to a high standard.

Commissioners were reassured that this provider was willing to work collaboratively with commissioners, children and young people and stakeholders to achieve a high level of service delivery.

The activity provided in the proposal suggests that over the three years of the initial contract period NELFT will achieve a 14% increase in activity over current levels. This increase is based on proposals for all client contacts, covering targeted, specialist and crisis provision. However, please note that there are some caveats over quality of existing amalgamated service data and caution should therefore be used with regard to the baseline activity numbers. More detailed activity planning will be developed with the provider once the contract is awarded.

Mobilisation

A mobilisation team with members from across the partnership will work with NELFT to finalise and implement transition plans.

The partnership will establish a Collaborative Forum to oversee the new contract, with WE CCG fulfilling the role as Lead Commissioner; this will be established once the Contract has been awarded. The forum will be used as the focus for discussion of matters relating to the Commissioning Contract and the pursuit of the objectives and performance of the function of the Collaborative. It will also oversee the transition arrangements and Contract negotiations

The vision of the C&YP EWMH partnership is to improve the Emotional Wellbeing & Mental Health of children and young people, aged 0-25, with EWMH needs. The aim being to improve their educational and social life chances by ensuring ease of access and the provision of high quality services that use evidence-based effective interventions.

Fit with Health and Well Being Plan - CYP EWMH Service Outcomes

The new service will deliver these outcomes

- Improved emotional wellbeing, emotional intelligence, resilience and self-esteem for children, young people, their families and carers
- Practitioners have improved access to Services and receive improved consultation, advice, support, training and guidance from the service.
- Children, young people, their families and carers;
    - receive easier access to services with a timely response to their needs
    - are appropriately signposted to universal services.
    - participate in and influence service provision and development.
    - experience integrated service provision with Emotional Wellbeing and Mental Health (EWMH) provision coordinated with other services without discriminatory, professional, organisation or location barriers getting in the way.
- Reduced inappropriate use of A&E to access CYP EWMH services
- Vulnerable groups such as Children Looked After Children, Fostered/Adopted, leaving Care, on the edge of Care, with a Disability and/or Statement of Educational Need and their families and carers receive appropriate evidence based interventions from EWMH services
- Young people aged 14-25 and their families and carers receive appropriate mental health support and experience a smooth transition to adult mental health services.

The Children and young people's mental health and well-being taskforce have published their report 'Improving mental health services for young people in March 14. Our joint re-procurement will deliver an integrated model that is outcomes focused and will improve access and resilience. This is the direction that the report recommends.

The taskforce co-chaired by Jon Rouse Director General, Social Care, Local Government and Care Partnerships at Department of Health and Martin McShane NHS England's director for people with long term conditions. It brings together experts on children and young people's mental health services and people who know about wider system transformation from education, social care and health. It commissions external advice from experts and others with experience in children and young people's mental health.

Our joint re-procurement supports the recommendations within the report and shows that our partnership has been ahead of national trends in developing integrated, outcomes focused services.

Risks identified

See table at end of report

Resource Implications

Employees from current providers will transfer over to the preferred provider at the start of the contract. Their current terms and conditions of employment will be protected by the Transfer of Undertakings (Protection of Employment) Regulations 2006 (as amended).

View of the Patients Carers or the Public and the extent of their involvement

Engagement

A Young People Engagement Group was established to gain insight from young people who have or currently are using the service. This group has been engaged on the Service Model and Specification; they also developed their own questions which were included in the tender and evaluated these as part of the final tender.

A Clinical Reference Group has been formally established. Membership includes GP Clinical leads from the Clinical Commissioning Groups. This group has been engaged on the Service Model and Specification, providing clinical advice and support. They also provided clinical advice during the procurement exercise and evaluation of the solutions provided by the bidders.

Implications

Financial

Implications verified by: **Kay Goodacre**

Finance Manager – Corporate finance

Procurement was carried out in accordance with all legislative requirements. The preferred bidder was recommended as it it presented the most economically advantageous tender. The financial submission is within the financial envelope with activity levels increased by 14% . The service will deliver additional savings and social value as children and young people will receive an earlier and timelier response preventing escalation to more expensive specialist services with an improved focus on maintenance of their future well-being. The bidder presented a high quality, safe and affordable solution.

Legal

Implications verified by: **Courage Emovon**

Contracts Lawyer

Section 17 of the Children's Act 1989 provides that local authorities have a duty to safeguard and promote the welfare of children within their area who are in need and so far as is consistent with that duty to promote the upbringing of such children by their families by providing a range of services appropriate to those children's need.

The proposals to come together to plan, design and deliver a single equal, integrated, emotional wellbeing and mental health service for children and young people conforms with the duty placed on local authorities and their partners to work together to ensure all children and young people are able to stay safe, healthy, enjoy and achieve economic wellbeing and make a positive contribution.

The Children's Act 2004 sets out the responsibilities of local authorities and their partners to co-operate and promote the wellbeing of children and this specifically includes their mental health and emotional wellbeing. The Mental Health Act 1983 as amended by the Mental Health Act 2007 provides for the treatment and care of people with mental disorder including children and young people.

Thurrock Council under the Health and Social Care Act 2012 as a local authority must take such steps as it considers appropriate for improving the health of the people in its area and this includes the mental health of people in its area.

Diversity and Equality

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

The implementation of a high quality Emotional Well Being and Mental Health (EWMH) service is key to ensuring equality of opportunity for the children and young people of Thurrock and the Diversity Team would want to ensure that access to EWMH services is available to those who require that support. This new service offers improved "swift and Ease" for a wider group of children and young people than previously.

Risks

Risk	Impact	Mitigation
Incumbent providers do not engage with the preferred provider during the Mobilisation period should they not win the contract.	This would cause delays in the mobilisation of the new service, if staff and critical information is not be made available during the mobilisation period.	Effective contract management of incumbent providers. Clear communication to all parties and an agreed Exit Strategy in place. Mobilisation Plan, Risk register, Communication plan produced.
The Preferred provider does not implement the new service model and specification effectively.	Services will not meet expectations. Quality and activity could suffer and the provider could cherry pick easier cases. There may be gaps in the service and this could lead to outcomes not being achieved.	Dialogue with providers on KPIs and the expectations around the service model and specification. After Dialogue finalise Specification, Service Model and KPIs and issue to Bidders to ensure they are clear on their exceptions. Clear Contract Management Plan in place with Lead Commissioner and Preferred Provider.

Appendices to the report

- Appendix 1 - Key performance indicators- final tender

Report Author:

Paula McCullough

Commissioning Officer,
Emotional Wellbeing and Mental Health
Children's Services

Appendix 1 – Key Performance Indicators

Southend, Essex, and Thurrock Commissioning Collaborative

Emotional Wellbeing and Mental Health Service For Children and Young People

Key Performance Indicators

West Essex Clinical Commissioning Group
Mid Essex Clinical Commissioning Group
North East Essex Clinical Commissioning Group
Southend Clinical Commissioning Group
Castle Point and Rochford Clinical Commissioning Group
Basildon and Brentwood Clinical Commissioning Group
Thurrock Clinical Commissioning Group

Key Performance Indicators for Emotional Wellbeing and Mental Health Services

The Key Performance Indicators (KPIs) within this document must be read in conjunction with the Service Specification for Emotional Wellbeing and Mental Health Services in Southend, Essex and Thurrock. It outlines the standards to be achieved, indicators and measurements, thresholds, and methods of data collection and will contribute to the achievement of the specific outcomes that are to be delivered from this service as outlined in Section 1.8 of the Service Specification and the following overarching outcomes:

NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**
Domain 2	**Enhancing quality of life for people with long-term conditions**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**
Domain 4	**Ensuring people have a positive experience of care**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**

No Health without Mental Health

• More people will have good mental health
• More people with mental health problems will recover
• More people with mental health problems will have good physical health
• More people will have a positive experience of care and support
• Fewer people will suffer avoidable harm
• Fewer people will experience stigma and discrimination

Notes: The following are the proposed Key Performance Indicators

The KPIs and measures draw on and reflect the CAMHS National Data Set, CORC, and Children and Young Peoples Improving Access to Psychological Therapies (IAPT). The measures will be further developed and revised to reflect any future progress in these areas. (www.cypiapt.org and www.corc.uk.net). The KPIs set out below are to be reported in addition to regular activity and quality reporting and together will form the performance and quality schedules for the contract.

Table 1: Key Performance indicators				
Outcome and standard	**Indicator/Measurement**	**Threshold**	**Method of data collection**	**Comments**
Outcome Improved emotional wellbeing, emotional intelligence, resilience and self-esteem for children young people, their families and carers **Standard** Of the service users on their caseload, staff monitor clinical outcomes, risk, and side effects at regular intervals using CYP-IAPT validated outcome tools as appropriate and relevant. Sessional outcomes monitoring to be phased in over the course of the contract.	**KPI 1:** Number and % of service users who have improved their validated outcome measurement score between commencement of treatment, and at 6 months (or case closure if before 6 months)	**Improvements in outcomes:** baseline to be collected in year one, with targets for completion of outcomes measures and improvements in outcomes to be agreed for years 2 and 3 (and onwards if the contract is extended to reflect year on year maintenance/improvement on the baseline.	6 monthly by locality Annual CORC report	Outcome measurement tools must be CYP-IAPT approved and include a service user-completed measurement and a clinician-completed measurement. Information to be available by locality and targets and thresholds to be set by locality.
Standard Increased numbers of CYP families and carers reporting satisfaction with services received – Experience of Service Questionnaire (ESQ) Friends & Family Test questions to be included as well.	**KPI 2:** Number and % of service users reporting satisfaction with services received	**Improvements in satisfaction:** Baseline to be set in year 1 Targets to be set for years 2, 3 and onwards based on improving on the baseline: expectation that service user satisfaction will increase as the new model is fully implemented.	Quarterly report – user feedback	We want as many CYP/families to be completing these as possible but more compliant/satisfied clients are more likely to complete

Outcome and Standard	Indicator/Measurement	Threshold	Method of data collection	Comments
Outcome Children young people parents/carers receive easier access to services with a timely response to their needs **Standard** Service users receive intervention within nationally agreed consultant led timescales Service users receive intervention without delays (maximum time of 18 weeks from referral to treatment – non Consultant)	**KPI 3**: Referral to treatment waiting times by locality: • Within 6 weeks • 6 to 12 weeks • 12 to 18 weeks 18+ weeks **KPI 4:** Referral to assessment waiting times for new cases by locality: • 0 <= 4 weeks • 4 to <=8 weeks • 8 to <= 12 weeks • 12 + weeks	National target (95% within 18 weeks) To identify baseline in year 1 Year on year % target for maintenance/improvement to be agreed for years 2 and 3 (and onwards if applicable)	Monthly activity report Monthly activity report	National target Agree local target based on length of wait for new cases (measured at point of assessment i.e. all assessments during the month) Monitor the number of CYP seen within local target
Standard Young people with emergency (crisis) MH needs receive specialist mental health assessments promptly and within nationally agreed timescales	**KPI 5**: Total number of crisis assessments undertaken in A+E for each locality, including out of hours • No. and % of those presenting assessed within 4 hours of referral	100%	Monthly activity report	National A+E target within 4 hours. Timeline to start from the time MH receive the request from A+E staff to attend. If the child is admitted to a paediatric ward due to medical circumstances such as OD or self harm, then assessment within 24hrs would be considered more appropriate in accordance with NICE guidance.
Standard If service users 'do not attend' or stop attending appointments before formal arrangements for this are made there are procedures in place to facilitate return to service, including outreach, use of digital technologies where appropriate	**KPI 6:** DNA rate in each locality, measured through aggregate of: Total No. and % of 1st appointments DNA's by service user Total No and % of subsequent appointments DNA's by service user	Year 1: baseline data to be provided Years 2 and onwards: targets to be set per locality to demonstrate maintenance/improvement on year 1 and work towards/improve on national average (depending on baseline position)	Monthly activity report	

Link to payment and service improvement incentives

The proposed payment mechanism structure is:

Period	Year 1	Year 2	Year 3	Subsequent
	Period to 31st March 2016	Year to 31st March 2017	Year to 31st March 2018	Subsequent periods inc contract extensions
Block Price	97.5%	95%	94%	94%
Contract price for achievement of key performance indicators or as a result of & CQUIN/Quality (*NB: year 3 to be the *higher* of 6% or to reflect any future national CQUIN values set for CAMHS , to reflect any potential future increases to CQUIN)	2.5%	5%	6%*	6%*

The conditions are:

1) A proportion of the total contract value will be withheld and paid quarterly (with an annual adjustment to reflect overall annual performance) if the provider meets the Key Performance Indicators as set out below. The proportion of the contract value linked to performance will increase as the contract matures.
2) As set out above, the performance payment will be within and not additional to the budget envelope.
3) The performance payments detailed are a local incentive scheme that replaces the national cquin scheme. Should national cquins that are applicable to this contract be mandated, these will be incorporated within the overall % payment as detailed above and not in addition. This would result in the % allocated to the local KPI being reduced.
4) During the life of the contract period, should the % value of the national CQUIN be set at a level in excess of the % value set for the local incentive scheme, then the higher of the % rates would apply.
5) KPIs performance payment will be measured against new cases entering the service on or after the first day of the new service being in operation. It is therefore expected that robust performance data will be collected and provided to commissioners (broken down into historic and new cases)
6) Performance payment will be scaled, within a margin that performance should be within 90% of meeting the target. E.g. if 90% of cases meet DNA targets set for year 2, 90% of the 1% set aside would be paid. If 85% of cases met DNA targets, the full 1% would be withheld for the quarter as this would be considered unacceptably low performance.
7) To achieve the performance payment, the KPIs linked to performance must be met within each locality as suggested below. The localities are: Southend, Thurrock, Castlepoint & Rochford CCG, West Essex CCG, Mid Essex CCG, North East Essex CCG, Basildon & Brentwood CCG

	KPI	% linked to performance payment	Conditions for each locality
Year 1 (indicative)	Provision of Baseline Data	2.5%	Baseline data to support the quality and performance framework must be provided for each locality including: • RTT waiting times (Consultant and Non-Consultant led) • RTA waiting times for new cases • DNA rate for first appointments • DNA rate for subsequent appointments • Provision of all information set out in the activity and performance schedule (see attached schedule) The information collected will inform the baseline for the 16/17 financial year performance management where an improvement over the baseline will be measured. By the 15th of February, forecast data should be available (subject to NHS planning guidance).
Year 2 (indicative)	Stretch target on RTA and/or RTT times	1%	Target, based on baseline data collected within year 1, must be reached in each locality in order to achieve payment.
	Stretch target for DNA for first appointments and subsequent appointments	1%	Target must be reached in each locality in order to achieve payment and there should be no deterioration in any locality from the baseline established in period one
	% showing improvements in MH	1.5%	Target must be reached in each locality in order to achieve payment. C&YP IAPT approved outcomes measurement tools to be agreed during mobilisation (and include a service user completed measurement and a clinician completed measurement)

	outcomes		
	Service user satisfaction and service improvement	1.5%	CQUIN/service improvement incentive to be agreed to improve management of demand and access to high quality service based on user and stakeholder feedback. Mechanism to be agreed during mobilisation period in line with agreed milestones in a transition plan. Increased numbers of C&YP families and carers reporting satisfaction with services received – Experience of Service Questionnaire (ESQ) Friends & Family Test questions to be included as well.
Year 3 (indicative)	Stretch target on RTA and/or RTT times	1%	Target, based on baseline data collected within year 1, must be reached in each locality in order to achieve payment.
	Stretch target for DNA for first appointments and subsequent appointments	1%	Target must be reached in each locality in order to achieve payment and there should be no deterioration in any locality from the baseline established in period one
	% showing improvements in MH outcomes	2%	Target must be reached in each locality in order to achieve payment. C&YP IAPT approved outcomes measurement tools to be agreed during mobilisation (and include a service user completed measurement and a clinician completed measurement)
	Service user satisfaction and service improvement	2%	CQUIN/service improvement incentive to be agreed to improve management of demand and access to high quality service based on user and stakeholder feedback. Mechanism to be agreed during mobilisation period in line with agreed milestones in a transition plan. Increased numbers of C&YP families and carers reporting satisfaction with services received – Experience of Service Questionnaire

			(ESQ) Friends & Family Test questions to be included as well. C&YP IAPT sessional monitoring tools should be used.
Years 4 and 5	As year 3		

15 June 2015	ITEM: 7
Health and Wellbeing Board	
Thurrock Response to Child Sexual Exploitation	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Alan Cotgrove, Thurrock Childrens Partnership and Local Safeguarding Children Board Manager	
Accountable Head of Service: Andrew Carter, Head of Childrens Social Care	
Accountable Director: Carmel Littleton, Director of Childrens Services	
This report is Public	

Executive Summary

The attached report and presentation provides an overview of the current partnership response to child sexual exploitation in Thurrock. It sets out the infrastructure that supports our approach and highlights some of the key activities undertaken.

1. Recommendation(s)

1.1 The Health and Wellbeing Board to note the progress of our response

1.2 To enable the Health and Wellbeing Board to make comments

2. Introduction and Background

2.1 The sexual exploitation of children and young people is completely un-acceptable. The Partnerships across Thurrock and Essex have been working together, developing its approach over the last three years taking into account the Childrens Commissioners recommendations, Working Together 2015 and the findings of a number of enquiries that have taken place across the country.

3. Issues, Options and Analysis of Options

3.1 Not applicable

4. Reasons for Recommendation

4.1 To inform the Board of the work of the Childrens Partnerships in developing its response and approach to child sexual exploitation.

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

5.1 Not applicable

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

6.1 Not applicable

7. Implications

7.1 Financial

Implications verified by: Michael Jones
Management Accountant

Funding of the work of the Children's Partnership and Local Safeguarding Board activities is conducted through partner's contributions with no additional financial impact on the local authority.

7.2 Legal

Implications verified by: Lyndsey Marks
Legal

There are no direct Legal implications for the Local authority.

7.3 Diversity and Equality

Implications verified by: Rebecca Price
Community Development Officer

There are no direct diversity or equality implications. The Thurrock approach to child sexual exploitation aims to improve services and support for all children and young people in Thurrock.

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):

- Children Commissioners report
- Working Together 2015
- Thurrock CSE strategy 2015

9. Appendices to the report

- Appendix A – Partnership Report
- Appendix B – CSE Presentation

Report Author:
Alan Cotgrove
CYPP and LSCB Business Manager
Children's Services

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Thurrock Children & Young People Partnership

THURROCK LOCAL SAFEGUARDING CHILDREN BOARD

Thurrock response to Child Sexual Exploitation
Update May 2015

This paper provides an overview of the Children and Young People Partnership (CYPP) and Local Safeguarding Children Board (LSCB) position in its development and continuing review of safeguarding children and young people from sexual exploitation in Thurrock.

Its content takes into account the development of our approach, local context and the reflective learning from a number of reviews and enquiries that have taken place over the last three years across various counties in England and Government and Children's Commissioners reports. It aims to provide the Boards and other relevant organisations with information on the progress and activity made in tackling CSE.

The development of our response is a continuing process and many of our partner agencies have made significant progress in their own approach as single agencies to support the Partnership Boards in achieving the best possible outcome for the children and young people of Thurrock.

The sexual exploitation of children and young people is completely un-acceptable and that is why the CYPP and LSCB have worked in partnership with our colleagues in Southend and Essex to develop a strategy and approach to meet the emerging needs across Essex as well as in Thurrock.

The Children's' Commissioner set out recommendations and minimum standards that LSCB's across the country need to ensure are in place to support tacking CSE. I am pleased to report that those recommendations relevant to Thurrock are in place and support our local response.

Our approach and response to CSE also takes into account the revised Working Together 2015 and its previous editions, the supplementary guidance published in 2009 and the legislation framework of the Criminal Justice System.

We have adopted our response and approach to enable it to be sufficiently flexible to respond to and learn from the experience of other LSCB areas, reviews and future guidance when available.

The CYPP and LSCB have identified tackling the sexual exploitation of children as a key strategic priority and acknowledge child sexual exploitation as an integral part of child abuse. Our LSCB Business Plan and Childrens' and Young Peoples Plan (CYPP) reflect this position and CSE is also one of the elements of focus of the Violence against Women and Girls Strategy (VAWG) which has been adopted across the Borough.

The Partnership Boards are committed to combating the sexual exploitation of children through effective and coordinated multi agency and partnership working. The Local Safeguarding Children Board work closely with the Children and Young People's Partnership Board (CYPP) and Adult Safeguarding to ensure that children and young people who have been subjected to child sexual exploitation will receive seamless support as they progress from childhood to adulthood.

It is our collective responsibility as agencies to identify those children at risk of CSE, and ensure that swift and appropriate actions are taken to prevent them from becoming sexually exploited and to safeguard them from further risk of harm.

One of the main challenges we have faced over the last 12 months is understanding the local context of CSE which does not stand in isolation from other safeguarding risks and is often hidden. We have reviewed our existing systems for recording safeguarding in this area and have taken a robust and proactive response to improving our approach. As a result, partners have been developing their understanding of risk and the methods of recording this element of child abuse. As part of that work agencies have been reviewing their current systems and processes and conducting audits of young people who may be at risk.

The outcome of those activities has led to a refreshed partnership infrastructure to support our approach to meet the strategic and operational needs over the last 12 months.

The Southend, Essex and Thurrock (SET) LSCB CSE Strategic Group was established in 2012 and is chaired by the Public Protection Lead for Essex Police. The Strategic Group, which includes representatives from agencies across the three LSCBs, is coordinating the multi-agency response to cases of CSE in Southend, Essex and Thurrock. The LSCB Business Manager, the Local Authority Quality Assurance, Child Protection and LADO Manager and CCG currently represent Thurrock on the group.

The SET CSE group meet on a regular basis and those meetings are recorded and the minutes available for scrutiny. The aspiration of the Strategic Group will always be to identify those at risk of CSE and take steps to prevent CSE occurring. However, if victims of sexual predators are identified, the response must be appropriate and timely to protect them and prevent further offences.

The priorities of the Strategic Group include:

- raising awareness across all agencies,
- the development of CSE Champions in each agency,
- a single co-ordinated intelligence framework
- Prevention, through the early identification and support for children and young people vulnerable to CSE.

Having agreed the whole Essex strategic approach, Thurrock has looked at its local needs and the LSCB has developed and implemented its local CSE strategy which is available on the website www.thurrocklscb.org.uk

The CYPP & LSCB Business Manager undertook a review in January 2015 of the existing structures to support our response to CSE. The outcome identified that our response could be enhanced further through developing the CSE strategy locally through a more joined up approach across those groups established within the CYPP and LSCB that support safeguarding children.

In March 2015 we implemented a Risk Assessment Group (RAG) that joined up the previous Missing Person Panel, E-Safety Group and CSE Group to support a seamless approach to risky behaviours. Early indications have already shown additional benefits by these changes with 87 children who have been reported missing being assessed for risk and 24 referrals being reviewed for risk of CSE or other safeguarding risk. This approach has been very positive and enabled a number of young people to be identified at various levels of risk at a much earlier stage.

The Risk Assessment Group (RAG) reports to a newly formed Multi Agency Sexual Exploitation Group (MASE) which looks at the strategic implications for the Borough on behalf of the Partnership Boards and report its activities on behalf of the Board on a quarterly basis.

The Thurrock RAG and MASE have the following key functions:

a) Meet the aims and objectives of the SET CSE strategy
b) To coordinate and monitor the delivery of a CSE Annual Action Plan for Thurrock
c) Develop and support the identification and understanding of the scale of the problem of CSE within Thurrock by improving the collecting and monitoring of local data
e) Report to the LSCB on progress, highlighting any specific barriers or areas of risk
f) Raise awareness of sexual exploitation within agencies and communities
g) Encourage the reporting of concerns about sexual exploitation
h) Support the identification of training and awareness needs of both professionals and the larger community
i) Disseminate guidance and examples of good practice across all professions and sectors

The groups are currently working on improving the local knowledge and extent of CSE in the Borough and raising awareness. It is in the process of developing a programme of work that will ensure that Thurrock meets and were possible exceeds the needs of tackling CSE and be in a position to respond to any call for evidence of delivery.

The Thurrock Violence against Women and Girls Strategy (VAWG) provides an overarching strategy that encompasses sexual exploitation as one of its components. This approach will enable the LSCB and CYPP to maintain its wider safeguarding responsibilities whilst maintaining oversight and scrutiny through the currently agreed reporting structures. Members of the Partnership Boards sit on all safeguarding groups which ensure that the views of the LSCB and CYPP are reflected in their work.

CSE Training provision

Until recently training in CSE has been covered under its broader context in the multi agency child protection training programmes. This has been reviewed by the Inter Agency Group of the Children's Partnership and a separate programme in addition to this training has been agreed.

The LSCB have also recommended that individual agencies review their single agency training of CSE and in support of this an initial multi agency training stakeholder event took place on 7th February 2014 and this is now an annual process.

The current multi agency training approach to CSE training has been developed to focus on front line staff across the Borough that may have contact with children, young people and families.

The LSCB have provided an online basic CSE awareness course – free for all partners and those agencies working with children and families in Thurrock. I am pleased to report that since embarking on the programme in December 2013 we have issued 1,794 licences at the time of this report, of which 877 have been completed. These include practitioners from children's social care, police, health, schools, academies and third sector services.

CSE Champion training is also being provided to enable additional knowledge and awareness to be available to supervisors and managers supporting front line staff. A champion will be an individual such as the safeguarding lead at a school, team leader or GP safeguarding practice lead. In addition to completing the e-learning course they will attend a day session explaining the Thurrock approach to CSE in more detail including a risk assessment toolkit and intelligence pathway. This training began in March 2015 with 72 champions trained with further courses planned.

Agency lead Champion training - All partners represented on the LSCB have nominated a lead professional for CSE, who will act as the single point of contact for all matters relating to child sexual exploitation for their individual agency. They will also have completed the on line course and attend a half day lead champion session planned for 2015.

CSE Risk Assessment toolkit

To aid front line practitioners and managers in determining the best response to a child or young person who may be at risk of CSE, the SET Strategic Group agreed a Common Risk Assessment Toolkit to aid identification of the risk a young person or child may face. This process is now embedded within the MASH and across Children's Social Care with further work continuing across all partner agencies.

Intelligence Pathway – Operation CARE

Essex Police have agreed to be the lead agency in collating CSE intelligence. There is no specific offence of CSE and its pathways have been varied. All intelligence received associated with CSE is now tagged "Operation Care". This enables analytical work to be conducted and produced to aid identification of linked offences or intelligence that will support a better understanding of the scale of the problem. An intelligence notification form is in place to enable any agency to provide information.

CSE Referral Pathway

CSE is recognised as a form of sexual abuse and to ensure clarity for those involved in working with children and young people the existing procedures for reporting or referring potential safeguarding cases will be in accordance with existing practice for safeguarding concerns. The SET Procedures have recently been refreshed (March 2015) and a more detailed section on CSE has been included to support practitioners.

Raising awareness

One of the core functions of the Partnership Boards is to build on raising the awareness of the CSE agenda which is being approached in two phases. The first phase is to ensure that front line staff is fully aware of the signs and indictors and the referral pathways. This is continually being delivered through a number of mediums including training, marketing material and on line development.

The warning signs and vulnerability checklist identified in the Interim Report from the Childrens Commission was originally circulated in December 2012 and are included in leaflets produced for professionals across the Borough by the LSCB.

The LSCB Conference 2012 was focused on child sexual exploitation and included information and learning workshops and continues to provide a platform for learning. This work is being built on further at the 2015 LSCB conference.

The second phase includes raising awareness of the risks of CSE with children, young people and parents. The LSCB conducted a series of 6 road shows during March 2014 to capture 5,570 young people from years 5, 6 & 7 from every School and Academy across the Borough. This engagement with young people in Thurrock took place again in March

2015 with 1,662 year 5 pupils attending the roadshows. During these events a survey is undertaken which has provided valuable insight into the virtual world of our young people and the potential risks they face. Hearing the voice of the child has provided a greater awareness for our partners to their safeguarding needs in this area.

This approach although a significant logistical challenge to implement, has provided further opportunities to develop our engagement with parents and professionals.

Following these roadshows we have conducted a series of events for parents and professionals to raise awareness of E-Safety, CSE and share what the young people were telling us. Since these programmes began they have been attended by over 376 professionals and parents with further programmes scheduled during 2015.

SCR Julia

As part of our learning improvement framework, the learning from the recent serious case review "Julia" published in December 2014 has been cascaded across the partner agencies through a series of front line workshops, leaflets and booklets to support learning from this case. The overview booklet of the review has been developed to provide an easy read for front line staff with over 550 of the booklets circulated. Workshop events with Children's Social Care and Education Safeguarding Leads and Head Teachers have taken place, along with single agencies cascading the learning across the children's workforce. A detailed action plan supporting the learning is in place and reviewed regularly to ensure practice reflects the learning from this review.

Youth Safeguarding Ambassadors.

I am pleased to report an exciting opportunity to develop further, hearing the voice of the child and capturing real time evidence of young people's needs through the introduction of Safeguarding Ambassadors. These are young people ages 11-19 from the Thurrock Youth Cabinet who want to support the partners in their safeguarding responsibilities. 12 young people so far have agreed to undertake the youth ambassador role. This will incorporate networking with safeguarding leads in Schools and Academies, speaking with their peers and being our eyes and ears on the ground capturing real-time information.

Next steps

The Partnership Boards will continue to closely monitor the impact and outcomes of Thurrocks approach to tackling CSE and the implementation of the action plans from the Children's Commissioners and other learning frameworks.

This report has provided an overview of where we are. Work continues on a daily basis as the developing landscape changes. Together the Partnership Boards will continue with

THURROCK LOCAL SAFEGUARDING CHILDREN BOARD

their focus on better engagement with children and young people to ensure that their voice is heard in our future policies and procedures and the understanding of the benefits of the early offer of help provision is embedded across the Borough.

A P Cotgrove

Alan Cotgrove
CYPP and LSCB Business Manager
May 2015

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15 June 2015	ITEM: 8
Health and Wellbeing Board	
Homelessness Prevention Strategy	
Wards and communities affected: All	**Key Decision:** Key
Report of: Dawn Shepherd, Housing Strategy Manager, Housing	
Accountable Head of Service: Dermot Moloney, Strategic Lead, Housing	
Accountable Director: Barbara Brownlee, Director of Housing	
This report is Public	

Executive Summary

Every Local Authority must have a Homelessness Strategy which sets out the local authority's plans for the prevention of homelessness and for securing that sufficient accommodation and support are, or will be, available for people who become homeless or who are at risk of becoming so.

The local authority must ensure that all organisations whose work can help to prevent homelessness and/or meet the needs of homeless people are involved in the strategy.

The last strategy was adopted in 2010.

A new homelessness prevention strategy is required which takes into account current homelessness, the impact of recent welfare reforms, and opportunities for preventing homelessness.

A review of current homelessness, its impacts and anticipated needs for prevention of homelessness in the future has been undertaken.

An initial review document and draft action plan is presented to the board.

Further consultation will be undertaken and the final strategy and action plan will be presented to Housing Overview and Scrutiny board in September 2015.

1. Recommendation(s)

1.1 That the board notes the outcomes of the initial review and draft action plan (Appendices 1 and 2)

1.2 That the board notes a further period of consultation will be undertaken and that subsequently a final action plan will be devised

1.3 That board members contribute to the consultation

2. Introduction and Background

Every Local Authority must have a Homelessness Strategy which sets out the local authority's plans for the prevention of homelessness and for securing that sufficient accommodation and support are, or will be, available for people who become homeless or who are at risk of becoming so.

The local authority must ensure that all organisations whose work can help to prevent homelessness and/or meet the needs of homeless people are involved in the strategy.

Thurrock Council last implemented a homelessness strategy in 2010. Since then there have been many changes which have impacted homelessness including welfare reform, the Localism Act, a new housing allocations scheme, a new tenancy policy, recession and funding cuts

The new strategy will have an emphasis on prevention and will identify actions to address the main causes of homelessness in the borough.

Between February and April 2015 a consultation with staff across the Council, and partner agencies, was undertaken. An online survey was sent out to 850 recent service users and presentations were made at the DMTs of Children's and adults services.

A statistical analysis of data was undertaken in order to inform the review

Subsequently a review document and draft action plan was written. (Appendices 1 and 2)

The directorate will now hold a full consultation between May and July 2015, including face to face meetings with partners and Members, a public online survey and presentations to the tenant's excellence panel and Youth Cabinet.

The final strategy and action plan will be presented to Housing Overview & Scrutiny board in September 2015.

3. Issues, Options and Analysis of Options

The initial consultation identified the following key issues. The new strategy will identify actions to specifically address these issues

- There are four main causes of homelessness in Thurrock
  - Eviction by parents, family or friend
  - The ending of an AST
  - Violence or harassment
  - Mortgage or rent arrears

- Non priority groups, i.e. those without children or vulnerabilities who would not be accommodated by the Council under a statutory duty if homeless, have few housing options
  - Home ownership is beyond the reach of many
  - Low cost home ownership is a more viable option for working residents
  - Private renting can be expensive with increasingly rising rents
  - Non-working residents in receipt of Housing Benefit may struggle to obtain good quality affordable rented accommodation since there is an increasing shortfall between Local Housing Allowances (the subsidy paid under benefit rules) and actual market rents

- The impact of welfare reforms, particularly the introduction of Universal Credit , are likely to worsen the situation – e.g. there are reports of local landlords who previously let to people in receipt of Housing Benefit but are now refusing to take tenants in receipt of Universal Credit, due to concerns over potential non-payment.

- Further predicted reforms include non-payment of Housing Benefit for young people under the age of 25 except in certain circumstances – this has yet to be confirmed but the impact could be substantial

- A number of London boroughs have purchased or rented property in the borough, as a means of accommodating people to whom they owe a duty to house. The impact is that landlords are asking for higher rents which widen the gap between Local Housing Allowance and actual rent. This means fewer properties are available for Thurrock residents.

- Anecdotally, a number of people have been moved into the borough with complex needs which are not being supported and there has been no pass over of services – this requires further investigation
- Debt and poor money management is a key factor to homelessness with rent and mortgage arrears as one of the top four reasons

4. Reasons for Recommendation

The Council has a duty to consult with organisations whose work can help to prevent homelessness and/or meet the needs of homeless people and to ensure they are involved in the strategy

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

An initial review of current homelessness in Thurrock has been undertaken over the past 3 months, including:

- Consultations meetings with staff and partners
- An online survey of recent service users
- A detailed analysis of the statistical evidence base
- A review of current policy, legislation and the socio-economic climate
- A review of the service working practices following a peer review in November for the Gold Standard
- Reports have been presented to the Children's, Adults and Housing DMTs

A second consultation period will start at the end of May 2015 – this will include further meetings with partners

An online public survey will be made available via the Councils public consultation portal

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

As part of the consultation a full impact assessment of proposed actions will be undertaken.

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**

Management Accountant

The Local Authority holds statutory duties under the Housing Act 1996 (as amended by the Homelessness act 2002) which have financial implications – especially around the provision of temporary accommodation.

The strategy will outline actions for minimalizing temporary accommodation and thereby reducing costs to the Council.

7.2 **Legal**

Implications verified by: **Dawn Pelle**

Adult Care Lawyer

The Homelessness act 2002, s1 (3) requires a Local Authority to review homelessness in its area and to produce a strategy. Section 1(4) requires that the strategy is reviewed and updated at least every 5 years

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Community Development Officer

A full impact assessment will be conducted as part of the consultation process to assess the impact of future actions on equality groups.

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

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):

9. Appendices to the report

- Appendix 1 – Draft Review of Homelessness in Thurrock
- Appendix 2 – Draft Homelessness Prevention Action plan

Report Author:

Dawn Shepherd
Housing Strategy manager
Housing, Business Development

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Thurrock Homelessness Prevention

Strategy Review

May/June 2015

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Thurrock Homelessness Prevention Strategy Review - 2015

1. Background

Legal background

Section 1 of the Homelessness Act 2002 places a duty on local authorities to formulate a homelessness strategy by carrying out a homelessness review for the district.
Section 2 of the Homelessness Act 2002 prescribes the considerations that local authorities should undertake in conducting a review of homelessness and the purpose of the review in terms of informing a future homelessness strategy.

The Homelessness Act 2002 determines that local authorities must formulate and publish a homelessness strategy based on the results of that review – the life of the strategy should be no more than 5 years, and when the strategy expires or is due for expiry, the authority must publish a new homelessness strategy.

There is a further duty on local authorities to keep the strategy under review – and they may modify it from time to time – however, any modifications must be published and before adoption of a homelessness strategy, or prior to modifying an existing strategy, the authority must carry out consultation.

In formulating or modifying a homelessness strategy, under section 153 of the Localism Act 2011, a local housing authority in England must also have regard to—

(a) Its current allocation scheme under section 166A of the Housing Act 1996
(b) Its current tenancy strategy under section 150 of the Localism Act 2011

Local background

Thurrock Council last reviewed its homelessness strategy in 2009 and implemented a new strategy in 2010.

In line with the legislative requirements and in view of the many changes over the past 5 years, including welfare reform, a new strategy is now required.

2. Consultation

In February and March 2015 an initial consultation was undertaken to review current homelessness. Meetings were held to receive feedback and those taking part included partner agencies, frontline housing staff and Council staff from other directorates. Three questions were asked:

- What are the issues & biggest challenges?
- Existing services & provision – what works well & where are the gaps?
- Identifying key areas for change / action points

Feedback from the groups can be broadly summarised into the following areas:

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Private Landlords	• Provision of incentives for landlords working with the Council • Improve working relationships with landlords • Consider use of private landlords outside of the Borough where appropriate
Finances	• Increase education & training on money management, budgeting and debt management • Provision of dedicated and specialised welfare advice for people across all tenures • Investigate options to increase Local Housing Allowance levels to meet higher market rents • Increase joint working over Discretionary Housing payments • Enable use of the homelessness prevention fund to include more creative options to prevent homelessness • Address welfare reforms in a more pro-active manner
Housing Supply	• Increase the supply of accommodation for single people and those with no priority need including young people under 25 • Increase the supply of supported accommodation – particularly for people with complex/dual needs • Increase the number of alternative housing options for working households on a low income e.g. shared ownership schemes • Investigate options for direct access hostel accommodation – possibly for the sub region
Education & Mediation	• Offer school programmes to educate on homeless prevention & money management as part of their curriculum from year 7 • De- incentivise homeless applications through use of the allocations scheme to prioritise those who remain at home with family • Increase the use of mediation services to enabling people to remain in their current homes e.g. between landlord & tenant, Parent & child
Partnerships	• Improve working relationships through better understanding of roles and responsibilities • Agree clearly defined working practices and robust service level agreements and protocols between partners • Strive for the earlier identification of vulnerable people • Agree pathways into housing for clients • Increase joint professionals working groups
Regional Working	• Arrange and monitor working agreements with London and regional boroughs particularly around moving people across boroughs and ensuring adequate support is in place • Joint working with other boroughs to minimise competition for private landlords

Tenancy Sustainment	• Increase resources for helping people to sustain tenancies – both Private and Social • Maximise the length of private sector tenancies to prevent the AST "revolving door" • Raise awareness of the implications of losing a social housing tenancy and be proactive in offering lessons in tenancy management • Robustly implement new Council introductory tenancy processes and intervene at an early stage to prevent evictions
Customer Service	• Make improvements to the online housing options assessment (HED) • Improve signposting and the customer service experience • Explore options for a one stop shop for housing to incorporate all tenures and options
Health & Wellbeing	• Ensure temporary accommodation is used for only minimal periods and that residents are still linked into medical services e.g. GPs/health visitors • Temporary accommodation should have appropriate facilities to meet basic needs e.g. cooking & laundry facilities, access to public transport • Ensure people have access to other services such as alcohol and drug support, debt advice and counselling services • Improved hospital discharge procedures and provision of adapted accommodation including temporary accommodation • Expand use of the mental health forum

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In addition to the meetings above, an 8 week online survey was also undertaken. Around 850 recent service users were contacted and invited to take part and 116 (14%) responded. Key points and actions can be broadly identified as follows:

Results from Service Users survey	Actions Required
• 66% expected the Council to rehouse them • 85% felt that expectations were not fulfilled	Need to better manage the expectations of service users before and after they approach for advice and assistance
Around 30-45% of those surveyed felt that staff never • Listened to their problems • Understood them • Offered helpful advice	This matter will need to be addressed through training and monitoring. NB. Caution should be given that those presenting unfavourable information to the service users can often be seen as unwelcoming and impolite.
Approximately 50% of service users stated they were not given a Housing Officers name and contact details In addition, 60% stated they were not given any written information to take away with them 55% claimed they did not know what would happen once the application had been made	Need to improve initial contact between service users and front line officers and to ensure that every service user receives written advice along with contact details for the case officer
90% felt that the council did not stay in regular contact with them regarding their housing circumstances 96% of those responding felt that the council did not stay in touch with them during their stay in temporary accommodation and provide them with support.	Need to improve communication between service users and front line officers throughout the assessment process and whilst in temporary accommodation
Over 80% felt that the advice and information they were given was unhelpful for their housing problem 72% of those responding felt that the Allocation Policy was not explained to them clearly 86%, of those responding felt that although accommodation was not offered they were still not given good advice and guidance	Need to improve the standard of information and advice provided Need to ensure that advice given is relevant to the service users specific situation

3. Statistical Background

A) Thurrock Population
B) Migration in and out of Thurrock
C) Housing Stock and tenures
D) Thurrock Housing market
E) Thurrock Privately rented market
F) Thurrock Social housing
G) Homelessness
H) Homeless Prevention & Relief
I) Rough Sleeping
J) Temporary Accommodation

A) Thurrock Population

Population:

At the 2011 census the population of Thurrock was recorded at just under 160,000

The population is predicted to grow by 5.2% over the next 5 years, which is not unexpected due to Thurrock being an area of regeneration – see A1

However, it is the 65+ age group that is anticipated to increase the most with an increase of over 13% on its 2011 level

A1 – Age comparison and predicted levels of population

	Current (at 2012)	Predicted (at 2017)	Increase	increase
0 to 19	42,700	44,800	2,100	4.92%
20 to 29	20,700	21,000	300	1.45%
30 to 44	36,300	36,400	100	0.28%
45 to 64	38,600	41,600	3,000	7.77%
65+	21,200	24,000	2,800	13.21%
Total	159,500	167,800	8,300	5.20%

Source: 2012 based ONS sub-national population projections

Ethnicity & Language

Thurrock has become increasingly diverse in the past 10 years; Black and Black British residents have replaced Asian and Asian British as the second largest group, with an increase of 6.65%, whilst white groups have reduced by over 9% - see A2

1.14% of the Thurrock population cannot speak English well or at all. This is higher than the neighbouring boroughs and the East of England see A3

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Actions:

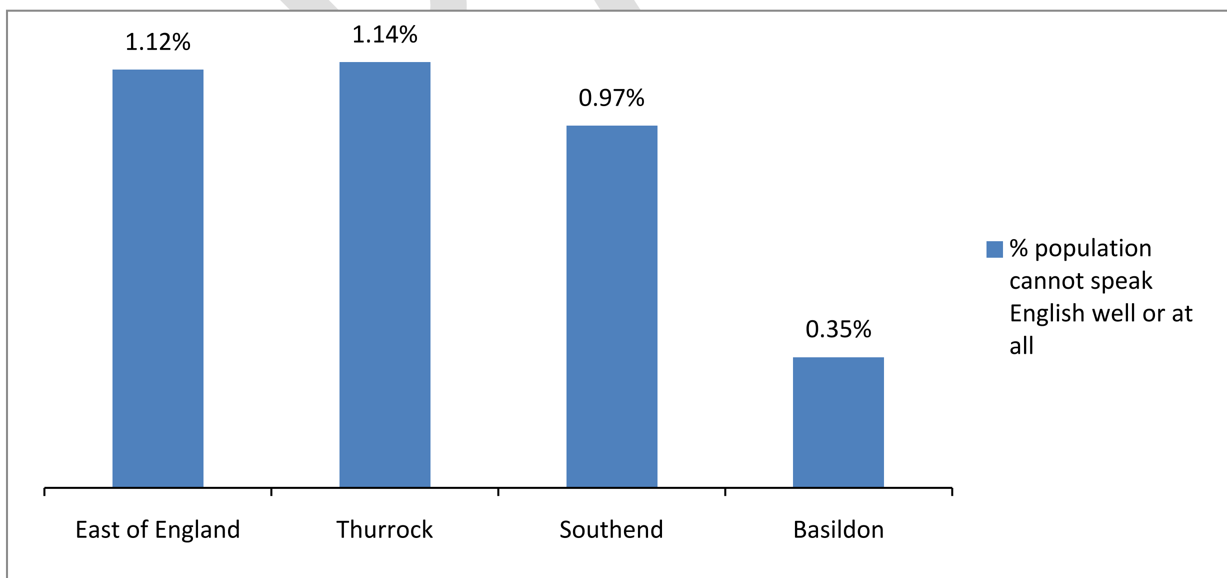
- Complete an equality impact assessment on the new strategy to monitor for adverse impacts on ethnic groups
- Continue to collect data on ethnicity of homeless households and monitor for any deviance from local data
- Ensure there are means of communication available for non-English speakers e.g. translations on web pages & application forms, translators available at interviews
- Encourage minority groups to be represented on Homelessness forums and during consultations

A2 – Ethnicity Comparison

	2001		2011		Change
White	136,399	95.30%	135,429	85.87%	-9.43%
Mixed	1,319	0.92%	3,099	1.97%	1.05%
Asian or Asian British	3,405	2.38%	5,927	3.76%	1.38%
Black or Black British	1,659	1.16%	12,323	7.81%	6.65%
Other Ethnic Group	346	0.24%	927	0.59%	0.35%

Source: ONS Census data 2011

A3 – English speaking



Source: ONS Census data 2011

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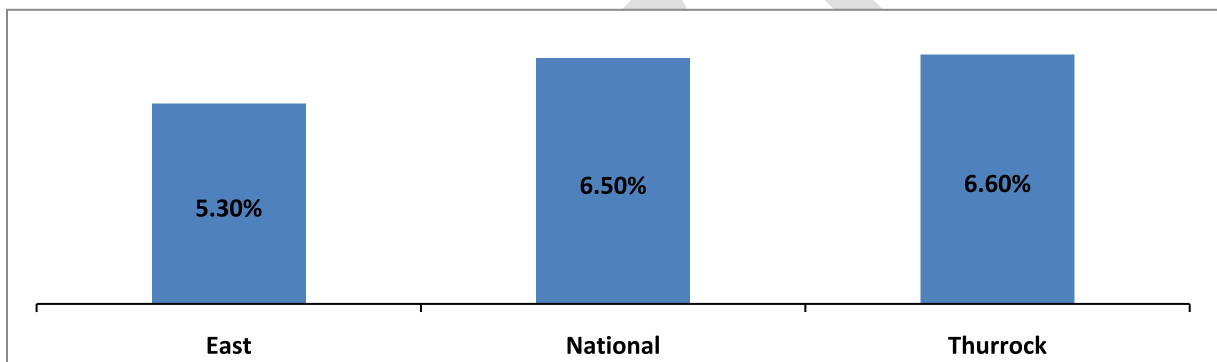
Unemployment:

Thurrock has a slightly higher level of unemployment compared to the regional and national picture – see A4

Actions:

- Ensure housing options incorporate employment advice and signposting
- Work in partnership with the Jobcentre to ensure access to skills training and employment services

A4 – Unemployment levels

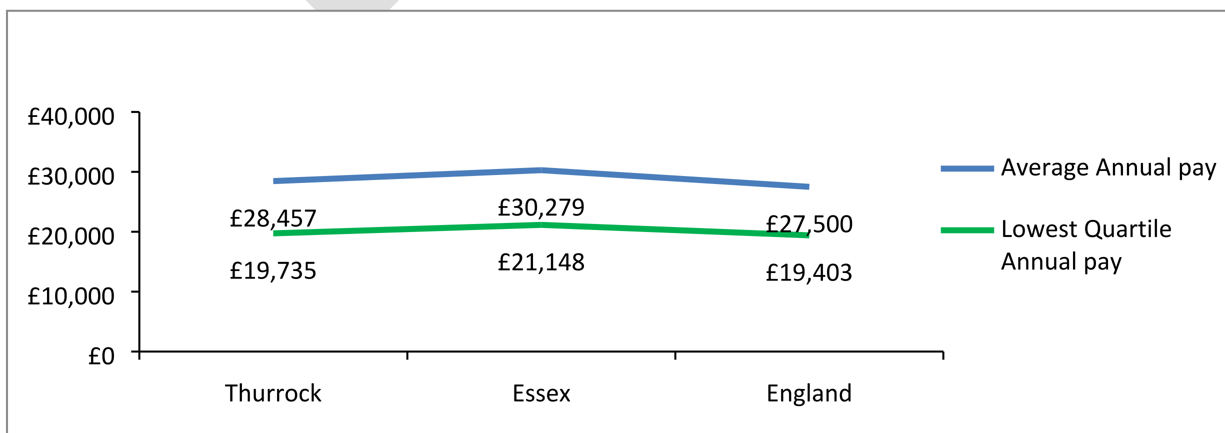


Source: ONS Census data 2011

Pay levels

Thurrock has slightly lower pay levels than Essex but is marginally higher than national figures – see A5

A5 – Pay levels



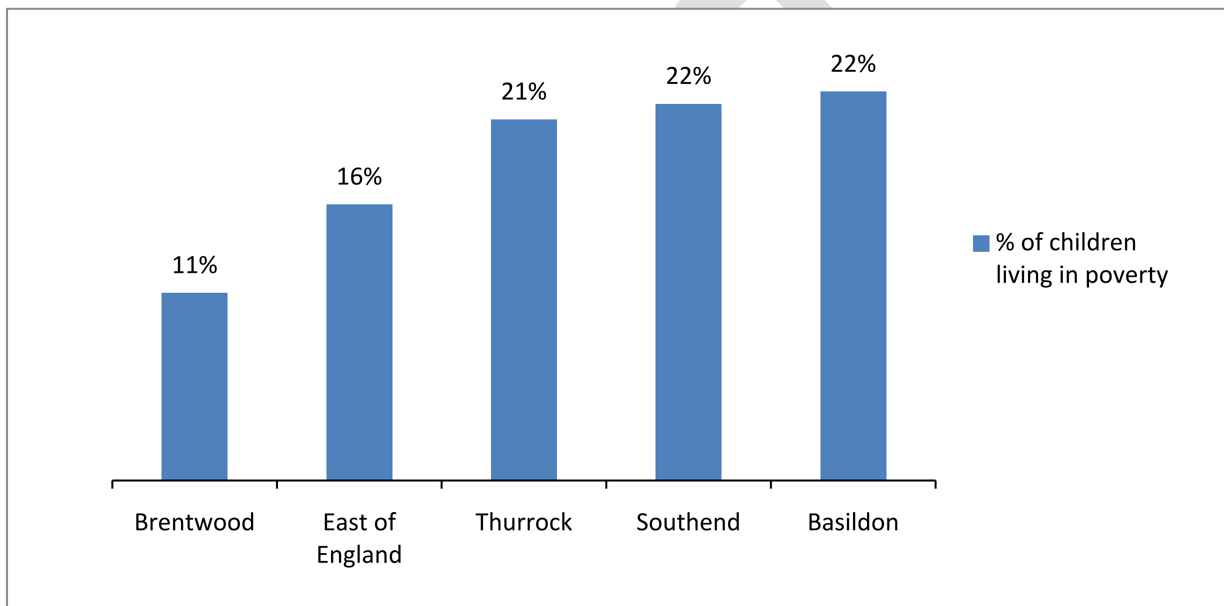
Source: Annual Survey of Hours and Earnings (2014)

Child Poverty

A6 shows the percentage of children in households where the income is less than 60% of the median income

Thurrock is higher than the East of England and the neighbouring borough of Brentwood and only slightly lower than its other neighbours Basildon and Southend

A6 – Child poverty levels



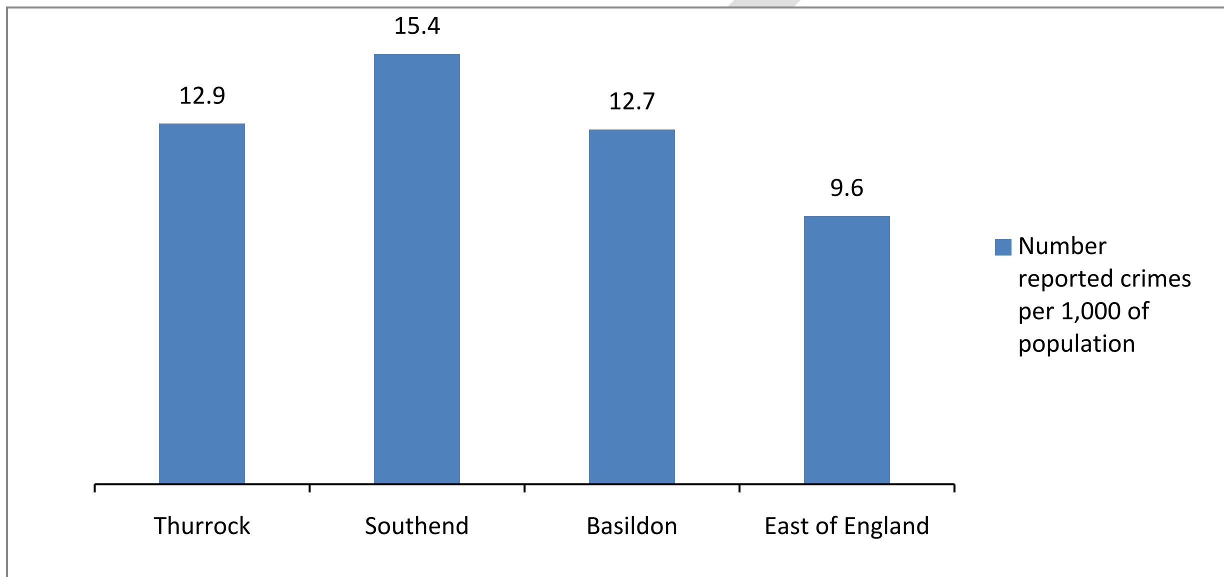
Source: Public Health England 2012

Crime levels

The borough has a higher level of reported violent crimes than the east of England as a whole but is lower than Southend and similar to Basildon - see A7

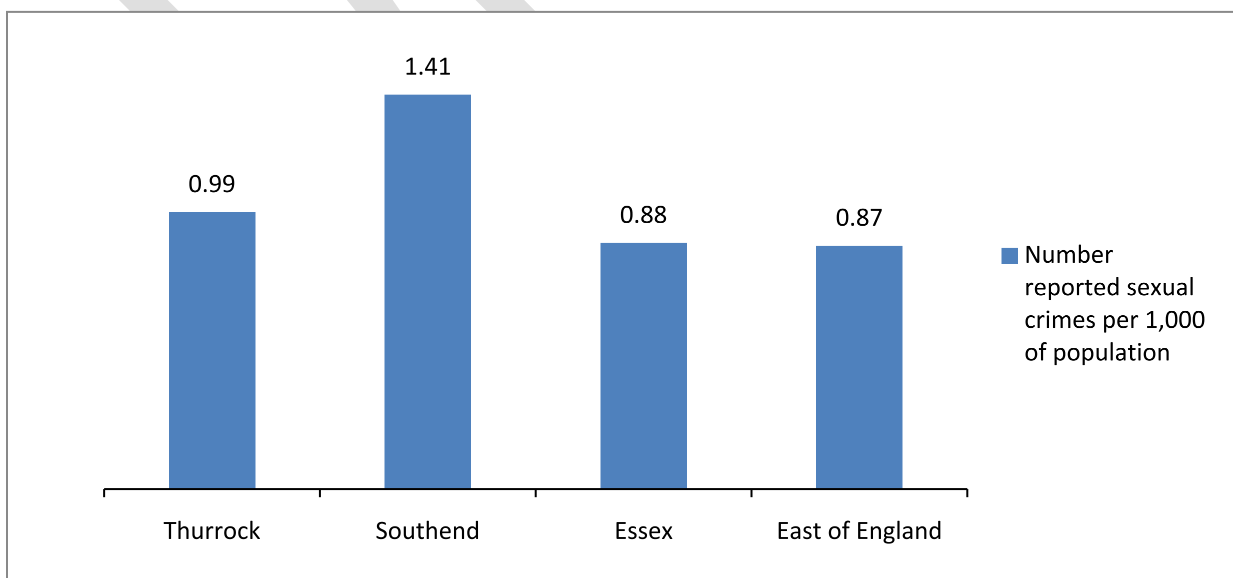
The picture is similar for sexual offences – see A8

A7 – Reported violent crimes and offences against a person



Source: Public Health England

A8 - Reported sexual offences



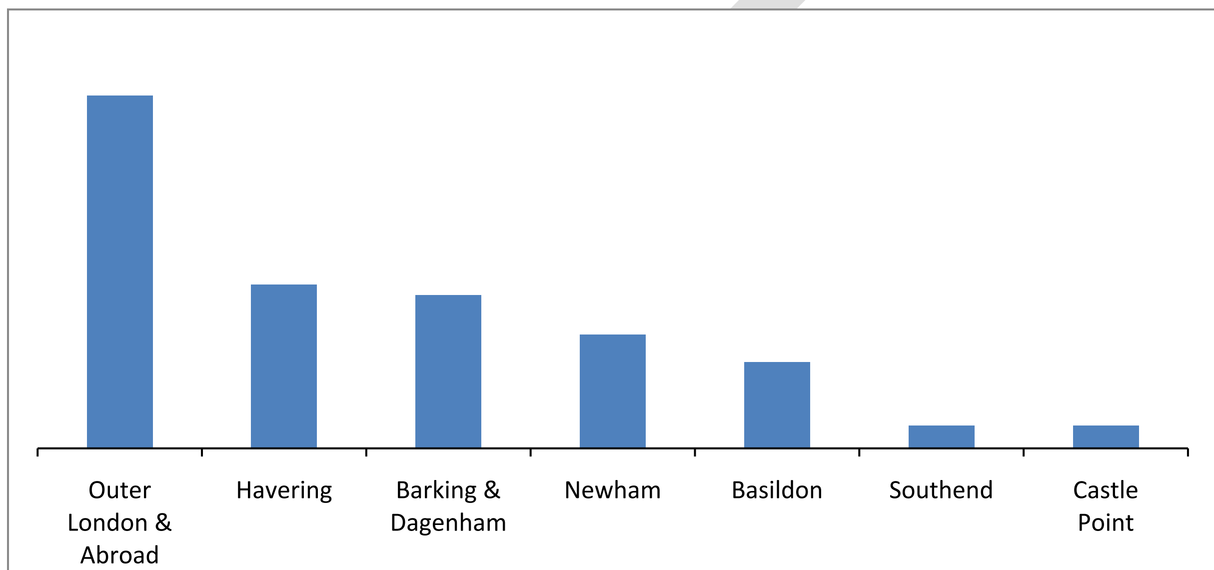
Source: Public Health England

B) Thurrock Migration

The 2011 census collected data on where people had migrated from and to and showed a net migration into Thurrock. It does not however show reasons why they have migrated.

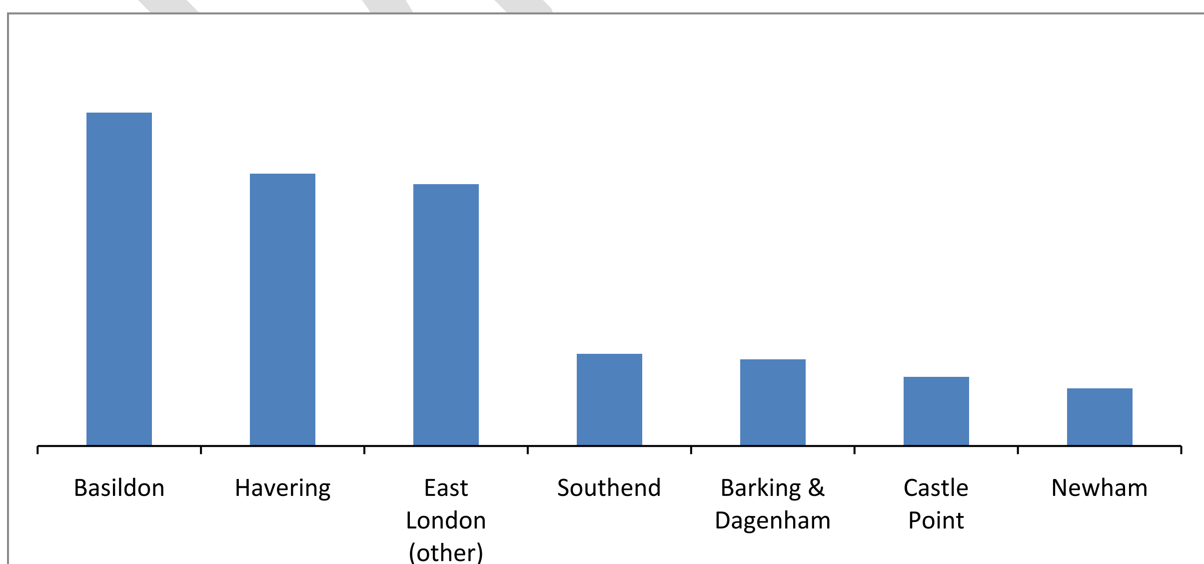
See B1 and B2

B1- Migration into Thurrock - Borough migrated from



Source: ONS Census data 2011

B2 – Migration out of Thurrock - Borough migrated to



Source: ONS Census data 2011

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Out of borough placements in Thurrock:

London Boroughs:

A number of London boroughs are discharging their rehousing duty into Thurrock following greater freedoms introduced by the localism Act 2011 and a cap on benefits which makes local rents less affordable

Private properties in Thurrock are being used for accommodating London households in temporary accommodation either to meet the interim housing duty or whilst awaiting discharge of the full rehousing duty

Recent Examples:

- Havering Council are offering Landlords financial incentives for private sector leasing schemes and assured short hold tenancies
- Westminster Council has purchased 25 properties in the borough
- Newham Council placed at least 16 households in the borough in 2014
- Tower Hamlets advertised a £2,500 payment for one-bedroom properties to landlords agreeing to let to council-vetted tenants for two years and a £4,000 lump sum for homes with two or more bedrooms
- Westminster Council pay up to £4,000 as an incentive to Landlords

Under s 208 Housing Act 1996 local authorities who secure accommodation for applicants outside of their district, should give notice to the local housing authority in whose district the accommodation is situated. However, this is not consistently being followed and a recent Freedom of Information request by Inside Housing showed that at least 8,000 households have been placed outside of London in the past 2 years with no notification to the receiving local authority. (Source: Inside Housing 23rd April 2015)

Anecdotally, local partner agencies such as CMHT and Sericc have reported cases of households either being placed in inappropriate accommodation or in need of support services due to complex needs, with no referrals being made to the support services required

These events raise the following issues:

- London boroughs can offer greater incentives to private landlords due to greater resources
- There are concerns that this has led to an increase in notices on assured short hold tenancies in Thurrock (highest cause of homelessness)
- Because landlords can sign up to “better offers” with London boroughs, this reduces the private rented stock available to Thurrock residents

Neighbouring Boroughs

Basildon Council is also offering incentives to landlords in Thurrock and the surrounding areas with an offer of £1,000 for 12-month tenancies and £1,500 for 24-month tenancies.

Other neighbouring boroughs (within the sub-region) have indicated that they will not be offering incentives to Thurrock landlords in the near future

Actions:

- Investigate improved landlord incentives for Thurrock clients
- Improve working relationships with landlords
- Set up information sharing agreements with London boroughs, particularly regarding households with complex needs such as mental health, medical, specialist schooling and ASB issues
- Remind London boroughs of their duty to notify Local Authorities when placing people out of borough under s208 Housing Act 1996
- Work with other boroughs in the sub region to consider cross boundary joint partnerships to incentivise landlords

C) Thurrock housing stock

Tenures:

More than two thirds of the housing stock in Thurrock is owner occupied. This is slightly lower than figures for the region but slightly higher than the national figure. See C1 & C2

Nationally there has been a s50% increase in the private rented sector over the past 10 years, but the increase in Thurrock is more than twice this figures at 130%

Subsequently, the Private rented sector is now at similar levels to the social rented sector see C1 and C3

Reasons for the increase could include:

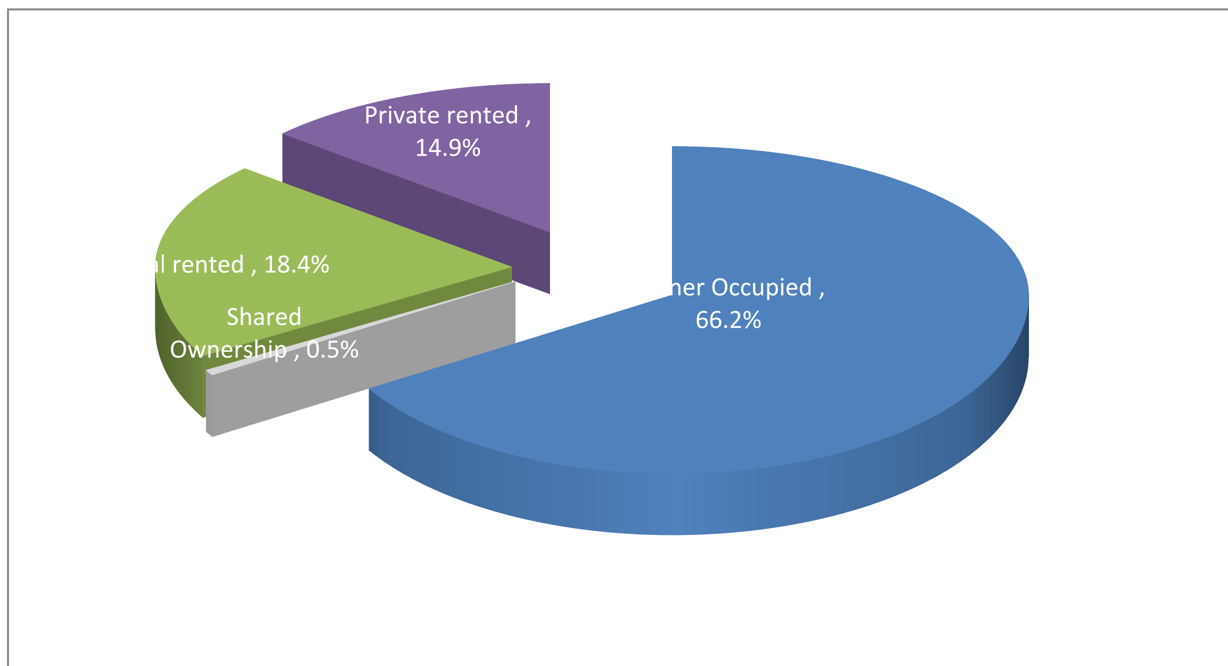
- reduced house prices over the past 10 years
- low interest rates for landlords buying to let
- an increase in the buy to let market

The increase provides greater opportunities for Thurrock residents to privately rent but also provides more opportunities for migration into the borough

Actions

- Explore incentives to landlords to offer accommodation to potentially homeless households
- Explore options for longer tenancies with private landlords
- Explore the long term impacts of welfare reforms on privately rented households – particularly Universal Credit - and any mitigations
- Consider improved monitoring of private landlords – e.g. Landlord licensing schemes

C1 – Tenure comparisons - Thurrock



Source: Source: ONS Census data 2011

C2 – National tenure comparisons

National Comparison				
	Thurrock	Essex	East	England
Tenure	%	%	%	%
Owner Occupied	66.2	71.4	67.6	63.4
Shared Ownership	0.5	0.6	0.7	0.8
Social rented	18.4	14.3	15.7	17.7
Private rented	14.9	13.8	16.0	18.1

Source: ONS Census data 2011

C3 – Changes to tenure

Thurrock Housing Tenure Profile – Comparison 2001 & 2011			
Tenure	2001	2011	Change
Owner Occupied with Mortgage	47.9%	40.7%	-7.2%
Owner Occupied no Mortgage	23.8%	25.5%	1.7%
Shared Ownership	0.3%	0.5%	0.2%
Social rented	20.4%	18.4%	-2.0%
Private rented	6.5%	14.9%	8.4%

Source: ONS Census data 2001 and 2011

Property type and size

Houses represent over 77% of all housing - See C4

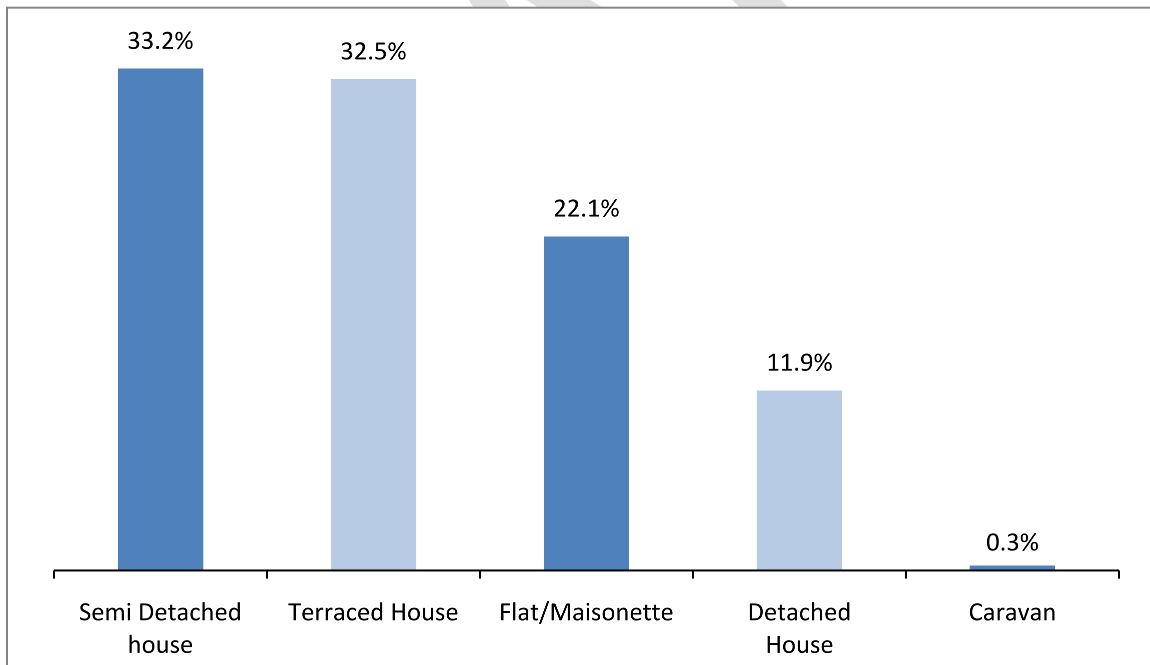
Over 75% of all housing stock is 2 or 3 bedroomed whilst just less than 12% is bedsit or 1 bedroomed. See C5

In comparison - 49% of households only require 1 bedroom (Singles and couples with no children). See C6

Action

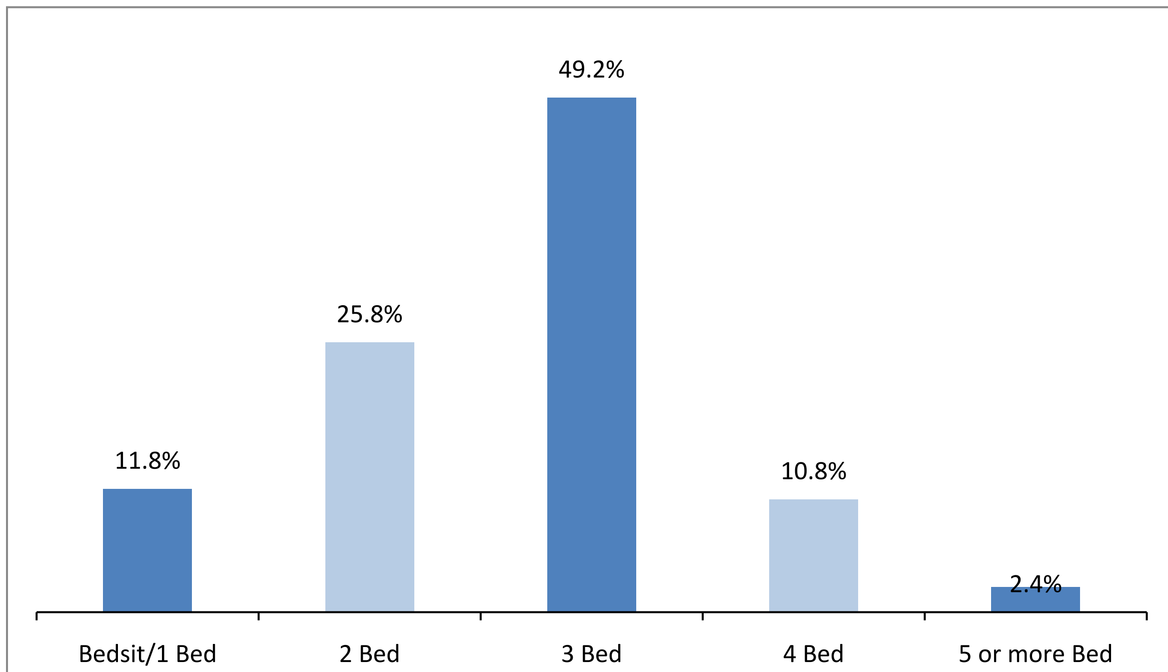
- Influence future house building and planning to achieve an increase in smaller properties (I bedroom or studio) to meet smaller household needs

C4 – Comparison by property type (all tenures)



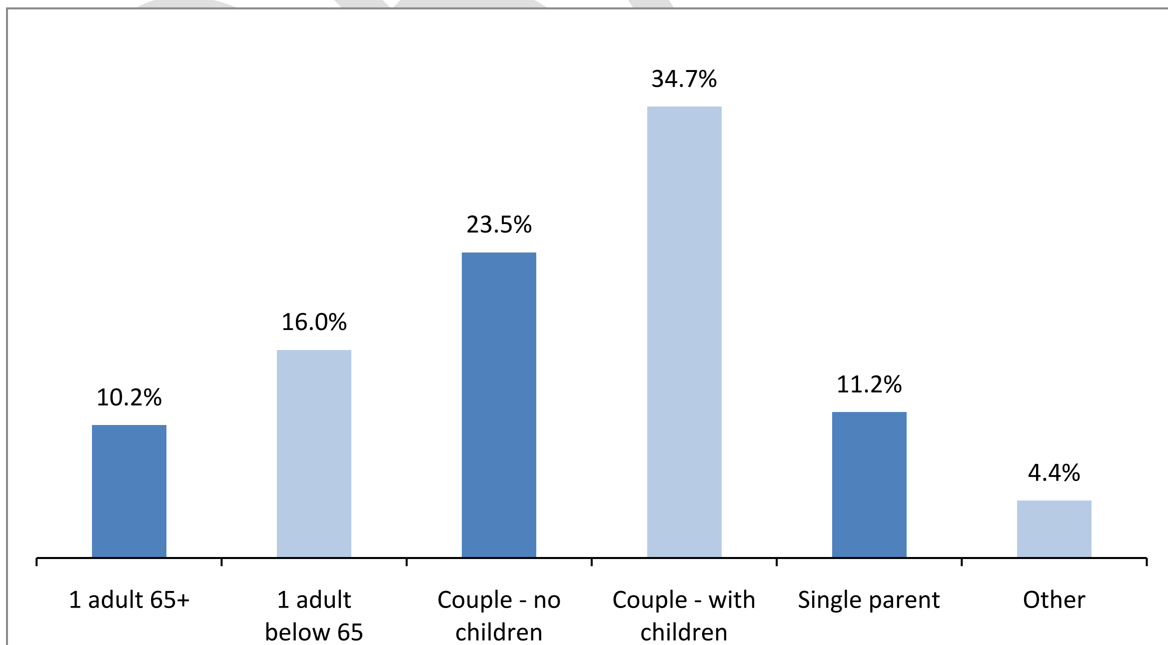
Source: ONS Census data 2011

C5 – Comparison by bedroom numbers (all tenures)



Source: ONS Census data 2011

C6 – Comparison by household make up (all tenures)



Source: ONS Census data 2011

Occupation levels

5.4% of households are over occupied (over crowded) in comparison to 64.3% who are under-occupied in the borough. See C7

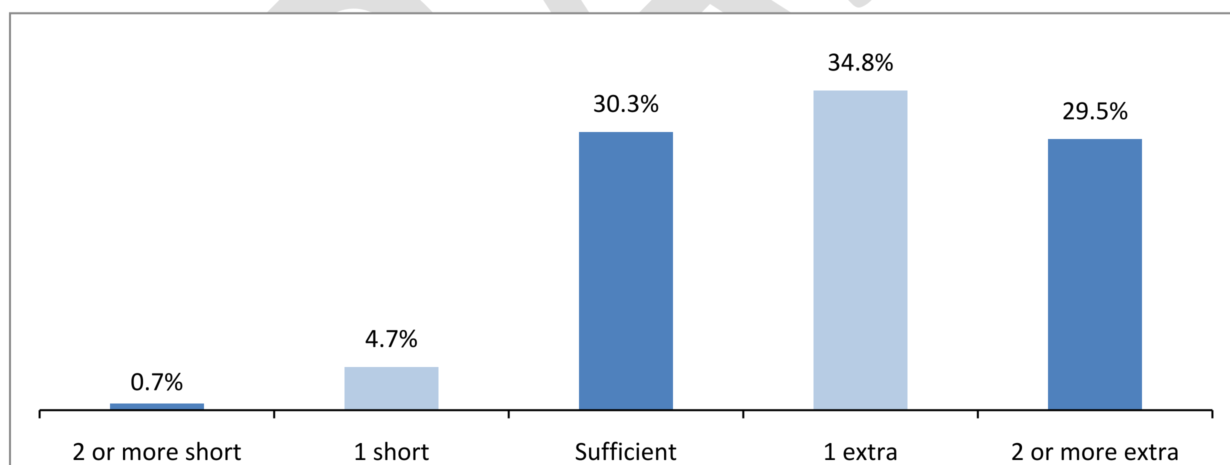
The greatest overcrowding is in the private rented sector at 11.9% see C8
This is almost double the national average at 6% (Source: Survey of English Housing 2013/14)

14.8% of socially rented stock is under occupied by 2 or more bedrooms – although lower than the owned stock, this represents around 1700 properties i.e. 36% of the total 3 and 4 bedroomed social stock

Actions

- Tackle under occupation across all tenure types
- Consider options for older under-occupiers (all tenures) to move into sheltered accommodation and rent out their properties to private renters
- Explore options for encouraging under-occupiers to take in lodgers

C7 – Comparison of overcrowding with under occupation (all tenures)
The chart shows the number of bedrooms short or extra to that required by the household size



Source: ONS Census data 2011

C8 – Overcrowding & under occupation by tenure comparison

Variance by tenure type	Under occupied (2 or more bedrooms)	Over occupied
Owned or shared ownership	37.6%	3.3%
Social rent	14.8%	7.8%
Private rented	10.9%	11.9%
All Stock	29.5%	5.4%

Source: ONS Census data 2011

D) Thurrock Home Ownership

Purchasing property

The average house price in Thurrock is £167,608 - lower than both the national and local figures. Average house prices in Thurrock have increased in the past 6 years by 12.35%. This also represents a lower increase than both Essex and the national figures – see D1 and D2

A survey in January 2015 identified lowest and average prices of properties available for sale - see D3

In order to outright purchase the cheapest property in Thurrock at that time, an annual income of at least £26,300 and a substantial deposit is required – see D3 and D4

Shared ownership allows households on a lower income the option to purchase a share of a property – lowest income requirement is £15,420 plus a deposit of £5,500 – see D5

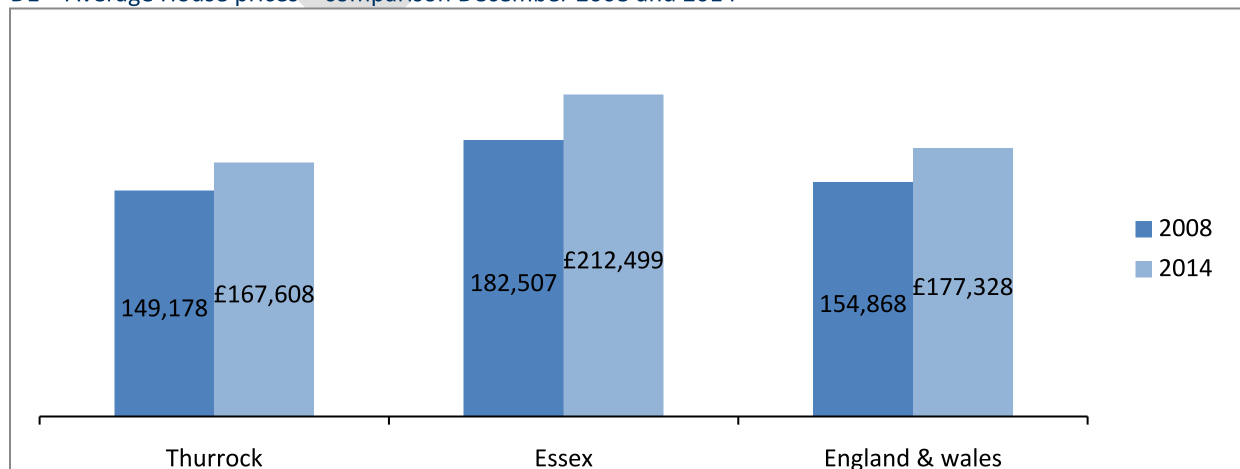
Help to Buy was introduced by the Government in 2013. Buyers can purchase a property with a 5% deposit and take out an interest free loan or mortgage guarantee for 20% of the purchase price.

Between April 2013 to March 2015, 47,018 properties were purchased across the country using the scheme of which 956 were purchased in Thurrock.

Actions

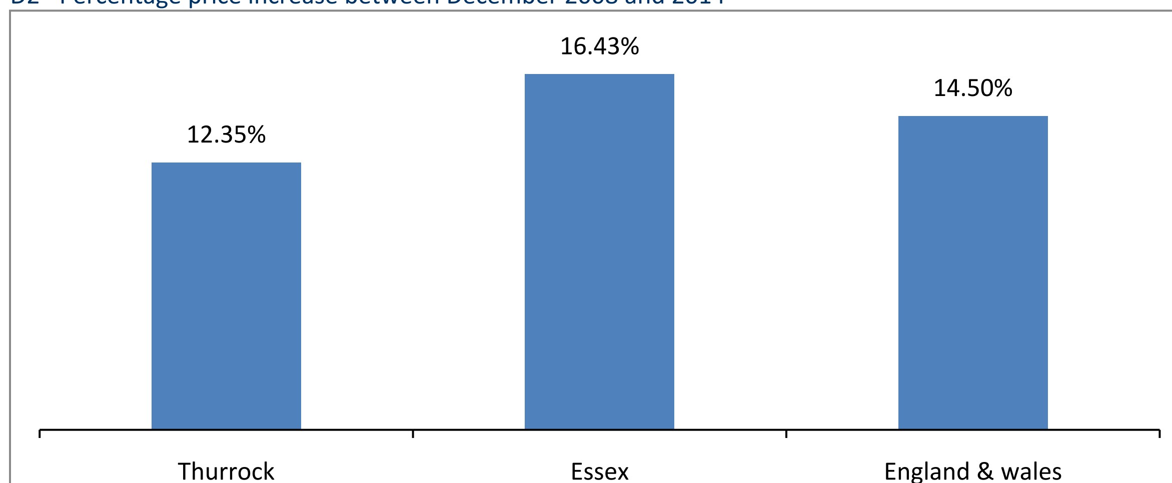
- Ensure all purchasing options are considered as a prevention to homelessness when providing advice and assistance through the housing options team
- Influence future housing supply to include more affordable purchasing options such as shared ownership

D1 – Average House prices – comparison December 2008 and 2014



Source: Land Registry

D2– Percentage price increase between December 2008 and 2014



Source: Land Registry

D3 – Property prices at January 2015

House Prices - sales	Lowest prices	Average prices
1 bed flat	£97,000	£115,313
2 bed flat	£124,995	£150,309
2 bed house	£178,995	£196,054
3 bed house	£199,995	£228,351

Source: DCA House price survey January 2015

D4 – Income Thresholds required to purchase

	Single income	Dual income	Deposit required 20%
1 bed flat	£26,300	£31,800	£19,400
2 bed flat	£33,900	£40,900	£24,999
2 bed house	£48,600	£58,600	£35,799
3 bed house	£54,300	£65,500	£39,999

Source: DCA House price survey January 2015

D4 – examples of shared ownership properties at January 2015

	Price	Share price	Share %	Rent	Mortgage	Total	Deposit needed	Income required
1 bed flat	£110,000	£55,000	50%	£126	£298	£424	£5,500	£15,420
2 bed flat	£150,000	£52,500	35%	£223	£284	£507	£5,250	£18,473
2 bed house	£200,000	£60,000	30%	£321	£325	£646	£6,000	£23,491
3 bed house	£230,000	£69,000	30%	£369	£374	£743	£6,900	£27,018

Source: share to buy

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E) Thurrock Private Rental market

Privately renting property

The cost of privately renting is influenced by supply and demand and there are no restraints on how much rent a landlord can charge or achieve – see E1

Income threshold requirements are shown in E2

Average and lower quartile pay levels are shown in E3

Therefore whilst someone on an average income in Thurrock could afford to privately rent a one bedroom flat, if they are on an income in the lowest quartile or require a larger property, private rental becomes unaffordable without financial assistance (benefits). Affordability is determined as monthly housing costs not exceeding 33% of gross income

Housing Benefit provision for private tenants is available through Local Housing Allowance (LHA) and is means tested

LHA rates relate to the area in which the claim is made. These areas are called Broad Rental Market Areas (BRMA). A BRMA is where a person could reasonably be expected to live taking into account access to facilities and services

LHA rates for Thurrock at January 2015 are shown at E4

LHA rates are based on the lowest third of private market rents being paid in the BRMA; these can differ widely from advertised rents. Valuation Office Agency (VOA) Rent Officers collect the rental information from letting agents, landlords and tenants.

The BMRA for Thurrock includes Basildon, Brentwood, Billericay and Wickford

There is a shortfall between the Local Housing Allowance for Thurrock and actual rents in the borough – both average and lowest quartile – see E5

The impact of London Boroughs moving people into the area and paying London rates and incentives could lead to even higher market rents. In addition, the increasing population will also lead to higher demand. Therefore the shortfall could worsen over time

Actions

- Improve working partnerships with Housing benefits
- Investigate possible influences on LHA rates

E1– Cost of private rentals

	Average monthly rental (Jan 2015)	Lowest quartile monthly rental (Jan 2015)	Local monthly Housing Allowance (Jan 2015)
1 bed flat	£650	£595	£550
2 bed flat	£849	£750	£692
2 bed house	£885	£850	£692
3 bed house	£1,055	£950	£808

Source: Thurrock Housing Needs Assessment 2015 and GOV.

E2 - Income required

Income thresholds required for private rental	
1 bed flat	£28,600
2 bed flat	£36,000
2 bed house	£40,800
3 bed house	£45,600

Source: DCA House price survey January 2015

E3 – Pay levels Thurrock

	Average	Lowest quartile
	£28,457	£19,735

Source: Annual Survey of Hours and Earnings (2014)

E4 – LHA rates Thurrock

	Local monthly Housing Allowance (Jan 2015)
1 bed flat	£550
2 bed flat	£692
2 bed house	£692
3 bed house	£808

Source: Gov.UK

E5 – Shortfall levels

	Monthly shortfall for average rental (Jan 2015)	Monthly shortfall for lowest quartile (Jan 2015)
1 bed flat	£100	£45
2 bed flat	£157	£58
2 bed house	£193	£158
3 bed house	£247	£142

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F) Social Housing

Social Housing stock

Thurrock Council own just over 10,000 properties and Registered Providers have around 1500 properties for social renting in Thurrock. Both are let through the Council's Choice based Lettings scheme Thurrock Choice Homes.

Waiting lists are long but the number of years required to supply full demand varies greatly according to the size of property required – see F1

Almost half of people waiting need a 1 bedroom property and of these almost 30% are aged 25 and under – see F2

Over 25% of people on the waiting list have a need for 2 bedroom properties but the time taken to supply full demand is the highest at more than 11 years.

Only 12.3% need a 3 bedroom property but 3 bedroom relets represent almost 30% of the total, hence the much shorter wait for a 3 bed property

Future building

Thurrock Council has an ambitious building programme with plans to build almost 1300 new affordable homes within the next 5 years, subject to planning etc. – see F3

Actions:

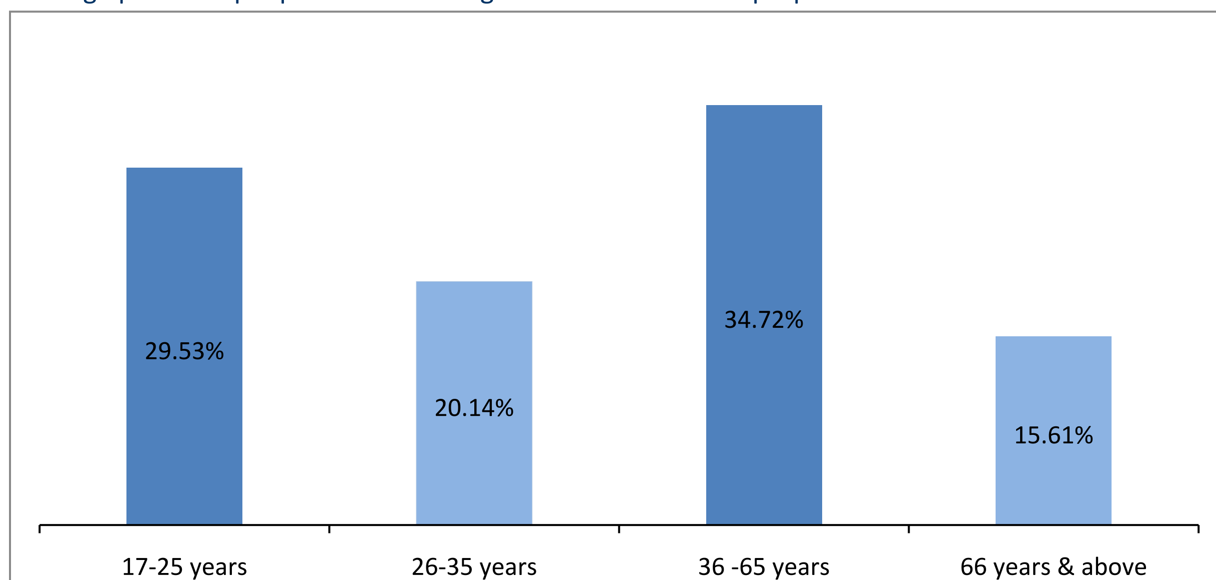
- Manage the expectation of being housed into social housing
- Ensure all housing options are represented in advice given
- Ensure a representative supply of 2 and 3 bedroom properties are included in the building programme

F1 – Council Housing stock

	Council stock	Waiting List (excl transfers)	% of waiting list	Relets in 2014	% of relets	*Years to supply full demand
1 bed	3,109	2,880	49.6%	317	44.1%	9.1
2 bed	2,307	2,066	25.6%	182	25.3%	11.4
3 bed	4,520	715	12.3%	214	29.8%	3.3
4+ bed	204	144	2.5%	6	0.8%	24
Total	10,140	5,805		719		

*Indicates the number of years required to fulfil the demand of current waiting list, through current rate of relets – i.e. takes no account of increases in waiting lists or other demands

F2 – Age profile of people on the waiting list for one bedroom properties



F3 – 5 year Building programme

	Total No. of units to be built	Of which - Affordable Homes	% of Affordable Housing on scheme	No. of units – affordable rented	No. of units – shared ownership/ LCHO
2014-15	709	148	20.9%	97	51
2015-16	305	142	46.6%	126	16
2016-17	635	419	66.0%	293	126
2017-18	1119	533	47.6%	328	205
2018-19	55	55	100.0%	30	25
Total	2823	1297	Av. 45.9%	874	423

The information is based on current planning permissions (April 2015) and the Council's own housing development programme

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G) Thurrock Homelessness

Homelessness data

Data is provided to the DCLG quarterly via the P1E statutory return, and is broken down into:

- The number of people approaching the local authority for advice and assistance
- The numbers of homeless applications subsequently taken (where homelessness could not be prevented or relieved) and decisions made
- The number of people for whom a rehousing duty has been accepted by the Council

Thurrock Council has a Housing solutions team who provide a generic service incorporating housing advice, homeless prevention and homeless applications

Key Points

- The number of people approaching has increased by more than 260% in the past 3 years – see G1

- The ability to prevent homelessness has varied over the past 3 years but averages out at 38% of cases – see G2

- The number of homeless decisions made has also varied over the past 3 years but averages out at 254 decisions per year – see G3

- Of decisions made, just over half result in the full rehousing duty being accepted by Thurrock Council – see G5

- Reasons for homeless can be broken down into five main areas – se G6 and G7
  1. Exclusion (36%)
  2. Termination of an AST (27%)
  3. Violence (17%)
  4. Arrears (8%)

- Lone female parent households with dependent children have consistently been the largest household type – see G8

- Younger households (16 to 44) have also been more predominantly represented - see G9

- The largest reason for priority need has consistently been dependent children and/or pregnancy - see G12

- The 2nd largest reason for priority need is mental illness – see G12

- The ethnic makeup generally mirrors the population of Thurrock and does not identify any specific ethnic group as being over represented - see G10 and G11

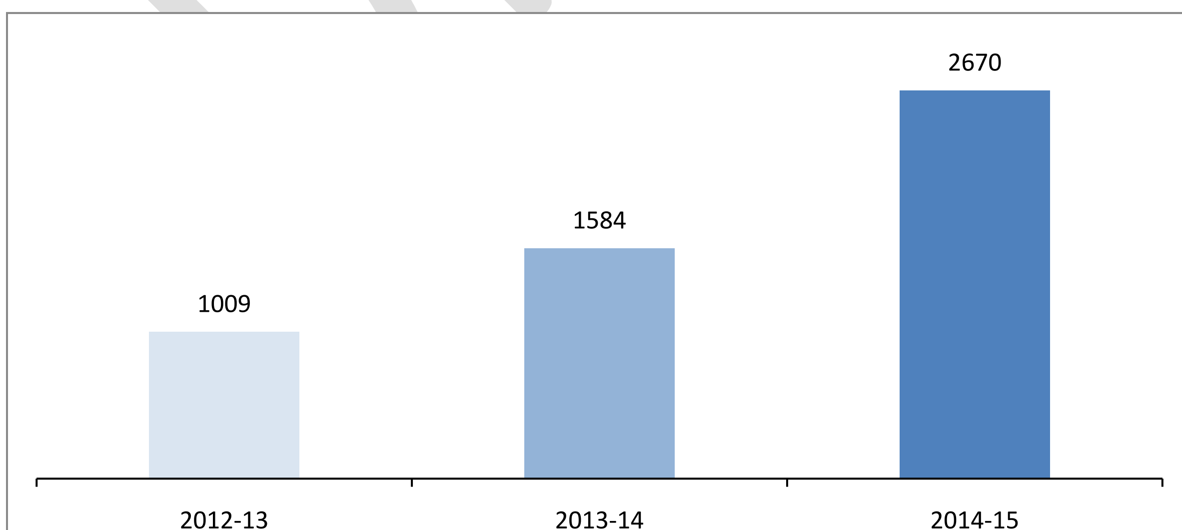
- The number of 16 & 17 year olds for whom a rehousing duty was accepted has decreased dramatically since 2010-11. See G13. This follows the implementation of a Thurrock Council Housing and Children's services protocol

- Council evictions were higher in 2014-15 than at any time in the past 7 years – see G14. The Council implemented a policy of Introductory tenancies for all new non sheltered tenancies from March 2014 in line with its Tenancy Policy. This allows a "trial" tenancy period during which tenants receive greater monitoring (quarterly visits) and more support if required to enable them to manage their tenancies. However, it also allows a mandatory right to possession within the introductory period where tenancies fail.
  It is impossible to determine whether or not the new policy has impacted eviction figures yet but careful monitoring is required

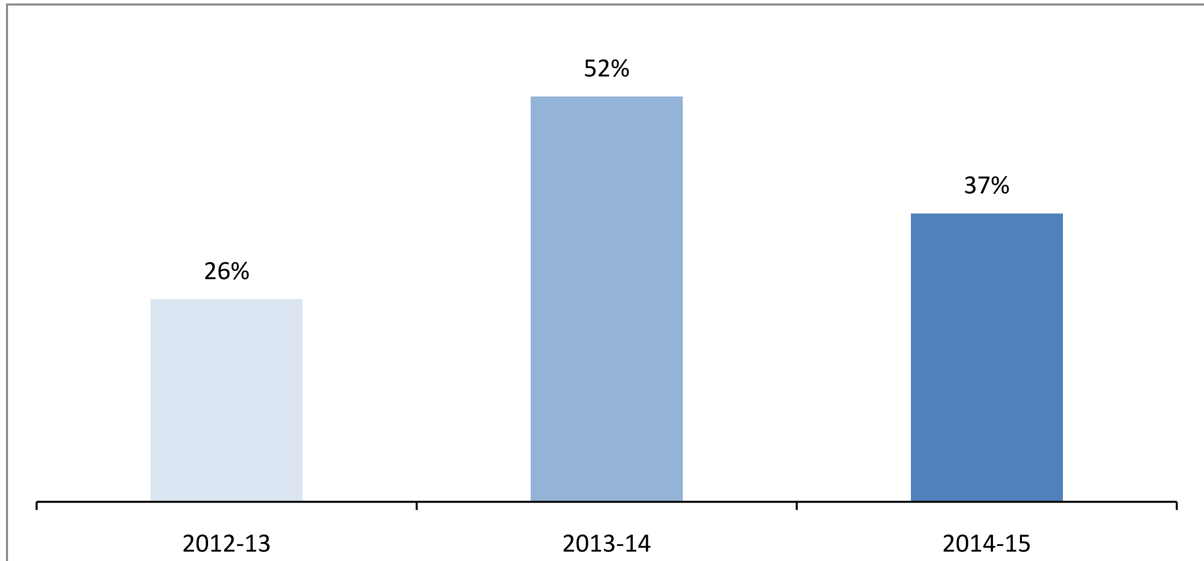
Actions:

- Develop action plans to specifically target the top 4 reasons for homelessness
- Continue to monitor ethnicity against local and national trends to ensure no specific ethnic groups is being adversely impacted
- Monitor Council evictions of Introductory tenancies to determine appropriate levels of support and monitoring
- Consider options for pre-tenancy training for potential tenants

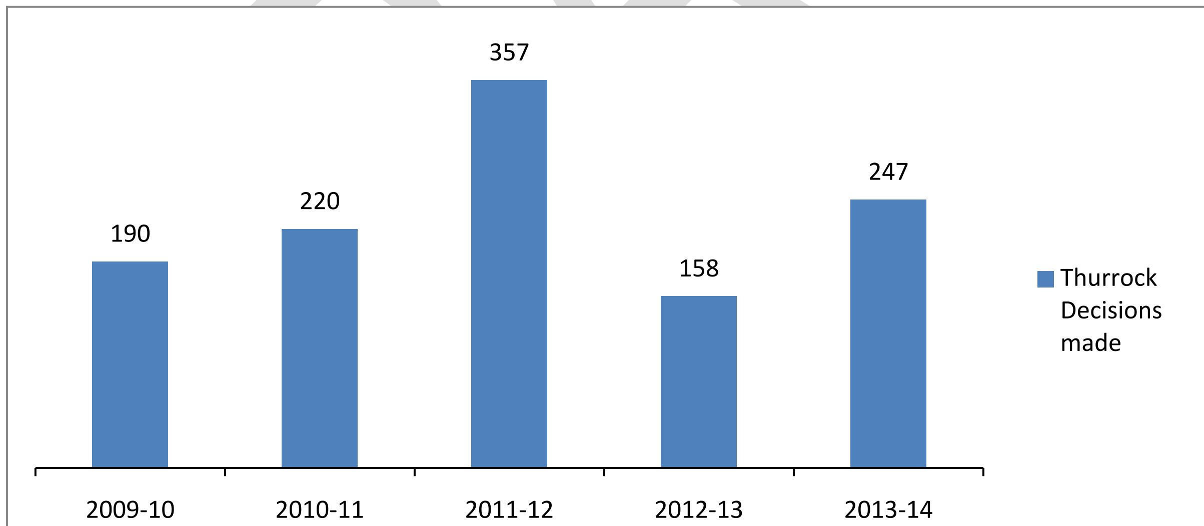
G1 – Number of households approaching for advice & assistance in Thurrock over past 3 years



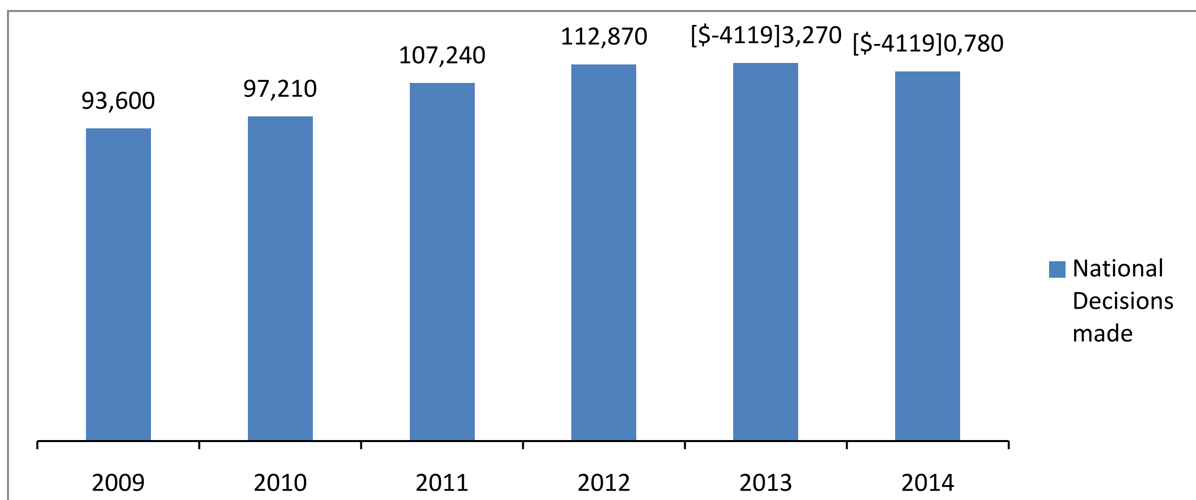
G2 Of these approaches –percentage where homelessness was prevented or relieved



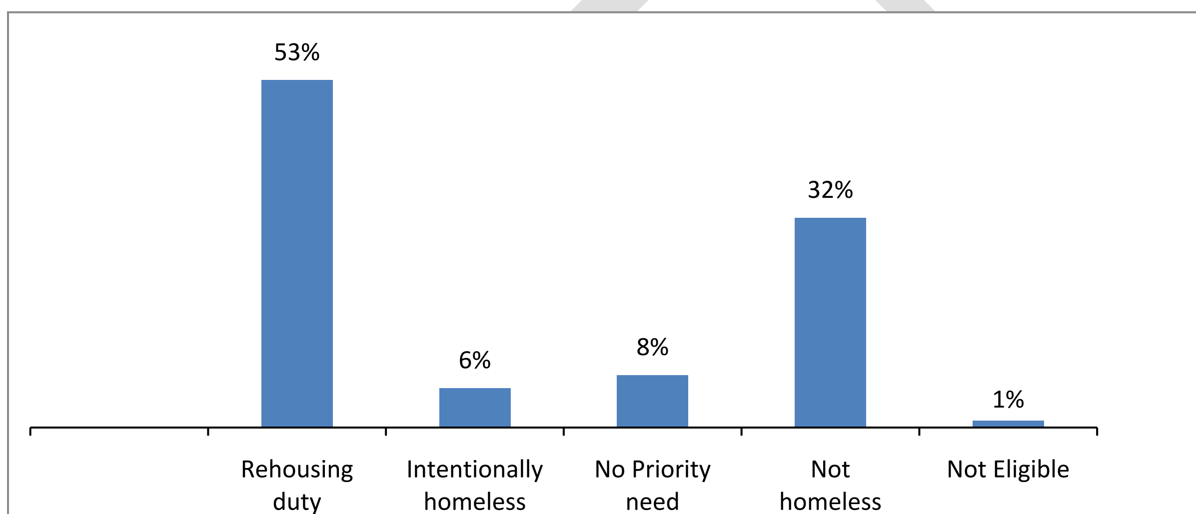
G3 – Number of homeless applications taken & decisions made in Thurrock



G4 – Number of homeless applications taken & decisions made nationally



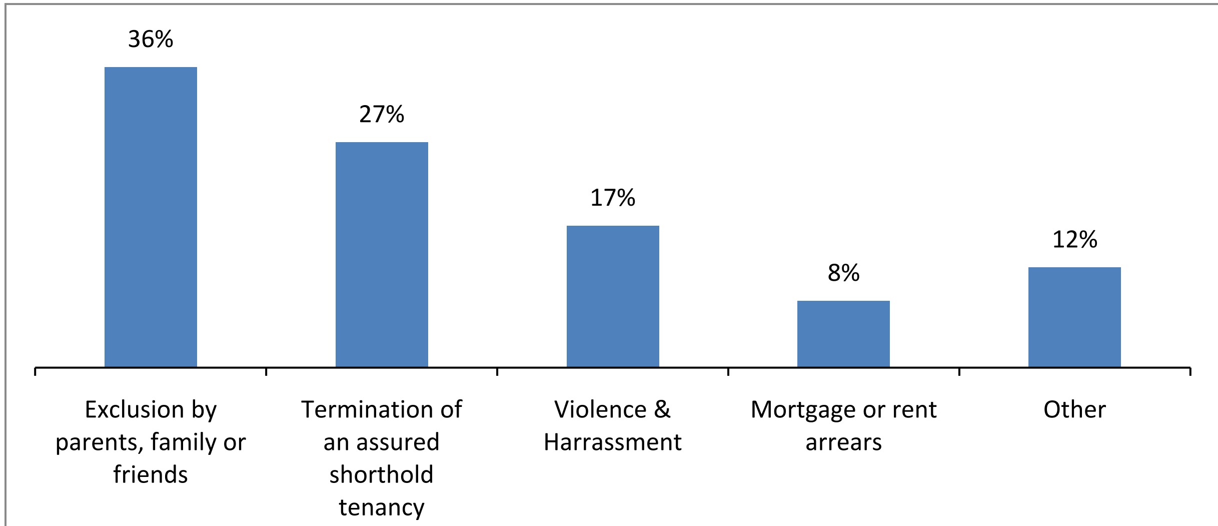
G5 Decisions made in Thurrock as a percentage over past 5 years



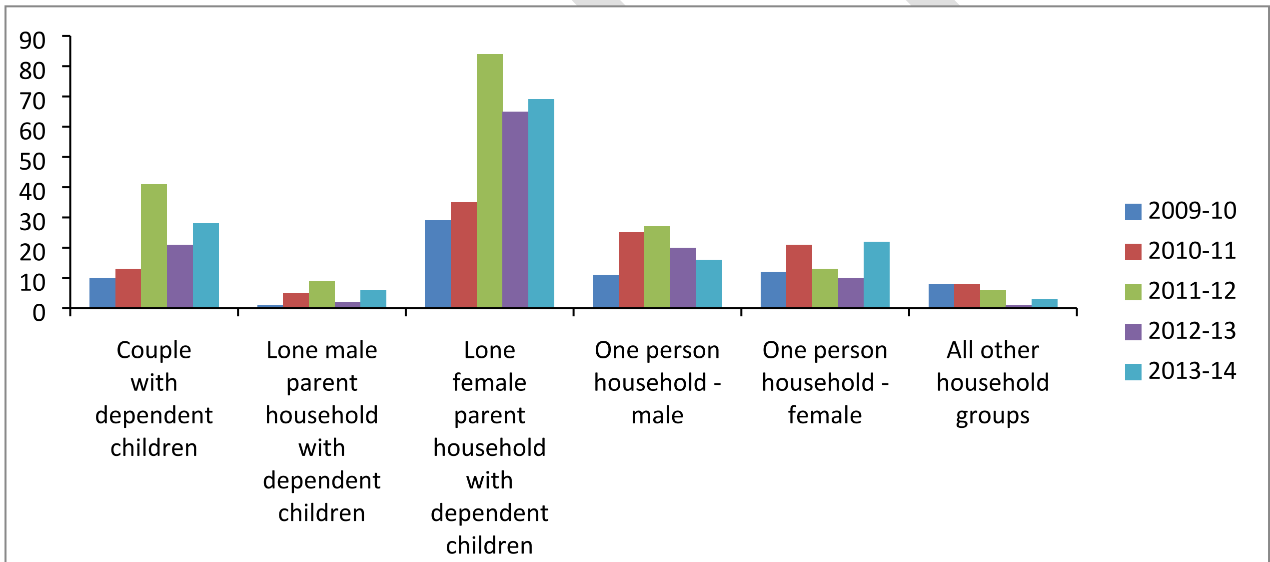
G6 – Top 10 reasons for homelessness in Thurrock for past 5 years (where rehousing duty accepted)

Causes of homelessness (2009 -14)	
Parental exclusion	25.44%
Termination of Assured short hold tenancy	23.67%
Other family or friends exclusion	10.95%
Violent relationship breakdown - partner	9.98%
Non-violent relationship breakdown	6.60%
Other reasons for ending AST	4.03%
Mortgage arrears	3.54%
Other forms of violence	2.74%
Violent relationship breakdown - associated person	2.42%
Rent arrears - Local Authority	2.25%

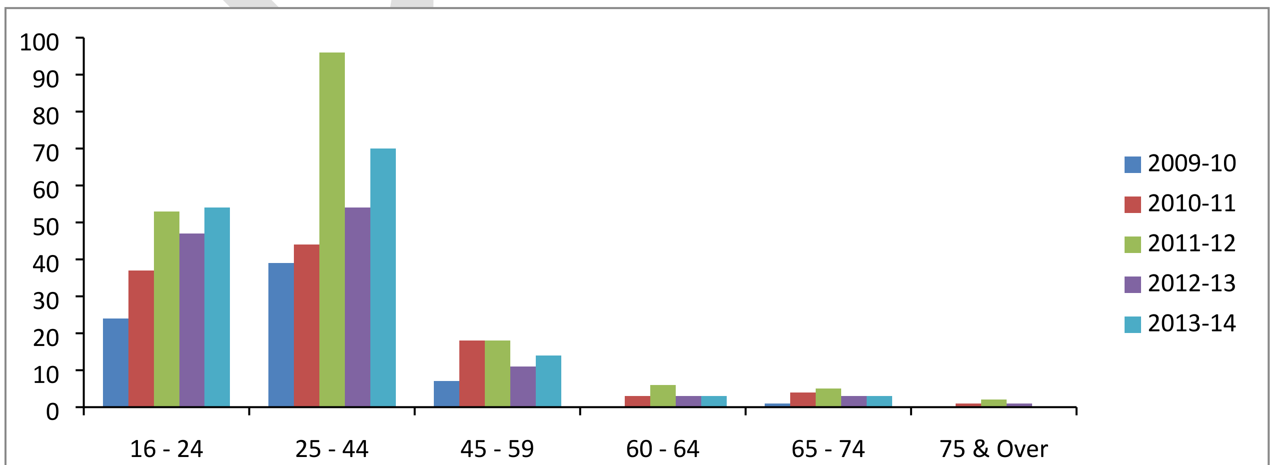
G7 – Homeless reasons by broad areas (where rehousing duty accepted)



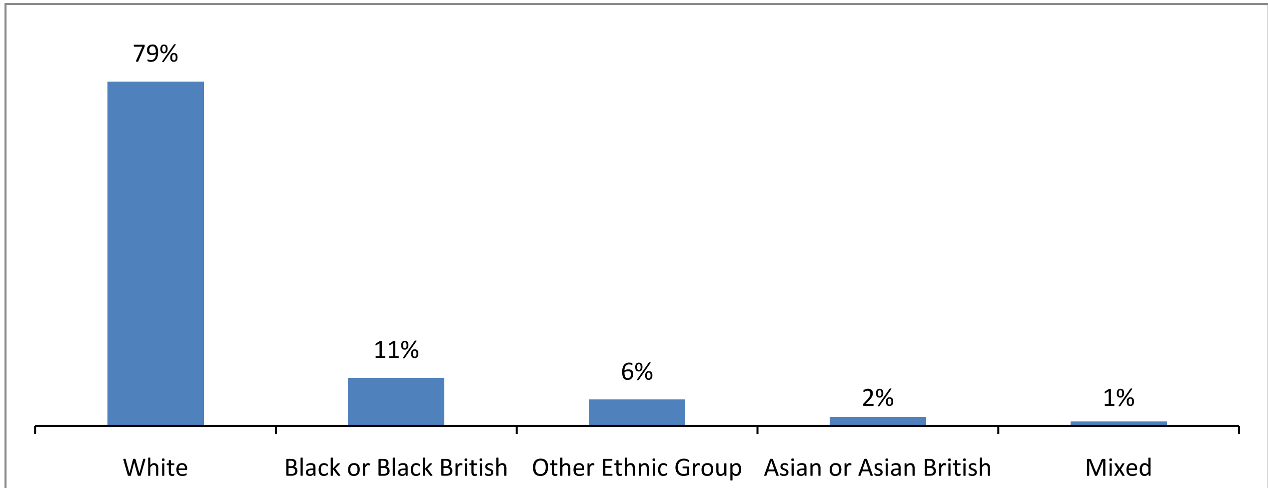
G8 -Household makeup (where rehousing duty accepted)



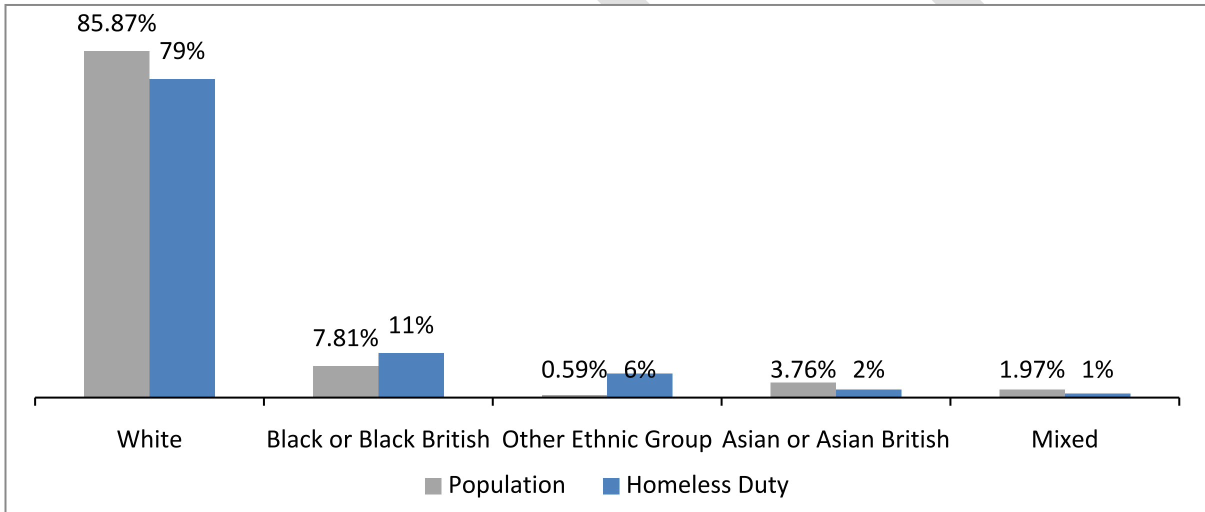
G9 - Household make up by age (where rehousing duty accepted)



G10 – Household make up by Ethnicity for past 5 years (where rehousing duty accepted)



G11 – Comparison of Household ethnicity for homeless cases with the population of Thurrock



Source: ONS Census data 2011 & Thurrock Council data

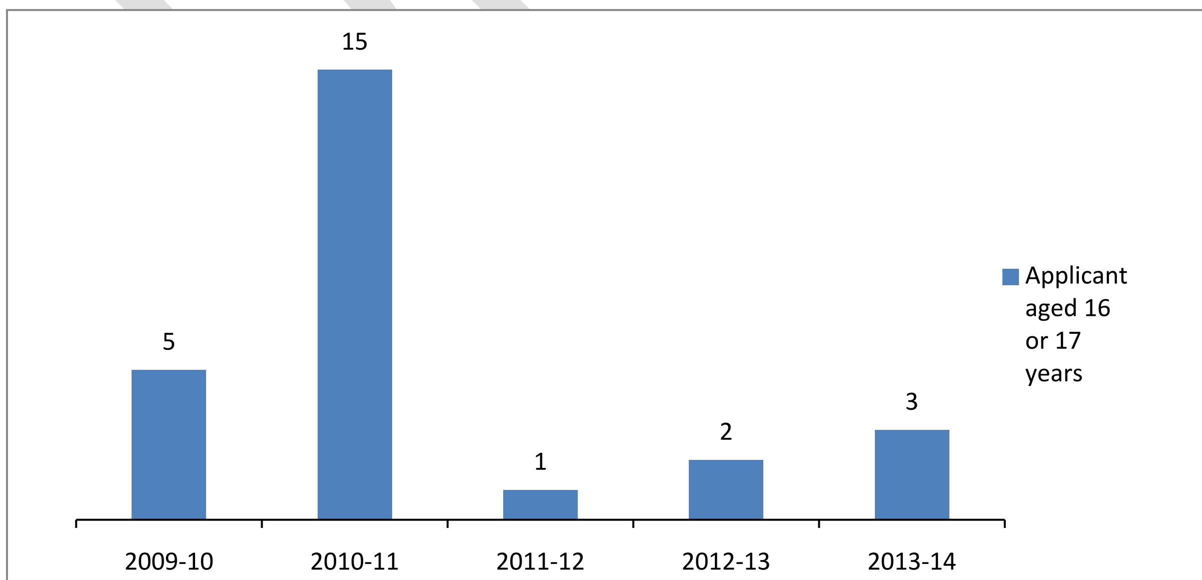
G12 - Household make up by Priority Need (where rehousing duty accepted)

2009-10
2010-11
2011-12
2012-13
2013-14

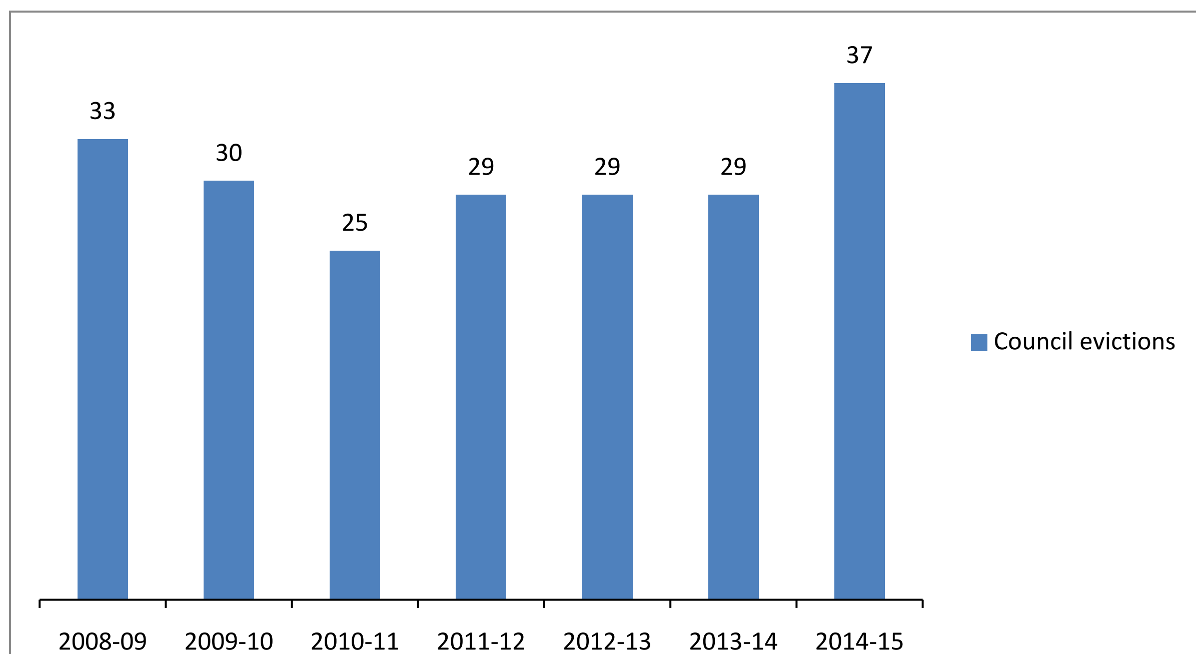
140
120
100
80
60
40
20
0

Emergency
Dependent children and pregnancy
Aged 16 or 17 or formally in care
Old age
Physical disability
Mental illness
Drug /Alcohol dependency
Vulnerable - served in HM forces
Vulnerable - been in custody /on remand
Violence / threats of violence

G13 – Number of 16 & 17 year olds for whom a rehousing duty was accepted



G14 – Number of Council evictions



H) Homelessness Prevention & Relief

Where a person approaches the Council as homeless or potentially homeless but actions taken by the local authority mean that the homelessness does not materialise, then prevention is counted. A prevention is the result of either

i) An actual prevention where an action taken prevents the homelessness from happening – e.g. mediation with the excluder

ii) A relief – where an action to find alternative accommodation for the household prevents the homelessness from happening - e.g. where alternative private rented accommodation is found

Prevention numbers were fairly consistent until 2012-13 but have decreased after that – see H1. Unfortunately, the statistics collected have not been consistently detailed – for example in quarter 4 of 2013-14, of the 120 cases where homelessness was prevented, 100 are described as “other” for the reason prevention was achieved.

Homeless prevention is a primary aim and therefore it is essential to monitor the actions which are successful and those which are not in order to direct future limited resources

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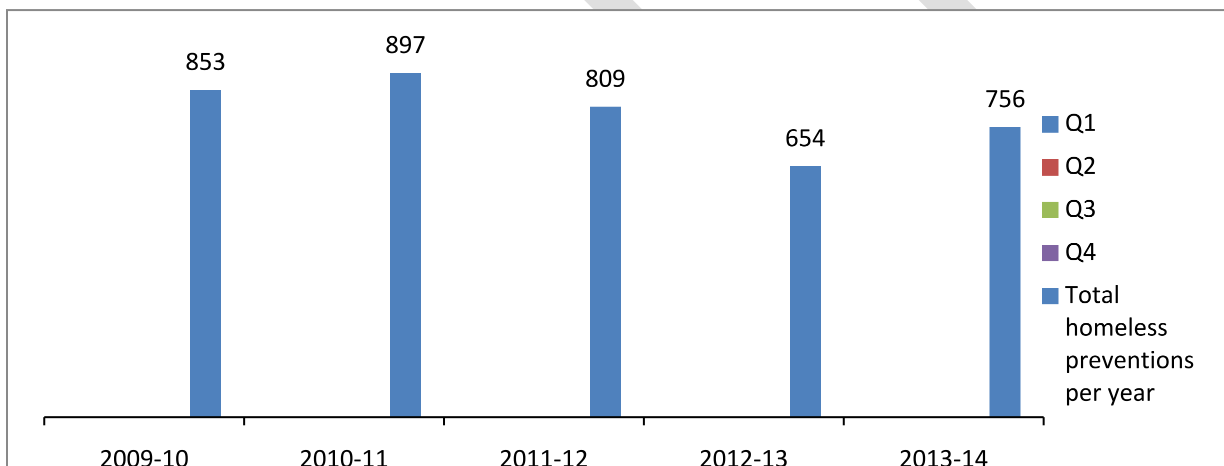
To do this a more detailed picture is required. Data is obtained through an integrated Housing IT system. The Council will be updating its IT system in 2014-15 so it is essential that the new system is configured to capture appropriate data.

Action:

- Ensure statistics collected are more detailed and consistent to enable a better understanding and assist with forward planning
- Ensure staff are trained in how to capture data accurately and that consistent definitions are used
- The new Housing IT system must capture appropriate and accurate data - ensure the correct parameters are set during the implementation programme
- Ensure sufficient expertise within the Housing department to update data requirements if necessary

H1 – total homeless preventions per year



I) Rough Sleepers

Rough sleeper count

Each year (October/November) local authorities report on the number of people sleeping rough in the borough on a specific night. This can be estimated through liaison with appropriate agencies such as the police, or an actual count can be organised.

Thurrock carried out an actual count in 2014 after 4 years of estimations. See I1

Of the ten people identified as meeting the criteria only one was actually sleeping rough on the street. The other nine were sleeping in 2 cars in a service station car park and were thought to be workers staying overnight in cars to prevent accommodation costs, however this could not be verified as the nine people were unwilling to engage.

Outreach & reconnection

In October 2014 Thurrock Council launched a new outreach and reconnection service through a sub-regional contract with St Mungos' Broadway. The key aims of the contract are

(1) providing an outreach and intensive support service, to identify rough sleepers and enable them to access appropriate support such as health and substance misuse
(2) providing assistance to reconnect where appropriate or to access new accommodation

A support worker is allocated to cover Thurrock, Basildon and Brentwood areas and he/she responds to reports of homeless individuals made via the national Street link website, which enables members of the public to report any person they believe is sleeping rough. Referrals are also made direct

The worker will attempt to locate the rough sleeper and support them as required. This involves joint working with the local authority and other partner agencies

Data provided by St Mungos Broadway show that 14 people were referred between the launch of the service and the end of year (Nov 14 to April 2015) - see I2 and I3

Of the 14 people identified 9 were rehoused from the streets – the other 5 refused to engage

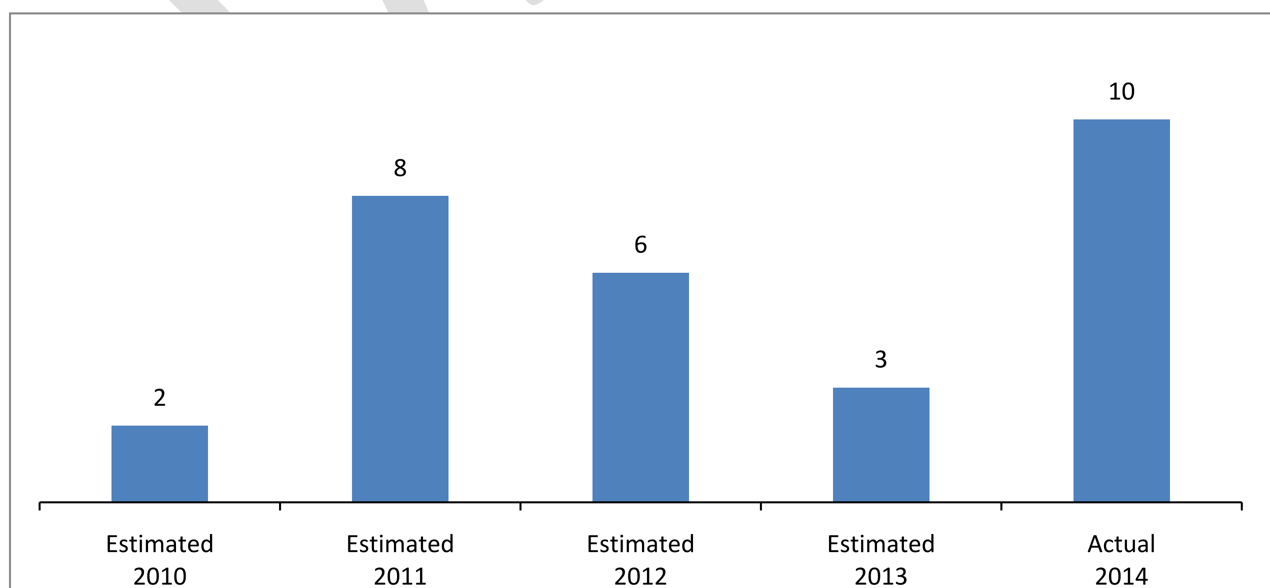
Whilst the data indicates that rough sleeping is not a large problem within the borough the Council is keen to promote the No second Night Out programme instigated by the DCLG – see section 5 below

Thurrock Council does not have a direct access hostel or night shelter and relies on space within other boroughs.

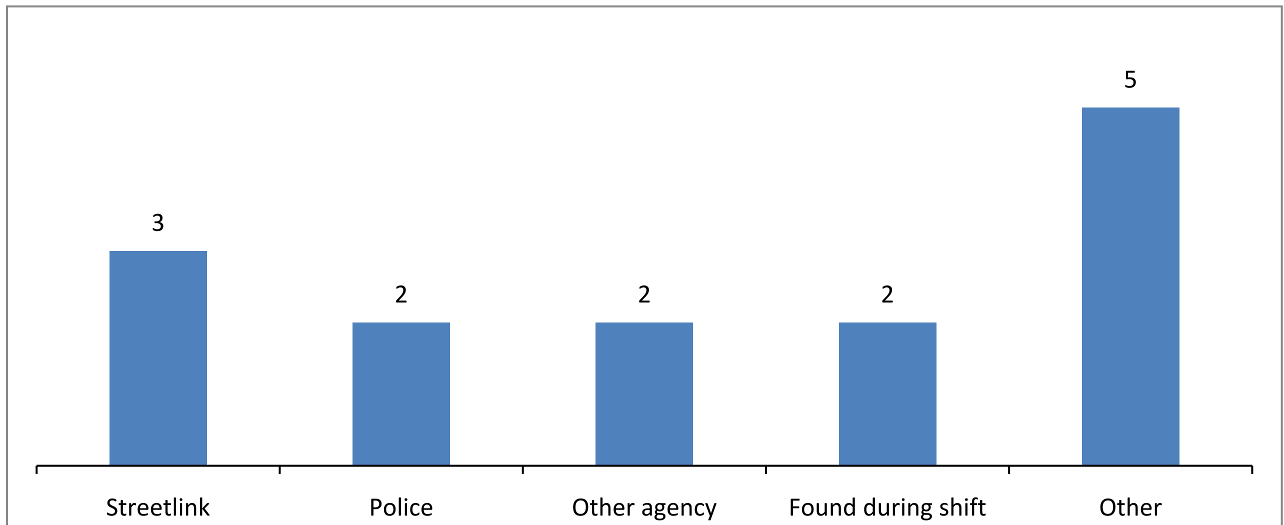
Action:

- Investigate options for non-priority need homeless applicants

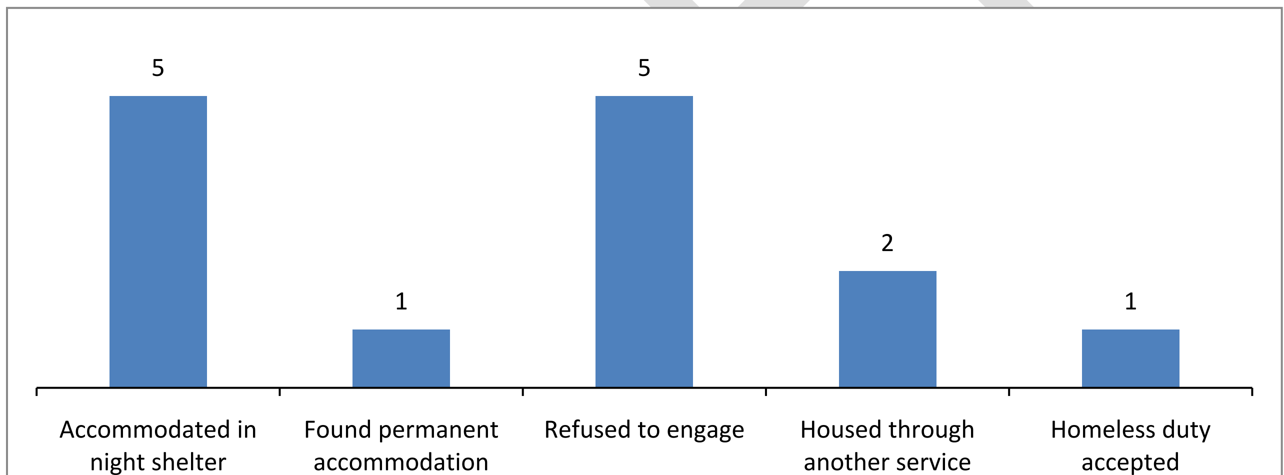
I1 – Rough Sleeper counts in Thurrock for past 5 years



I2 Referrals to St Mungos (Nov 2014 – April 2015)



I3 Outcomes of referrals received by St Mungos (Nov 2014 – April 2015)



J) Temporary Accommodation

Accommodation profile

There is a duty to provide temporary accommodation to applicants where there is reason to believe the applicant is homeless, eligible for assistance and in priority need. The duty continues whilst a homeless assessment is made and may continue until a rehousing duty is discharged

In order to meet this duty Thurrock Council uses the following types of temporary accommodation

- Bed & Breakfast (private establishments)
- Hostel (Charles Street hostel in Grays)
- Self-contained (Private accommodation rented on a nightly basis)
- Furnished lets (Furnished accommodation within the Council's own stock)

Thurrock Council recognises the unsuitability of bed & breakfast (B & B) accommodation for families and young people and is committed to using alternative suitable temporary accommodation

wherever possible

Charles Street hostel provides 29 units of supported accommodation for single people and families and includes 5 rooms for 16 & 17 year olds supported by Children's Services.

The Council acquired a new 18 bed hostel in Clarence Road, Grays which is due to open in May 2015. The accommodation consists of

- 16 single person rooms with en-suite shower rooms and shared kitchens.
- 2 self-contained family units

The accommodation will be managed by a 3rd party who will provide intensive housing management and support services. Four of the 16 single rooms will be provided to Children's Services as move on accommodation for care leavers and unaccompanied asylum seekers with a higher package of support

Brooke House in Grays accommodated 10 people, with referrals through a multi-disciplinary panel and was used to provide accommodation for single people who do not meet the priority need threshold. Due to funding cuts Brooke House closed on 31st March 2015 and there is subsequently no hostel or night shelter provision in the borough

During the recent Gold Standard peer review the standard of temporary accommodation was recognised as high with an overall score of 86%

Statistics
The number of households being provided with temporary accommodation has increased by 13.5% over the past 2 years –see J1

However the average time spent in the accommodation has decreased by more than 50% – see J2

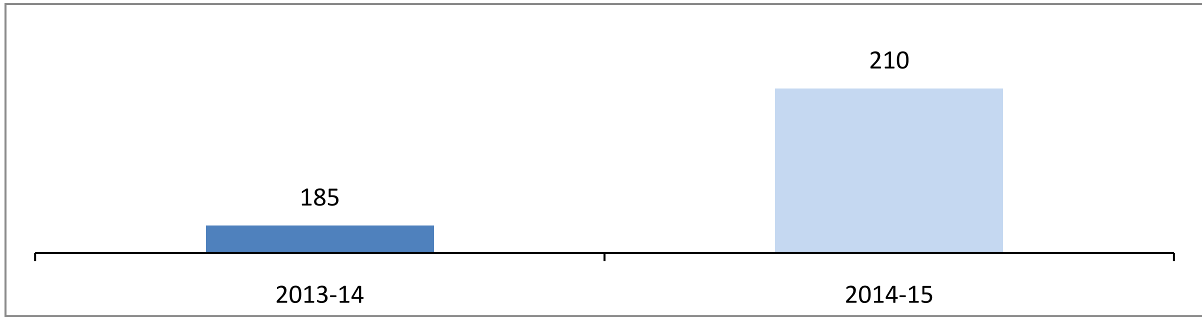
Four households with children have been accommodated in B & B for more than 6 weeks in the past 5 years (2009 – 2015)

No 16 & 17 year olds have been accommodated in B & B for more than 6 weeks in the past 5 years (2009 - 2015)

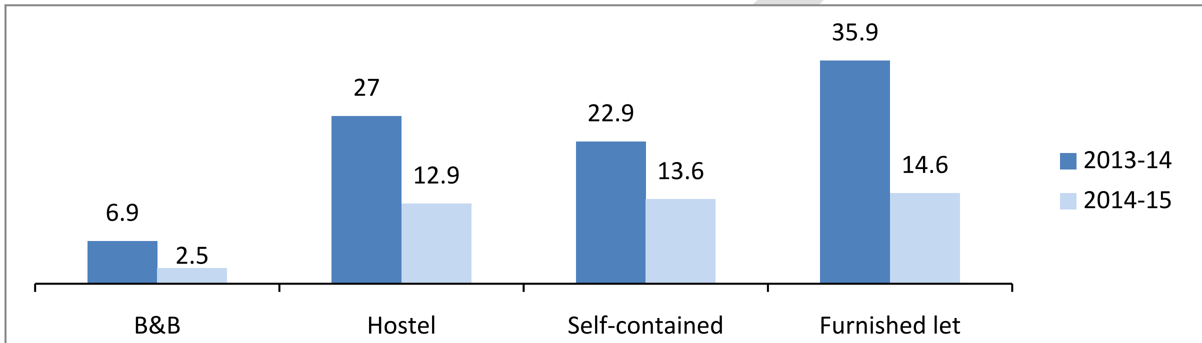
Actions:

- Ensure there is sufficient supported accommodation available so that no 16 & 17 years are placed in B & B accommodation
- Ensure no households with children are placed into B & B unless in an emergency
- Eliminate the use of B & B for all customers except in an emergency and then for a minimal period
- Work closely with children's services to provide suitable (supported) accommodation for homeless 16 & 17 year
- Ensure temporary accommodation meets high standards
- Consider options for accommodation for homeless non-priority need customers

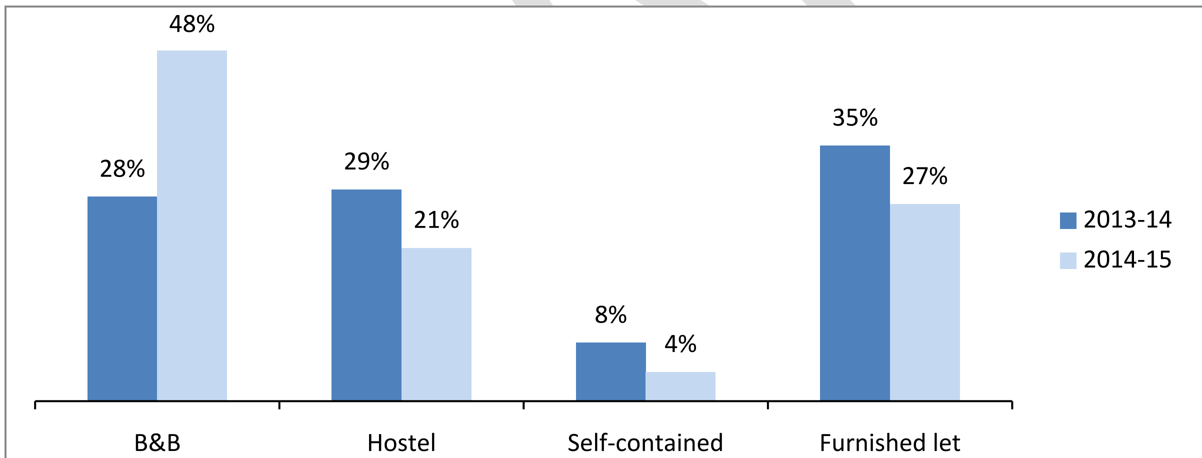
J1 – Households provided with temporary accommodation during the year



J2 – Average number of weeks spent in Temporary accommodation



J3 – Type of accommodation used as a percentage of total accommodation



4. Health & Wellbeing

Physical health & disability

Thurrock has a worse than average figure for overall premature deaths in England. It is particularly badly placed in the listings for lung cancer, heart disease and stroke

These statistics are supported by high overweight and obesity levels in the borough, both adults and children, which are linked to the prevalence of these diseases - see 4.1, 4.2 and 4.3

Obesity figures show that Thurrock is the worst local authority area in the east of England region with almost one third of adults categorised as obese and more than two thirds categorised as either

overweight or obese.

It is also the worst local authority area for smoking related deaths

Poor quality housing has long been established as a contributor to poor health:

- damp, mould and excess cold increases the risk of cardiovascular and respiratory disease
- psychological illness such as depression and anxiety are linked to poor housing and uncertainty around homelessness
- falls are more common when residents need adaptations or where there are structural faults
- high housing costs often lead to the purchase of cheaper unhealthy food

Thurrock Councils' Housing allocations scheme recognises the need to prioritise people with insanitary or hazardous housing conditions through its priority banding for reasonable preference groups. It also prioritises those with medical conditions which are worsened by their housing situation.

However, removing people from poor housing does not resolve the root of the problem and could result in those people simply being replaced with others. It is therefore important to tackle landlords of poor quality housing and provide alternative options for owner occupiers who are unable to meet the costs of repairing their own unsatisfactory housing.

People with disabilities who face homelessness will not only suffer the uncertainty of a homeless situation but may also be placed into temporary accommodation that is not adapted to meet their specific needs. Prevention of homelessness in such circumstances is of an even high priority.

Actions:

- Housing solutions team to work closely with environmental health and other enforcement agencies to ensure that landlords carry out their responsibilities to provide safe and sanitary conditions in order to prevent homelessness
- Consider options for offering alternative accommodation to owners who are frail or elderly and repairing their properties in return for long lease arrangements
- Ensure the Council makes good use of adapted properties via its Accessible Housing Register – for example by early maximisation of priority banding for potentially homeless applicants in need of adapted properties, even where they are not yet homeless within 28 days
- Ensure temporary accommodation meets disability criteria wherever possible

Mental health

Thurrock has a slightly lower percentage of people with long term mental health problems than the national picture but mental health is the 2nd highest reason for priority need in homeless people (after dependent children and/or pregnancy) - see 4.4

South Essex Partnership University NHS Foundation Trust (SEPT) provide mental health services across Essex including the Assertive Outreach service from Grays Hall and the Community mental health team from Basildon hospital.

The Housing and Mental Health forum was established as a joint project between SEPT and Housing

in June 2011 and brings together housing, mental health and other professionals on a regular basis. Individual cases can be brought to the group for a multi-disciplinary approach to resolving housing issues and a number of successful homeless preventions have been achieved. However numbers attending can be low and when this is the case it is more difficult to resolve issues.

Thurrock has a supported housing scheme for adults with mental health problems – Balfour Court – which accommodates 8 people

Unfortunately a number of the tenancies at Balfour Court (historically) are assured tenancies which indicate a lifetime tenancy rather than a supported housing move on plan. This has meant that very few properties become available for new residents and subsequently people in need of supported accommodation may have to be housed in general needs without the support needed.

Thurrock has a number of agencies and charities that offer other support to people with mental health problems including Mind, POhWER and Family Mosaic. Support ranges from day to day budgeting skills & maintaining a tenancy through to advocacy and counselling

Often such support can prevent a homeless situation from occurring or escalating and therefore it is essential that all agencies are aware of service provision and how to access it

Thurrock Councils' housing strategy recognises the need to provide more specialist housing for those with mental health problems and one of its action points is to "support those with mental health needs, autism and learning disabilities through working with Adult Social care and identify suitable accommodation and support services meeting REACH standards"

Actions:

- Research the need for more supported housing accommodation for people with mental health problems and feed into development programmes
- Work with ASC to identify suitable accommodation and support services which meet REACH standards
- Improve knowledge of partnership support provisions and how to access them
- Improve commitment to, and attendance at, the mental health forum by all partners
- Encourage a programme of move on from Balfour Court to free up valuable supported accommodation

Learning Disabilities

Thurrock has a slightly lower percentage of adults with learning disabilities compared to Southend and Essex at 3.6% of the population - see 4.9. This equates to around 5700 people

Just over a quarter of these adults are living in unsettled accommodation – see 4.10

There are two supported housing accommodation schemes in Thurrock for adults with learning disabilities –

- Lloyd House – accommodates 8 people
- Devon House – accommodates 10 people

It is envisaged that many people with learning disabilities will be able to live independently but may

require a period of time in supported accommodation in order to build their independent living skills. The two schemes offer supported accommodation for up to two years

It is essential that spaces become available within supported housing schemes and that a robust move on programme is maintained

Thurrock council does not have statistics which quantify the number of adults who come through the housing solutions service and who need supported housing

Thurrock Councils' housing strategy recognises the need to provide more specialist housing for those with a learning disability and one of its action points is to "support those with mental health needs, autism and learning disabilities through working with Adult Social care and identify suitable accommodation and support services meeting REACH standards"

Actions:

- Promote and encourage move-on from the supported housing schemes
- Feed into the Councils housing development programme
- Work with ASC to identify suitable accommodation and support services which meet REACH standards
- Maintain statistics on people with learning disabilities approaching the Council for assistance

Young parents

Thurrock has a much higher level of teenage conceptions than neighbouring boroughs - see 4.5. However for live births the figure is similar to neighbouring areas. Subsequently there is a large gap between the two in comparison, suggesting higher levels of aborted pregnancies

The highest priority need group amongst homeless acceptances is single females with children or pregnancy

Thurrock has young parent accommodation at Ruth House which provides supported accommodation services for 9 people. There are also two move-on flats and a floating support service. The client group is primarily aged 16 to 25

Between January and December 2014

- 35 referrals were made to the scheme
- Referrals came from the Housing solutions team, Social care and self-referrals
- Of the 35 referrals made, 30 were added to the waiting list and of these 21 were accommodated during the year (60% of referrals)
- 10 of the 35 referrals were aged 16-17 years and 25 were 18 to 25 years

The Council offers a move on priority banding through its allocations scheme where residents of Ruth House have completed the required support programme and are ready to live independently – usually this lasts up to 2 years and allows a flow through of supported accommodation

Actions:

- Ensure all partners are aware of the young parent scheme and services for young people and

make referrals to prevent homelessness
- Make use of the floating support service as a means of helping young women to remain at home where they are threatened with exclusion

Drug and Alcohol abuse

The percentage of people in drug treatment in Thurrock is lower than Southend but higher than the rest of Essex.

For alcohol treatment the figures are fairly consistent across Essex - see 4.6
20% of those in drug treatment and 15% in alcohol treatment have a housing problem – see 4.7 and 4.8

KCA have been commissioned by the Council to provide drug and alcohol services. Their aim is to provide a simplified whole treatment system to make it easier and more accessible for adults with drug and alcohol issues to get the support, guidance and treatment they need to achieve their recovery goals

Often people have both alcohol and drug abuse, and accompanied with mental health problems prove to have complex needs which often result in homelessness and abuse

There is no specific supported accommodation for people with complex needs. Where the person faces homelessness and has to be placed in temporary accommodation this often fails due to a chaotic lifestyle and/or behavioural issues. Subsequently the person loses their accommodation which exacerbates the problems. Often housing is an essential first requirement before any support can be implemented

Actions:
- Ensure all partners are aware of the young parent scheme and services for young people and make referrals to prevent homelessness
- Make use of the floating support service as a means of helping young women to remain at home where they are threatened with exclusion
- Explore options for a “Housing First” approach

Domestic Abuse and Sexual violence

Violent relationship breakdown with a partner represents almost 10% of reasons for homelessness where a rehousing duty has been accepted over the past 5 years – this equates to around 62 cases over 5 years but does not account for cases where Thurrock tenants apply to other local authorities for rehousing

Violent relation breakdown with an associated person represents a further 2.4%

The Council’s housing allocations policy provides for the highest banding (Band 1 priority) for applicants who need urgent rehousing due to violence or threats of violence and a housing management panel regularly reviews applications.

Band 2 priority can be awarded where the urgency to move is less

Thurrock Council has recently adopted a Community Safety Strategy which states the following:

- *We will not tolerate domestic abuse perpetrated by our tenants against their partners, family members or others who live with them*
- *We will work with other agencies to empower survivors and reduce immediate harm and use existing legal remedies against any tenant causing domestic abuse*
- *We will seek to reduce harm to both adults and children who are at risk as a result of domestic violence*
- *We will support survivors who report of domestic violence*
- *We will facilitate effective action against offenders so that they can be held accountable*
- *We will adopt a proactive multi-agency approach in preventing and reducing domestic abuse and violence*
- *We will work with Essex Police to allow victims to remain safe in their home with professionally installed security measures through the Sanctuary Project*
- *Our Domestic Abuse Officers are trained to carry out risk assessments and appropriate referrals; give practical information and advice on housing options and referrals to secondary support agencies for residents suffering domestic abuse*

The council uses management moves for Council tenants fleeing domestic abuse and provision of Sanctuary schemes where appropriate – both are effective homeless prevention measures

Thurrock has refuge provision which accommodates 15 women (plus children) and offers a floating support service

South Essex rape and incest crisis centre (SERICC) is based in Thurrock and offers information, support, advocacy and counselling

The housing directorate has dedicated domestic abuse officers who assess all homeless applicants and tenants who are victims of Domestic Abuse

Recent cases with very complex needs have highlighted requirements for safe houses/refuge with high levels of support especially around drug & alcohol abuse and mental health problems which are often associated with domestic abuse and sexual violence

Closer working with support agencies and defined housing pathways have been identified as necessary and a dedicated protocol is required

Actions

- Increase access to specialised refuge spaces
- Improve working relationships between housing solutions team and partners
- Promote the domestic abuse service within housing as the single point of entry for all homeless domestic abuse cases
- Increase training and awareness for housing staff
- Research options for safe houses within Council stock
- Promote the sanctuary scheme as an alternative to moving home – across all tenures
- Agree a working protocol with support agencies

Autism

Thurrock Council has a specialist school for children and young people (aged 3 to 19 years) on the autistic spectrum. A recent OFSTED report (November 2014) found the school to be Outstanding and subsequently it is a popular choice for parents around the country. This in turn has led to more people moving into the borough to attend the school and subsequently a higher chance of homelessness amongst households with a member who is on the autistic spectrum

Thurrock Council developed an autism strategy in 2014 which states:

"People with autism have varying levels of support and housing needs with some being able to live completely independently whilst others need full residential care

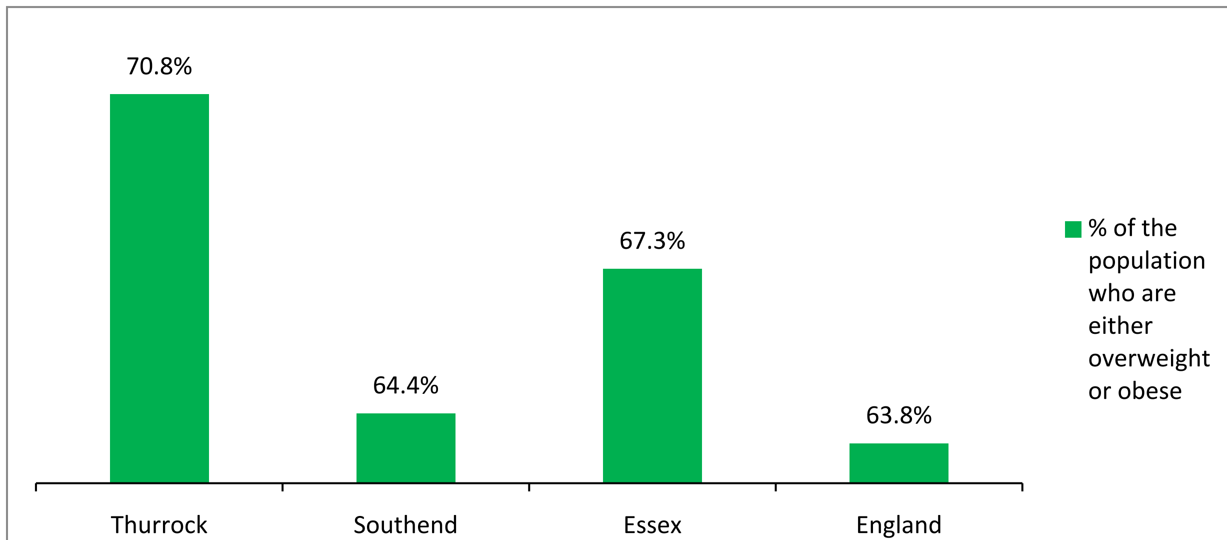
Currently there is no specific provision within Thurrock and therefore no options for a household with a member on the autistic spectrum. Should the local authority have a homeless rehousing duty it would be very difficult to discharge that duty into a suitable accommodation locally"

Thurrock Councils' housing strategy recognises the need to provide more specialist housing for those with autism and one of its action points is t *"support those with mental health needs, autism and learning disabilities through working with Adult Social care and identify suitable accommodation and support services meeting REACH standards"*

Action

- Work with the housing development team to ensure adequate numbers of supported accommodation are included in work programmes
- Work with ASC to identify suitable accommodation and support services which meet REACH standards for those in temporary accommodation or facing homelessness
- Improve the collection of data around homeless applicants with supported housing needs and autism in order to inform further development

4.1 – Overweight and obesity levels

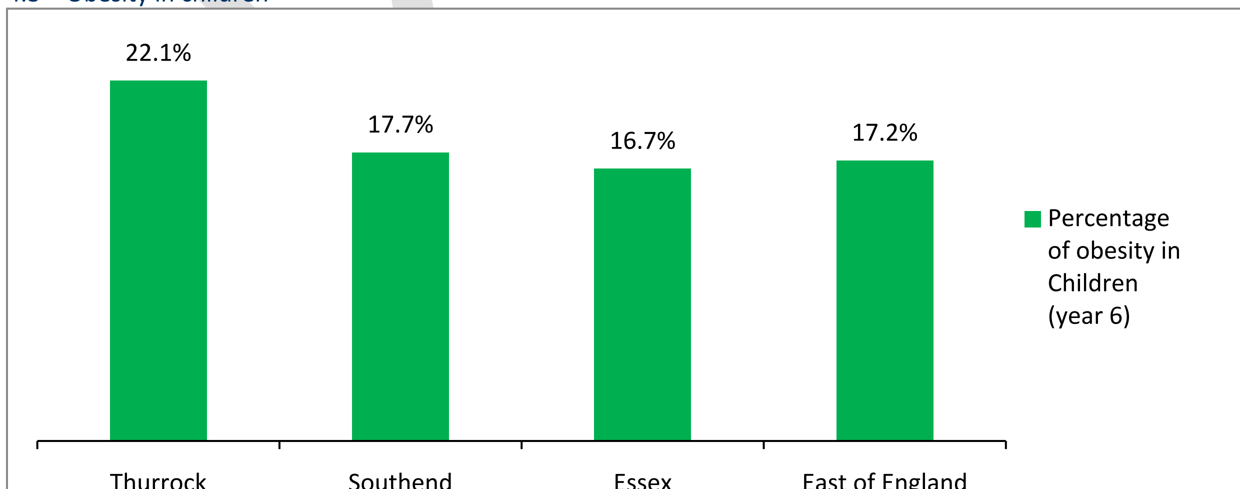


Source: Public Health England

4.2 – Obesity in Adults

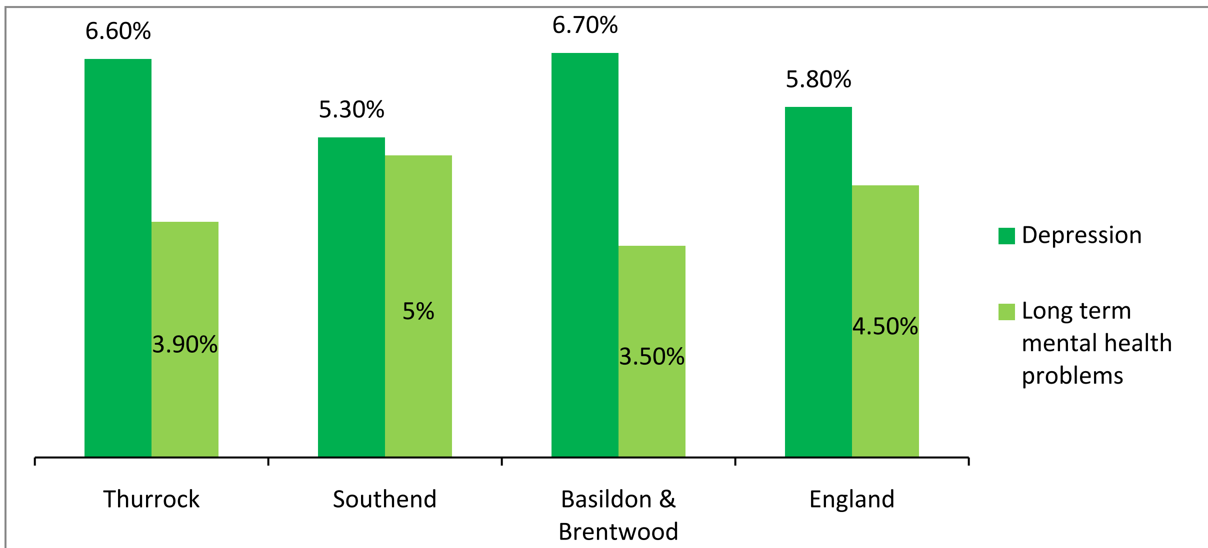
Source: Public Health England

4.3 – Obesity in children



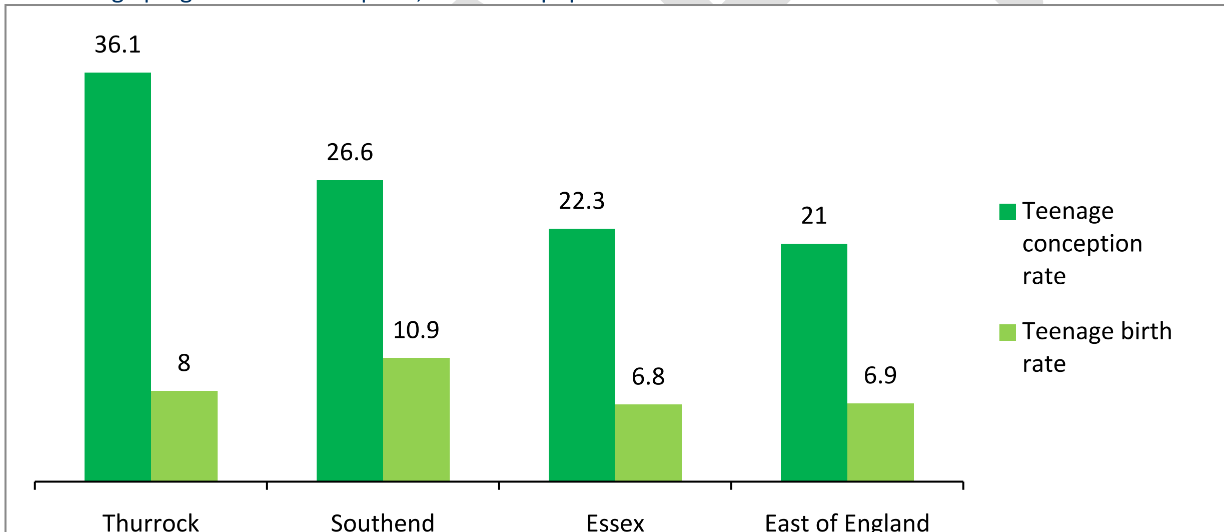
Source: Public Health England

4.4 Prevalence of mental health problems



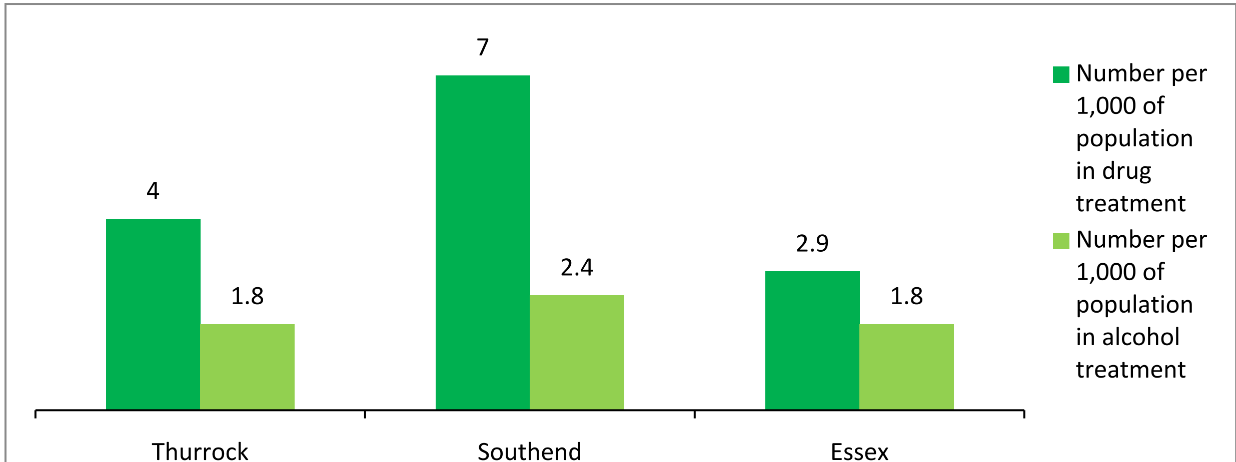
Source: Public Health England

4.5 Teenage pregnancies – rates per 1,000 of the population



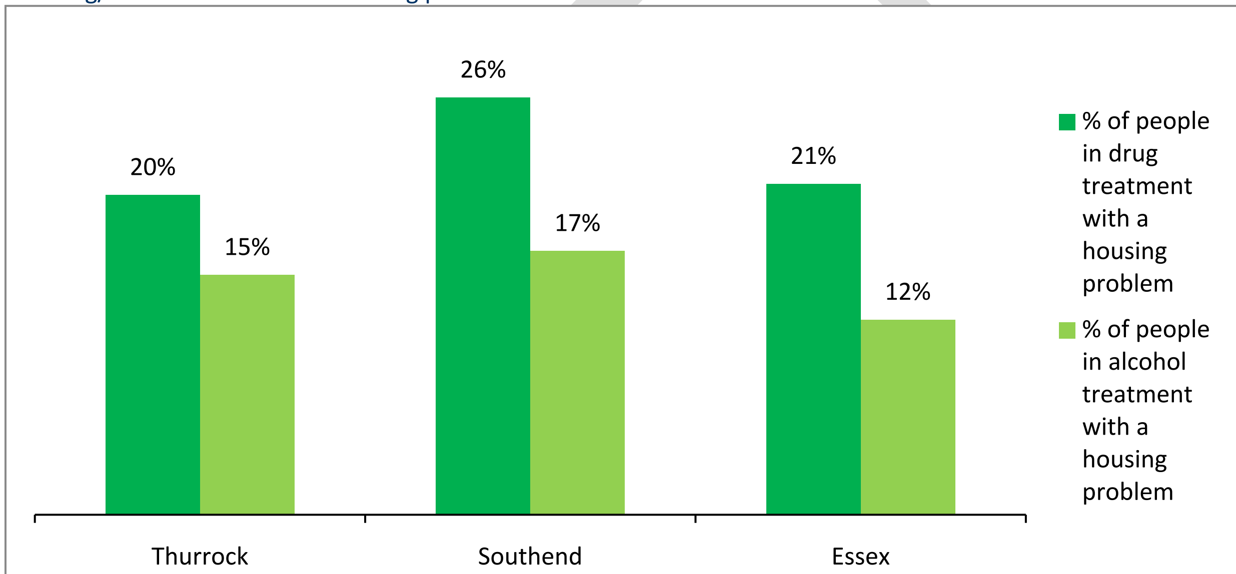
Source: Public Health England

4.6 Drug & alcohol treatment



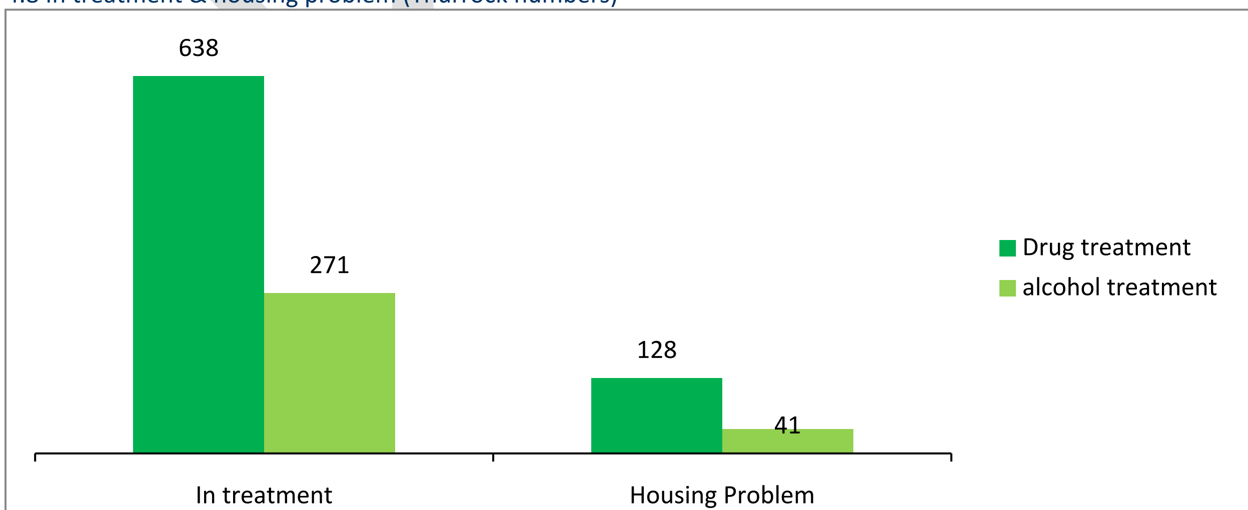
Source: Public Health England

4.7 Drug/alcohol treatment & housing problem



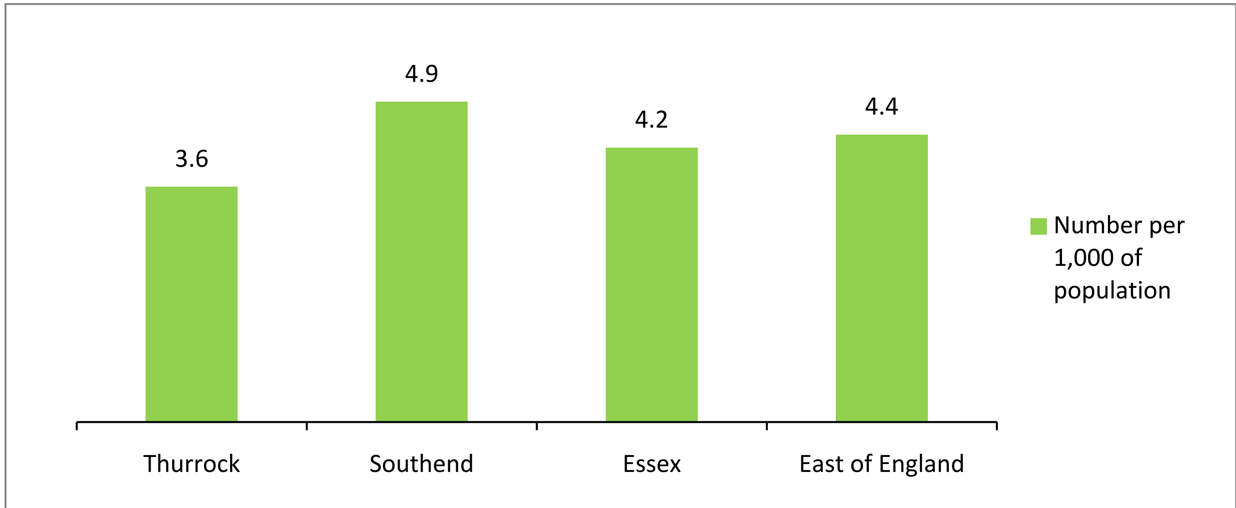
Source: Public Health England

4.8 In treatment & housing problem (Thurrock numbers)

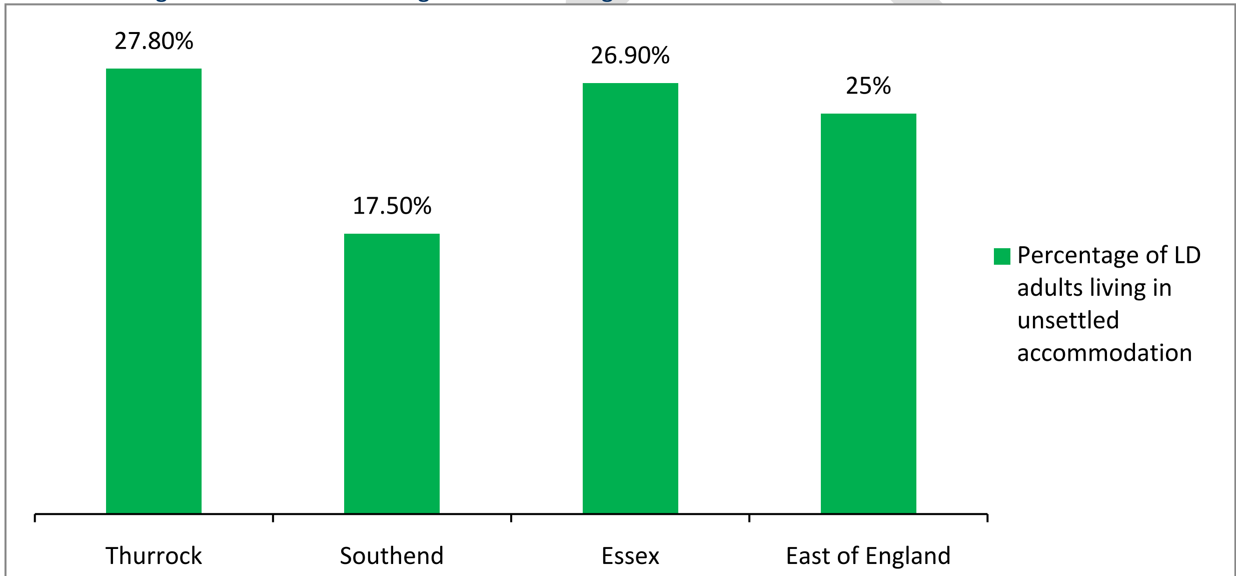


Source: Public Health England

4.9 Percentage of adults with learning difficulties who are known to the local authority



4.10 Percentage of adults with learning disabilities living in unsettled accommodation



5. Policy, legislative and the socio economic context

5.1 The recession, austerity measures and economic downturn

Due to the world economic situation and the need for financial austerity, the government has prioritised reducing the national deficit and both local authorities and voluntary sector organisations have seen a significant reduction in budgets over the last 5 years.

The impact of the reductions in public expenditure locally is:

- An end to ring fencing of LA grants – including supporting people and homelessness grant
- Reduction in homeless prevention budget
- Reduction in government subsidy for Council tax and localised schemes from 2013 – Thurrock council residents will have to make a contribution of at least 25% of their Council tax bill
- Localised welfare system has replaced community care grants and crisis loans for general living expenses (including rent in advance
- Changes to the Legal Aid system resulting in decreased funding

5.2 Localism and social housing reform

The Localism Act 2011 gave new flexibilities and powers to local housing authorities and providers of social housing to meet local needs more effectively. The key measures of the Localism Act with regards to homelessness and housing include:

Flexible tenancies

From April 2012 all registered providers were able to introduce fixed term tenancies or continue with lifetime tenancies. These tenancies could be as short as two years although this would be viewed as exceptional.

Some Registered Providers in the borough have subsequently introduced flexible tenancies.

Thurrock Council Members chose not to introduce fixed term tenancies and the Council's Tenancy Strategy lays out its intention to continue with secure tenancies but to introduce an Introductory Tenancy period of one year with the option to extend if required.

Discharge homelessness duty into the private rented sector

Provisions allow Councils to end the main homelessness duty with the offer of a private rented property and unlike the preceding provision of a "Qualifying Offer" the duty may be ended without the applicants consent. The tenancy needs to be for a minimum period of 12 months and suitable in terms of affordability, property condition and household circumstances. Guidance on what constitutes suitability is provided.

Thurrock Council has chosen to use the new provisions as a means of discharging its main rehousing duty and has produced a policy document outlining how and when the provisions will be used.

Guidance on suitability with regards to location given in the recent case of Nzolameso v City of Westminster [2015] UKSC22 will also be taken into account.

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Housing allocations

Provisions allow Local authorities to restrict who can access their Housing Waiting list by means of Qualification criteria. Thurrock Council reviewed its Allocations Scheme and in May 2013 implemented 5 year local connection, financial threshold and behaviour requirements.

However, applicants meeting the reasonable preference criteria within Part 6 of the Housing act 1996 cannot be disqualified.

Neighbouring boroughs have also implemented qualifying criteria including Basildon Council with a 7 year local connection qualification rule.

The new housing allocations scheme awards a priority banding (Band 3) to applicants who meet any of the Reasonable Preference criteria including the main rehousing duty under Part 7 of the 1996 Housing Act.

A higher (Band 2) priority can be awarded where there is cumulative priority.

5.3 Welfare benefit reform

The government's welfare reforms have set out to cut the increasing expenditure on benefits, reduce benefit dependency, reduce the budget deficit, provide incentives for people to work and reduce under occupation of rented accommodation.

Reforms have included the following:

- Local Housing allowance – now fixed at the 30th percentile rather than the previous 50th – this means the LHA covers only one third of private rents rather than a half;
- An increase in non-dependent deductions for Housing benefit – this means council tenants with non-dependents will have to find more of their rent;
- Increasing the age threshold for the shared room rate in housing benefit from 25 to 35 years old – this means single people under the age of 35 will receive the lower level and may only be able to access shared accommodation; there are exemptions for certain categories;
- LHA rates set annually and indexed to CPI;
- The spare room subsidy – widely referred to as the "Bedroom Tax". This affects social housing tenants of working age who are under-occupying their property. Tenants have had their housing benefit cut by 14% for one bedroom under-occupied and by 25% for two or more bedrooms under-occupied. Thurrock Council has offered incentives to council tenants wishing to downsize including a priority banding to transfer and financial payments. Where tenants have indicated a wish to down size and are actively bidding for properties Discretionary Housing Benefit has generally been awarded to meet any shortfall;
- Household benefit cap – this provides a cap (limit) to the total benefits a household can receive – currently capped at £500 a week for couples (with or without children living with them) and for single parents whose children live with them and £350 a week for single adults who don't have children, or whose children don't live with them

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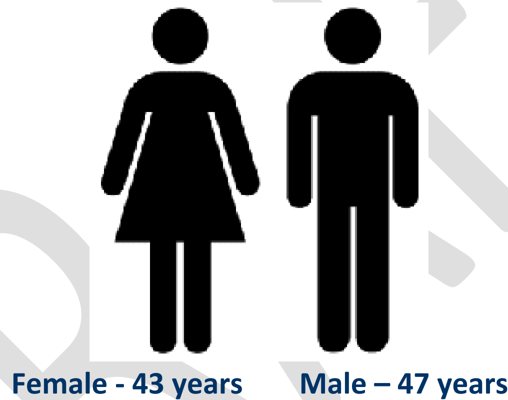
- Universal Credit replaces six benefits, including Housing Benefit and aims to give individuals responsibility to manage their own benefits; It is paid directly to the individual who is responsible for making payments for rent, Council tax etc. direct to their landlord. Payments are made monthly rather than weekly and in arrears. Thurrock has started to move over to Universal Credit, initially with all new claims for single people from April 2015. Private and social housing landlords have expressed concerns regarding potential arrears and some are refusing to offer tenancies/licences to people in receipt of Universal Credit

5.4 No Second Night Out

The government introduced a programme to identify new rough sleepers and reconnect them so that their rough sleeping was minimised.

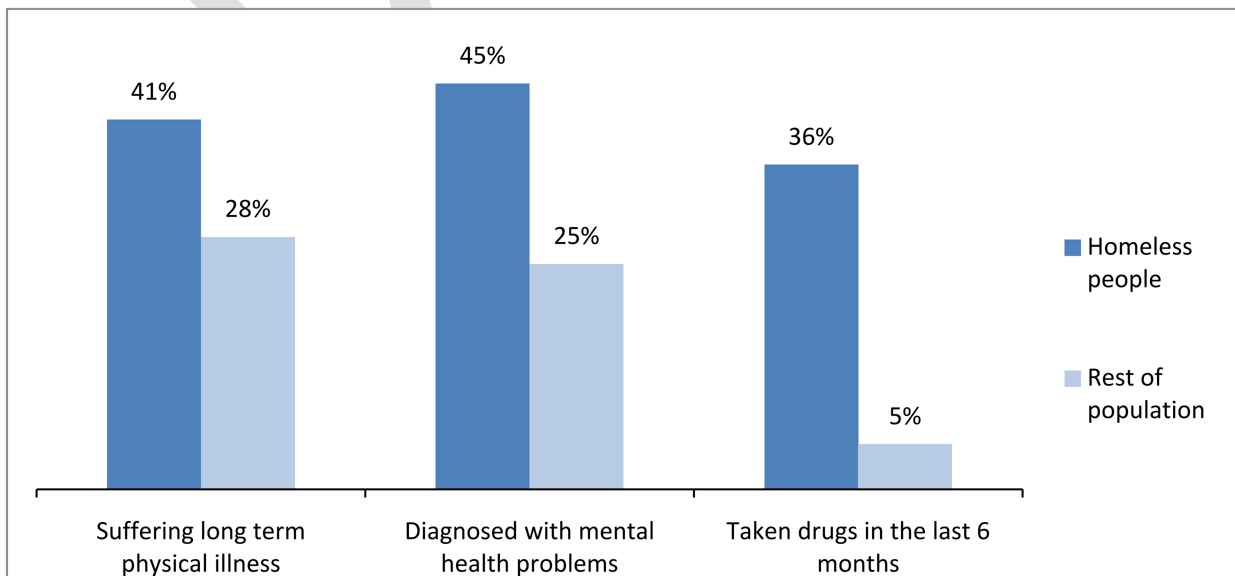
It is estimated that rough sleeping shortens life expectancy by about 30 years with the average life expectancy of a rough sleeper estimated at:



Female - 43 years **Male – 47 years**

Source: Crisis 2012

Rough sleeping can also lead to higher levels of illness and substance misuse



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Source: Homeless Link 2014

Thurrock Council has joined with eight other local authorities in the region to provide a reconnection and support service through a joint contract with St Mungos Broadway

A reconnection worker seeks out rough sleepers in the borough following referrals from Homeless Link who provide a reporting mechanism for members of the public identifying rough sleepers. Referrals can be made via telephone, email or via an online form

The worker will assess any rough sleepers found and offer support to reconnect them or to find alternative accommodation. Referrals to support agencies can also be made

The contract which started in September 2014 lasts 18 months

5.5 Making every contact count: A joint approach to preventing homelessness

The government's second report on preventing homelessness was published in August 2012 and focuses on how services can be managed in a way that prevents all households, regardless of whether they are families, couples, or single people, from reaching a crisis point where they are faced with homelessness

The report aims to make sure that every contact local agencies make with vulnerable people and families really counts and it brings together a number of government commitments to:

- Tackle troubled childhoods and adolescence
- Improve health
- Reduce involvement in crime
- Improve skills; employment; and financial
- Pioneer social funding

From this report the DCLG posed ten local challenges to all local authorities:

1. Adopt a corporate commitment to prevent homelessness which has buy in across all local authority services
2. Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs
3. Offer a Housing Options prevention service, including written advice, to all clients
4. Adopt a *No Second Night Out* model or an effective local alternative
5. Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support
6. Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords
7. Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme
8. Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually so that it is responsive to emerging need
9. Not place any young person aged 16 or 17 in Bed and Breakfast accommodation
10. Not place any families in Bed and Breakfast accommodation unless in an emergency

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These ten challenges form part of the Gold Standard programme which has been developed and administered by the National Practitioner Support Service (NPSS) to encourage local authorities to develop a continuous programme of improvement. Thurrock Council has pledged to develop this improvement and has subsequently signed up for the Gold Standard challenge.

5.6 The Test for Priority Need

The "Pereira Test" has been established law since 1998 and is identified within the 2006 Homelessness guidance as the test for vulnerability in homeless applicants without dependent children or pregnancy. The test required officers to determine:

"[whether the applicant] when homeless [will be] less able to fend for himself than an ordinary homeless person so that injury or detriment to him will result when a less vulnerable man would be able to cope without harmful effects"

Lord Justice Hobhouse in R v Camden London Borough Council, Ex p Pereira (1998) 31 HLR 317 at p.330

That test has been challenged in the courts through three joined cases and a Supreme Court ruling in May 2015 has determined that a different test now applies.

"In order to decide whether an applicant falls within section 189(1)(c), an authority or reviewing officer should compare him with an ordinary person, but an ordinary person if made homeless, not an ordinary actual homeless person."

Lord Neuberger in Hotak v London Borough of Southwark; Kanu v London Borough of Southwark; Johnson v Solihull Metropolitan Borough Council [2015] UKSC at 58

The correct comparator is then, not the "ordinary homeless person", but the ordinary person who is homeless.

We have yet to see further court definitions of the "ordinary person who is homeless" but the implication is that a wider group may now meet these criteria and that they are likely to be singles or couples with no children/pregnancy.

Since Thurrock Council's highest cause of homelessness is eviction by family/friends this could increase the number of people owed a duty in the coming years and the requirement for studio or one bedroom accommodation.

It is also important to note that, following the Conservative Governments re-election on 7th May 2015 with a majority of seats in the House of Commons, further welfare reforms are expected. The possibility of removing Housing benefits for under 21 year olds job seekers has been widely predicted.

It is important to monitor the impact of any proposed reforms and to ensure a better supply of affordable accommodation for smaller households is available.

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6. Gold Standard – Ten local challenges

As part of the Gold standard programme, Thurrock Council Housing solutions team undertook a Peer review of its services in November 2014 and achieved an overall score of 64%. This involved an intensive review of current services by housing service managers from Basildon and Southend Council's and enabled the service to move onto the next stage of the programme.

Subsequently, the service is working on the ten challenges set out by the Gold Standard Programme (see above) in order to achieve Gold Standard status and has identified specific areas work for improvement:

- To develop a Homelessness Prevention strategy with a proactive approach to preventing homelessness;
- To continually monitor the quality of the service provided including frontline service provision, case work and new procedures;
- To review and make good use of online services including an online Self-assessment programme (HED) which allows clients to access housing advice and information on line with sign posting to appropriate services including the facility to identify potentially homeless applicants at an earlier stage in order to take a more proactive approach to homeless prevention
- To actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs & to ensure partners are fully aware of the Councils strategic objectives
- To agree housing pathways with key partners and client groups that include appropriate accommodation and support
- To set up quarterly partnership forums for sharing information, training & developing links with the Housing solutions teams
- To work with partners to investigate the impacts of welfare reforms & austerity measures & develop an action plan to mitigate the impacts
- To adopt a corporate commitment to prevent homelessness which has "buy in" across all local authority services
- To investigate all funding streams to ensure effective use for homeless prevention including homelessness grant, DHP & DWP funding and one off government funding opportunities
- To develop a Housing advice service which encompasses all housing options
  To investigate the option of a one stop shop for all housing options either within the Civic offices or in another location
- To investigate a local mortgage rescue scheme
- Prepare a pre-tenancy information programme/workshop and roll out for all new incoming tenants
- Develop specific Temporary Accommodation options for 16 & 17 year olds to eliminate the use of B & B for this group
- Review the terms of reference for the Joint Referral Panel to ensure co-operation and pathways through accommodation for non-statutory homeless
- Improve and develop services for all client groups – statutory and non-statutory homeless

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7. New ways of working

Since the last homelessness strategy was implemented (2010) new operational working practices have been introduced:

- The Homeless and allocations teams were restructured into one Housing Solutions team in 2012
- An online Housing application form was introduced in 2013 and applications for housing (new applicants and transferring tenants) are accessed through this single entry
- An online single point of access for housing advice and options (HED) was introduced in 2014. Applicants completing the assessment who are facing homelessness are highlighted within the system and offered face to face and telephone appointments whilst those requiring only advice and information can obtain this 24/7. A specific action plan is produced to meet the individual requirements depending on the information provided.

8. Partnerships

Thurrock Council housing solutions work in partnership with many agencies including the following:

- Adult Social Care
- Children's Services
- Probation
- SEPT
- NHS Trust
- Public Health
- Education
- Police
- Family Mosaic
- Sanctuary housing association
- Open Door
- Mind
- POhWER
- Women's Aid
- Sericc
- Thurrock Racial Unity Support Task group (TRUST)
- St Mungos Broadway

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9. Next steps

This review document and accompanying initial action plan will feed into a further consultation period and will provide an evidence base to identify key areas for improvement and development.

This second consultation period will provide an opportunity for meaningful and effective discussions on the issues identified, and communication of ideas for tackling them. It will be delivered across a range of mediums including

- Face to face conversations
- Joint meetings with a wide range of partners, staff , private and social landlords, and Members
- An online public survey

The review will also be presented to the Councils Youth Cabinet, the Education, Children's and Social Care directorates and the Health & Wellbeing Strategic Board for further consultation.

Because Prevention is key the Action plan will link every actions to one of the four main causes of homelessness which have been identified – this should focus attention on prevention

The Four main causes of homelessness are:

1. Exclusion by parents, family or friends
2. Termination of an assured short hold tenancy
3. Violence or Harassment
4. Mortgage or rent arrears

Clear proposals will be identified within the action plan that

- Are able to drive through improvements
- Are "SMART" with short, medium & long term aims
- Involve Partnership working – particularly amongst Social Care & Registered Providers who have a statutory duty to assist with the Homelessness strategy

There will be an Emphasis on positive and proactive actions and more delegated leadership across partners

Following the consultation period a new homelessness strategy will be completed with identified links into Thurrock Council's

- Allocations scheme
- Tenancy strategy
- Discharge into private sector strategy
- Housing Strategy
- Autism Strategy

Mechanism for regular reviews will be identified – including shorter (annual) reviews with the first review being 12 months after implementation of the strategy.

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Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
Housing Supply	Increase the supply of affordable housing in the borough	Influence future house building and planning to meet smaller household needs			Exclusion by parents, family or friends		
		Influence future housing supply to include more affordable purchasing options such as shared ownership & help to buy			Termination of an assured short hold tenancy		
		Raise awareness of purchasing options & ensure all are considered as a prevention to homelessness when providing advice and assistance through the housing options			Termination of an assured short hold tenancy		
		Ensure the Council makes good use of adapted properties via its Accessible Housing Register	Early maximisation of priority banding for potentially homeless applicants in need of adapted properties, even where they are not yet homeless within 28 days		Termination of an assured short hold tenancy		
					Exclusion by		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
Housing Supply	Increase the supply of supported housing in the borough	Increase the provision of supported housing for people with Autism, learning disabilities and mental health problems			parents, family or friends		
		Increase the provision of supported housing for under 25s including homeless 16 & 17 year olds			Exclusion by parents, family or friends		
		Work with Adult Social Care to identify suitable accommodation and support services which meet REACH standards			Exclusion by parents, family or friends		
		Encourage a programme of move on from Supported accommodation to free up spaces			Exclusion by parents, family or friends		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
Housing Supply	Increase the supply of good quality private rented housing in Thurrock	Improve working relationships with private landlords and options for longer tenancies			Termination of an assured short hold tenancy		
		Develop incentives for Thurrock landlords to take Thurrock homeless applicants as a discharge of duty			Termination of an assured short hold tenancy		
		Develop improved monitoring of private landlords – e.g. Landlord licensing schemes			Termination of an assured short hold tenancy		
		Develop an offer for under occupying elderly home-owners	Package of options available for owners who are frail or elderly in return for long lease arrangements		Termination of an assured short hold tenancy		
		Joint working with environmental health and other enforcement agencies to ensure that landlords carry out their responsibilities to provide safe and sanitary conditions in order to prevent homelessness			Termination of an assured short hold tenancy		
		Encourage under occupying residents to take in lodger			Exclusion by parents, family or friends		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
Housing Supply	Improve cross boundary working and monitoring of placements within Thurrock to ensure maximisation of Thurrock properties for Thurrock residents	Improve working relationships with London boroughs and set up information sharing agreements particularly regarding households with complex needs such as mental health, medical, specialist schooling and ASB issues			Termination of an assured short hold tenancy		
		Regularly remind London boroughs of their duty to notify Local Authorities when placing people out of borough under s208 Housing Act 1996 and monitor placements closely including impacts on other services			Termination of an assured short hold tenancy		
		Work with other boroughs in the sub region and consider cross boundary joint partnerships to incentivise landlords			Termination of an assured short hold tenancy		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
Page 127 Finance	Improve knowledge & understanding of money management and budgeting skills	Improve working partnerships with Housing benefits & agree dedicated officers for the housing solutions service			Mortgage or rent arrears		
		Increase understanding of access to welfare benefits amongst staff and customers			Mortgage or rent arrears		
		Improve access to debt advice and encourage its use			Mortgage or rent arrears		
		Offer programmes to Increase understanding of money management & budgeting skills within secondary schools & colleges			Mortgage or rent arrears		
		Investigate the use of prevention funds for loans to clear debts and pay deposits in advance – set up processes for			Mortgage or rent arrears		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		monitoring and recharging					
Tenancy sustainment	Improve Tenancy sustainment across all tenures	Monitor Council evictions of Introductory and secure tenancies to determine appropriate levels of support and monitoring			Mortgage or rent arrears		
		Increase awareness of the implications of evictions amongst tenants of all tenures			Mortgage or rent arrears		
		Investigate options for increased floating support across all tenures including secure tenancies			Mortgage or rent arrears		
		Consider options for pre-tenancy training for potential tenants across			Mortgage or rent arrears		

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Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		all tenures					
Domestic abuse & sexual violence		Increase access to specialised refuge spaces for people with complex needs such as drug, alcohol and/or mental health issues			Violence or Harassment		
		Promote the domestic abuse service within housing as the single point of entry for all homeless and tenant domestic abuse cases			Violence or Harassment		
		Increase training and awareness of sexual and domestic abuse for housing staff			Violence or Harassment		
		Research options for safe houses within Council stock			Violence or Harassment		
		Agree a working protocol with Domestic abuse support agencies			Violence or Harassment		
		Promote the sanctuary			Violence or		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		scheme as an alternative to moving home across all tenures			Harassment		
Non Priority homeless	Increased options for non-priority need homeless groups	Increase emergency provision and self-referral options – HMOs, hostels etc.			Exclusion by parents, family or friends		
		Investigate options for cross boundary working to achieve better options for non-priority need customers			Exclusion by parents, family or friends		
		Consider rehousing options for non- priority need groups including those coming out of prison or hospital					
		Review the Joint Referral Panel to ensure there is an effective means of addressing co-operation and pathways to accommodation for non-					

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		statutory homeless groups					
Education & mediation		Work in partnership with schools and colleges to promote staying at home			Exclusion by parents, family or friends		
		Develop an education programme for teachers and assistants to enable them to teach pupils about homelessness and its implications			Exclusion by parents, family or friends		
		Set up regular conferences to update knowledge for teachers and assistants					
		Reduce the number of parental evictions through the Young Person's mediation service			Exclusion by parents, family or friends		

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Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
Partnership working	Develop Agreed Housing Pathways	Develop a robust hospital discharge policy for both mental health and physical health			Termination of an assured short hold tenancy		
		Improve knowledge of partnership support provisions and how to access them			Termination of an assured short hold tenancy		
		Explore options for a “Housing First” approach			Exclusion by parents, family or friends		
		Homelessness forum to be set up and partners to take the lead on identified areas			All causes of homelessness		
		Work with supported			Exclusion by parents, family		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		housing providers to incentivise "move on" schemes			or friends		
Partnership working	Improved communication between agencies	Ensure partners including health visitors and GPs are linked with customers in temporary accommodation through better notification & communication methods			All causes of homelessness		
		Ensure partners are updated with regards to customers applications and outcomes			All causes of homelessness		
		Increase the use of case reviews at the earliest stage of threatened homelessness for complex cases	Increased number of and confidence in case reviews with agreed outcomes and defined actions		All causes of homelessness		
					All causes of		

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Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		Set up quarterly partnership forums for sharing information, training & developing links with the Housing solutions teams			homelessness		
Partnership working	Develop a corporate commitment to preventing homelessness	Increase opportunities for joint working, shadowing, training and regular partnership meetings to improve relationships and develop named contacts			All causes of homelessness		
		Develop SLAs and working protocols between Housing solutions and partner agencies			All causes of homelessness		
		Improve commitment to, and attendance at, the mental health forum by all partners			All causes of homelessness		
		Increase the knowledge of members around homelessness prevention			All causes of homelessness		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		and the advice they can provide to constituents					
		To adopt a commitment to preventing homelessness which has “buy in” across all local authority services	Homelessness prevention is on the agenda for all corporate directives		All causes of homelessness		
Partnership working	Improve Working relationships between agencies to achieve better outcomes for customers	Work in partnership with the Job Centre to maximise job opportunities for customers					
		Ensure housing options advice incorporates signposting to employment and training advice					
		Develop better working practices to offer customers with complex needs the support they require sooner – including increasing the use of multi-disciplinary case reviews			All causes of homelessness		
		Develop better mechanisms for			All causes of homelessness		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		identifying vulnerable people sooner					
		Make use of the floating support service as a means of helping young people to remain at home where they are threatened with exclusion			Exclusion by parents, family or friends		
Customer service	Improve the customer experience and reduce unnecessary confusion and anxiety	Manage customer expectations better			All causes of homelessness		
		Improve effective communications between officers and customers		Improved satisfaction levels amongst service users	All causes of homelessness		
		Improve delivery of advice ensuring accuracy and relevance and written advice is always provided			All causes of homelessness		
		Investigate the option of a one stop shop for all housing options either within the Civic offices or in another location			All causes of homelessness		
		Ensure means of communications for Non-English speakers and			All causes of homelessness		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		those with sight and hearing impairments					
		Improve HED to incorporate better options advice, signposting to employment and to make more user friendly			All causes of homelessness		
Strategic planning	Investigate Welfare reforms and finance to determine long term impacts	Explore the long term impacts of welfare reforms on privately rented households – particularly the impact of Universal Credit - and any mitigations			Mortgage or rent arrears		
		Investigate possible influences on LHA rates in conjunction with neighbouring boroughs			Mortgage or rent arrears		
		Tackle under occupation across all tenure types but in particular social housing tenants unaffected by the bedroom under-			Mortgage or rent arrears		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		occupation reforms					
		Investigate all funding streams to ensure effective use for homeless prevention including homelessness grant, DHP & DWP funding and one off government funding opportunities			Mortgage or rent arrears		
Strategic planning	Improve Monitoring to enable the highest standards of future strategic planning	Continue to monitor equality strands against local and national trends to ensure no specific group is being adversely impacted			All causes of homelessness		
		Ensure statistics collected are more detailed and consistent to enable a better understanding and assist with forward planning			All causes of homelessness		
		Ensure staff are trained in how to capture data accurately and that consistent definitions are			All causes of homelessness		

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		used					
		Improve the collection of data around homeless applicants with supported housing needs and autism in order to inform further development			All causes of homelessness		
Strategic Planning	Up-grade the current Housing Management system to include homelessness case management and data collection	Ensure homeless officers are involved in the implementation programme for the new ICT system					
		Ensure sufficient expertise within the Housing department to update data requirements if necessary					
		The new Housing IT system must capture appropriate and accurate data - ensure the correct parameters are set					

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Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		during the design stages					
	Review the priority given to homeless customers through the Housing allocations Policy	Consider impact of priority bandings for statutory homeless and those who are homeless at home			All causes of homelessness		
		Consider options for improving priority to non- statutory homeless groups			All causes of homelessness		
Temporary Accommodation	Minimise use of temporary accommodation and ensure that when necessary it provides accommodation of a high standard	Ensure high standards of accommodation are maintained and that customers are linked in with GPs, health visitors, support services etc.					
		Ensure there is sufficient provision of adapted temporary accommodation					
		Ensure no 16 & 17 years are placed in B & B accommodation					

Key area	Objective	Action required	Outcome required	Measure of success	Homelessness cause addressed	Completion By	Lead responsibility
		Eliminate the use of B & B for all customers except in an emergency and then for a minimal period					

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15 June 2015	ITEM: 9
Health and Wellbeing Board	
Demography JSNA	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Debbie Maynard, Head of Public Health and Maria Payne, Health Needs Assessment Manager	
Accountable Head of Service: Debbie Maynard, Head of Public Health	
Accountable Director: Roger Harris, Director of Adults Health and Commissioning	
This report is Public	

Executive Summary

Every Health and Wellbeing Board has the responsibility to produce a Joint Strategic Needs Assessment for their area, which should give a comprehensive overview of the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services. This paper aims to request approval for the draft Demography document.

1. Recommendation(s)

1.1 Endorse the key recommendations and priorities identified in the Demography document

1.2 Approve the Demography JSNA document for publication

2. Introduction and Background

2.1 Since 2013 it has been the responsibility of every Health and Wellbeing Board to produce a Joint Strategic Needs Assessment for their area to provide a comprehensive overview of the current health and wellbeing of their population, form an evidence base for future commissioning priorities, and inform a Health and Wellbeing Strategy. Within Thurrock, the Health and Wellbeing Board have delegated this responsibility to the Public Health team to coordinate.

2.2 The last full JSNA in place for Thurrock was published in 2012, and is available https://www.thurrock.gov.uk/healthy-living/joint-strategic-needs-assessment. This document provides an overarching view of the whole population, and is very data-focussed. A proposal for the new JSNA process

which was agreed by Directors Board in January 2014 was to produce separate JSNA documents for key population groups or topic areas, which together would form a comprehensive overview, but could stand alone and give more detailed information about current services and needs. The documents would also have more focus on what we are doing locally already to address needs, and move further towards an asset approach. In particular, the considerable regeneration and population growth that Thurrock has begun and will continue to experience will lead to a number of benefits, opportunities and challenges, and it is hoped that the JSNA documents will support commissioners and decision-makers in identifying and meeting future needs. A timeline was agreed to enable these documents to be produced in a staged process between 2014-2016.

2.3 Whilst each JSNA document is project-managed and collated from within the Public Health team, each document has been and will be produced with contributions from a range of internal and external partners in order to ensure the accuracy and usefulness of the information. Focussed Task and Finish groups have been established to ensure the right people are involved in producing the documents and submitting recommendations for consideration when making commissioning decisions.

2.4 A JSNA document focussing solely on the needs of Children and Young People in Thurrock was approved by Children's Partnership Board and Health and Wellbeing Board in March 2015, and has recently been published.

2.5 A JSNA document on the Demography of the Thurrock population is the next to be produced. The aim of this document is to give an overview of the characteristics of the local population, including where there might be differences within the borough, in order to underpin the other JSNA documents which will focus on key groups.

2.6 The plan is for JSNAs on the Wider Determinants of Health, Adults and Older People, and Assets to be produced in 2015.

3. Issues, Options and Analysis of Options

3.1 The options identified for consideration by the Health and Wellbeing Board are:

- **Do nothing** – this gives no commitment to endorsing the recommendations or approving the draft JSNA document. However this carries a risk that Thurrock would not be meeting its responsibilities to maintain a JSNA that provides a current overview of the population and their needs. It will also mean that the last Thurrock JSNA produced in 2012 will become further and further out of date and therefore less meaningful.

- **Endorse the key recommendations from the Demography document and give formal approval to the publication of the**

Demography JSNA document - this would enable a current overview of the key demography of Thurrock to be known now, and ensure Thurrock meets its responsibilities to maintain a current JSNA.

4. Reasons for Recommendation

4.1 The preferred option for the Health and Wellbeing Board is to endorse the recommendations and approve the document. This is preferred in order to ensure the information in the document is still current when it is published, and to facilitate the process of maintaining JSNAs in the future.

4.2 If this document is not published, there is a risk that Thurrock will not meet its responsibilities to maintain a JSNA that provides a current overview of the population and their needs.

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

5.1 This document was completed in collaboration with a range of partners. Regular updates on progress were provided to the Public Health Strategy Board and the JSNA Delivery Group, both of which have a range of internal and external members. Adults DMT members have also had the opportunity to comment on this document.

5.2 An update on the progress of the new JSNA process was presented at Health Overview and Scrutiny Committee on 13th January 2015. Members were supportive of the way in which the documents have been developed.

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

6.1 Publication of the Demography JSNA document will ensure the priorities and recommendations set forth can be used to effectively underpin and support commissioning decisions in the future.

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**

Finance Officer

There are no implications currently – But in the future the JSNA could have future financial implications to commissioners both in health and social care.

7.2 **Legal**

Implications verified by: **Dawn Pelle**

Adult Care Lawyer

The document is confirming the position in relation to the Demography and advising that the appropriate consultation has taken place. As a consequence there are no legal implications.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Communities and Diversity Manager

The JSNA captures robust up-to-date details around diversity and equality and should inform commissioners and members of the current position locally.

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

None

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

- Demography JSNA

9. Appendices to the report

Report Author:

Debbie Maynard / Maria Payne

Head of Public Health / Health Needs Assessment Manager

Public Health

Thurrock

Joint Strategic Needs Assessment

Demographics and Population Change

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Key Contact:

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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 2013 the total population of Thurrock was 160,850 (ONS mid-year estimates 2013) of which 79,330 (49.3%) were male and 81,520 (50.7%) female.
- Thurrock's age structure is similar to that of, regional and national figures but generally has a larger young population aged 0-19 years – particularly 0-4 year olds, and a larger population in their 30s and early to mid-40s than both East of England and England. Conversely, Thurrock has a smaller proportion of older people than both East of England and England.

Population Distribution

- The population is not evenly distributed across the borough - there are more densely populated areas within the southern and central areas of Thurrock
- The areas with the highest percentage of under 15s in Thurrock are heavily clustered around the south and south west of the borough including the wards of Tilbury St Chads, Chafford and North Stifford, South Chafford and West Thurrock and South Stifford where up to 34% of the population fall within this age group
- The highest proportion of the over 65s (22-36%) reside in the north of the borough in areas such as Orsett, Corringham and Fobbing.

Population Change between the 2001 and 2011 Census

- There has been a 20% increase in 0-4 year olds between 2001 and 2011 (equating to almost 2,000 additional residents in this age group since 2001). This age group makes up 7.6% of the Thurrock's population which is greater than the proportion of the national population.
- The borough's population aged 60 years and above has increased by 16.5% since 2001. However, the proportions of people in each of the 60+ age groups are lower than the England and East of England averages.
- There has been a 47.5% increase in the over 85 population, equating to 846 more residents in this age group since 2001.

Population Projections

- The ONS subnational population projections (2012) estimate that, from 2012, the total population will increase to 176,500 by 2022 and 192,535 by 2032 (an increase of 10.6% and 20.7% respectively).

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- The population is predicted to increase for almost all quinary age groups. However, the most significant increases occur in age groups clustered in the 0-14, 25-29, 50-59 and 70 and over age groups. As a proportion of the total population, the largest percentage increases from 2012 to 2022 are predicted to occur in the 5-9, 50-54 and 70-74 years age groups.

Ethnic groups

- Despite an overall population increase, the White British and Irish groups have decreased in number from 134,348 residents representing 93.9% of the resident Thurrock population in 2001 to 128,348 in 2011 representing 81.6% of the total population. All other main groups have increased both in number and proportion, particularly within the Black groups and Other White Group.

Components of population change

- The number of births in Thurrock has continued to increase, from 1,852 births in 2001, to 2,326 in 2013.
- The number of deaths has decreased from 1,216 in 2001 to 1,170 in 2013.
- The natural population change (births minus deaths) shows a large increase in number of people from 636 in 2001 to 1,213 in 2013. This accounted for 12,898 additional residents between 2001 and 2013.
- There has been substantial movement of people from London to Thurrock, particularly from geographically close boroughs, including Havering, Barking and Dagenham and Newham. The London boroughs as a whole account for over 50% of all internal migration into Thurrock.
- Since 2001, ONS has estimated that international migration into Thurrock has varied from about 500 people annually in 2001, rising to a peak of 1,300 in 2006/7, before decreasing to 723 in 2012/13 - leading to a net flow of about 4,200 people over the period.

Tenure

- There has been a small increase in number of total households rising from 58,485 to 62,353 between 2001 and 2011: a 3.6% increase.
- There has been a significant rise in the proportion of private rented sector housing from 5.9% in 2001 to 13.2% in 2011. The number of households in this sector has risen from 3,456 to 8,220 representing an increase of 137.9%.

Household Structure

- There has been a 12.5% decrease in one person households aged 65 and older, and a 9.7% decrease in family households all aged 65 and over, together representing 10,379 households in 2011. The overall borough household proportion for both of these groups is substantially less than for either the East of England or England.
- Lone parent households with dependent children have increased by 880 to 4,744 in 2011, representing a rise of 22.7% between 2001 and 2011. Thurrock has 7.6% lone parent households with dependent children, which is a slightly higher proportion than for the East of England but similar to the 7.1% for England.

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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 this year 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 2,326 in 2013.

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

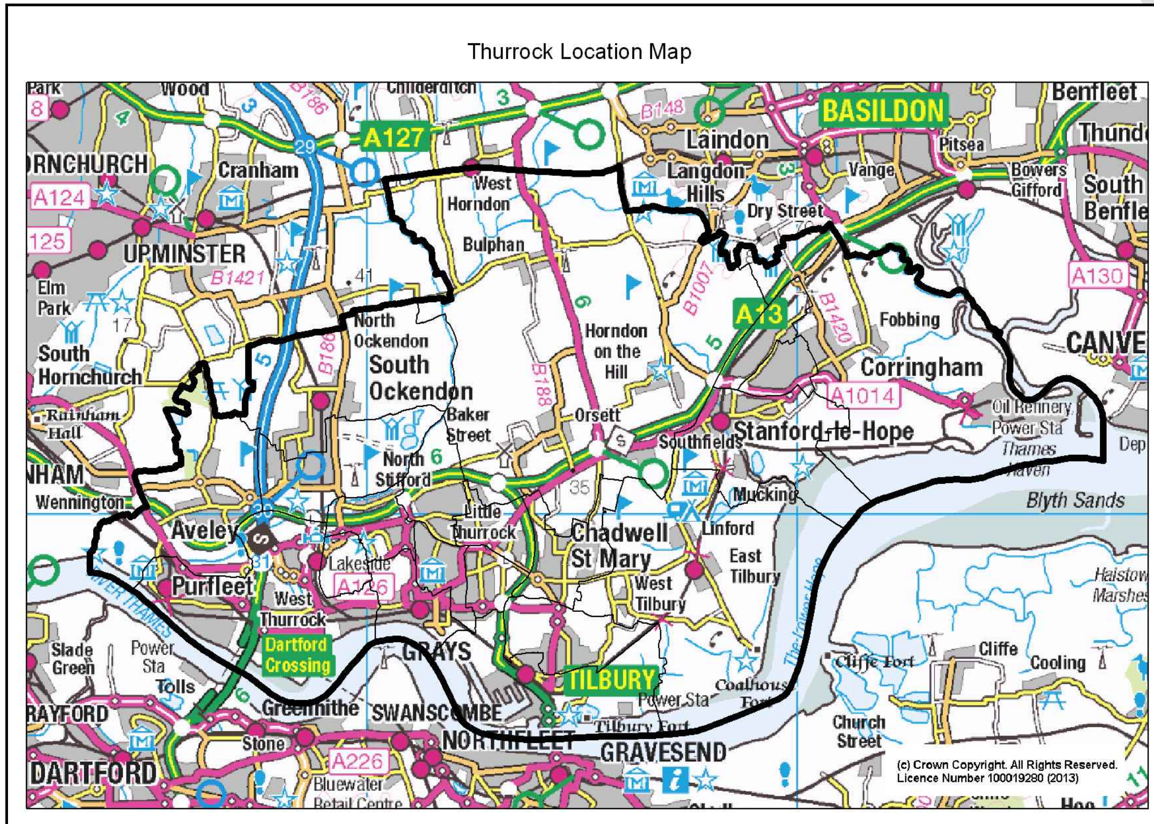
7. There has been a significant rise in the proportion of private rented sector housing from 5.9% in 2001 to 13.2% in 2011. The number of households in this sector has risen from 3,456 to 8,220 representing an increase of 137.9%.

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 2013 mid-year estimated population of Thurrock was 160,850 of which 79,330 (49.3%) were males and 81,520 (50.7%) females. This is the latest population estimate for the authority and is published annually.

Table 1: 2013 Mid-Year Estimates ONS by Age-Group

Age Group	Males	Females	Persons	Males	Females	Persons
	Number	Number	Number	% of males	% of females	%
0 - 4	6,160	6,000	12,150	7.8%	7.4%	7.6%
5 - 9	5,740	5,660	11,400	7.2%	6.9%	7.1%
10 - 14	4,940	4,780	9,720	6.2%	5.9%	6.0%
15 - 19	5,030	4,870	9,900	6.3%	6.0%	6.2%
20 - 24	4,700	4,640	9,340	5.9%	5.7%	5.8%
25 - 29	5,510	5,910	11,410	6.9%	7.3%	7.1%
30 - 34	5,690	6,270	11,960	7.2%	7.7%	7.4%
35 - 39	5,840	6,010	11,850	7.4%	7.4%	7.4%
40 - 44	6,210	6,180	12,380	7.8%	7.6%	7.7%
45 - 49	6,240	5,990	12,240	7.9%	7.3%	7.6%
50 - 54	5,190	4,960	10,150	6.5%	6.1%	6.3%
55 - 59	4,310	4,180	8,490	5.4%	5.1%	5.3%
60 - 64	4,080	3,970	8,050	5.1%	4.9%	5.0%
65 - 69	3,610	3,830	7,430	4.6%	4.7%	4.6%
70 - 74	2,260	2,660	4,910	2.8%	3.3%	3.1%
75 - 79	1,760	2,100	3,860	2.2%	2.6%	2.4%
80 - 84	1,180	1,670	2,850	1.5%	2.0%	1.8%
85 - 89	650	1,200	1,850	0.8%	1.5%	1.2%
90 +	250	660	920	0.3%	0.8%	0.6%
Total	79,330	81,520	160,850	100.0%	100.0%	100.0%

Source: ONS mid-year estimates

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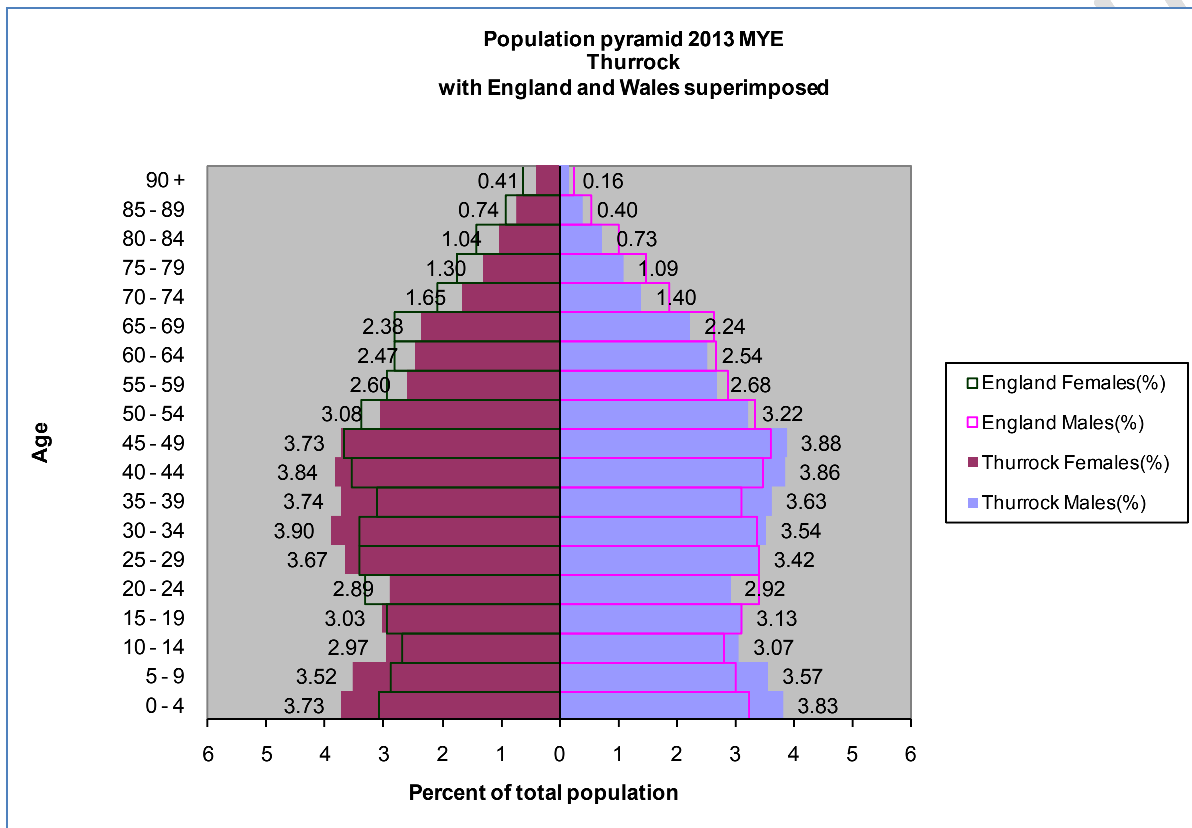
Figure 2 shows a population pyramid which depicts the age structure of Thurrock in 2013 compared to that of England and Wales. Whilst the pyramids are similar there are some clear differences: Thurrock has a relatively young population with almost all the quinary age groups under 50 years forming a greater proportion of the total population compared to England and Wales; and conversely the age groups over 50 years forming a lower proportion of the total population compared to England and Wales.

Figure 2: Population Pyramid by Quinary Age-Group in Thurrock and England



Source: ONS mid-year estimates

2.1.2 Census 2011 Age Structure and Change

Whilst the mid year estimates provide the latest population figures, the 2011 Census is a much richer source of information.

Table 2 describes the change in age structure between 2001 and 2011.

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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

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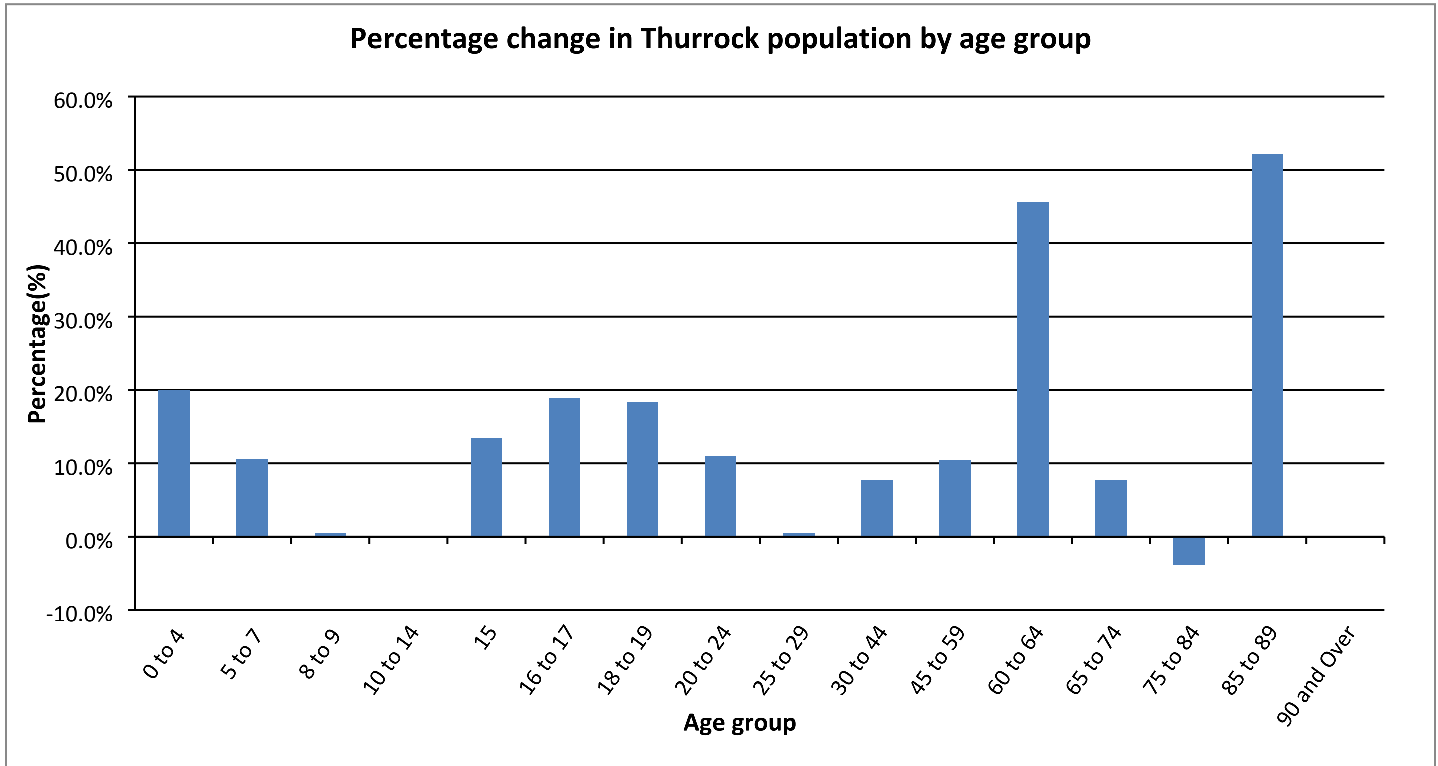
- There has been a 20% rise in 0-4 year olds between 2001 and 2011. This age group makes up 7.6% of the Thurrock's population which is greater than the England average.
- The borough's population aged over 60 years has increased by 16.5% since 2001. However, the proportions of people in each of the 60+ 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.

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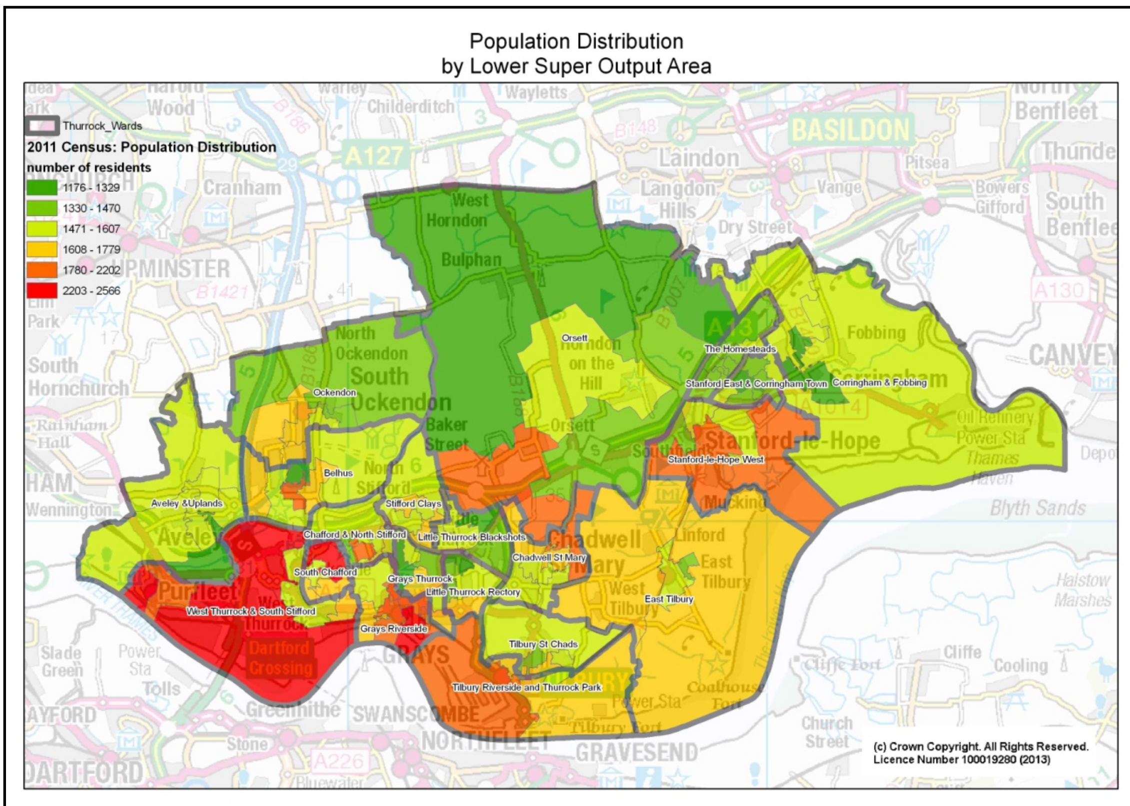
Figure 4: ONS 2011 Population Distribution by Lower Super Output Area



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.]

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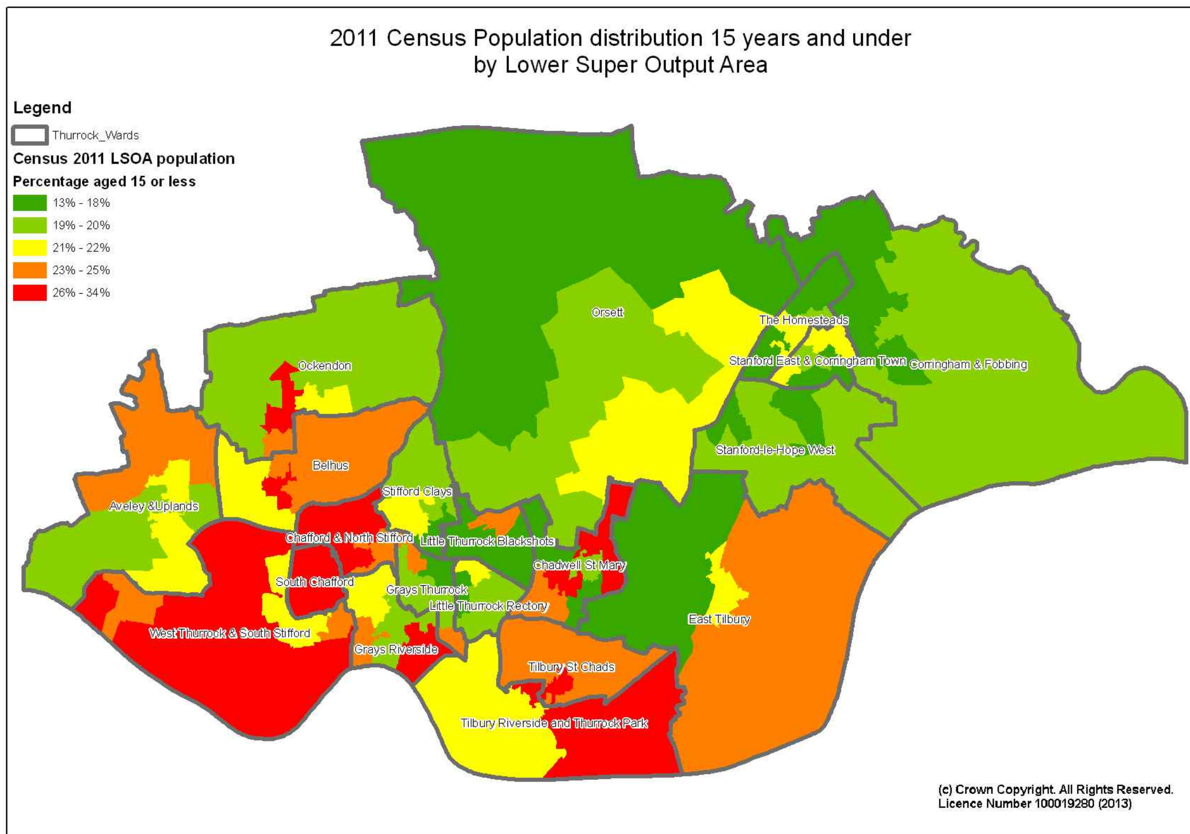
Figure 5: Population Distribution for people aged under 15 years by Lower Super Output Area

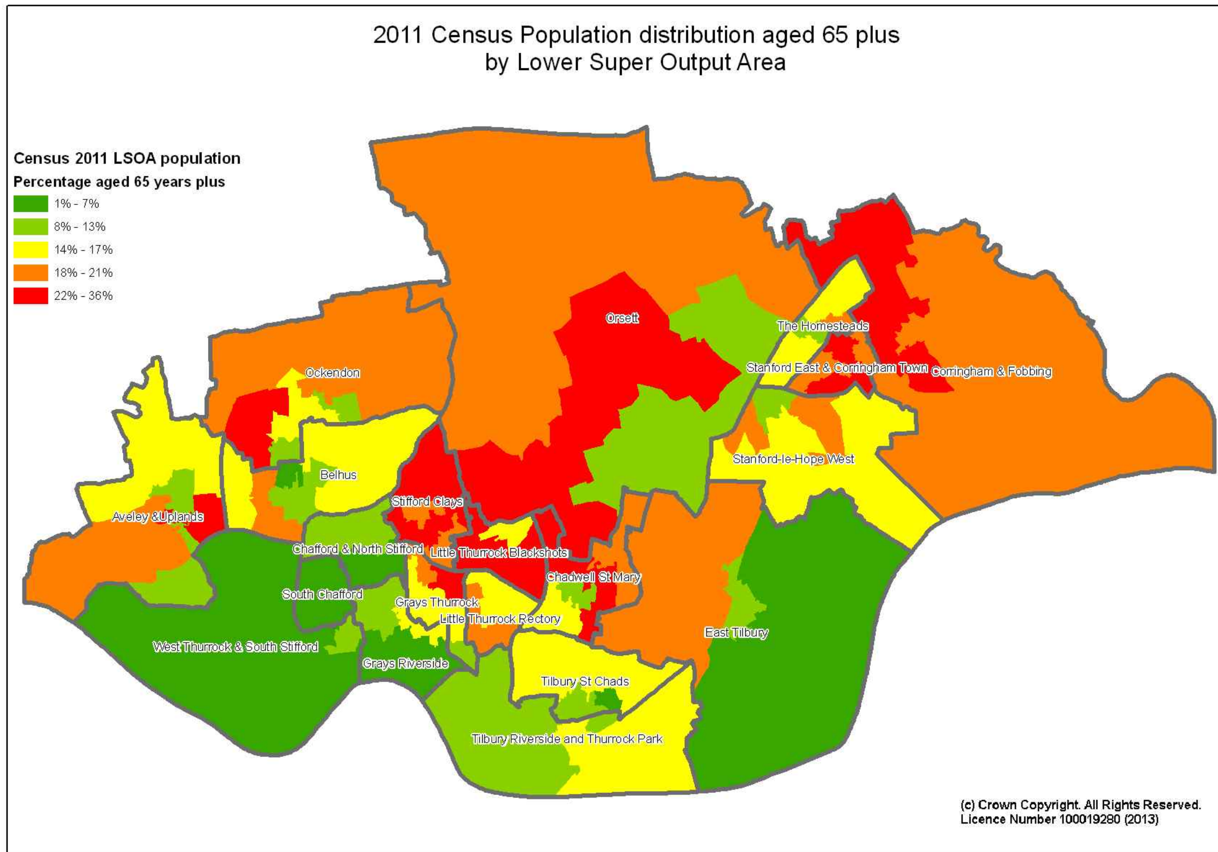


Source: Census 2011

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

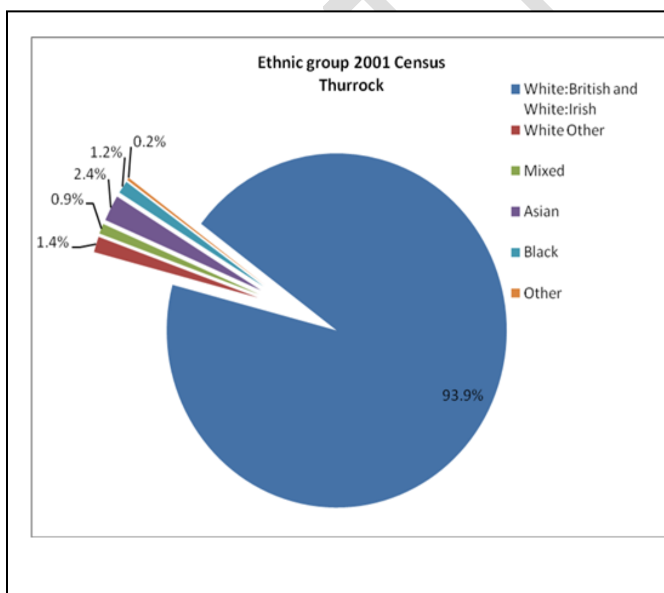
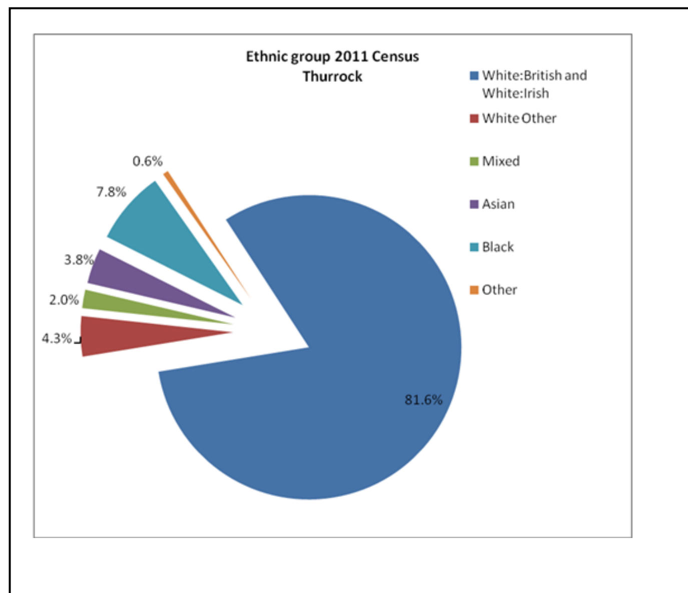


Figure 8: 2011 Condensed Ethnic Groups



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.

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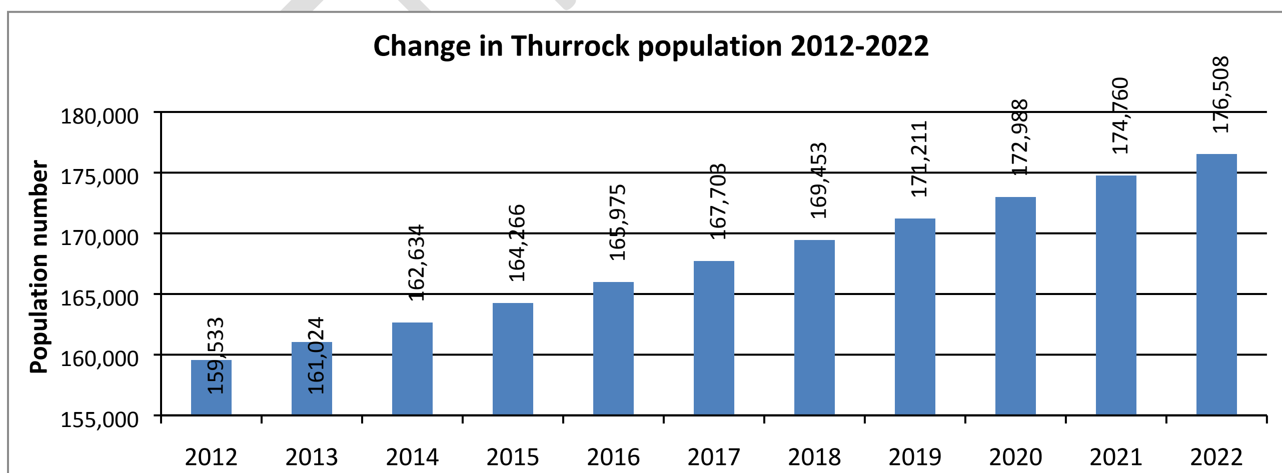
Figure 9: Population Projections, 2012-2022



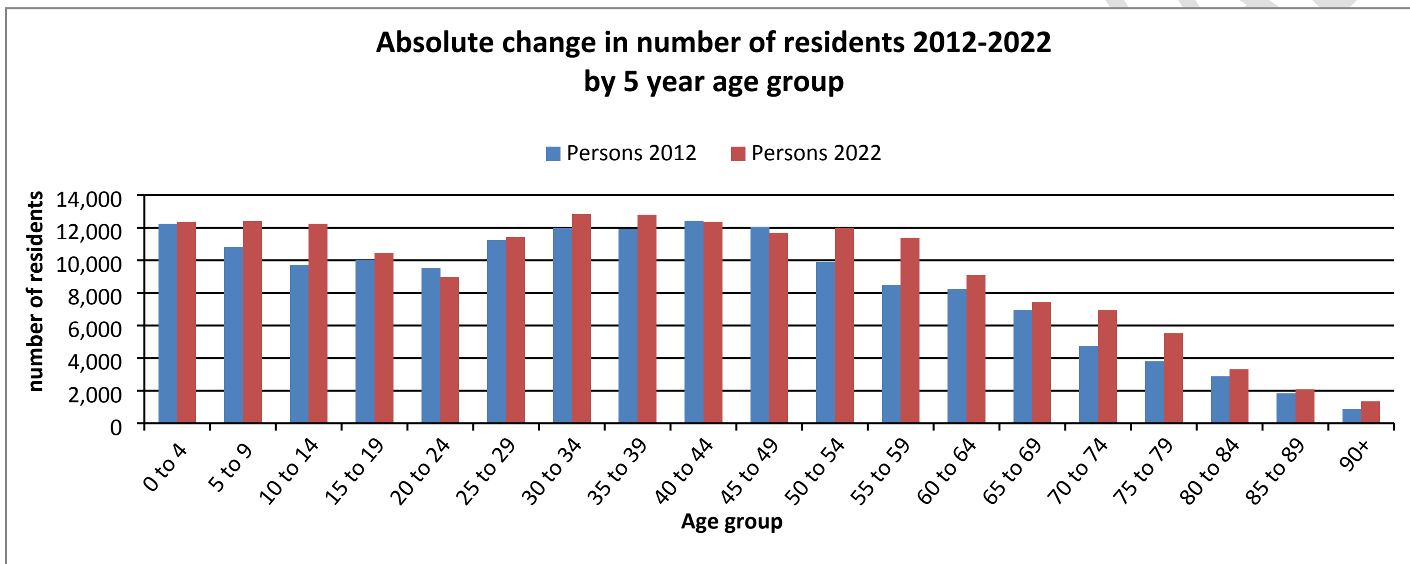
Source: ONS Subnational population projections; 2012

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%

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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

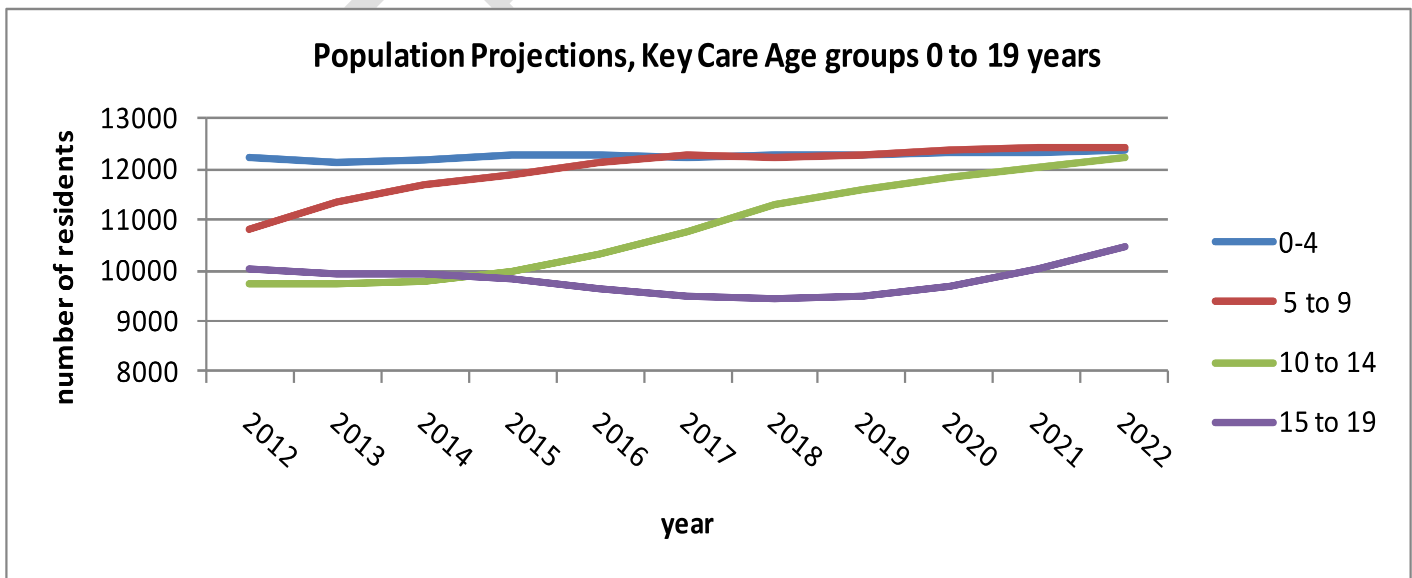
2.4.2 Key Care Groups

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.

2.4.2.1 Residents 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

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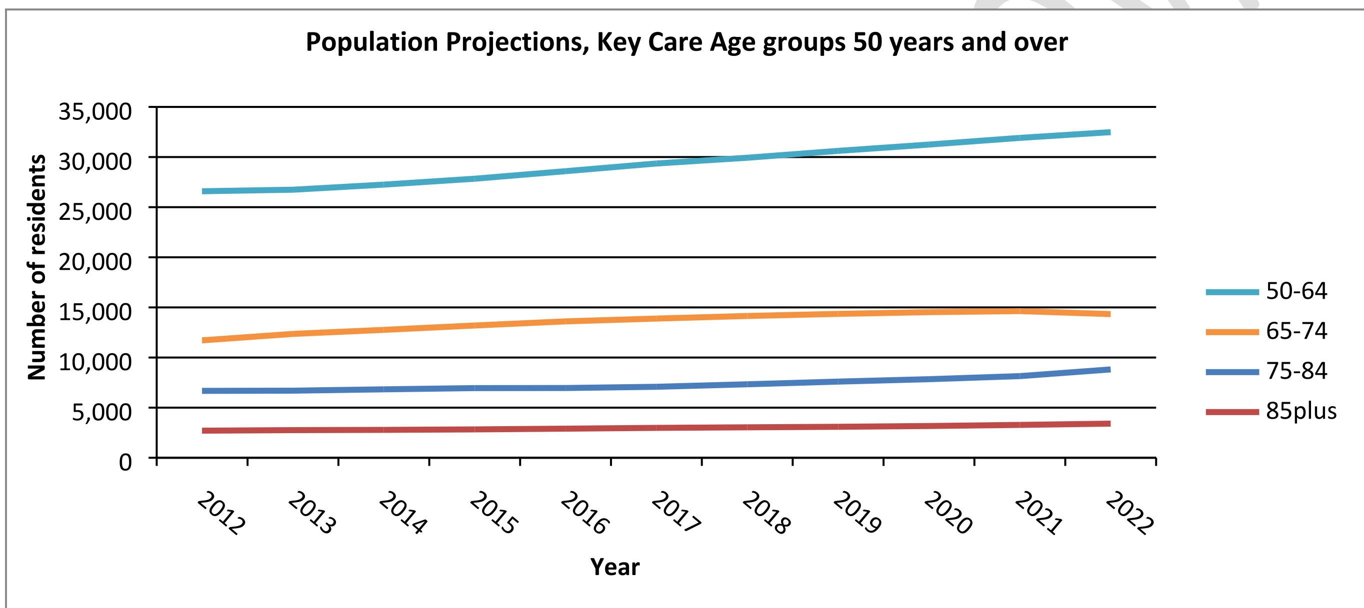
2.4.2.2 Residents aged 50 years and over:

Figure 12 shows the ONS absolute population projects for four age bands for the population aged 50 years and over. As the figure shows, Thurrock will see a significant ageing of its population among the key older care groups – 50-64, 65-74, 75–84 and 85+, all of which will increase in absolute terms and as a proportion of the population.

By 2022, the population group aged 50-64 is projected to increase by 5,900, which is an 18% increase, and the population group aged 75-84 is projected to increase by 2,139 (26%).

Figure 12: Population Projections by Key Care Group – Older People 2012-2022



Source: ONS Subnational Population projections; 2012

2.5 Components of Population Change

Population change reflects the influence of several different components. The principal components of change are births and deaths (reflecting fertility and mortality rates), and internal and international migration. This section describes the effect these components have on the population of Thurrock.

Table 6 shows the details of these components of population change for the latest 2013 mid-year estimates.

Table 6: Components of change 2012-2013 (figures are rounded to the nearest hundred)

	2012	2013
Population	159,500	160,800
Natural Change		1,200
Births		2,400
Deaths		1,200

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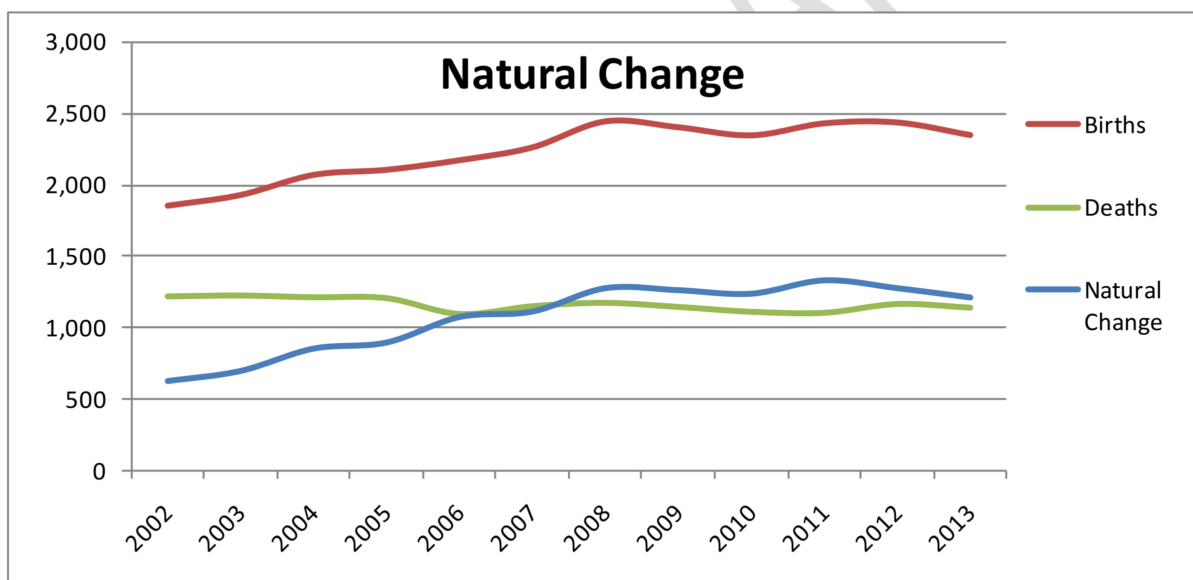
All Migration NET		300
Internal Migration In		*6,300*
Internal Migration Out		*6,100*
International Migration In		*800*
International Migration Out		*700*
Cross-border Migration In		*100*
Cross-border Migration Out		*200*

Source: ONS

2.5.1 Natural Change

The reason for a net population increase has been the process of natural change which is the difference between the number of births and number of deaths in an area. Figure 13 shows the natural change between 2002 and 2013. The net effect of these components (births minus deaths) shows a large increase from 636 in 2002 to 1,213 in 2013. Further information on births and deaths in Thurrock is provided further down in this chapter.

Figure 13: Natural Change: Components of population change between 2002 and 2013



Source: ONS mid-year estimates

2.5.2 Internal Migration

Internal migration defines movement of people between one area of England and Wales to another. This is principally measured by changes in home address registered with a General Practitioner. Figure 14 shows movement in and out of Thurrock within England and Wales for each year between 2002 and 2013.

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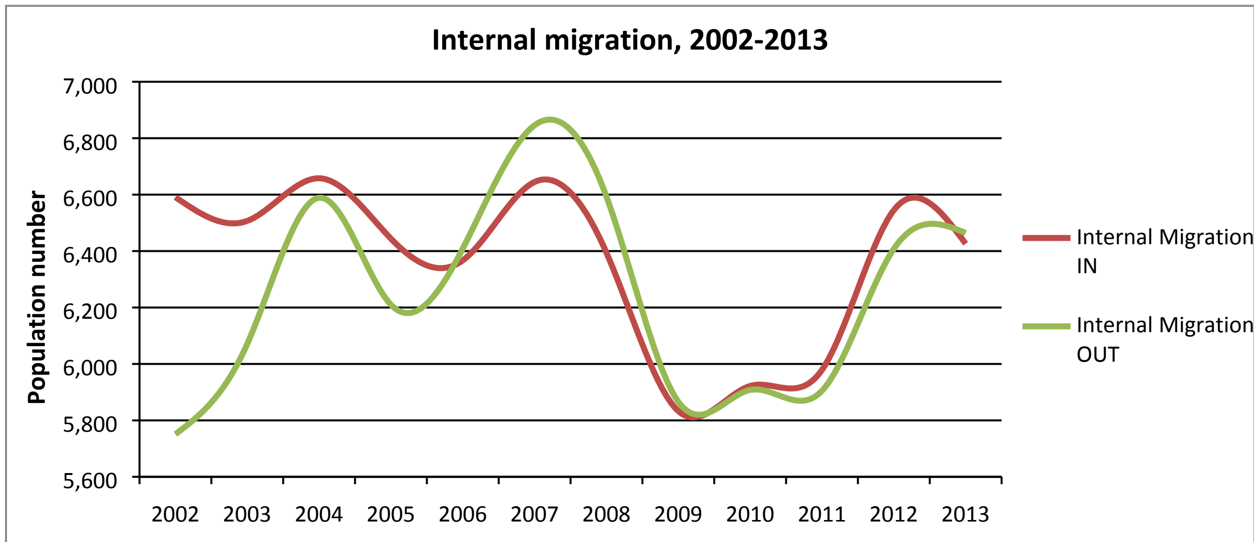
Figure 14: Internal migration between 2002 and 2013



Source: ONS mid-year estimates

6,591 people moved into Thurrock from other parts of England in 2001/02. This annual number has remained fairly stable up to 2012/13 (6,426). The number of people moving out of Thurrock has also remained fairly stable over the period and has roughly balanced the inward internal migration. There has been a net increase of 1,291 people due to internal migration over the period.

Internal migration is an important component influencing the characteristics of the population. Even though overall, the number of people moving out of and into Thurrock has roughly balanced over the 10 years, the demographic characteristics of these people may be substantially different. Internal migration data indicates that there are a larger proportion of children and adults under 30 years moving into Thurrock than older adults. There has been substantial movement of people from London to Thurrock, accounting for 62% of all internal migration into the area. This has come particularly from geographically close boroughs, including Havering, Barking and Dagenham and Newham - between 2012 and 2013, 3,860 people moved from these areas to Thurrock. Internal migration out of Thurrock tends to be much more confined to other parts of Essex and the eastern region rather than London which only accommodates 27% of people leaving Thurrock.

2.5.3 International Migration

This section describes international migration into Thurrock. Information is taken from a number of sources:

- The International Passenger Survey (which feeds into the mid year estimates)
- National Insurance registrations for overseas nationals
- Detail taken for the 2011 Census on country of birth and length of time resident in the UK.

International migration estimates are largely derived from sample surveys (International Passenger Survey) and at local level are subject to more error than internal migration estimates. Since 2001, ONS has estimated that international migration into Thurrock has varied from about 500 people annually in 2001, rising to a peak of to 1,300 in 2006/7 before decreasing to 713 in 2012/13. International migration out of Thurrock has consistently been less than this, leading to a net increase of about 4,200 over the period.

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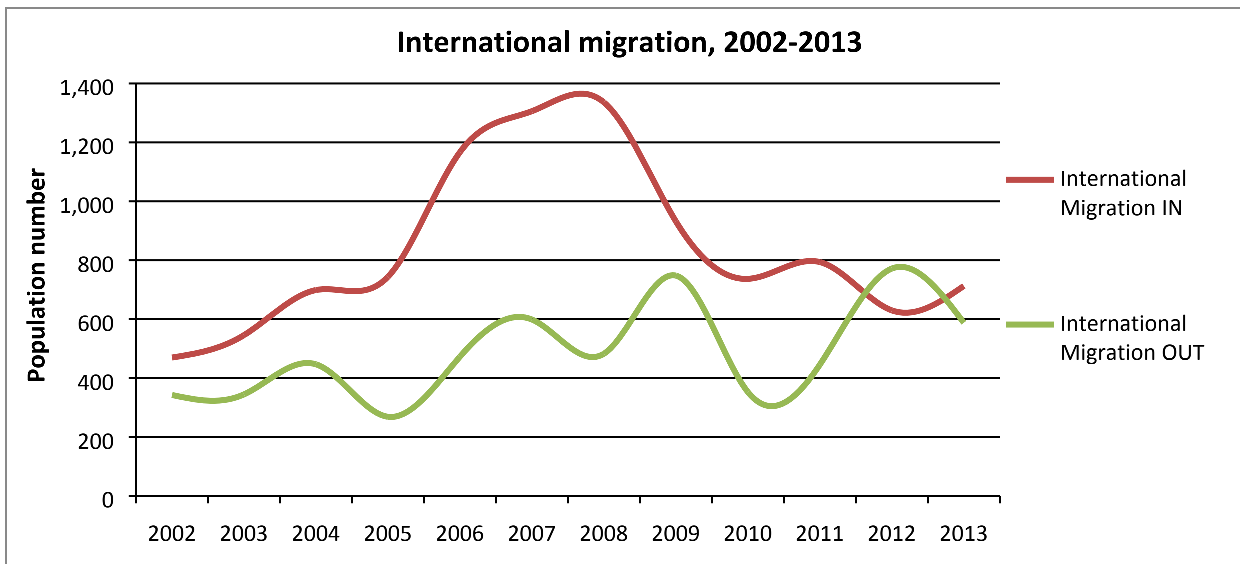
Figure 15: International Migration between 2002 and 2013



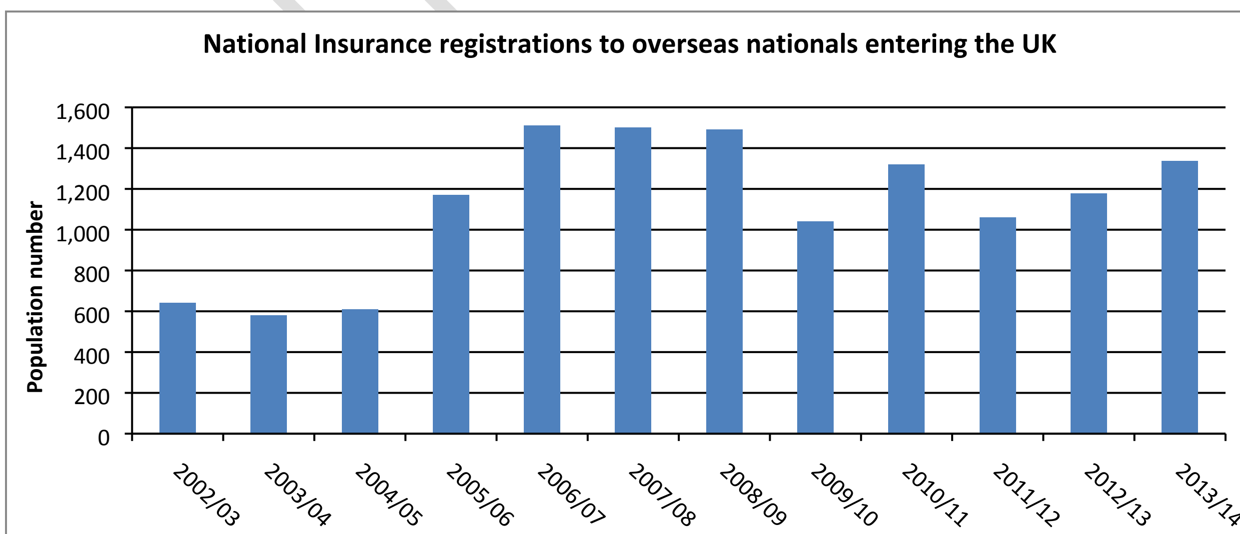
Source: ONS mid-year estimates

2.5.3.1 Economic Migration – National Insurance Number Registrations

The number of new national insurance number registrations by non-UK nationals provides another indication of the extent of international migration. This data suggests that economic international migration has been increasing in Thurrock in recent years, although falling slightly since 2009/10.

In 2013/14 1,338 non-UK nationals registered for a new NI number in Thurrock. Most new registrations in the decade occurred in 2006/7 to 2008/9 at about 1,500 per annum. The figures are higher than official ONS estimates for international migration suggest, but will also include short term migrants. It can be seen from figure 16 below that registration numbers have been increasing since 2011/12.

Figure 16: National Insurance Registrations to overseas nationals entering the UK



Source: DWP 2014

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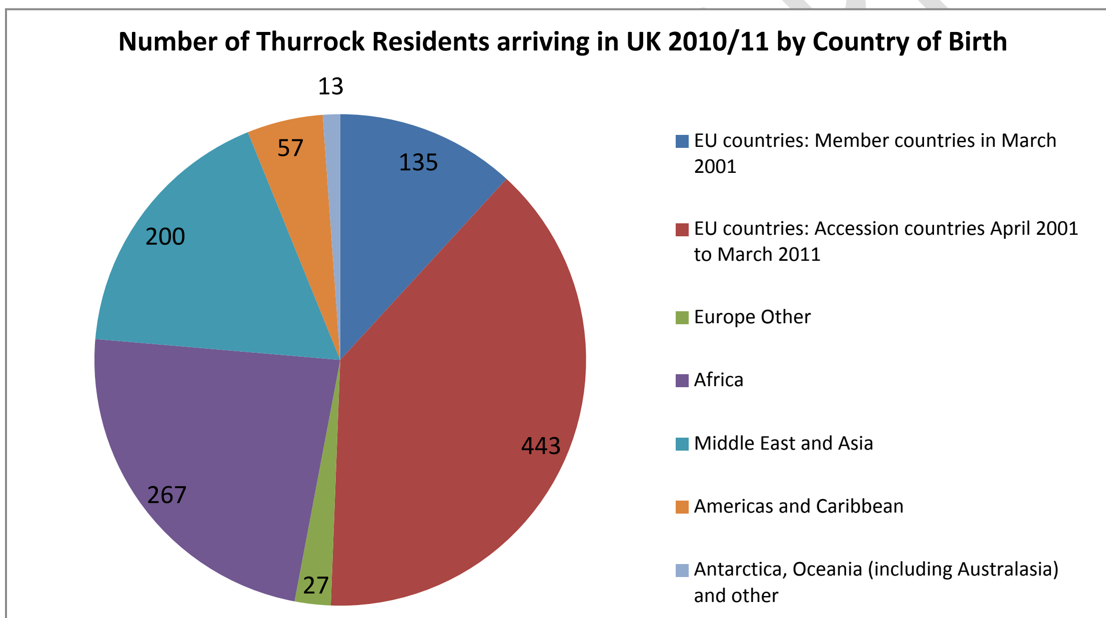
The majority of migrants newly registered with a national insurance number in Thurrock came from Eastern Europe and Africa. The top five countries of origin in 2013/14 were Poland (306), Romania (186) Nigeria (118), Slovak Republic (117) and Lithuania (102). These 5 countries accounted for 63% of all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

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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.

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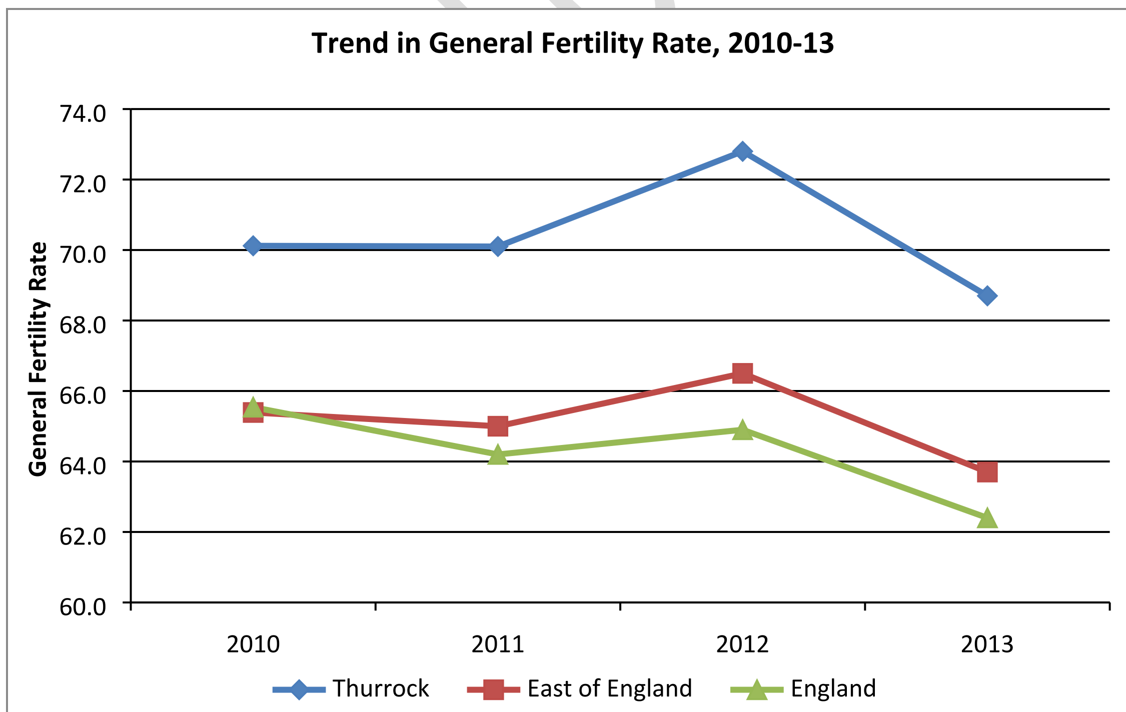
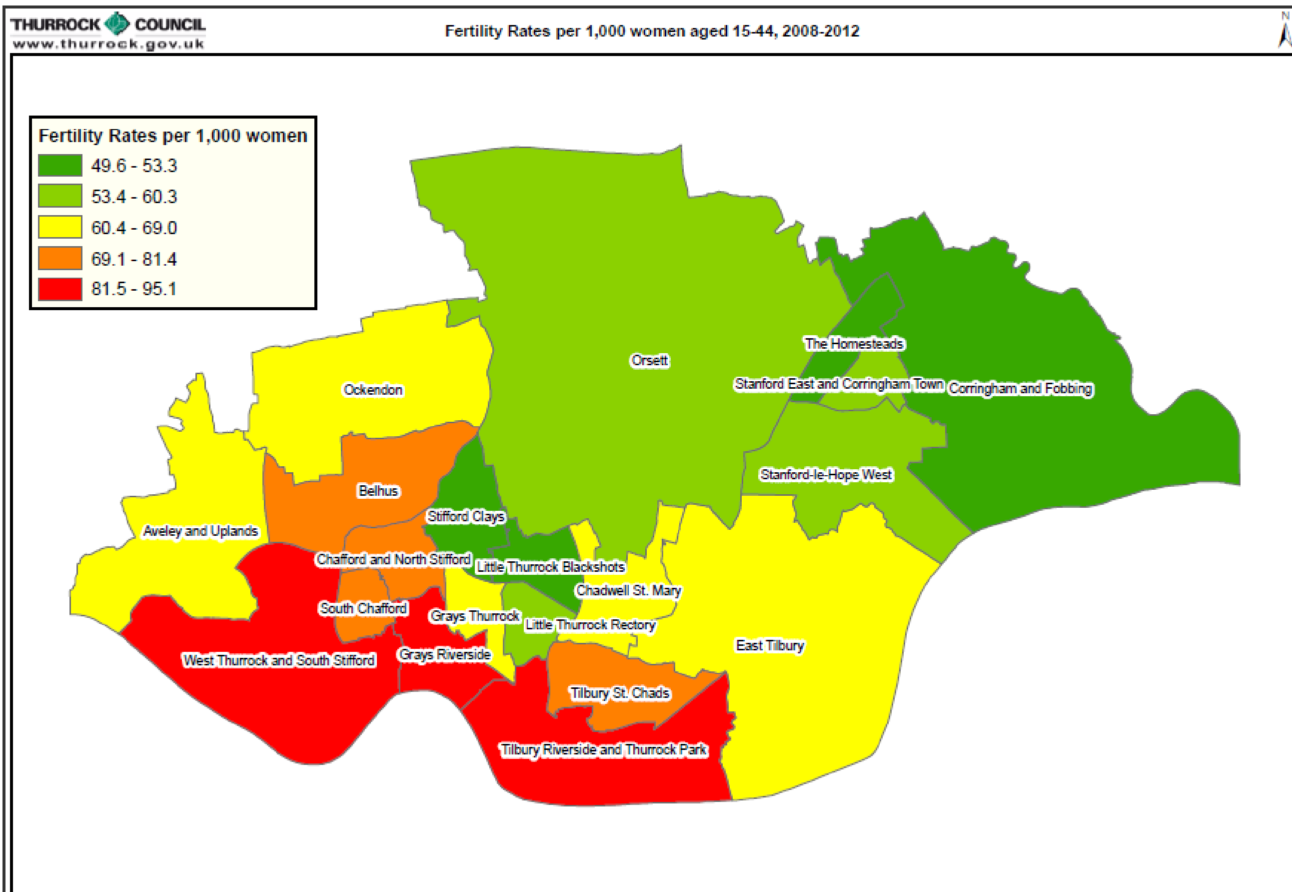
Figure 18: Trend in General Fertility Rate, 2010-2013



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

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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.

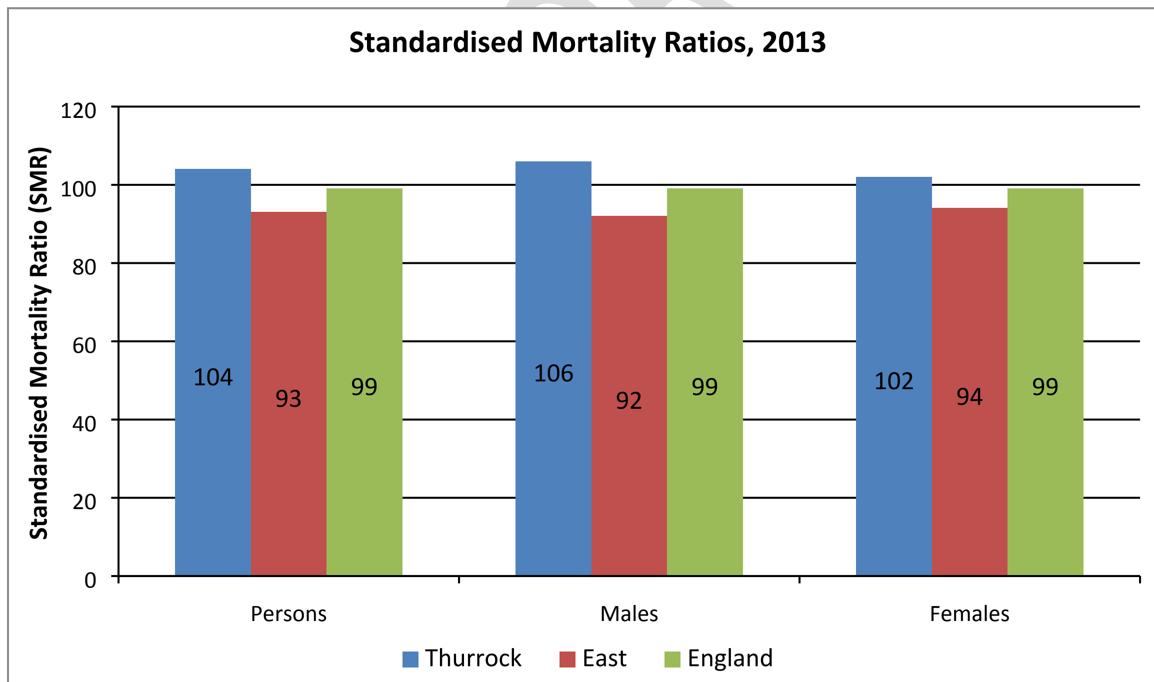
Area	Males			Females		
	2000	**2012**	**% change**	**2000**	**2012**	**% change**
Thurrock	839.94	624.88	-25.6%	594.80	479.06	-19.4%
England	841.84	614.31	-27.02%	564.50	447.70	-20.69%

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

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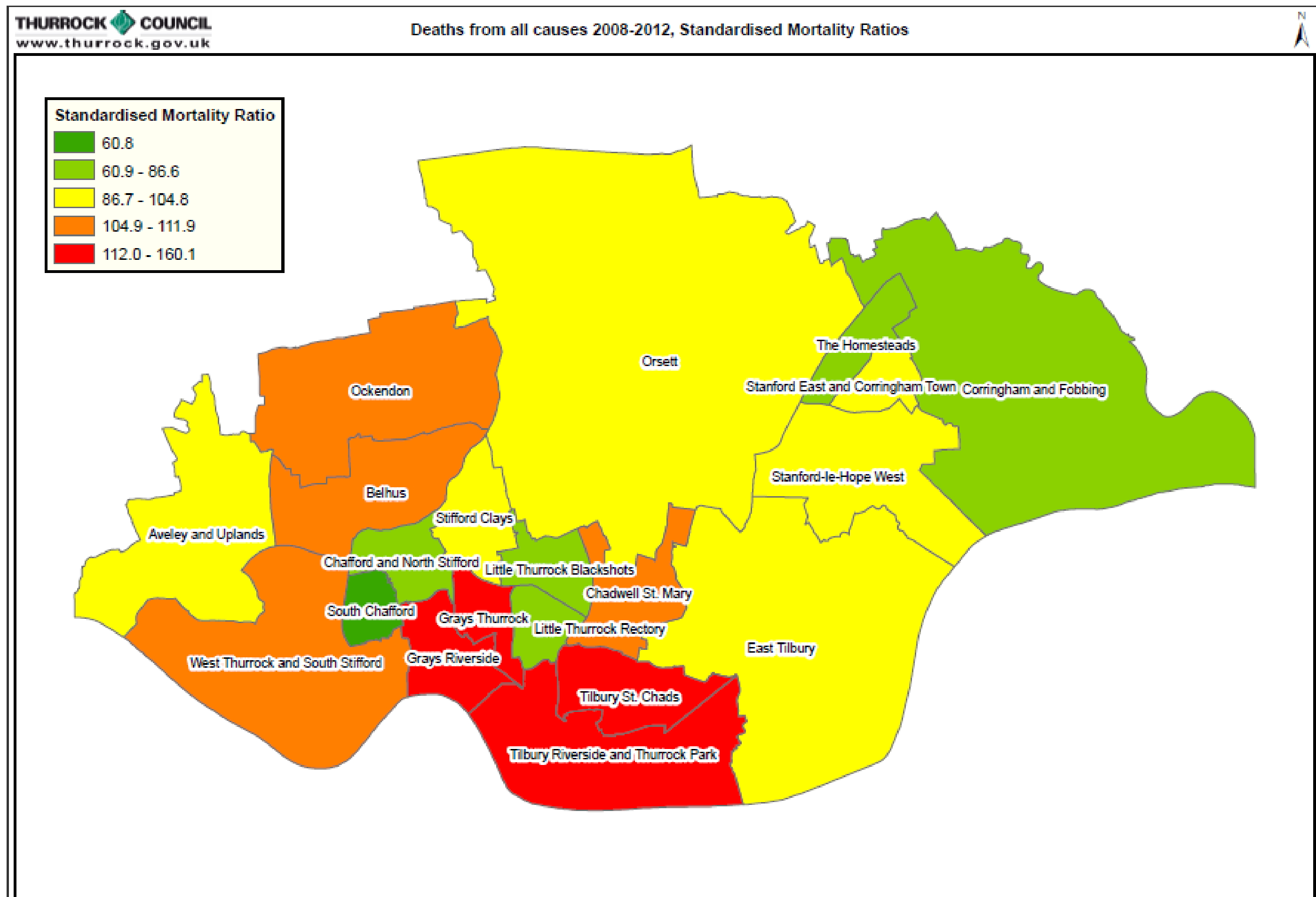
Riverside, Grays Thurrock and Tilbury St Chads also having high ratios. The lowest SMRs are in South Chafford (60.1) and The Homesteads.

Figure 21: Deaths from all causes in Thurrock by ward, 2008-2012, Standardised Mortality Ratios



Source: Local Health

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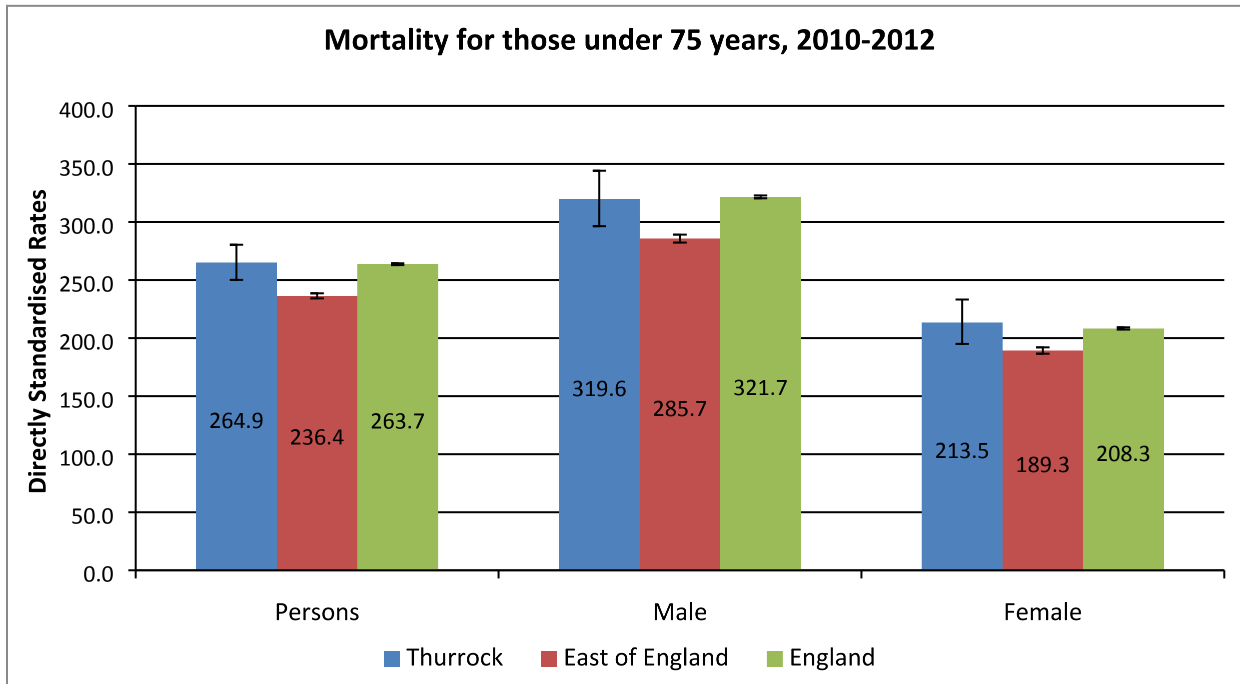
3.2.1 Premature mortality

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

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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:

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- 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:	3,703	2,601	1,102	42.4%	5.9%	4.4%	4.3%	4.0%

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	Thurrock (Number)		number Increase / Decrease	% Increase / Decrease in number	Thurrock (%)		East of England (2011)	England (2011)
Dependent children								
One family only: Cohabiting couple: All children non-dependent	457	242	215	88.8%	0.7%	0.4%	0.5%	0.5%
One family only: Lone parent: Dependent children	4,744	3,864	880	22.8%	7.6%	6.6%	6.2%	7.1%
One family only: Lone parent: All children non-dependent	2,210	2,070	140	6.8%	3.5%	3.5%	3.2%	3.5%
Other household types: With dependent children	2,097	1,200	897	74.8%	3.4%	2.1%	2.2%	2.7%
Other household types: All full-time students	44	12	32	266.7%	0.1%	0.0%	0.3%	0.6%
Other household types: All aged 65 and over	137	174	-37	-21.3%	0.2%	0.3%	0.3%	0.3%
Other household types: Other	2,532	1,517	1,015	66.9%	4.1%	2.6%	3.7%	4.5%

Source: Census 2011 and 2001

Although the Census data has shown a decrease in one person households aged 65 and over since 2001, recent projections indicate that Thurrock will see a large increase in this group in the future, with an additional 4,006 people aged 65 and over estimated to live alone by 2030. This should be considered in line with the projected increase in the older population as shown in Figure 12, which forecasts a large increase in the number of older people living in the borough. Figure 23 below depicts the estimated increase in people living alone by gender up to 2030.

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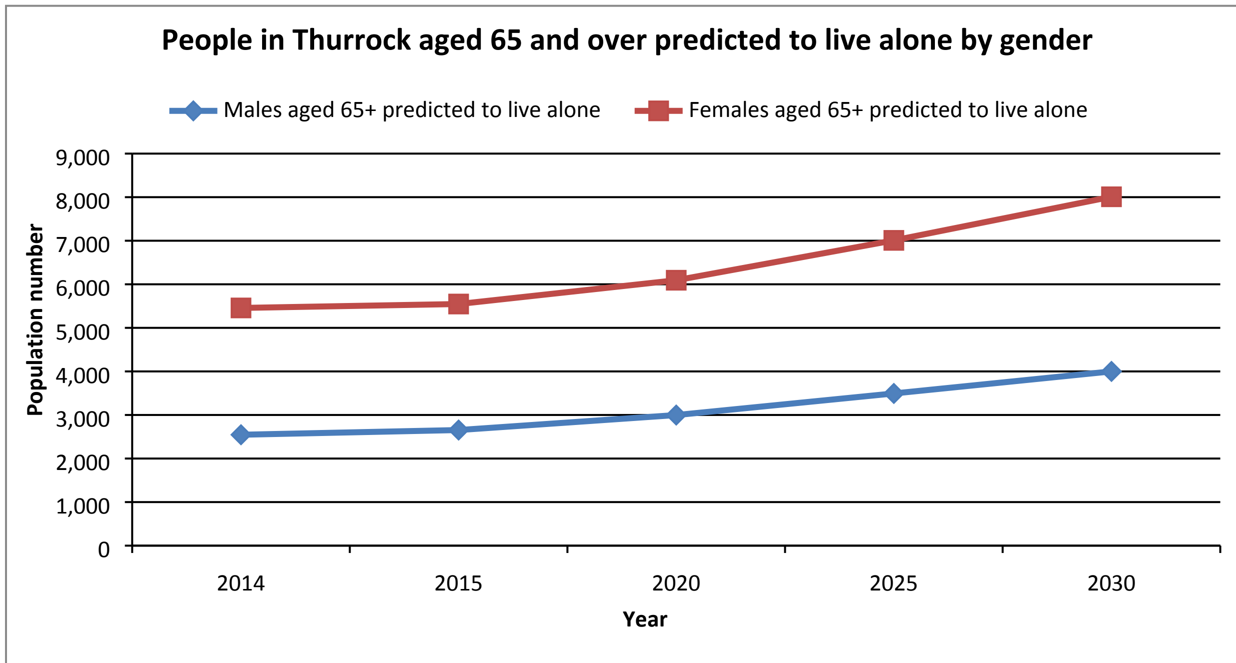
Figure 23: People aged 65 and over predicted to live alone by gender, 2014-2030



Source: Projecting Older People Population Information (POPPI) System

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15 June 2015	ITEM: 10
Health and Wellbeing Board	
Tobacco Control Strategy	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Kev Malone, Public Health Manager	
Accountable Head of Service: Debbie Maynard	
Accountable Director: Roger Harris, Director of Adults, Health & Commissioning	
This report is Public	

Executive Summary

This report provides the Thurrock Tobacco Control Strategy 2014 – 2019 for ratification by the Board.

This Strategy was developed following a public consultation in the summer of 2014 and a stakeholder workshop in October 2014.

It has been approved by the Tobacco Control Alliance and the delivery plan within the strategy remains a live document of which the Alliance monitors progress. The objectives link to Public Health and Corporate priorities.

1. Recommendation(s)

That the Board:

1.1 Ratify the Thurrock Tobacco Control Strategy 2014 - 2019

1.2 Ratify the Delivery Plan contained within this document

2. Introduction and Background

2.1 Health harms caused by tobacco remain a main public health priority for Thurrock. Our adult smoking prevalence rate crept up slightly to 22.8 per 1,000 in 2013/14, (against the national trend that saw a further decline) meaning more than 1 in 5 adults in Thurrock smokes. Tobacco is a uniquely dangerous product because when used as the manufactures intend it will kill half of all life-long users.

2.2 Yet footfall into stop smoking services is currently in decline, partly due to e-cigarettes and smokers switching to ‘vaping’ or dual-using both products. Nevertheless, helping people to quit smoking with behavioural support makes them 5 times more likely to quit. Quitting tobacco is the single biggest thing a smoker can do to improve their health and it is never too late to quit.

3. Issues, Options and Analysis of Options

3.1 However, we needed to think more broadly beyond just a treatment model, with a greater emphasis on prevention and enforcement that reflects the consultation results from last summer. This is why we developed this Tobacco Control Strategy, evolved the Smoke Free work stream into a Tobacco Control Alliance and redesigned the Local Stop Smoking Service away from a treatment model and into a Tobacco Control model of which the three key tenets are prevention, treatment and enforcement.

3.2 In November 2013 Thurrock Council became only the 22nd Local Authority to sign up to the Local Government Declaration on Tobacco Control. This committed us to a range of actions including:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and securing maximum benefit for our communities;
- Monitor the progress of our plans against our commitments and publish the results.

This strategy realises this commitment and provides a framework for its delivery alongside supporting the ambition set out in the vision.

4. Reasons for Recommendation

4.1 Ratifying this Strategy and Delivery Plan will provide the Tobacco Control Alliance with the mandate to drive this document, in turn achieving the associated targets and objectives.

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

5.1 In June and July 2014 a public consultation was conducted, including council staff and the Youth Cabinet, which informed Public Health of the community’s attitude to tobacco. The findings of this consultation are summarised in Appendix 3 of the Strategy and were presented to the October stakeholder workshop where the foundations of this Strategy were laid.

5.2 In April 2015 the final document was sent for comment to the 11-19 Strategy Group, the Youth Cabinet and children's social care (Children In Care and Foster Care) at the recommendation of Children's DMT. No representations have been received.

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

6.1 The Strategy and Delivery Plan contribute to both the Council's and CCG's priorities as stated in the Joint Strategic Needs Assessment (JSNA). It also underpins the Council's Smoke Free Policy for staff and visitors to the council.

7. Implications

7.1 Financial

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

There are no financial implications.

7.2 Legal

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

There are no legal implications.

7.3 Diversity and Equality

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

There is significant evidence available to demonstrate that smoking and the impact of smoke has a high potential impact on pregnancy, children and those with health conditions including heart and respiratory disorders. Thurrock's smoking rates are currently above the national average indicating that smoking does impact our communities moreso overall when compared to some other areas. This strategy will identify and implement actions and initiatives to prevent young people from starting smoking, ensure a range of options to motivate current smokers to stop smoking, with a view to protecting families and communities from the harm caused by smoking.

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):

- Smoking & Obesity Scoping Paper, Item 9, HWBB, 11th July 2013

9. Appendices to the report

- Appendix 1: Glossary
- Appendix 2: JSNA Section: Smoking – What do we know?
- Appendix 3: Thurrock Smoke Free Workshop Survey Summer 2014
- Appendix 4: The Six Strands (of tobacco control)

Report Author:
Kev Malone

Public Health Manager

Adults, Health & Commissioning

Thurrock

Tobacco Control Strategy

2014 – 2019

Kev Malone

Tobacco Control Lead, Thurrock Public Health

Jacqui Sweeney

Health Improvement Officer, Thurrock Public Health

"Public health is the science and art of preventing disease. Prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals"

(Winslow, 1920)

"Comprehensive tobacco control is more than just the provision of local stop smoking services or the enforcement of smokefree legislation. The effectiveness of tobacco control is dependent on strategies which implement a wide range of actions that complement and reinforce each other"

Tobacco Control Plan for England

Acknowledgements

Maria Payne	Health Needs Assessment Manager
Beth Capps	Senior Public Health Manager
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Lewis Collantine	Trading Standards
Elizabeth Cox	Licensing

Document Control

Title:	**Tobacco Control Strategy**
Purpose:	In partnership to produce a robust strategy with measureable outcomes and delivery plan
Owner:	Dr Andrea Atherton – Director of Public Health
Approved by:	Public Health Strategy Board Date Health and Wellbeing Board Date
Status:	Draft 0.4 30 January 2015
Review Frequency:	Annually

Amendment History

Version	Date	Author	Comments
Draft 0.1	10/12/14	KM	
Draft 0.2	12.01.15	KM	
Draft 0.3	13.01.15	KM	
Draft 0.4	28.01.15	DM	
V 0.5	16.04.15	KM	Final approved by Tobacco Control Alliance
V 0.6	13.05.15	KM	Updated Delivery Plan

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Executive Summary

Smoking continues to be the single biggest cause of death in England. In 2013 Thurrock's smoking prevalence was 22.8% which was above the national and regional rates but broadly in line with its Chartered Institute of Public Finance & Accountancy (CIPFA) comparators. Nationally prevalence for 2013 reached 18.4%, its lowest rate since records began.

This strategy sets out our vision for a five year plan from 2015 to 2019 for prevention, treatment and enforcement utilising the 6-strand approach of a tobacco control programme.(see appendix 1) Targets within the strategy stretch to 2019 in order to lay the foundations needed to achieve our aspirations that:

- By 2020 we will reduce by half the smoking prevalence of our under 20 year olds
- Between 2013 – 2016 we will reduce the prevalence of smokers.

We know that 80% of smokers take up the smoking by the age of 20, with 40% starting before the age of 16, shifting the strategy away from treatment and weighting it towards prevention will yield measurable future outcomes for individuals, families, communities and businesses.

Therefore this strategy will focus on prevention, setting challenging targets to engage with our young people in our schools and colleges to raise awareness of the harms of smoking.

The management and responsibility of this strategy will be through the Tobacco Control Alliance which reports into adults and children's directorate management team meetings (DMTs) and the Health and Wellbeing Board (HWBB).

Introduction and Strategic context

The Health and Social Care Act 2012 introduced the establishment of a new public health system. All local authorities now have a duty to improve the health of the people in their area and have responsibility for commissioning appropriate public health services. Progress in public health is measured by the Public Health Outcomes Framework (PHOF). Public Health's key areas are:

- Health improvement
- Health protection
- Healthcare public health

The PHOF has domains relevant to addressing the topic of Tobacco Control and the following areas are relevant to the new duties of the local authority:

- Smoking prevalence – 15 year olds
- Smoking prevalence – Adults (over 18 years)
- Smoking status at the time of delivery
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives on workplace health

One of Thurrock Council's five corporate priorities is to 'Improve Health and Wellbeing', demonstrating the Council's commitment to this agenda. The council has established a Health and Wellbeing Board (HWBB) that brings partners together to lead the integration of

health and well-being services across the NHS and local government, to assess the community's assets and needs and develop a Health and Wellbeing Strategy (HWBS) to improve the health and well-being of the community and to reduce inequalities.

The HWBB priority to 'improve health and well-being' has three specific objectives:-

- Ensure people stay healthy longer
- Reduce inequalities in health and well-being
- Empower communities to take responsibility for their own health and well-being.

Its vision is to have 'resourceful and resilient people in resourceful and resilient communities'.

The Thurrock Health and Wellbeing Strategy for 2013 – 2016; health and wellbeing targets are to improve the physical health and wellbeing of the people of Thurrock, with initial focus on reducing the prevalence of smoking. This will be accomplished by:

- Identifying and implementing actions and initiatives to prevent young people from starting smoking
- ensuring a range of options to motivate and encourage current smokers to stop smoking
- protecting families and communities from the harm caused by smoking
- developing approaches that use prevention, treatment and enforcement – particularly in restricting the supply of tobacco products to minors

In November 2013 Thurrock Council became only the 22nd Local Authority to sign up to the Local Government Declaration on Tobacco Control. This committed us to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and securing maximum benefit for our communities;
- Participate in local and regional networks for support; and
- Monitor the progress of our plans against our commitments and publish the results.

This strategy realises this commitment and provides a framework for its delivery alongside supporting the ambition set out in the vision.

Prevalence of smoking

Today smoking continues to be the leading preventable cause of death in England with over 8 million smokers. Tobacco is a uniquely dangerous product because when used as the manufactures intend it will kill half of all life-long users[1].

This diagram illustrates the number of deaths attributable to the following causes, as at October 2013

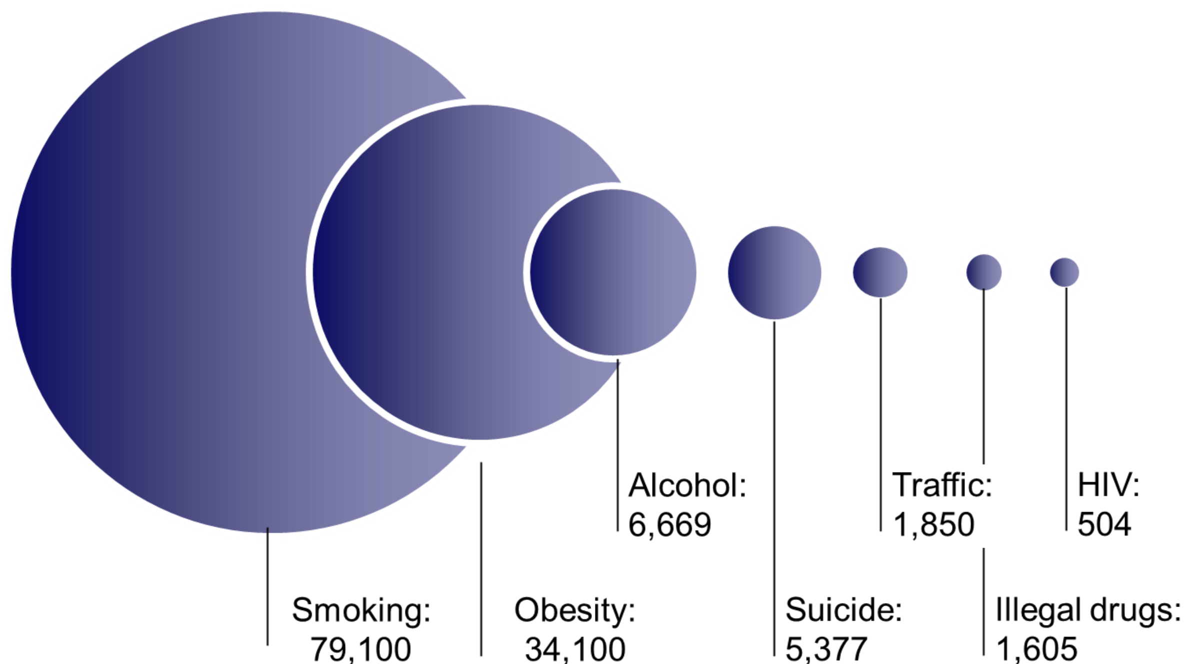


Figure 1, Source: ASH Factsheet, Smoking Statistics: illness & death, October 2013
http://ash.org.uk/files/documents/ASH_107.pdf

Local Profile

Over a fifth (22.8%) of Thurrock adults aged 18 years smoke. This is both an increase from the previous years (20.7%) and above the national average, the latter of which is currently the lowest figure since records began (18.4%)[2].

In 2013, Thurrock had the highest smoking prevalence out of its CIPFA (Chartered Institute of Public Finance and Accountancy) (nearest neighbours) comparator authorities. It was also significantly higher than the regional and national averages.

[1] Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years observations on male British doctors. BMJ 2004, 328: 1519 http://www.bmj.com/content/328/7455/1519

[2] http://www.tobaccoprofiles.info/profile/tobacco-control/data#gid/1000110/pat/6/ati/102/page/0/par/E12000006/are/E06000034

None of the CIPFA comparators were statistically better than the national average - of the 15 authorities, 8 were statistically similar and 7 were statistically worse.

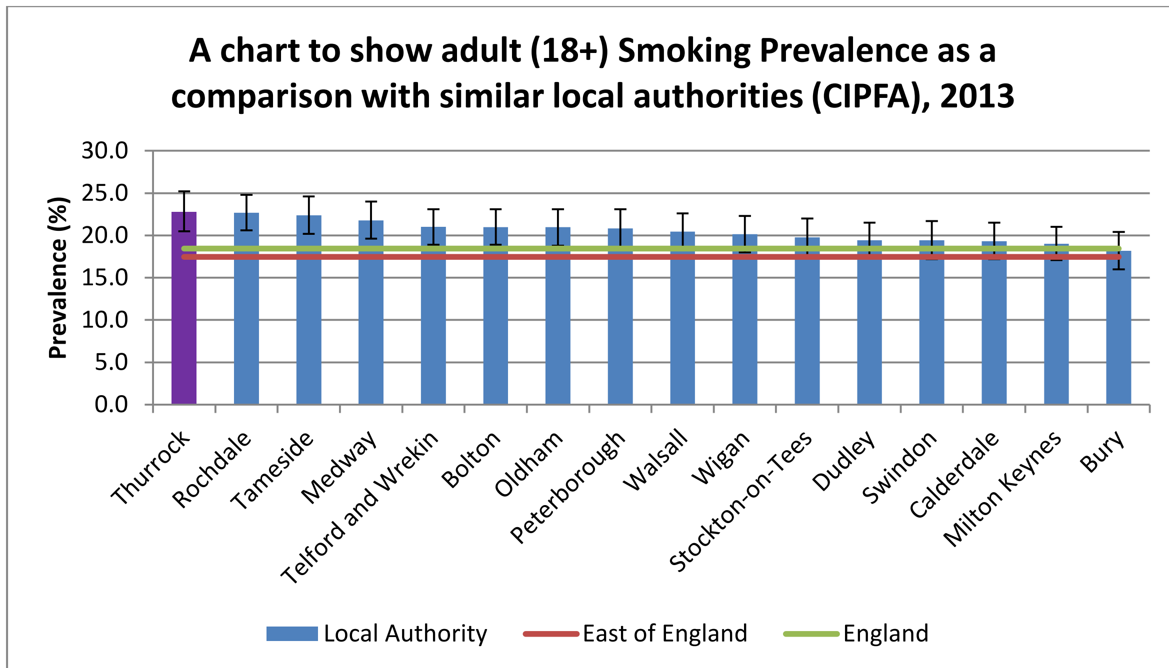
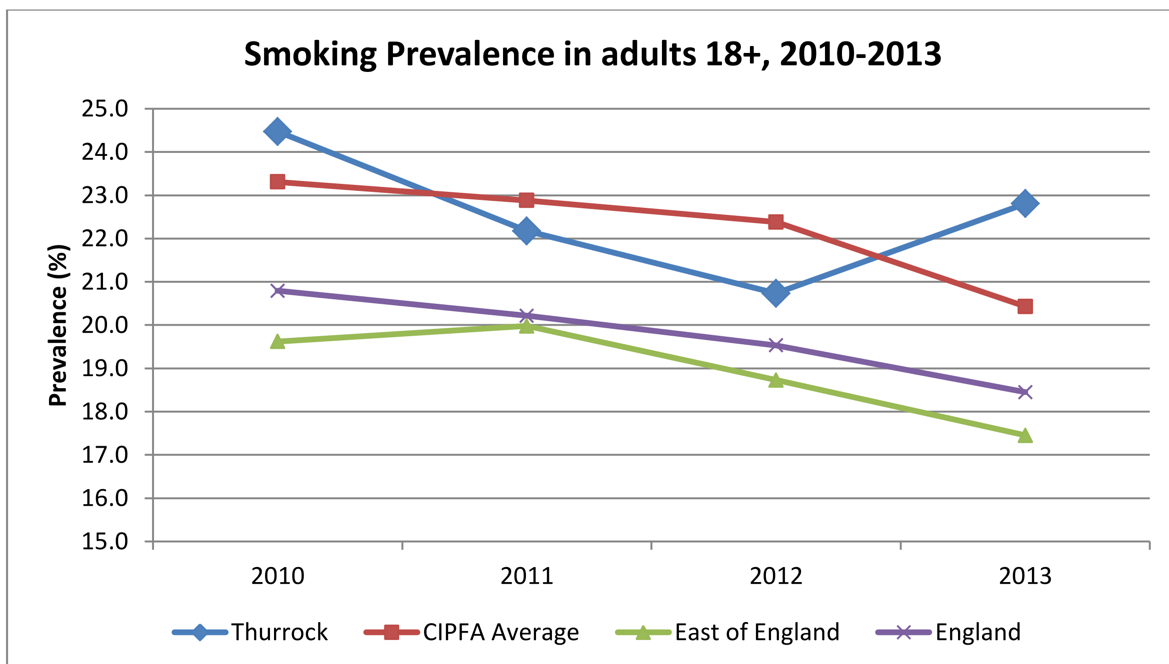


Figure 2, Source: Integrated Household Survey 2013.

Figure 3 illustrates how Thurrock outperformed the CIPFA comparator sites in reducing prevalence between 2010 and 2012, but in 2012/13 there is an increase of 2% where our comparator sites continue to reduce the smoking prevalence. Therefore a new approach is required. The cause in the 2% increase is currently unknown.



thurrock.gov.uk

Research tells us that 80% of smokers take up the habit before the age of 20[3], with 40% starting before the age of 16 years. Young people smoking prevalence rates for 2013 are currently estimated at some 11.5% for all under 20 year olds in Thurrock, with prevalence amongst 15 year olds (regular smokers) estimated at some 8.2%, reaffirming our focus for early intervention and preventative work with young people[4].

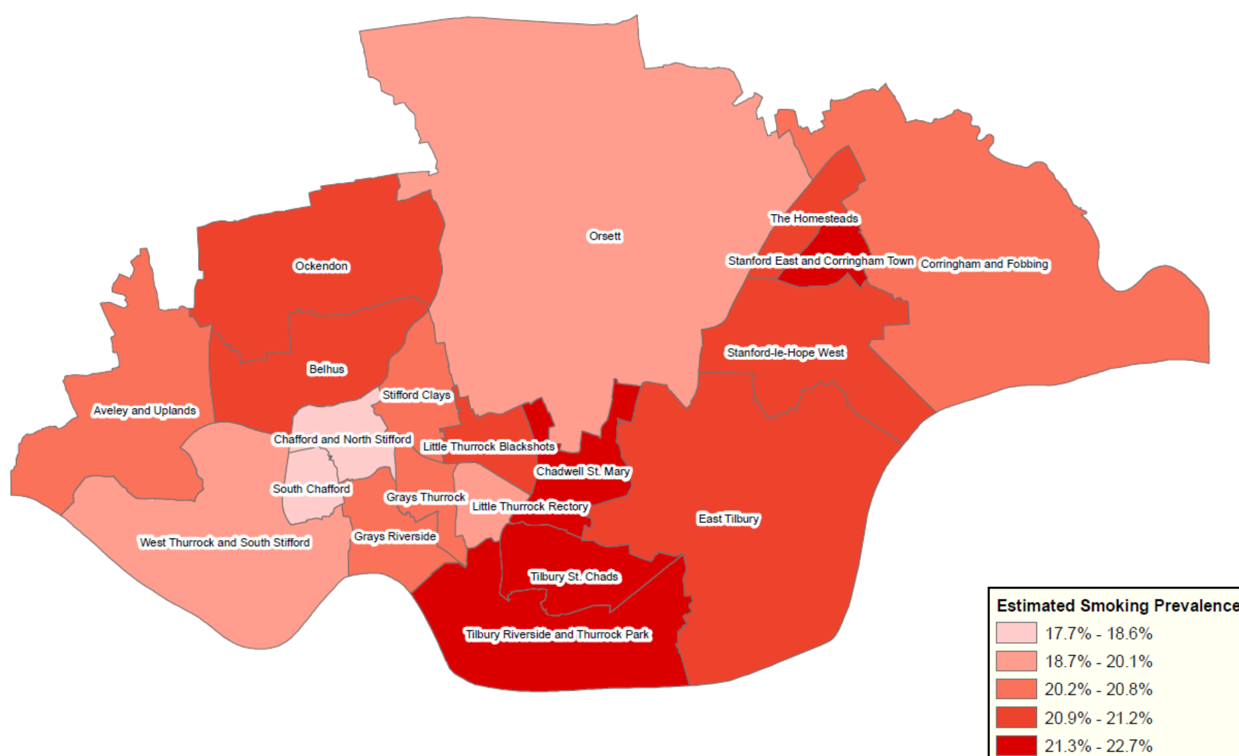
A level of caution needs to be applied to prevalence data as this based on self-reported evidence i.e. the Integrated Household Survey and GP records with the assumption that people and patients have been honest about their smoking status.

We are unsure if those who use e-cigarettes report themselves as a smoker or not which could have impact of prevalence figures.

If we can stop people from starting smoking this will make a measurable difference in future datasets, particularly if we target the young and those living in areas of deprivation; smoking is directly linked to health inequalities with prevalence significantly higher in areas of deprivation and vulnerable groups (see appendix 2).

The map in figure 4 below shows modelled synthetic estimates based on the 2012 Integrated Household Survey to illustrate smoking prevalence data in different wards in Thurrock. These data show a direct correlation with the more deprived areas of Thurrock demonstrating a clear health inequality.

Smoking Prevalence at ward level, 2012



[3] General Lifestyle Survey 2008
[4] Source: Children and Young People's Health Outcomes Framework http://fingertips.phe.org.uk/profile/cyphof (Accessed Feb 2015).

Figure 4

Thurrock's smoking prevalence in routine and manual occupational groups is higher than the overall smoking prevalence average for Thurrock.(25.6%) of adults aged 18+ within these groups smoke, which is just under the regional and national averages (28.4%, 28.6% respectively).

- The mortality rate attributed to smoking in Thurrock is 235.76 per 100,000 populations (2012/13). This is equivalent to 229 smoking-related deaths per year[5].
- Smoking status at time of delivery (for pregnant women) indicator (2012/13) for Thurrock is (11.4%) this remains below the East of England (12.4%) and England (12.7%) averages[6].
- Young people are more likely to smoke if their friends smoke and generally exhibit greater ambivalence about the present health dangers of their tobacco use than adults. 200,000 new smokers start each year and two thirds are under 18, the legal age of purchase in the UK[7]. See chart 5 below.

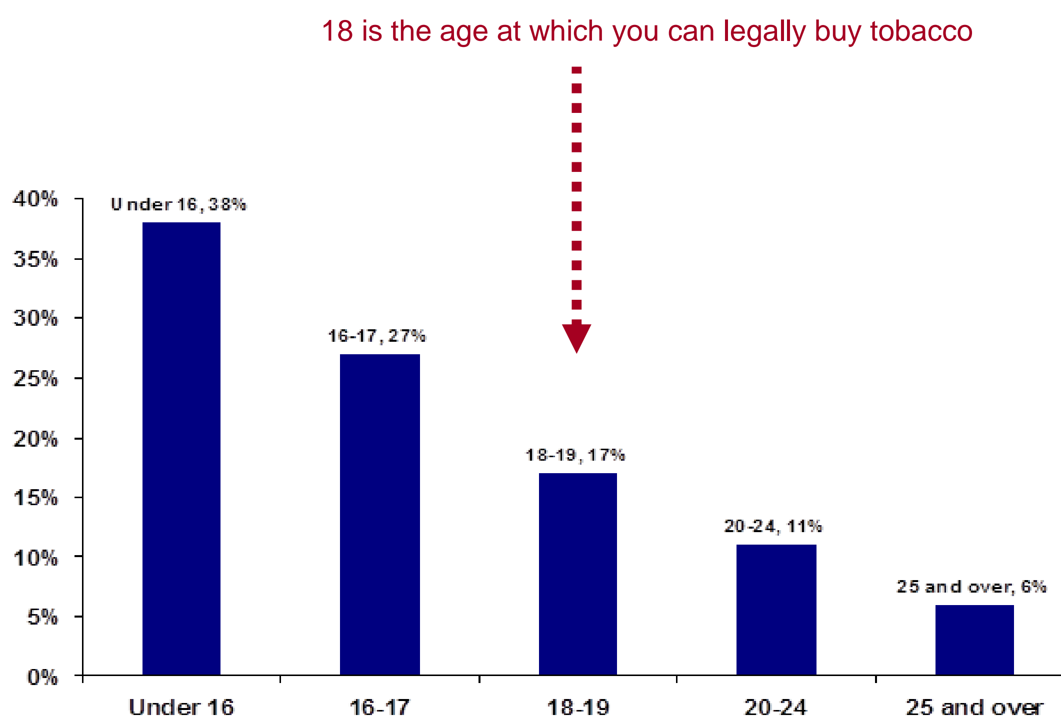


Chart 5. Source: Smoking Attitudes & Behaviours, ONS 2011

[5] Public Health England Thurrock Health Profile 2014, http://www.healthprofiles.info
[6] Public Health England Thurrock Health Profile 2014, http://www.healthprofiles.info
[7] Smoking Attitudes & Behaviours, ONS 2011

Estimated costs to our local economy

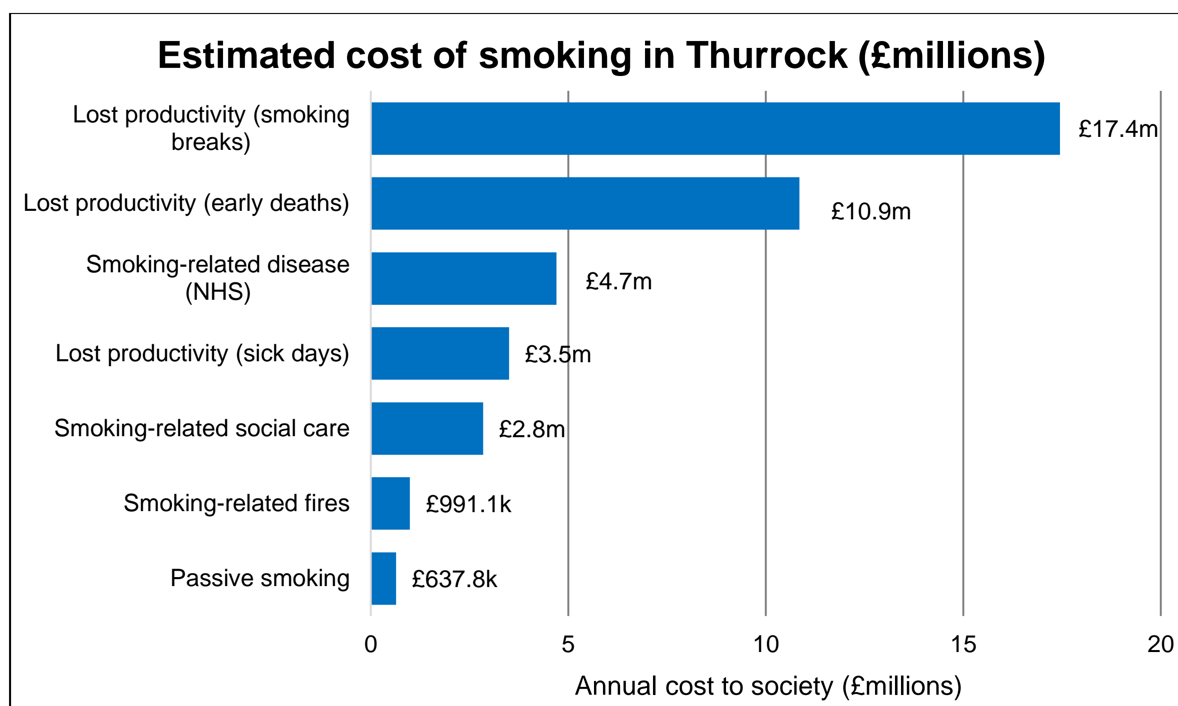


Figure 6, Source: The Local Cost of Tobacco, ASH Ready Reckoner 2014.

These costs can be broadly divided into two groups; costs to smokers and costs to society:

Costs to smokers

- In 2013, a 20 a day smoker of a premium cigarette brand will spend around £2,900 a year on cigarettes.
- Estimates for the total amount spent on tobacco in the UK in 2011 range from £15.3 billion to £18.3 billion[8] [9].
- The proportion of total household expenditure on tobacco has decreased from 3.6% 1980 to 1.9% in 2012[4]. In 2012, tobacco was 27.9% less affordable than in 1980[5].

Costs to society

- Contrary to popular belief smokers do not "bankroll the NHS". £9.5 billion is collected by the Treasury every year in tax, but the costs to society have been estimated to be £13.74 billion every year[10] [11].
- Costs to the NHS include the costs of hospital admissions, GP consultations and prescriptions. The government also pays for sickness/invalidity benefits, widows' pensions and other social security benefits for dependants.
- There are wider costs such as increased absenteeism, productivity lost due to smoking breaks etc. that tend to impact on the employer. The loss of economic output from the premature death of smokers costs £4.1 billion every year.

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[8] AC Nielsen Market Track cited in The Grocer, 18 Feb. 2012.
[9] Statistics on smoking: England, 2012. The Health and Social Care Information Centre, 2012.
[10] Tobacco Bulletin. HM Revenue & Customs, Apr. 2014
[11] Nash, R & Featherstone H. Cough Up: Balancing tobacco income and costs in society. Policy Exchange, 2010

- Smoking-related diseases include illnesses such as lung cancer, heart disease, bronchitis and chronic obstructive pulmonary disease (COPD).
- Social care costs include those costs related to the wellbeing of smokers who on average need social care support such as home care nine years earlier than non-smokers.
- The national cost of cleaning up cigarette butts every year is estimated to be £342 million, with the cost of fires being £507 million every year. Cigarettes are the leading cause of fatal accidental fires in the home: in 2008 smokers' materials accounted for 113 deaths and 932 non-fatal casualties from fires in the home. Costs to society from house fires also include increased insurance premiums.

The Thurrock Approach

Our five year strategy sets out the priorities and actions for the council and our local partners, including statutory and voluntary agencies and local communities, we aim to achieve a coordinated reduction of smoking prevalence and the associated harm caused by tobacco in Thurrock. This will include looking at age-specific smoking issues and strategies.

Our Ambition

From 2013 Thurrock's multi-agency Smoke Free Work Stream has had some significant achievements including

- sign up to the Local Government Declaration for Tobacco Control
- refresh its own Smoke Free policy to include e-cigarettes and recognise their harm-reduction benefits.
- led a public consultation on tobacco
- delivered a multi-agency workshop to discuss the results of the consultation and explore the future for tobacco control in Thurrock. (see appendix 3 for the consultation summary report).

In 2015 the Smoke Free Work Stream will develop into a Tobacco Control Alliance with the responsibility of overseeing the implementation of this strategy.

The findings following the consultation and the workshop will now inform our commissioned services. From April 2015 a new preventative tobacco control model will be developed with the existing provider. We will still continue to commission interventions around stopping people smoking with a focus on targeted groups and targeted areas and we will continue to work with trading standards on enforcement

Shifting to a tobacco control programme will release the potential to affect the entire population of Thurrock including those who want to quit and also those who are passive smokers. including monitoring and enforcement of national legislations (e.g. smoke free, illicit tobacco sales, advertising bans), taking responsibilities for paid and unpaid mass media, evaluating and monitoring progress of the control programme and advocacy work to influence national and international actions.

Prevention

Prevalence refers to activity designed to stop people from smoking in the first place. Given that we know most smokers take up the habit before they are old enough to legally purchase cigarettes (18), we will focus our preventative work at schools, colleges, youth settings and other places where young people access; creating an environment where young people choose not to smoke.

A multi-agency approach with shared objectives is the key to success here

The offer can be a mixture of both universal (open to all) and targeted (aimed at certain groups/individuals). Evidence tells us that particular people are more likely to smoke, e.g. children from households where 1 or more adults already smokes. manual workers, people suffering with mental health and those using substances

Evidence Base:

Nicotine addiction plays a strong part in smoking, and most adult smokers become addicted to nicotine when they are children or young people during a time of their lives when they do not have the knowledge or experience to understand either the nature of addiction or the difficulty many smokers have in quitting smoking. Children who smoke become addicted to nicotine very quickly, and currently 200,000 young people in the UK take up the habit each year. That is 548 new young smokers every day (DECIPHer IMPACT 2011).

A randomised control trial of ASSIST (A Stop Smoking in Schools Trial) results suggest if implemented on a population basis, the ASSIST intervention could lead to a reduction in adolescent smoking prevalence of public-health importance[12].

Nationally, education regarding smoking forms part of the Science and the Personal, Social and Health Education (PSHE) curriculum in both primary and high schools. The curriculum focuses on educating children on the health effects of smoking.

- Key Stage 2 (age 7–11) pupils are taught that tobacco has harmful effects.
- Key Stage 3 (11-14) pupils are taught that tobacco will affect health including lung structure.
- Key Stage 4 (14-16) pupils are taught the effects of smoking on the body functions. Education regarding skills development, e.g. in resisting the pressure to smoke, can also form part of the PSHE programme.

Commissioning programmes that successfully prevent young people from starting smoking could have a much greater long term impact on smoking prevalence than commissioning services to help current smokers to quit. We will ensure that all our schools are meeting the targets at each key stage in Thurrock.

[12] Campbell R, et al, Lancet 2008, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60692-3/abstract

Treatment

Despite the strategy having a bias towards prevention, it is still important that treatment is available for those smokers that wish to quit. The NICE best practice recommendations that service providers should aim to treat at least 5% of their local smoking population[13].

Quitting smoking can take a smoker an average of 7 attempts, but smokers are 5 times more likely to quit with support from a Local Stop Smoking Service (LSSS). This can include behavioural support from a trained professional, 1:1 support, group support and medications such as free Nicotine Replacement Therapy (NRT) more commonly known as nicotine patches, gums and sprays or medications such as Varenicline (Champix) or Buproprion (Zyban).

Currently smokers can access support via a dedicated LSSS or through their local pharmacist or GP; we will continue to commission treatment services with a focus on our hard to reach groups and areas

In Thurrock, older people who set quit dates were more likely to quit smoking, with almost 57% of those aged 60+ successfully quitting (self-reported) at 4 weeks[14].

Evidence Base:

Stopping smoking is arguably the single most effective thing a smoker can do to improve their health and it's never too late to quit.

Surveys show that at least 70% of adult smokers would like to stop smoking and of those who express a desire to quit, more than a third are very keen to stop[15]. Many smokers continue to smoke, not because they choose to, but because they are addicted to nicotine and are unable to beat the addiction.

Reducing smoking prevalence in our adults is also likely to have an effect on preventing young people from starting smoking, as there will be fewer adult smokers acting as role models to young people.

[13] Local Stop Smoking Services, Service and Delivery Guidance 2014, NCSCT, http://www.ncsct.co.uk
[14] HSCIC: http://www.hscic.gov.uk/article/2021/Website-Search?productid=15174&q=stop+smoking&sort=Relevance&size=10&page=1&area=both#top
[15] Smoking-related Behaviour and Attitudes, Lader and Goddard, ONS, 2004

Enforcement

Enforcement includes where tobacco is available for sale, we ensure that these are genuine products with UK duty paid and only sold to those old enough to purchase tobacco products working with agencies such as Trading Standards, Boarder Force and Her Majesty's Revenue and Customs (HMRC).

Within the last decade there has been significant achievements including the introduction of smoke free public buildings and businesses, bigger health warnings on cigarette packets, greater restrictions on cigarette advertising and the introduction of plain screens in front of tobacco cabinets.

There has been increased pressure on government to pass legislation that supports plain (standardised) cigarette packets, with the Chantler review[16] finding no evidence to support the tobacco industry's arguments that standardised packaging would increase the illicit trade in tobacco.

There has also been a call to introduce legislation to protect children from the effects of second-hand smoke by banning adults from smoking in cars that carry children. The regulations to prohibit smoking in cars when children are present were laid before Parliament on 17th December 2014 and were approved in February 2015. The law will take effect on 1 October 2015.[17]

Evidence Base:

The UK has the most expensive cigarettes in the EU and among the most expensive cigarettes in the world. Price increases have successfully helped people become non-smokers. UK budget changes to tobacco duty have saved lives and prevented serious illness.

Research has shown that four times more people die from the effects of smuggled tobacco than from all illicit drugs combined. Furthermore, other studies estimated that eliminating smuggling could lead to an overall fall in the number of cigarettes smoked by around 5 per cent, resulting in 4,000 fewer premature deaths[18]. It is essential that work should be continued to reduce illegal tobacco sales within Thurrock.

[16] https://www.gov.uk/government/speeches/chantler-report-on-standardised-packaging-of-tobacco-products
[17] http://www.smokefreeaction.org.uk/SmokeCars.html
[18] http://tobaccocontrol.bmj.com/content/17/4/230.short

Targets

The future targets are set against ambitions laid out in the Coalition Government's 2011 Tobacco Control Plan for England and national data provided by the Office for National Statistics. The ONS data for male and female prevalence rates have then been averaged. The Thurrock average takes account of the fact that deprivation is not evenly distributed across the local population.

***Table 1 - smoking prevalence milestones* by quintiles**

DATE	Quintile 5 *Most deprived*	Quintile 4	Quintile 3	Quintile 2	Quintile 1 *Most affluent*	THURROCK AVERAGE
2012 baseline	29.5	22.9	18.9	15.2	12.3	**22.8%**
2015	25	18	13	11	10	**21%**
2017	21	13	9	8	7	**19%**
2019	17	9	6	5	4	**14%**

Public Health England have modelled some local estimates for smoking prevalence in particular age groups, however, this doesn't exist for all young people under 20 years. Therefore, for table 2 we have calculated the baseline from the national prevalence rates for young people. A local measure is expected in 2016 from the What About YOUth survey[19], at which point table 2 may get amended.

Table 2 – young people prevalence milestones

DATE	THURROCK AVERAGE
2013 baseline	**11.5%**
2015	**10%**
2017	**9%**
2019	**8%**

19 http://www.whataboutyouth.com/

Conclusion

The work of the tobacco control work stream over the last twelve months has informed this five year strategy which included completing a public consultation and holding a multiagency workshop. The findings have resulted in our vision and remodelling of the way we commission tobacco control in Thurrock.

Over the next five years we will focus on preventative services with the young people of Thurrock, we will work with targeted populations and target local hot spot areas Quintiles 4 and 5 on stop smoking services, and finally we will work in partnership with trading standards and enforcement agencies on the enforcement agenda.

We will ensure that our commissioned programmes are updated to reflect these findings.

We have developed a delivery plan which will monitor progress ongoing. The delivery plan will be managed through the work stream reporting into the PHSB and the HWBB. We will continue to refresh our approach following continued engagement and consultation with partners and our communities.

Draft Delivery Plan (being completed through work stream June 2015)

Action / KPI	How will we know it's made a positive impact?	Can it be done?	Responsible person	Completed by when
Specific	*Measurable*	*Achievable*	*Realistic*	*Time-bound*
Evolve the Smoke Free Work Stream in to a Tobacco Control Alliance	When activity reports are submitted to the Public Health Strategy Board that demonstrate a directly measurable improvement in the areas of Prevention, Treatment and Enforcement	Yes. The nucleus of the group already exists as a work stream	Kev Malone	Spring 2015
Prevention				
(Strand 2) Annual support of ASH and UKCTCS budget submission to the Chancellor of the Exchequer	Tobacco taxation increased above inflation in annual budget report. Tobacco is less affordable	Linked to Key Strand 2 of strategy. Submission to be reported to the TC Alliance	Kev Malone	End of financial year, each year
Support campaigns to lobby for the implementation of standardised (plain) packaging for cigarettes	Achieve a drop in youth smoking prevalence	The regulations were approved by the House of Lords on 16.03.15	Tobacco Control Alliance	May 2016
CLeaR / babyClear	When peer assessment is completed	Preparatory work is being undertaken to ensure delivery in 2015	Jacqui Sweeney / Kev Malone	2015/16
(Strand 1 & 5) Work with public and private landlords to ensure properties are smoke free	Work with Housing to make it a condition that all new council housing stock is smoke free. This would need to be supported by the director of Housing and ratified by the Councillors prior to implementation (currently only at the very beginning stages of drafting a proposal)	Yes. Common practice in private tenancy agreements	Lynette Royal	2015/17

All council properties have smoke free tenancy agreements	Based on the above being successful, roll-out to make all of our future void properties smoke free, ensuring all council housing stock will gradually become smoke free	As above	Lynette Royal	2018/19
(Strand 1 & 5) Increase smoke free outdoor zones at pubs and restaurants via the Public Health Responsibility Deal	Patrons can dine alfresco at on-licenses and restaurants without having to breathe second hand smoke	Yes, provided businesses sign up to this and enforce the rule at their establishment	Tobacco Control Alliance	2018/19
Promote to the public the risks of hand-rolled tobacco and niche tobacco products e.g. shisha	Myths dispelled about these products being lower risk. Users of these products accessing LSSS for quit support	Via prevention programme in secondary schools and general campaigns e.g. Stoptober and Health Harms campaigns	QUIT / Vitality Public Health	2016/17
Promote to the public the adverse effects of counterfeit tobacco	Myths dispelled about these products being okay. Educate people about how tax evasion and organised crime impacts on communities and society	Via prevention programme in secondary schools and general campaigns e.g. Stoptober and Health Harms campaigns	QUIT / Vitality with Public Health and Trading Standards advice	2018/19
Work with schools and colleges to promote local and national prevention campaigns	Evaluation of programmes to assess the level of understanding gained and assess the likelihood of uptake of tobacco by young people following their intervention	A programme of interventions will be delivered by QUIT within schools to prevent the uptake of smoking and demonstrate the harm of tobacco smoking as outlined in NICE guidance (PH23)	QUIT/Vitality	2015/16
Treatment				
(Strand 4) Evaluation of new service / Service Review	Service is delivering against targets and demonstrating value for money	Yes	Kev Malone	2015/16
Value for Money benchmarking exercise	Service compares favourable against CIPFA comparator sites	Underway	Kev Malone	2015/16
Engage with more older people e.g. retirement homes	Increase in number of over 65's engaging in quit attempts	Yes	Vitality / Housing / LACs	2015/16

to offer quit support				
Hospitals: Implement Quit Manager onto desktops in hospitals for secondary care referrals at pre-op assessment including support for pregnant smokers via maternity services with an opt out policy NICE PH48, PH22	Increase in stop smoking referrals from BTUH	Ensure relevant hospital staff are trained to deliver smoking cessation interventions to patients	Vitality	2015-19
		Support local hospitals to refer patients in to the stop smoking service	Vitality	2015/16
Community Healthcare: Dentists, Optometrists, Mental Health and Substance misuse	Increase in referrals for quit support from these partners	Train dental nurses and dental reception staff in level 2 smoking cessation brief intervention training.	Vitality / KCA / CRI	2015/16
		Train optometrist staff in level 2 smoking cessation brief intervention training.	Vitality	2015/16
		Ensure pharmacy staff are trained or refreshed in level 2 smoking cessation brief intervention training.	Vitality	2015/16
		Develop referral pathways with all mental health services and providers within Thurrock.	Vitality	2015/16
		Develop referral pathways and train staff in level 2 smoking cessation brief intervention training for adult and young person substance misuse services in Thurrock.	Vitality	2015/16
Workplaces	Increase in referrals for quit support from local businesses, especially routine and	Build relationships with businesses and their occupational health departments	Vitality	2015/16

	manual employers	and offer the stop smoking services for their employees and volunteers		
Young people	Increase in referrals for quit support from schools and colleges	Work with schools and colleges to offer cessation services to young people	Vitality / QUIT	2015/16
E-cigarettes: promote the LSSS as an e-cigarette friendly service	Increase in people engaging in a quit attempt but using their own e-cigarette	Yes	Vitality	2015/16
		Enforcement		
Reduce illegal tobacco sales	Increase in number of seizures of illegal and illicit tobacco from our borders and retailers	Work with Trading Standards to maximise the inclusion of other agencies to reduce illegal sales to minors including, for example, the use of covert cameras with underage volunteers	Border Force / HMRC / Trading Standards	2018/19
Promote the Crimestoppers number to the public to report retailers, traders or members of the public who make illegal sales of counterfeit and smuggled products	Increase in number of seizures of illegal and illicit tobacco from our retailers / traders	Yes	Trading Standards & Tobacco Control Alliance	2015/16
Enforce point of sale regulations, for example, reduction of exposure to tobacco product advertising by enforcing the Tobacco Advertising and Promotion (Point of Sales) Regulations and associated legislation	Regulations adhered to	Enforcement of tobacco display ban	Trading Standards	2015-19
Ensure the 'Challenge 25' proof of age scheme is implemented and adhered to	Scheme adhered to and evidenced via refusal books	Yes	Trading Standards	2015-19

(Strand 5) Support the ban on adults smoking in cars that carry children and promote pressure on MP's to support this	Fewer adults witnessed smoking in their cars while carrying children *(The latter has since been achieved since the regulations were approved by Parliament in February 2015)*	Via Civil Enforcement Officers issuing fixed penalties where vehicles are stationary and via local marketing to raise awareness of the law change on 01.10.15	Tobacco Control Alliance	2015/16
Work with HM Revenue & Customs to maximise the inclusion of other agencies to reduce the supply of smuggled tobacco products including hand-rolled tobacco and niche tobacco products e.g. shisha	Reduction in amount of illicit and illegal tobacco products available in Thurrock	Via information sharing of intelligence and coordinated resources to respond to intelligence	Tobacco Control Alliance	2015-19
Work with Trading Standards to collate greater intelligence on illicit and illegal tobacco	Successful operations with tobacco detection dogs	Cost implication regarding tobacco detection dogs	Tobacco Control Alliance	2015-19

Appendices

Appendix 1 Glossary

Appendix 2 JSNA section: Smoking - What do we know?

Appendix 3 Thurrock Smoke Free Workshop Survey – Summer 2014

Appendix 4 The Six Strands

Appendix 1

Glossary

ASH	Action on Smoking and Health
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CIPFA	Chartered Institute of Public Finance & Accountancy
CLeaR	Excellence in local tobacco control
DMT	Directorate Management Team
DOH	Department of Health
HMRC	Her Majesty's Revenue and Customs
HSCIC	Health and Social Care Information Centre
HWBB	Health and Wellbeing Board
LSSS	Local Stop Smoking Service
NCSCT	National Centre for Smoking Cessation and Training
NICE	National Institute for Health and Care Excellence
NRT	Nicotine Replacement Therapy
ONS	Office for National Statistics
PHOF	Public Health Outcomes Framework
UKCTCS	UK Centre for Tobacco Control Studies

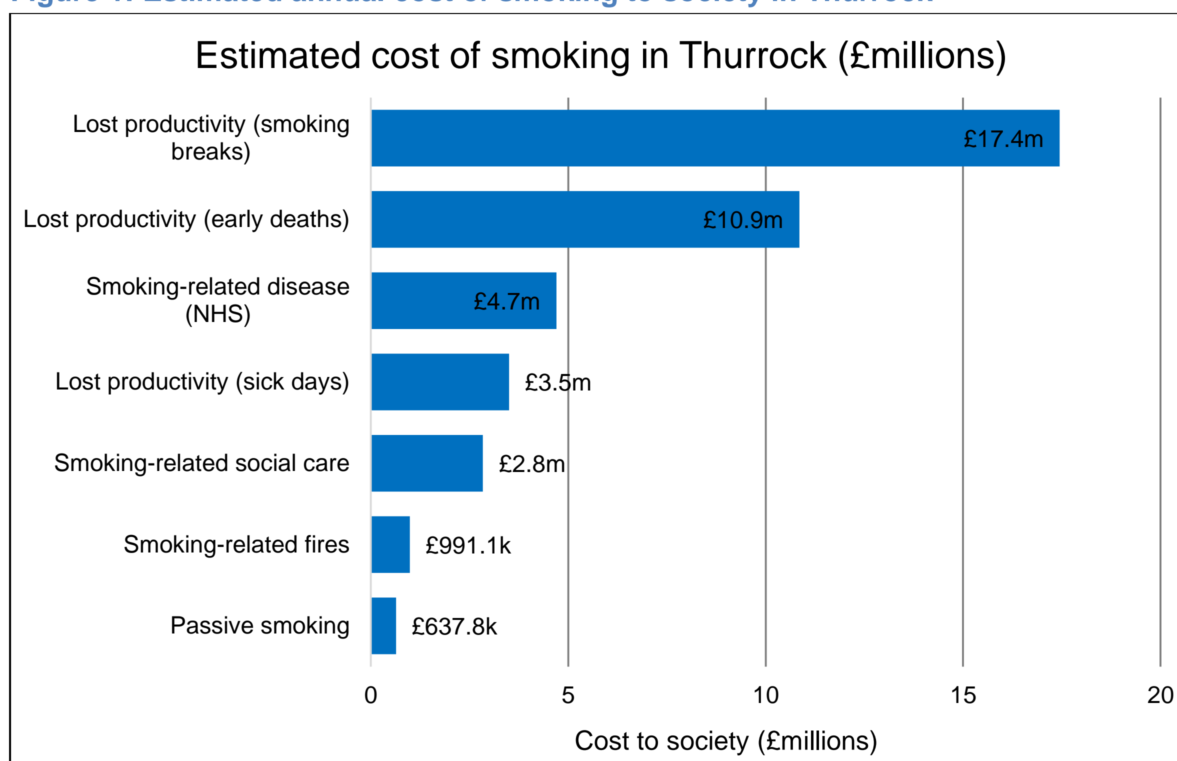
Appendix 2

JSNA section: Smoking - What do we know?

Economic Cost

There are a wide range of costs to society due to smoking. In Thurrock, it is estimated that smoking costs society approximately £41 million each year. Below is a breakdown of the estimated impact of smoking in Thurrock, and it can be seen that the largest cost is due to lost productivity from smoking breaks (£17.4 million), followed by lost productivity due to smoking-related deaths – an estimated 525 years of productivity is lost, at a cost of £10.9 million.

Figure 1: Estimated annual cost of smoking to society in Thurrock



Source: ASH and LeLan

Children and Young People

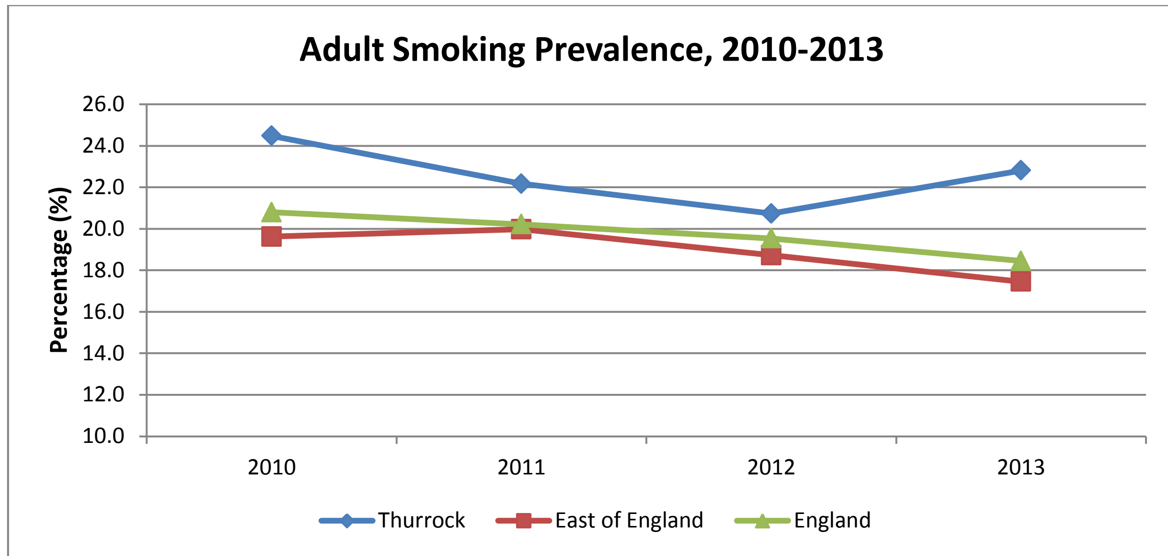
Data collected by the Health and Social Care Information Centre (2013) indicates that 3% of pupils in England reported that they smoked at least one cigarette per week. When results were broken down by age, it can be seen that the prevalence of smoking increased with age: less than 0.5% of 11 and 12 year olds said that they smoked at least one cigarette per week, compared with 4% of 14 year olds and 8% of 15 year olds.

Accurate local data is limited. The most recent data on smoking habits in children and young people originates from the TellUs4 survey (2009), which indicates that 4% of Thurrock children in years 6, 8 and 10 usually smoke at least one cigarette per week, which was the same as the national average but higher than the regional average (3.4%).

Adults

Data from the Integrated Household Survey in 2013 indicates that 22.8% of adults aged 18+ in Thurrock smoke, which is significantly higher than the regional and national averages. The prevalence of smokers in Thurrock has increased from 2012, where it was statistically similar to the national average.

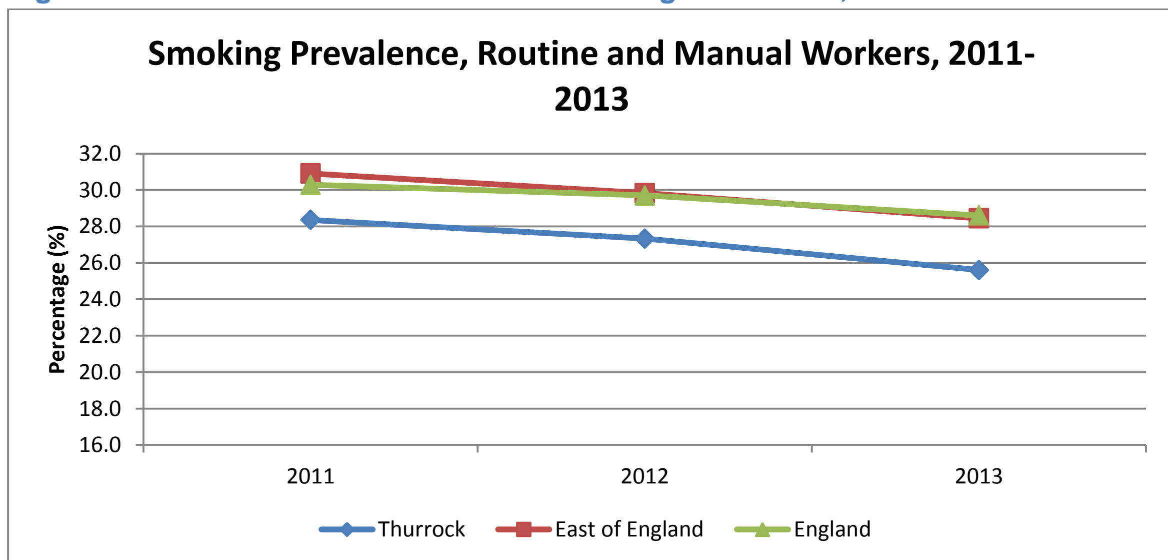
Figure 2: Adult Smoking Prevalence, 2010-2013



Source: Integrated Household Survey

Routine and manual workers are a key priority group whose smoking prevalence is monitored as it is an occupation group with a particularly high prevalence of smoking. In Thurrock, the latest data shows that smoking prevalence within this group is 25.6%, which is statistically similar to the regional and national averages. The prevalence in Thurrock for this population group has decreased slightly over the last three years.

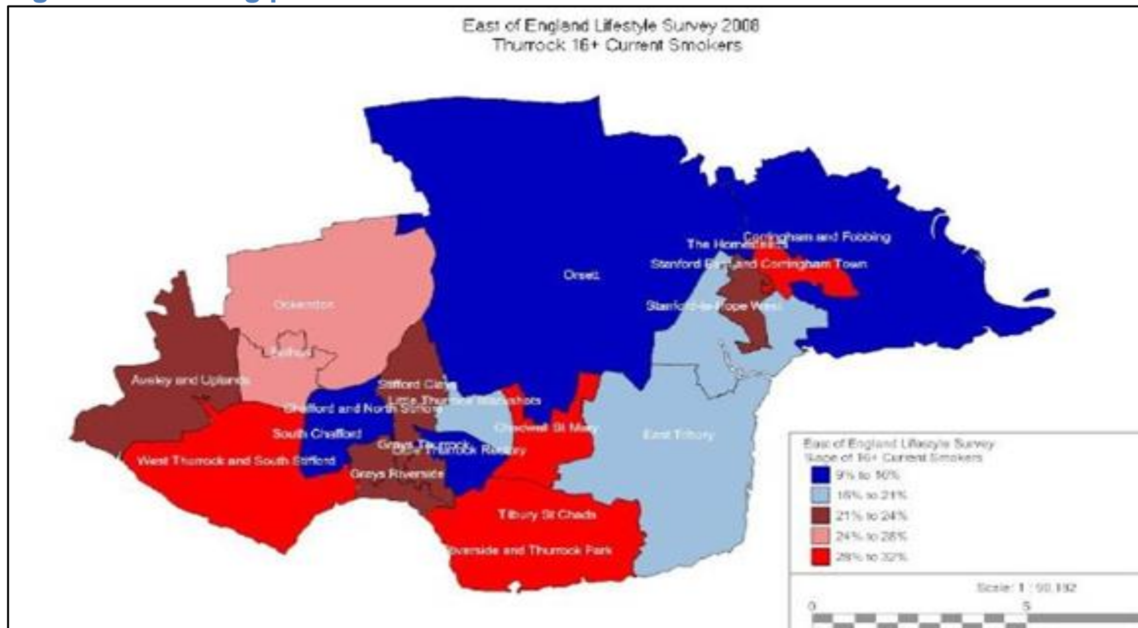
Figure 3: Routine and Manual Workers Smoking Prevalence, 2011-2013



Source: Integrated Household Survey

Smoking across the borough of Thurrock is not uniform. Modelled estimates from the 2008 East of England Lifestyle Survey indicate that areas such as Tilbury St Chads, Tilbury Riverside and Thurrock Park, West Thurrock and South Stifford, and parts of Stanford East and Corringham Town have higher prevalence of adults who smoke.

Figure 4: Smoking prevalence across Thurrock

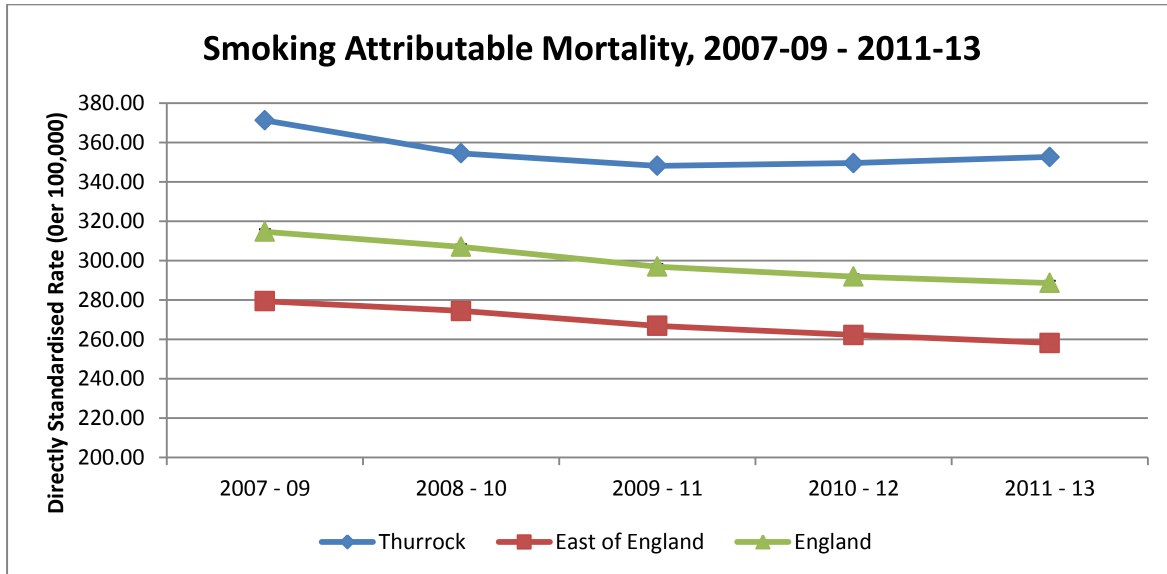


Source: East of England Lifestyle Survey, 2008

Smoking-Attributable Mortality

For many years the rate of deaths attributable to smoking has been significantly higher in Thurrock than the regional and national rates. The rate per 100,000 in Thurrock is 352.66 in 2011-13, compared with the regional rate of 258.15 and the national rate of 288.66.

Figure 5: Smoking Attributable Mortality, 2007-09 - 2011-13

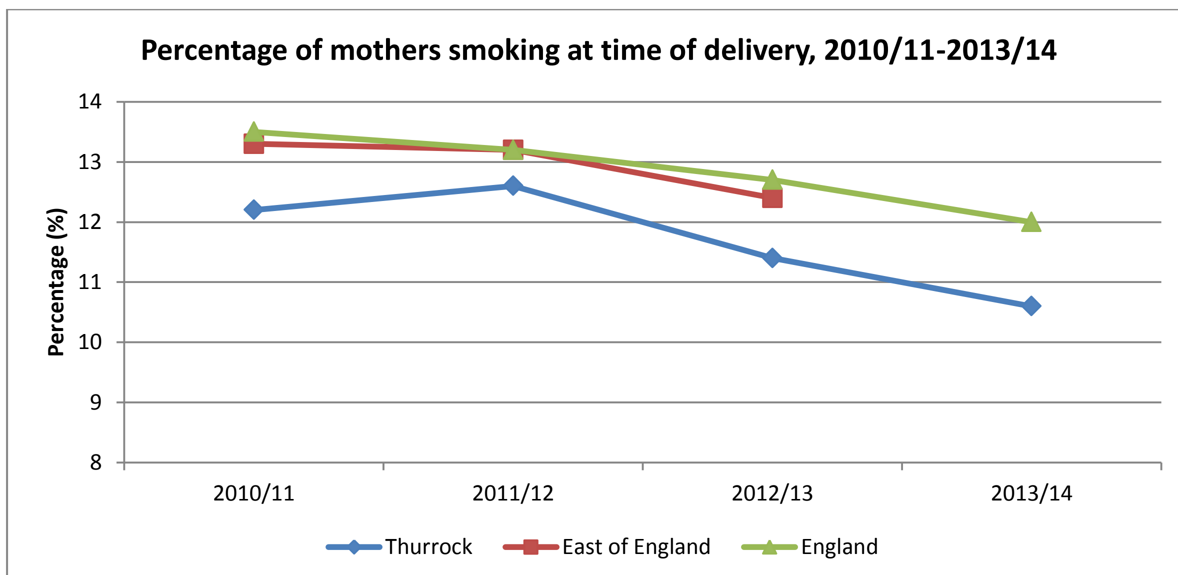


Source: Public Health England

Smoking in Pregnancy

The latest information shows that 10.6% of women were smoking at the time of delivery in 2013/14, which is lower than the previous two years. Comparing the data to East of England and England, Thurrock's figures do appear to be consistently lower; however confidence intervals mean that the authority is statistically similar to the national average.

Figure 6: Percentage of mothers smoking at time of delivery 2010/11-2013/14

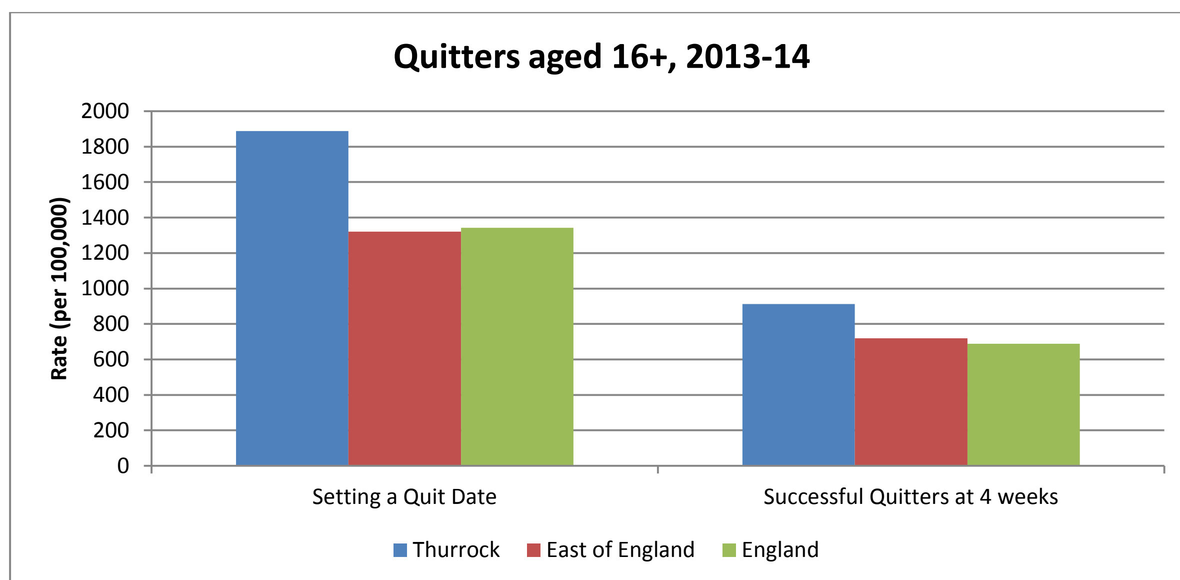


Source: Public Health England / Health and Social Care Information Centre

Smoking Quitters

In 2013-14, there were 2,372 people aged 16+ who set a quit date in Thurrock, of which 1,145 (48.1%) self-reported to have successfully quit at 4 weeks. To enable comparison to regional and national figures, rates per 100,000 population were calculated, and as below it can be seen that Thurrock had both a higher rate per 100,000 of smokers setting quit dates, and a higher rate per 100,000 of successful self-reported quitters.

Figure 7: Smokers setting a quit date and successful quits at 4 weeks, 2013/14



Source: Health and Social Care Information Centre

In Thurrock, older people who set quit dates were more likely to quit smoking, with almost 57% of those aged 60+ successfully quitting at 4 weeks, compared to just 26% of those aged 16-18. The proportion for all age groups in Thurrock was 48.1%.

Figure 8: Successful quitters by age group, 2013-14

Source: Health and Social Care Information Centre

Appendix 3

Thurrock Smoke Free Workshop Survey Summer 2014

This Survey consisted of a Public online survey which generated 105 responses and was conducted by Thurrock Council Public Health Department.
The survey ran for 6 weeks across June and July and consisted of 12 main smoking related questions with further interrelated sections.

The aim of this public survey was to gain current views amongst local residents around specific national and local smoking issues in order to obtain an improved understanding of public perception within the borough.

Summary of findings

- The majority of respondents felt that peer pressure (47%) and stress (33%) were the main reasons why children and young people take up smoking. Other reasons were cited as learned behaviour from family members where smoking is considered normal rather than a bad habit or addiction. These reasons were also recognised as obstructions to quit smoking.
- Almost three quarters of respondents felt that smoking on television and in the media has an effect on how people view smoking and whether it influences people to start, compared to only a quarter who think it makes no difference.
- Smoke-free zones were largely supported with 70% of respondents in favour of this idea.
- Over 80% of respondents had heard of the Stoptober smoking campaign with 66% agreeing it helps people to quit smoking.
- 73% of respondents felt that standardised tobacco packaging will not have a positive effect on reducing smoking.

Review of Findings

Question 1& 2
Results suggest that young people are attracted to a perceived “cool image” that they feel smoking presents, and there is still a strong desire to “keep in” with friends that smoke. Smoking was also linked as a tool for weight management.
In families where parents smoke there is a danger children become desensitised to the health effects, and there is more likely to be a lack of positive guidance within these families.

Question 3
Responses to whether smoking on screen has an effect on how people view smoking and whether it may encourage smoking indicates that almost three quarters felt it did have an effect, compared to almost a quarter of respondents (24%) that think it makes no difference. It was largely agreed that smoking in films and soaps presents smoking as a normal and acceptable activity in our society.

Question 4
It was encouraging to note that almost three quarters of respondents (69%) were in favour of smoke free zones, although a further 78% thought these would be difficult to enforce and may not be adhered to.

Question 5
81% of respondents had heard of the NHS Stoptober challenge, recognised as a high profile campaign that is successful due to it being a group activity offering focussed support to people

wishing to give up smoking. Media communication and education around smoking – viewed by the World Health Organisation as the cornerstone of any successful tobacco control programme.

Question 6
Almost three quarters of respondents felt that standardised packaging on cigarettes will not influence consumption, posting comments such as “it doesn’t change what’s inside” and “we don’t even look at the packaging anyway”, this is contrary to scientific studies which shows a positive impact.

Question 7
25% of respondents thought the legal age to purchase cigarettes was 16. Some 41% of 15-year-olds who smoke say they usually buy their cigarettes from someone else rather than from a shop.[i] The new rules on adults buying cigarettes for under-18’s could be in force by the autumn and may mean anyone caught buying cigarettes for a child could be given a £50 fixed penalty notice or a fine of up to £2,500. Further publicity around this will coincide with the launch of the new ruling.

Question 8 and 8a

Cigarettes will now have to be hidden under the counter or behind shutters in a bid to cut down on the number of smokers and deter young people from taking up the habit.

69% of respondents feel that plain screens when selling cigarettes will not help to quit smoking, while 32% feel it will discourage non-smokers to start smoking. This is in contrast to the Department of Health’s view that said the move was in response to evidence that cigarette displays in shops can encourage young people to take-up the habit.

Question 9
90% of respondents felt that the sale of illegal tobacco in Thurrock was a bad thing. There are national concerns over an increase in illegal tobacco if the standardised packaging of cigarettes comes into force as people will attempt to bypass the product in favour of illegal imported cigarettes with branded packaging. Local trading standards and customs and excise are aware of the potential problem. The high percentage of opposition to illegal cigarettes in Thurrock was encouraging.

Question 10
93% agree that passive smoking in cars has an effect on child passengers.
90% agree that smoking while pregnant has an effect on unborn babies.
79% agree that passive smoking while pushing a pram/walking with a child has an effect.
88% agree that smoking in the home with children in the same room has an effect.
79% agree that smoking in the home but with children in a different room has an effect.
Results indicate a reassuring level of support within Thurrock.

Question 11
E-cigarettes generated a mixed response, only 12% of respondents saw them as a good stepping stone to quitting, 13% saying there is not enough evidence to support their use and 8% think they are good for your health.
An estimated 1.3m people in the UK use e-cigarettes which were designed to help smokers quit. Concerns have been raised that electronic cigarettes could be a gateway into smoking for young people. Although there is no evidence to suggest this it is recommended that e-cigarette use is closely monitored and make sure advertising and promotion does not glamorise their use. We do not yet know the harm that e-cigarettes can cause to adults or children, but we do know they are not risk free and that they currently remain unregulated in the UK.

Question 12

43% of respondents think public health should target its resources into education and prevention.
25% think public health should target greater enforcement in buying/accessing cigarettes.
31% think public health should target resources into treatment and helping more smokers to quit.
The results represent a mixed reaction to how public health should target its resources and is reflective of Thurrock's current multi-component approach to resources.

Conclusions and Recommendations

Children are very impressionable and the "smoking is cool image" still remains very much a problem. More focus should be given to Initiatives that improve self-confidence and self- esteem to empower children to make their own decisions and become more self-assured. Thurrock will strive to advocate a culture of well-being where children are empowered with the knowledge and the confidence to make rational decisions.

More focus could be given to stress reduction initiatives aimed specifically at children and young people to addresses more psychological issues. The introduction of specialised programs that teach coping mechanisms or yoga/relaxation classes in schools can help prevent some of the consequences of stressful behaviour, such as smoking, becoming apparent.

Smoking is sometimes perceived as an activity for young people to do with their friends to alleviate boredom. Offering alternative choices such as involvement with community groups, recreational facilities, clubs, hobbies and interests instead of smoking socially with friends should be promoted further.

The promotion of positive healthy role models and mentors in our borough that advocate regular exercise and healthy eating as a cool image should be more abundant and high profile.

A weight management message linked with the fundamental principles of healthy diet and regular exercise should be consistently reinforced at every opportunity which overshadows other less desirable mind-sets such as smoking as a tool to control weight.

It was encouraging to note that the majority of the respondents were in favour of smoke free zones and plans to expand on existing zones or the introduction of new smoke free areas e.g in play areas and parks could be considered in response to this.

The high recognition of Stoptober confirms that people are aware and responsive to national campaigns and find it helpful to quit as part of a supportive programme with other smokers. Thurrock Council need to ensure that advice on quitting remains high profile and there is plenty of access to group activities and stop smoking clubs throughout the year. National campaigns play an important role in raising profiles and encouraging people to quit and Thurrock will continue to work closely with these initiatives to support local quitters.

Reactions to e-cigarettes were mixed and respondents were unclear about the associated health risks. E-cigarettes are a relatively new phenomenon and although perceived as a better option than smoking and a helpful aid when quitting, it is important to remember they still contain nicotine and as such are as addictive as cigarettes. Not to smoke anything should still remain the ultimate goal.

Appendix 4

The Six Strands

1. **Stopping the promotion of tobacco**

   A reconfigured treatment service that looks more broadly at tobacco control will advocate work to highlight the need to tackle the broad range of tobacco harms, including, for example, lobbying for standardised (plain) packaging for cigarettes. Early evidence from Australia suggests that the measure is beginning to have an impact on smoking rates.

   The preventative work conducted with children and young people will include information from Public Health, supported by Trading Standards, to inform and educate people on key areas of enforcement, in particular how the illicit and illegal tobacco machine operates and how purchasing such products sustains this illegal industry and its activities.

2. **Making tobacco less affordable**

   The simplest way to make tobacco less affordable is to massively increase the duty, but we have no influence over tobacco pricing at a local level since their taxation is determined by central government. However, through mechanisms such as local and regional tobacco control alliances and in partnership with recognised organisations such as Action on Smoking and Health (ASH) [20] we can help exert pressure towards achieving such changes.

3. **Effective regulation of tobacco products**

   The effective regulation of tobacco products remains a high priority for Trading Standards who will be using intelligence to identify target areas to focus their efforts, particularly around underage sales.

   While it is accepted that niche tobacco products such as smokeless products and shisha may exist in Thurrock, intelligence and evidence of their use is currently very limited to a few isolated incidents. Nevertheless, future work should include making the public more aware of such products and their harms so that subsequent reported incidents can be responded to by Trading Standards.

4. **Helping tobacco users to quit**

   The service will work broadly across all organisations in Thurrock to ensure the benefits of quitting are promoted as widely as possible and that referral pathways exist for those that wish to quit. In addition it will develop better pathways to support mental health service users and people with long term conditions.

[20] Action on Smoking and Health (ASH) was established in 1971 by the Royal College of Physicians . It is a campaigning public health charity that works to eliminate the harm caused by tobacco. ASH provides the secretariat for the All Party Parliamentary Group on Smoking and Health.

In February 2015 NICE are scheduled to publish new guidance on reducing tobacco use in the community. This guidance will include mental health and behavioural conditions and therapeutic procedures[21], both of which will feature in the smoking cessation service redesign in 2015.

E-cigarettes re-normalising smoking is a complex issue for Public Health; on the one hand there is a current lack of evidence to support this concern, yet on the other hand their harm reduction possibilities for smokers appear to be enormous and some estimates suggest that if all 9 million UK smokers switched to using e-cigarettes tomorrow this would save 54,000 lives a year[22].

Nevertheless, the footfall of smokers entering their LSSS for quit support has reduced in recent years, particularly in 2014, which impacts on the subsequent 4-week quit targets that are also below trajectory. Anecdotally e-cigarettes are believed to be one cause of this phenomenon whereby smokers are independently switching to e-cigarettes in recognition of their harm-reduction benefits.

5. Reducing exposure to second hand smoke

This strand includes compliance monitoring of existing smokefree legislation and work around challenging compliance areas e.g. taxis and work vehicles; advocacy around smoking in cars with children; smokefree homes programmes; outdoor smokefree spaces programmes

The redesigned LSSS will develop policy and practice to embrace the harm reduction agenda, particularly the use of e-cigarettes. As the rise of e-cigarettes continues, so does the response to their use. We can expect to see e-cigarettes feature within the NICE Harm Reduction guidance scheduled for release in July 2015 [23].

The latest briefing released from the NCSCT on electronic cigarettes recommends that smoking cessation services provide behavioural support for clients who are using e-cigarettes and to include these clients in their national returns[24].

6. Effective communications for tobacco control

Work here will include supporting Public Health England campaigns such as Stoptober, providing year round PR on a range of tobacco issues, promoting local campaigns and the LSSS, developing local media campaigns on wider tobacco issues and working with others around regional media campaigns.

[21] http://www.nice.org.uk/Guidance/InDevelopment/GID-QSD83
[22] West, R, University College London, 5th September 2014, http://www.bbc.co.uk/news/health-29061169
[23] http://www.nice.org.uk/Guidance/InDevelopment/GID-QSD103
[24] http://www.ncsct.co.uk/usr/pub/e-cigarette_briefing.pdf

[i] Department of health

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15 June 2015	ITEM: 11
Health and Wellbeing Board	
Health impacts of Air Pollution in Thurrock	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Dr Cate Edwynn, Consultant in Public Health	
Accountable Head of Service: Deborah Maynard, Head of Public Health	
Accountable Director: Mr Roger Harris, Director of Adults, Health and Commissioning.	
This report is Public	

Executive Summary

This report provides an overview of the multiple sources and types of air pollution and the associated acute and chronic health effects from exposure to air pollution.

There are a range of measures that can be taken to improve air quality including traffic management and public health approaches such as active travel, urban greening, living streets, which can improve local air quality as well as having other benefits to health and wellbeing.

Thurrock Council has a statutory duty to undertake monitoring of air quality across the Borough, against the air quality standards and objectives laid out in the Air Quality Regulations 2000.However, it is acknowledged that effective impact on air pollution requires cross-boundary action, spanning a range of actions beyond the local level and usually needing to involve a range of players to be effective. In light of this, this report advocates an approach based on lowering exposure as well as impacting on emissions to mitigate health risks.

There are a number of new local regeneration developments occurring in Thurrock which may have an impact on air quality, and so it seems timely to consider the health impacts and how we might mitigate these.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board note the contents of this report.

1.2 That the Health and Wellbeing Board supports the work of a cross-directorate Officer Working Group which has been established to consider actions that might lower exposure as well as reduction of emissions to mitigate health impact.

1.3 That the Officer Working Group brings the integrated Air Quality plan to Health and Wellbeing Board to help to identify and prioritise joined up actions and approaches that might improve the health experience of individuals and communities in Thurrock

2. Introduction and Background

2.1. The Environment Act of 1995 included a requirement for the development of a strategy to address areas of poor and declining air quality, to reduce any significant risk to health and to achieve the wider objectives of sustainable development in relation to air quality in the UK. The National Air Quality Strategy was published in response to this Act on March 12th 1997, with commitments to achieve new air quality objectives throughout the UK by 2005. A review of the Strategy led to the publication of Air Quality Strategy for England, Scotland, Wales and Northern Ireland in January 2000.

2.2 The Strategy sets out standards and objectives for the 8 main health-threatening air pollutants in the UK.[1]

- Particulates (PM10 & PM2.5)
- Nitogen dioxide
- Ozone
- Sulphur dioxide
- PAH
- Benzene
- 1,3-Butadiene
- Carbon monoxide
- Lead

2.3 Local authorities are responsible for seven of the eight air pollutants under Local Air Quality Management (LAQM). National objectives have also been set for the eighth pollutant, ozone, as well as for nitrogen oxides and sulphur dioxide.

2.4 Local authorities in the UK regularly review and assess air quality in their area and determine whether or not the air quality objectives are likely to be achieved. Where air quality objectives are unlikely to be met, Air Quality Management Areas (AQMAs) must be declared and action plans developed outlining how the local authority intends to address air pollution in this area.

[1] The standards are based on an assessment of the effects of each pollutant on public health. They are based on recommendations by the Expert Panel on Air Quality Standards, The European Union Air Quality Directive and the World Health Organisation

LAQM is the main tool for local authorities to deal with problem areas of pollution.

2.5 Thurrock is no exception and in line with other Councils works hard to identify areas where the government's air quality objectives are likely to be exceeded.

3. Issues, Options and Analysis of Options

3.1 Overview of issues – the impact of air pollution on health

The nature of air pollution has changed over the past 40 years; emissions of smoke and sulphur dioxide associated with smogs of the past have declined, but the proportion of pollution from vehicles has greatly increased. Pollutants from these sources may not only prove a problem in the immediate vicinity of these sources but can travel long distances.

3.2 The 2010 Global Burden of Disease (GBD) assessment, showed exposure to air pollution is a significant contributor to ill health and when the impact of air pollution is ranked against other harms. In a recent study ambient particulate matter pollution was ranked 12th in the UK[2], below top risk factors such as tobacco, alcohol, lack of physical activity and some aspects of diet but above factors such as "diet high in processed meat", "diet low in vegetables" (See Appendix 1).

3.3 The Committee on the Medical Effects of Air Pollutants (COMEAP[3]) report 'Long-term Exposure to Air Pollution: Effect on Mortality'[4] summarised the latest evidence. The report estimated that long term exposure to a 10µg per m^3 increase in $PM_{2.5}$ concentrations[5] leads to a 6% increase in 'all cause mortality', or total deaths. A later report[6] included an estimate of the mortality burden of existing air pollution on the population of the UK: demonstrating an effect on mortality in 2008 equivalent to 29,000 deaths and an associated loss to the population of 340,000 life years.

3.4 The evidence for effects of long-term exposure to sulphur dioxide, nitrogen dioxide, carbon monoxide and ozone on mortality were also assessed but judged to be weaker than that regarding particles and insufficient to justify quantification, either in place of, or in addition to, the mortality effects of long-term exposure to PM 2.5.

3.5 The Defra publication 'Air Pollution: Action in a changing climate'[7], contained updated values for loss of life-expectancy and costs based on anthropogenic

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[2] UK health performance: findings of the Global Burden of Disease Study 2010

[3] COMEAP provides independent advice to government departments and agencies on how air pollution impacts on health.

[4] Committee on the Medical Effects of Air Pollutants. (2009) Long-Term Exposure to Air Pollution: Effect on Mortality. Health Protection Agency.

[5] Definition of PM2.5

[6] COMEAP: The Mortality Effects of Long-Term exposure to Particulate Air Pollution in the UK, December 2010

[7] Department for Environment, Food and Rural Affairs (Defra) (2010a) Air Pollution: Action in a Changing Climate: http://www.defra.gov.uk/environment/quality/air/airquality/strategy/documents/air-pollution.pdf

PM2.5 levels in 2008. The loss of life-expectancy due to PM2.5 at 2008 levels was estimated at about 6 months, with estimated equivalent costs in 2005 prices of between £7.7 billion and £16.9 billion per annum.

3.6 A recent report issued by Public Health England (PHE) [8] focuses on the long-term effects of background PM2.5 due to human activity, i.e. fuel combustion (vehicles, industry, power generation, etc.). The report found that, in some parts of London, PM2.5 pollution contributes to 8.3% of deaths in people aged over 25, while the estimate for Somerset is 4.4%. The national estimate for the UK is that PM2.5 pollution contributes to 5.3% of deaths, which converts into 28,969 deaths per year.

3.7 The impacts on health from air pollution can be considered to be both short and long term**.**

Short term: In most healthy individuals, moderate levels of air pollution levels are unlikely to have any serious short term effects. However, elevated levels and/or long term exposure to air pollution can lead to more serious symptoms and adverse effects. These mainly affect the respiratory and inflammatory systems. These can include exacerbations of asthma, negative effects on lung function, increases in hospital admissions for respiratory and cardiovascular conditions, as well as increases in mortality. People with existing lung or heart conditions may be more susceptible to the effects of air pollution[9][10].

3.8 The most vulnerable groups including children, older people and those with heart and respiratory conditions are most affected by elevated levels of air pollution. People living in deprived areas are also more affected by poor air quality, partly because these areas are often near busy roads. This can exacerbate health inequalities.

The table below shows the types of health effects experienced by the most common pollutants at elevated levels:

Pollutant	**Health effects at very high levels**
Nitrogen Dioxide, Sulphur Dioxide, Ozone	Cause inflammation and consequent narrowing of the airways after short exposure and can increase response to irritants. Asthma symptoms can be exacerbated
Particles	Long-term exposure to particles (especially PM2.5) is associated with premature mortality, especially from heart and lung conditions. Recent studies have also suggested that high levels of PM2.5 in childhood can permanently impair lung function. High levels of particles can affect asthma sufferers
Carbon Monoxide	This gas prevents the uptake of oxygen by the blood. This can lead to a significant reduction in the supply of oxygen to the heart, particularly in people suffering from heart disease

3.9 Long-term:

[8] Estimating Local Mortality Burdens associated with Particulate Air Pollution, PHE, 2014
[9] COMEAP (1998). The Quantitation of the Effects of Air Pollution on Health in the UK.
[10] COMEAP (2001) Statement on Long Term Effects of Particles on mortality.

The World Health Organisation (WHO) estimate air pollution caused 3.7 million premature deaths worldwide per year in 2012; largely due to exposure to small particulate matter of 10 microns or less in diameter (PM_{10}), which cause cardiovascular and respiratory disease, and cancers.

3.10 The WHO IARC study in 2013 found outdoor air pollution to be a leading environmental cause of cancer deaths in humans. Some deaths may be attributed to more than one risk factor at the same time. For example, both smoking and ambient air pollution affect lung cancer. Some lung cancer deaths could have been averted by improving ambient air quality, or by reducing tobacco smoking.

3.11 Health outcomes resulting from particulate matter:
Particulate matter affects more people than any other pollutant. Research evidence strongly suggests that chronic exposure to particulate matter can lead to higher levels of mortality (death), increased admissions to hospital of people suffering from cardiovascular disease (heart attacks and strokes) and pulmonary (lung) disease, such as chronic obstructive pulmonary disease (COPD), bronchitis and asthma. The effects may be due to size, as the most health-damaging particles are those with a diameter of 10 microns or less, ($\leq PM_{10}$), which can penetrate and lodge deep inside the lungs. But other factors such as composition (some hydrocarbons, fossil fuels[11] or metals which can cause cancer, poisoning or adverse health outcomes[12].), length of time of exposure as well as source and age of particle are also relevant.

In the UK, annual mean objectives for the protection of human health have been set at 40 µg/m3 for PM10 and 25 µg/m3 for PM2.5. However, the WHO 'Review of evidence on health aspects of air pollution (REVIHAA) project': suggests there is no safe level below which no adverse health effects occur.

3.12 **The Picture in Thurrock**
In April 2001, Thurrock Council declared 20 AQMAs for exceeding threshold annual average limit values for NO2, four of which were also exceeding the 24 hour mean limit value for particulate matter (PM10). This was reassessed in 2004, identifying that 7 AQMAs could be withdrawn and 2 additional AQMAs should be designated. This resulted in Thurrock having 15 AQMAs exceeding the annual average NO2 objective, four of which were previously designated for problems with PM10. Source apportionment exercises determined that the primary reason in all 15 AQMAs was road transport. A further AQMA was declared in November 2014 in part of Tilbury. The location of current AQMAs is shown in Appendix 2.
Currently local authorities are required to submit an assessment every three years, plus further detailed assessments and a formal action plan when an Air Quality Management Area is declared.

[11] Review of evidence on health aspects of air pollution, REVIHAAP, WHO, Europe, 2013
[12] Review of evidence on health aspects of air pollution, REVIHAAP, WHO, Europe, 2013

3.14 The Local Authority is working hard to bring improvements to air quality within current AQMA's and work being progressed is highlighted in the Air Quality Progress Report for Thurrock Council[13], including promoting use of greener buses, engagement to reduce car usage and promote active travel ("beat the street") and working with businesses and workplaces. However, it has to be acknowledged that local action alone is unlikely to bring about all the improvements required in order to comply with the air quality objectives. One of the main issues for Thurrock is that it is a major transport hub for Heavy Goods Vehicles (HGV's) and most of the current AQMA's in the west of the borough are impacted by the weight of traffic and HGV's moving along the roads. The local authority manages these roads to lower impact, but it has to ensure a balance between air quality considerations and potential economic and political consequences. An important issue which has had a negative impact on air quality in recent years is the increasing uptake of diesel vehicles over petrol vehicles. This has unfortunately been incentivised nationally by lowering car tax on these vehicles and has impacted on recent trends for both nitrogen dioxide and particulate matter.

3.15 The air quality action plan contains some very good initiatives aimed at lowering emissions and changing behaviour, but given that the Council is constrained in its' ability to influence local air quality directly, partly as a result of pollution arising from neighbouring areas, London (and beyond) and partly because it has limited responsibility for the main sources of emissions in Thurrock, it might be suggested that Thurrock Council might have more health impact by focusing on lowering exposure.

3.16 **Public Health Outcomes Framework air pollution indicator**
Due to the significant impact on human health, the Public Health Outcomes Framework (PHOF) includes an air pollution indicator. This relates to the mortality effect of man-made particulate matter expressed as the percentage mortality fraction attributable to PM2.5 for upper tier local authorities.

3.17 Reviewing the PHOF for the PHE Centre Essex and Anglia Region, (Appendix 3) it can be seen that Thurrock has the highest outcome indicator value for particulate pollution (5.9). It has been suggested that work to improve the air pollution indicator would see beneficial impacts on other PHOF indicators. For example lifestyle indicators such as excess weight or physically active adults, as improving air pollution might foster living streets developments and more engagement in active travel schemes.

3.18 Options going forward
The introduction of the Public Health Outcomes Framework (PHOF), greater evidence on health impacts of air pollution and the likely benefits of addressing this, and the transfer of public health responsibilities to local authorities offers great opportunities in improving both health and wellbeing.

[13] Thurrock Council, July, 2014

Joined up approaches could be of great value in both promoting air quality at a local level and bringing together action to improve public health across all our communities. This is especially relevant for the health impacts of PM2.5.

3.19 Air quality and impact on health and wellbeing should be highlighted in the Joint Strategic Needs Assessment. Health and Well Being Boards and local Directors of Public Health are able to prioritise action on air quality as part of the need to tackle the wider determinants of health in order to reduce the health burden from air pollution and more generally.

3.20 A number of measures can be undertaken at a national and local level to reduce air pollution including:

- Proactive enforcement of vehicle emissions standards for cars and buses, and awareness raising campaigns.
- Responsible fleet procurement and management e.g. nationally enforced age limit for Public Service Vehicles (PSVs).
- Reduce car journeys within towns and cities and improve sustainable travel options.
- Incentivise the uptake of clean fuels.
- Better controls over biomass burning and installations.
- Requesting low emission strategies for new developments.

3.21 Measures to tackle PM2.5 include:

- Implementation of protocols for PM2.5 reduction through a package of measures such as Low Emission Zones for city/town centres; planning restrictions (i.e. suitable mitigation) on polluting activities such as incinerators upwind of AQMAs; and implementation of sustainable low emission transport
- PM2.5 particularly associated with diesel vehicles and Heavy Goods Vehicles (HGVs), and therefore curbs/controls on HGV through-traffic in town/city centres would help, including weight restrictions on trucks; on the spots emissions testing (at the tailpipe) with fines for the worst polluters.
- A key national measure to control PM2.5 would be for car Manufacturers to reduce particulate matter from diesel vehicles and from vehicle brake and tyre wear.
- Utilisation of the planning process to ensure PM2.5 levels are taken into account in new developments e.g. include special particulate reducing plants, green walls, green roofs, and construction of dust mitigation measures

3.22 Improving health and wellbeing by joining up action including:

- Encouraging active travel i.e. walking or cycling so lowering car travel, encouraging park and ride schemes

- Encouraging' living streets' by pedestrian schemes, traffic management, public transport interventions, relocation of road space
- Developing urban green spaces that help to improve air quality and have secondary health benefits e.g. mental health, physical activity

3.23 A recent national Conference on air quality hosted by PHE[14] suggested that local initiatives should re-focus on reducing exposure to traffic emissions, and by encouraging behavioural change related to travel modes and routes. These actions could be supported by the promotion of national and local alerting and other local information schemes and interventions tailored to different audiences. This stance is a pragmatic one, but achievable as impact on air pollution is a cross-boundary issue requiring coordination of actions beyond the local level and usually needing to involve a range of players to be effective.

4. Reasons for Recommendation

4.1 The Health and Wellbeing Board is asked to note the contents of this report.

4.2 That the Health and Wellbeing Board supports the work of a cross-directorate Officer Working Group which has been established to consider actions that might lower exposure as well as reduction of emissions to mitigate health impact.

4.3 That the Officer Working Group brings Air Quality integrated Plan to Health and Wellbeing Board to help to identify and prioritise joined up actions and approaches that might improve the health experience of individuals and communities in Thurrock

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

5.1 This report has been to Health and Wellbeing Overview and scrutiny panel.

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

6.1 This report should be used by the Council and partners to influence new ways of working and supporting policies and actions that minimise impact of air pollution and impact on health and wellbeing.

[14] Birmingham, 02.02.15

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Management Accountant

There are no direct financial costs arising from this report. Costs associated with monitoring of air quality can be contained within the relevant revenue budget for Environmental Protection. The public health budget already funds a number of initiatives to promote active travel and any new proposed such schemes would be subject to the normal budget process.

7.2 Legal

Implications verified by: **Dawn Pelle**

Adult Care Lawyer, Legal and Democratic Services

There are no legal implications for the following reasons:

The report acknowledges the duties imposed upon local authorities by statute. Further you have taken into account the Air Quality Regulations 2000 as well as the UK strategy on Air Quality setting out the standards and objectives. It is noted that Air Quality Management Areas (AQMAs) have found in Thurrock and measures being taken to address them accordingly. For example those set out in paragraph 3.17 of the report.

There is a recognition that an assessment has to be submitted every 3 years and a detailed assessment along with a formal action plan when an AQMA has been declared

7.3 Diversity and Equality

Implications verified by: **Rebecca Price**

Community Development Officer

The introduction of measures to reduce air pollution will help to improve the health and wellbeing of some of the more vulnerable members of the local community, including those suffering from health conditions affecting the upper-respiratory system or those with cardiovascular disease.

The implementation and ongoing monitoring of the Air Quality Action Plan will help to tackle existing air quality problems, including a reduction in the levels of nitrogen dioxide and particulate matter, reducing the health impacts for people living and working in and around the AQMAs.

The Council will have due regard to the Equality Act 2010 when there are any major proposed actions or schemes for the reduction of air pollution in Thurrock.

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

The impact of air pollution on health is the topic of the report.

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):

There are a number of reports and research studies cited and can be found in footnotes of relevant sections. The principal reports are:

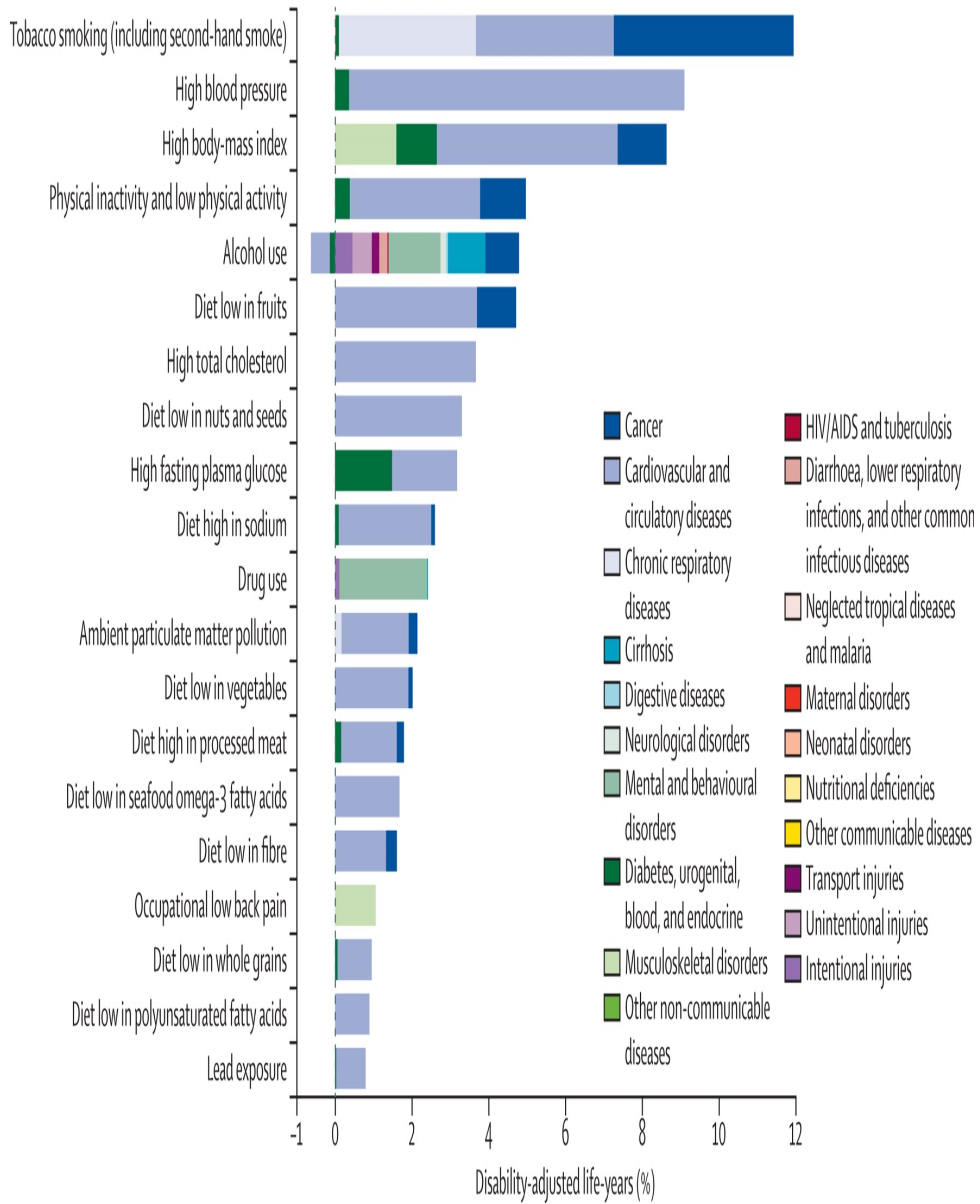
- Committee on the Medical Effects of Air Pollutants. (2009) Long-Term Exposure to Air Pollution: Effect on Mortality. Health Protection Agency.
- COMEAP: The Mortality Effects of Long-Term exposure to Particulate Air Pollution in the UK, December 2010
- Estimating local mortality burdens associated with particulate air pollution, PHE, April 2014
- Thurrock Interim Air Quality Action Plan for Transport – 2012-2014-2015, March 2013
- Air Quality Progress Report for Thurrock Council, July 2014
- Review of evidence on health aspects of air pollution, REVIHAAP, WHO, Europe, 2013

9. Appendices to the report

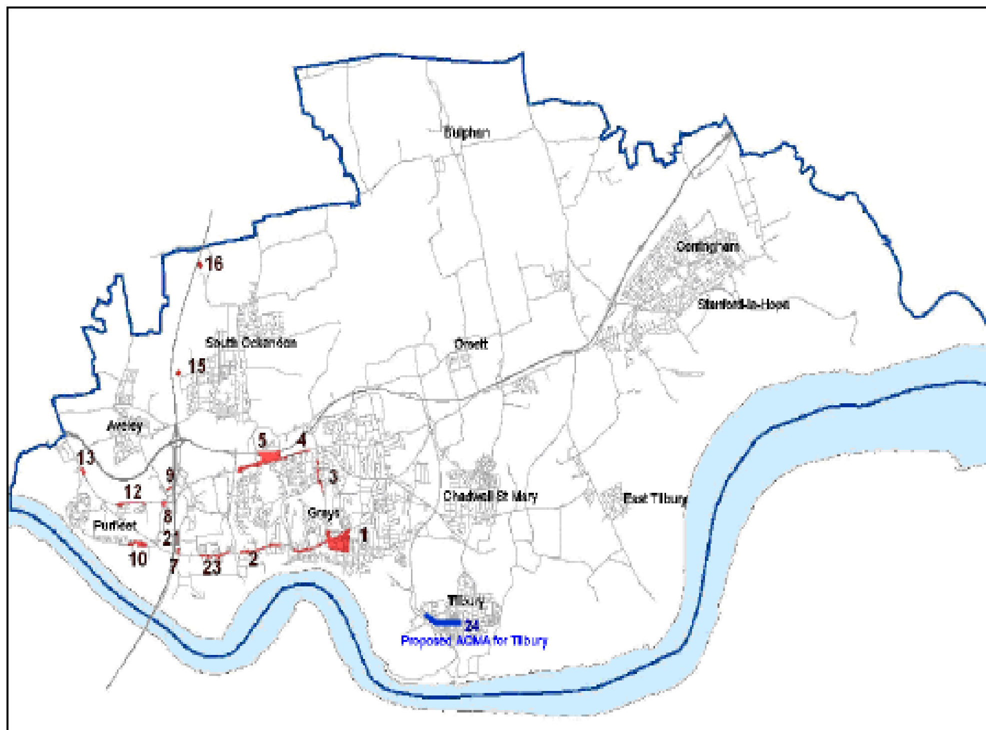
Appendix 1: Ranking of risk factors for UK
Appendix 2: Thurrock Air Quality Management Areas in Thurrock
Appendix 3: Public Health Outcomes Framework indicator for air pollution

Report Author:
Dr Cate Edwynn
Consultant in Public Health
Public Health

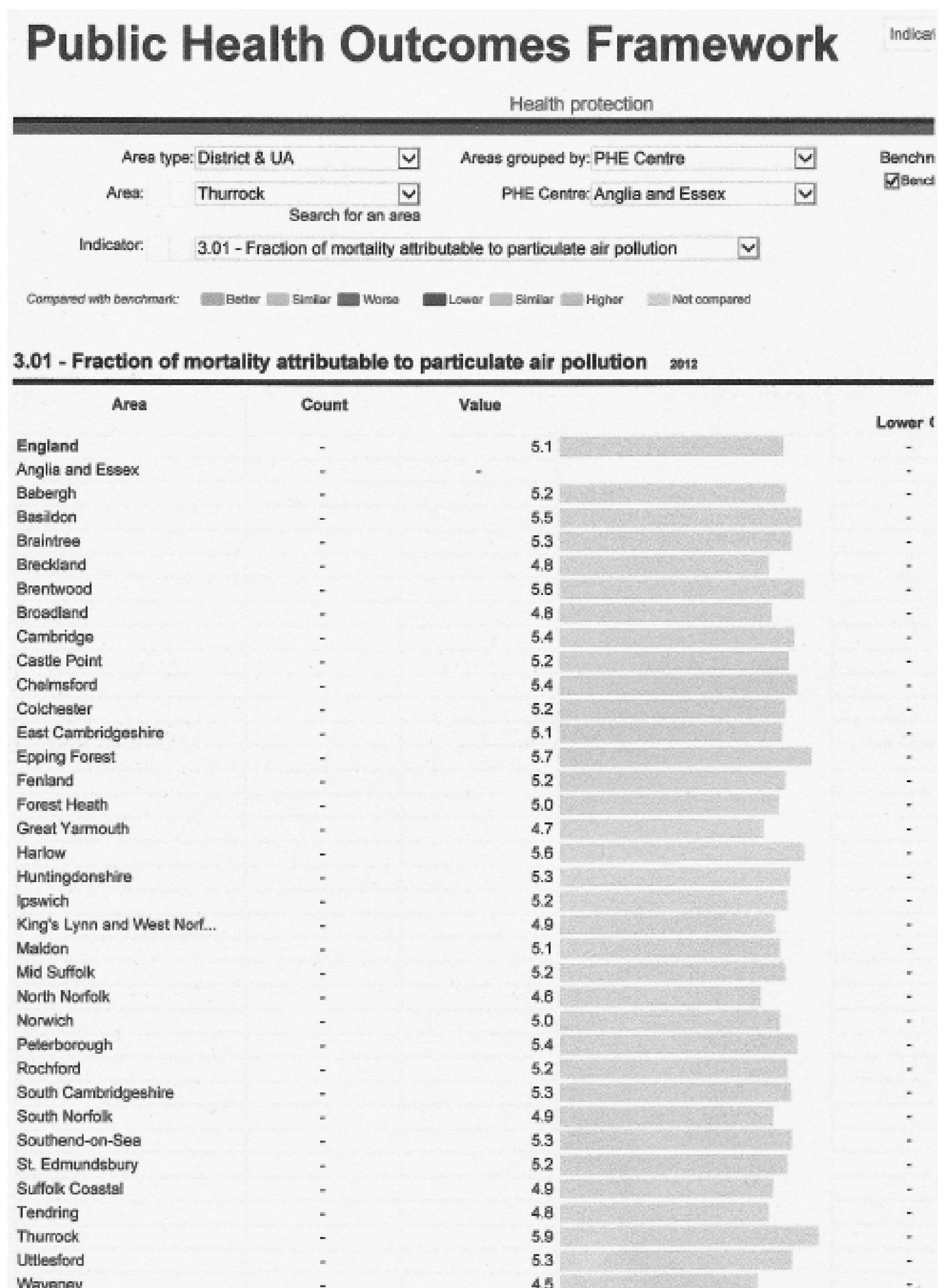
Appendix 1: Ranking of risk factors for UK



Appendix 2: Thurrock Air Quality Management Areas in Thurrock



Appendix 3: Public Health Outcomes Framework indicator for air pollution



Public Health Outcomes Framework

Health protection

Area type: District & UA — Areas grouped by: PHE Centre

Area: Thurrock — PHE Centre: Anglia and Essex

Search for an area

Indicator: 3.01 - Fraction of mortality attributable to particulate air pollution

Compared with benchmark: Better, Similar, Worse, Lower, Similar, Higher, Not compared

3.01 - Fraction of mortality attributable to particulate air pollution 2012

Area	Count	Value	Lower (
England	-	5.1	-
Anglia and Essex	-	-	-
Babergh	-	5.2	-
Basildon	-	5.5	-
Braintree	-	5.3	-
Breckland	-	4.8	-
Brentwood	-	5.6	-
Broadland	-	4.8	-
Cambridge	-	5.4	-
Castle Point	-	5.2	-
Chelmsford	-	5.4	-
Colchester	-	5.2	-
East Cambridgeshire	-	5.1	-
Epping Forest	-	5.7	-
Fenland	-	5.2	-
Forest Heath	-	5.0	-
Great Yarmouth	-	4.7	-
Harlow	-	5.6	-
Huntingdonshire	-	5.3	-
Ipswich	-	5.2	-
King's Lynn and West Norf...	-	4.9	-
Maldon	-	5.1	-
Mid Suffolk	-	5.2	-
North Norfolk	-	4.6	-
Norwich	-	5.0	-
Peterborough	-	5.4	-
Rochford	-	5.2	-
South Cambridgeshire	-	5.3	-
South Norfolk	-	4.9	-
Southend-on-Sea	-	5.3	-
St. Edmundsbury	-	5.2	-
Suffolk Coastal	-	4.9	-
Tendring	-	4.8	-
Thurrock	-	5.9	-
Uttlesford	-	5.3	-
Waveney	-	4.5	-

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Air Quality, Regeneration & Health

IMPACT ON HEALTH IN UK & THURROCK

Dr Cate Edwynn

Interim Consultant in Public Health

17th February 2015

Presentation Plan

- National Air quality Strategy
- Health impact of air pollution on health, with particular reference to PM
- Quantification of impact of air pollution
- Is this a priority for Thurrock?
- Opportunities to develop integrated and joined up response to lower exposure

National Air Quality Strategy

- Sets national air quality standards
- Policy options to improve air quality in UK

- Regulated Pollutants
  - Benzene
  - 1,3-Butadiene
  - Ozone
  - Sulphur dioxide
  - Carbon monoxide
  - Lead
  - **Particulates (PM10 & PM2.5)**
  - **Nitrogen dioxide**

Health Impacts of air pollution

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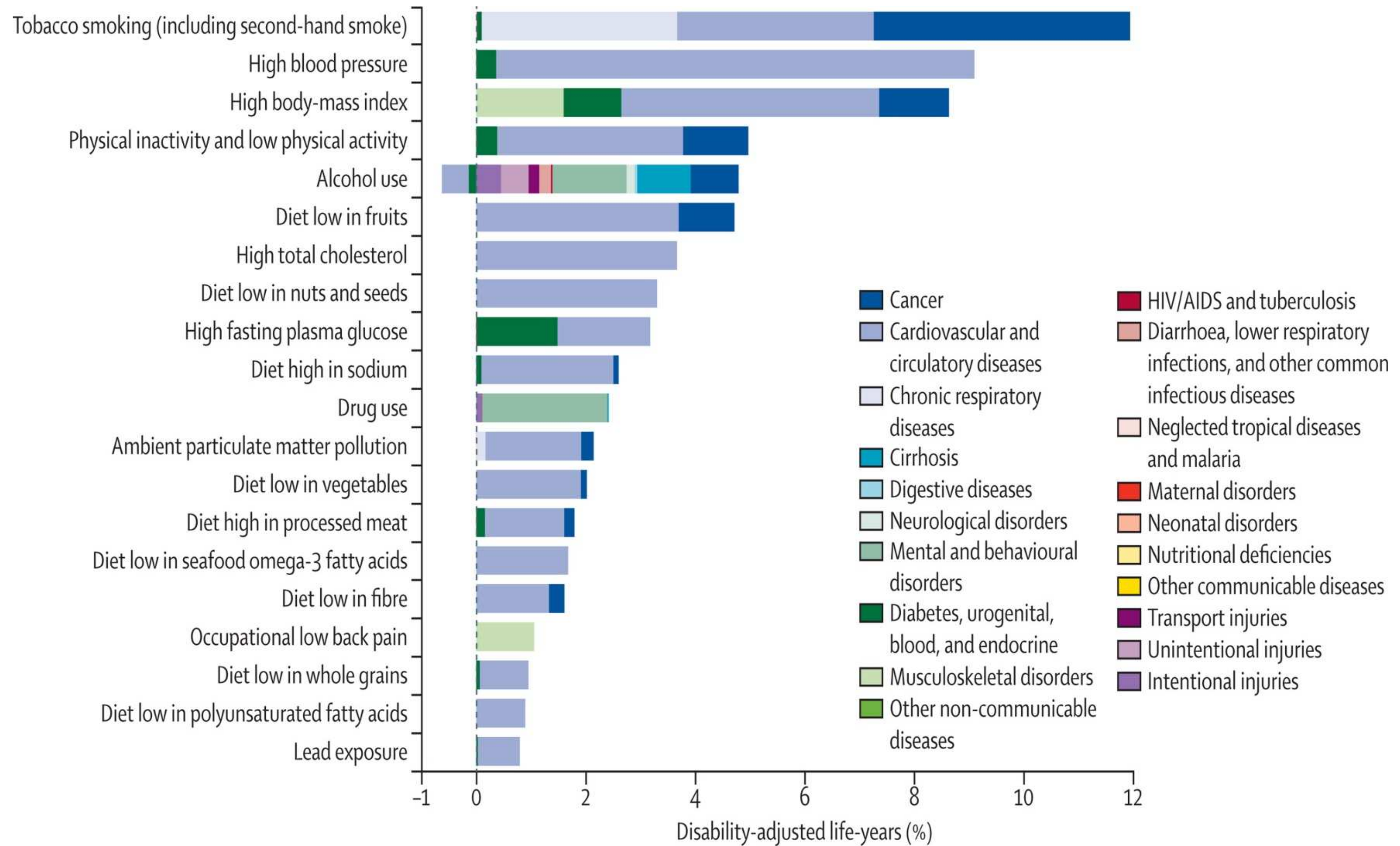
Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years, *The Lancet* 2013



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What is Particulate matter (PM2.5)?

- **Solid particles and droplets**
- Composition:
- Biological (spores, viruses, pollen)
- Non-biological (soot, soil, salt, minerals, metals, fibres etc)

- **Classification by size fraction:**
- PM10: <10µm in diameter (example: mineral dusts)
- PM2.5: <2.5µm (example: car exhausts)
- Ultrafine: <0.1µm
- **NB. Smaller: more health damaging**

- **Main Sources**: **Fuel combustion - traffic emissions, stationary combustion and industrial processes**

PM2.5: How does it affect individuals and our communities?

- **Short term**
  - Worsening of frequency & severity of symptoms for those with respiratory disease (including asthma)
  - Increased hospital admissions for cardiopulmonary related conditions
  - Higher impact on susceptible individuals – those with existing cardiopulmonary disease, diabetes, vulnerable groups
- **Long term**
  - Premature death from cardiovascular and respiratory diseases, including lung cancer.
  - High levels in childhood may permanently impair lung function.

Who's affected?

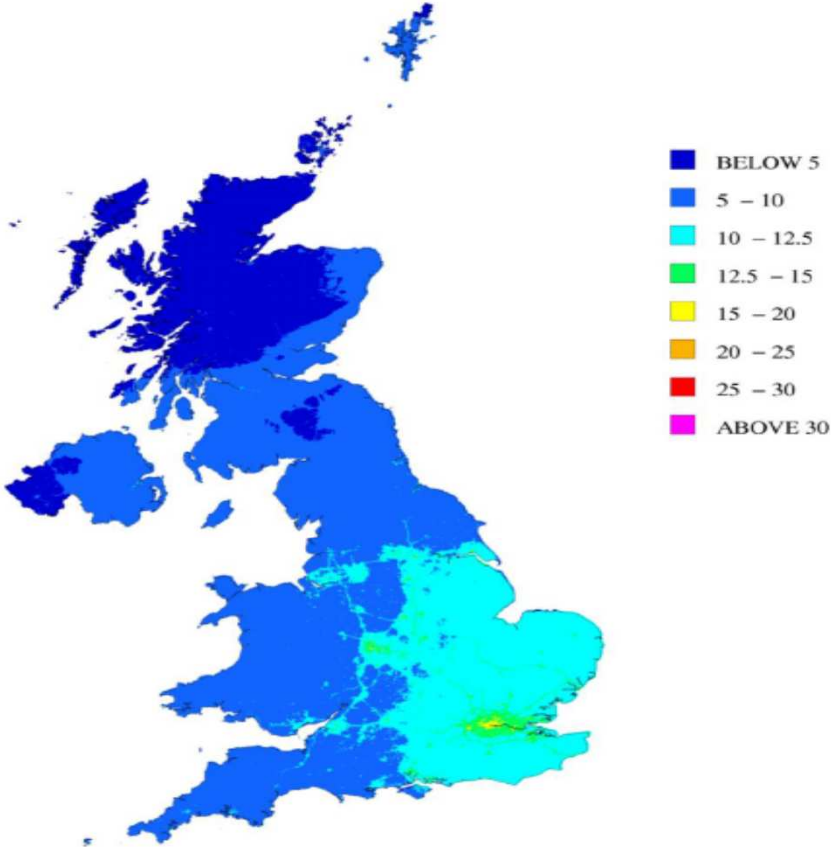
Greatest burden falls on most vulnerable groups - children, older people, deprived communities.

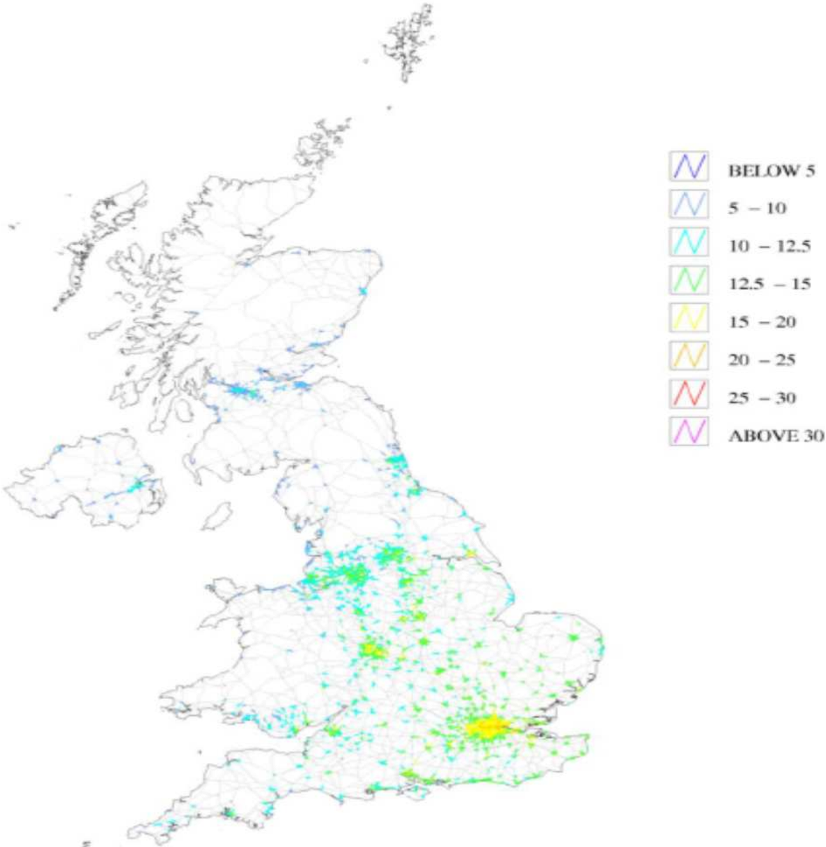
Those who live or work near roads, car occupants.

There is no safe limit for exposure for PM2.5

PM2.5 levels over UK

$PM_{2.5}$ in 2009 ($\mu g\ m^{-3}$)





Air Pollution

Quantifying health impacts

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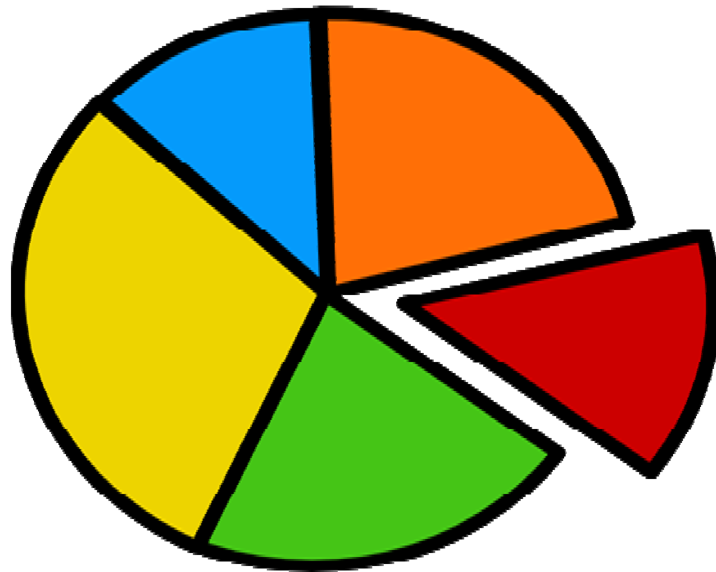
Ways of thinking about health impacts of air pollution

- Number
- Proportion
- Years of life lost



- **Attributable fraction** - proportion of local deaths attributable to exposure
- **Attributable deaths** - number of deaths attributable to exposure
- **Years of life lost** – using numbers of attributable deaths and the age at which these occur to determine the total loss of life associated with exposure in community

Estimates UK – COMEAP (2010) & PHE Report (2014)

- **COMEAP - Burden of human–made particulate pollution in 2008**
  - An effect equivalent to 29,000 deaths
  - A loss of 340,000 years of life
  - Loss of 6 months of life expectancy from birth
- **PHE Report suggested**
  - PM2.5 contributes to 8.3% of deaths in London & 5.3% nationally (28,969 deaths/annum)
- **Impact of changing levels of pollution**
  - Estimate that long term exposure to a 10µg per m^3 increase in $PM_{2.5}$ concentrations leads to a 6% increase in 'all cause mortality', or total deaths
  - Increase in LE from birth of about 20 days (by 1µm/m3 PM2.5)

Table 2.1: Adjusted mortality relative risk [a] (with 95% CI) associated with a 10 µg/m³ increase in fine particles measuring less than 2.5 µm in diameter

Cause of mortality	1979–1983 [b]	1999–2000 [b]	Average
All-cause	1.04 (1.01–1.08)	1.06 (1.02–1.10)	1.06 (1.02–1.11)
Cardiopulmonary	1.06 (1.02–1.10)	1.08 (1.02–1.14)	1.09 (1.03–1.16)
Lung cancer	1.08 (1.01–1.16)	1.13 (1.04–1.22)	1.14 (1.04–1.23)
All other cause	1.01 (0.97–1.05)	1.01 (0.97–1.06)	1.01 (0.95–1.06)

(a) Estimated and adjusted based on the baseline random-effects Cox proportional hazards model, controlling for age, sex, race, smoking, education, marital status, body mass, alcohol consumption, occupational exposure and diet.

(b) The time periods (i.e. 1979–1983 and 1999–2000) given in the table refer to the time during which concentrations of fine particles were measured.

CI, confidence interval.

(Reproduced with permission from the American Medical Association.)

Air Pollution Outcome Indicator

- Because of the significant impact on health, the Public Health Outcomes Framework includes an air pollution indicator, which relates to the mortality effect of man-made particulate matter expressed as the percentage mortality fraction attributable to PM2.5 for a upper tier local authority.

Public Health Outcomes Framework

Indicat

Health protection

Area type: District & UA | Areas grouped by: PHE Centre | Benchm

Area: Thurrock | PHE Centre: Anglia and Essex | Bench

Search for an area

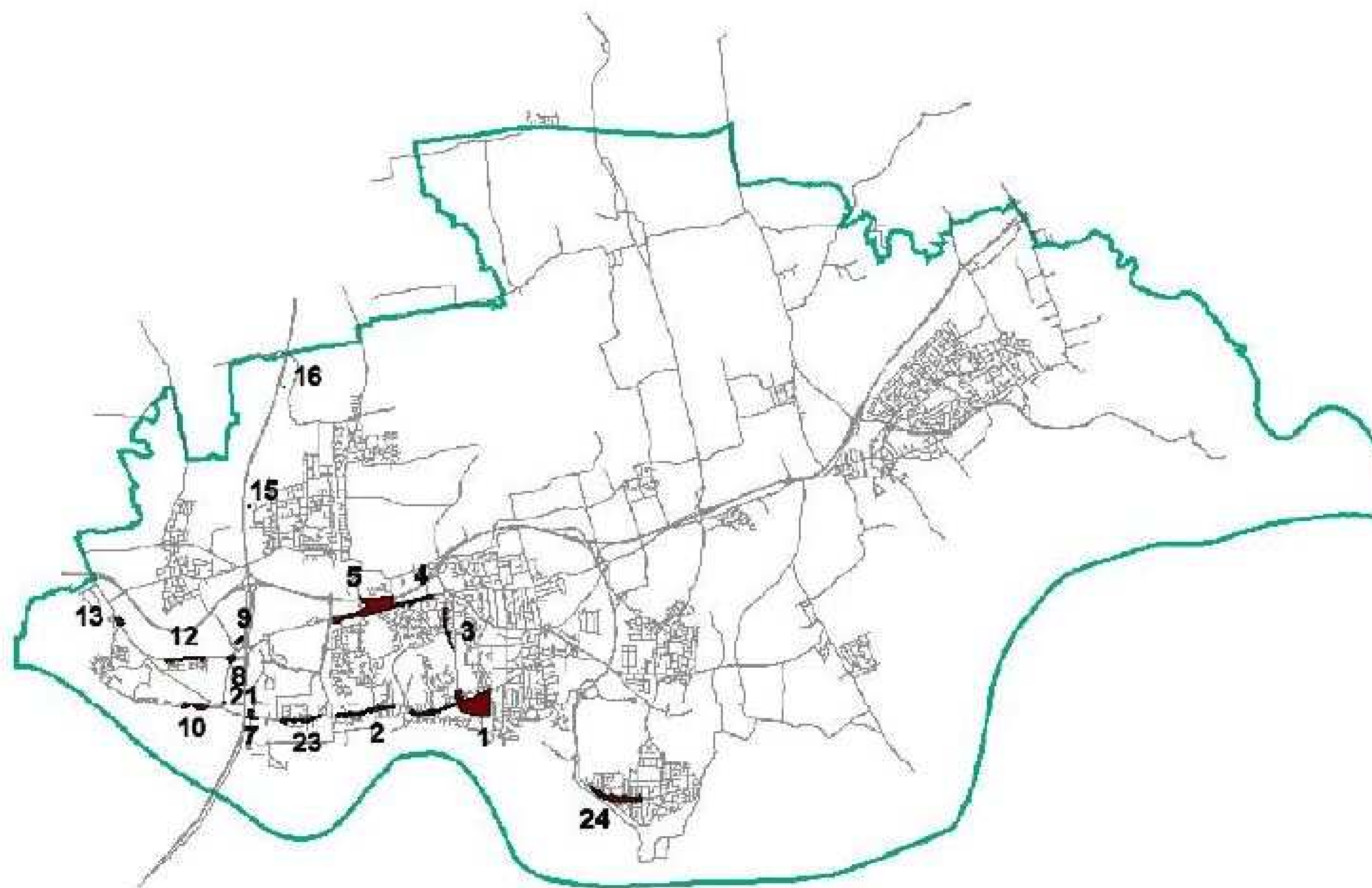
Indicator: 3.01 - Fraction of mortality attributable to particulate air pollution

Compared with benchmark: Better Similar Worse Lower Similar Higher Not compared

3.01 - Fraction of mortality attributable to particulate air pollution 2012

Area	Count	Value	Lower C
England	-	5.1	-
Anglia and Essex	-	-	-
Babergh	-	5.2	-
Basildon	-	5.5	-
Braintree	-	5.3	-
Breckland	-	4.8	-
Brentwood	-	5.6	-
Broadland	-	4.8	-
Cambridge	-	5.4	-
Castle Point	-	5.2	-
Chelmsford	-	5.4	-
Colchester	-	5.2	-
East Cambridgeshire	-	5.1	-
Epping Forest	-	5.7	-
Fenland	-	5.2	-
Forest Heath	-	5.0	-
Great Yarmouth	-	4.7	-
Harlow	-	5.6	-
Huntingdonshire	-	5.3	-
Ipswich	-	5.2	-
King's Lynn and West Norf...	-	4.9	-
Maldon	-	5.1	-
Mid Suffolk	-	5.2	-
North Norfolk	-	4.6	-
Norwich	-	5.0	-
Peterborough	-	5.4	-
Rochford	-	5.2	-
South Cambridgeshire	-	5.3	-
South Norfolk	-	4.9	-
Southend-on-Sea	-	5.3	-
St. Edmundsbury	-	5.2	-
Suffolk Coastal	-	4.9	-
Tendring	-	4.8	-
Thurrock	-	5.9	-
Uttlesford	-	5.3	-
Waveney	-	4.5	-

AQMAs in Thurrock in 2015



Should Air Quality be a key priority for Thurrock?

- Major issue as is both a major transport hub for HGVs and regeneration area
- PHE report suggests Thurrock has equivalent of:

  6.5% of deaths due to long term exposure (PHOF 5.9%)

  73 deaths in those over 25 years

  821 years of life lost from population
- Tackling air pollution would not only (1) increase healthy life expectancy and reduce early death from cardio-pulmonary disease, but (2) impact on number of other PHOF indicators.
- Transport measures are an excellent opportunity to deliver further public health benefits across the life course.
- But should we be linking action across the Council to have more health impact by lowering exposure, improving air quality and encouraging behavioural change?

Opportunities to increase impact for health?

- Transfer of public health responsibilities offers opportunities for **joined up approaches to health and wellbeing**. This is why the integrated air quality officer group should report progress into HWBB as HWBBs can prioritise environmental issues that impact on health & wellbeing.
- More emphasis on **"greening"** of the planning process to ensure PM2.5 levels are taken into account in new developments e.g. could include "special particulate reducing plants, green walls & roofs, and dust mitigation measures.
- **Reducing car usage**: encouraging active travel; i.e. walking or cycling, lowering car travel, encouraging park & ride schemes
- **Encouraging "living streets"** by prioritising pedestrian access and use, traffic management, public transport interventions, relocation of road space, greener" buses, anti-idling measures.
- **Lowering exposure and supporting individual action:** Working with schools and more vulnerable communities, raising awareness, pollution alerts, anti-idling initiatives
- Developing **urban green spaces** that help to improve air quality and have secondary health benefits e.g. mental health, physical activity

What should Thurrock be doing?

- **Thurrock is already taking this seriously. But we want to link up health, planning, and transport to have a bigger impact on people's lives and reduce inequalities. We already have 16 AQMAs, active and improved travel, but we have been considering other ideas**:

- **Reducing pollution from idling vehicles –** 2 ideas: outside schools, targeting idling vehicles within a new LEZ area with known poor air quality.
- Encouraging **smarter travel behaviour**
- **Promoting Living streets** - action on congested roads, traffic management, prioritising pedestrian access – links to smarter travel
- **"Planning for health"** – "greening" development, reducing non-road emissions, greener urban spaces/encouraging biodiversity, use of HIA and checklists
- **Action for vulnerable individuals** – cleaner air for schools, alerts, AirText systems.

Going forward……

- Strong evidence around health impact on health of air pollution
- Officer Working Group established to look at all approaches that could limit exposure of communities to air pollution to protect health and wellbeing
- HWBB to consider integrated plan in order to identify and prioritise actions and approaches within document.

15 June 2015	ITEM: 12
Health and Wellbeing Board	
Health and Social Care Transformation Update	
Report of: Roger Harris, Director of Adults, Health and Commissioning, and Mandy Ansell, Acting Interim Accountable Officer, Thurrock Clinical Commissioning Group	
Accountable Head of Service: Les Billingham, Head of Adult Social Care	
Accountable Directors: Roger Harris, Director of Adults, Health and Commissioning, and Mandy Ansell, Acting Interim Accountable Officer, Thurrock Clinical Commissioning Group	
This report is Public	

Executive Summary

This purpose of this report is to provide the Board with a progress report on the Health and Social Care Transformation Programme – including highlighting any key risks and issues. This report focuses on two key areas of the Programme:

- Implementation of the Care Act 2014, and preparation for part 2 of the Act (cap on care charges); and
- Arrangements for and implementation of the Better Care Fund Plan.

Contained within this report is a BCF implementation project plan which the Board is asked to agree.

1. Recommendation(s)
That the Health and Wellbeing Board:

1.1 Note the Health and Social Care Transformation Progress Report; and

1.2 Agree the Health and Social Care Transformation BCF Implementation Project Plan (Appendix 1).

2. Introduction and Background

2.1 The purpose of this report is to provide the Health and Wellbeing Board with a progress report on the Health and Social Care Transformation Programme and to highlight any key issues or decisions.

2.2 This report will focus on the implementation of the Care Act 2014, and the implementation of the Better Care Fund Plan – linked to the broader Whole System Redesign agenda.

3. Issues, Options and Analysis of Options

Care Act 2014 Implementation – Part 1

3.1 Since the last Health and Social Care Transformation report was brought to the Board, part 1 of the Care Act 2014 has come in to operation. The March report detailed the Council's readiness to meet the Act's requirements and highlighted possible areas of risk. These are as follows:

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

3.2 Whilst the Council is confident that it has made the changes necessary to be compliant with the Act, it recognises that some changes will take time to embed – for example a shift in practice. As a result, the Council – through the Care Act Implementation Group – has agreed to undertake activity to measure how well embedded certain elements of the Act are. This includes the following:

- Audits of assessments carried out since April – a new Care Act compliant assessment has been introduced;
- Secret shopper activity;
- Action learning sets for practitioners; and
- Formal practice reviews – e.g. follow-up workshops to refresh and develop practice based on staff feedback.

Sufficient time for changes to embed will be allowed prior to measurement activity taking place.

3.3 Any elements of the Act which are not as embedded as they should be, or as we would want them to be, will be accompanied by development actions. These will be overseen by the Care Act Implementation Group. Updates will be brought to the Board in future progress reports.

Care Act 2014 Preparation – Part 2

3.4 As previously reported, the Act is being introduced in two parts. Part 2 of the Act relates to the cap on care costs and will be introduced in April 2016. April 2016 may also see the introduction of a new appeals system for Adult Social Care.

3.5 With the final guidance and regulations related to part 2 expected at the end of October, the Council has already started to prepare for the changes. This has included the refresh of the Care Act Implementation Group, the establishment of themed working groups, the recruitment of a project manager, and the development of an accompanying project plan.

3.6 Key elements of implementing part 2 of the Act are as follows:

- Identification and assessment of current self-funders – and application of new Independent Personal Budgets;
- Development and implementation of Care Accounts;
- Implementation of the 'Care Cap' – and related system changes; and
- Implementation of the new Appeals System for Care and Support.

3.7 Accompanying the changes will be communication and engagement activity, policy development and also workforce development.

3.8 Key risks associated with the introduction of part 2 are:

- Financial impact on the Council of the changes – in particular the extension of means testing support (upper threshold will increase to £118k), the cap on care (£72k cap), and the introduction of a lower or zero cap for working age adults.
- Capacity required to identify and assess current self-funders prior to April 2016.
- Potential impact on market sustainability and provider failure.
- Extent of system upgrades required to manage the change to the current system.

3.9 Further reports will be brought to the Board as part of future progress updates.

Better Care Fund Implementation

3.10 Thurrock's Better Care Fund Plan received ministerial sign off in January 2015. Since then a Better Care Fund section 75 agreement has been developed and agreed, and arrangements have been put in place to oversee its delivery.

3.11 The Better Care Fund is focused on the delivery of a number of national conditions through the integration of health and social care. The main emphasis is the reduction of total emergency admissions, with an expectation of a reduction of 3.5% being achieved over the course of a year. Thurrock's Better Care Fund is just over £18m and is focused on the delivery of four key schemes:

- Locality Service Integration
- Frailty Model
- Intermediate Care Review
- Prevention and Early Intervention

Remaining schemes are:

- Disabled Facilities Grant and Social Care Capital Grant
- Care Act Implementation
- Payment for Performance (related to the delivery of a reduction in emergency admissions)

3.12 Governance arrangements include the establishment of an Integrated Commissioning Executive and the appointment of a Better Care Fund Manager (within an existing role – Strategic Lead for Commissioning and Procurement). The Integrated Commissioning Executive's membership includes officers from both Thurrock CCG and Thurrock Council, including the Director of Adults, Health and Commissioning, the CCG's Interim Accountable Officer, the Head of Corporate Finance, CCG's Chief Finance Officer and Head of Integrated Commissioning, and the Strategic Lead for Commissioning and Procurement (also acting as the Better Care Fund Manager).

3.13 The remit of the Integrated Commissioning Executive (ICE) extends beyond that of overseeing the implementation of the section 75 agreement. The Group will also ensure the development of and provide strategic direction to the whole system redesign agenda. Whilst the development of the inaugural BCF was separate to the development of the broader redesign programme, it is hoped that any future iteration of the BCF will incorporate a far broader redesign agenda. At its last meeting, the ICE agreed to the development of a strategic document setting out the direction of travel for the whole system. This document will influence all redesign work.

3.14 As part of ensuring the schedules contained within the section 75 agreement are implemented, the ICE has agreed an implementation plan (appendix 1). The plan consists of a number of separate projects spanning the health and social care spectrum. The strategic document mentioned in paragraph 3.12 will help to ensure the projects developed contribute to system change. For example, a greater emphasis on prevention and early intervention (prevent, reduce, delay), a focus on ensuring that when people do develop a long-term condition they are able to manage it well, and a greater focus on community-based and non-service solutions rather than a reliance on a traditional service route. The ICE will oversee the development implementation projects. The Health and Wellbeing Board are asked to agree the implementation plan.

3.15 Progress, issues and risks will be reported through future reports to the Board.

4. Reasons for Recommendation

4.1 To provide the Board with the assurance it requires that sufficient progress is being made on the health and care transformation programme, and that any significant risks are being identified and controlled.

4.2 To enable the Board to review and agree the BCF implementation plan.

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

5.1 Consultation and engagement on the development of the projects contained within the implementation plan will be undertaken via the steer provided by the Health and Social Care Transformation Engagement Group.

5.2 A series of workshops for the public, service users, carers, and providers will be organised later in the year to communicate the changes brought by the implementation of part 2 of the Care Act 2014. The workshops for the public will be organised in conjunction with Thurrock Coalition as per part 1 of the Act.

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

6.1 The development and delivery of the Health and Social Care Transformation Programme supports the delivery of the Community and Corporate priority – Improve Health and Wellbeing.

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**

Management Accountant

The development and delivery of the programme is being managed within existing budgets, including as part of the Better Care Fund.

7.2 **Legal**

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

The Better Care Fund Section 75 agreement is a legal agreement between the Council and Thurrock CCG.

The Council is required to meet the legal requirements set out within the Care Act 2014, its guidance, and its regulations.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Price**

Community Development Officer

The implementation of the Care Act 2014 and Better Care Fund provides a framework and means to support vulnerable adults with a focus on safeguarding, producing better outcomes and well-being at the core of all adult social care activity.

Workshops for the public, service users, carers, and providers will be organised later in the year to communicate the changes brought by the implementation of part 2 of the Care Act 2014. The workshops for the public will be organised in conjunction with Thurrock Coalition as per part 1 of the Act.

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 – BCF Implementation Project Plan

Report Author:

Ceri Armstrong

Strategy Officer

Adults, Health and Commissioning

Integrated Commissioning Executive Programme

Last updated: 2015/05/20

NHS Thurrock Clinical Commissioning Group

				Status Summary			General		RACI				Gateway
Project Code	**Portfolio**	**Project Name**	**Project Description**	**PMO Ready**	**Comment**	**Planned date to be PMO Ready**	**Governance process**	**Footprint**	**R (Responsible)**	**A (Accountable)**	**C (Consulted)**	**I (Informed)**	**Status**
PR100001	BCF	BCF 15/16 Projct Reporting	1) To comply with the reporting and financial requirements set out within the 15/16 BCF s75 agreement	No			Full	Thurrock	Catherine Wilson	Roger Harris			2. Programming
PR100002	BCF	Developing and communicating a frailty framework	1) to draft a framework setting out our approach to commissioning services for older people with frailty 2) to engage and communicate our vision to the people of Thurrock	No	Work in progress to describe the 16/17 transformational aspects of the BCF work plan		Full	Thurrock	Phillip Clark	Mark Tebbs	Alison Hall		2. Programming
PR100003	BCF	Development of Locality Model	1) Implementation of four integrated health and social care communities; 2) Ensuring each locality has a named workforce for all specialities; 3) Development of joint Health & Social Care Fair-Share data, by practice, by locality to inform commissioning and operating practice; 4) Shared estates review within each of the four localities. 5) Review and implementation of locality-based Long Term Condition co-morbidity clinics including social care provision. This initiative aims to improve the quality of care delivered and minimise the number of venues a patient needs to attend for their planned needs.	No	This forms part of the SDIP within the NELFT contract.		Medium	Thurrock	Phillip Clark	Mark Tebbs	Tania Stitch/Michelle Stapleton		2. Programming
PR100004	BCF	Development of Risk Stratification tool	1) Review and implementation of the new Electronic Frailty Index (EFI) published on SystmOne; 2) Development of a service algorithm to ensure a systematic approach to assessment / service access points; 3) Review and identification of frailty assessment tools appropriate for each health, social and voluntary sector service to ensure every contact counts; 4) Identification of pooled data-sets that present an opportunity for the system to offer / respond differently.	No	This forms part of the SDIP within the NELFT contract.		Medium	Thurrock	Rhodri Rowlands	Roger Harris	Phillip Clark/Ian Wake	NELFT	2. Programming
PR100005	BCF	Prevention, Screening and Protection	1) Frailty working group have identified a number of initiatives linked to the twelve preventable components for frailty. These work-streams largely relate to Public Health commissioning arrangements. 2) Falls Prevention Programme.	No			Medium	Thurrock	Ian Wake	Roger Harris			2. Programming
PR100006	BCF	Over 65 Long Term Condition Management	1) Review of existing Telehealth usage and implementation of revised Telehealth criteria with a specific LTC; informed on local/national research in conjunction with acute activity data. 2) Targeted communications strategy identifying exacerbation triggers for each condition and proposed communication plan for each; 3) Targeted promotion of RRAS (key-ring torches) with specific identified LTCs e.g. HF / COPD.	No			Medium	Thurrock					1. Scoping/ Opportunities
PR100007	BCF	Review and Expansion of RAS	1) Review and expand RRAS operating hours and cover; in conjunction with EEAST and SUS data as supporting evidence of need; 2) Review North East Lincolnshire model – Cat.3/4 diverts direct to RRAS response.	No			Medium	Thurrock					1. Scoping/ Opportunities
PR100008	BCF	Front-Door		No	There is workshop planned to define the scope of this work		Full	South West Essex	Mark Tebbs	Mandy Ansell			1. Scoping/ Opportunities
PR100009	BCF	Back-Door	1) To develop an Hospital Integrated Discharge Service (HIDS) through a mini-selection process.	No	There is a business case on Verto for this project		Full	South West Essex	Mark Tebbs	Mandy Ansell			3. PMO Ready
PR100010	BCF	Effective Rehibilitation & Reablement	1) Post south west Essex Estates analysis; Thurrock will review its bed-base to inform revised commissioning arrangements including increased rehab bed facilities prior to entering care home; 2) Explore model adopted within Sweden which sees a period of intensive rehab within the patient's own environment before CHC is considered. 3) Intermediate care review	No			Medium	Thurrock	Catherine Wilson	Roger Harris	Mark Tebbs		1. Scoping/ Opportunities
PR100011	BCF	Review of Carehome Pathways	Review of current provision for nursing and residential homes including: 1) Service capacity / alignment to nursing homes within each area; 2) Central register process implemented to identify all patients in nursing and residential homes; 3) Workforce planning / development; 4) Care Home Commissioning / Incentive management.	No			Medium	Thurrock					1. Scoping/ Opportunities
PR100012	BCF	End of Life	1) Increase uptake of GSF reviews and identification of patients in the last year of life; 2) Improved reporting to highlight decedent profile of each practice to highlight disparity in the identification of specific patient groups; 3) Review interface of new local Electronic Frailty Index and End of Life; 4) Application of GSF prognostic indicator for all NEL Admissions >65yrs; 5) Medicines Management – implementation of single primary care formulary and improved access to required meds; 6) One Response – entering first full financial year; 7) Fast Track Assessments & Provision – Devolved budget to ensure Fast Track packages are fulfilled in a community setting (where this is the patient's choice).	No			Medium	South West Essex	Philip Clark	Mark Tebbs	Alison Hall/Tania Stitch		2. Programming
PR100013	Transformation	15/16 Market Shaping & Development	1) to review options for procurement of integrated community, mental health, learning disability and social care services. 2) to decide and implement agreed approach to market management 3) to consider and refine the market position statement 4) to agree optimum commissioning structure to deliver integrated working	No	BB progressing with intentions around ICO model, meeting held with Attain re: procurement options, Essex wide procurement of LD services,		Full	South West Essex	Attain/Catherine Wilson				1. Scoping/ Opportunities
PR100014	Transformation	IM&T Strategy	1) To develop an integrated IM&T strategy	No	Care Track failed to deliver intended benefits, NELLIE being progressed by CCG, meeting with outside consultancy to understand potential opportunities.		Full	Thurrock	Rhodri Rowland	Roger Harris	Phillip Clark		1. Scoping/ Opportunities
PR100015	Transformation	Integrated Information & Advice	1) to refine QuickHeart to incorporate health information and advice 2) to develop a communication strategy to roll out our integrated health and social care information and advice online portal	No			Medium	Thurrock	Kelly Redlow	Catherine Wilson			2. Programming
PR100016	Transformation	Learning Disability Crisis Response		No									
PR100017	Transformation	Mental Health Service Redesign		No									

TOTAL

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15 June 2015	ITEM: 13
Thurrock Health and Wellbeing Board	
Joint Health and Wellbeing Strategy End of Year Report 2014 - 2015	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Sharon Grimmond, HWBB Business Manager, Thurrock Council	
Accountable Head of Service: Not applicable	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

This report provides the End of Year report against the 2014-15 Health and Wellbeing Strategy Delivery Plan.

The End of Year Report details progress against the 14/15 actions as provided by action owners.

The delivery plan for 15/16 will be presented to the Board in July. A full review of the existing Strategy, which expires in March 2016, has commenced.

1. Recommendation(s)

That the Board:

1.1 Agree the End of Year Report against the 2014 – 2015 Delivery Plan

2. Introduction and Background

2.1 The Joint Health and Wellbeing Strategy 2013 – 2016 was agreed by the Health and Wellbeing Board in January 2013, and the delivery plan covering the second year of the Strategy (2014-2015) was subsequently agreed in July 2014.

2.2 Throughout the year, the Board has received as part of meeting agendas, updates, decisions, and progress reports related to the deliverables contained

within the 2014-15 delivery plan. It was agreed at the September 2013 Board that there should be one mid-year progress report, followed by an end of year report. The Executive Committee also fulfils a key role in monitoring and highlighting any concerns in terms of performance.

2.3 Since the Strategy and second year delivery plan were agreed, the Better Care Fund Plan has been agreed and part 1 of the Care Act 2014 has come into operation. These are two significant changes within the health and (adult) social care sector – particularly in relation to integration across health and social care. When the delivery plan for 2015-16 is presented to the Board in July a number of references will be made to the Health and Social Care Transformation Programme and reflects much of the work that will take place. The Health and Wellbeing Board will continue to receive regular reports throughout the year concerning the Health and Social Care Transformation Programme.

2.4 It is important that the delivery plan always reflects the current status. The Plan may therefore be altered during the year to reflect key changes.

3. Issues, Options and Analysis of Options

3.1 ISSUES, OPTIONS AND ANALYSIS OF OPTIONS:

3.1 Updates have been received by action owners and are contained within the annual report for 2014-15. The Board are asked to agree to this report.

3.2 The15-16 delivery plan will be presented to the Board in July which will reflects actions that will take place to achieve the outcomes detailed within the Strategy. The delivery plan will be monitored by the Executive Committee and through reports received at the Health and Wellbeing Board. The Children's element of the plan will be further monitored through the Children and Young People's Strategic Partnership arrangements – the 14/15 end of year review and 15/16 delivery plan for Children and Young People will be brought jointly to the July Board.

4. Reasons for Recommendation

4.1 To ensure that the objectives within the Strategy are being met.

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

5.1 There has been no consultation on the annual report, but there has been engagement relating to many of the deliverables contained within the Strategy and delivery plan – e.g. Mental Health and Learning Disabilities Strategy, Primary Care Strategy, Housing Strategy, Public Health Strategy etc.

6. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

6.1 The Strategy and delivery plans contribute to both the Council's and CCG's priorities as stated in the Joint Strategic Needs Assessment (JSNA), Community Strategy and CCG's 2 year Operational Plan.

7. Implications

7.1 Financial

Implications verified by:

Mike Jones

Management Accountant

There are no financial implications.

7.2 Legal

Implications verified by:

Dawn Pelle

Adult Care Lawyer

There are no legal implications.

7.3 Diversity and Equality

Implications verified by:

Rebecca Price

Community Development Officer

The annual report has been prepared without consultation however there has been engagement relating to many of the deliverables contained within the Strategy and delivery plan (Need to note and update who has been engaged).

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):

- Joint Health and Wellbeing Strategy

9. Appendices to the report

- Appendix 1: Annual Report (Adults) 2014/15

Report Author:

Sharon Grimmond

HWBB Business Manager

Adults, Health and Commissioning

Appendix 1

Joint Health and Wellbeing Strategy
End of Year Delivery Plan 2014/15

Improve the Quality of Health and Social Care						
Objective	**Where do we want to be (3 year ambition)**	**Action 14/15**	**Lead**	**Deadline**	**Comments**	**RAG**
Improve the Quality of Primary Care	1. Primary Care services that are sustainable in to the future; 2. Providing consistent, accessible and good quality information and advice; 3. Good intelligence gathering systems; 4. Provision of consistent primary care delivery and quality; 5. Increased numbers of integrated care pathways and joint areas of work; 6. Individuals better able to manage their health conditions – in particular long-term conditions; 7. Adequate numbers of GPs in all areas of the Borough; 8. All GP practices score on or above the EoE average for patient satisfaction – including access; 9. Consistency of clinical quality – disease registers, diagnoses, immunisation, screening;	Finalise Primary Care Strategy "To continue to develop"	Mandy Ansell	On-going	As part of Thurrock's Primary Care Strategy, four 'extended access' GP hubs have been planned. The opening of the Hubs will be phased. The CCG has also been successful in accessing funding which will extend opening hours of the Hubs to increase access and capacity.	G
		Develop Primary Care Strategy Implementation Plans	Mandy Ansell	On-going	Primary Care capacity has been expanded through the delivery of 4 GP hubs with extended opening hours. One of the 4 GP hubs will open in April 15.	A
		Develop role of Accountable Professional (over 75s)	Mark Tebbs	Commence May 2014	Within 2014/15 NHS England published new guidance in which practices would need to identify a named lead for patients over the age of 75. In addition, Thurrock practices have established a Primary Care MDT review processes to support the identification and review of their complex patients and have a dedicated service for patients in crisis in the form of	G

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Joint Health and Wellbeing Strategy
End of Year Delivery Plan 2014/15

	10. Increased focus on early intervention; 11. Reduction in unplanned admissions; 12. GPs provided with greater options; 13. Access to good quality health care equitable – e.g. 'hard to reach'				RRAS. The Community Geriatrician also works to support those people over the age over 75.	
		Development of Primary Care Federation Model	Mark Tebbs	Commence May 2014	The development of the four GP Hubs acts as a catalyst for a federated model of care – including community care and the alignment of social care. Development of 2 federated models co-divides across SW Essex to date no provider activities has taken place. NB: Not the CCG's responsibility	A
		Develop 7-day access to services – including dental and pharmacy	Sara Lingard/ Mandy Ansell	Proposals to be developed by July 2014	The four GP hubs will provide extended opening hours across a 7 day period. This is through the CCG successfully securing additional funding to extend primary care opening hours – Prime Minister's Challenge Fund (PMCF). This would include Saturday and Sunday opening. Not successful on the PMCF.	A
		Identify Thurrock priorities for the Essex Primary Care Strategy	Mandy Ansell	July 2014	Through the continuation of the following: Primary Commissioning Recruitment estate, Increasing capacity.	A

Joint Health and Wellbeing Strategy
End of Year Delivery Plan 2014/15

		Undertake re-commissioning of Thurrock Health Centre and Walk-In Service	Mandy Ansell/ Sara Lingard	April – December 2014	A public consultation has been carried out on the future of the Walk-in Service. A decision about the future of the service will be made during 15/16. We are looking to develop joint health and Social Care hubs around GP hubs. Decision at the May 27th CCG Board.	**G**
		Implementation of QA framework for Primary Care – including local quality mark for general practice	Mandy Ansell	On-going	The CCG's Chief nurse is engaged in the CQC's visits to GP practices. Supports area team in the Care Quality Group. Increasing capacity Chief Nurse team to address this.	**A**
Improve the Quality of Secondary Care	14. Greater provision of secondary care services in a community setting; 15. Consistently meeting CQC standards of care; 16. Improving particular areas of concern related to the quality of care: • Paediatric Service; • Medicine Management; • Accident and Emergency; and • Mortality Data. 17. Innovative solutions to delivering savings whilst maintaining quality of care; 18. Improvements embedded	BTUH were rated 'good' by regulator CQC and taken out of 'special measures'. The action is to maintain focus on improvement – including review findings of CQC/Keogh Report, with further monitoring of any actions being taken through the Clinical Quality Review Group (attended by	Jane Foster-Taylor via Clinical Quality Review Group	Last review visit week commencing 16th March 2015	The CQC has revisited the Trust to review the action plan relating to medicines management, monitoring will continue into 2015-16. NB: Trust in significant financial deficit, a monitor review is underway.	**A**

Joint Health and Wellbeing Strategy
End of Year Delivery Plan 2014/15

	and sustained; 19. BTUH enjoys a good reputation from professionals and patients; and 20. Improved early warning systems.	Executive Nurse)				
		Special focus on cancer pathways (due to breach of 18 week target) – review pathways and develop action plan	Mandy Ansell	March 2015	A CCG Cancer recovery plan is in place that incorporates a 62 day target. Plan to be completed by Q2.	A
		Identify how A&E 4 hour wait can be maintained	Mandy Ansell	On-going	Thurrock is working closely with Basildon CCG to review work and identify efficiencies in BTUH.	A
		Full compliance of referral to treatment target (18 weeks) by end quarter 2	Mandy Ansell	October 2014	18 weeks modelled exemplar capacity compliance end of quarter 2.	A
Improve the Quality of Residential and Community Care	21. Provision of a diverse selection of residential and community care services available to residents; 22. Preventative services that are accessed in local communities and enable the individual to remain independent and manage their own care. 23. People remaining independent for longer and accessing public funded services much later – if at all. As part of this, supporting residents to take control of their care and support needs and assisting them to make	Continue to develop integrated approaches between health and social care – e.g. undertake joint monitoring visits as appropriate	Louise Brosnan Jane Foster-Taylor	Quarterly review against progress and action plans, last joint visit 3 March 2015	Joint visits are regularly arranged and monthly meetings are held to discuss any concerns with local provision.	A
		Work in partnership with providers to maintain the quality of care delivered	Louise Brosnan	On-going	We maintain regular partnership working with our providers. We currently have an excellent working relationship with them.	A
		Further development of skills-based work academy to encourage more people in to the care profession	Louise Brosnan	Roll out with all domiciliary care providers by March 15	No new starters participating in the skills-based work academy.	R

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	informed decisions; 24. Less demand for high-level public funded/commissioned services and those that do exist re-modelled to meet the needs of people with very high and complex levels of need; 25. No contractual default action being taken against providers as performance is of consistent satisfactory performance levels; 26. Well trained residential and community care workforce meeting the needs of the Thurrock community;	Implementation of Workforce Plan for Commissioned Services	Louise Brosnan	Consultation to be carried out July 14	New workforce charter has been signed by providers.	A
	27. Full use of support available to recruit, develop and retain the workforce – including National Minimum Data Set (NMDS-SC); 28. The recently published Winterbourne report will act as a prompt to ensure our contract compliance		Louise Brosnan	March 15	This is always discussed at the provider meetings, a good relationship with our Skills for Care Reps - who is always on hand to offer advice and guidance regarding NMD-SC.	
	processes are rigorous and fully implemented; 29. Vulnerable people, particularly those with Learning Disabilities and Autism, receive safe,		Louise Brosnan	March 15	Financial incentive had to be offered -as there is no capacity to provide this within the contract.	

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	appropriate high quality care; 30. service are local and people remain in their communities.					
Improve the Quality of Care across the whole system pathway	31. Effective monitoring of quality and strengthening of data sharing to ensure appropriate action taken – including across partners (e.g. via Quality Surveillance Group); 32. Rapid Response and Assessment Service with extended hours of provision to meet demand – this will be a priority for the joint reablement funding; 33. Stronger focus on telecare and telehealth solutions across health and social care, across children's and adults that manages conditions, keeps people safe, offers choice and control, and keeps more people in their own homes – this will be a priority for the joint reablement funding; 34. Skilled, effective and trained workforce able to respond to meet reablement needs of the community; and 35. All residents receive equitable and accessible care	Continued attendance at regional Quality Surveillance Group and information sharing meetings	Jane Foster-Taylor Louise Brosnan	Bi-monthly meetings attended, last meeting Feb 2015	These are always well attended by staff, monitoring is more robust than other councils in the region.	**G**
		Implementation of new Adult Safeguarding Board requirements (Care Act 2014)	Fran Leddra	March 15	Arrangements are in place and compliant with the Care Act 2014.	**G**
		Development of frailty pathway	Mark Tebbs	September 14	This work is being progressed by the Older People Strategy Group as part of the Better Care Fund. The Whole System Redesign network *(chaired by Catherine Wilson & Mark Tebbs)* established an Older People's Strategic Working Group in December to create a single strategic vision for Older People in Thurrock that encompasses all tiers of health, social care, voluntary sector and the wider community in Thurrock; spanning Health, Social,	**A**

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	services across health and social care, including those residents who are most vulnerable or at most risk of being excluded – e.g. learning disabled, transient communities.				Community and Voluntary sector agencies. A number of the recommendations made within the draft strategy have been embedded within service development intentions with providers to ensure these are implemented within 2015/16.	
		Improve the number of people recorded as 'end of life' and achieving place of death – including extending end of life pathway in to social care	Jane Foster-Taylor	March 15	NELFT community providers have an end of life CQUIN which is reviewed quarterly and has met the required milestones	**G**
		Delivery of 7-day access to services across health and social care	Mandy Ansell/Tania Sitch/ Sara Lingard	TBC	Hospital expanded to 7 days, Rapid Response 7 days. GP Hubs will include a 7 day a week service.	**A**
		Implementation of Rapid Response and Assessment Service review recommendations – including expanding RRAS to provide care for 72 hours	Tania Sitch	Throughout 14/15	Recommendations not currently implemented due to funding restrictions, yet the service does offer a 7 day a week service offer.	**R**

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		Increase interim bed capacity (via Collins House)	Tania Sitch	Bid for additional funding to support growth in capacity	Better Care Fund will fund 12 beds and funding has been increased to sustain what is in place. Short term – Need to review as part of social work review of intermediate care.	A
		The Health and Social Care Transformation Programme will in part focus on improving the quality of care across the whole system pathway. This work will be taken forward through the Programme's Whole System Redesign Project Group. The Group's focus during 14/15 will be to identify what will be reviewed, the review process, and commence reviews. It is unlikely that reviews will have been completed or implemented prior to March 15.	Ceri Armstrong	Throughout 14/15	Thurrock's Better Care Fund Plan was developed in 2014 and signed off in January 2015. The Plan outlines how joint health and adult social care monies will be used to deliver schemes that will assist with reducing the number of people being admitted to hospital. The schemes within the Plan will be reviewed and redesigned throughout 15/16. This work will take place in conjunction with the broader Health and Social Care Transformation agenda. Health, Mental Health and Social Care teams integrate where possible.	A

Appendix 1

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Strengthen the mental health and emotional wellbeing of people in Thurrock						
Objective	**Where do we want to be (3 year ambition)**	**Action 14/15**	**Lead**	**Deadline**	**Comments**	**RAG**
People have good mental health	New model of service developed that ensures the following outcomes: 36. People have good mental health 37. People with mental health problems recover 38. People with mental health problems have good physical health and people with physical health problems have good mental health; and 39. People with mental health	Work with the provider SEPT to embed the new model of working through the revised section 75 agreement	Catherine Wilson/ Mark Tebbs	Model to be implemented from 15th August	Section 75 agreement signed and implemented. New models of working now established. Initial response recovery and wellbeing teams.	G
People with mental health problems recover		Explore the option of commissioning a recovery college for Thurrock jointly between the CCG and Council	Catherine Wilson/ Mark Tebbs	Options explored by October 14	Recovery college to be commissioned 15/16 Service spec written.	G

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People with mental health problems achieve the best quality of life	42. Strategic leadership of a jointly agreed outcomes framework; 43. Informed by service user-needs at population and locality level; 44. Commissioning of service through best-value principles including integrating commissioning support resources and shared information; 45. Driving up performance and delivering improved mental health outcomes; 46. Commissioning which addresses the specific issues of age transition and LD/CAMHS/Substance Misuse	Support the implementation of personal health budgets to enable people to have much more choice and control.	Catherine Wilson / Jane Foster-Taylor	April 2015	Personal health budgets to be introduced initially for day opportunities within Mental Health (Mind Contract) Assessments of current service user's complete, start April 2015. Further project to establish integrated health and social care personal budgets – Steering Group to be established April 2015 to build on the Business Case.	A
	47. Commissioning which reduces fragmentation by age and allows for services to be delivered effectively to children and adults with complex needs;	Begin the redesign of commissioning to support an integrated health and social care whole system approach	Catherine Wilson	New model of commissioning by April 15	Restructure to deliver model of commissioning in Mental Health that integrate Health and Social Care. Memorandum of understanding in place to create virtual Mental Health commissioning team by April 2015 (will develop 15/16)	A
	48. Commissioning with workforce skills fit for the future – including enhanced business and market analysis skills, provider negotiating skills.	Mental health forum and partnership groups to be consulted and inform developments in whole system	Catherine Wilson	Embed process of engagement in service development and commissioning decisions by	Mental Health Service User Forum will be involved in the above work. Joint integrated commissioning 7 CCGs and 3 Local Authorities	G

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	49. Integrated commissioning for individuals through a jointly contracted assessment service or strengthened management of commissioning for individual care.	commissioning – including strength-based approaches		April 15		
	50. Improve our ability to provide alternatives that keep people from requiring acute-sector interventions – e.g. management of condition prior to an individual reaching crisis. This includes the increased ability to provide supported-living options and early intervention. 51. Dual Diagnosis services exist for those with severe and enduring mental health issues but a more comprehensive pathway is needed to include those with less intensive mental health needs. 52. All referrals including children and young people and families know where they can get support with whatever level of emotional wellbeing need they may have and understand the basic nature	Training and updating of commissioners' skill based to take place through 14/15 through a programme of events to support integration, reduce fragmentation, and increase market development skills. We will also focus this year on increasing the more locally-based individual skills to support service users to commission a local community-based response to need.	Catherine Wilson	Throughout the year – April 15	Workshops have been held to undertake development regarding a range of commissioning approaches. The focus was on strength based commissioning facilitating the resilience of a local community to respond to the needs of its citizen's. Strengthening links to the voluntary sector, building skills regarding the development of micro enterprises. Resulting from this work we have produced a Market Position Statement, a requirement of the Care Act 2014, this has been subject to full consultation and shared at providers events and has been very well received.	**A**

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	area (including specialist support). 53. Children, young people and families make positive health choices to support their emotional well being; 54. The delivery of these services contributes to the mental health and wellbeing of children and young people in schools and as a result supports their educational attainment and attendance. 55. Children and young people with both a learning disability and a mental health disorder have access to appropriate child and adolescent emotional wellbeing and mental health services. 56. All relevant professionals are fully trained in early identification of mental health issues and low emotional wellbeing, so that situations can be prevented from deterioration EWMH (previously CAMHS) procurement completed. Award of Contract due 1st May 2015.				From this two key pieces of work regarding developing a Shared Lives Scheme and a Community Catalyst approach to market development are to start shortly.	
		Work to begin on the mental health pathway for individuals with a range of mental health issues – to be supported by personal health budgets and the recovery college proposals	Catherine Wilson	Throughout the year – April 15	This work has begun and will develop with the new project.	A
		Examine how information, advice and guidance are made available locally for people.	Catherine Wilson	April 15	As part of meeting its Care Act requirements, the Council has launched an information and advice portal.	A
		Implementation of the CAMHS Strategy through the procurement of a new model of service to support the emotional	Paula McCullough	November 2015	Via the Children and Young People (C&YP) Emotional Wellbeing and Mental Health (EWMH) group, one provider has been appointed to deliver a new integrated tier 2 and tier 3 services and that the CYPP will	G

	New EWMH Service will commence 1st November 2015. The new service model, service specification and contract will ensure that the service delivered is fully integrated and delivered in partnership with other agencies and services including 3rd sector providers. The removal of tiers will reduce a bounce in the system. The contract will be robustly managed to ensure the best outcomes for Children and Young People and their families.	wellbeing of children and young people.	Paula McCullough	November 2015	review and refresh the Strategy.	

Improve our response to the frail elderly and people with dementia						
Objective	**Where do we want to be (3 year ambition)**	**Action 14/15**	**Lead**	**Deadline**	**Comments**	**RAG**

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Early diagnosis and support for people living with dementia	57. Encourage help-seeking and create a dementia-friendly community that knows how to help 58. Increase diagnosis rates through memory clinics (SEPT) 59. Development of an effective, trained and skilled workforce	Increase early recognition and onward referral for dementia – with achievement of national target	Irene Lewsey / Jane Hangata Irene Lewsey	Action plan in place by June 14 Achievement of target by September 14	There has been a year on year improvement in dementia diagnosis rates in Thurrock (41% in 2011 to 59% in 2015). We have made significant progress in our aim to make Thurrock a 'Dementia Friendly Community' – uniquely Council agreed a motion for Thurrock to become Dementia Friendly. In addition, Directors Board and local Councillors all attended a session to become a Dementia Friend. A large number of sessions have also been held for council staff. All social care staff attended comprehensive dementia awareness and advanced risk planning training to increase their understanding and enable them to respond to this growing need.	G
		Development of Dementia Action Alliance	Sarah Turner	Alzheimers Society worker in place July 14 Action Alliance	Alzheimer's Society worker had been appointed. Public Health received the bid regarding the dementia friend	R

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				developed by December 14	agenda. Joint work with Essex and Southend is being explored to develop Dementia Action Alliance.	
		Improve end of life awareness for social work staff, in particular with regard to dementia – staff to be given training to encourage people to plan early for end of life.	Bill Clayton / Sarah Turner	On-going throughout 14/15	Did not take place 14/15 Expected to commence 15/16 subject to available funds.	**R**
Make Thurrock a great place in which to grow older	**Continued delivery of Building Positive Futures Programme – as detailed below:**					

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	1. In response to these challenges, Thurrock Council has developed a vision for promoting the independence, health and wellbeing of older adults. 2. Building Positive Futures comprises three major elements which, combined will make Thurrock a great place in which to grow older: • Creating the communities that support health and well-being • Creating the homes and neighbourhoods that support independence (Les/Barbara Brownlee) • Creating the social care and health infrastructure to manage demand. 3. Thurrock in the future will consist of communities	Implementation of new service model for sheltered housing – to ensure consistency across the service offer.	Dermot Moloney	Proposals to be considered by Overview and Scrutiny July 14 – then further milestones to be confirmed dependent upon O&S comments	The new service model was approved and has since been introduced. This included a new management structure to ensure a consistent service for residents.	G
		Continued influence of developments to HAPPI standard An initial approach has already been made by a developer who is keen to incorporate the HAPPI standard in his proposed development design.	Les Billingham	Case by case basis and via Planning and Housing Advisory Group Meetings.	Homes being developed by the Housing Department in Tilbury (Calcutta Road) with HCA grant funding. Private development applied for planning permission for HAPPI Standard development in Chadwell St Mary.	G
		Establishment and development of Housing and Planning Advisory Group to provide advice on health and wellbeing issues relating to proposed new major development applications that are submitted to the Council.	Les Billingham	Applications to be influenced via monthly meetings of the Housing and Planning Advisory Group	Has continued to develop and is now linked to the Planning process for Purfleet new town centre. Links have been made with NHS Property Services team to develop bids around autism spectrum and dementia housing.	G

Joint Health and Wellbeing Strategy
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<table>
<tr><td></td><td rowspan="2">that support health and wellbeing – achieved through an Asset Based Community Development approach. The achievement of this approach will result in:
• More people live longer, healthy, independent lives – only requiring limited periods of intensive support
• More people live with compressed morbidity rates (i.e. living longer, free from disease/infirmity for a longer period);
• More people with dementia feel supported and secure in their own communities
4. Fewer people prematurely move into residential care in acute medical settings.</td><td>Completion of Derry Avenue Scheme</td><td>Les Billingham</td><td>Start date September 14
Completion date 61 weeks +/- 5 weeks</td><td>2nd Phase of Department of Health funded speciality housing.
Launched Feb 2015.
To establish a small project</td><td>A</td></tr>
<tr><td>Creating communities that support health and wellbeing</td><td>Local Area Coordination initiative to be expanded to ensure borough-wide coverage – four LACs already in place. Funding secured for recruitment of 5 more co-ordinators and a LAC manager.</td><td>Tania Sitch</td><td>September 14</td><td>14 months evaluation report – completed. LAC providing compelling evidence of success of the service, supporting a broad range of marginalised service users.
LACs have expanded to a total of 9 LACs.</td><td>G</td></tr>
</table>

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	5. Fewer people in old age report depression and loneliness; • Fewer people with dementia withdraw from everyday activities and outside contacts because they no longer feel confident. 6. Significantly changing the experience of residential care to one that supports service users to remain in control and encourages independence				Funded until 31st March 2016. Funding approved through the Better Care Fund. Thurrock has been featured as a prevention case study in guidance for Care Act Implementation.	
		Delivery of more Community Hubs (as part of Stronger Together Programme): Chadwell (opened May 14) Aveley and Tilbury Hubs in progress Along with recruitment of 2 community builders	Natalie Warren	On-going	Two Hubs are open (South Ockendon and Chadwell) and Tilbury and Stifford Clays should open 2015/16. Two community builders are in post in Chadwell St Mary and South Ockendon Progress on Hubs is ongoing.	G
		Ongoing training with social work team on how to apply strength-based approaches. Fieldwork restructure has led to early intervention and prevention with multi-disciplinary teams.	Les Billingham	Training sessions throughout 14/15	Cultural change training programme with social work teams is ongoing. Evidence that greater emphasis on strength based processes is when it is being applied in practice. Field work restructure completed move to locality base working – to facilitate greater integration with Primary Health	G

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					Hubs model.	
		Development of micro enterprises – small scale initiatives to help foster community connections by offering locally run services and activities for older and vulnerable people.	Catherine Wilson	Throughout 14/15	Strength based commissioning workshops held to develop commissioners' skills. Community Catalysts consulted regarding developing micro-enterprises and it is hoped that by 15/16 we can work alongside Community Catalyst. (Funding is required) Market Position Statement has been completed and well received, seeking to deliver a more varied offer to enable service user choice.	**A**
Creating the social care and health infrastructure to manage demand		This objective will be achieved through the development and delivery of the Health and Social Care Transformation Programme. The work of the Programme includes the following specific work streams: • Care Act Implementation; • Pooled Fund	Ceri Armstrong	Through the development of the Health and Social Care Transformation Programme	The Health and Social Care Transformation Programme has progressed throughout the year. This includes: • Delivery of arrangements to meet the requirements of part 1 of the Care Act; • Development and agreement of the Better Care Pooled Fund S75 Agreement;	**A**

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		Arrangements (Section 75 Agreement); • Whole System Redesign; and • Realising Short-Term Efficiencies. The Board will receive regular updates in relation to progress and decisions to be made as part of the Programme's governance arrangements. The key deliverables for 14/15 are as follows: • Delivery of Care Act requirements that come in to force from April 2015; • Identify size of pooled fund for 15/16 and programme of redesign work to be carried out during 15/16; • Establish Section 75 pooled fund agreement; • Identification of schemes for 15/16 as part of BCF; • Implement the results of service/provider			• Identification and delivery of short-term efficiencies.	

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		reviews during 14/15 to release necessary efficiencies/savings for 15/16				

Improve the physical health and well-being of people in Thurrock						
Objective	**Where do we want to be (3 year ambition)**	**Action 14/15**	**Lead**	**Deadline**	**Comments**	**RAG**
Reduce the prevalence of smoking in Thurrock	7. Preventing young people from starting smoking 8. A range of options to motivate and encourage current 9. smokers to stop – particularly in areas where smoking is most prevalent 10. Protect families and communities from the harm caused by smoking 11. Compliant with legislation around 'point of sale' ban and working with partners to eradicate counterfeit and illicit tobacco sale.	Expand the development of preventative programmes within the 14/15 service specification. Work with the provider to deliver a Peer-Led prevention programme (e.g. ASSIST) as described in NICE guidance.	Kevin Malone	August 14 March 2015	We are working with current provider NELFT to develop a revised model with a greater preventative focus for 15/16. Ongoing work to introduce appropriate evidence based programme within schools for Youth Provision (called QUIT)	G
		Review E-cigarettes in terms of Harm Reduction for smokers, summarising Thurrock's position following pilot scheme in partnership with ASH to develop a policy.	Kevin Malone	September14	Well attended multiagency workshop to discuss e-cigarettes. Recent harm reduction guidance (NICE) facilitated by ASH (Action on Smoking and Health). Successful adoption by the Council of amended smoke free policy Thurrock Council. Pilot - region working with ASH to incorporate e-cigarettes within smoke free policy.	G
		Develop an engagement communications plan for 14/15 to include all	Kevin Malone	September 14	• Very successful Stoptober Campaign engaging partners.	G

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		stakeholders – internal and external, GPs, Schools etc.			• Multiagency workshop with stakeholders delivered October 14 resulting in Tobacco Control Strategy within delivery plan to be presented at the June Health and Wellbeing Board.	
Reduce the prevalence of obesity in Thurrock	12. Halt the rise in adult and childhood obesity and promote a downward trend in obese adults and children by: • Empowering individuals to make healthy affordable choices • Delivering a 'whole systems approach' which is integrated across partnerships and departments – • Development of good practice – based on evidence of what work • Commissioning a variety of interventions to support individuals and communities to make better lifestyle • choices and to achieve a healthy weight	Develop a greater understanding of community needs across our local areas, offering more localised provisions at a community level by the development of pilot projects to inform the commissioning of a revised service model for children's and adult obesity in response to engagement with Healthy weight workshop of 2013.	Beth Capps	June – September 14 Dec 2014	A grant funding process was piloted with CVS from Dec 14 – for community wellbeing. Following consultation we have commissioned a number of smaller community projects through a Grant finding process for adults tier 1 + 2 and children – age 2-5 and 16-19 years to commence 1st April 15.	G
		Drive the strategic delivery plan from the healthy weight strategy including developing a pathway across tiers 1-4 linking in with partners (CCG etc)	Beth Capps	March 15	Ongoing monitoring of plan through work stream well attended by partners. Pathway development through new Healthy Weight contracts developing in partnership with the CCG.	A
		Deliver the 'Beat the Street' project to activate the community in thurrock	Beth Capps	Nov 2014	Delivered with a positive impact demonstrated significant increase in Physical measured	G

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	• Develop and promote a better sporting and leisure infrastructure which encourages and increase in physical activity	with a particular focus on children and the most inactive adults. Full evaluation and sustainability plan in place.			activity and active travel. Ongoing sustainability developing through Thurrock World 100 Project.	

Key: **RAG**

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Thurrock Council's Successes – Health and Wellbeing

Achievements for 14/15	What have we done
Thurrock's Primary Care Strategy	• One GP Hub opened in Corringham.
Creating communities that support health and wellbeing	• Successful delivery of Community Hubs (as part of Stronger Together Programme): Two Hubs are open (South Ockendon and Chadwell) and Tilbury and Stifford Clays opening in 2015/16. • Recruitment of 2 community builders • Deployment of 9 Local Area Co-ordinators providing clear evidence of improved outcomes, greater community connectedness and improved efficiency. • Introduction of Time Banking in Thurrock to stimulate volunteering and community support.
Strengthen the mental health and emotional wellbeing of people in Thurrock Mental Health	• Mental Health Service User Forum will be involved in the restructure to deliver a model of commissioning in Mental Health that integrates Health and Social Care. • Joint integrated commissioning involves 7 CCGs and 3 Local Authorities • A grant funding project for preventative MH and wellbeing is being piloted in partnership with Community Voluntary Service (CVS), this was set up and projects awarded during quarter 4 of 2014/15 and will be reviewed and evaluated in 2015/16.
Creating communities that support health and	• Market Position Statement has been completed and well received, seeking to deliver a more varied offer to enable service user choice.

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wellbeing	• Field work restructure completed move to locality base working – to facilitate greater integration with Primary Health Hubs model. • Training of Social Care Teams in strength-based approaches
Reduce the prevalence of obesity in Thurrock	• Healthy Weight Strategy – developed and monitored through the workstream including a strategic delivery plan. • Following extensive consultation and engagement we have commissioned a number of smaller community projects through a Grant finding process for adults tier 1 + 2 and children – age 2-5 and 16-19 years to commence 1st April 15. • Successfully delivered a new initiative 'Beat the Street' with a positive impact demonstrated in the significant increase in physical activity and active travel. • Sustainability around increasing Physical activity and embedding walking behaviour being developed through a new initiative 'Thurrock World 100 Project' which also looks to increase wellbeing and community cohesion. • A grant funding process was piloted with CVS from Dec 14 –for community wellbeing which has incorporated various projects and initiatives impacting on Healthy weight.
Reduce the prevalence of smoking in Thurrock	• Well attended multiagency workshop to discuss e-cigarettes. Recent harm reduction guidance (NICE) facilitated by ASH (Action on Smoking and Health).
Strengthen the mental health and emotional wellbeing of people in Thurrock	• The Seven CCGS, Essex County Council, Southend Council and Thurrock Council have worked closely to jointly re-commission integrated targeted and specialist emotional wellbeing and mental health services for children and young people. The procurement has been successfully completed. • A redesigned and comprehensive service model that integrates Tier 2 and Tier 3 services has been produced, based on the findings from needs assessment and consultation with young people, clinicians and stakeholders. An integrated approach will improve resilience and life chances and

	better support vulnerable children and young people.

15 June 2015	ITEM: 14
Health and Wellbeing Board	
Health and Wellbeing Board Development Session and Recommendations Report	
Wards and communities affected: All	**Key Decision:** Non- Key
Report of: Sharon Grimmond – HWBB Business Manager	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is Public	

Executive Summary

This report is being presented to the Health and Wellbeing Board (HWBB) following a development session held on 12th January 2015. An event report was produced on the findings and the actions, recommendations have been presented. This report aims to update the Board on the options and the recommendations agreed by the Health and Wellbeing Executive Committee on 20th March 2015.

1. Recommendation(s)

1.1 The Health and Wellbeing Board to approve and agree to the recommendations drawn from the report. (Appendix 2)

1.2 The Health and Wellbeing Board input into further developments and future progression of the Board.

2. Introduction and Background

2.1 A constitute of the Health and Wellbeing Board where an annual development session is organised to ensure that the Board are able to focus and review the direction of the Board, areas for improvement and how the Board as a committee can work together collectively.

2.2 The Development Session this year also included members from the Health and Wellbeing Executive Committee this was to make sure that both committees were able to review and evaluate the strategic priorities and address/focus on the direction of the Board.

Some of the recommendations produced from the development session have been achieved such as:

- Extending HWBB membership - a paper is being presented to extend the membership of the Board.
- Communications and engagement – a Task and Finish Group has been established.
- The Joint Health and Wellbeing Strategy (JHWBS) 2013-2016 is to approach its 3rd year where we are to work with the Task and Finish Group to refresh the JHWBS 2016-2019 this will also be produced at a stakeholders workshop in the near future, a timetable has been produced to map the milestones.

Some of the recommendations below have been reviewed in details and presented in Appendix 2:

- Review and revise the JHWBS (including the priorities are they still fit for purpose?)
- Consider how to measure effectiveness and impact of the Board
- Communications and Engagement Plan
- Review Membership and role of the Health and Wellbeing Board
- Public Stakeholders Event

3. Issues, Options and Analysis of Options

3.1 At the development session it was discussed that the HWBB should play a vital role and querying items within our JHWBS we will be in a position to tackle and raise issues promptly and efficiently.

An ‘item in focus’ has been introduced to the Board to ensure a more detailed review of key priories being undertaken by the Board

4. Reasons for Recommendation

4.1 To provide the Health and Wellbeing Board with an update on the development session held on 12th January 2015 and to note the recommendations that came out of the session.

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

5.1 The HWBB agreed to the development session and the recommendations within this report were endorsed by the HWBB Executive Committee on the 20th March 2015. From the development session a report was produced with actions and objectives.

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

6.1 The recommendation from the development session will assist to scope the structure of the Board, building on the HWBB priorities and the priorities within the JHWBS. A paper is to be presented to the Board on the JHWBS in July 2015.

7. Implications

7.1 Financial

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

There are no financial implications.

7.2 Legal

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

There are no legal implications.

7.3 Diversity and Equality

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

The purpose of this report is to update on the options and recommendations arising from a development session of the HWBB. Diversity and equality implications arising from the implementation of the recommendations and proposals contained in Appendix 2 will be considered separately where appropriate.

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):

None identified

9. Appendices to the report

- Appendix 1: Development Session Report 12th January 2015
- Appendix 2: Recommendations for the Health and Wellbeing Board

Report Author:
Sharon Grimmond
HWBB Business Manager
Adults, Health and Commissioning

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Summary of key themes and suggested actions from the Thurrock HWBB Development Workshop 12 January 2015

Appendix 1

Equipping Thurrock HWBB with the capability and capacity to fulfil its ambitions for Thurrock's residents - as contained within the JHWBS

Key themes	Suggested Actions
1. Prioritisation: Design and test a methodology for prioritisation of HWBB activities (saying 'No' as well as 'Yes')	Review the four central strategic themes - are they still our core criteria? Identify and test additional criteria for prioritisation
	Equip HWBB Members with the knowledge and confidence to make decisions on priorities (see Theme 4)
	Ensure we have access to the right expertise to help us decide our priorities – are the right partners in the room – i.e. pharmacy?'
	HWBB to be clear about roles and responsibilities for delivery of its priorities – roles of other committees and of the Exec
2. Extending HWBB membership Engaging new partners in the work of the Board	Invite/induct NHS Provider and Pharmacy representatives
3. Communications and engagement: Design a communications plan for the HWBB which promotes engagement, awareness, listening and acts as an exemplar for the promotion of increased personal responsibility	HWBB to set up a cycle of its meetings in venues around Thurrock and to design and test the way those sessions will be run
	Map current networks, and channels that HWBB can access as part of extending 'reach' for engagement and mobilisation
	Identify current and best practice methodologies for engagement and listening (Open Space, World Café, Social Media, Surveys, Citizen's Juries etc.) which can be used and promoted by HWBB
	Engage Council Members as champions of local Health and Wellbeing and as access points into local networks
4. HWBB performing collectively Building on our shared passion, experience and learning to develop how we work together collectively as a HWBB	Create and maintain a rolling annual forward plan for core agenda items that ensures we have a balanced and manageable agenda throughout the year
	Review how best to construct agenda items so that we can do the topic justice as a Board and make it interesting and engaging rather than be overwhelmed by the weight
	Provide clear and regular feedback to those drafting papers for the HWBB about what is expected and how papers can be improved to do justice to the topic and aid HWBB discussion
	Build into the agenda and the annual cycle opportunities for shared learning and development for HWBB members
5. Supporting the individual HWBB member Supporting the individual HWBB Members' contribution	Develop an induction process for all new and recently joined HWBB members that enables them to better understand the role of HWBB, the pattern of services in Thurrock and to build supportive relationships
6. Data The HWBB using and promoting the use of data more effectively to support priorities, decisions and track progress and outcomes	A core priority of the HWBB is to act as 'enabler' for better sharing of information for care delivery and service planning. As a result we will get better information
	Be clear what data the HWBB requires to support its priorities

In attendance

- Councillor Barbara Rice (Chair) - Portfolio Holder Adult Social Care and Health
- Councillor Joy Redsell - Opposition Group Representative
- Roger Harris - Director Adults, Health and Commissioning
- Len Green - Lay member CCG
- Mandy Ansell - Acting Interim Accountable Officer Thurrock CCG
- Carmel Littleton - Director of Children's Services
- Barbara Brownlee - Director of Housing
- Dr Anjan Bose - GP/ CCG
- Debbie Maynard - Head of Public Health
- Les Billingham - Head of Adult Social Care
- Ceri Armstrong – Strategy Officer, Adults, Health and Commissioning
- Sharon Grimmond – HWBB Business Manager

Note:

This is a one-page summary of the outputs from the HWBB workshop. Key themes and actions may need to be aligned with existing workstreams where they exist.

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TRUE WISDOM IS THE ART OF THE QUESTION

Thurrock Health and Wellbeing Board Development Session 12 January 2015

Session Report

Background

1. Thurrock Health and Wellbeing Board (HWBB) held an afternoon development session on 12 January 2015

2. The objectives of the session were described in the agenda as:
    - A development workshop to link our past performance and future priorities with our development needs as a Board.
    - Following the workshop the outputs are synthesised into a development priorities and plans

In attendance

3. The following were part of the workshop
    - Councillor Barbara Rice (Chair) - Portfolio Holder Adult Social Care and Health
    - Councillor Joy Redsell - Opposition Group Representative
    - Roger Harris - Director Adults, Health and Commissioning
    - Len Green - Lay member CCG
    - Mandy Ansell - Acting Interim Accountable Officer Thurrock CCG
    - Carmel Littleton - Director of Children's Services
    - Barbara Brownlee - Director of Housing
    - Dr Anjan Bose - GP/ CCG
    - Debbie Maynard - Head of Public Health
    - Les Billingham - Head of Adult Social Care
    - Ceri Armstrong – Strategy Officer, Adults, Health and Commissioning
    - Sharon Grimmond – HWBB Business Manager

Session structure

4. An introduction and challenge to the HWBB from Councillor Barbara Rice

5. 'Different Eyes Exercise' – asking small groups to consider how three different stakeholder groups would provide feedback to the HWBB on its performance to date (detailed outputs at Annex A).
    - Frail elderly
    - Children and Young People
    - Local Communities
6. An update from Debbie Maynard on the progress with the updating of the JSNA

7. Review in small groups of three key topic areas (detailed outputs at Annex B)

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a. Horizon Scanning
- How well do we look to the future and identify potential opportunities and challenges?
- How well do we prioritise and act on those priorities?
- How well do we ensure that we match our capacity and capability to those priorities?

b. Relationships and partnerships
- How well do we engage with and involve the key partners in planning, commissioning and delivering services in Thurrock? For example:
  - Safeguarding Children's Board
  - Children's Partnership Board
  - Clinical stakeholders
  - NHS Providers
- How well do we ensure that we match our capacity and capability to our ambitions?

c. Users and Community Voice
- How well do we engage with and capture the voice of the user, carer, patient and our communities?
- How well do we encourage and support personal and community responsibility – a two way partnership
- How well do we ensure that we match our capacity and capability to our ambitions?

8. A personal reflections and learning session for individuals (detailed outputs at Annex C).
- One thing my colleagues could do to help me realise my potential as a HWBB member in the coming year
- One thing I could do to improve my own contribution to the HWBB in the coming year

Key themes emerging from the session

9. Prior to the session the facilitator had calls with a number of the participants. Emerging from these calls were a number of questions which participants were asked to hold in their minds during the session and which were used to help frame the agenda. These are shown in the slide capture below.

Questions for the HWBB to keep in mind

We have made good progress in establishing the HWBB, setting our strategic agenda and creating a momentum for change

- How do we say no as well as yes?
  - How do we find space for on our own priorities and not be the default or 'just in case' place for everything else?
- How do we better balance NHS/Social Care operational priorities (such as BCF) with the priorities of our other partners and stakeholders?
- Do we feel that we are sufficiently challenging, constructive and robust in our debate rather than sitting in polite comfort zones?
- How do we provide space for and encourage a strong Public Health contribution?
- How do we have an adult to adult discussion with our communities about what they can do for themselves as well as what we are trying to do for them?
- Is there actually a direct cause and effect relationship between our priorities and achievement on the ground?

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10. Following the session we have reviewed the key development themes emerging from the three different sets of outputs. A single 'at a glance' summary sheet is provided at the start of this report using what is known as a 'Driver Diagram' structure.

11. Based on the outputs we have identified five key themes and a series of 'actions' or 'tasks' within each of the themes although there is inevitably some cross-over. It is for the HWBB and support team to take these themes and actions and align them with the current development plan. A number of these areas may already be under consideration.

12. The overarching HWBB development statement is framed as:

> ***Equipping Thurrock HWBB with the capability and capacity to fulfil its ambitions for Thurrock's residents as contained in the JHWBS (Joint Health and Wellbeing Strategy)***

13. The key themes and action statements emerging from the synthesis of outputs are:

1. Prioritisation - Design and test a methodology for prioritisation of HWBB activities (saying 'No' as well as 'Yes')

- Review the priorities within our JHWBS
- Review the four central strategic themes - are they still our core criteria? Identify and test additional criteria for Prioritisation
- Equip HWBB Members with the knowledge and confidence to make decisions on priorities (see Theme 4).
- Ensure we have access to the right expertise to help us decide our priorities – are the right partners in the room – i.e. pharmacy?'
  - Consider Board Membership
  - Provider / Pharmacist
- HWBB to be clear about roles and responsibilities for delivery of its priorities – roles of other committees and of the Exec – Review Terms of Reference of key sub groups – e.g. Exec Committee.

2. Extending HWBB membership - Engaging new partners in the work of the Board

- Invite/induct NHS Provider and Pharmacy representatives

3. Communications and engagement - Design a communications plan for the HWBB which promotes engagement, awareness, listening and acts as an exemplar for the promotion of increased personal responsibility

- HWBB to set up a cycle of its meetings in venues around Thurrock and to design and test the way those sessions will be run – Need to find a solution- How can this be achieved?
- Map current networks, and channels that HWBB can access as part of extending 'reach' for engagement and mobilisation – How to involve parts of the community at appropriate times to inform HWBB decisions.

- Identify current and best practice methodologies for engagement and listening (Open Space, World Café, Social Media, Surveys, Citizen's Juries etc.) which can be used and promoted by HWBB
- Engage Council Members as champions of local Health and Wellbeing and as access points into local networks
- Stakeholder Annual Event
- Develop a Communications and Engagement Plan

4. HWBB performing collectively - Building on our shared passion, experience and learning to develop how we work together collectively as a HWBB

- Create and maintain as early as possible a rolling annual forward plan to enable engagement for core agenda items that ensures we have a balanced and manageable agenda throughout the year to reflect chosen priorities
- Review how best to construct agenda items so that we can do the topic justice as a Board and make it interesting and engaging rather than be overwhelmed by the weight
- Provide clear and regular feedback to those drafting papers for the HWBB about what is expected and how papers can be improved to do justice to the topic and aid HWBB discussion
- Build into the agenda and the annual cycle opportunities for shared learning and development for HWBB members
- How we measure the impact of the Board regarding: improved outcomes

5. Supporting the individual HWBB member - Supporting the individual HWBB Members' contribution

- Develop an induction process for all new and recently joined HWBB members that enables them to better understand the role of HWBB, the pattern of services in Thurrock and to build supportive relationships
- Clarifying expectations of members of the HWBB

6. Data and intelligence – intelligence – led decision-making. The HWBB using and promoting the use of data more effectively to support priorities, decisions and track progress and outcomes

- A core priority of the HWBB is to act as 'enabler' for better sharing of information for care delivery and service planning. As a result we will get better information
- Be clear what data the HWBB requires to support its priorities and the development of priorities and decision making

Next steps

14. It is suggested that the HWBB:
    a. review this report,
    b. identify any omissions or changes it wishes to make,
    c. identify where existing work can be aligned with these development priorities,
    d. agree its development priorities based on the outputs from the session
    e. and review progress against the development objectives on a regular basis
    f. review progress with the personal development objectives (Annex C) in 6 months

Annex A

Different Eyes Exercise

Task Group 1 – Children and Young People

Through the eyes of Children and Young People and those that are their carers

How do we think the HWBB is doing in engaging with us? What do we think they are doing well and what would we suggest the HWBB might try to do differently next year?

HWBB Strategic Ambitions:

- Children and Young People: Every child has the best possible start in life
- Our Inequalities in health and well-being are reduced

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Through the eyes of Children and Young People

What do we expect of the HWBB – how would we know it was working well on our behalf?			
1. I'd expect to know what the HWBB is and what it is doing for me 2. How does it link in with my life? 3. What can it do for me?			
Raising your game as a HWBB			
What we think you do well – or at least shows promise – that you need to do more of?		What we think you need to do better, differently or stop doing entirely?	
• I didn't know it was you but… a. You've told us (kids) lots about healthy eating but my family do not know as much as me! b. I loved Beat the Street – why don't you do it again?		a. Tell us (and our families) more about what happens if we do not brush our teeth b. Ask us what we want to improve, maybe through the youth cabinet c. Don't patronise us, let young people talk to us about health	
What are the top four things we would suggest you need to do to improve the way you work for and with us?			
Have school nurse there at parent's evenings	Listen to us more	Tell us what we need to know in a way we understand it	Give us some incentives! Some fun!

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Appendix 1

Task Group 2 – Frail Elderly

Through the eyes of the Frail Elderly and those that are their carers

How do we think the HWBB is doing in engaging with us? What do we think they are doing well and what would we suggest the HWBB might try to do differently next year?

HWBB Strategic Ambitions:

- Frail Elderly: People stay healthy longer, adding years to life and life to years
- Our Inequalities in health and well-being are reduced

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Through the eyes of the frail elderly

What do we expect of the HWBB – how would we know it was working well on our behalf?

- Not aware of the HWBB. Critical so what – difference!
- Role of members? –raise awareness? Older people's parliament
- Role of HealthWatch?
- Use current forums – messages up to HWBB
- Intervening earlier – How? (MECC)

HWBB
Services – enablers
Communities
Individuals

Raising your game as a HWBB

What we think you do well – or at least shows promise – that you need to do more of?	What we think you need to do better, differently or stop doing entirely?
• Locality Focus • Partnerships with Providers – RAS, JT • Dementia Friendly – early days	• Community voice • Use members • Understanding how we intervene earlier • Role of GPs/Pharmacist • JSNA/Strategic Plan • How we could link Young People to the Elderly • Neighbours • Role of schools? • Dementia?

What are the top four things we would suggest you need to do to improve the way you work for and with us?

• Raise profile of Frail Elderly Members • Charter for Older People	• Pharmacist – to work with enablers – frail and elderly • Add Pharmacy representation to HWBB • Intervene earlier	• Young people – links with Frail Elderly – neighbourhoods • Pride • Reduce risky behaviours • Caring	• Dementia

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Appendix 1

Task Group 3 – Local Communities

Through the eyes of our local Communities

How do we think the HWBB is doing in engaging with us? What do we think they are doing well and what would we suggest the HWBB might try to do differently next year?

HWBB Strategic Ambitions:

- Communities: Communities are empowered to take responsibility for their own health and well-being
- Our Inequalities in health and well-being are reduced

Through the eyes of our communities

What do we expect of the HWBB – how would we know it was working well on our behalf?			
Successes • Influenced sheltered housing: health audit. As result interventions are being redesigned - a direct result of Public Health being in the Council and Director of Housing sitting on HWBB • Well Homes intervention for private housing • Early evidence of success i.e.: community resilience – e.g. Small Sparks • Communities feeling empowerment without needing support			
Raising your game as a HWBB			
What we think you do well – or at least shows promise – that you need to do more of?		**What we think you need to do better, differently or stop doing entirely?**	
• Broader membership – e.g. housing		• Data sharing and analysis • Evidence – can we measure • Remove distinction between 'health' and 'social care' • Fewer priorities – refocus our strategy	
What are the top four things we would suggest you need to do to improve the way you work for and with us?			
• Interdependencies between partners e.g. health problem = housing solution	• Recognise what are the questions/solutions we need to ask/solve as a whole system	• Data sharing/analysis incl. measurement to target	

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Annex B

Topic Review Session

Group 1 - Horizon scanning

- How well do we look to the future and identify potential opportunities and challenges?
- How well do we prioritise and act on those priorities?
- How well do we ensure that we match our capacity and capability to those priorities?

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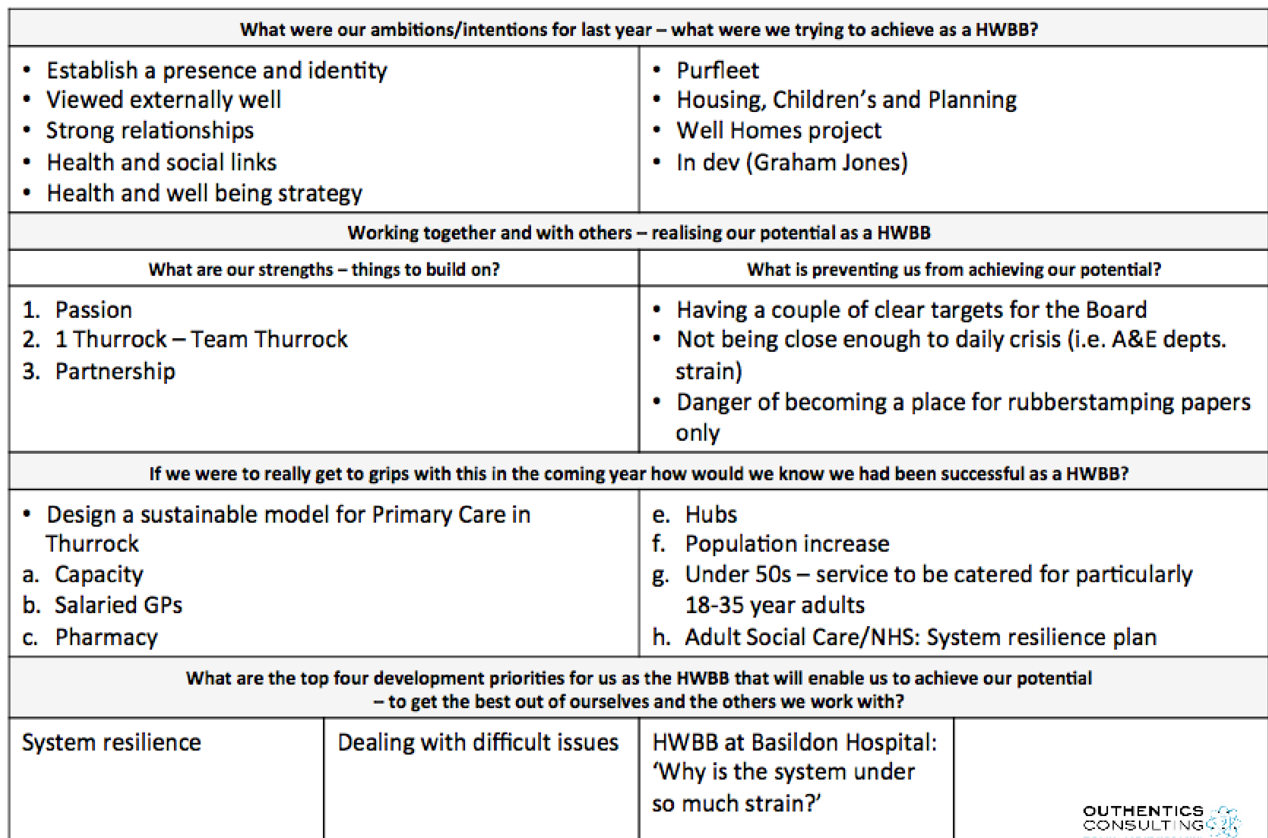

Group 1 - Horizon scanning

What were our ambitions/intentions for last year – what were we trying to achieve as a HWBB?	
• Establish a presence and identity • Viewed externally well • Strong relationships • Health and social links • Health and well being strategy	• Purfleet • Housing, Children's and Planning • Well Homes project • In dev (Graham Jones)
Working together and with others – realising our potential as a HWBB	
What are our strengths – things to build on?	**What is preventing us from achieving our potential?**
1. Passion 2. 1 Thurrock – Team Thurrock 3. Partnership	• Having a couple of clear targets for the Board • Not being close enough to daily crisis (i.e. A&E depts. strain) • Danger of becoming a place for rubberstamping papers only
If we were to really get to grips with this in the coming year how would we know we had been successful as a HWBB?	
• Design a sustainable model for Primary Care in Thurrock a. Capacity b. Salaried GPs c. Pharmacy	e. Hubs f. Population increase g. Under 50s – service to be catered for particularly 18-35 year adults h. Adult Social Care/NHS: System resilience plan

What are the top four development priorities for us as the HWBB that will enable us to achieve our potential – to get the best out of ourselves and the others we work with?			
System resilience	Dealing with difficult issues	HWBB at Basildon Hospital: 'Why is the system under so much strain?'	

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Group 2 - Relationships and partnerships

- How well do we engage with and involve the key partners in planning, commissioning and delivering services in Thurrock? For example:
  - Safeguarding Children's Board
  - Children's Partnership Board
  - Clinical stakeholders
  - NHS Providers
- How well do we ensure that we match our capacity and capability to our ambitions?

Group 2 - Relationships and partnerships

<table>
<tr><th colspan="4">What were our ambitions/intentions for last year – what were we trying to achieve as a HWBB?</th></tr>
<tr><td colspan="4">• Increasing/developing partnership working
• Build relationships and embed</td></tr>
<tr><th colspan="4">Working together and with others – realising our potential as a HWBB</th></tr>
<tr><th colspan="2">What are our strengths – things to build on?</th><th colspan="2">What is preventing us from achieving our potential?</th></tr>
<tr><td colspan="2">• Passionate board members and knowledgeable
• Closely working to agenda of council</td><td colspan="2">• Lack of engagement from certain partners/lack of consistency
• Raising the profile of the HWBB – why is the Board a priority, raising profile and holding to account
• Formal committee structure
• Complexity of papers
• Too big an agenda and expectations
• Engaging and influencing – Businesses; individuals and communities; Pharmacy; Schools; GPs</td></tr>
<tr><th colspan="4">If we were to really get to grips with this in the coming year how would we know we had been successful as a HWBB?</th></tr>
<tr><td colspan="2">• General public more aware of HWBB and how it links to their HWB
• Successful community engagement – beyond the 'usual suspects'</td><td colspan="2">• Resurrect 'Lets Talk' in the Community
• Figure out what we should measure
• Stakeholder engagement
• Review our strategic priorities – too many? Are they still right?</td></tr>
<tr><th colspan="4">What are the top four development priorities for us as the HWBB that will enable us to achieve our potential
– to get the best out of ourselves and the others we work with?</th></tr>
<tr><td>• Role of groups below HWBB in ensuring Board delivers its priorities/ objectives – eg review of role of Exec</td><td>• Roadshows to widen knowledge of HWBB</td><td>• Missing partners:
• Pharmacists
• Schools
• Businesses</td><td>• NHS England
• Lack of engagement from some Board Members
• Health providers - HWB
OUTHENTICS CONSULTING</td></tr>
</table>

Group 3 – User and community voice

- How well do we engage with and capture the voice of the user, carer, patient and our communities?
- How well do we encourage and support personal and community responsibility – a two way partnership
- How well do we ensure that we match our capacity and capability to our ambitions?

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Group 3 - User and community voice

What were our ambitions/intentions for last year – what were we trying to achieve as a HWBB?	
Building community cohesion	
Working together and with others – realising our potential as a HWBB	
What are our strengths – things to build on?	**What is preventing us from achieving our potential?**
• We have some good networks • We have some good special interest groups who inform practice: e.g. Thurrock Disability Network; TTSG (Transitions); Voices for Choices (Autism) • We have strong mental health user forums • CRG – Clinical Reference Group	• A limited number of voices are being heard e.g. same 20-30 people at each event • Hold the HWBB at different venues to encourage public engagement • Its still early days for some groups • Danger of groups just being a talking shop
If we were to really get to grips with this in the coming year how would we know we had been successful as a HWBB?	
• Listen to feedback, conduct surveys, collect data to check progress against ambitions • Visible and tangible evidence of the work of the HWBB around the Borough	

What are the top four development priorities for us as the HWBB that will enable us to achieve our potential – to get the best out of ourselves and the others we work with?			
• Taking the HWBB out to the community – using other venues	• Communication and PR must be a top priority	• Better engagement and consultation with the community	• Engage better with a broad range of council members

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Personal Development Reflections

Task as individuals

- One thing my colleagues could do to help me realise my potential as a HWBB member in the coming year.
- One thing I could do to improve my own contribution to the HWBB in the coming year
- One large post-it for each - clearly written please!

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Personal development reflections

One thing my colleagues could do to help me realise my potential as a HWBB member/participant/ officer in the coming year

- Think and act more on a day to day basis i.e. H&W Being/ So its not all about a committee more an ingrained ambition to improve Thurrock's health and well being (BR)
- Help me – get into the wider council machinery to spot opportunities (MA)
- More communication; more openness; more togetherness; more joined up in and out of the council (JR)
- Want to be able to have a richer discussion on problems and solutions. More breadth and depth (RH)
- Deepen my understanding of the health labyrinth (CL)
- I need to understand more about the health system – money flow, Responsibilities; even simple issues like geographic spread of GP surgeries/ Perhaps others could help if I arrange 1:1's for discussions and coffee (BB)
- Be part of and hold Roadshows/engagement events and attend public meetings. Ensure co-production and engagement is first priority (LG)
- Be prepared to take risks. System change will not happen in an environment that is too 'safe' (LB)
- Help me support to enhance projects with feedback (AB)
- To meet with each member to ensure there is clarity around the expectations on - to make sure 2015/16 is successful (DM)
- Forward plan – identify potential items for Board earlier (CA)

One thing I could do to improve my own contribution to the HWBB in the coming year

- Discuss with elected members re: elected member responsibility for ambitions and priorities (BR)
- Stop the treadmill – hamster wheel image (MA)
- Make sure that things come to fruition – to do my best (JR)
- 'Get out more'! Want to understand issues better from a community perspective, 3rd sector, user/carer groups community fora etc. (RH)
- Publicise the work of the HWBB further afield and bring more info onto the agenda (CL)
- Prioritise the Board more i.e. plan housing's involvement over the year; read papers and think about them and bring them to life in housing; go and visit public health colleagues (BB)
- Be part of roadshows and events; better focus on right events; continue with holding HWBB to account! Public Voice. (LG)
- Develop a greater understanding of every perspective (LB)
- Engage more with the Board and public to raise issues and get feedback (AB)
- To link with every member to agree jointly how we achieve priorities; understand governance and accountability clearer over next 12 months (DM)
- Try to understand what's on other people's agendas – e.g. their priorities and make any links (CA)

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Health and Wellbeing Board Development Plan – Recommended Actions

Appendix 2:

Theme	Recommended Actions	Executive Committee Response/Update
Prioritisation	• Consider forming a Strategy refresh task and finish group – reporting to the Executive Committee • Hold stakeholder workshop to review current priorities and objectives • Director of Children's Services and Director of Adults, Health and Commissioning to consider whether the Strategy should remain in two parts • Consider engagement approach as part of task and finish group remit • Board involvement in refresh process – e.g. via stakeholder event • Include review of priorities as part of the Board's development/away-day event • Development/refresh of set of Board member roles and expectations – to be agreed by the Board and included as part of its ToR • Partnership Protocol to be brought to the Executive as an agenda item – and then agreed by the Board • Undertake review of Executive Committee ToR alongside review of HWBB governance arrangements	• Establish Task and Finish Group to lead the refresh of the Health and Wellbeing Strategy (already established and in progress • Stakeholder (and public) workshop to be organised as part of Strategy refresh • Strategy to be divided in to two separate 'chapters' – adults and children – but will be refreshed jointly • Strategy Task and Finish Group to also consider engagement approach • Priorities to be agreed by the Board, and Board members to be part of stakeholder events. • Board away day to be organised for late 2015. • To be developed and agreed by the Executive. • In development – via Community Safety Partnership • To be part of HWBB away day in late 2015.

Extending HWBB membership	• Invite NHS Providers to become members of the Board • Invite CVS to become member of the Board • LPC invite as per agenda	• Paper on the Board agenda recommending that key NHS Providers and Thurrock CVS be given a seat on the Board.
Communications and engagement	• Establish a small task and finish group to consider how to improve communication and engagement with the public (production of communication and engagement plan) – to report back to the Executive. • Invite CVS to become a member of the Board	• Consider approach via liaison with HealthWatch – 'item in focus' part of this. • Recommended that CVS invited to be member of the Board.
HWBB performing collectively	• Earlier identification of items for the Board's forward plan • Revise agenda and forward plan to ensure it identifies items in focus • Agree to invite appropriate organisations/representatives as part of engagement • Papers to be signed off via the appropriate Board member prior to submission to HWBB business manager • Papers to be reviewed by the Chair prior to publishing • Development of a guidance note to be sent to report authors setting out expectations for the Board • As above – Board meetings to feature an 'item in focus'	• Board members to identify as early as possible • Item in focus to commence from June agenda – will also allow opportunities for engagement • As above – this will be part of the 'item in focus' • Part of sign off process • Meetings to take place with Chair prior to publication • Guidance note to be circulated alongside papers required

	• Schedule at least one Board development session per year	• Next session to be held towards end of 2015
Supporting the individual HWBB member	• Refresh of the induction pack • New members to have face to face briefing – suggested with Chair and certain board members	• Refreshed • Invite new members to have pre-meeting briefing
Data	• When developing/refreshing the HWBS, consider development of a scorecard (with small number of indicators) • Task and Finish Group developing the Strategy to consider the role of data/evidence in supporting priorities	• Task and Finish Group to consider as part of refresh of Health and Wellbeing Strategy

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15 June 2015	ITEM: 15
Health and Wellbeing Board	
Proposed Amendments to Thurrock's Health and Wellbeing Board Membership	
Wards and communities affected: None	**Key Decision:** Not applicable
Report of: Sharon Grimmond, HWBB Business Manager	
Accountable Head of Service: n/a	
Accountable Director: Roger Harris, Director of Adults, Health and Commissioning	
This report is public.	

Executive Summary

The Health and Wellbeing Board (HWBB) and Executive Committee took part in a Development Session on 12th January. The session concluded with a number of recommendations and actions which were subsequently presented to the Health and Wellbeing Executive Committee for discussion and agreement. This included a review of current membership and the proposal to invite key NHS Providers to become members of the Board. The Executive endorsed this recommendation and also recommended that the Council for Voluntary Services (CVS) be invited to become a member of the Board.

If agreed by the Board, additional members will include chief officer representation from:

- **North East London NHS Foundation Trust (NELFT)**
- **South Essex Partnership University NHS Foundation Trust (SEPT)**,
- **Basildon and Thurrock University Hospitals Foundation Trust (BTUH)**
- **Thurrock Council for Voluntary Services (CVS)**

1. Recommendation(s)

1.1 The Board agrees to NHS Providers NELFT, SEPT, and BTUH becoming members of the Health and Wellbeing Board subject to agreement at full Council on 22nd July.

The Board agrees to Thurrock CVS becoming a member of the Health and Wellbeing Board subject to agreement at full council on 22nd July.

2. Introduction and Background

2.1 As a committee of the Council, changes made to the Health and Wellbeing Board's membership have to be agreed by Council. The Health and Social Care Act 2012 states that the Board must be consulted about any proposed changes and that elected members must be nominated by the Leader of the Council.

2.2 At the Health and Wellbeing Board's away day held in January 2015, there was a recommendation that key NHS providers should become members of the Board. Upon reviewing this recommendation at the Health and Wellbeing Executive Committee, the Committee also recommended that Thurrock CVS be invited to become a member of the Board.

2.3 The Health and Wellbeing Board has a responsibility for influencing and setting the agenda across the whole system to improve health and wellbeing and reduce any inequalities in health and wellbeing within the local area. As part of this, Boards have responsibilities for encouraging integrated working and partnership arrangements for health and social care services – such as integrated provision and pooled budgets via the development of Better Care Fund Plans. As the agenda continues to evolve and as Boards continue to develop their system leadership role, it is difficult to see how comprehensive discussions and decisions about the future of the system governing health and wellbeing can take place without all partners – including NHS providers – being included.

2.4 A significant number of Boards (estimated one third October 2014 but now likely to be higher as a result of the agreement of Better Care Fund Plans) have already taken the step to include key NHS providers as full members. A recent letter from the current secretary of state (October 2014) for Health urged Boards who did not have providers as members to reconsider this position stating 'that where providers have been included as full members on Boards there have been clear advantages' and going on to say that Boards should 'at least consider current arrangements, and assure themselves that the right structures and relationships are in place'.

2.5 Health and Wellbeing Boards will continue to shape the system so that it not only responds effectively when people become ill and/or need a service, but so a greater number of people can be supported within their communities and by their communities – to prevent, reduce, and delay a decline in health and wellbeing or the need for a traditional service response. Due to the growing emphasis on the role communities play as part of the 'system', this paper also recommends that Thurrock CVS are invited to be a member of the Board.

2.6 As part of the review of the Board's membership, the Executive Committee also considered a request from the Local Pharmaceutical Committee to have a place on the Board, but recommended that the LPC be invited to attend as and when the agenda contained items appropriate to their input.

3. Issues, Options and Analysis of Options

3.1 As a result of the rationale set out in paragraphs 2.2 – 2.4, this paper recommends that the Board agree, subject to agreement by full Council, to key NHS providers NELFT, SEPT, and BTUH becoming members.

3.2 With reference to paragraph 2.5, this paper also recommends that, subject to agreement by full Council, Thurrock CVS be invited to become a member of the Board.

3.3 An alternative option would be to keep the Board's membership as it is currently, but this could potentially undermine the Board's ability to make and influence decisions concerning the whole system and its role as a system leader.

4. Reasons for Recommendation

4.1 To ensure that the Board is able to fully embrace its system leadership role and that all key partners are able to play a full and active role in influencing the future shape and direction of that system.

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

5.1 The recommendations within this report were endorsed by the Health and Wellbeing Executive Committee on the 20th March 2015 and followed discussions and recommendations subsequent to the Health and Wellbeing Board's away day in January 2015.

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

6.1 The Board has a significant role in contributing to the Community and Corporate priority 'improve health and wellbeing'.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Management Accountant

There are no financial implications.

7.2 Legal

Implications verified by: **Dawn Pelle**

Adult Care Lawyer

There are no legal implications.

7.3 **Diversity and Equality**

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

There are no diversity and equality implications.

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: Health and Wellbeing Board Terms of Reference

Report Author:

Sharon Grimmond
HWBB Business Manager
Adults, Health and Commissioning

Draft Terms of Reference

Key Strategic Aims of Thurrock Health and Wellbeing Board

Resourceful and resilient people in resourceful and resilient communities where:

- Every child has the best possible start in life;
- People make better lifestyle choices and take more responsibility for their Health and Wellbeing;
- People stay healthier longer, adding years to life and life to years; and
- The Health and Wellbeing of communities in Thurrock are more equal.

Purpose
- To improve health and reduce inequalities;
- To develop and facilitate the delivery of transitional arrangements to meet statutory requirements within the emerging health agenda; and
- To determine the health improvement priorities in Thurrock

Functions
- Identify and join up areas of commissioning across the NHS, social care, public health, and other services directly related to health and wellbeing and reducing health inequalities;
- Encourage and develop integrated working – for the purpose of advancing the Health and Wellbeing of and reducing health inequalities amongst Thurrock people;
- Oversee the on-going development and refresh of the Joint Strategic Needs Assessment (JSNA);
- Oversee the on-going development, refresh, and implementation of Thurrock's Joint Health and Wellbeing Strategy (JHWS) – ensuring that it provides an overarching framework for commissioning plans related to Health and Wellbeing and Health Inequalities;
- Sign-off key commissioning plans, strategy, and policy related to Health and Wellbeing;
- Oversee the development of the pharmaceutical needs assessment; and
- Performance manage the achievement of and progress against key outcomes identified within the JHWS and against key commissioning plans.

Membership
- Leader of the Council
- Portfolio Holder for Adult Social Care and Health
- Opposition Group Representative x 2
- Clinical Representative: Thurrock NHS Clinical Commissioning Group
- Chair of Thurrock NHS Clinical Commissioning Group
- Chief Operating Officer of Thurrock NHS Clinical Commissioning Group

- Portfolio Holder for Children's Social Care
- Chair of Local Safeguarding Children Board
- Chair of Safeguarding Adults Partnership Board
- Lay Member for Patient Participation: Thurrock NHS Clinical Commissioning Group
- Director of Adults, Health and Commissioning
- Director of Housing
- Director of Children's Services
- Director NHS England Essex Area Team
- Director of Commissioning NHS England Essex Area Team
- Director of Public Health
- Chief Operating Officer Healthwatch Thurrock
- Chair Thurrock Community Safety Partnership Board
- NHS Providers (NELFT, SEPT, BTUH)
- Council for Voluntary Services -Thurrock

In accordance with the Health and Social Care Act 2012:

- Elected members will be nominated by the Leader of the Council
- The Local Authority may nominate additional Board members in consultation with the Health and Wellbeing Board
- The Board may appoint additional members as it thinks appropriate

Chair arrangements

- Portfolio Holder for Adult Social Care and Health

Meeting Frequency

- The Board will meet a minimum of six times a year

Governance and Approach

- The Board will function at a strategic level, with priorities being delivered and key issues taken forward through existing partnership arrangements – which may at times include the establishment of task and finish groups
- Only a small number of permanent sub-groups will exist to support the work of the Board: Health and Wellbeing Executive Committee; and Joint Commissioning Board
- Decisions taken and work progressed will be subject to scrutiny by the Health and Wellbeing Overview and Scrutiny Committee – and other Overview and Scrutiny Committees as appropriate (nb Healthwatch has a scrutiny function)

Wider Engagement

- The Board will ensure that the decisions it makes and the priorities it sets take account of the needs of all of Thurrock's communities and groups – particularly those most in need
- The Board will ensure that stakeholders including providers are engaged, with a Health and Wellbeing Stakeholder Network established to assist with this purpose

- The Health and Wellbeing Board will host at least one Stakeholder Forum per year

The development of the Health and Wellbeing Board and its agenda is a dynamic process. As a result, the Board's Terms of Reference will be reviewed at least annually and altered to reflect changes as appropriate.

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15 June 2015	ITEM: 16
Thurrock Health and Wellbeing Board	
Bid to the Care and Support Specialised Housing Fund for housing for young people with autism	
Wards and communities affected: All	**Key Decision:** Key
Report of: Mandy Ansell, (Acting) Interim Accountable Officer, NHS Thurrock CCG and Roger Harris, Director of Adults, Health and Commissioning, Thurrock Council	
Accountable Head of Service: Not applicable	
Accountable Directors: As above	
This report is public	

Executive Summary

The Council bid successfully to Phase 1 of the Care and Support Specialised Housing Fund (CASSH Fund) in July 2013 and the resulting scheme for older people is now under construction at Derry Avenue, South Ockendon. The Department of Health, in association with the Homes and Communities Agency launched phase 2 of the Fund in February 2015. The prospectus for the Fund included an opportunity to bid for capital to develop specialised housing for people with autism.

This report provides details of the bid to the CASSH Fund submitted by Family Mosaic to develop a scheme for young people with autism in Grays. The proposed scheme, if the bid is successful, will provide housing for up to 6 local young people (18-25 years). The scheme will help deliver one of the objectives of the Autism Strategy.

1. Recommendation(s)

1.1 The Health and Well-Being Board is asked to note the terms of the bid to the Care and Support Specialised Housing Fund for housing for young people with autism, including the proposal for a capital contribution of £140,000 to be made from the Better Care Fund pooled fund.

2. Introduction and Background

2.1 The Care and Support Specialised Housing (CASSH) Fund was announced in July 2012 and Thurrock Council was successful in bidding for funding from Phase 1 in July 2013. The bid was for £1.327m of grant towards the cost of specialised housing (28 flats) for older people at Derry Avenue in South Ockendon. This scheme is now under construction and due for completion in November this year.

2.2 Phase 2 of the CASSH Fund was announced on 17th February with a bidding deadline of 29th May 2015.

2.3 This report provides further details about the proposal by Family Mosaic to develop specialised housing for young people with autism in Grays. The proposed scheme, which the Council and the CCG both support because it will help deliver the aims of the Autism Strategy, will enable people with autism to live independently in a safe and secure environment instead of hospital or residential care.

3. Issues, Options and Analysis of Options

Need

3.1 The draft Adult Autism Strategy 2014-2018 recognises that there is currently no long term residential or supported housing services for people with autism in Thurrock. This often results in people needing to move into specialist provision some distance away from their families and communities.

3.2 Exercising choice and control over where and with whom people live is a fundamental part of life and independence for most adults. Thurrock shares this vision and our aim is to support people with autism to live as independently as possible.

3.3 Accordingly Thurrock aims to:

- Support people to access mainstream housing where they can have a tailored package of support of their choosing using a personal budget
- Build on existing projects to enable people with autism to have access to housing projects that have suitable support with staff having specialist knowledge of Autism Spectrum Conditions
- Continue to encourage the development of a range of new and innovative housing options offering care and support
- Include the needs of people with autism in the housing strategy

3.4 The need for accommodation for young adults approaching transition from education to adult services is particularly acute. In the absence of suitable local housing options, most are forced to accept placements in residential care outside the Borough. This limits their choices and opportunities to retain and build connections with their friends, family and the wider community. Placement in residential care homes for older adults (aged 18-64 years) will also in some cases mean that the skills they have developed during their time

in education are not further developed as they may not have access to suitable programmes in those homes to maintain and further develop skills for independent living.

Design

3.5 Shortly after the prospectus for the CASSH Fund was issued the Council was approached by Family Mosaic seeking support for a proposal to redevelop a supported housing scheme they own and operate in Grays. The size and location of the site meant the development could help address the requirement in the Autism Strategy for new and innovative housing options for young people with autism.

3.6 Officers worked closely with Family Mosaic to develop the proposal which comprises:

- 6 self-contained units of accommodation for people with autism;
- access to a private outdoor space (patio/garden) for each unit
- Small lounge/common room for residents
- 1 unit of accommodation for use by the on-site care and support team.

3.7 The units will be fully wheelchair accessible and in addition the scheme will be designed in accordance with the following good practice guidance:

- Advance Full Spectrum Housing – Designing for adults with autism spectrum disorders
- Living in the community – Housing design for adults with autism

3.8 If the bid to the CASSH Fund is successful, a detailed design brief for the scheme will be developed in consultation with a range of stakeholders including service users and carers.

Costs

3.9 The design standards adopted for the scheme mean that the scheme will be very high cost and a significant amount of grant from the CASSH Fund has been requested. In order to make the bid more competitive, the Council and the CCG have agreed to make a capital contribution of £140,000 to be financed from the Social Care Capital Grant received from the Department of Health (which is currently held within the Better Care Fund Pooled Fund). Family Mosaic will make a capital contribution of nearly £250,000 to the scheme.

3.10 Family Mosaic expect that the tenants' housing costs (rent, service charges and an element of intensive housing management) will be met by Housing Benefit.

3.11 The costs of the on-site care and support service provided by Family Mosaic will by £421.08 per tenant per week. Family Mosaic proposes that the tenants should fund this service using part of their personal budget.

Operation

3.12 In recognition of the Council's support for the scheme Family Mosaic have agreed to provide the Council 100% nominations rights to the accommodation. The procedures and time scales for nominations will be set out in an agreement between the Council and Family Mosaic.

3.13 It is assumed that the level of need to be met in the scheme will require a staffing presence 24 hours each day, and may require both waking and sleeping night cover. However, it is anticipated that the autism friendly design will positively affect the abilities and sensitivities of the tenants. That, together with the focus in the scheme on developing skills for independent living, will serve to reduce dependence on services, and so the costs of those services, over time.

4. Reasons for Recommendation

4.1 The bid for CASSH Fund resources to develop a scheme for young people with autism requires the support of both the CCG and the Council. The bidding deadline meant that it was not possible to seek the support of the Health and Well-Being Board prior to submission by noon on Friday 29 May 2015. However, the Chair was able to send a letter of support immediately after being reappointed on 27 May.

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

The deadline for this bid has made it difficult to hold a specific consultation although the Autism Action Group have been informed about the proposals and have agreed to support the bid. If the bid is successful, detailed consultation about the design and model of service will be undertaken.

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

6.1 As noted above the scheme will help deliver one of the objectives of the Autism Strategy, in particular: "Continue to encourage the development of a range of new and innovative housing options offering care and support."

7. Implications

7.1 Financial

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

The financial implications of this proposal are as set out in the report.

7.2 Legal

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

Legal Services have provided advice on the terms of the support the Council can provide to Family Mosaic in taking forward this scheme. Further advice on the terms of the agreement between the Council regarding the proposed capital contribution of £140,000, as well as the Nominations Agreement, will be required to ensure compliance with the procurement directive and EU state aid criteria.

7.3 **Diversity and Equality**

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

If the proposed bid is successful, Council will work closely with Family Mosaic to ensure the development is undertaken with due regard to equality and diversity considerations and, in particular, to ensure that any third party partners and contractors involved in the final scheme will follow the Council's Equality Codes of Practice and will deliver social value including through training and apprenticeships.

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

None identified at this time.

8. Background papers used in preparing the report

The Care and Support Specialised Housing Fund: phase 2 prospectus:
https://www.gov.uk/government/publications/care-and-support-specialised-housing-fund-phase-2-prospectus

9. Appendices to the report

None

Report Author:
Christopher Smith
Programme Manager,
Adults, Health and Commissioning

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Health and Wellbeing Board Forward Plan

Date	Agenda	Lead
16/07/15	• **Item in Focus 'BTUH'** • **Autism Strategy** • **Market Position Statement** • **Healthwatch Annual Report** • **Health and Transformation Report** • **Joint Commissioning Statement Special Educational Needs Report** • **CCG Update**	Claire Panniker Alison Hall Catherine Wilson Kim James Ceri Armstrong Malcolm Taylor Mandy Ansell
10/09/15	• **Health and Social Care Learning Disability Self-Assessment**	Kelly Jenkins
12/11/15	• **Update Thurrock 100 Project** • **Progress new Weight Management Programmes**	Beth Capps/ Sue Bradish Beth Capps/ Sue Bradish
14/01/16		
10/03/16		

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